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Government of India

Induction Training Module for Counsellors under National AIDS Control Programme

An Integrated Training Module for ICTC, ART and STI Counsellors

Facilitator Guide

November, 2014

Prepared by

NACO

and

saksham

TISS

National AIDS Control Organization,
(Basic Services Division)
Ministry of Health & Family Welfare,
Government of India, New Delhi.

GFATM-Project Saksham,
(HIV/ AIDS Counselling under NACP)
Tata Institute of Social Sciences,
Mumbai.

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Government of India

INDUCTION TRAINING MODULE FOR COUNSELLORS UNDER NATIONAL AIDS CONTROL PROGRAMME

An Integrated Training Module for ICTC, ART and STI Counsellors

November, 2014

R.K. JAIN
Additional Secretary
& Director General (CGHS)
Tel. (O) : 011-23062985
Telefax : 011-23062579

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

FOREWORD

The National AIDS Control Programme (NACP) was launched in 1992 and presently is in its Phase IV (2012-17). Due to rigorous implementation of NACP, there has been a reduction of 57% in the new HIV infections over the last decade in the country. The adult HIV prevalence has also witnessed a fall from 0.41% (2001) to 0.27 % (2013). Raising awareness, behavior modification and psychosocial support through skilled counsellors constitute a vital part of our strategy to combat HIV/AIDS in India.

The National AIDS Control Organization (NACO) has expanded the HIV counselling services by making counsellors available up to the sub-district level of public health facilities providing Integrated Counselling and Testing (ICTC), Sexually Transmitted Infection (STI) prevention, and Anti-Retroviral Treatment (ART) services. The number of counsellors continuously increased to more than 8000 at present, which highlights the importance being given to the prevention and control of HIV in the country.

NACO with the support of 36 State AIDS Control Societies (SACS) regularly undertake well designed trainings and capacity building of the counsellors at the induction as well as refresher levels in order to ensure quality counseling services under NACP.

NACO has been continuously involved in planning, implementation, monitoring, evaluating and improvising of counsellors training modules. In this context, during the current year NACO in collaboration with TISS has developed an Integrated Induction Training Module for all the counsellors working in ICTC, ART & STI facilities. The joint efforts of Basic Services Division (BSD) along with Care, Support and Treatment (CST) and Sexually Transmitted Infections (STI) Divisions of NACO as well as Tata Institute of Social Sciences (TISS) for bringing out this module are greatly appreciated. All the SACS need to ensure an efficient implementation of the training module.

(R. K. Jain)
Addl. Secretary
National AIDS Control Organisation

Dr. Ashok Kumar, M.D.
F.I.S.C.D & F.I.P.H.A
Dy. Director General
Tele :91-11-23731956
Fax :91-11-23731746
E-mail :ddgak.dac@gmail.com

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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
एड्स नियंत्रण विभाग
6वां तल, चन्द्रलोक बिल्डिंग, 36 जनपथ, नई दिल्ली -110001
Government of India
Ministry of Health & Family Welfare
National AIDS Control Organization
6th Floor, Chandralok Building, 36 Janpath, New Delhi - 110 001

PREFACE

The project Saksham at Tata Institute of Social Sciences (TISS) was initiated with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) support under its counselling component. This project is functioning with the objective to strengthen the capacities of the institutions and counsellors to meet the long term goals of the National AIDS Control Programme (NACP) in India. The National AIDS Control Organisation (NACO), Government of India (GOI) works in close collaboration with TISS to address the training needs of HIV/AIDS counsellors in India.

Under NACP, the counsellors work at Integrated Testing and Service Centers (ICTC), Sexually Transmitted Infections (STI) Units and Anti-Retroviral Treatment (ART) Centers throughout India. These counsellors provide information regarding HIV/AIDS and enable behavior change in the clients. In addition to this, they also offer necessary psychosocial support required for addressing HIV/AIDS related stigma and discrimination faced by People Living with HIV/AIDS (PLHIV). Thus, counselling forms the backbone of NACP in providing comprehensive care to the PLHIVs. Quality training plays a crucial role in building and sustaining the counsellors' capacity to effectively meet the varied needs and expectations of clients.

Earlier, the training modules for counsellors working at ICTC, STI and ART units were separate and their induction training was of 12 days, each. Because of significant similarities in the job responsibilities and the programme needs, it was felt desirable to sensitize and train counsellors from all these three settings on a common standardized module. The matter related to integrated induction training for counsellors working in ICTC, STI and CST was deliberated with the subject specialists, programme managers and training experts, who unanimously agreed that the existing induction training to be remodeled while not sacrificing the desired objectives of the comprehensive induction training. It also called for reducing the duration of the induction training to 7 days.

The outcome of continued efforts of over the last nine months has resulted in bringing out this integrated training module which will make a significant contribution in fulfilling the goals and objectives of National AIDS Control Programme. This integrated induction training module will ensure that counsellors are oriented and sensitized during the training, while the consolidation of the learning happens at the service delivery settings.

(Dr. Ashok Kumar)

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1. Ms Annie Shajan, Sr. Programme Officer, Saksham-TISS, Mumbai.
2. Ms Dharmishtha Nanawati, Capacity Building Officer, Saksham-The Maharaja Sayajirao University of Baroda, Vadodara.
3. Dr Neelam Sukhramani, Faculty-in-charge, Saksham-Jamia Millia Islamia, Delhi.
4. Dr Nilesh Gawde, School of Health Systems Studies, TISS, Mumbai.
5. Dr Sudhir Chawla, JD CST, SACS, Gujarat
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9. Dr Shalini Anant, Technical Specialist – Counselling, Saksham-TISS, Mumbai.
10. Ms Shivranjani Kulkarni, Capacity Building Manager, Saksham- TISS, Mumbai.
11. Ms Shweta Bajaj, Zonal Program Manager, Saksham-TISS, Mumbai.
12. Dr Veena Yardi, Assoc. Prof., Dept of Foods, Nutrition and Dietetics, Nirmala Niketan, Mumbai.
13. Ms Nurith Samuel, Ex-Capacity Building Officer, Saksham-TISS, Mumbai.
14. Dr Poonam Sharma, Capacity Building Officer, Saksham-TISS, Mumbai.
15. Mr Md. Rehan, Sr. Programme Officer, Saksham-Jamia Millia Islamia, Delhi.
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LIST OF ABBREVIATIONS

ABC	Abacavir
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ARS	Acute Retroviral Syndrome
ARSH	Adolescent Reproductive and Sexual Health Programme
ART	Anti Retroviral Therapy
ARV	Anti retroviral
ASHA	Accredited Social Health Activist
ATT	Anti Tubercular Therapy
ATV/r	Atazanavir / Ritonavir
AZT	Zidovudine
BCC	Behaviour Change Communication
BP	Bridge Population
BPL	Below Poverty Line
CBT	Cognitive Behaviour Therapy
CCC	Community Care Centre
CD4	White Blood Cells which are part of Immune system / Cluster of Differentiation 4
CDC	Centre for Disease Control
CLHA	Children living with HIV/ AIDS
CLHIV	Children living with HIV
CMV	Cytomegalo Virus
CNS	Central Nervous System
CP	Clinical Psychologist
CPT	Co-trimoxazole Prophylactic Treatment
CRC- UN	United Nations Convention for Child Rights
CSF	Cerebrospinal Fluid
CST	Care, Support and Treatment
D4t	Stavudine
DAC	Department of AIDS Control
DIC	Drop-in-Centre
DLN	District Level Network
DMC	Designated Microscopy Centre
DNA	Deoxyribonucleic Acid
DOTS	Directly Observed Treatment - Short course

DTO	District Tuberculosis Officer
EBF	Exclusive Breast Feeds
EC	Exposure Code
EFV	Efavirenz
EID	Early Infant Diagnosis
ELISA	Enzyme Linked Immunosorbent Assay
ERF	Exclusive Replacement Feeds
FDC	Fixed Dose Combination
FGD	Focussed Group Discussion
FNAC	Fine Needle Aspiration Cytology
FSH	Follicle Stimulating Hormone
FSW	Female Sex Worker
HAART	Highly Active Antiretroviral Therapy
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Worker
HEI	HIV Exposed Infant
HIV	Human Immuno-deficiency Virus
HRB	High Risk Behaviour
HRG	High Risk Group
HSV	Herpes Simplex Virus
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Scheme
ICSI	Intra-Cytoplasmic Sperm Injection
ICTC	Integrated Counselling and Testing Centre
ID	Incidence Density
IDU	Injecting Drug User
IEC	Information, Education, Communication
IIPS	International Institute of Population Sciences
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPC	Indian Penal Code
IR	Incidence Ratio
IRIS	Immune Reconstitution Inflammatory Syndrome
ITP Act	Immoral Trafficking Prevention Act,1986
IUD	Intra Uterine Device
IUI	Intra Uterine Insemination

IVF	In Vitro Fertilisation
LAC	Link ART Centre
LAP	Lower Abdominal Pain Syndrome
LFU	Lost-to-follow up
LGV	Lympho Granuloma Venereum
LH	Luteinising Hormone
LPV/r	Lopinavir / Ritonavir
LWS	Link Worker Scheme
MARP	Most At Risk Population
MCH	Maternal and Child Health
MDR-TB	Multi-Drug Resistant Tuberculosis
MO	Medical Officer
MSM	Men who have sex with men
MTCT	Mother to Child Transmission
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NBSS	National Behaviour Surveillance Survey
NCAER	National Council of Applied Economic Research
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NNRTI	Non-nucleoside Reverse Transcriptase Inhibitor
NRHM	National Rural Health Mission
NRTI	Nucleoside Reverse Transcriptase Inhibitor
NSEP	Needle and Syringe Exchange Programme
NVP	Nevirapine
OI	Opportunistic Infections
OPIM	Other Potentially Infected Material
ORS	Oral Rehydration Salt / Solution
ORW	Outreach Worker
OVC	Orphans and Vulnerable Children
PCP	Pneumocystis Pneumonia
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PI	Protease Inhibitor
PID	Pelvic Inflammatory Disease
PID	Personal Identification Digit

PITC	Provider-Initiated Testing and Counselling
PLHA	People living with HIV /AIDS
PLHIV	People living with HIV
PLWHA	People living with HIV/AIDS
PPE	Personal Protective Equipment
PPTCT	Prevention of Parent- to- Child Transmission
PSW	Psychiatric Social Worker
PTSD	Post Traumatic Stress Disorder
QAP	Quality Assurance Programme
RCH	Reproductive and Child Health
RNA	Ribonucleic Acid
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SC	Source Code
SCC	Short Course Chemotherapy
SIMS	Strategic Information Management System
SLRC	State Level Rehabilitation Committee
SMO	Surveillance Medical Officer
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
STS	Senior Treatment Supervisor
TB	Tuberculosis
TCA	Trichloro Acetic Acid
TDF	Tenofovir
TG	Trans Gender
TI	Targeted Intervention
TISS	Tata Institute of Social Sciences
TRG	Technical Resource Group
UIP	Universal Immunisation Programme
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VAS	Visual Analogue Scale
WBC	White Blood Corpuscle
WHO	World Health Organisation
WLHIV	Women living with HIV
ZDV	Zidovudine
3TC	Lamivudine

INSTRUCTIONS TO TRAINING INSTITUTES

A NOTE TO THE TRAINING ORGANISERS ABOUT CONDUCTING INDUCTION TRAINING USING THIS MODULE

This module is meant for conducting integrated induction training of HIV counsellors working in ICTC, ART and STI settings. The training carried out through this module is not aimed to be exhaustive, but rather to orient counsellors to HIV and STI counselling and to equip and empower them to deal with different issues commonly faced in ICTC, ART and STI settings.

The training consists of one session on orientation to the training and 23 sessions on the topics covered in the training. Each session has clearly stated objectives and session plans. Each session is divided in up to three sections:

- Facilitators' Guide (FG), which provides the session plan and an overview of the training content.
- Power Point (PPT) presentation, which aids the facilitator during the session. This section may or may not be there depending upon its need based on the session plan in FG.
- Handout (HO), which provides background information, homework exercises and additional reading for the participants.

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

1. SETTING THE STAGE FOR TRAINING

No training is complete without the necessary preparation, even if the best training modules and resources are available. The preparation has to set the stage for learning and for achieving the training objectives. This includes:

- **Adult learning styles** must be planned to ensure involvement of all participants. Learning through discussions, role-plays, brainstorming sessions and games helps increase the participants' receptivity and learning potential. It also helps the facilitator understand the knowledge level and experience of the participants.
- **Field visit** to co-located ICTC, PPTCT, STI, ART, DMC, or blood bank can further illustrate key points and support the learning. A detailed guideline for conducting field visit is included in Annexure 1.

- **Local language** and terminology should be used as far as possible during the training in settings where participants are more conversant with the local language. To make the best use of time during the training and to enhance learning, it is advised that the organisers get all the annexure material translated in the local language.
- An introduction and a conclusion to every topic helps the participants recapitulate the main messages from the modules. **Key messages** are added at the end of every session. The facilitator needs to make sure the participants understand and retain these, thus they need to be emphasised.
- **Translate all the material in the annexure** for all the sessions into the local language in advance. This is because the annexure is supposed to be read and used by the participants, and a lot of time can be saved and learning can be significantly enhanced if the language is easily understandable for the participants. **Also translate the handout for Enhancing Counsellor Competence** because that is also to be read and used by participants.

Although the sessions have been designed to address all aspects of the training, the ultimate success of the training lies with the facilitators and the training coordinator. This includes assigning the modules to facilitators/resource persons with appropriate experience and assuring that the facilitators familiarise themselves with the handouts, activities and presentations well before the training.

The organisers must send the relevant session to the facilitator well in advance. The facilitator needs to be asked to follow the session plan and not carry out a session just on one's own. The activities, film viewing, homework assignments and role plays given in the sessions are of utmost importance. **The training organisers must make sure to carry out these activities as per the session plans** to enhance learning and not follow merely a lecture method.

The organisers also need to inform the participants in advance that the training will be **very rigorous** and that the evenings will also be utilised for training related activities. The participants need to thus come prepared to dedicate the entire 7-day period completely for the training and NOT plan any recreational activity for the evenings.

2. TRAINING SCHEDULE

The complete set of modules covers a continuous seven (7) day programme (including half day's field visit and a day of holiday suggested on the third or fourth day of the training). However, more sessions may be added according to their relevance to the culture and epidemic profile of the location where the training is conducted, time available for the training and the participants' level of practical experience in hands-on client management.

To fit the very tight schedule of the training, the training has been made residential even for the local participants. It is suggested that the organisers **insist that all the participants reach the training venue**

on the evening prior to the first day, such that they get ample rest before the training begins, and so that there are no chances of any participant missing any session due to delays in travel. Similarly, the participants' **return journey needs to be planned the next morning after the training is over, or, at the earliest - not before 9 pm** (after dinner) on the last day, to complete the post-training assessment, evaluation and other formalities **after** covering the full day's training on the last day. Participants need to also be requested to return from the breaks (lunch, tea) and be settled well before the next session's time, so as to utilise the time most optimally.

Further, it is suggested that the training could be started on a Wednesday, Thursday or Friday so that the participants as well as organisers get a break on Sunday around the middle of the hectic training schedule. The training needs to start everyday at 9:00 am (soon after the breakfast), and go on till around 6:15 pm so that the curriculum can be covered within the stipulated time. The organisers need to also **make sure the evenings are utilised for watching films** on the specific days mentioned in the schedule, and that the **participants are reminded to carry out the group discussions and / or assignments** needed for the next day's training. Thus, the participants need to come prepared that the training period needs to be a time completely dedicated to the training.

3. KEY CONSIDERATIONS FOR TRAINING

A good training program is supposed to equip counsellors with **communication skills** needed in a counselling setting. There will also be a need to develop **attitudes and skills for coping with emotions like fear, anger and embarrassment**. Learning objectives in these areas can be achieved only when the **teaching methods are interactive** and involve the participants in practising communication skills and in expressing their feelings.

Training for counsellors should be **competency-based**, bearing in mind the realities of the situation in the field. The most important method of training in any situation depends on the nature of the learning objectives. For example, the learning of facts requires different teaching methods from the learning of skills. Thus, even though participants and facilitators may be most familiar with the lecture method, this method alone is **NOT** enough to learn communication skills or counselling skills.

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

3.1 Group size

The group size for classroom counselling training should not exceed 25 participants. The smaller the group, the more quality time and opportunity are afforded for participants to practise their skills (see also 'Group discussions' later in this section).

3.2 Interactive training strategies

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

- Role-play exercises
- Group discussions
- Educational games
- Case-based small group learning activities
- Brainstorming sessions

Presentations

A PowerPoint (PPT) presentation can be used to highlight key points. Facilitators need to promote interaction during and in addition to PPT presentations by:

- Explaining in one's own words rather than reading out the slide word-by-word.
- Use of individual/group exercise HOs that participants complete
- Encouraging questions from the group following the presentation
- Conducting group work to discuss and answer questions
- By assigning issues or tasks to small groups

Visual aids

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

Role-plays

Role-plays need to be used to 'act out' specific roles of identified people or to act out a scene. This is useful when practising skills such as counselling and to explore how people react to specific situations. Please refer to Annexure 2 for guidelines for doing role plays.

