



Facilitator's Guide



National AIDS Control Organization
Ministry of Health and Family Welfare • Government of India

with technical support from
WHO • UNICEF • CDC



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Technically edited, designed and typeset by
Byword Editorial Consultants
email: editbyword@gmail.com

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
APCASO	Asia Pacific Council of AIDS Service Organizations
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
AS	Activity sheet
ATS	Amphetamine-like stimulants
BCC	Behaviour change communication
BSS	Behavioural surveillance survey
CARAM	Coordination of Action Research on AIDS and Mobility, Asia
CBO	Community-based organization
CIRR	Client information record and result
CMV	Cytomegalovirus
CSW	Commercial sex worker
CT	Computerized tomography
DOT	Directly observed therapy
DOTS	Directly Observed Treatment, Short-course
EBE	Exotic becomes erotic (theory)
ELISA	Enzyme-linked immunosorbent assay
EQA	External quality assurance
EQAS	External quality assurance scheme
FACS	Fluorescent activated cell sort
FSW	Female sex worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HAART	Highly active antiretroviral therapy
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCW	Health-care worker
HIV	Human immunodeficiency virus
HO	Handout
HRB	High-risk behaviour
HST	Humsafar Trust, Mumbai
HSV	Herpes simplex virus
HZV	Herpes zoster virus
ICAAP	International Congress on AIDS in Asia and the Pacific
ICMR	Indian Council of Medical Research
IDU	Injecting drug use/user
IVDU	Intravenous drug user
IEC	Information, education and communication

LFT	Liver function tests
MCH	Maternal and child health
MRI	Magnetic resonance imaging
MH	Mental health
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NACP	National AIDS Control Programme
NEP	Needle exchange programme
NGO	Non-governmental organization
NRTI	Nucleoside reverse transcriptase inhibitor
NNRTI	Non-nucleoside reverse transcriptase inhibitor
OI	Opportunistic infection
ORW	Outreach worker
PCR	Polymerase chain reaction
PEP	Post-exposure prophylaxis
PHC	Primary health centre
PI	Protease inhibitor
PID	Personal identification digit
PLHA	People living with HIV/AIDS
PPD	Purified protein derivative
PPTCT	Prevention of parent-to-child transmission
PPT	PowerPoint presentation
PT	Proficiency test
PTSD	Post-traumatic stress disorder
QA	Quality assurance
QC	Quality control
RNTCP	Revised National Tuberculosis Control Programme
SACS	States AIDS control societies
SEARO	South-East Asia Regional Office
SHG	Self-help group
SOP	Standard operating procedure
SP	Session plan
STI	Sexually transmitted infection
SWAM	Society Welfare Association for Men, Chennai
TB	Tuberculosis
ToT	Training of trainers
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly
VCTC	Voluntary counselling and testing centre
VDT	Voluntary diagnostic testing
WHO	World Health Organization

Background

HIV COUNSELLING

Counselling in the context of HIV has become important in the provision of prevention, treatment and care services over the past years. HIV counselling initially focused on prevention of HIV infection, HIV testing and dealing with the emotional and social impact of a positive HIV test. HIV counselling expanded to include counselling on prevention of parent-to-child transmission (PPTCT) of HIV, and on care for the baby. Most recently, with the introduction of antiretroviral therapy (ART), the scope of counselling further expanded to include preparedness and adherence counselling for people on ART.

As part of the third phase of the National AIDS Control Programme (NACP-III), NACO will further roll out access to ART. Voluntary counselling and testing (VCT) centres and PPTCT services will be expanded from the current district and tertiary care level to CHC and PHC levels especially in rural areas. Integrated counselling and testing centres (ICTC) will be established to provide clients with a comprehensive package of information and counselling.

The planned expansion requires a large cadre of qualified and skilled counsellors and peer counsellors to be available in the VCTCs, PPTCTs and ICTCs. Therefore, a set of comprehensive standardized HIV counselling training modules using a combination of teaching techniques (from lectures to hands-on demonstrations, role-plays, etc.) and regular HIV counselling trainings are important.

The training modules provide hands-on training for counsellors to develop and fine-tune their skills, to increase their sensitivities and to be able to reach out to their clients. These training modules help counsellors in enhancing their counselling skills and in providing state-of-the-art counselling to their clients.

NACO, with technical support from WHO, UNICEF and the Centers for Disease Control and Prevention (CDC), has developed the current HIV counselling training modules (2006) with an aim to provide standardized trainings to all cadres of HIV counsellors in the country. The training modules support the NACO's VCT, PPTCT and ART programmes.

THE DEVELOPMENT OF THE HIV COUNSELLING TRAINING MODULES

The NACO HIV Counselling Training Modules have been developed through six regional consultations and field-testing of the WHO South-East Asia Regional Office (SEARO) Voluntary HIV Counselling and Testing: Manual for training of trainers

between 2003 and 2005 held at Imphal, Chennai, Panchgani (Maharashtra), Ranchi, Delhi and Lucknow. A total of 235 teaching faculty from 111 institutions in 30 states, who were selected as master trainers (ToTs), underwent counselling training and provided technical inputs.

In May 2004, a three-day national consultation conducted by NACO, and supported by WHO, with 38 master trainers and senior experts reviewed the comments and provided technical inputs for the development and standardization of the modules. Each topic had been assigned to two to three experts for review. Their comments and suggested modification were discussed by experts in small groups. Further, the content of modules from CDC, FHI, BPNI, UNICEF and NIMHANS were reviewed for inclusion.

Dr Sushma Mehrotra (formerly Consultant Counselling, NACO) was the chief coordinator of the zero draft supported by Professor B.L. Barnes and her team from Mumbai including Ms Rohini Ramamurthy and Ms Tasneem Raja who edited the modules and gave the document its final shape.

UNICEF took the lead in field-testing the zero draft of the HIV counselling modules during a 12-day training in Mumbai in October 2004 with 30 participants from six high-prevalence states and three moderate-to-low prevalence states primarily to validate the appropriateness of the modules for counsellors in HIV settings.

The contents of the module were found to be extensive with clear session instructions and PowerPoint (PPT) presentations for trainers/facilitators and detailed handouts for trainees. The modules were considered useful as a standardized training tool to conduct uniform HIV counsellor trainings across the country.

SOME HIGHLIGHTS OF THE PRESENT MODULES

The VCT and ART parts of the current modules are based on the WHO-SEARO Manual which was developed for the Asian context by experts from Bangladesh, Bhutan, India, Indonesia, Sri Lanka and Thailand.

The PPTCT parts of the modules are based on UNICEF training modules. UNICEF has been a key partner in the national PPTCT programme and works closely with NACO and State AIDS Control Societies (SACS) to ensure quality in PPTCT services of which counselling is an important part.

The modules cover VCT issues including counselling for risk reduction and facilitating HIV test decision. The PPTCT parts address issues related to HIV testing, care of pregnant women and infant feeding. The ART parts provide training in basic counselling skills on treatment preparedness, adherence and follow-up counselling. The ART module further includes specific issues when providing HIV counselling

for high-risk and vulnerable groups such as CSW, MSM, IDU and young people. Additional topics are introduced in the current modules to enrich the contents of training:

- Crisis intervention and problem-solving counselling
- Family counselling
- Infant feeding counselling
- Mental health issues and suicide prevention in HIV
- Role of PPTCT in HIV prevention
- Group counselling
- Managing psychological distress
- Grief counselling
- Counselling for occupational stress and burn-out
- Legal and ethical issues
- Nutrition counselling
- ART counselling
- Home-based care

Organization of the HIV Counselling Modules

The material for the HIV Counselling Training Modules is divided into two folders. The folder titled **Facilitator's Guide** is meant for training organizers, trainers and facilitators. It contains, for each training session (submodule), a detailed session plan with information on the content of the session, materials required, and instructions on how to conduct the session in a logical manner. The folder also includes 'ready to use' PowerPoint presentations and specific session activities which need to be conducted with the trainees. Some activity sheets will need to be photocopied beforehand for use by the trainees during the training.

The folder titled **Handouts** is meant to provide detailed background information on each topic and complement the information provided by the facilitator/trainer during the session presentations. It is therefore important that facilitators/trainers are familiar with the content of the handouts. Ideally, to enable them to prepare beforehand, the trainees should be given the respective handouts a day before the session presentations are to be conducted. At the end of the training, each trainee has a complete set of handouts which they can take back with them for future use and easy reference.

However, as is the case with all training materials, the contents of these modules need to be revised and updated periodically and should always be reviewed and updated by the trainers before conducting trainings.

HIV COUNSELLING TRAININGS

The modules can be used as a complete 12-day training package when providing induction training to counsellors or these can be used in parts during refresher trainings to meet the specific needs of the counsellors. The proposed 12-day and 5-day training schedules have been included as guidance for training course organizers. These need to be adapted to the specific training requirements and availability of resource persons.

NACO envisions that the standardized HIV counselling trainings will support the scale up of quality VCT, PPTCT and ART services. The modules will allow the states to build the capacity of local institutions for regular training (induction and refresher trainings) of counsellors. The same institutions can be engaged to provide ongoing support for counsellors which includes mentoring, supervision and monitoring. The goal is to make available quality HIV counselling services close to people's doorsteps as entry points to HIV prevention and care for all segments of society in all parts of the country.

Introduction

CONTEXT

Within the South and South-East Asia Region, an estimated 7.4 million are people living with HIV/AIDS (PLHA) (as of December 2005). This region ranks second in HIV prevalence, after sub-Saharan Africa, and accounts for about 20% of new annual HIV infections globally.

The epidemic in India is varied, with areas of generalized epidemic in the South and North-east, and with pockets of concentrated epidemics and highly vulnerable regions with low-levels of HIV infection. At the end of 2004, 5.3 million Indians were estimated to be infected with HIV. A hundred and eleven districts in the country are classified as high HIV prevalence districts. Transmission of HIV is predominantly through the sexual route (86%). Other routes include injecting drug use (IDU) (2.4%), vertical transmission from mother to child (3.6%) and transfusion of blood and blood products (2%), and others (6%) (as of July 2005).

HIV transmission is on the increase among both adults and children in most parts of the country. Regional trends indicate increases in the occurrence of sexually transmitted infections (STIs). The extent of HIV infection in many states and rural areas is currently unclear.

Increasing the reach of voluntary counselling and testing (VCT), prevention of parent-to-child transmission (PPTCT) and antiretroviral therapy (ART) interventions enables and encourages people with HIV to access appropriate care and treatment early and strengthens prevention of HIV infection in the community. In NACP-III, VCT, PPTCT and ART services will be expanded up to the sub-district level.

VCT AND PPTCT—GATEWAYS TO PREVENTION, TREATMENT AND CARE

Both VCT and PPTCT provide important entry points to prevention, care and treatment services, and have the following benefits. They

- Increase awareness about HIV/AIDS and its modes of transmission
- Strengthen prevention and facilitate behaviour change (risk reduction)
- Facilitate behaviour change in both HIV-negative and HIV-positive people. It supports HIV-negative clients to remain negative and HIV-positive clients to prevent the further spread of HIV (positive prevention)
- Help in acceptance and coping with one's serostatus
- Provide psychosocial support through referral to social and peer support
- Identify the need for prophylaxis and effective ART

- Reduce parent-to-child transmission of HIV
- Facilitate early management of HIV-related infections and STIs
- Facilitate planning for the future
- Encourage orphan care
- Promote ‘will’ making
- Increases the visibility of HIV in communities, thus ‘normalizing’ HIV/AIDS.

Factors that contribute to high-quality VCT and PPTCT services include easy accessibility; a non-threatening environment; confidentiality of client information; skilled, sensitive counsellors and experienced laboratory technicians.

TRAINING AND EDUCATION

High-quality and skilled counsellors are not born, nor is basic orientation and skill-building for counselling sufficient to deal with all aspects of HIV/AIDS. Training forms the cornerstone for developing competent and effective HIV counsellors who can support the various aspects of the programme.

Counselling is not merely the provision of information or advice. Counselling is a process of enabling an individual to take personal decisions in the context of HIV/AIDS. Thus, counselling can include facilitating a client’s decision whether or not to undergo an HIV test or preparing clients for lifelong ART.

The conviction held by NACO is that clients accessing a VCT, PPTCT or ART centre need to understand the context of HIV/AIDS from prevention to treatment and care. The HIV counsellor needs to equip the client to prevent HIV infection, to make an informed choice about HIV testing, to cope with an HIV test result and to understand the implications of lifelong treatment. Thus, HIV counsellors are challenged not only to keep abreast with new trends in HIV/AIDS prevention, treatment and care but also to continually fine-tune their skills and to equip themselves to address the various needs of their clients in the most comprehensive and sustainable manner. The objective of these training modules is to provide HIV counselling skills to health-care workers, especially ‘counsellors’. The modules address an array of knowledge and skills required for effective HIV counselling in VCT, PPTCT and ART settings.

OBJECTIVES OF THE HIV COUNSELLING TRAINING

The objectives of the HIV Counselling Training are:

- To train a cohort of HIV counsellors
- To provide knowledge on prevention, treatment and care issues in HIV/AIDS
- To build and strengthen the skills of counsellors and health workers to provide quality VCT, PPTCT and ART counselling to their clients.

Key points for conducting trainings

While no training can be exhaustive, these modules outline the key activities and information involved in training HIV counsellors.

The training consists of seven modules organized into submodules with clearly stated objectives and session plans (SPs). Each submodule is divided into up to four sections which provide the content of the submodule and the detailed training resources:

- Session plan (SP), which provides an overview of the training content
- PowerPoint (PPT) presentation, which aids the trainer during the session
- Handout (HO), which provides background information for the trainees
- Activity sheet (AS), which provides information on the activities that are to be conducted

Modules 1–6 contain the core HIV counselling content. Module 7 includes supplementary content providing advanced counselling skills.

The section ‘evaluation forms’ includes formats to evaluate the trainee’s knowledge level before and after the training, and forms to assess the training and the trainers.

The annexure contains guidelines, checklists and references.

The complete training material is available on a CD-ROM for easy duplication and training preparation.

Disclaimer

The training programme requires supervised skills rehearsal; therefore, it is not suitable for use as a self-directed learning tool. Trainers are further advised that only those who have been trained as trainers should use the modules. It is not recommended that these modules be used by clinicians/trainers who have not participated in the specific training activities; doing so, may compromise the quality of the training.

1. SETTING THE STAGE FOR TRAINING

No training is complete without the necessary preparation, in spite of the best training modules and resources. The preparation has to set the stage for learning and for achieving the training objectives. This includes:

- Adult learning styles must be planned for to ensure involvement of all trainees.
- Local language and terminology should be used during the trainings in settings where trainees are more conversant with the local language.

- A conducive environment should be established for learning through discussions, role-plays, brainstorming sessions and games. This helps to increase the trainees' receptivity and learning potential. It also helps the trainer to understand the knowledge level and experience of the trainees.
- Field visits to VCT, PPTCT or ART centres can further illustrate key points and support the learning. A detailed guideline for conducting field visits is included in Annexure 3.
- An introduction and a conclusion to every topic helps the trainees recapitulate the main messages from the modules.

Although the modules have been designed to address all aspects of the training, the ultimate success lies with the trainers and the training coordinator. This includes assigning modules to trainers/resource persons with appropriate experience and assuring that trainers familiarize themselves with the handouts, activities and presentations before the training. A detailed checklist for planning and organizing HIV counselling trainings is given in Annexure 1.

2. TRAINING SCHEDULE

The complete set of modules cover a 12-day programme (including field visits and a day of holiday suggested on the sixth day of training), which may be adapted as appropriate for longer or shorter periods (see proposed 12-day and 5-day training schedules at the end of this section). However, sessions or 'modules' should be added or subtracted according to their relevance to the culture and epidemic profile of the location where the training is conducted, time available for training and the level of practical experience of the trainees in hands-on patient management.

3. KEY CONSIDERATIONS FOR TRAINING

It is important to identify the combination of skills that counselling staff and supervisors will need to support each other so that, together, the entire staff at a VCT, PPTCT or ART centre will be able to deliver high-quality services to their clients. Making sure that supervisors also receive counselling training as well as counselling supervision training is critical to maintain the quality of clinical services and to strengthen the management of the programme. Supervisors must see their roles as educative and supportive (as well as being able to provide appropriate challenges, where necessary), but not interrogative.

Training for counsellors should be *competency-based*, bearing in mind the realities of the situation in the field. This means that the relevant competencies must be defined before training programmes are designed. Careful consideration must be given to the procedures that counsellors should follow and the skills they require. The most important method of training in any situation depends on the nature of the learning objectives. (The learning of facts requires different teaching methods from

the learning of communication skills; local cultural factors; and the style of teaching that learners are familiar with and capable of using.)

Example: Even though trainees may be most familiar with lectures, this method cannot be used to teach communication skills.

The competencies identified with regard to training in counselling depend on communication skills. There will also be a need to develop attitudes and skills for coping with fear, anger and embarrassment. Learning objectives in these areas can be achieved only when the teaching methods are interactive and involve the trainees in practising communication skills and in expressing their feelings.

Effective training of counsellors always has a closely supervised *practical* component. Therefore, counselling training programmes should be designed in such a way that ample opportunity is provided for this practical training in the field as well as in the classroom.

3.1 Group size

The group size for classroom counselling training should not exceed 30 trainees. The smaller the group, the more quality time and opportunity are afforded for trainees to practise their skills. As a number of group activities require splitting the trainees into groups of threes, it is suggested that the number of trainees be divisible by three (*see also* 'Group discussions' later in this section).

3.2 Interactive training strategies

These modules use interactive training methodologies, allowing instruction, practice and feedback to take place as these are crucial to address the sensitive and confidential issues discussed during HIV pre- and post-test counselling. Each session of training involves one or more of the following strategies:

- Role-play exercises
- Group discussions
- Educational games (card game for risk assessment, the 'trust walk')
- Case-based small group learning activities
- Brainstorming sessions

Presentations

A PowerPoint (PPT) presentation can be used to highlight key points. The duration of each presentation should not exceed 30 minutes. Trainers can promote interaction by:

- the use of individual/group exercise HOs that trainees complete
- encouraging questions from the group following the presentation

- conducting group work to discuss and answer questions
- by assigning issues or tasks to small groups

Visual aids

Visual aids can be used to highlight oral presentations or points. For example, key points can be noted on the blackboard and questions for debate or discussion (and responses) can be written on the board. The use of the board in this way promotes discussion and interaction. Visual aids should be clear, readable and should not be filled with too many details.

Rapporteur sessions

Following group discussions, the trainer can develop a list of the points made, which can be used to summarize the presentation. Alternatively, the trainer can call upon a trainee to be a rapporteur to document a list of summary points that can be derived from brainstorming lessons learnt from the presentation.

Role-plays

Role-plays should be used to ‘act out’ specific roles of identified people or to act out a scene. This is useful when practising skills such as counselling and to explore how people react to specific situations. The time limit for a role-play is 15–20 minutes. (For more information on how to conduct role-plays see Annexure 2.)

Role-plays have the following advantages:

- They allow for safe rehearsal of skills and activities, and provide practical preparation for genuine situations
- The trainees are able to experience activities and to relate theory to practice
- They allow for full expression and interpretation of concepts

Some individuals may feel intimidated by role-playing. The trainer must be skilful in ensuring that they are relaxed and should:

- keep the role-play appropriate to the learning context, and
- emphasize that the characters are ‘in role’ and that group observers are looking at the characters and their reactions, not the individual people enacting the role.

Group discussions—large group discussions

These should be led by the trainer and involve the entire group. The advantages of such discussions include the following:

- The trainees are involved in problem-solving
- The trainees are active, which stimulates interest

- The learning process becomes more personal, requiring the trainer to provide feedback on individual opinions and ideas
- The trainer is able to evaluate the trainees' understanding and absorption of material
- The trainees have an opportunity to share their acquired expertise and skills

Large group discussions require a skilful trainer who:

- Asks questions or suggests topics, maintains objectivity and directs the discussion to keep it relevant to the learning objectives
- Stresses confidentiality
- Ensures that all group members have an equal opportunity to participate and that no one person (including the trainer!) dominates the discussion
- Perceives and responds to differences in the group, such as the skills level, education and comfort with the topic
- Is aware of cultural and gender issues
- Encourages trainees to answer questions and share expertise
- Is flexible if the group begins to explore other relevant issues
- Is respectful and non-judgmental of the trainees' ideas and opinions to allow open expression of concerns
- Keeps to the time, leaving adequate periods for discussion
- Obtains feedback and responses from the group to provide evaluation mechanisms for the session
- Provides an appropriate balance of supportive and challenging facilitation in which to foster learning

Group discussion—small group discussions

These are usually conducted in groups of four to six persons. The advantages of small group discussions include the following:

- Trainees have more opportunity to talk and are less likely to be embarrassed than in a large group
- The atmosphere is more conducive to a discussion of feelings
- Trainees gain self-confidence through sharing of information
- More ideas come from the group

The trainer may also ask the group to appoint a facilitator and a rapporteur. Small group discussions and/or work with pairs should be followed by a large group discussion so that general conclusions can be drawn.

The trainer does not lead the group, but must be skilful in structuring the discussions so that the stated objectives are accomplished.

It is important to provide clear guidelines for group discussions, such as the ones below, at the beginning of the discussion.

- Which topics are to be discussed?
- Will the group draw conclusions or make decisions?
- Can opinions or feelings of the trainees be shared beyond the small group?
- Will the group be expected to report its discussions to the larger group?

Working in pairs

Working in pairs is effective when in-depth sharing or analysis of particularly personal or sensitive issues is required. Individuals may feel more free to disclose their attitudes and opinions with one trainee rather than within the larger group.

Case studies

Case studies are designed to give counselling trainees an understanding of the impact of HIV infection on the individual, and to enable them to deal with problems trainees may encounter in real-life settings. The trainers need to develop case studies that are specific to the local setting. Where included, case studies are introduced in the Session Plan for each individual submodule, some of these are followed by a discussion of key points pertaining to the case study. Case studies should be printed and provided to trainees as part of the activity. These case studies provide a detailed description of an event, different characters and settings. The case studies may be followed by a series of questions that will challenge the trainees to discuss the positive and negative aspects of the event.

The advantages of case studies are that they allow an examination of a real or simulated problem that mirrors the outside world, and help trainers to develop confidence and problem-solving skills.

The case studies prepared for use in the individual clinical risk assessment and HIV pre- test counselling sessions should NOT be included in the trainees' folders. They have been designed to be handed out to the trainees during the activities. (Refer to the session plan.)

Trainees who role-play 'counsellors' in these activities should not see the cases before the commencement of the activities. This will ensure that the 'counsellor' gains experience in acquiring information from 'clients'. In 'real-life' situations, clients do not send all their details to the counsellor in advance; rather the counsellor uses counselling skills to gather information from the client. Conducting role-plays in this way ensures that training approximates real-life situations.

