HIV Counseling Facilitator's Guide

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Preface

Since the first case reported in 1988, HIV has gradually gone from being “low prevalence” to a “concentrated epidemic” in Nepal .

In order to combat this virus and challenges it bring to the people of Nepal, we have revised the HIV Counseling Training Package with recent guidelines and policies which aims to facilitate and assist our ART counselors as well as the frontline health workers who provide other health services to people living with HIV/ AIDS.

Further more, details regarding the nature and duration of the training will be provided shortly to all the participants.

On the behalf of NCASC, I would like to express my gratitude to every individual and /or teams involved in finalizing this training package and thank you all for your hard work which has helped this training package revision to be a success.

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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
EID	Early Infant Diagnosis
ELISA	Enzyme-linked Immunosorbent Assay
ESSE	Exit, Survive, Sufficient, Enter
FTM	Female to Male
GUS	Genital Ulcer Syndrome
HAART	Highly Active Antiretroviral Therapy
HBC	Health Behavior Communication
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HLA	Human Leukocyte Antigen
HPV	Human Papilloma Virus
HTC	HIV Testing and Counseling
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	Non-governmental 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	Pneumocystis Carinii Pneumonia
PEP	Post-exposure Prophylaxis
PrEP	Pre-exposure Prophylaxis
PI	Protease Inhibitor
PITC	Provider-initiated Testing and Counseling
PLHIV	People living with HIV and AIDS
PWID	People Who Inject Drug
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 Counseling and Testing
WHO	World Health Organization

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Introduction

This training package consists of following training materials:

Facilitator's Guide: the facilitator's guide consists of course syllabus, training schedule, learning instructions for exercise, pre-course and mid-course questionnaire answer sheet, objective guideline of training process/ methodology and scheduled time to meet the defined learning objectives.

The session plans and activity sheets included in this facilitator's guide should be used in conjunction with the counseling handbook and counseling exercise book in this training package.

Reference Manual: Necessary elements and important fact-based information needed for the participants during the course are included in this material. This material will be useful for participants, facilitators and others.

Participant's Exercise Book: This book consists of the exercise to be carried out by the participants under the guidance of facilitators.

Method/ process of training:

This training is based on adult learning principles. This training has adopted participatory approach which enables the participants to become competent to deal with PLHIV and key population (KP) of HIV program. This training is modular based rather than other lecture method. All the participants should go through each module during the training.

Evaluation:

Training evaluation is to assess how much knowledge, skill and attitude have the participants gained on the defined objectives. Basis to clarify participants' competency is:

Knowledge: Score at least 85% mid-course evaluation.

Skill: Able to perform skills satisfactorily according to learning objectives during practical session or role playing.

Attitude: Participants active participation and involvement and verbal commitment to apply the knowledge and skills after the training.

Training objectives

At the end of the course participants will be able to perform the following activities:

- Find out the key elements of HIV counseling
- Identify a client's stage of change, that may help move the client to the next stage of change
- Conduct a group pretest information session in their health care setting
- Manage a sensitive issues arising during counseling
- Conduct a post-HIV test counseling session with a client who has tested negative and positive
- Rehearse a suicide risk assessment interview
- Develop a post-diagnosis support plan
- Demonstrate partner disclosure counseling skills
- Assess the barriers to treatment adherence among client
- Provide key information on preventing mother to child transmission (PMTCT) using various tools to a client whose HIV status is known

- Identify key information and prevention strategies for men in the prevention of mother-to-child transmission
- Assess personal values and attitudes that may influence the provision of HIV counseling
- Assess the risk factors of HIV among KP
- Make strategies to reduce the risk factors among KP
- Identify the signs and symptoms of drug and alcohol users
- Make appropriate treatment and referral for drug and alcohol users
- Identify key issues and strategies in the management of occupational exposure to HIV

List of materials

Below is a list of the documents and tools that make up this package.

Handbook

Name	File name
Handbook for HIV Counseling: A Comprehensive Guide to HIV testing and counseling in different approaches and Care Counseling.	HIV Counseling Handbook

Facilitator's Guide

Session plan name	File name
1. Basics of HIV, sexually transmitted infection (STI) & tuberculosis (TB)	M01-SP Basics of HIV, STI & TB
2. Key elements in HIV and STI counseling practice	M02-SP Key elements of counseling
3. Behavior change strategies in HIV counseling	M03-SP Behavior change counseling
4. Pre-HIV test counseling and group pretest information provision	M04-SP Pretest and group information
5. How to provide HIV test results	M05-SP HIV test results
6. Counseling 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. Counseling for treatment adherence	M09-SP Adherence counseling
10.Pregnant women, new mothers, and their partners	M10-SP Pregnant women
11.Counseling children and adolescents	M11-SP Children and adolescents
12.Working with men who have sex with men (MSM), transgender people and clients of sex workers (SW)	M12-SP MSM ,transgender and sex worker clients
13.Counseling drug and alcohol users	M14-SP Drug and alcohol users
14. Counseling for pre-and post-exposure prophylaxis (PrEP and PEP)	M14-SP pre and post exposure prophylaxis

Activity sheets

Activity sheets	File name
1. Communicating key information to clients	M01-AS1.1 Communicating Information
2. Counselor ethics	M02-AS2.1 Ethics case studies
3. Counselor-client roles	M02-AS2.2 Counselor-client roles
4. Questioning quiz	M02-AS2.3 Questions about sexual practices
5. Group pretest information	M04-AS4.1 Group information
6. Case studies on HIV test results	M05-AS5.1 Test results case – studies
7. Case studies on suicide risk assessment and management	M6-AS6.1 Suicide risk case – studies
8. Case studies on post-diagnosis support plans	M07-AS7.1 Support plan case – studies
9. Counselor challenge response	M08-AS8.1 Counselor challenge
10. Case studies on supporting HIV disclosure	M08-AS8.2 Disclosure case studies
11.Explaining resistance	M09-AS9.1 Explaining resistance
12. Case studies on pre-adherence screening	M09-AS9.2 Pre-adherence case studies
13.Case study on supporting client adherence	M09-AS9.3 Supporting adherence case study
14. Fast-facts quiz about pregnant women, new mothers,	M10-AS10.1 Fast-facts quiz and their partners
15. Role-play on counseling for PMTCT	M10-AS10.2 PMTCT
16. Counseling men for PMTCT	M10-AS10.3 Counseling men for PMTCT
17.Talking to children about HIV	M11-AS11.1 Talking to children
18.Case studies on MSM risk and vulnerability	M12-AS12.1 MSM risk case studies
19. Case studies on SW risk and vulnerability	M13-AS13.1 SW risk cases
20. Role-play on behavior change and drug use assessment	M14-AS14.1 Drug use assessment
21. Case studies on accidental occupational exposure	M15-AS15.1 Exposure case studies

Exercise book

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 (STIs)	T1.4 STI
5. Where are you in the change process?	T3.1 Change-ready

6. Decision making	T3.2 Decision
7. The window period	T4.2 window period
8 Suicide risk assessment interview guide	T5.1 Suicide assessment
9. Suicide risk assessment matrix	T5.2 Suicide matrix
10. Post-diagnosis follow-up counseling form	T6.1 Follow-up
11. Pretreatment adherence counseling: Checklist	T8.1 Pre-adherence checklist and summary record form
12.How antiretroviral therapy (ART) works	T8.2 ART works
13. Reference cards for barriers to adherence	T8.3 Barriers to ADH
14. Pre-ART adherence screening tool	T8.4 Pre-adherence screening
15. What causes HIV resistance to ARV drugs?	T8.5 Resistance
16. ART drug side effects	T8.6 Side Effects
17. Practical problem solving for managing common barriers to adherence	T8.7 Problem solving (ART)
18. What can I do to have a healthy and safe pregnancy?	T9.1 Safe and healthy pregnancy
19. Assessment of drug and alcohol use	T9.2 Drug and alcohol assessment

Preparation for the training

1. **Venue**:
   Select a suitable training venue.

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

3. **Venue characteristics and facilities:**
   This is participatory training, requiring participants 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 participants 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 participants. 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 participants arriving late to class each day.
   When training is not to be residential, consider the advantages of providing meals to the participants 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 participants 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 participants and allows them to focus to a greater degree on the material being learned.

4. 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
- Administration Assistants
- Facilitators
- Training Assistants, and
- Participants

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

5. Prepare for Training

Several months before the training is to be conducted the coordinator 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 facilitators, send invitations and training details (dates, venue, contact details) to potential facilitators, and participants
- Arrange for course materials, including session plans, hand-outs, and powerpoint or overhead presentations, to be forwarded to facilitators so they can become familiar with the content of their sessions
- Decide on an appropriate number of participants
- Develop criteria for participants and send invitations to potential participants or send course announcements to relevant health facilities, asking them to identify suitable participants
- Choose the training facility, keeping in mind the number of participants attending and ensuring that all necessary equipment and resources will be available and within the budget
- Arrange accommodation for facilitators and participants if necessary and according to budget
- If applicable, arrange transportation for facilitators and participants from their accommodation to the training venue and back
- Arrange payment for facilitators (if appropriate), or reimbursement for their related training expenses
- Arrange catering for the course, including morning and afternoon tea 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 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 facilitators
- Facilitate opening and closing ceremonies during the training course, and invite guest speakers, if appropriate, and brief them
- At the completion of the training, collate the training evaluations and write a report or delegate someone else to do this

6. Administrative Assistants

Where staff are available to support and assist the coordinator, 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 facilitators or participants. These staff can also be responsible for registration, distribution of training materials, documentation for auditing or report writing, and maintenance of equipment.

7. Preparing the training materials

Each participant and member of the training team must be given a copy of the *HIV Counseling Handbook:* All the training activities assume the availability of this resource.

Each participant will also need a copy of the *Tools for HIV Counseling*, and all members of the

training team should have a copy of the *facilitator's guide* and a set of the *exercise book for HIV Counseling*.

8. Preparing the activity sheets

As many of the activities require the participants 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.

9. 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.

10. Checklist of supplies and space requirements for training

- Timetable
- Adequate seating ("café style" seating for table group work)
- Personnel (facilitators, 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 Counseling Handbook*
- 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)
- Overhead projector and markers
- Box for collecting written questions from participants
- 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 Counseling for Treatment Adherence module

11. How to be an effective facilitator

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 facilitators make sure they have the needed materials and resources ready and that the venues and facilities meet their expectations. Facilitators 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., LCD, HIV counseling 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.

a. 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 facitilators 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.

b. Know the material

Facilitators 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.

c. Know the environment

Arrive early at the training facility and find out where the training room is located. Orient yourself to the area. Participants 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. Participants 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 participants 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 newsprints and want to stick the paper on the walls, find out from the owner of the facility what is acceptable.

d. 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. Participants do not want to hear every breath you take but they must be able to hear your words clearly. Check that your jewelry 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 news print, will widen your choice of alternative equipment.

e. Know the resources required

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

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

f. Know the participants

If possible, try to obtain a list of the participants 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 participants attending allows facilitators to plan activities and group work adequately.
- Knowing the participants' professions will give facilitators an idea of the participants' level of education.
- Knowing their place of employment can tell facilitators:
  - 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 facilitators an idea of the range of seniority among the group. This may be important in identifying less-senior participants so that they can be encouraged to contribute to the training session to the same extent as senior participants.

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

Knowing the audience also gives facilitators an understanding of the social and cultural background of the participants.

12. 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.

a. 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 participants.

