

# HIV Testing and Counseling in Health Care Settings: Somalia 2011

---

FACILITATOR GUIDE



## Acknowledgements

The World Health Organization - Somalia as part of its mandate to support the health sector response to HIV provided technical and financial support to the development of this manual. UNDP Somalia deserves special thanks to their financial support to produce this guide.

This revised version of the Voluntary Counseling and Testing in Health Care Settings: A Facilitator's Guide is the result of a workshop to revise WHO Somalia's training materials. WHO Somalia expresses gratitude to the following people for their hard work and dedication in making this publication possible: Bernard Lukwago (Uganda) and Linda Bruce, WHO consultants (USA); WHO/Somali team members Dr. Said Deq (Hargesa), Dr. Tahil Abdi (Mogadishu), Dr. Ibrahim Obsiye (Bosaso), Dr. Dahir Aden (Bosaso), Mr. Abubakar Ahmed (Bosaso) as well as Ms. Alessandra Bozza (COOPI) and Dr. Fernando Morales (UNICEF/Global Fund). The WHO/Somali team would also like to thank Ms. Loise Mathathi for her support with this effort.

Gratitude goes to Dr. Ibrahim Betelmal, the former WHO Representative, and Dr. Abdalla Ismail Elgozoli, former WHO Medical Officer HIV/AIDS, Dr Gabriele Riedner, Dr Veronique Bortolotti and Ms Joumana Hermez as the ASD unit WHO/EMRO provided technical guidance at the different stages of the development of the manual.

This manual is the outcome of tremendous encouragement and support from a team of colleagues from within Somalia and from Nairobi. Including Jacqueline Mulungu, Harbi Guled, Hellen Fayemi, Dr. Dahir, Dr. Sheikh Ali and the WHO HIV teams from WHO Offices in Garowe and Bosaso. In addition, Ayan Hassan Sugulle, Dr. Deeqa Hassan, Dahir Hassan Guled, Abdiqaadir Mohammed Almi, Mohammed Abdiqaadi, Ahmed Sadik Abdi, Dr. Tahlil Abdi Afra, Mohammed Abdilla ali, Ahmed Norsh Mohammed, Abdi Ahmed Hassan, Ibrahim Rashid Hassan, Dr. Hanafi Abdi Aden (RIP), Sahra Hussien Ali, Sharazad Hassan Dalel, Nawal Momin Dirie, Dr. Bilal are all acknowledged for having enabled the final review and adaptation of this material.

## Background

The steady growth of the AIDS epidemic does not stem from the deficiencies of available prevention strategies but rather from the world's failure to use the highly effective tools at its disposal to slow the spread of HIV.

A study on Knowledge, Attitudes, Behaviour and Practices on HIV and Sexually Transmitted Infections among the Somalis by UNICEF 2004, recommended that "Given the low percentage of respondents who considered themselves at risk of HIV, compounded by the low number of respondents who had ever taken or would be willing to take an HIV test, it is critical to emphasise the importance of everyone knowing their HIV status and taking informed actions based on this information. This needs to be supported by improved access to services including, counseling, testing and home based care services."

In Somalia since the initiation of facility based counselling and testing in 2004 reasonable numbers of clients have been tested in an increasing trend year by year. Interestingly, good numbers of self initiated clients have been reported to request the service.

Voluntary Counseling and Testing in a Health Care setting including client and provider initiated approaches gives an opportunity to people who get into contact with the health care system to access HIV testing. It also serves as part and parcel of a clinical evaluation of a patient. It is aimed at early detection of HIV infection and hence early initiation of appropriate care. It benefits those who test negative by empowering them with information that will help them avoid HIV infection. The client is offered the HIV test and, importantly, has the right to opt out or decline testing. The client must be provided with sufficient pretest information that should enable informed choice.

This manual therefore has been developed to equip health care providers with skills and knowledge necessary to deliver high quality HIV testing and counseling services in a health care setting. It also, to some extent, reflects on the regional evolving policies and is recommended as a resource for all HIV testing and counseling trainings in Somalia. It is the result of an initial document adapted by a WHO consultant that was further reviewed at a workshop looking at HIV testing and Counseling training materials for Somalia.

# Table of Contents

Acknowledgements.....	2
Background.....	3
List of Abbreviations.....	6
Introduction to HIV Testing and Counseling in Health Care Settings: Facilitator’s Guide.....	8
Purpose.....	8
Overall Goal.....	8
Target Audience.....	8
Course Duration and Organisation.....	8
How to Use This Facilitator Guide.....	9
Learning Methods.....	9
Sample Agenda.....	11
Welcome, Introductions, Expectations, Roles and Ground Rules.....	13
<b>Module One: Epidemiology &amp; Basic Facts of HIV Infection and Disease.....</b>	<b>15</b>
Session 1.1: Basic Facts About HIV and the Global and National Status of the HIV/AIDS Epidemic.....	16
Session 1.2: Pathogenesis & Natural History of HIV infection.....	16
Session 1.3: Clinical Presentation of HIV and WHO Staging.....	17
<b>Module Two: Approaches and Rationale for HIV Testing and Counseling in a Health Care Settings.....</b>	<b>27</b>
Session 2.1: Approaches and Rationale for HIV Testing and Counseling in Health Care Settings.....	28
<b>Module Three: HIV Counseling in Health Care Settings.....</b>	<b>34</b>
Session 3.1: Concept and Ethics of Counseling.....	35
Session 3.2: Communication skills and barriers.....	36
Session 3.3: The Counseling Process.....	37
<b>Module Four: Technical Guidelines &amp; Procedures for VCT Integration.....</b>	<b>56</b>
Session 4.1: Integrating HIV Testing and Counseling into Health Care Services.....	57
Session 4.2: Definition and components of HIV testing and counseling Guidelines and Procedures.....	58

<b>Module Five: HIV Testing</b> .....	<b>62</b>
Session 5.1: HIV testing .....	63
Session 5.2: HIV Testing: Types, Protocols, Algorithms and Procedures.....	63
Session 5.3: Infection Control, PEP and Quality Assurance for HIV Testing.....	64
<b>Module Six: Care Options for People Living with HIV/AIDS (PLHIV)</b> .....	<b>69</b>
Session 6.1: Basic care package for PLHIV.....	69
Session 6.2: Stigma and Discrimination .....	71
<b>Module Seven: Voluntary Counseling and Testing Practicum</b> .....	<b>78</b>
Session 7.1: Counseling Practicum .....	78
Session 7.2: Action Planning .....	80
Session 7.3: Post test .....	80
Session 7.4: official closing .....	80
<b>Counselor-In-Training Checklist</b> .....	<b>81</b>
<b>VCT Practicum Assessment Tool</b> .....	<b>82</b>

## List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ART	Antiretroviral therapy
ARVs	Antiretroviral Drugs
BC	Basic Care
BMI	Body Mass Index
CBO	Community-based organization
CD4	Cluster determination No4/ Count of the lymphocytes with the CD4 surface maker/mm <sup>3</sup> of blood
CITC	Client-initiated HIV Testing and Counseling
FBO	Faith-based organization
FP	Family Planning
HBHTC	Home Based HIV testing and counseling
HIV	Human Immune Deficiency Virus
HTC	HIV Testing and Counseling (includes client- and provider- initiated HIV testing and counseling and is always voluntary)
ITN	Insecticide-treated nets
MOH	Ministry of Health
MSM	Men who have sex with men
MTCT	Mother to Child Transmission of HIV
NGO	Nongovernmental organization
NVP	Negative predictive value
OIs	Opportunistic infections
PCP	Pneumocystis carni pneumonia
PEP	Post-Ex Posure Prophylaxis
PITC	Provider-initiated HIV Testing and Counseling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PVP	Positive predictive value
RCT	Routine Counseling and Testing
RNA	Ribonucleic acid
RTC	Routine Testing and Counseling
SIV	Simian immunodeficiency virus
SOPS	Standard Operational Procedures
STI	Sexually Transmitted Infections
TASO	The AIDS Support Organization

TB	Tuberculosis
TV	Television
UNAIDS	United Nations AIDS Organization
UNICEF	United Nations Children Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
DNA	Desoxy ribonucleic acid
SIVsm	Simian Immunodiffiency Virus
HBV	Hepatitis B Virus
MAC	Mycobacterium avium Complex
IV	Intra-venous
OPD	Out-Patient-Department
SD	Standard Diagnostic bioline
EIA	Enzyme Immunoasay
PCR	Polymerase Chain Reaction
ELISA	Enzyme Linked Immuno Sorbent Assay
IFA	Indirect Immino Fluorescent Antibody Assay
SSV	Supervisory Support Visits
ZN	Zeil – Nelson
AFB	Acid Fast Bacili
WBC	White Blood Cell Count
ESR	Erythrocyte Sedimentation Rate
PDD	Purified Derivative
EPI	Expanded Program of Immunization
HBHCT	Home Based HIV Counselling and Testing

# Introduction to HIV Testing and Counseling in Health Care Settings: Facilitator's Guide

## Purpose

This training manual is designed to equip service providers with the knowledge, skills and attitudes needed to provide quality HIV testing and Counseling services in health care setting.

## Overall Goal

The overall goal of this HIV testing and counseling training programme is to increase and/or initiate the provision of high quality HIV counseling services. This will be done through building the capacity of service providers to carry out HIV testing and counseling in health care settings.

## Training Objectives:

**By the end of the training programme, participants will be able to:**

- Educate clients and patients about the rationale and benefits of testing
- Explain the activities needed for integration of HIV testing and counseling into the Health Care Setting
- Provide HIV pre and post-test counseling as part of clinical care offered to patients at a health facility
- Conduct an HIV rapid test and provide the test results accurately
- Know how to refer clients to ART services
- Collect and use data related to HIV testing and counseling for managing logistics and planning.

## Target Audience

This training course is designed for health workers such as nurses, midwives, counselors, doctors, clinicians, etc. that work in the health care setting. If possible, limit the number of participants to 20 per training. Have two trainers available to facilitate each day.

## Course Duration and Organisation

This Facilitator Guide describes 9 days training programme. There are 8 days in class and one day of practicum assignment.

**Note:** The duration can be extended to a maximum of 10 days if it reveals enormous gaps in the HIV and AIDS knowledge levels among the targeted service providers.

To meet the minimum standards for HIV testing and Counseling, the participants will need to have attended 95% of the sessions with maximum participation. They should also achieve a score of at least 60% on the final exams of the course and completed their four hours of practicum.

## How to Use This Facilitator Guide

This Facilitator Guide has been developed for use within the different zones in Somalia to support the scale up of HIV testing and counseling services over the region. Facilitators using this Guide should be health workers trained and experienced in HIV testing and counseling. Trainers must be recognized by the Key Partners in the implementation of the HIV/AIDS response. They must be knowledgeable about current policies, strategies and technical guidelines on HIV testing and counseling including HIV laboratory testing strategies for Somalia. This is so that they can: 1) deliver accurate and current information to the participants and 2) adapt the sessions to reflect changing priorities in the delivery of services.

Facilitators should also know how to facilitate participant-centered activities such as role-plays and case studies. These provide opportunities for participants to prepare for the real world of counseling. HIV and AIDS services are constantly changing. Thus, facilitators are expected to take the initiative in updating themselves and the materials provided during training.

Two facilitators should work together to manage this training for approximately 20 participants. Additional expert resources should be identified and brought in as required, e.g., for HIV care and treatment, laboratory testing and other critical topics that cannot be covered by the two facilitators.

The activities in this Facilitator's Guide are learner-centered and require facilitation, not teaching. They provide opportunity for learning through active participation in discussions and group work, including role-plays, case studies, etc. As they follow the instructions in this Guide, facilitators will be:

- Explaining the activities in each session and helping participants to complete the activity properly.
- Facilitating group discussions.
- Solicit participants' learning and supplement as needed.
- Giving participants the opportunity to express their concerns, views and opinions.
- Summarizing key points from each session.
- Acknowledging the key points that participants have already noted.
- Evaluating the outcome of training sessions.

## Learning Methods

The learning methods used in this Facilitator Guide are designed for adult learners. In order to endorse adult learning principles, the Guide utilizes a variety of learning methodologies and training aids, including (but free feel to add other methods as appropriate):

- Brainstorming:** This method encourages active involvement and builds on participant knowledge and expertise. The facilitators' role is to encourage all participants to say the first things that come in their minds and to keep ideas flowing.

**Note:** During brainstorming, when the topic is given to the group and there are no ideas expressed, or the group seems to be struggling for ideas, stop the brainstorm. Then present the concepts you deem important. This will save time and keep the training flowing.

- Case study:** This technique encourages participants to analyse on-the-job situations they might face and decide how they might respond. This encourages participants to think about problems, options, and solutions to challenges they might experience.
- Role – plays:** This technique is a safe way for participants to practice knowledge and skills learned. It is a good preparation for real on-the-job situations. Role-plays particularly well suited for practicing counseling and other communication skills. They can also demonstrate ideal on-the-job skills and behaviors. Participants may observe a role-play of an actual situation.

- ❑ **Lecturettes:** This technique involves short forms of lectures, which are used to highlight key points of the content. They are different from the traditional lectures as they often include interaction with participants. Sometimes they even seem like a discussion. Lecturettes are useful as introductions to topics.
- ❑ **Small group discussions:** This technique is a special type of small group that is used when participants need to discuss a topic, express opinions and reach consensus.
- ❑ **PowerPoint presentations:** PowerPoint presentations are visual aids that usually accompany lectures or lecturettes. When using PowerPoint presentations, be sure that the slides are readable from any vantage point of the room. Use 18 point Font size or larger for optimal readability. Only use bullets, key concepts and talking points to remind you of what to tell participants. Leave space between sentences and avoid crowding of text as much as possible. Use a variety of formats, backgrounds and animations to help keep interest of participants. Avoid reading every word on the slide. Be familiar with the content and use it as a guide for your presentation.
- ❑ **Video presentation:** participants are video recorded during role-plays and the clips are video presented at the plenary.

### Training Tips:

- Be prepared.
- Remember the time you have.
- Remember that there are often three types of participants (the prisoner, the vacationer, and the learner).
- Attend to ALL participants.
- Maintain high energy levels by encouraging discussions, using energizers, taking breaks when needed, etc.
- Actively involve all participants. This increases the likelihood of engaging the prisoner, vacationer and the learner.
- Deal with difficult participants by:
  - Asking other participants to address the difficult person's concerns or questions.
  - Shifting the dynamics of the group by changing the sitting arrangement
  - Dealing with side bar conversations right away
  - Speaking to the difficult participant outside the training room.
- Participants should be allowed to brainstorm new concepts in Somali and present an agreed position for acceptance and inclusion in English

### Checklist of training materials/equipment needed:

- ❑ Blank flipchart paper
- ❑ Flipchart stands
- ❑ Colored markers
- ❑ PowerPoint projector
- ❑ Computer (laptop) for showing PowerPoint
- ❑ Extension cords and power strips
- ❑ Name tags
- ❑ A watch
- ❑ Tape
- ❑ Thumb tacks
- ❑ Scissors/stapler/paperclips
- ❑ Note pads and pens for participants

- Handout
- video camera
- Video tapes
- TV screen
- Digital camera

### Advance Preparation:

- Read through each module of the workshop.
- Prepare all flipcharts and other materials/equipment mentioned in each module.
- Make copies of handouts for all participants.
- Organize all the learning aids needed.

### Sample Agenda

<b>Day 1</b>	
8:00 – 9:00	Welcome, Introduction, Expectations and Ground Rules Module one
9:00 – 10:30	Session 1.1: Basic Facts
<b>10:30 – 10:45</b>	<b>Break</b>
10:45 – 12:00	Session 1.2: Pathogenesis and Natural History of HIV Infection
<b>12:00 – 1:00</b>	<b>Lunch</b>
1:00 – 5:15	Session 1.3: WHO Staging (includes 15 minute break)
<b>Day 2</b>	
<b>Modules Two &amp; Three</b>	
8:00 – 8:30	Review/learning activity
8:30 - 9:30	Session 2.1: Approaches and Rationale for HIV Tesing and Counseling in a Health Care Setting
9:30 – 10:45	Session 3.1: Concept and Ethics of Counseling
<b>10:45 – 11:00</b>	<b>Break</b>
11:00 – 1:00	Session 3.2: Communication skills
<b>1:00 – 2:00</b>	<b>Lunch</b>
2:00 – 5:00	Session 3.3: The Counseling Process (includes break)
<b>Day 3</b>	
<b>Modules Four &amp; Five</b>	
8:00 – 8:30	Review/learning activity
8:30 – 9:30	Session 4.1: Integrating HIV testing and Counseling into health care services
9:30 – 11:30	Session 4.2: Definition and components of HIV testing and Counseling guidelines & procedures
<b>11:30 – 11:45</b>	<b>Break</b>
11:45 – 12:30	Session 5.1: HIV Testing
<b>12:30 – 1:30</b>	<b>Lunch</b>
1:30 – 3:00	Session 5.2: HIV Testing, Types, Protocols, Algorithms, and Procedures
<b>3:00 – 3:15</b>	<b>Break</b>
3:15 – 4:30	Session 5.3: Infection Control and Quality Assurance
<b>Day 4</b>	
<b>Modules Six &amp; Seven</b>	
8:00 – 9:30	Session 6.1: Basic Care Package for PLWA
9:30 – 10:45	Session 6.2: Stigma and discrimination
<b>10:45 – 11:00</b>	<b>Break</b>
11:00 – 1:00	Session 7.1: Practicum
<b>1:00 – 2:00</b>	<b>Lunch</b>
2:00 – 3:00	Session7.2: Action Planning
3:00 – 3:30	Closing activities

## Welcome, Introduction, Expectations and Ground Rules

### Purpose

This session provides an overview of the course, highlighting the rationale and objectives of the training. It also fosters team building among participants.

### Objectives:

- At the end of this module, participants will be able to:
- Get to know each other and the facilitators
- Define the ground rules and their expectations.
- Explain the training goal and objectives for the HIV testing and counseling workshop.
- Explain the course structure.

### Time to complete module:

3 hrs

### Training materials:

- Flipchart stands and paper
- Colored markers
- Equipment for showing PowerPoint

### Advance preparation:

- Prepare a PowerPoint or flipcharts with the following:
  - Workshop agenda
  - Training course goal and objectives (from Introduction to the Facilitator's Guide)
- Write on flipchart page, "Clarification Issues"

### Content:

Welcome, Introductions, Expectations and Ground rules

- Official Opening
- Welcome, introductions, expectation, roles, and ground rules
- Course structure and goal and objectives for HIV testing and Counseling training

## Welcome, Introductions, Expectations, Roles and Ground Rules

**Approximate Duration: 90 minutes**

### Training/Learning Activity

#### A. Introduction and participants expectations (Large group discussion)

1. **Welcome** participants
2. **Begin** by introducing yourself briefly to the participants
3. **Ask** participants to introduce themselves (i.e.
  - Names,
  - Organization/Agency/Hospital,
  - Department,
  - Role within organization
  - Years of experience,
  - What they expect to get out of the training course (expectations)
4. **Ask** participants what are their expectations for the workshop.
5. **Write** their expectations on a flip chart and post in the room.
6. **Clarify** the expectations that need immediate attention.
7. **Conduct** pre-test

**Facilitator's note:** Refer to the participants' expectations at the end of the training session. This helps to ensure that the participants' expectations have been met.

#### B. Roles and Ground rules (Large group session)

1. **Ask** participants what roles are needed for the training (i.e.
  - Overall course leader
  - Time keeper
  - Welfare,
  - Morale booster, etc.
2. **Let** participants nominate and/or vote for participants for each of the roles identified
3. **Ask** for volunteers to give some recommended ground rules. List them on the blank flipchart paper titled "Ground Rules".
4. **Listen and or prompt** for the following:
  - **Commitment to participate:** Use this training as an opportunity to practice new skills. Successful completion requires a commitment to actively participate.
  - **Manage time:** Trainers will maintain structure and keep time. Every one will share responsibility for arriving on time in the morning, after breaks and lunch.
  - **Speak slowly and loudly:** Trainer(s) and participants should speak loudly and slowly so that they can be clearly understood.
  - **Turn cell phones off or set them to vibrate:** Cell phones may distract the trainer(s) as well as the participants.
  - **Respect all opinions:** Participants may disagree on issues. Respect these differences. They bring diversity to the training.

**Facilitator's note:** Be mindful of bringing participants' attention back to the ground rules if they are forgotten. Often simply walking over to where they are posted to draw attention will suffice. Also, facilitators should adhere to the ground rules and model appropriate behaviour.