4. USE OF RESOURCE PERSONS/EXTERNAL TRAINERS

Using a range of resource persons or external trainers presents both advantages and disadvantages. Advantages include:

- Trainees have access to ‘experts’ in their respective fields
- Trainees establish important linkages with external individuals and agencies that will assist them in their clinical work
- External presenters add variety to the programme of regular trainers

Some disadvantages of using external trainers or guest speakers are as follows:

- Inadequately briefed speakers may not focus on the topic
- Speakers may present nonevidence-based or erroneous information
- Speakers may pitch their presentation inappropriately in terms of language used and target audience
- Some speakers may be uncomfortable with the use of more interactive learning methodologies
- Speakers may not adhere to the time frame provided

Follow these guidelines to maximize the use of external trainers or guest speakers:

- Ensure that the speakers are adequately briefed, verbally as well as in writing, in terms of what is expected of them. Provide a guideline that specifies the content to be covered, the methodology to be used, the level and type of language, and the time frame. In addition, clearly describe the type of trainees they will be working with and the overall aims of the training programme
- Choose speakers who are known to be effective for your goals. Alternatively, ‘groom’ them to attain the desired outcome
- The regular trainer should be present where possible when the external speaker makes their presentation. This ensures continuity in case an issue arises. In addition, regular trainers are also able to observe and provide useful feedback to the resource persons/guest speaker
- Always ensure that external trainers/guest speakers are given a feedback from both the organization and that based on trainee evaluations to continue improving their sessions

5. ASSESSING TRAINEES KNOWLEDGE LEVELS

Before beginning the training, assess the trainees’ knowledge of HIV and the counselling process with a pre-training knowledge questionnaire (see section ‘evaluation forms’). This information can be used to fine-tune the training to the knowledge level of the trainees. At the end of the training, the same questionnaire can be administered to determine how much knowledge and skills the trainees have gained and how effective the training has been. For trainees who are not familiar with questionnaires or are illiterate, use focus groups to assess the knowledge levels.

6. ASSESSING TRAINING QUALITY

It is important for the training coordinator to assess the quality and effectiveness of the HIV counselling training. This feedback will help in conducting future trainings, improving sessions and identifying appropriate resource persons for trainings. Forms for evaluating the overall training and for evaluating the trainers is included in section 'evaluation forms'.

7. SUMMARY OF KEY CONSIDERATIONS FOR SUCCESSFUL TRAININGS

1. **Ensure that the Training Materials Outline is close at hand for easy reference.** This will prevent usage of wrong HOs or case studies for accompanying presentations.
2. **Encourage all trainees to be present for the ENTIRE training.** It is suggested that certificates may not be given to trainees who do not attend the entire course. In the event of an emergency, in which case a trainee cannot complete the course, the trainer should negotiate with the trainee to complete the missed segments at a future course and then hand over the certificate. Note that this strategy is critical to ensuring the quality of counselling. If a trainee misses any segments of the training programme, the trainer should brief the trainee about the missed segments when they return. This will ensure that they do not put their role-playing partner to a disadvantage when they do role-plays or other activities.
3. **Ensure that the training sessions commence on time.** Request all trainees to arrive in time. Inform them that there is much material to be covered each day, and it can be very disruptive to have trainees arrive late at the training sessions.
4. **Discussion of sensitive issues.** Discussions on sex, sexuality, HIV and STIs can be difficult. It is important for trainers to make a statement about this potential discomfort to trainees at the commencement of the course and invite the course trainees to discuss their concerns with the trainers on an individual basis. The training group must respect a trainee's decision to pass on a specific question or activity.
5. **Encourage trainees to use the question box.** Questions on sensitive issues can be written down on a piece of paper and dropped in a question box. The questions should be drawn out at the end of each day and discussed during the 'question-and-answer' session before the close of the day.
6. **Maintain confidentiality at all times.** This should be the case, especially if counsellor trainees refer to their own personal experiences or those of their clients. Trainers are urged to ask all trainees to agree to maintain the confidentiality of all fellow trainees.
7. **Encourage trainees to respect individual differences.** Trainees frequently come from different ethnic and cultural groups, and their lifestyles, beliefs, personal experiences and expertise may differ.
8. **Encourage trainees to listen carefully and with empathy, and respect each**

other's contributions, opinions and experiences. Explain that it is important in the training, and as professionals, to practice active listening by allowing each other to share their own experiences and opinions with the group.

9. Create a congenial environment in which each trainee feels comfortable asking questions. Trainees need to be able to ask questions about what they do not understand. Again, the question box can be a useful tool.
10. Due to the constant change in transmission patterns, treatment, perceptions, attitudes, etc., trainees should be reminded to consistently update their information regarding HIV/AIDS. With the VCT training programme in the 12-day schedule, latest information, resources and treatments available, we can provide better services to our clients.
11. **Ensure you get the right trainees.** Establish clear criteria for participation and communicate these criteria not only to the trainees but also to their employers.
12. **Ensure that an evaluation form is distributed to trainees at the end of the training.** These need to be completed by the trainees and placed in the 'evaluation box' to be collected by the trainer once all the forms have been submitted.
13. **Consider the advantages of providing meals to the trainees.** The training course follows a very strict timetable. It is therefore essential that sessions commence and conclude according to the schedule. The provision of morning tea, lunch and afternoon tea at the site of training has the advantage of ensuring that all trainees promptly return from breaks. It also creates flexibility within the programme should there be a need to shorten breaks or complete work within a break. Further, it contributes to the general satisfaction of trainees and allows them to focus on the study material to a greater degree.

Proposed training schedules

12-day training of HIV counsellors

Venue: _____

Date: _____ To: _____

Day 1:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
08.30–09.00			Registration	
09.00–09.30			Inauguration of the training programme	
09.30–09.45			<i>Tea break</i>	
09.45–10.15			Ice-breaking and interaction with trainees, pre-training evaluation	
10.15–11.15	1.1	1.00	Overview of HIV/AIDS epidemiology country and global scenario	
11.15–12.45	1.2	1.30	Introduction to HIV testing	
12.45–13.45			<i>Lunch</i>	
13.45–15.15	1.3	1.30	Role of VCT in prevention and care of HIV/AIDS	
15.15–15.30			<i>Tea break</i>	
15.30–17.00	2.1	1.30	Orientation to HIV/AIDS counselling	

Day 2:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	2.2	1.30	Values and attitudes of a counsellor	
10.30–10.45			<i>Tea break</i>	
10.45–12.45	2.3	2.00	Counselling: Microskills	
12.45–13.45			<i>Lunch</i>	
13.45–15.15	2.4	1.30	Stages and process of counselling	
15.15–15.45			<i>Tea break</i>	
15.45–17.15	2.5	1.30	Behaviour change counselling: HIV transmission	

Day 3:**Date:** _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	2.6	6.00	Clinical risk assessment and HIV pre-test counselling	
10.30–10.45			<i>Tea break</i>	
10.45–12.45			Clinical risk assessment and HIV pre-test counselling	
12.45–13.45			<i>Lunch</i>	
13.45–15.00			Clinical risk assessment and HIV pre-test counselling	
15.00–15.15			<i>Tea break</i>	
15.15–16.30			Clinical risk assessment and HIV pre-test counselling	

Day 4:**Date:** _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	2.7	4.00	HIV post-test counselling	
10.30–10.45			<i>Tea break</i>	
10.45–13.15			HIV post-test counselling	
13.15–14.15			<i>Lunch</i>	
14.15–15.15	6.2	1.00	Condom promotion and STI	
15.15–15.30	6.3	1.00	<i>Tea break</i>	
15.30–16.30			HIV–TB co-infection	

Day 5:**Date:** _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	3.1	1.30	Role of PPTCT in HIV prevention	
10.30–10.45	3.2	1.30	<i>Tea break</i>	
10.45–12.15			Counselling for PPTCT	
12.15–13.15			<i>Lunch</i>	
13.15–16.30		3.15	Field visit (VCTC/PPTCT centre)	

Day 6:**Date:** _____**Holiday**

Day 7:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	3.3	1.30	Case management in PPTCT	
10.30–10.45			<i>Tea break</i>	
10.45–12.45	3.4	2.00	Infant feeding in the context of HIV	
12.45–13.45			<i>Lunch</i>	
13.45–15.45	4.3	2.00	Targeted VCTC intervention: Counselling youth and children	
15.45–16.00			<i>Tea break</i>	
16.00–17.30	4.6	1.30	Targeted VCTC intervention: Mobile population	

Day 8:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	4.1	1.30	Targeted VCTC intervention: IDU	
10.30–10.45			<i>Tea break</i>	
10.45–12.15	4.4	1.30	Targeted VCTC intervention: MSM	
12.15–13.15			<i>Lunch</i>	
13.15–14.45	4.2	1.30	Targeted VCTC intervention: Sex workers	
14.45–15.00			<i>Tea break</i>	
15.00–16.30	4.6	1.30	Targeted VCTC intervention: Prisoners	

Day 9:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	5.1	3.00	Counselling: ART	
10.30–10.45			<i>Tea break</i>	
10.45–12.15			Counselling: ART	
12.15–13.15			<i>Lunch</i>	
13.15–17.00		3.45	Field Visit (ART centre/Care NGO)	

Day 10:**Date:** _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.00	5.2	1.00	Counselling in HIV/AIDS home-based care (HBC) settings	
10.00–10.15			<i>Tea break</i>	
10.15–11.15	5.3	1.00	The role of diet and nutrition for people living with HIV/AIDS (PLHA)	
11.15–12.15	7.1	1.00	Group therapy	
12.15–13.15			<i>Lunch</i>	
13.15–14.15	7.2	1.00	Family and marital therapy	
14.15–15.15	7.4	1.00	Crisis intervention and problem solving	
15.15–15.30			<i>Tea break</i>	
15.30–16.30	7.9	1.00	Legal–ethical issues relating to HIV/AIDS	

Day 11:**Date:** _____

Time	Module number	Time allotted (hours)	Topic	Resource person
9.00–10.30	7.3	1.30	Counselling for sexual assault	
10.00–10.15			<i>Tea break</i>	
10.45–12.15	7.5	1.30	USP and PEP	
12.15–13.15			<i>Lunch</i>	
13.15–15.45	7.11	1.30	Grief and bereavement counselling	
15.45–16.00			<i>Tea break</i>	
16.00–17.00	7.8	1.00	Mental health issues in HIV/AIDS	

Day 12:**Date:** _____

Time	Module number	Time allotted (hours)	Topic	Resource person
9.00–10.00	7.6	1.00	Management of psychological distress	
10.00–10.15			<i>Tea break</i>	
10.15–11.15	7.7	1.00	Suicide risk assessment and management for HIV/AIDS	
11.15–12.15	7.10	1.00	Identification and management of caregivers and counsellors burn-out	
12.15–13.15			<i>Lunch</i>	
13.15–14.15		1.00	Record maintenance and monthly reporting to SACS / NACO	
14.15–14.45			Post training evaluation	
14.45–15.00			<i>Tea Break</i>	
15.00–17.00			Valedictory session and next steps	

5-day training of HIV counsellors

Venue: _____

Date: _____

To: _____

Day 1:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
08.30–09.00			Registration	
09.00–09.30			Inauguration of the training programme	
09.30–09.45			<i>Tea break</i>	
09.45–10.15			Ice-breaking and interaction with trainees, pre-training evaluation	
10.15–11.15	1.1	1.00	Overview of HIV/AIDS epidemiology country and global scenario	
11.15–12.45	1.2	1.30	Role of VCT in prevention and care of HIV/AIDS	
12.45–13.45			<i>Lunch</i>	
13.45–15.15	3.1	1.30	Role of PPTCT in prevention and care of HIV/AIDS	
15.15–15.30			<i>Tea break</i>	
15.30–17.00	2.1	1.30	Orientation to HIV/AIDS counselling	

Day 2:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	2.2	1.30	Values and attitudes of a counsellor	
10.30–10.45			<i>Tea break</i>	
10.45–12.45	2.3	2.00	Counselling: Microskills	
12.45–13.45			<i>Lunch</i>	
13.45–15.15	2.4	1.30	Stages and process of counselling	
15.15–15.30			<i>Tea break</i>	
15.30–17.00	2.5	1.30	Behaviour change counselling: HIV transmission	

Day 3:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	2.6	6.00	Clinical risk assessment and HIV pre-test counselling	
10.30–10.45			<i>Tea break</i>	
10.45–12.45			Clinical risk assessment and HIV pre-test counselling	
12.45–13.45			<i>Lunch</i>	
13.45–15.00			Clinical risk assessment and HIV pre-test counselling	
15.00–15.15			<i>Tea break</i>	
15.15–16.30			Clinical risk assessment and HIV pre-test counselling	

Day 4:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
09.00–10.30	2.7	4.00	HIV Post-test counselling	
10.30–10.45			<i>Tea break</i>	
10.45–13.15			HIV Post-test counselling	
13.15–14.15			<i>Lunch</i>	
14.15–15.15	6.2	1.00	Condom promotion and STI	
15.15–15.30			<i>Tea break</i>	
15.30–16.30	6.3	1.00	HIV–TB co-infection	
16.30–17.30			Record maintenance and monthly reporting to SACS/NACO	

Day 5:

Date: _____

Time	Module number	Time allotted (hours)	Topic	Resource person
9.00–10.00	3.4	2.00	Infant feeding in the context of HIV	
10.00–10.15			<i>Tea break</i>	
10.15–11.15			Infant feeding in the context of HIV	
11.15–13.15	5.1	3.00	Counselling: ART	
13.15–14.15			<i>Lunch</i>	
14.15–15.15			Counselling: ART	
15.15–15.30	7.6	1.30	<i>Tea break</i>	
15.30–16.30			Management of psychological distress	
16.30–17.00			Valedictory Session and next steps	

Field visit to PPTCT/VCT centres and ART centre/care NGO

Module 1

Submodule 1: Overview and epidemiological issues for voluntary counselling and testing

Time allotted: 1 hour

TRAINING MATERIALS

- Handout (HO), including those containing regional HIV/AIDS data (to be updated yearly, visit the NACO website: www.nacoonline.org)
- PowerPoint (PPT) presentation (to be updated yearly from the NACO website).
- Activity sheet
- Question box

CONTENTS

- What is HIV/AIDS?
- HIV/AIDS care and treatment
- HIV situation in India
- HIV trend analysis for Indian states

SESSION INSTRUCTIONS

1. Conduct Activity 1: The HIV transmission game.
2. Lecture using the PPT presentation. During the presentation, ask questions to keep trainees actively involved in the presentation, e.g. before showing patterns of infection among vulnerable subgroups, ask the trainees which groups they think are the most vulnerable to HIV infection.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 1

Submodule 1: Overview and epidemiological issues for voluntary counselling and testing

INSTRUCTIONS

Activity 1: 'The HIV transmission game'

Objective: To help trainees experience how quickly HIV can spread.

Methodology: Role-play

Time allotted: 20 minutes

- Prepare folded slips of paper, one for each trainee and one for yourself—25% marked with a '+' (plus) sign, 75% with a '-' (a minus) sign. Keep one for yourself too, making sure it has a '+' sign on it.
- Ask each trainee to take a slip of paper from a box or a hat. Emphasize that no one should look at his/her slip of paper until the end of the exercise.
- Ask the trainees to move freely about the room, stopping to greet trainees by shaking their hand. Do this yourself as well.
- After each person has greeted 4 or 5 trainees, stop the activity and ask everyone to look at their slips of paper.
- Ask all those who have a '+' (plus) sign on their paper to come forward. Explain that these people are playing HIV-positive individuals. Reinforce the point that there is no risk of catching HIV through normal social greeting—this is a game to show how fast HIV can spread.
- Then ask all trainees who greeted anyone with a '+' (plus) sign on their slip of paper to come forward to join their friends. Explain that this game is pretending that these people are playing individuals at high risk of being infected with the HIV virus.
- Next, address the remaining participants. Explain that the status of these people is unknown. They may be friendly with HIV-infected individuals before they had acquired the infection; but in any case, they are at risk.
- Finally, ask the following questions, according to this game :
 - How many people were originally infected with the HIV virus?
 - How many are at high risk of being infected?
 - How many others are at risk of being infected?
 - How many remain uninfected?
 - What does this activity tell us about the spread of HIV in the community?

Module 1

Submodule 2: Introduction to HIV testing

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Laboratory diagnosis of HIV infection
- Situations when HIV antibody assays cannot be used to diagnose HIV infection
- Counselling issues related to HIV antibody result provision
- Assays for staging HIV disease and monitoring the efficacy of ART
- Ensuring the quality of HIV testing in VCT services

SESSION INSTRUCTIONS

1. Lecture using the PPT presentation.
2. Ask questions to keep trainees actively involved, e.g. ask trainees to write a list of what they perceive are the strengths and weaknesses of rapid tests for VCT in their cultural and workplace settings.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 1

Submodule 3: Role of VCT in HIV prevention, care and support

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- What is VCT?
- VCT versus traditional health-care services
- VCT: The gateway to HIV prevention and care
- Purpose of HIV testing
- United Nation's Policy on VCT
- Counselling in VCT
- Legislation and public education to prevent discrimination
- Quality control
- Need to scale up VCT services
- Evidence of the effectiveness of VCT in HIV prevention and care
- Beneficial disclosure and ethical partner notification
- Requirements for successful VCT implementation
- Public health challenges

SESSION INSTRUCTIONS

1. Conduct Activity 1: Maintaining confidentiality.
2. Lecture using the PPT presentation.
3. Ask questions to keep trainees actively involved, e.g. before showing patterns of infection among vulnerable subgroups, ask trainees which groups they think are the most vulnerable to HIV infection.
4. Conduct Activity 2: Voluntary versus mandatory testing.
5. Summarize the key points of the session.
6. Ask the group if they have any questions and remind them of the question box.

Module 1

Submodule 3: Role of VCT in HIV prevention, care and support

INSTRUCTIONS

Activity 1

- Divide trainees into three small groups and nominate a spokesperson for the group.
- Each group only has only 10 minutes to prepare. Presentations to the larger group should not be longer than 10 minutes.

Activity 2

- Divide trainees into two groups A and B. Nominate a spokesperson for each group.
- Ask group A to discuss advantages and disadvantages of voluntary testing and group B on mandatory testing. Give them 10 minutes to prepare.

ACTIVITY 1

Group 1

You are asked by your hospital to justify why VCT is important. The Director of the hospital has asked you to make a short 10 minute presentation at the staff meeting. The Director does not see any reason why testing cannot proceed as it already does in the hospital where blood is collected and the patient is told that they must have a HIV test. The Director also says that they will provide health information about HIV in a brochure.

Group 2

You have been asked to provide a briefing paper for an advertising company that is going to market VCT to the community. You will need to think about how to explain to the general public about what VCT is and why they may want to attend for VCT. They will also need to know about privacy and confidentiality.

Group 3

Many VCT services have difficulty attracting men. How could we market VCT to men? Before you decide what to do it may be useful to discuss the reasons why men may not request or attend VCT services.

Module 2

Submodule 1: Orientation to HIV and AIDS counselling

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- Handout (HO)
- PowerPoint (PPT) presentation
- Activity sheet
- Question box

CONTENTS

- What is counselling?
- Counselling and health education
- Definition of HIV/AIDS counselling
- Aims and importance of HIV/AIDS counselling
- Methods of support

SESSION INSTRUCTIONS

1. Conduct Activity 1: Trust walk.
2. Lecture using the PPT presentation.
3. Conduct Activity 2: Brainstorm the definition of HIV/AIDS counselling.
4. Continue with the PPT presentation.
5. Conduct Activity 3: Case study
6. Summarize the key points of the session.
7. Ask the group if they have any questions and remind them of the question box.

Module 2

Submodule 1: Orientation to HIV and AIDS counselling

INSTRUCTIONS

Activity 1: Trust walk

- Do not specify that the activity is called a trust walk
- Do not specify that each group will receive a separate set of instructions
- Instruct each group separately; with each not knowing what instructions the other group has received

Material: Scarf or a lengthy material for a blindfold

Time allotted: 25 minutes

Part 1

Pair the trainees, with one being blindfolded and the other acting as the guide. In complete silence, the guide should lead the blindfolded person to an outdoor area. The guide should stop periodically and silently direct the blindfolded person to touch an object or smell or listen. All communication is to be **non-verbal**. Explain that you will visually signal them to rally at a shaded spot in about 8–10 minutes, and the guide should look out for your signal; also they are to remain within the eyesight of the facilitator at all times and not wander off. As the pairs move about, the facilitator moves among the pairs making strange noises, stamping his or her feet, whistling, jangling keys, clapping, or brushing the blindfolded trainees with a scarf. If you are in or near a parking area and a car drives by, signal the driver to honk. Encourage the teams to walk, CAREFULLY, near or across a lane where cars are occasionally moving. The idea is to create some level of concern on the part of the blindfolded trainee while avoiding real danger and not pushing the blindfolded partner into a feeling of terror.

Part 2

Interchange the guides of the blindfolded trainees. Instruct the guide to lead the blindfolded person to an outdoor area. The guide should stop periodically and direct the blindfolded person to touch an object or smell or listen. The same procedure as Part I is to be followed but encourage the guide to **verbally** interact with his partner and instruct him through the walk.

Debrief

The facilitator asks the trainees to arrange their chairs in a circle and asks them what they thought or felt during the exercise. If you need to break the ice, ask whether it was easier to lead or be led. Many people will conclude that they are not as trusting as they thought. Others will observe that they become anxious when they are not in control. Did any of the blindfolded trainees (Part 2) notice that their partner had changed? What did that do to the rapport that they had established as a pair through non-verbal communication? What were the insights or 'Ah-ha's' of this exercise?

Activity 2: Brainstroming session

Brainstorm the definition of HIV/AIDS counselling

Activity 3: Case study

Present the case.

Rani is a 30-year-old female, married for two years and has come to the antenatal care (ANC) clinic. During the pre-test counselling session, she denies a history of risky behaviour. Her test result is HIV-positive. She says that she had sex with a boy four years back. Her family is not aware of it. She does not want to 'disclose' her seropositive status to her husband, as she is afraid of being rejected.

Debrief

1. What do you think is Rani's problem?
2. Discuss the problem expressed.
3. What should be the role of the counsellor?
4. How would you help Rani solve her problems?
5. Summarize the key points and discuss why we need counselling in HIV/AIDS and define VCT.

Module 2

Submodule 2: Values and attitudes of a counsellor

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- Qualities and attributes of an effective counsellor
- Attitudes, values and beliefs
- Managing counsellor's discomfort

SESSION INSTRUCTIONS

1. Commence the session with Activity 1: Brainstorm the qualities of an effective counsellor.
2. Lecture using the PPT presentation.
3. Conduct Activity 2: Assessment of self as an effective counsellor.
4. Continue with the PPT presentation.
5. Conduct Activity 3: Role-play.
6. Conduct Activity 4: Controversial statements.
7. Conduct Activity 5: Emotional responses to certain words/terms.
8. Summarize the key points of the session.
9. Ask the group if they have any questions and remind them of the question box.

Module 2

Submodule 2: Values and attitudes of a counsellor

INSTRUCTIONS

Activity 1: Brainstorm

- Ask the trainees what are the words that they can think of when they see the words 'effective counsellor'?
- Brainstorm the qualities and attributes of an effective counsellor.

