- Note where people stand: What does this tell us about opportunity vis-á-vis the role we were playing?

➢ Now ask the participants to run and grab a space for themselves against the wall.

➢ Following this, ask the participants to assemble back into the training hall.

➢ Ask the participants to share their experiences of doing this activity :

- How did they feel when they had to take a step backwards?
- How did it feel to leave hands?
- At the end of all the questions, who was nearest to the wall and who was the farthest?
- What does this say about the opportunities that are available to some and not to others?
- Who could grab the wall? Who could not?
- Did anyone try to accommodate others so that they could also touch the wall?
- Do we take our privileges for granted?
- Where there any participants, who did not try to run toward the wall at all? If yes, why?

➢ At the end of the discussion ask the participants to 'de-role'. They could say the following – "I am (name of the participant), I am not a policeman" (the role the participant was playing).

➢ Ask the participants if they could draw any connections between this exercise and the previous discussion on marginalisation?

➢ Invite them to share their feelings about being in a marginalised position without doing anything to be in this position?

➢ Ask the participants if they could identify some factors that further marginalise individuals? Some of them could be education, socio-economic status, religion.

➢ Introduce the topic of marginalisation in the context of HIV/AIDS and ask the participants to name the marginalised groups in the context of HIV/AIDS.

(This activity is adopted from the 'Car Park' activity developed by CARAT, TISS and 'Power Walk' activity developed by TARSHI)*

Key points to emphasise:

- Those with greater opportunity owing to either the social groups, family or caste they belong to, enjoy more benefits and power to make choices in their lives. Those people who lack access to opportunities may be 'left behind'.
- One particular person may also have multiple advantages – for example in India, a person who is an educated upper-middle class Hindu, male living in a metropolitan city has multiple advantages over a lower-middle class Muslim woman who has very little education and lives in a village or small town.
- Often the more 'different' a person appears from 'normal' in the society, the greater the discrimination and marginalisation faced.
- A person can experience stigma without any experiences of marginalisation. For example, a person may be stigmatised for being lesbian but she may not be marginalised because of other factors in her life (income, class, caste, and race).
- Marginalisation has many interpretations and is experienced differently by each person. These experiences can further vary due to the influence of structural factors like age, class, caste, gender, educational status, disability and access to services.
- Structural factors and marginalisation contribute to increasing vulnerability of a particular group and community.
- Refers to the likelihood of being exposed to HIV infection because of a number of factors or determinants in the external environment, which are beyond the control of a person or particular social group.

Tips to the facilitator:

- ✓ Manage your time effectively from the beginning.
- ✓ Make sure participants do not see this activity as a judgment of them being fortunate or unfortunate, but rather a chance to examine opportunities and privileges individuals have in society.
- ✓ Encourage participants to get into the role.
- ✓ There is a possibility that the participants will not imbibe the identity to the fullest and will answer based on what they feel. If such a situation arises, the facilitator will have to discuss the same and address issues of the perceptions of the participants regarding a particular community/ identity.
- ✓ The participants (in the role) might not perceive themselves as marginalised or vulnerable. You as a facilitator will have to address this.
- ✓ De- rolling is extremely important for this activity.
- ✓ The facilitator is free to add or subtract more identities and frame more questions for this activity.

Activity 3: Cause and effect (Understanding vulnerability, stigma and discrimination in the context of the social drivers and structural factors) – 25 minutes

- ✓ Start the activity by suggesting that many of us have either witnessed or heard stories about cases of stigmatising and discriminating treatment of PLHIV. Explain them that this activity will provide opportunity for sharing some of them.
- ✓ Divide the participants into 4 groups and assign each with a setting where marginalised communities viz. female sex workers, men who have sex with men, intravenous drug users and migrant populations are vulnerable to HIV and face stigma and discrimination. The participants can also show the linkages between stigma, discrimination and vulnerability.
- ✓ At the same time the participants will have to discuss structural factors that add to the vulnerability and discrimination. Encourage the participants to recall the discussions on social drivers undertaken in the previous session on social drivers of the epidemic. In case the participants need more clarity, *you could tell them how individuals are forced to migrate due to poverty and how isolation and alienation in a new city can put them at a risk to HIV. Further they face stigma and discrimination at the public health centres because of their migrant and HIV positive status.*
- ✓ The settings could be family, local community, workplace, care setting, education and media.
- ✓ Ask each group to develop it as a case study.
- ✓ Ask them to identify the particular expressions of stigma, discrimination and vulnerability in terms of attitude, language and actions.
- ✓ Ask the participants to come back to the larger group. Ask a volunteer from the group to readout the case study for the larger group and list out the manifestations the group has listed out.
- ✓ Ask the other groups to supplement with a few more examples of stigma and discrimination within the particular setting.

Key points to emphasise:

- 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 shape social vulnerability to infection.
- Structural factors can be understood as the factors external to individual. These factors arise out of political, employment or economic conditions such as poverty and migration.
- Recently the term *driver* is also used to describe those risk factors which are so widespread as to account for the increase and maintenance of an HIV epidemic at the population level.
- It is important to understand that it is not just individual behaviour or choices that put people at risk to HIV infection. Choice is never absolute.
- There is ample epidemiological and demographic evidence from the trajectory of the HIV pandemic to show that certain populations are more vulnerable to infection because of the particular social, cultural, economic and legal circumstances to which they are subject.
- In India, it has been seen that marginalised populations that live in an environment of inequity, criminalisation, oppression and violence have an increased vulnerability to HIV and AIDS, and have been disproportionately affected by it.
- Stigma and discrimination can result in violence, abuse or denial of services and information for individuals.
- Stigma and discrimination increases the vulnerability of individuals to HIV. Being infected with HIV further increases the stigma and discrimination, thus creating multiple layers of stigma and discrimination.

Tips to the facilitator:

- Request the participants to go through the leaflet on structural factors and vulnerability.
- Inform them the leaflets are provided to them as a quick reference when they have to conduct the session.
- The participants also need to go through the handout on 'Marginalised population outside the pale of human rights' and stigma and discrimination for further clarity.

Encourage participants to give examples from their practice.

Activity 4: Making the connections (Developing strategies to reduce marginalisation and vulnerability at the structural level) – 25 minutes

- Ask the participants to reconvene in the groups which were formed for the previous exercise. Provide each group with a case study prepared by another group.
- Ask the groups to identify the impact of stigma and discrimination given in the particular case study and then in the particular setting.
- Ask the groups to discuss upon the possible measures to mitigate stigma discrimination at the structural level and reducing vulnerability.
- Ask the group to come back to the larger group. Ask a volunteer from each group to present the discussion findings and their suggestions.
- Record the suggestions on white board or chart paper and compile them to common suggestions.
- Ask the participants to find out measures which they can initiate or advocate from the ICTC/ART/STI and work out plans for them.
- At the same time ask the groups to also discuss strategies that can make the counselling centres (ICTC, ART and STI) sensitive to the needs of marginalised population and reach out to marginalised groups thereby reducing vulnerability.
- This plan can be given as an extra home work for the participants, if time is limited. Alternatively , in case the time is not enough, immediately after the after the " Piece of the sky" activity , the facilitator can ask the participants to discuss strategies that can make the counselling centres (ICTC, ART and STI) sensitive to the needs of marginalised population and reach out to marginalised groups thereby reducing vulnerability and the end the session there itself.

Key points to emphasise:

- HIV prevention and care efforts cannot succeed in the long term without addressing the underlying drivers of HIV risk and vulnerability in different settings.
- Linking clients with government schemes or livelihood programmes can be some of the options to mitigate the vulnerabilities arising out of poverty or loss of livelihoods.
- Sensitising the judicial system, the police force and the public health system about needs of persons belonging to alternate sexuality can be another option of reducing marginalisation and vulnerability of HRGs. Participants can read the handout on 'Law and the marginalised population' for further clarity.
- Stigma, marginalisation and a sense of being different from the normative model can lead to clients experiencing unique stressors and challenges in their lives. Counsellors should know about these challenges and adapt their counselling and counselling centres (ICTC, STI and ART) to provide affirmative services to their clients. For more information on affirmative approach to counselling, please go through the manual developed by Saksham.
- Counsellors at the ART centres need to develop different adherence strategies for sex workers keeping in mind their working hours. For migrant workers, counsellors can suggest and include the 'transfer out' option to enable migrants to seek services at their desired location.
- The ICTC centres can be kept open till late evening to provide services to populations that are unable to access services in regular time, for example, persons who are engaged in daily wage work, MSM or FSW clients.
- Counsellors at the STI clinic need to be sensitive to and include partners of MSM and regular partners of FSW in partner treatment plans.

You can encourage the participants to watch the movie, "My brother Nikhil" and "68 pages". Both the movies cover the issue of stigma and marginalised communities very well. The movies can be screened post dinner. The movies are available in "Visual Voices" *(A compilation of videos on Gender, Sexuality and HIV/AIDS.)*

Key messages:

- Marginalisation refers to being on the margin (not in the centre) of the society, and thus having reduced power or importance in the society.
- The social process of marginalisation (especially as a group within the larger society) is a means to keeping or taking away power from someone, because of their identities, practices or appearance. The process of marginalisation makes the marginalised person or group feel left out.
- Stigma is associated with disfiguring or incurable diseases, in particular, diseases that society perceives to be caused by the violation of social norms, including norms about sexual behaviour.
- A person can experience stigma even without any experiences of marginalisation. For example, a person may be stigmatised for being lesbian but because of other factors in her life (income, class, caste, race) she may not be marginalised.
- Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group.
- There is ample evidence that certain populations are more vulnerable to HIV infection because of the particular social, cultural, economic and legal circumstances to which they are subjected.
- Stigma and discrimination increases the vulnerability of individuals to HIV. Being infected with HIV further increases the stigma and discrimination, thus creating multiple layers of stigma and discrimination.
- Stigma, marginalisation and a sense of being different from the normative model can lead to clients experiencing unique stressors and challenges in their lives. Counsellors should know about these challenges and adapt their counselling and counselling centres (ICTC, STI and ART) to provide affirmative services to their clients.

Annexure

Annexure I Activity 1: Identities for piece of the sky

(Please cut along the dotted lines and fold the same into small chits)

Heterosexual married woman who is a house wife. Her husband works as a taxi driver

---

Heterosexual Hindu male, who is married, is an engineer and works in a government undertaking

---

Female sex worker who operates from a brothel

Hindu policeman who is single

MSM who works in a massage parlour

Gay man who works in a multinational company

Female IDU who is Catholic

Unmarried Muslim male who works as an embroider

Unmarried Hindu girl who is a teacher in a public school

Transgendered person who begs for a living

Transgendered person who works as a dancer in a dance bar

Home based female sex worker who is married

Muslim male who has migrated from his hometown, lives in Delhi and works at a construction site

Lesbian woman who works as a receptionist in a five star hotel

Male who is undergoing the sex reassignment surgery procedure and works in an NGO

Bisexual man who works as a watchman

Hindu male who works as a rag picker

Muslim girl who holds a doctoral degree and works as a professor in a university

Catholic female who works in a bakery

Parsi female who runs a boutique

List of questions for the facilitator: (Not to be photocopied)

1. **Will you get a loan?**
2. **Can you make your passport?**
3. **Can you hold your lover's hand in public?**
4. **Can you go abroad for further studies?**
5. **Can you marry your lover / lovers?**
6. **Will you get respect in a public health setting?**
7. **Can you adopt a child?**
8. **Can you get a job in the government sector?**
9. **Does your family know about your profession?**
10. **If yes, is your family proud of your profession?**
11. **Do you get promotions at your work place?**
12. **Will you get medical insurance?**
13. **Does the majority of the country celebrate your festivals?**
14. **Can you afford an IVF?**
15. **Can you contest in an election?**

SESSION 6

Understanding Vulnerability and Risks of High Risk Groups (Core Groups and Bridge Population)

Session Overview:

- Activity 'Truth of the Matter' – 20 minutes
- Case study presentation by groups
- Power point presentation by the facilitator on each case study
- Summarisation – 5 minutes

} 1 hour 50 minutes

Session Objectives:

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

- Describe the reasons of vulnerability of various high risk groups i.e. core groups (FSW, MSM, TG, IDU) and bridge population (Migrants and Truckers).
- Get information on counselling strategies for High Risk Groups (HRGs).
- Apply the knowledge and skills learnt in the session, while counselling HRGs.

Time allowed:

- 2 hours 15 minutes

Material required:

- Two posters, one with the term TRUE and the other FALSE
- Chart papers
- Sketch pens/markers
- PPT / Projector
- Photocopies of case studies

Method:

Preparation before the session:

Activity I - You, as the facilitator, will place two posters, one on either side of the training hall with the terms TRUE and FALSE.

Activity II – (to be done as a homework assignment the previous day and presented by the group on the day of the session). Prepare sufficient photocopies of case studies so that each participant will get a case study of his/her group. Distribute the case studies the evening prior to the session and ask the respective groups to make a presentation on the same on a chart paper for discussion on the next day. Each case study shall be presented for 8-10 minutes by each group before the topic on the PPT and you can explain the slides post discussion of the case for 10 minutes.

The participants can add on points they might have missed or not known before and refresh the presentation of the case study.

If time permits the groups can present their cases once again at the end of the session as a refresher.

Activity I: Truth of the Matter – 20 minutes *

1. Ask the participants to stand in the middle of the training hall, with the posters saying 'True' and 'False' on their either side. Inform them that you will read out a statement. When they hear the statement, they have to individually decide whether it is true or false, and according to their view, they have to move towards the respective poster.
2. Read out each of the statements given in Annexure 1and give the participants a moment to move towards the poster of their choice. You may ask some participants why they elected to move towards 'True' or 'False'. But do this briskly.

After all the statements have been read out, ask the participants briefly what they thought of the exercise. Each participant should be given an opportunity to express their views.

Politely inform them that every single statement you read is false and discuss the details. You may focus on one or two particular statements. However, inform the group that more details follow in the session. If some participants try to force their opinions on others, inform them politely to avoid it and engage in proper discussion.

**(The above activity is adapted from Refresher Training Programme for ICTC Counsellors – second edition developed by NACO, April 2011)*

Activity II: Group presentation on cases studies and PPT (1hr 50 minutes)

1. Divide the participants in 5 groups. Give one case study to each group the day prior to the

session. Ask them to read the case study and note down major points in terms of various issues faced by the key persons, reasons of their vulnerability and counsellor's role with reference to that case.

Refer to annexure II for case studies.

2. On the day of the session ask each group to make a presentation for 8-10 minutes on the above points. Ask other participants to add points, if missing, in the presentation. Facilitator needs to explain the topic on the PPT and debrief after each case presentation. **(Total time for case presentation – 50 minutes i.e., 10 minutes for each group) Power Point Presentation (60 minutes) – (10 minutes for each topic in the case study)**

Activity III: Summarisation (5 minutes):

Ask participants to narrate key points discussed during the session.

The following points need to be emphasised –

- HRGs are vulnerable to HIV because of various reasons e.g. marginalisation, poverty, gender issues, living conditions, lack of awareness, lack of education, limited choices, limited or no access to services and various other systemic and structural factors as well as psychological factors.
- The categories of Core groups and Bridge population may not be exclusive. Many persons belong to various categories at the same time e.g. a person can be a truck driver as well as IDU and MSM. A young girl can be an IDU as well as a sex worker. MSM can be in sex work.
- While counselling, the counsellor need to understand the reasons of vulnerability of the clients.
- Marginalisation is one of the major reasons of vulnerability.
- The counsellor needs to carry out the detailed risk assessment of each client.
- HRGs may find it difficult to utilise various services due to various reasons like systemic issues, stigma and discrimination, or lack of information about services. The counsellor needs to address these issues and make appropriate strategies so that these groups can avail the services.
- Counsellors need to be sensitive about the needs of these groups and should have unconditional positive regard for all clients.
- While considering the language difficulties and literacy level, counsellors need to make use of simple language and also utilise visual material to make the information simpler.
- Counsellor need to link the clients with STI and TB services as per the NACP guidelines.
- Apart from HIV services, counsellors need to link the clients with TI NGOs and other social protection schemes.

Key messages:

- HRGs (Core groups and bridge population) are vulnerable to HIV because of various reasons e.g. marginalisation, poverty, gender issues, living conditions, lack of awareness, less or no education, limited choices, limited or no access to services and various other systemic and structural factors.
- The categories of Core Groups and Bridge Population may not be exclusive. Many persons belong to various categories at the same time e.g. a person can be a truck driver as well as IDU and MSM. A young girl can be an IDU as well as a sex worker.MSM can be in sex work.
- While counselling, the counsellor needs to understand the reasons for vulnerability of clients.
- Marginalisation is one of the major reasons of vulnerability.
- The counsellor needs to carry out a detailed risk assessment of each client.
- HRGs (Core groups and bridge population) may find it difficult to utilise available services due to various reasons like systemic issues, stigma and discrimination, or lack of information about services. The counsellor needs to address these issues and make appropriate strategies so that all clients who need these services can avail them.
- Counsellors need to be sensitive about the needs of people from HRGs and should have unconditional positive regard for all clients.
- In case of language difficulties and lower literacy level, counsellors need to make use of simple language and also utilise visual material to convey the necessary messages.
- Counsellors need to link the clients with STI and TB services as per the NACP guidelines.
- Apart from HIV services, counsellors also need to link the clients with TI NGOs and other social protection schemes as and when needed.
- **Counselling process should not be limited only for providing HIV related information and services but it should also aim to empower the client.**

Annexure

Annexure I: Statements for Activity I 'Truth of the Matter' –

1) Counsellors should advise MSM clients to become heterosexual for their own well being.
2) Some boys become transgender /hijras (TG) because their parents grow them like a girl child.
3) All MSM have anal sex.
4) All MSM clients have feminine look and they behave in a feminine manner.
5) All hijras sell sex.
6) All sex workers enjoy sex and so they are in this profession.
7) Sex workers should take more responsibility to control the HIV/AIDS epidemic.
8) Migrants are irresponsible as they bring back the HIV epidemic to their homes.
9) All migrants have sex with sex workers.
10) Long distance truck drivers are careless. They drink and have accidents.

Annexure II: Cases for Activity II 'Discussion on case studies'

1. Case study for MSM Counselling

Sohaib was a 24-year-old matriculate belonging to an orthodox Muslim family in a district of North India. He was soft spoken, with fair complexion and fairly good looks. At the age of 17, he came to Mumbai and started working in his uncle's garage to make a living and to learn the trade of a motor mechanic. His uncle was married and used to stay with a few other migrants from North India. His wife lived away in the village with their three children. The uncle soon started asking Sohaib for sexual favours against the obligation of keeping him in the job. Sohaib felt helpless and had no other support in the city except his uncle. His 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, Sohaib 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 campaign organised by SACS for migrants. He met a counsellor there who gave him information about the routes of HIV transmission. Sohaib was frightened and decided to get himself tested. He gathered the courage to visit the ICTC at his district despite the fear of being found out. During the counselling session he disclosed his sexual identity to the counsellor. He was tested negative for HIV. Counsellor counselled him and further suggested that he should undertake HIV test regularly i.e. quarterly or at least once in six months.

Presenting problem:

After a few months Sohaib came back to the ICTC once again for his regular HIV testing. Sohaib had gotten married a month back because of immense family pressure. He informed the counsellor that he had sexual intercourse with his wife a few times without condoms. He also informed the counsellor that after a few months there will be family pressure to have a child.

After a few months he was tested for HIV and found positive. Sohaib 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.

Questions for discussion:

- What are the major issues to be discussed in this case?
- What were the reasons of Sohaib's vulnerability?
- What is the role of a counsellor in this case?
- How should the counsellor handle various emotions expressed by Sohaib?
- How are the categories of HRGs not exclusive but overlapping?

2. Case study for FSW counselling

A 29-year-old woman Neela is into home based sex work. She has been in the profession for over 10 years. She is married and has children and engages in this work purportedly without the knowledge of her family. The husband does not support the family economically and is an alcoholic. She belongs to a family from the lower economic strata and has received very little education.

She has used condoms occasionally saying that some customers do not want to use condoms and are willing to give more money for that. She has the apprehension that if she keeps the condoms, her husband may doubt that she is into sex work and so it is risky for her to keep condoms. She was tested negative for HIV last month but has come to the counsellor as her white discharge is not getting cured. She also informs the counsellor that she will not be able to come to the hospital regularly for HIV testing because her family members may ask her the reasons for visiting the hospital.

Questions for discussion:

- What are the major issues in this case?
- What are the reasons of Neela's vulnerability?
- How can the counsellor address her issues?
- What are the difficulties faced by home based sex workers?

3. Case study for IDU Counselling

Sunny was a 24-year-old male from a Sikh family. He had 12 years of schooling. His father was no more. He had a sister and a brother. His mother was a school teacher in a North Indian city. He had never liked to study or to be bound by rules. Unable to handle his indiscipline any longer, he had been sent by his mother to another city, where he lived with his uncle and continued his schooling, but also made friends with some miscreants. He also started to take intravenous drugs. When his uncle discovered this, he took him out of the school and put him to work in his transport business.

There he got himself to the ways of the transport operators and was also soon engaging in sex with an FSW. He was convicted of a criminal offence and was put behind bars. His drug addiction continued even in the jail. He used to steal used injections discarded by the jail doctors for injecting, and the drugs were smuggled into the jail. He also began having sex with men. He was tested positive for HIV and started on ART, however, he did not disclose this to his mother and siblings. He decided to go back to his home town as he was severely sick. He consulted a local doctor for severe cough, and was found to have TB. Meanwhile Sunny was extremely unwell, depressed, and did not want to live any more.

Presenting Problem:

A friend brought him to the IDU Targeted Intervention NGO in the city. The counsellor in the TI counselled him and also took him to the sanatorium for treatment of his persistent cough. Meanwhile Sunny did not disclose either his high risk behaviour or his HIV positive status to the TI counsellor. The TI counsellor referred him to the ICTC for testing, where he also accompanied him. On the way, Sunny disclosed his high risk behaviour and his HIV status to the counsellor. However, he was counselled and tested again at the ICTC and tested positive.

The issue was now of referral and continuation of ART and also of disclosure of the test result to his mother and family members. His siblings asked their mother to throw him out of the house immediately. His mother felt helpless and hopeless. However, after she was counselled by the TI counsellor, she decided to take care of the son. After requisite follow up by the ICTC and TI counsellors, Sunny produced his papers of ART for starting the treatment afresh at his hometown. His ART began soon after his TB treatment.

