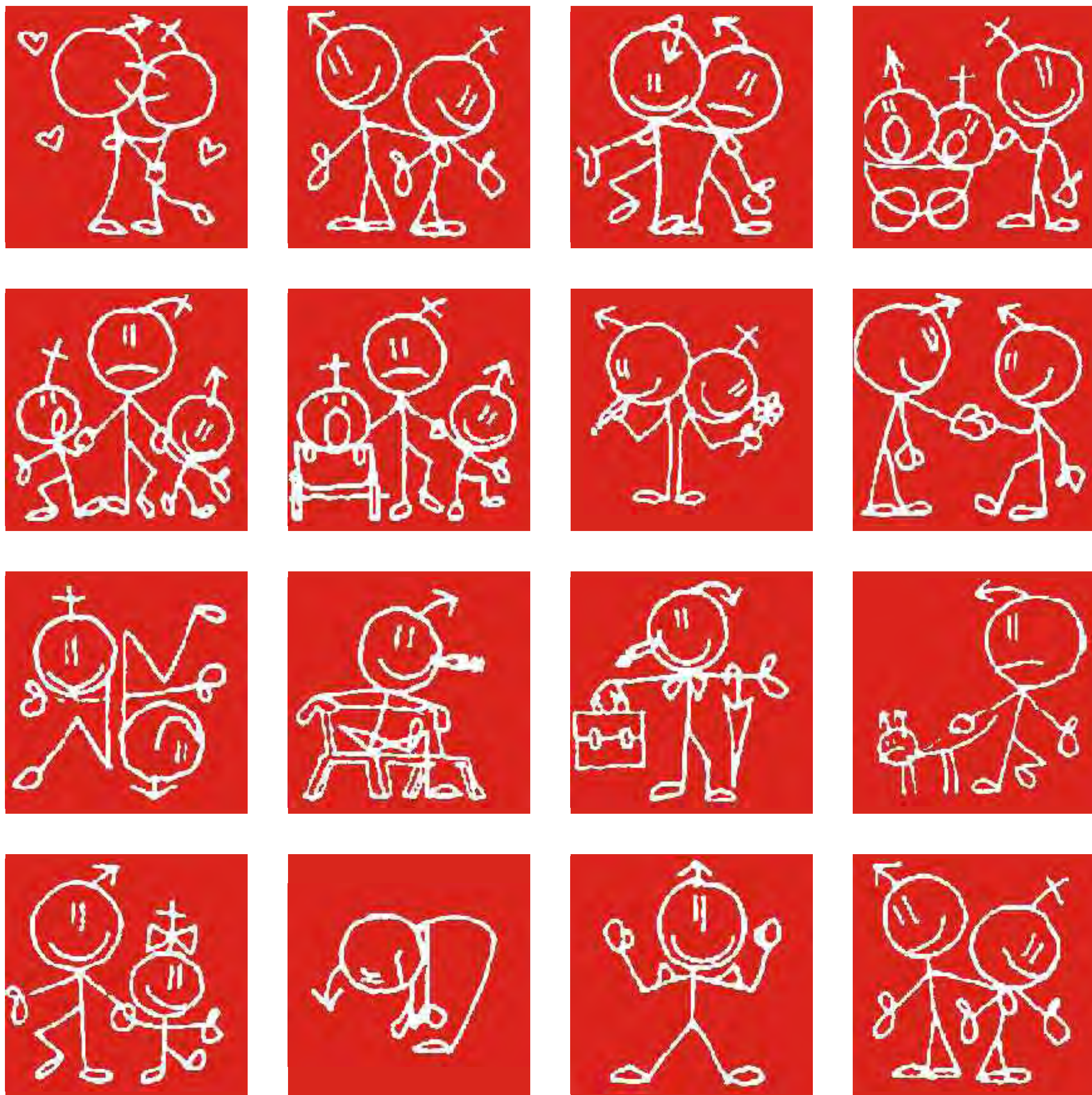
# Pre- and post- HIV test COUNSELLING



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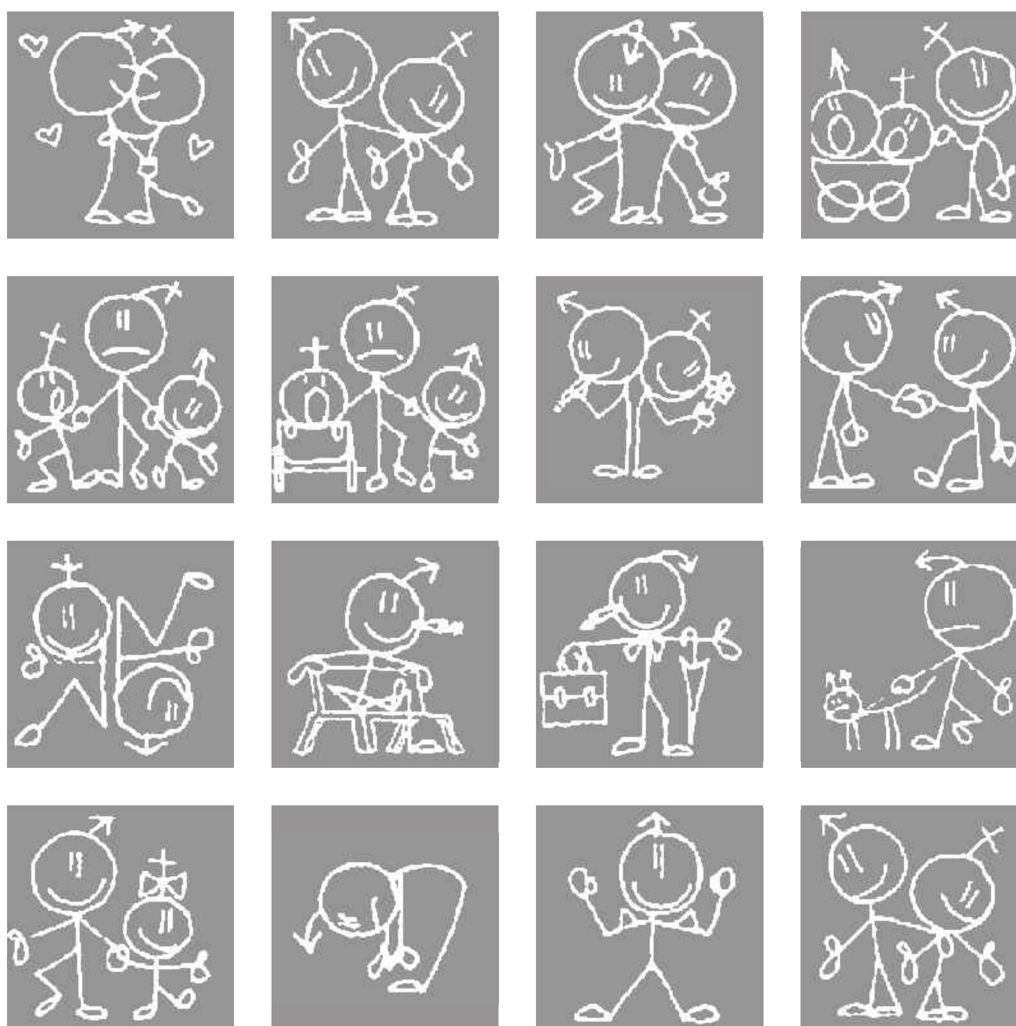
# Pre- and post- HIV test COUNSELLING



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JSI R&T

2006

Author:
Liana Velica
Collaborators:
Galina Musat, Mihaela Blejan, Costin Militaru

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ARAS – Romanian Association Againts AIDS
Bd. Garii Obor nr. 23, et. 2, ap. 8, sect. 2
Bucuresti, Romania
www.arasnet.ro;e-mail: aras@arasnet.ro
and
JSI Research & Training Institute, Inc.
44 Farnsworth Street
Boston, MA 02210-1211, U.S.A
www.jsi.com/romania; Email: office@jsi.ro

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I. Asociaţia Română Anti-SIDA (Bucureşti)

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# ARAS – the Romanian Association Against AIDS

ARAS is a non-governmental, apolitical, voluntary based organisation whose mission is to inform and educate all population categories on the danger represented by HIV/AIDS, with a special stress on human rights protection. ARAS was founded in Bucharest, in April 1992, by a group of young persons, mostly students, who considered that HIV/AIDS prevention was given too little attention in Romania.

Ever since, ARAS has developed a network of 10 branches: Bucharest, Arad, Bacău, Braşov, Constanța, Craiova, Cluj-Napoca, Iaşi, Piatra-Neamþ, Timişoara and has become a member or an initiator of several partnerships with national and international networks. Its main programs are:

## HIV/AIDS prevention

- Behavioural change by communication (information/education for HIV prevention, public campaigns):
  - information/education for pupils in schools and high-schools, children and teenagers living in placement centres or day care centres, by innovative methods, based on art: education by drama, concerts, media campaigns, web site, Names Project, Candlelight Memorial
  - design and production of information/education materials for different target groups
- AIDS HelpLine – information and counseling on HIV/AIDS and STIs (national, free of charge call)
- Outreach activities for vulnerable, hard to reach groups: commercial sex workers, homeless, Roma, injecting drug users, persons with physical disabilities
- Training for specialists (doctors, nurses, teachers, educators, etc), for peers, for ARAS staff and volunteers: education for HIV/STIs prevention, pre and post HIV test counseling
- Voluntary Counseling and Testing Centres, operated in partnership with the Directorates for Public Health in 3 districts

## Social services:

- Social, psychological and material assistance for persons affected by HIV/AIDS and their families
- Self support groups for persons affected by HIV/AIDS
- Community awareness on the rights and special needs of persons living with HIV/AIDS, in order to create a protective environment and to facilitate their integration
- Day care centre for children and teenagers living with HIV/AIDS
- Self-financing dentistry unit, opened for the general public (including persons living with HIV/AIDS, vulnerable groups), best practice model in HIV/AIDS prevention, by applying universal precautions

## *Advocacy* for:

- Human rights (non-discriminatory access to medical services, education, social assistance, for all groups of population, including vulnerable groups)
- An updated, realistic, evidence based reaction of the Romanian society to HIV/AIDS (coordinated implementation of the national AIDS strategy both at national and local levels).

## JSI Research and Training Institute, Inc.

It is an international public health management consulting firm with headquarters in Boston, United States, and more than 60 offices worldwide. The mission of JSI is to improve the quality and accessibility of medical services around the world. Its purpose is to develop and implement improved management systems and to increase the organizational efficiency and efficacy.

Since 1978, JSI has responded to pressing public health issues in the United States, and in 84 countries around the world, developing more than 300 projects and managing 324 million USD in international contracts. JSI has done this by identifying and applying innovative solutions and by providing technical support for the development of governmental and non-governmental institutions and organizations.

In all activities, JSI collaborates with local institutions, including community organizations and governmental ministries, and with international organizations.

JSI's multidisciplinary, international staff of over 400 specialists has proven its capacity to manage an extensive array of long-term, multinational and country-specific programs.

JSI contributes to the improvement of the health of individuals and communities worldwide by:

- Developing medical care systems for children, particularly in the areas of diarrheal disease control, oral rehydration therapy, immunization of pregnant women and children, control of acute respiratory infections, and prevention and treatment of malnutrition.
- Designing and implementing accessible, high quality reproductive health programs.
- Developing comprehensive maternal health projects, encompassing prenatal and postnatal care, nutrition, family planning, breastfeeding, and the prevention and treatment of AIDS and other sexually transmitted diseases.
- Developing the private sector's capacity to provide family planning and primary care health services.
- Designing and implementing coherent logistic systems, necessary to ensure efficiency of public health programs.

**Romanian Family Health Initiative (RFHI)** was formed by the signing of Partnership Convention between the United States Agency for International Development (USAID), Romanian Government and JSI Research & Training Institute, Inc. and its partners in November 2001. This partnership is working to increase access to and use of reproductive health (RH) services across Romania, and to expand the availability of these services at the primary health care level. To this end, RFHI supports the Ministry of Health and a number of NGOs in capacity building efforts to improve the effectiveness of family planning, pre and post-natal care, breast and cervical cancer, and HIV/AIDS/STI services for underserved populations. The objectives of this Initiative are to increase access to high quality client-oriented services, encourage the implementation of policies and regulations to promote reproductive health initiatives, mobilize resources toward primary health care and prevention, and increase population awareness about, and community mobilization in, all issues related to reproductive health.

Key approaches used by the Initiative to achieve these objectives include:

1. The integration of reproductive health services (family planning, pre- and postnatal care, breast and cancer cervical screening, sexually transmitted diseases including HIV/AIDS and domestic violence) into the primary health care system.
2. The development of an effective network of, and referral system for, reproductive health services.
3. Promotion of the reproductive health services among the Romanian population.

Some of the key anticipated results of the Initiative include:

- A reduction in the maternal and infant mortality rate, the number of abortions and the incidence of HIV/AIDS and other STIs;
- Increased awareness among the population about the importance and availability of reproductive health services, the screening for cervical and breast cancer and the prevention of HIV/AIDS and other sexually transmitted infections;
- An increase in the number of service delivery points offering basic reproductive health services;
- An increased rate of modern contraceptive method use by the Romanian population.
- An increase in screening for breast and cervical cancer.
- An improvement in services provided to victims of domestic violence.

## Acknowledgements

The *Pre- and Post-test Counselling* manual is based not only on the author's efforts and experience, but also on that of:

- Alina Bocai, psycho-educator, who, together with the undersigned, took part in the first pre- and post-test counselling course held by ARAS in 2000;
- All the counsellors of the ARAS counselling and testing centres, who played great parts in the manual's development;
- ARAS colleagues: Galina Muşat, Maria Georgescu, Monica Dan and Cătălina Iliuță, who have been a real help, in debates and advice, in creating our own counselling services, drawing up the courses and establishing working procedures;
- Dr. Florin Popovici, who supported us in developing the necessary instruments for counselling (fiches, database);
- Infectious disease hospital physicians, especially Dr. Sorin Petrea, who provided technical assistance for all activities;
- Public Health Authorities (Romanian DSP) in Bucharest, Constanța and Iaşi, who stood by our side as partners from the very beginning of the pre- and post-test counselling programme;
- The Institute of Professional Training for Physicians and Pharmacologists (Romanian IPMF)[1], which understood, as early as 2000, the importance of training health care professionals in pre- and post-test counselling;

And last, but not least:

- The clients of the HIV counselling and testing centres, as well as the participants in the HIV counselling courses, who helped us see the way in which services and the course *curriculum* should look.
- The United States Agency for International Development (USAID) and JSI Research & Training Institute, Inc., which offered us financial and technical support in developing the voluntary HIV counselling and testing programmes;
- University Professor Dr. Emilian Dobrescu, who provided useful editing remarks for the manual.


## Suggestions/Advice

To get the most from this manual, one must have read *HIV Test Counselling*, by Dr. Adrian Streinu-Cercel and Dr. Sorin Petrea and edited by the Romanian Angel Appeal. This work is available online at www.raa.ro and www.hivability.ro. It contains important medical information on HIV and testing procedures.

In order to develop practical skills in counselling, it is recommended that you participate in specialized workshops accredited by the Institute of Professional Training for Physicians and Pharmacologists and organized by ARAS.

Trainees will be rewarded with continuous education points (www.arasnet.ro).

[1] Currently the National Professional Training Centre for Physicians, Pharmacologists, Nurses and other medical staff.

# Acronyms

AIDS – Acquired Immunodeficiency Syndrome

ARAS – Romanian abbreviation for the Romanian Association Against AIDS

CDC – Centres for Disease Control and Prevention Atlanta (Georgia, USA)

CNPMFAM – Romanian abbreviation for the National Professional Training Centre for Physicians, Pharmacologists, Nurses and other medical staff

CNLAS – Romanian abbreviation for the National Committee for the Fight Against AIDS

DSP – Romanian for Public health authority

ELISA – *Enzyme-Linked Immuno-Sorbent Assay* (laboratory technique used to detect HIV antibodies during seroconversion and also used in diagnosing hepatitis, etc.)

HBV –hepatitis B virus

HCV –hepatitis C virus

HIV – Human Immunodeficiency Virus

IDU –intravenous drug userCSW – commercial sex worker (persons accepting money for sex)

IPMF – Romanian abbreviation for the Institute of Professional Training for Physicians and Pharmacologists

JSI – John Snow Research & Training Institute, Inc.

MOH – Ministry of Health

NGO – nongovernmental organization

RAA – Romanian Angel Appeal

STI –sexually transmitted infections; sometimes also STD (sexually transmitted diseases)

TB – tuberculosis

TPHA – *Treponema Pallidum* HemAglutination (diagnosis method in syphilis serology)

Trans. –persons [RTF annotation: }This is unclear receiving transfusions[RTF annotation: }Verify this

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNOPA – Romanian abbreviation for the National Union of Organizations of Persons affected by HIV/AIDS

USAID – United States Agency for International Development

VCT – voluntary HIV counselling and testing

VCTC – voluntary counselling and testing centre

VDRL – *Veneral Disease Research Laboratory,* diagnosis method for the syphilis serology

WHO – World Health Organization

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# Foreword

The "Pre and post HIV test counseling" represents a general, integrative framework including internationally accepted principles in the field of general counseling (concepts, theories, techniques, practices) and also of HIV pre and post test counseling.

The authors generously share their experience with their present and future colleagues, and make this manual a work tool necessary for each of us.

We appreciate the content and structure of the manual, the approach of such a sensitive topic and the success in producing a material that can be considered a reference in the field.

It is with great pleasure that we favourably acknowledge the above-mentioned manual and, on behalf of all the members of the National Commission of Fight

Against AIDS (CNLAS) of the Ministry of Health, we congratulate the editing team.

**Prof. Dr. Adrian Streinu Cercel,**
**Co-president CNLAS**

**Dr. Sorin Petrea**
**Programme Coordinator CNLAS**

# Introduction

Many countries consider voluntary HIV testing, accompanied by counselling, as a priority public health intervention for preventing HIV transmission. For those who turn to counselling, it raises awareness about risks and motivates behavior change to reduce health risks; for those who take advantage of testing services, it provides an informed diagnosis and access to care services.

The *UNAIDS/WHO Policy Statement on HIV Testing* states that:

Voluntary testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits.

The following key factors, which are mutually reinforcing, should be addressed simultaneously:

- ensure an ethical process in conducting the testing, including a defined purpose of the test and the benefits to the individuals being tested;
- assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;
- address the implications of a positive test result, including nondiscrimination and access to sustainable treatment and care for people who test positive;
- reduce HIV/AIDS-related stigma and discrimination at all levels, notably within health care settings; ensuring a supportive legal and policy framework within which the response is scaled up, including safeguarding the human rights of people seeking services;
- ensure that the health care infrastructure is adequate to address the above issues and that there are sufficient trained staff in the face of increased demand for testing, treatment and related services. [2]

Pre- and post-test counselling was instituted in Romania in 1998,[3] and it was put into practice by counsellors from nongovernmental organizations (ARAS, RAA), as well as some physicians and nurses, beginning in 1999. Their counselling activities can act as examples and may in turn be scaled up and put in practice by all institutions that recommend or effectively carry out HIV testing. It is understood that the first step in accomplishing this is to inform and train professionals. So far, very few persons among those who recommend testing or announce the result of the test have had the chance to attend an HIV counselling course or have information on the standards and

2 UNAIDS Global Reference Group on HIV/AIDS and Human Rights – *UNAIDS/WHO Policy Statement on HIV Testing,* Geneva, Switzerland, June 2004.

3 Order of the Minister of Health no. 889/1998, of updating the Order of the Minister of Health no. 912/1992 regarding the set up of a system for declaring the HIV infection and the approval of a methodology for its implementation; see the entire text in Annex V.

working protocols recommended at the international level. We hope that this manual will provide basic training in pre- and post-test counselling and that those interested in deepening their knowledge and developing their skills in this field will seek more detailed training (workshops, courses, other books, and the internet).

This book is based on the five years of experience acquired by ARAS counsellors. During this time, they have provided pre- and post-test counselling services in the HIV counselling and testing centres in Bucharest, Constanța and Iaşi. These centres were opened on the basis of partnerships between the district public health authorities (DSP) and local ARAS branch offices. It is notable that the activities of these centres benefited from support from both other programmes developed by the DSP and the ARAS programmes for *persons from groups vulnerable to HIV infection*[4] (such as those involved in commercial sex, drug users, street children) or from social assistance programmes for those infected and affected by HIV.

So that HIV prevention and support to infected persons is effective, all service providers in this field must give correct information and, especially, find a way to integrate prevention or support messages into the individual's daily life and be able to adapt interventions to the beneficiary's individual needs. The use of a condom isn't always within everybody's reach (for real and complex reasons), just as abstinence from the use of injected drugs is not possible for everybody. For instance, for some, access to free-of-charge condoms can be essential while for others, the support in finding a place to live may represent a more effective risk reduction strategy than a box of condoms.

In order to ensure that the counsellor has the necessary knowledge to support his/her beneficiary, so that the latter can assess the risks on his/her own and then identify ways to reduce them, the chapter ”Counselling – theories, techniques, practice” includes a review of effective communication methods and Annex II contains a number of theories and behavior change models.

Announcing HIV test results constitutes an important component of post-test counselling. The chapter ”Post-test Counselling” presents both procedures for communicating results and the factors that influence the necessary approach – factors related to the experience and knowledge of the person receiving the result and the counsellor's beliefs and values as well. At the same time, one will see that in order to be a qualified counsellor, holding correct information is not enough; positive, empathizing attitudes and communication skills (that may be continuously improved) are also needed.

Some chapters contain exercises aimed at self-assessment of the acquired knowledge and development of the skills necessary in the practice of counselling.

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4 According to the definition set by the National Committee for the Surveillance, Control and Prevention of HIV/AIDS infection in the „National Strategy for the Surveillance, Control and Prevention of HIV/AIDS infection in 2004-2007”, published in the *Romanian Official Journal* no. 865, Part I, 22 September 2004.

This manual is addressed to all involved in HIV prevention, who, by the nature of their work activities, have to talk to beneficiaries about the HIV test or the reduction of HIV infection risks. These persons may be physicians, nurses, psychologists, social workers, health educators, helpline operators, educators or peer counsellors (persons who belong to the beneficiary group and have attended training courses in HIV prevention). Each of the groups mentioned above may find themselves in the position to refer beneficiaries to a testing centre, to recommend they take an HIV test, to provide counselling before and after the test, and to offer support to the persons who learned the result of their test.

# A Chronology of Voluntary HIV Counselling and Testing (VCT)

1985: ELISA test for HIV becomes available around the world. The World Health Organization (WHO) and the Center for Disease Control and Prevention, Atlanta (CDC) begin recommending that the test should be accompanied by HIV counselling, as an interactive approach focused on information and education, in order to reduce the risk of HIV infection among beneficiaries after testing.

1986: The first counselling guides for health professionals appear, drawn up by WHO and by CDC. These guides are regularly updated and associated with recommendations regarding the quality of services.

1990: The HIV test becomes accessible in Romania (at that moment in time, an AIDS diagnosis was determined in keeping with the patient's clinical state of health). As we know, during the first years after 1990 it was considered that children were mostly affected and, for a while, the efforts in this field centred round the safety of donated blood and on the observance of universal precautions in medical/health care settings. Post-HIV test counselling was provided by specialized physicians in infectious disease hospitals when announcing the result.

1991: A private laboratory in Bucharest, the "Simona" Laboratory, provides HIV testing accompanied by information and counselling at the time the result is announced.

1992: The first Romanian nongovernmental organization, ARAS, the Romanian Association Against AIDS, is established with a mission to halt the AIDS epidemic through information, education and communication in prevention activities and through the development of medical and social services designed for people infected and affected by HIV.

1992: WHO organizes a training on pre- and post-HIV test counselling in Romania that was attended by 12 people. Very few of them will later do counselling, and those who do will concentrate on the post-HIV test counselling upon announcing a positive result. The same year, counselling guides, developed by WHO and translated into Romanian, are distributed.

1994: CDC publishes guides and pre- and post-HIV test counselling standards, which emphasize client-centred counselling, or, to put it differently, counselling that takes each individual's type of behaviour, circumstances and need into consideration.

1996: The first counselling guide is edited and published in Romania (Dr. Sorin Petrea, *HIV Counselling*), in a small number of copies, for use by professionals working in specialized hospitals or NGOs.

1997: Antiretroviral medications become available in Romania; efficacy of treatment increases, still without being able to ensure recovery. The treatment contributes not only to an improvement in the quality of life of infected individuals, but also to a decrease in HIV transmission, which encourages test seeking.

1997: The RESPECT Project (CDC Atlanta, USA) proves the efficiency of working protocols for pre- and post-test counselling in prevention.

1998: The Ministry of Health issues Order no. 889/1998, instituting HIV testing and pre- and post-test counselling.

1999: ARAS, in a partnership with three district public health authorities, opens the first voluntary HIV counselling and testing centres in Romania in Bucharest, at Constanța and Iaşi (reaching 3,500 beneficiaries in the first year). Within these centres, HIV testing is free-of-charge, accompanied by counselling and can be anonymous.

2001: RAA initiates a mother-to-child HIV transmission prevention programme in Constanța, including HIV counselling and testing and which is later extended to other counties.

2001: ARAS organizes the first training sessions in pre- and post-test counselling for family doctors and medical assistants/nurses (100 persons trained/year). The courses are accredited by the Institute of Professional Training for Physicians and Pharmacologists.

2001: AIDS Helpline is set up (0.800.800.033), which later becomes an AIDS Hotline operated by ARAS programme beginning in October 1993): a free-of-charge telephone line, providing information about HIV infection, data regarding the sites where HIV tests are conducted and the conditions of conducting them at the national level.

2002: ARAS, in a partnership with the Bucharest Municipal Public Health Authority, opens the second voluntary counselling and testing centre in the national capitol.

2003: RAA launches the first HIV counselling e-courses.

2003: The regional conference ”Promoting voluntary HIV counselling and testing,” organized by the Ministry of Health, ARAS and JSI in Iaşi, acknowledges the importance of increasing the population’s access to this kind of service.

2004: RAA, in a partnership with public health authorities in 10 counties, opens voluntary HIV counselling and testing centres in each of those districts.

2004: Direct tests begin to be processed in Romania; still, they are conducted only if there was exposure to HIV and, aside from professional accidents, they are not free-of-charge.

2005: A reflection[RTF annotation: }Another term is needed here group is set up in order to design national standards and working protocols for counselling. Members of the group include professionals in the field, and the results of their activities are to be submitted to the National Committee for Surveillance, Control and Prevention of HIV/AIDS.

# The Need for VCT in Romania

**General information on HIV infection**

The context of HIV/AIDS in Romania has recently shifted, given the increasing access to antiretroviral treatment and the diminishing of stigma and discrimination of HIV-infected people. This change, although insufficient, presents an opportunity both for infected people and for those who want to prevent infection or to learn about their health status.

According to Ministry of Health statistics, as of June 30, 2004, 14,981 HIV/AIDS cases were recorded in Romania, out of which 3,602 were adults. At present, heterosexual transmission is the prevailing cause of infection; still, most HIV-infected people are teenagers aged 13 to 16 years old. The number of cases continues to grow.

**General HIV/AIDS statistics, June 30, 2004**[5]

| | |
|---|---|
| Total AIDS cases, cumulative: | 8,908 |
| Cases of children with AIDS | 6,924 |
| Cases of adults with AIDS | 1,984 |
| Total HIV cases, cumulative: | 6,073 |
| Cases of children with HIV | 4,455 |
| Cases of adults with HIV | 1,618 |
| Total no. of HIV+AIDS patients removed from the registry | 467 |
| Number of living patients | 10,444 |
| Total no. of patients actively registered: | 7 771 |
| Children (0-14 years old) | 2 825 |
| Adults (>14 years old) | 4 946 |
| Total no. of patients receiving ARV treatment: | 5 752 |
| Children (0-14 years old) | 2 058 |
| Adults (>14 years old) | 3 694 |

**Treatment and social protection**

Romanian legislation stipulates the nondiscriminatory access of HIV-infected people to health care services and social protection. Antiretroviral treatment is free-of-charge for patients, and the treatment of opportunistic infections is reimbursable depending on the social situation of each individual.

The social protection of HIV-infected people is ensured by public institutions, in accordance with legislation regarding the disabled and that which is specific to HIV infection. According to 2004 National Authority for Persons with Disabilities statistics, only 3,917 of the 10,000 living HIV-infected persons benefited from special protection, as persons with disabilities. The fact that people do not exercise their rights in this respect may be partially related to the bureaucracy and partially to the suspicion/perception of those infected and affected by HIV; there is a high risk that personnel who manage the files may breach their confidentiality.

---

5 *Source:* Ministry of Health/National Committee for Fight against AIDS, The „Prof. Dr. Matei Balş" Institute for Infectious Diseases, Compartment of Evaluation and Monitoring of the HIV/SIDA infection in Romania; www.cnlas.ro.

A monitoring report regarding human rights and HIV infection,[6] released by the National Union of the Organizations of Persons Affected by HIV/AIDS (Romanian UNOPA) in 2004, underlined:

– a decrease in the number of cases where antiretroviral treatment was prematurely ceased, as compared to the previous years. Instead, delays were recorded of 1-2 weeks. It is notable that an evaluation of the immunological and clinical status of HIV-infected persons (viral load and the level of CD4 lymphocytes) was not conducted in all districts, according to the *Therapeutical Guide in HIV infection;*[7]
– a decrease in the number of cases where the right to social protection ensured by the State (for persons with disabilities) was only partially covered due to the limited funds of local authorities;
– a number of complaints regarding breach of confidentiality and cases of discrimination.[8]

**HIV Prevention**

Services to prevent HIV infection are provided by public institutions and nongovernmental organizations. Still, for the time being, they cannot cover the entire country, especially rural areas, as was shown in *Knowledge, attitudes and practices of young people aged 15 to 24 years old, in relation to the STI/HIV/AIDS transmission and to the consequences of unprotected sex.*[9]

*This study also shows that:*

– the majority of young people (98%) appreciate that one HIV prevention method is to use a condom, but only 61% think that fidelity will ensure a reduced risk of infection and only 33% counted (spontaneously or after being questioned) abstinence as an HIV prevention method;
– 99% of young people consider that one way in which to avert HIV infection is to avoid relationship with unknown persons (and especially with prostitutes);
– among the young people’s sources of information on HIV/AIDS and on condoms, friends are placed at the top (38%), followed by the media (41%); medical and teaching staff are counted less than 3.4%, that is by 11% of the youngsters;
– 53% of young condom users used one during their most recent sexual contact; the number of persons who used a condom at their first sexual contact increased as compared to 1999 (from 30% to 56%);
– 70% of young people considered HIV testing for their partner as a method of reducing risk, but this answer came following the questions, and was not a spontaneous response.

Persons involved in commercial sex, injection drug users, men who have sex with men (MSM), homeless persons, Roma and convicts are vulnerable because of their limited access to information and to medical and social services, and also because their behavior practices are illegal/border on illegality or are unaccepted by society.

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[6] National Union of the Organizations of Persons Affected by HIV/SIDA (Rom. UNOPA) – *Initiative for promoting and effectively defending the rights of persons living with HIV/AIDS* (Monitoring Report, July-September 2004), www.unopa.ro/download/raport_UNOPA_002_ro.pdf, 2005

[7] Ministry of Health and Family/the National Committee for Fight against AIDS – *Therapeutical Guide in HIV infection,* Bucharest, 2001.

[8] The complaints registered may have been determined by a high level of information of the HIV-infected persons or by an increased efficiency of the monitoring.

[9] National Institute of Health Research and Development – *Knowledge, attitudes and practices of young people aged 15 to 24 years old, in relation to the STI/HIV/AIDS transmission and to the consequences of unprotected sex,* Bucharest, 2004.

Discrimination and stigma diminishes their access to services even more and, implicitly, to HIV prevention.

**HIV testing Information**

Taking statistics of the Ministry of Health as a reference, it is apparent that 406,583 HIV tests were conducted in Romania in 2003, of which 55% for blood donors. This number also includes repeated and confirmation tests (for which reason the number of positive test results is greater than new HIV/AIDS infections during the same period and recorded by the same ministry). An increase in the share of HIV tests among persons other than blood donors is notable as compared to 2000, (from 10%[10] to 57%[11]), as well as an increase in the global number of tests conducted in Romania.

**Cumulative report on HIV tests conducted in 2001-2003[12]**

| Year | 2001 | | 2002 | | 2003 | |
|---|---|---|---|---|---|---|
| Tested Group | Total tests | Positive Tests | Total tests | Positive Tests | Total tests | Positive Tests |
| DSP | 65 009 | *653* | 92 797 | *1 466* | | |
| Hemodialised/trans. | | | 1 113 | | 1 148 | |
| Medical staff | | | 2 239 | *4* | 5 612 | *4* |
| Convicts/prisoners | 88 | | | | 1 043 | *2* |
| Upon request | | | | | 78 915 | *1 349* |
| Maternity | 7 515 | *3* | 1 769 | *4* | 334 | *5* |
| Pregnant women | 26 064 | *15* | 43 024 | *33* | 51 978 | *27* |
| STD | 8 216 | *46* | 14 414 | *60* | 13 283 | *42* |
| Tuberculosis | 10 578 | *37* | 11 946 | *55* | 11 025 | *55* |
| Pre-nuptial test | 2 271 | | 5 272 | *2* | 6 249 | *5* |
| HIV Contact | 769 | *7* | 655 | *19* | 977 | *36* |
| Drug users | 6 | | 651 | | 392 | *4* |
| Commercial sex workers | 88 | | 114 | *7* | 92 | *5* |
| Drivers | 2 | | 7 | | | |
| Sailors | 2 | | 42 | | 5 | *1* |
| Homosexuals | | | | | 19 | *2* |
| Travel abroad | 23 | | 165 | | 43 | |
| Work abroad | 169 | | 902 | *2* | 84 | *1* |
| Blood donors | 364 739 | *35* | 365 455 | *15* | 235 384 | *67* |
| TOTAL | 486 158 | *797* | 540 565 | *1 667* | 406 583 | *1 605* |

A national report on pre- and post-HIV test counselling provision is not yet available. According to the existing data, at present only ARAS and RAA provide pre- and post-test counselling services in 14 centres. Four of these became operational in 1999, and the other 10 were opened in 2004. On an average, a centre provides HIV counselling and testing for 1,200 people/year.

There are very few persons from groups vulnerable to HIV infection who have taken the test voluntarily and free-of-charge. According to international recommendations, HIV testing must be encouraged so that the test may turn into a routine analysis, taken by the beneficiary upon request, providing an informed diagnosis and motivating behavior changes that lead reduced risk of HIV transmission.

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[10] Ministry of Health/ General Public health authority – *Epidemiological Surveillance of the HIV/AIDS Infection in Romania (1990-1999),* a technical report.

[11] Ministry of Health /National Committee for Fight against AIDS, the „Prof. Dr. Matei Balş" Institute for Infectious Diseases – *Evolution of the HIV/AIDS Infection from 1985 to 2003.*

[12] *Ibid.*

At present*, the HIV test* can be taken at:
- voluntary HIV counselling and testing centres, where it can be anonymous, free-of-charge and accompanied by counselling. There are such centres in 16 districts of the country, set up by the public health authorities in partnership with NGOs;
- public health authorities in districts where voluntary counselling and testing centres have not been established. These tests can be free-of-charge and confidential for people from vulnerable groups (pregnant women, injection drug users, persons involved in commercial sex, MSM);
- hematology centres, where the test is free-of-charge and included in the set of compulsory analyses for blood donors;
- infectious disease hospitals, where the test is free-of-charge and confidential for partners or family members of HIV-infected persons; for others, a fee is charged for the test;
- polyclinics/laboratories, where tests are offered free-of-charge if it is being made based on the recommendation of a family doctor (usually provided to pregnant women or to persons showing symptoms of HIV infection); a fee is charged for the test if it is conducted upon request.

*Pre- and post-test counselling* is practiced by:
- specialized HIV counselors, often NGO employees;
- family doctors and nurses who have attended training courses in pre- and post-test counselling.

*Training in pre- and post-test counselling* is provided by:
- ARAS provides a 15 hour-workshop accredited in 2001 by the National Professional Training Centre for Physicians, Pharmacologists, Nurses and other medical staff ([RTF bookmark start: }OLE_LINK4Romanian CNPMFAM[RTF bookmark end: }OLE_LINK4) and by the College of Physicians in Romania. The objective of the workshop is for trainees to acquire knowledge on the counselling and testing process and the development of counselling skills. Workshop participants receive diplomas and 15 hours of sustained/continuous education. The workshop can be organized free-of-charge or a modest participation fee may be charged, depending on ARAS resources.
- RAA offers an e-training course accredited in 2003 by CNPMFAM and by the College of Physicians. Its purpose is for trainees to acquire knowledge of HIV infection and on the counselling process. The course is part of a series of training courses on HIV infection, including modules on the prevention of mother-to-child transmission, universal precautions and communicating a positive diagnosis to children. Participation is free-of-charge, but it requires internet access. Graduates receive diplomas and earn 30 hours of continuing education.

