FEDERAL MINISTRY OF HEALTH NIGERIA

HIV TESTING SERVICES (HTS)

TRAINEE'S MANUAL

MAY, 2017

National AIDS and STIs Control Programme (NASCP)
Federal Ministry of Health, Nigeria.

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FOREWORD

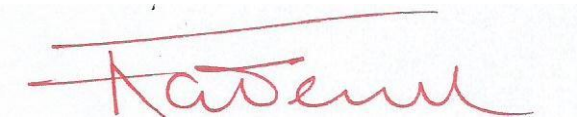
The HIV/AIDS pandemic has been one of the greatest public health challenges in the world affecting development and social progress in affected countries especially in Nigeria. Nigeria contributes significantly to the global HIV/AIDS burden with an estimated population of 3.4 million people living with HIV and AIDS.

HIV Testing Services (HTS) remains the entry point to the HIV continuum of care and therefore a cornerstone to attaining the UNAIDS 90-90-90 goals. HIV Testing Services has become increasingly available in Nigeria with over 8,308 health facilities providing HTS. The Federal Ministry of Health (FMOH) in its commitment to the prevention and control of HIV/ AIDS aims to increase access and uptake of HIV Testing services for those who are undiagnosed and persons at high risk of HIV infection. With the expanded delivery of HTS, capacity building of service providers is key to closing the gaps of inadequate man power and provision of poor quality HTS.

The National HTS training manual has been reviewed to include new global initiatives with the intention to improve uptake of HTS and linkage to appropriate prevention, treatment and care services. New concepts introduced in this manual include Partner Notification Services (PNS) and HIV self-testing (HIVST), which have been shown to reach more people with HTS and linkage services.

The technical language used and the flow in the arrangement of the modules in this manual have been simplified to ensure that lay counsellors and other health professionals (Doctors, Nurses, Pharmacists, Laboratory Scientists and Social worker) can easily benefit from the manual and be empowered to provide quality HIV Testing Services.

I therefore recommend the National HTS training manual for use by all HTS Trainers and Service providers for effective training and service provision of HTS.



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On behalf of the Federal Ministry of Health, I wish to acknowledge the contributions of all stakeholders who participated in the review of the HIV Testing Services (HTS) Trainees Manual. We acknowledge the technical contributions of the National Task Team on HTS, the National HTS Trainers, the National Agency for the Control of AIDS (NACA), Civil Society for HIV/AIDS in Nigeria (CiSHAN), Network of People Living with HIV and AIDS in Nigeria (NEPWHAN).

Our sincere appreciation also goes to the development partners: World Health Organization (WHO), US Centers for Disease Control and Prevention (CDC), US Agency for International Development (USAID), US Department of Defense (DOD), and the Implementing partners: FHI360, Institute for Human Virology, Nigeria (IHVN), AIDS Healthcare Foundation (AHF), Heartland Alliance International (HAI), the Centre for Integrated Health Programs (CIHP), Friends for Global Health Initiative in Nigeria (FGHiN), APIN Public Health Initiatives, Society for Family Health(SFH), Clinton Health Access Initiative (CHAI), and Jhpiego/MCSP.

Finally, we commend the staff of the National AIDS and STI Control program (NASCP) whose efforts lead to the successful review of this document.

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EXECUTIVE SUMMARY

HIV Testing Services (HTS) refers to the full range of services that should be provided together with HIV testing – counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment and care services and other clinical and support services; and coordination with laboratory services to support quality assurance and the delivery of correct results.

The effort of the government is focused towards achieving the UNAIDS 90-90-90 goals by 2020, which aims to ensure 90% of PLHIV know their status, 90% of those who know their status are receiving treatment, and 90% of those on treatment are virally suppressed. In order to break the chain of HIV transmission and reduce the impact of HIV in our country, substantial efforts must be made reach people who are not currently accessing testing, especially women, men, children, partners of people living with HIV, and key populations. Furthermore, we must make every effort to successfully link people living with HIV to care and treatment services, and to support PLHIV to adhere to their treatment regimens and achieve viral suppression. This can be achieved through the provision of quality HTS training to service providers who will be providing these services to in the community.

The Federal Ministry of Health in collaboration with development partners developed the HCT training manuals (Trainee's, Trainers) in 2003. These were first reviewed in 2006, 2011 and again in 2017. They are useful resource materials that ensure standards and uniformity in the provision of high quality trainings to service providers on HTS across the country. As the Federal Ministry of Health is scaling up HTS and other HIV services, the importance and the urgent need of these documents cannot be overemphasized.

The document is divided into six modules: (i) Current Trends and Basic Facts on HIV and AIDS (ii) General HIV Counseling Technique (iii) Care and Support (iv) Counseling in other Situations (v) Cross-Cutting Issues in HTS (vi) HIV Diagnostics

The reviewed trainee's manual will be used in conjunction with the National Guidelines on HTS for the training of counselor-testers to ensure effective and efficient service delivery at HTS centers. It has been designed to suit our socio-cultural circumstances and also provides national standards that must be adhered to, both at trainings and in the provision of high quality HTS services in the country.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
APIN	APIN Public Health Initiatives
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CBCs	Community Based Counsellors
CBO	Community Based Organisation
CDC	Centres for Disease Control
CIHP	Center for Integrated Health Programme
CiSHAN	Civil Society on HIV/AIDS in Nigeria
CRH	Centre for the Rights to Health
CSP	Community Support Project
CT	Counselling and Testing
CHCT	Couples HIV Counselling and Testing
DOD	United States Department of Defense
DFID	Department For International Development (UK)
DNA	Deoxyribonucleic Acid
ELISA	Enzyme-linked Immunosorbent Assay
ENHANSE	Enabling HIV/AIDS and Social Sector Environment
FBOs	Faith Based Organizations
FMOH	Federal Ministry of Health
FP	Family Planning
GHAIN	Global HIV/AIDS Initiative Nigeria
HAART	Highly Active Antiretroviral Therapy
HAD	HIV/AIDS Division
HCT	HIV Counselling and Testing
HTS	HIV Testing Services
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
IHVN	Institute of Human Virology, Nigeria
ILO	International Labour Organisation
LACA	Local Government Action Committee on AIDS
KAPs	Key Affected Populations
MARPs	Most at Risk Populations
MCH	Maternal and Child Health
MSM	Men having Sex with Men
NBTS	National Blood Transfusion Service
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drugs Administration and Control
NASCP	National AIDS/STIs Control Programme
NEPWHAN	Network of People Living with HIV and AIDS in Nigeria
NGOs	Non-Governmental Organisations

NHMIS	National Health Management Information System
NNRIMS	Nigeria National Response Information Management System
NMOD	Nigerian Ministry Of Defence
NPHRL	National Public Health Reference Laboratory
NTT / HCT	National Task Team / HIV Counselling and Testing
Ois	Opportunistic Infections
PATHS	Partnership for Transforming Health Systems
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PHCC	Primary Health Care Coordinator
PICT	Provider Initiated Counselling and Testing
PLHIV	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
SBFAF	Safe Blood for Africa Foundation
SACA	State Action Committee on AIDS
SFH	Society for Family Health
ENR	Expanding Nigeria's Response to HIV and AIDS
SOP	Standard Operation Procedure
STIs	Sexually Transmitted Infections
SWs	Sex Workers
SWAAN	Society For Women Against AIDS In Nigeria
TB	Tuberculosis
TOT	Training of Trainers
TTIs	Transfusion Transmissible Infections
TV	Television
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCR	Video Cassette Recorder
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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MODULE 1. CURRENT TRENDS AND BASIC FACTS ON HIV/AIDS

SESSION 1. HIV/AIDS EPIDEMIC GLOBALLY & IN NIGERIA AND BASIC FACTS ON HIV/AIDS

LEARNING OBJECTIVES

LEARNING OBJECTIVES

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

- Discuss HIV and AIDS globally and in Nigeria.
- Describe the impact of the epidemic
- Identify the factors driving the epidemic
- Definition of HIV/AIDS
- Explain differences between HIV/AIDS
- Explain transmission and non- transmission modes

1.1 Introduction

The HIV and AIDS pandemic remains a major public health problem worldwide, about 68% of all people living with HIV and AIDS live in the sub-Saharan Africa. Globally the epidemic of HIV and AIDS has continued to constitute serious health and socio economic challenges for more than three decades. In the underdeveloped and developing countries like Nigeria, the epidemic has also led to the re-emergence of disease conditions such as pulmonary tuberculosis and other opportunistic infections. It has furthermore reversed many of the health and developmental gains, since the HIV/AIDS scourge is not easily managed within the health systems that are weak or collapsed.

Since the start of the epidemic, over 78 million people have become infected with HIV and over 39 million people have died of AIDS-related illnesses globally. Around 12.9 million people living with HIV have access to antiretroviral therapy.

1.2 Nigerian HIV Situation

The first case of HIV was identified in Nigeria in 1986.Currently Nigeria has the 2nd highest number of people living with HIV in the world after South Africa with about 3.4million people infected. HIV incidence has declined in recent years, but still more than 200,000 new HIV infection occur each year, about 60,000 of these in children. Approximately 750,000 people are currently receiving antiretroviral therapy (ART), and only 12% of children living with HIV are receiving antiretroviral drugs (ARVs). National HIV prevalence is showing signs of stabilizing around 3%, but there is great variation in geography (0.2–15.2%), age group (4.4% among those aged 35 to 39, 2.9% among those aged 15 to 19), sex (5.3% among men aged 35 to 39, 3.5% among women aged 35 to 39), and by population (19.4% among brothel-based female sex workers, 8.6% in non-brothel-based female sex workers, and 22.9% among men who have sex with men, and 3.4% among persons who inject drugs) (IBBSS, 2014) Despite progress in recent years, coverage for prevention of mother-to-child transmission (PMTCT), ART, viral load, and early infant diagnosis (EID) is still low.

From the current trend it is noteworthy that:

- All States of Nigeria have a prevalence of 1% and above; the FCT and 16states have a prevalence of greater than 4%
- Young women in the 25-34 years age bracket, have the highest prevalence rates (5.4% for the 25-29 age group and 5.7% for 30-34 age group)
- The urban prevalence was found to be higher than the rural prevalence in all the States and FCT with exception of eight states in five zones

The burden of HIV and AIDS in Nigeria is still quite high; this calls for dedicated and sustained acceleration of prevention strategies against the transmission of the virus. The need to strengthen Nigerian health systems and other relevant sectors in order to respond to and meet the UNAIDS 90-90-90 target cannot be overemphasised.

1.3 Global impact of HIV

The global impact of the HIV and AIDS pandemic is severe in resource-constrained

settings and results in the following:

Negative impact on countries' economic development
Overwhelmed healthcare systems
Decreased life expectancy
Deteriorating child survival rates
Increased number of orphans

1.4 Effects of HIV and AIDS pandemic on individuals include the following:

Illness and suffering
Shortened life span
Loss of work and income
Death of family members, grief, poverty, and despair
Barriers to healthcare services due to stigma and discrimination
Deteriorating child health and survival
Weakened integrity and support structure of the family unit

1.5 Effects of HIV on families

- Transmission of infection
- Burden of nursing care
- Impoverishment
- Infringement of children's rights (such as education, loss of family assets)
- Parental loss

1.6 Basic Facts
Definition of HIV and AIDS

HIV stands for

H: **H**uman
I: **I**mmunodeficiency
V: **V**irus

HIV breaks down the body's immune system - i.e. the body's defence against infection and disease by infecting specific white blood cells, leading to a weakened immune system.
When the immune system becomes weak or compromised, the body loses its protection against illnesses.

AIDS stands for:

A: **A**cquired, (not inherited)
I: **I**mmune, because it attacks the immune system and increases susceptibility to infection
D: **D**eficiency of certain white blood cells in the immune system
S: **S**yndrome, meaning a group of symptoms or illnesses that result from the HIV infection
At this stage, the immune system is unable to fight the HIV infection and the person may develop serious and deadly diseases, including other infections and some types of cancer,

Differences between HIV, and AIDS

HIV is the virus that causes the infection. The person who is HIV-infected may have no signs of illness but can still infect others. Most people who are HIV-infected will develop AIDS (with no medical intervention) after a period of time, which may be several months to more than 15 years.
AIDS on the other hand, is a group of serious illnesses and opportunistic infections that develop after being infected with HIV for a long period of time. A diagnosis of AIDS is based on specific clinical criteria and laboratory test results.
Having an HIV positive result does not mean that the individual has developed AIDS

1.8 Characteristics of HIV

When HIV infects a cell it combines with that cell's genetic material. It reproduces in white blood cells (CD4+ cells) of the infected person and uses them to produce more viral particles. This destroys the infected person's white blood cells making him or her more susceptible to other illnesses. As HIV disease progresses, the person's immunity becomes more damaged and they become vulnerable to serious infections and other conditions that characterise AIDS.

How Does HIV cause sickness?

- **Immune suppression**
  HIV attacks the white blood cells which protect us from illness. Over time, the body's ability to fight common infections is lost and opportunistic infections occur
- **Direct infection of organ systems**
  HIV directly infects the brain (HIV dementia), the gut (wasting), the heart (cardiomyopathy)

1.9 HIV Disease Progression

The progression can be divided into three phases:

Asymptomatic

Body's immune system is still strong enough to control virus replication

People may not know they are infected

Virus can be transmitted to others

Symptomatic

- Some symptoms and some conditions due to immune suppression occur e.g. candidiasis, recurrent infections (sinusitis, bronchitis)

AIDS

- Severe immune suppression, which leads to wasting and opportunistic infections (e.g. TB, Kaposi's sarcoma, Pneumocystis Pneumonia (PP))

How HIV multiplies itself inside the CD4 cell and spreads through the body

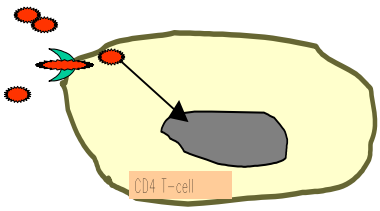
Although HIV infects a variety of cells, its main target is the CD4 cell: a kind of white blood cell that is responsible for informing the immune system that there are invaders (germs) in the body. Once HIV binds to the CD4 cell, it hides HIV material inside the cell: this turns the cell into a sort of HIV factory.

= HIV = HIV that has changed

= gate of entry for HIV in the CD4 cell = part of new HIV

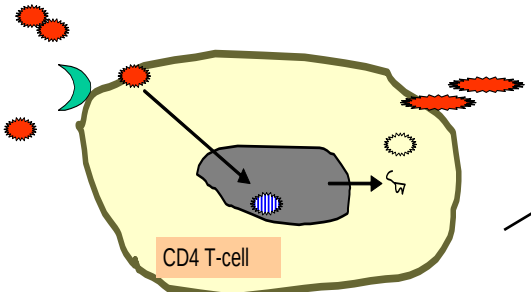
= centre of the CD4 cell

a.



HIV enters the cell and wants to enter the centre of the cell. To do this, it needs to make some important changes in the way it looks, in order not to be 'recognised' by the cell. HIV has a special substance to make these changes in its structure.

b.



HIV is present in the centre of the cell, in a different shape.
Now, the centre of the cell starts to make new parts of HIV instead of making new parts for the body's defence, which are put together to form the new HIV that is released in big numbers from the CD4 cell. This is just like parts of a car put together in a factory before they can be sold.

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

The severity of illness is determined by the amount of virus in the body (increasing viral load) and the degree of immune suppression (decreasing CD4+ counts). The higher the viral load, the sooner immune suppression occurs. People with severe clinical symptoms or immune suppression have AIDS

1.10 Transmission of HIV

Basically there are three major modes of HIV transmission:

Sexual contact

Unprotected sexual intercourse(anal > vaginal > oral) with an HIV infected person
Direct contact with HIV-infected body fluids such as semen and vaginal secretions

Heterosexual transmission is the primary mode of acquiring HIV in Nigeria as in other developing countries.

Infected Blood–and –blood products

Transfusion with HIV–infected blood
Direct open skin contact with HIV–infected blood
Re-use and sharing of unsterilized skin piercing objects and sharps (needles, razor blades, surgical blades etc)
Needle-stick injury

- Injection of drugs with needles or syringes contaminated with HIV

Vertical transmission (MTCT)

- From mothers who are HIV–positive to their infants during pregnancy, labour, delivery, and breastfeeding

1.11 HOW HIV IS NOT TRANSMITTED.

- Coughing or sneezing
- Being bitten by an insect (e.g. mosquitoes)
- Touching or hugging
- Holding a baby
- Kissing
- Going to a public bath/pool
- Using a public toilet
- Shaking hands
- Working in the same office or going to school with a person who is HIV–infected
- Living in the same house
- Using telephones
- Drinking water or preparing or eating food
- Sharing cups, glasses, plates, or other utensils

1.12 OPPORTUNISTIC INFECTIONS ASSOCIATED WITH HIV INFECTION

HIV causes a chronic infection that leads to profound immuno-suppression. The hallmark of this process is the depletion of CD4+ lymphocytes. This predisposes the patient to develop a variety of opportunistic infections and certain neoplasms. CD4+ T-lymphocyte counts are the best-validated predictors of the likelihood of developing an opportunistic infection.

Susceptibility to opportunistic infections increases as HIV induced immunodeficiency becomes more severe. As the CD4+ cell count falls, certain marker infections may occur (e.g. oral candidiasis, diarrhoea and TB).
In managing OIs, it is important to bear in mind the following principles:

- Do no harm
- Do the simple things well (e.g. hydration, pain relief, proper nutrition, etc) in accordance with the relevant guidelines

1.13 COMMONLY OCCURING OPPORTUNISTIC INFECTIONS

CATEGORY	EXAMPLES
Diseases of the skin	Fungal rashes Itchy rashes Skin lumps/swellings Ulcerations/wounds Warts, herpes zoster lesions
Diseases of the respiratory system	TB Pneumonia
Diseases of the mouth, stomach, intestine	Oral thrush Painful oral ulcers Lumps in the mouth Diarrhoea and vomiting TB of the abdomen
Diseases of the brain	Mental disturbance Meningitis (severe headaches/stiff neck)
Diseases of the Nerves	Numbness, pain, tingling sensation, etc.

TUBERCULOSIS

TB is a life-threatening infection that often occurs concurrently in patients with HIV and AIDS and as such requires that every counsellor knows about it. This infection is:

caused by an organism called *Mycobacterium tuberculosis*
more common in patients with HIV infection than in HIV-negative individuals
Sseen at any stage of the HIV disease
Kknown to enhance the progression of HIV
Sseen more commonly in the lungs (pulmonary) but could also be seen in other tissues (extra-pulmonary) and its symptoms include cough, weight loss, fever and night sweats
Aamenable to treatment provided the client adheres to instructions given by the health worker
DOTS is the nationally accepted treatment modality for TB

It is important for all HIV positive people to be screened for TB. It is also important for all people diagnosed with TB to be tested for HIV. This will assist in the correct treatment of both infections that may be fatal if not attended to.

IF A CLIENT HAS COUGH, REMEMBER TO REFER FOR TB SCREENING

SESSION 2: PREVENTION OF HIV TRANSMISSION

LEARNING OBJECTIVES

At the end of this session, Participants should be able to:

- Explain the different prevention measures
- Demonstrate correct use of condoms
- Explain dual protection
- Demonstrate ability to counsel for HIV prevention

PREVENTION OF HIV TRANSMISSION

HIV infection can be prevented in many ways as shown below:

2.1 Prevention of Infected body fluids

- Transfuse only fully screened (HIV Negative) blood and blood products using the appropriate methodology(e.g. ELISA)
- Avoid sharing skin piercing objects or sharps e.g. razor blades, needles, manicure and pedicure instrument, barbing instruments, intravenous drug injections.
- Avoid touching all body fluids with bare hands
- Always use gloves when handling blood and body fluids

2.2 PREVENTION OF MOTHER-TO-CHILD-TRANSMISSION (PMTCT)

HTS plays a vital role in reducing MTCT by helping to identify mothers who are HIV positive for treatment, care and support. The following PMTCT options are available:

- **Anti-retroviral therapy(ART)** is recommended for all HIV positive pregnant women
- ***Planned Caesarean section*:** Caesarean section does not provide additional benefits in reducing risk of transmission in a HIV positive pregnant woman on ART as was earlier thought. However it may be used to reduce risk of transmission in a positive pregnant woman who is not on ART or who has a Viral load of >1000 c/ml .
- ***Informed breastfeeding practice***: total replacement feeding from birth, or exclusive breastfeeding for 6 months, or heat-treating expressed breast milk has been demonstrated to reduce MTCT.

2.3 PREVENTION OF SEXUAL TRANSMISSION

- ***Abstinence:***Abstaining from sex will help people avoid infection with HIV and AIDS. This needs a lot of targeted messages for behavioural change. It re*quires a strong decision to practice* abstinence. Youths require education on relevant life skills that will help them not to indulge in sex before marriage and remain faithful in marriage. The more people you have unprotected penetrative sex with, the more likely you are to meet someone with HIV and become infected yourself. The same applies to your partner. Some forms of sexual intercourse have a higher risk of infection compared to others e.g. anal sex

- ***Faithfulness:***Being faithful in this context refers to an individual having sexual relationship with one partner and *vice versa*. If such faithful partners have tested HIV negative, they do not have to use condoms unless advised by the doctor or a family planning specialist
- ***Condom Use/ Safer Sex:***Safer sex is any sexual practice that prevents exchange of semen, vaginal fluids or blood between partners. Correct and consistent use of condom will prevent HIV transmission from one partner to another during sexual intercourse. Currently there are two types of condoms (male and female condoms) available which when used correctly and consistently, can help protect against many sexually transmitted infections (STIs), including HIV. Even if a woman uses another contraceptive method, such as the pill, the couple still needs to use a condom to protect each other from HIV.

REMEMBER CORRECT AND CONSISTENT USE OF CONDOMS DURING SEXUAL INTERCOURSE IS EFFECTIVE IN REDUCING THE RISK OF HIV TRANSMISSION AS WELL AS OTHER SEXUALLY TRANSMITTED INFECTIONS.

a. Correct use of male condoms

Male condoms made of latex have been proven to be effective against HIV transmission. Research has shown that HIV cannot pass through the latex rubber. Note however that condoms are not 100% effective. Their effectiveness is dependent on correct use by the person using it. Condoms can tear very easily if used incorrectly.
People who are allergic to latex can use condoms made of polyurethane (a type of plastic that is used to make female condoms). Condoms made of other substances such as membranes (e.g. lambskin) must be avoided for HIV prevention.

It is important therefore that all people requesting the male condom must be taught on how to use them correctly.

Instructions on how to use a male condom correctly:

- Use a new condom each time you have sexual intercourse
- Always use a condom from the beginning to the end of the sexual encounter
- Always put the condom on an erect penis, before actual intercourse begins
- Before putting it on, check for the expiry date and make sure it has no leakages. Carefully push it to the side and open it by tearing at the free corner with your hands. Do not bite with teeth or scissors
- In an uncircumcised, the fore skin has to be pulled back gently before putting the condom on
- Make sure that the nipple looking side is on the outside when you place the condom on the penis
- Once placed on the penis, squeeze the nipple to remove the air and open space for the semen. If this is not done correctly, it may result in breakage. Then roll it down to the base of the penis
- If the condom breaks in the middle of sexual intercourse, withdraw the penis whilst it is erect and put on a new condom.

- After ejaculation, withdraw penis while it is erect. Hold the rim of the condom as you withdraw so that semen does not spill on the partner
- Remove the condom, tie it using tissue or towel then dispose correctly either by burning or throwing it in a pit latrine. ***Flushing it down the drain may cause problems in the drainage.***

b. Correct use of female condoms

The female condom is a strong sheath made of polyurethane plastic (not latex) that is inserted into the vagina before sexual intercourse. Some key features about the female condom are as follows:

- It can be inserted for up to 8 hours before commencing actual sex
- It does not require immediate withdrawal after ejaculation
- It does not require a fully erect penis before insertion
- It can be used during menstruation

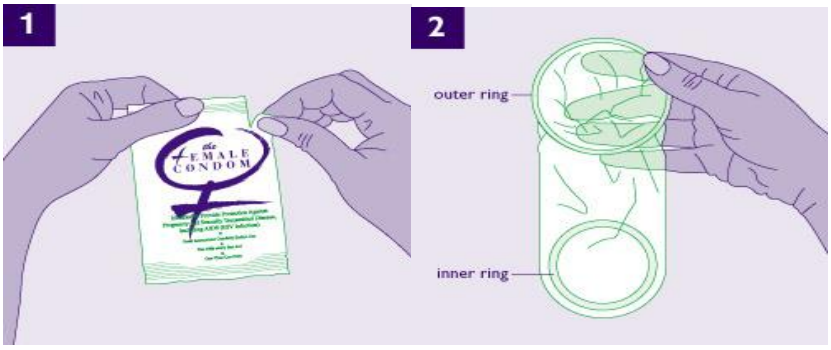
It is important that all people requesting the female condom must be taught on how to use them correctly.

Instructions on how to use a female condom correctly:

- Before opening the female condom, rub it between your fingers in order to spread the lubrication evenly around, then open from the side with a slit by pulling it apart with your hands. No teeth or cutting with scissors.
- Squeeze the inner ring in the middle such that it forms the number 8.
- The vagina must be relaxed when you insert the condom. Squat or sit with your knees apart or stand with one leg raised.
- Using your index finger, push the inner ring into your vagina right up to the mouth of the cervix (where it feels like the tip of the nose). Be careful to ensure that your fingernails or jewellery do not damage the condom. The outer ring should hang outside the vagina and should not be twisted.
- During intercourse it is necessary to guide the penis into the condom and to check that the penis has not entered the vagina outside the condom wall. Make sure that the condom is not pushed into the vagina by the penis.
- At the end of the sexual intercourse, hold the outer ring, twist and then gently pull it out,wrap with tissue or paper and dispose correctly (burning it or put in a pit latrine or rubbish bin).

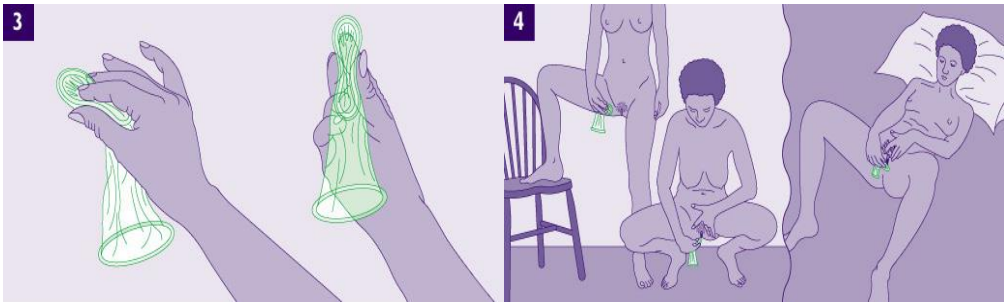
It is very important to dispose condoms in a way that they are not a danger to other people e.g. children playing with them.