Presently, Sunny has recovered significantly. He has also shown tremendous behaviour change. He has opened his own small business. From a regular injector, he has turned into a low volume injector. He also picks up condoms from the TI NGO regularly and says that he practices safer sex.

Questions for discussion:

- What are the major issues in this case?
- What are the factors which are making Sunny vulnerable?
- What can a counsellor do if a client does not disclose the source of infection or some other crucial information like sexual history or history of taking drugs?

- Besides referring him to the TI NGO, what else could the counsellor do while dealing with this client?
- How are the categories of HRGs not exclusive but overlapping?

4. Case study for counselling migrant population

Soman was a 37-year-old unmarried male from a lower socio economic class family in Kerala. He had been working as a cook in a circus for the last 16 years, but did not have sufficient savings. Once in a year or so he used to visit his family.

Presenting problem:

Soman went to the counsellor at the STI clinic through the public relation officer (PRO) of the circus because he had been having an itching sensation in the genital region. While the PRO waited outside, the counsellor heard the client patiently. As part of history taking, Soman revealed that the pain, itching and ulcers in the genital region were there for the last few months, and it was never treated. When the counsellor took his sexual history, Soman reported engaging in high risk sexual activities with multiple partners - men and women. Soman was then referred to the Medical Officer who carried out a careful examination, and sent Soman to the counsellor with a kit medicine. The counsellor provided essential guidelines on use of the medicine, regular follow up, partner notification, safer sex practices and so on. Thereafter Soman was referred to the ICTC for VDRL and HIV tests.

Soman approached the ICTC counsellor the next day itself with the results. He was tested positive for HIV. Soman was a bit nervous about the result that was disclosed by the ICTC counsellor. The STI counsellor prepared the client to cope with the results as an initial step. Subsequently he described the importance of the regular usage of STI medicine and ART registration and advised Soman to visit the STI clinic after 7 days. The counsellor also showed and handed over relevant IEC material among the circus artists and other employees with the help of Soman and PRO without disclosing the HIV status of Soman.

After a week, Soman visited the counsellor again. The counsellor noticed that the client got registered at the ART centre and his STI symptoms were consistently reducing. Later he was referred to a clinician to continue the treatment. The counsellor also linked Soman to the network of positive people associated with the STI clinic. As Soman was HIV positive, he was invited to be an outreach worker in the positive people's network, and he joined them.

Questions for discussion:

- What are the issues faced by Soman?
- Why migrant population is vulnerable?
- How have counsellors played a supportive role in this case?
- What role can a peer play in creating awareness among migrant population?

5. Case study for counselling Truckers

Rambabu, a 32-year-old man is a long distance truck driver. He is from a farmer family but because of consistent drought, his father left the village and came to a city to make a living. Rambabu became a truck driver and began earning enough to feed his family, but it was not sufficient because of pressing needs in the family like clearing debts, father's illness, sisters' marriages and so on. Rambabu used to work quite hard to earn more and more money. Since the last year he had not been feeling well. He felt very tired and his health was deteriorating. He had developed the habit of drinking. He had gotten married a few months back but his wife left him. Now he was sexually involved with a dhaba based sex worker.

Presenting Problem:

Rambabu consulted a clinic run by an NGO and as per the outreach worker's advice, and got tested for HIV at an ICTC. The result came out to be positive. He informed the counsellor that he did not have any hope in his life and he was not interested in registering for ART. He also informed that he had to reach somewhere early next morning and that he could not wait further at the clinic.

Points for discussion:

- What are the issues faced by Rambabu?
- What are the reasons of his vulnerability?
- How can the counsellor address his issues?
- Why truckers are vulnerable?
- What strategies of linkages need to be followed for truckers as they cannot wait at one centre for a long time?

Following TV show/ films can be shown if time permits –

https://www.youtube.com/watch?v=mHr87BxZYcw (Satyamev Jayate episode 'Accepting Alternate Sexualities', duration 1 hr 11 minutes)

https://www.youtube.com/watch?v=vT7W8vOb7Cc (Film 'In The Flesh' by Magic Lantern. 2 minute film on lives on women and TG in sex work)

SESSION 7
Enhancing Counsellor Competence

Session Overview:

- Objectives and instructions – 10 minutes
- Preparation time – 50 minutes
- Demonstration and discussion – 2 hours 20 minutes
- Summing up – 10 minutes

Session Objectives:

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

- List the skills and competences required for counsellors.
- Practice the competence required for counsellors.
- Know when and how to apply counselling skills in HIV counselling setting.

Time allowed:

- 3 hours 30 minutes

Materials required:

- Chart paper
- Papers
- Markers

Method:

Preparation before the session:

You as the facilitator will photocopy the handout "Enhancing Counsellor Competence" for all the participants. Because the session requires a lot of reading, it would be ideal to translate the handout into the local language in advance.

- Divide the participants into 5 groups; distribute the handout to all the participants.
- Each group will be given one set of skills, namely:
  - Group 1 – Inter personal relationships
  - Group 2 – Gathering information
  - Group 3 – Giving information
  - Group 4 – Handling special circumstances
  - Group 5 – Counselling skills
- Inform the participants that each group has to go through their set of skills in the handouts and prepare a role play demonstrating that particular set of skills. The verbatim statements given in the handout can be used in the role play.
- The facilitator will have to play an active role in this activity and may need to step in to clarify, correct or demonstrate a particular skill as and when required.
- Facilitator needs to emphasise that participants need not present any case in detail. Only demonstration of the skill is required.
- For the role plays, follow the 'instructions to the training institutes' given in the beginning of the manual.
- The groups will be given 50 minutes to prepare for skill demonstration. After this, each group will get about 25-30 minutes for demonstrating the skill through role plays.

Key points to emphasise:

- ✓ It would be best if an experienced and practicing counsellor / psychotherapist facilitates this session.
- ✓ These are the basic skills required for counsellors to undertake HIV counselling.
- ✓ The information gained and attitudes developed by the counsellors during the training programmes have to be translated into practice by using these sets of skills.

Tips to the facilitator:

- The skills partly overlap with each other. Kindly communicate the same to the participants as well.
- The handout is given as an aid for the participants to develop their role plays. Please feel free to substantiate the description of the skill or the verbatim mentioned in the handout during the course of the session.

Key messages:

- The counselling skills and competences covered in this session **are very crucial to effective counselling.**
- Counsellors need to practise and internalise these proficiencies. With practice these skills becomes more natural.
- Skilful counselling does not necessarily require more time. Counsellors need to understand when and how to use the skills even in a five minute interaction with the client.
- Skills cannot be considered in isolation. Appropriate attitude (as discussed in the session on self awareness) and subject knowledge are also MUST for effective use of any skill.
- Empathy is a key skill in counselling, wherein a counsellor is able to put oneself in the client's position and understand what the client must be thinking and feeling; and then conveying to the client what has been understood.
- Certain skills and techniques like use of silence, confrontation, disclosure, handling defensiveness are important and need practice. Practice of different skills can also be done through discussion and role play during supervisory visits.

SESSION 8
Body Basics and Family Planning

Session Overview:

- Discussion of body mapping -10 minutes
- Lecture session using slides -50 minutes

Session Objectives:

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

- Describe the structure and functions of male and female external and internal reproductive/ sexual organs.
- Understand where STI/RTI occur.
- List different family planning methods available in India and their use in the context of people with HIV/ STI/RTI.
- Address issues related to family planning in the context of sero-discordant couple.

Time allowed:

- 1 hour

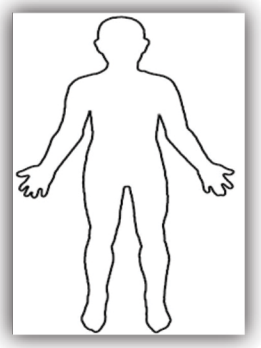
Material required:

- Body map
- Drawings/ cut outs of pictures of external and internal male and female reproductive / sexual organs
- Power-point Presentation
- Different methods of contraception

Method:

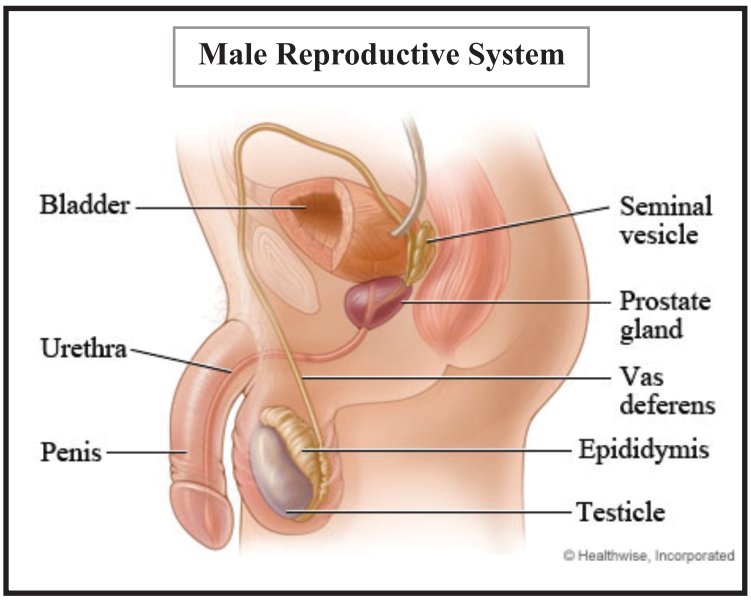
Preparation before the session:

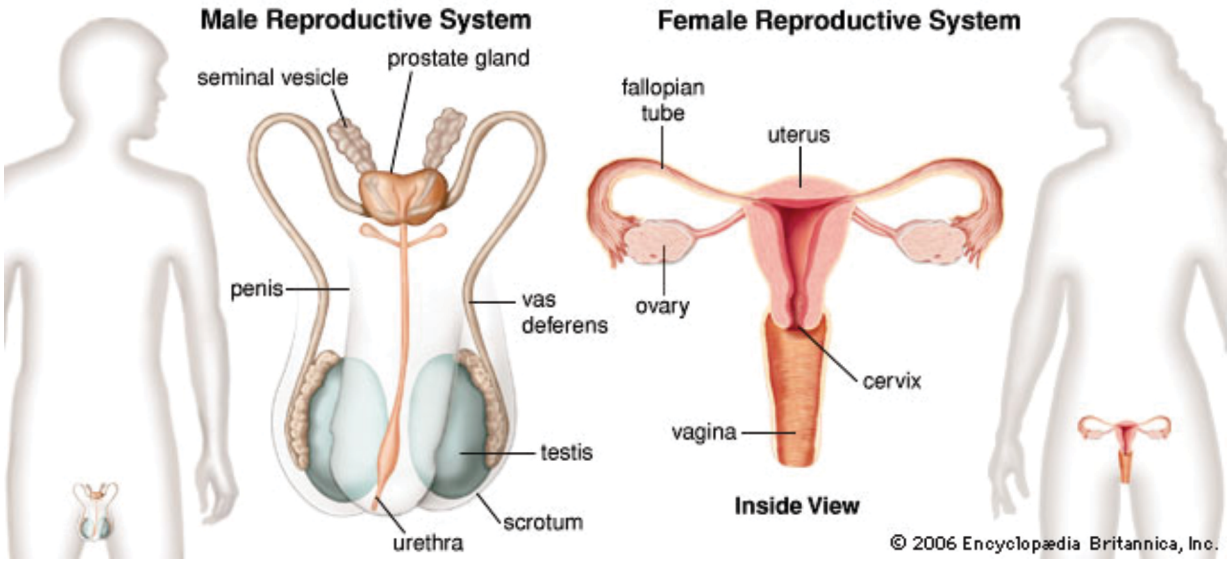
1. The training institute needs to prepare a body map in advance. To prepare a body map three chart papers may be stuck with each other using tape or glue. A body outline of any volunteer / staff needs to be drawn on the chart paper as shown in the figure below:

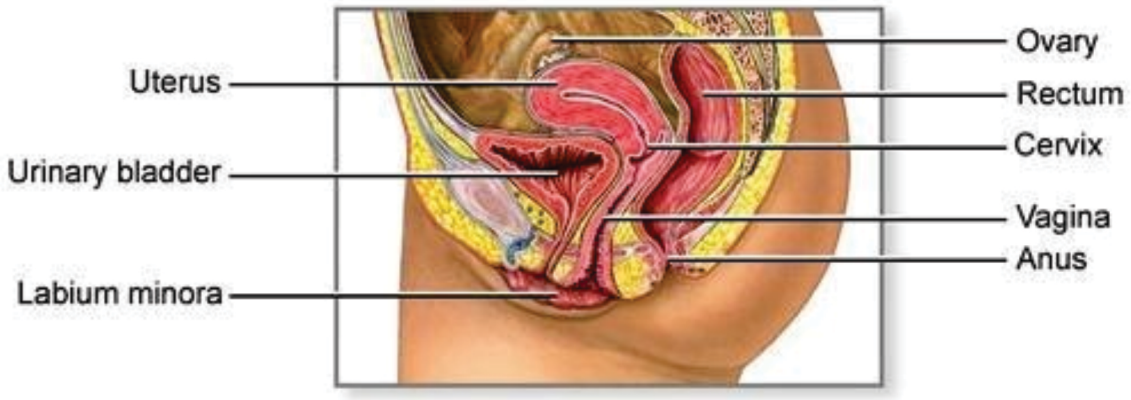


2. The session needs to be facilitated by a medical professional.

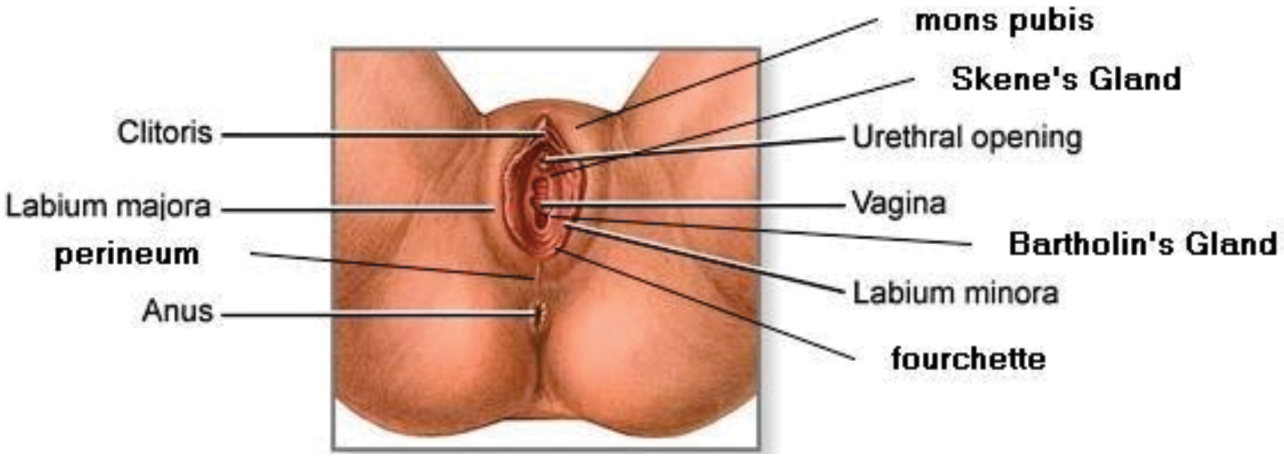
3. Drawings / cut outs of pictures of internal and external male and female reproductive / sexual organs may be either prepared by the training institute or the facilitator may be requested to bring the same. (In case the drawings / cut outs are not available, the facilitator can photocopy and use the figures given below.)







Female Reproductive System



Female Reproductive System

1. **Discussion of body mapping (10 minutes)**

   Using the body map and the drawings / cut outs of pictures of body parts, the facilitator needs to clarify the structure and function of different sexual and reproductive organs. The drawings / cut outs need to be placed at the appropriate places on the body map, and the participants need to be made familiar and comfortable with the names of all the body parts.

Tip to the facilitator:

Please ensure to not disclose the name of the person who has volunteered to be the model for body mapping to avoid embarrassment and to stay focused.

2. **Lecture using slides (50 minutes)**

   - The facilitator needs to explain the key points in the session using slides.
   - The facilitator needs to demonstrate a sample of different contraceptive methods to familiarise the participants with the same.

Key Messages:

- Understanding one's own body, especially sexual organs, is essential for everyone.
- Poor knowledge and lack of sanitation facilities lead to poor genital hygiene, especially in women, resulting in Reproductive Tract Infections (RTI). This increases their vulnerability to other genital infections and illnesses including STI and HIV.
- It is important to understand social norms associated with maleness and femaleness as well as the various facets of gender inequality in sexual relationships. This knowledge provides the counsellor with confidence in dealing with clients' sexuality issues in the context of HIV.
- Counselling on family planning methods discusses two aspects:
  - How well the method works to regulate pregnancy.
  - How well the method works to prevent transmission of HIV and other STI.
- Not all methods are suitable for everyone. A family planning method may be at times useful or may cause additional harm in PLHIV with an underlying medical condition.
- Ask every client who is married or in a committed relationship about the number of children they would like to have, and what method they use to plan their family. Planning a family can mean delaying pregnancy as well as limiting the number of children.
- Be gender-sensitive – do not discuss only the female contraceptive methods.
- Address HIV prevention concerns clearly.
- Guide the clients clearly about where and when they may access family planning services.

SESSION 9
Basics of STI / RTI

Session Overview:

- Lecture using slides (45 minutes) or
- Modular reading (45 minutes)
- Discussion (15 minutes)

Session Objectives:

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

- Define STI and RTI.
- Name some common STI and RTI.
- List the modes of transmission of STI and RTI.
- Describe conditions that put people at greater risk of STI and RTI.
- Correct common misconceptions related to transmission of STI.
- Counsel clients on getting diagnosed and treated for STI/RTI.
- Refer clients for further follow up to the STI clinics.

Time allowed:

- 1 hour

Material required:

- Slides related to the session
- Participants handout

Method:

Lecture using Slides (45minutes)

1. Explain the key points in the session using the slides and the dialogue given for your convenience.

Optional: Modular Reading (45 minutes)

- You, as the facilitator, will ask counsellors to open their handouts titled Basic Fact Sheet on STI/RTI.
- Invite a volunteer with a loud and clear voice to read out a section.
- Stop the reading and explain that section. Remind participants to make notes on their handouts.
- Invite another volunteer to read the next section and follow the same pattern till all sections are read.
- There are facilitator notes in the PPT slides for your assistance. Use them at your discretion.

Note: In case some participants are not comfortable reading in English, they should be given the choice to refuse.

Discussion (15 minutes):

Answer any queries or doubts of the participants during or after the modular reading / slide presentation.

Key messages:

- **Sexually Transmitted Infections** (STI) are infections that are spread primarily through person-to-person sexual contact. STI reflects **modes of transmission of infection**.
- **Reproductive Tract Infections** (RTI) are infections which are present in the reproductive tract of males or females. RTI represents **site of infection**.
- Not all reproductive tract infections are sexually transmitted and not all sexually transmitted infections are located in the reproductive tract.
- STI often, **but not always** cause discomfort and pain to people who have them.
- STI can **spread** quite easily to other people.
- STI can cause **serious health problems** such as infertility, stillbirth, ectopic pregnancy and blindness in newborns.
- Shame and guilt over STI / RTI make people delay treatment or visit quacks for help. So it is important for the counsellor to be **respectful and nonjudgmental** with every client to get the required treatment and emphasise the importance of **complete treatment**.
- Make sure that during counselling you address any **misconceptions** such as, "patients cannot have more than one STI at a time," or "sex with a menstruating woman causes STI."
- Some forms of sex like **anal sex** make the transfer of STI organisms easier. But **all forms of sexual contact** can transmit infection.
- Women and adolescents are more prone to get STI.

SESSION 10
STI Syndromic Management Counselling

Session Overview:

- Lecture using slides (5 minutes) (slides1-5)
- Sorting exercise (5 minutes) (slides 6-18)
- Modular reading assisted with slides (55 minutes) (slides19-43)
- Processing exercise (20 minutes) (slides 44-48)
- Quiz (20 minutes) (slides 49-60)
- Lecture using slides (10 minutes) (slides 61- 65)
- Role play (15 minutes) (slide 66)
- Lecture using slides (20 minutes) (slides 67-80)

Session Objectives:

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

- Differentiate between signs and symptoms.
- Explain the concept of syndromic case management.
- Apply the information sheets for management of common syndromic conditions in India.
- Carry out patient education relevant to each of the syndromic conditions.
- Understand what a counsellor in the STI/RTI service should do in relation to HIV.
- Explain the importance of partner management.
- Make appropriate referrals for STI/RTI clients.

Time allowed:

- 2 hour 30 minutes

Material required:

- Flipchart
- Markers
- PPT slides / Projector

Method:

Lecture using slides (5 minutes)

You, as the facilitator, will begin the session by explaining the difference between a sign and a symptom using the slides.

Sorting exercise (5 minutes)

Ask counsellors to turn to the Sorting exercise in their handouts and ask them to sort out the various terms given into two categories: Signs or Symptoms

> Syndromic management of STI relies heavily on the doctor recognising the signs and eliciting the symptoms from patients. So let us do an exercise. Look at the exercise in your handout. Sort the statements into the columns for Sign and Symptom. You have 5 minutes for the job.

Debrief using the slides (Slide 6 to 18 are related to the exercise)

Slide 6 is the instruction slide. Slides 7 to 18 are the debriefing slides which contain the answers. They are animated slides. A mouse click will highlight the answer.

