



HIV Counselling Trainer's Manual for the Asia-Pacific

- Voluntary counselling and testing
- Provider-initiated testing and counselling
- Treatment and care counselling



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 Family Health International

 World Health Organization
South-East Asia Region Western Pacific Region

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- Treatment and care counselling

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Preface

HIV Counselling Resource Package for the Asia Pacific Region

Antiretroviral treatment offers hope of arresting a communicable disease that was once untreatable and remains incurable. The prospects of surviving HIV and living longer should in many ways lessen the fear of HIV testing and the consequent discovery of HIV-positive status. Yet, the advent of antiretroviral therapy and new drugs have not provoked wide test-seeking behaviour, and the uptake of voluntary and confidential counselling and testing services has been slow.

In 2005, in some countries, particularly those in sub-Saharan Africa, 12%–25% of women and 8%–24% of men living with HIV learnt of their HIV status only after participating in a survey. An estimated 0.1% of adults in Asia and the Pacific have been tested, and it is believed that less than 10% of those living with HIV are aware of their status.

The urgent need to help more adults and children, especially in vulnerable, marginalized communities, find out their HIV status and receive treatment is beyond question. But HIV testing—whether client- or provider-initiated—is more than simply uncovering HIV cases. The quality of counselling and respect for the right to opt out of testing, as well as support measures for coping with the results, are just as important. Counselling, before or after testing, should increase knowledge of HIV prevention and enhance primary health care and positive prevention, as well as curative care when positive status is confirmed. The quality of counselling also shows itself in the quality of referrals, follow-ups, treatment adherence, and care, including nutritional, psychosocial and medical support, such as cotrimoxazole prophylaxis, to sustain the well-being of adults and children living with HIV.

This comprehensive HIV counsellors resource package answers the pressing need to improve the quality of counselling as countries step up their drive to contain the AIDS epidemic. Prepared over two years by WHO and UNICEF with technical assistance from the Family Health International Asia-Pacific Regional Office, it is designed to equip trainers, counsellors in training, and working counsellors in the Asia Pacific Region with essential skills and knowledge to deliver high-quality HIV testing and counselling services in a range of approaches and settings. The HIV counsellors handbook, trainer's session plans, participatory learning activities, and HIV counsellor toolkit found here were updated from the *Voluntary HIV Counselling and Testing Manual for Training of Trainers* (2004) prepared jointly by the WHO South-East Asia Regional Office and the UNICEF East Asia and the Pacific Regional Office.

The newer features of the current package reflect the new types of tests being used by health care providers. The provider-initiated testing and counselling approach is based on the UNAIDS/WHO Policy Statement on HIV Testing (2004), which was drafted after numerous rounds of consultations to deal with the low uptake of Voluntary and Confidential Counselling and Testing worldwide.

The expansion of client- and provider-initiated testing and counselling services in health care settings must be carefully considered. HIV testing and counselling strategies, particularly for high-risk and vulnerable populations, must be implemented in an ethical manner that respects human rights. Utmost priority must be given to training and supervising health care providers, particularly in counselling clients, obtaining their informed consent, keeping HIV test results confidential, referring clients for treatment and giving them better access to appropriate services, and reducing stigma and discrimination. Understanding of the role and effectiveness of HIV counselling and counsellors-an area that deserves further support and investment-must improve.

We hope that this comprehensive resource package informs and inspires greater efforts to upgrade HIV prevention, care and support and that it strengthens the capacity and quality of health care, as well as its links with communities and families affected by AIDS, towards greater universal access and the fulfillment of the Millennium Development Goals.



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Acronyms

ADC	AIDS dementia complex
ADLS	activities of daily living
AIDS	acquired immune deficiency syndrome
APRO	Asia and Pacific Regional Office (of Family Health International)
ARV	antiretroviral
ART	antiretroviral therapy
BBV	blood-borne virus
CDC	US Centers for Disease Control and Prevention
CNS	central nervous system
EIA	enzyme-immune assay
ELISA	enzyme-linked immunosorbent assay
ESSE	exit, survive, sufficient, enter
FBO	faith-based organization
FTM	female to male
GUS	genital ulcer syndrome
HAART	highly active antiretroviral therapy
HBC	health behaviour communication
HBV	hepatitis B
HCV	hepatitis C
HCW	health-care worker
HIV	human immunodeficiency virus
HLA	human leukocyte antigen
HPV	human papilloma virus
HTC	HIV testing and counselling
IDU	injecting drug user
MARA	most-at-risk adolescents
MARPS	most-at-risk populations
MSM	men who have sex with men

MTF	male to female
NGO	nongovernmental organization
NNRTI	non-nucleoside reverse transcriptase inhibitor
NRTI	nucleoside reverse transcriptase inhibitor
OI	opportunistic infection
OST	oral substitution therapy
OVC	orphans and vulnerable children
PCR	polymerase chain reaction
PCP	<i>Pneumocystis carinii</i> pneumonia
PEP	post-exposure prophylaxis
PI	protease inhibitor
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV and AIDS
RIPA	radio-immunoprecipitation assay
STI	sexually transmitted infection
SSRI	selective serotonin reuptake inhibitor
SW	sex worker
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WHO	World Health Organization
ZDV	zidovudine

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Annex 2: HIV counselling knowledge questionnaire answer key

Annex 3: HIV counselling knowledge questionnaire results sheet

Annex 4: HTC training course evaluation

References

Introduction and use of this manual

Overall objectives of the training

- To improve the technical capacity of counsellors to provide HIV testing and counselling across the disease continuum;
- To train counsellors in evidence-based counselling strategies that may help reduce HIV transmission;
- To provide counsellors with skills to support adherence to HIV treatment and care; and
- To reduce the psychological morbidity associated with HIV disease and improve the quality of life of people living with HIV.

Introduction to the resource package

While no training manual can be exhaustive, this package attempts to outline the key activities and information involved in training HIV counsellors to work in voluntary counselling and testing (VCT), provider-initiated testing and counselling (PITC), and HIV care counselling settings in the Asia and Pacific regions.

The resource package comprises three complementary elements:

- *HIV Counselling Handbook: A Comprehensive Guide to Voluntary Counselling and Testing, Provider-Initiated Testing and Counselling, and Care Counselling for the Asia and Pacific Regions;*
- *HIV Counselling Trainer's Manual for Voluntary Counselling and Testing, Provider-Initiated Testing and Counselling, and Care Counselling for the Asia and Pacific Regions; and*
- *Tools for HIV Counselling.*

This trainer's manual contains essential information for the use of those facilitating or conducting the training of HIV counsellors for low- and high-concentration HIV epidemic areas in the Asia and Pacific regions. This manual contains 16 modules with clearly stated objectives and session plans. The printed manual contains all the training resources listed in the Training Resources Outline. This outline gives the module and sub-module numbers, the titles of the sessions, and the corresponding numbers of these associated materials:

- Session plans, and
- Trainee activity instructions.

The annex of this trainer's manual contains sample training evaluation materials.

The handbook and the trainer's manual can also be found on the CD-ROM under the various module and sub-module numbers.

Before starting any training programme, you may wish to refer to the Preparation for the Training section, which follows this introductory section.

Remember: The session plans and activity sheets included in this trainer's manual should be used in conjunction with the counselling handbook and counselling tools in this training package.

Disclaimer: The training programme requires supervised rehearsal of skills; therefore, this manual is not suitable for use as a self-directed learning tool. This manual should be used only by persons who have successfully completed this course. Its use by clinicians or trainers who have not participated in the specific training activities may compromise the quality of the training provided, and is not recommended.

Time required for training

This is an eight-day training programme that may be adapted as appropriate to longer or shorter periods of training. Where funding and logistic arrangements permit, one day during the eight-day period could be set aside for site visits, to allow the trainees to see how practising counsellors deliver services.

The modular format allows sessions or “modules” to be added or omitted according to their relevance to the culture and epidemic profile of the country in which the training is taking place, the time available for training, and the participants’ level of practical experience in hands-on patient management. Specific suggestions for adapting the programme to different time frames and training contexts are outlined here. In general, with limited time and special groups, core modules should be included, and activities and case studies that will highlight issues specific to the objectives of the training and the epidemiology in the local area should be selected. For example, in settings where transmission is associated with injecting drug use (IDU), the IDU module should be included; if health-care workers providing antenatal care are being trained, then the training must include the module Pregnant Women, New Mothers and Their Partners. Reading materials or follow-up training could be offered instead of some modules, to shorten the training programme. Training for counsellors who offer HIV counselling only in association with HIV testing could omit the modules related to the provision of HIV care counselling and treatment adherence counselling. For counsellors who are required to provide only HIV care counselling or treatment adherence counselling support, on the other hand, the training could leave out the modules related to HIV counselling in association with the HIV test.

Some specific course examples are outlined in the section Training Programme Timetable.

Note on using these tools

*The tools included in the HIV counselling resource package are **not** intended to replace national programme monitoring tools. The counselling forms are designed to inform clinical decision making and case management, and may also be used to provide a medico-legal record of a counsellor-client interaction. The client worksheets are intended to assist the counsellor in performing specific counselling activities, and other tools are included to help clients and patients understand more complex clinical concepts.*

List of materials

Below is a list of the documents and tools that make up this package. File names are provided for each to facilitate their location on the CD-ROM included in the package.

Handbook

Name	File name
1. <i>Handbook for HIV Counselling: A Comprehensive Guide to Voluntary Counselling and Testing, Provider-Initiated Testing and Counselling, and Care Counselling for the Asia and Pacific Regions</i>	HIV Counselling Handbook

Trainer's manual

Session plans

Session plan name	File name
1. What HIV counsellors need to know about HIV, STI, and TB: The basics	M01-SP What counsellors need to know
2. Key elements in HIV and STI counselling practice	M02-SP Key elements of counselling
3. Behaviour change strategies in HIV counselling	M03-SP Behaviour change counselling
4. Pre-HIV test counselling and group pretest information provision	M04-SP Pretest and group information
5. How to provide HIV test results	M05-SP HIV test results
6. Counselling for suicide prevention	M06-SP Suicide prevention
7. Developing a post-diagnosis support plan	M07-SP Post-diagnosis support
8. Supporting HIV disclosure	M08-SP Supporting HIV disclosure
9. Counselling for treatment adherence	M09-SP Adherence counselling
10. Pregnant women, new mothers, and their partners	M10-SP Pregnant women
11. Counselling children and adolescents	M11-SP Children and adolescents
12. Working with MSM and transgender clients	M12-SP MSM and transgender clients
13. Counselling sex workers	M13-SP Counselling sex workers
14. Counselling drug and alcohol users	M14-SP Drug and alcohol users
15. Counselling health workers after accidental occupational exposure	M15-SP Accidental exposure
16. Grief, bereavement, and loss	M16-SP Grief and bereavement
17. Post-exam and course evaluation	M17-SP Assessment

Activity sheets

Activity sheets	File name
1. Communicating key information to clients	M01-AS1.1 Communicating Information
2. Counsellor ethics	M02-AS2.1 Ethics case studies
3. Counsellor-client roles	M02-AS2.2 Counsellor-client roles
4. Questioning quiz	M02-AS2.3 Questions about sexual practices
5. Case studies on strategies for counselling and motivational interviewing	M03-AS3.1 Motivational interview
6. Group pretest information	M04-AS4.1 Group information
7. Case studies on risk assessment	M04-AS4.2 Risk assessment case studies
8. Case studies on pre-HIV test counselling	M04-AS4.3 Pretest case studies
9. Case studies on HIV test results	M05-AS5.1 Test results case studies
10. Case studies on suicide risk assessment and management	M6-AS6.1 Suicide risk case studies
11. Case studies on post-diagnosis support plans	M07-AS7.1 Support plan case studies
12. Counsellor challenge response	M08-AS8.1 Counsellor challenge
13. Case studies on supporting HIV disclosure	M08-AS8.2 Disclosure case studies
14. Explaining resistance	M09-AS9.1 Explaining resistance
15. Case studies on pre-adherence screening	M09-AS9.2 Pre-adherence case studies
16. Case study on supporting client adherence	M09-AS9.3 Supporting adherence case study
17. Counselling for treatment adherence	M09-SP Adherence counselling
18. Fast-facts quiz about pregnant women, new mothers, and their partners	M10-AS10.1 Fast-facts quiz
19. Role-play on counselling for PMTCT	M10-AS10.2 PMTCT
20. Counselling men for PMTCT	M10-AS10.3 Counselling men for PMTCT
21. Talking to children about HIV	M11-AS11.1 Talking to children
22. Case studies on child disclosure issues	M11-AS11.2 Child disclosure case studies

Activity sheets	File name
23. Case studies on MSM risk and vulnerability	M12-AS12.1 MSM risk case studies
24. Case studies on sex-worker risk and vulnerability	M13-AS13.1 SW risk cases
25. Role-play on behaviour change and drug use assessment	M14-AS14.1 Drug use assessment
26. Case studies on accidental occupational exposure	M15-AS15.1 Exposure case studies
27. Case studies on loss in an adult	M16-AS16.1 Adult-loss case studies
28. Case studies on loss in a child	M16-AS16.2 Child-loss case studies

Toolkit

Tool name	File name
1. How you can get HIV	T1.1 HIV transmission
2. HIV replication (technical version, page 1; low-literacy version, page 2)	T1.2 Viral replication
3. Explaining HIV in the body	T1.3 HIV in the body
4. Sexually transmitted infections	T1.4 STI
5. Where are you in the change process?	T3.1 Change-ready
6. Decision making	T3.2 Decision
7. Goal setting and commitment to change	T3.3 Prep for change
8. Pre-HIV test counselling interview form	T4.1 Pretest form
9. The window period	T4.2 Window period
10. Correct condom use	T4.3 Condom
11. Safe injecting	T4.4 3 x 2 x 6
12. Post-HIV test counselling form	T4.5 Post-test form
13. Referral form	T4.6 Referral form
14. Consent for release of information	T4.7 Release info
15. Suicide risk assessment interview guide	T5.1 Suicide assessment
16. Suicide risk assessment matrix	T5.2 Suicide matrix
17. Post-diagnosis follow-up counselling form	T6.1 Follow-up
18. Psychological problem screening checklist	T6.2 Psych screen
19. Pretreatment adherence counselling: Checklist and summary record form	T8.1 Pre-adherence checklist

Tool name	File name
20. How antiretroviral therapy works	T8.2 ART works
21. Reference cards for barriers to adherence	T8.3 Barriers to ADH
22. Pre-ART adherence screening tool	T8.4 Pre-adherence screening
23. What causes HIV resistance to ARV drugs?	T8.5 Resistance
24. ART drug side effects	T8.6 Side Effects
25. Practical problem solving for managing common barriers to adherence	T8.7 Problem solving (ART)
26. What can I do to have a healthy and safe pregnancy?	T9.1 Safe and healthy pregnancy
27. Assessment of drug and alcohol use	T9.5 Drug and alcohol assessment
28. Activities for processing children's grief	T10.1 Child grief

Other

Game name	File name
1. Activity cards for four principles of transmission activity cards	M3-SP-AC 4 Principles

Preparation for training

Selecting a suitable training venue

Location

Ideally the training should be located away from the trainees' normal workplace to avoid interruption. It will be also be important to consider the transport needs of the trainees when selecting the venue.

Venue characteristics and facilities

This is participatory training, requiring trainees to participate in role-plays and small-group, case-based learning activities. It is therefore essential that you use a room that does not have fixed lecture-style seating. The room should be large enough to allow the anticipated number of trainees to be seated in small table groups (usually not more than five per table), and to have enough space to engage in other learning activities that require individuals to move around the room.

It is further recommended that the training venue have an adequate number of toilet facilities, and have adequate heating or air conditioning and lighting to ensure the comfort of trainees. A backup power supply is highly recommended. Avoid venues near construction zones.

It is highly desirable that the room be used exclusively for training throughout its duration. This will avoid the necessity of having to pack up equipment and materials and then reorganize the room again each day. The room should also have adequate security so that equipment can be left and be available for use each day, thus requiring minimal daily preparation.

Consider the advantages of offering residential training. This will reduce the disruption to training that occurs as a consequence of trainees arriving late to class each day.

When training is not to be residential, consider the advantages of providing meals to the trainees at the training venue. The training course follows a very strict timetable. It is therefore essential that the sessions begin and end at the appointed times. The provision of morning tea, lunch, and afternoon tea at the site of the training has the advantage of ensuring that all trainees return promptly from breaks. It also creates flexibility within the program should there be a need to shorten breaks or complete work within a break. Further, it tends to contribute to the general satisfaction of trainees and allows them to focus to a greater degree on the material being learned.

Determining group size

Group size for classroom counselling training should not exceed 28 participants. The ideal number is 21-27. The smaller the group, the more quality time and opportunity the trainees have to practice their skills. As some group activities require splitting the trainees into groups of threes, it is suggested that the number of trainees be divisible by three.

Forming the training team

Roles and responsibilities

Many people may be involved in conducting a training course. These can include the following:

- A training coordinator or director,
- Administration assistants,
- Trainers,
- Training assistants, and
- Trainees.

In training courses a trainer may assume one or more of these roles. Each role has different responsibilities:

Training coordinator or director

Several months before the training is to be conducted the director should do the following:

- Obtain approval from relevant bodies for conducting the training;
- Develop a training programme and timetable;
- Develop a budget for training;
- Obtain funding for conducting the training course, e.g., through training grants, from government bodies, nongovernmental organizations, or sponsors;
- Develop criteria for trainers, send invitations and training details (dates, venue, contact details) to potential trainers, and identify trainer availability;
- Arrange for course materials, including session plans, hand-outs, and PowerPoint or overhead presentations, to be forwarded to trainers so they can become familiar with the content of their sessions and practice presenting;
- Decide on an appropriate number of participants (it is recommended that you do not invite more than 28 trainees to a course to ensure that they all benefit from the discussions and practical work);
- Develop criteria for trainees and send invitations to potential trainees or send course announcements to relevant health facilities, asking them to identify suitable trainees;
- Choose the training facility, keeping in mind the number of trainees attending and ensuring that all necessary equipment and resources will be available and within the budget;
- Arrange accommodation for trainers and trainees if necessary and according to budget;
- If applicable, arrange transportation for trainers and trainees from their accommodation to the training venue and back;
- Arrange payment for trainers (if appropriate), or reimbursement for their related training expenses;
- Plan the timetable and details for trainer preparation;
- Arrange catering for the course, including morning and afternoon teas and lunch;
- If training is to take place in another language besides English then the course materials, and perhaps the training sessions as well, will need to be translated, and the participation of an appropriate interpreter arranged;
- Arrange the printing of trainer's and trainee manuals (and other supporting materials like compact discs), as resources and the budget allow;
- Arrange for other training resources such as name badges, male and female condoms, pens and paper (*refer to checklist below for further supply details*);
- Develop overall evaluation forms;
- Develop a training checklist to help in planning;
- Delegate some of the responsibilities to administrative assistants or trainers;
- Facilitate opening and closing ceremonies during the training course, and invite guest speakers, if appropriate, and brief them; and
- At the completion of the training, collate the training evaluations and write a report or delegate someone else to do this.

Administrative assistants

Where staff are available to support and assist the director, they should undertake any of the above tasks as delegated by the director. The administrative assistant or support staff should be available throughout the training course in case problems arise with any of the arrangements for trainers or trainees. These staff can also be responsible for trainee registration, distribution of trainee materials, documentation for auditing or report writing, and maintenance of equipment.

Trainers

Ideally trainers should:

- Be working in the field on which they will be asked to present, to allow the trainees to establish important links to external individuals and agencies that may assist them in their future clinical work;
- Have had previous training experience;
- Be fluent in the language in which the session will be delivered;
- Be motivated and enthusiastic;
- Be willing to attend the entire course;
- Be willing to prepare adequately for the course and assist or work with other trainers where required;
- Be willing to attend a planning and preparation day before the course, where trainers are briefed, details are reiterated, and the presentation of sessions practiced, and to modify training styles, techniques, or length where suggested by peer review;
- Be guided by the training coordinator;
- Be willing to attend daily debriefing sessions if required; and
- Evaluate their training sessions and analyse results for contribution to final training report.

External trainers/Guest speakers

The use of a range of external trainers or guest speakers presents both advantages and disadvantages. Some of the advantages are:

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

Some of the disadvantages of using external trainers or guest speakers are:

- When inadequately briefed, speakers may launch into their standard lecture response.
- Speakers may present non-evidence-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 methods.
- Speakers may not keep within the time-frame provided.

To maximize the use of external trainers or guest speakers:

- Ensure they are adequately briefed, orally and in writing, about what is expected of them. Provide guidelines that specify 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.
- Ensure that the regular trainer remains present where possible while the external speaker presents. This ensures continuity if any issues arise. In addition, regular trainers are also able to observe and provide useful feedback to the external trainer/guest speaker.
- Always ensure that external trainers / guest speakers are given feedback from both the organization and trainee evaluations in order to continue to improve their sessions.

Training team members should attend a pre-training meeting to discuss logistics, roles, and responsibilities.

Preparing the training materials

Each participant and member of the training team must be given a copy of the *HIV Counselling Handbook: A Comprehensive Guide to Voluntary Counselling and Testing, Provider-Initiated Testing and Counselling, and Care Counselling for the Asia and Pacific Regions*. All the training activities assume the availability of this resource.

Each trainee will also need a copy of the *Tools for HIV Counselling*, and all members of the training team should have a copy of the *Trainer’s Manual* and a set of the *Tools for HIV Counselling*.

Preparing the trainee activity sheets

As many of the activities require the trainees to have no advance knowledge of the content, you must photocopy enough activity sheets for each participant just before the training. Make sure you bundle each activity according to the activity number and distribute them only when the session plan so directs, i.e., photocopy and bundle all activity sheet (AS) 1.1s together, all AS 1.2s together, and so forth.

The activity sheets required for each day should be placed in a bundle on the “materials table”, accessible only to the training team.

Preparing the tools

Make sure that you have enough copies of the toolkit items for all the participants.

Again, it is recommended that the various tools be passed out as instructed in the relevant module session plan.

Checklist of supplies and space requirements for training

- Timetable
- Room
- Adequate seating (“café style” seating for table group work)
- Personnel (trainers, resource persons, administrative support)
- Notebooks and pens for participants
- Coloured crayons or markers (at least one box per class table)
- Enough copies of the *HIV Counselling Handbook* (one per trainee)
- Flipchart paper and stand
- Markers, blue and black (other colours are not discernible from a distance)
- “Sticky stuff” / Cellotape
- Scissors
- Enough copies of activity sheets (all copies of each activity sheet bundled together)
- Blank overhead transparency sheets
- Overhead projector and markers
- Box for collecting written questions from trainees
- Box for collecting evaluation forms
- Condoms, male and female (allow two per trainee)
- Penis and vagina models for condom demonstrations
- Injecting equipment (needle, syringe, two small bowls, red food colouring, and water)
- Samples or photographs of antiretroviral pills for the Counselling for Treatment Adherence module

Providing pre-course information to potential trainees, and their employers

The effectiveness of training is diluted when firm trainee selection criteria are not applied. This training assumes the ability to read and write, though individuals unable to read or write have attended the course with additional trainer support. But participants with no interest in HIV counselling or prospect of engaging in such counselling after the training would be disruptive of the learning environment.

Trainers and course organizers are strongly encouraged to issue selection criteria and to follow up this matter with prospective trainees and their employers. Prospective participants should also be told in advance of the attendance, punctuality, and level of participation in learning activities expected of trainees. Often, when these expectations are spelt out in advance only participants who truly wish to be involved will attend the training.

To ensure a satisfactory learning environment:

- All trainees must be present **throughout** the training. Trainees who do not attend the entire course should not be given certificates. If a trainee cannot complete the course because of some emergency, the trainer should negotiate with the trainee to complete the missed segments at a future time and receive the certificate at that time. This is critical to ensuring the quality of counselling. If a trainee misses any segments, the trainer should brief the trainee on his or her return about what was missed, to maintain continuity in the training and not place the trainee's role-playing partner at a disadvantage during role-plays or other activities.
- Begin training sessions on time. All trainees should arrive on time. There is much material to be covered each day, and it can be very disruptive to have some trainees arrive at the training sessions after the sessions have begun.
- Enforce the use of mobile phones and other communications media only during meal breaks and not during class time. Prospective trainees and their employees should be told of this requirement before the training. A copy of the training schedule, with the break times indicated, should be sent to all prospective participants ahead of the training.

How to be an effective trainer

Prepare for the training

Whether you have been invited to facilitate a training session or are conducting training as a training coordinator, you can prepare and organize yourself *in advance* in a number of ways to avoid problems during the training. A checklist can help trainers make sure they have the needed materials and resources ready and that the venues and facilities meet their expectations. Trainers must know and understand the material they will be presenting so they can present confidently and answer questions satisfactorily. They also need to be familiar with the education techniques to be used and the presentation equipment, e.g., overhead projectors, HIV counselling tools.

An example of a training checklist is provided in the Preparation for Training section of this manual. With the help of such a checklist, you can quickly be assured you have all the necessary materials, equipment, and resources you need to do the training.

Know the training arrangements

Check the training timetable. Be sure you know exactly what day and time you are scheduled to train and the venue and room you will be training in. Take all relevant documentation with you: letters from the organization running the training that outline the training details such as the name of the person or persons coordinating the training, contact details for these people, the names of any support or administration staff who may be available to help you, and the names of other trainers who may be attending your training session. Take all this information with you to the training; it may come in handy in case you forget the details or need assistance at any time.

Know the material

Trainers must be familiar with the material they are presenting. Read over the material again before the presentation. Be prepared to answer questions about it. You may wish to have a reference list handy so that you can let the participants know where they can find more information on a specific subject.

Make sure you *read the session plan* and keep it visible for ready reference throughout the session. This way you do not forget anything and the training runs according to schedule. A session plan can help you know when to allow questions to continue and when to suggest that the group move on to the next subject.

Check the order of your activity sheets and session plans. It can be very disconcerting to have information out of order when presenting. Additionally, try to have training materials available in more than one form, e.g., PowerPoint presentation and overheads. This can be very helpful in an equipment breakdown or failure. If you have time, run through the presentation before the participants arrive. Know approximately how long the presentation will run and then allow extra time for questions or discussion.

Know the environment

Arrive early at the training facility and find out where the training room is located. Orient yourself to the area. Trainees may ask you where the toilets are or the nearest phone is. Make sure the training room is appropriate. It should be large enough for all participants and should allow you to conduct training as necessary, e.g., form small groups. If you feel that the room is not adequate, inform the training director or facility administrator and see if another room is available. Trainees can always be redirected to the new room as they arrive.

Minimize distractions. If the environment is noisy or there is a great deal of movement in the corridors, etc., close the doors before you start presenting. Note, however, that if the doors are closed, the ventilation and temperature inside the room must be kept comfortable. If trainees are too hot or cold, or feel the room is stuffy, they may not be able to concentrate on the training. Open windows if you need to, or check the temperature setting of the air conditioner if there is one.

If you are the first to arrive, don't be afraid to *arrange furniture* to suit the needs of the training. This can save time later.

Be familiar with the location of *light switches* and controls for blinds, curtain strings, etc. The training session may have different lighting requirements, e.g., darkness for slide presentations and natural light for group work or activities. Try out different lighting arrangements before the training; this can help save time when moving from one technique to another.

Make sure you know what is and is not allowed within the training room. If you are working on flipcharts and want to stick the paper on the walls, find out from the owner of the facility what is acceptable.

Know the equipment

Well in advance of the training, make sure you determine (with the course facilitator or the training director) *what equipment will be available* at the training. There is no use turning up to present a PowerPoint session when the facility has only an overhead projector available.

When you arrive make sure that all the equipment that you need is available and then check this off on the checklist. Practice using each piece of equipment to make sure it is working correctly and that the overhead machine or slide projector is focused adequately for your presentation. See to it that the screen is visible from where the participants may be seated in the training room.

If the training session is for a large group and you are to use a *microphone*, make sure you know how to turn it on and off and adjust the height so you can use it comfortably. Also, if the microphone has a lead (cord) make sure you know how far you can walk about with the microphone without having the lead catching on something or tripping you up. If the microphone is the small, clip-on kind, make sure you have somewhere to clip it on to and ask someone to help you check the sound. Trainees do not want to hear every breath you take but they must be able to hear your words clearly. Check that your jewellery or clothing does not interfere with the sound, e.g., by banging or rustling against the microphone.

If any equipment is not working, first check to see that it is plugged in correctly and that the outlet itself is working. If you suspect the equipment is faulty, contact the training director, primary facilitator, or administrator immediately; another piece of equipment of the same kind may be available within the facility. Preparing the support materials in more than one format, e.g., overhead transparency as well as flipchart, will widen your choice of alternative equipment.

Know the resources required

Make sure all the resources you require for the training are available. These may include:

- The *HIV Counselling Handbook*. Make sure that there are enough copies for all trainees and trainers.
- Activity instruction sheets. Make sure that enough copies are available for all trainers and trainees.
- Stationery equipment (pens, paper, etc.).

Know the audience

If possible, try to obtain a list of the trainees for the training course in advance. The list should contain their positions and place of employment. This information is important for a number of reasons:

- Knowing the number of trainees attending allows trainers to plan activities and group work adequately.
- Knowing the trainees' professions will give trainers an idea of the trainees' level of education.
- Knowing their place of employment can tell trainers:
 - What field the participants are working in so that examples or case studies can be made relevant to them, and
 - How many of the participants come from the same organization.

- Knowing their positions will give trainers an idea of the range of seniority among the group. This may be important in identifying less-senior trainees so that they can be encouraged to contribute to the training session to the same extent as senior trainees.

Advance knowledge of the average level of education of the trainees and the degree of their background knowledge allows trainers to pitch the training content and materials at the correct level. The trainees must not find the training too difficult or not challenging enough.

Knowing the audience also gives trainers an understanding of the social and cultural background of the trainees.

Presentation skills

Some people are naturally interesting and entertaining speakers, but anyone can learn some skills to help them present information. These presentation skills are broken down here into a series of “micro-skills” to make them easier to learn.

Getting attention

As discussed in the sub-module on session planning, one of the functions of the introductory part of the session is to gain the attention of the trainees.

The trainer can gain attention by:

- Explaining how the session is relevant to the trainees;
- Asking the trainees what they expect from the session;
- Providing a relaxed and open learning environment;
- Using humour or an activity as an icebreaker;
- Using novelty, variety, or surprise in the introduction;
- Using a case study or telling a story that is relevant to the situation of the trainees;
- Using interesting pictures or audiovisual aids at the start of the session; and
- Using a quiz to identify gaps in knowledge.

Maintaining interest

For adults to focus on learning, they need to remain interested throughout the session. The trainees must recognize the relevance of the session and be able to participate in the session, and the session must be presented in an interesting way.

The trainer can help the trainees remain interested by:

- Personalizing the presentation—smiling, making eye contact, and addressing trainees by name when interacting;
- Keeping the subject relevant and emphasizing how the topic relates to their needs;
- Being enthusiastic;
- Making sure the pace is neither too fast nor too slow;
- Using a variety of presentation styles;
- Introducing a new activity or information about every 20 minutes;
- Encouraging the trainees to participate;
- Using stories as examples;
- Having brief physical activity or game breaks;
- Using humour; and
- Using appropriate and consistent non-verbal behaviour (discussed on the following page).

Selecting appropriate presentation styles

Using more than one technique in each session will maintain interest, and help in retention because trainees have different learning styles.

The technique used will depend on the following:

- Trainer—knowledge of topic and group, skills, personal style;
- Content—whether the aim is to learn knowledge or skills or change attitudes;
- Trainees—number, abilities, needs, and experience; and
- Environment—location, room set-up, time of day, day of week.

The following activities can be used with groups of different sizes.

Type of activity	Large group	Small group	Pairs/Threes	Individual
Lecture	✓			
Group discussion	✓	✓		
Question and answer	✓	✓	✓	✓
Case study	✓	✓	✓	
Brainstorming	✓	✓		
Quiz	✓	✓	✓	✓
Game	✓	✓	✓	
Panel game	✓	✓		
Hypothetical situation	✓	✓		
Debate	✓	✓		
Description of past situation	✓	✓	✓	✓
Problem solving		✓	✓	✓
Role-play		✓	✓	✓
Demonstration		✓	✓	✓

Non-verbal communication

When we watch someone presenting information, we learn more from his or her non-verbal communication (body language) than from the words spoken. Some studies indicate that around 65% of our communication is done through non-verbal signals. Non-verbal communication includes a range of different signals that convey a message to the audience apart from the dialogue. Non-verbal communication can be a powerful tool that reinforces what the trainer is saying, or it can contradict the trainer's message. For example, if the trainer is standing with hunched shoulders and arms crossed while saying that counsellors need to be motivated and committed to their work, the trainer's body language seems to convey a lack of belief in his or her own message. Trainers should try to be aware of their non-verbal communication messages.

Non-verbal communication includes:

- *Voice*. The trainer should speak clearly and project his or her voice. Speaking conversationally while occasionally varying loudness and pitch helps sustain the trainees' interest. The trainer can vary his or her voice to emphasize important points that the trainees need to learn.

- *Dress.* We tend to make judgements about people when we first meet them, depending on the way they are dressed. The trainer must therefore dress in a way that is appropriate for the group of trainees and their culture. Some trainers may need to modify their usual dress style for the training. Looking good may also give the trainer added confidence.
- *Eye contact.* Trainees will feel involved if the trainer makes eye contact with them. In a large group the trainer should make eye contact with several people in the room. However, some trainees, because of their culture, may not feel comfortable making eye contact with the trainer, either throughout the training or for particular topics or activities.
- *Posture.* Depending on the size of the group, the trainer may need to stand upright to help project his or her voice to the whole group. Even in a small group, posture is important. The trainer should attempt to look relaxed (i.e., not stiff) without slouching or looking too casual.
- *Position.* Where the trainer stands is also important. When using audiovisual aids such as a board or a screen, the trainer should stand back from the board or screen or to the side so the audiovisual aid can be seen. If the trainer has to write on a board, he or she should finish doing that first and speak to the trainees only when facing them again. The room should be set up so there are as few barriers as possible. Trainees find it much easier to talk about sensitive issues if the trainer is not sitting behind a desk or table, or standing at a lectern.
- *Movement and gestures.* A trainer should move about the room from time to time—not too much as to be distracting—to sustain the interest of trainees. The trainer should also use gestures for emphasis or explanation, as he or she would in conversation, but these should also not be distracting. Some gestures may be inappropriate to some cultures in a mixed group of trainees.

Overcoming nerves

Many people can get nervous before and during a presentation. Practice can help settle the nerves, but even the most experienced trainers may feel nervous before a training session. Here are some ideas to help you overcome nerves and anxiety:

- Be well rested. Have plenty of sleep the night before and allow enough time to get to the training venue early.
- Be well prepared and familiar with your session plan, and do everything on your training preparation checklist (review your Session Plans).
- Do a practice run of your presentation before the training session.
- Try to greet the trainees as they arrive. If you see some friendly faces you may not feel as if you are presenting to strangers.
- Help yourself relax. Try standing up straight and breathing deeply. Tense and then relax your muscles and even do some stretching.
- Try talking to yourself in a positive way. Tell yourself that you are well prepared—you know the subject—and everything will be all right.
- Wear something you feel comfortable in. If you feel constricted or unable to move freely about the training room, you may not be able to present confidently.
- Have a glass of water handy in case you develop a dry throat or nervous cough.
- At the start of the session, once you have been introduced to the trainees, give a short summary of your experience in the field. This helps to establish your credibility and remind you that you are the right person to conduct this training.

Personal style

There is no “right” way to train. At the start of the session, when you thought about presentations you liked, you probably thought of presenters with quite different styles. Some of the characteristics of personal style are:

- Use of appropriate humour,
- Use of relevant anecdotes,
- Personal enthusiasm,

- Self-confidence,
- Ability to develop rapport with trainees, and
- Knowledge of the subject.

