

UNIVERSITY OF NAMIBIA

POLICY ON HIV/AIDS

1. CONTEXT

1.1 Introduction

In less than a decade, HIV/AIDS has emerged as a leading cause of death in Namibia. The UNDP has identified the disease as a major national development challenge. The country ranks third in the SADC region in terms of HIV/AIDS infection, third in the world per population and seventh in Africa. One in five Namibians aged between 15-49 are infected with the virus and are expected to die within the next seven years. The country has a growing population of AIDS orphans. Clearly, the HIV/AIDS pandemic has far-reaching socio-economic impact, particularly in the health, education and employment sectors as well as for the national fiscus. The impact of HIV/AIDS in the education sector in Namibia's only beginning to be researched and is one which requires urgent research attention.

This Policy has been drafted by an ad-hoc Senate committee on HIV/AIDS and has been widely discussed with experts within and without the University. The current policy guidelines of the University of Namibia (UNAM) on HIV/AIDS were drafted in September 1997 and approved by Senate in that year. In the four years since while UNAM's 1997 policy guidelines provided a basis for action, the country and the region have seen a massive escalation in the HIV/AIDS pandemic. The 1997 guidelines do not promote a coherent focus on HIV/AIDS across the curriculum and in all faculties and are not informed by a strategic work plan. Accordingly, Senate decided that an integrated and more coordinated policy be developed.

Senate mandated this ad hoc committee to review and recast existing policy guidelines. The purpose of this policy is to provide a framework of information and action that will guide the University community to develop an adequate response to HIV/AIDS. As such, this policy framework commits UNAM to mitigate the impact of the disease on the University community and their dependents, as well as on the wider community through its community service remit.

It is inevitable that the HIV/AIDS pandemic will have a profound effect on student recruitment and enrolment, both directly and indirectly. Accordingly this policy is intended to provide an institutional response to both the national, as well as personal challenges, that the HIV/AIDS pandemic poses.

1.2 National Policy Response

The University's HIV/AIDS Policy supports the National Strategic Plan on HIV/AIDS-Medium Term Plan II 1999-2004 and the recent Namibian HIV/AIDS Charter of Rights. The Human Rights provisions contained in the Constitution of the Republic of Namibia provide the overall normative framework for policy.

Other policies that influenced this Policy include among others, the Labour Act No. 6 of 1992 and the National Gender Policy of 1999.

The University recognizes that there is an undeniable link between human rights and public health in the context of HIV/AIDS. One aspect of the interdependence of human rights and public health is demonstrated by studies showing that HIV prevention and care programmes with coercive or punitive features result in reduced participation and increased alienation of those at risk of infection. In particular, people will not seek HIV-related counseling, testing, treatment and support if this would mean discrimination, lack of confidentiality and other negative consequences. Therefore, it is evident that coercive public health measures drive away the people most in need of such services and fail to achieve their public health goals of prevention through behavioural change, care and health support. The protection and promotion of human rights are thus necessary both to the protection of the inherent dignity of persons affected by HIV/AIDS and to the achievement of public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV/AIDS on those affected and empowering individuals and communities to respond to HIV/AIDS.

1.3 The University Response

A 1999 study conducted by UNAM, showed that over half of entering students are sexually active; the frequency of students' sexual activity increased over the course of their studies at UNAM. For this reason, among many, it is imperative the University develops a response to the HIV/AIDS pandemic for three principal reasons.

- (1) The University is the principal agency for the development of high-level human resources to the nation. UNAM has a responsibility to build high-level research capacity relevant to all areas of national development.
- (2) The nature of the university community with its diverse membership and strategic national importance.
- (3) Leadership: through this policy the University will provide leadership in teaching, research, and community engagement on HIV/AIDS and its impact. The University can also provide leadership in promoting a human rights based approach to HIV/AIDS in Namibia.

Community involvement lies at the heart of this policy and is key to its overall success.

2. PREAMBLE

Recognizing that Namibia is currently experiencing a devastating HIV/AIDS pandemic and striving, as an institution of higher learning, to be socially engaged;

And further acknowledging the relevant provisions of the Constitution of the Republic of Namibia, the Namibian HIV/AIDS Charter of Rights, the National Gender Policy, the Labour Act of 1992, the National Policy on Population and Sustainable Development;

And further accepting the importance of addressing stigma on the basis of HIV/AIDS and the need to promote a human rights based approach to HIV/AIDS;

And further recognizing that a 1999 study revealed that over half of entering students are sexually active and that the rate of students' sexual activity increased over the course of their University career;

Therefore the University is committed to playing its full part with other sectional, regional and international partners in mitigating the impact of HIV/AIDS, both on its internal constituency of staff and students and on the Namibian society.