Activity 2: Assessment of self as an effective counsellor

1. Provide each trainee with the self-evaluation form.
2. Discuss each statement in the form.
3. Ask the trainees to rate themselves.
4. Inform them that the form will remain with them. Ask them to answer honestly. Emphasize that this is a self-evaluation form.
5. Hold a general discussion to sum up the activity.

Activity 3: Role-play

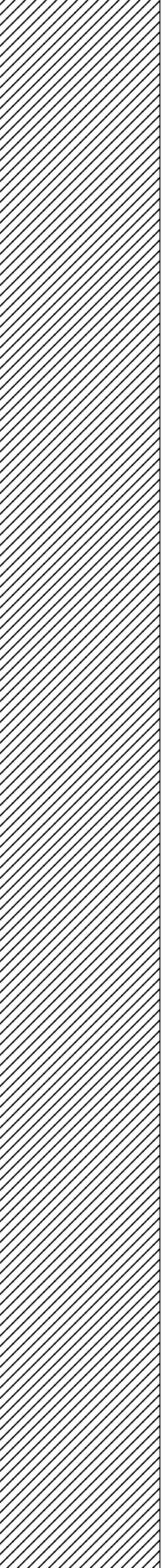
Conduct the role-play as per guidelines provided in the introduction to the Manual using the case study given in Activity 3, Module 2, Submodule 1.

Form a group of three persons—one counsellor, one client and one observer.

The client will enact a problem. The counsellor uses different skills during the counselling process. The observer carefully records the ongoing process of counselling. The trainer moves to each group and makes observations. During feedback session discuss the stages and process of counselling.

Activity 4: Controversial statements

1. Divide trainees into small groups.
2. Provide each trainee with a copy of the form given below.
3. Ask the trainees to read each sentence and mark 'A' if they agree with the statement and mark 'D' if they disagree.
4. When trainees have filled the form, ask them to discuss the answers within the group.
5. Emphasize that there are no correct or wrong answers.
6. Summarize the activity by explaining that the difference within the group reflects different values, attitudes and beliefs.



Activity 5

1. Provide each trainee with the form presented below
2. Read the instructions presented in the form aloud.
3. Have trainees fill the form.
4. Assure confidentiality. Let the trainees know there are no right or wrong answers.
5. Encourage trainees to read their answers aloud.
6. Conduct a discussion. Using answers shared by trainees summarize the topic on values and attitudes of a counsellor.

ACTIVITY 2: ASSESSMENT OF SELF AS AN EFFECTIVE COUNSELLOR

Checklist for interactive counselling

You can check your own progress in counselling clients at the clinic

	Always	At times	Rarely
You create rapport by:			
• Greeting your client in a culturally acceptable way • Arranging for client privacy • Sitting facing or close to your client			
You maintain two-way interaction by:			
• Asking open-ended questions and using encouraging remarks • Listening attentively and observing without interrupting or writing • Encouraging the client to talk and ask questions			
You find out what the client knows about:			
• The problem, the issue, or concern under discussion • Its effects on his or her health and/or family/child			
You explain facts about the problem or issue, especially:			
• Symptoms and effects of the problem • Possible technical/factual solutions • Rumours, misconceptions and relevant facts • Need for treatment, continuity, behaviour change, or referral, if necessary • Causes of the problem or potential problem			
You clarify or check the client's understanding of the facts (causes, effects, solutions and possible next step) by:			
• Asking the client to repeat (or restate) the basic factual information in his/her own words			

	Always	At times	Rarely
• Clarifying misunderstood information • Asking the client if he/she has any questions • Answering the client's questions politely and completely			
You help the client determine what to do about the problem, or issue, or concern by:			
• Encouraging the client to consider the need to act on the problem; explain the consequences if it is ignored • Encouraging the client to make a decision that is safest and most practical in the circumstances • Provides required service or referral when appropriate			
You genuinely invite the client to return to the clinic whenever they need to, e.g. if they have more questions. You also tell the client about the suitable hours of service.			

ACTIVITY 4

Fill in the blanks

Write A for 'agree' and D for 'disagree'.

1. ____ Women with HIV infection should not have children.
2. ____ People with AIDS should be allowed to continue work.
3. ____ AIDS is mainly a problem of people indulging in immoral behaviour.
4. ____ Men who have sex with men (MSM) indulge in abnormal sexual behaviour.
5. ____ People with HIV infection should be isolated to prevent further transmission.
6. ____ It is a collective responsibility to care for people with HIV infection.
7. ____ I would feel uncomfortable inviting someone with HIV infection to my house.
8. ____ Surgeons should screen all patients for HIV infection before surgery.
9. ____ I would feel uncomfortable discussing sexuality with a person of the opposite sex.
10. ____ Injecting drug users (IDUs) should compulsorily be tested for HIV.
11. ____ It is alright for men to have sex before marriage.
12. ____ Schoolchildren should not be educated about safe sex.
13. ____ Women should never have extramarital sexual relations.
14. ____ All professional blood donors should be jailed.
15. ____ It is difficult for male counsellors to talk to women clients about condom use.
16. ____ HIV-infected pregnant women should abort their fetus.
17. ____ HIV test results should not be disclosed to the spouse/partner.
18. ____ Males should produce an HIV-free certificate before marriage.
19. ____ HIV-infected women should feed their infants.
20. ____ Unmarried persons should not have sex.

ACTIVITY 5: EMOTIONAL RESPONSE TO CERTAIN WORDS/TERMS

List two words that spontaneously come to your mind when you think of the following words. As far as possible, list words that reflect your emotional response to the given word instead of a mere translation or definition of the word. For example, two words for sex may be: 1. Fun; 2. Immoral.

Sex worker	1. _____	2. _____
Professional blood donor	1. _____	2. _____
Pregnancy	1. _____	2. _____
IDU	1. _____	2. _____
Teenager	1. _____	2. _____
Condom	1. _____	2. _____
STI	1. _____	2. _____
Homosexual	1. _____	2. _____
Masturbation	1. _____	2. _____
Wife	1. _____	2. _____
Boyfriend	1. _____	2. _____
AIDS	1. _____	2. _____
Truck driver	1. _____	2. _____
TBsss	1. _____	2. _____
Orgasm	1. _____	2. _____
Erection	1. _____	2. _____
Abortion	1. _____	2. _____
Rape	1. _____	2. _____
Multiple sex partners	1. _____	2. _____
Counsellor	1. _____	2. _____

Module 2

Submodule 3: Counselling: Micro-skills

Time allotted: 2 hours

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- Active listening
- Questioning
- Using silence
- Accurate empathy

SESSION INSTRUCTIONS

1. Conduct Activity 1: Counselling skills.
 - Facilitators should explain the activity and followed by debriefing/discussion.
2. Lecture using the PPT presentation. During the presentation, solicit comments and ask trainees questions to keep them actively involved.
3. Conduct Activity 2: Listening skills.
 - Use the PPT presentation on active listening to debrief the trainees.
4. Conduct Activity 3: Quiz.
 - Continue the lecture using the PPT presentation.
5. Summarize the key points of the session.
6. Ask the group if they have any questions and remind them of the question box.

Module 2

Submodule 3: Counselling: Micro-skills

INSTRUCTIONS

Activity 1: Counselling skills

Time allotted: 20 minutes

1. Divide the trainees into two pairs.
2. One of the pair will be called the counsellor, the other client.
3. Provide each group instructions as presented below.
4. The client group should not know the instructions provided to the counsellor.

Counsellor

- Your job in this activity is to be a 'bad' counsellor, but DO NOT tell your client you have been asked to be bad—this must be kept confidential! The purpose of the activity will be explained afterwards and the clients will be told that you were asked to be 'bad'.
- Find your partner, who has been nominated as your 'client'.
- Ask your client to tell you about an achievement in their lives, a time they did something they were proud of and happy about.
- As your client begins to answer, demonstrate poor counselling skills, e.g. look at your watch, write notes, play with your hair, look around the room, look for something in your bag, fix your make-up, play with your jewellery, talk to someone else across the room, interrupt and tell your own story, display inappropriate facial expressions, sit with a forbidding posture, look disinterested, do not encourage the conversation, do not ask questions, etc. Remember that you need to be as bad a counsellor as possible.

Clients

- Your job in this activity is to be a 'client'.
- Find your partner, who has been nominated as your counsellor, and participate in their counselling session as the 'client'.
- You need to think of an achievement in your life, a time you did something you were proud of and happy about.
- It should be something you feel comfortable about and are able to discuss for five minutes.

- The ‘counsellors’ will be practising their basic skills during this activity.

Debrief

1. After the activity is over, ask the ‘client’ what they felt about the session. Was the ‘counsellor’ effective? If not, then in what ways did the ‘counsellor’ fail to be effective?
2. Close the activity by letting the client group know that you had instructed counsellors to act as bad counsellors.
3. What are your observations of the situation now?
4. What did you feel like when you did not receive attention?
5. Discuss as a group what was wrong about the situation.

Activity 2: Listening skills

The group should be divided into subgroups of three with each member playing one of the following roles: speaker, listener, and observer. Each person will play each role once in this activity, so each subgroup needs to decide who will play which role first.

Objective

The purpose of this activity is to give each trainee the opportunity to learn how to use verbal and non-verbal communication skills and become a better listener.

To the speaker

Your task is to talk about something that is important for you: your job or family, a decision or a question. The activity will be more helpful if you talk about something you really care about, although role-playing is possible. You may find yourself in the midst of discussing something important when the allotted time runs out. If this happens, you could arrange with the person listening to continue later, after work session or during a break.

To the listener

Your task is to practise the skills learnt in the session: eye contact, body language, silence and verbal minimal encouragers. Don’t panic! Just concentrate on following the speaker’s chain of thought. Try to limit your responses to the skills discussed in this session.

To the observer

Your task is to observe the listener’s verbal and non-verbal skills. Observe and count only as many behaviours (eye contact, body posture, verbal minimal encouragers, topic jumping) as you can manage with relative accuracy.

Debrief

1. The first speaker talks with the listener for three to four minutes.
2. The listener then discusses their listening experience with the other two members of the subgroup.
3. Listener: What was comfortable? Difficult? Did you stay with the speaker?
4. Speaker: shares their feelings about the listener's response.
5. Speaker: Did you feel listened to? Was it helpful? Did the listener have any habits you found distracting?
6. The observer then shares observations. This sharing process should take about three or four minutes.
7. How are these skills relevant to their work?
8. Where else would they be useful?
9. Go around the group so that you have a chance to share at least one thing you have learnt about yourselves in this activity session.

Now everyone changes roles. The listener becomes the speaker, the speaker the observer, and the observer the listener. Go through five minutes of talking and listening, and five minutes of exchanging remarks twice more so that each person plays each role once.

The entire activity should take about 25 minutes.

Activity 3: Quiz

1. Provide each trainee with the format given below
2. Ask them to read each question and mark against it if it is an open-ended or close-ended question.
3. Review the questions in a large group. Ask trainees to speak out their answers loudly. Discuss and correct answers where required.

ACTIVITY 3: QUIZ

- | | |
|--|---------------------|
| 1. You always practise safe sex, don't you? | Closed/open/leading |
| 2. What are some of the difficulties you could face when using a condom? | Closed/open/leading |
| 3. Do you take your medication? | Closed/open/leading |
| 4. You should tell your wife, shouldn't you? | Closed/open/leading |
| 5. When were the occasions that you shared needles? | Closed/open/leading |
| 6. What do you know about HIV? | Closed/open/leading |
| 7. Do you understand how HIV is transmitted? | Closed/open/leading |
| 8. Do you protect yourself from HIV? | Closed/open/leading |
| 9. What are the different ways you could protect yourself from HIV? | Closed/open/leading |
| 10. How do you clean your injecting equipment? | Closed/open/leading |
| 11. Have you ever had a blood transfusion? | Closed/open/leading |
| 12. Who could you talk to for support if you were to test HIV-positive? | Closed/open/leading |

Module 2

Submodule 4: Stages and process of counselling

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- What is counselling?
- Some assumptions in the counselling process
- Characteristics of counsellors' attitude
- Skills of counselling
- Stages of counselling

SESSION INSTRUCTIONS

1. Discuss with the group their knowledge and understanding of the stages and processes of counselling.
2. Lecture using the PPT presentation, asking the trainees to share their experience during the presentation.
3. Conduct Activity 1: Role-play.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 2

Submodule 4: Stages and process of counselling

INSTRUCTIONS

Activity 1: Role-play

Based on the guidelines provided in the Introduction of this Manual, conduct role-play sessions. Emphasize that the counsellor should use the skills presented in this session. Debrief after the role-play.

ACTIVITY 1: ROLE-PLAY

Case study 1

A 30-year-old man goes to his local hospital for a health check-up. While waiting to see the doctor, he asks if he can see a counsellor to discuss some problems in his family. He tells you (the counsellor) that he had discovered that he was HIV-positive three years back when he applied for a visa to work overseas. He is not currently on any medication. He says that he has had a cough with sputum for three weeks. He has lost weight and also sweats excessively in bed at night.

Debrief

What do you think might be wrong with the client? What specific information in the case are you basing this on? What are the treatment, care and referral options for the client in your setting?

Case study 2

A 36-year-old male went to a hospital and had his CD4 count measured. He reports that the doctor said that it was so low that he needed to start on medication. The doctor appears to have given him ART (a combination of d4T, 3TC and nevirapine). He has been taking the medicines for two weeks. He reports that he has a rash all over his body and does not feel well.

Debrief

What are the possible explanations for the rash? What are the treatment, care and referral options for the client in your setting?

Module 2

Submodule 5: Behaviour change communication: HIV transmission

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Condoms (for demonstration of use in the Activity)
- Question box

CONTENTS

- Consequences of unsafe behaviour
- Behaviour change models and HIV infection
- The process of behaviour change and adoption of safe behaviour
- Use of condoms
- Safe injecting
- Essential elements of behaviour change counselling for condom use and safe injecting
- Helping clients become aware of their risks
- Promotion of condoms, condom use and safe injecting

SESSION INSTRUCTIONS

1. Explain the four principles of HIV transmission and advise trainees to use the acronym: Exit, Survive, Sufficient and Enter (ESSE).
2. Engage the group in a discussion on how HIV infection spreads.
3. Lecture using the PPT presentation.
4. Conduct Activity 1: Demonstrate the use of a condom. Have each trainee demonstrate the use of condom.
5. Link this topic to
 - Module 4, submodules 1,2,5 and 6
 - Module 6, submodule 2.
6. Summarize the key points of the session.
7. Ask the group if they have any questions and remind them of the question box.

Module 2

Submodule 5: Behaviour change communication: HIV transmission

INSTRUCTIONS

Activity 1: Demonstration

How to use a male condom?

1. Provide each trainee with a condom.
2. Keep a few with the trainer.
3. Demonstrate the use of the condom step-wise—reading the expiry date on the packet, opening the packet and using it. Demonstrate how to identify the right side (see guidelines in HO).
4. Demonstrate how they can instruct clients on how and where to store condoms.
5. Have each trainee demonstrate the use of a condom.

Module 2

Submodule 6: Clinical risk assessment and HIV pre-test counselling

Time allotted: 6 hours

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheets
- Condoms (to demonstrate how to use them)
- Cards for risk game (with high risk, medium risk and low risk indicated on them)
- Overhead transparency sheet, projector and screen
- Pre-test form as per NACO guidelines
- Question box

CONTENTS

- Risk assessment in HIV/AIDS
- Need for detailed clinical risk assessment
- Aims of HIV pre-test counselling
- Process of pre-test counselling

SESSION INSTRUCTIONS

1. Introduce the objectives of the session.
2. Conduct Activity 1: Assessing personal risk
3. Lecture using the PPT presentation.
4. Conduct activity 2 to 5
5. Continue with the PPT presentation.
6. Summarize the key points of the session.
7. Ask the group if they have any questions and remind them of the question box.
8. Role-play, as per guidelines provided in the Introduction of this Manual.

Submodule 6: Clinical risk assessment and HIV pre-test counselling

INSTRUCTIONS

Activity 1: Assessing personal risk

This activity helps counsellors reflect on how they handle risk in their own lives. It increases their understanding of why other people take risks and helps them to examine their feelings about this. Before deciding to take an HIV test, people need time to think about what it may mean to discover they are HIV-positive. Many people are anxious about discussing their personal risk of HIV infection (often for the first time) and are worried about being judged.

1. Invite trainees to consider the following on their own for a few minutes:
'Think back on your own life and identify any occasion when you took a risk, related to sex and relationships, work or money. It may have been a small risk or a big one, but was very important to you at the time.'
 - What factors influenced your decision to take a risk?
 - What were your feelings at the time?
 - What was the result of taking that risk?
 - Do you generally take risks?
 - How do you view risk-taking in others? How does risk-taking among your friends affect you?
 - How does this affect your attitude towards the risk of HIV infection?

It may be useful to write these questions down.

After a few minutes, ask everyone to choose a partner and share as much of their situation as they wish. Each person should talk for a few minutes and then listen to the partner's story.

2. Invite everyone to join the full circle. Encourage them to explore links between how people deal with risk and ways in which it may affect their responses to HIV/AIDS. It may be useful to make the following points:
 - We often feel that it is all right to take risks if they turn out well. But we tend to blame others if things/ go wrong.
 - We are generally much less harsh in judging ourselves than we are in judging others. Is this fair?
 - We all take risks all the time.

3. Then invite participants to link this discussion with their counselling work. How can they introduce the subject of risky sexual behaviour without being judgemental? How can this be linked to information about safe sex and reducing the risk of HIV infection?

Source: Working with uncertainty. Published by FPA, England.

Activity 2: Risk game

Prepare cards indicating the following risks. Randomly distribute the cards to the trainees. Place three cards with high risk, medium risk and low risk indicated on them on the floor. Ask the participants to place their cards on the one indicating the appropriate level of risk. Have the group discuss the correct answers.

[The answers in italics are only to assist facilitators—DO NOT include these on the cards given to the trainees.]

- Blood splash to the eye during a delivery
—*Low risk only—only one case in the world, which was concentrated virus in a laboratory.*
- Cleaning up vomit
—*No—low risk for HB, HCV without gloves.*
- Sharing spoons and forks
—*No risk.*
- Using drugs before sex; using alcohol before sex
—*Moderate—high risk—less likely to be safe sex.*
- Withdrawal (before ejaculation)—an option for safe sex?
—*Low—moderate risk. Poor option for safe sex as the couple may ‘forget to withdraw’; also, virus present in the pre-ejaculate; risk for STIs.*
- Oral sex—man entering a woman’s mouth: Risk to woman?
—*Low—moderate for woman; no risk to man for HIV.*
- Vaginal sex—no condom, no ejaculation: Risk to woman?
—*Low—moderate risk. Poor option for safe sex as the couple may ‘forget to withdraw’; also virus present in the pre-ejaculate; risk for STIs.*
- Oral sex—with ejaculation (between men): Risk to the receptive man?
—*Low—moderate.*
- Sharing injecting equipment (e.g. swabs, water, mixing bowls)
—*Low for HIV; high for HBV and HBC.*
- Needle stick injury: ‘suture’ needle
—*Low: Solid bore needle, often a subcutaneous injury.*
- Sharing syringe/needle
—*High.*
- Vaginal sex—no condom, withdrawal then ejaculation: Risk to man?
—*Moderate—high—poor option for safer sex as the couple may ‘forget to*

withdraw’; also, virus present in the pre-ejaculate; risk for STIs and parasites.

- Penetrative anal intercourse—no condom, withdrawal then ejaculation
—*Moderate–high—poor option for safe sex as the couple may ‘forget to withdraw’; also, virus present in the pre-ejaculate; risk for STIs and parasites.*
- Vaginal sex—no condom, ejaculation: Risk to the woman?
—*High.*
- Receptive anal intercourse—no condom, no ejaculation
—*Moderate–high—poor option for safe sex as the couple may ‘forget to withdraw’; also, virus present in the pre-ejaculate; risk for STIs and parasites.*
- Needle stick injury: ‘venepuncture’ needle
—*Moderate level of risk dependent on factors such as depth of the puncture, etc. Emphasize the need to collect detailed information on exposure.*
- Sharing sex toys
—*Low–moderate. More information required on the type of the sex toy and circumstances.*
- Oral sex—with ejaculation (between men): Risk to the penetrating partner?
—*No risk for HIV, avoid if the receptive person has oral herpes.*
- Oral sex—male to male, no ejaculation: Risk to the receptive man?
—*No risk for HIV; possible risk for STIs parasite.*
- Oral sex—man entering a woman’s mouth: Risk to the man?
—*No risk; possible risk for herpes lesions.*
- Deep kissing
—*No risk for HIV.*
- Mosquito bite
—*No risk.*
- Crying—getting someone’s tears on yourself
—*No risk.*
- Sharing a toothbrush
—*No risk.*
- ‘Rimming’—contact between the mouth and the anus: Risk to the person performing?
—*No risk.*
- Mutual masturbation: Risk to either?
—*No–low risk depending on the context and behaviours.*
- Sex during menstruation—with a condom, without a condom.
—*With condom, low; without, high.*
- Tattooing
—*Requires further information on the method and context of tattooing—could be low, moderate or high for ritual ‘group’ tattooing.*

Activity 3: Risk Assessment

1. Use the trainer's overhead transparencies with the 'individual risk assessment activity worksheet'. Trainers should make several overhead transparencies for large group feedback.
2. Place the transparencies on the overhead projector and ask trainees to read all the cases as presented in activity 5
3. Complete the transparency form in front of the class by asking the trainees the relevant questions, e.g. 'Did this client share needles? When did this last occur? Is this in the window period? When should the next test occur?'. Work through all of the cases.
4. If a trainee offers an incorrect answer, ask the group if they agree with it?
5. Mark the responses on the transparency.

RISK EVALUATION FORM

Client code: _____

Client has a regular partner: Yes/No

Regular partner's status: HIV-positive/unknown/HIV-negative

Date of last test: _____

Client/partner* indicates history of STI infection: Yes/ No

Treatment referral required: Yes/ No

Client/partner* reports

symptoms of TB: Yes/ No

Treatment referral required: Yes/ No

Occupational exposure: Yes/ No

Date: Window period: Yes/No

Tattoo, scarification: Yes/ No

Date: Window period: Yes/No

Blood products: Yes/ No

Date: Window period: Yes/No

Vaginal intercourse: Yes/ No

Date: Window period: Yes/No

Oral sex: Yes/ No

Date: Window period: Yes/No

Anal intercourse: Yes/ No

Date: Window period: Yes/No

Sharing injecting equipment: Yes/ No

Date: Window period: Yes/No

Client risk was with a known

HIV-positive person: Yes/ No

Client is pregnant: Yes/ No

Stage of pregnancy: 1st trimester/2nd trimester/3rd trimester

Client/partner* is using

contraception regularly: Yes/ No

Client requires repeat HIV test due to window period exposure: Yes/No

Date for repeat retest:

* Circle either or both client/partner

Activity 4: Case study for risk education and assessment of self-risk

- Introduce yourself and explain your role to the client.
- Explain the difference between HIV and AIDS.
- Explain the window period. You could try using the script below:

When HIV infects a person's body, their body realizes that HIV is a virus that should not be in the body.