The facilitator can gain attention by:

- Explaining how the session is relevant to the participants
- Asking the participants 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 participants
- Using interesting pictures or audiovisual aids at the start of the session
- Using a quiz to identify gaps in knowledge.

b. Maintaining interest

For adults to focus on learning, they need to remain interested throughout the session. The participants 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 participants remain interested by:

- Personalizing the presentation–smiling, making eye contact, and addressing participants 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 participants to participate
- Using stories as examples
- Having brief physical activity or game breaks
- Using humour
- Using appropriate and consistent non-verbal behavior (discussed on the following page).

c. Selecting appropriate presentation styles

Using more than one technique in each session will maintain interest, and help in retention because participants 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;
- Participants–number, abilities, needs, and experience; and
- Environment–location, room set-up, time of day, day of week.

d. 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 counselors 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. Facilitators should try to be aware of their non-verbal communication messages.

Non-verbal communication include :

- *Voice. The trainer should speak clearly and project his or her voice. Speaking conversationally while occasionally varying loudness and pitch helps sustain the participants' interest. The trainer can vary his or her voice to emphasize important points that the participants 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 participants and their culture. Some facilitators may need to modify their usual *dress style for the training. Looking good may also give the trainer added confidence.*
- *Eye contact. Participants 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 participants, 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 participants only when facing them again. The room should be set up so there are as few barriers as possible. Participants 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 participants. 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 participants.*

e. Overcoming nerves

Many people can get nervous before and during a presentation. Practice can help settle the nerves, but even the most experienced facilitators 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 participants 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 participants, 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.

f. 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 participants
- Knowledge of the subject

g. Selecting appropriate audiovisual aids

This specific training package seeks to minimize the need for complicated media. But all facilitators 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 colors and sounds can distract the participants 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 participants will read the information rather than concentrate on what you are saying.
- Make sure that all the participants 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 participants.
- 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 color–preferably blue or black, which can easily be read from a distance.
- Finish writing and turn to face your audience before speaking
- *Newsprint:* 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 participants may focus on reading the handouts and not listen to your presentation. On the other hand, giving them out early can also allow the participants to follow the discussion without taking notes.

13. Managing common difficulties in training

Even the most experienced facilitators 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.

a. Mixed group expertise and experience

The participants 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 participants' 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 participants 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.
- meet their needs.

b. Managing Time

Facilitators 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 participants 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 participants' 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 participants 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 participants a summary of the remaining material.

c. Equipment failure

Virtually every facilitator 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.
- 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 participants.
- 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.

d. Managing challenging behaviors

Groups are made up of individuals, and individuals can be unpredictable. Certain individual and group behaviors can present challenges for the facilitator in facilitating and managing the group. These group behaviors 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 participants 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 behaviors in the group. Differences in culture and gender can mean that people behave, interact, and communicate differently. The facilitator must be aware of cultural differences that might affect how a group behaves. For example, participants may be uncomfortable asking questions in class, as it would be a sign of disrespect for the teacher or facilitator 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 behaviors that facilitators may encounter are discussed below. However, it is important to select techniques that are culturally appropriate.

e. When participants 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 participants. Open questions encourage participants 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.

f. 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 participants 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.

g. Dominating participants

What you can try:

- Be respectful and courteous. Participants 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.

h. Unresponsive participants

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 participants and get them to respond, either as a whole or in small groups.

i. Sleeping or inattentive participants

- 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 participants, during the break.

j. The argumentative participants

Some participants 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 facilitator 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 participant, 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 participants. Ask if anyone else in the group has a different opinion.
- Use direct and calm but assertive body language.

14. Evaluating the Training

Many stakeholders are involved in the conduct of training courses. Among these are the trainer, the participants, the facilitators 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.

a. What are the benefits of evaluating training?

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

- *For facilitators:*
  - Information about ways of improving the training and
  - Information about possible improvements in training style and skills.
- *For participants:*
  - Assessment of whether they have achieved their learning goals
  - Consideration of how the knowledge and skills learned can be applied to their work

b. 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 participants?
  - 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 participants)?
  - Was the trainer friendly, personable, approachable?
  - Did the trainer know the material (e.g., could he or she answer questions about the material confidently)?

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

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

Outcomes. Evaluating outcomes can be difficult, as it has to occur sometime after the course to assess what the participants have changed or done in their practice as a result of the training. *Independent observation of participants 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.

c. What do we do with the results?

On the basis of the findings of the evaluation, facilitators can improve certain aspects of the training so that future courses may better meet participant's expectations or training objectives.

d. 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:

- Facilitators:
  - 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).
- Participants:
  - A training evaluation form, mostly for assessing training processes (quantitative and qualitative measures);
  - Pre- and post-course knowledge tests for participants;
  - 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 participants and facilitators, e.g., through interviews and mailed questionnaires.

Recommended modules and duration of training

Focused group	Recommended Module	Duration of training
Core course HIV testing and counseling sites	Basics of HIV STI & TB (module:1) Key elements in HIV and STI counseling Practices(module:2) Behavior change counseling (module:3) Pre-HIV test counseling and group pre test information(module:4) HIV test result (module:5) Counseling for suicide prevention (module:6) Supporting HIV disclosure(module:8) Counseling pregnant women, new mothers, partners(module 10) counseling children and adolescents(module:11)	5 days
HIV care counseling 3days	Key elements in HIV and STI counseling Practices(module:2) Counseling for suicide prevention (module:6) Development of post diagnosis support plan (module:7) Supporting HIV disclosure(module:8) Counseling for Treatment Adherence (module:9) Counseling for PreP and post exposure prophylaxis (module:14)	6 days for the new participants who has not taken HTC and 3 days for the old participants who had already taken HTC
Counseling for key population 3 days	Core course + counseling MSM , transgender and sex worker clients (module 12) counseling drug and alcohol users (module 13)	6 days for new participants 3 days for those who has already participated in HTC

Daily schedule of the training

The schedule begins each day at **10:00** 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 **10:00a.m.**.

Day 1: Orientation to HIV counseling

10:00-10:30 Registration and introduction
10:30-11:00 Training formalities
11:00 -11:30 Pre-course evaluation
11:30-11:45 Tea break
11:45-12:00 National situation and response of HIV in Nepal
12:00-13:30 Basic of HIV,TB and STI
13:30-14:00 Refreshment

14:00-15:30 Basics of HIV, TB and STI (module 1)
15:30-15:45 Tea Break
15:45-17:00 Key elements of counseling (module 2)

Day 2: Facilitating key elements of counseling

10:00-10:15 Review of previous day
10:15-11:00 Key elements of counseling (module 2)
11:00-11:15 Tea Break
11:15-12:00 Key elements of counseling (module 2)
12:00-13:30 Behavior change strategies in HIV counseling (module 3)
13:30-14:00 Refreshment
14:00-15:30 Counseling in association with HIV test (module 4)
15:30-15:45 Tea Break
15:45-17: 00 Counseling in association with HIV test (module 4)

Day 3: Counseling in association with the HIV test

10:00 -10:15 Review of **previous** day
10:15-11:00 HIV test results (module 5)
11:00-11:15 Tea Break
11:00-13:30 HIV test results (module 5)
13:30-14:00 Refreshment
14:00-15:30 Counseling for suicide prevention (module 6)
15:30-15:45 Tea break
15:45- 17:00 Supporting HIV disclosure (module 8)

Day 4: Counseling for supportive HIV disclosure

10:00-10:15 Review of the previous day
10:15-11:30 Supporting HIV disclosure (module 8)
11:30-11:45 Tea Break
11:45-13:00 Supporting HIV disclosure (module 8)
13:00-13:30 Refreshment
13:30 15:00 Counseling pregnant women new mother and their partner (module 10)
15:00-15:15 Tea Break
15:15-17:00 Counseling children and adolescents (module 11)

Day: 5

10:00-10:15 Review of the previous day
10:15-11:00 Pre exposure prophylaxis (module 14)
11:00-11:15 Tea Break
11:15- 12:30 Pre-exposure prophylaxis (module 14)
12:30-13:30 Post-exposure prophylaxis (module 14)
13:30-14:00 Refreshment
14:00-14:30 Post exposure prophylaxis (module 14)
14:30-15:15 Mid -course evaluation
15;15-15:30 Tea Break
15:30-16:00 Training evaluation
16:00-17:00 Closing and certificate distribution

Schedule for HIV care counseling additional one day

Providing post-diagnosis support

10:00-10:15 Review of previous day
10:15-11:45 Development of post diagnosis support plan (module 7)
11:45-12:00 Tea Break

12:0013:30 Treatment adherence counseling (module 9)
13:30-14:00 Refreshment
14:00-15:30 Treatment adherence counseling (module 9)
15:30-15:45 Tea Break
15:45-17:00 Treatment adherence counseling (module 9)

Schedule for HIV counseling for risk group additional one day

10:00-10:15 Review of previous day
10:15-11:00 Counseling MSM, transgender and sex worker clients (module 12)
11:00-11:15 Tea break
11:15-13:30 Counseling MSM, transgender sex worker clients (module 12)
13:30-14:00 Khaja Break
14:00-15:30 Counseling drug and alcohol users (module 13)
15:30-15:45 **Tea break**
15:45-17:00 Counseling drug and alcohol users (module 13)

M01-SP: Basics of HIV, STI and TB

Time: 3 hours

Session objectives

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

- Explain the mode of HIV transmission
- Diagnose the HIV status
- State the treatment of HIV
- Describe the relationship between HIV, STI and TB.

Training materials:

- HIV Counseling Handbook, chapter 1
- Video clip
- Case situations (AS1.1)
- Tools T1.1, T1.2, T1.3, and T1.4
- Newsprint paper
- Question box

Session instruction

1. Introducing the session (10 minutes)

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

2. Referring participants to the *HIV Counseling Handbook (*30 minutes)

- Ask the participants to spend the next 30 minutes reading "What HIV Counselors Need to Know about HIV, STI, and TB: The Basics" in the HIV Counseling Handbook.

3. Recapping the reading (60 minutes)

- Brainstorm. Ask the participants to tell you the key messages for clients. Ask the participants 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.

4. Communicating information to clients (60 minutes)

- Make one or two copies of the Case Situations (AS1.1). Make sure the number of scenarios is equal to the number of participants. More than one participants may receive the same scenario.
- Roll or fold each scenario strip and place into a bag or box. Ask each participants to take one of the strips.
- If the participants do not already have them in their training package, make copies of tools 1.1, 1.2, 1.3, and 1.4 for the participants to use as appropriate.
- Ask each participants to take one scenario strip from the bag or box.
- Explain to the participants that they will now practice communicating information to clients on the basis of the scenario they have received. They will have 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 participants to communicate the specified information only, and not provide a full counseling session.

- Introduce the participants 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 facilitators should present an example of communicating information to a client, without and then with one of the tools.
- Each participants will present his or her response in front of the large group. One of the facilitators will act as the client and ask the counselor-trainee for information. The participants will have a maximum of 5 min to provide a response to the question.
- After each situation has been presented, the facilitators should ask the participants whether they understood what was communicated to them and how they felt about the way it was communicated.
- Ask participants 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 is large, divide the participants into smaller groups to practice communication skills.

5. Recapping the session (20 minutes)

- Ask the participants to summarize the key messages from this session.
- Summarize the key messages once again on newsprint paper.
- Recommend that the participants 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 participants if they have any questions about the content of the session.
- Remind the participants to place any additional questions they have in the question box.

