Government of Malawi

MALAWI COMPREHENSIVE HIV TESTING AND COUNSELLING TRAINING

PARTICIPANT HANDBOOK

October 2013—Final Version

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List of HTC Sub-Group Core Team:

Dr Ben Chilima	CHSU, Ministry of Health
Dr Beth Barr	Centers for Disease Control and Prevention
Mr Ken Warren	UNICEF
Dr Andrina Mwansambo	National AIDS Commission
Mr James Kandulu	HTSS, Ministry of Health
Mr Mabvuto Chiwaula	CHSU, Ministry of Health
Mr Lutho Zungu	HTSS, Ministry of Health
Mrs Florence Kayambo	JHPIEGO, SSDI
Mr Lucious N'gomang'oma	HIV & AIDS Department, Ministry of Health
Mrs Mtemwa Nyangulu	HIV & AIDS Department, Ministry of Health

List of Master Trainers

Pigza Kumwenda	Karonga District Hospital
Frank Isaac Banda	Mzuzu Central Hospital
Joseph Phiri	Mzimba District Hospital
Mark Chakwiya Mwalabu	Salima District Hospital
Nelson Dzinza	CHSU, Ministry of Health

Hadds Nkhwazi	Thyolo District Hospital
Alick Sixpence	Machinga District Hospital
Lydia Moyo	Chiradzulu District Hospital
Theresa Sumani	Zomba Central Hospital
Edwin Chitandale	Kamuzu Central Hospital
Getrude Ngwata	Malawi Defense Force
Elizabeth Timvere	Lilongwe District Health Office
Maria Sanena Mndolo	Lilongwe District Health Office
Martha Muyaso	MACRO Training Centre, Blantyre
Richard Chilongosi	MACRO Mzuzu
Onani Mughogho	MACRO Training Centre, Blantyre
Harold Malinda	Queen Elizabeth Central Hospital
Khumbo Ng'ona	Queen Elizabeth Central Hospital
Margaret Muskambo	Mzuzu Central Hospital
Angela Khonyongwa	Blantyre District Health Office

List of HIV and AIDS Department (MoH) staff members

Dr Andreas Jahn

Caroline Ntale

Dorica Chirwa

Dalitso Midian

Amon Nkhata

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Acronyms/Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
CDC	Centre for Disease Control and Prevention
CHAM	Christian Hospitals Association in Malawi
CITC	Client Initiated Testing and Counselling
CPT	Cotrimoxazole Prophylaxis
DBS	Dried Blood Spot
DNA	Deoxyribonucleic acid
DTS	Dried Tube Specimen
EID	Early infant diagnosis
FEFO	First-to-Expire, First-Out
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IEC	Information Communication and Education
MoH	Ministry of Health
MTCT	Mother-to-child transmission
NAC	National AIDS Commission
NGO	Non-Governmental Organisation
PCP	Pneumocystis Carininii Pneumonia
PCR	Polymerase Chain Reaction
PGL	Persistent Generalised Lymphadenopathy
PITC	Provider Initiated Testing and Counselling
PLWA	People Living With HIV/AIDS
PMTCT	Prevention of mother-to- child transmission
PT	Proficiency Testing
RNA	Ribonucleic acid
SMART	Specific Measurable Achievable Realistic Time-bound
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

Background on the Course

Great strides have been made in Malawi since 2000 when rapid testing was introduced, resulting in a rapid expansion in provision and utilization of HIV testing and counselling services at community and facility levels. The Ministry of Health has provided leadership resulting in soaring numbers of persons tested, and the target during HTC week in 2012 was to test 250,000 persons, a goal unthinkable merely 12 years ago. At the end of March 2013, 422,866 patients were alive and on ART. Additionally, 825 static (607 within and 218 outside of health facilities) and 534 outreach HTC sites were reported, along with 655 (static) ART sites, 580 PMTCT sites (Option B+), 602 Pre-ART sites, and 590 sites offering HIV-exposed child follow-up services.

This rapid expansion in quantity and coverage has compromised quality of testing. Task shifting has taken root in Malawi, with much of the rapid testing performed by non-health worker HTC providers and health surveillance assistants (HSAs). Research conducted in many countries has documented that non-health worker testers can maintain a high level of accuracy when they are well trained and supervised.

In August 2012, a team of experts from CDC in collaboration with the MoH, conducted an assessment of HTC quality in Malawi. This team observed some important challenges faced by practicing HTC providers, including improper following of HTC protocol, improper use of test kits, poor handling and storage of supplies and improper handling of discordant results (1st test and 2nd test did not agree). These challenges led to a range of issues, including clients receiving incorrect test results.

These findings led the Ministry of Health to drive forward a set of initiatives to improve the quality of HTC in Malawi. Included among them was an initiative to retrain practicing HTC providers to improve adherence to the HTC protocols and to introduce the most current issues in counselling related to HIV and AIDS. The *Skills Intensive* course is being rolled out nationally to currently practicing HTC providers.

A comprehensive review of the training package for new HTC providers was also a recommendation. In the past, the national curriculum included 5 courses covering all aspects of HTC in Malawi. The two core courses, HTC and PITC were designed for new counsellors and included certification to practice in Malawi. The other courses: couple counselling, child counselling and EID were intended for counsellors with at least 6 months of experience in counselling. Having separate trainings for each topic was noted as being very cumbersome for the MoH to manage, difficult to track and left counsellors feeling unprepared to counsel and test specialized populations.

This revised training package has been updated to reflect the most recent international guidance, and is aligned with the national HTC policy. Upon being certified in this new training course, every HTC provider will be certified to counsel adults, couples, infants, and children.

Comprehensive HIV Testing and Counselling Training Agenda

Week 1

Time	Topic	Duration
Day 1		
7:30-8:30	Welcome and Introductions	1 hour
8:30-9:30	Course Introduction	1 hour
Module 1: Introduction to HTC		
9:30-10:00	Unit 1.1 Basics of HIV	2 hours 15 minutes
10:00-10:15	*Break*	
10:15-12:00	Unit 1.1 cont'd	
12:00-1:00	*Lunch*	
1:00-3:00	Unit 1.2 Importance of HTC	2 hours
3:00-3:15	*Break*	
3:15-6:00	Unit 1.3 Counselling Principles	6 hours 45 minutes
6:00-6:30	Facilitator Meeting	
Day 2		
7:30-7:45	Recap	
7:45-10:00	Unit 1.3 cont'd	
10:00-10:15	*Break*	
10:15-12:00	Unit 1.3 cont'd	
12:00-1:00	*Lunch*	
Module 2: Pre-Test Counselling		
1:00-1:45	Unit 2.1 CITC Pre-Test	45 minutes
1:45-2:30	Practice Session (CITC only)—Trainer Demonstration and questions	45 minutes
2:30-3:00	Practice Session (CITC only)—Participant Role Play	30 minutes
3:00-3:15	*Break*	
3:15-3:30	Practice Session (CITC only)—Participant Role Play Feedback	15 minutes
3:30-4:15	Practice Session (CITC only)—Participant Role Play + Feedback	45 minutes
4:15-5:00	Unit 2.2 PITC Pre-Test	45 minutes
5:00-5:30	Unit 2.3 Group Pre-Test Education	30 minutes
5:30-6:15	Practice Session (PITC only)—Trainer Demonstration and questions	45 minutes
6:15-6:45	Facilitator Meeting	
Day 3		
7:30-8:00	Recap	
Module 3: HIV Testing		
8:00-8:30	Unit 3.1 Overview of HIV Testing	30 minutes
8:30-9:30	Unit 3.2 Safety	1 hour
9:30-10:00	Unit 3.3 Using HIV Rapid Tests	1 hour 30 minutes
10:00-10:15	*Break*	
10:15-11:15	Unit 3.3 cont'd	

11:15-12:00	Unit 3.4 Preparing and Handling DBS	1 hour 15 minutes
12:00-1:00	*Lunch*	
1:00-1:30	Unit 3.4 cont'd	
1:30-3:00	Practice Session—Fingerprick procedure, Preparing/Handling DBS, Safety	3 hours 30 minutes
3:00-3:15	*Break*	
3:15-5:15	Practice Session cont'd	
5:15-6:00	DTS for testing/QC (theory)—DTS for testing algorithm/QC (practice)	45 minutes
6:00-6:30	Facilitator Meeting	
Day 4		
7:30-8:00	Recap	
8:00-10:00	Unit 3.5 Using the HIV Testing Algorithm	2 hours 30 minutes
10:00-10:15	*Break*	
10:15-10:45	Unit 3.5 cont'd	
10:45-12:00	Unit 3.6 Performing Quality Controls	1 hour 15 minutes
12:00-1:00	*Lunch*	
1:00-3:00	Practice Session—Using HIV rapid tests, using the algorithm, QC	4 hours
3:00-3:15	*Break*	
3:15-5:15	Practice Session cont'd	
5:15-5:30	Practice Session—Packaging DBS	15 minutes
5:30-6:00	Facilitator Meeting	
Day 5		
Module 4: Post-Test Counselling		
7:30-9:00	Unit 4.1 CITC Post-Test	1 hour 30 minutes
9:00-10:00	Practice Session (CITC only)—Trainer demonstration and questions	1 hour
10:00-10:15	*Break*	
10:15-12:00	Practice Session (CITC only)—Participant Role Play	3 hours 45 minutes
12:00-1:00	*Lunch*	
1:00-3:00	Practice Session (CITC only) Participant Role Play cont'd	
3:00-3:15	*Break*	
3:15-4:15	Practice Session (CITC only)—Participant Return Demonstration	1 hour
4:15-4:45	Unit 4.2 PITC Post-Test	30 minutes
4:45-5:45	Practice Session (PITC only)—Trainer Demonstration and questions	1 hour
5:45-6:15	Facilitator Meeting	

WEEK 2

Day 6		
7:30-8:00	Recap (Week 1)	
8:00-10:00	Unit 4.3 Documentation	3 hours
10:00-10:15	*Break*	

10:15-11:15	Unit 4.3 cont'd	
11:15-12:00	Practice Session—HTC Register	1 hour 45 minutes
12:00-1:00	*Lunch*	
1:00-2:00	Practice Session—HTC Register cont'd	
2:00-3:00	Practice Session—EID	1 hour
3:00-3:15	*Break*	
3:15-5:30	Unit 4.4 Stock Management	3 hours
5:30-6:00	Facilitator Meeting	
Day 7		
7:30-8:00	Recap	
8:00-8:45	Unit 4.4 cont'd	
Module 5: Adapting HTC for Specific Populations		
8:45-10:00	Unit 5.1 HTC for Couples	5 hours
10:00-10:15	*Break*	
10:15-12:00	Unit 5.1 cont'd	
12:00-1:00	*Lunch*	
1:00-3:00	Unit 5.1 cont'd	
3:00-3:15	*Break*	
3:15-4:15	Practice Session (Couples)—Trainer Demonstration and questions	1 hour
4:15-5:15	Practice Session (Couples)—Participant Role Play	4 hours
5:15-5:45	Facilitator Meeting	
Day 8		
7:30-8:00	Recap	
8:00-10:00	Practice Session (Couples)—Participant Role Play cont'd	
10:00-10:15	*Break*	
10:15-11:15	Practice Session (Couples)—Participant Role Play cont'd	
11:15-12:15	Practice Session (Couples)—Participant Demonstration and Feedback	45 minutes
12:15-1:15	*Lunch*	
1:15-3:15	Unit 5.2 HTC for Pregnant Women and Infants	3 hours 45 minutes
3:15-3:30	*Break*	
3:30-5:15	Unit 5.2 cont'd	
5:15-5:45	Facilitator Meeting	
Day 9		
7:30-8:00	Recap	
8:00-9:00	Practice Session (Pregnant Women and Infants)—Trainer Demonstration and questions—ANC protocol	1 hour
9:00-10:00	Practice Session (Pregnant Women and Infants)—Participant Role Play—ANC protocol	2 hours
10:00-10:15	*Break*	
10:15-11:15	Practice Session (Pregnant Women and Infants)—Participant Role Play—ANC protocol cont'd	
11:15-12:00	Practice Session (Pregnant Women and Infants)—Participant Demonstration and Feedback—ANC protocol	45 minutes

12:00-1:00	*Lunch*	
1:00-2:00	Practice Session (Pregnant Women and Infants)—Trainer Demonstration and Feedback—EID protocol	1 hour
2:00-3:00	Practice Session (Pregnant Women and Infants)—Participant Role Play—EID protocol	2 hours
3:00-3:15	*Break*	
3:15-4:15	Practice Session (Pregnant Women and Infants)—Participant Role Play—EID protocol cont'd	
4:15-5:15	Practice Session (Pregnant Women and Infants)—Participant Demonstration and Feedback—EID protocol	1 hour
5:15-5:45	Facilitator Meeting	
Day 10		
7:30-8:00	Recap	
8:00-10:00	Unit 5.3 HTC for Children	4 hours 30 minutes
10:00-10:15	*Break*	
10:15-12:00	Unit 5.3 cont'd	
12:00-1:00	*Lunch*	
1:00-1:45	Unit 5.3 cont'd	
1:45-2:45	Practice Session (Children)—Trainer Demonstration and questions	1 hour
2:45-3:00	*Break*	
3:00-5:00	Practice Session (Children)—Participant Role Play	2 hours
5:00-6:00	Practice Session (Children)—Participant Return Demonstration	1 hour
6:00-6:30	Facilitator Meeting	

WEEK 3

Day 11		
7:30-8:00	Recap (Week 2)	
8:00-10:00	Unit 5.4 HTC for Adolescents/Youth	2 hours
10:00-10:15	*Break*	
10:15-11:15	Practice Session (Adolescents/Youth)—Trainer Demonstration and questions	1 hour
11:15-12:00	Practice Session (Adolescents/Youth)—Participant Role Play	2 hours 45 minutes
12:00-1:00	*Lunch*	
1:00-3:00	Practice Session (Adolescents/Youth)—Participant Role Play cont'd	

3:00-3:15	*Break*	
3:15-5:15	Practice Session (Adolescents/Youth)—Participant Return Demonstration	1 hour
5:15-5:45	Facilitator Meeting	
Day 12		
7:30-8:00	Recap	
8:00-10:00	Unit 5.5 HTC for At Risk Groups	4 hours
10:00-10:15	*Break*	
10:15-12:00	Unit 5.5 cont'd	
12:00-1:00	*Lunch*	
1:00-2:00	Practice Session (At Risk Groups)—Trainer Demonstration and questions	1 hour
2:00-3:00	Practice Session (At Risk Groups)—Participant Role Play	2 hours 45 minutes
3:00-3:15	*Break*	
3:15-5:00	Practice Session (At Risk Groups)—Participant Role Play cont'd	
5:00-6:00	Practice Session (At Risk Groups)—Participant Return Demonstration	1 hour
6:00-6:30	Facilitator Meeting	
Day 13		
Module 6: Quality Assurance		
7:30-9:30	Unit 6.1 QA for Counselling	2 hours
9:30-10:00	Unit 6.2 QA for Testing (including PT)	2 hours
10:00-10:15	*Break*	
10:15-11:45	Unit 6.2 cont'd	
11:45-12:00	Unit 6.3 QA for HTC Providers	1 hour 30 minutes
12:00-1:00	*Lunch*	
1:00-2:15	Unit 6.3 cont'd	
2:15-3:15	Comprehensive Role Plays (CITC/PITC)	2 hours
3:15-3:30	*Break*	
3:30-4:30	Comprehensive Role Plays (CITC/PITC) cont'd	
4:30-6:45	Comprehensive Role Plays (Couples)	2 hours 15 minutes
6:45-7:15	Facilitator Meeting	
Day 14		

7:30-8:00	Recap	
8:00-10:00	Comprehensive Role Plays (Pregnant Women)	2 hours
10:00-10:15	*Break*	
10:15-12:00	Comprehensive Role Plays (EID)	1 hour 45 minutes
12:00-1:00	*Lunch*	
1:00-3:00	Comprehensive Role Plays (Children)	2 hours
3:00-3:15	*Break*	
3:15-5:30	Lab Practice—Fingerprick Procedure, DBS Collection	2 hours 15 minutes
5:30-6:00	Facilitator Meeting	
Day 15		
7:30-8:00	Recap	
8:00-10:00	Written Exam	2 hours
10:00-10:15	*Break*	
10:15-11:15	Practice Session Debrief	1 hour
11:15-12:00	Preparation for Site Visit	45 minutes
12:00-1:00	*Lunch*	
1:00-3:00	Site Visit	4 hours
3:00-3:15	*Break*	
3:15-5:15	Site Visit cont'd	
5:15-5:45	Facilitator Meeting	

WEEK 4

Day 16		
8:00-12:00	Practicals	4 hours
12:00-1:00	*Lunch*	
1:00-4:30	Practicals	3 hours 30 minutes
4:30-5:00	Debrief with Facilitator	30 minutes
5:00-5:30	Facilitator Meeting	
Day 17		
8:00-12:00	Practicals	4 hours
12:00-1:00	*Lunch*	
1:00-4:30	Practicals	3 hours 30 minutes
4:30-5:00	Debrief with Facilitator	30 minutes

5:00-5:30	Facilitator Meeting	
Day 18		
8:00-12:00	Practicals	4 hours
12:00-1:00	*Lunch*	
1:00-4:30	Practicals	3 hours 30 minutes
4:30-5:00	Debrief with Facilitator	30 minutes
5:00-5:30	Facilitator Meeting	
Day 19		
8:00-12:00	Practicals	4 hours
12:00-1:00	*Lunch*	
1:00-4:30	Practicals	3 hours 30 minutes
4:30-5:00	Rehydrate DTS	30 minutes
5:00-5:30	Facilitator Meeting	
Day 20		
8:00-12:00	Proficiency Testing	3 hours
12:00-1:00	*Lunch*	
1:00-4:30	Individual Feedback to Participants	3 hours 30 minutes
4:30-5:00	Closing	

Course Goal

The goal of this course is to equip you with the knowledge and skills to perform HIV testing and counselling in both client-initiated and provider-initiated settings for all clients and patients, including: adults, couples, pregnant women, infants, children, youth, and adolescents.

Course Objectives

By the end of this course, you will be able to:

- Explain what HIV is and how it affects the immune system using clear, simple terms
- Describe the impact of psychosocial issues on HIV counselling
- Demonstrate effective counselling skills in the provision of HTC to clients/patients
- Deliver HTC services in accordance with the appropriate national testing protocols
- Demonstrate appropriate referral for prevention, care, treatment and support services for clients
- Demonstrate proper testing procedures for using HIV rapid tests
- Properly collect, store and package DBS samples
- Accurately document and report HTC services
- Explain quality assurance for counselling, testing, personnel and stock management
- Adapt HTC approach for specific populations (couples, pregnant women and infants, children, adolescents/youth, and most at risk groups)

Target Audience

This training is designed to reach two groups: medical and non-medical providers.

For medically trained providers, the following minimum qualifications are recommended:

- Motivated to provide HTC services in a clinical setting, with an intention to practice after training (this course is not appropriate for providers who intend to recommend testing to patients, then refer them to a HTC provider for HTC)
- Fluency in English
- Certificate in any medical discipline i.e. nurse, clinical officer, medical assistants, dental therapist, and environmental health officers / assistants,
- At least one-year experience working in Malawi
- At least 18 years of age or older
- No criminal record
- Adequate near vision or wear corrective lenses

For non-medical providers, the following minimum qualifications area recommended:

- An individual who is motivated, enthusiastic, sensitive and with a genuine desire to help others.
- Be fluent in English
- Be a holder of a MSCE certificate.
- Have at least one-year experience working in Malawi
- Be at least 18 years of age and not yet reached the national retirement age
- Have no criminal record
- Be familiar with the language, culture and religious beliefs of the community s/he is to work with
- Be recruited by an HIV implementing organization, with the objective of providing HTC services at the end of the training
- Be affiliated with an HIV organization social or support group, with the objective to provide HTC services at the end of the training.
- Adequate vision or wear corrective lenses

Certification

Upon successful completion of this course, you will be awarded a certificate and receive an HTC Counsellor Logbook in which to record your work. After certification, HTC providers are expected to perform HTC under supervision for the first 3 months after training. Community HTC counsellors should work at a facility for the first 3 months to ensure supervision before practicing alone in the community.

The MoH intends to train only HTC counsellors who plan to practice HTC. As such, any graduate of this training program who does not see at least 5 clients in the first 3 months risks having his/her certification withdrawn. If facilitators become aware that a trainee will not practice right away upon successful completion of the course, they may recommend that the participant complete the course at a later time (for example, after maternity leave instead of before maternity leave). To maintain certification, each HTC provider should be practicing HTC services and be supervised at least a minimum of once in a quarter. All trainings, supervision, proficiency testing and numbers tested per month should be recorded in the Counsellor Logbook.

Passing criteria:

- Written exam: 70% or better – any trainee who does not pass the written exam should be released from the training and not proceed to the practicals.
- Practical sessions: must complete a *minimum* of 5 observed practice sessions. A trainee must have 3 sessions with a score of 80% or better to pass the practical component. Any trainee who does not successfully pass practicals should not be given PT.
- Proficiency Testing: must achieve a score of 100% to pass.

NOTE: Trainee must achieve passing scores in all three of these areas to receive a certificate and a Counsellor Logbook.

References

The following materials were consulted in the creation of this training:

MODULE 1: Introduction to HTC

1. *Guidelines for HIV testing and counseling [HTC].* 3rd ed . Government of Malawi; 2009
2. *The National HIV Prevention Strategy (2009-2013*) National AIDS Commission Malawi; 2009
3. *Clinical Management of HIV in Children and Adults.* Ministry of Health, Malawi; 2011.
4. *Malawi Ministry of Health Training for Site Counselors, Participant Manual.* Government of Malawi; Version 3.0 June 2007
5. *Provider initiated HIV testing and counseling in health care services Facilitators' training manual*. Government of Malawi; January 2011
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10. *Starting you ARV Treatment: Body Defense, HIV, and ARV Treatment. Flip chart for client education.* Ministry of Health and Lighthouse, LCH.
11. *Clinical Management of HIV in Children and Adults. Certification Course.* Ministry of Health, Malawi; July 2011
12. Mermin et al. *Effect of co-trimoxazole prophlaxis on morbidity, mortality, CD4-cell count, and viral load in HIV infection in rural Uganda.* The Lancet, Vol. 364, Issue 9443, 16-22 Oct 2004 Pg. 1428-1434.
13. Avy Violari, et al. *Early Antiretroviral Therapy and Mortality among HIV-Infected Infants.* N Engl J Med. 2008 November 20; 359 (21): 2233-2244.

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2. *Malawi Ministry of Health Training for Site Counselors , Participant Manual.* Government of Malawi; Version 3.0 June 2007
3. *Provider initiated HIV testing and counseling in health care services Facilitators' training manual*. Government of Malawi; January 2011
4. *Kayezetseni HIV Lero Kuti Mukonze Tsogolo Lanu.* Ministry of Health Health Education Unit.
5. WHO Factsheet Number 110, May 2013

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1. World Health Organization. HIV RAPID TESTING: training package. 2005
2. *Guidelines for HIV testing and counseling [HTC].* 3rd ed . Government of Malawi; 2009
3. *Skills Intensive: Improving the Quality of HTC.* Government of Malawi; February 2013

MODULE 4: Post-Test Counselling

1. *Guidelines for HIV testing and counseling [HTC].* 3rd ed . Government of Malawi; 2009

2. *Malawi Ministry of Health Training for Site Counselors , Participant Manual.* Government of Malawi; Version 3.0 June 2007
3. *Provider initiated HIV testing and counseling in health care services Facilitators' training manual*. Government of Malawi; January 2011
4. *Early Infant Diagnosis Training Package.* Ministry of Health, Malawi.
5. *Clinical Management of HIV in Children and Adults. Certification Course.* Ministry of Health, Malawi; July 2011
6. *Skills Intensive: Improving the Quality of HTC.* Government of Malawi; February 2013

MODULE 5: Adapting HTC for Specific Populations

1. *Delivering HIV test results and messages for re-testing and counseling in adults*. World Health Organization; 2010
2. *Guidelines for HIV testing and counseling [HTC].* 3rd ed . Government of Malawi; 2009
3. *Couples HIV Testing and Counseling Training, participant's manual*. Government of Malawi; 2009
4. *Early Infant Diagnosis Training Package.* Ministry of Health, Malawi.
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Module 1, Unit 1.1: Basics of HIV

Learning Objectives By the end of this unit, you will be able to:

- Define HIV and AIDS
- Describe how the immune system works
- Describe how HIV is and is NOT transmitted
- Explain how HIV is diagnosed in both adults and children
- Describe treatment for HIV/AIDS
- Identify 3 key groups who are eligible for ART

Definition of HIV and AIDS

HIV stands for Human Immuno Deficiency Virus. It is a virus that affects the immune system and over time, causes damage to the immune system.

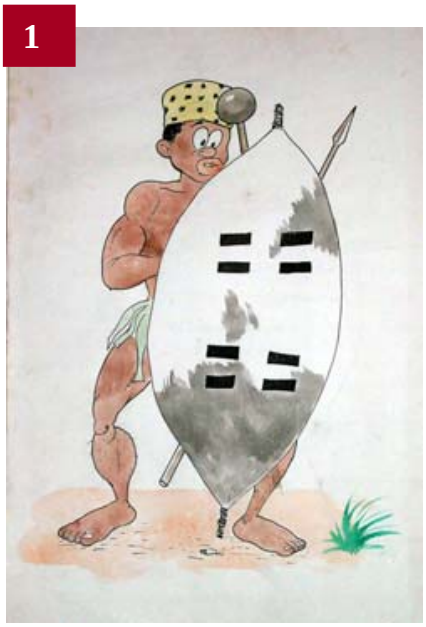
AIDS stands for Acquired Immune Deficiency Syndrome. It represents the most advanced stage of HIV disease. A person is diagnosed with AIDS when he/she has a combination of certain illnesses that result from a weakened immune system.

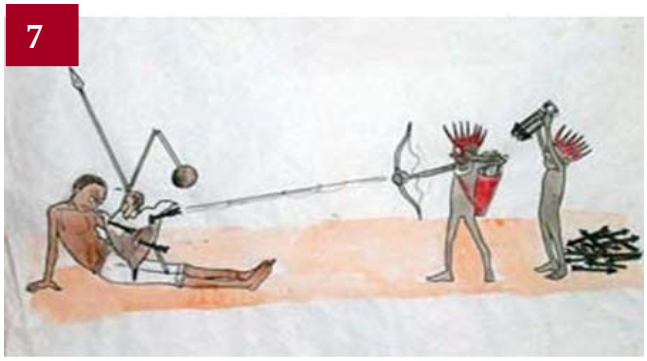
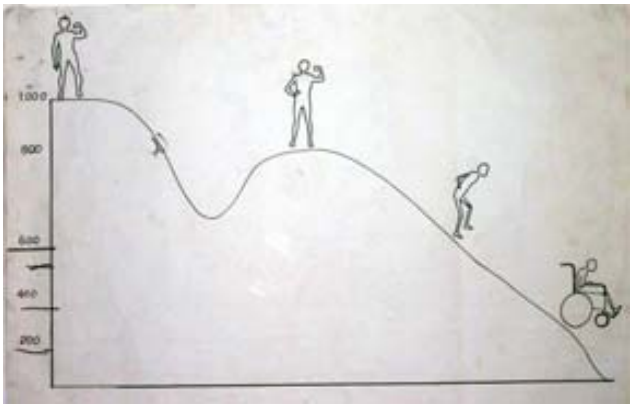
Relationship between HIV and AIDS

HIV is the virus that causes AIDS. Over time, a person with HIV will become more and more ill. That person will develop a set of symptoms (or syndrome) that may then be diagnosed as AIDS. A person who has HIV may not appear sick at all. A person with HIV does not necessarily have AIDS.

What is the Immune System?

On the following page you'll see some images that are taken from the client education flipchart *"Starting your ARV treatment: Body Defense, HIV, and ARV Treatment"*. This flipchart provides an easy way to explain HIV to clients.

1 	2
Everyone has a natural immunity, which acts as a shield against sickness arrows. We keep our shield strong by taking care of our health (ie. eating a balanced diet daily, managing stress, and keeping fit always).	Our shield minimizes the impact of different illnesses in our body. Despite having a strong shield, some sickness arrows can still pierce the human body. Therefore, one can still get sick at one time or another.
3	4
HIV works differently from other viruses, it doesn't make us sick by itself, it attacks our shield making tears, holes etc.	With our shield gone, other illnesses like TB, malaria, etc. can pass through easily and with more strength. We call these opportunistic infections.

Even if HIV+, we still start feeling strong and well. This is because we still have a strong shield, and fewer HIV arrows. We cannot see this outside.	Over time, this begins to change. More HIV arrows are produced which attack more of our shield. Slowly the person may start showing some signs of the infection like weight loss. The shield inside is getting severely affected.
	
With AIDS, there are many HIV arrows in our bodies, and almost no shield left to defend us. Here, the shield has collapsed. This time the person becomes incapacitated because multiple illnesses like TB, skin cancer and others can easily invade the body.	As our shield falls apart, a person's health gets worse until they are very sick.

Immune Response

Just as the Ngoni shield has different parts, so does our immune system. The three most important parts of the immune system are CD4 cells, antigens, and antibodies.

CD4 cells (sometimes called T-cells)

These cells direct the other cells in the immune system. CD4 cells are like the sticks that provide shape and strength in the shield.

Antibodies

Antibodies are proteins (immunoglobulins) produced in the body in response to the presence of a foreign substance. In many ways, antibodies are like the rope that ties the shield together. They don't fight invading germs, but without antibodies, the immune system would fall apart.

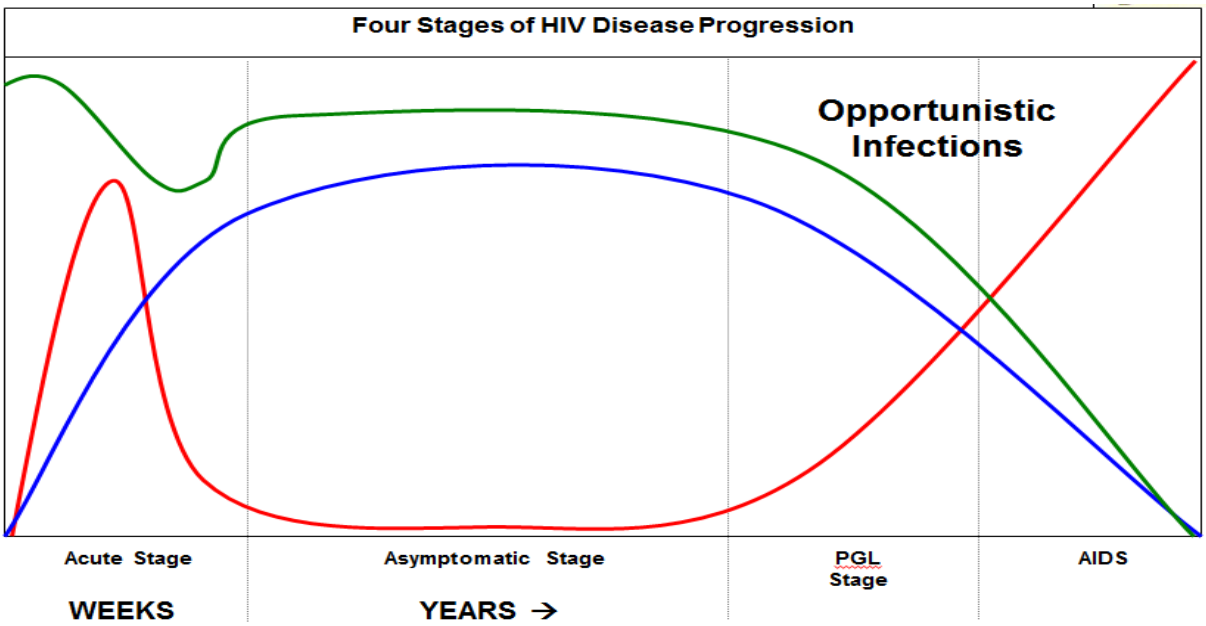
Antigens

Antigens are substances which are recognized as foreign by the immune system and elicit the body to produce antibodies, which will react specifically against it.

Stages of HIV Infection

The amount of time it takes for a person with HIV to get sick and be diagnosed with AIDS is different from person to person. The diagram below shows the progression from HIV to AIDS.

The left side of the diagram represents when a person first gets infected with HIV. As you move to the right, months and years go by. This progression is often divided into 4 stages. The green line represents the overall strength of the immune system. The red line represents the amount of HIV in a person's body. The blue line represents the level of antibodies in a person's body.



Stage 1: Acute Infection

This stage comes right after a person gets infected with HIV. About half of people infected will experience mild flu-like illness at this time. This stage typically lasts 4 weeks but can last as long as 12 weeks in rare cases.

You can see from the diagram that the amount of virus [red line] is increasing as HIV makes many copies of itself. Because of this, the immune strength [green line] takes a slight dip. Antibody levels are also increasing [blue line].

Stage 2: Asymptomatic

During this stage, no signs or symptoms are present. A person looks and feels healthy. You can see that the immune strength [green line] remains steady. Antibody levels [blue line] also remain steady. The amount of virus in the body [red line] is low.

Stage 3: Persistent Generalized Lymphadenopathy (PGL)

Over time, small infections start in the body. Some of these infections take a long time to treat, which shows that the immune system is becoming damaged. This is the time when opportunistic infections begin to take over the body.

You can see that the immune system [green line] gets weaker, and antibody levels [blue line] begin to drop. At the same time the amount of virus [red line] increases. The shield is getting weaker and many HIV arrows are getting in.

Stage 4: AIDS

The last stage is AIDS. This takes place as a person infected with HIV develops many opportunistic infections. The infections may affect the brain, nervous system, skin and many other parts of the body.

In the diagram, the immune strength [green line] has dropped. Antibody levels [blue line] are very low. Viral load [red line] is very high. Medications that fight HIV help to keep the amount of virus low for as long as possible [red line]. Healthy eating and positive living can help keep the immune system strong [green line].

Disease Progression in Children

Many children are affected by HIV. A pregnant woman may pass HIV infection to her baby. For infants and children with HIV, the disease progresses more rapidly. This is due to the fact that infants (and to a lesser degree, young children) have under-developed immune systems that can mount very little containment of the HIV.

Imagine if 10 HIV positive infants are born today and do not get care…

- 34% will die after 1 year
- 50% will die after 2 years
- 75% will die after 3 years

Early diagnosis and treatment are critical!

HIV Transmission

It is important to note that even if people infected with HIV feel and appear healthy, they can transmit the virus to others. Let's discuss how HIV is transmitted.

HIV is transmitted from one person to another through 4 bodily fluids:

- semen
- vaginal secretions
- breast milk
- blood

There are many other fluids that do not transmit HIV. For example, you cannot get HIV from contact with urine, faeces, sweat or tears.

The modes of transmission include:

- Unprotected sexual intercourse (vaginal or anal) with infected partner
- Mother to child transmission during pregnancy, labour/delivery or breastfeeding
- Contact with infected blood– sharing needles/razor blades, blood transfusion or other contact with infected blood.

When we talk about sharing needles to inject drugs, it is important to realize that this is a very real concern for some people. Because drugs like heroin are illegal, people who are addicted may not be able to get clean injecting equipment.

The risk involved in getting HIV from a blood transfusion is very low. Why is this true? The Malawi Blood Bank screens all blood donations for HIV antibodies. There is a small risk that a person could get HIV from a transfusion--the tests used to screen blood may not detect a very early HIV infection. In almost every case, however, the blood transfusion is a lifesaving procedure– the benefits of the transfusion outweigh the risk of HIV infection.

The risk of getting HIV from a car accident or other accidental injury is also very low. Why? When blood is exposed to air, HIV cannot survive. In order for HIV to be passed in this way, blood would have to go directly from one person's body into another (as happens with sharing needles). This is not very likely, even in a bad car accident.

What about an accidental needle stick? Again, the numbers of health care workers who get infected this way is very low. Health care workers use universal precautions when handling patients—they wear gloves and masks. HCWs are trained to handle sharps carefully and avoid needle sticks.

The following behaviours do NOT transmit HIV:

- Sitting together
- Touching someone
- Sharing utensils
- Eating together
- Shaking hands
- Sharing toilets
- Mosquito bites

These behaviours do not pose any risk for HIV. Even mosquito bites pose no risk, as the virus can only live in human cells.

Exposure vs. Infection

It is important to realize that if a person is exposed to HIV it does not mean that they will become infected with HIV.

Not every exposure leads to transmission

- ***Not every act of sex*** *with an infected person results in transmission*
- ***Not every baby born*** *from an HIV+ mother will become infected with HIV*
- ***Not every HCW who gets a needle stick*** *from an HIV+ patient will become infected with HIV*

To further illustrate the difference between exposure and infection, think of a person with a cold. He/she is sniffling and sneezing. If he/she walks into the middle of a room full of people and sneezes, then goes around and shakes each person's hand—will they ***all*** catch the cold? **No**. Some of them will get sick, some will not. Why? A person's risk for becoming

infected is related to several factors. For HIV, the factors that affect transmission are listed below.

Factors That Affect Transmission: Sexual Exposure

Let's look at sexual exposure first. Many factors need to be considered that affect the likelihood of transmission occurring. For example:

A: Condition of the person who is HIV-infected—Where is he/she in the disease progression (newly infected or in later stages?) What is his/her viral load? Is he/she on ART? Does he/she have other STIs? Each of these things affect the likelihood that he/she may pass the virus onto his/her partner.

B: Their sexual exposure—how frequently do they have sex? How much semen is she/he exposed to? Do they use condoms sometimes or always?

C: Condition of the person who is not HIV-infected—how is his/her health? Is his/her immune system strong? Does he/she have any STIs? Is he/she well-nourished?

Factors that Affect Transmission: MTCT

Now let's look at mother to child transmission. Will all infants born of HIV infected mothers contract the virus? Many people don't realize that with no medical intervention, some babies of HIV infected mothers will not contract the virus. Whether or not this happens depends on several things--how healthy the mother is during her pregnancy, and when the mother becomes infected.

Risk of transmission to the infant is greatest when a mother's viral load is high. You'll remember that a mother's viral load is highest when she is in stages 3 and 4 (PGL and AIDS) and during the acute stage (4-12 weeks after infection). A mother's viral load can be high for other reasons—such as treatment failure or other illnesses (STIs, malaria). Other infections can weaken the immune system and allow the viral load to increase. Mothers are at particular risk of transmitting HIV to their babies if they become infected with HIV ***while*** they are pregnant.

For women who know that they are HIV positive, ARVs can dramatically reduce the likelihood that the baby will become infected with HIV and keep the mother's body strong during pregnancy. ARVS help to reduce the viral load. We will discuss more about ARVs later in this unit.

Testing for HIV

Since a person with HIV may look and feel healthy, testing is the ONLY way to know if you are infected. This section will review how to test both adults and children.

Antibody Tests

Antibody tests are HIV tests used for adults that detect HIV antibodies in the blood. There are times after becoming infected when antibody levels are too low to be detected by the test (Stage 1 and Stage 4).

