Community Health Agent Training Curriculum

CURRICULUM

Day 1 Introductions

- Expectation from the Training
- Objectives

Day 2: Understanding HIV

- Assessing attitudes toward HIV and PLWHIV
- Impact of HIV/AIDS on Individual, Family and Nation
- Knowing HIV/AIDS
- HIV Transmission
- Risk Assessment – How Risky is it?
- The differences between HIV and AIDS

Day 3: Understanding HIV/AIDS Treatment

- Myths and Misconception About HIV/AIDS
- Opportunistic Infections in HIV
- ARV Treatment and Management
- Preparation process before taking ARVs

Day 4 HIV Counselling & Testing

- Myths & Misconceptions about HIV/AIDS
- HIV Counselling & Testing
- Preventing Mother to Child Transmission

Day 5 HIV Counselling & Testing

Day 6: Introduction to Counselling

- HIV/AIDS & Counselling
- Definition of counselling
- Trust Building
- Counselling Skills
- Empathy
- Reflecting Skills
- Probing & Action Skills
- Person Centered Counselling
- Model of Counselling Session
- Ethics in Counselling

Day 7: HIV Counselling & Testing

- What is HIV counselling and testing?
- Why is it helpful to know our HIV status?
- What stops us wanting to know our HIV status?

- Understanding the Pre and Post test counselling

Day 8 Understanding Counselling

- HIV Treatment / Adherence Counselling Overview
- STAGE 1: Pre-HIV Treatment Initiation
- Personal Experiences with Medication
- Adherence Factors
- NIMART: Introduction to ART & Adherence Counselling

Day 1: Introduction, Expectations, Objectives

Registration Admin to provide the registration lists.
Introduction of Participants

Activity 1: Introducing oneself and getting acquainted with one another through games

Objectives

- To create a sense of familiarity and a friendly atmosphere that will encourage the participants to feel free to express themselves (express their feelings).
- To allow the participants to listen and to get to know one another more.

Process

Each participant is asked to take a posttik and write a word that comes to his/her mind related to his work and stick it on his/her chest.
One by one each participant is asked to introduces him/herself and explain what s/he means by the word s/he has written
After everyone has finish introduces, trainer will conclude the session.

Conclusions about this activity

- It is an activity for getting to know one another.
- Being open minded in listening to other participants is a way to enable everyone to know one another better.

Facilitator Notes

The facilitator must explain the activity well to prevent a participant going into too much detail about their life. This is not an activity to relieve emotional stress, rather, everyone should converse in a manner of familiarizing themselves with one another to create a friendly and open atmosphere.
Some participants may be quiet while others may be talkative. The facilitator should be able to encourage those who are quiet to express themselves or to express their thoughts more. As for the talkative ones, the facilitator should be able to summaries their main points.

Introduction of SHINE
Introduction of MSF
Question and Answer-

Roles of CHAPS (Presentation, experience sharing by present CHAs and group discussion)

Presentation on CHAP Programmes

Pre test Questionnaire

- Give the participants pre test questionnaire to fill, collect the filled one

Expectation from the training

- Ask participants to take 2 minutes to write down two expectations they have for the workshop.
- Ask participants to discuss these expectations with their neighbors for 2 minutes.
- If there are other expectations of the workshop that were not mentioned by participants, explain these.
- Any expectations that do not fall within the scope of the workshop should be written on flipchart paper marked ―Parking Lot‖

Introduction of the training

- Provide a brief overview of the course, including each module and the subjects that will be covered in them. Also, mention that the course is designed to be participatory. They will be required to take part in large and small group activities and group discussion as well as in written exercises.

OBJECTIVES:

Setting of Ground Rules

- Agree on a set of rules for the group during its time working together.
- Begin to form relationships and discussion within the group.
- Establish ownership of the group by each individual member.

During this week and in the weeks to come, we will be working together as a group. In order for us to make the best of this time, it is useful for everyone to agree to some group rules.

The purpose of these rules is to create an environment that is supportive, respectful and safe in order for us to accomplish our goals and objectives for this course.

Facilitators Notes

- The purpose is not to come up with lots of rules.
- Rather, it is to establish a supportive, respectful and safe environment.
- Immediately treat participants as adults, not as children or learners.
- It may be helpful to do the group rules in two steps. First, brainstorm a list
- of rules. Then, prioritise those rules. Ask the question: Which rules are important? Then circle or somehow highlight the main rules as decided by the group.

Day 2 Understanding HIV/AIDS

Recap of Day 1: question and answers.

ASSESSING ATTITUDES TOWARD HIV AND PLHA (PERSONAL AND SOCIETY)

Objectives:

- To help participants examine their attitude towards various behaviors of people in society.
- To raise awareness on the effect of personal attitudes on judging the value of human beings, especially the effect of personal attitudes on providing services to people
- Help participants to realize that we all share society's perception of risk groups based on stereotypes and therefore can make mistakes in assessing our own personal risk.
- Enable participants to question stereotypes and value judgments.

Process:

- Engage the participant in discussion on there own attitude towards HIV/AIDS and how they perceive risk groups based on the stereotypes.

Activity : 1

- The participants sit in a semi-circle. The 2 large cards are placed at each end of the semi-circle. The 'occupation' cards are distributed: one to each participant.
- Ask the participants to move to the position which reflects their idea of the degree of risk of the occupation / behavior on their card. Encourage the participants to negotiate with each other.
- When everybody is seated, start with the participant in the 'highest risk' seat and ask why they sat there. Ask if any participants want to change places. Proceed to other participants.

Discussion points:

- Do people perceived as at high risk know how to protect themselves? In practice, are they able to protect themselves?
- Do people perceived as at low risk know how to protect themselves? In practice, are they able to protect themselves?
- What factors contribute to the risk of someone such as a housewife? Can she influence these factors (such as the behavior of her husband)?
- If you have sex with someone you think is at high risk, will you protect yourself?
- If you have sex with someone you think is at low risk, will you protect yourself?
- AIDS is associated in the mind of the public with special groups of people. Others (not in these groups) think it's not their problem. Can this lead to unexpected new cases of HIV infection?

Materials:

1. Two (2) large cards

Highest risk	**Lowest risk**

- A series of cards listing occupations, activities or life-styles. The total number of these cards needs to be the same as the number of participants and can be chosen from the following list (or similar):

Drug addict	**Widow**
Commercial Sex worker (CSW)	**Karaoke ladies**
Singer	**Salesperson**
Bisexual	**Construction worker**
Homosexual	**Doctor**
Someone with a sexually transmitted disease	**Someone taking care of a person with AIDS**
Someone regularly visits a Commercial Sex Worker (CSW)	**Community leader**
Alcoholic	**Teacher**
Apprentice	**Blood donor**
Nurse	**Motor-bike taxi driver**
Manual worker	**Policeman**
Housewife	**Health volunteer**
Local government officer	**Teenager**
College student	**Slum dweller**
Someone who sleeps around	**Fisherman**
Public health official	

Activity 2: Behavior Evaluation

- Distribute the Behavior Evaluation Forms and allow each person to give quick comments anonymously
- Once the form is complete separate the large group into small groups
- Distribute another blank evaluation form to each group and let group members discuss and complete the evaluation form on behalf of the whole group.
- The trainer collates the answers from each group and writes the outcome on the flipchart.
- The group reviews the outcome together.
- The trainer encourages the participants to analyze how the answers reflect the attitude of the participants.

- Use some of the scenarios to discuss what reasons are used to be able to adjust to or accept various behaviors. Relate them to the point of making judgment on human value and what factors can bring about certain decisions or judgments.
- Ask the participants the following points:
  - Whether the behaviors mentioned in the Evaluation Form really happen in the society?
  - What is the likelihood that people with such behaviors will come for our services?
  - If they come to our service, and we have an attitude of "they need to change their behavior", "Can they sense this and how?
  - What effects might be produced if we, as a counselor, worker or service provider use our personal attitudes to judge the value of each behavior of the client?

Conclusion:

- Judgments and values arise from various learning experiences of each person.
- Judging people will be a barrier to our work of providing services.
- Those receiving services might not disclose their stories, details on behaviors or their existing problems if they fear being judged.
- If a trusting relationship cannot be established it will lead to an inability to fully give or receive services.
- Judging people will be an obstacle in providing appropriate services.
- We should be aware of our attitudes.
- Thinking without judgment, the acceptance and understanding of the reasons for behaviors can begin by giving an opportunity to the clients to tell their stories. For us to act as a listener only, without adding our attitude or advice.
- Once we learn to hear their stories, we can begin to understand the motives of people's behaviors better.
- Such an understanding can lead to neutral or impartial attitude and helps us in not judging the value of people's behaviors.

Materials:

- Behavior Evaluation Form with the same information written on the flip chart.

IMPACT OF HIV/AIDS ON INDIVIDUAL, FAMILY AND NATION

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

Describe the impacts of the HIV/AIDS epidemic at individual, family and community, and national levels in KZN

Activity:

- Ask participants to break into 3 small groups. Explain that this exercise will help participants understand and communicate the impact of HIV/AIDS at different levels. This will help CHAps see the "big picture" of HIV/AIDS.
- Give each group flip chart paper and assign them one of the following topics:
  - Individual (adults and children)

- Family and community
- Nation

- Tell each group to think about the impact of HIV/AIDS at the level they have been assigned.. For example, “what happens when a person has HIV/AIDS? How does it impact his/her life? How did it impact their life?” Or, “what happens when HIV/AIDS enters a family, or many members of a community are living with HIV/AIDS?” Or, “what happens when more and more people in KZN have HIV/AIDS?”
- Give groups 15 minutes to discuss HIV/AIDS impacts and write them flipchart.
- Trainers should walk around the room to help the small groups understand the exercise.
- After 15 minutes, ask each group to present their “impact flipchart” to the larger group. The group should ask questions and discuss the impact of HIV/AIDS at different levels. Use the content below to add to the discussion as needed (not all items in the lists below need to be mentioned – this should just serve as a guide).
- Ask if there are any positive impacts of HIV/AIDS? For example, that it can bring communities together for a common goal.

CONTENT:

Some of the impacts of HIV/AIDS on individuals:

- Fear of telling others and being stigmatized, hiding
- Weight loss
- More frequent, severe illness
- More trips to the clinic and hospital
- Need to take many pills every day if on treatment
- Loss of job due to illness
- Violence
- Distanced from family and friends
- Property can be taken away
- Feeling hopeless
- Feeling guilty and/or angry
- Pass the virus to other people, such as sexual partners and babies

For children, specifically:

- More frequent, severe illness
- Many trips to the clinic
- Slow growth
- Treated differently by other children, teachers, or family members
- Need to take a lot of pills/syrups every day
- Not able to stay in school

Some of the impacts of HIV/AIDS on communities and families:

- Loss of wages and family/community resources due to illness
- Poverty because of increased health care costs
- Increased number of orphans to care for
- Stigma and discrimination, forcing people to hide their status

- Not enough food because people can't raise animals or crops
- Children can't attend school because they are caring for sick relatives or working
- Teachers are sick or taking care of relatives who are sick
- Community health care systems are overstretched

Some of the impacts of HIV/AIDS on the nation:

- There are over 5.6 million South African living with HIV/AIDS.
- Increased health service demand and Client loads, often resulting in reduced quality of services
- Increased health expenses for drugs, equipment, training, supplies, taking away from other health needs
- Reduced teacher and health care worker supply due to illness/death
- Reduced student enrollment and increased drop outs because children may have to work or care for a sick relative
- Decreased life expectancy
- Increased number of orphans that need to be cared for
- Reduced productive work force (because of deaths, but also absenteeism to attend funerals, care for sick family members, or because of illness)
- Reduced agricultural output and increased food shortages and numbers of hungry families
- Reversed development gains made in past years and increased poverty
- View by others that the country is a "lost cause" because so many people have HIV/AIDS

The trainer should:

- Ask participants what they think are the key points of this Unit. What information will they take away from the Unit?
- Ask if there are any questions or clarifications.

CONTENT:

The key points of this Unit include:

- HIV/AIDS impacts not only individual people, but also families, communities, and the nation as a whole.
- HIV does not discriminate in KZN, where about 40% of people are living with HIV/AIDS.

KNOWING HIV/AIDS

Objectives:

Participants will:

1. Give accurate and specific information about HIV transmission.
2. Enable participants to give accurate and specific information to patients, clients and their families
3. Understand the mechanism of the immune system with different infections especially HIV.
4. Understand the life cycle of the HIV virus and the way it spreads.

5. Help participants understand the differences between HIV and AIDS.
6. Help each participant understand why knowing the differences between HIV and AIDS is important

Content:

- The fundamental principles of immunity - how the white blood cells (WBC) fight infection and make antibodies.
- The components of CD4 and HIV virus.
- Life cycle of the HIV virus once entering CD4.
- How the HIV virus weakens and depletes the body's immunity.

Process:

Small group discussion on HIV and AIDS, Transmission etc and presentation to large group.

Facilitator to summarize and provide with right information whenever required.

HIV TRANSMISSION

Facilitators Notes:

- One-by-one, ask each person to list a body fluid that contains HIV. The person can sit down once a correct answer is given. Write these on flip chart.
- Afterwards ask each person to list a body fluid that does not contain HIV. Record answers on flip chart and have participants sit down once a correct answer is given. Fill in using the content below, if needed.
- Prepare 2 sheets of flip chart, one that says "DOES NOT TRANSMIT HIV" and one that says "DOES TRANSMIT HIV." Now ask participants to think of the ways HIV is and is not transmitted and record on the appropriate flip chart. Fill in using the content below, as needed.
- Close the session by reviewing some of the myths and wrong information in the community about how HIV IS and IS NOT transmitted. Ask CHAPs to discuss what they can do to make sure people have the right information and can protect themselves.

CONTENT:

HIV can be transmitted in these body fluids:

- Semen
- Vaginal fluids
- Blood
- Birthing fluids
- Breastmilk

HIV is not transmitted in these body fluids (unless there is also blood present)**:**

- Urine
- Feces
- Saliva
- Sweat
- Mucous (snot)

Ways HIV is transmitted:

Sexual transmission:

- Unprotected sexual intercourse with infected person
- Direct contact with body fluid of infected person (blood, semen, vaginal secretions)
- *Note: sexual transmission accounts for 87% of HIV transmission worldwide*

Mother-to-child transmission:

- During pregnancy
- During labor and delivery *(note: most mother-to-child transmission happens at this stage)*
- • During breastfeeding

Blood-to-blood transmission:

- Transfusion with infected blood
- Direct contact with infected blood/body fluids

Use of unsafe sharp objects:

- Injecting drugs and sharing needles with an infected person
- Piercing, tattooing, or cutting with unclean knives or other objects.

Ways HIV is NOT transmitted:

- Sharing food or a drinking cup
- Hugging
- Kissing
- Shaking hands
- Coughing or sneezing
- Being near a PLWHA
- Sharing a latrine/toilet
- Using condoms
- Mosquitoes or insect bites – even if they carry human blood, HIV cannot live outside of humans

HIV Prevention

ACTIVITY:

Facilitators Notes:

- Tell participants that the next steps after knowing how HIV is passed from person to person, is to know all the ways to prevent HIV and help people practice safe behaviors.
- Break the large group into 4 smaller groups. Ask each group to elect aspeaker. Assign each group one of the modes of transmission (sexual, MTCT, blood-to-blood, and sharp object use). Ask each group to come up with 5 key messages to tell clients and other community members about preventing this kind of transmission. Ask groups to write the messages on flip chart.
- After 10 minutes, the chosen speaker for each group should present the 5 key messages to the larger group, as if they are leading a meeting of PLWHA and their

families at the hospital. Remind them that they need to speak clearly and slowly and explain each message in common terms. It's best if they can use "real life" examples and experiences. Give each group about 5 minutes to present, ask if there are questions, and fill in with content below.