Answer key to the exercise-

(Clue is underlined)

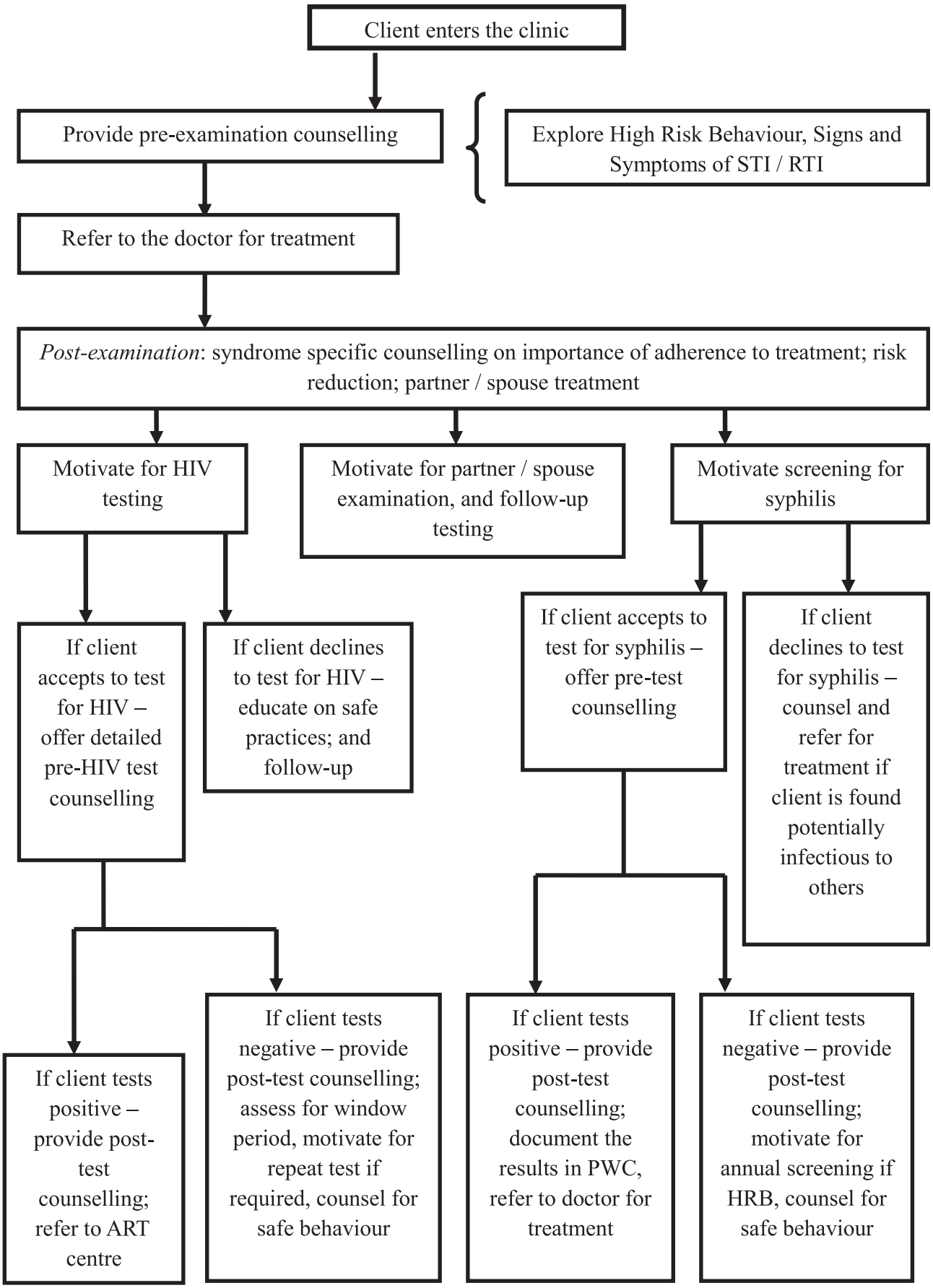
- Woman says, "I have a discharge from my vagina." - SYMPTOM
- Discharge is seen from the anus. - SIGN
- On physical examination, sores, ulcers, blisters, small hard lumps or rashes are seen in and around the sexual organs. - SIGN
- Man says, "Oh! I have a discharge from my penis." - SYMPTOM
- Teenager says, "My mouth burns when I have to eat food." - SYMPTOM
- Doctor examines teenager's mouth and finds blisters or sores inside the mouth. - SIGN
- Sore throat sensation - SYMPTOM
- Pain in vagina while having sex - SYMPTOM
- Burning sensation in vagina - SYMPTOM
- Lower abdominal pain - SYMPTOM
- Frequent urination - SYMPTOM
- Patient complains of swelling of scrotum/ groin area - SYMPTOM

Modular reading assisted with slides (55 minutes)

Continue the lecture using the slides (Slides 19-43). Ask counsellors to continue reading the section on Syndromic Management in their handouts. Discuss each syndrome listed on the slides while pointing to the handouts when necessary.

Slide 43: Below is the Standard Operating Procedure (SOP) for STI/RTI Counsellors to ensure quality counselling services:

FLOW CHART FOR STI/RTI COUNSELLORS



Processing exercise (20 minutes)

As an energiser, ask the counsellors to stand in order of when they have joined the SACS as a counsellor. Some might have earlier worked as an ICTC counsellor. Please see diagram:

1year 3mths 2 years 2 years 5 mths 3 years 2 mths 5 years

Ask 4 senior-most counsellors to come forward and let each of them choose an equal number of people to join their team.

Inform them that each group will have 20 minutes to review a certain section of the handouts and to answer the following questions **(Slide 44)**:

a. What do you notice is common in these syndromes?

b. What do you notice is different in these syndromes?

c. What are the implications for patient education and counselling?

Ask 3 groups to read the handout pages related to Urethral Discharge Syndrome, Painful Scrotal Swelling Syndrome, Inguinal Bubo Syndrome, Genital Ulcer Syndrome (Non-herpetic) and Genital Ulcer Syndrome (Herpetic).

Ask the other 3 groups to read the handout pages related to Vaginal Discharge Syndrome, Cervical Discharge Syndrome, Lower Abdominal Pain and Oral/Anal STI.

After 20 minutes, stop the group reading and record the answers on a flipchart. Participants should be able to recognise that:

a) Many of the complications from untreated STI are similar.

b) They cause damage to body organs.

c) Sexual partners also get affected.

d) There are many contra-indications during pregnancy. Full and complete treatment is required.

e) The symptoms of different syndromes are quite distinct – especially in males and females.

Conduct a group discussion on the following questions **(Animated slides 45- 48)**:

a) How easy is it for a person with an STI to come for treatment?
Answer: It is not easy. There are many barriers.

b) When are they likely to come?
Answer: When their symptoms become unbearable.

c) Who might not be likely to come?
Answer: People who are asymptomatic. Women: because they do not want to speak to a male provider.

d) What makes it easier for a person with STI to seek treatment?
Answer: Caring, non-judgmental health care providers.

Review with the quiz on the **Animated slides 49 – 60 (20 minutes)**

a) Imran Khan comes to your STI/RTI centre. After seeing the doctor, he comes to you with his patient-wise card which reads under diagnosis "LAP." What's wrong with this scenario?
Answer: Imran is a man. LAP is a woman's complaint.

b) What is DOTS-STI? Which drugs/ drug kits come under the category of DOTS-STI?
Answer: DOTS-STI stands for Directly Observed Treatment – STI. It includes Kit 1 which contains drugs like sd-Azithromycin and sd-Cefixime (stat) which are taken in the presence of the health worker.

c) Name a syndrome which is seen only in males.
Answer: Urethral discharge syndrome, Painful scrotal swelling syndrome.

d) Which disease when passed on from a mother to her baby during delivery can affect the baby's eyes and even lead to loss of eyesight?
Answer: Gonorrhoea and Chlamydia.

e) Name a drug which should not be taken during pregnancy.
Answer: Doxycycline (Kit no.6 and 7) and Podophylin.

f) Name one condition that can be linked with cervical cancer in women.
Answer: Certain types of warts.

g) One syndromic drug when taken with alcohol can cause nausea, vomiting, flushing and sinking feeling. The counsellor will advise the client not to take any alcohol until 24 hours have passed after the last dose is taken. Which drug is this?
Answer: Secnidazole and Metronidazole. So counsellors should clearly advise patients who take this medicine to avoid taking it along with alcohol.

h) Which syndromic condition may recur during stressful periods?

Answer: Genetic ulcer disease syndrome (Herpetic). So counsellors advise such clients to find ways to reduce stress.

i) For which drug does the client have to make repeat visits to the clinic on the 7th day, the 14th day and the 21st day?

Answer: Doxycycline (100 mg) BID for 21 days which is used for treating Inguinal Bubo Syndrome. This is part of patient education when dealing with this Drug Kit (Kit 7)

j) Which syndromic condition is sometimes treated with an injection of penicillin?

Answer: Genetic ulcer disease syndrome (non-herpetic) which can be cured with an injection of Benzathine penicillin in each buttock.

k) When counselling pregnant women, information about STI is very important. What are some of the consequences of the mother's untreated STI to a new-born baby?

Answer: Still-birth, eye infection.

l) If a client with herpes argues with a counsellor that herpes sores heal on their own after10-14 days and therefore there is no need to get treated, how should the counsellor respond convincing the person to take treatment till the end?

Answer: The counsellor can explain to this client that the medicines for herpes shorten the time of healing. Further, if the client's herpes cures faster, it may be possible to resume sexual relations that much faster.

Role Play (15 minutes)

- Invite 2 volunteers to role play a situation of a counsellor preparing a patient with Genital Ulcers-non-herpetic to bring their partner for treatment. (See slide 65)

- Ask the group to make sure that the volunteers cover all the arguments in favour of referral by client.

Lecture using slides: Referral services for STI/RTI patients (Slides 68-77)

Key messages:

- A symptom is what the client / patient complains of or reports to a doctor.
- A sign is that which the doctor /counsellor observes on examination of the client / patient.
- People with no symptoms (asymptomatic) should also be treated.
- Most of the STI/RTI are asymptomatic.
- Syndromic management is to identify the syndrome affecting the patient with the help of signs and symptoms and to treat all infections that could possibly cause that syndrome.
- Treatment for STI/RTI is:
  - ✓ To be taken from a trained doctor.
  - ✓ To be taken for the duration prescribed.
  - ✓ To be taken in the dosage prescribed.
  - ✓ To be also given to the sexual partner.
  - ✓ To use condoms during treatment.
- More than 50% of STI in women are without symptoms!
- Women are more easily infected than men.
- STI/RTI in women can lead to a number of complications like infertility, cancer and so on.
- Untreated STI/RTI in women can affect her child: still born, abortions, eye infections at birth.
- Presence of an STI can increase risk of acquisition and transmission of HIV 5 to 10 times!
- Explain and encourage HIV testing to a client presenting with STI/RTI.
- Establish referral services to other centres.
- Network for expanded STI and HIV care and support - general laboratory, ICTC, PPTCT, ART, CCC, and TB-HIV, for example.
- All STI are curable except HIV, Herpes and Hepatitis B.
- **Partner management is needed in case of STI to prevent:**
  - ✓ STI re-infection.
  - ✓ Further spread of STI.
  - ✓ Possible long term effects of untreated STI for the partner.
- Encourage the patient to take his/ her prescribed STI/RTI treatment.
- Help him/her understand how to avoid re-infection.
- Help him/her understand the importance of possible transmission that might have occurred and further transmission.
- Help him/ her on how and what to communicate with partner(s).

SESSION 11
Basics of PPTCT and Programme Guidelines

Session Overview:

- Reading the PPTs – 90 minutes
  - Cause and occurrence of HIV in children.
  - Factors that increase and decrease transmission of HIV from Mother to Child.
  - Four prongs for PPTCT.
  - Importance of lifelong ART for HIV positive pregnant mothers.
  - Choice of ART regimen for pregnant mothers / PPTCT scenarios.
  - Standard Operating Procedures (SOPs) during event of labour.
  - Care for the HIV exposed infant.
- Case studies – 25 minutes
- Discussion – 50 minutes

Session Objectives:

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

- Gain knowledge about the cause and occurrence of HIV in children.
- Enumerate the factors that increase and decrease the transmission of HIV from mother to child.
- Understand the four prongs of the PPTCT Program.
- Understand the importance of lifelong ART for HIV positive pregnant mothers.
- Gain knowledge on the SOPs during the event of labour and care for the HIV exposed infant.
- Practice methods of prevention of transmission of HIV from infected mother to her child.

Time allowed:

- 2 hour 45 minutes

Material required:

- Paper / pen
- PPT slides and projector

Method :

You as the facilitator:

- Read the PPTs and explain to the participants.
- Mail a copy of the handout on 'Basics of PPTCT and programme guidelines' to the participants one week prior to the training programme.
- Keep copies of handout ready in-case the participants need to refer to it again.
- Photocopy the case studies and the answer key (1 copy for each facilitator).

Activity 1:

- At the end of the session on ART regimen for pregnant women, the facilitator can give each group a case study to read aloud and select the correct answer.
- Explain the right answer to the participants and also clear their doubts if any.

Key messages:

- Mother-to-child transmission is the main cause of HIV infection in children. It can occur during pregnancy, delivery and breast feeding.
- Four prongs of PPTCT program are as follows:

  1. Primary prevention of HIV (HIV negative, general population (ARSH)).
  2. Prevent unintended pregnancies (HIV positive, not pregnant, family planning counselling in ICTC and more importantly at ART centres).
  3. Prevention of MTCT (HIV positive and pregnant).
  4. Care, support and treatment (HIV positive mother and child).

- All pregnant women at the ART centre need to be seen on priority.
- **India National Technical Resource Group (TRG) recommendation on PPTCT:**

  1. All HIV positive pregnant women including those presenting in labour and breast-feeding women should be initiated on a triple ART irrespective of CD4 count, for preventing mother-to-child transmission risk and should continue life-long ART.
  2. The duration of NVP to infant should be for 12 weeks, especially if ART to mother was started late in pregnancy, during labour or after delivery and the mother has not been on ART for adequate duration (which is at least 24 weeks) to be effective to achieve optimal viral suppression.
  3. This recommendation on extended NVP duration applies to infants who are breast - fed and not those who are receiving exclusive replacement feeds.

Annexure

CASE STUDIES

Case study 1:

- A HIV positive pregnant women comes to the ART centre at 12 weeks with CD4 count >700 mm3. Will you start ART?

  Answer: Yes.

Case study 2:

- Rizwana 24 years old, HIV positive, came directly-in-labour, she is reactive to HIV whole blood finger prick test done by a nurse.
- Do you give ART to the mother?

  Answer: Yes. (Make sure the medical officer in Labour room prescribes ART)

Case study 3:

- Uma 26 years old, HIV positive, no prior ART, breast feeding with CD4 count 1000 mm3. Will you start ART?

  Answer: Yes.

Case study 4:

- Mary, 25 years old, came to know that she is HIV positive at 36 weeks of pregnancy. She was initiated on ART immediately. She is breast-feeding post delivery. How long the new born child should continue on ARV prophylaxis (NVP)?

  A. Till 6 weeks

  B. Till 12 weeks

  Answer: B

Case study 5:

- Suman, 35 years old, came to know that she is HIV positive at 30 weeks of pregnancy. She was initiated on ART immediately. She has decided to do exclusive replacement feeding. How long the new born child should be given ARV prophylaxis?

  A. Till 6 weeks

  B. Till 12 weeks

  Answer: A

SESSION 12

Basics of HIV-TB co-infection and Programmatic Linkages

Session Overview:

- Power point presentation: 1 hour and 30 minutes
- Role Play: 30 minutes

Session Objectives:

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

- Provide correct information on modes of transmission and available diagnosis and treatment for TB.
- Explain the effect of TB disease on HIV status and effect of HIV on TB infection.
- Clarify the myths and misconceptions related to TB.
- Identify patients with symptoms suggestive of TB.
- Refer the TB suspects to RNTCP Unit for TB investigations and further management.
- Be able to keep a record of patients referred to RNTCP Unit.
- Motivate patients with symptoms suggestive of TB to undergo sputum examinations and any necessary examinations.
- Provide adherence counselling for TB treatment, and explain the importance of ART evaluation and treatment.
- Maintain the standard records and reports (as provided by the national programme) on TB-HIV collaborative activities.

Time allowed:

- 2 hour

Material required:

- Computer
- Projector
- Copies of the handout

Method:

Preparation before the session:

You as the facilitator:

-- Keep copies of handout ready.

Activity 1: (one and half hours)

– The facilitator will use power point presentation to explain various aspects of HIV-TB interaction and linkages.

-- To make the presentation interactive, the facilitator will ask questions during the presentation before discussing a particular slide.

-- The facilitator should remind participants to refer to relevant guidelines of NACO.

Activity 2: (half hour)

Role plays

Role Play key for the facilitator

1. Pavani needs to be counselled for HIV and TB. She should be assessed for risk of TB. Explain about TB and then probe for symptoms.

Some questions to discuss the role play:

- You told me that you are having diarrhoea for last 6 months. Apart from this have you been experiencing any other problems? Can you tell me what problems?
- Were you suffering from cough? For how long?
- Can you tell me whether you have any other symptoms which I am going to tell you: Fever, weight loss, night sweats, chest pain on breathing, blood in cough, breathlessness, loss of appetite, tiredness?
- Do you have anybody at your home diagnosed with TB or having cough persistent for more than two weeks?

2. Nidhi is in a shocked situation. She is thinking that she is going to die and is worried about her child. She is also feeling that her husband will hate her. She is not accepting that she may have TB. The counsellor has to counsel Nidhi on why it is important to get tested for TB. Counsellor also needs to tell the implications of HIV on her TB, and what she needs to do now with regards to her TB treatment, and any additional HIV-related care and support.

Sample questions for initiating discussion

"I understand that you are concerned about your child and relation with your husband. I also understand that you do feel that you may die soon. Let me tell you the fact. You can live healthy and look after your child. For that you have to take some steps like taking ARV drugs if required and getting your illnesses treated." Explain to her about ART, need of nutrition and so on.

"I heard from you that you are having cough for last one week. Hope you remember what I told you about TB. Let me once again brief you what TB is and how important this information is for you. Then you can tell me whether there is any chance of you having TB."

Key Messages:

- TB is caused by Mycobacterium tuberculosis and is spread through air.
- HIV infection makes persons:
  - much more susceptible to developing TB disease,
  - more likely to die of TB, and
  - more likely to develop TB again.
- All clients who have symptoms or signs of TB disease, irrespective of their HIV status, should be referred to the nearest facility providing RNTCP diagnostic and treatment services.
- Cough of more than two weeks duration could be TB and all such clients should be referred to RNTCP.
- Among HIV positive persons, cough of ANY duration could be TB, refer them to RNTCP.
- Tell the clients that the TB tests available under RNTCP are adequate to diagnose TB and are accurate. If they do undergo testing at the government facilities, they can also avoid unnecessary expenses.
- Patients with sputum-positive pulmonary TB are the most infectious to others, and priority is given to their care for this reason.
  - Ensure that information on cough hygiene is strongly reinforced.
  - Also inform the patient that if he/she is diagnosed with sputum positive TB, they should get their contacts (family and friends) tested for TB at the nearest health facility.
- Any child in the family aged less than 6 years should also be provided with chemoprophylaxis for TB from the nearest DOTS centre.
- TB is curable.
- TB is curable among HIV positive patients as well.
- Taking complete treatment is the key to success of treatment.
- DOTS is the recommended strategy for treatment in adults and children.
- DOTS ensures that patients complete the treatment.
- DOTS improves survival in HIV positive individuals.
- The key to reducing the risk of tuberculosis transmission at health facilities is early diagnosis and prompt initiation of RNTCP treatment regimens until cure.
- Infectious TB patients become rapidly non-infectious once they are started on directly observed treatment under RNTCP.

SESSION 13
Pre Test Counselling

Session Overview:

- Assessing personal risk (20 minutes)
- Risk assessment (30min)
- Risk game (20 minutes)
- Risk reduction (30min)
- Pre-test counselling (20 minutes)

Session Objectives:

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

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

Time allowed:

- 2 hour

Material required:

- Risk assessment cards
- PPT presentation
- Pre test form

Method:

Preparation before the session:

You as the facilitator will:

1. Keep handouts ready to be distributed to the participants.
2. Translate the risk cards given in Annexure 1 in the local language and keep them ready for the game on risk assessment.

Lecture using slide no. 3-6

- Give introduction to HIV testing.
- Explain process of HIV pre test counselling.
  (Notes are provided under each slide).

Activity 1: Slide 7

Assessing personal risk (20 min)

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

1. Invite participants to consider the following on their own for a few minutes:

'Think back on your own life and identify any occasion when you took a risk, related to sex and relationships, work or money. It may have been a small risk or a big one, but was very important to you at the time.'

- What factors influenced your decision to take a risk?
- What were your feelings at the time?
- What was the result of taking that risk?
- Do you generally take risks?
- How do you view risk-taking in others? How does risk-taking among your friends affect you?
- How does this affect your attitude towards the risk of HIV infection? It may be useful to write these questions down.

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

2. Invite everyone to join the full circle. Encourage them to explore links between how people deal with risk and ways in which it may affect their responses to HIV. It may be useful to make the following points:

   - We often feel that it is all right to take risks if they turn out well. But we tend to blame others if things go wrong.
   - We are generally less harsh in judging ourselves than we are in judging others. Is this fair?
   - We all take risks all the time.

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

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

Risk assessment (30 min)

Lecture using slide no. 8 -10

Activity 2: Slide 18

Risk game (20 min)

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

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

- o Blood splash to the eye during a delivery.
  Low risk only—only one case in the world, which was concentrated virus in a laboratory.
- o Cleaning up vomit.
  No–low risk for HB, HCV without gloves
- o Sharing spoons and forks.
  No risk
- o Using drugs before sex; using alcohol before sex
  Moderate–high risk, less likely to be safe sex
- o Withdrawal (before ejaculation)—an option for safe sex?

Moderate risk, Poor option for safe sex as the couple may 'forget to withdraw; also virus present in the pre-ejaculate; risk for STIs, high risk in the presence of fresh ulcers or wounds in the genitals.

- Oral sex–man entering a woman's mouth: Risk to woman?
  Low–moderate for woman

- Vaginal sex—no condom, no ejaculation: Risk to woman?
  Moderate risk, Poor option for safe sex as the couple may 'forget to withdraw; also virus present in the pre-ejaculate; risk for STIs, high risk in the presence of fresh ulcers or wounds in the genitals.

- Oral sex—with ejaculation (between men): Risk to the receptive man?
  Low–moderate risk

- Sharing injecting equipment (e.g. swabs, water, mixing bowls)
  Low for HIV; high for HBV and HBC

- Needle stick injury: 'suture' needle
  Low risk, solid bore needle, often a subcutaneous injury

- Sharing syringe/needle
  High risk

- Vaginal sex—no condom, withdrawal then ejaculation: Risk to man?
  Moderate risk, poor option for safer sex as the couple may 'forget to withdraw'; also virus present in the pre-ejaculate; risk for STIs and parasites, high risk in the presence of fresh ulcers or wounds in the genitals.

- Penetrative anal intercourse—no condom, withdrawal then ejaculation
  Moderate to high risk, poor option for safe sex as the couple may 'forget to withdraw'; also, virus present in the pre-ejaculate; risk for STIs and parasites.