Selecting appropriate audiovisual aids

This specific training package seeks to minimize the need for complicated media. But all trainers should know how to use a variety of audiovisual aids to reinforce their presentation in ways that suit various styles of learning and retaining information. When choosing audiovisuals, make sure they are relevant, simple, and not distracting. Fancy PowerPoint presentations with many colours and sounds can distract the trainees from the content. The technology available at the training venue, as well as its reliability, is also an important consideration. If no computer will be available, PowerPoint will not be a good choice. The following are some general tips for using audiovisual equipment:

- Practice beforehand.
- Do not obscure the screen.
- Use a pointer.
- Cover the information until you are speaking about it. Otherwise, the trainees will read the information rather than concentrate on what you are saying.
- Make sure that all the trainees can see the audiovisual aid.
- Talk to the audience, not the board or screen.
- Check that the slides or overheads are properly focused before starting.
- If using slides or computer projection check that the room is not too brightly lit. Ask someone to help you adjust the lighting.
- Use only one audiovisual aid at a time.
- Have a backup. For example, if using PowerPoint slides, also have overhead transparencies just in case the equipment does not work.
- Keep the layout simple, with minimum detail.
- Use colours that can be seen clearly (not red or green for text).

Some tips for using specific audiovisual equipment are as follows:

- *PowerPoint:*
 - Keep the slides simple.
 - Avoid placing too much text on one slide. Use two slides.
 - Avoid using too many different colours and sounds.
 - Make the text large enough so it can easily be read by the trainees.
 - Use a darker background to provide a good contrast to the text.
- *Overhead projector:* Turn it off when not in use.
- *Whiteboard:*
 - Write legibly.
 - Use the right type of pen.
 - Cover or keep blank when not in use.
 - Use more than one colour—preferably blue or black, which can easily be read from a distance.
 - Finish writing and turn to face your audience before speaking.

- *Flipchart:* Cover pages that are not being used. Alternate blank and written pages.
- *Handouts and activity sheets:* Consider the right time to give them out. If you give them out at the start of the presentation, the trainees may focus on reading the handouts and not listen to your presentation. On the other hand, giving them out early can also allow the trainees to follow the discussion without taking notes.

Managing common difficulties in training

Even the most experienced trainers can face difficulties when presenting or facilitating a session with a group. It is important to be aware of the common problems and to understand how to address them. No one is a perfect trainer; we all have shortcomings, which we constantly need to be aware of when managing a session. Below are common problems and some practical responses that can be employed to get the session back on track.

Mixed group expertise and experience (high to low)

The trainees may have a wide range of knowledge and experience. Some of the following strategies can be effective in meeting this challenge:

- Aim the content at the lower end of the trainees' range of knowledge, while acknowledging the knowledge and experience of those in the upper range and involving them by asking them to contribute, e.g., to provide examples based on their experience.
- Split the trainees into different groups on the basis of ability, knowledge, or experience. Assign specific activities to each group and ask all the smaller groups to report back to the larger group.
- Provide basic information to one group and have another group focus on problem solving or a case study. Then integrate the groups for a further activity.

The trainee who doesn't want to be there

Early in the session, the trainer will become aware that one or more persons would rather not be at the training session. They may indicate this by being unwilling to participate in activities, talking to others, or just generally showing disinterest. In response, the trainer can:

- Ask the persons how they feel about being present at the training.
- Offer them the option of leaving the training: "It is OK by me if you don't want to stay." Usually they will choose to stay.
- Ask them what can be done to make the session relevant to their needs. You could perhaps clarify their objectives in attending the training and suggest how the training can meet their needs.

Late arrivals

Enforcing punctuality among trainees can be a challenge. Those who arrive late can delay the start of the session or disrupt training that has already begun. Other trainees should not be penalized for the late arrival of one or two persons.

- At the start of training it is important to stress the necessity of arriving on time to allow the training to start at the designated hour.
- Tell the trainees that you will begin the training session at the designated time and will not wait for them to arrive.
- Set group rules. Most groups usually agree that punctuality is important. Peer group pressure can be very effective in encouraging trainees to be punctual.
- See to it that all trainees are aware of the timetable. Ask them if they are happy with the current timetable and if there is any reason that they cannot arrive on time.
- Stress the importance of punctuality in any promotion or invitation letters for the course.

Non-attendance

Attendance at all the sessions and for their entire duration is important. People who leave early or skip sessions can slow down the progress of the group, as they will need time to catch up. If they have been assigned to teams for group work, then the rest of their team is at a disadvantage. To help ensure full attendance at the training:

- At the start of the training, tell the trainees that those who do not attend the whole course will not receive certificates (unless they have a valid reason for being absent and miss only a small part of the training).
- A trainee who misses any segments should be briefed on his or her return about what was missed.
- If a trainee cannot complete the course because of an emergency, negotiate with him or her trainee to complete the missed segments at a future course and obtain the certificate at that time.

Lack of time

Trainers often run out of time. It is easy to underestimate the time needed to teach a certain subject. This is especially true if there is a group activity, as group activities generally take longer than expected. Besides, if you are passionate or especially knowledgeable about a subject you may lose track of time as you provide case studies and examples from personal experience to illustrate a point. Time management may also be a problem if you are teaching a particular session or training programme for the first time. Use the following strategies to keep on time:

- Keep an eye on the time. If there is no clock in the room, use your watch or borrow a watch from someone in the group. Check it regularly but discreetly. Use your session plan to tell you how much time to spend on each topic.
- Skim topics and refer to the reading list if there are subjects that cannot be covered in the time available. Avoid skipping planned activities, as these are an important part of reinforcing the learning.
- Acknowledge the problem and negotiate with the trainees for an extension of time, e.g., through shorter meal breaks or work through part of the scheduled breaks. If you do not ask the trainees' permission they may get angry and anxious about going overtime, especially if they are due for a break or have made plans for the end of the day. It is also unfair to take time from the next presenter's session without permission.
- Provide an overview of the remaining material and ask the trainees what they consider most important and relevant to their work, or what the host organization or professional body should cover.
- Offer to forward to the trainees a summary of the remaining material.

Equipment failure

Virtually every trainer faces equipment failure at some time in his or her career. The more sophisticated the technology, the more likely it is to malfunction or cause difficulties. Preparation is the best strategy for avoiding equipment failure or overcoming it.

- Check first that the equipment is working, although sometimes equipment failure is unavoidable. Arrive early and familiarize yourself with the equipment, especially if you have not used it before. Check the power source.
- Apologize and remain calm. Tell a joke and move on.
- Write key points from transparencies on a whiteboard.
- If you were planning to use a video, provide an outline of the video information and have a group discussion.
- If you are using a PowerPoint presentation, try to have transparencies as backup and printed handouts that you can speak from and give out to trainees.
- Know your subject so you can present without equipment. A good trainer who is well prepared should be able to present without the aid of sophisticated technology.

Managing challenging trainee behaviours

Groups are made up of individuals, and individuals can be unpredictable. Certain individual and group behaviours can present challenges for the trainer in facilitating and managing the group. These group behaviours may be due to the way in which the training is being conducted or a range of other reasons outside the trainer's control. Some trainees could be inattentive because their manager forced them to attend and they see no benefit in being there. Others could lack enthusiasm because threatened cuts in funding have brought down morale in the workplace.

There may also be cultural and gender reasons for the challenging behaviours in the group. Differences in culture and gender can mean that people behave, interact, and communicate differently. The trainer must be aware of cultural differences that might affect how a group behaves. For example, trainees may be uncomfortable asking questions in class, as it would be a sign of disrespect for the teacher or trainer in their culture. Others may feel uncomfortable participating in group discussions with people who are assigned a higher social status in their culture (such as people who are more senior, older, or a different gender).

Many of the difficulties that arise in group presentations can be dealt with through common adult education techniques. Suggested strategies for some of the more common challenging group behaviours that trainers may encounter are discussed below. However, it is important to select techniques that are culturally appropriate.

When trainees do not respond to calls for feedback or questions after a focal activity (e.g., after watching a video)

What you can try:

- *Open and closed questions.* Open questions are much more likely to get a response. The difference between closed and open questions is illustrated below.

Closed: "Any questions? Any points people want to raise?"

Open: "What are some of the key points raised by the video?"

"What did you like about the video?"

The difference between open and closed questions is quite clear. Closed questions discourage responses because they are too broad and offer no point of entry for the trainees. Open questions encourage trainees to respond to a specific issue.

- *Silence:* What happens if you use open questions and there is silence? Silence can add pressure to an effective end! **Use silence** to create willingness to respond. Eventually someone in the group will speak up. Answering your own questions could convey anxiety or the need to control the group.

When a group discussion gets out of control or off the subject

What you can try:

- *Set the discussion up with clear guidelines and parameters.* Define clearly the issue for discussion and encourage trainees to stay on the subject. This can be difficult in a discussion of sensitive or moral issues, like HIV and AIDS and sexual health.
- *Ask people with special experience in the group to contribute.* If someone in the group is particularly knowledgeable about the topic, ask him or her to contribute. If time is a constraint (and especially if the person is known to be fond of talking), remind the person to be brief.
- *Be a good gatekeeper.* A good gatekeeper moderates the discussion to ensure a reasonable level of participation by all. A common misconception is that "I'll come across as rude if I control the group". Videotape your sessions and observe your gate-keeping skills.

Dominating trainees

What you can try:

- *Be respectful and courteous.* Trainees are unlikely to respond if you are angry or aggressive. Be assertive and confident in your manner.
- *Verbal responses.* You can try a range of verbal strategies. For example, "Thank you very much. I would now like to hear what (*use name*) has to say on this topic." Do not say "Why don't we come back to this later?" if you do not intend to return to the topic.
- *Non-verbal responses.* Orient your body away from the dominating trainee so you disengage from eye contact and your body language discourages him or her from continuing to speak. Combine this with a verbal response, such as inviting another trainee to contribute.

Unresponsive trainees

Some groups are naturally talkative and easy to work with. Others are unresponsive and may require you to call on additional techniques to engage them.

What you can try:

- *Use silence to pressure the group.* Ask a question that you know someone in the group can answer and wait for an answer. Remain silent and do not answer the question yourself. Eventually (in most cases) someone will respond.
- *Identify one or two people in the group whom you can ask to say something.*
- *Be controversial or challenging.* Used carefully, this technique can get a group going. In HIV and sexual health there are usually many controversial issues, so finding something that challenges the group at some level should not be too difficult.
- *Ask for feedback.* Say: "I sense that there is not a lot of interest in this subject" or "I sense that you feel this subject is not relevant to you."
- *Introduce an activity,* something to energize the trainees and get them to respond, either as a whole or in small groups.

Sleeping or inattentive trainees

What you can try:

- *Walk near the person,* while talking to the group. Do not single the person out by looking directly at him or her. Stand next to the person for a while without necessarily looking at or drawing any other attention to him or her.
- *Throw a question* at the inattentive person, but remember to allow him or her to save face. Ask a question that the person is likely to know the answer to, or provide a quick summary of the current issue and then ask the question.
- DO NOT say, "While you were asleep..."; rather say, "Let me explain where we are up to."

With chatterers (people talking among themselves):

- *Walk over to the chatterers* while continuing to address the whole group. Your close proximity will discourage them from chatting.
- *Direct questions at the chatterers,* noting the above points on saving face.
- *Be a good gatekeeper.* Say, for example, "I'm having difficulty hearing what (*use name*) is saying. (*Wait for silence.*) Could you continue please."
- If all else fails, *have a discreet chat* with the individuals concerned, away from the other trainees, during the break.

The argumentative trainee

Some trainees may be argumentative. They may be genuinely upset or disturbed by something and choose to demonstrate this by arguing with the presenter or other members of the group.

What you can try:

- *Don't get hooked into the power struggle.* It is not your function as trainer to win the argument, even though you may strongly disagree with the person's opinion. The more you assert your opinion, the more likely it is that the person will stop listening to you.
- *Don't use personal attacks.* In challenging the argumentative trainee, do not use personal attacks. These tend to put people on the defensive and undermine your credibility as a facilitator.
- *Use assertive communication:* "I can see how you would think that. However,..."; "Some people feel that..."; "There is a range of opinions on this subject...".
- *Redirect discussion to other trainees.* Ask if anyone else in the group has a different opinion.
- *Use direct and calm but assertive body language.*

Evaluating your training

Many stakeholders are involved in the conduct of training courses. Among these are the trainer, the trainees, the training institution, and the organization purchasing the training. Different stakeholders may have different expectations of the training and anticipate different outcomes. It is important to speak with different stakeholders to understand what they need to know about the training. The person in charge of training evaluation can then develop the appropriate tools and methods for finding out the extent to which the training outcomes and stakeholder expectations have been met, and transmit this information to the stakeholders through the training report.

What are the benefits of evaluating training?

Evaluating specific aspects of training can benefit all stakeholders. The possible benefits may include the following:

- *For trainers:*
 - Information about ways of improving the training; and
 - Information about possible improvements in training style and skills.
- *For trainees:*
 - Assessment of whether they have achieved their learning goals;
 - Consideration of how the knowledge and skills learned can be applied to their work; and
 - Decisions about whether training has been a worthwhile investment of time, effort, and money.
- *For contractors and sponsors:*
 - Information about the extent to which the training was worth the time and money they invested in it; and
 - Information about what staff are capable of, including their limitations and readiness for new responsibilities.

What does evaluation measure?

Goals. Evaluation can tell us about the appropriateness of the goals or learning objectives of the training. Evaluation can also provide information about how well the training met the identified goals or learning objectives.

Inputs. Evaluation can give us information about:

- Training tools:
 - Was the course content targeted at the appropriate level of trainees?
 - Were the handouts easy to understand?
 - Was appropriate audiovisual equipment used?
 - Was the audiovisual equipment working?
- Training environment: Were the training facilities (e.g., room size, ventilation, temperature, refreshments, audibility) adequate?

Processes. Evaluation can tell us about the quality of the training, including the following:

- Training framework:
 - Was the training too long or too short?
 - Were there enough breaks?
 - Were the sessions in logical sequence?
- Training techniques:
 - Was a variety of techniques (e.g., group work, role plays, games, exercises, didactic teaching) used?
 - Which techniques worked best?
- Trainer's style:
 - Did the trainer have good teaching skills (e.g., maintained the interest of the group, used a variety of teaching techniques, facilitated discussions, created a supportive environment for trainees)?
 - Was the trainer friendly, personable, approachable?
 - Did the trainer know the material (e.g., could he or she answer questions about the material confidently)?

Outputs. Evaluating outputs can tell us about the immediate benefits of training, including the following:

- Change in trainee knowledge: Trainers need to be sure that trainees have understood the course content.
- Trainee satisfaction:
 - Did the course meet the trainees' expectations?
 - What did the trainees like about the course and what didn't they like?

Outcomes. Evaluating outcomes can be difficult, as it has to occur some time after the course to assess what the trainees have changed or done in their practice as a result of the training. *Independent observation of trainees is the best, most impartial, method of assessment.* Outcome evaluation is important, as it tells us whether course objectives have been met. It can also help us to identify barriers to implementing what has been learned.

What do we do with the results?

On the basis of the findings of the evaluation, trainers can improve certain aspects of the training so that future courses may better meet trainee expectations or training objectives.

How do we collect the data?

Two main techniques are used in any evaluation:

- *Qualitative techniques.* These are concerned with the collection of descriptive data, allowing trainers to obtain more in-depth information about particular aspects of training. The tools of qualitative data collection include the following: reflective diary (used, for example, in self-assessment), evaluation forms with open-ended questions, and notes from open discussions with peers or trainees. Qualitative techniques can help answer questions like Why? and How?
 - *Advantages:* Qualitative data can be used to assess training processes, outputs, and outcomes. They are more likely to provide an overall picture of the perceptions of training and to elicit positive responses.
 - *Disadvantages:* Qualitative techniques take longer to complete and require more thought on the part of the trainee. Analysing qualitative data can be time-consuming and the results may not always be seen as rigorous or “scientific” enough by some stakeholders.
- *Quantitative techniques.* These are concerned with collecting measurable data, to help answer questions like How much? and To what degree? Tools for collecting quantitative data include checklists and evaluation forms using “yes” and “no” answers, or a choice among preset answers with assigned values. The scores will allow comparison over time or between trainers or training sessions.
 - *Advantages:* Quantitative surveys are relatively cheap to conduct; they are quick and easy to complete and to score.
 - *Disadvantages:* Making comparisons requires an understanding of some basic statistical techniques and, in some instances, statistical software packages. Manual analysis, by calculator, can entail a significant amount of time.

A mix of qualitative and quantitative techniques is thought to be the best way of achieving a thorough evaluation. The findings can be supported with information collected from more than one source, e.g., from trainees and peers.

What tools and methods can be used to evaluate training?

A number of tools and methods can be used to evaluate training. These include evaluation by the following:

- Trainer:
 - A checklist for pre-training evaluation to assess readiness for training, e.g., to check that the necessary equipment, materials, and tools have been prepared and are ready (quantitative);
 - A reflective journal or self-assessment diary (qualitative); and
 - A videotape or audiotape of the training session for self-assessment, with the help of a checklist or informal feedback (quantitative and qualitative).
- Trainees:
 - A training evaluation form, mostly for assessing training processes (quantitative and qualitative measures);
 - Pre- and post-course knowledge tests for trainees;
 - Assignments or “homework”;
 - Discussion questions at the end of each session to assess level of knowledge and understanding;
 - Problem solving using a case study and information discussed previously; and
 - Skill testing through role-play.

- Peers:
 - A training evaluation form (quantitative and qualitative);
 - Observation of training and use of a criterion-referenced training skills checklist (quantitative and qualitative measures) or post-training discussions (qualitative) to collect data; and
 - A videotape of the training, for observation and assessment , as above.
- External evaluator (training consultant, to review objectives, curriculum, and evaluation documents):
 - Observation of training and use of a training skills checklist to collect data (quantitative and qualitative measures);
 - Post-course informal discussions with stakeholders (qualitative); and
 - Short- and long-term follow-up of trainees and trainers, e.g., through interviews and mailed questionnaires.

Further information on evaluation tools

Self-assessment (reflective) diary or journal. Trainers may use journals to record their impressions or thoughts about how training was carried out or about problems encountered in the training. They can thus identify where they might improve their training technique or methods. Trainees may also record information in a journal about what they have been able to change in their practice as a result of the training. A reflective learning journal can be a good tool for evaluating training outcomes, although the results of self-evaluation are subjective.

Peer assessment. Other trainers can sit in on a training session, observe the trainer at work, and evaluate the trainer's skills and knowledge against set criteria. Their findings can then be scored and the scores quantitatively compared with those of other trainers, or a qualitative record of the information can be fed back to the trainer. Peer assessment is a valuable method for assessing training inputs, processes, and outputs. It is also a more objective method of evaluation than self-assessment.

Pre- and post-course knowledge tests. A short questionnaire about the course content is developed. It can contain qualitative (open-ended) questions or quantitative (yes-or-no, multiple-choice, etc.) questions. A variety of question types allows the collection of a range of data. The test is administered at the start of the training and again at the end. Results are then compared to see if there has been any improvement in knowledge as a result of the training. A pre-course questionnaire can also provide information about the baseline level of knowledge of the trainees so that trainers can assess whether the content is pitched at the right level. Pre- and post-course knowledge tests are a good tool for evaluating training outputs.

Evaluation forms. Evaluation forms can be used to evaluate trainees' perceptions of all aspects of training, from an individual training session to a whole course or programme. Short questionnaires using a mix of qualitative and quantitative questions can be developed so that a clear picture of trainees' views of training inputs and processes can be gained. Evaluation forms can tell us to what degree the trainees feel the course met their training needs.

Follow-up questionnaires. Short questionnaires can be developed and sent out to trainees up to six months after the training. Trainees may be asked how far they have used the skills and knowledge gained through the course and what barriers have kept them from using the skills and knowledge. These questionnaires are a good way of assessing training outcomes, although not many trainees may complete and return them.

Analysing evaluation results

Qualitative analysis. For each qualitative question all the trainees' answers are collected and reviewed. Common themes and points most often mentioned are identified. The main responses are summarized and any other supporting information, contextual information, or observations that may help to explain or support the findings of the analysis are added in. Qualitative analysis can be time-consuming but may provide rich and in-depth information.

Quantitative analysis. Quantitative questions are first marked and a score is assigned to each possible response, e.g., for yes-and-no questions, a score of “1” for each “yes” response and a score of “2” for each “no” response, and for multiple-choice questions, a score of “1” for each correct response and a score of “0” for each incorrect response. For Likert-type questions, which provide a range of possible responses (e.g., from “a little” to “a lot”), each possible response is allocated a score, e.g., from “1” (least positive) to “4” (most positive). All the scores from a trainee’s questionnaire are added to give a total for that trainee. In some instances the trainee is given a code number, e.g., when pre- and post-course tests are marked. Group means (or averages) before and after training can then also be compared. For those with access to statistical packages, a paired t-test may be used to identify areas where statistically significant changes have occurred.

Interpreting a poor evaluation result

When a training session is evaluated poorly, it is important for the trainer to analyse the results to understand whether the training needs to be improved or whether the result reflects other events outside the control of the trainer that have had an impact on the training.

The trainer should not be disheartened by critical comments made in evaluations. Some evaluation forms have specific questions relating to what the trainees feel could have been done better. Even the most experienced trainers can get critical comments. These should not be taken personally and should be seen as an opportunity to improve the course. On the basis of the comments in the evaluation forms, the trainer should try to identify the specific areas of the training that need changing and develop strategies for improving these aspects. Peers can be asked to provide feedback on how the session could be improved. Training is a skill that can improve with experience, feedback, and adaptation.

The trainer should also think about whether the poor evaluation result is due to other factors beyond their control. Many factors, not just those attributable to the trainer, can affect how people perceive the training course. For example, trainees may have been forced by their manager to attend a course and did not really want to be there, or may have been distracted by their difficult personal circumstances or by thoughts of the amount of work they will have to do when they return to their workplace. All these factors can contribute to a poor evaluation but do not reflect on the trainer’s conduct of the course.

Recommended HIV counsellor training programme timetable

- The schedule begins each day at **08:30** and ends at **17:00**. However, in some instances courses may extend beyond scheduled times to allow interpretation from the English language. Registration on the first day is at **08:00**.
- The schedule assumes **strict adherence** to the specified break times: 15 minutes for morning tea and afternoon tea; one hour for lunch.

Day 1: Orientation to HIV and HIV counselling

08:00-08:30	Registration and introduction
08:30-10:00	What counsellors need to know about HIV, STI, and TB (module 1)
10:00-10:15	Morning tea
10:15-12:30	What counsellors need to know about HIV, STI, and TB (module 1)
12:30-13:30	Lunch
13:30-15:15	Key elements of HIV/STI counselling practice (module 2)
15:15-15:30	Afternoon tea
15:30-17:00	Key elements of HIV/STI counselling practice (module 2)

Day 2: Facilitating behaviour change and pre-HIV test counselling

08:30-10:00	Behaviour change strategies in HIV counselling (module 3)
10:00-10:15	Morning tea
10:15-12:30	Behaviour change strategies in HIV counselling (module 3)
12:30-13:30	Lunch
13:30-15:15	How to provide individual pretest counselling and group pretest information (module 4)
15:15-15:30	Afternoon tea
15:30-17:00	How to provide individual pretest counselling and group pretest information (module 4)

Day 3: Counselling in association with the HIV test

08:30-10:00	How to provide individual pretest counselling and group pretest information (module 4)
10:00-10:15	Morning tea
10:15-12:30	How to provide individual pretest counselling and group pretest information (module 4)
12:30-13:30	Lunch
13:30-15:15	How to provide HIV test results (module 5)
15:15-15:30	Afternoon tea
15:30-17:15	How to provide HIV test results (module 5)

Day 4: Counselling in association with the HIV test and post-diagnosis support

08:30-10:00 How to provide HIV test results (module 5)

10:15-10:30 Morning tea

10:30-12:30 How to provide HIV test results (module 5)

12:30-13:30 Lunch

13:15-15:15 Working with suicidal clients (module 6)

15:15-15:30 Afternoon tea

15:30-17:00 Working with suicidal clients (module 6)

Day 5: Providing post-diagnosis support

08:30-10:30 Developing a post-diagnosis support plan (module 7)

10:30-10:45 Morning tea

10:30-12:30 Supporting HIV disclosure (module 8)

12:30-13:30 Lunch

13:30-15:15 Supporting HIV disclosure (module 8)

15:15-15:30 Afternoon tea

15:30-17:00 Counselling for treatment adherence (module 9)

Day 6: Post-diagnosis support/Addressing special needs

08:30-10:00 Counselling for treatment adherence (module 9)

10:00-10:15 Morning tea

10:15-12:30 Counselling for treatment adherence (module 9)

12:30-13:30 Lunch

13:30-15:15 Counselling pregnant women, new mothers, and their partners (module 10)

15:15-15:30 Afternoon tea

15:30-17:00 Counselling children and adolescents (module 11)

Day 7: Addressing special needs

08:30-10:00 Counselling MSM and transgender clients (module 12)

10:00-10:15 Morning tea

10:15-11:15 Counselling with MSM and transgender clients (module 12)

11:15-12:45 Counselling sex workers (module 13)

12:45-13:45 Lunch

13:45-15:30 Counselling drug and alcohol users (module 14)

15:30-15:45 Afternoon tea

15:45-17:00 Counselling drug and alcohol users (module 14)

Day 8: Addressing special needs/Community orientation

08:30-10:00	Counselling substance users (module 14)
10:00-10:15	Morning tea
10:15-12:30	Counselling health workers after accidental occupational exposure (module 15)
12:30-13:30	Lunch
13:30-15:45	Grief, bereavement, and loss counselling (module 16)
15:45-16:00	Afternoon tea
16:00-17:00	Post-exam and course evaluation

Allow 1-2 days for (optional) field visits and debriefing.

As seen above, the complete training is intended to be an eight-day programme. But the resource package is modular: activities and case studies can be included or omitted to best supplement the core modules within the time and human resource constraints, and to highlight specific social, geographical, or epidemiological issues of particular interest to the trainees. The time devoted to training and practical, hands-on exercises can also be adjusted to meet scheduling demands. The following table offers some course examples with a specific focus:

Focus	Recommended modules									
Core modules only (VCT or PITC) 4 days	M1 What Counsellors need to know about HIV, STI, and TB	M2 Key elements of counselling practice	M4 How to provide pretest counselling and group pretest information	M5 How to provide HIV test results	M6 Working with suicidal clients	M8 Supporting HIV disclosure				
VCT for MARPs (core + special populations) 5-6 days	M1 What counsellors need to know about HIV, STI, and TB	M2 Key elements of counselling practice	M4 How to provide pretest counselling and group pretest information	M5 How to provide HIV test results	M6 Working with suicidal clients	M8 Supporting HIV disclosure	M12 Working with MSM and transgender clients	M13 Counselling sex workers	M14 Counselling substance users	
Care counselling (core + adherence/disclosure) 3-5 days	M1 What counsellors need to know about HIV, STI, and TB	M2 Key elements of counselling practice	M13 Treatment adherence	M8 Supporting HIV disclosure	± M6 Working with suicidal clients	M12 Supporting HIV disclosure	± M14 Counselling substance users			
VCT for antenatal care (core + M10) 4 days	M1 What counsellors need to know about HIV, STI, and TB	M2 Key elements of counselling practice	M4 How to provide pretest counselling and group pretest information	M5 How to provide HIV test results	M6 Working with suicidal clients	M8 Supporting HIV disclosure	M10 Counselling pregnant women, new mothers, partners			

HIV = human immunodeficiency virus, MARP = most-at-risk population, PITC = provider-initiated testing and counselling, STI = sexually transmitted infection, TB = tuberculosis, VCT = voluntary counselling and testing.

Training resources outline

Training modules	Title	Session plan	Activity sheets	Counselling tools
M1 (core)	What counsellors need to know about HIV, STI, and TB	M01-SP	AS1.1 Communicating key information to clients	T1.1 How you can get HIV T1.2 HIV replication T1.3 Explaining HIV in the body T1.4 Sexually transmitted infections
M2	Key elements in HIV counselling practice	M02-SP	AS2.1 Counsellor ethics case studies AS2.2 Counsellor-client roles AS2.3 Questioning quiz	
M3	Behaviour change strategies in HIV counselling	M03-SP	AS3.1 Case studies on strategies for counselling and motivational interviewing	T3.1 Where are you in the change process? T3.2 Decision making T3.3 Goal setting and commitment to change
M4 (core)	How to provide pretest counselling and group pretest information	M04-SP	AS4.1 Group pretest information AS4.2 Case studies on risk assessment AS4.3 Case studies on pre-HIV test counselling	T4.1 Pre-HIV test counselling interview form T4.2 The window period T4.3 Correct condom use T4.4 Safe injecting (3 x 2 x 6) T4.6 Referral form T4.7 Consent for release of information T1.4 Sexually transmitted infections
M5 (core)	How to provide HIV test results	M05-SP	AS5.1 Case studies on HIV test results	T4.5 Post-HIV test counselling form T4.6 Referral form T4.7 Consent for release of information

Training modules	Title	Session plan	Activity sheets	Counselling tools
M6 (core)	Working with suicidal clients	M06-SP	AS6.1 Case studies on suicide risk assessment and management	T5.1 Suicide risk assessment interview guide T5.2 Suicide risk assessment matrix T4.7 Consent for release of information
M7	Developing a post-diagnosis support plan	M07-SP	AS7.1 Case studies on post-diagnosis support plans	T6.1 Post-diagnosis follow-up counselling form T6.2 Psychological problem screening checklist T4.6 Referral form T4.7 Consent for release of information
M8 (core)	Supporting HIV disclosure	M08-SP	AS8.1 Counsellor challenge response AS8.2 Case studies on supporting HIV disclosure	
M9	Counselling for treatment adherence	M09-SP	AS9.1 Explaining resistance AS9.2 Case studies on pre-adherence screening AS9.3 Case study on supporting client adherence	T8.1 Pretreatment adherence counselling: Checklist and summary record form T8.2 How ART works T8.3 Reference cards for barriers to adherence T8.4 Pre-ART adherence screening tool T8.5 What causes HIV resistance to ARV drugs? T8.6 ART drug side-effects T8.7 Practical problem solving for managing common barriers to adherence

Training modules	Title	Session plan	Activity sheets	Counselling tools
M10	Counselling pregnant women, new mothers and their partners	M10-SP	AS10.1 Fast-facts quiz about pregnant women, new mothers, and their partners AS10.2 Role-play on counselling for PMTCT AS10.3 Men and PMTCT	T9.1 What can I do to have a healthy and safe pregnancy?
M11	Counselling children and adolescents	M11-SP	AS11.1 Talking to children about HIV AS11.2 Case studies on child disclosure issues	
M12	Working with MSM and transgender clients	M12-SP	AS12.1 MSM Case studies on risk and vulnerability	
M13	Counselling sex workers	M13-SP	AS13.1 Case studies on sex-worker risk and vulnerability	
M14	Counselling drug and alcohol users	M14-SP	AS14.1 Role-play on behaviour change and drug use assessment	T9.2 Assessment of drug and alcohol use T4.4 Safe injecting (3 x 2 x 6)
M15	Counselling health workers after accidental occupational exposure	M15-SP	AS15.1 Case studies on accidental occupational exposure	
M16	Grief, bereavement, and loss counselling	M16-SP	AS16.1 Adult loss cases AS16.2 Child loss cases	T10.1 Activities for processing children's grief

ART = antiretroviral therapy, HIV = human immunodeficiency virus, MSM = men who have sex with men, PMTCT = preventing mother-to-child transmission, STI = sexually transmitted infection, TB = tuberculosis.

Session Plans



What HIV counsellors need to know about HIV, STI, and TB: The basics

Session objectives

At the end of the training session, the trainees will be able to communicate the following to others:

- How HIV is transmitted;
- How HIV is diagnosed;
- How HIV disease progresses;
- How HIV treatments work;
- How sexually transmitted infections are transmitted and treated, and how they are related to HIV; and
- How HIV and TB are related.

Time to complete module

3 hours and 45 minutes

Training materials

- *HIV Counselling Handbook*, chapter 1
- HCT Pre-course Knowledge Questionnaire (**annex 1**)
- Case situations (**AS1.1**)
- Tools **T1.1, T1.2, T1.3, and T1.4**
- Flipchart paper/Overhead transparency sheets
- Question box

Content

- AIDS and how it differs from HIV
- The immune system
- How HIV is transmitted
 - Vaginal, anal, and oral sexual contact with an HIV-infected person
 - Transmission in clinical settings, through infected blood, blood products, organs, etc.
 - Through needle sharing, during injecting drug use and tattooing, among others
 - Transmission during pregnancy, delivery, and breast-feeding
- How HIV is diagnosed

M01-SP: What counsellors need to know

Session Plan

- Types of tests
 - Antibody tests
 - Rapid HIV testing
 - Virological tests
 - HIV tests and children
- Interpreting HIV test results
 - False-positives
 - False-negatives
 - The “window period”
- HIV disease progression
- WHO clinical staging
- Clinical management
 - Immune system monitoring tests
 - Antiretroviral therapy (ART)
 - The prevention and management of opportunistic infections (OIs)
 - HIV-related neurological and psychiatric conditions
 - Tuberculosis (TB) co-infection
 - Sexually transmitted infections (STIs)
 - Hepatitis B (HBV) and hepatitis C (HCV) co-infection
- STI counselling
 - Clinical manifestations of STI
 - Recommendations for STI
 - Six most common STI syndromes

Session instructions



1. Introducing the session

Time
10 minutes

- Introduce the session by explaining the importance of communicating information to clients clearly and concisely.
- Ask the trainees to provide examples of information that is difficult to communicate to clients. Why is it difficult to communicate?
- Display the session objectives on flipchart paper and discuss with the trainees.
- Discuss with the trainees the importance of providing the counsellor with appropriate information about HIV, STI, TB, testing, and other related services. Explain to the trainees that they will now be asked to complete a pre-course knowledge questionnaire on HIV counselling and testing.

2. Administering the HCT Pre-course Knowledge Questionnaire

30 minutes

Objectives:

- To enable the trainees to assess what they know about HIV testing and counselling.
- To collect baseline information for monitoring the change in knowledge about HIV testing and counselling, before and after the course.

Preparation:

- Make two copies of the Pre- and Post-Training Knowledge Questionnaire for each participant in the training workshop. One copy will be distributed to each participant during this session of the training workshop. The remaining copies will be used to evaluate change in knowledge at the end of the workshop.
- Copies of the answer sheet for the Pre- and Post-Training Knowledge Questionnaire may also be copied at this time. These should not be distributed to the training participants until after the post-course knowledge questionnaire has been administered.

Instructions:

- Distribute a copy of the HCT Pre-course Knowledge Questionnaire to each participant.
- Tell the participants that they will have **30 minutes** to complete the questionnaire. If they are unsure about the meaning of a question, they should ask one of the facilitators for assistance.

3. Referring trainees to the *HIV Counselling Handbook* 30 minutes

- Ask the trainees to spend the next 30 minutes reading “What HIV Counsellors Need to Know about HIV, STI, and TB: The Basics” in the *HIV Counselling Handbook*.

4. Recapping the reading 10 minutes

- Brainstorm. Ask the trainees to tell you the key STI messages for clients. Ask the trainees to use simple, understandable, and non-technical messages. At the end of the activity refer them to the answers in chapter 1 of the handbook.

5. Activity 2: Communicating information to clients 90 minutes

Objectives:

The trainees will practice communicating to others in different situations:

- How HIV is transmitted;
- How HIV is diagnosed;
- How HIV disease progresses;
- How HIV treatments work;
- How sexually transmitted infections are transmitted and treated, and how they are related to HIV; and
- How HIV and TB are related.

Preparation:

- Make one or two copies of the Case Situations (**AS1.1**). Make sure the number of scenarios is equal to the number of trainees. More than one trainee may receive the same scenario.
- Roll or fold each scenario strip and place into a bag or box. Ask each trainee to take one of the strips.
- If the trainees do not already have them in their training package, make copies of tools 1.1, 1.2, 1.3, and 1.4 for the trainees to use as appropriate.

Instructions:

- Ask each trainee to take one scenario strip from the bag or box.
- Explain to the trainees that they will now practice communicating information to clients on the basis of the scenario they have received. They will have **5 minutes** to think about and prepare what they will say to the client in the scenario they have drawn, and then present their response before the group. Tell the trainees to communicate the specified information only, and not provide a full counselling session.
- Introduce the trainees to tools 1.1, 1.2, 1.3, and 1.4 from the toolkit. If any of these are helpful in answering the question(s) posed by the client in the scenario, then these should be incorporated into their response. One of the trainers should present an example of communicating information to a client, without and then with one of the tools.