The University will aim to achieve this by integrating HIV/AIDS into its teaching, research, and community service, the components of which are outlined in this policy. In achieving the above, the University hopes to build a caring and socially-engaged community based on the integrity of, and respect for, the human person.

The University is guided by the following norms and values as the bedrock of this policy:

- “Create awareness among the University community through giving health information in the prevention of HIV/AIDS as a killer disease.”
- People living with HIV/AIDS will not be discriminated against in obtaining access to education, scholarships, accommodation, employment and accompanying employment benefit at the University;
- People living with HIV/AIDS are guaranteed equal protection under the law;
- People living with HIV/AIDS have the right to dignity, respect, and privacy concerning their HIV/AIDS status;
- Voluntary and confidential rapid testing (on and off campus in Windhoek and Oshakati) and counselling for persons with HIV/AIDS should be encouraged;
- HIV/AIDS has to be understood and addressed in its social context that includes gender power relations, sexual violence against women and children and changing values and meanings around sexuality ¹
- The University has an obligation to provide access to information, prevention, care and support services for students, staff, and their dependents infected and affected by HIV/AIDS. Staff and students are encouraged to seek this information and these services;
- The University must create a learning and working environment that is supportive, sensitive, and responsive to employees, students, and their dependents with HIV/AIDS. ² The University does not have an obligation to accommodate employees and students who “refuse to work with, study with, or be housed with other employees or students living with HIV/AIDS”. ³

3. POLICY COMPONENTS

This policy has four principle components:

1. Rights and responsibilities of staff and students affected and infected by HIV/AIDS;
2. Integration of HIV/AIDS into teaching, research and service activities of all University faculties, centers and units;
3. Provision of preventive, care and support services on campus;
4. Implementation of policy: structures, procedures, monitoring and review.

3.1 Rights and Responsibilities of Staff and Students Infected and Affected by HIV/AIDS

3.1.1 Rights of Staff

1. No employee or applicant for employment at the University shall be required to undergo an HIV test, or disclose his or her HIV/AIDS status.
2. The University acknowledges that HIV status is not on its own an indication of fitness for employment. The University shall thus not use the HIV/AIDS status to deny an employment contract or refuse to renew a contract. UNAM shall actively promote the GIPA (Gender Involvement of People Living with AIDS) principles of UNAIDS
3. HIV/AIDS status shall not be used as a criterion in human resource development, including promotion and training.
4. Employment shall not be terminated on the grounds of HIV/AIDS status. HIV/AIDS status shall not be used to influence retrenchment or retirement decisions on grounds of ill health, unless a member of staff is no longer physically or mentally fit to continue his/her work.
5. HIV/AIDS status shall not be reflected in the personal files of employees.
6. The HIV/AIDS status of employees shall not be disclosed without the informed consent of the employee concerned.
7. While the University practices non-discrimination with respect to its employees' HIV/AIDS status, it recognizes that the practices of parties external to the University (i.e., medical schemes, provident and pension funds) are not entirely within its control. (4) The University, however, shall endeavour to negotiate with benefit providers for equal and non-discriminatory benefits.

8. Employees have a right to a supportive and safe working environment in which persons with HIV/AIDS are accepted and not stigmatized.
9. Employees have a right to know of possible risks of occupational exposure to HIV in their working environments.
10. The University endeavours to provide a working environment in which the occupational exposure to HIV is minimised, and will provide the necessary protective equipment. In addition to providing the necessary protective equipment, staff will be taught how to use it and will be educated in general on the use of universal precautions. See Annexure 2.

3.1.2 Rights of Students

1. No prospective student at the University shall be required to undergo an HIV test, or disclose his or her HIV/AIDS status prior to admission.
2. No student at the University shall be required to undergo an HIV test, or disclose his or her HIV/AIDS status.
3. The University shall not use HIV/AIDS status in considering the granting of loans, bursaries and scholarships. The University shall actively promote the GIPA (Greater Involvement of People Living with AIDS) principles as announced by UNAIDS.
4. The University shall not use HIV/AIDS status in determining admission to residence on campus.
5. Students' registration shall not be terminated on the grounds of their HIV/AIDS status, unless the student is no longer physically or mentally fit to continue his/her studies.
6. The results of HIV tests conducted at University medical facilities will remain confidential between the student and the person authorized to give the result.
7. The HIV/AIDS status of a student shall not be disclosed without the informed consent of the person concerned.
8. Students have a right to a supportive and safe learning and working environment in which persons with HIV/AIDS are accepted and not stigmatized.
9. The University endeavours to provide a working environment in which the occupational exposure to HIV is minimised, and will provide the necessary protective equipment. (See Annexure 2)

3.1.3 Responsibilities of Staff and Students

1. Everyone has an individual responsibility to protect herself/himself against infection. Students and staff living with HIV/AIDS have a special obligation to ensure that they behave in such a way as to pose no threat of infection to any other person.