- Vaginal sex—no condom, ejaculation: Risk to the woman?
  High risk

- Receptive anal intercourse—no condom, no ejaculation
  High risk—poor option for safe sex as the couple may 'forget to withdraw' also, virus present in the pre-ejaculate; risk for STIs and parasites.

- Needle stick injury: 'venepuncture' needle
  Moderate-level of risk dependent on factors such as depth of the puncture Emphasise the need to collect detailed information on exposure.

- Sharing sex toys
  Low–moderate, more information required on the type of the sex toy and circumstances.

- Oral sex—with ejaculation (between men): Risk to the penetrating partner?
  No risk for HIV, avoid if the receptive person has oral herpes.

- Oral sex—male to male, no ejaculation: Risk to the receptive man?
  No risk for HIV; possible risk for STIs parasite.

- Oral sex—man entering a woman's mouth: Risk to the man?
  No risk; possible risk for herpes lesions.

- Deep kissing
  Low risk for HIV

- Mosquito bite
  No risk

- Crying—getting someone's tears on yourself
  No risk

- Sharing a toothbrush
  No risk.

- 'Rimming'—contact between the mouth and the anus: Risk to the person performing?
  No risk.

- Mutual masturbation: Risk to either?
  No–low risk depending on the context and behaviour

- Sex during menstruation—with a condom, without a condom.
  With condom low; without high

- Tattooing
  High for ritual 'group' tattooing

Risk reduction (30 min)

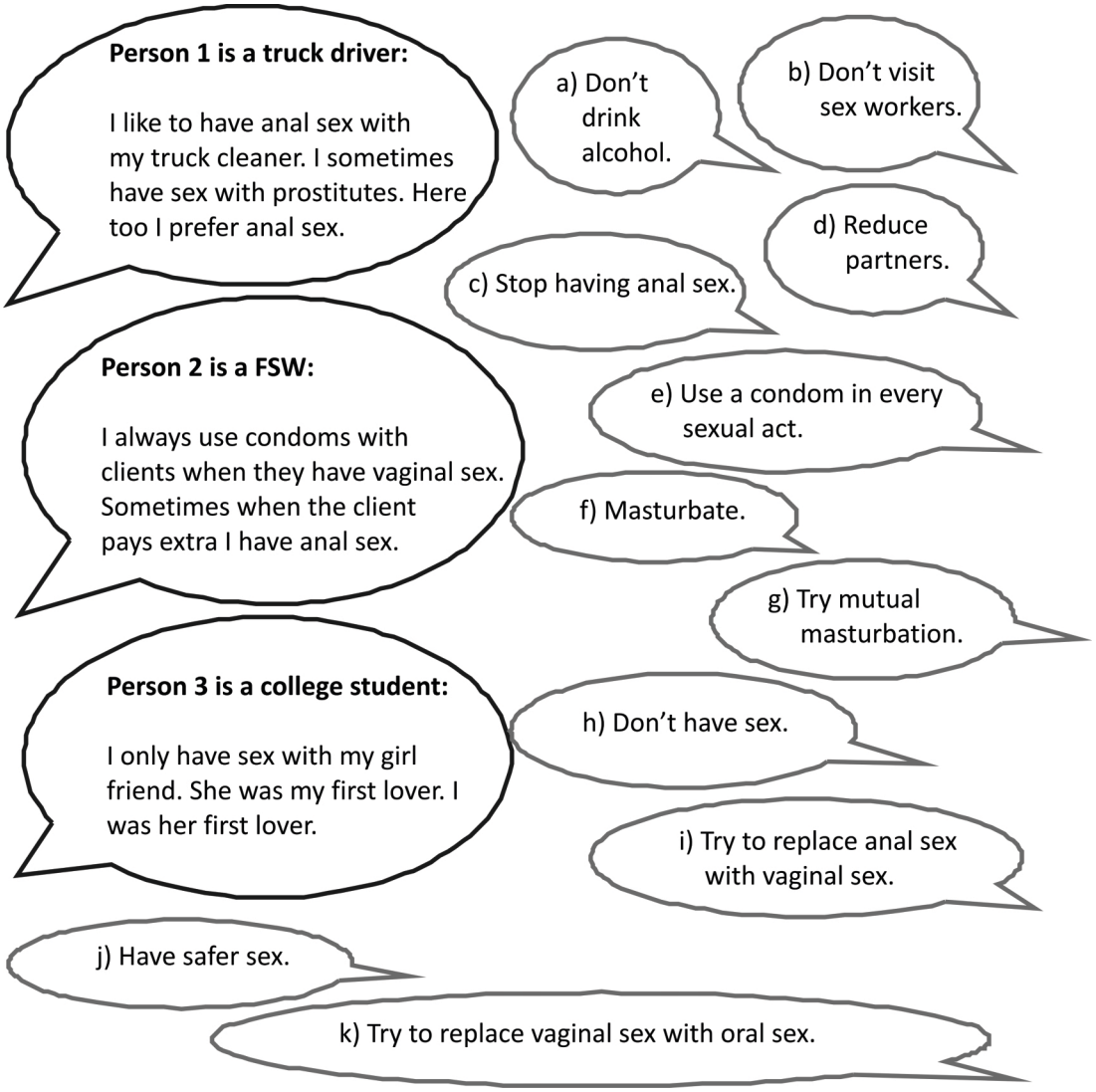
Lecture using slide no. 19-23

Activity 3: Slide no. 24-26

Customised Risk Reduction Plan

The Right and Wrong Way

Here are some risk behaviours. Explain which risk reduction dialogues are more suitable. You can choose more than one option. Explain also why you did not choose certain suggestions. Try to think of suggestions which have been missed.



Discuss the risk reduction options for each profile. Cover the following points:

a) "Stop having anal sex" or "Don't have sex," **are poor messages** because they prohibit behaviour but do not provide an alternate action.

b) "Have safer sex" **is a vague message** which assumes that patients understand safer sex.

c) Messages related to replacing a risky behaviour with a non-risky behaviour are better options.

d) Discuss other options not mentioned for lack of space such as use of KY jelly for anal sex.

Pre-test counselling (20 minutes)

Lecture using slide No. 27-34

Annexure

Risk game: (Statements for risk assessment) (To be translated in the local language and printed / written on separate cards for distribution among participants).

Blood splash to the eye during a delivery

Cleaning up vomit

Sharing spoons and forks

Using drugs before sex; using alcohol before sex

Withdrawal (before ejaculation) - an option for safe sex

Oral sex – man entering a woman's mouth: Risk to woman?

Vaginal sex - no condom, no ejaculation: Risk to woman?

Oral sex – with ejaculation (between men): Risk to the receptive man?

Sharing injecting equipment (e.g. swabs, water, mixing bowls)

Needle stick injury: 'suture' needle

Sharing syringe / needle

Vaginal sex – no condom, withdrawal then ejaculation: Risk to man?

Penetrative anal intercourse – no condom, withdrawal then ejaculation

Vaginal sex – no condom, ejaculation: Risk to woman?

Receptive anal intercourse – no condom, no ejaculation

Needle stick injury: 'venepucture' needle

Sharing sex toys

Oral sex – with ejaculation (between men): Risk to the penetrating partner?

Oral sex – male to male, no ejaculation: Risk to the receptive man?

Oral sex – man entering a woman's mouth: Risk to the man?

Deep kissing

Mosquito bite

Crying – getting someone's tears on yourself

Sharing a toothbrush

'Rimming'—contact between the mouth and the anus: Risk to the person performing?

Mutual masturbation: Risk to either?

Sex during menstruation—with a condom, without a condom

Tattooing

SESSION 13
Post Test Counselling

Session Overview:

- General principle of HIV post- test counselling (20 minutes)
- Guidelines for the provision of negative test results (20 minutes)
- Provision of positive test result (30 minutes)
- Other important issues and follow-up counselling (20 minutes)

Session Objectives:

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

- Apply knowledge of basic counselling techniques for post-test counselling.
- Understand the basic requirements for the provision of HIV results.
- Conduct post-test counselling for HIV negative result.
- Conduct post-test counselling for HIV positive result.

Time allowed:

- 1 hour 30 minutes

Material required:

- PPT presentation
- Post test form

Method :

Activity 1

Prepare chits – 'HIV Positive' and 'HIV Negative'. Make equal number of HIV positive and negative chits as per the number of participants. Distribute the chits randomly among the participants. Explain to them saying, "We have taken your blood sample for HIV testing and now you have the result in your hands. Please check your result." Maintain silence for 2 minutes. Observe the expressions and reaction

of the participants. Now ask the participants: How many are HIV negative and how they feel. The expected answer would be: they were confident that it would be negative, they are happy to receive negative result. Then ask how many are HIV positive and how do they feel. The expected answers would be: unbelievable; it can't be my report or depressed. Then explain the objective of the activity. One should know how one would feel when one receives a HIV test report. Counselling should be to empathise with the client and accordingly give result, understand the emotion of the client and provide psychosocial support. At the end of the activity, explain about HIV positive and HIV negative test results.

- HIV tests detect the antibodies that the body produces to fight HIV, once infection has occurred.
- A positive result means that HIV antibodies are present in the blood. In other words, a person is infected with HIV and can infect others.
- A negative result means that no HIV antibodies were found in the blood at the time it was drawn.
- It ordinarily takes three weeks to three months (the window period) for people infected with HIV to develop enough antibodies for HIV to be accurately detected. This may mean that a person needs to be tested again even if the first test results are negative.

- Describe the general principle of HIV post- test counselling using slide no. 6-10
- Describe frequent HIV–negative testers using slide no.11
- Describe post test counselling using slide no. 12-14
- Describe other important issues and follow-up counselling using slide no. 15-16

Key messages: (slide 17)

- Avoid giving false reassurance.
- Clarify misinformation about the meaning of the test result and its implications.
- Reinforce information on transmission, safe sex/drug use.
- Assess the support available to the client.
- Make appropriate referrals and accompany referred client wherever possible.
- Refer to a specialist for psychological /psychiatric / mental health related issues if needed.

SESSION 14
Behaviour Change Communication and Condom Demonstration

Session Overview:

- Lecture using slides (20 minutes)
- Behaviour change stories (40 minutes)
- Condom demonstration and practice (45 minutes)
- Optional: Lecture using slides (15 minutes)

Session Objectives:

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

- Describe the trans-theoretical model of behaviour change.
- List appropriate counselling techniques for each stage of behaviour change.
- To understand and apply the principles of 'Behaviour Change Communication'.
- Demonstrate how to use a condom.

Time allowed:

- 2 hour

Material required:

- Slides related to the session
- Behaviour Change Story 1 (already printed in the handouts)
- Behaviour Change Story 2 (already printed in the handouts)
- Condoms (Sufficient pieces so each participant has one)
- Penis model

Method:

Lecture using slides (25 minutes)

- Explain the key points in the session using the BCC slides and the dialogue given for your convenience.
- Ask the participants to open their handouts to Behaviour Change Story 1. Read this story paragraph by paragraph and help the participants to relate the story to the behaviour change stages: *Pre-contemplation, Contemplation, Preparation, Action, and Maintenance*. A key is provided for your convenience.
- Variation: Alternatively, you could begin the session by reading the first part of the story and then showing the slides.

Activity 1: Behaviour Change Story 2 (35 minutes)

- Divide the participants into 8 groups. Ask the groups to read the handout titled Behaviour Change Story 2 and answer the questions after the story. Give them 20 minutes for the task.
- Discuss the story in the larger group. An answer key is given for your convenience.

Condom demonstration and practice (45 minutes)

- You, as the facilitator, will invite a participant to demonstrate condom usage on penis model.
- When they have demonstrated, ask another participant to suggest how to improve the condom demonstration. Encourage all the participants to actually do the demonstration.

Optional lecture using slides (15 minutes)

- You, as the facilitator, will cover the key points of the session using the slides and the notes given in the note view for your convenience.

Key messages:

- Behaviour change is not easy either for oneself or for the client.
- Only knowing the need for behaviour change does not actually lead to change in behaviour.
- Repeated efforts of the counsellor through identification of the different stages of change and communicating the various techniques at those stages can cause behaviour change to happen in a client.
- Keep a penis model in the clinic and ask the client to demonstrate how to use a condom correctly. Most people are ignorant about correct use of a condom.
- No matter how well done, explaining and demonstrating are not sufficient to ensure correct condom use. It is necessary that the person practices doing what you have done. This process is called return or re-demonstration.
- Stress the use of a condom for family planning and prevention of STI.

Annexure

Behaviour Change Story 1

This is an exercise to apply the Transtheoretical Model. Read the story and identify statements which show the different stages of change the person is at:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

'I have been gaining weight for some 10 years now ever since the age of 28. Then I was slim. But the weight gain began very slowly. At first my family would tell me that I was putting on weight. But I would ignore their comments. Once I actually threw and broke a china cup when my father went on and on about how he could not distinguish between my mother and me in the dark as we were the same size. When professional colleagues mentioned my weight, I would joke, "I usually skip meals when I am depressed. Therefore, the fact that I am getting fat means that I am happy," or simply "Now there is more of me for you to appreciate." I would dismiss their comments by saying that I was eating healthy.'

'But a lot of this changed three years ago. My father passed away from a heart condition. He had been a little on the stout side. I began to realise just how out-of-shape I was. As he also had diabetes, I began to worry about family history issues. I even took a blood sugar test and breathed with relief when I was found to be in the normal range. I noticed how breathless I would become after climbing a few stairs. I noticed that a favourite sari could not be worn till I made a new blouse as I had already altered the seams once. Whereas before I did not mind people clicking my photographs, I suddenly became conscious that certain angles made me look fat. I began to dislike having my photograph taken.'

'Still I did not do much. But then I met with a colleague who had experienced good outcomes with a brand new diet. I was impressed. I thought wistfully about how nice it would be if I could also do so. I began to read about the diet. I liked the book so much that I went out and bought it. I even began experimenting with the recipes.'

'When I felt ready to make the change, I went out and brought some of the foods necessary for my new diet. I opened my diary and measured my weight. I was 78 kilos at that time. I started my new diet from the first of January. I would weigh myself every Monday morning and note it on the calendar. I felt really happy when I had dropped 10 kilos at three weeks of dieting. At this point my clothes began to hang on my body. So I went out and bought a new suit. I felt lighter and more energetic. I began to walk about more. This was something I had lost the habit for as I used to get breathless. The more I walked of course, the more I lost weight.'

'Now it is August. I am 18 kilos lighter. I have had to buy new clothes. But I feel good.'

Answer Key

1. **Identify the different stages-**

   a. Stage of pre-contemplation: *But I would ignore their comments... I would dismiss their comments by saying that I was eating healthy.'*

   Here the person displays a complete lack of readiness to change her behaviour or lifestyle. Well-meaning comments from friends are ignored.

   b. Stage of preparation: *I began to read about the diet. I liked the book so much that I went out and bought it. I even began experimenting with the recipes.*

   Here the individual begins making tentative steps towards changing the behaviour but has not yet made a full commitment.

   c. Stage of maintenance: *Now it is August. I am 18 kilos lighter.*

   Here the individual has lost weight and has managed to maintain it for more than 6 months.

2. **Some ways to help the person move from precontemplation to contemplation of behaviour change-**

   a. **Consciousness raising:** Presenting facts and figures linking over-weight with heart disease and other health problems.

   b. **Dramatic relief:** Presenting stories about how good people feel after they have managed to lose weight, how their personal well-being improves; Role-playing during counselling about how other people might respond to the "new and reduced You."

   c. **Self re-evaluation:** Encouraging the client to think of how being fat negatively impacts her life (e.g., she has to endure nicknames, she is no longer comfortable to have her photo taken, she has difficulty finding clothes that fit, she does not have energy to play with her children, she tires easily, she is at greater risk of heart disease, her boss has overlooked her for a promotion as he/she prefers a smart looking employee.)

   d. **Environmental re-evaluation:** Encouraging the client to think about how her fat stature negatively impacts other people in her life (e.g., her children miss playing with her, her family is embarrassed.)

3. **An example of counter conditioning for this individual-**

   One example of counter-conditioning for this individual is to substitute unhealthy eating with healthy eating, that is green salads in place of high-cholesterol foods which are deep fried. As the person may enjoy deep fried items, the replacement foods should provide comparable enjoyment to her. Another example is to bake or steam food items instead of frying them.

4. An example of contingency management for this individual-

The individual mentions: *I would weigh myself every Monday morning and note it on the calendar. I felt really happy when I had dropped 10 kilos at three weeks of dieting. At this point my clothes began to hang on my body. So I went out and bought a new suit.*

Here the individual is using the technique of contingency management on herself. She rewards herself when she has reached a level of behaviour change that is meaningful to her. She also uses a calendar to track her progress.

Behaviour Change Story 2

Practice Time

I began smoking when I was 14 years old. I used to steal cigarettes from my father's pocket. Later I began to also "borrow" money from my mother's purse to buy cigarettes. In college I found out that for the same money I could buy a small 'pudi' of stuff that was better. I enjoyed myself.

My best friend warned me that I was going down the wrong track. I laughed at him. I told him that I was not like those "druggies," "smackiyas" or "charasis". I could stop at any time. Yes! I could stop. I had tried to stay away from the stuff during exams. The longest I could do was 7 days. But soon I was back to taking the "stuff" again.

When I began working at the age of 21, I had already begun taking a cocktail of pharmaceutical stuff. You crush it together, dissolve it and inject it. This was clean stuff, not like those "charasis." I worked in sales. It was difficult to keep my focus. But I managed. More than half my salary would disappear.

My mother started to notice my behaviour patterns. She would grumble that I was not the good child she had known before. Then one day she found me injecting myself in the bathroom. The whole family started harassing me. By now I knew I was hooked. The family tried many things. They took me to a "baba" who prayed over me. They began accompanying me to work but I would find a way to escape. They locked me in the house one day. But my withdrawal pain was very great. I started screaming and cursing. This frightened them and they let me out.

A friend came over to talk to me. She tried to make me see the light. But all I could think of was how to avoid the withdrawal pain. I looked forward to my "nasha," my "intoxication."

My family left me alone. But they would leave pamphlets about drug NGOs around the house. I would throw them in the waste-paper basket.

Then one day my mother came to me and in tears asked me if I could give her a birthday gift. She said I could afford this one. I loved my mother. So I said, "Yes." She took me to a support group meeting. I did

not like the idea of being in Narcotics Anonymous. But I had promised my mother. So I decided to wait for 20 minutes. There were two speakers who had to speak. I kept looking at my watch.

Five minutes before I was ready to walk out, an older man got up to speak. He had a soothing voice. I began to listen to his testimony. His words were very familiar to me. He could have been saying my life story. He described his own trouble with drugs. I realised how much I had sunk down. My mother looked over at me and held my hand. I had no thought now to leave.

After the meeting she requested that man to speak to me. I was now starting to get twitchy. I needed my fix. But I spoke to that man a little. He took my telephone number. He would call me every week and speak to me gently about turning my life around. His message slowly sunk in.

One day, I decided that I would go to a drug agency to get straight. I told my friend from Narcotics Anonymous. He told me that he would go along with me as a support. I agreed. I knew that if I was alone, I would be tempted to give up.

My first week at the drug centre was like sitting in a fire. There are no words to describe it for you. But later it got better. I learned to control my need for the drugs through yoga prayer and hard work. I was allowed to smoke cigarettes because I still got twitchy. When I went out, I was encouraged to go with another addict friend so we could support each other to remain sober. I still have the certificate that the centre gave me for remaining sober for 50 days. Even Sachin's half-century could not be better!

It has been 8 months since I have taken drugs. I am with my family now. We spend a lot of time together because I still worry about meeting my old friends who would lead me back to my bad habits. I still think about the drugs. So I began learning how to paint as a distraction. This works sometimes.

I look forward to the future. The centre has warned me about sliding back, about relapse. I go to Narcotics Anonymous meetings. Being around other ex-addicts helps.

- **Read the story and identify sentences in the story which show the person passing through the different stages of behaviour change according to the Transtheoretical Model: Precontemplation, Contemplation, Preparation, Action, and Maintenance.**

- **Identify the different types of techniques used in this story.**

Answer Key

Comments on Behaviour Change Story 2

For facilitator's guidance only: not intended for verbatim use.

- **Identify the different stages.**
- **Identify the different techniques used.**

a. Stage of pre-contemplation:

Paragraphs 1, 2 and 3 are stage of pre-contemplation because the person does not see any need to change.

b. Stage of contemplation:

This individual went through a long phase of contemplation. We recognise this from the fact that though many people told him about the need to change, all he could see were the disadvantages of withdrawal pain.

The technique mentioned here is 'Dramatic Relief' (when the speaker at the Narcotics Anonymous meeting tells his life-story).

c. Stage of preparation:

Paragraph 10 is the stage of preparation: "One day I decided…" In the case of this individual, it is a very brief moment. He decides to go in for de-addiction. He informs his friend. He agrees to the concrete plan of going to the centre with his friend. (Contrast this with the earlier description of throwing the pamphlets into the waste-paper basket in Paragraph 6.)

d. Stage of action:

Paragraph 11 describes the person in the stage of action. – He has taken actions to be drug-free but has not yet maintained it for 6 months.

The techniques mentioned here are 'Stimulus Control' (being in the company of new friends. yoga, prayer) and 'Counter-Conditioning' (smoking cigarettes instead of using harder drugs).

e. Stage of maintenance:

Paragraph 12 describes the person in the stage of maintenance – He has been drug-free for more than 6 months. (Contrast this with the earlier description in Paragraph 2 where he could not stay without drugs for more than 7 days).

The technique mentioned here is 'Stimulus Control' (being in the company of friends, painting, going to Narcotics Anonymous meetings) to avoid relapse prevention.

SESSION 15

Managing Mental Health Issues in the Context of HIV

Session Overview:

- PPT presentation – 1 hour 15 minutes
- Role plays – 1 hour 45 minutes

Session Objectives:

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

- Learn the meaning of mental health and mental illness.
- Understand the relevance of mental disorders in the context of HIV.
- Enhance counselling competence for a few common mental health issues in the context of HIV.
- Learn to plan a referral to a mental health professional.

Time allowed:

- 3 hour

Material required:

- PPT slides and Projector
- White board markers
- Translated handouts
- 2 copies of cases for role plays

Tips to the facilitator: 

- Participants' reading the handouts in advance is crucial to completing the session in time.
- Do translate the handouts in the local language to increase the chances of participants reading the handouts in advance, and understanding them enough to utilise the learning in the role plays and in the actual counselling setting.