M01-SP: What counsellors need to know

Session Plan

- Each trainee will present his or her response in front of the large group. One of the trainers will act as the client and ask the counsellor-trainee for information. The trainees will have a maximum of **5 minutes** to provide a response to the question.
- After each situation has been presented, the trainer should ask the trainees whether they understood what was communicated to them and how they felt about the way it was communicated.
- Ask trainees who drew the same scenario to present in succession to allow comparison of the information being communicated and the way it is communicated.

Note: If the group of trainees is large, divide the trainees into smaller groups to practice communicating information in order to keep to the time allotted for this activity (90 minutes). At least one facilitator should be attending to each group.

6. Recapping the session

30 minutes

- Ask the trainees to summarize the key messages from this session.
- Summarize the key messages once again on flipchart paper.
- Recommend that the trainees ask each other some information questions during the breaks and in the evening hours in the course of the training workshop to gain some additional practice in communicating information to clients.
- Ask the trainees if they have any questions about the content of the session.
- Remind the trainees to place any additional questions they have in the question box.

Key elements in HIV and STI counselling practice

Session objectives

At the end of this training session, the trainees will be able to do the following:

- Describe the different types of HIV counselling;
- Discuss ethical and effective counselling; and
- Demonstrate effective client-counsellor communication skills.

Time to complete module



3 hours and 45 minutes

Training materials



- *HIV Counselling Handbook*, chapter 2
- Activity sheets **AS2.1**, **AS2.2**, **AS2.3**
- Counsellor's code of ethics (see handbook appendix)
- Flipchart paper/Overhead transparency sheets
- Question box

Content



- Types of HIV counselling
- Provision of counselling
- Definition of counselling
- Ethical standards
- Counselling micro-skills

Session instructions



1. Introduction: Brainstorming and discussing counselling

Time
30 minutes

- Explain to the class that this session will explore ethical and effective HIV counselling and what it involves, and review some basic counselling micro-skills.
- Write the following question on flipchart paper or on an overhead transparency and ask the trainees to brainstorm responses: WHAT DOES HIV COUNSELLING INVOLVE? Record their responses on flipchart paper.

M02-SP: Key elements of counselling

Session Plan

- Next ask the trainees to brainstorm the following question: WHAT ARE THE DIFFERENT TYPES OF HIV COUNSELLING?
- List the different types of HIV counselling on a sheet of flipchart paper. Then write down each type of counselling on a separate half-sheet of flipchart paper and ask the trainees to identify common characteristics of each type. Write the trainees' responses on the paper.
- Next, ask the trainees to brainstorm a definition of counselling. The trainers should write the responses on flipchart paper. Tell the trainees that the class will revisit the definition later.
- Lastly, ask the trainees to brainstorm what they feel should be important elements of ethical and effective counselling. Once again, write the trainees' responses on flipchart paper.

2. Referring to the handbook (chapter 2)

25 minutes

- Ask the trainees to open their handbook at chapter 2 and read the sections titled "What does HIV counselling involve?" and "Types of HIV counselling". Instruct them to **read only those sections of the chapter. (15 minutes)**
- When the trainees have finished reading, ask them if they would like to add any comments to the different types of HIV counselling listed on the flipchart paper and record those other comments. **(5 minutes)**
- Ask the trainees to revisit their definition of counselling and compare it with the definition given in the handbook. Highlight the common elements identified in their definition by underlining key words. **(5 minutes)**

3. Discussing ethical concerns in counselling

45 minutes

- Ask the trainees to discuss some ethical concerns in counselling. List their responses on flipchart paper.
- Next, ask the trainees to locate and read the counsellor code of ethics in the **appendix of their handbooks.**
- Ask the trainees why they think a code of ethics is necessary.
- Ask the trainees to divide into six smaller groups and provide each group with a copy of activity sheet **AS2.1.**
- Ask each small group to discuss a separate case study and then to present the group's analysis and conclusions in front of the larger group.

4. Introducing counselling communication

5 minutes

- Explain that counselling micro-skills are essential for effective communication and the development of a supportive client-counsellor relationship.
- Tell the trainees that counsellors need to develop specific micro-skills as a foundation. These include:
 - Listening,
 - Questioning,
 - Silence, and
 - Non-verbal behaviour.
- Explain to the trainees that they will briefly explore each of these.

5. Activity: Engaging in counsellor-client role-play (1)

30 minutes

- Allow 30 minutes in total: 10 minutes for an explanation of the activity; 5 minutes for pair activity; and 15 minutes for debriefing/discussion.
- Ask the trainees to divide into pairs for the activity.
- Instruct them to pick one person to be the "counsellor" and the other to be the "client".

- Ask all the “counsellors” to assemble in one area of the training room for their instructions. Provide them with the “counsellor’s role” (from **AS2.2**). Ask them NOT to share this with their partners (“clients”).
- Ask all the “clients” to assemble in one area of the training room for their instructions. Provide them with the “client’s role” (from **AS2.2**).

Instructions for *counsellors*:

- Your task in this activity is to be a “bad counsellor”.
- Ask your client to tell you about an achievement in his or her life—a time when he or she did something to be 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, make inappropriate facial expressions, sit with a closed posture, look disinterested, do not encourage the conversation, do not ask questions.
- Remember that you need to be as bad as possible.
- 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 client will be told that you were asked to be bad.

Instructions for *clients*:

- Your task in this activity is to be a “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 are comfortable discussing and can discuss for 5 minutes.
- The “counsellors” will be practicing their basic skills during this activity.
- Ask everyone to find his or her partner and begin the activity.
- Allow the activity to proceed for 3-5 minutes. Use your judgement as to how much time is needed as you observe whether pairs are continuing or ending conversations.
- Reassemble the group after the activity and ask the “clients” to share their experiences.
- Explain that the “counsellors” were asked to be bad and that the purpose of the activity was to quickly highlight the importance of the basic skills of communication.

6. Discussing listening

15 minutes

- Ask the trainees to identify important elements of listening. Tell them to relate points to the discussion generated from the activity.
- Write the trainees’ responses on flipchart paper. Be sure that the list includes the following:
 - Making (culturally appropriate) eye contact;
 - Demonstrating attention, e.g., by nodding;
 - Giving encouragement, e.g., by saying, “Mm-hmm”, “Yes”;
 - Minimizing distractions, e.g., from television, telephone, noise;
 - Not doing other tasks at the same time;
 - Acknowledging the client’s feelings, e.g., by saying, “I can see you feel very sad”;
 - Not interrupting the client unnecessarily;
 - Asking questions if there is something you do not understand;
 - Not taking over and telling your own story; and
 - Repeating the main points of the discussion in similar but fewer words to check whether you have understood the client correctly (paraphrasing, reflecting feelings, clarifying, summarizing).

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Session Plan

- Explain that it is also important to demonstrate active listening to the client. This may be done with a simple statement indicating that you have heard what the client has said.
- Ask the trainees for further ideas about demonstrating active listening. Ask them for examples. Here are some:
 - *"You seem to be saying..."*
 - *"In other words,..."*
 - *"You feel...because..."*
 - *"You seem... What's happening? What are you thinking about?"*
 - *"I wonder if you are feeling...because..."*
 - *"Correct me if I have not understood you correctly. You... Is that correct?"*
 - *"What I hear you saying is..."*

Tell the trainees that chapter 2 of the handbook contains more information on these micro-skills.

7. Activity: Discussing questioning skills

15 minutes

Preparation:

- Photocopy **AS2.3** for each trainee and make one copy on overhead transparency.
- Ask the trainees what types of questions they are aware of (answer: closed, open, leading).
- Provide the trainees with **AS2.3**. Give them a few minutes to review the questions listed and to circle the type of question corresponding to each one (closed, open, or leading).
- Review the questions as a large group (on overhead transparency, if possible). Ask the trainees to say their answers out loud. Discuss and correct answers where required (the answers are provided for you at the end of this session plan).
- Refer to the list of dos and don'ts of questioning in chapter 2 of the handbook:
 - DO ask one question at a time.
 - DO look at the person.
 - DO be brief and clear.
 - DO ask questions that serve a purpose.
 - DO use questions to help the client talk about his or her feelings and behaviour.
 - DO use questions to explore and understand issues and to heighten awareness.
 - DO NOT ask questions simply to satisfy curiosity.
- Irrelevant questions may cause people to feel pushed or reluctant to answer.
- Too much time may be spent thinking of questions rather than actively listening.
- Too many questions will be experienced as intrusive and similar to an interrogation.
- Explain that the class will discuss a few more micro-skills.

8. Discussing other communication skills

25 minutes

- Ask the trainees to list other skills that are important for effective communication in counselling. Make sure that the following skills are included:
 - Empathy,
 - Silence, and
 - Non-verbal behaviour.
- Then ask the trainees to provide examples of the skills on the list. You may have to start by giving an example, but you should then ask the trainees to give additional examples.
- The trainers may draw from the following examples:

Empathy and listening skills

- Explain that empathy can be demonstrated in the two following ways:
 - *Paraphrasing* involves restating, in your own words, the essence of what the client has said. **Example:** The client says, “*I feel so helpless. I can’t get the housework done, get the children to school on time, or even cook a meal. I can’t do the things my wife used to do.*” Then the counsellor says, “*You are feeling overwhelmed by having to do things you did not have to do in the past when your wife was alive.*”
 - *Reflecting emotions* is similar to paraphrasing except that the focus is on the emotions expressed by the client. **Example:** The client says, “*I don’t know what to do. Before he died I promised my husband that I would take care of his mother for the rest of her life. But I no longer have the energy. I cannot seem to get myself sorted out to do anything. He knew that his mother and I did not get along and that the situation would be miserable. Why did he die and leave me in this mess?*” The counsellor reflects, “*You seem to be feeling very low and helpless right now, but at the same time you seem to be feeling guilty and angry about your promise to your husband.*”

Silence

- Explain that silence is often difficult for people to manage at first. We want to quickly fill up the time with the client with conversation. However, silence is important because it gives the client
 - time to think about what to say,
 - the chance to experience his or her feelings,
 - the ability to proceed at his or her own pace,
 - time to deal with ambivalence about sharing, and
 - freedom to choose whether or not to continue.

Non-verbal behaviour

- Tell the participants that communication is not always what you say but HOW you say it. The majority of communication we have in our interactions with others is non-verbal. The counsellor must be aware of his or her own non-verbal communication with the client as well as the client’s non-verbal communication with the counsellor. The counsellor must become particularly sensitive to body language.

Give examples of the following common forms of body language:

- Gestures,
- Facial expressions,
- Posture,
- Body orientation,
- Body proximity / distance,
- Eye contact,
- Mirroring, and
- Removal of barriers (e.g., desks).

(Try to act out the body language and paralinguistic features of non-verbal communication. Choose a co-trainer or trainee to help you demonstrate body orientation, body proximity/ distance, and mirroring.)

The counsellor should also recognize his or her own paralinguistic behaviour as well as the client’s. The trainers should give examples of these:

- Sighs,
- Grunts,
- Groans,
- Voice-pitch change,

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Session Plan

- Voice volume,
- Voice fluency, and
- Nervous giggles.

9. Activity: Engaging in counsellor-client role-play (2)

30 minutes

- Allow 30 minutes in total: 5 minutes for an explanation of the activity; 15 minutes for pair activity; and 10 minutes for debriefing/discussion.
- Ask the trainees to divide into the same pairs as in the opening activity.
- Ask them to repeat the activity using the skills discussed in the session.
- Ask the "client" to talk about a personal experience for 5 minutes while the "counsellor" listens and applies other micro-skills. Then the two switch roles: the "counsellor" becomes the "client" and the "client" becomes the "counsellor".
- Reassemble the trainees into the large group and ask them to reflect on the difference between the opening and closing activities.

10. Recapping the session

5 minutes

- Summarize the key points of the session.
- Ask the trainees if they have any questions and remind them about the question box.

Questioning quiz: Answer key

Questioning quiz (for each question listed below, circle the type of question in the right-hand column).

- | | |
|--|--------------------|
| 1. You always practice safer sex, don't you? | Closed and leading |
| 2. What are some difficulties that you would have using a condom? | Open |
| 3. Do you take your medication? | Closed |
| 4. You should tell your wife, shouldn't you? | Closed and leading |
| 5. On which occasions did you share needles? | Open |
| 6. What do you know about HIV? | Open |
| 7. Do you understand how HIV is transmitted? | Closed |
| 8. Do you protect yourself from HIV? | Closed |
| 9. What are the different ways you could protect yourself from HIV? | Open |
| 10. How do you clean your injecting equipment? | Open |
| 11. Have you ever had a blood transfusion? | Closed |
| 12. Whom could you talk to for support if you were to test HIV-positive? | Open |

Behaviour change strategies in HIV counselling**Session objectives**

At the end of the training session, the trainees will be able to do the following:

- Identify the stages of behaviour change and the key elements of motivational interviewing (MI);
- Illustrate the importance of considering the context of risk behaviour;
- Review the different transmission modes for different transmission risk situations; and
- Illustrate the use of the four principles of HIV transmission.

Time to complete module

3 hours and 45 minutes

Training materials

- *HIV Counselling Handbook, chapter 3*
- Motivational interviewing case studies (**AS3.1**)
- Charts showing Stages of Change and Behaviour Change Strategies
- Motivational interviewing tools (**T3.1, T3.2, T3.3**) (make copies of these on overhead transparencies)
- Risk Situation Cards (see suggested cards below; the cards may be printed from the file on the training kit CD-ROM)
- Flipchart paper / Whiteboard
- Question box

Content

- What it takes to change behaviour
- Behaviour change counselling in relation to HIV
- How to get a client to want to change his or her behaviour
- Motivational interviewing: Getting started
- Behaviour change counselling strategies
 - Strategies for the action and maintenance phases
- Modes and principles of HIV transmission
- Analysis of risk behaviour in context

Session instructions



- | | |
|-----------------------------------|----------------------------|
| 1. Introducing the session | Time
10 minutes |
|-----------------------------------|----------------------------|
- Introduce the session by explaining the importance of communicating information to clients clearly and concisely.
 - Ask the trainees to provide examples of information that is difficult to communicate to clients. Why is the information difficult to communicate?
 - Display the session objectives on flipchart paper and discuss them with the trainees.
- | | |
|---|-------------------|
| 2. Activity 1: Reviewing the four principles of HIV transmission | 90 minutes |
|---|-------------------|
- Objective**
- To be able to assess critically the levels of risk of infection with HIV and other STIs associated with different behaviours and practices.
- Preparation**
- Prepare flipchart paper with the Four Principles of HIV Transmission:
 - Exit–the virus must **exit** the body of an **infected** person;
 - Survive–the virus must be in conditions in which it can **survive**;
 - Sufficient–**sufficient** quantities of the virus must be present to cause infection; and
 - Enter–the virus must **enter the bloodstream** of another person.
- For HIV to be transmitted, all four principles of HIV transmission must be met.
- Even though HIV transmission may not occur with certain behaviours, there may still be a risk of infection with other sexually transmitted infections.
- Prepare risk situation cards. You can design your own or ask the group to write down a broad range of risks. Include general social contact and daily living activities and situations. See the suggested risk situation cards below. It is recommended that each of these cards be printed on A4 paper for easy visibility.
 - Prepare four cards that indicate level of risk–“high risk,” “medium risk,” “low risk,” and “no risk”. These should also be printed on A4 paper.
- Instructions:**
- Explain that motivational interviewing is done to help the client identify behaviours that can realistically be changed to reduce their risk of HIV infection. However, identifying behaviours alone will not facilitate behaviour change. Therefore, the counselling session must also go into the strategies that the client may use to achieve behaviour change.
 - Briefly discuss with the trainees the strategies for the action and maintenance phases of behaviour change.
 - Remind the trainees that behaviour change is a gradual process. A person who engages in risk behaviour may find it difficult or be unwilling to give up the behaviour all at once. It is therefore beneficial to assist the client in exploring a variety of options or alternative behaviours that will help him or her move towards the behaviour change goal. Explain that this next activity is designed to build awareness of the level of risk that comes with certain behaviours. If a client is at high risk of HIV infection because of a certain behaviour but finds it difficult to give up this behaviour, he or she could consider less risky behaviour as an alternative, e.g., mutual masturbation or oral sex instead of unprotected vaginal or anal sex.
 - Display the flipchart paper and explain the four principles of HIV transmission and discuss them with the trainees. Advise the trainees to use the acronym ESSE (exit, survive, sufficient, and enter) to facilitate recall. *Emphasize to them that all four principles of HIV transmission must be met for transmission to occur.*

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Session Plan

- Distribute risk situation cards among the trainees. If there are extra cards, some trainees may be given more than one.
- Place the four cards indicating level of risk on the floor in the following arrangement:



- Explain to the trainees that they each have a risk situation card (or maybe more than one) and that they will be asked to identify the level of risk according to the four principles and then to place the card beside the appropriate card showing level of risk (high risk, medium risk, low risk, no risk).
- Before the trainees begin, show the trainees what they are expected to do by using the “mosquito bite” card and going through each of the four principles. *Emphasize that it is equally important to discuss why something is “no risk”.* Conclude the activity by emphasizing that risks vary with the context and the manner of behaviour.
- Have each trainee explain each of the four principles in relation to his or her risk situation card before placing it beside the card showing the level of risk involved.
- Then ask the whole group whether everyone agrees with the level of risk chosen or whether some trainees have other recommendations.
- Ask the trainee who put down the card whether or not a different level of risk should be chosen to reflect the risk of transmission of other STIs (e.g., hepatitis C, gonorrhoea).
- Provide additional information as needed. (See The Four Principles of HIV Transmission-Legend below.)
- After all the trainees have put down their cards, ask the following questions:
 - What behaviours put us at highest risk of HIV infection? Why?
 - What behaviours lower our risk of HIV infection? Why?
 - What activities/behaviours carry no risk of HIV infection?
 - How does the risk of HIV infection vary with different types of sexual intercourse?
 - How can the Four Principles of HIV Transmission help a counsellor assess whether a client is at risk of infection or not?
 - How can the Four Principles of HIV Transmission help a client assess his or her own behaviour?
 - How can the Four Principles guide a client in practising safer behaviour?
- Conclude the activity by emphasizing the following:
 - *Risks vary with the context and manner of behaviour.*
 - *This activity emphasizes the importance of asking detailed information of clients when conducting a risk assessment.*

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Session Plan

- This activity clearly shows that detailed and explicit information is needed to assist the client in understanding what is safe and what is not.

Facilitator's tip: Add that it is essential to be sensitive but explicit about a wide range of sexual behaviours.

3. Referring trainees to the *HIV Counselling Handbook* 25 minutes

- Ask the trainees to spend the next 20 minutes reading through the information in chapter 3, "Behaviour Change Counselling", in the *HIV Counselling Handbook*.

4. Discussing the stages of change and behaviour change strategies 30 minutes

- Draw a circular diagram with the stages of change (from chapter 3 of the handbook) on the flipchart paper. Review the stages and emphasize to the trainees the value of motivational interviewing.
- Introduce the trainees to tools T3.1, T3.2, and T3.3 from the toolkit.

5. Activity 2: Learning from a case study on the stages of change and motivational interviewing 60 minutes

Objective:

- To identify a client's stage of change, the behaviour change strategy that may help move the client to the next stage of change, and the questions a counsellor might ask in a motivational interview.

Preparation:

- Photocopy the motivational interview case studies (**AS 3.1**) below and cut out the individual cases. Provide enough copies of the case studies for each member of the group to read.

Instructions:

- Explain that the trainees will now practice communicating information to different clients in different situations. Distribute the situations to the trainees.
- Explain the Stages of Change diagram to the trainees. The stages are:
 - **Pre-contemplation**—the person either is unconvinced that he or she has a problem or is unwilling to consider change.
 - **Contemplation**—the person is actively considering the possibility of change. He or she is evaluating options but is not yet ready to take action.
 - **Preparation**—the person makes a commitment as well as initial plans to change the behaviour.
 - **Action**—the person takes effective action to make the change. He or she adopts strategies to prevent a relapse and a return to problem behaviour.
 - **Maintenance**—the person consolidates the change and integrates it into his or her lifestyle.
- Explain that everyone goes through these stages in the attempt to change behaviour. However, it is also natural for people to "recycle" through or revisit earlier stages several times before successfully making and maintaining the change. Explain that, rather than being viewed as a failure, a "slip" can be seen as an opportunity to provide useful information and experiences for the next attempt.
- Introduce the motivational interview tools T3.1, T3.2, and T3.3 via overhead transparency.
- The trainees will look at a case study to identify the stage of change the client is at and the behaviour change strategy that may be appropriate in each case. The trainers will demonstrate a motivational interview, using one of the case studies and the motivational interview tools. Divide the trainees into two groups. Instruct the trainees to identify the stage of change and the appropriate behaviour change strategy for the case given to their group. The groups must also identify questions that might be asked in a motivational interview to help a client see how he or she might be in another stage for a different behaviour. One trainer will act as facilitator for each group.

- After the groups have fully discussed the issues and strategies of the second role-play, ask each of the two groups to present the group's findings before the large group.

6. Recapping the session

- Ask the trainees to summarize the key messages from this session.
- Ask the trainees if they have questions
- Remind the trainees about the question box.

Activity 2: The Four Principles of HIV Transmission (Suggested Risk Cards)

It is recommended that each of the risk cards below be enlarged and printed on A4 paper.

Mosquito bite	Deep kissing	Crying getting someone's tears on you
Sharing a toothbrush	Cleaning up vomit	Sharing spoons and forks
Using drugs (non-injecting) before sex	Using alcohol before sex	Needle stick suture or solid needle
Needle stick injection or hollow-bore needle	Sharing contaminated syringe and needle	Tattooing
Vaginal sex with ejaculation no condom risk to woman?	Vaginal sex with ejaculation no condom risk to man?	Mutual masturbation risk to either partner?
Anal sex no condom, withdrawal then ejaculation risk to penetrating partner?	Vaginal sex withdrawal before ejaculation risk to the woman	Working/Studying in the same room as an HIV-positive person

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Oral-anal sex "rimming" risk to either partner?	Sex during menstruation with a condom and without risk to man	Vaginal sex no condom risk to male
Oral sex mouth to vagina risk to man?	Swimming in pool with someone infected	Sharing injecting equipment (swabs, water, mixing bowls)
Vaginal Sex with condom risk to man or woman?	Oral sex mouth to penis, ejaculation risk to the person who accepts the penis into his/her mouth	Sharing sex toys
Anal sex no condom, no ejaculation risk to receptive partner?	Blood splash to the eye during delivery	Other (a local cultural risk)

The Four Principles of HIV Infection-Legend

DO NOT include the answers in italics on the cards given to the trainees.

- **Mosquito bite.** *No risk of HIV.¹*
Exit: HIV may exit a person infected with HIV through a mosquito bite.
Sufficient: The amount of HIV in blood in the mosquito is negligible.
Survive: HIV cannot survive in the mosquito. HIV is a specifically human-hosted virus.
Entry: Mosquitoes do not bite persons in succession. They also do not inject blood.
- **Deep kissing.** *No risk of HIV.*
Exit: Minute amounts of HIV are found in the saliva of a person infected with HIV.
Sufficient: Saliva contains insufficient amounts of HIV for transmission.
Survive: Saliva is alkaline, so if HIV comes in contact with the saliva of a non-infected person, it will be destroyed.
Entry: Only possible risk is through bleeding sores in the mouth; however, kissing would be unlikely under this circumstance.
- **Crying (getting someone's tears on you).** *No risk of HIV.*
Exit: Tears of a person infected with HIV contain a minute amount of HIV.
Sufficient: The amount of HIV in tears is insufficient for transmission
Survive: The minute amount of HIV in tears cannot survive when exposed to air.
Entry: Even if tears splash on you, there is no entry if your skin is unbroken.
- **Sharing toothbrush.** *No risk of HIV. Possible risk of hepatitis A virus.*
Exit: Minute amounts of HIV may be found in the saliva remaining on a toothbrush.
Sufficient: In normal brushing practices, the toothbrush is rinsed with water before and after using.
Survive: Toothpaste and your own saliva will destroy any remaining amounts of HIV in any saliva remaining on the brush from another person.
Entry: It is unlikely that a person would use a bloodied toothbrush-at least not without proper cleaning first.
- **Cleaning up vomit.** *No risk to low risk of HIV. Possible risk of hepatitis B and hepatitis C virus if no gloves are used.*
Exit: Blood, and thereby HIV, may be present in vomit.
Sufficient: Quantities of HIV will depend on the context.
Survive: Once it leaves the body, HIV will not survive long.
Entry: Entry would have to occur through cuts in the skin.
- **Sharing spoons and forks.** *No risk of HIV.*
Exit: Small amounts of HIV may be present on utensils from an infected person's saliva.
Sufficient: The quantity of HIV in saliva is insufficient for transmission.
Survive: Once exposed to the air or other substances, HIV will not be able to survive.
The saliva of the person sharing these utensils will also destroy the HIV.
Entry: There will be no entry into the bloodstream.
- **Using drugs (non-injecting) before sex.** *Moderate to high risk of HIV.*
Using drugs before sex makes a person less likely to remember to practice safer sex.
Substance use will also affect motor skills, making it more difficult to use condoms correctly.
- **Using alcohol before sex.** *Moderate to high risk of HIV.*
Using alcohol before sex makes a person less likely to remember to practice safer sex.
Alcohol use will also affect motor skills, making it more difficult to use condoms correctly.

¹ Additional information: The parasites that cause malaria and other diseases are transmitted through the saliva of mosquitoes and not through sucked blood. HIV thrives in blood, not in saliva, and is a specifically human-hosted virus. When mosquitoes bite, they inject saliva that may contain one of the parasites to increase the flow of blood into the stomach. This fluid is toxic to humans and produces the itching reaction. Mosquitoes do not inject blood.

- **Needle-stick injury (suture or solid needle, like a sewing needle).** *Low risk of HIV.*
Exit: HIV may exit a person infected with HIV.
Sufficient: Only minute amounts of blood will remain on a solid needle.
Survive: When exposed to the air, HIV will be destroyed rapidly.
Entry: Entry into the blood is unlikely. Most needle-stick injuries of this kind occur in the top layers of skin, without bleeding.
- **Needle-stick injury (injection or hollow-bore needle).** *Medium risk of HIV, depending on depth of puncture or other factors.*
Exit: HIV can exit an infected person into the needle and syringe.
Sufficient: There may be sufficient quantity of HIV in blood remaining in the needle or syringe.
Survive: HIV can survive in the needle and syringe.
Entry: Entry possible, but risk dependent on depth of puncture or other factors.
- **Sharing contaminated syringe/needle.** *High risk of HIV. Also risk of STIs, especially hepatitis B and C virus.*
Exit: HIV can exit an infected person into the needle and syringe.
Sufficient: There may be sufficient quantity of HIV in blood remaining in the needle or syringe.
Survive: HIV can survive in the needle and syringe.
Entry: Use of contaminated needles and syringes can facilitate the transmission of HIV directly into the bloodstream (drugs commonly injected directly into the blood).
- **Tattooing**
Requires further information on method and context of tattooing. If traditional tattooing is done, with a pipette, as used in Buddhist temples, then there may be high risk of HIV because of the drawing of blood and the practice of tattooing more than one person in one sitting. All four principles of transmission would apply. The risk from other forms of tattooing would depend on whether the needles are changed or cleaned. There is also risk of hepatitis B and C virus from needles and the ink.
- **Vaginal sex, no condom.** *Woman is at high risk of HIV. Also risk of STI and pregnancy.*
Exit: Virus may exit through pre-ejaculate and semen.
Sufficient: The quantity of HIV is sufficient for transmission.
Survive: HIV can survive in the vagina.
Entry: Entry is possible through tears in the mucosal tissue. Risk is greater if STI is present.
- **Vaginal sex, no condom.** *Man is at moderate to high risk of HIV.*
Exit: Virus may exit through vaginal fluid.
Sufficient: The quantity of HIV is sufficient for transmission.
Survive: HIV can survive in the vagina and in the man's urethra.
Entry: Entry is possible through tears in the penile tissue or the urethra. Risk is greater if STI is present or has been treated improperly.
- **Mutual masturbation.** *Both partners are at no risk to low risk of HIV, depending on context and behaviour.*
Exit: HIV may exit with ejaculation from masturbation.
Sufficient: With ejaculation there is sufficient quantity for transmission.
Survive: Depending on the context, HIV may be able to survive.
Entry: If ejaculation takes place near the anal or genital openings, risk increases.
- **Anal sex, no condom.** *Penetrating partner has moderate to high risk of HIV.*
Exit: HIV can exit through anal bleeding of the receptive partner.
Sufficient: There is sufficient quantity of HIV for transmission.
Survive: HIV can survive in the anus.
Entry: Small tears may occur in the penis during anal intercourse, facilitating the transmission of HIV. The penetrating partner will be at higher risk if he has an untreated STI. Improperly treated STI may also facilitate the transmission of HIV through weakened mucosal tissue in the urethra.

- **Vaginal sex, withdrawal before ejaculation.** *Woman is at moderate to high risk of HIV.*
Exit: HIV may exit an infected person through pre-ejaculate.
Sufficient: There is sufficient quantity of HIV in pre-ejaculate for transmission.
Survive: HIV can survive in the vagina.
Entry: HIV may enter through tears in the mucosal tissue. Withdrawal is a poor option for safer sex as couple may forget to withdraw.
Relying on one's partner to withdraw before ejaculation is very risky.
- **Working or studying in the same room as an HIV-positive person.** *No risk of HIV.*
Exit: There is no exit of HIV.
Sufficient: There is insufficient quantity of HIV.
Survive: Not applicable.
Entry: There is no entry.
It is risky only if one has sex or shares injecting equipment with the HIV-positive person.
- **Oral-anal sex.** *No risk of HIV. Risk of hepatitis A virus if there is contact with faecal matter. Possible risk of hepatitis B virus. Risk of papilloma virus if warts are present.*
Exit: No exit of HIV unless penetrative sex took place before oral-anal sex.
Sufficient: There may be sufficient quantity if there was bleeding from penetrative sex.
Survive: HIV can survive in the anus.
Entry: There will be no entry unless there are sores in the mouth.
- **Sex during menstruation.** *With a condom, man is at low risk of HIV; without a condom, man is at high risk.*
Exit: HIV can exit an infected person through semen or menstrual blood.
Sufficient: There is sufficient quantity of HIV in menstrual blood and semen for transmission.
Survive: HIV can survive.
Entry: No entry if a condom is used correctly; entry if no condom is used.
- **Vaginal sex, no condom but with use of other birth control methods.** *High risk of HIV. Birth control methods other than condoms do not provide protection against HIV or STI.*
Exit: There is exit of HIV in semen, pre-ejaculate, or vaginal fluid.
Sufficient: There are sufficient quantities of HIV in semen, pre-ejaculate, or vaginal fluid for transmission.
Survive: HIV can survive in the vaginal cavity.
Entry: There can be entry of HIV into the blood through micro tears in mucosal tissue during sex.
- **Oral sex, mouth to vagina.** *Partner using mouth is at low to moderate risk of HIV; woman is at no risk. Possible risk of herpes if ulcers are present near the mouth or on the sex organ.*
Exit: There is exit of HIV in the vaginal fluid of the woman.
Sufficient: The quantity of HIV is sufficient for transmission.
Survive: HIV can survive in the vagina.
Entry: There may not be direct entry into the blood. Entry may occur through sores in the mouth (gums and mucosal tissue).
- **Swimming in the same pool as someone infected with HIV**
Exit: There is no exit, unless an infected person has sustained an injury.
Sufficient: Quantity will depend on the context.
Survive: HIV cannot survive when exposed to the air or to chemicals in the swimming-pool water.
Entry: Entry will depend on the context.

- **Sharing injecting equipment** (e.g., swabs, water, mixing bowls). Low risk of HIV. High risk of hepatitis B and C virus.
Exit: There is exit of HIV through blood in used needles and syringes.
Sufficient: Depending on the injecting practices, the quantity of HIV may be sufficient.
Survive: HIV will not be able to survive in minute quantities outside the body and in contact with different substances for long. Hepatitis B and C virus will be able to survive.
Entry: HIV is more likely to enter through blood remaining in the needle or syringe than from the equipment.
- **Vaginal sex with a condom.** Both partners are at low risk of HIV. Condoms must be used correctly and consistently and with appropriate lubricants.
Exit: HIV will be present in either the vaginal fluid or the semen of an infected person.
Sufficient: There is sufficient quantity of HIV for transmission.
Survive: HIV will be able to survive in either the vaginal fluid or the semen.
Entry: HIV will not enter either partner if condoms are used correctly and consistently.
- **Oral sex, mouth to penis.** Partner using mouth is at low to moderate risk of HIV; man putting his penis in the partner's mouth is at no risk. Possible risk of herpes if ulcers are present near the mouth or on the sex organ.
Exit: There is exit of HIV in the semen of a penetrating partner.
Sufficient: The quantity of HIV is sufficient for transmission.
Survive: HIV can survive for some time in sufficient quantities.
Entry: There may not be direct entry into the blood. Entry may occur through sores in the mouth (gums and mucosal tissue).
- **Sharing sex toys.** Low to moderate risk of HIV.
More information is required on the type of sex toy and how it is used, e.g., whether the sex toy is washed or sterilized before sharing. Possible risk of infection with hepatitis B and C virus.
- **Anal sex, no condom.** Receptive partner at high risk of HIV.
Exit: HIV can exit through semen of the penetrating partner.
Sufficient: There is sufficient quantity of HIV for transmission.
Survive: HIV can survive in the anus.
Entry: Trauma (tearing) of the mucosal tissues is common in anal intercourse, facilitating the transmission of HIV.
- **Blood splash to the eye during delivery.** Low risk of HIV. Only one documented case of infection from blood splash to the eye in the world, and that was from a splash of concentrated virus in a laboratory.
Exit: The blood of a person infected with HIV will contain HIV.
Sufficient: The quantity of HIV may be sufficient for transmission.
Survive: The immediate physical response to anything coming in contact with the eye is to tear. The tears of a non-infected person will help destroy HIV, especially in small quantity.
Entry: HIV cannot easily enter through the mucosal tissue surrounding the eye. Tearing or rinsing will make entry more difficult.

Pre HIV test counselling and group pre-test information provision

Session objectives

At the end of the training session, trainees will be able to:

- Conduct a group pre HIV test information session.
- Manage discussing sensitive issues.
- Conduct a risk assessment interview
- Assess risks within the HIV test window period
- Assess and individual's coping strategies and psychosocial support system.
- Integrate risk assessment, HIV prevention education, and counselling into HIV pre test counselling.

Time to complete module



Total time for delivery is seven hours excluding meal and tea breaks and the sessions can be held across a day period if required

Please note time indications are approximate and may vary according to training contexts.

Training materials



- *HIV Counselling Handbook, chapter 4*
- Activity Sheets (**AS4.1, AS4.2, AS4.3**)
- Tools (**T4.1, T4.2, T4.3, T4.4, T4.6, T4.7**)
- Flipchart paper / overhead transparency
- Question box
- Overhead transparencies of the 'pre HIV test counselling interview form'
- IDU Injecting Education tools (disposable syringes, containers, water, bleach)
- Condom demonstrations tools
- Penis/vagina models
- Condoms (2 per training participant)

Content



- Providing group pre test information
- Incorporating HIV prevention education, risk reduction counselling into pre HIV test counselling
- Assessing clients capacity to cope with a possible HIV positive results
- Assessing an individual psychosocial support network
- Procedure for obtaining informed consent.

Session instructions



1. Introduction (Approx. 15 minutes)

Introduce the sub-module by discussing the following questions:

- What are the different approaches to HIV testing and counselling?
What approach is most widely used in your country?
- Emphasize that, regardless of the approach, HIV testing and counselling must be voluntary and must maintain the “three Cs”—informed consent, counselling, and confidentiality.
- Ask the trainees to read chapter 4, section 1, “Approaches to HIV Testing and Counselling”, in their handbooks and the first part of section 2, “Pre-HIV Test Counselling”. **(10 minutes)**

Ask the trainees to summarize the key steps in pretest counselling. Write their responses on flip chart paper **(5 minutes)**

2. Inform the trainees that we will look at the first part of pre test counselling, the individual risk assessment

- Ask the trainees what the clinical and public health reasons for conducting a detailed risk assessment are. Key answers you may need to prompt them on are:
 - It allows other health conditions to be screened for, identified, and treated, e.g., STIs, TB, and parasites.
 - It presents an opportunity to educate clients about risks in a detailed manner.
 - It enables the health worker to provide more adequate feedback on risks.
 - It assists the counsellor in determining whether the client will need to retest to cover significant window period exposures and engage in risk reduction while in the window period.
- Ask the trainees what type of difficulties counsellors or clients might experience during a clinical risk assessment.