**Results of VCT projects developed by NGOs**

*ARAS* (1999-2004):
- 12,200 persons have taken an HIV test accompanied by counselling in Bucharest, Constanța and Iaşi, 15% of who were from vulnerable groups and 35% of who were pregnant women.

Besides testing, the beneficiaries also received:
- information on HIV and the test;
- support in assessing their risk of infection and developing a concrete plan of risk reduction;
- referrals to other services;

- informational and protection materials (condoms). Promotion of voluntary HIV testing was continuously carried out and 30,000 informational materials were distributed annually;
- 320 physicians, medical aids/nurses and psychologists/social workers were trained in pre- and post-test counselling (Bucharest, Ilfov, Iaşi, Constanța, Neamț, Botoşani, and the Republic of Moldova).

*RAA* (2000-2002)[13]:
- 11,400 pregnant women in Constanța and Giurgiu took an HIV test accompanied by counselling provided by area physicians;
- 20,000 leaflets promoting HIV testing for pregnant women were distributed every year;
- 400 physicians were trained in four sessions held in Constanța District.

Starting in 2004, RAA initiated, in a partnership with the district public health authorities, anonymous and free-of-charge voluntary counselling and testing centres, as well as mobile counselling and HIV testing services for pregnant women in 10 districts (Constanța, Bacău, Braşov, Bucharest, Dolj, Galați, Suceava, Prahova, Timiş, Cluj).

**Legal and moral considerations regarding VCT**

WHO and UNAIDS recommendations refer to:
- ensuring pre- and post-test counselling;
- seeking informed consent before testing (a voluntary test);
- ensuring confidentiality;
- providing quality services, both in testing and counselling.

Romanian legislation contains references to HIV infection and to VCT, as follows:

- *Law no. 584 of 29 October 2002, regarding measures to prevent the transmission of AIDS in Romania and protect HIV-infected persons or persons living with AIDS*[14]*, stipulates access to information and education for the prevention HIV infection, the observance of standards on diagnosing HIV-infected persons (HIV testing), and respecting confidentiality.*
- *Order of the Minister of Health no. 889/1998, updating the Order of the Minister of Health no. 912/1992 regarding the institution of a system for declaring HIV infection and the approval of implementation methodology.*[15] The order stipulates required testing of pregnant women, couples to be married and other categories of persons. Standards for the implementation of this order describe in detail the procedures and methods to be taken in the provision of HIV counselling and testing, the responsibilities of those providing (such) services and procedures for reporting and monitoring cases. It is the first regulation that precisely states the importance of and mandates compulsory counselling before and after an HIV test is taken.
- The *2004 Framework-Contract regarding the conditions for providing medical assistance within the system of social health insurance*[16] stipulates that pre- and post-HIV test counselling must be provided by family doctors as part of the basic services package, and that testing is free-of-charge for pregnant women or for persons showing symptoms of HIV infection.

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[13] www.raa.ro

[14] See Annex V, for its entire text.

[15] *Id.*

[16] Romanian Government – The „2004 Framework-Contract regarding the conditions for providing medical assistance within the system of the health social insurances", in *Romanian Official Journal,* no. 920, Part I, 22 December 2003.

▪ According to the national programmes for public health,[17] an HIV test can be given free-of-charge on the basis of a medical recommendation (if the person is insured and is pregnant or shows symptoms of HIV infection) or if the beneficiary belongs to social groups with a high risk of infection/transmission.

▪ The law regarding the protection of personal data[18] includes sanctions for failure to observe the norms regarding the recording and use of personal data.

▪ The Penal Code includes sanctions for failure to observe the professional confidentiality[19] and for voluntary transmission of the infection through sexual relationships.[20]

▪ The law regarding patient's rights[21] includes norms related to the respect of and patient consent for any analysis conducted, as well as to correct patient information (on the implications of investigations or treatments and also on diagnosis).

*The 2004-2007 national strategy against HIV/AIDS*[22] has the following guidelines:

- "HIV/AIDS is more than a public health priority. It is a complex issue, affecting all components of society.
- The strategy will mainly focus on prevention and diminishing of social impact. The allocated resources must take into consideration vulnerable groups (at risk) and the affected communities.
- Multisectoral and interdisciplinary involvement is essential to form an appropriate response to the HIV epidemic.
- Individuals and groups must have the necessary knowledge to prevent HIV infection; it is essential to ensure that they have this capacity.
- Equal access to care and primary services is guaranteed to all infected/affected by HIV/AIDS.
- All persons infected with HIV or living with AIDS, as well as vulnerable groups, have equal and sustained access to treatment, medical care and services, according to the standards provided by the legislation in force.
- The rights of persons infected with HIV or living with AIDS, as well as of those belonging to vulnerable groups, are guaranteed, according to 'national legislation and international treaties to which Romania is a signatory, with a special stress on the right to confidentiality.
- The individual responsibilities of persons infected with HIV or living with AIDS are enacted.

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[17] Order of the Minister of Health and of the President of the National House of Health Insurances no. 172/113/2004, which approves the deployment of health programmes and sub-programmes financed from the State budget and from the 2004 budget of the National Unique Fund for health social insurances, and the Methodological Norms on the organization, funding and monitoring the above-mentioned health programmes and sub-programmes", in *the Romanian Official Journal*, no. 214/11, Part I, March 2004 (acc. to the *Public Health Community Programme*; sub-programme 1.2., *Surveillance and Control of the HIV/AIDS infections).*

[18] Law no. 677/21 November 2001 on the protection of persons, regarding the processing of personal data and the free movement of these data, in the *Romanian Official Journal* no. 790, Part I, 12 December 2001.

[19] The Penal Code, the special part, title I: Crimes and offences against the individual, chap. VI: Crimes and offences against the liberty of the individual, Art. 214: Disclosing the professional secret, published in the *Romanian Official Journal* no. 303, Part I, 12 April 2005.

[20] *Id.,* the special part, title VIII: Crimes and offences relating to public danger, chap. IV: Crimes and offences against public health, Art. 384: The veneral contamination and the transmission of the aquired immunodeficiency syndrome.

[21] Law no. 46/21 January 2003 regarding the patient's rights, in the *Romanian Official Journal* no. 51, Partea I, 29 January 2003.

[22] The National Committee for the Surveillance, Control and Prevention of the HIV/AIDS infection – the „National Strategy for the Surveillance, Control and Prevention of the HIV/AIDS infection in 2004-2007", in the *Romanian Official Journal* no. 865, Partea I, 22 September 2004.

- Conditions must be assured for the application of universal precautions, so as to avert any possible transmission of HIV infection in medical and social care systems.
- HIV testing is voluntary and/or anonymous, confidential and pre- and post-test counselling is guaranteed, both by the State and private sectors.
- The drawing up of policies and programmes of socio-economic development must take into consideration the HIV/AIDS phenomenon.”

The National Strategy, as presented in the chapter ”Elements necessary for improvement of HIV/AIDS Surveillance,” also includes an increase in access to counselling and HIV/AIDS testing of the general population and of vulnerable populations, by:

- increasing counselling capacity by introducing the compulsory character of HIV/AIDS counselling for each voluntary test taken;
- scaling up, at the national level, programmes that facilitate access of vulnerable groups—persons involved in commercial sex, drug users, MSM and street children—to testing and counselling;
- developing the capacity to ensure universal access of pregnant woman to counselling and testing;
- regularly reviewing estimates of HIV incidence among population groups at risk.”

**Benefits of VCT**

For many of the HIV prevention interventions or support interventions for infected persons, the HIV serological status must be known. The importance of voluntary counselling and testing in realizing this information was recognized and is demonstrated by the expansion of services.

VCT has an essential role in HIV prevention: it helps people make positive changes in their behaviour, so as to avoid getting infected or infecting their partners (in the case of infected persons). Other essential benefits consist of facilitating linkages to other health or social services and, last but not least, in reducing stigma and discrimination of HIV infected persons by informing and raising the awareness of the population.

The benefits of voluntary counselling and HIV testing can be structured in *individual benefits* and *benefits for society.*

Among the individual benefits, there can be counted:

- The prevention of HIV transmission:
  - from HIV-infected persons to their non-infected or untested partners;
  - from an HIV-infected mother to her child.
- The prevention of HIV infection:
  - for persons with behaviours placing them at risk of infection.
- Support in the effort to face the diagnosis:
  - accepting the diagnosis;
  - identifying support resources;
  - identifying ways to alert partners.
- Early access to services:
  - medical care (antiretroviral therapy, treatment for opportunistic infections, prevention of some associated diseases);
  - counselling for adherence to treatment;
  - family planning;
  - emotional support (counselling, support groups);

  social support (material support, counselling, legal information).

The benefits of VCT for society include:

– a reduction of stigma of HIV-infected people: society becomes aware that HIV infection can affect anyone, irrespective of social status, race or age, and, in fact, it is one's behaviour that exposes people to the risk of infection, and not their belonging to a certain group or social category;
– a reduction of the social costs associated with HIV infection: by changing behaviours to reduce infection risks (HIV prevention) and by receiving an informed diagnosis, ensuring access to treatment, avoiding opportunistic infections and, in effect, extending the period of time in which HIV-infected people are able to integrate socially and professionally and, correspondingly, will not need facilities, pensions and home care;
– a ”normalization” of HIV (de-dramatization of the diagnosis): at present, HIV infection is considered a chronic, long-lasting disease that is transmitted only through sexual contact, via blood or from an infected mother to her child. HIV counselling and testing, if conducted as part of the usual routine analysis, is part of the basic medical services package and is accompanied by the delivery of correct information about HIV infection. This ensures correct perceptions among the population that HIV infection is a chronic disease, among others.

Although VCT benefits are considerable, many are afraid or are reserved about taking an HIV test, because of possible disadvantages (breach of confidentiality, job loss, social rejection, stigma, the need to change behaviours, loss of friends).

According to legislation (the right to privacy, the patient's rights), people are free to decide on their own about whether they should take an HIV test or not. The role of pre- and post-HIV test counselling is to provide correct and complete information that includes both the advantages and the possible, unfavorable consequences.

In addition, the role of all involved in medical, social activities or in education is to advocate for the reduction of discrimination and for respect of human rights: health, access to information, privacy, etc.

An individual may want to take an HIV test, if:

– she is going to have a child;
– intends to begin a sexual relationship;
– wants to start a family;
– engaged in risky behaviours (for example, a sexual contact not protected by a condom);
– received a transfusion before 1990;
– used needles and syringes in common with others;
– had an accident that involved contact with someone else's blood (for instance, offered help to an injured person without protecting him/herself);
– has been sexually abused;
– wishes to learn about his/her state of health;
– has another sexually transmitted disease;
– found out a former partner is HIV-infected.

## Counselling – theories, techniques, practice

**The concept of counselling**

The British Association for Counselling and Psychotherapy defines counselling as the use of an interpersonal relationship to facilitate self-knowledge, emotional acceptance and personal growth, the optimum development of the beneficiary's personal resources. The general objective of this approach is to stimulate the client's self-knowledge, personal development and adjustment. It aims for the beneficiary to find him-/herself in a new position, that of an independent and fully responsible person kept in balance.

In other words, counselling procures/provides the client a set of abilities that may help him/her in understanding his/her problem, in coping with feelings and worries and in assuming responsibility to evaluate alternatives and make decisions. Thus, the counsellor is not the one who solves the client's problem; he is the one who helps him/her solve it.

For a better understanding of counselling, we will attempt to see what it is and what it is not.

**Relationships among information, education and counselling**

The correct use of these three terms often brings rise to confusion. What for one person means counselling, for another one means education. Certainly, there is a close relationship among these concepts, especially when it is about pre- and post-HIV test counselling.

*Informing* implies providing data about a certain topic, without any responsibility attributed to the counsellor regarding the way the beneficiary will use the information received.

*Educating* consists of offering specific data in specific contexts that may occur during dialogue with the client. The main characteristic of educating is to ensure *feed-back* (that is, to review what the beneficiary understood).

*Counselling* aims at providing active support to clients, so that they may be able to identity and explore their feelings, priority issues and then make appropriate decisions. The essential characteristic of this process is that, according to the needs and the knowledge of the beneficiary, s/he is the one who provides information and determines the content of counselling.

**Differences among informing, educating and counselling**

| Component | Purpose | Content | To whom it addresses | Where it takes place |
|---|---|---|---|---|
| Information | Change of behaviour | Delivery of knowledge, Awareness raising | Public at large | Everywhere |
| Education | Change of behaviour | Information Knowledge adapted to the beneficiary's level *Feed-back* | Group Individual | An organized place |
| Counselling | Change of behaviour | Information and education Involvement of the client in the identification of the problem and in finding solutions | Individual Couple, Small group | A secure place |

For instance, let's think of a pupil, Z, who is to go on holidays somewhere near the Ceahlău Mountains. He is very interested in this trip and, theoretically, he might get some information about it, since a television programme on holiday locations in Moldova is scheduled on the following day. On the other hand, the geography class is to follow as well. Although, according to his school curriculum, the geography teacher has to speak to them about the Black Sea, and the TV programme is only about the monasteries in Moldova.

If we think of somebody who wants to reduce their risks of becoming HIV-infected, we understand that a TV programme (or a leaflet) will only provide him/her only basic information. Additionally, an hour of education on HIV prevention, although it provides thorough information as it includes a check-up of what has been understood, might very well not answer the needs of each beneficiary (possibly not identified even by him/her).

**Differences among advising, guiding and counselling**

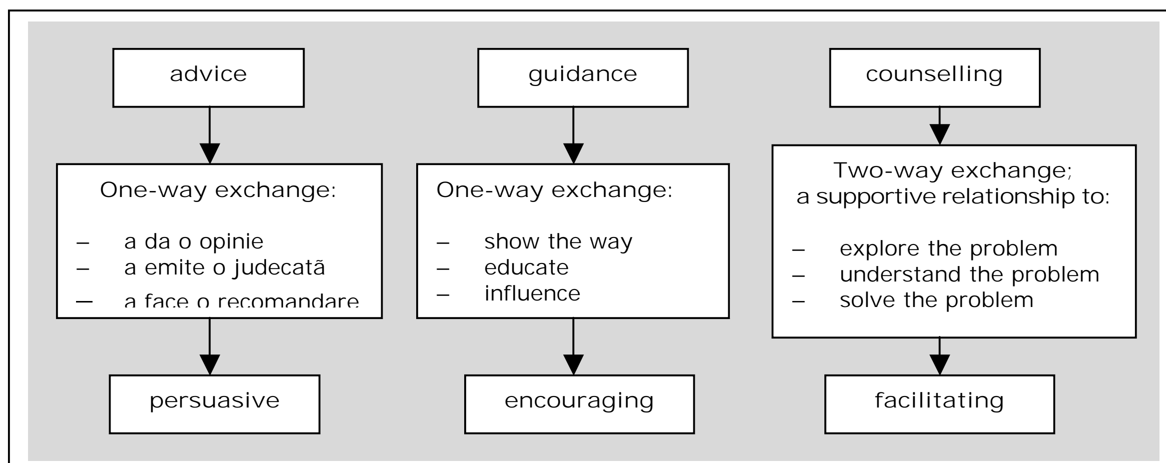
*The Explanatory Dictionary of the Romanian Language* defines counselling as the action of giving an advice or guidance, even though for many of counsellors, "giving advice" is an unacceptable construct.

To give advice means to tell people *what they should do* or *what they need to,* and counselling is not about that. Within the counselling process, professionals help their clients to catch a glimpse of *what they can possibly do*, and not what to choose. The counsellor who answers the question: "What do you advise me to do?" with the question: "What alternatives can you see?" helps the client understand that s/he, her/himself, plays an important part in decision-making, helping her/him to assume responsibility.

There are people who appreciate that counselling is successful if it manages to put the beneficiary in the solution, so that s/he considers this solution belongs to her/him. As a matter of fact, such behaviour is called manipulation. We have to admit that there is a very fragile limit between "to influence" and "to manipulate"; still, let's not forget that manipulation has long-lasting effects and, more importantly, is not ethical. It does sometimes brings benefits to the one who is practicing it, however, and that is why there is the temptation to use it.

To be sure that s/he provided good counselling, the counsellor must give an honest answer to the question: "Who benefits from the solution the client chose?" If the answer is: "The counsellor", then we may consider the counselling unsuccessful for the beneficiary.

**Differences among advice, guidance and counselling**[23]




**Differences between counselling and psychotherapy**

Psychotherapy is generally defined as a form of psychological treatment structured on set techniques and methods, applied deliberately to a group or individual by a specialized therapist. The therapist wants to identify psychological conflicts and work on them in a systematic way (usually a long-term process).

Most of the time, psychotherapy adopts a curative model based on deep structural changes, starting with the client's history and laying stress upon intervention, treatment and reconstruction.

Counselling is different from psychotherapy in duration, as it occurs over a shorter period of time, as well as by its ”historical perspective.” Thus, unlike psychotherapy to which the present is the expression of a history that continuously repeats in an ever changing context, counselling focuses on what belongs to the present (here and now) and is directed towards the processes of development and facilitation.[24]

Despite these differences, we can see that the principles that form the basis of counselling–non-directivism and center on the client (Carl R. Rogers)[25]–are thoroughly used in some psychotherapy interventions as well.

**Client-centered therapies**

The basis of counselling is its client-centred therapies (non-directive), the reason for which necessitates a brief description of these therapies.

Psychotherapy centred on the client or on the individual was developed in the 1940s by Carl R. Rogers in reaction to psycho-analysis. It started from the idea that people own an innate motivation to surpass themselves and develop their own capacities.

In his theory of non-directive psychotherapy, Rogers replaces the term ”patient” with that of ”client” and tries to address the individual and not his/her problem. The author sees in therapy a process that removes compulsions obstructing the self-recovery process. These compulsions originate in the unrealistic requirements people impose upon themselves when they imagine they must not experience certain feelings (such as those of hostility). Therefore, the main objective of this therapy is to help the client in

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[23] *Apud* Sutton, Jan; Stewart, William – *Learning to counsel* (2nd edition), Oxford (UK), How to Books Ltd., 1999.

[24] Dafinoiu, Ion – *Elemente de psihoterapie integrativă,* Iaşi, Ed. Polirom, Col. „Collegium. Psihologie”, 2000.

[25] Rogers, Carl R. – *Client-centred Therapy: Its current practice, implications and theory,* Boston (USA), Houghton Mifflin, 1951.

his/her attempt of coping with the incongruities between what s/he feels and what s/he considers s/he should feel, more exactly to help the client accept her/himself the way s/he is.

Irina Holdevici and I. P. Vasilescu wrote in *Psychotherapy – a treatment without medicines*,[26] that it's not the therapist's task to guide the process of client-centred therapy (non-directive) and that s/he does not give answers or interpretations, does not follow unconscious conflicts and does not actively intervene in the patient/client's speech. All the therapist must do is to listen carefully to what the client says, approving him/her and interrupting him/her only to rephrase what the client has just said (in order to be sure s/he has understood and also to show the client s/he has understood).

Client-centred psychotherapy is the foundation for other therapies, especially in several forms of counselling (its basic principles are also applied in pre- and post-test counselling). Most of all, it draws attention on the fact that the main actor in the curative process is the patient/client, while the therapist is only acting as a catalyst.

**HIV prevention counselling**

HIV prevention counselling is also called *client-centred HIV prevention counselling, counselling for reducing the risk of HIV infection* or *pre- and post-test counselling* by the CDC.[27] *In this manual, we will focus on the importance of this concept and use this term.*

*Within the process of HIV counselling and testing, prevention counselling aims to reduce HIV transmission by:*

- *information:* the beneficiary receives information about HIV transmission and prevention, as well as on the meanings of test results;
- *HIV prevention counselling:* the beneficiary receives support to identify specific behaviours that may expose her/him to the risk of HIV infection and to draw up a plan to reduce her/his risks of becoming HIV-infected.

One may notice that this specific type of counselling includes information about the beneficiary on one side, and the counselling itself on the other side. It is the support provided to the client in identifying risks and in reducing them. In other words, HIV prevention counselling aims to help the beneficiary change her/his behaviour step by step.

***An HIV infection risk reduction model,*** published in 1990 (Catania et allii[28]), uses concepts of several models of behavioural change[29] to describe the process individuals (or groups) experience while changing their behaviour regarding the risk of HIV. The model identifies three stages involved in HIV transmission risk reduction, including:

- behaviour labelling;
- commitment (decision) to change;
- shifting to action.

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[26] Holdevici, Irina; Vasilescu, I.P. – *Psihoterapia – tratament fără medicamente,* Bucureşti, Ed. Ceres, 1993.

[27] We mention that, even though one of the denominations used by CDC refers to the client-centred psychotherapy (Carl R. Rogers), the HIV prevention counselling uses only *some* of the non-directive methods and must not be taken for psychological therapy.

[28] Catania, Joseph A; Kegeles, S. & Coates, T. – „Towards an understanding of Risk Behavior: An AIDS risk reduction model (ARRM)", în *Health Education Quarterly,* 17 (1), 1990.

[29] A review of the most important theories and models of behavioural change are presented in Annex II.

In the first stage, knowledge about HIV transmission, the perception of one's own vulnerability to HIV, as well as the negative emotions each influence the way people perceive AIDS. The stage of commitment to change is defined by four factors: the perception of pleasure, self-efficiency, social rules and negative emotions.

Again, in the last stage, negative emotions, sexual communication, help-seeking behaviour and social factors affect the human process to make decisions (Catania, 1990).

Programmes using the *HIV infection risk reduction model* focus on:

- assessment of the client's risk;
- facilitating risk reduction decisions through motivation, taking into account the perception of pleasure or the confidence the client has in their own capacity to change;
- supporting the client in applying changes (access to condoms, social/medical support).

HIV prevention counselling implies two face-to-face sessions of about 15-20 minutes in length each (for the clients with a high risk of HIV infection) or of 5-10 minutes (for the clients with no risk of infection). The main elements of the reduction counselling are:

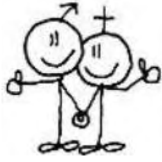
- to center and maintain the meeting around the idea of risk reduction;
- to support the client in assessing his/her own risk of infection;
- to clear up the client's incorrect opinions regarding HIV;
- to negotiate concrete and workable steps to reduce risk;
- to develop the client's prevention abilities (also through demonstrations).

The working method at the basis of the HIV prevention counselling is active listening, by which the beneficiary is encouraged to identify risks and find solutions to reduce them.

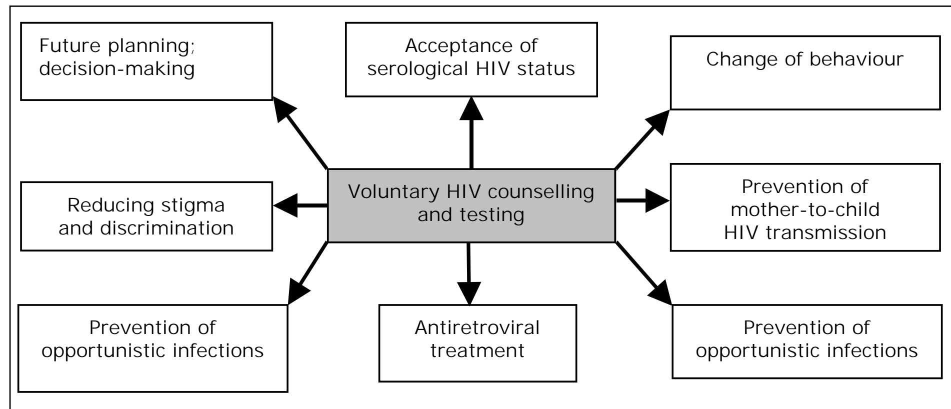
Most of the time, HIV prevention counselling is also characterized by a beneficial cost-efficiency ratio within the process of pre- and post-test counselling. The method is used outside HIV testing centres as well, as a component of case management for the HIV prevention (a long-standing process with higher costs and also with greater efficiency in prevention). It may be used in outreach HIV prevention interventions as well, but, in this case, its efficiency is minimal due to environmental conditions and insufficient time.

**VCT process**

Voluntary HIV counselling and testing represents an essential link between HIV prevention on one hand, and the treatment and support of HIV-infected persons on the other. VCT promotes and encourages behaviour change, providing referrals to services and interventions for the prevention of mother-to-child HIV transmission for the prevention of sexually transmitted infections (STI), facilitating the individual's integration in the health and social care system. Moreover, VCT improves quality of life and may play an important role in reducing stigma and discrimination.



**VCT – important in HIV prevention and in providing treatment and support for HIV-infected people[30]**



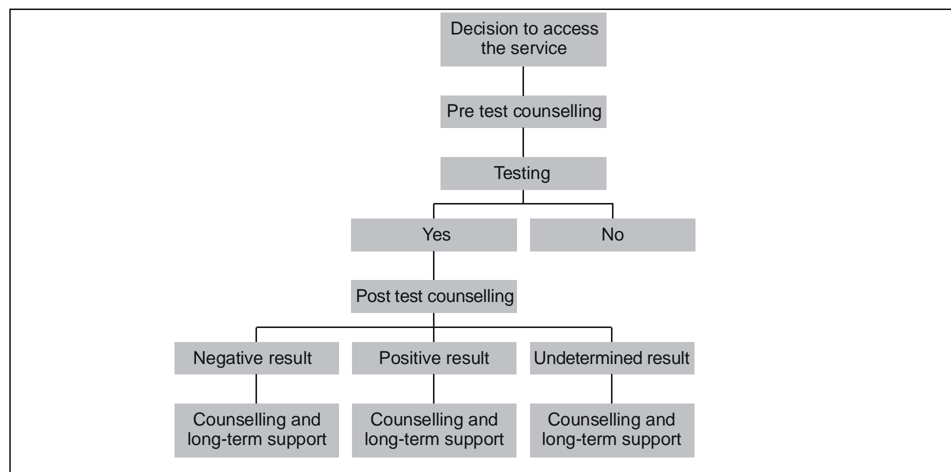

"Voluntary HIV Counselling and testing represents the process by which an individual receives support in making an information-based decision to take an HIV test, thus having the opportunity to know his/her serological HIV status. The decision must fully belong to the individual, and s/he must be reassured that the VCT process is confidential."[31]

As part of this process, counselling is defined as the professional relationship between a counsellor and a client, based on confidence, listening and mutual respect. Its aim is to support the client/patient in his/her efforts to cope with stress and to make personal decisions in connection with HIV/AIDS.

Within the VCT process, counselling is provided before the HIV testing, called *pre-test counselling,* and after the testing when the result is announced, called *post-test counselling.*

In some cases, several counselling meetings may take place before and/or after testing, depending on the client's needs.

**The HIV counselling and testing process**




[30] Adapted after UNAIDS – *Voluntary Counselling & Testing, Technical Update* (UNAIDS Best Practice Collection), Geneva, Switzerland, 2000.

[31] UNAIDS – *Voluntary Counselling & Testing (VCT), Technical Update* (UNAIDS Best Practice Collection), Geneva, Switzerland, may 2000.

**Clients – VCT beneficiaries**

Counselling beneficiaries are called ”clients” in order to differentiate them with patients (who are access a physician to solve their concerns) or assisted persons (who do not always have the opportunity to choose whether they accept a certain service).

The meaning of the term ”client”, according to the *DEX (*Romanian for *Explanatory Dictionary of the Romanian Language)*, is not a person who pays for a service, but a person who chooses a service (and may also refuse that service, if it does not correspond to the person's needs).

”Client” means a person (family, group) to whom services are offered:

- upon request or with the person's consent (that of the family, group – the consent of all members);
- on account of a court ruling

Before asking for an HIV test, each individual goes through a decision-making process, which is often accompanied by anxiety. Sometimes, appreciations are made on the partners HIV status (they are compared to infected or sick persons) during this process, the pros and cons of whether one wishes to be aware of the diagnosis are weighed, testing is discussed with friends or partners, and assumptions are made about the possible diagnosis. When they choose to take an HIV test, people find themselves in a situation in which they have to cope with fears and behaviours from the past. In this way, some of clients:

- may consider they are HIV-infected, as they engaged in risk-taking behaviour or were in a situation presenting an infection risk;
- may hope they still were not infected, although they may fear the effects of some risk-taking behaviours/situations from their past;
- may consider they are HIV-negative and want to prove it to themselves;
- may need the result of the test, as required by the partner, physician or employer.

The decision to take an HIV test belongs, in all cases, to the beneficiary.

**Who can be an HIV counsellor**

According to Romanian regulations regarding pre- and post-test counselling (Order of the Minister of Health no. 889/1998), these services can be provided by physicians, medical aids/nurses and specialized counsellors (psychologists, social workers). Unfortunately, training in pre- and post-test counselling, evaluation of these services and their support and supervision have not been clearly established to date. Professional training of personnel who may provide counselling (according to the above-mentioned Order) includes basic knowledge and skills, but they must be updated and developed on a consistent basis.

We mention that in many countries there are services based on the involvement of HIV-infected persons in providing counselling services (so-called ”peer counselling”), on the condition that these persons have attended a specialized training course.

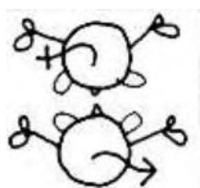
The minimal training of a person offering pre- and post-test counselling services should include:[32]

- explanation of the counselling and HIV testing process;
- clarification of his/her own values and attitudes;
  - practice for developing basic skills for counselling, including active listening;

[32] Cf. Commonwealth Department of Health, Housing & Community Services, Australia – *HIV/AIDS National Counselling Guidelines,* Canberra, 1992.

- abilities to facilitate counselling and group education (for cases where needed);
  - self-analysis and self-development, also for reducing stress and recognizing symptoms of being overly stressed;
- awareness raising in:
  - the emotional, social and physical impact of HIV infection;
  - various types of sexual preferences and practices and drug use practices;
  - limits of pre- and post-test counselling;
- HIV/AIDS-related legislation;
- professional ethics.

Each counsellor must know and be able to understand all aspects of HIV infection and adherent support, and not strictly those of her/his field of activity (for instance, only prevention and testing).



**Key-points in providing support for HIV-related problems**

| The client's problem: | Skills needed by the service provider: | Preliminary training regarding: | Empathy/ understanding to: |
|---|---|---|---|
| HIV prevention | Ease in talking about high-risk behaviours<br>Ease in talking about prevention methods (e.g.: condoms, risk-free sexual practices, risk-free injection) | HIV infection<br>HIV transmission<br>Negotiation of safe behaviours | Denial<br>Lack of interest<br>High-risk behaviours |
| To decide to take an HIV test | Ease in talking about sexual activities<br>Identification of risky behaviours<br>Preparation for the results<br>Anticipation of the emotional impact | HIV testing | Denial<br>Ambivalence<br>Fear |
| To accept, become aware of HIV serologic status | Ability to empathically announce bad news<br>Anticipation of common concerns<br>Encouraging discussion<br>Evaluation of emotional impact | HIV testing<br>Evolution of HIV infection<br>Behaviours facilitating HIV transmission<br>CD4, viral load | Denial, fury<br>Fear of rejection and stigma<br>Fear of death<br>Continuation of high-risk practices |
| Learning HIV status | Talking about the decision – who may be told<br>Talking about the decision – when it may be told | Anticipation of reactions<br>Negotiation of risk-free practices | Fear of rejection |

| To accept the "patient's role" | Establishing a relationship, confidence, mutual respect<br>Encouraging partnership<br>Encouraging questions<br>Clear information on the patient's responsibilities | Patient's responsibilities | Ambivalence, mistrust/suspicion<br>Fury, rejection<br>Testing limits |
|---|---|---|---|
| To initiate healthy behaviours | Identifying behaviours with negative consequences<br>Referrals for treatment, detoxification<br>Establishing a link with health care services | Health promotion<br>Reducing negative consequences from behaviours<br>Change of behaviour/life style | Fury, mourning<br>Difficulties in changing behaviour<br>Resistance to treatment |
| To observe programmes, adherence to treatment | Strengthening the link for the treatment<br>Understanding treatment-related barriers<br>Discussions on the risks and benefits following the decision<br>Anticipating adverse effects | Importance of a sustained training<br>Treatments, secondary effects<br>Abilities needed to supervise treatment<br>Viral resistance | Fury, hostility<br>Fear of failing, self-blame<br>Forgetting appointments, appointments, medication |
| To cope with symptoms | Identifying symptoms, capacity to soothe/mitigate<br>Encouraging a complete description of the symptoms<br>Emotional support | Symptom etiology<br>Limits of treatment<br>Risks/benefits from treatment | Discomfort, pain<br>Fury, impatience<br>Fear of the course of the disease |
| Confrontation of severe diseases | Diagnose, treatment, pain reduction<br>Ability to empathically announce bad news<br>Recognizing the emotional impact<br>Providing emotional support | Diseases, specific treatments, prognosis<br>Opportunities for behavioural change | Fury, self-accusation<br>The service provider's fear of death, pain or dependence |

| | | | |
|---|---|---|---|
| Improvements to their health state | Consolidating lessons learned from the state of severe disease<br>Encouraging the adoption of health-protecting behaviours | Realistic expectations<br>Re-evaluation of work limitations | Unrealistic expectations<br>Return to denial |
| Handicap/ disability | Ease in talking about disability-related matters<br>Evaluation/sticking to the legal provisions regarding disabilities | Realistic expectations and objectives<br>Preparation for complex care<br>Social facilities<br>Sustained planning | Loss, discouragement<br>Fury, denial<br>Loss of self-esteem |
| Confrontation with death | Talking about fears<br>Correct prognosis, allowing preparation time<br>Palliative care, communication with the family | Prognosis<br>Palliative measures | Denial, fury, accusation, fear, loss |

**Needed skills of a counsellor**

A counsellor must be a good professional, attracted by the activity s/he is undertaking, sincere to the client and accepting of the client as a peer. Self-knowledge is also imperative for a counsellor.

*Sincerity*

An essential condition for successful counselling is the counsellor's sincerity, defined as "being yourself," open-mindedness, transparency, truthfulness in the professional relationship without hiding under the mask of professionalism. Sincerity may also be regarded as a condition in absence of which an uncritical acceptance of the client, nor her/his empathetic understanding, can be achieved. Among the "indicators" of sincerity (or its absence) we may count: gestures, mimicry, body language, expressions, voice intonation and rhythm.

If we refer to a conversation about the use of a condom, we may question the efficiency of the counsellor who personally thinks it is difficult to use, but still tells her/his client that using such a means of protection is a very simple. If need be, s/he also counts the steps that are to be followed, to make sure the client got the message. It's quite likely that the verbal message the counsellor sent is accompanied by a contradictory (unintentional) non-verbal message or by a para-language,[33] which will cause the client confusion and isn't safe.

Sincerity cannot be interpreted as the counsellor's availability to openly answer personal questions (regarding his/her life) or to those that are not related to the topic of the meeting.

*Accepting the client as a peer*

The acceptance of a client can be defined as his/her value and respect as a unique human being, excluding any attempt of turning him/her in somebody else. An accepting attitude may represent the acceptance of the other's qualities, and also the shortcomings, without criticism or judgment.

We may include in the definition of acceptance – besides respect and valuation – care, compassion, politeness, interest/attention, and listening. Such an attitude favors the establishing of a counselling relationship and facilitates exchange, communication, co-operation, provided these are expressed among equals.

A parent's acceptance attitude towards a child (such as defined by the transaction analysis) can hardly be a sincere constructive talk, when both get involved in solving the problem. If we take as a reference the parent-child relationship, we can see that, in many situations, although the parent tells the child "Don't do...!", "You mustn't...!", the child refuses to comply with the interdiction or obeys it without understanding the reason (and the risk is that, after a while, the child repeats the mistake). Solving a problem in an equality-based relationship assures the participation of all those involved, by raising awareness, assuming responsibility and seeking feasible, realistic solutions.

The client/patient's expectances from the interaction may represent a difficulty in establishing an equality-based relationship. Some clients are likely to suppose that, to solve their problem, it is enough to offer as many data as possible on their situation, after which the counsellor will provide them a

[33] See chapter "Communication in the counselling relationship".

solution. This may be a suitable option when it is about waiting for a diagnosis (which is not the case in a counselling relationship), but the client's involvement in choosing a plan of behavioural change is absolutely necessary.

Passing from a parent-child (or superior-subordinated) type relationship to an equality-based one, founded on acceptance, is though essential for the counselling process. An equality-based relationship, which involves the client in the counselling process, may be set up from the beginning of the meeting, by establishing the objectives (that include the client, too): "We will try to find a solution together" or: "After this discussion, you may choose what prevention methods you will use".

Acceptance can be proved by:

– the interest shown to the individual, not to the individual's problem;
– the effort to understand the meaning the problem has to the client.