- Debrief by asking the speakers how they felt presenting in front of the large group. Did they feel comfortable that they knew the right information and could answer questions?

CONTENT:

CHAPs have an important role to play in teaching people how to prevent HIV for themselves, their families, and in their communities.

The ABCs of preventing sexual transmission

- **A:** Abstinence – for young people
- **B:** Be faithful to one uninfected partner
- **C**: Consistent and correct condom use (male or female) - every time - for "dual protection" against pregnancy and HIV
- **D**: Delay sexual debut
- **E**: Early and complete treatment of sexually transmitted infections (STIs)
- **F**: Free and open communication between partners about sex
- **G**: Get to know you HIV status

Male circumcision can also reduce the risk of sexual transmission, but should not be used as the only risk reduction method. People still need to use condoms and get tested for HIV even if the man is circumcised. Circumcisions should only be done by trained doctors at a health facility.

Prevention of mother-to-child transmission (pMTCT)

- Prevention of unwanted pregnancies in the first place (good family planning and communication about family planning between couples)
- HIV testing before deciding to become pregnant
- Good, early antenatal care
- HIV testing as part of antenatal care
- Counseling for mothers and fathers on PMTCT
- Safer sex during and after pregnancy
- Family support and reducing stigma against pregnant women with HIV
- ARVs for mother during pregnancy and for the baby when it's born
- Prioritizing pregnant women for ART if they are eligible – during pregnancy and ongoing – because half of pregnant women living with HIV in KZN need ART
- Safe, normal delivery at a facility
- Safe infant feeding – exclusive breastfeeding (no other fluids, foods, or herbs at all, including water) for as long as possible - 6 months is best. Then when the baby is 6 months old, giving others foods along with breastmilk
- Prevention and treatment of breast infections
- Regular follow-up of mother and baby

Prevention of blood-to-blood transmission

- Screen all blood and blood products for HIV (and Hepatitis)
- Follow infection prevention procedures at clinics
- Use protective equipment (like apron, gloves, eye shield)
- Throw out needles and other sharp instruments directly in sharps containers (or a can or bottle will work too)
- Clean and disinfect all surfaces with a solution of bleach and water

Prevention of unsafe sharp object use

- Don't share blades or knives in traditional ceremonies involving blood or cuts on the skin.
- Don't inject drugs or share needles. If you have to, be sure to clean them every time with bleach mixed with water.
- Don't share piercing or tattooing tools, or clean them with bleach solution every time.

RISK ASSESSMENT - HOW RISKY IS IT?

- Divide the participants into 3 or 4 groups
- Show the following definitions, and explain what is meant by high, medium, low and no risk in the context of this activity.
  - *<u>High Risk</u>*

    Behaviors which have a high chance of transmitting HIV. Nearly all cases of HIV infection result from this kind of behavior.
  - *<u>Low Risk</u>*

    There is a theoretical risk of HIV transmission by these behaviors but in reality, the probability is almost nil there have either been no reported cases of HIV infection or very small numbers of cases of HIV transmission through these channels.
  - ***<u>No Risk</u>***

  Behaviors which have no opportunity to cause an infection at all.

- Distribute the Risk Behavior cards to each group. Each group discusses the level of risk of the behavior on each card. Then group the cards according to level of risk.
- When all groups of participants are satisfied with their ranking they show their results to the group.
- The facilitator then takes a set of "risk behavior" cards and shows them one by one to the whole group. If there is agreement on the level of risk, the facilitator attaches that card to the flip chart in the appropriate place. If there is disagreement, the cards are placed aside.
- In cases where there is disagreement about the level of risk, ask for reasons and discuss what may happen if health workers give contradictory information to patients and their families.

- The facilitator leads a discussion about the chance of HIV transmission actually happening in the situations, in which participants express concern, and explains the basic principles of HIV transmission.
- The facilitator should point out those sexual activities such as kissing on the mouth and oral sex pose small or almost no risk.
  - For example, of 775,000 cases of HIV infection in USA to the end of 1996, there was one possible case by deep kissing (from an HIV infected man with gingivitis and bleeding gums to a female partner (MMWR 1997; 46: 620). There were 52 documented cases of HIV transmission due to occupational exposure, of which 45 were sharps injuries.
- The facilitator summarizes and makes the following points.
  - Health workers and counselors must know their facts correctly because they are disseminators of information.
  - Answering questions or doubts about HIV/AIDS needs a sensitive touch. We must try to understand our patients' or clients' underlying perceptions or anxiety.
  - Information about HIV/AIDS must be clear to the target groups and in language they can understand. Giving vague or unclear information can affect our clients or patients ability to protect themselves. It can also affect families' ability to accept the issue of living with people with HIV/AIDS.

Materials:

- Sets of 3 cards labeled HIGH RISK, LOW RISK and NO RISK
- Sets of 21 cards, with a risk behavior on each card.
- Definitions of High, Medium and Low Risk

The "Risk Behaviour" Cards
Vaginal intercourse without using a condom
Anal intercourse without using a condom
Vaginal intercourse without a condom while having genital lesions or STDs.
Sharing needles or syringes amongst injecting drug users.
Touching a wound, blood or plasma of a HIV positive person
Oral sex (the mouth belongs to someone without HIV and the vagina or belongs to a HIV positive person).
Oral sex (the mouth belongs to someone without HIV and the penis belongs to a HIV positive person).
An infant breast feeds from a HIV positive mother
Vaginal intercourse using a condom
Sharing nail clippers and razor blades
Oral sex (the mouth belongs to an HIV positive person and the vagina or penis belongs to someone without HIV).
Medical examination of a patient with HIV in the out-patient department
Daily living activities with a HIV positive person, in a household, office, etc.

Discussion

- Theoretical risk data may impact daily life in the society and lead to stigma and discrimination. Preoccupation with theoretical risks may make them less aware of more risky behaviour and hence make them more susceptible to HIV.
- We use the "3 factors" to assess the risk of transmission of certain activities or behaviuors. When we assess the risk we need to take into account all these 3 factors, quantity, quality and the route of transmission. High risk does not mean that one will definitely contract HIV from this behaviour rather it indicates that there may be a chance of infection by engaging in this activity.
  1. **Sources**
  - HIV only in humans, mostly in white blood cells and some body fluid e.g. semen, vaginal secretion, breast milk
  2. **Quality & Quantity**
  - HIV virus needs to be in a proper condition (easily destroyed by heat/detergent)
  - Need enough to cause infection.
  3. **Route of transmission**
  - HIV needs a specific factor to get out of one person and into another.
    - Sexual contact
    - Direct contact to virus from injection
- HIV is tranmitted, AIDS is not tranmitted. HIV can be tranmitted from one person to another through Blood and Sexual fluid- Saliva, urine, sweat etc does contain HIV virus, but the volume is very low.
- The four principles of HIV transmission are -the acronym ESSE —
- exit, survive, sufficient, and enter.
  - EXIT – the virus must exit the body of an infected person
  - SURVIVE – the virus must be in conditions in which it can survive
  - SUFFICIENT – there must be sufficient quantities of the virus present to cause infection
  - ENTER – the virus must *enter the bloodstream* of another person

THE DIFFERENCES BETWEEN HIV AND AIDS

Process:

- Share the objective of this exercise with the group.
- Divide the group into three and ask each group to come up with three things that make HIV different from AIDS when they consider:
  - Group 1: Things that are happening INSIDE the bodies of people with HIV and AIDS
  - Group 2: Things that are happening OUTSIDE the bodies of people with HIV and AIDS
  - Group 3: The different LIFESTYLES of person with HIV and a person with AIDS
- Report with each group adding only new points.

- After the groups have reported, present the information below. The groups' three points on the differences between HIV and AIDS may have been organized in other ways. That is okay. The main point t was to get every participant thinking about and discussing the differences.

Group 1: Various things are happening inside the bodies of people with HIV and AIDS.

- HIV is the infection stage of the condition; AIDS is the disease phase.
- When the virus enters the body, it comes into contact with the front line of the body's defence system. In the early stages of infection (during the first few days or week) the infected person might feel as though the flu is coming on. HIV overpowers this front line (made up of white blood cells called macrophages) and makes its way into other body cells, living on them, destroying them and multiplying at a rapid rate.
- Antibodies (chemical substances) to the virus are produced. The body produces and releases antibodies into the bloodstream anywhere from six weeks to six months from the point of infection.. This six-week to six-month period (shorter or longer depending on the particular body) is called the "window period."
- *Note: The common lab tests look for the anti-bodies; they do not look for the virus itself.*
- When the amount of viruses in the body reaches a high point and the amount of body cells that are supposed to fight off disease reaches a low point, the body is more open to other infections. HIV and various diseases then take over the body. This is when the person may be said to be living with AIDS.

Group 2: The bodies of people with HIV and AIDS look different from each other on the outside. People with HIV look healthy while people with AIDS look unhealthy.

- You can't tell when a person has HIV. A person who is HIV positive can look and feel as good as a person who does not have the virus. HIV-infected people can even look better, as many begin taking better care of their health and physical appearance.
- A person who is HIV positive can live for several years, looking just like a person who is not HIV positive. There are no signs on the person's body to show that he or she is carrying the virus.
- People who are HIV positive develop AIDS (or can be said to "live with" AIDS) when they have three or more signs of the syndrome (collection) of diseases listed earlier. Those with AIDS may have signs such as significant weight loss, thinning hair and skin diseases. Other signs that may not be as obvious to another person are the frequent
- Bouts of diarrhea, enlarged lymph glands under the jaw, neck, armpits and groin. Thrush, a white furry coating on the tongue, the roof of the mouth and sometimes the vagina, is another sign.
- *Note: No one of these signs by itself means that a person is living with AIDS.*
- People who live with AIDS may not only look sick, but they may also feel sick. Diseases take over the body because HIV has broken down the body's defence force or resistance (the immune system). These diseases are caused by

"opportunistic infections." They are called that because when the body's resistance is weak, infections of all types take the "opportunity" to invade and take over the body. Usually a normally healthy person can "resist" these infections. The body's immune system is designed to fight infections and disease.

- There are cures for most of these other infections and diseases, but science has not yet come up with a cure for HIV. A vaccine against HIV is now being tested.
- A person living with AIDS can return to feeling well when diseases are treated and symptoms disappear.
- People don't actually die of AIDS. Death usually comes after a series of illnesses and when the body finally succumbs to (that is, is overpowered by) one or more of the diseases which take over in the AIDS stage.

Group 3: Those with HIV and those with AIDS lead very different lives. People with HIV can get on with their lives as usual, taking extra care with their health; those with AIDS may be too sick to carry on normally. They need care and medical treatment.

- People who are HIV positive have to make important changes in their sex lives.
- People who are HIV positive have to be careful not to infect others or to get re-infected with the virus. Every time an HIV-positive person is re-infected, the body's resistance is weakened. AIDS will develop sooner because of this.
- Those who are HIV positive need to be extra careful not to pick up other infections. Every new infection, of whatever type, further weakens the immune system. We all know how easy it is to pick up a "bug" or virus when our resistance is low or down, and how hard it is to shake it off.
- Those living with AIDS need a lot of care and attention, medical and otherwise.
- Although both are infectious, a person who is only HIV positive is more likely to infect others than someone with AIDS, for two main reasons. First, the person with only HIV is more likely to continue to attract and desire sexual partners. Second, partners, caregivers and health care professionals are more likely to take risks with people who are HIV positive and don't have AIDS because they look good and their status may not be known.

Why it is important to understand the differences between HIV & AIDS

Process:

- Organize your large group into four small groups. Ask each small group to think of at least five reasons why it is important to know the difference between HIV and AIDS. If your group has already been "trained" or you think they are pretty sharp, give them a target of at least 10 reasons.
- If you wish, you may tell them to find endings for this sentence: "Knowing the difference between HIV and AIDS, can help . . ."
- Tell the pairs to appoint someone to report their answers. Each group will have to listen very carefully so that their reporter will only share those points not already made by others.
- Add points from below that did not come up.
- Add to your guide any points that came from the group (giving them credit) that are not listed below.

Knowing the difference between HIV and AIDS, can help people:

- Understand that it makes no sense to look at a person's face or "ready body" and decide to have sex. The ready body may not really be ready.
- Pay closer attention to their own lives and bodies and the lives and bodies of potential sex partners.
- Actively think about HIV before sex, before exposing themselves to the blood of others, and before (long before) having children.
- Become conscious of the fact that anyone can have the virus: men in "good" positions and "decent" girls and young women.
- Understand the dangers of making love in the dark – in places where they can't see, with people about whose sexual parts and pasts they have no information.
- Realize that one act of unprotected sex with an infected person may be all that is required for transmission of the virus. Even individuals who are usually careful about sex can become infected.
- Start taking steps to protect themselves from HIV and other sexually transmitted infections.
- Infected with HIV to begin taking better care of themselves, physically and psychologically, including guarding against re-infection with the virus.
- Including those who test positive, understand why they need to take personal responsibility for their health and their bodies.
- Who have tested positive for the infection to have hope, because HIV does not mean death.
- Who do not have HIV to take HIV seriously, because HIV does lead to dying before one's time, and in what can be a very unpleasant manner.
- Understand that it is less difficult to make changes in their lives and lifestyles now, instead of waiting until after being infected.
- Who are infected with HIV to know that even if a test comes out negative (or non-reactive), they are infected and can infect others.

- Who have good reason to suspect that they may be infected to know that a negative test result does not mean that they are not infected, simply because they continue to look good and feel good. In other words, “negative” may not mean “negative.”
- Understand that a lab report verifying a negative test result, even if reliable and genuine, only speaks of the lack of an infection months ago, not an infection (or infections) that may be only a few nights old or a couple of weeks old.
- Understand that they are not in danger of “catching or getting AIDS” from a person living with AIDS. This can help remove some of the stigma surrounding people who are living with AIDS. However, there may be other infections and communicable diseases affecting the person living with AIDS that a caregiver needs to guard against, for example, tuberculosis and hepatitis B.

Day 3: Understanding HIV/AIDS and Treatment

Recap

MYTHS AND MISCONCEPTIONS ABOUT HIV/AIDS

ACTIVITY:

The trainer should:

- Post a large “TRUE” sign on one side of the room and also a large “FALSE” side on the other side of the room.
- Tell participants that in order to guide the training and make it useful to the participants, the trainers need to have an idea of what people already know and what gaps exist.
- Read out the statements below (or a sub-set of them) and ask participants to move to either the TRUE or the FALSE side of the room – participants can also stand in the middle if they are not sure. Ask a few participants to justify their responses, and allow participants to move their position
- After the activity, ask participants how they felt about the questions. “Were the questions easy? Hard?” Again, remind participants that we are all here to learn and that at the end of the training they will be able to answer all of these questions, and many more, with confidence!
- Tell participants that an important part of being an CHAP is knowing all the facts about HIV/AIDS and being able to communicate the facts to other people in the clinic and in the community.
- Remind participants that while everyone is entitled to his/her own opinions, knowing the facts about HIV/AIDS will help decrease stigma and discrimination of PLWHA and encourage people to seek prevention, care, and treatment services. This Unit will help CHAP learn the facts.