Group discussions—large group discussions

Group discussion may be carried out in the large group (involving all the participants) or in smaller groups of 3-4 participants each. Please refer to Annexure 3 for guidelines on group discussions.

Case studies

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

The advantages of case studies are that they allow an examination of problem that mirror the real world, and help facilitator build participants' confidence and problem-solving skills.

> The facilitators' guide for each specific module needs to be referred to know what to do in each specific module. In some module the case studies may need to be shared with the participants in advance while in some others they may need to be given only during the session.
>
> Participants who role-play 'counsellors' in these activities should not see the cases before the commencement of the activities. This will ensure that the 'counsellor' gains experience in acquiring information from 'clients'. In 'real-life' situations, clients do not send all their details to the counsellor in advance; rather the counsellor uses counselling skills to gather information from the client. Conducting role-plays in this way ensures that training approximates real-life situations.

4. USE OF EXTERNAL RESOURCE PERSONS/ FACILITATORS

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

- Participants have access to 'experts' in their respective fields.
- Participants establish important linkages with external individuals and agencies that will assist them in their clinical work.
- External presenters add variety to the programme of regular facilitators.

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

- Inadequately briefed speakers may not focus on the topic.
- Speakers may present no evidence-based or erroneous information.

- Speakers may pitch their presentation inappropriately in terms of language used and target audience.
- Some speakers may be uncomfortable with the use of more interactive learning methodologies.
- Speakers may not adhere to the time frame provided.

Follow these guidelines to maximise the use of external facilitators or guest speakers:

- **Ensure that the speakers are adequately briefed**, verbally as well as in writing, in terms of what is expected of them. Provide a guideline that specifies the content to be covered, the methodology to be used, the level and type of language, and the time frame. In addition, clearly describe the type of participants present in the training and the overall aims of the training programme. Please ask the facilitator to come half an hour early and take time to brief them clearly about these things. **Do insist that the time frame is followed** under all circumstances, so that the sessions do not keep spilling over into each other.
- While inviting a facilitator who has conducted a session earlier, please ask them to go through the session completely because the **sessions have been modified**, thus they should not assume that they know what the session is like.
- Choose speakers who are known to be effective for your goals. Alternatively, 'groom' them to attain the desired outcome.
- The regular facilitator should be present where possible if the external speaker conducted the session. This ensures continuity in case an issue arises. In addition, regular facilitators are also able to observe and provide useful feedback to the resource persons/guest speaker.
- Always ensure that external facilitators/guest speakers are given a feedback from both the organisation and from the participant evaluations so as to continue improving their sessions.

5. ASSESSING PARTICIPANTS' KNOWLEDGE LEVELS

Before beginning the training, assess the participants' knowledge of HIV and STI and the counselling process with Pre- & Post-Training Assessment Tool.

The information gathered through the tool can be used to fine-tune the training to the knowledge level of the participants. At the end of the training, the same assessment tool can be administered to determine how much knowledge and skills the participants have gained and how effective the training has been.

6. ASSESSING TRAINING QUALITY

It is important for the training coordinator to assess the quality and effectiveness of the HIV counselling training. This feedback will help in conducting future trainings, improving sessions and identifying appropriate resource persons for trainings.

7. KEY CONSIDERATIONS FOR SUCCESSFUL TRAININGS

1. Ensure that the **material** required for each session have been made available well in advance. This will prevent usage of wrong HOs or case studies for different sessions.
2. Encourage all participants to be **present** for the ENTIRE training. It is suggested that certificates may not be given to participants who do not attend the entire course. In the event of an emergency, in which case a participant cannot complete the course, the facilitator should negotiate with the participant to complete the missed segments at a future course and then hand over the certificate. Note that this strategy is critical to ensuring the quality of counselling. If a participant misses any segments of the training programme, the facilitator should brief the participant about the missed segments when they return. This will ensure that they do not put their role-playing partner to a disadvantage when they do role-plays or other activities.
3. Ensure that the training sessions commence on **time**. Request all participants to stay at the venue, as it is a residential training even for the local participants. Those who insist on going home everyday must arrive in time and leave only after all the evening activities are completed. Inform them that there is much material to be covered each day, and it can be very disruptive to have participants arrive late or leave early at the training sessions.
4. The organising team members need to be constantly there in the training sessions, and be ready with ample number of **energisers** to keep the participants interested and alert during the training.
5. **Discussions on sensitive issues** like sex, sexuality, HIV and STIs can be difficult, especially in induction training. It is important for the facilitators to make a statement about this potential discomfort to participants at the commencement of the course and invite the course participants to discuss their concerns with the facilitator on an individual basis. The training group must respect a participant's decision to pass on a specific question or activity.
6. Encourage participants to use the **question box**. Questions on sensitive issues can be written down on a piece of paper and dropped in a question box. The questions should be drawn out at the end of each day and discussed during a 'question- and-answer' session just before the close of the day.
7. Maintain **confidentiality** at all times. This should be the case, especially if counsellor participants refer to their own personal experiences or those of their clients. Facilitators are urged to ask all participants to agree to maintain the confidentiality of all fellow participants. Facilitators need to also instruct participants to never share the clients' names or other identifying information during any discussions, and to follow the same principle even beyond the training programme.
8. Encourage participants to **respect individual differences**. Participants frequently come from different ethnic and cultural groups; and thus their lifestyles, beliefs, personal experiences and expertise may differ.

9. Encourage participants to listen carefully and with empathy, and respect each other's contributions, opinions and experiences. Explain that it is important in the training, and as professionals, to practice **active listening** by allowing each other to share their own experiences and opinions with the group.
10. Create a **congenial environment** in which each participant feels comfortable to ask questions. Participants need to be able to ask questions about what they do not understand. Again, the question box can be a useful tool.
11. Due to the constant change in transmission patterns, treatment, perceptions, attitudes, and so on, participants should be reminded to consistently **update** their information regarding HIV.
12. Ensure that you get **the right participants**. Establish clear criteria for participation and communicate these criteria not only to the participants but also to their employers.
13. Ensure that an **evaluation form** is distributed to participants at the end of the training. These need to be completed by the participants and placed in the 'evaluation box' to be collected by the facilitator once all the forms have been submitted.
14. Consider the advantages of providing **meals** to the participants. The training course follows a very strict timetable. It is therefore essential that sessions commence and conclude according to the schedule. The provision of morning tea, lunch and afternoon tea at the site of training has the advantage of ensuring that all participants promptly return from breaks. It also creates flexibility within the programme should there be a need to shorten breaks or complete work within a break. Further, it contributes to the general satisfaction of participants and allows them to focus on the study material to a greater degree.
15. The organisers could also consider the possibility of **keeping the meals and refreshments light and nutritious**, like home food, rather than heavy. For example, if possible, emphasis could be placed on salads, seasonal / local fruits, buttermilk, lemonade in addition to or if possible instead of heavy desserts, rich and spicy food, biscuits, tea / coffee. This can help in keeping the participants' digestion intact even after 8 days of eating outside food, and could also help them feel alert and prevent lethargy.

ANNEXURE

Annexure 1: Guidelines for field visits

Field visit should be organised to provide the participants with hands-on understanding of the operation and day-to-day functioning of settings like ICTC/PPTCT/ART/STI/Blood Bank. Field visit should include observation of activities at the centre, interaction with staff members and with clients visiting the centre. It should be followed by a debriefing session during which participants discuss their observations and lessons learnt.

Planning and conducting a training field visit by the training coordinator Ideally one month before the training, start to plan and organise the visit to settings where there are 3 or more co-located centres like ICTC/PPTCT/ART/STI/Blood Bank.

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

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

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

The day before the field visit

Call the centre in-charge and reconfirm the visit. Provide important updates on the training that you had not anticipated when you first spoke to them (for example the final number of visitors).

On the day of the visit

Field visit teams:

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

The training coordinator should provide

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

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

1. Describe the flow of clients to your centre.
2. How many clients/patients visit the centre each day? How are they managed?
3. Describe the process on how clients/patients move through the centre—from when they enter the centre to the time they receive reports.
4. List the different registers and records maintained.
5. How are records maintained? Where are they stored?
6. Who prepares the monthly reports? Where is data extracted from the monthly report?
7. Describe the role and responsibility of each staff member in the centre.
8. What are the changes the centre has undergone since its inception?

9. Where are the monthly reports sent?
10. What does the centre do with the client data they collect?
11. What linkages and referrals have been set and how?
12. Who supervises the staff and how?
13. Is information, collected on clients, shared with the staff? When and how?
14. Are regular meetings held within the centre? Who attends the meeting, what are the issues discussed in these meetings?
15. In case the counsellor needs help whom do they go to?
16. Is there a DOTS/DMC centre within the hospital?
17. What are the different IEC materials you use?
18. What other monitoring data do you collect (clients satisfaction surveys, information received from staff during review meeting)? How are they used?
19. Are any other tests offered at the centre?
20. Is emergency testing performed at the centre? What is the procedure followed?

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

Word of caution:

If the participants are visiting a TI centre, **please sensitise them** in advance, so that they do not look at the clients or staff with inappropriate amazement, or ask awkward personal questions.

Information that the team at the centre could share:

- Clinician (counsellor, nurse and or physician)
  - For how long have they been working with the ICTC/STI/PPTCT/ART centre?
  - How many clients/patients visit their centre each day?
  - Describe the client/patient flow at the centre?
  - Share information on forms, records, registers and reports that they complete at the ICTC/STI/PPTCT/ART centre.
  - When do they complete these records (e.g., when the patient is in front of them or after the clinical visit)?
  - Do they record information for each client/patient?
  - What other reports does each staff member write or contribute to?

- To whom do they submit the reports/forms?
- What comments do they have on the process of completing the forms and reports?
- Do they feel like the effort they put into reporting is worth it?

- Support staff:
  - Explain their role in the centre
  - What (if any) are the records they maintain?
  - What thoughts/feedback do they have around this entire process of running the centre?

- Programme manager and/or clinic director;
  - Share their responsibility in reference to the ICTC/ PPTCT/ART/STI centre.
  - How do they supervise their staff?
  - What ICTC/PPTCT/ART/STI reports are they responsible for submitting? Who do they submit them to?
  - Share the most recent report submitted to SACS—do they try to interpret any of the data collected at their centre? What additional information do they get from this data? What do they do with the data here at a local level?
  - Share examples of initiatives they have undertaken using the data from the monitoring process.
  - What other monitoring data do they collect? For example do they have clients/ patients?
  - Fill in satisfaction surveys? Do they interview clients/patients to find out about their experience with your service?
  - How do they get monitoring feedback from their staff?

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

After the training is completed:

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

Annexure 2: Guidelines for doing role plays

Role plays can serve the important purpose of helping the participants practice skills in a safe environment, where no harm can be caused to a 'real' client, and the presence of the facilitator can provide an opportunity to hone one's skills. However, role plays may sometimes be seen as a way of practicing one's acting skills (!), which might lead to losing a lot of precious time and also take away from the primary purpose of the training. Thus, the organisers as well as facilitators need to guide role plays well.

The time limit for a role-play is 15-20 minutes. The facilitator should **hand over the cases only to the participants playing a client's role.** The 'counsellors' should not be permitted to read the cases. This is to make the role-play as real as possible, just as in the real scenario the counsellor does not know the case in advance. The facilitator needs to emphasise that **the focus is on what a 'counsellor' does** in the role play and **not on the 'client's' acting.** The group observers need to observe and **give feedback on the counselling process;** not on the individual people enacting the role.

Role-plays have the following advantages:

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

Some individuals may feel intimidated by role-playing. The facilitator must be skilful to ensure that they are relaxed and should:

- Tell the participants that we all are bound to make mistakes while learning counselling. It is **better to make mistakes here** rather than in real settings, because here no one is actually harmed, whereas in the real setting the client may get harmed by our mistakes.
- Keep the role-play appropriate to the learning context.
- Always **first give positive feedback** and then constructively suggest what could have been done additionally or differently.

Annexure 3: Guidelines on group discussions

Group discussions—large group discussions

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

- The participants are involved in problem-solving.
- The participants are active, which stimulates interest.
- The learning process becomes more personal, requiring the facilitator to provide feedback on individual opinions and ideas.
- The facilitator is able to evaluate the participants' understanding and absorption of material.
- The participants have an opportunity to share their acquired expertise and skills, and learn from each other.

Large group discussions require a skilful facilitator who:

- Asks questions or suggests topics, maintains objectivity and directs the discussion to keep it relevant to the learning objectives.
- Stresses confidentiality.
- Ensures that all group members have an equal opportunity to participate and that no one person (including the facilitator!) dominates the discussion.
- Perceives and responds to differences in the group, such as the skills level, education and comfort with the topic.
- Is aware of cultural and gender issues.
- Encourages participants to answer questions and share expertise.
- Is able to politely bring the discussion back to the point if the group begins to discuss issues beyond the session's scope.
- Is respectful and non-judgmental of the participants' ideas and opinions to allow expression of diverse concerns.
- Sticks to the time – starting on time, and leaving adequate periods for discussion.
- Obtains feedback and responses from the group to provide evaluation mechanisms for the session.
- Provides an appropriate balance of supportive and challenging facilitation in which to foster learning.

Group discussion—small group discussions

The advantages of small group discussions include the following:

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

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

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

It is important to provide clear guidelines for group discussions in advance. These can include:

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

PROGRAM SCHEDULE

Training Schedule for the 7-day Integrated Induction Training for HIV Counsellors

Session No.	Session Name	Duration	Time
Day 1			
	Introduction, Ice Breakers, Pre training evaluation	30 min	9:00-10:00
Session A	Orientation to the Training Programme	1 hr 30 min	10:00-11:30
	Tea		**11:30-11:45**
1	Basics of HIV/AIDS and HIV Diagnosis	1hr 45 min	11:45-1:30
	Lunch		**1:30-2:00**
2	National AIDS Control Programmme Updates	1 hr	2:00-3:00
	Tea		**3:00-3:15**
3	Counsellor's Self-Awareness, Attitudes, Values, and Ethics in HIV Counselling	3 hrs	3:15-6:15
	Discussion on case studies by groups for session 9 (Understanding Vulnerability of HRGs and BPs)		**Evening group activity**
Day 2			
	Recap	15 min	9:00-9:15
4	Social Drivers of the HIV Epidemic: Gender, Sex, Sexuality, Violence, Migration	4 hrs	9:15-1:15 **(with working tea)**
	Lunch		**1:15-1:45**
5	Understanding marginalisation, vulnerability, stigma and discrimination in the context of HIV/AIDS	2 hrs	1:45-3:45
	Tea		**3:45-4:00**
6	Understanding vulnerability and risks of High Risk Groups (Core groups and Bridge Population)	2 hrs 15 min	4:00-6:15
	Screening of movie 'Queen' or 'Astitva' or any other movie in the context of gender		**Evening movie time**
Day 3			
	Recap	15 min	9:00-9:15
7	Enhancing Counsellor Competence	3hrs 30 min	9:15-12:45 **(with working tea)**
	Lunch		**12:45-1:15**
8	Body Basics and Family Planning	1 hr	1:15-2:15
9	Basics of STI/RTIs	1 hr	2:15-3:15
	Tea		**3:15-3:30**
10	STI syndromic management counselling	2 hrs 30 min	3:30-6:00
	Screening of movie 'Aa Muskura'		**Evening movie time**

Session No.	Session Name	Duration	Time
Day 4			
	Recap	15 min	9:00-9:15
11	Basics of PPTCT and programme guidelines	2 hrs 45 min	9:15-12:00 **(with working tea)**
12	Basics of HIV-TB co-infection and Programmatic Linkages	2 hrs	12:00-2:00
	Lunch		**2:00-2:30**
	Field Visit to (co-located)ICTC, ART, STI centre and debriefing	4 hrs 15 min	2:30-6:15
Day 5			
	Recap	15 min	9:00-9:15
13	Pre test and Post test counseling	3 hrs 30 min	9:15-12:45 **(with working tea)**
	Lunch		**12:45-1:15**
14	Behaviour Change Communication and Condom Demonstration	2 hrs	1:15-3:15 **(with working tea)**
15	Managing Mental Health Issues in the context of HIV	3 hrs	3:15-6:15
	Practice assignment on Counselling with Sero discordant Couples.		
	Ask the participants to plan and prepare for the breakfast session to be conducted two days later.		**6:15-7:15/Evening**
Day 6			
	Recap	15 min	**9:00-9:15**
16	Counselling Children and Adolescents	2 hrs 30 min	9:15-11:45
17	Counselling Sero-discordant Couples	2 hrs	11:45-1:45
	Lunch		**1:45-2:15**
18	Basics of Antiretroviral Therapy	1 hr 30 min	2:15-3:45
	Tea		**3:45-4:00**
19	Counselling for ART adherence and treatment including paediatric ART	4 hrs	4:00-8:00

Session No.	Session Name	Duration	Time
Day 7			
	Breakfast and Activity 'Kaun Banega Sanjeev Kapoor'		**8:00-9:00**
	Recap	15 mins	**9:00-9:15**
20	Nutrition in the context of HIV/AIDS	1 hr	9:15-10:15 **(with working tea)**
21	Linkages for effective counselling	2 hrs 20 mins	10:15-12:25
	Lunch		**12:25-1:00**
22	Post Exposure Prophylaxis (PEP) and Universal Precautions #	1 hr	1:00-2:00
23	SIMS	4 hrs	2:00-6:00 **(with working tea)**
	Post training evaluation (Valedictory)	45 min	6:00-6: 45

#This session may be covered during the field visit if needed.