Demonstration of Female Condom Use



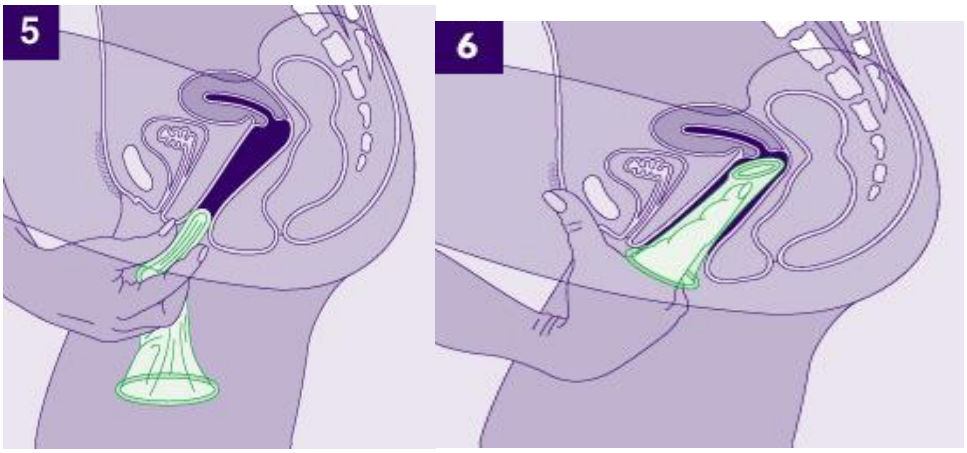
Remove it from its package and rub the outside of the pouch end of the together to be sure the lubrication is evenly spread inside the pouch hanging down

Be sure the inner ring is at the bottom, closed pouch. hold the pouch with the open end



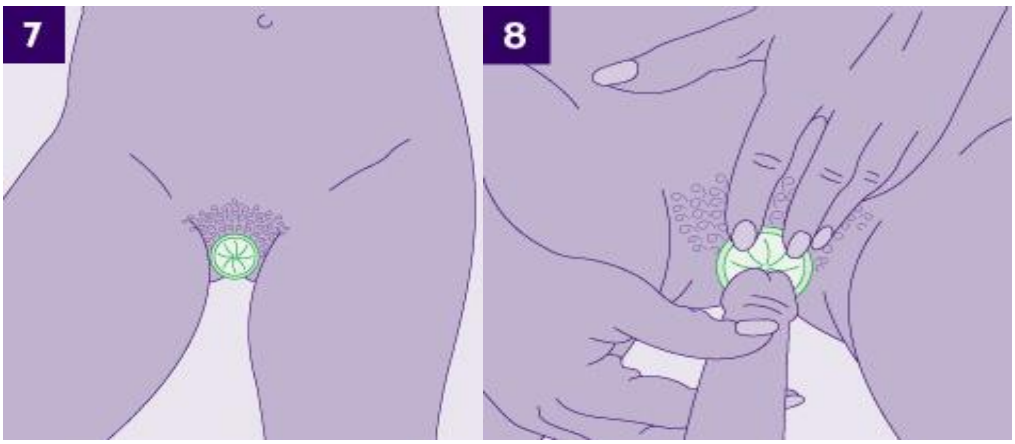
Squeeze the inner ring with thumb and middle Finger with the index pouch way up into the vagina, making sure the inner ring is up past the pubic bone

Insert the inner ring and pouch into the vaginal opening and finger, push this inner ring with the



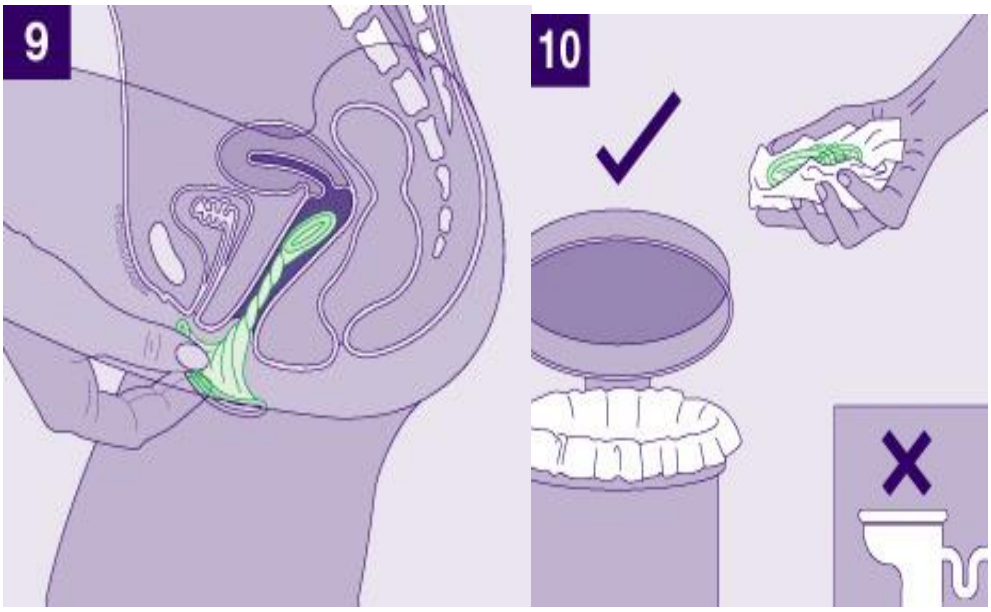
Make sure the female condom is inserted straight (not twisted) with about one inch staying into the vagina during intercourse.

Now the outside ring lies against the outer lips, with outside the body, this helps protects both partners



Once the penis enters, the vagina will expand and the "slack" will Decrease in order to avoid having the female condom enter the vagina with sex

You may have to use your hand to guide the penis into the vagina



After the intercourse, to remove the female condom, squeeze and twist the outer ring gently to keep the sperm inside the pouch

Pull out gently and discard. do not flush, do not reuse.

If the condom slips during intercourse or enters the vagina stop immediately, take the female condom out. Insert a new one, and add extra lubricant to the opening of the pouch or on the penis

Dual Protection

This is protecting one's self from both unwanted pregnancy and STI/HIV at the same time.

Dual protection can be achieved by:

1. Using a male or female condom correctly every time one has sex

OR

2. Using a condom AND another family planning method in addition

OR

3. Abstinence

OR

4. Avoiding all types of penetrative sex

OR

5. Using any contraceptive method AND mutual monogamy (absolute faithfulness) among uninfected partners

Dual protection is important for *ALL OF US*, especially:

*Sexually active young persons

*persons who put themselves and their partners at risk because of their sexual behaviour

*persons who are at risk because of the high-risk sexual behaviours of their partners

* Partners of those who have an STI and/or HIV

*Sexually active people in settings where the prevalence of STIs and/or HIV is high.

*Commercial sex workers

DUAL PROTECTION IS RECOMMENDED FOR ALL CLIENTS BOTH HIV NEGATIVE AND POSITIVE. DON'T MISS ANY OPPORTUNITY TO PROMOTE DUAL PROTECTION TO YOUR CLIENTS

PREVENTION IN HTS

COUNSELLING FOR PREVENTION IS THE CORE BUSINESS IN HTS. ONCE A PERSON HAS KNOWN HIS/HER HIV STATUS, WHETHER POSITIVE OR NEGATIVE IT IS IMPORTANT THAT THEY PREVENT EITHER TRANSMISSION OF HIV TO OTHER PEOPLE OR CONTRACTING HIV THEMSELVES. USUALLY THE MOST CHALLENGING PREVENTION METHOD IS THE USE OF CONDOMS AS THERE ARE MANY SOCIO–CULTURAL OBSTACLES TO THEIR USE. THE TABLE BELOW IDENTIFIES SOME OF THESE AND WHAT EFFECTIVE RESPONSES CAN BE USED FOR THESE OBSTACLES

You will work in three groups. Each group is to brainstorm some of the common myths and misconceptions about condoms and their use in Nigeria. Work out how best these can be corrected or dealt with. One of you will present for the group in plenary.

MAIN BARRIERS TO CONDOM USE AND EFFECTIVE RESPONSES

BARRIERS	EFFECTIVE RESPONSES
1. Societal, cultural and religious disapproval including stigma.	Stress cultural and societal benefits; include condoms as one of the approaches to HIV and STI prevention, educate on widespread evidence that condoms do not increase promiscuity.
2. Lack of awareness, especially among the young, about HIV, STIs, and condom's effectiveness, myths, misconceptions and misinformation	Use of multiple strategies for information sharing, correcting myths and misinformation, including peer education and participatory behaviour change communication. Teach how to use condoms correctly.
Lack of control over condom use	Promote negotiation skills, particularly for women and work towards greater gender equality in education, work and relationships to build self-esteem and social skills.
4. Implications for trust and fidelity in stable partnerships especially marriage.	Destigmatise condom use, promote the link between condom use and respect, care, love and the desire to protect; promote condom use for contraception as well as HIV/STI prevention. Encourage

	communication between couples.
5. Lack of availability of condoms due to: cost, access, lack of privacy at points of sale or distribution and inadequate promotion.	Social marketing and free government distribution, including distribution through shops, hotels, bars, markets, workplaces, schools, colleges, prisons. The use of vending machines and placing boxes of condoms in washrooms can reduce -- embarrassment in obtaining condoms.
6. Personal dislikes of condoms or condom failure (particularly where dry sex is practised or other activity that puts high stress on the condom)	Market condoms as trendy and recommend use of water-based lubricant to avoid breakage. Extra strong condom can be used if possible; educate people about the risks in sexual practices such as dry sex or severe genital rubbing.
7. Poor quality or design of condoms, poor storage	Enforce strict guidelines for condom promotion and for quality control

MODULE 2: GENERAL HIV COUNSELLING TECHNIQUES AND STRATEGIES

SESSION 1: OVERVIEW OF HIV TESTING SERVICES (HTS)

LEARNING OBJECTIVES

At the end of this session, Participants should be able to:

- Define HTS
- Explain the key elements of HTS
- Discuss the benefits and challenges of HTS
- Identify models of HTS delivery in Nigeria

2.1. Introduction to HTS?

The term HIV Testing Services (HTS) is used to embrace the full range of services that should be provided together with HIV testing-counselling (pre-test counselling and post-test counselling); linkage to appropriate HIV prevention, treatment and care services and other clinical and support services; and coordination with laboratory services to support quality assurance and the delivery of correct results.

HTS could be client or provider initiated.

Client-initiated HTS is the traditional Voluntary Counseling and Testing (VCT) in which the client voluntarily walks in to seek HTS to confidentially explore and reduce risks of getting infected with or transmitting HIV. Knowledge of one's HIV status also enables the client to access other HIV care and prevention services.

Provider-initiated HTS approach, in this approach, the health care provider recommends and provides HTS as a routine investigation of the patients irrespective of the signs and symptoms they present. This often applies to pregnant women; those with HIV related illnesses such as tuberculosis, sexually transmitted infections. The patient maintains the right to opt-out or decline testing.

2.2 Components of HTS

- Counselling and Testing.
  It includes the initial pre-test counselling session that can be provided to an individual or group (which vary in duration according to the purpose, needs of the client and setting in which it is provided).
  This is followed by the HIV rapid test after an informed consent by client and a post-test counselling session to provide the client with his/her test result (involves HIV test result disclosure and discussion on their meaning and implications). HTS also includes quality assurance and referral to the next level of prevention, treatment, care and support services according to clients' needs

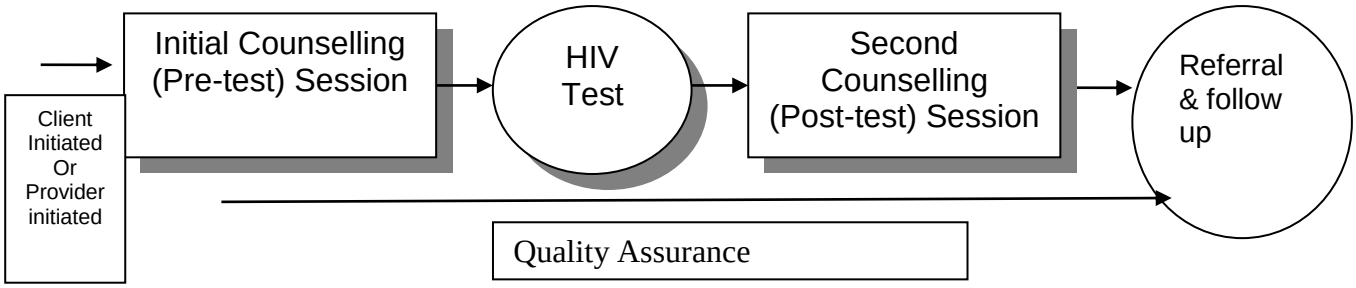


Figure 2.1. Components of HTS

2.3.Key Principles of HIV Testing Services

The WHO 5 Cs are principles that apply to all models of HTS and in all circumstances

- **Confidentiality**

This is when personal information about a client whether obtained directly or indirectly is not revealed without the client's permission. This information includes biographical details that may permit the clients HIV test results to be identified.

- The results of HIV tests must also be kept absolutely confidential. However, shared confidentiality with other professionals such as counselors and health workers may be necessary in order to provide appropriate care. It is important to inform clients and obtain their consent before this is done.

- At all service delivery points provisions must be made for maintaining confidentiality in the storage and disposal of client or patient records.

- During individual or couple counselling session's visual and audio confidentiality should be ensured. Counselling should therefore take place in a private and confidential setting.

- **Counselling**

All persons taking HIV test must be counselled. Counselling is a helping process. It is not giving advice, command or praying.

- **Consent**

This is to obtain permission or approval from a client for HTS.

- Providers must obtain their clients' consent to engage in the HTS process.
- All persons taking HIV test must give informed consent (written or verbal) prior to being tested.
- Testing without the client's consent cannot be justified in any circumstance.

***Voluntary**

The whole process of HIV counseling and testing must be *voluntary*. In order words no one should be coerced to take an HIV test rather it should be based on the choice or decision of the individual

- **Correct test result**

Providers of HIV testing should strive to provide high quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis.

- **Connection to care, treatment and prevention services**

This should include effective and appropriate follow up, including long term prevention and treatment support.

2.4 Benefits and Challenges of HTS

Education on HTS should provide information about the benefits of HTS in order to encourage people to access the service. HIV/AIDS presents multi-dimensional challenges to individuals, families and communities. These challenges may present as feelings of hopelessness, rejection and stigma at various levels. Some people may feel that knowing their HIV status may not help them or their communities. They may assume that more people are infected than is actually the case. Many people are only aware of those in their community who are ill with AIDS and are not aware of those who are HIV-infected and living healthy and productive lives.

BENEFITS OF HTS TO THE FOLLOWING:

a. Client

- Empowers clients to make informed decision to know their HIV status.
- Reduced anxiety/fear.
- Empowers the uninfected person to protect himself or herself from becoming infected with HIV.
- Assists infected persons to protect others and to live positively and seek other support services.
- Encourages partner notification and testing
- Offers the opportunity for treatment of HIV and associated illnesses
- It helps in timely intervention which will slow down disease progression to AIDS

b. Couple

- Supports safer relationships – enhances faithfulness.
- Encourages family planning and treatment to help prevent mother-to-child HIV transmission.
- Allows the couple/family to plan for the future.
- Promotes trust among couples.
- Enhances prevention through partner notification and testing.
- Enables them to provide care and support to each other

c. Community:

- Generates optimism when large numbers of persons test HIV-negative.
- Facilitates modification of community norms e.g. socio-cultural practices and beliefs that increase risk of transmission.
- Provides opportunity for community members to know their status and take necessary action as well as support those infected and affected by HIV/AIDS.
- Reduces stigma as more persons "go public" about having HIV
- Serves as a catalyst for the implementation of care and support services
- Reduces transmission and changes the tide of the epidemic

d. Healthcare workers:

- Provides an entry point to comprehensive HIV/AIDS care interventions and management including PMTCT, treatment of opportunistic infections (OIs), use of ARVs and psychosocial care.

- Helps to comply with professional ethics.
- Assists in disease surveillance and better planning and appropriate allocation of available resources.

CHALLENGES OF HTS

a. Limited access to services and this may be due to the following:

- Ignorance about the services and its benefits to the populace
- Inadequate awareness of the evidence of reducing HIV transmission
- Limited technical and financial capacity to provide HTS
- Shortage of manpower leading to service providers playing multiple roles thereby leaving limited time for HTS.
- Burnout (emotional exhaustion) due to non-availability of support systems for counsellors

b. Stigma and Discrimination

- HIV is highly stigmatized in most communities (visiting an HTS site is inferred as being HIV positive)
- Social reflections (issues of confidentiality: providers not trusted)
- Reflection by families or communities (client's or patient's family feels betrayed/humiliated when family member goes for HTS).
- HIV positive people are subject to discrimination in the workplace, educational institutions, places of worship etc.

c. Gender inequalities

- Violence against women who access HTS without consent of their spouses
- Discrimination against HIV positive women who are often wrongly accused of bringing the infection into the home
- Women being abused, abandoned and divorced by husbands or disowned by family members if their HIV status becomes known.

Take Home Message

HTS providers need to promote the benefits of HTS to clients, couples and community at large while being mindful of the challenges this may pose at the various levels. Hence HTS provision requires joint planning, effective partnership and an effective referral network system, with meaningful involvement of the community.
HTS providers need to promote the importance of everyone knowing their HIV status.

2.5 MODELS OF HTS SERVICE DELIVERY IN NIGERIA

There are various models of HTS service delivery but the most operational service delivery models in Nigeria are categorised into two:

- Facility-based and
- Community-based.

Health Facility

HIV testing in health facilities is generally initiated by a healthcare provider, and is referred to as Provider-Initiated HIV Testing and Counselling, or PITC. There are three main approaches to delivering HTS in health facilities:

1. Integrated as a routine service into multiple delivery points within a health facility;
2. Through referral to a central HTS site or room after initiation by a healthcare provider in a medical ward or other department;
3. At a co-located voluntary HIV Testing Services site on the grounds of the health facility.

In settings where HIV testing is initiated by a healthcare provider, that provider should carefully explain how the client(s) can decline testing and ensure that each person has a private opportunity to opt-out of testing if they prefer.

Integrated PITC

HTS should be integrated as part of routine health care at multiple service delivery points within a health facility. In high prevalence geographic areas or settings, healthcare providers should integrate HTS for all patients at these multiple service delivery points, not just to persons with signs or symptoms of HIV infection. Testing all patients within a health facility can lead to early identification of HIV before a patient becomes ill. When providers initiate or offer the test to all patients, this can result in high uptake of testing services, and often results in high HIV prevalence among those tested. Offering services at all service delivery points within a health facility increases opportunities for patients to be tested, and can help identify patients with undiagnosed HIV infection and link them with HIV care and treatment services. To date HTS have been well integrated within ANC and TB clinics, but additional focus is needed on expanding integrated HTS at other testing points and streams within facilities. In geographic areas or settings with low HIV-prevalence, it may be necessary to prioritize HTS for persons at high risk. At a minimum, HTS should be routinely offered to the following persons:

- All persons (including children) who have signs or symptoms of HIV
- All sexual partners and family members of PLHIV
- Persons with diagnosed or confirmed TB, and/or with presumptive TB
- Pregnant women and their male partners attending ANC
- Infants born to HIV-positive mothers (early infant diagnosis, or EID)
- Persons being tested for other sexually transmitted infections (STIs)
- Key populations at high risk of infection
- Children of HIV-positive mothers who have never been tested for HIV
- All children admitted to a malnutrition ward

- All patients (including children) admitted to an inpatient ward for medical reasons

In this model, existing healthcare providers deliver HTS, while infrastructure is modified or renovated in order to meet standards necessary for effective service delivery.

Referral to a Central HTS Point

Many health facilities have a central HTS point where patients are referred from other wards within the health facility, or where clients may also walk in voluntarily. This is a temporary solution for making HTS available when there is not space or sufficient staffing to provide truly integrated HTS within the wards themselves. However, when HTS are not integrated and offered at the point of care, patients can get "lost" within the health facility and may not actually get tested for HIV. Their HIV test results may not make it back to the clinician in the ward, which means they may not be used to inform the patient's care. Furthermore, if data collection is poor at the central HTS point, it may be hard to know where patients are being referred from, and so hard to assess HTS coverage and improve efficiencies. Sites with a central HTS point should identify strategies to overcoming these barriers, so that clients who are tested in these settings get linked with appropriate follow-up services.

Co-located HTS

Some health facilities also have co-located HTS on the grounds of the health facility, where clients may walk in voluntarily and request an HIV test. At times patients may also be referred to the co-located HTS from the other wards within the health facility, but this is generally not their primary function. Programs that do community-based testing may refer clients from the community to these co-located HTS.

Community based HTS

Testing in communities is a complement to health facility testing, and should be targeted to persons at high risk for HIV infection who are not likely to access healthcare services. This includes key populations such as sex workers (SW), men who have sex with men (MSM), persons who inject drugs (PWID), transgender persons (TG), and their social and sexual networks; priority populations such as men, adolescent girls and young women, and prisoners; partners of PLHIV; and orphans and vulnerable children (OVC) who have not previously been tested.

In order to reach the hard-to-reach populations, community-based HTS may wish to provide services outside of normal business hours (i.e. evenings and/or weekends). This approach has been shown to reach persons who do not normally come for services because of work or other daytime conflicts.

For many years community-based testing approaches were untargeted and included things like door-to-door testing for the general population, large mass testing campaigns, stand-alone VCTs in areas with low HIV prevalence, and a focus on re-testing all HIV-negative clients in 3-months, regardless of their specific risk of acute HIV infection. These approaches are no longer supported as they were generally not cost effective for case finding. Even the approach of targeting hot spots should focus specifically on reaching key populations and their social and sexual networks, and/or partners of people living with HIV.

The primary approaches supported for community-based testing are:

1. Stand-alone VCT
2. Targeted mobile and outreach testing, including campaigns, moonlight, schools, and workplaces
3. Targeted home-based testing (for partners and family members of PLHIV)
4. Drop in-centres or "one stop shops" (to reach key populations)

Stand-Alone VCT

Stand-alone VCTs may provide only HTS or may also provide other healthcare services, such as STI screening and treatment and/or other HIV prevention, treatment, care, and support services. Stand-alone sites are often operated by non-governmental (NGO), faith-based (FBO), and/or community-based organizations (CBOs), and should have strong linkages with health facilities to ensure persons who test HIV-positive are linked with ART. Anyone from the community may walk into a VCT and request HTS, but sites should aim to target persons at highest risk.

Targeted Mobile, Outreach, and Workplace

Mobile and outreach HTS can be offered in a mobile van, tent, school, church, mosque, community building, or other location in the community that does not typically offer HTS. Programs offering outreach HTS should aim to test hard-to-reach populations, such as persons living in remote areas, migrants, refugees, prisoners, and other high-risk populations.

Outreach HTS may be integrated with other healthcare services such as blood pressure screening or STI screening and treatment. Such *multi-disease campaigns* can be useful for reaching persons who may be interested in more than just HIV testing.

Mobile or outreach services may be offered at night to reach hardest-to-reach populations such as KP. This approach is referred to as *moonlight HTS.* Programs offering moonlight HTS should ensure there are systems in place to ensure their staff's safety and adherence to ethical policies and procedures.

Testing in *schools* or *institutions of higher learning* can be good opportunities to reach adolescents and young people who have a difficult time seeking HTS at a health facility during school hours and in a school uniform. School-based testing increases access to HTS for young people by bringing services to the students, but students should not be coerced or forced to disclose their status, and age of consent policies do apply.

Finally, *workplace* testing can be a good strategy for reaching men, who are less likely than women to access healthcare services or other HTS delivery points. Testing may be offered in formal or informal workplaces, and may be organized by the employer or by an outside organization. It may also be beneficial to offer testing for workers' spouses or other family members. Workplace HTS should not be mandatory, and workers shall not be hired or fired based on their willingness to test or based on their HIV status. However, workers shall be supported to access HIV prevention, treatment, care, and support services, as necessary.

Targeted Home-Based

Targeted home-based HTS may be provided using a door-to-door approach within a specific high-prevalence geographic area or community, or by targeting the homes of sex partners and family

members of PLHIV with their consent. Under this approach, the HTS provider goes to the home of potential clients and offers HTS in that setting. This can remove structural and logistical barriers to HTS, and make clients feel more comfortable by receiving HTS in a familiar, non-clinical setting. A primary benefit to home-based HTS is the ability to reach partners and children of PLHIV, and to promote family testing. Efforts must still be made to link clients with appropriate prevention, treatment, care, and support services, as indicated.

Drop-In Centres

A drop-in centre is a comprehensive site that offers HIV prevention, testing, treatment, care, and support services to KP and persons in their social and sexual networks. These sites are typically located in communities around where KP live or work, and are established to be KP-friendly sites. In addition to HIV testing, KP may also receive STI screening and treatment, FP services, cervical cancer screening (for female SW), peer education, condom and lubricant promotion and distribution, and support groups for KPliving with HIV. KP peers can be trained to deliver these services in order to make the sites peer-led and attract other KP.

SESSION 2: SELF AWARENESS, VALUES AND ATTITUDES OF A COUNSELLOR AND DISCUSSING SENSITIVE ISSUES

LEARNING OBJECTIVES

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

- Appreciate oneself including one's own knowledge, attitudes and opinion
- Explain the concepts:Sex; Sexuality; Sexual Health
- Develop strategies for self-awareness

2.1 Introduction to Self-Awareness

Counseling entails going into the private world of an individual and finding out about them, obtaining or eliciting information and history that may have been forgotten or the individual desire to put behind them. It entails talking and discussing about sex which is often a taboo in our socio-cultural environment.

It is important that being a counselor you should know that:

- HIV/AIDS is a disease that has no cure
- There are ways to avoid getting the virus
- There are ways for HIV positive persons to stay healthy and have better quality of life

Counsellors should therefore be aware of their own beliefs, biases, feelings, perceptions, and reactions and how their perspectives may affect the counselling session. The counsellor who is in tune with personal attitudes, biases, and emotions has the ability to gauge his or her responses to the couple. Self-awareness also allows the counsellor to provide unbiased empathy, understanding, and support to the couple. This is important, and we will be discussing the issue of self-awareness in detail.

If we want to be effective counselors, we need to know how we function emotionally. If we don't know 'who lives in here'' and feel at home with ourselves we cannot help effectively.

Why should we be concerned about it?

One reason for increasing self-awareness is the importance of being genuine in a counseling interaction. The more self-aware we are the more genuine we can be.

2.2 The Johari Window

Johari window is a technique used to help people understand their relationship with themselves and others which was created by psychologists Joseph and Harrington.

The Johari Window describes four possible aspects of self and the awareness that comes with each of these.

	What you see in me	What you do not see in me
What I see in me	The Open Self: Information about yourself that you and others know	The Hidden Self: Information you know about yourself but others don't
What I do not see in me	The Blind Self: Information you don't know but others know about you	The Unknown Self: Information about yourself that neither you or others know

.

2.3 Benefits of Self-awareness

Self-awareness helps you to avoid establishing a dependent relationship with the client, helps counselors to communicate better, and to take responsibility for themselves. Self-awareness enhances the ability of the counselor to empathize with client's problems without adding to them by projecting your own feelings and needs

Self-awareness helps you as counselors to avoid establishing a dependent relationship with a client; encourage clients to take responsibility for themselves.

As counselors, we should ask ourselves the following questions:
Do I feel uncomfortable with a client or with a particular subject area?
Am I aware of my own avoidance strategies?
Can I really be honest with the client?
Do I always feel as if I need to be in the control of the situation?

2.4 Strategies to Develop Self Awareness

The following methods are helpful:
Self-disclosure –sharing something that another person does not know about you

Being introspective – means being able to reflect on one's own inner feelings and reactions to situations

Accepting feedback from others – means that other people can help us see ourselves as we are and not as we think we are

What motivates people to have sex?

- Procreation
- Fun
- Love
- Adventure

- Monetary, material gain and exchange for favor,

2.5 Talking about sensitive issues

In HIV/AIDS counseling, counselors have to discuss sensitive issues with their clients, such as: Sex, Sexuality and Sexual Health

The question is: are we ready to discuss these sensitive issues with any type of client: old, young, sick, healthy, man, woman etc.

Sexuality

Sexuality encompasses the physical, physiological, psychological, social, emotional, cultural and ethical dimensions of sex and gender. Sexuality influences thoughts, feelings, actions and interactions and thereby our mental and physical health. Being able to positively express our sexuality is a basic human need that must be met if health is to be achieved and maintained. (Maslow 1954)

Sexuality – A broad concept that are influenced by social, religious, political environment and economic factors.

Sexuality – a powerful and purposeful aspect of human nature and an important dimension of our humaneness.(Fogel, 1990)

Sexuality – is an essential element of being human and is an integral part of the personality of everyone: man, woman and child. It is a basic need and integral part of being human that cannot be separated from other aspects of life. (WHO 1975).

Sexual Health

Health and Sexual health are fundamental human rights. (Langfeldt1986). It is the capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethics. It also relates to freedom from fear, shame, quiet, false belief and other psychological factors inhibiting sexual response and impairing sexual relationships; as well as freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions. (WHO 1775)

Positive sexual health is associated with high self-esteem, respect for self and others, non-exploitive sexual satisfaction rewarding human relationships and for many the joy of desired parenthood.