When this happens during stage 1, it is said that the person is in the "window period." The window period lasts from the time a person is first infected until antibodies are detectable in the blood or other body fluids by laboratory tests. It typically lasts for 4-6 weeks, after the initial infection, for the majority (>95%) of HIV infected persons. For a minority (<5%) it may extend between 6-12 weeks. It is rare for it to be more than 12 weeks. During this time the HIV test will be negative. However, the HIV infected person is capable of pressing the virus onto others during this time. Individuals in the window period are clinically healthy.

Virological Tests for Infants

Antibody tests used to diagnose HIV infection in adults can be used to diagnose children 12 months and older. However, HIV antibody tests *cannot* be used to diagnose infants under 12 months because infants are born with their mother's antibodies. This means that infants born to HIV infected mothers ***will*** test positive for HIV antibodies from the day they are born. At ***9-12 months*** of age, the mother's antibodies will start to decline in a child who is not actually infected with HIV. A child who did contract HIV from their mother will continue to test antibody positive because even as the antibodies of the mother decline, the child will develop their own HIV antibodies. If an infant under 12 months has a positive antibody test, this indicates that the mother has been infected and that the baby has been *exposed.* We cannot tell yet if the baby is infected with HIV.

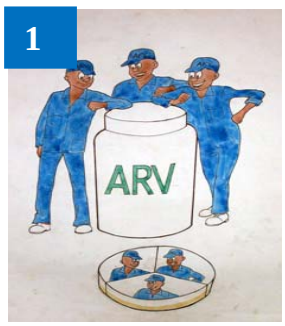
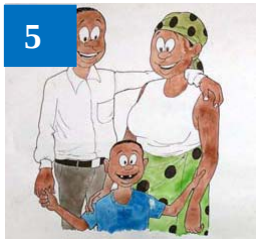
For infants under 12 months, a test that detects parts of the virus must be used (DNA PCR) instead to determine infection.

Overview of HIV Treatment

There are some medications available that help to fight HIV in the body. These medications are called anti-retrovirals or ARVs.

When we talk about treating HIV, it is important to remember that there is no cure for HIV. A person who is infected will be infected for the rest of his/her life.

Disease progression, however, can be delayed by preventing opportunistic infections (OIs), treating OIs early, and starting anti-retroviral therapy (ART). Let's take a look at the client education flipchart again. This provides an easy way to explain ART to your client.

	
ARVs are three medicines that work together in one tablet to strengthen a person's immune system. Many people who have taken ARVs as prescribed, find that they feel stronger, and healthier.	ARVs work by suppressing the production of arrows so that their number is reduced. This gives the body time it needs to mend its shield. ARVs are not a cure.
ARVs work in two shifts regularly, so people on ART need to take one pill every morning and evening as prescribed by their doctor. Everyone starts with a starter pack which is taken every day for two weeks. After two weeks, the patient comes back to the hospital, to receive a continuation pack of ARVs. ARVs are not a cure. If a person forgets to take his/her tablets every day or stop, the HIV arrows will come back even stronger.	Because ARVs are a strong medicine against HIV, some people may experience strong side effects. These can include rash, jaundice, nausea or vomiting, abdominal pains, numbness, or pricking pains in the legs. If a patient experiences any side effects, it is important to come back to the hospital as soon as possible. A person should seek immediate treatment, and take all medicines as prescribed.
 In some people the drugs may not work and for some people the help may come too late and they are still going to die, but many people do very well and live happy and healthier lives. ARV treatment may seem difficult to take at first, but	**Who is eligible for ARVs?** • Those who have undergone HTC and have tested HIV positive. • Those who have attended the education session for the drug. • Those who have been assessed by the clinician and have been approved for treatment. Usually, people in stage 3 or 4 of the disease progression.

with the support of family, friends, and health staff, a person can do very well and live happy, healthier lives.	

Who is eligible to start ART?

When a person is first infected with HIV, they may feel healthy for some time. When a person starts to show signs that the immune system is weak or failing, it is time to start ARVs. We have identified specific criteria that signal that it is time to start taking drugs– these criteria help clinicians avoid starting patients too early (which can lead to adherence problems) and avoid starting patients too late (which can lead to poor response to treatment).

Any person with signs that the body's defense system has been damaged is eligible to start ART. Specifically, those with:

- Specific diseases classified as WHO Stage III or IV (adults and children)
- CD4 count below 350 (adults)
- CD4 count below 750 or 25% (children 2-5 yrs)
- Infants with presumed severe HIV disease

Some patients may start treatment, even when their immune systems are still strong.
All HIV+ pregnant and breastfeeding women can start ART. The reason that we want pregnant women to start taking ART is to prevent transmission from the mother to baby. When the mother's viral load is low, it is less likely that the baby will get HIV.

Also, all confirmed HIV+ children under 2 years are eligible to start treatment– in fact, these children SHOULD start treatment as soon as possible.

WHO Clinical Staging

Key Facts for Providers and Patients

- Untreated HIV infection leads to a gradual destruction of the immune system.
- Different HIV-related diseases tend to appear at different levels of immune suppression.
- HIV-related diseases are grouped into 4 WHO clinical stages that correlate with disease progression and prognosis of survival:
    - Stage 1: Asymptomatic
    - Stage 2: Mild
    - Stage 3: Advanced
    - Stage 4: Severe
- Many patients have several HIV-related diseases from different stages

    - List all conditions on the *ART Patient Card*
    - Note that the most severe condition determines the WHO clinical stage
- Most WHO stage defining conditions apply to all ages, but some are only for children under 15 years and others are only for adults
- Patients in WHO stage 3 or 4 are always eligible to start ART. Other conditions apply to patients in stage 1 or 2 (see Section 6.4.4 of the *Malawi Integrated HIV Guidelines 2011)*
- WHO clinical staging requires confirmed HIV infection
- An infant aged under 12 months with only a positive HIV rapid antibody test can NOT be given a WHO clinical stage because in infants, HIV antibodies do not confirm HIV infection.
- However, an infant with HIV antibodies and specific clinical conditions is very likely to have AIDS and needs to start ART without delay (see definition of *Presumed Severe HIV Disease* on the table below)
- WHO clinical staging is mandatory for all HIV patients, including those who are universally eligible for ART (confirmed infected children under 2 years, pregnant or breastfeeding women) or those with a CD4 count result
    - Keep a stack of blank (pre-) *ART Patient Cards* at OPD and complete staging for every new HIV patient

Source: ***Clinical Management of HIV in Children and Adults: Malawi Integrated Guidelines, 2011***

Table 3: WHO clinical staging for children and adults with confirmed HIV infection and definition of presumed severe HIV disease for infants

	Adults and Children	Adults only (15 years or older)	Children only (below 15 years)
1	• Asymptomatic • Persistent generalized lymphadenopathy		
2	• Respiratory tract infections, recurrent (sinusitis, tonsillitis, otitis media, pharyngitis • Herpes zoster • Angular cheilitis • Oral ulcerations, recurrent • Papular pruritic eruptions / Fungal nail infections	• Moderate weight loss <10%, unexplained • Seborrhoeic dermatitis	• Hepatosplenomegaly, persistent unexplained • Lineal gingival erythema • Wart virus infection, extensive • Molluscum contagiosum, extensive • Parotid enlargement, persistent unexplained
3	• Fever, persistent unexplained, intermittent or constant, >1 month • Oral hairy leukoplakia • Pulmonary tuberculosis (current) • Tuberculosis (PTB or EPTB) within the last 2 years • Anaemia, unexplained < 8 g/dl • Neutropaenia, unexplained < 500 /mm^3 • Thrombocytopaenia, chronic < 50,000 /mm^3	• Severe weight loss >10% and/or BMI <18.5kg/m^2, unexplained • Diarrhoea, chronic (>1 month) unexplained • Oral candidiasis • Severe bacterial infections (pneumonia, empyema, pyomyositis, bone/joint, meningitis, bacteraemia) • Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis • Hepatitis B or C infection	• Moderate unexplained wasting / malnutrition not responding to treatment (weight-for-height/ -age 70-79% or MUAC 11-12cm) • Diarrhoea, persistent unexplained (14 days or more) • Oral candidiasis (from age 2 months) • Acute necrotizing ulcerative gingivitis or periodontitis • Lymph node tuberculosis • Bacterial pneumonia, severe recurrent • Symptomatic lymphoid interstitial pneumonitis • Chronic HIV-associated lung disease including brochiectasis
4	• Pneumocystis pneumonia • Candidiasis of oesophagus, trachea, bronchi or lungs • Extrapulmonary tuberculosis • Kaposi's sarcoma • HIV encephalopathy • Cryptococcal meningitis or other Extrapulmonary cryptococcosis • Disseminated non-tuberculous mycobacterial infection • Cryptosporidiosis, chronic with diarrhoea • Isosporiasis >1 month • Disseminated mycosis (coccidiomycosis or histoplasmosis) • Symptomatic HIV-associated nephropathy or cardiomyopathy • Progressive multifocal leukoencephalopathy • Cerebral or B-cell non-Hodgkin lymphoma	• HIV wasting syndrome (severe weight loss + persistent fever or severe weight loss + chronic diarrhoea) • Bacterial pneumonia, recurrent severe • Chronic herpes simplex infection (orolabial, genital / anorectal >1 month or visceral at any site) • Cytomegalovirus infection (retinitis or infection of other organs) • Toxoplasmosis of the brain • Non-typhoidal Salmonella bacteraemia, recurrent • Invasive cancer of cervix • Leishmaniasis, atypical disseminated	• Severe unexplained wasting / malnutrition not responding to treatment (weight-for-height/ -age <70% or MUAC <11cm or oedema) • Bacterial infections, severe recurrent (empyema, pyomyositis, bone/ joint, meningitis, but excluding pneumonia) • Chronic herpes simplex infection (orolabial or cutaneous >1 month or visceral at any site) • Cytomegalovirus infection: retinitis or other organ (from age 1 month) • Toxoplasmosis of the brain (from age 1 month) • Recto-vaginal fistula, HIV-associated **Presumed Severe HIV Disease in infants <12 months *(PSHD)*** Positive antibody (rapid) test *PLUS* one or several of the highlighted clinical conditions in the WHO staging list *OR* combination of at least 2 of the following: • Oral thrush • Severe sepsis • Severe pneumonia

Option B+

Option B+ is lifelong ART for HIV positive pregnant or breastfeeding women and 6 weeks of Nevirapine after birth for infants. Option B+ facilitates:

Increased access to ART:

- After a positive HIV antibody rapid test, a pregnant woman may start on ARVs. This makes antenatal clinics an ideal entry point for ART.
- Many women have at least 1 ANC appointment and availability of HIV rapid testing at all ANC sites enables more women to access PMTCT and ARVs.

Prevention of mortality after delivery:

- When HIV+ women are on ART, they are stronger and healthier during and after delivery.

Reduction of HIV transmission:
Maternal ART reduces viral load which:

- Provides optimal protection during delivery and for subsequent pregnancies, especially given high fertility rates in Malawi
- Enables safe breastfeeding and avoids the need for extended infant HIV prophylaxis
- Reduces HIV transmission to sexual partners, especially for discordant couples

Option B+ leads to safer breastfeeding for HIV infected women. Breastfeeding recommendations are now identical for HIV infected and non-infected women:

- Breastfeeding recommended until age 2
- Add suitable food from age 6 months

Option B+ makes a big difference in reducing HIV transmission. Option B+ keeps the mother's viral load low, so that the risk of passing the infection to the infant is dramatically reduced. In addition, infants can breastfeed longer, which leads to healthier, stronger infants (and fewer cases of malnutrition).

ART Assessment

After testing positive for HIV, all clients should be referred to the ART clinic for assessment. If eligible to start ART, the clinician will usually initiate treatment at the same visit which includes conducting: an assessment, a patient education session, and prescribing ARVs. If not yet eligible, the patient will be enrolled in an HIV Care Clinic (HCC). Follow up continues for exposed children until age 24 months and pre-ART children and adults – until they start ART. It should be noted that if breastfeeding has stopped by 24 months, there is no need for follow-up. If breastfeeding continues beyond 24 months, however, monitoring should continue.

CD4 Count

This is the test given to someone who is HIV infected to determine the strength of the immune system (the green line in the earlier diagram). Since HIV destroys CD4 cells, a low CD4 cell count suggests that the disease has progressed. It is used to help determine when

to start treatment. This test is available at a limited number of facilities in Malawi. Where it is available, it is used to stage patients and determine when to start treatment.

Viral Load

Both patients on ART and those enrolled in HCC need regular monitoring. Disease progression and response to therapy is tracked using 1 test: viral load. Viral load tests measure the amount of virus in the body (the red line in the earlier diagram). Generally, viral load tests are used to determine if treatment is working. A high viral load—for a person on treatment—suggests that the treatment is not working well. A low viral load suggests treatment is successful. In Malawi, there are very few places that offer viral load testing. Where it is offered, the viral load test is used to monitor treatment effectiveness.

Post Exposure Prophylaxis (PEP)

HIV infection can be prevented after a high risk contact with body fluids from an HIV infected person. If taken correctly, it reduces the risk of infection by 80%. However, starting PEP more than 72 hours after exposure is not effective and should not be done as it is ineffective at that point. Anyone is eligible for PEP who has had an exposure classified as risky in the past 72 hours. NEVER refuse PEP on moral judgment about the kind of exposure (accident, negligence, rape, “burst condom”).

PEP Job Aide

Occupational Exposure:
Take Immediate Measures: Wash exposure site with soap (do not use bleach or antiseptics)

Refer to clinician immediately
Clinician will give 3-day supply of PEP
(PEP should not be delayed if a counsellor is not

Patient/Client Reports Exposure Within Last 72 Hours
PEP should be recommended for any client with

Step 1: Assess Risk from Exposure

	Substance	Type of contact	Source person
Risk	• Blood • Semen • Vaginal fluid • Cerebro-spinal fluid • Pleural fluid • Amniotic fluid • Synovial fluid • Ascites fluid	• Skin penetrated with contaminated needle (hollow or non-hollow) • Large amount of substance on mucous membrane • Sexual intercourse no condom • Risk substance on lacerated skin / open wound	• Known HIV infected • Unknown HIV status • Recently tested negative (may be in window period)
No Risk	• Urine • Stool • Pus • Tears • Saliva • Sputum • Nasal secretions	• Risk substance on intact skin	

If NO Risk:
Client NOT eligible for PEP
STOP

If Risk:
Eligible for PEP

Step 2: Conduct HIV Test

If Positive:
Client was infected with HIV prior to recent exposure--NOT eligible for PEP
STOP

If Negative:
Continue PEP for 30 days
Emphasize importance of adherence

Step 3: Follow Up
At 30 days: stop PEP, assess adherence, give 60 condoms
Repeat HTC at 3 months, 6 months

Cotrimoxazole Prophylaxis (CPT)

CPT is an antibiotic used to prevent opportunistic infections in HIV infected individuals. All patients eligible for ART are also eligible for CPT. CPT is also offered to DNA-PCR negative children born from HIV infected mothers who continue to breast feed. A study by Mermin and colleagues in Uganda has shown a 46% reduction in mortality when this drug is given to HIV infected patients. Lower rates of malaria, diarrhoea, bacterial pneumonia, and hospital admissions were also observed during the study (*Source: Mermin et al., Oct 2004*)

Key Points

- HIV is the virus that causes AIDS
- HIV affects immune system and body's ability to fight off infections
- HIV is transmitted through 4 bodily fluids:
  - semen
  - vaginal secretions
  - breast milk
  - blood
- Adults are tested for HIV using an HIV antibody test
- HIV antibody tests cannot be used to diagnose infants under 12 months, use DNA PCR test instead
- Antiretroviral treatment (ART) is used to treat HIV by delaying disease progression and strengthening the immune system
- 3 groups are eligible for ART:
  - Adults, children w/signs of a weak immune system
  - All HIV+ infants and children under 2 years
  - All HIV+ pregnant and breastfeeding women

Module 1, Unit 1.2: Importance of HTC

Learning Objectives

By the end of this unit, you will be able to:

- Identify HTC clients
- List the goals of HTC
- Identify the 5 key guiding principles in the counselling process
- Describe the models of HTC delivery
- Define the 4 types of HTC and where they are conducted
- Describe who does HTC in Malawi and why
- Describe the drivers of the HIV epidemic in Malawi and current strategies to address them

Definition of HTC

HTC is the process through which an individual or couple is confidentially counselled AND tested for HIV. As an HTC provider, you must be able to provide appropriate testing and counselling to individuals, couples, pregnant women, infants, children, adolescents, youth and at risk groups.

HTC is an Important Intervention

Malawi has among the highest prevalence of HIV in the world at 10.6% (MDHS 2010). About 1 million Malawians are living with HIV; 100,000 are children under the age of 15. 110, 000 new HIV infections occur each year—88% through hetero-sexual intercourse and 10% through mother-to-child transmission.

Many people in Malawi do not know their status—most are *not* infected with HIV but *do not know* they are not infected. Others *are* infected and also do not know. The Ministry of Health recognizes HTC as an essential part of the nation's response to the HIV/AIDS crisis and is committed to the implementation of quality HTC services nationwide.

HTC Goals and Principles

The goals of HTC are to:

- Prevent or minimize exposure to HIV
- Prevent or minimize re-exposure and further transmission
- Mitigate the impact of HIV through psychosocial support to infected and affected
- Serve as an entry point to HIV treatment, care and supportive services

The guiding principles of HTC can be summed up with the "5 Cs": consent, confidentiality, counselling, correct test results and continuum of care. The World Health Organization (WHO) states that the 5 Cs must be respected and adhered to by all HTC services.

Consent

HIV testing is not mandatory. The client always has the right to refuse HTC at any point in the process, in any HTC setting. It is important that we explain issues of consent to clients so that they understand that the decision to test is in their hands. Even when a clinician recommends testing (such as in a hospital or ANC setting) the patient will still receive quality care, even if they refuse an HIV test. Our job is to encourage testing for the patient's health while respecting their right to choose not to be tested, if they wish.

Confidentiality

Confidentiality is the agreement of the HTC provider not to share anything that is said or done in the counselling room with anyone else without the express permission of the client. This issue of confidentiality is a central one to counselling and it is important that HTC providers have a thorough understanding of it before they begin counselling clients.

Confidentiality is an agreement of the HTC provider not to share anything with anyone else. Confidentiality….

- Enables the client to feel safe
- Protects the client after the session
- Promotes trust

Counselling

HIV testing should not be done on its own– it should always be accompanied by some form of counselling to ensure that the client understands what he/she is being tested for, why HIV testing is important and is able to understand his/her test results. Counselling is also important for encouraging behaviour change, both in HIV+ and HIV- clients.

Correct test results

It is important to emphasize this– there are very serious consequences for giving incorrect test results. And yet, it happens. As HTC providers, we need to ensure that we follow our testing SOPs without exception. We must adhere to the highest professional standards– if clients believe that they may be given incorrect test results, our HIV program is at risk of failing.

Continuum of Care

HIV testing and counselling is the entry point to care. One of our main goals is to identify HIV+ people and ensure that they get the care and treatment they need to live longer, healthier lives. We do this by assisting HIV+ clients to be assessed by a clinician and start treatment. Our other goal is to support HIV negative clients to remain negative by adopting risk-reduction behaviours. We can connect our clients to support groups and resources to help them stay safe.

HTC Delivery Models

A variety of models can be used to deliver HTC as shown below.

Stand-alone model:
'Stand-alone' refers to static sites located outside of a health facility and HIV and Counselling service is often the core service offered. They have fully devoted HTC staff and are usually located in densely populated urban areas. The traditional community based VCT sites run by NGOs and CBOs are examples of stand-alone HTC services. However, in most cases, these sites are really never alone as they maintain linkages with health care and other services for referral purposes.

Integrated model:
Integrated model of HTC refers to static sites, mostly in health facilities, where HTC is provided along with other health services like treatment for tuberculosis, consultation and treatment of various symptoms in outpatient departments, treatment of STIs, in ANC and MCH, etc. Appropriate referral is facilitated by the close proximity of all other services within the facility. HTC providers are either non-health or health personnel fully dedicated to HTC or could be health/clinical personnel providing consultation and clinical care in other services in the facility.

Outreach model:
Outreach HTC involves regular non-full time service provision at designated health centres or community sites using staff from another static or mother site. These health centres or community based sites often do not have adequate staff and other resources to implement static full–time services throughout the week. A plan is then arranged with a mother HTC site that has adequate resources to provide a regular part-time HTC service, e.g. one or two days a week or one or two days in a fortnight. A separate register is dedicated to each outreach site; and each outreach site is responsible for reporting its data to the DHO and Ministry of Health (HQ), through the Zonal Health Office as an outreach site. Outreach sites often develop into full-time static sites when staff and resources become available. Outreach sites can also stop operating if the demand for HTC has been depleted.

Mobile model:
The mobile HTC service is commonly implemented through a 'mobile unit' van or other suitable vehicle with tents and portable furniture that can easily be utilized as counselling rooms. The mobile unit and HTC providers move into the designated place in the community and provide services in accordance with a predetermined plan. It is often the best model for targeting hard-to-reach communities where other models are either not feasible or unavailable. Mobiles are temporary and do not have long term commitment for subsequent service delivery at the same sites. The mother site keeps one register for all mobile activities and is responsible for reporting HTC data to the DHO.

Home Based Door-to-Door:
The Home Based Door- to- Door HIV testing model is a community based HIV testing model in which HTC providers move from house to house offering HIV education and HIV testing and counselling to family members within their homes. Members of the family can test for

HIV as an individual, or as a couple or as a family unit. Appropriate referrals are made during post-test counselling for further consultation, treatment, care and psychosocial support to the nearest health and /or HIV service facility.

Variants of Home Based Door-to Door HTC, acceptable and feasible in Malawi are:

- Integrating HTC in Community and Home Based Family Planning and Home- Based Care Services: HIV Testing and counselling is offered and provided as part of home based family planning services. Timely appropriate referrals are made soon after HIV Testing and Counselling.
- Targeted Home Based HTC: HTC providers from static HTC sites, outreach or mobile sites being invited by clients to their homes to offer HIV testing to other members of the family within their homes. Timely appropriate referrals are made soon after HIV Testing and Counselling.

Moonlight HTC

In addition to door to door HTC services, another innovative approach is the moonlight HTC service that has been introduced by MACRO where clients patronize services at night. Preliminary results from the pilot conducted by MACRO show that it can contribute significantly towards increasing the number of people being tested in Malawi. The population targeted includes couples, ordinary people, high profile individuals, youth and high risk behavioral groups. Overtime MACRO has realized that the urban population is reducing in terms of HTC uptake possibly attributable to saturation of the population by static sites and as such strategies to use mobile van, *moonlight* and outreach programs have been intensified to target the rural community.
(Source: 2012 Global AIDS Response Progress Report: Malawi Country Report for 2010 and 2011, 3/31/2012. Government of Malawi).

Types of HTC

The four main types of HTC are:

- Provider-initiated testing & counselling (PITC)
- Client-initiated testing & counselling (CITC)
- Mandatory
- Research-based surveillance

Of these, CITC and PITC are the most common. Mandatory testing is ONLY required for the National Security Services upon recruitment. In all other settings, the patient/client has the right to decline testing at any time.

One important concept for understanding different types of testing is the opt-in vs. opt-out testing strategy. This distinction has much to do with how a person is asked about HIV testing and how the client is required to respond.

Opt-out Approach to HIV Testing

- HIV testing and information session offered as a routine part of standard care
- Individual or group pre-test counselling

- Client given opportunity to decline the test. The HTC provider will say something like: "if you do not wish to be tested, you may refuse at any time."
- Testing is not mandatory. It is assumed that the client will test, and the client makes a choice about testing by saying "no" if he/she does not want a test.

Provider initiated testing is always opt-out.

Opt-in Approach to HIV Testing

- Client provided with information on HIV and testing
- Individual or group pre-test counselling
- Client is asked if they wish to be tested for HIV. The HTC provider will say something like: "Are you ready to test for HIV today?"
- Client is given the option to test or not test, both are presented in a neutral, supportive manner. The client makes a choice about testing my saying "Yes, I do want to be tested for HIV."

Client initiated testing is always opt-in.

Who Provides HTC?

Both medical and non-medical providers may deliver HTC. The important role of non-medical providers has been recognized globally. In Malawi non-medicals perform 90% of HTC. Clinicians and nurses also play a vital role. When a test is needed, clinicians/nurses can perform it on-the-spot, rather than needing to refer. They can also ensure that results are obtained quickly for medical decision-making.

Client Initiated Testing and Counselling (CITC)

In CITC, the client decides to test on his/her own. The focus is on giving the client information about HIV, on preparing and encouraging the client to test, and on making behavioural changes.

Provider Initiated Testing and Counselling (PITC)

In PITC, the clinician or nurse recommends an HIV test. It can either be provided as routine testing (all patients are offered this test) or diagnostic testing (used to more clearly understand the patient's problem). The focus of PITC is on early diagnosis of HIV and links to care and treatment.

PITC should be available for patients seeking care in any healthcare setting. In clinical settings, priority should assigned to the following groups:

- TB cases and suspects
- STI and family planning patients
- Pregnant women

- Paediatric and adult inpatients on the medical and surgical wards (including partners and families)
- Clients who have been sexually violated

Two models of PITC are used in Malawi—the health care worker model and the task shifting model. In the health care worker model, the health care worker conducts the test and provides the counselling, whereas in the task shifting model, the health care worker initiates the service but the actual testing and counselling is provided by another designated HTC provider. Regardless of the model used, it is critical that the clinician get the result and continue with case management and linkages to appropriate care.

Drivers of the HIV Epidemic in Malawi

Now that we've learned what HTC is and why it is a critical intervention, the next step is to know our epidemic! In order to be successful at combating HIV, we need to understand what is driving it and what is currently being done to address it. This section will take a look at these critical issues.

The following drivers are taken from the National Prevention Strategy (2009-2013):

- Multiple and concurrent sexual partnerships
- Discordancy in long-term couples (one partner HIV negative, one HIV positive)
- Late initiation of HIV treatment.
- TB/HIV co-epidemic
- Low and inconsistent condom use
- Poor implementation of HIV prevention interventions within clinical settings (including HTC)
- Transactional sex related to income and other social and material benefits
- Gender inequalities/imbalances including masculinity
- Harmful cultural practices
- Stigma and discrimination
- Low prevalence of male circumcision (currently 21%)

Malawi has developed strategic objectives to address these drivers. It is critical that all HTC providers are familiar with these objectives and recommended approaches. They are outlined below:

Strategic Objectives:

1. Reduce sexual transmission of HIV
    a. Reduce multiple and concurrent sexual partners among adults and youth
    b. Reinforce both primary and secondary abstinence for young people
    c. Scale-up positive prevention among PLHIV
    d. Reduce HIV transmission among HIV discordant couples

e. Provide timely access to ART
f. Increase access to VMMC
g. Increase condom use
h. Reduce intergenerational sex

2. Prevent mother-to-child HIV transmission of HIV
   a. Provide universal HTC for women and their partners, adolescents in child bearing age
   b. Increase access and quality of PMTCT services
   c. Strengthen linkages between complementary services
   d. Increase access to family planning and HIV prevention services
   e. Provide comprehensive care and treatment to HIV+ pregnant and breastfeeding women and their families
   f. Provide care and support to all HIV exposed infants
   g. Promote integration of PMTCT with HTC and ART services
   h. Promote male and community involvement in PMTCT

3. Prevent HIV transmission through blood, blood products and invasive instruments
   a. Increase proportion of voluntary blood donors to 80%
   b. Encourage voluntary, non-remunerated blood donation
   c. Ensure 100% of blood supply accurately screened for HIV
   d. Promote appropriate clinical use of blood
   e. Promote implementation of infection prevention in all health facilities
   f. Ensure access to PEP

Key Points

- HTC clients include individuals, couples, pregnant women, infants, children, adolescents, and youth
- The goals of HTC are to:
  - Prevent or minimize exposure/re-exposure to HIV
  - Mitigate the impact of HIV through psychosocial support to infected and affected
  - Serve as an entry point to HIV treatment, care and supportive services
- The 5 Cs must be respected and adhered to by all HTC services
- PITC and CITC are the two most common types of HTC in Malawi
- Testing is only mandatory for the National Security Services upon recruitment; in all other settings, the patient has the right to decline testing at any time

- All HTC providers should be familiar with the drivers of the epidemic and the strategies put in place to address them

Module 1, Unit 1.3: Counselling Principles

Learning Objectives

By the end of this unit, you will be able to:

- Explain how personal beliefs and feelings can affect interactions with clients
- Identify psychosocial issues in HTC
- Explain key components of each counselling theory:
  - Psychoanalytic
  - Behavioural
  - Cognitive/Behavioural
  - Humanistic
- Describe the importance of Egan's 3 Stage model in HIV counselling
- List basic communication skills for HTC providers
- Explain 2 common pitfalls in HIV counselling

Understanding Yourself: Self-Awareness

One of the things that you will become aware of quite early on in your training is that learning about counselling is not a theoretical exercise. In fact, there is a substantial element of self-awareness and personal development! This means that a great deal of what you learn throughout this course will be experiential. From the very beginning you will probably think much more about yourself, the experiences you have had, the opinions you hold, prejudices that you may not have been aware of, your relationships, and any other significant factors of your personal and professional life. This experience is both rewarding and challenging. This unit will help you to explore, acknowledge and understand yourselves and others.

Values, Attitudes and Prejudices

The way we see the world will always affect how we treat others in our lives. It is important to be aware of your values, attitudes, and prejudices, so that you can have an open mind with your patients/clients. This is key to treating each patient/client fairly and with respect.

Values: the importance we attach to a particular belief, practice, idea or object

Attitudes: a tendency to respond or behave in certain ways.

Prejudices: pre-judgments learned from our community

Self-Concept

There are different ways we can describe ourselves based on our body image, self-image, ideal self and self-esteem.

For example:

- Body image, e.g., “I am dark, tall, big, short…”
- Self-image, e.g., "I am a mother, teacher, sister, Malawian…”
- Ideal self, e.g., “I want to be a good mother, good swimmer, excellent HTC provider…”
- Self- esteem, e.g., “I am proud to be a good HTC provider, I am ashamed to be lazy…”

Body image – can mostly be seen by anyone (public domain)
Self-image – some can be seen by others, but not all (public and private domain)
Ideal self – many things unknown to others (private and hidden domain
Self-esteem – mostly hidden from the public (private and hidden domain)

When we feel good, all the domains are more or less equal. But when there is a trauma in our life, our images of ourselves will change. This will always be the case for people who learn of their HIV status. We can describe ourselves in many different ways. HTC providers should be aware that the clients also have self-concept, which should be taken into account during the counselling process.

Understanding Your Client: Common Psychosocial Issues

Learning about how HIV works in the body is only half of the story when it comes to preventing the spread of HIV. Plenty of people who know all the facts about HIV still become infected with the virus. Why? Our behaviour is a reflection of the social, cultural, political and religious environment we are surrounded by. We make changes—or don’t make changes—largely as a result of the support we get from people around us. In this way, if we are to prevent the spread of HIV, we need to look at the psychological and social environment around us.

Quality Sex

It is important to learn about parts of the body, to practice talking openly about them, to think about language used. It is also important to recognize how the embarrassment caused by talking about the might affect our clients. People are different. We all have sex for different reasons at different times. We may value certain types of sexual activity while disliking other types, even if they are safer. People must choose for themselves what behaviours they are willing to adopt. The HTC provider can only give information and help the client explore the issues.

Recent research has shown that ‘quality sex’ or ‘satisfying sex’ between couples minimizes the frequency of partner change among men and women. Reducing the number of partners

is one way to reduce the incidence of STIs and HIV. Promoting quality sex is an important way to curb the spread of HIV.

Definition: Quality sex is when both partners want sex. It happens between people old enough to know what they are doing, is pleasurable for both partners, and is free from the risk of infection or unwanted pregnancy.

Gender and HIV

Both men and women are vulnerable to HIV infection, and in every country of the world, HIV affects both. However, women are about twice as likely to be infected with HIV than men. In Malawi, women between the ages of 15 and 24 are 2.2 times more likely to be HIV-infected than their male counterparts in the same age group. In simple terms, this means that for every 100 men infected with HIV in Malawi, there will be 220 women infected. Why do you think this so? There are a lot of reasons that women are more vulnerable to HIV. Some are biological factors; some are social factors; some are cultural factors.

Biological

- The design of a woman's body (her organs are internal) facilitates transmission
- The particular cells in the cervix allow HIV a way to get in the body
- Women are more likely to have undiagnosed STIs and may not notice symptoms as easily

Social and Cultural

- Women tend to have lower levels of education and less information about sex
- Women may have less control in a sexual relationship
- Women may experience trauma or bleeding during sex
- May have relationships with older men (who may be more sexually experienced, therefore at greater risk for HIV)

Stigma and Discrimination

Stigma is something that occurs when a person is labelled by a society. That person may experience negative effects from that labelling—they may be rejected, threatened, isolated or generally treated badly. This can result in feelings of shame. Discrimination happens when someone treats a person differently from others. Discrimination is an action that is taken biased against a particular person or type of person.

Counselling Theories

What is Counselling?

Counselling is a structured conversation between two or more people that assists one of the participants to work through particular problems or conflicts that they face, explore their feelings and find ways to resolve or cope with them. Counsellors encourage people to

recognize and develop their own coping capacity, so they can deal more effectively with problems.

While the term 'counselling' may be unfamiliar to some, the behaviour is probably common in all cultures. In counselling, we not only help people with their immediate problems, we also help them to recognize and draw upon their own resources, which they can use for future problems they encounter.

Counselling is about creating new perspectives and change. The change may be inside the person, for example, helping them feel differently about a situation; or a change in their behaviour, for example, practising safer sex; or a change in something in their environment, for example, setting up a support group.

Counselling aims to help people to:

- Understand their situation more clearly
- Identify a range of options for improving the situation
- Make choices that fit their values, feelings and needs
- Make their own decisions and act on them
- Cope better with a problem
- Develop life skills such as being able to talk about sex with a partner
- Provide support for others while preserving their own strength

Goals of Counselling

There are many goals of counselling. Some of the goals of counselling are to:

- Encourage the client to become self-reliant and feel confident about his/her own ability to make decisions.
- Help a client feel better or at least more comfortable particularly in the long run.
- Help a client to become more self-sufficient to deal with on-going and future life situations in a constructive way without requiring continual help.

There are several theories on which the counselling process is based.

A theory is an idea that helps explain why something is happening in a particular way. Someone might observe something—for example, a man riding a bicycle—and want to explain why it is happening. You might come up with a theory that the man is going to the store. Or your theory might be that he is too tired to walk. Or your theory might be that his car is broken.

Many theories offer a way to look at something, but any one theory does not offer the whole explanation.

In this unit, we will discuss 4 theories that will help to guide our practice:

- Psychoanalytical Theory
- Behavioural counselling Theory
- Cognitive-Behavioural Theory
- Humanistic Theory

Psychoanalytic Theory

The Psychoanalytical counselling theory was developed by Sigmund Freud who lived from 1856–1939. This theory says that:

- Experiences in the past influence the present.

- Everything we have ever done or felt is stored in our memory. However, we may not remember some of these things because they may be stored in our subconscious mind.
- Freud believed that from birth to age 12 we have certain basic needs and that unless these are fulfilled, we will grow up repressed and unable to function well. He believed that these early years influence our whole life.
- He believed that we are sexual beings from birth and that our relationships in the first few years of our lives will affect our sexuality as adults.
- Based on these early experiences, we develop the ways we cope with life. These coping mechanisms enable us survive at the time but may not help us form good relationships later on—for example, a child who is beaten when admitting to bad behaviour may learn to tell lies to avoid being beaten.
- Another concept of psychoanalysis is 'transference', which is when we respond to someone in a particular way because they remind us of someone in our past. Transference can affect all our relationships but can particularly affect the relationship between counsellor and client.
- Psychoanalytical counselling can help us bring the subconscious to light. Therapists encourage clients to say anything that comes into their heads.
- The counsellor is the expert and can interpret the client's dreams, thoughts and behaviour.
- We will then be able to understand why we are as we are and take steps to change.

Benefits and Limitations of Psychoanalytical Theory

It is helpful for counsellors to know about this theory, as it is the foundation of all counselling theories.
If people are able to understand what happened to them as children, they may be able to take steps to change and live more fully.
However, the client can give up responsibility for their actions and put the blame for their behaviour on their parents or other influential people.
The power is held by the counsellor or therapist rather than by the client.
Psychoanalytical therapy usually takes many years before a client can see a change. It is a very slow process. In a 1-hour HCT session, the use of techniques from psychoanalytic theory is very limited.
Key message: Experiences in the past influence the present.

Behavioural Counselling Theory

I.P. Pavlov (1849–1946), J.B. Watson (1878–1958) and B.F. Skinner (1904–1990) developed this theory:

- We are born as 'blank slates'. Everything we are, as individuals, we have learned from other people or from our experiences in life.
- Learning does not change us completely, so behaviour learned can be unlearned.
- We can unlearn thoughts, feelings and behaviour that distress us and replace them by learning better ways of thinking, feeling and behaving.
- This theory deals with behaviour in the here-and-now. The past is insignificant.
- The counsellor asks the client to act rather than talk.
- Counsellors help clients identify and make specific plans to change their lives.

- The emphasis is put on clients' responsibility for their behaviour.
- Behavioural therapy helps the client to develop self-management skills.
- Behaviour is measurable and so the outcome of counselling can be measured.

Benefits and limitations of Behavioural Counselling Theory

In HTC, behaviour change is an important goal. Behavioural theory of counselling can therefore be very significant.
Behavioural theories emphasize the responsibility of the client and focus on action planning and self-management. This emphasis is strongly relevant to planning risk-reduction strategies.
However, behavioural theory is not focused on the emotional responses of the client or the way in which the past will influence the present. It can therefore feel a little cold and mechanical.
Although it works much faster than psychoanalysis, behavioural therapists usually see clients for a number of sessions whereas the majority of clients for HCT are seen only once.
Key message: Behaviour learned can be unlearned.

Cognitive Behavioural Counselling Theory

Aaron Beck (1921–) and Albert Ellis (1913–) developed this theory.
The theory states that:

- All human beings are rational and have the capacity to reason.
- No two people will respond to an event in the same way. So it is not events that produce bad feelings but the way these events are interpreted.
- Emotions and behaviour are determined by thinking.
- Emotional disorders result from negative and unrealistic (maladaptive) thinking and that by altering this maladaptive thinking emotional disturbance can be reduced.
- Clients may only be semi-aware of maladaptive thinking.
- Childhood experiences may be the origin of maladaptive patterns of thinking but their thinking here and now is more significant in CBC.
- Counsellors will help clients understand how their thinking influences their emotional responses and their behaviour.
- This may be done through logical discussion to challenge negative and unrealistic thinking by examining the evidence for and against such thinking.
- The counsellor and client will also agree tasks—homework—as with behavioural counselling so that the client can check out the results of different ways of thinking.
- The counsellor and client collaborate to achieve the goals of CBC.

Benefits and limitations of Cognitive Behavioural Counselling Theory

As with behavioural counselling, CBC focuses on behaviour change, which is the key aim of HCT.
It allows for a wider interpretation than behavioural counselling and allows for childhood's influences to be considered.
CBC enables counsellors to challenge client's beliefs.
Challenging clients needs to be done very carefully.