Opposite to the acceptance stands a critical attitude, of judging or immediately sizing up the client, on the basis of some obvious or so-called false beliefs, wrong decisions, slow or quick reactions etc. Criticism is arbitrary, does not allow negotiation or understanding, being instead a simple evaluation of the other's way of being. Moreover, it may induce the client with an inferiority complex.

Words expressing critical attitude, as well as the intention of changing the client's way of being are: "(you) must", "(you) should", "don't", "in my opinion…", "(you) had better…".

*Self-knowledge*

Nowadays, the fact that HIV/AIDS infection represents a challenge for the entire society and especially for the professionals who provide services in this field has become obvious. In addition to that, HIV infection brings on all the individual and social attitudes in connection with sexuality, life style, morality. Many people appreciate that HIV/AIDS is different from other chronic or fatal diseases. Others wonder why confidentiality is so important, why counselling is necessary, why it is mandatory to inform the individual concerned on the diagnosis. Rarely are these representations in contradiction to the attempt of considering HIV infection a chronic disease, just like any of the infectious illnesses.

In *Illness as a Metaphor*[34], Susan Sontag brings forward two interesting things. The first refers to the fact that some illnesses turn to metaphors, and she gives as an example the speech of a general who used to say about his people that they had invaded, "like a cancer", a certain territory. Cancer and AIDS, she says, are, in turn, considered as invasions: the first works over the body from the inside, while the other does it from the outside. Another important idea is that HIV infection runs the risk of turning, in some societies/communities, into something "chique", on the model created by the precedents of other diseases; Sontag illustrates this ides with the 19th century novels, which described tuberculosis in a romantic way: "beautiful young ladies, who retired from the world in luxurious sanatoriums as they were ill". If we think of examples from the Romanian culture, we can find quite a number of famous writers who, in their youth, wanted to get syphilis, so that, possessed by the madness it generates, they could create.

[34] Sontag, Susan – *Illness as a Metaphor,* (Rom. ed.: *Boala ca metaforă,* Cluj-Napoca, Ed. Dacia, 1995).

Each individual has its own representation about what HIV infection means, also about its ways of transmission or about its transmission-encouraging behaviours. In addition to this, people have very clear opinions about what is moral or acceptable, about what is or is not hazardous.

Professionals in the medical or social field say they can control themselves and that their personal opinions do not influence the relationship with their patients or clients. Supposing it is indeed possible that one's own opinions do not affect in any way this individual's professional relationship, it's still recommendable that every professional be able to analyze his/her beliefs and to admit his/her limits. For instance, a counsellor who considers drug consumption as something immoral and believes that only an effort of will is necessary to give it up, will hardly manage to support a client – who cannot or does not want to give up drug use – in finding risk reduction options, which usually suppose the continuing of the consumption. If a professional cannot do that, it means s/he is not the most suitable person for providing the service concerned and must admit that to him-/herself and to refer the client to another counsellor.

A solution for changing one's own attitudes about a subject is, besides self-analysis, self-awareness or the personal development. This can be realized by searching detailed and correct information, as well as by discussing the matter with the colleagues or the supervisors. In the situation when someone comes with some personal negative experiences – for instance, a friend who died because of HIV infection or because of an overdose –, it is essential that the counsellor evaluates his/her attitude and admits his/her limits, referring the client to a colleague. In case s/he doesn't do it, the message s/he sends can be too strong or unjustifiably pessimistic, suggesting the imminence of death.

In conclusion, for the counsellor, the self-analysis, the awareness raising of his/her own feelings and opinions represent a condition in the absence of which counselling cannot be efficacious. Counsellors are not immune to the fears and feelings people experience towards HIV/AIDS. If they do not manage to accept themselves and to seek for further development, counsellors cannot effectively help others.

# Communication in the counselling relationship

Communication is the process of transmitting, receiving, storing, processing and using information. Interpersonal communication is defined as a transfer of meaningful information from one person to another, by which a person sends a message to another and waits for an answer in exchange.

In the communication process when people are engaged, they aim to attain some goals. According to N. Stanton's opinion (1995),[35] there are always key purposes pursued by the communication process:

- to be received (heard or read);
- to be understood;
- to be accepted;
- to provoke a reaction (a change of behaviour or attitude).

There are two basic types of interpersonal communication: *verbal* and *nonverbal.*

Each can be divided into one-way communication and communication with *feed-back*.

**Aspects of verbal communication**

According to Nicki Stanton,[36] words carry information and para-language[37] offers ″information about information.″ If there were no elements of para-language or signs of punctuation, the meaning of the following phrase would be difficult to decifer: ″To forgive cannot be sentenced to death″. This phrase may be understood either as a capital sentence or as a pardon, depending on the communicator's intonation or on the placement of a comma.

In the counselling relationship, besides transmitting information/verbal messages, open or indirect questions are frequently used.

*The use of questions*

The major risk for inexperienced counsellors when using questions is to turn the communication into a routine relationship of the "question-answer" type which looks rather like an interrogation. According to this model, the counsellor in such a situation is supposed to be an expert, and the client has a problem that needs to be solved. So, in this case, if the information about the problem is brought forward, the ″expert″ counsellor will surely find a solution. This is the  wrong model, however, because it's the client who must find a solution with the counsellor's help.

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[35] Stanton, Nicki – *Comunicarea,* Bucureşti, Societatea „Ştiinţă şi Tehnică" S.A., 1995.

[36] *Id., ibid.*

[37] The para-llanguage refers to nonverbal aspects of speech, vocalic aspects, still not words yet.

This ”routine” can be avoided if the following aspects are taken into consideration:

- The counsellor is attentive when using a question.
- For what purpose is a questions used? Is the required information essential and to help the client tell his/her story and clarify it?
- Is there any alternative to using the question (paraphrasing or reflecting the client’s feelings)?
- Is it important and is it the right time to use the question? What kind of question can be used?

***Open questions***

Suppose a larger category of answers and the client is free to answer the way s/he wishes to (e.g.: *What did you feel when he said that?*).

Invite the client to express his/her opinions, feelings and point of view.

Help the client talk freely about her/himself and analyze his/her problems.

***Closed questions***

Suppose yes/no answers or a limited number of possible answers (*Are you married? How many children do you have?*).

By frequent use, the tendency to a question-answer type routine becomes visible.

Are useful in getting specific information.

***Direct questions***

Are precise questions, oriented to a certain problem or information (e.g.: *How did you manage with school?*).

***Indirect questions***

Aim at getting certain information, not necessarily by the means of a question (e.g.: *It must have been difficult at school…*).

The question may be much more open, thus offering the client more options in choosing an answer.

**Aspects of the nonverbal communication**

*Nonverbal communication* refers to body language: mimicry, gesture, attitude/posture, (facial) expression, look, voice tonality and rhythm. Human communication uses a wide range of nonverbal signs, but all of them replace verbal signs or are translated, in the interpretation process, into verbal signs, being saturated with the significance the latter confer on them.

Silence, far from being the absence of communication, is loaded with deep communication. Silence is related to listening and to the correct reception of the messages. By using it correctly, we may stimulate communication, thus giving the conversational partner the chance to express ideas or feelings that, otherwise, would remain hidden. As it encourages responses, silence proves to be a powerful communication instrument.

Listening is an extremely important link in the communication chain, being an essential precondition for the correct reception of a message. If a message is not correctly received, it will only be background noise. The danger is that either the individual is thinking of something else while listening or is thinking about his/her own answer, thus neglecting effective listening. Listening is not a passive process, it presumes understanding, interpreting and integrating received information into one’s own models of knowledge.

According to Albert Mehrabian's observations,[38] out of the total number of messages transmitted in an inter-personal interaction, approximately 7% are verbal signs (just words), 38% are vowel aspects, including tonality, the voice inflection and modulation, rhythm and pitch, and inarticulate sounds, such as sighing, meaningful coughing and other guttural sounds, and 55% are nonverbal messages.

The nonverbal aspects of communication reveal a lot of information about the speaker, his/her emotions and feelings, his/her attitude and the verbal messages s/he is sending:

– V*oice tonality* must not depend on the content of the message. A convincing tone must be strong and firm enough that the conversational partner perceives them with maximum clarity. It mustn't be so intense as to sound violent to the conversational partner's ears.

– *Voice timber* changes/fluctuates according to the speaker's emotional state. It will be warm or resonating, if the emotion is a positive one, or it will be high-pitched if emotions are negative. The latter is easier to size in a voice than the former.

– The *rhythm or fluency of speech* – other element of para-language – can be a way by which the speaker communicates, sometimes unconsciously, information related to his/her state. A slow rhythm of the voice may indicate insecurity, while a too alert rhythm may indicate either that the person is anxious or that his/her message refers to a state of emergency. Persons who take too many breaks or use padding (″errr...,″ ″you know... ,″ ″so…″) are perceived as willy-nilly/hesitating persons, while persons talking too quickly are considered unrestrained or lacking self-control. In conversation, we can control people's behaviour by using certain elements: for instance, if we want to keep someone who wants to go, we can make that person keep on listening to us by increasing the volume and the rhythm of speech and by reducing breaks.

– V*isual contact* has a privileged position in emitting/sending and receiving interpersonal signals and many authors consider it as the most powerful nonverbal sign. One cannot be persuasive unless s/he looks into his/her conversational partner's eyes. Effective visual contact occurs when we are able to look right into the eyes of our discussion partner, more or less continuously, without insisting in an annoying manner.

– *(Facial) Expression:* by imperceptible movements of the eyebrows, lips and eyes, the face can create subtle and quick expressions, and by doing so communicate a large variety of messages. Communication by means of facial expressions is effective when the content of the verbal messages is the same as those with facial expressions. If a person displays ″wrong″ facial expressions or does not change them at all, that person will most likely be taken as ″strange″ or even ″abnormal″ and will face big difficulties in establishing normal relations with other individuals.

– *Attitudes and body posturing:* persons who communicate effectively through their body posturing seem to be relaxed, they do not stand hunched over, keep upright without being rigid and use their hands and shoulders to make their conversation more colourful, but they are not inflexible or rude.

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[38] Mehrabian, Albert – *Nonverbal communication,* Chicago, IL (USA), Aldine Atherton, 1972.

**Effective – ineffective**
**in nonverbal communication**

| Forms of nonverbal communication | Efficiency (encourages communication, showing approval and respect to the conversational partner) | Inefficiency (interrupts or makes communication more difficult) |
|---|---|---|
| Distance | Approximately equal to an arm's length | Far off (very big), too close (very small) |
| Attention | Completely dedicated to the conversational partner | Dispersed to several activities |
| Movement | Of approaching (bent towards the conversational partner) | Removed/approaching |
| Posture | Relaxed but alert, sitting slightly forward | Rigid, sensual, sitting back |
| Visual contact | Permanent, proper, looks in the conversational partner's eyes | Absent, defiant, intermittent |
| Time | Answers promptly, dedicates the entire time to the conversational partner | Rash, does not interrupt prior activities |
| Position of legs and hands (sitting) | Not ostentatious (stayed, not disruptive) | Such as to impose distance to the conversational partner |
| Furniture | Used to approach people | Used as a barrier |
| Clothes | Smart, decent | Flashy, loose, provocative |
| Facial expressions | Smiling, in full accord with feelings | Opaque look, frowning, discrepancy with feelings |
| Gestures | Emphasize warm, relaxed words | Diverts attention from the speech, in discrepancy with speech |
| Mannerisms (strange behaviours) | Absent or not disruptive | Obvious, embarrassing |
| Vocal volume | Temperate, easy to understand | Very strong, very weak |
| Rhythm of speech | Moderate or a little bit slower | Tumbling, impatient or *staccato:* very rare or hesitating |
| Level of attention | Alert during the entire conversation | Indifferent, asleep, forced or nervous |

## Active listening

*"When you listen to somebody completely, attentively, means that you listen not just to his words, but also to his feelings, to everything it is expressed, not just a part."*
(Jiddu Krishnamurti)

Active listening is an important way to effect change in people. In spite of prevailing opinions, according to which listening is a passive approach, clinical studies and research proved that active listening leads to changes in the personality of individuals and in the development of groups. It may induce changes in people's attitudes and in the way we behave towards ourselves and towards others (Carl R. Rogers).

When they are actively listened to, people's answers are more sincere and they become less defensive and more confident in themselves.

By listening actively, we show interest, we prove we consider the speaker important and we also show respect (not necessarily agreement), non-judgemental, and an uncritical attitude towards his/her thoughts.

**Recommended attitudes / attitudes not recommended to active listening**

| | |
|---|---|
| **Recommended atitudes** | ▪ Try to forget yourself. Your aim is to find out as much as possible about the real feelings of the conversational partner.<br>▪ Rephrase what you are told periodically during the conversation to see whether you understood correctly.<br>▪ Use intonation.<br>▪ Answer by using encouraging expressions.<br>▪ Ask many open questions (which require complex answers).<br>▪ Accept the conversational partner's feelings by using expressions such as: "You might have found it difficult," "You seem content with it." |
| **Atidudes not recommended** | ▪ Do not pretend you are listening and on no account interrupt when you are not interested in what you are told.<br>▪ Do not rush to fill each moment of silence with a piece of advice or a joke.<br>▪ Do not direct, at any time, the discussion to your self.<br>▪ Do not consider that your opinion is always the best.<br>▪ Do not "obstruct" the conversational partner's direct speech.<br>▪ To correct or to change the subject is not an advisable strategy. |

*Exploring the situation/problem*

This refers to verbal tactics used in order to help the client speak about him/herself and define more precisely and specifically the problems s/he has.

There are some techniques that can be used:

- Exploring the client's states about which we know are actual, by:
  - Using open or indirect questions (e.g.: *You said that you had a fight with your girl-friend last week. Maybe you can tell me more about what happened then.*);
  - paraphrasing (restate the client's thoughts and feelings in your own way), underlining one or several words of the client's previous answer.

**Example:**

Client: *I was a little bit nervous at a certain moment.*
Counsellor: *A little bit?*
Client: *Well, in fact I was very furious.*

Summarizing: *"May I summarize what you said, to make sure I've understood well?".*
Rephase: *"So, What you were saying is…", "In other words, what you said is…"*.

- Reflecting the client's experience and feelings

This represents the capacity to show the client we understand his/her feelings and experience, by mirroring the message sent by the client.

Most of the time, this technique resorts to picking up on a word or a sentence used by the client and, by rephrasing it, to stimulate the client to tell more (e.g.: *You felt relieved…*). It is essential that the selection takes into

account what is important for the client, and not what the counsellor is interested in.

Mirroring may take the shape of a paraphrase: it's rephrasing or repeating what the client said, in other words but with the same meaning. Paraphrasing may take a cognitive shape, by which we show we have understood the message, its content (*You mean…*) or an affective one, when we show the client we have received his/her feelings.

Mirroring is a difficult technique, as it supposes the interpretation not only of the client's words, but of his/her tone also, of his/her facial expressions and of the movements of his/her body. Certain emotions may appear as general emotions (upset, sad), while others as much more specific (humiliated, deceived).

By paraphrasing the client's message, we may check whether we have correctly understood the meaning of the message, the way in which the client sees what is going on and, by the responsiveness shown, we may facilitate the exploration of the behaviours and attitudes of the client in the counselling relationship.

- Expressing empathy

The expression of empathy goes beyond the mirroring of the client's message. Not only does the counsellor express understanding of the client's feelings, but s/he also shows availability to "experience" these feelings and to pass this back to the client. Empathy is the ability to get into someone else's world and to understand it, as well as to communicate this.[39] To answer empathically supposes the answer to the question is known based on the essence of the message the client expressed at one time.

The technique of expressing a minimum of empathy lies, on one hand, in identifying the client's feelings and, on the other hand, in sending them back and in mirroring them to the client (*You feel…*), by reproducing not only his/her emotions, but also by locating/spotting those experiences or behaviours that generated the feelings in question: (*You feel so furious as it is as if you were betrayed again?*).

Such an empathetic specification/addition may help the client explore other fields or problematic aspects of his/her life, as well as to identify and, possibly, to focus on ways to make changes/totally change.

**Exercise**

Reactions of the client that prove the counsellor's active listening. Tick the box corresponding to the reaction you believe the client has when s/he really feels s/he is listened to.

1. *You are repeating what I told you…* ☐
2. *Your experiences are interesting.* ☐
3. *Thank you for solving my problem.* ☐
4. *You resist against the temptation to give me advice.* ☐
5. *You accept me the way I am, with my good and bad sides.* ☐
6. *You are embarrassed of what I am saying and you avoid the subject.* ☐
7. *You don't criticize my beliefs, even though you do not agree with them.* ☐
8. *I see you are confident that I can find a solution to the problem.* ☐
9. *You let me think and express myself.* ☐
10. *You are speaking enthusiastically.* ☐
11. *You criticize me for the way I am speaking –with an accent.* ☐

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[39] Egan, Gerard – *The Skilled Helper: A Systematic Approach to Effective Helping* (3rd edition), Pacific Grove, CA (USA), Brooks/Cole Publishing Company, January 1986.

12. You are trying to find meaning when I am confused. ☐
13. You do not look at me when I am speaking. ☐
14. You are looking at your watch. ☐
15. You interrupted me before I finished what I had to say. ☐
16. You haven't demoralized/judged me for what I did. ☐
17. You are polite and encouraging. ☐
18. You are not in my shoes. ☐
19. You didn't laugh at me and you didn't hold me up to ridicule either. ☐
20. You showed me that my experiences are important. ☐
21. You came with a solution to my problem before I have described it entirely. ☐
22. You say you understand before I finish what I have to say. ☐
23. You make me feel important. ☐
24. You've let me express my negative feelings without becoming defensive. ☐

Answers: 4, 5, 8, 9, 10, 12, 16, 17, 19, 20, 23, 24.

**Difficult situations in counselling**

Psychosocial reactions regarding the discussion of certain problems of an intimate nature or, especially, regarding the result of an HIV test, may turn out to be very difficult for counsellors. Psychological reactions are very strong, especially when a suggestive result (of the first ELISA test, which must be confirmed with a WESTERN BLOT to determine whether the person is infected or not), or a positive one (an already confirmed result) is announced. The counsellor must be prepared to help the client in his/her effort to face these situations.

The situations in which the client shows an obvious discomfort or those in which the counsellor doesn't know how to continue the counselling session are considered difficult moments for a counsellor:[40]

– *The client is silent:* doesn't want or is not able to speak. His/her reasons for this may be various, from needing some time to think through shock to anxiety or fury. Most of the time, silences appear at the beginning of a meeting or when learning the result of a test. It is important for a counsellor to understand the reason for which the client is silent, wait for the latter to express his/her feelings and, only after a time try to draw his/her attention by continuing the discussion: "As you were saying…" or by starting a conversation round the client's present, temporary feelings: "Sometimes, it's difficult to talk about HIV/sexuality/feelings…".

– *The client is crying:* a client who starts crying or who becomes hysterical makes the counsellor feel uncomfortable, but, for many clients, crying is a defense mechanism that reduces stress. Aware of that, the counsellor must leave his/her client some time to express his/her feelings and then to try to support him/her: "Crying is quite natural, it's a normal reaction of persons who are angry." Although s/he could show the client solidarity and understanding by touching him/her or by getting closer to him/her, the counsellor has to keep in mind that s/he has a professional relationship with the client, and not a social or a personal one; s/he is allowed to do this only in the situation s/he considers it absolutely necessary in supporting his/her client.

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[40] Adapted after Family Health International – *Interpersonal Communication and Counselling Manual on HIV and AIDS* (Institute for HIV/AIDS ed.), Arlington, VA (USA), August 2002.

– *The client talks about suicide:* this is the most stressful situation in the activity of a counsellor and it may occur when a positive result is announced, although among a very small number of clients. In such moments, it is important that the counsellor send positive feelings, or feeling of appreciation to the client's person, instead of discussing/contradicting the latter's decision. Starting from the idea that nobody, except his/her own self, can stop him/her from doing so, it is essential to show the client s/he is a nice person, worthy of admiration and that such an act would make many persons suffer.

– *The counsellor made a mistake:* there are multiple ways by which a counsellor can make a mistake: by delivering incorrect information, by being embarrassed or irritated about something the client expressed or by criticizing the client's message. It is important that the counsellor admits his/her mistake, first to him/herself and then to the client. If the counsellor expresses her/his feelings sincerely, s/he will provide a good example to the client andit will not affect the counselling relationship.

– *The client refuses counselling services:* this situation appears especially when the client does not voluntarily take part in the counselling and HIV testing process. Still, the counsellor may try to talk to the client by telling him/her that s/he understands his/her refusal, and that s/he asks for a few minutes to discuss what counselling and testing are. If the client maintains his/her position, the counsellor thanks him/her for coming, a test is made (only if the client is interested in it) and s/he is invited to come back if s/he wishes. If a client accepts the counselling but refuses the test, the counsellor must remember that the HIV test is not the purpose of a pre-test counselling, but only for risk reduction counselling.

– *The client was referred to post-test counselling, but s/he does not know s/he was tested:* HIV testing, not associated with counselling and without the consent of the person concerned, represents a serious violation of human rights. Still, there are situations where persons are tested for HIV in hospitals, after which they are referred to counselling to be informed of the result. If the person in question does not know s/he is HIV infected and does not even suspect it, the process can be re-initiated with pre-test counselling, a new test and communication of the result. If the person suspects s/he is HIV infected, s/he may be provided two post-test counselling sessions: in the first, the person receives explanations about the HIV test, the meaning of the results and the reason s/he was tested, and in the second session the person learns about the result. This method leaves the client some time to psychologically prepare in the event of a positive result.

– *The client prefers a counsellor of the opposite sex:* the client may directly express this request: "I don't want to talk about that with a woman/man" or it may be noticed by the counsellor during discussions. The counsellor may try to help the client overcome this obstacle by keeping a respectful and uncritical attitude. Or the counsellor may point out that at the beginning, people might feel uncomfortable discussing intimate problems with persons of the opposite sex, but, in time, the procedure may turn out to be more effective. In case the client maintains his/her request, another counsellor may be recommended.

– *The counsellor and the client know each other (they are acquaintances or friends):* this situation often rises in small communities. If the relationship is not very close, counselling may take place by stressing confidentiality

principles. If there is a close relationship between the counsellor and the client, counselling cannot take place and the client has to be referred to another counsellor.

– *The client addresses personal questions to the counsellor:* as the relationship between the counsellor and the client is a professional one, and not a social one or a friendship, the counsellor must maintain a different position towards a client than to other persons s/he knows. Answering personal questions may affect the counsellor's concentration on the client's situation and may constitute the beginning of very intimate questions, to which the counsellor would not be prepared to answer, and this would send confusing messages to the client. The counsellor may respond to the client's personal questions in this way: "The rule is not to talk about myself, as it is of no use for our conversation or for clients."

# Pre- HIV Test Counselling

Pre- HIV test counselling uses an approach centered on the client, which aims to support individuals in achieving behavioural changes, so they may reduce risks of HIV transmission. Centering on the client represents the essential element of this type of counselling, which means it must be personalized and adapted according to the behaviour, circumstances and the individual needs of the client.

**Essential elements of pre- HIV test counselling**

– *Protecting confidentiality for clients requesting an HIV test.* Information about the range of services offered to the client has to remain private and undisclosed to other persons, aside from situations where the client gives his/her consent or where there is a court ruling requiring that the data be revealed. Another exception is a report sent to the public health authority,[41] of which the client must be informed.

Discussing all aspects related to confidentiality right from the beginning of a counselling relationship is absolutely necessary, as it ensures an atmosphere of confidence between the counsellor and the client. Ethically *limits of confidentiality* is also covered, conveying that, in the event counsellors receive a request from the prosecutor's office, they are obliged to breach client-counselor privilege.

– *Obtaining informed consent regarding HIV testing.* Consent with full knowledge of the facts is defined in the laws regarding patient rights. Accepting or refusing a test must have no consequence on the quality of the services provided.

– *Offering the possibility to take a test anonymously.* Anonymous testing (when the coordinates of the client's results are not recorded) offers important benefits for the individual's health and for public health as well. Unfortunately in Romania, anonymous testing is only available in Bucharest for the time being. The option of confidential testing is applied when the client has not precisely asked for anonymous testing.

- *Observance of all legal provisions regarding counselling and testing.* So that patients' rights are not violated and quality services are provided, it is necessary: to observe regulations regarding the minimal age of consent for testing; in the case of legally and mentally challenged persons, that services are provided only in the presence of a family member or the psychiatrist; interpretation is provided for persons with hearing impairments, etc.

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[41] See Annex IV: Working standards in pre- and post-test counselling, chap. „Specific Regulations", subchap. „Monitoring the client's data".

– *Providing services that meet the needs of beneficiaries and communities.* Service providers must ensure that their support is wanted and accepted by the client and be available to adapting the conditions the services they provide to the client's needs (for instance: working hours, location, materials disseminated, interval up to the announcement of the result).

– *Providing quality services.* Service providers must observe working standards and procedures, develop and implement programmes to guarantee the quality of services and ensure programmes to evaluate the client's level of satisfaction so as to make sure services respond to the real needs of beneficiaries and the community.

– *Focusing and maintaining the session on the idea of reducing HIV infection risk.* Each counselling session must address the beneficiary's personal risks of HIV infection and avoid providing a pre-established set of information with no connection to his/her situation or focusing the discussion on the client's other problems.

**Components of pre-HIV test counselling**

*Introduction/establishing a counselling relationship*

To request an HIV test one needs courage, and many clients are confronted with insecurity or mistrust when meeting the counsellor. Establishing a calm and safe atmosphere is an essential step for pre- and post-HIV test counselling, which, as we know, implies intimate discussions and sincerity. From the beginning, the counsellor must try to build a relationship based on equality and paying attention to "politeness": greeting and welcome messages and an invitation to take a seat.

This introduction is followed by the counsellor's introduction, where s/he outlines the session's purpose, its estimated duration (15 minutes) and the outcomes expected from counselling. A essential element in introducing the session involves assuring the beneficiary about the confidentiality of the topics that are to be discussed (also regarding the limits of this confidentiality, if need be). The counsellor must not forget to invite the client to discuss freely and ask any questions about HIV prevention or on what living with HIV means.

To obtain essential data about the client (age, name/pseudonym), the counsellor must ask direct questions. Still, they should not necessarily be asked at the beginning of the counselling session, but rather at its end, when the date of post-test counselling is established.

*Discussing data on HIV and testing*

This stage represents a fundamental component of pre- HIV test counselling. All clients who request an HIV test must receive the following information, even if some of them later choose not to take a test:

- data on the HIV test, including its benefits and consequences;
- HIV transmission risks and how they can be prevented;
- the importance of learning the result.

In addition to this, depending on the client's risks, the following aspects can be very useful:

- demonstrations of how to use a condom;
- information on risk-free sexual practices;
- data on other sexually transmitted infections;
- emphasize the efficiency of using syringes – individually and only once –, for injection drug users.

People have different ideas of what HIV/AIDS means or on the best protection methods against HIV and other sexually transmitted infections. Some opinions may be correct/effective, while others are not. It is possible, for example, that the clients' opinions on protection in general are not very effective for HIV prevention (interrupted ejaculation or regular HIV testing). For this reason, it is important to discuss what the client knows or believes in relation to HIV infection and to clarify his/her incomplete or erroneous information by consolidating correct information. In other words, we must avert myths on HIV prevention.

As examples, low-risk sexual practices and their level of effectiveness in preventing HIV are provided in the table below:

| Minimally efficive HIV prevention practices | Moderatly effective HIV prevention practices | Very effective HIV prevention practices |
|---|---|---|
| Taking an HIV test (possibly a regular one)<br>Medicine for other STIs (e.g.: penicillin)<br>Washing after sexual contact<br>Urinating after sexual contact<br>Use of contraceptives<br>Use of a condom just before ejaculation<br>Withdrawal of the penis before ejaculation | Use of spermicides<br>Use of a diaphragm<br>Reduced number of partners<br>Avoiding risk-taking partners<br>Discussing HIV with the partner/s before sexual contact<br>Use of a condom only with some of partners<br>Sexual contacts only with partners who have taken a test | Correct and permanent use of a condom<br>Sexual contact only with an HIV-negative partner, who is faithful<br>Female condom (not yet available in Romania)<br>Activities without penetration:<br>▪ fantasies<br>▪ touch<br>▪ masturbation<br>▪ reciprocal masturbation<br>▪ massage<br>▪ kissing<br>Abstenence |

In order to make this information easier to assimilate, it is advisable to provide beneficiaries with leaflets, brochures or video materials before the pre- HIV test counselling session, rather than offer them during counselling, so that the session may focus on risk reduction. These materials will be available in the waiting room, and the information the client already has can be completed or corrected during counselling.

Information has to be provided in a language accessible to every client.

**Possible open questions:**

– *What do you know about HIV or AIDS?*
– *How do you believe the virus can pass from one person to another?*
– *How did you make up your mind to take a test today?*
– *What is the reason for your visit?*
– *What would you like the end of our talk to bring you?*

*Risk (self) assessment*

Counselling that aims to identify HIV infection risks is difficult, because it is difficult to estimate or quantify the risk. Within HIV prevention education, clients are helped to classify situations into three groups: high-risk, low-risk and risk-free situations. But, taking into account the complex factors that influence risk, this approach may be extremely difficult for those self-assessing their risks.

Each individual has his/her own perception of risk. Some take risks more easily than others. In addition, a recently emerging risk–or the perception of the person involved in that risk–may vary. For example, finding out that unprotected anal sexual contact with an infected person represents a very high risk, some people may decide to accept some risk, and, in the meantime, try to reduce them by using a condom; others, who do not accept risk, will avert them by giving up this type of sexual contact. It is an issue relating to personal choice.

Since risk perception is so personal and so individual, it is important that counsellors do not classify risk activities, but provide the client complete information, as far as possible, about the risk, in order to enable him/her to put them into his/her own hierarchical system. The discussion will also include factors that influence risk: effects of emotions or of drug use on risk perception (for example, women frequently underestimate risks, due to their feelings towards their partner, and in case of the drug users, assume risks that in other circumstances they would not have accepted).

An essential element in assessing risks is focusing the conversation on recently taken risks, especially on the latest risky circumstance experienced. The reason the discussion is focused on only one situation is that, to asses risk, specific details regarding risk are necessary as is context in which the risk occurred. For example, it is essential to discuss the type of sexual contact, the way a condom was used (if it was used), the partner's sexual history and that of drug use, the existence of any sexually transmitted infections, antiretroviral treatment the partner might have followed, etc.

**Factors influencing**
**the risk of sexual transmission of HIV:**

- circumstance in which the partner became HIV infected;
- whether the infected partner is or is not under treatment (the treatment reduces the quantity of the virus in the bloodstream);
- frequency of sexual contacts (the greater the number of sexual contact is, the higher the infection risk is, especially if it is with multiple partners);
- the influence of emotions on the adoption of risk-free sexual practices;
- type of sexual contact (anal, vaginal, oral);
- the way condom is used (access, conformity to instructions);
- existence of a sexually transmitted disease (lesions or irritations may increase the risk).

We mention that the client's sex can also be a factor influencing risk, as women are more exposed to HIV infection risk due to both biological and social reasons.4242 See Annex I: The HIV infection risks.

**Factors influencing HIV transmission**
**by common use of syringes:**

- circumstance in which the partner [using the same syringe] is infected;
- frequency of using syringes in common;
- influence of the injected substances on thought and the decision to use new syringes;
- access to single-use syringes.

To support the client in assessing risks, as well as in completing knowledge on HIV transmission or in creating a risk reduction plan, the counsellor needs to be familiar with the ways HIV is transmitted and a the classification of these ways, as well as ease in talking about sexual practices or drug use.

*In order for counselling to be effective, it is important not to make assumptions about the client's sexual behaviour, his/her sexual orientation or on the possibility s/he may be a drug user.* Some clients may not give complete information or may not be willing to discuss their sexual practices or drug use. The assumption that a client doesn't use drugs or that s/he has a certain sexual orientation can make the counsellor skip over important information or questions, and this would be to the detriment of the field and also of the client.

Categories of behaviour exposing the client to the risk of infection and their frequency will be identified together with the client, and, at the same time, the discussion will focus on those categories of behaviour, situations and partners that contribute to infection risk.

An essential element in achieving the plan to reduce the risk of HIV infection is to evaluate the stage of behavioural change the client has reached.[43]

If a client is in the *stage of not recognizing the problem* (situation which rarely occurs among individuals who voluntarily take a test), it is likely that the pre-test counselling session determines him/her to pass to the next stage, that of *awareness of the problem.* At the same time, it is possible the client

[43] See Annex II: Theories and models of changing a behaviour (The model of the change stages).

him/herself takes action, and tries to change something. If a client is in the *intention stage regarding behaviour change,* counselling offers him/her, the "instruments" for taking action – information, planning and referrals.

The situation most likely to be a success is when the client is already in the *stage of taking action.* In this stage, taking an HIV test represents only a component of the plan of behaviour change, and pre-test counselling (including risk assessment and the plan for risk reduction) takes on the role to consolidating behaviours the client has already adopted.

**Possible open questions:**

- *What made you want to take a test?*
- *What do you think the test result is? Why so?*
- *If you were infected, how do you believe this could have happened?*
- *Have you ever taken a test before? If you have, why? What was the result?*
- *Tell me more about your sexual life. How many persons have you had sexual relations with? How often? Do you believe they presented an HIV infection risk? Were they drug users? Did they have many partners?*
- *What has been the most recent date when you believe you were at risk of becoming infected? What happened then?*
- *What is the riskiest thing you do?*
- *What are the situations most likely to put you at risk of infection?*
- *How often do you take drugs or alcohol? How does this influence your HIV infection risk?*
- *How would you describe your HIV infection risk?*
- *When do you use a condom?*
- *How often do you use a condom with partners you don't know well?*
- *What about when you are with your stable/permanent partner?*
- *Do you think injection drug users are at risk of infection? Have you ever used them? If you have, have you ever used a syringe or a needle together with other persons?*

***N.B.:*** Exploring behaviours during the risk assessment process is an important component of pre-test counselling, its aim being to facilitate the client's understanding of his/her own infection risks. It does not aim to be a data collection instrument.

*Developing a plan to reduce the risk of HIV infection*

Reducing HIV infection risks include the following dimensions, which may also be considered working principles:[44]

– Effective prevention and sexual pleasure are compatible. Individuals can voluntarily adopt sexual practices, if they have a good image of themselves, of prevention measures they are taking and about their capacity to make these measures part of their life.

– HIV prevention messages must treat the consumption of illegal substances (drugs) as a health problem, rather than as a moral or criminal one. Prevention programmes must accept that giving up alcohol or illegal drug use is not possible for everybody, but that risk reduction strategies provide a wide range of options to reduce HIV transmission risk associated with drug use.

– Women living with HIV have the right to make their own decisions regarding birth or pregnancy. For this it is necessary that they have access to correct and complete information regarding the options they may have,

[44] McClure, Craig; Grubb, Jan – *HIV & HCV Transmission: Guidelines for Assessing Risk. A Resource for educators, counsellors and healthcare professionals* (3rd edition), Ottawa, Canadian AIDS Society & Health Canada, 1999.

including those regarding the termination of pregnancy or antiretroviral treatment, or those regarding the prevention of HIV transmission to the child.

– Information, education and counselling on HIV transmission must take into consideration all social and psychological factors that may influence the individuals' capacity to adopt or maintain low-risk behaviour.

**Factors influencing behaviour change:**[45]

- *knowledge:* factual, basic information on how HIV can be contracted and on how it can be prevented;
- *risk perception:* the feeling of vulnerability when it comes to a health problem;
- *perception of consequences:* the anticipation of what is going to happen, positively and negatively, following a new behaviour;
- *current consequences:* current experience, both positive and negative, determined by the practice of a certain behaviour;
- *access:* the existence of services and products–as well as the personal possibility to get access to them–necessary for initiating or maintaining a certain behaviour;
- *abilities:* set of habits necessary to adopt a behaviour;
- *self confidence:* the belief or confidence that it is possible to adopt a certain behaviour;
- *attitudes:* thoughts and feelings about current behaviour or about new behaviour;
- *intentions:* what a person wishes to do in the future;
- *perception of social rules:* actions an individual considers other close persons expect from him/her;
- *social policies:* laws and regulations affecting behaviour.

Risk reduction takes into account that the degree to which people assume risk varies very much from one individual to another and, at the same time, the right of everyone to assume risks, but not failing to take the most effective protection measures available. There are risk-free options both for the sexual practices and for injection drug use, and some individuals will try to adopt them. Others, however, will assume a risk level, which once again makes the wide range of options of reducing HIV infection risk necessary. In order to be able to achieve a realistic plan for behaviour change the, a preliminary evaluation of the acceptable level of risk for each client is needed, enabling the client to establish, based on this evaluation, his/her objective for prevention.

Once the client has identified HIV infection risks and decided to change his/her behaviour (towards adopting safe or ow-risk behaviours), the next step is to define (by the client) the target of the approach/ behaviour change and then achieving, with the counsellor's help, a concrete plan for attaining set objectives.