Sexual Health – safe sexual practices which does not expose an individual or the sexual partner to any risk of sexually transmitted infection.

Taking Sexual Histories

Why

- To identify sexual behaviours/practices.
- To identify any sexual risk a client may be disposed to.
- To give clients required health and sexual information and education.

- To aid in clarifying misunderstanding and misconceptions.

Where

- STI Clinic
- Family Planning Clinic
- Antenatal Clinic
- Post Natal Ward
- Gynaecological Ward
- During Discharge at Post Natal Ward
- Community Health Clinic
- Counseling Unit.

When

- There must be privacy
- After establishing rapport
- Confidentiality
- Gender Maturity
- There is no danger barrier
- When patient/client is in a stable state of mind.
- Must be done by someone knowledgeable

Exercise/ Activities

Exercise one: Group 1- Value clarification:

Rank the following in terms of their values to you (1-7)

Health ----
Pleasure---
Freedom---
Sexuality---
Family----
Control---
Career---

Exercise Two: Group 2- De-sensitization exercise

Write down all the synonyms of the following sexual terms/words in English, slang/pidgin and local vernacular for:

- Intercourse (sexual)
- Penis
- Vagina

- Breast
- Buttock
- Pregnancy
- Masturbation
- Prostitution
- Condom
- Homosexual
- Lesbianism
- Sex (oral, anal, vagina)

SESSION 3: ISSUES IN HIV/AIDS COUNSELLING

LEARNING OBJECTIVES

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

- Discuss the various issues in HIV and AIDS counselling from the cultural, client and counsellor perspectives
- Describe client reactions to HIV infection

3.1 CULTURAL ISSUES

There are certain issues involved in HIV/AIDS Counselling, these include:

Cultural issues in the context of client-counsellor interaction

Culture is a way of life, which includes norms, beliefs values, traditions, religion etc. Every culture has certain kinds of beliefs, moral principles and ideas preferred above all others. These are called values and they translate into customs, traditions, practices, and beliefs. Some values are practically universal- preserving life, for example ceremonies and rites. Values that guide and direct day-to-day behaviour are usually specific to the culture in which they evolved.

Counsellors should be sensitive to the way culture influences people's response to HIV and AIDS. If it is not culturally acceptable to openly express emotion, for example, the counsellor might help clients find relief by talking about their feelings in private. In some communities it is easier to discuss certain topics with strangers than with family members, the counsellor may help to find or establish a group of similarly affected people and empower them to support one another.

The counsellor needs to be sensitive to cultural difference and admit unfamiliarity with the client's culture if this is the case. Counsellors should explore their clients prevailing beliefs about illness and HIV infection in particular. HIV is mainly transmitted sexually; as such cultural and personal attitudes towards sex and sexuality are extremely important. The counsellor should realize that some people may hesitate for cultural, religious or moral reasons to consider the use of condoms, or any form of contraception.

The following questions are critical in relation to counselling in the context of HIV and AIDS:

- What do people believe causes illness, and how do they explain illness and death?
- What do they call HIV and AIDS (slangs and local languages) and what do they believe causes it?

- What do people think about HIV infected people? Are they blamed for their illness? If so, would they be abandoned?
- Who are recognized as helpers and healers? What types of treatment do they provide?
- What is expected of people with regard to caring for the sick? Is the family expected to provide care? Who else is expected to provide care?
- How do people feel about discussing intimate matters with people who are strangers to them, of the opposite sex, or from different backgrounds?
- How do people feel about discussing condom use and other safer sex methods with their sexual partners?

Cultural expectations about gender roles, sexuality, and childbearing should be discussed. In some cultures, the absence of penetrative sex is the same as not having sex at all. Suggestions for safer sexual practices may therefore not be well received in some cultural contexts. In these cases, it should be emphasised that the only completely safe behaviour (other than abstinence) is a monogamous, long lasting relationship in which neither party is infected with HIV.

The counsellor should anticipate that some information might be met with embarrassment, laughter or anger depending on the cultural context. The counsellor should, therefore, respect the client's beliefs but give them information about options for changing their behaviour.

3.2 Value Clarification

Counsellors interact with people of all ages, different tribes, and races, from the social environment they live and work. Counsellors have certain stereotypes and prejudices about other people and groups and these have a major impact on their social and interpersonal interactions with others. Counsellors therefore need to have some understanding of how stereotypes, prejudices, beliefs, values and culture impact on the counselling process.

Counsellors should be aware of how the following concepts often have a great impact in a counselling context;

- ***Ethnicity:*** refers to a group of people sharing common believes, norms and traditions. What is appropriate for one ethnic group or tribe may not be so for another group.
- ***Culture:*** In some cultures, a child cannot address an adult by his/her first name as this is viewed as rudeness.
- ***Stereotype****:* refers to a pattern of persistent, fixed repeated idea, and perception in relation to the way of life of other people.Stereotyping other people can jeopardize a counselling session.

Exercise

- Describe the difference between values and attitudes or beliefs.

- Identify some examples of values, not necessarily ones that you share.

- How do you feel about the each of the following groups of people and explore how these generalizations can affect your relationships with clients:
    - Black people are…
    - White people are…
    - Citizens of my neighboring country are…

- Homosexuals are…
- Men are…
- Women are…
- Teenagers are…
- Thin people are…
- Fat people are…
- Rich people are…
- Muslims are…
- Christians are…
- People in the military are…
- Old people are

3.3 Client-related issues (Psychological states)

A diagnosis of HIV infection will create considerable psychological pressures. The psychological states that develop in most people with HIV revolve around uncertainty and adjustment.

HIV infection gives rise to uncertainty about all aspects of life, including the quality and length of life, the effect of treatment and the response of society. These issues need to be discussed openly and frankly.

In response to uncertainty, the person with HIV must make a variety of adjustments. Even the apparent absence of a response may, in itself, be an adjustment through denial. There is no way of predicting the reaction to news of HIV infection.

The following are some of the possible reactions that a counsellor may have to deal with:

Shock

Shock is a normal response to life threatening news. Common shock reactions include the following:

- Numbness, "stunned" silence or disbelief
- Confusion, distractibility or uncertainty about present and future circumstances
- Despair (*"Oh my God, everything is ruined"*)
- Emotional instability *(moving quickly and unpredictably from tears to laughter and vice-versa.)*
- Withdrawal – distancing from present issues and circumstances, reluctance to become involved in conversation, activities or plans for treatment.

Denial

Some people may respond to news of their infection or disease by denying it *("This cannot be happening to me")*. While initial denial may be helpful to reduce stress, if it persists, it can prevent appropriate changes in behaviour and adjustments in life which are necessary to cope with HIV and to prevent transmission. If denial is not challenged, people may not accept the social responsibilities that go with being infected.

Anger
Some people become outwardly angry because they feel that they are the "unlucky ones" to have caught the infection and they may engage in destructive behaviour such as harming themselves or others. Boredom due to restrictions in life – diet, activity, social contacts may be source of anger. Anger can be expressed as irritability, sometimes triggered by unimportant events. Anger can also be directed inwards in the form of self-blame for acquiring and transmitting HIV infection, or in the form of self – destructive (suicidal) behaviour.

Suicidal thoughts or actions
People who learn that they are HIV infected have a significantly increased risk of suicide. Suicide may be seen as a way of avoiding their own pain or of lessening that of relatives. It may be active (*deliberate self-injury resulting in death*) or passive, (*self-destructive behaviour, such as drug overdose*)

Fear
People with HIV infection or disease have many fears. The fear of death or of dying alone and in pain is very common. Other common fears may include fear of desertion, rejection, leaving children and family uncared for, disability, loss of bodily or mental functioning and loss of confidentiality or privacy. Fear may be based on the experiences of others. It may also be due to *not* having enough information about HIV and AIDS. Fear can often be reduced by discussing it openly with a trusted person.

Isolation
The HIV-infected person may react by withdrawing from all social contacts. A significant factor is the fear of being abandoned, with the consequent reaction
"Everyone is going to abandon me, so I will turn away from them first." Initially the counsellor should respect the felt need for isolation while continuing a supportive counselling relationship. If isolation continues for a long time, the counsellor will need to look for the causes and encourage a change of attitude.

Loss
People with HIV and AIDS experience feelings of loss about their ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial stability and independence. As the need for physical care increases, there will also be a loss of privacy and control over life. Loss of self- confidence is critical since it can undermine the individual's ability to cope with HIV and AIDS

Grief
People with HIV and AIDS often have deep feelings of grief over the losses they have experienced or anticipated. They may also sense the grief of their close family members or others who care for them and are witnessing their declining health.

Guilt
When HIV infection is diagnosed, there is usually a feeling of guilt about the possibility of having infected others, or about the behaviour that may have resulted in the HIV infection. There is also guilt about the sadness, disruption and loss that the illness will cause loved ones and families, especially children. Any unresolved guilt from the past will intensify.

Depression
Depression may arise for a number of reasons, including the realization that a virus has taken over one's body, the absence of a cure and the resultant feeling of powerlessness. A person may become depressed due to loss of personal control associated with repeated medical examinations and other factors.

Anxiety
Anxiety can quickly become a fixture in the life of the person with HIV, reflecting the chronic uncertainty associated with the infection. Some of the anxieties include the increased risk of infection with other diseases; a declining ability to function efficiently and the loss of physical and financial independence.

Loss of self – esteem
Self-esteem is often threatened as soon as HIV is diagnosed. Rejection by neighbours, co-workers, acquaintances and loved ones can cause a loss of social status and confidence, leading to feelings of reduced self-worth. The physical impact of HIV-related diseases that leads to, physical wasting and loss of physical strength or body control can compound this situation.

Spiritual concerns
The fear of death, or other common reactions to incurable illnesses, may create or increase an individual's interest in spiritual matters. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may get them closer or further away from God.

Factors affecting the severity of the client's psychosocial status:

- The person's physical health at the time;
- How well prepared the person is for the news of HIV infection;
- How well supported the person is in the community and how readily he/she can call on the assistance of family and friends;
- The person's prior personality and psychological condition;
- The cultural and spiritual values attached to HIV and AIDS, to illness, and to death.

3.4 : Counsellor-related issues

Counsellor self-reflection and self-awareness are integral to counselling interaction. To be effective, counsellors need to know how they themselves function emotionally. Counsellors are not isolated from the fears and emotions that all people deal with when facing HIV and AIDS. Just like the clients they see on a daily basis, counsellors must face their own inner feelings about HIV and AIDS. If counsellors are not in touch with themselves they cannot help others effectively.

By being self-aware, counsellors are better able to communicate an attitude of equality, respect, and confidence and to empathise without projecting their own feelings and needs on the client in a way that will be detrimental to effective counselling

Part of the counsellor's responsibility is to encourage clients to take responsibility for themselves. Thus it is useful for counsellors to assess their own needs and feelings continually and discuss them with peers and supervisors.

Counsellors need to be aware of their values, attitudes and beliefs and how these impact upon their perception of society. Counsellors also need to fully comprehend their individual strengths and limitations as individuals as well as counsellors, in order to be effective helpers. *Genuineness is a fundamental quality of a counsellor.* Counsellors, like any other health professionals, are expected to provide services to all people irrespective of their race, culture, religion or grouping. As such, counsellors need to feel comfortable exploring and addressing personal and/or sexual issues, and know when to refer if issues are outside their comfort zone. They should:

- Know their own feelings about sex and sexuality
- Understand their own mind and body, and the relationship between the two.
- Know themselves before knowing others, so as to work more effectively with clients.

Effective counselling must therefore take into account the impact of values, attitudes and culture on the client's perception of the world.

SESSION 4: STIGMA AND DISCRIMINATION

Learning objectives:

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

- Define the terms "stigma" and "discrimination" in HIV/AIDS.
- Describe the types of stigma
- Explain the causes or determinants of stigma and discrimination
- Explain the manifestation of stigma and discrimination at different levels.
- Identify ways of reducing stigma and discrimination.

4.1 Definitions

What is Stigma?

Stigma refers to negative thoughts or labelling directed towards anindividual or group of persons based on a prejudiced position. It is also a negative perception towards people living with HIV or AIDS which leaves them feeling unwanted and rejected.

What is discrimination?

Discrimination can be expressed as both negative behaviours or actions directed towards people living with HIV and AIDS. HIV related discrimination is the action/outcome that results from stigma.

Stigma and discrimination are as old as the epidemic itself. HIV/AIDS stigma and discrimination is widely spread which results to rejection, denial, discrediting and consequently, leads to violation of human rights particularly those of women and children. Stigma and discrimination associated with HIV/AIDS are the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating (the) impact of HIV/AIDS (UNAIDS 2002).

4.2 Types of stigma and discrimination

- ***Internal (self) stigma***, examples: blaming oneself, keeping away from other people, failing to seek health care, abandoning ones jobs, self-rejection/neglect, and failure to participate in economic and social activities.

- **External stigma,** examples: other people talking negatively about the person, refusal to offer medical services to the person, refusing to offer jobs, rejection by others, discrimination against the children of the infected person and other family members.

4.3 Causes/determinants of stigma and discrimination in HIV/AIDS:

- The chronic nature of the disease
- AIDS is life threatening

- HIV has no cure yet
- Low level of awareness and information
- Negative attitude of some community and health workers
- Religious and cultural belief

4.4 Manifestations of stigma and discrimination

Stigma can occur in different settings - health care setting, home, office, institutions, church or community.

Health care setting

- Denial of appropriate level of care
- Inability to disclose HIV status
- Selective use of universal precautionary measures
- Labelling
- Segregation/Isolation

Home

- Rejection of infected person by family members
- Denial
- Sadness
- Family may not want to invest in the future of the infected person
- Being seen as a disappointment by family members
- Lack of willingness to share food, room or talk with infected person
- Pity

Workplace

- Gossip
- Finger pointing
- Unkind gestures at the known infected person
- Sack/Loss of job
- Denial of promotion, employment
- Colleagues may not come near - isolation
- Deprivation of official rights/protocol
- Lack of consideration of health needs in the design of workload

- Denial of medical care payment
- People will not reckon with the person
- Treating the infected person as an outcast
- Keeping distance from infected person
- Being regarded as a sinner
- Being looked upon as a disappointment

Infected person

- Loss of interest/withdrawal
- Dejection
- Suspicion
- Loss of self esteem
- Suicidal tendencies
- Self-guilt
- Isolation
- Non-disclosure of status
- Hostility

4.5 Strategies to address stigma and discrimination at all levels

- Community sensitization and mobilization.
- Use of PLWHA activists - speak out to give the virus a human face
- Advocacy for human rights.
- Inclusion of HIV/AIDS into various curriculum
- Improving access to medical care and support
- Promotion of HTS.
- Adoption of policies aimed at reducing stigma - protect rights of PLWHA
- Development and Implementation of workplace policies

Key message

- While stigma reflects an attitude, discrimination is an act or behaviour.
- Stigma encourages the development of discriminatory attitudes and prejudice
- Discrimination is often defined in terms of human rights and entitlements in health care, employment, the legal system, social welfare, reproductive, and family life.
- Stigma and discrimination exist in a vicious cycle,they are often interlinked and reinforce or perpetuate the other.
- HIV/AIDS-related stigma and discrimination may discourage PLHIV from accessing key HIV services. It may also:
    - **Discourage disclosure of HIV status**
    - **Limit access to education, counselling, and treatment even when services are available and affordable**

SESSION 5: COMMUNICATION SKILLS

5.1 Definition

LEARNING OBJECTIVES

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

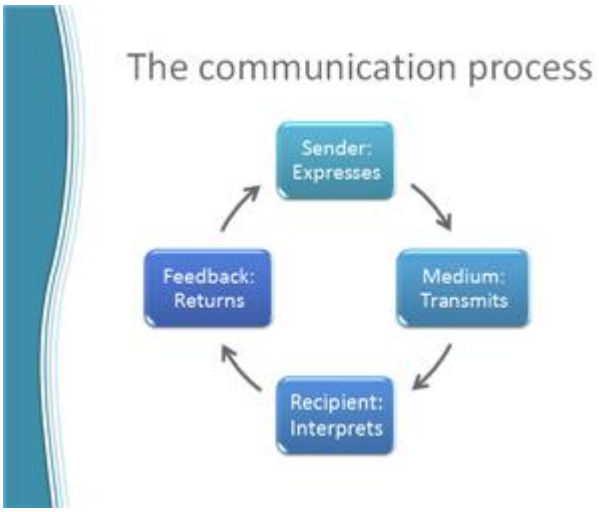
- Explain communication
- Describe communication types and skills
- Discuss the Guiding Principles for effective communication in counselling
- Demonstrate skills required for effective communication in counselling

Communication is a "two-way process of exchanging information from the sender to the receiver and to receive feedback".

5.2 Process of communication

Communication involves:

- Sender, Medium or Channel, Receiver and feedback to Sender.



Communication is a process of sharing information and ideas. Through communication, thoughts, opinions or information are shared via speech, writing or physical signs/ gestures.

Good communication is very important in counselling in order to explain what is to be done and needs to be done; avoid misunderstanding and to get ideas from others. It is important to show genuine interest when an individual is speaking so that you can understand the problems, fears or concerns and what brought them about. Communication is a skill and can be acquired with patience and practice.

5.3 Types of communication

Communication is a two-way dialogue that can be both verbal and non-verbal

Verbal communication: Involves expressing ideas, thoughts or feelings through spoken words. It entails speaking clearly, using terms that are understood by the target group.

Non-verbal communication: Involves expressing oneself using body language, facial expression, gestures, etc. It entails observing what was said and was not said and establishing a link. If a person is saying one thing but is sending a different message non-verbally, it is often a sign that what the person is saying is not entirely true.

Usually messages (verbal and non-verbal) are matching, so if a person says that he or she appreciates something you have done s/he is smiling and expressing warmth non–verbally (see examples below). Communication problems arise when a person's verbal and non- verbal messages contradict each other.

Examples of matching verbal and non-verbal communication

Action	**Interpretation**
Smile	Happy
Frown	Unhappy
Does not sit still on the seat	Uncomfortable
Nodding of the head	Understanding
Eyes widened	Afraid
Cannot keep hands still or moving legs up and down	Tense

5.4 Guiding Principles for effective communication in HIV/AIDS counselling:

- Discuss issues in a straight forward fashion to foster trust and openness.
- Be realistic about the seriousness of HIV disease and yet instill hope.
- Be optimistic about the potentials to restore health and to provide comfort
- Give accurate and factual information regarding prognosis and benefits of ARV.
- Deliver important information in easily understood terms and in small amounts at a time.

- Reassess patients/clients understanding of crucial information at subsequent visits and repeat important information as necessary.

5.5 Factors that affect effective communication

- Age
- Sex
- Attitude/Mood
- State of mind of sender or receiver – anxiety or nervousness
- Biases
- Ambiguity (Inexactness) of message
- Language barrier
- Culture/Religion – mode of dressing
- Interruptions
- Beliefs
- Environment
- Poor audibility
- Making assumptions
- Inadequate knowledge and skills
- Fear of doing harm and provoking emotions

5.6 Communication skills

Communication is vital to counselling. As such, counsellors need to be able to communicate effectively with their clients. In order to be an effective counselor, one needs to develop good communication skills; this is because communication skills enable people to share their problems and consider how they might cope with them. There are basically 4 skills that a counselor should use to enable him/her provide quality counseling. These skills include; Attending and listening skills; checking understanding; asking questions and answering questions.

Some examples of communication skills include:

- **Listening and attending skills:** It involves listening carefully to what is being said and ensuring the information is understood. Listening motivates the client to give others

feedback and it helps the counsellor to understand and communicate effectively. It requires:

- Patience
- Maintaining eye contact
- Using verbal and non-verbal encouragers/prompts (such as "Yes", Go on", occasional nodding etc.)
- Not interrupting while client is talking

- **Checking understanding**: It is important to check that we understand what the client is saying and the client also understands what the counselor is saying. This will enable the client/patient know that the counselor has been listening and trying to understand what he/she has been saying. It also helps the client to think about how to cope with the problem. We check understanding by using the following communication skills:
  - **Paraphrasing and Interpretation:** captures the essence or central ideas of what the speaker is saying and show an understanding of the information that has been conveyed**.** To paraphrase the counsellor needs to listen actively to be able to determine what is being said and check with the client that the paraphrase is accurate e.g. 'You have told me that …".
  - **Repeating:** At times of stress and crisis, people do not always understand everything they are told as they may be in a state of denial or feel overwhelmed. It becomes important that information is repeated to ensure that it was understood.

    Reflection of Feeling (Empathy) - Picking up the patients/clients feelings and letting him/her know you have understood how and what he/she is feeling and providing support
- **Asking Questions:** Counselors need to be experts in both asking and answering questions. Questions are asked for the following reasons; to help people explore their problems more fully, think more about their situations and perhaps find a way of coping with their problems. It also helps a person explain what she/he already knows or understands about a situation, for example; facts about HIV. It helps counseling sessions to move at the person's own pace and helps prioritize problems and focus the counseling sessions.

  There are basic principles of asking questions. Ask simple and clear questions, using open-ended questions, which will not give a "Yes" or "No" answer but gives the individual an

opportunity to provide more details about an issue or concern. Open-ended questions are useful in starting a dialogue, finding a direction and/or exploring a client's concern. Close-ended questions on the other hand tend to be interrogative or seem to be judgmental and its use should be limited as much as possible.

- ***Answering Questions***: In answering questions, clients may ask counselors questions for various reasons, for example, they may ask for information and to seek the counsellor's opinion. It is important to remember the following when answering questions; behind every question there is a story; therefore, it is important to always consider why the person is asking the question. Before giving information, check carefully using open-ended questions about what the person already knows, only give accurate information and be honest. It is alright to say you do not know, because some questions do not have answers. Answer questions using simple language, as complicated medical jargons can confuse the client. When giving information, check that the person has understood you by asking open ended questions.

SESSION 6: COUNSELLING CONCEPTS, SKILLS AND PROCESSES

LEARNING OBJECTIVES

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

- Explain the concept of Counselling
- Itemise the aims of Counselling
- Describe the outcomes of Counselling
- Explain the principles of counselling
- Describe counselling skills
- Discuss selected approaches to counselling
- Demonstrate skills required for effective communication and counselling

6.1 COUNSELLING CONCEPTS

Counselling Definition

Counselling is a face-to-face confidential interpersonal communication through which a person is helped to assess his/her current situation, explore his/her feelings, and provided with options to help them arrive at a solution to cope with the problem.

HIV Counselling

HIV Counselling is a "confidential dialogue between a client(s) and a counsellor aimed at enabling the client to cope with stress and make personal decisions related to HIV and AIDS. The counselling process includes evaluating the personal risk of HIV transmission and discussing how to prevent infection" (WHO 1994).

Aims of HIV counselling

HIV Counselling helps each individual to:

a. Obtain information on HIV and AIDS in order to prevent HIV infection or its transmission.
b. Develop the ability to make realistic decisions and appropriate plans for the future.
c. Alter and change their behaviour to produce desirable outcomes.
d. Receive psychological support to enable them cope with challenging situations.

Roles of a Counsellor

- Be familiar with the client and the client's needs and interests
- Convey the message at the knowledge level of the receiver
- Choose an appropriate communication channel to transmit the message

The counsellor's role is to help the client to prevent HIV infection by promoting behaviour change and providing psychosocial support to people infected and affected by HIV. In a HTS setting, counselling can be done with an individual, couple or group.

Counselling is **NOT**

- Giving advice
- Telling someone what to do
- A solution to all problems
- Teaching
- Preaching or praying
- An interrogation
- A conversation
- A confession
- Forum to speak or promote counsellor's opinion

Some examples of **non-counselling responses**

- "You think you have a problem, let me tell you about mine"
- "Let me tell you what to do"
- "If I were you, I would…"
- "I understand because I once had the same problem"
- "I will take charge and deal with it or, leave it all to…"

Outcomes of counselling:

When counselling has been successful, clients often experience the following outcomes:

- They begin to own their problems and issues. "Owning" is an important word in counselling. It means clients begin to accept responsibility for themselves, their problems and solutions and for their lives. Many clients come into counselling blaming their problems on other people, situations or circumstances. Owning one's problems is the first step towards resolving them.
- Clients develop a more useful understanding of problems and issues. Once clients begin to accept some responsibility for problems, they frequently develop some understanding or insight into the problem.
- Clients acquire new responses to old problems. In addition to developing greater understanding of issues, clients also need to acquire more effectiveways ofresponding, verbally or otherwise to the situation.
- Clients learn how to develop effective relationships. The major issue with most clients who seek counselling is the non-existence of effective and satisfying interpersonal interaction. Since change is often created and supported by a network of social support, it is essential for clients to begin to develop more adequate relationships with other persons. Often counselling is the initial vehicle by which this occurs.

6.2 Counselling Approaches

There are different approaches for the delivery of HTS.. One particular approach may not fit all target groups and as such a variety maybe required based on cultural factors and the needs of the specific group. It is also essential that cost-effectiveness, sustainability, affordability and convenience of the clients are considered in the planning of the approach to be adopted in each setting. In whichever approach that is used, the underlying principle remains the "**5 Cs"** which are:

- **Confidentiality** - which must be maintained
- **Counselling** – which should accompany testing
- **Consent** - which requires that testing should only be conducted with informed consent; i.e. the client has given consent and has done so voluntarily
- **Correct test result**
- **Connections to care treatment and prevention services**

The two common **approaches** used for providing HTS services are:

- **Client-initiated approach** – this is the traditional VCT in which an individual voluntarily seeks Testing Services. The primary driver for this approach is the desire for individual to know their HIV status. The client-centered approach to HIV counselling is designed to decrease the emphasis on education, persuasion and test results and increase the emphasis on personalized risk assessment. The approach encourages the development of a personalized risk reduction plan for each client. The client's risk reduction plan takes into account the client's emotional reactions, interpersonal situation, social and cultural context, specific risk behavior and readiness to change.However, due to current perceptions about HIV/AIDS, uptake of services by individual clients still remains low, but this approach will continue to be offered in all HTS settings.
-
- **Provider-initiatedapproach –** Provider Initiated Testing and Counselling (PITC) refers to HTS which is recommended by Health Care Providers to persons attending healthcare facilities as a standard component of medical care.This approach is aimed at increasing HTS access, early diagnosis and linkage to ART and treatment of other opportunistic infections. Provider-initiated approach is neither compulsory nor mandatory HIV testing. It incorporates informed right of the patient to decline the recommendation of an HIV test.

The Table below outlines the differences between the two approaches

Comparisons between Client and Provider Initiated HTS

	Client initiated	**Provider initiated**
Overall Difference	• Individual chooses to seek HTS • The client is self-referred • First user of the test result is the client who uses the information to make personal life decisions • Counselling focuses on addressing risk behavior and risk reduction • Anonymous or confidential services may be offered	• Individual is seeking medical care • HTS recommended and offered by health care provider • First user of the test result is the health provider to make diagnosis and provide appropriate treatment • Counselling focuses on coping with the test and the diagnosis • Services provided are confidential and documented in medical record to ensure continuity of care
Clients	• Clients coming to the site specifically to get HTS. • If HIV infected, more likely to be asymptomatic. • Expecting to get tested.	• Clients coming to clinic because they are ill. • If HIV infected, more likely to have AIDS. • Not necessarily expecting to get tested for HIV.
Providers	• Counselors, not necessarily trained as healthcare providers	• Healthcare providers, not necessarily trained as counselors
Purpose	• Primary focus is on preventing HIV transmission through risk reduction	• Primary focus is on diagnosing HIV for medical management
Pre-test session	• Client-centered counselling, usually a one-on-one session • Group sessions very rare	• One–on-one counselling with provider most common • Group information sessions in high volume settings as well
Testing	• Rapid testing	• Rapid testing
Post-test session	• Is important to discuss results with negatives as well as positives because of the focus on preventing acquisition of	• Little time spent with those testing negative. • Primarily focusing on those testing positive with emphasis

	infection	on their medical care. • Psychosocial issues addressed by ancillary providers (e.g., social workers)
Follow-up and referral	• HIV positive clients referred to medical care services and other support services, some in community	• Care of HIV positive clients integrated between care providers, referred for other support services, some in community

Who should receive counselling?

