HIV Counselling and Testing

A National Counsellor Training Manual
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Foreword

Uganda, like many countries in the world, is toiling on many fronts to meet the enormous demand for HIV/AIDS services. Uganda was first among sub-Saharan countries to be affected and in the early 1990s HIV prevalence reached nearly 30% in some major urban areas.

Through strong leadership and a proactive response, Uganda successfully brought that prevalence rate down. Today, the national prevalence of HIV is estimated at 7%.

The Ministry of Health recognizes that HIV counselling and testing (HCT) is the primary entry point to HIV/AIDS prevention and care services. The country began providing Voluntary Counselling and Testing (VCT) services in 1990 and VCT remains the main model of implementation. To date only 10-15% of Ugandans have had access to HIV counselling and testing services. However it is well documented from various studies that 70% of Ugandans would like to know their HIV status. Therefore we have over 60% unmet HCT need.

Working with partners to identify approaches to meet the urgent need for scale up of HCT services, the Ministry of Health recommends testing policies that take the burden of seeking services off the client and put it on the health system. This provider-initiated approach gives clients the ability to “opt-out” if they do not want to get tested. The routine offer of testing integrates HIV screening into mainstream health service delivery, and dramatically increases the number of individuals benefiting from targeted treatment, care and prevention services. The Government of Uganda is committed to assuring that all forms of HCT are backed by sound ethical principles of consent and confidentiality coupled with proactive campaigns to tackle stigma and discrimination.

As counselling and testing continues to evolve to increase access and meet the needs of different populations, it is important for all service providers to be flexible and knowledgeable about HCT.

This manual has been developed to equip HCT service providers with skills and knowledge necessary to deliver high quality services in a range of approaches and settings. It reflects the GOU and MOH evolving policies and is recommended as the resource for all HCT Training conducted in Uganda.

Dr. Elizabeth Madraa
Programme Manager
STD/ACP Ministry of Health
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## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACP</td>
<td>Aids Control Programme</td>
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<tr>
<td>AIC</td>
<td>AIDS Information Centre</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AIM</td>
<td>AIDS/HIV Model District Programme</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral Drugs</td>
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<tr>
<td>BCG</td>
<td>Bacille Calmette-Guérin (BCG)</td>
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<tr>
<td>CBO</td>
<td>Community-based Organization</td>
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<tr>
<td>CHCT</td>
<td>Couple HIV Counselling &amp; Testing</td>
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<td>CMV</td>
<td>Cytomegalovirus</td>
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<tr>
<td>COC</td>
<td>Combined Oral Contraceptive</td>
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<tr>
<td>DDHS</td>
<td>District Directorate of Health Services</td>
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<tr>
<td>DMPA</td>
<td>Depot medroxyprogesterone</td>
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<tr>
<td>DNA</td>
<td>Deoxyribosenucleic acid</td>
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<tr>
<td>DPT</td>
<td>Diphtheria Pertusis Tetanus</td>
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<td>ECP</td>
<td>Emergency Contraception Pills</td>
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<td>ELISA</td>
<td>Enzyme Linked Immunosorbtent Assay</td>
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<tr>
<td>FBO</td>
<td>Faith-based Organization</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GOU</td>
<td>Government of Uganda</td>
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<td>HBHCT</td>
<td>Home-based HIV/AIDS Counselling and Testing</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immune Deficiency Syndrome</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HSV</td>
<td>Herpes Simplex Virus</td>
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<td>INH</td>
<td>Isoniazid</td>
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<td>IUD</td>
<td>Intrauterine Device</td>
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<tr>
<td>LAM</td>
<td>Lactational Amenorrhea Method</td>
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<tr>
<td>LMIS</td>
<td>Logistics Management Information System</td>
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<tr>
<td>MAC</td>
<td>Mycobacteriumavium complex</td>
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<tr>
<td>MMJAP</td>
<td>Mbarara-Mulago Joint AIDS Project</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MTCT</td>
<td>Mother To Child Transmission</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
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<tr>
<td>NTLP</td>
<td>National TB/Leprosy program</td>
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<td>NVP</td>
<td>Nevirapine</td>
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<tr>
<td>OIs</td>
<td>Opportunistic Infections</td>
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<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>PHA</td>
<td>People living with HIV and AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother To Child Transmission</td>
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<td>PTC</td>
<td>Post Test Clubs</td>
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<td>PWDs</td>
<td>People living With AIDS</td>
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<td>RNA</td>
<td>Ribonucleic acid</td>
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<tr>
<td>RTC</td>
<td>Routine Testing and Counselling</td>
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<td>RTI</td>
<td>Research Triangle International</td>
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<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TASO</td>
<td>The AIDS Support Organisation</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TIMS</td>
<td>Training Information Monitoring System</td>
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<td>UHSBS</td>
<td>Uganda HIV Sero-Behavioural Survey</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on AIDS</td>
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<td>UPHOLD</td>
<td>Uganda Programme for human and Holistic Development</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WB</td>
<td>Western Blot</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Introduction

Although Uganda was among the first sub-Saharan countries to be affected by HIV/AIDS, its Voluntary Counselling and Testing (VCT) services and policies have lacked development. Currently, less than 10% of the 1.1 million people living with HIV in Uganda know their HIV status. A 2003 report prepared by the AIDS Information Centre (AIC) indicated that it had registered less than one million people who had tested for HIV in its 14 years of existence.

There is therefore need for service providers to employ other approaches like Routine Testing and Counselling (RTC), Home-based HIV Counselling and Testing (HCT) in addition to VCT. The United Nations and other institutions have been adapting testing policy to promote the offer of routine HIV Testing and Counselling by health care providers. With this approach, testing is provider-initiated rather than client-initiated, giving clients the ability to “opt-out” if they do not want to get tested. The routine offer of testing integrates HIV screening into mainstream health service delivery, dramatically increasing the number of individuals benefiting from improved treatment, care and prevention services. Accompanying this shift is a need for sound ethical principles of non-discrimination and confidentiality which should be coupled with proactive campaigns to tackle stigma and discrimination.

However, VCT still remains an important approach to HIV testing because many people do not come regularly to a health care setting but still need to know their HIV status.

As approaches for counseling and testing continue to evolve to meet the needs of different populations, it is important for counsellors to be flexible and knowledgeable about the different approaches. By working in a variety of settings, counselors help to ensure that people who are living with HIV or at increased risk have access to HIV counseling and testing. Counselors also ensure that people are referred for other prevention, care, treatment and support services that are available in their community.

This training manual is designed to equip service providers with knowledge, skills and attitudes needed to provide comprehensive HCT services. Beyond VCT, it includes RTC, HBHCT, Mandatory HIV Testing and Diagnostic HIV Testing. This manual also addresses issues of counseling special groups like children, repeat testers, people with disabilities and people who are sexually abused.

Overall Goal of the Training Programme

The overall goal of the HCT training programme is to increase the production and provision of high quality HIV counseling services through training of service providers.
Organization of this Manual

This manual is designed as a 3-week training programme, which includes a 1 week practicum assignment. This manual includes:

1. **Training plans for 2 weeks (12 days) of in-class learning:**
   This manual includes 10 modules which consist of 43 sessions.

2. **Suggested learning aids, (including technical publications, videos, sample commodities and MOH forms):**
   These aids will assist in reinforcing the material presented within this manual.
   - **Videos**
     Most District Offices have video equipment and selected video tapes. Trainers are encouraged to preview and select relevant video tapes ahead of time in order to prepare discussion questions that will guide group discussion. The following films are recommended for HIV counsellors:
     - Philly Lutaaya
     - AIDS and Development – A Window of Hope
     - Time to Care
     - Hope for your family’s future
   - **Commodities**
     Workshop facilitators should liaise with the District Directorate of Health Services (DDHS) office to ensure that sample commodities are available for demonstration, including ARVs, test kits, and family planning commodities.
   - **Technical Publications**
     Workshop facilitators need to have accurate information to explain the latest trends and research related to HIV. The following types of resources are essential:
     - Information on prevention: The Essentials of Contraceptive Technology: A Handbook for Clinical Staff;
     - Information on HIV prevalence: reports from UNAIDS, national surveys;
     - Policy documents Policies: HCT Policy Guidelines;
     - Treatment options and guidelines for the forms of treatment: National Antiretroviral Guidelines for Adults and Children; Sexually Transmitted Infections: Treatment Guidelines for use by Operational Level Health Workers in Uganda; National Policy Guidelines for Cotrimoxazole Prophylaxis for People with HIV/AIDS.
3. **Guidelines for planning and evaluating the practicum assignment**

Following the classroom instruction, the participants will be required to undergo a practicum with an experienced counsellor and conduct at least 40 hours of counselling sessions using different HCT approaches. Guidelines and resources are provided to help the facilitators support the participants on this assignment – though it should be noted that support and supervision for the practicum should be provided by the HCT Site Coordinator or Manager at the facility where the practicum takes place. The training team should coordinate with the practicum site staff to ensure that expectations are clear, that the client load is sufficient for the number of participants, and to share and discuss the guidelines for the practicum, including feedback to the participants.

4. **Tests to evaluate learning and skill achievement**

A test is included in this manual, to identify existing knowledge prior to the training and to assess knowledge and skills gained as a result of the training.*

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*To meet the minimum standards for HIV counselling, participants must attend 100% of the sessions with maximum participation. They should also achieve a score of at least 75% on the final exam of the course and complete their 1-week practicum.
How to Use this Training Manual Effectively

Facilitators using this manual should be trainers who are recognized by the Ministry of Health. They should be aware of the current national policies, implementation guidelines and priorities in Uganda, so that they can deliver accurate and current information to the participants. Facilitators should make possible participant centered activities such as role plays and case studies that provide opportunities for participants to prepare for the real world of counseling. In addition, facilitators should adapt the sessions to reflect changing priorities in the delivery of services.

Four facilitators (two full time and two part time) should work together to manage this training, for approximately 20 Counselor -participants (30 is the maximum). Each facilitator should all be familiar with the training sessions before the training, and divide responsibilities for facilitating each session. The facilitators will identify and bring in expert resources as needed. The facilitator’s notes will be compiled, together with a list of the participants, as a training report to be presented to the District HCT Coordinator and the funding agency.

Ideally, the facilitators should review and memorize the activities for each session, and prepare flip charts and other visual aids the day before. Instead of ‘teaching’ the group, the facilitators should use the manual to create opportunities for learning through discussion and group work, including role plays and case studies. To do so, the facilitators will need to:

- Explain the activities in each session to the participants and help them to do the activity properly.
- Facilitate group discussion, giving participants the opportunity to express their concerns, views and opinions.
- Ask participants’ what they have learned thus far and supplement additional learning points as needed.
- Summarize the key points from each session.

Learning methods

The learning methods used in the manual are designed for adult learners. In order to make the training programme interesting, a variety of methods have been presented to communicate different concepts. They include:

**Brainstorming**

This technique encourages active involvement from participants and builds on the knowledge and expertise of the participants. The facilitator’s role is to encourage all participants to say the first things that come to their minds and to keep ideas flowing.
To brainstorm effectively:

The facilitator asks a question on a topic. The participants are asked to use their personal experience and opinions to respond with as many ideas as possible. Each idea is recorded on a flip chart as they are given. There is no discussion of individual items as they are posted. The goal of brainstorming is to generate ideas. Afterwards, the group analyzes the information given. Brainstorming is often an effective way to introduce a topic, gathering knowledge from participants. For example, as the introduction to a session on counselling ethics and principles, a facilitator might invite a group to “brainstorm” a list of characteristics of an effective counsellor.

Case study

This technique encourages participants to analyze situations they might face and to decide how they would respond. This method encourages participants to think about problems, options and solutions to challenges they might experience.

To use case studies effectively:

The facilitator reads out a case study to describe a relevant situation or problem to be addressed. (The facilitator can also write the case studies on separate flip charts prior to the session.) Participants then work in small groups to discuss or in the large group to discuss the situation. The facilitator should have relevant discussion questions prepared on a flipchart, and encourage groups to seek alternative solutions.

Role play

This technique encourages participants to practice skills acquired during the training. Role plays are a safe way to rehearse skills and activities and they provide good preparation for real life situations. They are particularly well suited for practicing counselling and other communication skills.

To do role plays effectively:

The role may be set up by the facilitator or participants may make up their own roles. The description of a role play can be given verbally or by handout. Participants act out role plays and those who are not acting are tasked to observe specific behaviours. The facilitator then generates discussion and analysis of what was seen or felt by the observing participants. The actors are asked to step out of their roles and are also given a chance to describe the role they were playing as well as what they were doing and how they felt during the role play. All participants should discuss the specific lessons from the role play and how the lessons can be applied to their own professional work.
**Fish bowl**

This technique provides a physical structure that allows participants on the 'outside' to see something being done on the 'inside'. Participants may observe a role play on an actual situation.

**To use the fishbowl effectively:**

The participants work in small groups. A small group performs the action or activity in front of the larger group. The larger group is asked to observe and give feedback to the group performing. The group observing should be seated around the group performing the action.

**Lecturettes**

This technique involves short forms of lecture which are used to highlight key points of content. They are different from traditional lectures because they often include interactions with participants – sometimes they even seem like a discussion. They are useful as introductions to topics. Lecturettes should not last more than 15 minutes.

**To give lecturettes effectively:**

Review or read through the information that you want to present. Write an outline of the key points that you want to cover. You may want to put a few key points on a flip chart to help you and the participants focus on the main points and the flow of the lecturette. Think about visual aides that you can use to help your presentation and prepare them in advance. Identify points where you can involve participants through questioning, discussion, or other activities. Practice and time your lecturette to make sure that you have not prepared too little or too much. Remember, a lecturette is only effective if you are able to keep participants listening, involved and aware of the points you are trying to share.

**Buzz session or small group discussions**

This technique is a special type of small group that is used when participants need to discuss a topic, express opinions and reach consensus.

**To do a buzz session effectively:**

A participant or the facilitator introduces one main topic or question in the large group. The facilitator then divides the participants into smaller groups of three or four people. (Participants can be grouped where they are sitting into small clusters). Each participant then shares his or her view in the small group and it is recorded. Participants’ views are then consolidated within small groups and shared with the large group. These should be done quickly and efficiently.

**The above-mentioned methodologies are not exhaustive. The trainers should feel free to adopt any other new methods as appropriate.**
Guide to Preparation and Facilitation

HCT Counselling will bring up issues, feelings and beliefs that are deeply personal. A Counsellor Trainer must be aware of his/her own issues, feelings and beliefs around HIV/AIDS and at the same time, be non-judgmental of others. Three specific areas of concern are noted here:

Talking about HIV/AIDS

Although it can be difficult to manage your own personal feelings and beliefs about HIV/AIDS, risk behaviours and personal choices, the facilitators must present this information in a non-judgemental and professional way.

General guidelines:

- If you choose to share your experiences and opinions, make sure you tell the group that these are your personal ideas. Other people may not want to share and you need to accept this.
- Think about how you may feel about what you might do if someone in the group shares a personal story that reminds you of your own experience. Be aware that talking about these kinds of personal issues can bring up strong and uncomfortable feelings for you, as well as for participants in the training session.
- ‘Debrief’ with someone you trust after the session to talk about your feelings. This could be a friend, a family member, or a spiritual leader. Or, you could simply give yourself time, go for a walk or write your feelings down on paper.

Dealing with hostility

HIV/AIDS and risk behaviours can be very emotional and sensitive topics. Because of this, some participants may not want to talk about the issues, and may not like the way you present them. It is often difficult for people to confront their own attitudes and behaviour.

Since many people find change hard, it is natural for them to resist. To deal with resistance and hostility, you will need to be open about your expectations for the course. Do not get drawn into arguments, but instead encourage participants to debate the issues with respect for the facts and for each other.

General guidelines:

- A good facilitator should remain neutral and resist reacting to participants’ opinions.
- Be an active listener.
- Ask questions instead of making demands.
- Encourage open communication.
- Keep the group focused on the issue, not the individual.

**Dealing with the emotional aspects of the training**

Since HIV/AIDS affects almost everyone in some way, it can be difficult to talk about. One way of dealing with this is to establish norms at the beginning of the training. These could include:

- Personal opinions or stories expressed during the course discussions remain confidential.
- Everyone is allowed his or her opinions and everyone is allowed to respectfully disagree.
- There is no obligation to share personal experiences or history with the group. Participants should only do this if they feel comfortable doing so.

**General guidelines:**

- Remind the group that discussion about HIV/AIDS and related topics can bring up strong feelings of hurt, anger, and despair. These are normal feelings.
- Decide how the group can show support (i.e. allow individuals to share their feelings, take a break, and/or give people time to talk to someone privately, if needed).

**Preparing to Implement the Training Program**

Training teams must meet ahead of time to plan for the training program. Established training teams may need less time together, but all training teams should achieve the following outcomes prior to the training event itself:

**Specific Outputs of the Planning Day**

- A shared sense of purpose and intended results of the training.
- A training team with clear shared objectives; clear roles, responsibilities, norms and feedback mechanisms to jointly monitor the program and to build a strong foundation for transfer of learning.
- Assignment of sessions with a co-facilitation plan that ensure that both trainers have articulated roles during all parts of the session.
- Schedule of team meetings to review day’s work, to provide developmental feedback to each other, to capture key lessons evolving from use of the modules, and to identify key areas for follow-up.
- Completed list of materials, practicums and transport requirements for the programme.
Proposed Agenda for ‘Planning Day Meeting’

► **Welcome and overview of the day.**

► **Re-introductions.**
  Each team member takes a few minutes to recall and share the:
  - Purpose and general objectives of the training program; and
  - Sessions of the modules that they have conducted/practiced previously and what worked well for them in conducting those modules as well as any challenges in specific modules.
  Note: this quick review will help us understand what skills, interests, achievements and examples we have as a training team to share with participants!

► **Develop a vision for this training.**
  What do we need to do together to make this the best training event you have ever conducted?
  - Brainstorm ideas and record on flipchart… this can be the basis for ground rules for the training team and can be used in the end of the day debriefing.

► **Establish ground rules for the training team.**
  Include mobile phone issue; teamwork; shared responsibility for quality of training; being prepared before sessions; starting and ending on time; negotiating time with participants; how to interrupt/support/invite each other to comment; expectations for evaluation; daily meetings; and giving and receiving feedback.

► **Review roles and responsibilities.**
  - Select a team leader if one has not been designated.
  - Agree the roles of the team leader and co-trainers.
  - Review and agree who will handle administrative and logistical details.

► **Review logistics of the workshop.**
  Workshop logistics include:
  - Developing a timetable for the workshop,
  - Clarifying assignments for trainers (*see note on following page),
  - Reviewing of any off-site activities, and
  - Coordinating special appearances/guests.
Review the evaluation plan for the training and assign duties.

 Assign members of the team for:

- Pre- and post-test administration and marking.
- Daily recaps with participants.
- Final Participant Evaluation.
- Facilitator Report.

Review the Supervisor’s Checklist for Assessing the Standard of HIV/AIDS Counselling and identify any specific areas in which individual trainers would like feedback (The Supervisor’s Checklist is included in the Annex.)

* Remember to assign one person on the team to request and to arrange transport of the necessary training materials; this includes:

- Markers
- Masking tape
- Flip charts
- Notebooks
- Pens
- Pencils
- Newsprint
- Laptop computer
- Projection equipment (LCD, overhead projector, etc.)
- Films: Philly Lutaaya; AIDS and Development: A Window of Hope
- Video deck
- Marking scheme for pre-test evaluation: HIV Counselling Training Assessment Tool
- Photocopies of MOH forms; included in Annex
Introduction to the HCT Course

<table>
<thead>
<tr>
<th>Session 1:</th>
<th>Course Overview and Introductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2:</td>
<td>Assessing Participants’ Knowledge and Attitudes</td>
</tr>
</tbody>
</table>

The purpose of these sessions is to create a conducive environment for workshop trainers to assess participants knowledge and attitudes related to HCT in order to adapt the training accordingly.
Introduction to the Training Programme

Session 1: Course Overview and Introductions

Time: 1 hour.

Methods: Lecturette, introductions, discussion, and brainstorming.

Materials: Participant manuals, nametags.

Objectives:
By the end of this session, participants will have:
- Acquainted themselves with one another.
- Shared their expectations, linking them with the workshop objectives and approach.

Activities:
- Lecturette: Welcome and introduction to workshop.
  
  Instructions:
  - Welcome participants.
  - Review the purpose, duration and structure of the training.

Notes for Facilitator:
This training is designed to strengthen HCT services to respond to the needs of both HIV negative and HIV positive clients. It includes two weeks of in class instruction, followed by a one week practicum.
2 Introductions.

Instructions:
- Ask participants to introduce themselves with the following information:
  - Name, occupation
  - Workplace
  - What do you like best about your job?
  - What has been your past experience in working with people who are interested in HIV testing?
  - What do you hope to gain from this course?
  - What are your fears about this course?

The last two questions will provide the participants expectations. These should be captured on a flipchart. One trainer can facilitate and another can record.

3 Discuss: Participants’ expectations and workshop objectives.

Instructions:
- Post workshop objectives and compare with participants’ expectations.
- Identify the expectations that cannot be met directly by the workshop and explain why. Discuss other opportunities for meeting those expectations.
- Respond to questions and comments.

Notes for Facilitator:

The following objectives should be placed on a flip chart prior to the session and posted on the wall throughout the training:

Course aim:
To equip participants with knowledge and skills in HIV Counselling and Testing (HCT) to enable them offer quality HCT services to individuals, couples, families and the community.
Course objectives

By the end of the course, the participants will be able to:

- Provide up-to-date information on HIV/AIDS to the clients, family members and the community.
- Offer quality counselling services in HIV/AIDS prevention, care and support.
- Offer HCT using the different approaches and protocols in Uganda, including Voluntary Counselling and Testing (VCT), Routine Testing and Counselling (RTC), Home Based HCT (HBHCT) and Post Exposure Prophylaxis (PEP).
- Refer clients for HIV/AIDS related prevention, care and support services.

Develop group norms for the workshop.

Instructions:

- Ask the group to develop a list of norms for the workshop. Make sure that the norms include remaining open and non-judgemental when sharing values and experiences that frequently arise in the context of HIV/AIDS.
- Write these on a flipchart and post throughout the training. Refer to them periodically to ensure that they are being followed.
Session 2: Assessing Participants’ Knowledge & Attitudes

Time: 1 hour.

Methods: Pre course assessment, values clarification exercise.

Materials: Copies of HIV Counselling Training Assessment Tool (see page 259) and marking scheme (available from MOH).

Objective:

By the end of this session, participants will have:

- Provided information that will enable trainers to assess their knowledge levels, beliefs, and attitudes. This will enable the facilitators to adapt the workshop sessions accordingly.

Activities:

1. Pre-Course Assessment.

   Purpose:
   - To help the facilitator and participant identify strengths and areas for learning.
   - To measure changes in the level of knowledge and skills gained as a result of the training.

   Instructions:
   - Distribute course assessment.
   - Each participant completes the test individually.
   - Collect the tests – make sure that each person has recorded their name clearly. (Some trainers prefer to assign numbers).
   - While the papers are being marked, the participants will discuss their experience in delivering HIV/AIDS-related services. Focus on areas of both confidence and uncertainty.
   - Note common areas of difficulty and record the individual scores on a flipchart to share and compare with participants.
   - Return the tests to the participants and explain that the results will be used by the facilitators to adapt the training to their needs.
Review the results of the pre-test together with the other facilitators, using the scores to determine points of emphasis in the training.

Notes for Facilitator:

The pre-course assessment tool shall be reviewed from time to time and adapted as new information becomes available.

Exercise: Values clarification activity, where do you stand?

**Purpose:**
- To identify and understand the different beliefs and attitudes toward HIV/AIDS and HCT services.

**Instructions:**
- Draw a continuum (or introduce an imaginary line) on the floor with masking tape to illustrate strongly agree on one end and strongly disagree on the other.
- Read the first statement and then ask the participants to place him/herself along the physical continuum.
- Participants give reasons for having placed themselves where they did along the continuum. The facilitator remains neutral but takes note of responses.
- Bring the activity to a close by communicating that different people may have different attitudes and beliefs towards HIV, AIDS and HCT services. During the workshop, facilitators and participants will be working towards mutual understanding and acceptance.
- Ask participants how different values might affect one’s approach to clients and how counsellors can remain open to clients with differing values and beliefs.

Notes for Facilitator:

Continuum:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Unsure</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Sample value statements are provided on the following page.)
Sample value statements
(Select some, but use those that will be the most challenging to your participants).

- Women with HIV infection should not have children.
- People with AIDS should be allowed to continue work.
- AIDS is mainly a problem of people with immoral behaviour.
- People with HIV infection should be isolated to prevent further transmission.
- It is a collective responsibility to care for people with HIV infection.
- I would feel uncomfortable to care for people with HIV infection.
- I would feel uncomfortable discussing sexuality with a person of the opposite sex.
- It is alright for men to have sex before marriage.
- School children should not be educated about safer sex.
- Women should never have extra-marital sexual relations.
- It is difficult for male counsellors to talk to women about condom use.
- HIV infected pregnant women should abort their foetus.
- HIV infected women should not breast feed their infants.
- Unmarried persons should not have sex.

Adapted from: Save the Children UK, Care for Children Infected and those Affected by HIV/AIDS.

Key messages:
- Our knowledge, beliefs, and attitudes can affect the way that we deal with others.
- Good counsellors do not allow their own attitudes, values, and beliefs to influence the counselling process.

# Module 1

## HIV/AIDS and Commonly Related Conditions

<table>
<thead>
<tr>
<th>Session 1:</th>
<th>Basic Facts: Definitions, Modes of Transmission, Magnitude and Trends of HIV and AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2:</td>
<td>Progression of HIV, Effects of HIV on the Immune System</td>
</tr>
<tr>
<td>Session 3:</td>
<td>Vulnerability to HIV</td>
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<td>Session 4:</td>
<td>Relationship Between STI and HIV</td>
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<td>Session 5:</td>
<td>Relationship Between TB and HIV</td>
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<td>Session 6:</td>
<td>HIV and Family Planning</td>
</tr>
</tbody>
</table>

The purpose of this module is to provide participants with accurate and up-to-date information on HIV/AIDS and commonly related conditions to facilitate information sharing.
Module 1: HIV/AIDS and Commonly Related Conditions

Session 1: Basic facts: Definitions, Modes of Transmission, Magnitude and Trends of HIV and AIDS

Time: 1 hour and 30 minutes.

Methods: Brainstorming, lecturette.


Objectives:
By the end of this session, participants will be able to:
- Explain the meaning and difference between HIV and AIDS.
- Explain the different modes, co-factors and clarify on myths about HIV transmission.
- Describe the magnitude and trends of HIV/AIDS at the global and national level.

Activities:
1. Review session objectives.
2. Brainstorm.

Instructions:
- Participant brainstorm on the meaning of HIV, AIDS, HIV infection and HIV disease.
- Facilitator should correct and clarify all myths and misconceptions on HIV/AIDS.
Notes for Facilitator:

Meaning of HIV

HIV is a virus that causes AIDS.

- H: Human (only attacks human beings)
- I: Immuno-deficiency (lowers immunity)
- V: Virus (Germ)

HIV infection is when the individual has the virus in blood but may not necessarily have any symptoms and signs.

HIV disease is when there are some symptoms and signs due to infection with HIV but not enough to conclude that it is AIDS.

Meaning of AIDS

AIDS is a group of diseases acquired as a result of a weakened defence (immune) system.

- A: Acquired (something you get)
- I: Immune (protection against disease)
- D: Deficiency (lack of)
- S: Syndrome (a group of different signs and symptoms)

AIDS is when the individual has overwhelming symptoms and signs and meets the WHO clinical case definition for AIDS which is two major and one minor symptom for adults and two major and two minor symptoms for children.

Modes of HIV transmission

- Un-protected sexual intercourse with an HIV infected person. 80% of HIV infections are transmitted through this mode.
- An HIV infected mother to her child (referred to as vertical transmission). This mainly occurs during pregnancy, labour, delivery and after birth through breast milk. Fifteen percent of HIV infections are transmitted through this mode.
- Infected blood and blood products e.g. through the contaminated skin piercing instruments e.g. needles, razor blades, safety pins, knives; Organ Transplants. Five percent of HIV infections are transmitted through this mode.
Myths and misconceptions about HIV and AIDS

- The virus was made in the laboratory to kill Africans.
- AIDS is caused by witchcraft
- People with blood group “O” do not get HIV.
- If a woman immediately washes her genital parts with Coca cola soda, she will not get HIV.

Factors for HIV transmission

In females:
- Pregnancy
- Oral contraceptives
- Cervical ectopy
- Cervicitis
- HIV disease state
- CD4+ cell counts
- Viral Load
- Viral type
- Nutrition deficiency
- Specific STDs
- Mucosal abrasion
- Douching/drying agents

In males:
- HIV disease stage
- CD+ count
- ART
- Gonorrhoea
- Urethritis
- Leukocytespermia
- Viral Load
- Viral type
- Nutrition deficiency
- Circumcision
- Mucosal abrasion

Other enhancing factors for transmission
- Sex during menstruation
- Many sexual partners
- Sex with an individual with HIV who has a primary infection

Interconnected factors that influence the sexual spread of HIV

<table>
<thead>
<tr>
<th>Partners</th>
<th>Host (Susceptibility)</th>
<th>Infectiousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence</td>
<td>Genital tract infection</td>
<td>Stage of illness</td>
</tr>
<tr>
<td>No. of sex Partners</td>
<td>Genital M/flora</td>
<td>Immune status</td>
</tr>
<tr>
<td>No of new Partners</td>
<td>STDs</td>
<td>Viral Load and Type</td>
</tr>
<tr>
<td>Sex practices</td>
<td>Genital trauma</td>
<td>ART</td>
</tr>
<tr>
<td></td>
<td>Contraceptives</td>
<td>STDs</td>
</tr>
<tr>
<td></td>
<td>Circumcision</td>
<td>Genital tract inflammation</td>
</tr>
</tbody>
</table>
Lecturette: Magnitude of HIV/AIDS at the National level.

Magnitude of HIV/AIDS at the Global level.

Instructions:
- Use current surveillance report and results of Uganda HIV Sero-Behavioural Survey (UHSBS) to provide current information on the state of the epidemic.

Session evaluation: Question and answer.

Key messages
- HIV is transmitted mainly through sexual intercourse and mother to child transmission.
- Seventy percent of the HIV infections are in sub-Saharan Africa where Uganda lies.
Module 1: HIV/AIDS and Commonly Related Conditions

Session 2: Progression of HIV, and Effects of HIV on the Immune System

Time: 1 hour and 30 minutes.

Methods: Brainstorming, lecturette


Objectives:

By the end of this session, participants will be able to:

- Explain the effects of HIV on the immune system.
- Explain the stages of HIV infection in the human body.
- Explain the signs and symptoms of HIV infection.
- Explain the natural progression of HIV in the body.

Activities:

1. Review session objectives.
2. Brainstorm: What happens when HIV enters the human body?
3. Lecturette: Explaining the effects of HIV in the body.
Notes for Facilitator:

Explaining the Effect of HIV in the Body

HIV belongs to a group of organisms called retroviruses. When a virus enters the body, it has to find a host cell in which to replicate. This is because all viruses depend on other living organisms for survival.

HIV infects cells in the immune system and the central nervous system. The main cell HIV infects is called a T helper lymphocyte. The T helper cell is a crucial part of the immune system, and co-ordinates the actions of other immune system cells. A large reduction in the number of T helper cells seriously weakens the immune system. HIV infects the T Helper cell because it has the protein CD4 on its surface, which HIV uses to attach itself to the cell before gaining entry. This is why the T helper cell is sometimes referred to as a CD4+ lymphocyte.

When HIV attacks the body, it enters, lives and multiplies in the body’s defence cells (CD4 cells and macrophages). The infected cells continue to produce many HIV babies that leave the cell and invade new defence cells. When exposed to HIV, the body’s immune system makes certain HIV antibodies and other specific immune cells to fight the virus and cells infected with the virus. It is difficult for the body to find and destroy all the viruses without killing its own cells. For a long time the body is able to make new defence cells to replace those that have died and the body remains well. After sometime, the body cannot replace defence cells fast enough, so the virus slowly overwhelms the defence system leaving the body weak and defenceless against other infections. The person then develops symptoms of HIV infection and progresses to AIDS.

HIV Life Cycle
**The Stages of HIV Progression**

Progression of HIV: HIV infection and its effects on the immune system can generally be broken down into four distinct stages: primary infection, clinically asymptomatic stage, symptomatic HIV infection, and progression from HIV to AIDS.

**Stage 1: Primary HIV infection**

During this stage, HIV is present in the blood but antibody laboratory tests cannot detect it for up to three months. This stage is divided into two parts:

**Entry / point of infection:** This is the time when the virus enters the body. The person has no signs or symptoms of the infection but can pass on the infection to others.

**Window period:** During this time, HIV is multiplying in the body but cannot usually be detected by antibody laboratory tests because the body has not produced sufficient antibodies. Frequently, this occurs for a period of time between two weeks and three months.

This stage of infection is often accompanied by a short flu-like illness. In up to about 20% of people the symptoms are serious enough to consult a doctor, but the diagnosis of HIV infection is frequently missed. During this stage there is a large amount of HIV in the peripheral blood and the immune system begins to respond to the virus by producing HIV antibodies and cytotoxic lymphocytes that keep viral replication in check. This process is known as sero-conversion. If an HIV antibody test is done before sero-conversion is complete then it may not be positive.

Note: Sero-conversion means that the person’s immunity has responded to the infection and produced HIV antibodies. As already mentioned, Some people might experience symptoms while they are sero-converting, such as fever, cough, sore throat, night sweats, lymphadenopathy (enlarged lymph nodes), skin rash and headaches. An antibody test taken will be positive.

**Stage 2: Clinically Asymptomatic Stage**

This stage lasts for an average of ten years and, as its name suggests, is free from major signs and symptoms, although there may be swollen glands. The time period ranges from two months to several years and varies from person to person. The length of time a person stays in good health depends on one’s immunity as well as other factors such as poverty, access to health care, nutritional status and stress.
The level of HIV in the peripheral blood drops to very low levels but people remain infectious and HIV antibodies are detectable in the blood, so antibody tests will show a positive result.

Research has shown that HIV is not dormant during this stage, but is very active in the lymph nodes. Large amounts of T helper cells are infected and die and a large amount of virus is produced.

A test is available to measure the small amount of HIV that escapes the lymph nodes. This test which measures HIV RNA (HIV genetic material) is referred to as the viral load test, and it has an important role in the treatment of HIV infection.

**Stage 3: Symptomatic HIV infection**

Over time the immune system loses the struggle to contain HIV. This is for three main reasons:

- The lymph nodes and tissues become damaged or 'burnt out' because of the years of activity;
- HIV mutates and becomes more pathogenic, in other words stronger and more varied, leading to more T helper cell destruction;
- The body fails to keep up with replacing the T helper cells that are lost.

As the immune system fails, so signs and symptoms develop. Initially many of the signs and symptoms are mild, but as the immune system deteriorates the signs and symptoms worsen. Symptomatic HIV infection is mainly caused by the emergence of opportunistic infections and cancers that the immune system would normally prevent. These can occur in almost all the body systems. Treatment for the specific infection or cancer is often carried out. Unless HIV itself can be slowed down the symptoms of immune suppression will continue to worsen.

During this stage, the HIV is in the body cells and laboratory tests can detect the virus. This phase can be divided into two parts:

**Early symptomatic HIV disease:** At this stage, the symptoms that appear include fever, unexplained weight loss, recurrent diarrhoea, fatigue, headache and loss of appetite. Cutaneous manifestations like seborrheic dermatitis, folliculitis, recurrent herpes simplex infections and oral hairy leukoplakia may occur. Other signs/ symptoms of opportunistic infections (OI) include sores (in or around the mouth or in the genital areas), continuous or severe headaches, unclear sight or other changes in vision, vaginal discharge, vaginal burning or itching, irregular menstrual bleeding or continuous abdominal pain.

Note: Some conditions and illnesses can present in a similar way to HIV, especially when the body’s immunity is low (e.g. malnutrition, TB, or when the patient is on cancer drugs). Counsellors should not assume that a person is HIV positive, even if they present with symptoms similar to those associated with a weakened immune system.
Viral replication leads to destruction of CD4 cells and progressive immunodeficiency. As immune depression progresses, the infected person becomes susceptible to other OIs. During this period the CD4 T-cells count continue to come down and peripheral blood CD4 T-cell count is usually above 500 cells/mm³. At this stage, the patient is still capable of taking care of themselves.

**Late symptomatic HIV disease:** As the CD4 count falls lower than 200 cells/mm³, the risk of developing AIDS related opportunistic infections or malignancy is very high. Such infections include: Pneumocystis jiroveci pneumonia (formerly called PCP), Tuberculosis (TB), Kaposi Sarcoma (KS), Toxoplasma encephalitis, Cryptococcosis, disseminated mycobacterium avium complex (MAC), Esophageal candidiasis, Cryptosporidiosis, Cytomegalovirus (CMV), Isosporiasis and Lymphoma.

**Stage 4: Progression from HIV to AIDS**

As the immune system becomes more and more damaged the illnesses that present become more and more severe leading eventually to an AIDS diagnosis.

An AIDS diagnosis is confirmed if a person with HIV develops one or more of a specific number of severe opportunistic infections or cancers. Such an infected person presents syndromic characteristics of severe immune depression. However people can still be very ill with HIV but not have an AIDS diagnosis.

At this stage of advanced HIV disease, the CD4 cell count is less than 50 cells/mm³. ART substantially increases the survival among patients with AIDS.

Note: Opportunistic infections are illnesses and some cancers that can seriously harm someone with a weakened immune system or a person living with HIV. Normally, the body’s immune system defends us against harmful germs, which are all around us. However, people with HIV may not have enough protection against these germs so they have more “opportunity” to become ill.

**Progression and Natural History of HIV/AIDS**


**Natural Progression of HIV Infection**

**Infection**

- **Seroconversion** (HIV+)

**Window Period**

- **Asymptomatic Period**

**Minor Signs / Symptoms**

**Severe Signs / Symptoms**

**HIV related Illness**

**AIDS**

**Death**

Adapted from: Ministry of Health Facilitator’s Manual for Training Health Workers in Counselling for PMTCT Service Provision, October 2004.
Film and Discussion: “Philly Lutaaya” (or other similar film).

**Purpose:**
- To learn what happens to the immune system at the various phases and stages of HIV progression.

**Instructions:**
- After watching the film, ask participants to identify the different phases and stages and discuss what happened in the film.

**Notes for Facilitator:**

**WHO Staging for HIV Infection and Disease in Adults**

**Clinical Stage 1:**
- Asymptomatic
- Persistent generalised lymphadenopathy

Performance Scale 1: Asymptomatic, normal activity

**Clinical Stage II:**
- Weight loss less than ten percent of body weight
- Minor mucocutaneous manifestations (seborrhoeic dermatitis, prurigo, fungal nail infections, recurrent oral ulcerations, angular stomatitis)
- Herpes Zoster within the last five years
- Recurrent upper respiratory tract infections, e.g., bacterial sinusitis

And/or Performance Scale 2: Symptomatic but normal activity

**Clinical Stage III:**
- Weight loss is more than ten percent of body weight
- Unexplained chronic diarrhoea for more than 1 month
- Unexplained prolonged fever, intermittent or constant, for more than 1 month
- Oral candidiasis
- Oral hairy leukoplakia
- Pulmonary tuberculosis within the past year
- Severe bacteria infections such as pneumonia, pyomyositis

And/or Performance Scale 3: Bed-ridden for less than 50% of the day during the last month
WHO Staging for HIV Infection and Disease in Adults (continued)

Clinical Stage IV:
- HIV wasting syndrome – weight loss of more than ten percent, and either unexplained chronic diarrhoea for more than one month, or chronic weakness or unexplained prolonged fever for more than one month
- Pneumocystis carinii pneumonia
- Toxoplasmosis of the brain
- Cryptosporidiosis with diarrhoea for more than 1 month
- Extrapulmonary cryptococcosis
- Cytomegalovirus (CMV) disease of an organ other than liver, spleen or lymph nodes
- Herpes simplex virus (HSV) infection, mucocutaneous for more than one month, or visceral of any duration
- Progressive multifocal leukoencephalopathy (PML)
- Any disseminated endemic mycosis such as histoplasmosis, coccidioidomycosis
- Candidiasis of the oesophagus, trachea, bronchi or lungs
- Atypical mycobacteriosis, disseminated
- Non-typhoid salmonella septicaemia
- Extrapulmonary tuberculosis
- Lymphoma
- Kaposi’s sarcoma
- HIV encephalopathy – disabling cognitive and/or motor dysfunction interfering with activities of daily living, progressing slowly over weeks or months, in the absence of concurrent illness or condition other than HIV infection that could account for the findings

And/or Performance Scale 4: Bed-ridden for more than 50% of the day during the last month

Session evaluation game: Finishing the Sentence.