The immune system in the body begins to produce antibodies to try to kill the HIV and protect the person. The test used to check for HIV looks for these antibodies in the blood, and is called an antibody test.

It can take up to 12 weeks after infection with HIV for these antibodies to be produced.

This means that an HIV test cannot guarantee a person's HIV status as negative if they have had any risk for HIV infection in the 12 weeks immediately before the test. This time period of 12 weeks before the test is called the 'window period'.

- Briefly explain the general modes of transmission—unprotected sex, mother-to-child, sharing injecting equipment and infected blood products.
- Then explain that you need to discuss some things that may be very sensitive and private—offer the explanation given in the box.

I need to discuss some things today that perhaps we wouldn't normally discuss with others. I need to discuss these things to be able to:

1. Give you a realistic feedback on your risk of being infected—you may be worrying unnecessarily.
2. Ensure that you know how to keep yourself and your partner/s safe in the future—different practices carry different risks.
3. See if you have other potential health problems that this test will not identify—maybe I will need to do other types of tests.
4. If you have been infected, it is important to know when you most likely became infected—it may make a difference to the type of treatment we offer. We can evaluate this only if we know what you have been doing and when.

As you can see, these are some good reasons for us to talk openly, even though it may not be comfortable.

- Start the pre-test questionnaire by asking why the client is getting tested and whether the client has undergone the test before; then ask if they have had sex with women, men or both.
- Choose an appropriate place to commence moving from less sensitive areas to more sensitive ones. First, educate then ask if the client feels the risk applies to them.

- Complete the ‘counsellor only’ section of the form. Make sure you note down whether the client is in the window period or not and whether he/she requires retesting and when.

Using the guidelines given above discuss the case studies with the trainees.

Activity 5: Role-play training

Conduct the role-play as per guidelines provided in the Introduction of this Manual.

1. At the conclusion of each round of role-play, each triad (group of three) should provide a brief feedback on what they experienced during the role-play.
2. Then the class should form 3 groups—‘*counsellors*’, ‘*clients*’ and ‘*observers*’.
3. Provide trainees with ‘Pre-test Counselling Form’.

Then discuss the following questions:

- What made the client feel comfortable?
- What micro-skills were particularly important for the counsellor to employ?
- How did you manage to balance the provision of information while being responsive to the need of the client’s emotions?

ACTIVITY 4: CASE STUDY FOR RISK EDUCATION AND ASSESSMENT OF SELF-RISK

Case study 1

A 35-year-old man, married, with two young children (aged four and two years) has decided to undergo an HIV test at the suggestion of his doctor. This suggestion followed the recent diagnosis of gonorrhoea, an STI, on his last visit to the doctor.

He reluctantly reports that he has often had anal sex with other men, the most recent occasion being three weeks back. He reports that this usually occurs when he drinks alcohol and that he does not use condoms. His wife is unaware of his sexual practices. He does not use condoms with his wife. He reports that the most recent occasion of vaginal sex with his wife was two weeks back.

He is unsure of what he would do if he tested HIV-positive. He is particularly concerned about how he would tell his wife and how she may react.

Case study 2

This is the case of a 28-year-old, married woman. Last week, a doctor confirmed that she was six weeks pregnant. When she told her husband about the pregnancy, he confided that he was HIV-positive. For this reason, she has decided to undergo an HIV test. She is very upset with her current situation. She is angry with her husband, and worried for herself and her unborn child. Her husband told her that he had visited commercial sex workers. She reports that she most recently had unprotected vaginal sex with her husband two weeks back.

Case study 3

A 21-year-old man states that he has heard about HIV from some of his friends and has started to worry about whether he may be infected. He reports having had unprotected vaginal sex with several different female partners. The most recent occasion was about one week back.

A discussion also reveals that he has experimented with injecting drugs. He reports that the needles he used were shared and were not cleaned between use. He most recently experimented with drugs four months back.

Case study 4

A 26-year-old man states that he had previously undergone testing for HIV. His most recent test was two years back and at that time he was HIV-negative.

He identifies himself as homosexual and states that all his sexual partners have been male since he was about 20 years of age. He expects that his result will be

HIV-negative and states that he is testing 'just to be sure'. He reports that he usually practises safe sex and makes sure that he or his partner always withdraw when ejaculating if condoms were not used. His most recent withdrawal without condoms was three weeks back. During discussion, he recalls two occasions where the condoms had broken during sex. These occasions were both more than 12 weeks back.

ACTIVITY 5: ROLE-PLAY TRAINING

Conduct the role-play as per guidelines provided in the Introduction of this Manual.

Case Study 1

A 35-year-old man, Married, with two young children (aged four and two years) has decided to undergo an HIV test at the suggestion of his doctor. This suggestion followed the recent diagnosis of gonorrhoea, an STI, on his last visit to the doctor.

He reluctantly reports that he has often had anal sex with other men, the most recent occasion being three weeks back. He reports that this usually occurs when he drinks alcohol and that he does not use condoms. His wife is unaware of his sexual practices. He does not use condoms with his wife. He reports that the most recent occasion of vaginal sex with his wife was two weeks back.

He is unsure of what he would do if he tested HIV-positive. He is particularly concerned about how he would tell his wife and how she may react.

Case Study 2

A 21-year-old man states that he has heard about HIV from some of his friends and has started to worry about whether he may be infected. He reports having had unprotected sex with several different female partners. The most recent occasion was one week ago. A discussion also reveals that he has experimented with injecting drugs, and the needles he used were shared and were not cleaned between use. He most recently experimented with drugs four months back.

He reports that he has since been worried about HIV; he has not been eating well and has had difficulty in sleeping. He believes that he would be rejected by his family and friends if he were to test HIV-positive. He mentions that he would consider suicide should he test positive.

Case Study 3

A 23-year-old woman presents for a HIV test as she has become worried that she may have contracted HIV from her former husband. She has heard that he is unwell and there are rumours in the village that he has AIDS. She last had unprotected

vaginal sex with him two months back. She recalls that during the last few months of their relationship he complained of feeling constantly tired and coughed a lot. Their relationship broke up when he left her for another woman. She has not had other sexual partners. She now suspects that he had other sexual partners when he travelled up-country for work. The client's family is poor and lives in a slum area; they are annoyed that she has not stayed with her husband. Her family has indicated that they feel she should have stayed with her husband. She is not comfortable with voicing her fears about HIV to her family. The client is very upset and worried. She is convinced that she has HIV infection.

PRE-TEST COUNSELLING FORM

Note to counsellor: Confidentiality of the client information should be strictly maintained at all times.

1. Date: ____ / ____ / ____
2. Time: (start of session): _____
3. PID number: _____
4. VCTC code number: _____
5. Age: ____ years
6. Sex: M/F/Transgender
7. Education: standard: illiterate/1-5/6-8/8-10/11-12/Graduate/Post-graduate
8. Occupation: _____ (Migrant/Nonmigrant)
9. Monthly income in Rs: 0-2,500/2,501-5,000/5001-7,000/7,001-10,000/more than 10,000
10. Marital status: unmarried/ married/widowed/divorced/separated/living together
11. Referred by: Self/Doctor/NGO/CBO/Spouse/Family/Friends/Others _____
12. Medical history: (*Does your client currently have any medical problems or symptoms?*)
Nil/Recurrent fever/weight loss/cough/diarrhoea/STIs/TB/OIs/Others _____
13. Currently on treatment: _____
14. Tested before for HIV: How many times? ____ Last test (month/year): ____ / ____
Where (Place): ____ Result: ____

The form is to be filled in **AFTER** the counselling session with whatever information was discussed.

Counsellor instruction: Please explore the following issues with your client:

15. Risk assessment of the past six months: (perception of risk to self)

Q: Why has the client presented for counselling and testing?

Q: Why does your client think he/she is at risk of HIV?

(a) No risk (b) Perinatal (from mother to child)

(c) Contaminated blood through:

- | | |
|----------------------|---------|
| —Blood transfusion | —IDU |
| —Organ transplant | —Tattoo |
| —Needle stick injury | |

(d) Unprotected sex: ____ Vaginal ____ Anal

(e) Partner or family member infected

Client's most recent potential exposure to HIV

(how and when?): _____

16. Development of a risk reduction plan

- (a) Increase condom use (b) Reduce number of sexual partners
- (c) Reduce needle sharing (d) Reduce alcohol or drug use
- (e) Discussion with spouse/partner (f) Others

17. Client's vulnerabilities:

- (a) Unprotected sex with Males Females Hijras CSW
- (b) Use of drugs/alcohol during or before sex
- (c) Gender related (violence, rape, etc.)

18. Client's current psycho-social stressors

Q. What are currently your client's major worries in life?

- (a) Finances/debt (b) Addictions (alcohol/drugs)
- (c) Family (d) Violence
- (e) Loss of work or occupation (f) Sex related
- (g) Serious illness/death (h) Social
- (i) Others

List issues and psycho-social stressors discussed:

19. Client's anticipated psycho-social stressors

Q. What are anticipated concerns of your client in case of a positive HIV Test result?

- (a) Prior history of self harm/suicide attempt
- (b) Harm to others in case of positive test result
- (c) Signs of suicidal thoughts
- (Feeling of hopelessness/helplessness/overburdened/no options/social withdrawal)

20. Client's coping mechanisms

Q. How has your client coped with a crisis in the past, e.g. loss of job, death of spouse or partner, or relationship issues? Who helped your client?

List coping strategies discussed (including alcohol, violence, attempted suicide):

Q. What plans does your client have for managing the crisis associated with HIV/AIDS?

21. Client's social support systems

Q. In case your client has a crisis in his/her life, who provides support to him/her?

- (a) Immediate family (Spouse) (b) Extended family
(c) Friends (d) Other

Q. Who will accompany the client to pick up the HIV test result?

- (a) Immediate family (Spouse) (b) Extended family
(c) Friends (d) No one
(e) Others

22. Client's readiness to undergo HIV test

Q. Would your client like another appointment before deciding on the HIV test?

23. Client's readiness to involve partner

Q. Will your client bring his/her spouse or partner for counselling? If not, explain why?

24. Date for follow-up visit given: ____ / ____ / ____

25. List of referrals given: (counsellor should have a referral list prepared)

26. Counsellor's checklist:

- _____ Client's understanding of STI/HIV/AIDS addressed
_____ Information about STI/HIV/AIDS provided including
 a. modes of transmission
 b. nature of HIV/AIDS
_____ Misconceptions corrected
_____ Information about HIV test provided
 a. Nature of test and testing process
 b. Benefits and consequences

- c. What does a positive result mean
- d. What does a negative result mean
- e. Window period
- _____ Client's emotional preparedness for HIV test result assessed
- _____ Checked for suicidal ideation
- _____ Importance of post-test counselling explained
- _____ Information on 'living with HIV' provided (nutrition, ARVs) provided
- _____ Risk reduction counselling done
 - a. Safer sex practices
 - b. Condom use
 - c. Safe needle use (for IDUs)
- _____ Prevention counselling provided
- _____ Condom demonstration done and condoms provided
- _____ Willingness to involve partner in follow-up assessed
- _____ Informed consent obtained
- _____ Identification of TB symptoms undertaken
- _____ Referrals discussed and given
- _____ Follow-up arrangements discussed (date provided)

27. Counsellor's remarks:

28. Time (end of session): _____

29. Length of session (minutes): _____

30. Counsellor's signature and date: _____

Module 2

Submodule 7: HIV post-test counselling

Time allotted: 4 hours

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Overhead transparency sheet, projector and screen
- Post-test assessment form as per NACO guidelines
- Question box

CONTENTS

- Recap on pre-test counselling
- HIV post-test counselling
- Guidelines for the provision of negative HIV test results
- Guidelines for the provision of positive HIV test results
- Follow-up counselling
- Beneficial disclosure from VCT guidelines
- Other important issues

SESSION INSTRUCTIONS

1. Conduct Activity 1: Ask the group what they would require of a VCT service if they were presenting for HIV test results. Limit the discussion to not more than 5 minutes.
2. Lecture using the PPT presentation, on the general principles of post-test counselling, allowing trainees to contribute and elaborate on key issues.
3. Conduct Activity 2: Post-test counselling form, before telling the trainees about the guiding principles for HIV post-test counselling.
4. Conduct Activity 3: Role-play
5. Summarize the key points of the session.
6. Ask the group if they have any questions and remind them of the question box.

Module 2

Submodule 7: HIV post-test counselling

ACTIVITY 1: BRAINSTORM

What would the client require of a VCT service if they were presented with an HIV test result?

ACTIVITY 2

Inform the trainees that you will now move to training on post-test counselling for positive results. Inform them that you plan to introduce the topic with an experiential group activity.

- Note that this activity makes no assumptions about the trainees' HIV status and that you recognize that this may raise personal issues for the trainees. Offer an opportunity for the trainees to engage in a confidential debriefing session with a workshop facilitator should the need arise. This is important for the group, as there may be trainees or someone close to them who has been diagnosed with HIV.
- Position the overhead transparency sheet for results on the overhead projector without turning it on. Inform the trainees that you will now briefly switch off the lights.
- Ask trainees to think back to their first job and career progression to this day and to think about their plans for the future in terms of professional growth, family members and relationships, etc. for about 5 minutes. Ask them to visualize family members, partners and colleagues.
- Switch on the lights and turn on the overhead projector. Ask trainees to note the emotions they would have experienced had they been told that they were HIV-positive. They are not to reflect on how the clients would react but how they themselves would react.
- Ask trainees to share with the group the emotions and thoughts that they had during this activity.
- List and discuss their 'needs' at the moment of being informed of their HIV results, bearing in mind the items on the 'emotions' and 'thoughts' list.
- Emphasize that the exercise that has just been completed illustrates what goes through the minds of HIV-positive clients when they receive their results.
- Discuss the implications of these emotions for the type of counselling that needs to be conducted at this stage.

ACTIVITY 3: ROLE-PLAY

Using the role-play method discussed in the Introduction of this manual, conduct the following sessions:

Case study 1

This is a case of a 35-year-old man. He is married and has two young children 4 and 2 years of age. He has decided to have an HIV test done at the suggestion of his doctor. This suggestion followed the recent diagnosis of gonorrhoea, an STI, on his last visit to the doctor. He reluctantly reports that he often has sex with other men, the most recent occasion being 3 weeks ago. He reports that this usually occurs when he has been drinking alcohol and that he does not use condoms. His wife is unaware of his sexual practices. He does not use condoms with his wife. He most recently had sex with his wife 2 weeks ago. He is unsure what he would do if he tested HIV-positive. He is particularly concerned with how he would tell his wife and how she may react.

Case study 2

This is a case of a 21-year-old man. He states that he has heard about HIV from some of his friends and has started to worry about whether he may be infected. He reports having had unprotected sex with several different female partners. The most recent occasion would have been one week ago. Discussion also reveals that he has experimented with injecting drugs. He reports that the needles he used were shared and not cleaned between use.

He most recently experimented with drugs four months ago. He reports that since he has been worried about HIV, he has not been eating well and has had difficulty in sleeping. He believes that his family and friends would reject him if he were to test HIV-positive. He mentions that he has thought about suicide should he receive a positive result.

Case study 3

A 23-year-old woman presents for a HIV test as she has become worried that she may have contracted HIV from her former husband. She has heard that he is unwell and there are rumours in the village that he has AIDS. She last had unprotected vaginal sex with him 2 months ago. She recalls that during the last few months of their relationship, he complained of feeling constantly tired and coughed a lot. Their relationship broke up when he left her for another woman. She has not had other sexual partners. She now suspects that he had other sexual partners when he travelled for work. The client's family is poor and lives in a slum area; they are annoyed that she has not stayed with her husband. Her family have indicated that they feel she should have stayed with her husband. She is not comfortable raising her fears about

HIV with her family. The client is very upset and worried. She is convinced that she has HIV.

1. At the conclusion of each round of the role-play, each triad (group of three) should provide brief feedback to each other about their experience in the role-play.
2. Then the class should form three groups as '*counsellors*', '*clients*' and '*observers*' to discuss:
 - What made the client feel comfortable?
 - What micro-skills were particularly important for the counsellor to employ?
 - How did the trainees manage to balance the provision of information with being responsive to the need of the client's emotions?

POST-TEST COUNSELLING FORM (NACO)

Note to counsellor: Confidentiality of the client information should be strictly maintained at all times.

- | | |
|---|------------------------------------|
| 1. Date: ____ / ____ / ____ | 2. Time: (start of session): _____ |
| 3. PID number: _____ | 4. VCTC code number: _____ |
| 5. Type of visit: Post-test counselling/follow-up visit | |
| 6. Test result: positive/negative/indeterminate | |
| 7. Age: ____ years | 8. Sex: M/F/Transgender |

The form is to be filled in **AFTER** the counselling session with whatever information was discussed

For **NEGATIVE Result (9–13 and 22–28)**

9. Initial reaction

Surprise/resentment/guilt/happy/relaxed/others

Observe and discuss with client:

10. Assessment of any concerns (Window period)

Summary of discussions with the client:

NEGATIVE Result (contd)

11. Development of a risk reduction plan

- | | |
|------------------------------------|--------------------------------------|
| (a) Increase condom use | (b) Reduce number of sexual partners |
| (c) Reduce needle sharing | (d) Reduce alcohol or drug use |
| (e) Discussion with spouse/partner | (f) Others |

List risk reduction plan developed:

12. Willingness to change behaviour to decrease vulnerability ____ Yes/ ____ No

13. Need for HIV test after window period discussed ____ Yes/ ____ No

For POSITIVE Result (14–28)

14. Initial reaction

Acceptance/shock/fear/denial/suppressed emotion/anger/violence/grief/sadness/depression/anxiety/crying spells/suicidal ideation/withdrawal/resentment/others

Observe reaction and discuss with client:

15. Assessment of immediate concerns

Stigma/fear of rejection (discrimination)/loneliness/loss of prestige/loss of job/loss of income/loss of self esteem/family disclosure/fear of death/loss of health

Summary of discussions with the client

16. Assessment of other concerns

- | | |
|--|--------------------------------------|
| (a) Marriage counselling | (b) Partner notification and testing |
| (c) Disclosure to spouse or family | (d) Concerns about support systems |
| (e) STI medical follow-up | (f) TB follow-up |
| (g) Nutrition counselling | (h) Sex with spouse/partner |
| (i) Social/psychological support follow-up | (j) Social support and referrals |
| (k) Rights and responsibilities | (l) Others |

POSITIVE Result (contd)

Summary of discussions with the client

17. Risk-reduction strategies discussed

- (a) Increase condom use (b) Reduce number of sexual partners
(c) Reduce needle sharing (d) Reduce alcohol or drug use
(e) Others

Summary of discussions with the client:

18. Willingness to increase safer behaviour ____Yes / ____No**19. Referrals* and follow-up given (*counsellor should have a referral list prepared)**

- (a) Individual counselling (b) Family counselling
(c) Within the hospital (d) To medical doctor (nonhospital)
(e) Psychiatric intervention (f) Support groups/PLHA
(g) Intervention and workplace (h) Community intervention
(i) TB/MC center (j) ANC
(k) IDU interventions (l) Needle stick
(m) Marriage counselling (n) Legal

List referrals made (types and places):

20. Agreed to disclose HIV status to spouse/partner ____

Client's issues associated with disclosure to spouse/partner

21. Willingness to bring spouse/partner for counselling ____

Summary of discussions:

For POSITIVE and NEGATIVE result

22. Date for follow-up visit given: ____ / ____ / ____

23. List of referrals given: (counsellor should have a referral list prepared)

24. Counsellor checklist

For negative result:

- _____ Result given
- _____ Immediate concerns/questions assessed
- _____ Window period explained
- _____ Risk reduction strategy developed
- _____ Willingness to change behaviour assessed
- _____ Need for an HIV test after window period discussed
- _____ Follow-up appointment given

For positive result:

- _____ Result given
- _____ Discussion of the meaning of the result for the client
- _____ Dealt with immediate emotional concerns
- _____ Client able to understand and absorb the result
- _____ Discussion of personal, family and social implications
- _____ Checking of availability of immediate support
- _____ Discussion of follow-up care and support
- _____ Partner evaluation
- _____ Risk reduction strategy developed
- _____ Willingness to change behaviour assessed
- _____ Immediate plans, intentions and actions reviewed
- _____ Discussion of symptoms of TB and importance of early referral
- _____ Further support and referrals given (ANC, TB, STI)
- _____ Rights and responsibilities discussed
- _____ Legal support discussed
- _____ Follow-up appointment given
- _____ Disclosure discussed
- _____ Bring spouse for counselling discussed

25. Counsellor's remarks

26. Time (end of session): _____ 27. Length of session (minutes): _____

28. Counsellor's signature and date: _____

Module 3

Submodule 1: Role of PPTCT in HIV prevention, care and support

Time allotted: 1 hour

TRAINING MATERIALS

- Handout (HO)
- PowerPoint (PPT) presentation
- Question box

CONTENTS

- Epidemiology of mother-to-child HIV transmission
- Advantages of voluntary counselling and testing (VCT) for prospective parents
- The PPTCT programme in India
- Modes of HIV transmission from the mother to the child
- Integration of VCT into the existing maternal and child health system

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of the topic.
2. Lecture using the PPT presentation.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 3

Submodule 2: Counselling for the prevention of parent-to-child transmission of HIV

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Principal concepts and role of a counsellor in PPTCT
- Psychosocial consequences of HIV infection among women
- Emotional reaction of HIV-infected women
- Skills needed to provide effective counselling
- Partner disclosure-related violence
- Other counselling issues

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of counselling at the PPTCT.
2. Lecture using the PPT presentation.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 3

Submodule 3: Case management in the prevention of parent-to-child transmission of HIV

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Question box

CONTENTS

- Effects of HIV on pregnancy
- Measures to reduce transmission of HIV
- Women first diagnosed with HIV infection during pregnancy
- HIV-infected women who become pregnant
- PPTCT in HIV-infected
- Short-course ARV prophylaxis and treatment postpartum
- Adherence to therapy during pregnancy and postpartum
- Immediate postpartum care of women with unknown HIV status and HIV-infected women

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of the topic.
2. Lecture using the PPT presentation
3. Summarize the key points of the session
4. Ask the group if they have any questions and remind them of the question box.