Changing behaviour established in our childhood can take time. HCT sessions are usually limited to 1 or 2 hours and so may not be long enough to make full use of CBC.
Key message: All human beings are rational and have the capacity to reason. Thoughts affect our behaviour and feelings.

Humanistic Theory

Carl Rogers (1902–1987) developed this theory. It states that
Human beings are basically good. If they behave badly, it is because of the environment and culture they live in.
Human beings have the capacity to solve their own problems.
Human beings are always striving to be the best they can. They strive for self- fulfilment and self-actualisation.
In the humanistic theory of counselling, the client is the expert, not the counsellor.
The role of the counsellor is to provide the necessary conducive climate characterized by core conditions to enable clients to solve their own problems.
It has three key core conditions: 1) respect, 2) unconditional positive regard and 3) empathy.

Benefits and Limitations of Humanistic Theory

Using humanistic theories of counselling enables the client to be the expert and to make their own decisions. Humanistic counselling therefore empowers the client.
Sometimes it may be hard for the counsellor to believe that clients are good and that they are striving towards self-fulfilment if their lifestyles appear destructive.
In HCT, however, even though the session is client focused, the counsellor leads the session to ensure that all issues are covered, so it is not totally humanistic.
As with psychoanalytical theory, achieving change may take long with humanistic therapy.
Key messages: Human beings are basically good. Human beings have the capacity to solve their own problems. Human beings are always striving to be the best they can. Core conditions are respect, unconditional positive regard and empathy.

Egan's 3 Stage Model

Egan devised a map to guide the counselling process. The map has three stages.

Stage 1: Exploration – To enable the client to explore her/his problems; to develop a warm relationship; to help the client tell his/her story; the HTC provider needs to be non-judgmental.

Stage 2: Understanding – To help the client to probe deeper into his/her problem; to identify options; and to identify resources.

Stage 3: Action – To help the client to make choices; to help the client understand the implications of her/his choices; to help the client plan action for the future.

Egan's model also helps HTC providers bring together all counselling theories

- Exploration – Psychoanalytic

- Understanding: Behavioural and cognitive behavioural
- Action: Behavioural and cognitive as well as humanistic

Action planning needs to be SMART. SMART is an acronym and stands for specific, measurable, achievable, realistic, time-bound.

Communicating with the Client

Now that we have discussed a number of theories that drive our HIV counselling, it is time to take a closer look at specific counselling skills and techniques. Counselling theory is like the frame of a house, it gives our sessions shape and structure. The skills and techniques in this unit are like the bricks, tiles, paint and boards that close-in the house. These are the particular tools that help a HTC provider conduct an effective counselling session.

Definition of Communication

Communication is a process through which information messages, thoughts, ideas, feelings are transmitted from one person to another. Effective communication is important because it enhances interactive processes to take place. Therefore a good and effective HTC provider MUST possess good communication skills.

Two Types of Communication

1--Verbal Use of Words—what is actually being said.
2--Non-verbal use of signs—this includes things like eye contact, touch, body movement, facial expression. Non-verbal communication includes mainly body language and good listening.

The HTC provider should be aware of what his/her body is saying (i.e. gestures like crossing of arms and legs). All forms of communication, verbal and non-verbal, should be clear, understandable and culturally acceptable.

The Communication Process

This is a two way process (interaction) which involves:

- The Sender—this is a person from whom information has originated
- Message—the idea that is being passed on either verbally or non-verbally
- Channel—the means by which the message is transmitted from source to receiver.
- Receiver—this refers to the person talked to who in turn interprets the message being transmitted
- Feedback—a response from the receiver of a message he/she received

Barriers to Effective Communication

Barriers to effective communication include the following:

- Moralizing
- Arguing
- Preaching
- Storytelling
- Blocking communication

These methods focus on YOU (the HTC provider) and what you think or believe. They are not focused on what the patient/client says.

Other communication barriers that involve non-verbal communication include:

- Shuffling papers
- Not looking directly at someone when (s)he is talking
- Looking out through the window
- Looking at your watch
- Dirty office
- Interruptions or distractions

The examples listed above can have consequences for both the HTC provider and the patient/client such as: lack of information shared; fewer questions asked, difficulty in understanding problem at hand, and/or lack of adherence to medical appointments and/or treatment.

Communication Skills

The HTC provider needs to use various communication skills to effectively communicate with the client. These include:

- SOLER
- Active Listening
- Questioning
- Paraphrasing
- Focusing
- Challenging
- Summarizing
- Working silence

These skills are like your "HTC provider's tool box". As you sit with clients, you will draw upon these skills to help the client discover what he or she needs from the counselling session.

SOLER

SOLER is a technique that demonstrates interest and attention non-verbally. It stands for:

S —Sit squarely to communicate presence and availability.

O—Open posture to signify that you are open to the client and to what the client is saying. Others see this as a non-defensive posture.

L—Leaning forward towards the client is a natural sign of involvement.

E—Eye contact. There should be eye contact but this should not be confused with staring. It is a way of communicating your presence and interest and that you want to hear what the other person wants to say.

R—Being Relaxed and natural when doing all the above is important. It means becoming comfortable with your body and the situation.

SOLER needs to be followed in all counselling sessions.

Active Listening

Active listening means demonstrating that you are listening. When you are listened to, how does it feel? How does it feel when you are not listened to? If your client thinks you are not listening, he/she may stop talking or think you disapprove.

Questioning

Questioning is a skill used to help HTC provider and client explore and understand more fully the issues being discussed. Questioning, probing and prompting have the same objectives—to help clients name, take notice of, explore, clarify, or further define issues.
There are many types of questions as listed below:

Open-ended questions give clients choice in how to respond and are aimed at leading into a discussion. Examples are the 'how', 'what', and 'when' questions.

Closed questions restrict choice and lead to single-word or yes/no answers.

Leading questions lead to yes/no answers and make assumptions.

'Why' questions often sound interrogative in nature and tend to put people on the defensive.

Those most commonly used in counselling are open-ended questions. Questions should not be asked simply to satisfy your curiosity.

Paraphrasing

Paraphrasing involves restating the content of the message in similar, but fewer, words. It shows understanding, provides reflection that is clearer than the original statements, and begins with feelings, ends with facts.

Its purpose is to ensure you and you client understand eachother correctly and can move forward in the counselling session.

Summarizing

Summarizing means making a brief statement bringing together the key points from a counselling session or a part of a counselling session.

Focusing

Focusing enables the client to understand his/her issues in greater depth. It also helps move the client from the general to the specific.

Challenging

Challenging is used to help a client examine beliefs or behaviours that seems to be self-defeating or harmful to the self and to others. It can be useful to challenge mixed messages such as discrepancies between vocal and body messages, verbal messages, words and actions, and between past and present statements. It can be used when clients are focusing on other people rather than themselves, when there seems to be a lack of reality, or when the client is not acknowledging choice.

For examples the HTC provider could say to a client:

- You say you are fine, yet your tone of voice is sad.
- You say you fear HIV/AIDS yet you don't want to use condoms or give up your multiple sex partners.
- I am aware that you have only talked about your partner; I wonder how you are feeling yourself.

By challenging, you can develop better understanding of your client. It might feel as if you do not believe your client and seem judgmental. Because of this, challenging needs to be done carefully.

Working Silence

Working silence involves maintaining silence as you allow a client to process and reflect on information. This technique is commonly used after giving HIV test results. It involves using minimal prompts such as nodding, maintaining eye contact, and/or leaning forward.

Empty Chair

The empty chair technique is typically used to explore patients' relationships with themselves, with aspects of their personality, their concepts, ideas, feelings, etc. or other people in their lives. The technique involves the client addressing the empty chair as if another person, or aspects of their personality, or a certain feeling, etc was in it. They may

also move between chairs and act out two or more sides of a discussion, typically involving the patient and persons significant to them. (Source: http://en.wikipedia.org/wiki/Gestalt_therapy)

Common Pitfalls

Two common pitfalls in counselling include disclosing too much about oneself and giving advice.

First, self-disclosure. This is when the HTC provider talks about his/her experiences. It can be seen as distracting and shifts focus away from the client's issues.

The disadvantages:

- It might take attention away from the client and shift it to the HTC provider
- The HTC provider might assume that because both have experienced the same thing, they both respond to the experience in the same way
- The client might want more information than the HTC provider is willing to give
- The client is not bound to protect the HTC provider's confidentiality
- The HTC provider might use this self-disclosure for personal therapy: a problem shared is a problem half solved

As an HTC provider, you need to remember that the client is not bound by confidentiality and that self-disclosure needs to be done very carefully if at all.

There are certain circumstances where self-disclosure is beneficial to the client. Consider the benefits listed below.

The benefits:

- It might help clients develop a new perspective on their problems.
- It might reduce a sense of isolation
- Might increase the bond and trust between the client and HTC provider

Advice directs the client. Information allows the client choice. By generalizing the information, clients will not feel judged or directed.

As HTC providers, we have a set of skills that we will use to counsel clients effectively. We have looked at 2 main pitfalls (self-disclosure and advice) that can interfere with effective counselling. But sometimes, very personal issues may arise that create difficulties for HTC providers.The individual benefits or disadvantages would be the same as for anyone testing negative or positive. The advantages of having a test for clients are the same as for HTC providers. Going for a test, whatever the result, gives an HTC provider good knowledge of the experience. It is important to consider our own HIV status and what the issues are for us in going for HCT. Having the test may give us real advantages in our lives and our work, but the testing needs to be safe for us as individuals.

Key Points

- It is important that we be aware of our own values, attitudes and prejudices, so that we can have an open mind to our clients
- We make changes—or don't make changes—largely as a result of the support we get from people around us
- HTC providers aim to help others:
    - Understand their situation more clearly
    - Identify a range of options for improving the situation
    - Make choices that fit their values, feelings and needs
    - Make their own decisions and act
    - Develop life skills
- 2 common pitfalls of HTC providers include too much self-disclosure and giving advice

Module 2, Unit 2.1: CITC Pre-Test Counselling

Learning Objectives

By the end of this unit, you will be able to:

- Explain steps 1-4 of the CITC Protocol
- Explain how to conduct a thorough risk assessment
- Describe a client's risk using the risk classification table
- Explain client-centred strategies to reduce HIV risk

Steps in Pre-Test Counselling

All types of pre-test counselling have 4 main components which include:

1. Introduction and orientation to session
2. Risk Assessment
3. Risk Reduction
4. HIV test preparation

Step 1: Introduction and Orientation to Session

In Step 1, it is important to greet client in a culturally appropriate way, introduce yourself and your role, and explain confidentiality. The HTC provider should inform the client about counselling, the rapid test process, and the session flow/expected session time (45 minutes to an hour). Finally, the HTC provider should address the client's immediate concerns and questions.

The introduction to pre-test counselling establishes trust between the HTC provider and client and ensures the client knows what to expect. In this part of the session, the HTC provider talks much more than the client. It is important for the HTC provider to be confident and friendly. Keeping the introduction simple will enable the HTC provider to cover the material needed. If the introduction is done well, the client will have more confidence in the HTC provider.

Step 2: Risk Assessment

In Step 2 of the pre-test counselling session, we want to talk with the client in order to assess his or her HIV risk. Sometimes, assessing the client's risk may not be easy. You can assess risk only based on what the person tells you, which may not be the whole story.

The risk assessment may begin by the HTC provider asking:

- What brings you in for a test today?
- Tell me what you have heard about HIV and AIDS.

During step 2, the HTC provider should explore the client's reason for seeking HTC services, his/her understanding of HIV and AIDS, and the client's risks, perception and expectations. Next, assess the client's recent risk pattern (who, when, where) and triggers/vulnerabilities, screen the client for TB, STIs, pregnancy, and summarize the client's situation and risk issues.

When assessing the client's risk for TB, the HTC provider should ask the following TB screening questions:

- Have you had a recent cough of any duration?
- Have you experienced night sweats?
- Have you had unintentional weight loss?
- Have you ever been treated for TB?

Note that a yes to any of these questions should trigger referral to TB Services. According to the Malawi Integrated HIV Guidelines (2011):

- Each year 27,000 (3%) of the 900,000 HIV infected Malawians develop TB
- 2 out of every 3 TB patients in Malawi are HIV infected
- The risk of developing TB remains high for the first 6 months on ART
- Most HIV patients with TB do not have typical TB symptoms (productive cough) and most are sputum smear negative
- HIV infected TB patients must start ART and TB treatment as soon as possible. The long term outcome is poor if only one treatment is taken.
- There is no problem with taking ART Regimen 5A at the same time as TB treatment.

When assessing the client's risk for STIs, the HTC provider should ask the following STI screening questions:

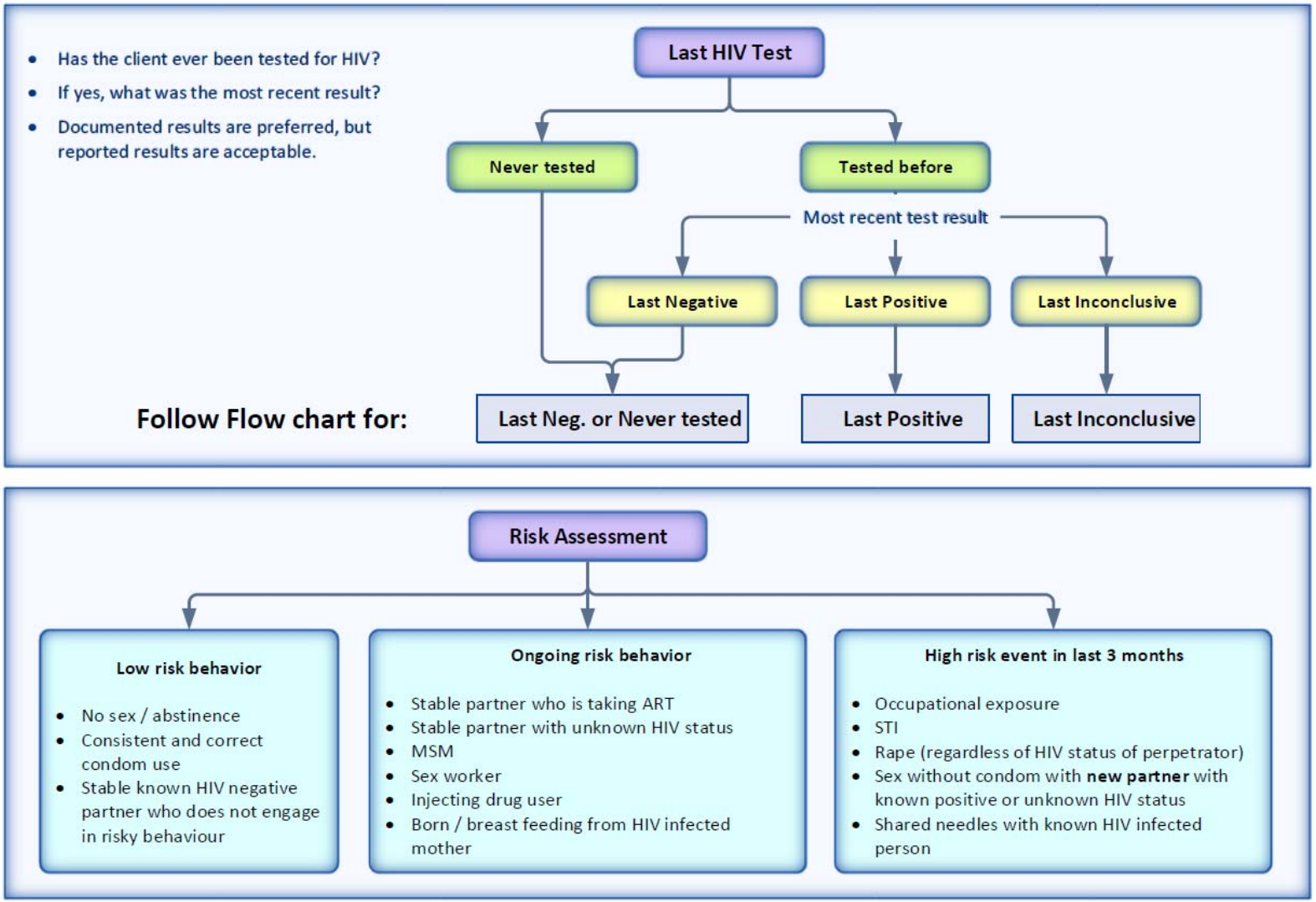
- Have you noticed the presence of abnormal vaginal or urethral discharge?
- Have you noticed the presence of genital ulcer?
- Have you ever experienced pain on passing urine?

Note that the presence of any of these should trigger referral to STI services. The presence of untreated STIs (both those which cause ulcers or those which do not) increase the risk of both acquisition and transmission of HIV, by a factor of up to two- to three-fold. Prompt treatment for STIs is thus important to reduce the risk of HIV infection. Controlling STIs is important for preventing HIV infection, particularly in people with high-risk sexual behaviours. (Source: WHO Factsheet Number 110, May 2013)

To assess risk and prevention of mother to child transmission (PMTCT), the HTC provider should facilitate a discussion every client (male & female) of child-bearing age. The HTC provider should ask the client whether there is a chance that the client (or the client's partner) may be pregnant and explain that HIV can be passed during pregnancy, delivery, breast feeding. Explain that steps can be taken to prevent infection, but the mother must know her HIV status. Women should discuss their HIV status with nurses and clinicians throughout pregnancy.

Classification of Risk

It is important to note that high risk behaviour is high risk behaviour no matter when it happens. The risk classification table below makes a distinction between "ongoing risky behaviour" and a "high risk even in last 3 months". This table is linked with the testing algorithm that we will cover in the next module and helps us to determine when retesting is needed. At this stage, the HTC provider's responsibility is to explore the patient/client's risk behaviours, and keep these categories in mind, so that as they proceed with testing and post-test counselling, retesting is recommended *appropriately.*


Has the client ever been tested for HIV?
If yes, what was the most recent result?
Documented results are preferred, but reported results are acceptable.
Last HIV Test
Never tested
Tested before
Most recent test result
Last Negative
Last Positive
Last Inconclusive
Follow Flow chart for:
Last Neg. or Never tested
Last Positive
Last Inconclusive
Risk Assessment
Low risk behavior
No sex / abstinence
Consistent and correct condom use
Stable known HIV negative partner who does not engage in risky behaviour
Ongoing risk behavior
Stable partner who is taking ART
Stable partner with unknown HIV status
MSM
Sex worker
Injecting drug user
Born / breast feeding from HIV infected mother
High risk event in last 3 months
Occupational exposure
STI
Rape (regardless of HIV status of perpetrator)
Sex without condom with new partner with known positive or unknown HIV status
Shared needles with known HIV infected person

Step 3: Risk Reduction

During step 3, the HTC provider should explore options for reducing risk, conduct a condom demonstration, and discuss the importance of partner testing and disclosure.

In discussing risk reduction, the HTC provider should consider the following questions:

- How could your client reduce the risk of either becoming infected or infecting others?
- What would help the client reduce risks?
- What barriers might exist that could prevent the client from reducing his/her risk?

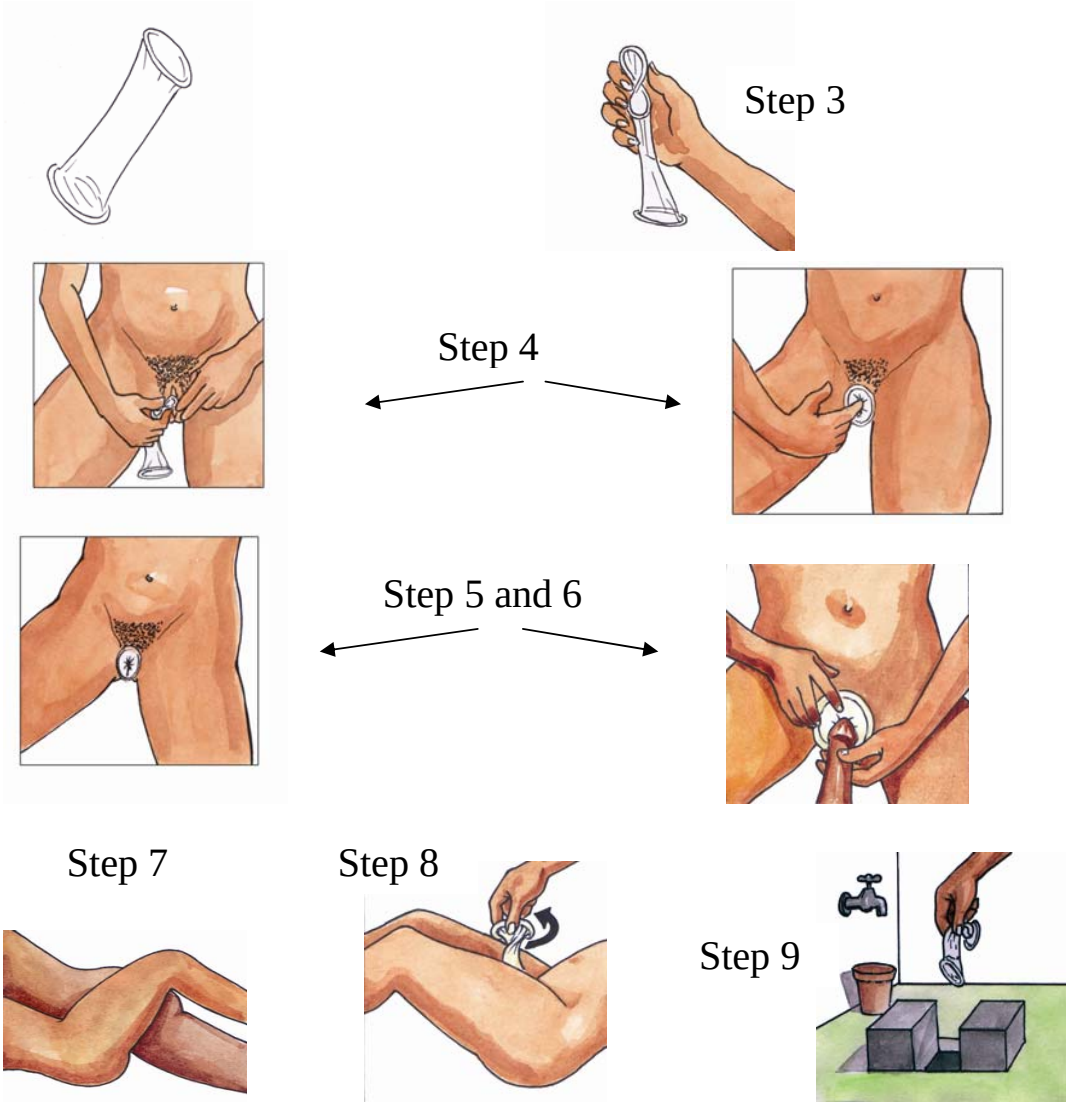
Condom Demonstration

This demonstration can either be conducted during Step 3 or while the HTC provider and client are waiting for the test results to develop.

How to Use a Female Condom

Correct use of a condom

1. Check the expiry date of the female condom, make sure that the package doesn't have any air-holes or tears
2. Open the package carefully (not with teeth!!)
3. There are 2 rings. Squeeze the inner ring into the shape of an 8 or else a C.
4. Insert the inner ring into the vagina. Once inside, the inner ring will open up around the cervix and will be anchored there.
5. Keep the outer ring on the outside of the vagina to prevent condom from going inside.
6. Make sure that the penis is erect and goes INSIDE the condom, and not to the side of it
7. Have intercourse
8. After sex, twist the outer ring of the condom and pull it out
9. Wrap the used condom and throw in the garbage



Source: *TACAIDS, Ministry of Health and Social Welfare, Tanzania***.** *Collins Mdaachi, Artist.*

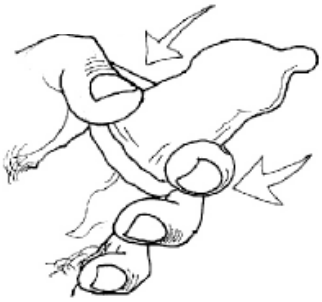
How to Use a Male Condom

Correct use of a condom

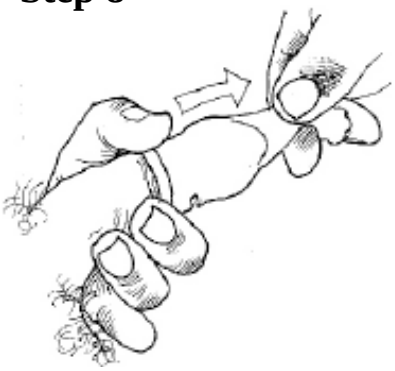
1. Check the expiry date of the condom
2. Make sure that the package doesn't have any airholes, tears, etc
3. Make sure that the penis is erect
4. Open the package carefully (not with teeth!!)
5. Make sure that the condom is facing the right way (so that it can roll down easily)
6. Pinch the tip of the condom
7. Unroll the condom all the way down to the base of the penis
8. After intercourse and ejaculation, hold the base of the condom and push it gently up towards the tip of the penis, making sure to keep semen inside
9. Throw the condom in the garbage
10. Wash hands with soap

Step 6

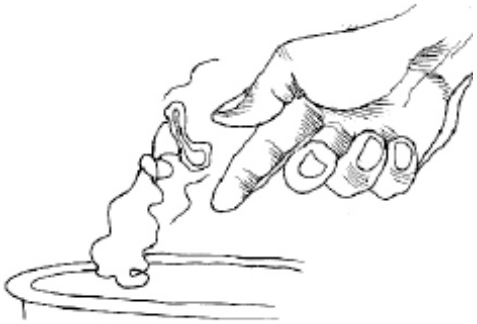
Step 7



Step 8



Step 9



Step 4: HIV Test Preparation

In step 4, the HTC provider should assess the client's readiness to test, and clarify possible test results (positive, negative, inconclusive) and window period. The HTC provider should find out who the client has told about coming in for the test, and obtain consent. Remember that the client may withdraw consent at any time.

Key Points

- Confidentiality is an ethical requirement of counselling and one of the 5 Cs
- 3 critical items to discuss during the risk assessment include STIs, TB, and pregnancy
- During pre-test counselling, the HTC provider should only be talking about possible ways of reducing risk rather than formulating concrete plans
- Consent must be obtained before beginning testing—remember the client may withdraw consent at ***any time***

Module 2 Practice: CITC Role Plays

CITC #1: Maria: You are a married woman with 2 children. Your husband says that he is faithful but you are worried. You think he is seeing someone else. You also had an affair about 4 years ago. It was very brief, but you feel bad about it, and have worried about your HIV status ever since.

CITC #2: Sam: You are a single man. You have a good job and good education. Your parents are keen for you to marry soon. When you were at university you had several sexual partners and have recently heard that one of them has now died of AIDS. You are very scared.

CITC #3: Agnes: You are a single woman who is about to marry. You have been having sex with your fiancé for about a year. You have not slept with anyone else. He has now told you that he had several sexual relationships before he met you but has been too scared to tell you. He has been very unwell lately.

Module 2, Unit 2.2: PITC Pre-Test Counselling

Learning Objectives

By the end of this unit, you will be able to:

- Explain the primary goal of PITC
- Describe the benefits and barriers to HIV testing from a patient's perspective
- Describe the two most common PITC models
- Explain the PITC protocol for inpatient and outpatient settings

Goal of PITC

PITC is done primarily to diagnose HIV-infected people early and link them to prevention, care, treatment, and support services. PITC is offered as a standard component of comprehensive clinical management of both in-patients and out-patients.

Benefits and Barriers of PITC

Some benefits of PITC include:

- Early access to treatment and care
- Ability to make family planning choices
- Possibility to make lifestyle changes
- Ability to change behaviour to avoid transmission to partners
- Ability to prevent transmission to infants
- Option of making choices about child custody
- Planning for possible health problems

Some barriers to PITC include:

- Loss of job
- Loss of family support
- Community rejection
- Fear of illness/mortality
- Fear of depression
- Denial of past risk behaviour
- Fear of abandonment or violence
- Need for spousal permission before testing

Two Models of PITC

As mentioned earlier, there are two main models of PITC: the healthcare worker model and the task shifting model. In the healthcare worker model, the HCW conducts the test and provides counselling. Whereas in the task shifting model, the HCW initiates the service but the actual testing and counselling is provided by another designated HTC provider.

Appropriate Settings for PITC

Appropriate settings for PITC include outpatient departments (OPD) including STI and FP clinics, and inpatient medical/surgical wards.

PITC in OPD

In outpatient departments, PITC involves offering HIV testing to all patients. Priority is given to: people with TB and/or STIs, family planning, pregnant women, victims of sexual assault, and men being circumcised. It is important to encourage these patients to have their partners tested. If partners are present, be sure to offer to test them both at that time.

In STI and family planning clinics, every patient should be offered PITC services. The HTC provider should check whether the patient has been previously tested and retest if necessary.

In OPD antenatal care (ANC) settings HTC is recommended to all pregnant women to enable them access to ART. Women have the option to refuse the service without jeopardizing their right to access antenatal services. Women in labour and of unknown status are also offered HTC (if not already tested in the 3rd trimester).

Inpatient Medical/Surgical Wards

In inpatient medical or surgical wards, HIV test results cannot be used as a basis for denying surgery. Standard infection prevention should be followed for all patients regardless of their HIV status.

PITC Protocol

The PITC protocol lists each step that is needed for PITC for both out-patient and in-patient services. Keep in mind that this model may not work perfectly in every facility. At times, the protocol may need slight modifications to suit a facility's specific needs.

Step 1: Introduction and Orientation to Session

For step 1, welcome the client and introduce yourself, explore the client's reasons for coming to the health facility and describe the role of the HTC provider or health worker in

PITC. Then explain the reasons that HIV testing is recommended, review the client's health passport for previous tests, and explain shared confidentiality.

Step 2: Benefits of Taking an HIV Test

In step 2, the provider should discuss the benefits of HIV testing and obtain the patient's consent to be tested for HIV. If the patient declines testing, then continue with or refer for medical management, express appreciation to the patient for coming and encourage the client to access to HTC in the future. If the patient does express interest in testing, then continue to Step 3.

Step 3: Risk Assessment

In step 3, explore the client's understanding of HIV and AIDS, as well as their risks, perceptions, and expectations (including HIV testing history). The provider should also assess recent risk pattern and explore risk triggers/vulnerabilities. Finally, the provider should ask TB and STI screening questions, and explore whether client or client's partner is pregnant.

Step 4: Risk Reduction

In step 4, the provider should explore options for reducing risk, conduct a condom demonstration and discuss the importance of partner testing and disclosure.

Step 5: Test Preparation

Finally, in step 5, the provider should assess the patient's knowledge of the antibody test and previous testing experiences. Implications/referrals for those with positive and negative results should also be discussed.

Key Points

- PITC is offered as a standard component of clinical care
- Highlighting the benefits of HIV testing while still being aware of the barriers will be very important in conversations with our patients
- Priority in OPD settings should be given to those with TB, STIs, pregnant women, victims of sexual assault, men being circumcised
- HIV test results cannot be used as a basis for denying surgery
- Consent must always be obtained before testing

Module 2 Practice: PITC Role Plays

PITC #1: Masiku: Masiku is a 21 year old woman who presented to OPD with cough and fever for 2 days. She has been seen by the clinician, who recommended that she test for HIV. She is married and has one child who is 1 ½ years old. She last tested for HIV when she was pregnant.

PITC #2: Mrs. Nyoni: Mrs. Nyoni, 46 years old, has been admitted to the female ward for one week. The clinician diagnosed her as having Malaria and started her on antimalarial drugs. She has never tested for HIV before and fears knowing her status.

PITC #3: Mr. Chintengo: Mr Chintengo, 55 years, presented at OPD convulsing, having difficulties in breathing and fever. After stabilizing Mr. Chintengo, the clinician recommended an HIV test to determine the cause of his illness. Mr. Chintengo is confused about why he needs an HIV test.

Module 2, Unit 2.3: Group Pre-Test Education

Learning Objectives

By the end of this unit, you will be able to:

- Explain the goals for group pre-test education
- Outline key differences between group pre-test education and individual counselling sessions
- Describe factors to consider when conducting group pre-test education
- Describe ethical issues for group pre-test education

Goals of Group Pre-Test Education

Group pre-test education is intended to introduce clients to the HTC process and to provide them with basic HIV information. It is especially beneficial for busy test sites as it reduces session and waiting times and increases the number of clients who can receive HTC in a day. Group pre-test education was used during HTC week to accommodate the many people who wanted to test.

Group Education Complements 1-on-1 Counselling

Covered in Group:

- Role of HTC provider
- Common reasons for accessing HTC
- HIV transmission
- Prevention strategies
- STIs, TB, PMTCT
- Benefits of HTC
- Confidentiality
- Rapid test procedure and possible results

Covered 1-on-1 (after group education):

- Confidentiality
- Readiness to test
- Perform HIV test
- Personal risk assessment
- Risk reduction plan
- Ask about support for the client
- Give results

Factors to Consider for Group Pre-Test Education

Some factors to consider for group pre-test education include group size (usually 5 to 15 clients), timing (usually 15-20 minutes, being sure to manage questions appropriately), and the setting which should be semi-private and free from distractions. Patient flow is also important; clients who have had group counselling should be easily identified by the HTC provider.

Group Pre-Test Education Protocol

GROUP

- Step 1: Introduction to Group Education
- Step 2: Basic Info on HIV and AIDS
- Step 3: Benefits of HTC
- Step 4: HTC Session Overview
- Step 5: Offer Test

INDIVIDUAL

- Step 6: Test Procedures
- Step 7: Test Results

Some ethical considerations to remember for group pre-test education include informed consent, age demographics, gender, and similar life stage.

Key Points

- Group education can be beneficial for busy test sites and help to increase the number of clients who receive HTC in a day
- The focus is on giving general information about HIV and confirming that clients have a base-level of knowledge about the virus
- Group pre-test education does NOT ask clients to talk about their personal risk factors
- Group education should be:
  - provided in an environment that is semi private and free from distractions
  - tailored to the group in front of you and their specific needs
- Consent also applies to group education; the decision to participate should be voluntary

Module 2 Practice: PITC Role Plays

PITC #1: Masiku: Masiku is a 21 year old woman who presented to OPD with cough and fever for 2 days. She has been seen by the clinician, who recommended that she test for HIV. She is married and has one child who is 1 ½ years old. She last tested for HIV when she was pregnant.

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Module 3, Unit 3.1: Overview of Testing

Learning Objectives

By the end of this unit, you will be able to:

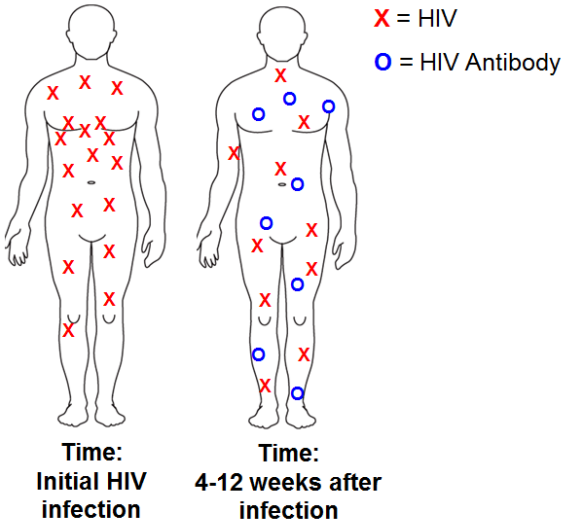
- Explain virological and antibody HIV tests
- Describe advantages of rapid HIV testing
- Explain the difference between sensitivity and specificity in HIV testing

Antibody vs. Virological Testing

HIV tests detect either antibodies or parts of the virus itself found in blood. These are known as antibody tests and virological tests. Antibody tests detect the body's response to the virus (antibodies) and include Determine and UniGold. Most adults are tested for HIV using antibody tests. Virological tests detect parts of the virus itself in the person's body and include DNA PCR testing.

Window Period

Antibody tests detect antibodies to HIV, which take time to develop after a person becomes infected; sometimes antibody levels are too low to register a positive test. This is known as the window period – the period between infection and detection of HIV. The length of the window period varies by the test and by the individual tested.



Virological Tests

Virological tests detect parts of the virus in the person's body. They can be effective 2 to 3 weeks after HIV infection and detect parts of the virus before antibodies can be detected on a rapid test. Virological tests include DNA PCR which is useful for diagnosing infants under 12 months old. Dried blood spot collection is the most common method for virological testing.

How Rapid Tests Work

Two types of antibody tests are used: Determine and UniGold. Both are rapid tests, and the results are ready in 15 minutes or less. The quick results allow for in-session testing. All rapid testing in Malawi is in session testing. The HTC provider and client/patient sit together while the test develops. The client/patient should not leave the room while the test develops.

To conduct a rapid test:

- Put a drop of blood in test device, then add reagent (buffer or wash solution)
- Blood combines with reagent then moves laterally on test strip
- When antibodies to HIV are present, a positive reaction is indicated by a red line on test line/window

Results are available in 10-15 minutes. Rapid tests are highly accurate if done properly by well-trained personnel. An HIV diagnosis is determined using 2 different rapid tests (Determine + UniGold).

Sensitivity and Specificity

Some tests are better at detecting positives, some are better at detecting negatives– this is called sensitivity and specificity:

- Sensitivity: ability of a test to identify infected (positive) individuals
- Specificity: ability of a test to identify all un-infected (negative) individuals

Key Points

- Antibody tests detect antibodies to HIV, while virological tests detect parts of the actual virus
- The window period is the time between infection and detection of HIV antibody
- Two types of antibody tests are used in Malawi: Determine and UniGold

Module 3, Unit 3.2: Safety

Learning Objectives

By the end of this unit, you will be able to:

- Explain how to follow personal health and safety practices
- Outline the approach for proper disinfection and disposal of infectious materials
- Identify appropriate actions to be taken following accidental exposure to potentially infectious specimen

Importance of Safety, Universal Precautions

Coming in contact with human blood or blood products is potentially hazardous. It is important to protect: people who may come in contact with testing by-products, the integrity of test products, and the environment from hazardous materials. Universal or standard precautions means that every specimen should be treated as though it is infectious.

Overview of Safety Precautions

Some Examples of Safe Work Habits

Wearing is an essential part of safety. The HTC provider should wear gloves when collecting blood, processing HIV rapid tests, and coming into contact with blood or body fluids (such as cleaning up a blood spill). It is important to wear a fresh pair of gloves with each patient. Remember that latex gloves do not provide protection from finger-sticks with sharps.

The HTC provider should also wash his/her hands before and after testing each patient, wear a lab coat or apron, and dispose of contaminated sharps and waste immediately after testing. Never eat, drink or smoke at the test site and keep food out of the laboratory/testing site refrigerator.

Maintain a clean and orderly work space by keeping work areas uncluttered and clean, disinfecting work surfaces daily, keeping supplies locked in a safe, secure area, and keeping emergency eye wash units in working order and within expiry date.

Causes of Needle Stick Injuries (and How to Prevent Them)

Needle stick injuries happen for a variety of reasons, including the health worker's lack of concentration or inexperience, lack of concern for others, and/or improper disposal of sharps. In order to prevent needle stick injuries, it is important to drop used sharps in special containers. Do not break, bend, re-sheath or re-use lancets, syringes or needles. Do not shake sharps containers to create space. And **never** place needles or sharps in office waste containers.