PRE- AND POST-TRAINING ASSESSMENT TOOL

Sample Tool & Answer keys

(Pre- & Post-Training Assessment)

Instructions: This tool consists of 4 sections. Please respond to all the questions/ items under each section. Please encircle your response clearly. You are not required to write your name anywhere on this tool but please do mention your ID number on top right hand corner of this page. Your responses will be kept confidential and used for program purposes only. **Each items of the tool should be attempted and no items should be unmarked.** [Time allowed: 30 min]

Total Marks = 50

SAMPLE ITEMS FOR REFERENCE ONLY.

Section A-I (Knowledge-Multiple choice items)

Instructions: Please read each statement and encircle the correct response.

[10 X 1 =10]

Sl No.	Statements	Response Options
1.	HIV positive pregnant women should preferably be initiated on ART/ARV Prophylaxis as early as:	(1) 6 weeks of gestation (2) 8 weeks of gestation (3) **14 weeks of gestation** (4) 20 weeks of gestation
2	The STI that is NOT curable is:	(1) Molluscum Contagiosum (2) Pelvic Inflammatory Diseases (3) **Hepatitis B** (4) Genital Scabies

Section A-II (Knowledge –True/False items)

Instructions: Please read each statement and encircle the correct response.

[10 X 1 =10]

Sl. No.	Statements	Response Options
1	Caesarean section increases the chances of HIV transmission from a mother to her baby.	True .....1 **False 2**
2	Female sterilization cannot protect a woman from HIV infection.	**True.....1** False.....2

Section A-III (Myths and misconceptions – True/False items)

Instructions: Please read each statement and encircle the correct response.

[5 X 1 =5]

Sl. No.	Statements	Response Options
1	HIV cannot transmit through mosquito bites.	**True .....1** False 2
2	HIV can be transmitted by hugging a person with HIV.	True .....1 **False 2**

Section B

Instructions: Please read each of the statements given below. Using a four-point rating scale, state to what extent you agree or disagree with each. If you agree on a particular statement then your code on the rating scale would be either '1' or '2'. '1' means you completely agree with the statement and '2' means you somewhat agree with the statement. On the other hand, if you disagree with a particular statement then your code on the rating scale would be either '3' or '4'. '4' means you completely disagree with the statement and '3' means you somewhat disagree with the statement. Please remember that there is no right or wrong answer to these statements. DO NOT LEAVE ANY STATEMENT UNMARKED.

[15 × 1=15]

Four-Point Rating Scale:

1= Completely agree 2=Somewhat agree 3=Somewhat disagree 4=Completely disagree

Sl No.	Statements	Four Point Rating Scale
1	HIV positive people have the right to marry.	**1** 2 3 4
2	Men who have sex with men should not be open about their sexual preference in society	1 2 3 **4**

Section-CI [Skill related knowledge]

Instructions: Please read each statement and encircle the correct response.

[10 X 1 =10]

Sl No.	Statements	Response Options
1	While listening to a client, a counselor should:	(1) Narrate his/her own experience (2) **Pay attention to client's perceptions** (3) Advice on good behaviour (4) Establish social relationship with the client
2	The appropriate referral for a patient, who has reported of severe weakness and chronic cough would be:	(1) **RNTCP** (2) Suraksha clinic (3) ART centre (4) Positive peoples network
3.	Identify and encircle the appropriate counselling techniques based on the dialogues given below. Counsellor: "In your situation, guilt feeling is normal. Many people, who face a similar situation, feel like you do."	(1) Reflecting (2) **Normalizing** (3) Paraphrasing (4) Summarizing

Thank you!

FACILITATOR GUIDE

SESSION A
Where are we and where we want to be? (Orientation to the training program)

Session Overview:

- Activity 1:Setting the mood for the session: (5 minutes)
- Activity 2:Triad interview to enable self assessment of counsellors: (30 minutes)
- Activity 3: Meri Manzil (My destination): (10 minutes)
- Activity 4: Manzil ka Raasta (Route to my destination): (15 minutes)
- Activity 5: Orientation to the training content: (15 minutes)
- Activity 6: Mind Mapping on perceived relevance of training (15 minutes)

Session Objectives:

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

- Do a self assessment of their existing knowledge and skills and its use in their current practice.
- List out their distinct roles and responsibilities as counsellors and the objective with which these roles and responsibilities are being performed.
- Develop a mind map of the relevance of this training in their service as a counsellor.
- To draw out the linkages between different topics being covered in the training.

Time allowed:

- 1 hour 30 minutes

Material required:

- Power point presentation
- White board markers, sheets, flip chart, chart paper

Method:

Preparation before the session:

- Keep the questions ready for Activity 4 (Manzil ka Raasta) and go through the power point presentation.
- Familiarise yourself with the available information about the profile of the participants well in advance.
- Read the roles and responsibilities of ICTC, STI and ART counsellors (Annexure I).
- Get yourself oriented to the training framework (Annexure II).
- Familiarise yourself with the strategy document of NACP-IV. (http://www.naco.gov.in/upload/NACP%20-%20IV/NACPIV StrategyDocument.pdf)

Activity 1: Setting the mood for the session: (Do not take more than 5 minutes for this)

Start the session by telling the participants that it is the first time that we are having all three types of counsellors (ICTC, ART and STI/RTI) in the same training programme. Tell them that the training team hopes that this would be a learning experience for each one of the participants as well as for the team implementing this training programme.

Ask two or three participants how they feel about this idea of a combined training. Once they have expressed themselves tell the participants that it would be a rich experience if they would work in tandem. Tell the participants that they are free to share their individualised experiences through the course of the training since this would help them gain clarity as well as prove to be a learning opportunity for others.

Activity 2: Triad interview to enable self assessment of counsellors: (30 minutes)

1. Tell the participants that we will do an exercise to know each other better. Ask participants to get into groups of threes. Now introduce the concept of **triad interview**. Inform them that in this activity in each group of three, one participant would play the role of an interviewer, one of an interviewee and the third one would play the role of a rapporteur (who would take down brief notes in points). The roles would be switched after the first 4-5 minutes so that each group member performs all three roles. This way each one in the group would take turns to become interviewer, interviewee and rapporteur.

Ideas to divide the participants in triads (Spend not more than 2 minutes in this):

(1) Ask the participants to quickly stand in order of their increasing height. The first three in the line would form the first triad and subsequently the next three the next triad till you have reached the end of the line.

(2) Play a number game. Ask the participants to come out to stand in an area free of furniture, or in an open space. Tell them that you will call out a number, and they have to quickly group themselves in the size of the called out number. E.g., if you call out 'five', the participants would get into groups of five. After calling out a few numbers, call out the number 'three' so that they get into triads.

Tell the participants that the following areas need to be covered in the interview.

a. Profile: Name, Age, Qualification, Professional experience

b. How do you see your role as different from other co-professionals?

c. How would you use your education and experience in the service as a counsellor?

d. What in your view is your biggest strength being in this profession?

e. Are there any clients or issues that you find easy to work with?

f. Do you find it difficult to work with any kind of clients/issues?

The interviewer needs to spend no more than **one minute per question**

NOTE FOR THE FACILITATOR

The facilitator can keep a list of these questions in the local language, and either, display them on the screen or give a copy to each participant to save time that might be spent on understanding the language.

2. Once the activity gets over, ask one member from each group to share the responses of all three members. After a couple of presentations, there is likely to be repetition of points. In case of repetition, ask the presenters to share only any additional points that they may have. Ask one participant to come up and keep jotting down the common points on the flipchart for future reference in training. Ensure that you do not spend more than **10 minutes** on the sharing.

3. Tell the participants that this activity serves several purposes:

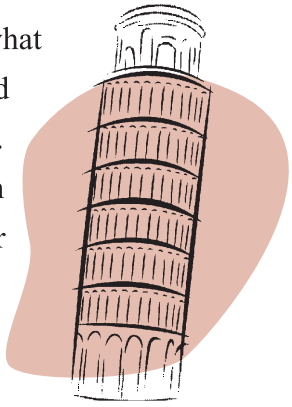
   Firstly, it has helped us recognise our distinctive or unique role as a counsellor in a multidisciplinary team.

   Secondly, it has helped us see how our current Knowledge, Attitudes, and Skills (KAS) are helping us in our work with clients.

   Thirdly, it has also helped us talk about our strengths and difficulties.

   This signifies where we stand today. Tell the participants that now if we also reflect on **where we want to be,** we would know exactly what we need to derive from this training. Inform them that this is what is going to be done in the next activity.

Activity 3: *Meri Manzil* (My destination) (10 minutes)



1. Tell the participants that we would begin this activity by talking about what we do as counsellors on a day-to-day basis, and tell them that you would want to know this separately from ICTC, ART and STI counsellors. Make three columns on the flip chart with ICTC, ART and STI written on top of one column each. Ask the ICTC counsellors to name any four or five tasks that they do on a regular basis, and jot down these roles in the ICTC column. Then similarly ask the ART counsellors to tell you the tasks that they handle on a day-to-day basis and jot them down in the ART column. Lastly ask the STI counsellors to tell you about the tasks that they handle and jot them also down in the respective column. Remember to be quick and not spend more than **5 to 7 minutes** on this task as this is just building up the momentum.

NOTE FOR THE FACILITATOR

The purpose behind this activity is to help counsellors see their work in the light of the larger national programme. The counsellors would be able to recognise the ultimate relevance of their intervention. This is likely to imbue them with a greater spirit and be able to look at the training programme as a step towards reaching their ultimate destination.

2. Now turn over the flip chart and ask the participants "What do you see as the purpose behind performing these roles?" The question could also be reworded as "What are we trying to ultimately achieve through these tasks; WHY are we doing these?" Give time to the participants to think and **ask one volunteer from the participants to jot down the responses on the flip chart.**

3. **After brainstorming for about 4-5 minutes, conclude the discussion by stating that our ultimate objective is two-fold:**

Important: Use the PPT slide to show the objectives to the participants.

Objective 1: Reducing new HIV infections

Objective 2: Comprehensive Care and Support to all persons living with HIV/AIDS and Treatment Services for all those who require it

Inform the participants that irrespective of whether they are working at ICTC, ART or STI setups, all of them have the same destination or goal, which is derived from NACP-IV. Tell them that they need to always look at the larger picture of what their work is ultimately achieving. Assure them that their contribution is extremely significant in achieving these objectives, like many drops make the ocean. Tell them that the next question that arises is about how to equip themselves to achieve these objectives.

Going through the Strategy Document of NACP – IV would enable the facilitator to explain these objectives further.

Activity 4: *Manzil ka Raasta* (Route to my destination): (15 minutes)

1. Picking up from the previous activity, tell the participants that we have now reached a point where we are clearer about our Manzil (goal / destination) but it is also equally vital to understand the Manzil ka Raasta (route to the destination). Tell the participants that through this activity they would become acquainted with the pathway to their destination. Tell them that certain knowledge and skills are required to achieve the destination. To provide the participants a glimpse of the knowledge and skills required, tell them that they would be asked certain questions. Assure the participants that it is absolutely fine even if they do not know the answers or have only partial answers to these questions at this point of time.

IMPORTANT NOTE FOR THE FACILITATOR:

The idea behind asking questions is to **create among participants a curiosity or a need to learn, rather than** to provide correct answers at this stage.

Important:
Please use the PPT while asking the questions

Question 1

Why are women more vulnerable to HIV infection?

After a couple of participants have shared the answer, ask all the participants to note down the question and their answer and wait for the session on "Social Drivers of the HIV epidemic: Gender, Sex, Sexuality, Violence, Migration" where they would be able to get the answer to this question.

Question 2

What steps should be taken to prevent the transmission of infection from an HIV positive mother to her child?

Like with question 1, after receiving 1-2 responses, ask everyone to keep in mind / write the question and their answer, and try to check it with what they learn in the session on "Basics of PPTCT and Programme Guidelines".

Question 3

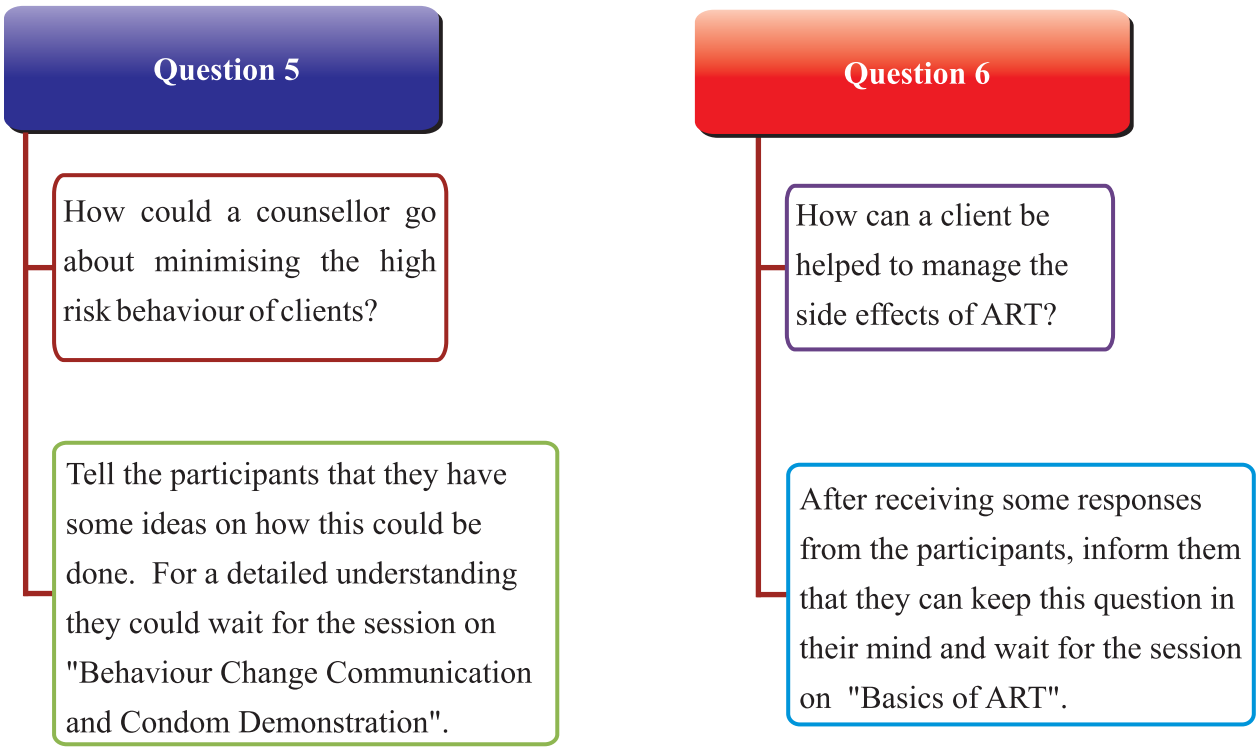
What all steps should be taken by the counsellor for the management of STIs?

Provide a chance to a couple of participants to answer the question and then inform them that they should now wait for the session on "STI Syndromic Management counselling".

Question 4

What can a counsellor do if a client has lost hope for living and is feeling suicidal?

After receiving some responses from the participants, inform them that they can keep this question in their mind and wait for the session on "Managing Mental Health Issues in the Context of HIV".



2. Ask the participants how they feel at this point of time. **Tell the participants that the idea behind asking the questions was to provide them a glimpse of what they would be learning through the training programme.** Assure them that learning is a never ending process and the more one learns the greater is the sense of satisfaction/enrichment that one feels.

Activity 5: Orientation to the Training Content (15 minutes)

1. Tell the participants that sessions during the training could be divided into three categories:

   ❖ One set of sessions tries to sensitise the participants regarding the **social factors (e.g., gender) which influence the HIV epidemic.** The sessions that fall within this category are:

   - Social Drivers of the HIV Epidemic: Gender, Sex, Sexuality, Violence, Migration.
   - Understanding Marginalisation, Vulnerability, Stigma and Discrimination in the context of HIV/AIDS.
   - Understanding Vulnerability and Risks of High Risk Groups (Core Groups and Bridge Population).

   ❖ Another set of sessions provide participants with **knowledge** that would increase their own understanding and which could be used with the clients to increase their understanding as well. The sessions that fall within this category are:

- Basics of HIV/AIDS and HIV Diagnosis.
- National AIDS Control Programme updates.
- Body Basics and Family Planning.
- Basics of STI/RTI.
- Basics of HIV-TB co-infection and Programmatic Linkages.
- Basics of Antiretroviral Therapy.
- Basics of PPTCT and Programme Guidelines.
- Nutrition in the context of HIV/AIDS.
- Post Exposure Prophylaxis (PEP) and Universal Safety Precautions.
- SIMS.