- People who are worried that they might be infected with HIV and want to know their status;
- Pregnant women and their partners
- Those intending to marry
- People considering being tested
- People who have been tested for HIV
- People who choose not to be tested despite past or current behaviours;
- People who are unaware of the risks involved in specific behaviour which they had previously or are currently engaged in
- People with AIDS or other diseases related to their HIV infection;
- People experiencing difficulties in their work place, homes and family as a result of HIV infection;
- The partner(s), family members and friends of people who are infected
- Health workers and others who come into regular contact with people infected with HIV.
- Everybody needs counselling (including incarcerated, IDPs, physically challenged etc)

Who should provide counselling?

Counselling can be provided by those who are professionally qualified trained and are interested.

These may include:

- Nurses, doctors, social workers, medical laboratory scientists, lay counsellors and other care providers
- Full-time counsellors (including psychiatrists, psychologists and family therapists)
- Community-based workers whose work consistently entails appropriate handling of confidential information and emotional issues; and
- People living with HIV and AIDS.

Qualities of a good counsellor

A good counsellor should:

- Understand all aspects of HIV and AIDS related issues
- Possess good communication skills and be familiar with counselling techniques
- Be accessible and available for clients and be able to deal with their reactions
- Be able to empathise
- Be genuine and non-judgmental
- Be able to express themselves coherently and precisely
- Be able to recognise their limitations
- Possess high level of self-awareness.
- Be respectful and honest
- Be friendly
- Be sensitive to other peoples' culture and religious
- Be observant
- Be patient
- Be able to maintain confidentiality (does not reveal clients' information without permission from the client).

Don'ts in Counselling

DON'T…

- Argue with the client
- Advise
- Judge
- Impose your own belief system
- Minimize client's problem
- Interrupt unnecessarily
- Block strong emotion: you must allow the client to "blow off steam"
- Sympathize
- Take responsibility for clients' problems and decisions.
- Get emotionally involved in clients' problems.
- Use words such as " should" and " must "

Where should counselling take place?

Counselling can be provided anywhere as long as the space is:

- Private (could be in a hospital ward, antenatal clinic, community centre, church, mosque, school, etc).
- Quiet and confidential setting devoid of interruptions.
- Safe and secure.
- Convenient to both client and counsellor.
- Well-lit and well-ventilated.

- No stigmatising label.

Guides for effective counselling

- Accurate information on HIV and AIDS
- Give enough time, do not rush clients
- Method and venue should be acceptable
- No open reference to client's HIV status without consent
- Be concerned about client's problems
- Start with personal data collection for example name, age, address, occupation etc

Health education and counselling

Difference between counselling and Health Education

Counselling	Health Education
Confidential	Not confidential
One to one or couple	Small or large groups of people
Evokes strong emotions in both client and counsellor	Emotionally neutral
Focused, specific and goal-targeted	Generalized
Information used to change attitudes and motivate behaviour change	Information used to increase knowledge
Issue-oriented	Content-oriented
Based on needs of client	Based on public health needs

Difference between counselling and advice

Counselling	**Advice**
Spend most of the time listening	Spend most of time talking.
Help the client figure out what to do.	Tell the client what to do
Try to understand barriers that interfere with client making changes.	Get angry when the client doesn't do what he/she told us.
Consider the client's feeling.	Does not consider the client's feeling.
Leaves a client in control of their problems	Leaves the client dependent on the adviser

6.3 Features of Counselling

The following are features necessary to ensure effective counselling:

Time

The time should be convenient and adequate for effective transfer of information and behaviour modification. Counselling session should not be rushed or unnecessarily prolonged but should allow for establishment of rapport and trust. The client should know the available time.

Acceptance
Counsellors should appreciate the stress caused by fear of being infected or the need to change behaviour. Counsellors should accept the consequent emotions and reactions of clients and their close associates when there is resistance and hostility to the counsellor. Clients should not be judged but accepted regardless of their socio-economic, ethnic, or religious background,
occupation and personal relationships.

Accessibility
Clients need to feel they can ask for assistance or call on a counsellor when needed. The HTS facility must be easily reached on foot or by public transport, and there should be arrangement for home visits to people who are too disturbed or physically unable to attend the facility.

Consistency and accuracy
All information about infection, transmission, risk of infection and risk reduction must be consistent. Counselling approaches will vary with the characteristics of clients and counsellors, but the essential AIDS-related information must always be accurate and consistent. Counsellors should be up-to-date with information about infection, prevention and control.

Trust and confidentiality
Trust is an essential element of counsellor-client relationship. Confidentiality is a basic principle of counselling. The relationship between the counsellor and the client is built on the understanding that whatever is discussed remains a private matter between the two.

Principles of counselling

As counsellors develop the necessary basic and specific skills they are guided by certain principles that promote the purpose or aims of counselling. The principles

also guide and limit the conduct of counsellors and create standards that ensure quality services. These principles include:

Confidentiality
Acceptance
Individualization
Non-judgmental
Self-determination
Controlled emotional involvement
Purposeful expression of feelings
Impartiality
Co-operation
Confidentiality

Confidentiality means keeping patient's information to oneself and not disclosing it to unconcerned people who have nothing to do with the client, or people that the client does not approve of. Counselling is a relationship based on trust and people seeking help must be confident that information about them will not be disclosed or shared with other people without their consent. People have the right to privacy and to decide with whom information about them is shared.

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Shared Confidentiality is when information about the client is disclosed to another person (who could be a family member, health worker, friend or relative) directly involved in the care of the client, with the client's expressed consent.

Guiding principles to shared confidentiality:

- Must be done only when necessary.
- Counsellors should ascertain clearly the need to do so and this should be for the benefit of the client more than of the counsellor.
- The client should be counselled and given time to assimilate the information about shared confidentiality.
- Clients should be assisted to carry out the disclosure themselves and not by the counsellor unless the client requests the counsellor to be part of the process.
- Counsellors should provide the necessary backup support to the client.

Acceptance

This means having an attitude of positive regard, unconditional warmth and understanding towards a person and his or her circumstances, irrespective of that person's behaviour or lifestyle. When people sense acceptance they will be less defensive, more open about themselves, their situation and difficulty. Their participation in the helping relationship will be greater and they will learn to handle

and accept themselves, enabling greater self-examination. In addition, the help given will be more effective because it can be designed to fit the needs of the individual.

Individualization

This means acknowledging and treating each person as an individual with unique feelings, needs, attitudes, problems and ways of experiencing his or her problems. Every individual whatever his/her social position, race, creed or belief system has a need for self esteem and feelings of uniqueness. Only when clients sense that you recognize and acknowledge their uniqueness will they venture to enter the helping relationship in a meaningful way. If a client feels that he/she is being treated as a case it can lead to rejection and hostility.

Non-judgmental

Counsellors are not to judge the behaviour, problems or needs of the client as right or wrong or to enforce their own ethical code or religious and/cultural beliefs on the client. Being non-judgmental means holding neutral views and interest in the absence of prejudice and with the ability to see the other person's point of view.

Self –determination

This means acknowledging that people have the right and need to make their own decisions and choices in matters that affect them. This is done by:

- Using communication and counselling techniques that help the person to view the difficulty objectively and in perspective.
- Linking the person with resource systems that could help (e.g. the extended family, church or social groups such as support groups)
- Affirming and stimulating the person's own strengths and abilities.
- Creating a collaborative mutual relationship.

However, the counsellor should be careful not to allow the client to develop dependency on him or her.

Controlled Emotional Involvement

This means caring for the other person, showing empathy without becoming emotionally involved or taking over the client's problems on oneself. It is inappropriate for a counsellor to cry or quarrel with a client, just as it is in appropriate for them to enter into a sexual relationship with the client.

NOTE:

- Dealing with one's own feelings is vital for the counsellor, especially those working in the HIV and AIDS context.
- Recognize your own fears, needs, concerns, feelings and difficulties and take care of them by talking to other colleagues about them. Do not suppress them.
- It is essential for you to have your own support and avoid burnout or being overwhelmed.

Purposeful Expression of Feelings

This means allowing clients to express their own feelings (e.g. shock, anger or even crying). Clients need time to verbalise how they feel about issues problems or situations.

Impartiality

A counsellor should not take sides in a dispute or blame the client for the problem he/she faces. A good counsellor is neutral: his/her personal values do not factor into the counselling process, which relies on impartiality to create an environment in which the client feels safe to speak freely.

Co-operation

Counselling is based on co-operation and not compulsion. The client and counsellor work together in mutual trust to arrive at possible solutions to problems identified during the process of counselling.

6.4 COUNSELLING SKILLS

There are a wide range of counselling skills that can be used by counsellors for different settings and clients. The counsellor uses certain skills depending on the client and the situation. These skills are not mastered in a day or in one training workshop, but with practice and application these skills can be improved.

Active Listening

Listening occurs at two levels:

- Listening to the content (words)
- Listening to the process (feelings, concerns, worries)

Listening involves:

- Knowing what you are listening to
- Suspending judgment
- Recalling expression
- Looking for themes
- Resisting distractions
- Reflecting on what is being said

How to listen effectively

- Demonstrate attention (see attending skills below)
- Use encouragement signs
- Minimize distraction
- Do not do other tasks at the same time
- Acknowledge the client's feelings.
- Check if you understood by paraphrasing
- Do not interrupt the client unnecessarily
- Ask questions if you do not understand.
- Do not take over and tell your own story

Relationship Building Skills

These are essential skills for building rapport and "joining in" with your clients. Some of the skills involved in rapport building include common courtesy (greetings and introductions appropriate to culture and context), emotional presence, appropriate vocal tone and speech rate.

Empathy

The ability to empathise is one of the most essential counselling skills. Empathy involves identifying with the client, understanding their thoughts and feelings, and communicating that understanding to the client. This involves trying to place one's self in another's situation. Although counsellors should empathize, they should control their emotions and find the correct balance between detachment and closeness in order to promote autonomy as well as problem solving skills of the client.

To understand what the client is feeling, the counsellor must be attentive to the client's verbal and nonverbal cues. The counsellor needs to ask himself/herself: "What feelings is the client expressing?" "What experiences and behaviours underlie these feelings?" "What is most important in what the client is saying to me?"

Carl Rogers gives a description of basic empathetic listening as:
"… entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive… to the fear, or rage or tenderness or confusion or whatever he or she is experiencing. It means temporarily living in the other client's life, moving about it delicately without making judgments"

Information Gathering Skills

In counselling, information gathering skills are the most important tools that a counsellor has, as they encourage the client to tell his story. For without hearing the story, a counsellor would not be able to help the client. These skills involve listening to the client's own words, focusing not only on the factual information but also on such details as choice and emphasis of words, and misuse of words. It also involves observing the mood, the feelings and the underlying messages that are conveyed through verbal cues *(actual words)* and non-verbal cues.

Non-verbal cues include:

- Bodily behaviour e.g. body movements, posture and gesture
- Facial expression e.g. twisted lips, frowns, twinkles and smiles.
- Voice tones e.g. pitch of voice, level and intensity, pauses and fluency etc.
- General appearances e.g. type of dress, walking mannerism, facial expression

Attending Skills

Attending skills include such elements as:

- Eye contact
- Relaxed body posture
- Good body language
- Listening to feelings
- Eliciting concerns

In practice, attending skills are best operationalized by following the acronym **SOLER** that stands for:

- **S –** Sitting squarely and facing client shows a posture that indicates involvement with the client.
- **O** - Open posture can be a sign that one is open to the client and to what he/she has to say.
- **L -** Leaning forward towards the client is often seen as saying *"I am interested in what you are saying".*
- **E** - Eye contact shows respect. Counsellor should avoid staring into the eyes of the individual which can be threatening or show disrespect. Therefore, eye contact must be used within the acceptable cultural context.
- **R** - Relaxed mood is important as such the counsellor should not fidget or nervously engage in distractive facial expressions.

Questioning Skills

Active listening, in addition to attending skills, also involves the use of appropriate questioning skills. These are the primary skills used to obtain information or seek further clarification on information obtained.

Information gathering can be facilitated when one:

- Asks one question at a time
- Looks at the client
- Is brief and clear
- DOES NOT ask questions to satisfy curiosity.
- Avoids irrelevant questions
- Does not spend a lot of time thinking of questions.
- Acknowledges that one has heard and understood the client
- Asks appropriate follow-up questions (probes)
- Asks client to elaborate on unclear issues

- Asks client to clarify confusing or contradictory information
- Blends reflective, guiding and directive statements with well chosen open-ended questions

Questions can be classified as either close ended questions or open-ended questions

Close ended questions
These demand short or one-word answers e.g. *"How old are you? What is your name? Do you have children?"* They are very useful for obtaining demographic data and at opening stages of the session. When overused they lead to interrogation rather than counselling. As a counsellor you overwork yourself if you use too many close ended questions.

Open ended questions
These questions demand long explanatory answers and cannot be answered in one word. These are the best to use in session when you want the client to talk more. They facilitate more conversation e.g. "*Can you tell me more about your relationship with your husband? Could you explain that? How did that make you feel?*"

Please remember, before you ask any question you should ask yourself:
What is my motivation in asking the question - do I really need to know?
What will I do with the information?
How will the client perceive me? E.g. magistrate, policeman etc
Is it necessary to ask a question or is a reflection better?

Examples of Open-ended & Close-ended Questions

Open-ended questions	**Close-ended questions**
How do you think you might have been infected?	Have you ever engaged in unprotected sexual intercourse?
What are you doing now that you believe may put you at risk for HIV?	Do you have more than one sex partner?
Tell me about the last time you put yourself at risk for HIV.	The last time you engaged in sexual intercourse did you use a condom?
When do you have sex without a condom?	Do you use condoms with your main partner? Do you use condoms when you first meet someone and want to have sex?
How does alcohol influence your HIV risk?	Do you drink a lot? Have you ever had sex when you were under the influence of alcohol?
What are you currently doing to protect yourself from being infected with HIV?	Are you able to decrease the number of partners you have sex with?
How can your partner help you in reducing your risk of contracting HIV?	Do you have someone who could help you reduce your risk?
Tell me your concerns about your	Is your partner infected with HIV?

partner's HIV risk behaviours.	

Counsellors often use more open-ended than close-ended questions during their counselling sessions.

Paraphrasing

Active listening requires reflecting on what the client has said. Paraphrasing—restating the client's words in the counsellor's own words—helps achieve this objective. To paraphrase effectively, the counsellor must listen actively; the counsellor must determine what is being said and check with the client that the paraphrase is accurate. Paraphrasing in the counselling session is meant to:

- Show that the counsellor is paying attention to the client;
- Facilitate understanding;
- Validate the client's statements;
- Encourage the client to explore his or her concerns further.

Occasionally paraphrasing can be ineffective, particularly when the counsellor:

- Repeats exactly what the client said;
- Uses technical language;
- Is judgmental;
- Debates the client;
- Fails to gain the client's acceptance of the paraphrase.

Clarifying

A counsellor should always check understanding of what the client has said by seeking clarification, for example:

Are you saying that…?
Did I get you right…?
Correct me if I am wrong...

Never make assumptions in counselling, always seek clarification. Ensure that your clarifying sentence is not judgmental.

Summarising

This is a way of sifting out the less relevant material and also summing up the client's concerns or issues discussed so far. A summary is used for the following reasons:

- To check that you have understood client's story
- When changing topics
- When closing discussion or clarifying an issue or a point
- To collect thoughts when stuck
- To show the client that you have heard and acknowledge their point of view
- When linking with last session.

Use of silence

There is need to be comfortable with silence. Silence forces the client to speak and to share more. When you pose a question and the client does not respond immediately, the temptation is to simplify the question or to ask another one. The fact that the client does not answer does not necessarily mean that the question is difficult. The client might just be processing the information they feel comfortable sharing and your asking another question might actually disrupt their trend of thought. Allow the client space, then if the silence prolongs comment on the process then seek clarification e.g. *it seems you are having difficulty in answering my question. Do you want me to rephrase the question or is it too sensitive for you?"*

Widening the system

When people are in a crisis they usually forget the other people who can be there for them. Widening the system is looking for support from the given systems surrounding the person. When looking for support we usually start from within the immediate family, and then move out to the other systems. *"You have just told me that you can not talk to your husband on your own. Who then, within your immediate family (brother or sister, uncle or aunt etc) can approach your husband on your behalf?"*

Reframing

This involves taking information given by the client and giving it back to them in a different frame i.e. getting the client to view the problem from a different perspective.

The purpose of reframing is to change the meaning that an individual attaches to certain behaviours or interactions. This helps to make the situation easier to deal with e.g. *a nagging wife* is reframed as *a caring wife, or a stubborn person* is reframed as *a person seeking independence.* It is much easier to deal with a caring wife than a nagging one. Reframes are used to normalize situations that the client thinks are abnormal.

When stuck a counsellor can:

- Comment on the process
- Summarize
- Widen the system
- Take a break

SUMMARY: COUNSELLING SKILLS

- Active listening
- Relationship building
- Empathy
- Attending skills
- Questioning
- Paraphrasing
- Clarifying
- Summarizing
- Use of silence
- Widening the system
- Reframing

REMEMBER, PRACTICE MAKES PERFECT.

It is only through your willingness to put into practice the skills that have been discussed and which you have started practicing during this training that you will become more proficient in counselling and more confident within yourself.

Counselling Process

The counselling process can be divided into three stages as outlined below. The outlined stages are only a guide and there is no fixed time or number of sessions required to complete each stage. Counselling is a process whose pace is determined by the client.

The Beginning stage – helping the client to tell his/her story (problem identification)

Relationship building starts when a counsellor meets a client and it continues right through the session. The way the counsellor welcomes the client, his/her body language and even tone of voice, all assist in establishing a relationship which will determine how the client will open up to you.

Some do's that will help in establishing a relationship

- Greet the client; and shake his/her hand if appropriate.
- Offer him/her a seat.
- Ensure that there is no barrier e.g. table
- Lean forward when talking to them
- Look him/her in the face during your conversation (do not stare)
- Let your face show that you are interested and that you care.

At this stage the counsellor also:

- Establishes the reason client has come
- Allows the client to discuss the problem by describing it and locating it cause(s) and effect(s).
- Clarifies the client's expectations
- Confirms what the counsellor can and cannot do
- Assures the client of confidentiality
- Set the rules for the session e.g. duration of the session

The Middle stage – identifying problem solving options (Helping the client consider options)

- Client shares own feelings and views about the problem at hand. The meaning that the client attaches to the problem should be discussed.
- Counsellor explores the problematic behaviour patterns of the client and the belief systems that support them
- Information is provided where necessary
- Talk about behaviour change
- Plan action toward behaviour change
- Discuss available resources

The End stage – make an implementation plan (Helping the cliuent plan)

- Summarise proceedings on session

- Work on tasks for behaviour change
- Review plans on management of health or illness
- Check on support systems
- Refer client if necessary and when ready
- Assure client that your door is always open for them to come back if they want to come back.

SUMMARY: COUNSELLING PROCESS

- Beginning stage - Relationship building and helping the tell his/her story (problem identification)
- Middle stage - identifying problem solving options (consider options)
- Concluding or end stage - make an implementation plan (action plan

SESSION 7: PRE-TEST INFORMATION

LEARNING OBJECTIVES

At the end of this session, Participants should be able to:

- Define pre-test information and explain its purpose
- Discuss clients risk of HIV infection
- Ensure that any decision to take the test is fully informed and voluntary
- Prepare the client for any type of result, whether negative or positive

7.1 PRE-TEST INFORMATION

Pre-test information is simply the stage in the counselling process prior to conducting blood tests for HIV antibodies. It is aimed at providing information to the clients to help them assess their readiness to be tested. Pre-test information can be offered to an individual, couple or group of people but all people should have the opportunity to ask questions in a private setting if they request it.

Before treatment was widely available, pre-test counselling included a heavy focus on risk assessment, preparing clients to deal with an HIV-positive result, and encouraging clients to return for their results. Now that HIV rapid tests are widely use and initial results are delivered on the same day or even within the same hour, intensive pre-test counselling may not be needed, and may create barriers to service delivery. Still, clients should be given information through individual or group information sessions, and all clients should have the opportunity to speak to a counsellor about their individual risk and concerns.

Offering, recommending, or discussing HTS to a client or group of clients in any setting or HTS approach should include providing clear and concise information about:

- the benefits of HTS
- the meaning of an HIV-positive and HIV-negative test results, including need for re-testing to verify an HIV-positive diagnosis
- the services available in case of an HIV-positive diagnosis, including where ART is provided
- the potential for incorrect results if a person already on ART is tested

- a brief description of prevention options and encouragement of partner or couples testing
- an explanation that test result and information shared by client is confidential
- the client's right to refuse to be tested, and explanation that declining testing will not affect the client's access to HIV-related services or other medical care
- the potential risks of testing to the client
- an opportunity to ask the provider questions

7.2 Suggested steps *to* follow when providing pre-test information:

Introduction

- **State your name, designation and role as follows:**

["*My name is ……. I am a counsellor at this facility. My role is to discuss with you issues pertaining to HIV/AIDS in relation to your health*."]

Assure patient or client of confidentiality

["*Whatever we discuss will remain within this facility. We will also discuss sensitive issues, but feel free NOT to answer any uncomfortable questions*."]

Basic facts about HIV/AIDS

- Assess client's knowledge of HIV/AIDS
- Check understanding of HIV/AIDS
- Modes of transmission and ways in which HIV is not transmitted
- Myths about HIV transmission
- Prevention including PMTCT
- Opportunistic Infections e.g. TB, Candida infection, Herpes Zoster

Preparing for HIV Test

If the client is not ready for testing, it should be emphasized that testing is OPTIONAL but the under listed should be discussed with the client:

- Testing procedure and provision of test results
- HIV tests and possible test results
- Window period/repeat testing
- Meaning of positive, negative and Invalid results
- How client would react to any of the above results
- What result the client *maybe* expecting
- Suicidal ideation
- Advantages and disadvantages of having an HIV test
- Implications of results to self, partner and family

If client wants to test, find out how he or she feels about taking the test.

If client does **NOT**want a test, review and reschedule counselling to allow client time for a rethink about testing.

SESSION 8: POST-TEST COUNSELLING

LEARNING OBJECTIVES

At the end of this session, Participants should be able to:

- Inform clients of their test results and interpret same accurately
- Handle reactions of clients on receiving HIV test results
- Discuss ways in which clients can be empowered to engage in risk reduction behaviours
- Discuss positive living
- Refer and follow up clients appropriately

8.1 Introduction

Post-test counselling is counselling offered to give the client his/her HIV test result. The counsellor prepares the client for the result, gives the result, and then provides the client with the necessary information. Post-test counselling is usually guided by the outcome of the HIV test, which could be negative or positive. Post-test counselling gives way to ongoing support counselling.

Post-test counselling is offered:

- To reinforce and review information given during pre-test information regarding risk reduction, the meaning of test results, disclosure issues etc.
- To provide emotional, psychological and physical support to help the client cope with the results of the test, whether positive or negative.
- To enable the client discuss more on prevention issues such as how she/he is going to prevent him/herself from getting infected, infecting others and re-infecting him or herself.
- To provide referral information for treatment, care and support services.

Counsellors should give clients their test results as soon as the client is ready. Initially, counsellors may have fears about telling clients their HIV status. Giving positive test results can be difficult and uncomfortable and the counsellor may have fears that she/he may not know what to say or do, or may have an emotional reaction that will not be helpful to the client. Some of the most common fears are that clients will harm themselves or others, or that clients will leave the session and not return. These fears are valid, but will often decrease as counsellors acquire experience in giving test results

Steps to be included in every post-test session regardless of outcome of test result:

- Ensure that the client is ready to receive the results.

- Provide results simply, clearly and precisely.
- Interpret results for the client and check for understanding.
- Allow time for client's emotional response.
- Provide referral information for follow up care and support.
- Ask if the client has any questions.

8.2 Post-test counselling when the result is negative

In providing HIV negative result the following should be addressed:

Assess client's readiness to receive result
Provide HIV negative result
Review risk reduction plan
Identify support for risk reduction plan
Negotiate disclosure and partner referral
Discuss referral for prevention and other health care services

Steps in providing HIV negative result

- Provide result clearly and simply

["Your result shows that you are HIV negative, meaning that at the time of testing you were NOT found to have HIV in your body"]

Tell the client his/her result in a neutral tone.(Do not congratulate the client when result is negative)
Give time for results to sink in, and avoid asking questions or giving information
Deal with emotions that might arise.
Review meaning of result and client's understanding of the result - recap on pre test information session - "window period" in reference to most recent risk exposure
Assess how client is coping with the result and support client emotionally
Comment on the process and acknowledge challenges the client might be facing
Assess client's emotional readiness to hold further discussion on practical issues

Review risk reduction plan

Prioritise risk reduction behaviour - likely risk triggers

[What issues need to be addressed in order to reduce risk?"]

- Discuss behaviour that client is capable of changing
- Discuss steps towards changing the identified behaviour – immediately, later
- Break down the risk reduction action into concrete steps
- Discuss support or barriers to the risk reduction steps
- ***Role play*** the plan
- Confirm that plan is doable, reasonable, acceptable, and client recognizes the challenges of behaviour change

Partner referral

- Explore client's feelings about informing partner/s of negative result
- Remind client that his/her result does not indicate partner(s) status
- Support client to refer partner/s for HIV testing
- End session by providing motivation and encouragement

Discuss referral for prevention and other health care services

Clients may need referral depending on their needs which may include reproductive health choices that can be addressed in the counselling session. Depending on the circumstances, you should guide the client through:

- Refer the client for FP, STI, viral hepatitis or TB care and services if appropriate and required by the client.
- Utilized the opportune moment to encourage the client diagnosed HIV negative to donate blood
- Refer for Pre Exposure Prophylaxis based on risk assessment for Key Population

8.3 Post-test counselling when the result is positive

In giving positive results, the counsellor should focus on the following:

- Provide test results
- Deal with reactions
- Revisit sources of support
- Negotiate disclosure and partner referral
- Discuss "positive living"
- Review risk reduction plan
- Discuss referral for treatment and support

Provide HIV positive test result

- Assess client's readiness to receive result
- Provide result clearly and simply in a neutral tone.
  ["Your result shows that you are HIV positive, meaning that you have HIV in your body. This result does not mean that you have AIDS neither does it indicate when you may become ill from the virus."]
- Give time for client to absorb the information (avoid asking questions or giving information)
- Deal with emotions that might arise
- Review meaning of result and client's understanding of the result
  ["What does this result mean to you?"]
- Recap on pre-test information session i.e. difference between HIV/AIDS
- Assess how client is coping with the result and support client emotionally
- Comment on the process and acknowledge challenges of dealing with a positive result

- Assess client's emotional readiness to hold further discussion on practical issue and deal with reactions

Some Emotions That Might Need To Be Dealt With Following a positive HIV Test Result:

i) Crying
If the client breaks down and starts crying, it is important to let him/her cry. Give them space to ventilate these feelings. Offer them tissues to wipe their tears. Comment on the process eg.''This must be difficult for you….."

ii) Anger
The client might start swearing or exhibiting outbursts of anger. Remember he/she is not angry at you. Therefore stay calm and give him/her space to express feelings but make it clear, that verbal abuse or physical violence is not acceptable . Acknowledge that his or her feelings are normal and let him or her talk about what it is that is making them angry.
iii) No response
This could be due to shock, denial or a sense of helplessness. Check that the patient understands the result. Ask the patient what it is that they understood you to have said about the test result.

iv) Denial
This could be verbal or non-verbal. It is important to remember that denial is a normal reaction especially when one is faced with a potentially painful reality. Therefore the health care worker should acknowledge the patient's difficulty in accepting the information. However, if denial persists it becomes maladaptive, as it gets in the way of the patient's ability to deal realistically with his/her situation, be it in terms of prevention or accessing treatment, care and support services.