The person using sharps is responsible for proper disposal and must dispose of sharps after each test; place sharps in proper containers– NOT on the floor or in the office waste bin; and NOT place sharps container near the workspace. To handle sharps appropriately, seal and remove the sharps container when the box is ¾ full and incinerate all waste. Incineration is burning of contaminated waste to destroy and kill micro-organisms. It is effective against potential re-use of sharps, helps to protect the environment, and it must be supervised. With mobile testing, ensure that waste is placed in appropriate container for later disposal. Note that waste hazard bags should be available for this purpose.

Another good safety practice is to disinfect work areas with bleach. Disinfection kills germs and pathogens, keeps work surface clean, prevents cross-contamination, and reduces the risk of infection. Different cleaning jobs require different bleach solutions. For general lab use, use hypochlorite solutions. You should have a bleach solution readily available at your test site for daily cleaning. For spills, use a 1% solution; for general disinfection use a .5% solution.

Forms of Hypochlorites Commonly Used in Malawi

The two main forms of hypochlorites commonly used in Malawi are either the liquid form (made from 3.5% Jik) or the powdered form (made from 70%, 60% & 35% Chlorine).

Preparation of 0.5% Hypochlorite Solution Using Jik

- Formula applied when using Liquid form (3.5%Jik)

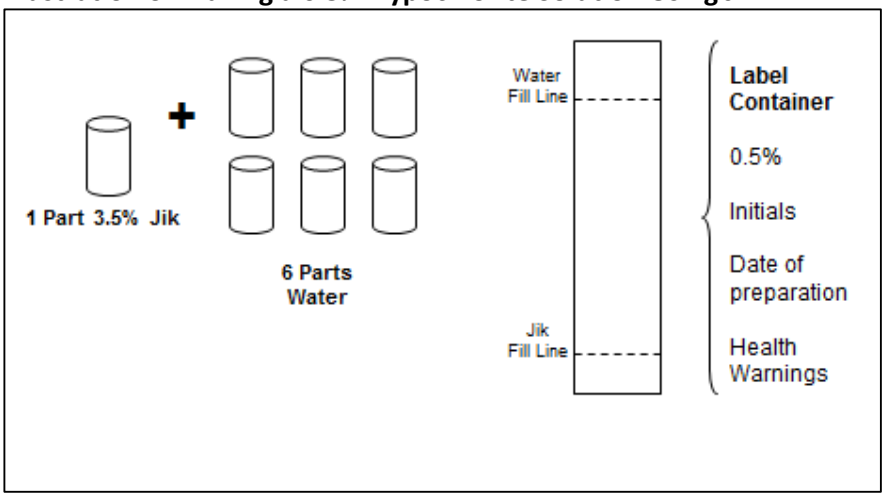
$$\left(\frac{\text{Concentration of available stock solution}}{\text{Desired concentration}}\right) - 1 = \text{Parts of water to be used}$$

Example: preparing 0.5% hypochlorite solution

$$\left(\frac{3.5\%}{0.5\%}\right) - 1 = 6 \text{ Parts of water to be used}$$

Therefore, to prepare 0.5% hypochlorite solution, you will add 6 parts of water to 1 part of 3.5% Jik.

Illustration of Making a 0.5% Hypochlorite Solution Using Jik



Preparation of 1% Hypochlorite Solution Using Jik

- Formula applied when using Liquid form (3.5%Jik)

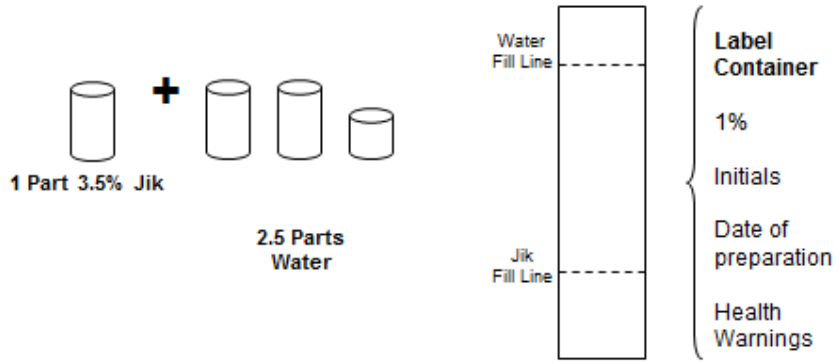
$$\left(\frac{\text{Concentration of available stock solution}}{\text{Desired concentration}}\right) - 1 = \text{Parts of water to be used}$$

Example: preparing 1% hypochlorite solution

$$\left(\frac{3.5\%}{1\%}\right) - 1 = 2.5 \text{ Parts of water to be used}$$

Therefore, to prepare 1% hypochlorite solution, you will add 2.5 parts of water to 1 part of 3.5% Jik.

Illustration of Making a 1% Hypochlorite Solution Using Jik



Preparation of 0.5% Hypochlorite Solution Using Chlorine

- Formula applied when using powdered form (70% Chlorine)

$$\left(\frac{\text{Desired concentration}}{\text{Concentration of available stock}}\right) \times 1000 = \text{g/l}$$

Example: preparing 0.5% hypochlorite solution

$$\left(\frac{0.5\ \%}{70\%}\right) \times 1000 = 7.1\ \text{g/l}$$

Therefore, to prepare 0.5% hypochlorite solution, you will add 1000ml (1 litre) of water to 7.1g of 70% chlorine.

Preparation of 1% Hypochlorite Solution Using Chlorine

- Formula applied when using powdered form (70% Chlorine)

$$\left(\frac{\text{Desired concentration}}{\text{Concentration of available stock}}\right) \times 1000 = \text{g/l}$$

Example: preparing 1% hypochlorite solution

$$\left(\frac{1\%}{70\%}\right) \times 1000 = 14.2\ \text{g/l}$$

Therefore, to prepare 1% hypochlorite solution, you will add 1000ml (1 litre) of water to 14.2g of 70% powdered chlorine.

In Case of Spill, Splash, or Accident

In case of a spill or splash, wear clean disposable gloves and immediately and thoroughly wash any skin splashed with blood. For a large spill, you should cover with paper towels, soak with 1% household bleach, and allow to stand for at least 5 minutes. For a small spill, wipe with a paper towel soaked in 1% bleach. Discard contaminated towels in infectious waste containers.

In Case of an Accident

The types of accidents that can happen include potential injury from needlesticks or falls, environmental accidents due to splashes or spills, or equipment damage. If any of these happens, then you should report to your supervisor immediately, assess and take action, record the incident using the appropriate form, and monitor the situation.

Post-Exposure Prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is used by HCWs after a needle stick or accidental exposure to HIV (it can also be given to clients with recent exposure to HIV). It consists of a small dose of ARVs to prevent HIV from taking root. It must be taken as soon as possible after exposure (no longer than 72 hours) and can also be used to prevent HIV transmission. HTC providers should know where PEP is stored and ensure access at ***ALL*** times (even at night).

With PEP, time is of the essence—the sooner one takes it, the more effective it will be. In cases where PEP is indicated, do not delay for any reason. Start PEP as soon as possible.

Key Facts on PEP for Providers and Patients:

- HIV infection can be prevented after a high risk contact with body fluids from an HIV infected person
- PEP, if taken correctly, reduces the risk of infection by 80%
- ARVs taken for PEP are usually well tolerated
- Mild side-effects may include: vomiting
- Severe side effects may include: anaemia (go to the clinic immediately)
- Keep ARVS for PEP at maternity for 24-hour access and at other well-advertised locations in every facility
- Offer STI treatment and emergency contraception, when indicated, for rape victims accessing PEP

Key Points

- Safety is important for protecting yourself and others at your site
- Always wash hands after performing each test and wear gloves when testing
- Dispose of sharps in proper containers
- Disinfect work surfaces with 0.5% bleach solution

Module 3, Unit 3.3: Using HIV Rapid Tests

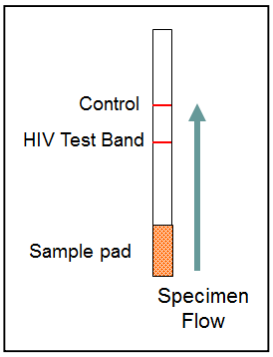
Learning Objectives

By the end of this unit, you will be able to:

- Explain HIV rapid test technology
- Demonstrate how to perform a finger prick
- Demonstrate how to perform HIV rapid testing using 2 types of test kits:
  - Determine HIV-1/2 rapid test
  - UniGold HIV-1/2 rapid test
- Accurately identify individual test results as reactive, non-reactive, or invalid

Introduction to Rapid Testing

An HIV diagnosis is determined using 2 different rapid tests (Determine + UniGold). Two tests ensure greater accuracy than one test kit alone. One is very sensitive and the other is very specific. In Malawi there has been an expansion from the traditional lab setting to settings outside of the lab. Testing services are guided by the goals set in the National HIV Testing and Counseling Strategic Plan. This testing strategy encourages health workers to incorporate non-traditional testing sites. However, these strategies must be linked back to lab system.

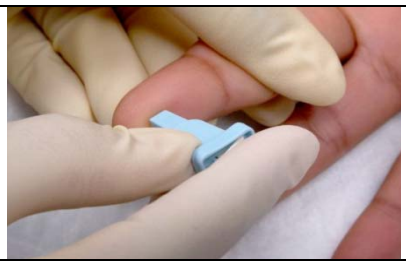
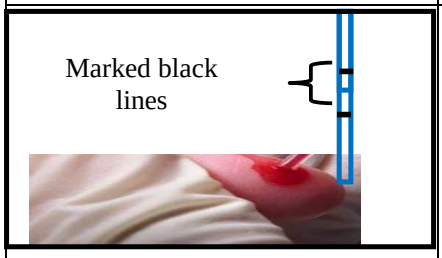


The format of HIV rapid tests used in Malawi are lateral flow tests. Lateral flow includes both Determine and UniGold tests.

The test device will reveal one of 3 possible outcomes:

Outcome	How it presents on the test kit
Reactive	• Test line **and** • Control line
Non-reactive	• Control line only
Invalid	• No control line present or in wrong location

Finger-Prick Procedure

		3. **Explain procedure to client:** • **Procedure is safe** • **All supplies are new, sterile, and have never been used on another person.** • **Describe procedure: I will make a small prick that might sting for a second. Then I will collect a few drops of blood and place it on the test device.**
1. **Collect supplies.**	2. **Wash your hands and put on gloves.**	
4. **Position hand palm-side up. Choose whichever finger is least calloused.**	5. **Apply intermittent pressure to the finger to help the blood to flow.**	6. **Clean the fingertip with spirit swab. Start in the middle and work outward to prevent contaminating the area. Allow the area to dry.**
		
7. **Hold the finger and firmly place a new sterile lancet off-center on the fingertip.**	8. **Firmly press the lancet to puncture the fingertip.**	9. **Wipe away the first drop of blood with a dry gauze pad or cotton ball.**
		
10. **Collect specimen using capillary tube to level indicated in image above. Ensure no air bubbles. Blood flows best if finger is held lower than elbow.**	11. **Apply a dry gauze pad or cotton ball to the puncture site until the bleeding stops.**	12. **Properly dispose of all contaminated supplies.**

Determine HIV-1/2 Rapid Test

For use with whole blood, serum, or plasma

Store Kits: 2 - 30° C

- Check kit before use. Use only items that have not expired or been damaged.
- Bring kit and previously stored specimens to room temperature prior to use.
- Always use universal safety precautions when handling specimens. Keep work areas clean and organized.

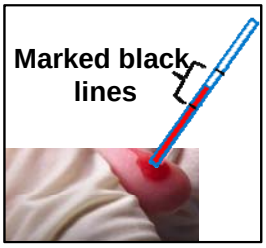
This outline is not intended to replace the product insert or your standard operating procedure (SOP).

1. Collect test items and other necessary lab supplies. Check expiry date.

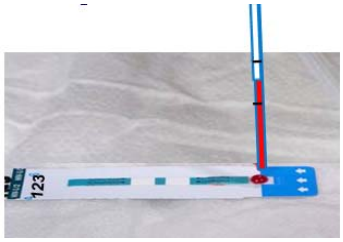
2. Use 1 strip per test and pull it apart and replace the remainder of the unused test back in the air-tight pouch.

3. Label the test strip with client identification number.

4. Pull off the protective foil cover.



5. Collect specimen using capillary tube. Fill the tube between the two black lines.



6. Hold capillary tube at a 90 degree angle in relation to the test pad. Release one free drop from the capillary tube onto the test pad.

7. <u>For whole blood only</u> – wait for 1 minute, then add 1 drop of chase buffer to specimen pad.

8. Wait 15 minutes (no longer than 60 minutes) before reading the results.

9. Read and record the results and other pertinent info on the appropriate documents.

Determine HIV Rapid Test Results

Reactive

2 lines of any intensity appear in both the control and patient areas.

Non-reactive

1 line appears in the control area and no line in the patient area.

Invalid

No line appears in the control area. Do not report invalid results. Repeat test with a new test device even if a line appears in the patient area.

UniGold HIV Rapid Test

For use with whole blood, serum, or plasma
Store Kits: 2 - 30° C

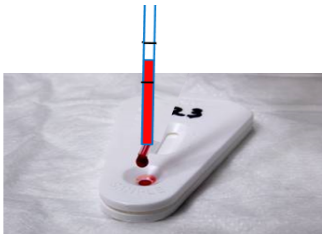
- Check kit before use. Use only items that have not expired or been damaged.
- Bring kit and previously stored specimens to room temperature prior to use.
- Always use universal safety precautions when handling specimens. Keep work areas clean and organized.

This outline is not intended to replace the product insert or your standard operating procedure (SOP).

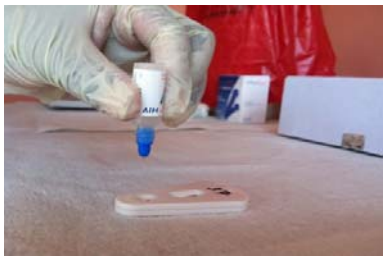
1. Collect test items and other necessary lab supplies. Check expiry date.

2. Remove device from package and label device with client identification number.

3. Collect specimen using a capillary tube.



4. Add 1 drop (approx. 50µl) of specimen to the sample port in the device.



5. Add 2 drops (approx. 60µl) of the wash solution to sample port immediately.

6. Wait for 10 minutes (no longer than 20 min.) before reading the results.

7. Read and record results and other pertinent info on the appropriate documents.

UniGold HIV Rapid Test Results

Reactive	Non-reactive	Invalid
2 lines of any intensity appear in both the control and test areas.	**1 line appears in the control area and no line in the test area.**	**No line appears in the control area. Do not report invalid results. Repeat test with a new test device even if a line appears in the test area.**

Key Points

- There are three possible outcomes for an HIV antibody test: Reactive, Non-reactive, and Invalid
- In order to give a client the correct test result, it is very important to understand how to use and read results for the Determine HIV-1/2 rapid test and the UniGold HIV-1/2 rapid test

Module 3, Unit 3.4: Preparing and Handling DBS

Learning Objectives

By the end of this unit, you will be able to:

- Define dried blood spot (DBS)
- List reasons for preparing DBS
- Demonstrate how to prepare DBS
- Describe how to package and store DBS in a way to maintain specimen integrity

DBS Overview

A dried blood spot is whole blood collected on filter paper and dried. DBS preparation is done for early infant diagnosis (EID) or for confirmatory testing. For EID, it is done using DNA PCR which detects parts of the virus rather than HIV antibodies. It is used for confirmatory testing for adults with inconclusive test results. Although very rare, sometimes a clear test result is not possible with rapid tests (Determine and UniGold give different results). A DBS may be taken to confirm the correct result.

DBS Preparation

Materials needed for DBS include: lancet, powder-free gloves, dry gauze, filter paper, spirit swab, sealable plastic bag, weighing paper, desiccant packs, humidity indicator card, drying rack, small biohazard bag, and a sharps box. If gloves are not powder-free, then wash off the powder before using.

To prepare DBS, start by clearly labelling each card with ID #, date, and time; avoid touching the area inside the circles. Then, select the area to prick. Use the heel for infants aged 6 weeks to 4 months, the big toe for infants aged 5 to 9 months, and the finger for infants from 10-12 months. Warm the area, wash your hands, and put on powder free gloves.

Heel Prick Procedure: Infants 6 weeks to 4 months

1. Warm the area

2. Position baby with foot down. Clean area, dry 30 seconds. Prick heel—wipe away first drop.

3. Allow large drop to collect - note position of foot

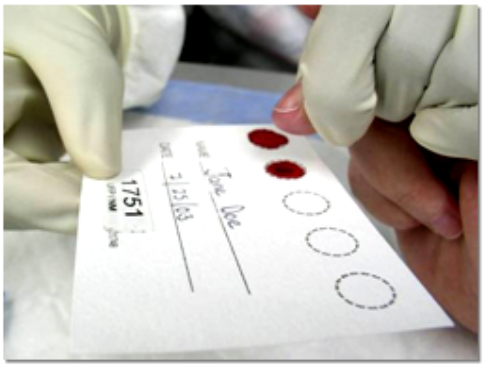
4. Fill 5 circles, then clean foot, no bandage is needed

Big Toe Prick Procedure: Infants 5 to 9 months

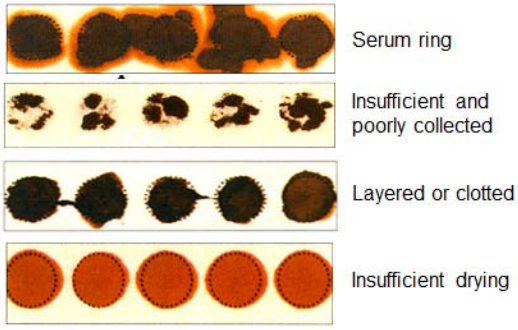
- Similar procedure
- Mother holds baby facing her

Finger Prick Procedure: Infants 10 to 12 months and adults for confirmatory testing

- Similar procedure, except that mother holds child facing HTC provider



Valid and Invalid DBS Specimens



Drying, Packaging, Storing, and Shipping DBS

In order to dry a DBS sample, you should avoid touching or smearing the blood spots. Allow the DBS specimen to fully air dry horizontally overnight at room temperature. Keep it away from direct sunlight and do not heat, stack or allow DBS to touch other surfaces during the drying process.

The next step is to package the DBS specimen. Start by stacking DBS specimens by layering each card with weighing paper and placing a piece of filter paper between sheets of weighing paper. Then insert these into a sealable plastic bag, add desiccant packets and humidity cards and seal the bag.

To store the DBS specimen, label the outside of the plastic bag with the contents. Store DBS (sealable plastic bags) in a cool and dry place until they are transported to the NRL. Avoid leaving them in a vehicle, as the sun and heat will deteriorate DBS specimens.

In order to package DBS for shipping, insert the bundled DBS into a rip-resistant envelope, include the appropriate documentation, insert both into a brown envelope, and then seal the package for shipment. The documents used for DBS packaging and shipping are the EID Lab Requisition Form and the EID Lab Sample Delivery Checklist. Be sure to follow the correct order when completing the forms

1. Fill out pink card
2. Fill out Lab Requisition form
3. Collect the sample
4. Fill out the EID DNA PCR Logbook
5. Package the sample
6. Fill out the Sample Delivery Checklist

Key Points

- Dried Blood Spot (DBS) is collected for:
    - Early Infant Diagnosis (EID)
    - Confirmatory testing for adults with inconclusive test results
- Knowing how to collect, dry, store, package, label, and ship DBS samples will ensure that the results are more easily readable, leading to more accurate results

Module 3, Unit 3.5: Using the HIV Testing Algorithm

Learning Objectives

By the end of this unit, you will be able to:

- Define the term algorithm
- Demonstrate how to determine HIV status based on approved algorithm
- Explain how to correctly determine final test results in a variety of testing scenarios

Overview of HIV Testing Algorithm

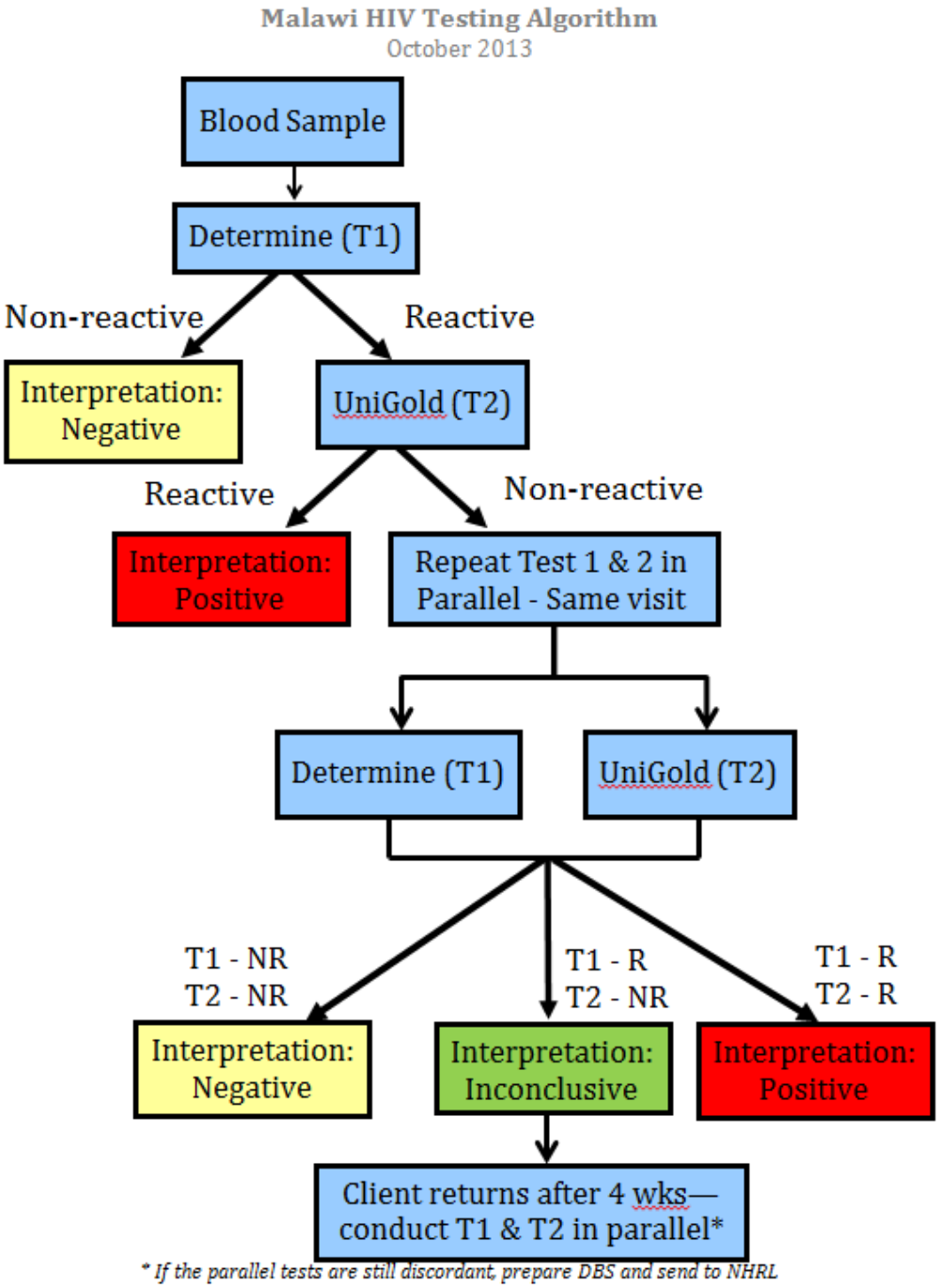
An HIV rapid testing algorithm is a sequence of steps to follow to establish a person's HIV status. It includes 2-3 different tests, performed either in sequence (serial) or at the same time (parallel).

Always follow the sequence of the tests as defined in the algorithm. All positive tests must be confirmed by a 2nd test before giving the result to the client.

National Testing Algorithms

Using a national algorithm is important for: country-wide standardization, simplified procurement, simplified supply management, uniform training, and quality monitoring.

The algorithm on the next page outlines the steps in HIV testing:


Malawi HIV Testing Algorithm
October 2013
Blood Sample
Determine (T1)
Non-reactive
Reactive
Interpretation: Negative
UniGold (T2)
Reactive
Non-reactive
Interpretation: Positive
Repeat Test 1 & 2 in Parallel - Same visit
Determine (T1)
UniGold (T2)
T1 - NR
T2 - NR
T1 - R
T2 - NR
T1 - R
T2 - R
Interpretation: Negative
Interpretation: Inconclusive
Interpretation: Positive
Client returns after 4 wks—conduct T1 & T2 in parallel*
* If the parallel tests are still discordant, prepare DBS and send to NHRL

HIV Repeat Testing and Retesting Recommendations

Repeat Testing
Repeat testing means conducting the same test a second time during the same visit. It is done when the first test is invalid or else when the first and second tests are discordant.

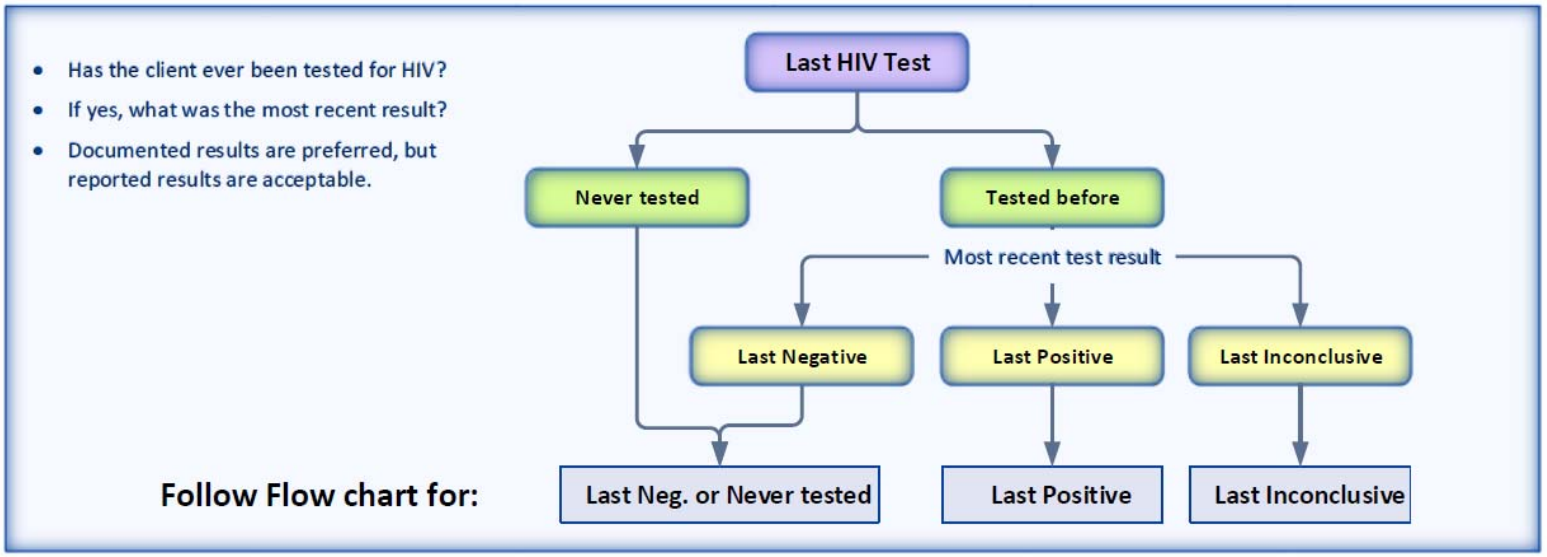
Retesting
Retesting occurs when a client is asked to come back after a specified period of time to be tested again. This happens when an inconclusive test result is given and when risk behaviour suggests that testing is needed again.

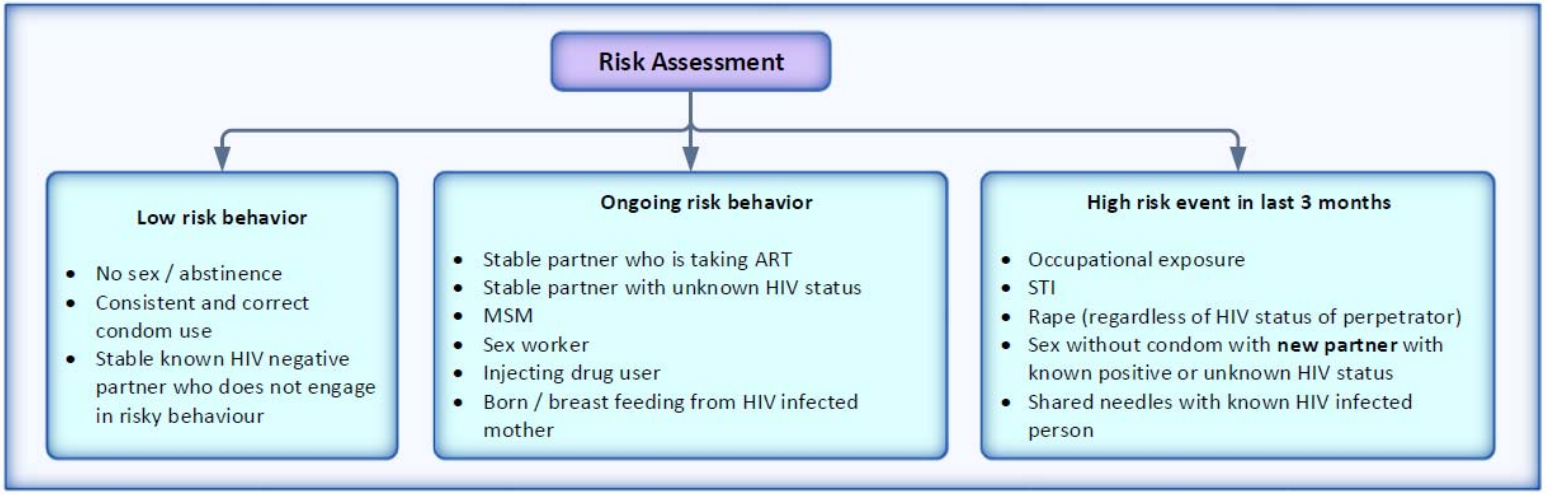
When the client has inconclusive results, it is recommended that he/she be retested after 4 weeks. Retesting is also recommended for those testing negative with specific risks as outlined in the table below:

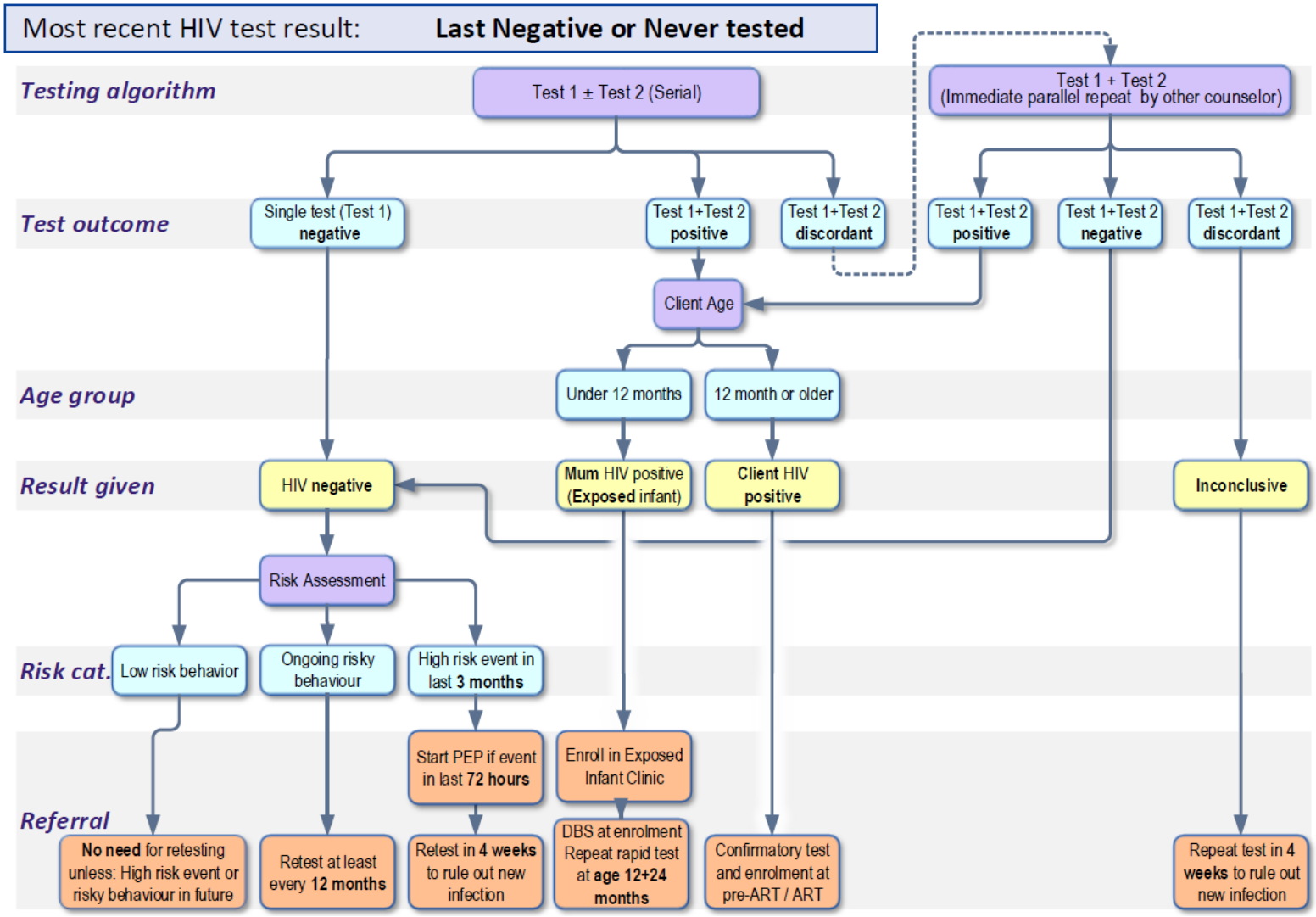
Risk Category	Advise to:
Pregnant woman	Retest in 3rd trimester
High Risk Event in last 3 months	Retest in 4 weeks--rule out new infection
STI patients	Retest after 4 weeks and with every new episode of STI
HIV negative person with on-	Retest annually
High risk event within last 72 hours	Provide PEP as per guidelines Retest after 4 weeks

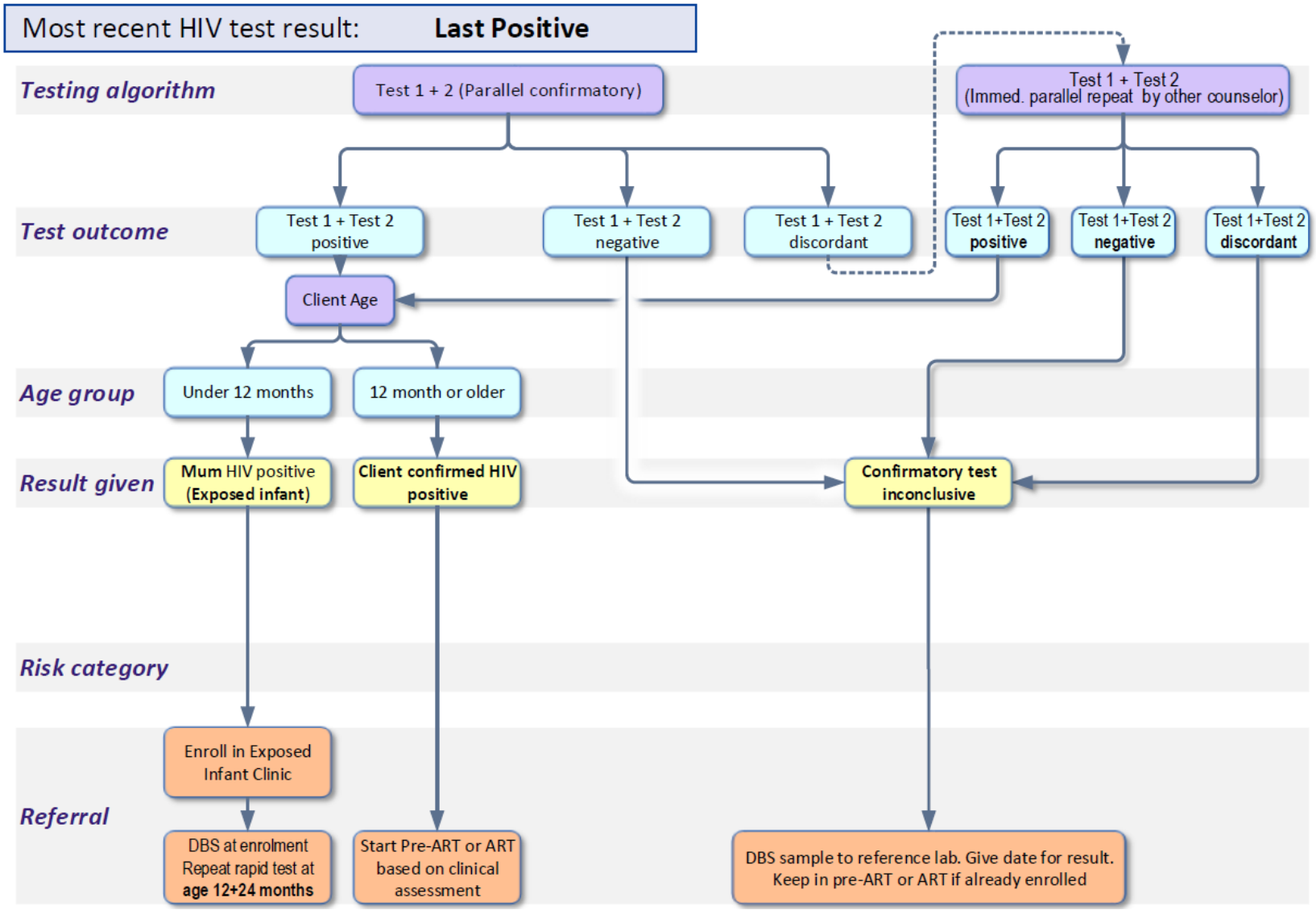
HTC Diagnostic Flowchart

As mentioned before, this flowchart (next page) is linked to the risk classification table and is used to guide decision making including retesting recommendations and/or referrals.