3. Demonstration of the how to conduct the risk assessment (allow 20 minutes)

- Three trainers are required to conduct the demonstration. Two to role play the client and counsellor interaction and the other to demonstrate the recording of information on the form projected onto a screen.
 - Introduce yourself and explain your role to the client.
 - Explain the difference between HIV and AIDS.
 - Explain the window period.
 - Briefly explain the general modes of transmission—unprotected sex, mother-to-child transmission, sharing of injecting equipment, and use of infected blood products.
 - Then explain that you need to discuss some things that may be very sensitive and private. Offer this explanation: *“I need to discuss some things today that perhaps normally we wouldn’t discuss with others. I need to discuss these things to give you realistic feedback about your risk of being infected. You may be worrying unnecessarily. I also need to make sure you know how to keep yourself and your partner(s) safe. Different practices have different risks. Finally, I need to see if you have other potential health problems that this test will not identify; I may need to do other types of tests. As you can see, there are some good reasons for us to talk openly about these things even though it may not be comfortable.”*
- Start the questionnaire session by asking why the client is testing and whether he or she has had the test before. Then ask if the client has sex with women, men, or both.
- Remind the trainees that detailed risk assessment follows this pattern:

Information → Risk reduction → Question

Demonstrate this in front of the class for each of the risk behaviours

- It is important to emphasize to the class that information on mother to child transmission should be provided to all clients irrespective of gender or sexuality. Inform the group that many MSM have female partners at sometime during their life.
- Remind the trainees that they should educate the client about the relationship between their risk behaviour and STIs, and the relationship between STIs and HIV.

4. Activity 1: Assessing individual risk (Allow total activity time 80 minutes)

This time allows for two rounds of role plays each round allowed 20 minutes and 40 minutes of feedback on the cases.

Objectives:

- To manage a discussion of sensitive issues;
- To conduct a risk assessment interview;
- To assess risks within the HIV test window period; and
- To assess an individual's coping strategies and psychosocial support system.

Preparation:

- Make photocopies of tool T4.1 for all the trainees.
- Make several photocopies of activity sheet AS4.2 and cut out the individual case studies.
- Explain that the class will now practice conducting a detailed and sensitive risk assessment interview. Inform the trainees that, if they have never done a risk assessment before, the first experience may be unusual.
- Divide the trainees into pairs and ask each pair to assign counsellor and client roles between the two of them.
- Then inform the class that the "counsellor" will have to complete the Pre-HIV Test Counselling Interview Form up to but NOT including the assessment of personal coping strategies. Hand out copies of the interview form to all "counsellors". The "counsellor will have **15-20 minutes** to conduct the interview.
- Next, hand out case study **AS4.2** to the "clients". Each "client" should read the case by himself or herself and not show it to the "counsellor".
- Before starting the practice assessment, review once again how the trainees could explain and explore the various risks on the interview form.
- Remind the trainees who are role-playing counsellors to first "educate" their clients about risk behaviour, explain how this risk may be reduced, and then inquire if this behaviour is a concern for them.
- Remind the "counsellors" to note the exposure for each risk, to aid them in determining different window periods for different infections such as HIV, hepatitis B virus, and STIs.
- Ask the "counsellors" and "clients" to switch roles and start the process again with a new case study.

5. Conducting role-play debriefing

- Make sure that all of the trainees have copies of the case studies. Using an overhead transparency of the interview form or projecting a computer image of the form, complete the form by asking 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?*"
- Mark the trainees' responses on the transparency. If the trainees provide an incorrect response, ask the class whether they agree with the response or not.
- After recording the responses for the case on the transparency, ask the trainees to identify the issues of concern for this client.

- Point out that the last two items on the interview form are about condom use and safe injecting. After providing information about potential risk from different behaviours the counsellor should take the opportunity to demonstrate how to reduce risk. Therefore, the counsellor will need to know how to demonstrate correct condom use and safe injecting. The counsellor should demonstrate first and then ask the client to demonstrate.

6. Assessing the client's capacity to cope with a possible positive test result (Allow 10 minutes)

- After a short break inform the class that we will continue with the remainder of the pre-HIV test counselling form.
- Review the relevant section on the pre-test counselling form. Emphasize to the class that it is important to psychologically prepare the client for the possibility of a positive result. Emphasize that they should remind the client that they have a number of risks and that whilst there is a chance that the test will show that they are not HIV infected, there is also a chance that their test may show that they have HIV. Inform the class it is important to ask the client to consider how they would cope with the news of a HIV positive result.
- If the client indicates that they would be suicidal then instruct the class they will need to ask the additional question that appears on the form. Inform the trainees that this will help the counsellor consider the severity of the risk of suicide in the event of the client attaining a positive result.
- Inform the trainees that the counsellor should inform client that if they are positive it will be important for them to tell their current or future sexual partners that they have HIV. Further inform the trainees that they should indicate to the client that you are available to help the client with this if this is needed. Finally, tell the trainees they should ask the client if they think partner disclosure would be difficult for them. Indicate that they should make a note on the form and tick the box on the form if the client specifically says that their partner would be violent.

7. Discuss the importance of the condom demonstration and discussion on safe injection practices. (Allow approximately 40 minutes)

Distribute a copy of tool **T4.3** to each trainee. Commence the following activity.

Male condom

- Distribute two condoms and a penis model to each trainee (or one penis model to every two trainees).
- Tell the trainees that condoms are an integral component of HIV prevention and that counsellors must be able to demonstrate condom use to clients, comfortably and confidently.
- Ask a volunteer from the group of trainees to demonstrate the correct use of a condom before the large group. Ask the volunteer to explain the appropriate steps while doing the demonstration on a penis model. Ask all the trainees to bring up any missing steps.
- Ask the trainees to find partners. They will observe each other as they put the condom on the penis model to verify that it was done correctly and to provide feedback.
- Tell the trainees to begin. They may follow the steps in the tool.
- Now ask the trainees to practice putting a condom on the penis model a second time, but this time with the lights turned off. Emphasize that starting to unroll the condom wrong side out on the penis and then flipping it over to put it on correctly may contaminate the outside of the condom with pre-ejaculatory fluid containing STI micro-organisms. If this happens the condom should be thrown away and replaced with a new one.

Female condom

- Distribute a female condom to each trainee (or at least one per table).
- Demonstrate the correct use of a female condom using a vagina model (if available). If a vagina model is not available, make a fist with one hand. The opening between the thumb and the index finger will function as the opening of the vagina and the small finger will be the base of the pubic bone. Instruct the trainees to repeat the procedure used in the demonstration by following the steps shown. Partners should observe each other to verify that the procedure was done correctly.

Discussing safe injection

- Where appropriate, ask the trainees during the pretest counselling to inform clients of the location of local needle and syringe exchanges and to educate them in safe injection, using tool T4.4.

8. Informed consent and discussion on the procedures for blood collection and result provision

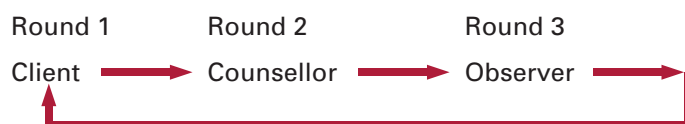
- Inform the trainees that counsellors should check that the client would like to proceed with the test; and then proceed to provide the client with information on blood draw.
- Remind trainees that counsellors should check that client's do not have a history of fainting during blood collection. If the client indicates that they do have problems, the counsellor should advise the personnel that are responsible for blood collection.
- The counsellor should inform the client of procedures for provision of results and post test counselling.
- Finally, tell the trainees counsellors should acknowledge to clients that having a HIV test provokes anxiety, and offer the client some suggestions on how to manage their anxiety whilst they wait for their test results. It is also important that the counsellor reinforces the importance of collection of their results. The counsellor should remind the client that knowing their result can mean that they are able to have the necessary medical care that will enable them to maintain their health. It is also important to remind the client that their result may show them that they are uninfected and that also is better than "not knowing".

It is recommended that a course break occurs at this time.

Activity Pre test counselling role plays

Timing: A total of approximately 150 minutes is allowed for the activity. Allow approximately 45-50 minutes per round. Approximately 20 minutes for each role play; with 10 minutes for each triad debrief and 15 minutes for the small group activities.

- Ask the trainees if they remember the stages of pretest counselling from the handbook. Randomly ask a few trainees to mention some of the stages.
- Next show the stages of pretest counselling on flipchart paper or overhead transparency and provide and discuss the stages with the trainees.
- Organize the class into triads (groups of threes), each one with a "counsellor", a "client", and an "observer". Explain that all trainees will rotate between "counsellor", "client", and "observer" roles.
- State that there will be three rounds of cases, one case per round.
- At the end of the three rounds, every trainee will have participated as "counsellor", "client", and "observer".



The following instructions should be issued per round:

- Instruct "counsellors" to use the detailed Pre-HIV Test Counselling Interview Form (T4.1) when role-playing for the different case studies.
- Instruct "observers" to observe the role-play and provide feedback to the "counsellors" after the role-play by answering the following questions:
- What made the client feel comfortable?
- What micro-skills were particularly important for the counsellor to employ?
- How did the trainees manage to balance providing information with being responsive to the client's emotional needs?

M04-SP: Pre-test & group information

Session Plan

- Remind “observers” that they are not to interrupt the role-play.
- Issue a case study (AS4.3) to each “client” and ask him or her not to share the details of the case with the “counsellor” or “observer”. Disclosure is permitted only when role-playing a client of a different gender. Emphasize that it is up to the counsellor to ask questions in such a way as to get the information from the client.
- Allow a maximum of 20 minutes for the role-play.
- At the end of each round of the role-play, ask the members of each triad to provide brief feedback to one another on the role-play experience. (5 minutes each round)
- Ask the class to form three groups—one comprising the “counsellors” for that round, another comprising the “clients”, and the third group comprising “observers”. A co-facilitator should be assigned to each group. The small-group facilitators should discuss the following:
 - What were the key pre-test counselling issues for the client?
 - What strategies should the counsellor employ to support the client in managing these issues?
 - How did the trainees manage to balance providing information with being responsive to the client’s emotional needs?
 - Limit the Counsellor, Observer, and Client groups debriefing to 15 minutes each round.

9. Giving feedback on the role play

10 minutes

- Ask the trainees to rejoin the large group.
- Provide feedback to the group on the basis of observations from the role-play and feedback sessions.

10. Give the class a short break or a longer scheduled break

Sub-module 2: Providing Pre-HIV Test Group Information (Time: Approx.1 hour)

1. Introduction

**Time
5 Minutes**

- Introduce the sub-module by discussing the following questions:
 - What are the different approaches to HIV testing and counselling?
 - What approach is most widely used in your country?
- Emphasize that, regardless of the approach, HIV testing and counselling must be voluntary and must maintain the “three Cs”—informed consent, counselling, and confidentiality.

2. Referring trainees to the handbook, chapter 4

15 Minutes

- Ask the trainees to read chapter 4, section 3 Providing pre-HIV test information in groups. (5 minutes)

3. Explaining the need for pretest group information

5 Minutes

- Explain that individual pretest counselling is considered to be the most effective pretest counselling strategy. However, where demand for testing and counselling is high and resources are limited, a combination of individual and group pretest counselling can be considered. Moreover, in settings where there is a high volume of clients, counsellors may conduct group pretest information sessions for those who request testing and counselling. Before testing can take place, however, clients still meet with a counsellor individually, although the session is much abbreviated and informed consent is still required. No test results are provided in the group.
- Ask the trainees to brainstorm settings in which pretest group information would be beneficial.

4. Activity 1: Providing pre-HIV test group information

20 minutes

Objectives:

- To conduct a group pretest information session; and
- To manage a discussion of sensitive issues.

Preparation:

- Make photocopies of activity Sheet **AS4.1** to distribute to all the trainees.
- Prepare flipchart paper and markers for group work.

Instructions:

- Inform the trainees that before the process of pre-HIV test counselling is discussed, the skills needed to provide pre-HIV test group information will be explored.
- Divide the class into two groups.
- Explain to the trainees that each group will design a pre-HIV test group information session.
- Hand out activity sheet AS4.1 to each trainee and explain that the session should include the following topics:
 - The confidentiality and privacy that you can offer clients;
 - Basic information about HIV and treatment; and
 - Basic information about HIV transmission.
- Explain the three main methods of HIV transmission—unprotected sex, sharing of injecting equipment, and mother-to-child transmission (during pregnancy, birth, or breast-feeding).
- Explain how STIs can make it easier to catch or pass on HIV. Then say you will discuss this in more detail later.
- Discuss risk behaviours one by one, as you would while providing a risk assessment. Describe how each one can result in infection and how you can reduce each risk.
 - Occupational exposure;
 - Tattooing, body piercing;
 - Infected blood products;
 - Vaginal intercourse (with or without ejaculation);
 - Oral sex (with or without ejaculation);
 - Anal sex (with or without ejaculation); and
 - Sharing injecting equipment.

Instruct the trainees who will serve as group facilitators that they should finish the discussion of these risks by telling the group that when they see the counsellor individually the counsellor will ask them whether or not they have had these specific risks. Give some examples of reasons why these questions need to be asked: "The counsellor (or I) will need to discuss some things today that perhaps normally we wouldn't discuss with others. I need to discuss these things in order to give you realistic feedback about your risk of being infected (you may be worrying unnecessarily); to make sure you know how to keep yourself and your partner(s) safe (different practices have different risks); and to see if you have other potential health problems that this test will not identify (I may have to do other types of tests). As you can see, there are some good reasons for us to talk openly about these things even though it may not be comfortable."

- Demonstration and discuss condom use (male and female).
- Provide HIV prevention information for injecting drug users.
- Discuss the benefits and potential issues related to testing.
- Explain the window period and inform the clients they may need to have further testing. Indicate that this will be discussed with them individually.

M04-SP: Pre-test & group information

Session Plan

- Explain the testing procedures and procedures for result provision. Reassure the group that all results will be provided in private and individually.
- Ask the group if they have any questions. Offer a question box; answers to questions can be posted on a bulletin board or incorporated into another session.
- Suggest to the group that they review the chapters in the handbook that have already been covered to find information they need for the pretest group information session. They may also make use of any of the tools that have been introduced so far, as appropriate.

Debriefing (5 minutes)

- At the end of each session, group participants debrief the facilitators. The group members should offer constructive criticism and then provide any positive feedback.
 - How did they think the session went?
 - Were they able to manage the session and maintain the interest of the clients?
 - What did they find most difficult?
 - What would they do differently if they had to do the session again?
- Congratulate the group on their work.

Conclude the pre HIV test counselling module

Recapping the session

5-10 minutes

- Ask the group to summarize and discuss the key learning points from the activities.
- Ask the group if they have any questions and remind them about the question box.

How to provide HIV test results

Session objectives

At the end of the training session, trainees will be able to do the following:

- Apply a knowledge of basic counselling techniques used in HTC;
- Understand the basic requirements for the provision of HIV results;
- Conduct a post-HIV test counselling session with a client who has tested negative; and
- Conduct a post-HIV test counselling session with a client who has tested positive.

Time to complete module



7 hours and 15 minutes:

- Sub-module 1: 3 hours and 30 minutes
- Sub-module 2: 3 hours and 45 minutes

Training materials



- *HIV Counselling Handbook, chapter 4*
- Activity sheets, case studies (AS5.1)
- Tools T4.2, T4.3, T4.4, T4.5, T4.6, T4.7
- Flipchart paper/Overhead transparency
- Question box

Content



- Giving results: General principles
- Providing a negative result
- Providing a positive result
- Rehearsing post-HIV test counselling
- Making a clinical risk assessment
 - Assessment and feedback on the level of risk
 - Assessment for referral
 - Window period
- Assessing coping skills
- Discussing sensitive issues
- Role-playing clinical risk assessment

Session instructions



Sub-module 1: Providing Negative HIV Test Results (Total time: 3 hours and 30 minutes)

- | | Time |
|--|--------------------|
| 1. Introducing the session | 5 minutes |
| <ul style="list-style-type: none"> ● Introduce the objectives of the session and explain that the session will be divided into two parts: the provision of negative HIV test results and the provision of positive HIV test results. | |
| 2. Referring trainees to the handbook, chapter 4 | 20 minutes |
| <ul style="list-style-type: none"> ● Ask the trainees to read chapter 4, section 4 (“Post-HIV Test Counselling”). (10 minutes) ● After the trainees have finished reading, randomly ask a few of them to quickly summarize the important steps in providing a negative HIV test result. Then ask other trainees to summarize some of the important issues to discuss with the client that were introduced in the pretest counselling session. (10 minutes) | |
| 3. Documenting post-HIV test counselling | 20 minutes |
| Preparation: | |
| <ul style="list-style-type: none"> ● Photocopy the Post-HIV Test Counselling Form (T4.5) onto overhead transparency and make enough paper photocopies for the entire training group. | |
| Instructions: | |
| <ul style="list-style-type: none"> ● Discuss the importance of documenting individual test cases. ● Display the overhead transparency of the Post-HIV Test Counselling Form (T4.5) and give each trainee a copy of the form. ● Clarify each item on the form and then demonstrate the use of the form. | |
| 4. Discussing referral and release of information | 15 minutes |
| Preparation: | |
| <ul style="list-style-type: none"> ● Photocopy the Referral Form (T4.6) and the Release of Information Form (T4.7) onto overhead transparencies and make enough photocopies for the entire training group. | |
| Instructions: | |
| <ul style="list-style-type: none"> ● Display the overhead transparency of the Referral Form (T4.6) and demonstrate how it should be filled out. ● Discuss the importance of establishing a referral network. ● Ask the trainees about their understanding of “shared confidentiality”. Provide additional clarification if necessary. ● Display the overhead transparency of the Release of Information Form (T4.7) as needed. | |
| 5. Activity 1: Role-playing HIV test counselling for a negative result | 130 minutes |
| Objective: | |
| <ul style="list-style-type: none"> ● To conduct a post-HIV test counselling session with a client who has tested negative. | |
| Preparation: | |
| <ul style="list-style-type: none"> ● Prepare the case studies from AS5.1. | |
| Instructions: | |
| Introduce the activity (10 minutes) | |
| <ul style="list-style-type: none"> ● Inform the trainees that they will now role-play post-HIV test counselling for negative HIV test results. Suggest the use of the tools that have been introduced so far in the counselling session. ● Organize the class into groups of three (triads), each one with a “counsellor”, a “client”, and an “observer”. Explain that all trainees will rotate between “counsellor”, “client”, and “observer” roles. | |

M05-SP: HIV test results



- There will be three rounds of cases, one case per round. Tell the trainees that they will use the same three pre-HIV test counselling cases issued earlier (**AS 5.1**).
- **Round 1** of the role-play should begin with role-playing case 1 of the pre-HIV test counselling cases (in **AS 5.1**), **round 2** should use case 2, and **round 3** should use case 3. The “client” can share the details of the case with the “counsellor” and the “observer”.
- Allow a maximum of 20 minutes for the role-play.

Issue the following instructions to the trainees for each round (20 minutes):

- One person in each triad is to take on the role of counsellor; the others take on the role of client and observer.
- Instruct “counsellors” to use the Post-HIV Test Counselling Form (**T4.5**), the Referral Form (**T4.6**), and the Release of Information Form (**T4.7**) as needed. They should also make use of any of the other tools that have already been introduced, as appropriate.
- “Observers” are to observe the role-play and provide feedback to the “counsellor” after it. The facilitators should remind the “observers” that they are not to interrupt the role-play.
- After **each round** of the role-play the members of the triad will debrief one another. (5 minutes)
- Then ask the trainees to form three small groups—one for the “counsellors” for that round, another for the “clients”, and a third group for the “observers”. A co-facilitator should be assigned to each group. The small-group facilitators should discuss the following:
 - What are the issues that the counsellor must address with the client now that a negative result has been presented?
 - What behaviour change interventions should the counsellor offer?
- The small-group debriefing should last no longer than **15 minutes** each round.
- Reassure the group that, while providing positive results is difficult, it improves with practice, debriefing, and clinical supervision.

6. Providing feedback

10 minutes

- The training team will provide feedback to the group based on their observations from the role-play and feedback sessions.

7. Recapping the session

10 minutes

- Ask the group to summarize and discuss the key learning points from the activities.
- Ask the group if they have any questions and remind them about the question box.

Sub-module 2: Providing Positive HIV Test Results (Total time: 3 hours and 45 minutes)

1. Introducing the session

**Time
5 minutes**

- Introduce the session.
- Ask the trainees to quickly review some of the important steps in providing the post-HIV test result.
- Ask the trainees, “Now that you have conducted a practice post-HIV test session for a negative test result, how do you think will the process of providing a positive result be different?”

2. Referring the trainees to the handbook, chapter 4

20 minutes

- Ask the trainees to read section 4 of chapter 4 of the handbook from the heading “Detailed Steps to Follow When Providing HIV-Positive results” to the end of the chapter. (15 minutes)
- When the trainees have finished reading, randomly ask a few of them to quickly summarize the important steps in providing a positive HIV test result. Then ask other trainees to summarize some of the important issues to discuss with the client that were introduced in the pretest counselling session. (5 minutes)

3. Activity 2: Dealing with emotions, thoughts, and needs

30 minutes

Objective:

- To conduct a post-HIV test counselling session with a client who has tested positive.

Preparation:

- Prepare a table with three columns—“Emotions”, “Thoughts”, and “Needs at This Moment”—on overhead transparency or flipchart paper (see sample table at the end of this session plan; the sample may be photocopied onto an overhead transparency).

Instructions:

- Inform the trainees that you plan to introduce the topic with an experiential group activity to sensitise the trainees to the needs of clients receiving the results.
- 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 the trainees an opportunity for confidential debriefing with a workshop facilitator, should the need arise. This is important as there may be trainees or people close to them who have been diagnosed with HIV.
- Position the overhead transparency sheet for results onto the overhead projector without turning the projector on. Tell the trainees that you will now briefly switch off the lights for part of the activity. The master sheet for the overhead transparency is attached to this session plan; the trainer can copy it onto an overhead transparency.
- Ask trainees to think back to their first job and career progression so far and to think about their plans for the future in terms of professional growth, family members, 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 the trainees to reflect on the emotions they would have experienced had they been told that they were HIV-positive. They are to reflect on how **they** themselves, and not the “clients”, would react.
- Ask the trainees to share with the group the emotions and thoughts that they had during this activity. The trainers should list the trainees’ responses in a table on overhead transparency or flipchart paper.
- 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.

4. Activity 3: Role-playing post-HIV test counselling

130 minutes

Objective:

- To conduct a post-HIV test counselling session with a client who has tested positive.

Preparation:

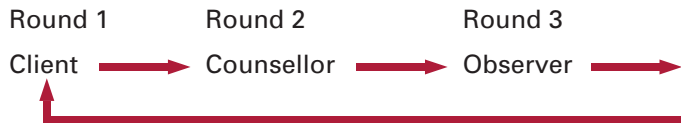
- Prepare the case studies from **AS5.1**.

M05-SP: HIV test results

Instructions:

Introduce the activity (10 minutes)

- Inform the trainees that they will now role-play post-HIV test counselling for an HIV-positive result. Suggest the use of the tools that have been introduced so far in the counselling session.
- Organize the class into groups of three (triads), each one with a “counsellor”, a “client”, and an “observer”. Explain that all trainees will rotate between “counsellor”, “client”, and “observer” roles.



- There will be three rounds of cases, one case per round. Tell the trainees that they will use the same three pre-HIV test counselling cases issued earlier (**AS 5.1**).
- **Round 1** of the role-play should begin with role-playing case 1 of the pre-HIV test counselling cases (in **AS 5.1**), **round 2** with case 2, and **round 3** with case 3. The “client” can share the details of the case with the “counsellor” and the “observer”.
- Allow a maximum of 20 minutes for the role-play.

Issue the following instructions be issued to the trainees for each round (20 minutes):

- One person in each triad is to take on the role of counsellor; the others will take on the role of client and observer.
- Instruct the “counsellors” to use the Post-HIV Test Counselling Form (**T4.5**), Referral Form (**T4.6**), and Release of Information Form (**T4.7**) as needed. They should also make use of any of the other tools that have been introduced, as needed.
- “Observers” are to observe the role-play and provide feedback to the “counsellor” after it. Facilitators should remind “observers” that they are not to interrupt the role-play.
- After **each round** of the role-play the members of the triad are to debrief one another. (**5 minutes**)
- Then ask the trainees to form three small groups—one group each for the “counsellors” for that round, the “clients”, and the “observers”. A co-facilitator should be assigned to each group. The small-group facilitators should focus the discussion on the following questions:
 - What are the key counselling issues for the client now that they have a positive result?
 - What are the referral needs of the client?
 - What micro skills were particularly important for the counsellor to employ?
 - How did the trainees manage to **balance** providing **information** with being responsive to the need of the client’s **emotional needs**?
- Limit the small-group debriefing to **15 minutes** each round.
- Reassure the group that, while providing positive results is difficult, it improves with practice, debriefing, and clinical supervision.

5. Providing feedback

15 minutes

- The training team will provide feedback to the group based on their observations from the role-play and feedback sessions.

6. Activity 4: Debriefing the group

15 minutes

- End this session with an activity to break tension, e.g., a knot game.
- Ask the trainees to form a large circle, close their eyes, and walk into the centre of the circle while keeping their eyes closed and arms outstretched. Ask them to grasp the hands of two other trainees, preferably on the other side of the circle, without opening their eyes. Then ask the trainees to open their eyes. They must now unravel the knot and form a circle again without letting go of the hands they are holding.

M05-SP: HIV test results

Session Plan

- This activity requires a shift of focus and group cooperation, and typically results in a lot of laughs. Where such an activity is considered culturally improper, provide the trainees with some other form of release from physical and mental stress after the session.

7. Recapping the session

10 minutes

- Ask the group to summarize and discuss the key learning points from the activities.
- Ask the group if they have any questions and remind them about the question box.

Emotions	Thoughts	Needs at this moment

Counselling for suicide prevention

Session objectives

At the end of the training session, trainees will be able to do the following:

- Identify reasons why clients may be contemplating suicide;
- Conduct a suicide risk assessment in a given case study;
- Identify when a client has suicidal symptoms or tendencies in a given case study; and
- Demonstrate the use of effective management strategies for counselling a suicidal client, in a given case situation.

Time to complete module



3 hours and 15 minutes

Training materials



- *HIV Counselling Handbook, chapter 5*
- Activity sheets **AS6.1**
- Tools **T5.1** and **T5.2**.
- Flipchart paper/Overhead transparencies
- Question box

Content



- Suicide risk in HIV
- Identification of suicidal clients
- Signs and symptoms of clinical depression
- Suicide risk assessment
- Key interventions for different levels of risk
- Case management planning

Session instructions



1. Introducing the topic

Time
10 minutes

- Introduce the topic and indicate to the trainees that this module may raise personal issues for them if they have had any personal experience with the topic. Acknowledge that trainees are welcome to confidentially discuss issues arising from the session after class.

M06-SP: Suicide prevention

Session Plan

- Ask the trainees to brainstorm why they think it is important to address the issue of suicide in HIV counselling.
- Then ask the trainees to quickly brainstorm when clients may be likely to consider suicide in relation to HIV testing. Write the responses on flipchart paper, then ask individual trainees to elaborate on their responses.

2. Referring trainees to the handbook, chapter 5

30 minutes

- Ask the trainees to read chapter 5, section 1, “Conducting a Suicide Risk Assessment”, in their handbooks.
- Ask the trainees to highlight some key messages from this section.
- Introduce the trainees to the Suicide Risk Assessment Interview Guide (T5.1). Display a copy of the tool on overhead transparency or refer the trainees to the toolkit.
- Together with another trainer, demonstrate a sample role-play following the steps outlined in the interview guide. (See the demonstration case study at the end of this session plan.)
- After completing the role-play counselling session, introduce the trainees to the Suicide Risk Assessment Matrix (T5.2 in the toolkit). Using the information obtained from the “client” in the role-play, demonstrate how to fill out the matrix. Allow some time between steps for questions.

3. Activity 1: Conducting the suicide risk assessment interview

1 hour, 50 minutes

Objective:

- To rehearse a suicide risk assessment interview.

Preparation:

- Prepare copies of the Suicide Risk Assessment Interview Guide and the Suicide Risk Assessment Matrix on overhead transparencies or flipchart paper.
- Make photocopies of the suicide risk assessment and management case studies together with the role-play instructions (AS6.1) for each pair.
- Also, make copies of the Suicide Risk Assessment Matrix, two for each pair.

Instructions:

- Tell the trainees that they will now have the opportunity to conduct a suicide risk assessment interview and to practice using the Suicide Risk Assessment Matrix.
- Pair off the trainees and ask one to play the role of a counsellor and the other a client. Ask them to practice a risk assessment for **20 minutes** as a role-play.
- Hand out the suicide risk assessment cases to the “clients” only.
- “Counsellors” are to be instructed to introduce themselves as counsellors and say that “you have been asked to see me because people who care about you are worried about you”. They should then conduct a suicide risk assessment according to the Interview Guide (T5.1). Emphasize the importance of using counselling micro-skills to convey concern, empathy, and calm support to clients.
- Instruct the “clients” to provide feedback to the “counsellors” after the role-play. The “counsellors” should be encouraged to discuss what they feel they could have done differently and their emotional response to the role-play. (**5 minutes**)
- Distribute a copy of the Suicide Risk Assessment Matrix to each pair. Each member of the pair should then review the case and the two should complete the matrix together.
- **Call the trainees together again for a debriefing.** Display a blank copy of the Risk Assessment Matrix either on overhead transparency or on flipchart paper that you have pre-prepared. Ask everybody to read case 1 and ask the trainees to help you complete the Risk Assessment Matrix in front of the group. Ask the trainees what the level of risk of suicide is. Ask them what they think the counsellor should do next to support this client. Refer them to the handout that outlines interventions for low-risk clients. (**15 minutes**)

M06-SP: Suicide prevention

Session Plan

- After the debriefing, ask the trainees to switch roles and repeat the process with case 2.
- **Again at the end of the role-play and debriefing**, display a blank copy of the Risk Matrix either on overhead transparency or on flipchart paper that you have pre-prepared. Ask everybody to read case 2 and to help you complete the Risk Matrix in front of the group. Ask the trainees what the level of risk of suicide is. Ask them what they think the counsellor should do next to support this client. Refer them to the handout that outlines interventions for high-risk clients. **(15 minutes)**

4. Developing a management plan

45 minutes

- Divide the trainees into two groups according to the case study they analysed in the role-play.
- Once they are in their groups, instruct the trainees to read chapter 5, section 2, of the handbook ("Suicide Management Interventions"). **(10 minutes)**
- After reading the section, each group should review its case study once again, including the Suicide Risk Assessment Matrix. The groups should then discuss strategies for managing their respective clients. Each group should designate a facilitator and a note taker to write down key strategies on flipchart paper. **(20 minutes)**
- Ask each group to present its findings before the large group. The presentations should be no longer than 5 minutes. Allow a few extra minutes for questions or clarifications.

5. Recapping the session

10 minutes

- Ask the trainees to come up with key points for counsellors to remember when conducting a suicide risk assessment.
- Then ask the trainees to come up with key points for counsellors to remember when developing a client management plan.
- Congratulate the group on their work and remind them that this topic can elicit strong responses. Ask the group to summarize the key learning points from the activities.
- Encourage the trainees to read the appropriate chapter in the handbook once again.
- Ask the group if they have any questions and remind them about the question box.

Suicide risk assessment: Demonstration (for trainers only)

For use in demonstrating the use of the Suicide Risk Assessment Interview Guide and the Suicide Risk Assessment Matrix.

Sample case study for trainers

A female, 27 years old, has just received an HIV-positive test result from you, the counsellor. During the pretest counselling session you learned that she and her fiancé had decided to be tested before getting married later in the year. Now she reveals that the two of them were previously tested at another HTC service. Although both tested positive, her fiancé blamed her for his infection and no longer wants to get married. She is distraught. Her relationship with her family is already strained because her parents disapprove of her fiancé. She says her situation seems hopeless. She has thought of suicide. Her work is the only thing that seems to be going well in her life, and now, with the confirmation of the test results, she is afraid that it is only a matter of time before her co-workers find out about her HIV status.

Developing a post-diagnosis support plan

Session objectives

At the end of this session, the trainees will be able to do the following:

- Identify psychosocial issues common among clients living with HIV; and
- Develop a post-diagnosis support plan.

Time to complete module



1 hour and 30 minutes

Training materials



- *HIV Counselling Handbook, chapter 6*
- Activity sheets **AS7.1**
- Flipchart paper/Overhead transparencies
- Tools **T6.1, T6.2, T4.6.**
- Question box

Content



- The counsellor's role in HIV-positive prevention
- The client's mental health needs and how they should be addressed
- Post-diagnosis support planning

Session instructions



1. Introduction

Time
5 minutes

- Introduce the session.
- Ask the trainees when they think HIV care counselling should begin.
- Then ask the trainees, "What is HIV-positive prevention?"

2. Discussing HIV-positive prevention

10 minutes

Preparation:

- Write the guiding principles of positive prevention on flipchart paper or copy onto an overhead transparency.

M07-SP: Post-diagnosis support

Session Plan

Instructions

- Present the guiding principles of positive prevention. Read out the principles and ask the trainees what each one means.
- Then ask the trainees to discuss the role of the counsellor in positive prevention. Record the trainees' responses on flipchart paper or on another overhead transparency.
- Ask the group to brainstorm psychosocial issues common among persons living with HIV and AIDS at each stage of the disease continuum.

3. Referring to the handbook (chapter 6, section 1) 10 minutes

- Ask the trainees to read chapter 6, section 1, "Your role in HIV-positive prevention", in their handbook. (5 minutes)
- Ask a few trainees at random to compare the group's earlier responses with what is presented in the handbook. (5 minutes)

4. Referring to the handbook (chapter 6, sections 2 and 3) 20 minutes

- Next ask the trainees to read chapter 6, sections 2 and 3, in their handbook. (15 minutes)
- Ask a few trainees at random to summarize key points from the reading. (5 minutes)

5. Activity: Developing a post-diagnosis support plan 40 minutes

Objective:

- To develop a post-diagnosis support plan.

Preparation:

- Make four copies of the post-diagnosis follow-up counselling form (T6.1) on an overhead transparency and make enough photocopies for all the trainees.
- On flipchart paper write down the following phrases:
 - "Someone who is asymptomatic";
 - "Someone who is becoming symptomatic"; and
 - "Someone with AIDS".

Instructions

Part 1 (10 minutes)

- Ask the trainees to look at the list of phrases on the flipchart paper and identify some of the psychosocial support needs of persons in different stages of the progression from HIV infection to AIDS. Then ask them how they identified these needs.
- Introduce the post-diagnosis follow-up counselling form (T6.1). Display the form on overhead transparency.
- Ask the trainees to look at the sample case scenario under "Mapping out the client's needs" in chapter 6, section 3. The trainer should demonstrate the use of the follow-up counselling form, using this case scenario.

Part 2 (15 minutes)

- Divide the trainees into three groups and then assign each group a case study from AS7.1. Give each group a copy of the form on overhead transparency.
- Instruct the groups to identify the key issues facing the client and the key support strategies by working through the follow-up counselling form. Tell the groups that they may also refer back to the appropriate sections in chapter 6 and other chapters in the handbook.
- Suggest that the groups look at both the immediate and ongoing support strategies and identify referral options that may be helpful.

Part 3 (15 minutes)

- Ask each group to summarize its findings for the large group. After each presentation, give the members of the other groups an opportunity to comment on the findings. The trainers may then provide additional comments (see case studies and possible responses below.)
- Remind the trainees of the need to make appropriate referrals and for the client to authorize the release of information if there should be a need to share confidential information.

6. Recapping the session

10 minutes

- Ask the group to summarize the key learning points from the session.
- Draw the trainees' attention to the links with other chapters in the handbook and topics discussed in other training sessions.
- Ask the group if they have any questions and remind them about the question box.

Below are the case studies and some possible ideas that the small groups may generate. You may choose to refer to these notes in assisting trainees with the activity and providing feedback after each group presentation.