CONTENT:

Myths, rumors, and truths about HIV/AIDS and PLWHA:

- Having sex with a virgin can cure AIDS.
- Only promiscuous people get infected with HIV.
- Anyone with TB or pneumonia has HIV/AIDS.
- Although HIV/AIDS is a risk for anyone, women and girls are more vulnerable than men and boys.
- An HIV positive woman must have been sleeping around.
- People over age 40 do not get HIV.
- PLWHA should never have sex again.
- PLWHA should be responsible and tell everyone about their HIV-status as soon as they know they are positive.
- Traditional healers and holy water can cure people with HIV/AIDS.
- A faithful couple that is HIV-positive does not need to use condoms.
- Being diagnosed with HIV is a death sentence.
- You can tell if a person has AIDS by looking at them.
- It is important for PLWHA to visit the clinic regularly, even if they are not on ART.
- ART is only available in rich countries, or for people that have a lot of money.
- ART makes you look better on the outside, but it makes you sick on the inside and may ultimately kill you.
- Feeling better after starting ARV treatment means an HIV-positive person has been cured.
- Being HIV-positive means a woman should never have children.
- All children born to women with HIV/AIDS will get infected with HIV.
- ART is too strong for pregnant women to take, as it will hurt the baby.

OPPORTUNISTIC INFECTIONS IN HIV

Objectives:

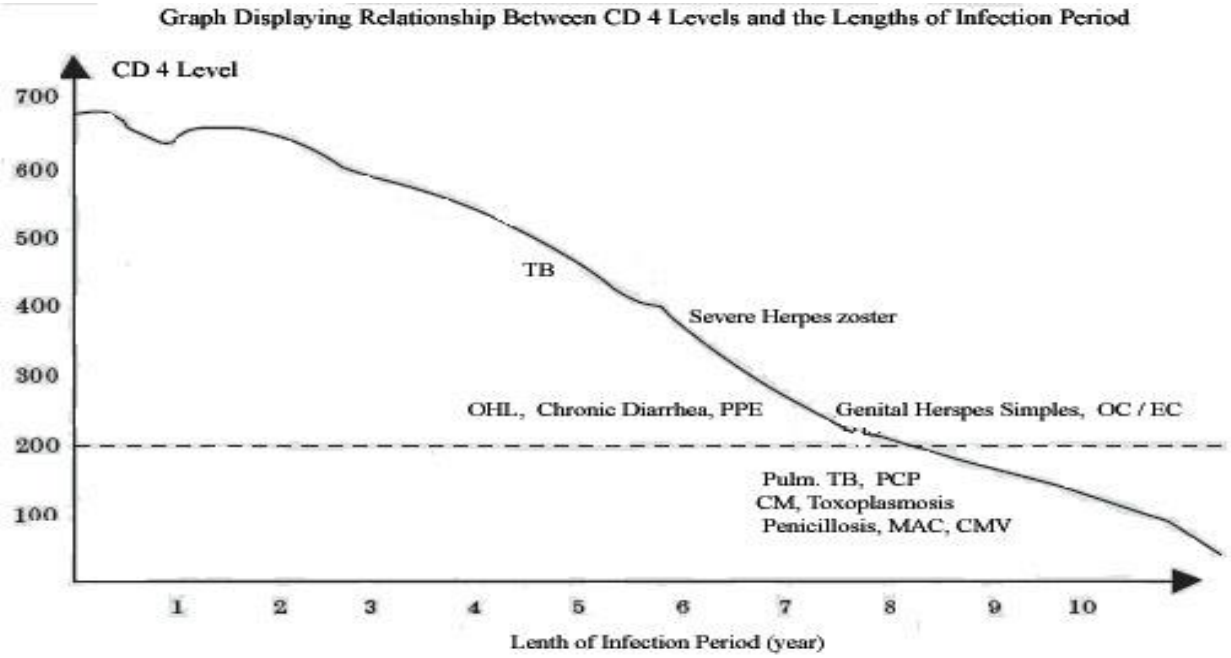
- To learn about the common opportunistic infections (OIs)
- To share experiences in taking care and treatment of these OIs
- To demonstrate that some OIs indicators of low immunity

Material:

- Cards with different OI and other disease, pre prepared Flip chart of CD4 and Length of Infection, flip chart, markers etc.

Process:

- Explain what OI is?
- Divide the group in 4 groups. (for the facilitator- divide the group according to the OIs of Gastro intestinal system, skin, Respiratory system +TB and CNS)
- Distribute the cards among the group ask them to group which disease can be termed as OI and which cannot, once they have divide they need to then discuss when does these OI's present on the chart of CD 4 and infection.
- Trainer can then discuss the sign and symptoms of different OIs and explain treatment and prophylaxis. And how early diagnosis can save life of the PLHA.



Discussion:

- HIV positive person can get OI of the Gastrointestinal system, Skin, TB, Respiratory System, Central Nervous System
- Common OIs in the GI and the skin can be the indicator of low immunity and in places where there is no access to a CD4 count, PLHAs can be taught to screen for these OIs. If an OI is found on screening, the PLHA can be given prophylaxis to prevent more serious OIs. Informed PLHAs can help take care of themselves if they develop skin or GI OIs. The treatment of OIs in PLHAs should be no different to the treatment of these same conditions in people who are HIV negative.
- TB is the most common OI that affects PLHAs and is responsible for the highest fatality amongst PLHAs. The most characteristic symptoms of TB are weight loss (10% or more over a month), prolonged fever and night sweats. The most effective way to reduce transmission of TB is for everybody to cover their mouth when they cough. It is unnecessary to isolate PLHAs with TB and in fact this can lead to further discrimination and non adherence of the treatment regime. PLHAs diagnosed with TB should begin taking PCP prophylaxis. The major route of transmission of TB is through droplets and it is extremely unlikely to contract TB through contact with caseous material.
- PCP is a common but undiagnosed OI in many countries and is a common cause of death. It can be easily prevented by taking 2 tablets a day of Co- trimoxazole which is very cost effective. This drug is available everywhere around the world and is very affordable. WHO recommends that PLHAs with OI or have CD4 count of less than 200 should start to take prophylaxis for PCP.
- CNS OIs are serious and can lead to permanent disability and death. Teaching PLHAs to screen and detect CNS infection early can avoid fatalities and unnecessary illness. They can be taught to look for symptoms such as vomiting, fever, headache and photophobia. In areas where there is no access to

investigations and treatment for Crypto-meningitis, primary prophylaxis is crucial and cost effective.

ARV TREATMENT AND MANAGEMENT

Objective:

- Dispel myths about ART to Clients and in the community.
- Explain when a person should start taking ART, including the clinical and social criteria.
- Discuss the goals of ART and the health and social benefits for men and women.
- Know common ART regimens and be able to explain how to take them.
- Help Clients recognize, manage, and know when to go to the doctor for ART related side effects.

Process:

- Trainer reviews the HIV infection mechanism related to the ARV mechanism using the HIV Infection Mechanism Model
- Trainer provides information on the criteria to start ARV and the principle of ARV treatment.
- Trainer introduces the types of ARV and some ARV.
- Trainer clarifies the following on each type of drug, pill burden, dose, diet instructions while taking the drug, drug patent, price, and resistance to drug, side effects.
- Participants are divided into groups and asked to propose an appropriate first line regimen of ARV using the information provided by the trainer.
- Each group makes a presentation.
- Trainer summarizes about the " Concept of Appropriate ARV Regiment"

Discussion:

- The goals of anti-retroviral treatment
- To suppress and control the amount of HIV virus
- To the lowest possible level and for as long as possible
- To restore and preserve immunologic function
- To reduce HIV- related morbidity and mortality
- To achieve the goals, the regime should be effective and be a combination of 3 drugs from 2 different groups. The combination should fit the patient's condition e.g. EFV containing regiment should be prescribed to PLHAs with TB. Good adherence needs minimal side effects and low number of pills taken once a day. To increase access to ARV there needs to be cheap and readily available drugs.
- The second activity talked about side effects and how they can be managed or prevented. This is important for adherence. A patient must be given information about potential side effects so they can properly monitor their health and know what to expect. Patients should be informed when their side effects may have serious consequences for their health and thus may need to change their regime.

Eg peripheral neuropathy, anaemia and jaundice. Some side effects if not checked in time can lead to permanent disability or death.

PREPARATION PROCESS BEFORE TAKING ARV

Process:

- Display the scenario on the flip chart.
- Ask participants to think if they were in this situation what would be their decision?
- Divide the participants into groups based on the answers they give.
- Each group should brainstorm their reasons for making that decision and what their future plans are and then present them to the large group.
- Trainer summarizes
  - The factors that have an impact on decisions to take or not to take ARV
  - The points that care providers should be aware of
  - The topics that need to be discussed with clients to preparing their readiness to take ARV.
- Trainer brings the flip chart from the activities of ARV 1- basic knowledge to discuss with participants and to let them clarity facts.
- Trainer summarizes the principle of providing information.

Materials

Scenario

- You were diagnosed with HIV 6 years ago.
- At present you are healthy. You have had diarrhea from time to time .
- Your CD4 count last month was 345. Counselor at the clinic has given you information about ART.
- But you are worried about Side effect, you have seen some of your friends die after stating ART and some have problems. Also it will be difficult for you to attend the clinic once a month as you are working. You are scared you will not be able to talk ART regularly and fear about resistance.
- You are thinking: **"Should I take ARV or not?"**

Discussion:

PLHAs may have different reasons behind their decisions on whether to start ARV or to wait. These decisions reflect peoples' past experiences, their personal beliefs and information that they have been given. As ARV is life long treatment, many people may choose other alternatives to care for their health such as OI prophylaxis or alternative therapies. As a PLHA group leader or health care provider we must be aware of the following:

- providing unbiased information
- exploring PLHA readiness (taking into account their lifestyle, family situation, career and economic situation and issues of disclosure)
- self determination- what is their decision? Ultimately the decision is theirs to make with the support of the clinic and the PLHA support group.

Day 4 – HIV Counselling & Testing

RECAP MYTHS AND MISCONCEPTION – ART

ACTIVITY:

The trainer should:

- Give each participant a card that says "true" and a card that says "false" on it.
- Go through the myths and facts statements below one by one, mixing up the myths and facts, and ask participants to hold up their "true" card if they think the statement is true or the "false" card if the statement is a myth about ART.
- Ask selected participants why they think a statement is true or false and encourage discussion and debate in the large group.
- Summarize the discussion by reminding participants that there are a lot of myths about ART that can be harmful and prevent people from starting treatment or taking their medicines the right way. All CHAPs should know the facts about ART and be able to explain them to other Clients and community members.

CONTENT:

Some common myths about ART:

- ART is a last resort and is only good for people that are sick and dying.
- ART cures AIDS.
- ART can kill you on the inside even though it can make you gain weight and look healthy on the outside.
- Without ART, there is nothing PLWHA can do to stay healthy.
- Only rich people can afford to take ART.
- Pregnant women can't take ART because it will hurt the baby.
- People can share ARVs with family members.
- Once you are feeling better on ART, you can stop taking it.
- If you feel well enough on ART, you can have sex without condoms because the HIV won't spread anymore.
- Traditional medicines are just as good as ART.
- There are no ARVs for babies and children.
- There is nothing you can do about side effects of ART.
- If the ARVs make you sick, you should stop taking them.

HIV COUNSELLING & TESTING

Objective: Understand the different kinds of HIV blood testing.

- Rapid test
- Elisa
- Western Blot
- PCR
- CD4 Count
- HIV Viral Load

Process:

- Presentation by Emilie
- Movie – HIV Rapid test
- Practicing testing and Hand pricking
- Tools – Passports, consent and results/referral

PREVENTING MOTHER TO CHILD TRANSMISSION (PMTCT)

Objetives:

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

- Understand the difference between PMTCT and PMTCT programs and services.
- Explain key PMTCT-Plus concepts and interventions for before and during pregnancy, during the time of labor and delivery, and after the baby is born – and the CHAPs role in each.
- Provide basic PMTCT counseling and referrals to Clients at Primary Health clinics, and hospitals.
- Explain the importance of ART for pregnant women and link women enrolled in PMTCT to ART services.
- Provide advice to Clients on safe infant feeding.
- Counsel Clients on needed follow-up and testing of HIV-exposed babies.

Process:

Presentation

CHAPS Training Materials PMTCT 201

Day 5: HIV Counselling & Testing

Recap: Presentation from participants on Activity of day 4

- Introduction of CHAPs –old and new
- Presentation on the HIV situation in the area (MSF 2013 Survey)

Day 6: Introduction to Counselling

HIV/AIDS & COUNSELLING

Anyone can give counselling (An activity for discussion and an exchange of experiences)

Objectives

- To emphasize the importance, benefits and definition of counselling.
- To install in participants the importance of confidentiality in order for them to be capable of developing themselves to be a good counselor.
- To persuade the participants to be interested in taking on the role of counselor.

Process

- The facilitator gives an introduction and poses a question for participants to brain storm within the big group "In your own experience, when you encountered a problem, whether it was serious or trivial, what was your experience trying to solve this problem or to confide in others? Who did you choose to talk to most of the time?"
- Ask each member to recall "an impressive experience on counselling". Instruct the participants to keep confidential any story they hear from others. The stories are not supposed to be discussed outside of the group. (In some cases, some participants may not want to tell their experience, the facilitator then is not required to make everyone participate in telling their story). Following is an order of what to do
  - What was the problem?
  - Who did you discuss the problem with?
  - Where?
  - How did you feel concerning the discussion and the person you chose to talk to?
  - What made it an impressive discussion for you?
- The main points of each story will be written down using the following format while the story is being told;

Problem		**Person selected to listen?**	**Where?**	**How did the storyteller feel concerning the discussion?**	**What made it an impressive one?**

Conclusion about this activity

- Everyone has experienced being both counselor and client. Problems brought to counselling span various issues; there is no limit on what can be brought to counselling. The issues could be about love affairs, health, career, economic situations, family etc.,
- Counselling is part of our everyday life. It is part of our life's activities. It is not a particular tool only for people living with HIV/AIDS.

- A counselor does not have to be an expert. It can be performed by anyone with the essential qualities such as acceptance, understanding, good listening etc., People living with HIV/AIDS can be counsellors.
- Generally, everyone has been to counselling because of certain problems. Everyone is capable of developing their skills as well as gaining more knowledge and understanding.
- The facilitator prompts the participants to acknowledge the value and importance of counselling as well as the definition of counselling; how beneficial it can be for those who are facing difficulties.
- Ask all participants how ready they are to carry out their task. They should expect to listen to various kinds of problems.

Facilitators Notes

- Making sure that the discussion follows given themes and that it does not go into too much detail. The facilitator shall listen and summarize the points of each story.
- After listening, the facilitator should write up a summary on a piece of paper. He should checking with the storyteller if it is what they want to convey, focusing on details concerning emotions and feelings. It may not be appropriate to divulge the name of the storyteller; for example when talking about someone divulging that they are gay. The person might have talked to their mother at home and felt comfortable and impressed that their mother acknowledged their sexuality.

DEFINITION OF COUNSELLING

Time: 1 hour

Objectives:

- Define counselling as a process and relationship.
- Identify characteristics of a counsellor.
- Discuss key qualities and unique characteristics of the counselling relationship.

Process:

Brainstorm- How would you define counselling? What is counselling?

Facilitators Notes*:*

- Brainstorm a list of what counselling is.
- It might be helpful to have someone act as a scribe. This person should write all responses on flipchart paper.
- When the list is exhausted, highlight that counselling is many things, but above all **counselling is a relationship.** Point out that the relationship is the foundation for counselling. How would you define counselling? What is counselling?