Revisit sources of support

- Who would the client inform about his/her positive HIV result: immediately, other persons to disclose to, disclosure to partner] – why, when, where, how?
- Expected reactions and management of reaction
- Expected support from persons to whom the client will disclose
- Who will help client cope with implications of the result and provide support and plan for the future.
- Identify current health care resources and where client can go for medical attention
- Explore client's access to routine medical care including STI care, TB evaluation and preventive therapy, family planning and PMTCT services
- Discuss and address obstacles to accessing health care
- Discuss the need for health care providers to know client's HIV status
- Discuss options of support groups
- Provide appropriate referrals and explore possible obstacles.

Negotiate disclosure and partner referral

- Recap on client's feelings about telling partner(s) about HIV positive status
- Remind client that their result does not indicate partner(s) status
- Recap on possible approaches to disclosure of sero-status to partner(s); potential partner reactions and management of reactions
- Support client to encourage partner to be tested
- Explore possibility of discordant results and how they will handle this
- ***Role play*** different approaches to disclosure

Discuss positive living

- Discuss positive living – Adequate diet, medical care; family planning; STI screening and treatment; TB preventive treatment; exercise and rest; support and sense of optimism, avoiding further re-infection, taking hard drugs, alcohol and smoking;
  ["Positive living means taking care of your health and your emotional well-being in order to enhance your life and stay well longer"]

Review risk reduction plan

- Discuss plan to reduce risk of transmission to current partner(s)
- Discuss plan to reduce risk of transmission to future partner(s)
- Discuss disclosure to future partner(s)
- Emphasise importance of disclosure to current **AND** future partner(s)
- Encourage client to come back for supportive counsellin

Discuss referral for treatment and support

Clients may need referral depending on their needs either for treatment or other care and support services and these can be addressed in the counselling session. Depending on the circumstances, you should guide the client through:

- Treatment options and management of opportunistic infections
- Referral to support groups
- Making decision about fertility if pregnancy is desired at this point in time or not?
- If a pregnancy is not desired, give information about the variety of contraceptive methods available and the client should decide what to do about HIV/STI prevention. Refer the client for FP services if appropriate and required by the client.
- Refer for Pre Exposure Prophylaxis for discordant couples
- Explore possible obstacles that may hinder client from accessing the support services

On-going Counselling

On-going HIV/AIDS counselling is a continuation of post-test counselling mainly to support those that are HIV positive and high risk negative clients.

The aims of on-going HIV/AIDS counselling are to:

- Help clients to cope with HIV and encourage positive living
- Consolidate future risk reduction plan
- Help clients deal with HIV related problems.

Issues/problems addressed in on-going HIV/AIDS counselling include:

- Psychosocial adjustment
- Preventive counselling
- Positive living
- Bereavement counselling
- Spiritual and other support

8.4 REFERRAL TO CARE AND SUPPORT SERVICES

Definition:

Referral is the process by which immediate client needs for care and supportive services are assessed and prioritized and clients are provided with assistance (e.g. setting up appointments) in accessing services.

Referral should also include follow-up efforts necessary to facilitate initial contact with care and support service providers and to ensure continuous feedback both from them and the client.

The number of people and families living with HIV/AIDS who need care and support services is increasing and this poses challenges to healthcare and community systems coping and responding capacity. As such counsellors should bear in mind that:

- Demand for care and support at institutional, community and family levels will continue to increase
- Counsellors must be aware of the limitations of the services they can offer.
- These limitations should be clearly explained to clients so that they do not feel rejected when counsellors make a referral.
- Counsellor can refer clients during the pre-test stage or the post-test session.

Counsellors should refer their clients to services that are responsive to their priority needs (using the referral forms) and that are appropriate to a client's culture, language, gender, sexual orientation, age and developmental level

Referral services should respond to clients' needs and priorities, and appropriate to their culture, language, sex, sexual orientation, age, and developmental level.

The needs of people living with HIV/AIDS can be categorized into: medical, psychological, socioeconomic, human rights and legal needs.

- When people infected with HIV progress into recurrent illnesses, the type of services they need will change.
- It is this provision of comprehensive care across a continuum – from home and community to institutional services – that will ensure that the specific needs of clients and their families are met.

The HTS centre cannot provide all of these needs. Linkages have to be established with resources where PLWHA have to be referred for further help.

Such resources include: appropriate diagnosis, treatment and prevention of tuberculosis and other opportunistic infections, ARV therapy and palliative therapies.

Others include: HTS, legal, welfare and spiritual support services within communities, peer support groups, PMTCT and family planning units.
The rest are: government agencies, non-governmental and religious organizations, community groups and services and home care programmes. OVC could also benefit from such services
It is important to:
Work with clients to decide what their immediate referral needs may be.

- Outline the various health and social service options available and help the client to choose the most suitable, in terms of distance, cost,client's culture, language, gender, sexual orientation, age and developmental level.
- In consultation with the client, assess what factors may make it difficult for the client to complete the referral (e.g. lack of transportation or childcare, work schedule, cost) and address them.
- Inform the client of the possible need to move from anonymity to confidentiality, depending on the type of referral indicated.

Make a note of the referral in the client's file. Ensure follow-up and monitor the referral process.
Give the client a list of other services with addresses, telephone numbers and hours of operation.
Ask the client to give feedback on the quality of services to which he or she is referred.
Be aware of community support groups located near the counselling site, services offered, hours of operation, and contact persons.
In certain cases it may be more appropriate to refer clients to a member of their family, a friend or a sexual partner.

Key messages
Referrals should be:

- Clear, specific and up-to-date information on the resource the client is being referred to
- Confidentiality
- Safe and easy accessibility to the resource
- Provision of several options to the client
- Creation of a system for clear communication between the counsellor and the services to which clients are referred
- Absence of discriminatory practices by service providers
- Documentation of referral and feedback

Identifying referral links

- Most development partners have a list of HIV service providers in each state.
- Information could also be obtained from:
- State Agency for the Control of AIDS (SACA)
- Network of NGOs working on HIV/AIDS (e.g. CiSHAN).
- Blood Safety organisations

SESSION 9: PARTNER NOTIFICATION SERVICES

LEARNING OBJECTIVES

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

- Understand what is PNS
- Itemize the benefits of PNS
- Explain PNS approaches
- List possible options

9.1 Definition of Partner Notification Services (PNS)

also known as disclosure or contact tracing; is defined as a voluntary process whereby a trained provider asks people diagnosed with HIV about their sexual partners and/or drug injecting partners, and then, if the HIV-positive client agrees, offers these partner(s) HTS. Partner notification is provided using passive or assisted approaches. (WHO 2016)

9.2 Partner Notification Services

Partner Notification Services (PNS) is sometimes referred to as index client testing, index case testing, or contact tracing. This process can be initiated in HTS settings for clients who are newly diagnosed, or in HIV care and treatment settings for clients who are already on ART. Then, with the consent of the HIV-positive index client, providers notify these partners of their potential HIV exposure and offer voluntary HTS. PNS is provided using passive or assisted approaches as outlined below:

Passive partner notification: the HIV-positive index client discloses their status to the partner, and encourages the partner to seek HTS. Providers should support HIV-positive index clients by discussing the benefits and challenges of notifying their partner(s) with this approach, identifying appropriate strategies for notifying their partner(s) with this approach, and following up to confirm whether disclosure has happened and the partner(s) has been tested.

Assisted partner notification: the provider offers to assist the HIV-positive index client with partner notification, which can increase uptake of HIV testing among partners of HIV-positive index clients, and lead to high proportions of HIV-positive people diagnosed and linked to follow-up services. Assisted partner notification services include provider, contract, and dual referral approaches:

Provider referral: using this approach, a trained PNS provider contacts the listed partners of HIV-positive index clients with their consent. They inform the partners that they may have been exposed to HIV and offer them voluntary HTS. This is done with the consent of the HIV-positive index client. The identity of the HIV-positive index client is not disclosed to the partner(s), and the partner(s) HIV test results are not shared with the HIV-positive index client, unless both partners consent to share their results together.

Contract referral: using this approach, the HIV-positive index client enters into a contract with a trained PNS provider, whereby he or she agrees to disclose their HIV status to their partner(s) within a certain time frame (i.e. 2-4 weeks) and refer their partners to HTS. If the partner(s) do not access HTS or contact the healthcare provider within that time period, then the provider gets the consent of the HIV-positive index client to reach out to the partner(s) directly and offer voluntary HTS.

Dual referral: using this approach, a trained provider accompanies and provides support to HIV-positive index clients when they disclose their status and the potential exposure to HIV infection to their partner(s). The provider also offers voluntary HTS to the partner(s). This can be done at the health facility or in the client's home.

Some HIV-positive index clients may not be comfortable with any of the approaches listed above, and so providers may also offer to bring HTS to the community or neighbourhood around where the partner(s) live. In this way, HTS can be offered to multiple households with the aim of also reaching the partner(s) and helping them know their HIV status.

PNS should be provided for any partner of an HIV-positive index client who may have been exposed to HIV and who may be at risk. This includes both married and casual partners, and may include multiple partners. Providers should work with HIV-positive index clients to identify all partners who may be at risk, and to determine the method of notification that will work best.

PNS is not a one-time event. PNS should be offered

- Introduced during pre-test information
- reinforced after HIV diagnosis;
- Routinely as part of HIV treatment services; and,
- Any time the HIV-positive index client has a change in their relationship status.

If a partner tests HIV-positive, then they also become an index client, and PNS should be offered for all their partners at risk.

Reports of social harm or other adverse events following voluntary PNS are rare, but programs should monitor PNS delivery to ensure services are offered respectfully and safely by trained providers. Providers should screen each partner for the risk of intimate partner violence (IPV), and together with the index client determine if PNS can be delivered safely to each partner. Providers should report any incidents of violence or other harms to a supervisor for follow-up, and refer clients reporting harm to counselling or other IPV support services, as indicated. Index clients should always be counselled about the benefits and risks of PNS so that they can make safe and informed choices together with the provider.

HIV-positive clients should be offered multiple options for PNS, and the approach selected should be based on client preferences. Clients should also be given the opportunity to decline. Index clients may wish to notify their partners using different

approaches; for example, an index client may wish to contact one partner using the client referral approach, and another partner using the provider referral approach.

PNS should always be voluntary; mandatory or coercive approaches to PNS are not justified. Criminal justice, law enforcement, or other non-health-related service providers should not be involved in PNS, especially in instances where the behaviours of KPs are criminalized.

Both the confidentiality of the index client and all named partners and children should be maintained at all times. The identity of the index client should not be revealed and no information about partners should be conveyed back to the index client (unless explicit consent from all parties is obtained).

Voluntary, assisted PNS should be offered to all PLHIV as part of a comprehensive package of services. This includes both newly diagnosed HIV-positive clients, and PLHIV already in care or receiving ART.

9.3 Social Network Testing

Social Network Testing (SNT) is when HIV-positive and/or high-risk HIV-negative persons—particularly from key populations—are enlisted as ***recruiters*** to identify individuals from their social, sexual, and drug using networks (***networkassociates***) for HTS. PLHIV can be engaged as recruiters immediately after diagnosis, or any time after they become engaged in HIV care and are on treatment. KP can be engaged as recruiters during HTS, or by programs providing other prevention services for these populations. Once a network associate tests HIV-positive (or if he/she is identified as KP), then he/she can be engaged as a recruit their network associates.

Recruiters may be given vouchers, coupons or invitation letters to distribute to their network associates. They may be given a concrete number of coupons (i.e. 3-5) or they may be engaged to continue distributing coupons as long as they are able to refer high-risk persons for testing that result in new HIV diagnoses. Recruiters may be given a modest incentive for each coupon they distribute that result in a network associate getting tested for HIV, or they may be given a stipend for the period of their engagement as a recruiter. Additionally, the network associates may also be incentivized to come in for HIV testing. Formative work should be done with the target populations to determine appropriate incentive levels. There is some risk of network associates repeatedly testing in order to get incentives, but programs should monitor this outcome and make every attempt to discourage unnecessary repeat testing.

Programs implementing social network testing should ensure that the right people are being engaged as recruiters – all PLHIV and key populations will not make good recruiters. Programs should look for someone with a vast social/sexual/drug using network who is willing to talk with their peers about HTS and refer them for testing. Recruiters should be knowledgeable about HTS and where testing is available.
HIV self-testing may also be integrated with social network testing—rather than distributing coupons for testing, recruiters may distribute HIV self-test kits, and may be given a modest incentive for each network associate who tests positive and

comes into the site for linkage to HIV care and treatment, or for each HIV-negative network associate who comes in for linkage to HIV prevention services.

9.4 HIV Self-testing

HIV self-testing (HIVST) refers to a process in which a person collects his or her own specimen (oral fluid or blood) and then performs an HIV test and interprets the result, often in a private setting, either alone or with someone he or she trusts. As with all approaches to HTS, HIVST should always be voluntary, not coercive or mandatory. Although reported misuse and social harm are rare, efforts to prevent, monitor, and further mitigate related risks are essential.

A reactive (HIV-positive) HIVST result always requires further testing and confirmation from a trained tester starting from the beginning of a validated national testing algorithm. Clear messages are essential to ensure users understand that HIVST does not provide a definitive HIV-positive diagnosis, and they are aware of what to do after a reactive self-test result.

Interpretation of a non-reactive (negative) self-test result will depend on the ongoing risk of HIV exposure. Individuals at high ongoing risk, or who test within six weeks of possible HIV exposure, should be encouraged to retest. HIVST is not recommended for users with a known HIV status who are taking antiretroviral drugs, as this may lead to an incorrect self-test result (false non-reactive).

HIVST is acceptable to many users across different contexts and can, therefore, increase uptake and frequency of HIV testing, particularly among populations at high ongoing risk of HIV, who may be less likely to access testing or test less frequently than recommended.

HIV rapid diagnostic tests (RDTs) used by self-testers can perform as accurately as when used by a trained tester, provided the HIVST products meet quality, safety and performance standards. In-person demonstrations and other support tools, such as videos, may also enhance the performance of HIVST.

HIVST can be delivered through various approaches in the public and private sectors, including community-based, facility-based, and internet-based channels. HIVST may be done by an individual alone (unassisted) or with the assistance of a trained provider (assisted). Approaches may also offer the option of using an oral fluid or blood-based HIV RDT for self-testing. As such, different populations can benefit from a range of choices when self-testing for HIV.

HIV self-testing offers opportunities to increase knowledge of HIV status and access to HIV prevention, treatment, care, and support services, and so can be offered as an additional approach to HTS.

SESSION 10: REFERRAL AND LINKAGES

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Objectives:

By the end of this session, participants should be able to:

- Understand concepts of Referrals and Linkages
- Enumerate services available for client referral
- Examine referral outcomes
- Discuss expected outcomes following referral
- Discuss interaction between referrals and linkages

10.1 INTRODUCTION

Current antiretroviral therapy (ART) guidelines reflect a growing consensus that the early initiation of treatment for HIV is associated with clinical benefits/outcome. Also, early HIV diagnosis has the potential to facilitate entry into stable care systems, optimize clinical outcomes and improve health care planning capabilities. (WHO Consolidated 2015 ART guidelines)

10.2 Concepts

Network – Set of connections, system, set-up

Referral – Transfer, recommendation, shift

Linkage – Connect, Bond, bring together

10.3 What is Referral?

The process of initiation of contact or linking a client with other relevant services. This involves providing them with the names of service providers/facility, or a particular service outlet, so they are able/allowed to make a choice. In the context of counselling and testing, Referral is the process by which immediate client needs for prevention, care and support services are assessed and prioritized and clients provided with assistance (e.g., setting up appointments, providing transportation) to access these services.

Referral also include the basic follow-up efforts necessary to facilitate initial contact with care and support service providers.

- **Types of HIV/AIDS Referral Services**

- Individual counselling
- Family/couple counselling
- ART,TB
- Adherence counselling
- Nutrition counselling
- Psychological services
- Support groups
- Consultation to schools, agencies and other providers
- Other specialized services for PLHIV

- **Assessing Clients' Needs for Referral**

- Factors likely to influence a client's ability to adopt or sustain behavior.
- Examination of the client's willingness and ability to accept and complete a referral.
- Service referrals that match the client's self-identified priority needs are most likely to be successfully completed.
- Clients are referred to either clinical or community support groups, depending on the needs of the client and on the client's responsiveness to counselling

- **Reasons for Referral**

- Complex needs that affect their ability to adopt and sustain behaviors
- Medical evaluation, care and treatment
- HIV-positive pregnant women – PMTCT Services
- Those addicted to drugs and/or alcohol
- Those with mental illnesses, developmental disabilities or difficulty coping with an HIV diagnosis or HIV-related illnesses
- Clients who need legal services to prevent discrimination in employment, housing or public accommodation
- Assistance with housing, food, employment, transportation, childcare and domestic violence

10.4 Referral Process

- Formal written referral is preferred to assist with prioritizing caseload
- Self-referrals are entertained as patient call the facility and state that they have been referred for a medical opinion
- Referral forms should include a brief history with relevant medical/social factors

- **Making a Successful Referral**

- Work with clients to decide what their immediate referral needs may be.
- Outline the various health and social service options available and help the client to choose the most suitable, in terms of distance, cost,client's culture, language, gender, sexual orientation, age and developmental level.
- In consultation with the client, assess what factors may make it difficult for the client to complete the referral (e.g. lack of transportation or childcare, work schedule, cost) and address them.
- Inform the client of the possible need to move from anonymity to confidentiality, depending on the type of referral indicated.
- Noting referral in the client's file.
- Monitoring of the referral process.
- Client given a list of services with addresses, telephone numbers and hours of operation.
- Clients asked to give feedback on the quality of services to which he or she is referred.
- Noting community support groups located near the counselling site, services offered, hours of operation, and contact persons.

- **Basic Elements of a Good Referral**

- Clear, specific and up-to-date information
- Confidentiality
- Safe and easy accessibility
- Provision of several options to the client
- Creation of a system for clear communication between the service provider and the services to which clients are referred
- Absence of discriminatory practices by service providers
- Documentation of referral and follow-up
- Maintain a good referral directory

- **Challenges in HTS Referrals**

- Co-ordination of referrals
- Distance from care and support services
- Quality of services
- Identifying the referral sites
- Accessibility to referral coordinators.
- Feedback from sites
- Financial limitations

10.5 LINKAGES

Linkages refer to all steps providers take to ensure that connection is made with a desired service. Linkages differ from referrals because linkages require providers to take whatever steps are necessary to ensure that clients access needed services. This involves contacting a referral source for a client to ensure that connection is made with a desired service.

- **Importance of Linkages**

- Enables patients/providers to achieve much more together than facing challenges as a lone body
- Pathway that enables service providers to share responsibilities
- Skills and knowledge are effectively utilized in supporting one another
- Network of relationships is established to help overcome the challenges of clients in accessing HIV/AIDS services
- Reduces burn-out for care providers
- Ensures continuity of care for patients/clients
- Effective management of resources
- Adequate experience sharing
- Enhances capacity building
- Creates appropriate channels of communication with other organizations and groups
- Puts in place an effective referral system

- **Types of Linkages**

- Intra and Extra Facility- based (private & public)
- Community support structures such as support groups, Faith- based organizations (FBO), NGOs, CBOs volunteer workers, etc
- Social workers, legal persons/groups
- Community gatekeepers, family members & friends

- **Linkage Barriers**

- Inadequate knowledge of operating environment/available services
- Hoarding of information
- Unwillingness to share and learn
- Fear of adopting new ideas
- Mistrust
- Lack of spirit of team work

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- **Effective Linkaging**

Smooth and effective linkage is achieved through:

- Clear division of labour and understanding of roles and responsibilities
- Knowledge and skills have to be sound
- Communication must be effective
- Team work and respect for all members
- Regular meetings to share information
- Proper identification of cases to be referred

Summary

- Referral enables patients to access other services for better, easier or continuum of care
- Various HIV/AIDS services should be adequately utilized for effective service delivery
- Appropriate linkages need to be established to facilitate referral for clients
- Formal written document is preferred when patients are referred for other services

MODULE 3 CARE AND SUPPORT

SESSION 1: POSITIVE LIVING

LEARNING OBJECTIVE

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

- Explain positive living
- List and discuss positive living strategies
- Empower clients with knowledge and skills to live positively with HIV/AIDS

1.1 Introduction to Positive living

Positive living is a concept in which a person develops a positive outlook towards his/her life and that of others following knowledge of their HIV sero-status. It entails adopting practices and lifestyles that are aimed at reducing the transmission of HIV and improving quality of life.

"No-one has ever said 'yes' to AIDS. No one has asked for it. Most of us who have it now had never even heard of it when we caught it. You cannot attach blame or assign guilt to anyone. It doesn't matter who was responsible – the husband or the wife or the blood transfusion. The important thing is to think and live positively."

The above quote sums up the positive attitude that counsellors need to promote in their contact with people living with HIV/AIDS:

- Accept themselves
- Avoid blame
- Avoid negative ideas such as giving up hope, attempting suicide etc

Note:

- Refer to people who are HIV-positive as 'clients' or 'people living with HIV', never as 'AIDS victims' or 'AIDS sufferers'
- Only use the term 'patient ' if a person has been admitted to hospital

1.2 Strategies for positive living

Whilst there might be no cure for AIDS, there is much that people who are HIV-positive can do to live long and healthy. Positive living involves change in both the way people behave and the way they think. It demands embracing those things, which are beneficial to their wellbeing and avoiding those things, which are detrimental to their health and wellbeing. The following are elements that contribute to living positively with HIV, which counsellors can communicate to their clients:

-Knowledge about HIV

People living with HIV/AIDS should learn whatever they can about HIV infection and correct any misconceptions they may have. They also need to keep expanding their

knowledge, and share it with others. Accurate information can help to overcome people's fears and worries.

-Acceptance

Upon discovering that they are HIV positive, many people go through a period of denial. To gain peace of mind, they need to accept their situation, without assigning blame or guilt. **Acceptance is not the same as inertia or resignation.** It involves telling others about their status so as to gain their support and understanding. It also allows the individual learn how best to take care of themselves.

-Positive attitude

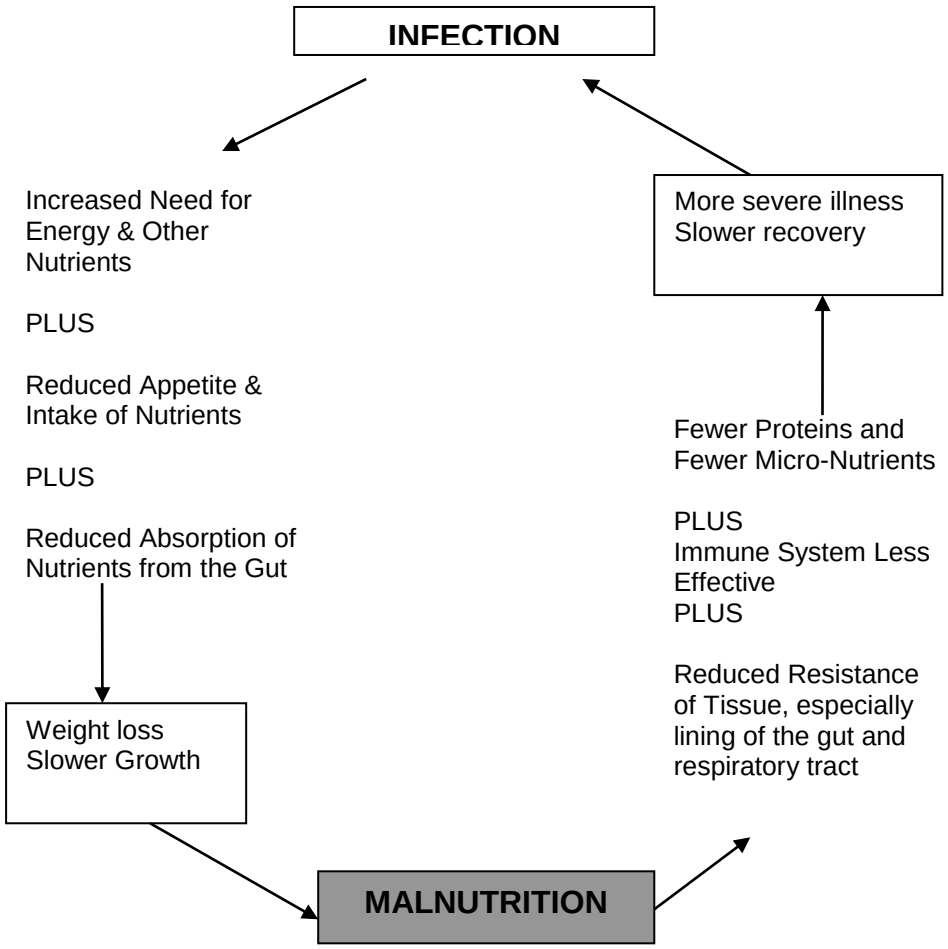
There is a recognised link between the mind and the body. With a positive attitude, PLHIV can fight the disease better. It involves a determination to live and to continue contributing to their family and community life, as much as possible.

-Risk behaviour

Living positively involves looking after oneself, but also looking after others. It is important to avoid risky behaviour. PLHIV should not be careless about sex and their partners. To avoid infecting others, they should practice safer sex – abstinence, faithfulness to one partner, consistent and correct condom use. PLHIV can also be re-infected if they have intercourse with a sero-positive partner without taking precautions and this will increase their viral load and other complications. .

1.3 Nutrition

Adequate nutrition enhances the immune system because most oftheimmunefactorsareproteininnature.Strengtheningthe immunesystemthroughimprovednutritionthereforehelpsreducetheincidenceofinfections,preventsweightlossandloss ofleanbodymass.Awell-nourishedpersonhasastrongerimmunesystemtofightinfectionsandcopewithHIVand AIDS (Figure ….).



CYCLE OF HIV INFECTION & MALNUTRITION

1. Malnutrition makes the body more susceptible to infections and diseases, e.g. HIV and AIDS, because it weakens the immune system. A weakened immune system makes the body more susceptible to infections and diseases, HIV and AIDS inclusive, thereby leading to malnutrition.

2. However, persons living with HIV are more susceptible to malnutrition through mechanisms that are not related to inadequate food intake

3. Poor nutrition makes PLHIV more prone to opportunistic infections.

To understand the principles of healthy eating, it is important to learn about the various Food groups and the macronutrients they provide. Food can be divided into four different food groups.

Macronutrients and their food sources

CARBOHYDRATES **Energy-giving**	**FATS** **Energy-giving**
Cereals:(Grains)-maize,sorghum, wheat , millet, rice, **Roots and Tubers:** Potato, Sweet Potato Cassava, Yam **Sugary Foods-** sugar, jam, sweets cake,	**Vegetable fat sources** Red palm oil, groundnut oil, etc margarine **Animal fat sources :** Butter, lard (fat from meat) Fatty meat and fish Nuts & seeds *Eating too much fats can cause digestive problems
PROTEINS **Body-building & repairing**	**VITAMINS AND MINERALS** **Body-protecting**
Vegetable Protein sources: Legumes- beans, soya beans, peas, Groundnut, beniseeds Bambara groundnuts, melon seeds, etc **Animal Proteinsources:** Meat, Fish, Milk, Eggs Crayfish, edible insects, etc *Animal food products like meat, milk and eggs provide a range of essential amino acids, which meet the body's needs. A good mix of cereals and vegetable protein sources also provides the full range. Therefore cereals and legumes should be combined*	**Vegetables**: green leaves, cabbage, pumpkin, tomato, squash, green beans, peas, avocado, carrot **Fruits:** mango, orange, guava, banana, pineapple, apple, paw-paw, lemon. *There are at least 17 different vitamins and 14 minerals. Each has a special role in the body and the body cannot work properly if anyone is missing. Each of the vegetables or fruits is rich only in a few vitamins or minerals, so it is important to eat a variety. Orange and fruits are best.*

An adequate diet requires a mixture of carbohydrates, fats, proteins, vitamins and minerals. No single food contains every nutrient. A healthy meal is made up of at least one food item from each of the four food groups**.**

Food Safety and Hygiene

People living with HIV are more vulnerable to infections because of their lowered immunity. It is important therefore to avoid infections caused by viruses and bacteria in contaminated food and water.