2. Medical and science professionals and students who are living with HIV/AIDS have an obligation to choose professional paths that eliminate the risk of transmission to their patients and colleagues.
3. Staff and students have a responsibility not to discriminate against and stigmatize members of the University community living with HIV/AIDS.
4. “Unless medically justified, no students may use HIV/AIDS as a reason for failing to perform work, complete assignments, attend lectures or field trips or write examinations”.⁽⁶⁾

3.2 Integration of HIV/AIDS into teaching, research and service activities of all Faculties

3.2.1 Teaching

UNAM will encourage and support efforts by faculties to incorporate aspects of HIV/AIDS and human rights into curricula, where possible.

The University will provide a compulsory core curriculum on HIV/AIDS, for all undergraduate students. The curriculum will include historical, epidemiological, health and legal and prevention/home based care aspects of HIV/AIDS.

Finally, the University will offer several short courses on HIV/AIDS for senior and mid-level academic and administrative management, as well as for student leaders. One such course will focus on HIV/AIDS in the workplace, including protection, performance management, and legal issues. Short courses in a variety of subjects will be offered, and may, whenever the need arises, be offered to the community, through appropriate centers, departments and faculties.

3.2.2 Research

UNAM will provide leadership on HIV/AIDS through research. The University will use research to inform its policy, teaching, community service, and endeavor to influence developments related to the cure of HIV/AIDS.

Faculties and the Multidisciplinary Research and Consultancy Center (MRCC) will develop research projects related to HIV/AIDS. The Research and Publications Committee will consider such proposals for funding.

The University commits itself to provide human and financial resources in support of HIV/AIDS research.

3.2.3 Community Service

The University commits itself to collaborate with the community in training and research on HIV/AIDS. It is essential that there is full community participation in the HIV/AIDS programme and that there is a good flow of support between the University and various communities and community structures. The University will share its experience of best practice and, where practicable, its skills and resources with NGO's and CBOs.

3.3 PROVISION OF UNIVERSITY PREVENTION AND SUPPORTS SERVICES FOR HIV/AIDS

3.3.1 Awareness and Prevention

The University has a duty to educate and inform its members about HIV/AIDS. Appropriate information on all aspects of prevention and care will be made accessible to staff and students.

In addition to teaching and research activities, strategies to prevent the spread of HIV/AIDS on campus include:

- Making condoms available throughout campus and in student residences;
- Encouraging responsible sexual behaviour inclusive of abstinence;
- Distributing literature on HIV/AIDS;
- Sponsoring public fora (i.e., dramas, discussions, debates, etc.) on HIV/AIDS;
- Training HIV/AIDS peer educators and counselors; and
- Increasing awareness about sexually transmitted diseases (STDs) and their treatment.
- Acting against sexual harassment of women and child abuse.

3.3.2 Counseling, Care and Support

Staff and students will have access to confidential counseling services on campus. WHO Guidelines on Counselling apply (See Annex 1). Peer counsellors and support groups will be available for students and staff affected and infected with HIV/AIDS. The University will also provide referral services for students and staff and advise on nutritional care to students and staff.

The University will explore the possibility of providing home-based care, including basic nursing care, counselling of the patient and significant others, and training of care givers.

Accidental/occupational exposure to HIV is covered under the guidelines for dealing with accidental exposure (Annex 2).

4. POLICY IMPLEMENTATION AND REVIEW

The overall responsibility for implementing this HIV/AIDS Policy lies with the senior management of UNAM. This includes the Vice Chancellor, Pro-Vice Chancellors, members of the management advisory committee, deans of faculties, centre directors, heads of departments and units, the Student Representative Council (SRC), and the University HIV/AIDS Task Force.

The University will appoint an officer at the level of a dean who will be responsible for policy coordination and oversight. This officer will chair an implementation committee, comprising of staff and students and will report directly to the Pro-Vice Chancellor Academic and Research. The committee's functions will include:

- Disseminating and coordinating the HIV/AIDS policy throughout the University;
- Organizing regular consultative meetings with the University community about matters related to HIV/AIDS;
- Establishing and implementing a system of policy monitoring and evaluation;
- Collaborating with the community and other tertiary institutions and stakeholders.