## Session 3: Course structure, goal and objectives for HIV testing and counseling training

**Approximate Duration: 30 Minutes**

### Training/Learning Activity

#### A. **Training goal and objectives** (Large group session)

Using a prepared flip chart or/and PowerPoint:

1. **Discuss** the overall training goal. Show goal on flipchart prepared beforehand.

**Goal:** to increase and/or initiate the provision of high-quality HIV counseling services through building the capacity of service providers to carry out HIV testing and counseling in health care settings.

2. **Review** the training course objectives. **Show** objectives on flipchart prepared beforehand:
  - Educate clients and patients about the rationale and benefits of testing
  - Explain the activities needed for integration of HIV testing and counseling into the Health Care Setting
  - Provide HIV pre and post-test counseling as part of clinical care offered to patients at a health facility
  - Conduct an HIV rapid test and provide the test results accurately
  - Know how to refer clients to ART services
  - Collect and use data related to HIV testing and counseling service delivery for managing logistics and planning.
3. **Match** objectives with participant expectations already noted.
4. **Ask** if there are any questions before proceeding.

#### B. **Course structure and timetable** (Large group session)

1. **Review** the course structure and agenda
2. **Discuss** the timetable, and the importance of keeping time.
3. **Discuss** 'clarification issues' and display flip chart to list these issues.
4. **Clarify** any questions and concerns.

#### C. **Team building exercise**

1. **Conduct** an icebreaker exercise to help participants get to know each other.
2. **Ask** if there are any questions before proceeding.

## Module One: Epidemiology & Basic Facts of HIV Infection and Disease

### Purpose

This module equips participants with basic knowledge about HIV infection and disease, the epidemiology, and impact as well as Somali's response to the HIV epidemic.

### Objectives:

- At the end of this module, participants will be able to:
- Define HIV and AIDS
- Explain the natural history of HIV infection
- Describe the global, regional & national trends of epidemic.
- Discuss the modes of transmission and vulnerability factors
- Describe the stages in the life cycle of HIV.
- Describe the Clinical Staging of HIV + patients based on WHO classification systems

### Time to complete module:

6 hours

### Training materials:

- PowerPoint 1.1: Epidemiology and Basic Facts of HIV/AIDS
- PowerPoint 1.2: Pathogenesis & Natural History of HIV infection
- PowerPoint 1.3: Clinical Presentation of HIV and WHO Clinical Staging
- Equipment for showing PowerPoint presentations
- Large poster on life cycle of HIV
- Flipchart stand and paper, and colored markers
- Copies of handout for all participants

### Advance Preparation:

- Write the objectives of Module 1 on flipchart ahead of time.
- Prepare 4 flipcharts: write "Stage 1" on 1st page; "Stage 2" on the 2nd page; "Stage 3" on the 3rd page; and "Stage 4" on 4th page.
- Post all four flipchart pages on the wall about 3 meters apart.

### Content:

- Basic facts of HIV infection and AIDS.
- Session 1.1: Definition, History and Basic Facts of HIV/AIDS
- Session 1.2: Pathogenesis & Natural History of HIV Infection
- Session 1.3: Clinical Presentation of HIV and WHO Staging

**Facilitator's notes:** When talking about HIV/AIDS, keep in mind the level of the participants' understanding. Use simple language, as participants will be giving the same messages to their clients. When complex scientific or technical terms are necessary, present them in layman's terms and in the local language.

## Session 1.1: Basic Facts About HIV and the Global and National Status of the HIV/AIDS Epidemic

**Approximate duration: 90 minutes**

### Training/Learning Activity

#### A. **Epidemiology & Basic Facts of HIV/AIDS** (Large group discussion)

1. **Introduce** the session by sharing the objectives of Module 1. Show objectives written on flipchart beforehand.
2. **Ask** participants to brainstorm the definitions of HIV and AIDS and the difference between the two. Record responses on flipchart.
3. **Present** the PowerPoint 1.1: Epidemiology & Basic Facts of HIV/AIDS.
4. **Point** out information not already mentioned by participants.
5. **Review** the history of HIV.
6. **Continue** with PowerPoint 1.1 and discuss the global, regional and National trends of the HIV and AIDS epidemic.
7. **Review** the impact of HIV in Somalia (social, economic, political health, etc.).
8. **Discuss** the country's response to HIV in Somalia.
9. **Distribute** the participant handout, "Epidemiology and The Basic Facts about HIV", and review keys points not already covered.

#### B. **Small group activity**

1. **Break** participants into 5 groups.
2. **Ask** each group to discuss the country's responses to HIV in terms of:
  - Ministry of Health (MOH)
  - International agencies
  - Community-based organizations (CBOs), faith-based organizations (FBOs), non-government organizations (NGOs)
  - People living with HIV/AIDS (PLHIV)
3. **Give** the groups 5 – 10 minutes.
4. **Ask** each group to present the key points of their discussion.
5. **After** each group has presented, ask the group at large if they have anything to add - any pertinent points which did not come up from the group.

**Facilitator's Note:** If you find the group discussion exhaustive during plenary, then it is not necessary to display the PowerPoint slides, which cover this information.

## Session 1.2: Pathogenesis & Natural History of HIV infection

**Approximate duration: 120 minutes**

### Training/Learning Activity

#### A. **Pathogenesis, Natural History of HIV infection and WHO clinical staging** (Lecturette)

1. **Using** PowerPoint 1.2, explain the pathogenesis and natural history of HIV infection.
2. **Mention** key points related to the pathogenesis of HIV infection.
3. **Review** the natural history of HIV infection.

## B. Small Group Activity

1. **Divide** participants into small groups.
2. **Assign** each group a topic, such as “the life cycle of HIV”.
3. **Have** them discuss how to talk to clients about it in the local dialect using simple terms they feel their clients will understand.
4. **Ask** them to write key points on a flipchart.
5. **Ask** each group to present on their topic to the whole group. Allow about 5 minutes for each group. Watch the time!
6. **Check** for clarity and make suggestions for improvement, if needed

## Session 1.3: Clinical Presentation of HIV and WHO Staging

**Approximate duration: 4 hours (includes a break)**

### Training/Learning Activity

#### A. Clinical presentation and WHO clinical staging (Large group discussion)

1. **Using** PowerPoint 1.3 Clinical Presentation and WHO Staging, Review the clinical presentations of HIV and WHO the clinical and immunological staging of the infection.
2. **Mention** key points related to the pathogenesis of the HIV infection.
3. **Review** the natural history of HIV infection.
4. **Present and discuss** the clinical staging of HIV, including all the clinical symptoms/infections involved in all four clinical stages.
5. **Review** WHO's improved staging system.
6. **Stop the PowerPoint presentation** on the slide that says “Game”.
7. **Ask** if there are any questions. **Answer** all questions before proceeding to the game.

#### B. Large Group Activity:

1. **If you have not already done so, post** each of the four flipcharts (prepared beforehand) on the wall with plenty of space between them.
2. **Return to the PowerPoint 1.3 and read** the first description of the HIV client (after the “Game” slide).
3. **Ask** the group to stand by the flip chart that represents the WHO stage that the patient's symptoms or infection(s) suggest.
4. **When everyone has chosen a stage, say** the correct answer and explain why.
5. **Answer** any questions that come up before proceeding to the next slide with another HIV client.
6. **Repeat** steps 3, 4, and 5 until the last slide. (Facilitator note: the correct answers can be found on the following page.)
7. **Review** the session's objectives and make a recap of what has been learnt.
8. **End the workshop for the day.**
9. **Before leaving the workshop,** gather all of the flipcharts (that have been written upon).
10. **Tape** them on the walls throughout the workshop for the refresher exercise the next day.

## Correct answers to WHO staging game

Patient's signs and/or symptoms	Clinical Stage
Patient is weak, has lost more than 12 kg and has been diagnosed with extra-pulmonary TB of the lymph nodes.	4
Patient presents with symptoms of oral and esophageal thrush. Also, he has had herpes simplex ulcerations for more than one month (on the penis).	4
Patient can't get out of bed without assistance and had diagnosis of HIN encephalopathy and oral thrush.	4
Patient has invasive cervical cancer, requires intensive care from family members and is extremely thin.	4
Patient has herpes zoster on the right leg.	2
The same patient has angular cheilitis and an itchy rash on arms and legs. He has chronic intermittent diarrhea.	3
Patient is losing a lot of weight, he is very thin now, and has chronic fever.	4
Patient has white patches in the mouth and severe chest pains when swallowing.	4
Patient has white patches in the mouth, looking like the picture in the slide.	3
Patient has a sputum negative pulmonary TB.	3
The same patient is symptom free,	3
Patient has a chronic middle ear infection, with discharge from the ear.	2
Patient appears healthy now but had herpes zoster 4 years ago. She also reports that she has lost some weight BMI = 19.	2
The same patient has chronic diarrhea and cryptococcal meningitis.	4
A patient has pulmonary TB and a brain abscess with weakness on one side of the body. Is responding to treatment for toxoplasma brain abscess.	4
Patient has intermittent diarrhea for several months.	3
Patient has developed a lot of purple lesions on the leg as well as edema.	4
Patient has been diagnosed with TB meningitis.	4
The same patient has been treated successfully for TB meningitis but has chronic sores on the penis.	4
Patient has ringworm and TB of the abdominal lymph nodes.	4
Later, same patient develops a chronic otitis.	4
Patient has disseminated herpes zoster and chronic diarrhea.	3
Later, the same patient has a headache, fever and double vision. He is diagnosed with TB meningitis.	4
Patient has responded well to treatment for TB and PCP. The only problem now is mild weight loss (from 50 to 48 kilos).	4

## Epidemiology and Basic Facts of HIV Infection and AIDS

### Definitions

#### HIV – Human Immune Deficiency Virus

When the HIV virus enters the body, it gradually destroys essential components of the immune system and lowers the immunity. Because of the attack on the immune system, the virus leads to AIDS.

There are two types of HIV: HIV – 1 and HIV – 2. HIV-1 is more aggressive and has a short incubation period and is common in East, Central and Southern Africa. In contrast, HIV-2 is less aggressive, has a long incubation period and is predominantly in Western Africa.

#### AIDS – Stands for Acquired Immune Deficiency Syndrome

This syndrome is a collection of diseases or signs and symptoms that may occur singly or together. These signs and symptoms are caused by opportunistic infections. Opportunistic infections (OIs) are infections that occur because of the weakened immune system. OIs take advantage of the individuals weakened defense against infections with viruses, bacteria and other microorganisms. The process of deterioration is usually slow. HIV infected people gradually progress to AIDS over a period of time. HIV infected people can be without OIs for many years and feel and appear healthy.

#### History and global trends of HIV

HIV infection was first diagnosed among sexually active homosexuals (men having sex with men) in San Francisco, United States of America in 1981. Later people who had regularly received blood transfusion, injecting drug users and then children were also found to have HIV. Many more men having sex with men and members of the wider community then tested HIV positive.

HIV is a chronic infection and progresses slowly. The infection is thought to have spread initially undetected. It must have started spreading substantially about 10 years earlier supposedly in the 1970s. The infection also had been spread worldwide. By 1985 almost all countries in the world had reported existence of HIV cases. The highest burden of disease was faced in developing countries. In 1991, there were 30 million infections worldwide. By 2001, WHO estimated that the world infection was close to 40 million people.

New data showed that global HIV prevalence – the percentage of people living with HIV- has leveled off. HIV prevalence has leveled off in part as a result of the natural course of the epidemic, the impact of HIV programmes and of more reliable estimates for some countries.

#### Global summary of the AIDS epidemic

##### December 2008

##### Number of people living with HIV in 2008

Total	33.4 million [31.1 million-35.8million]
Adults	1.3 million [29.2 million-33.7 million]
Women	15.7 million [2.0 million-17.2 million]
Children under 15years	2.1 million [1.2 million-2.9million]

##### People newly infected with HIV in 2008

Total	2.0 million [2.4 million-3.0 million]
Adults	2.3 million [2.0 million-2.5million]
Children under 15years	430 000 [240 000-610 000]

---

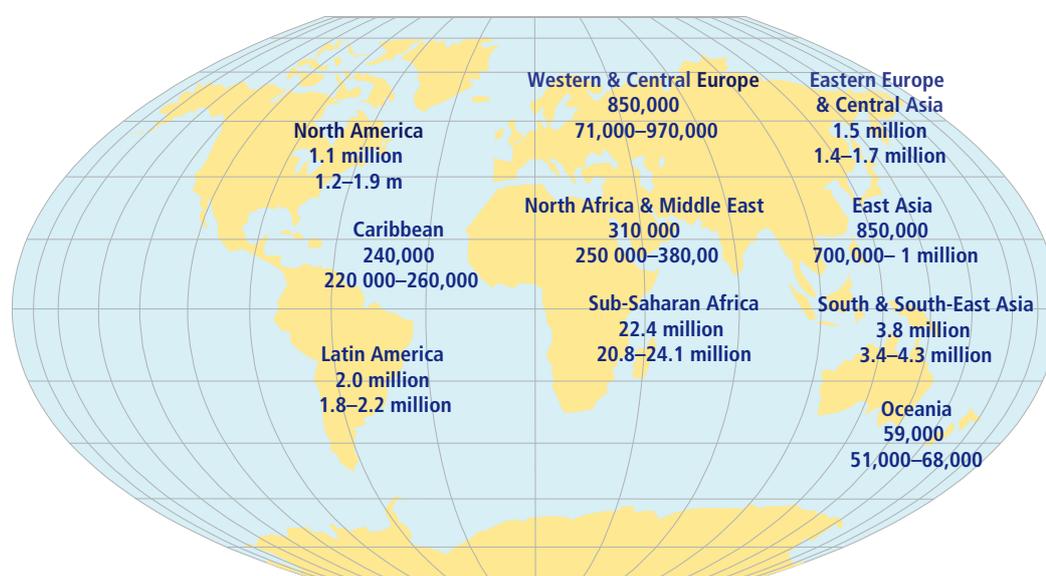
AIDS-related deaths in 2008		
Total		2.0 million [1.7 million-2.4 million]
Adults		1.7 million [1.4 million-2.1 million]
Adults under 15years		280 000 [150 000-410 000]

---

The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. The number of people living with HIV world-wide continued to grow in 2008, reaching an estimated 33.4 million [31.1 million]. The total number of people living with the virus in 2008 was more than 20% higher than the number in 2000 and the prevalence was roughly threefold higher than in 1990.

The regional magnitude of HIV infection by the year 2005 is shown in the world map illustration below.

### Map showing spread of HIV globally, 2008



Death globally are projected to continue as significant global cause of premature mortality in the coming decades (WHO) 2008. The estimated number of AIDS related deaths in 2008 is roughly 10% lower than in 2004

The epidemic appears to have stabilized in most regions, although prevalence continues to increase in Eastern Europe and Central Asia and in other parts of Asia due to a high rate of new HIV infections. Sub-Saharan Africa remains the most heavily affected region, accounting to 71% of all new HIV infections in 2008.

AIDS continues to be a major global health priority. Although important progress has been achieved in preventing new HIV infections and in lowering the annual number of AIDS- related deaths, the number of people living with HIV continues to increase. AIDS- related illness remain one of the leading causes of death globally and are projected to continue a significant global cause of premature mortality in the coming decades (World Health Organization, 2008). Although AIDS is no longer a new syndrome, global solidarity in the AIDS response will remain a necessity.

There is evidence of success in HIV prevention. There is growing evidence of HIV prevention successes in diverse settings. In five countries where two recent national household surveys

Improved access to treatment is having an impact. Antiretroviral therapy coverage rose form 7% in 2003 to 42% in 2008, with especially high coverage achieved in eastern and southern Africa (48%) World Health Organization, United Nations Children fund, UNAIDS

### Middle East and North Africa

Number of people living with HIV	2008:310 000 [250 000-380 000]	2001:200 000 [150 000-250 000]
Number of new HIV infections	2008:35 000 [240 000-46 000]	2001: 30 000 [23 000-40 000]
Number of children newly infected	2008:4600 [2300-7500]	2001:3800 [1900-6400]
Number of AIDS-related deaths	2008:20 000 [15 000-25 000]	2001: 11 000 [7800-14 000]

In 2008, an estimated 35 000 [24 000-46 000] people in the Middle East and North Africa became infected with HIV, 20 000 [15 000-25 000] AIDS-related deaths occurred. The total number of people living with HIV in the region at the end of 2008 was estimated to be 310 000 [250 000-380 000].

### Sub-Saharan Africa

Number of people living with HIV	2008: 22.4million [20.8 million-24.1 million]	2001: 19.7 million [18.3 million-21.2 million]
Number of new HIV infections	2008: 1.9 million [1.6 million-2.2million]	2001: 2.3 million [2.0 million-2.5million]
Number of children newly infected	2008:390 000 [210 000-570 000]	2001: 460 000 [260 000-640 000]
Number of AIDS-related deaths	2008: 1.4 million [1.1 million-1.7 million]	2001: 1.4 million [1.2 million-1.7 million]

In 2008, an estimated 1.9 million [1.6 million-2.2 million] people living in Sub-Saharan Africa became newly infected with HIV, bringing the total number of people living with HIV to 22.4 million [20.8 million-24.1 million]. While the rate of new HIV infections in Sub-Saharan Africa has slowly declined-with the number of new infections in 2008 approximately 25% lower than at the epidemic's peak in the region in 1995-the number of people living with HIV in Sub-Saharan Africa slightly increased in 2008, in part due to increased longevity stemming from improved access to HIV treatment. Adult (15-49) HIV prevalence declined from 5.8% [5.5-6.0] in 2001 to 5.2% [4.9-5.4%] in 2008

In 2008, an estimated 1.4 million [1.1 million-1.7 million] AIDS-related deaths occurred in sub-Saharan Africa. This number represents an 18% decline in annual HIV-related mortality in the region since 2004

### History and Trends of HIV and AIDS in Africa and the Middle East

The African Region particularly the sub Saharan Africa (SSA) has been hit hardest by the pandemic. By 1985 most African countries had reported cases of HIV and about 8-10 million people were estimated to be infected. At the beginning of the epidemic in Africa, the HIV infection was often over-looked because the signs and symptoms were not well known to health care providers.

By 2008, the estimated number of adults and children living with HIV/AIDS increased to an estimated 22.5 million people in sub-Saharan Africa, a 9 percent increase since 2001. The estimated number of deaths in this region has increased from 1.4 million in 2001 to leveling 1.6 million in 2007. These deaths account for 76 percent of all deaths from HIV worldwide. AIDS remains the leading cause of death in the SSA region. (UNAIDS/WHO 2008).

Further, over 60 percent of the adults with HIV/AIDS in sub-Saharan Africa are women, ten percent above than the global average. Children from sub-Saharan Africa are also the most vulnerable and account for 90 percent of all HIV positive children worldwide. There is an estimated 11.4 million orphans due to AIDS in this region.

The epidemic in Africa has matured having entered its third decade now. Some African countries have the highest prevalence rates in the world. For example, Botswana, with a population of 1.5 million people, had prevalence rates of 24.1 percent in 2005. The majority of the people in the world with HIV and living in one country are found in South Africa. With a population of 42 million people and prevalence of 18.8 percent, there are over 7.9 million South Africans with HIV.

In the Northern part of Africa the infection rates are much lower. This is attributed to the early circumcision of males in Arab and Muslim cultures, very low use of alcohol and the adherence to the strict Islamic regulations of sexual activity. HIV is largely concentrated among key populations at high risk and their direct sexual and/or drug injecting contacts.

West Africa is also affected. Further, the HIV- 2, which is less virulent and has a longer incubation period, is more prevalent in this area.

However, there should be no complacency. Since it may be a matter of time before the epidemic spreads in the less affected parts of Africa depending on trends in risk and vulnerability factors.

Details of the prevalence in Sub-Saharan Africa – UNAIDS/WHO 2007

Indicator	Year	Sub-Saharan Africa	World
Adults and children living with HIV/AIDS	2007	22,500,000	33,200,000
Adults (ages 15+) living with HIV/AIDS	2007	22,400,000	30,800,000
Women (ages 15+) living with HIV/AIDS	2007	13,200,000	15,400,000
Children (ages 0-14) living with HIV/AIDS	2007	2,200,000	2,500,000
AIDS Orphans currently living (ages 0-17)	2007	11,400,000	15,200,000
Adult and children AIDS deaths	2007	1,600,000	2,100,000
Adults and children newly infected with HIV	2007	1,700,000	2,500,000

NB: Facilitator should have some information about HIV/AIDS in Somalia

## Basic Facts on HIV and AIDS

Currently HIV has no cure. But HIV and AIDS are both preventable

### Modes of Transmission

- Hetero sexual intercourse with an infected person
- Men who have sex with men (MSM)
- Mother to child transmission (MTCT)
  - During pregnancy
  - During labour and delivery
  - After birth through breastfeeding
- Blood and blood products (plasma, serum, backed cells, etc)
- Organ transplant
- Insemination

### Sources/risks of infection

- Unprotected sex with infected person
- Contaminated injection/surgical procedures instruments
- Mother to child transmission
- Blood and blood products transfusion
- Organ transplants

### Myths and misconceptions: HIV cannot be transmitted by:

- Casual person-to-person contact at home, work or in social or public places
- Food, air, water
- Insect/mosquito bites
- Coughing, sneezing, spitting
- Shaking hands, touching, dry kissing or hugging
- Swimming pools, toilet, etc.