Purpose:
- To give everyone an opportunity to reflect on one thing that they have learned.

Instructions:
- Ask each participant to complete the sentence: “In this session, I learned that…”
- Refer to the session objectives to confirm that all of the goals were achieved.
- Write as many sentences as possible.

Key messages:
- HIV entry and progression in the body to full blown AIDS is a process.
- People living with HIV need to adopt preventive measures to reduce the risk of getting opportunistic infections.
### Session 3: Vulnerability to HIV

**Time:** 1 hour.

**Methods:** Brainstorm, group discussion.

**Materials:** Selected surveillance reports on trends of HIV infection by vulnerability.

### Objectives:

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

- Explain the meaning and concept of vulnerability in relation to HIV transmission
- Define the terms adolescence, puberty, and young people
- Explain the changes that occur during adolescence
- Explain reasons/factors that make females and young people more vulnerable to HIV infection.

### Activities:

1. Review session objectives.
2. Brainstorm definitions: Vulnerable.
   - Adolescence.
   - Puberty.
   - Young people.
   - Changes that occur during adolescence.
Notes for Facilitator:

Vulnerable:

Vulnerable is to be prone to or have higher risks of contracting HIV.

Adolescence:

Adolescence is the transitional period in human development from childhood to adulthood. It begins at the age of 10 to 12 years and continues till the age of 18 to 19 years. Girls may start adolescence at an earlier stage compared to their male counterparts. It occurs at different speeds in different people and is always marked by profound changes in the individual. At adolescence, an individual acquires biological maturity, psychological growth and economic independence.

Puberty:

Puberty describes the changes that occur during adolescence. This could be physical, physiological, emotional, and behavioural changes.

Young Person:

Young Person is a boy or girl aged between 10-24 years.

Changes that occur from childhood to adolescence:

The changes that occur from childhood to adolescence include the physical, sexual, and behavioural changes. Examples of physical, behavioural, and sexual changes:

Physical changes:

- Appearance of pubic and armpit hair.
- Voice changes and becomes deep in males.
- Sudden increase in growth.
- Penile growth.
- Weight gain.
- Enlargement of sexual organs/ body shape.
- Enlargement of breasts/ hips.
- Menstruation begins.
- Wet dreams begin.
- Production of sperm by males.
- Acne develops (pimples).
Sexual changes:
- Sexual arousal is awakened.
- Masturbation.
- Sexual experimentation.
- Sexual attraction begins.

Behavioural changes:
- Peer group formation.
- Independence from family members.
- Habit formation.

Group discussion: Why are females more vulnerable to HIV infection than men?

Why are young people vulnerable to HIV and other STIs?

Instructions:
- Form four small groups.
- Two groups discuss factors that contribute to female vulnerability and the other two discuss vulnerability factors for young people.
- One group will develop a list of reasons to explain how these factor increase female vulnerability to HIV more than their male counterparts; another group will develop a list of reasons why young people are vulnerable to HIV and other STIs.
- Groups present to the large group.
- Record responses and build on what participants have presented. Use illustrations of the male and female reproductive organs to emphasize the physiological reasons that increase women’s susceptibility to HIV infection, e.g. women’s genitalia have a large surface area, tenderness of the vaginal lining.
Notes for Facilitator:

Factors that increase vulnerability of females to HIV compared to males:

1. Physiological and biological factors:
   - Female genitalia cover a much larger surface area than the male penis, giving opportunity for HIV to enter the body.
   - The vagina is a cavity. When semen is deposited there, it stays there for a long time, increasing the chances of HIV crossing over the thin mucosal lining.
   - Child bearing exposes the woman more to HIV infection, i.e. pregnancy weakens the vaginal linings, increasing the likelihood of HIV crossing over.
   - Immature vaginal canal and cervix in young women are fragile and more likely to be affected by the trauma of sex, leaving tears that allow for transmission of HIV.
   - It is more difficult to detect the presence of sexually transmitted infections (STI) in women than in men, which makes them more vulnerable to HIV.
   - Vaginal cleansing practices in some cultures lead to trauma and cuts to the vagina which makes it easier to acquire HIV.

2. Socio-cultural factors:
   - Social and economic dependence of women to men.
   - Risky cultural practices e.g. widow inheritances.
   - Lack of access to information on HIV/AIDS.
   - Sexual abuse and exploitation women e.g. rape.

3. Economic factors:
   - Poverty among women.
   - High levels of illiteracy among women.

Factors that contribute to vulnerability of young people to HIV and other STIs:

   - As a result of sexual arousal the young person may tend to experiment on sex, which may not be protected (adventurous).
   - Most adolescents like to explore and respond to their body changes, or practice what they read, hear, or see from newspapers, magazines, TV and radio.
   - Alcohol and drugs.
   - Risky cultural practices like early marriages.
   - Less power to negotiate for safer sex.
   - Poverty.
   - Peer pressure.
Lecturette: Misconceptions: childhood to adolescence.

Instructions:
- Give a lecturette on the common misconceptions or myths associated with the transition from childhood to adolescence.
- Ask participants what other misconceptions, or myths, they have heard from their interactions with young people in their community and make clarifications accordingly.

Notes for Facilitator:

There are a lot of misconceptions associated with these changes that occur from childhood to adolescence which young people get from their peers.

For example:
- Erections mean one should have sex.
- Menstrual cramps can be healed with sex.
- Wet dreams mean that one should have sex.

If these "myths" are not clarified, they can lead to risky behaviour.

Session evaluation: Question and answer.

Instructions:
- Use question and answer method to evaluate the session.
  - What do we mean by vulnerability?
  - Why are females more vulnerable to HIV infection than men?
  - Why are young people more vulnerable to HIV infection?
- Wrap up by clarifying on any ideas that were not well answered by the groups in the evaluation method.

Key messages:
- Females and young people are more vulnerable to HIV due to physiological, biological, social, cultural and economic factors.
Module 1: HIV/AIDS and Commonly Related Conditions

## Session 4: Relationship between STI and HIV

**Time:** 2 hours and 30 minutes.

**Methods:** Group discussion, lecturette, brainstorm.

**Materials:** Sexually Transmitted Infections: Treatment Guidelines for use by Operational Level Health Workers in Uganda.

### Objectives:

By the end of this session, participants should be able to:

- Describe causes and types of STIs.
- Describe the syndromic management of STIs.
- State preventive measures to the spread of STIs.
- Describe the relationship between STIs and HIV.

### Activities:

1. Review session objectives.

2. Lecturette: Causes and types of STI. Syndromic management and prevention of STIs.

### Notes for Facilitator:

Refer to STI Treatment Guidelines.
Brainstorm: Relationship between STI and HIV.

Notes for Facilitator:

Relationship between STI and HIV
- Definition of Sexually Transmitted Infections (STIs): diseases that one gets from having unprotected sex with an infected sexual partner.
- A person with an STI has a higher risk of HIV infection. Therefore STIs are co-factors for HIV transmission.
- In 85% of cases, HIV is sexually transmitted.
- Both HIV and some STIs can be transmitted from mother to child.
- Both need counselling as part of its management.
- Both have social consequences like stigma, divorce, and domestic violence.
- Both can be prevented using the same methods like abstinence, being faithful and condom use,
- HIV infection aggravates signs and symptoms and complications of STIs. It can also complicate STI management.

Session evaluation: Question and answer.

Key messages:
- Both HIV and STIs are preventable.
- Both HIV and some STIs are transmitted in the same way.
- Counselling is a common element in the management of both HIV and STIs.
Module 1: HIV/AIDS and Commonly Related Conditions

Session 5: Relationship between TB and HIV

Time: 1 hour and 30 minutes.

Methods: Lecturette, brainstorm

Materials: National TB Treatment Guidelines

Objectives:
By the end of the session, participants will be able to:

- Explain what Tuberculosis (TB) is.
- Explain the transmission of TB.
- Describe signs and symptoms of TB.
- Explain how TB can be prevented.
- Explain the relationship between TB and HIV/AIDS and its implications.

Activities:

1. Review session objectives.
2. Brainstorm: What is TB?
Notes for Facilitator:

What is TB?

- Tuberculosis is a disease of the lungs caused by mycobacterium (germ) that is spread from an infected person through the air when he or she coughs, sneezes or talks. It can attack other parts of the body like the bones, kidney and spine.
- Although TB can be cured, it is one of the most common causes of HIV related illness and death.
- People who are living with HIV need early diagnosis and treatment of TB to protect their health and the health of their family and other contacts.
- People with HIV are at a greater risk of becoming infected with TB due to their weakened immune system.
- Half of people who have TB are also HIV+. It is very important that everyone with TB get tested for HIV.


Notes for Facilitator:

How is TB transmitted?

- TB can be transmitted through inhalation (through droplet production such as sneezing, coughing, or close contact) or by ingestion (through drinking TB infected milk or eating TB infected meat).
- Risk of infection is increased by presence of smear positive source, close and prolonged contact and indoor exposure.

What are the signs and symptoms of TB?

- Prolonged cough for more than three weeks.
- Weight loss.
- Producing sputum.
- Coughing up blood.
- Chest pain.
- Profuse night sweats.
- Loss of appetite.
- Even fevers.

Note: Some of these signs and symptoms are common to other conditions as well. A person can be infected with TB and not show any symptoms, which is known as the latent stage of TB infection. If the person is not treated during the latent stage, the infection can progress to the point where the person begins to show symptoms, which is the disease stage.
Prevention of TB includes:

- Screening and early treatment of TB among HIV positive individuals to prevent spread to others.
- Treatment of latent TB Isoniazid (INH) in those who are HIV positive. This will prevent latent TB progressing to active TB disease. This is not yet national policy in Uganda, but settings with good case detection and cure rates have started TB preventive therapy programs. National Tuberculosis and Leprosy Programme (NTLP) and AIDS Control Programmer (ACP) are also supporting the scaling up of screening programs for TB in all HCT sites.

Prevention of TB includes: (continued)

- Improving ventilation in the house.
- Encouraging someone with persistent cough to seek diagnosis.
- Helping remind the person on TB drugs to complete the full medication.
- Adopting a healthy lifestyle—no smoking, little or moderate drinking, good nutrition.
- Practicing good hygiene measures (eg. TB infected people should avoid spitting anywhere. Spit in a container and bury sputum or burn it, encourage people to cover their mouth when coughing).
- Make sure children receive Bacille Calmette-Guerin (BCG) at appropriate moment.
Discussion: The links between HIV and TB and its implications.

Notes for Facilitator:

Links between HIV and TB:

- Both HIV and TB suppress immunity.
- The two diseases represent a deadly combination because they are more destructive together than either disease alone.
- TB progresses faster in HIV-positive people.
- TB occurs earlier in the course of HIV infection than many other opportunistic infections.
- Each disease speeds up the progress of the other, and TB considerably shortens the survival time of people living with HIV/AIDS.
- TB in HIV-positive people is almost certain to be fatal if undiagnosed or left untreated.
- TB kills up to half of all AIDS patients worldwide. People who are co-infected with HIV and TB are up to 50 times more likely to develop active TB in a given year than people who are HIV-negative.
- HIV infection is the greatest risk factor for the progression of latent TB into active TB, and TB can accelerate the progress of HIV.
- Many HIV-positive people in developing countries develop TB as the first sign of the later stages HIV.
- When the immunity level drops due to HIV, smear negative pulmonary and extra pulmonary TB is more common.
- Diagnosis of smear negative TB in a HIV positive person is difficult because the clinical signs of TB are also common in HIV patients without TB (e.g. chronic cough, fever and weight loss).
- When an HIV/AIDS patient develops TB, his HIV/AIDS may progress rapidly leading to severe immunosuppression. Such a patient will then fall sick more easily from other HIV related diseases.
- A person who is HIV infected and has TB also has AIDS by definition.
- Both TB and HIV are diseases that have social stigma around them.
Implications of the relationship between TB and HIV:

TB/HIV collaboration activities must be put in place at the sites which provide HCT and TB services. These include, but not limited to:

- RTC for patients.
- Cotrimoxazole prophylaxis for HIV positive patients.
- Prevention of HIV among patients.
- Isoniazid prophylaxis where active TB disease has been ruled out.
- Health workers who are HIV positive not working with TB patients.
- Providing ARVs (or provide guidance) for eligible patients with HIV and TB.
- Psychosocial support to address stigma related to the diseases.

Outputs from these activities will be measured by:

- No. of HIV positive clients screened for TB symptoms over a given period divided by the total number of HCT clients seen over a given time,
- No. of HIV positive clients diagnosed with TB divided by total number HIV clients attending HIV treatment and care services who were screened for TB, over a given time period
- No. of TB clients registered over a given time period who tested for HIV during the time period divided by total number of TB patients registered over the same given period
- No. of all TB patients registered over a given period who test who HIV positive during their treatment divided by the number of TB patients registered over the same time period who test for HIV.

Session evaluation: Question and answer.

Key messages:

- TB is preventable and can be cured if detected early and managed properly.
- TB is the most common cause of illness and death among people infected with HIV.
- People who are HIV positive should be screened for TB and vice versa.
Module 1: HIV/AIDS and Commonly Related Conditions

Session 6: HIV and Family Planning

Time: 2 hours.

Methods: Brainstorming, group discussion, lecturette.


Objectives:

By the end of this session, participants will be able to:

- Explain the meaning of family planning.
- List methods of family planning in Uganda.
- Identify target groups for family planning.
- List benefits and challenges of family planning.
- Describe the relationship between family planning and HIV so as to understand the need to integrate client education on family planning (FP) in every HCT session.

Activities:

1. Review session objectives.
2. Brainstorm: The working definition of ‘family planning.'

Notes for Facilitator:

Family Planning:

Family Planning is a voluntary and informed decision on when to have children, and the interval between the children. Individuals and couples can achieve family planning by natural methods or by using contraception (the use of devices, drugs, or surgery) to prevent pregnancy.
Brainstorm: Relationship between family planning and HIV.

**Notes for Facilitator:**

**Relationship between family planning and HIV:**

- Pregnancy and HIV result from unprotected sex.
- Condoms can prevent both HIV and pregnancy.
- Both HIV and pregnancy lower immunity.
- Prevention of pregnancy in HIV positive women will prevent Mother to Child Transmission (MTCT).
- Prevention of HIV infection in pregnant women will prevent MTCT.

Brainstorm: How can HCT be an entry point for family planning services?

**Notes for Facilitator:**

**How can HCT be an entry point for family planning services?**

- Individuals requesting HCT services are almost always sexually active and may be at risk for unwanted pregnancy as well as HIV and other STIs.
- Some family planning methods, such as the condom, offer couples needed protection from both infection and unwanted pregnancy – dual protection.
- The integration of family planning and HCT services provides opportunities for both HIV+ and HIV- individuals to access comprehensive reproductive health care.
- Offering family planning to HIV+ individuals or those with a higher risk of infection can prevent unintended pregnancies (including MTCT of HIV).
Lecturette: Dual protection.

Notes for Facilitator:

Dual protection:

Dual protection is protection against unwanted pregnancy, HIV and other STIs.

Methods of dual protection:

- Abstinence and/or delay of sexual debut.
- Mutually monogamous, uninfected partners to practice effective contraception.
- Correct and consistent condom use.
- Correct and consistent condom use along with another effective FP method (“DUAL METHOD USE”).

In all FP and HIV programs, clients need counselling to help understand their risk for both unintended pregnancy and HIV/STIs in order to make choices that suit their individual circumstances. They have the right to be informed and to have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility.

Activities: Client Education Session – Dual Protection.

Purpose:
- To reinforce the variety of ways that couples can protect themselves from unwanted pregnancy and HIV, including: (1) mutually monogamous partners practicing effective contraception, (2) condom use, (3) condom use with another family planning method (dual method).

Instructions:
- Form small groups (maximum 5/group) and distribute handouts on family planning methods.
- Each group will review the family planning methods that they have been assigned and develop a 10-minute presentation that can later be adapted for a group education session at their facility.
- Each presentation should explain the selected family planning methods and how a client could use each method for dual protection (protection from unwanted pregnancy and protection from HIV).
- After each presentation, correct misinformation and give the participants time to provide feedback.
Notes for Facilitator:

Condoms

Condoms are a thin sheath worn over the erect penis or vagina before a couple plays sex.

**Effectiveness:** If 100 couples used condoms for one year, typically 12-15 of the women would become pregnant. If used correctly with every act of intercourse, condoms are highly effectively in protecting against pregnancy and most STI (except Herpes Simplex and other genital ulcer diseases).

**How it works:** The condom catches the male sperm so that it cannot enter the vagina.

**Advantages:** Safe, effective and easy to use; does not require a prescription or medical examination; may prevent premature ejaculation; protects against STI and HIV.

**Disadvantages:** Interrupts the sex act; may cause decreased sexual sensitivity; requires skills to use properly and negotiate their use with a partner; a new condom must be used each time the couple has sex; a supply of condoms must be available before sex occurs.

Note: Condoms should be widely available at HCT sites, and both men and women should be counselled that correct and consistent use is needed in order to achieve the benefits of condoms in preventing HIV and pregnancy. However, counsellors may also want to encourage clients to abstain from having sex or to remain faithful to their partners.

Combined Oral Contraceptives (COC)

Combined Oral Contraceptives (COC) are tablets containing estrogen and progestin hormones. A woman takes one tablet daily to prevent pregnancy.

**Effectiveness:** If taken consistently everyday, COCs are highly effective (one pregnancy in 1000 women). However, there is a higher failure rate for adolescents than all other ages, since adolescents have trouble remembering to take pills regularly.

**How it works:** COCs work by preventing the release of the egg from the ovary. Without an egg to be fertilized, a woman cannot become pregnant.

**Advantages:** Safe, effective and easy to use; can be used before the onset of menstruation; may lead to lighter, regular periods with less cramping; if one wishes, she can become pregnant after stopping the pill; does not interfere with sex; may be beneficial for adolescents who have irregular or heavy periods, menstrual cramps or acne; decrease risk of cancer of the female reproductive organs.

**Disadvantages:** COCs has some side effects; must be taken every day; does not protect against STI/HIV.
Norplant

Norplant is a set of six very small plastic capsules containing the hormone progestin. The capsules are placed under the skin of a woman’s upper arm and prevent pregnancy for at least five years.

**Effectiveness**: Norplant is highly effective. If 100 women use Norplant, typically one of them might become pregnant during the first year. Over five years, typically 1.6 women of 100 might become pregnant.

**How it works**: Norplant works by thickening cervical mucus, making it difficult for an egg to pass through, and by preventing the release of the egg from the ovary in about half of menstrual cycles.

**Advantages**: Safe and effective; lasts for five years; periods may become light and often disappear after a year of use; completely reversible – can become pregnant again after removing Norplant; can be used while breastfeeding; does not interfere with sex; may improve anemia.

**Disadvantages**: The woman’s menstrual pattern will probably change; does not protect against STI/HIV.

DPMA

DPMA is an injection containing the hormone progestin. The injection is given every three months.

**Effectiveness**: DPMA is highly effective if the injections are given every three months. If 100 women use DMPA regularly for one year, typically only one of them would become pregnant.

**How it works**: DPMA works by preventing the release of the egg from the ovary. Without an egg to be fertilized, a woman cannot become pregnant.

**Advantages**: Safe and effective; lasts for three months; periods become light and often disappear after a year of use; completely reversible – can become pregnant again after stopping DPMA – although there might be a delay of several months; can be used while breastfeeding; does not interfere with sex; may improve anemia.

**Disadvantages**: menstrual pattern will probably change; increased appetite may cause weight gain; typically a four-month delay in getting pregnant after stopping DPMA; does not protect against STI/HIV; may be difficult to remember to return for next injection.
**Intrauterine Device (IUD)**

Intrauterine Device (IUD) is a small plastic and copper device that can be inserted into the uterus to prevent pregnancy.

**Effectiveness:** If 125 women used the IUD for one year, typically one of them would become pregnant.

**How it works:** The IUD works by preventing sperm from joining with the egg.

**Advantages:** Safe, effective and long-lasting (10 years); easy to remove if the woman wants to become pregnant; does not interfere with sex; does not interfere with breastfeeding.

**Disadvantages:** Not suitable for women with multiple sexual partners, or whose partner has other sexual partners, due to an increased risk of pelvic inflammatory disease; menstrual pattern may change; greater risk of expulsion and painful menses for women under the age of 20 who have not given birth; slight pain during the first few days after IUD insertion; does not protect against STI/HIV.

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**Lactational Amenorrhea Method (LAM)**

Lactational Amenorrhea Method (LAM) is the use of breastfeeding as a temporary family planning method and a bridge to a longer term method. (Lactational means ‘related to breastfeeding’ and amenorrhea means ‘not have menstrual bleeding’.)

**Effectiveness:** If 100 women use LAM in the first six months after childbirth, typically two of them would become pregnant. While exclusively using breast feeding as the way to feed the baby, LAM is even more effective (one pregnancy among 200 young women).

**How it works:** LAM works by preventing ovulation because breastfeeding changes the rate at which natural hormones are released.

**Advantages:** Effectiveness in preventing pregnancy for at least 6 months; encourages the best breastfeeding practices that have health benefits for the mother and baby; can be used immediately after childbirth; no need to do anything at the time of sexual intercourse; no direct cost for family planning or for feeding the baby; no supplies or procedures needed to prevent pregnancy.

**Disadvantages:** Effectiveness after six months is not certain; does not provide protection against STI/HIV.
Emergency Contraception Pills (ECPs):

Emergency Contraception Pills (ECPs): Is a hormonal method of contraception that can be used to prevent pregnancy following an act of unprotected sexual intercourse.

**Effectiveness:** If 100 women used ECPs once, typically two of them would become pregnant.

**How they work:** ECPs are thought to prevent ovulation and fertilization. They are not effective once the process of implantation of a fertilized ovum has begun.

**Advantages:** Safe and readily available; reduce the risk of unwanted pregnancy; appropriate for use after unprotected intercourse (including rape or contraceptive failure); provide a bridge to the practice of regular contraception; drug exposure and side effects are of short duration.

**Disadvantages:** do not protect against STI/HIV; do not provide ongoing protection against pregnancy; should be used within five days of unprotected intercourse as effectiveness decreases with time; may change the time of the woman’s next period; are inappropriate for regular use.


**Challenges to adapting Family Planning methods:**

- Religious beliefs.
- Cultural values attached to children (prestige, free labour and security).
- High mortality rates in children.
- Women’s low status in society.
- Norms and traditions whereby members of society are expected to marry early.
- Low development (e.g. illiteracy, poverty, unrealistic politicise etc).
- Some males may have a negative attitude towards family planning
- Rumours, misconceptions and fears about FP method.
Session evaluation: Question and answer.

Key messages:

- In all FP and HIV programs, clients need counselling to help them understand their risk for both unintended pregnancy and HIV/STIs in order to make choices that meet their needs.

- An ideal method is one that is affordable, has little side effects, is in consistent supply, is acceptable to both partners, is easy to use, and is convenient to the clients. An ideal method is one that provides maximum protection against pregnancy and STDs.

- Dual protection against pregnancy, HIV and STIs is the best option for HIV positive people.
# Module 2

**HIV Prevention, Care, and Support**

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The purpose of this module is to provide participants with knowledge & skills in HIV/AIDS prevention, care, and support.
Module 2: HIV Prevention Care and Support

Session 1: Prevention of Sexual Transmission of HIV

Time: 2 hours.

Methods: Group discussion, brainstorm, role play, demonstration.

Materials: Penis models, vaginal models, condoms.

Objectives:
By the end of this session, participants will be able to:
- Describe HIV prevention strategies.
- Describe the use of male and female condoms.
- Clarify myths and misconceptions about condoms.
- Demonstrate correct use of condoms using models.

Activities:
1. Review session objectives.
2. Sharing experiences: Discussing sexual behaviour with clients.

Instructions:
- Counsellors need to be able to discuss sexual behaviour. An effective counsellor is able to manage his/her own discomfort.
- Invite participants who have had experience discussing behaviour with clients to talk about the following:
  - What measures have they taken to make it easier to talk about sexual behaviours?
  - How did they use slang and other simple terms to communicate in ways which clients could understand?
  - What helped them manage their discomfort?

Notes for Facilitator:

Summary of key prevention strategies

- Abstinence.
- Faithfulness (after determining sero-status of a couple/sexual partner).
- Correct and consistent use of condoms.
- Delay sexual debut.

Notes for Facilitator:

Brainstorm: Myths and misconceptions about condoms.

Common false statements about condoms are listed below. Possible responses to correct misinformation are marked in **bold**. Read the false statement, and then ask participants to comment.

1. Condoms don't work very well.
   [False statement]
   **If used consistently and correctly, condoms are effective in preventing both the transmission of STIs including HIV, and pregnancy.**

2. The male condom can come off and get lost inside the woman.
   [False statement]
   **If put on correctly, a male condom is very unlikely to come off. Even if it does, it will remain within the vagina and can be removed with the fingers, it cannot 'get lost' within the women. The same applies for the female condom.**

3. Most condoms are too small for African men.
   [False statement]
   **The latex used to make condoms is very flexible and can stretch to several times the size of even the biggest penis!**

4. Using two condoms at the same time offers greater protection.
   [False statement]
   **Using two condoms at the same time creates greater friction during sex, which may result in the condoms breaking or slipping off. Only one condom should be used at a time.**

5. The HIV germ is so small that it can pass through the condom.
   [False statement]
   **Tests have shown that neither semen nor HIV can pass through the material used in making condoms.**
Demonstration: Correct use of male and female condoms.

Instructions:

- Before demonstrating condom use, ensure that it is appropriate to talk to clients about their feelings toward and beliefs about condoms. Correct any misunderstandings.
- The counsellor should be very sensitive to the client’s feelings when demonstrating condom use with a penis and vagina model.
- For clients who have used condoms before, ask the client to demonstrate how to use it, using the model. Make corrections as needed.
- For clients who have never used condoms, provide a demonstration, and ask clients to practice using the model until they are able to demonstrate condom use correctly.
- Request volunteers to demonstrate proper condom use, while others observe.
- Acknowledge the participants contributions, and discuss any questions or comments.

Brainstorm: Suggestions for condom negotiation.

Notes for Facilitator:

Suggestions for Condom Negotiation:

- Say no to sex without condoms – clearly and directly.
- State firmly and clearly that your life and health are more important than the sexual relationship.
- Before any sexual activity begins, ensure that (a) partner has condoms and is willing to use them or (b) is willing to use condoms you have.
- Convince partner that you will make putting on and using a condom fun and exciting.
- State your reasons for refusing sex without a condom, in a firm way.
- Tell partner that, in addition to your concern for your own safety, you are concerned about his/her safety.
- Have condoms readily available.
- Suggest other ways of having sexual pleasure without penetration.
- Ask someone with influence to intervene, if necessary.
- Always be conscious of situations you may not be able to handle, and wherever possible, avoid them or have a well-thought out escape route.
Role play: Condom negotiation skills.

Instructions:

- In pairs, instruct participants to demonstrate condom negotiation skills in the following situations:
  - One partner is drunk.
  - One partner is older.
  - One partner is known to be violent.
  - Money or gifts are offered for sex without a condom.
  - The male partner is being aggressive.
  - The female partner suggests condom use with a long-time boyfriend.
  - The male partner suggests condom use with a long-term girlfriend.
  - The participants review selected role plays. Encourage feedback on the effectiveness of the communication skills of the person negotiating condom use.
  - Encourage each participant to comment on the exercise and what they have learned.
  - Distribute the handout for future reference.

Adapted from: Family Health International/Nigeria. 2002. Interpersonal Communication and Counselling Manual on HIV and AIDS.

Session evaluation: Question and answer.

Key messages:

- Partner communication and negotiation is a critical skill for HIV prevention.
- Condoms are effective when used correctly and consistently.
- Counsellors should be able to demonstrate the use of a condom to a client in a counselling session (as part of making a risk reduction plan).
- Knowing one’s HIV-sero-status is important for selection and adoption of an HIV prevention strategy.
Session 2: Behaviour Change

**Time:** 2 hours.

**Methods:** Lecturette, group work, brainstorming, group discussion, case study.

**Objectives:**

By the end of this session, participants will be able to:

- Define the term ‘behaviour’.
- Explain the meaning of ‘behaviour change’.
- Describe the behaviour change process.
- Identify obstacles to behaviour change.
- Identify factors which can influence positive behaviour change.

**Activities:**

1. Review session objectives.

2. Brainstorm: Working definition for “behaviour”.
   Working definition for “behaviour change.”

**Notes for Facilitator:**

**Behaviour** is an observable action performed in response to a situation; or the way one relates and conducts himself in a given situation.

**Behaviour change** is a gradual process from one lifestyle to another. Such a change is possible if there are enabling factors, such as continuous support and reinforcement from peers, friends, community leaders, or counsellors and enabling tools, such as condoms.

Clients may need assistance in resolving the problems they face in trying to practice safer sex or adopting other behaviours that will help them to reduce their risk of HIV. Although clients might understand how to protect themselves, they may not have the skills or be able to overcome the problems they face in changing their behaviour.
Individual exercise: Personal motivation to change.

Instructions:
- Ask participants to think about any behaviour they have successfully changed.
- Read each of the following questions and ask participants to write responses. Allow two minutes for each question.
  - When did you first become aware that your behaviour might be a problem for you? How did you become aware that it was a risky behaviour?
  - When you actually started to change, what prompted you to change?
  - What was the most difficult obstacle in changing?
  - What additional challenges did you meet in the process of changing?
  - What helped you most in succeeding with the change?
- Debrief by emphasizing the following points:
  - We often become aware of the need to change by receiving information. But, information alone is rarely enough to cause a change.
  - Often we actually begin to change as a result of a personal experience or crisis that motivates us to try to modify our behaviour or lifestyle.
  - Almost all of us stumble along the way, because of our own personal obstacles or obstacles that others put in our way.
  - To succeed, most of us receive some form of support from something we find within ourselves or from peers, family, and others who are important to us.

Discussion: Steps in behaviour change.

Instructions:
- Ask participants to think about their personal behaviour changes (from previous activity).
- Ask participants to describe the steps that they went through in order to make the change.
- Facilitator should post/draw a behaviour change continuum.
- Facilitator should highlight key points, see notes.
Notes for Facilitator:

Behaviour Change Continuum:

- Unaware
- Aware
- Assess personal risks, accept need to change.
- Intention to change.
- Initial change stage.
- Sustain new change.
- Relapse.

Discussion: Counselling and the role of the counsellor in supporting behaviour change.

Notes for Facilitator:

Essential elements of behaviour change counselling:

- Assess risk and vulnerability – clients need to assess personal risks for HIV infection and the various obstacles that may prevent them from practicing safer sex.
- Making a plan during pre-test counselling, the client should identify ways to maintain safer sex practices (ABCD = Abstain, Be (have) faith, Correctly and consistently use condoms, and Delay sexual debut.) Encourage critical thinking, decision-making, and communication skills.
- Supplies and resources – availability and access to condoms.
- Reinforcement and commitment – review the client’s plan for safer sex practices.
- Supportive environment – continued encouragement and support from counsellors. During pre-test and post-test counselling, the counsellor should ask the client to review his/her choices to reduce their risk of HIV/STI infection.
- There are many factors that influence behaviour change: internal factors; individual knowledge, attitudes and practices; and external or environmental factors (peer pressure, financial obstacles, family and school culture).

The role of the counsellor:

- The counsellor’s role is to support the behaviour change process, particularly to help clients adopt new behaviours.
Group discussion: Factors that influence behaviour change.

Instructions:
- Form two groups.
- Have participants in each group identify and discuss:
  - The factors that influence behaviour change.
  - The obstacles to HIV related behaviour change.
- After 20 minutes, have each of the two groups present their findings to the other.

Notes for Facilitator:

Factors that influence HIV related behaviour change:
- Knowledge.
- Attitude.
- Beliefs.
- Personalization of risk.
- Practice.
- Supportive environment, i.e. the things that you need to know, believe or feel so that you are able to adopt and sustain a new behaviour.

Obstacles to HIV related behaviour change:

Internal obstacles:
- Lack of knowledge about sex issues.
- Denial of personal risk.
- Fear to talk about sex matters.
- Dependency, addiction.

External obstacles:
- Traditional and cultural practices that encourage risky behaviours.
- Peer pressure.
- Conflicting cultural norms and beliefs.
- Religious policies.
- Government policies.
- Pressure from family members.
Discussion: The importance of identifying obstacles to change.

Notes for Facilitator:

HIV prevention counselling is a client-centred exchange designed to support individuals in making behaviour changes that will reduce their risk of acquiring or transmitting HIV.

Behaviour changes, where the counselling focuses on personal risk assessment and development of a personalized action plan, are also important.

Counsellors need to help clients explore the obstacles to behaviour change because these are the issues that stand in the way of the HIV related behaviour change. In this way, the counsellor can:

- Help clients to recognise the resources they have to deal with difficult situations.
- Teach clients different methods of overcoming or reducing the impact of their current problems.
- Enhance their sense of control over problems.
- Equip them with a method for tackling problems.

Client-centred means that counselling is tailored to the behaviour, circumstances, and special needs of a person.

Experience sharing in HCT counselling.

Instructions:

- Invite participants to share their experiences.
- Record key elements to show that experience was client centered and focused on an individual’s behaviour and special needs.
- Work with one participant to establish (step by step) the process they went through to change behaviour. Structure the experience into 3 stages.

Session evaluation: Question and answer.

**Key messages:**

- Counsellors need to understand that it is difficult for clients to change their behaviour.
- Counsellors need to establish a relationship with the client that will help to support the behaviour change.
Module 2: HIV Prevention Care and Support

Session 3: Prevention of Mother to Child Transmission

Time: 3 hours.

Methods: Lecturette, video, group discussion, questions and answer.


Objectives:
By the end of this session, participants will be able to:

► Explain the meaning of Mother to Child Transmission of HIV (MTCT) and PMTCT.
► Explain how children can get HIV.
► Discuss factors that influence mother to child transmission of HIV during pregnancy, labour, delivery and after delivery.
► Describe the national PMTCT programme and the strategies to prevent MTCT.

Activities:

1. Review session objectives.
2. Recap: Modes of HIV transmission.
3. Lecturette: Meaning of MTCT.
   Meaning of PMTCT.
   Timing and mode of vertical transmission of HIV.
Notes for Facilitator:

MTCT
MTCT means transmission of HIV from mother to her child. It is also referred to as vertical transmission.

PMTCT
Prevention of Mother to Child Transmission (PMTCT) is preventing HIV transmission from an HIV+ mother to her child during pregnancy, delivery and during breastfeeding.

Over 90% of HIV transmissions to children come from their parents. Approximately 15-40% of HIV+ mothers transmit the virus to their children if there is no PMTCT intervention.

 Mothers can infect a child with HIV during pregnancy, during labour and delivery and during breastfeeding.

Timing for MTCT is as follows:

- In utero (during pregnancy) 15-20%.
- During labour and delivery (Intra-partum) – 60-70%.
- Post partum (post-natal period) 15-20%.

Factors that influence MTCT:

Viral:
- Viral load.
- Viral genotype and phenotype.
- Viral resistance.

Maternal:
- Maternal immunological status.
- Trauma.
- Maternal nutrition status, vitamin A deficiency.
- Maternal clinical status.
- Infection and infestation of the placenta e.g. STD, T.B and malaria and early separation of placenta (abruptio placenta).
- Behaviour factors like unprotected sex with infected partner.
- Antiretroviral treatment.
- Cracked nipples, mastitis, breast abscesses.
Obstetrical:

- Prolonged rupture of membranes (> 4 hours).
- Mode of delivery.
- Intra-partum haemorrhage.
- Obstetrical procedures: forceps, episiotomy, vacuum extraction.
- Invasive foetal monitoring.
- Sharing same scissors between mother and baby.
- Use of non-sterile instruments.

Foetal:

- Pre-maturity.
- Genetic.
- Subsequent pregnancies.
- Twin deliveries – (1st twin at higher risk).

Infant:

- Breast feeding, mixed feeding.
- Gastrointestinal tract factors like oral sores.
- Pre-maturity/ Immature immune system.

Lecturette: National PMTCT programme and strategies to prevent MTCT

Notes for facilitator:

National PMTCT programme and strategies to prevent MTCT

Introduction

The National PMTCT programme was initiated by the government of Uganda in collaboration with UNICEF, UNAIDS, WHO and other partners in an effort to reduce vertical transmission of HIV.

In Uganda, MTCT translates to about 25,000 infected babies each year. The PMTCT interventions have been proved to be cost effective and significantly reduce the risk by 50% in Uganda.

PMTCT Programme Goal:

- To provide a comprehensive package of care to pregnant mothers in order to reduce the transmission of HIV from infected mothers to their babies.
- To contribute towards reduction of infant mortality and morbidity.
PMTCT Programme Objectives:

- To initiate HIV counselling and testing among pregnant women and their partners at implementing PMTCT sites in all districts by the year 2005.
- To increase the involvement of male partners in PMTCT services by 20%.
- To provide a recommended package of antenatal care to over 75% of pregnant women attending PMTCT sites.
- To make available Anti-retroviral (ARV) drugs to all HIV positive pregnant mothers and their babies at the implementing sites.
- To provide a comprehensive post-partum care package to mothers and infants at PMTCT sites.
- To work with existing institutions to provide a sustainable follow up support package to the families of PMTCT clients.

Target groups for the PMTCT Programme:

The PMTCT programme targets:

- All pregnant women attending ANC at the PMTCT sites and their spouses.
- All HIV positive women reporting at ANCs.
- Babies born to HIV positive mothers who have been on PMTCT Programme.

Strategies for PMTCT:

Prong 1: Primary prevention

The focus is on prevention of HIV infection among women and men of child bearing age as well as the general population.

- Behaviour change interventions including promoting abstinence.
- Correct and consistent use of condoms.
- Promotion of voluntary counselling and testing before sexual relationships.
- Mutual faithfulness after knowledge of HIV sero-status.

Prong 2: Prevention of unintended pregnancy among HIV positive:

The focus is on counselling and supporting HIV positive women to avoid getting pregnant.

- Abstinence.
- Use of dual protection methods for family planning.
**Prong 3: Reduction of MTCT among HIV positive pregnant women:**

When the first two strategies fail, then provide the recommended package for PMTCT:

- Adoption of safer sexual practices during pregnancy and lactation.
- Comprehensive care during antenatal, delivery and post-delivery periods.
- Provision of anti-retroviral drugs for reduction of MTCT.
- Counselling on optimal infant feeding practices.
- Promote community and family support especially of the spouses.

**Prong 4: Care and support for HIV positive women and their families:**

This is a strategy in the overall prevention package:

- Monitoring and follow up care and social support.
- Comprehensive management of opportunistic infections.
- Provision of antiretroviral therapy.
- Counselling support.

**Coordination Structure of the PMTCT Programme in Uganda:**
Coordination structure of the PMTCT Programme in Uganda (continued)

**National Level**
- A national technical committee that holds Quarterly meetings. Main role is to advise the Ministry on policy related issues concerning the PMTCT interventions.
- A national stackholder’s forum that meets twice each year. This plays a role of bringing partners and interested parties together in order to strengthen collaboration and coordination.

**Implementation Level**
- A meeting at the national level during the second half of the year for all implementers to share experiences and discuss challenges at this level.

**Regional Level**
- The technical committee is duplicated at the regional referral hospital level to provide guidance to the districts within their catchment area. They also provide support supervision.

**District Level**
- The implementers and stakeholders’ forums are duplicated at the district level in order to improve collaboration and coordination.

**Health Facility Level**
- A health facility level task force/committee whose main task is to coordinate and guide the activities at the implementing site. The committee is responsible for operationalising the policy and guidelines at the health facility level.
Session evaluation: Question and answer.

**Key messages:**

- MTCT takes place during late pregnancy, labour/delivery and in the puerperium. Various factors influence MTCT including material, placental, foetal, obstetric and infant factors. In implementation of PMTCT, all these factors should be addressed.

- Prevention of Mother to Child Transmission includes the following strategies:
  - Prevent women from becoming HIV+.
  - Prevent unwanted pregnancies among HIV+ women.
  - Prevent MTCT from pregnant women to newborns.
  - Care and support to HIV+ women, infants, and families.

- Both husband and wife have important roles in PMTCT. They both need to know their HIV status and take steps to reduce their risk of infecting or re-infecting their partner, and to reduce the risk of transmitting the virus to their child.
Module 2: HIV Prevention Care and Support

Session 4: Antiretroviral Therapy

Time: 2 hours and 30 minutes.