The University will establish an appropriate budget line for the implementation of this policy. A strategic work plan will guide the implementation of this policy. This policy will be subjected to regular review and appraisal.

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NOTES

1. This formulation comes from the University of Witwatersrand proposed Draft HIV/AIDS Policy, August 200, p.1;
2. A similar provision exists in the HIV/AIDS Policy of University of the Western Cape, (UWC), South Africa, October 2000, pp.1-18;
3. University of Witwatersrand proposed Draft HIV/AIDS Policy, August 2000, pp.1-2.

4. Medical schemes registered in Namibia, all provide for claims against prescribed drugs for the treatment of HIV/AIDS (such as ante-retroviral drugs) as well as for hospitalization. Namibia Medical Care Administrators administers medicine for HIV/AIDS under a confidential in-house code. A member claims against an HIV/AIDS benefit. For this purpose he/she has to complete a special application and declare his/her HIV status to the service provider. Information on a member's HIV/AIDS status is treated as confidential and apart from the member, is only disclosed (with consent) to the person who administers the medication. Most medical schemes, such as "Prosperity Health" cover medication for HIV/AIDS subject to the limits specified under the different membership categories.
5. This formulation comes from the University of Witwatersrand Draft HIV/AIDS Policy, August 2000, p.4.

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Health wise – Columbia University

National Health Information Center

Harvard AIDS Institute

Harvard Office of Health Education [<http://www.uhs.harvard.edu/COOLS>]

Harvard Student Peer Counselling

APPENDIX 1:

WHO COUNSELLING GUIDELINES FOR HIV TESTING

COUNSELLING BEFORE HIV TESTING OR SCREENING

Undergoing a test for HIV infection is likely to be an important step in a person's life, and should always be accompanied by pre-test and post-test counseling.

THE AIM OF PRE-TEST COUNSELLING

- Counselling before the test should provide individuals who are considering being tested with information on the technical aspects of screening and the possible personal, medical, social, psychological, and legal implications of being diagnosed as either HIV-positive or HIV-negative. The information should be given in a manner that is easy to understand and should be up to date. Testing should be discussed as a positive act that is linked to changes in risk behaviour.
- A decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result. In some countries, the law requires explicit informed consent before testing can take place: in others, implicit consent is assumed whenever people seek health care. There must be a clear understanding of the policy on consent in every instance, and anyone considering being tested should understand the limits and potential consequences of testing.
- Testing for HIV infection should be organized in a way that minimizes the possibility of disclosure of information or of discrimination. In screening, the rights of the individual must also be recognized and respected. Counselling should actively

endorse and encourage those rights, both for those being tested and for those with access to the records and results. Confidentiality should be ensured in every instance.

ISSUES IN PRE-TEST COUNSELLING

- Pre-test counselling should focus on two main topics: first, the client's personal history and risk of being or having been exposed to HIV; secondly, assessment of the client's understanding of HIV/AIDS and previous experience in dealing with crisis situations.

ASSESSMENT OF RISK

In assessing the likelihood that the person has been exposed to HIV, the following aspects of his or her life since about 1990 should be taken into account:

- Frequency and type of sexual behaviour: specific sexual practices, in particular, high risk practices such as vaginal and anal intercourse without use of condoms, unprotected sexual relations with prostitutes;
- Being part of a group with known high prevalence of HIV infection or with known high-risk life-styles, for example, users of injecting drugs, male and female prostitutes and their clients, prisoners, and homosexual and bisexual men;
- Having received a blood transfusion, organ transplant, or blood or body product;
- Having been exposed to possibly non-sterile invasive procedures, such as tattooing and scarification.

ASSESSMENT OF PSYCHOSOCIAL FACTORS AND KNOWLEDGE

The following questions should be asked in assessing the need for HIV testing:

- Why is the test being requested?
- What particular behaviour or symptoms are of concern to the client?
- What does the client know about the test and its uses?
- Has the client considered what to do or how he/she would react if the result is positive, or if it is negative?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?
- Who could provide (and is currently providing) emotional and social support (family, friends, others)?
- Has the client sought testing before and, if so, when, from whom, for what reason, and with what result?

The initial counselling should include a discussion and assessment of the client's understanding of (a) the meaning and potential consequences of a positive or a negative result, and (b) how a change in behaviour can reduce the likelihood of infection or transmission to others.