❖ The third set of sessions is aimed at enhancing the participant's **skills** to work with clients. The sessions that fall within this category are:

- Counsellor's Self-Awareness, Attitudes, Values, and Ethics in HIV Counselling.
- Enhancing Counsellor Competence.
- Pre test and Post test Counselling.
- Managing Mental Health Issues in the Context of HIV.
- Behaviour Change Communication and Condom Demonstration.
- Counselling for ART Adherence and Treatment including Paediatric ART.
- STI Syndromic Management Counselling.
- Counselling Children and Adolescents.
- Counselling Sero-discordant couples.
- Linkages for Effective Counselling.

2. Conclude this activity by informing participants about how the different sessions complement each other. Inform them that they would have to use the inputs received from the training in an integrated manner. Assure them that if they consciously practice this, the integration would start happening naturally.

As a facilitator, give some examples of how the sessions are interlinked with each other. For instance, what the participants have learnt in the session on counselling micro skills would be used during pre-test and post-test counselling.

Similarly, while working with children, adolescents, couples, high risk groups; the same basic skills of counselling would be required. Tell the participants that the understanding from the session on social drivers of the epidemic would also have to be kept in mind while doing any counselling.

Activity 6: Mind Mapping to understand what counsellors believe they would be deriving from the training and using in their work (15 minutes)

1. Finally tell the participants that now they have an idea of what all would be covered in the training programme. There is also clarity about what our destination is.

   The facilitator may say, "Thus, at this juncture it would be valuable to understand from you, what you see as the relevance of the training content to your area of work." Inform the participants that this process of understanding relevance would also be carried out in each of the sessions individually. But this activity is being carried out to get an initial view on how they feel they would be using this training.

2. Divide the participants into groups as per their area of work, which means all ICTC at one place likewise STI and ART.
3. Give five minutes to each of the groups to think about what they think they will be taking back with them from the training. Ensure that every group has a final copy of the curriculum.
4. Tell the participants that as each of the groups would be sharing their points, you as a facilitator would be drawing a mind map which would remain with them till the end of the training.
5. You may begin with any group of counsellors and complete the mind map. Take about three to four minutes to draw the mind map for each of the groups. An example of how the mind map could be made is given below:

NOTE FOR THE FACILITATOR

Relevance for this activity: This activity would help the resource person solidify and ensure the continued interest of the participants. By having feedback about what participants find relevant in the training and thereby developing the mind map ascertains that participants have understood the relevance of the training in their respective area of services. The map created here would serve as easy reference for all the resource persons to understand what participants find relevant in the training. Apart from this, it would also be a set of relevant points for participants to look for in different sessions to come in the training.

The facilitator would finally ask the participants if they want any other area/s to be a part of the training programme. If they come up with any suggestion in consensus then the team may take some time out to address that need. Or it may be kept in the parking lot and addressed during leisure time of the training.

References:

Department of AIDS Control, Ministry of Health and Family Welfare, Government of India. National AIDS Control Programme Phase-IV (2012-2017): Strategy Document.

NACO. (2012). National Guidelines for Prevention of Parent-to-Child Transmission (PPTCT) of HIV. Retrieved July 27, 2014, from

http://www.naco.gov.in/upload/Publication/Basic%20Services/National%20Guidelines%20for%20PPTCT_01_05_2013.pdf

NACO. (2012, July). Operational Guidelines for ART Services. Retrieved July 27, 2014, from

http://www.naco.gov.in/upload/Publication/Treatment%20Care%20and%20support/Operational%20guidelines%20for%20ART%20services.pdf

NACO. (2007, October). Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI Services. Retrieved July 27, 2014, from *http://naco.gov.in/upload/Policies%20&%20Guidelines/21,%20Operational%20Guidelines%20STI%20RTI.pdf*

NACO. (2007, July). Operational Guidelines of Integrated Counselling and Testing Centres. Retrieved July 27, 2014, from *http://naco.gov.in/upload/Policies%20&%20Guidelines/20,%20Operational%20Guidelines%20for%20Integrated%20Counseling%20and%20Testing%20Centres.pdf*

NACO. (2012). Refresher Training Programme for Counsellors in STI/RTI Services: Trainer's Guide. Retrieved August 7, 2014, from *http://www.naco.gov.in/upload/Publication/STI%20RTI%20services/STI%20Training%20material/STI%20Counsellor%20Refresher%20Training%20Trainer%27s%20Guide.pdf*

NACO. (2011, April). Refresher Training Programme for ICTC Counsellors (Second Edition): Trainee Handouts. Retrieved August 7, 2014, from *http://www.naco.gov.in/upload/Publication/Basic%20Services/ICTC%20REFRESHER%20II%20MODULE_2011/ICTC%20Refresher%20II%20Trainee%20Handout.pdf*

ANNEXURE

Annexure I: Roles and Responsibilities of STI/RTI Counsellors

Information-Provision

Provide information about STI, HIV/ AIDS, Opportunistic infections, healthy lifestyles and explore any myths and misconceptions and clarify the same.

Risk Assessment and Risk Reduction

Assist clients to correctly assess their risk for STI and HIV, motivate and help them to make plans for reducing their risk, and help/enable/empower the client through the process of adaptation of healthy behaviours and coping with the same.

Treatment-Related Services

Act as an interface between client and provider, organise the treatment schedule, follow up, compliance to treatment, condom usage, partner management, and syphilis screening and other lab tests for STI/RTI.

Services to HRG Members

Ensure that every HRG receives the essential STI/RTI service package including early diagnosis and treatment of current STI episode, quarterly regular check-up, presumptive treatment of sex workers and biannual syphilis screening by closely working with respective TI NGO and through outreach

HIV and Other Referrals

Explain and encourage HIV testing, establish referral services to other centres and network for expanded STI and HIV Care and Support - General Laboratory, ICTC, PPTCT,ART, CCC, and TB HIV.

Patient-wise Documentation

Ensure documentation of history taking, counselling and risk reduction plans and filling up and maintaining patient-wise cards and clinic register.

Monthly Documentation

Collect, compile reports on computer from both Gynaec and STI OPDs and prepare and submit timely monthly CMIS formats in consultation with Medical Officer-in-charge.

Monitoring Supplies

Closely monitor the drug kit and condom consumption, and place appropriate indent in consultation with Medical Officer-in-charge and other designated staff, if available.

Supervisory Visits

Facilitate visits of the clinic by supervisory teams.

Roles and Responsibilities of ART Counsellors

Before we understand the roles and responsibilities of ART counsellors it would be useful to understand the major objectives and functions of ART Centres as the roles and responsibilities of ART counsellors are based on these objectives:

Objectives of ART Centre:

- Identify eligible persons with HIV requiring ART through laboratory services (HIV testing, CD4 Count and other required investigations).
- Provide free ARV drugs to eligible persons with HIV continuously.
- Provide counselling services before and during treatment for ensuring drug adherence.
- Educate persons and escorts on nutritional requirements, hygiene and measures to prevent transmission of infection.
- Refer patients requiring specialised services or admission.
- Provide comprehensive package of services including condoms and prevention education.

Functions of ART Centre:

Functions of ART centre can be categorised as medical, psychological and social as indicated below

Medical Functions

- To diagnose and treat Opportunistic Infections.
- To screen PLHIV for eligibility to initiate ART.
- To monitor patients on ART and manage side effects, if any.
- To provide in-patient care as and when required in linkage with other hospital departments.
- To facilitate linkages between other service providers.
- To facilitate easy access to specialist's care as necessary.

Psychological Functions

- To provide psychological support to PLHIV accessing the ART centre.
- To provide counselling for adherence to ARV drugs.
- To educate PLHIV on proper nutrition.
- To advise for risk reduction behaviour including usage of condoms.
- To provide problem solving and other counselling services.

Social Functions

- To facilitate PLHIV to access available resources provided by government and NGO agencies.
- To facilitate linkages between other service providers and patients, like educational help for the children and Income generation programmes.

Role of the ART Counsellor:

Key Functions: The ART counsellor is the key person responsible for providing overall psychosocial counselling support to PLHIV including children and their families who frequent the CSCs. The counsellor will work closely with ORWs and Peer Counsellor and equip them with skills on developing support groups, providing counselling support on selected thematic areas.

Specific roles and responsibilities of the Counsellor:

- Provision of advance level counselling on selected themes to PLHIV beneficiaries and their families. Understand the sub-group-specific special needs in counselling (e.g., PLHIV from HRGs, CLHIV) and provide advanced psychosocial and family counselling on emotional and spiritual well-being of PLHIV.
- Provide treatment, education and adherence counselling at the CSC with PLHIV clients/caregivers who visit CSC.
- Counselling on positive prevention, including discordant couple counselling.
- Counselling on reproductive health and child bearing.
- Drug/alcohol and substance abuse counselling.
- Give basic information on legal rights and if required refer them to District Legal Service Authority (DALSA).
- Nutrition/dietary counselling and conduct nutrition assessment.
- Information sharing (related to the HIV disease and quality of life).
- Counselling of children and adolescents infected and affected by HIV by assisting in varied activities such as life skills training, talent promotion, recreational activities, child protection issues, formation of children support groups, youth clubs, sports activities, and family support groups.
- Ensure that PLHIV, wherever necessary, are linked to other services/service providers both within the CSC and outside (as part of linkages established by the CSC), and linkage with social entitlements is facilitated.
- Facilitating the process of capacity building of peer counsellors.
- Help the ORW/peer counsellor in organising and facilitating Support Group Meetings (SGM).
- Assist/develop the communication activities of CSC.
- Assist with the development of content/strategy for sensitisation meetings with different stakeholders as part of the advocacy initiatives.
- Undertake field visits along with peer counsellor and ORW to meet with members of PLHIV community and their families.
- Ensure compliance with the ethical norms in counselling as established in line with the NACP guidelines.

Roles and Responsibilities of ICTC Counsellors

The ICTC counsellor is the bedrock of the HIV control programme and therefore the most important functionary in an ICTC. The counsellor reports to the ICTC manager/in-charge. Following are some broad roles and responsibilities of ICTC counsellors:

Preventive and health education

- Ensure that each client is provided pre-test information/counselling, post-test counselling and follow-up counselling in a friendly atmosphere.
- Ensure that strict confidentiality is maintained.
- Ensure that all IEC materials such as posters are displayed prominently in the ICTC.
- Ensure that communication aids in the form of flip books and condom demonstration models and fliers are available in the ICTC.

Psycho-social support

- Provide psycho-social support to help HIV-positive clients cope with HIV and its consequences.
- Ensure that the extended family of the HIV-positive client is sensitised on how to deal with HIV-positive members of the family.
- Conduct weekly visits after obtaining consent, to the homes of HIV-positive clients facing severe crisis.

Referrals and linkages

- Maintain effective coordination with the RCH and TB programmes as well as with the antiretroviral therapy (ART) programme, and visit key persons in the facilities run by these programmes once in a fortnight so as to strengthen linkages and minimise loss of clients during referrals.

Supply and logistics

- Report to the ICTC manager on the adequacy of stocks of condoms and prophylactic nevirapine tablets and syrup available in the ICTC as well as in the facility.

Monitoring

- Maintain counselling records and registers, and prepare monthly reports which are to be sent to the SACS.
- Facilitate the establishment of linkages and referrals to the ICTC from within and outside health-care settings.

Annexure II :

Training Schedule

Sl. No.	Name of the session	Duration
Session A	Orientation to the Training Programme	1 ½ hrs
1	Basics of HIV/AIDS and HIV Diagnosis	1 hr 45 min
2	National AIDS Control Program updates	1hr
3	Counsellor's Self-Awareness, Attitudes, Values, and Ethics in HIV Counselling	3 hrs
4	Social Drivers of the HIV Epidemic: Gender, Sex, Sexuality, Violence and Migration	4 hrs
5	Understanding Marginalisation, Vulnerability, Stigma and Discrimination in context of HIV/AIDS	2 hrs
6	Understanding Vulnerability and Risks of High Risk Groups (Core Groups and Bridge Population)	2 hrs 15 min
7	Enhancing Counsellor Competence	3 ½ hrs
8	Body Basics and Family Planning	1 hr
9	Basics of STI/RTI	1 hr
10	STI Syndromic Management Counselling	2 ½ hrs
11	Basics of PPTCT and Programme Guidelines	2 hrs 45 min
12	Basics of HIV-TB co-infection and Programmatic Linkages	2 hrs
13	Pre test and Post test Counselling	3 ½ hrs
14	Behaviour Change Communication and Condom Demonstration	2 hrs
15	Managing Mental Health Issues in the Context of HIV	3 hrs
16	Counselling Children and Adolescents	2 ½ hrs
17	Counselling Sero-discordant Couples	2 hrs
18	Basics of Antiretroviral Therapy	1 ½ hrs
19	Counselling for ART Adherence and Treatment including Paediatric ART	4 hrs

20	Nutrition in the context of HIV/AIDS	1 hr (session) + 1 hr (breakfast)
21	Linkages for Effective Counselling	2 hrs 20 min
22	Post Exposure Prophylaxis (PEP) and Universal Safety Precautions	1 hr
23	SIMS	4 hrs

*An additional two hours would be allocated for the screening of the film **Aa Muskura** on the evening of the 2nd or 3rd day of the training.

An additional two and a half hours would be allocated for the screening of the film **Queen** on the evening of the 3rd or 4th day of the training.

SESSION 1
Basics of HIV/AIDS and HIV Diagnosis

Session Overview:

- Reading the PPTs – 1 hour 30 minutes
  - What is HIV/AIDS?
  - HIV/AIDS care and treatment.
  - Laboratory diagnosis of HIV infection.
  - Situations when HIV antibody assays cannot be used to diagnose HIV infection.
  - Counselling issues related to HIV antibody result provision.
  - Assays for staging HIV disease and monitoring the efficacy of ART.
  - Ensuring the quality of HIV testing in ICTC services.
- Discussion – 15 minutes

Session Objectives:

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

- Demonstrate improved knowledge of the natural history of HIV/AIDS.
- Understand the HIV/AIDS scenario in India.
- Appreciate the role of ICTC, DSRC, and ART.
- Discuss the current and proposed scaling-up of HIV/AIDS care including antiretroviral therapy (ART).
- Understand misconceptions about HIV and other associated diseases.

Time allowed:

- 1 hour 45 minutes

Material required:

- PPT slides and LCD Projector
- Pen / Paper
- Activity sheet
- Question box

Method:

Preparation before the session:

You as the facilitator:

Keep a box (like an empty shoe box) with a slit on top, in which the participants can put their chits of questions as and when they arise and especially if they feel hesitant to ask the facilitator directly.

In the session:

- Read and explain the PPTs to the participants.
- During the presentation, ask questions to keep participants actively involved in the presentation, e.g. before showing patterns of infection among vulnerable subgroups, ask the participants which groups they think are the most vulnerable to HIV infection.
- Summarise the key points of the session.
- Ask the group if they have any questions and remind them of the question box.
- Mail a copy of the handout on 'Basics of HIV/AIDS and HIV Diagnosis' to the participants one week prior to the training programme.
- Keep copies of handouts ready in-case the participants need to refer it again.

Activity 1: (Slide 4)

The HIV transmission game

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

Methodology: Role-play

Time allotted: 20 minutes

- Prepare folded slips of paper, one for each participant and one for yourself—25% marked with a '+' (plus) sign, 75% with a '–' (a minus) sign. Keep one for yourself too, making sure it has a '+' sign on it.
- Ask each participant to take a slip of paper from a box or a hat. Emphasise that no one should look at his/her slip of paper until the end of the exercise.
- Ask the participants to move freely about the room, stopping to greet participants by shaking their hand. Do this yourself as well.
- After each person has greeted 4 or 5 participants, stop the activity and ask everyone to look at their slips of paper.

- Ask all those who have a '+' (plus) sign on their paper to come forward. Explain that these people are playing HIV positive individuals. Reinforce the point that there is no risk of catching HIV through normal social greeting—this is a game to show how fast HIV can spread.
- Then ask all participants who greeted anyone with a '+' (plus) sign on their slip of paper to come forward to join their friends. Explain that this game is pretending that these people are playing individuals at high risk of being infected with the HIV virus.
- Next, address the remaining participants. Explain that the status of these people is unknown. They may be friendly with HIV-infected individuals before they had acquired the infection; but in any case, they are at risk.
- Finally, ask the following questions, according to this game:
  - How many people were originally infected with the HIV virus?
  - How many are at high risk of being infected?
  - How many others are at risk of being infected?
  - How many remain uninfected?
  - What does this activity tell us about the spread of HIV in the community?