Case study 1: Asymptomatic

A 31-year-old male found out two months ago that he was HIV-positive. He and his girlfriend had decided to get married and they had gone for a test at the anonymous clinic in Bangkok. He tested positive and his girlfriend tested negative. After he got his positive result his girlfriend left him. He has previously had sex with many other girls and thinks he could have infected some of them. He worries whether he can find a wife and have children. His family is asking why he is no longer getting married and he is not sure how to explain his situation to them. He does not know anyone else who is HIV-positive and feels scared about what could happen to him.

Possible responses for case study 1:

- Issues: adjustment to diagnosis, loss of relationship, history of unprotected sex, fear of having infected others, possible guilt feelings, fear of disclosure, lack of social support, lack of information about HIV and disease progression
- Immediate strategies: education and information about HIV and AIDS, discussion about possible reactions to diagnosis, normalization of adjustment difficulties, education about safer sex, brainstorming of strategies to ensure safer sex
- Ongoing strategies: planning and rehearsing for disclosure, counselling for loss of relationship and development of new relationships
- Referral options: ongoing counselling, peer support

Case study 2: Symptomatic

Eight months ago a 22-year-old male had a rash on his body that would not go away. He was tested for HIV by a doctor and was diagnosed HIV-positive. He lives at home with his mother, father, and two sisters. They are aware of his HIV status but have kept it a secret from other family members and friends. Recently, he has been losing weight and feeling very tired. Some traditional medicine recommended by the village healer made him feel a bit better for a time, but then he started to have diarrhoea every day. He went to the pharmacy and was given tablets that help the diarrhoea sometimes. When he last weighed himself at the pharmacy he had lost another five kilos. These physical symptoms have led him to stay home more than he used to.

M07-SP: Post-diagnosis support

Session Plan

Possible responses for case study 2:

- Issues: noticeable rash, weight loss, fatigue, diarrhoea, loss of physical appearance, possible discrimination due to physical symptoms, social withdrawal, lack of access to other forms of care, fear of disclosure to extended family and friends
- Immediate strategies: education and information about HIV and AIDS, strategies for managing discrimination, strategies for continuing social activities
- Ongoing strategies: planning and rehearsing for disclosure to other family members and friends (if desired), counselling for loss of physical control and changes in physical appearance, preparation for continued deterioration of functioning
- Referral options: ongoing counselling, peer support, health clinic or hospital for prophylaxis for opportunistic infections

Case study 3: AIDS

A 37-year-old male found out three years ago that he had HIV. He has had many opportunistic infections since then. He has been very distressed by his recurrent periods of illness and feels that he is a burden to his family. He is currently in hospital with TB and a second episode of pneumonia (PCP). Doctors have recommended antiretroviral (ARV) treatment but he has no money to buy expensive medicine. The doctors are not sure he will recover from this infection and believe he may be too ill to return home again. His family is at his bedside when the doctors tell him the bad news.

Possible responses for case study 4:

- Issues: recent history of recurrent illness, unlikelihood of recovery, possible fear of death, concern for family, lack of money for care, physical deterioration, loss of control (hospitalized)
- Immediate strategies: grief counselling for illness and unlikelihood of recovery, support for family, strategies for maintaining some control and dignity
- Ongoing strategies: preparation for further deterioration and death, will making, discussion of ideas and fears related to death and dying
- Referral options: ongoing counselling, peer support, palliative care, spiritual support, pastoral care, home-based care

Supporting HIV disclosure

Session objectives

At the end of the training session, trainees will be able to do the following:

- Discuss the barriers clients face in partner disclosure; and
- Demonstrate practical skills in partner disclosure counselling.

Time to complete module



4 hours

Training materials



- *HIV Counselling Handbook, chapter 7*
- Activity sheets **AS8.1** and **AS8.2**
- Overhead transparency sheets or flipchart paper
- Sample client referral form
- Question box

Content



- Why partner disclosure counselling is important
- The client's barriers to partner disclosure
- Strategies for partner disclosure
- Problem-solving partner disclosure
- Partner contact strategies

Session instructions



1. Introducing the session

Time
10 minutes

- Introduce the session by asking the trainees to brainstorm a number of questions:
 - What is disclosure?
 - Why do we need to encourage disclosure?
 - What is the role of the counsellor in supporting partner disclosure?
 - When should the counsellor begin discussing disclosure?
- Explain that these questions will be examined further throughout the session.

M08-SP: Supporting HIV disclosure

Session Plan

2. Activity 1: Brainstorming the advantages and disadvantages of HIV/STI disclosure

30 minutes

Objective:

- To identify the advantages (benefits) and disadvantages (barriers) of HIV/STI partner disclosure.

Preparation:

- Prepare overhead transparency sheets or flipchart paper for group work.

Instructions:

- Divide the participants into two groups.
- Explain to the trainees that group 1 will identify the advantages (benefits) of HIV/STI partner disclosure, while group 2 will identify the disadvantages (barriers) of partner disclosure through group brainstorming (**10 minutes**). Each group should write its responses on flipchart paper or on an overhead transparency sheet.
- After this activity, let the groups swap flipchart sheets or transparencies. Ask them to add any answers or correct the mistakes of the other group. The groups should use different-coloured marker pens to clearly distinguish the new answers from the old (**10 minutes**). Then ask the groups to return the sheets to the original group to review.
- Provide any additional points as needed (see trainer talking points at the end of the session plan) and then discuss the advantages and disadvantages to couple counselling in the context of disclosure.

3. Referring the trainees to the handbook, chapter 7, section 1

20 minutes

- Ask the trainees to read chapter 7, section 1, "Counselling for HIV Status Disclosure", in their handbook. (**15 minutes**)
- Ask a few trainees at random to quickly summarize a disclosure option suggested in the reading. (**5 minutes**)

4. Activity 2: Preparing the counsellor challenge response

30 minutes

Objective:

- To challenge client concerns about partner disclosure.

Preparation:

- Prepare a copy of Counsellor Challenge Response (**AS8.1**) for each trainee.

Instructions:

- Revisit the question asked at the beginning of the session, "How do counsellors support disclosure?" Randomly ask a few trainees for responses and then explain that counsellors support disclosure by:
 - Raising the issue with clients and exploring the barriers to disclosure;
 - Helping the client decide on disclosure;
 - Helping the client determine what to disclose to whom, why, and when; and
 - Allowing the client to rehearse
 - The manner of disclosure,
 - The partner's response, and
 - Plans for managing the partner's response.
- Discuss strategies for the counsellor to use in exploring the client's potential barriers to and constraints on partner disclosure. (**10 minutes**)
 - Step 1: Open with an open-ended question, e.g., "*Many clients I give results to feel it will be difficult or not possible to tell their partner they have HIV. What difficulties do you think you will have?*"

- Step 2: Listen and list. List the concerns of the client. Use reflection of feeling and paraphrase to demonstrate to the client that the counsellor understands his or her feelings and concerns.
- Step 3: Challenge the client's thinking. Review the client's reasons gently one by one and ask a counsellor challenge question. Challenge questions are designed to assess the validity of the client's fears, gain more information, and challenge the client to think realistically and evaluate perceived threats and negative consequences, e.g., in response to the fear of violence from the partner, *"What has happened in the past to make you believe your partner will be violent?"*
- Hand out copies of **AS8.1** to all the trainees. Explain that the statements on the activity sheet are partner disclosure concerns of different clients.
- Instruct the trainees to write down questions that will challenge each of the statements. **(10 minutes)**
- Copy the activity sheet onto overhead transparency or flipchart paper. Ask for two or three volunteers among the trainees to give examples of challenge questions to each statement. Request each trainee to provide at least one response. Record the trainees' responses on the overhead transparency or flipchart paper. **(10 minutes)**

5. Referring the trainees to the handbook, chapter 8, section 2

15 minutes

- Ask the trainees to read chapter 7, section 2, "Partner Contact Strategies for Other STIs", in their handbook. **(10 minutes)**
- After the trainees have finished reading, ask a few of them at random to quickly summarize the different referral approaches. Then ask other trainees to summarize some advantages and disadvantages of each approach. **(5 minutes)**

6. Activity 3: Supporting HIV/STI disclosure (role-play)

2 hours, 5 minutes

Objective:

- To practice partner disclosure counselling skills.

Preparation:

- Prepare the case studies from Supporting HIV Disclosure (**AS7.2**).

Instructions:

- Divide the trainees into small groups of three.
- Inform the trainees that they will now conduct another triad role-play to practice partner disclosure counselling skills. If necessary, remind the trainees of the steps in the role play (see below). **(5 minutes)**
- Explain that the tasks set for the counsellor are:
 - Explore the client's barriers to partner disclosure;
 - Problem-solve a key barrier to partner disclosure; and
 - Develop a disclosure plan with the client.
- Hand out copies of case study 1 to the "clients". Remind them that they should not reveal information about their case to the "counsellor" and the "observer".

Role-play steps

- **Step 1: Role-play (20 minutes each round)**

Each triad should nominate a “counsellor”, a “client”, and an “observer”. The triad members will be rotated between these three roles so that all will have an opportunity to experience each role. Accordingly, there should be three rounds of cases, with one case per round, e.g., case 1 in round 1, case 2 in round 2, case 3 in round 3.

“Counsellors” are to practice applying the knowledge and skills learned through the reading, discussion, and other activities by completing their nominated tasks. If they should become confused or uncertain during the role-play they should be instructed to refer to their notes, review their material, and begin again when ready. They should not ask for assistance from their “client” or “observer”. If necessary, they should be instructed to signal a trainer for assistance. At the end of the role-play the “counsellors” should discuss what they were happy with in their practice and what things they would have liked to have done differently.

“Clients” are to play the role of the client 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. Trainers should instruct the “clients” to inform the “counsellor” if they are role-playing a person of different gender, e.g., a female trainee playing the role of a male client. “Clients” should provide feedback to the “counsellor” after the role-play.

“Observers” are to observe the role-play and provide feedback to the “counsellor” after the role-play. “Observers” should be asked to give positive feedback first and then constructive criticism. This helps to increase confidence and avoids bad feelings between trainees. Facilitators should remind “observers” that they are not to interrupt the role-play.

- **Step 2: Triad feedback (5 minutes each round)**

Five minutes should be allowed at the end of each round for discussion and feedback within the triad. “Observers” should take the lead by stating what they observed.

- **Step 3: Debriefing (15 minutes each round)**

Form three small groups—the “counsellors” for that round, the “clients”, and the “observers”.

Ask the trainees to share their role-play experiences and guide the discussion to the following four questions:

- What made the client feel comfortable in discussing disclosure?
- What skills were particularly important for the counsellor to employ?
- How did the trainees manage to balance providing information with being responsive to the client’s concerns?
- What disclosure plan was the counsellor able to develop with the client?

7. Recapping the session

10 minutes

- Ask the group to summarize and discuss the key learning points from the activities.
- Ask the group if they have any questions and remind them about the question box.

Trainer talking points

- Why do we need to encourage disclosure?
 - So people can have access to treatment and care
 - Major transmission risk reduction strategy for HIV and STI
 - We need to explain to clients that we encourage partner notification for the following reasons:
 - People can have HIV for a long time without their knowing it, and can therefore pass it on to others (partners, children, blood donation)
 - A person in the window period (with a recent high risk) may receive a negative test result while actually being highly infectious and able to pass on HIV
- STI and HIV
 - If the partner is not aware of the risk he or she will not think of getting tested and will therefore be unable to get treatment and care
 - Clinical visits should be used to facilitate discussion of transmission risk reduction
 - Constraints on transmission risk reduction
 - Suggestions for dealing with these constraints
- In the case of STI infection, if only one partner is treated and then has unprotected sex with the untreated partner, the treated partner will get the infection again (reinfection)
 - How do counsellors support disclosure?
 - By raising the issue with clients and exploring the barriers to disclosure
 - By helping the client decide on disclosure
 - By helping the client determine what to disclose to whom, why, and when
 - By allowing the client to rehearse
 - The manner of disclosure
 - The partner's response
 - Plans for managing the partner's response

Counselling for treatment adherence

Session objectives

At the end of the training session, trainees will be able to do the following:

- Explain to clients how the virus replicates and how ART combination works;
- Discuss how ART/STI treatment resistance can develop in clients;
- Discuss how ART/STI treatment resistance can possibly be transmitted to others;
- Conduct a pretreatment assessment of the potential individual barriers to adherence and offer the client strategies for reducing potential non-adherence;
- Calculate the individual client's adherence; and
- Offer clients simple strategies for overcoming problems encountered after starting therapy.

Time to complete module



6 hours and 45 minutes

- Sub-module 1: 2 hours
- Sub module 2: 2 hours
- Sub module 3: 1 hour and 45 minutes

Training materials



- *HIV Counselling Handbook, chapter 8, "Providing Treatment Adherence Counselling"*
- Tools **T1.2** (previously distributed in module 1), **T8.1, T8.2, T8.3, T8.4, T8.5, T8.6**
- Activity sheets **AS8.1 AS8.2, AS8.3, AS8.4**
- Flipchart paper/Whiteboard
- Overhead projector (OHP) and screen (if available)
- Blank overhead transparencies and OHP pens (if available) and OHP pens
- Question box

Content



- Content of pretreatment and post-commencement follow-up counselling sessions
- Overview of how ART works
- Development of ARV/STI resistance and possible ARV or STI resistance
- Common barriers to adherence and strategies for addressing these barriers
- Use of the various adherence support tools in the HIV counsellor's toolkit

Session instructions



Sub-module 1: Explaining to clients how ART works and how resistance develops and is transmitted

- | | |
|--|----------------------------------|
| | Time
45 minutes |
|--|----------------------------------|
- 1. Introducing the session and the tools**
- Organize the trainees into four to five table groups.
 - Ask the groups to reread chapter 1 of the handbook from the section “What Does Clinical Management Involve?” (**allow 10 minutes**)
 - Ask the trainees to review the Viral Replication tool (**T1.2**), which was handed out in module 1. Inform the trainees that this tool is to facilitate the counsellor’s own understanding of the life cycle of the virus. The counsellor **should interpret and explain** the process in a simple way to their clients. Explain that the tool contains a detailed technical explanation suitable for doctors on one side and a simpler explanation for counsellor with limited medical background, on the other. Ask the trainees to review the cards (**allow 10 minutes**).
 - Hand out the ART Works tool (**T8.2**). Explain that no single drug can effectively stop HIV from entering the human cells, replicating and attaching to other cells, and repeating the process. Explain that a combination of drugs is needed to stop the virus at all stages of its action in the body. Review the tool with the class by discussing the role of fusion inhibitors and attachment drugs and the role of protease inhibitors. Remind the trainees that the implications for educating clients are: that, if given multiple tablets, they cannot share them with family members or friends who have not been prescribed the medication. Tell the trainees that they should explain to the client that they need **all** of the tablets for ART to work effectively (**allow 10 minutes**).
 - Introduce the notion of ARV resistance by handing out the Resistance tool (T8.5). Explain that counsellors can use this tool to explain the concept of the virus becoming resistant to the drugs (ARV and STI) drugs. Ask the trainees to review the tool in their table groups (**allow 10 minutes**).
 - Inform the participants that once HIV/STI is resistant to ARV / STI medications then that resistant strain of HIV or STI can be transmitted to another person through unprotected sex, shared injecting equipment, and in some cases breast milk (in the case of babies) or body fluids (e.g., through blood transfusions). Indicate that, although the scientific evidence for ART is not strong, transmission remains a possibility. It is a well-documented fact that STI treatment resistance can be transmitted through sexual activity.
 - **Game (5 minutes)**. Call five people to the front of the room. Name two of them HIV-positive: person #1 is taking ARVs or STI medications but has developed treatment resistance after missing medication; person #2 is not taking ARVs or STI medications. Explain that if person #1 has unprotected sex or shares injecting equipment with person #2, the latter could become infected with a treatment resistance strain. If HIV-positive person #2, who has never taken ARVs or STI medications, has unprotected sex with uninfected person #3, person #3 becomes HIV-positive or infected with an STI and may now be resistant to the ARVs or STI treatments that person #1 was taking. If person #3 has unprotected sex with person #4 (also HIV-negative) then the ARV or STI resistance could be passed on. The remaining person #4 needs to be protected—how? The key message for the trainees is that resistance to drugs can be transmitted and clients should be alerted to this possibility.
- | | |
|---|---------------|
| 2. Activity 1: Explaining resistance | 1 hour |
|---|---------------|
- Pass around activity sheet **AS9.1** and form pairs (total time: **60 minutes**). Tight time keeping is essential.
 - 5 minutes for handing out materials; and
 - 20 minutes per round, including organization of trainees (15 minutes for role-play and 5 minutes for feedback).

M09-SP: Adherence counselling

Session Plan

- Issue these instructions: One person in each pair is to role-play a counsellor and the other will be the client. “Counsellors” are to start the discussion with “clients” by saying that they want to explain something about the medication that the “clients” will be taking.
- The “counsellor” should explain to the “client” how HIV replicates in the body, the ART Works tool (T8.2) can be used with educated clients to explain ART to the “client”, and the Resistance tool (T8.5) to let the “client” know how the drugs can lose their effectiveness against the HIV virus (resistance) and how resistance can be transmitted to others (**15 minutes for role-play and 5 minutes for debriefing**).
- Advise the trainees that “counsellors” and “client” are to debrief each other (**5 minutes**). First, the “counsellor” acknowledges what he or she could have done better, and then the “client” provides feedback to the “counsellor” on the latter’s strengths and weaknesses. Then the two switch roles and repeat the process.

Sub-module 2: Pre-ART treatment counselling

2 hours

- Ask the trainees to read chapter 8. (**allow 20 minutes for this**)

3. Activity 2: Engaging in group activity

15 minutes

- Ask all trainees to stand.
- Ask them to think about times in their lives when they have been prescribed medication and tell them that they can sit down only if they have always taken medication exactly as prescribed.
- Ask those who remain standing to consider an occasion when they failed to comply with instructions or complete a course and to think about the reasons why this happened.
- Randomly ask various trainees to give their reasons for non-adherence. To avoid repetition, after getting a few initial responses you may ask the group, “*Who has a different reason?*”, and ask them to give the reason.
- Record their responses on an overhead transparency or on a whiteboard or large butcher paper. Place this on display on the wall of the training room throughout the module.
- Remark that clients have the same difficulties, that many reasons contribute to non-adherence. Information provision clearly is not enough. They are health workers and had information but still did not adhere to their prescriptions.

4. Assessing barriers to adherence

20 minutes

- Hand out tool T8.1 and discuss how it may be used to document the pre-ART preparation of clients. Indicate that the same form can be used throughout the three pretreatment sessions and that each time a task is completed the session date can be recorded beside the task. Explain that in different treatment and care settings different people on the treatment and care staff may have responsibility for completing specific tasks, e.g., the doctor may conduct CD4 and viral load tests, the nurse or pharmacist may be responsible for discussing the side-effects. Where different individuals share the responsibility for pretreatment preparation, the pretreatment record may be stored in the client’s medical record and the staff members sign off on the form when they have completed their respective tasks. Counsellors can also take responsibility for contacting other treatment and care team members who have not signed off on the form. Each client should have a care support worker (also known as a case manager) assigned to oversee all the client support needs. (**10 minutes**)
- Mention the fact that various tools used in this module and in other modules can support counsellors in discussing the first section of the checklist with the client. For example, tools T8.2 and T8.5 discussed in the previous sub-module relate to how ARV works and ART resistance develops.
- Indicate that the assessment of the client’s barriers to adherence will now be looked at more closely. First of all, remind trainees that they should have completed a standard follow-up counselling assessment on other client visits. If not they should do so on this initial pretreatment visit. Ask them to locate and quickly review the Follow-Up Counselling Form (tool T6.1), which will provide them with a significant amount of information on a number of issues to be explored when discussing adherence barriers.

M09-SP: Adherence counselling

Session Plan

- Then inform the trainees that specific potential barriers to adherence must be explored in more detail. Hand out the Pre-adherence Screening tool (T8.4). Inform the trainees that they should complete these interviews with clients in the first pretreatment counselling session. Highlight the fact that the second part of the form is intended to provide a quick way of screening for cognitive problems that may be common in HIV infection, especially among people who have not taken ART. Instruct the trainees to use the explanation for the assessment offered in the text box on the form, before starting the interview. Allow the trainees time to review the form (10 minutes).

5. Activity 3: Conducting pre-adherence screening

65 minutes

- Total time for the activity: **70 minutes**. Tight time keeping is essential.
 - 10 minutes for handing materials; and
 - 30 minutes per round, including the organization of trainees (20 minutes for role-play and 10 minutes for feedback).
- Quickly organize the trainees into pairs, preferably different from those in the previous activities. One person is to be the counsellor and the other is to be the client.
- Ask all the “clients” to come forward and distribute activity sheet **AS9.2, case 1**. Instruct the “clients” to give basic information about themselves to the counsellor, e.g. *“I am a 32-year-old HIV-positive woman about to go onto ART”*. Ask the “clients” NOT to share the specific case details with the “counsellor”. “Clients” can add information to their story if the information is necessary but not supplied.
- Instruct all the “counsellors” to use the Pre-adherence Screening tool (T8.4) in the detailed assessment. The “counsellor” must get all of the information from the “client”. “Counsellors” will not be shown the case in advance.
- When the 30-minute period is up, advise the trainees that “counsellors” and “clients” are to debrief each other (10 minutes). First, the counsellor acknowledges what he or she could have done better and then the “client” provides feedback to the “counsellor” on the latter’s strengths and weaknesses.
- Ask the trainees to switch roles. Provide the new “clients” with activity sheet **AS9.2, case 2**.

Sub-module 3: Final pretreatment and follow-up of ART clients

1 hour

- Remind participants that the last session focused on aspects of client preparation. Tell them that before clients begin therapy they should be shown the regime (refers to the sample ART cards in the appendix of the handbook; ask the trainees to look at them quickly).
- Inform the trainees that, before the start of therapy, they should also address any potential barriers to ART that the client may face. Pass around the Barriers to Adherence tool (T8.3). Allow the trainees to review the tool, which offers potential ways of addressing common barriers (10 minutes).
- Ask the trainees to quickly review the chapter 8 section from the heading “Support during ART”. Review each of the processes counsellors should undertake in follow-up visits after the start of treatment. Indicate to the trainees that client adherence is sometimes monitored by counsellors and in some services by other staff.
- Ask the trainees to turn to the appendix of their handbooks and locate the Adherence Calculation Worksheet in the appendix. Briefly explain how the rate of adherence is calculated (15 minutes).
- Explain to the trainees that if the client missed any pills the underlying problem must be addressed. Explain that while this was discussed to some extent in the pretreatment session it must be discussed in more specific detail with the client.
- Inform the participants that it is important when clients come back for the follow-up session to open the discussion with a statement such as *“Many people I see find it difficult to take the correct dose in the correct way at the correct time, and some even forget some pills... Let’s check your pills and discuss any problems that you have had. It is important that we identify any problems.”* Instruct the trainees to do the pill count if that is part of your role. Then ask the client, *“What are some of the problems that you have had taking your medication?”* Ask this even if the pill count demonstrates 100% adherence. You may prevent a future problem.

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Session Plan

- Distribute the Practical Problem Solving (ART) tool (**T8.7**). Allow the trainees time to review the tool (**10 minutes**).
- Distribute the Side-Effects (ART Drugs) tool (**T8.6**) and inform the trainees that often clients do not adhere to ART because of the side-effects. This tool can be used both in pretreatment counselling and in problem solving once the client has begun ART. Explain that the tool was designed to offer simple strategies for the client to use. Note that some ideas are also mentioned in tool **T8.7**. Allow the trainers some time to review the tool (**10 minutes**).

6. Activity 4: Learning from a case study on treatment adherence 45 minutes

- Pass out activity sheet **AS9.3**. Ask everybody to read the case study. Using the tools and referring to chapter 8, ask the group to discuss key strategies that they would employ to support the client in adhering to treatment (**allow 15 minutes of group discussion**). Then write the strategies on the whiteboard or overhead projection sheet.
- List the key problems and key strategies in two columns. Brainstorm all of the problems the case reveals that the client is experiencing. Then brainstorm strategies for each of the problems identified in the case (**allow 30 minutes**).
- Ask the trainees what other tools they have already received and used in training they think would be useful in adherence counselling.

7. Recapping the session 5 minutes

- Conclude the session by asking the group to identify key learning points from this session. Note down the key learning points either on the overhead transparency or on flipchart paper.
- Ask the group if they have any questions and remind them about the question box.

Pregnant women, new mothers, and their partners

Session objectives

At the end of the training session, trainees will be able to do the following:

- Inform all clients (including men) about how to reduce mother-to-child transmission of HIV;
- Facilitate informed decision making in relation to family planning for discordant couples;
- Offer specific counselling to women in relation to the prevention of mother-to-child transmission; and
- Identify symptoms of postpartum depression and psychosis in HIV-positive women and make appropriate referrals.

Time to complete module



1 hour and 45 minutes

Training materials



- *HIV Counselling Handbook*, chapters 1 and 9 (section 1)
- Tool T10.1
- Activity sheets AS10.1, AS10.2, AS10.3
- Flipchart paper/Overhead transparency
- Question box

Content



- HIV transmission from mother to child
- Counselling of discordant couples
- Informed decision making about family planning and pregnancy in the context of HIV
- ARV prophylaxis and ART therapy
- Counselling on delivery methods
- Reduction of risks associated with infant feeding
- Counselling of male partners of pregnant and lactating women
- Signs and symptoms of postpartum depression and psychosis

Session instructions



Time

1. Introducing the session

- Briefly introduce the objectives of the session. Discuss the importance of the title. Say *“The title of this module emphasizes that prevention of mother to child transmission needs to cover counselling of pregnant women, and their male partners. It also implies that counselling needs to continue of women and their partners after the delivery of the child.”*

2. Activity 1: Completing the fast-facts quiz**35 minutes****Objective:**

- To identify key information on the prevention of mother-to-child transmission (PMTCT).

Preparation:

- Prepare photocopies of activity sheet **AS10.1** for all trainees.

Instructions:

- Divide the trainees into groups of four or five individuals and give each one a copy of **AS10.1**.
- Instruct the trainees to work in their table groups. They will have **20 minutes** to complete the fast-facts quiz on pregnant women, new mothers, and their partners.
- Tell the groups that they may refer to chapters 1 and 9 of the handbook and any of the tools provided during the training, including those provided in the previous session.
- Write down each group’s detailed answers on a piece of paper.
- At the end of 20 minutes, ask the group that has answered all of the questions to come to the front of the room. (If no group has completed the quiz, ask the group that has answered the most questions to come forward.)
- Address each question one by one. Read the questions to the class and then ask the presenting group for their response.
- If there are questions left unanswered by the group doing the presentation, ask the other trainees if they able to respond.

3. Activity 2: Counselling for PMTCT role-play**35 minutes****Objective:**

- To provide key information on PMTCT, using various tools, to a client whose HIV status is known

Preparation:

- Prepare copies of the Healthy Pregnancy and Infant Feeding tool (**T10.1**) for all the small groups.
- Prepare photocopies of activity sheet **AS10.2** for all the trainees.

Instructions:

- Briefly introduce tool **T9.1 (5 minutes)**. Explain that the tool should be used by the counsellor to discuss important prevention information face-to-face with the client.
- Instruct the trainees to form triad groups and give each one a copy of **AS10.2**.

Role-play (15 minutes)

- One person in each triad is to role-play a counsellor and another person a client, and the third person will be an observer.
 - “Counsellors” will use their knowledge of PMTCT interventions and any of the tools provided in this session or any other session to advise an HIV-positive pregnant woman on how she can reduce the chance of infecting her child with HIV.

- The “client” plays the role of a poor woman from the rural areas who lives with her HIV-positive husband and his extended family. The family is not aware that the husband and wife both have HIV. In this woman’s hometown babies are traditionally delivered at home with the help of a village birth-assistant and newborn babies are breast-fed.
- “Observers” **must** take notes during the counselling and later report on the following: the accuracy and style of general advice provided to the mother about looking after her health during pregnancy; the interventions available during pregnancy to reduce HIV transmission; interventions available at birth; and infant-feeding options that will need to be considered after the baby is born.
- Inform the trainees that unlike other role-plays they completed in previous training sessions, in this one the case is already known to the “counsellor”. Tell them further that for the purposes of this activity the “counsellor” is assumed to have already collected this information and is about to counsel the woman.
- “Observers” are requested not to interfere during the role-play. If they see or hear something they do not agree with during the role-play, they should simply make a note of it and discuss the matter at the debriefing. They should also note the things they think the “counsellor” did well.

Debriefing (15 minutes)

- When the time allotted to the role-play is up, ask the members of each triad to debrief each other in the following ways:
 - The “counsellor” goes first and indicates what he or she could have done better or what information he or she found difficult to provide.
 - The “observer” provides positive feedback first and then indicates what he or she feels could have been done better.
 - The “clients” try to provide feedback from the client’s perspective. They should let the “counsellor” know how they were feeling, what was helpful, and what could have been more helpful.
- Instruct the triad to correct any unclear or inaccurate factual information, first by consulting their handbooks and then, if they cannot find the answer, to address their questions to you when the large group convenes. Alternatively, remind them that they may place questions anonymously in the question box if they prefer to do so.

4. Activity 3: Counselling men and PMTCT (a large-group case study)

30 minutes

Objective:

- To identify key information and prevention strategies for men in the prevention of mother-to-child transmission.

Preparation:

- Prepare photocopies of activity sheet AS10.3 for all the trainees.

Instructions:

- Hand out copies of AS10.3 to the trainees and ask them to read the case study.
- While the class is reading write the following questions on the board:

- **What are the key HIV transmission risks to his wife and child?**

(You are hoping to elicit the following risks. The man may already be HIV-positive and may already have infected his wife. She may pass HIV on to the child in utero, during delivery, or during infant feeding. If the wife is already infected, we do not know how long she has been infected and therefore the 18-month-old son may also be infected.)

- **What specific information do we need to give him?**

(You are hoping to elicit the following information from the trainees:

The man needs to be made aware that, as he has a history of unprotected sex with men, he may have contracted HIV. He may have already put his wife at risk; therefore, he should have an HIV test.

M10-SP: Pregnant women

Session Plan

He will need a follow-up test anyway as he is in the window period. He could be highly infectious even if he tests negative on today's test, putting his wife and unborn child at even greater risk. If he is negative on a follow-up test he needs to use condoms all the time with his other partners if he cannot use them with his wife.

If he tests positive he will need to consider telling his wife so she can have an HIV test. If she is infected she will need PMTCT interventions urgently or consider whether she wishes to continue with the pregnancy. If she tests positive, then their 18-month-old son will have to be tested as we do not know how long she has been infected.

He will also need information on STIs and, if he has had unprotected sex with his wife, she will also need treatment or he will be reinfected the next time he has unprotected sex with her. STIs can also be harmful to the unborn baby.)

- **What counselling interventions can we offer to address the issues in this case?**

(You will need to elicit the following:

- *Pre-HIV test and post-HIV test counselling will have to be provided.*
- *If he is infected he will need to be offered a menu of partner disclosure options and support with disclosure skills. He may choose partial disclosure—not tell her he is having sex with men, just acknowledge he has had sex with others without saying it was with a man.*
- *Once disclosure is complete, the wife will need testing and counselling regarding PMTCT interventions if she is positive. Also, if she is positive, their 18-month-old son will have to be tested.*
- *You need to refer the man for post-STI treatment check-up, and the wife for STI treatment.*
- *The couple may have to be referred for psychological support and relationship counselling if required and available.)*

- Ask the trainees to respond to each of the questions.

5. Recapping the session

5 minutes

- **End the session** by asking the group to identify key learning points from the session. Note down the key learning points either on the overhead transparency or on flipchart paper.
- Ask the group if they have any questions and remind them about the question box.

Counselling children and adolescents

Session objectives

At the end of the training session, trainees will be able to do the following:

- Draft sample information tools that may aid in discussing HIV and AIDS with children and adolescents; and
- Demonstrate the provision of information about HIV to a child or adolescent that is appropriate to the child's or adolescent's level of development and understanding.

Time to complete module



1 hour and 30 minutes

Training materials



- *HIV Counselling Handbook*, chapter 9, section 2
- Activity sheets **ASM11a**, **ASM11b**, **ASM11c**
- Flipchart paper or overhead transparency sheets
- Question box

Content



- Understanding the counselling context
- Informing children and adolescents about HIV and related issues
- Disclosing HIV status to children
- Managing anxiety related to clinic visits

Session instructions



1. Introducing the topic

Time
5 minutes

- Introduce the topic by explaining to the trainees that this session will look at only a few of the important issues in the counselling of children and adolescents in relation to HIV testing.
- Ask the trainees to quickly brainstorm some possible concerns they may have if they should have to provide counselling to children and adolescents, and write these on flipchart paper.

2. Referring trainees to the handbook, chapter 9, section 2

20 minutes

- Ask the trainees to read chapter 9, section 2, "Children and Adolescents". (10 minutes)
- Ask the trainees to highlight some of the key issues on informing children about HIV, and write these on flipchart paper. (5 minutes)

3. Activity 1: Talking to children about HIV

30 minutes

Developing a communication strategy (15 minutes)

- Divide the trainees into two groups and inform them that they will be asked to develop a communication strategy or tool that can assist them in explaining difficult concepts related to HIV and health to children.
- Hand out copies of activity sheet **AS11.1** to the trainees. Explain that the activity sheet describes one doctor's strategy for explaining HIV and AIDS to young children. Read the strategy out loud to the group.
- In their groups the trainees should then develop strategies or tools to explain HIV to children of other ages and circumstances.
 - Group 1: Develop a strategy to discuss HIV and AIDS with children aged 5-7 in the rural areas.
 - Group 2: Develop a strategy to discuss HIV and AIDS with children aged 12-15 years.
- Inform the groups that they will have 15 minutes to come up with the strategy/tool. It should be written on flipchart paper or on an overhead transparency sheet.

Presenting communication strategies (15 minutes)

- Invite each group to present its communication strategy before the large group. One of the group members should be selected to present the strategy within 5 minutes.
- The trainees not presenting should put themselves in the shoes of the children targeted. Do they understand what is being presented? What would still be difficult for a child to understand?

4. Activity 2: Role-playing

30 minutes

Role-play (10 minutes)

- Explain to the trainees that they will continue to practice communicating information to children on other issues related to HIV, namely, disclosing a child's HIV status to the child and dealing with anxiety related to visits to the clinic or hospitalization.
- Instruct the participants to form pairs and distribute page 1 of activity sheet **AS11.2** to all trainees. Each pair should decide who will first be the counsellor and who will be the client/observer.
- Inform the trainees that this will not be a blinded role play. Therefore, each pair should take a moment to read the case study. The "counsellor" will then address the concerns highlighted in the case study with the "client/observer". The "observer" will also take notes on the communication strategy demonstrated by the "counsellor", using the chart provided in the activity sheet.

Feedback (5 minutes)

- The "counsellor" will assess his or her own delivery of information, following the items listed on the observation form.
- The observer will provide feedbacks based on the observation form.

Repeat the process (15 minutes)

- Hand out copies of page 2 of activity sheet **M11.2** to all trainees.
- Instruct the "counsellor" and the "client/observer" to switch roles and repeat the process.

5. Recapping the session

5 minutes

- In the large group, ask a few of the pairs to describe their experience in providing information to a child or adolescent.
- Ask the trainees to summarize the key messages from this session and summarize their responses on flipchart paper.
- Ask the group if they have any questions about the session or about the provision of counselling to children and adolescents and remind them about the question box.

Working with MSM and transgender clients

Session objectives

At the end of the training session, trainees will be able to do the following:

- Explain why MSM and transgender clients are at high risk of HIV;
- Identify the sexual health needs of MSM and constraints on their access to services;
- Identify the psychosocial issues surrounding MSM and transgender clients;
- Describe prevention measures for MSM and transgender clients;
- List possible barriers to the use of prevention by MSM and transgender clients, and suggested solutions.

The participants will be able to demonstrate, given a case study:

- How MSM and transgender clients can negotiate safer sex; and
- How the clients should refer partners for testing and counselling.