Methods: Lecturette, brainstorming.

Materials: Samples of ARVs, National ART Policy and Guidelines.

Objectives:
By the end of this session, participants will be able to:

- Describe ARVs and ART.
- Explain how ARVs work.
- Explain the use of ARVs (goals, principles, criteria).

Activities:
1. Review session objectives.
2. Lecturette: Notes on ARVs and ART.

Notes for Facilitator:

What are ARV drugs?
Antiretrovirals (ARV) are drugs that, if taken correctly, can be highly successful in fighting the rate of HIV multiplication in the body. They are NOT a cure for HIV/AIDS. Also, once a client starts antiretroviral therapy (ART), they must continue taking them for the rest of their life.

What is ART?
This is general care for patients on ARVs from the time of initiation to monitoring and adherence and includes counselling, treatment of opportunistic infections, nutrition.
ARVs work by slowing or stopping the multiplication process of HIV within an individual’s body (Use the illustration of HIV life cycle to explain how ARVs work).

**Types of ARVs:**

There are 3 main classes of ARVs, namely:

- **Nucleoside Reverse Transcriptase Inhibitors (NRTIs) – nukes** e.g. Zidovudine (AZT), 3TC, DDI, D4T
- **Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) – non nukes** e.g. Efavirenz (EFV), Nevirapine (NVP)
- **Protease inhibitors (PIs)** e.g. Indinavir, lopinavir, ritonavir

Each class acts at a different stage and in a different way to prevent HIV replicating within the CD4 cell (Refer to Life Cycle of HIV).

**Combinations of ARVs**

The most effective regimens utilize drugs from different classes:

Examples of ARV drug combinations:

- D4T + 3TC + NVP (Most common)*
- D4T + 3TC + EFV
- AZT +3TC (combi) +EFV
- AZT + DDI + lopinavir/Ritonavir

**Why are ARVs used in combination?**

- The combination therapy gives better results, because each drug acts at different sites to prevent the replication of HIV in the life cycle thereby achieving maximum viral suppression.
- To avoid development of resistance to one drug. Combinations of ARVs delay resistance to one single drug.
- Some drugs enhance each other. If used in combination the drugs can better suppress the virus.
What are the limitations of ART?

ARVs cannot kill the virus. The individual enrolled in ART still has HIV and can transmit the virus to others.

Side effects of ARVs:

The ARVs have to be taken every day, on a strict schedule, for life. Long term use of ARVs may increase the possibility of side effects, although some side effects are felt almost immediately. Individuals on ARVs should be given appropriate, drug-specific counselling when using ARVs. Some of the side effects to ARVs are specifically related to the type of drug.

**Minor side effects:**
- Headaches.
- Skin rash.
- Vomiting.

**Severe side effects:**
- Liver damage.
- Damage to the pancreas.
- Fat redistribution.
- Anaemia.

How to deal with side effects?

Counsellors should always refer clients to clinicians to administer ARVs. Counsellors should anticipate the onset of side effects in their clients who are using ARVs and refer them immediately to centres that provide ARVs for possible change of treatment and management of side effects.

Principles of good ART include:

- Not starting too soon (when CD4 count is close to normal) or too late (when the immune system is irreversibly damaged.)
- Efficacy of the chosen drug regimens.
- Freedom from serious adverse effects.
- Ease of administration.
- Affordability and availability of drugs and drug combinations.
- Ongoing support of the patient to maintain adherence.

Resistance:

If the drugs are taken incorrectly, strains of HIV can become resistant to the drugs. Clients need to understand and follow the instructions for taking each ARV drug. For example, some must be taken before, with, or after food, and some may need to be taken once, twice, or even three times a day. In addition, clients need to understand that they have to take the drug for the rest of their lives.
Lecturette: Assessing clients for ART eligibility.

Notes for Facilitator:

Adults and Adolescents:

Not everyone who is HIV positive needs ART. Initiating ART should be based on the level of HIV immune suppression, as assessed by WHO HIV stages (presence or absence of certain HIV related symptoms), or CD4 cell count. If available, the risk of progression of HIV disease, as indicated by the viral load in plasma, may be used in addition to WHO stage and CD4 cell count in deciding when to start ART. It is recommended that ART should be administered only to those who are symptomatic and have evidence of significant immune system damage. If treatment starts too early, essential resources may be wasted, and the risks of unnecessary toxic effects and drug resistance are increased. Similarly, treatment started too late may not yield positive results, because the immune system may take longer to recover.

In Uganda, it is recommended to initiate ART in adults and adolescents with documented HIV infection and:

- WHO stage IV disease, irrespective of CD4 count.
- Advanced WHO Stage III disease, including persistent or recurrent oral thrush and invasive bacterial infections irrespective of CD4 cell count or total lymphocyte count.
- When CD4 testing available, ART can be started for patients in WHO Stage I, II, or III with CD4 counts < 200/mm3.
- Tuberculosis and CD4 count between 200-350/mm3.

If patient fulfils the above criteria, certain patient-specific factors should also be considered before starting ARVs.

These factors include:

- Interest and motivation in taking therapy.
- Presence of co-morbidities, especially tuberculosis. Patients must have a screening history, physical exam, and, if necessary, laboratory tests to rule out active infection. The treatment of co-existing infection takes priority over starting ART.
- Psychosocial barriers.
- Financial barriers.
- Potential for adherence (willingness to participate in ARV educational sessions and peer support ARV groups and to complete a personal adherence plan with a counsellor.)
Children and Infants:

Although the pathogens of HIV and the underlying principles of ART are similar in adults and children, there are specific physiological, clinical, practical and social issues to consider when treating HIV+ children with ART.

The table below summarizes the guidelines on when to start ART in infants and older children. The majority of children, who contract the infection from their mothers, become symptomatic in the first two years. Treatment of these children should be started as early as possible since morbidity and mortality is highest in young children. In children, indicators of HIV infection include recurrent or persistent bacterial infections, oral thrush, or failure to thrive despite adequate nutritional support:

<table>
<thead>
<tr>
<th>Age</th>
<th>Diagnosing HIV infection</th>
<th>Recommendation for ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18 months</td>
<td>1. Clinical assessment AND 2. Positive HIV test or history in the mother Optional: 3. PCR-DNA if available 4. p24 Ag if available</td>
<td>1. WHO Pediatric Stage III (AIDS) 2. Advanced Pediatric Stage II disease 3. WHO Pediatric Stage I disease (asymptomatic) or Stage II disease with CD4 cell percentage &lt;20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children started on ART at &lt;18 months on the basis of 1 &amp; 2 should have an HIV test when they reach the age of 18 months.</td>
</tr>
<tr>
<td>&gt;18 months</td>
<td>1. Clinical assessment AND 2. Positive HIV test</td>
<td>1. WHO Pediatric Stage III (AIDS) 2. Advanced Pediatric Stage II disease 3. WHO Pediatric Stage I disease (asymptomatic) or Stage II disease with CD4 cell percentage &lt;15%</td>
</tr>
</tbody>
</table>

Adapted from: National Antiretroviral Treatment and Care Guidelines for Adults and Children (2003.)
Session evaluation: Question and answer.

**Key messages:**
- ARVs do not cure HIV.
- ARV drugs should be administered only by trained providers.
- ARV drugs must be taken for life.
- Not all HIV+ individuals need ART.
Module 2: HIV Prevention Care and Support

Session 5: Counselling in ART

Time: 1 hour and 30 minutes.

Methods: Lecturette, brainstorming, discussion, demonstration.

Objectives:
By the end of this session participants will be able to:

- Identify the counselling issues in ART.
- Explain the importance of counselling for adherence in ART.

Activities:
1. Review session objectives.
2. Group work: Counselling issues in ART.
   Adherence counselling.

Instructions:
- Divide participants into four separate groups.
- Instruct participants in each group to discuss the following three questions:
  - What are some of the counselling issues in ART?
  - What factors affect adherence?
  - What are the effects of non adherence to ART?
Lecturette: Adherence counselling.

Notes for Facilitator:

Adherence counselling

Referrals for ART are part of HCT services. If a person comes to a counselling session requesting information on ARV drugs, then the counsellor should provide him/her with basic information listed below and refer him/her to a centre that provides ARV care and support.

- Address the following issues for ART in adults and adolescents:
- ARV drugs don’t offer a cure. The HIV may be suppressed, but is not eradicated from the body.
- For the majority of people who use them, ARVs improve quality of life and prolong survival.
- The ARV drugs should be taken daily, for life unless doctors advise structured treatment interruption or another protocol.
- ARV drugs, like any other medication, have side effects.
- Adherence to the treatment regimen yields better results.
- Some patients may fail to respond to treatment and may require several changes of their drugs.

Facts about ARVs:

- A successful combination of ARV therapy may slow or stop the multiplication process of HIV within an individual’s body.
- ARVs may improve immune system functions, because they halt HIV multiplication, and therefore reduce the destruction of the immune system.
- ARVs may make the person taking them feel better or enable that person to continue or resume his/her usual activities.
- ARVs may be used to prevent HIV infection, following rape or exposure to infected blood or any other body fluid. This process is called Post Exposure Prophylaxis (PEP). In this case, the individual may be required to follow an intensive regimen of ARVs for a period of 4 weeks or 1 month.
- ARVS can be used as a measure of Prevention of Mother To Child Transmission of HIV (PMTCT).
- ARVS can be used as a measure of Prevention of Mother-to-Child Transmission of HIV (PMTCT), because they increase the chances that an infected mother will produce an HIV-negative child.
- ARVs are not a cure for HIV/AIDS.
- ARVs cannot completely kill the virus, but the individual’s viral load can be undetectable.
- An individual on ARVs can still infect others.
- If the drugs are taken incorrectly, drug-resistant strains of HIV can develop.
The aims of ARV Therapy:

The aims of ARV therapy are to:

- Help in the acquisition of maximum and durable suppression of HIV multiplication, leading to the reduction of viral load.
- Enhance the prevention of rapid damage to the immune system
- Promote the prevention of opportunistic infections
- Prevent the acquisition of HIV infection. ARV Therapy is used in the prevention of Mother-to-Child Transmission (PMTCT) and Post Exposure Prophylaxis (PEP)
- Reduce stigma, especially if the stigma is associated with the physical perception of HIV patients. ARVs may help improve poor skin and weight loss.

All of the above aims lead to the reduction of HIV-related morbidity and mortality, resulting in improved quality of life and a longer life span for clients.

Improving the lives of people living with HIV/AIDS (PHA), helps to reduce their psychological and social problems. For example, a person who was socially withdrawn, isolated, stressed and depressed, might regain the desire for social interaction, and seek social support. An individual with improved quality of life and expected longer life span can carry out activities that enhance self, community and national development.

The Importance of Counselling:

With the introduction of ARV drug therapy, it is increasingly important to counsel people with HIV/AIDS.

People taking ARV therapy need to know:

- The ARV therapy is new in the management of HIV/AIDS.
- ARVs should be taken for the rest of an individuals lifetime, or until another remedy is developed.
- ARVs are not a cure for HIV/AIDS.
- The drugs may cause some side effects.
- The ARV supply is limited in some areas, and the drugs are not available throughout Uganda.
Counselling should help clients to problem solve issues of adherence to their ARV therapy regimen. This includes:

**Support for decision making:**

It is necessary to guide people towards making their own decisions concerning ARV therapy. One major topic to discuss is financial status, specifically, an individual’s ability to consistently cover the drug costs and other monetary requirements.

A number of people find it difficult to disclose their sero-status to their significant others. The counsellor should assess the situation, and, if possible, empower the client to disclose decisions. In some cases, disclosure is essential and may greatly improve ARV drug adherence.

**Social and psychological support:**

People also require social and psychological support to help them adjust to ARV therapy requirements. This might include the routine schedule of ARVs, family budgets and life styles. To some, the adjustments may be required in their work schedule and at times necessitates disclosure to the employers or colleagues.

**Fostering adherence of ARVs:**

People are dynamic. That is, they are bound to change their thoughts, decisions, and actions every now and then. A person, who decided to start on ARVs, may, due to various reasons, feel like quitting. Counselling is an essential tool that helps people to adhere to ARV therapy.
Who should receive counselling for ARVs?

Ideally, counselling should be offered to people who seek counselling services. However, due to the stigma surrounding HIV/AIDS, some people find it difficult to readily avail themselves of these services. The counsellors, other medical team members, and caregivers should do everything possible to encourage people with HIV/AIDS to seek counselling.

People who should receive counselling include:

- Any adult with a confirmed diagnosis of HIV
- A child aged 12 years and above, with a confirmed diagnosis of HIV. The parents/guardians of such a child must also be appropriately counselled. The child may be individually or jointly counselled.
- Children under 12 years of age should be counselled with their parents/guardians. In situations where a child does not have a parent or a guardian, the child can choose another individual to participate in joint counselling. This choice must be accepted by the medical team.
- Any person who is aware of his/her HIV situation and wants to start ARV therapy.
- Family members, as necessary. The client and the counsellor work together to identify those family members.
- People who have been exposed to HIV infections at work, on defilement, or as a result of rape.
- Couple counselling should take place during Prevention of Mother To Child Transmission (PMTCT) and other occasions, as necessary.

When should counselling for ARVs be carried out?

1. During Pre-test counselling:

As part of the provisional action plan towards treatment, it would be very helpful for the counsellor to give required information about ARVs. The counsellor must first identify the client’s knowledge about ARVs, and then fill in the gaps or clarify some misconceptions.

2. During HIV post-test counselling:

At this point, ARV counselling would be ideal specifically if the individual is considering taking ARVs.
When should counselling for ARVs be carried out? (continued)

3. Before commencing ARV Therapy:

Intensive ARV counselling should be given prior to its administration.

The counsellor still has to find out what the clients know and give the required information:

- What information do individuals have concerning ARVs?
- What are their expectations about use of ARVs?
- Do they understand that ARV drugs do not offer a cure for HIV/AIDS?
- What is the individual’s income or support? Can they consistently afford the drugs, travelling and time?
- Do they understand that ARV drugs are to be taken for life?
- Have they had the required tests, such as the CD4 count and the viral load?
- Are they able to regularly carry out such tests, so medical providers can properly monitor their ARV therapy? (In this case, monitoring refers to the process of carrying out periodical laboratory tests that would indicate the progress of the individual, on the use of ARVs.)
- Consistent adherence to ARVs is essential, because the client will have better results if he/she strictly adheres to the treatment regimen. Proper adherence to ARVs may enhance the maintenance of undetectable viral load level and will strengthen an individual’s body immunity. It is important to explain to the client the necessity of following the recommended regulations while taking ARVs.
- The client should be aware of the likely side effects of ARVs. Like all medicines, ARVs can cause side effects. Different ARV drugs cause different side effects, and it is therefore helpful for the doctor to explain how the selected combination to be taken by the client. Common side effects mostly appear during the first weeks of initiating treatment, although they may appear later. The common side effects include nausea, vomiting, fatigue, headache, and, very rarely, hypersensitivity. In addition, some people on ARVs might have body changes such as shape and colour. These side effects may be minor and wear off with time, or they may be severe. In either case, the clients need to know how to identify the side effects and where to seek help in case side effects are intolerable.
- There is a possibility that some individuals may fail to respond to treatment. This may necessitate changing the drug regimes. Just because one regime fails does not mean that they will all be ineffectual.
- Discuss the time schedule to start and take ARVs. This schedule should relate to the client’s level of CD4 cell accounts and his/her ability to start the ARV treatment.
- Do the drugs have any food restrictions? Nutrition is also an important part of the therapy. Proper nutrition improves positive response to treatment. Individuals, who eat well respond faster to treatment than those who do not.
When should counselling for ARVs be carried out? (continued)

4. Throughout therapy:

- It is important in order that the counsellor may identify and address any non-adherence to ARVs.
- For the purposes of Prevention of Mother-to-Child Transmission (PMTCT), it is best to ensure that the mother has discussed the issue with her partner and that counselling is offered to both parties.

5. During the treatment of opportunistic infections.

What should the counsellor try to find out?

The counsellor should try to learn more about the client. This creates a stronger platform to deal with problems.

Counsellors need to assess the following:

From the client, it is necessary for the counsellor to create a good relationship with the client/s; it is important to find out:

- The client’s physical, social, emotional, spiritual, economical and psychological states.
- Verbal and non-verbal expressions.
- Client’s experience, feelings and behaviour.

From their significant others, it is important to find out:

- Whether the significant others are in agreement with the client, concerning the taking of ARVs.
- Whose initiative is for the client to take ARV drugs.
- Any other responsibilities that are shouldered by the client.
- Who, among their significant others, needs counselling.
- Level of discussion about sex during the administration of ARVs, issues of child bearing while on ARVs, and Mother To Child Transmission (PMTCT).
Discuss: Common causes of non adherence to ARVs:

Instructions:
- Discuss the common causes of non adherence to ARVs.
- Close the discussion by emphasizing:
  - The importance of using ARVs,
  - The need to adhere to treatment for the greatest success, and
  - That ARV therapy is a lifelong treatment.

Notes for Facilitator:

Common causes of non adherence to ARVs:

It is important for the counsellor to be aware of the common hindrances to HIV disclosure and adherence to ARVs. There are a number of reasons that clients do not adhere to ARV therapy.

**Stigma:** In adults, HIV infection is mostly sexually transmitted. People feel that they will be labelled as promiscuous. This hinders them from disclosing their sero-status and seeking information about ARVs. Stigma also prevents HIV positive people from attending recognised HIV/AIDS health centres, because they are afraid to be identified as patients.

**Guilt:** If multiple family members are infected, but the family can only afford ARV therapy for one person, that individual may feel guilty for taking the medicine. This guilt may cause the individual to skip treatments.

**Blame:** If a family judges or blames an individual for contracting HIV, that individual may be less likely to adhere to ARV therapy.

**Fear:** Fear is a common and real concern for patients taking ARV drugs. Fear manifests itself in several ways: fear of side effects, fear of costs, and fear that treatment won’t work.

**Ignorance:** People still lack proper information about ARVs, and this can lead to inconsistency in taking them. It must be emphasized that the drugs must be taken for life.

**Negative Outlook:** Some people believe that since ARV therapy is not a cure for HIV/AIDS, there is no point in taking the drugs.

**Lack of communication skills:** People fail to disclose to their spouses, children, or their employers that they are taking ARV drugs. Everyone close to the individual needs to understand the disease and therapy regimen, so they can help the individual.
Common causes of non adherence to ARVs (continued):

**Lack of proper counselling:** It is absolutely necessary for an individual taking ARV drugs to receive counselling before and during the treatment regimen. Without counselling, individuals are more likely to give up on ARVs and cause themselves harm.

**Reduced availability of ARVs in the rural settings:** ARVs are not available throughout Uganda; generally they are only available in urban areas. The limited availability limits an individual’s access to ARVs and may lead to inconsistent usage.

**Discrimination and Gender issues:** In households with limited resources, infected males in the family may be given priority over the females.

**Religious beliefs:** In some belief systems, obtaining medical treatment, such as ARVs, is considered sacrilegious.

**Violation of Human Rights:** This occurs when children, who are infected with HIV and are eligible to receive ARV treatment, are not made aware of their condition:

- It is often due to lack of communication skills by the parents or carers to disclose the nature of the illness to the child
- Also, there is often failure on the part of the health workers to devise means of early disclosure. The child may ask “Why am I taking drugs?”

**Discuss: Questions about ARVs.**

**Instructions:**

- Show samples of ARVs and answer any questions that may arise.

**Session evaluation: Question and answer.**

**Key messages:**

- ARV drugs, when taken correctly, help decrease a person’s viral load to the lowest level thus improving and prolonging their life.
- Non adherence may lead to resistance.
- On going care and support is important for clients on ART
- ARV drugs are important.
- Clients on ARVs need to adhere to treatment for the greatest success.
- Clients on ARVs need to know that it is a lifetime treatment.
Module 2: HIV Prevention Care and Support

Session 6: Post Exposure Prophylaxis in Clinical Settings

Time: 1 hour.

Methods: Lecturette.

Materials: National Antiretroviral Treatment and Care Guidelines for Adults and Children.

Objectives:
By the end of this session, participants will be able to:

► Explain principles of prevention of blood-borne infections and Post Exposure prophylaxis (PEP).
► Describe when and how to provide PEP.
► Describe counselling issues for PEP.

Activities:
1. Review session objectives.

Notes for Facilitator:

PEP and Accidental Blood Exposure (ABE)

PEP is an emergency medical response for individuals exposed to the HIV virus. It consists of medication laboratory tests and counselling. PEP must be initiated within hours of possible HIV exposure (not later than 72 hours) and must continue for a period of approximately four weeks.

The risk of transmission after ABE is as follows:

- 30% for HBV, if percutaneous accident.
- 3% for HCV.
- 0.3% for HIV.
Types of risks of ABE:

**Low risk:**
- Solid needle, superficial exposure on intact skin.
- Small volume (drops of blood) on mucous membrane or non-intact skin.
- Source is asymptomatic or Viral load < 1,500 copies/ml.

**High risk:**
- Large bore needle, deep injury, visible blood on device, needle in patient artery/vein.
- Large volume (major blood splash on mucous membrane or non-intact skin exposures).
- Source is symptomatic, acute sero-conversion, high viral load.

Principles of prevention of accidental blood exposure (ABE):

- Prevention is possible
- Respect of universal precautions.
- Reduction of sero-conversion risk: ARVs.
- Systematic reporting of ABE.

**Universal precautions:**
- All blood and body fluids assumed to be infected.
- Hand washing access, policies, practices after every examination and procedure.
- Gloves, needle disposal.
- Avoid blood/fluid contact with inflamed skin, eyes, sores.
- Supervision, education, motivation.

Management of ABE: Initial steps:

- Copious washing with soap & water.
- Determine the extent of the exposure.
- Superficial exposition: minor injury.
- Severe exposition.
- Exposure involving mucous membrane, non-intact skin.
- Percutaneous injury.
- Determine HIV status of patient source:
  - Patient source known HIV negative: no risk.
  - Patient source known HIV positive: high risk.
  - HIV patient status unknown.
- Determine susceptibility of exposed person.
  - Confirm hepatitis/HIV status.
Recommended ARVs for PEP for low risk:

- 3TC and AZT (or D4T) are recommended in case of lower risk.
- Women of childbearing age: offer a pregnancy test prior starting PEP.
- In event of pregnancy don’t use Efavirenz.

Recommended ARVs for PEP for high risk:

- AZT + 3TC + Efavirenz (not in pregnant women).
- AZT + 3TC + Lopinavir/Ritonavir or Nelfinavir.

ARV chemophylaxis after ABE:

- Initiation: as soon as possible-within hrs of exposure (not later than 72 hours).
- Duration of the chemoprophylaxis is 4 weeks.
- PEP should be modified to account for the source patient’s ARV Experience.
  - If s/he has an undetectable VL: same ARV regimen.
  - If s/he has detectable VL: discussion with an expert.

Post-Exposure Follow-up

- Counselling support to health worker.
- Explain the side effects of the ARV drugs.
- HIV antibody testing for the health worker.
  - Duration the first week: 0 – 8 days (baseline).
  - Month 3 and month 6.
- Tansaminases.
- Adopt safe sexual practices during follow-up.

Hepatitis B/C:

- Assess source.
- Assess exposed person.
  - Antibody positive, no further issues.
  - Antigen positive: counselling to reduce risk of infecting others.
  - Neither-immunize with HepB vaccine/HepB immunoglobulin.
- Start PEP within 24 hrs.
- No immunoglobulin/vaccine for HepC.
Counselling and care guidelines in possible occupational exposure:

- First aid.
- Express blood from wound if bleeding.
- Wash exposed area thoroughly with soap and water or antiseptic solutions, such as polyhexdrine, if available.
- If contaminated, rinse eye or mouth with plenty of water.
- Report the injury to a senior staff member or the supervisor or the Post-exposure Prophylaxis (PEP) designated officer of the unit.

Exposure risk assessment and feedback:

- Evaluate risk of infection according to severity of exposure, depth of injury, duration of exposure, type of instrument involved, stage of disease of the patient, and possible ARV resistance in the patient.

Prophylaxis counselling

Pre-test counselling:

Follow the protocol for pre-test counselling and:

- Include information on how to reduce future occupational exposure.
- Identify additional support needs – fear of colleagues seeing them take medications; side effects from medicines that may make it difficult to work; pregnancy; safer sex practices.
- Procedures for testing to cover window period.
- Schedule follow-up test. Take note of the different sero-conversion periods and if the worker is taking PEP.
- HIV testing should have a baseline in 8 days then 6 weeks, 3 months of exposure.
Session evaluation: Question and answer.

Key messages:
- Universal precautions should be applied in all procedures.
- Ensure safety of health workers in the health care settings.
- Promote the use of safe equipment and procedures.
- Safe and proper disposal of sharps and other wastes.
- Promotion of Hepatitis B vaccination for HCW
- Provide timely treatment.
Module 2: HIV Prevention, Care and Support

Session 7: HIV Basic Care Package

Clock icon

Time: 3 hours.

Methods: Lecturette, brainstorming.


Objectives:
By the end of this session, participants will be able to:
- Explain the HIV Basic Care Package.
- Describe the components of HIV Basic Care Package.

Activities:

1. Review session objectives.

2. Lecturette: Meaning of HIV Basic Care Package.
   Components of HIV Basic Care Package.

Notes for Facilitator:

The Basic Care Package for HIV/AIDS patients- opportunistic infections (OI) treatment and prophylaxis:

Access to good clinical care including diagnosis, treatment and health education remains an option so limited to patients living in resource constrained setting. Due to this situation, the focus needs to be on simple approaches/interventions that will improve on the quality of life HIV/AIDS patients focusing on preventive measures.
Components of the basic care package:

- Cotrimoxazole prophylaxis for Opportunistic Infection prevention
- Diarrhoea prevention and Safe water systems
- Malaria prevention and Insecticide -treated mosquito nets
- Prevention with positives Counselling.
- Provision of micronutrients and Vitamin A
- Anti-retroviral therapy (ART)
- Referral.

Cotrimoxazole prophylaxis:

Prophylaxis with Cotrimoxazole/Septin has been shown to be effective in preventing a number of common illnesses in HIV/AIDS patients. These include PCP, Toxoplasmosis, diarrhoeal diseases and malaria which are very common in our setting.

Recommended regimen:

Adults:
- Two single strength tablets of cotrimoxazole (2 x 80 mg Trimethoprim/400 mg sulfamethoxazole) or one double strength tablet (1 x 160 mg Trimethoprim/800 mg sulfamethoxazole) daily for life.

Children:
- Recommended dosage for children is 4 mg/kg trimethoprim and 20 mg/kg sulfamethoxazole once daily.
- Cotrimoxazole syrup should be administered once a day; syrup use is recommended in very young children up to 10-12 kg: 5ml of cotrimoxazole paediatric suspension contains 40 mg Trimethoprim/200 mg sulfamethoxazole. If syrup is unavailable, crushed tablets may be used and depending on availability, one may switch from syrup to tablet to ensure uninterrupted medication.
- Once tablets can be taken (a single strength tablet provides Sulfamethoxazole 400 mg and trimethoprim 80 mg):
  - ≤ 10 kg: half of a single strength adult tablet.
  - 10-25 kg: one whole single strength adult tablet.
  - > 25 kg: two single strength adult tablets.
- Adjust dosages according to body weight rather than body surface area doses.

Pregnant women:

Cotrimoxazole prophylaxis is recommended for all HIV-positive pregnant women, after the first trimester. HIV-positive pregnant women eligible for cotrimoxazole prophylaxis or already receiving daily cotrimoxazole should not be given Sulfadoxine-Pyrimethamine prophylaxis as intermittent preventive treatment for malaria; cotrimoxazole is sufficient and has been proven to have prophylactic effect on malaria as well as other opportunistic infections.
HIV-positive persons with advanced immuno-suppression are at an increased risk of developing malaria, especially severe forms of malaria. For those who require malaria prophylaxis, including pregnant women, and are eligible for cotrimoxazole prophylaxis or already on daily cotrimoxazole, there is no need to take additional drugs for malaria prophylaxis.

**Safe drinking water:**

Due to the immune suppression caused by HIV, diarrhoea is 4 times more common among children with HIV and 7 times more common among adults with HIV than their HIV-negative household members. Bacterial/parasitic contamination of drinking water is common too so purification and boiling water is necessary to make it safe. What would be harmless levels of these bacteria or parasites like Cryptosporidium parvum/Microsporidium in water for normal people can cause infections in people with HIV.

A study of the provision of plastic water vessel with a spigot and a supply of dilute chlorine solution to be added to water for purification was associated with a reduction in microbial contamination of household water and a 34% reduction in diarrhoea among persons with HIV. The same results were seen among HIV negative children in the same household.

The other way to get safe drinking water is to ensure that all the water for drinking is boiled adequately. A minimum of 5 minutes of boiling then cooling is required. Boiling is an easy method of providing safe drinking water. The patients must be continuously educated about this. Safe drinking water will enable a reduction in diarrhoeal and other water borne diseases among both the HIV negative and positive people.

**Insecticide-treated mosquito nets:**

Malaria is the number one cause of morbidity in Uganda. It is twice more common and parasitemia higher for adults and children with HIV than persons without HIV. Severe complications from malaria are probably more common among persons with HIV. Studies of bed nets have shown a 50% reduction in malaria and a 17% in all cause mortality among children. This reduction in the incidence of malaria will benefit persons with HIV and thus enable them live with lesser incidences of malaria attacks. Thus persons with HIV are recommended to sleep under treated mosquito.
**Provision of micronutrients and vitamin A:**

People with HIV are more predisposed to suffer nutrient deficiency than the negative in according to a number of studies. More often malnutrition and mal-absorption are major problems for people with HIV.

Eating well is the first step for a patient to take good care of their health because nutritious food helps build a strong immune system which enables fighting diseases. HIV/AIDS is a chronic illness however nutritional efficiencies have been shown to occur early in the course of then disease.

Multivitamins containing vitamins B,C and E given to pregnant mothers have been associated with reduced maternal and infant mortality, lower rates of mother- to- child transmission of HIV, greater birth weights plus short and long term beneficial effects on CD4 cell and viral load among women.

Given the available information, daily supplements of micronutrient supplements containing vitamins B, C and E should be considered for adults and children with HIV. In addition, Vitamin A should be given to all children with HIV.

**ART in patients with active Tuberculosis:**

Nevirapine which is in the first line of treatment has drug interactions with Rifampicin so the 2 drugs should not be given together. Note: Treatment with ARVs should be continuous and non- interrupted to maintain a continuous viral suppression.

**ART in pregnant patients:**

An HIV positive woman who is taking ARVs and would like to become pregnant should be counselled appropriately because some ARVs should not be taken in some stages of pregnancy, likewise, an HIV positive pregnant woman who wishes to start taking ARVs should be counselled appropriately.

**Prevention with positives:**

These are prevention interventions targeting individuals who have already tested positive for HIV and those who may be at risk of transmitting HIV to sexual partners and unborn children.

**Strategies for prevention with positives:**

- Utilize various ways to diagnose HIV infection/status-VCT, RTC, home based counselling and testing.
- Work with HIV positive persons and their partners to prevent new infections.
- Decrease mother-to-child transmission.
**Interventions for Prevention with positives constitute the following:**

- Partner testing and disclosure.
- Individual focused behavioral interventions.
- STI screening and management.
- Family planning.
- PMTCT services.

**Sources of support and referrals:**

It is important to provide appropriate and necessary referrals to help clients “live positively.” At the point of referral, the patient should receive the appropriate care depending on whether it is an initial visit or follow up visit.

The Referral System:

Adapted from: Draft Ministry of Health Routine Counselling and Testing/Basic Care- Participants Manual, March, 2005
Session evaluation: Question and answer.

Key messages:
- Access to good clinical care including diagnosis, treatment and health education remains a limited option to patients living in resource constrained setting. Due to this situation, the focus needs to be on simple approaches/interventions that will improve the quality of life for HIV/ AIDS patients.
Module 3

HIV Testing

Session 1: Overview of HIV Testing

The purpose of this module is to provide participants with basic knowledge in HIV testing.
Module 3: HIV Testing

Session 1: Overview of HIV Testing

Time: 5 hours.

Methods: Lecturette, demonstration.

Materials: Testing algorithm, test kits, appropriate laboratory consumables, blood samples, laboratory training manual, user’s manuals.

Objectives:

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

- Describe the different methods of HIV tests.
- Describe the commonly used testing algorithms in Uganda.
- Explain the procedure of HIV Testing.
- Interpret the HIV test results.

Activities:

1. Review session objectives.

2. Lecturette: Methods of HIV tests.

Notes for Facilitator:

Methods of HIV tests:

A. HIV Antibody Test

These tests detect antibodies to HIV and are of several types. Antibody tests can be classified as rapid and non-rapid.

(i) Non-rapid Tests:

ELISA: These are confirmatory tests used in the detection of HIV antibodies in whole blood, serum or plasma. They are easy to perform but require strict adherence to procedures.
ELISAs have the following characteristics:

- Good sensitivity and specificity
- Adaptable for testing many samples at a time
- Do not require use of radioactive substances

**Western Blot (WB):** It is the most widely accepted antibody confirmatory test and it is referred to as a gold standard in HIV testing. WB has high specificity due to its ability to separate and concentrate all the antigens in their specific bands, thus enhancing antigen/antibody binding to specific sites on the strip. It is easy to perform the test but difficult to interpret the results.

The ELISA and Western Blot tests are NOT rapid tests and are NOT used widely in programmatic settings.

**(ii) Rapid Tests**

**MODIFIED ELISAS:** These are simple and easy to perform tests, which do not require sophisticated equipment. Results are read within a specified time, usually within 30 minutes. Test samples can be run individually. All these tests can detect HIV-1 and HIV-2 antibodies but only Multispot, one of the rapid tests, is able to distinguish between the two. All rapid tests use whole blood, serum or plasma, but preferably serum or plasma is better due to higher concentration of the virus in them.

**B. HIV Viral Test**

These are tests that detect the presence of HIV. There are 2 types:

**(i) Polymerase Chain Reaction (PCR):** Detects RNA/DNA of HIV even before antibodies are produced.

**(ii) Viral Culture:** HIV can be isolated by culture in highly sophisticated laboratories.

**Examples of commonly used HIV test kits:**

- Capillus.
- Heamastrip.
- Determine.
- Unigold.
- Statpack.
- Tridote.
- Murex.
The “3 C’s” for HIV testing:

The principles for conducting an HIV test for individuals require that:

- Test results are confidential.
- Testing is accompanied by counselling.
- Testing can only be conducted with informed consent*.

*Informed consent means that (1) The client has enough information to understand what they are agreeing to and what the implications are; and (2) The counsellor is honest and objective and allows the client to make his/her own decision regardless of the counsellor’s opinion or preference.


3 Demonstration: HIV testing procedure.

Instructions:

Before the session, prepare the following:

- Invite a Laboratory Officer to provide a demonstration of a rapid HIV testing procedure.
- Agree on the key points that should be discussed before, during or after the demonstration.

During the session:

- Distribute lab request form and discuss common mistakes and how to avoid them.
- Lab Technician provides demonstration and describes testing procedure.
- Use the briefing notes to highlight important points in HIV testing, including testing protocol, and HIV Test kits.
Notes for Facilitator:

Testing Protocol:

HIV antibody testing is the standard screening test used routinely to detect HIV infection in a person. The test determines whether there are antibodies for the HIV in a person’s blood. The test does not detect the presence of the virus itself in the blood, but the antibodies that the person’s immune cells have made in response to infection with the virus. Although there are different tests that can be done to detect the virus itself, (including Polymerase Chain Reaction (PCR), Viral Culture) in Uganda, HIV antibody testing is commonly used.

The three test algorithm refers to the concept of cross checking with more than one HIV test to confirm the results. The first test is very sensitive and may give a false positive result, the second is a confirmatory test and is run on only positive samples to confirm that they are truly positive, and a third test breaks the tie when necessary.

- **Screening test (1st test):**
  All specimens are submitted to this test which should be highly sensitive*. Samples that react positively on this test are submitted to the next test. Those that react negatively are taken to be negative.

- **Confirmatory test (2nd test):**
  Samples that react positive on the screening test are then submitted to this test, which is highly specific**. Positive results are given as positive results. Samples that react negatively on this test yet were given positive on the screening test (the results are discordant) are tested for a third time.

- **Tie-breaker (3rd test):**
  Discordant samples are submitted to this test. The result from this test is the one that is taken in the case of these samples because this test is highly sensitive and specific.

*Sensitive: This describes the ability of a test to detect a positive result as truly positive. A highly sensitive test will give very few false negative results.

**Specific: This describes the ability of a test to detect a negative as truly negative. A highly specific test will give very few false positive results. Highly specific tests are used to diagnose an individual with HIV infection.
The Screening Test must be conducted with a test kit that is highly sensitive. Examples of sensitive test kits: DETERMINE, Capillus.

The Confirmatory Test must be conducted with a test kit that is highly specific. Examples of specific test kits: Unigold, Serocard.

The Tie-breaker test must be conducted with a test kit that is highly sensitive and specific. Examples of test kits that are both sensitive and specific: InstantScreen, Multispot, Stat Pak, Sure Check, Genedia.

Examples of serial algorithm:

- Determine .......... Statpak .......... Unigold
- Tridot ........... Statpak .......... Unigold
The Parallel Testing Algorithm

The parallel testing algorithm is as follows:

1. **Test Specimen with two rapid test kits of different antigenic specificity at the same time**
2. Both tests give the same results?
   - **YES**: Report test results as shown
   - **NO**: Test specimen on a different third test (tie-breaker)
3. Report results as shown on third test only (tie-breaker)
**Testing Children Below 18 Months of Age**

For children below 18 months, DNA PCR will be done after counselling the caretakers. The testing algorithm for children below 18 months born to HIV infected mothers is as follows:

- **Infant born to HIV positive mother or with symptoms suggestive of HIV**
  - **HIV DNA PCR at week 6/or at earliest opportunity after week 6**
    - **Negative**
      - Continue Follow up care for the baby
        - Do Immunoglobulin G antibody test at 18 months to determine child’s status
        - In case child develops symptoms earlier than 18 months, repeat TNA PCR
    - **Positive**
      - Repeat PCR at week 14
        - **Negative**
        - **Positive**
          - Infection Confirmed
The testing algorithm for symptomatic children below 18 months is as follows:

- Child < 18 months with features suspicious of HIV/AIDS
  - Do qualitative HIV DNA PCR at earliest opportunity
    - Negative
      - Repeat PCR at earliest opportunity
        - Negative
          - No HIV infection
        - Positive
          - Positive
            - Infection confirmed
    - Positive
      - Repeat PCR at earliest opportunity
        - Positive
          - Repeat PCR at earliest opportunity
            - Positive
              - Infection confirmed

Testing Children Above 18 Months of Age:

Follow the protocols for testing adults using the rapid HIV test kits.
Demonstration: HIV testing procedures involving finger stick and venous method.

Instructions:
- Form small groups and ask pre-selected volunteers to join their assigned small group.
- The laboratory technician demonstrates and describes the testing procedure including finger-stick and venous methods.
- Discuss questions and concerns with the testing procedure.
- Laboratory technician explains how to read /interpret test results.

Notes for Facilitator:

You will need a few volunteers willing to have their blood examined for HIV. They should be known to be HIV-negative and should not be participating in the course. The volunteers will have the finger-stick procedure performed on them by participants, and then their blood will be used to process the HIV test. This is a sensitive situation and should be arranged before the training. Never ask a person to volunteer in front of others. You should ask him or her privately so he or she can decline this activity without explanation. You may also want to get confirmed HIV positive blood from the nearest blood bank if possible for demonstration.

The structure of this exercise depends on the number of pre-selected volunteers. For example, if you have three volunteers, you can divide the participants into three small groups. The volunteers can supervise the activity and reinforce the correct steps. If you have only one volunteer, a few participants can practice on this volunteer, while you review the steps and answer questions.

Session evaluation: Question and answer.

Key messages:
- Presence of HIV infection in a person can be confirmed through the HIV tests.
- The HIV rapid tests are accurate and reliable.
- HIV antibody test must not be used for determining HIV infection in children below 18 months.
Module 4
Approaches of HCT

Session 1:  HCT protocols/approaches

The purpose of this module is to enable participants to understand the different approaches/protocols to HIV counselling and testing in Uganda.
Module 4: Approaches of HCT

Session 1: HCT Protocols/Approaches

Time: 1 hour and 30 minutes.

Methods: Lecturette, brainstorm, discussion.


Objectives:
By the end of the session, participants will be able to:

- Describe the different HCT approaches in Uganda.
- List the differences between VCT and RTC
- Explain the benefits of HIV Counselling and Testing.