Key messages:

- HIV is the acronym for Human Immunodeficiency Virus. A person infected with HIV is medically known as an HIV-positive person.
- AIDS stands for Acquired Immune Deficiency Syndrome. AIDS is the advanced stage of HIV infection. It is a disabling and incurable condition caused by HIV.
- HIV-infected people may remain asymptomatic for as long as 10 or more years. It may take a person anywhere from 6 months to 10 years after getting HIV infection to develop AIDS, and thus the person may not show any signs or symptoms of the infection. On an average, 50% of the HIV-infected take about 8 years to progress to AIDS. People in this phase can play an important role in the spread of HIV as they remain infectious but can be identified only by a blood test.
- A person infected with HIV has AIDS only if and when:
  - Their immune system is totally destroyed.
  - They suffer from many opportunistic infections.
- The three most commonly reported OIs in the South-East Asia Region are TB, Pneumocystis carinii pneumonia and extra pulmonary cryptococcosis (usually meningitis). The prevention and treatment of OIs delays the progression of HIV infection.
- HIV infection is diagnosed largely by the detection of antibodies against HIV in the blood of infected patients.
- There are three main types of HIV antibody tests:
  - ELISA.
  - Western blot assay.
  - Rapid HIV tests.
- The testing for HIV needs to follow the mandate given below:
  - **Voluntary testing**—the client must give informed consent for the HIV test to be performed after pre-test counselling and in the absence of coercion.
  - **Confidentiality** —is maintained by three general methods:
    - Linked testing.
    - Linked, anonymous testing.
    - Unlinked, anonymous testing.
- **ART is**
  - Life-long.
  - Not to be given with single or dual drug but with a combination of three or more drugs due to the rapid emergence of drug resistance.
- **Counsellor's role and ART:**
  - Assess readiness for ART.
  - Treatment literacy.
  - Adherence.

SESSION 2
National AIDS Control Programme updates

Session Overview:

- Reading the PPTs – 1 hour
  - The global, regional and national HIV/AIDS epidemic.
  - Prevalence and incidence of the epidemic.
  - Concentrated v/s generalised epidemic.
  - Categorisation of states and districts according to HIV prevalence.
  - Goals, objectives and focus areas of NACP IV.

Session Objectives:

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

- Understand the global and national HIV/AIDS epidemic.
- Review the list of categorisation of states and districts based on HIV prevalence.
- Describe goals, objectives and focus areas of NACP IV.

Session covers the following points:

- Unpacking **global, regional and national** HIV/AIDS epidemic scenario.
- Meaning of a **concentrated v/s generalised** epidemic.
- Epidemiology of HIV.
- HIV positivity amongst **HRG**.
- **Categorisation** of states and districts based on the HIV prevalence.
- **NACP-IV-**goals, objectives and focus areas.
- Functions of the NACO.
- Principles of **'getting to zero'**.

Time allowed:

- 1 hour

Material required:

- PPT slides and LCD Projector
- Pen / Paper
- Activity sheet
- Question box

Method:

Preparation before the session:

You as the facilitator:

Keep a box (like an empty shoe box) with a slit on top, in which the participants can put their chits of questions as and when they arise and especially if they feel hesitant to ask the facilitator directly.

In the session:

- Read and explain the PPTs to the participants.
- During the presentation, ask questions to keep participants actively involved in the presentation, e.g. before showing patterns of infection among vulnerable subgroups, ask the participants which groups they think are the most vulnerable to HIV infection.
- Summarise the key points of the session.
- Ask the group if they have any questions and remind them of the question box.
- Mail a copy of the handout on 'National AIDS Control Programme updates' to the participants one week prior to the training programme.
- Keep copies of handouts ready in-case the participants need to refer it again.

SESSION 3

Counsellor's Self-Awareness, Attitudes, Values, and Ethics in HIV Counselling

Session Overview:

- Activity 1: Rapid Fire Round (10 minutes)
- Session 1: Introduction (4-5 minutes)
- Activity 2: How to be (or not be!) an Effective Counsellor (30 minutes)
- Session 2: Effective and Ethical Counselling (PPT Presentation) (20 minutes)
- Activity 3: Manure and Pests (20 minutes)
- Session 3: Counsellor's Attitudes, Values and Beliefs (PPT Presentation) (25 minutes)
- Activity 4: Inside out (case discussions) (60 minutes)
- Summarisation: (10 minutes)

Session Objectives:

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

- Become aware of one's values, attitudes and beliefs.
- Understand the components of effective counselling.
- Learn counselling ethics and apply the same in HIV counselling.
- Understand the significance of counsellor's self awareness, values, attitudes and beliefs in HIV counselling.
- Become aware of one's strengths and challenges.
- Prevent personal biases to influence HIV counselling.

Time allowed:

- 3 hours

Material required:

- PPT slides
- LCD projector
- Copies of Handouts
- Translated print outs of Activity Annexure
- White board / Chart papers
- White board markers / Permanent markers

Method:

Preparation before the session:

You as the facilitator:

- Translate the questions in Annexure 1 in your local language for Activity 1.
- Print out the figure and questions given in Annexure 1 and photocopy the same as per the number of participants for Activity 1.
- Translate the statements in Annexure 2 in your local language for Activity 3.
- Print out the statements given in Annexure 2 and photocopy the same as per the number of participants for Activity 3.
- Translate the cases given in Annexure 3 for Activity 5.

Activity 1: Rapid Fire Round (10 minutes)

Tips to the facilitator:

- Please translate the statements in **Annexure 1** in the local language and provide the same to the participants on a sheet of paper.
- **You may give the following instructions to the participants:**

  "I will read out and present some statements. The same statements are there in the handout given to you. Please keep the handout and a pen ready. Listen to the statement that I read, and respond to each statement in your handout with **'Agree' or 'Disagree'**. Please respond very quickly with the first response that comes to your mind. If you are in doubt while responding to any statement, please select one of the two options that you feel relatively closer to. **You do not have to share your answers with anyone, thus please be honest** to yourself while responding, without worrying about what the 'right' or 'wrong' answer is. So, here we go with the activity, 'Rapid Fire Round'."
- After the instructions, read aloud from the PPT slides each statement clearly. Pause for a second or 2 after each statement, while the participants respond in their respective handouts. Proceed to the next statement quickly, and continue with all the 15 statements.
- **Do not discuss any of the statements or participants' responses** as being 'right' or 'wrong'. At the end of the statements, inform the participants that the remaining session and a few other sessions would clarify the issues that may have come up in this activity. Thus **avoid any discussions** to stick to the time as well as to prevent any participants feeling defensive. In case any participant has further questions after the entire session, do address them in a break.

Session 1: Introduction (4 - 5 minutes)

Read out the session objectives and introduce the session to the participants saying that every profession requires different tools in addition to knowledge and skills of the profession. E.g., a doctor needs tools like stethoscope / thermometer; a carpenter needs a saw / hammer and so on. Ask the participants what tools does a counsellor need? What is it that a counsellor brings to the counselling process that cannot be done through books / computer/ internet or IEC material alone? Give a moment to the participants to think. If the participants answer with things like 'condoms', 'penis model', and so on; appreciate their replies, and say that there is more that a counsellor uses. The most important tool that a counsellor has is one's own **'self'**. To be an effective counsellor requires us to be aware of different aspects of our self. The exercise done in activity 1 was to help counsellors become aware of their different beliefs, attitudes and values.

Key points to emphasise:

- The client feels heard, understood, cared for and guided by an effective counsellor, which is because the **self** of the counsellor can connect with a client,
- The counsellor also uses one's **self** to inspire the client to lead healthier lifestyles and feel more self assured and hopeful, which is much more than any source of merely giving information can do.
- The counsellor **needs to be aware** of different aspects of one's **self**.

Activity 2: How to be (or not be!) an effective counsellor: (30 minutes)

Divide the participants into 2 groups.

- Please try to remember a difficult time in your life when you felt very sad, helpless, ashamed or guilty.
- Have you ever talked to someone (e.g., friend, relative, mentor or counsellor) about it?
- Sometimes talking to someone makes us feel better, but it can also make us feel worse!

Ask Group 1:

- What qualities in that person helped you feel better, take wiser decisions and make healthier choices?
- Please list the qualities of such a person or what the person did to help you.
- You do not have to describe the 'event' that made you feel bad.

Ask Group 2:

- ***What qualities in that person made you feel worse, lose hope, feel ashamed / guilty/ demoralised/ angry, or make unhealthier choices?***
- ***Please list the qualities of such a person or what the person did that made you feel worse.***
- ***You do not have to describe the 'event' that made you feel bad.***

Tips to the facilitator:

- Explain the activity and split the groups in the first 3-4 minutes.
- Each group is given 10-12 minutes for discussion.
- From group 1's discussion will emerge the qualities of an ethical and effective counsellor, and from group 2's – that of unethical / ineffective counsellor.
- Group 1 can present soon after their group discussion, and Group 2 can present when the slide on 'Features of Ineffective Counselling' is shown.
- Both the groups to present their points for 5-6 minutes (white board or flip chart).
- Do not get into elaborate discussions on the group 1's presentation because the following session shall cover these points.

Session 2: Effective and Ethical Counselling (PPT presentation) (20 minutes)

Read the PPT slides in an interactive manner and relate it to the group presentations of Activity 2.

Tips to the facilitator:

- Make sure to complete activity 2 and session 2 in a total of 50 minutes.
- In case of shortage of time, the points which are already covered during the group presentations may be skipped from the PPT or only briefly mentioned.

Activity 3: Manure and Pests: (20 minutes)

Ask all the participants to stand up. Tell them to imagine being a very healthy tree that is merrily swinging with the breeze. Ask each participant to act like a healthy and happy tree. Give a moment for this.

Now ask everyone to imagine being an unhealthy tree, the one that has hardly any leaves, and no fruits, and is merely existing but not at all happy. Ask everyone to act like that tree.

Now say that, we all know that there are various factors (like manure, sunlight, water) that help a tree grow healthy and bear fruit. There are also some factors (like pests, storms, soil erosion) that hinder the growth of a tree or damage it. Similarly, there are different factors that help human beings grow personally and professionally, and factors that hinder our growth.

What are such helpful and harmful factors – internal and external – for your growth? Please enlist these factors on the left and right side of the tree diagram provided to you. Your individual responses will remain with you and do not have to be shared with anyone.

Tip to the facilitator:

Please translate the questions given in **Annexure 2** in the local language and provide the same to the participants along with the tree diagram.

➢ Being aware of one's own strengths and weaknesses helps one become a more effective counsellor.

Session 3: Counsellor's Attitudes, Values and Beliefs (25 minutes)

- While our behaviour is visible; our attitudes, values and beliefs are not directly visible to others.
- As part of our personal growth, we need to make constant efforts to become aware of our attitudes, values and beliefs.
- This is because our attitudes, values and beliefs:
  - influence our appraisal of and responses to events / situations / persons / objects
  - determine the way we feel
  - guide our day-to-day behaviour
  - are enduring, yet amenable to change

Key points to emphasise at the end of Session 3:

- The counsellor needs to be aware of one's own values, morals, attitudes and prejudices as you did in the rapid fire round.
- Counselling in the field of HIV involves dealing with highly sensitive and personal issues like sexuality and gender. This requires a counsellor to be aware of one's own beliefs, values and feelings around sexuality and gender to be able to understand a client better.
- A counsellor needs to have a greater cognitive flexibility and is required to understand how their personal belief system might influence the counselling process. For example, a counsellor coming from a strong religious background where his/her religion prohibits consumption of liquor, might find it difficult to respect a client with alcohol addiction, and thus, feel unable to empathise with and remain nonjudgmental with the client. The counsellor needs to be aware of one's own biases so as to control one's emotions while counselling.

Activity 4: Inside out (45 minutes)

Tips to the facilitator:

- Tell the participants that now we shall discuss 3 cases.
- Divide the participants into 3 groups and hand over to each group one translated case and questions for discussion as in **Annexure 3**.
- Points for discussion are to be shared only after the group work and presentations are over and not to be photocopied.
- Allow the participants to discuss their respective cases within their group for 15 minutes.
- Groups may then present for 5 minutes each.
- After the first group presents share the points for discussion of the first case.
- Follow the same procedure with the second and third group.
- **In case of shortage of time divide the participants into 2 groups instead of 3 and give cases 1 and 2.**

CASE 1: Ethical Dilemma

Points for discussion of Case 1 (Not to be photocopied):

The counsellor needs to delicately balance the information about HIV with handling the client's emotions about being positive and about her anxieties regarding her planned marriage. In the counsellor's dilemma between the ethics of confidentiality and of doing no harm (to the partner), the ethic of confidentiality needs to be first upheld as far as possible, and partner disclosure needs to be done only in collaboration with the client.

About Amrita's insistence about repeating the test, the counsellor needs to understand that she is saying this only due to her anxiety and not to distrust or inconvenience the counsellor. The counsellor can gently guide her about getting the test once again. In case she still asks for repeating the test after that, the counsellor can politely and sensitively inform her that repeating the test may not really change anything and that she can still lead a healthy and long life through ART and a healthy lifestyle.

The client needs to also be informed and guided about the partner's HIV testing. This needs to be done only when is less anxious, so that the given information can be registered and processed by her.

The counsellor need not inform her parents about the test results because the client is an adult and is financially independent. They can instead be calmed down. Amrita can be asked about how she feels about disclosing the status to the parents. She needs to be supported about the pros and cons of disclosure

to them and about how and when to disclose her status to them if she decides to. This can be done over a few sessions.

CASE 2: Self awareness and ethics

Points for discussion of Case 2 (not to be photocopied):

The counsellor is also a member of the society, and might imbibe some of the societal attitudes, beliefs and values. The counsellor here probably has beliefs like: a 'good-looking' person is more likely to get sexually abused; a male child who gets sexually abused by a male is more likely to become homosexual; it is okay if one has sex with a same sex partner because one has no choice, but if one is willingly having sex with same sex partners, then it is not okay; someone who gets HIV is either a 'sinner' (e.g., homosexual, FSW) or a 'saint' (e.g., a young woman unaware of the ways of the world, a monogamous woman). Our beliefs are evident through the language we use with the others, as that is likely to be the language in which we think.

While dealing with a client who is into same sex relations, the counsellors need to do the same things that they would do with a heterosexual client. There is no such thing as 'homosexual counselling' or 'bisexual counselling'. The counsellor also needs to express complete acceptance of the client verbally as well as nonverbally, irrespective of the client's sexual orientation.

If the client says that they are being punished for their deeds (e.g., through getting HIV), it indicated the client's belief that they deserve to suffer through HIV. This kind of a belief can lower the client's hope and might affect adherence to treatment and increase high risk behaviour. The counsellor needs to help the client ventilate their feelings; provide support and validation; and instil hope.

CASE 3: Awareness of our attitudes

Points for discussion for Case 3 (Not to be photocopied):

In childhood you might have played with coloured glasses, which when worn, make everything in the world seem to be of the colour of the glasses. Many of our attitudes, beliefs and values colour our perceptions in a similar way. We like or dislike people, find it easier or difficult to empathise or even believe people on the basis on many of our own attitudes, beliefs or values. For example, if we believe women are weaker than men, we would not trust a client to be able to accept her HIV positive report just because she is a woman. If we believe all men are abusive to wives, or sex workers are shrewd, or Christians are kind, or Muslims are aggressive and so on, we would tend to perceive the reality through this lens, rather than seeing it objectively. There can be many other such examples. This can affect our ability to empathise with clients or look at the world through their perspective.

Sometimes we also assume others are like us. For example, if we love our mother, we assume that everyone does and that all mothers are wonderful, which may not always be the case. If we like to smoke or drink, we might assume that everyone does, and so on.

In the profession of counselling it is essential for an effective counsellor to be nonjudgmental and to be able to accept different realities. This includes different sexual orientations, occupations, religions, routes of HIV transmission, and so on. An effective counsellor is able to empathise with all clients. It might help a counsellor to understand that everyone's source of sorrow is different, but the pain all humans feel is the same. If you are not dependent on alcohol, it might help you to think of any one habit that you have been trying very hard to break but have been unable to. It may be getting into a routine of exercise, joining a hobby, avoiding junk food, attending to a health issue, or even meditating. Even when we know some habit is good for us to imbibe, we are not always successful in doing so. The sadness and betrayal a man would feel at being cheated upon by his boyfriend may be the same as what you or your near and dear ones may feel at being cheated upon in a heterosexual relationship.

When our personal values, beliefs or attitudes come in the way of being an effective counsellor, it is essential to be aware of our bias; put our bias away as far as possible, and be emotionally present with the client.

Key messages:

- Each individual has values, attitudes and beliefs.
- Each profession also has certain values, which define the ethics of the profession.
- The counsellor needs to be aware of different aspects of one's self, including one's own beliefs, attitudes, and values around sexuality and gender.
- An ethical counsellor keeps the client's information confidential; respects a client from every background, sexual orientation and occupation; works for the good of the individual client and society; avoids actions that cause harm; is honest to each client as well as to the profession of counselling.
- A counsellor needs to have cognitive flexibility and is required to understand how their personal belief system might influence the counselling process.
- **When the counsellor's personal values clash with professional values of counselling, it is essential to put personal bias away as far as possible, and be emotionally present with the client.**

Annexure

Annexure 1: Statements for Rapid Fire Round

"I will read out some statements. The same statements are there in the handout given to you. Keep the handout and a pen ready. Listen to the statement that I read, and respond to each statement in your hand out with '**A**gree' or '**D**isagree'. Please respond very quickly with the first response that comes to your mind. If you are in doubt while responding to any statement, please select one of the two options that you feel relatively closer to. You do not have to share your answers with anyone, but it would help you to be honest while responding, without worrying about what the 'right' or 'wrong' answer is. So, here we go with the activity, 'Rapid Fire Round'."