Counselling is a **process**, based on a **relationship** that is built on empathy, acceptance and trust. Within this relationship, the counsellor focuses on the client's feelings, thoughts and actions, and then empowers clients to:

- cope with their lives,
- explore options,
- make their own decisions, and

- take responsibility for those decisions.

Activity: Qualities of Good counsellor

Objectives:

Know what are the quality which makes one a good counselor

Process

- Brainstorm activity. Qualities and attributes of a good counsellor
- Ask the trainees to brainstorm on what they think are the qualities of a good counsellor
- List the points while the discussion is taking place
- The facilitator should try to elicit as many qualities as possible from the trainees. At the end, go over the list in the presentation and add any qualities that have not been mentioned by the trainees

***Facilitator Note*:**

- Qualities and attributes of a good counsellor
- **CONFIDENTIALITY is vital**. At all times respect the confidentiality of what is disclosed to you. Do not fall into the trap of easy gossip. There is nothing more calculated to destroy your credibility than this. It will also cause distress to the person you are working with. Lack of confidentiality will make a mockery of the whole process of counselling.
- **Effective** counsellors need to command the respect of the person(s) being counselled but should not be so far removed from them so as to inspire awe or fear. Key qualities of a good counsellor include:
- **Genuineness**. This is an important part of the communication process. The genuine person is one who is simply him/herself, without facade. A genuine relationship between counsellor and client is the basis of successful counselling. Genuine interest is also reflected in your body language
- **Listening. Listening involves attending to the client's verbal and non-verbal** messages. As a counsellor, the way you respond is effectively dependent on how you listen. The way you listen plays a big part in encouraging or discouraging a client to keep talking. Only when one has listened can one empathise
- **Unconditional** positive regard. Sensitivity, respect, friendliness and consideration are effective as counselling ingredients. Showing personal warmth is basic in any relationship
- **Believing** the client. Be able to communicate to the client that you believe him or her. For the client, it is very comforting to realise that someone understands how they are feeling
- **Cultural sensitivity**. Respect the client's cultural and belief systems. Be sensitive to cultural contexts and traditions. Culture informs people on how they do things and when they do them.
- **Acknowledge differences**, explore beliefs and ask questions to increase understanding and optimise assistance provided
- **Showing the way**. Help the client think of various alternatives available to them and work with them to consider the advantages, disadvantages and implications

of each alternative. Do not, however, take responsibility for the client's problems as this can create dependency and helplessness

- **Honesty**. Recognise your own limitations and refer them to another expert source, if possible. If you do not know something tell, your client. Counsellors need to have self-awareness of their own issues and the ability to prevent them from influencing the counselling relationship
- **Patience**. Move at the client's pace — do not rush him or her. Make sure adequate time is provided for the counselling process. Some issues might be too sensitive or maybe he or she is not sure yet whether to trust you or not
- **Free expression**. Do not block free expression of feelings, e.g. crying, anger, etc. Blocking free expression of feelings can be due to pressure of work — the counsellor has other clients waiting – or maybe the counsellor is uncomfortable with the expressed emotions. If the counsellor is under pressure, it is important to remember that the most important person at any given time is the client you have right in front of you. You need to work with them first before moving to the next client. If you are getting uncomfortable with the expressed emotions, could it be that you have your own unresolved issues?
- **Non-judgmental**. Avoid falling into the trap of taking sides and deciding who is right and who is wrong. You are there to listen and not to judge. You need to demonstrate acceptance
- **Being in control**. Stay focussed and do not wander all over the place. This usually happens if
- you are following content – enjoying the interesting bits of the story – and not following the process
- **Empathetic**. This is the ability to see the problem as the client sees it, yet at the same time, standing back and objectively observing what is happening with the client and the counselling relationship
- **Knowledgeable**. It is essential to have accurate and up-to-date knowledge. Counsellors should be well informed about the field they work within, including the services and resources available to their client group within their setting and community

TRUST BUILDING EXERCISE

Time: 30 minutes

Process:

- Please stand up and find a partner. You should all be in pairs.
- Hand out blindfolds, one blindfold for each pair.
- One person in each pair, please put on the blindfold. Make sure you cannot see anything.
- Now, I would like for the “seeing” partner to guide the blindfolded person around the room.
- *Give the group about 5 – 10 minutes and then switch roles.*

Processing Questions:

- What was it like to be blindfolded?
- What did your guide do to make you more comfortable? Did it work?
- What was it like to be the guide?
- How did you make the blindfolded person more comfortable?
- Which role was more comfortable for you: being the leader or the follower?
- Why did we do this exercise? Make sure the responses include the following:
  - Develop empathy for our clients.
  - Identify and experience ways to create a trusting environment.
- How does this exercise relate to counselling? (see above)
- How is a client's role similar to the role of the blindfolded person? How is it different?
- How is the counsellor's role similar to the role of the guide?
- How is it different?
- Once the counselling relationship has been established and trust has begun to be developed, the counsellor and client can work together towards:
  - Immediate steps to empower and enable the client(s).
  - Understanding, insight and acceptance.
  - Enabling the exploration of options and making choices.
  - Discovery of appropriate community resources/referrals.

COUNSELLING SKILLS

Objective:

Participant will understand the counseling skills and be able to implement it during counseling.

Activity: skill of counseling

- Ask trainees to form pairs for an activity
- Instruct them to nominate one person to be the 'counsellor' and the other to be the 'client' Ask all the counsellors to meet together in one area of the training room for their instructions Provide them with the instructions for counsellors, as below
- Ask them NOT to share this with their partners (i.e. the client) Ask all the clients to meet together in one area of the training room for their instructions.
- Provide them with their 'client' instructions as below Instructions for counsellors:
- Your job in this activity is to be a 'bad counsellor'. Ask your client to tell you about an achievement in their lives; a time they did something they were proud of and happy about. As your client begins to answer demonstrate poor counselling skills:
  - look at your watch
  - write notes
  - play with your hair
  - look around the room
  - look for something in your bag

- fix your make-up
- play with your jewellery
- talk to someone else across the room
- interrupt and tell your own story
- make inappropriate facial expressions
- sit with a closed posture
- look disinterested
- do not encourage the conversation
- do not ask questions, etc.

- Remember that you need to be as bad as possible
- DO NOT tell your client you have been asked to be bad – this must be kept confidential!
- The purpose of the activity will be explained afterwards and the clients will be told that you were asked to be 'bad'
- Instructions for clients:
- Your job in this activity is to be a 'client' You need to think of an achievement in your life, a time you did something you were proud of and happy about It should be something you are comfortable with and able to discuss for 5 minutes
- The 'counsellors' will be practising their basic skills during this activity Ask everyone to find his or her partner and begin the activity
- Allow the activity to proceed for 3-5 minutes – use your judgement as to how much time is needed as you observe whether pairs are continuing or ceasing conversations
- Reassemble the group after the activity and ask the 'clients' to share their experiences
- Explain that the 'counsellors' were asked to be 'bad' and that the purpose of the activity was to quickly highlight the importance of the basic skills of communication
- Lecture with Power Point presentation During the presentation solicit comments and ask trainees questions to keep them involved actively in the presentation.

Facilitators Note

- Counselling microskills are essential for effective communication and the development of
- a supportive client-counsellor relationship. As a foundation, counsellors need to develop specific
- microskills. These include:
  - Listening and empathy
  - Questioning
  - Silence
  - Non-verbal behaviour

EMPATHY: WHAT IS IT?

Objectives:

- Define empathy.
- Distinguish between empathy and sympathy

This session is on empathy. In order to discuss empathy, we first need to understand what this word means.

- Have any of you ever heard the word empathy? What does this word mean to you?
- What is empathy?
  - *Let the participants come up with their definitions. Below are some to add if the participants do not mention them. You may need to explain some of these definitions. It may be helpful to put these definitions on a flipchart or refer to the Participant Manual.*
- Putting yourself in someone else's shoes.
- An attempt to penetrate the "aloneness" of the other.
- Respectfully stepping into someone else's life.
- Temporarily living in the other's life; moving around in it delicately without making judgements.
- Entering the private perceptual world of the other person, being sensitive to any changes, stumbling blocks or experiences
- Empathy translates your (the counsellor's) understanding of the client's experiences, behaviour and feelings into a response through which you share that understanding with the client.
- View an experience from another's perspective (view the other's perception).
- "To empathise is to see with the eyes of another, to hear with the ears of another and to feel with the heart of another."
- An anonymous English tutor
- Requirements for Empathy: It is hardest to empathise with those who are different from us. In order to empathise with another, you must have the following characteristics:
  - Open-mindedness: you must set aside for the moment your own beliefs, values and attitudes in order to consider those of the other person.
  - Imagination: To picture another's background, thoughts and feelings.
  - Commitment: a desire to understand another.
  - Knowing and accepting yourself: knowing yourself and accepting who you are also helps to develop empathy for others.

LISTENING SKILLS

Objectives:

- Participant will be able to understand the importance of listening skill in counseling

Process:

- Ask two participants to role play, one acts as counselor and other client, ask the client to tell the counselor some story they have experienced which has made them feel very sad. Client keeps on speaking for at least 10 to 15 minutes. Instruct the counselor that when the client is telling his story the counselor needs keep counting numbers in his head and continue till the client finishes.

Facilitators Note

- Good listening involves all of the following:
- Eye contact (culturally appropriate)
- Demonstrate attention, e.g. nodding
- Encouragement, e.g. “Mm-hmm”, “Yes”
- Minimise distractions, e.g. TV, telephone, noise
- Do not do other tasks at the same time
- Acknowledge the client’s feeling, e.g. “I can see you feel very sad”
- Do not interrupt the client unnecessarily
- Ask questions if you do not understand
- Do not take over and tell your own ‘story’
- Repeat back the main points of the discussion in similar but fewer words to check you have understood the client correctly (this is known as paraphrasing, reflection of feelings, clarification, summarising)
- An important component of good listening skills is the ability of the counsellor to convey empathy.
- Empathy involves trying to understand how individuals view themselves or their world.
- Demonstrating empathy helps establish rapport with clients, and facilitates the client feeling “safe” to disclose the truth about their feelings and circumstances.
- Empathy is conveyed by using all of the listening skills indicated earlier. In particular, the following techniques can be utilised:
  - **Paraphrasing**, which involves restating, in your own words, the essence of what the client has said. Paraphrasing assures the client that you are listening and it assists the client in focusing on his/her situation more clearly.
  - *Client: “I feel so helpless. I can’t get my housework done, get the children to school on time or even cook a meal. I can’t do the things my wife used to do.”*
  - *Counsellor: “You are feeling inadequate about doing things you have not had to do in the past when your wife was alive”*

Activity: *Questioning*

- Ask trainees what types of questions they are aware of (answer closed/open/leading)
- Give the lecture on the different types of questions
- Provide trainees with (AS11). Give them a few minutes to review the questions listed and to circle the answer according to whether they are closed/open/leading
- Review the questions as a large group – ask the trainees to say out loud the answers they have chosen. Discuss and correct answers where required
- Refer to this guide as required:
  - You always practise safer sex don’t you?
    Closed and leading
  - What are some of the difficulties that you would have using a condom?
    Open
  - Do you take your medication?

Closed

- You should tell your wife, shouldn't you?
  Closed and leading
- When were the occasions that you shared needles?
  Open
- What do you know about HIV?
  Open
- Do you understand how HIV is transmitted?
  Closed
- Do you protect yourself from HIV?
  Closed
- What are the different ways you could protect yourself from HIV?
  Open
- How do you clean your injecting equipment?
  Open
- Have you ever had a blood transfusion?
  Closed
- Who could you talk to for support if you were to test HIV positive?
  Open
- Continue the lecture on do's and don'ts of questioning

Facilitators Notes

- Questioning is an important part of counselling. It helps us understand the client's situation and it
- helps us assess clinical conditions.
- When asking questions:
  - DO ask one question at a time
  - DO look at the person
  - DO be brief and clear
  - DO ask questions that serve a purpose
  - DO use questions to help the client talk about their feelings and behaviours
  - DO use questions to explore and understand issues and to heighten awareness
  - DO NOT ask questions simply to satisfy curiosity — irrelevant questions may cause people to feel pushed or reluctant to answer. Too much time may be spent thinking of questions rather than actively listening. Too many questions will be experienced as intrusive and similar to an interrogation

There are essentially three styles of questions:

- Closed questions
  - A closed question limits the response of the client to a one-word answer.
  - e.g. "Do you practice safer sex?"
  - e.g. "Do you know how to use a condom?"
  - Closed questions may not require clients to think about what they are saying. Answers can be brief and often result in the need to ask more questions.
- Open questions

- An open question requires more than a one-word answer.
- e.g. “What difficulties do you experience in practicing safer sex?”
- e.g. “How might you react if you received a HIV-positive test result?”
- Open questions generally begin with ”what”, “where”, “how” or “when”. They invite the client to continue talking and to decide what direction they want the conversation to take.

- Leading questions
  - Leading questions are questions where the counsellor guides the client to give the answer they desire. These questions are usually judgemental.
  - e.g. “You do practice safer sex, don’t you?”
  - e.g. “Do *you agree that you should always use a condom?”*

Silence:

Discuss the importance of counsellors being comfortable with silence during counselling

Facilitators Note

- Gives a client time to think about what to say
- Gives a client space to experience their feelings
- Allows a client to proceed at their own pace
- Provides a client with time to deal with ambivalence about sharing
- Gives a client freedom to choose whether or not to continue

Non-verbal behaviour:

- During this section of the lecture it is important to provide clear examples
- Facilitators should try to ‘act out’ the body language and paralinguistic features of nonverbal communication
- Choose a co-facilitator or participant to act as partner to demonstrate body orientation,body proximity/distance and mirroring

Facilitators Note

- It’s not what you say but HOW you say it!
- The majority of communication is non-verbal. Counsellors need to be aware of what they may be communicating to their clients through their non-verbal behaviour. They also need to give attention to what is being communicated through the non-verbal behaviour of their clients.

WHAT IS COUNSELLING?

- Counselling has to do with feelings.
- Counsellors are people who help others express, understand and accept their own feelings.
- This process helps people to:
  - feel less anxious,
  - make decisions,
  - take actions, and
  - grow and change.

- People solve their own problems. Counselling gives no advice, only helps people to be able to face their problems, examine their options, understand their feelings and choose alternatives that seem best to them.

- The main tools of the counsellor are:
  - empathy
  - active listening
  - reflecting feelings
  - asking good questions
  - affirming and accepting
  - Counsellors create conditions where clients can become better acquainted with their thoughts and feelings by hearing themselves talk about them.

Activity Telephone Game

- **Time**: 10 minutes
- Divide participants into groups of 8 to 10 participants. All participant should stand in a circle. If your group is not more than 18-20 people, you can do this in one large group.
- Instruct one person to come up with a very short story (no more than 3 sentences) and whisper it to the person to his/her right.
- That person then whispers what he/she heard to the next person.
- When whispering the message you may only say it once. You may not repeat it.
- The message goes around the circle to the last person. The last person then says what he/she heard out loud to the whole group.
- This is compared to the original message.

Facilitators Notes

- Below are some sentences you could use for this game. You can simplify them for the group if needed. Only use one sentence.
  - My mother went to Pick-n-Pay last Saturday morning. She bought a five kilo bag of maize meal and two loaves of white bread.
  - Last Sunday when my sister went to church she wore a pink, flowered dress and sandals.
  - Next weekend I am going to Windhoek to visit my brother and his family. My cousin is getting married.
  - Every weekend I wash my clothes, do my shopping, clean my house and visit my mother's house.
- *Processing Questions:*
  - How did the original message compare to the final message?
  - What happened to the meaning of the message?
  - Why did this happen?
  - What was the purpose of this activity?
  - Does this happen in real life?