Module 3

Submodule 4: Infant feeding in the context of HIV infection

Time allotted: 1 hours 15 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Question box

CONTENTS

- Basic facts about malnutrition, infant feeding and child survival
- Global recommendations for infant and young child feeding
- Feeding options
- Counselling and support for infant-feeding
- Complementary feeding after six months

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of infant feeding.
2. Lecture using the PPT presentation.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 4

Submodule 1: Targeted VCT intervention: Injecting drug users (IDUs)

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- Handout (HO)
- PowerPoint (PPT) presentation
- Question box

CONTENTS

- Introduction
- Social and ethical issues in the provision of VCT care and treatment to IDUs
- Role of VCT and prevention counselling
- Evidence for the effectiveness of VCT for IDUs
- Considerations and challenges in the testing of IDUs

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of and experience with IDUs.
2. Lecture using the PPT presentation.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 4

Submodule 2: Targeted VCT intervention: Sex workers

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Question box

CONTENTS

- Who are sex workers?
- A profile of commercial sex work in India
- Sex workers and the risk of HIV infection
- Vulnerability of HIV infection
- Service delivery settings
- Programmatic responses
- Prevention counselling
- Counselling HIV-positive sex workers
- Sex workers and psychological morbidity
- Key issues in service provisions

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of and experience with sex workers.
2. Lecture using the PPT presentation.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 4

Submodule 3: Targeted VCT intervention: Youth and children

Time allotted: 2 hours

TRAINING MATERIALS

- HO
- PPT presentation
- Question box

CONTENTS

- Why target young people
- Service issues for young people
- Psychosocial issues for young people
- Children infected by and affected by HIV
- HIV testing for children
- Communicating with children
- Issues for counsellors
- The counselling process

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of issues relating to counselling youth and children for HIV.
2. Lecture using the PPT presentation.
3. Accept question from the trainees.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 4

Submodule 4: Targeted VCT intervention: Men who have sex with men (MSM)

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Definition
- Categories of MSM
- The Humsafar MSM circle
- Risk of HIV/AIDS among MSM
- Theories of sexual orientation
- Sexually transmitted infections
- Why VCT for MSM?
- Constraints to programmes for MSM
- Strategies to access MSM
- VCT services for MSM

SESSION INSTRUCTIONS

1. Discuss with the group their understanding and experience of working with MSM.
2. Lecture using the PPT presentation.
3. Conduct Activity 1: Role-play.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 4

Submodule 4: Targeted VCT intervention: Men who have sex with men (MSM)

ROLE-PLAY

Divide the group into triads and work as per the guidelines for the role-play provided in the Introduction to this Manual.

CASE STUDY 1

Sameer, a 23-year-old boy is brought to the clinic by an outreach worker. He has studied up to the sixth standard. He came to the city in search of work and lives in a slum close by. He reports that he has family in the village, however, they have disowned him due to his sexual orientation.

CASE STUDY 2

Rajeev is a 27-year-old man working in a private company. He is highly educated and holds a good post at work. His family is not aware of his sexual orientation. His family would like him to get married. As Nikhil has had multiple partners, he visits the VCT for testing.

Module 4

Submodule 5: Targeted VCT intervention: Mobile populations

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- Vulnerability to HIV infection
- Programmatic responses
- Intervention at various stages of migration
- Issues in service provision for migrants and mobile populations
- Mandatory testing and human rights
- Follow-up with migrant workers

SESSION INSTRUCTIONS

1. Discuss with the group their knowledge, understanding and experience in dealing with mobile populations.
2. Lecture using the PPT presentation.
3. Conduct Activity 1: Role-play.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 4

Submodule 5: Targeted VCT intervention: Mobile populations

INSTRUCTIONS

Activity 1

Case study 1

Discuss the following with the trainees

- The client's risk behaviour
- The client's understanding and acceptance of risk behaviour
- The client's vulnerability to HIV/AIDS and other STIs
- Indicators of increased risk
- Risk-reduction strategies

Case study 2

Discuss with trainees

—The components of your counselling session in terms of testing, dealing with the HIV status of the woman and her children, support systems, and referral network.

ACTIVITY 1

Case study 1

A 23-year-old male labourer, married, with a child, migrates from a village to Mumbai for work for a period of four to five months. He reports that peer pressure and adjustment to the metropolitan lifestyle makes him join his friend for a drink at a bar near a red-light area. When urged on by his friends, he had relations with a commercial sex worker. He comes to the VCTC with complaints of genital warts.

Case study 2

Vimala, a 25-years-old female, widowed 2 months back, was referred by her GP following her husband's death due to AIDS. She has two children, 1 and 3 years of age. She still seems numb, and in shock and emotional turmoil.

Module 4

Submodule 6: Targeted VCT intervention: Prisoners

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- Prisoners and mental health
- Rates of HIV infection among prisoners
- HIV transmission in prisons and detention centres
- Key strategies for HIV/AIDs care and prevention

SESSION INSTRUCTIONS

1. Lecture using the PPT presentation. During the presentation, ask the trainees questions to keep them actively involved in the presentation.
2. Conduct Activity 1: VCT in prison.
3. Ask the trainees to design a flowchart of potential counselling, prevention and referral activities for prisoners.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 4

Submodule 6: Targeted VCT intervention: Prisoners

INSTRUCTION

Activity: VCT in prisons

1. Divide the trainees into three groups
2. Give each group three questions as given below.
3. Have the groups discuss and develop a plan as asked
4. Have each group select one trainee from among themselves as a representative who will share the group's discussion with all the trainees
5. Provide sufficient time for discussion
6. Ask the group representative to present the group's discussion to the larger group.

ACTIVITY: VCT IN PRISONS

Group 1

- Ask the trainees to design a flowchart of potential counselling, prevention and referral activities for prisons. While doing so, they should consider the following:
- How could a prisoner access VCT in a confidential manner?
- How could results be provided to prisoners (including calling up a prisoner to deliver results)?

Group 2

- Who would have access to medical records? How can security be ensured?
- What are the different ways to carry out HIV awareness and prevention activities?
- How could you organize medical attention for a prisoner with a serious HIV-related condition?

Group 3

- How could you manage pre-release VCT and prevention education?
- How might you manage issues relating to a prisoner diagnosed as HIV-positive?
- How can you help prisoners to disclose their HIV status to a spouse or a regular sexual partner?

Module 5

Submodule 1: Antiretroviral therapy: Counselling and medical aspects

Time allotted: 3 hours

TRAINING MATERIALS

- Handout (HO)
- PowerPoint (PPT) presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- Life-cycle of HIV and action points for antiretroviral agents
- Structure of HIV
- Side-effects of drugs
- The need for guidelines on adherence
- Significance of adherence to ART
- Challenges in taking ART
- Important factors that predict high adherence
- Role of counsellors in preparing the patient for ART
- Preparation of the patient
- Pre-ART adherence counselling
- Strategies and tools to enhance adherence

SESSION INSTRUCTIONS

1. Conduct Activity 1: Brainstorm—personal adherence to any medication regimen.
2. Lecture using the PPT presentation.
3. Link this module to Module 1, Submodule 1 (especially for epidemiology, viral replication and staging).
4. Conduct Activities 2 to 7.
5. Summarize the key points of the session.
6. Ask the group if they have any questions and remind them of the question box.

Module 5

Submodule 1: Antiretroviral therapy: Counselling and medical aspects

INSTRUCTIONS

Activity 1

Brainstorm: Personal adherence to any medication regimen

1. Ask all the trainees to stand.
2. Ask them to think about times in their lives when they were prescribed medication and tell only those who have always taken medication exactly as prescribed may sit down.
3. Ask those who remain standing to consider the occasion when they failed to comply with instructions or complete a course, and to think about why this happened.
4. Ask each person to give their reasons for non-adherence. Try to group these experiences under the following headings:
 - Beliefs about medication (e.g. 'It is better I stop because the drugs are toxic.')
 - Practical difficulty (e.g. 'I had to have the tablet within two hours of eating.')
 - Memory (e.g. 'I just forgot to take it.')
 - Social (e.g. 'I didn't want anyone to know I wasn't well and see me taking it.')
 - Misinformation (e.g. 'My symptoms disappeared, so I thought I was cured.')
5. Record their responses on an overhead transparency or on a whiteboard.
6. Remark that clients have the same difficulties.
7. That there are many reasons that contribute to non-adherence. Information provision clearly is not enough—they are health workers and had information but still did not adhere to their prescription.

Activity 2

Brainstorm: Biological aspects of HIV

Ask the group to list down the stages of viral replication and the possible targets of ART.

- Gp120 binds to CD4
- RNA is left loose in the host cell
- Reverse transcription occurs
- Proviral DNA is synthesized
- Proviral DNA integrates with the host cell DNA (integrase)

- Synthesis of mRNA (viral RNA)
- Synthesis of viral protein (protease)
- Assembly and budding of the virus
- Maturation of core proteins

The various possible targets of blocking the replication of the virus can be:

- Block binding of HIV to the target cell
- Block the cleavage of viral RNA and the one that inhibits transcriptase
- Inhibits the enzyme reverse transcriptase
- Block the enzyme integrase, which helps proviral DNA to be incorporated into the host cell chromosome
- Block the RNA to prevent production of viral protein
- Block the enzyme protease
- Inhibit viral budding

Activity 3

Ask the group to draw a table and write the names of antiretroviral drugs under the three classes which are currently in clinical use.

Classes of antiretroviral drugs

Currently, three classes of antiretroviral drugs are in clinical use. These are:

Nucleoside reverse transcriptase inhibitors (NRTIs)	Non-nucleoside reverse transcriptase inhibitors (NNRTIs)	Protease inhibitors (PIs) 3000

Activity 4

Brainstorm: Strategies to promote adherence

(adapted from *Adherence to antiretroviral therapy in adults: A guide for trainers*, Horizons/Population Council)

Divide trainees into three groups. Provide a list of strategies to discuss as presented below and ask the groups to discuss strategies to promote adherence. Select a leader from the group who would write the list on a flip chart and present to the larger group. Ask each group to discuss the pros and cons of each of the listed strategies, list practical strategies for their programme and patients.

List of strategies to discuss

- a. Counselling
- b. Pillboxes
- c. Electronic devices
- d. Telephone reminders
- e. Medication diaries
- f. Buddy system
- g. Pill charts
- h. Directly Observed Therapy (DOT)
- i. Incentives

Activity 5

Brainstorm: Patient preparedness for adherence

(adapted from *Adherence to antiretroviral therapy in adults: A guide for trainers*, Horizons/Population Council)

This activity is designed to improve the knowledge of trainees about patient preparation prior to initiating ART. The counsellor will build on the information provided in the handouts. The counsellor will lead the trainees through a brainstorming exercise to identify barriers to adherence and the role of the different health providers. The counsellor will ask trainees to list possible barriers for PLHA and ways to address them. The counsellor will use lead questions that are based on the handouts provided in this module enabling trainees to recall the issues discussed when going through the handouts. In case the group is too large, this activity may be done in two groups. Each group will present their findings.

Activity 6

Adherence training case studies

Divide the trainees into three groups and ask each group to discuss one case study along the outline given below. Ask each group to present the case and their findings to the larger group (follow the instructions).

Case Study 1

A 45-year-old man has been sent to you for counselling before starting HAART. This is his first preparatory session. He has some information on ARVs received from a radio programme. He has done primary school, lives alone and still works full-time at a car repair workshop. He has not disclosed his status to his family; his wife left him 5 years ago. He drinks alcohol most evenings. He has a CD4 count of 160 cells and has had oral thrush, herpes zoster and TB. Please conduct the first preparatory counselling session.

Case Study 2

A 35-year-old woman has come for the third preparatory counselling visit. She is eager to start her ARVs. She has studied up to primary school and lives with her husband who is also infected but not on treatment. She works part-time as a maid. She has a CD4 cell count of 96 cells but does not understand what it means. She has had meningitis last month and was hospitalized for 10 days. Discuss the counselling needs for this patient. Discuss the use of dummy pills, a pill diary, reminder 'cues' and literacy material. Assess her treatment readiness.

Case Study 3

A 28-year-old woman has come for her second preparatory counselling session. She works as a sex worker on the beachfront. She has a CD4 count of 35 cells and has had PCP, herpes zoster and meningitis in the previous year. She is a widow, living in a slum with two friends who also work as sex workers. She has completed high school. She has been losing weight steadily, feels weak and finds it difficult to concentrate. She has not been able to go to work for the past few weeks, as she has been feeling unwell. Her friends have been supporting her. She is keen on starting ART. She is planning to visit her family in a distant city next month.

Discuss

- Disease knowledge and status
- Barriers to treatment
- Factors that might influence adherence
- Use of adherence enhancement tools—dummy pills, a pill diary, reminder 'cues' and literacy material.

If time permits, each group can conduct actual counselling for the three cases.

Activity 7

Adherence training role plays

Using instructions on conducting role-plays (page xvi and annexure 2) conduct the following role-plays. Use the checklists provided below.

Role Play 1

An 18-year-old Ram tout with symptomatic HIV infection is started on first line ART (3TC/D4T/EFV) and is being followed in the ART centre at GHTM. He has had TB and cryptococcal meningitis last year. He lives with his girlfriend in rural areas and has just recently disclosed his HIV status to his girlfriend, so she knows about his treatment. He consumes moderate amounts of alcohol. At his 3-monthly visit it is noticed that he has failed to attend the ART centre on two occasions in the last month. His home district is Namakkal. He has been complaining of numbness and tingling in his feet.

Discuss the implications of this non-adherence and your adherence counselling plan highlighting the relevant issues (side effects, travel, change in routine, depression, alcohol). Conduct the session.

Role Play 2

Lakshmi is a 40-year-old widow who lives in the Dharavi slum with her four children. She is on first-line therapy (3TC/AZT/EFV) and fails to come to her second routine monthly visit ART centre. The community health worker visits her at home. She is unkempt and neighbours report she has become quiet, sad and withdrawn. She has not been eating anything because of nausea and vomiting. She is also complaining of pain in her abdomen. Her CD4 count was 23 cells at the time of starting ART. She has had TB and herpes zoster before starting ART.

Discuss the implications of this non-adherence and your adherence counselling plan, highlighting the issues relevant to the case. Conduct the session.

Role Play 3

Shankar is a 40-year-old bartender in a city hotel. He lives alone. He started ART (3TC/D4T/EFV) 7 months back. He has attended all his monthly appointments until the last 2 months when he had to be traced by a community health worker. He has been drinking heavily and says he is feeling better so has stopped treatment since last month. He had been complaining of changes in his appearance, sunken cheeks and fat around his abdomen. Liver function tests show raised SGOT/SGPT levels.

Discuss your adherence counselling plan highlighting issues relevant to this case. Conduct the session.

ANSWERS TO ACTIVITY 3

Classes of antiretroviral drugs

Currently, three classes of antiretroviral drugs are in clinical use. These are:

Nucleoside reverse transcriptase inhibitors (NRTIs)	Non-nucleoside reverse transcriptase inhibitors (NNRTIs)	Protease inhibitors (PIs) 3000
Zidovudine 750	Nevirapine 800	Saquinavir
Lamivudine 550–600	Delavirdine	Ritonavir 3500
Stavudine 550–600	Efavirenz 2180	Indinavir
Didanosine 1200		Amprenavir
Zalcitabine (ddC)		Lopinavir
Abacavir 5000		Nelfinavir

These drug target different points in the life cycle of a retrovirus. Another group of drugs, the integrase inhibitors, are still undergoing clinical trials.

ANSWERS TO ACTIVITY 5

List of Barriers to adherence and ways to address them

1. Communication difficulties (language, cultural differences, patient attitudes regarding treatment efficacy, lack of comprehension about treatment plan or regimen)
 - (i) Discuss in an open and non-judgemental way
 - (ii) Provide patients with scientific basis for treatment
 - (iii) Repeat and paraphrase
 - (iv) Use counsellors who speak the same language and understand the cultural context of the patient
2. Literacy levels
 - (i) Verbal repetition of adherence message, treatment plan and regimen
 - (ii) Use patient literacy materials
 - (iii) Use dummy pills for demonstration
 - (iii) Review information with patient
3. Inadequate knowledge or awareness about HIV disease
 - (i) Provide patients with scientific information about HIV disease
 - (ii) Review information with patients
 - (iii) Use examples
4. Inadequate understanding about effectiveness of medications
Inform patients and bring change in attitudes and understanding of effectiveness of medications
5. Lack of social support
 - (i) Establish contact with PLHA support groups
 - (ii) Link with community health workers and home-based care services
 - (iii) Link with charitable institutions, faith-based organizations
6. Discomfort with disclosure of HIV status
 - (i) Counselling patient to support disclosure
 - (ii) Identify other support persons such as friends or peers if patient unable to disclose to the family
7. Difficult life conditions (lack of income, housing, food, support for childcare)
 - (i) Establish contact with PLHA support groups
 - (ii) Link with community health workers and home-based care services
 - (iii) Link with charitable institutions, church programmes
8. Alcohol and drug use
 - (i) Counselling—emphasize link between alcohol, ARV drugs and liver damage
 - (ii) Family support
 - (iii) Peer group support programmes, church programmes
 - (iv) Medical consultation—de-addiction programmes
9. Depression and other psychiatric problems
Refer to physician for treatment
10. Negative or judgemental attitude of providers
Training of providers
11. System barriers (drug stock-out, shortage of staff, health facility closed)

ACTIVITY 7: ADHERENCE COUNSELLOR CHECKLIST FOR THE PREPARATORY SESSION

ADHERENCE COUNSELLING CHECKLIST 1 COUNSELLING SESSION 1

Name of the client

Date of counselling session

Assess the patient		
Medical history Knowledge of HIV/AIDS Prior use of ART Determine the social support Disclosure—have they disclosed to anyone? Alcohol/drug use Mental state		
Review the health status		
OIs CD4/viral load		
Review living conditions and employment		
Housing Employment/income		
Describe the treatment programme and importance of adherence		
Drug regimen—name/frequency/storage/dietary instructions/not to share pills What ART does—suppresses virus/improves immunity/lessens OIs/not a cure Cost Side-effects and what to do Follow-up Importance of adherence and consequences of non-adherence		
Discuss adherence promotion strategies		
Buddy reminder—discuss role of support person Pill diary Other reminder cues		
Identify barriers to adherence	Yes	No
Poor communication Low literacy Inadequate understanding about HIV/AIDS Lack of social support Failure to disclose the HIV-positive status Alcohol and drug use Mental state		

ADHERENCE COUNSELLING CHECKLIST 2

COUNSELLING SESSION 2

Name of the client

Date of counselling session

Review client's understanding of HIV/AIDS

What is HIV and AIDS?

What are opportunistic infections?

What do they understand by CD4 counts/viral load?

What are the effects of treatment?

Review the treatment programme and importance of adherence

Drug regimen

Dummy pill demonstration

What ART does—improves immunity/lessens OIs/ART is not a cure?

Need for continued prevention—use of condoms

Side-effects and what to do

Follow-up

Importance of adherence and consequences of non-adherence

Review proposed adherence promotion strategies

Buddy reminder—discuss the role of a support person

Review the pill diary

Other reminder cues—discuss HAART

Review barriers to adherence and the progress made so far

Poor communication skills

Low levels of literacy

Inadequate understanding about HIV/AIDS

Lack of social support

Failure to disclose the HIV-positive status

Alcohol and drug use

Mental state

Take the client's address and establish contact system with a treatment centre

Schedule the next counselling session and complete the appointment card

ADHERENCE COUNSELLING CHECKLIST 3

COUNSELLING SESSION 3

Name of the client

Date of counselling session

Assess the client's understanding of the disease and readiness to start

What is HIV disease?

What are opportunistic infections?

What is meant by CD4 count/viral load

What are the effects of treatment

What is their level of commitment to adherence

Review the treatment programme and importance of adherence

Drug regimen

Dummy pill demonstration

What ART does—improves immunity/lessens OIs/ART is not a cure

Need for continued prevention—condom use

Side-effects and what to do

Follow-up

Link between adherence and successful outcome

Review proposed adherence promotion strategies

Buddy reminder—discuss the role of a support person

Review the pill diary

Other reminder cues—discuss HAART

Fill the ART register, schedule the next appointment and complete the appointment card

Refer to the Pharmacy/Chemist

Checklist after the initiation of ART

1. Have I determined, in collaboration with the patient, that she/he is ready to start treatment?
2. Have I prescribed the simplest regimen?
3. Have I explained to the patient details about dosing of medications? Have I reviewed with the patient any special instructions for taking and storing the medications?
4. Is the dosing schedule compatible with the patient's lifestyle?
5. Have I reviewed potential or common side-effects and considered pre-emptive treatment of predictable adverse events?
6. Did I ask the patient to repeat the medication names, dosing times and instructions?
7. Does the patient know how to contact the health-care team in case he/she has a problem or question?
8. Does the patient know where and when to collect his medications from?
9. Have I fixed the next appointment?

ADHERENCE COUNSELLING CHECKLIST 4

COUNSELLING SESSION 4

Name of the client

Date of counselling session

Review the patient's experience with treatment and adherence over the past month

Drug regimen and adherence—pill counts, self-report

Discuss the side-effects and the actions taken

Discuss the need for continued prevention—use of condoms

Review the experience with a follow-up plan

Discuss the follow-up plan for the next month

Review the patient's goals and success at achieving them

Review barriers to adherence

Buddy reminder—discuss the role of a support person

Review the pill diary

Review barriers to adherence

Poor communication skills

Low levels of literacy

Inadequate understanding of HIV/AIDS

Lack of social support

Failure to disclose the HIV-positive status

Alcohol and drug use

Mental state

Fill the ART register, schedule the next appointment and complete the appointment card

Refer to a pharmacy/chemist

Module 5

Submodule 2: The purview of counselling in HIV/AIDS home-based care

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- The rationale and meaning of home-based care
- The involvement of PLHA
- The component of counselling in home-based care
- Spiritual care
- Shared confidentiality within the local communities
- Dealing with grief and bereavement
- Caring for the caregiver
- Support groups and networks
- Nutrition and HIV/AIDS

SESSION INSTRUCTIONS

1. Introduce the topic using the PPT presentation.
2. Conduct the Activity of conducting home visits.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 5

Submodule 2: The purview of counselling in HIV/AIDS home-based care

GUIDELINES FOR COMPLETING THE HOME VISIT DATA SHEET FORMAT

Purpose of home visit

This includes the primary reason for making a home visit. Visits are basically classified into three categories:

1. The purpose of this visit is preliminary assessment of the client's status on various parameters.
2. The follow-up visit, which is conducted when there is a break in OPD follow-up by the patient. The criteria for a follow-up visit are set for an absence period of one month.
3. Request visits are those which are made on request by the client.

Observed emotional and physical status of the patient

1. The physical condition of the patient on observation—does the person look well? If unwell, what makes you feel so?

All observed features of

- Appearance
- Personal hygiene
- Skin tone
- Dress
- Movement
- Weight
- Verbal expressions

2. Eating habits

- The eating habits of the family as a whole
- Special meal requirements for the patient
- Problems related to nutrition
- Use of nutrition supplement
- Implementation of nutrition guidelines
- Expressed issues and concerns

3. The psychological state of the person as judged by
 - Appearance
 - Verbal expressions
 - Non-verbal expressions
 - Mood

Chief caregiver

1. Who is the primary caregiver?
2. What is the caregiver's relationship with the patient?
3. The health status of the caregiver

Observed dynamics at home

This is an analysis of the observations made by the field worker on the situation and atmosphere at home. This will include

- the total number of family members,
- reactions to the patient's illness, and
- physical and psychological support systems available to the patient.

Observed dynamics with the caregiver

1. Attitude of the caregiver towards the patient
2. The relationship with the caregiver
3. Willingness of the caregiver
4. Personal issues of the caregiver
5. Burn-out issues in the caregiver

Locality and neighbourhood

A home visit provides the basic understanding about the general environment and the background the person belongs to. Features included in this section are

- the nature of the locality (rural/urban),
- kind of housing,
- attitude of the neighborhood,
- health-care infrastructure in the neighbourhood, and
- accessibility to facilities.