Activities:

1. Review session objectives.

2. Lecturette: The approaches of HCT in Uganda.

Instructions:
- Participants to define the word “protocol” and “HIV Counselling and Testing (HCT)”.
- Process responses to come up with the following definitions:
Notes for Facilitator:

Protocol is the step by step procedure, which a counsellor or other health worker follows when offering a service, in this case, HCT.

HIV Counselling and Testing (HCT) is a term that includes all of the approaches to HIV testing being practiced in Uganda. In 2005, these approaches included:

- Voluntary Counselling and Testing (VCT)
- Routine Testing and Counselling (RTC)
- Home-based HCT (HBHCT)

All of these models include the following 5 steps:

1. Initial contact.
2. Pre-test session.
3. HIV testing.
4. Post-test session.
5. Referral and follow-up.*

Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT) is a client initiated HIV prevention and care intervention. VCT gives the client an opportunity to confidentially explore and reduce risks of acquiring or transmitting HIV. Knowledge of HIV status also enables the client to access care and prevention services.

VCT follows the following procedures:

- Pre-test counselling (individual or group).
- HIV testing following informed consent by client.
- Post-test counselling (involving HIV test results disclosure and discussion on their meaning and implications).
- Individual risk assessment and risk reduction of HIV.
**Justification / rationale for VCT**

VCT has been and remains the primary approach for delivery of HCT services in Uganda. VCT is client-initiated and can be offered in stand-alone sites or as a specialized service in health centres or outreach sites. VCT clients are assured of full confidentiality – that is, HIV test results linked to the client’s name are only known by the counsellor. The client may request the counsellor to provide results to a third party, but otherwise there is no sharing of results.

**Routine Testing and Counselling (RTC)**

Routine Testing and Counselling (RTC) is a provider initiated approach, where HIV testing is integrated into the routine investigation of the patient irrespective of their presenting signs and symptoms. In RTC, patients are given pre-test information, HIV testing, post-test results and referral for treatment as well as care and support services. RTC should not be confused with mandatory testing, as the patients maintain the right to opt out or decline testing. RTC is aimed at identifying HIV positive and negative individuals so that they can access appropriate care and prevention services respectively.

**Justification/ Rationale for RTC**

In medical ethics, the first responsibility of a clinician is to make a proper diagnosis. A survey conducted among patients attending Mulago Hospital showed that 70% of them wanted an HIV test. Of these, only 10% actually accessed the HIV test. When asked why they did not take the test for HIV, the majority said the reason was that the attending doctor did not ask for it. This is an indicator of missed opportunities in hospitals. ([Survey Reference: Rhoda Wanyenze, Moses Kamya, Cheryl A. Liechty, Allan Ronald, David J. Guzman, Fred Wabwire-Mangen, Hamlet Mayanja-Kizza, David R. Bangsberg. HIV counseling and testing practices at an urban hospital in Kampala, Uganda. AIDS and Behavior in Press. 2005.](#))

The prevalence of HIV positive individuals is highest in health care settings and it is cost effective to do HIV testing where HIV prevalence is highest. The majority of patients who come to health units with HIV related problems do not know their HIV status and are discharged without being tested for HIV. Some of the individuals are in the late stage of the disease and urgently need care.

Many patients with the HIV virus do not have obvious HIV-related symptoms. The offer of HIV testing based solely on clinical or social assessment for likelihood of HIV infection is inaccurate and misses many patients who could be infected. In order to reach all the HIV positive people who urgently need care, it is important to offer the test routinely to all patients, especially in high prevalence areas and units. This will require integration of HIV counselling and testing into the routine care of patients. Patients will hence receive comprehensive care, including HIV/AIDS care for HIV infected patients.
Integrating HIV testing into routine care coupled with the widespread provision of HIV/AIDS care in clinical settings reduces the stigma associated with HIV testing and HIV infection. It normalizes HIV infection as HIV is treated as other chronic diseases. It is also convenient to both the patient and the care giver.

Routine counselling and testing is HIV testing done routinely as part of health care services in health care settings where the clients or patients are not very sick e.g. antenatal care. The RCT approach is provider-initiated, is intended to increase access to HCT services. RCT facilitates couples counselling and follow up services. The protocols and other details are described in the revised policy on PMTCT.

**Diagnostic HIV Testing:**

Diagnostic HIV Testing is part of RTC. Diagnostic HIV Testing is testing which occurs when a clinician decides to conduct a HIV test on a patient on the basis of his observation of signs and symptoms of HIV infection. In this case, the clinician needs information on the patient’s HIV status in order to make appropriate decisions on management and care of the patient. In diagnostic testing, the three C’s in HIV testing are still followed (that is, testing is accompanied by consent, counselling and confidentiality). Even when symptomatic, one must always obtain informed consent before conducting an HIV test. The clinician should inform the patient that his/her symptoms are sometimes associated with HIV/AIDS and that he/she needs to do the test to better manage the patient. In the event that the patient is unable to give informed consent (e.g. when patient is unconscious or mentally ill), the provider can conduct an HIV test provided the knowledge of the HIV sero-status of the patient is necessary for managing the patient’s condition.

**Differences between VCT and RTC:**

<table>
<thead>
<tr>
<th>VCT</th>
<th>RTC</th>
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<tr>
<td>Client initiated</td>
<td>Provider-initiated</td>
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<tr>
<td>Individual chooses to seek HIV counselling and testing</td>
<td>Individual is seeking medical care</td>
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<tr>
<td>First user of the test result is the client who uses the information to make personal life decisions</td>
<td>First user of the test result is the health care worker to make a correct diagnosis and provide appropriate treatment</td>
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<tr>
<td>Counselling focuses on addressing risk behaviour and risk reduction</td>
<td>Counselling is part of routine care provided to clients who come for different services</td>
</tr>
<tr>
<td>Anonymous or confidential services may be offered</td>
<td>Services provided are confidential and documented in medical record to ensure continuity of care</td>
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**Home-based HCT:**

Home-based HCT is HIV counselling and testing that is provided in the home setting. It includes household education, identification of adults and children who consent for testing, orientation to testing, HIV testing, results counselling and referral for treatment as well as care and support.

Home-based HCT is also known as family-based HCT.

Discuss: Benefits of HIV Counselling and Testing.

Instructions:
- Form five groups.
- Ask each group to discuss the benefits of HCT to:
  - The individual.
  - Healthcare Worker.
  - Couple and family.
  - Community.
  - The nation.
  - Groups present to the larger group.
- Record responses and build on what participants have presented.
Notes for Facilitator:

Benefits to the Individual:

**HIV positive**
- Early access to care and support.
- Prevention of Re-infection and other STIs.
- Prevention of HIV transmission to partner and/or unborn child.
- Encourages partner disclosure and testing.

**HIV negative**
- Risk reduction for the HIV negative individual.
- Reduced anxiety/fear.
- Motivation to remain negative.
- Encourages partner disclosure and testing.

Benefits to the Healthcare Worker:

- Entry point to comprehensive HIV/AIDS care interventions and management including PMTCT, treatment of opportunistic infections (OIs) use of ARVs and psychosocial care.
- Compliance with professional ethics.
- Disease surveillance and better planning and appropriate allocation of available resources.

Benefits to the couple and family:

- Supports safer relationships – enhances faithfulness.
- Enhances prevention through partner notification and testing, PMTCT.
- Allows the couple/family to plan for the future.
- Information about HIV prevention, care and behaviour change.
- Reduces stigma and discrimination.
- Enables the family to provide care to the infected individual.

Benefits to the community:

- Generates optimism as large numbers of persons test HIV-negative.
- Impacts community norms (testing, risk reduction, discussion of status, condom use).
- Reduces stigma and discrimination as more persons “go public” about having HIV.
- Serves as a catalyst for the implementation of care and support services.
- Reduces transmission and changes the tide of the epidemic.
- Information about HIV prevention, care and behaviour change.
Benefits to the nation:

- Provision of HIV surveillance data to aid in planning, drawing of HIV/AIDS mitigation strategies and mobilizing for funding and resources from donors and appropriate allocation of resources.

Key message:

- Counsellors should consider the basic principles of confidentiality, consent, respect for human rights, right to information, as well as legal and social cultural issues whenever they apply any of the HCT approaches/protocols.
Module 5
Introduction to Counselling

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The purpose of this module is to provide participants with knowledge and skills regarding HIV counselling.
Module 5: Introduction to Counselling

Session 1: The Concept of Counselling

-Time: 1 hour and 30 minutes.

-Methods: Brainstorming, lecturette, group discussion, case scenarios.

Objectives:
By the end of the session, participants will be able to:

- Define the term ‘counselling’.
- Identify who may need counselling.
- Describe the qualities of a good counsellor.
- Explain the importance of counselling in relation to HIV/AIDS.
- Explain where and when counselling should be done.
- Explain the counselling process.

Activities:

1. Review session objectives.

2. Brainstorm: The meaning of counselling.

3. Small group discussion on the following:
   - Who should be offered counselling and why?
   - Why is it important to counsel?
   - Who should do the counselling?
   - Where and when should counselling be done?
Notes for Facilitator:

What is counselling?

- Counselling is a supportive relationship that helps a person cope with some aspect of his/her life.
- The process of counselling aims to empower people to acknowledge and understand their problem(s) so that they can reduce/solve them.
- Counselling is an interpersonal communication through which a person is helped to assess his/her current situation, explore his/her feelings, and arrive at a solution to cope with the problem.

Who should be offered HIV counselling?

- Those who want to know their HIV status.
- Pregnant women and their partners.
- Those worried about HIV infection.
- Those intending to marry.
- Those intending to enter into a sexual relationship.
- Those planning to have children.
- Patients coming to health facilities.
- Families of HCT clients.
- Those affected by HIV.

Why is counselling important?

- Helps clients make informed decisions.
- Helps clients to make appropriate plans for the future.
- Helps clients cope with challenging situations.
- HIV infection is chronic and fatal; counselling offers continuous support.

Who should counsel?

Qualities of a good counsellor:

- Someone trained in counselling.
- Someone with good communication skills.
- Someone with a positive attitude.
- Someone who is accepting, empathetic, and non-judgemental.
- Someone with the time and interest to help others with their problems.
- Someone who practises confidentiality (does not reveal clients' information without permission from the client) and has exemplary behaviour in that particular community.
- Someone who is honest.
Where and when should counselling be done?

Counselling can be done anywhere as long as the space is:

- Private.
- Quiet, without interruptions.
- Safe and secure.
- Well-lit and well-ventilated.
- Convenient to both client and counsellor.

Lecturette: The counselling process.

Instructions:

- Review the ‘3 stages’ of counselling.
- Refer to the “counselling table”. Draw attention to:
  - Each “plate” on the table: (1) story telling and problem identification; (2) consider options; (3) make a plan. Discuss each stage of counselling, emphasizing the importance and purpose of each stage.
  - Each “leg” of the table: (1) communication skills; (2) ethics; (3) positive attitude; (4) principles.
  - The knowledge base.

Notes for Facilitator:

The three stages of counselling:

1. Helping the client to tell his/her story (problem identification).

Here the client discusses the problem by describing it and locating its cause(s) and effect(s). The counsellor should be able to differentiate between the real problems versus the presented problem, if such a difference exists. The counsellor guides the client to prioritise his/her problems — to deal with the life-threatening issues first and address the underlying or root causes later.

2. Identifying problem solving options (consider options).

The counsellor helps the client to consider his/her options: what can be done to solve the problem? Together the client and counsellor identify and discuss possible interventions. The counsellor provides necessary information for each option and conveys its specific advantages and disadvantages.
3. Make an implementation plan (action plan).

Here the counsellor helps the client to develop the steps to implement his/her chosen option. Together they review the plan, and the counsellor equips the client with the knowledge and skills to carry it out. This involves demonstration wherever necessary/possible, such as proper condom use. Counsellor and client schedule a future appointment to appraise the strategy.

Session evaluation: Review the counselling table.

Instructions:
- Participants summarize the session by drawing the ‘counselling table’. See notes below.

Notes for facilitator:

Counselling table/model:

Key message:
- Counselling is meant to empower clients to make informed decisions to cope with their problems.
Module 5: Introduction to Counselling

Session 2: Ethics, Principles, and Attitudes in Counselling

Time: 2 hours and 30 minutes.

Methods: Brainstorming, lecturette.

Objectives:
By the end of the session, participants will be able to:

- Explain the terms ‘ethics’, ‘attitudes’ and ‘principles’.
- Describe ethics in counselling.
- Describe attitudes in counselling.
- Describe principles in counselling.

Activities:

1. Explain the session objectives.

2. Brainstorm: Definition: professional ethics.
   Principles of counselling.
   Definition: attitudes.

Notes for Facilitator:

Instructions:

- Facilitator clarifies and summarizes participant’s contributions coming up with the following:
  - Ethics refers to an expected code of conduct. Ethics focuses on the relationship between individuals within the profession and their clients. Good ethical behaviour implies treating others with respect, care, compassion, and fairness.
  - Principles refer to a set of norms that guide implementation; they create standards that ensure quality services.
  - Attitudes are the way we perceive things or situations, which impacts our response to them.
Lecturette: Ethics in counselling.

**Notes for Facilitator:**

**Ethics:**

Ethics refers to an expected code of conduct. Ethics focuses on the relationship between individuals within the profession and their clients. Good ethical behaviour implies treating others with respect, care, compassion, and fairness.

**Why are professional ethics important? What role do they play?**

**Professional ethics:**

- Ensure discipline within the profession.
- Build confidence/trust in the profession.
- Ensure uniformity within the profession.
- Maintain healthy relationships within the profession and with other professions and clients.
- Serve as security for professionals and their clients.

**Different ethics in counselling:**

**Maintaining confidentiality**

- Confidentiality is one of the most important ethical issues for a counsellor. Clients must feel secure knowing that the information they have shared will be treated, in most circumstances, as absolutely confidential.
- There are instances where confidentiality does not hold:
  - The need to keep and utilise records for educational and research purposes. (Note: there is a difference between anonymity and confidentiality—e.g. your case history might be made public but it won’t be attached to your identity.
  - To meet the requirements of professional supervision.
  - Where a sexual partner needs to be protected from HIV infection, as might occur in couples counselling.

**Respect for the client**

- Regardless of who the client is, his/her behaviour, the client has come to you for help and deserves to be treated with dignity.
- The counsellor has a responsibility to help his/her clients feel okay about themselves and to increase their feelings of self-worth.
Different ethics in counselling (continued):

Client precedence

- When a client comes to the counsellor there is an implied contract with him/her to provide the confidential help required. Counsellors frequently experience a sense of conflict between their responsibilities to the client, the employing agency and the community. However, the counsellor’s responsibility to the client must take precedence.
- Counsellors have an obligation to abide by professional ethics and national policies.

Competence

- A counsellor has a responsibility to ensure that he or she gives the highest possible standard of service to the client(s). This calls for adequate training and supervision.
- Counsellors need to attend to their own professional development and wellbeing, and should be supervised and supported on a regular basis.
- A counsellor needs to be aware of his/her competence both professionally and personally. In case of any limitations, appropriate referrals should be made.
- Failure to do so results in the counsellor’s own issues impinging on the counselling process to the detriment of the client.

Appropriate referrals

- When a counsellor cannot adequately meet a client’s needs, the counsellor has the responsibility to consult with the client and make an appropriate referral.
- Counsellors should have knowledge of available services for referral and networking.

‘Limit the client-counsellor’ relationship

- There are limits to the client-counsellor relationship. This relationship must be purely professional; it must avoid creating any suspicions or temptations. The counsellor must establish appropriate boundaries; without them, the counsellor’s ability to help the client diminishes.

Avoiding self-promotion

- It is unethical for a counsellor to make claims about himself or his services which are inaccurate or which cannot be substantiated. Counsellors who do this not only put their clients at risk, but may also face prosecution.
Different ethics in counselling (continued):

Ensuring safety

- Counsellors should take all reasonable steps to ensure their own health and safety.

Responsibility to other counsellors

- Counsellors must not conduct themselves in their counselling-related activities in ways that undermine the work of other counsellors. As professionals they should respect each other and work in harmony with their colleagues.

Termination of counselling

- It is not ethical to terminate counselling at a point where the client still needs further help. If a counsellor must terminate his/her sessions for an unavoidable reason, then he/she must offer a suitable referral to continue the counselling process.

Legal obligations

- Counsellors, like all other professionals and members of the community, need to operate within the law. A counsellor therefore needs to familiarise him/herself with the relevant legal requirements; e.g. if the client is an offender or a victim, the counsellor should encourage the client or their next of kin to seek legal action

Being Exemplary

- The counsellor’s personal life style should incorporate and reflect all the characteristics of good counsel. The counsellor espouses familial harmony; to this end, neither alcoholism nor domestic violence features in his/her life. He/she should be model of leadership in the community to whom others look for guidance. In this sense, the counsellor is exemplary.

Being Honest

- A good counsellor is reliable. He/she is available when scheduled and provides clients with truthful, unbiased information.
Lecturette: Principles of counselling.

Notes for Facilitator:

Principles:
Principles refer to a set of norms that guide implementation; they create standards that ensure quality services.

The Importance of Principles
Principles:
- Ensure quality of service.
- Ease implementation of the activities.
- Act as safety measures.
- Ensure cost-effectiveness.

Universal principles that counsellors are expected to know and practice:

Individualization: People prefer to be treated as individuals rather than as a case or type; while dealing with a client, do not treat him/her as a person of a particular type, religion or region. For if a client senses that he is being treated as a case it can lead to rejection and hostility. For each one is unique though might face similar circumstances.

Acceptance creates honesty: All people need the opportunity to express their feelings, including negative ones. In counselling, the client’s negative feelings can be very intense, and it is the counsellor’s duty to absorb the client’s concerns without judgement. Honest discussion permits the counsellor to understand the situation from his client’s perspective. Speaking openly about feelings of stress or despair makes the process of counselling cathartic for the client.

Client self-determination: The counsellor ought to imply that the client holds the best solutions to his/her problems; the counsellor’s role is to help the client unlock those solutions. The counsellor should structure each session so that the client feels empowered to develop the life-skills he/she requires to cope with the situation at hand. The counsellor helps the client feel independent rather than dependent.

Impartiality: A counsellor should not take sides in a dispute or blame the client for the problems he/she faces. A good counsellor is neutral; his/her personal values do not factor into the counselling process, which relies on impartiality to create an environment in which the client feels safe to speak freely.
**Controlled emotional involvement:** A counsellor is expected to control his or her emotions. It is inappropriate for a counsellor to cry, quarrel, or celebrate with a client, just as it is inappropriate for them to enter into a sexual relationship. A good counsellor is empathetic without being emotionally involved.

**Self-appraisal/reflection awareness:** A good counsellor is not complacent; continuous self-critique fosters his/her improvement. A good counsellor is also flexible, willing to adapt his/her strategies to the individual client. It is important that a counsellor is able to assess whether he/she is best suited for a particular client; in the event of an ill match, he/she can refer the client to another counsellor.

**Externalisation:** A counsellor should not label clients according to their problems; this promotes discrimination and stigmatisation. A counsellor distinguishes the client from his/her predicament – women on PMTCT Programme are not ‘PMTCT mothers’, but instead mothers participating in a PMTCT programme.

**Notes for Facilitator:**

**Attitudes:**
Attitudes are the way we perceive things or situations, which impacts our response to them.

**Interpersonal Skills:**

- **Establishing rapport:** Establishing rapport with patients is crucial in all situations. It is key to developing a trusting relationship and it demonstrates the health worker’s interest in and respect for a patient’s issues and concerns.

- **Ensuring privacy and confidentiality:** Contrary to previously held notions that confidentiality is a strictly western concept, research indicates that patients everywhere need to be assured of privacy and confidentiality.

- **Showing respect:** This can be achieved when health workers are aware of cultural and role differences of gender, race, ethnicity, religion, disability, and socio-economic status, yet eliminate personal prejudices and biases about such differences. Health workers must not participate in or condone discriminatory practices based on these differences. Health workers must also respect the clients’ views and beliefs and build on them.
Interpersonal skills (continued):

**Showing empathy:** Empathy involves identifying with the patient, understanding their thoughts and feelings, and communicating that understanding to the patient. Simply stated, this means that health workers should “put themselves in their clients’ shoes.” Empathy requires sensitivity and a moment-by-moment awareness of fear, rage, tenderness, confusion, or whatever the patient may be experiencing.

**Acknowledging difficult feelings:** To help address difficult feelings, health workers should: Be aware of their own feelings, acknowledge the patients’ feelings and realities, understand that it is not the health worker’s job to take feelings away or to fix them, articulate and respond to non-verbal messages, and, normalize and validate patients’ feelings.

**Offering acceptance:** For patients to be honest in describing their problems and concerns during counselling, it is critical that he/she feels acceptance. The health worker can facilitate this by being non-judgemental and accepting, irrespective of socioeconomic, ethnic, or religious background, occupation, or personal relationships.

**Evaluation Session:** Question and answer.

**Key message:**

- Application of the aforementioned attitudes, ethics, and principles is very important throughout the counselling process.
Module 5: Introduction to Counselling

Session 3: Communication Skills in Counselling

Time: 3 hours

Methods: Brainstorming, lecturette, small group discussion, demonstration, role plays

Objectives:
By the end of the session, participants will be able to:

- Explain the meaning and types of communication.
- Describe effective communication skills in counselling.
- Identify factors that affect effective communication in counselling.
- Demonstrate effective communication skills in counselling.

Activities:

1. Review session objectives.
2. Brainstorm: The meaning and types of communication.

Notes for Facilitator:

Communication skills: A major component of a health worker’s job is communicating with patients and clients. This exchange is a two-way dialogue that uses both verbal and non-verbal methods of communication. To identify a patient’s needs and provide appropriate information; health workers must practise solid communication skills.

Definition of Communication:

- The exchange of information from one person to another with feedback from both parties.
- A message understood in the same way by sender and receiver.
- Thoughts, opinions, or information shared via speech, writing, or physical signs/gestures.
Two Types of communication:

Verbal communication:

Verbal communication includes face-to-face communication. Some short words can be used encouraging client to talk more e.g. “can we go on”, “what else”, “is that all”, “then” etc. The counsellor should speak clearly and slowly and also avoid using technical languages and jargons that the client might not understand.

Non-verbal communication:

Non-verbal communication includes the use of facial expressions, hands, posture, eyes etc to communicate a message. If a person is saying one thing but is sending a different message non-verbally, it is often a sign that what the person is saying is not entirely true.

Usually these messages are matching, so if a person is saying that he or she appreciates something you have done s/he is smiling and expressing warmth non-verbally (see examples below). Communication problems arise when a person’s verbal and non-verbal messages contradict each other.

Examples of matching verbal and non-verbal communication:

<table>
<thead>
<tr>
<th>Verbal Communication</th>
<th>Non-verbal Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smile</td>
<td>happy</td>
</tr>
<tr>
<td>Frown</td>
<td>unhappy</td>
</tr>
<tr>
<td>Does not sit still on the seat</td>
<td>uncomfortable</td>
</tr>
<tr>
<td>Moving legs up and down</td>
<td>tense</td>
</tr>
<tr>
<td>Cannot keep hands still</td>
<td>tense</td>
</tr>
<tr>
<td>Eyes widen</td>
<td>afraid</td>
</tr>
<tr>
<td>Scratches head</td>
<td>unsure of herself/himself</td>
</tr>
<tr>
<td>Eye contact</td>
<td>serious, paying attention</td>
</tr>
<tr>
<td>Nodding the head</td>
<td>understanding</td>
</tr>
<tr>
<td>Sitting close by</td>
<td>relaxed</td>
</tr>
<tr>
<td>Leaning towards</td>
<td>interested/encouraged to continue</td>
</tr>
<tr>
<td>Eyes wide open, mouth agape</td>
<td>Disgusted</td>
</tr>
</tbody>
</table>
3 Discuss: Effective communication skills in counselling.

Instructions:
- Participants brainstorm the 4 basic communication skills:
  - Active listening.
  - Checking understanding.
  - Asking questions.
  - Answering questions.

Notes for Facilitator:

Active listening:
Active listening is the key to motivating others to give us feedback. Listening and feedback are both essential ingredients of good communication. The counsellor has to be a good listener in order to understand and communicate effectively. The following techniques are required for one to be an effective listener, these include:

Paying attention

This comes out clearly in the body languages. The person counselling needs to keep eye contact and sit near the client. The formula below could help you to remember what is required in the technique of paying attention.

Sitting posture:

<table>
<thead>
<tr>
<th>R</th>
<th>Be relaxed</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>be open</td>
</tr>
<tr>
<td>L</td>
<td>Lean forward towards the person</td>
</tr>
<tr>
<td>E</td>
<td>Keep eye contact with the client</td>
</tr>
<tr>
<td>S</td>
<td>Sit near the client</td>
</tr>
</tbody>
</table>

Using silence constructively

A person may communicate through silence. This could be some expression of a feeling or attitude towards the situation. The counsellor should not hurriedly interrupt, but give sometime of quietness.
**Tips on active listening:**

- **Stop talking:** Obviously you can’t listen and talk at the same time. It is a good principle to listen to your clients while talking to you other than interrupting them.

- **Remove distractions:** If something is distracting your attention get rid of it. Turn off the TV, radio or cell phone and don’t fiddle around with objects while counselling.

- **Concentrate:** Listening takes concentration; don’t let your mind wonder off onto other things. Listen to what the person is saying and respond later after person has stopped talking.

- **Look interested:** Maintain good eye contact without staring.

- **Hear more than the words:** Watch for non-verbal signs in the face, eyes, hands and tone of voice. Look for feelings behind the words; often what we say at first is not what we feel.

- **Check that you are hearing right:** Often the message we hear is not the same as the message the other person thinks they are telling us. Do not say ‘I see’ or ‘I understand’ unless you are sure that you do. From time to time, repeat and summarize what you hear.

- **Use probing questions:** This shows you are listening and encourages the other person to keep talking and to consider useful goals towards solving his/her problem.

- **Be patient:** Listening takes time you need to be prepared to give it. If you don’t have time at the moment, explain this to the person and offer to make time later. It often takes time for a person to get what they really want to talk about. You need to be prepared to go through the chitchat so that the person can ease into what is really on her or his mind.

- **Be non-judgemental:** Try not to judge people. Your role as a listener is to create an atmosphere that is open and safe, that will help the other person to freely and honestly share his/her feelings.

**Dos and Don’ts of Listening**

In listening we should...

<table>
<thead>
<tr>
<th>Be able to do the following:</th>
<th>Not do the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Show interest</td>
<td>Argue</td>
</tr>
<tr>
<td>Be understanding</td>
<td>Interrupt</td>
</tr>
<tr>
<td>Single out the problem</td>
<td>Pass judgement</td>
</tr>
<tr>
<td>Listen for causes of the problem</td>
<td>Give advise unless it is the last thing you can do</td>
</tr>
<tr>
<td>Encourage the client to believe that can solve the problem</td>
<td>Jump to conclusions</td>
</tr>
<tr>
<td>Observe silence appropriately</td>
<td></td>
</tr>
</tbody>
</table>
Checking Understanding:

Importance of checking that you have understood what has been said:

- It lets the person know that you have been listening carefully
- It lets the person know that you are trying to understand his/her situation and therefore caring.
- It gives an opportunity for the person to think more clearly about his/her problem.

You can ‘check understanding’ with the following techniques:

Repeating: At times of stress and crisis, people may be in a state of denial or feel overwhelmed, so they may not always comprehend everything they are told. Health worker should repeat important information and summarize what the person has told you.

Clarifying: When talking to a patient, there are circumstances when certain issues are not clear to either party (patient or health worker). Clarifying unclear points can enhance communication (e.g., by asking, “Do you mean…?”) or supply facts (e.g., by asserting, “No, HIV is not transmitted by eating from the same dishes.”).

Paraphrasing: Paraphrasing—restating the client’s words in the counsellor’s own words—helps achieve this objective. To paraphrase effectively, the health worker must listen actively; the health worker must determine what is being said and check with the client that the paraphrase is accurate. e.g. “You have told me that…."

Reflecting feelings: This is to help the client evaluate and moderate his/her own feelings as expressed by the counsellor. Useful phrases help to reflect feelings in a counselling context, particularly when the patient is primarily expressing feelings and not giving clues about the association.

For example:

- “You feel excited…..
- “What’s happening to you?”
- “So it was a shocking thing as you saw it?”
- “You felt you were not taken seriously?”

Summarizing: To wrap up and bring the discussion into focus. This serves as a launching point for further discussion on a new aspect of the problem.

- “These are the key ideas you have expressed…"
- “If I understand you correctly, you feel that…"

Restatement: Helps the counsellor check their interpretation with the client. Restatement shows that the counsellor understands what the client is saying. It helps the counsellor analyze other aspects of the problem for further discussion with the client.

- “As I understand it then, your idea is…"
- “So it seems you have decided to do…and the reasons are…"
- “So what you have said is…"
**Asking questions:**

**Importance of asking questions**

- It helps the person explore his/her problems or situation
- It helps counsellor get the required information from the client.
- It helps the person to think and visualize more clearly the problem or situation he/she is confronted with.
- It helps the counsellor assess the needs of the person
- Asking questions helps the counsellor to direct and focus the counselling session.
- It helps the counsellor (helper) help the person prioritize urgent issues/problems.

**Types of Questions:**

**Closed-ended questions**

These usually have a “No” or “Yes” answer e.g. they tend to be interrogative and seem to be judgmental. The use of this type of questions should be limited as much as possible.

Examples:
- “Are you sick?” – “No”
- “Have you ever used this drug?” “Yes”

**Open-ended questions**

Open-ended questions give patients an opportunity to express themselves freely and make it easier for you to identify their needs and priorities. Open ended questions are useful in starting a dialogue, finding a direction, and/or exploring a client’s concerns.

Examples:
- What are your major sources of income?
- Why was your child’s blood tested?

**Probing Questions**

Probes are verbal tactics to help clients talk about themselves and define their concerns concretely in terms of specific experiences, behaviours, and feelings. Probing also helps identify themes that may emerge when exploring these elements.
**Answering Questions:**

The client may ask questions when he/she is seeking more information and clarification. The counsellor has to answer questions asked by the person he is counselling.

**Important points to note when answering questions:**

- Behind every question there is a story or problem therefore the counsellor should probe for more information. Find out what the client asked that question.
- Accurate answers should be given.
- It is okay to admit that you do not know what has been asked. Some questions do not have answers.
- Counsellors should be free to say ‘I don’t know’.
- Give information not advice.
- Use clear and simple language.
- Before answering any question find out what the client already knows.
- Answer questions appropriately and relevantly.
- Give time: After answering a question or giving information a counsellor should give time to client to think about and internalize it.
- Clarity and simplicity: Use simple and culturally appropriate language to create a common level of communication. Explain important points more than once, and consider putting them in writing or using visual diagrams as memory aids so patients can refer to the points after the session.
Group Work: Practice: effective communication skills.

Instructions:
- Review the SOLER behaviours to demonstrate active listening:
  - S sitting squarely,
  - O open position,
  - L lean forward,
  - E eye contact, and
  - R relaxed.
- Work in pairs and sit facing each other. Decide who will be the first ‘listener’ and who will be the ‘talker’. As listener, try to follow all the SOLER behaviours and encourage the other person to speak.
- After 10 minutes, the talker gives the listener feedback about the effectiveness of the listening.
- Then change roles. After another 10 minutes, the talkers offer feedback.
- Discussion points:
  - What behaviours encouraged free and focused talk?
  - What behaviours discouraged free and focused talk?

Evaluate learning: Checking for understanding.

Instructions:
- Review statements that a counsellor can use to ‘check for understanding,’ examples include:
  - “Let me check with you that I am hearing you correctly…”
  - “What you seem to be saying is…”
  - “It sounds as though…”
  - “Did I hear you say…?”
- Work in pairs, with one person as counsellor and the other as client.
- The client should discuss his/her current work situation while the counsellor periodically ‘checks for understanding’. The client should give significant detail.
- Switch roles after 15 minutes.
- Discussion points: “What did you learn from the exercise?”
- Be careful, though, not to overuse this technique. Only ‘check for understanding’ when the content is not clear or when you feel that it would be useful to summarise a number of points.
Demonstration: Effective communication.

Instructions:

- Ask 2 participants to conduct a role play where they demonstrate effective communication skills.
  - In plenary, discuss:
    - What was easy?
    - What was difficult?
    - What effective communication skills did you use?
    - What skills would you have improved?
    - What helped you use good communication skills?
    - What made you not use good communication skills?
- Encourage constructive feedback on the role play:
  - What effective communication skills did you see?
  - Suggestions for improving communication?
Discuss: Common barriers to effective communication.

Notes for Facilitator:

Common barriers to effective communication:

- **Making assumptions:** Making assumptions about what a client is experiencing or feeling is a common mistake that counsellors make. It is easy, for example to assume that a patient who has advanced AIDS is worried about dying. They may in fact have many other concerns such as what will happen to their children, how to access effective treatment etc. We should use communication skills to help us find out what the individual client is concerned about.

- **Distancing:** Counsellors may have personal experiences with HIV, having been affected in different ways. Some may be HIV positive themselves. Caring for individuals and families experiencing similar problems can be very distressing. Sometimes we avoid attending to certain clients with problems similar to ours, often without realising it. As counsellors we need to develop self-awareness. If we notice that we are experiencing such difficulties it is valuable to seek support from our peers or counsellor supervisors.

- **Fear of doing harm and provoking emotions:** Issues associated with HIV/AIDS are very sensitive. They often touch on topics that are taboo in many cultures e.g. sex, death and dying. Fear of upsetting clients can prevent counsellors from using their skills effectively.

- **Inadequate knowledge & skills:** Counsellors can feel very frustrated if not equipped with adequate knowledge and skills to handle some difficult issues and emotions presented by their clients. Counsellors need to be committed to reach greater depths of self-knowledge and strengthen their skills to be able to cope with the carrier without feeling overwhelmed and incompetent.

- **Lack of motivation and recognition:** The associated pressure of caring for clients can lead to stress and lack of motivation more so among counsellors who are also responsible for other demanding roles as health professionals.

- **Differences in cultures:** The culture that we come from influence the way we communicate. Many cultures have norms that influence how sensitive issues are dealt with in the family. Some of these norms can greatly inhibit effective communication.

- **Language barriers:** Language is a factor that is often overlooked. Lack of fluency in a particular language can be a very big hindrance to effective communication.
Group Work: Listening activity.

Instructions:

- This demonstration illustrates the difficulties in effective communication. You will need 6-8 participants to play a "listening game" in front of the group.
- Six to eight individuals will sit in a close circle in front of the participants. They will choose a topic that is slightly controversial but easy to talk about, e.g. contraceptives for adolescents, domestic violence in the community, or defilement in the schools.
- Before anyone can speak, they first have to repeat (paraphrase) what the previous speaker has said. The previous speaker will reply “yes” if they are satisfied with the paraphrasing or “no” if the person has not restated their comments accurately.
- In case the response is “no”, another individual will try to paraphrase the person’s statement.
- The remaining participants will observe and note the things that seem to get in the way of effective communication.
- Discuss:
  - What got in the way of listening effectively?
  - What kinds of noise could be identified?
  - What noises can prevent health workers from communicating well with clients?
  - What noise can prevent clients from communicating well with health workers?

Adopted from: Talking with Adolescents: A Manual for Health Workers

Session evaluation: Question and answer.

Key messages:

- Effective communication skills enable counsellors to communicate with clients. In order to understand the situation from the client’s point of view, the counsellor should not talk about their own experience or opinions.
- Counselling should be client centred must emphasize problem solving.
- Counselling must emphasize problem solving – so that the session leads to positive action.
Module 5: Introduction to Counselling

Session 4: Stigma and Discrimination

Time: 2 hours.

Methods: Lecturette, video, group discussion, brainstorming.


Objectives:
By the end of this session participants should be able to:

- Describe the meaning of the terms “stigma” and “discrimination” in HIV and AIDS.
- Explain the effect of stigma and discrimination on individuals and the community.
- Identify ways of reducing stigma and discrimination.

Activities:

1. Review session objectives.
2. Brainstorm: Meaning of stigma and discrimination.

Notes for Facilitator:

Stigma:

- Negative thoughts about a person or group based on a prejudiced position.
- The undesirable and spoiled identities that HIV/AIDS causes.
- HIV/AIDS related stigma builds upon and reinforces earlier prejudices.
- It plays into, and reinforces existing social inequalities—especially those on gender, sexuality, and race.
- It is also associated with behaviours that may be illegal or forbidden by religious or traditional teachings, such as pre and extra marital sex, sex work, men having sex with men, and injecting drug use.
Discrimination:

- HIV related discrimination is the action/outcome that results from stigma.
- It occurs when distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their actual or presumed HIV status or their belonging, or being perceived to belong to a particular group.
- HIV/AIDS stigma and discrimination is wide spread, results into rejection, denial, discrediting, which consequently leads to violation of human rights particularly those of women and children.

Group work: Types of stigma.

Route causes of stigma.

Effects of stigma and discrimination.

How to reduce these effects.

Instructions:

- Form 4 groups.
- Each group will discuss and prepare a group education session on their assigned topic.
  - Group 1: Describe different forms of stigma and discrimination in different contexts.
  - Group 2: Discuss root causes of HIV/AIDS related stigma.
  - Group 3: Discuss the effects of stigma on individuals, groups, and institutions.
  - Group 4: Discuss possible ways of eliminating stigma and discrimination among people infected and affected by HIV/AIDS. Then, discuss feelings associated with stigma and discrimination.
- Summarize and highlight key issues on stigma and discrimination.
Notes for Facilitator:

**Forms/types of stigma and discrimination**

- Internal (self) stigma, examples: blaming themselves, keeping away from other people, failing to seek health care, abandoning their jobs, self rejection/neglect, and failure to participate in political community, economic and social activities.
- External stigma, examples: other people talking negatively about the person refusal to treat the person, refusing to offer jobs, rejection by others.

**Root causes of stigma and discrimination in HIV/AIDS:**

- The chronic nature of HIV
- AIDS is life threatening.
- HIV/AIDS has no cure
- People are scared of contracting HIV
- HIV is associated with immoral behaviours stigmatized in society, like promiscuity etc.
- People living with HIV are often blamed as being responsible for being infected.
- Personal values and religious beliefs influence people’s thinking to believe that HIV infection is a result of immoral acts that should be punished.
- HIV/AIDS clients have no place in the kingdom of God
- Clients think they will die anytime

**Effects of stigma and discrimination on individuals, groups and institutions:**

- Affect health care seeking behaviour
- Lead to hopelessness, anxiety/stress, depression, self hatred, suicidal tendencies.

**How to reduce stigma and discrimination:**

- Community sensitization and mobilization.
- Use of supportive groups.
- Advocacy for human rights.
- Use of HCT services.
- Disclosure to the partners, friends, relatives, and the public.
- Sharing experiences and testimonies.
Show video.

Instructions:
- Facilitator shows relevant video with message on stigma and discrimination (for example “AIDS and Development – A Window of Hope”)
- Have participants watch the video and observe situations of stigma and discrimination.
- After the video, discuss observations.

Session evaluation: Question and answer.

Key messages:
- HIV/AIDS is like any other chronic infection and people who are infected and affected should not be stigmatised and discriminated against.
- HIV infects and affects anybody and therefore there is no reason for stigmatisation and discrimination.
Module 5: Introduction to Counselling

Session 5: Caring for Counsellors

Time: 1 hour and 30 minutes.

Methods: Brainstorming, group discussion.

Objectives:
By the end of this session, participants will be able to:

▸ Participants explain the concepts of stress and burnout, counsellor support.
▸ Participants can identify causes and signs of stress and burnout and ways to prevent burnout.
▸ Explain ways of Participants recognise the importance of supervision and develop personal strategies to strengthen their performance managing burnout.

Activities:
1. Review session objectives.
2. Brainstorm definition: stress, burnout, and counsellor support.

Notes for Facilitator:

**Stress:**
Stress is a physical, mental, emotional, psychological, or spiritual strain or tension caused as a result of over working of the mind body and soul.

**Burnout:**
Burnout is a reaction to the stress of counselling work that affects counsellors’ physical and emotional wellbeing.

**Counsellor support:**
Counsellor support is a set of measures that a counsellor or others can take to improve counsellor performance and prevent or address burnout.
3 Brainstorm: Sources of stress.

Instructions:
- Introduce the following categories:
  - Organizational issues.
  - Counsellor’s feelings or behaviour.
  - The nature of the counsellor’s role.
- Record issues on a flipchart under each category.
- Identify ways to resolve some of the organizational issues.