Activity: Birthday Order

Time: 10 minutes

- Before we define non-verbal communication, I want to do a short activity.
- Everyone please stand up. You are going to arrange yourselves in a queue according to your birthday. This is only the month and day of your birthday, not the year. When you are finished, you all should be in a queue with the first person in the queue having a birthday inJanuary or early in the year and the last person with a birthday in December or latest in the year.
- However, while you are doing this you are not allowed to talk. There should be no sound while you are arranging yourselves in order.
- Make sure you observe the participants and see how they are communicating.
- When they are finished, you may want to check the order to make sure it was done correctly.

Key Point:

- What is said and what is heard are often different. In order to make sure that you are heard and understood, it is often important to check the client's understanding by asking them what he/she understood. It is also important to make sure you regularly check your understanding of what the client has said to you.
- *Note*
  - There are two other key concepts to understand about interpersonal communication:
  - • Verbal communication
    - What is said out loud
    - Includes the message, but is not limited to that
    - Includes volume (how loudly or softly the words are said)
    - Tone of voice
    - Language
    - Sighs
  - • Non-verbal communication
    - What is communicated that is not oral (or is not heard)
    - Uses other senses besides hearing, such as seeing and touching
    - There is a great deal more to communication than words that are exchanged back and forth.
    - Also called body language and includes:
      - Gestures – legs crossed or folded arms
      - Facial expressions
      - Posture – sitting upright or slouching
      - Eye contact
      - Seating or height
      - Proximity – how close or far away you are from the person you are communicating with (closeness or distance)
      - Touch

REFLECTING SKILLS: REFLECTING FEELINGS

Objectives:

- Define reflecting skills.
- Understand the purpose and general guidelines for reflecting skills in counselling.
- Develop and expand feeling word vocabulary in local languages.
- Practise reflecting feelings.

What do you think reflecting skills are? Think about the word reflect: what does it mean to you?

- Brainstorm a definition. Again, letting the participants generate their own ideas empowers them. You are modelling the skills you want them to use in counselling.
- Bring out the mirror to talk about what a reflection is. A reflection just shows what is there; it does not make a judgement about it, it does not add to the image, it does not say you cannot do that or you should not have said that, etc.

Key points:

- Reflecting skills act like a mirror; they reflect back to the client what he/she is communicating.
- They are a way of communicating your understanding of the client's perspective.
- Reflecting skills also communicate empathy.

Facilitator Notes

- Why are reflecting skills important? What do you think the purpose is of reflecting back to the client?
  - Let the participants list their reasons; ask someone to record them on a flipchart for you.
- Reflecting Skills are valuable in building a relationship with the client by communicating trust, acceptance and understanding.
- Help clients clarify for themselves their problems and feelings.
- Help the counsellor gain information about the client and how he/she views his/her situation.
- Verification: it helps the counsellor check his/her perception of what the client communicates.
- We are going to highlight four different reflecting skills. These are skills that can be used at any stage of the counselling session, but are especially important for trust building and exploration.
  - Reflecting feelings*
  - Restating/Reframing
  - Affirmation*
  - Summarising**
  - **Reflecting Feelings**:
    - Reflect what the client is feeling; focus on feelings, NOT content.
    - Example:
    - *Client:* "I'm the only one working in my family. My mother, my sister and her two children stay with me and my three kids. My sister just came a

month ago and she can't find any work. I can't afford the school fees for my own children so I don't know what to do about schooling for my sister's kids."

- *Counsellor*: "You sound tired and overwhelmed

Tips for reflecting feelings:

- Listen for and reflect both verbal and non-verbal communication of feelings.
- Read body language and reflect what you see if feelings are not expressed verbally.

PROBING AND ACTION SKILLS: ASKING QUESTIONS AND INTERPRETATION

Objectives:

- Define probing and action skills.
- Understand the purpose and general guidelines for probing and action skills in counselling.
- Identify, understand and practise two probing and action skills: asking questions and interpretation.

Asking Questions (Clarifying): asking questions is a very important part of counselling. However, as a counsellor you must be careful about what kinds of questions you ask and how you ask them.

Open & Closed Questions

- Has anyone heard about open and closed questions? If so, can you explain what closed questions are?
- Closed Questions: questions that can be answered with one word.
  - Sometimes they are called yes/no questions. Can you give me some examples?
  - Examples: Do you want to be tested?
  - Do you know how to use a condom?
  - How old are you?
  - What is your name?
  - When are closed questions useful?
  - *Let participants respond.*

Key point:

- Used closed questions when you need specific information

PERSON-CENTRED COUNSELLING

Objectives:

- Describe person-centred counselling and its basic theoretical assumptions.
- Explain these assumptions as they apply to the counselling setting.
- Discuss how this approach may be different from pre-conceived ideas of counselling.

Time: 45 minutes

We have highlighted the fact that counselling is a relationship. There are many theoretical approaches to counselling which highlight different aspects of counselling.

- Most of the counselling training you will be receiving here as community counsellors will be based on the person-centred approach to counselling.
- Person-centred counselling focuses primarily on the relationship between the client and the counsellor.
- Person-centred counselling began as a result of Dr. Carl Rogers' work in the 1930's and 1940's. The central part of Carl Rogers' theory is that **the client, or the person, knows best**.
- The client is essentially the expert on his or her life, and what he/she is thinking and feeling, etc.
- This style of counselling has also been called "non-directive" counselling, to emphasise that the counsellor's role is to enable theclient to rely on his/her own inner resources rather than the counsellor guiding the client or offering advice.
- The person-centred approach highly values the experience of the individual person and the importance of his or her subjective reality (perspective)..
- This approach challenges each person to accept responsibility for his or her own life and to trust in the inner resources which are available to all those who are prepared to set out along the path of self-awareness and self-acceptance.
- What do we mean when we say that a person relies on his/her inner resources?
- Let participants brainstorm. You can draw it on flipchart paper as a spider diagram with "inner resources" in the centre and lines going out from the centre for each idea. These can include the following:
  - Skills and abilities
  - Mind
  - Emotions
  - Coping mechanisms
  - Willingness to seek help
  - Faith in God
  - Ability to find solutions
- You can also list external resources such as relationships, community, family, job, etc.
- Based on Carl Roger's theory, there are some basic assumptions to this counselling approach we will be teaching you.
- Basic theoretical assumptions: (refer to prepared flipchart or overhead)
- Some of these assumptions may need to be simplified or explained using different words so that the participants can understand them. It is also helpful to give examples. Some examples are included below in italics to facilitatethe discussion.
- People are responsible for and capable of making their own decisions.
- People are controlled to a certain extent by their environment, but they are able to direct their lives sometimes more than they realise. People do have options available to them.

- Additional Explanation: There are things that people cannot change in their environment. For instance, they may not be able to change their living situation. However, they often do have more options or choices than they may perceive. In a difficult living situation, for instance, they may be able to rearrange the rooms, suggest a cleaning schedule, or change an attitude. People often feel trapped when in fact they have more options than they realise.
- Behaviours have a purpose and are goal-directed. People are always trying to meet their own needs.
- Additional Explanation: Understanding that people are simply trying to meet their needs can sometimes help in treating them with compassion. People do things for a reason and sometimes looking past the behaviour in order to understand the purpose can be helpful.
- People want to feel good about themselves and continuously need positive confirmation of their own self-worth from significant others (important people in their lives, loved ones).
- Additional Explanation: When someone does something well, tell them. Reinforce people for their successes by telling them.
- People are capable of changing; they can learn new behaviours and unlearn existing behaviours.
- Additional Explanation: While old habits are hard to break, people are capable of change. So much depends on one's self-motivation and willingness to change
- People feel trusted and respected when you have enough confidence in them to offer honest and constructive feedback and allow them to make their own choices and direct their own growth.

MODEL OF A COUNSELLING SESSION

Time: 1 hour

Objectives:

- Identify and discuss the four phases of a counselling session.
- Apply this counselling process model to role play scenarios.

Display *the "Model of a Counselling Session" (page 35).* Looking at this diagram, what does it tell you about the process of a counselling session? *Let the participants come up with their ideas based on the diagram.*

Activity 2: Phases of a Counselling Session

There are five main stages or phases in the process of a counselling session:

1. Trust Building
2. Establishing the Relationship (Greetings and Introduction)
3. Exploration (Understanding the Problem)
4. Resolution (Decision-Making)
5. Termination

1. Trust Building (Building the Relationship)

- Trust building is the foundation for counselling. It is crucial in the beginning, but is always something to go back to during the course of the session.
- Notice that in the counselling model, it lies at the centre of the diagram and underlies each stage of the counselling process. Remember that counselling is a relationship; building trust is part of developing a relationship. Building trust continues throughout the counselling relationship for as many sessions as a counsellor and client work together.
- We need to create a warm and safe environment for counselling.
- Physical Environment:
- Room: it should be quiet with doors that close. This should be a room where people do not walk through so there are few, if any, interruptions or disturbances. Small rooms are also better than large rooms.
- Seating arrangement: chairs should be arranged so they face each other and should not be too far apart. Ideally, the chairs should be the same height.

2. Establishing the Relationship (Greeting and Introduction):

- This is the first thing you do to build trust. You are setting the framework for the counselling relationship.
- Introduction: introduce yourself and give a short explanation of your role and the length of time you have together (i.e. half an hour or 45 minutes).
- Confidentiality: explain that what is discussed in counselling is confidential, which means that it is not talked about with other people, but is private. However, there are two exceptions—two situations where what is said in counselling will not be kept in confidence:
- Supervision: in order to improve the care a counsellor give clients, the counsellor will share details of the case with his/her supervisor and supervision group. However, the counsellor will not disclose the client's name and personal information.
- Harm: the other situation in which the counsellor will break confidentiality is when the client is a danger to himself or someone else, i.e. if the client says he or she will kill himself or someone else.
- Ways to begin a counselling session after introduction and explanation of confidentiality:
  - We have about 50 minutes together now. How would you like to use the time?
  - Can you tell me what brought you here today?
  - Where would you like to begin?
  - When you are ready, please feel free to start where you would like.
- If your client seems uncomfortable, you can always start with easier questions to put the client at ease. These questions should be common knowledge questions or questions you would ask someone when you first meet them. Think about things that would fall into the "Free Self" window of Johari's Window. Some examples of these questions:
  - Can you tell me a little bit about your family?
  - Where are you from?

- How long have you lived in _____?

- There is no magic formula for establishing trust. The experience of being heard and understood is in and of itself a powerful tool for creating trust. If the counsellor can show empathy from the beginning, this also will help to develop a trusting relationship.
- Some clients are so ready for counselling that they almost instantly trust the counsellor and very quickly develop a high level of self disclosure, but for others this will be a slower process.
- For clients who are more sceptical or suspicious, continuously rely on empathic listening skills and reflecting skills. These are ways to develop a trusting relationship.
- Ventilation (expression) of the client's feelings and problems begins in the "Trust Building" phase and continues into the "Exploration" phase.

3. Exploration (Understanding the Problem)

- This phase focuses on the expression and exploration of the pain or the problem that the client is presenting.
- Notice that in the counselling model, "Exploration" is the longest (or the largest based on the model) stage or phase of the counselling session: This is where you will spend most of your time.
- Ventilation continues in the Exploration phase. Let the client talk about the thoughts, feelings and actions around the problem or problems he/she is experiencing.
- Use empathic listening and reflecting skills during the beginning of the exploration phase.
- Often clients are so stuck in their own emotions, experiences and circular thought patterns that they are unable to find solutions for their problems or even to think straight to sort it out. In this middle stage, you can help the client to organise his/her thoughts and feelings as well as explore some options or choices.
- After the client has "vented" (expressed their thoughts and feelings), you can start to help him/her focus by defining the problem. In order to do this, you will use more probing or action skills. You will start to ask more questions and maybe make some interpreting statements.
- Make sure that when you define the problem you give it clarity, both in terms of the situation as well as the thoughts and feelings associated with the issue.
- There may be multiple problems to address, in which case you should help the client to organise and distinguish between the different problems. Then you may help the client prioritise which issues to address first.
- The counsellor may use some confrontation towards the end of the "Exploration" phase if the trusting relationship has been established.
- The counsellor may also begin to use information sharing and problem-solving techniques at the end of the "Exploration" Phase.

4. Resolution (Decision-Making)

- Towards the end of the counselling session, you move into the resolution phase.

- It is often important that the counselling process generate some kind of focus or plan for problem-solving or future action. Sometimes this plan or focus is simply a change in perspective or choosing to accept the situation.
- Remember to keep the focus on something that is realistic and obtainable.
- It is very important that the decision-making come from the client. The counsellor can help the client explore the options, but it is ultimately the client's decision to make.
- The client might not be ready to make a decision by the end of the counselling session. If that is the case, let the client leave with the resolution to make a decision before he/she returns. Do not force the client to make a decision prior to the end of the session.

Note (Model of Counselling Session): the arrows back and forth on the sides between Exploration and Resolution mean that it does not always move smoothly from exploration to resolution.

- Sometimes a client will be ready to resolve only a small portion of the problem and then they will jump back to exploration of the broader issue.
- If the client is hesitant or resistant to come to a resolution about the problem, it could mean that there are other issues involved that he/she has not talked about. In this case, jump back to the exploration phase. Explore the thoughts and feelings around the problem at length.
- Especially for beginning counsellors, there is a tendency to race through these phases because of our anxiety about helping the client. Slow down, take deep breaths and allow full exploration of the problem before trying to work with the client to resolve it.
- Remember that it may come as a huge relief to the client to just talk openly about his/her problems. Often clients feel as though they have no one to talk to, so just being able to talk freely is healing in and of itself.

Termination (Ending the Session)

- Summarise what was discussed during the session; include the focus and any decisions or plans that were made.
- Reiterate the focus. This is important in order to make sure the client stays focussed on what he/she has control over and lets go of what he/she cannot change.
- Highlight any referrals that were provided to the client.
- Discuss any future counselling sessions and make necessary appointments.

Why is this model for counselling important? *Let participants discuss. Key points to highlight:*

- Keeps the counsellor and client focussed.
- Gives the counsellor some tools, or a map, for guiding the client through a problem.

ETHICS IN COUNSELLING

Objectives:

- Define ethics, boundaries and confidentiality.
- Discuss case scenarios related to these ethical issues.

What are ethics? *Let participants respond. Possible responses include the following:*

- Standards
- Responsibility
- Moral rules or principles for a particular profession

We are going to focus on two aspects of ethics that relate to counselling.

1. Boundaries/Limit Setting: boundaries are limits set around the counselling relationship.

- Do you think there should be any limits on who a counsellor can counsel?
- For instance, is it ethical to counsellor your sister or your good friend? If not, why not? Let participants discuss this briefly before continuing on. It will allow them to think about these issues before presenting the material below.
    - Defines who the counsellor should counsel (who you should see in counselling).
    - Counselling is a relationship that is unequal in power. The counsellor is in a position of power over the client.
- Boundaries in a counselling relationship protect the client. For instance, a counsellor should not have other relationships with a client in addition to the counselling relationship. These other relationships could include a sexual relationship, a dating relationship, a business relationship or as a close family member.
    - The counsellor is bound to the limits or boundaries of the counselling relationship even if the client pushes these and wants to extend the relationship. For instance, even if the client may make sexual at the counsellor, the counsellor may not act on this and engage in a sexual relationship.
    - Counsellors must be comfortable with setting limits as well as following the agreed-on boundaries to ensure that clients feel secure within the counselling relationship.
    - Avoid multiple relationships. The counselling relationship is most effective if there are not other relationships between the counsellor and the client, i.e. if the client is a stranger to the counsellor.