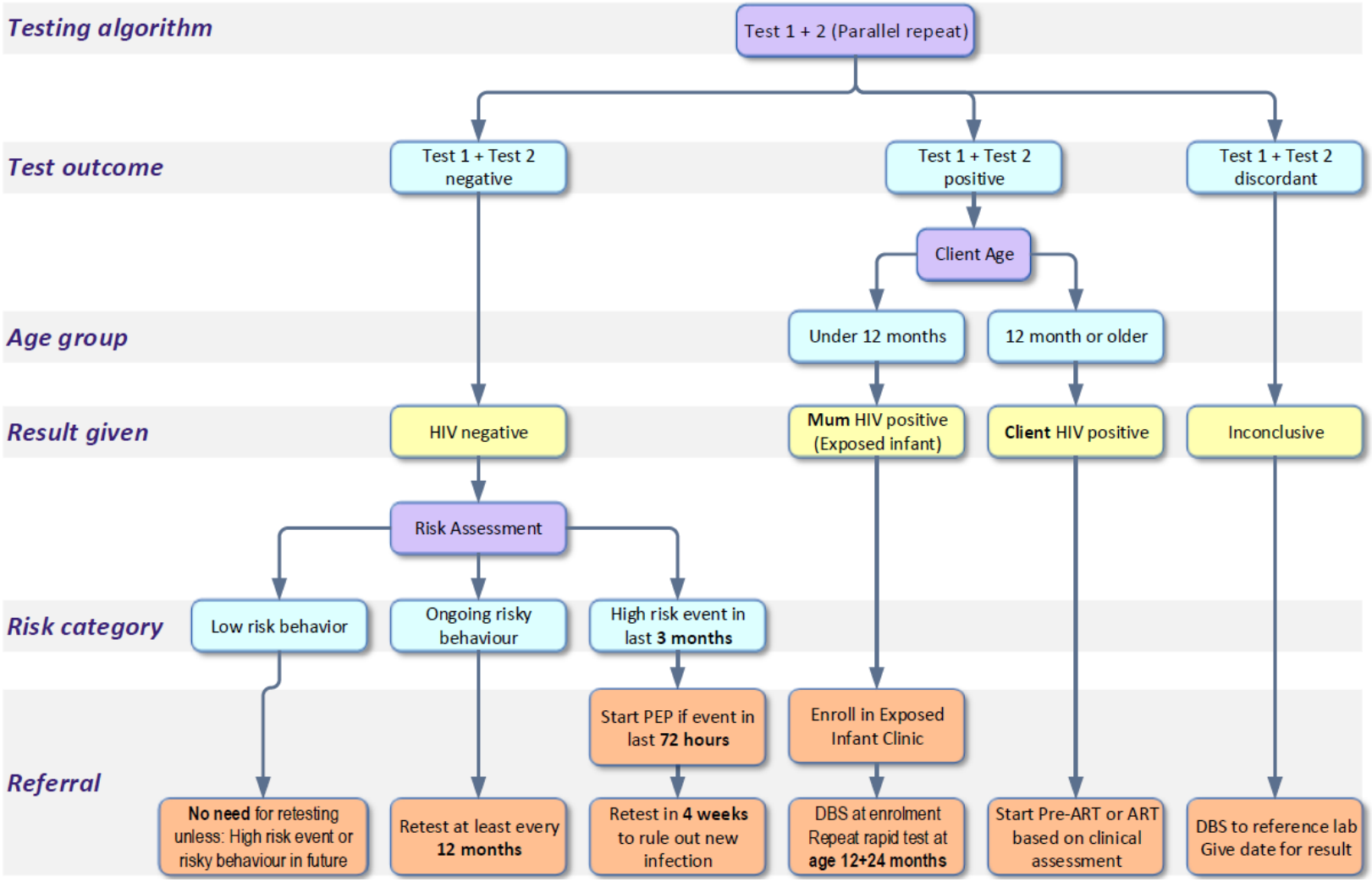

Has the client ever been tested for HIV?
If yes, what was the most recent result?
Documented results are preferred, but reported results are acceptable.
Last HIV Test
Never tested
Tested before
Most recent test result
Last Negative
Last Positive
Last Inconclusive
Follow Flow chart for:
Last Neg. or Never tested
Last Positive
Last Inconclusive


Risk Assessment
Low risk behavior
No sex / abstinence
Consistent and correct condom use
Stable known HIV negative partner who does not engage in risky behaviour
Ongoing risk behavior
Stable partner who is taking ART
Stable partner with unknown HIV status
MSM
Sex worker
Injecting drug user
Born / breast feeding from HIV infected mother
High risk event in last 3 months
Occupational exposure
STI
Rape (regardless of HIV status of perpetrator)
Sex without condom with new partner with known positive or unknown HIV status
Shared needles with known HIV infected person


Most recent HIV test result: Last Negative or Never tested
Testing algorithm
Test 1 ± Test 2 (Serial)
Test 1 + Test 2 (Immediate parallel repeat by other counselor)
Test outcome
Single test (Test 1) negative
Test 1+Test 2 positive
Test 1+Test 2 discordant
Test 1+Test 2 positive
Test 1+Test 2 negative
Test 1+Test 2 discordant
Client Age
Age group
Under 12 months
12 month or older
Result given
HIV negative
Mum HIV positive (Exposed infant)
Client HIV positive
Inconclusive
Risk Assessment
Risk cat.
Low risk behavior
Ongoing risky behaviour
High risk event in last 3 months
Referral
Start PEP if event in last 72 hours
Enroll in Exposed Infant Clinic
No need for retesting unless: High risk event or risky behaviour in future
Retest at least every 12 months
Retest in 4 weeks to rule out new infection
DBS at enrolment Repeat rapid test at age 12+24 months
Confirmatory test and enrolment at pre-ART / ART
Repeat test in 4 weeks to rule out new infection


Most recent HIV test result: Last Positive
Testing algorithm
Test 1 + 2 (Parallel confirmatory)
Test 1 + Test 2 (Immed. parallel repeat by other counselor)
Test outcome
Test 1 + Test 2 positive
Test 1 + Test 2 negative
Test 1 + Test 2 discordant
Test 1+Test 2 positive
Test 1+Test 2 negative
Test 1+Test 2 discordant
Client Age
Age group
Under 12 months
12 month or older
Result given
Mum HIV positive (Exposed infant)
Client confirmed HIV positive
Confirmatory test inconclusive
Risk category
Referral
Enroll in Exposed Infant Clinic
DBS at enrolment Repeat rapid test at age 12+24 months
Start Pre-ART or ART based on clinical assessment
DBS sample to reference lab. Give date for result. Keep in pre-ART or ART if already enrolled

Most recent HIV test result: **Last Inconclusive**



Key Points

- An algorithm is a sequence of steps to follow to establish a person's HIV status
- The national HIV testing algorithm in Malawi is serial, in which:
    - Determine HIV-1/2 is test 1 and
    - UniGold HIV-1/2 is test 2
- An HIV positive status must be based on two reactive tests—1 Determine and 1 UniGold
- Retesting recommendations are based on risk

Module 3, Unit 3.6: Performing Quality Controls

Learning Objectives

By the end of this unit, you will be able to:

- Explain what Quality Control (QC) is in the context of HTC
- Outline processes for Quality Control (QC)
- Describe dried tube specimen (DTS) technique as a QC tool
- Demonstrate rehydration of DTS

Overview of Quality in HTC

Quality in HIV rapid testing means that clients receive accurate test results within a reasonable time period. This requires: available test kits and supplies in good condition; the right type and amount of proper specimens; proper handling of specimens; following standard test procedures; and accurately interpreting, recording, and reporting results. Everyone is responsible for quality, including all test site personnel implementing the procedures and laboratory management and program staff who supervise the procedures.

Errors can occur for a variety of reasons including: individual responsibilities are unclear, there are no written procedures or written procedures are not followed, or training is not done or not completed. In addition, errors can be caused because checks are not done for transcription errors, test kits are not stored properly, QC, EQA is not performed, equipment is not properly maintained and/or timing is not done properly. Errors can occur throughout the testing process.

Quality Controls

Quality control means monitoring the quality of the test itself which involves testing the controls of test samples of known HIV status (positive and negative). Malawi QC requirements require that QC be performed at least once per week and also anytime a new HTC provider is performing testing, a new test kit lot is opened, or a new shipment of test kits is received. QC should also be performed if rapid test kits are exposed to environmental conditions that fall outside the range of stability. QC results should be recorded into the HTC Register. Any QC failure should be reported to your supervisor and testing should be stopped until the QC failure has been resolved.

If you get invalid QC results, the test should be repeated. If the second test is invalid, then STOP testing for the day. Identify the cause of the problem, inform the manager, and take corrective actions.

Please refer to the table below for guidance on how to troubleshoot specific problems:

Problem	Potential Cause	Action
No control line or band present	• Damaged test device or controls	• Repeat test using new device
	• Proper procedure not followed	• Follow each step of testing according to SOP • Re-check buffer and/or specimen volumes
	• Expired or improperly stored test kits or controls	• Check expiry date of kits and QC samples. Do not use beyond stated expiry date • Check temperature records for storage and testing area

Problem	Potential Cause	Action
Positive reaction with negative QC sample, i.e. false positive	Mixed up samples	Re-test negative control using a new device and read results within specified time limit
Extremely faint control line	The control line can vary in intensity	No action required. Control indicator can vary in intensity As long as the control indicator is present, the test is valid

Troubleshooting Problems with Test Kits

If there is a problem with a test kit, they should be reported to the District Laboratory. They then report the problem to the National Reference Laboratory.

Using DTS for QC

Please refer to the DTS Reconstitution and Testing Procedure below for information about how to use DTS for QC. Document results in the Quality Control Testing Log, which is part of the HTC Register. Ensure that the form is filled out completely and accurately, and contact the NRL if any components of a panel are missing or compromised. Roles and responsibilities for QC include: verifying DTS components upon receipt, rehydrating DTS, testing according to SOPs, recording QC results in the HTC Register, and implementing corrective actions in case of failure.

Using plastic pipette, add DTS buffer to each tube as per recommendations

Tap the tubes to mix well

Leave tubes standing upright at room temperature overnight (2 tubes QC; 5 tubes PT)

The next day, tap tubes, mix and test according to SOPs

Record results (QC in HTC Register; PT on form)

Note that this is an overnight procedure. Reconstitute only when you are ready to test the DTS panel the next day

Key Points

- Ensuring quality results is everyone's responsibility
- QC should be conducted regularly
- Invalid results should be investigated and responded to in a timely manner
- It is important to understand proper handling of DTS to ensure good quality control

Module 4, Unit 4.1: CITC Post-Test Counselling

Learning Objectives

By the end of this unit, you will be able to:

- Explain steps 6-8 of CITC Post-Test counselling protocol
- Describe the steps to providing a positive, negative, and inconclusive test result
- Appropriately recommend retesting
- Demonstrate how to assist patients in coping with the news of HIV infection
- Compare and contrast negotiating a risk reduction plan for a client with a positive vs. a negative result
- List 3 referrals that may benefit an HIV positive client

Overview of CITC Post-Test Counselling

Post-test counselling is everything that happens in a counselling session after the test. The aim of this part of the session is to ensure that the client understands the implications of the test result—positive or negative or inconclusive. Some things may differ depending on the result of the test. For example, a negative test result should include a reminder about the window period. A positive test result should include a referral for clinical assessment. The basic components, though, are consistent for both a positive and negative test result.

Step 5 in the protocol covers the testing procedures. Steps 6-8 cover post-test counselling. Note that different guidance is provided for steps 6-8 for negative, positive and inconclusive test results. Just like the pre-test, the post-test should be fluid and follow the direction that the client wants to go. Some of the steps in a post-test may not be accomplished if the client is too distracted or upset to focus on them.

Step 6: Giving Test Results

Step 6 involves providing and explaining HIV test results to client, allowing the client to absorb the meaning of the results, dealing with the client's emotional reaction, and exploring the client's understanding of the result. The counselling technique "working silence" is used when giving test results.

Positive Result—suggested language:

- Your results are ready. The test result is positive, indicating that you are infected with HIV. It does not mean you have AIDS and does not show when you may become ill from the virus. It also cannot tell us when you became infected.
- Take your time. We have plenty of time to talk about the results.
- It can be difficult dealing with the knowledge that you are infected with HIV. How are you doing? How are you feeling about this test result? You need to take time to

adjust to learning of this result, but in time you will be able to cope with the situation and continue with your life.
- How do you understand this result? What does it mean to you?

Negative Results—suggested language:
- Your results are ready. Let's look at your test result, and then we'll talk about how to best understand the result. The test is negative, which means that at this time, there are no signs of HIV infection.
- What does this test result mean to you? How does it feel to hear that it is very likely that you are not infected with HIV?

Inconclusive Results

The client is given inconclusive results when:

- 1st Determine was positive, then
- 1st UniGold was negative
- Repeated Determine + UniGold in parallel, yielding the same results (D=Pos; U=Neg)

If this happens, then inform client that the results of the HIV test are not clear at this time and that the client should return in 4 weeks for retesting. Emphasize the importance of risk reduction during this time.

Step 7: Risk Reduction Plan--Negative

If the client is HIV negative, then revisit the discussion on the client's most recent risk exposure, consider the window period, and recommend a date for retesting. Also explore behaviours the client is most motivated about or capable of changing. Finally, discuss and agree on an individualized risk reduction plan.

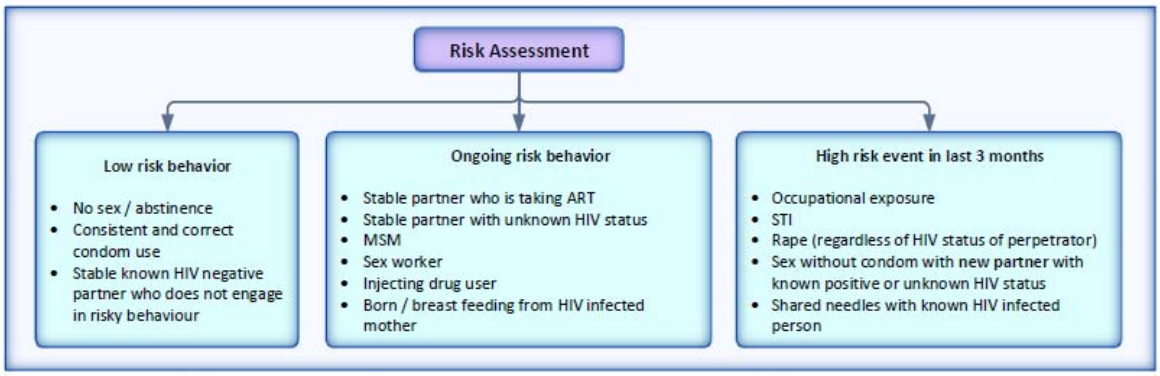
Retesting recommendations for negative clients are as follows:

HIV negative persons with on-going risk behaviours:
- IDU, MSM, Sex workers ***– Retest annually***
- Persons with stable HIV positive partner who is taking ART– ***Retest annually***
- Persons with partners of unknown HIV status***– Retest annually***

HIV negative persons who have had a specific incident of known HIV exposure within the past three months--***Re-test after 4 weeks***

HIV negative persons who have had a specific incident of possible HIV exposure within the past 72 hours--***Offer PEP, then re-test after 4 weeks to rule out new infection***

Remember that a "high risk event in last 3 months" includes the following noted below:

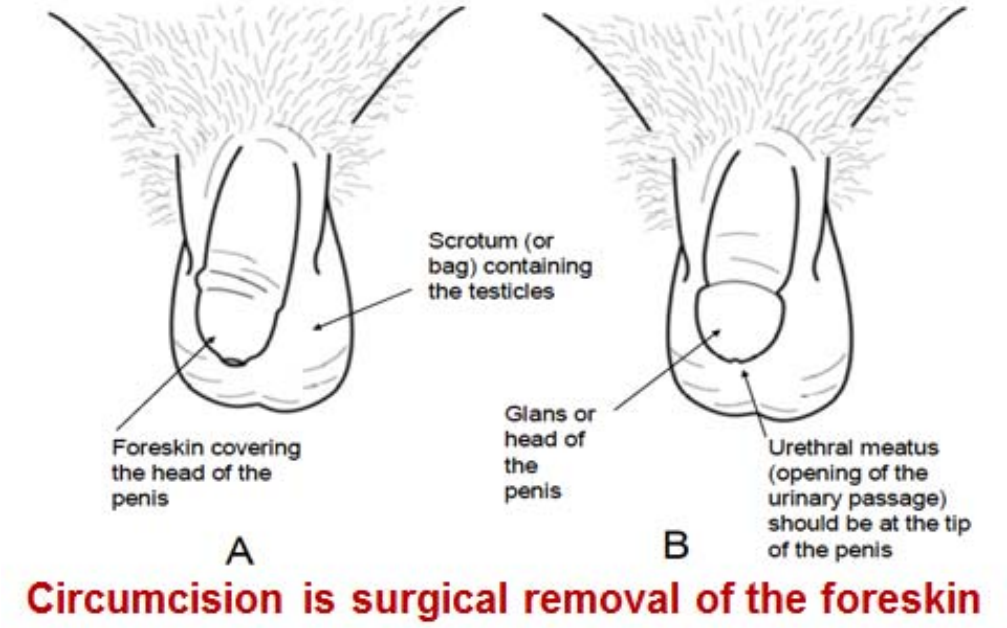


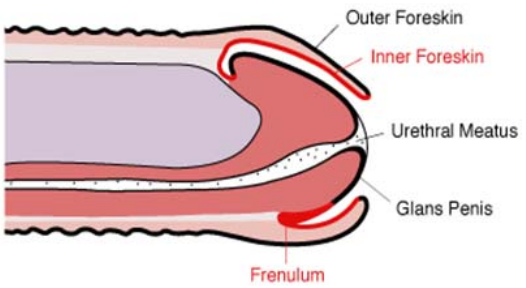
Prevention messages for clients testing negative include talking about partner testing, being faithful, abstaining from sex, using condoms, and VMMC.

VMMC

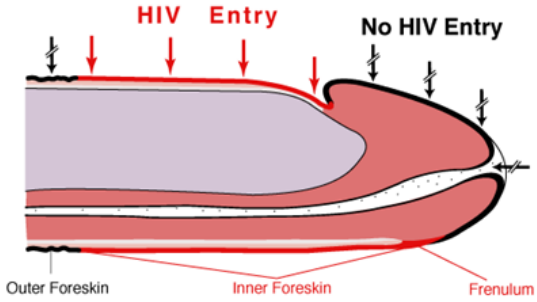
Recent studies in Africa (RSA, Kenya, Uganda) have demonstrated that HIV incidence is 60% lower among circumcised men compared to uncircumcised men. There is also lower incidence of other STIs, including HPV. Reducing risk for men leads to risk reduction for their sexual partners.

What is Circumcision? How does the foreskin increase HIV risk?





The inner foreskin (in red above) is a warm, moist environment, suitable for pathogen replication



When erect, the mucosal layer of inner foreskin (in red above) is exposed to vaginal fluids

When explaining VMMC to a client, tell him/her that circumcision is surgical removal of the foreskin. The inner foreskin is a warm, moist environment, suitable for pathogen replication. When erect, the mucosal layer of inner foreskin is exposed to vaginal fluids. HIV target cells are found in high concentration in the inner foreskin. Because it is moist, covered and soft, the foreskin is a perfect environment for organisms that cause most ulcerative STIs, and these ulcerations in the foreskin allow HIV to enter the body more easily.

It is important to also discuss the benefits of circumcision with your client. Circumcision reduces the risk of acquiring HIV by 60%. It also reduces the risk of urinary tract infections and some STIs in men (ie. Herpes). It can prevent some problems of the penis and foreskin and makes it easier to use condoms.

Step 7: Risk Reduction Plan – Positive

If the client tests HIV positive, then remind the client of the risk reduction options discussed in the pre-test session. Explore behaviours that the client is most motivated about or capable of changing and discuss and agree on an individualized risk reduction plan. Prevention messages for clients testing positive include talking about partner testing and testing for children under 5, abstaining from sex, using condoms, and regular clinical visits *plus* taking cotrimoxazole and ART to keep the body strong (and viral load low).

Step 8: Disclosure and Referral

During Step 8, it is important to explore support available for the client and to discuss positive living OR strategies for maintaining HIV negative status. It is important to encourage the client to disclose his/her status to partner and others. Remind the client that his/her partner may have a different HIV status and encourage client to refer his/her partner for testing (give referral slips as required). Finally, refer the client for post-test services and offer the client condoms.

Explain that clients may have immediate needs for care and supportive services that cannot be provided by the HTC provider. These services might include medical care, prevention of mother-to-child transmission, nutrition counselling, post-test clubs and youth friendly services. Referral is an essential element of counselling. The image below is of a partner/referral slip.

HTC Serial Number	Facility Name:	Date:	HTC Serial Number
Issue date Visit date Test Result	Muli kupemphedwa kubwera ku chipatala ndi okondedwa anu pamodzi ndi ana anu osapitirira zaka zisanu pa tsiku lomwe mungapeze mpata. Cholinga ndi chakuti tidzakambirane zinthu zokhudza umoyo wa banja lanu. Zikomo kwambiri		

It should also be emphasized that as an HTC provider, it is important to develop networks with the various care and support service providers in the area you are working in. Clients should be referred to services that assist with their needs and are appropriate to their culture, language, sex, religion, sexual orientation, age, and developmental level. These services include:

- medical care and treatment
- PMTCT
- Mental health services

Often clients have multiple needs that are barriers to their desire to remain healthy. HTC providers are encouraged to develop relationships with services that can be responsive to other needs such as assistance with social service, housing, transportation, domestic violence or legal services.

Key Points

- Clients need to understand the implications of their test results—positive or negative or inconclusive
- Retesting is recommended for:
    - Clients with inconclusive results—retest after 4 weeks

- HIV negative persons with on-going risk behaviours: IDU, MSM, Sex workers--retest annually
- Persons with HIV positive partner--retest annually
- Persons with partners of unknown HIV status--retest annually
- HIV negative persons who have had a specific incident of known HIV exposure within the past 3 months—retest after 4 weeks
- HIV negative persons who have had a specific incident of possible exposure within the past 72 hours—retest after 4 weeks to rule out new infection

- Circumcision can help HIV negative men STAY negative. It has no protective effect for men who are HIV positive.
- Key referrals for HIV positive clients include medical care and treatment, PMTCT, and mental health services.

Module 4 Practice: CITC Role Plays

CITC #1: Maria: You are a married woman with 2 children. Your husband says that he is faithful but you are worried. You think he is seeing someone else. You also had an affair about 4 years ago. It was very brief, but you feel bad about it, and have worried about your HIV status ever since.

CITC #2: Sam: You are a single man. You have a good job and good education. Your parents are keen for you to marry soon. When you were at university you had several sexual partners and have recently heard that one of them has now died of AIDS. You are very scared.

CITC #3: Agnes: You are a single woman who is about to marry. You have been having sex with your fiancé for about a year. You have not slept with anyone else. He has now told you that he had several sexual relationships before he met you but has been too scared to tell you. He has been very unwell lately.

Module 4, Unit 4.2: PITC Post Test Counselling

Learning Objectives

By the end of this unit, you will be able to:

- Explain PITC protocol for giving results in an inpatient/outpatient setting
- Describe key items to discuss for patients testing negative
- Describe when to recommend retesting for patients testing negative
- Describe key items to discuss for patients testing positive
- Outline key prevention messages for pregnant women

PITC Protocol Step 7: Test Results

Negative Result

If the patient tests HIV negative, then confirm that the patient understands the result, review the concept of the window period if appropriate, and discuss partner disclosure and testing. Manage the patient for his/her presenting illness, refer the patient appropriately, and refer to HTC for on-going counselling, if needed. Also, identify the patient's risk category and recommend a date for the patient to return for retesting.

Retesting is based on the client's risk:

- **High risk in last 3 mos → retest in 4 wks**
  - Occupational exposure
  - STI
  - Rape
  - Sex w/o condom with new partner whose status is positive or unknown
  - Needle sharing with known HIV+ person
- **Ongoing risky behaviour→ retest annually**
  - Stable HIV+ partner taking ART
  - Stable partner with unknown status
  - MSM
  - Sex worker
  - Injecting drug user
  - Born or breastfeeding from HIV+ mother
- **Low risk → no retest (unless risk changes)**
  - No sex/ abstinence
  - Consistent and correct condom use
  - Stable known HIV negative partner who does not engage in risky behaviour

Positive Result

If the patient tests HIV positive, then confirm that the patient understands the result, discuss implications of being HIV positive, discuss partner disclosure and testing, and give family referral slips. In addition, review the services available for PLHAs with the patient and manage or refer the patient for his/her presenting illness. Refer the patient to HCC and record the results in the patient's Health Passport.

Inconclusive Result

If the patient's results are inconclusive, inform the client that the results of the HIV test are not clear at this time. Inform the client that he/she should return in 4 weeks for retesting and emphasize the importance of risk reduction until we have a clear test result.

It is critical that the clinician managing your patient receives the result and continues with case management.

Prevention Messages for HIV Positive Pregnant Women

For pregnant women who test HIV positive, it is important to discuss getting her partner tested and preventing the spread of HIV, as well as discussing antenatal care, Option B+, safe delivery, and breastfeeding recommendations.

Key Points

- It is important to tailor your messaging and follow up with the client based on the result
- Retesting is recommended based on risk ONLY
- It is critical to convey the importance of preventing HIV transmission to partner(s) and children to pregnant women testing HIV +
- Results must be shared with the clinician for continued case management

Module 4 Practice: PITC Role Plays

PITC #1: Masiku: Masiku is a 21 year old woman who presented to OPD with cough and fever for 2 days. She has been seen by the clinician, who recommended that she test for HIV. She is married and has one child who is 1 ½ years old. She last tested for HIV when she was pregnant.

PITC #2: Mrs. Nyoni: Mrs. Nyoni, 46 years old, has been admitted to the female ward for one week. The clinician diagnosed her as having Malaria and started her on antimalarial drugs. She has never tested for HIV before and fears knowing her status.

PITC #3: Mr. Chintengo: Mr Chintengo, 55 years, presented at OPD convulsing, having difficulties in breathing and fever. After stabilizing Mr. Chintengo, the clinician recommended an HIV test to determine the cause of his illness. Mr. Chintengo is confused about why he needs an HIV test.

Module 4, Unit 4.3:Documentation

Learning Objectives

By the end of this unit, you will be able to:

- Demonstrate how to fill out the HTC register
- Explain how to use the patient health passport
- List key forms for EID documentation
- Demonstrate how to fill out pink card
- Describe how to complete daily and monthly activity registers

HTC Register

The purpose of the HTC register is to track HIV testing and counselling at the site and national levels. Use a separate register and fill a separate report for each *Location Type* at your site. All columns in the register must be complete before the client leaves the room.

General Instructions

The register contains confidential information, so only HTC Program staff should have access. Keep the register in a locked room or cabinet when not in use. Ask for consent before HIV testing, regardless of the type of client or the HTC setting. Do not record clients who are counselled but not tested. Draw a line through the entire row and write comment "opt out" if client opts out after he/she has already been entered into the register. Exclude these clients from the Page / Month Totals. *Circle* selected options; do not use ticks, cross, underline, etc. Circle only 1 option for each box and start a new page for each new month.

Reporting Instructions

When the page is full, count the circled options and write the numbers into the Page Totals – boxes. The Totals-boxes must not be left empty. Write 0 (zero) into a box if none of the options in a column were circled. Calculate the total number of clients tested and receiving results by adding M + FNP + FP, and then write this number into the Sum-box. Fill all of the Totals-boxes with a bold frame for the standard monthly report. The boxes with a dashed frame are not mandatory for reporting. The numbers at the very bottom of page correspond with the boxes on HTC Monthly Report Form.

The register is divided into columns and 1 client record goes across the double page!

Serial Number
Assign a unique running number for each client visit. Do not re-assign the old number if the same client visits again. Re-start the Serial Number at 1 from the 1st July every year. Use a different prefix for each site or location.
HTC Provider ID

Write your MOH HTC Provider ID (from the HTC Provider Log-Book). Write your name in full if you have not yet been registered as an HTC Provider.

Client Name, Phone, Address
The only reason to record these details is to contact the client in the future. Write the client's name in full, as well as his/her phone number and/or physical address with sufficient detail to allow tracing in the community. Explain that the client is free to refuse giving contact details; in this case, leave the box empty.

Sex/Pregnancy
This is where you record the sex (gender) of the client and pregnancy status for all females. All women aged 12-50 years must be asked whether they are currently pregnant. Circle **FP** if she is pregnant or **FNP** if she is not pregnant.

Age/Age Group
This is where you write in the age in years for adults, or the age in months for young children. For example, write ***27*** for 27 years, write ***16m*** for 16 months. Translate the age from the previous column into the correct age group and circle it.

HTC Access Type
This is where you want to find out what made the client come in for HTC? One possibility would be **PITC -** routine testing of clients accessing health services (so through ANC, maternity, OPD, wards, TB, blood donor, VMMC, STI, etc.). Another possibility would be **FRS** – that the client comes in because of a Family HTC Referral Slip. Circle **FRS** even if s/he has lost slip or if the slip comes from another HTC site. Circle **Oth**er for all other HTC access types (VCT, door-to-door, community, hotspot, testing campaigns, etc.).

Last HIV Test
This is where you want to find out whether the client has ever been tested for HIV. If yes, what was the most recent result? Documented results are preferred, but reported results are acceptable. **Last Positive** clients are allowed to come for confirmatory testing. Be careful when interpreting rapid test outcomes for clients on ART: these may have low antibody levels that can give a negative outcome, especially in children who started ART early.

Time since Last Test
In this box, you will record the answer to the question, "How long ago was the most recent HIV test?" Write ***3Y*** for 3 years, ***10D*** for 10 days, ***4W*** for 4 weeks, etc.

Partner Present at this Session
Is the client attending the session together with his / her sexual partner? Circle **Y** regardless if partner is being tested during the session (partner may already know status). The focus is on counselling couple together and facilitating disclosure. Note that mother-child pairs, etc. are not considered as *Partner Present.*

Test Kit, Lot, Expiry
Always fill out the Name, Lot Number and Expiry Date of test kits. The lot number and expiry date are stamped on the pack. Draw a bold line under the test result box to show when a new lot is started halfway through page. Do not start a new page when a new lot is used.
Record details for new lot on the next page.

HIV Rapid Test Outcomes
When recording HIV rapid test outcomes, you have the first pass, and then potentially an immediate repeat. For the first pass, circle the outcome of each rapid test used following the correct testing protocol. Leave **Test 2** column empty if only **Test 1** was used to obtain the final result.

For the immediate repeat, repeat immediately Test 1 & 2 in parallel if there are discordant outcomes on the *First Pass.* A different tester should conduct *Immediate Repeat* testing. Always review the testing protocol and ensure that the test kits are in good condition.

Outcome Summary
Circle one of 5 options to summarize client test outcomes as this helps aggregate different possible combinations for reporting. If only 1 test is used, then either circle **single negative** if the outcome is negative on the *First Pass*, or circle **single positive** if the outcome is positive on the *First Pass*. If two tests are used, whether it is test 1 and test 2 and/or a repeat test, then:

- Summarize outcome of **Test 1** and **Test 2** from First Pass if concordant
- Look at outcome from *Immediate Repeat* testing if *First Pass* results discordant
- Circle **Test 1 & Test 2 Neg / Pos** if Test 1 and Test 2 were concordant negative / positive
- Circle **Test 1 & Test 2 Discordant** if Test 1 and Test 2 remained discordant after *Immediate Repeat* testing

Result Given to Client
In this section, you will circle the HIV-status that was given to the client. Look at the outcome of *Immediate Repeat* testing if this was done. Leave box empty if the client refused post-test counselling and did not receive test result.

	For Clients Who Were . . .
New Neg / Pos/ Exp Inf / Inconclusive	• *Never Tested, Last Negative, Last Exposed Infant* or *Last Inconclusive* • Children under age of 12 months with positive rapid antibody tests are classified as **Exposed Infant**
Confirmatory Pos / Inconcl.	• *Last Positive* regardless if came for confirmatory testing before enrolment at HIV Clinic • Send DBS sample to lab for all clients with a *Last Positive* result who are negative or inconclusive on current test

Partner HIV Status
Does the client have a sexual partner? If yes, circle the partner's current HIV result if they were tested together today. Otherwise, circle the partner's HIV status as reported by the client.

Client Risk Category
Circle the correct category following client HIV risk assessment. The client's current test result and client risk category guide the referral for retesting. Always refer ***New Negative*** clients with a ***High Risk Event*** in the last 72 hours for Post-Exposure Prophylaxis (***PEP***) assessment.

Referral for Re-Testing
Recommend re-testing based on the test result and risk assessment. Explain that the client can re-test at any HTC site and offer to contact the client after the appointment date to confirm that re-testing has been done.

No Re-Test	• *New Negative* result, *Low Risk* category • *Confirmatory Positive* results
Re-Test	• In 4 weeks - *New Inconclusive* or *New Negative* and high risk • In 12 months - *New Negative* and *On-Going Risk* • In 3rd trimester - *New Negative* pregnant women • At age 12 and 24 months - HIV exposed infant
Confirmatory Test	• Do *Confirmatory Testing* as soon as possible for *New Positive* clients

Number of Items Given
For Family HTC Referral Slips, write down the total number of slips given. Give 1 slip for each sexual partner with unknown status regardless of client's HIV result, and give all HIV Positive parents 1 slip for each child under 5 years with unknown status.

Patient Health Passport

The purpose of the patient health passport is to document the patient health history and clinic visits. Ask whether client has health passport with him/her. Then, explain that recording test results (negative or positive) is important for the health record. Find the pre-printed page to record the HIV test results (note that older passports may not have this page) and ensure standardized recording of test results so any provider can understand.

EID Forms

The EID forms are made up of the Laboratory Requisition Form, the Sample Delivery Checklist, the Results Report, and the EID DNA PCR Logbook. All of the information from those forms is summarized in the pink card.

Pink Card

It is important to note that many people are responsible for adding information to this card. As such, it is critical to work together with your colleagues to ensure it is complete.

Birth Cohort
This section is where you write in the month and year of birth. It is needed for filing the card in the right birth cohort.

PTMTCT History
This information can be found in the mother's health passport. The mother should be asked how long the NVP syrup was actually taken.

Status at Enrolment
The age of enrolment, and whether or not a DNA PCR result was available at the time of enrolment, goes in this section. Remember that the interpretation of the test result depends on age! Children less than 24 months with confirmed infection are started on ART immediately and should not be in exposed child follow up!

Rapid Antibody Testing
Any new rapid test results should be reported in this section. There is a reminder on the left for scheduled tests after 12 and 24 months.

DNA PCR Testing
In this section, record DBS samples taken, including the specimen ID and date, as well as the date when the result was received from the lab (plus the result), and the date when the result was given to the guardian. It is important to write the child's current age when the result was given to the guardian, as the aim is for every child to have received a DNA PCR result by the age of 2 months!

Age (current)
It is important to keep track of the current age in months. It should be filled in at every visit as it is needed to schedule and interpret testing.

Wasting/Malnutrition
Wasting and malnutrition should be classified at every visit. It is based on weight for height or MUAC (classified based on 'worst' indicator). Remember that 'severe wasting/malnutrition not responding to treatment' plus positive antibodies defines PSHD. ART should be started for the infant even without a positive DNA PCR result!

Breastfeeding
Breastfeeding status should be classified at every visit.

- → **Exclusive BF** recommended under age 6 months
- → **Mixed feeding** child <6 months receives BF + other foods or liquids. *This is not recommended → counsel!*

- → **Complimentary feeding** child >6 months receives BF + other foods or liquids. *This is recommended!*
- → ***Stopped BF in last 6 weeks:*** *too soon for the final rapid test to confirm the child is uninfected! Give new appointment!*
- → ***Stopped BF completely >6 weeks ago:*** *time for the final rapid test to confirm HIV free!*

All options in the box mean that the child is currently exposed to HIV and must be kept in follow-up. This is different from the current HIV infection status (which may be confirmed negative)!

Mother Status
Always confirm that the mother is indeed adherent to ART.

Clinical Monitoring
Clinical monitoring should be classified at every visit according to the clinical monitoring checklist. Any significant sickness should be recorded in the *Notes* section.

HIV Infection
Current HIV infection status should be classified at every visit:

A – Confirmed <u>not</u> infected
- → negative rapid test or DNA-PCR at any age
- → **<u>BUT</u>** keep in FUP if still exposed to breast milk!

B – Confirmed infected
- → positive DNA-PCR at any age
- → Or: positive rapid test over 12 months of age
- → Always start ART!

C – HIV infection not confirmed, no sign of PSHD
- → positive rapid test <12 months (could be mum's antibodies)
- → Or: no new test result
- → Keep in FUP if still ***Exposed***

D – HIV infection not confirmed, but fulfills ***PSHD***
- → positive rapid test under 12 months of age
- → Clinical signs defining *PSHD* → *Start ART!*

Laboratory Requisition Form

This form has yet to be rolled out nationally, but once it is, the forms will come in a bound book with each form in duplicate. Sections 1 – 5 should be filled out at the health facility, whereas Section 6 should be filled out at the Central Laboratory. Sections 1-5 need to be filled out BEFORE sample collection.

Section 2—Infant Information
If the new HIV Care Clinic has not started at your facility, use the Infant Registration number from the master card. If the HIV Care Clinic has started at your facility, then use the HCC

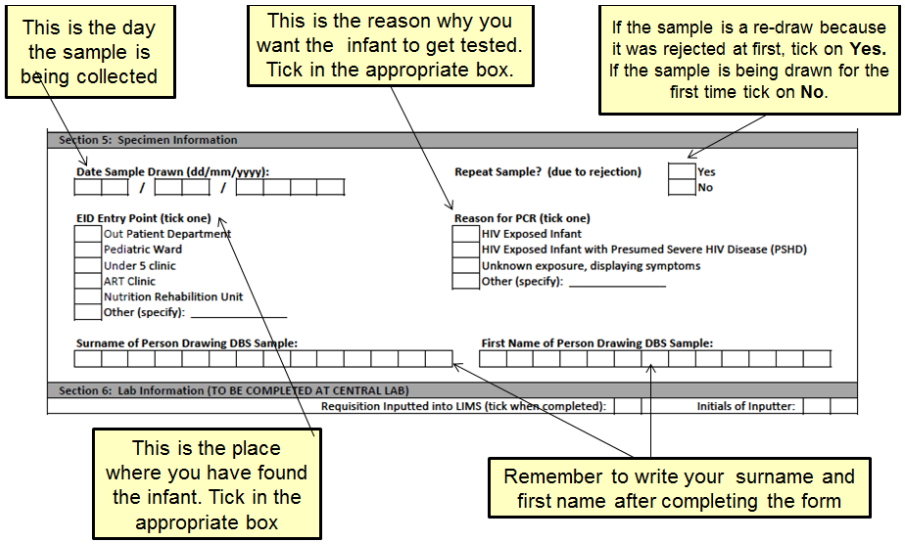
number. The old master card should be filed under the new HCC card in the same plastic sheet protector.

If the babies are twins, triplets or whatever number tick on **Yes**. If it is only one baby, then tick on **No**. Write **1** in the box if the form is for the first twin and write **2** in the box if the form is for the second twin. Note that information for the Infant Feeding Options can be found at the back of the Pink Card under the column "Breastfeeding", sex and birth date information can be found in the "Child and Guardian Details" box on the front page of the Pink Card, and information about infant ARVs can be found in the "PMTCT history at Enrolment" box on the front page of the Pink Card.