Method:

Preparation before the session:

You as the facilitator:

- Translate the handouts in the local language.
- Go through all the handouts in advance
- Divide the participants into three groups in advance, to read the translated handouts **before the session,** with the instructions that "you need to read and understand the handouts thoroughly, such that each of you comes prepared in the session to demonstrate your learning through a role play in the session". Thus, each individual participant (and not just one or two members of the group) needs to be able to do the role play. The division of groups is as follows:
  - **Group 1**: Dealing with suicidal clients and
    - Grief Counselling
  - **Group 2**: Crisis intervention and
    - Anger Management
  - **Group 3**: Dealing with anxiety, and
    - Helping a client with sleep difficulty
- In addition, if possible, the handout "Making a referral to a mental health professional" may also be given to all the participants to read in advance.
- Make 2 copies of each case for role plays – one for the 'client' and one for the facilitator (not to be handed over to the person playing the role of the counsellor).

I. Sessions 1-3 (1 hour 15 minutes)

- Present the PPT slides in an interactive manner.
- Make the session participatory; keep the participants involved by explaining and asking them questions, but stick to the time.

Tips to the facilitator: 

- The handouts are one the information covered in session 3. The handouts are to be read by the participants in advance, and the presentation is meant to briefly revise what has been learnt through self-study of the handouts, and to clarify any doubts.
- Activity 1 (role plays) needs to be given adequate time, because it is likely to help give practical tips and enhance skills while most of the other things covered in the session can be learnt through reading.

II. Activity 1 (Role Plays – 1 hour 45 minutes)

- Invite a participant to act as a client.
- Invite a participant from group 1 and ask them to counsel the client using what they have learnt from the handouts studied by them.
- **The facilitator needs to try and make as many participants as possible, act as the counsellor during the role plays.**
- Alternatively, all the participants from that group can join as 'counsellors' to support each other while counselling on the issue prepared by them.
- Keep one copy of the case (given in the annexure) with you, and give one copy to the person acting as the client.
- You can read out the case aloud once the client and counsellor have already volunteered for the role play.
- Give about 10 minutes for each role play.
- The focus needs to be on mental health counselling and not on the 'client's' acting.
- In the role play, the facilitator needs to be supportive to the person acting as the counsellor and help if they get stuck.
- When a 'counsellor' is stuck, other members from the group may be invited to quickly take over as the counsellor with the same case.
- **Guidelines for role plays (given in the instructions to the training institutes) may be used.**

Tips to the facilitator: 

- The facilitator needs to invite different participants to act as counsellors and clients for each role play.
- Encourage the participants to come forward to play the counsellor's role saying that the facilitator will be there to support them.
- This is an opportunity for counsellors to learn that counselling is different from common sense.
- Ideally everyone should be able to counsel with every case if they have read the handouts in advance.
- After the 'counsellor' has completed counselling, the facilitator needs to add, if needed, to demonstrate how the issue can be handled.

Remember: 

There is a lot of stigma around mental illness. The facilitator needs to make sure throughout the session to not make fun of mental illness or the mentally ill, and to gently dissuade the participants also from doing so.

Key messages:

- There is no 'health' without mental health.
- HIV can lead to a) increased mental stress and b) mental health problems due to ART side effects.
- Mental health problems can indirectly lead to increased chances of HIV infection. Thus, **poor mental health can negatively impact fulfilment of NACP goals.**
- The prevalence of HIV is higher among people with severe mental illness as compared to the general population.
- The counsellor needs to know some general warning signs that require a referral to a mental health professional, and make an appropriate and timely referral.
- Common psychiatric disorders among PHLIV are: mood disorders, anxiety disorders, substance use disorders, delirium, cognitive disturbances, sleep disorders, psychosis, and personality changes.
- A counsellor needs to be sensitive to mental illness and the mentally ill. We must NOT stigmatise people with mental disorders, and thus avoid using terms like 'mad', 'mental', 'paagal', 'lunatic' and 'derailed', for example.
- **Suicide risk is higher** among HIV-positive patients than in general population.
- **A counsellor must ask a client about suicide** if they feel that the person might be suicidal.
- Using common sense can sometimes do more harm than good while dealing with a suicidal client, thus it is important to learn the do's and don'ts about different issues like suicidality; sleep difficulties; dealing with anger, anxiety and grief, for instance. This is important so that we do not do any harm to the client.

Annexure

Cases for role plays

The cases need to be handed over to the person acting as a client and NOT to the person acting as a counsellor.

The 'client' will summarise to the counsellor and the audience at the same time the brief information given here.

Case 1 for role play:

"I am a 23-year-old married woman. I have recently come to the city from a village, where I studied up to 12th class. My husband works as an assistant to an electrician. I got to know that he has TB and HIV, and today I got to know that I also have HIV."

"I feel as if everything is over, as if there is no point living. I will die, my husband will die. No one in the village will accept me. My father also died recently. I want to end my life (begins to cry)."

Case 2 for role play:

"I am 34 years old. I have 2 young children, and I run a small business. I got to know of my HIV 2 years back, and I have been on ART.

"I feel very worried about what will happen to my wife and kids if I die. I know that I will not die, but I keep thinking constantly about all the negative things, even though I try very hard not to. I get startled very easily, I just cannot be positive no matter how hard I try. I know I need to eat, but I do not feel like eating. I cannot concentrate on anything, and that is why my work is also affected. I love my family and I do not want to trouble them with my worries. I have also been finding it very difficult to sleep. I take a long time to fall asleep."

Case 3 for role play:

"I am 36 years old. I have 2 children, and my husband works in an office. I got to know of my HIV 4 years back, and I have been on ART.

"I sometimes feel so angry that I just cannot control myself. Because of this I sometimes hit my children and then I feel very bad and cry because I love my children a lot."

Key (Not to be shared with participants before the role plays are over):

Case 1 is related to counselling for grief / suicidality.

Case 2 is related to counselling for anxiety / sleep.

Case 3 is related to counselling for anger management.

SESSION 16
Counselling Children and Adolescents

Session Overview:

- **Sub session 1: Counselling children in an HIV setting**

  Lecture using slides: (40 minutes)

  Activity 1: Fast forward (5 minutes)

- **Sub session 2: Counselling adolescents in an HIV setting**

  Activity 2: Case discussion from PPT presentation: (10 minutes)

  Lecture using slides (35 minutes)

  Activity 3: Case discussion of child and adolescent cases (50 minutes)

- **Summing up (10 minutes)**

Session Objectives:

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

- Understand the need to learn advanced counselling skills for counselling children and adolescents.
- Demonstrate strategies required for working with children and adolescents during counselling in the field / clinic.

The focus of this session is counselling in an HIV counselling setting with -

- Children
- Adolescents

Sub session 1: Counselling children in an HIV setting

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

- Identify children with developmental delays and take appropriate actions.
- Match counselling according to the developmental stages in children.
- Explain parental issues in relation to counselling children at the HIV counselling setups.
- Demonstrate interactive strategies for working with children.

Sub session 2: Counselling adolescents in an HIV setting

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

- List the characteristics of adolescence.
- Analyse the ethical issues related to HIV testing of adolescents.
- Demonstrate skills in counselling adolescents.

Time allowed:

- 2 hours 30 minutes

Material required:

- Lecture slides related to the session
- Copies of instructions for the practice session on working with children
- Copies of instructions for the practice session on working with adolescents
- Blackboard or flip chart

Method:

Preparation before the session:

You as the facilitator:

- Translate the handout and annexure in the local language and distribute the same at least one day prior to the session.
- Read the facilitator's guide, PPT slides and the handout before the session.

Sub session 1: Counselling children in an HIV setting

Lecture using slides (5 minutes)

Explain the objectives of the session and sub session 1. Explain the slides on Children and HIV and development milestones and HIV.

Activity 1: Fast forward (5 minutes)

Ask the participants to fill in the activity sheet on developmental milestones based on the information received from the previous slide.

Lecture using slides (10 minutes)

Explain how to match child counselling to the development stage. Also explain briefly the various emotions a child goes through and how a counsellor can help express and manage that emotion.

Brainstorm and lecture using slides (15 minutes)

Brainstorm on what is child centred counselling and what a counsellor can do to make his /her centre child friendly.

Explain how a counsellor can walk the child and parent through the testing process and how he /she can break the news of a positive diagnosis.

Brainstorm and lecture using slides (10 minutes)

Explain how communicating with children is different from communicating with adults. Brainstorm on what strategies could be adopted for communicating with children.

Sub session 2: Counselling adolescents in an HIV setting

Activity 2: Case discussion: (10 minutes)

Display the slide with the case study on the projector. Ask the participants the following questions:

a. Explain ALL the ways this boy could have got infected.

b. List 6 risk assessment questions the counsellor should ask the boy.

Discuss the different responses and check for any misconceptions about route of infection.

Lecture using slides (30 minutes)

Explain the key points in the session using the slides and the dialogue given for your convenience.

Activity 3: Case discussion of child and adolescent cases (50 minutes)

Tips for facilitators:

- Discuss the 3 cases with the participants in an interactive manner to learn the practical application of the issues covered so far.
- Invite participants to give their suggestions before adding further points for each case.
- If time permits participants can be divided into 3 groups to discuss one case of each of the additional cases given in **Annexure 2**.

Summing up (10 minutes)

Read out the key messages and answer any relevant questions from the participants.

Key messages

Counselling Children

- Monitor the growth of the child by checking the child for any signs of developmental delay or asking caregivers.
- Address concerns of the caregiver regarding the child's delay in showing the expected motor skills or behaviours and direct them to required services such as special schools.
- Enable the child to express emotions in a safe environment.
- Create a child friendly corner by mobilising toys etc. from schools, NGOs.
- Use drawing, story -telling, puppetry while communicating with children tailored to the age, maturity, level of comprehension and extent of the child's relation with him/her.
- Use sandwich technique to communicate a positive diagnosis.

Counselling Adolescents

- Normalise feelings of shyness, anxiety and embarrassment. Explain that it is common or normal to feel this way.
- Acknowledge adolescent sexual activity – heterosexual as well as homosexual.
- Maintain a balance between the rights of the adolescent and those of the parent.

Annexure

Annexure 1: (Fast forward) (5minutes)

(Activity 1)

Key to the developmental milestones worksheet (Not to be photocopied)

Situation	Is this child facing a developmental delay?	When would a "normal child" complete this?
Ishani is 5 months old. When her grandmother holds her, her head falls to the side.	Yes	10 weeks
Afsaana is 2 years old. She can walk without holding the wall.	No	12 months
Dhanesh is 18 months old. He has just learned to sit up.	Yes	9 months
Balbir Kaur was born 6 weeks ago. She delights her family with her new development – smiling.	No	6 weeks
Bhavna is 3 months old. She has begun sliding around and will learn to turn over in a few days.	No	14 weeks
Kamlesh is 6 months old. He is very pleased at his new trick – moving his rattle from one hand to the next.	No	6 months

Annexure 2: Case discussion of child and adolescent cases (50 minutes)

(Activity 2)

CASE 1 Managing emotions of children/adolescents:

Shiny is 11 years old. Her parents passed away some time ago due to HIV. She lives with her aunt who brings her to the counselling centre and reports that she has not been eating well recently. She is very restless and has been pulled up in school. She has also become clingy. When the counsellor asks Shiny's aunt, she also reports that Shiny does not get sound sleep nowadays.

CASE 2 Techniques for child counselling:

Jaimala is a 7-year-old child on ART. She has been tested at your ICTC and is fond of you. She realises that she is the only one in her school taking medicines. She does not want to be different from her friends. So she is refusing to take medicines.

CASE 3 Risk assessment:

Emaan is a 14-year-old girl who is brought by her parents to the hospital for a Medical Termination of Pregnancy (MTP). She was referred from the Gynaecology department to the ICTC. Her parents are very scared that their family secret will be found out and bring them shame. But Emaan knows that she is pregnant through her uncle who is abusing her.

Additional cases for managing emotions of children/adolescents:

1. Bipin is feeling very low. He is 13 years old. He has been taking ART since the age of 3. He is fed up of having to take medicines all the time. His mother reports that he has become very irritable and snaps over small things. As compared to earlier, he neither goes to play with his friends nor completes his homework.

2. Sharda is 8 years old. She lost her mother recently to HIV-related illness. Her grandfather who is her caregiver brings her to the counsellor because he is upset over her temper tantrums.

Additional cases for 'Techniques for child counselling':

1. Rosy is a 4-year-old child. She is brought to the ICTC for HIV testing. She was missed on the EID protocol because her HIV-positive parents left the district to avoid stigma. Now her health is failing. To check if she is eligible for ART, she must take the HIV test. She does not like hospitals and is crying bitterly when her parents bring her to you. You know that she will be even more scared when it comes to drawing the blood.

2. Jehana is a 4-year-old child. She was brought to the centre for HIV testing because her health is failing. She was missed on the EID protocol because her HIV positive parents left the district to avoid stigma. She tested positive. Her parents took her to the ART centre where she started ART. She came to your hospital today because her father wanted to get checked for his own condition. He brings her to the ICTC just to chat. You learn from him that Jehana does not like taking the medicine and is making a fuss to take it. She has not been very regular in having medicines. You realise how dangerous this is for her health. Her father explains that she tells him to take medicines as he is unwell, but refuses to take the medicines herself because she is currently doing better.

Additional cases for risk assessment:

1. Sam is 18 years old. He has been having sex with his college friends. He attended a talk on HIV and got scared. As he does not have much pocket money, he found out the test is done free of cost at the ICTC. So he goes there.

2. Kapil has come from the STI clinic to the ICTC for testing. He is 16 years old. So he is accompanied by his mother. He developed an abscess on his arm which appears to be festering around a needle puncture site. He injects drugs but does not want his family to know. So he resolves not to tell the counsellor anything.

SESSION 17
Counselling Sero-discordant Couples

Session Overview:

- **Counselling sero-discordant couples in an HIV setup**

  Activity 1: Parking lot (20 minutes)

  Lecture using slides (60 minutes)

  Activity 2: Whose line is it anyway? (30 minutes)

- **Summing up (10 minutes)**

Session Objectives:

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

- Understand the need to learn advanced counselling skills for counselling sero-discordant couples.
- Demonstrate strategies required for working with couples during counselling in the field / clinic.
- Assess and reduce the risk of sero-conversion among discordant couples.
- Carry out fertility planning among sero-discordant couples.
- Use couple counselling techniques with sero-discordant couples.

Time allowed:

- 2 hour

Material required:

- Lecture slides related to the session
- Copies of instructions for the practice session on working with Sero-discordant Couples
- Sero-discordant Parking Lot statements
- Whose Line is it Anyway: Complaints
- Whose Line is it Anyway: Appropriate Counselling Lines
- Blackboard or flip chart

Method:

The training team must schedule the session on Body Basics and Family Planning BEFORE this session.

Preparation before the session:

You as the facilitator:

- Translate the handout and annexure in the local language and distribute the same at least one day prior to the session.
- Read the facilitator's guide, PPT slides and the handout before the session.

Activity 1: Sero-discordant Parking Lot (20 minutes)

NOTE: This exercise is inspired by the famous Parking Lot Exercise related to Stigma and Discrimination.

- Ask the participants to stand in an open area free of furniture in the room or in the open.
- The participants have to hold two balloons (one red and one green) in each hand.
- Explain that you will read out an action or behaviour in a discordant couple. For each behaviour you read out, they should SILENTLY raise the hand with the **green balloon** if they think this is safe in terms of risk of transmission from a positive person to their negative partner. If they think the action will increase the possibility of transmission they should raise the hand with the **red balloon**. This is in line with green symbolising safe and red symbolising danger.
- Read out each behaviour statement and allow the participants to raise the hand with the red or green balloon. A participant can also keep both hands down for any statement if he /she find it difficult to make a choice. The participants have to explain the reason behind their raising the hand with the red or the green balloon.
- Ensure that you cover each behaviour statement. Some statements generate more debate, so try to avoid too much time on any one statement, and reassure that it will either get clarified in the session or during a break.

Lecture: Explain the key points in the session using the slides and the dialogue given for your convenience. Refer to the handout wherever necessary. **(45 minutes)**

Activity 2: Practice exercise in counselling discordant couples: (Discussion of Home Assignment) (45 minutes)

This exercise has to be done one day prior to the session by the participants as a home assignment. The answers shall be discussed in groups on the day of the session as a practice exercise.

The following exercise aims to help a counsellor put oneself in a client's shoes, so to speak, to help improve empathy. Further the exercise also gives an opportunity to the reader to think what a counsellor needs to say or do in a certain situation.

As you read the following exercise, imagine yourself being a client who is visiting a counsellor. You are one of the partners in a sero-discordant couple relationship or marriage. Imagine yourself saying the following line ('you say') to the counsellor. What might you be thinking? What might you be feeling? What does a counsellor need to say or do to be most helpful to you? Some of the answers are given as examples to the first situation.

You may fill the answers in the practice sheet (Annexure 2).

Refer to Annexure 3 and Annexure 4 for filling the form.

Tips to the facilitator:

- Read the first statement ('you say') in the practice sheet and read out the corresponding statements ('you think', 'you feel' and 'the counsellor needs to say / do').
- Read the second statement and ask the participants to respond with what they have filled as part of their home assignment.
- The facilitator may keep adding to the points given by the participants.

Summing up (10 minutes)

Read out the key messages and answer any relevant questions from the participants.

Key messages

- The counsellor has a duty to protect other persons from HIV infection. For instance if a client does not disclose the sero-status to the spouse, or has sex without informing the sexual partner, the counsellor has a duty to inform. The PLHIV should be informed about this additional duty of the counsellor in a gentle manner and disclosure to the partner needs to be done only in collaboration with the client as far as possible.
- Safer sex between discordant partners is a programme goal. The techniques of couple counselling offer you a way to reach this goal.
- There is some evidence that a good couple intervention may reduce the risk of HIV transmission within a sero-discordant couple from 22% to 6%.

Annexure

Annexure 1: Key to sero-discordant 'Parking Lot' statements (Not to be photocopied)

(Activity 1)

- **Positive Partner takes ART regularly** (green balloon). But in some cases the partners may become careless about practicing safe sex.
- **Positive Partner treats STI** (green balloon).
- **Negative Partner does not treat STI** (red balloon).
- **Positive Partner is in the window period and has sex with Negative Partner** (red balloon).
- **Positive Partner is in the advanced HIV disease phase and has sex with Negative Partner** (red balloon).
- **Positive Partner has sex using a condom** (green balloon).
- **Partners decide to abstain from sex** (green balloon).
- **Male partner is circumcised** (green balloon). This is not a suggestion that every male should get circumcised. This is a sensitive issue because of religious associations. But all counsellors should be aware of the facts.
- **Discordant couple has sex frequently with a condom** (This is tricky). The more frequent sex, the greater the likelihood of transmission. Using a condom consistently will reduce the risks.
- **Negative partner is a female and the couple has sex frequently** (red balloon).
- **Negative partner is a female aged 15 years and the couple has sex frequently** (red balloon).
- **Positive partner shares their ART medicine with the negative partner** (red balloon). The positive partner needs to take all the medicine for the viral load to remain low.

Annexure 2: Practice sheet for Activity 2 (Home assignment)

Please read the following carefully and fill all the columns from item 2 onwards in your own words. Item 1 is already filled as an example.

	Imagine that you are:	**You say:**	**You think:**	**You feel:** *Please refer to the list of feeling words*	**The counsellor needs to say / do:** *Please refer to couple counselling techniques for an idea*
1	Negative husband of a Positive woman	*"When do you think my partner got infected with HIV?"*	*Maybe she was infected when I got married. She was cheating on me. She must be having a boyfriend I do not know about…*	Confused, upset, sad, worried, betrayed, angry…	• Listen calmly and attentively. • Normalise the feelings. E.g., *"It is common for people to be curious about where their partner got infected. I might have also wondered about this if I were in your situation."* • Deflect the question that is targeted at the source of infection. Then focus on the present and the future. E.g., *"But this question will shift the focus away from dealing with handling the infection. Isn't it better to think about the future right now? Let us try to stabilise your partner's health first."*
2	Negative wife of a Positive man	*"I don't want to use a condom because I want to get pregnant."*	If you were to be the negative wife of a positive man who said *"I don't want to use a condom because I want to get pregnant,"* my thoughts would be:	My feelings would be:	A good counsellor needs to say / do this in this situation:
3	Positive husband of a Negative woman	"I don't want to use a condom because I do not feel as much "sex" as I would be able to without wearing it."			

	Imagine that you are:	You say:	You think:	You feel: *Please refer to the list of feeling words*	The counsellor needs to say / do: *Please refer to couple counselling techniques for an idea*
4	Negative partner of a Positive person	"How could my husband/ wife do this to me? I feel like killing him/ her."			
5	Negative boyfriend of a Positive man	"Please tell me how AIDS came into our life, into our relationship."			
6	Negative partner of a Positive person	"I am so upset and angry and sad and worried. I am upset at my partner for bringing this into my life. I am sad because our child will miss one parent. I am worried that I might also have it."			
7	Negative wife of a Positive man	"I am so angry at him/ her because he/ she had sex with someone else."			
8	Negative partner of a Positive person	"I am so angry at him/ her because he/ she has brought this thing into the family."			

	Imagine that you are:	You say:	You think:	You feel: *Please refer to the list of feeling words*	The counsellor needs to say / do: *Please refer to couple counselling techniques for an idea*
9	One of the partners in a discordant couple	"We know that one of us is infected. But we want to have a child."			
10	Negative wife of a positive man	"I knew when I got married that my life with this person would be useless. Look at how I am trapped now."			
11	Positive husband of a Negative woman	"I have HIV but my wife does not. What should I do next? She is pregnant. I understand that she should get tested for the sake of the baby. But what if she finds out that I am infected! I am scared about knowing her result. I am also guilty about my own behaviour. Tell me what to do please."			
12	One of the partners in a discordant couple	"I am so confused. I do not know how to react."			

How did you feel doing this exercise?

Annexure 3: List of feeling words for Activity 2 (Home assignment)

A very short list of feeling words can be:

- Angry
- Happy
- Sad
- Scared

But not ALL our feelings may be described using this tiny list. Sometimes it helps us to know more words that can describe our or others' feelings. Here is a list that you can refer to. The words on top in bold font are the broader categories under which the words in that column describe specific feelings.