M02-SP: Key Elements of Counseling

Time: 3 hours

Session objectives

- At the end of this training session, the participants will be able to:
- Describe the different types of HIV counseling
- Discuss ethical and effective counseling
- Demonstrate effective client-counselor communication skills

Training materials

- Counseling handbook chapter 2
- Activity sheets AS2.1, AS2.2, AS2.3
- Counselor's code of ethics (see handbook appendix 1)

1. Introduction: Brainstorming and discussing counseling (25 minutes)

- Introduce the session by displaying the session objectives.
- Explain to the class that this session will explore ethical and effective HIV counseling and what it involves and review some basic counseling micro-skills.
- Write the following question on newsprint paper and ask the participants to brainstorm responses: WHAT DOES HIV COUNSELING INVOLVE? Note their responses on newsprint paper.
- Summarize the key points.
- Ask the participants to brainstorm the following question: WHAT ARE THE DIFFERENT TYPES OF HIV COUNSELING?
- List the different types of HIV counseling on a sheet of newsprint paper. Then write down each type of counseling on a separate half-sheet of newsprint paper and ask the participants to identify common characteristics of each type. Write the participants' responses on the paper.
- Summarize the key points
- Ask the participants to brainstorm a definition of counseling. The facilitators should write the responses on newsprint paper. Tell the participants that the class will revisit the definition later.
- Ask the participants to brainstorm what they feel should be important elements of ethical and effective counseling. Once again, write the participants' responses on newsprint paper.

2. Referring to the handbook: chapter 2 (25 minutes)

- Ask the participants to open their handbook at chapter 2 and read the sections titled "What does HIV counseling involve?" and "Types of HIV counseling". Instruct them to **read only those sections of the chapter. (15 minutes)**
- When the participants have finished reading, ask them if they would like to add any comments to the different types of HIV counseling listed on the newsprint paper and record those other comments. **(5 minutes)**
- Ask the participants to revisit their definition of counseling 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 counseling (40 minutes)

- Ask the participants to discuss some ethical concerns in counseling. List their responses on newsprint paper.
- Ask the participants to locate and read the counselor code of ethics in the **appendix 1 of**

handbook.

- Ask the participants why they think a code of ethics is necessary.
- Ask the participants 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 counseling communication (5 minutes)

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

5. Engaging in counselor-client role-play 1 (20 minutes: 5 minutes for an explanation of the activity; 5 minutes for pair activity; and 10 minutes for debriefing/discussion).

- Ask the participants to divide into pairs for the activity.
- Instruct them to pick one person to be the "counselor" and the other to be the "client
- Ask all the "counselors" to assemble in one area of the training room for their instructions. Provide them with the "counselor'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 *counselors:*

- Your task in this activity is to be a "bad counselor".
- 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 counseling 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 "counselors" 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 "counselors" 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 (10 minutes)

- Ask the participants to identify important elements of listening. Tell them to relate points to the discussion generated from the activity.
- Write the participants' responses on newsprint 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).

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

7. Discussing questioning skills (15 minutes)

- Distribute photocopy AS2.3 for each participants and make one copy on news print paper.
- Ask the participants what types of questions they are aware of (answer: closed, open, leading).
- Provide the participants 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 participants 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 dont's 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 behavior.
  - 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 (10 minutes)

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

- 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 counselor 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 counselor. The counselor 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 counselor should also recognize his or her own paralinguistic behavior as well as the client's. The facilitators should give examples of these:

- Sighs,
- Grunts,
- Groans,
- Voice-pitch change,
- Voice volume,
- Voice fluency, and
- Nervous giggles.

9. Engaging in counselor-client role-play (2)(25 minutes)

- Allow 25 minutes in total: 5 minutes for an explanation of the activity; 10 minutes for pair activity; and 10 minutes for debriefing/discussion.
- Ask the participants 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 "counselor" listens and applies other micro-skills. Then the two switch roles: the "counselor" becomes the "client" and the "client" becomes the "counselor".
- Reassemble the participants 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 participants 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

M03-SP: Behavior Change Strategies in HIV Counseling

Time: 1 hour 30 minutes
Session objectives

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

- Illustrate the importance of considering the context of risk behavior
- Review the different transmission modes for different transmission risk situations
- Illustrate the use of the four principles of HIV transmission

Training Materials

- HIV Counseling Handbook, chapter 3
- Activity sheet 3.1
- Charts showing Stages of Change and Behavior Change Strategies
- Motivational interviewing tools (T3.1, T3.2)
- Risk Situation Cards (see suggested cards below; the cards may be printed from the file on the training kit
- Newsprint paper / Whiteboard
- Question box

1. Introducing the session (10 minutes)

- Introduce the session by explaining the importance of communicating information to clients clearly and concisely.
- Ask the participants to provide examples of information that is difficult to communicate to clients. Why is the information difficult to communicate?
- Display the session objectives on newsprint paper discuss them with the participants.

2. Reviewing the four principles of HIV transmission (30 minutes)

Preparation

- Prepare newsprint 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 behaviors, 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 behaviors that can realistically be changed to reduce their risk of HIV infection. However, identifying behaviors alone will not facilitate behavior change. Therefore, the counseling session must also go into the strategies that the client may use to achieve behavior change.
- Briefly discuss with the participants the strategies for the action and maintenance phases of behavior change.
- Remind the participants that behavior change is a gradual process. A person who engages in risk behavior may find it difficult or be unwilling to give up the behavior all at once. It is therefore beneficial to assist the client in exploring a variety of options or alternative behaviors that will help him or her move towards the behavior change goal.

Explain that this next activity is designed to build awareness of the level of risk that comes with certain behaviors. If a client is at high risk of HIV infection because of a certain behavior but finds it difficult to give up this behavior, he or she could consider less risky behavior as an alternative, e.g., mutual masturbation or oral sex instead of unprotected vaginal or anal sex.

- Display the newsprint paper and explain the four principles of HIV transmission and discuss them with the participants. Advise the participants 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.
- Distribute risk situation cards among the participants. If there are extra cards, some participants may be given more than one.
- Place the four cards indicating level of risk on the floor in the following arrangement:

- Explain to the participants 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 participants begin, show the participants 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 behavior.
- 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 participants 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 participants have put down their cards, ask the following questions:
  - What behaviors put us at highest risk of HIV infection? Why?
  - What behaviors lower our risk of HIV infection? Why?
  - What activities/behaviors 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 counselor 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 behavior?
  - How can the Four Principles guide a client in practising safer behavior?
- Conclude the activity by emphasizing the following:
  - Risks vary with the context and manner of behavior.

- This activity emphasizes the importance of asking detailed information of clients when conducting a risk assessment.

- 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 behaviors.

3. Referring participants to the *HIV Counseling Handbook (*15 minutes)

- Ask the participants to spend the next 15 minutes reading through the information in chapter 3,
  "Behavior Change Strategy in HIV Counseling", in the *HIV Counseling Handbook*.

4. Discussing the stages of change and behavior change strategies (30 minutes)

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

  - **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 act.
  - **Preparation**–the person makes a commitment as well as initial plans to change the behavior.
  - **Action**–the person takes effective action to make the change. He or she adopts strategies to prevent a relapse and a return to problem behavior.
  - **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 behavior. 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 and T3.2, in their handbook.
- After the groups have fully discussed the issues and strategies of the other case studies, ask each
  of the two groups to present the group's findings before the large group.

5. Recapping the session (5 minutes)

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

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**

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 transmission

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

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.

MO4-SP: Counseling in association with HIV Test

(Pre HIV test counseling and group pre-test information)

Time: 3 hours

Session objectives

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

- Conduct a group pre-HIV test information session
- Manage discussing sensitive issues
- Assess risks within the HIV test window period
- Assess and individual's coping strategies and psychosocial support system

Training Materials

- *HIV Counseling* ***Handbook, chapter 4***
- Activity Sheets **(AS 4.1)**
- Newsprint paper
- Question box
- Condoms (male and female)

Session instruction

1. Introduction (40 minutes)

- Introduce the session objectives **(10 minutes)**
- Introduce the module by discussing the following questions:
  - What are the different approaches to HIV testing and counseling?
  - Emphasize that, regardless of the approach, HIV testing and counseling must be voluntary and must maintain the "five Cs"–informed consent, counseling, confidentiality, correct testing and connection to treatment care and support.
- Ask the participants to read chapter 4, section 1, "Approaches to HIV Testing and Counseling" and steps of counseling, in their handbooks. **(20 minutes)**
- Ask the participants to summarize the key point's approach of testing and counseling. Write their responses on computer or newsprint paper (**10 minutes)**

2. Discuss the importance of the condom demonstration and discussion (40 minutes)

Male condom

- Distribute two condoms and a penis model to each trainee (or one penis model to every two participants).
- Tell the participants that condoms are an integral component of HIV prevention and that counselors must be able to demonstrate condom use to clients, comfortably and confidently.
- Ask a volunteer from the group of participants 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 participants to bring up any missing steps.
- Ask the participants 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 participants to begin. They may follow the steps in the tool.
- Now ask the participants 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 participants 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 participants during the pretest counseling to inform clients of the location of local needle and syringe exchanges and to educate them in safe injection, needle syringe exchange program.

3. Informed consent and discussion on the procedures for blood collection and result provision (15 minutes)

- Inform the participants that counselors 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 participants that counselors 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 counselor should advise the personnel that are responsible for blood collection.
- The counselor should inform the client of procedures for provision of results and post-test counseling.
- Finally, tell the participants counselors 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 counselor reinforces the importance of collection of their results. The counselor 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."

4. Ask the participants to read chapter 4, section 2 providing pre-HIV test information in groups **(10 minutes)**

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

5. Group work on pretest group information session (60 minutes)

- Make photocopies of activity Sheet AS4.1 to distribute to all the participants.
- Prepare newsprint paper and markers for group work.
- Inform the participants that before the process of pre–HIV test counseling is discussed, the skills needed to provide pre–HIV test group information will be explored.
- Divide the class into two groups.
- Explain to the participants 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 behaviors 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 participants who will serve as group facilitators that they should finish the discussion of these risks by telling the group that when they see the counselor individually the counselor 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 counselor (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.
  - Explain the testing procedures and procedures for result provision. Reassure the group that all results will be provided in private and individually.
- 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.

6. Debriefing (10 minutes each group)

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.

7. Recap the session (5 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.

M05-SP: HIV Test Result

Time : 3 hours

Session objectives

At the end of the session, participants will be able to :

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

Training Materials:

- HIV Counseling Handbook, chapter 4
- Activity sheets, case studies (AS5.1)
- Newsprint paper
- Question box

1. Introducing the session (5 minutes)

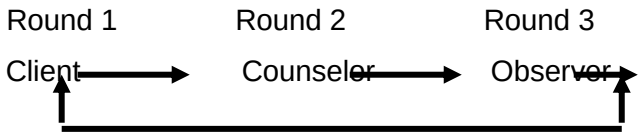
- Introduce the objectives of the session.
- Explain that the session will be divided into two parts:
  the provision of negative HIV test results and the provision of positive HIV test results.

2. Referring participants to the handbook, chapter 4(10 minutes)

- Ask the participants to read chapter 4, section 3 (‘“Post-HIV Test Counseling‘”).
- After the participants 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 participants to summarize some of the important issues to discuss with the client that were introduced in the pretest information session.

3. Activity 1: Role-playing HIV test counseling for a negative result (60 minutes)

- Prepare the case studies from **AS5.1**.
- Introduce the activity (5 minutes)
- Inform the participants that they will now role-play post-HIV test counseling for negative HIV test results. Suggest the use of the tools that have been introduced so far in the counseling session.
- Organize the class into groups of three (triads), each one with a “counselor”, a “client”, and an “observer”. Explain that all participants will rotate between “counselor”, “client”, and “observer” roles.



- There will be three rounds of cases, one case per round. Tell the participants that they will use the
  same three pre-HIV test counseling cases issued earlier (**AS 5.1**).
- **Round 1** of the role-play should begin with role-playing case 1 of the pre-HIV test counseling 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 “counselor” and the “observer”.
- Allow a maximum of 15 minutes for the role-play

Issue the following instructions to the participants for each round

- One person in each triad is to take on the role of counselor; the others take on the role of client and observer.
- "Observers" are to observe the role-play and provide feedback to the "counselor" 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.
- Then ask the participants to form three small groups—one for the "counselors" 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 counselor must address with the client now that a negative result has been presented?
  - What behavior change interventions should the counselor offer?
- The small-group debriefing should last no longer than (**5 minute)** each round.
- Reassure the group that, while providing positive results is difficult, it improves with practice, debriefing, and clinical supervision.