### Vulnerability to HIV:

1. Social risk factors
  - Illiteracy
  - Lack of awareness of preventive measures
  - Multiple sexual partners
2. Social Mobility
  - Globalization of economy and labour migration
  - Partners living apart
  - Conflict, war (displacement, acute poverty, sexual violence)
  - Decreasing influence of protective norms and values
  - Famine
  - Climate change
  - Transport industry (e.g. long distance truck drivers)
3. Stigma and denial
  - Denial and silence around HIV
  - Stigma prevents acknowledgement of problem and care-seeking
4. Cultural factors
  - Traditions, beliefs, and practices affect understanding of health and disease and acceptance of conventional medical treatment.
  - High divorce rate
  - Wife inheritance
5. Gender
  - In many cultures it is accepted for men to have many sexual relationships
  - Women suffer gender inequities
  - Many women unable to negotiate condom use

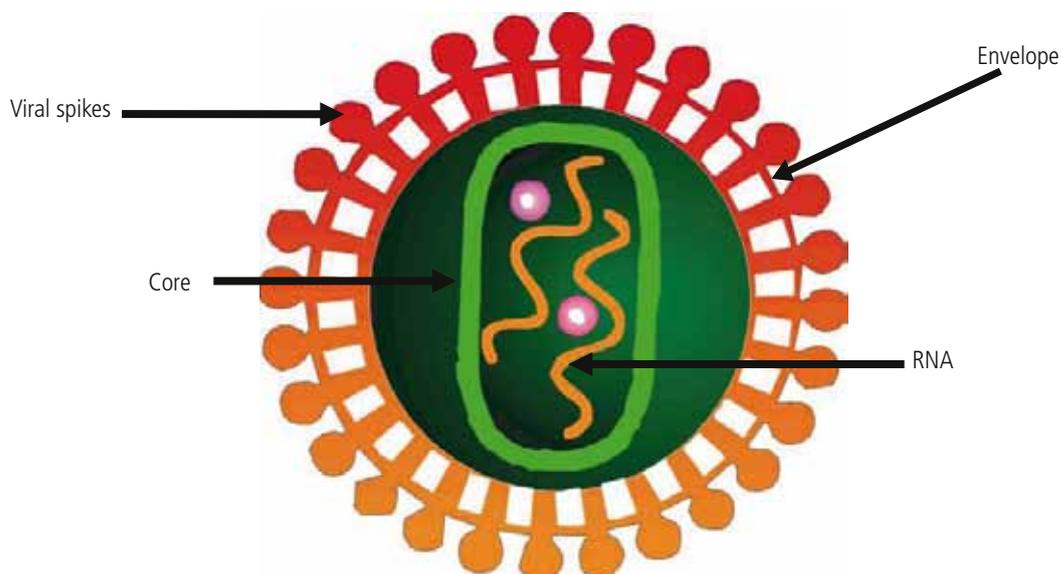
6. Poverty
  - Lack of information needed to understand and prevent HIV
7. Drug use and alcohol consumption
  - Causes impaired judgment
  - Sharing of needles and equipment
  - Chewing khat
8. Biological risk factors
  - Female anatomy
  - Physiology of women (e.g., menstruation, intercourse)
  - Pregnancy-associated conditions (e.g. anemia, menorrhagia and hemorrhage) increase the need for blood transfusion)
  - Sex practices (anal sex, forced sex)
9. Rape
10. Transactional sex (Having multiple sex partners as a means to access opportunities, freedom and favors, e.g. carpet interviews).

## Pathogenesis/Natural History of HIV infection

### Subtypes

There are two main types of HIV: HIV-1 and HIV-2. The virus's origins are not clear but it is believed to have joined the humans as zoonosis of a simian immunodeficiency virus (SIV) strain endemic in sooty Magbey monkeys (SIVsm). HIV-1 is believed to have entered humans around 1940 and is similar to the SIVcmz detected in chimpanzees.

### The HIV Viral Structure



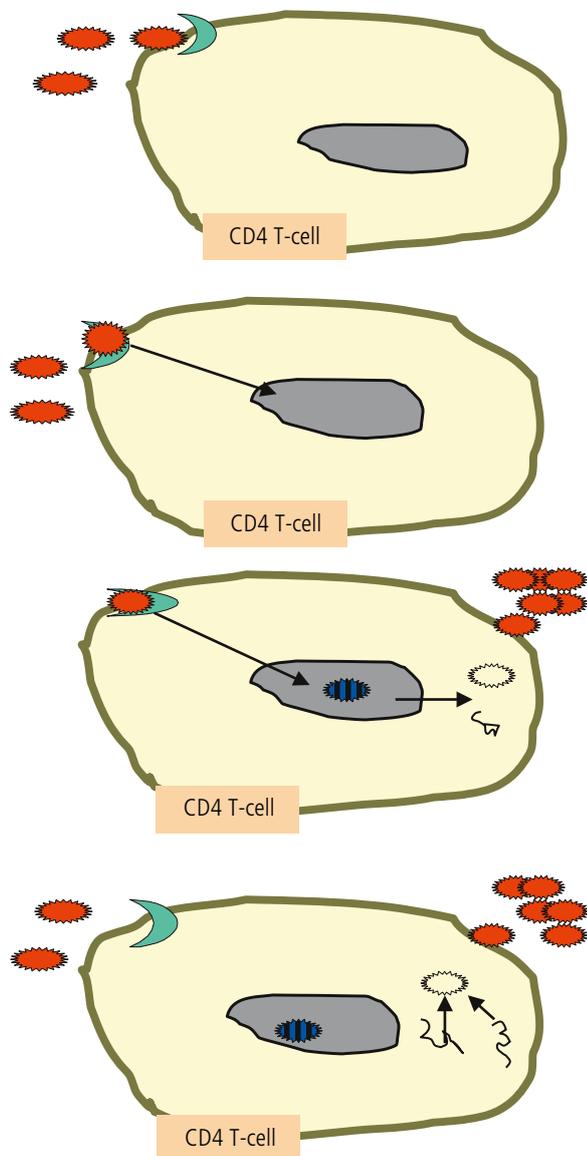
HIV particles surround themselves with a coat of fatty material known as the viral envelope (or a membrane) with around 72 little spikes. These are formed from proteins gp120 and gp41. Just below the viral envelope there is a layer called the matrix. It is made from protein p17.

The viral core (or capsid) is usually bullet shaped and is made from protein p24. Inside the core are three enzymes required for HIV replication; (1) reverse transcriptase, (2) integrase, and (3) protease. The core contains HIV genetic material, which consists of two identical strands of RNA.

## What is RNA?

Almost all organisms, including most viruses store their genetic materials on long strands of DNA (Desoxy Ribonucleic Acid). Retroviruses are the exceptions because their genes are composed of RNA (Ribonucleic Acid). RNA has a very similar structure to DNA. However, small differences between the two molecules mean that HIV's replication process is a bit more complicated than that of most other viruses.

## Stages of HIV Life cycle



- HIV enters the CD4 cell.

- HIV wants to enter the centre of the cell.
- To do this, it needs to make some changes in the way it looks. This is so that it will not be 'recognized' by the cell.
- HIV has a special substance to make these changes in its structure.

- HIV is present in the centre of the cell, but in a different shape.
- Now, the centre of the cell starts to make new parts of HIV instead of making new parts for the body's defence.

- Before leaving the cell, the new parts of HIV need to be put together – just like parts of a car need to be put together.
- HIV has a special substance that helps put the different parts together to form a new HIV before it leaves the cell.

HIV attacks many CD4 cells. The infected CD4 cells will first produce many new copies of the virus, and then die. The new copies of HIV will then attack other CD4 cells, which will also produce new copies of HIV and then die. This goes on and on: more and more CD4 cells are destroyed, more and more new copies of HIV are made, and new CD4 cells get infected.

## Progression of HIV infection

The effects that HIV has on the immune system and on the human body occur over a period of time as follows:

### Primary HIV infection:

At the time of the initial HIV infection, some people may experience a recognizable acute illness, with symptoms such as fever, lymphadenopathy, night sweats, skin rash, headache and cough. These symptoms are usually ignored or are passed off as general flu-like symptoms or as malaria in malaria endemic areas. Opportunistic infections are not seen at this stage. A large majority remains asymptomatic. The majority of those infected do not give a history of this stage of infection because it goes unnoticed resembling other common infections.

### Asymptomatic HIV infection:

This is an asymptomatic phase of HIV infection. After sufficient induction of the antibody response, viral replication is kept under control. Most of PLWH during this phase maintain normal health and are unaware of the disease. The person is asymptomatic and may remain so for a period varying from a few weeks to 7 – 10 years. The peripheral blood CD4 T-cell count is usually above 500 cells/mm<sup>3</sup>.

### Early symptomatic HIV disease:

At this stage symptoms appear including fever, unexplained weight loss, recurrent diarrhea, fatigue and headache. Cutaneous manifestations like seborrheic dermatitis, folliculitis, recurrent herpes simplex infections and oral hairy leukoplakia may occur. During this period the CD4 T-cell count continues to decline. Usually antiretroviral therapy is started at this stage.

### Late symptomatic HIV disease:

As the CD4 cell count falls lower than 200cell/mm<sup>3</sup>, the risk of developing AIDS related opportunistic infections or malignancy is very high. These include pneumocystis carini pneumonia (PCP), toxoplasma encephalitis, disseminated mycobacterium avium complex (MAC), esophageal candidiasis, lymphoma and kaposi sarcoma. AIDS is diagnosed when an infected person presents syndromic characteristics of severe immune depression.

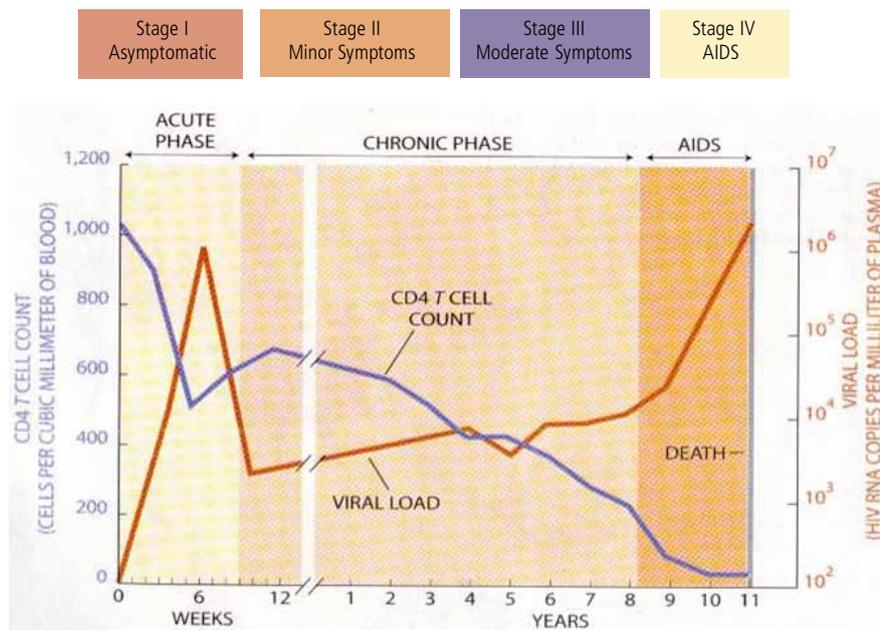
### Advanced HIV disease:

In advanced HIV disease stage the CD4 cell count is less than 50 cells/mm<sup>3</sup>. The patients usually have multiple opportunistic infections and malignancies. ART substantially increases the survival among patients with advanced HIV disease

## Other important issues to note during the progression of HIV

- Significant viral replication induces the immune system to produce antibodies to HIV. The period between infection and production of antibodies, also called “window period”, lasts usually between 2 – 12 weeks but may continue as long as six months. During this time, client is infectious but may not test positive on common HIV antibody tests.
- AIDS is diagnosed when an infected person presents syndromic characteristics of severe immune depression.

## An illustration of HIV infection progression



## Module Two: Approaches and Rationale for HIV Testing and Counseling in a Health Care Settings

### Purpose

This module orients participants to the different approaches to HIV testing and counseling. It also covers the rationale of HIV testing and counseling in health care settings

### Objectives:

- At the end of the module, participants will be able to:
- Describe 4 approaches to HIV testing and counseling
- Explain the rationale for provider-initiated HIV testing and counseling in health care settings
- Explain the rationale for client-initiated HIV testing and Counseling in health care settings
- Describe the benefits of HIV testing and Counseling
- Discuss the challenges and ethical concerns for HIV testing and counseling in a health care setting

### Time to complete module:

90 minutes

### Training materials:

- PowerPoint 2.1: Approaches and Rationale for Health Facility-Based HIV testing and counseling
- Equipment for showing PowerPoint presentation
- Flipchart stand and paper and colored markers
- Copies of handout for all participants

### Advance preparation:

- Tape to the walls the previous Day's flipcharts, if not already done the previous evening.
- Prepare objectives of Modules 2 and 3 on flipchart paper.

### Content:

Approaches and Rationale for HIV Counseling

- Session 2.1: Approaches and Rationale for HIV Testing and Counseling in Health Care Settings

## Session 2.1: Approaches and Rationale for HIV Testing and Counseling in Health Care Settings

**Approximate duration: 90 minutes**

### Training/Learning Activity

#### A. Refresher/learning activity (Large group exercise)

1. **Ask** participants to stand up and find a partner.
2. **Tell** participants to go around the room and teach their partner everything that is on all the flipcharts hung on the wall.
3. **Mention** that the partners should take turns teaching each other.
4. **Allow** about 15-20 minutes for this refresher exercise.
5. **Ask** if there are any questions before proceeding.
6. **Review** objectives for Module 2 prepared on flipchart.

**Facilitator Note:** This group exercise is an excellent way to review information from the previous day and actively engage participants in the learning process.

#### B. Types of HIV Testing and Counseling (Large group session)

1. **Using PowerPoint 2.1: Approaches & Rationale for Health Facility Based HIV Testing and Counseling, describe** the framework in Somali.
2. **Briefly assess** the level of acceptance for HIV testing and Counseling by asking participants:
  - a. What have you heard about HIV testing and Counseling or VCT?
  - b. How do you feel being asked to do it?
3. **Allow** participants to express any resistance to HIV testing and Counseling before proceeding. Listen for issues like: no time, discomfort with topic, forcing patients, etc.
4. **If there is resistance, say,** "We understand you may have some concerns about this service. For the training we ask that you be open to what is presented. Then, at the end of the session, we will see if we have addressed your concerns.
5. **Using PowerPoint 2.1, present** the approaches for HIV testing and counseling.
6. **Continuing with the PowerPoint, review** the rationale for HIV testing and Counseling in health care settings.
7. **Ask** participants what is the rationale for HIV testing and Counseling in the health care setting. Note responses on flipchart.
8. **Using PowerPoint 2.1, review** the rationale for HIV testing and Counseling and highlight anything not mentioned by participants.

#### C. Challenges and Benefits of HIV Testing and Counseling (Large group discussion)

1. **Ask** participants what are challenges and benefits to HIV testing and counseling in a health care setting and present back to the group.
2. **Write** participants' responses on flipchart.
3. **Using PowerPoint 2.1, review** challenges and benefits not mentioned by participants (also see handout).

**D. Ethical Dimensions** (large group discussion)

1. **Ask** participants what are the ethical dimensions related to HIV testing and counseling.
2. **Continuing with PowerPoint 2.1, review** ethical dimensions of HIV testing and counseling in health care settings.
3. **Ask** if there are questions and clarify any misinformation before proceeding to Module 3.

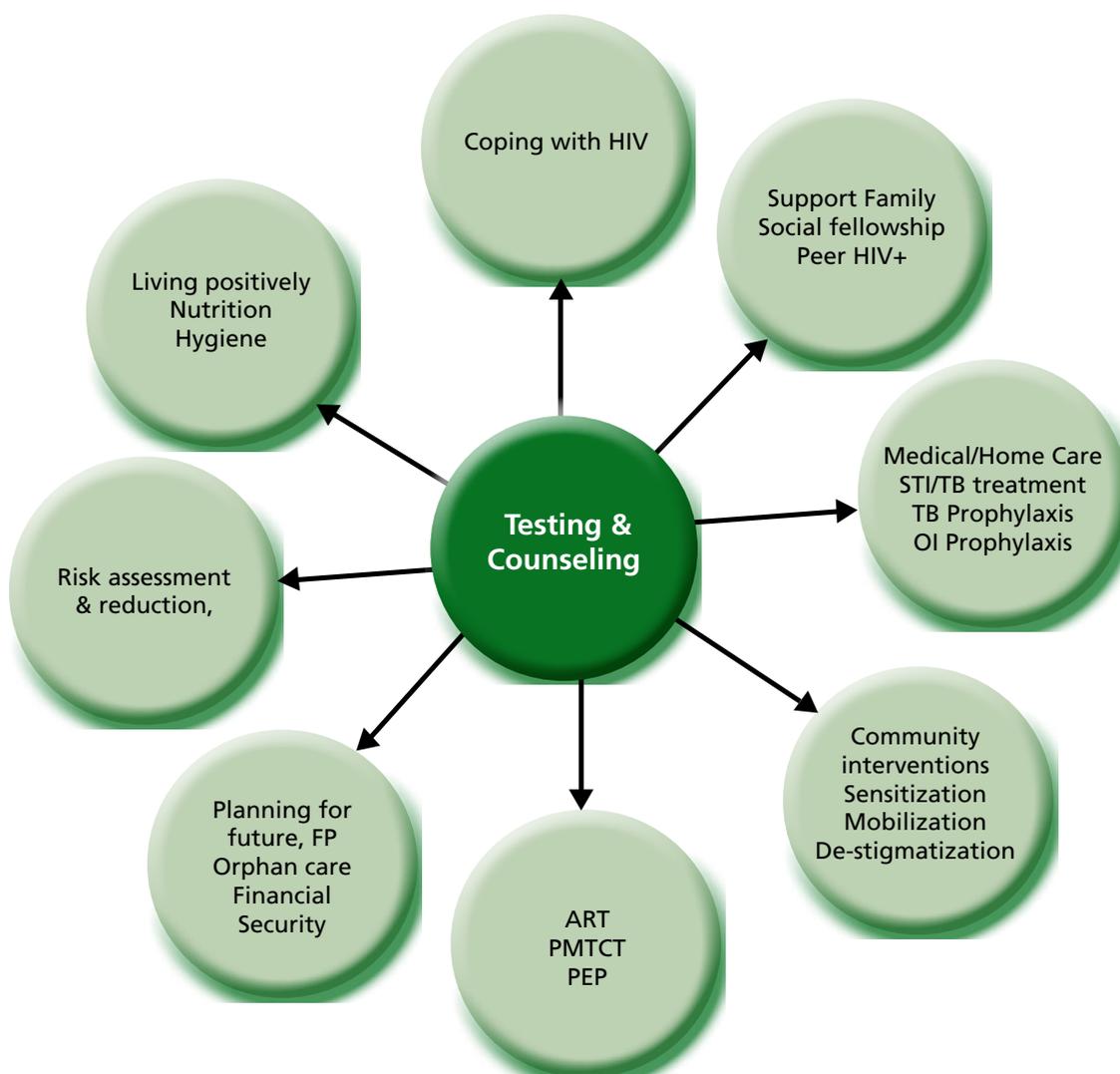
## Approaches and Rationale for HIV testing and Counseling in a Health care setting

### Introduction

HIV testing and counseling is a very important intervention in controlling the HIV/AIDS epidemic. It is the entry point to HIV/AIDS care and prevention. Knowledge of HIV status can help people make better choices for themselves and plan for their future. By providing this knowledge HIV testing offers many benefits.

### Framework for HIV Testing and Counseling in Somalia

Below is a Hub and Spokes model of the most important interventions related to HIV testing and counseling as an entry point to HIV prevention and care:



## The Different Approaches to HIV Testing and Counseling

### Approaches to HIV testing and counseling

All HIV Testing and Counseling must be voluntary.