Section 4—Mother Information

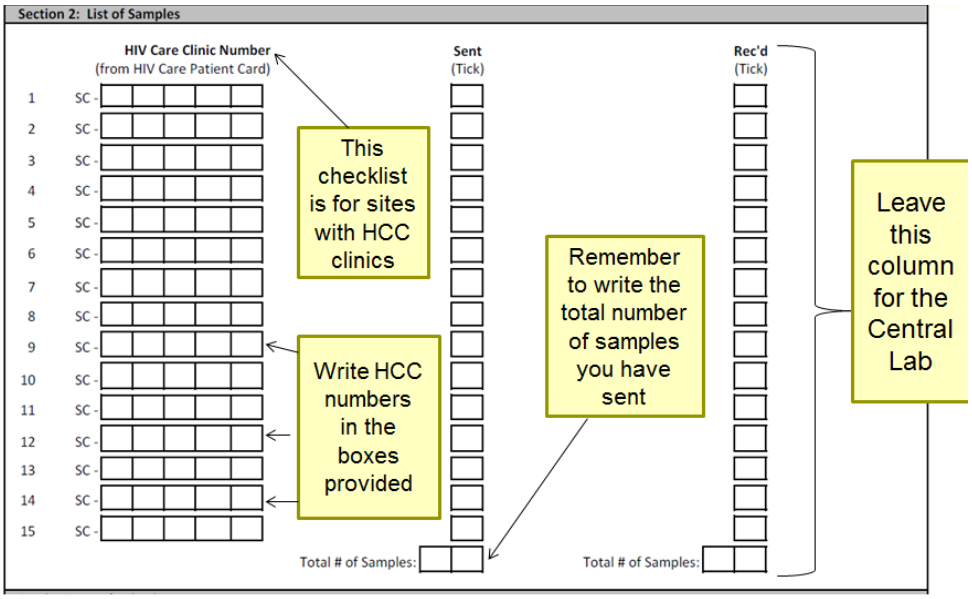
Please note that "Mother HIV Status" can be found on the back page of the pink card under the column "Mother Status", and "Mother ARVs in Pregnancy" and "Mother ARVs in Labour" can be found on the front page in the box entitled "PMTCT History at Enrolment".

Section 5—Specimen Information



Sample Delivery Checklist

When rolled out nationally, the forms will come in a bound book with each form in duplicate.



In Section 2, when it asks for the infant registration number, note that this checklist is for sites without HCC clinics. Stop using infant registration numbers as soon as you have an HCC clinic onsite.

In section 3, write the date you are sending the samples and remember to write your name in full.

The Logbook

In the EID DNA PCR logbook, in the section that requests physical address, remember to write the village or town name and a well-known landmark that can be used for follow up. "Reasons for test" are reasons for testing that are found at the bottom of the logbook. Remember to write the page number on every page in the logbook.

Results Report

For section 1-5: information that was written on the Requisition Form is what comes back from the laboratory. For section 6, write the result e.g. Negative, Positive, or Inconclusive. It is also the place where you fill in sample validation – whether the sample is accepted or rejection plus the reason for rejection. Reasons for rejection may include: sample not received, clotted Samples, collected on expired filter paper, heamolysed sample, incomplete/missing requisition form, patient over age (if not a tie-breaker), patient under age, poor drying, samples packaged together, serum rings, small spots, or technical problems at the laboratory. Section 7: Turnaround Times is used to log the time it takes to c complete a given task. It is calculated by testing software (EID LIMS) software at the central laboratory and can be used to track stages where samples are delayed.

Daily Activity Register/Monthly Site Report/Quarterly Report

The purpose of these forms is to track test kit consumption. They will be covered in further detail in the next unit on stock management.

Key Points

- HTC register should be fully completed after every client and for QC
- HTC register includes confidential information and should be locked away when not in use
- The patient health passport is used to document patient health history and clinic visits
- The pink card provides the foundation for all other EID forms
- The daily activity register, monthly site report and quarterly report are all used to track test kit consumption.

HTC Register – Practice Scenarios

Review the scenarios below and complete the HTC register accordingly.

Client #1234

This morning, John Doe was treated for a burn on his right arm and when the told the clinician that he had never been tested for HIV, the clinician referred him to you. John is 47 years old and has been married for 30 years. His wife tested for HIV during each of her pregnancies and has always tested negative. John has been faithful and believes that his wife has done the same. When you ask for contact info, John gives you his phone number (0888123456). After testing him with Determine the result is negative. During post-test counselling he opts to get 30 condoms.

Client #1235

Martha Miller has come for testing today because her husband tested positive for HIV 1 year ago. He is taking ARVs and is feeling much better and is back to work. She is 23 years old and is not pregnant– she wants to finish her last year of school before having children. She understands the risk of having sex with an HIV+ partner and is committed to testing regularly. Her last test was 3 months ago at the clinic near her home and she tested negative. She lives in Kachere villiage, behind the market. Today she tests negative as well and during post-test she is given 20 condoms.

Client #1237

Betty Smith has come to ANC for her regular pre-natal visit. She is 17 years old and expects to deliver in 5 weeks. She was tested for HIV during her 1st pre-natal visit, 4 months ago. The test was negative. When she became pregnant, her boyfriend (also 17 years) told her that he was not ready to become a father. She has not spoken to him in several months. He was her only sexual partner. When you ask for contact info, she gives you her phone number (0999123456).

Client #1238

Margaret Baker from Lungu village next to PTC was told to come to your office after visiting the paediatrician for her 10-month old son, Rob. She delivered at home and was admitted to the hospital shortly after giving birth. She tested HIV+ and was started on ARVs. Rob was doing well until two weeks ago, when he became severely ill and has had difficulty breastfeeding. The baby has never been tested for HIV. After testing the child with Determine, the result is negative.

Module 4, Unit 4.4: Stock Management

Learning Objectives

By the end of this unit, you will be able to:

- Outline best practices in stock management
- Explain the importance of stock status assessment
- Describe how to complete:
  - LMIS Requisition and Issue Voucher (RIV) Forms
  - Daily and monthly activity registers
  - Relocation form
- Explain the importance of inspecting supplies upon delivery and before acceptance
- Explain the process for reporting to the Ministry of Health on HIV test kits logistics

Overview of Stock Management

What Does Stock Management Entail?
Stock management entails ensuring adequate supplies, properly stored, to ensure uninterrupted, quality service for clients.

Stock Management Involves …
Stock management involves knowing which supplies and consumables are on hand, when to report on stock imbalances (over or under stocked), and how to store HIV Test kits. It also means performing a physical inventory/stock count, maintaining proper inventory records, determining when to report consumption data through monthly reports and LMIS forms, inspecting received products for integrity and expiry dates, and ensuring proper storage of HIV related diagnostics.

Perform a Stock Count
Performing a stock count means physically counting each item in the stock. The recommendation is that it be done at the end of every month (before entering transactions for the new month) by the personnel storing the test kits. All items must be accounted for; everything that comes in and goes out must be recorded.

Maintain Inventory Records
The Stock Card tracks receipts from Central Medical stores and it also tracks stock movement for commodities stored in the health facility store. It must be updated immediately after every transaction. All test kit requests must be made using the Requisition and Issue Vouchers. These must be signed by the DHO for all district hospitals.

Note the importance of establishing an accounting system that tracks items that come in, items that are used, and items that are remaining in the stock. Ideally, the number of a certain item remaining in the stock should equal the number of the item that came in minus the number used. But in reality, there is usually a discrepancy due to loss.

LMIS Forms

Stock Cards
Stock Cards must be kept with commodities in the store. They track the following information: receipts, issues, adjustments, and stock on hand. All test kits must have stock cards tracking the receipts from the central level and issues to the user sections (e.g. Lab and other testing areas).

Requisition and Issue Vouchers (LMIS RIV)
Requisition and Issue Vouchers must be filled out when ordering HIV Test kits.

Relocation Forms
Relocation Forms must be used to track test kits relocations. These forms are printed in triplicate—the white copy is for the sending site; the blue copy is for the receiving site; and the pink copy is for the Ministry of Health.

Daily Activity Register
The purpose of the daily activity register is to track test kit consumption. It provides a summary of test kits used per day which includes the opening balance (physical inventory), quantity received (receipts), number of tests used and losses, and the closing balance. It is a one page summary of HIV tests and serves as a record of all test kits used which helps the MoH to track consumption for test kits.

Monthly Site Report
The purpose of the monthly site report is for HTC locations to compile their data into one monthly summary page. It provides a summary of clients by gender, age, HIV test results, HTC access type, and summary of test kit use.

Maximum-Minimum Stock Levels

Term	Definition
Minimum stock	Minimum stock level maintained at the HTC site ***(HIV Test kits = 2 months)***
Lead time	Time between placing an order and receiving it ***(3 months – Quarterly distribution)***
Maximum stock	Maximum stock level maintained at the testing site ***(HIV Test kits = 5 months)***

Assessing Stock Status

Use the following formula to determine current stock status:

$$\frac{\text{Stock on Hand (amount we have now)}}{\text{Average Monthly Consumption (amount we use)}} = \text{Months of Stock on Hand (how long it will last)}$$

The numerator, stock on hand, should be obtained through physical inventory and the denominator, Average Monthly Consumption (AMC), is the average of the last three months' consumption of a particular product (so the total consumption for three months divided by three).

Calculating Minimum Stock Level

Minimum Stock Level = Average Monthly Consumption X 2 months

Example: Determine

Based on the Monthly Consumption for this year : Jan = 200 tests, Feb = 300 tests Mar =100 tests

Average monthly Consumption (**AMC) = 200** Tests

Minimum stock level = 200 x 2 = 400 tests

Minimum stock level in kits = 400/100 = 4 kits

When you get to your minimum stock, notify the HIV department logistics team

Calculating Maximum Stock Level

Maximum Stock Level = Average Monthly Consumption X 5 months

Example: Determine

Based on the Monthly utilization for this year : Jan = 200 tests, Feb= 300 tests Mar =100 tests

Average monthly Consumption (AMC) = 200 Tests

Maximum stock level = 200 x 5 = 1000 tests

Maximum stock level in kits = 1000/100 = 10 kits

When 20 kits are left with an expiry of less than 6 months, notify the HIV dept logistics team

HIV Test Kits Logistics System

HIV Test kit distribution is currently integrated with distribution of other HIV commodities. HIV commodities have to be managed as controlled commodities hence stock cards must be updated, requisition and issue vouchers must be filled in before issues are made from the pharmacy to testing point and the HTC register and HIV Daily Activity Register must be updated daily. Authorization codes must be obtained from the HIV department before test kits are moved between health facilities. Do a stock status assessment on a monthly basis and ACT! Communicate all potential stock outs to the ministry of health, logistics team.

Inspect Delivery/Ensure Proper Storage of Test Kits

Upon receipt of new test kits, you should: verify contents of the items being received, check the integrity of received supplies, note the lot number expiration date, store the new shipment behind the existing shipment, and create or update your records. Ensure proper storage of inventory by keeping it in a clean, organized, and locked storeroom; storing it according to the manufacturer's instructions, placing it in a well-ventilated room, and storing it away from direct sunlight. Place items on shelves and organize the existing and new shipments by expiration date.

Logistics Feedback

To provide feedback about logistics, call one of the HIV department Logistics Toll free lines:

- Airtel **59191**
- TNM **58181**
- MTL **80008089**

Alternatively, you could email them at **hivdeptlogistics@gmail.com.**

Key Points

- Maintain an adequate inventory at all times to ensure uninterrupted service
- Perform a:
    - physical inventory on a monthly basis
    - stock assessment to establish how long stocks will last to minimize stock outs and expiries
- All inventory items must be accounted for & recorded
- Always inspect new shipment before accepting
- The Daily Activity Register helps the MoH track test kit use and prevent pilferage

Module 5, Unit 5.1: HTC for Couples

Learning Objectives

By the end of this unit, you will be able to:

- Define the term "couple" and list different types of couples you are likely to encounter
- Describe the benefits and barriers to CHTC
- Highlight the importance of gender dynamics in CHTC
- Describe 3 different result types a couple could receive
- Describe key CHTC communication skills include mediation and diffusion of blame
- Describe the solution focused model
- Demonstrate pre- and post-test counselling techniques using the CHTC protocol

HIV and Couples

HIV Epidemic and Couples

The majority of people living with HIV are in stable, long-term relationships. As many as 50% of all HIV-positive persons who are in stable relationships have a partner who is HIV-negative. CHTC can decrease transmission by more than 60% among discordant couples.

HIV Prevention for Couples and Partners

HIV transmission between discordant couples in long-term relationships has been noted as one of the most important modes of transmission in Malawi, being estimated to account for over 40% of all new infections. This discordancy occurs in stable partnerships where one partner becomes infected either prior to marriage or when engaging in sexual activity outside the marital relationship. Overall, evidence from several studies indicates that the annual rate of transmission with in discordant couples is quite high, at about 5-10% per year, making this population a high risk group.

What do We Mean When We Say a "Couple"?

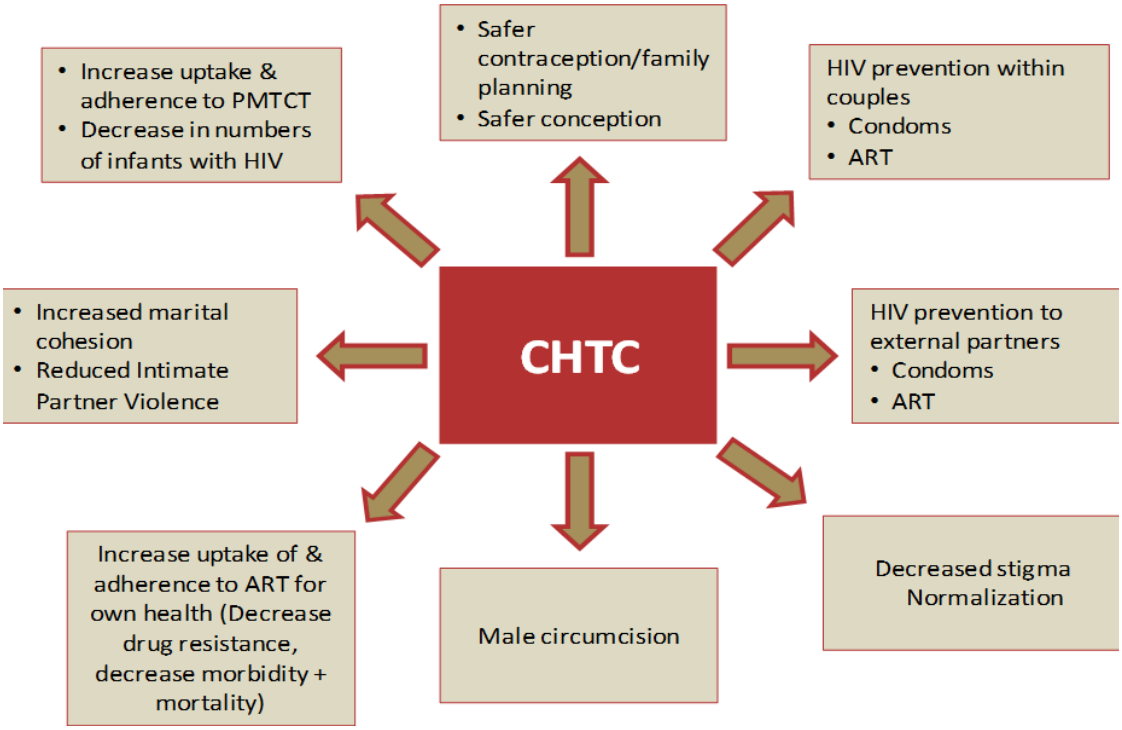
Two or more persons in a relationship who are having or are planning to have sex are considered a couple. Types of couples include: pre-sexual, engaged, married or cohabiting, polygamous, re-uniting, casual sex partners, and non-cohabitating partners.

CHTC vs. Partner Testing

The difference between CHTC and partner testing is that CHTC occurs when two or more partners are counselled, tested, and receive their results together whereas partner testing happens when one partner has already been tested and the other partner is tested separately.

Benefits and Challenges of CHTC

Potential Benefits of CHTC



Challenges with Getting Tested Together

Couples may also face challenges if they try to test together. They may have difficulty finding child care or getting time off work together. There are potential associated costs for couples with taking time off from work, child care, and transportation to the clinic. In addition, women may have trouble getting their partners to test or they may feel uncomfortable talking about HIV. They may assume that their partner's HIV status is the same as theirs or they may fear finding out their status and worry about stigma.

Gender and CHTC; CHTC and Violence

There are various gender issues which need to be considered in the context of HTC. These include economic dependency; property rights and legal issues; equal access to care, treatment and support services; and domestic violence, abandonment, or both. As providers, being aware of different cultural norms, male-female relationship expectations, possible power imbalances and other gender inequalities can help us to better manage these issues during the CHTC session.

Look for dominance by one partner, such as speaking for or making decisions for the other partner. Probe for issues of economic dependency of one partner on the other partner. This may create a fear of abandonment and contribute to power imbalances in the relationship. Note that CHTC is not associated with increased violence or negative events. There is no evidence that inviting male partners to ANC & VCT increases risk of partner violence

Assessing Safety in CHTC

In order to assess safety in CHTC, take the following steps:

Step 1: Screen for coercion/ensure both have come voluntarily
Step 2: Engage both partners and recognize and address power imbalances
Step 3: Screen for intimate partner violence if suspected
Step 4: Refer the couple to other services, including individual HTC

Step 1: Screen for coercion and ensure that both partners are there voluntarily.
If the provider does not feel that both partners are there voluntarily, he or she may decide not to provide CHTC services.

If you identify that there is coercion, couples HTC may not be appropriate. You might suggest that the partners receive individual HTC or that they return at a later time for couples HTC. Meeting them individually gives you an opportunity to talk with each partner separately to determine if they are both there voluntarily. If support serves are available in your community, you may screen for Gender Based Violence (GBV) and make referrals to these or other counselling services.

Step 2: Engage both partners and recognize and address power imbalances.
It is important for providers to encourage both partners to communicate equally and to ask questions to both members of the couple to encourage balanced participation. If the provider notices that the female partner is not opening up, he or she can also specifically ask questions that make women feel comfortable, or ones they are more likely to respond to—for example, questions about their children.

Step 3: Screen for intimate partner violence if suspected.
Because prior violence in a relationship is a significant predictor of future violence, providers should consider any information that comes up about past violence to determine whether CHTC is appropriate for the couple.

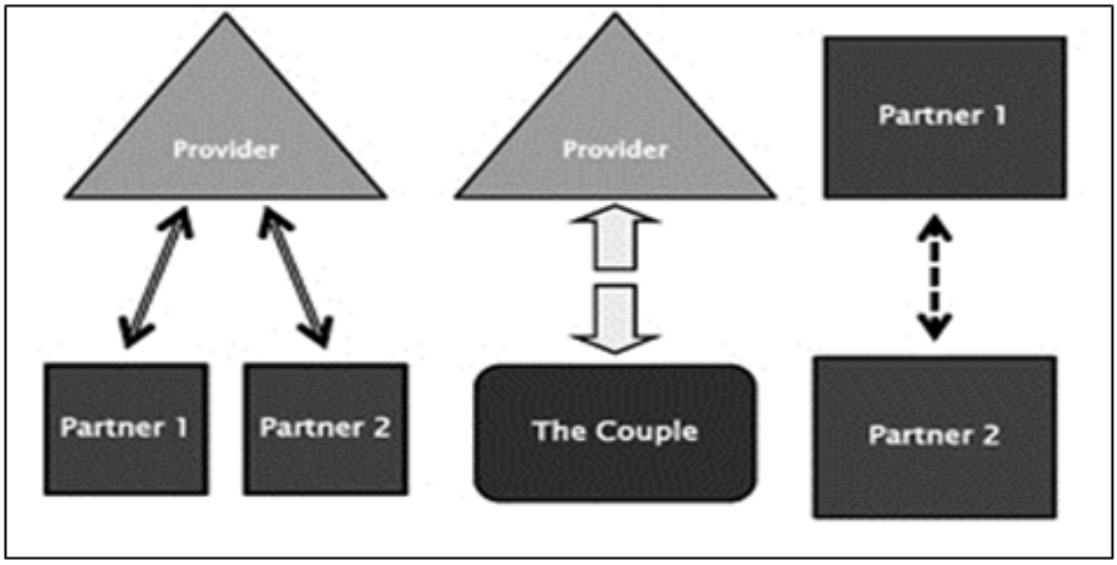
Step 4: Refer the couple to other services, including individual HTC.
If you sense that a couple experiences physical, sexual, or emotional abuse in their relationship, it may be best to stop the CHTC session and refer them to additional counselling services for assistance. It is also important that you have a comprehensive list of appropriate referral services available in your community, including support for violence and abuse as well as legal support. Referral made for these services should be done in way that protects the confidentiality and safety of the at-risk partner. Typically, they should be provided without the other partner present.

CHTC Communication Skills

CHTC Communication Skills

There are various communication skills that the HTC provider should have in order to provide effective CHTC. The HTC provider should demonstrate neutrality and nonbiased concern for both members of the couple. Convey respect for the couple's relationship, facilitate the balanced participation of both partners, and model appropriate listening and communication skills. The HTC provider should facilitate dialogue between the couple, raise difficult issues the couple may need to address, and attempt to ease tension and diffuse blame.

4 Essential Communication Pathways in CHTC

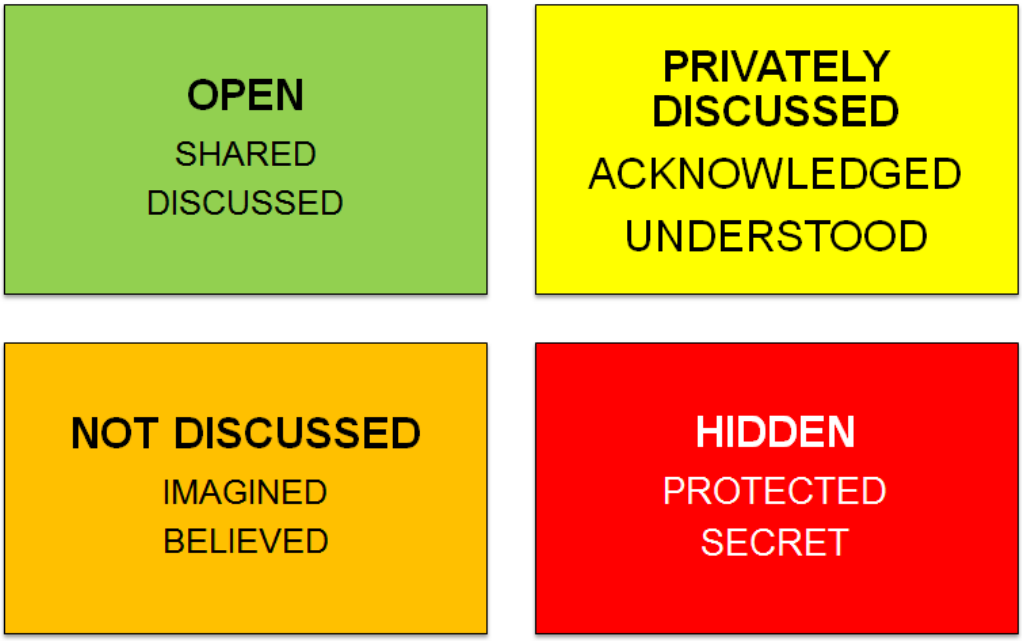


In order to ensure that couples feel like an HTC provider is actively listening and engaging the couple, a provider needs to pay attention to all four communication pathways in a CHTC session. The four pathways are:

- Between the provider and partner 1
- Between the provider and partner 2
- Between the provider and the couple as a collective unit
- Between the couple as partners

Johari's Window for Couples

Johari's Window is a tool that has been adapted for working with couples. This tool will help identify things about ourselves that we may want to either share or to keep secret from others; particularly in a counselling situation.



The **Green Box** represents things that you are proud of and that you share and discuss openly with your family and extended family. For example:

- Your child's accomplishments
- Professional goals and ambitions
- Relationship status (such as engaged or married)

The **Yellow Box** represents things that you share in your home between you and your partner. For example:

- Financial circumstances
- Detailed information regarding personal family situations

The **Orange Box** represents things in your relationship you know about but do not talk about. For example:

- Believing your partner drinks when away from home on business
- Believing your partner dislikes your mother or relatives

The **Red Box** represents things that cause you to feel guilty, ashamed, or embarrassed. For example:

- A sexual encounter or fantasy
- Something you did under the influence of alcohol
- Having been in an abusive relationship
- Having been sexually assaulted or forced to have sex

Sample Johari's Window:

1. The green area might have my goals to be the best trainer from my organization
2. The yellow area might have the details of my uncles recent death
3. The orange area might have my suspicions that my husband is unfaithful while I'm away conducting trainings
4. The red area might have details about a previous relationship

CHTC Protocol

CHTC Pre-Test Counselling

Step 1: Introduction to CHTC/concurrence to receive services
Step 2: Explore couple's life stage/reason for seeking CHTC
Step 3: Discussion of risk issues and concerns
Step 4: Explore risk reduction options

Conditions for Receiving CHTC
In order to provide CHTC most effectively, the couples should discuss risk issues and concerns, express a willingness to receive results together, and show a commitment to shared confidentiality (including mutual disclosure decisions).

Couples should treat each other with respect and dignity, ensure equal participation of both partners, listen and respond to one another, engage in candid and open discussion, and provide understanding and support.

Importance of Maintaining Client Confidentiality
In some cases, both partners do not know their HIV status and will learn it for the first time. In other cases, one partner might know his/her status and the other may not. This partner may or may not have disclosed his/her status to the other partner. Getting tested together is one way to help client disclose his/her status to the spouse or partner.

HIV Testing

Step5: Prepare for testing and discussion of possible results
Step 6: Conduct HIV testing according to the SOPs and algorithm

Mediation Skills for Easing Tension and Diffusing Blame
There are many ways in which the HTC provider can help couples to ease tension and diffuse blame. First, it is important to normalize feelings, reactions, and experiences. Remind the couple that HIV infection is common; they are not alone. The HTC provider should focus on the present and future and avoid and deflect questions aimed at identifying the source of infection. Express confidence in the couple's ability to deal with HIV-related issues and acknowledge feelings expressed or observed.

Solution-Focused Model
As part of the Solution-Focused Model, HTC providers should focus on solutions, not problems; build on strengths rather than weaknesses; validate feelings, but focus on

positive actions; and acknowledge that small behaviour changes can lead to bigger ones. Focus on the present and future--the past is in the past, and cannot be changed!

Three Types of Test Results for Couples
The three types of test results for couples are: concordant positive where both partners are HIV positive, concordant negative where both partners are HIV negative, and discordant where one partner is HIV positive, the other is HIV negative.

CHTC Post-Test Counselling

Test Result	Action: Provide results and then…
Concordant Negative	• Provide risk reduction counselling • Develop a risk reduction plan • Discuss ways to ensure couple remains negative

Concordant Positive	• Discuss coping and mutual support and:
	  • positive living
	  • family planning and PMTCT
	  • disclosure and risk reduction

Discordant	• Discuss coping and mutual support and:
	  • positive living
	  • family planning and PMTCT
	  • disclosure and risk reduction

Explaining Discordance

Correcting Myths about Discordance
It is important to make sure to dispel myths about discordance. For example, HIV is not "sleeping" to be detected sometime in the distant future; if one tests negative, then one probably does not have HIV, unless it is the window period. The "window period" does not explain discordance, however. In addition, the uninfected partner is not immune to HIV. Faith cannot protect one from becoming infected and a curse cannot cause one to become infected. Finally, the characteristics of a woman's vagina or a man's penis are not explanations for discordance.

Essential Messages to Convey to a Discordant Couple
The HTC provider should emphasize that the results are very accurate and that they are common even when a couple has been together for a long time and/or have children. Immunity to HIV is exceedingly rare; it is not an explanation for discordance. There is only a small possibility that the uninfected partner is in the window period, and the uninfected partner remains at high risk.

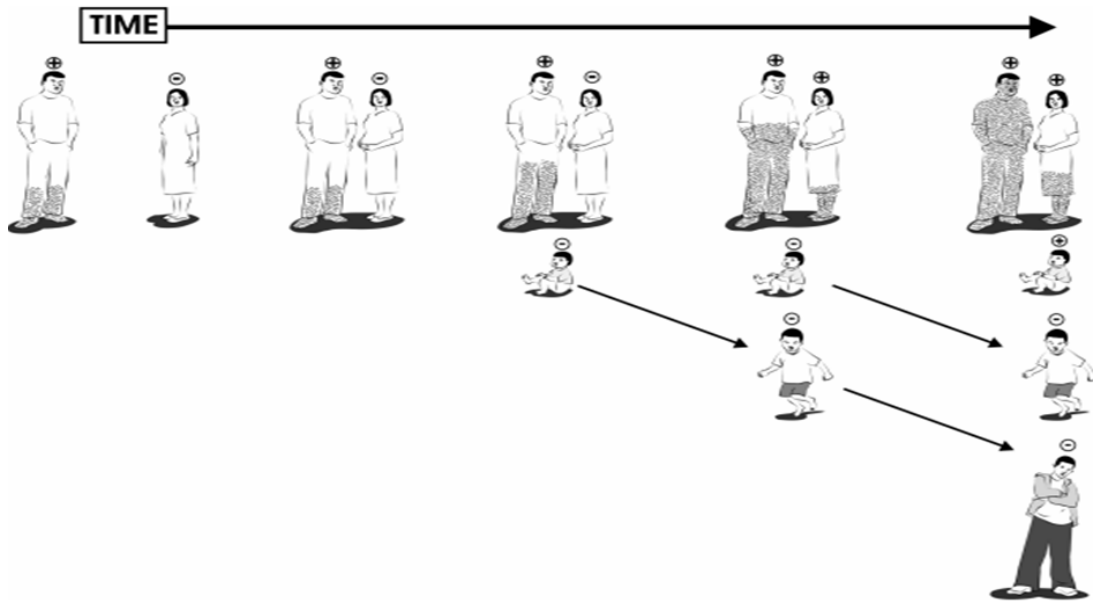
Role of Children in a Couple's Relationship

If one or both partners in a couple are HIV-infected, the decisions about children are never easy. Couples who already have children are more likely to continue their relationship regardless of their test results. Couples without children may be more likely to end their relationship. The well-being and future of their children is a powerful influence in the relationship, the extended family, and the community.

Benefits of Parental Disclosure to Children

There are many benefits of parental disclosure to children. Not knowing can be stressful—children can be highly perceptive. They may know something is wrong even if the parent has not disclosed. It is best for children to learn about their parent's HIV status from the parents themselves. This serves to open communication and allows parents to address their children's fears. In the end, it is less stressful for parents if they just go ahead and disclose to their children.

HIV Transmission in the Family



Here we see a typical family in which the couple is HIV-discordant. When this couple met, the man was young and healthy and unaware he was infected with HIV. When the couple married, they were unaware they were discordant. Like most couples, they soon had a child and the child was not at risk for HIV because the mother had not yet become infected with HIV. When they had their second child, the woman had become infected with HIV, but fortunately she did not transmit the virus to the child. Unfortunately when the couple had their third child, this child was infected with HIV.

Key Points

- CHCT can decrease HIV transmission by more than 60% among discordant couples
- CHTC is not associated with increased violence or negative events (Semrau et al., 2005)
- HTC Providers need to be prepared to:
    - Explain discordance
    - Dispel myths
    - Enhance communication
    - Provide solutions
- CHTC requires that couples share a willingness to go through process together and make mutual decisions about disclosure
- The solution focused model advocates:
    - Focusing on solutions, not problems
    - Building on strengths rather than weaknesses
    - Validating feelings, but focus on positive actions
    - Acknowledging that small behaviour changes can lead to bigger ones

Module 5 Practice: HTC for Couples Role Plays

Practice Role Plays: Giving Concordant Negative Results

1) The first group will conduct the role play with the HTC provider giving **concordant negative results** to the couple.

Allow 45 minutes for this counselling session. When time is called, you will then have 15 minutes to debrief. Think about and learn from what went well/needed improvement and apply it to the next role play. Review the protocol and note any areas that were challenging. Then, switch roles and do the role play again, giving different results, and incorporating feedback from the debrief.

Practice Role Plays: Giving Concordant Positive Results

2) The second group will conduct the role play using the second role play in their manuals (Silas and Pamela) with the HTC provider giving **concordant positive results** to the couple.

Allow 45 minutes for this counselling session. When time is called, you will then have 15 minutes to debrief.

Practice Role Plays: Giving Discordant Results

3) In your same groups, you will conduct new role plays using the third couples scenario in the manual (Andrew and Geraldine), this time giving discordant results. Conduct the discordant couple role play, and then switch roles so that others have the opportunity to practice a different role when giving results to the discordant couple.

Allow 45 minutes for each role play, and debrief for 15 minutes after each one. Note that the second debrief can be done as a large group prior to the return demonstration.

Scenario for Concordant Negative couple

Husband: Elias age 31, driver for an aid organization
Wife: Jane age 28, sells fruits, vegetables and other staples at roadside vending stand
Marriage: 5 years
Children: 5 year old son, 2 year old daughter

Jane and Elias are a very close couple and after years of hard work they feel like their life is going pretty well. Jane met Elias at a friend's wedding. He was very charming and she liked him immediately. He seemed to be a good man. He had a good job and was building a house for his mother. Elias and Jane never talked in detail about their past relationships. Jane is aware that prior to the time they met, Elias drove truck for another aid organization and delivered supplies to programs in various neighboring countries. He was away for weeks at a time and she imagines he may have met girls along the way. Elias knows that for a brief time Jane had a boyfriend who she

was serious about but the relationship ended long before they met. Since they married they have built a nice home for their family. Elias's mother lives close by and helps to take care of the children when Jane is working. Elias and Jane are considering having another child. Elias, in particular, would like another son. The nurse midwife, a family friend, who delivered their youngest daughter, recommended to Jane that the couple receive CHCT service prior to adding another child to their family. Elias has a coworker who has been ill and Elias is concerned that this friend may have AIDS. Elias' concern about his coworker has caused him to talk to Jane a little more about his worries about HIV. The youngest child of Elias and Jane has had some minor health problems and this has added to their worries. As a result, they decided to go together to receive couple HIV testing.

You are Elias:
Prior to his current position Elias delivered construction and food commodity supplies for another aid organization. He would be gone for several weeks at a time. This was a lonely time for Elias and he would sometimes go to the local bars in the evenings. Occasionally he would meet a girl and have sex with her. He would usually use condoms but not always. For a while he had a steady girlfriend in the northern part of the country. He was fairly serious about her and thought they might marry. Initially he used condoms with this girl to prevent pregnancy but eventually they stopped. This relationship ended when the girl moved to the city to live with her sister and find a better job. Not long after that Elias met Jane and they later married. Elias is very happy with his life. He is dedicated to his wife and children. Elias feels that he and Jane have a strong bond and have worked together to build a better future for their family. Although Elias is worried about going for an HIV test, he feels a bit reassured that his employer is scaling-up a program to provide access drugs to treat HIV as part of the employee health package. He doesn't know a lot about these drugs but thinks they may offer some hope.

You are Jane:
While in secondary school Jane had a boyfriend. This boy really pressured her to have sex with him. Jane only had sex with this boy twice. Later, Jane met a boy from her village and was involved with him for a while. He ended their relationship when he got the opportunity to go away to a technical school for training. She was hurt and disappointed when this young man left. About a year later she met Elias and finally found the relationship she was looking for. Jane feels that she and Elias have a strong bond. Elias is a responsible and kind husband, a good father and works hard to provide for the family.

Scenario for Concordant Positive couple

Scenario 1: Silas and Pamela. *Silas and Pamela are very young—just 18 and 19 years old. They plan to get married and start a family. When they receive their test results, they find they both are HIV-positive and are very upset. Neither expected to be HIV-positive. Now it feels like their whole life together has been torn apart. As they begin to recover from their first reaction, they start to wonder how this could have happened. Although both were aware that the other partner had relationships with others before they were a couple, they did not think they could be infected because they were so young. Silas, the male partner, starts to ask Pamela who she knew before he met her. She has the same reaction.*

Scenario for Discordant couple

Scenario # 2: Andrew and Geraldine*. Andrew and Geraldine are a couple that has been together for 12 years. They have 2 children, 8 and 10 years old. Andrew has worked on and off as a construction worker over the last 10 years. Money is tight, but they have always managed to support themselves and their children who are in school. When the couple underwent CHTC because of the husband's lingering respiratory illness, they found that he was HIV-positive. Geraldine is HIV-negative. She is very angry that he has endangered both her health and possibly the health of their children. She is also afraid that he will become increasingly sick and will not be able to work, making them lose their home. He is also afraid that he will not be able to work and his wife will leave him.*

Module 5, Unit 5.2: HTC for Pregnant Women and Infants

Learning Objectives

By the end of this unit, you will be able to:

- Describe the importance of testing and counselling pregnant women and infants
- List service delivery points to identify HIV exposed infants
- Describe the target groups of infants to be identified
- Discuss pre and post-test counselling for mothers with HIV exposed and HIV infected children
- Describe optimal follow up care for HIV exposed and infected infants and children
- Discuss tracing of infants lost to follow up

Overview of Testing for Pregnant Women and Infants

What is Your Role?

As an HTC provider, your role is to raise community awareness and dispel myths about testing and treatment, provide timely and accurate information, and assist clients while they go through the process.

We should look for pregnant women and HIV exposed infants at: MCH clinics, HTC rooms, hospital wards, ART clinics, outreach clinics, high risk clinics, and village clinics (CCM). We should be targeting all infants and children presenting for first immunizations in under 5 clinics; children in family planning clinics; all infants identified as HIV exposed; mothers, infants, and children with unknown HIV status; infants and children failing to thrive; and children admitted in paediatric, outpatient, TB wards, and Nutrition Rehabilitation Units.

Two protocols are relevant for testing and counselling pregnant women and infants. They describe the key steps to follow when conducting counselling and testing for pregnant women/infants. The ANC/Maternity protocol is for women planning on becoming pregnant or currently pregnant. The EID protocol is targeted to parents/guardians responsible for the care of infants.

ANC/Maternity Protocol

Tips for Conducting the Group Pre-Test Education Session

When conducting the group pre-test education session, it is important to keep messages simple and avoid complicated terminology. Focus on the positive - that a healthy pregnancy is still possible. Emphasize that all testing is VOLUNTARY and results will remain CONFIDENTIAL; anyone who declines testing will still receive antenatal care.

Step 1: Introduction and Orientation to Group Education
During step 1, you should introduce yourself, describe the role of the HTC provider, discuss confidentiality, and discuss routine blood tests for pregnant women, including: HIV testing, haemoglobin, and Syphilis.

Step 2: Basic Information on HIV MTCT
During Step 2, provide information about: the difference between HIV and AIDS, modes of transmission and prevention, PMTCT and access to treatment – Option B+, delivery in a health facility, nutrition for the mother and the infant, family planning, and disclosure, couples and partner HTC. Emphasize the need to inform relevant health workers of HIV status as well as the need to test the HIV exposed baby.

Review: What is Option B+?
Option B+ is for HIV+ pregnant/breastfeeding women and means lifelong ART for the mother and infants take 6 weeks of NVP after birth. Option B+ facilitates increased access to ART, prevention of maternal deaths after delivery, and reduction of HIV transmission to both the infant and to sexual partner(s).

Option B+ makes breast feeding (BF) safe for HIV infected women. Breastfeeding recommendations are now identical for HIV infected and non-infected women. As such, breastfeeding is recommended until age 2, and then add suitable food from age 6 months.