4. Providing feedback (5 minutes)

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

Providing Positive HIV Test Result

1. Introducing the session (5 minutes)

- Introduce the session.
- Ask the participants to quickly review some of the important steps in providing the post-HIV test result.
- Ask the participants, *"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 participants to the handbook, chapter 4 (10 minutes)

- Ask the participants to read section 3 of chapter 4 of the handbook from the heading "Detailed Steps to Follow When Providing HIV-Positive results" to the end of the chapter.
- When the participants 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 participants to summarize some of the important issues to discuss with the client that were introduced in the pretest counseling session. (5 minutes)

3. Activity 2: Dealing with emotions, thoughts, and needs (20 minutes)

- Prepare a table with three columns—"Emotions", "Thoughts", and "Needs at This Moment"—
  on overhead transparency or news print paper (see sample table at the end of this session plan;
  the sample may be photocopied onto an overhead transparency).
- Inform the participants that you plan to introduce the topic with an experiential group activity to sensitise the participants to the needs of clients receiving the results.
- Note that this activity makes no assumptions about the participants' HIV status and that you recognize that this may raise personal issues for the participants. Offer the participants an opportunity for confidential debriefing with a workshop facilitator,

should the need arise. This is important as there may be participants or people close to them who have been diagnosed with HIV.

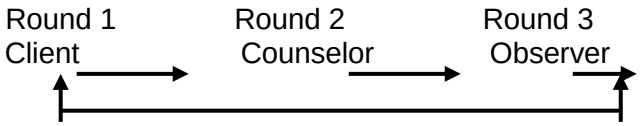
- Position the overhead transparency sheet for results onto the overhead projector without turning the projector on. Tell the participants that you will now briefly switch off the lights for part of the activity. The master sheet for the overhead transparency is attached to this session plan; the trainer can copy it onto an overhead transparency.
- Ask participants 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 participants 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 participants to share with the group the emotions and thoughts that they had during this activity. The facilitators should list the participants' responses in a table on overhead transparency or news print 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 counseling that needs to be conducted at this stage.

4. Activity 3: Role-playing post-HIV test counseling (60 minutes)

- Prepare the case studies from **AS 5.1**

Introduce the activity (5 minutes)

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



- There will be three rounds of cases, one case per round. Tell the participants that they will use the same three pre-HIV test counseling cases issued earlier (AS 5.1). **Round 1** of the role-play should begin with role-playing case 1 of the pre-HIV test counseling 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 "counselor" and the "observer".
- Allow a maximum of 20 minutes for the role-play

Issue the following instructions be issued to the participants for each round (45 minutes):

- One person in each triad is to take on the role of counselor; the others will take on the role of client and observer.
- Instruct the "counselors" to use the Post-HIV Test Counseling Form (**T4.5**),. 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 "counselor" 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.
- Then ask the participants to form three small groups—one group each for the "counselors" 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 counseling 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 counselor to employ?
  - How did the participants manage to **balance** providing **information** with being responsive to the need of the client's **emotional needs**?
- Limit the small-group debriefing to **5 minutes** each round.
- Reassure the group that, while providing positive results is difficult, it improves with practice, debriefing, and clinical supervision.

5. Recapping the session (5 minute)

Ask the group to summarize and discuss the key learning point from the activities.

MO6-SP: Counseling for Suicide Prevention

Time: **1 hour 30 minutes**

Session objectives

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

- 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
- Demonstrate the use of effective management strategies for counseling a suicidal client, in a given case situation.

Training Materials

HIV Counseling ***Handbook, chapter 5***

- Activity sheets AS6.1
- Tools T5.1 and T5.2.
- Newsprint paper
- Meta card

1. Introducing the topic (5 minutes)

- Introduce the topic and indicate to the participants that this module may raise personal issues for them if they have had any personal experience with the topic. Acknowledge that participants are welcome to confidentially discuss issues arising from the session after class
- Ask the participants to brainstorm why they think it is important to address the issue of suicide in HIV counseling.
- Then ask the participants to quickly brainstorm when clients may be likely to consider suicide in relation to HIV testing. Write the responses on newsprint paper, then ask individual participants to elaborate on their responses.

2. Referring participants to the handbook, chapter 5 (10 minutes)

- Ask the participants to read chapter 5, section 1, “Conducting a Suicide Risk Assessment”, in their handbooks.
- Ask the participants to highlight some key messages from this section.
- Introduce the participants to the Suicide Risk Assessment Interview Guide (T5.1). Display a copy of the tool on overhead transparency or refer the participants 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 counseling session, introduce the participants 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 sometime between steps for questions.

3. Conducting the suicide risk assessment interview (40 minutes)

- 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.
- Tell the participants 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 participants and ask one to play the role of a counselor 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.

- "Counselors" are to be instructed to introduce themselves as counselors 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 counseling micro-skills to convey concern, empathy, and calm support to clients.
- Instruct the "clients" to provide feedback to the "counselors" after the role-play.
- The "counselors" should be encouraged to discuss what they feel they could have done differently and their emotional response to the role-play.)
- 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 participants together again for a debriefing. Ask to locate Risk Assessment Matrix on their exercise book . Ask everybody to read case 1 and ask the participants to help you complete the Risk Assessment Matrix in front of the group. Ask the participants what the level of risk of suicide is. Ask them what they think the counselor should do next to support this client. Refer them to the handout that outlines interventions for low-risk clients. (15 minutes).
- After the debriefing, ask the participants to switch roles and repeat the process with case two.

Again at the end of the role-play and debriefing, ask participants to locate the Risk Matrix on their exercise book. Ask everybody to read case 2 and to help you complete the Risk Matrix in front of the group. Ask the participants what the level of risk of suicide is. Ask them what they think the counselor 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 (30 minutes)

- Divide the participants into two groups according to the case study they analyzed in the role-play.
- Once they are in their groups, instruct the participants to read chapter 5, section 2, of the handbook ("Suicide Management Interventions").
- 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 newsprint paper.
- 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 (5 minutes)

- Ask the participants to come up with key points for counselors to remember when conducting a suicide risk assessment.
- Then ask the participants to come up with key points for counselors 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 participants 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

M07-SP: Development of Post Diagnosis Support Plan

Time: **1 hour 30 minutes**

Session objectives
At the end of this session, the Participants will be able to:
- Identify psychosocial issues common among clients living with HIV
- Develop a post-diagnosis support plan.
- *HIV Counseling* ***Handbook, chapter 6***
- Activity sheets **AS7.1**
- Newsprint paper
- Tools **T6.1**
- Question box

1. Introduction (5 minutes)
- Introduce the session.
- Ask the participants what the roles of counselor in HIV care counseling are.

2. Referring to the handbook (chapter 6, section 1) (15 minutes)
- Ask the participants to read chapter 6, section 1, "HIV and mental health", in their handbook. (5 minutes)
- Ask a few participants at random to compare the group's earlier responses with what is presented in the handbook. (5 minutes)

3. Referring to the handbook (chapter 6, sections 2 and 3) (20 minutes)
- Ask the participants to read chapter 6, sections 2 and 3, in their handbook. (15 minutes)
- Ask a few participants at random to summarize key points from the reading. (5 minutes)

4. Developing a post-diagnosis support plan (40 minutes)
- Make four copies of the post-diagnosis follow-up counseling form (T6.1) on an overhead transparency and make enough photocopies for all the participants.
- On newsprint paper write down the following phrases:
  - "Someone who is asymptomatic";
  - "Someone who is becoming symptomatic"; and
  - "Someone with AIDS".

<u>Part 1 (10 minutes)</u>
- Ask the participants to look at the list of phrases on the newsprint 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 counseling form (**T6.1**)
- Ask the participants 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 counseling form, using this case scenario.

<u>Part 2 (15 minutes)</u>
- Divide the participants 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 counseling 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 facilitators may then provide additional comments (see case studies and possible responses below.)
- Remind the participants 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.

5. Recapping the session (10 minutes)
- Ask the group to summarize the key learning points from the session.
- Draw the participants' 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 participants 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, counseling for loss of relationship and development of new relationships
- Referral options: ongoing counseling, 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

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), counseling for loss of physical control and changes in physical appearance, preparation for continued deterioration of functioning
- Referral options: ongoing counseling, peer support, health clinic or hospital for prophylaxis for opportunistic infections

Case study 3: AIDS

A 37 years old male was found to be HIV positive 7 years ago. He has been in severe distress due to his re-current period of illness and feels that he is a burden to his family. He is currently in the hospital, suffering from TB, PCP pneumonia and other opportunistic infections. Although, he was prescribed antiretrovirals (ARVs) soon after his diagnosis, however, he is not taking it regularly and thus has become resistant to his ARVs. As a result, his condition has started to deteriorate day by day. The doctors have tried their best, however, his condition has not improved and the doctor shares this with the family members.

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 counseling 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 counseling, peer support, palliative care, spiritual support, pastoral care, home-based care

M08-SP: Supporting HIV Disclosure

Time: 3 hours

Session objectives
At the end of the session, participants will be able to:
- Discuss the barriers clients face in partner disclosure.
- Demonstrate practical skills in partner disclosure counseling

Training Materials
- *HIV Counseling* ***Handbook, chapter 7***
- Activity sheets **AS8.1** and **AS8.2**
- Newsprint
- Question box
- Meta cards

Session instruction

1. Introducing the session (10 minutes)
- Introduce the session by asking the participants to brainstorm a number of questions:
- What is disclosure?
- Why do we need to encourage disclosure?
- What is the role of the counselor in supporting partner disclosure?
- When should the counselor begin discussing disclosure?
- Explain that these questions will be examined further throughout the session.

2. Activity 1: Brainstorming the advantages and disadvantages of (30 minutes)
HIV/STI disclosure.
- Divide the participants into two groups.
- Explain to the participants 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 news print paper.
- After this activity, let the groups swap news print 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 counseling in the context of disclosure.

3. Referring the participants to the handbook, chapter 7, section 1 (20 minutes)
- Ask the participants to read chapter 7, section 1, “Counseling for HIV Status Disclosure”, in their handbook. (**15 minutes**)
- Ask a few participants at random to quickly summarize a disclosure option suggested in the reading. (**5 minutes**)

4. Activity 2: Preparing the counselor challenge response (30 minutes)
- Prepare a copy of Counselor Challenge Response (**AS8.1**) for each participants
- Revisit the question asked at the beginning of the session, “How do counselors support disclosure?” Randomly ask a few participants for responses and then

explain that counselors 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 counselor 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 youwill 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 counselor 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 counselor 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 participants. Explain that the statements on the activity sheet are partner disclosure concerns of different clients.
    - Instruct the participants to write down questions that will challenge each of the statements.
    - Copy the activity sheet onto overhead transparency or news print paper. Ask for two or three volunteers among the participants to give examples of challenge questions to each statement. Request each trainee to provide at least one response. Record the participants' responses on the overhead transparency or news print paper. (**10 minutes**)

5. Referring the participants to the handbook, chapter 7, section 2 (10 minutes)

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

6. Activity 3: Supporting HIV/STI disclosure (role-play) (70 minute)

- Prepare the case studies from Supporting HIV Disclosure (AS8.2).
- Divide the participants into two groups
- Inform the participants that they will now conduct another set of role-play to practice partner disclosure counseling skills. If necessary, remind the participants of the steps in the role play (see below). **(5 minutes)**
- Explain that the tasks set for the counselor 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 "counselor.