There is client-initiated voluntary HIV testing and counseling and provider-initiated voluntary HIV testing and Counseling

Client-initiated HIV testing and counseling has been termed “Voluntary HIV testing and counseling”. WHO recommends the use of the term client initiated HIV prevention if a person self-initiates the testing and counseling process. Although self-initiated by the client, health care providers often explain HIV testing and Counseling to clients who then decide whether to get tested or not. It gives the client an opportunity to confidentially explore and reduce risks of acquiring or transmitting HIV. Knowledge of HIV status also enables the client access, care and prevention services. Client-initiated HIV testing and counseling follows the following procedures:

- ✓ Pre-test counseling (individual or group)
- ✓ HIV testing following informed consent by the client
- ✓ Post-test counseling (involving HIV test results disclosure and discussion on their meaning and implications)
- ✓ Individual risk assessment and HIV risk education and reduction plan.

Client-initiated HIV testing and counseling can take place in health care facilities or other settings as long as it is provided in a professional, safe and confidential manner.

### Home Based HIV testing and counseling (HTC)

HBHCT is intended to provide quality home-based HTC to individuals, couples and families. Its activities include educating households and communities about the benefits of home-based HCT; conducting pre-test counseling sessions with individuals, couples and children in the home; conducting a rapid HIV testing using the finger stick method; providing HIV test results to individuals, couples and children in the home; supporting couples and individuals to identify safer goal behaviors and develop a risk reduction plan as well as supporting individuals and couples to disclose their sero-status and encourage partner testing.

### Provider-initiated HIV testing and counseling

Many times client-initiated HIV testing and Counseling cannot fully meet the demand for HIV testing.

Provider-initiated HIV testing and counseling in health care settings has been put in place to use the opportunity of people being in contact with health service delivery to offer an HIV test and Counseling:

- Provider-initiated HIV Testing & Counseling (PITC) - In PITC the health care provider initiates the HIV test by giving information about HIV testing. The client is offered an HIV test with the explanation the test is strictly voluntary and confidential and that the test is not performed if the client does not consent. The health care worker does not conduct an extensive counseling session before the test is done. If the client wishes to make use of counselors, s/ he is referred to a counselor. This is because of the busy nature of the health care environment. However, more extensive counseling is provided when the HIV test result is available and communicated to the client, in particular if the client turns out to be HIV +ve.

It is essential that clients/patients must be provided with sufficient pre-test information that should enable informed choice. Couple and group counseling can be applied as appropriate.

It must be stressed that PITC is not a form of mandatory testing. Clients can “opt-out” if they don’t want to get tested. The routine offer of testing integrates HIV testing into the mainstream health service delivery. This dramatically increases the number of individuals benefiting from approved HIV/AIDS treatment, care and prevention services.

## Rationale for PITC in Health Care Settings

Globally, a lot of attention has been put on the need for increased access to HIV testing as to advance HIV prevention and treatment.

In Uganda, a survey conducted among patients attending Mulago Hospital showed that 70% of the patients wanted an HIV test (Wanyenze et al, 2004). Of these patients who expressed a wish to test, only 10% actually accessed the HIV testing during the period they were hospitalized. When asked why they did not test for HIV, the majority said the reason was that the attending doctor did not ask for it. This is an indicator of missed opportunities in hospitals.

The prevalence of HIV positive individuals is highest in health care settings and the cost effectiveness of HIV testing is enhanced where HIV prevalence is highest. Fewer resources would be required to test and identify a bigger number of HIV positive individuals who would be linked to HIV/AIDS care, compared to VCT.

Majority of patients, who come to the health units with HIV related problems, don't know their HIV status. Many of these are in late stage disease and urgently need care. Further, many patients with early HIV and some with late stage disease do not have obvious HIV-related symptoms. In order to reach all the HIV positive people who urgently need care, it is important to offer the test routinely to all patients, in high HIV prevalence ( $\geq 1\%$  HIV infection among ANC attendees) settings. In low-prevalence settings ( $< 1\%$  HIV infection among ANC attendees) PITC should be offered to all patients with signs or symptoms suggestive of HIV infection and PITC should be considered for selected client/patient groups, i.e. TB patients, STI patients and pregnant women attending antenatal care,

In low HIV prevalence settings PITC should be provided for all patients with symptoms or signs suggestive of HIV infection as part of the clinical evaluation of the patient.

It should be considered for TB patients, STI patients and pregnant women attending antenatal care. In particular TB and STI patients are more likely to be HIV infected than healthy people or other patients with non-HIV related symptoms. The reasons are: TB is a frequent opportunistic infection in PLHIV, and STI patients were exposed to STI through sexual risk behaviour (of their own or of their sexual partners), and may also have been exposed to HIV. These patients benefit from HIV testing because – if found HIV+ve – they will be referred for early initiation of appropriate care. It also benefits those who test HIV negative by empowering them with information that will help them avoid HIV infection.

PITC for pregnant women attending antenatal care should be implemented in generalized epidemics and considered even in low-prevalence settings in order to facilitate access to prevention of mother-to-child transmission services including antiretroviral prophylaxis to prevent infection of the baby and care and treatment for the mother.

Integrating HIV testing into routine care for all patients or selected patient groups whether or not they have HIV related signs and symptoms would reduce stigma associated with testing and HIV infection. In addition, integrating HIV testing into routine service delivery coupled with provision of HIV/AIDS care in health care settings other than specialized HIV clinics normalizes HIV infection; HIV is treated as other chronic diseases.

Providing HIV testing routinely for patients in the health care setting is more convenient than referral to other units for HIV testing. This reduces stigma, discrimination and makes HIV to be handled like any other disease.

Since treatment for HIV related illnesses is now available, HIV testing and counseling in health care setting provides an opportunity for health care workers to discuss and initiate care for the patients early enough which lead to better outcomes of preventive and care interventions. Ultimately, when HIV testing is incorporated into all health care settings, it will provide good HIV/AIDS surveillance data.

Challenges to VCT in Health care setting include:

- Increased workload for health workers
- Staff burnout
- Poor motivation
- High demand for the service
- Human resource, drugs, logistics and infrastructure shortages
- Referral

## Benefits of HIV Testing and Counseling

### Benefits to the individual

For HIV positive clients:

- Early access to care and support
- Access to prevention information and services
- Prevention and treatment for other STIs
- Prevention of HIV transmission to partner and/or unborn child
- Encourages partner disclosure and testing
- Promotes better decision making and planning for future

For HIV negative clients:

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

### Benefits to couples and families

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

### Benefits to the community

- Generates optimism as large numbers of person test HIV-negative
- Impacts community norms (testing, risk reduction, discussion of status, condom use)
- Reduces stigma and discrimination as more persons get tested and HIV testing becomes “normalized”
- Serves as a catalyst for the implementation of care and supports services
- Minimizes on the role of pessimism on transmission of HIV
- Information about HIV prevention, care and behavior change

### Benefits to the health care system

- Entry points to comprehensive HIV/AIDS care interventions and management including PMTCT, treatment of OIs, use of ARVs and psychosocial care
- Compliance with professional ethics
- Reduces fear and stigma related to HIV among health care workers
- Job satisfaction
- Provision of HIV surveillance data to aid in planning, drawing of HIV/AIDS mitigation strategies and mobilizing for funding and resources from donors and appropriate allocation of resources

### **Benefits to the nation/country**

- Provision of HIV surveillance data to aid planning and drawing of HIV/AIDS mitigation strategies
- Data for mobilizing funding and resources from development partners
- Appropriate allocation for resources

### **Ethical Dimension of HIV Testing and Counseling in Health Care Settings**

Medical ethics provide the basis for protecting patients and offer guidance to improve professional practice. All health workers must conform to the code of conduct and medical ethics;

- Respect for persons (autonomy).
- Provide adequate information to patients and all procedures/interventions that will enhance patient's decision making'
- Always obtain consent on all procedures/interventions you are planning;
- Beneficence and non-maleficence.
- Must always select procedures/interventions that maximize benefits and minimize harm to the patients;
- Must have competence to provide the necessary care required of your level of qualifications;
- Ensure confidentiality
- Justice
- Cases considered alike must be treated alike; those that are different should be treated differently to the extent of that difference

#### **For details refer to the medical code of ethics and conduct for health workers:**

- The provision of HIV testing and counseling in health care settings must follow a high level of ethical standard by ensuring that informed consent is obtained and confidentiality of the patient's information is maintained.
- Disclosure and storage of patient's records- whether when dealing with HIV or not- must follow the set ethical standards.

#### **Challenges of HIV testing and counseling in health care settings**

- Stigma
- Logistic
- Civil strike/conflict
- Human resource capacity shortage
- Inadequate infrastructure in counseling (privacy!)
- Lack of enough awareness in the population

## Module Three: HIV Counseling in Health Care Settings

### **Purpose**

To impart knowledge and equip service providers with skills to offer quality basic HIV counseling in health care settings.

### **Objectives:**

- At the end of this module, participants will be able to:
- Define the meaning of counseling
- Describe the benefits of Counseling
- Describe the qualities of a good counselor and the importance of positive attitudes
- Explain the professional ethics in counseling
- Describe four key communication skills
- Describe the counseling process as part of HIV testing and counseling services
- Demonstrate the counseling skills

### **Time to complete module:**

6 hours

### **Training materials:**

- PowerPoint 3.1: HIV Counseling in Health Care Settings
- PowerPoint 3.2: Communication Skills
- PowerPoint 3.3: The Counseling Process
- Equipment for showing PowerPoint presentations
- Role-play scenarios
- Flipchart stand and paper and colored markers
- Copies of handout for all participants

### **Advance preparation:**

- Prepare a flipchart with objectives of Module 3
- Revise case studies in PowerPoint 3.1, if necessary
- Prepare 2 to 3 role-play scenarios

### **Content:**

#### **HIV Counseling in Health Care Settings**

- Session 3.1: Concept and Ethics of Counseling
- Session 3.2: Communication skills and barriers
- Session 3.3 The Counseling process

## Session 3.1: Concept and Ethics of Counseling

**Approximate Duration: 60 minutes**

### Training/Learning Activity

#### A. Introduction

1. **Review** the objectives for module 3.
2. **Explain** that the rest of the day will be spent on counseling and communication skills.

#### B. Concept of Counseling (Large group discussion)

1. **Using PowerPoint 3.1: HIV Counseling in Health Care Settings, discusses** the concept of counseling.
  - What is counseling?
  - Who should counsel and why?
  - When and where to counsel?
  - How should counseling be done?
2. **Ask** participants what are the benefits of counseling. Record responses on flipchart.
3. **Review** benefits of counseling in PowerPoint 3.1. Add any not already mentioned by participants.

#### C. Qualities of a good counselor (Large group discussion)

1. **Ask** participants to brainstorm the definition of “attitudes”.
2. **Process** what they come up with and link with the following definition:

Attitude can precisely be defined as “The way someone perceives a situation, respond to and react towards other people”. Attitudes can be positive or negative. The attitudes we have tend to determine how we respond and react towards other people or their actions.

3. **Continuing with PowerPoint 3.1, review** qualities of a good counselor.
4. **Discuss** the importance of having positive attitudes when counseling. Refer to the handout as needed.
5. **Using PowerPoint 3.1, discuss** how to handle different emotions.
6. **Demonstrate** some examples of handling different emotions.

#### D. Ethics and principles of Counseling (Brainstorm and discussion)

1. **Brainstorm** on the definitions of professional ethics in counseling
2. **Using PowerPoint 3.1, process** participant responses with the following definition:

Ethics refer to a legal set of conduct. They focus on the relationship between individuals within the profession, with other professions and clients. Good ethical behaviour implies treating others with respect, care, compassion, justice and fairness in all aspects of life.

3. **Ask** participants if they have a set of ethics in their health care facility.
4. **Continuing with PowerPoint 3.1, review** principles in counseling.

5. **Ask** participants to give examples of principles they used when counseling clients.
6. **Ask** participants why ethics and counseling principles are important for their profession.
7. **Record** responses on flipchart.
8. **Review** any of the points below not mentioned by participants:
  - Builds confidence and trust in the profession
  - Ensures uniformity within the profession
  - Ensures discipline within the profession
  - Maintains a health relationship within the profession and other professions and clients
  - Serves as security for the professionals and their clients

## Session 3.2: Communication skills and barriers

**Approximate Duration: 2 hours**

### Training/Learning Activity

- A. **Communication Skills** (Large group discussion, lecturette, role play)
  1. **Ask** participants to brainstorm the meaning of communication.
  2. **Process** their responses to come up with a group definition.
  3. **Using PowerPoint 3.2 Communication Skills, review** the definition and types of communication.
  4. **Continuing with PowerPoint 3.2, discuss** the four key communication skills.
  5. **Discuss** the three actions that help you to actively listen.
  6. **Demonstrate** some of the verbal and nonverbal behaviours.
  7. **Continue with PowerPoint 3.2 and explain** the skill of checking understanding.
  8. **Review** ways that a counselor checks understanding.
  9. **Explain** the different questioning skills.
  10. **Demonstrate** questioning skills. **Then ask** participants to demonstrate how to use open and close-ended questions for counseling clients.
  11. **Using PowerPoint 3.2, review** the many responding skills.
- B. **Barriers to effective communication** (Role play and large discussion)
  1. **Conduct** a role-play with a participant demonstrating the different barriers that impede communication.
  2. **Ask** the class what barriers to communication they did observe.
  3. **Using the PowerPoint 3.2, review** barriers/gaps to effective communication.
  4. **Ask** participants to pick a partner.
  5. **Have** one person play the health care provider and the other play the client.
  6. **Using the PowerPoint 3.2, show** the Case Study #1 for role-play.
  7. **Ask** participants to role-play the scene described. Allow about 5-7 minutes for the role-play.
  8. **Ask** the person playing the client to tell their partner about their communication skills – which ones did they use, which ones should they have used, etc.
  9. **Have** the partners switch and role-play Case Study #2. Repeat step #8.
  10. **Answer** any questions before proceeding.

## Session 3.3: The Counseling Process

**Approximate Duration: 3 hours**

### Training/Learning Activity

**A. Counseling process** (Lecturette and large group discussion)

1. **Using PowerPoint 3.3: The Counseling Process, review** the three stages in the counseling process.
2. **Discuss** with participants each one of the three stages.
3. **Talk** about the G.A.T.H.E.R steps.
4. **Continuing with PowerPoint 3.3, review** the counseling model.
5. **Discuss** crisis counseling – the causes and how to identify. Ask participants how they would handle a crisis.
6. **Returning to the PowerPoint, review** the guidelines for crisis counseling and supplement/correct what participants have told you.

**B. Couple counseling - Lecturette, large group discussion**

1. **Using PowerPoint 3.3, discuss** the various aspects of couple counseling.
2. **Discuss** how to counsel HIV discordant couples.
3. **Point out** key counseling messages for discordant couples; adapt for your region, if necessary.
4. **Initiate** a discussion among participants how they handle discordant couples in their health care facilities.
5. **Continuing with PowerPoint 3.3, review** risk reduction strategies.

**C. Role play**

1. **Demonstrate** a proper role-play with a co-facilitator
2. **Ask** 2 volunteers to conduct a role-play demonstrating the counseling process for a person in crisis the way you have done.
3. **Process** the role-play and make a recap of what has been learnt.
4. **Ask** 2 volunteers to role-play a discordant couple.
5. **Process** the role-play and make a recap of what has been learnt.

**Facilitator's note:** Look out for positive attitudes and use of good communication skills during this role-play, give additional feedback that participants have not already said during processing.

## HIV Counseling in Health Care Settings

### Introduction

In health care settings, patients are often critically ill and need other services as such HIV testing and counseling is done within a limited amount time. This calls for health care providers to apply abridged condensed version of counseling that has been proven to be effective in resources constrained health care settings.

## Definition of Counseling

Counseling refers to a supportive relationship that enables a person to help him/herself deal with a problem/concern, such as:

- An interpersonal supportive relationship
- To gain insight into the problem
- Explore options
- Make a plan

Counseling involves a dialogue between a potential (client) and a service provider aimed at identifying the client's concerns and options for dealing with them. The goal of counseling is to help a patient to make an informed decision about VCT and related concerns (HIV prevention, care and treatment).

### Why is it important to do counseling?

- Helps clients make an informed decision
- Helps clients make appropriate planning
- Helps clients cope with difficult situations
- HIV infection is chronic and fatal; therefore, one needs continuous support.

### Who should do counseling?

- Someone trained in counseling
- Someone with good communication skills and positive attitudes
- Someone with the interest and time to help people with their problems
- Someone credible in the community

### Who should do counseling in health care setting

- Health Workers trained in counseling (Doctor, clinical officers nurse, midwife, Auxiliaries, lab tech, Pharmacist, etc)

### Good counseling involves having positive attitudes, which include the following:

- Caring, empathetic, non-judgmental and acceptance
- Confidentiality
- Exemplary

## The Concept of Counseling

### Meaning of Counseling

- Counseling is a process involving a series of sessions as well as follow-ups. This can be done in any location that offers peace of mind and confidentiality for the client.
- It is also a helping relationship to help a person help him/herself cope with some aspect of his/her life.
- It is an interpersonal communication through which person is helped to assess his/her current situation, explore more of his/her own feelings and be able to cope with appropriate interventions.
- It is a dialogue between a person with a problem (Client) and care provider aims at enabling the client to cope with stress and to take personal decisions related to HIV/AIDS.

## Benefits of counseling

- Counseling is necessary for it provides social and psychosocial support to people affected by HIV infection and disease.
- People with HIV often go through periods of acute illness and often need support adjusting to this change in life expectations.
- HIV/AIDS is a new and frightening disease, which has neither cure nor vaccine.
- Counseling helps in the prevention of HIV infection.

## Who needs counseling?

- People who may be worried about their sero-status.
  - Sex Workers
  - Men/women engaging in transactional sex
  - Families wanting to re-unite
  - Men/women engaging in casual sex
  - People exposed to dental or surgical procedures (fearing that equipment was unsterile)
  - Rape victims
  - Couples wanting to get married
  - IV drug users
  - Men having sex with men
  - People having multiple partners
  - Health workers who perform surgical procedures
  - Those whose sexual partners died
- Relatives and families of PLHIV.
- People diagnosed as having HIV/AIDS.
- Care givers of HIV/AIDS patients
- Children born of infected mothers.
- Patients with chronic diseases
- Patients who wish to start the treatment with ARVs.
- Women who wants to have baby
- Blood donors
- People involved in accidents

## The counseling environment

The environment where a counseling activity or session takes place must be given careful consideration. One may possess all the desired counseling skills but may fail to conduct an effective counseling session if the environment is not conducive. The counseling environment should ideally be one that is:

- Clean, airy/well ventilated quiet and private.
- Cool/warm and dry.
- Physically comfortable
- Free from dust, pollution and foul smell.
- Generally welcoming (as much as possible)
- Accessible to the client and the counselor.
- Safe for the client (where they feel secure)

## Who should offer counseling?

A counselor is a person who has the following:

- Knowledgeable about HIV infection and disease.
- Positive attitude
- Good communication skills.
- Presentable and willing to help

Counselors should be well trained and equipped with basic communication skills such as:

- Active listening and clarifying.
- Paraphrasing and reflection
- Summarization.

## Qualities of a Good Counselor

### 1. Empathetic understanding

Empathy is the ability to cognitively and emotionally experience the world from the other person's perspective. Empathy also helps the other person cope and enables them to stand up on their own feet as soon as possible.

### 2. Genuine/sincerity

The ability and willingness to be open, real and consistent in the relationship with the client. To be prepared to give time and attention, to be a "real" person not just someone in a professional role.

### 3. Unconditional positive regard

This is the ability to communicate with the client without blame or negative feeling. Unconditional positive regard enable them to feel accepted the way they are and that they are wanted despite the weaknesses they may feel. The counselor cares and respects the client.

- This conveys love and care.
- Reduces fear and resistance from the clients.
- Brings about healing.

### 4. Emotional stability and maturity

The counselor should be a mature person, who can handle his/her own problems effectively. S/he should be aware of his/her feelings and motives, free from unnecessary anxiety and insecurities. This helps them to offer counsel that is objective, unbiased, wise and supportive. In short, be able to fame your personality to fit in the required attitudes of counseling.

### 5. Warmth

The counselor should express warmth and caring to the client. This helps the client to feel more connection with the counselor and open up.

### 6. Knowledgeable

Counselors should be well trained and equipped with basic skills such as:

- Basic facts of HIV infection and diseases
- Basic theory and practice of counseling

- Basic knowledge on human health issues
- Basic knowledge in adult training

## Handling Different Emotions

### Important points:

- Any emotions experienced under whatever circumstance are natural reactions.
- Such emotions are healthy human responses that help one under go or cope with difficult circumstances.
- Everyone experiences these emotions at one time or another.
- Understanding one's emotion can be helpful.
- Note facts about the emotion are a better way to deal with it. That is, face the reality, and deal with the feelings (whatever it may be).
- Accept it; be a strong person, you will live happily.