2. Confidentiality and Privacy

- This is a way of providing safety and privacy to the client. What is discussed in counselling is private and will not be shared with others.
- Even the fact that someone has gone to counselling is confidential.
- You as the counsellor cannot disclose that you have seen someone in counselling.
- Confidentiality and privacy are also part of the MoHSS Policy on HIV/AIDS Confidentiality, Notification, Reporting and Surveillance.
- *See the insert at the end of this session for more clarification if the issue of partner notification comes up in discussion.*
- However, there are two exceptions:

- Counselling Supervision: the counsellor will be sharing the case with his/her supervisor in order to provide good counselling. In counselling supervision, it is best to avoid identifying the client (do not mention his/her name and personal characteristics) when discussing the case.
- Harm: If the client is at risk of causing harm to him/herself or to someone else, the counsellor can break confidentiality. For example, if a client is suicidal and will not develop a safety plan, then the counsellor will call the police. Allow participants to come up with more examples. Other examples could include situations related to child abuse and domestic violence

Day 7 – HIV counseling and testing

WHAT IS HIV COUNSELLING AND TESTING?

Objective:

- To increase understanding of how the HIV antibody test is carried out.
- To increase understanding of the different steps involved in HIV counselling and testing.
- To increase understanding of people's needs before and after the HIV antibody test and how counselling can meet those needs.

Facilitators Notes

- Prepare flip charts:
  - how we feel before the HIV test
  - how we feel when the test result is positive
  - how we feel when the test result is negative
  - HIV testing and counselling – the key steps
  - instructions for work in small groups

Instructions

Part 1

- Explain the aim of the activity.
- In plenary, ask participants what they know about the HIV test. You can help participants with questions such as:
  - How does the test result indicate that a person has HIV in their body?
  - How can you be sure that the result of the test is accurate?
  - How much time does the test take?
  - How long must you wait after taking the HIV test before receiving the result?
  - Is the test the same for everybody, including babies and adults?
- For each comment or answer by a participant, ask other participants whether they agree or not. Correct any misconceptions and summaries.

Part 2

- In plenary, give each participant three small pieces of blank paper.
- Ask participants to imagine that they are going to take an HIV test. Make it absolutely clear that no one will be expected to reveal anything about their own HIV status.
- Ask them to imagine how they would feel just before the test, and to write on one of the pieces of paper three words describing their feelings and thoughts (words can be adjectives, nouns or verbs). Tell participants that this is anonymous and that they should not write their name on the paper.
- Circulate a bag and ask participants to put their piece of paper in the bag. Collect the bag.
- Next, ask participants to imagine that they have been tested, that they receive the test result from a counsellor and the result is positive. Ask them to write on a second piece of paper three words that describe how they might feel when they receive the positive result.

- Circulate a second bag and ask participants to put their piece of paper in the bag.
- Finally, ask participants to imagine that they have been tested, that they receive the test result from a counsellor, but this time the result is negative. Ask them to write down on a third piece of paper three words that describe how they might feel when they receive the negative result.
- Circulate a third bag. Make sure that the bags are different, or if they are similar, identify each bag with a distinguishing mark.
- Tell participants that you are now going to analyse how people feel before the HIV test.
- Open the first bag, ask one of participants to pick out the pieces of paper and read what is written on them. Write the words on a flip chart entitled "How we feel before the HIV test". If a word is repeated, write it only once on the flip chart.
- Ask participants if they have any comments. Stress that the feelings expressed are how most people feel before they take the HIV test.
- Tell participants that now you are going to look at how people feel when they receive their test result and the test is positive. Open the second bag and ask another participant to read out the pieces of paper.
- Write the words on a flip chart entitled "How we feel when the test result is positive". If a word is repeated, write it only once on the flip chart.Section 2
- Ask participants if they have any comments.
- Finally, tell participants that you are going to look at how people feel when they receive their test result and the test is negative. Open the third bag and ask another participant to read out the pieces of paper. Write the words on a flip chart entitled "How we feel when the test result is negative". If a word is repeated, write it only once on the flip chart.
- Ask participants if they have any comments. It is important to include a debriefing activity before closing the session to help participants step out of an experience that, for some, may have been difficult.

Part 3

- Explain that because of all the feelings and thoughts that people have before and after the HIV test, the test should never be carried out without counselling.
- Explain that there are several steps in the HIV testing and counselling process
- Answer any questions and make sure you explain clearly the differences between post-test counselling and ongoing counselling after the test.
- Explain that participants will be divided into three groups. Each group will focus on one type of counselling:
- • Group 1 on pre-test counselling
- • Group 2 on post-test counselling when the test result is positive
- • Group 3 on post-test counselling when the test result is negative.
- For each type of counselling, the corresponding group should brainstorm and list the following:

- The themes they think should be explored by the counsellor; for example, client's knowledge of HIV transmission, health condition of the client, issues of sexuality and violence, etc.
- The kind of information that should be given by the counsellor; for example, how to reduce risks of infection or transmission, healthy nutrition for people who are HIV positive, etc.
- Other tasks that should be carried out by the counsellor; for example, providing emotional support, checking what kind of family or other support the client has, referring the client to other sources of support, etc.
- Instructions for group work should be summarised on a flip chart prepared in advance. Tell participants that they should also look at the flip charts from the previous session: "How we feel before the HIV test"," How we feel when the test result is positive" and "How we feel when the test result is negative". Explain that what happens during counselling should address the feelings and thoughts that were identified by participants in that session. Ask participants to make notes on a flip chart while they brainstorm.
- Divide participants into the three groups and give each group flip charts and markers. Give them up to 30 minutes to brainstorm.
- Ask the groups to come together in plenary and share the result of their work. Each presentation, including comments and questions, should last no more than 20 minutes.

Key messages:

- HIV counselling and testing is a process that involves several different steps. It is not just about having an HIV test. It is the ideal standard to have access to pre- and posttest counselling when considering taking an HIV test, and testing should always be placed in a wider context of prevention.
- Counselling after the HIV test does not always stop when a counsellor gives the test results. Ongoing counselling may be necessary in various situations.
- HIV testing should always be voluntary. It should be our choice whether to take an HIV test or not, based on appropriate information and support that has been given to help us make the best decision for ourselves.
- If we decide not to test, our decision is respected and we should be encouraged and supported to test at a time when we feel ready to do so. We should never be persuaded or forced to test.
- HIV counselling and testing should always be confidential. The counsellor should not discuss any of the information – including the test result – with anybody else (except for professional purposes) unless we give our express permission to do so. The counsellor should also make sure that the recordkeeping is done in such a way that confidentiality is maintained.
- HIV counselling and testing is for any one of us who wants to know our HIV status. It is not just for pregnant women, people who are already sick or those who have multiple sexual partners or who inject drugs.

- One-to-one counselling can be combined with couple, family, group and community counselling.
- Mandatory HIV testing is ineffective for prevention. It is unethical and it can be harmful to individuals who find out that they are HIV positive.

WHY IS IT HELPFUL TO KNOW OUR HIV STATUS?

Aim: To raise awareness about the benefits of knowing our HIV status.

Facilitators Notes

- Prepare four to six small pieces of paper with one benefit of knowing our HIV status written clearly on each. Examples of benefits include:
  - knowing the truth about whether we are HIV positive or negative gives us relief from worrying about the possibilities
  - if we test HIV positive, we can get social support and medical help so that we can lead a healthier and longer life
  - if we test HIV positive, we can take certain steps to improve our quality of life; for example, positive living
  - if we test HIV negative, we can stop worrying and take action to protect ourselves from becoming positive in the future
- knowing if we are HIV positive or negative helps us to plan better for our future and that of our family.

Instructions

- Explain the aim of the activity.
- Ask for a volunteer to pick one of the pieces of paper. Ask them to read out the benefit of knowing our HIV status and say whether they agree or not, and explain why. Explain that they should look at the benefits not only for the person who takes the test, but also for their partner(s), friends and the rest of the community. Note the benefits mentioned on a flip chart.
- Ask for another volunteer and repeat the activity. Keep doing this until all of the pieces of paper have been used.
- Ask participants if they can think of other benefits of knowing our HIV status. Add any benefits that they do not mention to the flip chart. You may wish to list the benefits according to the person who knows their HIV status, their partner(s), their family, etc.
- Facilitate a discussion about what has been learned from the activity, asking questions such as:
  - What are the two to three most important benefits of knowing our HIV status?
  - Are these benefits relevant to most community members? Why?
- End the activity by emphasizing the key messages about the benefits of knowing our HIV status.

WHAT STOPS US WANTING TO KNOW OUR HIV STATUS AND TAKING THE HIV TEST?

Aim: To help identify and understand barriers to HIV counselling and testing.

Time 45 Minutes

Facilitators Notes

- Prepare sheets of A4 paper or card. Fold them in half lengthways so that they stand up (like a tent) when put on the floor.

Instructions

- Explain the aim of the activity.
- Divide participants into pairs.
- Ask participants to think about the reasons that people in their community give for not going for HIV counselling and testing. Imagine how those people would finish the sentence: "I won't go for HIV counselling and testing because …"
- Give each pair of participants about four to five sheets of A4 paper or card folded in half lengthways and ask them to write one reason on each folded sheet of paper lengthways on one of the outward-facing panels.
- Ask participants to stand all the folded sheets of paper, ridge upwards, in a line along the floor. Explain to participants that the reasons are like "barriers" or "road blocks" because they slow down our journey towards HIV counselling and testing but do not stop it.
- Ask participants which reasons for not going for HIV counselling and testing seem to be the most common.
- Take each of the most common reasons or barriers one at a time. Discuss what could be said in response to each to overcome the barrier. Responses should be written on flip charts either by facilitators or participants.
- End the activity by emphasizing the key messages about what stops people from seeking HIV counselling and testing services.

Facilitators notes

- Encourage participants to think broadly about the different types of personal, social and financial reasons why people might not go for HIV counselling and testing.
- Make sure that participants spend as much, if not more, time developing responses as identifying the reasons why people do not go for HIV counselling and testing.

Key Messages:

- It is better to know our HIV status than to worry about the possibilities. Once we have the facts, we can do something about our situation – whether we are HIV positive or negative.
- If we find out that we are HIV positive, we will not be alone. The counsellor can assist us to get the care and support we need to help us to live a longer, healthier and happier life. Visible involvement of people living with HIV in the community may also lead to a reduction of stigma and discrimination.
- If we find out that we are HIV negative, we can stop worrying and take action to prevent ourselves becoming HIV positive in the future.

- Whether we are HIV positive or negative, HIV counselling and testing is a chance to plan for our future and that of our family.
- Although some barriers to HIV counselling and testing are very challenging, there are ways to overcome them. Some barriers can be overcome easily. Others take time and effort on our part and on the part of other community members.
- Despite barriers to HIV counselling and testing, there are still many good reasons to know our HIV status.
- Even if there are no barriers to HIV counselling and testing, it is still our personal decision and individual choice whether to test for HIV or not. We should not be persuaded or forced to do it.

UNDERSTANDING THE PRE AND POST TEST COUNSELING SOP

Objective:

To understand the SOP for Pre and Post test counseling.

Process:

SOP presentation and discussion, step by step

Practice Pre and post test counseling – Role plays.

Day 8: Understanding Counselling

HIV TREATMENT/ ADHERENCE COUNSELLING OVERVIEW

Objectives:

- List the four stages of HIV treatment adherence counselling.
- Identify the purpose for each stage of HIV treatment adherence counselling.

Time: 15 minutes

Activity 1: Folding Paper Instructions

- I need five volunteers to come up to the front of the room. Each of you is going to be blindfolded. You may also just have them close their eyes. You may not peek and also, you may not speak.
- I am going to hand each of you a piece of paper. I will give you instructions for what to do with the piece of paper. Follow those instructions exactly, but remember, no peeking or talking!
  - Fold the paper in half.
  - Tear off the bottom right hand corner of the paper.
  - Fold the paper in half again.
  - Tear off the bottom left hand corner of the paper.
- • Now all of you can take off your blindfolds (or open your eyes). Please show your papers to everyone.

***Processing Questions**:*

- It is highly unlikely that all four pieces of paper will have been torn in the same way.
  - What happened? Were all of you watching? Did each of the volunteers follow the instructions?
  - Ask the participants: Were my instructions clear?
  - Ask the volunteers: Did each of you understand the instructions? Could you hear me and did you understand what I was saying?
  - If everyone followed the instructions and all the volunteers understood me, how can the papers look so different?
  - What can this activity show us?
  - Why did we do this activity? How does it relate to adherence counselling and HIV treatment?

Key Points:

- People have different perceptions, and the same simple instructions can mean different things to different people.
- It makes no difference how smart or literate someone is.
- What we have meant and what another person may have understood are often very different.
- Everyone followed the instructions correctly, but the results were very different
- Many think that by giving instructions to a client on how to take ARVs, the client will adhere. However, there is a lot more to adherence than giving instructions. This is what adherence counselling is about

Presentation

It is helpful to think about HIV treatment adherence counselling as having a number of stages. These stages are helpful for the whole Health Care Team, but are most important for the client to go through. These stages are key to understanding adherence as an ongoing process.

The four stages of ARV adherence counselling are:

1. Pre-HIV Treatment Initiation
2. HIV Treatment Initiation
3. HIV Treatment Maintenance
4. Re-Motivation or Treatment Change

In this session, we will be looking at the whole HIV treatment adherence counselling model and briefly discussing each stage of adherence counselling. In later sessions, we will discuss each stage of adherence counselling in detail, and practise role plays to understand and develop the skills needed.

Refer to the HIV Treatment Adherence Counselling Model.

- HIV Treatment Adherence Counselling begins after a client already knows his/her HIV-positive status.
- Remember that HIV treatment is treatment for life, at least until a cure is found. Therefore, this adherence model is for the duration of treatment, for the rest of the client's life.

- While this model clearly outlines separate counselling sessions in each stage, remember that this may not always work. Sometimes a number of sessions may be combined in order to best meet the needs of the client.
- A high level of adherence can best be met if this four-stage model of adherence counselling is followed. It allows the client to take an active role in the treatment process and gives him/her the time to fully understand and develop a successful adherence plan.

Stage 1: Pre-HIV Treatment Initiation

- In stage 1, the client already knows his/her HIV-positive status. He/she has been tested for HIV.
- In this stage, the client begins to think and talk about the possibility of beginning anti-retroviral treatment.
- This discussion happens between the client and the counsellor, as well as involving other members of the Health Care Team, such as doctors and nurses. The client also should be encouraged to discuss starting treatment with his/her friends and family.
- The counsellor must explore the client's thoughts and feelings about HIV treatment and what this would involve.
- • The purpose of the first stage:
  - Educate client on HIV/AIDS and introduction to HIV treatment o Determine client's HIV treatment readiness: does he/she meet the MoHSS criteria?
  - Establish full commitment to treatment o Prepare client for what treatment involves
  - Select and involve treatment supporter
  - Develop a personalised treatment and adherence plan

Stage 2: HIV Treatment Initiation

- Once the client meets the MoHSS criteria and is informed and committed to treatment, he/she can begin HIV treatment.
- At this stage, the client may experience a wide range of feelings and thoughts. The client is required to make lifestyle adjustments and faces issues that might make adherence difficult. He/she should be able to explore and address all of these issues with his/her Health Care Team.
- The **purpose** of the second stage is to:
  - Tailor the HIV treatment regimen to the client
  - Discuss side effects
  - Develop a personalised adherence plan
  - Problem solve about factors that may lower adherence.