This plan must address the identified risks and incorporate previous attempts to reduce HIV infection risks, considering the discerned barriers. Discussions focus on how the client will carry out this plan by appealing to specific steps. An emergency plan (a plan B) must also be drawn up.

Before finalizing this stage of pre-test counselling, the counsellor must have confirmation that the plan is acceptable to the client, then record the plan in the template[46] and hand a copy to the client. The counsellor will openly admit the plan is a challenge and will confirm once again that at the next visit (post-test counselling) they will work together to update or rediscuss the plan.

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[45] Academy for Educational Development [for the CDC Atlanta] – *Fundamentals of HIV Prevention Counselling. A Training Program (Participant's Manual),* Atlanta, GA (USA), November 1998.

[46] See Annex IV bis: Working protocol in VTC, Template 1: „Plan for reducing the HIV infection risks".

To draw up a plan for risk reduction, it is first necessary to identify objectives target of behaviour change: for example, this can include the consistant use of condoms, a decrease in the number of partners, discussing HIV-related issues among both members of a couple, practicing lower-risk types of sexual contact, averting of sexual practices involving penetration, the use of new syringes only once, sterilizing syringes with chlorine etc.

For each of these objectives, detailed action plans can be drawn up based on each client's situation. Thus, according to the objective to reduce the risk chosen by the client, concrete, achievable benchmarks can be set, meant to help to the achievement of the objective.

We present, in the following table, the possible steps of risk reduction by objective (the risk reduction plan):

| *Risk assessment* | |
|---|---|
| Identified risk:<br>– Unprotected sexual contact with the current partner. | Previous success in adopting safe behaviours:<br>▪ Used a condom with other partners. |
| Barriers to adopt safe behaviours:<br>▪ Had no condom at hand.<br>▪ Feared the partner's reaction.<br>▪ Found no way to initiate a discussion about protection. | Benefits of behaviour change:<br>▪ Friends believe it is important (social support).<br>▪ Also prevents pregnancy and sexually transmitted infections.<br>▪ Individual feels safe. |
| *Risk reduction* | |
| Objective of reducing HIV infection risk:<br>– The use of a condom with a new sexual partner. | Possible steps in fulfilling the risk reduction objective:<br>– buying a condom;<br>– keeping a condom;<br>– talking with the partner about the possibility of using a condom (with arguments);<br>– talking about the correct use of a condom. |

**Possible open questions:**

- *What can you do now to reduce HIV infection risk?*
- *What can you do to suit your situation?*
- *How and when are you going to use prevention methods?*
- *How will you discuss these methods with your partner?*
- *What will you tell him/her?*
- *When do you believe you can do it?*
- *How realistic is this plan for you?*
- *What is the first stage of this change?*
- *Who can help you?*
- *What is the most difficult part for you?*
- *What are the good parts of this change?*
- *How could drug use practices be changed, so as to be out of HIV infection danger?*

In order to identify the resources necessary to put this plan into practice, the client must be helped in identifying of any previous (successful) attempts to change his/her behaviour and with the evaluation of their social support network. The identification of support points, and also of the possible obstacles/barriers to adopting behaviours with low infection risks is ensured by drawing up a realistic plan of behaviour change. The whole discussion is focused on the client's confidence in his/her power to change something in his/her own behaviour.

**Possible open questions:**

– *Does your sexual partner play any role in your decision to take atest?*
– *What do you talk about with your partner/s about HIV and other sexually transmitted infections?*
– *Who did you talk with about your HIV infection related fears?*
– *Do you know an HIV-infected person?*
– *What are you doing to protect yourself from becoming infected?*
– *Do you wish to reduce your infection risks?*
– *Have you done anything so far to reduce risk? How did it work?*
– *Do you remember any period of time when you practiced protected sex or used sterile injection equipment? What made you do so? How was it?*
– *What barriers/obstacles have you faced?*
– *How did you overcome these obstacles?*

**Encouragements:**

– *It is very good you are here.*
– *You have made the first step.*
– *The simple fact that you are thinking about HIV infection is already very important for prevention.*
– *It is important that you analyze the way in which you have already tried to reduce risk, in order to find even more effective ways.*

*Consent for testing*

In order to apply the risk reduction plan, referrals to services that may provide support are made, according to the chapter on "Referrals."

The client's decision to take a test and the consent to testing (preferably in writing)[47] represents the final stage of pre-test counselling, as after all that remains is to establish the date and hour for post-test counselling (in writing, preferably ).[48]

The use of a template form for consent for testing:

– underlines the fact that the HIV test is voluntary (and that it is important to be done at the beneficiary's request, because only in this case premises are created for adopting HIV prevention measures);
– avoids possible accusations brought against the counsellor or the laboratory (there were situations where families of tested children didn't know their diagnosis nor the fact that they had been subjected to an HIV test).

[47] See Annex IV bis: Working Protocol in VCT, Template 2: Consimțământ în cunoştință de cauză (consent for the testing).
[48] *Ibid.,* Template 3: Visiting card for pentru programarea şedinței de consiliere post-test HIV.

Under some circumstances, an HIV test can be postponed. If a client decides to postpone the test, his/her decision does not mean s/he was provided with a lower quality of counselling, but counselling that enables him/her to decide, in full knowledge of the facts, whether to take the test or not.

During pre-test counselling, discussions cover possible reactions that learning about a positive result may generate, for some clients, states of anxiety may be caused that need to be carefully analyzed by the counsellor, as they may lead to depressions/breakdowns (in some situations, few in number, even to suicide), if the result proves to be positive. In this stage of counselling, the events from the client's past need to be very carefully analyzed to detect possible trauma and to investigate the mental health of his/her life. Some counsellors may have insufficient qualifications to correctly evaluate the clients' mental health history, at which time the counsellor must admit his/her limits and to refer the client to specialists.

In situations where the counsellor does not consider a client able to confront a positive result and his/her life might be in danger, s/he must discuss the advisability of taking a test right away. It is likely that such a refusal from the counsellor would cause the client to take a test somewhere else. Although the final decision belongs to the client, the counsellor has to underline how important it is for the diagnosed HIV-positive person to have support.

In some contexts, it is good to have the test postponed until the client identifies sourcess of social support in the eventuality of a positive result. In cases, very rare, when clients have taken a test before and tested HIV-positive, but they do not accept the result and wish to repeat the test, the counsellor must discourage the testing or at least have it postpone it, by guiding the clients to psychological or psychiatric intervention.

In a client suggests that, if s/he tests positive, s/he will express his/her resentment against a person that might have been involved in his/her getting infected, the counsellor is free to consider postponement of the testing as convenient and to refer the client to a specialized service (psychotherapy).

Another situation when postponement of the testing is advisable when clients are in the beginning stages of a rehabilitation programme for drug users, as the stress accompanying the change of behaviour and lifestyle aggravate their reactions if they test positive.

**The check-list for pre- HIV test counselling** 49

| | |
|---|---|
| Establishing a relationship | ☐ |
| – Objectives of the meeting | ☐ |
| – Confidentiality limitations | ☐ |
| | |
| Discussing data on HIV infection | ☐ |
| – Differences between HIV and AIDS | ☐ |
| – HIV transmission | ☐ |
| – Evolution of HIV infection | ☐ |
| | |
| Discussing testing procedures | ☐ |
| – Sample-gathering procedures | ☐ |
| – Types of tests/ need form confirmation | ☐ |
| – Meaning of the results | ☐ |
| | |
| Risk self-assessment | ☐ |
| – Reason for testing | ☐ |
| – Identified risks | ☐ |

[49] Detailed in Annex IV bis: The working protocol in VCT.

Drawing up a risk reduction plan ☐
– Acceptable risks ☐
– Establishing objectives ☐
– Developing a concrete plan, on stages ☐

Consent for testing ☐

Referrals ☐

**Exercise –pre- HIV test counselling**

Read the following text carefully and identify the five errors the counsellor makes.

1. *Hello, you're welcome. Have a seat, please.*
2. Hello.
3. *My name is M.N. and I am a counsellor with this center. If you wish to take a test on an anonymous basis, you don't have to introduce yourself.*
4. No… I am L.M. and I wish to take an HIV test.
5. *You have come to the right place. You can take an HIV test, but, before the test itself, we may discuss HIV testing and prevention, depending on what you are interested in. Our talk will take no more than 15 minutes and it is confidential. We hope that, following this discussion, you are able to draw a clear plan to avoid the risk of HIV infection.*
6. OK. I believe it is never a wrong moment for a discussion on HIV. As for risk reduction, it's clear: if I hadn't wanted it, I wouldn't have come here.
7. *Would you like to learn something specific about HIV infection? Would you like to find out something about transmission, testing and the dynamics of the infection?*
8. Well, …, I think - all of them.
9. *Very well; of course, you also know a lot. Can you tell me how is HIV transmitted?*
10. By sexual contact and blood. And… can be prevented by using a condom. Err… and drug users must use only one syringe only once. And those guys… to ruin their lives in such a way! Not to mention you have to be careful when you go to a doctor, and ask him to unpack the syringe in you presence.
11. *Quite true. It is transmitted by unprotected sexual contact, because the virus is largely in the sperm and genital secretions. We are talking about all types of sexual contact, but we know that, for some, risks are even higher. It is transmitted through blood too, and there is also another way of transmission – that from the infected mother to her infant. If we talk about prevention of sexual transmission, there might also be other methods, as well. For example, abstinence or fidelity to one another.*
12. Yes, temporary abstinence. Fidelity is more difficult. Could you swear on someone else? Although… Ough, if the mother is ill, will the child surely be infected? Because I've heard some aren't.
13. *That is right. The infection risk to the child is of approximately 40% if the mother doesn't know her diagnosis and takes noprevious measures, but this risk can drop to 5% if the infected mother is tested positive in the first three months of pregnancy and undergoes antiretroviral treatment, gives birth by a caesarean operation and does not breastfeed her child. Have you heard of antiretroviral treatment?*
14. No, what is it?
15. *It's the treatment for HIV infection. This treatment does not cure the disease, but it significantly extends the period when the HIV infected person feels well. It is a treatment that has to be taken everyday for the rest of your life.*
16. How long can one live with AIDS?

17. *If we talk at first about HIV infection, one may live many years with it. There are people who have had the virus for 20 years and they feel fine: it depends on each individual and on the way s/he takes care of him/herself. AIDS is the advanced stage of HIV infection, the final one. If we talk about life span, we may notice it has increased as medicines have improved effects. Still, there are persons who die, either because they do not take care of themselves or because they catch serious illnesses associated with HIV infection.*
18. Yes, I've heard you don't die of AIDS, but of other diseases.
19. *Indeed. This is because HIV weakens the defenses of the immune system against aggressors… I can see you know a lot about HIV. Have you also read the materials in the waiting room?*
20. Yes, I've tried to find out as much as possible about this topic. And now I've heard something new about mother-to-child transmission.
21. *Do you have some knowledge about HIV testing?*
22. So-so. The test does not show if I am ill now, but if I were 6 months ago. This is because it doesn't look for the virus, but for the anti-bodies created against it.
23. *That's right. In most of cases, the test is relevant even three months after, but it is safer to take it or retake it 6 months after the potentially risky situation. The result of the test can be…*
24. Negative or positive. It means exactly the opposite than the words say.
25. *Yes, a negative result means you do not have the anti-bodies now, but also that you have to repeat the test if you have been involved in any risky behaviours in the last 3-6 months. And the positive result?*
26. That it is an HIV infection and that I might get AIDS.
27. *True, but only a specialized doctor can say which stage the infection is at and what is the suitable treatment to follow. If we talk about a positive result, how do you believe your friends and colleagues would consider an HIV infected person?*
28. Most of them would run away. Maybe some will try to help her. But I don't believe they need to know who is and who isn't ill. I think I wouldn't tell them.
29. *To anyone?*
30. Well, I would tell my parents. Maybe to Z. too, he is a nice guy. Anyway, I wouldn't tell anyone at work. … Yes, but they may find out. It surely is confidential?
31. *Both our discussion and the results of the test are confidential. The results and your name only go to the Public Health Authority, and the people working there are obliged to keep it secret, apart from the situations where the prosecutor's office requested it. We are discussing about positive results, but you haven't taken the test yet. Besides these small inconveniences, the test also has benefits…*
32. Yes, I will know what the situation is. If I am not ill, I'll sober up; and if I am, I'll go for treatment.
33. *Sober up? What's the meaning of this?*
34. To stop having casual relationships.
35. *Since we are talking about the HIV test, can you tell me the reason you decided to come here and take this test?*
36. It's because I had a relationship–unprotected–with a girl that I suspected was not well. In fact, with several girls. And I want to know if anything bad happened to me.
37. *Have you taken an HIV test before?*
38. Yes, a few years ago.
39. *Can you tell me the reason you took the previous test?*
40. Well, I didn't have the same reason then. I guess I had heard some things about AIDS and I took the test. I believe I had encountered no risk. Coming back to the reason of this test …

41. *Coming back to the reason for this test… Can you tell me more about the context of where those risky situations occurred? For example, how long ago was the last occurrence, how often did they occur, the type of sexual contact and any other information that you think might be useful in understanding how great the risk was that you were exposed to.*
42. How great? Does that matter?
43. *I believe it is important if we want to see how it can be eliminated or averted. What do you think?*
44. Yes, this is true. Let's see. Because I can't manage to find a stable partner …
45. *…?*
46. I've had about six lately. I guess it was normal sexual contact. I tried anal contact with only one … I saw in the folder that this presents a higher risk, because the mucous membranes of the anus are more sensitive. And that oral sexual contact presents lower risks, as spittle doesn't contain enough of the virus. It's just that, in this case, wounds may appear and they imply blood. Ooh, and there can be higher risks for a woman or, let's say, for a receiver?
47. *That is correct. You were saying about six partners. If we take the last 12 months, how many partners were there?*
48. …About 20, I guess. But the last one wasn't very trustworthy.
49. *What do you mean?*
50. I paid for … the services.
51. *What do you believe was the risk in this situation? Do you think she was HIV-infected? Or infected with other diseases?*
52. The risk? I saw no risk then, but now… First of all, I didn't know her. Secondly, I didn't use a condom and there was also anal contact. I don't know whether she was infected or not. If I'd known she was, I don't think I would have come here!
53. *No?…*
54. Well, it was clear I took it, too.
55. *It's not certain. The same as we don't know who is ill and who isn't, because there are no visible signs. One might say it is, somehow, just like Russian roulette: you may get infected at the first exposure, at the second or at the tenth sexual contact. And anyone can get sick, HIV infection does not choose… Coming back to the situation that worries you, did you use a condom?*
56. A condom? I don't really know. I guess not… Maybe I had some drinks before. And I was very confident. No, it was because I find condoms an uncomfortable trifle.
57. *Uncomfortable?*
58. You must put it on, take it off, and throw it away. And you also must have it when you need it, and it's not free. Anyway, I use them.
59. *How often do you use them?*
60. Sometimes. I didn't have one with me then.
61. *Do you consider you have been in other at-risk situations as well? Drug use, transfusions or hospitalizations before 1990?*
62. Drugs?! No way! And I haven't been hospitalized either. It seems it's only with the sexual contacts that I have problems.
63. *It's very good you use condoms, even if not always. It brings benefits for HIV prevention, the prevention of other sexually transmitted infections and unwanted pregnancies as well. And, if we are to value health and …how will we call it?*
64. …pleasure or, maybe, comfort/laziness?

65. *Let's look for HIV prevention options that don't affect pleasure or comfort… Let's start with comfort. What can we do?*
66. I should use a condom every time – it's simple! Or, maybe, I should stop having casual relationships That's complicated. I better stick to condoms!

67. *Indeed, it would be relatively simple. There are advantages, but also barriers we should take into consideration…*
68. It's simple with the advantages: I protect my health. As for the barriers, it's more complicated: condoms require money, diminishes pleasure, sometimes a partner doesn't want to use one or, even worse, she becomes suspicious that something is wrong with me or with her. You know that after a few dates, many of them say they take pills and don't want a condom… I'm lucky I don't often get into such situations …

69. *Do you consider you have resources to overcome these barriers?*
70. Yes, I can buy condoms and I can freely discuss about them with the girls. And maybe I'll drink less.

71. *Has you ever been without a condom when you needed one, or have you had one tear?*
72. No, I have never had one tear. But not to have one when I needed it? Well, this has happened to me.

73. *What could you do to eliminate such a problem?*
74. Have a condom with me. Always. But not in the pocket, as I've already read in the folder down the corridor.

75. *If we fill in this form with some steps to reduce risk, what would you note down?*
76. That I should always have a condom with me, discuss with the girls about that and drink less.

77. *OK. Let's get back to the test: you will get the result–personally–in a fortnight from here. What time could you come?*
78. Shall we say Thursday at 18:00?

79. *It is very well. I understand you decided to take a test?*
80. Of course.

81. *Then, please read and sign this form, and then go to the next room to give a blood sample.*
82. Thank you.

83. *Don't mention it. We are expecting you in a fortnight: it's important that you come and pick up the result. Good bye.*
84. Good bye.

***Answer:***

**a.** After point 6, the discussion could have focused on the risks the client referred to, and not about the need for information (following that, beginning with the risks, the discussion went towards HIV). The conversation has to follow the way indicated by the client, who talks about risks.

**b.** At point 27, the client should have been asked, at first, about his/her own reaction to a potentially positive result and only after that about the reaction of the people around him.

**c.** At point 49, the talk might also have been on the possible risk from/to other partners, by emphasizing the fact that HIV has no visible signs and symptoms and that, this way, anybody can be infected.

**d.** After point 61, the counsellor could have approached drug use of his/her client's partners and, implicitly, potential risks.

**e.** At point 79, the ways in which a test is provided–on a confidential or an anonymous basis–are not discussed. Although it is obvious from the beginning of the discussion that there is the option of an anonymous test, the client is not asked to specify the way in which he wants to take the test.

# Post- HIV test Counseling

Post- HIV test counseling includes the announcing of the HIV test results and the reinforcement of the people's efforts to put into practice the plans for reducing the risks of HIV transmission.

In a post-test counseling, clients:

- will receive the result of the HIV test, accompanied by an interpretation based on their risks of infection and taking into consideration the period of „immunological window";
- will understand the meaning of the result;
- will talk again on and adopt the risk reduction plan, established during the pre-test counseling.

The duration of a post- HIV test counseling is similar to that of the pre-test counseling (15 minutes), except for the situation when a positive result is announced, when the session may be longer. In case more time is needed, a new meeting is established.

**Key-principles**

- Acknowledging and supporting the client's approaches towards a behavior change;
- Clarity in announcing the results;
- Provision of emotional support;
- Provision of referrals.

**Announcing the results**

This is the first stage in post-test counseling, after the greeting messages. The results must be announced in a clear and simple language, avoiding the professional jargon. It must always be checked whether the person understood the result, including the situation when it is necessary to repeat the test after a while – for example, in case of some recent behaviors or situations at risk.

Postponing the announcement of the result, no matter what this is, runs the risk of making the client tensed, of determining reactions of mistrust or of perceiving the result as being very serious.

**Meaning of the results**

It is necessary to explain the meaning of the results within any post-test counseling and it has to be done on account of previous discussions, which took place in the pre-test counseling, about the possible results.

Thus, the result can be:

1. *Negative* – there are no evidences (antibodies) related to the existence of an HIV infection, with the mention that, if the person in question has got infected recently, s/he might be HIV-infected, while the test might not have been reactive or positive yet. The anti-HIV antibodies develop in 3 month time from the infection, and for some individuals even in 6 month time.
2. *Undetermined* – the test result is not clear enough. It is possible that the person in question has got infected recently and the reaction of the organism has not been strong enough yet or it is possible that the test has taken the anti-HIV antibodies for something else. In this situation, a new testing is advisable – according to the provisions set by the Ministry of Health.
3. *Reactive* (to an ELISA test) – the test result indicates the presence of anti-HIV antibodies, but, as we have already said in chapter *Communication in the counseling relationship,* subchapter „Difficult situations in counseling", to be able to put the diagnosis of HIV infection, a confirmation test is necessary.
4. *Positive* (in the situation when a confirmation with WESTERN BLOT was done, according to the provisions set by the Ministry of Health) – the test result indicates there is an HIV infection, the stage of the infection not having been evaluated yet. For that, a specialized evaluation is needed, in a setting for infectious diseases care.

For each of these results, the post-test counseling has its own characteristics, and especially at the last 3 ones, it includes – besides the re-discussion of the risk reduction plan for the HIV transmission – the provision of emotional support, the discussion of the limits of confidentiality and the partners' notification. This is the reason why we will present on one side, the post-test counseling in case of a negative result and, on the other side, the post-test counseling in case of a positive result, which is valid also in the case of an undetermined or reactive result – situation when, otherwise, a discussion on the need of repeating the test is compulsory.

**Post-test counseling if the result is negative**

*Rediscussing the plan to reduce the risk of HIV infection – possible reactions when facing a negative result*

The provision of the post- HIV test counseling after a week, and two weeks respectively, after the pre-test counseling has good effects on the client's approaches of risk reduction. The interval of time gives the client the possibility to try to adopt prevention measures and, in case they meet difficulties, to get support in adapting/rebuilding the strategy.

The re-discussion of the risk reduction plan is based on the decisions made during the pre-test counseling on the steps to follow in order to prevent infection.

The objectives of re-discussing the plan are: the evaluation of its level of fulfillment, the encouragement of the client to make him/her go on with and/or adapt the plan – if it proved difficult to carry out.

**Possible assertions/questions:**

*Exploring the application of the plan:*

- In our previous meeting, we discussed about some of your risks of getting HIV-infected, which were… etc.
- Starting from these risks, we built up a risk reduction plan, on several stages. How has it gone so far?
- Did the plan prove suitable for you?
- How did your partner react?
- Are you satisfied with the way you applied the plan?

*Reinforcement of the client's actions:*

- It's good you've managed to do that.
- I am impressed with what you've done.
- Indeed, you've been trying to change something, it's very good.

If there were *difficulties in carrying out the plan for reducing infection risks,* the following questions may also be asked:

- What part of the plan went all right?
- What part of the plan involved greater efforts?
- What prevented you from putting it into practice?
- What could have been done in a different manner?
- When will you try again?
- What would make it easier to apply?
- What else could you try?

In case the application of the plan failed, and the client rebuilt or adapted the plan, the counselor provides him/her with referrals towards services that may support him/her in changing the behavior[50].

*Possible reactions when facing a negative result*

The provision of the post-test counseling, in case of a negative result, may seem to be the easiest part of post-HIV test counseling, but it may be considered also as the part of the counseling which supposes the highest responsibility from a service provider. Many of the counselors fear the person who took the test and received a negative result leaves the centre or the testing laboratory and, maybe the same day, engages into an infection-risk behavior. An additional argument to this fear is the fact that some of the clients, when hearing a negative result, „hop on their foot and leave the office". By this behavior, they show they don't want to take part in the discussions on the risk reduction. In such situations, the counselor may invite the client back to the office, if s/he wishes to discuss about the risk reduction. It may also be useful to repeat messages such as: „HIV testing does not provide immunity to the HIV infection" and „the protection is not provided by a periodical testing, but by adopting risk-free behaviors or with the lowest risks possible".

This type of reaction at learning a negative result may be determined by a feeling of invulnerability – „I have been through a very risky situation and I haven't got infected, which means HIV doesn't affect me".

[50] See chapter „Referrals".

Such an attitude may prove to be dangerous and, sometimes, it lies at the basis of giving up the protection methods or of adopting inefficient behaviors for the HIV prevention – such as HIV testing.

Another type of reaction is the feeling of guilt that may appear to persons that are part of a couple with discordant serology (in which only one of the partners is HIV-infected) when a negative result is announced, or when the client feels guilty for the infection risk behavior s/he had and considers s/he should have got infected with *HIV* (as a punishment). A first manifestation of this psychology may be the denial of the test result, when it is also possible to adopt behaviors with high-risk infection. As for the couples with a discordant serology, referrals may be provided to a service specialized in counseling HIV-infected persons and their partners, while persons who believe they are HIV-infected, although the tests are negative, may be referred to a psychotherapy service.

**Post-test counseling if the result is negative**

*Ensuring emotional support – possible reactions when facing a positive result – applying crisis counseling in the case of HIV infection*

The post-test counseling in case of a positive result will take into account the client's reaction when hearing the result (shock, denial, acceptance) and will focus on supporting him/her to solve the crisis situation determined by learning the result[51].

The counselor gives the client the chance to:

- express his/her emotions and find the ways to face them (the problem has to be defined from the client's point of view) by:
- talking about the diagnosis;
- crying and being furious;
- thinking of who might support him/her;
- thinking of new goals for the future, new possibilities;
- make clear the understanding of the next stages (studying the alternatives):
- accessing the evaluation and treatment services (a test for determining the quantity of virus, prophylactic treatments for other diseases);
- contacting self-support organizations – associations of the HIV/AIDS-infected people, groups of support, long standing counseling, information (on the treatment, dynamics of the infection, social support, referrals to other services);
- drawing up a strategy for announcing the partners – in order to cope with the fears of having exposed other persons as well to HIV infection and to find solutions to inform them on that (so that they know they might have been exposed to the risk of HIV infection);
- elaborate a plan to cope with the situation (with concrete, durable steps).

**Possible questions/assertions**:

- *There are people who say the diagnosis determined them make favourable changes for their life: to face up things in a positive way, to look for a better job, etc.*
- *HIV infection does not necessarily mean AIDS. You know that AIDS is an advanced stage of the infection.*
- *Current treatments are more and more efficient – the development of more efficacious medicines is ongoing.*

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[51] See *infra*, The application of the crisis counseling to the HIV infection.

- *There are people who have been living for many years with the virus.*
- *Do you think of changing something in your life?*
- *What options can you see to face this diagnosis?*
- *Out of them, which will be the first thing you will do after you leave this place?*
- *What do you need to manage to face this diagnosis?*

The discussion about the ways by which a client may inform his/her partner on his/her diagnosis represents an important component of the post-test counseling when it's about a positive result. Many of the HIV-infected individuals may consider themselves guilty for having passed the virus, without being aware, to their partners, but to inform them on that is not always an easy thing to do. In order to find the best ways to inform the partners (and to keep on providing emotional support), a second session of post- test counseling frequently proves to be necessary. The clients may choose various options of information: from a festive supper to a letter or, in case they fear a possible extreme reaction from their partners, up to insistently disseminating leaflets on the HIV testing in their neighbourhood (with the help of a social service).

**Possible questions:**

– *Whom could you talk to about your diagnosis?*
– *How can you inform your partners?*
– *How can you make sure their reaction will be acceptable for you?*
– *Which is the worst thing that can happen to you?*
– *How can you help your partners?*

*Possible reactions when facing a positive result*

Reactions to a positive result are quite various, depending on how the person in question is interpreting the result that moment and on his/her own way of coping with trauma. Some experience a deep shock and an obvious anger, others – a kind of stun, and some others – an apparently calm acceptance of the situation. Some people's reaction when hearing about the infection is to deny it. In certain cases, the initial denial can be a constructive way to face the shock. The denial can reduce stress, but, if it lasts, it can be distructive and can prevent from changing behavior. Some people grow furious because they feel victimized, because they were not prepared or because they find it unfair they have got infected. They can put the blame on themselves or on others.

– *Shock.* The information has a very strong impact, sometimes beyond the individual's defense capacity, who feels overwhelmed by the events. Afterwards, many evoke those moments by describing feelings of stupor, of „black hole", a state of apathy, a loss of contact with the outside („I couldn't hear anything", „it was as if I were stroke", „everything drowned"). The individual is no longer responsive to the surrounding environment. That moment, it is extremely important that the counselor keeps silence, to allow the client come to him/herself again and, later on, to re-establish a visual or physical contact to stimulate him/her express in words the state of stunning or of breakdown.

– *Denial.* Another possible reaction is to deny the result: „No, no, it can't be!", „it's a mistake!", „I can't believe that!". Sometimes, this stage

cannot be avoided – somehow, the denial helps in surpassing a situation too difficult to be accepted right away. This stage must be respected, but not fed up (never say: „Yes, it may be a mistake”).

– *Fury.* It is a more elaborated defensive reaction and stands for the integration, the incipient awareness of the information on the positive result. The fury finds expression in verbal reactions hard to bear for those present, because the fury is an unacceptable and depreciative feeling. It's important you tolerate this fury and let it be expressed. It can be directed towards the outside, by searching for some guilty persons or scapegoats („If I only found the one who did it to me!”), full of resentments towards the others – partners who did not inform him/her, doctors who did not make the announcement properly, the society which is not doing enough... The fury can also be directed to one's own person – „It's my fault, I received what I deserve!”. It is important that people around can accept the fury, let it be expressed without feeling broken-hearted or offended.

– *Withdrawal into oneself.* It is a non-systematical stage, very important and dangerous, as it may pass unnoticed. The person in question is inclined to withdraw into him/herself, doesn't go out any longer, doesn't meet friends, doesn't answer the phone, nor eat. This moment of seclusion may help him/her regain forces to face the outside world and find the right words to talk about his/her problem. In this stage, the suicidal thought may appear, and it may turn to real (idea that has only been verbalized in the previous stage). Any will of living fades away, the individual feels useless, without a future, and has no more aspirations. The company/circle of friends must be ready to support him/her, to show their interest in everything the HIV-infected person thinks or does, to remind him/her how important and loved s/he is.

– *Change.* The individual invests in projects for the future, makes decisions, settles different rituals or life styles, such as: „I'll lead a healthier life”, „I'll stop smoking”, „I'll do some exercises”, „I'll get involved in humanitarian causes”, „If I get actively involved, I will save myself”. This is the right time to start civic activities, to engage in various campaigns, to participate in scientific trials. It's a stage of hope, in which the HIV-positive individual needs no more information and s/he is ready to act over his/her own self in various ways.

– *Acceptance.* The individual accepts the information on the HIV-positive result, admits s/he has to live with it, has integrated this aspect in his/her life, which represents a reinvestment in him/herself, in the personal history and future as well. It's turning over a new leaf with the feeling of it's-urgent-that-I-were, with the willpower of enjoying every second of it, in order to give life a new meaning and even to undertake something symbolizing life: build a house, travel, start writing, directing a movie, meet other people and tell them about his/her own life: „I would have never thought I would be able to get over the situation I was and, still, here I am: I have lots of things to do in the years to come! Completely different things of what I planned to do ten years ago”.

Passing through these stages is not the same experience for all people, especially if they have not a straight development. It is about a route with many ups and downs, generated by different events in the life of an HIV-positive individual or in the life of those close to him/her: the increase of immunity, the loss of a friend, the appearance or prescription of new treatments.

Those above-mentioned are not an exhaustive presentation of the possible reactions, they only reproduce *few* types of reactions. It is important that the counselled individual knows s/he can discuss about what s/he feels without being judged, ignored or excluded. The counselor has to answer him/her sincerely, warmly, by showing tolerance and understanding to help him/her express his/her feelings.

**Crisis counseling in HIV infection**

Many of the events occurring while living with HIV may generate a crisis (the diagnosis, the initiation of an antiretroviral treatment, the first hospitalization, the first opportunistic infection, the retirement, the death of an acquaintance with AIDS, etc.). These events may occur separately or at the same time and, each time, they may generate a crisis.

When the infection is diagnosed, the intensity of a crisis varies very much, according to factors such as:

- whether the individual in question has taken the test voluntarily and with full knowledge of the facts;
- whether s/he considers her/himself at risk/possibly infected;
- the quality of the pre-test counseling s/he was provided;
- how the person perceived him/herself before the diagnosis – image of the self;
- the efficiency of the self-defence mechanisms used in the past;
- how powerful the social support network at his/her disposal is;
- the existence of other personal problems or stressing events (the family relationship, sexual orientation, abuse, drug use in the past);
- drug addiction;
- the socio-economic status;
- access to good quality care;
- access to credible sources of information on the HIV infection and the possibility of absorbing the information;
- the reaction of the community towards the HIV infection.

Dynamics of the reactions towards a diagnosis can be explained by using the model of the crisis theory[52]:

| **Application of the crisis theory to the HIV infection** | |
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| Generating event | It is a stressing situation, that may generate actions and crisis reactions.<br>For some people, the diagnosis may be anticipated, while for others, it is unexpected and may aggravate the crisis. Even if a person anticipates a positive result, any change in the health status becomes a stress and may determine emergence of a crisis. |
| State of vulnerability | It is the emotional reaction to the generating event.<br>It includes the individual reaction when hearing about the test result, when s/he gets it or afterwards. People's reactions are influenced by the way they perceive the event, the defensive mechanisms and the personal system of social support. When they hear about a positive result, people experience various reactions (fear, fury, panic, anxiety, etc.) and make use of defence mechanisms (cry, search for information, discuss on the subject), but, because of the stigma and discrimination that accompany the HIV infection, these defence mechanisms are not enough, and then people resort to inefficient defence mechanisms (alcohol, drugs, denial, avoiding the problem). Many individuals who have passed through this stage describe it as a time when they were waiting for the next bad thing to happen to them. |

[52] Canadian Association of Social Workers – *A Comprehensive guide for the care of persons with HIV Disease, Module 6: Psychosocial care,* funded by Health Canada, Ottawa, 1997.

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| Precipitant factor | It is the event which oversteps the person's capacity to face a situation.<br>It may be described as the „drop that fills the glass to the brim". For someone who is trying to face a positive result, the precipitant factor may be represented by an important aspect (serious symptoms, for which many medicines are prescribed) or by something apparently not important (a joke or a remark). For some persons, the diagnosis itself may constitute the precipitant factor. |
| Active crisis | It is a limited period of time (usually, up to 10 weeks), during which the person feels pitiful, unable to cope with the situation. During this period, his/her mechanisms of defence don't work and there are situations when the individual in question doesn't manage to cope with the everyday life requirements or with those at work, as s/he experiences strong emotional and behavioral reactions (run away, cry, fury, suicidal thoughts). People cannot bear for a long time this high level of anxiety and, with or without help from outside, they still manage to come into equilibrium.<br>The role of the professionals in the health or social field is to help those people overpass these crises as easily as possible, so that:<br>– they don't let the diagnosis control and destroy their lives;<br>– they believe they may find again a quality of life, a changed one, but at least equal to what they used to have before the diagnosis. |
| Reintegration | It is an extension of the active crisis, when anxiety lowers little by little, and socially speaking the person is operational again,.<br>The individual begins to accept his/her diagnosis and to integrate it into his/her life, by developing new mechanisms to cope with it. |

To support a person in a crisis, the counselor may intervene on a short term (in the post-test counseling) or on a long term (in the support counseling):

| | **Short term intervention („psychological first aid")** | **Long term intervention** |
|---|---|---|
| **Duration of intervention** | From a few minutes to a few hours | Weeks or months |
| **Who intervenes** | The person who announces the diagnosis | A specialized counselor |
| **Purpose of the intervention** | To provide support at once, to reduce tension, referring to resources | Solving the crisis – the integration of the crisis into the client's life |
| **Intervention procedures** | Establishing the relationship, exploring the dimensions of the problem, exploring the potential solutions, support in making some decisions | Facilitating the expression of crisis-related feelings, support in understanding the crisis (cognitive and emotional), developing mechanisms of coping with it |

The crisis intervention has stages similar to those of the counseling:

- defining the problem from the client's point of view (including possible guilt feelings for having got infected or for having infected other persons – being unaware of the diagnosis);
- providing the client with support, backing him/her, by proving (verbally and not only) his/her being accepted and by neither criticizing nor judging him/her;
- identifying and analyzing the options, also by offering information about as many options possible, out of which the client may choose the one s/he appreciates as suitable;

– drawing up plans – what the client wants and can do;
– providing referrals to other services, according to the plan the client drew up or to his/her needs.

**The check-list for the post- HIV test counseling**

Results were announced in a simple and clear manner ☐
Time was allocated for understanding/absorbing the result ☐
A check-up of what was understood was done ☐
The meaning of the result was re-discussed ☐

*In case of a positive result:*

Family/social implications (including the resources) were evaluated ☐
To whom and how can the result be imparted ☐
Emotional support was provided ☐
Referrals were provided ☐

*In case of a negative result:*

Risk reduction plans were re-discussed ☐
– to what level the plan was put to practice ☐
– what were the successes ☐
– what were the obstacles ☐
– how can the plan be modified, to be efficient ☐
– barriers in applying the risk reduction plan were analyzed ☐

The possibility of taking the test once more (if need be) was discussed ☐
Referrals were provided ☐

## Referrals

Each client or beneficiary of the pre- and post- HIV test counseling needs referrals to other services, according to his/her specific situation. Counselors must understand how important it is to provide complete and good quality referrals to the existing, accessible and user friendly services. In case these services are not yet organized at a local level, it is the counselors duty (and also the duty of all institutions providing counseling and testing) to advocate for the developing of services that might complete their activity.

The counseling sessions (both the pre-test, and especially the post-test counseling) contain the following steps: the evaluation of the referral needs, the provision of referrals and the documentation of referrals.