Time to complete module



2 hours and 30 minutes

Training materials



- *HIV Counselling Handbook*, chapter 9, sections 3 and 4
- Activity sheets **AS12.1**
- Flipchart paper/Overhead transparencies
- Question box

Content



- Definitions and identities of men who have sex with men (MSM) and transgender clients
- Why do some men engage in same-sex behaviour?
- Risk and vulnerability to infection
- Need for health services and access strategies
- Special sexual health and psychosocial needs of MSM and transgender clients
- Challenges of counselling HIV-positive MSM

Session instructions



- | | Time |
|---|-------------------|
| 1. Introducing the session | 10 minutes |
| <ul style="list-style-type: none"> ● Explain that this session is going to explore the special counselling needs of men who have sex with men (MSM). ● Ask if any of the trainees have any direct experiences in working directly with groups of men who have sex with men. Ask participants who have experience with MSM to briefly state what that experience is. These participants may be a useful resource during the session activities. | |
| 2. Activity 1: Brainstorming on MSM and transgender clients | 20 minutes |
| <p>Objectives:</p> <ul style="list-style-type: none"> ● To define the terms “men who have sex with men” and “transgender person”; and ● To assess personal values and attitudes that may influence the provision of counselling. <p>Preparation:</p> <ul style="list-style-type: none"> ● Prepare flipchart paper and markers or overhead transparencies and transparency pens. <p>Instructions:</p> <ul style="list-style-type: none"> ● Tell the trainees that they are now going to explore the special counselling skills needed in the provision of counselling services for MSM and transgender persons. ● Explain that the first step will be to come up with a clear definition of the terms “MSM” and “transgender person”. In the large group, ask the trainees to brainstorm the words and images that come to mind when they hear the term “men who have sex with men”. These words may relate to the characteristics of men with same-sex behaviour or sexual behaviours. Write the responses on flipchart paper or on overhead transparencies. Summarize the range of responses that the trainees have given and then ask them to think why these words and images come to mind. Ask the trainees if they think the list of words presents an accurate description of all men who have sex with men. Ask for explanations. ● Instruct the large group to synthesize their responses into a useful definition of “MSM” and “transgender persons” in the context of counselling. ● If necessary, summarize by stating that the term “MSM” is meant to refer to all men who have sex with men, regardless of their sexual identities or specific behaviours. Highlight some of the broad examples provided in the brainstorming session. | |
| 3. Activity 2: Understanding MSM and transgender clients | 30 minutes |
| <p>Objective:</p> <ul style="list-style-type: none"> ● To identify interventions and information the counsellor can provide to assist in risk reduction and support of MSM and transgender clients. <p>Instructions:</p> <ul style="list-style-type: none"> ● On flip chart paper or an overhead transparency draw up a paper like the one below. Conduct the brainstorming and record participants answers Note: Answers recorded here are the type of answers that you are hoping to get from the participants. An example as follows: | |

Risk	Vulnerabilities
<ul style="list-style-type: none"> ● Unprotected anal intercourse; ● Non-consensual forms of male-to-male sex/sexual violence that causes tissue damage and occurs without condoms ● Unsafe injecting practices ● Tattooing ● Blood products 	<ul style="list-style-type: none"> ● Numbers and types of sex partners ● Involvement in transactional sex; ● Perception of self risk Psychoactive substance (drug) use; ● Limited access to condoms and appropriate lubricants ● Limited information on risk of HIV for MSM ● Legal status of same-sex behaviour Sexual/ Gender identity ● Empowerment within a relationship ● Social stigma against same-sex behaviour

Summarize the following:

As well as addressing the risks of our MSM clients we also need to address the vulnerabilities. For examples making sure clients know how to get lubricants and condoms, how having multiple partners can be made safer, how to negotiate for condom use with partners who have more power in relationships.

4. Referring trainees to the *HIV Counselling Handbook* 20 minutes

- Ask the trainees to spend the next 20 minutes reading through the information on “Counselling MSM and Transgender Clients” in chapter 9, sections 3 and 4, of the *HIV Counselling Handbook*.

5. Activity 3: Outlining risk and vulnerability 45 minutes

Objective:

- To identify the factors of risk and vulnerability in MSM and transgender clients.

Preparation:

- Photocopy the Outlining Risk and Vulnerability Case Studies (AS12.1) and cut out the individual cases. Provide enough copies of the case studies for each member of the group to read.
- Photocopy and distribute the Counselling MSM and Transgender Clients Worksheet (AS12.1) to all trainees.

Instructions:

- Ask the trainees to form six small groups. Allocate one case study to each group.
- Instruct the trainees to read the case study and determine what activities or behaviours are placing the client at risk of infection and what factors are affecting the client’s ability to practice safer behaviours. (Remind the trainees that *risk* is the level at which an individual or population engages in activities which place them at risk of HIV. *Vulnerability* is a person’s ability (or lack of it) to act on the decisions he or she makes.) The trainees should recall the factors from the previous activities.
- The small groups should also assess the stage of change and determine a motivational strategy to assist the client either to maintain present levels of behaviour or to move to the next stage of behaviour change.
- Ask the group to nominate one person to facilitate the group discussion, one to record the group’s responses, and another to present the responses.
- Inform the group that they have 30 minutes to complete the activity.
- Prepare the class for feedback to the large group. Instruct everybody to read case 1, then ask the group that worked on that case to present the case.
- Ask the class for additional comments and suggestions. Then repeat the process until all cases have been presented.
- At the end the facilitator highlights the key learning points, emphasizing the potential counsellor interventions.

M12-SP: MSM and transgender clients

Session Plan

6. Recapping the session

15 minutes

- Ask the group to summarize the key learning points from the activities.
- Ask the trainees to brainstorm what key things the counsellor must do to be responsive to the needs of MSM and transgender clients.
- Ask the group if they have any questions and remind them about the question box.

Counselling sex workers

Session objectives

At the end of the training session, the trainees will be able to do the following:

- Identify the specific HIV transmission risk behaviours of sex workers;
- Understand the psychosocial issues surrounding sex workers; and
- Appreciate the need to adapt testing and counselling services to the specific needs of sex workers.

Time to complete module



1 hour and 30 minutes

Training materials



- *HIV Counselling Handbook*, chapter 9, sections 5
- Role-Play Case Studies (AS13.1)
- Flipchart paper/Overhead transparencies
- Question box

Content



- Who are sex workers?
- Sex workers and HIV risk
- How are VCT and psychosocial care different for sex workers?
- Service delivery settings
- Prevention counselling
- HIV-infected sex workers
- Sex workers and psychological morbidity

Session instructions



1. Introducing the topic with a question-and-answer session

Time
10 minutes

- Explain that this session is going to explore the special counselling needs of sex workers. Introduce the session with a question-and-answer session with the trainees.
 - What are sex workers?
 - What makes sex workers especially vulnerable to HIV infection?

M13-SP: Counselling sex workers

Session Plan

- How should testing and counselling services and psychosocial care be different for sex workers?
- What are some examples of service delivery settings for sex workers that you know of?
- Ask if any of the trainees have any direct experiences in working directly with groups of sex workers. Ask those trainees who have experience with sex workers to briefly state what that experience is. These participants may be a useful resource during the session activities.

2. Activity: Outlining risk and vulnerability

45 minutes

Objective:

- To identify the factors of risk and vulnerability among sex workers.

Preparation:

- Photocopy the Outlining Risk and Vulnerability Case Studies (activity sheet AS7.1) and cut out the individual cases. Provide enough copies of the case studies for each member of the group to read.

3. Referring trainees to the *HIV Counselling Handbook*

20 minutes

- Ask the trainees to spend the next 20 minutes reading through the information on “Counselling Sex Workers” in chapter 9, section 5, of the *HIV Counselling Handbook*.
- Based on the chapter contents, ask the participants key questions related to the following:
 - Use of microbicides;
 - Sex work and menstruation; and
 - HIV-infected sex workers.
- Discuss what new strategies and information the participants have gained from the activities and the reading.

4. Activity: Discussing counsellor interventions to facilitate behaviour change

- Remind the trainees once again that individuals do not change behaviour easily, and briefly review the stages of behaviour change on flipchart paper or overhead transparency from chapter 3 (and module 3): “Behaviour Change Strategies in HIV Counselling”.
- Ask the trainees to form six small groups. Allocate one of the Outlining Risk and Vulnerability Case Studies to each group.
- Instruct the trainees to read the case study and determine what activities or behaviours are placing the client at risk of infection and what factors are affecting the client’s ability to practice safer behaviours. (Remind the trainees that *risk* is the level at which an individual or population engages in activities that place them at risk of HIV and *vulnerability* is a person’s ability (or lack of it) to act on the decisions he or she makes.

Answer the following questions in respect of each of the cases:

- What are the key barriers to the sex workers engaging in safer sex practices?
- What specific strategies can the counsellor suggest to manage these barriers?
- If this client has a positive HIV test result, what referrals will be required, and what specific support is required?
- Ask the group to nominate one person to facilitate the group discussion, one to record the group’s responses on flipchart paper or overhead transparency, and another to present the responses.
- Inform the group that they have 30 minutes to complete the activity.
- Prepare the class for feedback to the large group. Instruct everybody to read case 1, then ask the group that worked on that case to present the case.
- Ask the class for additional comments and suggestions. Then repeat the process until all cases have been presented.

M13-SP: Counselling sex workers

Session Plan

- Remind class to provide both clients information in the Handbook page 11 Box 1.1
- At the end, the facilitator highlights the key learning points, emphasizing the potential counsellor interventions.

5. Recapping the session

15 minutes

- Ask the group to summarize the key learning points from the activities.
- Draw training participants' attention to the appropriate sections in the handbook (chapter 9) for this session with more detailed information on targeted interventions for sex workers.
- Ask the group if they have any questions and remind them about the question box.
- Ask trainees to complete an evaluation form and place it in the evaluation form collection box.

Counselling drug and alcohol users

Session objectives

At the end of the training session, the trainees will be able to do the following:

- Offer clients basic information on the short- and long-term effects of the use of specific drugs and alcohol;
- Conduct a simple drug and alcohol use assessment interview;
- Demonstrate knowledge of the WHO ICD-10 diagnostic criteria for drug and alcohol dependence syndrome;
- Understand the specific issues, processes, and procedures to be employed in relation to ethical HIV testing and counselling of drug and alcohol users; and
- Make appropriate referrals to drug and alcohol and HIV treatment services.

Time to complete module



4 hours and 30 minutes

Training materials



- *HIV Counselling Handbook*, chapter 9, section 6
- Tools **T4.4** and **T9.2** (and make a display copy of T9.2 onto overhead transparency) or flipchart
- Activity sheet **AS14.1**
- **Annex 2** of the handbook
- Flipchart paper/Whiteboard, overhead projector (OHP) and screen, blank OHP transparencies
- Question box

Content



- Recognizing drug use: Signs and symptoms
- Drug and alcohol use assessment
- Ethical HIV testing and counselling of drug and alcohol users
- Issues, processes, and procedures related to diagnosis and support of drug and alcohol users
- Diagnosis of drug and alcohol dependency syndrome
- Post-diagnosis referral of drug and alcohol users

Session instructions

- 1. Referring trainees to the handbook, chapter 9, section 6** **Time**
30 minutes
- Indicate to the trainees that this is a long module and that the session will be interrupted by lunch and tea breaks. Indicate that these breaks will be worked into the schedule so that they do not interrupt any activity such as role-play in progress. Tell the trainees that the breaks may occur at times that are slightly different from the normal scheduled break times.
 - Ask the trainees to read chapter 9, section 6, of the handbook. Instruct them to read up to and including the section “How Do I Know If the Client is Substance-Dependent?” Remind them to also refer to the handbook annex to see the short-term and long-term effects of drug use. **(Allow 30 minutes for this)**
 - Then while the trainees are reading the white board or OHP transparency, write the following:

Alcohol	Nicotine	Cannabis	Stimulants	Opioids	Depressants	Hallucinogens	Volatile inhalants

- 2. Defining psychoactive drugs** **20 minutes**
- Ask the trainees to look at the annex “What are Psychoactive Drugs?” in the handbook and to provide some local nicknames for each of the drug and alcohol substances under each of the specific categories. Record these nicknames under the appropriate headings on the board or OHP.

- 3. Conducting a drug and alcohol use assessment** **10 minutes**
- Distribute tool **T9.2** and, by using a copy of the tool on overhead transparency, guide the trainees through the tool, explaining how to conduct a drug and alcohol use assessment.

- 4. Conducting the role-play interview, round 1** **30 minutes**
- Distribute activity sheet **AS14.1** and guide the trainees through the tool, explaining how to conduct a drug and alcohol use assessment.
 - Divide the group into pairs. Inform the trainees that we will do **two rounds** of role-plays. Ask one person in each pair to role-play the counsellor, the other the client.
 - Write down the time for the activity on flipchart paper.
 - 30 minutes for the role-play interview;
 - 30 minutes for the pair debriefing and case planning; and
 - 30 minutes for the large-group feedback on the case.
 - Ask the clients to come forward and provide them with activity sheet **AS14.1**.
 - Provide the following oral instructions to the “client”: *“In this activity you will play the role of the CLIENT. Do not share your case with the COUNSELLOR. It is his or her job to get information from you by asking appropriate questions. You may only say you are coming to the counselling session because one of your friends is HIV-positive and you are worried. You can tell the COUNSELLOR the gender and the age of the CLIENT that you are role-playing. The COUNSELLOR may ask you questions that cannot be answered from the information below. If this happens provide an answer that you think the character you are playing would be likely to give.”*

M14-SP: Drug and alcohol users

Session Plan

- Then call all of the “counsellors” together. Provide the following instructions: “In this activity you will play the role of the COUNSELLOR. You will have 20 minutes to conduct a drug dependence assessment of the CLIENT. It is important that you make sure the CLIENT is comfortable with discussing these issues and has an understanding of why you need to ask these questions. You will need to use tool 8.1 to interview the CLIENT. By the end of the consultation you should have a clear idea of:
 - the CLIENT’S history of drug use, related risk behaviours, and previous treatment;
 - the CLIENT’S dependency on any drugs;
 - how the CLIENT feels about his or her drug use and what his/her goals related to drug use might be; and
 - any other relevant information that you will need as a COUNSELLOR to formulate a support plan (including referral) to address this patient’s drug use issues.”

5. Debriefing the pairs and undertaking case planning, round 1

30 minutes

- At the end of 30 minutes ask the pairs to begin the debriefing.
- Assess their ability to conduct the assessment with the client.
 - What made the client feel comfortable?
 - How was the “counsellor” able to get the “client” to talk about his or her drug use behaviour?
 - How was the “counsellor” able to get the information needed to conduct the drug and alcohol use assessment?
 - What micro-skills were particularly important for the “counsellor” to employ to do this?
- Instruct the trainees to read the case together. They are to identify what information the counsellor failed to collect and discuss the reasons why (e.g., forgot to ask a question, or sounded judgemental and hence was not able to get the client to disclose). In addition, they should discuss what stage of change the client has reached and plan interventions that are the most appropriate for the counsellor right now. They should refer to chapter 3 of the handbook. Tell the pairs they have 30 minutes to complete this activity. Let the class know that a group discussion will be conducted after the debriefing.

6. Providing large-group feedback, round 1

30 minutes

- At the end of 30 minutes, get all of the trainees together and review the case activity (**allow 30 minutes**). Ask the trainees what drug and alcohols the client used and whether they thought the client’s use may indicate a drug and alcohol dependency syndrome, and if so why. Also ask the class what stage of change they think this client is at and ask them what evidence supports their answer.
- After a brief “wake-up activity” or schedule break, ask the pairs to re-form and the trainees to swap roles. Ask the new “clients” to come to the front and collect their copies of case study 2.

7. Conducting the role-play interview, round 2

30 minutes

- Call the “counsellors” together and provide the same briefing you gave to “counsellors” in round 1.

8. Debriefing the pairs and undertaking case planning, round 2

30 minutes

- Carry out round 2 from activity sheet **AS14.1** and repeat the role-play instructions to the “clients” and “counsellors” that were provided for round 1. At the end of 30 minutes, ask the pairs to debrief again, following the same instructions issued for round 1.

9. Providing large-group feedback, round 2

30 minutes

- At the end of 30 minutes, again ask all the trainees to come together and complete a review of the case as they did for case 1.

M14-SP: Drug and alcohol users

Session Plan

10. Brainstorming special considerations for working with drug and alcohol users

30 minutes

- After a brief “wake-up” activity, ask the trainees to close their handbooks and then brainstorm the special considerations for pre-HIV test counselling of drug and alcohol users under each of the following scenarios:
 - Negative result;
 - Indeterminate result;
 - Positive result;
 - Types of referrals they are likely to need to make; and
 - Types of ongoing counselling that may be needed.
- If trainees are unable to answer they may refresh their memory by reviewing chapter 9, section 6, of the handbook.
- Finally, refer clients back to chapter 3 of the handbook for a reminder on motivational interviewing and close the session.

11. Recapping the session

10 minutes

- Conclude the session by asking the group to identify key learning points from this session. Note down the key learning points either on the overhead transparency or flipchart paper.
- Ask the group if they have any questions and remind them about the question box.

Counselling health workers after accidental occupational exposure

Session objectives

At the end of the training session, the trainees will be able to do the following:

- Adapt the testing and counselling process to the context of management of accidental occupational exposure to HIV.

Time to complete module



2 hours and 15 minutes

Training materials



- *HIV Counselling Handbook*, chapter 9, section 7
- Activity sheet **AS14.1**
- Flipchart paper/Overhead transparencies
- Question box

Content



- Introduction of pre-HIV test and post-HIV test counselling sessions
- Flowchart showing HCT in the management of accidental occupational exposures
- Post-exposure prophylaxis (PEP) counselling
- Source testing

Session instructions



1. Introducing the session

Time
5 minutes

- Ask the trainees who is at risk of accidental occupational exposure. Ensure that police, cleaners in hospitals, garbage handlers, etc., are included, as well as health workers (laboratory technicians, phlebotomists, nurses doctors, etc).
- Brainstorm a list of occupational exposures and the first-aid actions that one would take to reduce the risk of infection.

2. Conducting a survey of accidental occupational exposures

15 minutes

- Conduct an anonymous survey of the trainees to find out whether or not they have had an occupational exposure.

Session Plan

M15-SP: Accidental exposure

- Distribute small pieces of paper to the trainees. Instruct them to write “Yes” on the piece of paper if they have previously had an occupational exposure and “No” if they have not. No names should be written on the paper.
- Collect the papers and then tally up the number of exposures and non-exposures.

3. Brainstorming types of accidental occupational exposures and first-aid actions 15 minutes

- Brainstorm a list of accidental exposures and the first-aid actions that one would take to reduce the risk of infection.

4. Counselling on the management of accidental exposures 30 minutes

- Presentation on the three types of counselling in the management of accidental exposures:
 - Post-exposure prophylaxis counselling;
 - Pre-HIV test counselling; and
 - Post-HIV test counselling.
- Lecture on the steps involved in the management of occupational exposure.

5. Activity: Conducting a demonstration role-play 45 minutes

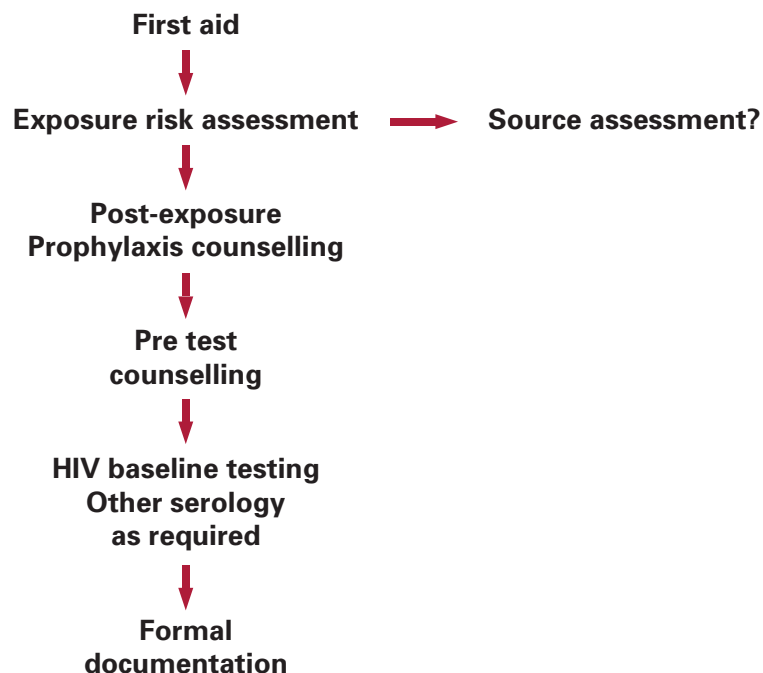
Objective:

- To identify key issues and strategies in the management of occupational exposure to HIV.

Preparation:

- Photocopy the Occupational Exposure Case Studies (AS15.1) and cut out the individual cases. Provide enough copies of the case studies for all the member of the group to read.
- Draw the following chart on flipchart paper:

Flow-Chart in the Management of Occupational Exposure



Instructions:

- Using the foregoing flow-chart, outline and explain the three types of counselling in the management of occupational exposures: post-exposure prophylaxis counselling, pre-HIV test counselling, and post-HIV test counselling.
- Explain that the first step in the management of occupational exposure is to administer first aid. Advise on first aid immediately if exposure has just occurred. If a needle-stick injury bleeds, wash the wound with mild soapy water. If blood splashes into the eyes, flush with clean water.
- The second step is exposure risk assessment by the medical staff to determine the severity of exposure, i.e., the depth of injury and duration of exposure, the type of instrument or needle involved (hollow-bore or suture needle), the serological status of the source person (symptomatic, viral load, CD4, etc.) and ARV resistance if on ARV. Add that if source testing is to occur, it should occur only where the patient has access to pre- and post-test counselling. If the source patient is being treated for a non-HIV condition it may be useful to inquire if he or she has taken or is taking medication prescribed for HIV and, if so, what the treatment is. Confidentiality and privacy should be respected.
- Post-exposure prophylaxis (PEP) counselling is the third step. This includes getting informed consent for the testing of the person with accidental exposure to HIV. PEP counselling should include discussion of research evidence on prophylaxis, potential side-effects, and window-period implications for ARVs and adherence issues.
- Explain that PEP should begin ideally within two to four hours and up to 72 hours of exposure. For severe exposure, PEP can be initiated within two weeks when delay is unavoidable. The regime is decided on the basis of drugs taken by the source patient.
- All the normal pretest counselling is at the core of step four. This step also includes, among others, education on how to reduce future occupational exposure, procedures for future testing, and formalities on insurance claims.
- Blood is drawn for the baseline test in step five. The health worker-client should be reminded of the need for follow-up testing. He/She should also consider testing for HBV, HCV, etc. If the rapid HIV test is used then post-test counselling should be given for baseline testing.
- Next, inform the trainees that they will now look at identifying the key issues and strategies in occupational exposure case management. First, however, the trainers should demonstrate a role-play of one of the case studies. (Debriefing notes are provided for the trainers below, if needed.)
- Divide the trainees into two groups. Instruct the trainees to identify the key issues and key strategies of the second case study. One trainer will facilitate each group.
- After these small groups have fully discussed the issues and strategies of the second role-play, each of the two groups will provide feedback on their findings to the large group.

6. Providing feedback

15 minutes

- The small groups provide feedback on the key issues and strategies to the large group.

7. Recapping the session

10 minutes

- Ask the group to summarize the key learning points from the activities.
- Draw the trainees' attention to the appropriate sections in the handbook (chapter 9, section 7) for this session with more detailed information counselling health workers after occupational exposure.
- Ask the group if they have any questions and remind them about the question box.
- Ask the trainees to complete an evaluation form and place it in the evaluation form collection box.

M15-SP: Accidental exposure

Session Plan

Special note for trainers

Debriefing notes for the cases used in this activity are provided below. They are for the trainers' use only and should not be provided to the trainees. The trainees should be encouraged to record their own responses to encourage active listening in the debriefing exercise.

Case study 1: Debriefing notes (for trainer's use only)

Key issues	Strategies
Blood exposure to the eyes 2 days ago	<ul style="list-style-type: none"> • Check to see what first aid was performed to mitigate risk, e.g., Were the eyes flushed with water? • Conduct exposure risk assessment and advise low-risk. PEP counselling if applicable.
Presenting for a baseline test	<ul style="list-style-type: none"> • Offer a baseline test. Indicate to the nurse that this test will only ascertain if she was HIV-positive at the time of the exposure. • Remind the nurse that this test will not tell her whether the exposure resulted in infection. • Advise the nurse that she will require follow-up testing to cover the window period. • Advise the nurse that, as this is a baseline test reflecting personal risk, she may wish to have an anonymous test elsewhere first. • Conduct normal pretest counselling and risk assessment.
HIV status of the patient unknown Believes she has a right to know the patient's status	<ul style="list-style-type: none"> • Advise the nurse not to request or pressure the source patient to reveal his or her HIV status. Another staff member can request the test. The patient has a right to decline and to refuse permission to reveal HIV status. • Remind the nurse that testing may not fully relieve her anxiety. The patient may have had exposure within the window period. Also, even if the patient is known to be HIV-positive the nurse may or may not have been infected.
Husband's status unknown but he is believed to be monogamous	<ul style="list-style-type: none"> • Gently remind her that there can be no absolute guarantees in unprotected sex with a partner of unknown status. The risk may be low. Explain that this is why you need to conduct a personal risk assessment. • Advise her to practice safer sex until her final test result related to the occupational exposure is known, but remind her that the occupational risk is low.
She is highly anxious	<ul style="list-style-type: none"> • Advise her that in the unlikely possibility her test is positive that you can assist her in deciding how to discuss the matter with her family.
Husband worries a lot	<ul style="list-style-type: none"> • Suggest that the husband come in for counselling with her. He can then be told that the exposure risk is low.

M15-SP: Accidental exposure

Session Plan

Key issues	Strategies
Family would be supportive if the nurse were to test positive	<ul style="list-style-type: none">● Advise her that, in the unlikely possibility her test is positive, you can assist her in deciding how to discuss the matter with her family.
Unclear how colleagues would respond; many know nurse has had an exposure	<ul style="list-style-type: none">● Advise the nurse on strategies for reducing concerned inquiries about how her test result went.● Coach the nurse in providing evasive and reassuring oral responses while waiting for the baseline result.● Advise nurse that if baseline test is positive you can provide assistance in developing strategies.● Reassure nurse about confidentiality.

M15-SP: Accidental exposure

Session Plan

Case study 2: Debriefing notes (for trainer's use only)

Key issues	Strategies
Exposure 1 hour earlier	<ul style="list-style-type: none"> • Check for first aid; assess and advise.
Needle-stick injury while performing venepuncture	<ul style="list-style-type: none"> • Perform exposure risk assessment.
The needle only just penetrated the skin of the nurse and the wound was not deep; she was not wearing gloves	<ul style="list-style-type: none"> • Advise of the risk and emphasize that the risk is reduced with the minimal penetration. Advise, however, that there is still a risk.
The patient is known to have HIV	<ul style="list-style-type: none"> • The nurse is not automatically entitled to know the status of the patient. However, the doctor who is treating the exposed worker may have access to the patient's status and can make appropriate clinical interventions.
The nurse is single and not pregnant	<ul style="list-style-type: none"> • Double-check whether contraception is being used if sexually active and check for pregnancy if indicated and permission is obtained.
Worried about being "banned from nursing" until her results come back	<ul style="list-style-type: none"> • Advise the nurse to avoid "exposure-prone" procedures such as episiotomy and dental work. Assist her in engaging in other duties. Most nursing duties will not be considered "exposure-prone" procedures.
She does not want anyone to know	<ul style="list-style-type: none"> • Inform the nurse who needs to know about her exposure. This should be restricted information that only very key personnel should know.
Must fill out an incident report	<ul style="list-style-type: none"> • Ideally policies should have linked anonymous codes on incident forms. Advise if this is not the case.
Fears the lab will not respect her confidentiality	<ul style="list-style-type: none"> • Code lab forms. Advise her of confidentiality measures that are in place. Ensure such procedures are in place in agency protocols. • Refer to anonymous VCT service for baseline test.
Fearful colleagues who fear HIV will reject her	<ul style="list-style-type: none"> • Discuss strategies for reducing the number of people knowing about the incident, and managing inquiries such as "How did your test result go?" Rehearse replies. Discuss strategies for making decisions about what to disclose to whom, why, where, and how.
She was not wearing gloves	<ul style="list-style-type: none"> • Provide information on how to avoid future exposure. Review the exposure to ascertain if procedures could be improved. Advise the use of gloves to reduce the risk of penetration and exposure.

Grief, bereavement, and loss

Session objectives

At the end of the training session, the trainees will be able to do the following:

- Identify what stage of the grief process the client is presenting in counselling;
- Demonstrate an understanding of, and work with, individual differences in grieving;
- Identify appropriate processes and tools that will help a client process grief; and
- Demonstrate an understanding of a child's concept of death, and use developmentally appropriate counselling interventions.

Time to complete module



2 hours and 15 minutes

Training materials



- *HIV Counselling Handbook*, chapter 10
- Tool **T10.1**
- Activity sheets **AS16.1** and **AS16.2**
- Flipchart paper/Whiteboard
- Overhead projector and blank transparency sheets (if not available, use flipcharts)
- Coloured marker pens or crayons, large flipchart sheets
- Question box

Content



- Characteristics of a normal grief reaction
- The stages of grief and loss
- Individual differences in grieving
- Processes and tools for grief counselling
- The developmental process of grief bereavement and loss counselling in children and adolescents with a focus on most-at-risk adolescents (MARA)

Session instructions



- | | Time |
|---|-------------------|
| 1. Introducing the topic | 5 minutes |
| <ul style="list-style-type: none"> ● Introduce the topic and indicate to the trainees that this module may raise personal issues for them. Acknowledge that trainees are welcome to confidentially discuss issues arising from the session after class. Acknowledge that all of us will have had or will have exposure to loss during our own lives that may colour our response to the client's grief. Consideration needs to be given to managing our own grief and loss issues when we are working with clients. | |
| 2. Activity 1: Identifying processes to facilitate adaptation to loss in an adult | 40 minutes |
| <ul style="list-style-type: none"> ● The suggested time breakdown for activity 1 is as follows: 20 minutes for reading and group work; 20 minutes for case feedback (5 minutes per group and 5 minutes feedback at the end of all presentations, with the trainer summarizing key point across all three cases). ● Form three groups and ask each group to nominate one person to record the group discussion, another to facilitate the discussion, and one to provide feedback to the large group. ● Pass around copies of activity sheet AS16.1. ● Assign case 1 to group 1, case 2 to group 2, and case 3 to group 3. Ask the groups to read the handbook section 1 ("Working with Grief, Bereavement, and Mourning in Adults") of chapter 10 of the handbook. Each group should be further instructed to read their cases and answer each of the questions, using the handbook as reference. Tell the group that they must work fast and prepare their answers on flipchart paper or overhead transparency sheets. ● Inform the groups they have 20 minutes to prepare their responses. ● At the end of the 20 minutes, ask the groups to read their cases and provide their answers. Total time for the feedback session is 20 minutes (5 minutes per group and 5 minutes feedback at the end of all presentations with the trainers). ● Allow not more than 5 minutes of feedback time for each case. Offer some feedback after the group presentations. At the end of each case you have 5 minutes to brainstorm with the class the key learning points arising from the activities. Write down all of the points on flipchart paper. | |
| 3. Activity 2: Identifying processes to facilitate adaptation to loss in a child | 60 minutes |
| <ul style="list-style-type: none"> ● Suggested breakdown of time: 30 minutes group reading and group work; 30 minutes feedback session (each group is allowed 5 minutes for feedback and 5 minutes of class discussion). ● Inform the group that they are allowed a total of 30 minutes in which to read section 2 of the handout and complete the tasks. ● Ask the class to move back into the three groups. ● Distribute a copy of activity sheet AS16.2. Ask group 1 to undertake case 1 tasks; group 2, case 2 tasks; and group 3, case 3 tasks. Instruct the groups to work fast. Tell them that they have only 30 minutes. ● At the end of the 30 minutes, call on each group to present their tasks before the large group. ● Allow the group 5 minutes each. At the end of the 5 minutes ask the class for their suggestions. | |
| 4. Activity 3: Recalling the experience of dealing with loss? | 20 minutes |
| <ul style="list-style-type: none"> ● Instruct all the trainees to think of one person they have lost in their own lives. The loss of a relationship, friendship, or pet would suffice. ● Hand each participant a few sheets of paper. Inform the class that this is a personal and private activity and that they will not be asked to provide any feedback to the class or the trainer on this activity. ● Ask the trainees to close their eyes, think of the person, and try to picture the person, the clothes he or she wore, and the way they interacted with this person. | |

M16-SP: Grief and bereavement

Session Plan

- Gently ask the trainees to recall how they responded immediately at the time of the loss and to write three feeling words and three thoughts that they may have had at the time.
- Then ask them to draw a picture that symbolizes the person-something that could be a living memory of that person. Instruct the trainees that it is acceptable to document in their picture both positive and less favourable memories. Allow the trainees to design a ceremony to honour that memory. In situations where a child was not able to participate in a funeral service of the deceased: Ask the child to draw a picture of the deceased or locate a photo of the deceased. Have a small ceremony with the child to bury the photo or drawing in the garden.
- At the end of the activity, inform the class that you are going to conduct a short tension breaker. Ask the group to form a circle and to grab hold of two other persons' hands. Then ask the class to form a circle **without letting go** of either hand. Say that the aim is for the group **to quickly get** themselves into a circle with all participants facing in the same direction, either towards the centre of the circle or outwards.
- At the end of this activity or time period allocated for this session, ask the class to clap for one another.

Post-exam and course evaluation

Session objectives

At the end of the training session, the trainees will be able to do the following:

- Assess how trainee levels of knowledge and skills or abilities in providing HIV testing and counselling have changed as a result of this workshop; and
- Obtain written feedback from trainees on the training course content and course delivery.

Time to complete



1 hour

Training materials



- HIV Counselling Pre- and Post-course Knowledge Questionnaire (**Annex 1**)
- HIV Counselling Knowledge Questionnaire Answer Key (**Annex 2**)
- HIV Counselling Pre- and Post-course Knowledge Questionnaire Results Sheet (**Annex 3**)
- HIV Counselling Training Course Evaluation (**Annex 4**)

Session instructions



1. Filling out the HTC Post-course Knowledge Questionnaire

**Time
40 minutes**

- Give each of the trainees a copy of the HTC Post-course Knowledge Questionnaire (Annex 1).
- Inform the trainees that they will have 35-40 minutes to complete the questionnaire. They may not use their HTC handbooks or refer to their notes.
- Remind the trainees that they are not to talk during the assessment unless they have a question for the trainers regarding the test.
- Let the trainees begin the assessments. Notify the participants when they have 5 minutes left.
- Collect the assessments at the end of the 35 minutes. (Note to trainers: If possible, allow more time if the majority of the trainees have not yet completed the questionnaire. The goal is to give the trainees every opportunity to undergo assessment.)
- The training team should quickly correct the questionnaires so that the trainees may receive their results before leaving the training site.

M17-SP: Assessment

Session Plan

2. Filling out the HTC Training Course Evaluation

20 minutes

- Give each of the trainees a copy of the HCT Training Course Evaluation (Annex 4).
- Explain to the trainees that the purpose of this evaluation is to see if any improvements are needed in the HTC training course.
- Inform the trainees that they will have 20 minutes to complete the evaluation.
- Let the trainees begin the assessments. Notify them when they have 5 minutes left.
- Collect the evaluations when the time is up.

Activity Sheets

Trainers please note before copying for training.

All files should be copied as they appear.

In order to allow for cutting and separating cases for “blinded” role-plays please ensure that these are singled sided copies.

ONLY AS1.1 and AS2.1 can be double sided.

AS 6.1 and AS 12.1 are to be single-sided copies but have two pages that must be prepared and handed out separately according to the session plan instructions.

Communicating key information to clients

Note: Both sides of this activity sheet should be copied onto two individual sheets to allow Situations to be cut out.

Situations:

Situation 1

A healthy professional woman has just received a positive HIV test result. She is wondering how many months she has left to live. How do you explain to her the difference between HIV and AIDS?

Situation 2

A young man with only some primary school education has come to the clinic for an HIV test. He mentions that he had unprotected sex only a few days ago. How do you describe the window period to him and the need to wait to be tested?

Situation 3

A secondary school student is writing a paper on HIV testing and has come to ask for some information about the types of tests available. How would you describe the types of tests to him/her?

Situation 4

A young, HIV-positive, pregnant woman is attending antenatal services and remembers some discussion on the need for her child to be tested. She comes to your clinic to find out more about HIV tests for children. What do you say to her?

Situation 5

A young man has just received an HIV-positive test result, but he doesn't believe that the test results are accurate. How do you describe the process of testing and the interpretation of the results so that he will come to accept the results?