Stage 3: HIV Treatment Maintenance

- Once the client has started on HIV treatment, other issues may come up.
- These could include how to deal with side effects and factors that influence adherence.

- Counselling at this stage should focus on listening to the issues the client is dealing with and helping him/her to identify problems and develop strategies for solving them.
- The **purpose** of the maintenance stage is to:
  - Simplify the HIV treatment regimen
  - Avoid drug interactions and minimise side effects
  - Discuss client's coping mechanisms and reinforce strengths

Stage 4: Re-Motivation or Treatment Change

- Clients may continue with the same regimen but require ongoing remotivation and support from the Health Care Team to maintain high adherence.
- After a period of time, clients may need to change their treatment regimen. This could be for a number of different reasons, such as treatment failure, toxicity (very severe side effects), or non-adherence. If treatment is changed, the client will need to be counselled about his/her new treatment regimen.
- The **purpose** of the fourth stage is to:
  - Re-motivate the client on the same regimen, provide support, and make adjustments to the adherence plan
  - HIV treatment adjustment or change: develop new adherence plan, problem-solve factors that influence adherence

STAGE 1: PRE-HIV TREATMENT INITIATION

Objectives:

- Discuss overview and goals of Pre-HIV Treatment Initiation Counselling.
- Identify topics and issues to be discussed in Pre-HIV Treatment Initiation Counselling.
- Review checklist and model of counselling sessions.
- Develop skills by practicing a Pre-HIV Treatment Initiation Counselling Session.

Recipe for Successful HIV Treatment:

Key Ingredients

- Provide information, education and support prior to HIV treatment initiation.
- Ensure HIV/AIDS and HIV treatment education.
- Encourage the client's belief in the need for treatment and adherence.
- Provide information on difficulties of following treatment regimen and on side effects.
- Establish a foundation for long-term adherence through support and counselling.

Pre-HIV Treatment Initiation Counselling:

- Should begin at least two to four weeks before starting treatment, but can begin much earlier than this. Pre-HIV treatment initiation counselling can begin as soon as a client tests positive for HIV.
- A person with HIV can be monitored for years before needing to start HIV treatment.

- Pre-HIV Treatment Initiation Counselling will require at least two counselling sessions before beginning treatment. It can take 3 – 6 sessions, depending on the commitment and preparedness of the client.
- What do you think are the goals of pre-HIV Treatment Initiation Counselling?
- *Let participants respond. You want to encourage them to focus on the purpose of this stage of adherence counselling, as this will help participants remember what to focus on during counselling.*

Pre-HIV Treatment Counselling has three main goals:

- To assess the client's understanding of HIV treatment and adherence.
- To assess the client's commitment and readiness to take HIV treatment medication.
- To develop a personalised treatment plan, taking into account factors influencing adherence and the client's lifestyle

Key Point:

- Starting ART is NOT an emergency. The client must be assessed, properly prepared for, and committed to treatment.
- Counselling is NOT just giving information or education.
- The counsellor must explore and listen to the client.
- Do not forget your basic counselling skills, especially reflecting skills.
- Telling the client of the importance of adherence will

Key Points about the Pre-HIV treatment Initiation Counselling Checklist:

- You do not have to follow this precise format. This is not VCT.
- All issues/topics should be discussed with the client, but not necessarily in this particular order.
- Ideally, this checklist should be covered over several counselling sessions. There it too much to explore and discuss in one session.
- Your role is to explore and assess the client's understanding and concerns, NOT simply to give information.
- Do not forget your basic counselling skillsnot necessarily make him/her adhere!

PERSONAL EXPERIENCES WITH MEDICATION

Objectives:

- Discuss personal experiences of having been on medicine or currently being on medication.
- Identify the difficulties in adhering to any medication regime.

Time: 30 minutes

Process:

- We are going to be talking a lot about taking medication. In order to understand a bit of what it might be like for our clients, I would like to begin by having each of you reflect on any experiences you have had taking medication.
- We are going to do this by discussing it briefly in small groups.

- *It might be helpful to list the items below on a flipchart so that small groups can refer to them during their discussion:*
- Discuss the following:
  - Think about and discuss times in your life when you have been on medication. This could have been medication for a chronic illness like diabetes, for short-term treatments like antibiotics, or medicine for more severe illnesses.
  - For how long did you take medication?
  - Did you experience any side effects?
  - Was it important to take the medication following specific instructions?
  - How were you about taking your medication? Did you remember every dose?
- You will have 15-20 minutes to discuss these issues in your groups.

Processing Questions:

- Focus on personal experiences; the purpose of the exercise is to develop empathy.
- In your discussions, what did you find out about taking medication?
- What was easy/hard about taking medication? What specifically made it harder/easier?
- How were you at following specific instructions related to your medication?
- Did your group like taking medicine regularly?
- Why did we do this small group activity

ADHERENCE FACTORS

Objectives:

- Generate ideas about adherence factors.
- Identify factors that influence HIV treatment adherence.
- Discuss ways to encourage and support adherence.

Why is adherence to HIV treatment so important? What is the relationship between adherence and resistance?

These are very important issues. This is a way to review some of the previous material.

- We are going to break into groups of 4 – 5 people. In your groups, discuss what influences adherence or the factors that affect adherence to HIV treatment. Keep in mind that these factors that influence adherence can be both positive and negative; they could increase or decrease adherence. Be very specific when listing the factors that influence adherence, and include how they influence adherence.
- In your groups, you should come up with at least 20 different adherence factors, but see if you can come up with more than that.
- Once you have come up with as many ideas as possible, it would be helpful to divide these factors into categories. Discuss what influences HIV treatment adherence in the following categories:
  - Factors related to the client
  - Factors related to the provider or health centre (hospital or clinic)
  - Factors related to the treatment regimen

- You will have 20 - 25 minutes to discuss this. Please list all the factors on flipchart paper.
- *When you bring the large group back together, you could have each group report on one of the factors, and the other groups can add any new ideas they had in their groups.*
- *Stress the fact that **adherence changes over time**. A client who may start out adhering to treatment may have periods of time where adherence is more challenging. Discuss this when sharing factors relating to adherence.*

Factors That Influence HIV Treatment Adherence

Client Factors:

- Client commitment: people who are committed to and actively involved in their treatment are more likely to achieve high levels of adherence.
  - Adherence rates vary not just between individuals but within the same individual over time.
  - An individual may achieve high levels of adherence sometimes and at others times will exhibit low adherence.
- Cultural and socio-economic issues:
  - Religious beliefs about illness and medication may influence motivation and adherence.
  - Medication use may disclose HIV status.
  - Stigma may inhibit disclosure and result in low levels of support or adherence.
  - Poverty may prevent people from being able to eat nutritious food.
  - Drug and alcohol use may impair judgment and the ability to take medication on time.
- • Family responsibilities may require adults to place the health care needs of others before their own.
- Psychological factors:
  - Mental health problems, such as depression, can result in low adherence. Also, an individual's perception of his/her ability or inability to follow a medication regimen and whether one believes he/she can succeed or not can impact treatment adherence.
- 4. Health beliefs: Beliefs about health and illness, especially the necessity of medication to treat illness, can significantly impact treatment adherence.
  - Expectations of symptom relief can have an effect on adherence. If these expectations are unrealistic, there may be poor adherence.
  - Side effects can make adherence very difficult. A client's concern about potential harm from HIV treatment can be increased by his/her experience of side effects. Missed doses may be a client's attempt to reduce the side effects.
  - People on HIV treatment frequently say low adherence is due to their experiences of side effects.

Provider Factors:

- Offer support to all: You cannot predict future adherence based on client characteristics. Adherence is not linked to social class, education, gender, race or age.
- Client education: Clients who understand how HIV treatment works and the importance of adherence seem to have better adherence rates.
  - Very often, clients misunderstand health care providers' instructions.
  - Instructions should be given verbally and in writing. Check that the information that has been given is understood.
- Medication alerts: People often forget to take their medication. Reminders to take medication are helpful, such as telephone, SMS, pill diaries, charts, medication containers and reminders from family and friends.
- Multi-disciplinary approach: Clients spend very little time with the doctor. Therefore, other health care professionals, such as nurses, pharmacists, and counsellors, should be involved in supporting client adherence.
- Provision of on-going support: Adherence is a process, not a single event. Support should be included in follow-up, as studies show that adherence decreases over time.
- Partnership of Health Care Team with client: Actively involve the client in adherence and his/her whole treatment, and provide support and respect from the Health Care Team.
- Attitude of health care providers: A friendly, supportive and non-judgmental attitude can help to develop a trusting relationship with the client. This relationship can influence adherence positively.

Regimen Factors:

- Dosing requirements: The difficulty of the requirements for taking the medication, i.e. how many times a day, and food or water requirements.
- Number of tablets: Combining drugs into one pill has been shown to increase adherence.
- Side effects: This is the reason why clients report poor adherence.

Key Point:

Adherence is dynamic. It changes in each client over time.

Activity: Small group Discussion

- **Case Scenario:** Jacob is a 35-year-old unmarried man with HIV. He is a truck driver, and frequently is away from home for at least three days at a time, going to different cities. He shared the route with another driver, his cousin, who takes turns driving with him. He is occasionally sexually active with women when he is on the road. When he is in his hometown, he stays with his sister. When he is on the road, he sleeps in the truck. He believes that taking ART will help him feel better, but is not sure he will be able to remember to take the medicines on time.

- We are going to break into groups of 3 or 4. In your groups, you are going to discuss the following scenario:
- In your groups, discuss the following:

- List some of the challenges that Jacob may face in achieving 100% adherence.
- What are some ways that he may be able to overcome these challenges?
- What are some of the positive factors that may contribute to adherence for Jacob?

- *After the groups have discussed Jacob's case, discuss their findings in the large group*

Activity : Large Group Discussion

- How do you think adherence can be encouraged and supported? What can you do as a community counsellor to improve adherence?
- Lead a discussion about how adherence could be improved. Include what participants think they can do as community counsellors.

NIMART: INTRODUCTION TO ART AND ADHERENCE COUNSELLING MODULE

Objective of the module:

In this module, we will cover the following topics:

- We will discuss on ART and adherence counselling before beginning treatment through maintenance and support for on-going treatment
- We will focus on adherence and the factors related to adherence. We will discuss the role of the Nurse in an inter-disciplinary team designed to support the client during treatment.

HIV TREATMENT ADHERENCE COUNSELLING OVERVIEW

Objectives:

- List the stages of HIV treatment and adherence counselling.
- Identify the purpose for each stage of HIV treatment adherence counselling
- Preparation Process before taking ARV

Objective:

- To provide participants with information on preparing for and the readiness to begin for ARV.

Process:

- Display the scenario on the screen.
- Ask participants to think if they were in this situation what would be their decision?
- Divide the participants into groups based on the answers they give.
- Each group should brainstorm their reasons for making that decision and what their future plans are and then present them to the large group.
- Trainer summarizes
  - The factors that have an impact on decisions to take or not to take ARV
  - The points that care providers should be aware of
  - The topics that need to be discussed with clients to preparing their readiness to take ARV.

- Trainer summarizes the principle of providing information.

Materials

Scenario

- You were diagnosed with HIV 6 years ago.
- At present you are healthy. You have had diarrhea from time to time.
- Your CD4 count last month was 375. Counselor at the clinic has given you information about ART.
- But you are worried about Side effect, you have seen some of your friends die after stating ART and some have problems. Also it will be difficult for you to attend the clinic once a month as you are working. You are scared you will not be able to talk ART regularly and fear about resistance.
- You are thinking: **"Should I take ARV or not?"**

Discussion: Slide 5

- PLHAs may have different reasons behind their decisions on whether to start ARV or to wait. These decisions reflect peoples' past experiences, their personal beliefs and information that they have been given. As ARV is lifelong treatment, many people may choose other alternatives to care for their health such as OI prophylaxis or alternative therapies. As a health care provider we must be aware of the following:
  - providing unbiased information
  - exploring PLHA readiness (taking into account their lifestyle, family situation, career and economic situation and issues of disclosure)
  - self determination- what is their decision?
- Ultimately the decision is theirs to make with the support of the clinic.

HIV TREATMENT ADHERENCE COUNSELLING

Presentation slides 6 to slide 11

- It is helpful to think about HIV treatment adherence counselling as having a number of stages. These stages are helpful for the whole Health Care Team, but are most important for the client to go through. These stages are important to understanding adherence as an ongoing process.
- The four stages of ARV adherence counselling are:
  - 1. Pre-HIV Treatment Initiation
  - 2. HIV Treatment Initiation
  - 3. HIV Treatment Maintenance
  - 4. Re-Motivation or Treatment Change

In this session, we will be looking at the whole HIV treatment adherence counselling model and briefly discussing each stage of ART initiation and Adherence counselling.

- HIV Treatment Adherence Counselling begins after a client already knows his/her HIV-positive status.

- Remember that HIV treatment is treatment for life, at least until a cure is found. Therefore, this adherence model is for the duration of treatment, for the rest of the client's life.
- While this model clearly outlines separate counselling sessions in each stage, remember that this may not always work. Sometimes a number of sessions may be combined in order to best meet the needs of the client.
- A high level of adherence can best be met if this four-stage model of adherence counselling is followed. It allows the client to take an active role in the treatment process and gives him/her the time to fully understand and develop a successful adherence plan.

Stage 1: Pre-HIV Treatment Initiation

- In stage 1, the client already knows his/her HIV-positive status.S/he has been tested for HIV.
- In this stage, the client begins to think and talk about the possibility of beginning anti-retroviral treatment.
- This discussion happens between the client and the counsellors, as well as involving other members of the Health Care Team, such as doctors and nurses. The client also should be encouraged to discuss starting treatment with his/her friends and family.
- The counsellors must explore the client's thoughts and feelings about HIV treatment and what this would involve.
- The **purpose** of the first stage:
  - Educate client on HIV/AIDS and introduction to HIV treatment
  - Determine client's HIV treatment readiness: does he/she meet the criteria?
  - Establish full commitment to treatment
  - Prepare client for what treatment involves
  - Select and involve treatment supporter
  - Develop a personalized treatment and adherence plan

Stage 2: HIV Treatment Initiation

- • Once the client meets the criteria and is informed and committed to treatment, s/he can begin HIV treatment.
- • At this stage, the client may experience a wide range of feelings and thoughts. The client is required to make lifestyle adjustments and faces issues that might make adherence difficult. S/he should be able to explore and address all of these issues with his/her Health Care Team.
- • The **purpose** of the second stage is to:
  - Tailor the HIV treatment regimen to the client
  - Discuss side effects
  - Develop a personalised adherence plan
  - Problem solve about factors that may lower adherence.

Stage 3: HIV Treatment Maintenance

- Once the client has started on HIV treatment, other issues may come up. These could include how to deal with side effects and factors that influence adherence.

- • Counselling at this stage should focus on listening to the issues the client is dealing with and helping him/her to identify problems and develop strategies for solving them.
- • The **purpose** of the maintenance stage is to:
  - Simplify the HIV treatment regimen – if taking with TB medication take at different time, not all tabs at ones,
  - Avoid drug interactions and minimise side effects
  - Discuss client's coping mechanisms and reinforce strengths

Stage 4: Re-Motivation or Treatment Change

- Clients may continue with the same regimen but require ongoing re-motivation and support from the Health Care Team to maintain high adherence.
- After a period of time, clients may need to change their treatment regimen. This could be for a number of different reasons, such as treatment failure, toxicity (very severe side effects), or non-adherence. If treatment is changed, the client will need to be counselled about his/her new treatment regimen.
- The **purpose** of the fourth stage is to:
  - Re-motivate the client on the same regimen, provide support, and make adjustments to the adherence plan
  - HIV treatment adjustment or change: develop new adherence plan, problem-solve factors that influence adherence

PERSONAL EXPERIENCES WITH MEDICATION

Objectives:

- Discuss personal experiences of having been on medicine or currently being on medication.
- Identify the difficulties in adhering to any medication regime.