Role-play steps

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

Each pair should nominate a “counselor”, a “client”, the pair’s role will be rotated between. Accordingly, there should be two rounds of cases, with one case per round, e.g., case 1 in round 1, case 2 in round 2..

“Counselors” 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 “counselors” 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 “counselor” to practice obtaining the information rather than simply reading out what is written in the case study. Facilitators should instruct the “clients” to inform the “counselor” 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 “counselor” after the role-play.

Step 2: feedback in pair (**5 minutes each round**)

Five minutes should be allowed at the end of each round for discussion and feedback within the pair.

Step 3: Debriefing (**10 minutes each round**)

After finishing the one round debrief in a large groups.

Ask the participants 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 counselor to employ?
- How did the participants manage to balance providing information with being responsive to the client’s concerns?
- What disclosure plan was the counselor 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 counselors 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

M09-SP: Treatment Adherence Counseling

Time: 3 hours

Session objectives

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

- 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
- Solve the problems encountered after starting therapy.

Training Materials

- *HIV Counseling* ***Handbook, chapter 8,*** "Providing Treatment Adherence Counseling"
- Tools **T1.2** (previously distributed in module 1), **T8.1, T8.2, T8.3, T8.4, T8.5, T8.6, T8.7,**
- Activity sheets **AS9.1 AS9.2, AS9.3**
- Newsprint paper/Whiteboard
- Question box

1. Introducing the session and the tools (35 minutes)

- Organize the participants into four to five table groups.
- Ask the groups to reread chapter 1 of the handbook from the section "What Does Clinical Management Involve?" (**10 minutes**)
- Ask the participants to review the Viral Replication tool (**T1.2**), which was handed out in module 1. Inform the participants that this tool is to facilitate the counselor's own understanding of the life cycle of the virus. The counselor 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 counselor with limited medical background, on the other. Ask the participants 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 participants 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 participants that they should explain to the client that they need all of the tablets for ART to work effectively (**10 minutes**).
- Introduce the notion of ARV resistance by handing out the Resistance tool (T8.5). Explain that counselors can use this tool to explain the concept of the virus becoming resistant to the drugs (ARV and STI) drugs. Ask the participants to review the tool in their table groups (**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 participants is that resistance to drugs can be transmitted and clients should be alerted to this possibility.

2. Explaining resistance (30 minutes)

- Distribute the activity sheet **AS9.1** and develop pairs among participants.
- Issue these instructions: One person in each pair is to role-play a counselor and the other will be the client. “Counselors” 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 “counselor” 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 participants that “counselors” and “client” are to debrief each other (**5 minutes**). First, the “counselor” acknowledges what he or she could have done better, and then the “client” provides feedback to the “counselor” on the latter’s strengths and weaknesses. Then the two switch roles and repeat the process

3. Ask the participants to read chapter 8. (**15 minutes**)

4. Engaging in group activity (15 minutes)

- Ask all participants 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 participants 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 news print 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.

5. 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. Counselors 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. Mention the fact that various tools used in this module and in other modules can support counselors 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 participants that they should have completed a standard follow-up counseling 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 Counseling 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.
- Then inform the participants that specific potential barriers to adherence must be explored in more detail. Hand out the Pre-adherence Screening tool (T8.4). Inform the participants that they should complete these interviews with clients in the first retreatment counseling 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 participants to use the explanation for the assessment offered in the text box on the form, before starting the interview. Allow the participants time to review the form).

6. Conducting pre-adherence screening (40 minutes)

- 10 minutes for handing materials; and 30 minutes per round, including the organization of participants **(20 minutes for role-play and 10 minutes for feedback).**
- Quickly organize the participants into pairs, preferably different from those in the previous activities. One person is to be the counselor 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 counselor, 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 "counselor". "Clients" can add information to their story if the information is necessary but not supplied.
- Instruct all the "counselors" to use the Pre-adherence Screening tool (**T8.4**) in the detailed assessment. The "counselor" must get all of the information from the "client". "Counselors" will not be shown the case in advance.
- When the 30-minute period is up, advise the participants that "counselors" and "clients" are to debrief each other). First, the counselor acknowledges what he or she could have done better and then the "client" provides feedback to the "counselor" on the latter's strengths and weaknesses.

- Ask the participants to switch roles. Provide the new "clients" with activity sheet **AS9.2**, **case 2**.

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 participants to look at them quickly).

- Inform the participants 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 participants to review the tool, which offers potential ways of addressing common barriers
- Ask the participants to quickly review section, "Support during ART" of chapter 8. Review each of the process counselors should undertake in follow-up visits after the start of treatment. Indicate to the participants that client adherence is sometimes monitored by counselors and in some services by other staff.
- Ask the participants 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 participants 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 participants 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.
- Distribute the Practical Problem Solving (ART) tool (T8.7). Allow the participants time to review the tool.
- Distribute the Side-Effects (ART Drugs) tool (T8.6) and inform the participants that often clients do not adhere to ART because of the side-effects. This tool can be used both in pretreatment counseling 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 facilitators some time to review the tool.

7. Learning from a case study on treatment adherence (20 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 15 minutes**).
- Ask the participants what other tools they have already received and used in training they think would be useful in adherence counseling

8. Recapping the session **(5 minutes)**

M10-SP: Counseling Pregnant Women, New Mothers, and Their Partners

Time: 1 hour and 30 minutes

Session objectives

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

- 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 counseling to women in relation to the prevention of mother-to-child transmission
- Identify symptoms of postpartum depression and psychosis in HIV-positive women and make appropriate referrals

Training Materials

- *HIV Counseling* **Handbook**, **chapters 1** and **9** (**section 1**)
- Tool **T9.1**
- Activity sheets **AS10.1, AS10.2, AS10.3**
- Newsprint paper
- Question box

Session instruction

1. Introducing the session (5 min)

Discuss the importance of the title.

"The title of this module emphasizes that prevention of mother to child transmission needs to cover counseling of pregnant women, and their male partners. It also implies that counseling needs to continue of women and their partners after the delivery of the child."

2. Completing the fast-facts quiz (30 minutes)

- Prepare photocopies of activity sheet **AS10.1** for all participants.
- Divide the participants into groups of four or five individuals and give each one a copy of **AS10.1**.
- Instruct the participants 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 participants if they able to respond.

3. Counseling for PMTCT role-play (30 minutes)

- Prepare copies of the Healthy Pregnancy and Infant Feeding tool (T9.1) for all the small groups.
- Prepare photocopies of activity sheet AS10.2 for all the participants.

- Briefly introduce tool T9.1 (5 minutes). Explain that the tool should be used by the counselor to discuss important prevention information face-to-face with the client.
- Instruct the participants to form triad groups and give each one a copy of AS10.2.
- One person in each triad is to role-play a counselor and another person a client, and the third person will be an observer.
- "Counselors" 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 counseling 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 participants that unlike other role-plays they completed in previous training sessions, in this one the case is already known to the "counselor". Tell them further that for the purposes of this activity the "counselor" 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 "counselor" 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 "counselor" 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 "counselor" 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. Counseling men and PMTCT (a large-group case study) (20 minutes)

- Prepare photocopies of activity sheet AS10.3 for all the participants.
- Hand out copies of AS10.3 to the participants 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 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 participants:

  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.

  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 counseling 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 counseling 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 counseling 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 counseling if required and available.)*

•Ask the participants 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 news print paper.
- Ask the group if they have any questions and remind them about the question box.

MO11-SP: Counseling Children and Adolescents

Time: **1 hour 30 minutes**

Session objectives

At the end of the session, participants will be able to:

- Draft sample information tools that may aid in discussing HIV and AIDS with children and adolescents
- Demonstrate the provision of information about HIV to a child or adolescent
- Demonstrate experience share by children living by HIV on disclosure

Training Materials

- HIV Counselling Handbook chapter 9 section 2
- Activity sheets **AS11.1**, **AS 11.2**
- Newsprint paper
- Question box

1. Introducing the topic (10 minutes)

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

2. Referring participants to the handbook, chapter 9, section 2 (20 minutes)

- Ask the participants to read chapter 9, section 2, “Children and Adolescents”. (10 minutes)
- Ask the participants to highlight some of the key issues on informing children about HIV and write these on newsprint paper. (10 minutes)

3. Talking to children about HIV (20 minutes)

Developing a communication strategy (10 minutes)

- Divide the participants 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 participants. 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 participants 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 10 minutes to come up with the strategy/tool. It should be written on newsprint paper or on an overhead transparency sheet.

Facilitator will facilitate question and answer session with each group (10 minutes)

4. Group works (30 minutes)

- Divide the participants into two groups
- Hand over the one case study to one group and another case study to another group

- Ask each group to discuss the case study for 15 minutes
- After the groups have fully discussed the issues and strategies of disclosure
- Ask each groups to present the group's findings before the large groups, 5 minutes for each group.

5. Recapping the session (10 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 participants to summarize the key messages from this session and summarize their responses on newsprint paper.
- Ask the group if they have any questions about the session or about the provision of counseling to children and adolescents and remind them about the question box

MO12-SP: Counseling Men Who Have Sex With Men, Transgender People and Sex Workers

Section 1: counseling men who have sex with men

Time: 3 hours

Session objectives

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

- 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, transgender clients
- Describe prevention measures for MSM, transgender clients
- List possible barriers to the use of prevention method by MSM, transgender and sex worker clients, and suggested solutions.

Training Materials

- *HIV Counseling* **Handbook**, **chapter 9**, **sections 3, 4** and **5**
- Activity sheets **AS12.1,AS 12.2**
- Newsprint paper
- Question box

1. Introducing the session (10 minutes)

- Explain that this session is going to explore the special counseling needs of men who have sex with men (MSM).

2. Brainstorming on MSM and transgender clients (20 minutes)

- Prepare newsprint paper and markers.
- Tell the participants that they are now going to explore the special counseling skills needed in the provision of counseling services for MSM and transgender persons.
- Ask the participants what images come in their minds if some one says “MSM” and “transgender person”. Write the responses on news print paper
- Summarize the range of responses that the participants have given and then ask them to think why these words and images come to mind. Ask the participants if they think the list of words presents an accurate description of all men who have sex with men. Ask for explanations.
- 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 behaviors. Highlight some of the broad examples provided in the brainstorming session. Similarly explain that transgender refer to all individuals whose biological sex does not match with the gender identity chosen by the individual.
- Also explain sexual orientation (sexual attraction to specific gender), sexual identity (sexual identity chosen by the individual) and sexual behavior (sexual practice of the individual). Explain that having a specific sexual orientation or choosing a specific sexual identity do not contribute for HIV transmission, HIV transmission is related to sexual behavior only.

3. Activity 2: Understanding MSM and transgender clients (30 minutes)

On the newsprint paper draw a table like the one below. Conduct the brainstorming and record participants answers. The risk blow is the risk of getting HIV, the vulnerability factors increase or decrease rate of getting infection.

Note: Answers recorded here are the type of answers that you are hoping to get from the participants.

Risk	**Vulnerabilities**
• Anal intercourse • Injecting drug use • Tatooing • Use of blood products	• Numbers and types of sex partners • Non-consensual forms of male-to-male sex with violence that causes tissue damage and occurs without condoms • 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 behavior Sexual/ Gender identity • Empowerment within a relationship • Social stigma against same-sex behavior

Summarize the following:

Risk and vulnerabilities go side by side. While addressing the risks, it also needs to address the vulnerabilities. Vulnerabilities is decreased by increasing availability lubricants and condoms, decreasing number of partners and improving condom negotiating skills with partners who are powerful in relationships.

4. Referring participants to the *HIV Counseling Handbook (20* minutes)

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

5. Activity 3: Outlining risk, vulnerability and strategy (30 minute)

- Photocopy the Outlining Risk and Vulnerability Case Studies (AS12.1)
- Ask the participants to form six small groups
- Allocate one case study to each group.
- Instruct the participants to read the case study and determine what activities or behaviors are placing the client at risk of infection and what factors are affecting the client's ability to practice safer behaviors. (Remind the participants 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 participants 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 behavior or to move to the next stage of behavior 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.