1. If a housewife gets HIV despite having sex with only her husband, she deserves more kindness and understanding than a female sex worker. **A / D**
2. Heterosexuality is a healthier sexual orientation than bisexuality or homosexuality. **A / D**
3. A counsellor should help transgender persons to become what they are born as – male or female. **A/ D**
4. If someone got an HIV through an infected needle while taking a routine blood test, I would be able to sympathise more than if he is an IDU. **A / D**
5. Transgender people are to be made fun of. **A / D**
6. It is a matter of shame for a family to get HIV. **A / D**
7. Sex work is an easy way to earn money. **A / D**
8. Some women need to be kept under control by their husbands for which he might even have to slap her a few times. **A / D**
9. Children's minds get negatively affected due to sex education. **A / D**
10. A woman is supposed to use protection to prevent pregnancy if her husband does not enjoy sex with condoms. **A / D**
11. A counsellor is supposed to decide whether an HIV positive client can marry or not. **A / D**
12. HIV positive children must not be allowed to sit in the same class with other children. **A / D**
13. Homosexuality is becoming more popular in India due to influence of western culture. **A / D**
14. It can help a counsellor relax a bit during lunch time by making fun of some cases. **A / D**
15. Engineers and other educated people know everything about HIV, thus pre test counselling is not needed. **A / D**

Annexure 2: Manure and pests

What are such helpful and harmful factors – internal and external – for your growth? Please enlist these factors on the left and right side of the tree diagram provided to you. Your individual responses will remain with you and do not have to be shared with anyone.

Some specific questions that will help us introspect are:-

- What are the factors within yourself that facilitate your personal and professional growth?
- What are the factors in your environment that facilitate your personal and professional growth?
- What are the factors within yourself that hinder your personal and professional growth?
- What are the factors in your environment that hinder your personal and professional growth?

Can you identify how you can overcome the challenges that are hindering your personal and professional growth? List a few action points for yourself.

BE HONEST – the answers will remain only with you.

WHAT HELPS YOU GROW?

WHAT HINDERS YOUR GROWTH?

Annexure 3: Inside out (case discussion)

CASE 1: Ethical dilemma

Amrita, a 25-year-old unmarried graduate, worked and lived on rent in a city. Her parents and siblings lived in a remote village. Her father was a retired embroiderer and the household depended on Amrita's salary for their upkeep.

Amrita had been getting recurrent cough and fever since the last two months. Initially she took some cough syrups and tablets, but there was no respite. She began feeling very weak and running a temperature. She finally went to a government hospital with her parents who had come down to see her. The doctor gave her some medicines and referred her to the ICTC.

At the ICTC, the counsellor very politely requested the parents to wait outside the counselling room. When she shared her confusion about what the ICTC was and why she was sent there, the counsellor explained to her the purpose of the ICTC and gave her some initial information about HIV. Amrita was shocked to know that the doctor had referred her for an HIV test. Amrita also seemed uncomfortable that her parents were not allowed to be with her. The counsellor calmed her down and explained the need for an HIV test, routes of transmission and information on opportunistic infection. Amrita finally agreed to undergo the HIV test, but did not share any history of high risk behaviour. She was very nervous about the test result and kept asking the counsellor about when she should come back for collecting it.

After a few minutes the counsellor informed Amrita that her test result was positive. Amrita broke down and kept repeating that the report was not hers and insisted on repeating the test. She also requested the counsellor not to reveal the report to her parents. The counsellor gave her some time to accept the report, shared information about the difference between HIV and AIDS and also gave her information about ART. Amrita once again broke down and shared with the counsellor that she had a steady partner for the past seven months whom she was living with and planned to marry soon. She was inconsolable and was crying bitterly. She also mentioned that it would have been better if she had not come for the test. Meanwhile Amrita's parents were getting agitated waiting outside the counselling room. They were angry at the counsellor for sending them out as they felt that they had all the rights to know their daughter's report. They were getting very worried and could not wait out any longer; they finally came into the counselling room.

Questions for discussion:

- **What are the ethical dilemmas that the counsellor may face in the given situation?**
- **How should the counsellor handle the given situation?**
- **Should the counsellor reveal Amrita's status to her parents as they had entered the counselling room?**
- **What should the counsellor do if Amrita continues to ask for repeating the test?**
- **What should be the counsellor's action plan for future counselling sessions?**

CASE 2: Self awareness and ethics

Sameer was a 24-year-old matriculate belonging to an orthodox Muslim family in a district of North India. He was soft spoken and fairly good to look at. At the age of 17 he had started working in his uncle's garage to make a living and to learn the trade of a motor mechanic. His uncle was married, but his wife and children lived away in the village. The uncle soon started asking Sameer for sexual favours against the obligation of keeping him in the job. Sameer's initial resentment and pain slowly turned into silent submission. After about two years he found himself being recognised by other boys who had the same sexual orientation. By this time, Sameer had started identifying himself as homosexual and developed relationship with two other men.

Once, while visiting a friend in another village, he happened to see a migration campaign organised by NACO, where he met the counsellor who told him about the routes of HIV transmission. Sameer was frightened and decided to get himself tested. To his great relief, he was detected negative. Now that he had learnt that the same test is available at all government health facilities free of cost, he gathered the courage to visit the ICTC at his district despite the fear of being seen by someone. During the counselling session he declared his sexual identity. He was tested negative for HIV, after which he disclosed about his previous test. The ICTC counsellor told him about an NGO that worked with other people like him and the services being provided there and referred him to the TI NGO. Sameer joined the TI as a beneficiary and after six months, he was selected as a peer educator.

Sameer came back to the ICTC once more for his regular HIV testing as a beneficiary of the TI. He knew the counsellor very well and informed her that he had been married just a month back because of immense family pressure. Upon being further probed, he informed that he had had sexual intercourse with his wife without condoms a few times.

He was tested but this time was found positive for HIV. Sameer was shocked and was full of remorse. He said that Allah was punishing him for his deeds and that he had been suffering since he was young.

The counsellor advised him to bring his wife for the test both for his referral to the ART centre and also for checking her positivity status. Sameer's wife Zaira was a young woman of 18, quite unaware of the ways of the world. The counsellor had great difficulty in counselling Zaira about HIV, the positivity status of her husband and also the reason for her testing. Meanwhile when Zaira was waiting for her test result, the counsellor heard her sobbing with helplessness. The counsellor also heard Sameer telling her that he had HIV because of blood transfusion at the block hospital when he had met with an accident. The counsellor thought it wise to conceal the information of Sameer's sexual orientation with Zaira.

To the great relief and happiness of both of them, Zaira was detected HIV negative. The counsellor advised her to come for testing again after six months and advised him about safer sex.

Questions for discussion:

- **What can a counsellor do if a client is into same sex relationships?**
- **What are the biased beliefs that a counsellor might have?**
- **What can the counsellor say / do when the client says that they were being punished by God and suffering since childhood?**

CASE 3: Awareness of our attitudes

Kabir is an ICTC counsellor. His parents had separated after a violent relationship. He has grown up with his mother and feels very angry with his father who was alcohol dependent. He is single because he questions the institution of marriage. He is currently seeing an HIV positive client who is addicted to alcohol. It is a challenge for him to counsel the client.

Questions for discussion:

- **What may be making it difficult for Kabir to counsel the client?**
- **Does a counsellor's mood affect the counselling process? In what ways?**
- **Do a counsellor's personal values, beliefs, and attitudes affect the counselling process? Do you think it can be more than how these might affect someone in a different profession?**
- **Can you think of any personal experiences, values, beliefs or attitudes that might come in the way of doing your work?**

SESSION 4

Social drivers of the HIV Epidemic: Gender, Sex, Sexuality, Violence, Migration

Session Overview:

- **Understanding social drivers of the HIV epidemic – 10 minutes**
- **Understanding Gender as a social driver of the HIV epidemic – 75 minutes**
- Social Construction of Gender
- Gendered vulnerability to HIV/AIDS in India
- Gendered responses to HIV/AIDS
- **Understanding sex and sexual behaviour as a social driver – 90 minutes**
  - Sex , sexuality, behaviour and practices
  - Sexual behaviour and HIV risk
  - Sexual norms and vulnerability
  - Sexual identity and marginalisation
- **Understanding violence as a social driver – 45 minutes**

Session Objectives:

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

- Understand the social drivers of the HIV/AIDS epidemic.
- Understand gender as a social construct.
- Understand the linkages between social construction of gender and vulnerability of women/girls and men/boys to HIV/ AIDS.
- Identify actions in HIV counselling to address gender related concerns in HIV/ AIDS.
- Enumerate the meaning of sex and sexuality.
- Appreciate the role of sexuality related norms as a social driver of the epidemic.
- Understand violence as a social driver.
- Enumerate ways to include the perspectives gained from this session into counselling practice at ICTC/ART/STI centres.

Time allowed:

- 4 hours

Materials required:

- Chart papers
- Markers
- Double side tape
- LCD with screen
- Power point slides

Method:

Preparation before the session:

You as the facilitator will keep the following things ready before the session:

- Print outs of Annexure.
- Identify the area for conducting activity 1 and 8.
- Boards with "Society, Biology, Violence, No Violence, Not Sure" written on it.
- Balloons that have been blown and tied up.

- Translate the handouts in the local language to ease as well encourage the participants to read the handouts.
- It is important to maintain one facilitator for this session and the session on marginalisation and vulnerability as both the sessions are organically connected and feed into each other.
- There are many activities in this session. The facilitator will have to play an active role to ensure that the participants assimilate the learning from each activity and relate it to their counselling practice. Care should be taken to ensure that the participants do not get carried away in the activity itself.
- **Power point presentation has been given in this session. However they should be viewed after the activity only for summing up the learning's of the activity. Session is on perspective building as this cannot be conducted by using the slides only, the participants have to undertake the activities , these sessions are experiential in nature i.e. the learning in these sessions occur because of their experiences while participating in the activities.**
- The activities in this session can be conducted in the outdoor outside the training hall. This will break the monotony of counsellors sitting in the training hall.

We strongly recommend that the movie *Queen*, (2014) should be seen with the participants after this session. This film through a mainstream medium depicts how a girl moves away from gender roles and defies patriarchy in her own way and ultimately finds herself. The journey shown in the film is subtle yet powerful. The discussions undertaken in this session can be linked to the film. The facilitator of this session should be present during the viewing of the film. The film is in Hindi. However the non-Hindi speaking states can find out if the film is available with English subtitles. Alternatively any film in the local language with a similar theme can be shown to the participants.

Activity 1: Social drivers of the epidemic (10 minutes)

- Begin the session by going through the objectives.
- Conduct a brainstorming with the participants and ask them what they understand by the term "social drivers". Jot down the thoughts and clarify doubts if any.
- Walk through slides 1 – 6 for further clarity on social drivers.
- Inform the participants that through the session, we will try to understand gender, sexuality and violence and its connection to the HIV/AIDS epidemic.
- Migration is also an important driver of the epidemic but this will be covered in the session on "Understanding Vulnerability and Risks of High Risk Groups (Core Groups and Bridge Population)."

Section 1: Understanding Gender as a social driver of the HIV epidemic

- Inform the participants that we will now try to understand gender as a social driver of the epidemic.
- There are three activities in this section (Activity 2 – 4).

Activity 2: Social construction of gender (30 minutes)

- Ask the participants to stand in a straight line at the centre of the room, equidistant from the labeled walls.
- Explain the participants what 'Biology wall' and 'Social wall' mean.
- Refer to the list of the statements outlined in **Annexure 1** and read aloud one statement at a time.
- After each statement, ask participants to move a step towards the Society Wall or the Biology Wall depending on whether they feel that the statement is based on socio-cultural factors or has a biological basis.
- After all the statements have been read, most people should be closer to the Society wall since all but the following statements have a social basis :

- Boy's voices break at puberty.
- Women can get pregnant, men cannot.
- Women can breast-feed babies, men cannot.

➢ Have participants discuss their views about all the statements and explain to one another why they felt a certain way about each statement.

➢ Follow this exercise with a discussion on the meaning of gender, sex, masculinity, femininity using slides 7 – 8.

Key points to emphasise:

- Except statements about breastfeeding, pregnancy, and men's voices breaking at puberty, all the statements have a social basis.
- Gender is a social construct. Gender roles and behaviour are assigned by society and are learned rather than innate. These vary from society to society, and at different times in history.
- Different agencies – the family, school, friends, and the media – teach boys and girls to behave in a way that is appropriate for their sex. Among the things that society teaches them right from childhood are that men and women have to perform fixed roles in society; more often than not, boys are socialised to be aggressive, dominating, controlling and therefore violence displayed by boys is considered acceptable. These fixed gender roles can affect both men and women negatively; yet both men and women continue to play these roles and even perpetuate them.
- As counsellors, it is important to distinguish between what society has constructed/ created for each gender as against what is biological. For example, the idea that women are gentle is created by society as against women giving birth which is biological.

Tips to the facilitator:

- This activity has been demonstrated in Avirat (The set of films created by Saksham). The facilitator can go through the CD before conducting the session.
- Read all statements beforehand and prepare responses to anticipated arguments. The statements about girls being gentle and women having maternal instincts can be contentious. Asking why people believe these statements to have a biological basis and what negative effects these stereotypes can have may help participants understand the importance of being aware of gender as a social construct.
- It is often mistakenly believed that all people have sexual 'instincts' and all women have 'maternal instincts'. Help participants examine how these assumptions can be dangerous. For example, those who believe in sexual instincts may use this argument to absolve abusers of any responsibility by pronouncing their actions as 'beyond their control'. Common terms associated with instinct are 'innate' 'uncontrollable', 'need', 'urge', and 'have to be fulfilled at all costs'
- In case of shortage of time, continue the activity with only some of the statements, remembering to include at least two of the statements that have social base.

- Assure the participants who are confused or not sure that it is ok to be in that position and this is an opportunity to probably unlearn and gather a newer perspective.

(Source: Adapted from Exercise 3, Understanding Gender, Module One, Chapter One in Basics and Beyond: Integrating Sexuality, Sexual and Reproductive Health and Rights - A Manual for Facilitators by TARSHI, (2006).)

Activity 3: Gendered vulnerability to HIV/AIDS in India (30 minutes)

- Divide participants into 4 – 6 small groups.
- Assign each small group a case study outlined in **Annexure 2**.
- Ask each of the small groups to read their case studies carefully and make a list of the significant events that have taken place in the lives of the people mentioned in the cases.
- Allow 10 minutes for the small groups to prepare the above mentioned list on a chart paper.
- Ask each group to present their list to the large group.
- Put up the entire list together and ask participants to identify themes in gender related vulnerabilities and impact to HIV and AIDS. For example, early marriage, lack of education, preference for male child, lack of access to services, stigma and discrimination, lack of economic independence, sex work and so on.
- Write these themes on the white board or chart paper and explain how each contributes to gender related vulnerability and impact of HIV/ AIDS.

Activity 4: Gendered response to HIV/AIDS (15 minutes)

- Explain to the participants that the current exercise is a natural extension of the discussions held so far on the gendered impact of HIV/ AIDS. Participants can continue to be in the small groups as per the previous exercise. Ask the small groups to brainstorm for 5 minutes about how the gender related concerns highlighted in the case studies, can be addressed through their work in the ICTC/ART/STI centre.
- Ask each group to present their discussions. Write all the suggestions for actions on a white board or a chart paper.
- Ask each participant to identify at least one action from the list generated above that their centre can initiate or implement immediately or in the near future to address the gender related vulnerability or impact of HIV and AIDS.
- Go through slides 10-14 for further clarity.

Section 2: Understanding sex and sexual behaviour as a social driver

- Conclude the activities on Gender and inform the participants that the session will now move to discussions on understanding sex and sexuality as a social driver of the epidemic.
- There are 4 activities in this section (Activity 5 – 8).

- Ask participants to brainstorm on what they understand by sex and sexuality. Sex and sexuality tend to be used interchangeably. It is important that participants understand the wider scope of sexuality.

Activity 5: Sex, sexuality, behaviour and practice (20 minutes)

- Following the above brainstorming activity, divide participants into 4 groups. Distribute flipchart paper and markers to the groups. Instruct them to list out every kind of sexual behaviour they have heard of, engaged in, seen, or read about.
- Bring the groups back together and ask representatives from each to present their list to the larger group. Ask a volunteer from the participant group to write the different sexual behaviours on a white board or a flipchart and retain this list for one of the following activities.

Key points to emphasise:

- Many forms of sexual behaviour and expression can take place between people of different genders and of the same gender. For example, oral sex can take place between two men, two women or a man and a woman.
- While some people may prefer not to engage in a certain type of behaviour, this does not mean it is wrong for others to enjoy it **if it is between consenting adults**.
- It is important for counsellors to be aware of different sexual behaviours and their own reactions to them. This helps them to be prepared and react appropriately when they hear about them during the course of their counselling practice. .
- Being aware of the diversity of sexual expression can also help design information and services to help people protect against potential adverse effects/ consequences of these behaviours. For example, with regard to conception, many believe that anal sex is a safe alternative to penile-vaginal sex. They may therefore engage in unprotected anal sex, which exposes them to risk of HIV infection.
- Coercive sexual behaviour of any kind, even between regular partners such as married couples, is unacceptable.
- After completing the discussions, take the participants through slides 16 – 22 for further clarity.