**Evaluation of the referral needs**

To ensure an optimum application of the risk reduction plan, the counselor helps the client to analyse the factors that might influence his/her capacity to put it into practice.

In case the client's needs are extremely various/complex, referrals should be made towards a long term counseling system, for HIV prevention, which is related to other services (case management for HIV prevention, which is still not developed in Romania) as well.

**Provision of referrals**

The way referrals are provided must answer the client's needs and priorities, and take into consideration the culture, sex, sexual orientation, age, his/her level of development, the barriers related to the location, means of transport, schedule, the costs of the services to which the client is guided. The client's chances to access the services increase if s/he is given precise data – not only the name and the address of the service, but also its phone number, schedule, contact person, public means of transport available. Written nominal referrals may also be provided, but only with the client's preliminary agreement. Outreach workers or health educators can be resource-persons for accessing the needed services in supporting the implementation of a plan to reduce the infection risks.

**Documentation upon referrals**

Each counselor should dispose of a precise referral database. In order that the database contains correct information, information about the necessary services may be collected (phone directories, guides of services, colleagues at work). In addition to this, the extent to which these services really meet the clients' need, can also be checked upon.

This check-up may be done by asking the clients, during the post-test counseling, regarding the level to which those services really met their needs, or by counting the number of clients (with written referrals) who accessed the services recommended.

A database regarding the available referrals[53] at local level should contain the following:

**HIV prevention services**

| Type of service | Service provider | Description of service | Address, contact person |
|---|---|---|---|
| Education for HIV prevention | Local Directorate for Public Health, NGO… | Information sessions<br>Outreach activities | |
| Long term counseling for HIV prevention (case management) | Local, if there is any | Long term risk reduction counseling (repeated services) | |
| Family planning | Local | Support in choosing a suitable contraceptive method (to also provide HIV prevention) | |
| Diagnosis and treatment for sexually transmitted infections | Local, including the HIV/AIDS regional centre | | |
| Gynaecology | Local | | |
| Free of charge access to condoms | Local | Condom distribution services, including the access conditions (income, sex, family situation) | |
| Free of charge access to needles and single use syringes | Local, if there is one | Needle and single use syringe distribution services – at the head-office of an institution or in the field (with the specification of locations) | |
| Charged access to condoms or to needles and syringes | Local | Pharmacies, shops | |
| Access to additional information on HIV | AIDS Helpline<br><br>Internet | Phone numbers (for the information provided by phone)<br>*Web pages*, internet forum | 0 800 800 033 etc. |
| Access to general medicine consults/exa-minations | Family doctor | Conditions for enlisting to a family doctor's record | |
| Access to social services (a place to live in, social allowance etc.) | Town hall, department X | Conditions for receiving a material support – income per family member; the existence, in the family, of a handicapped person; situation of the housing | |

[53] All the services described here are provided upon the request of the person in question or of his/her tutor, on condition the criteria stipulated by the legal provisions and the regulations on the functioning of the service providers are met.

## Social support (HIV+)

| | Type of service | **Provider** | **Additional information (necessary documents, value of the service)** | **Address, contact person** |
|---|---|---|---|---|
| **Child** | Double allowance | Town hall | **Necessary documents: handicap certificate, birth certificate** | |
| | Facilities | Town hall | Necessary document: handicap certificate<br>Facilities consist in: exemption of payment for the public transport and for travels by train (a limited number), exemption of payment for the phone subscription<br>Implies a social investigation | |
| | Accompanying person | Town hall | Severe handicap certificate<br>Value: economy-wide minimum wages<br>One may opt for hiring an accompanying person (on employment contract basis) or for receiving an allowance.<br>Implies a social investigation | |
| | Nutrition supplement | Town hall | Handicap certificate, other documents<br>Value: food allowance for hospitalized children | |
| | Food allowance | **County Directorate for Labour and Social Solidarity** | Medical certificate with a revenue stamp<br>Value: food allowance in the hospital<br>Does not imply a social investigation | |
| | | | | |
| **Adult** | Pension | Pension Office | If s/he has many years of work – according to the length of service and wages<br>In case of a 1st grade pension, the allowance for an accompanying person is included in the pension | |
| | Special allowance | Town hall | Depending on the handicap certificate, if the person has no other income<br>Value: ½ of the economy-wide minimum wages<br>Implies a social investigation | |
| | Personal assistant | Town hall | Severe handicap certificate (AIDS, other diseases)<br>One may opt for hiring an accompanying person, or for receiving the corresponding sum of money<br>Implies a social investigation | |
| | Facilities | Town hall | **Handicap certificate etc.** | |
| | Food allowance | County Directorate for Labour and Social Solidarity | Medical certificate with a revenue stamp<br>Identity documents<br>Value: food allowance in hospital | |

## Social services provided by the NGOs

| Type of service | Service provider | Description of service | Address, contact person |
|---|---|---|---|
| Psychosocial counseling | | Support in analyzing the problems and in choosing the best solutions to solve them<br>Includes information and education | |
| Support group | | Regular meetings of the infected persons, for mutual support (at present available only for adults) | |
| Day care Centre | | Centre for spending spare time (available only for children) | |
| Recreational Activities | | Trips, festivals, visits (available only for children) | |
| Material support | | Packages with food stuff or hygienic products (available only in few towns) | |
| **Information by phone** | | AIDS Helpline: information according to the seeker's needs<br>Free of charge, anonymous service, on an anonymity basis | 0 800 800 033 |
| **Referrals to other services** | | Information and guidance toward services, according to the beneficiaries (information include address, working hours of the service, necessary documents) | |
| Housing | | Temporary or long term shelters (at present available only for children) | |

## Medical services

| Type of service | Service provider | Description of service | Address, contact person |
|---|---|---|---|
| HIV Diagnosis | Testing centres<br><br>Directorates for Public Health<br><br>Other laboratories | The test is free of charge only for pregnant women, for persons from vulnerable groups or for those with a medical recommendation (possible symptoms).<br>Prices vary from 200 000 to 500 000 ROL (January 2005).<br>In Bucharest, a test can be taken free of charge and anonymously (identity documents not needed; without delivering a testing certificate). | |
| **Medical evaluation for HIV infection** | Hospitals for infectious diseases | Conditions for access: medical recommendation or an testing certificate | |
| **Antiretroviral treatment** | Hospitals for infectious diseases | Treatment is free of charge | |
| **Evaluation and support care** | Family doctor | Provides also compensated or free of charge prescriptions for infections other than HIV or referrals to hospitals | |
| Treatment for other diseases | Any specialized hospital – depending on the affection | | |

## Counseling in specific situations

**Pre- and post- HIV test counseling for pregnant women**

Women are vulnerable to HIV infection for anatomic and/or social reasons.

- Some women wrongly consider that the HIV infection does not affect women, but only men with risky behavior or children.
- Many women do not consider them to be at risk, as they have only one partner, but there are situations when the partner has or had infection risk behaviors.
- During a sexual intercourse, HIV is more easily transmitted from a man to a woman than from a woman to a man, because the contact area with the infecting fluids is larger at a woman than at a man. The infection risk is higher in case the woman has a genital infection.
- Condom is used by men, which restricts the woman's control over its correct use. The other means of protection against unwanted pregnancy do *not* provide protection against the sexually transmitted infections or HIV/AIDS.
- In many communities, women consider it's shameful to talk about sexuality and/or cannot decide on the type of sexual contact or the use of means of protection.
- Access to health services is difficult for women, because of their working hours, their income or because of their domestic responsibilities, reason for which many women find out about their diseases after a very long time.

The health of the new-born children is strongly influenced by the mother's state of health. If the mother is HIV-infected, she might transmit the virus to her child. Unless some protection measures (treatment, assisted child-birth and avoidance of breastfeeding) are adopted, about 40% of the children born from HIV-infected mothers will also be infected. Most of the infections occur near delivery term, during the labour or on delivery. Certain risk factors favour the virus transmission during pregnancy. The most important of them is the mother's viremy.

Other risk factors include premature birth, the lack of a prenatal anti-HIV care, and breastfeeding.

Beginning with 1998[54], all women in Romania might have been suggested to take an HIV test for free. This is part of the medical routine, is voluntary (not compulsory), has to be accompanied by counseling and taken during the first months of pregnancy. In case the test can be provided only in the maternity (imminent delivery), it is essential that the woman's psychical and physical state is of a nature to allow her make decisions and participate in the (individual or group) counseling.

[54] Order no. 889/1998 (its entire text is reproduced in Annex V).

Up to 31.12.2003, the Ministry of Health had registered 491 HIV-infected children for which the way of transmission was determined to be the vertical one[55].

In this context, and also taking into account that 4 577 persons of the total number of HIV/AIDS cases (by 31.12.2003) are aged 15 to 49 years old, the intensification of the approaches of the mother-to-child HIV transmission is absolutely necessary.

An approximate costs-benefits analysis of the HIV testing accompanied by counseling *vs.* Treatment of the HIV-infected children shows that, besides emotional costs – that cannot be evaluated –, financial costs are lower for prevention:

– an HIV test costs approximately 3 Euros (for maximum 200 000 pregnant women, the annual cost might be of 600 000 Euro);
– the price for the treatment of a child may be at least 5 000 Euro/year (for treating, on a 10-year period, 20 infected children, the costs might raise to 1 000 000 Euro).

Counseling includes, besides the support for planning the reduction of the woman's infection risks, a component of information and support for preventing the mother-to-child HIV transmission, by taking into account the situation of the pregnant woman – the involvement of the family, the man and wife (partners') relationship, the affection between parents and children.

The essential components of a pre-test counseling for pregnant women are:

- the importance of HIV testing;
- the meaning of the period called „immunological window", that is the need of repeating the test, in case the mother has been recently exposed to a risk;
- the involvement of the partner in the HIV prevention (testing, information, change of behavior). Still, we have to mention that an HIV-positive status of the father does not have a direct influence on the child's health status, but it may influence the mother's health status and, indirectly, the one of the child.
- the avoidance of wet nurses (as a wet nurse may be infected and transmit the virus to the child, through breastfeeding);
- the reinforcement of the importance of HIV prevention during the pregnancy, as the infection may occur after the test is taken as well.

In case the test result is positive, the support provision for the pregnant woman includes:

- complete information about prevention measures that can be taken in order to reduce the risk of infecting the child;
- support for making a decision with full knowledge of the prevention methods;
- support in making a decision on whether to keep the child or not;
- referrals to health services (gynecology and infectious diseases);
- referrals to social support and psychological services;
- information on the meaning of the tests the child might take – up to the age of 18 months, the indirect tests (ELISA) may not indicate HIV status of the child, as s/he still has the mother's antibodies, and not necessarily the virus itself.

[55] Ministry of Health/The National Committee of Fight against AIDS, the „Prof. Dr. Matei Balş" Institute for Infectious Diseases – *Dynamics of the HIV/AIDS Infection from 1985 to 2003*, Bucharest, 2004, p. 23.

**Pre- and post- HIV test counseling for persons belonging to groups vulnerable to HIV infection**

Persons from groups vulnerable to HIV infection are those who, due to the socio-economic circumstances, a low self-esteem, lack of education or information, to the necessity of meeting some basic needs, on account of a dependence, of the family conditions, of the pressures made by the circle of friends, etc., are at risk of getting HIV-infected.

These individuals may:

- explore their own sexuality, when they do not have the needed information or abilities to protect themselves;
- practice prostitution for surviving;
- have relationships within which they may not negotiate the practice of safe sexual relations;
- be socially marginalized and discriminated;
- belong to an injecting drug use group;
- be imprisoned, together with other persons with risk-taking behaviors (possibly abused by them);
- have to cope with so many problems, that HIV prevention is not a priority.

In this context, in order to be efficient, the HIV prevention approaches focus on *harm reduction* – the reduction of the negative consequences of practicing a risk-taking behavior. More precisely, these approaches rather focus on a gradual change of the behavior, starting from a small change, towards the reducing of the potential evil, and not necessarily on abstinence (a sure method of averting the HIV infection through sexual practices or drug use).

*Pre- and post- HIV test counseling for individuals involved in commercial sex (prostitution)*

We can define prostitution as the practice of sexual relationships with the purpose of gaining a material reward – that may consist in money or products, including drugs. Many people may consider that only women are involved in prostitution, but the male prostitution should also be taken into consideration, including the bisexual or transsexual persons. Moreover, many other persons are often involved in the prostitution networks – those who mediate the relations or those who assure protection against possible aggressions or abuses.

In order to be able to provide counseling services to persons involved in prostitution, it is essential that we are able to understand their practices and the circumstances under which they carry out their activity, that is:

- the places where commercial sexual relations are practiced – in a brothel, in the street, in a hotel, bar, in apartments;
- the price of a sexual contact – with significant differences between those in hotels and those in the street;
- the socio-economic statute (level of school-based education, family to support, the existence of a legal workplace, etc.);
- the terms of their work: they prostitute themselves occasionally or daily, receive money or other goods in exchange, can decide who the clients are, may negotiate the sexual practices;
- whether they are trafficked persons or not or dependent on other persons (pimps);
- whether prostitution is associated to drug use, including alcohol;
- the sexual behavior – chosen or forced;
- the perception of the risk – for example, it is possible that, for some of the persons involved in sex work, the risk of not having access to drugs or of being assaulted is considered much higher than the risk of getting infected with HIV or with other sexually transmitted disease;
- the access to medical and social services.

Since legislation penalizes prostitution, the persons involved may receive with reserve both the abuse denunciation and the accessing of medical and social services, which is of a nature to restrict the efficiency of HIV prevention programmes.

Stigma and discrimination related to commercial sex constitute an additional barrier to preventing HIV infection, as well as to preventing prostitution and to integrating persons willing to change their life style.

At the other end stands the counselors or other personnel offering services to persons involved in sex work. They sometimes find themselves in the situation to „fight” with the wish to help the beneficiaries, by offering them solutions that may solve the problem. Whereas the prostitution is illegal and implies high risks of HIV infection, the obvious (and also moral) solution – in certain counselors' opinion – is to recommend giving up this „occupation”. Although this suggestion may suit some individuals, to others it is unacceptable and may be perceived as a critical attitude and therefore rejected. The choice of a proper manner (adapted to the situation) of risk reduction has to belong to the person in question and must be done being aware of its advantages and disadvantages – by following the principle „I do what I want, but I know what I do!”, a slogan of one of the HIV prevention campaign developed by Population Services International in 2001.

The HIV counseling and testing need to lay their foundation on an uncritical attitude and respond to the needs of the persons involved in sex work. All the stages of the pre- and post-test counseling must be treated with even more attention:

- an informed consent, in full knowledge of the problem;
- a strict confidentiality – both regarding the result and the content of the counseling;
- the completion of the knowledge on the HIV infection, a self-assessment of the infection risks and the elaboration of a realistic and feasible plan for reducing these risks;
- the preparation for a potentially positive result;
- the referral to other services – which, in turn, are welcoming and friendly, and include treatment for the sexually transmitted diseases (if they are not treated, these may facilitate the HIV infection).

The essential factors to reduce the HIV transmission to the persons involved in sex work are:

- the information and education of the population, including the clients of the persons involved in sex work;
- an increased access to condoms (both male and female condoms, the latter not being yet available in Romania), as well as the promotion of the use of *dental dams* (latex barriers for use in the oral sexual intercourse);
- the discrimination and stigma reduction – both of the HIV infected persons, and of those who are socially vulnerable.

*Pre- and post- HIV test counseling for the injecting drug users (IDUs)*

When working with the IDUs, a fact must be accepted from the very beginning, which is that no counselor can make a drug user give up drugs, unless the latter has an inner motivation to adopt an abstinence behavior. The counselor may assist, facilitate and support the process towards abstinence or towards a „controlled" use.

The context and the practices relating to the drug use vary from one person to another, from one community to another and, therefore, the counselor must know:

- the type of drug(s) used by the population targeted;
- the ways drug is administrated;
- the injecting equipment used;
- the HIV prevalence within the population concerned;
- the practices of sharing syringes;
- specific treatments, support treatments, detoxification, post-cure or other existing services for the drug users.

The IDU counseling must take into consideration the provision of information on the risk-free injecting practices and on those allowing the drug user client to reduce effects associated to drug consumption:

- the development of a new type of behavior: „a new syringe, used just once" (one syringe, one injection!);
- the use of sterile injecting equipments (needles, syringes, filters, distilled water etc.);
- information related to correct injecting (alternation of the two arms, the change of the injecting spot, areas of the body that an IDU must not inject etc.);
- information related to the care of the lesions/wounds emerged following the latest injection (the use of heparine-based ointments for the recovery of the destroyed veins, treatment of abscesses etc.);
- information on HIV/AIDS, B and C hepatitis – ways of transmission, prevention procedures, the protection of the other members of the group or of the sexual partners.

In order to have an efficient counseling, the counselor must not make appeal to moral judgements regarding the client's behavior as a drug user, who might have already faced discrimination and rejection, from the medical staff and from the family as well, or those promoted at the societal level. Hence, the counselor will not confirm or statute such attitudes! Moreover, the counselor will listen to what the client has to say: which is, from the client's viewpoint, his/her most important problem, which is the information the client needs the most.

Even though the long term objective is abstinence, both the counselor and the client must have an approach as realistic as possible of this fact. It rarely happens that a drug user decides to give up drug use and also to manage to do it from his/her first attempt. If the objectives proposed overpass the individual's real possibilities and are not adapted to the context, they may demobilize the client, who will not feel able to reach them in a near future and will feel even more powerless and more helpless: „it's too hard for me, I can't do it!".

The counselor who works with the IDU, either carrying out his/her activity in a centre of needle-exchange or in an *outreach* programme, may provide the client with information that may help him/her avert the risks associated to the drug use:

- changing the way of administration: by smoking cigarette, by thin sheet, or snuffing;
- passing to a substitution treatment: methadone;

- using only sterile, single use injecting equipment;
- including him/her in a needle-exchange programme;
- not using in common, within the injecting group, any of the drug administration equipments (to use one's own sterile syringe is not enough if filters, ampoules, the needle for extracting the prepared drug are shared in the group).

*Pre- and post- HIV test counseling for the partners of injecting drug users*

Many pre- and post- HIV test counselors may find themselves in the situation to suppose (incorrectly) that a person who has only one partner and doesn't take drugs is not at risk of HIV infection. However, the cases in which the client is the partner of an injecting drug user or of an alcohol user are quite numerous.

Many of the injecting drug users' partners are at a very high risk of HIV infection, as they do not know the drug use behavior (maybe not even the fact that their partner uses drugs), and this ignorance makes them adopt sexual behaviors which do not involve protection.

The negotiation of the type of sexual practices with a partner who is under the (legal or illegal) drug influence may be a tough one. In addition to this, drug users often invite their partners to join them in taking drugs. On the other hand, even if drug use is stigmatized by the society, there are sub-cultures which value it.

Practicing unprotected sexual intercourse may be also influenced by the power relationships within a couple, which is often built on the basis of a socio-economic dependence of one of the partners.

In these situations, the pre-test counseling must include:

– the assessment of the risk of HIV infection and of type B and C hepatitis (the last two having a very high incidence among the drug users in Romania): „Sometimes, when a partner of an individual is a drug user, that individual finds it very hard to talk about that"; „Do you know that women are more exposed to HIV infection risk than men?"; „Somebody I know found out s/he is HIV-infected after having a relationship with someone who used to be a drug user. He didn't know he was infected and she didn't either." In order to identify the type of relationship between the partners, questions like the following may be used: „Do you talk with your partner about the sexual intercourse?" or: „How do you decide what kind of sexual practices you adopt?". The fact that the client might use drugs (which makes even more complicated the adoption of prevention practices within a couple) or that there may be other drug-related problems and to the need of money to procure the substances must be taken into consideration as well;

– the risk reduction, including plans regarding abstinence from drug use for the partner, keeping him/her on methadone or changing the sexual practices – practice of protected sexual contacts –, offering new needles and syringes to the partner, cleaning them, persuading the partners to use drugs at home, individually.

**Exercise**

Choose the answer you consider appropriate:

1. The majority of the drug users' partners knows they take drugs:
   *a. true;*
   *b. false.*

2. Women who have drug users as partners are:
   *a. at a fertile age;*
   *b. in precarious economic situations;*
   *c. at  risk of using drugs them too;*
   *d. in all of these situations.*

3. If they have a job, the partners of the drug users have greater chances to know about their risk of infection than those who do not work:
   *a. true;*
   *b. false.*

4. In order to reduce HIV infection risk, the drug users' partners must develop:
   a. *self-respect;*
   *b. a social support network;*
   *c. awareness gaining;*
   *d. all of these.*

5. Injecting drug users usually do not have sexual relations immediately after having taken a dose:
   *a. true;*
   *b. false.*

6. A drug user's partner may try to reduce his/her risks by:
   *a. cleaning the user's syringe;*
   *b. buying him/her new needles and syringes;*
   *c. educating him/her;*
   *d. all of these.*

*Answers: 1) b; 2) d; 3) a; 4) d; 5) b; 6) d.*

*Pre- and post- HIV test counseling for persons from minority groups (Rroma, homeless persons)*

Persons from minority groups may be exposed to the HIV infection risk because of their little access to information or because of their precarious living conditions (lack of elementary hygienic conditions, frequent physical or emotional abuse). For some groups, discussing sexuality-related topics may represent a taboo; in other situations, current problems make the members of a group not consider health as a priority.

Taking an HIV test (following an information campaign or an outreach information programme*)* may constitute a first contact of the members of disfavoured groups with the sanitary system or with the social protection one, a reason for which it is essential an uncritical attitude, of acceptance, of a nature to encourage them access, in the future, some similar services.

Information on the HIV infection might also be prepared (even from the waiting room of an HIV counseling and testing centre) in an accessible language (drawings, video materials) for persons with a minimum level of school-based education, so that pre- and post- HIV test counseling may focus on the assessment and reduction of HIV infection risks.

Even though information on HIV is transmitted through images, the counseling has to be carried out in an accessible language for the beneficiaries and must include referrals to friendly and accessible services (according to whether the clients have a health or social insurance, identity documents). It is absolutely necessary that services for persons from marginalized groups, services facilitating their access to specialized medical or social services appear in the list of referrals. Otherwise, the efficiency of an HIV test or of a test for another sexually transmitted infection proves its use only for an epidemiological study and not also for the beneficiary of the counseling (who will leave the centre with a diagnosis that may expose him/her to discrimination inside the group or the society and with no chance to treat/improve it).

**Disability**

People of all ages and social category, with or without a handicap, may have certain sexual preferences and may have an active sexual life. It should not be considered that one person's mental state or physical condition limits him/her the interest in sex or the capacity to have sexual relations. Certain sexual activities may be risky for a handicapped person or for his/her partner. Due to their physical or mental handicap, some persons may need a counseling for specific conditions.

In order that persons with mental deficiencies receive the necessary support and information, the counselor must address his/her parents, families and those working with them, by educating and informing them on the HIV infection risks of those they are taking care of.

The efficacy of the counseling also depends on the work directly with the persons involved in taking care of handicapped people. Disabled people, no matter the nature of their handicap, need information about risk-free activities and help to develop the skills to negotiate the risk-taking activities. The provision of information and the reinforcement of their self-confidence has to be done by taking into account the individual's capacity to receive them (for example, by reading or listening to explanations). In the case of persons with hearing deficiencies, the counseling can be provided with the help of an interpreter (the mimic-and-gestures language).

Counselors may refer the disabled clients to family planning services or to NGOs working on HIV/AIDS prevention (especially if they involve in their activity educators from among the disabled persons, that may send a message adapted to the beneficiaries' needs).

The more it involves the support and advice of those working in this field, the more efficient is the HIV/AIDS counseling of the individuals under psychiatric care. Clients under psychiatric treatment need time for understanding and becoming aware of the knowledge acquired. In these situations, as well as in the case of the mentally retarded clients, the counselor may assume the role of the educator of the care-taking personnel, by offering them HIV related information[56].

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[56] See Annex IV: *Work standards in the pre- and post- HIV test counseling,* chapter „Activities within the VTCC", subchapter „Juridical and moral considerations".

# Support and supervision in the counseling activities

**Need for support**

Counselors – and, in fact, all the other professionals in the field of health services who work a lot with HIV–infected persons – might get affected by the emotional implications of their work. Clients often have to cope with many life problems – such as the perspective of death, the choice of the medication (that may extend their life time, but which sometimes does not have the expected results), discrimination and losses. Deep fears generated by these topics prevail in the work with HIV-infected persons. Specialists in the field are exposed to the risk of frustrations and their consequences: depression and isolation/rejection. That is why it is essential to develop support structures for counselors and those working in health services.

**Supporting counselors in their work environment**

The management of the organizations/institutions providing HIV counseling must take into consideration the stress associated to this activity and their responsibility to ensure a comfortable working environment, very good control and supervision methods, that may support the counselors in their work. The more pregnant this support is, the more members of the staff understand the implications of HIV/AIDS counseling. Counselors-related incidents – as a consequence of overpressure – need an immediate reaction. In addition, the working environment has to be kept healthy, by a strict observance of the universal precaution rules.

**Employer support in the case of accidents at work**

In all the work environments where there is a risk of exposure to HIV infection while performing work activities, the analysis methods of the infection risk which a healthy employee is exposed to as a consequence of an accident at work must be treated very carefully, in order to be able to provide an adequate counseling and to decide whether and when a preventive antiretroviral therapy is needed.

**Autonomy in counseling relationship**

Supporting counselors supposes the acknowledgement of autonomy in the counseling relationship. In the situations when the counselor or the client feels there is nothing more to say or to learn, if the counseling relation is continued, any of them has the right to stop the counseling process. An open discussion must take place, on the reasons that led to the cessation of the counseling relationship. In such cases, the counselor may guide the client to another counselor or the client him/herself may look for another counselor. It is important that no counselor feels obliged by his/her employer to continue an unproductive or stressing counseling relationship.

**Nature of supervision**

We understand supervision as a formal collaboration regarding the monitoring, training and supporting the persons playing the role of a counselor.

The institutions and organizations providing HIV/AIDS counseling are responsible of ensuring an adequate supervision for the counselors and the staff. Ideally, this takes place outside the hiring organization, during the working hours and without any financial obligations from the counselors.

**Importance of supervision**

In the counseling work, a supervision made by an experienced counselor in this kind of activity is a must. HIV/AIDS counseling is a very challenging work: the fact that HIV infection is fatal for some of the clients, that sometimes it generates social discrimination and serious financial problems has an impact on the counselors, too. This is why supervision is essential for ensuring the counselor a good disposition and for keeping his/her work efficient.

Many times, the staff carrying out HIV/AIDS counseling find themselves „isolated" in small hospitals or laboratories where no other employee has any experience in this type of counseling. In such situations, s/he has no access to supervision and cannot consult anybody. For this reason, s/he must be given some time to participate in workshops and preparing sessions, to contact other professionals from groups outside his/her working areas and to regularly take part in advisory processes.

The high qualification level and the longstanding experience of those working in counseling do not exclude the need for supervision.

**Responsibilities of the counseling supervisor**

While the counselors are incumbent the immediate responsibility to work with a client, the supervisor's task is to help the client, by supporting the counselor:

*– to evaluate the counseling process:*

The efficiency of the counseling activity is sometimes difficult to evaluate while it is ongoing. The supervision refers, first of all, to helping the counselor analyze in a critical manner all the aspects of his/her work.

*– to make surveys/examinations:*

In HIV/AIDS supervision, counselors are encouraged to draw their attention and to become responsive to the most various information related to life styles, so as to be able to talk easily on sexual behaviors. The supervisor will encourage the counselor to be acquainted with the new information on HIV/AIDS and different life styles. It is important that all counselors are helped to identify the gaps in their way of work and then encouraged to participate in appropriate training programmes.

*– to find solutions to difficult situations and conflicts:*

Counselors can be helped to identify the types of problems and the areas where they appear (among clients, among counselors, between the client and the counselor, in the working environment of a counselor or between the counselor and the organization s/he is working with) and must be encouraged to find their own solutions in order to solve them.

*– to adopt methods to handle the counseling-related stress:*

The nature of the HIV infection, the attitudes of some segments of the society and the requirements for the role of a counselor turn the counseling process into a very stressing one. Stress also appears when the counselor's tasks are not various or when s/he has a very intense work (for example, in a hospital). The supervisor must help the counselor analyze the structure, the balance among the activities and the context of his/her work. It is often necessary that a counselor is relieved of some of his/her duties, by appealing to the help of the colleagues. The supervisor must offer the counselors information on any training courses dealing with the development of the stress-relieving skills.

*– to keep the appropriate limits:*

The counselor must be helped to cope with the worries and impressions generated by the situation the client is in and, whenever necessary, to mark the limits of the professional aspects from the social ones in his/her relation with the clients.

# ANNEXES

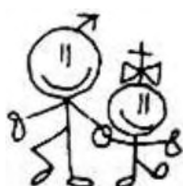
ANNEX I

# HIV Infection Risks

The transmission of HIV is not exclusively a biological process, but is caused by various factors- biologic, sociologic, psychologic and economic–which influence the vulnerability of individuals or groups to HIV infection.

Creating a hierarchy of risks can be useful for clients, in the event they want to change their behavior and adopt less risky practices. In order to be able to assist clients in changing their behavior, all counselors should have a clear understanding of HIV transmission mechanisms, the practices that do not pose any infection risk and the risk reduction processes. However, we have to discard the idea that the notion of risk is equivocal (and a hierarchy thereof so much more), which does not allow us to objectively quantify the possibility that one person may get HIV infected.

**Modes of HIV transmission**



Three modes of HIV transmission have been identified:

- through specific sexual practices – unprotected sexual intercourse with penetration,
- through blood – in case of joint use of syringes and needles, in cases where the skin is cut or stung and in cases of where infected blood is exchanged (transfusions, organ transplant),
- from mother-to-child – during birth or breastfeeding, if the mother is infected.

In each of the aforementioned cases, certain conditions have to be met in order for HIV infection to occur. They include the following:

– *Existence of an infection source* – this condition is often interpreted as representing "an HIV-infected person," and people try to "guess" who is infected or not, although there are no visible signs and specific tests cannot identify the existence of infection during the first months (the "immunologic window" period). This kind of approach can trigger discrimination of persons living with HIV. Moreover, bodily fluids containing the virus (blood, genital secretions, sperm, even a mother's milk) or organs, in the case of a transplant, should also be considered infection sources when speaking about transmission.

- *Existence of a mode of transmission* – the fact to be kept in mind is that not all sexual or injection activities allow HIV transmission. Certain practices pose very high risks of HIV infection, others do not necessarily entail infection but pose increased risks of transmitting other sexually transmitted infections.

– *Existence of a (new) host for the virus* – as the virus only lives in living cells, it is not dangerous outside the human body (if it does not get into a healthy body).

– *Existence of an entry point into a healthy body* – in order for infection to occur, the virus has to get into a healthy body–and it is known that this can occur through skin lesions (which, if intact, represent a barrier against getting infected) or though the mucous membranes (absorption or lesions of mucous membranes). The absorption level and lesion occurrence risk differ depending on the type of mucous membrane (vaginal, anal, oral, nasal, ocular).

–*A quantity of the virus present that is large enough to cause infection* – in order for this to occur, a high concentration of the virus must exist, for which reason certain body fluids are "efficient" vehicles of HIV transmission, whilst others are not. Thus, blood, sperm, genital secretions (including those preceding ejaculation) and a mother's milk are part of the first category, as they may contain large quantities of the virus. Even in this case, the possibility exists that the quantity of the virus getting into a healthy body may be too small to cause infection, the more so when the person/host of the virus is undergoing antiretroviral treatment (effective in diminishing the quantity of the virus in blood).

**Risk evaluation**

In order to evaluate HIV transmission risk, the existence of a mode of transmission or the existence of "proofs" that such transmission has occurred in the respective case should be taken into consideration. Further on, we classify the risks into four classes, defined as follows:
- high infection risk behavior/situation: where the possibility of transmission exists and there is a lot of evidence (cases where the infection has occurred),
- low infection risk behavior/situation: where the possibility of transmission exists, but there is little evidence (cases where infection has occurred),
- negligible risk behavior/situation: where the possibility of transmission exists, but no evidence has been recorded (there are no cases where infection occurred),
- no infection risk behavior/situation: where there is neither the possibility of transmission nor any evidence of infection.

**Hierarchy of risks**

*Behaviors and cases posing a high risk of HIV infection:*
- joint use of needles and syringes for the administration of intravenous drugs,
- unprotected anal sexual intercourse (practiced without a condom),
- transfusions made before 1990,
- joint use of sexual toys (contusive),
- unprotected vaginal sexual intercourse,
- joint (immediate) use of manicure nail scissors, shaving sets, toothbrushes,
- brotherhood rituals,
- rape.

*Behavior/situation posing a low risk of HIV infection:*
- unprotected oral sexual intercourse for the receiver,
- condom protected vaginal or anal sexual intercourse,
- use of syringes and needles previously sterilized (with chlorine/water, in the case of inject able drug consumers),
- intense kissing – with possible biting,
- accidents involving blood-skin contact.

*Behavior/situations posing a negligible risk of HIV infection:*
- protected oral sexual intercourse,
- mutual masturbation.

*Behavior/situations posing no HIV infection risk:*
- sexual abstinence,
- abstinence from drug consumption,
- mutual fidelity with a healthy partner (HIV tested, taking into account the immunologic window period),
- social kissing,
- embracing,
- on-line or phone sex,
- masturbation.

In order to reduce the *risk of HIV transmission from mother to child,* certain measures can be taken: the HIV-infected woman may choose to terminate the pregnancy or to keep her child; in the latter case the following is necessary to prevent the transmission of HIV:

- commencing antiretroviral therapy,
- birth through Caesarian operation,
- abstain from breastfeeding,
- commencing antiretroviral therapy of the child.

To prevent HIV does not imply avoiding behaviors and cases posing an infection risk. In case these cannot be avoided, one can try to reduce the risks as much as possible.

The alternatives set out further on represent certain methods to reduce HIV infection risks, not necessarily valid in the case of other sexually transmitted infections (which may pose greater risk of HIV transmission).

**Reducing HIV infection risks in the case of:**

- *Joint use of needles and syringes for administering injectable drugs*

Drug consumption poses very high risks for health. The risk reduction message could be: ”Don’t take drugs but if you do, use single-use syringes and needles and only use them once!”. In case that is not possible as well, there are further alternatives for reducing HIV infection risks:

- using a syringe and needle several times, but by only one person; a behavior posing the risk of catching other infections, but not those transmitted via blood,
- using the syringe and needle after sterilizing it with chlorine and water; a behavior that does not exclude infection risk, but can reduce it,
- using syringes in common, but with a reduced number of partners and preferably persons who have taken an HIV test; an alternative that still poses infection risks, but however represents a step further to changing one’s behavior.

- *Sexual intercourse*

Sexual abstinence represents a behavior that ensures the elimination of the risk of HIV infection via sexual transmission, however it is not always possible, acceptable for the clients. Another method of risk elimination is mutual fidelity between healthy partners (who have taken an HIV test and have not exposed themselves to infection risks during recent months).

However, if the client wishes to have sexual intercourse and he/she knows nothing about his/her partner’s health state, one way to reduce the risks is to resort to condom (see *infra*, “Rules for the correct use of the male condom”). In case that cannot be used, there is the option to select another form of sexual practice with a lower or no risk of infection: oral sexual intercourse, masturbation, internet/phone sex.

Reducing the number of partners can be another risk reduction method.

It is notable that the greatest HIV infection risk is posed by unprotected anal sexual intercourse, as the probability of lesions occurring is very high. Vaginal sexual intercourse also poses infection risks, which to a certain extent are higher for women than for men (because of the quantity of potentially-infected fluids that remains in the vagina).

During oral sexual intercourse, a condom can be used. If that is not possible, one should avoid swallowing sperm or using a toothbrush before sexual intercourse (as brushing your teeth can cause lesions that facilitate HIV transmission).

The correct use of a condom during vaginal and anal sexual intercourse is a very effective method of preventing HIV infection and other sexually transmitted infections. However, the incorrect use of a condom or the poor quality thereof may cause potential risks.

**Rules for the correct use of the male condom:**

- Select a condom made of latex, lubricated, with a reservoir and electronically tested.
- Use condoms only within their warranty period.
- Do not keep condoms in a place that is directly exposed to sun or a heat source.
- Condoms kept for a long time in trouser pockets or a wallet may deteriorate.
- Open the package gently, without using scissors, nails or teeth, as they can destroy a condom.
- Apply the condom on the erect penis, before penetration, taking care to catch it at the reservoir in order to remove air and ensure the space necessary for sperm to flow down.
- Pull the condom up to the base of the penis, the rubber ring to the outside.
- Do not use oil or Vaseline-based lubricants, which corrode the latex.
- Change the condom if you switch from anal sexual intercourse to oral or vaginal sexual intercourse.
- Take the condom off after using it by pulling it by its head as soon as the erection has diminished (but is not completely gone).
- Do not use one condom several times, even if you have sexual intercourses with the same person.
- Dispose of the used condom after having knotting it and wrapping it in a napkin.