Section 2: counseling sex workers

Session Objectives

At the end of the session the participants will be able to do the following:

- Identify the specific HIV transmission risk behaviors of sex workers
- Understand the psychosocial issues surrounding sex workers
- Appreciate the need to adopt testing and counseling services to the specific needs of sex workers

6. Introduce the topic with question and answer session (10 minute)

- Ask the participants about the following question.
  - What is sex work? Who are the sex workers?
  - What makes the sex workers especially vulnerable to HIV infection?
  - How should testing and counseling services and psychosocial care be different for sex workers?
- Summarize the key points.

7. Referring participants to the *HIV Counseling Handbook (*20 minutes)

- Ask the participants to spend the next 20 minutes reading through the information on "Counseling Sex Workers" in chapter 9, section 5, of the *HIV Counseling Handbook*.
- Based on the chapter contents, ask the participants key questions related to the following:
  - Sex workers & HIV
  - Prevention of HIV among Sex workers
- Discuss what new strategies and information the participants have gained from the activities and the reading.

8. Activity: Outlining risk, vulnerability and strategy (30 minutes)

- Photocopy the Outlining Risk and Vulnerability Case Studies (AS12.2) and cut out the individual cases.
- Remind the participants once again that individuals do not change behavior easily, and briefly review the stages of behavior change on news print paper or o from chapter 3 (and module 3): "Behavior Change Strategies in HIV Counseling".
- Ask the participants to form three small groups. Allocate one of the Outlining Risk and Vulnerability Case Studies to each group.
- Instruct the participants to read the case study and determine what activities or behaviors are placing the client at risk of infection and what factors are affecting the client's ability to practice safer behaviors. (Remind the participants 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 news print 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.

9. Recapping the session (10 minutes)

- Ask the group to summarize the key learning points from the activities.
- Ask the participants to brainstorm what key things the counselor must do to be responsive to the needs of MSM, transgender and sex worker clients.
- 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.

MO13-SP: Counseling Drug and Alcohol Users

Time: 3 hours

Session objectives

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

- 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
- Make appropriate referrals to drug and alcohol and HIV treatment services
- Describe the key messages for people who inject drugs (PWIDs)

Training Materials

- HIV Counseling Handbook, chapter 9, section 6
- Tools T4.4 and T9.2 (and make a display copy of T9.2 onto overhead transparency) or newsprint
- Activity sheet AS13.1
- Annex 3 of the handbook
- Tool 9.2
- Newsprint paper/Whiteboard
- Question box

Session Instructions

1. Referring participants to the handbook, chapter 9, section 6 (20 minutes)

- Ask the participants 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. (**20 minutes**)
- Then while the participants are reading the newsprint or white board, write the following:

Alcohol	Nicotine	Cannabis	Stimulants	Opioids	Depressants	Hallucinogens	Volatile inhalants

2. Defining psychoactive drugs (20 minutes)

Ask the participants to look at the Annex-3 "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 bo.

3. Conducting a drug and alcohol use assessment (20 minutes)

Distribute tool T9.2 and, by using a copy of the tool on participants exercise book, guide the participants though 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 **AS13.1** and guide the participants though the tool, explaining how to conduct a drug and alcohol use assessment.
   - Divide the group into pairs. Inform the participants that we will do **two rounds** of role-plays. Ask one person in each pair to role-play the counselor, the other the client.
   - Write down the time for the activity on newsprint paper.
     - 10 minutes for the role-play interview;
     - 10 minutes for the pair debriefing and case planning; and
     - 10 minutes for the large-group feedback on the case.
   - Ask the clients to come forward and provide them with activity sheet **AS13.1**.
   - 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 COUNSELOR****. It is his or her job to get information from you by asking appropriate questions. You may only say you are coming to the counseling session because one of your friends is HIV-positive and you are worried. You can tell the COUNSELOR the gender and the age of the CLIENT that you are role-playing. The COUNSELOR 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."*
   - Then call all of the "counselors" together. Provide the following instructions: "In this activity you will play the role of the COUNSELOR. 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 understands why you need to ask these questions.
     - You will need to use tool 9.2 to interview the CLIENT. By the end of the consultation you should have a clear idea of:
     - CLIENT'S history of drug use, related risk behaviors, and previous treatment;
     - 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 COUNSELOR to formulate a support plan (including referral) to address this patient's drug use issues."

5. **Debriefing the pairs and undertaking case planning, round (10 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 "counselor" able to get the "client" to talk about his or her drug use behavior?
     - How was the "counselor" able to get the information needed to conduct the drug and alcohol use assessment?
   - What micro-skills were particularly important for the "counselor" to employ to do this?

   • Instruct the participants to read the case together. They are to identify what information the counselor failed to collect and discuss the reasons why (e.g., forgot to ask a question, or sounded judgmental 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 counselor 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. **Conducting the role-play interview, round 2 (15 minutes)**

   • Call the "counselors" together and provide the same briefing you gave to "counselors" in round 1.

7. 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 "counselors" 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.

8. Providing large-group feedback, round 2 (15 minutes)

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

9. Brainstorming special considerations for working with drug and alcohol users (10 minutes)

- After a brief "wake-up" activity, ask the participants to close their handbooks and then brainstorm the special considerations for pre-HIV test counseling of drug and alcohol users under each of the following scenarios:
  - ✓ Negative result;
  - ✓ Inconclusive result;
  - ✓ Positive result;
  - ✓ Types of referrals they are likely to need to make; and
  - ✓ Types of ongoing counseling that may be needed.

- If participants are unable to answer they may refresh their memory by reviewing chapter 9, section 6, of the handbook.
- Explain key messages to encourage behaviour change among people who inject drugs.
- Finally, refer clients back to chapter 3 of the handbook for a reminder on motivational interviewing and close the session.

10. 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 newsprint paper.
- Ask the group if they have any questions and remind them about the question box.

MO14-SP: Counseling for Pre-exposure and Post-exposure Prophylaxis

Time: **3 hours**

Session objectives

At the end of the session, the participants will be able to:

- Differentiate between PrEP and ART
- Provide PrEP for eligible client
- Demonstrate the process of counseling for clients requiring PEP

Training materials

- HIV Counseling Handbook, chapter 9, section 7,8
- AS 14.1
- Newsprint paper
- Question box

1. Introducing the session (5 minutes)

- Introduce the session by explaining the session objective
- Explain to participants that this session will cover Counseling for pre-exposure and post-exposure prophylaxis.
- Encourage the participants to share any experience about PEP in their life.

2. Instruction on pre-exposure prophylaxis (PrEP) (20 minutes)

Ask the participants to brainstorm on the following questions:

- What do you understand by PrEP?
- What is the difference between ART and PrEP?
- Write the response in newsprint paper

3. Group work (40 minutes)

Divide the participants into two groups. Instruct the participants to discuss in the group and write the discussion point in newsprint paper. One trainer will facilitate each group.

For group 1 ask to discuss in the group and write on the newsprint paper what is difference between ART and PrEp

For group 2 ask to discuss in the group and write on newsprint paper why counseling is necessary to the PrEp users.

Ask them to nominate a person to present in large group

4. **Referring participants to the handbook, Chapter 9, Section 7 (20 minutes)**

Ask participants key points what they learn from the book

5. **Introducing post exposure prophylaxis (5 minute)**

- Ask the participants 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).

6. Conducting a survey of accidental occupational exposures (15 minutes)

- Conduct an anonymous survey of the participants to find out whether or not they have had an occupational exposure.
- Distribute small pieces of paper to the participants. 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.

7. Referring participants to the handbook, Chapter 9, Section 7(20 minutes)

- Ask the participants to read Chapter 9, Section 8, “Health workers after accidental exposure.”

8. Counseling on the management of accidental exposures (15 minutes)

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

9. Activity: Conducting a demonstration role-play (30 minutes)

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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 newsprint paper

Instructions:

- Using the foregoing flow-chart, outline and explain the three types of counseling in the management of occupational exposures: post-exposure prophylaxis counseling, pre-HIV test counseling, and post-HIV test counseling.
- 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 counseling. 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) counseling is the third step. This includes getting informed consent for the testing of the person with accidental exposure to HIV. PEP counseling 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 counseling 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.

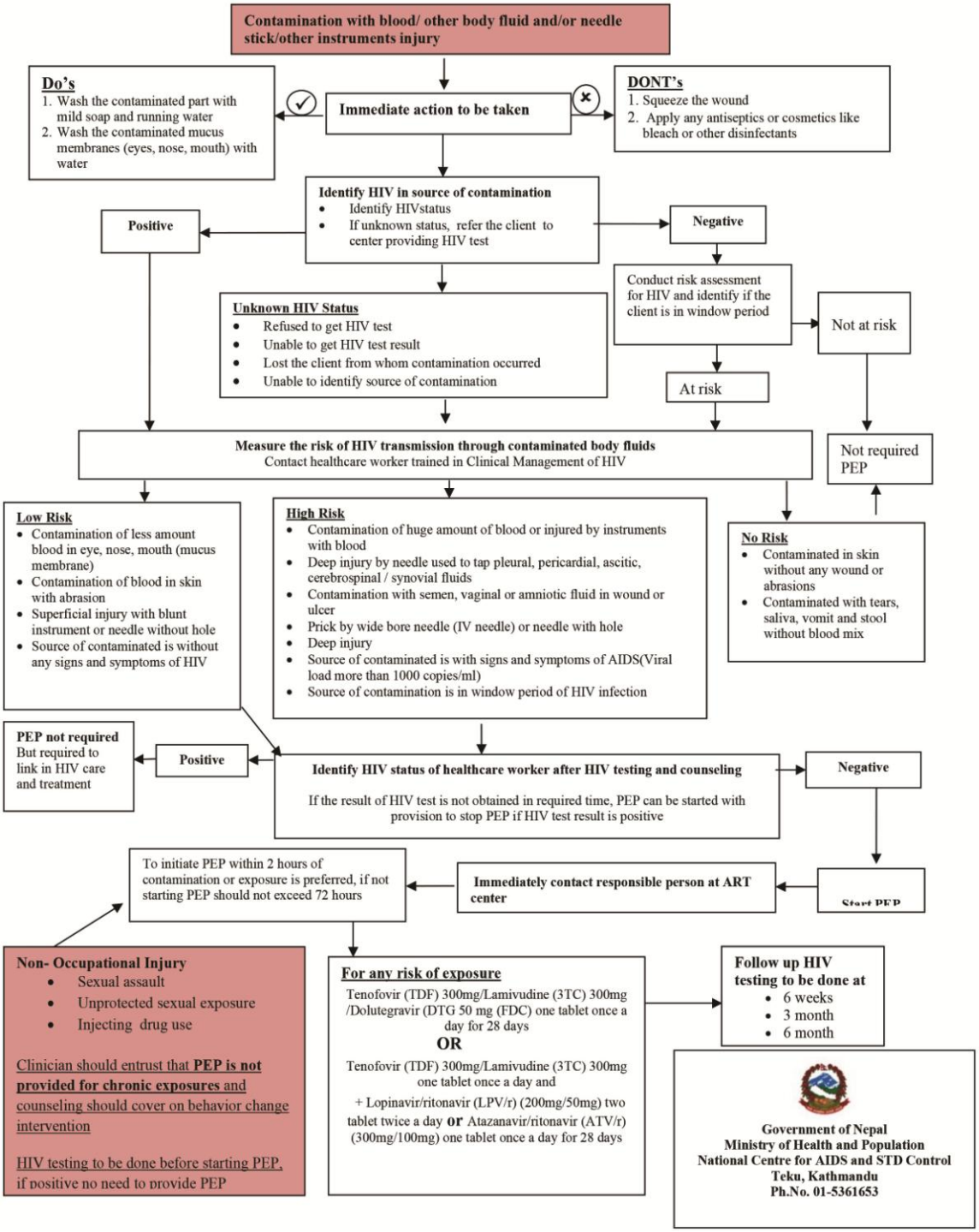
- Blood is drawn for the baseline test in step five. The health worker-client should be reminded of the need for follow-up testing. He/she should also consider testing for HBV, HCV, etc.
- If the rapid HIV test is used, then post-test counseling should be given for baseline testing.
- Inform the participants that they will now look at identifying the key issues and strategies in occupational exposure case management. First, however, the facilitators should demonstrate a role-play of one of the case studies. (Debriefing notes are provided for the facilitators below, if needed.)
- Divide the participants into two groups. Instruct the participants 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.