.**Water**

- Use clean water from protected sources, but if the source is unprotected, boil the water before consumption. Allow the water to boil for 10 minutes before using it for making pap or drinks.
- Keep the boiled water in a clean container and cover with a lid.
- Do not dip hands or cups into the container. You can store the water in a bucket with tap or use a clean cup with long handle. Alternatively you can pour out the water directly from the water container.

- Always wash your hands with soap or ash and water after:
  - ✓ touching pets or livestock;
  - ✓ visiting the toilet;
  - ✓ changing baby's nappy;
  - ✓ touching soil (compost) potted or garden plants

Animal products

- Keep meat, poultry and fish separate from other foods, to avoid contamination with bacteria and disease-causing agents
- Cook all animal foods thoroughly
- Do not eat half-cooked meat, egg, fish, or foods containing raw eggs. Eggs should be hard-boiled
- Thoroughly wash hands and all utensils and surfaces that have touched uncooked foods, particularly meats, before handling other foods

Fruits and vegetables

- Use safe water to wash all fruits and vegetables to be eaten raw thoroughly to avoid contamination.
- If it is not possible to wash fruits, peel off the skin to avoid contamination.
- Remove bruised parts of fruits and vegetables.
- Do not eat mouldy fruits and vegetables.
- Boil vegetables thoroughly but do not overcook to avoid loss of nutrients

General hygiene

- Always keep toilets/latrines clean and free from flies
- Keep the surroundings clean (including food preparation areas and latrines)
- Always wash hands with clean water and soap or ash after visiting the toilet/latrines
- Cover all wounds to prevent contamination of food during preparation and handling
- Wash clothes, beddings and surfaces that might have been contaminated with faeces in hot water and soap
- Wash clothes, beddings and surfaces contaminated with blood and blood products in hot water to which bleach has been added. Allow to soak for at least 10 minutes before washing

1.4 Alcohol, drugs and smoking

PLHIV should consider reducing or stopping their consumption of alcohol, cigarettes and other drugs. These substances impair immunity and may quicken disease progression. Equally, when under the influence of alcohol or drugs judgement is impaired, people can find themselves more vulnerable to engaging in risky behaviour.AdditionallySmoking suppresses appetite, which leads to reduced food intake that affects many nutritional processes and Alcohol consumption interferes with adequate food intake by reducing appetite Therefore, it is recommended that smoking and alcohol should be avoided.

1.5 Medical care

With a weakened immune system, PLHIV are particularly susceptible to opportunistic infections. These are infections that in a person without HIV would not necessarily lead to illness, but with PLHIV are likely to do so. Prompt medical treatment should always be sought, and medication regimes properly adhered to.

1.6 Rest, exercise and work

PLHIV need to ensure that they take adequate rest and avoid strenuous labour which puts a strain on their body. This might require seeking employment which is less physically demanding. However, gentle exercise can improve the body's general well-being and the immune system in particular. It can also be good for the mind. Staying mentally and physically active helps prevent depression and anxiety. PLHIV should continue to work and to maintain their daily routine for as long as they feel strong enough to do so.

-Stress

Stress affects the body's ability to cope with illness. As far as possible, it is of benefit to PLHIV to try to avoid the situations or resolve the issues in their lives which worry or trouble them and can lead to stress.

-Social support

PLHIV need to be open to the help that is offered to them by their family, friends and community. They need also to make the most of the formal supports available, which might be professional ongoing counseling or home-based care services. Many PLHIV have found that participation in a support group helps to reduce their sense of isolation and stigma. It allows them to share their experiences, ideas and information, and many individuals talk of how a support group has given them confidence to speak openly about their condition.

Summary is important for PLHIV to observe and understand their health and disposition, and to be aware of their needs and of what they can continue to bring to their family and community

SESSION 2: INTRODUCTION TO ANTIRETROVIRAL THERAPY (ART)

LEARNING OBJECTIVES

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

- To understand the process of viral replication and the action of ART
- To identify factors that can affect adherence to antiretroviral regimens

2.1 Introduction:

Evidence from various clinical trials demonstrates that ART reduces HIV and AIDS-related morbidity and mortality. With increasing opportunities for the access to ART through the national and international response to the needs of PLHIV, more Nigerians can now benefit from rational use of ART. ART should only be prescribed and monitored by trained professionals because, in spite of immense benefits improper use is inherent with dangers for the individual, the country and the entire world.

2.2 Uses of ART

- Treatment of HIV disease
- Prevention of mother-to-child-transmission (PMTCT)
- Post exposure prophylaxis for health care workers and other groups of people as indicated(e.g. victims of rape)
- Pre-exposure prophylaxis (e.g. Discordant couples, key population)

2.3 Benefits of ART

- Decreasing viral load
- Increasing CD4+ counts
- Decreasing the incidence of opportunistic infections
- Preventing disease progression
- Prolonging survival
- Improving quality of life

SESSION 3: ADHERENCE COUNSELING

LEARNING OBJECTIVES

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

- Discuss ARV adherence
- Define adherence counselling
- Identify and discuss barriers to adherence
- Identify who should receive adherence counselling

3.1 Overview of Adherence:

Treatment with antiretroviral drugs (ARV) succeeds only when clients adhere strictly to the prescribed treatment regimen. Poor adherence leads to treatment failure and development of drug resistance, a situation in which the Human Immunodeficiency virus (HIV) is no longer controllable using that particular ARV regimen.

For optimal treatment response more than 95% of the ARV doses need to be taken, if the client adherence falls below 95% the chances of treatment failure becomes very high. One way of measuring adherence is to express the number of doses of ARVs taken as against the number of doses prescribed. If a client is prescribed 20 doses but takes 19 doses (missing one dose in one week), the adherence is 95%. .

Counsellors should remember that referrals for ART are part of HTS services. If a person comes to a counseling session requesting information on ARV drugs, then the counsellor should provide him/her with adherence counseling and refer him/her to a centre that provides treatment care and support.

3.2 Definition of Adherence Counseling:

Adherence is defined as the degree to which a client follows a treatment regimen, which has been designed through a consultative partnership between the client and the health care worker/counselor. Adherence counseling is a process which encourages the engagement and active participation of a client in the plan of care and provides opportunity for discussion about the various factors in the client's life that will influence the ability to exactly follow the treatment.

3.3 COMMON BARRIERS TO ADHERENCE :

Counsellors should be aware and work with clients to address the factors that may be responsible or contribute to client's non-adherence to ART, some of which include:

-Stigma: HIV infection in adults is mostly sexually transmitted and infected persons are often branded as promiscuous. The stigma resulting from this branding hinders them from disclosing their sero- status. If such an individual is on ART he or she will not take the drugs in public and will find it almost impossible to adhere to the

prescribed treatment regimen. Stigma also prevents people from seeking information about ART, attending recognized HIV/AIDS health centers, because they are afraid to be identified as clients.

-Guilt: If multiple family members are infected, but the family can only afford ART- for one person, that individual may feel guilty for taking the medicine. This guilt may cause the individual to skip treatments or share treatment with other family members.

-Blame: If a family judges or blames an individual for contracting HIV, that individual may be less likely to adhere to ART.

-Fear: Fear is a common and real concern for clients taking ARV drugs. Fear manifests itself in several ways: fear of side effects, fear of costs, and fear that treatment won't work.

-Ignorance: People still lack proper information about ART, and this can lead to inconsistency in taking them. It must be emphasized that the drugs must be taken for life.

-Negative Outlook: Some people believe that since ART is not a cure for HIV/AIDS, there is no point in taking the drugs.

-Lack of communication skills: People fail to disclose to their spouses, children, or their employers that they are taking ARV drugs. People that are close to the individual need to understand the disease and therapy regimen, in order for them to provide support to the individual.

-Lack of proper counseling: It is absolutely necessary for an individual taking ARV drugs to receive counseling before and during the treatment regimen. Without counseling, individuals are more likely to give up on ART and cause themselves harm.

-Reduced availability of ART in the rural settings: Although ART have become widely available, it is not universally available throughout Nigeria; generally they are more available in urban areas. The limited availability limits an individual's access to ART and may lead to inconsistent usage.

-Discrimination and Gender issues: In households with limited resources, infected males in the family may be given priority over the females.

-Religious beliefs: In some belief systems, clients may opt to stop taking ART based on religious teachings and beliefs.

-Violation of Human Rights: This occurs when children, who are infected with HIV and are eligible to receive ARV treatment, are not made aware of their condition when they have reached the age for disclosure:

- It is often due to lack of communication skills by the parents or caregivers to disclose the nature of the illness to the child

- Also, there is often failure on the part of the health workers to devise means of early disclosure. The child may ask "Why am I taking drugs?"

3.4 Drug side effects and frequency of dosage

-Side Effects and Adherence

Fear of adverse effects of medications can affect client willingness to initiate or to continue treatment. Adverse effects of medications can negatively affect adherence. Some persons will self-discontinue medications, some will selectively discontinue some medications, some will drop out of care. Side effects can negatively impact doctor-client relationship and suboptimal adherence is associated with treatment failure, emergence of drug resistance, and disease progression

-Side Effects: Counseling Interventions

Counsel clients about treatment options and appreciate aversion to side effects. Encourage clients to review possible side effects with their doctor prior to selecting treatment, Anticipate and treat side effects; develop a strategy to help the client address the side effect with his/her doctor (using non-judgmental communication) before starting a new regimen, Assess adherence and side effects at every visit,

3.5 Who should receive Adherence Counseling for ART?

Adherence counseling should ideally, be offered to all people who are receiving ART. However, due to the stigma surrounding HIV/AIDS, some people find it difficult to readily avail themselves of these services. The counsellors, other medical team members, and caregivers should do everything possible to encourage people with HIV/AIDS to seek counseling. People who should receive adherence counseling include:

- Pre-ART clients (persons living with HIV who are yet to be commenced on treatment)
- Any adult on ART
- A child aged 12 years and above receiving ART. The parents/guardians of such a child must also be appropriately counselled. The child may be individually or jointly counselled. (Children under 12 years of age should be counseled with their parents/guardians. In situations where a child does not have a parent or a guardian, the child can choose another individual to participate in joint counseling. This choice must be accepted by the team).
- Any person who is aware of his/her HIV situation and wants to start ART.
- Family members, as necessary. The client and the counsellor work together to identify those family members.
- People who have been exposed to HIV infections at work, on defilement, or as a result of rape.
- Couples who seek counseling during Prevention of Mother to Child Transmission (PMTCT) and other occasions, as necessary.

When should adherence counseling for ART be carried out?

- ***During Pre-test counseling/Information giving*****:** As part of the provisional action plan towards treatment, it would be very helpful for the counsellor to

give required information about ART. The counsellor must first identify the client's knowledge about ART, and then fill in the gaps or clarify some misconceptions.

- ***During HIV post-test counseling*:** At this point, ARV adherence counseling would be ideal specifically if the individual is considering taking ART.

- ***Before commencing ART*:** Intensive ARV adherence counseling should be given prior to ART. Adherence counselling should be continued throughout the duration of ART

SESSION 4 HOME-BASED CARE

Objectives:

By the end of this session, participants should be able to:
•To understand the background and scope of home-based care as a methodology in the management of HIV/AIDS
•To understand the objectives of home-based care
•To understand the special counselling requirements in the spectrum of home-based care services
•To understand the outcomes of home-based care in our society

4.1 Introduction

The magnitude and nature of the HIV/AIDS epidemic has made health-care providers, governments and international agencies consider home-based care as one of the most feasible and cost-effective systems for the management of HIV/AIDS.

Home-based care is an approach to care provision that combines clinical services, nursing care, counselling and social support. It represents a continuum of care from the health facility to the community, family and the individual infected with HIV/ AIDS and back to the facility. The component of counselling in this continuum is particularly important given the emotional and spiritual upheavals the disease causes. It is of utmost importance to remember that 'care' in the home-based care does not end when a person succumbs to the disease, and is extended to the survivors, especially children.

4.2 The Rationale and Meaning of Home-Based Care

Home-based care as a methodology has a wide perspective. It helps change attitudes towards PLHIV and towards the disease itself. Home-based care recognizes that a diagnosis of HIV does not necessarily mean that death is at hand. It helps reduce the stigma attached to the disease. It helps provide the support that will help HIV-positive persons to extend their productive lives for many years.The disease of HIV/AIDS as of today remains without a cure and without a vaccine, and is ultimately fatal. Prevention efforts are yet the backbone of the management of this epidemic. It is here again that home-based care has an important role to play. When an entire community is involved in the process of care, it increases not only the community's access to care but also enhances the process of involvement in prevention activities.

4.3 Objectives of home-based care

- To facilitate a continuum of care and support to PLHIV extending from the healthcare facility to the home and family
- To promote family and community awareness of HIV/AIDS prevention and care
- To empower PLHIV, the family and community with the knowledge needed to ensure long-term care and support
- To reduce stigma and discrimination associated with HIV/AIDS within families as well as communities

- To create an effective network of referral services from institutional health-care facilities and into the community, and from communities to adequate health setups as required

- To develop home-based care as the vital link between prevention and care
- To mobilize both human and fiscal resources essential for the sustainability of the system

4.4 The Involvement of PLHIV

Models that recognize the importance of the contribution made by PLHIV are better able to respond to the epidemic and create a further space within society for the enhanced involvement of PLHIV. Thus an active involvement of PLHIV removes the long-held notion that they are passive recipients of care and support services. There are four levels of involvement of PLHIV in community and home-based care programmes:

(i) **Access**: Use of the service

(ii) **Inclusion**: Working as support staff or volunteers, providing peer outreach or home visits.

(iii) **Participation**: Providing HIV/AIDS services either as volunteers or staff, using their experience and training

(iv) **Greater involvement**: Designing services and managing organizations, engaging in advocacy activities and public speaking

This kind of meaningful involvement helps in improving providers' attitudes and understanding of issues affecting PLHA and creates a more supportive environment.

4.5 The Component of Counselling In Home-Based Care

People with HIV/AIDS experience a variety of social support needs, psychological distresses and spiritual yearnings. These needs are felt in varying intensity throughout their lives. The phase when a person finds out his HIV status is a very difficult and sensitive stage. To a large extent, how the person will manage his life with HIV will depend on adjustments made during this stage. Support also needs to intensify during phases of illness. It has been seen that often, when people with HIV

fall sick intermittently, it is not viewed as a phase of illness but rather as a progression of the disease which brings the end closer. Support needs are also very intense in cases when there is a loss of partner or one's child to the disease. Reduced income or employment comes as a major obstacle to the emotional and spiritual well-being as the HIV-positive individual may either be denied employment or be unable to generate income due to phases of ill health.
Counseling Component of home base care includes the following:

-Spiritual Care

Spirituality is recognized as a factor that contributes to health in many people. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family and humanism. All these factors can influence how patients and health-care professionals perceive health and illness and how they interact with one another. It is important that all members in a home-based care team accept and honour all approaches to existential concerns. This requires open-mindedness, cultural sensitivity and a willingness to learn from the life experiences of others. Much of medical training has to do with 'finding a cure' or fixing a problem. This may no longer be possible in chronic illnesses which have no known cures. To continue to care for patients when disease-specific therapy is no longer available is where spiritual care becomes so critical.

The basic principles of spiritual care:

- Spiritual assessment or history taking.
- Involve compassion and the ability to be present for the patient in the midst of their suffering.
- Helping patients appreciate aspects of life they have never noticed before and to find new priorities that make life have a meaning and purpose.

-Shared Confidentiality within the Local Communities

Home base care is effective in reducing stigma. It builds the patient's self-confidence, promotes involvement of the family, and enhances prevention. Successful home base care teams include not only professionals but also helpers and volunteers from the community and CBOs. Home-base care teams are characterized by an expression of caring that is distinct from providing care. They are sensitive to the shared confidentiality that normally flourishes within close-knit local communities. Shared confidentiality within groups frequently exists when potentially stigmatizing issues are at play, such as HIV, domestic violence and drug abuse. Matters of private significance to people, and their immediate family and friends, are often shared with other people in the immediate living environment. Confidential

sharing is characterized by issue-centered confidentiality in this group context, rather than by person-centred confidentiality. Health-care workers in the field commonly come across such instances

-Dealing With Grief and Bereavement

Grief is the normal dynamic process that occurs in response to any type of loss. It is highly individualized depending on the person's personal perception of the loss and is influenced by context and concurrent stressors. PLHIV and their caregivers often experience complicated grief reactions. There is usually a chain of reactions throughout the disease process right from the time the individual is informed about his seropositive status. Oftentimes, caregivers are also HIV-positive and are dealing with their own physical health issues as well as facing personal loss and witnessing the loss of loved ones.

It is essential that health-care professionals are trained to identify feelings of grief and bereavement in their patients. This will equip them to help the client work through their grief by;

- Identifying and legitimizing feelings of sadness, anger, guilt and anxiety
- Encouraging the expression of these feelings
- Enabling people to complete unfinished business
- Encouraging people to live fully and enjoy life to the best possible extent

-Caring For the Caregiver

People living with HIV are cared for by a variety of individuals including family members, community volunteers and health-care workers. It is these caregivers who are at the frontline of the epidemic. A unique feature of the disease of HIV/AIDS is that often caregivers are also infected with HIV. Thus, they experience a parallel process of disease. Caregivers have special needs, which require attention, if not attended to there may be significant distress and burn-out issues.

Home-based care programmes require a component that attends to the caregivers. The kind of support offered depends upon the resources available, however, there exist wide modalities of support systems, which can be built into the programme.such as:

- A caregivers' group to provide people the space to ventilate feelings and share experiences
- Training caregivers in basic care and Counseling
- Respite care: a person to will sit in for the caregiver and allow the caregiver time to rest

4.6 Support Groups and Networks

Due to misconceptions and myths surrounding HIV/AIDS, PLHIV often experience feelings of isolation, stigmatization and abandonment. In many settings, they fear rejection by friends and family, restrictions on travel, and exclusion from employment, housing and educational opportunities. These fears often lead individuals to hide their HIV status from loved ones and the community at large. Peer support groups and networks of PLHIV provide individuals with a sense of solidarity and understanding that they might not gain with trained counselors and medical professionals. These groups offer opportunities for members to share experiences and discuss problems openly, which counteract feelings of isolation, fear and despair. The groups often have role models for 'living positively' with hope and purpose. These groups also assist individuals to cope with HIV infection and empower them to engage in safer behaviors. Formation of support groups, including groups with counselors who themselves may be infected with HIV, should be encouraged. When counselors living with HIV are involved, clients/members have a role model with whom they can identify with.

MODULE 4: COUNSELLING IN OTHER SITUATIONS.

SESSION 1: COUNSELING FOR THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

LEARNING OBJECTIVES

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

- Understand the aims of pre- and post-test counselling for pregnant women.
- . Identify the concepts and impart the skills needed to provide effective counselling to women and their partners for prevention of mother-to-child transmission (PMTCT).

1.1 Introduction:
HIV Testing Services in the context of PMTCT:

- Plays vital role in identifying pregnant women who are HIV-positive for PMTCT services.
- Provides an entry point to comprehensive HIV/AIDS treatment, care, and support.
- Helps identify and reduce behaviours that increase HIV transmission risks.
- Becomes available to all women of childbearing age and their male partners.

1.2 Guiding Principles for HTS in PMTCT

The following guiding principles should be applied when addressing HTS in PMTCT:

Confidentiality
All client information should be kept confidential.
Information is shared with providers directly involved in care only on a "need to know" basis.
All medical records and registers should be kept in a secure place.

Informed Consent
- Clarifies the purpose, advantages and disadvantages of testing
- Ensures understanding of the counselling and testing process
- Respects the client's testing decision

Post-test support and services
- Always give results in person.
- Provide appropriate post-test information based on outcome of test result.
- Offer counselling or referral as required by client.

1.3 **Issues to consider in HTS for PMTCT**

Explain that HIV can be transmitted from the mother-to-child during pregnancy, delivery or during breastfeeding.
If the woman is HIV negative, point out the possibility of putting herself at risk of HIV transmission by becoming pregnant. The partner's behaviour must be discussed and appropriate actions to minimize the risk must be identified and initiated with the assistance of the counsellor**.**

***If the woman is HIV-positive*,** the counsellor should discuss the following:

- *the risk of re-infection or infecting others while trying to become pregnant*
- *the risk of mother-to-child transmission of HIV*
- *The possible negative impact pregnancy can have on the progression of HIV disease, especially if the woman already has AIDS since pregnancies in women with AIDS are more often complicated***.**

The counsellor should encourage the woman to use the information provided in making her decision on whether to become pregnant or not.
Emphasize that HIV-infected women who become pregnant must also be provided with appropriate information to assist them in their decision making. The counsellor should discuss the existing interventions based on the need of each woman

The counsellor should help any pregnant woman develop a plan of what she may do to minimise the risk of transmitting the infection to her child (PMTCT), how she will care for her child, how she will cope with the possible illness of the child if infected and how she expects to support and care for her child if she becomes sick.

1.4 Breast feeding in the context of HIV infection

In settings where infectious diseases and malnutrition are prevalent among infants and where access to clean water and breast milk substitutes are limited, the risk of infant's illness and death due to these factors may be more than the risk of HIV transmission through breast feeding.

To help women make informed decision about how to feed their babies, discuss the following:

- HIV can be transmitted from an infected mother through breast feeding
- That mother to child HIV transmission account for about 15% of perinatal HIV
- The risk of transmission seem to be higher among mothers who are recently infected, mothers with advanced disease and mothers with breast problems e.g. cracked nipples
- Prolonged breast feeding increases the risk of mother to child transmission of HIV
- Breast milk is normally the best food for babies as it provides high quality nutrients that are easily digested and protect babies against diarrhoea and other infections

The counsellor should discuss the available options to reduce the risk of HIV transmission through breast feeding taking into account each woman's peculiar situation. The ultimate decision on the method of infant feeding must be left with the woman or the couple if the partner is involved in the process. Take into account issues of not breast feeding, stigma and discrimination, as well as the financial implications of any decision made.

The counsellor should discuss the available options to reduce the risk of HIV transmission through breast feeding taking into account each woman's peculiar situation. The ultimate decision on the method of infant feeding must be left with the woman or the couple if the partner is involved in the process. Take into account issues of not breast feeding, stigma and discrimination, as well as the financial implications of any decision made.

For HIV-negative women, the counsellor should make it clear to them that breast feeding is the best way to feed their babies. The importance of avoiding infection during breast feeding should be stressed as the risk of transmission of HIV to the baby is higher if the mother becomes infected during breast feeding. The counsellor should revisit the personalised risk reduction plan with the woman as appropriate. The counsellor should also be aware of the ***"window period"*** and when appropriate discuss the possibility that although the woman tested negative, she may still be infected and can transmit HIV to her child

1.5 Approaches to HIV Testing Services in PMTCT

Opt-Out

- Testing routinely offered
- Clients not explicitly asked to be tested
- Client may refuse

SESSION 2: COUNSELING ISSUES RELATED TO HIV-STI CO-INFECTION

LEARNING OBJECTIVES

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

- Provide information about different types of sexually transmitted infections (STIs) prevalent in Nigeria
- Discuss with clients the interrelationship between STI and HIV infection,
- Stress and demonstrate the correct use of condoms
- Identify some common signs of STIs

2.1 Introduction:

Sexually transmitted infections (STIs) are diseases contracted principally through sexual intercourse. STIs are particularly high in developing countries and among sexually active young people. Many different organisms are responsible for STIs. Some of the most common STIs include gonorrhoea, syphilis, genital herpes, Chlamydia, human papilloma virus (HPV), and trichomoniasis. Left untreated, STIs can have serious consequences for men, women and newborn children.

2.2 The relationship between HIV and STIs

STIs are a powerful cofactor for transmitting or acquiring HIV infection in adults. The presence of genital ulcers or inflammation from STIs enables HIV to enter and establish itself in the body. The presence of STIs increases a person's vulnerability to acquiring HIV. Infection with HIV also affects the other STIs. In people with HIV infection other STIs may be more resistant to treatment. Therefore, to reduce the risk of HIV transmission, it is crucial to avoid contracting other STIs. If other STIs occur, early and effective treatment is essential to reduce the risk of acquisition or transmission of HIV.

2.3 Modes of Transmission of Sexually Transmitted Infections

Sexually transmitted infections are acquired through unprotected homosexual or heterosexual relations. Another means of transmission is from mother-to-child: during pregnancy, (syphilis), during delivery (gonorrhoea, Chlamydia), or after delivery, through breastfeeding (HIV).

> The same behaviours that put individuals at risk for HIV also expose them to the risk of acquiring other STIs, namely multiple sex partners, high risk partners, and engaging in unprotected sex.

2.4 Some common symptoms of STIs

In men, common symptoms of STIs include: discharge from the penis, itching in the penis area, pain when urinating, urinating more frequently than usual, pain or sores in the scrotum and penis areas.

In women, common symptoms of STIs include: discharge from the vagina, itching in the vagina areas, pain when urinating, urinating more frequently than usual, sores in the vagina areas and pain in the lower abdomen. More than 50% of women may be symptomless in the presence of STIs.

If your client complains of any of these symptoms,refer the client for STI screening and treatment services IMMEDIATELY.

Prompt and effective treatment of STIs reduces one's risk of contracting HIV

SESSION 3: HIV COUNSELLING IN FAMILY PLANNING

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

- Appreciate reproductive health rights of clients accessing HTS
- Describe benefits of family planning in the context of HIV

3.1 Introduction

Clients accessing FP services are sexually active individuals.
HTS services should be offered to optimize opportunities for early diagnosis of HIV.

3.2 Reproductive Health Rights of Clients accessing HTS
Like everyone else, clients who access HTS should be supported in exercising their reproductive health rights regardless of the outcome of their results/HIV status.

- **Why talk about Family Planning in HTS?**

- HIV infection can lead to lower pregnancy rates, spontaneous abortions and still births, smaller and less healthy babies and HIV infected babies.
- Family planning has an important role to play in the prevention of mother-to-child transmission of HIV.
- HIV positive women can get pregnant and need to address the issue of future pregnancies.
- Many HTS clients want to talk about family planning but do not have the opportunity to do so.

Counseling about HIV risk reduction and condom use must take into account client's plans and desires to conceive. Depending on the client's needs, counselling about family planning may occur during the post test or follow up counselling.

3.3 Definition of Family Planning

Family planning is planning your family so that you can have children when you want to have them, space them or stop having them

3.4 Benefits of Family Planning in HIV context

- Family planning protects against unwanted pregnancies to allow men and women to plan pregnancies when they are ready for them.
- Family planning reduces HIV infections among children by helping women with HIV avoid unintended pregnancies

.

- Condoms, a family planning method, prevent against STIs including HIV.

SESSION 4: GROUP INFORMATION-GIVING

LEARNING OBJECTIVES

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

- Define the concept of Group Information Giving
- Itemize the guidelines to be followed when providing group information on HTS
- Discuss the procedure to be followed when conducting a group information-giving

4.1 Introduction:

Different groups of people make up large societies like Nigeria. Segments of people with common socioeconomic background and challenges form communities which require HTS services. Some of these groups are uneducated/un-empowered women, in-school youths, out-of-school youths, rural communities, factory workers, and groups of ad-hoc nature such as uniformed forces requiring medical reports to certify their fitness for proposed jobs, pregnant women attending ANC and various groups attending other clinics for HIV related diseases.

Group information-giving session is very helpful with groups mentioned above and in settings where there is high demand for HTS as it can result in the reduction of the overall time spent with clients.
In resource-constrained settings where there is shortage of human resources, group information-giving sessions can be a cost-effective way of preparing clients or clients for HIV Testing.

4.2 Guidelines in providing group information:

- Group size: Maximum number of clients to attend a group session should not exceed ten, if possible.
- Gender mix: depending on the clients present, same sex groups or around an equal number of men and women per group is preferable.
- Ask how the group feels about gender mix.

4.3 Procedures in conducting Group Information-Giving Sessions:

- Welcome clients and introduce self
- State the purpose of the group information session in line with the target group (e.g. ANC, TB clients, STI and other social groups identified)
- Talk about the offer of HIV counseling and testing to the entire group
- Give clients a choice to opt out of testing after the group information session

- ♦ Assure those who choose not to take the test that they will not be penalised or discriminated against in the provision of services that they have come to access.
- ♦ Give opportunity for the clients to see the counsellor on one-on-one basis if they so desire.