Pleasant Feelings			
OPEN	**HAPPY**	**ALIVE**	**GOOD**
understanding	great	playful	calm
confident	gay	courageous	peaceful
reliable	joyous	energetic	at ease
easy	lucky	liberated	comfortable
amazed	fortunate	optimistic	pleased
free	delighted	provocative	encouraged
sympathetic	overjoyed	impulsive	clever
interested	gleeful	free	surprised
satisfied	thankful	frisky	content
receptive	important	animated	quiet
accepting	festive	spirited	certain
kind	ecstatic	thrilled	relaxed
	satisfied	wonderful	serene
	glad		free and easy
	cheerful		bright
	sunny		blessed
	merry		reassured

	elated		
	jubilant		
LOVE	**INTERESTED**	**POSITIVE**	**STRONG**
loving	concerned	eager	impulsive
considerate	affected	keen	free
affectionate	fascinated	earnest	sure
sensitive	intrigued	intent	certain
tender	absorbed	anxious	rebellious
devoted	inquisitive	inspired	unique
attracted	nosy	determined	dynamic
passionate	snoopy	excited	tenacious
admiration	engrossed	enthusiastic	hardy
warm	curious	bold	secure
touched		brave	
sympathy		daring	
close		challenged	
loved		optimistic	
comforted		re-enforced	
drawn toward		confident	
		hopeful	
Difficult/Unpleasant Feelings			
ANGRY	**DEPRESSED**	**CONFUSED**	**HELPLESS**
irritated	lousy	upset	incapable
enraged	disappointed	doubtful	alone
hostile	discouraged	uncertain	paralysed
insulting	ashamed	indecisive	fatigued

sore	powerless	perplexed	useless
annoyed	diminished	embarrassed	inferior
upset	guilty	hesitant	vulnerable
hateful	dissatisfied	shy	empty
unpleasant	miserable	stupefied	forced
offensive	detestable	disillusioned	hesitant
bitter	repugnant	unbelieving	despair
aggressive	despicable	sceptical	frustrated
resentful	disgusting	distrustful	distressed
inflamed	abominable	misgiving	woeful
provoked	terrible	lost	pathetic
incensed	in despair	unsure	tragic
infuriated	sulky	uneasy	in a stew
cross	bad	pessimistic	dominated
worked up	a sense of loss	tense	
boiling			
fuming			
indignant			
INDIFFERENT	**AFRAID**	**HURT**	**SAD**
insensitive	fearful	crushed	tearful
dull	terrified	tormented	sorrowful
nonchalant	suspicious	deprived	pained
neutral	anxious	pained	grief
reserved	alarmed	tortured	anguish
weary	panic	dejected	desolate
bored	nervous	rejected	desperate

preoccupied	scared	injured	pessimistic
cold	worried	offended	unhappy
disinterested	frightened	afflicted	lonely
lifeless	timid	aching	grieved
	shaky	victimised	mournful
	restless	heartbroken	dismayed
	doubtful	agonised	
	threatened	appalled	
	cowardly	humiliated	
	quaking	wronged	
	menaced	alienated	
	wary		

Annexure 4 for Activity 2 (Home assignment): Whose Line is it anyway? Appropriate Counselling Lines using couple counselling techniques:

1. Normalise feelings , reactions , experiences:

   The effort here is to help the couple to recognise that their feelings such as guilt and betrayal are common and that other couples also feel similar emotions. Learning that their emotional reaction is common or natural gives the clients a sense of reassurance and validation that their emotions are justified – even if they cannot act on their deepest hurt or anger. The counsellor here demonstrates acceptance of the emotion, and not of any harmful or negative behaviour.

- *"Many couples in this situation feel like you do right now."*
- *"You are not the only one who feels this way. Other husbands (or wives) also feel betrayed (or guilty or angry) like you do right now. I can reassure you that many of them also manage to work through their problems."*

2. Effectively use silence while remaining calm and supportive:

   We have already seen that couple counselling involves a high level of intense feeling. Sometimes creating a deliberate moment of silence may bring the emotion to a manageable level. The counsellor may also use this technique when she/ he judges that the couple would benefit from a period of silence so they can collect their thoughts and respond accordingly.

Sometimes, the counsellor's silence may prompt the couple to open up. Many counsellors are uncomfortable with silence or pauses in the conversation. But if used effectively, this is a very effective technique.

- *"It seems like the atmosphere in the room is very hot. I'd like us all to be silent for just a little while so that we can regain our composure."*
- *"Let us pause a bit while I let you think about what I have just explained."*

3. Focus on the present and the future:

   It is common for a couple to recall past deeds and hurts. These may surface during the session. It is, therefore, helpful for the counsellor to gently bring back the focus of the session to the here and now, and to emphasise that the past cannot be altered. But it is also important not to use this technique to avoid an issue or to brush it under the carpet.

- *"It is easy to recall past incidents that have been painful in the relationship. But these cannot be rewritten or undone. All that we really have control over is our current and future direction."*

  Here there are some gender dimensions of which a counsellor should be aware. In India, married women are often expected to suppress their anger and betrayal when their spouse is unfaithful. Counselling personnel should be careful to avoid conveying to female clients that infidelity is acceptable, and thus negate or fail to validate their deepest anguish and hurt. Rather this technique should be used when clients appear to be narrating woeful stories that they have told several times before.

4. Avoid questions aimed at identifying source of infection:

   Related to the point above is the almost inevitable desire of the partners to identify when exactly HIV was transmitted. This is bound up in the possible infidelity of the infected partner and it also moves the focus of counselling to the past which cannot be undone. So the counsellor should point out that any discussion about the source of the infection is neither helpful nor relevant to the couple's current situation and life decisions.

- *"While the question of how and when HIV got in is something that everyone asks, you should also realise that HIV is present and we have to deal with it. Knowing where it came from does not really help our decision-making for the immediate present and the future."*
- *"Let me answer your question about when HIV entered with a short story. If a house is burning down and there are two people still stuck in the building, what is the immediate need? Would you stop to guess how the fire started or would you try to rescue those people and put out the fire? In a similar manner, worrying about where HIV came from, and trying to pin-point the source will distract you from the more urgent concerns before you."*

  Once again it is important to emphasise that this technique should not be used to cover up really important issues such as wife-beating, emotional abuse or spouse's alcohol misuse. This technique is recommended to help client couples progress to concrete decision-making on key

issues such as registering at the ART centre, getting their child or spouse tested. The counsellor should address underlying conflicts during follow-up counselling sessions.

5. Express confidence in couple's ability to deal with issues:

   The counsellor must project a sense of optimism that the couple will be able to deal with their life decisions. She/ he can accomplish this by jointly reflecting with them on their strengths and shared history. By examining how they, as a couple, have effectively addressed challenges in their lives, the counsellor can highlight their strengths. The counsellor should not only acknowledge these strengths but should show appreciation that the couple is willing to deal with HIV.

   "It appears to me that together you have survived some difficult times. I am sure that once you have a chance to catch your breath, the same strength will help you in this current situation also." Together, I believe, the two of you have the strength needed to deal with these difficult events. It might be helpful to make a list of all the difficult times you have faced successfully in the past."

6. Project sense of optimism in couple's abilities:

   "It appears to me that together you have survived difficult times. I am sure that once you have had time to catch your breath the same strength will help you in dealing with this problem as well.

7. Work with intense emotions :

   In couple counselling, it is important to acknowledge the feelings expressed by the couple verbally and nonverbally. As these emotions may be overwhelming, it is important to also reassure them that as time passes the intense emotions and reactions will change or shift. This is a common and known pattern.

- *"Many couples show the same initial reactions as you, but I have seen that over time this gradually changes, and they adjust."*
- *"It is normal to feel so upset (or sad or angry). But slowly you will find yourself adjusting and coping."*

8. Reframe questions that are blaming or hostile:

   The emotional intensity between couples is sometimes due to blaming and angry reactions. The counsellor can defuse this situation by identifying underlying softer feelings and helping the couple to recognise that. For instance, fear, anxiety, and uncertainty are sometimes expressed as anger. One way to understand this concept is to recall an instance when you saw a child run towards some danger like a burning stove or a busy road. Your reaction might have been to rush and pull the child away, to express relief ("Thank God, I got you in time.") or to shout at the child

for not being more careful. What is underlying all of this is deep fear at the possibility of hurt to the child. But this is expressed differently.

- "It is common to feel many mixed-up emotions at the same time. Could you list what is going on in your mind right now?"
- "Sometimes people express frustration and anger but they are also experiencing many other things at the same time."

Annexure 5: Key to 'Whose line is it anyway?' (Not to be photocopied)

1. "When do you think my partner got infected with HIV?"

- First normalise the feelings. Deflect the question that is targeted at the source of infection. Then focus on the present and the future.
- "It is common for people to be curious about where their partner got infected. But this question will shift the focus away from dealing with handling the infection. Isn't it better to think about the future right now? Let us try to stabilise your partner's health first."

2. "I don't want to use a condom because I want to get pregnant."

- First normalise the feelings. Then discuss the issues.
- "Wanting to have a child is a normal human urge. Let us discuss the issues."

3. "I don't want to use a condom because I do not feel as much "sex" as I would be able to without wearing it."

4. "How could my husband/ wife do this to me? I feel like killing him/ her."

- This is an intense emotion that you should work with.
- "Many partners in a sero-discordant couple often feel really strong emotions. These do not stay at the same level. Let us explore what is upsetting you."

5. "Please tell me how AIDS came into our life, into our relationship."

6. "I am so upset and angry and sad and worried. I am upset at my partner for bringing this into my life. I am sad because our child will miss one parent. I am worried that I might also have it."

- Reframe these emotions and responses.

7. "It is common to feel many mixed-up emotions at the same time. Often we are angry with others when we are actually upset with ourselves for not being able to do something?"

8. "I am so angry at him/ her because he/ she had sex with someone else."

9. "I am so angry at him/ her because he/ she has brought this thing into the family."

10. "We know that one of us is infected. But we want to have a child."

11. "I knew when I got married that my life with this person would be useless. Look at how I am trapped now."

12. "I have HIV but my wife does not. What should I do next? She is pregnant. I understand that she should get tested for the sake of the baby. But what if she finds out that I am infected! I am scared about knowing her result. I am also guilty about my own behaviour. Tell me what to do please."
    - First normalise the feelings. Reflect some of the feelings that the client is feeling. Then focus on the present and future.
    - "In such a situation many people feel very confused and have mixed feelings. You have expressed confusion, worry about your wife's sero-status, and guilt about being positive. Let us discuss; what are the important steps you need to take right now."

13. "I am so confused. I do not know how to react."

SESSION 18
Basics of Antiretroviral Therapy

Session Overview:

- Lecture using slides (40 minutes)
- Carousel Activity (30 minutes)
- Debriefing of Carousel Activity (20 minutes)

Session Objectives:

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

- The relevance of understanding the ART regimen for ICTC and STI/RTI counsellors.
- How counsellors may use the information about ART in their session.
- Describe the progression of HIV infection to AIDS and the WHO clinical staging.
- Explain about ART, its benefits, side-effects and limitations.
- Describe the effects of ARV drugs in relation to the HIV life cycle in the body.
- Identify the reasons for treatment failure and need of 'switch' and 'substitution' of treatment.
- Assess and evaluate these issues jointly with clients.

Time allowed:

- 1 hour 30 minutes

Material required:

- Slides related to the session
- Carousel Situations
- Cello tape
- Participants Handbook

Method:

Preparation before the Session

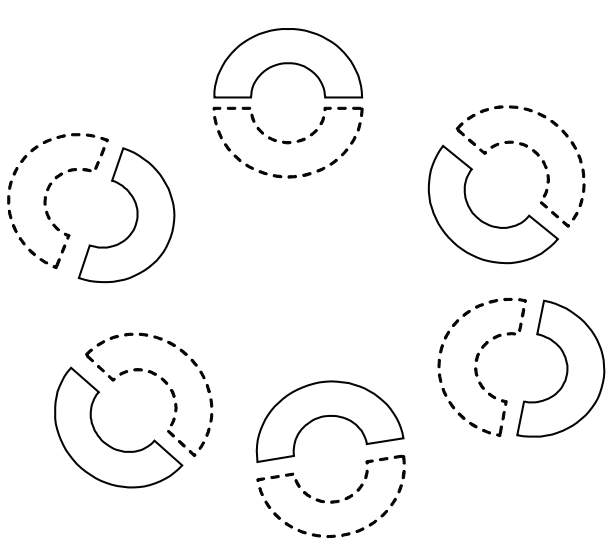
1. You, as the facilitator, will cut up the Carousel Situations and keep them handy BEFORE the session. The Capacity Building Officer will have to assist here.

Lecture using Slides (40 minutes)

2. Explain the key points in the session using the slides and the dialogue given for your convenience.
3. For the slides on side-effects, guide the participants to the relevant pages in their hand- outs and permit sufficient time for them to understand the key points.
4. In summary, emphasise the following points: *The client should not stop taking medication OR skip OR reduce doses; and that ART is at present a LIFETIME treatment.*

Carousel Activity (30 minutes)

5. For this activity, request the participants to help you arrange their chairs in two concentric circles with the inner circle facing the outer circle. Place the chairs slightly apart such that one can recognise distinct pairs and such that each pair has some privacy. See sample image. The Capacity Building Officer will have to assist here.



6. Use the cello tape to paste the Carousel situations to alternate chairs in the inner and the outer circles (that is the chairs with dashed outline as shown in the above figure). Thus each set of chairs will have one Carousel situation.
7. Explain the activity: Each pair has a situation to role-play. The person who is seated on the chair with the situation has to role-play a client with the problem described on the paper while the opposite person plays the role of a counsellor. "Clients" may take one minute to think about the situation and then describe it to their "counsellor." "Counsellors" have to listen carefully to the situation, ask relevant questions, identify the possible causes of the side-effects, discuss management of the side-effect, and suggest a suitable course of action. "Counsellors" may use their hand-outs for correct information.

8. Ask the participants to select a seat and perform the first round for 5 minutes.
9. After the first practice round of 5 minutes, it is time to move to the next practice situation. For this, ask each participant to shift to the next seat ON THEIR RIGHT. This means that the pairs will move away from each other and form new pairs. Each pair will have a new carousel situation and each person will have a chance to reverse roles. Those who were "counsellors" before will now become "clients." Those who were playing the "client" can now try their hand at being "counsellor." Each "client" may take a minute to read and prepare their role, and the new "counsellor" may open up their handbook for the activity.
10. Conduct two more rounds for 5 minutes each. Thus each person should have 2 chances to be both counsellor and client.

Debriefing of Carousel Activity (20 minutes)

11. First ask participants for general feedback on the exercise: how they felt and whether the exercise was helpful in preparing to counsel HIV clients.
12. Then discuss two or three Carousel situations. To guide you, there are some sample discussions prepared. Ensure that you cover the possible causes of the side-effects, their management and what the counsellor should do (viz. early identification and referral where required).
13. To ensure the take away messages give participants a sheet called reflective diary. Explain it to participants and help them to fill it. This will help them to develop a list of points to be remembered while practicing the information given in the session.

Reflective Diary

The Topic of the Session	What did you learn?	What difference will it make to your Practice?
Example: Basic ART	**Example:** Learned about clinical stages of HIV. Also understood the time for the initiation of ART as per WHO. Learned about three major groups of ART. National ART regimen. First and second line of regimen. Side effects and adherence issues.	**Example:** I am a STI counsellor and now understood the importance of ART in the life of PLHIV. Now I would be able to help my client in a better way. I have also understood the drug interaction as well as its side effects which I may tell my client to help him seek the appropriate service at time of side effect or drug interaction. After getting information about why people do not adhere to treatment I may help my client in adherence also.

Remember: The counsellor's role is to suspect, screen and refer. The Counsellor is not trained to prescribe!

Alternative methodology to establish take home messages:

Quiz may be developed on the important points in the session. The participants would answer the question flashed on the screen and facilitator would fill the gap. The selected questions would be asked. Question on the following areas may be asked to create take home message:

- The question on ART regimen.
- First line and second line.
- Three major groups of ART.
- When to start ART as per WHO?
- Some side effects of ART.
- How to make the client adherent to treatment?

- ***Quiz may be used before the activity of Reflective Diary. The quiz would refresh their memory about major learning in the session. After this they may fill the Reflective Diary to consolidate the learning in their respective situation.***

Key messages:

- Although ART dramatically improves the health and life expectancy for PLHIV, ART is not a cure for AIDS.
- ART is to be taken life-long. The virus can never be eradicated completely from the body, so ART has to be continued forever, even if the patient is asymptomatic.
- HIV can still be transmitted to others, even when the PLHIV is healthy and taking his/her medication regularly. Thus safe sex should be practiced even if the patient is on ART.
- The reinforcement of the principles of adherence and limitations of ART treatment by the counsellor is of great help for the client. You need to make sure that clients have the information sheets specific to the ART regimen that they are taking.
- During counselling sessions emphasise that even when on ART, people need to continue using condoms regularly and practice safe injecting drug use.
- Also, remember that ART means hope. You need to emphasise the positive aspects of the treatment while making sure that the clients know the most appropriate way to consume the drugs.

Annexure

Annexure1 : Carousel Situations

- You are Sandeep, a 32-year-old man who is on ART. You are suffering from diarrhoea with nausea and vomiting for last few days. You feel that whenever you take the ART drugs the frequency of diarrhoea and vomiting increases. So you have decided to consult the counsellor at the HIV clinic for help.

- You are Ramu, a 23-year-old man who is regularly taking his ART medicines, a combination of Stavudine, Lamivudine and Nevirapine. But for the last few days you have a tingling and painful sensation in your legs and hands. You have come to the HIV centre to seek help.

- You are Rehana a 24-year-old woman who is on ART (Zidovudine, Lamivudine and Efavirenz) from last 10 months. Since the last month you are feeling very low. You don't feel like to talk to anyone or to do any work. Nowadays you easily become irritable and aggressive. You are very disturbed with these changes in yourself and thus look for the counsellor to help.

- You are Suman, a 30-year-old woman who is taking ARV drugs (Zidovudine, Lamivudine and Efavirenz) for the last two years. You are not feeling well for a few days. You feel that your ability to work has reduced. Whenever you try to do some work you get tired easily and develop shortness of breath. You have also observed that your palm and fingers now looks paler. So you have come to the HIV clinic to seek the counsellor's help.

- You are Razia, a housewife. You have recently been shifted from the Nodal ART centre to the LAC centre. But since few days you are experiencing headache and bad dreams because of which you are not able to sleep well. You also experience that these symptoms increases when you take ARV drugs. So sometimes you tend to skip the drugs.

- You are Rose, a 30-year-old woman is on ART (Stavudine, Lamivudine and Nevirapine) for the last three years. You explain to the counsellor on your monthly visit that your arms, legs and cheeks have become thin whereas the area around the neck has become fatty.

- You are Manpreet, a 28-year-old man who has been shifted to LAC last month only. For the last few days you are experiencing a sensation of a dry mouth and have painful white patches on your tongue and mouth.

Annexure 2 : Sample Discussion of Carousel Situations

For facilitator's guidance only: not intended for verbatim use.

Note: This session was prepared before Stavudine was phased out. But it is still useful to know this.

Carousel Situation: You are Ramu, a 23-year-old man who is regularly taking his ART medicines, a combination of Stavudine, Lamivudine and Nevirapine. But for the last few days you have a tingling and painful sensation in your legs and hands. You have come to the HIV centre to seek help.

Discussion: The counsellor should explain to the client that ARV drugs have some unwanted effects known as side-effects. These side-effects can occur immediate to the use of drug or with long use of the drug. The symptoms of tingling, numbness or pain in feet or legs and hands can be the result of the use of Stavudine for months and years. Counsel the client to wear loose-fitting shoes and socks, to walk a little (but not too much), to keep feet uncovered in bed, to soak the feet in warm water or massage them with a cloth soaked in warm water. Reassure him that the pain and tingling sensation will go away with time. However, if tingling does not go away and pain prevents Ramu from walking, then he should go and seek medical help. Reinforce that he should not stop taking medication or skip or reduce doses on his own as adherence to treatment is important to prevent resistance.

Carousel Situation: You are Suman, a 30-year-old woman who is taking ARV drugs (Zidovidine, Lamivudine and Efavirenz) for the last two years. You are not feeling well for a few days. You feel that your ability to work has reduced. Whenever you try to do some work you get tired easily and develop shortness of breath. You have also observed that your palm and fingers now looks paler. So you have come to the HIV clinic to seek the counsellor's help.

Discussion: The counsellor has to first check for the signs of anaemia (pale palms and finger nails, shortness of breath and muscle pain) and should explain to Suman that the symptoms that she has developed indicate anaemia which can be because of Zidovudine. The counsellor has to educate her that anaemia is a common side-effect of the drug and could be managed at home by eating food rich in iron (Fish, meat, chicken, green leafy vegetables like, spinach) and folic acid and Vitamin B12 (fortified cereals, orange juice, fish, dairy products) as well as iron tablets prescribed by the medical officer. She also has to be informed that if the symptoms do not go after 3-4 weeks or if they worsen i.e. if the feet get swollen or she develops difficulty in breathing, then she should seek urgent medical care.

After counselling and answering her queries related to the symptoms, refer her to Medical OPD for assessment of her anaemic status and prescription if needed. Emphasise the importance of taking regular medicine. If ART is stopped then ART resistance is likely to develop.

Carousel Situation: You are Rose; a 30-year-old woman is on ART (Stavudine, Lamivudine and Nevirapine) for the last three years. You explain to the counsellor on your monthly visit that your arms, legs and cheeks have become thin whereas the area around the neck has become fatty.

Discussion: The counsellor has to explain to Rose that long use of Stavudine can cause redistribution of body fat resulting in thinning of arms, legs, buttocks, cheeks or accumulation of fat in breasts, belly and back of neck. However, this redistribution of body fat (Lipodystrophy) can be managed by eating in moderation. The counsellor can suggest to reduce intake of fat, especially ghee, butter, fatty meals: to eat more fibre-rich food like whole cereals *(dalia, bajra)*, whole pulses *(rajma, chana)* and fruits like pineapple, apple, pears; to limit intake of refined sugars like sweets, *mithai*, soft drinks; to avoid alcohol and smoking; to exercise regularly; to do weight-bearing exercises (Running, jogging, walking, Sports that involve running and/or throwing such as basketball, tennis, baseball, volleyball)and to lead a regular life ensuring adequate rest and sleep. The counsellor must also inform Rose about the other side-effects of the regimen that need urgent medical care and should ask her to seek doctor's help if she develops severe abdominal pain, severe fever, body ache and running nose, yellow eyes, and severe skin rash with mouth ulcers, fatigue and shortness of breath. Inform her that these are the signs of the severe side-effects of ARV drugs and should be treated as soon as possible. Reinforce that the client should not stop taking medication or skip or reduce doses by their own as the adherence to the treatment is important to prevent resistance.