Socioeconomic situation as observed

An overall analysis of the socioeconomic situation of the patient based on factors such as the following:

- The socioeconomic level of the locality, whether it is a slum locality or a fishing locality, a chawl or an upper middle class locality, etc.
- the infrastructure in the locality
- the number of working members in the family
- the patient's employment status
- the number of dependant members in the family
- the patient's role in the family (breadwinner)

Expressed concerns/issues/opinions

This includes all concerns or opinions which may have been expressed by the family, caregiver or the patient

Home visit conducted by

Mention the name of the person who has conducted the home visit along with his/her designation.

Visit requested by

Who requested for the visit?

Visit commissioned by

Who commissioned the visit?

Date of request

Date on which the request for the visit was submitted

Date of visit

Date on which the visit was conducted

HOME VISIT DATA SHEET

Name of the patient _____ Registration No _____

Sex: M/F

Purpose of home visit _____

Observed emotional and physical status of the patient _____

Chief caregiver _____

Observed dynamics at home _____

Observed dynamics with the caregiver _____

Locality and neighbourhood _____

Socioeconomic situation as observed _____

Expressed concerns/issues/opinions _____

Home visit conducted by _____

Visit requested by _____

Visit commissioned by _____

Date of request _____ Date of visit _____

Module 5

Submodule 3: The role of diet and nutrition in the management of PLHA

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- HIV/AIDS and nutrition
- Increased nutrient needs of PLHA
- Dealing with diet-related problems in PLHA

SESSION INSTRUCTIONS

1. Conduct Activity 1: Brainstorm on the importance of diet and nutrition in the life of PLHA.
2. Lecture using the PPT presentation.
3. Conduct Activity 2: Micronutrients, their role and source.
4. Continue the lecture with the PPT presentation.
5. Conduct Activity 3: Weight management.
6. Summarize the key points of the session.
7. Ask the group if they have any questions and remind them of the question box.

Module 5

Submodule 3: The role of diet and nutrition in the management of PLHA

ACTIVITY 1

Brainstorm on the importance of diet and nutrition in the life of PLHA

ACTIVITY 2

Below are listed some edible items. Suggest recipes for the same. Define the nutritive value of each of them.

Micronutrient	Role	Source
Vitamin A		
Thiamine		
Vitamin B ₁		
Riboflavin		
Vitamin B ₂		
Niacin		
Vitamin B ₃		
Vitamin B ₆		
Folate		
Vitamin B ₁₂		
Vitamin C		
Vitamin E		
Calcium		
Iodine		
Iron		
Magnesium		
Selenium		
Zinc		

ANSWER SHEET

Micronutrient

- Their source
- Their role

	Role of micronutrients	Source
Vitamin A	Makes white blood cells—essential for vision, healthy skin and mucosa, teeth and bone development. Protects against infection associated with accelerated HIV progression, increased adult mortality, increased mother-to-child transmission, higher infant mortality and child growth failure	All yellow and orange fruit and vegetables, dark green leafy vegetables, alfalfa, liver, oily fish, dairy products and egg yolks
Thiamine Vitamin B ₁	Important for energy metabolism, supports appetite and nervous, system functions	Whole-grain cereals, beans, meat and poultry and fish
Riboflavin Vitamin B ₂	Important for energy metabolism, supports normal vision, health and integrity of skin	Milk, yoghurt, meat, green leaves and whole-grain cereals
Niacin Vitamin B ₃	Essential for energy metabolism, supports health and integrity of the skin, nervous and digestive systems	Milk, fish, eggs, meat, poultry, peanuts, whole-grain cereals
Vitamin B ₆	Facilitates metabolism and absorption of fats and proteins, helps to make red blood cells	Sweet potatoes, white beans, maize, avocados, cabbage, whole-grain cereals, seeds, Brazil nuts, walnuts, eggs, leafy green vegetables, alfalfa, bananas, legumes, meat and fish
Folate	Required for building new cells, especially red blood cells and gastrointestinal cells	Liver, red meat, green leafy vegetables, fish, oysters, legumes, groundnuts, oilseeds, whole-grain cereals, egg yolks and avocados
Vitamin B ₁₂	Important for new cell development and maintenance of the nerve cells	Red meat, fish, poultry, seafood, sardines, cheese, eggs, milk, whole-grain cereals and seaweed

Vitamin C	Helps the body to use calcium and other nutrients to build bones and blood vessel walls. Increases non-haem iron absorption. Increases resistance to infection and acts as an antioxidant. Important for protein metabolism.	Citrus fruits (such as baobab, guava, oranges and lemons), cabbage, green leaves, tomatoes, sweet peppers, potatoes, yams and cooking plantains. Vitamin C is lost when food is cut, reheated or left standing after cooking
Vitamin E	Protects cell structures and facilitates resistance to disease	Leafy vegetables, vegetable oils, peanuts, egg yolks, dark green vegetables, nuts and seeds, whole-grain cereals
Calcium	Builds strong teeth and bones, aids heart and muscle functions, blood clotting and pressure and immune defences.	Milk, green leaves, shrimps, dried fish (with bones), nuts, beans and peas
Iodine	Ensures the development and proper functioning of the brain and the nervous system	Fish, seafood, milk and salt with iodine
Iron	Transports oxygen to the blood, eliminates old red blood cells and builds new cells	Red meat, poultry, liver, fish, seafood, eggs, peanuts, beans, some cereals, green leafy vegetables, seeds, whole-grain cereals, dried fruit and alfalfa
Magnesium	Strengthens the muscles and is important for proper functioning of the nervous system. Involved in bone development and teeth maintenance	Cereals, dark green vegetables, seafood, nuts and legumes
Selenium	Prevents impairment of the heart muscle	Seafood, liver, meat, carrots, onions, milk, garlic, alfalfa, mushrooms and whole-grain cereals
Zinc	Reinforces the immune system, facilitates digestion and transports vitamin A	Meat, chicken, fish, cereals, leafy green vegetables, seafood, oysters, nuts, pumpkin seeds, milk, liver, whole-grain cereals, egg yolks, garlic and legumes

Weight management

- ## Form to monitor weight changes over time

[illegible]

ACTIVITY 4

Form to monitor food intake over one week

This form can help you to monitor your clients' food intake. Fill it in carefully every day, noting the amount he eats each time. List all the amounts of food eaten daily for every day of the week. Review the form or discuss it with your nutritionist, doctor, nurse, local health worker or counsellor after one week. Compare the sheets from week to week to see if the client is eating less from one week to another. This will help you to see if food intake is going down, even if the client does not feel he is eating less. If you find that he is eating less, identify the reasons (e.g. diarrhoea, sore mouth, feeling weak) and follow the guidelines provided to increase food intake.

Meal	Breakfast <i>7 am</i>	Snack <i>10 am</i>	Lunch <i>1 pm</i>	Snack <i>4 pm</i>	Supper <i>7 pm</i>	Bedtime <i>10 pm</i>
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Module 6

Submodule 1: Counselling for blood safety

Time allotted: 1 hour

TRAINING MATERIALS

- Handout (HO)
- PowerPoint (PPT) presentation
- Activity sheet
- Question box

CONTENTS

- Blood safety
- Pre-donation counselling in blood banks and pre-test counselling in a voluntary counselling and testing (VCT) centre
- Promoting rational use of blood among clinicians
- Ensuring blood safety and implications for VCT
- Promotion of voluntary blood donation programme
- Voluntary blood donation in India
- Blood donor questionnaire and consent form

SESSION INSTRUCTIONS

1. Lecture using the PPT presentation.
2. Conduct Activity 1: Pre-donation counselling.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 6

Submodule 1: Counselling for blood safety

INSTRUCTIONS

Activity 1

Divide the group into triads—a counsellor, a client and an observer. Conduct role-plays as per guidelines provided in the Introduction to the Manual.

1. Present in the handout is a format used in the blood banks during pre-donation counselling.
2. Presented below are guidelines on information presented and issues covered in a blood bank through pre-donation counselling session.
3. Using guidelines presented in the introduction of the manual on conducting role-plays, ask the participants conduct role-plays on pre-donation counselling session.
4. Provide the observer with a copy of the information presented below. Ask them to note down their observations of the counselling session.
5. Debrief
 - a) Ask the observers to discuss their observations.
 - b) Discuss what additional information is provided in a blood donation counselling session apart from the VCT information.
 - c) Discuss strategies to motivate clients to test for HIV.

Guidelines for the observer

The observer should note if the following issues were included during pre-donation counselling of donors:

- One unit of donated blood can help save the lives of more than one person.
- Trauma victims, cancer patients and those with inherited blood disorders require most of the donated blood.
- There is no substitute for blood.
- People who are anaemic cannot donate blood. However, they should undergo treatment for anaemia and can donate blood once the haemoglobin is within the normal range.
- Whole blood donation can be made safely at an interval of 3 months if the donor has no risk of anaemia, particularly iron deficiency anaemia. Repeated blood donation at this interval does not cause any sort of weakness. As pre-menopausal women are more prone to iron deficiency, their donation interval is usually longer.
- There is absolutely no risk of acquiring AIDS or any other disease (such as hepatitis B and C) from donating blood.
- An individual can safely donate blood from the age of 18–60 years without any risk to their health.
- The donor is examined before donation for his/her suitability to give blood.
- The donor must know that he/she needs to undergo many tests before blood can be donated. It may take about 3 days to complete all these tests.
- Donating blood does not take a long time. The actual blood collection procedure takes about 8–10 minutes.
- Individuals who have suffered or suffer from hepatitis B, hepatitis C or AIDS should not donate blood.
- As a blood donor, it is your moral responsibility to ensure that the blood you donate is safe and not likely to transmit any infection you may be carrying. To ensure good donor selection, you will be asked a few questions in confidence about your lifestyle and your sexual history. The purpose of asking these questions is to select a healthy and safe donor for needy and sick patients, and to collect blood which is safe and unlikely to transmit any infection. You must answer these questions as correctly as possible, because we know that you want to help rather than harm a patient in real need.
- Please enroll yourself as a voluntary donor. You can either donate blood at a blood centre or at any of the mobile donor sessions organized by the blood donation service.

Module 6

Submodule 2: Counselling issues related to HIV–STI co-infection

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Question box

CONTENTS

- Background information
- Relationship between STIs and HIV infection
- Impact of HIV infection/AIDS on other STIs
- Policy on the control of STIs
- Syndromic management of STIs
- Condom promotion
- Where to refer

SESSION INSTRUCTIONS

1. Discuss with the group their knowledge and understanding of and experience in dealing with clients who have STIs.
2. Lecture using the PPT presentation.
3. Link this topic to Module 2 on 'behaviour change counselling for risk reduction'.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 6

Submodule 3: Counselling issues related to HIV–TB co-infection

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Role of the counsellor
- TB burden in India
- Symptoms of TB
- HIV–TB interaction
- Diagnosis of TB
- Treatment of TB
- Record-keeping and reporting

SESSION INSTRUCTIONS

1. Discuss with the group their knowledge and understanding of and experience in dealing with clients who have TB.
2. Lecture using the PPT presentation.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 1: Group therapy

Time allotted: 1 hour

TRAINING MATERIALS

- Handout (HO)
- PowerPoint (PPT) presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- Some basic guidelines for effective group therapy
- Process of group therapy
- Stages of group therapy

SESSION INSTRUCTIONS

1. Discuss with the group their understanding and experience of working with groups.
2. Lecture using the PPT presentation.
3. Conduct Activity 1: Counselling activity on groups.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 1: Group therapy

INSTRUCTIONS

Activity 1

Time allotted: 30 minutes

Ask for a volunteer to play the role of the counsellor. The other trainees will play the role of members of the therapeutic group.

ACTIVITY 1: COUNSELLING ACTIVITY ON GROUPS

Instructions to the group

1. Assume you are part of a therapeutic group. Each member of the group comes from a different background, and has different needs and expectations. Participate as a group to resolve your problems and issues of concern. Each group member may think about what he or she thinks makes for a good/bad group and participate accordingly.

Guidelines for the counsellor

1. Thinks of ways of preventing problems from arising. Consider creating guidelines or ground rules based on the concerns people raise, such as 'avoid cliques' or 'avoid gossip'.
2. Discuss various strategies for keeping communication channels open before a conflict or resentment develops. Each group member should feel that there is a repertoire of tools for communication available that will work for them.
3. Seek compromise or a middle ground with others when conflicts arise. Perhaps each group member could articulate what they ideally want, what they will settle for, and what they are unwilling to sacrifice—work out a compromise from there.
4. If there is somebody in the group who can act as an intermediary, ask that person to discuss disruptive behaviour sympathetically with the person in question.
5. Give this person a particular responsibility that will focus his/her energies.
6. Conduct an activity, such as using a 'suggestion box' that allows complaints to be voiced and discussed anonymously.
7. You can encourage participants to develop self-critical awareness about the quality and length of contributions to discussions, e.g. Would anyone like to comment on that? What do other people think? Some of you have a special knowledge of this subject, would any of you like to say something about it?
8. *Deal with difficult individuals publicly only in exceptional circumstances.*

Repeat this exercise with more than one volunteer.

Module 7

Submodule 2: Family and marital counselling for patients with HIV/AIDS

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Definition
- Aim of marital counselling
- Aim of family counselling
- Family as a structure and system
- HIV/AIDS and the role of the family
- Family counselling
- Marital counselling
- Other beneficial counselling sessions
- Socioeconomic issues of concern

SESSION INSTRUCTIONS

1. Discuss the group's understanding of and experience in family and couple counselling.
2. Lecture using the PPT presentation.
3. Conduct Activity 1: Role-play.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 2: Family and marital counselling for patients with HIV/AIDS

INSTRUCTIONS

Activity 1: Role-play

This is a role-playing session wherein the members will be requested to contrive a real-life family situation which could be simulated to understand the problems of PLHA in a family set-up. Trainees should try to resolve the issues that arise during the course of the session. Ideally, the master trainer should play the role of the counsellor to demonstrate the appropriate role-model for family counselling sessions.

The following steps are involved:

1. A live session of family counselling has to be enacted by selecting a situation from the case-studies/real-life situations provided by the group.
2. Identify volunteers to play the various roles of the family members.
3. Specify the role of each family member in detail.
4. Make the family sit in a circle in comfortable positions.
5. The counsellor begins by greeting the group and defining the role of each family member. This is done by creating a congenial environment wherein the counsellor initiates self-introduction followed by encouraging the introduction of each family member. The counsellor predominantly uses reflection, paraphrasing and summarizing to sustain focus on the problem the family is undergoing (**rapport building**).
6. Each family member has to be given the opportunity to express their perceptions of the prevailing situation.
7. This should be initiated by the dominant family member followed by the rest of the members of the group.
8. The counsellor should be very attentive, and their gestures and body movements should be appropriate for active listening. The counsellor should also use 'reflecting', 'paraphrasing' and 'summarizing' techniques to clarify the proceedings of the session (**assessment and analysis of the problem**).
9. The counsellor should politely but firmly handle any heated arguments, conflicting dialogues, blame-game, interruptions, etc. by saying, 'Please allow the person to complete what they are saying.'
10. After the first round of self-introduction and statement of problem(s) is over, the group members, by rotation, should be asked to reverse the roles by changing their positions. It has been observed that dominant family members do not like to physically get up and change their place during role-play and role-reversal.

Role-reversal and interchanging of the position should be done frequently so that everyone gets a chance to enact the role of some/all family members.

11. During role-reversal, it might be observed that family members will advocate the role of the infected member and look at the problem from their perspective, while seated in the designated place. This helps the process of attitudinal change.
12. After each participant has been given an opportunity and the session is moving towards the desirable goal, the counsellor should request each 'family member' to take their original seats.
13. Towards the end of the session, the counsellor should summarize the shift in communication observed during the role-play session. The counsellor, enacting the role of facilitator, should ask the dominant family members and others to give their opinion about the actions to be taken for solving the crisis the family is undergoing (**planning and initiating steps**).
14. The session should end by redefining the roles of each family member as well as practising the decisions taken as an outcome of the process (**implementation**).
15. A homework assignment should be given and follow-up should be encouraged (**termination and follow-up**).

ACTIVITY 1: ROLE-PLAY

Case study 1

Rekha, a 26-year-old woman, comes to the centre with her family. She reports that her in-laws trouble her and want her to leave the house. Rekha's husband passed away three months back of AIDS. She has lost her job and is unwell. Her in-laws blame her for their son's death.

Case study 2

Ram, a 34-year-old man, lives in a single-room tenement with his parents, brothers and their families. He reports that his sisters-in-law is very concerned and does not want him to stay in the same house as he is HIV-positive. Ram is educated up to the 12th standard. He works as a clerk in a private firm. His mother is very fond of him and requests the counsellor to help them.

Module 7

Submodule 3: Counselling for sexual assault

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- What constitutes sexual assault?
- What are the effects of sexual violence?
- Reporting of sexual assault
- Client presentation to VCT services
- Key areas of response
- Dealing with disclosure of sexual assault
- Counselling survivors of sexual assault

SESSION INSTRUCTIONS

1. Conduct Activity 1: Brainstorming session.
2. Lecture using the PPT presentation.
3. Conduct Activity 2: Role-play.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 7

Activity Sheet

Submodule 3: Counselling for sexual assault

INSTRUCTIONS

activity 1: Brainstorming session

Time allotted: 10 minutes

1. Conduct a brainstorming session with the participants on issues presented below
2. Summarize the discussion using information in the handout on 'What are the effects of sexual violence?'

What are the consequences of sexual assault?

- Physical
- Psychological
- Social

Activity 2: Role-plays

Conduct role-plays as per the guidelines provided in the Introduction to the Manual.
Use the cases presented on the next page.

ACTIVITY 2: ROLE-PLAYS

Case study 1: Sexual assault (male)

An 11-year-old boy used to normally be excited about going to school. One afternoon, a teacher asked him to stay back after school to help make some teaching material for the next day's class. As the other students and teachers were leaving for home, he started working on the material. The teacher came into the room and started complimenting him on his diligence and intelligence. Then he started to touch the child in an inappropriate manner. When he tried to resist, the teacher forced him onto the floor and sexually assaulted him. The boy was forced into being the receptive partner in anal sex. No condom was used and he had slight anal bleeding afterwards.

Next morning, his mother noticed that he was hesitant to leave for school. Later, while she was washing his undergarments she found blood. The mother went to the school to take him out of class to see a doctor. The doctor has referred the boy for tests. They are both very distressed about the assault and feel nervous about the testing and what the results may show.]

Case study 2: Sexual assault (female)

A 15-year-old girl travelling home from work was raped by a policeman. She was threatened with dire consequences if she reported the matter to anybody. She was referred by a physician for complaints of pain in the stomach and vaginal discharge with the suspicion that she was infected with HIV. The client is still in a state of shock. She reports the penetration was vaginal, anal and oral. She also has scratches and injury marks on her body.

Case study 3: Sexual assault (female)

A 16-year-old girl has been reportedly raped by her father for the past few years. The father is an alcoholic and physically abuses his wife. The girl did not report the crime to anyone for fear of her father. Encouraged by her schoolteacher, she informed her mother. Subsequently, a local NGO handled her case.

Issues to be discussed to summarize the activity

- What are the first steps you will take?
- What are the special concerns of the victims of these cases?
- How are anal and vaginal penetration different in medicolegal matters, and how should they be handled?

Module 7

Submodule 4: Crisis intervention and problem-solving counselling for patients with HIV/AIDS

Time allotted: 2 hours

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box
- Chart paper
- Marker pens

CONTENTS

- What is a crisis?
- Phases of crisis
- Essential features of a crisis
- Outcome of a crisis
- Crisis counselling
- Problem-solving counselling

SESSION INSTRUCTIONS

1. Discuss with the group their understanding of crisis.
2. Lecture using the PPT presentation.
3. Conduct Activity 1: Problem-solving.
4. Continue with the PPT presentation.
5. Conduct Activity 2: Brainwriting 6-3-5.
6. Continue with the PPT presentation.
7. Summarize the key points of the session.
8. Ask the group if they have any questions and remind them of the question box.

Submodule 4: Crisis intervention and problem-solving counselling for patients with HIV/AIDS

INSTRUCTIONS

Activity 1: Problem-solving

Pass out a copy of the dots. Ask the trainees to complete the directions given at the bottom of the drawing. Give them about 5 minutes to work on the puzzle. At the end of the time period, ask if anyone has found the solution.

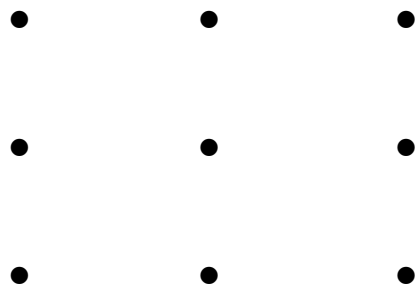
This exercise will demonstrate that we often limit our perspectives and choices. Discuss this exercise in terms of problem-solving skills and choices that can be made by individuals faced with a problem.

Activity 2: Brainwriting 6-3-5

The name 'brainwriting 6-3-5' comes from the process of having 6 people write 3 ideas in 5 minutes. Each person has a blank 6-3-5 worksheet.

Draw a table as on the next page, on a chart paper. Write down a problem statement the trainees want to discuss on the top row of the worksheet. Ask each trainee to write three solutions or ideas on resolving this problem. Have a large group discussion on problems that have been written on the sheet. You may work on more than one problem depending on the group's size or need to discuss problem situations.

ACTIVITY 1: PROBLEM-SOLVING



Connect all the dots above with four straight lines. Do NOT lift your pencil off the paper. Do NOT retrace any line. Lines may cross if necessary.

ACTIVITY 2: BRAINWRITING 6-3-5

Problem statement: How to . . .		
Idea 1	Idea 2	Idea 3
1.		
2.		
3.		
4.		
5.		

Module 7

Submodule 5: Universal safety precautions and post-exposure prophylaxis

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Question box

CONTENTS

- Principles of infection control and universal safety precautions
- What are universal precautions?
- Post-exposure prophylaxis for HIV following occupational exposure

SESSION INSTRUCTIONS

1. Lecture using the PPT presentation. During the presentation, ask participants to
 - Discuss infection control, universal precautions and episodes of occupational exposure in their institutions
 - If their institutions have standard procedures for dealing with occupational exposure to potentially infectious fluids
 - Describe these and discuss how they might be improved
 - Reporting/documentation associated with such incidents and whether a database is maintained to keep track
 - Infection control team exists at their institution and what its role is in dealing with occupational exposure.
2. Summarize the key points of the session.
3. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 6: Management of psychological distress in patients with HIV/AIDS

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box
- Chart paper/transparency sheets
- Marker pens

CONTENTS

- What is the cognitive-behavioural approach?
- Stages of cognitive management
- Cognitive retraining for neuropsychological deficits associated with HIV/AIDS

SESSION INSTRUCTIONS

1. Conduct Activity 1: Brainstorming.
2. Lecture using the PPT presentation.
3. Conduct Activity 2: Role-play.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 6: Management of psychological distress in patients with HIV/AIDS

INSTRUCTIONS

Activity 1: Brainstorming session

Discuss cases handled by trainees as well as their own negative thought processes when they are subjected to failure, humiliation and rejection.