Activity 1: Small Group Discussion

- In order to understand a bit of what it might be like for our clients, I would like to begin by having each of you reflect on any experiences you have had taking medication.
- We are going to do this by discussing it briefly in small groups.
- Discuss the following:
  - Think about and discuss times in your life when you have been on medication. This could have been medication for a chronic illness like diabetes, for short-term treatments like antibiotics, or medicine for more severe illnesses.
  - For how long did you take medication?
  - Did you experience any side effects?
  - Was it important to take the medication following specific instructions?
  - How were you about taking your medication? Did you remember every dose?
- You will have 15-20 minutes to discuss these issues in your groups.

Processing Questions:

Focus on personal experiences; the purpose of the exercise is to develop empathy.

- In your discussions, what did you find out about taking medication?
- What was easy/hard about taking medication? What specifically made it harder/easier?
- How were you at following specific instructions related to your medication?
- Did your group like taking medicine regularly?
- Why did we do this small group activity?

ADHERENCE AND RESISTANCE

Objectives:

- Explain the difference between adherence and compliance.
- Understand how this difference may influence one's attitude and approach towards working with clients on HIV treatment.
- Define adherence and resistance related to HIV treatment.
- Discuss adherence strategies

Activity : Large Group Discussion

- Does anyone know what compliance means? Compliance: (Presentation slide 15)
  - The extent to which the client's behaviour, i.e. for taking medications, following diets, or other lifestyle changes, coincides with medical or health advice.
  - We have already defined adherence in a previous session. Can anyone tell me what adherence means?
- Adherence:
  - The degree to which a client follows a treatment regimen, which has been designed by a consultative partnership between the client and the healthcare worker/counsellor. It encourages discussion about the various factors in the client's life that will influence the ability to exactly follow the treatment.
  - The engaged and accurate participation of a client in a plan of care.We need to look at these definitions again and talk about the similarities and differences between compliance and adherence.
- Brainstorm a list of similarities and differences. The lists should include the following:
  - Similarities:
    - Both refer to a behaviour that follows advice or treatment.
    - Both involve a health care worker.
  - Differences:
    - Compliance implies a value judgment; it assumes the health care worker's guidelines are always right, and the client's behaviour is measured against this standard. This makes is easier to blame the client for any failures in the treatment.
    - In compliance, the health care worker is seen as the expert and the client as ignorant.
    - Adherence implies a partnership between the client and the health care worker or counsellor.

- Adherence allows for a discussion between the client and the health care worker and a collaborative process to develop a plan or strategy.
- Adherence implies the client's understanding, consent and partnership.

- Why do we talk about adherence with HIV treatment? Why is this important?
- Let participants think about this and begin a discussion.

Key Points about Adherence in HIV Treatment:

- It is important to involve the client in his/her treatment. Let the client be his/her own expert.
- The adherence plan should be personalized to the individual client. What works for one person may not work for another.
- Adherence fits better with our basic counselling approach. Remember that the client is the expert on her/himself.
- Clients are crucial as members of the health care team

Activity 2: Presentation/Discussion

What is HIV treatment Adherence?

- HIV treatment adherence means that the medication is taken according to the prescribed instructions:
  - The recommended dose
  - At the recommended time
  - In the recommended way
- Studies have shown that adherence with HIV treatment means taking at least 19 out of 20 doses. An adherence rate of more than 95% must be sustained in order for the replication of HIV to be controlled. For HIV treatment adherence, this means that a client cannot miss more than one dose a week.
- Most people get better with treatment. For many, the treatment works for many years. For some, the treatment does not work or only works for a short time.
- What is non-adherence?
- Non-adherence means that any one of the above three criteria is not met. If the client for any reason is NOT:
  - Taking the recommended dose, **OR**
  - Taking it at the recommended time, **OR**
  - Taking it in the recommended way
- Some examples of **non-adherence**:
  - Missed doses, i.e. due to holidays, travel or forgetfulness
  - Delayed doses, i.e. not taking the dose on time
  - Failing to follow guidelines, i.e. because of social pressures, misinformation
  - Drug holidays, i.e. structured treatment interruptions, temporary dislike of taking tablets

Why does the treatment not work for some people?

- The tablets do not work if you do not take them.
- Some of the medicines do not stay in the body for a long time. You have to take these every 12 hours to maintain a consistent level of the drug in the body.

- If you do not take the tablets every 12 hours each day, the virus changes (or mutates) and the medicines do not work anymore.
- What is **resistance**?
  - A reduction in HIV's sensitivity to a particular drug.
- This means that a particular drug or combination of drugs is unable to block replication of HIV, so the virus can continue to grow even in the presence of the drug.
- Some strains of HIV naturally develop resistance to anti-retroviral drugs because of the random mutations that happen regularly as the virus replicates.
- Resistance can make some drugs less effective or even completely ineffective.

How does resistance develop?

- Through lack of adherence or low adherence. For instance, if someone taking ARVs misses many doses, the virus is likely to develop a resistance to some or all of those drugs.
- The more often the client misses doses or takes doses late, the more likely the virus will develop resistance.
- Resistant viruses can also be transmitted through unprotected sex. This is one reason people living with HIV need to avoid re-infection.

Why are we talking about resistance?

- Resistance is a major reason why HIV treatment fails.
- If a client develops resistance to first-line regimens, then there are fewer treatment options. He/she will have to take the second-line regimens.
- Understanding resistance allows us to understand how important adherence is.

Second-line Regimens:

- The second-line regimens are much harder to adhere to because they have more requirements and restrictions about how the medications should be taken.
- Second-line treatments have more severe side effects.
- If a client develops resistance to second-line regimens, there are currently less other treatment options in South Africa. (Optional)

ADHERENCE FACTORS Slide: 18 & 19

Objectives:

- Generate ideas about adherence factors.
- Identify factors that influence HIV treatment adherence.
- Discuss ways to encourage and support adherence

Activity: Small Group Discussion

- In a previous session, we talked about adherence and resistance. Why is adherence to HIV treatment so important? What is the relationship between adherence and resistance?

- We are going to break into groups of 4 – 5 people. In your groups, discuss what influences adherence or the factors that affect adherence to HIV treatment. Keep in mind that these factors that influence adherence can be both positive and negative; they could increase or decrease adherence. Be very specific when listing the factors that influence adherence, and include how they influence adherence.
- In your groups, you should come up with at least 20 different adherence factors, but see if you can come up with more than that.
- Once you have come up with as many ideas as possible, it would be helpful to divide these factors into categories. Discuss what influences HIV treatment adherence in the following categories:
  - Factors related to the client
  - Factors related to the provider or health centre (hospital or clinic)
  - Factors related to the treatment regimen
  - You will have 20 - 25 minutes to discuss this. Please list all the factors on flipchart paper.
- When you bring the large group back together, you could have each group report on one of the factors, and the other groups can add any new ideas they had in their groups.
- Stress the fact that adherence changes over time. A client who may start out adhering to treatment may have periods of time where adherence is more challenging. Discuss this when sharing factors relating to adherence.

FACTORS THAT INFLUENCE HIV TREATMENT ADHERENCE

This is a generic list for reference. The list that the small groups generate should be much more culturally appropriate and specific.

Client Factors:

- Client commitment: people who are committed to and actively involved in their treatment are more likely to achieve high levels of adherence.
- Adherence rates vary not just between individuals but within the same individual over time.
- An individual may achieve high levels of adherence sometimes and at others times will exhibit low adherence.

Cultural and socio-economic issues:

- Religious beliefs about illness and medication may influence motivation and adherence.
- Medication use may disclose HIV status.
- Stigma may inhibit disclosure and result in low levels of support or adherence.
- Poverty may prevent people from being able to eat nutritious food.
- Drug and alcohol use may impair judgment and the ability to take medication on time.
- Family responsibilities may require adults to place the health care needs of others before their own.

Psychological factors:

- Mental health problems, such as depression, can result in low adherence. Also, an individual's perception of his/her ability or inability to follow a medication regimen and whether one believes he/she can succeed or not can impact treatment adherence.

Health beliefs:

- Beliefs about health and illness, especially the necessity of medication to treat illness, can significantly impact treatment adherence.
- Expectations of symptom relief can have an effect on adherence. If these expectations are unrealistic, there may be poor adherence.
- Side effects can make adherence very difficult. A client's concern about potential harm from HIV treatment can be increased by his/her experience of side effects. Missed doses may be a client's attempt to reduce the side effects.
- People on HIV treatment frequently say low adherence is due to their experiences of side effects.

Provider Factors:

- Offer support to all: You cannot predict future adherence based on client characteristics. Adherence is not linked to social class, education, gender, race or age.
- Client education: Clients who understand how HIV treatment works and the importance of adherence seem to have better adherence rates.
- Very often, clients misunderstand health care providers' instructions.
- Instructions should be given verbally and in writing. Check that the information that has been given is understood.
- Medication alerts: People often forget to take their medication. Reminders to take medication are helpful, such as telephone, SMS, pill diaries, charts, medication containers and reminders from family and friends.
- Multi-disciplinary approach: Clients spend very little time with the doctor.
- Therefore, other health care professionals, such as nurses, pharmacists, and Nurses, should be involved in supporting client adherence.
- Provision of on-going support: Adherence is a process, not a single event.
- Support should be included in follow-up, as studies show that adherence decreases over time.
- Partnership of Health Care Team with client: Actively involve the client in adherence and his/her whole treatment, and provide support and respect from the Health Care Team.
- Attitude of health care providers: A friendly, supportive and non-judgemental attitude can help to develop a trusting relationship with the client. This relationship can influence adherence positively.

Regimen Factors:

- Dosing requirements: The difficulty of the requirements for taking the medication, i.e. how many times a day, and food or water requirements.

- Number of tablets: Combining drugs into one pill has been shown to increase adherence.
- Side effects: This is the reason why clients report poor adherence.

Key Point: Adherence is dynamic. It changes in each client over time.

ADHERENCE STRATEGIES

Brain storm about Adherence Strategies:

- Disclosure
- Support groups
- Memory aids (alarm, TV series etc)

Key Point: Disclosure is a process; it does not happen all at once. Research shows that those who take HIV treatment (ART) in secret have lower levels of adherence.

Tips on Disclosure:

- Do not impose your views, beliefs or experiences concerning disclosure.
- Disclosure or not is the client's decision. Respect his/her decision.
- Who the client discloses to is also his/her choice. As the Nurse, you can encourage the client to disclose to people he/she lives with, but you cannot decide to whom the client should disclose.
- Try to be available to the client after he/she has disclosed. Talk about how it went.

TOOLS AND SYSTEMS FOR ADHERENCE SUSTAINABILITY

Objectives:

- Think creatively about ways to help and support adherence with clients.
- Develop examples of tools that can be used for adherence sustainability in local communities

Activity

Introduction

- We have talked some about adherence and some of the factors that influence adherence, but we have not talked about tools that could be used to help people remember to take their medicine.
- What sorts of things can be used to help clients remember to take their medicines?
- Let participants brainstorm tools that can be used. Below is a list of ideas that could be included.
- Examples of Tools to Sustain Adherence:
  - Pill/tablet boxes: do not assume the clients know how to use pill boxes. Show them how to fill their pill boxes, count their tablets and monitor their adherence.
  - Timers/alarm clocks
  - Cell phone alarms
  - Pictures
  - Calendar

- Stickers
- TV series

INTER-DISCIPLINARY TEAM AND THE ROLE OF THE NURSE

Objectives:

- Describe the interdisciplinary team recommended for HIV treatment adherence.
- Identify roles for team members in HIV treatment adherence.
- Identify Nurses' roles in the Health Care Team for HIV treatment adherence.

Activity: Warm-Up Activity: Team Building

Round 1:

- Everyone, please gather here. Select an area that has plenty of room.
- Please face me. Now I want you to take hold of two people's hands: they could be in front of or behind you. You cannot hold the hands of the people standing next to you.
- Select one participant or ask for a volunteer before starting this activity; the volunteer will be part of the tangled circle. Now, [volunteer's name] will untangle you. You may not speak or move without being instructed. You may only follow [volunteer's name] instructions.
- Give the volunteer some time to try and untangle the group. You many need to remind the participants that they cannot move on their own or speak.

Processing Question:

- What was that like? Make sure to ask both the volunteer leader/problem solver as well as the whole group.

Round 2:

- We are going to do the activity again, but this time, the rules are going to change. We are not going to have one person trying to untangle you; you can all take part in the untangling. You may also talk to one another.
- Processing Questions:
  - What was that like? How was it different from the first time?
  - What is easier or more complicated?
  - What was the process used in actually untangling the group? OR How did you end up getting untangled?
  - Why did we do this exercise? What do you think the purpose could be?

Activity : Large Group Discussion

- Adherence is a team commitment. But who is the team?
- Let the participants offer their answers.
- **Key Point:** Adherence should involve the **entire community**, not just health care professionals
- **Larger Community**: You can extend this to the whole country of South Africa. It could include national government programs, NGOs, etc. Can you think of examples of what could be included as adherence support in the larger community? *Let participants brainstorm a list*.

- **Local Community**: This could include the private sector, NGOs, local organisations and local government programs. This is the community surrounding where the client lives. Can you think of examples of what this could include? *Let participants brainstorm a list.*
- **Health Care Team**: First, I want you to take a look at this model. Who is at the centre of the Health Care Team? Why is this? *Remind participants of adherence vs. compliance. The client is the expert on him/herself and therefore is the most important person in HIV treatment adherence.*
- Members of the **Health Care Team** include:
  - Client
  - Doctors
  - Pharmacists
  - Nurses, including enrolled nurses
  - Counsellors
  - Social workers
  - Treatment supporter
  - Community volunteers, such as CCG/CHAP/Peer, etc.

Activity: Small Group Discussion

- Roles of the HIV treatment Adherence Health Care Team
- We are going to break into groups of 4 or 5. In your groups, discuss the roles and tasks of different members of this large adherence team that we have been talking about.
- First, make a list of all the tasks you think are part of the Inter-Disciplinary Health Care Team's responsibility. Write each of the tasks on a Post-It.
- Then divide these tasks among the following Health Care Team members:
  - Doctor
  - Pharmacist
  - Nurse
  - Counsellors
  - Treatment Supporter
  - Client
- You can write the different team members on flipchart paper and then stick the Post-Its with a task or role with the correct Health Care Team member.
- You will have 20 minutes to discuss this in your small groups.
- Remember to circulate among the groups so that you can help them during their discussions as needed
- Bring the large group together and have each group present a Health Care Team member's responsibilities. Encourage discussion and allow groups to change their minds about who should be responsible for different tasks.
- Once you have discussed all the Health Care Team members, focus on the list of the roles and responsibilities of Nurses.

Key Points:

- Point out that doctors, pharmacists and nurses are the ones who provide medical information, such as information on medication, side effects, treatment regimens, etc.
- The counsellors primary role is to **support the client emotionally**. There is no one else in the health care team whose role is to support the client. The counsellors can do this by: listening to the client's experiences and supporting the client in healthy living and adherence, assessing the client's understanding, and exploring issues and potential solutions for adherence.