SESSION 19
Counselling for ART Adherence and Treatment

Session Overview:

- Lecture using slides (30 minutes)
- Demonstration of the '5As' method (10 minutes)
- Lecture using slides (15 minutes)
- Let us count some pills (30 minutes)
- Disputing statements activity (20 minutes)
- Lecture using slides (10 minutes)
- Small group discussion on 'Special Counselling Situations' (15 minutes)
- Lecture using slides (10 minutes)
- Demonstration of the 'Adherence Calculator' (10 minutes)

Session Objectives:

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

- Understand adherence and consequences of poor adherence to treatment.
- Understand why counselling is important for adherence to treatment.
- Understand the barriers to adherence and how a counsellor can help an individual deal with it.
- Demonstrate ART adherence counselling.
- List methods to monitor and support PLHIV's adherence through counselling.
- Learn how to use the adherence calculator.
- Understand how counsellor can deal with special situations like: missed appointment, lost to follow up and so on.

Time allowed:

- 2 hours 30 minutes

Material required:

- Slides related to the session.

- Table on adherence calculation (Provided in the annexure).
- 190 dummy pills (or items which are countable and resemble pills such as 'Cadbury Gems' or buttons).
- 15 bottles (or suitable containers which resemble a pill box) A chocolate bar.
- Demonstration situation of the '5As' method.
- Counselling checklists (Provided in the annexure).
- Special counselling situations (Provided in the annexure).

Method:

Preparation before the Session:

1. You, as the facilitator, will prepare the ART pill bottles BEFORE the session: Take 190 "pills," fill and label the bottles as given in the table

Case No	Number of bottles	Number of pills in each	Bottle Label
1	5	9	28th day
2	5	23	25th day
3	5	6	35th day
Total pills		**190**	

You will have 5 sets of 3 bottles each.

2. BEFORE the session, take print outs of:
   a. Role-play situation on 'Barriers to Adherence'.
   b. The 'Special Counselling Situations'.

Lecture using slides (30 minutes)

3. Explain the key points in the session using slides (1 to 13) and the dialogue given for your convenience.

Demonstration of the '5As' method (Slide 14) (10 minutes)

4. Play the role of counsellor and invite one participant to act as the client. Share the demonstration situation with the volunteer.
5. Demonstrate how to use the 5As in addressing the barriers to adherence. You have to act as the counsellor.

6. After completing the role-play, discuss the demonstration with the following questions:
    - What were the questions used by the counsellor to assess the barriers?
    - How did the counsellor assist the client in addressing the barriers?
    - What advice was given to the client?

Demonstration situation on the use of '5As':

Facilitator will play the role of counsellor and a participant will volunteer to act as Mr. Hassan – the client.

Mr. Hassan is a client at your ART CENTRE who has been regular in visiting the centre. He used to tell you that he would be able to run his small shop till his son is able to take over it. Recently you have noticed that Mr. Hassan is gloomy and speaks less during the counselling session. His adherence level has also started coming down. You offer him a special counselling session in the afternoon to trace the reasons for the change. He is hesitant to open up at the start. However, later he tells you that he has lost his belief in the medicine. You learn that his close friend, who was also on ART, has passed away recently.

For facilitator's guidance only: not intended for verbatim use.

Mr. Hassan has been adherent to ART as he wanted to be healthy. However, as revealed, his friend's death has affected him much. He has lost his belief that ART will keep him healthy. The key for the counsellor is 5 As:

- **Assess:** How much is the effect? Has he fully lost his belief in the medicine? Is there any other reason? How is his understanding about adherence? Has he already developed any consequences of poor adherence?
- **Assist:** Understanding the problems of poor adherence, relate adherence with well- being, being able to differentiate his case from that of the friend.
- **Advice:** Need of adherence, how to come out from the depressed situation; discuss such issues with the counsellor.
- **Arrange:** Follow-up visits and consultation with doctor, if required. Support group meetings with other PLHIV.
- **Agree:** Continuation of medicine without missing pills, follow-up sessions.

Lecture using slides (15-20) (15 minutes)

7. There are two brainstorms and one problem related to calculating adherence using the 'Pill Count Method'. This is a critical competency for ART counsellors. So you are advised not to cut down on time here. As part of the lecture you also have to demonstrate the use of the **Visual Analogue** as demonstrated to you at the 'Training of facilitators' workshop.

Let us count some pills (slide 21) (30 minutes)

8. For this activity, the participants should remain in the same groups.
9. Introduce the exercise by explaining that counsellors should be able to calculate client adherence using the pill-count method and the following formula (which they have seen on slide 16).

% Adherence

$$= \frac{\text{Number of pills the client should have taken - Number of pills missed}}{\text{Number of pills the client should have taken}} \times 100$$

This is also equal to

$$= \frac{\text{Number of pills given to the client – Number of pills balance in the bottle}}{\text{Number of pills the client should have taken}} \times 100$$

For 1st line ART only

No. of pills client should have taken = No. of days client took the pills x 2

10. Give each group one set of the three drug bottles with the different pills (Cases 1, 2) and instruct the groups to calculate the adherence by using the information: number of pills left in the bottle and the days on which the client has returned. Permit them 10 minutes to complete the task. It is more effective if each member tries this activity individually and then the group compares numbers. You should go around and check on the group progress. Note, which group is first in completing the task accurately.
11. Gather the groups together and discuss the solutions to the problems. Where possible, invite participants to demonstrate the use of the formula. Repeat the calculations in case there are participants who experience difficulty. For your convenience, the solution key to each situation is provided. Announce the group who first completed the calculations accurately and give them the chocolate as a reward.

Solution key for 'Let us count some pills':

For facilitator's guidance only: not intended for verbatim use.

Please practice this well before conducting the session.

Case No.	Number of Balance Pills	Daywhichclient returns to centre	Adherence calculation	% of Adherence
1	9	28th day	Adherence % = (60- 9)x 100 (28x2)	91
2	23	25th day	Adherence % = (60- 23) x 100 (25x2)	74
3	6	35th day	Adherence % = (60- 6)x 100 (35x2)	77

Disputing statements activity (slide 22) (20 minutes)

12. Divide the participants into 5 groups and ask each group to fill the 'Disputing Statements' work sheet in their hand-outs: Ask the groups to develop appropriate counselling responses to dispute or challenge the client's statement. Provide them one example of a counselling line. (See slide 22) Give them 10 minutes for the task.
13. Next, discuss each statement one by one with inputs from different groups. Ask the groups to also explain their reason for suggesting the counselling response.

Solution key for 'Disputing statements activity':

For facilitator's guidance only: not intended for verbatim use.

The column given on the left side of the slide presents different statements which may be made by the clients during the course of treatment. Counsellor's intervention starts from listening to the statement, analysing the reason/problem behind the statement and systematically addressing the same.

For example,

If the client says, "I don't think I can take the medicine for my life time" counsellor should put forward the following question:

Assess: "Can you tell me why are you feeling so?" "Did you have any difficulties in taking medicine so far?" or "Do you expect some problems in the future?" "Will you like us discussing these issues and finding a way out?" "Have you missed your medicines before because of this reason? Had you faced any issues because of it?"

Assist: "Let us see, how this is going to affect you."

Advice: "Let me explain what will happen if you are not able to solve the problem and take your medicines."

Arrange: "If you would like to have support from somebody else, I can arrange for that." Agree: "So, as we discussed; what will you do?"

Sr. No.	Client's Statement	Counselling Questions
1	*"I don't think I can take the medicine for my life time"*	"I understand your concern. But may I know why you feel so?" "Let us see how you can take it every day." "I work with many other people and I can tell you that there are many people who have been on ART for at least three years." "Yes, it is difficult to take ART day after day. But if you make it a habit, it is possible to do so." "Do you have someone in your family who can help you in this matter?" "Have you heard of diabetes? People with diabetes also have to make such adjustments for a lifetime. I agree it is difficult. But it is not IMPOSSIBLE."
2	*"I don't want to come to the Link ART centre. Staff behave rudely."*	"I am sorry for the way other staff has behaved with you. I can understand your feelings." However, other people's behaviour is not a reason for you to stop medicine. Let me see how I can help you. Was there something specific you needed from the centre which you were not able to get?" The counsellor may have to do some advocacy work within the centre and sensitise other staff members about the perceptions of the ART clients **without naming** the client.
3	*"I don't think ART can help me."*	"You do not seem to be feeling good with medicine. May I know what makes you worried?" Probe for side-effects as this may disrupt adherence.
4	"I don't know how to take the medicines."	"You seem to be worried about the medicine. Don't worry I can explain the things to you. If you don't understand, you can always ask me to explain again." "Can you tell me what you have been doing?"

Note for facilitator:

The term 'Disputing Statements' comes from Rational Emotive Therapy where the therapist disputes or counters unrealistic statements of the client with logic and examples.

Lecture using slides (slides 23-26) (10 minutes)

14. Explain adherence fatigue using the **slides (23 to 25)** and the dialogue given for your convenience. There is a demonstration of the 'Balloon Game' **(Slide 26)** which if time permits, can be demonstrated by the facilitator.

Small group discussion on 'Special Counselling Situations' (Slide 27) (15 minutes)

15. Divide the participants into five groups and provide each group a special counselling situation given in **Annexure 1**.
16. Instruct them to discuss the situations, identify the problems and counselling strategies.
17. Assign them 10 minutes for the task.
18. Invite the groups to present to the larger group. Invite feedback and suggestions from the other groups for each situation. Once all groups finish their presentations, summarise.

Lecture using slides (10 minutes)

19. Explain MIS and LFU and how to counsel them using **slides (28-30)** and the dialogue given for your convenience.

Demonstration of the 'Adherence Calculator' (10 minutes)

20. Explain that you are now going to teach them a simpler way to calculate adherence where they will not have to use the formula. Give the participants the laminated adherence calculator. For instance, if working out Problem 1, ask them to look at the first column showing **pills remaining**, identify the number 9 and then move their finger across till they come to the column for the 28th day. The answer reads 91.
21. Practice a few more problems asking different people.
22. Ask them to turn the adherence calculator which shows regimens for which 90 pills are used. Practice some problems here as well.
23. Conclude with a brief discussion of why it is necessary to know the formula but also how it may not always be easy to calculate adherence correctly.

Though we are training counsellors to use a simple chart for adherence calculation, it is also important for them to understand the formula. Therefore, please give enough time and emphasis to *both* methods.

Slides 31-41: Checklists for adherence counselling to be referred by the counsellor.

Key messages:

- Adherence simply means following the treatment plan as prescribed by the doctor. This includes taking the correct dosage, at the prescribed time, in the correct manner. Apart from medicines, it also requires timely follow-up at the health facility, following a proper diet, and maintaining a healthy lifestyle.
- Counselling plays a vital role in preparing the client for treatment and also in supporting adherence.
- Help the client identify and adopt the most suitable way to ensure that he/she takes medicines. The focus must be on the client since he/she is the person who knows best about his/her life situation and is best able to plan ways to integrate ART treatment in his/her life.
- The role of the counsellor could be described in three major stages:
  - Treatment preparedness counselling.
  - Counselling during treatment commencement.
  - Follow-up counselling for adherence.
- Adherence monitoring is the process of gathering information on all aspects of treatment adherence, including treatment of OIs, routine prophylactic treatment or other medication such as Anti-Tuberculosis Treatment (ATT).
- Adherence can be calculated using the following formula:

  % Adherence =

  Number of pills the client should have taken - Number of pills missed x 100

  Number of pills the client should have taken
- The client should be given a comfortable atmosphere where he/she feels able to openly confide about missed doses and seek help from the counsellor for changing this pattern in the future.
- Routinely check for any kind of potential barriers for the client's adherence to medicine as well healthy life-style practices.
- Help the client to analyse the situation of barriers to adherence and seek possible ways to address such issues. The 5 'A' principle (Assess, Assist, Advice, Arrange and Agree) can be utilised in such situations.
- Adherence fatigue is the state when the client gets bored of the routine of taking medicines, stops bothering about the disease and stops taking medicines subsequently.
- Keep in mind that adherence is a dynamic behaviour and it may change at any time. Proper counselling during each visit can prevent adherence fatigue to a great extent.

Annexure

Annexure 1: Small group discussion on special counselling situations

Situation 1 (Client reports adherence <80)

Mrs. Rose, 34 years old, lives 50 km. away from your centre with her husband and children. She has been regular in visiting the centre. During her current visit, there are 24 pills remaining in her pill bottle.

Situation 2 (Client frequently misses visit)

Before closing the register today you check the daily due list - the names of clients who have to visit the centre today. You notice that Mr. Prakash, from a distant area in your district, has not collected his medicine today. You recollect that this client has been shifted to your centre 3 months ago. This is not the first time he has missed his appointment.

Situation 3 (Client attempts suicide)

Mr. Kulbir, a 47-year-old truck driver, is on ART for last 4 years. He has been receiving medicine from your centre for 10 months. During his last visit, he told you that he is not able to drive properly, as he feels tired. Today, his wife has come to meet you. She told you that Kulbir tried to hang himself the day before and has been admitted in your own hospital.

Situation 4 (Client takes an overdose)

Mrs. Annie, 46-year-old lady, is on ART for one year. During her third visit, she shared that she felt much better after starting ART. This time she has come 5 days before to collect her pills with an empty bottle. She tells you that she has taken all the tablets you gave her so that she can escape from the disease.

Situation 5 (Goes to Bhuva/ Sadhu)

Mr. Raghav is a 50-year-old client at your centre. You have noted down that he misses his appointments and comes to the centre late. His adherence is below 95%. This time you understood that he has not taken pills for one week. When you ask him the reason, he replies: “Nothing will happen to me, even if I don’t take the medicine. A baba has told me that he will cure me”.

Annexure 2: Quick reference boxes:

Quick Reference Box 1: Signs of treatment fatigue

Client says the following-

- "I am no longer HIV positive."
- "Now I do not have any problem and I am cured."
- "I am fed-up with medicines."
- "I think I can stop medicine now, I don't think I have to take more."
- "I think I am not HIV-positive, I need to do test once more."
- "I don't think there is any issue if I stop medicine for some time."
- "I forgot to take medicine."

Quick Reference Box 2: Possible Signs and Symptoms of OIs and ART Side-Effects

- Feeling dizzy.
- Pain when swallowing.
- Trouble in breathing.
- Frequent or very bad headaches.
- Problems in seeing.
- Feeling more and more tired.
- Fever or feeling hot for more than a day.
- Sweat soaks the bed.
- Cough lasting over 2 weeks.
- Shivering and chills.
- Problems with balance, walking or speech.
- Skin rashes.
- Losing weight for no reason.
- Watery diarrhoea for more than 4 times a day, nausea, despite treatment.
- Vomiting.
- Dry mouth.
- Sore mouth or tongue.
- Stiff neck.
- Severe stomach or abdominal pain
- Swelling, burning, itching, soreness, discharge or smell on or near the vagina.
- Changes in menstrual cycle or menstrual flow.
- Pain during sexual intercourse.

Quick Reference Box 3: Signs and symptoms of STIs	
Males	**Females**
• Sores, ulcers, blisters on genital area • Small hard lumps • Rashes around and in the sexual organs including mouth/anus • Burning sensation while passing urine • Frequent urination, and discharge from penis or anus • Infection or inflammation inside rectum/ anus • Swelling of the scrotum/groin area • Sore throat	• Excessive/foul smelling vaginal discharge • Sticky greenish and yellowish vaginal discharge • Itching in genital area • Lower abdominal pain • Sores, ulcers, blisters • Small hard lumps • Rashes around and in the sexual organs • Painful itching • Burning while passing urine • Swelling in and around vaginal area • Inflammation of rectum • Pain when having sex • Frequent urination • Sore throat

Annexure 3: Adherence Calculator:

Instructions for calculators on the next page:

1) **Count the number of pills remaining in the bottle.**

   For example, the client came with 8 pills.

2) **Look down the first column of the chart for that number.**

   Go to Pills Remaining = 8

3) **Move your finger in that row till you reach the column for the day of the client's visit.**

   If the client attends on the 29th day after the last visit, adherence is 90% (Example based on 60-pill regimen).

Adherence Calculator for SLN/ ZLN/ TDF-3TC-EFV

Pills Remaining	Day of Visit for 60-Pills											
	24	25	26	27	28	29	30	31	32	33	34	35
0							100	97	94	91	88	86
1							98	95	92	89	87	84
2						100	97	94	91	88	85	83
3						98	95	92	89	86	84	81
4					100	97	93	90	88	85	82	80
5					98	95	92	89	86	83	81	79
6				100	96	93	90	87	84	82	79	77
7				98	95	91	88	85	83	80	78	76
8			100	96	93	90	87	84	81	79	76	74
9			98	94	91	88	85	82	80	77	75	73
10		100	96	93	89	86	83	81	78	76	74	71
11		98	94	91	88	84	82	79	77	74	72	70
12	100	96	92	89	86	83	80	77	75	73	71	69
13	98	94	90	87	84	81	78	76	73	71	69	67
14	96	92	88	85	82	79	77	74	72	70	68	66
15	94	90	87	83	80	78	75	73	70	68	66	64
16	92	88	85	81	79	76	73	71	69	67	65	63
17	90	86	83	80	77	74	72	69	67	65	63	61
18	88	84	81	78	75	72	70	68	66	64	62	60
19	85	82	79	76	73	71	68	66	64	62	60	59

Pills Remaining	Day of Visit for 120-Pills (TWO MONTHS)										
	55	56	57	58	59	60	61	62	63	64	65
0						100	98	97	95	94	92
1						99	98	96	94	93	92
2					100	98	97	95	94	92	91
3					99	98	96	94	93	91	90
4				100	98	97	95	94	92	91	89
5				99	97	96	94	93	91	90	88
6			100	98	97	95	93	92	90	89	88
7			99	97	96	94	93	91	90	88	87
8		100	98	97	95	93	92	90	89	88	86
9		99	97	96	94	93	91	90	88	87	85
10	100	98	96	95	93	92	90	89	87	86	85
11	99	97	96	94	92	91	89	88	87	85	84
12	98	96	95	93	92	90	89	87	86	84	83
13	97	96	94	92	91	89	88	86	85	84	82
14	96	95	93	91	90	88	87	85	84	83	82
15	95	94	92	91	89	88	86	85	83	82	81
16	95	93	91	90	88	87	85	84	83	81	80
17	94	92	90	89	87	86	84	83	82	80	79
18	93	91	89	88	86	85	84	82	81	80	78
19	92	90	89	87	86	84	83	81	80	79	78

Adherence Calculator for SL-Efv/ ZL-Efv/ TDF-3TC-ATV

Day of Visit for 90-Pills

Pills Remaining	24	25	26	27	28	29	30	31	32	33	34	35
0							100	97	94	91	88	86
1							99	96	93	90	87	85
2							98	95	92	89	86	84
3						100	97	94	91	88	85	83
4						99	96	92	90	87	84	82
5						98	94	91	89	86	83	81
6					100	97	93	90	88	85	82	80
7					99	95	92	89	86	84	81	79
8					98	94	91	88	85	83	80	78
9				100	96	93	90	87	84	82	79	77
10				99	95	92	89	86	83	81	78	76
11				98	94	91	88	85	82	80	77	75
12			100	96	93	90	87	84	81	79	76	74
13			99	95	92	89	86	83	80	78	75	73
14			97	94	90	87	84	82	79	77	75	72
15		100	96	93	89	86	83	81	78	76	74	71
16		99	95	91	88	85	82	80	77	75	73	70
17		97	94	90	87	84	81	78	76	74	72	70
18	100	96	92	89	86	83	80	77	75	73	71	69
19	99	95	91	88	85	82	79	76	74	72	70	68
20	97	93	90	86	83	80	78	75	73	71	69	67

SESSION 19
Counselling for ART Adherence and Treatment (Paediatric ART)

Session Overview:

- Lecture using slides (20 minutes)
- Demonstrate ART calendar/dairy (10 minutes)
- Lecture using slides (20 minutes)
- Quiz (10 minutes)
- Fishbowl on disclosure to children (30 minutes)

Session Objectives:

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

- List the reasons why CLHIV require counselling.
- Understand how adherence counselling for children has special challenges and how to address these challenges.
- Understand how counsellors can support children.
- Understand age-appropriate ways to handle disclosure of HIV status to children.

Time allowed:

- 1 hour 30 minutes

Material required:

- Slides related to the session
- Sample copies of 'My ART Calendar'
- Role - play situations for disclosure counselling
- Chocolate bar
- Charts and markers
- White or black board

Method:

Preparation before the Session:

1. You, as the facilitator, will keep sample copies of 'My ART Calendar' handy for distribution to groups BEFORE the session.

Lecture using slides (slides 1 – 10) (20 minutes)

2. Explain the key points in the session using the slides (1 to 5) and the dialogue given for your convenience.
3. Introduce the topic of 'Adherence counselling for children.' (Slide 6) Remind them they have already heard about adherence counselling but that adherence counselling for children has special challenges. Continue with slides 7-10.
4. Emphasise the point in slide 10 that it is essential to involve children in assessment, so that they also realise that adherence is important. Also as facilitator, focus on interactive methods such as pill charts and storytelling to monitor adherence in children.

Demonstrate ART calendar/ diary (slide 11) (10 minutes)

5. The facilitator can demonstrate the use of My ART Calendar or can ask one participant to demonstrate.

Lecture using slides (slides 12-24) (20 minutes)

6. Explain factors affecting the child's adherence and adherence fatigue in children using slides 12-14.
7. Explain disclosure, when, how and how much to disclose with children using slides 15-21.

Quiz (10 minutes)

8. Slides 24-31 contain a quiz on disclosure.
9. To build a competitive environment, divide the participants into teams. You may permit them to keep their handouts open. But maintain time limits.
10. Take each quiz item slowly. After the correct answer flashes, make sure you discuss the answer against the text. Make sure that different participants answer. It is important to avoid having one or two people dominate the discussion.

Fishbowl on disclosure counselling Slide 32 (30 minutes)

11. Read the following situation to the participants:

A six-year-old boy has been receiving ART from your ART Centre, for the last three months. He started attending school two months ago. He found out from the school that, no other student needs to take

medicine every day, as he does. He asked his father directly: "Why do I need to take medicine every day?" His father tried to avoid the question and give some answers without telling anything about his condition. But the child keeps on asking.