Pre-test counselling should include a careful consideration of the person's ability to cope with the diagnosis and the changes that may need to be made in response to it. It should also encourage the person being counselled to consider why he or she wishes to be tested and what purpose the test will serve. When asking about personal history, it is important to remember that the client:

- may be too anxious to absorb fully what the counsellor says;
- may have unrealistic expectations about the test; and
- may not realize why questions are being asked about private behaviour and therefore be reluctant to answer.

During pre-test counselling, it is also important that the client be told that current testing procedures are not infallible. Both false-positive and false-negative results occur occasionally, although supplementary (confirmatory) test are very reliable if an initial test is positive. These facts must be clearly explained, together with information about the "window" period during which the test may be unable to assess the true infection status of the person.

IF TESTING IS NOT AVAILABLE

There may be locations where reliable facilities for testing are not readily available. Where this is so, every efforts should be made to emphasize prevention counseling, especially the need for changes in behaviour among people who have engaged in high-risk activities, and the reinforcement of appropriate behavioural changes. Counselling, education, information and support are the crux of behaviour change.

COUNSELLING AFTER HIV TESTING OR SCREENING

Counselling after testing will depend on the outcome of the test, which may be a negative result, a positive result, or an equivocal result.

COUNSELLING AFTER A NEGATIVE RESULT

It is very important to discuss carefully the meaning of a negative result (whether this was anticipated or not). The news of being uninfected is likely to produce a feeling of relief or euphoria, but the following points should be emphasized:

- Following a possible exposure to HIV, there is a "window" period during which a negative test result cannot be considered reliable. This means that, in most cases, at least three months must have elapsed from the time of possible exposure before a negative test can be considered to mean that infection did not occur. A negative test

result carries greatest certainty if at least six months have elapsed since the last possible exposure.

- Further exposure to HIV infection can be prevented only by avoiding high-risk behaviour. Safer sex and avoidance of needle-sharing must be fully explained in a way that is understood and permits appropriate choices to be made.
- Other information on control and avoidance of HIV infection, including the development of positive health behaviour, should be provided. It may be necessary to repeat explanations and for the counselor and the person being counselled to practice methods of negotiating with others in order to assist the client in introducing and maintaining new behaviour

COUNSELLING AFTER A POSITIVE RESULT

People diagnosed as having HIV infection or disease should be told as soon as possible. The first discussion should be private and confidential, and then the client should be given time to absorb the news. After a period of preliminary adjustment, the client should be given a clear, factual explanation of what the news means. This is a time for acknowledging the shock of the diagnosis and for offering and providing support. It is also a time for encouraging hope—hope for achievable solutions to the personal and practical problems that may result. Where resources are available, it may also be justifiable to talk of possible treatments for some symptoms of HIV infection and about the efficacy of anti-viral treatments.

How the news of HIV infection is accepted or incorporated often depends on the following:

1. The person's physical health at the time. People who are ill may have a delayed reaction. Their true response may appear only when they have grown physically stronger.
2. How well prepared the person was for the news. People who are completely unprepared may react very differently from those who were prepared and perhaps expecting the result. However, even those who are well prepared may experience the reactions described in the following pages.
3. How well supported the person is in the community and how easily he or she can call on friends. Factors such as job satisfaction, family life and cohesion, and opportunities for recreation and sexual contact may all make a difference in the way a person responds. The reaction to the news of HIV infection may be much worse in people who are socially isolated and have little money, poor work prospects, little family support, and inadequate housing.
4. The person's pre-test personality and psychological condition. Where psychological distress existed before the test result was known, the reactions may be either more or less complicated and require different management strategies than those found in persons without such difficulties. Post-result management should take account of the person's psychological and/or psychiatric history, particularly as the stress of living with HIV may act as a catalyst for the reappearance of earlier disturbance.

In some cases, news of infection can bring out previously unresolved fears and problems. These can often complicate the process of acceptance and adjustment and will need to be handled sensitively, carefully, and soon as possible.

5. The cultural and spiritual values attached to AIDS, illness, and death. In some communities with a strong belief in life after death, or with a fatalistic attitude towards life, personal knowledge of HIV infection may be received more calmly than in others. On the other hand, there may be communities in which AIDS is seen as evidence of antisocial or blasphemous behaviour and is thus associated with feelings of guilt and rejection.

Counselling and support are most needed when reactions to the news of HIV infection and disease appear. Some reactions may initially be very intense. It is important to remember that such responses are usually a normal reaction to life-threatening news and as such should be anticipated.