10. Recapping the session (10 minutes)

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

Management of Post Exposure Prophylaxis



Special note for facilitators

Debriefing notes for the cases used in this activity are provided below. They are for the facilitators' use only and should not be provided to the participants. The participants 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	• 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 counseling if applicable.
Presenting for a baseline test	• 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 counseling and risk assessment.
HIV status of the patient unknown Believes she has a right to know the patient's status	• **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	• **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. • **Advice** 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	• 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	• Suggest that the husband come in for counseling with her. He can then be told that the exposure risk is low.

Key issues	Strategies
Family would be supportive if the nurse were to test positive	• **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	• **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.

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

Key issues	Strategies
Exposure 1 hour earlier	• Check for first aid; assess and advise.
Needle-stick injury while performing venipuncture	• 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	• 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	• 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	• **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	• **Advise t**he 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	• **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	• **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	• 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	• **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	• **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.

Activity sheets

M01 – AS 1.1: Communicating Information

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?

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 behavior 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?

M02 – AS2.1 : Ethics Case Studies

Counselor Ethics

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

- She cannot practice her counseling because there is no time once she has attended to the nursing duties.
- There is no room or private space to hold counseling sessions.
- The doctor sends clients to her with no proper handover, and without explaining to the client why he/she is being referred for counseling.
- 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/counselor?

Case study 2

You are supervising a counselor 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 counselor 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 counselor 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 counselor comes to you and tells you that another one of your fellow counselors is making sexual advances to his clients.

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

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 counselor in training under an HIV counseling 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 judgmental in his comments.

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

M02 – AS2.2: Counselor-Client Roles

Counselor-client roles

Counselor's role

- Your job in this activity is to be a "bad" counselor, 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 counseling 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 "counselors" will be practising their basic skills during this activity.
- Find the other person who has been selected as your "counselor" and participate in the counseling session as the "client".

M02 – AS2.3 : Questions about Sexual Practices

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

M03 – AS3.1 : Motivational Interview

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.

M04 – AS 4.1: Group Information

Activity Instructions

The participants 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 counselor individually the counselor 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.

M05-AS5.1 : Test Results Case Studies

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.

M06-AS6.1: Suicide Risk Case Studies

Distribute to CLIENTS at the start of round 1.

Activity Instructions

1. Pairs are formed. One person role-plays the counselor, and the other the client.
2. Case 1 is handed to the CLIENT. He/She must not share it with the counselor, who must get the information given in the case study from the client. The client may, however, share with the counselor his/her age and gender and whether he/she has had a positive result or some other reason for seeing the counselor.
3. The COUNSELOR follows the Suicide Risk Assessment Interview Guide (tool 5.1).
4. At the end of the role-play, COUNSELOR AND CLIENT read the case study together and complete the Suicide Risk Assessment Matrix (tool 5.2). Normally a counselor 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

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

Case studies on suicide risk assessment and management

Case Study 1

A female, 30 years old, is attending a post-test counseling session. A nurse at the local health centre, she has two young children and is impulsive by nature. Her husband has told her that he is HIV positive. When she came in for pre-test counseling she had informed you that she was very worried about getting a positive result. She said 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.

Suicide Risk Case Studies

Distribute to CLIENTS at the start of round 2.

Activity Instructions

1. Pairs are formed. One person role-plays the counselor, and the other the client.
2. Case 2 is handed to the CLIENT. He/She must not share it with the counselor, who must get the information given in the case study from the client. The client may, however, share with the counselor his/her age and gender and whether he/she has had a positive result or some other reason for seeing the counselor.
3. The COUNSELOR follows the Suicide Risk Assessment Interview Guide (tool 5.1).
4. At the end of the role-play, COUNSELOR AND CLIENT read the case study together and complete the Suicide Risk Assessment Matrix (tool 5.2). Normally a counselor 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

10 minutes	Role-play
5 minutes	Pair debriefing
10 minutes	Pair completion of the Suicide Risk Assessment Matrix
10 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 counseling 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 counselor that he is disappointed that his previous suicide attempts 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.

M07 – AS7.1: Support Plan Case Studies

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 is 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 years old male was found to be HIV positive 7 years ago. He has been in severe distress due to his re-current period of illness and feels that he is a burden to his family. He is currently in the hospital, suffering from TB, PCP pneumonia and other opportunistic infections. Although, he was prescribed antiretrovirals (ARVs) soon after his diagnosis, however, he is not taking it regularly and thus has become resistant to his ARVs. As a result, his condition has started to deteriorate day by day. The doctors have tried their best, however, his condition has not improved and the doctor shares this with the family members.

M08-AS 8.1 : Counselor challenge

Counselor 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. I cannot tell my doctor. If I do, he will not operate on my leg.

5. My family will want to know how I get infected. They will press me to tell everything. I cannot tell them I am gay.

6. I cannot tell my wife. She will be angry and tell everybody. I am a respected member of the community.

7. I cannot tell my family. They will all reject me and blame me. Nobody will be sympathetic.

8. My father gets very angry. He will probably beat me up and make me leave home.

M08-AS8.2: Disclosure case studies

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 25-year-old male labor migrant. You have a wife and three children who live in a remote area of Nepal. You work as a seasonal labor migrant and have decided to go home during your holidays. While you are at home in Nepal, you decide to get examined in the STI clinic for a sore on your penis which you developed when you were working as a season migrant. The doctor examines you and suggests you get tested for HIV. Your test results of HIV come positive. Now, you are worried to disclose the result with your wife, as you fear that she might leave you and you love your wife and children and cannot bear to lose them. At the same time you are also scared that, your wife might reveal your status to everyone in the community and knowing your status your community people will disown you.

M09-AS9.1: 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 counselor, and the other the client.

Counselor: 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.
Counselor and client will then debrief each other for five minutes. The counselor acknowledges what he/she could have done better, and the client provides feedback on the counselor'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.

M09-AS9.2: Pre-adherence case studies

Round 1

Case studies on pre-adherence screening

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

Round 2

Client: Do not read the case study with your counselor until after the role-play. Just inform the counselor 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 forgot 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”.

M09-AS9.3: Supporting adherence case study

Group instructions:

Case study on supporting client adherence

- 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 dance bar in the evenings.
- At the dance 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.

M10-AS10.1: Fast-facts quiz

Time allocation: 20 minutes group work; 10 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 counseling with men who have sex with women and follow-up counseling with HIV-positive men what specific things should we tell them about preventing mother-to-child transmission?

M10-AS10.2: PMTCT

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

Role-play on counselling for PMTCT

Form triads. One person in each triad will role-play a counselor 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 counselor is assumed to have collected this information and is about to counsel the woman-client in response.

Counselor: 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 counseling take notes on the accuracy of the information provided by the counselor 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 counselor did well.

Debriefing

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

- The counselor 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 counselor 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.

M10-AS10.3: Counseling men and PMTCT

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 counseling 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 four and two. 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.

M11-AS11.1: Talking to children

Children need to have HIV and AIDS clearly explained in a way that is appropriate to their

Talking to children about HIV

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.

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 news print 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 news print 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).

M.11- AS 11.2: Child Disclosure Case Studies

Activity

Case study 1
Geeta is 37-year divorced women living with HIV and is on regular treatment. She is the mother of 2 children: 8 years Ram and 4 years old Shyam. Ram is HIV-negative and Shyam is HIV-positive and he doesn't know his HIV status. He has been on HIV care and treatment since his diagnosis at 3 years. He is prescribed an ART regimen ABC/3TC/LPV/r and is responsible for taking it every day. Geeta use to feed medicine saying it is a nutritional supplement which will make him strong and healthy.
Now days Shyam always quarrels and denies in taking the medicine as he feels fine and strong. She has difficulties coming to terms with her own HIV status and Shyam must not be told. She feels he is not yet ready. Geeta brought him to ART center and again Shyam ask why he comes to the clinic when he is so well. She wants you to talk to Shyam about his treatment.
How would you like to proceed with the disclosure?

Case study 2.
Shyam is now 11 years old and studies in grade 5. He is aware that he got a red bug from his mother when he was 4year. He is regular on his medicine and he also ensure that his mother takes her medicine on time and regularly. He never misses his follow up-date in ART clinic, and this is his 7th visit to ART clinic for his Viral load testing. His last viral load result was undetectable; however, he does not know his complete HIV status. Whenever he visits ART clinic for viral load report, he is always curious to know how red bug is doing now in his body and he asks you when that bug is going to go away from his body.
Shyam's mother informs you that he uses internets help to do his homework and he spends his leisure time by surfing net, she is afraid that he might know his HIV status from those social medias.
How would you counsel Shyams mother?
How would you like to proceed with the disclosure?

Case study 3.
Shyam is now 17 years old now he is in boarding school and is preparing for his SLC examination. He knows his HIV status since the age of 11. He has been under treatment for most of his life and he is stable on ART, his last viral load is undetectable. He meets Hari in his school and they become close and hang out together, going to the school, movies and talking on social media during the night. After some time, they became roommate.
Shyam has been taking medicine regularly and hide them among his personal belongings and take them mostly at night when his roommate sleeps. One night his roommate saw him taking medicine and asked him what that medicine was about? He lied him saying he take that as a nutrition supplement, Now Shyam is not regular on medicine as his roommate is awake most of the time at night.

How would you counsel Shyam?

How would you like to proceed ahead?

M12-As12.1: MSM and transgender worksheets

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.

MSM and Transgender Worksheets

What activities or behaviors 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 behavior?)

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.

M:12-12.2 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

Twenty-eight-year-old woman; lives in Kathmandu and works as a shop assistant in departmental store. She also works at a bar as an attendant during evening hours. She is worried about her current STI though it was successfully treated before. She needs to make sexual contact with her clients for money. She does not prefer to use condoms with her clients. She gets paid more if she does not use condoms. She does not want to spend her money in condoms. She is using some of her earnings to help and support her family and son in village. She has recently met a man. He is a respected member of the community. She had sexual contact with him. As he was respected member of the community, she thought it was not necessary to use condom with him and did not wanted to disclose her status as a sex worker also.

M 13-AS 13.1 : Case study on drug use assessment

Case 1 (Round 1) :
26 years uneducated young Rajendra hasn't caring himself and his family, they are live in slum areas from last decade. He was suffering quite chronic addiction in inject drugs from last 6 years. His current family situation was drastically poor and unmanaged. He was using heroin 4 years back but now injecting buprenorphine through sharing needle and use alcohol parellels with his friends due to lack of money. He refused Cannabis after using couple of month in starting period. Her wife was taken rehabilitation center 4 years ago when he was addicted in Nitrosun tablets along with cannabis.

He was unable to have drug due to his poor economical condition but dependency nature cannot control himself he also stayed in jail several time doing pick pocketing work in public transportation as well. He got counseling through his brother to go rehabilitation center but he ignore. He had tested HIV 9 months back with Negative report.