Step 3: HIV Testing Process
During Step 3, explain the testing process as well as possible results and what they mean. If the client has a negative test result, then discuss the window period and the need to retest in the third trimester; explain that testing is done in labour only if testing was not done in the third trimester. If the test result is positive, then steps can be taken to reduce the risk of transmission to the baby. Also describe the need for HIV risk reduction and ask clients to move to the testing room; if they have come with their partners, they are encouraged to be tested together.

Step 4: Offer HIV Test
If the client consents, then conduct the test according to the recommended SOP and algorithm. If the client declines, then continue with case management and/or refer back to the clinician.

Step 5: Test Procedures (Individual or Couple Session)
During Step 5, review confidentiality; assess the client's readiness to test; administer the HIV test, following safety procedures, SOPs and the algorithm; and ask whether the client has any questions from the group pre-test education session. All tests are done in-session; never ask the client to wait outside while the test develops.

Step 6: Provide Test Results
During Step 6, inform the client that the results are ready. Provide and explain the results, allow time for the client to reflect on the results, and confirm that the client understands the test results.

Negative Result - Key Messages
If the client has a negative result, then it is important to explain the window period and retesting in the 3rd trimester. Explain the risk to the baby of becoming infected with HIV during pregnancy as well as safer sex and family planning. Make sure that the client understands discordance, partner testing and male involvement. Then, make an appointment for the client for retesting provide the client with a Family Referral Slip and condoms.

Positive Result - Key Messages
If the client has a positive result, then it is important to provide emotional support, discuss PMTCT interventions and discuss disclosure to partner. Emphasize the importance of informing HCWs of your HIV status, facility delivery, nutrition for mother and infant (breastfeeding recommended), and safer sex and family planning. Explain discordance as well as the need for children and partner testing and male involvement. Make sure that the client understands the importance of obtaining clinical care for all ailments. Assess the client's coping mechanisms and social support, link the client to HCC for further management, provide him/her with Family Referral Slip and condoms, and record the results in the client's health passport.

Inconclusive Result – Key Messages
If the client receives an inconclusive result, then encourage the client to retest in 4 weeks. Explain the window period, and record the results in their health passport. Discuss recent exposure, as well as the need to protect oneself and others. Discuss support for behaviour change, the need for partner testing, and provide family referral slips.

EID Protocol: First Visit

The pre-test for EID focuses on identification of exposed/infected infants.

Keep the Following in Mind When Conducting the Pre-Test Session….
Keep messages simple; try to avoid using complicated terminology. Focus on the positive - that something can be done to ensure the health of the baby. Emphasize that all testing is VOLUNTARY and results will remain CONFIDENTIAL.

Step 1: Introduction to EID
In Step 1, introduce yourself; describe the role of the HTC provider including shared confidentiality; and give an overview of EID, including the possibility that MTCT may occur during pregnancy, labour, or breastfeeding. Explain factors that increase one's risk of MTCT as well as interventions to reduce that risk. Explain the recommendation for DNA PCR testing for infants 6 wks to 12 months.

Step 2: Discuss Reasons for EID
In Step 2, explain that knowing the infant's status provides the foundation for care and that early diagnosis and referral to HIV care significantly reduces morbidity and mortality. Recommend CPT from 6 weeks to prevent infections, and explain the difference between

HIV exposed vs. infected infants. Finally, emphasize the need to retain mother-baby pairs in care until the infant is 24 months of age.

Step 3: Introduce Need for an HIV Test
During Step 3, explain that HTC is important for all pregnant women and all children born of HIV+ mothers and that the DNA PCR test is routine for HIV exposed infants aged 6 weeks to 12 months. Then, explain the testing process including the area to be pricked, collecting the sample, and when results will be ready. The area to be pricked depends on the child's age. From 6 weeks to 4 months, prick the heel. From 5-9 months, prick the toe. And for a child between 10-12 months, prick the finger. Inform the parent or guardian of the need for further care and treatment if the infant tests PCR+.

Step 4: Blood Sample Collection
During Step 4, obtain consent for testing the infant and collect the blood sample, label the filter paper and place the DBS to dry (according to SOP). Complete the required EID DNA PCR documentation and advise the parent when to return for PCR results.

Rapid Testing for Children Over 12 Months
Children should be tested at 12 months and 24 months (or 6 weeks after cessation of BF). Perform *in-session* rapid test. If the result is negative, then retest at 12 and 24 months or 6 weeks after cessation of breastfeeding. Recommend CPT through 24 months. If the result is positive, then the infant is infected with HIV. Children under 2 should start ART and CPT right away and continue for life– refer them to the ART clinic. Recommend breastfeeding through 2 years of age.

EID Protocol: Second Visit

Step 5: Post-Test Counselling - PCR Negative Result
If the child has a PCR Negative result, then explain the meaning of a negative result. Conduct follow-up rapid testing at 12 and 24 months (or 6 weeks after cessation of breastfeeding). Continue CPT until 24 months or 6 weeks after cessation of breastfeeding. Explain the importance of continued infant immunizations and refer the mother and infant to the HCC.

Step 5: Post-Test Counselling - PCR Positive Result
If the child has a PCR positive result, then explain the meaning of the positive result. Allow time to adjust and support the caregiver to cope with the situation. Emphasize the need to start ART right away, and initiate the child on life-long CPT. Encourage breastfeeding through 2 years, refer the mother and infant to the HCC, and answer any remaining questions.

HIV Care and Treatment for Infants

HIV Care Clinic (HCC)
All infants born from HIV+ mothers should be referred to the HCC for: follow up of HIV exposed infants, initiation and monitoring of CPT, initiation of ART, clinical monitoring, and

preventive services for family member. Note that family appointments make on-going care easier.

HCC Visit Schedule

HIV exposed infants should be brought back to the clinic monthly for infants up to 6 months; appointments can be aligned with EPI vaccination visits. After that, every 3 months from 6 to 24 months and then schedule more visits if the child is unwell. Discharge from the HCC if the infant has a negative rapid test 6 weeks after cessation of breastfeeding. HIV+ pregnant women should be identified in the ANC and referred to the HCC - mothers, their infants and family members can all receive care in one clinic.

Tracing of Lost to Follow Up

Any child or mother who misses an appointment should be followed up. Two weeks after date of appointment, she is classified as lost to follow up. Priority clients who need tracing include mother-infant pairs who do not return for DNA PCR results one month after testing and infants enrolled in paediatric ART clinics or exposure clinics who default on appointments.

Many different workers should assist in following up lost to follow up children. These include the HSA to assist in tracing – he or she can ask the mother to report to the clinic. Also, the community health nurse can perform home visits. Involve CBO members if possible to assist with tracing.

Key Points

- Many children are living with HIV
- Few who require ART are accessing it
- HIV+ positive children can lead normal life however they progress faster to AIDS
- All service delivery points are important in identification of HIV exposed children
- Proper and accurate documentation is part of HIV care
- Mother/guardian should never go home without next appointment date
- All HIV exposed children should be enrolled in HCC
- All HIV positive children under 2 years of age must be on ART
- Age of the child determines the type of HIV test either rapid or DNA-PCR test
- Caregivers should always be counselled before sample collection and when giving the results
- HCW should always react to the result either negative or positive
- Mothers and infants lost to follow up need to be linked to care

Module 5: Practice: Scenarios for HTC for Pregnant Women and Infants

ANC Scenarios

Scenario # 1: Grace: Grace is 19 years old, single, and recently learned she is pregnant. She comes to the Namiyasi HTC Site for testing. She learns that she is HIV negative.

Scenario # 2: Mrs Bwanali: Mrs. Bwanali is 25 years old and recently married. She comes for a routine prenatal checkup during her third trimester. While waiting for her appointment, she participates in the group pre-test education session and decides to get tested. She learns that she is positive.

EID Scenarios

Scenario # 1: Grace: Rose comes to the Namiyasi HTC Site with her 6 week old infant for testing. She learns her infant is negative.

Scenario # 2: Mrs Dumisani: Mrs Dumisani comes to the clinic with her sister's 11 month old baby girl for testing. Her sister recently passed away. She learns her niece is positive.

Module 5, Unit 5.3: HTC for Children

Learning Objectives

By the end of this unit, you will be able to:

- Define age brackets for a child
- Describe key legal and ethical issues for children
- Define age of consent for children
- Explain the developmental stages for children
- Describe how HIV can impact a child's life
- List the key steps in the child protocol
- Differentiate between partial and full disclosure
- Describe key follow up, care and support strategies for children

Overview of HIV in Children in Malawi

Definition of a Child

A child is any individual below the age of 18 years.

Type of Child	Age
Infant	Less than 12 months
Young child	1 - 5 years
School age child	6 - 9 years
Adolescent	10 - 14 years
Youth	15 - 18 years

HIV and Children in Malawi

12.9% of reproductive age women are HIV positive. If they do not know they are infected (or do not seek PMTCT), about 36% infants will be infected. More than half of the orphans in Malawi (550,000 children) are orphaned due to AIDS (UNICEF, 2009). There are currently 120,000 children living with HIV (UNAIDS 2009).

Legal and Ethical Issues Related to HTC for Children

Overview of Legal and Ethical Issues for Children

HTC providers providing HTC for children commonly see ethical and legal dilemmas. Children in Malawi should have access to HTC services which comply with national and international legal and ethical standards. HTC providers must fully understand these principles in order to protect the best interests of children at all times.

5 Main Legal and Ethical Principles Guiding HTC for Children
The 5 main legal and ethical principles guiding HTC for children are: 1. Rights of the Child, 2. Best Interests of the Child, 3. Age of Consent, 4. Informed Consent, and 5. Confidentiality.

Rights of the Child
Every child has the inherent right to life and freedom of expression, including the freedom to seek, receive and impart information and ideas of all kinds. No child shall be subjected to arbitrary or unlawful interference with his or her privacy. It is every child's right to enjoy the highest attainable standard of health. No child will be deprived of the right to access health services. Parents/guardians are responsible for the child's upbringing and development. Every child has a right to a standard of living adequate for physical, mental, spiritual, moral and social development.

Best Interests of the Child
The best interests of the child shall be a primary consideration. When HTC providers face legal and ethical dilemmas, this principle guides the HTC provider in how to manage the situation. If the HTC provider acts in the best interests of the child at all times, the child will be protected and legal and ethical principles will be upheld.

Age of Consent
According to National HTC guidelines, the HTC provider cannot engage a child below the age of 13 years without consent of parent /guardian with exception of mature minors. The age of consent for children below the age of 13 years must be handled with extreme care in order to ensure that the rights of the child and the family are upheld.

Informed Consent for a Child
Informed consent refers to a child or parent/guardian being given an opportunity to consider: the benefits and potential difficulties associated with having access to information regarding a child's HIV status, an understanding of the testing procedure, and making a decision for the child to be tested (or not) for HIV. The child or parent/guardian should consider implications of a positive HIV test result on the child's and family's life. The HTC provider should use this opportunity to discuss and encourage HIV testing for parents/guardians so they can also benefit from knowing their own HIV status.

Elements of Obtaining Informed Consent
Three crucial elements in obtaining truly informed consent in HIV testing are: providing pre-test information on the purpose of testing; providing the treatment, care and support available once the test result is known; and ensuring understanding by the child (if of an appropriate age) and parent/guardian.

Confidentiality for Children
Confidentiality is a guiding principle for HTC services and must be protected at all times as the child's privacy should be respected. It is important to remember that a child's positive HIV status at any age may be assumed to mirror that of the parents and can result in the family being stigmatized. Shared confidentiality has been shown to help people living with and affected by HIV reduce stigma and denial and it also helps them to be accepted and supported by community. All records of HTC service provision for the child must be managed only by persons with a direct role in the management of child.

Benefits of and Barriers to HTC for Children and Their Parents/ Guardians

Benefits of HTC for Children
There are many benefits of HTC for children. First, it serves as a critical entry point to prevention, treatment, care and support services. It ensures early identification of children who are HIV-infected and benefits HIV exposed children who are uninfected through prevention, treatment care and support services.

Benefits of HTC for Parents or Guardians
There are also many benefits of HTC for parents or guardians. First, it assists parents to care for their child through access to HIV prevention, treatment, care, and support services. In addition, knowledge of a child's HIV status can reduce stress. It helps them develop coping mechanisms through supportive counselling and encourages parents or legal guardians to know their own status.

Barriers to HTC for Children
Unfortunately, sometimes there are barriers to HTC for children. These may include inadequate HTC services for children, or inadequate child friendly organizational structures and procedures. In addition, when society, communities, and families fail to understand the benefits of testing children, this may lead to: negative attitudes towards testing children; reluctance of families to have children tested; and/or fear and stigma on the part of parents/ guardians.

Understanding Unique Needs at Different Developmental Stages

0 to 1 year: Consistency and Continuity
Children at this age learn about the world through their senses. They respond to faces, voices and bright colours, discover their hands and feet, smile, start to understand and say a few words, sit up, crawl, stand and start to explore and to play with objects.

They need:
- Consistent caregivers who respond to them
- Physical affection, including being held close and cuddled to help them feel secure
- Talk, stories, things to look at, touch, hear and play with
- Physical protection and a safe environment to explore

1 to 3 years: Encouragement, Enthusiasm and Independence
Children at this stage learn to walk and run, understand and speak words, communicate ideas and feed themselves. They become more independent, develop friendships but prefer familiar people. They like to help, can solve simple problems, enjoy learning new skills and show pride in accomplishments, but get frustrated if they cannot do things.

They need:
- Opportunities to play with other children and develop independence

- Encouragement and praise
- Someone who listens to and talks to them

3 to 5 years: Initiative and Inspiration
At this stage, children talk a lot, ask questions, like to play with friends, learn to share, feel angry or guilty if they think they have failed; and become competitive, especially with their siblings and playmates. They also become more adventurous and start to imitate adults.

They need:
- Opportunities to participate in activities, explore and make choices
- Help to learn to use language well through reading, talking and singing
- Praise when they try new things and do things well.

6 to 8 years: Curiosity and Learning
At this stage, children show increased interest in the world, people, letters and numbers. They become more physically confident, start to take responsibility, play cooperatively and build trust with friends, and use words to express feelings.

They need:
- Support to develop additional language, physical and thinking skills
- Encouragement with school work
- Opportunities to learn cooperation and self-control, to take responsibility and complete tasks

8 to 10 Years: Exploration and Understanding
At this stage, children have increased ability to understand things clearly, and need to put meaning to the events affecting them. They want to learn more about why things are as they are.

They need:
- Explanations about why things are the way they are
- Encouragement to learn new things
- Opportunities to boost their self-esteem and confidence
- Lots of acknowledgement, constructive criticism and praise

Understanding the Impact of HIV on Children

Social Stressors

- May not be cared for properly as parent is sick
- May be cared for by elderly relatives, siblings or people who do not want to care for them
- Living in poverty
- Inadequate nutrition
- Poor access to health services
- Unable to attend school

- Frequent change in residence
- Unable to interact and socialize with peers

Possible Emotional Reactions

- Loss of Control / Helplessness
- Confusion
- Anger
- Loneliness
- Abandonment
- Sadness
- Mistrust

Loss of Control / Helplessness

- Loss of parents / siblings
- Frequent change of residence
- Recurrent illness and frequent medical investigations
- Drop out from school
- Child abuse

Fear and Anxiety

- Who will look after me then?
- What will happen to me?
- What is happening to me?
- Will I keep having painful tests?
- Will I die too? What happens when I die?
- Will people find out that I am positive?
- What happens if my ARVs stop working?
- Will I be able to get married and have children?

Loneliness

- One or both parents may be dead
- Other family or friends may not be in a position to provide the love the child needs
- Stigmatized and discriminated against by friends , family, communities

Sadness

- Children with HIV may be grieving the loss of parents, siblings, other relatives and friends.
- Intense sadness about their own health and social circumstances
- Fear of death

Confusion

- Why did my mother/father die?
- Why do they ask me to leave the room while they talk about me?
- Why do I keep getting sick, even though I take the medicines?
- Why does everyone I love get sick?

- Why do I have to carry on taking this medicine if I am feeling better?
- Why am I sick more often than my friends?
- Why do I have to take lots of medicines/blood tests?
- Why do I have to miss so much school?
- What have I done wrong? Why do people talk about me / tease me?

Abandonment

- Where is our mother/father?
- Why does he/she not want to take care of us anymore?
- Why have we been sent to live here?
- They don't want us
- Who will look after us now?

Changes in Behaviour

- Withdrawal
- Bed wetting
- Aggression
- Self-harm
- Clinging
- Regression

Counselling Skills and Techniques for Children

When counselling children, it is important to establish a relationship, ask open ended questions, listen, clarify and summarize, and show empathy. The HTC provider should provide opportunities for children to express themselves, for example through drawing, storytelling, drama , or play. Many of these skills and techniques are similar to the techniques we use for adults. There are key differences, however. The age, development stage and individual needs of the child in front of you will determine which skills/techniques you use.

Counselling requires a variety of skills and techniques for both adults and children. However when counselling a child, the process is enhanced when we use certain skills that take into account the child's developmental stage, current needs and context. Some of these skills and techniques include:

1. Establishing a relationship

Establishing a relationship with the child at the beginning of the counselling session is essential. Children need to feel safe, secure and confident that they can trust the counsellor in order for them to communicate what they are thinking and feeling. This process of establishing a relationship is also known as 'joining'. Joining is also an important part of counselling for adults but joining with children involves a variety of different techniques, including:

- Welcoming the child and caregiver in a warm friendly manner

- Stand up to greet the child and the caregiver. Get down to the child's level to greet him/her where necessary
- Offer the child the seat nearest to you, indicating you are interested in him/her
- Acknowledge the child, showing them clearly that you are interested and happy to see him/her, not just the caregiver
- Introduce yourself so that the child and caregiver can get to know you
- For children who can talk, take time to ask the child to introduce themselves. Show the child you want to know from him/her, not just the caregiver. This is important even for very young children
- Talk with the child about something they are interested in, that they like to do, that they have done that day or play a game with them
- Use positive body language at all times, such as leaning towards them, looking directly at the child, use of friendly facial expressions
- Explain to the child that your role is to talk with children to find out what problems they are having so that you can try to help with those problems.

What To Do When A Child Will Not Speak

- Take time to get to know the child. Use a variety of methods to help the child to relax. Introduce games, activities, etc.
- Show an interest in the child as a person. Where do they go to school, who are their friends, what sports do they like? etc
- Assure that a support person (a relative or trained professional in working with children) can relax the child, and can communicate this to the child.

Note –

- Both the verbal and non-verbal language of the support person should be observed to assure that it supports and relaxes the child.
- Create trust by informing the child of what will be happening and informing them of your role.
- Check if the child is hungry or thirsty.
- Show that you respect and accept the child. Do not be judgmental or critical.

After you have relaxed the child and given information about what will happen, look at them carefully to see if they are still nervous or scared. If they are showing a high level of anxiety, see if you can guess what questions they might have and answer them or ask the support person for help (this can be the parent, guardian or a staff member).

Your questions may evoke subjects that the child cannot easily talk about. Ask questions that are easier to respond to. Once rapport is again established, return to more difficult questions. Remove obstacles in verbal communication by being patient and providing the child with other means of expression such as writing their answers, drawing what happened etc.

It is recommended that when a child comes to you, you offer them all of the possible languages in which to communicate i.e. play, spoken language etc. Many children speak and play at the same time. For older children, the counsellor needs to evaluate in which language the child communicates best. Some may prefer spoken language; others may prefer writing or even play.

2. Open Ended Questions

Children are often ignored – rather than talking with children, adults tend to talk about them. They are commonly left to sit quietly and are not engaged in conversations.

Counselling for children requires that children are asked questions, providing them with an opportunity to tell their own story and to describe how they are feeling. This may well be the first time in their life when they have been given such an opportunity and is an extremely important part of understanding and assessing the child's needs.

Asking children questions involves:

- Asking open ended questions, such as "Can you tell me about....?"
- Asking simple, straightforward questions
- Using words that they will understand
- A non-threatening, sensitive and caring approach
- Looking at things from the child's point of view
- Patience. Do not rush the child – he/she may need time to gain the confidence or words to reply to your question

3. Listening

In the same way that children are often not asked questions, they are often not listened to. Effective counselling requires that children are not only asked questions but that they are listened to. This may be an unusual experience for the child and the role of the counsellor is to show the child that you really want to hear what they have to say:

- Use positive body language to show the child you are really listening and that you are interested (e.g. maintain eye contact, lean forward, positive facial expressions)
- Make the child feel that she/he is the most important person to you at that time
- Encourage the child that you are listening by responding with Yes, OK etc
- Do not interrupt - wait for the child to finish talking
- Do not judge what the child is saying or show shock, anger or other negative emotions
- Observe the child's verbal and nonverbal behaviour

4. Clarify and Summarize

Children may find it difficult to articulate clearly what they are thinking and feeling. Counsellors therefore need to regularly clarify and summarize what the child has been saying in order to ensure that they have gained an accurate understanding of what the child is saying.

- Occasionally summarize what the child has been saying
- Ask the child to confirm that this is what he/she meant?
- If it is not clear what the child is saying, encourage the child in an open, friendly manner to explain further what he/she meant so that you really understand. Avoid discouraging them from talking further.

5. Empathy

Use of empathy in counselling children is an important technique for showing the child that he/she has your support. It helps to give them strength.

- Show the child that you understand what they have been / are going through
- Do not pity or sympathize with the child as this can make the child feel more helpless
- Help the child to realize their strengths

6. Providing Opportunities for Children to Express Themselves

As stated earlier, children may find it very difficult to talk and share how they are thinking and feeling. Creative, visual strategies are powerful tools for providing children with an opportunity to express themselves. In turn, these assist the counsellor to understand more about the child.

These techniques require time, commitment and the right attitude but if children are provided with these opportunities, the results are very rewarding.

Drawing

Drawing can be a powerful activity for opening 'hidden cupboards' in a child's life. It enables children to communicate their emotional state without having to put it into words. Most children enjoy drawing and it is a useful practical tool for counseling. When using drawing as a counselling tool, it is helpful to:

- Give the child different materials to use (e.g. pencils, pens, paints, crayons)
- Ask the child to draw something related to what you would like them to explore (e.g. ask them to "Draw a picture of your family having fun" or "Draw a picture of something that makes you angry")
- Gently follow up by asking the children to describe what is happening in their drawing
- Use 'open' questions to encourage them to talk more about what they have drawn and why (e.g. How do the people in the drawing feel about what is happening?)

Story Telling

Children tend not to like lots of direct questions or long lectures. When they are finding it difficult to talk about painful issues, listening to a story about someone in a similar position can be very comforting. It can give the children the sense of being understood, and it can help them to recognize that they are not alone. A story can also serve as a useful tool for problem solving around their own situation.

When using story telling as a counselling tool, it is helpful to:

- Use a familiar story, fable or folktale to convey a message to the child, perhaps using animals to represent humans
- Avoid using real names or events
- At the end of the story, encourage the child to talk about what happened e.g. ask about the message of the story to confirm that the child has understood its relevance
- If helpful, ask the child to make up a story, based on a topic that you give them e.g. Tell me a story about a little girl who was very sad.

Drama

Drama or role play is an excellent way for children – and friends, siblings and other family members – to raise issues they want to communicate with others, but find difficult to discuss directly. When using drama as a counselling tool, it is helpful to:

- Give the children a topic to perform – such as "A Day in my Life" – that is related to issues you want to explore with them
- After the performance, encourage each child to discuss what happened in the drama and what issues came up
- Ask questions to explore specific areas such as "What was the happiest / saddest part of the day?"

Play

Adults often think play serves no serious purpose. Yet play is an important way that children explore their feelings about events and make sense of their world. When children play, much of their activity involves imitation or acting out, which helps us to begin to understand what type of emotions they are experiencing.

When using play as a counselling tool, it is helpful to:

- Give the child a variety of play materials including simple everyday objects and toys
- Ask the child to show you parts of their life using the play materials e.g. "Show me what you like to do with your family". While the child is using the objects to show you, you can ask him or her also to tell you what is happening
- Follow and observe what the child is doing and do not take over the play. If you want to check that you have understood what the child is communicating, make comments e.g. "I see the mummy doll is so sick she cannot get out of bed" and see if the child agrees
- If the child gets stuck and cannot proceed further ask him or her questions such as "What is going to happen next?" or "Tell me about this person". Such questions can help them to continue.

Summary

Effective counselling requires assessment and understanding of the way an individual is thinking, feeling and coping with events in their life. When counselling children, there are

various factors which make this process difficult and thus act as challenges in effective counselling.

One of the most important skills required of child counsellors is the ability to overcome challenges in communicating with children. This then enables the counsellor to accurately assess and understand what the child is thinking and feeling and identify how best to meet their needs.

This is achieved with the use of child friendly counselling skills and techniques which are adapted according to the age, development and individual needs of each child.

Pre-Test Counselling for Children

Counselling Approach
It is recommended that the HTC provider meets with the parent/ guardian before meeting with the child. This is especially applicable to children under 7. However, other possibilities would be to either meet with the parent first, then ask the child's preference about meeting or else to meet with the parents and child first, before meeting separately.

Step 1: Introduction
In Step 1, the HTC provider should welcome the caregiver and the child. Introduce yourself and have the clients do the same. Explore reasons for the visit and the relationship between the caregiver and the child. Explain your role as the HTC provider and acknowledge the clients for coming for services. Explain confidentiality.

Step 2: Assessment
There are many questions to be asked in order to assess the child. Some of these questions include:

- What is the child's age and developmental stage?
- Who has decided the child should come in for testing and why?
- Who will provide consent for the child's test?
- What do the child and caregiver already understand about the child's situation?
- Why does the *child* think he/she has come to see you?

Naming HIV
Explore with the caregiver whether HIV should be named to the child. If the child knows he/she has come for an HIV test, proceed with communication which includes naming HIV. If the child does not know he/she has come for an HIV test, then reassure the child and inquire of the caregiver the reason for not informing the child about the test.

Step 3: Information Sharing
During the information sharing step, it is important to discuss basic information on HIV/AIDS at an appropriate level to child's developmental stage. Explain the importance of the test and how it will help; connect the explanation to the child's situation. If not naming HIV, then use the analogy of warriors and soldiers.

Explaining HTC to the Child
Speak to the child directly, in a non-judgmental, honest way. Explain that the test will give us important information about his/her health. You can say things like:

- "The immune system is your body's army"
- "Germs can invade the body and make us sick. This test will help us understand if germs are making you sick."
- "If you have these germs, medicine can help to make your body's army stronger."

Step 4: Decision Making Process
During Step 4, the decision making process, talk with the child openly and honestly and prepare the child for the test; do not just pounce on the child with a needle! Explain why

the test is important using age and developmentally appropriate explanations. Discuss feelings about the test, the meaning of a negative result, and the meaning of a positive result.

Step 5: Implementing the Decision
If a decision is reached to conduct the test, then proceed with the testing according to the SOPs. If the child/guardian decides NOT to test, then respect their wishes and reassure them. As well, revisit the discussion on the importance of the test.

How Should HTC Provider Approach Giving the Child a Blood Test?
The HTC provider needs to keep many things in mind in order to effectively approach giving a child a blood test. First, it is important to understand the possible impact of a blood test on the child, recognize and anticipate signs of distress in children having blood tests, and see events from the child's point of view. Remain non-judgmental and maintain a sensitive, empathetic approach to the child's fears and concerns. Avoid distractions which may prolong the experience. Give the child an opportunity to ask questions, involve the family / caregiver, and give choices where possible to empower the child with a sense of control over what happens.

Post-Test Counselling for Children

Step 6: Post Test Counselling and Discussion
Assess whether the child and/or the family are ready to receive test results. Inform the child and the caregiver of test results in an appropriate manner according to the child's age, developmental stage, level of understanding, and ability to cope with new information.

Disclosure in Child Testing and Counselling

Disclosure
Disclosure of HIV status to a child is based on the need to protect the best interests of that child at all times. It is carried out in partnership with the family / caregiver and respects their views and wishes. Disclosure is a process, beginning with the first contact with the child and planned together with the family/caregiver. The age at which disclosure is carried out is based upon each child's individual needs, understanding and maturity. The process may begin from 5-7 years. Disclosure is honest and does not involve lies.

Benefits of Disclosure
There are many benefits of disclosure. For one, it equips children with accurate, appropriate information in a way they can understand. It assists children to cope with the implications of their HIV status through greater knowledge and understanding. It empowers children by involving them in their care, promotes children's sense of self control and self-esteem, and reduces their anxiety. Disclosure assists children to make choices and decisions about issues which affect them and improve their quality of life, including adherence to treatment. It helps both the child and family adopt a positive attitude.

Barriers to Disclosure
There are also some barriers to disclosure. First is the belief that the child will not understand or be able to adjust and cope. There is the desire to protect the child (e.g. fears of stigma and discrimination). Parents often have the firm belief that disclosure will take away the child's hope and will to live. Service providers' attitudes can also be a barrier to disclosure. Another barrier is parental non-readiness (e.g. not yet ready to face questions, sense of fear and/or guilt). In addition, inadequate skills of service providers to inform a child or adolescent of HIV status can make disclosure difficult. There is also the fear of how the child will react, concern that the child will tell others, and the fear that the child may hate parents, especially in the case of mother to child transmission (MTCT).

What are Some Effects of Delaying Disclosure?
There are a lot of consequences to delaying disclosure. For one, the child is made more vulnerable as he/she is unable to understand events in his/her life, has no sense of control over things affecting him/her, may imagine things have happened/will happen and/or come up with the wrong conclusion, may blame him/herself for traumatic events, may be unable to trust adults, or may learn HIV status in a way that is not supportive. Also, in the unfortunate event of a parent's death, the opportunity for them to discuss the illness with the parent is now lost.

Types of Disclosure
There are two types of disclosure: full disclosure and partial disclosure. Full disclosure means naming and directly mentioning and disclosing HIV. It includes disclosing all information on transmission and prevention of HIV as well as CD4 counts and viral load, ART, and adherence. Partial disclosure is a gradual, step by step process that may begin in early childhood of giving information that will one day end up by disclosing full and actual HIV diagnosis.

Preparing for Disclosure
In order to prepare for disclosure the parent/caregiver and the HTC provider must ask: Is the child ready for disclosure? Disclosure may begin as early as 5 years, however age alone is an unreliable indicator for the "right" time to choose. The other question is: Is the parent/guardian ready for disclosure? If he/she is not ready, then counselling should continue at each contact with the family. If he/she is ready, then discuss and confirm with the caregiver exactly what will be said to the child.

Explaining Negative Results
If the child and caregiver have confirmed that they are ready to receive the test results, the HTC provider must state clearly: "The test result is negative. This means that you do not have HIV infection". Inevitably, it is considerably easier to give the child and caregiver a negative test result. Inform them that the test has confirmed that the child does not have HIV infection. Ensure that they understand what this means, provide them with an opportunity to express themselves and to ask any questions they may have. It is essential that children in the window period for infection (e.g. sexually abused or sexually active children) are aware that the test will need repeating. Children who are sexually active need

considerable counselling about the continued risks of HIV infection. Legal issues must be handled carefully and appropriately.

Discussion - Negative Result

When giving a negative test result, ensure that the child and/or caregiver has further opportunities to discuss the meaning of the negative test. Address the ongoing counselling needs of exposed children, including infants and caregivers, and those in the window period.

Explaining Positive Results

If the child and caregiver have confirmed that they are ready to receive the test results, the HTC provider must state results clearly to the caregiver clearly by saying, "(Child's name) is HIV positive. This means that (name) is infected with HIV." Confirm the disclosure plan in terms of when and how to tell the child. State results clearly to the child by saying:

- "The results of this test say that you have an illness. What do you know about germs and illness?"
- "[When child is ready] The name of the germ/virus you have is HIV. What do you know about HIV?"
- "HIV can harm healthy cells that protect you from sicknesses. Medicines can help keep you healthy."

Give the child and caregiver time to absorb the information and time to respond. It is extremely important to help the child feel that he can react as he wishes. If the child wishes to cry, reassure the child that he may do so. Be prepared for different responses. Whilst some children may remain quiet, withdrawn or shocked, others may react by crying or become angry. Whatever the response, the child is extremely vulnerable and needs immense support.

Positive body language, such as sitting next to the child, holding the child's hand, and talking directly to him, is vital at this point as it clearly demonstrates to the child that you are there to support and care for him/her. Equally, whilst the caregiver will have his/her own emotions, the caregiver should be encouraged to support the child at this moment.
Do not rush the child by moving on with more information and discussion – give him time. When the child has had time to think about the test result and time to respond, gently move on to the third step of post-test counselling, the Discussion.

Discussion - Positive Result

Ask the child whether he understands what the positive HIV test result means. Encourage him to express himself and be sure to clarify any misunderstandings. The child may now have many questions and these should all be encouraged. Common questions include:

- Does this mean that I am going to die?
- What will happen to me?
- Who else is going to know I have HIV?
- How did I get it?
- Why did no one tell me before?

Always respond openly and honestly. Be careful what you promise. Answer questions by reinforcing the explanations you used in the pre-test counselling session. Remind them of what you talked about then.

In particular, reassure them that they are not alone, that they are loved and will be taken care of. Remind them that there are many other children their age who also have HIV infection and that they are strong and well because they are taking medication.

A challenge for HTC providers at this stage is the time involved in meeting the child's needs. Some children may require considerable time according to their need for immediate emotional support. This is a difficult dilemma as the HTC provider will know that there are children waiting to be seen who also have considerable needs, yet do not want to turn the child away at this vulnerable time.

How Might the Child React?
All responses are appropriate and the child must be given time to absorb what he has been told and to then express how he is feeling. The child may have already suspected his/her diagnosis or may be completely shocked. Responses will differ from one child to the next. Different responses may include: quiet and withdrawn; crying; accepting, matter of fact; asking lots of questions; relief as they can now make sense of experiences; wanting to get on with other things; anger; and/or surprise, shock.

Often, after disclosure occurs, children do not have any questions at first. Many need to process what they have been told. Ideally a clinic visit or counselling session or home visit should be scheduled shortly after the disclosure to assess how the child and family are coping.

The child should be allowed to meet privately with a member(s) of the health care team. Often children have questions that they do not feel comfortable with the parent present – this is no reflection on the quality of the relationship. Children are very protective of their parents and withhold certain questions as they fear upsetting their parent/caregiver. Even if children have no response when disclosed to, they should be reassured that the team is there to help them stay healthy and to deal with their illness. Whenever possible, they should be given positive messages that their family and the health care team will be partners in caring for them.

Follow Up Counselling Post Disclosure
Provide opportunities for the child and family to gather more information, gain further understanding and express difficulties they are facing. Help the child to know who he/she can talk to. Regularly assess the child's understanding of his/her condition, potential coping difficulties (e.g. behaviour change), and link with other social and spiritual support services, including socializing with other children.

Planning the Way Forward

The final stage of post-test counselling involves planning the way forward for the child and their caregiver. HIV negative children may not need any follow up counselling regarding HIV infection. However, counselling may have identified that the child has other significant

physical, social, emotional, spiritual and mental needs. The HTC provider has a responsibility to ensure that these are addressed through follow up care and support and appropriate referral. For children testing HIV positive, this final step of post-test counselling represents the first step in ensuring that the considerable follow up care and support for the child and caregiver is planned.

Why is Ongoing Counselling Important?
Ongoing counselling is important because it helps children to: adjust and cope with situations they face as they grow older; face new challenges and manage their emotions; develop coping strategies to minimize negative impact of situations they face; and make decisions to improve their quality of life.

It serves to equip children with accurate and appropriate information in a way they can understand and empower children by involving them in care. On-going counselling can assist children to develop goals and recognize and build on their own strengths. As such, it helps to promote children's sense of self control and self-esteem, thereby reducing anxiety.

Common Counselling Areas
Common counselling areas include difficulties coping with how one became infected, coping with stigma and discrimination, disclosure, grief and bereavement counselling, fear and uncertainty about the future, developmental issues, and lack of family support and love and a sense of burden on other relatives.

Types of Referrals for Children
Types of referrals for children include medical care, treatment and support; social welfare support and assistance; peer support groups, and multidisciplinary liaisons. The course of HIV infection varies between different children. One child may progress very quickly and become sick with opportunistic infections within the first few months of life. These children are sometimes known as 'rapid progressors.' Other children may remain relatively well for several years, only becoming unwell in early childhood or as late as 9 or 10 years of age.

Where children have acquired HIV infection later in childhood (i.e. not through MTCT) they may remain well and only present with opportunistic infections in their adolescent years. At whatever stage the child starts becoming unwell, he commonly has to endure painful and frequently debilitating illnesses. This not only has a physical impact on the child but leads to immense emotional stress on the child and their caregiver. Similarly, frequent medical procedures can cause physical and emotional stress. All HIV positive children require referral for medical care and treatment. Antiretroviral drugs have had a dramatic impact on the prognosis for children with HIV. However, their effectiveness is dependent on strict adherence to the drug regimen. The need to adhere to these drugs has major psychosocial implications for children and their caregivers. Children taking ARVs require extensive supportive counselling by counsellors/ health care providers like clinicians, nurses who have been trained in Antiretroviral Therapy for children.

Referral for social welfare support and assistance
It is important that HTC providers have established links with social welfare and other support services. Very commonly the HIV positive child and their family will have significant social challenges. The child's family may lack sufficient resources to provide the care that

the child needs including the costs associated with transport to clinic, medication and medical fees. Basic needs such as adequate nutrition may not be met. Furthermore, frequent illness and hospitalization commonly results in HIV positive children falling behind at school or dropping out of school completely. This has profound effects on the child's educational needs but also on their emotional need to feel like their peers and to realize their own potential. It is often very difficult to 'solve' the child's social difficulties but with appropriate referral, it may be possible to alleviate some of the stressors on the children and families.

Peer Support Groups
As children grow through childhood, they develop a strong need to be like their peers. An HIV diagnosis leads children to feel that they are different, to feel isolated and afraid. Peer support groups are a powerful follow up counselling, care and support strategy for any HIV positive child. The groups provide children with an opportunity to socialize with others who share similar experiences and difficulties in life in a safe, supportive, trusting environment. Depending on the activities of the support group, children can benefit from group and /or peer counselling and learn essential skills for living positively. Children's natural desire for normal physical and emotional relationships starts to develop as children develop through adolescence. Those with HIV therefore become increasingly aware of the implications of their HIV status and begin to develop fears about the future. How will they meet a boyfriend / girlfriend? What will they tell him/her about his/her HIV status? Can they have an HIV negative partner? Will they be able to have children? At a time when the adolescent should be planning and looking forward to the future, the future is full of uncertainty and fear. Again, peer support groups provide a safe environment in which these issues can be explored.

Multidisciplinary Liaison
Due to the diversity of the needs of HIV positive children, multidisciplinary teamwork is essential. Principles of confidentiality and the need to protect the child's best interests at all times must be adhered to.

Key Points

- A child is defined as any individual below the age of 18 years
- Age and developmental stage determine how you counsel child
- A child is defined as any individual below the age of 18 years
- Age and developmental stage determine how you counsel child
- Every child has the inherent right to:
    - Life
    - freedom of expression, including freedom to seek, receive and impart information and ideas
- It is important to remember that a child's positive HIV status at any age may be assumed to mirror that of the parents and can result in the family being stigmatized
- With early diagnosis and ART children can lead happy, healthy lives
- Child's readiness for disclosure depends on:
    - Family wishes and available support post-disclosure
    - Age and developmental stage
    - Child's current needs and experiences

Module 5: Practice: HTC for Children Role Plays

Scenario # 1: Philip: Philip is 9 years old. He has been brought to see you by a carer from the children's home where he lives. The carer informs you that he has been unwell and that she has brought him for a blood test.