Tips to the facilitators:

- Be prepared for discomfort by participants, which may manifest as inappropriate humour, silence or outbursts of anger. Let these reactions emerge spontaneously. However, remind the group that the purpose of the exercise is for them to become aware of behaviours to enable them to work more effectively on sexual and reproductive health issues and HIV/ AIDS.
- Pay attention to the terms listed out by the groups. Participants might include sexual or gender

identities in the list of sexual expression. Point out that sexual behaviour or expression is different from identity. For example, homosexuality is a sexual identity, not behaviour.

- Make note of the kinds of words being brought up during the exercise. Do they reflect any values of the group or individuals and/ or do they focus on any particular kind of sexuality (heterosexual, monogamous)? If so, ask participants why they focused on these and introduce other sexual identities.

Activity 6: Sexual behaviour and HIV risk (25 minutes)

- Keep a chart paper ready with a traffic signal lamp post which has three colours namely, red, orange and green. Explain that red colour stands for high risk, orange colour stands for moderate or low risk while green colour stands for no risk.
- Refer to the list of sexual behaviours developed in Activity 4. Go by the list numerically and ask a volunteering participant to place the particular sexual behaviour on the appropriate colour of the traffic signal lamp post and explain the reason for doing so. Encourage the lesser vocal/ active participants to match the sexual behaviour with the levels of risk.
- After all the sexual behaviours are covered, conclude the exercise by discussing the ABCD model for HIV prevention.
- Inform participants that condom demonstration and practice will be conducted in the further sessions.

Key points to emphasise:

- Penetrative forms of sexual behaviours like anal and peno-vaginal sex have the highest risk to HIV transmission wherein consistent and correct use of condom is a must.
- Oral sex is considered to be of lower risk however condom use is recommended.
- People living with HIV/AIDS have a right to express their sexuality and options like mutual masturbation, thigh sex are considered as safer sex options.
- Go through slides 23 – 25 for further clarity.
- Inform the participants that the learning from this exercise can be applied by them during their counselling practice, especially while conducting risk assessment and risk reduction counselling.
- Encourage the participants to clear all their doubts and misconceptions in relation to this activity, so that they will be able to answer the queries or concerns raised by the clients comfortably and confidently.

Activity 7: Sexual norms and vulnerability (45 minutes) (Annexure 3)

- Print the statements given in Annexure 3, cut individual statements and put them in a small basket. Request the participants to sit in circle. This activity has to be played like the " passing the parcel activity" i.e. music has to be played, a small parcel like a ball has to be passed amongst

the participants, the person who has the ball in his/her hand when the music stops has to pick up one chit from the basket . Ask the participant to read the statement and give his/her views and whether they agree with the statement or not and the reasons thereof.

- Encourage participants who do not usually participate in large group discussions to pick up the chits. After the participant has shared his/her thoughts, put the floor open for discussion within the larger group.

Key points to emphasise:

Statement: Masturbation leads to loss of virility in men.

- ✓ *It is a normal sexual activity practiced by both males and females and does not lead to loss of virility.*

Statement: Only penetrative sex can lead to sexual satisfaction.

- ✓ *Other non-penetrative forms of sexual behaviours like petting, hugging, kissing, self-masturbation, mutual masturbation and the like can also lead to sexual gratification. In case of HIV positive couples, whether sero-discordant or concordant, heterosexual or homosexual, non-penetrative forms of sexual behaviours are preferred to prevent the risk of HIV transmission and increase in viral load of partners.*

Statement: Condoms provide protection against HIV/STI and pregnancy:

- ✓ *Correct and consistent use of condoms can provide protection.*

Statement: Using a copper "T" for birth control also protects you from HIV.

- ✓ *Condoms are the only form of birth control which also offers protection from the sexual transmission of HIV. Until now condoms were predominantly understood as a contraceptive and until the advent of the ICTCs, were available with the family planning department or OB-GYN department in hospitals.*

Statement: Anal sex has a higher chance of HIV transmission than vaginal sex.

- ✓ *Both anal and vaginal sex are unsafe. Both the vagina and the rectum are lined with a mucus membrane through which the virus can pass directly into the blood stream., but anal sex has higher chance of transmission because the chances of minor abrasions or tearing is higher.*

Statement: Most of the women with HIV are prostitutes.

- ✓ *We are now in the third phase of the epidemic where women and children are infected. In the first and second phase of the epidemic, prostitutes were targeted through the NACP under the targeted intervention approach. This approach though required at that point of time, left out women and children.*

Statement: Sexually transmitted infections can be cured if the infected man has sex with a virgin.

- ✓ *STIs require regular medical treatment. By having sex with a virgin or anyone else, one will only pass on the infection.*

Statement: The size of the penis is equivalent to masculinity or virility.

- ✓ *The size of the penis either when it is flaccid or erect is no indication of man's masculinity or ability.*

Statement: Menstruation is unclean.

- ✓ *Menstruation is related to the cycle of life. The uterus prepares itself for growth of the fetus, if and when conception takes place. When this does not occur, the soft, temporary lining of the uterus sheds which results in menstruation.*

Statement: Homosexuality is abnormal.

- ✓ *A homosexual is a person who is attracted to people of the same sex and derives sexual pleasure from them. Both men and women can have such an attraction. At different times in a person's life they may find they are attracted to different kinds of people. At some time in most people's lives they will experience some level of attraction to others of the same sex. It is considered normal.*

Tips to facilitators:

- At the beginning of the exercise assure the participants that there are no right or wrong answers and each one has a right to their opinion.
- If you know your group well, you can include statements which you need to be addressed within the group.
- This is a good time to initiate discussions around the concept of normality and abnormality which will be carried through in the following exercises. It is important to understand that sexuality like gender is a social construct. We have to broaden our understanding about sex and sexuality and include dialogues in relation to choice, rights and diversities while planning interventions.
- You can write out statements like sing a song or share a joke on a chit and introduce this chit in the container after half of the statements have been read out. This will serve as a breather or lighten the mood if the discussions are getting too heavy or serious.

(Source: Adapted from the Naz Foundation (India) Trust Guide to Teaching about Sex and Sexuality (Naz Foundation (India) Trust, 1996).

At the end of the activities on sex and sexuality , it is important to stress the fact sexuality or certain sexual identities is not fuelling the HIV epidemic; it is rather the lack of complete information and avenues for facilitating discussions on sex and sexuality that makes individuals vulnerable to the HIV infection.

It is therefore imperative for counsellors to be clear about facts and updated information as well as develop their comfort in talking about issues pertaining to sex and sexuality; this will help them during their counselling practice, which in turn will help reduce client's vulnerability.

Activity 8: Sexual identity and marginalisation (20 minutes / Home work assignment)

- Distribute **Annexure 4** to each participant.
- Instruct the participants to list out the various identities mentioned in Annexure 4 within the concentric circles, based on the level of stigma and discrimination they experience in their societies/communities. For example, identities that experience the least amount of discrimination will fall into the inner most circle, whereas the outer most circles will have the most marginalised identities. Give participants 10 minutes to complete the activity.
- Invite participants to share how they have listed the identities in the concentric circles and explain the basis upon which they categorised identities.

Suggested Questions:

- Were there similarities among the least marginalised people? Similarly were there any similarities among the most marginalised? How does society stigmatise some of these identities?
- What do the similarities indicate about certain identities? Are there some groups such as married men that experience the least stigma and most opportunities in society?
- Are there stereotypes associated with any of these identities? How would these stereotypes cause discrimination or marginalisation of those concerned?
- Who creates these stereotypes and decides what is 'normal'? Why/How are these stereotypes and this marginalisation maintained? For example, do media images of certain identities help perpetuate these attitudes or do laws or customs in a community maintain this marginalisation?
- Inform the participants that it is important that they understand this as they will come across clients with different sexual identities and preferences during the course of their counselling practice. They need to understand and accept that everyone has a right to their sexual likes and

dislikes, as counsellors they have to discuss options for prevention, testing and care and support with all the clients.

[Source: TARSHI (2006).Basics and Beyond: A Manual for Facilitators, India]

- Stereotypes maintained in society and communities contribute to stigma and discrimination against certain individuals like MSM or IDUs. These individuals are called 'marginalised populations' viz. MSM, IDU, FSW and migrant populations.
- Stigma and discrimination can result in violence, abuse or denial of services and information for individuals. Participants can go through the handout provided on stigma and discrimination for further clarity.
- Stigma and discrimination increases the vulnerability of individuals to HIV/AIDS. Being infected with HIV further increases the stigma and discrimination, thus creating multiple layers of stigma and discrimination.

Tips to the facilitator:

- Participants may not be familiar with some of the identities listed. If necessary, go through the identities beforehand and discuss any questions they might have about the identities.
- Inform them that a detailed discussion on High Risk Groups and vulnerability will be discussed in the next session.
- Participants may express discomfort around some identities, especially those that are new to them or those considered 'wrong' according to certain cultures/religions.
- Be sensitive to the above and encourage participants to participate in the exercise in the spirit of learning, even if they do not fully understand them.
- In case of shortage of time, this activity can be clubbed with the tea break and the participants can complete the exercise with 'working tea'.
- Encourage the participants to go through the handout on stigma and discrimination for further clarity.
- **In case of shortage of time, this activity can be handed over to the participants as a home work assignment and the discussions from this assignment can be carried out at the beginning of the session on " Understanding Vulnerability and Risks of High Risk Groups (Core Groups and Bridge Population)."**

Section 3: Understanding violence as a social driver of the HIV/AIDS epidemic (45 minutes)

- The participants will now try to understand violence as a social driver of the epidemic.
- This will be done through part A and B of Activity 9.

Activity 9:

Part A

- Before beginning this activity, please place the blown and tied up balloons on the training hall floor.
- Inform the participants that the objective of this activity is to collect as many balloons as possible.
- The participant with the maximum number of balloons at the end of 5 minutes is the winner. There are, of course, no points for burst balloons.
- Now initiate the activity. It is likely that all the balloons would be burst well before the end of the activity if not, declare the winner(s) and end this activity.
- Ask the group to describe what happened in the game.
  - Did anyone try to push or hit others or try to forcibly snatch their balloons?
  - Would you describe this as 'violence'?
- Encourage participants to think about why they would or would not describe the pushing/ shoving or trying to snatch another person's balloon as 'violence'.
- Allow the participants to express and debate different views for some time. It is likely that the group will not be able to come to any agreement on whether there was any violence involved in the game.
- You do not need to arrive at a conclusion at this stage. Tell them that in the next part of the activity, we will try to understand what exactly the term 'violence' means.

Part B

Put up the three cards in different parts of the room. Give participants the following instructions for the activity:

- In order to further clarify the meaning of 'violence', we will undertake another activity.
- Three cards have been put up. I am going to read out descriptions of a few situations.
- If you think that the situation is a case of violence, then go and stand near the card that says Violence.
- If you think that the situation does not depict a case of violence, then take your place near the card that says No violence.
- If you are undecided, take your place near the card that says 'Not sure'.
- Once the instructions have been understood, initiate the activity. Read out one situation **(Annexure 5)** at a time and let the participants take their positions.
- Ask the three groups to explain their reasons for taking that particular position.
- Let each group convince the other groups about their position. In the course of the discussion, if anyone wants to change sides, they are free to do so.
- After this discussion, sum up the situation. Points for summing up have been provided for your reference at the end of each situation.
- Encourage the groups to participate enthusiastically. The more they discuss and argue, the livelier the activity will be.

After reading out all the situations discuss the following question with the group:

Were you surprised that any particular situation was indeed an act of violence? Why?

Key points to emphasise:

- In every situation, there was some form of violence. While the violence was clearly evident in some cases, in other cases it was less. This violence took different forms – in some cases, it was sexual violence, while in other cases it was verbal, physical, emotional or economic violence.
- In each case, the person at the receiving end suffered either physical or emotional hurt. Violence is therefore not only causing physical injury – causing emotional or mental trauma or economic deprivation is also violence.
- When we try to decide whether an action is an act of violence or not, we need to look at two things – **the intention of the person committing the violence and the impact on the person at the receiving end.** So, even in the balloon activity, where there may be no intention to cause hurt, if someone does get hurt there is violence. In other words, while the violence may be deliberate in some cases, it may not be deliberate in other cases.
- Violence is generally committed by those who are more powerful on those who have less power.
- Our society is predominantly patriarchal, that is, it is a society in which men enjoy more power and more privilege than women, which often leads to men committing violence against women. These two points when put together help us realise why violence against women takes place on such a large scale.
- As counsellors it is extremely important to understand what violence is; especially so that we don't perpetuate gender stereotypes and patriarchal norms in our counselling practice.
- **It is important for us to know that society has created certain fixed images of what it considers to be 'real' men. Such 'real' men are supposed to be brave, aggressive, dominating, in control, virile…they are the *protectors, providers* and *procreators*. We then make the point that such images put pressure on men to proclaim their masculinity by behaving in aggressive, violent ways.**
- **Violence can lead to disempowerment, which can increase the vulnerability of an individual to HIV/AIDS.**
- It is important for the counsellors to know that violent behaviour is learnt; it has an extremely negative impact and can be unlearnt.
- As counsellors it is very important to have a list of contact persons or agencies where the client's can be referred to for further help and redressal if they are facing violence. This will be further discussed in the session on strengthening service linkages.
- Please carry forward the discussions undertaken in the activities on gender and sexuality here.
- Go through slides 26-32 to sum up the discussion on violence.

Apart from screening the movie Queen for gender issues, the training institute can also screen the movie, " Migration" for discussing migration as a social driver, this movie is available in "Visual Voices" (A compilation of videos on Gender , Sexuality and HIV/AIDS) . Also Episode 1 of Satyamev Jayate, Season 2 can be screened. This episode covered gender based violence and is featured in Hindi with English subtitles. The episode is available at http://www.youtube.com/watch?v=9J8ifuHyHjk

Key messages:

- The term driver relates to the structural and social factors, such as poverty, gender inequality and human rights violations that increase people's vulnerability to HIV infection. These factors operate at different societal levels and different distances to influence individual risk and to shape social vulnerability to infection.
- Gender is a social construct. Gender roles and behaviour are assigned by society and are learned rather than innate. These vary from society to society, and at different times in history.
- As counsellors, it is important to distinguish between what society has constructed for each gender as against what is biological. Many forms of sexual behaviour and expression can take place between people of different genders and of the same gender. For example, oral sex can take place between two men, two women or a man and a woman.
- It is important for counsellors to be aware of different sexual behaviours and their own reactions to them. This helps in being prepared and responding appropriately when they hear about them during the course of the counselling practice.
- Violence is generally committed by those who are more powerful on those who have less power.
- Violence is not only causing physical injury – causing emotional or mental trauma or economic deprivation are also forms of violence.
- It is important for the counsellors to know that violent behaviour is learnt; it has an extremely negative impact and can be unlearnt.

Annexure

Annexure 1: List of statements

(In case of time constraint, the facilitator can make a decision to select a few of the statements, however the statements in bold have to be covered)

- **Girls are gentle, boys are not.**
- Men are good at logical and analytical thinking.
- Women are creative and artistic.
- **Women like to dress up and wear makeup.**
- **Boy's voices break at puberty.**
- **Boys do not cry.**
- Women use contraceptives. Men do not.
- **Women can get pregnant, men cannot.**
- **Women can breast-feed babies, men cannot.**
- **Women have maternal instincts.**
- A girl cannot get pregnant prior to marriage.
- **A bridegroom is older than the bride.**
- **A bride is a virgin on her 'first night'.**
- **Men engage in sexual acts prior to marriage to 'perform' on their first night of marriage.**
- **Having sex with her husband is a woman's duty.**
- **Men have a greater sex drive than women.**
- Women remain faithful in their relationships.
- Men can have multiple 'affairs' at the same time.
- Men are the wage earners of a family.

Annexure 2: Gendered vulnerability and impact of HIV/ AIDS

Case Study 1

Lajjo was forced to marry someone 17 years older than her after class ten. Lajjo gave birth to two daughters after marriage. During this period her husband was detected with tuberculosis and subsequently found to be HIV positive. Their family began treating them differently. They were kept in a separate room as if in quarantine. Their clothes, utensils and other necessary things were kept separately and were not allowed to mix with others. Since her husband's illness was kept a secret from her, she was unable to understand the reason for such behaviour from her in-laws.

Then she gave birth to a son, but unfortunately she could not feel the joy as she too tested HIV-positive. When her husband realised that the situation was going out of control, he explained the nature of his illness to her and on hearing that she collapsed.

The situation continued to steadily deteriorate. When her husband was admitted to a hospital, she was sent back to her parents' house with her children, with instructions not to disclose her illness to anyone, to save the reputation of the family. While discharging him, doctors had instructed his family members not to keep him at home when he breathed his last since the virus in his body might affect other people. Hence, his family took him to a remote field and left him alone to die.

His wife was not allowed to see his body, she was told by her in-laws not to come back to the house, since they were afraid that if she was allowed to stay with them, they might also get infected. She was also deprived of her legitimate share in the family property.