SESSION 5: HIV COUNSELING FOR CHILDREN

Learning Objectives:

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

- Explain the importance of counselling children for HIV.
- Describe the principles of counselling children for HIV.
- Explain barriers that affect communication with children.
- Identify the challenges in counselling children.
- Demonstrate the necessary attitudes and skills for communicating with and counselling children.
- Discuss disclosure of HIV status

5.1 Why is counselling children important?

- Helps the children to understand what HIV is about.
- Helps the children understand and cope with feelings and issues which they experience due to their positive HIV status.

- Equips children with the skills and information to cope with their parents HIV related' sickness, death and the denial, stigma, and discrimination which may be shown by their peers in schools, families and community.

- Helps HIV infected children and those who have grown up into teenagers to make informed choices and make responsible decisions, which will prolong and improve their quality of life.

5.2 General principles for counselling children:

- **Form good relationship with them**. This is also called "joining". This involves greeting and talking about something that is easy for children under 5 years, get down on the floor and find the game they like to play, children 6-12 years - find a fun activity to do together like discussing a magazine or object, teenagers 13-18 years - find their likes, dislikes and interesting topics such as sports or music.
- Ensure that parents or guardian are available.
- Prepare for sessions - prepare for space for family if necessary;

- Create welcome environment - child friendly colors, toys, drawing paper available for use.
- Keep record of important development
- Recognize that this is a two way process - where child is active participant, rather than just a recipient.
- Establish boundaries of confidentiality with children - ask if there are any issues which they do not wish to discuss during family sessions involving parents, siblings or guardians.
- Continually acknowledge and validate what the children feel and say about their situation, rather than making presumptions or waiting to hear what the adults have to say.
- Observe what the children do and say - body and eye contact of the children.
- Encourage children to access support.
- Facilitate family counseling sessions - with one or both parents, guardians. Family sessions build a sense of team spirit, because it does not focus solely on the child or HIV infected person, it involves discussions around how everybody feels about family life and HIV/AIDS.

5.3 Barriers in communicating with children

Barriers to effective communication can exist either with the children or with the counsellor.

Some barriers in communicating with children include:

- Traditions and customs- some cultures do not allow children to disagree with adults.
- Children may feel embarrassed or ashamed to discuss HIV/AIDS with adults; Children may be too young to put their feelings or experiences into words. In practice, the counsellor must always consider the age of the children.

- Children often fear hurting those they love. For example, they might hide their feelings in order to protect their partners, especially if their parents are sick or unhappy.

- Language.

- The personality of the child (for example shyness) may make communication difficult, amongst other issues.

- **Counsellor's barriers to communication:**

Personal issues: A client's feelings will influence their behaviour and this might impact the Counseling skills of the counsellor. The counsellor should have a support system in place for themselves.

Cultural, traditional, religious and gender issues:

Counsellors should be aware of their own cultural, traditional, religious and gender norms that they believe influence children with HIV or children affected by HIV/AIDS.

When dealing with death and dying, counsellors should not impose their own religious beliefs on the children with whom they are working.

Confidentiality issues:
Counsellors might feel that releasing information about a child's situation would be in his or her best interests, but counsellors need to know that this might go against the family's wishes. Counsellors should encourage the children and their family to reach a consensus about confidentiality.

Advocacy issues:
Counsellors should serve as advocates for their clients by standing up for their clients' rights, helping them overcome obstacles, and by taking action with the community and authorities.

Attitudes and skills for effective communication:
The same attitudes and skills required for effective communication apply when communicating with children. However, the counsellor should try to assess the unconscious world of the child by asking about dreams, wishes, favorite stories, drawings. Stick and comment on the following tools of communication.

5.4 Challenges with providing HTS to children.

Children have the right to voice their opinions about issues that affect their lives: counsellors need to be aware of these complexities and discuss them with clients and their families. Counsellors can address this challenges and complexities by;

- Striking a balance between listening to a child's concerns, respecting the parents' wishes and ensuring the child's overall welfare.
- Counsellors need to understand the policy issues related to the age ofconsent for HIV testing in the country.
- Enable the child to feel in control and listened to.
- Give the child information appropriate to his or her level of development and use tools such as drawing to explain what an HIV test involves.
- Recognize that an HIV test may raise different issues for children of different ages. For example, young children may be most scared of the physical pain involved in having their blood taken.
- Give honest answers to the children and do not hide information, even if it might be difficult and uncomfortable for you to say or for them to hear.

5.5 Children Communication Tools

Drawing: This communication tool enables children to communicate their emotional state of mind without necessarily having to use words. It is a fun and useful tool for communicating and counseling children. The children should be provided with different materials; asked to draw something related to the issue being discussed; follow child thoughts by asking what the drawing symbolizes and use open ended questions such as **how do these people in the drawing feel about what is happening?**

Storytelling*:* This tool is very useful for problem solving for HIV infected children. When the child listens to a story like their own, it gives the child a sense of being understood and makes them feel that they are not alone. The counsellor should use familiar story, folklore, if possible use animals to represent human beings. Avoid using real names; at the end of the story encourage the child to talk about what happened. In addition, ask the children to make up a story based on a topic, which counsellor will give to them.

Drama: This tool is an excellent tool for children, friends and family members to raise issues which, they will want to communicate with others, but find quite difficult to do. Give the children a topic to perform, which will be related to the issue, encourage children to discuss the drama and ask questions on specific areas such as **what was the happiest/saddest part of the drama?**

Play*:* This tool enables counsellor understand the type of emotions which the children are experiencing because a greater part of this tool involves imitation and acting out. Give children a variety of play materials, ask children to show you parts of their lives using the materials, follow and observe what each child is doing and do not take over play. If child get stuck ask the child questions such as **what is going to happen next? What is going to happen to this person next?** Such questions help the children to continue communication.

5.6 Guidelines for pre-test counseling with children*:*

- Create a friendly and private environment. If adults are present and the child is comfortable, proceed. If the child is not comfortable, ask the adults to wait outside.

- Gain the child's trust so that he or she can speak openly.

- Explore the child's feelings about being in the session and any fears he or she might have.

- Answer the child's questions accurately and honestly – the information should be appropriate to the child's age and level of development.
- Explain the testing procedures accurately. Address any of the child's worries about the process.

- Discuss who will receive the results, how they will be given and who will provide support. (If the child is alone, the counsellor should give the result. However, if the parent/guardian has consented, then he/she should be the one to tell the child of his/her HIV test result with support from the counsellor.

- If the child does not seem ready for the test and asks for more time, offer another pre-test session. Encourage them to bring someone for support.

- **Guidelines post-test counseling with children:**

- The child should be gently supported to receive the test result – do not move too fast.
- Gain the child's trust so that he or she can speak openly.
- Results for children below 12 years should be given to consenting parent/guardian. Only give the child results, with consent of parent/guardian.
- Assess how much information the child has remembered from the pre-test session.
- Assess if the child is ready for their result. If the child says he or she is not ready, ask when they will be ready and make a plan for that.

Disclosure of HIV test results to children:
Pull from national guideline and add up.

Counsellors need to think carefully about the disclosure of HIV positive status to a child. Because this has a lot of implications for the child, depending on how much information is disclosed; to whom status will be disclosed and how status will be disclosed.

The counsellor should ensure the following:

- Plan how test results will be disclosed before conducting testing.
- Determine with the parent or guardian in advance whether the result will be disclosed to the child and, if so, how it will be done.
- If there is no parent or guardian involved, determine the child's readiness to receive results and arrange for the child to have a support person of his or her choice present at the post-test session, if appropriate.
- Results may be provided to children who are 12 years and above at their request, after proper counseling and if the counsellor judges them to be capable of dealing with the result (especially a positive result).
- Encourage a child to involve the parent or guardian if appropriate. Children below 12 years of age should be given results only with the consent of parents or guardians and, again, with proper counseling.

Whether the child's results are positive or negative:

- Give the child time to react. Be supportive; allow tears, silences, anger and despair.
- Answer the child's questions.

- Make sure that the child (and their parent or guardian if present) understand and accept the result.
- Be aware of the children's level of energy and concentration. If they are ready to receive more information and support at this session, continue. If not, schedule a follow-up visit.

SESSION 6: HTS FOR ADOLESCENTS AND YOUNG PERSONS (AYP)

Learning Objectives:

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

- Appreciate the importance of HTS for AYP
- Discuss the modalities of HIV testing services for AYP
- Understand specific counselling skills that can be used with AYP

Introduction

AYP may feel reluctant to attend HTS providing facilities where adults are also receiving similar services. The AYP may also feel intimidated by the HIV/AIDS counsellors who may not have the skills to work with young people. It may therefore be necessary to set up "youth friendly corners" where trained staff peer educators and counsellors can work with this age group.

The legal age of consent in Nigeria is (18 years). Adolescents and young persons below the age of consent cannot be legally deemed to have consented to HIV testing. However, AYP below the legal age of consent (18 years) who are pregnant, married or are parents are considered "mature or emancipated minors" who can give consent for HIV testing. AYP deemed to be below the age of consent should nevertheless be provided with information and referrals for treatment, care and support services if needed. The consent of parent or guardian would be required for this age group for testing.

Psychosocial characteristics of adolescents and young persons (AYP) that may be barriers to the provision of HTS

These include:

- Belief in their own invincibility which may lead to inaccurate risk perception
- Lack of ability to negotiate safer sex
- Difficulty in disclosing status to parents and guardian
- Perception of being misunderstood by the counsellor
- Peer influence or peer pressure
- Image-conscious youth may react impulsively and the risk of suicide should be considered.
- Desire to 'revenge' through rebellion and risky behaviour.

1. AYP Counseling dynamics

- Adolescents who come to counseling and testing centres may come by themselves or accompanied by parents or guardians.
- They may have a broad range of HIV/AIDS-related needs, some of which may be met adequately through access to comprehensive health education and life-skills training
- Research has shown that young people value opportunities for counseling. To be efficacious, more than one counseling session is needed.

- Counsellors should be aware that they require patience and understanding of the needs of adolescent and young adults

Support during pre-test counseling

- Exploration of reason for presenting and provision of unconditional support;
- Commendation to the young person for attending and attempting to implement healthy practices.
- Exploration of risk assessment, perceptions and factors relating to vulnerability;
- Decision-making support for testing (including outlining test procedures and practice, what a positive or negative result would mean to them, to whom they would disclose their status);
- Exploration of existing support systems;

Opportunity for health education and/or information as required (including modes of transmission and prevention, condom demonstration and distribution);

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-
- Brief exploration of personal risk reduction as appropriate (including opportunity for role play)

- Opportunity for young person to ask questions and communicate their concerns

- Referral as appropriate (including for generic or specialized counseling, drug and alcohol services, abuse and domestic violence services, medical services, support groups, peer support person, legal and financial services, religious organizations, etc.);

- Distribution of IEC materials as appropriate
- Opportunity to facilitate or mediate for familial and spousal support as desired

and appropriate

Support during post-test counseling

- Exploration of readiness to receive test results;
- If not on the same day as the pre-test: exploration of how things have been/what has changed since last meeting;
- Re-visitation of risk assessment and risk-reduction plan as required;
- Opportunities to role play/practice behaviour modification;
- Opportunity for additional health education and/or information as required (including modes of transmission and prevention, condom demonstration and distribution);
- Opportunity for young person(s) to ask questions and communicate their concerns;
- Re-visitation of support systems, disclosure and coping capacity (especially where the result is positive);

- Referral as appropriate (including for generic or specialized counseling, drug and alcohol services, abuse and domestic violence services, medical services, support groups, peer support person, legal and financial services, religious organizations, etc.);
- Distribution of additional IEC materials as appropriate;
- Opportunity to facilitate or mediate for familial and spousal support as desired and appropriate;
- Planning for additional or ongoing support as possible and desired

It is essential to identify possible sources of support for adolescent and young adultwhich may include appropriate role models and peers who have successfully gone through the experience.

SESSION 7: FUNDAMENTALS OF COUNSELLING FOR KEY POPULATIONS

Objectives:

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

- Understand why there is a need for special considerations for Key population.
- Explain how to provide population-friendly HTS
- Describe key areas that should be addressed in a risk-reduction counseling session with key population.
- Describe how inappropriate language, personal bias and stigma can be overcome when counseling key population.
- List different tips for improving health care services for key population.
- Describe different ways for engaging key in sexual-health services

1. Introduction

Apart from HTS services for general population, specific groups such as Key population need extra consideration for HTS services. Key populations are defined groups who due to specific higher risk behaviours are at increased risk of HIV irrespective of epidemic type or local context. This include Men who have sex with men (MSM), female sex workers (FSWs), injecting drug user (IDU) or People Who Inject Drugs (PWID), and other close settings, and transgender people.

PWIDPeople Who Inject drugs (PWID)

Background

PWID are at a high risk of contracting HIV through sexual and injection risk. Injecting drug use is a practice that is both illegal and socially stigmatized in Nigeria. Because many drug users have experienced social stigma and unpleasant encounters with the law, they may distrust or fear government or hospital based social services

Special considerations and strategies for service provision

Successful HTS programmes for PWID should be integrated into existing HIV prevention and community based outreach programmes targeted at this population. HIV prevention services should adopt creative and innovative approaches to improve access to HTS services such as mobile programmes and/or any other approach as appropriate to the target population.

Service provision goals for PWID

- HTS providers should be sensitizedon issues around drug and substance abuse
- Promote community Involvement in programme design, implementation, monitoring and evaluation
- Integrate HTS services into drug dependence and rehabilitation facilities and social support services
- Promote harm reduction through safe injection use, safe sex behaviours, and build skills on correct and consistent use of condom.
- Promoting effective condom programming (availability, accessibility and affordability)
- HTS should be an entry point for effective referral into drug dependence and rehabilitation facilities and other associated HIV services such as ART and management of OIs/STIs

Female Sex workers and their clients

Surveys have identified two broad types of FSW in Nigeria. These are the brothel-based female sex workers (BBFSW) and the non-brothel based female sex workers (NBBFSW) The brothels for sex work activities are usually located in low rated "hotels' with bars where women rent rooms. In some of the cases the "hotels" are conveniently located where clients can be easily recruited such as major markets and motor parks[1]. A larger proportion of FSWs enter into sex business for economic reasons, either being homeless or unemployed, abusive spouse, or coerced into sex business through kidnapping and trafficking. In many parts of the country, sex workers lack access to HTS, due to stigma and discrimination, police harassment and exploitation. Many sex workers also engage in drug/substance abuse. .

Special Considerations and Strategies

HTS services for FSWs and their clients needs to be sensitive in addressing the issues of stigma and socio-cultural barriers associated with sex work in the country. Counsellors need to understand and help address factors associated with high risk behavior of FSWs such as unprotected sex (through financial inducement or coercion by the pimp or client) or desire not to use condom with boyfriend/spouse/partner, influence of alcohol and substance abuse.

[1]Family Health International. Anambra State, Nigeria: Report of rapid assessment in selected LGAs. November 2000

Service provision goals for FSWs

- HTS providers should be sensitized on issues around sex work
- Promote community Involvement in programme design, implementation, monitoring and evaluation
- Integrate HTS services with SRH and social support services
- Promote safe sex behaviours and build skills on correct and consistent use of condom.
- Promoting effective condom programming (availability, accessibility and affordability)
- HTS should be an entry point for effective referral for other associated services such as ART and management of OIs/STIs

Men who have Sex with Men (MSM)

. The MSM community is hidden, due to homophobia, criminalization, stigma and discrimination. This has resulted in limited access to prevention and care services. Unprotected anal sex carries a high risk of HIV, especially for the receptive 'bottom' partner. The presence of untreated STIs can greatly increase the risk of HIV transmission. There is a high rate of multiple sex partners and sex work.

Special Considerations and Strategies

Securing the participation of MSM is essential for the development and implementation of comprehensive HIV interventions in the country. HTS services should not only address personal factors directly related to health (e.g. risk practices, condom use, STIs), but also address social factors, such as enhancing self-esteem and empowerment.

HTS for MSM should include education on safe sex, the use of condoms and lubricants and promote low risk sexual behaviours such as reduced multiple partnering, alcohol and substance abuse

- It is important to understand the sexual roles of MSM and their partners and their associated risk to HIV transmission.
- Insertive anal sex – occurs when a man uses his penis to penetrate his partner. This is also called topping, fucking, being the active role, etc.
- Receptive anal sex – occurs when a man is penetrated by his partner's penis. This is also called bottoming, being the passive partner, getting fucked, etc.
- MSM who engage in anal sex may prefer to engage in only one type of anal sex, insertive or receptive, or they may prefer to engage in both.

HTS provide a **'safe space'** where they can discuss their personal issues, assess their risk, get STI care, and appropriate referrals.

Service provision goals for MSM

- Adopt innovative and creative approaches to promote HTS services through MSM social networks, social events plug-in, drop-in centres and men-friendly services.
- Sensitize HTS providers to understand issues on sexual diversity, stigma and discrimination.
- Promote community Involvement in programme design, implementation, monitoring and evaluation
- Integrate HTS with SRH and social support services
- Promote safe sex behaviours and build skills on correct and consistent use of condom.
- Promoting effective condom programming (availability, accessibility and affordability)
- HTS should be an entry point for effective referral for other associated services such as ART and management of OIs/STIs

Pre-and Post-Test counseling for key population

Evidence indicates that personalized and interactive prevention counseling models using goal-setting strategies might be effective in reducing injection drug use and sexual risk behavior. While counselors should discuss risk reduction with their clients during both pre and post test counseling, they should also understand that target populations may not be willing or able to change certain types of behavior, such as drug use or multiple partnering . In these cases, counselors should discuss safer methods of practicing these behaviours, such as not sharing needles or sterilizing needles and syringes, condom use and negotiation, not using excessive drug and alcohol if they want to have sex.

Improving communication during counseling

The use of appropriate language and terminology of the target populations is a key component to promote community support, ownership and create enabling environment for provision of HTS services.

The following are a few useful tips that would guide counseling with key population

The terms *top* and *bottom* both refers to sexual roles as the insertive and receptive partners respectively during anal sex.

- For PWID, the terms 'jonsing', refers to being high 'shooting ',the act of taking the drug ' 'hustle' act off trying to get the drugs
- For FSWs the terms, 'hustle',or 'runs', soliciting for clients……

Do not automatically label clients or assume details about their behaviour

Making assumptions on sexual behaviours, dressing, mannerism could influence clients' responses during counseling sessions.

Do not include value judgments or personal beliefs

It is not the job of counselors to judge their clients because this will not provide a client with any helpful service. An example is a man who is married to a woman but having sex with other women and men , a counselor should not judge him/her but provide correct and relevant information on HIV prevention to enable informed decision by the client. .

Create a friendly counseling environment

- This can be achieved by making your clients feel comfortable by reminding them of their ensured confidentiality, and asking questions to show you are open minded, knowledgeable and non-judgmental.
- Establishing a mutual relationship based on trust with the key population is absolutely critical for creating a sustained relationship.

Exercise

The following are case studies involving KP and their sexual practices.

For each case study address the following questions:

Case study 1

Yahaya is a 31 year-old man who is married to a woman and has three kids. On Saturday nights he likes to go to a local club across town that is known for being frequented by gay men. On these nights, he often drinks heavily at the bar and waits to be approached by one of the men.

Frequently, he will offer to drive one of them home and in exchange have penetrative anal sex with them. He says he doesn't like to use condoms because they don't fit well and he doesn't carry them because he doesn't want his wife to suspect him.

Case study 2

Taiwo is a 20 year-old and was born male but lives her life as a female. She wears women's clothes and many would consider her extremely effeminate. Taiwo's father kicked her out of her house when she was 14 because her father did not like her behaviour and did not want a '*girlish'* son. Because of the way in which she acts and dresses, it is difficult for Taiwo to find steady work and so often she engages in casual sex work to make ends meet. Many times the men who pay her for sex will pay more if they don't have to use condoms.

Case study 3

Emeka is a 34 year-old male who defines himself as gay. He lives in the typical 'gay' neighborhood and goes out to the bars and clubs every weekend with his close friends. Many nights his friends end the evening at the local gay bath house and Emeka likes to tag along. Practically every time Emeka goes to the sauna he is offered cocaine. When he gets high he regularly will have sex with a number of guys whom he doesn't know.

- What are the key risk behaviours of the client?
- What strategies would you create to help each client reduce their risk?
- How would you prevent the client from feeling judged?
- What types of language would you use when speaking with the client.

- Identify a partner to practice these case studies with.
- One individual should be the client and the other the health care worker.

Exercise

- Individually, in groups or in pairs brainstorm different ways you could engage KP KPin your community on an individual, organisational and community level.
- Think of reasons why it might be difficult to contact or interact with KP in your community and how you might overcome those challenges.
- Share these ideas with your group or co-workers.

Summary

There is a need to provide HTS for key population and vulnerable population . There are special considerations for each sub group. Risk-reduction counselling is an effective behavioural intervention that can help reduce an individual's risk for STIs and HIV. Appropriate and socially relevant language should be used with key population members to make them feel comfortable. Personal bias or stigma should be addressed before working with a key population client so as not to affect the client negatively. The use of health care services by key population and vulnerable group communities can be improved by training health care workers on KP sensitive services,.

SESSION 8: COUPLE HIV TESTING SERVICES (CHTS)

Session Objectives

At the end of the training session, trainees will be able to:

:

- . Understand important facts about CHTS
- Advantages of Couples HIV Testing Services
- . Conditions for Receiving CHTS. Itemize roles, responsibilities, and expectations of the couple
- Adduce the important issues to focus on when discussing couple's HIV risk and concerns:
- Recall important issues to consider when communicating HIV test results to couples:

COUPLE HIV COUNSELLING AND TESTING (CHTS)

Couple HIV counselling and testing is where two or more individuals, who have had or who intend to have sexual relations, wish to discuss issues concerning HIV infection and disease together. There are different types of couples. These include: Pre-sexual, engaged, married, cohabiting, reuniting and polygamous couples.

The goal of couple HIV Counselling and Testing is to bring together the views of the couple and create a shared vision. This shared vision is the couple's acceptance of the realities of HIV in their lives, being empowered to prevent acquiring and transmitting HIV, and sharing their support and compassion for each other.

Important facts about CHTS

- The couple is a collective unit representing two individuals or more ('our family' 'our life').
- HIV/AIDS is a disease of the family, the community and society.
- To contend with HIV and plan for their future, both partners must know their status
- Couple HIV services enhance opportunities to prevent mother-to-child transmission of HIV.
- It is fairly common for one partner to be HIV infected and the other uninfected – meaning that they are HIV sero-discordant, or simply 'discordant'.
- Couples can remain discordant for a long time – even more than 10 years.
- Individual testing leads to assumptions about partner's HIV status

- Discordant couples are not protected only by remaining faithful, as such, they should practice safer sex.
- Before knowing their HIV status, most discordant couples do not use condoms; however, CHTS has been shown to increase condom use.
- In many cases, the couple enters the relationship when they are already discordant – discordance is NOT a sure sign of infidelity

Advantages of Couples HIV Counselling and Testing

- Environment is safe for couple to discuss risk concerns.
- Partners hear information and messages together, enhancing likelihood of a shared understanding.
- Counsellor has the opportunity to ease tension and lessen blame.
- Counselling messages are based on the results of both individuals.
- Individual is not burdened with the need to disclose results and persuade partner to be tested.
- Counselling facilitates the communication and cooperation required for risk reduction.
- Treatment and care decisions can be made together.
- Couple can engage in decision-making for the future.

Conditions for Receiving CHTS

- Partners agree to discuss HIV risk issues and concerns together.
- Each partner should voluntarily consent to testing for HIV
- Each partner should be given equal opportunity to talk and ask questions
- Couple is willing to receive results together.
- Couple commits to shared confidentiality.
- Disclosure decisions are made mutually

Roles, responsibilities, and expectations of the couple

- Participate equally in the discussion
- Listen carefully and respond to each other

- Treat each other with respect and dignity
- Be as open and honest as possible
- Show understanding and support to each other

Important issues to focus on when discussing couple's HIV risk and concerns:

- Focus on the couple's present and future.
- Ease Tension
- Lessen blame.
- Address risk issues each partner is capable of disclosing.
- Emphasise communication and cooperation.
- Deal with potential undisclosed risk issues without relating directly to the couple.

Things to consider when communicating HIV test results to couples:

- Partners chose to come together to learn their HIV status as a couple
- Couple may be either concordant (when the results are the same) or discordant (when one partner is positive and the other negative).
- The better able the partners are to handle HIV in their shared lives as a couple, rather than as individuals, the more likely they will be able to cope.
- Counsellor should support the couple to address HIV in terms of "we" and "our," rather than "I," "his," or "hers."
- If discordant, counsellor starts by saying the results are different.
- Counsellor provides results for the HIV-positive partner first thereafter to the HIV-negative partner.
- Discuss the window period and the possibility of recent infection with the couple.
- Discuss safer sex practice with the couple

Couple counselling in PMTCT when discordance occurs

Check for understanding of the meaning of these results
Discuss the possibility that the HIV negative partner may currently be in the "window period"
Discuss and support emotions and feelings of both clients
Discuss disclosure issues (for instance - do they plan to share results with other family members or friends).
Explain the possible reasons for discordant results (Negative partner may be in the "window period")
Discuss PMTCT issues, partner transmission, and importance of condom use, infant feeding, delivery plans and "safer sex".
Discuss future plans
Arrange further supportive counselling and refer when necessary.

SESSION 9: COUNSELLING FOR SEXUAL ASSAULT

Session Objectives

At the end of the training session, trainees will be able to:

- Discuss under what circumstances HTS workers may come in contact with survivors of sexual assault
- Discuss what constitutes sexual assault and the effect of sexual assault on the victim
- Discuss the requirements for the care of persons who have been sexually assaulted
- Outline the steps to be undertaken once a sexual assault has been disclosed

What Constitutes Sexual Assault*?*

Sexual assault is deemed to have occurred

- Where threat, force or coercion has been used in order to have the victim perform sexual acts, either with the perpetrator or with a third person
- When assault, obstruction, exploitation or molestation occurs without necessarily physical harm or penetration
- When rape, attempted rape, oral or anal intercourse, or insertion of objects into genital openings are perpetrated

What are the Effects of Sexual Violence?

Sexual assault is often meant to harm, control or humiliate, thus violating a person's innermost physical and mental integrity. The client may feel powerless and fear retribution and lack of support from the family and society. The physical consequences of sexual abuse could include bruises, knife wounds, pelvic pain, headache, backache, STI and gynaecological complaints. The client may experience post-traumatic stress disorder, develop emotional detachment, sleep disturbances, experience flashbacks and replay the assault in their minds. Other psychological reactions include depression, suicidal behaviour, anxiety, loss of self-esteem, loss of faith and fear of intimacy.