Scenario # 2: Kondwani: Kondwani is 4 years old. She is brought in to see you by her Aunt. Kondwani is crying and trying to leave the room. The Aunt informs you she has been looking after her since her father died 6 months ago. Her father was HIV positive. She would now like Kondwani tested to establish whether she is also positive.

Scenario # 3: Mercy: Mercy is 3 years old. She arrives with her mother who has brought her for HIV testing. The mother learned that she was HIV positive 6 months ago and would like to have Mercy tested for HIV.

Scenario # 4: Alice: Alice is 7 years old. Both her parents are deceased and she is living with her maternal aunt. Alice is well with no significant health problems reported but her aunt would like her to be tested for HIV as that was the cause of her parents' death. During your conversation with the aunt, Alice continually re-enters the consulting room asking what you are talking about.

Scenario #5: Ruth: Ruth is 9 years old. She is brought to see you by one of the carers at the local Children's Home. The carer informs you that Ruth is an orphan and has been staying with them for the past three months. In that time, she has had recurrent episodes of diarrhoea and is rapidly losing weight. Whilst her previous medical history is unknown, Ruth informs you that she has been sick on and off for many years. The carer tells you that the Children's Home had phoned your health facility to organize for Ruth to come for a blood test. Ruth appears to be shocked by this news and asks you what the blood test is for.

Module 5, Unit 5.4: HTC for Adolescents and Youth

Learning Objectives

By the end of this unit, you will be able to:

- List key tips for working with adolescents and youth
- Describe specific needs of adolescents & youth
- Define the age of consent
- Explain why adolescents and youth are particularly vulnerable to HIV
- Demonstrate use of the appropriate protocol for conducting pre and post-test counselling

Overview of HTC and Youth, Interacting with Youth

Definition of Adolescent and Youth

Type of Child	Age
Infant	Less than 12 months
Young child	1 - 5 years
School age child	6 - 9 years
Adolescent	10 - 14 years
Youth	15 - 18 years

HTC and Youth

Most adolescents and youth become infected through sexual contact and the majority of youth have experienced sexual intercourse by age 15. Young teens are less likely to be protected from the consequences of intercourse as their caregivers often do not want to recognize that they are sexually active.

Interacting with Adolescents and Youth

When interacting with children, find a fun relaxing activity to do together with them, such as discussing a magazine or an interesting object. For adolescents and youth, find out about their interests such as sports or music or ask them about their likes and dislikes.

Needs of Adolescents/Youth: 10 to 18 Years

Teenagers are complex. They are still defined as 'children' yet their needs are rapidly evolving as they progress towards adulthood. They are in a transition period in which their personality is developing and they begin to learn the skills to cope with adulthood. Their need to conform to peers is often a strong desire during this stage. It is a period of possible conflict as they learn to prepare themselves and make decisions about their lives ahead.

Those who feel confident and able to trust others with their feelings may discuss them openly whilst others may feel that no one will understand them and attempt to deal with these emotions alone. Adolescents/youth need considerable support. They need:

- Opportunities to develop personality and sense of purpose in life
- To feel a sense of belonging and acceptance by peers
- Open, honest communication with those they can trust
- Strong support networks

What are Some Tips for Working with Adolescents and Youth?
There are a variety of ways to increase the effectiveness of your work with adolescents and youth. It is important to ensure a youth friendly environment; if resources are available, then the availability of music and TV work well. Remember that youth work better in groups, so try to have group education sessions rather than individualized ones. Have them sit in a circle when working with them, listen, and use examples they can relate to such as examples of celebrities that they look up to. Also, encourage them to come with their partners.

Communicating with Adolescents and Youth
When communicating with adolescents and youth try to be non-judgmental, not commanding and prescriptive; be open to discussion, do not impose adult values; focus on the person in front of you, never compare adolescents; and do not assign blame. Finally, avoid interrupting the adolescent; listening is very important!

Consent

The age that a child can consent for his or her own test is 13 years. Mature minors are the exception to that rule. They are children aged 10-12 years old, married, or sexually active. Regarding medical management of children without guardians, the guidelines advise, "In the event that a child has no guardian, it is the responsibility of service providers to consent on behalf of the parent/ guardian to test children aged less than 13 years for the purpose of medical management." (*HTC Guidelines, 2008*).

Adolescent and Youth Vulnerability to HIV

What Risk Factors Increase Adolescent Vulnerability to HIV?
There are a variety of risk factors which can increase an adolescent's vulnerability to HIV. These include: early sexual activity, early puberty and later marriage which lengthens the potential window for premarital sex, biological vulnerabilities of young women, lack of knowledge relating to SRH, and lack of skills to negotiate sexual behaviour including condom use, and sexual coercion and violence. In addition, transactional sex (exchange for money or gifts for sex), cross-generational sex, alcohol and drug abuse, and societal discomfort around teen sexuality (parents and other adults) are also risk factors.

Youth Vulnerability
The highest number of people infected with HIV is in the group aged 17 - 25 years. Young people are the most sexually active and the most vulnerable to HIV infection, are highly hormonal and likely to experience and act on sexual attraction, and have low perception of HIV risk. They are often experiencing freedom from parents and educational institutions for the first time, and they are prone to peer pressure and influenced by media (especially social media). Young people have easy access to alcohol and substance abuse and are more likely to engage in transactional and intergenerational sex. All of this increases their vulnerability to HIV.

Risk Reduction
In order to reduce risk, adolescents need basic information about: puberty, relationships, sexual health and how to keep themselves safe. It is important for the HTC provider to provide clear and frank information about condom use, showing love and affection in a non-sexual way, and discussing HIV and STIs with a partner. It is important to help them identify support for healthier behaviours and agree on a plan for reducing risk.

Pre-Test Counselling

Review: Steps of Pre-Test Counselling
Compare the steps in CITC with the steps in child HTC for pre-test counselling.

Child Protocol:
1. Introduction
2. Assessment
3. Information Sharing
4. Decision Making Process
5. Implementing the decision (testing)

CITC Protocol
1. Introduction/Orientation to the session
2. Risk assessment
3. Risk reduction
4. HIV test preparation
5. Test procedures

Post-Test Counselling

Review: Steps of Post-Test Counselling
Compare the steps in CITC with the steps in child HTC for pre-test counselling.

Child Protocol:
6. Post-Test Counselling and Discussion

CITC Protocol

6. Test results
7. Risk reduction plan
8. Disclosure and referral

Disclosure

Review: Types of Disclosure
There are two main types of disclosure: full disclosure and partial disclosure. Full disclosure involves naming and directly mentioning and disclosing HIV. It includes disclosing all information on transmission and prevention of HIV, as well as CD4 counts and viral load, ART, and adherence. Partial disclosure is a gradual, step by step process that may begin in early childhood of giving information that will one day end up by disclosing full and actual HIV diagnosis.

Review: Preparing for Disclosure
When preparing for disclosure, it is important to ask whether the child is ready for disclosure. Disclosure may begin as early as 5 years, however age alone is an unreliable indicator for the "right" time to choose. It is also important to figure out whether the parent/guardian is ready for disclosure. If he or she is not ready, then counselling should continue at each contact with the family. If he or she is ready, then discuss and confirm with the caregiver exactly what will be said to the child.

Strategies to Increase the Number of Adolescents/Youth Getting Tested
There are a variety of strategies that HTC providers can use to encourage adolescents and youth to get tests. These can be divided into three categories: provider and staff, policies and procedures, and environment and facilities. Regarding providers and staff, it is helpful if the: staff is friendly and responsive to youth clients; staff is respectful to and ensures privacy of youth clients; and the staff is understanding of and knowledgeable about youth concerns and needs. It is important that the staff is specially trained to work with youth, and that the counsellor and medical providers spend enough time with youth clients. Staff should also make sure that the information on need for and timing of follow up visit(s) is provided and clear and that peer counsellors are available.

Regarding policies and procedures, it is helpful if youth drop-ins are welcome and accommodated; services are offered to both male and female clients; and that the facility provides informational and/or audiovisual materials on RH services and concerns of youth clients. Facilities should also make sure that group talks/discussions available, services are linked to other youth services, program network and necessary referrals are available, and that the cost of RH services is affordable.

Regarding the environment and facility, it is helpful if ARH services are provided at convenient (and separate) hours for youth clients; the décor and surroundings are inviting to youth clients; counselling and examination rooms ensure privacy for youth clients; and facilities are conveniently located for youth easy access. In addition it is important that education materials are displayed and available to youth clients to take away; that peer youth education outreach programmes are available; that youth are involved in decision

making on youth friendly services provision; and that the community is informed about the benefits and availability of youth friendly services.

Key Points

- The age of consent in Malawi is 13; however, mature minors can consent before this age
- Adolescents and youth are particularly vulnerable to HIV
- Adolescents/youth need basic information about:
    - Puberty
    - Relationships
    - Sexual health and how to keep themselves safe
    - Condom use
    - Showing love and affection in a non-sexual way
    - Discussing HIV and STIs with partner

Module 5, Unit 5.4 Handout: Scenarios for Disclosure

Client Scenario 1

Elton is 14 years old. He has been attending your clinic for ARV treatment since two years ago. He lives with his mother who is also on ARV treatment but has had great difficulties coming to terms with her own HIV status and that of Elton. She has always made it clear she does not want anyone to know their status and Elton must not be told. She feels he is not yet ready as he does not ask any questions about why he comes to clinic or takes medication.

Client Scenario 2

Thandie is 12 years old. She was sexually abused by her father four years ago and infected with HIV. Her father is now late and Thandie lives with her mother who is HIV negative. Thandie is well and not yet on ARVs but is being monitored closely. Her mother has informed you in the past that she is terrified of the day when she has to inform her daughter of her HIV status. Today in your clinic, Thandie's mother informs you that Thandie has started asking many questions about why she must come to clinic when she is so well.

Client Scenario 3

Mercy is 13 years old. She is on ARVs but doesn't know why she takes them. She is an orphan living with her aunt. She is brought to your clinic because the aunt feels it is high time Mercy knows why she takes the medication. The aunt does not want to be available/present during the session. She wants you to disclose to Mercy.

Module 5: Practice: Scenarios for HTC for Adolescents and Youth

Scenario #1: Chikondi
Chikondi is 15 years old. She has attended your facility alone, requesting an HIV test. During pre-test counseling, she shares with you that she has a 17 year old boyfriend but reports that they are not having a sexual relationship.

Scenario #2: Monica
Monica is 16 years old. She has come to your facility with her father. Her mother died 3 years ago with TB. Monica's father explains that she completed TB treatment 4 months ago and was recently treated at the local clinic for Herpes Zoster. He informs you that they were referred to you for HIV testing. Following your suggestion, Monica's father agrees to leave the room while you talk with Monica alone. She then becomes very distressed, informing you that she does not want an HIV test. She tells you her father treats her very badly.

Scenario # 3: Chifundo: Chifundo is 14 years old. He lives on the streets and has been brought to you by two members of a CCAP church who have come to know him through their street children feeding programme. They are concerned about his health as they have observed he suffers with recurrent skin infections, continues to lose weight and now has herpes zoster. Whilst Chifundo waits in the waiting room, they ask you if he could be tested for HIV.

Module 5, Unit 5.5: HTC for At-Risk Groups

Learning Objectives

By the end of this unit, you will be able to:

- Explain how to counsel specific at-risk populations, including MSM, sex workers and the persons with disabilities
- Identify key messages for at-risk populations
- Identify barriers to accessing HIV services

Overview of Counselling At-Risk Populations

Recognize that your role as an HTC provider is to advance a public health imperative. Seek to expand your knowledge on at-risk populations. Avoid being judgmental about the choices a person has made – do not take a moral or religious position (such as homophobia). Do not ask why the client has chosen a particular life style.

Counselling Sex Workers

Key Facts about Sex Workers

HIV incidence among sex workers in Malawi stands at 0.5%; partners of clients of sex workers have the highest incidence rate at 6.3%. Poverty underpins transactional sex– most women engage in sex work to feed themselves or their families. Note that the risk of contracting HIV is compounded by gender inequality, sexual violence, drug and substance abuse, and the inability to negotiate safe sex practices.

Key Messages for Sex Workers

Emphasize condom use with every partner and encourage the use of lubricants. Help sex workers strengthen their ability to negotiate for safer sex including condom use. Emphasize the need for regular STI and cervical cancer screening and couple/partner testing for regular sexual partners.

Counselling Men Who Have Sex with Men (MSM)

Key Facts about MSM

There is an HIV incidence of 4.3% for MSM in Malawi. MSM may be gay men, bisexuals, non-gay MSM, or MSM sex workers. Those who practice anal sex are vulnerable to HIV infection.

Barriers to HIV Services for MSM

There are a variety of barriers to HIV services which MSM may face. These include: high stigma and discrimination; legal, political, religious and socio-cultural resistance; hostility and intolerance from the community; services are denied, unique needs are ignored; and fear amongst the population that MSM are the drivers of the epidemic.

Key Messages for MSM

Key messages for MSM include encouraging couple/partner testing and knowing the status of your partner and recognizing that that some MSM have more than one sexual partner. Explain that MSM who are the *recipient partner* are at higher risk for HIV and STIs than the *penetrating partner.* Refer MSM for STI screening– many STIs can also present anally. Emphasize condom use for EVERY sexual act whether anal, oral or vaginal. Explain that for anal sex, condoms MUST be accompanied by water-based lubricants because the anus is not self-lubricating (like the vagina); lubricants decrease the likelihood of condom breakage. Tell clients to avoid oil based lubricants because they destroy condoms. Focus on ***reducing risk***: encourage steps from current behaviour toward lower-risk behaviours.

Counselling Disabled Persons

Disability is a condition which makes an individual unable to function normally in a particular social-cultural context (Source: WHO). The disabled include the hearing impaired, the physically impaired, and the visually impaired.

Challenges Faced by the Disabled in Accessing Health Services

Challenges for the Hearing Impaired

The hearing impaired may face certain challenges when accessing health services. For example, they may communicate with sign language and not many HCWs are able to sign. Also, they have limited access to radio/TV education campaigns. Communication challenges may include lack of privacy and confidentiality—interpreters may be family members; interpreters may not be available (and costly); it may be difficult to request condoms without an interpreter; and they also may be vulnerable to verbal and sexual abuse.

Challenges for the Visually Impaired

In addition, the visually impaired may face certain challenges when accessing health services. For example, they may have difficulty accessing information as there are few materials in alternative formats like braille, audio tapes and large print. Some may never learn to read, as reading braille requires specialized education. They may also encounter a lack of privacy as they may need an escort to the clinic.

Challenges for the Physically Impaired

There are also challenges for the physically impaired. First, health facilities may be inaccessible to the physically challenged. Lack of mobility aids (wheelchair, walker) to facilitate travel to community clinics can also pose a challenge. Finally, long distances and lack of accessible transportation may limit access to testing, condoms, and community forums on HIV prevention and care. The physically impaired may experience increased vulnerability due to: unsafe sex, lack of knowledge/education, lack of access, poverty, societal perceptions and stigma, lack of information, poor laws and policies related to HIV, and/or lack of confidentiality.

Key Points

- Everyone has the right to health, equality, and non-discrimination
- Do not be judgmental about people's choices
- Poverty underpins transactional sex– most women engage in sex work to feed the family
- MSM may be gay men, bisexuals, non-gay MSM, and MSM sex workers
- It is important to be aware of the special needs of the disabled in providing services

Key considerations for offering HTC services to persons with disability

Welcome and Orientation to the Session	For all PWDs, explore reasons for coming to the clinic—do not assume they have come for HTC only For the Hearing impaired • If possible, identify a counselor familiar with sign language. • Ask if the client is willing to communicate by writing (if yes, use writing during the entire session) For the physically impaired • Reorganize the sitting arrangement according to need. • Give ample time for the client to get settled and feel comfortable. For the visually impaired • Ask if the client would like to be seen with a guide. • If s/he chooses to be seen alone, explain each step of the HTC process (i.e. I will perform a finger prick and get a few drops of your blood) as this will help the client to feel comfortable with the process.
Risk Assessment and Risk Reduction	• Perform a complete risk assessment—do not assume that the PWDs are not at risk . Give complete information about HIV, as with any client. • Clearly explain what positive and negative results mean. • Do risk reduction plan
Test Preparation	• Clarify confidentiality and confirm with the PWD if s/he wants to be tested and get results alone. • Explain procedures i.e. fingerpick and amount of blood needed. Use job aides such as posters /pictures/charts to help client fully understand the procedure and results especially for the hearing impaired. • For visually impaired: explain everything you do and devices you are using (i.e. I will use a spirit swab to sterilize your finger, I will use a lancet to prick your finger, I will use a capillary tube to collect blood from your finger). Where possible allow the visually impaired person to touch devices. Be careful to avoid contamination of devices • For clients with low vision, use a magnifying lens or large print result interpretation chart
Perform Test	• Revisit procedure, prepare for finger prick and amount of blood needed, explain what a positive or negative result means. Get confirmation that they understand. • While test is running, allow clients to express any concerns and respond to them. • For visually impaired, give condom and penile model to the client and walk them through the process by describing each step and allowing them to do it themselves. • Fill in a data form. Inform the visually impaired client what you are doing.

Post-Test Intervention	• Ask if the client is ready to receive results. Use magnifying glass, or braille cards to help the client understand the results. • Give PWD time to reflect on the results whether positive or negative. • Give ample time to PWD to share plan of action on risk reduction. • Check what the client understands by the results • Give ample time for questions and clarification • Give PWD information to PWD and ensure it is well understood. • Revisit other services available in the facilities for clarity and access.
For Negative Results	• Explore and acknowledge client's immediate feelings, concerns and offer support. • Review implications of being HIV negative and risk reduction plan. • Revisit window period. • Encourage client to disclose. • Offer condoms
For Positive Results	• Explore and acknowledge client's feelings, fears, concerns and offer necessary support. • Review implications of being HIV positive. • Discuss positive living • Encourage disclosure. • Offer condoms. • Help client come up with a SMART action plan for risk reduction and positive living.
Referrals and Linkages	• Refer client to PWD friendly facilities and confirm with contact person(s) before releasing the client. • The referrals should be specific to the services needed and must be well documented. • Follow-up must be done to all the PWD clients after referral and outcome of the referrals documented

Module 5: Practice: Scenarios for HTC for At-Risk Groups

Client Scenario #1: Mary
Mary is a 16 year old girl. She comes to your HTC for testing. When you ask her about her HIV risk, she explains that she is paid for sex. She uses her money to support her two younger siblings. She sometimes uses condoms with her clients. She also has a boyfriend who she has been with for the past 6 months. *[Mary tests HIV negative]*

Client Scenario #2: Pumani
Pumani, 25 years, is a single man who is not married and has no children. When the HTC provider is in the room with Pumani, he explains that he is concerned about HIV because he sometimes has anal sex with men. *[Pumani tests HIV positive]*

Client Scenario #3: Elisabeth
Elisabeth, a 42 year old woman, is blind. She comes to the HTC with her 20 year old daughter. Her husband recently passed away. Her daughter has encouraged her to test. *[Elisabeth tests HIV positive]*

Module 6, Unit 6.1: QA for Counselling

Module Introduction: Overview of Quality in HTC

There are several aspects of quality HTC including accuracy of test results, accessibility of HTC, the interaction between the client and the HTC provider, and ensuring privacy. This module will cover QA for counselling, QA for testing and QA for personnel.

All sites should have at least 2 trained, certified HTC providers, 1 private counselling room with proper furniture and space four in-session testing, secure storage space for reagents, and consumables, an appropriate was disposal system, and good lighting and ventilation.

Learning Objectives

By the end of this unit, you will be able to:

- Define quality assurance in HTC
- Explain the importance of HTC quality assurance
- Identify quality assurance issues in counselling
- Describe quality assurance measures to ensure quality counselling
- Describe key human rights issues for counselling adults and children

Quality Assurance for Counselling

What is Quality Assurance?

Quality assurance is a system to ensure that standards are being met. It involves looking at: accessibility of services; interpersonal relationships; privacy, which includes confidentiality of client information and infrastructural privacy; technical competence (service provider skills), and referrals - to ensure comprehensive services. Additional dimensions of quality include effectiveness of services offered, efficiency of service delivery, safety, and physical infrastructure & comfort (amenities).

Monitoring the Quality of Counselling

During the training, we measure your skill in counselling through observation of role plays (and observation of actual counselling sessions) using the Observation Checklist as well as through the written examination. After the training, your counselling skills will be measured through: peer observation and feedback, MoH supervision visits, and client satisfaction surveys. An HTC update training will be offered to ensure that HTC providers understand emerging issues. Ensure that your logbook is updated after each supervision visit and training.

National Guidelines for HTC

The key to achieving quality is having a shared set of standards. HTC Guidelines lay out those standards in a clear and straightforward way. They serve as a reference tool to use as

questions arise, and they cover the key areas of HTC (counselling, testing, personnel and site management).

Counsellor Logbook
Actively tracking key aspects of your practice is also key to quality assurance. Every HTC provider should have his/her own logbook and keep it updated. There are several sections in the counsellor logbook, including the Duty Station Log, HTC Training Log, Monthly Activity Log, HTC Sit-in Observation Log, and the Proficiency Testing Record.

Ensuring Quality HTC
Every HTC provider should ensure a 1-to-1 counselling session appropriate for the client's circumstances, give the right facts about HIV and HIV testing, and make correct recommendations for retesting based on the client's risk as most people who test negative do not need frequent retesting. HTC providers should also speak with a senior counsellor to seek answers to their questions and make sure that they are performing well.

Ethics and Human Rights for Adults and Children

WHO Ethical Code
The WHO ethical code includes the following components: confidentiality, competence, consent, respect for human rights, appropriate personal conduct, and integrity.

Confidentiality
Maintain good records and take all reasonable steps to preserve confidentiality. You should not give any information out without permission from the client. Communicate confidentiality guidelines clearly to the client so he/she knows what to expect and be aware of laws governing counselling.

Competence
It is important for you to be responsible for your own safety, effectiveness, competence and conduct. Ensure that you have received required training, monitor your own competence through supervision or consultative support, and recognize your own boundaries and limitations. Make appropriate referrals to assist the client when you do not have the expertise to do so.

Consent
Client must give consent for CITC and PITC; the client always has the right to refuse testing. Informed consent means giving the client enough information about HTC process to make a decision. Recognize clients who cannot give valid consent due to mental state, age or disability. Also, recognize the right of clients to withdraw consent at any time.

Informed Consent for a Child
For children under 13 years, the parent or guardian must be given an opportunity to weigh benefits and potential difficulties associated with knowing the child's HIV status. He/she should also understand the testing procedure and ensure that the child (if appropriate age) has a good understanding of treatment and support available after testing. HTC providers must respect decisions made by the parent or guardian.

Respect for Human Rights
It is important to recognize the dignity and worth of all people. The HTC providers should provide fair, supportive services to all regardless of race, culture, religion, values, or belief systems. Be aware of personal prejudices and do not let them affect quality of counselling, avoid discriminatory practices, and ensure that clients suffer no physical or psychological harm during counselling.

Appropriate Personal Conduct
Behave in a way that does not damage the interests of clients or undermine confidence in services. Maintain respect for clients by putting their needs ahead of your own. Refrain from counselling when your judgment is impaired from alcohol, drugs or any other reason. Be professional and presentable in dress and manner.

Personal Conduct with Children
The best interests of child should always be a primary consideration; when facing ethical dilemmas, ask: what is in the best interests of the child? If the HTC provider acts in the best interests of the child at all times, then the child will be protected and legal and ethical principles will be upheld.

Integrity
Promote integrity through honesty, fairness, and respect for others. It is never acceptable to engage in sexual relationships with clients. Do not counsel clients with whom you had a sexual relationship in the past.

Key Points

- QA = is system to ensure standards are being met
- To provide quality counselling, HTC providers should:
    - Ensure a 1-to-1, client-focused counselling session
    - Give correct information about HIV and testing
    - Make correct recommendations for retesting
- Quality counselling means incorporating components from the WHO ethics code:
    - Confidentiality
    - Competence
    - Consent
    - Respect for Human Rights
    - Personal Conduct
    - Integrity

Ethics in Practice: Scenarios

1. Your client is HIV+. He has told his parents and other family members but does not want his wife to know. His wife comes to you because she has heard rumours and wants you to tell her husband's HIV status.

2. A couple come to you bringing their 17-year-old daughter and 50 year old man for an HIV test. The daughter was defiled by the man last week. Neither the daughter nor the man wants to be tested but the parents insist.

3. Your sister in law asks whether she can come to you for an HIV test. She is one of your closest friends.

4. You find yourself attracted to one of your clients. They are clearly attracted by you and you are both single and unattached.

5. You have counselled a very depressed person who threatens to commit suicide that evening if their test results are positive.

6. You strongly disapprove of homosexuality. A gay man comes to you for counselling.

7. You have recently been bereaved. You feel terrible and want to cry all the time. You know that clients are waiting for counselling.

8. A client comes to you who tells you he hasn't eaten for several days and that he has no money. He asks you for help.

9. A young woman comes to you for counselling. She tells you she is 14 years old.

10. A person comes for counselling and testing who you have had a sexual relationship with in the past.

Module 6, Unit 6.2: Quality Assurance for Testing

Learning Objectives

By the end of this unit, you will be able to:

- Explain the meaning of quality in HIV testing
- Describe some challenges of HTC delivery
- Outline consequences of HIV testing errors
- Describe how to overcome these challenges and consequences
- Explain what proficiency testing is

Overview of Quality in HTC

Review: What Do We Mean by "*Quality*" in HIV Rapid Testing?
Quality in HIV rapid testing means that clients receive accurate test results within a reasonable time period. This requires: available test kits and supplies in good condition; the right type and amount of proper specimens collected; proper handling of specimens; following standard test procedures; and accurately interpreting, recording, and reporting results.

Review: Why Do Errors Occur?
Errors can occur for a variety of reasons including: individual responsibilities are unclear, there are no written procedures or written procedures are not followed, or training is not done or not completed. In addition, errors can be caused because checks are not done for transcription errors, test kits are not stored properly, QC and EQA are not performed, or equipment is not properly maintained. Another problem that can arise is that timing is not done properly, for example through the use of cell phones as timers. Errors can occur throughout the testing process.

Challenges in HTC Delivery
Common challenges in HTC delivery include HTC providers not following SOPs or else confusing SOPs for Determine and UniGold (e.g. amount of sample, drops of reagent, timing), not depositing enough blood on the test strip, and/or not dealing appropriately with discordant results. Be aware of these common mistakes– they can all lead to wrong test results.

Can Someone With a Previous Positive Test Outcome Have a Negative Test Outcome Today? Case 1.
Case 1: An infant is born to an HIV infected mother and is tested with a rapid test before age 12 months. The infant has a positive test because the mother's HIV antibodies remain detectable in the infant's blood for up to 12 months. However, the infant tests negative once the mother's antibodies are lost (if the infant did not get infected). This is not a mistake; the infant should have been given the result "exposed" when first tested, rather than "infected."

Can Someone With a Previous Positive Test Outcome Have a Negative Test Outcome Today? Case 2.

Case 2: An adult receives a positive antibody test. Six months later, the same person receives a negative antibody test *[positive test was wrong].* This could have happened because the tester swapped test results between clients, there was a mistake in reading the first HIV rapid test, or cross-reactive antibodies (very rare). This is a mistake: the client may have never been HIV infected but was previously given wrong result. In-session testing reduces the possibility of swapped results.

Can Someone With a Previous Positive Test Outcome Have a Negative Test Outcome Today? Case 3

Case 3: An adult receives a positive antibody test. Six months later, the same person receives a negative antibody test *[negative test is wrong].* This could have happened for any number of reasons including:

- Overlooked faint line / poor eye sight / poor light
- Insufficient amount of blood / incubation time too short
- Expired test kits/ storage temperature too hot
- Patient on ART has very low antibody levels
    - Especially infants started early on ART
    - Patients on ART (especially after long time)

However, this is a mistake: the client still has HIV - nobody gets 'healed' from HIV infection.

Testing Quality Problems Have Serious Consequences

Population	Consequences of Incorrect HIV Test Results
HIV+ pregnant women	• Do not get PMTCT • More infants infected with HIV
HIV positive infants	• May not be identified - missed opportunities for life-saving treatment
HIV negative persons	• Take ART unnecessarily
HIV positive persons	• Told they are negative, may expose others and miss out on care and treatment

As a certified HTC provider, it is your responsibility to ensure fully accurate results

Monitoring the Quality of Testing

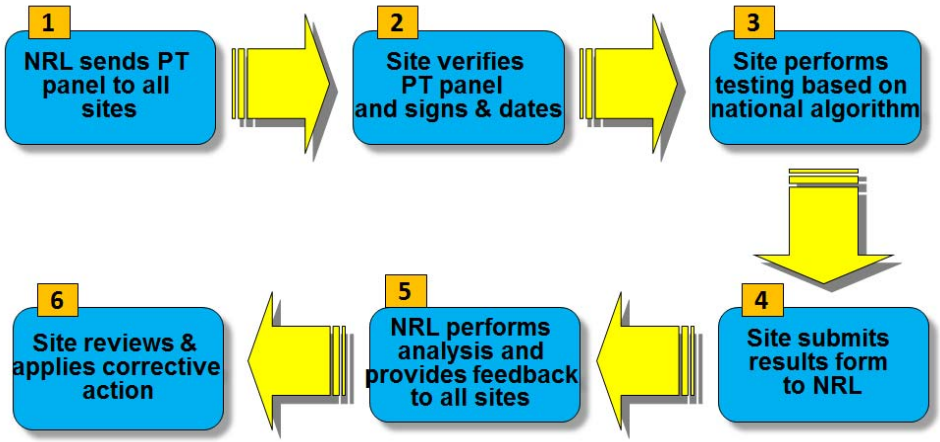
After training, your testing skills will be measured through proficiency testing, peer observation and feedback, and MoH supervision visits. Quality assurance is a routine review of a test site's operations and performance by an external agency (such as MoH).

Site Visits	DBS Retesting	Proficiency Testing
A team of supervisors assesses site and provides feedback for improvement	Random selection of a proportion of client samples collected by testing sites and sent to NHRL for verification	Testing of blinded samples received at regular interval by all testing providers
EXAMPLES		
Supervisory visit	All Positive & 10% Negative	5 blinded samples 4 times/year

QA Should Lead to Corrective Actions When Necessary
Corrective actions are taken to correct a problem or deficiency or taken to improve the accuracy of or test result. They are NOT taken as a disciplinary action against the provider. Examples of procedures in need of corrective action include production of an incorrect result and not following procedures.

Proficiency Testing (PT) Process, DTS

Proficiency Testing (PT) Process



Dried Tube Specimen (DTS)
A dried tube specimen (DTS) is a practical choice for a PT program. DTS will be used for both quality control and proficiency testing. A DTS PT pack includes 5 sample tubes, 1 buffer tube, 2 droppers, 1 results recording form, and 1 testing instructions. Refer to your DTS Job Aide for more information about the process.

Roles and Responsibilities (for PT)
Roles and responsibilities for PT include: verifying panel components upon receipt, rehydrating the DTS panel, testing according to the national algorithm, reporting problems

with testing, submitting the report within the deadline, reviewing the feedback report, and implementing corrective actions in case of failure.

Sample Results Reporting Form
Ensure that the form is filled out completely and accurately and contact NRL if any components of the panel are missing or compromised.

Frequency of Proficiency Testing
Each HTC Provider will perform PT quarterly and is responsible for performing the test based on the national algorithm and reporting the results within the deadline (report form). Ensure that each round of PT is recorded in your Counsellor Logbook.

Quality Matters
QA for both testing and counselling help ensure delivery of quality services. Check yourself regularly to ensure that you are following correct procedures and interpreting results correctly. Remember that quality is in your hands.

Quality Monitoring Questions

Category	Questions
Resources	• Do facilities meet HTC site readiness requirements? • Are staff properly trained? • Do sites have all the HTC service delivery requirements
Processes	• Are **ALL** HTC service delivery standards adhered to?
Products	• Do clients have correct information to make informed decisions? • Did clients get CORRECT results? • Were clients APPROPRIATELY referred? • Did clients REACH referral points?

Key Points

- Testing quality problems have serious consequences which is why monitoring testing quality is so important
- Monitoring HIV testing comes in the form of:
    - Proficiency Testing
    - Peer observation and feedback
    - MoH supervision visits

Module 6, Unit 6.3: Quality Assurance for HTC Providers

Learning Objectives

By the end of this unit, you will be able to:

- Explain how personnel are supported once they are in the field and working in HTC
- Explain what self-care is and how HTC providers can practice it
- Define stress and burnout
- Describe symptoms and causes of stress and burnout as well as solutions to overcome them

Overview of QA for Personnel

Quality assurance for HTC providers is both externally and internally driven. Externally, it is managed by the institution that has engaged the service provider; internally, it is self-driven.

What are Some Ways HTC Providers Can Maintain High Quality Work?

There are a variety of ways in which HTC providers can maintain high quality work. First, they can actively participate in quality assurance and/or supportive supervision. They can also do it through monitoring their own performance in counselling, testing and data management and through self-reflection. In addition, they can access observed practice sessions each year and attend continuous professional development (CPD) sessions. It is important for HTC providers to read and understand relevant HTC policy guidelines and documents, access continuous mentorship to enhance competence in HTC service delivery, and adhere to standard operating procedures and National guidelines on HTC as well. Overall, we want to make sure that the HTC provider is trained and has access to continuous professional development and supervision.

Ensuring Quality of Personnel

To ensure the quality of personnel, it is important to review certificates to ensure HTC providers are trained through spot checks or supervisory visits as well as the Counsellor Log book to assess whether the HTC provider is accessing continuous professional development, supportive supervision and observed practice.

It is also important to assess the HTC provider's participation and performance in quality assurance and proficiency testing. Note that tools and methods used to assess and ensure quality include spot checks, supportive supervision visits, and the use of checklists.

Self-Care, Managing Stress, and Preventing Burnout

Overview of Self-Care

Self-care means more than just patting yourself on the back once in a while. It means taking time to yourself to "recharge" alone after spending time in a people-saturated environment. Self-care is also about turning the encouragement you give to others toward yourself.

People in helping professions – HTC providers, doctors, police officers, social workers, and many more – are often held to impossible standards by the general public.

Origins of the Need for Self-Care

There is a notion that those in helping profession should be available to give all the time, never come first, and never make mistakes. Counselling is a demanding profession, but we need to be careful that we don't give *everything* we have, because this can lead to burnout. The mentality that can creep in (if not checked) is that setting boundaries is being selfish. Self-care also means allowing oneself to be a human being with needs to be respected. It means committing to one's growth as a professional; pursuing knowledge, expanding abilities, developing skills; and dedicating one's efforts towards professional development. It says, "I care about nurturing what I do, because what I do matters." It is important to recognize that when one feels fulfilled, everything else in life becomes easier.

Holistic Self-Car

Category	Types of Self-Care
Social	• Assertiveness • Values • Relationships • Positive confrontation
Emotional	• Self-care plans • Coping w/ anger, anxiety, pain, injury, & trauma • Enhancing sense of self-worth • Exploration, life planning
Cognitive	• Increase satisfaction & personal success
Spiritual	• Principles • Growth, wisdom • Journal writing, meditation

Definitions of Stress and Burnout

Stress:

- When you sense danger—whether it's real or imagined—the body's defenses kick into high gear in a rapid, automatic process known as the "fight-or-flight" reaction, or the *stress response*.
- The stress response is the body's way of protecting you. When working properly, it helps you stay focused, energetic, and alert. In emergency situations, stress can save your life—giving you extra strength to defend yourself, for example, or spurring you to slam on the brakes to avoid an accident.
- The stress response also helps you rise to meet challenges. Stress is what keeps you on your toes during a presentation at work, sharpens your concentration when you're attempting the game-winning free throw, or drives you to study for an exam when you'd rather be watching TV.

- But beyond a certain point, stress stops being helpful and starts causing major damage to your health, your mood, your productivity, your relationships, and your quality of life.

Burnout:

- It occurs when you feel overwhelmed and unable to meet constant demands. As the stress continues, you begin to lose the interest or motivation that led you to take on a certain role in the first place.
- Burnout reduces your productivity and saps your energy, leaving you feeling increasingly helpless, hopeless, cynical, and resentful. Eventually, you may feel like you have nothing more to give.
- Most of us have days when we feel bored, overloaded, or unappreciated; when the dozen balls we keep in the air aren't noticed, let alone rewarded; when dragging ourselves out of bed requires the determination of Hercules. If you feel like this most of the time, however, you may be flirting with burnout.
- You may be experiencing burnout if:
    - *Every* day is a bad day
    - Caring about your work or home life seems like a total waste of energy
    - You're exhausted all the time
    - The majority of your day is spent on tasks you find either mind-numbingly dull or overwhelming
    - You feel like nothing you do makes a difference or is appreciated.
- The negative effects of burnout spill over into every area of life—including your home and social life. Burnout can also cause long-term changes to your body that make you vulnerable to illnesses like colds and flu. Because of its many consequences, it's important to deal with burnout right away.

The Difference between Stress and Burnout:

- Burnout may be the result of unrelenting stress, but it isn't the same as too much stress. Stress, by and large, involves *too much:* too many pressures that demand too much of you physically and psychologically. Stressed people can still imagine, though, that if they can just get everything under control, they'll feel better.
- Burnout, on the other hand, is about *not enough.* Being burned out means feeling empty, devoid of motivation, and beyond caring. People experiencing burnout often don't see any hope of positive change in their situations. If excessive stress is like drowning in responsibilities, burnout is being all dried up. One other difference between stress and burnout: While you're usually aware of being under a lot of stress, you don't always notice burnout when it happens.

Source: http://www.helpguide.org/mental/burnout_signs_symptoms.htm; http://www.helpguide.org/mental/stress_signs.htm

Factors that Contribute to HTC Provider Stress and Burnout

Factors that contribute to HTC provider stress and burnout include: the environment, organizational factors, the nature of client-helper interactions, perceived inequities, over-identification/over-involvement with the client, and/or one's coping style and needs.

What are Some Symptoms of Stress and Burnout?
Some symptoms of stress and burnout include: emotional exhaustion, lack of positive feelings, fatigue, frustration, apathy, psychosomatic illness, listlessness, emotional overextension, depersonalization, unfeeling reactions to clients, feeling a lack of personal accomplishment, glassy eyes, feeling incompetent, anxiety, and emotionally worn down.

How Can HTC Providers Manage Stress and Prevent Burnout?
HTC providers can manage stress and prevent burnout by avoiding over-identification/over-involvement with the client, setting boundaries, having clear professional objectives, maintaining a sense of humour, exercising self-care, and understanding that to err is human.

Key Points

- Both HTC providers as well as supervisors and administrators are responsible for ensuring that employees are performing at a high level
- It is important that HTC providers have access to supervision and continuing education
- Self-care is essential in the field of counselling in order to prevent burnout