12. Ask the participants: Should the child be told the HIV status? If yes, who should tell? Facilitate the group discussion noting key points and making linkages with the slides displayed earlier.
13. Next invite three volunteers to come forward and act out the counselling scene at the centre one by one, taking the roles of Counsellor, Child and Caregiver.
14. After one set of volunteers has role-played, ask the next set to come forward and role- play.
15. Debrief the exercise with the following questions:
    a. What are the challenges faced by the counsellors?
    b. Which counselling approaches worked in this situation? Which did not?
    c. How can a counsellor improve counselling in such situations?

Slides 33 and 34: Checklists for adherence counselling to be referred by the counsellor.

Key messages:

- Provide a friendly environment so that children and as well as their caregivers feel comfortable and supported.
- Disclosure is important for promoting adherence to treatment.
- The time for disclosure should be determined by the child's developmental level and emotional maturity.
- The time to disclose also depends on the preparedness of the caregiver to disclose or her/his willingness to let others disclose the status to the child.
- It is essential to involve children in assessment, so that they also realise that adherence is important.
- Interactive methods such as pill charts and storytelling should be used with children.
- Children who know their "HIV-positive" status have higher self-esteem and are better able to cope with their illness than children who have not been told about their positive status.

SESSION 20
Nutrition in the Context of HIV/AIDS

Session Overview:

- Brain storming (Relation of nutrition to health; nutrition for HIV) (5 minutes)
- Activity 1- Quiz (Classification of foods according to the food groups- Slides 4 to 16 (5 minutes)
- Lecture using slides (17-34, 36-40) (20 minutes)
- Activity 2- (Individual) Correct identification of pasting of food slips (5 minutes)
- Activity 3 (Group Activity) on nutrition counselling (25 minutes)
- Activity 4- (Kaun Banega Sanjeev Kapoor) (1 hour) (to be conducted next to next day in the morning)

Session Objectives:

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

- Explain the relationship between HIV and nutrition.
- Identify appropriate nutrition actions-
  - to manage HIV-related symptoms.
  - to promote effective treatment.
  - to ensure adherence to drug regimens.
  - to manage side-effects of ARV drugs and
  - to minimise negative effects of interaction of ARV drugs with food.
- Provide comprehensive nutrition counselling to clients in the field.

Time allowed:

- 2 hours

Material required:

- Slides related to the session.
- Food slips for the Food Group Activity. (Individual) Activity No.2.

- Slips of topics on nutrition counselling.
- Chart papers, markers, glue/gum.
- Money for buying material for recipe development.

Method:

Preparation before the workshop:

You, as the facilitator, will cut the food slips for Food Group Activity and the topic slips on **nutrition counselling** and keep these handy BEFORE the session.

Activity 1: Food quiz using slides 4-16.

Activity 2: Distribute food slips among the participants. Let each one come forward and paste the food slip on appropriate chart. (Energy giving, Body building and Protective foods)

Activity 3: Nutrition Counselling Group Activity (25 minutes)

1. Make four groups and give each group one slip with topic written on it for the Nutrition Counselling Group Activity. Provide them with charts and markers. Explain that nutrition counselling is much more than what to eat. Ask them to take 10 minutes to identify and write down suggestions for PLHIV on the topic they are assigned:
   - Counselling on **weight loss:** What to eat when one is losing weight?
   - Counselling on **food preparation:** How best to prepare food? (Retention, enhancement of nutrients and tips for making food balanced)
   - Counselling on **common symptoms:** Diarrhoea, oral thrush and fever.
   - Counselling on **ensuring food safety:** How to prepare food safely? (Principles of food and personal hygiene)
2. Reassemble the groups and ask one representative to come forward and present the group findings. Ask other groups if they want to add something. Correct any wrong or missing information.
3. In this manner, ask each group to present their activity.
4. The facilitator should focus not so much on the local dishes mentioned as much on the principles underlying the suggestions. For instance, do not focus on suggestion of whether it is better to eat chicken or meat, so much as focus on the principle that there is need for sufficient protein in the diet.

Activity 4:- Kaun Banega Sanjeev Kapoor: group activity (1 hour)

This activity shall be taken next to next day in the morning, so that participants shall be able to apply their knowledge on nutritional factors in food and how to make nutritious recipes.

Objectives

Participants will be able to appreciate the practical aspects of nutritional counselling.

Material required

1. Tables to display the breakfast prepared by the groups.
2. Plates and spoons.
3. Stationery including chart paper, pen and paper, which the participants may require to describe their preparation in detail.

Methodology

Demonstrate through group work.

Procedure

1. This activity is to be performed in the groups that have been formed on the first day of training. Each group will have approximately four to five participants.
2. Following the instructions given two to three days prior to the session, each group is given a sum of Rs. 50/- to prepare breakfast as per the case study specified. The four groups are given a common case study (Kindly refer the case study given in the annexure).
3. The groups have to come prepared with their respective breakfasts and display the same on the tables set up (stipulate the place). Along with their breakfasts, they also have to provide a breakup of the money spent in preparing and buying the breakfast items. Some groups may additionally want to elaborate on their preparation through the use of charts and pictures.
4. The resource person/facilitator then goes to each of the groups, asking them various leading questions on 'the amount spent on preparing the breakfast', 'reasons the group included certain food items' and 'the nutritive value of the prepared breakfast' and other relevant questions. Group members are also encouraged to question other groups.
5. Subsequently, all the four groups come together and eat these 'preparations' as the breakfast for the day.
6. This is followed by a short discussion facilitated by the resource person/facilitator, where participants share their experiences and the learning which they have gained through the completion of this activity. Also the resource person can lay emphasis on the importance of providing nutritional plans to clients, rooted in the client's everyday realities and life experiences.

Tips for resource person/facilitator:

1. The participants may have queries regarding how much money to spend or what they should buy. The facilitator should suggest to the group to use their own discretion and not give any more instructions.
2. Also, while giving instructions the facilitator should reinforce the fact that the family in the case study has no access to any stove/wood/fire or utensils.

Key messages:

- HIV can cause poor nutrition through reduced eating, greater energy requirements, and poor absorption of nutrients in the food.
- Poor nutrition, in turn, makes the immune system weak, increases the person's vulnerability to infection and worsens the impact of the disease.
- When counselling on dietary intake it is critical to remember that the dietary needs of a PLHIV are greater than those of an uninfected person.
- Encourage the healthy actions that you want people to continue.
- Discourage unhealthy or harmful actions.
- Ignore/ overlook the actions that neither help nor harm health.

Annexure

Activity 1: Key to the Food Groups

Energy-giving foods	Body-building foods	Protective foods
Wheat	Eggs	Tomato
Rice	Milk/Curd	Brinjal
Maize	Pulses	Onion
Bajra	Fish	Spinach
Jawar	Meat	Chaulai
Raagi	Almonds	Cabbage
Semolina(Rava)	Ground nuts	Pumpkin
Potato/Sweet potato	Rajma	Orange
Oil	Chhole	Papaya
Ghee	Green Gram (Moong)	Apple
		Banana
		Amrud (Guava)
		Mango
		Grapes

Activity 2: Nutrition Counselling Group Activity

1. Counselling on **weight loss:** What to eat when one is losing weight?

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2. Counselling on **food preparation:** How best to prepare food? (to maximise nutrient retention and to achieve nutritionally complete food)

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3. Counselling on **common symptoms:** Diarrhoea, oral thrush and fever.

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4. Counselling on **ensuring food safety:** How to prepare food safely? (Principles of food and personal hygiene)

Activity 3: Case study

A family of 4 (which includes a mother, father, daughter aged 7 and son aged 4) has migrated from a village in Haryana to Delhi, looking for livelihood. All four of them are HIV positive for the last 4 years. They have recently migrated to Delhi and hence don't have any utensils or even a gas stove with them. They live in a makeshift home on the streets.

You are a Non Governmental Organisation (NGO) who works on care and support issues and have invited the family to your NGO to demonstrate a nutritional breakfast for the family.

Please prepare a breakfast for the family and bring the same in the morning prior to the session on Nutrition. Please keep in mind the positive status of the family and bear in mind the fact that at the moment the family does not possess any utensils or cooking options.

SESSION 21
Linkages for Effective Counselling

Session Overview:

- Session objectives - Lecture – 5 minutes
- Case discussion in small groups – 45 minutes
- Services available under NACP and need for linkages: PPT and large group discussions – 20 minutes
- Panel discussion – 60 minutes
- Summarisation and question and answers -10 minutes

Session Objectives:

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

- Understand various types of referrals required for clients so that their needs will be addressed.
- List health and other services with which counsellors should make programmatic linkages.
- Discuss the advantages of creating an effective system of referral and linkages.
- Discuss the benefits of this system for clients as well as for the effective implementation of the national programme.
- Describe various challenges while developing programmatic linkages and making referrals.
- List and discuss reasons why clients do not access services.
- Develop the ability to make use of knowledge from this session, in the setting of counselling.

Time allowed:

- 2 hours 30 minutes

Material required:

- White board markers
- Permanent markers
- Chart papers
- Plain papers
- Scissors

Method:

Preparation before the training:

You as the facilitator will have to photocopy the cases listed in Annexure 1. Invite three panellists (listed in activity 4) for the panel discussion.

Activity 1: Session Objectives (5 minutes): Discuss the objectives briefly and emphasise the need of referral and linkages.

Activity 2: Case discussion in small groups (45 minutes)

- Divide the participants in 3 or 4 groups (depending on batch size, there will be 5 - 6 members in each group).
- Each group will be given a case study. (The case study will be of a client who requires support other than HIV testing and counselling.)
- Instruct the participants to read the case study carefully and think about what are the needs of the clients and what type of support they need. (15 minutes)
- The points can be listed on a paper. (To make it experiential, the facilitator can ask participants to imagine themselves as the client and then list the type of support he/she may require).
- After discussion in small groups, all the groups will make presentations in the larger group. Facilitator will summarise the discussion. (half an hour)

Key points:

- The client should be viewed as a person/human being as opposed to only being seen as a client at HIV testing centre. The client should be viewed in a broader context, so as to understand his/her vulnerability and consequently to address the client's needs other than HIV testing.
- Clients need various types of services and support apart from HIV counselling and testing.
- Any specific centre cannot fulfil all the needs of a client. Hence the counsellor should develop linkages with various centres and services (in both the health as well as the non health field) in order to make appropriate referrals.

Activity 3: Large group discussion while using power point presentation (20 minutes)

Various services available under NACP and need for linkages.

Activity 4: Panel discussion (60 minutes)

Two persons will be invited for the panel discussion:

- Senior counsellor or district supervisor. If they are not available, official from SACS- BSD/ART department can be invited. These persons are service providers and hence they need to be invited to understand the approaches of service providers.

- A person from positive network and from MSM/TG/FSW NGO. This person will represent the issues beneficiaries are facing.

The facilitator will interview them based on following questions. Participants can be encouraged to ask a few questions by end of the session.

Questions for district supervisor/counsellor/SACS official –

- What types of services are provided by your centres?
- What linkages do you have with other programmes under the NACP?
- What type of challenges do you face while referring clients to various services?
- How do you ensure whether the client has reached the centre where you have referred?
- Why some clients do not avail the services and especially when the services are free?
- How do you help clients avail these services?
- What are the social protection schemes available for the clients?
- What are the challenges for availing the benefits of these schemes?
- Do you have any strategies to address the challenges?
- Can you share a few challenging and successful cases in terms of creating effective linkages?

Questions/discussion points for a person from NGO and positive network –

- Various services are available under NACP for PLHIV and marginalised groups.

  How do you link the group (with whom you work) with these services?
- What benefits the group gets from these services?
- Are there any challenges in accessing these services?
- What are the challenges?
- Have you ever discussed these challenges with any concerned officials?
- What are your other needs apart from NACP services?
- Are these needs being addressed by the HIV counselling centres? If yes, how?
- Can you please share one example where you or your team members have benefited by the services? Alternatively can you share an example where appropriate services were not received?
- Though services are available, many a times these services are not availed by the needy persons. According to you what are the reasons for this?

(If panel discussion is not possible – following alternate activity can be done)

Divide participants into 3 groups. The roles of the groups are as mentioned below –

Group A – ICTC centre in a remote area, where access is difficult. One public transport bus comes there in the morning and goes back in the afternoon. Private transport is available, however it is very expensive.

Group B – ART centre at a district hospital where counsellor counsels 70 – 80 clients each day.

Group C – STI counselling centre at district hospital where a counsellor gets various clients that are referred by the STI officer, in addition to direct walk in clients.

- These groups will be given challenging cases and they need to work on counselling and referral strategies for the cases. (Refer Annex II for cases)
- They also need to establish systems at place for referrals and linkages.
- Each group will share their experiences in large group.

Points for debriefing

a) What challenges did you face while linking clients to additional services?

b) What strategies did you use to address these challenges?

c) In your experience do you think that the strategies discussed are practical and can be replicated in the field of HIV/AIDS counselling?

Activity 5: Summarisation (10 minutes)

Key messages:

- Be aware of the services available at the referral units (care and support services, RNTCP, Maternal and Child Health, STI services, positive people's Network, TI projects), as also the schemes, and guide clients appropriately.
- **Role of the counsellor:**
    - *Referral:* An effective counsellor gathers information on the locally available schemes and seeks to link people to the right resource.
    - *Managing Barriers:* As a counsellor, you must be aware of the barriers that a PLHIV can face while trying to avail a package of services. Based on experience, you need to explore solutions to these barriers on a case-to case basis. Remember it takes time for people to feel comfortable. Therefore, work with them at their pace. Always tell the clients the need to get registered for treatment as soon as possible as this is a lifesaving measure.
    - *Enhancing Linkages:* Develop linkages with the various government departments as it is extremely important for the benefit of your client. A good rapport with your counterparts in these departments will ensure timely and hassle-free services to your clients.
- Prepare your clients on what they should expect when they go to a particular office to register for the scheme/ service. This is the skill of anticipatory guidance.
- Ensure that each and every one of your positive clients has reached and registered at the ART centre.
- Give hope to the client by informing him/ her about ART, its importance and its free availability at the ART centre.
- **For registration at the ART centre, clients must carry-**
- ICTC test result.
- Documentary proof of address.
- 2 passport-size photographs.
- Referral form.
- Provide the referral form to the clients and give them accurate instructions to reach the ART centre.

Annexure

Annexure 1: Cases for discussion:

CASE 1:

A, 6 year old girl is suffering from Pneumonia. She falls ill very frequently. The doctor advised for HIV test and the test is positive.

The girl is an adopted child of her parents. The child's biological father was an auto driver and died due to fever which was untreated. Later, her mother also died of TB. The girl is adopted by her father's distant cousins. The couple who adopted the girl now wants to disown her, as she has tested positive. The man informs the counsellor that he is a poor fisherman and cannot bear the burden of the girl's illness. He requests the counsellor to give them contact details of orphanages where they can send the girl.

CASE 2:

A 28-year-old woman has come for her second ART preparatory counselling session. She works as a sex worker on the beachfront. Her CD4 is 34 and she had developed herpes zoster in the previous year. She is been losing weight steadily, feels weak and finds it difficult to concentrate. Also she is not been able to go to work for the past few weeks, as she has been feeling unwell She is a widow, living in a slum with two friends who also work as sex workers. As she is ill, her friends have been supporting her. She is keen on starting ART. However, she is planning to visit her family in a distant city next month. Demonstrate how you would help this client.

CASE 3:

The client is a 62 year old woman who is the sole caregiver of her infant grandchild, aged 2 years. The child's parents died after a long battle with HIV. The grandmother's sole possession is the hutment where she lived with her husband. However, recently her husband abandoned her to live with a younger woman. The grandmother is now suicidal, and feels her only escape from the situation is to kill herself as well as her grandson.

CASE 4:

A 54 years widow is admitted in a private hospital for the treatment of a tumour in her stomach. She is HIV positive as per the hospital report. The hospital is now asking the woman to pay more money for her treatment than earlier quoted as she is HIV positive. Her son who is a college student has found an ICTC centre in a nearby government hospital and has come to meet the counsellor there. The son tells the counsellor that he cannot afford the charges, which the private hospital is now asking for. He also shares that he always suspected that his father who had died a few years earlier was HIV positive.

Points for debriefing:-

Above cases can be discussed while using following points:

1) What is the issue described in the case?
2) What type of support is required for the client?

3) What are the various services available in the field so as to help the client address his/her needs?

4) Are there any challenges in receiving the services? What are they? How the challenges can be addressed?

5) What is the role of the counsellor in the context of above cases?

Note: Discussion should focus on referral and linkages and not on other issues like content of the session or micro skills.

Annexure 2: Cases for discussion for ICTC:

CASE 1:

A 15 year old girl has come with complaints of white discharge and stomach ache. The counsellor asks her to bring her mother to the clinic as the girl is a minor and cannot give consent for an HIV test. The girl is refusing to call her mother. The counsellor calls the girl to follow up with her however she does not take the counsellor's call. The counsellor then sends the outreach worker (ORW) to contact the girl. However the girl tells the ORW that she has never been to the centre.

CASE 2:

A 45 year old man is tested for HIV and is found positive. He is a landless farmer and works as a daily wage labourer in another's fields. Owing to the drought in the area, he is unable to get any work and therefore does not have money to travel to the district to access the ART centre and its services.

CASE 3:

A 20 year woman is pregnant and has tested positive for HIV. She is referred to the District ART centre by the counsellor. However when the counsellor is cross checking his data with the District ART centre, he finds that the woman had not reached the centre. He remembers that during post test counselling the woman shared that she was in conflict with some of her family members. The counsellor tries to call her, but is unable to contact her.

CASE 4:

A long distance truck driver is tested for HIV at a centre. However, the truck driver leaves for his next destination, without collecting his report (which is HIV positive) as the report was delayed owing to the Medical officer unavailability. The counsellor is worried that he will not be able to disclose the truck driver's report to him. The counsellor calls the truck driver, who informs him that the truck's route has changed and he will not be visiting the area (where the counsellor is located) anytime soon in the future.

Cases for discussion for ART:

CASE 1:

A hotel waiter who is HIV positive is registered for ART and begins his medication. After 2 months, the ART counsellor is unable to trace him. The outreach worker (ORW) goes in search of the client and is informed by the other waiters that the client has returned to his village in Bihar. The ORW tries to get the address and contact details of the client but the other waiters provide her with incomplete information.

CASE 2:

A sex worker comes to ART centre. After her CD4 test, the doctor starts her on ART. During counselling session, she informs the counsellor that she does not have a permanent address. She travels from one place to another during various festivals and seeks clients at various fairs at distant religious places. She expresses her inability to seek treatment from one particular centre.

CASE 3:

A daily wages worker is HIV positive and has begun ART. He does not come to seek medicines for two months. When the ORW tries to contact him, he informs her that the timings of the ART centre are inconvenient to him, as he is a daily wage labourer and cannot afford to visit the centre in the day as he loses his income for the day.

Cases for discussion for STI:

CASE 1:

The client is an 18 year old boy who has come to the STI clinic after attending a group education session on STI and HIV in the community. He informs the counsellor that his friend is suffering from a genital ulcer. As the session progresses, he shares that he himself has the ulcer, which he noticed a few days ago. He explains that his friends had forced him to have sex with a sex worker. He is now scared that his parents will know about his act when he goes to the doctor in his own neighbourhood. Additionally he shares that he cannot take medicines at home since his parents may notice this and will force him to explain reasons for the same. He further added that he cannot come to the clinic repeatedly as he is afraid that he may be seen by his neighbours.

CASE 2:

A 32 year man is on treatment for painful genital sores. However, his health is declining and he is constantly admitted to the hospital. Consequently he loses his job. Recently he has been employed as a daily wage worker at a construction site. Owing to the nature of his work, he is unable to come to the centre for follow up treatment. When the counsellor calls him, he refuses to come to the centre as he says that he will lose half a day's wages or risk losing his current source of income.

CASE 3:

A truck driver who is HIV positive and is currently on ART informs the counsellor that he is unable to adhere to ART owing to his uncertain duty hours, and erratic sleep as well as food patterns. He also dismisses the possibility of follow up at any one particular place as his work takes him to varied and distant locations.

References (used in PPT only):-

1) HIV Counselling Training Module (Handouts), National AIDS Control Organisation, Year 2006

2) Refresher Training Programme for ICTC counsellors (Second edition) Trainee's Handouts, April 2011

SESSION 22

Post - Exposure Prophylaxis and Universal Safety Precautions

Session Overview:

- Reading the PPTs – 60 minutes
  - Environmental transmission, who are at risk , risk of HIV transmission
  - Management of exposure site
  - Categories of exposure , source codes and exposure codes
  - Assessment of exposed person, counselling, prescription for PEP , follow up
  - PEP register
  - Universal precautions

Session Objectives:

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

- Understand the need for a system of Post Exposure Prophylaxis (PEP).
- Enumerate the illnesses transmissible occupationally.
- Enumerate the categories, source and exposure codes.
- Evaluate a health care worker sustaining an injury and prescribe the appropriate PEP.
- Discuss the follow-up procedures after PEP.

Time allowed:

- 1 hour

Material required:

- PPT slides / LCD projector

Method :

You as the facilitator:

- Read and explain the PPTs to the participants.
- Mail a copy of the handout on 'Post-Exposure Prophylaxis' to the participants one week prior to the training programme.
- Keep copies of handouts ready in case the participants need to refer it again.

Key messages:

- Treat all patients / samples as potentially infectious.
- Implement universal precaution plan in the facility.
- Use barriers to prevent blood / body fluid contact.
- Prevent percutaneous injuries.
- Document and report injury or exposure.
- Implement PEP plan and sensitise all the Health Care Workers (HCWs).
- Promote Hepatitis B vaccination.

Annexure

This session should take approximately 60 minutes to implement.

Step 1: Introduction and session objectives (Slides 1-2) - 2 minutes

Step 2: Exercise 1: Story Time (Slide 4) - 3 minutes

Step 3: Presentation of transmission of HIV, infectious body fluids and risk of transmission (Slides 5-9) – 10 minutes

Step 4: Presentation of elements of post-exposure management (Slides 10-11) – 5 minutes

Step 5: Categorising and assessing exposure codes (Slides 12-16) – 12 minutes

Step 6: PEP and health care workers, including PEP Register (Slides 17-31) – 22 minutes

Step 7: Prevention aspects and PEP (Slides 33-34) – 4 minutes

Step 8: Summary (Slide 35) – 2 minutes