4 Brainstorm: Causes and signs of burnout.

How to prevent burnout.

Notes for Facilitator:

Causes of burnout:
HCT counsellors face daily challenges and stresses that can affect their physical and emotional health. Signs of burnout are lower energy, enthusiasm or idealism for doing one’s job, and a loss of concern for the clients and for the work.

Signs of burnout include:
- Exhaustion or tiredness that does not go away after resting.
- Unusual anger.
- Irritability and negativity.
- Frequent headaches or stomach problems.
- Weight loss or gain.
- Difficulty sleeping.

Ways of preventing burnout:
Counsellor support measures can help prevent burnout, but counsellors must take time to notice if their work is affecting them and identify early signs of burnout. Counsellors should routinely practice stress management techniques both in the work setting and in their personal lives. To prevent burnout and remain effective and satisfied in their work, counsellors and supervisors must find ways to meet the following needs of counsellors:
- The need to share work issues with another person while respecting client confidentiality.
- The need for feedback and guidance on performance.
- The need for improving professional skills.
- The need to express emotions and feelings.
- The need to feel valued as a person and as a colleague.
Counsellors and supervisors can institute measures at the HCT site that will help meet these needs and prevent burnout.

Ways to take care of counsellor needs include:

- Making sure counsellors are assigned clear and specific duties.
- Making sure counsellors know the boundaries of their professional obligations.
- Enlisting volunteers from community organizations to perform some site tasks.
- Allowing adequate break time during the work day.
- Allowing counsellors to vary their tasks and responsibilities from time to time.
- Providing for continuing education opportunities.
- Holding regular support group meetings of counsellors.
- Convening regular staff/team supervision meetings.

**Key messages:**

- Counsellors should routinely practice stress management techniques both in their work station and personal lives.
- Support systems should be put in place to prevent and address stress.
- Counsellors need to learn to recognize signs of stress and be able to deal with them in time or time.
Module 6

Counselling Using the VCT Protocol

<table>
<thead>
<tr>
<th>Session 1:</th>
<th>Forms of Counselling</th>
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<tbody>
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<td>Session 2:</td>
<td>Pre-test Counselling</td>
</tr>
<tr>
<td>Session 3:</td>
<td>HIV Testing Results and their Implications</td>
</tr>
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<td>Session 4:</td>
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<td>Session 8:</td>
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<td>Session 9:</td>
<td>VCT for Couples</td>
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<td>Session 10:</td>
<td>Counselling for Discordant Couples</td>
</tr>
</tbody>
</table>

The purpose of this module is to provide participants with knowledge and skills to offer HIV counselling services to different target groups using the VCT approach.
Module 6: Counselling Using the VCT Protocol

Session 1: Forms of Counselling

Time: 1 hour.

Methods: Lecturette, brainstorming, small group discussion.

Materials: Prepared case scenarios.

Objectives:
By the end of the session, participants will be able to:

▶ Explain the meaning of individual, group and couple counselling.
▶ Describe advantages and principles of each of the three forms of counselling.
▶ Demonstrate skills in offering individual, group and couple counselling.

Activities:
1. Review session objectives.
2. Brainstorm definitions: individual, group and couple counselling.

Notes for Facilitator:

Individual counselling:
Individual counselling is counselling offered to one person at a time. The counsellor will help the client to make decisions about HIV testing and how to manage their lives whether the test results are positive or negative.

Group counselling:
Group counselling is where more than two people with a common concern or interest are counselled at the same time. It involves an interactive discussion between the counsellor and the group members.

Couple counselling:
Couple counselling is when a pair of partners (male and female) come to be counselled and tested together. They may already be having sex together or they may be planning to have sex together in the future.
Brainstorm: Advantages and principles of individual, group and couple counselling.

Notes for Facilitator:

Individual counselling:

Advantages / benefits of individual counselling:

- It enables the client to express him/herself freely.
- It enables the client to participate fully in the session.
- It facilitates ownership of decisions.
- It helps the counsellor handle a person as an individual and therefore he/she is able to get appropriate and relevant options to the situations.
- It enhances development of rapport between client and counsellor.
- It enables free discussion of sensitive issues.
- It ensures confidentiality.
- It helps in dealing with strong emotions especially during post-test counselling and giving of results.
- It is easier to handle compared to group and couple counselling.

Principles of Individual Counselling:

- Use client-centered approach
- Handle each client as an individual and not as a case.
- View each client and his/her situation as unique.
- Perceive the situation from the client’s perspective. (Start from where the client is).
- Facilitate clients to fulfil their goal within their reach.
- Continually emphasize the attitude of high regard to the client.
- Facilitate self-determination of the client.
- Facilitate client to develop and improve life skills needed to cope with the problem and situations.
**Group counselling:**

**Advantages of situations when group counselling is necessary:**

- Group counselling is often applied during the pre-test counselling in crowded situations where there are few counsellors.
- Group counselling is also necessary and can be helpful to a group of people with same concerns/interests.
- Group counselling is commonly applied in preventive counselling.
- This can be useful when you need to provide information to a group of pregnant women about PMTCT and VCT before the testing.
- This counselling arrangement can also be used effectively to provide mutual support following testing. For example, peer support groups for pregnant women following testing so that they can share experiences on issues such as coping, living with HIV/AIDS and infant feeding concerns.
- It is helpful in case of male partners have come in big numbers (even if without their partners).
- In institutional settings (e.g. prisons or schools).
- When there are many clients compared to the number of counsellors.

**Principles of group counselling:**

- Clients in the group should be from the same age bracket.
- Each group should have not more than ten clients.
- Where there are couples, they should be grouped separately.
- Choose one language in which the entire group can freely interact and understand.
- Encourage participation of each group member (group involvement).
- Education level should be considered when forming the groups.
- Share the information in a simple way and make sure you give the relevant information to the right group.
- The sitting arrangement should be a semi-circle or oval, for eye-contact.
- Clarify to the group members that there is provision for personal discussions about personal issues and concerns after the general talk and inform them when and where this could be possible.
- Always be in control of the group.
- Allow time for questions.
- Wrap up the session and remind them of available individual counselling, time and place of convenience.
- Involve participants in group discussion, not lecturing.
Couple counselling:

Advantages / benefits of individual counselling:
- The couple is supported to discuss risk concerns and issues.
- The couple learns together about how to adopt safer sex practices. They learn about shared responsibility among partners and they hear information and messages together.
- The couple learns their results together and receives appropriate counselling and support. If the test results are positive or discordant, the counsellor can help reduce tension and prevent blaming.
- The couple can plan for their future and that of their family. Couple HCT can help to strengthen the relationship and promote mutual understanding between the couple.

Principles of Couple Counselling

In couple HCT, the couple agrees to:
- Voluntarily participate in the counselling and testing sessions.
- Discuss HIV risk issues and concerns.
- Discuss the advantages of knowing their status as a couple.
- Receive their HIV test results together.
- Keep confidentiality.
- Make a mutual decision about disclosure of results.
- Treat each other with respect and dignity.
- Equal participation.
- Engage in frank and open discussion.
- Listen and respond to one another with respect.
- Provide support to each other.

* Module 7, Session 9 provides specific information and guidelines for couple counselling.
Small group discussion: group dynamics.

Notes for Facilitator:

Counselling skills for group counselling sessions:

The counsellor who leads a group session will need similar skills to those required for individual counselling, but in addition will need to cope with the complex dynamics which may arise in the group setting:

Group dynamics:

- Dealing with an over-assertive, dominant individual.
- People who hardly speak in public.
- Ensuring inclusion of quiet, shy or overwhelmed individuals.
- Allowing all participants to speak.
- Coping with people who become emotionally distressed in a group.
- Being non-judgmental and inclusive of the different beliefs of group members, whether these are religious, cultural, medical etc..
- Refraining from “lecturing” the group-allowing the group to learn from each other.
- Some people may not want to share for fear of despair.

Session evaluation: Question and answer.

Key message

- Although group counselling is important, decision-making can be influenced by views of majority hence the counsellor should always seek individual opinions and give the opportunity for individual counselling for those who may need it.
Module 6: Counselling Using the VCT Protocol

Session 2: Pre-test Counselling

Time: 2 hours and 30 minutes.

Methods: Lecturette, role plays, brainstorming, small group discussion.

Materials: Prepared case scenarios.

Objectives:
By the end of the session, participants will be able to:

- Outline the protocol for VCT.
- Explain the key issues in pre-test counselling.
- Demonstrate ability to provide pre-test counselling.
- Support clients to assess their risk of infection and make a risk reduction plan.

Activities:

1. Review session objectives.
2. Lecturette: VCT protocol.
### Notes for Facilitator:

#### The VCT Protocol:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Client reception and registration (Initial contact)</td>
</tr>
<tr>
<td>2</td>
<td>Pre-test counselling (Pre-test session)</td>
</tr>
<tr>
<td>3</td>
<td>If client consents to testing: HIV testing (HIV testing)</td>
</tr>
<tr>
<td>4</td>
<td>Post-test counselling (Post-test session)</td>
</tr>
<tr>
<td>5</td>
<td>Referral for treatment, care and support (During post-test session)</td>
</tr>
</tbody>
</table>

### Brainstorm: The importance of pre-test counselling.

#### Importance of pre-test counselling:

Pre-test counselling is counselling provided to clients before blood is drawn for HIV testing. It is aimed at providing information to the clients to help them to assess their readiness to be tested.

#### Key issues/ elements in pre-test counselling:

- Ask client the reason he/she came for testing.
- Assess the client’s knowledge of HIV /AIDS and related conditions and provide accurate information.
- Assess client’s risk of HIV infection and discuss risk reduction plan.
- Provide information about testing procedure and provision of results.
- Explain the HIV test and clarify its meaning; explain the limitations of test results, i.e. window period.
- Check to see if client has questions/issues for discussion.
- Help client understand the benefits of HIV testing and to make a decision about testing.
Checklist for pre-test counselling:

The checklist can help counsellors to help them remember the elements of pre-test counselling.

During the session, the counsellor should:

1. Interpersonal relationship
   1.1. Greet client and introduce self and role.
   1.2. Demonstrate active listening skills.
   1.3. Demonstrate a balanced use of open and closed questions.
   1.4. Be non-judgemental and supportive.
   1.5. Assure client about confidentiality.

2. Content
   2.1. Ask client the reason they came for testing.
   2.2. Assess the client’s knowledge of HIV and transmission.
   2.3. Provide accurate information on all modes of transmission.
   2.4. Assess personal risk.
   2.5. Ask client about symptoms of TB/ treatment for TB.
   2.6. Ask client about symptoms of STI/ treatment for STI.
   2.7. Reinforce information about the window period and provide client with details of date for repeat testing.
   2.8. Check to see if client understood window period*/ repeat testing.
   2.9. Provide information about testing procedure & provision of results.
   2.10. Discuss meaning of potential results.
   2.11. Assess client capacity to cope with possibility of HIV positive result.
   2.12. Discuss personal needs and available support.
   2.13. Discuss personal risk reduction plan.
   2.14. Provide time to review advantages and disadvantages of testing.
   2.15. Ensure Informed consent is given.
   2.16. Discuss follow-up arrangements.
   2.17. Check to see if client has questions/ issues for discussion.
4 Role Play: Pre-test counselling session.

**Purpose:**
- To allow participants the opportunity to practice general pre-test counselling.

**Instructions:**
- Formulate scenarios and take turns role playing the pre-test counselling session.
- Assign scenarios to groups and give instructions.
- Feedback is given by participants and facilitators, pointing out what was done well and what was done poorly.
- The counsellors should practice SOLER (sitting squarely, open position, lean forward, eye contact, and relaxed) as they role play.

5 Lecturette: Risk assessment and risk reduction.

**Notes for Facilitator:**

**Risk:**
Risk is an action that puts somebody in a dangerous situation.

**Why conduct a risk assessment?**
- To determine when a client may have had an exposure to HIV.
- To help clients understand the need for HIV testing.
- To help the client realise the risk of being infected and coming up with a risk reduction plan.

**When conducting risk assessment, counsellors should:**
- See each individual separately – do not take history with another person present unless consent has been given.
- Ensure that the client understands the terms used.
- Use models or drawings where necessary.
- Begin with less confrontational issues to put the client at ease.
- Reflect and address the client’s emotions.
- Encourage the clients to share experiences.

**Risk reduction:**
Risk reduction is a strategy to reduce chances of getting HIV infection using various ways like abstinence, being faithful to one uninfected sexual partner or using condoms.
Role play: Risk assessment and risk-reduction plan.

**Instructions:**
- Distribute the case scenario.
- Follow instructions in activity five above.

**Case study 1:**
26-year old male university student with many sexual partners. He uses condoms at the beginning of relationships, but stops as soon as he 'knows and trusts' his partners.

Role play: Pre-test counselling session.

**Instructions:**
- Form groups of four: a counsellor, a client, and two observers.
- Participants come up with their own scenarios or case studies in addition to those below.
- Practice the entire pre-test counselling session.
- The client should comment on how the introductions have been made, attitudes, and communication skills. The observers will be the last to give feedback to the counsellor.
- Each participant should have an opportunity to role play as counsellors.
Notes for Facilitator:

Case Study 1:

29-year old married male, two young children. His doctor referred him for HCT. He was recently diagnosed with gonorrhoea, a sexually transmitted infection. He reluctantly explains that he has sex with other women, the most recent occasion being 3 weeks ago.

Case Study 2:

18-year old female. She has heard about HIV from some of her friends and has started to worry about whether she may be infected. She has had unprotected sex several times with different men, the most recent occasion was one week ago. She believes that she might be rejected by her family if she tests HIV+.

Case Study 3:

A 23-year old woman is worried that she may have contracted HIV from her former husband. She has heard that he is sick and there are rumours in the village that he has AIDS. She last had unprotected sex with him two months ago. She has not had other sexual partners. The client is very upset and worried as she is convinced that she has HIV.
Lecturette: Ways of adapting the standard VCT approach.

Notes for Facilitator:

Ways of adapting the standard VCT approach:

Pre-test counselling can be offered as individuals, for couples and with groups. The table below shows topics that are suitable for group sessions and topics that must be discussed with the individual only:

<table>
<thead>
<tr>
<th>Individual pre-test counselling</th>
<th>Information suitable for group sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Personal risk assessment.</td>
<td>☐ Privacy of services and results.</td>
</tr>
<tr>
<td>☐ Individual risk reduction strategies.</td>
<td>☐ Basic information about HIV.</td>
</tr>
<tr>
<td>☐ Coping with a possible positive result.</td>
<td>☐ HIV transmission and risk reduction.</td>
</tr>
<tr>
<td>☐ Informed Consent.</td>
<td>☐ Condom discussion and demonstration.</td>
</tr>
<tr>
<td></td>
<td>☐ Benefits and issues related to testing.</td>
</tr>
<tr>
<td></td>
<td>☐ Testing procedure.</td>
</tr>
<tr>
<td></td>
<td>☐ General reproductive health education.</td>
</tr>
<tr>
<td></td>
<td>☐ Group counselling.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group information-giving</th>
<th>Group pre-test counselling</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Not confidential.</td>
<td>☐ Confidential.</td>
</tr>
<tr>
<td>☐ Small or large groups of people.</td>
<td>☐ Small groups.</td>
</tr>
<tr>
<td>☐ Generalized discussions.</td>
<td>☐ Focused, specific discussion.</td>
</tr>
<tr>
<td>☐ Information to educate.</td>
<td>☐ Information to change attitudes and behaviour.</td>
</tr>
<tr>
<td>☐ Discussion based on public health needs.</td>
<td>☐ Discussion based on needs of client.</td>
</tr>
</tbody>
</table>

Session evaluation: Question and answer.

Key messages:
- Pre-test counselling prepares the client to make an informed decision about HIV testing.
- Pre-test counselling helps the client to identify his/her risk of HIV infection and make a risk reduction plan.
Session 3: HIV Testing Results, Interpretation, and Implications

Time: 1 hour.

Methods: Discussion, group discussion, brainstorming.

Objectives:
By the end of this session participants will be able to:
- Identify possible results.
- Explain the meaning of possible results.
- Explain the implications of test results.

Activities:
1. Review session objectives.
2. Brainstorm: Possible results of an HIV test.
   Implications of HIV test results.

Instructions:
- Divide participants into 4 small groups and distribute handout.
- In each group, discuss the correct interpretation and implications of each test result.
- After each person in the group is clear about the meaning and implications of the test result, choose one person to summarize what the group has discussed.
- Make corrections and clarify as needed.
- Conclude by relating antibody test results with the stages of HIV progression.
Notes for Facilitator:

Interpreting HIV test results

HIV tests detect the presence of antibodies to HIV in the blood. This means that a person tests positive only after developing antibodies to HIV. The rapid tests used for HIV testing detect the presence of antibodies within 12 weeks after infection.

HIV Negative (HIV-) test result:

How to interpret this result:
- There are no antibodies of HIV present on the day of the test.
- The client is not infected (true negative).
- The client may be infected but is in the window period (false negative).

Implications:
- The client can still get infected if exposed to HIV.
- The client needs to adopt safer sex practices.
- The client needs to reduce level of risk.
- The client may need to return for a repeat test in 3 months.
- A negative test result does not mean the client’s partner is negative for HIV. It may mean that client has not yet been infected.
- The client may need support to plan for disclosure of HIV status.

HIV Positive (HIV+) test result:

How to interpret this result:
- HIV antibodies were detected in the person’s blood sample.
- The person can pass the virus to another person.

Implications:
- The client is infected with HIV but may not have AIDS.
- The client can still lead a healthy and productive life.
- The client needs to adopt safer sex practices.
- The client remains infectious for life.
- The client’s partner may be negative but needs to be tested.
- The client should be referred for clinical care.
- The client may need support to plan for disclosure of HIV status.
**Indeterminate test result:**

**How to interpret this result:**
- Presence of HIV antibodies could not be confirmed.

**Implications:**
- It is not possible to confirm the client’s test results at that time.
- The client will need to return for a repeat test in 3 months.
- The client needs to adopt safer sex practices.

**Discordant test result:**

**How to interpret this result:**
- This applies to couples. It means that one partner is HIV+ and the other is HIV-.
- The HIV- partner remains at very high risk of becoming infected through future exposures. He/she is not immune to HIV.

**Implications: (same as for HIV+ and HIV- results):**
- The HIV- partner is at very high risk of infection and could be infected at anytime if the couple does not adopt safer behaviours.
- The couple needs to develop a risk reduction plan to protect the HIV-partner.
- Discordant results do not necessarily mean that someone has been unfaithful in the relationship – often the infected partner was infected before meeting his/her current partner.
Lecturette: Antibody testing during different stages of HIV.

Notes for Facilitator:

Antibody testing during different stages of HIV:

Antibody Testing will yield the following results during the different stages of HIV progression:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of infection</td>
<td>Negative results*</td>
</tr>
<tr>
<td>Window period**</td>
<td>Negative results*</td>
</tr>
<tr>
<td>Sero-conversion</td>
<td>Positive results</td>
</tr>
<tr>
<td>Asymptomatic stage</td>
<td>Positive results</td>
</tr>
<tr>
<td>Symptomatic stage</td>
<td>Positive results</td>
</tr>
<tr>
<td>Terminal stage</td>
<td>Either positive or negative</td>
</tr>
</tbody>
</table>

*At point of infection and during the window period, the body has not yet produced antibodies to HIV. As such, the HIV test will likely show a negative result because the test is designed to detect antibodies to HIV. For this reason, every client needs to understand the window period so he/she can make appropriate decisions related to repeat testing.

** Window period is the period when one is HIV infected but the body has not produced enough antibodies to be detected by tests based on antibodies. This period ranges from two weeks to three months (12 weeks) after infection. If the client thinks that he/she may have been exposed to HIV in the past three months, advise him/her to return for a second HIV test. Also, the client should abstain from sex or use condoms until after he/she receives the results from the second HIV test.

Antigen testing (Polymerase chain reaction- PCR) can detect the presence of the virus at any stage because this type of testing detects the actual presence of HIV.

Key message:

- All clients tested should be helped to understand the meaning and implications of their results.
Session 4: Post-test Counselling

Time: 4 hours

Methods: Lecturette, brainstorming, role plays

Materials:

Objectives:

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

- Define post-test counselling.
- Describe procedures of post-test counselling.
- Explain components of positive living.
- Demonstrate skills in post-test counselling.

Activities:

1. Review session objectives.

Notes for Facilitator:

Post-test counselling

Post-test counselling is counselling offered to a person who is learning his/her HIV test result. The counsellor prepares the client for the result, gives the result, and then provides the client with the necessary information. Post-test counselling is usually guided by the outcome of the HIV test, which could be negative, positive or undetermined. Post-test counselling goes on for some time and gives way to ongoing support counselling.

Post-test counselling is offered:

- To reinforce and review information given during pre-test counselling regarding risk reduction, the meaning of test results, disclosure issues etc.
- To provide emotional, psychological and physical support to help a person cope with the results of the test, whether positive, negative or indeterminate
- To enable a person to discuss more on prevention issues such as how s/he is going to prevent him/herself from getting infected, infecting others and re-infecting him or herself
- To provide referral information for care and support
Brainstorm: Fears of counsellors in giving positive results

Notes for Facilitator:

Common fears among counsellors about giving test results:
- Giving results (positive) can be difficult and uncomfortable
- Counsellors may not know what to say or do or may have an emotional reaction that may not be helpful
- Counsellors worry that clients may leave the session and not return

Common client reactions following HIV+ test result:
- Shock.
- Denial.
- Anger
- Suicidal thought or action.
- Fear.
- Sense of loss.
- Grief.
- Guilt.
- Depression.
- Anxiety.
- Spiritual concerns.

Adapted from: Family Health International/Nigeria. 2002. Interpersonal Communication and Counselling Manual on HIV and AIDS.
Lecturette: Steps in every post-test session.

Notes for Facilitator:

Steps included in every post-test session:
- Ensure that the client is ready to receive the results.
- Provide results simply, clearly and precisely.
- Interpret results for the client and check for understanding.
- Allow time for client’s emotional response.
- Provide referral information for follow up care and support.
- Ask if the client has any questions.

In addition, post-test counselling is guided by the outcome of the HIV test, which could be negative, positive or indeterminant.

### Post-test counselling for HIV negative result
- Provide test result
- Review risk reduction plan
- Identify support for risk reduction plan
- Negotiate disclosure and partner referral
- Discuss referral for prevention and other health care services

### Post-test counselling for HIV positive result
- Provide test result
- Identify sources of support
- Negotiate disclosure plan and partner referral
- Review risk reduction plan
- Discuss referral for treatment and support

### Post-test counselling for indeterminant results:
For indeterminant results, follow the protocol for post-test counselling for HIV. However, you must provide referral for repeat testing:
- Discuss when clients can collect confirmatory test results.
- Discuss risk reduction plans.
- Identify sources of support for risk reduction plan.
- Discuss immediate plans before next results are collected.
- Discuss the possibility of encouraging partner(s) to seek HCT services.
**Post-test counselling checklist for HIV negative test result:**

This checklist can be used by Counsellors to help them remember the elements of post-test counselling for HIV-test result. Supervisors can also use this checklist to monitor quality of counselling at their site:

1. **Interpersonal relationship**
   1.1. Greet client and introduce self and role.  
   1.2. Demonstrate active listening skills.  
   1.3. Demonstrate a balanced use of open and closed questions.  
   1.4. Be non-judgemental and supportive.  
   1.5. Assure client about confidentiality.

2. **Content**
   2.1. Check client details (ensure results are to be given to the right client).  
   2.2. Give results simply and clearly.  
   2.3. Give time for client to reflect on the result.  
   2.4. Check for understanding of result.  
   2.5. Discuss meaning of result with client.  
   2.6. Discuss the window period and repeat testing.  
   2.7. Discuss personal risk reduction strategy.  
   2.9. Offer other referrals, e.g., family planning etc.
Post-test counselling checklist for HIV negative test result:

During the session, the counsellor should:

1. **Interpersonal relationship**
   1.1. Greet client and introduce self and role.
   1.2. Demonstrate active listening skills.
   1.3. Demonstrate a balanced use of open and closed questions.
   1.4. Be non-judgemental and supportive.
   1.5. Assure client about confidentiality.

2. **Content**
   2.1. Check client details (results are given to the right client).
   2.2. Give results simply and clearly.
   2.3. Give time for client to reflect on the result.
   2.4. Check for understanding of result.
   2.5. Discuss meaning of result with client.
   2.6. Encourage ventilation of emotional response.
   2.7. Discuss personal, family and social implications for client.
   2.8. Assist client in thinking through strategies for disclosure of status.
   2.9. Check about adequacy of support available to client.
   2.10. Discuss risk reduction strategies.
   2.11. Discuss follow-up care and support available.
   2.12. Identify options and resources.
   2.13. Assess harm to self/others.
   2.14. Discuss/review immediate plans, intentions and actions.
   2.15. Follow-up plans discussed and referrals made where necessary.

Role play: Post-test counselling session.

**Instructions:**
- Form groups of three or four: a counsellor, a client and one to two observer(s). Use/adapt the cases provided on the following page.
- Every participant should play the role of a counsellor.
- Following each role play, there will be a brief time for feedback. The counsellor will be the first to express feelings, followed by the client and then the observers. The observers will comment on effective use of the protocol and offer general feedback and support.
  - The client should select the case study and the counsellor should select the test result that they would like to practice.
  - The counsellors should keep in mind the protocol for the specific result that they are reporting.
  - All participants should play the role of the counsellor.
Notes for Facilitator:

Case Study 1:
Mary enters the counselling room for post-test counselling. Her test results are HIV negative. As a counsellor, give the results using the guide below:

Case Study 2:
A woman, age 25, married with four children, whose husband refuses to use condoms – and denies that he has relationships with other women. She knows that he is unfaithful, even with some of her own friends.

Case Study 3:
Paul enters the counselling room for post-test counselling. His test results are HIV positive. As a counsellor, give the results using the guide below:

Case Study 4:
A 35-year old male, married with no children, who sometimes visits commercial sex workers. His wife does not know about these behaviours. The man thinks that his wife also has other partners.

Case Study 5:
A 17-year old female student with several sexual partners who uses condoms at the beginning of the relationship, but stops as soon as she ‘knows and trusts’ her partner. She is anxious about her test results.

Case Study 6:
A 50-year old male widow who never visits sex workers but has unprotected sex with other female friends. He was recently treated for gonorrhoea, but has not told any of his partners.

Adapted from: Family Health International/ Nigeria. 2002. Interpersonal Communication and Counselling Manual on HIV and AIDS.

Session evaluation: Question and answer.

Key messages:
- No one should get results without post-test counselling.
- Post-test counselling helps both the infected and the affected understand and cope with different situations.
Module 6: Counselling Using the VCT Protocol

Session 5: Supportive Counselling and Positive Living

Time: 1 hour.

Methods: Discussion, group discussion, brainstorming, role play.

Objective:
By the end of the session, participants will be able to:

- Explain the meaning of ‘supportive counselling’ and positive living.
- Demonstrate skills in supportive counselling.
- Describe ways of positive living.

Activities:
1️⃣ Review session objective.
2️⃣ Brainstorm: Supportive counselling.

Notes for Facilitator:

Preventive counselling
Preventive counselling is aimed at equipping clients with knowledge and skills to protect themselves and their sexual partners from being infected with HIV.

Supportive counselling
Supportive counselling is offered to people who have received their HIV test results. It is aimed at empowering them to develop coping skills, and can be done over a period of time. Supportive counselling is also offered to family members of the clients, to help them to provide care and support to infected clients.
**Importance of supportive counselling**

- Helps clients implement their risk reduction plan.
- Help clients cope or overcome their problems.
- Addresses the client’s problems in the context of his/her social networking, e.g. family.
- Provides an opportunity for the client to plan for the future.
- Information discussed under this type of counselling depends on the problem and situation of the client.

**Role play: Supportive counselling.**

Instructions:
- See role play instructions under post-test counselling Module 6: Session 4.
- Develop case scenarios for supportive counselling.

**Brainstorm: Positive living.**

**Notes for Facilitator:**

**Positive Living in HIV infection**

Positive living is a concept, in which a person develops a positive outlook towards his/her life and that of the others. It entails adopting practices and lifestyles that aim at reducing the transmission of HIV and improving quality of life. In short, positive living means living responsibly with HIV.

People with HIV infection can improve or strengthen their immunity through the following ways:

**Physical Care**

**Personal hygiene:**
- Maintain cleanliness of the body, clothing and beddings.

**Environmental hygiene:**
- Keep clean: the house, its surroundings, and items like household utensils to keep away flies in order to prevent diarrhoea.
- Keep clean and cover food properly.
- Destroy breeding places for mosquitoes and sleeping under a mosquito net to reduce episodes of malaria.
- Drink boiled water.
Physical exercise and rest:
- Exercise the body by doing light work; recreational activities or continuing with normal socio-economic activities as and according to the person’s ability.
- Rest in between work and sleep at least eight hours a day.

Positive behaviour practices:
- Avoid drinking alcohol and smoking cigarettes of drugs as they weaken the lungs, heart and the brain.
- Practice safer sex by either abstaining or using a condom accurately and consistently.

Nutritional Care
- Eat fresh foods and try to ensure that each meal has a combination of good values of protein (animal and plant foods); vitamins (fresh fruits and green leafy vegetables and avocado); energy foods such as cereals, plantains, potatoes and yams. Always try to eat meals at regular times.

Medical Care
- Seek prompt medical care for every illness (Opportunistic Infections) and from medical practitioners.
- Enroll on Septrin prophylaxis to help reduce occurrences of some common opportunistic infections such as cough, fevers, diarrhoea, and skin infections.

Psychological Care
Counselling
- Always seek counselling to help cope with issues as they arise.
- Seek support from peers to share challenges and learn coping mechanisms from one another.
- Spiritual care from religious leaders or fellowship also helps to deal with various issues.

Session evaluation: Question and answer.

Key messages:
- Supportive Counselling helps the client to cope with the results of their test and related issues.
- Information on positive living should be provided to both HIV negative and positive individuals.
- Positive living can help to improve quality of life a person living with HIV.
- People who test negative should be helped to draw risk reduction plans as part of the positive living package.
Module 6: Counselling using the VCT Protocol

Session 6: Crisis Counselling

Time: 1 hour

Methods: Brainstorming, role play, group discussion

Objectives:
By the end of this session, participants will be able to:

► Explain 'crisis counselling.'
► Identify possible causes and indicators of a crisis.
► Demonstrate techniques in handling a crisis.

Activities:

➊ Review session objectives.

➋ Brainstorm: Meaning of ‘crisis counselling.’

Notes for Facilitator:

A crisis is:

- A situation that seems disastrous and completely out of the person’s control.
- A situation of excessive stress.
- A situation where the client feels unable to manage or cope.

Crisis counselling:

Crisis counselling involves helping a person who is experiencing a crisis to gain some sense of control over the situation. The person usually needs immediate attention.
Brainstorm: Indicators of a crisis.

Notes for Facilitator:

Indicators of a crisis:
- When an individual feels intensely threatened.
- When an individual is completely surprised by whatever is happening.
- When an individual feels a loss of control.
- When there does not seem to be any solution to the problem and when all efforts to resolve the situation seem hopeless.

Discuss: Share experiences on indicators of a crisis.

Notes for Facilitator:

Indicators of a crisis:

Crying:
If the client breaks down and starts crying, it is important to let them cry. Give them space to ventilate feelings. Comment on the process, ‘this must be difficult for you, would you like to talk about it? Would you like to tell me what is making you cry?’

Anger:
The client might start swearing or exhibit outburst of anger. Do not panic; stay calm and give the client space to express his/her feelings. Acknowledge that these feelings are normal and let the person talk about what is making him/her angry.

No response:
This could be due to shock or denial or helplessness. Check that the client understands the result.

Denial:
This could be verbal or non-verbal. Counsellor should acknowledge client’s difficulty in accepting this information. Let client talk about their feelings.

Anxiety:
The client may feel overwhelmed by fear and worry which prevents him or her from doing simple tasks. Remain calm. Accept the fear as genuine and guide the client accordingly.

Threats of suicide:
The client may talk about ending his or her life.
**Panic:**
The client is terribly afraid.

**Things client might say:**

“This cannot be happening to me.”
“I just cannot believe it.”
“Nothing makes sense to me anymore.”
“I don’t know what to do.”
“I don’t know where to turn for help.”
“Nobody understands what I am going through.”

Brainstorm: The role of the counsellor during crisis counselling.

**Guidelines for crisis counselling.**

**Notes for Facilitator**

The role of the counsellor during a crisis counselling session is to define the problem and restore a sense of control:

- Begin where the client is, ‘Here and Now’.
- Be reassuring and supportive as the client discusses the crisis.
- Listen carefully and actively; client may have trouble communicating.
- Remain calm and show confidence.
- Show acceptance and do not be judgemental.
- Show empathy and reflection of feelings.
- Provide a relaxing atmosphere/office.
- Allow client to speak freely, with few interruptions.
- Allow ventilation of feelings.
- Explore immediate crisis, instead of underlying causes.
- Assess suicide risk, ask the client about suicidal feelings.
- Have local resources to help; take all precautions necessary if there is a risk of suicide.
- Do not minimize the crisis; accept the client’s fears as genuine.
- Agree on a plan of action; do not prescribe.
- Prioritize; agree on aspects that can easily be dealt with.
- Referral in case of difficult situation.

Adapted from: Family Health International/Nigeria. 2002. Interpersonal Communication and Counselling Manual on HIV and AIDS.
Approaches of crisis counselling

Whenever clients become unresponsive or show difficult emotions during counselling, the counsellor can use the WEATHER approach to move them through the emotional block or crisis.

The WEATHER Approach

W  **Watch the client:** including verbal and non-verbal expressions for changes that signal a difficult emotional response or increasing unresponsiveness.

E  **Elicit emotions:** allow and encourage the client to express the emotions they are feeling, however difficult they may seem. Take care to ensure they will not cause physical harm.

A  **Ask about concerns and fears:** when the client is more calm, help the client talk about concerns or fears that cause the emotional distress.

T  **Treat the concerns and fears as normal:** Tell the client that his/her fears and concerns are normal.

H  **Help with hope:** Assure the client that although the situation is difficult, believe that she/he can do something about it.

E  **Empower the client:** Commend the client for having come for HCT. Explain that this shows the client is taking control of his/her life.

R  **Relate to HIV:** Reaffirm your empathy and hope.

After the counsellor has gone through these steps, he/she should assess the client and decide whether or not the client is able to resume the counselling session where it was interrupted. Resume the counselling session where it left off, or engage the client in problem-solving.
Role play: Demonstrate crisis counselling.

Notes for Facilitator:

Instructions:
- Create a role play to demonstrate crisis counselling.

Session evaluation: Question and answer.

Key messages:
- Crisis counselling may take longer than a regular counselling session and may need repeat information and follow up sessions.
- Counsellors should remain calm, take control of the situation and support the client to make an informed decision.
- Crises are common and can be disastrous, so the counsellor should detect them early and manage them appropriately.
- In case the counsellor is unable to handle a crisis, he/she should refer the client appropriately.
Module 6: Counselling Using the VCT Protocol

Session 7: Disclosure

Time: 2 hours.

Methods: Lecturette, brainstorming, group discussion.

Objectives:
By the end of the session, participants will be able to:

- Describe disclosure and its various forms.
- Describe benefits of disclosure with HIV.
- Identify challenges to disclosure
- Discuss dangers of non-disclosure.

Activities:
1. Review session objectives.
2. Brainstorm and discuss: Disclosure.
   Various forms of disclosure.

Notes for Facilitator:

Disclosure

Disclosure is a situation where information about clients’ HIV sero-status is shared. A counsellor can help a client develop a plan to share information about their HIV status with others. This involves exploring the options of whom, how, and when to tell.

Forms of Disclosure:
- Voluntary disclosure.
- Involuntary disclosure.
- Full disclosure.
- Partial disclosure.
- Supported disclosure.
Discuss: Benefits and barriers to disclosure.

Dangers of non-disclosure.

Instructions:
- Form three groups.
- Group 1: Discuss benefits and challenges of young person to parent disclosure.
- Group 2: Discuss benefits and challenges of parent-to-child disclosure.
- Group 3: Discuss benefits and challenges of partner disclosure.
- Group 4: Discuss dangers on non-disclosure.

Notes for Facilitator

Benefits of disclosure (for young people and adults):
- Enables an individual to begin dealing with the issue of reducing transmission and obtaining support.
- Access to care, support and treatment services is easier, as is adoption of safer behaviours to protect family and partners.
- Creates a sense of empowerment and control over the virus as the person is able to talk with a friend or counsellor for advice and support.
- Client can feel confident and no longer has to worry about having to disclose.
- Client may be able to influence others to avoid infection.
- The client can protect his or her partner(s) from being infected with HIV during sex.
- Openness about HIV Status can stop rumours and suspicion.

Barriers to disclosure (for young people and adults):
- Fear of stigma and rejection.
- Fear of possible conflicts.
- Ignorance about HIV infection and disease.
- Fear of shame and public opinion.
- Fear of blame and possible breakdown of relationships.
- Fear of breaking confidentiality.
Likely challenges and fears to disclosure (for parent to child):

- Failure of the child to cope with the news if assessment was not well done.
- Deterioration at school, depression and withdrawal.
- Stigma and social discrimination.
- Keeping confidentiality on the part of the child.
- Emotional pain in seeing one’s child hurt.
- Feelings of powerlessness.
- Gives implications about one’s own sero-status.
- Fear of becoming upset.
- Failure to face worries about their children’s future.

Dangers of non-disclosure:

- Lack of support.
- Risk taking.
- Lack of care.
- Suspicion.
Lecturette and discussion: Principles to support disclosure.

Notes for Facilitator

Basic principles to support disclosure (for young people and adults):

Help the client to take time to make a decision. Make sure that it is what he/she wants to do and assist him/her to plan.

- “Give yourself time to accept your status.”
- “Make sure that you feel ready and comfortable to disclose.”
- “Choose someone you can trust and who will support you.”
- “Practice what you will say.”
- “Think about how the person will respond and plan your answers.”

If the client wishes to disclose, encourage him or her to think about the issues listed below:

- Choose a place that is comfortable and private.
- Choose a time when the person client wants to tell has enough time to listen and is in a good mood.
- Speak calmly and clearly.
- Identify sources of support, including post-test clubs and other networks of people living with HIV.
- Role plays (and ‘empty chair’ rehearsals where the individual practices disclosure alone, pretending that the person is sitting next to him/her in an empty chair) could be used to help the client prepare.
- Provide support and reassurance to the client and encourage self-acceptance.
- Discuss sexual partners who need protection from infection.
- Prepare the client for a shocked or even hostile reaction. Reassure client that in time people close to him/her should learn to accept HIV status.
- Help the client to realise that once he/she has decided to disclose, it may be easier to start with those nearest: family, friends or someone trusted.
- When a client has decided to disclose, help client to think about the likely response. He/she will need to think about how much the person already knows and understands about HIV and AIDS. This will help the client decide what and how to tell the person.
- It is important that the client to be strong enough to allow others to express their feelings and concerns after disclosure. A counsellor can assist the client to work on these issues over time.
- Provide the client with information and support to live positively.
Basic principles to support disclosure (for parent to child):

- Age of child and personal assessment of the child.
- Assess how much the child knows about the disease.
- Get an appropriate entry point for example when the child asks a related question.
- Prepare the child, share information in bits.
- Seek support from a counsellor.
- Consider the likely reactions and how to deal with them.
- The earlier a person thinks of doing it the better and easier.

Session evaluation: Question and answer.

Key message

- Disclosure is important but sensitive; clients are encouraged to disclose status with support from the counsellor.
- Disclosure must always be done with the consent of the client.
- The preparation of a client for disclosure should be addressed from the time of pre-test counselling.
Session 8: Counselling Repeat Testers

Time: 30 minutes.

Methods: Brainstorming, discussion.

Objectives:
By the end of this session, participants will be able to:

- Explain the importance of counselling repeat testers.
- Discuss general guidelines for counselling repeat testers.

Activities:
1. Review session objectives.
2. Brainstorm: The importance of counselling repeat testers.

Notes for Facilitator:

Repeat testing:
Someone who has tested for HIV before and has returned for another test.

Reasons for repeat testing
There are many reasons why a client may decide to test more than once:

- Client tested negative but was possibly exposed to HIV (occupational exposure, risky behaviours, discordant couple).
- Client is in denial about her/his test result.
- Client is in window period.
- Need to confirm client’s sero-status.
- Mothers who want to access PMTCT services.
- To initiate Anti-retroviral therapy.
- To facilitate disclosure before marriage.
**Importance of repeat testing:**

- Helps client to review and modify risk reduction plans and adjust to new situations.
- Helps client accept and cope with test results.
- Helps client adopt and sustain new behaviours.
- Helps client deal with pressing concerns.