Situation 6

A man has come to your clinic because he has an ulcer on his penis. How do you explain that he should also consider having an HIV antibody test?

M01-AS1.1: Communicating information

Activity

Situation 7

A woman in her 30s has come to your clinic for a confirmation test for HIV. She mentions that she is already making preparations for sickness and for death. How do you describe the progression from HIV to AIDS to her so that she understands that her preparations may be a bit premature and that she should have hope?

Situation 8

A man comes to the clinic for testing on the recommendation of a physician. He doesn't believe that he could possibly be at risk of HIV. How do you explain to him why he should be tested?

Situation 9

A client has just received a positive HIV test result. How would you describe the benefits of screening for tuberculosis to him/her?

Situation 10

A client is considering having an HIV antibody test. How would you describe the benefits of also screening for hepatitis B and hepatitis C to him/her?

Situation 11

A client is interested in learning about sexually transmitted infections but is embarrassed to discuss personal behaviour and whether or not he/she currently has any signs or symptoms of STI. What recommendations would you give to him/her?

Situation 12

A client asks why it may take many years for HIV to progress to AIDS. How would you describe the immune system to him/her?

Counsellor ethics¹

Note: Both sides of this activity sheet should be copied onto two individual sheets to allow Situations to be cut out.

Case study 1

You supervise a nurse/counsellor in a government health clinic. The clinic is very busy and understaffed. The nurse/counsellor has support from the head nurse to practice her counselling as long as it does not interfere with her nursing duties. She expresses her frustration that:

- She cannot practice her counselling because there is no time once she has attended to the nursing duties.
- There is no room or private space to hold counselling sessions.
- The doctor sends clients to her with no proper handover, and without explaining to the client why he/she is being referred for counselling.
- There are poor records at the clinic and she is worried about how to record her sessions since confidentiality seems to be a problem

What are the issues? How do you work with the nurse/counsellor?

Case study 2

You are supervising a counsellor who works in HTC. He tells you he is in a dilemma. He has been seeing a couple who wished to be tested. The couple were tested separately and returned separately for the results. The man tested negative and the woman, positive. The woman refused to disclose her status to the husband-to-be. The counsellor is very distressed and contacts you for assistance on the matter. He is very worried that another life (the husband's) that could be saved may now be lost.

What are the issues? How do you respond?

Case study 3

You are supervising a counsellor who refuses to distribute condoms to young people who request them. He argues that since they are not married, giving them condoms would be promoting promiscuity.

What are the issues? What is your response?

Case study 4

A counsellor comes to you and tells you that another one of your fellow counsellors is making sexual advances to his clients.

What are your thoughts about what the counsellor has told you? What are the issues? How do you respond to her?

¹ These case studies were provided by Population Services International (2000), New State VCT Training Package, Zimbabwe.

M02-AS2.1: Ethics case studies

Activity

Case study 5

You are the manager of an HTC site. You notice that one of your staff members has not been performing well, has been sleeping on duty, is reporting for work smelling of beer, and is looking untidy.

What are the issues? How do you respond?

Case study 6

You are supervising a counsellor in training under an HIV counselling and testing training programme. He has completed the first part of the course. On observing his sessions you are very concerned about his abilities. He is advising his clients on what to do and is very judgemental in his comments.

What are the issues? In your response what steps would you take to address this situation?

Counsellor-client roles

Counsellor's role

- 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".
- Locate the person who has been selected as your "client".
- Ask your client to tell you about an achievement in his/her life, a time he/she did something he/she was 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, make inappropriate facial expressions, sit with a closed posture, look disinterested, do not encourage the conversation, do not ask questions.
- Remember that you need to be as bad as possible.

Client's role

- Your job in this activity is to be a "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 are comfortable discussing and able to discuss for five minutes.
- The "counsellors" will be practising their basic skills during this activity.
- Find the other person who has been selected as your "counsellor" and participate in the counselling session as the "client".

Questioning quiz

Questioning quiz: Circle the type of question on the right that fits each question listed below.

- | | |
|--|---------------------|
| 1. You always practice safer sex, don't you? | Closed/Open/Leading |
| 2. What are some of the difficulties that you would have 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. On which occasions did you share 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. Whom could you talk to for support if you were to test HIV-positive? | Closed/Open/Leading |

**Case studies on strategies for counselling
and motivational interviewing****Case study 1**

The client is a male who is 35 years old. He has been married for the past six years. Since the wedding, he hasn't had sex with any other women. However, after some discussion, he reluctantly reports that he often has anal sex with other men, the most recent occasion being three 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 but thinks he should start.

Case study 2

The client is a 21-year-old woman, a university student who is beginning a new relationship. She has had two sexual relationships in the past, but has never been tested. She had unprotected sex in each of those relationships. She has already had unprotected sex with her new partner as well but has recently found out that he sleeps with other women and wants to discuss using condoms with him.

Case study 3

This is a case of a male who is 21 years old. He states 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. Discussion also reveals that he occasionally uses injecting drugs with his closest friend. He reports that the needles he uses are shared and not cleaned between uses. He feels that it is not possible to give up this activity with his friend but he would like to discuss safe injecting with him.

Group pretest information

Activity Instructions

The training class will be divided into two groups.

Your group should nominate two people who will facilitate the pre-HIV test information session. The rest of the group will assist in preparing the information session and will then act as clients for the group information session presented by the other group.

The pre-HIV test group information session should include the following:

- The confidentiality and privacy that you can offer clients
- Basic information about HIV and treatment
- Basic information about HIV transmission
- The three main methods of HIV transmission: unprotected sex, sharing of injecting equipment, and mother-to-child transmission (during pregnancy, during birth, or during breast-feeding)
- How STIs can make it easier to catch or pass on HIV-then say you will discuss this in more detail
- Discussion of each risk one by one, as is done in risk assessment-how each risk can result in infection and how the risk can be reduced
 - Blood products
 - Sharing of injecting equipment
 - Vaginal intercourse (with/without ejaculation)
 - Oral sex (with/without ejaculation)
 - Anal sex(with/without ejaculation)
 - Accidental occupational exposure
 - Tattooing, body piercing

Finish the discussion of these risks by telling the group that when they see the counsellor individually the counsellor will ask them whether or not they have had these specific risks. Explain the reasons why these questions need to be asked.

- Demonstration and discussion of condom use (male and female)
- HIV prevention information for injecting drug users
- The benefits and potential issues related to testing
- The window period and the procedures for testing and for result provision-reassure the group that all results will be provided in private and individually
- Questions from the group-ask the group if they have any questions; offer a question box

At the end of the activity all the facilitators should do a self-evaluation.

They should then ask for feedback from the group. The group should offer constructive criticism and then provide any positive feedback.

Case studies on risk assessment**Case study 1**

A 22-year-old woman has recently lost her husband who had been an intravenous drug user from the age of 14. Her husband died of AIDS. Her next-door neighbours found out about this and they have been yelling abuse at her when she leaves the house and refusing to let their children play with her three-year-old daughter. Since her husband died she has taken up sex work at a hotel to support herself, as her family has rejected her. Her last sex was with a sex-work client four weeks ago. On that occasion she reports (only when asked by the counsellor) that she had unprotected vaginal sex with ejaculation and oral sex.

She has been refusing to have an HIV test and does not think her daughter is at risk of HIV infection because she looks so pretty and well. The woman was sent to the clinic today after she complained of a rash.

Case study 2

A female hotel employee presents with a skin rash and a bad cough. Last week a doctor confirmed she was six weeks pregnant. When she told her husband about the pregnancy, he told her that he was HIV-positive. For this reason she has decided to have 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, as many believe that HIV-positive pregnant women should have an abortion. Her husband has told her that he has visited commercial sex workers. She reports she most recently had unprotected vaginal sex with her husband two weeks ago but has not had anal sex. Neither she nor her husband injects drugs.

Case study 3

A 16-year-old girl has started working in a beauty parlour after school till the early morning to pay for her high-school education. She has become very tired, is finding it hard to study, and is not eating well. Some of the extra money she earns supports her family, as she is the only one able to get work.

She didn't realize at the start that her work would entail providing sex for her clients though it does earn her more money. She knows about condoms but not how to use them properly. She is worried about her vaginal discharge and has missed her last menstrual period. She reports she has not received any blood products, and has never injected drugs. She has no tattoos. She last had oral sex with a client three weeks ago; she most recently had vaginal sex two nights ago and, after being asked by the counsellor, discloses that a client forced her to have unprotected anal sex eight weeks ago.

Case study 4

A male 26 years old presents for an HIV test. He states that he has tested previously for HIV. His most recent test was two years ago and was HIV-negative.

He is very shy and states that all his sexual partners since he was about 20 years old have been male and asks you not to tell anyone what he has told you. He expects that his result will be HIV-negative and states that he is testing "just to be sure". He reports that he usually practices safer sex and makes sure that he or his regular partner, who is married, always withdraws when ejaculating if condoms are not used. He most recently used withdrawal without condoms three weeks ago. During discussion he recalls two occasions more than 12 weeks ago when condoms were broken during sex. He has two tattoos, which he had done by friends three years ago. He has had no blood transfusions and has not injected drugs.

Case studies on pre-HIV test counselling**Case study 1**

A 35-year-old male hotel worker, married, with two young children aged four and two, has decided to have an HIV test at the suggestion of his doctor after being recently diagnosed with gonorrhoea, a sexually transmitted disease, during his last visit. He reluctantly reports that he often has sex with other men, most recently three weeks ago, usually when he has been drinking alcohol. He has also had sex with foreign businessmen for money at hotels. He does not use condoms and last had unprotected anal penetrative (insertive) intercourse and oral sex two months ago. His wife is unaware of his sexual practices. He most recently had sex with her two weeks ago. He is not sure 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 female sex worker states she has heard her friends talking about HIV and has started to worry about whether she may be infected. She reports having had unprotected sex with several different male partners, most recently a week ago. Discussion also reveals that she has experimented with injecting drugs. She reports that the needles she used were shared and not cleaned between uses; the last time she shared needles was three weeks ago. She most recently experimented with drugs four months ago. She reports that since she has been worried about HIV, she has not been eating well and has had difficulty sleeping. She feels that she has brought shame to her family and is worried about how her friends would react should she test HIV-positive. She mentions that she has thought about suicide if she receives a positive result.

Case study 3

A 23-year-old woman presents for an HIV test, worried that she may have contracted HIV from her former husband, who used to work as a truck driver. She suspects that he had other sexual partners when he delivered goods to country areas. She has heard that he is unwell and is rumoured to have AIDS. She last had unprotected vaginal sex with him two 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 started working at a hair salon and reports her boss is pressuring her to have sex with clients. She tells you she does not want to do this, but she says she is desperate for money. Her family is poor and lives in a slum area. Family members are annoyed that she did not stay with her husband; they feel she should have stayed with him. She is convinced that she has HIV but is not comfortable raising her fears about HIV with her family. She is very upset and worried.

Case studies on HIV test results**Case study 1**

A 35-year-old male, married, with two young children aged four and two has decided to have an HIV test at the suggestion of his doctor after being recently diagnosed with gonorrhoea, a sexually transmitted disease, during his last visit to the doctor. He reluctantly reports that he often has sex with other men, most recently three weeks ago, usually when he has been drinking alcohol. He has also had sex with foreign businessmen for money at hotels. He does not use condoms and last had unprotected anal penetrative (insertive) intercourse and oral sex two months ago. His wife is unaware of his sexual practices. He most recently had sex with her two weeks ago. He is not sure 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 female sex worker states she has heard her friends talking about HIV and has started to worry about whether she may be infected. She reports having had unprotected sex with several different male partners most recently a week ago. Discussion also reveals that she has experimented with injecting drugs. She reports that the needles she used were shared and not cleaned between uses; the last time she shared needles was three weeks ago. She most recently experimented with drugs four months ago. She reports that since she has been worried about HIV, she has not been eating well and has had difficulty sleeping. She feels that she has brought shame to her family and is worried about how her friends would react should she test HIV positive. She mentions that she has thought about suicide if she receives a positive result.

Case study 3

A 23-year-old woman presents for an HIV test as she has become worried that she may have contracted HIV from her former husband who used to work as a truck driver. She now suspects that he had other sexual partners when he delivered goods to country areas. She has heard that he is unwell and is rumoured to have AIDS. She last had unprotected vaginal sex with him two 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 started working at a hair salon and reports her boss is pressuring her to have sex with clients. She tells you she does not want to do this but she says she is desperate for money. Her family is poor and lives in a slum area. Family members are annoyed that she did not stay with her husband; they feel she should have stayed with him. She is convinced that she has HIV but is not comfortable raising her fears about HIV with her family. She is very upset and worried.

Case studies on suicide risk assessment and management

Distribute to CLIENTS at the start of round 1.

Activity Instructions

1. Pairs are formed. One person role-plays the counsellor, and the other the client.
2. Case 1 is handed to the CLIENT. He/She must not share it with the counsellor, who must get the information given in the case study from the client. The client may, however, share with the counsellor his/her age and gender and whether he/she has had a positive result or some other reason for seeing the counsellor.
3. The COUNSELLOR follows the Suicide Risk Assessment Interview Guide (tool 5.1).
4. At the end of the role-play, COUNSELLOR AND CLIENT read the case study together and complete the Suicide Risk Assessment Matrix (tool 5.2). Normally a counsellor would not do this with a client; however, in this instance it is a learning exercise for both.
5. The larger group will now be debriefed and the instructor will review the answers to the questions in the Suicide Risk Assessment Matrix.
6. After the large-group discussion the participants return to their pairs and swap roles.

Approximate time for each round

- 20 minutes Role-play
5 minutes Pair debriefing
10 minutes Pair completion of the Suicide Risk Assessment Matrix
15 minutes Large-group discussion and debriefing

Case study 1

A female, 30 years old, is attending a pretest counselling session. A nurse at the local health centre, she has two young children and is impulsive by nature. She is attending the session because her husband has told her that he is HIV-positive. She is very worried about the result and says that she will kill herself if she turns out to be HIV-positive. Since learning about her husband's HIV status she has already tried once to kill herself by taking a non-lethal dose of pills. After taking the pills she called her mother for help.

She says that she worries about who will look after the children but, particularly since her suicide attempt, her family has been very supportive. She still works every day. She says this helps to take her mind off her worries. From working at the health centre she is aware, she says, that there are services in the community helping people and families that are affected by HIV.

Case 2 is on a separate page.

M06-AS6.1: Suicide risk case studies

Activity

Distribute to CLIENTS at the start of round 2.

Activity Instructions

1. Pairs are formed. One person role-plays the counsellor, and the other the client.
2. Case 2 is handed to the CLIENT. He/She must not share it with the counsellor, who must get the information given in the case study from the client. The client may, however, share with the counsellor his/her age and gender and whether he/she has had a positive result or some other reason for seeing the counsellor.
3. The COUNSELLOR follows the Suicide Risk Assessment Interview Guide (tool 5.1).
4. At the end of the role-play, COUNSELLOR AND CLIENT read the case study together and complete the Suicide Risk Assessment Matrix (tool 5.2). Normally a counsellor would not do this with a client; however, in this instance it is a learning exercise for both.
5. The larger group will now be debriefed and the instructor will review the answers to the questions in the Suicide Risk Assessment Matrix.
6. After the large-group discussion the participants return to their pairs and swap roles.

Approximate time for each round

- | | |
|------------|---|
| 20 minutes | Role-play |
| 5 minutes | Pair debriefing |
| 10 minutes | Pair completion of the Suicide Risk Assessment Matrix |
| 15 minutes | Large-group discussion and debriefing |

Case study 2

The client, a 20-year-old male, found out that he was HIV-positive after attending the VCT service a month ago. A person he met through a peer support group has brought him to the counselling session because he talked in detail to the group about planning to kill himself; he said he would kill himself this very afternoon. The person who brought him had a hard time convincing him to come and following what he was saying. The client has not seen his family or friends since they learned about his HIV status. His relations with his family had already been strained the past year after family members found out he was injecting drugs.

He tells the counsellor that he is disappointed that his previous suicide attempt the week before did not work. He feels he is a burden to everyone, even his peer support group. Suicide is all he can think about. He feels there is nothing else he can do.

Case studies on post-diagnosis support plans**Case study 1: Asymptomatic**

A 31-year-old male found out he was HIV-positive two months ago. While on holiday abroad with his girlfriend, he had gone with her for a test at a local clinic because they had decided to get married. He tested positive and his girlfriend tested negative. His girlfriend left him after that. He has had sex with many girls before and thinks he could have infected some of them. He worries about whether he will still be able to find a wife and have children. His family is asking him why he is not getting married and he is not sure how he should explain the situation to them. He does not know anyone else who is HIV-positive and is scared about what may happen to him.

Case study 2: Symptomatic

Eight months ago a 22-year-old male developed a rash on his body that would not go away. He was tested for HIV by a doctor and diagnosed HIV-positive. He lives at home with his mother, father, and two sisters. They are aware of his HIV status but have kept it a secret from other family members and friends. Recently, he has been losing weight and feeling very tired. Some traditional medicine recommended by the village healer made him feel a bit better after two weeks, but then he started to have diarrhoea every day. He went to the pharmacy and was given tablets that help the diarrhoea sometimes. When he last weighed himself at the pharmacy he had lost another five kilos. These physical symptoms have led him to stay home more than he used to.

Case study 3: AIDS

A 37-year-old male found out that he had HIV three years ago and has had many opportunistic infections since then. He has been very distressed by his recurrent periods of illness and feels that he is a burden to his family. He is now in hospital with TB and a second episode of pneumonia (PCP). Doctors have recommended ARV treatment, but he is poor and has no money to buy expensive medicines. The doctors are not sure he will recover from this infection and believe he may be too ill to return home again. His family is at his bedside when the doctors tell him the bad news.

Counsellor challenge response

The following is a list of concerns expressed by different clients about partner disclosure. Respond to each one of them by asking a counselor challenge question.

1. My parents would disown me and kick me out of our family home.
2. My husband will beat me. He always gets very angry.
3. My girlfriend will not marry me if she finds out, so I cannot tell her.
4. My boss (the brothel owner) will not let me leave work and I cannot tell him why I must.
5. I cannot tell my doctor. If I do, he will not operate on my leg.
6. My family will want to know how I get infected. They will press me to tell everything. I cannot tell them I am gay.
7. I cannot tell my wife. She will be angry and tell everybody. I am a respected member of the community.
8. I cannot tell my family. They will all reject me and blame me. Nobody will be sympathetic.
9. My father gets very angry. He will probably beat me up and make me leave home.

Case studies on supporting HIV disclosure**Case study 1**

You are a 24-year-old male. You have been diagnosed HIV-positive and you have recurrent genital herpes. You have sex with men but nobody else knows about this. Your wife is eight weeks pregnant and looking forward to your first child. Your family members are all anxiously awaiting the child's birth. You felt pressured to marry. You cannot tell your wife that she is at risk as you do not want her or anyone else to know you are an MSM. You say you are worried your wife will leave you and that both she and your family will reject you. You are worried because you work in the family business. If your family finds out, you will have no job. You feel your life will then be over.

Case study 2

You are a 19-year-old male IDU who also does some sex work. You have been diagnosed HIV-positive. You have also been told you have syphilis, and you have frequent bouts of genital herpes. You have a female regular partner. She works as a brothel-based SW. You love her very much and are afraid she will leave you if she knows you are infected with HIV. You are also afraid she will tell everybody and you will no longer be able to find work. You need to work as you have a very serious addiction. You have no other job skills and only limited education. Your family members have already rejected you because of your drug use.

Case study 3

You are a 22-year-old married woman. You have been diagnosed HIV-positive and also have trichomonas and recurrent genital herpes. Five years ago you worked in a hotel and had sex with some men for money. You do not know how you got infected. Your husband may have HIV but has never said so. He does not know about this previous life of yours. Your husband and family would be very angry if they knew. Your husband sometimes gets very angry after he has been drinking. He often threatens you, but so far has never hit you. You are worried he will hit you if he finds out and that the family will reject you. You are not using contraception at present as your husband wants you to have a baby. You are not yet pregnant.

Explaining resistance

Total time for this activity: **40 minutes**

Approximate time for each round

15 minutes Role-play

5 minutes Pair debriefing

Instructions:

Form pairs. One person will role-play a counsellor, and the other the client.

Counsellor: Start the discussion with the client by saying that you want to explain something about the medication that he/she will be taking. Use the HIV Replication tool (T1.2) to explain to the client how HIV replicates in the body; the ART Works tool (T8.2) to explain to the client how ARV drugs work; and the Resistance tool (T8.5) to let the client know how the drugs can lose their effectiveness against HIV (resistance) and how resistance can be transmitted to others (15 minutes for role-play, 5 minutes for debriefing).

Client: Try to realistically role-play the client and ask questions.

Counsellor and client will then debrief each other for five minutes. The counsellor acknowledges what he/she could have done better, and the client provides feedback on the counsellor's strengths and weaknesses.

Now switch roles and repeat the activity, following the same procedure.

At the end the trainer will summarize key points and answer questions.

Case studies on pre-adherence screening**Round 1**

Client: Do not read the case study with your counsellor until after the role-play. Just tell the counsellor that you are a 42-year-old farmer with primary-school education and that your doctor has decided that you should take ARVs.

Case study 1

You are a 42-year-old farmer with primary school education. You were diagnosed with HIV and AIDS two years ago, and your most recent CD4 count was 98. Your doctor has told you that you need to start medications for HIV to stay alive. You want to take the medications because you do not want to die. But you do not know which medications you need to take for HIV. You do not know the names of the Western medicines and are worried they might be harmful to your body. An acupuncturist from your village has also told you that he can cure you of HIV with acupuncture and traditional Chinese herbal medications.

You live in a rural area about two hours away by bus from the doctor's clinic. During the rainy season in the summer, mud and floods make the dirt roads in your area impossible to drive through. You do not know anyone else with HIV and AIDS in your village.

Your wife is also HIV-positive. But the doctor has not talked about medications for her yet. Your only son, a 14-year-old, has never been tested for HIV. You do not want your wife or your son to die

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Round 2

Client: Do not read the case study with your counsellor until after the role-play. Just inform the counsellor that you are a 36-year-old male bar owner and that your doctor has decided that you should take ARVs.

Case study 2

You are a 36-year-old male restaurant owner. Nobody at your restaurant knows you have HIV. Only your wife knows you have HIV. You work long hours and are at the restaurant around 12 hours a day. When you are home, you eat meals with your family. Your widowed mother lives with you and your two children. Your wife and one of your children have also been diagnosed HIV-positive. Your wife is well and the child has no symptoms.

When you were on medication in the past you would often forget to take the medicine because of your many responsibilities at work. You often failed to complete the prescribed medication. Often you reduced the dose when you had side-effects such as nausea.

You have been sleeping badly and you are becoming a bit forgetful. You feel quite depressed (waking up early in the morning, lacking motivation) and have to force yourself to get out of bed. You have no appetite.

You believe HIV will kill you. You are not so sure that you can afford to take your medication. The doctor has told you ART is free but you need to take other drugs to prevent something called "OIs".

Case study on supporting client adherence**Group instructions:**

- Discuss this case study in your group.
- Identify the key problems that interfere with treatment adherence and discuss a strategy that would help overcome the problems.
- Be ready to answer questions for your group in the large-group discussion.

Case study for large-group discussion

A 28 year-old female bar worker has begun ART. You have completed a pill count and calculated that her adherence rate is only around 70%.

You interview her to find out her problems.

She reveals the following:

- Nobody at home or at work knows that she has HIV. She does not take her morning dose as she eats with the whole family and has no privacy.
- She leads a busy life. She looks after her widowed mother and younger sister during the day and works at a karaoke (KTV) bar in the evenings.
- At the KTV bar, she sometimes has to drink with clients. She usually eats with the other girls in the bar at night.
- She has also been prescribed medication for an STI. She stopped taking it when she felt better.
- She has started taking some traditional herbal medicine. She has been told that traditional medicines can extend life and are better than the chemicals that doctors prescribe. She has decided to take both.
- She also reports that the ART medication is making her sick and she vomits it up sometimes.
- She has been having problems remembering things lately and has also had hallucinations at times (hearing things others say they cannot hear). Sometimes she has boundless energy. Her friends find this unusual.
- She does not know if she is pregnant. She has missed one menstrual period.

Fast-facts quiz about pregnant women, new mothers, and their partners

Time allocation: 20 minutes group work; 20 minutes feedback

Instructions:

Work within your group. Write your detailed answers on a piece of paper.

You have ONLY 20 minutes to complete the quiz.

Refer to chapters 1 and 9 of the Handbook and any of the tools provided during the training including those provided to you in previous sessions.

The group that answers all of the questions first is asked to come to the front of the room and to present the group's answers to the questions. The other groups may question the presenting group and decide whether the answers presented were accurate and sufficient (i.e., no important issues or facts were left out) (20 minutes).

Questions

1. What are the main ways HIV is transmitted from mother to child?
2. At what stage(s) of HIV infection is a woman most likely to pass HIV to her unborn child? State your reasons for your answer.
3. What strategies can be employed with an HIV-positive pregnant woman to reduce the risk of HIV transmission to her baby? List the specific things that are done to reduce the risk **during pregnancy and birth**.
4. What is the WHO advice to new mothers about infant feeding in situations where the mother has tested HIV-negative?
5. What is the WHO advice to HIV positive women regarding infant feeding? Be specific in your answer.
6. What alternatives are there for a woman who does not want to breast-feed and who cannot use commercial infant formula? Should any special precautions be taken if she uses these different methods? Be specific.
7. What is postpartum depression and what are some common symptoms?
8. What is ARV prophylaxis for PMTCT? How effective is it?
9. What specific advice should be given to HIV-positive women who inject drugs?
10. During pre- and post-test counselling with men who have sex with women and follow-up counselling with HIV-positive men what specific things should we tell them about preventing mother-to-child transmission?

Role-play on counselling for PMTCT

Time allocation: 20 minutes role-play; 15 minutes debriefing

Form triads. One person in each triad will role-play a counsellor and another a client, and the third person will be an observer.

The case details (see under “Client” below) may be read by all members of the triad before the role-play as the counsellor is assumed to have collected this information and is about to counsel the woman-client in response.

Counsellor: Use your knowledge of PMTCT interventions and any of the tools provided to you in this session or any other session to advise an HIV-positive pregnant woman how she can reduce the chance of infecting her child with HIV.

Client: Play the role of a woman from the countryside who is poor and lives with both her HIV-positive husband and his extended family. The family is not aware that the couple have HIV. In the woman’s hometown babies are delivered at home with the help of a village birth-assistant. Newborn babies are also traditionally breast-fed.

Observer: During the counselling take notes on the accuracy of the information provided by the counsellor on the following and the way in which the information is provided:

- general advice about health precautions during pregnancy;
- interventions available during pregnancy to reduce HIV transmission;
- interventions available at birth; and
- infant-feeding options that will need to be considered after the baby is born.

Observers are requested **not to** interfere during the role-play. If they see or hear something they do not agree with during the role-play they should simply take note of it and discuss it at the debriefing. They should also note the things they think the counsellor did well.

Debriefing

After the role-play debrief one another in the following ways:

- The counsellor goes first and indicates what he/she could have done better or what information he/she found difficult to provide.
- The observer provides positive feedback first and then indicates what he/she feels could have been done better.
- The client tries to provide feedback from a client’s perspective, letting the counsellor know how he/she feels, what was helpful, and what could have been more helpful.

Finally correct any unclear or inaccurate factual information. To do this you may consult your handbooks or ask the trainer when the large group convenes.

Alternatively, place your question anonymously in the question box.

Counselling men to prevent mother-to-child transmission

Instructions:

Read the case study below and answer the following questions:

- What are the key HIV transmission risks to the client's wife and unborn child?
- What specific information do we need to give him?
- What counselling interventions can we offer to address the issues in this case?

Case study

The client is a 35-year-old male who is married and has two young children, aged 4 and 2. His wife is pregnant with their third child. He was recently diagnosed with gonorrhoea, a sexually transmitted infection, and has decided to have an HIV test at his doctor's suggestion.

He reluctantly reports that he often has unprotected anal sex with other men, most recently three weeks ago and usually after drinking alcohol. His wife is unaware of these sexual practices. He also does not use condoms with her. He last had vaginal sex with his wife two weeks ago.

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

Talking to children about HIV

Children need to have HIV and AIDS clearly explained in a way that is appropriate to their level of development and understanding. The following is how one doctor explained HIV and AIDS to a group of children. Take a few moments to read the doctor's explanation, then follow the instructions for your group below.

In our town there are many busy streets with lots of traffic. Our body is like a town where the blood vessels are the roads connecting one place to another. On our town's roads, there are many different kinds of cars and trucks. In our blood vessels, the traffic is of three main kinds: red blood cells (RBCs), white blood cells (WBCs), and platelets. The RBCs are the delivery trucks that take oxygen and nutrients wherever they are needed. The WBCs are the police that protect the body from infection, and platelets are the repair trucks fixing the roads (repairing the blood vessels).

When we get a cut, a few RBCs will tumble off the road as the platelets rush to stop the flow. When cold germs invade the nose, the police are called in and the WBCs come to stop the infection.

HIV is a virus, a type of germ that attacks the WBCs. When HIV attacks our roads, it weakens or destroys many WBCs. As other germs attack there are not enough policemen to defend the body. The body gets very sick and eventually dies. This is what we call AIDS. No cure for AIDS has been discovered, but there are ways that people can stay healthier longer.

Adapted from Alan Greene, MD, FAAP, 12 February 1996.

<http://www.drgreene.org/body.cfm?id=21&action=detail&ref=605>

Instructions for group 1:

1. Dr Greene's description may be useful in building understanding of HIV and AIDS among young children in towns and urban areas. Your group's task will be to develop a strategy for discussing HIV and AIDS with children aged 5-7 years in rural areas. You will have 15 minutes to do this.
2. Write your strategy on flipchart paper or on an overhead transparency sheet. Include pictures or other media that can help build understanding among the children.
3. Select one of your group members to present your group's strategy. He/She will be asked to present to the large group as if he/she were presenting to the group of children (presentation time: 5 minutes)

Instructions for group 2:

1. Dr Greene's description may be useful in building understanding of HIV and AIDS among younger children, but what about adolescents? Adolescence is a time when sexuality becomes a key issue. Your group's task will be to develop a strategy for discussing HIV and AIDS with children aged 12-15 years. You will have 15 minutes to do this.
2. Write your strategy on flipchart paper or on an overhead transparency sheet. Include pictures or other media that can help build understanding among the children.
3. Select one of your group members to present your group's strategy. He/She will be asked to present to the large group as if he/she were presenting to the group of children (presentation time: 5 minutes).

Case studies on child disclosure issues

Case study 1

An 11-year-old girl has been brought by her parents to the HIV testing and counselling clinic where you work. The parents tell you that their daughter was infected with HIV at birth but has been relatively healthy so far, thanks to ARVs. The father is HIV-negative. The parents have never told the child she is HIV-positive. Recently the girl has been asking her parents, "What is AIDS?" and "Why do I need to take medications?" She has overheard others in school and the community whisper, "That child's mother has HIV." The girl is asking more and more questions. She even wants to know whether she has AIDS. The parents have turned to you for advice and are asking you to help let the girl know her HIV status as well as her mother's.

Role of observer

Observe the counsellor and the young client. Do not interrupt while the role-play is in progress. Take notes if necessary, and provide feedback and discuss the observations at the end of each role-play. Fill out the following checklist:

Counselling task observed	How was the task addressed?	Comments and recommendations
Building rapport		
Using listening skills		
Using non-verbal skills (body language, eye contact, etc.)		
Questioning the child		
Discussing HIV and AIDS with the parents and the child		
Exploring the child's knowledge of HIV		
Disclosing to the child his/her HIV status		
Disclosing the mother's HIV status to the child		
Conducting crisis counselling with the distressed child		
Addressing the child's questions		

Case study 2

A 5-year-old boy is brought to your counselling services by his grandmother. She tells you that he was diagnosed HIV-positive as an infant. In the past six months, he has had to make periodic visits to the hospital. He doesn't understand why he needs to go to the hospital, especially as he is not feeling sick. He doesn't like having to spend long hours sitting and waiting and then having doctors do all sorts of tests that he does not understand. On a few occasions, he has had to stay in the hospital alone, without his grandmother.

Recently, he has been asking his grandmother many questions, wanting to know what is wrong with him and why he needs to go to the hospital. The grandmother does not know how to explain his situation to him and is asking you to do the explaining.

Role of observer

Observe the counsellor and the young client. Do not interrupt while the role-play is in progress. Take notes if necessary, and provide feedback and discuss the observations at the end of each role-play. Fill out the following checklist:

Counselling task observed	How was the task addressed?	Comments and recommendations
Building rapport		
Using listening skills		
Using non-verbal skills (body language, eye contact, etc.)		
Questioning the child		
Discussing HIV and AIDS with the parents and the child		
Exploring the child's knowledge of HIV		
Disclosing to the child his/her HIV status		
Disclosing the mother's HIV status to the child		
Conducting crisis counselling with the distressed child		
Addressing the child's questions		

Case studies on risk and vulnerability**Case study 1**

The client is a 35-year-old male who got married at the request of his family and now has two children. He often has sex with other men, usually after he has been drinking, and he does not use condoms. He has heard that one of his former partners tested positive for HIV. His wife is unaware of his same-sex practices. He does not use condoms with her either and does not know how he can start using them, particularly as he has recently been having difficulty maintaining an erection. He is not sure what he would do if he were found to be HIV-positive.

Case study 2

The client is a 28-year-old male. Most of his sexual partners since he was 20 years old have been male. He usually practices safer sex and makes sure he or his partner always withdraws when ejaculating without condoms. A friend convinced him recently to try having sex while high on drugs and he has been experimenting with different kinds of drugs and different uses. He has tested previously for HIV and the results were negative so he is confident that he will not get HIV.

Case study 3

The client is a 22-year-old male who is happy and confident about his sexuality and his feminine appearance. When he has sex with other men, he is always the receptive partner. He insists on condom use every time. The day before, however, a group of students from his school forced him to perform anal sex on all of them. He is not sure whether a condom was used each time.

Case study 4

The client is a 40-year-old businessman. His business is very successful but it is a lot of work. He usually has sex with transgendered sex workers; he does not have to worry that they will get pregnant and so he does not need to use a condom. He also doesn't need to worry about being in a relationship. He is still unmarried and always tells others that he is too busy to have a wife and family. But he has recently become engaged at the urging of his associates. He decided to have an HIV test because he noticed pus coming out of his penis. He did not think much of it at first, believing the symptom would clear up on its own.

Case study 5

The client is a 19-year-old male with little education and no professional skills or training. To make a living, he sells sex mainly in the parks at night. His clients are usually businessmen who come to the parks in the evening after work. Most are married men who sometimes look for sex with other men and will pay to keep it discreet. Some will also pay not to use condoms. He does not mind this because condoms make him feel sore afterwards when he is the receptive partner, and he is able to get the job done more quickly without them when he is the penetrative partner. He lives with his girlfriend, who sometimes sells sex to make extra money.

Worksheet for case studies on defining risk and vulnerability

What activities or behaviours place the client at risk of infection with HIV or STI?

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

What factors may increase the client's vulnerability to infection? (What factors may prevent the client from practicing safer behaviour?)

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

What questions should be asked to get a full assessment of the risk and vulnerability of the client? What questions would you ask?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

Case studies on sex-worker risk and vulnerability**Case study 1**

A young female sex worker has come to you for an HIV test. She has no work skills, has been abandoned by her family, and is supporting a young child.

Her clients, even the “nice ones”, generally refuse to use condoms. They complain that they are paying for a service and do not want her to spoil their enjoyment. She often feels dirty after sex and uses a vaginal wash sold at a store nearby. Colleagues have told her that it can kill AIDS and that she will not need condoms if she uses it. She knows very little about STIs or HIV.

She asks how she can tell which clients have infections. She says clients often want to try different types of sex, including anal sex, and that she agrees because at least she cannot get pregnant that way.

Case study 2

A young male assistant in a trucking company often has sex with truck drivers. He sometimes get paid for this; at other times he is given food or a place to sleep.

He says he has anal sex and that he sometimes has sores on the outside of his anus that really hurt. He does not know how he can ask his male partners to use condoms. Besides, he does not know where to get condoms for free. He also says that condoms hurt him when he uses them for receptive anal sex.