- *Rape*

Rape is a risk situation beyond one's control, but whose dramatic consequences can be diminished if medical services (for example, emergency medical services, infectious disease hospitals) provide HIV infection post-exposure prophylaxis (PEP) immediately.

- *Joint use of sex toys*

As some sex toys are contusive, in order to avoid infection risk they should be used by a single person or, in the case of their joint use, certain barriers may be applied (new condom, used only once).

- *Use of shaving and manicure sets*

Personal hygiene objects (shaving sets, nail scissors, toothbrushes, depilation sets) should be used individually. If these objects are used in common, they should be correctly disinfected/sterilized. For example, they can be disinfected with chlorine or by boiling them. A discussion on this subject with the hairdresser/cosmetician can reduce infection risk.

- *Medical interventions*

Transmission of HIV infection and hepatitis B and C through medical interventions did occur before 1989 due to the absence of tests and the scarcity of hygienic materials. Beginning in 1990, donated blood is now tested, and medical instruments used are single-use or correctly sterilized. It is each patient's right to request information about the way medical instruments are sterilized and to check whether single-use instruments (e.g., syringes) are taken out of their packaging and are new.

- *Accidents involving blood-skin contact*

Any person may be HIV infected. Many of those infected with HIV/hepatitis B or C do not show any visible signs or symptoms and are not aware of being infected. The education of each person should comprise, from childhood, information about basic hygiene rules. Although intact skin is a barrier against HIV, the following rules (which ensure the prevention of other infections as well) should be followed:

- If you come into contact with another person's blood (by mistake or when trying to help him/her), immediately wash your hands with warm soap and water.
- If a colleague or friend of yours has been hurt and is bleeding heavily, call a physician.
- If the bleeding is not heavy, try to guide your friend to stop it himself/herself. If possible, make clean sterile bandages, cloth or paper materials, as clean as possible, cleaning and disinfecting solutions (oxygenated water, spirits) or at least water available to him/her.
- Use a clean bag (or better, if available, single-use gloves) before dressing or disinfecting a wound. Wash your hands after you take the bag or gloves off your hands.
- In order to stop the bleeding, use a product that can be disposed of thereafter (a clean paper napkin, for example).
- Put blood-tainted articles in a plastic bag before disposing of them.
- Always cover your wounds with band-aids until they scab.
- Immediately wash blood-tainted surfaces. If possible, disinfect them with chlorine or at least with spirit or hydrogen peroxide.

ANNEX II

# Behavioral Change Theories and Models[57]

As HIV transmission is driven by behavioral factors, the theories of how individuals change their behavior have offered a foundation for the majority of HIV prevention efforts worldwide. Only one of the psychosocial models was further developed, the *HIV infection risk reduction model*, especially for AIDS and is used in HIV pre-test counselling.

**Health conception model**

The health conception model defined in the 1950s asserts that the individual's behavior against his/her health is structured depending on the individual's attitudes, knowledge and social demographic characteristics. According to this model, a person should appropriate, integrate the following beliefs in order to be able to change his/her behavior:

- perception of one's own vulnerability against a health matter ("Am I really in danger of getting HIV infected?"),
- perception of the seriousness of the situation ("How serious is AIDS, how difficult would my life be if I catch it?"),
- belief in the effectiveness of the new behavior ("Are condoms effective against HIV transmission?"),
- suggestions/opportunities/challenges to take action ("death or sickness of a close friend or a relative because of AIDS"),
- perception of benefits that preventive action may bring ("If I start using condoms, I can avoid becoming HIV infected"),
- barriers to taking action ("I don't like to use condoms").

According to this model, the promotion of behavior change includes changing the individual's personal beliefs. Individuals balance benefits *versus* the costs and barriers they perceive. In order for the change to take place, the benefits should weigh heavier than the costs.

Regarding HIV, interventions often aim at the perception of risk, beliefs regarding the seriousness of AIDS ("there is no cure"), beliefs about the effectiveness of using condoms or of postponing sexual debut, etc.

[57] Adaptation after UNAIDS – *Sexual behavioral change for HIV: Where have theories taken us?* (UNAIDS Best Practice Collection, Key Materials), Geneva, Switzerland, June 1999.

**Social cognitive (or social learning) theory**

The premise of *social cognitive theory* (SCT), or *social learning theory,* is that new behaviors are assimilated either by following the behaviors of others or by direct experience. The central principles of SCT are the following:

- self-sufficiency or personal effectiveness –belief in one's own ability to adopt the necessary behavior ("I know I can insist on my partner using a condom"),
- expected results: beliefs about the finality of action, such as correct use of a condom would prevent HIV infection.

Programs built on SCT integrate information and attitude changes, in order to strengthen risk reduction motivation and abilities, as well as self-sufficiency. Specifically, activities are focused on the experiences people have when talking with their partners about sex and about using a condom, on their positive and negative beliefs about adopting the use of condoms, as well as on the types of barriers to risk reduction.

**Rational action theory**

*Rational action theory,* outlined in the mid-1960s by Fishbein and Ajzen,[58] is based on the assumption that humans are usually rational enough and, therefore, they systematically use information available to them. People take into account the bearings that their actions may have in a certain context and at a given moment before deciding on whether to engage or not into a given behavior. The majority of their actions of social significance are put under volitional control.[59] *The rational action theory* is similar, from a conceptual point of view, to the health conception theory, to which, however, the idea of *behavioral intention* is added as a determining factor of health-related behavior. Both theories are centered around vulnerability awareness, on perception of benefits and experiencing constraints posed by behavior change. The rational action theory is especially focused on the role of *personal intention* in deciding whether to adopt a certain behavior or not. One person's intention is a function with two basic determinants:

- personal attitude (toward behavior) and
- "subjective norms" referring to behavior (social influence).

"Normative" beliefs play a central role in this theory and, generally, are focused on what an individual believes other people, especially influential people, would expect him to do.

For example, in order for a person to start using condoms, his/her attitude could be: "Having sex with condoms is just as good as having sex without condoms," and the subjective norms (or normative beliefs): "they expect me to do the same". Interventions using this theory are focused on attitudes toward risk reduction, on responses to social norms and the intention to change risky behaviors.

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[58] Fishbein, M.; Ajzen, I. – *Belief, Attitude, Intention & Behavior: An Introduction of Theory and Research,* Reading, MASS (USA), Addison-Wesley, 1975.

[59] Ajzen, I.; Fishbein, M. – *Understanding attitudes and predicting social behavior,* Englewood Cliffs, NJ (USA), Prentice Hall, 1980.

**Change phases model**

This model, developed by Prochaska, DiClemente and collaborators at the beginning of 1990s to help people quit smoking,[60] postulates that there are six phases that individuals and groups go through during behavioral change: pre-contemplation, contemplation, preparation, action, maintenance and relapse. With application to condom use, such phases could be described as follows:

- individual has not considered the idea of using condoms (pre-contemplation),
- acknowledges the necessity of using a condom (contemplation),
- plans to use condoms in the following months (preparation),
- regularly uses condoms for a duration less than 6 months (action),
- regularly uses condoms for a duration of at least 6 months (maintenance),
- no longer thinks about using condoms (relapse).

In order for an intervention to be successful, it has to focus on the precise phase that the group or the individual is going through. For example, the awareness occurs in between the first and the second stage. Groups and individuals go through all phases, but not necessarily in a linear manner (Prochaska, 1994).

[60] Proshaska, J.O., Norcross, J.C. & DiClemente, C.C. – *Changing for Good,* New York (USA), William Morrow and Company, Inc., 1994.

# Living HIV-positive

Persons living with HIV have to cope with many challenges. Living with a weakened immune system may be hard both for the body and for the mind. Reactions upon finding out the diagnosis and in the various difficult moments during the sickness vary from one person to another. One often encounters feelings of helplessness, rage, sadness, discouragement, loneliness, but sometimes of joy, too, when overcoming an obstacle or when one is able to help another person.

Obviously, there is no ”recipe” or ”correct” way to cope with HIV infection, and it is very hard for people to manage their own emotions and feelings. For example, one person may find it incredibly difficult to tell his/her partner that he/she is HIV infected or to share that to his/her child. Sometimes, the infected person tells the dentist that he/she is HIV infected (out of the wish to protect the other), and the dentist refuses to treat him/her... Last but not least, he/she could hear his/her current physician saying (after the patient has undergone adverse reactions for months): “I’m sorry, this treatment is no longer working...”. However, he/she could live to hear the following: “I have good news: the current treatment is working; the virus quantity has diminished.”

These situations are overcome or accepted (not necessarily in the sense of resignation, but merely as: “Life goes on”), with additional efforts (and suffering) and with support from friends, family or professionals.

Many persons are trying to have an active and balanced life, take exercises, keep a balanced diet, strictly abiding the treatment, gather documentary evidence about all that HIV/AIDS means, including about the last news, take part in social/entertainment events, and get involved in social activities. All these are helping them to better cope with the diagnosis, both physically and especially psychologically.

Society’s reaction to HIV infection may be seen as oscillating between supporting the HIV infected persons and rejecting them. Public institutions, nongovernmental organizations and communities are trying to develop effective mechanisms to educate people (for HIV prevention and acceptance of infected persons) but some still have reactions of rejection and discrimination towards infected people. The social service system, still developing in Romania, provides medical treatment, allowances, pensions and nutritional supplements. However, there are cases where confidentiality is breached or beneficiaries are not treated with respect. NGOs provide social services: education, guidance, counselling and crisis intervention. Some communities can provide assistance and care. Institutions and programs protecting the rights of citizens have been developed, including for HIV-infected persons such as the National Council for Fighting Discrimination and Ombudsmen.

HIV-infected people and those close to them (families, relatives, persons who care for them) may find it difficult to fight with the illness and society's reaction at the same time.

The fight against the disease may be regarded, in its turn, as an attempt to accept and cope with physical symptoms, but also as an attempt to psychologically cope with losing one's health and, sometimes, one's social position.

Among the psychosocial aspects leaving an imprint on an HIV-infected person are, at the individual level, those related to the chronic disease (limitation of physical capabilities, limitation of professional and family prerogatives, overprotection or rejection on behalf of the family, desire to know as much as possible about the disease), and some aspects characteristic of HIV infection (losing friends, rejection from social and medical services, affecting the whole family, aggravation of already existing problems: drug consumption, lack of permanent housing, etc.).

**Needs of the HIV-infected person**

The HIV-infected person needs access to ongoing attention and services during the illness, depending on each individual case. In the first place, as the disease evolves, the types of required services change. For many, HIV infection is caused, accompanied or followed by other social problems.

*Medical needs*

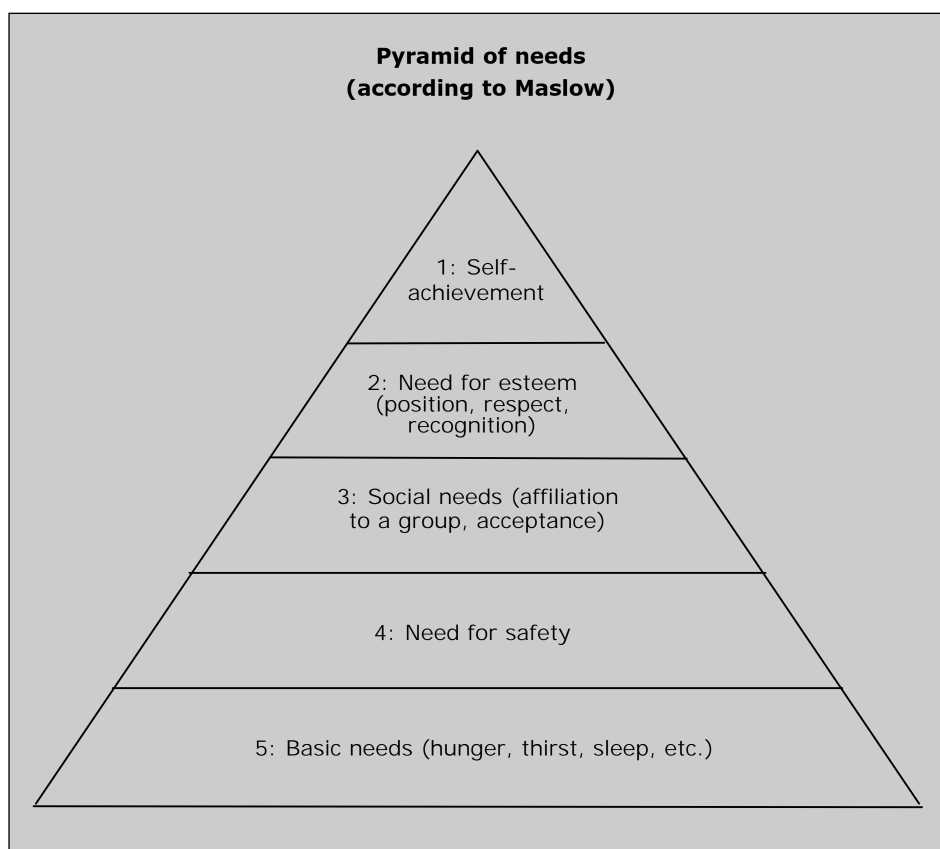
- specialized medical assistance, including regular evaluation of the evolution of infection and opportunistic infections (including their prevention),
- treatment of HIV infection (antiretroviral therapy) which is free and provided in infectious disease departments,
- treatment of opportunistic infections, which is compensated (depending on the patient's social situation and the disease for which the treatment is recommended) and can be recommended by the family physician or physicians in the infectious disease departments,
- access to other medical services (e.g., family planning, gynecology, stomatology, etc.), which require health security and/or references from the family physician.

As the HIV-infected patient is a patient with a chronic disease, he/she needs clear information about his/her disease and medical services to allow him/her to go on with his/her social (scholastic or professional) life. One of the problems often raised by HIV-infected persons is the fact that they cannot access specialized medical services in the afternoon or in the evening (for regular visits to the hospital they need to leave from their working place).

In the event that persons have serious social problems (lack of permanent housing) or have addictions (to drugs or alcohol), access to certain medical services is more difficult. Access to antiretroviral treatment is conditioned by the renunciation of drugs or by "guarantees" that the treatment is to be followed according to the prescription, as the effects of its interruption or superimposing it upon drug consumption can be harmful.

*Psychological needs*

They are the same as any other person's (see, in the figure, the pyramid of needs according to Maslow), except that stigmatization and discrimination may affect the self-image of the HIV-infected person, as they can also influence the attitudes of people around them. The role of all medical or social professionals is both to provide services to HIV-infected persons (in order to help them cope with stress), and to act and for the reduction of labeling, stigmatization and discrimination.

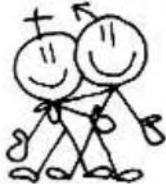



*Social and economic needs*

HIV infection may cause or aggravate economic or social problems. Whenever difficulties (unemployment, lack of permanent housing, alcohol or drug consumption, etc.) pre-exist the HIV diagnosis of a person, they are aggravated (with certain exceptions) by the discovery of their serological status. There are also many cases when medical and social problems are caused by the diagnosis and nonobservance of confidentiality (e.g., losing one's home, dismissal, alcohol consumption).

In Romania, HIV-infected persons can obtain, depending on their age and labor seniority, special protection as disabled persons or welfare maintenance. Moreover, they are entitled to financial support in order to provide nutritional supplements.

The protection and social assistance systems are not ready to cover all the needs of HIV-infected persons', as they are unable to guarantee confidentiality and nondiscriminatory access to services.



*Needs related to the observance of human rights*

Fundamental human rights are the same for everybody. The right to privacy, family, health, social protection, education and freedom of movement are essential elements to any society. Violation of such rights may constitute discrimination and, in certain cases, is sanctioned by the penal code.

Nongovernmental organizations, Ombudsmen and the National Council for Fighting Discrimination are institutions that follow-up, analyze and may penalize any violation of HIV-infected persons' rights.

Monitoring the respect of human rights of HIV infected persons proved that, in 2004, out of 1,316 total interviews achieved by UNOPA, a total of 317 rights violations were documented.[61] Out of these:

- 20% (or 63 cases) refer to rights violation in the sector of HIV infection-specific treatment,
- 30% (or 98 cases) refer to rights violation in the sector of medical attention,
- 16% of violations refer to maintenances due based on the Law no. 519/2002[62] and no. 584/2002,
- 3% refer to the violation of confidentiality of diagnosis,
- 2% refer to problems in the field of homeschooling,
- 1% refer to school rejection situations,
- 11% refer to rights violations of the personal assistant of the seriously disabled person (respectively, of the HIV/AIDS infected person).

A study carried out by ARAS in September 2004 (attended by 112 HIV infected persons benefiting from the social assistance programme) pointed to an alarming percentage of persons who considered themselves discriminated against. Thus:

- 51% believe they were discriminated against,
- 20% of those who did not believe they had been discriminated against recognized themselves in discrimination events,
- 19% alleged that they were treated differently or rejected when they accessed the medical services.

The answers to the question of who discriminated them were:

- 19% – the hospital, medical services,
- 16% – the family,
- 14% – the social services,
- 16% – the school,
- 4% – the work place.

As discrimination is caused by the violation of confidentiality, part of questions aimed at this aspect.

40% of respondents believed that the violation of confidentiality came from:

- medical staff: 22%,
- relatives, neighbors: 11%,
- teaching staff: 23%,
- public servants: 12%.

[61] The National Union of Organizations of HIV/AIDS Afflicted Persons (NUOAP) – *The Initiative for the Efficient Promotion and Defense of the Rights of People Living with HIV/AIDS* (Monitoring Report, July-September 2004), www.unopa.ro/download/raport_UNOPA_002_ro.pdf, 2005.

[62] Law no. 519/12 July 2002 for the approval of the Government Urgency Ordinance no. 102/1999 on the special protection and employement of disabled persons, published in the *Official Gazette of Romania,* Part I, no. 555 of 29 July 2002.

**Psychological impact of HIV infection on family, friends and partners**

HIV has a powerful impact on those close to the one who received an HIV infection diagnosis. Family members, friends and partners may have a variety of reactions, among which are: fear of being infected, anticipated loss, negation, anger, shame and helplessness, feelings which are hard to cope with and which may cause problems in relationships with the HIV-infected person. They may also be affected by real—or perceived—discrimination in the community and even in the family. For these reasons, it can be stated that the persons close to the HIV infected person are affected themselves as well.

The affected persons' reactions to the disease – fear, loss, helplessness, negation – are common to other chronic diseases as well, such as cancer and heart diseases. However, characteristic of HIV infection is the fact that to all these is added the powerful impact of discrimination and stigmatization expressed by society toward the HIV-infected person.

At the same time, the possibility of HIV transmission also poses an element of stress. Thus, the affected persons and even the HIV-infected person may be afraid of transmitting HIV, which alongside with the social rejection may make the infected person feel ”dirty” or ”contaminated”.

Moreover, some persons may be affected by their own infection  Not clear, the existence of several infected members in the family, the loss of friends, the many crises caused by the first hospitalization, the beginning of treatment, reactions to treatment, the emergence of other disease, etc.

*Parents*

In the family, the situations may be very different. For example, there are families where the parents are infected and the children are not, situations where the adult children are infected, situations where the younger children are infected or situations where both the parents and the children are infected. Their reactions may be different, depending on the characteristics of each family, age, geographical area, culture or religion, starting with rejection or neglect of HIV infected persons, to the neglect of the healthy members of the family and the overprotection of sick ones.

Another important problem is the disclosure of diagnosis, especially for children, regardless of whether the diagnosis in question is the child's or the parents'.

*Partners*

In the case of sexual partners, difficulties may occur within the couple or in relation with the outside world. If the partners (hetero- or homosexual) are not married, they cannot represent each other in critical situations, such as acceptance or rejection of a treatment.

Another difficult situation is encountered in the case of serodiscordant couples (where one partner is HIV infected and the other is not). These couples could be classified into three categories: those who had already formed a couple and had made an HIV test together, those who had already formed a couple and thereafter one of them found out that he/she is infected, and those who had been aware of their HIV status before forming a couple. In these couples, the difficulties may occur upon negotiation of safe sexual practices and, especially, upon telling partners. Sensible subjects when negotiating safe sexual practices are, in general: avoiding drugs or alcohol, fighting against the wish to be wholly at the partner's side, for better or for worse, to increase the intensity of sensation during sexual acts and lack of the

noninfected partner’s ability to negotiate safe sexual practices (because of possible physical or emotional abuse). Other problems may be caused by the “fault of surviving” the healthy partner, jealousy of infected partners of the other’s health or the fear of being deserted in critical situations.

In couples where both partners are infected, the negotiation of safe sexual practices (to avoid being re-infected) may be difficult, sometimes accompanied by accusations regarding mutual infection or infidelity. Nevertheless, in these couples there is a high degree of empathy and support, even when there are health problems, provided that both partners are not ill at the same time.

For those who work in the field of HIV infection, it is essential to understand HIV infected persons and those close to infected persons, so that they can provide appropriate support services.

**ANNEX IV**

# Working Standards in HIV Pre- and Posttest Counselling

**Foreword**

The voluntary HIV counselling and testing (VCT) is the process whereby an individual is assisted in making decisions regarding the HIV testing, thus having the opportunity to accept his/her HIV status. The HIV counselling and testing process includes the counselling for prevention and assistance, the diagnosing, the guidance/reference to medical and social services.

The HIV pre- and posttest counselling is defined as being a professional relationship based on mutual trust, listening and respect between a counselor and a client. Its purpose is to assist the client/patient in his/her effort to cope with the stress and make personal decisions regarding HIV/AIDS.

The counselling does not merely come to information and education for HIV prevention but is also based on involving the client in identifying the problems and finding solutions thereto.

VCT represents the way of access to medical and psychosocial services.

**Types of voluntary HIV counselling and testing centers (VCTC)**

| No. | VCTC | Advantages | Disadvantages |
|---|---|---|---|
| 1. | Opened by public institutions in the precincts of sanitary units | The services are integrated with other medical services, lead to the "normalization" of HIV infection | It is possible that the services thus offered be of low quality (overwhelming of personnel, limitation of personnel's diversity – excluding counselors between equals, of trained and experienced personnel but without specialized training, insufficient time for counselling) |
| 2. | Opened by public institutions outside of sanitary units | Provide quality and accessible services | May cause discrimination (accentuation of separation of services, negative attitude in the community) |

| 3. | Opened by nongovernmental organizations, outside of sanitary units, having as beneficiaries persons from vulnerable groups | Are easily accessible by the target-population, provide counselling adapted to the beneficiaries' needs | They need a very good collaboration with sanitary units in order to ensure the quality of tests and references to specialized medical services |
|---|---|---|---|
| 4. | Opened by partnerships between public institutions and nongovernmental organizations | Provide the quality of counselling and education services, the promotion of services for target-groups (through the activities of the nongovernmental organizations) and, at the same time, the quality of laboratory tests (through the activities of the public institution) | |

**Legal framework**

- *Law no. 584 of 29 October 2002 on the measures for the prevention of AIDS disease spreading in Romania and the protection of HIV infected or AIDS afflicted persons*[63].

This law regulates the access to information and education for HIV infection prevention, the observance of the norms regarding the diagnosing of HIV infected persons (HIV testing), as well as the observance of confidentiality.

- *Order of the Minister of Health no. 889/1998 for the updating of the HM's Order no. 912/1992 on instituting the system for the declaration of HIV infection and approval of its enforcement methodology.*

This Order sets forth the testing of pregnant woman, of couples who are to get married, as well as of other classes of persons. The enforcement norms detail the procedures and methods for providing HIV counselling and testing, the responsibilities of the service providers, the case reporting and monitoring procedures. It is the first regulation in Romania setting out the importance of counselling as always accompanying the HIV test.

- *Order of the Minister of Health no. 1611/2004* stipulates the compulsoriness of granting the HIV pre- and posttest counselling, thus strengthening the enforcement norms of the Order 889/1998.

*Gratuity/payment terms:* The test can be made free-of-charge[64], in case there is a medical recommendation or the beneficiary is part of social groups with high risk of infection/transmission.

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[63] See Annex V.

[64] Cf. „Master agreement on the conditions of granting medical assistance under the health social security system on 2004", in the *Official Gazette of Romania,* Part I, No. 920/22 December 2003. Also according to the „Order of the Minister of Health and President of the National House of Health Security no. 172/113/2004 for the approval of the development of health programs and subprograms financed from the State budget and the budget of the Unique national fund of health social security in 2004, as well as the Methodological norms of organization, financing and monitoring of the aforementioned health programs and subprograms", in the *Official Gazette of Romania,* Part I, No. 214/11 March 2004 (*The communitary program of public health*; subprogram 1.2., *Supervision and control of HIV/AIDS infections).*

**Objectives**

*General objective:* Providing quality VCT services accessible to the population.

*Special objectives:*
- providing a quality level of services consistent with the standards,
- providing the possibility of measuring the efficiency of such services (quality evaluation instruments),
- defining the activities developed in a voluntary counselling and testing center,
- defining the personnel's responsibilities,
- defining the profile of suppliers of counselling and testing services,
- defining the data administration system.

**Organization and operation of a VCTC**

*Guiding principles*

- The VCTC is opened to the large public, regardless of sexual orientation, age, ethnic group, marital status, social economic situation, etc.
- The VCTC provides counselling before and after making the HIV test. The VCTC provides quality tests, with the observance of the legal provisions in force.
- The VCTC will observe the clients' rights:
  - access to services,
  - access to information adapted to each one's needs,
  - informed consent,
  - intimacy,
  - confidentiality,
  - dignity,
  - comfort,
  - expressing one's opinion,
  - nondiscrimination,
  - safety.
- The voluntary counselling and testing centers can be integrated into a network of prevention and treatment services – made up of NGOs and public institutions, with the observance of the norms and laws referring to such services.
- The clients will have access to other prevention and treatment services as well, depending on the needs identified during the counselling (possibility of counselor to guide the clients to other medical or social services).
- Monitoring and evaluation of activities will be performed both from the quantitative and from the qualitative points of view (in order to ensure quality services).

*VCT Beneficiaries*

Any person may request the performance of a HIV test, confidentially or anonymously, accompanied by counselling, free-of-charge or against cost – depending on the regulations of the voluntary HIV testing and counselling center.

Amongst the applicants of a HIV test accompanied by counselling there are persons who:
- believe they have had behaviors posing a HIV infection risk (unprotected sexual intercourse, joint use of drug injection equipment),
- believe that they have been in situations posing a HIV infection risk (rape, transfusion before 1990),

- have a HIV infected partner,
- are willing to know their health condition,
- have a medical recommendation for the HIV test,
- are pregnant women,
- wish to start a sexual relationship or to get married.

*Testing ways*

▪ *„Compulsory”* – the testing thus styled is actually performed (according to the legislation in force) only upon the donation of blood or organs. Sometimes, the HIV test is requested by certain institutions (e.g., employers, hospital-hostel, children centers, etc., upon the arrival of new residents). The beneficiaries erroneously perceive this test as being “compulsory”, however they have the possibility to refuse or to contest the lawfulness of such test request.

▪ *Voluntary confidential* – this test is performed at the beneficiary’s request, the confidentiality of the discussion (counselling), of the applicant’s personal data and the test results being ensured.

▪ *Voluntary anonymous* – the test is performed at the beneficiary’s request, the confidentiality of the discussion contents being ensured and no identification data of the beneficiary being registered or requested. The voluntary anonymous testing is easily accessible to persons from vulnerable groups or having no identification documents. The testing is free-of-charge.

*Location/access*

The location ensures the anonymity and confidentiality, is adapted to local needs and observes at least the following criteria:
- VCTC should be easily accessible,
- should dispose of near by transportation means,
- should be provided with parking places,
- should have extended working hours, likely to allow the access to all the classes of clients,
- free access in the building – clients should not be asked where are they going and why.

*Infrastructure*

The VCTC should have at least three separate rooms, that is:
- waiting room,
- counselling room,
- blood taking room,

and
- a laboratory for test performance.

The location of rooms should ensure a functional circuit for the clients (e.g., numbered rooms).

▪ The waiting room will:
- only service the VCTC,
- dispose of enough chairs,
- be endowed with means of information on HIV infection and other sexually transmitted infections (at least written materials: folders, posters, magazines; TV and video, if the financial resources allow that).

- The counselling room will be endowed with:
  - comfortable chairs, of the same type, for counselor and client,
  - fan and heating installation (thermal comfort),
  - shelves and drawers for informative materials and registries,
  - objects likely to provide a pleasant atmosphere (flowers, pictures),
  - a system ensuring the intimacy (closing door, secretary-receiver, present at any time in the waiting room and not allowing the access of other persons to the counselling room, etc.).

- The blood taking room will be endowed with adequate equipment: needles, sterile equipment, and containers for collecting the used materials, special chair for blood taking, in accordance with the legislation in force.

- The laboratory will dispose of special kits, likely to ensure the correctness, accuracy of testing and the observance of the national norms on HIV testing. If possible, the laboratory should be in the same building with the VCTC. In case the laboratory has another location, an adequate transportation of samples – in refrigerating box and within the shortest time possible (according to the norms in these fields) should be ensured.

*Personnel providing the HIV pre- and posttest counselling*

- Structure:
  - HIV pre- and posttest counselor,
  - medical assistant,
  - secretary-receiver.

- Requirements/responsibilities for a good counselor:

1. Minimum qualifications:
   - course of minimum 15 hours on HIV pre- and posttest (course achieved by the ARAS and accredited by the Institute for the Training of Physicians and Pharmaceutical Chemists),
   - Higher education in the medical or social field.

Indispensable knowledge: date about HIV infection, testing procedures, communication, emotional support, behavioral change theories, counselling methods, references.

2. Experience:

Before starting his/her activity, any counselor should have, as minimum practical experience in the HIV pre- and posttest counselling, 10 hours under the supervision of a trainee counselor (always with the beneficiary's consent).

3. Ongoing formation:

The personnel should keep themselves informed at any time on the last data regarding the treatment, testing, to document themselves on the last knowledge about HIV infection and other ITSs.

4. Required abilities
   - active listening (verbal and nonverbal),
   - using open questions,
   - negotiation *vs.* persuasion,
   - capability to create a counselling atmosphere likely to inspire confidence to the client,

- ability to focus the discussion on HIV infection prevention and on the behaviors posing no risks,
- involving clients in the conversation,
- discussing sensible, delicate subjects at a level adapted to the cultural, educational, spiritual particularities of the various clients,
- identification of priorities, for an effective management of the time destined to a counselling session,
- coping in a professional manner with the clients' psychological relations.

5. Personal qualities:
   - ability to comfortably discuss about sex and ITS, HIV/AIDS,
   - approachable person with whom one can easily discuss, without barriers,
   - tolerance, open attitude towards all the clients,
   - awareness on his/her own preconceived ideas and values, therefore treating his/her clients in a noncritical manner,
   - belief in the value of counselling,
   - empathy, respect toward individuals,
   - understanding with the clients having powerful negative feelings.

*Special regulations*

1. Monitoring the clients' data

The data offered by any client coming to the HIV counselling and testing center are recorded on a *counselling and testing sheet*[65]. The following are written down on this sheet: client's code number or, as the case may be, family name and first name, birth date, gender, residence locality and other epidemiological information (number of HIV tests performed up to the respective moment, reason for testing, treatments followed for venereal diseases, previous hospitalizations, surgical interventions, whether he/she received any blood transfusions before 1990, etc.).

The information in the counselling sheets is monthly registered in a database. This last one is daily filled in and reviewed each month, various reports on the risk types, counselling efficiency, testing results being obtained. The sheet is inserted in the database only with a code, without mentioning the name (in the case of anonymous test). The data in the counselling sheet are used only for statistical purpose, for recording the counselling sessions and tests performed in the center, as well as for performing reviews on the reasons for requesting the HIV test, the risks identified by the clients, the counselling efficiency. Moreover, these data are necessary for the continuity of the discussion in the second session – the posttest counselling. Only the counselor has access to such database and the statistics will strictly observe the confidentiality.

The reporting of HIV infection cases to the specialized institutions is performed with the observance of the legislation in force (the positive results reporting sheets to the directorates of public health).

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[65] See Annex IV bis: Working protocol in the VCT, Form 4: HIV counselling and testing sheet.

2. Confidentiality

The discussion with the client – before and after testing – is confidential; the counselor will keep the secrecy of the information received from the beneficiary and of the testing and its result. The diagnosis or information received during the counselling cannot be disclosed to other persons except with the beneficiary's written consent or at the request of the prosecutor's office.

The confidentiality limits – reporting procedures (in accordance with the legislation in force).

3. Safety of client's data

Methods for ensuring the confidentiality or anonymity:

- anonymous or confidential recording sheets are kept in adequate areas, where the access to them is only allowed to the authorized personnel,
- any other document/registry containing data about the beneficiaries will also be kept in areas where only the authorized personnel has access (locked drawers, electronic files with password),
- visit cards[66] for setting the following appointment will have as columns the beneficiary's name and code, the appointment date and the mention: „The result will not be announced to any other party and will not be communicated by phone".

4. Consent

Before taking a blood sample for testing, each client will sign a confidentiality form in full awareness[67]. This document will contain at least the following specifications:

- client has not been compelled (by any occurrence or person) to make such test,
- client has received information about the HIV/AIDS infection and other ITSs,
- client has received information about what does the HIV test mean ("immunologic window" period, result),
- client has had the possibility to request any information related to HIV infection,
- client has agreed to make the HIV test.

5. Crisis situations

The crisis situations may consist in the client's aggresivity or shock state. The following will be resorted to in order to accommodate and/or settle such situations:

- balanced verbal intervention,
- reporting the incident,
- dialing the available emergency numbers.

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[66] See Annex IV bis: Working protocol in the VCT, Form 3: Visit card for scheduling the HIV posttest counselling session.

[67] *Ibidem,* Form 2: Consent in full awareness (consent for testing).

**Activities in the VCTC**

**Ethical and legal considerations**

– Age:

The minimum age for consenting in full awareness to the tests is of 18 years. In the case of marriage, the test performance may be accepted for the persons between 15 and 18 years of age.

As regards the minors (0-18 years), the parents' or relatives' consent is required. At the same time, when in question is a person having no power of judgment, the consent of relatives (who have to be provided with pre- and posttest counselling) is required.

– Confidentiality:

Confidentiality should be guaranteed at all times. In the case of references to other services, the beneficiary's consent is required. It is necessary to discuss the confidentiality limits (reporting system, circulation of data).

– Anonymity:

The anonymity is a right of the beneficiaries. In the case of references to treatment services, it is necessary to renounce to anonymity or to repeat the testing under confidentiality regime.

– Research:

In the VCTC all the research programs will be enforced with the observance of all the legal and ethical regulations, the beneficiary's consent in the first place.

– Observance of professional deontology:

The professionals acting in a VCTC should observe the professional deontology, the specific legislation, and the VCTC regulations. All these include provisions regarding the nondiscrimination, confidentiality, provision of quality services, respecting the beneficiaries.

The activities developed in a HIV counselling and testing center are the following:

*1. HIV pre- and posttest counselling*[68]

*2. Blood taking and test analysis (testing)*

These are provided with the observance of universal precautions and norms of blood taking and testing of blood samples.

The testing activities should be coordinated by State or local laboratories, in order to ensure a quality HIV testing as regards blood taking, preservation and transportation of samples. The laboratory errors are often due to certain deficiencies occurred during the activities preceding the actual blood examination.

The laboratories performing HIV tests should be authorized and develop their activities in accordance with the standards and norms in force.

*3. HIV post testing counselling*[69]

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[68] Detailed in Annex IV bis: Working protocol in the VCT.

[69] *Idem.*

*4. Counselling in special cases*

- Pregnant women and their partners: discussing HIV transmission risks, on the one hand from mother to fetus, and on the other hand within the sexual relationships of the couple; discussing the ways of reducing such risks.

- Serodiscordant couples: assistance to cope with the situation (a negative result and a positive one within the couple), the necessity to repeat the test, adopting safe sexual practices.

- Indeterminate result of test: even though it is not frequent, this situation may induce fear to beneficiaries and calls for a discussion about repeating the test.

- Teenagers: the counselling will take into account the age characteristics and the beneficiaries' level of understanding.

- Raped persons: since these counselling beneficiaries are in a crisis situation, it is important that they not be unbalanced by the information given to them but, at the same time, they should be prepared to receive a possible positive result.

- Persons who want to get married: in this case, both partners should consent to counselling and testing.

- Persons involved in commercial sex: their counselling requires a noncritical attitude, focused on reducing the risks and developing the abilities to negotiate the use of condom.

- Persons making use of injectable drugs and their partners: the discussion will focus both on using single use syringes and needles, as well as on using condoms in the sexual relationships.

- Occupational exposure: in this case, information will be provided about safe sexual practices and post exposure therapy.