**Discussion: General principles of counselling repeat testers.**

**Notes for Facilitator:**

**General principles for counselling repeat testers:**

- Discuss major reasons for repeat testing, including previous results.
- Review possible test results and their implications.
- Review previous risk reduction plans, options chosen. Find out progress on those plans as well as challenges encountered.
- Assess most recent exposure/risk behaviour and come up with a new realistic reduction plan.
- Identify sources of support for risk reduction plan.
- If the previous results are available, the counsellor should validate them.
- Negotiate disclosure and partner referral where applicable.
- Refer for additional services.

**Session evaluation: Questions and answer.**

**Key messages**

- Knowledge of the reasons for repeat testing is very important to both clients and counsellors.
- Clients who have tested HIV negative but have been exposed to HIV should be encouraged to repeat the test.
- In case the current test results differ from previous ones, the counsellor must provide a satisfactory explanation to the client.
Module 6: Counselling Using the VCT Protocol

Session 9: HCT for couples

Time: 1 hour.

Methods: Lecturette, brainstorm, group discussion, role play.

Objectives:
By the end of this session, participants will able to:

- Describe the term Couple HIV Counselling and Testing (CHCT) and the benefits of CHCT.
- Explain principles of CHCT.
- Describe the roles and responsibilities of the counsellor in CHCT.
- Explain challenges of CHCT.
- Demonstrate skills in CHCT.

Activities:
1. Review session objectives.
2. Brainstorm: Definition of CHCT.

Notes for Facilitator

Couple HIV Counselling and Testing (CHCT):

CHCT is the HCT services provided to any two clients who have come to take an HIV test together. The couple may be planning to have sex together or they may already be having sex together.

Types of couples that might attend CHCT:

- Dating/Engaged couples.
- Married couples.
- Co-habiting couples.
- Polygamous couples.
- Re-uniting couples.
Brainstorm and Discuss: Benefits of CHCT.

Notes for Facilitator

Benefits of CHCT:
   - The couple is supported to discuss risk concerns and issues.
   - The couple learns together about how to adopt safer sex practices. They learn about shared responsibility among partners and they hear information and messages together.
   - The couple learns their results together and receives appropriate counselling and support. If the test results are positive or discordant, the counsellor can help reduce tension and prevent blaming.
   - The couple can plan for their future and that of their family. Couple HCT can help to strengthen the relationship and promote mutual understanding between the couple.

Counsellors can adapt the following messages to explain the benefits of CHCT to clients:
   - Always aim to test before starting a new relationship. HCT helps couples to say safe.
   - If you are both negative, you work out how to keep staying safe. If you are both positive, you plan to live together positively.
   - If one of you is negative and the other is positive, HCT can help you to support the positive one to live longer.
   - Testing together is one of the best things you can do. Never judge your partner.

Lecturette: Principles of couple counselling.

Notes for Facilitator:

Principles of Couple Counselling

In CHCT, the couple agrees to:
   - Voluntarily participate in the counselling and testing sessions.
   - Discuss HIV risk issues and concerns.
   - Discuss the advantages of knowing their status as a couple.
   - Receive their HIV test results together
   - Keep confidentiality.
   - Make a mutual decision about disclosure of results.
   - Treat each other with respect and dignity.
   - Equal participation.
   - Engage in frank and open discussion.
   - Listen and respond to one another with respect.
   - Provide support to each other.
Roles and responsibilities of the counsellor in CHCT:

The role of the counsellor during pre-test counselling is to:

Create a trusting relationship with the couple.

- Discuss the reasons why each partner in the couple has come for HCT.
- Ensure that each partner in the couple agrees to:
  - Voluntarily participate in the counselling and testing sessions.
  - Discuss HIV risk issues and concerns.
  - Receive their HIV test results together.
  - Respect the confidentiality of their partner’s result.
  - Make a mutual decision about disclosure of results.
  - Treat each other with respect and dignity.
  - Engage in frank and open discussion.
  - Provide support to each other.

Check understanding of HIV/AIDS.

Explain the process of testing and the meaning of testing results.

- Discuss the possibility of discordant test results:
  - What will it mean to them if they don’t get the same result?
  - Ask each one how they will cope?
  - How will they protect themselves?
  - What will be the advantage of knowing their status as a couple? Any disadvantages?
  - Who else might be affected by the outcome of his/her test?
- Encourage the couple to receive their results together.

Check willingness to have a test done.
Lecturette: Post-test counselling protocol for HIV- couples
Post-test counselling protocol for HIV+ couples.

Notes for Facilitator

<table>
<thead>
<tr>
<th>Post-test counselling for couples with HIV negative test results</th>
<th>Post-test counselling for couples with HIV positive test result</th>
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<tbody>
<tr>
<td>1. Provide test result.</td>
<td>1. Provide test result.</td>
</tr>
<tr>
<td>2. Review risk-reduction plan.</td>
<td>2. Identify sources of support.</td>
</tr>
<tr>
<td>3. Identify support for risk-reduction plan.</td>
<td>3. Negotiate disclosure plan and partner referral.</td>
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<td>5. Discuss possible referral for care and support.</td>
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Brainstorm: Challenges of couple counselling.

Notes for Facilitator

Challenges of couple counselling

- One partner dominates/suppresses the other.
- Difficult to reveal sensitive personal issues.
- Requires more time to handle a couple than an individual.
- Disagreements in the counselling room may extend to home.
- Discordance issues difficult to handle.
- Difficult to reconcile opinions/decision between people.
- Difficult to maintain impartiality.
6 Role play: Demonstrate CHCT.

Instructions:
- Develop scenarios/case studies for role plays to demonstrate HCT.

7 Session evaluation: Questions and answer.

Key messages:
- In couple counselling, individual consent and views must be respected.
- Test results MUST always be given together.
- The counsellor should recognise and accept different types of couples.
- Couple counselling can avert new HIV infections, promote understanding and support.
Session 10: Counselling for Discordant Couples

Time: 1 hour.

Methods: Brainstorm, lecturette.

Materials:

Objectives

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

- Explain the concept of discordance.
- Explain the implications of HIV-discordant test results.
- Describe the guidelines in communicating discordance.
- Explain challenges of counselling discordant couples.
- Demonstrate skills in giving results to discordant couples.

Activities:

1. Review session objectives.

2. Brainstorm and lecturette: Concept of discordance.

Notes for Facilitator

Concept of discordance

Discordance occurs when one partner in a couple is infected with HIV and the other is not infected.

- HIV discordance is common.
- HIV discordance is NOT a sure sign of infidelity.
- A couple can remain HIV discordant for a long time.
- HIV is not transmitted on every exposure.
- HIV transmission within discordant couples can be prevented.
- No one is immune to HIV.
When does discordance occur?

- In many cases, couples are already discordant when they enter the relationship. Couples can remain discordant for a long time.
- Couples can become discordant because of outside partners or other exposures to HIV. However, discordance is not always a sign that a person was unfaithful.

How common is discordance in Uganda?

- It is estimated that 10% of couples in Uganda are discordant.
- It is estimated that each year 10-12% of discordant couples will transmit HIV to the HIV negative partner.

Why does discordance happen?

HIV is not transmitted at each exposure. There are several issues that affect the risk of HIV transmission:

Condom use
Couples that use condoms correctly and consistently each time they have sex have a lower chance of transmitting the virus to the HIV negative person.

Frequency of sex
Couples that have sex less often have fewer chances of spreading the virus to the HIV negative person.

Viral load
The amount of the HIV virus in a person rises and falls depending on the overall health of the person and time since infection. A person with a higher viral load has a higher chance of transmitting the virus to their partner.

Window period
The period of time during which the HIV test is not yet able to detect the presence of HIV antibodies in the client’s blood. HIV tests detect the presence of antibodies to HIV in the blood. This means that a person tests positive only after developing antibodies to HIV. The period of time when a person is infected but does not yet have antibodies detectable by the tests is called the window period. It is now thought that a person is highly infectious during this time. This means that the person may be more likely to transmit the virus to a sexual partner. Someone who may have been recently exposed but tests negative should get a repeat HIV test in 3 months, and abstain from having sex or use condoms until after the test.

Other factors:
Recent or late infection with HIV, presence of sexually transmitted infections, use of ARV.
Demonstration: Post-test counselling for discordant couples.

Instructions:

- Review the protocol for post-test counselling for HIV positive test results; explain that this protocol should be followed when counselling discordant couples.
- Select 3 volunteers to demonstrate a counselling scenario that involves post-test counselling to a discordant couple.
- Provide the following sample messages to the ‘counsellor’ and encourage him/her to use them during the demonstration:
  - HIV discordance is common.
  - HIV discordance is NOT a sure sign of infidelity.
  - A couple can remain HIV discordant for a long time.
  - HIV is NOT transmitted on every exposure.
  - HIV negative partners in discordant couples are at a very high risk of infection.
  - HIV transmission within discordant couples CAN be prevented.
  - No one is immune to HIV.

Notes for Facilitator:

What are the advantages of discordant test results?

- HIV- partner can provide care and support of HIV+ partner.
- Cost of care and treatment is reduced.
- HIV- partner can ensure care of the children.

What are the risk reduction options for discordant couples?

- Use condoms correctly every time you have sex.
- Abstain or reduce the frequency of sex.
- Adopt safer sexual practices (masturbation, oral sex).
- Diagnose and treat STI.
- Access services for on-going support (couples clubs).

Challenges and opportunities in counselling discordant couples.
**Challenges:**
- Emotions/ reactions to different HIV test results: denial, blame, guilt.
- Keeping HIV- partner uninfected: discussing safer sex and condom use, family planning issues, referral for other partners.
- Continued care and support for HIV+ partner: withdrawal of support, separation/ divorce.
- Possible abuse: domestic violence.
- Possible economic impact, need to care for HIV-infected partner.
- Increased difficulty in communication between couples.

**Opportunities:**
- Counsellors can support discordant couples in risk reduction.
- Counselling discordant couples can save lives: HIV- partner’s life saved.
- HIV- partner can provide care and support of HIV+ partner.
- Cost of care and treatment can be reduced.
- HIV- partner can ensure care of the children.

**Session evaluation:** Question and answer.

**Key messages**
- HIV discordance is NOT a sure sign of infidelity.
- Discordant couples need help to understand their test results. HIV positive partners in discordant couples are at a very high risk of infection. There is great need to protect the uninfected partner from becoming infected with HIV.
Module 7

Counselling in Other HCT Approaches

<table>
<thead>
<tr>
<th>Session 1:</th>
<th>HCT in the Clinical Care Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2:</td>
<td>Home-Based HCT</td>
</tr>
</tbody>
</table>

The purpose of this module is to equip participants with knowledge and skills to provide effective counselling in clinical and home-based settings.
Module 7: Counselling in Other HCT Approaches

Session 1: HCT in the Clinical Care Setting

Time: 1 hour and 30 minutes.

Methods: Discussion, lecturette, brainstorming.


Objectives:
By the end of the session, participants will be able to:

- Outline the components of the counselling protocols used in clinical settings.
- Identify the challenges and limitations of counselling in clinical setting.
- Demonstrate skills in using the counselling protocols for clinical settings.

Activities:

1. Review session objectives.

2. Review and discuss: Counselling in clinical settings.

Notes for Facilitator

Concept of Routine Testing and Counselling (RTC)

Medical ethics demand that a clinician must make a complete diagnosis. In order to do this, the patient must be fully investigated. There is no law that makes an HIV test a special test. Therefore HIV testing is considered like any other test which a clinician administers (e.g. a malaria test, HB determination, etc.) In order to be in accordance with the law, all investigations performed on the patient must be administered with his/her consent. Human rights norms also demand that the patient gets full information about their health status. Since the beginning of the HIV/AIDS epidemic, the health care system omitted this practice. With advent of ARV’s and other treatment and prevention options, we now realise there has been missed opportunities for increasing access to care and treatment.
HIV testing should therefore be fully integrated into routine clinical care and handled just like other investigations. This implies that the health providers participate in the testing process at all levels: offering the test, providing the pre- and post-test information, giving the test result, discussing and initiating HIV/AIDS care for patients who are HIV positive and/or referring them for follow-up care.

3 Lecturette: Counselling protocol on RTC.

### Notes for Facilitator

#### The RTC Protocol:

<table>
<thead>
<tr>
<th>Clinical assessment</th>
<th>Initial contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-test information giving</td>
<td>Pre-test session</td>
</tr>
<tr>
<td>If client consents to testing: HIV testing</td>
<td>HIV testing</td>
</tr>
<tr>
<td>Results giving</td>
<td>Post-test session</td>
</tr>
<tr>
<td>Referral for treatment, care and support</td>
<td>Referral and follow-up</td>
</tr>
</tbody>
</table>
Guidelines for health workers:

Ask the patient about history of HIV testing.
- While taking the patient’s history, health workers must ask the patient about history of HIV testing.
  - If the patient has never been tested, discuss the benefits of knowing his/her HIV status.
  - If the patient has tested previously, ask what the test result was.
  - If the patient tested HIV negative but more than three months ago, offer another HIV test.
  - If the patient tested HIV positive, ask if they are accessing treatment, care and support services.

Explain why HIV testing is being offered.
- Explain that the health facility offers HIV testing to all patients who have never previously tested as well as to those who have tested HIV negative more than 3 months ago.
- Explain that consent must be obtained.

Explain confidentiality of patient information.
- Medical ethics provide a basis for protecting patients and offer guidance to improving professional practice as well as making ethical decisions regarding the management of a patient. The provision of RTC must follow a high level of ethical standards by ensuring that informed consent and confidentiality are achieved. Disclosure and storage of patient records (whether dealing with HIV or other diseases) must follow strict ethical standards.
- For all patients who consent to RTC, explain that the results will be placed in the client’s file so that the health workers can make appropriate decisions regarding care. Emphasize confidentiality of patient information.

Post-test information giving

Like pre-test information and for similar reasons, post-test information is a substitute for post-test counselling in RTC.

Regardless of the specific test results, if the patient is not ready to receive the results, defer the process until the patient is ready. In such cases, all the appropriate treatment and support services including referral should still be given.
Provision of HIV negative (HIV-) results:

Inform the patient that their results are available.
- If the patient is ready to receive the results:
  - Provide the results clearly and simply.
  - Review the meaning of the test result.
  - Discuss the test result in relation to the most recent risk exposure.
  - If the client has a recent risk exposure, discuss the option of repeat testing in 3 months.

Discuss disclosure and partner referral
- Remind client that his or her test results do not indicate partner's HIV status.
- Support client to refer partner for testing.
- Discuss partner disclosure. The patient should know that they do not have to disclose immediately; they can take time.

Address risk reduction issues.
- Explore HIV risk behaviour.
- Reinforce positive behaviour.
- Emphasize ABC as appropriate.
Provision of HIV positive (HIV+) results:

Inform the patient that their results are available.

- If the patient is not ready to receive the results, give them a chance to opt out or to defer disclosure.
- If the patient is ready to receive the results: provide the results clearly and simply.

Let the patient know that HIV/AIDS care is available.

- Discuss antiretroviral therapy and/or prophylaxis for opportunistic infections.
- Assess if patient needs further counselling.
- Explore patient’s access to medical services.
- Discuss sources of support, including care support groups (post-test clubs)

Negotiate disclosure and partner referral

- Remind client that his or her test result does not indicate the partner’s HIV status.
- Support client to refer partner for testing.
- Inform client that the results will be placed in the patient files.
- Emphasize that the files will only be accessed by the health care team in order to make clinical decisions (shared confidentiality).
- Discuss disclosure to other parties (sexual partners, family members, and friends).
- Offer options for disclosure (patient or provider disclosure). The patient should know that they do not have to disclose immediately; they can take time.

Discuss and initiate care

- Refer to positive living guidelines

Further care and support

All patients regardless of the test results should make a quick plan of action. For those who are HIV-, they should be encouraged to access additional information on prevention and support. For those who are HIV +, a quick plan of action on how to access care and support services should be discussed.
Flow of clients in RTC:

Roles and responsibilities in RTC:

<table>
<thead>
<tr>
<th>Site</th>
<th>Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting room</td>
<td>Pre-test information giving</td>
<td>Health Care Provider/Educator</td>
</tr>
<tr>
<td>Consultation room</td>
<td>History (past HIV test, partner HIV Status)</td>
<td>Health Care Provider</td>
</tr>
<tr>
<td>Consultation room</td>
<td>Fill the RCT data form</td>
<td>Health Care Provider</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Bleeding, rapid test, documentation</td>
<td>Laboratory Staff</td>
</tr>
<tr>
<td>NA</td>
<td>Transfer of results to the consultation room</td>
<td>Laboratory Attendant</td>
</tr>
<tr>
<td>Consultation room</td>
<td>Disclosure of results</td>
<td>Health Care Provider</td>
</tr>
<tr>
<td>Consultation room</td>
<td>Basic care</td>
<td>Health Care Provider</td>
</tr>
</tbody>
</table>

Note: Healthcare provider refers to the attending Doctor, Clinical Officer, Nurse/Midwife manning the consultation room.
The main differences between RTC and VCT are:

- RTC is done in clinical settings and the clients are patients.
- RTC is service provider initiated.
- Since the clients are ill and sometimes in life threatening conditions, the counselling protocol has been modified for RTC and is referred to as pre-test information instead of pre-test counselling.
- Pre-test information giving is part of history taking.

Lecturette: Counselling protocol for the diagnostic testing approach.

Notes for Facilitator

While the RTC protocol mandates that an HIV test is conducted for all patients who come to the health facility, the diagnostic testing approach outlines that an HIV test is conducted only for selected patients in whom the health provider has observed signs and symptoms of HIV infection. Since this requires diagnostic capacity, only clinicians should use this approach.

Even when symptomatic, one must always obtain informed consent before conducting an HIV test. The clinician should inform the patient that his/her symptoms are sometimes associated with HIV/AIDS and that he/she needs to do the test to better manage the patient. In the event that the patient is unable to give informed consent (e.g. when patient is unconscious or mentally ill), the provider can conduct an HIV test provided the knowledge of the HIV sero-status of the patient is necessary for managing the patient’s condition.

Sharing the HIV result is done just as in the RTC protocol. If the patient was initially unable to receive the result, attempts should be made to communicate the result as soon as possible. In the event that the patient dies and the result turns out to be HIV positive, attempts should be made to inform the significant others such as the spouse, or parents of a child under 12 years, in order to ensure prevention and care among these people.
Brainstorm: Challenges of counselling in the clinical setting.

Notes for Facilitator

Challenges of counselling in the clinical setting

Although HCT in the clinical setting has many benefits, it also has several challenges. Challenges include:

- Providing adequate information before and after testing due to high volume of work for health workers.
- Ensuring the confidentiality of patient records.
- Ensuring that all patients testing HIV positive are effectively referred for support.
- Ensuring the availability of testing kits and lab consumables.

Session evaluation: Question and answer.

Key messages

- RTC is beneficial as it maximizes access to prevention, care and support services.
- When conducting HIV testing in clinical settings, consent and confidentiality are paramount. However, clinicians can still conduct an HIV test for a patient who is unable to give informed consent (e.g. when the patient is unconscious or mentally ill), in order to provide the necessary care and support.
Module 7: Counselling in Other HCT Approaches

Session 2: Home-based HCT

Time: 30 minutes.

Methods: Lecturette.

Materials: Home-Based HCT Trainers’ manual, HBHCT job aides.

Objectives:

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

- Describe Home-based HCT.
- Discuss the benefits of Home-based HCT.
- Understand and follow the protocol for home-based HCT.

Activities:

1. Review session objectives.
2. Brainstorm: Meaning of Home-based HCT.

Notes for Facilitator:

Home-based HCT

Home-based HIV Counselling and Testing (HBHCT) is a modified model of HCT provided to individuals and families in the home environment. HBHCT is also called family-based HCT which may be initiated through different entry points which include:

- Home to Home in a selected area
- Provision of services through an index client
Brainstorm: Benefits of Home-based HCT.

Notes for Facilitator:

Benefits of HBHCT

- Increases access to HIV Testing.
- Promotes early knowledge of HIV sero-status.
- Fosters prevention counselling.
- Identification of discordant couples.
- Facilitates early care of HIV infected individuals and couples.
- Supports change of risky behaviour to prevent new infections.
- Supports family centred care and prevention.
- Lays foundation for adherence.

Explain the Home-based HCT Protocol.

Instructions:
- Distribute zop cards. On each card, write one component of the protocol for home-based HCT.
- Ask the participants to organize the cards according to the protocol.

Notes for Facilitator:

Home-based HCT:

Home-based HCT (HBHCT) is a modified model of VCT provided to individuals in their home. It is also known as family-based HCT. In this model, HCT is offered to every household in a particular community (home-to-home) or it is limited to households where one individual is HIV positive and who are on antiretroviral therapy.
### Home-Based HCT Protocol:

<table>
<thead>
<tr>
<th>Household education session to adults and children.</th>
<th>Initial contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-test counselling to individuals, couples and groups.</td>
<td>Pre-test session.</td>
</tr>
<tr>
<td>If client consents to testing: HIV testing.</td>
<td>HIV testing.</td>
</tr>
<tr>
<td>Post-test counselling for individuals and couples.</td>
<td>Post-test session.</td>
</tr>
<tr>
<td>Referral for treatment, care and support.</td>
<td>Referral &amp; follow-up.</td>
</tr>
</tbody>
</table>

**Lecturette:** Explain each component of the protocol.

**Notes for Facilitator:**

**Procedures for the different protocol requirements:**

**Household education session (Group Session)**
- Explanation of the programme activities.
- Education on HIV and AIDS.
- Explanation on Testing Procedures.

**Pre-test counselling to individuals, couples and groups**
- Verification of House Hold registration.
- Pre-test to identified household members (Children, Adolescents, Individual adults, Couples).
- Risk assessment.
- Filling in HBHCT card and consent form.
HIV Testing

- Orientation to testing.
- Explain possible results.
- Rapid HIV testing and same day results.

Post-test counselling for individuals and couples

- Couple.
- Individual adult.
- Adolescent.
- Parent/Guardian of infant and young child.

Negative Result:

- Re-test after 3 months.
- Safer goal behaviour and risk reduction plan.
- Disclosure.

Positive Result:

- Care and treatment.
- Risk reduction plan.
- Referral.
- Disclosure.

Referral for treatment, care and support

6 Session Evaluation: Question and Answer

Key messages:

- HBHCT increases access to HCT services for families.
- HBHCT facilitates disclosure of results to family members.
- HBHCT supports compliance with treatment regimes (e.g. household members are able to support adherence to treatment and understand the dangers of sharing medicines).
Module 8

Counselling Special Groups

<table>
<thead>
<tr>
<th>Session 1:</th>
<th>Counselling People with Disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2:</td>
<td>Counselling and Sexual Abuse</td>
</tr>
</tbody>
</table>

The purpose of this module is to enable participants to provide counselling to special groups like people with disabilities and those who have been sexually abused.
Module 8: Counselling Special Groups

Session 1: Counselling People with Disabilities

Time: 1 hour.

Methods: Brainstorming, lecturette, group work.

Materials: Teaching aids: Blank cards.

Objectives:
By the end of this session participants will be able to:

- Define the term disability and related terms
- List the causes and the common types of disabilities and their prevalence.
- Provide appropriate health education and counselling to people with disabilities and their caretakers.
- List the challenges of counselling people with disabilities.

Activities:

1. Review session objectives.


Instructions:
- Distribute a blank card to each participant. On each card, they should write down what ‘disability’ means.
- Form small groups of three and share individual definitions. Discuss and develop a revised definition.
- Record definition on a flip chart.
**Notes for Facilitator:**

**Disability:**

A person with a disability is someone who in his or her society is regarded as disabled, because of a difference in appearance and behaviour.

**United Nations (UN) Definition of disability:**

Disability summarizes many different functional limitations occurring in any population in any country in the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. These impairments, conditions or illnesses may be permanent or transitory in nature.

**World Health Organization (WHO) definitions of related terms:**

- Functioning refers to all body functions, activities and participation as an umbrella term.
- Disability serves as an umbrella term for impairments, activity limitations or participation restrictions.
- Impairments are problems in body function or structure.
- Activity limitations are difficulties an individual may have in executing activities.
- Participation restrictions are problems an individual may experience in involvement in life situations.
- Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.


**Brainstorm: Common types of disabilities in Uganda.**

**Notes for Facilitator:**

**Common types of disabilities and their prevalence in Uganda**

<table>
<thead>
<tr>
<th>Type</th>
<th>% of the population</th>
<th>Estimated # of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual (ocular) impairment</td>
<td>1</td>
<td>200,000</td>
</tr>
<tr>
<td>Healing impairment communication difficulty</td>
<td>2</td>
<td>400,000</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>0.4</td>
<td>80,000</td>
</tr>
<tr>
<td>Loss of sensation</td>
<td>0.2</td>
<td>40,000</td>
</tr>
<tr>
<td>Mobility/skeletal impairment</td>
<td>2.5</td>
<td>500,000</td>
</tr>
<tr>
<td>Mental illness</td>
<td>0.2</td>
<td>40,000</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>4</td>
<td>800,000</td>
</tr>
</tbody>
</table>

Adapted from: Trainers manual for health workers on disability MOH 2001.
Lecturette: The causes of disability.

Notes for Facilitator

Direct causes of disability:

Direct Causes are conditions that directly affect people and cause impairment. Identifying and understanding these conditions can lead to prevention and better management of the impairment.

Before birth:
- Hereditary defects: e.g. dwarfism, clubfoot (sometimes, not always).
- Non-genetic disorders: e.g. congenital absence of limbs, clubfoot, cleft palate, rickets, Down’s syndrome.
- Conditions of the mother such as: diabetes, measles, rubella in pregnancy.
- Alcoholism and drug abuse of the mother.

During birth:
- Birth trauma.

After birth:
- Neonatal problems: e.g. jaundice, neonatal infections like meningitis.

Disease:
- Communicable Diseases e.g. poliomyelitis, trachoma, leprosy, malaria, measles, meningitis, ear infections.
- Non-communicable diseases.
- Degenerative conditions.
- Diabetes mellitus.
- Sickle cell disease.

Trauma / injury:
- Traffic, occupational, and domestic accidents.
- Wars and violence.

Other direct causes:
- Malnutrition.
- Drug and alcohol abuse.
**Indirect causes of disability:**

Indirect causes are conditions that may not directly cause disabilities but are predisposing factors to causing impairment.

- Malnutrition.
- Poor environmental sanitation.
- Lack of information about proper health measures.
- Lack of proper stimulation and early education of children.
- Drug and alcohol abuse.
- Poor infrastructures.
- Few health services.
- Long distances from the health services.
- Poorly equipped health services.
- Poverty.
- Social stress and emotional disturbances.

Group work: Health Education and counselling for people with disabilities.

Instructions:

- Form four groups.
- Ask the members to discuss the content of health education and counselling sessions for people with disabilities and their caretakers taking into consideration the role of the counsellor in providing services that are consistent with the three “C’s” of HIV testing: consent, counselling and confidentiality.
- Groups present in plenary.
Notes for Facilitator:

Health education and counselling people with disabilities

Health education should include the following:

- Causes of disabilities.
- Effects of disabilities.
- Availability of treatment.
- Importance of completing treatment.
- Importance of early intervention.
- Clarification on misconceptions and myths about disabilities.

Counselling of patients:

- Ask for new complaints and try to explain the cause.
- Counsel for informed acceptance of disease. This may involve a number of sessions.
- Counsel for self care so that an affected person knows what to do to care for himself/herself.
- Counsel for integration in the family.
- Family members and friends should also be counselled to accept and support the person with a disability.
- Probe about patients/thoughts, fears and general feelings about the disease and disability.

Counselling caretakers:

- Re-assure the parent/caretaker. Give him/her information about the condition and what can be done for the child or person with a disability.
- Encourage the parent/caretaker to care for the child and visit the health centre/hospital whenever any sickness occurs.
- Let the caretaker know about the importance of early treatment intervention for better outcome.
- Inform the caretaker about the nearest services to help the person with a disability.
- Encourage the person or child with a disability to participate in the family.
- Encourage the caretaker to be patient because progress often is slow. Improvement may not be seen quickly.
Brainstorm: Challenges faced by people with disabilities at health units.

**Notes for Facilitator**

Challenges faced by people with disabilities at health units:

- Limited staff to handle PWDs.
- Few trained staff to counsel PWDs.
- Few referral centres for PWDs.

Session evaluation: Questions and answers.

**Key messages**

- A disability is a major feature of life and can affect anybody at anytime.
- We need to acknowledge and understand our own attitudes towards disability.
- The term ‘disability’ is not a universal concept and varies according to culture, gender, the individual and prevailing attitudes within societies.
- Although we are born with different needs, we all have the same rights. This includes the right to adequate and appropriate health services.
Module 8: Counselling Special Groups

Session 2: Counselling and Sexual Abuse

Clock

Time: 1 hour

Methods: Brainstorming, lecturette

Objectives:
By the end of this session, participants will be able to:

► Define ‘sexual assault’, ‘sexual abuse’ and ‘sexual violence’ and identify the effects of these.
► Explain the general principles utilized when counselling people who have been sexually assault or abused.
► Identify factors contributing to sexual abuse.

Activities:
1. Review session objectives.
2. Brainstorm: Forms and meaning of sexual violence.

Notes for Facilitator

Forms of sexual violence:

Sexual violence includes all forms of rape, sexual threat, assault, interference and exploitation, defilement, incest without physical harm or penetration.

Examples of sexual violence:
- Rape – Rape is the unlawful forced penetration or defilement of any bodily orifice (vaginally, anally, or orally). Rape is committed when a person’s resistance to sexual activity is overcome by force, fear, threat of bodily injury, and coercion.
- Defilement - Defilement is the forced insertion of body parts or objects into the mouth or genitals.
- Forced oral or anal intercourse.
- Attempted rape.

Sexual violence can also include the use of threat or force in order to have sexual acts performed by a third person.
Effects of sexual violence:

- Pains, nightmares, loss of appetite, headaches.
- HIV infection.
- STIs.
- Pregnancy.
- Miscarriage.
- Mutilated genitalia.
- Menstrual disorder.
- Internal injuries.
- Self-mutilation as a result of psychological trauma.

Psychological consequences of sexual violence:

- Trauma—signs include sadness, fear, confusion, loss of memory, attention problems, and isolation.
- Powerlessness.
- Self-disgust.
- Apathy.
- Denial.
- Inability to function in daily life.
- Depression leading to chronic mental disorders.
- Suicide.
- Abortion of pregnancy as a result of rape.

Social consequences of sexual violence:

- Rejection by spouse or family members.
- Stigma and discrimination in the community.
- Further sexual exploitation.
- Severe punishment.
- Deprivation of education, employment or other assistance or protection.

Brainstorm: Benefits of counselling.

**Benefits of counselling:**

Most survivors of sexual violence can regain their psychological health through emotional support, social support and psychological counselling, which are essential components of care for the survivor of sexual violence.

People who have been sexually abused can benefit from counselling in the following ways:

- Help clients to develop a sense of control over their lives and to overcome their feelings of guilt.
- Help clients to realise they are not responsible for the attack in order that they stop blaming themselves.
- Help clients to realise that they are not alone and that many other people have overcome similar experiences and still lead normal lives.
- Help clients to understand feelings of anger and fear and to help them express anger towards their attacker in order to alleviate feelings of self blame.
- Help to break the client’s feelings of isolation by linking them to support groups and networks, which can integrate them into community activities.
- Support the survivor in resolving family and community disputes (where appropriate).

Lecturette: General principles for counselling people who have experienced sexual violence.

Notes for Facilitator:

**General principles for counselling people who have experienced sexual violence:**

- Where possible, counsellors should work as part of a team of trained health providers, other service providers and members of the community.
- Counselling should be offered to the client but they should not be pressured to undertake it.
- Counselling is more effective when the person is ready for it.
- Counselling should be carried out as soon as possible by health workers with appropriate training, including training in HIV and crisis counselling.
- Counsellors should practice active listening and at all time, respect the survivors’ wishes and choices – including maintaining client confidentiality.
- Immediate interventions can help to minimize the severity of the psychological trauma.

Where sexual violence has occurred within the domestic situation, counsellors need to be mindful that the client may decide to return to the perpetrator (or have no alternative). Be careful when discussing options available to the client, and refer where necessary.

Note: Do not use the term ‘victim’ of sexual violence. This type of language is disempowering and discourages resilience. Using positive terms, like ‘survivor of sexual abuse’ helps the client recognize their strengths and their ability to deal with these circumstances.

Session evaluation: Question and answer.

**Key messages**

- Counselling for survivors of sexual abuse can help clients to realise they are not responsible for the attacks and need not blame themselves. Furthermore, it can assist clients to understand that they are not alone as many other people have overcome similar experiences and still lead normal lives.
- Survivors of sexual abuse need to be linked to support groups and networks in order to help them to integrate into community activities.
Module 9

HCT for Children and Young People

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The purpose of this module is to provide participants with knowledge and skills to enable them to offer HIV counselling to children and young people.
Module 9: HCT for Children and Young People

Session 1: Effects of HIV on Children and Young People

Time: 1 hour and 30 minutes.

Methods: Lecturette, discussion.

Objectives:
By the end of this session, participants will be able to:

- Explain modes of HIV transmission in children and young people.
- Explain HIV progression in children and how it affects them.
- Identify the signs and symptoms of HIV/AIDS in children.

Activities:

1. Review session objectives.


Notes for Facilitator:

Many children in Uganda under 15 years of age are infected with HIV through Mother to Child Transmission (MTCT).

Recap on how MTCT occurs:
MTCT accounts for over 90% of HIV transmission among children below five years of age and below two years of age. Other children get infected through unprotected sexual intercourse with infected persons, blood transfusion, sharing of contaminated needles and other sharp instruments as well as accidents resulting from playing. Some young people, 10 to 24 years, also get infected through MTCT.

In children above 15 years, it is important for the counsellor to probe for the likely cause of infection to guide discussion and come up with an action plan.
Notes for Facilitator:

HIV progression in children:

The natural history of children infected through MTCT fits into one of the three categories.

- Category 1: Rapid progressors, who die by age 1 and are thought to have acquired the infection in utero or during the early perinatal period (about 25-30%)
- Category 2: Children who develop symptoms early in life, followed by a downhill course and death by age 3 to 5 years (about 50-60%)
- Category 3: Long-term survivors, who live beyond age 8 (about 5-25%)

Stages of HIV/AIDS in children

Asymptomatic Stage:

Just like in adults, HIV attacks the immune system of children and progresses until they get AIDS. The clinical course of HIV infection in children therefore is more rapid than in adults. A child usually becomes ill with HIV much more quickly (2-5 years).

Symptomatic Stage:

As time passes, children become ill with conditions like swollen glands (particularly in the next and cheeks) and skin rashes. They may also lose weight or become tired.

AIDS:

With time the amount of HIV in the child’s body increases and the child’s immunity decreases weakening the body further and he/she may get ‘opportunistic infections’ This is when the child is said to have AIDS.
Proposed WHO Staging System for HIBV Infection and Disease in Children:

Clinical Stage I:
- Asymptomatic
- Persistent generalised lymphadenopathy

Clinical Stage II:
- Unexplained chronic diarrhoea
- Severe persistent or recurrent candidiasis outside the neonatal period
- Weight loss or failure to thrive
- Persistent fever
- Recurrent severe bacterial infection

Clinical Stage III:
- AIDS-defining opportunistic infections, ie, cryptococcal meningitis, histoplasmosis, toxoplasmosis, non-typhoid salmonellosis, Pneumocystis carinii pneumonia, cryptosporidiosis, cytomegalovirus (CMV), disseminated herpes simplex virus (HSV) infection, coccidioidomycosis, candidiasis of the oesophagus, trachea, bronchi or lungs, atypical mycobacteriosis, extrapulmonary tuberculosis.
- Severe failure to thrive
- Progressive encephalopathy
- Malignancy
- Recurrent septicaemia or pneumonia


Session evaluation: Question and answer.

Key messages
- Children, like adults with HIV, have special needs which should be identified and addressed by the counsellor.
- The counsellor should help the parents and caretakers to identify signs and symptoms of HIV/AIDS among children so they can seek appropriate care and support services.
Module 9: HCT for Children and Young People

Session 2: HCT Policy Issues for Children

Time: 45 minutes.

Methods: Brainstorming, lecturette, game, discussion.

Materials: HCT Policy guidelines.

Objectives:
By the end of this session, participants will be able to:

- Describe the different age categories in HIV counselling and testing for children.
- Explain the policy issues for HIV counselling and testing in children.
- Explain the principles of HCT for children.
- Appreciate the importance of provision of HCT services to children.
- Discuss the challenges associated with provision of HCT services to children.

Activities:

1. Review session objectives.

Notes for Facilitator:

Definition of a ‘child’:
Child is any person below age 18.

Age categories of children:

- Infants: Under 18 months old.
- Children: 18 months to less than 12 years old.
- Children: 12 years to below 18 years old.
3. Game: Who gives consent?

Purpose:

- To underline the importance that HCT for children must be done in the best interests of the child.

Instructions:

- Choose ten participants for the game and ask them to come to the front of the room.
- Each of the ten participants will select a number between 1 and 19. They will write their chosen number on a piece of paper and display that number to the rest of the group. Each 1 through 19 number represents the age of a client who has come to your HCT site.
- The remaining group (not the ten chosen participants) must now organize the ages of each client into two groups. Group one will consist of clients who are of an age that requires parental consent. Group two will consist of clients who are of an age that does not require parental consent and therefore the person can consent to HIV testing on their own accord.
- Explain what the legal age of consent is in Uganda.
- Ask the participants to reorganize the ages within each group to reflect their new understanding of consent and the guidelines for counselling children.

Notes for Facilitator:

Policy issues for HCT in children:

Principles of HCT for Children:

In Uganda, a child is an individual who is under 18 years of age. HCT services for children in Uganda are guided by the Convention on the Rights of the Child. Specifically, any intervention for children should be done in the best interest of the child and should be aimed at improving health, development, and social well-being of the child. HCT service providers must also protect a child’s rights to privacy and access to appropriate information while respecting the rights and duties of parents and guardians to guide and direct children in the exercise of their rights.
Informed Consent for Children:

Consenting and testing procedures for children depends on their age.

Infants below 18 months will be offered an HIV test only if the biological mothers have tested HIV positive or if the infant presents signs and symptoms suggestive of HIV infection.

For children above 18 months to less than 12 years of age, consent by parents or guardians must be sought and documented. For children below 12 years of age without a parent or guardian, the head of the institution, health centre, hospital, clinic or any responsible person may give consent.

Children age 12 and older may receive HIV testing services at all HCT sites without knowledge or consent of their parent(s) or guardian(s) provided they have the capacity to understand the implications of the results of the HIV test. Children age 12 and older may be provided services if they seek the services freely and without coercion on the part of parents or others. Youth receive their results according to the protocol and results are not shared with parents or guardians except at the request of the child.

Providers should, however, encourage minors to involve parents or guardians and facilitate the child to disclose results to parents and guardians if requested by the child to do so.

For children below 12 years of age, consent by parents or guardians must be documented. For children below 12 years of age without a parent or guardian, the head of the institution, health centre, hospital, clinic or any responsible person may give consent.

When children are brought for testing by parents or guardians, the HIV antibody test is to be done only to facilitate the medical care of the child. Testing must be clinically indicated or a health provider must concur that a risk of infection is present. The test is not to be used to screen children, nor to satisfy the curiosity of parents, guardians, providers, or care takers.

Counselling children who have been sexually abused:

Child sexual abuse is the involvement of a child in any sexual activity that occurs prior to the legally recognized age of consent (age 18). Child sexual abuse occurs when a child is used by an older person or more knowledgeable child for sexual pleasure.

A child must be tested for HIV if infection from sexual abuse is suspected. In such situations the counsellor must:

- Give appropriate information to the child where possible
- Give honest answers if the child asks a question
- Discuss with parents/guardians information given the child
Sometimes there is a need to meet with legal personnel or other persons involved in the investigation of a criminal offence, for example the police or the probation officers. If the child has been defiled, counsellors on their own discretion should refer to the appropriate agency. The counsellor should however make a follow up of the referred cases, where possible and continue with the counselling thereafter.

**Disclosure of HIV test results to children:**

Providers must plan how test results will be disclosed before conducting testing. Providers should determine with the parent or guardian in advance whether the result will be disclosed to the child and, if so, how it will be done. If there is no parent or guardian involved, the provider must determine the child’s readiness to receive results and arrange for the child to have a support person of his or her choice present at the post-test session, if appropriate.