1. Record group feedback.
2. Enumerate different emotional states accompanying negative thoughts.
3. Get feedback from the group on thought-stopping.

ACTIVITY 2: CASE STUDY FOR ROLE-PLAY

Act out the case given below. See how thoughts can be controlled and what coping skills can be developed in Mr Ramamurthy.

ACTIVITY 2: CASE STUDY FOR ROLE-PLAY

Case study 1

Ramamurthy has come to Mumbai in search of a job. He is staying in a very cheap boarding house. He has many companions in the dormitory where he stays. The young men wanted to have fun and went to a red light area to have sex. Though Ramamurthy was reluctant his friend told him to experience sex. After this episode, he has lost his sleep and has recurrent thoughts that he has contracted HIV. He is ashamed of himself and repentant, but he cannot undo the act and is unable to talk to anybody about it. His problem is how to control these thoughts and be able to sleep as before.

Module 7

Submodule 7: Suicide risk assessment and management for patients with HIV/AIDS

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box
- Chart paper/transparency sheets
- Marker pens

CONTENTS

- Introduction
- Suicide risk in HIV-positive patients
- Classification of suicide methods
- Suicide risk assessment
- Referral indications
- Steps for the management of suicidal clients
- Questions used to probe for suicidal thoughts
- Drug/Alcohol consumption and risk of suicide attempt
- Antidepressants and suicide risk
- Medical complications following an unsuccessful attempt
- Post-attempt stage

SESSION INSTRUCTIONS

1. Discuss with the group their knowledge and understanding of and experience in dealing with clients who have attempted suicide.
2. Lecture using the PPT presentation.
3. Conduct the activity as prompted in the PPT.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 7: Suicide risk assessment and management for patients with HIV/AIDS

SUICIDE RISK ASSESSMENT GUIDELINE EXERCISE

Using the case presented in the post-test module, conduct this activity. Instruct the participants to role-play as per guidelines. Using the assessment format given below, assess the client's risk for suicide.

The suicide risk assessment provides a guideline for professionals on how to interview persons at risk for suicide. As guidelines rather than a ready-to-use questionnaire, many questions would need more exploration and probing in order to evaluate the subjective reality of each individual at risk.

- | | |
|--|----------|
| 1. Do you sometimes feel so bad/hopeless/helpless you think about suicide? | YES / NO |
|--|----------|

Follow this up with the following explorations:

- | | |
|---|----------|
| 2. How often? | |
| a. Are you currently thinking of suicide? | YES / NO |
| b. Have you thought of how would you do it? | YES / NO |
| 3. Do you have a plan? | YES / NO |
| a. How lethal is the planned method? | |
| (EXPLORE the perception of the person at risk!) | |
| 4. Do you have the means? | EXPLORE |
| 5. Have you decided when you would do it? | EXPLORE |
| 6. Have you ever tried suicide before? | EXPLORE |

If 'yes' check whether previous attempt was:

- | | |
|--|--|
| a. Impulsive? | |
| b. Planned? | |
| c. Did you use any 'booster' to make you do it, such as alcohol/drugs? | |
| 7. If you have tried suicide before, what difference, if any, did it make? | |

Write down the client's answer. Generally, any positive change perceived by the client makes the risk higher.

Check for symptoms of clinical depression.

a. Neurovegetative symptoms:

- Sleep disturbances
- Loss of appetite
- Tiredness/lack of energy
- Agitation/slowing down
- Loss of interest in sex

b. Mood and motivation

- Prolonged unhappiness
- Loss of interest or pleasure
- Hopelessness/helplessness
- Difficulties performing at work
- Difficulties carrying out routine activities
- Withdrawal from friends and social activities
- Check for somatization (pains, aches, physical discomfort without any organic cause)

Module 7

Submodule 8: Mental health issues associated with HIV/AIDS

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box
- Chart paper/transparency sheets
- Marker pens

CONTENTS

- Introduction
- Impact of HIV/AIDS on mental health
- Management strategies

SESSION INSTRUCTIONS

1. Discuss with the group their knowledge and understanding of, and experience in dealing with clients who show signs of mental illness.
2. Lecture using the PPT presentation.
3. Summarize the key points of the session.
4. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 9: Legal–ethical issues related to HIV/AIDS

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Chart paper/transparency sheets
- Marker pens
- Question box

CONTENTS

- Introduction
- HIV and human rights
- The legal framework

SESSION INSTRUCTIONS

1. Discuss with the group their knowledge and understanding of and experience in dealing with legal–ethical issues related to HIV/AIDS.
2. Lecture using the PPT presentation.
3. Conduct Activity 1: Discussion.
4. Summarize the key points of the session.
5. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 9: Legal–ethical issues related to HIV/AIDS

INSTRUCTIONS

Activity 1: Discussion

Discuss what the counsellor can do in the following situations during counselling:

- An HIV-positive lady is thrown out of her house
- A widow who tests positive does not get a share in the family property
- A person referred for surgery comes for preoperative testing
- A person tests positive in a pre-employment test

Module 7

Submodule 10: Identification and management of burn-out in caregivers and counsellors

Time allotted: 1 hour

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Overview of HIV/AIDS caregiving
- Role of informal caregivers
- Understanding burn-out
- Factors causing burn-out among formal caregivers
- Factors leading to stress in HIV/AIDS counselling and care
- Management of burn-out
- Personal coping tools

SESSION INSTRUCTIONS

1. Discuss with the group what they understand by burn-out, which may be experienced by both the caregiver and the counsellor.
2. Lecture using the PPT presentation on the concept of burn-out
3. Conduct Activity 1: Progressive muscular relaxation (PMR).
4. Summarize the key points of the session
5. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 10: Identification and management of burn-out in caregivers and counsellors

INSTRUCTIONS

Activity 1: Progressive muscular relaxation (PMR)

Time allotted: 20 minutes

There are two steps in the self-administered PMR procedure:

- (a) Deliberately tensing muscle groups, and
- (b) Releasing the induced tension.

This two-step process will be described after you have been introduced to the muscle groups.

Muscle groups

You will be working with almost all the major muscle groups in your body, but for convenience you will make a systematic progression from your feet upwards. Here is the most popular recommended sequence:

- Right foot
- Right lower leg and foot
- Entire right leg
- Left foot
- Left lower leg and foot
- Entire left leg
- Right forearm and hand
- Entire right arm left hand
- Left forearm and hand
- Entire left arm
- Abdomen
- Chest
- Neck and shoulders
- Face
- Tension relaxation procedure

Step one: Tension. The process of applying tension to a muscle is essentially the same, regardless of which muscle group you are using. First, focus your mind on the muscle group; for example, your right hand. Then inhale and simply squeeze the muscles as hard as you can for about 8 seconds; in the example, this would involve making a tight fist with your hand.

Step two: Releasing the tension. This is the best part because it is actually pleasurable. After 8 seconds, just quickly and suddenly let go. Let all the tightness and pain flow out of the muscles as you simultaneously exhale. In the example, this would be imagining tightness and pain flowing out of your hand through your fingertips as you exhale. Feel the muscles relax and become loose and limp, tension flowing away like water out of a faucet. Focus on and notice the difference between tension and relaxation.

Remember

- Always practise complete PMR in a quiet place, alone, with no electronic distractions, not even background music
- Remove your shoes and wear loose clothing
- Avoid eating, smoking, or drinking. It is best to practise before meals rather than after for the sake of your digestive processes
- Never practise after using any intoxicants
- Sit in a comfortable chair if possible. You may practise PMR while lying down, but this increases the likelihood of falling asleep
- If you fall asleep, give yourself credit for the work you did up to the point of sleep
- If you practise in bed at night, plan on falling asleep before you complete your cycle. Therefore, consider a practice session at night, in bed, in addition to your basic practice
- When you finish a session, relax with your eyes closed for a few seconds, and then get up slowly (*orthostatic hypotension*—a sudden drop in blood pressure due to standing up quickly—can cause you to faint). Some people like to count backwards from 5 to 1, timed to slow, deep breathing, and then say, ‘Eyes open. Supremely calm. Fully alert’

Module 7

Submodule 11: Grief and bereavement counselling

Time allotted: 1 hour 30 minutes

TRAINING MATERIALS

- HO
- PPT presentation
- Activity sheet
- Question box

CONTENTS

- Introduction
- Phases of grieving
- Dying and HIV/AIDS: Its implications
- Helping clients deal with loss and bereavement
- Tools for grief counselling
- Spiritual wellness for clients with HIV/AIDS

SESSION INSTRUCTIONS

1. Conduct Activity 1.
2. Lecture using the PPT presentation.
3. Detail the tools used for grief counselling.
4. Conduct Activity 2: Role-play using the case studies provided.
5. Summarize the key points of the session.
6. Ask the group if they have any questions and remind them of the question box.

Module 7

Submodule 11: Grief and bereavement counselling

INSTRUCTIONS

Activity 1

Time allotted: 20 minutes

Divide the trainees into groups of 3–4 persons.

Ask group members to define bereavement in relation to PLHA.

Identify the potential areas of loss in relation to

1. Physical health
2. Sexual relationships
3. Employment
4. Financial matters
5. Social status
6. Family
7. Children
8. Friends
9. Control over life
10. Self-respect

Activity 2: Role-play

Time allotted: 30 minute

Divide the trainees into triads: a counsellor, a client and an observer. Have the group role-play based on the case studies provided. Have each group's counsellor, client and observer discuss their thoughts and observations.

ACTIVITY 1:

Case 1

Smita is a housewife whose husband has just told her that he is HIV-positive. She comes from an educated family and cannot accept what he has told her. She had always thought that they had a good marriage but now has to face the prospect of an HIV test herself. They have a six-month-old baby. The thought that she and her daughter will be destitutes along with the social stigma was too much for her to handle. She is sad and depressed.

Case 2

Rekha is a 21-year-old housewife. She has a husband who is HIV-positive and requires recurrent hospitalization. She has two children. Rekha's in-laws are reluctant to keep Rekha and her children with themselves. She has no financial support even for medication. She feels hopeless in such a situation.

Case 3

Meena and husband Murli are HIV-positive. They have a three-year-old child Ram who is not HIV-positive. Meena has been feeling very ill and cannot look after Ram. Murli is working very hard to support his family. There are rumours about his health condition in the village and he is asked to leave his job.

Case 4

Laxmi is a commercial sex worker. She is HIV-positive. She has a three-year-old daughter. Laxmi's health is deteriorating. The lady who controls the brothel wants Laxmi to leave her house. Laxmi is concerned about her daughter's future.

Evaluation Form 1

Pre- and post-training knowledge questionnaire

Code number: _____

Score _____

1. List the three routes of HIV transmission.

1.

2.

3.

2. List three ways HIV is *not* transmitted.

1.

2.

3.

3. What do we call the period between when a person becomes infected with HIV and when it is possible to detect HIV antibodies?

4. A person can transmit HIV to someone else as soon as they become infected.

True/ False (underline correct response)

5. What are the two ways to test for the presence of HIV in a person?

1.

2.

6. All babies born to HIV positive mothers will test positive for HIV antibodies at birth.

True/ False

7. Give three reasons why HIV counselling is important.

1.

2.

3.

Pre- and post training knowledge questionnaire

8. Someone you see for pre-test HIV counselling tells you they have a partner but had sex with someone else four months ago. They did not use condoms with the other person and want to make sure they did not get HIV. The only other person they have had sex with is their regular partner. They do not use condoms with their regular partner because they trust them. They last had sex with their regular partner two days ago. Should this person have follow-up test?

Yes / No (*Underline correct response*)

9. In order what are the four principles of transmission?
- 1.
 - 2.
 - 3.
 - 4.
10. Underline which of the following are the **highest** risk behaviours for the transmission of HIV:
- Sharing needles to inject drugs
 - Kissing
 - A woman getting semen into her mouth
 - Mutual masturbation (male to male)
 - A baby in womb during mother's seroconversion to HIV
 - Mopping up blood spill
 - A man receiving oral sex from a woman
 - Anal sex with ejaculation
11. List four things that should be covered in a pre-test counselling session.
- 1.
 - 2.
 - 3.
 - 4.
12. List three ways to show you are listening to a client.
- 1.
 - 2.
 - 3.
13. Name two types of questioning used in counselling and give an example of each.
1. Example:
 2. Example:

14. When taking a risk practices history with a client who has had an occupational exposure to HIV you should not ask them any questions about their sexual history.

True / False

15. List four things you should cover when giving someone a negative HIV test result. (Order is not important)

- 1.
- 2.
- 3.
- 4.

16. What are the five things you should cover when giving someone a positive HIV test result? (Order is not important)

- 1.
- 2.
- 3.
- 4.
- 5.

17. Rapid HIV tests have low sensitivity and may miss identifying HIV infection.

True / False

18. You are using a serial rapid HIV test algorithm on a client. The test comes back HIV positive on one test. You run another test and it comes back positive. Can you report the test to the client that the tests are positive?

True / False.

19. You are a VCT counsellor. A male client has come for a test today. He admits he has visited sex workers when he goes out of town on business. You later recognise this man to be the husband of a woman attending your daughter's school. This woman has become a friend and you feel you should warn her about her husband's behaviour. As a counsellor, you should warn this woman of her husband's behaviour.

True / False

Pre- and post training knowledge questionnaire

20. List three self-care strategies for counsellors.
- 1.
 - 2.
 - 3.
21. Imagine there is a needle stick injury in the hospital. The client is sent to you after the injury. List in **correct order** from the first thing you should do down to the last one for VCT in the context of the management of occupational exposure (Assume that post-exposure prophylaxis is [PEP] is available for occupational exposures amongst health workers).
- 1.
 - 2.
 - 3.
 - 4.
 - 5.
22. When a client discloses a sexual assault what are the first three things you should do before conducting a forensic interview?
- 1.
 - 2.
 - 3.
23. Is there any evidence that there is a reduction in risky sexual behaviour of IDUs following VCT?
- Yes / No
24. Provide at least three examples of how to make a service more user friendly for MSM.
- 1.
 - 2.
 - 3.
25. List three ways HIV can be transmitted in prison.
- 1.
 - 2.
 - 3.

26. Provide at least two reasons why young people might be at risk of HIV infection.

- 1.
- 2.

27. What are the three signs that would indicate that a client is at high risk for suicide?

- 1.
- 2.

28. Underline only the **NO** HIV transmission risk method to guarantee that HIV is not transmitted from mother-to-child through breastfeeding.

- Exclusively breastfed babies
- Only use breast milk supplement
- Mix feed a combination of breast milk and supplement to reduce risk of infection
- Wet nurse (ask another woman to provide breast milk)

29. List three reasons why you might need to refer a client to another service or institution.

- 1.
- 2.
- 3.

30. List three advantages of group supervision for counsellors.

- 1.
- 2.
- 3.

Evaluation Form 2

Pre- and post-training knowledge questionnaire: Answer sheet

Code number: _____

1. List the three routes of HIV transmission. (One point for correct answer)
 1. Sexual
 2. Exposure to infected blood, blood products, or transplanted organs or tissues:
 3. Mother-to-child (infected mother to her infant before, during, or after birth)

2. List three ways HIV is *not* transmitted.
(One point for each correct answer—maximum three points)

Shaking hands, hugging, touching or kissing, using toilets, swimming pools, sharing eating or drinking utensils, through insects (such as mosquitoes).

3. What do we call the period between when a person becomes infected with HIV and when it is possible to detect HIV antibodies?
(One point for correct answer)

The window period

4. A person can transmit HIV to someone else as soon as they become infected.
(One point for correct answer)

True / False

5. What are the two ways to test for the presence of HIV in a person?
(One point for each correct answer—maximum two points)

1. The HIV antibody test, (which is often just referred to as the HIV test)
2. The antigen test (PCR)

6. All babies born to HIV positive mothers will test positive for HIV antibodies at birth. (One point for correct answer)

True / False

(Infants born to HIV infected mothers will have antibodies to HIV in their serum as a result of maternal-foetal transfer during pregnancy, delivery or breastfeeding but they may not necessarily be infected.)

7. Give two reasons why HIV counselling is important. (One point for each correct answer—maximum two points)
- Prevention counselling and behaviour change can prevent transmission
 - HIV diagnosis has many implications—psychological, social, physical, spiritual
 - HIV is a life threatening illness and it is lifelong
 - Counselling can help a person to deal with an HIV positive result
 - Counselling can provide information on other services
 - Counselling can help to address other issues in the client's life which might impact on HIV
8. Someone you see for pre-test HIV counselling tells you they have a partner but had sex with someone else four months ago. They did not use condoms with the other person and want to make sure they did not get HIV. The only other person they have had sex with is their regular partner. They do not use condoms with their regular partner because they trust them. They last had sex with their regular partner two days ago. Should this person have follow up test?
(One point for correct answer)

True / False

9. In order, what are the four principles of transmission? (One point for correct answer—maximum one point)
1. Exit—Virus must exit the body of an infected person
 2. Survive—The virus must remain alive and able to infect
 3. Sufficient—The virus must be in sufficient quantity to cause infection
 4. Enter—The virus must be able to enter another's body blood
10. Underline which of the following are the **highest** risk behaviours for the transmission of HIV:
(Award one point for correct answer—maximum three points)
- **Sharing needles to inject drugs**
 - Kissing
 - A woman getting semen into her mouth
 - Mutual masturbation (male to male)
 - **A baby in womb during mother's seroconversion to HIV**
 - Mopping up blood spill
 - A man receiving oral sex from a woman
 - **Anal sex with ejaculation**

Pre- and post-training knowledge questionnaire: Answer sheet

11. List four things that should be covered in a pre-test counselling session.

(Award one point for correct answer—maximum four points for any of the following)

1. Clinical risk assessment
2. Safe sex and safe injecting information.
3. Personal risk reduction plan
4. Assessment of personal coping strategies if test was to come back HIV positive
5. Basic information about the HIV test meaning of results and the window period.
6. Discussion of any potential negative social and legal issues related to a possible HIV diagnosis.

12. List three ways to show you are listening to a client.

(Award one point for correct answer—maximum three points for any of the following)

1. Make eye contact
2. Use minimal encouragers (mmmh, ah ah etc.)
3. Summarize (paraphrase) information the client has told you and repeat back to check that you have understood.

13. Name two types of questioning used in counselling and give an example of each.

(Give one mark for each correct answer, to a maximum of three)

1. Open questions Example: What difficulties do you have practising safer sex?
(The example would probably start with who, what, where, why and require the trainee to give more than a single word response.)
2. Closed questions Example: You do know that you should use a condom, don't you?
(The example would be a question that will only get a single word response like yes or no.)

14. When taking a risk practices history with a client who has had an occupational exposure to HIV you should not ask them any questions about their sexual history.

(One point for correct answer.)

True/ **False**

15. List four things you should cover when giving someone a negative HIV test result. (Order is not important)

(One point for any of the below response—maximum of four points)

- *Provide the result and explain the meaning*
- *Check for any window period exposure*
- *Advise client of any need or date to retest*
- *Assist client in solving any difficulties in practising safer sex or safer injecting*
- *Suggest partner is tested*
- *Reinforce safer sex/injecting issues.*

16. What are five things you should cover when giving someone a positive HIV test result? (Order is not important)

(One point for any of the below response—maximum of five points)

- *Provide the result and explain the meaning*
- *Assess for ability to cope with result including suicide risk assessment*
- *Assist client in concrete planning (e.g. who to tell, how they will get home from your office, what will they do over the next couple of days)*
- *Refer for follow up medical investigations*
- *Reinforce safer sex/injecting issues*
- *Discuss disclosing HIV status to current or future sexual partners*

17. Rapid HIV tests have low sensitivity and may miss identifying and infection.

True / **False**

18. You are using a serial rapid HIV test algorithm on a client. The test comes back HIV positive on one test. You run another test and it comes back positive. Can you report the test to the client as positive? (One point for correct answer.)

True / False

19. You are a VCT counsellor. A male client has come for a test today. He admits he has visited sex workers when he goes out of town on business. You later recognise this man to be the husband of a woman attending your daughter's school. This woman has become a friend and you feel you should warn her about her husband's behaviour. As a counsellor, you should warn this woman of her husband's behaviour. (One point for correct answer.)

True / **False**

20. List three self-care strategies for counsellors. (One point for any of the below response—maximum of three points)

Any three of the following:

- *Regular exercise*
- *Using relaxation techniques*
- *Discuss issues with another professional colleague (protecting client's confidentiality)*
- *Attend peer support peer supervision group*
- *Attend clinical supervision*
- *Be organized in your office*
- *Keep educating yourself about counselling and HIV*

21. Imagine there is a needle stick injury in the hospital. The client is sent to you after the injury. List in correct order from the first thing you should do down to the last one for VCT in the context of the management of occupational exposure (Assume that post exposure prophylaxis is [PEP] is available for occupational exposures amongst health workers).

(One point for each correct answer, response must be in correct order—maximum five points)

- *First aid*
- *Exposure risk assessment and feedback on risk*
- *Prophylaxis counselling—including informed consent for ARV's*
- *Pre-test counselling*
- *Blood drawn for baseline*

22. When a client discloses a sexual assault what are the first three things you should do before conducting a forensic interview? (One point for each correct answer—maximum three points)

- *Ensure clients immediate safety*
- *Contact police/authorities (if the client gives you consent to do so)*
- *Provide immediate medical care if required*

23. Is there any evidence that there is a reduction in risk sexual behaviour of IDUs following VCT?

(One point for correct answer)

Yes / No

The majority of studies show a reduction in risky sexual behaviour of IDUs following VCT.