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.

M:14-AS 14.1 Case studies on occupational exposure

1

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 needle stick injury while performing venipuncture 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 venipuncture.

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.

References

Baker, A., Dawe, S. (2005). Amphetamine use and co-occurring psychological problems: Review of the literature and implications for treatment. *Australian Psychologist*, 40(2), 87-94.

Beyer, J.L., Taylor, L., Gersing, K.R. and Krishnan, K.R. (2007). Prevalence of HIV infection in a general psychiatric outpatient population. *Psychosomatics*, 48(1), 31-37.

Brew, B.J. and Gonzales-Scarano, F. (2007). HIV-associated dementia: an inconvenient truth. *Neurology*, 68(5), 324-325.

Carvalhal, A.S., Rourke, S.B., Belmonte-Abreu, P. , Correa, J. and Goldani, L.Z. (2006) Evaluation of neuropsychological performance of HIV-infected patients with minor motor cognitive dysfunction treated with highly active antiretroviral therapy. *Infection*, 34(6), 357-360.

Chader, G., Himelhoch, S., and Moore, R.D. (2006). Substance abuse and psychiatric disorders in HIV-positive patients: epidemiology and impact on antiretroviral therapy. *Drugs*, 66(6), 769-789.

Forsyth, B.W. (2003). Psychological aspects of HIV infection in children. *Child Adolesc. Psychiatr. Clin. N. Am (United States)*, 12(3), 423-437.

Huba, G.H., Panter, A.T., Melchior, L.A., Anderson, D., Colgrove, J., Driscoll, M., et al. (2000). Effects of HIV/AIDS education and training on patient care and provider practices: a cross-cutting evaluation. *AIDS Educ Prev*, 12(2), 93-112.

ITECH. (2006). *Working with MSM: A Training for Health Care Providers*. Retrieved 10 April, 2007, from http://www.go2itech.org/itech

Kelly, B., Raphael, B., Burrows, G., Judd, F., Kernutt, G., Burnet, P. , et al. (2000). Measuring psychological adjustment to HIV infection. *Int J Psychiatry Med*, 30(1), 41-59.

National center for AIDS and STD control Nepal 2020, National testing and treatment guideline

Panter, A.T., Huba, G.J., Melchior, L.A., Anderson, D., Driscoll, M., German, V.F., et al. (2000). Trainee characteristics and perceptions of HIV/AIDS training quality. *Eval Health Prof*, 23(2), 149-171.

Scharko, A.M. (2006) DSM psychiatric disorders in the context of pediatric HIV/AIDS. *AIDS Care*, 18(5), 441-445.

Trotta M.P., Ammassari, A., Murri, R., Monforte, A., and Antinori, A. (2007). Sexual dysfunction in HIV infection. *Lancet*, 369(9565), 905-906.

Turton, C.G., C.K.B., Cairns D.P., Kaewduangjai, P. (2004) *HIV voluntary counselling and testing (VCT): Implementation of a training-of-trainers (TOT) program in Thailand*. Paper presented at the XV International AIDS Conference, Bangkok.

UNAIDS (2000). *Opening up the HIV/AIDS epidemic: Guidance n encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case reporting*. (Vol. UNAIDS/00.42E (English original)). Geneva: UNAIDS/WHO.

UNAIDS (2000). *Preventing the transmission of HIV among drug abusers- position paper of the United Nations System*. Geneva: Joint United Nations Programme on AIDS.

UNAIDS (2000). *Technical update: Voluntary counselling and testing (VCT)*. Geneva: Joint United Nations Programme on AIDS.

WHO (2004). *Testing and counselling toolkit*. Retrieved 6 December, 2004, from http://who.arvkit.net/tc/en/index.jsp

WHO (2006). *WHO case definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-Related Diseases in Adults and Children*. Geneva: World Health Organization.

WHO (2007) *Guidance on provider-initiated HIV testing and counselling in health facilities*. Retrieved July, 2007 from http://www.who.int/hiv/topics/vct/PITCguidelines.pdf

WHO (2007) *Management of HIV infection and antiretroviral therapy in adults and adolescents – a clinical manual*. WHO Technical Publication No. 58.

WHO (2008) *Post-exposure prophylaxis to prevent HIV infection*

WHO Regional Office for South-East Asia (2007) *Management of HIV infection and antiretroviral therapy in adults and adolescents – a clinical manual*

WHO Regional Office for South-East Asia (2007) *Management of HIV infection and antiretroviral therapy in infants and children – a clinical manual*

WHO, UNICEF, UNAIDS, UNFPA (2006) *HIV and infant feeding update*

Wong V., Macleod I, Gilks C. Higgins D., Crowley S. (2006) The lost children of universal access – issues in scaling-up HIV testing and counselling. *Vulnerable children and youth studies*, 1(1); 44-55

WHO, unicef and family health international (2009) HIV counseling resource package for Asia and pacific region.

WHO, (2016), HIV prevention, Diagnosis, Treatment and case for key populations.

WHO,(2011), Guideline on HIV Disclosure Counseling for Children upto 12 years of age.

Annex

ANNEX 1

HIV counselling pre- and post- course knowledge questionnaire

Direction: Please circle the best answer or write the response.

1 HIV is transmitted through the following except
A. Unsafe sex
B. Sharing injecting equipment
C. Infected mother to child
D. Eating with the HIV infected people

2 HIV is not transmitted through except
A. Using public toilets
B. Hugging/kissing
C. Eating in the same plate
D. Transfusion of untested blood

3 what are four principle of HIV transmission
A.
B.
C.
D.

4 Which behavior has more risk depending upon four principle of HIV transmission
A. sharing contaminated needle
B. anal sex
C. oral sex
D. vaginal sex

5 pretest counseling should cover the following except
A. risk assessment
B. information about safe sex and safe injection
C. personal risk reduction plan
D. provision of ARV

6. Components of active listening are:
A. making eye contact
B. using encouraging noise
C. paraphrasing
D. All of the Above

7. Types of questions used in counseling except:
A. Open ended questions
B. Close ended questions
C. Probing
D. Leading questions

8. Suggestion to a client who comes for testing and tells that he had unsafe sex only one week before.
   A. Test after one week
   B. Test after one month
   C. Test after two week
   D. Test after six week

9. Lists of suggestion to a client who has negative test result except
   A. Provide the result and explain the meaning
   B. Check for any window period exposure
   C. Suggest for risks reductions
   D. Suggestion for partner test

10. Things to cover when giving a clients a positive test results.
   A. Provide the result and explain the meaning
   B. Access the ability to cope with the result including risk of suicide
   C. Refer for follow-up medical investigation
   D. All of the above.

11. Imagine there is a needle –stick injury in the hospital. The client is sent to you after the injury. Lists in correct order what you should do as a part of HIV testing and counseling in the context of management of accidental occupational exposure.
   A. Provide prophylaxis counseling including informed consent for ARV
   B. Draw blood sample for baseline.
   C. Frist-aid
   D. Provide pre-test counseling

12. What are the three signs that a client is at high risk of suicide?
   A. History of suicide attempts or thoughts, or history of self-harm
   B. Clear plan for suicide
   C. History of depression
   D. All of the above

13. Underline only the no transmission risk method to guarantee that HIV is not transmitted from mother to child through breast feeding
   A. Exclusively breast-feeding babies
   B. Using only breast milk supplements
   C. Mix- feeding a combination of breast milk and supplement to reduce the risk of infection
   D. Using a wet-nurse (asking another women to provide breast milk)

14. Reasons for you might need to refer a client to another services
   A. Social support
   B. Specialized medical care
   C. Legal support
   D. All, of the above
   E. None of the above

15. Treatment resistance can be transmitted to other.
   A. If the person became resistant to ARV
   B. If the person is not taking ARV regularly
   C. If the person is not taking ARV and became resistant to the virus and if he has unsafe sex or shared needle with un infected person the resistant virus is transmitted to un infected person
   D. If the person is not used condoms regularly

16. What are the things the counselor can do to maintain adherence to treatment, except.
    A. Discuss how ART works
    B. Discuss ways to reduce the side effects
    C. Discuss how the client may became resistance to treatment if adherence falls
    D. Suggest to change the medicine

17. Clients eligible for pre-exposure prophylaxis are:
    A. Sex workers
    B. MSM and Transgender people
    C. Discordant couple
    D. All of the above

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 with all clients too long
    A. Identifying what she want to change
    B. Identifying the advantages and disadvantages of making that change
    C. Setting a goal for change
    D. All of the above

19. Points to cover in providing pre-test information in groups except
    A. Basic information about HIV and treatment
    B. Basic information about HIV transmission
    C. Benefits and potential issues related to testing
    D. Individual personal risk assessment
    E. Demonstration and discussion of condom use
    F. HIV prevention information for injecting drug users

20. Which three steps should you follow to explore the potential barrier to, and constrains on partner disclosure for the client numbed 1, 2 and 3 for the relevant steps
    A. Use of open-ended questions
    B. Listen and lists the client's concerns
    C. Challenge the clients thinking
    D. Suggest to disclose to partner by their own

Annex 2

HIV counseling pre and post course questionnaire answer key

Serial no	Questions	Correct answer
1	QN 1	D
2	QN 2	D
3	QN 3	EXIT,SURVIVE,SUFFICIENT,ENTER
4	QN 4	B
5	QN 5	A
6	QN 6	D
7	QN 7	D
8	QN 8	D
9	QN 9	D
10	QN 10	D
11	QN 11	CDBA
12	QN 12	D
13	QN 13	B
14	QN 14	D
15	QN 15	D
16	QN 16	B
17	QN 17	D
18	QN 18	D
19	QN 19	E
20	QN 20	ABC

Annex 3

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

- Module 8: Supporting HIV disclosure

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

- Module 9: Counselling for treatment adherence

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

- Module 10: Counselling pregnant women, new mothers, and their partners

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

- Module 11: Counselling children and adolescents

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

- Module 12: Working with MSM and transgender clients

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

- Module 13: Counselling sex workers

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

- Module 14: Counselling substance users

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

- Module 15: Counselling health workers after accidental occupational exposure

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

- Module 16: Grief, bereavement, and loss counselling

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?

_____

_____

_____

Annex 4

ADHERENCE PILL COUNT CALCULATION

Adherence from Pill counts

$$\%\text{Adherence} = \frac{\#\text{ Of pills patient should have taken} - \#\text{of pills missed}}{\#\text{ of pills patient should have taken}} \times 100$$

Name of medication	Number of pills dispensed	Number of pills patient expected to have taken (A) (take into account whether patient has come early, on time or after the refill due date)	Number of pills patient actually took (take into account remaining pills and whether patient has come early, on time or after the refill due date)	Number of pills missed (B)	% Adherence $\frac{A - B}{A} \times 100$
E.g, D4T One tablet Taken twice Daily	60 (for 30 days)	54 (patient came in 3 days early)	50 (10 pills remaining when there should have been only 6)	4	$\frac{54-4}{54} \times 100$ =92 5%

Adherence could be <100% when patients have taken fewer pills than required or >100% when they have taken extra pills by mistake

Adherence from self-report

Adherence measured using a self-report will only reflect the adherence over the period of recall; e.g. 3 days in the table below.

Patients should be asked about missed doses: how many doses of TDF did you miss – yesterday, the day before that and the day before that (3 days ago)?

$$\%\text{Adherence} = \frac{\#\text{ of doses patient should have taken} - \#\text{of doses missed}}{\#\text{ of doses patient should have taken}} \times 100$$

Names of Medications	Yesterday (missed dose)	Day before yesterday (missed dose)	The day before that (3 days back) (missed dose)	% Adherence
E.g.d4T ONE TABLET Taken twice • Daily	0	1	1	$\frac{6-2}{6} \times 100=67\%$

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