### Some of the most common emotions that occur around HIV testing and counseling:

#### 1. Denial

Sometimes people react by denying the facts about a situation as a way of coping temporarily. It is better to help such people face the reality of the emotion.

#### 2. Anger

The experiences one undergoes may seem to be unfair. Therefore, one may feel angry with oneself, others and the situation at large.

#### 3. Guilt

Some people blame themselves for the incidents, it is comforting to help them know and believe that they are also human – capable of making mistakes. These are events in life one may not control, get rid of or undo.

#### 4. Loneliness

Some incidents such as isolation and discrimination may make one lonely and afraid. Help them share with trustworthy friends their experience; join support groups, make friends and these feelings may fade. Help clients to become involved in various activities, relax and focus on the future with hope. This will help them through no matter how difficult the circumstance may be. It is important for them to know that we shall all die. The most important thing is the quality of life one lives.

#### 5. Feelings of Shame

Some people who hold a significant position in society like religious, clan leader family head and all parents may feel that their infection will create a situation of shame in the eyes of their people.

### General tips on counseling

- Remain calm, even though a client may be upset crying or angry during counseling. If you are completely overtaken by emotion, don't deny it but stop a bit and explain.
- Show interest in the client as a person.

- Show some understanding for what a person has to say.
- Focus on the most important problem, if there is one.
- Listen for cause of the problem.
- Try to be silent, if this is required.
- Accept the client's feelings, whatever they are.
- Help people talk about their feelings.
- Give comfort and care.

The following are some guidelines the counselor should not do:

- Interrupt the person while he/she is talking.
- Argue with a person about their feelings or views.
- Pass judgment.
- Give advice unless requested (rather give information).
- Jump to conclusions.
- Moralize, preach or patronize.
- Give unwarranted reassurance.
- Label a person rather than find out the patient's motivations, fears and anxiety.
- Encourage dependency on the counselor by making him or her more important than is necessary.
- Try to solve all the client's problems or take on responsibility for the client.

## Positive Attitudes in Counseling

**Attitudes** can be precisely defined as "The way someone perceives a situation, responds and reacts towards other people." Attitudes can be positive or negative. The attitudes we have tend to determine how we respond and react towards other people or their actions.

As counselors, it is essential that we have "Positive Attitudes" in order to be able to help others. There are 5 basic attitudes we must have as counselors when offering help to people with HIV/AIDS, their families or anyone who is concerned about HIV.

### 1. Caring

A counselor cares and wants to help. We show that we care by being approachable; interested in each person we are offering help to and prepared to make time to talk. We try to show warmth and concern and that we are trustworthy, honest and reliable.

### 2. Empathy

A counselor should want to understand fully how the person is feeling. We try to imagine what it is like to be in the situation of the person we are trying to help, by imagining ourselves in their "shoes". Empathy is different from sympathy in that the former does not involve one's emotions in the counseling sessions.

### 3. Accepting (Non-Judgmental)

A counselor accepts the person they are offering help to as they are. A counselor should not be moralistic or judgmental about what the person tells him/her and should always show respect and neutrality towards any client.

#### 4. Maintaining privacy and confidentiality

It is the duty of the health care provider to provide privacy when talking to a client about HIV. It is also very important to keep the confidentiality of the information provided to you. The World Health Organization defines privacy and confidentiality as the following:

- **Privacy** is the “right and power to control the information about oneself that others possess”(WHO 2000b). Privacy also commonly refers to the privacy of a person and the rights of individuals not to be physically exposed against their will.
- **Confidentiality** is “the duty of those who receive private information not to disclose it without the patient’s consent (WHO 2000b). Confidentiality is the mechanism through which the client’s right to privacy is protected.

### Professional Ethics in Counseling

#### Ethics

This refers to a legal set of conduct. Ethics focuses on the relationship between individuals within the profession, with other professions, and with the clients. Good ethical behavior implies treating others with respect, care, compassion, justice and fairness in all aspects of life. Ethics are very important for a profession because they help to:

- Build confidence/trust in the profession.
- Ensure uniformity within the profession.
- Ensure discipline within the profession.
- Maintain a health relationship within the profession and with clients.
- Serve as security for the professionals and their clients

Just like other professions, counseling has a legal set of conduct. This includes:

#### 1. Respecting the client

- Regardless of who the client is, his/her behavior, the client has come to you for help and deserves to be treated as a human being of worth.
- The counselor has a responsibility to help his/her clients feel okay about themselves and to increase their feelings of self worth.
- If the counselor imposes his/her own moral values on the client, the client is likely to feel judged. This damages their self-worth, and as a result clients are likely to reject the counselor’s advice as well as the services he/she is offering.

#### 2. Giving the client precedence:

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

#### 3. Ensuring competence

- A counselor has a responsibility to ensure that s/he gives the highest possible standard of service to the client(s). This calls for adequate training and supervision.
- Counselors need to attend to their own professional development and should be supervised and supported on a regular basis.
- A counselor needs to be aware of his/her competence both professionally and personally in case of any limitations, appropriate referrals should be made.

#### **4. Making appropriate referrals**

- When a counselor cannot adequately meet a client's needs, that counselor has the responsibility to make an appropriate referral in consultation with the client.
- Counselors should be knowledgeable about available services and referral and networking.

#### **5. Knowing the limits of the client – counselor relationship**

There should be a limit to the client counselor relationship. This relationship should be purely professional. The relationship must avoid creating any suspicions or temptations. Appropriate boundaries have to be set; if no then the ability to help the client diminishes.

#### **6. Avoiding self-promotion**

It is unethical for a counselor to make claims about him/herself or his/her services, which are inaccurate or can't be substantiated. Counselors who do this not only put their clients at risk, but may also face the possibility of prosecution.

#### **7. Ensuring safety**

Counselors should take all reasonable steps to ensure their own safety and ensure that their health is not compromised.

#### **8. Maintaining responsibility to other counselors**

During counseling related activities, counselors must not conduct themselves in ways that undermine the work of other counselors. Professional counselors should respect each other and should work in harmony with fellow counselors.

#### **9. Knowing when and how to terminate counseling**

It is not ethical to terminate counseling at a point where the client still needs further help. If for some unavoidable reason (e.g. shifting) then a suitable referral must be made to another counselor.

#### **10. Following legal obligations**

Counselors like all other professionals and every other member of the community need to operate within the law. As a counselor, you need to be familiarize with the regular legal requirements e.g. if your client is an offender or a victim then a legal action is to be undertaken.

#### **11. Maintaining confidentiality**

Confidentiality is one of the most important ethical issues for a counselor. The client must feel secure after knowing that the information they have shared will be treated with a high degree of confidentiality. However, there are some instances where confidentiality ought to be shared:

- When there is a need to keep and utilize records e.g. educational and research purposes
- For the requirements of professional supervision
- When a sexual partner needs to be protected from HIV infection, encourage supported disclosure.

#### **12. Being exemplary**

The counselor's personal life style should incorporate and reflect all the characteristics of a good counselor. The counselor must avoid substance abuse, being promiscuous engaging in domestic violence or other forms of behavior and abuses not consistent with family, professional and community harmony.

## Principles of Counseling

These refer to a set of norms that guide implementation (standard). Principles aim at ensuring quality services. Below are universal principles that counselors are expected to know and practice:

### 1. Treat clients as individuals

People want to be treated as individuals rather than a case or type. Thus, when dealing with a client do not treat him/her as a person of a particular type, religion, or region. If a client senses that he is being treated as a case, this can lead to rejection and hostility. Everyone is unique though they may face similar circumstances. It is important for counselors to honor that.

### 2. Allow self-expression of feelings

All human beings need to be given the opportunity to express their feelings including negative feelings. The client's self-expression enables the counselor to understand the client's situation from the client's perspective. The client is also given an opportunity to air out the stressful feelings. When heard, they are more likely to feel acceptance of being listened to and being attended to.

### 3. Create rapport

This involves setting a conducive atmosphere where the client feels free to express his/her feelings and concerns. The kind of relationship developed with a counselor determines the quality of the session and service offered.

### 4. Client self determination

Help clients identify and fulfill their goals as well as needs within the limitations of their capacity, potential, and circumstances. Proceed as if the best solutions to a client's problems are to be found within client self. Counseling helps enable clients to develop and improve the life skills needed to cope with their problem/situation within their resources. The counselor should help the client become independent and not dependent.

### 5. Be impartial

A counselor should not take sides or blame any client for what is happening in their lives or the problems they are facing. A counselor should always take a neutral stand while handling clients. The counselor should control their own personal values from influencing the way you deal with clients. Continually emphasize an attitude of high regard for the clients as worth people need to be listened to impartiality.

### 6. Control emotional involvement

If a counselor cannot control his or her feelings, the client then doubts whether the counselor is able to help him/her. Such emotions or feelings may include crying, quarreling, developing sexual relationships, etc. Counselors should represent an alternative source of support to the client. Therefore, counselors need to have empathy instead of sympathy.

### 7. Allow for self-reflection

Dealing with human beings calls for continuous self-critique in order to improve a counselor's ability to help his/her clients. Counselors need to always reflect into their personal values and attitudes towards different clients they handle and improve where necessary.

### 8. Know yourself - self-awareness

This involves knowing one's strong and weak areas. It is important for a counselor to know where his/her strong and weak areas. This helps him/her to determine what kind of situation s/he can or cannot handle effectively with a client. In most cases, if a counselor finds out that he cannot handle a situation, then s/he can easily refer the client to another counselor.

## 9. Externalization.

Counselor should not label clients according to their problems. This promotes discrimination and stigmatization. Separate the client from the problem. For example, never refer women on PMTCT program as 'PMTCT mother's or "NVP babies." Instead, refer to them as mothers on PMTCT Program or babies who receive NVP.

## Communication

### What is a communication?

A communication is when two or more people exchange messages using verbal and non-verbal language. Communication is when a person sends a message to another person with the hope and desire of receiving a response through an appropriate channel. It happens because two people want to share information, ideas, thoughts, feelings etc and get another person's feedback. Therefore, communication is a key to every aspect of our lives. It plays an important role in building and strengthening our relationships with people. The way a person communicates with another will affect how the other person reacts: For example,

- Aggressive communication will trigger an aggressive or defensive response.
- Assertive behavior is important so we can negotiate for the things we want without being bullied or influenced by other.

### Types of communication

Every face-to-face communication involves verbal and non – verbal messages. Usually these messages are matching. So, if a person is saying that he or she appreciates something you have done s/he is smiling and expressing warmth non – verbally.

- **Verbal communication** is the exchange of ideas through spoken and written words.
- **Non – verbal communication** involves the expression of ideas, thoughts, or feelings without the spoken or written word. This is generally expressed in the form of body language that includes hand gestures, body posture, and eye and facial expressions. If a person is verbally saying one thing but is sending a different message non – verbally, it is often a sign that what the person is saying is not entirely true. It is important to pay attention to verbal and non – verbal messages.

Non – verbal communication	Associated feeling
Smile	Happy
Frown	Unhappy
Does not sit still on the seat	Uncomfortable
Moving legs up and down	Tense
Cannot keep hands still	Tense
Eyes widen	Afraid
Scratches head	Unsure of herself/himself
Eye contact	Serious, paying attention
Nodding the head	Understanding
Sitting close by	Relaxed
Leaning towards	Interested/ encouraged to continue
Eyes wide open, mouth agape	Disgusted

## Communication Skills

Counseling involves a two-way communication between a health worker and the client aimed at identifying the patient's needs, providing appropriate information and enabling the client to make his/her own decision based on his/her needs. Effective counseling requires the use of good communication skills so that health workers can understand the situation from the patient's point of view, not their own experiences or opinion. Because counseling is client centered and must emphasize problem solving, it is essential for the health worker to use skills that they help clients solve many of their own problems.

Effective communication involves the use of four key communication skills:

1. Listening
2. Checking understanding
3. Asking questions
4. Responding

### 1. Listening skills

Often we hear, but we aren't listening to the clients. Studies done on client/counselor interaction show that counselors often interrupt the client many times during counseling exchanges, cutting off critical information that the counselor can use in assisting with decision making. This does not show respect for the client and does not allow the client to feel at ease.

It is important to listen because it:

- Builds rapport and makes the client feel as if his/her needs are important.
- Helps you evaluate the client's comprehension of what you say
- Clarifies information given by the client.
- Encourages the client to talk because they know you are listening to them.

Below are several skills that counselors can use to improve their capacity to actively listen to their clients.

#### **Be attentive**

Attending skills are essentially verbal and non-verbal actions that demonstrate to a client that you are attentive to them and their needs. In this way, the client feels heard. Good non-verbal attending behaviors include:

**R** – Relax – make time to attend to the patient and keep an open body posture.

**O** – Be open

**L** – Lean forward.

**E** – Eye contact - Keep eye contact with the patient and other persons he/she is talking to.

**S** – Sit/Stand close enough, facing the client, to indicate good rapport and acceptance.

#### **Observe**

While it seems obvious, many health workers do not observe how the client is receiving their messages. They continue talking and do not tailor their messages based on how a client is feeling. Observing helps you to:

- Read a client's nonverbal behaviour, posture, facial expressions and tone of voice
- Understand how what you are saying is being received
- Tailor your messages or behaviour based on what you observe

Observing involves three simple steps:

1. Look at the client's face, body position and body movements.
2. Formulate an inference of the client's feelings based on what you have observed.
3. Take appropriate action based on the inferences made.

### **Be Neutral**

It is important to remain neutral so that you show you are listening to the client and are interested in what they are saying. This encourages the client to continue talking. Examples of ways to show neutrality are:

- "I see."
- "Uh huh."
- "That is interesting."
- "Is that so?"
- "I understand."

### **Don'ts in listening:**

- Don't argue
- Don't interrupt
- Don't pass judgment too quickly
- Don't give advice unless client asks for it
- Don't jump to conclusions

### **Other tips on active listening:**

- Stop talking
- Remove distractions, e.g. phones, fiddling around with objects
- Concentrate
- Look interested (maintain good eye contact)
- Check that you are understanding you hear (time to time repeat and summarize)
- Be patient

## **2. Checking understanding**

It is important to check your understanding of what the client has said. This demonstrates to the client that you are listening and interested in what they are saying. It also gives you the opportunity to make sure you understood the problem or issue. If not, the client can restate what they wanted to tell you. Below are several ways the health worker can check understanding.

### **Clarify**

The purpose of clarifying is to get additional facts and/or to make sure that you understood what the client was expressing. Clients feel that you are really listening to them when you seek to clarify information. Clarifying also gives you the opportunity to supply additional information or correct misinformation. Examples of clarifying are:

- "Are you saying that.....?"
- "Exactly what do you mean by that?"
- "Correct me if I am wrong....."
- "Do you mean...?"
- "No, HIV is not transmitted by eating from the same dishes."

### **Paraphrasing**

The purpose of paraphrasing is to explain back what you think you heard the client say. You essentially restate what you heard in your own words. Paraphrase both facts and feelings. This gives the client an opportunity to correct the facts if you have incorrectly summarized the situation. It is also a useful way to keep the client talking. To paraphrase effectively, the health worker must listen actively; the health worker must determine what is being said and check with the patient that the paraphrase is accurate. Some ways to paraphrase are to say:

- "If I heard (or understood) you correctly ..."
- "These are the key ideas I heard you express..."

- "What I think I hear you saying is...."
- "This sounds as though."
- "Did I hear you say...?"

### **Reflect**

Reflecting shows that you understand the feelings expressed by the client. It also helps the client evaluate and moderate his/her feelings as expressed by the counselor. Useful phrases help to reflect feelings in a counseling context, particularly when the patient is primarily expressing feelings and not giving clues about the association. Examples of ways to reflect are:

- "So it is a shocking thing as you said..."
- "You must have felt that you were not taken seriously..."
- "You felt you were not treated fairly...?"
- "You feel (feeling word: sad, anxious, relieved) because (paraphrase..)."
- "You seem (feeling word: confused, happy, excited). What is happening to you?"

### **Repeat**

Saying what the patient has said in his or her own words. At times of stress and crisis, people may be in a state of denial or feel overwhelmed, so they may not always comprehend everything they are told. Health workers should repeat the important information for the client if they believe he or she has not absorbed what has been said.

## **3. Asking questions**

Why do we ask questions? In order to get more information, clarify a point, or confirm what we have heard. There are two main types of questions:

- Close-ended questions
- Open-ended questions

### **Close-ended questions**

Close-ended questions demand short answers, e.g. "How old are you?", "What is your name", "Do you go to school", etc. Often they require a "Yes" or "No" answer. For example, "Did you have unprotected sex?" or "Are you married?" When overused, they tend to lead to an interrogation, rather than counseling. These questions also limit the conversation, your ability to gather information as well as ask follow-up questions.

### **Open-ended questions**

These invite longer explanatory answers. They allow the patient to talk more about their concerns. For example, "How did you know your wife was pregnant?" or "What is composition of your family?" Open-ended questions give patients an opportunity to express themselves freely and make it easier for you to identify their needs and priorities. They are also useful in starting a dialogue, finding a direction, and/or exploring a patient's concerns. Open-ended questions usually begin with "How", "When", "What", "Could".

Open-ended question also help the health worker to avoid making directive statements such as, "You have to use a condom every time you have sex", and put the responsibility in the patient's hands. "What do you think you can do to protect yourself?"

Sometimes after you ask a question, there is silence. Often the client is thinking of his/her response or how to phrase what they want to say. This silence questions is a golden opportunity for the health work NOT to say anything. Don't jump in to fill the void. Eventually the client will talk. Often the most revealing information follows such silent periods.

## **4. Responding**

When answering questions use simple, clear, age-appropriate language. Make sure to provide accurate and complete information. Most importantly, be honest when don't know the answer to a patient's question. Note that some questions do not have answers. Responding to questions also requires good communication skills.

### **Paraphrasing**

The purpose paraphrasing what a client says is to check if your interpretation coincides with that of the client. It also helps to show that you, the counselor, understand what the client is saying. It mirrors reflections that clarify the original statement. Ways to paraphrase are 1) Repeat what the client has said and 2) use different words for clarity.

Examples of ways to begin a paraphrase are:

- "As I understand it, your idea is."
- "This is what you have decided to do and the reason is."
- "So what you have said is."

### **Reflecting feelings**

The counselor should comment on the feelings being expressed by this client. Clients' feeling may or may not be congruent with what is discussed. For example,

- Sad topic and client is crying (congruent). Appropriate response might be, "You seem distressed."
- Sad topic but client is laughing (not congruent). The verbal and nonverbal behaviors do not seem to match. An appropriate response might be, "We're discussing death and your are laughing, help me understand you better."

### **Clarifying**

This helps to ensure that the counselor understands clearly what is being said. Clarifying helps:

- Prevent misunderstanding
- Focus on what has been said, e.g. "When you talk about taking care of things, do you mean.....?"

### **Summarizing**

Summarizing pulls conversation together so that the client can view the whole picture. This enables the counselor and client to understand each other correctly. When summarizing a counselor should review all the important points, highlight the decisions made and reinforce the next steps forward.

## **Barriers to Communication/Gaps in Communication:**

Below are factors that affect the effectiveness of communication:

- Detractors, like shuffling papers, noise, other people interrupting
- Inconvenient venue
- Language
- Doubts not cleared
- Lack of information by the health worker
- Too much information
- Not listening
- No time
- Not checking understanding
- No follow-up
- Asking inappropriate questions
- Interpreting and jumping into conclusions
- Distance
- Cultural/religion differences
- Generation gap (age, etc)
- Professional Gap

- Economic gap
- Lack of trust
- Mannerism
- Audibility
- Pride and prejudice
- Closeness and intimacy
- Gender
- Social conflict
- Disability
- Socially branded people
- Social abnormality
- Fanatic

## The Counseling Process

For health care providers to help patients to make an informed decision about HIV testing and counseling and deal with their related concerns, they need to help patients to explore their problems, identify realistic options and make plans. Health care providers should use an appropriate mix of interpersonal and communication skills and knowledge about HIV testing and counseling following the three stages of the counseling process as described below:

### The stages in the counseling process:

#### **1st Stage: Telling the story (Problem identification stage)**

The main question at this stage is, "What is the problem?" Help the client narrate his/her story/problem(s) this stage involves:

- Creating rapport
- Explaining services offered
- Assuring the person of privacy and confidentiality
- Giving orientation information when necessary
- Helping client identify and assess his/her problems. (Probe in order to identify the real problem as opposed to the one presented.)
- Helping client prioritize his/her problems
- Addressing problems according to urgency.

#### **2nd stage: Identifying possible options**

The main question at this stage is, "What can be done to solve the problem?"