Results may be provided to children who are 12 years and above at their request, after proper counselling and if the provider judges them to be capable of dealing with the result (especially a positive result). Providers should always encourage a child to involve the parent or guardian if appropriate. Children below 12 years of age should be given results only with the consent of parents or guardians and, again, with proper counselling.

Before disclosing results, the counsellor should assess if the parent or guardian is willing to discuss HIV and the test results with the child openly. If the child is HIV positive the counsellor should work with the parent of guardian to plan for the child’s future care. For children who can not clearly understand the results, the parent or guardian may choose to disclose results at a later date. The counsellor should provide ongoing support and counselling until the child is old enough to understand the results. In no case should the provider or parent/guardian lie to a child of any age about their HIV results.

**Notification to schools and Institutions.**

No one except the child’s parents or guardians and the provider has a need to know the child’s HIV status. The family has no obligation to inform school authorities. If the family chooses to inform school authorities in the best interests of the child, the child’s right to privacy must be assured. Teachers must be trained and should be prepared to handle knowledge of the status of the children. Teachers and schools must respect the confidentiality of children and young people under their care.

*Adapted from: Uganda National Policy on HIV counselling and Testing September 2005*
Brainstorm: The importance of providing HCT services to children.

Notes for Facilitator:

**HIV Prevention and the Importance of counselling children:**

Asymptomatic HIV infected children may be just like other children, but they have a fatal illness. Most children infected with HIV suffer from fatigue, receive frequent medical treatments, and experience continuous pain. Frequent and prolonged outbreaks of illnesses can also cause HIV infected children to miss school and social activities. It is important that HIV infected children understand their illness, avoid isolating themselves, and communicate their concerns to others.

Children with parentally acquired HIV have to come to terms with the fact that they have a fatal disease they contacted from their mother. When children witness their parents’ sickness and death it increases their fear of death and dying. Sometimes these children suffer denial, stigma, and discrimination by their peers in schools, families and community, so they need to communicate to someone. Due to the loss of parents, some children live in child-headed households, or they themselves are the head of households.

HIV infected children who have grown up into adolescents/teenagers, have concerns related to healthy lifestyles, how to avoid re-infection and infecting others, and disclosing information to partner(s):

- Counsellors need to give adolescents information that they can use when pressured by peers to engage in risky behaviour.
- Counsellors should also help adolescents consider behaviour changing options, risk reduction, and opportunities to detect STDs and seek treatment.
- Counsellors should provide accurate information about HIV infection and help adolescents make an informed decision to take an HIV test.
- Counsellors should help adolescents cope with the results of their HIV test and provide adolescents with appropriate care and support services.
Discuss: Concerns and challenges with providing HCT to children.

Notes for Facilitator:

Concerns and challenges with providing HCT to children:

Children have the right to voice their opinions about issues that affect their lives: HCT opens up many complex issues and counsellors need to be aware of these complexities and discuss them with clients and their families. It is important that counsellors find a balance between listening to a child’s concerns, respecting the parents’ wishes and ensuring the child’s overall welfare.

To achieve this balance, counsellors need to:

- Make sure that you understand the policy issues related to the age of consent for HIV testing in Uganda. For children where parental consent is required, discuss with the parents what information they have already given to the child, so that you can reinforce what has already been said, correct any misconceptions, and introduce additional details.
- Enable the child to feel in control and listened to. Give the child information appropriate to his or her level of development and use tools (e.g. drawing, to explain what an HIV test involves).
- Recognize that an HIV test may raise different issues for children of different ages. For example, young children may be most scared of the physical pain involved in having their blood taken.
- Give honest answers to the children and do not hide information, even if it might be difficult for you to say or for them to hear it.
Discuss: How your counselling centre meets the needs of children.

Instructions:
- Post a list of the psychological effects of HIV in children and young people:
  - Dealing with chronic ill health, pain and discomfort.
  - Looking and feeling different from others.
  - Watching and caring for a terminally ill parent.
  - In case of orphans exposed to physical, sexual and social abuse.
  - Bereavement and its consequences.
- The participants should brainstorm ways that their health facility can provide holistic care to children and referral for services not available at their unit.

Adapted from: Save the Children UK, Care for Children Infected and those Affected by HIV/AIDS.

Notes for Facilitator:
Health facilities should be able to provide holistic care to children and referral for services not available at their unit. The following is a list of possible psychological effects of HIV in children and young people. Brainstorm

Session evaluation: Question and answer.

Key messages
- In Uganda, the constitutional age of consent for testing is 18 years; therefore consent below this age should be done with caution and should be in the best interest of the child as guided by the HCT policy.
- The policy puts a lot of responsibility to counsellors to make a final decision on whether to test or not to test a child. In Uganda, counsellors have an important responsibility to ensure that HCT of a child is only done when it is in the best interests of the child.
Module 9: HCT for Children and Young People

Session 3: Counselling Children

Time: 3 hours and 30 minutes.

Methods: Lecturette, discussion, brainstorming, group work.

Objectives:
By the end of this session, participants will be able to:

- Explain the importance of counselling children for HCT and in bereavement situations.
- Describe the principles for counselling children.
- Explain barriers that affect communication with children.
- Identify the challenges in counselling children.
- Demonstrate the necessary attitudes and skills for communicating with and counselling children.
- Describe the care and support needed for a child dying of HIV.

Activities:

1. Review session objectives.
2. Discuss: Barriers to communication.
Notes for Facilitator:

Barriers to communication:

Working with Children who are HIV positive can be challenging. Children often have a difficult time expressing their fears and emotions, so counsellors may need to use different methods to help the child and counsellor communicate. Working with children who are HIV positive or who are affected by HIV and AIDS can also be personally and emotionally challenging to counsellors.

Children may not be able to communicate sensitive issues for the following reasons:

- Traditions and customs pose barriers to their communication. For example, some cultures do not allow children to disagree with adults.
- Children may feel embarrassed or ashamed to discuss HIV and AIDS with adults.
- Children may be too young to put their feelings or experiences into words. In practice, the counsellor must always consider the age of the children, how much they know, and their ability to express their knowledge or emotions.
- Children often fear hurting those they love. For example, they might hide their feelings in order to protect their partners, especially if their parents are sick or unhappy.
- Borderline and below average intellectual development can make communication difficult.
- Language barriers also can pose a challenge to communication.
- The personality disposition of the child (e.g. shyness) may make communication difficult.
- Separation anxiety disorder or any other psychiatric problem like Attention Deficit Hyperactivity Disorder (ADHD) can impair communication.
- The Developmental Level e.g. in the sensorimotor stage could also be a barrier.

Adapted from: Southern African AIDS Trust (SAT). 2003. Guidelines for Counselling Children who are Infected with HIV or Affected by HIV and AIDS. Harare: SAT.
Counsellors may also create barriers to communication:

**Personal issues:**
- A client’s feelings will influence their behaviour and this might impact the counselling skills of the counsellor.
- Counsellors should recognize their own emotional issues and separate these emotional issues from emotional issues relevant to the families they are counselling.
- Counsellor should have a support system in place for themselves.

**Cultural, traditional, religious and gender issues:**
- Counsellors should be aware of their own cultural, traditional, religious and gender norms that they believe influence children with HIV or children affected by HIV and AIDS.
- Counsellors should consider which norms would or would not be appropriate to raise and/or challenge during a counselling session.
- When dealing with death and dying, counsellors should not impose their own religious beliefs on the children with whom they are working.

**Confidentiality issues:**
- Counsellors might feel that releasing information about a child’s situation would be in his or her best interests, but counsellors need to know that this might go against the family’s wishes.
- Counsellors should reassure the children and their family that things discussed during counselling sessions will remain confidential.
- Counsellors should encourage the children and their family to reach a consensus about confidentiality.

**Advocacy issues:**
- Counsellors should serves as advocates for their clients by standing up for their clients’ rights, helping them overcome obstacles, and by taking action with the community and authorities.
- Counsellors should encourage children to speak for themselves when possible.
- Counsellors should have all the necessary information available to them. Otherwise, it might be difficult to get others to back them up or to convince the authorities to take action.
- Counsellors should agree on issues of confidentiality with the children, such as whether they are happy for the authorities to know their names.
Brainstorm: Attitudes and skills for effective communication.

**Notes for Facilitator:**

**Attitudes and skills for effective communication:**

The following attitudes and skills promote effective communication with children:

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<th>Skills:</th>
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<td>Nurturing.</td>
<td>Good communication skills.</td>
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<td>Caring.</td>
<td>Using simple language.</td>
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<td>Acceptance.</td>
<td>Using simple open-ended</td>
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<td>Respect for the child’s</td>
<td>questions.</td>
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<td>privacy.</td>
<td>Using age appropriate</td>
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<td>Confidentiality.</td>
<td>information.</td>
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<td>Appreciation.</td>
<td>Acknowledge feelings.</td>
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<td>Understanding.</td>
<td>Adopt a non-judgmental attitude.</td>
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<td>Empathy.</td>
<td>Allow the child to communicate</td>
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<td>Willingness to help.</td>
<td>and follow through.</td>
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<td>Make empathic comments.</td>
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<td>Assess the emotional state.</td>
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<td>Assess the unconscious world</td>
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<td>Stick to the metaphor in play</td>
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**Methods to help younger children communicate:**

The following creative and non-threatening methods help younger children communicate and express their feelings:

**Drawing:**

- This enables children to communicate their emotional state without having to put it into words, especially when children are given different materials.
- Ask the child to draw something related to what you would like them to explore.
- Gently follow up by asking the children to describe what is happening in their drawing.
- Use ‘open’ questions to encourage them to talk more about what they have drawn and why. For example, ‘how do the people in the drawing feel about what is happening?’
Methods to help children communicate (continued):

**Telling stories:**

- Telling stories can be a tool for problem solving around their own situation. When children are finding it difficult to talk about painful issues, listening to a story about someone in a similar position can be very comforting.
- Use a familiar story to convey a message to the child.
- Avoid using real names or events in the story.
- At the end of the story, encourage the child to talk about what happened. For example, ask about the message of the story to confirm that the child has understood its relevance.
- If helpful, ask the children to make up their own story, based on a topic that you give them. For example, ‘Tell me a story about a little girl who is very sad.’

**Make- Believe Play:**

- Play is an important way that children explore their feelings about events and make sense of their world. When children play, they act out – which helps us to begin to understand what type of emotions they are experiencing.
- Give the child a variety of play materials (things like boxes, string, sticks).
- Ask the children to show you parts of their life using the play materials. For example: ‘Show me what you like to do with your family.’ While the child is using the objects to show you, you can ask him or her also to tell you what is happening.
- Follow and observe what the child is doing and do not take over the play.
- Make comments if you want to check understanding e.g. “I see that the mama doll is so sick that she cannot get out of bed” and see if the child disagrees.
- If the child gets stuck and cannot proceed, ask him or her questions such as “what is happening next?” or “Tell me about this person”. These questions can help him/her to continue.
- You may also want to use toys in the play, if available.

The skills, ethics and attitudes discussed earlier to counsel adults apply to counselling children, especially adolescents.
Lecturette: Principles for pre-test and post-test counselling for children.

**Notes for Facilitator:**

**Cognitive Development of children in relation to counseling:**

- 0 – 2 Years: - Sensorimotor.
- 2 – 6 Years: - Pre – operational.
- 7 – 11 Years: - Concrete Operational.
- > 11 Years: - Operational.

**General principles for counselling:**

- Take into account the child’s, the care giver’s, and the health provider’s perspective.
- Find a comfortable and adequate room for the counseling to occur.
- Be a good listener, attentive, and make good eye contact.
- Listen more and talk less.
- Summarize to ensure you are together.
- Paraphrase clients’ story to clarify issues.
- Give correct information where needed.
- Do not be judgmental or use negative language.
- Have empathy and not sympathy.

**Skills and techniques for counselling children:**

- Parent or guardian should be available.
- Find a clean room with child friendly colours, pictures, toys and drawing paper.
- Use a mat or clean (carpet) floor.
- Use story books to help the child relate to a particular issue, feeling, etc.
- Provide a space for family if necessary.

**Pre-test counselling for children:**

In a pre-test session, a child might come alone or together with a parent. According to the HCT policy (draft 2005), if a child below age 12 asks for HIV testing, the parents or guardian should be fully involved. However, if a counsellor determines that the child can understand the test results, they should be counselled, tested and given their results.
**General Principles for pre-test counselling:**

- Create a friendly and private environment. If adults are present and the child is comfortable, proceed. If the child is not comfortable, ask the adults to wait outside.
- Gain the child’s trust so that he or she can speak openly.
- Explore the child’s feelings about being in the session and any fears he or she might have.
- Answer the child’s questions accurately and honestly – the information should be appropriate to the child’s age and level of development.
- Explain the testing procedures accurately. Address any of the child’s worries about the process.
- Discuss who will receive the results, how they will be given and who will provide support. (If the child is alone, the counsellor should give the result. However, if the parent/guardian has consented, then the parents should be the one to tell the child their HIV test result. Counsellors may need to help parents provide practical information and emotional support.
- Explain the possible test results and what each might mean for the child.
- If the child does not seem ready for the test and asks for more time, offer another pre-test session. Encourage them to bring someone for support.

**General principles for post-test counselling:**

- The child should be gently supported to receive the test result – do not move too fast.
- Gain the child’s trust so that he or she can speak openly.
- Results for children below 12 years should be given to consenting parent/guardian. Only give the child results, with consent of parent/guardian.
- Assess how much information the child has remembered from the pre-test session.
- Assess if the child is ready for their result. If the child says he or she is not ready, ask when they will be ready and make a plan for that.

**Whether the child’s results are positive or negative:**

- Give the child time to react. Be supportive; allow tears, silences, anger and despair.
- Answer the child’s questions.
- Make sure that the child, (and their parent or guardian if present) understand and accept the result.
- Be aware of the children’s level of energy and concentration. If they are ready to receive more information and support at this session, continue. If not, schedule a follow-up visit.
Counselling and disclosure:

Benefits of counselling and disclosure:

This helps the child and family adopt positive attitudes, is empowering, is educational, is reassuring, minimizes psychological reactions and can even prolong life. It also helps the child adhere to treatment.

General principles for counselling and disclosure:

- It should be done in the presence of a parent or close guardian who will provide support.
- Observe reactions and interactions of child and his/her family.
- Get permission from parent to discuss sensitive information.
- Counsel parents/caregiver first to help them understand the importance of informing the child.
- The age to counsel the child about their HIV status depends on understanding and maturity. From about 5-7 years, the process can begin.

Bereavement counselling

Importance of bereavement counselling:

- There is a need to help those children and parents cope with the situation and accept that the child is dying and life has to go on.
- The goal is to reduce the amount of suffering and offer as much support and dignity as possible.
- The counsellor can provide reassurance that everyone is doing their best.

General principles for bereavement counselling:

- Answers should be given in simplest form.
- Use a memory book, box, or basket to facilitate discussion about the child’s family history and how to prepare for the future is often recommended.

Care of the dying child:

- Terminal care preparation is a long term process.
- Support must be offered to both the parents and child.
- Basic nursing care and effective pain management is required.
- Appropriate acute care facilities are needed.
- The preferred place of death should be noted and respected.

Group work: Using the ‘tools’.

**Instructions:**
- Divide the participants into 5 separate groups and assign one of the scenarios listed below.
- Each group will discuss the scenario and answer the assigned question.
- Each group will then present their proposed response to the rest of the participants.

**Notes for Facilitator**

**Scenario 1:**
In your community there is a child headed household. You realize that the boy who is the head of the family is struggling to care for his 4-year-old sister who has poor health. You know that both parents died of AIDS-related illnesses and suspect that this child could be HIV positive. You would like both the child and her other siblings of 6 and 8 years old to understand what is happening. **Question:** How would you help these children?

**Scenario 2:**
Nancy is HIV positive and her son of 7 years old has poor health. Currently he is revealing symptoms of HIV infection. Nancy is one of your clients and has asked you to talk to her child and explain what is happening to him. **Question:** How would you handle the situation?

**Scenario 3:**
John is sixteen years old and a secondary school student. In the last three months he has had a sexual relationship with three girls. Recently he has noticed a whitish rash on his penis. He also saw one of the girls in company of a man who was widowed due to AIDS. He is so worried and turns up for HCT services. **Question:** How would you counsel John?

**Scenario 4:**
Christine is fifteen years old. Three months ago an unknown man raped her. She has since missed her monthly periods. Christine is worried that she could also be infected with HIV. **Question:** How would you counsel Christine?

**Scenario 5:**
Salima is a sixteen years old senior student in boarding school. She has lately experienced a lot of sexual urges, especially when in the company of boys she is attracted too. Many boys in the school and some teachers have complimented her on her beauty and smartness. All of them say they love her. One teacher said he would marry her after her college if she accepted to have sexual intercourse with him. She is considering having sexual intercourse with this teacher. Salima cannot confide in any of her relatives and she says her mother has never talked to her about growing up. Salima has come to you for guidance. **Question:** How would you help Salima?
Lecturette: Helping children with HIV stay well, advice for parents.

**Notes for Facilitator:**

**Issues in care for children:**

Home-based care for children involves many different types of care: medical/nursing, nutritional care, social care, love and support, spiritual care, and emotional care. HCT counsellors need to advise parents/guardians of children with HIV on how to provide the necessary care to help their children stay well.

**Things to do at home to help children stay well:**

- Keep your home clean.
- Keep your garden or compound clean.
- Avoid malaria.
- Practice good personal hygiene.
- Prepare food and water.

Prepare nutritious foods, including:

- Energy rich foods such as rice, cassava, matoke, maize or millet porridge, bread, sweet potato, and sorghum. These provide the main part of the meal and most of the energy. Sugar, animal fats, groundnuts and vegetable oil are concentrated sources of energy.
- Body-building foods include meat, chicken, liver, fish, eggs, simsim, peas, groundnuts, ordinary beans and soya beans. These foods contain protein and help the body to grow and repair.
- Body-protection foods are rich in vitamins and minerals. These include vegetables and fruits, for example green leafy vegetables (dodo, nakati, and bugga), pumpkins, tomatoes, carrots, mangoes, bananas, avocados, passion fruit and oranges.

**Emotional well being among children:**

In order to help children cope with emotional concerns:

- Be honest with the child.
- Accept how the child is feeling.
- Help the child to talk.
- Reassure the child.

Adapted from: Save the Children UK, Care for Children Infected and those Affected by HIV/AIDS.
Session evaluation: Question and answer.

Key messages

- Like adults, children need counselling
- HCT for children requires special knowledge, attitudes and skills on the part of the service providers.
Module 9: HCT for Children and Young People

Session 4: Counselling Young People

Time: 2 hours.

Methods: Lecturette, brainstorming, group discussions, group exercises.


Objectives:
By the end of the session participants will be able to:

- Identify categories of young people who come for HCT services and the reasons why they come for these services.
- Identify challenges and solutions to challenges when counselling young people.
- Demonstrate skills in counselling young people for HCT.

Activities:

1. Review session objectives.
2. Recap definitions: ‘young person,’ ‘adolescent’.
Exercise: Values clarification.

Instructions:

- Conduct a values clarification exercise with participants to find out how participants perceive adolescents. Using a physical continuum method, ask participants to place themselves along the continuum in response to the selected value statements and ask them to explain why they placed themselves where they did.
- Demonstrate how the participants can place themselves along the continuum with the following value statement:
  - “All adolescents are risk-taking pleasure-seekers who live only for the present.”

Notes for Facilitator:

Value statements:

- Adolescents may be commonly stereotyped as uniformly irresponsible and pleasure seeking, but the facts are that the majority are at least as responsible as adults.
- Adolescents represent a wide range of cultures and beliefs, and are a very diverse group of people.
- Often parents and family members do not talk with young people about sex and alcohol or drug abuse because they believe that knowing about these subjects may lead to experimenting with them.
- There is clear evidence that well-designed and well-delivered messages about safer sex and abstinence may:
  - Keep adolescents from having sex until a later age.
  - Reduce the numbers of sexual partners they have.
  - Increase the use of contraceptives among those who are sexually active.
  - Adolescents who communicate with their parents about sexual matters are less likely to be sexually active or, in the case of girls, to become pregnant before marriage.
Group activity and brainstorm: HCT for young people.

Instructions:

- Using ZOP cards, (manila paper cut into small pieces), request participants to write out at least 2 categories of young people who come for HCT. Process the list and record the list to include:
  - Young people in school, both day and boarding
  - Commercially exploited young people
  - Married young people
  - Street young people
  - Sexually abused young people

Note: Adolescents in any of the categories above may be involved in substance abuse. Be careful not to stereotype them.

- Brainstorm: Using zop cards, request participants to write out two reasons why young people come for HCT services. Include the following likely reasons why young people come for HCT services:
  - Feeling ill.
  - Wanting to marry.
  - STD related signs.
  - Being anxious and worried.
  - Sexually abused.
  - Peer influence to start sexual relations.
  - Young people who want to start sexual relations of their own free will.
  - Parents forcing them to get tested.
  - Visa for overseas studies.
Brainstorm and lecturette: Challenges and solutions to communicating with young people.

**Notes for Facilitator:**

**Communicating with young people**

<table>
<thead>
<tr>
<th>Possible challenges:</th>
<th>Possible solutions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young person presents opinions, values and customs that are contrary to that of the counsellor.</td>
<td>Adults should avoid biasing their own values with the adolescent’s because we are all different and entitled to our values so long as they do not put us at risk.</td>
</tr>
<tr>
<td>Young person uses language that is not understood by the counsellor.</td>
<td>Adult should be neutral and offer meaningful options to help them make a decision.</td>
</tr>
<tr>
<td>A smelly mouth, body and uncombed hair.</td>
<td>Adult should have effective probing skills to ensure that the language used is understood.</td>
</tr>
<tr>
<td>Adult is not youth friendly.</td>
<td>Adult must remain calm and understanding. This will help open up communication.</td>
</tr>
<tr>
<td>Young person may not tell the truth.</td>
<td></td>
</tr>
<tr>
<td>Adult may not be skilled enough to communicate effectively.</td>
<td></td>
</tr>
</tbody>
</table>

**Session evaluation:** Question and answer.

**Key message:**

- Adolescents are going through a critical stage in their growth and development which may affect their understanding of issues related to HIV. The counsellor therefore needs knowledge and skills to effectively respond to their needs.
Module 10

Management of HCT Services

<table>
<thead>
<tr>
<th>Session 1:</th>
<th>Elements, Ethical and Management Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2:</td>
<td>Monitoring, Evaluation, and Record Keeping</td>
</tr>
<tr>
<td>Session 3:</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>Session 4:</td>
<td>Integration and Referral</td>
</tr>
</tbody>
</table>

The purpose of this module is to enable participants to effectively manage and integrate HCT services with other services.
Module 10: Management of HCT Services

Session 1: Elements, Ethical and Management Issues

Clock

Time: 1 hour.

Methods: Brainstorming, group and plenary, lecturette.

Materials: Logistics management and information system (LMIS) forms.

Objectives:
By the end of the session participants will be able to:

- Define ‘management’ and identify management issues/elements in HCT services.
- Explain ethics and code of conduct in HCT services.
- Describe the management of post-test clubs.

Activities:

1 Review session objectives.

2 Brainstorm: Meaning of management.

Notes for Facilitator:

Management

Management is the process of planning, organizing, implementing, coordinating, monitoring, and exercising control.

Management Process:

The management process follows a cycle: planning, implementation, monitoring, and back to planning. The management process is initiated when establishing an HCT site for the first time, and followed continuously through the operation of a site.
Lecturette: Management issues/ elements of HCT services.

Notes for Facilitator:

Client services hours and days of operation

Where resources permit, HCT should be provided during all working days. If not possible, every effort should be made to offer HCT on the same days as TB, STI and Family Planning services.

Human resources for HCT Services

HCT sites should have adequate human resources.

Key personnel include:

- HCT site supervisor or coordinator
- Counsellors
- Laboratory personnel
- Clinicians
- Records assistants
- Counselling assistants

All HCT service providers should be trained in an approved training program. Clinic-based HCT services should be linked to community resource persons like community counselling aides.

Infrastructure for HCT Services

HCT requires privacy and a generally comfortable environment both for the client and service provider. In all cases there must be easy access to laboratory space and equipment for HIV Testing.

- Logistics and supplies
  Delivering quality health services requires access to specific equipment, materials and supplies. When these items, known as stocks or commodities, are not available, health service providers will not be able to provide the same quality of services or any services at all.

In Uganda, stock management is done through a pull system which is health facility driven, rather than a push system, which is centrally driven. With a pull system, supplies are delivered only when you request them. For the pull system to work well, you need to practice effective stock management.

Steps for effective stock management are provided on the following page.
Steps for effective stock management

1. **Selection of HCT commodity supplies**
   It is important that every HT health facility selects essential commodity supplies needed for the uninterrupted provision of HCT services. It is the responsibility of the health facility management and staff to ensure that these are always stocked in the right quality and quantities.

2. **Quantification of HCT commodity supplies**
   Establish the number of materials needed to provide uninterrupted HCT service. Knowing these numbers helps the service manager and providers to plan and order the right quantities of the material supplies on time.

   Common Methods of Quantifying HCT commodity supplies:

   **Population-Based Method**
   - Know your general service population (100,000).
   - Know your target population for HCT (e.g. 13 years and above).
   - Set targets to be served by HCT per plan period (e.g. 50% of target population).
   - Multiply number of persons targeted to be served by number of supplies needed per capita (e.g. 50,000 kits needed).
   - Add a buffer factor of 10-20% to cater to contingencies.

   **Service-Based Method**
   - Determine the initial expected stock by estimating the quantity of supplies needed (using experience from similar programmes elsewhere).
   - Push start-up stock to launch the service.
   - Determine service utilization rate for the service (OPD/IPD attendance rates) using service data.
   - Establish quantities actually used from current service data.
   - Use commodity supply consumption rate for previous month to forecast the quantity of supplies required in the coming month.
   - Adjust for unforeseen circumstances.

3. **Ordering of HCT supplies**
   - Place your initial order.
   - Set minimum and maximum stock levels.
   - Minimum stock level (lasts for 1-2 months).
   - Maximum stock level (lasts for 3-6 months).
   - Re-order items you have quantified as soon as stock level is at minimum.
   - Do not wait till the last testing kit is used before you place an order.

There is a lag time between ordering, processing your order, and delivering your stock.
Who to send your order to and how?

Be sure to whom to place your order:
- Ministry of Health (MOH).
- National Medical Stores (NMS).
- DELIVER
- District Directorate of Health Services (DDHS).
- Medical Superintendent.

What forms to use to place order for supplies, and how frequently?

4. Financing HCT Logistics and Supplies
- Central Government of Uganda (grants).
- MOH.
- District Local Government revenue.
- DDHS, Hospital, HSD budgets.
- Community initiatives.
- Donors.

5. Delivery of commodity supplies
- Be sure who is responsible for delivering your HCT supplies.
- The supplies may be delivered by the supplier to your store OR;
- You may have to ferry supplies yourself.
- You may hire a third party.
- The choice is yours and your funder’s.

6. Storage and distribution of HCT supplies
- On receipt of your supplies you need to verify them and enter them in your stock book register/cards.
- Use your existing system of requisitioning for commodity supplies from Stores.
- Push system –items given to you periodically by stores manager.
- Pull system- you requisition for items according to need.

7. Rational use of HCT supplies

Ensure rational use of commodity suppliers through:
- On-the-job training
- Provision of standards guidelines and protocols for use of supplies
- Regular supervision
- Customer mobilization and sensitization
8. **Supervision and control of HCT Logistics and supplies**

- Regular supervision of service providers and stores managers to ensure good HCT logistics management practices.

  The following are responsible for support supervision of HCT Supplies
  - DDHS.
  - HCT Focal person.
  - Medical superintendent.
  - HCT District coordinator.
  - Hospital administrator.
  - Laboratory supervisor/stores manager.

- **Lecturette: Ethics and code of conduct in HCT services.**

**Notes for Facilitator**

**Informed Consent**

All people taking an HIV test must give informed consent, except in specific cases (e.g. children and mentally handicapped).

Informed consent requires that:
- The client be given information in enough detail to understand to what they are agreeing to and the implications.
- The client is capable of understanding what they are told.
- The client not be forced or coerced into giving consent. The counsellor must be honest and objective and allow the client to make his/her own decision, regardless of the counsellor’s opinion or preference.

**Confidentiality**

Health workers must not disclose an individual’s HIV status to any other person without specific permission from the client. This includes a referral agency, a health worker not directly involved in the client’s care, the client’s family or sexual partner.

In health units, all HCT records should be kept in a secure place and should not be accessed by unauthorised people.
Post-test clubs (PTC) are voluntary support groups whose membership is composed of persons who have gone through HIV counselling and testing. PTCs are usually linked to an HCT centre and are facilitated by a trained HCT counsellor. PTC should support both positive and negative testers to develop and follow a risk reduction plan. PTC may help to reduce stigma as both positive and negative testers interact in a structured format. In addition to general health education and HIV prevention information, PTC should also provide the following services:

- Access to condoms
- Psychosocial counselling and ‘positive living’ skills education
- Access or referral to cotrimoxazole prophylaxis for HIV-positive members
- Referral to care and support services such as TASO or home-based care as needed.

Module 10: Management of HCT Services

Session 2: Monitoring, Evaluation and Record Keeping

Time: 2 hours.

Methods: Brainstorming, demonstration.


Objectives:

By the end of this session, participants will be able to:

- Explain the following terms: ‘monitoring,’ ‘evaluation,’ ‘record keeping,’ ‘Health Management Information System (HMIS),’ ‘indicators’ and ‘quality assurance.’
- Explain the methods and importance of record keeping in HCT service management.
- Explain ways to ensure quality of counselling services.
- Demonstrate the ability to correctly fill HCT forms, registers, referral forms and other records.

Activities:

1. Review session objectives.

2. Brainstorm definitions: Record keeping.
   - Health Management Information System.
   - Indicators.
   - Quality Assurance.
**Notes for Facilitator:**

**Record keeping**

Record keeping is ensuring that essential information is recorded and that documents are put in order and kept safely.

**Health Management Information System (HMIS)**

Health Management Information Systems are a way of recording and analyzing information about health services, using computers and other information technology, so that it can be used to make decisions.

**Indicators**

Indicators are measures used in monitoring or evaluation that describe a concept or phenomenon that a programme or project wishes to track. Since the concept or phenomenon may be complex, programmes choose simple measures that give an “indication” of it. Indicators allow programmes to quantify the phenomenon. An indicator can be expressed as an absolute number, a percentage, a rate, or a “yes/no.”

Indicators often tracked in HCT services include:

- Number of people counselled.
- Number of people tested for HIV.
- Number of first time testers.
- Number of repeat testers.
- Number receiving test results.
- Number testing positive.
- Number of couples counselled and tested.
- Number of clients referred for HCT.
- Number of HIV+ screened for TB.
Brainstorm: Importance of recording keeping.

Types of records.

Notes for Facilitator:

Importance of record keeping:

- Keep track of progress.
- Identify and solve problems.
- Reduce waste.
- Provide information for reports and other accountability.
- Remind participants that all HCT records should be kept confidential and only available to or accessed by authorized staff.

Types of records used in HCT service provision:

- HCT registers.
- Client cards.
- Laboratory HIV Test results form.
- Monthly reports.
- HCT section.
- LMIS forms for HCT.
- Special data collection forms.
- Tally sheets.
- Referral forms.

Brainstorm: Ways to ensure quality of HCT services.

Notes for Facilitator:

Ways to ensure quality of HCT services

- All service providers should refer to and use the protocol for HCT, including referral where necessary.
Demonstration: Filling of records.

Instructions:
- Distribute copies of current records required at HCT sites.
- Discuss experience in using these records and demonstrate the correct way to complete each form.
- The participants clarify questions and practice completing selected forms in small groups.

Session Evaluation: Question and answer.

**Key message:**
- Record keeping is very important for effective management of HCT services.
Module 10: Management of HCT Services

Session 3: Quality Assurance

<table>
<thead>
<tr>
<th>Time:</th>
<th>30 minutes.</th>
</tr>
</thead>
</table>

Methods: Brainstorming, lecturette.

Materials: No additional materials required.

Objectives:
By the end of this session participants will be able to:
- Describe Quality Assurance in HCT.
- Identify methods of monitoring quality of services.
- Explain ways to improve quality of HCT services.

Activities:
1. Review session objectives.

Notes for Facilitator:

Quality assurance
Quality Assurance systems set minimum standards for good care in areas such as provider performance, infrastructure, and client satisfaction, then establish mechanisms to assess these areas and improve areas of weakness.

Minimum standards of quality:
The Ministry of Health and individual HCT sites must have ways of assuring that the services being provided meet a minimum standard of quality. In Uganda the minimum standards are set in the HCT Policy Guidelines. All HCT site managers and providers should be familiar with the HCT Policy Guidelines document and the standards it sets.
The policy states that to ensure quality HCT services a site must, at a minimum, have:

- Competent counselling and laboratory personnel
- Appropriate infrastructure
- Appropriate test kits and protocols

**Who is responsible for meeting minimum standards?**

Monitoring (or 'assuring') quality is the responsibility of all members of the health team but always requires support from supervisors and managers.

**How do you monitor quality of services?**

**Tracking service statistics:**

All sites should keep track of their statistics. It is the most basic way to know how you are performing. All sites are required to report to the district on a regular basis, but often neglect to use the data themselves to assess or plan. Charting and posting monthly or quarterly numbers for the indicators you report will help all personnel improve the quality of services. Your site may be delivering top quality services but only serving a few people. Service statistics are a rich source of information and should be fully exploited at all levels.

**Supportive supervision:**

Supportive supervision to assure that infrastructure, supplies and logistics, infection control, record keeping, and patient flow are being handled correctly.

**Observation of counselling sessions by a supervisor:**

Observation of counselling sessions should be done by a senior counsellor/supervisor with the permission of the client. When a counselling session is assessed for quality, the observer should use a standard checklist that lists the essential elements of a counselling session and provides space for the observer to make comments and score the counsellor on the how well he/she conducted each part of the session. The most important part of the observation session is giving feedback to the counsellor on his/her strengths and weaknesses to support the counsellor and improve quality of services. Between supervision visits, counsellors can use the observation checklist to remind themselves of all the elements of a high-quality counselling session. In this way, the quality of counselling work is independently improved.
How do you monitor quality of services? (continued)

**Client Satisfaction Assessment:**

Another important element of quality services is the extent to which they meet the needs of clients. There are several ways that HCT sites can assess client’s satisfaction with services. Client comment or suggestion boxes allow clients to anonymously submit comments or suggestions for consideration. Comment boxes should be locked and only opened in the presence of several people to assure transparency. Some sites make sure boxes are opened in the presence of a community representative as well.

**Client Exit Interview:**

These interviews are conducted with a random selection of clients as they leave the site after receiving HCT services.

**Quality Control for HIV Testing**

HCT sites must have mechanisms for assuring that test results are accurate. In Uganda there are several approaches used to validate test accuracy.

- Supervision by a senior laboratory technician to assure that procedures and equipment are appropriate.
- External validation of a proportion of test results by higher-level Laboratories.
- Validation of test results by mobile laboratory quality teams.

**Session evaluation: Question and answer.**

**Key message:**

- Continuous monitoring of the quality of services helps to improve performance.
Module 10: Management of HCT Services

Session 4: Integration and Referral

Time: 40 minutes.

Methods: Brainstorming, lecturette, group work.

Materials: HMIS referral forms.

Objectives:
By the end of this session, participants will be able to:

- Define integration and referral system.
- Explain the benefits of integration.
- Explain how HCT can be integrated into existing health care services.
- Explain the likely challenges and possible solutions to the integration.
- Demonstrate skills in filling referral forms.

Activities:

1. Review session objectives.

2. Brainstorm: Meaning of Integration.
   Meaning of referral system.

Notes for Facilitator

Integration of and referral system for HCT

Integration is a way of providing a variety of services by having one or more competent service providers within one facility on a daily basis. Service providers within the same facility, depending on their competence, may provide different services.
**Benefits of Integration:**

The most effective way of achieving the benefits of integration is by incorporating the new activities within the existing services, in this instance OPD, STI, OI, and inpatient wards.

- It increases entry points for access to preventive prophylaxis, and antiretroviral therapy where available, and access to needed clinical services (antenatal clinics, STI and TB clinics, primary care clinics).
- Convenience for the client.
- Cost-effectiveness: multiple components provided in a synergistic manner.
- Using similar equipment and materials.
- Reduces missed opportunities and enhance utilization of the services.
- Enhances competence of the service providers.
- Strengthens spirit of teamwork and responsibility sharing.

**Referral System**

The referral system is an important process to assure that clients access a full range of care and support services as needed. Each district or county should have a directory of care and support services that address physical, psychological, and social needs of clients. Each HCT site should have a referral system or protocol and should use the HMIS form to refer patients for other services. Feedback should be given to the referring health facility.

***Lecturette: How HCT can be integrated into existing health care services.***

**Instructions:**

- In discussion of client flow, the following important issues should be covered:
  - Registration.
  - Educational talk.
  - Pre test counselling.
  - Bleeding and laboratory HIV testing.
  - Post test counselling.
Notes for Facilitator:

Consider the client flow for HCT

The client flow should avoid stigmatization and unnecessary delay.

The following are important issues in client flow:

- **Registration**: for all patients who come for health services
- **Educational talk** to include routine information and information specific to HCT. Sessions should contain simple and precise health education messages.
- **Pre-test counselling**.
- **Bleeding and laboratory HIV testing**.
- **Post-test counselling**.

Brainstorm: Possible challenges.

Possible solutions to the challenges.

Notes for Facilitator

Integration and referral

<table>
<thead>
<tr>
<th>Possible challenges</th>
<th>Possible solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased workload.</td>
<td>Orientation of other staff in HCT services</td>
</tr>
<tr>
<td>Lack of space.</td>
<td>Delegation of work</td>
</tr>
<tr>
<td>Inadequate staff.</td>
<td>Sharing available space</td>
</tr>
<tr>
<td>Shortage of lab supplies.</td>
<td></td>
</tr>
<tr>
<td>Client tracking.</td>
<td></td>
</tr>
<tr>
<td>Minimal follow up of clients.</td>
<td></td>
</tr>
<tr>
<td>Lack of team work.</td>
<td></td>
</tr>
</tbody>
</table>
Group work: Filling referral forms.

Instructions:
- Distribute copies of the HMIS referral form in Annex.
- The participants work in small groups to complete the forms.

Session evaluation: Question and answer.

Key message
- HCT should be integrated into all existing services for cost effectiveness, increased access and utilisation.
The purpose of this module is to bridge the gap between theory and practice among the training participants; to be able to strengthen their knowledge on HIV/AIDS and skills in counselling.

The overall objectives of the Practicum are to:
- To assess the levels of knowledge and skills acquired by the participants and address identified gaps.
- To enhance skills development through observation and appropriate feedback.
- To allay fears and anxiety and initiate confidence building among counsellors in training.
Module 12: Practicum

Session 1: Action Planning

| Time: | 1 hour. |
| Methods: | Reflection. |

**Objective:**

By the end of this session, participants will have:

- Developed a plan for sharing and applying what they've learned from the training in the work place.

**Activities:**

- **Group discussion: Action Planning.**
  
  **Instructions:**
  
  - Ask the participants to write the following on a piece of paper:
    - 3 new pieces of information and/or practices that they have learned in the workshop that they would like to share with their colleagues.
    - 3-5 things (knowledge, skills, and attitudes) from the training that they want to apply on the job.
    - Distribute the Action Planning Sheet in Annex and ask each participant to fill it out as an individual. If several participants are from the same facility, they might complete the form together and develop a facility level plan.
    - Ensure that the participants include the following activities in their plans:
      - Sharing what they've learned with supervisor and co-workers from all services
      - Providing HCT counselling services in the facility.
      - Let the participants know that they need to include how they will involve others at the facility in their action plans.
      - Conclude the session by asking participants to discuss their action plan with 1 other participant, and then ask each pair to share one activity from their plan.
      - Close the session by reminding participants that the purpose of training is to improve/expand HCT services.
Module 12: Practicum

Session 2: Practicum Preparation

Time: 30 minutes.

Methods: Discussion.


Objectives:
By the end of the session participants will be able to:

- Conduct a field practicum in HIV Counselling and Testing.
- Utilise HCT and other related HMIS tools during the practicum.