PSYCHOLOGICAL ISSUES

The psychological issues faced by most people with HIV infection or diseases revolve around uncertainty and adjustment.

With HIV infection, uncertainty emerges with regard to hopes and expectations about life in general, but it may focus on family and job. An even more fundamental uncertainty may concern the quality and length of life, the effect of treatment, and the response of society. All these are relatively unpredictable in terms of their long-term outcome. They need to be discussed openly and frankly, but care should always be taken to encourage hope and a positive outlook.

In response to uncertainty, the person with HIV must make a variety of adjustments. Even the apparent absence of a response may, in itself, be an adjustment through denial. People start to adjust to news of their infection or disease from the time they are first told. Their day-to-day lives will reflect the tension between uncertainty and adjustment. It is this tension that causes other psychosocial issues to assume more or less prominence and intensity from time to time.

FEAR

People with HIV infection or disease have many fears. The fear of dying and, particularly, have dying alone and in pain is often very evident. Fear may be based on the experiences of loved ones, friends or colleagues who have been ill with, or died of, AIDS. It may also be due to not knowing enough about what is involved and how the problems can be handled. As with most psychological concerns, fear and the pressures such fear creates can often be managed by bringing them clearly and sensitively into the open. They should be discussed in the context of managing the difficulties, including with the help of friends and family or with the counsellor.

LOSS

People with HIV-related disease experience feelings of loss about their lives and ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial stability, and independence. As the need for care increases, a sense of loss of privacy and control over life will also be experienced. Perhaps the most common loss that is felt is the loss of confidence. Confidence can be undermined by many aspects of life with HIV, including fear for the future, anxiety about the coping abilities of loved ones and caregivers, by the negative and/or stigmatizing actions of others. For many people, recognition of HIV infection will be the first occasion that forces them to acknowledge their own mortality and physical vulnerability.

GRIEF

People with HIV infection often have profound feelings of grief about the losses they have experienced or are anticipating. They may also suffer the grief that is projected on to them by close family members, lovers, and friends. Often these same people are supporting and taking care of them on a day-to-day basis, and watching their health decline.

GUILT

A diagnosis of HIV infection often provokes a feeling of guilt over the possibility of having infected others, or over the behaviour that may have resulted in the infection. There is also guilt about the sadness the illness will cause loved ones and families, especially children. Previous events that may have caused pain or sadness to others and remain unresolved will often be remembered at this time and may cause even greater feelings of guilt.

DEPRESSION

Depression may arise for a number of reasons. The absence of a cure and the resulting feeling of powerlessness, the loss of personal control that may be associated with frequent medical examinations, and the knowledge that a virus has taken over one's body are all important factors. Similarly, knowing others or about others who have died or are ill with HIV-related disease, and experiencing such things as the loss of potential for procreating and for long-term planning may contribute to depression.

DENIAL

Some people may respond to news of their infection or disease by denying it. For some people, initial denial can be a constructive way of handling the shock of diagnosis. However, if it persists, denial can become counter-productive, since people may refuse to accept the social responsibilities that go with being HIV positive.

ANXIETY

Anxiety can quickly become a fixture in the life of the person with HIV, reflecting the chronic uncertainty associated with the infection. Many of the reasons for anxiety reflect the issues discussed above and concern the following:

- prognosis in the short and long term
- risk of infection with other diseases
- risk of infecting others with HIV
- social, occupational, domestic, and sexual hostility and rejection
- abandonment, isolation, and physical pain
- fear of dying in pain or without dignity
- inability to alter circumstances and consequences of HIV infection
- how to ensure the best possible health in the future
- ability of loved ones and family to cope
- loss of privacy and concern over confidentiality
- future social and sexual unacceptability
- declining ability to function efficiently
- loss of physical and financial independence.

ANGER

Some people become outwardly angry because they feel they have been unlucky to catch the infection. They often feel that they have been, or information about them has been badly or insensitively managed. Anger can sometimes be directed inwardly in the form of self-blame for acquiring HIV, or in the form of self-destructive (suicidal) behaviour.

SUICIDAL ACTIVITY OR THINKING

People who are HIV infected have a significantly increased risk of suicide. Suicide may be seen as a way of avoiding pain and discomfort or of lessening the shame and grief of loved one. Suicide may be active (i.e., deliberate self injury resulting in death) or passive (i.e., concealing or disregarding the onset of a possibly fatal complication of HIV infection or disease).