- Help the client explore possible options and explain the implications of each.
- Discuss the implications of each option.
- Help the client identify the possible practical option.

#### **3rd stage: Making an implementation plan**

The main question at this stage is "when, with who, where and what to do to solve the problem?"

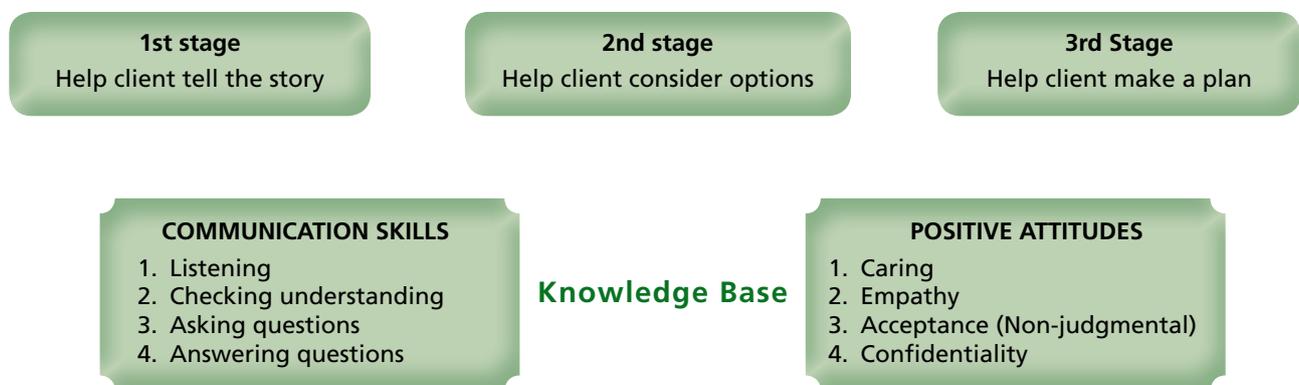
- Help the client come up with a realistic plan for implementing the option chosen.
- Help the client make a program on how and when to implement it.
- Help the client identify appropriate referral units for care and support.
- Encourage client to come back for supportive counseling.

The three stages can best be summarized using the GATHER steps:

- G – Greet the person, show respect and assure confidentiality.
- A – Ask about the problem, anxieties, worries, and determine their access to help.
- T – Tell them any relevant information – accurate, specific, simple language, repeat important points.
- H – Help them make a decision to test and explore various options for risk reduction.
- E – Explain any misunderstanding.
- R – Return for follow up.

## The Counseling Model

Counseling is a framework that comprises of three main stages that form the counseling process standing on two major pillars that is positive attitudes and good communication skills. To be effective in providing the service, it is important that the HBVCT counselor is very knowledgeable on facts about HIV/AIDS and related issues. This can be illustrated as a table with two sides (pillars) and three plates (stages).



## Counseling of Special Cases (For the refresher training only)

### 1. Crisis Counseling

A counseling crisis is a situation that seems dangerous and completely out of a person's control at the time. Examples of such crises are:

- A situation of excessive stress, pain.
- A period when one lacks control of what is happening
- Crisis counseling
- Helping a person experiencing a crisis to gain some control over a situation
- The situation usually needs immediate attention.

#### Common causes

- Intensely threatened
- Surprised completely
- Loss of control or hope
- No solution

#### How to identify a crisis (indicators):

- Crying
- Anger
- No response – the client could be in shock or denial

- Denial
- Anxiety – client may feel overwhelmed by fear or worry which prevents him or her from doing simple tasks

**A crisis can occur where there is panic or threats of suicide, e.g.:**

- “This cannot happen to me”
- “I just can’t believe it”
- “Nothing makes sense anymore”
- “I don’t know what to do”
- “I don’t know where to turn for help”
- “No body understands what I am going through”

**Possible Solutions**

Sign/Indicator of crisis	Possible Solution
Crying	<ul style="list-style-type: none"> <li>■ Allow client to ventilate.</li> <li>■ Comment, e.g.: “This must be difficult for you... would you like to tell me what is making you cry?”</li> </ul>
Anger	<ul style="list-style-type: none"> <li>■ Don’t panic and stay calm.</li> <li>■ Allow client to express feeling.</li> <li>■ Explain that their feeling is normal and let them explain what is making them angry</li> </ul>
No response	<ul style="list-style-type: none"> <li>■ Acknowledge client’s difficulty in accepting this information</li> <li>■ Let them talk about their feelings.</li> </ul>
Anxiety	<ul style="list-style-type: none"> <li>■ Remain calm</li> <li>■ Accept as genuine and guide accordingly</li> </ul>

**Guidelines for crisis counseling – W-E-A-T-H-E-R approach**

W – Watch the client’s verbal and non-verbal expressions	<ul style="list-style-type: none"> <li>■ Remain calm and show confidence.</li> <li>■ Listen actively.</li> </ul>
E – Elicit emotions	<ul style="list-style-type: none"> <li>■ Show empathy and reflect on feelings.</li> </ul>
A – Ask about concerns and fears	<ul style="list-style-type: none"> <li>■ Show empathy.</li> </ul>
T – Treat concerns as normal	<ul style="list-style-type: none"> <li>■ Allow client to ventilate.</li> <li>■ Assess risk suicide</li> </ul>
H – Help with hope	
E – Empower the client	Agree on plan of action; don’t prescribe.
R – Relate to HIV. Reaffirm your empathy & hope	Refer in case of difficult situation.

**2. Couple counseling**

A couple is any two clients who come to take an HIV test together; they may already be having sex or planning to have sex.

**Types of couples**

- Pre-sex couples.
- Dating/engaged couples.
- Married couples

- Secret marriage (qudbo siro)
- Polygamous couples
- Re-uniting couples

#### **Benefits of couple counseling**

- Strengthens relationship and promotes mutual understanding between the couples.
- Promotes behavior change
- Educates that HIV is a disease of the family
- Helps couple to cope with HIV and plan for their future together
- Enhances opportunities of PMTCT
- It becomes easier to deal with issues of discordance
- Eases disclosure of HIV sero status
- Helps to reduce conflicts between couples around HIV

#### **Principles of couple counseling**

- Seek consent of couple to be counseled, tested and receive results together.
- Create conducive and trusting relationship with the couple.
- Contract with both of them
- Let them know that there will be equal air space
- Pay a lot of attention to verbal and non-verbal communication
- Address individual needs of each member of the couple
- Don't judge – remain impartial
- Be in control of session and remain focused

#### **What to emphasize**

- Discordant results among other results
- What it will mean to them if it happens.
- How they will each cope with the results
- Discuss advantages of knowing their status as a couple
- Discuss about other people that might be affected/infected

### **3. HIV Discordance Counseling**

Discordance occurs when the couple's HIV sero status is not the same, that is to say, one partner is HIV positive and the other is not.

#### **When does discordance occur?**

- In many cases, a couple enters the relationship when they are discordant
- Sometimes a couple becomes discordant due to outside partners or other exposures to HIV.
- Couples can remain discordant for a long time – even more than ten years (Among married couples who tested at AIC, discordance was 15%).

#### **How common is discordance?**

- Very common: 5-35% of couples in sub-Saharan Africa are discordant. In Uganda, 10% of couples are estimated to be discordant relationships of these; in about half the male is positive.
- About 40% of all new infections in Uganda today take place in married couples. As a matter of fact, 35% of TASO female clients living with an HIV – negative spouse of TASO Mbale (Uganda 2002).

### **Risk of HIV transmission in HIV negative partner**

- On average in a year, 10-12% of discordant couples will transmit HIV to the negative partner.
- Negative partners in discordant couples are the highest known risk group in Uganda today, with a risk ~10 times higher than that of the general population
- Of 415 discordant couples in Rakai study, 12% transmitted HIV to the negative partner (zero-converted) per year
- In a recent study in Tanzania, HIV-negative partners in discordant couples were 58 times more likely to get infected than individuals in concordant negative couples.
- Opportunities for HIV discordant vs. concordant couples
- Negative partner's life saved.
- Partner availability for quality support of infected partner
- Reduced cost of care and treatment
- Partner availability for child care

### **Health care providers who are counsel opportunity to support discordant couples in the following ways:**

- Reduce risk of transmission to HIV negative partner
- Save lives
- Provide accurate information
- Explain discordance
- Dispel disbelief and myths
- Help couple understand advantages of being discordant
- Help couple develop coping strategy and risk reduction plan

### **Counseling concerns of discordant couple**

- Emotions/Reactions to differing results
- Shock
- Disbelief, confusion
- Blame
- Anger
- Relief, etc.
- Keeping negative partner uninfected.
- Continued care and support for positive partner.
- Confusion about discordance - "I am puzzled, and sometimes I think that perhaps the virus is still too immature to be detected from my blood—I really don't know. Perhaps I have it but it just hasn't shown yet..." ((HIV-negative female in discordant couple)
- Emotional stress - "Most times my husband complains of using condoms. He threatens me that he may refuse to use them, saying 'was I born to suffer with condoms?' This makes me fear that one time he will refuse to use condoms. This puts me at risk. Sometimes he beats me if I refuse to have sex ..." (HIV-negative female in discordant couple)

### **Counseling messages**

- HIV discordance is common - it is NOT a sure sign of infidelity.
- NO ONE is immune from HIV infection.
- A Couple can remain HIV discordant for a long time.
- HIV is NOT transmitted on every exposure.
- The chance that HIV will be transmitted depends on a number of factors.

- HIV negative partners in discordant couples are at very high risk of infection
- HIV transmission within discordant couples CAN be prevented.

#### **Risk Reduction Options**

- Use condoms every time you have sex.
- Abstain or reduce frequency of sex.
- Diagnose and treat sexually transmitted diseases.
- Seek on-going support (Couple Club).
- If all other options fail, consider separation

## **Module Four: Technical Guidelines & Procedures for VCT Integration**

### **Purpose**

The prevalence of HIV positive individuals is highest in health care settings. Therefore, there is clear need for HIV/AIDS testing and care to be integrated in health services that are already serving clients. This will help clients to access early care and provide support for HIV positives. Integrated VCT services will also result in fewer of hospitalization due to opportunistic infections, and improve HIV risk reduction. In this module, participants will be taken through the process of integrating VCT in health care settings.

### **Objectives:**

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

Describe the four steps needed to integrate VCT into the health care service delivery

Describe the typical patient flow for VCT integration and adapt it to participants' health care facility.

Describe the procedures for providing HIV testing to a client

Demonstrate providing VCT to a client

### **Time to complete module:**

3 hours

### **Training materials:**

PowerPoint 4.1 Guidelines and Procedures for VCT Integration

Role-play scenarios

Typical patient flow chart (**where is this?**)

Cue cards (**what are these?**)

Equipment to show PowerPoint presentations

Flipchart stand, paper, and colored markers

Copies of handout for all participants

### **Advanced preparation:**

Write objective for Modules 4 and 5 on flipchart.

Make copies of handout for all participants.

Tape to the walls the previous Day's flipcharts, if not already done the previous evening.

### **Content:**

HIV Testing and Counseling Guidelines and Procedures

Session 4.1: Integrating HIV testing and counseling into Health Care Services in Somalia

Session 4.2: Definition and components of HIV Guidelines and Procedures

## Session 4.1: Integrating HIV Testing and Counseling into Health Care Services

Approximate duration: 90 minutes

### Training/Learning Activity

#### A. Refresher/learning activity

1. **Ask** participants to stand up and find a partner.
2. **Tell** participants to go around the room and teach their partner everything that is on all the flipcharts hung on the wall.
3. **Mention** that the partners should take turns teaching each other.
4. **Allow** about 15-20 minutes for this refresher exercise.
5. **Ask** if there are any questions before proceeding.
6. **Review** objectives for Module 4 prepared on flipchart.

#### B. Process of integrating HIV Testing and Counseling in the Health Care Setting - Large group discussion

1. **Using PowerPoint 4.1 Guidelines and Procedures for Integration, review** the benefits of integrating HIV testing and counseling into the health care service delivery
2. **Review** Step 1 to integrating HIV testing and counseling into services. **Ask** participants how would they assess their facility to integrate HIV testing and counseling services.
3. **Review** Step 2 and **discuss** what needs to be included when making a plan.
4. **For Step 3, discuss** key activities that are needed to implement the plan.
5. **Discuss** Step 4 and how to set up an evaluation and monitoring plan.

#### C. Client flow for HIV testing and counseling in Health Facilities - Large group discussion

1. **Present** a typical patient flow chart. **(Where is this?)**
2. **Describe** patient flow for HIV testing and counseling integration and how it can be adapted to different settings.
3. **Guide** participants to develop a client flow that is appropriate for their setting.
4. **Break** into groups according to their departments or units in the health center.
5. **Ask** the groups to discuss how HIV testing and counseling can be implemented in their units, i.e:
  - Describe routine activities in the unit
  - Identify the new tasks that are related to integration of HIV testing and counseling services.
  - Discuss what needs to be changed to accommodate the new activities
  - List the challenges that will be faced in introducing the new activities
  - Suggest solutions to address these challenges.
6. **Ask** participants to mention some of the activities they anticipate in the routine offer of HIV testing to the patients.
7. **Listen and prompt** for the following HIV testing and counseling activities that would take place at the respective points in the patient flow in a typical hospital or health center:
  - Health talks, giving pre and post-test information
  - Phlebotomy, performing rapid HIV tests
  - Initiation of the basic care package

Facilitator's note: If not mentioned, probe for 1) staffing level and roles in the programme and 2) linkage between HIV testing and counseling services and other programmes, i.e. Home Based Care, ART, TB, MCH, OPD, Medical Ward, Surgical Ward.

## Session 4.2: Definition and components of HIV testing and counseling Guidelines and Procedures

**Approximate duration: 2 hrs**

### Training/Learning Activity

#### A. **Definition of HIV testing and counseling Guidelines and Procedures** (Large group discussion)

1. **Define** health care facility guidelines and procedures and relate it to the process of providing HIV testing and counseling in a health care setting.
2. **Ask** participants to look at the handout on guidelines.
3. **Take** the participants through the components of the guidelines and procedures.
4. **Distribute** the cue cards to the participants.

**Facilitator's note:** Remind the participants that HIV testing and counseling focuses on providing **risk reduction** messages for those who test negative or positive and **effective management** (including referral for ongoing counseling and further care) for those who test positive.

#### B. **Introducing HIV Testing to Clients** (Large group discussion)

1. **Ask** for a volunteer to read through **component one (Where are these components?)**, as the rest of the participants follow.
2. **Take** the participants through the messages of the health talk/information giving on the Cue Cards (ask a volunteer or do it yourself).
3. **Discuss** each element and allow the participants to ask questions during the discussion.
4. **Read** the elements of component one summarized on the Cue Card.

**Facilitator's note:** Let the participants understand that the cue card is used only when the full content of the elements have been understood.

#### C. **Information Giving/Health Talks (Role-Play)**

1. **Demonstrate** how to conduct a health talk using the cue cards
2. **Ask** for a volunteer to come to the front of the class and role-play "conducting a health talk on HIV testing and counseling to patients in a waiting room.
3. **Allow** 5 - 7 minutes for the role-play.
4. **Use** the role-play as a learning opportunity by guiding the volunteer if s/he turns off the guidelines and procedures.
5. **Do** this in supportive manner, by letting participants know you will do this.
6. **Ask** the rest of the class to role-play as patients in the waiting room.
7. **Ask** questions and make observations for discussion at the end of the role-play. (Remind the participants who are playing 'patients' to be realistic, but not overly difficult.)
8. **Ask** your co-facilitator to also observe and prepare to make comments at the end of the role-plays.
9. **At the end of the role-play ask** for comments from the rest of the class. Start with what went well, then the areas for improvement and any additional comments
10. **Ask** your co-facilitator to make comments.

11. **Have** participants practice role-playing by breaking into small groups or into pairs. Ask them to follow the guidelines and procedures or the cue cards.

**D. Providing HIV testing and counseling during medical consultation** (Large group discussion & role play)

1. **Explain** that giving pre-test information has been incorporated into the introduction of HIV testing. It should fit in normally without need for extra time for additional pre-test counseling.
2. **Ask** a volunteer to read the guidelines and procedures on introduction of HIV testing to the patient. **Clarify** each step.
3. **Inform** participants that pre-test information giving should not be long. It is the type of history we ought to take for all chronic infectious diseases like TB.
4. **Emphasize** that the pre-test session should focus mainly on the following:
  - Benefits of HIV testing
  - Past HIV test and sexual partners HIV status
  - Patients have the freedom to opt out if not ready for the test
5. **Explain** that sometimes the interaction with the client may occur during a follow up visit, in a ward or in side rooms. It does not necessarily happen when taking a history and examining the client. .
6. **Ask** another volunteer to read the summarized HIV testing and counseling guidelines and procedures on the cue card.
7. **Clarify** as necessary.
8. **Ask** for two volunteers to role-play the process of offering HIV testing and counseling (provider-initiation of HIV testing and counseling). Have one person play a health worker and the other a client.
9. **Ask** the volunteers to role-play for 10 minutes as the rest listen and watch.
10. **Ask** for comments at the end of the play starting with what went well. Also ask your co-facilitators for comments.
11. As a group, discuss what pretest information can be integrated with the history taking process.
12. **Acknowledge** the volunteers for their participation.
13. **Discuss** the session flow with participants. Allow participants to ask questions and respond.

**E. Giving HIV Negative Results** (Lecturette & role play)

1. **Review** the guidelines and procedures component.
2. **Ask** for two volunteers to role-play the disclosure of HIV negative results. Have one person act as the health worker and the other as a patient with negative results
3. **Allow** 10 minutes for the role-play and process.
4. **Observe** for and encourage the use of the basic communication and interpersonal skills

**F. Giving HIV Positive results** (Large group discussion)

1. **Take** participants through this component just like you did for component two.
2. **Explain** that participants should use the components discussed in the HIV testing and counseling guidelines and procedures as their guide when providing HIV testing and counseling services.
3. **Mention** that they will be expected to follow the guidelines and procedures and rely on them while handling the patients.
4. **Explain** that participants should not read the guidelines and procedures while talking to patient. They should learn and apply them when providing HIV testing and counseling.
5. **Ask** if there are questions about the structure and content of component of any of the guidelines and procedures.
6. **Clarify** questions about guidelines and procedures for participants.

**Facilitator's note:** Often participants will share their discomfort and unease with using the cue cards. Encourage the correct and consistent use of cue cards in this training and when seeing patients. You may need to remind participants that this is an intervention that differs from other types of counseling models and approaches.

## Integration of HIV Testing and Counseling into Health Care Delivery

### Introduction

For HIV testing and counseling to be effective, health care providers at all levels need to enthusiastically encourage HIV testing during all patient interactions. This is much more effective than channeling HIV testing and counseling as a parallel or marginalized service. In order to do this, health workers will need to assess and organize their health facilities and find ways to feasibility integrate HIV testing and counseling in the existing health care services.

### Integrating HIV testing and Counseling into the Health Care Facility

#### Benefits

There are many benefits to integrating HIV testing and counseling into health care services for both the patient and the health worker: Integration:

- Is convenient for the client
- Is cost effectiveness: multiple components provided in systematic manner using similar equipment and materials.
- Reduces missed opportunities and enhance utilization of the services
- Enhances competence of the service providers
- Strengthens spirit of teamwork and responsibility sharing

#### Steps to integrating HIV testing and counseling services

There are various "stops" a client makes before, during and after his/her rapid test is conducted. Also, are differences in clinic flow, depending on the health care facility where the HIV testing and counseling is provided. The key issue is to ensure that high quality services are provided and that the patients' time is utilized constructively. This means that clinic flow systems should also be patient focused. Flow and services should be reviewed periodically to ensure that there are no unnecessary movements for patients that would be inefficient or unprofessional.

Below are steps for integrating quality HIV testing and counseling services.

1. Conduct an assessment
2. Make a plan based on the findings of the assessment
3. Implement the programme
4. Monitor and evaluate

#### 1. Conducting an assessment

- Determine policy guidelines?
- Explore community/patient needs
- Decide how will the programme affect service utilization?
- Find out the level of stigma and discrimination against PLHIV in the community?
- Assess organizational capacity

- Staff readiness and training needs
- Attitudes among the staff
- Infrastructure and resources
- Assess operational changes
  - What changes need to be instituted in e.g. patient flow, patient records, provider responsibility in patient care
  - Available care options within the facility and outside where patients would be referred for ongoing care
  - Learn from others

## 2. Making a Plan

- Work within the policy guidelines
- Determine which care and support services will be offered at the site
- Identify the extra resources needed to provide a quality service and raise the funds
- Determine what needs to be changed or adjusted to accommodate the new activity
- Conduct community mobilization and education campaigns
- Identify the range of available medical and social care and support services in the community to provide ongoing care
- Build partnership with others involved in HIV/AIDS prevention and care services

## 3. Implement the programme

- Orient and train staff
- Develop SOPs, Guidelines and procedures
- Promote HIV testing and counseling in the community using media and traditional channels of communication
- Provide quality services – ensuring that staff’s delivering services are well trained, well supported and motivated in their work
- Pertinent issues in implementation
  - Informed consent and confidentiality
  - Type of HIV test to be used
  - Who does what

## 4. Monitoring and evaluation/Quality assurance

- Be sure to set up monitoring and evaluation plan

## Module Five: HIV Testing

### **Purpose**

To orient participants to HIV Testing, related infection control measures and quality assurance.