24. Provide at least three *examples* of how to make a service more user friendly for MSM. (One point for each correct answer—maximum three points)
- *An anonymous service*
 - *Assures confidentiality*
 - *Staff who do not make value judgements about behaviours*
 - *Provides appropriate IEC material; is open at appropriate times such as late at night on at least some nights and on weekends*
 - *Is located in an accessible area*
 - *Provides free or low cost HIV and STI testing*
 - *Provides free or low cost condoms and water-based lubricant*
25. List three ways HIV can be transmitted in prison. (One point for each correct answer—maximum three points)
- *Sharing of injecting equipment*
 - *Sexual transmission*
 - *Tattooing 'blood brother' or group rituals with blunt instruments*
 - *Poor infection control in custodial medical settings*
26. Provide at least two reasons why young people might be at risk of HIV infection (One point for each correct answer—maximum two points)
- *Belief in their own invincibility / inaccurate risk perception*
 - *Lack of ability to negotiate safe sex*
 - *Difficulty to disclose status to parents, partners etc.*
 - *Abuse by health service providers.*
 - *Normal tasks of adolescence*
 - *Greater peer influence*
27. What are the three signs that would indicate that a client is at high risk for suicide? (Any three of the below—maximum of three points)
- *Previous history of suicide attempt or thoughts or history of previous self harm*
 - *Clear plans for suicide—able to describe how they would commit it*
 - *History of significant (high) of drug and alcohol use*
 - *History of depression*
 - *Has been on antidepressants (such as Serotonin reuptake inhibitor)*
 - *Image conscious*

28. Underline the only 'no risk' method to guarantee that HIV is not transmitted from mother-to-child through breastfeeding. (One point for correct answer)

- Exclusively breastfeed babies
- Only use breast milk supplement
- Mix feed a combination of breast milk and supplement to reduce risk of infection
- Wet nurse (ask another woman to provide breast milk)

29. List three reasons why you might need to refer a client to another service (Any three of the below—maximum of three points)

- *Social support*
- *Specialized medical care*
- *Home-based or community care*
- *Legal support*
- *Income generation activities*
- *Palliative care*

30. List three advantages of group supervision for counsellors. (Any three of the below—maximum of three points)

- *There is richness in having access to and hearing other people's work*
- *For people working in isolated ways the group provides interaction with colleagues and a sense of belonging*
- *It allows fuller feedback and reflection of who you are as a counsellor*
- *If safe enough, it's the place where you can be authentic, take risks and disclose failure or vulnerability and be helped to do something about it*
- *It is possible to receive support and challenge at the same time*
- *You can rest as well as be active*
- *There is opportunity to learn to supervise others—and practice.*

Pre-and post-knowledge questionnaire: Result sheet

Code number	Pre-course total score	Post-test total score
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

For data analysis

Paired sample test

Range and standard deviation from mean

Evaluation Form 3

HIV Counselling: Training evaluation

Please circle the most appropriate response.

1. The training provided me with knowledge to conduct voluntary counselling and testing (VCT) with clients:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

2. The training provided me with skills to conduct VCT with clients:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

3. The teaching methods used were helpful in developing practical skills:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

4. Most of the trainers demonstrated that they knew the material:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

5. Most of the trainers had good presentation skills:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

6. Most of the trainers demonstrated that they had practical experience in HIV counselling:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

7. On a scale of 0–10, to what extent has your knowledge of the following areas changed as a result of the training.

(Please indicate your response by placing a cross on one of the numbers).

- *HIV epidemiology / HIV transmission:*

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not				A little						A lot
at all										

1 2 3 4 5 6 7 8 9 10
/...../
Not A little A lot
at all

A horizontal Likert scale ranging from 0 to 10. The scale is represented by a series of dots with diagonal slashes (/) at each integer value. Below the scale, three anchor points are labeled: "Not at all" at position 0, "A little" at position 4, and "A lot" at position 10.

1 2 3 4 5 6 7 8 9 10

/..... /..... /..... /..... /..... /..... /..... /..... /..... /.....

Not A little A lot
at all

[illegible]

10. List three changes you could implement in your work as a result of completing this training?

11. Is there any other information you would like to have included in this training?

12. Do you have any other recommendations for changes to the training?

Evaluation Form 4

HIV Counselling: Trainer evaluation

Please circle the most appropriate response.

1. The trainer of this session had good presentation skills:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

2. The trainer of this session demonstrated that they knew the material:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

3. The trainer of this session was able to answer questions from the delegates:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

4. The trainer of this session demonstrated that they had practical experience in HIV counselling:

Very much disagree	Somewhat disagree	Don't know	Somewhat agree	Very much agree
-----------------------	----------------------	------------	-------------------	--------------------

5. Do you have any other comments about the trainer?

Annexure 1

Checklist for planning training

1. Setting the agenda

What to do	Required on which day of training	Date of task completed	Remarks
Decide training objectives Identify trainees Decide number of training days • For 12 days • For 5 days Decide day-to-day schedule Identify resource persons Type and print the schedule			

2. Accommodation

What to do	Required on which day of training	Date of task completed	Remarks
Name of the hotel Address Telephone number Fax number Cost per room Single room Double room No. of rooms required Date required: From....To... Transport from hotel to training venue			

3. Training venue

What to do	Required on which day of training	Date of task completed	Remarks
Number of training days (12/5) Spacious enough to conduct activities Electrical outlets, lighting, microphone Furniture, availability of photocopier machine, fax, telephone Comfortable seating Wall space for displaying charts Does the venue provide for flip charts, white board, marker pens, projector, computer/laptop Vehicle parking space available Check for break time facilities • Tea/Coffee • Lunch			

4. Provide the training centre/hotel/venue with the following information

What to do	Required on which day of training	Date of task completed	Remarks
Start and finish time on each day Coffee, tea and lunch break time Contact names and number of senior staff Information on specific requirements Copy of training schedule			

5. Letters to be sent to resource persons/trainees should contain

What to do	Required on which day of training	Date of task completed	Remarks
Name of training programme Objective of training Training schedule Date(s) of training Time Address of venue Contact person—name, address, phone number Is confirmation required? Travel directives (information on transport/ payment for travel)			

6. Checklist for Training Coordinator

What to do	Required on which day of training	Date of task completed	Remarks
Resource person's contact number Copy of letters sent Brief note on speaker Thank you note to speaker Extra handouts Activity sheets Activities for ice breaking, energizers, fillers Pre-/Post-knowledge questionnaire Evaluation of training questionnaire Stationery required • Pens/pencils • Notepad • Paper • Masking tape • Stapler/staples • Scissors			

(contd)

What to do	Required on which day of training	Date of task completed	Remarks
• Scotch tape • Two-sided tape • Flip cards • Index cards • Chart paper • Transparency sheets • Marker pens			

7. Audiovisual aids required

Item	Required on which day of training											
	1	2	3	4	5	6	7	8	9	10	11	12
White board LCD projector Overhead slide projector Computer/laptop Extension cord												

8. Preparing for field visit

- ✓ Select site(s) for visit as per guidelines provided in Annexure 3
- ✓ Arrange for transport
- ✓ Send letters to the centres informing
 - i. Date and time of visit
 - ii. Background and number of participants visiting
 - iii. Objectives of visit
 - iv. Name and contact details of officials visiting the centre with the trainees
 - v. Requirements from the centre

9. On the first day of training

- ✓ Provide information on housekeeping rules
- ✓ Mention ground rules for training
- ✓ Introduce the training team
- ✓ Introduce the trainees
- ✓ Introduce concepts such as question box and parking lot
- ✓ Review training schedule
- ✓ Administer pre-training knowledge questionnaire
- ✓ Provide information on handouts/activity sheets
- ✓ Introduce the concept of trainee summary

10. On each day of training

- ✓ Check for questions in the question box and answer the same at the start of the day or through experts (resource persons).
- ✓ Keep handouts and activity sheets ready.
- ✓ Be prepared with fillers and energizers.
- ✓ Have the nominated trainee summarize the previous day's sessions.
- ✓ Ask for feedback, if any.
- ✓ Send reminders to resource persons for the next day.

11. Final day of training (in addition to the above point 10)

- ✓ Post-training knowledge evaluation
- ✓ Evaluation of training

12. Post-training work

- ✓ Score the evaluation forms
- ✓ Prepare report
- ✓ Submit Statement of Expenditure (SOE), if required

Annexure 2

Guidelines for conducting role-plays

Overview of the role-play process

1. Divide trainees into groups of three (triads).
2. Each triad nominates a ‘counsellor’, a ‘client’ and an ‘observer’.
3. Give the case study to all clients.
4. Role-play the case provided.
5. Debrief within the triad for five minutes.
6. Debrief within small groups of all counsellors, all clients and all observers for 5–10 minutes. Discuss the following:
 - What made clients feel comfortable?
 - What skills were particularly important for counsellors to employ?
 - How did counsellors manage to balance provision of information with being responsive to the needs of the client’s emotions?
7. As per number of case studies provided swap roles
 - Counsellors become observers
 - Observers become clients
 - Clients become counsellors
8. Repeat the process until all case studies are completed

Implementing HIV Counselling role-plays

Ideally, role-plays should be arranged by dividing the trainees into triads. Each triad should nominate a ‘counsellor’, a ‘client’ and an ‘observer’. These three roles should be rotated between trainees so that they have an opportunity to experience each role. Accordingly, there should be three rounds of cases with one case being conducted per round. The trainer should hand the cases only to the trainees who are playing a client. The counsellors and observer should not be permitted to read the cases. The trainer should inform clients that ideally they **should not** share the cases with either counsellors or observers to make the role-play as real as possible.

Instructions to be given to each group

Counsellors are to practice applying the knowledge and skills learned through the lectures and other activities by completing the nominated task. If during the role-play become confused or uncertain, they should be instructed to refer to their notes, review their material and re-commence when ready. They should not ask for

assistance from their client or observer. If necessary, they should be instructed to put up their hand for assistance from a facilitator. At the conclusion of the role-play, the counsellor should discuss what they were happy with in their practice and what they would have liked to have done differently.

Clients are to play the role of the case outlined in the case study. They should attempt to allow the counsellor to practice obtaining the information rather than simply reading out what is written in the case study. Facilitators should instruct the clients to inform the counsellor if they are role-playing a person of the other gender, e.g. if the trainee is a female and playing a male client she should inform the counsellor that she is playing a male client. Clients should provide feedback to the counsellor at the conclusion of the role-play.

Observers are to observe the process of the role-play and provide feedback to the counsellor at the conclusion of the role-play. Observers should be asked to first give positive feedback and then constructive criticism. This helps in increasing confidence and avoiding discontent among trainees. Facilitators should remind observers that they should not interrupt the role-play.

Conclusion of each round

At the conclusion of each round, five minutes should be allowed for discussion and feedback within the triad. This exercise is to be followed by requesting the class to form three small groups. One small group should comprise all the trainees who played counsellors for that round, another group should comprise all the trainees who played clients and the third group should comprise all the trainees who played observers. A facilitator from among the trainers should be nominated to debrief each small group. One facilitator will debrief the counsellors, the other will debrief the clients and the third will debrief the observers. The small group facilitators should ask the trainees to share their role-play experiences and guide the discussion to the following three questions:

- What made clients feel comfortable?
- What skills were particularly important for counsellors to employ?
- How did counsellors manage to balance provision of information with being responsive to the needs of the client's emotions?

The small group debriefing should last no longer than 10 minutes following each round. Trainees should then return to their triads and swap roles. Different case studies should then be provided to the trainees who swap to being counsellors.

If only one or two facilitators are available then the debriefing should be performed as one large group following each round. Following the triads debriefing each other,

the trainees should be asked to return to one large group. Trainees should be asked to share their role-play experiences and the discussion should focus on the above three questions.

Finally, it is important to remind the trainees that they are in the process of learning. While they may feel overwhelmed at the beginning, each time they use the knowledge and skills they acquire, they will become more confident and improve their abilities.

Annexure 3

Guidelines for field visits

Field visit should be organized to provide the trainees with hands-on understanding of the operation and day to day functioning of VCT/PPTCT/ART centres. Field visits should include observation of activities at the centre, interaction with staff members and with clients visiting the centre. It should be followed by a debriefing session during which trainees discuss their observations and lessons learnt.

Planning and conducting a training field visit by the training coordinator

Ideally **one month before** the training, start to plan and organize the visit to a VCT/PPTCT/ART centre.

1. Contact one or more centres to gain permission for trainees to visit and meet with staff members.
2. Ideally, if there are several VCT/PPTCT/ART centres near the training venue, the trainees should break up into groups of 5 to 12 people each and visit different sites. Try not to send more than 20 trainees to any single facility.
3. In each centre organize meetings with the following groups:
 - Health-care worker (counsellors, technicians, I/C, nurse and/or physician)
 - Support staff
 - Programme manager and/or clinic director
 - Clients/patients visiting the centre
4. Send confirmation letter to the centres.

Once you have permission for the visit from the centre, follow up with a letter confirming the date and timing of the visit and the visit objectives. It may be a good idea to include the following in the letter:

- A brief description of the training (how many trainees, the disciplines of the trainees, etc.)
- The training content and how the field visit supports the overall goals of the training
- The geographic area from which the trainees come
- Information on how long you expect the visit to last
- Information on what the centre should share with the visiting trainees
- Other information you feel the centre should know
- Consider attaching a copy of the training agenda.

The day before the field visit

Call the I/C of the centre and reconfirm the visit. Provide important updates on the

training that you had not anticipated when you first spoke to them (for example the final number of visitors).

On the day of the visit

Field visit teams:

Divide trainees into teams and assign trainees to the different centres. Select a team leader for each team from among the trainees by asking the team to appoint a team leader. The team leader will be responsible for speaking on behalf of the group, when only one voice is necessary. For example they should ask trainees to introduce themselves, explain the objective of the visit and how long it will take, take the lead on asking questions, ensure that the other trainees in the group have an opportunity to ask their questions, conclude the visit and ensure the staff of the centre are thanked for their time and expertise. The leader should, on no account, dominate the meeting; instead they should simply facilitate, guide the discussion to ensure that it achieves its objectives, ensure that everyone in the group has a chance to speak and ensure that the group keeps to time. Ask the trainees to return to the training room at a pre-designated time.

The training coordinator should provide

1. The team leader with contact details (name, phone number, location) of the in-charge of the centre the team is visiting.
2. The trainees with information on what they should observe during visit.
3. The centres with information they should share with the trainees.

Once the team arrives at the VCT/PPTCT/ART centre, the team leader should contact the in-charge of the centre. After introductions, the team leader should initiate the discussion using the following questions as a guide:

1. Describe the flow of clients to your centre.
2. How many clients/patients visit the centre each day? How are they managed?
3. Describe the process on how clients/patients move through the centre—from when they enter the centre to the time they receive reports.
4. List the different registers and records maintained.
5. How are records maintained? Where are they stored?
6. Who prepares the monthly reports? Where is data extracted from the monthly report?
7. Describe the role and responsibility of each staff member in the centre.
8. What are the changes the centre has undergone since its inception?
9. Where are the monthly reports sent?
10. What does the centre do with the client data they collect?
11. What linkages and referrals have been set and how?
12. Who supervises the staff and how?
13. Is information, collected on clients, shared with the staff? when and how?

14. Are regular meetings held within the centre? Who attends the meeting, what are the issues discussed in these meetings?
15. In case the counsellor needs help whom do they go to?
16. Is there a DOTS/DMC centre within the hospital?
17. What are the different IEC materials you use?
18. What other monitoring data do you collect (clients satisfaction surveys, information received from staff during review meeting)? How are they used?
19. Are any other test offered at the centre?
20. Is emergency testing performed at the centre? What is the procedure followed?

Adapt these questions as appropriate keeping in mind the objective of the field visit. Feel free to re-arrange the questions to allow the discussions to flow and delete questions that seem inappropriate. Try not to ask questions that seem inappropriate. Try not to ask questions that were answered earlier.

Information which the team at the centre could share;

- Clinician (counsellor, nurse and or physician)
 - For how long have they been working with the VCT/PPTCT/ART centre?
 - How many clients/patients visit their centre each day?
 - Describe the client/patient flow at the centre?
 - Share information on forms, records, registers and reports that you complete at the VCT/PPTCT/ART centre.
 - When do they complete these records (eg. when the patient is in front of you or after the clinical visit)?
 - Do they record information for each client/patient?
 - What other reports do each staff member write or contribute to?
 - To whom do they submit the reports/forms?
 - What comments do they have on the process of completing the forms and reports?
 - Do you feel like the effort they put into reporting is worth it?
- Support staff:
 - Explain their role in the centre
 - What are the records they maintain (if any)
 - What thoughts/feedback do they have around this entire process of running the centre?
- Programme manager and/or clinic director;
 - Share their responsibility in reference to the VCT/ PPTCT/ART centre.
 - How do they supervise their staff?
 - What VCT/PPTCT/ART reports are they responsible for submitting? Who do you submit them to?
 - Share the most recent report submitted to SACS

- Do you try to interpret any of the data collected at their centre? What additional information do they get from this data? What do you do with the data here at a local level?
- Share examples of initiatives they have undertaken using the data from the monitoring process
- What other monitoring data do you collect? For example do they have clients/patients?
- Fill in satisfaction surveys? Do they interview clients/patients to find out about their experience with your service?
- How do you get monitoring feedback from their staff?

Debrief following field visit:

- Have each team leader summarize observations from field visit.
- Ask the larger group of trainees if they have any other observations they would like to share or questions to ask.
- Ask the trainees to prepare a brief action plan on changes they would like to bring about at their centre based on lessons learnt from field visit.

After the training is completed

It may be appropriate to send a short note to the centre, thanking the in-charge and the staff for their time and readiness to share their experiences. A thank you note is especially important if the training coordinator plans to send further teams of trainees to the centre.

Annexure 4

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Annexure 5

List of experts

The following experts contributed to the development of this training manual.

- | | |
|--|---|
| 1. Dr Sushma Mehrotra
P-1A, Hauz Khas Enclave
New Delhi 110016
mehrotrasushma@hotmail.com | 6. Dr Sudha Bhogle
Professor of Psychology
Social Science Block
Bangalore University
Jnanabharathi Campus
Bangalore 560056
080-56720860/3211486 (O) |
| 2. Professor B.L. Barnes
Dr Leo Barnes Foundation
Samudraseema
329, Dr B.R. Ambedkar Road
Bandra, Mumbai 400050
bb7d@hotmail.com | 7. Dr Anna Mathew
R.M. College of Social Work
Paan Maktha, Gachibowli
Golconda
040-23001887 (O)
040-23879254/23878960 (R)
ushmat@rediffmail.com |
| 3. Dr Geeta Joshi
18, Nutan Society, M.G. Road
Naupada, Thane
sbjoshi@bom3.vsnl.net | 8. Dr K. Promodu
Department of Psychiatry
Calicut Medical College
Kozhikode
0495-2352665/2354579
09447152665 (Mob.)
drpromodu@yahoo.com |
| 4. Ms Tasneem Raja
Manoshakti, Crisis Intervention Center/
SNDT Women's University
1, Nathibai Thakarsey Road
Mumbai
kripafound@sancharnet.in | 9. Dr K. Giresh
Mental Health Centre
Thiruvananthapuram
0471-2465263 (O)
09447065263 (Mob.)
krishnangirreesh@hotmail.com |
| 5. Dr Romate John
Counselling Psychologist
Centre for Psychological Counselling
Bangalore University
Bangalore 560056
080-56720860/3211486 (O)
080-8602424 (R)
Romate_j@hotmail.com | 10. Mr Ashok Rao Kavi
Hamsafar Trust
10, Rivera, 15th Road Santa Cruz (W)
Mumbai 400054 |

11. Mr Srinath Radder
ICHAP
Pisces Building, #4/13-1,
Crescent Road
High Grounds
Bangalore 560001
srinaddur@vsnl.net
12. Dr Anjali Gandhi
D-40 East of Kailash
New Delhi 110065
13. Dr Uma Ravikumar
F3, 2nd Floor, Prime Rose Appartment
15, Ellaiamman Koil St Adyar
Chennai 600020
umak@indiatimes.com
ckr@cpcl.co.in
14. Ms Rama Shridhar
G-103, Lenyadri Cooperative Society
Sector 19-A
Plot No. 8/9
Nerul Navi Mumbai
09819229212 (Mob.)
Sridhar@thehindu.co.in
15. Dr Sibnath Dev
Department of Applied Psychology
Calcutta University
Kolkata
033-23501014 (O)
033-23233601 (O)
sibnath@vsnl.net
16. Ms Anuradha Patil
Lecturer
Karve Institute of Social Service
Karve Nagar
Pune 411052
020-5434203 (O)
020-5383980 (R)
17. Dr Nilima Mishra
Professor and Head
Department of Psychology
Lucknow University
Lucknow
18. Dr Archana Shukla
Professor, Department of Psychology
Lucknow University
Lucknow
archana1942@sify.com
arch_shuk_2000@yahoo.co.in
19. Dr R.K. Lenin Singh
Assistant Professor of Psychiatry
RIMS
Wangkhei Ningthem Pukhri Mapal
Imphal 795001
Manipur
0385-2224508/2310750 (O)
leninrk@yahoo.com
20. Dr S. Haque
Director and Medical Superintendent
Central Institute of Psychiatry
Ranchi 834006
rch_cip45@sancharnet.in
21. Professor S.R. Khan
Head, P.G. Department of Psychology
University of Jammu
Baba Saheb Ambedkar Road
Jammu 180006
khanshamsjmu@yahoo.com
22. Professor U.N. Dash
Centre of Advanced Studies, Psychology
Utkal University
Vani Vihar
Bhubneshwer 751004
0674-2587226 (R)
0674-2581739 (O)

23. Dr Amool Ranjan Singh
Professor and Head
Department of Psychology
RINPAS
Kanke Road
Ranchi
dr_amool_r_singh@rediffmail.com
24. Dr Neeru Bhatia
NACO
25. Ms Rohini Ramamurthy
14/270, Sanghani Sadan
Deodhar Road, Matunga
Mumbai 400019
rohiniramamurthy@hotmail.com
26. Dr Shantha Thayumanavan
Professor of Microbiology
Stanley Hospital
Chennai
thayshan@hotmail.com
27. Dr V. Ravi
NIMHANS
Bangalore
28. Dr Shubhangi Parkar
Professor and head
Department of Psychiatry
G.S. Medical College and
K.E.M. Hospital
Parel, Mumbai
pshubhangi@mantraonline.com
29. Dr N. Desai
Institute of Human Behaviour and Allied
Sciences
Delhi
9810797933
ndg1955@rediffmail.com
ndg2000@hotmail.com
30. Ms Trupti Tandon
Lawyers Collective HIV/AIDS Division
1st Floor, 63/2 Masjid Road, Jangpura
New Delhi 110014
aidslaw1@del2.vsnl.net.in
31. Ms Magdalene Jayaratnan
Magdalene20@hotmail.com
32. Dr Shantibala
Department of Psychiatry
J.N. Hospital
Porompat, Imphal
Manipur 795001
shanty_koijam@rediffmail.com
sasoiimph@sancharnet.in
33. Dr Arun Gupta
National Coordinator
BPNIBP-33, Pitampura
New Delhi 110088
34. Dr M.M.A. Faridi
Professor and Head
Department of Paediatrics
University College of Medical Sciences
GTB Hospital
New Delhi 110095
35. Dr M. Bhattacharya
Head, Dept of CHA
National Institute of Health and
Family Welfare
New Mehrauli Road
Munirka
New Delhi 110067
36. Dr Sanjeev Sinha
Department of Medicine
AIIMS
Ansari Nagar
New Delhi

- | | |
|--|--|
| <p>37. Professor S.K. Sharma
Professor and Head
Department of Medicine
AIIMS, Ansari Nagar
New Delhi</p> <p>38. Dr V.K. Sharma
Professor and Head
Department of Dermatology
AIIMS, Ansari Nagar
New Delhi</p> <p>39. Dr H.K. Kar
Consultant STD
RML Hospital
New Delhi</p> | <p>40. Dr B.B. Rewari
Senior Physician
RML Hospital
New Delhi</p> <p>41. Mr Binod Mahanty
Technical Officer, VCT
World Health Organization
New Delhi</p> |
|--|--|



Facilitator's Guide



National AIDS Control Organization
9th Floor, Chandralok Building
36 Janpath, New Delhi 110001
Phones: 23325335, 23325343,
23731774, 23731778, 23731954
Fax: 23731746
Website: www.naco.nic.in