*5. Supervision and evaluation*

▪ Supervision:

The supervision is the process whereby the counselor is given the possibility to discuss his/her activity with a trained, experienced colleague, in order to:

- identify uncertain and problematic areas,
- obtain guidance, when needed,
- be encouraged and challenged to competition,
- develop his/her abilities.

The supervision may be accompanied by assistance services: counselors' meetings, therapy, experience exchanges.

The supervisors should be aware of the counselling activity purposes and the abilities necessary in order to provide that service.

The case sessions – previously scheduled – may offer the coordinator the information referring to the counselors' abilities, the aspects which need to be improved, and for counselors are an occasion to learn from their colleagues various techniques useful in the development of their activities.

- Evaluation:

The evaluation is necessary in order to prove the efficiency of services and become aware of the extent to which they answer the beneficiaries' needs. Depending on the evaluation process results, the services can be adapted/improved.

A regular evaluation of the physical counselling area (sessions should take place in adequate place, likely to ensure the confidentiality of the discussions), of the number of clients and the time management (clients should not wait for too long before entering for counselling and testing) will be achieved.

The regular evaluation of the counselors' and clients' level of satisfaction as regards the offered services, respectively received, is also an important component of the VCT's evaluation process.

**Evaluation process rules**

The data collection system should be rhythmically checked up, at all the levels, in order to be sure that the information is correctly registered and filled in.

All the personnel members should benefit from data collection training, so that the service offer should not be affected be registrations.

The information obtained during the evaluation process should be regularly reviewed and reported to the persons and institutions involved in this process or to those who can support the smooth development of the center's activities.

*6. Community's education and mobilization*

In the absence of an adequate understanding on behalf of the community, the acceptance of VCT services would be most likely poor. In order to foster the community's understanding and involvement in the VCT process, it is necessary to educate and mobilize the population in the sense of normalizing the attitudes toward HIV, to promote the benefits of being aware of one's own HIV serological status and the publicity of VCT available service, to reduce the stigmatization and discrimination of HIV infected persons. The information and education approaches will be adapted to the real needs of each community and will be based on the partnership between public institutions and nongovernmental organizations.

# Working protocol in VCT[70]

**First counselling session: HIV pretest counselling**

*The purpose* of this session is to support the client/patient in:
- making the decision on performing the HIV test,
- evaluation of his/her own HIV infection risk,
- establishing a risk reduction plan.

The pretest counselling will give the clients/patients the possibility to:
- complete/correct the information about HIV infection (transmission, prevention, evolution),
- obtain information about the testing process,
- make a decision in full awareness on making the HIV test,
- initiate a behavioral change process, in order to prevent HIV infection or transmission,
- become aware of their own infection risks,
- acknowledge and strengthen the preceding efforts of reducing the infection risks,
- better identify the personal barriers against the risk reduction,
- achieve a risk reduction plan,
- become aware of available resources for the risk reduction plan.

*Objectives*

At the end of the counselling session, the clients/patient will:
- have established a support relationship with the counselor,
- have knowledge about HIV infection and testing process,
- have achieved an evaluation of their own infection risk,
- have identified and planned specific actions for increasing the level of use of prevention methods,
- have obtained references to other resources (including other services) which may support the behavioral change,
- have made a decision on making the HIV test.

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[70] The working protocol has been elaborated in collaboration with Galina Muşat and Mihaela Negoiţă, ARAS counselors *(n. m. – Liana Velica).* The following resources have been used as a model: Centers for Disease Control and Prevention – *Project RESPECT: Enhanced Counselling Intervention Manual,* Atlanta, GA (USA), July 1993; Academy for Educational Development [for the CDC Atlanta] – *Fundamentals of HIV Prevention Counselling. A Training Program (Participant's Manual),* Atlanta, GA (USA), November 1998; ARAS – *Detailed curriculum for the HIV pre- and posttest counselling course,* Bucharest, *in-house* publication, 2001.

**Structure of HIV pretest counselling session**

| Activity | Method | Time (minutes) | Materials |
|---|---|---|---|
| | | | |
| Presentation/establishing the counselling relationship | Discussion | 1 | |
| Discussing the general data about HIV and testing | Discussion/Open questions | 3 | |
| Risk evaluation | Discussion, Active listening | 4 | |
| Identifying the previous attempts of reducing the risk and identifying the barriers | Discussion Active listening | 2 | |
| Achievement of a risk reduction plan | Discussion, Active listening | 4 | Writing down the plan |
| Written consent for making the test<br>Appointing the meeting for the posttest counselling | Discussion<br>Filling in the form | 1 | Signing the agreement<br>Visit card for the following meeting |
| Necessary time: 15 minutes | | | |

1. *Presentation/establishing the counselling relationship (1 minute)*

– Welcoming message
– Presentation of counselor/center.
– Presentation of the purpose of meeting, its estimated time and envisaged results. The client's/patient's consent to focus the discussions on the themes likely to allow the reaching of the proposed objectives.

During the session the counselor will be polite, have a professional attitude and show respect, empathy and sincerity toward the client. He/she will be involved in the discussion and interested in the client's opinion.

2. *Discussing the general data about HIV and testing (3 minutes)*

The discussion will be focused on clarifying the data about HIV infection and testing process. The following information will be covered (to be found in the Health Minister's Order no. 889/1998[71]):

– difference between HIV and AIDS,
– transmission ways,
– evolution,
– social reaction (society's reaction, treatment, support),
– testing process (benefits, window period, blood taking, significance of results),
– confidentiality and consent (including the limits of confidentiality).

The information should be provided in a language accessible to clients and adapted to their needs. The client will be involved in the discussion, and the counselor will fill in/correct the information held by the client.

The counselor will be professional and sincere.

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[71] See Annex V: Legislation on HIV/AIDS, quoted Order, „To know is to live" – pretesting counselling sheet.

*3. Risk evaluation (4 minutes)*

The client will be assisted in recognizing/identifying specific behaviors exposing him/her to the infection risk.

The discussion will focus on the client's sexual/injectable drug consumption behaviors and on the circumstances in which such behaviors take place. The counselor should try to leave from recent problems (symptoms, references, etc.) which brought to client to the center. Together with the client, the counselor will identify both the classes of behaviors posing the infection risk, as well as their frequency and, at the same time, will focus the discussion on those behaviors, situations, partners likely to contribute to the infection risk.

The counselor will create an atmosphere likely to ensure a collaboration in exploring the significant matters. The counselor will use the active listening (open questions, using the nonverbal language, listening).

> *Remember!* The exploration of behaviors during the risk evaluation is an important component of the pretest counselling, aimed at facilitating the understanding by the client of his/her own infection risks. It is by no means intended to be a data collection instrument.

*4. Identifying the previous attempts of reducing the risk and identifying the barriers against the risk reduction*

The client is assisted to identify any previous attempt of him/her to change the risky behavior and to evaluate his/her social support network (which can assist him/her in initializing a risk reduction plan).

At the same time, the clients' efforts to act and communicate in the sense of adopting a safe behavior are reinforced. Simultaneously, the clients' questions about HIV infection are answered in a manner adapted to the clients' needs. The identification of barriers against adopting certain behaviors posing reduced infection risks is necessary for the achievement of a realistic behavioral change plan.

The whole discussion is focused on consolidating the client's trust in his/her own power to change something in his/her behavior. The counselor will use open questions and encouragements.

*5. Achievement of a risk reduction plan (4 minutes)*

The client is assisted in establishing a plan for the reduction of HIV infection risks. The plan should address the risks identified by the client during their evaluation phase and should incorporate the previous attempts of reducing them, taking into account the perceived barriers. The discussion will be carried on how is the client to apply this plan, using specific steps and a reserve plan.

The counselor will encourage the client to develop plans which include a condom or the single use syringes. The plans which do not comprise them but still reduce the risk are also accepted.

The counselor should obtain the confirmation of the fact that the plan is acceptable to the client, write down the plan on the form (see *infra)* and offer a copy thereof to the client. The counselor will admit that the plan is a challenge and will reconfirm the fact that, on the occasion of the following

visits (posttest counselling), he/she will work together with the client to update or rediscuss said plan.

Before the finalization of this phase, the counselor will invite the client to ask, if he/she wants that, any additional questions referring to the plan.

*6. Written consent for making the test*

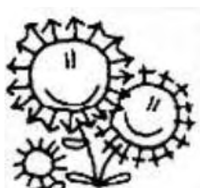
Appointing the meeting for the posttest counselling (2 minutes)

Before making a test, the client's consent regarding the testing will be asked for, and the client will be handed over the consent form (see *infra*), with the kind request to carefully read it and thereafter sign it.

Before the client's leaving to the blood sample taking office, a meeting will be mutually appointed – when the client would come back to the center to receive the result and posttest counselling. The counselor will write down the day and hour on a visit card (see *infra)* which will be handed over to the client. The counselor will remind the client that he/she may call and reschedule the appointment, in case of any occurrence which might prevent him from arriving to the center at that time.

After the client's departure, the counselor will fill in the HIV counselling and testing sheet (see *infra*).

**Second counselling session:**
**HIV posttest counselling**



***The purpose*** **of this session consists in announcing the HIV test results and supporting the risk reduction plan.**

The intervention will help the client to:

- obtain and understand the HIV test result,
- identify and strengthen the efforts made by him/her with a view to reducing the infection risk, such as defined in the preceding session / cope with HIV infection diagnosis.

*Objectives*

At the end of the session, the client/patient will:

- have received the HIV test result, with an interpretation based on the personal risk of getting HIV infected,
- have understood the significance of the test result,
- have reviewed, renegotiated and reinforced the risk reduction plan,
- have received and understood the references to other services answering his/her personal needs.

**Structure of HIV posttest counselling**

| Activity | Method | Time (minutes) | Materials |
|---|---|---|---|
| | | | |
| Announcing the test result | Discussion | 1 | Test result |
| Significance of result | Discussion | 2 | |
| Rediscussing the risk reduction plan/<br>Crisis intervention | Discussion<br>Active listening | 10 | |
| References | Discussion | 2 | |
| Total time: 15 minutes | | | |

*The following are necessary:*

- pretest counselling performed by the same counselor,
- announcing the test result – only face to face – to the person who has made the test,
- available resources for references (addresses, program, contact persons).

*1. Announcing the result (1 minute)*

The test result will only be announced to the client who has performed it (or his/her relative, in the case of children or persons having no power of judgment), avoiding the cant and technical terms. The tone of rhythm of voice upon announcing the result should be balanced in order to avoid the accentuation of the fear or relief feelings.

*2. Discussing the test significance (2 minutes)*

The provisions of the posttest counselling sheet (HM's Order 889/1998[72]) will be observed.

- A negative result of the test means that there is no actual proof of the presence of HIV, the virus causing the AIDS.

> *Remember:* if a person has been recently exposed to the infection risk, he/she may be seropositive but the test is not yet positive (immunologic window period). In these cases, the test repeating will be discussed.

- An inconclusive/indeterminate result means that the test is not relevant, which may indicate a recent infection (antibodies have not formed as yet) and, in may cases, a reaction to something else than HIV.

- A positive result means (depending on the tests performed – ELISA, WESTERN BLOT) that the test should be confirmed or that the test is positive. If no additional result confirmation has been performed, a new blood sample will be taken or references to a service providing confirmation test will be ensured.

*3. Rediscussing the risk reduction plan (negative result)/crisis intervention (positive result) (10 minutes)*

a. Negative result/Rediscussing the risk reduction plan

Leaving from the risk reduction plan written down on the form on the pretest counselling occasion, at this stage the counselor will discuss the steps established at the end of the pretest counselling and run in the meantime by the client with a view to changing his/her behaviors. The risk reduction plan will be reviewed, the way of enforcing it will be evaluated, and the furthering of these efforts will be encouraged or the whole plan will be adjusted, depending on the encountered difficulties.

[72] V. Annex V: Legislation on HIV/AIDS, quoted Order, Posttesting counselling sheet of seropositives.

b. Positive result/Crisis intervention

During the session the counselor will prove empathy, professional, noncritical attitude.

The posttest counselling in the case of a positive result will take into account the client's reaction upon the announcement of the result (shock, negation, acceptance) and will focus on assisting him/her to overcome the crisis situation generated by finding out the result.

In case the client enters into a shock state (has no reaction, does not talk), the counselor will wait for him/her to get over (at most tells that he/she is on the client's side, offers him/her a glass of water). In case a client reacts at being announced a positive result by denying it, the counselor (in case he/she already has the confirmation of result) will not encourage such negation, even if he/she is aware that such reaction is a normal, often met reaction.

The session will follow the crisis counselling rules. The evolution of a crisis comprises several stages: risky event, vulnerable situation, precipitating factor, active crisis, and reintegration. After being announced the positive result, the clients may enter into a crisis, and the counselor will not propose himself/herself to solve it (the crisis intensity will gradually diminish) but to help the client find out ways in order to be able to be socially operational.

The counselor gives the client the possibility to:

- express his/her emotions and find out ways to cope with them (defining the problem from the client's point of view) through:
  - talking about the diagnosis,
  - crying and be furious,
  - thinking about who could help him/her,
  - thinking about new purposes in the future, new possibilities,
- clarifying the next stages (examination of alternatives):
  - accessing the evaluation and treatment services (test for establishing the quantity of virus, prophylactic treatments for other diseases),
  - connecting to support organization and services – associations of HIV/AIDS afflicted persons, support groups, long-term counselling, information (about treatment, social assistance, infection evolution, references to other services),
  - elaborating a strategy of announcing the partners – in order to cope with the fears of having exposed other persons as well to HIV infection and find solutions to notify them (so that they should become aware of the possibility of having been exposed to HIV infection risk);
- creating a plan aimed at coping with the situation (with concrete, possible steps).

*4. Providing references to other services* (2 minutes)

Depending on the plan established by the client, the counselor will provide written references to other services. In order to be able to provide references as much adequate to the client's case, the counselor should have available a database of such services, updated on an ongoing basis. The references will include the following: name, address, telephone, program, services, and contact person.

The counselor will provide the session closing, thank the client and wish him/her good health. The counselor will also remind him/her that he/she may come back to the center should he/she has any further questions.

In case of a positive result of the test, the client will always be invited to a new meeting (in case the counselor and the client mutually agree that such meeting is necessary).

After the client's departure, the counselor will write down the HIV counselling and testing sheet (see *infra*).

***Form 1:* Plan of reducing HIV infection risks**

Code/Name: ___________________

Identified risk: _________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Preventive objective:
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Risk reduction plan:
1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________
4. ___________________________________________________________
5. ___________________________________________________________

***Form 2:* Consent in full awareness**
**(consent for testing)**

The undersigned: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
Holder of the code: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
I hereby declare that I have received the information about:
- ☐ HIV/AIDS infection,
- ☐ other sexually transmitted infections,
- ☐ testing procedures,
- ☐ disease evolution and treatments,
- ☐ infection prevention,
- ☐ legislation in force.

I hereby declare that I had the possibility to address any question related to HIV infection/other ITSs and the ways to prevent them.

In full awareness, I agree to make the tests for:
- ☐ HIV
- ☐ HBV/HCV
- ☐ VDRL/TPHA

Date: . . . . . . . . . . . . . . . . . . . . . . .
Signature: . . . . . . . . . . . . . . . . . . . . .

Counselor: . . . . . . . . . . . . . . . . . . . . . . .

***Form 3:* Visit card for scheduling the HIV posttest counselling session**

Code: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
Family name and first name: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
Tested*: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Posttest counselling scheduling:
Day: . . . . . . . . . . . . . . . . , hour: . . . . . . . . . . . . . . . . . . . . . .

Counselor: . . . . . . . . . . . . . .

** The result will not be announced to any other person and will not be communicated by phone.*

***Form 4:***
**HIV testing and counselling sheet**[73]

***COUNSELLING DATA:***
Center name/number: ______________________
Counsellor's name: ______________________
Pretest counselling: __ /__ /__ /__ (h/d/m/y)
Posttest counselling scheduling: __ /__ /__

***TEST RESULT:***
ë Negative ë Positive ë Uncertain
Test type: ë Anonymous ë Confidential

***TYPE OF SERVICES:***

***PRETEST:***

ë Information
ë Risk evaluation
ë RR Plan
ë References

***POSTTEST:***

ë Announcement of result
ë RR Plan
ë References

Test:

ë Blood taking
ë Laboratory

Code: __ /__ /__ /__ (no/day/month/center)
Family name: _________ First name: ________
Gender: M ë F ë
Date of birth: _______ /______ /____________
Locality:___________ County: _____________
Address:_________________________________

***SEXUAL ORIENTATION:***

ë No sexual activity
ë Heterosexual
ë Homosexual
ë Bisexual
ë Not answering (NR)

The client has been sent by:
ë HIV+ partner
ë IEC Program
ë outreach
ë school education
ë labor place education
ë SIDA Helpline
ë Disintoxication/ methadone substitution program
ë Family physician / specialized physician
ë Friend / relative
ë Media (radio, TV)
ë Others _________________________
ë Not answering (NR)

***CLIENT'S REASON FOR BEING TESTED:***

ë Medical recommendation – confirmation
ë Medical recommendation – symptoms
ë HIV+ partner at present
ë HIV+ partner in the past
ë TBC or ITS diagnosis
ë Pregnancy, month _______
ë Risk infection behavior
ë Starting a new relationship
ë Employment
ë Leaving abroad
ë Wish to make the test regularly
ë Curiosity
ë Other (specify) ____________________

***HISTORY OF HIV TESTING***
Number of previous tests:
ë 0 ë 1 ë 2 ë 3 ë 4 ë 5 ë >5

Date of last result: ______ (month) _____ (year)

Last result:
ë Positive ë ELISA ë WB ë PCR ë fast ë NR
ë Negative
ë Uncertain
ë Has not picked up the result

Testing reason: __________________________

***RISK REDUCTION-RR***

***RR PHASE:***
ë Indifference (does not think of a change)
ë Contemplation (does think of a change)
ë Intention (action preparation)
ë Action (adopts a new behavior)
ë Maintenance (keeps the new behavior)

***PRETEST: IMMEDIATE RR PLAN***
_________________________________
_________________________________
_________________________________

***POSTTEST: PLAN ENFORCEMENT***
ë No plan has been established
ë Client made no efforts
ë Attempt to enforce the plan
ë Accomplished plan

***POSTTEST: IMMEDIATE PLAN***
_________________________________
_________________________________
_________________________________

***LONG-TERM PLAN***
_________________________________
_________________________________
_________________________________

***SENT TO***

pretest/posttest:

ë ë No references

ë ë ITS Clinic

ë ë Infectious diseases hospital

ë ë Other medical services

ë ë Disintoxication

ë ë Exchange of syringes

ë ë Social services

ë ë ONG services

ë ë Support groups

ë ë HIV+ association

ë ë Sexual education

ë ë Access to condoms

ë ë Family planning

ë ë Psychotherapy

ë ë Others (specify) ___________________

Other tests performed: ë TPHA ë pos. ë VHB ë pos. ë VHC ë pos. ë Others (specify) ____________
Program outreach: ë CSW ë IDU ë Roms ë Street children ë Others (specify) ____________

---

[73] *N.B.:* As already specified, the counselling sheet will always be filled in after the client's departure, by no means in his/her presence!

The client's behavior during the last year (12 months) will be discussed and written down.

Total number of partners ëëë

ë men

| Sexual activity | Protection frequency never/sometimes/frequent/always |
|---|---|
| Oral | ë 1 ë 2 ë 3 ë 4 |
| Vaginal | ë 1 ë 2 ë 3 ë 4 |
| Anal | ë 1 ë 2 ë 3 ë 4 |

ë women

| Sexual activity | Protection frequency never/sometimes/frequent/always |
|---|---|
| Oral | ë 1 ë 2 ë 3 ë 4 |
| Vaginal | ë 1 ë 2 ë 3 ë 4 |
| Anal | ë 1 ë 2 ë 3 ë 4 |

ë sexual relationship with CSW

| Sexual activity | Protection frequency never/sometimes/frequent/always |
|---|---|
| Oral | ë 1 ë 2 ë 3 ë 4 |
| Vaginal | ë 1 ë 2 ë 3 ë 4 |
| Anal | ë 1 ë 2 ë 3 ë 4 |

ë sexual relationship with IDU

| Sexual activity | Protection frequency never/sometimes/frequent/always |
|---|---|
| Oral | ë 1 ë 2 ë 3 ë 4 |
| Vaginal | ë 1 ë 2 ë 3 ë 4 |
| Anal | ë 1 ë 2 ë 3 ë 4 |

ë HIV+ partner

| Sexual activity | Protection frequency never/sometimes/frequent/always |
|---|---|
| Oral | ë 1 ë 2 ë 3 ë 4 |

Injection of substances

| Substances used | injectable |
|---|---|
| Alcohol | |
| Marijuana | |
| Heroin | ë Yes |
| Cocaine | ë Yes |
| Amphetamines | |
| Others (specify) _______________ | ë Yes |

Consumption at present:

ë Yes

ë No

Use of syringes in common:

ë Never

ë Sometimes

ë Always

Exchange of syringes:

ë Never

ë Sometimes

ë Always

Disintoxication/methadone:

ë Yes

ë No

Syringe cleaning:

ë Never

ë Sometimes

ë Always

Sexual transmission diseases

ë None

ë Syphilis

ë Hepatitis B

ë Hepatitis C

ë Others (specify) ________________________________

Other risk factors

ë Receives money or other goods for the sexual intercourse

ë Tattoo, piercing

ë Transfusion, year ___ë hospitalizations ë injections ë surgery

ë Stomatology

ë Blood diseases

ë Professional exposure to blood

Counselor's notes: ________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

**Annex V**

# Legislation on HIV/AIDS

**MOH ORDER**
**No. 889/5 Nov. 1998 to update Ministry of Health Order No. 912/1992 that instituted the HIV-name reporting system and approved the enforcement methodology thereof**

The Minister of Health – after reviewing the Memorandum of the General Directorate of Preventive Medicine and Health Promotion registered under no. GH/7501 of 26.10.1998, whereby it was proposed that MOH Order No. 912/1992 be updated in order to complete annex number 1 and replace the standard form set forth in annexes number 2 and 3 with new, updated forms – with the justification of GD No. 244/1997 on the organization and operation of the Ministry of Health, hereby issues the following

**ORDER**

1. Annex number 1, point 2 of MOH Order 912/1992 shall be completed with point 2.7, having the following content: patients with sexually transmitted diseases, pregnant women, long-distance drivers, sailors, persons of Romanian nationality working for more than six months abroad, as well as for the issuance of a premarital certificate, shall be tested for HIV and recorded as such, in order to institute prophylactic methods against vertical transmission – from mother-to-child, in the case of the pregnant woman – and, respectively, in order to receive out-patient treatment in the case of other aforementioned classes, with the application of pre- and post-test counseling.
2. The standard form comprised of the HIV-positive child's questionnaire and the name reporting sheet for AIDS cases in the case of children (0-12 years) set forth by annex 2 will be replaced with the updated standard form proposed in the aforementioned memorandum.
3. The standard form comprised of the HIV-positive adult questionnaire and the name-reporting sheet for AIDS cases in the case of adults (13 years and older) set forth in annex 3 will be replaced with the updated standard form proposed in the aforementioned memorandum.
4. The General Directorate of Preventive Medicine and Health Promotion, as well as the other directorates of the Ministry of Health, District Public Health Authorities and specialized units shall fulfill this Order.

MINISTER
Gabor Hajdu

**Enforcement Methodology MOHMOH Order 889/1998**

Within the current Romanian social and economic context, MOH Order 889/1998 aims to achieve active health education in order to prevent the transmission of HIV infection among high risk populations (young couples, pregnant women, persons working abroad for extensive periods of time

This Order does not exclude, but emphasizes, the importance of effective health education provided by all accredited bodies in the field (District Public Health Authorities, MOH Preventive Medicine Directorate, the Ministry of Education, NGOs, mass-media, churches, etc.) in preventing the transmission of HIV.

*I. HIV testing of pregnant women, with pre- and post-test counseling*

1. PURPOSE: prevent mother-to-child transmission of HIV.

The risk of transmitting HIV from the mother to her newborn child iis estimated at 13-40 percent (%) (M.M.W.R. 44/July 1995). The child may be infected in the uterus, precos intra-/postpartum (~18%) and late postpartum phases by breast feeding (~4%). Clinical studies prove that zidovudine therapy lowers HIV transmission by to 8.3 percent (%) (N.E.J.M. 331:1173, 1994).

2. OBJECTIVES:

Provide health education to the pregnant woman on the risks and means of preventing HIV infection for herself, as well as for the future child.

Track the HIV-positive pregnant woman (with pre- and post-test counseling) and adopting in full awareness the most correct medical behavior.

Provide active prophylaxis for mother-to-child transmission of HIV infection.

3. METHODOLOGY:

This Order sets forth compulsory counseling for all pregnant women, presenting the importance of being aware of HIV-status in order to prevent mother-to-child transmission.

The MOH National Anti-AIDS Commission requests the support of all involved institutions to encourage HIV testing among pregnant women.

In order to achieve the proposed objectives, an inter-disciplinary approach between the family physician, laboratory, gynecologist, infectious diseases physician, as well as the staff trained to provide counseling (psychologist, social assistant) is necessary.

**Phases:**

*A. First medical consultation of the pregnant woman (see algorithm 1)*

The pregnant woman comes for a first medical consultation with one of the following:

a) family physician,
b) Health Center gynecologist of the, or
c) Ob/Gyn ward gynecologist.

In order to be able to adopt correct medical behavior, this consultation should preferably take place in the first trimester of pregnancy; the following approaches remain valid irrespective of the stage of pregnancy.

*a) Family physician*

On the occasion of the first consultation, the physician will inquire about HIV-status.

If a pregnant woman has not previously been tested for HIV infection, the family physician will counsel her, asserting the importance of HIV-status awareness both for her own health and in order to prevent mother-to-child transmission.

In order to facilitate counseling activities in the field, the MOHMOH National Anti-AIDS Commission proposes the use of a special pre-testing counseling sheet (annex 1).[74] It is noteworthy that counseling should be personalized, as a "mechanical" use of the sheet could jeopardize the very objectives of this approach (active health education).

After providing counseling, the family physician recommends administering standard tests (hemoleucogram, blood group, Rh, VDRL), also requesting an HIV test of the pregnant woman. There are two alternatives:

– Tests are made in the consulting room of the family physician. In this case, the methodology in annex 2 is applied for HIV testing, the blood taken is sent by courier to the nearest laboratory with HIV serology capabilities (transfusion centers, laboratories of the Public Health Authority, infectious diseases hospitals), or
– The pregnant woman is guided to the nearest laboratory with HIV serology capabilities.

In order to ensure the confidentiality of the test, as well as guide the family physician, the latter will complete an HIV test request bulletin (annex 3) and an envelope with his/her name and the address of the unit where he/she works. The envelope with the request bulletin will accompany the blood of the pregnant woman. The role of the laboratory is to notify the physician of the HIV test results promptly.

As soon as the family physician receives the HIV test results by mail or courier, he/she is bound to notify the pregnant woman of her HIV-status promptly.

If the result is positive, the physician is bound to:

- Provide post-test counseling; he/she may use the post-test counseling sheet proposed by the National Commission (annex 4),
- Complete an HIV infection case confirmation form (annex 5) and submit it to the Public Health Authority,
- Promptly guide the pregnant woman to the nearest infectious disease service.

[74] We only reproduce here the annexes referring to the pre- and post-test counseling: "To know is to live" – the pre-testing counseling sheet and post-testing counseling sheet for seropositives.

*b) Gynecologists (Ob/Gyn)*

If the pregnant woman goes directly to a gynecologist within a diagnostic centre or Ob/Gyn department, the same protocol will be performed, but with several particular features:

- Pre- and post-test counseling may be performed in the family planning consultation room of the respective unit.
- In order to ensure the most accurate and effective counseling, certain counseling positions will be established in diagnostic centers and gynecology departments. Special training courses for the counselors will be organized in the two infectious disease clinics of Bucharest, as well as in other specialized university clinics in the country.
- If the pregnant woman consents to have an HIV test, the gynecologist will complete an HIV test request form and envelope, which the pregnant woman will present at the nearest specialized laboratory.
- If the result is positive, after providing post-test counseling, he/she will present to the pregnant woman the alternative of a uterine abortion.
- The fact that a single HIV-positive test result does not confirm an HIV infection diagnosis should be stressed, for which reason the pregnant woman should preferably be guided to the nearest infectious disease service. In the event that the pregnancy is in an advanced stage and the pregnant woman requests uterine abortion before the diagnosis is confirmed, she will be subsequently guided to an infectious disease specialist.
- If the pregnant woman requests that her pregnancy be terminated during the first trimester and comes to an Ob/Gyn consulting room for a uterine abortion, counseling at respective unit is recommended.

*B. HIV testing of pregnant women* is assured by Public Health Authority laboratories, transfusion centers, and laboratories accredited for HIV testing within diagnosis centers.

HIV testing of the pregnant woman is done free-of-charge, observing the principles of confidentiality.

The aforementioned laboratories receive either a blood test taken in the field (observing the methodology in annex 2) or the pregnant woman goes to the laboratory directly. In both cases, the laboratory receives the test request form and envelope specifying the address of the applicant's physician.

The laboratory performs a single test for each case.

The HIV test result will be communicated to the applicant's physician by mail or courier.

In the case where the blood sample taken in the field is compromised (e.g., hemolyzed serum), the laboratory will promptly inform the applicant's physician thereof.

A positive result will not be handed over directly to the pregnant woman; there are exceptions where the laboratories ensure post-test counseling.

Test results may be communicated to the applicant's physician by telephone, if this possibility exists.

*C. Arrival of the HIV-positive pregnant woman to the infectious disease specialist*

All infectious disease hospitals or departments, as well as the day sections of infectious disease hospitals, will grant specialized medical assistance and, if needed, emergency treatment for the HIV-positive pregnant woman.

First, confirmation or invalidation of the HIV infection diagnosis will be determined using the proscribed methodology.

In the case that diagnosis is confirmed, the following activities will be carried out:

- Counseling the pregnant woman; focus will be made on her future behavior and the risk of transmission to the fetus. Counseling will be performed by trained specialized staff.
- The pregnant woman in the first trimester of her pregnancy will be informed that she may opt to terminate her pregnancy or undergo antiretroviral prophylaxis; the final decision will be made by the pregnant woman and taken in full awareness.
- If the pregnant woman requests to terminate her pregnancy, she will promptly be directed to an Ob/Gyn department, and the specialist there will be informed about her HIV-status. Subsequently, she will return to the infectious disease service for diagnosis information about the clinical and immunological phases of infection, adequate therapy and out-patient treatment.
- If the pregnant woman wishes to continue the pregnancy, the clinical and immunological phase of infection will be specified, and, depending on the term of pregnancy, prophylaxis will be administered (see algorithms 2, 3, 4 and 5). Simultaneously, the pregnant woman will be informed of all associated obstetrical and non-obstetrical factors that pose an increased risk of mother-to-child transmission of HIV (amniocentesis, trophoblastic punctures, cervical and vaginal infections or sexually transmitted diseases, premature tearing of reproductive membranes, vitamin A deficiency, smoking, drug use, unprotected sexual intercourse during pregnancy, high viral load).
- Confirmation of HIV infection is recorded on the forms.
- The pregnant woman who receives antiretroviral therapy will be clinically and para-clinically monitored according to current methodology (see the *Guide*[75]*).*
- The pregnant woman will be directed to a gynecologist who will keep records of her case and collaborate with the infectious disease specialist throughout the pregnancy.
- After delivery, the HIV-positive mother will be reevaluated and appropriate therapeutic behavior will be appraised.
- The HIV-status of the newborn will be diagnosed promptly in one of the specialized laboratories in the country by ascertaining the viral load. Until the diagnosis of such HIV-status, the child will receive prophylaxis with zidovudine-syrup according to existing guidelines (see the *Guide*).
- All HIV-positive women of reproductive age will be referred for a family planning consultation in order to determine adequate contraceptive methods.

[75] The Ministry of Health and Family/The National Anti-AIDS Commission , „Prof. Dr. Matei Balş" Institute of Infectious Disease – Therapeutic Guide on HIV Infection, Bucharest, 2001

*D. Role of the Gynecologist in preventing mother-to-child transmission of HIV infection*

The Gynecologist will participate, together with other specialists, in preventing mother-to-child transmission of HIV.

He/she will inquire about the HIV-status of the pregnant woman.

If the pregnant woman has not previously been tested and comes to the gynecologist first, the latter will apply the approach under point A, a and b, herein.

If the HIV-positive pregnant woman wishes to terminate her pregnancy, the gynecologist will review the risks and benefits and, based on that, he/she will perform a uterine abortion, observing the universal means to transmission to prevent.

He/she will keep records of the HIV-positive pregnant woman who wishes to carry the pregnancy to term, performing regular controls and assisting to prevent the main obstetrical risk factors of HIV transmission; he/she will collaborate with the infectious disease specialist who cares for the HIV-positive pregnant woman.

During treatment, he/she will supervise treatment of antiretroviral therapy, according to established guidelines (IV or oral).

As performing a Caesarian operation before treatment is started can contribute to lowering the risk of mother-to-child transmission of HIV, the Ob/Gyn will take into account the ratio between the benefit (for child)/risk (for mother) whenever the question of performing a Caesarian operation arises. It is notable that Caesarian operations performed after the start of treatment or on torn membranes has no benefit.

He/she will inform the expectant mother that the newborn should not be breastfed.

At the infectious disease specialist's request, specialists working in family planning cabinets will advise the HIV-positive woman of reproductive age about the most adequate methods of contraception.

*E. Role of the neonatal pediatrician in preventing mother-to-child transmission of HIV*

The pediatrician in the maternity hospital will care for the newborn of an HIV-positive mother and, in addition to other medical care provided, he/she will give the newborn prophylactic treatment with zidovudine-syrup, according to the guidelines (see the *Guide)*.

He/she will inform the mother that the newborn should not be breastfed.

He/she will collaborate with the infectious disease specialist with regards to the HIV-status of the newborn.

*F. Miscellaneous*

The pregnant woman in prison will follow the necessary protocol. The Ministry of Justice is bound to request the appropriate medical counseling and assistance from the Ministry of Health.

The same approaches will be applied in the case of mentally challenged minors and women.

The raped woman will be counseled and receive preventative treatment for HIV. The responsibility for counseling is incumbent on the forensic medicine laboratories, and the HIV prophylaxis to the local infectious disease departments.

Throughout this approach, the confidentiality of the medical act will be kept.

The funds necessary for running this program will be provided by the Ministry of Health.

*II. Premarital HIV testing,*
*with pre- and post-test counseling (see algorithm 6)*

1. PURPOSE: Raise awareness about the increasing number of sexually transmitted HIV cases in Romania, and the necessity to have an active health education program to prevent the further spread of the disease, especially by the use of protected sexual behavior.

2. OBJECTIVES:

Provide active health education for couples on the risks of HIV infection and means of prevention.

3. METHODOLOGY:

This Order sets forth compulsory counseling for couples on the risks of HIV infection and means of prevention, emphasizing the importance of protected sexual behavior.

The MOH National Anti-AIDS Commission requests the support of all involved institutions in order to encourage HIV testing among sexually active persons.

In order to achieve the proposed objective, collaboration must be effected between the physician who issues premarital certificates in diagnostic centers, family physicians, infectious disease physicians, as well as staff trained to ensure pre- and post-test counseling (psychologists, social assistants).

**Phases:**

*A. Referral of the couple to a diagnostic center in order to obtain a premarital certificate*

The physician issuing a premarital certificate will inquire about the HIV-status of each partner.

The couple will be counseled by the respective physician, who will insist on the importance of being aware of HIV-status, both for their own health, as well as to bring a healthy child into the world.

In order to facilitate counseling, The National Anti-AIDS Commission proposes the use of the pre-test counseling form (annex 1). Attention is drawn on the fact that the counseling should be personalized, as the ”mechanical” use of the form could jeopardize the objective of this approach (active health education).

In order to ensure correct and effective counseling within Diagnostic centers, certain counselor positions (psychologists, social assistants) are to be established.

After counseling, the physician in issuing a premarital certificate will recommend performing standard tests, also requesting couples be tested for HIV.

In order to ensure that the medical act is performed correctly and confidentiality, the respective physician will complete HIV—test request bulletins. These will be put into envelopes addressed to the physician and the unit where he/she works, in order to facilitate confidential notification of the result from the laboratory (see annex 3).

The couple is referred to the nearest laboratory that can perform an HIV test (preferably laboratories accredited for HIV testing within a diagnostic center or Public Health Authority laboratory transfusion centers).

As soon as the physician receives the HIV—test results by mail or courier, he/she is bound to notify the couple of their HIV-status.