### **Objectives:**

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

- Discuss HIV testing and counseling guidelines
- Demonstrate how to conduct the finger stick blood collection
- Explain at least 4 HIV rapid testing procedures and principles
- Describe how to interpret results of rapid HIV tests
- Describe infection control measures
- Explain HIV post-exposure prophylaxis (PEP) risks and procedures for health care settings
- Describe quality assurance in HIV testing

### **Time to complete module:**

6 hours

### **Training materials:**

- PowerPoint 5.1: HIV Testing
- PowerPoint 5.2: HIV Rapid Testing Procedures and Principles
- PowerPoint 5.3: Infection Control in HIV and PEP
- PowerPoint 5.4: Quality Control and Quality Assurance for HIV Testing
- Equipment to show PowerPoint presentations
- Flipchart stand and paper, and colored markers
- Copies of handout for all participants

### **Advance preparation:**

- Have available samples of Lateral flow assay, SD Bioline assay, Uni-Gold assay, OraQuick assay, and any other locally available rapid HIV test for demonstrations.
- If participants are going to practice venepuncture and finger sticks, have equipment and pre-selected anonymous blood available.

### **Content:**

- HIV Testing
- Session 5.1: HIV Testing
- Session 5.2: HIV Testing: Types, Protocols, Algorithms and Procedures
- Session 5.3: Infection control, PEP and Quality Assurance for HIV testing

## Session 5.1: HIV testing

**Approximate Duration: 45 minutes**

### Training/Learning Activity

#### A. HIV testing – Large group discussion

1. **Review** objectives for Module 5 prepared on flipchart.
2. **Ask** participants what are HIV tests.
3. **Ask** participants what are the reasons for HIV testing. Record responses on flipchart.
4. **Using PowerPoint 5.1 HIV Testing, review** the “whys” of testing.
5. **Highlight** points not already mentioned by participants.

#### B. Sample collection (venepuncture) and Finger Pricking Procedure in VCT (large group discussion & lecturette)

1. **Using PowerPoint 5.1, review** how to conduct a finger prick for HIV testing.
2. **Explain** the procedures for a finger stick.
3. **Review** procedures for packaging and storing dry blood spots.
4. **Stop the PowerPoint presentation and demonstrate** how to do a finger prick procedure.
5. **If resources are available, have** participants practice the finger prick technique.
6. **Walk around and correct** participants’ technique, as needed.

## Session 5.2: HIV Testing: Types, Protocols, Algorithms and Procedures

**Approximate Duration: 90 minutes**

### Training/Learning Activity

#### A. HIV Test Types, Protocols, Algorithms and Procedures (Large group discussion, demonstration)

1. **Introduce** the session.
2. **Using PowerPoint 5.2: HIV Rapid Testing Procedures and Principles, review** basic VCT guidelines.
3. **Discuss** the different definitions needed for understanding HIV testing.
4. **Brainstorm** the different types of HIV rapid testing known.
5. **Record** participants’ responses on flipchart.
6. **Using PowerPoint 5.2, review** the different rapid HIV tests and testing protocols.
7. **Together with PowerPoint 5.2 and live demonstration, show** how to interpret results of each rapid HIV test reviewed.
8. **Demonstrate** the steps in performing the different HIV rapid tests.

#### B. Practical on HIV Rapid Testing (Practicum on blood collection)

1. **With** a co-facilitator or a volunteer, demonstrate how a venipuncture and finger sticks are performed
2. **Ask** volunteers to perform venipuncture and finger sticks on one another.
3. **With** a co-facilitator or a volunteer, demonstrate how rapid HIV tests are performed.
4. **Ask** volunteers to perform rapid HIV tests using pre-selected anonymous blood samples.

- C. **Group work – mentioned in PowerPoint 5.2 – Divide the participants in to groups and type them out and flash as power point.**

## Session 5.3: Infection Control, PEP and Quality Assurance for HIV Testing

**Approximate Duration: 6 hrs**

### Training/Learning Activity

**A. Infection Control and PEP** (Large group session)

1. Introduce the topic.
2. **Using PowerPoint 5.3: Infection Control in HIV and PEP, review** Universal precautions when conducting HIV tests.
3. **Review** infection control measures and steps using PowerPoint 5.3.
4. **Point** out the correct procedures for sharps disposal.
5. **Ask** participants what sharps disposal procedures exist in their facilities.
6. **Ask** participants what post-exposure procedures they have in their health care setting.
7. **After the discussion, use PowerPoint 5.3** to review Post Exposure Prophylaxis (PEP).
8. **Inquire** if any health worker they know has been exposed to HIV through skin contact.
9. **If so, ask** what they did about it.

**Facilitator's Note:** This is the time to probe for what is done in health care settings if a health worker is exposed to HIV. Correct any misinformation before proceeding.

10. **Review proper PEP and correct** any misinformation provided by participants.

**B. Quality Control and Quality Assurance in HIV Testing** (Large group discussion)

1. **Brainstorm** on the definition of "quality assurance" in VCT.
2. **Using PowerPoint 5.4: Quality Control and Quality Assurance for HIV Testing, provide** a standard definition.
3. **Discuss** the importance and measures for quality assurance in HIV testing.

**Facilitator's Note:** Please refer to the National Standards to HIV testing. Not available now

## Rapid HIV Testing Procedures and Principles

There are many test kits for HIV antibody screening available. When a test indicates antibodies are present, this gives strong support to the diagnosis. Over 99 percent of subjects infected with HIV have detectable antibodies to viral proteins. There is, however, a very low frequency of both false positive and negative test results.

### VCT Guidelines

- VCT services are voluntary – a client requests the testing or a provider initiates
- Counselors should be trained on VCT procedures and be aware of the ethics involved

- HIV testing is offered as a package with counseling – never by itself!
- There are simple/rapid tests that give same hour or same day results
- A technician or counselor does testing
- Parallel testing will also be done
- No written results will be given to protect the client confidentiality of results
- Confidentiality of results is a high priority
- Regular supervision for Quality assurance and control

### Important Definitions

- Sensitivity – ability of the HIV test method to detect correctly sera that contain HIV antibodies.
- Specificity – ability of the test method to detect correctly sera that do not contain antibody to HIV.

### Chronology of Assay Development

- Early 1980s – EIA/Western Blot
- Mid 1980s – Viral Culture p24 antigen detection
- Mid 1990s – DNA PCR
- 1995 – RT PCR
- 2000s – Rapid antibody testing

### Benefits of HIV Rapid Testing

- Sensitivity and specificity equal to ELISA
- No electricity or machinery needed
- No highly skilled technical staff needed
- Whole blood, plasma, or serum accepted
- Very small amounts of blood suitable for finger prick
- Provision of same day/hour results
- Built-in controls

### Antibody Detection

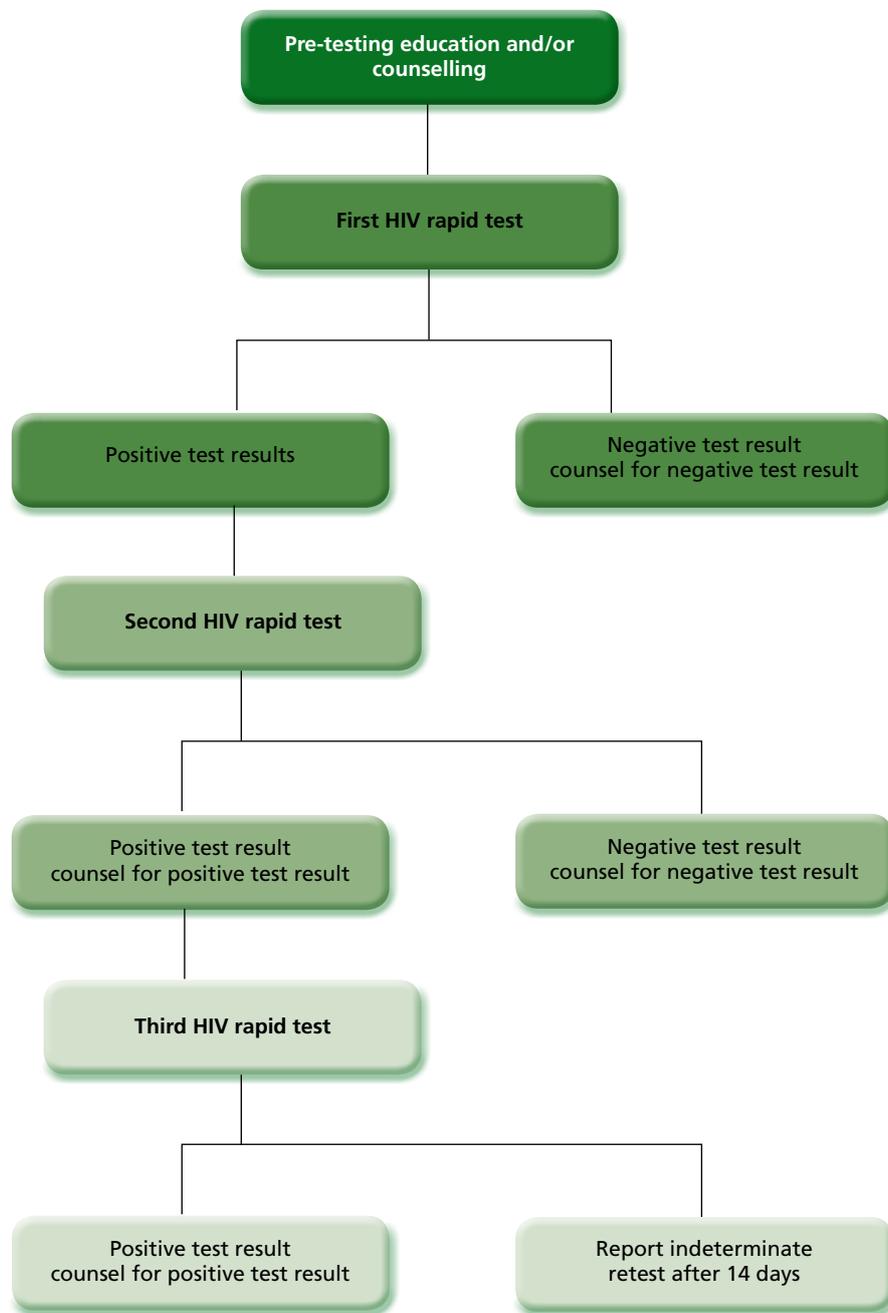
#### Screening tests

- Simple/rapid tests – most commonly used
  - Lateral Flow
  - SD Bioline® Assay
  - UniGold® Assay
  - Double Check GOLD™
- EIA (ELISA) – for discordant results

#### Confirmatory tests

- Western blot
  - Gold Standard
  - Electrophoretic separation of antigens
  - Specific antibodies to each viral antigen
- Indirect Immunofluorescent Antibody Assay (IFA) – fluorescent microscopy to visualize HIV infected cells

## Algorithms for HIV Testing:



### Screening and diagnosis of HIV infection

- For detection of anti-HIV antibodies
- Objectives of tests:
  - Screen transfusions
  - Surveillance of populations
  - Diagnosis of client

### Interpretation of results for simple rapid tests

- Negative – presence of only one coloured band in the control 'C' band in the results window.
- Positive – presence of more than one coloured band, i.e.:
  - '1' and 'C' or
  - '2' and 'C' or
  - '1', '2' and 'C'
- Invalid – if the control 'C' band is no visible in the results window after performing the test.

### Important notes

- Serial testing strategy will continue to be used until further notice.
- The VCT and PMTCT programme will use:
  1. Determine® → the first test kit
  2. SD Bioline® → the second test kit
  3. UniGold®/Double Check Gold™ → the tiebreaker
- DCT and Diagnostic programmes will use:
  1. Bioline® → the first test kit
  2. UniGold® /Double Check Gold™ → the second test kit
  3. Laboratory will do the tiebreaker test
- Do not interpret results after 10 minutes (too long). Interpreting results after this time may not always give true results – it may give false positives or false negatives.
- As you already know:
  - False positive could be personal disaster for the client
  - False negative results could be a public health hazard.

## Alternatives to Classic tests

### Alternative tests

- Saliva tests (OraQuick)
  - Oral fluids contain crevicular fluid from capillaries beneath the tooth-gum margin
  - Concentration of antibodies about 1/400 of that in plasma
- Urine tests
  - Intact IgG antibodies are found in urine

### Advantages

- Ease of specimen collection
- Group collection possible
- Increase in collection compliance
- Ease in specimen storage

### Disadvantages

- Low concentration of antibodies
- Limited approved confirmatory assays

## Universal Precautions

Universal precautions are essential as we are more at risk from the unknown HIV+ person, than the HIV+ person. There are more unknown HIV+ people than there are known HIV positive ones. It is essential that health workers follow Universal Precautions when dealing with clients/patients. These include:

- Always dispose of needle immediately post venepuncture.
- Do NOT recap needles after use.
- Always have a sharps container next to you, Don't shake or squeeze and dispose when  $\frac{3}{4}$  full
- Never leave sharps for another to dispose of.
- Preferably, lie the patient down (in case s/he faints).
- Use syringes with retractable needles, if possible.
- Avoid butterfly needles.
- Always wear gloves.
- Wear gloves when cleaning up spills of body fluids.
- Clean spills with detergent and/pr dilute solution of bleach (chlorhexidine).
- Wear masks and eye protection when splash injuries are possible – at lumbar puncture, skin biopsy, etc.
- Use HIV/TB special masks.

## Quality Control and Quality Assurance for HIV Testing

Components that need quality control:

- Working environment
- Staff
- Test kits
- Testing technique
- Specimen handling
- Bio-safety and infection control methods
- Records and data management

Supervisory support visits (SSV) by staff from reference lab should be made once or twice a year for:

- Providing updated information on HIV testing and related topics
- Evaluating and monitoring adherence to SOPs
- Stimulating information exchange and networking amongst VCT sites
- Re-training or other form of building capacity where the need for is indicated
- Offering refresher courses

## Module Six: Care Options for People Living with HIV/AIDS (PLHIV)

### Purpose

The purpose of this module is to provide knowledge and skills for basic HIV care and antiretroviral therapy for people living with HIV and AIDS.

### Objectives:

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

- Name the eight core components of the basic care package for PLHIV
- Describe antiretroviral therapy for adults and children living with HIV/AIDS
- Describe three key ways (other than ART) to control infection
- Describe a good diet for PLHIV
- Name four prevention-with-positives (PWP) measures.
- Give three supportive care messages
- Define stigma and discrimination.
- Describe ways to reduce stigma & discrimination toward PLHIV

### Time to complete module:

3 hours

### Training materials:

- PowerPoint 6.1: Care Options for People Living with HIV/AIDS
- PowerPoint 6.2: Stigma and Discrimination
- Cotrimoxazole tablets, safe water vessel plus water guard, Insecticide treated nets (ITNs), condoms
- Charts on the different FP methods and Flow chart for the referral system
- Copies of handout for all participants

### Advance preparation

- Prepare objectives for Modules 6 & 7 on flipchart.
- Put Tape to the walls the previous Day's flipcharts, if not already done the previous evening.
- Gather the cotrimoxazole tablets, safe water vessel, ITNs, condoms, FP methods and flow chart for use in the session.

### Content:

- Care Options for PLHIV
- Session 6.1: Basic Care package for PLHIV
- Session 6.2: Stigma and Discrimination

## Session 6.1: Basic care package for PLHIV

**Approximate Duration: 90 minutes**

### Training/Learning Activity

#### A. Introduction

1. **Ask** participants to select a partner and have them teach each the content of all the flipcharts hung on the walls.
2. **Encourage** them to take turns teaching one another.
3. **Review** flipchart with objectives for Modules six and seven.

## B. Prophylaxis and infection control

1. **Ask** participants what is the basic care package for PLHIV.
2. **Using PowerPoint 6.1: Basic Care Package for PLHIV, initiate a** discussion on the basic care options for PLHIV.
3. **Discuss** cotrimoxazole prophylaxis for HIV positive clients or infants at high risk of HIV.
4. **Show** samples of co-trimoxazole tablets. Review recommended dosage and side effects as per national or WHO standards.
5. **Review** basic safe water, hygiene and sanitation practices.
6. **Discuss** local malaria control interventions.
7. **Show** participants ITNs. Discuss where clients can get them.
8. **Review TB control and discuss** local facilities' TB screening measures.

## C. Nutrition

1. **Using PowerPoint 6.1, explain** why nutritional needs of someone with HIV increase significantly.
2. **Brainstorm** ways HIV positive clients can improve their diet using local foods.
3. **If available, discuss** vitamin supplementation for children and adults with HIV.

## D. Prevention with Positives (PWP) strategies

1. **Using PowerPoint 6.1, review** HIV prevention with positives strategies.
2. **Discuss** ways that HIV is transmitted from mother to child.
3. **Review** the four pillars of preventing mother-to-child transmission (PMTCT).
4. **Discuss** other interventions available to infants born to HIV positives.

## E. Family planning and dual protection

1. **Using PowerPoint 6.1, explain** the importance of family planning.
2. **Discuss the meaning** of dual protection and why it is so important.
3. **Discuss** the importance of correct and consistently condom use to prevent HIV infection for HIV negatives and re-infection for HIV positives. **Demonstrate**, if appropriate.
4. **Review** family planning methods available in the region. **Present** the flow chart for the referral system and discuss among participants.

## F. Supportive care

1. **Using PowerPoint 6.1, discuss** supportive care interventions.
2. **Ask** participants what kind of supportive care they can offer their clients.

## Session 6.2: Stigma and Discrimination

**Approximate Duration: 3 Hrs**

### Training/Learning Activity

#### A. **Definitions of Stigma** (Large group discussion)

1. **Using PowerPoint 6.2: Stigma and Discrimination, discuss** what it means to have an identify.
2. **Review** the meaning of stigma and discrimination.
3. **Ask** participants how do you spot stigma.
4. **Initiate** a discussion about the cause of stigma.
5. **Continuing with PowerPoint 6.2, review** how to spot stigma and the causes of stigma.
6. **Ask** participants to describe forms of stigma.
7. **Supplement** what participants have said with information from PowerPoint 6.2
8. **Brainstorm** the effects of stigma, **and then supplement** what participants discussed with information from PowerPoint 6.2.

#### B. **Stigma and HIV** (Large group discussion)

1. **Using PowerPoint 6.2, review** the causes of stigma on HIV.
2. **Discuss** the barriers to helping PLHIV and the impact of stigma on HIV positives, the health care system, and treatment, care and support of PLHIV.
3. **Review** the impact of HIV using PowerPoint 6.2 and **highlight** areas not discussed by participants.
4. **Continuing with PowerPoint 6.2, discuss** the rights and responsibilities of PLHIV.

#### C. **Challenging Stigma** (Large group discussion)

1. **Discuss** the benefits of stigma reduction on HIV.
2. **Initiate** a discussion about how we can challenge stigma around HIV. Probe for what individual, community, workplace, and government can do.
3. **After the discussion, review** the information in PowerPoint 6.2 and supplement what participants discussed.
4. **Continue with PowerPoint 6.2 and review** individual care interventions for PLHIV.
5. **Finalize** session with summary points and conclusions.

## Treatment, Care and Support for PLHIV

### The Basic Care Package for PLHIV

The basic care package is a set of simple approaches/interventions that will improve the quality of life of HIV/AIDS patients and focuses on preventive measures. This is very important because access to good clinical care including diagnosis, treatment and health education remains an option so limited to patients living in resource constrained settings.

The component of the basic care package includes the following:

### 1. Cotrimoxazole prophylaxis

Prophylaxis with cotrimoxazole is known to be effective in preventing a number of common illnesses in HIV/AIDS patients. Daily cotrimoxazole prophylaxis has been associated with 25% to 46% reductions in mortality and 30% to 70% reductions in malaria, diarrhoea and hospitalization. It is also helpful in preventing other diseases associated with HIV/AIDS, such as PCP and toxoplasmosis.