SELF-ESTEEM

Self-esteem is often threatened early in the process of living with HIV. Rejection by colleagues, acquaintances, and loved ones can quickly lead to loss of confidence and social identity, and thus to reduced feelings of self-worth. This can be compounded by the physical impact of HIV-related diseases that cause, for example, facial disfigurement, physical wasting, and loss of strength or bodily control.

HYPOCHONDRIA AND OBSESSIVE STATES

Preoccupation with health and even the smallest physical changes or sensations can result in hypochondria. This may be transient and limited to the time immediately after the diagnosis, or it may persist in people who find difficulty in adjusting to the disease.

SPIRITUAL CONCERNS

Concern about impending death, loneliness, and loss of control may give rise to an interest in spiritual matters and a search for religious support. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may appear in the context of religious and spiritual discussions.

Many of these and other concerns will appear or become more pronounced when a diagnosis of AIDS is made. The appearance of new infections, cancers, and periods of severe fatigue all have a significant emotional and psychological impact. The effect is likely to be even greater if the person with AIDS has been rejected by family or friends and has withdrawn from normal social relationships.

OTHER COUNSELLING ISSUES

HIV infection often highlights other issues critical to quality of life.

SOCIAL ISSUES

Environmental and social pressures, such as loss of income, discrimination, social stigma (if the diagnosis becomes commonly known), relationship changes, and changing requirements for sexual expression, may contribute to post-diagnosis psychosocial problems. The patient's perception of the level and adequacy of social support is of vital concern and may become a source of pressure or frustration.

MEDICAL MANAGEMENT

The type of counselling support usually required and requested is often influenced by the person's experiences with other forms of health care related to the infection. Where the patient or loved ones feel that medical management has been insensitive or has been conducted without sufficient regard for privacy, counselling may be all the more necessary in order to persuade the patient to comply with recommended treatment programmes.

Counselling may also involve helping the person gain access to appropriate medical care and participate more fully in decisions about treatment. If there is any evidence of neurological disease, day-to-day management of the patient may be complicated, and special emphasis will have to be given to counselling of family, loved ones and care-givers.

At this stage, counsellors may need to co-ordinate a range of health and social services. Many people with HIV will also seek care from traditional or complementary healers: this may first

be revealed in the context of supportive counselling. Where this is the case, counselling can help patients talk about their perceived needs and their satisfaction with these caregivers.

COUNSELLING AFTER AN EQUIVOCAL TEST RESULT

If the result of the HIV test is equivocal, the counsellor has particular responsibilities to provide information. In particular, there are two main issues to cover:

1. The person should be given a clear explanation of what such a test result means. The first test most commonly used on all samples is the enzyme-linked immunosorbent assay (ELISA). The ELISA has levels of sensitivity and specificity approaching 99.5%, meaning that a non-reactive result with this technique can be regarded as a definite indicator that the person is not infected, except for test during the “window period”. However, a reactive result suggests the possibility of HIV infection. The usual procedure in that case is to perform a second test using the ELISA; if the second ELISA test is also positive, supplementary testing is required, for example using the Western blot test. The results of such supplementary testing may be positive (indicating HIV infection), negative (indicating no infection), or indeterminate (giving an equivocal result). Where the result of supplementary testing is indeterminate (which may be the case in up to 10% of samples in some areas), the reason may be one of the following:
 - the test is cross-reacting with a non-HIV protein (usually, the protein reaction is simulating the reaction associated with p24 core protein).
 - There has been insufficient time for full seroconversion to occur since the person was exposed to HIV.

When presented with an indeterminate result, the options are to:

- Use other methods to try to achieve a reliable result. Combinations of laboratory techniques may be needed to exclude false-positive results.
 - Refrain from further testing for the moment. If the result is indeterminate and further testing is not possible, the person cannot reliably be considered HIV-infected. The counsellor should advise the person to come for repeat testing in three months. It is important to remember that the risk of finding a false-positive result in the ELISA is higher in areas with a low level of HIV infection than where the background rates of HIV infection are high. Thus, in places where there are many people with AIDS in the community, it is more likely that a reactive or positive result on the ELISA is accurate.
2. Prevention and support while waiting for an unequivocal result. The period of uncertainty following an equivocal test result may be three months or longer. It is important for counsellors to stress essential messages related to prevention of transmission, regarding sexual activity, drug use, donation of body fluids or tissues, and breast-feeding. Just as importantly, however, the uncertainties associated with this period may lead to acute and severe psychosocial difficulties, and the counsellor must

be prepared to assess and manage such issues or to make appropriate referrals, if possible.