Activities:

1. Review session objectives.

2. Discuss: Guidelines for conducting the practicum.
**Notes for facilitator:**

Case study preparation and presentation guidelines

1. **Counsellor-in-training should record client information in HCT register:**

   **Client Information:**
   - Client number
   - Sex and age
   - Marital status

   **Counselling information to be recorded from each client:**
   - Why client came to be tested
   - Client knowledge of HIV/AIDS and testing (please describe)
   - Information given by counsellor regarding HCT
   - Identified risk behaviours
   - Risk reduction plan
   - Consent issues and support networks
   - Post test issues if positive or negative
   - Client emotional state at pre-test
   - Clients emotional state at post-test
   - Counselling skills used at pre-test
   - Counselling skills at post-test

   **Assessment guide:**
   - The biggest challenge with this client
   - What I felt I did best during the session
   - What would I have liked to have done differently during this session

2. **HCT counsellor training practicum schedule should be filled by the site supervisor** (Refer to Annex).

3. **Checklist for assessing the standard of HIV/AIDS Counselling to be used by the site supervisor** (Refer to Annex).

4. **Supervisors practicum guide** (Refer to Annex).

Note: The practicum sessions should be conducted for five days.
Session 3: Practicum Feedback

Time: 1 hour.

Methods: Presentations and Discussions.

Materials: Presentation guidelines (refer to ‘Notes for Facilitator’ on page 254).

Objectives:
By the end of the session participants will be able to:
  ▶ Share their practicum experiences and identify areas of further skills development.

Activities:
1. Review session objectives.
Discuss: Practicum experiences.

Areas for further skills development.

Instructions:
- Welcome participants from the practicum and mention that this session is to enable them to share experiences from the practicum.
- Introduce objectives and schedule of the session by reviewing prepared flipcharts.
- Put up three flipcharts labelled as following:
  - What I enjoyed most
  - What was challenging
  - Lessons learned
  - Areas of self improvement
- Review the flip charts, placing emphasis on those areas that were commonly found challenging and try to fill in gaps.
- Participants review their self improvement areas as they noted during the practicum and develop a plan to work on them (facilitator could ask one or two people to share their self improvement plans if time allows)
- Remind them that they will have time in the field to work on specific areas of improvement and that some areas will improve as they gain more experience as counsellors with time.
- Review the objectives of this session and how they were met.
- Thank participants for their commitment throughout the training and practicum.
# Annex

| Form 1: | HIV Counselling: Training Assessment Tool |
| Form 2: | HCT Card |
| Form 3: | HCT Register (HMIS 055b) |
| Form 4: | Health Unit Monthly Report (HMIS 105) |
| Form 5: | Bi-monthly Report Order Form (LMIS) |
| Form 6: | Monthly Report form (HMIS) |
| Form 7: | Bi-monthly Report Order Form (LMIS) |
| Form 8: | Stock card (HMIS 015) |
| Form 9: | Referral Note (HMIS 032) |
| Form 10: | General Tally Sheets (HMIS 091) |
| Form 11: | Supervisor’s Checklist for Assessing the Standard of HIV Counselling |
| Form 12: | Strategic Health Education: Group Evaluation Form |
| Form 13: | Action Planning Sheet |
| Form 14: | Site Supervisor: HCT Counsellor Training Practicum Schedule |
| Form 15: | HCT Counsellor Training Practicum Schedule |
| Form 16: | Supervisor’s Practicum Guide |
| Form 17: | Training Participant Registration Form |
| Form 18: | Trainer Information Form |
| Form 19: | Course Information Form |
| Form 20: | Trainer Observation Checklist |
HIV Counselling: Training Assessment Tool

Instructions: Please answer all questions

Time: 45 minutes

1. List the three modes of HIV transmission.
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

2. What is discordance?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

3. What are the types of tests used to detect the presence of HIV in a person
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

4. List 5 risk factors which increase chances of mother-to-child transmission of HIV.
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

5. All babies born to HIV+ mothers will test positive for HIV antibodies at birth.
   (Circle the correct option)
   a) True
   b) False

6. What is counselling?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

7. Mention at least three factors that increase the vulnerability of women to getting HIV infection.
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

8. List four points that should be covered in a pre-test counselling session:
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
9. List three ways to show you are listening to a client.

10. Name three types of questioning used in counselling and give an example of each.

11. List five points you should cover when giving someone a negative HIV test result (order is not important).

12. What are four points you should cover when giving someone a positive HIV test result?

13. In which 3 circumstances would you advise someone to do repeat HIV testing?


15. Imagine in the course of your work you get a needle stick injury in the hospital. List the steps you would take to prevent HIV infection. Assume that post-exposure prophylaxis (PEP) is available for occupational exposures against health workers.

16. Give at least three reasons why young people are at risk of HIV infection.
17. List three reasons why you may need to refer a client to another service or institution.

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

18. If a mother, who does NOT know her HIV sero-status, requested you to test her 2-year-old baby in order to find out her HIV sero-status, as a counsellor, would you test the child? (Circle Yes or No and give reasons)

a) Yes: Give reason

b) No: Give reason

19. Who is eligible to ARV therapy?

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

20. Can a person receiving ART infect others?

a) Yes
b) No.

21. What is the implication of non-compliance to ART?

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

22. Mention at least three signs and symptoms of TB that are commonly observed among people living with HIV/AIDS

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

23. Mention 5 aspects of positive living?

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
HCT Card 2005

Visit Date ______/_____/______
Name of Health Unit __________________________Health Unit Code _________ Serial No. ____/____/____/

Is the centre static or an out reach?  Static = 1 specify (a) VCT □  (b) RCT □  (c) HBVCT □
Out reach = 2 specify area _______________________________

SECTION A: SOCIODEMOGRAPHIC CHARACTERISTICS

Client’s Name (Optional) _____________________________________________________________________

Sex:  Female = 1  Male = 2  Age in complete years \____\____\ 

Residence: Sub-county ____________ Parish ____________ Village______________

Marital status: Never married = 1  Married = 2  Divorced/Separated = 3
Widowed = 4   Cohabiting = 5

SECTION B: COUNSELLING

SESSION TYPE:  Individual = 1  Couple = 2  Group = 3

Have you ever tested for HIV before  Yes = 1  No = 2

Has your spouse/partner been tested for HIV before?  Yes =1  No = 2  Don’t know = 3

If yes what were the results?  HIV Negative = 1  HIV Positive = 2  Don’t know = 3

Partner’s Client Number______________________________

LABORATORY RESULTS

District Name ________________________ Health Unit Code________________ Serial No. ____/____/____/

1st TEST :  □ HIV Negative  □ HIV Positive  □ Indeterminate

2nd TEST:  □ HIV Negative  □ HIV Positive  □ Indeterminate

3rd TEST:  □ HIV Negative  □ HIV Positive  □ Indeterminate

SUMMARY HIV Results:  □ HIV Negative  □ HIV Positive  □ Indeterminate

SYPHILIS Test Results:  □ Reactive  □ Non-Reactive  □ Not done

Name of Lab. Technician_________________________ Sign____________  Date _____/____/____/
CLIENTS' SLIP

District Name _______________________ Health Unit Code________________ Serial No. _____/____/____/
Counsellor’s Name _____________________ Visit Date _______/______/_______/

CONSENT

______________________________________ having received pre-test counselling from my counsellor hereby voluntarily decide and consent for an HIV test

Signature _________________________________ Date _______/_______/________/

COUNSELLOR’S SUMMARY

Visit date _______/_____/______
Counselling Done  Yes = 1  No = 2
Syphilis test done Yes = 1  No = 2
Blood drawn:    Yes = 1  No = 2  If not why ______________________________
Result given:    Yes = 1  No = 2  If not why ______________________________
Counselling and tested as a couple: Yes = 1  No = 2
Referred for ___________________________ Referral place ______________________
HIV test results: HIV Negative = 1  HIV Positive = 2  Indeterminate = 3
For Couples HIV Results: Concordant = 1  Discordant = 2
Syphilis test results:  Non Reactive = 1  Reactive = 2  Not Done = 3
Is a repeat test needed? Yes = 1  No = 1
For RCT, what is the possible diagnosis ______________________________
Action taken incase of any problem ______________________________
## HIV Counselling and Testing (HCT) Register (HMIS 055b)

### Left side:

<table>
<thead>
<tr>
<th>Serial No</th>
<th>Client No./ Year</th>
<th>Age (in years)</th>
<th>Sex</th>
<th>Marital status</th>
<th>Village/Parish</th>
<th>Has Client been tested before</th>
<th>Counselling</th>
<th>Tested today</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt; 5 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 - &lt; 18 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 years and &gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Right side:

<table>
<thead>
<tr>
<th>Received results on HIV</th>
<th>Started on CTX</th>
<th>Tested as a couple</th>
<th>Referred for HIV Testing</th>
<th>Screened for TB</th>
<th>TB results</th>
<th>Screened for syphilis</th>
<th>Syphilis results</th>
</tr>
</thead>
</table>

### Description of columns:

The date is written at the beginning of each clinic day in the middle of the right and left page. Nothing else is written on the line. This register should be confidential and thus the reason why it is not in the OPD register.

Fill columns on the first visit of the client:

- **Serial No:** The numbers should start with “1” on the first date of each month
- **Client No./ Year:** Start with the number “1” on the first of July each year. This number also goes on the HCT card.
- **Age in years:** Write the age of the client in years in the respective age group
- **Sex:** Write the sex of the client
- **Marital Status:** Write the marital status of the client e.g. “Single”, “Married”, “Cohabiting”, “Separated”, “Divorced”, “Widowed”.
- **Village/Parish:** Write the name of the Village and parish of residence of client
- **Has client been tested before:** Write “Yes” if client had ever been tested or “No” if this is the first time of testing
- **Counselling:** Write “Yes” if the client has been counselled on HIV/AIDS on this visit
- **Tested today:** Write “Yes” if a patient who has been counselled on HIV during the current visit accepts to be tested and is actually tested.
- **Received results on HIV:** All clients tested should receive their results. Write “yes” for those who receive the results and “No” for those that do not receive the results within the month
- **HIV test result:** Write “positive (+ve)” for tests that are positive or “Negative” (-ve) for tests that are negative
- **Tested as a couple:** Write “Yes” for a client who comes in with a partner and they are tested together in the facility and receive results together as a couple, or “No” if not.
- **Referred for HIV Testing:** Write “Yes” if a client is not tested at the site and is referred to another site for HIV testing
- **Screened for TB:** Write “Yes” for clients who have screened for TB and “No” for those who have not.
- **Results for TB test:** Write “positive (+ve)” for tests that are positive or “Negative” (-ve) for negative tests
- **Screened for Syphilis:** Write “Yes” for clients who have screened for Syphilis and “No” for those who have not.
- **Results for Syphilis test:** Write “positive (+ve)” for tests that are positive or “Negative” (-ve) for negative tests
## Health Unit Monthly Report (HMIS 105)

- **Health Unit:** ____________________________  
- **Level:** _____  
- **Code:** _________  
- **District:** __________________  
- **HSD:** __________________  
- **Month:**  __ ______  20 ________

### 1. OPD ATTENDANCE AND LABORATORY TESTS TOTALS FOR THE MONTH

#### OUTPATIENT ATTENDANCE

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>New attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals to unit (all ages)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals from unit (all ages)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### LABORATORY TESTS

<table>
<thead>
<tr>
<th>Category</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria blood smear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB sputum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap smear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Lab. Tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. OUTPATIENT DIAGNOSES

#### Epidemic-Prone Diseases

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>0-4 years</th>
<th>5 and over</th>
<th>0-4 years</th>
<th>5 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 Acute flaccid paralysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>02 Cholera</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03 Dysentery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04 Guinea worm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05 Meningitis (meningococcal)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>06 Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>07 Tetanus (neonatal) (0–28 days age)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08 Plague</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09 Rabies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Yellow Fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Other Viral Haemorrhagic Fevers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Other emerging infectious disease</td>
<td>Specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Maternal and Perinatal Diseases

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>0-4 years</th>
<th>5 and over</th>
<th>0-4 years</th>
<th>5 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 Abortions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 Malaria in pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37 High blood pressure in pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 Obstructed labour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39 Haemorrhage related to pregnancy (APH &amp;/or PPH)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 Perinatal conditions (in newborns 0–28 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Non-communicable diseases

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>0-4 years</th>
<th>5 and over</th>
<th>0-4 years</th>
<th>5 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>41 Anaemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43 Oral Diseases and Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44 Diabetes mellitus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 Gastro-Intestinal disorders (non-Infective)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46 Hypertension</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47 Anxiety disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48 Mania</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49 Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 Schizophrenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51 Alcohol and Drug abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52 Childhood Mental Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Infectious/Communicable Diseases

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>0-4 years</th>
<th>5 and over</th>
<th>0-4 years</th>
<th>5 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Diarrhea- Acute</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Diarrhea- Persistent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 ENT conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Eye conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Sexually Transmitted Infection (STI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Urinary Tract Infections (UTI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Intestinal Worms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Leprosy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Malaria</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Other types of meningitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 No pneumonia - Cough or cold</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Schistosomiasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Onchocerciasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Skin Diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Tuberculosis (New cases)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Typhoid Fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 Tetanus (over 28 days age)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Sleeping sickness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 Pelvic Inflammatory Disease (PID)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34 Deaths in OPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### More Non-communicable diseases

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>0-4 years</th>
<th>5 and over</th>
<th>0-4 years</th>
<th>5 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>53 Epilepsy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54 Other forms of mental illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55 Other cardiovascular diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56 Severe Malnutrition (Marasmus, Kwashiorkor and Marasmic-kwash)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57 Low weight for age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58 Injuries- Road traffic Accidents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59 Injuries- (Trauma due to other causes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 Animal/ snakes bites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61 Other diagnoses (priority diseases for District)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Diagnoses
## 3. MCH AND FP ACTIVITIES

### ANTENATAL/POSTNATAL CLINIC

#### Category | Number
---|---
New ANC attendance |  
ANC re-attendance 4th visit |  
Referrals to unit |  
Referrals from unit |  
First dose IPT (IPT1) |  
Second dose IPT (IPT2) |  
Postnatal visits |  
Vit A supplementation (postnatal) |  

### CHILD HEALTH

#### Category | Number
---|---
Vit A supplem 1st Dose in the year |  
Vit A supplem 2nd Dose in the year |  
Dewormed 1st dose in the year |  
Dewormed 2nd dose in the year |  
Weight below bottom line at Measles vaccination |  
Total weighed at Measles vaccination |  
No of children treated with HOMAPAK |  
No of children who received HOMAPAK within 24 hours |  
Number of under 5 children who slept under a Net the previous night (as per HOMAPAK) |  

### MATERNITY

#### Category | Number
---|---
Admissions |  
Referrals to unit |  
Referrals from unit |  
Deliveries in unit |  
Deliveries HIV positive in unit |  
Deliveries HIV positive who swallowed ARVs |  
Live births in unit |  
Babies born with low birth weight (< 2.5 kg) |  
Babies born with HIV positive mothers |  
Babies (born to HIV positive mothers) given ARVs |  
Still births in unit |  
Birth Asphyxia |  
Maternal deaths |  
Deliveries by private practitioners |  
Deliveries with TBA |  

### FAMILY PLANNING USERS

#### Category | Method | New Users | Revisits
---|---|---|---
Refrerrals to unit | Oral : Lo-Femenal |  
Refrerrals from unit | Oral : Microgynon |  
Deliveries in unit | Oral : Ovrette |  
Deliveries HIV positive in unit | Oral : Others |  
Deliveries HIV positive who swallowed ARVs | Condoms |  
Live births in unit | IUDs (Copper T) |  
Babies born with low birth weight (< 2.5 kg) | Injectable |  
Babies born with HIV positive mothers | Natural |  
Babies (born to HIV positive mothers) given ARVs | Other methods |  
Still births in unit | Total family planning users |  
Birth Asphyxia |  
Maternal deaths |  
Deliveries by private practitioners |  
Deliveries with TBA |  

### TETANUS IMMUNISATION

#### Category | Number
---|---
Pregnant women TT vaccine |  
Dose 1 |  
Dose 2 |  
Dose 3 |  
Dose 4 |  
Dose 5 |  
Non-pregnant women TT vaccine |  
Dose 1 |  
Dose 2 |  
Dose 3 |  
Dose 4 |  
Dose 5 |  

### CONTRACEPTIVES DISPENSED

#### Category | Number
---|---
Pregnant women TT vaccine |  
Dose 1 |  
Dose 2 |  
Dose 3 |  
Dose 4 |  
Dose 5 |  
Non-pregnant women TT vaccine |  
Dose 1 |  
Dose 2 |  
Dose 3 |  
Dose 4 |  
Dose 5 |  

### FROM THE OPERATING THEATRE

#### Category | Number
---|---
BCG |  
Polio 0 |  
Polio 1 |  
Polio 2 |  
Polio 3 |  
DPT-HepB+Hib 1 |  
DPT-HepB+Hib 2 |  
DPT-HepB+Hib 3 |  
Measles |  
DPT-HepB+Hib doses wasted |  

### FROM THE OPERATING THEATRE

#### Category | Number
---|---
Female Sterilisation (tubal ligation) |  
Male Sterilisation (vasectomy) |  
Implant new users |  
Implant revisits |  
Implant removals |  

4. HCT, PMTCT and ART

<table>
<thead>
<tr>
<th>PMTCT SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women tested for HIV</td>
</tr>
<tr>
<td>Pregnant women positive for HIV</td>
</tr>
<tr>
<td>Pregnant women given ARVs for prophylaxis</td>
</tr>
<tr>
<td>(PMTCT)</td>
</tr>
<tr>
<td>Pregnant women given ARVs for treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>No. of individuals &lt; 5 years</th>
<th>No. of individuals 5 - &lt;18 years</th>
<th>No. of individuals 18 years and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV counselled</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>HIV tested (from lab register)</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>Received HIV results</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>HIV positive (from lab register)</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>HIV positive cases with confirmed TB</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>HIV positive cases started on CTX</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>(Cotrimoxazole) prophylaxis</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ART SERVICES</th>
<th>No. of individuals &lt; 5 years</th>
<th>No. of individuals 5 - &lt;18 years</th>
<th>No. of individuals 18 years and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible for ART</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>Started on ART</td>
<td>Male Female</td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
</tbody>
</table>
# Bimonthly Report and Order Calculation Form (LMIS)

**Facility Name:** __________________________________________________________

**District:** ______________________________________________________________

**Health Sub District:** _____________________________________________________

**Report Period:** ___________________________ month - month/year

**Date Prepared:** ___________________________ day-month-year

## REPORT

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Item Description</th>
<th>Basic Unit</th>
<th>Number of Test Available at the Beginning of the two months</th>
<th>Total Number of Test Received During the two months</th>
<th>Total Number of Tests Used During the two months</th>
<th>Loses / Adjustments (+/-)</th>
<th>Total Number of Test Remaining at the end of the two months (Physical count)</th>
<th>Maximum Stock Quantity</th>
<th>Quantity on Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine HIV 1/2 (+1 bottle Chase Buffer per 100 tests)</td>
<td>1 test</td>
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<td></td>
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</tr>
<tr>
<td>2</td>
<td>Unigold HIV 1/2</td>
<td>1 test</td>
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<td></td>
</tr>
</tbody>
</table>

## Bimonthly Summary of HIV test by Purpose of use

<table>
<thead>
<tr>
<th></th>
<th>VCT</th>
<th>PMTCT</th>
<th>Clinical Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Determine HIV 1/2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Unigold HIV 1/2</td>
<td></td>
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</tr>
</tbody>
</table>

## Remarks:

Prepared by: __________________________________________________________

Full Name ___________________________ Signature ___________________________ Designation ___________________________ Date ___________________________

Reviewed by: __________________________________________________________

Full Name ___________________________ Signature ___________________________ Designation ___________________________ Date ___________________________
# Stock Card (HMIS 015)

### Description:  

**Special Conditions:**  

<table>
<thead>
<tr>
<th>Strength/ Size</th>
<th>Expiry Date(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Issue Unit</th>
<th>AMC</th>
<th>Maximum Stock</th>
<th>Minimum Stock</th>
<th>Quantity to Order</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>To or From:</th>
<th>Voucher Number:</th>
<th>Quantity in:</th>
<th>Quantity out:</th>
<th>Losses and Adjustments</th>
<th>Balance on Hand:</th>
<th>Remarks/ Batch Number</th>
</tr>
</thead>
</table>
Referral Note (HMIS 032)

Date of Referral______________________________

TO: __________________________________________

FROM: Health Unit__________________________ Referral number ______________

REFERENCE: Patient name____________________ Patient number _____________

Age _______ Sex _______ Date of first visit____________________

Please attend the above person who we are referring to your health unit for further action.

History and Symptoms:

Investigations done:

Diagnosis:

Treatment given:

Reason for referral:

Please complete this note on discharge and send it back to our unit

Name of clinician____________________________ Signature__________________________

Date of arrival__________________________ Date of discharge ______________________

Further investigations done

Diagnosis:

Treatment given:

Treatment or surveillance to be continued:

Remarks:

Name of clinician ____________________________ Signature _________________________
# General Tally Sheet (HIMS 091)

<table>
<thead>
<tr>
<th>Description</th>
<th>Where</th>
<th>Time Period</th>
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<tbody>
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</tbody>
</table>
Supervisor’s Checklist for Assessing the Standard of HIV/AIDS Counselling

A. Introduction

This is designed to assess the standard of HIV counselling by monitoring the content of the counselling session. The content of the counselling session will vary depending on its purpose and needs of the client.

For counselling in relation to testing and for counselling around an HIV diagnosis in clinical settings (where an HIV test may not always be possible), the diagnosis needs to cover certain minimum ground.

This observation needs to be completed by an experienced and trained or counselling supervisor.

B. Prevention Counselling

<table>
<thead>
<tr>
<th>During the session, have the following occurred:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assisting a client to give reason for coming to be counselled?</td>
</tr>
<tr>
<td>2. Client’s knowledge about facts of HIV and AIDS assessed?</td>
</tr>
<tr>
<td>3. Knowledge about HIV and mode of transmission explored.</td>
</tr>
<tr>
<td>4. Misconceptions</td>
</tr>
<tr>
<td>5. Knowledge about modes of prevention explored.</td>
</tr>
<tr>
<td>6. Assessment of personal risk profile carried out.</td>
</tr>
<tr>
<td>7. Appropriate referral to professional services directly at addressing specific issues the client may have identified.</td>
</tr>
</tbody>
</table>

C. Pre-test Counselling

<table>
<thead>
<tr>
<th>During the session, have the following occurred?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reason for attending discussed.</td>
</tr>
<tr>
<td>2. Information given by counsellor. (Assess knowledge, attitude and skills)</td>
</tr>
<tr>
<td>• HIV infection mentioned and discussed as a reality.</td>
</tr>
<tr>
<td>•Misconceptions corrected.</td>
</tr>
<tr>
<td>3. Assessment of personal risk carried out.</td>
</tr>
<tr>
<td>4. Information on possible HIV test results and subsequent implications given.</td>
</tr>
<tr>
<td>• Process of HIV testing explained [in a simple manner].</td>
</tr>
<tr>
<td>• Meaning of possible HIV test results discussed.</td>
</tr>
<tr>
<td>• Discussion of meaning of HIV positive results and possible implications done.</td>
</tr>
<tr>
<td>• In case of couple, discussions of the meaning of HIV, discordant results and possible implications done</td>
</tr>
<tr>
<td>• In issues of window period explained in relation to sexual risks taken.</td>
</tr>
<tr>
<td>5. Capacity to cope with positive results assessed.</td>
</tr>
<tr>
<td>6. Sharing (disclosure) of either negative or positive results discussed.</td>
</tr>
</tbody>
</table>
### D. Post-test Counselling

**During the session, has any of the following occurred?**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Pre-test counselling plans reviewed.</td>
</tr>
<tr>
<td>2.</td>
<td>Giving results</td>
</tr>
<tr>
<td></td>
<td>• Results given simply and clearly</td>
</tr>
<tr>
<td></td>
<td>• Silence observed after breaking news</td>
</tr>
<tr>
<td></td>
<td>• Time allowed for results to sink in.</td>
</tr>
<tr>
<td>3.</td>
<td>Checked for understanding of given results.</td>
</tr>
<tr>
<td>4.</td>
<td>Discussion of meaning or results with client</td>
</tr>
<tr>
<td>5.</td>
<td>Discussion of personal, family and social implications.</td>
</tr>
<tr>
<td></td>
<td>• Who (if any one) to tell?</td>
</tr>
<tr>
<td></td>
<td>• Who is to help?</td>
</tr>
<tr>
<td></td>
<td>• Client guided to generate many options.</td>
</tr>
<tr>
<td></td>
<td>• Client guided to come up with one suitable option for plan.</td>
</tr>
<tr>
<td>6.</td>
<td>Reflection and support for dealing with immediate emotional reactions.</td>
</tr>
<tr>
<td>7.</td>
<td>Checking adequate immediate emotional reactions.</td>
</tr>
<tr>
<td>8.</td>
<td>Discussions of follow up care and support.</td>
</tr>
<tr>
<td>9.</td>
<td>Options and resources discussed.</td>
</tr>
<tr>
<td>10.</td>
<td>Immediate plans, intentions and actions reviewed.</td>
</tr>
<tr>
<td>11.</td>
<td>Follow up plans discussed.</td>
</tr>
</tbody>
</table>

### E. Counselling around the HIV diagnosis

**During the session, have the following occurred?**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Symptoms and course of illnesses reviewed and discussed.</td>
</tr>
<tr>
<td>2.</td>
<td>Investigations and treatments reviewed and discussed.</td>
</tr>
<tr>
<td>3.</td>
<td>Possibility/certainty of HIV related diagnosis based on clinic presentation.</td>
</tr>
<tr>
<td>4.</td>
<td>Review of knowledge about HIV, including transmission and prevention.</td>
</tr>
<tr>
<td>5.</td>
<td>Misconceptions corrected and information given.</td>
</tr>
<tr>
<td>6.</td>
<td>Personal risk assessment carried out with respect to sexual and drug injecting behaviour and history of blood contact.</td>
</tr>
<tr>
<td>7.</td>
<td>Further discussions of possibility/certainty of HIV related.</td>
</tr>
<tr>
<td>8.</td>
<td>Diagnosis combining risk profile symptoms and clinical status</td>
</tr>
<tr>
<td>9.</td>
<td>Time allowed for news to sink in understanding checked.</td>
</tr>
<tr>
<td>10.</td>
<td>Discussion of personal, family and social implications of diagnosis of the client.</td>
</tr>
<tr>
<td>11.</td>
<td>Dealing with emotional reactions.</td>
</tr>
<tr>
<td>12.</td>
<td>Discussion of strategies and options for further support and care.</td>
</tr>
</tbody>
</table>
F. Supportive counselling

**During the session, have the following occurred?**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Client assisted in discussing how he/she live positively.</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Discussing emerging problems/health, economic, etc and how the client can address.</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Was the client assisted in identifying available support system?</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Were psychological issues and dilemmas with respect to use of protective materials during caring discussed and was the client assisted in coping with them?</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Discussion on plans and preparations for the care of children (where applicable).</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>Discussion of concerns and feelings of impending or imminent death.</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>Did counsellor allow client time in dealing with difficult decisions?</td>
</tr>
<tr>
<td><strong>8.</strong></td>
<td>Was support given for provoked emotions?</td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td>Was psycho-emotional support given to the grieving family?</td>
</tr>
</tbody>
</table>
# Strategic Health Education: Group Evaluation Form

Name of facilitator: 

Date of evaluation: 

Type of group and participants: 

Circle YES or NO for each of the following questions:

<table>
<thead>
<tr>
<th>Facilitator's Performance</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of introduction to group:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Was the purpose of the group made clear?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>2. Was confidentiality stressed?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>3. Did the leader establish rapport with the group?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>4. Did the facilitator probe appropriately?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>5. Were questions asked in a good sequence?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>6. Were differences of opinion identified?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>7. Did leaders get detailed answers to questions?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group dynamics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the group’s conversations lively?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>2. Was there occasional laughter?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>3. Did everyone speak?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>4. Did anyone dominate the conversation?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
<tr>
<td>5. Did each topic get discussed in depth?</td>
<td>YES □ NO □</td>
<td></td>
</tr>
</tbody>
</table>
## Action Plan for Implementing HCT Counselling

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing information with supervisor and co-workers</td>
<td>What exactly will we do?</td>
</tr>
<tr>
<td>Planning and preparing for their “sit-in” counselling sessions.</td>
<td></td>
</tr>
<tr>
<td>Preparing for their supervised sessions.</td>
<td></td>
</tr>
<tr>
<td>Completing certification/practicum</td>
<td></td>
</tr>
<tr>
<td>Providing HCT at the facility</td>
<td></td>
</tr>
</tbody>
</table>
# HCT Counsellor Training Practicum Schedule

<table>
<thead>
<tr>
<th>Overall Supervisor:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Site:</td>
<td>--</td>
</tr>
<tr>
<td>Dates of Practicum:</td>
<td>From:</td>
</tr>
<tr>
<td></td>
<td>To:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time (from-to)</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
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Observer
Supervisor’s Practicum Guide

During the practicum, a supervisor who is the facilitator or an identified experienced counsellor will observe each training participant’s counselling sessions through sit-in sessions. A checklist as a tool for assessment should be used by the supervising counsellor. This should help identify areas of strength and those that need improvement by both the counsellor and trainee. It is important that the supervisor:

- Orient counsellors-in-training on the different procedures of HIV/AIDS services delivery available at the center/ facility.
- Identifies clients whom trainee can easily communicate with (language).
- Avails as many opportunities as possible to counsellors-in-training to practice counselling in different forms and situations including group, one-to-one, couples, adolescents, children, etc.
- Ensures that each counsellor-in-training handles at least two pre-tests, post-tests and supportive counselling sessions.
- One counsellors-in-training should be observed at a time.
- Give feedback to counsellor-in-training at the end of the session highlight.

Before observed practicum sessions:
- Management and relevant staff of the health facility notified and involved in arranging and coordinating the practicum.
- Ensure that clients consent is sought and received thoroughly.
- Explaining to client that two counsellors will be present in the session.
- Assuring client of confidentiality.
- Checking with client whether this is okay (seek consent).

During observation:
- Check through observing that knowledge and skill used are within the set standards of counselling as discussed during training (SOLER, use of aides like client cards, communication skills, attitudes and abiding by protocol guidelines).
- Provide feedback.
- Analyze each session immediately when it ends, enforcing strengths, and discussing steps for improving weaknesses.
- Support counsellor-in-training to develop strategies for self development/improvement.
- Supervisor must be friendly, calm and set a re-assuring and confidence building environment for the trainee.
- Extensive note taking is discouraged, where possible avoid writing during the session.
After observed session:

- Allow counsellor-in-training to assess him/herself first using an assessment guide provided.
- Provide feedback focusing on strengths and give specific examples.
- While providing feedback on weak areas, do not be generalist. Cite specific instances during the session, provide alternative way trainee could have handled it or behaved (don’t focus on things the counsellor-in-training cannot change like stammering).
- Reinforce strengths and the positive aspects of the session. Supervisor should end on a note that makes the trainee feel she can improve.

End of observation/practicum:

The supervisor should:

- **Prepare a brief written report** about the performance of each trainee at the end of the practicum exercise, highlighting strengths, weaknesses, and personal challenges.
- **Provide feedback to the practicum site** on some of the operational aspects that need to be strengthened within the health facility.

Note: The counsellor supervisor is responsible for the successful implementation of the practicum exercise. Counsellor supervisors and counsellor trainers should work as a team to ensure smooth service delivery while trainees are on the practice.

The practicum participant should:

- **Case study preparation** – maintain a record of one challenging and one easy case for presentation during the feedback session.
- **Counselling skills assessment & building** – self assess and identify personal issues that enhance or are barriers to effective counselling.
- **Resource and referral development** - identify and keep record of places in the area to use as referral for diverse needs of clients, provide information for the resource or place in the referral list.
- **Support group work** - Take time to identify and establish contact with an existing support group and share what they do during the feedback session.
Training Participant Registration Form

To be completed by Participant:
First Name: ____________________________
Other Names: __________________________
Surnames: ____________________________
Date of Birth: __________/________/______

Current Contact Information:
Home or mobile phone: ____________________________

What is your professional role? ☐ Tick only one.
☐ Obstetrician
☐ Paediatrician
☐ Physician
☐ Medical Officer
☐ Clinical Officer
☐ Registered Comprehensive Nurse
☐ Enrolled Comprehensive Nurse
☐ Registered Nurse
☐ Public Health Nurse
☐ Enrolled Nurse
☐ Registered Midwife
☐ Enrolled Midwife
☐ Nursing Assistant
☐ Health Administrator/In-charge
☐ Social Worker
☐ Nutritionist
☐ Professional Counsellor
☐ Lay Counsellor
☐ Lab Technician/Technologist
☐ Lab Assistant
☐ Pharmacist
☐ Pharmacy Assistant/Dispenser
☐ Community Health Worker
☐ Traditional Healer
☐ Traditional Birth Attendant
☐ Community/Religious Leader
☐ Volunteer
☐ Other, please specify: ____________________________

Where do you currently work?
Organization/Facility Name: _____________________________________________
Address: _______________________________________________________________
District: __________________________________________________________________
County/Municipality: __________________________________________________________________
Sub-county/Division: __________________________________________________________________
Parish/Ward: __________________________________________________________________
LC1/Village/Zone/Cell: _______________________________________________________
Organization/Facility Type: _____________________________________________________
☐ National Ref. Hospital
☐ Regional Ref. Hospital
☐ District Hospital
☐ Health Center IV
☐ Health Center III
☐ Health Center II
☐ MOH Office
☐ District Health Office
☐ CBO
☐ NGO (not faith-based)
☐ FBO
☐ Local Council
☐ Medical School
☐ Nursing School
☐ Training Center
☐ Other (specify): _________________________________________________________
Organization/Facility Phone: _______________________________________________
Organization/Facility Fax: _________________________________________________
Ownership: ____________________________
☐ Government
☐ NGO/CBO/FBO
☐ Private

What HIV services do you currently provide?
☐ Tick all that apply.
Administration
☐ Monitoring & Evaluation
☐ Program Coordination
☐ Program Management
☐ District Management
Health Service Provision
☐ Clinical Diagnosis & Treatment
☐ Monitoring of Treatment
☐ Counselling/Patient Education
☐ VCT
☐ DOT Treatment Support
☐ PMTCT
☐ Other (specify):
Community Services
☐ Community Mobilization
☐ Home-Based Care
☐ Treatment and Support
☐ Lay/Peer Counselling
Training & Education
☐ Skills-building Training
☐ Counselling Training
☐ Knowledge-building (Didactic) Training
Course Name: ____________________________
Course Venue: ____________________________
Course Start Date: __________/________/______

Day/ Month / Year
Trainer Information Form

To be completed by Participant:

First Name: ____________________________________________
Other Names: __________________________________________
Surname(s): _____________________________________________
Date of Birth: __________________________ Day / Month / Year

Current Contact Information:
Home or mobile phone: _____________________________
Work phone: _____________________________
E-mail address: ___________________________________________

Please tick your Trainer Type.  ☑ Tick only one.
☐ National Trainer
☐ Regional Trainer
☐ District Trainer
☐ Other, specify: _____________________________

What is your profession?  ☑ Tick only one.
☐ Obstetrician
☐ Paediatrician
☐ Physician
☐ Medical Officer
☐ Clinical Officer
☐ Registered Comprehensive Nurse
☐ Enrolled Comprehensive Nurse
☐ Registered Nurse
☐ Public Health Nurse
☐ Enrolled Nurse
☐ Registered Midwife
☐ Enrolled Midwife
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☐ Pharmacy Assistant/Dispenser
☐ Community Health Worker
☐ Traditional Healer
☐ Traditional Birth Attendant
☐ Community/Religious Leader
☐ Volunteer
☐ Other, specify: _____________________________

Where do you currently work?

Organization/Facility Name: _____________________________
Address: _____________________________________________
District: _____________________________
County/Municipality: _____________________________
Sub-county/Division: _____________________________
Parish/Ward: _____________________________
LCI/Village/Zone/Cell: _____________________________
Organization/Facility Type: _____________________________
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☐ Regional Ref. Hospital
☐ District Hospital
☐ Health Center IV
☐ Health Center III
☐ MOH Office
☐ CBO
☐ FBO
☐ Medical School
☐ Training Center
☐ Other (specify): _____________________________

Organization/ Facility Phone: _____________________________
Organization/ Facility Fax: _____________________________
Ownership: ☐ Government ☐ NGO/CBO/FBO ☐ Private

Please tick all languages that you can train in
☐ English
☐ Swahili
☐ Luganda
☐ Luo
☐ Runyankole/Rukiga
☐ Runyoro/Rotoro
☐ Ateso
☐ Lugbara
☐ Nubian
☐ Other(s), specify: _____________________________

Please tick all Training Courses which you can train.  ☑ Tick all that apply.
☐ Comprehensive HIV Management, Care and Treatment Orientation
☐ Clinical Management of HIV/AIDS
☐ Post-exposure Prophylaxis (PEP)
☐ VCT
☐ Logistic Management
☐ Laboratory Diagnosis for HIV and Syphilis
☐ Comprehensive Laboratory Training
☐ Quality Assurance for HIV Testing
☐ Early Diagnosis of HIV in Young Children (PCR)
☐ Infection Control Training
☐ Nutrition Support and Care for PLWHA
☐ Home-based Care Training
☐ Training Course in TB Management
☐ Strategies for Prevention of MTCT
☐ Integrated Infant and Young Child Feeding
☐ Counselling for PMTCT Service Provision
☐ PMTCT Data Management
☐ Performance Improvement and Support Supervision
☐ Syndromic Management of STDs
☐ Health Information Systems and Surveillance
☐ Training Information Monitoring System (TIMS®)
☐ Other, specify: _____________________________
Course Information Form

The following information is to be completed by the course coordinator.

Training Venue: 

<table>
<thead>
<tr>
<th>Care &amp; Support Programme Unit (Tick only one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ART</td>
</tr>
<tr>
<td>☐ Clinical Care</td>
</tr>
<tr>
<td>☐ Home-based Care</td>
</tr>
<tr>
<td>☐ Nutrition</td>
</tr>
<tr>
<td>☐ PMTCT</td>
</tr>
<tr>
<td>☐ VCT</td>
</tr>
</tbody>
</table>

Course Name: 

Course Start Date: __________________________ Day/Month/Year

Course End Date: __________________________ Day/Month/Year

Course Length:

District:

County/Municipality:

Sub-county/Division:

Parish/ Ward:

LC1/Village/Zone/Cell:

Training Course (☐ Tick only one option):

ART
☐ Comprehensive HIV Management, Care and Treatment Orientation
☐ Clinical Management of HIV/AIDS
☐ Post-exposure Prophylaxis (PEP)

HIV Counselling & Testing
☐ HCT
☐ Logistic Management

Laboratory
☐ Laboratory Diagnosis for HIV and Syphilis
☐ Comprehensive Laboratory Training
☐ Quality Assurance for HIV Testing
☐ Early Diagnosis of HIV in Young Children (PCR)

Medical Transmission: Injection Safety
☐ Infection Control Training

Palliative Care (TB in HIV Patients)
☐ Nutrition Support and Care for PLWHA
☐ Home-based Care Training
☐ Training Course in TB Management

PMTCT
☐ Strategies for Prevention of MTCT
☐ Integrated Infant and Young Child Feeding
☐ Counselling for PMTCT Service Provision
☐ PMTCT Data Management

Policy Analysis and Systems Strengthening (Capacity Building)
☐ Performance Improvement and Support Supervision

STI Management
☐ Syndromic Management of STDs

Strategic Information
☐ Health Information Systems and Surveillance
☐ Training Information Monitoring System (TIMS©)
Trainer Observation Checklist

Please rate your performance in this program: 1 = Never  3 = Sometimes  5 = Always

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Scale</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Session Objectives were clearly stated at the beginning and end of session.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. Trainer links objectives and activities to needs, interests and workplace issues of participants.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Instructions for participant activities are clear, including tasks, product, timeframe and group members.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. Trainer completes the experiential learning cycle, e.g., asking questions to help participants reflect on, analyzing and drawing conclusions from activities.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. Trainers invited participants to share how they can apply their learning in the classroom, school or community.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. Participants share questions, comments and lessons learned freely.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. Trainers encourage participation of all and solicit input from those who did not seem active.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. Time allocated to the session is budgeted well for introductions, activity, discussion, conclusions and evaluation.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9. Co-trainer plays an active role in the session by adding comments and insights, posing additional questions, and helping participants to understand.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10. Trainers model effective communication, listening skills, questioning skills, and are centered on the learners.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11. Materials, handouts and visual aids are displayed and used in a way that promote learning and interest.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12. Trainers’ use of the module and session guide was appropriate.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

What should the facilitator(s) continue to do, as individuals or as co-facilitators?

What might the facilitator(s) do to be more effective, as individuals or as co-facilitators?