Case Study 2

When Mariam's husband died due to AIDS related illness nine years ago, she and her daughter went to stay with her parents. Out there, her father was too old to work. Her married brother was a daily wage earner and had to support his family. This meant that she was not able to meet her basic expenses. Due to this desperate situation, she felt forced to resort to commercial sex work one year after her husband's death.

Mariam is now a non-brothel based sex worker and operates through pimps at various hotels. After giving a certain commission to the hotel owner, she is able to earn between Rs. 3,000 to 4,000 per month. She uses this money to provide for her family and educate her nine year old daughter, who is currently studying in class II. Some years ago came bad news. Since she was frequently falling sick and suffered from STI, a test was done which confirmed her HIV status. She is now in the second stage of infection and in the last one year she has been suffering from a number of health problems like hypertension, sinusitis, skin infection and STI related ailments. When she works, she insists that her clients use condoms but some clients refuse. It isn't always in her power to bargain.

Case Study 3

Sujata had two daughters. Her in-laws were desirous of a grandson. She was forced to become pregnant again. It was during this period, her husband started falling ill frequently and she had to sell her jewellery to meet the medical expenses of her husband.

When Sujata went to her parent's home for the delivery of the third child, she was totally unaware of his HIV status. During her delivery, she learnt that she is HIV positive and realised that her husband was actually suffering from AIDS related illnesses. However, her husband died two days after the delivery.

Timely medication (Nevirapine) and care saved her daughter from being HIV positive. When she returned to her in-laws house they told her they cannot afford to take care of her and her three daughters and if she wanted to stay with them she had to earn for the family. Her mother-in-law blamed her for her son's death. She was forced to work as a daily wage labourer despite education till class 8. However her earnings are not sufficient to take care of herself and her daughters.

Sujata is worried about her deteriorating health and the future of her three daughters. She even thought of committing suicide, but with the moral support given by an NGO she is somehow surviving. Though the first two daughters are currently studying in a school, she is not sure who is going to educate them and take care of them after her death.

Case Study 4

Adhuna, a domestic worker, lived with her husband, who was a mechanic. In 2003, she started getting fever, cough, lost appetite and weight. She was admitted in a hospital where she was diagnosed with TB. Her doctor asked for an HIV test. Adhuna tested HIV positive. Her husband was informed about it and was asked to get himself tested too. He tested positive but did not disclose it to her.

But after that he just did not come to the hospital to see Adhuna. Adhuna's sister tried calling him but he gave vague reasons for not visiting her. He completely deserted Adhuna. Much later she came to know that he had sold all their belongings and had left the place where they stayed and her personal belongings were dropped at her sister's house. He did not even come to the hospital to discharge her. After Adhuna was discharged she tried calling him to find out his whereabouts and to know why he wasn't meeting her; in response to that he said that he did not want to have relations with her anymore and that she could find her own way out along with her son.

Subsequently after her husband's death she claimed his share of property for her son, but she was not given the same; rather she was blamed for having infected her husband with the disease.

Annexure 3: List of Statements: Sexual norms and Vulnerability

- Masturbation leads to loss of virility in men.

- Only penetrative sex can lead to sexual satisfaction.

- Condoms provide total protection against HIV/STI and pregnancy.

- Using a copper "T" for birth control also protects you from HIV.

- It is possible for a woman to get pregnant through anal sex.

- Anal sex has a higher chance of HIV transmission than vaginal sex.

- Most of the women with HIV are prostitutes.

- Sexually transmitted diseases can be cured if the infected man has sex with a virgin.

- The size of the penis is equivalent to masculinity or virility.

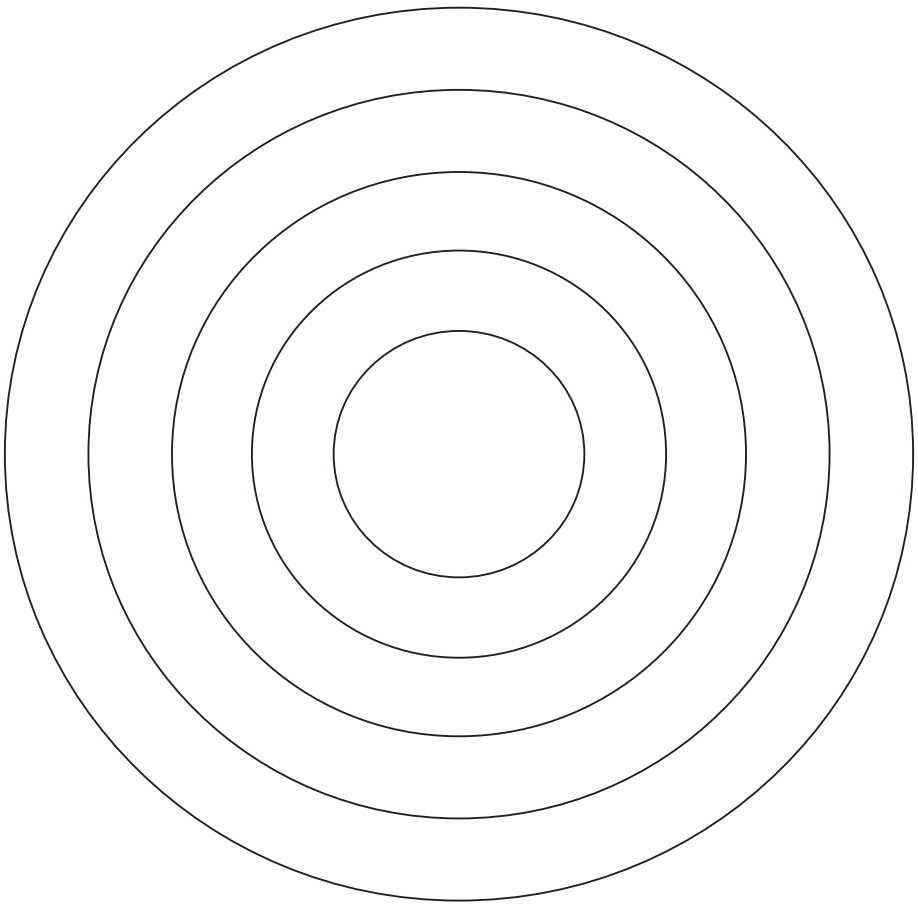
- Menstruation is unclean.

- Homosexuality is abnormal.

Annexure 4: Plotting marginalisation

- **Heterosexual:** An individual who is sexually attracted to people of a gender other than their own and/or who identifies as being heterosexual.
- **Bisexual:** An individual who is sexually attracted to people of the same gender and to people of a gender other than their own, and/or an individual who identifies as being bisexual.
- **Homosexual:** An individual who is sexually attracted to people of the same gender as their own, and/or who identifies as being homosexual.
- **Asexual:** An individual who is not sexually attracted to other individuals.
- **Transgendered person:** An individual who does not identify with her/his assigned gender. Transgendered people may or may not identify as homosexual, bisexual or heterosexual. For example, transgendered people can be men who dress, act or behave as women do, but do not necessarily identify as homosexuals.
- **Transsexual:** An individual who wants to change from the gender they are born as to another gender. Surgery, hormonal treatments, or other procedures can be used to make these changes. People in this group may or may not identify as homosexual, bisexual or heterosexual.
- **Inter-sexed person:** An individual born with some or all physical characteristics of both males and females. They may or may not identify as men or women.
- **Lesbian:** A woman who is sexually attracted to other women and/or identifies as a lesbian.
- **Gay:** A man who is sexually attracted to other men and/or identifies as gay. This term can also be used to describe any person (man or woman) who experiences sexual attraction to people of the same gender.
- **Queer:** Those who question the heterosexual framework of identity and relationships. This can include homosexuals, lesbians, gays, intersex and transgendered people as well as heterosexuals. To some this term is offensive, while other groups and communities have adopted it as a statement of empowerment to assert that they are against a dominant heterosexual framework, and dissatisfied with the labels used to categorise people on the basis of sexuality.
- **Transvestite:** An individual who dresses in the clothing typically worn by people of another gender for sexual arousal and gratification. Often transvestites are men who dress in the clothing typically worn by women.
- **Female to male transsexual:** A person born as a woman who wants to change her gender to become a man. Surgery, hormonal treatments, or other procedures may be used to make these changes. This individual may or may not identify as homosexual, bisexual or heterosexual.
- **Male to female transsexual:** A person born as a man who wants to change his gender to become a woman. Surgery, hormonal treatments, or other procedures may be used to make these changes. This individual may or may not identify as homosexual, bisexual or heterosexual.

- **Married woman:** A woman who is in a committed relationship with another person that is legally recognised by the state/country she lives in.
- **Married man:** A man who is in a committed relationship with another person that is legally recognised by the state/country he lives in.
- **Unmarried woman:** A woman who is not in a committed relationship with another person, which is legally recognised by the state/country, she lives in.
- **Single person:** A person not married or in any committed relationship with another person.
- **Sexually active man:** A man who engages in sexual activities.
- **Sexually active woman:** A woman who engages in sexual activities.
- **Sex worker:** A person who negotiates and performs sexual services for remuneration. Some use this term to mean only prostitution, while others use the term to refer to those in the sex industry such as porn actors, bar girls, striptease dancers, performers in peep shows and live sex shows; this is not the social or psychological characteristic of a class of women, but an income-generating activity or form of employment for women, men and transgendered people.



Annexure 5: Understanding Violence

Situation 1

A girl is standing near a movie theatre, waiting for her friends. A group of boys, who are waiting nearby, call out to her and pass remarks on her clothes and make-up. They ask her if she wants to join them.

- **Would you call the boys' behaviour violent? Why?**

Points for sum up

The boys' behaviour is an act of sexual harassment, even if the boys were just doing it for 'fun'. This is also a form of sexual violence. Even though they might not have harmed the girl physically, their remarks could have hurt and humiliated the girl; since she was alone, she might have been frightened as well.

Situation 2

In a school, children belonging to a particular caste are made to sit separately because they are considered 'inferior'.

- **Would you say there is any violence involved in this situation? Why?**

Points for sum up

Every individual has the right to be treated equally and fairly, regardless of religion or sex or caste. In this case, the children are being forced to sit separately because of their caste. This will definitely harm them mentally and emotionally, and they will grow up feeling inferior. This is therefore an act of violence. It is also against the law to discriminate on the basis of caste.

Situation 3

A woman and her husband work in the same company. The woman has just got a promotion while the man has not. So he is upset and has stopped talking to his wife; he taunts her in front of his friends, telling them that she is now "too big" for him.

- **Do you think there is any violence involved in this situation? Why?**

Points for sum up

Yes, the husband's behaviour is a form of violence. It will cause emotional and mental harm to the woman. It is his jealousy that is making the man hurt his wife in this manner. Also, most men are brought up to believe that they are 'superior' to women; so when his wife does better than him at her job, he probably feels inferior, he feels he is 'less of a man'. But the fact is that, like a man, a woman too has a right to have a career, and to secure a promotion based on her hard work and good performance.

Situation 4

A well-off couple has employed a 13-year-old girl to work as a domestic help. The girl is expected to do all the housework, including washing the clothes and vessels, cleaning the house, taking care of the couple's two-year-old baby and buying things from the market. She is expected to work seven days a week. She gets a salary and two meals every day.

- **Do you think there is any violence involved in this situation? Why?**

Points for sum up

Yes, this is a form of violence. This is a clear example of child labour. And every case of child labour causes serious mental, emotional and even physical harm to the child. The law prohibits child labour. However, this is a common situation in our country. Children often work in hazardous and extremely harsh conditions. This deprives them not only of basic rights like education, but they also lose out on their childhood. Children are employed because they provide cheap labour; employing a child does not mean that the employer is 'helping' the child's family. Employing an adult in the child's place would not only put an end to this practice, but also reduce the large-scale prevalence of adult unemployment in our country.

Situation 5

Praveesh is 14 years old and studies in Class IX. He is very particular about his appearance and likes to dress well. He is a rather quiet boy and does not have many friends. Every day when Praveesh goes for his tuition classes, a group of boys tease him; they whistle at him and call him names like 'chikna'. This has been going on for the last one month. Praveesh is now scared to take that route or go anywhere near that street.

- **Do you think there is any violence involved in this situation? Why?**

Points for sum up

Yes, this is a form of violence. The behaviour of the boys has frightened and humiliated Praveesh. Even if the boys are not causing him any physical harm, and even if they think they are having some "harmless fun", the fact is that their behaviour has hurt Praveesh; it is therefore a form of violence.

Situation 6

Hameed is a loving and caring husband and father to his 3 children. He works very hard in his office in order to provide well for his wife and children. He is usually very gentle and soft with his wife. He very rarely hits her only if she provokes her; especially when she is looking after the children and inadvertently delays him when he is running late for office.

- **Do you think there is any violence involved in this situation? Why?**

Points for sum up

Yes, this is a form of violence. Occasionally hitting your wife is still a form of physical violence. There is no justification for violence, no one can provoke violence and no one deserves violence.

SESSION 5

Understanding Marginalisation, Vulnerability, Stigma and Discrimination in the Context of HIV/AIDS

Session Overview:

- Introduction to the session - 05 minutes
- Our story (Understanding marginalisation) – 20 minutes
- Piece of the sky (Experiencing marginalisation) – 45 minutes
- Cause and effect (Understanding vulnerability in the context of the social drivers and structural factors of the HIV/AIDS epidemic) – 25 minutes
- Making the connection (Developing strategies to reduce marginalisation and vulnerability) – 25 minutes

Session Objectives:

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

- Understand the concept of marginalisation and vulnerability in the context of HIV / AIDS.
- List the structural factors and social drivers that make individuals vulnerable to HIV infection.
- Appreciate the linkages between addressing the social drivers and thus achieving the goals of the national programme.
- Enumerate ways to include the perspectives gained from this session into counselling practice at ICTC/ART/STI centres.

Time allowed:

- 2 hours

Materials required:

- White board markers
- Permanent markers
- Chart papers

- Paper
- Scissors
- Double sided tape

Method:

Preparation before the session:

You as the facilitator:

- Photocopy handouts and leaflets for all the participants.
- Print the identities outlined in Annexure 1 and prepare chits of the same for Activity 3.
- Ascertain a space for the 'Piece of the Sky' activity. This activity will need a large area that can accommodate approximately 20 or more participants. (The space could be either indoors or outdoors). This area should include a wall or any other solid structure, as participants are required to stand in a horizontal line against this structure/wall.
- Translate the handouts in the local language to ease as well as encourage the participants to read the handouts.
- It is important to maintain one facilitator for this session and the session on *social drivers of the epidemic* as both the sessions are inter-connected and feed into each other. There might be some repetition in this session and the session on social drivers (especially in Activity 3), the topic was introduced there, but the applicability is covered in this session. Use your discretion as the facilitator, cover the topic if you feel there is a need for reinforcement , you can skip through the topic if you feel the participants have understood the concept and will be able to use the perspectives in their counselling practice.

Introduction to the session and going through the objectives (5 minutes)

- Introduce the session and outline the objectives of the session.

Activity 1: Our story - Understanding marginalisation (20 minutes)

- Start this activity by asking the participants to think of at least one way in which they have felt 'marginalised', i.e., any one way in which they have felt that they have a disadvantage over most people or the dominant group."

> In case there is a need to elaborate, the facilitator can say: "This may be within your family, your friends, colleagues, city and state. Anywhere where you felt you were treated as less visible or less important than some or all other people. For any one or more reasons have you ever felt at the margin and not in the mainstream?"

- The facilitator can then ask the participants to voluntarily share their experiences.
- To begin the discussion, the facilitator can share his /her own experiences.

Key points to emphasise:

- We all have felt marginalised at different times for different reasons. It could be because of the profession we chose, our marital status or weight issues.
- Marginalisation refers to the reduced power and importance of certain people in our society.
- The social process of becoming/being made marginal (especially as a group within the larger society) is a means to keep someone away from power, because of the choices they make in their identities, practices or appearance.

- The facilitator can then ask the participants to read the handout on marginalisation in order to further understand marginalisation.
- Alternatively the facilitator can also present the same as a power point presentation; however the handout has to be given to the participants for their quick reference.

Activity 2: Piece of the Sky – experiencing marginalisation * (45 minutes)

- Print out the identities (Annexure 1) on a piece of paper and then cut them and convert each identity as a separate chit.
- Hand over one chit to each participant. In case there are more participants than the identities, ask some of the participants to play the role of an observer.
- Give participants some time to understand the identity and relate to the same.
- Move the participants to the space designated for this activity.
- Ask the participants to stand in a horizontal line and hold hands. The participants should be facing the wall/solid structure and there should be some distance between them and the wall.
- Inform the participants that you will be reading a list of questions listed in Annexure 1. The participants have to answer the questions from the point of the view of the identity they have assumed. If they feel that the answer is 'yes', they need to take one step forward and if the answer is 'no' they need to move one step backwards.
- Urge the participants to get into the role of the identity and begin thinking of themselves as the 'identity' they have assumed and not as themselves. Explain to them that the answer to some of the questions can be yes for themselves but no for the identity they are playing out.
- Inform the participants that they have to hold hands for as long as possible.
- After reading all the questions, ask the participants to look around at the others in the line and observe the following :
  - Who is still holding hands?
  - Who is ahead of the others in the line?
  - Ask the participants to then mention the identity they were acting out.