SELF-HELP GROUPS

In some places, the counsellor can call on peer-support or self-help groups, part of a growing network of non-governmental AIDS service organizations (ASOs). These can provide a type of personal care and peer-based psychosocial support that may not be available elsewhere. If no such groups exist, the counsellor may be able to encourage clients to form one. Where this is not possible, the counsellor may be able to put clients in touch with each other on an individual basis, at the discretion of the counsellor and with the express consent of the individuals and on a confidential basis. Matters that are often best dealt with through self-help groups, but which need to be raised by the counsellor in any event, include the following:

1. Learning to live with HIV infection. Self-help groups are often in a good position to address this because many of the people involved may have already gone through the process. They can describe the medical and psychological problems they have experienced and the interventions they have found most useful.
2. Helping care-givers and loved ones handle the pressures of living with sick or distressed people on a daily basis, especially where this involves managing bleeding, vomiting, incontinence, disposal of dressings, etc., and advice regarding sexual relations.
3. Reducing stress and avoiding conflict. The need to overcome anxiety, depression and other possible challenges to sustained health has to be handled on a practical, "I did this..." basis.
4. Deciding how best to talk about HIV/AIDS. Fears of disclosing a diagnosis of HIV or AIDS to loved ones, family, friends, and colleagues need to be examined and solutions sought, including what to say, to whom, when, and how.
5. Dealing with feelings of loneliness, depression, and powerlessness. Self-help or peer support groups can provide help and mutual support. Advice from people who have themselves gone through such feelings may be more meaningful than advice provided on a second-hand or theoretical basis.
6. Managing the implications of adopting and maintaining safer sex behaviour. Peer support groups can organize discussions and training that can be far more relevant than advice provided through formal health care programmes. Peer commitment to safer sex also helps make these practices socially acceptable, attractive and thus sustainable.

The essence of peer-support group activity is a feeling of group cohesion, a sharing of experiences and mutually supportive activities. At times, such groups may need help in getting started and in maintaining regular activities. They will all look to the counselor for

help in identifying medical services and caregivers. Providing legal advice and, in some cases, financial support may also become issues in establishing such groups and giving them operational legitimacy.

APPENDIX II

Guidelines for dealing with spillage of blood and other body fluids

The University adheres to universal precautions in the form of three infection control guidelines. These are: Personal protective equipment (PPE), Engineering controls and work practice controls.

Personal Protective Equipment (PPE), includes gloves, lab coats, gowns, shoe covers, goggles, glasses with side shields, masks and resuscitation bags. The purpose of PPE is to prevent blood and body fluids from reaching a persons skin, mucous membrane, or personal clothing.

Engineering Controls, refer to methods of isolating or removing hazards from the workplace. Examples of engineering controls include: sharps disposal containers, laser scalpels, and ventilation including the use of ventilated biological cabinets (laboratory fume hoods)

Work Practice Controls, refer to practical techniques that reduce the likelihood of exposure by changing the way a task is performed. Examples of such techniques include: hand washing, handling of used needles and other sharp and contaminated reusable sharps, collecting and transporting fluids and tissues according to approved safe practices. (Taken from the web-page of the Canadian Centre for occupational Health and Safety).

Blood and other body fluid specimens which are known or suspected to be infected with HIV should be handled in accordance with guidelines produced by the Ministry of Health and Social Services. A higher level of risk may arise from work with concentrated HIV solutions.

Staff undertaking higher risk work should undergo pre-placement screening by a qualified medical practitioner. Certain disorders may make an individual susceptible to infection if accidental exposure occurs; the general suitability of an individual for this type of work must be considered. Prospective laboratory technicians and health workers will be counselled confidentially by a qualified physician/counsellor so that they are aware of the risks involved and know what to do in the event of an accident.

Before any member of staff embarks on higher risk work, a blood sample will be taken; this will be stored frozen and kept until destruction is ordered with the agreement of the individual. The sample will be coded and will not be tested without the consent of the person concerned. There is no need for pre-employment or routine HIV testing. An annual health review will be required to record occupational incidents and to monitor the individual's health. HIV testing may be performed at the request of the individual after appropriate counseling.

Accidental exposure to HIV in the laboratory may occur from splashes to the skin and eyes or through inoculation injury; aerosols of high titre material can also be a hazard. Splashes to the eyes or mucous membranes should be washed with soap and water and made to bleed freely. The University will not allow the use of human blood in laboratories or for experiments at undergraduate level.

The accident must be reported to the University Safety Officer and the Occupational Health Unit as soon as possible. The Occupational Health Unit will consider the desirability of administering prophylactic Zidovudine, and will arrange counselling and further follow-up.