The Ministry of Health recommends that adults and children who are HIV positive be given cotrimoxazole daily. The Ministry also stipulates that all children above 4 weeks of age born to HIV positive mothers should receive cotrimoxazole until they are confirmed to HIV negative. Dosage requirements are as follows:

For:	Dosage requirement
Children above 4 weeks of age born to HIV positive mothers	Provide according to body weight for life or until proven HIV negative: 4 mg/kg/day of trimethoprim component - OR - 20 mg/kg/day of sulfamethaxazole component.
Adults	Give one double strength or 2 single strength tablets (480 mg tabs) daily for life. Make sure not to exceed 1600 mg sulfamethaxazole and 320 mg trimethoprim.

Note: Patients allergic to cotrimoxazole should be put on alternatives like dopsone. (The dose can be gotten from dosing formularies).

Use simple language when explaining medication and dosage to HIV+ clients. For example, you can say, “Septrin will help you stay healthy and not get sick from malaria and diarrhoea. Remember to take two tablets everyday at the same time and it will help you stay healthy, so you won’t need ARVs soon”.

### 2. Safe water, Hygiene and sanitation

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

A study was conducted to explore the impact of giving HIV positive clients a plastic water vessel with a spigot and a supply of dilute chlorine to be added to water for purification. Results indicated a reduction in microbial contamination of household water and a 34% reduction in diarrhoea among persons with HIV. The same results were seen among HIV negative children in the same household.

The other way to get safe drinking water is to ensure that all the water for drinking is boiled adequately. Water should be boiled for a minimum of 5 minutes of boiling and then cooled. Boiling is an easy method of providing safe drinking water. HIV positive clients must be continuously educated about this.

Clean, safe drinking water will help to reduce diarrhoea and other water borne diseases among HIV negative and positive people. In addition to safe water, advise clients to properly wash their hands after visiting the toilet and when going to eat. Human and animal excreta should also be properly disposed of.

Use simple language when talking about infection control. For example, "Drinking clean, safe water will keep your whole family healthier." "Cleaning your water is an easy way to keep from getting diarrhoea."

### 3. Malaria Control

Malaria is the number one cause of morbidity and mortality in Uganda. Malaria parasitemia is higher for adults and children with HIV than persons without HIV. Severe complications from malaria are probably more common among persons with HIV. Studies on the use of mosquito bed nets have shown a 50% reduction in malaria and a 17% in all cause mortality among children (Uganda MOH).

This reduction in the incidence of malaria will benefit persons with HIV and enable them to live with fewer incidences of malaria attacks and consequent mortality. Therefore, persons with HIV are recommended to sleep under insecticide treated nets (ITNs).

### 4. TB Screening & Management

Tuberculosis is one of the most common causes of death in people with HIV worldwide. HIV infection increases likelihood of new tuberculosis infections with M.Tuberculosis (due to immune suppression), which rapidly progresses to TB disease. HIV is the most potent factor known to increase risk of progression from M.Tuberculosis infection to disease.

Among HIV infected individuals, lifetime risk of developing active TB is 50% compared to 5-10% in persons who are not HIV-infected. In a person infected with HIV, the presence of other infections, including TB, allows HIV to multiply more quickly. This may result in more rapid progression of HIV infection. Most important symptoms related to TB infection:

- Coughing lasting more than 3 weeks and not responding to usual antibiotic treatment
- Production of purulent, sometimes blood stained sputum
- Evening fevers and/or night sweats
- Weight loss >10 %

TB screening (through history taking) should routinely be done for every HIV positive patient at every visit to the chronic HIV care clinic. And when necessary, the screening should be supported by laboratory investigations. Screening investigations include:

- 3 sputum samples for ZN staining for AFBs
- Chest X-ray if available
- Full blood count for WBC and ESR
- Montoux test-PPD

### 5. Nutrition

People with HIV have greater nutritional needs than HIV negatives. Energy requirements are likely to increase by 10% just to maintain body weight and physical activity in asymptomatic HIV-infected adults and growth in asymptomatic child. During symptomatic HIV and, subsequently during AIDS, energy requirements increase by approximately 20 to 30% to maintain body weight. Thus, HIV positives need to increase their normal daily food intake. For children experiencing weight loss, energy (total calories) intake needs to be increased by 50% to 100% over normal requirements.

There are other factors that determine the nutritional needs of the AIDS patients. For example, patients at different stages of the disease, those taking ART and pregnancy all affect the nutritional needs. Those who are at late stages often require special diets if they develop symptoms, which prevent them from taking hard solid foods

Because of their nutritional needs, HIV positive clients are more predisposed to suffer nutrient deficiencies than the negative ones. More often malnutrition and mal-absorption are major problems for people with HIV. These factors need to be taken into consideration when discussing nutrition and diet with your client.

Eating well is the first step for a patient to take good care of their health. Nutritious foods help to build a strong immune system, which enables the patient to fight diseases. Although HIV/AIDS is a chronic illness, nutritional efficiencies have been shown to occur early in the course of the disease.

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

Given the available information, daily supplements of micronutrient supplements containing vitamin B, C & E should be considered for adults and children with HIV. In addition, children above 5 years of age should continue receiving vitamin A supplements at 6 months intervals plus de-worming.

## 6. Prevention with Positives (PWP)

This refers to prevention interventions targeting individuals who have already tested positive for HIV and may be at risk of transmitting HIV to sexual partners and unborn babies. Strategies include the following:

- (a) Diagnosis of HIV infection through VCT
- (b) Working with HIV positive persons and their partners to prevent new infections
  - Partner testing and disclosure
  - Individual focused behaviour interventions
  - STI screening and management
  - Family planning
- (c) Prevention of mother-to-child transmission

### Prevention of mother-to-child transmission

Majority of children infected with HIV acquire the virus through maternal-to-child transmission (MTCT). The transmission rates lie between 15-45% with lowest in Europe and the highest Africa (probably due to very ill mothers and breastfeeding practices). MTCT can occur during

- Pregnancy 10-20%
- Labour and delivery (intrapartum)
- Breastfeeding

Prevention of MTCT includes 4 pillars:

1. Primary prevention of HIV infection
2. Prevention of unintended pregnancies among HIV positive women
3. Prevention of HIV transmission from HIV positive mothers to their unborn babies and infants.
4. Provision of treatment, care and support to HIV positive women, their infants and their families.

In addition to the above interventions, children, especially infants born to HIV positive mothers, should have the following:

- Early confirmation of HIV infection
- All EPI vaccines
- Adequate feeding options
- Regular follow up to monitor growth and development progress as well as receiving clinical care and ongoing Counseling.

## 7. Family Planning

Family planning is when a couple/ individual makes a voluntary and informed decision on:

- When to have children, the number of children
- The interval between the children
- Use of a family planning method of their choice to carry this decision.

HIV positive woman should use an effective family planning method to reduce the chance of unintended pregnancy. There are several family planning methods that can be used by HIV positive clients. Talk to the HIV positive client about family planning and refer him or her to a family planning service provider to select a family planning method best suited for their needs and reproductive intentions.

An HIV+ couple will also want to avoid spreading the HIV virus to their partner or re-infecting themselves. This is why it is important to use **dual protection** – that is protection against unintended pregnancy **and** against the transmission of STI/HIV. Dual protection requires that a client use an effective family planning method as well as correctly and consistently using a condom for each act of sex. During each clinic visit, always encourage HIV positive clients to use dual protection.

## 8. Supportive Care

- Encourage PLHIV to talk openly about their feelings and listen.
- Don't decrease your interaction with them – treat PLHIV as you treat other colleagues
- Chat and spend time with them. Make them feel wanted.
- Emphasize that HIV is a chronic illness like diabetes or high blood pressure
- Eat a balanced diet, avoid too much khat, and avoid stress
- Explain that with proper treatment one can lead a long and productive life.
- Encourage PLHIV to:
  - Join a support group
  - Identify and get treatment for infections
  - Live positively
  - Continue being productive
  - Do things that build confidence and self-esteem
  - Focus on the positive – “I want to stay alive for my children.”
  - Use positive anger to fight back – join campaigns to lobby for human rights
- Supportive psychosocial

## Dealing with Stigma, discrimination, rejection, shame and HIV

Stigma is a form of discrimination that destroys a person's identity seeks to separate “others” from “me” or “us”. Stigma sees others as inferior because of an attitude or condition they possess. It is also an unfavorable belief or attitude towards someone or something. Some causes of stigma and HIV are:

- Insufficient knowledge, misconception and/or fear about how HIV is transmitted
- The life potential/capacity of PLHIV
- Fears about disease or death
- Lack of recognition of one's own stigma or feelings of discrimination
- Moral judgments about people who we assume are sexually promiscuous

### Effects of stigma on PLHIV

- Being kicked out of the house, work, rented accommodation
- Being denied employment or forced to retire
- Loss of friends and family
- Poor self esteem
- Worry, depression and becoming withdrawn, isolated – may resort to drinking, violence or very risky living
- Suicide

- Failure to disclose status to partner and less likely to practice safe sex practices and condom use
- Failure to seek comprehensive care, treatment and support
- Prevents PMTCT and ART adherence
- Denial and secrecy

### Effects of shame

- Less uptake of VCT
- Increased infection especially among married
- Suicidal tendency

### Rights and Responsibilities of PLHIV

#### The right to:

- Be respected to say NO!
- Have friends
- Be hugged
- Contribute to family decisions
- Have food, housing, medical care and clothing
- Have sex, to get pregnant and have a child
- Right to marry

#### The responsibility to:

- Be open to advice.
- Help out in the house when you can
- Listen to others
- Help with finding money when you are well
- Talk to younger family members about protecting themselves [from STI/HIV]
- Practice safer sex

### Benefits of stigma reduction

- Greater use of VCT services to facilitate personal behavior change and risk reduction
- More spouse disclosure, sharing of disease burden and safer sex
- People taking more control of their lives
- Healthier, more productive and more informed public
- Greater openness about sexuality, negotiation for safer sex
- Less “judging” of others and ourselves
- Reduced HIV transmission through PMTCT and screened blood and blood products
- Greater protection of the rights of orphans and vulnerable children

### Challenging stigma

#### Individual responsibility

- Seek correct information about STIs, HIV and AIDS
- Know your HIV status
- Practice safe sex
- Be aware of and deal with stigmatizing attitudes and fears in yourself

- Spot and challenge stigma in your circle of influence
- Provide support to PLHIV to live positively

#### **Community responsibility**

- Demystify HIV. Re-label it as a chronic disease
- Raise awareness on stigma and promote dialogue on its effects
- Correct myths and misconceptions about the spread of HIV, e.g. HIV = immediate death
- Reduce stigma
- Promote the correct information about HIV transmission and PLHIV
- Get help from and participate in Home Based Care programs
- Promote VCT and couple counseling
- Promote constructive dialogue about sex and sexuality
- Provide accessible treatment for STIs
- Provide accessible ART and comprehensive care
- Spread the message that:
  - PLHIV can lead long and productive lives
  - Their ability to do so should be recognized and valued

#### **Health care facility**

- Encourage staff to use respectful language towards all colleagues
- Provide a feedback forum for staff to lodge complaints about discrimination
- Affirm the value of each member of staff irrespective of status
- Encourage teamwork and mutual concern in staff units and reward those who comply
- Draw up an anti-stigma code of conduct
- Model compassion, empathy and acceptance
- Promote a culture of respect and confidentiality
- Create a safe environment for staff to discuss their fears and challenges about HIV
- Provide accessible PEP and comprehensive ART
- Create a supportive environment for the infected or affected staff members
- Educate staff on principles of informed consent
- Empower PLHIV staff to be role models
- Provide support groups
- Promote advocacy among opinion leaders
- Advocate for the development institutional policy guarding against discrimination
- Ask for feedback from clients about felt stigma and discuss with staff to promote positive change

## Module Seven: Voluntary Counseling and Testing Practicum

### Purpose

The purpose of this module is to guide participants into conducting an efficient practicum

### Objectives:

At the end of the module, participants will have:

- Conducted a counseling practicum with a client.
- Assessed their practicum and defined areas for improvement
- Developed an action plan for addressing areas that need improvement.
- Shared lessons learned from the training.

### Time to complete module:

6 hours

### Training materials:

Template of practicum schedule

Presentation guidelines

Prepare 4 flipchart papers: Label one with "*What I enjoyed most*"; a second with, "*What was challenging*", the third with, "*Lessons learnt*", and the fourth with, "*Areas of self-improvement*".

Prepare flipchart with questions in Session 7.2, Question 1.

### Advance Preparation

Develop 10 Somali-specific role plays/case studies for the practicum.

Make copies of the Counselor-In-Training Checklist for all participants.

Make copies of the VCT Practicum Assessment Tool for all participants.

### Content:

HIV Counseling Practicum

Session 7.1: Counseling Practicum

Session 7.2: Action Planning

Reference to the HIV testing and counseling Manual (??)

## Session 7.1: Counseling Practicum

**Approximate duration: 2 hours**

### Training/Learning Activity

#### A. Counseling Practicum (90 minutes)

##### Practice Session One

1. **Divide** the participants into teams of two.
2. **Ask** one person in the team to play the client and the other to play the health care provider.
3. **Distribute** half of the roles/case studies (5) to the teams. Each team gets a role. It is fine if more than one team gets the same role/case study.
4. **Ask** the person playing the client to read the role they are playing, making sure not to let their teammate see.
5. **Distribute** the Counselor-in-Training checklist to each person playing the health care provider. **Tell** them that they will need to make notes on the checklist as they counsel.

6. **Remind** the person playing the health care provider to treat their teammate like a real client in the clinic. Counsel them as they have been taught over the past 4 days.
7. **Encourage** the person who is playing the client to be natural and act like a real client. Be real as they can and don't make it impossible for their teammate.
8. **Allow** the teams to practice their counseling session for 30 minutes.
9. **Walk around and observe** how teams are doing.
10. **After about 30 minutes ask** the teams to wrap up the role-play.
11. **When they are done with the role-play ask** the participants playing the counselors to complete the last three questions on the Counselor-in-training checklist.
12. **Ask** the person playing the client to complete the VCT Practicum Assessment tool.
13. **Allow** participants 10 to 15 minutes to complete the assessment work.
14. **Ask** the participants who completed the VCT Practicum Assessment to give it to their partner.

### Practice Session Two

1. **Have** the teams stay together, but switch roles. The person playing the health care provider will now be the client and vice a versa.
2. **Distribute** the other 5-roles/case studies to the teams. Each team gets one role. It is fine if more than one team gets the same role.
3. **Repeat steps 3 to 10** from Practice Session one on the previous page.
4. **When they are done with the role-play ask** the participants playing the counselors to complete the last three questions on the Counselor-in-training checklist.
5. **Ask** the person playing the client to complete the VCT Practicum Assessment tool.
6. **Allow** participants 10 to 15 minutes to complete the assessment work.
7. **Ask** the participants who completed the VCT Practicum Assessment to give it to their partner.

### B. Sharing experiences and further skills development (30 minutes)

1. **Explain** that this session for sharing experiences from the practicum
2. **Put up** three flipcharts labeled as below. Ask participants to review the notes they took after the practicum:
  - What I enjoyed most
  - What was challenging
  - Lessons learnt
  - Areas of self improvement
3. **Ask** participants to share what they enjoyed most about the practicum. Record responses on the appropriate flipchart.
4. **Ask** participants what was the most challenging. Record responses on the appropriate flipchart.
5. **Ask** participants what were lessons learnt. Record responses on the appropriate flipchart.
6. **Ask** participants what were areas for self-improvement. Record responses on the appropriate flipchart.
7. **Based on areas of self-improvement mentioned, ask** participants to develop a action plan to work on them.
8. Allow about 20 minutes for this. (Note: Facilitator could ask one or two people to share their self improvement plans if time allows)
9. **Remind participants** that they will have time in the field to work on specific areas of improvement. Some areas will improve as they gain more experience as counselors with time.
10. **Thank** participants for their commitment throughout the training and practicum.

## Session 7.2: Action Planning

**Approximate Duration: 1 hour**

## Session 7.3: Post test

## Session 7.4: official closing

Training/learning activity:

### A. Action Planning (45 minutes)

1. **Ask participants** to write the following on a piece of paper: (show questions on flipchart)
  - 3 new things I learned in the workshop that I would like to share with their colleagues.
  - 3 – 5 things (knowledge, skills, and attitudes) from the training that I plan to apply on the job
2. **Distribute** the action-planning sheet and ask each participant to fill it out as an individual. If several participants are from the same facility, they might complete the form together and develop a facility level plan.
3. **Ensure** that the participants include the following activities in their plans:
  - Sharing what they have learnt with supervisors and co-workers from all services,
  - Providing VCT counseling services in the facility
4. **Let** the participants know that they need to include how they will involve others at the facility in their action plans.
5. **Conclude** the session by asking participants to discuss their action plan with one another participant.
6. **Ask** each pair to share one activity from their plan.

### B. Expectation (15 minutes)

1. **Return** to the list of expectation developed by participants on the first day.
2. **Review** the expectations and ask participants if it has been met.
3. **If not, either ask** participants how they can get their needs met or refer participants to where they can get more information.

### C. Closing (30 minutes)

1. **Close** the session by reminding the participants that the purpose of training is to improve and/or expand HIV testing and counseling services.
2. **Distribute** certificates, if available.

# Counselor-In-Training Checklist

1. Record client information in HCT register, including the following:

**Client information**

Client number \_\_\_\_\_

Sex and age \_\_\_\_\_

Marital status \_\_\_\_\_

2. Record the following information from each client counseled:

Why client came to be tested

Client knowledge of HIV/AIDS and testing

Information given by counselor regarding HCT

Identified risk behaviours

Risk reduction plans

Consent issues and support networks

Post-test issues

Client emotional state at pretest

Client emotional state at posttest.

3. Write down the answers to the following questions:

What was the biggest challenge with this client, if any?

What I feel I did best during the session?

What would I like to have done differently during this session?

## VCT Practicum Assessment Tool

Name of Trainee: \_\_\_\_\_

Rate performance according to:

Excellent = 5      Good = 4      Fair = 3      Poor = 2      Not done = 1

Introducing VCT to Clients - Pretest Information Giving

Preparing client for test	5	4	3	2	1
Established rapport with the client					
Ensured confidentiality					
Asked if the client ever tested for HIV					
Explained why it is important for the client to know their HIV status and offered the test					
Assessed clients readiness to test for HIV					
Obtained consent of the patient to test for HIV					
For the client who had previously tested, asked when last tested and asked if they were willing to share their results.					
Established if client (if positive) is seeking HIV/AIDS care					

Use this space below to fill in any other comments

### Giving HIV Results, Risk Assessment and Risk Reduction

<b>Giving HIV results</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Checked if client has been given information about HIV testing (if different health worker is handling the session)					
Assessed readiness to receive results					
Provided results clearly and simply					
Allowed time for client to internalize results and express feelings					
Addressed feelings appropriately					
Reviewed the meaning of results and clarified appropriately					
Noted the need to take another test in reference to the most recent risk exposure					
<b>Discussing risk reduction</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Explored HIV risk behaviour, reinforced positive and discouraged negative behaviour, and emphasized ABC as appropriately.					
Gave patient opportunity to ask questions and provide information on risk reduction and/ or referred for more detailed information as appropriate.					
<b>Discussing disclosure and partner referral</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Reminded client that his/her results do not indicate partner's HIV status.					
Discussed with client, partner referral or notification for HIV testing.					
Offered options for disclosure; whether the patient wishes to disclose results to the partner(s) or s/he would like to be supported by the provider to do so.					

### Giving HIV Positives Results, Risk Assessment and Risk Reduction

<b>Giving HIV Results</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Checked if client has been given information and s/he knows that the HIV test has been done.					
Provided results clearly and simply					
Allowed time to internalize results and express feelings					
Addressed feelings appropriately					
Reviewed meaning of results and clarified appropriately					
Let client know that HIV/AIDS care is available including treatment and/or prophylaxis for OIs and ARVs.					
Drew a care plan with the client including tests and medications that will be required					
Assessed if the client needs further counseling as appropriate e.g. if the patient is depressed e.t.c.					
Explored clients access to medical services					
Discussed sources of support, incl. support groups (post-test clubs).					

<b>Discussing Disclosure and Partner Referral</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Reminded client that his or her results do not indicate the partner's HIV status.					
Supported client to refer partner for testing					
Offered options for disclosure; whether the client wishes to disclose results to partner(s) or would like to be supported by the provider to do so.					
<b>Discussing Risk Reduction</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Explored HIV risk behaviour, Reinforced positive and discouraged negative behaviour.					
Emphasised ABC&D as appropriate.					
Gave client an opportunity to ask questions. Provided literature on risk reduction and/or referred for more counseling as appropriate					
Encouraged the client to protect others from HIV					

**Example of Action planning Sheet**

Action Steps and Sub Steps	Timeline	Resources