In the case that the results are negative, he/she is bound to complete the following columns on the premarital certificate:

# HIV counseled: YES,

# HIV tested: YES (or NO).

In the case of a positive result, the physician is bound to:

- Ensure post-test counseling of the individual and couple; therefore, he/she may use the post-test counseling sheet proposed by the MOHMOH National Anti-AIDS Commission (annex 4) or utilize the staff trained in counseling,
- Complete the HIV infection case confirmation sheet and submit it with the Public Health Authority,
- Refer the HIV-positive person to the infectious disease service for HIV infection confirmation or invalidation,
- Allow the partners to decide, in full awareness, whether they wish to get married or not,
- If the partners decide to get married, the physician must complete the following columns on the premarital certificate:

  # HIV counseled: YES,

  # HIV tested: YES.

Only the partners have been counseled and tested may be noted. *Specification of HIV-status on the premarital certificate is forbidden.*

*B. HIV testing of the couple* that consents to be tested is assured by: laboratories accredited for HIV-testing within diagnostic centers and Public Health Authority laboratories.

HIV testing of the couple is made at cost, observing the confidentiality principle.

The laboratory performs a single test for each case in turn.

HIV test results will be sent by mail or courier, using the form and envelope sent by the applicant’s physician. In order to avoid fraud, results will not be given to tested persons in person. The failure to observe this principle will result in penalties awarded to the person in default; sanctions will be set by the College of Physicians and, respectively, by the College of Medical Assistants.

*C. Presentation of the tracked HIV-positive person to the infectious disease physician*

First, confirmation or invalidation of HIV infection will be pursued.

In the case of a confirmed diagnosis, the following approaches will be made:

- The HIV infection case is recorded on special forms,
- The clinical immunological phase of HIV infection is determined, appropriate therapy is started and the person is sent for out-patient treatment.

*III. HIV testing of long-distance drivers, sailors and other persons working abroad for extensive periods of time*

1. PURPOSE: Raise awareness of the risk of HIV infection and the need for active health education in order to prevent the spread of the disease, especially by means of protected sexual behavior.

2. OBJECTIVES: Provide active health education to certain at-risk persons (long-distance drivers, sailors, other persons working abroad for extensive periods of time).

3. METHODOLOGY:

This Order sets forth the compulsory counseling of persons working abroad for extensive periods of time, long-distance drivers and sailors on HIV infection risks and the means of prevention, emphasizing the importance of protected sexual behavior.

The MOHMOH National Anti-AIDS Commission requests the support of all the involved institutions in order to encourage HIV-testing of sexually active persons working abroad for extensive periods of time, long-distance drivers and sailors.

In order to achieve the proposed objective, collaboration must be effected between physicians in diagnostic centers who ensure regular medical examinations for employment (the equivalent of the workplace physician), infectious disease physicians, family physicians, as well as staff trained to ensure pre- and post-test counseling.

**Phases:**

*A. Presentation for a regular medical examination*

During the regular medical examination, pre-test counseling of all aforementioned persons will be assured, insisting on the importance of being aware of HIV-status the means pre-test counseling (annex 1). It is notable that counseling should be personalized as the ”mechanical” use of the sheet could jeopardize the objective of this approach.

In order to ensure correct and effective counseling at the unit level during the performance of regular medical examinations for persons targeted by this Order, certain counselor positions (psychologists, social assistants) are to be established.

For persons who consent, the physician will complete an HIV—test request form. The form will be placed in an envelope addressed to the physician at the unit where he/she works. The role of the form and the envelope is to facilitate confidential notification of the HIV-test results from the laboratory.

The person consenting to testing is referred to the nearest laboratory performing HIV serology (preferably laboratories accredited for HIV testing within diagnostic centers, transfusion centers or Public Health Authority laboratories).

As soon as the physician receives the HIV—test results by mail or courier, he/she is bound to notify the respective person of his/her HIV-status.

If the result is negative, he/she is bound to complete the following columns in the regular medical form:

# HIV counseled: YES,

# HIV tested: YES.

If the result is positive, the physician is bound to:

- Ensure post-test counseling; he/she may use the post-test counseling sheet proposed by the MOH National Anti-AIDS Commission (annex 4) or resort to staff trained in counseling,
- Complete an HIV infection case confirmation form and submit it to the Public Health Authority,
- Guide the HIV-positive person to the infectious disease service for confirmation or validation of HIV infection,
- Complete the following columns in the regular medical form:
  # HIV counseled: YES
  # HIV tested: YES (or NO)

Attention is drawn to the fact that the person has been counseled, and once tested, must be notified. Specification of HIV-status on medical documents issues to the respective person is forbidden.

*B. HIV testing of persons working abroad for extensive periods of time, long-distance drivers and sailors* is assured by laboratories accredited for HIV testing within diagnostic centers, transfusion centers or Public Health Authority laboratories.

HIV testing is made at cost, observing principles of confidentiality.

The laboratory performs a single test for each case in turn.

The HIV test result will be communicated to the applicant's physician by mail or courier.

*C. Presentation of the tracked HIV-positive person to the infectious disease physician*

First, confirmation or invalidation of the HIV infection diagnosis will be pursued.

If the diagnosis is confirmed, the following activities will be carried out:

– The confirmation of HIV infection is recorded on special forms,
– The clinical immunological phase of HIV infection is determined, adequate therapy is started and the person is sent for out-patient treatment.

**Annex I**

# ”To know is to live“: pre-test counseling sheet

Even though the incidence is relatively low in Romania, HIV/AIDS represents a significant public health issue. Therefore, if you request or propose an HIV test, you should consent once you have been informed about the following aspects:

*1) What is HIV/AIDS infection*

- Acquired immunodeficiency syndrome (AIDS) is caused by a virus known by the term “human immunodeficiency virus” (HIV).HIV destroys the defense mechanisms of the body, which thus can no longer fight other diseases (infections, various cancers).
- HIV-infected individuals can usually live for many years without experiencing any symptoms; they may look and feel perfectly healthy. But any HIV-infected individual can transmit the virus to other individuals.
- AIDS is the last stage of HIV infection. The disease may occur, on average, 7-10 years after the moment of infection. There is no cure, although certain medicines have been developed that can better maintain the AIDS patient’s health status for a longer period of time.

*2) Information about the modes of transmission and means of preventing HIV infection*

- HIV is transmitted from one person to another in a limited number of ways:
  - Sexual intercourse (vaginal, anal or oral), during which the sperm or vaginal fluid of the infected person penetrates the other person’s body. 90 percent (%) of adult infection cases are transmitted by sexual intercourse,
  - Use of contaminated needles and/or syringes, invasive medical instruments or other sharp objects,
  - Use of injectable drugs,
  - Blood transfusions, if the blood or blood products have not been HIV-tested
  - Transmission from mother-to-child during the pregnancy, birth or by breastfeeding,
  - You cannot become infected with HIV just by sitting in close proximity to those infected with the virus. Hugs, hand shaking, coughing or sneezing are not modes of transmission of the disease. HIV cannot be transmitted by using public toilets, telephones, dishes, glasses, eating utensils, linen, swimming pools or public bath houses.
- An HIV-infected person is not a threat to the health of others.

- Mutual fidelity of non-infected partners protects both of them against sexually contracting HIV.
- The more sexual partners you have, the greater the risk that one of them might infect you. The more sexual partners your partner has, the higher the risk of becoming infected yourself.
- Those with lesions, ulcerations or genital inflammations pose a higher risk of becoming HIV-infected and transmitting the virus to others as well. It is very important to treat all genital infections immediately.
- Pregnancy examination methods (local, oral) cannot prevent the transmission of HIV and sexually transmitted diseases.
- If you do not have sexual intercourse exclusively with your partner and if you are not sure whether both of you are uninfected, you should reduce the risk of becoming infected with HIV by practicing safe sexual relationships. The risk of HIV infection by sexual intercourse can be lowered significantly by using latex condoms with spermicides. These should be used on a consistent basis and correctly.
- Transmission by an unsterilized needle and/or syringe is a risk.
- Whenever any injectable treatments are recommended to you, they must be performed by a qualified person, who has to use of a single-use or correctly sterilized needle and syringe. Before accepting an injectable treatment, you have the right to check whether the needle and syringe are sterile.
- The practice of non-medical procedures that cause bleeding (piercings for ear rings, tatoos or acupuncture, shaving) may pose risks if the instruments used are not sterile.
- The risk of HIV transmission by use of injectable drugs is very high. It is thus recommendable to refrain from using drugs or to follow special treatments in order to be able to give up such practices. Any class of drugs poses the risk of HIV infection, as they lead to neglecting the practice of protected sexual intercourse.
- There is a 30-40 percent (%) risk of transmitting HIV infection from mother-to-child. The virus can be transmitted during pregnancy, at birth and stfeedby breastfeeding.Many children infected with HIV will die before reaching three years of age. Therefore, before bringing a child into the world, it is advisable to have an HIV test. Today, there are a number of means that can reduce the risk of HIV transmission (drugs, not feedbreastfeeding).
- In addition to your personal and your partner’s protection, you have to contribute to the protection of your children against HIV. Make sure that they know what HIV infection is, how it is transmitted and how to prevent it.

*3) HIV testing*

- HIV tests search for the presence of HIV antibodies in a blood sample. Blood is taken using a sterile needle and syringe.
- All sexually active persons, those making injectable treatments performed by unskilled persons and drug users are advised to take an HIV test. Undoubtedly, while waiting for the result you may go through unpleasant emotional stress, but testing is the only way to find out whether or not you are infected.

The idea of ”rather not know” is very wrong because:

- If the test result is negative and you were not engaged in behaviors that pose an infection risk (sexual, drugs) in the last six months, you are most likely not HIV infected,
- If you are not infected, you should take precautionary measures in order to prevent becoming HIV-infected in the future,

- If the result is positive, you may benefit from evaluation, supervision and treatment programs,
- If you are seropositive, you can take measures that prevent the transmission of HIV infection to other persons. It is your moral obligation to learn such measures, so as not to infect other persons as well,
- If you were infected during pregnancy, your child needs medical attention and treatment,
- If you are pregnant and aware that you are HIV-infected, you must receive appropriate medical attention and information in order to decide whether to proceed with the pregnancy or to terminate it. If you decide to keep the child, you are to receive antiretroviral treatment in order to reduce the risk of transmission to the child.

*4) What an HIV-negative test represents:*

- A. In the majority of cases, a negative test means that the tested person is not infected.
- B. You should take into account that the person usually becomes positive within three months (but may be within 2-9 months) from being exposed to infection. If you think that you were exposed to HIV during the last six months, it is necessary to repeat the test in order to be sure that you are not infected.
- C. An HIV-negative test does not mean that you are protected against infection.
- D. The test result is not absolutely positive or negative, and you need to be retested for a confirmed diagnosis.

*5) What an HIV-positive test represents:*

- A. An HIV-positive test indicates that you have been exposed to HIV and are infected. You might infect other persons through the aforementioned modes.
- B. An HIV-positive test does not mean that you already have AIDS. Other medical tests and examinations are necessary to determine the infection phase.
- C. If the result is positive, you may go through unpleasant physical and emotional stress. If your result is disclosed to the community, you might be discriminated against at your place of employment or in personal relationships.

*6) Testing types:*

- A. Anonymous testing: neither your name nor any document is requested of you.
- B. Confidential testing: the test result will be recorded in your medical file and kept confidential, but you are not guaranteed absolute confidentiality.
  Romanian legislation protects your HIV information. The disclosure of positive results will be done with your consent. (There are a few exceptions that permit physicians providing you with medical attention to exchange information about you.)

*I had the opportunity to ask questions and received an answer before being tested.*

*I agree to be HIV tested, and therefore I affix my signature hereon:*

# Post-test counseling sheet for seropositive persons

*(a seropositive result should be handed over and communicated to the patient in person)*

*1) Significance of a positive HIV test:*

A positive test result means that:
A. You are HIV infected and your body has produced anti-HIV antibodies,
B. You are contagious and can infect other persons through blood and bodily fluids,
C. A positive result does not automatically mean that you have AIDS.

*2) Importance of adequate medical control:*

It is important for you to enter a medical network promptly, because:
A. Laboratory investigations can offer information about the extent to which your immune system is affected and the existence of any opportunistic infections or of cancer,
B. Existing treatments can slow down the evolution of HIV infection, prevent or cure some related infections and solve a series of other manifestations of HIV/AIDS. At present, there is no cure for HIV.
C. In order to take advantage of available medical services, it is important to follow your physician's advice and to ask for his/her assistance whenever needed.
D. A positive test also means that there is a possibility that your partner or partners, and even your children, are infected. For this reason, it is advised that your partner(s) and children also be tested for HIV.
E. If you have recently given birth, you should know that:
   - All children of HIV-positive mothers are born with HIV antibodies that come from the mother's infected blood. This means that, if tested immediately after birth, these children will test positive for HIV,
   - The mother's infection is not always transmitted to her child. If the child is not infected, the HIV test may become negative after the age of 16-24 months.
   - If the child is infected, then his/her HIV test will continue to be positive; therefore, it is important that your child receive regular medical supervision as well.
   
   F. Go to the nearest infectious disease service. There, physicians will provide you specialized medical attention or will guide you to referral centers for care/treatment.

*3) Preventing transmission of HIV infection to other persons*

- Even when you do not show any signs of disease, you can transmit the infection:
  - Through unprotected sexual intercourse or incorrect use of a condom,
  - By lending needles or contaminated syringes (contaminated, unsterilized or incorrectly sterilized) to other persons for injections

(with drugs or for therapeutic purposes). Other infected sharp objects risk the transmission of infection,
  - Perinatally, from the seropositive mother to her child (during pregnancy, birth and through breastfeeding).
- HIV is not transmitted within common social relationships, in family life, in public spaces, through hand shaking, athletics, etc.
- HIV transmission can be prevented through abstinence: the absence of vaginal, anal or oral sexual relationships is the safest form of prevention.
- The risk of transmitting HIV can be lowered within sexual relationships through the correct and consistent use of condoms by partners (at each sexual intercourse, correctly applied/removed; not to be used again). Condoms lower risk, but do not eliminate it 100 percent (%).
- Contraceptive methods (local, oral) cannot prevent the transmission of HIV infection and sexually transmitted diseases.
- Due to the risk of transmission from mother-to-child, it is recommended that pregnancy be prevented for seropositive women. Adequate contraception means are to be used.
- HIV transmission can be prevented by not reusing instruments that can transmit infection (needles and syringes) and, respectively, by not lending such instruments.
- Giving up the use of intravenous drugs is the safest way to prevent HIV infection among drug users.
- Risk of infecting seronegative partners with HIV can occur due to loss of control over sexual behavior when using certain substances such as: alcohol, barbiturates or other sedatives, amphetamine, hallucinogens, cocaine, heroin and marijuana.
- You should not donate blood, sperm, tissues or milk.
- You should not lend toothbrushes, shaving or depilation devices or other appliances and objects that can be contaminated (even if it has not been demonstrated that they could transmit HIV).
- You are advised to wash and disinfect surfaces tainted with blood or secretions that could contain blood or sperm. In this respect, you have to use chloramines or hypochlorite.
- If you are pregnant, you will receive all necessary information regarding the risk of transmission to your child. You will be able to decide whether to proceed with the pregnancy or to terminate it. fIf you decide to keep the child, you are to receive antiretroviral treatment in order to reduce the risk of transmission to the child.
- Ask your current physician for information about local support services, nongovernmental organizations with programs in this respect, telephone numbers for information and confidential psychological assistance.
- Request specialized treatment or rehabilitation programs for alcohol or drug users (if applicable).
- It is recommended that you list your partners: the health department may contact these partners for HIV pre- and (potentially) post-test counseling. It is important to be aware of the HIV-status of your partner(s), because:
  - If they are positive, they may benefit from consultation, clinical and laboratory evaluations and appropriate treatment,
  - If they are positive, comprehensive treatment may slow down the evolution of HIV infection and prevent secondary infections,
  - If they are negative, they may be counseled on how to lower their risk of HIV infection in the future.

- Be careful with who you disclose your seropositive status, as you may be subject to discrimination. Generally, it is not necessary to notify your employer or kindergartens, schools or other public places where you interact.
- Romanian legislation protects HIV information. The disclosure of positive results will be done with your consent. It is your obligation to disclose or accept the disclosure of the result in certain cases. There are some exceptions that permit physicians providing you with medical attention to exchange information about your HIV infection, without requesting your consent:
  - Discussion among specialists on correct therapeutic behavior, in order to be able to provide you and/or your child the appropriate medical attendance,
  - The physician may inform your sexual partner(s) without giving your name, in order to counsel and test him/her.
- The deliberate (intentional) spread of HIV infection is punishable according to the Penal Code, regardless of the mode of transmission.
- If you refuse to provide the name(s) of your sexual partner(s), the Preventative Medicine Department of the Health Police will make inquiries in this respect, in using your name without being required to request your consent.

*I have read and understand the counseling sheet.*

*I had the opportunity to ask questions and have received answers to each.*

*Signature:……………………………………………*

**Law no. 584 of 29 October 2002 on the measures for the prevention of the AIDS disease spreading in Romania and the protection of the persons infected with HIV or afflicted with AIDS**

Published in the *Official Gazette,* Part I, no. 814 of 8 November 2002

The Parliament of Romania hereby passes this law.

## CHAPTER I
## General Provisions

**Art. 1 -** (1) In order to prevent the HIV infection transmission and to efficiently fight against the AIDS disease, as well as for the special protection of the persons affected by this calamity, this law regulates the main courses of action and sets forth the necessary measures.

(2) The objectives set forth at par. (1) herein will be achieved based on the National Strategy of the Government in this field and by the application of the national programs of prevention, supervision, control and reduction of the social impact of the HIV/AIDS infection cases, elaborated by the Ministry of Health and Family together with The Ministry of Labor and Social Solidarity, The Ministry of Education and Research, The Ministry of Youth and Sport, The General Secretariat of the Government, The National Authority for Child Protection and Adoption and the State Secretariat for Disabled Persons, with the endorsement of The National House of Health Security, The College of Physicians of Romania and The College of Pharmaceutical Chemists of Romania.

(3) The specialized directorates of The Ministry of Health and Family, the county and Bucharest municipality Public Health Authorities, the public health institutions and the State or private units with powers and responsibilities in this field are comprised in the national network of prevention, supervision and control of the HIV infection and AIDS disease.

(4) In all the State or private education units there will be ensured the spreading through the mass-media of education and information programs regarding the HIV infection transmission and the adequate behavior as against the persons afflicted with the AIDS disease.

**Art. 2 –** The activity of preventing the AIDS disease spreading in Romania comprises a plan of measures instituted at national and regional level within the public health assistance, aimed at preventing the infection and transmission of the HIV virus, providing specialized medical attendance and specific antiretroviral treatment and treatment of HIV/AIDS infection related diseases, in hospital and under out-patient regime, the education of the individual, family and collectivities, the professional, qualitative and ongoing training of the medical and sanitary staff providing medical assistance services to the HIV/AIDS patients, as well as at developing the medical research in this field.

**Art. 3 –** The persons infected with HIV or afflicted with AIDS will benefit from social protection, nondiscriminatory treatment as regards the right to education, the right to work and social protection of work and to professional promotion, and the state of their health cannot constitute a dismissal criterion.

**Art. 4 –** For the purpose of substantiating, elaborating and subjecting to Government approval the National Strategy for Supervision, Control and Prevention of HIV/AIDS Infection Cases, of abiding by the conventions, treaties and other international acts Romania is part of, and of monitoring the entire activity in this field, the National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases is established, organized as inter-ministerial body without legal personality, under the Prime-Minister's authority, within the General Secretariat of the Government, led by the Prime-Minister's counselor with powers in the field of ensuring the population's health.

**Art. 5 –** The funds necessary for the application of the National Strategy for Supervision, Control and Prevention of HIV/AIDS Infection Cases will be provided from the State budget, the Health Social Security Fund, certain extra budgetary revenues and the PHARE funds – the „AIDS Prevention" community program, on the basis of the PHARE Financing Memorandum between the Government of Romania and the European Commission, signed at Bucharest on 29 December 2000 and ratified by the Government Ordinance no. 47/2001, approved by the Law no. 616/2001.

## CHAPTER II
## Measures for prevention of HIV infection transmission

**Art. 6 –** The measures for the prevention of HIV infection transmission consist in the following:

a) education of population on the HIV infection transmission way,

b) establishing the groups exposed to the risk of HIV/AIDS infection and enforcing the prevention measures set forth by the national programs stipulated at art. 1 par. (2) herein,

c) setting a package of useful information about the HIV/AIDS infection and ensuring the free and unconditional access thereto of all the social classes of population,

d) permanent collaboration of the National Commission for Supervision, Control and Prevention of HIV/AIDS with Romanian governmental and non-governmental bodies and with the international specialized associations,

e) compulsory application of universal precautions and provision of necessary means at the level of all the sanitary units, with or without beds,

f) compulsory provision of means for the prevention of HIV infection transmission from mother to fetus,

g) obligation of the entire mass-media to promote, freely and quarterly, the use of condom, with a view to preventing the sexual transmission of HIV infection,

h) free provision by employer of the professional post-exposure prophylaxis, according to the methodology set by The National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases.

## CHAPTER III
## Measures for social protection of persons infected with HIV or afflicted by AIDS

**Art. 7 -** (1) The social protection measures are the following:

a) ensuring the unrestricted and unconditional right to work of the HIV/AIDS patients,

b) non-discriminatory professional promotion of HIV infected or AIDS afflicted persons,

c) observance of the right to education of children and youths infected with HIV or afflicted by AIDS and their integration into the forms of education.

(2) Depending on the infection phase, the HIV infected or AIDS afflicted persons will benefit from professional orientation or reorientation or retirement, set by specialized medical expert's report, as the case may be.

(3) The HIV testing is performed according to the norms and methodology approved by order of the minister of health and family.

(4) Monthly nourishment alimonies in the quantum approved by Government decision are granted to patients in hospitals and specialized centers, as well as to out-patients, in order to provide proper nourishment likely to ensure the efficiency of the treatment with antiretroviral medicines.

## CHAPTER IV
## Confidentiality and adequate treatment

**Art. 8 -** (1) The following are bound to keep the confidentiality of the data regarding the HIV infected or AIDS afflicted persons:

a) employees of sanitary network,

b) their employers,

c) public officials having access to such data.

(2) In the case of physicians, the information on the HIV/AIDS status of a patient should be communicated between specialists, in order to ensure the accuracy of diagnoses and of surgical and non-surgical therapeutic behaviors in the various phases of the HIV/AIDS infection evolution.

(3) The patient is bound to inform his/her current physician, the dentist included, about his/her HIV-status whenever he/she is aware of that.

(4) The HIV infected or AIDS afflicted persons who are aware of their HIV positive status are liable, according to the law, for the voluntary transmission of infection, if that has occurred due to reasons which can be imputed to them.

(5) The HIV infected persons who are not aware of their HIV positive status are not liable for the potential transmission of HIV infection.

**Art. 9 –** The sanitary units and physicians, regardless of their specialty, are bound to hospitalize and provide specialized medical attendance according to the specialty they represent, in accordance with the pathology displayed by the patient.

**Art. 10 –** The specific antiretroviral medication and the medical treatment for the HIV/AIDS related diseases will be instituted based on the *Therapeutic Guide on HIV Infection* by The National Commission of Anti-AIDS Fighting and is free for the entire period whilst same is necessary.

**Art. 11 –** The activity of diagnosis, treatment and therapy monitoring of hospitalized patients and out-patients will be achieved under the coordination of the regional HIV/AIDS centers, based on the norms elaborated by The National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases.

## CHAPTER V
## Specialized professional training and development of medical research in this field

**Art. 12 -** (1) A basic element of the National Strategy of the Government in the field regulated by this Law is the quality professional training of the persons providing medical assistance services to the HIV/AIDS patients.

(2) The ongoing training of the medical sanitary personnel in the HIV/AIDS infection field shall be achieved at the level of the HIV/AIDS centers.

**Art. 13 –** The medical research in this field is a priority. The research shall be coordinated by The ‟Prof. Dr. Matei Balº“ Institute of Infectious Diseases of Bucharest and The ‟Victor Babeº“ Centre for the Study of Human Retroviruses of Bucharest, in collaboration with the national and international medical centers.

**Art. 14 –** The epidemiological research shall be achieved by the directorates of the Ministry of Health and Family set forth by order of the minister of health and family.

**Art. 15. –** Other researches in this field, the sociological research included, shall be performed by the specialized departments of each ministry.

## CAPITOLUL VI
## Financing of HIV transmission prevention and AIDS disease treatment activities, as well as of measures for social protection of afflicted persons

**Art. 16 -** (1) The financing of prevention, education and social protection is ensured from the State budget by distinct chapter at the level of each ministry and department represented in The National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases.

(2) The financing of therapeutic and medical attendance activities shall be achieved by the National House of Health Security, the National House of Health Security of the Defense, Public Order, National Safety and Judicial Authority and the Health Security House of the Ministry of Public Works, Transportation and Houses, according to the law.

(3) The activity developed in this field by the non-governmental bodies shall be supported by the Government.

**CHAPTER VII**
**Efficient enforcement of national programs of prevention, supervision, control and reduction of social impact of HIV/AIDS infection cases**

**Art. 17 –** With a view to efficiently enforcing the national programs of prevention, supervision, control and reduction of the social impact of HIV/AIDS infection cases, the organization and operation of The National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases shall be approved by Government decision which shall set forth its main powers, structure and convening method.

**Art. 18 –** The minister of health and family shall regularly inform the health commissions of the Senate and the Chamber of Deputies on the developed activity and the enforcement of the programs for the prevention of HIV/AIDS infection transmission, the provision of specific therapy, the social protection of infected persons and the monitoring of results.

**Art. 19 –** The persons in default of the unjustified interruption of the enforcement of national programs set forth by this law or the provision of related financial resource, as well as of the inappropriate enforcement of the provisions of these programs shall answer according to the regulations regarding the ministerial liability.

**CHAPTER VIII**
**Transitory and final provisions**

**Art. 20.** – Within 30 days from the coming into effect of this law, the regulations for the enforcement of the previsions hereof shall be elaborated and subjected to approval by Government decision.

**Art. 21.** – Within 60 days from the coming into effect of this law, the president of The National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases shall propose the approval, in its first session, of its operating regulations.

This law was passed by the Senate in the session of 7 October 2002, with the observance of the provisions of art. 74 alin. (2) of the Constitution of Romania.

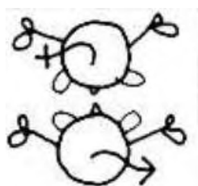
On behalf of the PRESIDENT OF THE SENATE,
GHEORGHE BUZATU

This law was passed by the Chamber of Deputies in the session of 8 October 2002, with the observance of the provisions of art. 74 alin. (2) of the Constitution of Romania.

PRESIDENT OF THE CHAMBER OF DEPUTIES,
VALER DORNEANU

Bucharest, 29 October 2002.
No. 584.

**D E C I S I O N**
**for the approval of the Regulations for the enforcement of the Law no. 584/2002 on the measures for the prevention of the AIDS disease spreading in Romania and the protection of the persons infected with HIV or afflicted with AIDS**



On the grounds of art. 108 of the Constitution of Romania as republished, and of art. 20 of the Law no. 584/2002 on the measures for the prevention of the AIDS disease spreading in Romania and the protection of the persons infected with HIV or afflicted with AIDS,

The Government of Romania hereby passes this Decision.

Sole article. – The Regulations for the enforcement of the Law no. 584/2002 on the measures for the prevention of the AIDS disease spreading in Romania and the protection of the persons infected with HIV or afflicted with AIDS, set forth in the annex which is an integral part hereof, is hereby approved.

PRIME-MINISTER
**ADRIAN NÃSTASE**

Countersign: The Minister of Health, Ovidiu Brânzan, for the Minister of Labor, Social Solidarity and Family, Valentin Mocanu, Secretary of State, for the Minister of Public Finance, Maria Manolescu, Secretary of State

Bucharest, 24 November 2004.
No. 2.108.

*ANNEX*

**R E G U L A T I O N S**
**for the enforcement of the Law no. 584/2002 on the measures for the prevention of the AIDS disease spreading in Romania and the protection of the persons infected with HIV or afflicted with AIDS**

**Art. 1** – These Regulations comprise the measures which have to be adopted at the level of the governmental institutions with responsibilities in the field of HIV/AIDS prevention and control.

**Art. 2** – The institutions with responsibilities in enforcing the Law no. 584/2002 on the measures for the prevention of the AIDS disease spreading in Romania and the protection of the persons infected with HIV or afflicted with AIDS are set forth in the annex no. 1 hereto.

**Art. 3** – The governmental institutions set forth in the annex no. 1 shall elaborate or, as the case may be, participate to the elaboration of the draft normative acts regulating the following:

a) measures for the prevention of HIV infection transmission,

b) measures for the social protection of the persons infected with HIV or afflicted with AIDS,

c) confidentiality of data regarding the persons infected with the HIV virus,

d) appropriate treatment of HIV infected persons eligible for treatment,

e) specialized professional training and development of medical research in this field,

f) financing of activities of HIV transmission prevention and treatment of HIV infected persons, as well as of the measures for the social protection of afflicted persons.

**Art. 4 –** The responsibility of elaboration of the regulations specific for each governmental institutions or common for several such institutions is set forth in the annex no. 2 hereto.

**Art. 5 –** The governmental institutions set forth in the annex no. 1 may collaborate with the national and international non-governmental organizations in this field, for the purpose of developing certain concordant activities for the prevention of HIV infection spreading and the protection of persons infected with the HIV virus or afflicted with AIDS.

**Art. 6 –** The National Commission for Supervision, Control and Prevention of HIV/AIDS Infection cases shall elaborate and subject to Government approval the National HIV/AIDS Strategy.

**Art. 7 -** The National Commission for Supervision, Control and Prevention of HIV/AIDS Infection cases shall organize the activity of the working groups elaborating the normative acts devolving from the provisions of the Law no. 584/2002 and ensure their harmonization with the legal provisions in force and the provisions of the National HIV/AIDS Strategy for the respective period.

**Art. 8 –** The elaboration of any other regulations necessary for the enforcement of the law shall be done at the level of each institution specified in the annex no. 1 hereto.

**Art. 9 –** The annexes no. 1 and 2 are an integral part of these Regulations.

*ANNEX No. 1*
*to the Regulations*

**L I S T**
**of governmental institutions with responsibilities as regards the enforcement of the Law no. 584/2002**

1. The Ministry of Health
2. The Ministry of Labor, Social Solidarity and Family
3. The Ministry of Education and Research
4. The Ministry of National Defense
5. The Ministry of Administration and Internal Affairs
6. The Ministry of Justice
7. The Ministry of Transports, Construction and Tourism
8. The General Secretariat of the Government
9. The Prime-Minister’s Chancellery

*ANNEX No. 2*
*to the Regulations*

**D E S C R I P T I O N**
**of the governmental institutions' responsibilities**
**as regards the elaboration of specific or joint regulations**

**Art. 1 –** In order to enforce the National HIV/AIDS Strategy, under the coordination of the National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases, the ministries and institutions with powers in this field and/or having their own sanitary network shall elaborate the national program for the prevention, supervision and control of HIV/AIDS infection, as well as measures for the reduction of the social impact of the HIV/AIDS infection cases.

**Art. 2** – The Ministry of Health shall collaborate with the Ministry of Labor, Social Solidarity and Family, The Ministry of Education and Research, The National Authority for Youth, the National Authority for Sport, the National Authority for Child Protection and Adoption, the National Authority for Disabled Persons, the National House of Health Security, the College of Physicians of Romania, with the national and international non-governmental organizations, for the purpose of developing certain campaigns and actions for the education of the population.

**Art. 3** – The Ministry of Health shall collaborate with the Ministry of Labor, Social Solidarity and Family, The Ministry of Education and Research, The National Authority for Youth, the National Authority for Sport, the National Authority for Child Protection and Adoption, the National Authority for Disabled Persons, the National House of Health Security, the College of Physicians of Romania, with the national and international non-governmental organizations, as well as with the civil society, with a view to making researches for establishing the groups exposed to risk.

**Art. 4** - (1) The Ministry of Health shall ensure the information of the population and the training of the medical and auxiliary staff on the universal precautions and the means necessary for the prevention of the HIV virus infection transmission.

(2) The Ministry of Health shall coordinate the activities aiming at their compulsory observance at the level of all the sanitary units with or without beds, as well as at the level of the medical social assistance units.

**Art. 5** - (1) The Ministry of Health shall set forth by order the compulsory means for the prevention of the HIV infection transmission from mother to fetus.

(2) These shall include measures regarding the provision of the antiretroviral treatment for the HIV infected pregnant woman, the clinical and laboratory monitoring of the new-born of a HIV infected or AIDS afflicted mother, as well as any other measures necessary for lowering the risk of HIV infection transmission from mother to fetus.

**Art. 6** – The Ministry of Health together with the Ministry of Social Solidarity and Family shall elaborate the list comprising the professions and activities posing the risk of professional exposure to HIV infection.

**Art. 7** – The Ministry of Health and the National Commission for Supervision, Control and Prevention of HIV/AIDS Infection Cases shall monitor the observance of the obligation incumbent on all the sanitary units and physicians, regardless of their organization form, to hospitalize and provide medical attendance to the HIV/AIDS infected patients, and shall take any required measures against the persons defaulting such obligation.

**Art. 8** – The Ministry of Health shall coordinate the activities aimed at the ongoing training of the medical sanitary staff in the field of HIV infection.

**Art. 9** - (1) The National House of Health Security shall be regularly informed about the number of patients eligible for the specific therapy, shall provide the corresponding level of the amounts allotted from the Sole National Fund of Health Social Security for the specific medicines and sanitary materials to be purchased with such destination and shall achieve their purchase.

(2) The National House of Health Security and the County Houses of Health Security are liable for the provision, follow-up and control of the use given to the amounts allotted from the Sole National Fund of Health Social Security, shall monitor, control and review the physical and efficiency indicators throughout the development of the respective programs.

**Art. 10** – The Ministry of Health shall half-yearly make available to the health commission of the Senate and the Chamber of Deputies the information on the prevention and control of HIV/AIDS infection, the way of providing the specific therapy and related to any associated infections.

**Art. 11 -** (1) The HIV infected or AIDS afflicted persons have the right to non-discriminatory treatment as regards the right to education, the right to work, the right to professional promotion and social protection, according to the national legislation on the prevention and penalization of all the forms of discrimination and according to the international conventions, pacts and treaties Romania is part of.

(2) The Ministry of Labor, Social Solidarity and Family through the Labor Inspectorate shall monitor the observance of the right to work of the HIV infected or AIDS afflicted persons.

(3) The county and Bucharest municipality agencies for the occupation of the labor power shall freely provide to the HIV infected or AIDS afflicted persons all the information and professional counseling services, and also the job searching depending on the phase of disease, in the conditions of the law.

**Art. 12** – The Ministry of Labor, Social Solidarity and Family together with the Ministry of Health shall inform the employers about the rights and obligations of the HIV infected or AIDS afflicted employees and about the obligation of non-discriminating them on the health criterion.

**Art. 13** – The Ministry of Labor, Social Solidarity and Family shall provide the education of employees on the right to free provision of professional post-exposure prophylaxis.

**Art. 14** – The Ministry of Labor, Social Solidarity and Family shall provide the payment of the monthly nourishment alimony due to the HIV infected or AIDS afflicted adults and children in hospitals, health centers and under State out-patient regime, according to the methodology approved by order of the minister of labor, social solidarity and family.

**Art. 15** – The Ministry of Labor, Social Solidarity and Family shall annually make sociological researches aimed at monitoring the number of beneficiaries of the monthly nourishment alimonies, of their family and social status, and shall make proposals regarding the elaboration of new social protection programs and measures.

**Art. 16** – The Ministry of Education and Research, together with The Ministry of Labor, Social Solidarity and Family, The National Authority for Child Protection and Adoption, The National Authority for Disabled Persons and the non-governmental organizations active in this field shall provide the spreading in all the State or private education units of educational and informative programs on the HIV infection transmission prevention and the adequate behavior as against the AIDS afflicted persons and the free, universal and unconditional access to such information of all the youths following a form of education.

**Art. 17** – The Ministry of Education and Research shall include in the *curriculum,* distinctly according to the education cycles, an education program which is to comprise, amongst others, a separate chapter on HIV/AIDS, and also shall include in the system of professional formation/training of the teaching staff the general information regarding the HIV/ADIS, the protection of afflicted persons and the behavior toward them, and the development of extra-curriculum and extra-school activities, and shall provide the monitoring of the enforcement of such programs.

**Art. 18** – The Ministry of Education and Research through the county school inspectorates shall promote in the education units the development of an appropriate behavior towards the HIV infected or AIDS afflicted persons, with a view to eliminating their marginalization and discrimination and creating a tolerant environment for them.

**Art. 19** – The non-governmental organizations or other legal persons acting in this field may participate in the conditions of the law to the achievement, jointly with the public ministries and institutions, of certain activities or programs regarding the HIV infection spreading prevention and the social protection of the HIV infected or AIDS afflicted persons.

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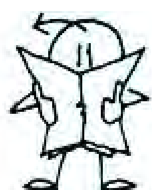


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