He does not know much about STIs or HIV and thinks he can simply take medicine if he gets sick. When he had a sore on his penis a friend gave him some tablets and it got better after that. He has a girlfriend his family wants him to marry. They have not had sex yet. Nobody in his family knows about the sex with men. He is having an HIV test today because an outreach worker suggested it.

Case study 3

A transgender sex worker has presented for an HIV test and indicates that she* usually avoids anal sex with clients. She has not had any gender reassignment surgery and often “tapes her penis” to perform trick sex (rubbing the partner’s penis between her legs). When she has anal sex she usually offers the client a condom she gets from outreach workers or from an NGO. Sometimes, however, the client refuses.

She is presenting for a test today after she allowed a client to tie her up during sex games and penetrate her (anal sex) without a condom. She later heard that this client had HIV. She remembers that he had a small lump on his penis.

* Transgender males are referred to as “she” or “her”.

Role-play on behaviour change and drug use assessment

Case 1 (round 1)

You are a 25-year-old single male who works as a casual labourer. You have come to the clinic for an HIV test. A friend has recently tested positive for HIV and you are concerned that you may also be infected.

You have smoked tobacco daily since the age of 16 and now smoke at least 15 cigarettes a day. You drink alcohol no more than once a month but when you do you will drink until you are drunk.

You first used heroin at age 21, when you began smoking occasionally in social situations for about a year. You then moved in with friends who were heavy heroin users and you began to smoke daily for about a year.

You began injecting heroin because many of your friends were now also injecting and smoking heroin was becoming expensive. Soon after you started injecting the amount of heroin you used each day greatly increased. You injected heroin three times a day for about 18 months. During this time you shared injecting equipment with friends on several occasions. Finding and keeping work became increasingly difficult.

You then attempted to “detox” at the insistence of your brother, who was extremely concerned about your deteriorating health and behaviour. Your brother supported you through withdrawal. During your “detox” you self-medicated with benzodiazepines to lessen your withdrawal symptoms. You managed to stop using heroin for about a month but when you moved out of your brother’s house you began using again and have been doing so for the last six months. You now inject once or twice a day. Most of your close friends use heroin.

You have used benzodiazepines occasionally over the last two years but increasingly in the last six months, especially when you do not have enough money to buy heroin. You now use between five and 15 oxazepam or diazepam tablets per day.

You have smoked cannabis sporadically in the past-no more than once every two months over the past year. You have used amphetamines only a few times in the past and have never used ecstasy.

You have thought about trying again to stop using heroin but, having failed to stay clean after your last attempt, you are unsure if there would be much point in trying again.

Case 2 (round 2)

You are a 19-year old female sex worker. You tested HIV-positive six weeks ago at a local clinic, where you were tested without your prior knowledge. The doctor tested your blood and when you went back to see him he said that you had AIDS. He also accused you of being a drug addict and said that you only came to see him because you wanted drugs. You are worried about this as you think the HIV is getting worse. You also mention that you have some sores in the genital area and say that it hurts when you have sex.

You first used sedatives at the age of 15 when you started hearing voices and feeling agitated. You have gradually increased your use of tranquilizers (from one to sometimes four oxazepam or diazepam a day. You also have periods when you are depressed-sometimes so depressed that you just want to "end everything". When you are like this the owner of a bar where you worked gives you something to "get you going again". He calls these "happy-girl pills". You have been taking these pills twice a day for a month. When on them you often do not feel like eating, and you are rapidly losing weight. When the effects wear off you feel really depressed. Sometimes, when you feel really agitated, you try to calm yourself by taking some of the "relax" pills. When you do not have these pills you feel feverish, have terrible body aches and headaches, and cannot sleep.

You have never been to a drug treatment centre but you have a friend who was sent to one after being arrested. She told you how bad the whole experience was. She could not have any drugs, got really sick, and had a lot of pain, yet the staff did nothing to help. They were terrible, she said, and they bossed her around.

Case studies on accidental occupational exposure

Case study 1

A 30-year-old female nurse presents for HIV testing after blood exposure to the eyes while assisting in the delivery of a baby two days earlier. She is presenting for a baseline test. She has two children aged seven and five, and has been married for 10 years. She believes her relationship with her husband to be monogamous.

She is highly anxious and wishes to know the status of the patient but does not show any pre-morbid psychological disturbance. She reports that her husband, who is inclined to worry a lot, is very concerned for her. Her family, she says, would be supportive if she tested positive, but she is not sure how her work colleagues would react (many of her immediate colleagues know about the exposure).

Case study 2

A female nurse had a needlestick injury while performing venepuncture an hour earlier. She is very distressed. The patient is known to have HIV. The needle only just penetrated the skin of the nurse and the wound was not deep. She was not wearing gloves during venepuncture.

The nurse is single and not pregnant. She does not want anyone to know about her injury, but the hospital regulations require her to fill out an incident report. She is worried about being “banned from nursing” until her results come back. She also fears disclosure of the results by the laboratory and rejection by colleagues who are afraid of HIV.

Loss in an adult**Case study 1**

Your client is a 23-year-old woman whose husband died two weeks ago with HIV. Several tests have confirmed that she herself does not have HIV. She was not sexually active with her husband for most of their two-year marriage. While he lay dying, she found out that he had had sexual relationships with other men. Her family now believes he married her only to please others. She says that she is sad and angry at the same time. She feels her life was a lie and that her husband did not love her. She also says she has nothing left of him. She always wanted a child and she now feels that chance has passed and no one else will marry her.

She adds that she loses her temper with her family and does not know how to spend her time. Before her husband became ill, the couple used to run a small restaurant together. The business took up most of their time.

- Identify the signs and symptoms of her grief
- Identify the specific losses she is grieving
- Discuss two activities that may help her to process her grief

Case study 2

Your client is a 42-year-old HIV-positive man whose wife died of AIDS six weeks ago. He thinks he is going mad. At home he hears his wife singing; in the market he thinks he sees her in the crowd. He sleeps in his living room because he cannot bear to go into the bedroom they once shared. He has trouble sleeping; when he does sleep, he dreams of her calling to him. She might not have died so quickly, he says, if only he had had the money to take her to a good hospital. He knows he should get back to work but he feels he should stay home to keep her spirit company. He feels guilty about having infected her. This could be his punishment, he says.

- Identify the signs and symptoms of his grief
- Identify the specific losses he is grieving
- Discuss two activities that may help him to process his grief

Case study 3

Your client is a 40-year-old mother whose HIV-positive son died of a drug overdose, which she feels was intentional. It is six months since his death but she is still angry with him. People look down on her, she says. She feels shame; she says she was a bad mother who did not do enough to stop her son from using drugs. She blames his young wife (also HIV-positive) for getting him started on drugs. She cannot forgive her and wants to have nothing more to do with her. She also cannot stand to touch her 3-year-old grandson (HIV-negative); she says he looks too much like her dead son. She is expected to take care of her grandson but has not been to the house where he lives with his mother, even though it is just a short bus trip away.

- Identify the signs and symptoms of her grief
- Identify the specific losses she is grieving
- Discuss two activities that may help her to process her grief

Loss in a child**Case study 1**

Your client is a 7-year-old girl who has lost her mother to HIV but is not infected herself. Her father died two years earlier. Worried that she might hear rumours about her parents' illness, the grandmother would like you to tell the child about HIV and to offer some counselling. She describes the child as being normally obedient but now quite rebellious and moody. "You are not my mummy," she yells when refusing to follow instructions. From reports, she is also becoming a little too aggressive in the playground at school.

- Design a developmentally appropriate activity that would explain the parents' death to the girl.
- Discuss strategies you would employ to allow this child to express her grief in an adaptive way.
- Discuss how you might advise the grandmother to respond to the girl's oppositional (disobedient) behaviour.

Case study 2

Your client is a 10-year-old boy with HIV who is in hospital. His father died three years ago and his mother is sick and in and out of hospital. The boy is dying. After another young boy in the same ward died, he asked the nurses if he was going to die too. His mother has given you permission to tell the boy that he is dying. The boy does not know he has HIV.

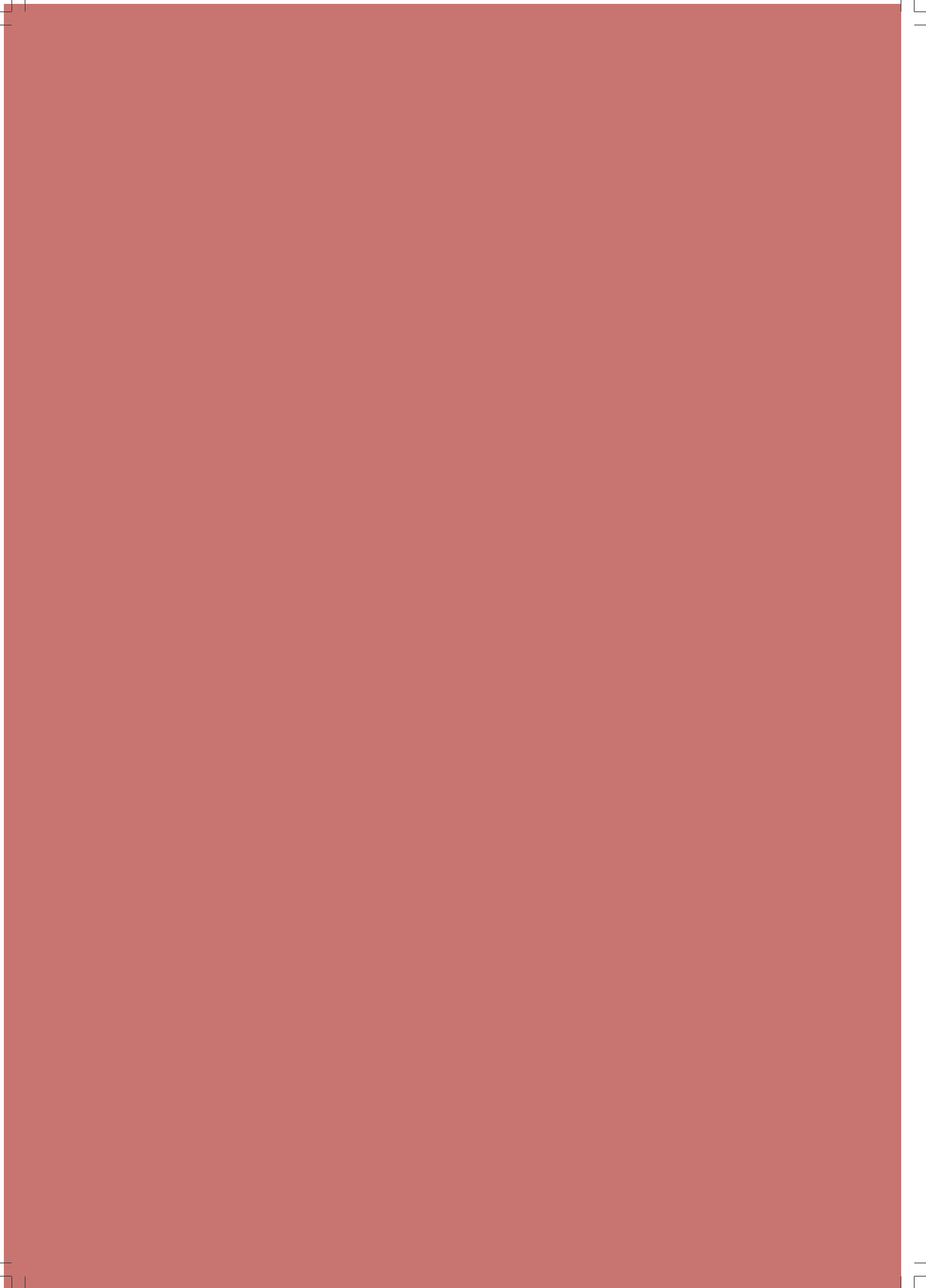
- Discuss how you would tell this child that he is dying, and describe how you would support him through this process.
- Provide clear examples of support activities that you would use.

Case study 3

Your client is a 15-year-old HIV-positive street child who has run away from home and is engaged in sex work and injecting drug use. He was in the care of two older boys until recently, when one of them died from an HIV-related illness. The client was apparently very close to that boy and relied a great deal on him for protection. He continues to live with the other boy, who seems well but also uses drugs. The client is increasingly engaging in risk-taking behaviour and was referred to your clinic after being picked up by the police for throwing tins at traffic. He is defiant and denies feeling any sense of loss.

- Discuss how you would discuss his behaviour with him and link it to his grief.
- What strategies would you employ to support this boy, while acknowledging that you may not be able to get him shelter and that he may have to go on living on the streets?

Annexes



ANNEX 1

HIV counselling pre- and post- course knowledge questionnaire

Code number: _____

Score: /60

1. List the three routes of HIV transmission. *One point for each correct answer; maximum 3 points.*
 - a.
 - b.
 - c.
2. List three ways HIV is *not* transmitted. *One point for each correct answer; maximum 3 points.*
 - a.
 - b.
 - c.
3. What are the four *principles* of transmission (in order)? *One point for each correct answer; maximum 4 points.*
 - a.
 - b.
 - c.
 - d.
4. Explain the level of risk of HIV transmission of the following behaviours, using the four principles:
 - a. Sharing contaminated syringe/needle
 - b. Anal sex, no condom
5. List four things that should be covered in a *pretest* counselling session. *One point for each correct answer; maximum 4 points.*
 - a.
 - b.
 - c.
 - d.
6. List three ways of showing you are listening to a client. *One point for each correct answer; maximum 3 points.*
 - a.
 - b.
 - c.
7. Name two types of questioning used in counselling and give an example for each. *One point for each correct answer; maximum 2 points.*
 - a. Example:
 - b. Example:
8. What should you suggest to a client who has come for testing but tells you that he or she had unprotected sex or shared injecting equipment two weeks ago? *One point for correct answer.*

9. List four things you should cover when giving someone a negative HIV test result (order *not* important). *One point for each correct answer; maximum 4 points.*
- a.
 - b.
 - c.
 - d.
 - e.
 - f.
10. Name five things you should cover when giving someone a positive HIV test result (order *not* important). *One point for each correct answer; maximum 5 points.*
- a.
 - b.
 - c.
 - d.
 - e.
11. Imagine there is a needle-stick injury in the hospital. The client is sent to you after the injury. List in *correct order* what you should do as part of HIV testing and counselling in the context of the management of accidental occupational exposure (assume that post-exposure prophylaxis is available for occupational exposures among health workers). *One point for each correct answer; maximum 5 points.*
- a.
 - b.
 - c.
 - d.
 - e.
12. What are three signs that a client is at **high** risk of suicide? *One point for each correct answer; maximum 3 points.*
- a.
 - b.
 - c.
13. Underline only the **NO** HIV transmission risk method to guarantee that HIV is not transmitted from mother to child through breast-feeding. *One point for correct answer.*
- a. Exclusively breast-feeding babies
 - b. Using only breast milk supplement
 - c. Mix-feeding a combination of breast milk and supplement to reduce risk of infection
 - d. Using a wet nurse (asking another woman to provide breast milk)
14. List three reasons why you might need to refer a client to another service or institution. *One point for each correct answer; maximum 3 points.*
- a.
 - b.
 - c.

15. Give one example of how treatment resistance can be transmitted to others. *One point for correct answer.*
16. A client has experienced side-effects of the prescribed ARV and is now sceptical of the effectiveness of ART. What are three things the counsellor can do to maintain adherence to treatment? *One point for each correct answer; maximum 3 points.*
- a.
 - b.
 - c.
17. A young couple is planning to get married and has come to the clinic for testing. The woman receives a negative test result; the man, a positive result. The counsellor is baffled by the man's result. Throughout pretest counselling the man maintained that he did not have sex with sex workers or other casual female partners, and used no drugs or other restricted substances. What question should the counsellor have asked during pretest counselling? *One point for correct answer.*
18. A young female sex worker comes to you periodically for HIV testing. She rarely used condoms in the past but has recently started to use them more often. She says that, while she would like to use condoms consistently, she still finds it difficult to use them with some clients. Mention the three steps that you would go through in a motivational interview to support the client in increasing condom use and to get her to consider using condoms with all clients. *One point for each correct answer; maximum 3 points.*
- a.
 - b.
 - c.
19. The client load at your clinic has increased dramatically. The clinic director has asked you to manage the case-load by providing pretest information sessions in groups to reduce the time needed for individual counselling. List five topics that you should include in your group information sessions. *One point for each correct answer; maximum 5 points.*
- a.
 - b.
 - c.
 - d.
 - e.
20. A young woman has just received a positive HIV test result. In the pretest counselling session you discussed the importance of disclosing a positive test result to her partner. At that time she thought that disclosure to her partner would be difficult, if not impossible. Now, you need to discuss the issue of disclosure again. Which three steps should you follow to explore the potential barriers to, and constraints on, partner disclosure for the client? Provide an example for each step. *One point for each step; maximum 3 points.*
- a.
 - b.
 - c.

ANNEX 2

HIV counselling knowledge questionnaire answer key

1. List the three routes of HIV transmission. *One point for each correct answer; maximum 3 points.*
 - a. Sexual
 - b. Exposure to infected blood, blood products, or transplanted organ tissues
 - c. 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 3 points.*
 - a. Shaking hands, hugging, touching, or kissing
 - b. Sharing eating or drinking utensils
 - c. Being bitten by an insect (such as a mosquito)
3. What are the four *principles* of transmission (in order)? *One point for each correct answer; maximum 4 points.*
 - a. Exit—HIV must exit the body of an infected person
 - b. Survive—HIV must remain alive and able to infect
 - c. Sufficient—HIV must be in sufficient quantity to cause infection
 - d. Enter—HIV must enter another's bloodstream
4. Explain the level of risk of HIV transmission of the following behaviours, using the four principles (*one point each; maximum 2 points*):
 - a. Sharing contaminated syringe/needle: *High risk, also risk of STIs, especially HCV and HBV*
Exit: HIV can exit an infected person into the needle and syringe
Sufficient: There may be enough HIV in the blood remaining in the needle or syringe
Survive: HIV can survive in the needle and syringe
Entry: Use of contaminated needles and syringes can facilitate the transmission of HIV directly into the bloodstream (for drugs commonly injected directly into the blood)
 - b. Anal sex, no condom: *High risk to receptive partner*
Exit: HIV can exit through semen of penetrating partner
Sufficient: There is enough HIV for transmission
Survive: HIV can survive in the anus
Entry: Trauma (tearing) of the mucosal tissues is common in anal intercourse, facilitating the transmission of HIV
5. List four things that should be covered in a pretest counselling session. *One point for each correct answer; maximum 4 points.*
 - a. Risk assessment
 - b. Information about safe sex and safe injecting
 - c. Personal risk reduction plan
 - d. Assessment of personal coping strategies if test comes back HIV-positive
 - e. Basic information about the HIV test, meaning of the results, and the window period
 - f. Discussion of any potential negative social and legal issues related to a possible HIV diagnosis

6. List three ways of showing you are listening to a client. *One point for each correct answer; maximum 3 points.*
- Making eye contact
 - Using encouraging noises ("Mmm", "Uh-huh", "I see", etc.)
 - Paraphrasing information given by the client and repeating it to the client to check that you have understood it correctly
7. Name two types of questioning used in counselling and give an example for each. *One point for each correct answer; maximum 2 points.*
- Open questions. Example: What difficulties do you have in practising safer sex?
The question would probably start with "who", "what", "where", or "why" and require the client to give more than a single-word response.
 - Closed questions. Example: *Do you use condoms every time you have sex?*
The question would elicit only a single-word response like "yes" or "no".
8. What should you suggest to a client who has come for testing but tells you that he or she had unprotected sex or shared injecting equipment two weeks ago? *One point for a correct answer.*
- The client should be told that he or she is in the window period and should consider having a test three months from the last risk behaviour. The counsellor could suggest that the client come back for testing in two-and-a-half months. The counsellor should also explain that the client could be highly infectious during this period and should practice safer behaviour.
9. List four things you should cover when giving someone a negative HIV test result (order *not* important). *One point for each correct answer; maximum 4 points.*
- Provide the result and explain the meaning
 - Check for any window-period exposure
 - Advise client of any need to retest and the date
 - Assist client in solving any difficulties in practicing safer sex or safer injecting
 - Suggest that partner be tested
 - Reinforce issues related to safer sex and safer injecting
10. Name five things you should cover when giving someone a positive HIV test result (order *not* important). *One point for each correct answer; maximum 5 points.*
- Provide the result and explain the meaning
 - Assess for ability to cope with result, including risk of suicide
 - Assist the client in concrete planning (e.g., whom to tell, how he or she will get home from the clinic, what he or she will do over the next couple of days)
 - Refer for follow-up medical investigations
 - Reinforce issues related to safer sex and safer injecting
 - Discuss the possibility of disclosing HIV status to sexual partners
11. Imagine there is a needle-stick injury in the hospital. The client is sent to you after the injury. List in *correct order* what you should do as part of HIV testing and counselling in the context of the management of accidental occupational exposure (assume that post-exposure prophylaxis is available for occupational exposure among health workers). *One point for each correct answer; maximum 5 points.*
- Give first aid
 - Assess exposure risk and provide feedback on risk
 - Provide prophylaxis counselling, including obtaining informed consent for ARVs
 - Provide pretest counselling
 - Draw blood sample for baseline

12. What are three signs that a client is at *high* risk of suicide? *One point for each correct answer; maximum 3 points.*

- a. History of suicide attempts or thoughts, or history of self-harm
- b. Clear plans for suicide (client can describe it would be done)
- c. History of significant (high) drug or alcohol use
- d. History of depression
- e. Use of antidepressant medication
- f. Image-consciousness

13. Underline *only* the **NO** HIV transmission risk method to guarantee that HIV is not transmitted from mother to child through breast-feeding. *One point for correct answer.*

- a. Exclusively breast-feeding babies
- b. Using only breast milk supplement
- c. Mix-feeding a combination of breast milk and supplement to reduce risk of infection
- d. Using a wet nurse (asking another woman to provide breast milk)

14. List three reasons why you might need to refer a client to another service or institution. *One point for each correct answer; maximum 3 points.*

- a. Social support
- b. Specialized medical care
- c. Home-based or community care
- d. Legal support
- e. Income-generation activities
- f. Palliative care

15. Give one example of how treatment resistance can be transmitted to others. *One point for correct answer.*

If a person on ARV becomes resistant to treatment and has unprotected sex with another person, that person can be infected with the resistant strain of HIV and thus be resistant to the drugs taken by the partner, and can spread the resistant strain to others.

16. A client has experienced side-effects of the prescribed ARV and is now sceptical of the effectiveness of ART. What are three things the counsellor can do to maintain adherence to treatment? *One point for each correct answer; maximum 3 points.*

- a. Discuss how ART works, providing the client with a scientific basis for HIV treatment
- b. Discuss ways to reduce the side-effects
- c. Present a case study or experience from other patients whom ARV has helped
- d. Discuss how the client may become resistant to treatment if adherence fails

17. A young couple is planning to get married and has come to the clinic for testing. The woman receives a negative test result; the man, a positive result. The counsellor is baffled by the man's result. Throughout pretest counselling, the man maintained that he did not have sex with sex workers or other casual female partners, and used no drugs or other restricted substances. What question should the counsellor have asked during pretest counselling? *One point for correct answer.*

Do you have sex with men, women, or both?

18. A young female sex worker comes to you periodically for HIV testing. She rarely used condoms in the past but has recently started to use them more often. She says that, while she would like to use condoms consistently, she still finds it difficult to use them with some clients. Mention the three steps that you would go through in a motivational interview to support the client in increasing condom use and to get her to consider using condoms with all clients. *One point for each correct answer; maximum 3 points.*
- Identifying what the client wants to change
 - Identifying the advantages and disadvantages of making that change
 - Setting a goal for change
19. The client load at your clinic has increased dramatically. The clinic director has asked you to manage the case-load by providing pretest information sessions in groups to reduce the time needed for individual counselling. List six topics that you should include in your group information sessions. *One point for each correct answer, maximum 6 points.*
- The confidentiality and privacy that you can offer clients
 - Basic information about HIV and treatment
 - Basic information about HIV transmission
 - Explanation of the three main methods—unprotected sex, sharing of injecting equipment, and mother-to-child transmission (during pregnancy, birth, or breast-feeding)
 - Explanation of how STIs can make it easier to catch or pass on HIV
 - Discussion of behaviours that can place one at risk of infection and how to reduce the risk
 - Demonstration and discussion of condom use
 - HIV prevention information for injecting drug users
 - The benefits and potential issues related to testing
 - Explanation of the window period, the testing procedures, and procedures for result provision (reassure the group that all results will be provided individually and in private)
 - Time for questions and answers (or offer to answer questions anonymously)
20. A young woman has just received a positive HIV test result. In the pretest counselling session you discussed the importance of disclosing a positive test result to her partner. At that time she thought that disclosure to her partner would be difficult, if not impossible. Now, you need to discuss the issue of disclosure again. Which three steps should you follow to explore the potential barriers to, and constraints on, partner disclosure for the client? Provide an example for each. *One point for each step; maximum 3 points.*
- Step 1: Use open-ended questions, e.g., *What difficulties do you think you will have in disclosing to your partner?*
 - Step 2: Listen and list. List the client's concerns. Use reflection of feeling and paraphrase to demonstrate to the client that you have understood her feelings and concerns.
 - Step 3: Challenge the client's thinking. Review the reasons gently one by one and ask a counsellor challenge question. Challenge questions are designed to assess the validity of the client's fears, gain more information, and challenge the client to think realistically and evaluate perceived threats and negative consequences. For example, if the woman fears violence from her partner, you could ask: *What has happened in the past to make you believe your partner will be violent?*

ANNEX 3

Results sheet for HIV counselling knowledge questionnaire

Code number:	Pre-course total score	Post-course 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.		

ANNEX 4

Evaluation of HIV testing and counselling training course

Please circle the most appropriate response.

1. The training gave me *knowledge* to provide counselling in HIV testing and counselling (HTC) settings.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: _____

2. The training gave me *skills* to provide counselling in HTC settings.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: _____

3. The training methods used were helpful in developing practical skills.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: _____

4. The trainers demonstrated knowledge of the material.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: _____

5. The trainers had good presentation and facilitation skills.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: _____

6. The trainers demonstrated that they had practical experience in HIV testing and counselling.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: _____

7. On a scale of 0-10, to what extent has your knowledge of the following areas changed as a result of the training? Indicate your response by placing a cross on one of the numbers.

● **Module 1: What counsellors need to know about HIV, STI, and TB**

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

● **Module 2: Key elements of HIV/STI counselling practice**

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

● **Module 3: Behaviour change strategies in HIV counselling**

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

● **Module 4: How to provide pretest counselling and group pretest information**

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

● **Module 5: How to provide HIV test results**

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

● **Module 6: Working with suicidal clients**

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

● **Module 7: Developing a post-diagnosis support plan**

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

8. What did you find were the three most useful parts of the training?

9. What did you find were the three least useful parts of the training?

10. List three changes you could make in your work after this training.

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

12. Would you recommend any other changes in the training?

Additional online resources

Further readings and resources on HIV testing and counselling may be found at a number of sources. A broad selection of tools and guidance for training for and implementing HIV testing and counselling is available on the Internet. For more information, you may also refer to the articles and documents listed in the reference section of the *HIV Counselling Handbook*.

Disclaimer: The websites are listed here for information purposes only; their inclusion does not constitute an endorsement by the World Health Organization (WHO), UNICEF, or Family Health International (FHI).

Antiretroviral therapy and clinical care

WHO. Antiretroviral therapy for HIV infection in adults and adolescents: Towards universal access. Recommendations for a public health approach, 2006 version.

<http://www.who.int/entity/hiv/pub/guidelines/artadultguidelines.pdf>

WHO. Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: Towards universal access. Recommendations for a public health approach, 2006 version.

<http://www.who.int/hiv/pub/guidelines/pmtctguidelines2.pdf>

WHO. Antiretroviral therapy of HIV infection in infants and children. Towards universal access. Recommendations for a public health approach, 2006.

<http://www.who.int/hiv/pub/guidelines/paediatric020907.pdf>

WHO ARV Toolkit. <http://who.arvkit.net/arv/en/index.jsp>

PDF version: <http://whqlibdoc.who.int/hq/2003/9241591161.pdf>

WHO. Integrated management of adolescent and adult illness (IMAI) and integrated management of childhood illness (IMCI). Various documents. <http://www.who.int/hiv/pub/imai/en/>

WHO Regional Office for South-East Asia. Management of HIV infection and antiretroviral therapy in infants and children: A clinical manual, 2006.

http://www.searo.who.int/LinkFiles/AIDS_Management_of_HIV_infection.pdf

WHO Regional Office for South-East Asia. Management of HIV infection and antiretroviral therapy in adults and adolescents: A clinical manual, 2007. http://www.searo.who.int/LinkFiles/Publications_Management_HIV_infection_antiretroviral_therapy_adults_adolescents.pdf

HIV and STIs

WHO. Guidelines for the management of sexually transmitted infections, 2004.

<http://www.who.int/entity/hiv/pub/sti/en/STIGuidelines2003.pdf>

WHO HIV and STI site. <http://www.who.int/hiv/pub/sti/en/>

University of California, San Francisco, HIV InSite. What are STDs and how do they relate to HIV infection? <http://hivinsite.ucsf.edu/hiv?page=basics-00-15>

US Centers for Disease Control and Prevention (CDC) STD site. <http://cdc.gov/std/>

Sydney, Australia, Health Services STI information website. <http://www.whytest.org>

HIV and TB

WHO TB and HIV site. <http://www.who.int/hiv/pub/tb/en/>

US Centers for Disease Control and Prevention HIV-TB webpage.

<http://www.cdc.gov/hiv/resources/factsheets/hivtb.htm>

CDC and WHO. Testing and Counselling in TB Clinical Settings Tools, 2007.

http://www.cdc.gov/nchstp/od/gap/pa_hiv_tools.htm

Module one: Introduction, background, and rationale.

http://www.cdc.gov/nchstp/od/gap/docs/tb_tools/TB%20Module%201_12.6.06.pdf

Module two: Understanding the provider-initiated and -delivered HIV testing and counseling process in the context of TB clinical settings.

http://www.cdc.gov/nchstp/od/gap/docs/tb_tools/TB%20Module%202_12.7.06.pdf

Module three: Preparing the provider to perform PTC.

http://www.cdc.gov/nchstp/od/gap/docs/tb_tools/TB%20Module%203_12.12.06.pdf

Module four: Administrative, implementation and standard operating procedures.

http://www.cdc.gov/nchstp/od/gap/docs/tb_tools/TB%20Module%204_12.13.06.pdf

Module five: Clinical considerations.

http://www.cdc.gov/nchstp/od/gap/docs/tb_tools/TB%20Module%205_12.6.06.pdf

Module six: Demonstration clinic.

http://www.cdc.gov/nchstp/od/gap/docs/tb_tools/TB%20Module%206%20Demo_12.1.06.pdf

Counselling practices (ethics and effectiveness)

FHI. VCT toolkit. HIV voluntary counseling and testing: Skills training curriculum participant's manual, 2005. <http://www.fhi.org/en/HIVAIDS/pub/guide/vcttrain2.htm>

FHI. VCT toolkit. Voluntary counseling and testing for HIV: A strategic framework, 2003.

http://www.fhi.org/en/HIVAIDS/pub/guide/VCT_HIV_Strategic_Frame.htm

FHI. VCT toolkit. Trainer's manual: Counseling supervision and training, 2005.

<http://www.fhi.org/en/HIVAIDS/pub/guide/VCTToolkitCounseling.htm>

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Behaviour change

EngenderHealth, Behaviour change.

<http://www.engenderhealth.org/res/onc/hiv/preventing/hiv6p3.html>

Change project (from 2005). <http://www.changeproject.org/>

Population Services International. Social marketing approach to VCT, 2004.

<http://www.aidsmark.org/resources/pdfs/vct-brochure.pdf>

Motivational interviewing: Resources for clinicians, researchers and trainers.

<http://www.motivationalinterview.org/>

HIV counselling and testing

FHI. Counselling and testing for youth.

<http://www.fhi.org/en/Youth/YouthNet/rhtrainmat/vctmanual.htm>

FHI. Counselling and testing. VCT webpage.

<http://www.fhi.org/en/Topics/Voluntary+Counseling+and+Testing+topic+page.htm>

FHI. Current issues in HIV counselling and testing in South and Southeast Asia, 2003.

<http://www.fhi.org/en/HIVAIDS/pub/survreports/Current+Issues+In+South+and+Southeast+Asia.htm>

PEPFAR. VCT page. <http://www.pepfar.gov/pepfar/press/76382.htm>

UNAIDS. Testing and counselling webpage.

<http://www.unaids.org/en/PolicyAndPractice/CounsellingAndTesting/default.asp>

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WHO. Guidance on provider-initiated testing and counselling in health settings, 2007.
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WHO. Voluntary counselling and testing: Manual for training of trainers. New Delhi: World Health Organization, Regional Office for South-East Asia, 2004.
<http://www.searo.who.int/en/Section10/Section18/Section1562.htm>

Suicide

Suicide Awareness Voices of Education. <http://www.save.org/>

US National Institute of Mental Health.
<http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>

US Department of Health. Suicide Prevention Resource Center. <http://www.sprc.org/>

WHO. Department of Mental Health: Suicide prevention.
http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/index.html

HIV care counselling

WHO. HIV psychosocial support. <http://www.who.int/hiv/topics/psychosocial/support/en/>

US Department of Health. Mental health information: HIV/AIDS.
<http://mentalhealth.samhsa.gov/cmhs/HIVAIDS/>

Joint United Nations Programme on HIV/AIDS (UNAIDS). Access to care and support.
<http://www.unaids.org/en/PolicyAndPractice/CareAndSupport/default.asp>

UNAIDS. Psychological help.
<http://www.unaids.org/en/PolicyAndPractice/CareAndSupport/PsychoSupport/>

The Body. HIV/AIDS resource. Mental health.
<http://www.thebody.com/Forums/AIDS/Mental/index.html>

New South Wales, Australia. AIDS Dementia and HIV Psychiatry Service.
<http://www.health.nsw.gov.au/adaahps/>

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UNAIDS. Opening up the HIV/AIDS epidemic, 2000. http://data.unaids.org/Publications/IRC-pub05/JC488-OpenUp_en.pdf and http://whqlibdoc.who.int/unaid/2000/UNAIDS_00.42E.pdf

WHO. Gender dimensions of HIV status disclosure to sexual partners: Rates, barriers, and outcomes, 2004. <http://www.who.int/gender/documents/en/genderdimensions.pdf>

Disclosure e-postcards. <http://www.whyttest.org/postcards/index.php>

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University of California, San Francisco, HIV InSite. ARV management: Knowledge base chapters and related resources. <http://hivinsite.ucsf.edu/insite?page=ar-00-00-01>

FHI. Adherence support worker training materials, 2007.
http://www.fhi.org/en/HIVAIDS/pub/res_ASW_CD.htm

Synergy Project. www.synergyaids.org/documents/mombasaarvtrainingguide.pdf

WHO. Medicines: Publications and documentation. www.who.int/medicinedocs/index.fcgi

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WHO. Prevention, treatment and care for injecting drug use (IDU) and prisons.

<http://www.who.int/hiv/idu/en/index.html>

WHO. Mother-to-child transmission of HIV. <http://www.who.int/hiv/mtct/en/index.html>

The Body. HIV/AIDS resource. <http://www.thebody.com/sitemap.html>

Transgender Care. What is gender and who is transgendered?

http://www.transgencare.com/guidance/what_is_gender.htm

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Most-at-risk populations

WHO. Online sex work toolkit. <http://who.arvkit.net/sw/en/index.jsp>

PDF version: http://www.who.int/entity/hiv/pub/prev_care/sexworktoolkit.pdf

WHO. Prevention, treatment and care for injecting drug use (IDU) and prisons.

<http://www.who.int/hiv/idu/en/index.html>

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Focus on marginalized communities, 2004.

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UN Convention on the Rights of the Child, 1989.

<http://whqlibdoc.who.int/publications/1998/9211541301.pdf>

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WHO. Addressing violence against women in the context of HIV testing and counselling:

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The Body. HIV resource: Ask the experts about women and HIV.

<http://www.thebody.com/Forums/AIDS/Women/>

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UNAIDS. Psychological support webpage.

<http://www.unaids.org/en/PolicyAndPractice/CareAndSupport/PsychoSupport/>

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HIV rapid testing

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WHO. HIV diagnostics webpage. <http://www.who.int/hiv/amds/diagnostics/en/index.html>

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