Reporting Of Sexual Assault

Due to the taboo associated with sexual assault in Nigeria and other cultural settings, only a small proportion of such incidents are formally reported. Most survivors do not report assault because of:

- Shame and fear of social stigma
- Fear of reprisal or ostracism from the family or community
- Possible detention and trial
- Further attacks by the perpetrator
- The perpetrator being in a position of authority
- Assault of men, boys or children are seldom reported

Client Presentation to HTS Services

- Highly emotional
- Anxious
- Depressed
- Non-communicative or in shock

Key Areas of Response

- *Protection*: Of human rights, ensuring physical safety and relocation of the client, if necessary
- *Medical*: Prevent further suffering, offer testing and health briefing
- *Psychological*: Culturally appropriate counselling, referral to other support
  networks and agencies

Dealing with Disclosure of Sexual Assault

Step one: Protecting the rights of the individual

- Provide emotional support
- Refer the victim to sexual assault services (where available and client consents to referral)
- Ensure same gender health-care worker
- Ensure that the person's privacy and confidentiality are protected
- Practice active listening
- Assess the need for immediate medical assistance
- Ensure the future safety of the person; this may involve arranging alternative housing
- Ascertain whether legal action will be taken. Explain the procedures involved
- Always be guided by the best interests of the person
- If the assault is not to be reported, assess the need for counselling and referral to other support services
- Respect the person's wishes under ALL circumstances

Step two: Contacting the police or other authorities

- Advise the client on reporting to the police and on the requirements for legal procedures
- Complete the necessary documentation

Step three: Medical assistance
Immediate attention to injuries

- Injuries sustained during the attack are treated by appropriate medical services
- If consent has been given for a forensic interview and medical examination, explain the procedures involved

Forensic interview

- Gain informed consent from the client
- Ensure the client's comfort, privacy and confidentiality
- Document the details elicited during the interview
- Assess the risk of pregnancy, and contracting HIV, STIs and other infections

Medical examination

- Assist in conducting a medical examination
- Collect forensic evidence
- Test for HIV, STI and pregnancy (where consent has been given)
- Ensure post-exposure treatments according to local protocols for HIV, STI and post-coital contraception

Step four: Referral

- Community services: Clothing, shelter, other NGOs, etc.
- Counselling services: By trained mental health professionals
- Services specifically for children: May be offered by paediatric hospitals, etc.
- Legal services: To assist with legal costs, other support during legal proceedings

Step five: Follow-up
Counselling services

- Follow-up is important since the client is in need of reassurance and requires repeated inputs to develop coping skills
- Prepare information, education and communication (IEC) material for the client to take home
- Ongoing suicide risk assessment should be done
- Follow-up testing should be performed after the window period

Counselling Survivors of Sexual Assault
General principles

- Counsellors work as part of a team
- The survivor should not be pressurized to receive counselling
- Counsellors should sincerely practise active listening skills
- Immediate intervention can help minimize the severity of long-term psychological trauma

Counselling objectives

- Help clients develop self-confidence and take control of their lives
- Overcome feelings of guilt or responsibility for the attack
- Help clients understand and articulate feelings of anger
- Help establish a link between the client and community services, and integrate them back into community activities
- Support the client in resolving family and community disputes (where appropriate)

Most survivors of sexual assault can regain their psychological health through emotional and social support, and psychological counselling.

SESSION 10: VALUES AND VALUE CLARIFICATION IN WORKING WITH KEY POPULATIONS

Objectives:

By the end of thissession, you will be able to:

- Understand and explore diversity as it affects the key populations
- know why Values and Value Clarification is important in counseling relationship with key populations

What are Values?

Values are ideas, beliefs, principles that are regarded as desirable and worthwhile, based on perceptions. We are the outcome of our values. People usually act according to their values. Every culture has certain beliefs, moral principles and ideas preferred above all others. These values are translated into customs, traditions and practices of a community.

Attitudes and Values

An attitude is a special state of mind or feeling based on values.

Values and attitudes can be likened to a crocodile under water, one may only see its small eyes (attitude) sticking out of the water but beneath the water lies a very large crocodile (values). Most of us have values and attitudes that may or may not be immediately apparent.

Sources of Value and attitudes

- Family
- Religion
- Society/environment
- Peer group
- Personality
- Education
- Media

Value Clarification

Values clarification means sorting out ones personal values from the values of others and acting on them. By understanding our values, service providers can appreciate and respect the various experiences that shape the values and belief systems of our clients.

It helps us to appreciate that our own perception and attitudes towards health issues may differ from our clients.

Value Statements

- KP (FSW, MSM, PWID) are responsible for spreading HIV/AIDS
- I feel sad for those who got HIV through blood transfusion.
- I feel comfortable counseling sex workers.
- Sexuality Education should be taught to teenagers
- Sex before Marriage is Okay
- I will not counsel an MSM
- Condoms should be banned
- Drugs are a good way of relaxing.
- HIV positive babies should be left to die since they are going to die anyway.
- To eradicate HIV infection, all HIV positive people must be quarantined.
- All HIV positive people must notify their partners and families.

Conclusion

As healthcare professionals, we all have great roles to play and we need to be mindful of our ethics and clarify our values in order to make the desired progress. This is more important as it affects HIV prevention, care, treatment and related program

SESSION 11: SEXUALITY AND BEHAVIOUR

Objectives:

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

- Understand and explore sexual differences among humans
- Conceptualise and appreciate situations in which people react negatively in our society Adduce reasons for negative reactions to differences
- Stereotyping and Impact of sexual stereotyping on the health of KPs
- Itemise our roles and responsibilities and care providers for KPs

Situations in which people react negatively in our society

There are a number of situations in which people react negatively in our society.Some of these are;

- Women as bread winners, in positions of authority, playing football.
- Men washing clothes and making food for the family (House-husbands)
- Having oral and anal sex
- Being a lesbian, homosexual, bisexual and transgender.
- Not believing in God or any religion
- Talking to young people about sex and using condoms
- Abortion

Reasons for negative reactions to differences

These are some of the reasons why people react negatively to differences:

- Fear
- Inability to handle the differences
- Concerns that differences challenge existing and accepted norms, views, values and practices
- The desire to want to have control and prevent divergence
- Lack of information or education about the issue and skills to handle them.

Stereotyping

Sterotyping is the social roles and behavioural expectations placed on individuals. From an early age, people are socialized to believe that these roles are "natural." There are stereotypes about cultures, norms, beliefs and attitudes including sex. Stereotyping could occur through our cultural, religious and educational beliefs amongst others.This also contributes to beliefs that risky sexual behavior is unavoidable eg the notion that men are polygamous in nature.

Common gender stereotypes in Nigerian cultural context

- Women are treated as inferior to men
- Only women go to the kitchen
- Women go the domestic chores
- Men are expected to be heads and leaders
- Mothers take the kids to the hospital
- Men are the financial providers for the family
- Men do not cry or show emotions publicly

- **Examples of sexual stereotyping**
- Sex must be only through the vagina
- A man must lie on the woman to have sex
- Sex must be only between men and women
- Two consenting unmarried persons cannot have sex until they are married
- Sex must only take place in a dark room and at night
- Sex is only to make babes
- Talking about sex is a *'sin'*
- Men are expected to show masculinity by having multiple sex partners

Impact of sexual stereotyping on the health of KP

- May restrict access to health information.
- Hinders effective communication.
- Encourages risky behaviour among women and men.
- Increases vulnerability to sexual health issues such as sexual violence & exploitation, unplanned pregnancy, unsafe abortion, and sexually transmitted infections (STIs) including HIV.

Diversity

Diversity is recognizing the different groups to which individuals may belong. It is acknowledging the legitimate possibility for differences. It is important to support and protect diversity in our society because if we foster an environment where **equity** and **mutual respect** are intrinsic, We will create a success-oriented, cooperative and caring community that draws on strength from the synergy of the people.

*All persons must be treated with **respect** and valued as an individual independent of their differences!*

Some situations that create diversity

Language
Culture
Socioeconomic status
Educational status
Sexual orientation
Religious beliefs

Colour
Gender
Age
Geograhical location

Abuses based on diversity
The holocaust – killing of the jews (based on race)
Apartheid – killing and maltreatment of blacks (based on colour)
Homophobia – discrimination and violence based on sexual orientation
Killing of persons based on conditions – PLHIV, psychiatric patients, deformed babies, twins, albinos, child witches etc.
Killing of persons based on religious differences, ethnic group

Alarmingly, these prejudices and stereotypes are often much more socially acceptable when directed towards sexual minorities than towards many ethnic, racial, and religious minorities.

What is Sexual Identity?
Sexual Identity refers to how a person sees or often portrays themselves as a sexual being.

Sexual minorities refers to sexual identities which for one reason or the other falls outside the cultural mainstream of a particular society.

Sexual minority groups consist of LGBTI- Lesbians, Gays, Bisexual, Trans-gender,) and Intersex people.

What does sexual orientation mean?
Sexual orientation is essentially defined by who we are emotionally and/or physically attracted too.
A person's sexual orientation can be asexual, heterosexual, homosexual or bisexual.
Differences between sexual orientation, sexual identity and sexual behavior
Sexual identity refers to how that person sees and often portrays themselves as a sexual being. In other words, sexual orientation is one's feelings of sexual attraction towards another while sexual identity is one's sexual attitude towards another or same sex.
A person's social and cultural environment helps shape one's sexual identity. Sexual identities are often informed – but not always by their sexual orientation.

Some useful terms

Asexual - *someone who has no sexual attraction to others or interest in sexual activity.*

Lesbian – women who derive sexual pleasure from only female partners

Gay – men who derive sexual pleasure from only male partners

Bisexual – man or woman who derives sexual pleasure from sexual relationship with both sexes at a point in time.

Heterosexual – men and women who engage in sexual relationship with the opposite sex

Homophobia - irrational fear of, aversion to, or discrimination against homosexuality or homosexuals

Pansexual:*Someone who has sexual attraction for all sexual orientation types.*

Down-Low: *is an African-American slang that refers to a subculture of men who identify as heterosexual but have sex with men.*

"Coming-Out"

Coming out is short for *'coming out of the closet'* and it means that you tell somebody else that you are lesbian, gay or transgender, etc. That moment is not a one-off event - it is a lifelong process. It usually depends on the level of self acceptance and level of support in the new environment. Some may be 'out' to everyone except co-workers, and some may only be 'out' to family.There is no specific age for coming out. Some people come out much younger, some much older - even after having been married – and some do not come out at all, because it is too dangerous or for other reasons. Some are 'outed' without their consent consciously or unconsciously.

Coming out is a choice, not a must!

Despite the efforts of a few brave KP, a person who is gay, lesbian, bisexual, transgender or intersex (GLBTI) cannot take their acceptance for granted-whether from their family, in the local shopping centre, in their working lives. Or from their health care provider. It does not take much imagination to consider the effects of this uncertain position on a person's health and this is why sexuality becomes relevant to providing good health care. While GLBTI people have the same basic health needs as the general population their shared experiences of discrimination or fear of discrimination, create common health issues, including:

- ✓ a higher prevalence of mental health disorders, obesity, smoking, and unsafe alcohol and drug use;
- ✓ delayed use of health services and/or keeping sexual identity and behaviours secret for fear of health
- ✓ providers' reactions ranging from discomfort and embarrassment to hostility;
- ✓ reduced use of preventive screening for a range of physical health conditions, such as cervical and

- ✓ breast cancer among lesbians and anal cancer among gay men;
- ✓ actual experiences of discrimination within the health care system.

Recognising the diverse needs of individuals and populations is a core component of providing good quality care especially in HTS contexts..

SESSION 12: TARGETED HTS INTERVENTION FOR KEY POPULATION

Targeted HTS intervention for People who Inject Drugs(PWID)[1]

Unit objectives
At the end of the session, trainees will be able to:
. Identify the specific HIV transmission risk behaviours of injecting drug users (PWID)
. Appreciate the need to adapt HIV counselling and testing (HTS) to the specific needs of PWID

Social and Ethical Issues in the Provision of HTS Care and Treatment to PWID

People who use drugs, especially PWID, often face judgmental attitudes and responses from counsellors and other health workers. Stigma and discrimination make PWID feel alienated, fearful and out of touch with the support and services they need. This has an adverse impact on HIV prevention, care and treatment programmes for PWID as the target population will not access services they deem as not being user-friendly. Legal and ethical factors are also creating challenges for HIV prevention, care and treatment programmes for PWID. For example, the illegal nature of drug use can drive drug users to hide from society, which effectively cuts them off from services they desperately need.

Creation of an enabling environment to enhance access to care and support services and reduction of the risk of contracting HIV and other sexually transmitted infections (STIs) include the following:

- Create an environment wherein PWID are not afraid to seek information, services and care
- Ensure that drug control and HIV prevention policies are mutually reinforcing
- Involve people vulnerable to or living with HIV in policy development and programme design
- Introduce early interventions while the HIV prevalence is still low
- Give PWID access to education, training and employment so that they have real opportunities
- Provide services via outreach to those with limited access to services
- Offer hope for a life after drugs by offering humane treatment choices, including substitution
- Consider also the sexual partners of PWID

Role of HTS and Prevention Counselling

Risk-reduction counselling

Risk-reduction counselling aims to use interpersonal communication to help PWID clarify their feelings and thoughts in the hope that they will take action to protect themselves and their partners against infection. Individual or group-based risk

reduction counselling, and the education and communication that accompanies it, can also assist HIV-positive PWID in relationships to minimize their personal risk behaviours and those of their sexual partners.

Counselling in such circumstances requires exploration of constraints and use of active problem-solving strategies.

Health education and clinical interventions

- Transmission reduction education: Counsellors need to be aware of all practices and cultural issues related to use, e.g. shooting galleries, frontloading practices, etc.
- Harm reduction
- Overdose prevention and management
- Treatment options for dependency

Evidence-based counselling interventions

- Structured problem-solving
- Exploration of constraints to safe sex/safe injecting
- Motivational interviewing
- Stages of change model
- Brief structured therapy
- Assessment for mood disorders and post-traumatic stress disorders (PTSD), which underlie both casual and addictive using patterns
- Suicide risk assessment—high co-morbidity

Targeted HTS Intervention: Sex workers

Unit Objectives

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

. Understand the dynamics of sex workers and their sexual behaviours

. Appreciate sex workers vulnerability and the consequent psychosocial pressures

. Assess the counselling needs of sex workers

. Identify HIV/AIDS prevention and support strategies for sex workers

Who Are Sex Workers?

Sex workers form a diverse group of people. Surveys have identified two broad types of FSW in Nigeria. These are the brothel-based female sex workers (BBFSW) and the non-brothel based female sex workers (NBBFSW) The brothels for sex work activities are usually located in low rated "hotels' with bars where women rent rooms. In some of the cases the "hotels" are conveniently located where clients can be easily recruited. FSWs could be people coerced into sex work and even taken to other countries, college students,

Sex Workers' Vulnerability to HIV Infection

Their vulnerability to STI/HIV infection increases due to

- Involuntary/coercive sex
- Sexual abuse/sexual assaults

- Sexual exploitation
- Sex workers' relationship with clients
- location where sexual activity takes place
- poor condom negotiation skills
- Poor access and availability of condoms .

Service Delivery Settings

Different types of sex workers will access HTS and psychosocial services in different environments. There is no single, universal model for providing prevention and care activities to sex workers, their clients and partners. Models will need to be adapted to different situations.

Assuring anonymity for sex workers and creating an environment where they feel reassured that their activities, which are often illegal in many countries, will not be disclosed to authorities. This is important to encourage them to access HTS and psychosocial services. For Non brothel based sex workers, outreach services may facilitate access, while for sex workers in places such as bars and clubs, liaison with these places may be appropriate. In some settings, it can be helpful to integrate these services with other health care and community services. It is important for sex workers to have access to sexual health services; however, the question of whether it is better to set up special services for vulnerable populations or to integrate STI services into primary health care (PHC) services remains unresolved.

Different service delivery options include:

- Mobile/outreach, i.e. services are taken to the sex workers or their clients
- Stand alone HTS
- STI clinics
- Prisons
- Refugee/migrant detention centres
- Integration of HTS services into general health settings
- Drug and alcohol services
- Gay and lesbian health services
- Women's health centres

It is recommended that HIV prevention activities among sex workers, their clients and partners are most effective when the service includes at least the following three key elements rather than provision of information alone:

Information and behaviour change messages.

- Condoms and other barrier methods.
- Sexual health services.
- Proven strategies to increase the effectiveness of targeted services include:
- Use of informal contacts, key informants and 'leaders' to access the population
- Peer health promotion and education
- Outreach activities
- Social marketing and distribution of condom
- Accessible sexual health services

Programmatic Responses

The needs of different types of sex workers require a range of programmatic responses including access to HTS. Counselling can be seen as one component. However, the background of sex workers has indicated that any programme response should aim at:

- Removing the violence, stigma and other social barriers.
- Facilitating them to come out freely.

Then the programme shall work towards

- Gaining confidence among sex workers
- Instilling in them confidence in the system of care and service

Prevention Counselling

Counselling to prevent transmission can cover a range of strategies and activities to convey information and behaviour change messages. The objective is to provide sex workers with knowledge of HIV transmission and ways to reduce the risk of transmission, for example, through alternative safe sex practices, use of male or female condoms and lubricants, how to identify symptoms of STIs, and clarification of any misunderstandings about unsafe traditional practices or beliefs.

Furthermore, counselling can play an important role in developing the communication and negotiation skills of sex workers so that they can successfully negotiate safe sex practices with:

- Clients,
- Personal relationships/partners, and
- Brothel owners to permit condom usage.

In particular, behaviour change messages are important to convey a message about the consistent use of condoms, rather than a judgment based on the extent to which the sex worker is familiar with the client. It is argued that relationships of sex workers other than their professional ones may be as risky or even more risky for HIV and STI transmission as they have less control and fewer possibilities for negotiation. There is emotional involvement as the relationship becomes more than just a commercial arrangement and sex workers put aside their professional attitudes and control. Counselling needs to address the needs of sex workers holistically rather than solely focusing on their professional sex work activities, e.g. strategies to help sex workers negotiate safe sex not only with their clients but also with their boyfriends or long-term clients who they feel they can trust, and may not consider they need to use condoms with. Some sex workers may be effective in negotiating safe sex with their clients, but not with their partners with whom they have more intimate relationships.

Peer-based programmes can be highly effective both as an entry point into the affected population and as means to influence their peers through their own experiences. Other example of creative strategies have included: compiling a booklet of responses to a survey of female sex workers about all their questions on HIV and STIs; and training peers as AIDS educators and distributors of condoms. Peer-based programmes will often require some training for the sex workers involved.

Peer group approach

. Identification of peers among sex workers
. Peer needs assessment
. Training and exposure to peers
The peer group approach demands understanding of the psychosocial pressures among sex workers.

Counselling Strategies
In these circumstances, counselling goes beyond the four walls. While ensuring that confidentiality and privacy is maintained, HTS needs to address the issues of sex workers through
• Group counselling,
• Community counselling, and
• Peer counselling.
Thus, HTS strategies should expand into the sex workers' community. HTS should examine the possibilities to liaise with other service agencies such as non-governmental organizations (NGOs)/community-based organizations (CBOs) to facilitate access of sex workers to HTS services.
Building partnership with other organizations is important. With limited resources, it is necessary to ensure that HTS services are linked with other service providers NGOs, peripheral hospitals, private clinics—and appropriate measures are taken.

MODULE 5 CROSS CUTTING HTS ISSUES

SESSION 1: SUPERVISION AND SUPPORTIVE SUPERVISION FOR COUNSELLORS

LEARNING OBJECTIVES

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

- Define Supervision
- Enumerate the types of supervision
- Explain the purposes of supervision and supportive supervision
- Explain guidelines towards effective supportive supervision.
- Define Quality Assurance
- Identify the strategies to quality assurance

5.1.1 Supervision and Support of Counsellors

Counselling supervision is a working alliance between a counsellor and a .supervisor in which the counsellor can offer an account or recording of his/her work, reflect on it and receive feedback and where appropriate, guidance. The objective is to enable the counsellor to gain ethical competence and creativity so as to provide his/her client with the best possible service.

Essentially, counselling supervision is concerned with:

- Ensuring that the counsellor maintains ethical standards throughout the counselling work.
- Ensuring timely monitoring, appraisal and support to the counsellor.
- Enhancing the therapeutic effectiveness of the relationship between the counsellor and the client.
- Clarifying the relationship between supervisor, counsellor and client.
- Enabling the counsellor to develop his/her professional identity and self-awareness through reflections on the counselling work.

There are various models of supervision. However, for the purpose of this discussion, the most common ones are:

- *One-on-One Supervision*

This involves a Counselling Supervisor providing supervision for another counsellor who is usually less experienced in counselling practise or has less advanced training background. After the initial counsellor training, counsellors are expected to observe other experienced counsellors and thereafter reverse roles. Less experienced counsellors may observe as many (minimum of 3) HIV counselling sessions as

possible, with *informed consent from clients*. Counsellors are oriented to the proper documentation of HIV counselling and HTS site policies and services.

- *One to Group Supervision*

This is group supervision. One way of conducting group supervision involves the counselling supervisor acting as the leader, taking responsibility for apportioning time between the counsellors and then concentrating on the work of the individuals in turn. The other involves counsellors allocating supervision time between themselves and using the supervisor as a technical resource or consultant.

- *Peer Group Supervision*

This takes place when three or more counsellors share the responsibility for providing each other's supervision within a group context. The arrangement works well if the counsellors are generally of equal status, training and experience.

- *Co-Supervision*

This involves two counsellors providing supervision for each other by alternating the role of supervisor and supervisee. Typically, this is consultative support between counsellors of equal experience and the time available for supervision sessions is divided equally between them.

Supervisors use the following tools to supervise and support counsellors:

- Self-assessment forms: Counsellors should complete Self-assessment forms after counselling sessions.
- Observer Checklist forms: Counsellors should be debriefed by supervisors using the Observer Checklist forms.
- Supervisory Checklist: counsellor should be supervised using the standard supervisory checklist

Other forms of supervision are:

- Supervisors should review documentation of counselling sessions (including risk reduction plans and referrals) carefully to identify and correct weaknesses.
- HIV/AIDS counsellors must attend weekly case conferences or meetings to discuss client issues and further develop knowledge and skills.
- Individual/pair /mentor support meetings
- Formal and informal observation of day-to-day activities and counselling sessions, and staff-client interactions

Counsellors may begin to conduct independent counselling sessions, if and when supervisors determine that they are ready.

5.1.2 HTS Supportive supervision

Overview of supportive supervision

The goal of supportive suppervision is to advance professional development and establish productive, independent service providers in HTS services. Supportive supervision is a one-on-one knowledge and skills transfer relationship between a more experienced individual (the mentor) and a less experienced individual (the mentee). In addition to imparting new skills and knowledge base, mentoring assists the mentee in establishing clear and defined learning goals, fosters individual growth and development, and facilitates strong professional relationships.

MENTORSHIP GUIDELINES

Objectives of Supportive supervision

- Strengthen the provision of quality HTS services
- Improve the health services provider's skills and knowledge on HTS
- Build understanding of the concept of mentoring and its potential role in capacity building
- Provide user-friendly guidelines for the implementation of a programme for integrated HTS

Supportive Supervision Guidelines

The mentorship programme is based on a flexible model that allows providers to learn while at the same time to continue providing much-needed HTS in their respective health facilities. Upon completion of the 3-day or 6-day training programmes, trainees will be placed under the mentoring tutelage of an experienced HTS personnel who will be selected on the basis of their competencies as well as his/her enthusiasm for mentoring and appropriate attitudes towards training others. The duration of the mentoring should be three months.

5.1.3 QUALITY ASSURANCE (QA)

QA is the process by which programmes are constantly monitored to ensure that standards are maintained. It is intended to demonstrate that procedures are followed and are effective.

QA in HTS: This is ensuring the provision of high quality counselling and testing. It entails measures adopted to assess staff competency, client satisfaction and the adherence to counselling and testing protocols.

QA Strategies for Counselling include the use of:

- Counselling Reflection Form (See Annex VII) .
- HTS Client Exit Survey Form (See Annex VI) .
- Mystery Client Reports.

- Shadowing (understudying an older experienced counsellor).
- Regular Individual, Peer and Group Supervision and Monitoring Sessions.
- Counsellor Quality Assurance Tools by Independent Observers/External Supervisory visits by FMOH and stakeholders.
- Follow-up training, Stress Management, Exchange visits and Formation of Counsellor's Support network.

SESSION 2: COUNSELLOR SELF-CARE AND STRESS MANAGEMENT

LEARNING OBJECTIVES

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

- Define concepts
- Identify signs and symptoms of stress and burn-out
- Discuss the possible causes of stress and burn-out in HTS providers
- Discuss possible strategies to manage stress and burn-out related to the provision of HTS

5.2.1 DEFINITION OF CONCEPTS

Self-care

HTS providers should take care of themselves for self-preservation and emotional survival for effectiveness and efficiency. They are predisposed to stress because they are dealing with an incurable disease that has psycho-social implications. Much of the stress they experience is inherent in the nature of the work itself. As they provide support and counselling to clients and patients, they go through a lot of physical and psychological strain that should not be ignored. HTS providers must grow in self-consciousness and be able to recognize when they need support, and arrange for it in order to prevent stress and burn–out. Therefore, self-awareness is a vital component of self-care.

Stress

Stress is a physical, mental, emotional, psychological, or spiritual strain or tension caused as a result of over-working of the mind, body and soul. Stress is a psychological and physical response that occurs in difficult situations.

Burn-out

Burn-out is a reaction to the stress of counselling sessions that affects HTS providers' physical and emotional wellbeing.

Stress and burn-out arise from physical and emotional exhaustion involving the development of a negative self-concept, negative attitude towards one's job, loss of concern and feeling for clients among others. Being human, HIV/AIDS Counsellors are affected by the pain clients go through and death of their patients.

Useful stress –eustress

Useful stress is the pressure that helps us meet and overcome unpleasant or painful situations. It is the stress that makes life worthwhile without which we would be unable to function e.g. meeting a deadline.

Harmful stress

This is the stress that can cause problems that surface in the form of illness.
It is excess mental and physical strain on the body that causes physical and mental problems. Harmful stress can cause problems such as heart disease, migraine among others.

HTS personnel face daily challenges and stresses that can affect their physical and emotional health. Signs of burn-out are low energy, lack of enthusiasm or idealism for doing one's job, and a loss of concern for the clients and for the work.

Causes of stress and burn-out in relation to HTS provision

- Financial hardship
- Stigma associated with HIV/AIDS and Key Population
- Secrecy and fear of disclosure
- Over involvement with People Living With HIV and their families
- Personal experience with the problems of People Living With HIV
- Difficult clients
- Prolonged counselling sessions
- Not getting the necessary support from superiors
- Training, skills and preparation for work may be inadequate
- Lack of medication for patients
- Referral mechanisms may not be effective

Signs and symptoms of stress

- Loss of interest and commitment to work
- Lack of job satisfaction
- Helplessness
- Loss of confidence and diminished self-esteem
- Isolation
- Loss of sensitivity in dealing with clients

Signs of Burn-out

- Irritability and negativity
- Frequent headaches or stomach problems
- Exhaustion or tiredness that does not go away after rest
- Unusual anger
- Weight loss or gain
- Poor sleep
- Poor concentration
- Avoiding patients and problems
- Withdrawing from others
- Resorting to alcohol
- Frustration

2.2 STRESS MANAGEMENT AND PREVENTION OF BURN-OUT

There are measures that can help counsellors prevent stress and burn-out, but HTS personnel must take time to notice if their work is affecting them and identify early signs of stress and burn-out. HTS personnel should routinely practice stress management techniques both in the work setting and in their personal lives.

Ways to prevent stress and burn-out

- Be aware of causes of stress and try to avoid them
- Discuss problems with someone else and ask for feedback and guidance
- Improve your professional skills
- Share work issues with another person or counsellor while respecting client confidentiality
- Use coping strategies that focus on problems rather than emotions
- Take care of your life outside of your work
- Feel valued as a person and as a colleague
- Establish linkages with existing psycho-social support networks.
- Ensure proper time management.

Some stress management strategies

- Re-evaluation of expectations and performance goals; be realistic, do not expect more of yourself or others. Set realistic goals (e.g. do not take more clients than you can cope with).

- Establish a routine – the better organised you are, the better your work.
- Make necessary changes; change your attitude towards your situation
- Establish priorities
- Allow adequate break time during the work day
- Care for yourself, keep fit, exercise regularly, rest adequately, create time for leisure (spend time with family and friends) and eat adequate diet
- Use organised support systems – such as counsel support groups
- Update your knowledge of HIV Counselling and Testing regularly.

Key messages:

- HTS personnel should routinely practice stress management techniques both in their work station and personal lives.
- Support systems should be put in place to prevent and address stress.
- HTS personnel need to learn to recognize signs and symptoms of stress and be able to deal with them on time.

SESSION 3: ETHICAL ISSUES IN HIV/AIDS COUNSELLING

LEARNING OBJECTIVES

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

- Define ethics and ethical codes
- Understand the importance of the 5Cs
- Understand the principles of Human Rights
- Understand Ethical Code of conduct for counsellors
- Discuss ethical dilemma for the counsellor

ETHICS IN COUNSELLING

Introduction

Ethics is a set of principles or standards. It can also be referred to as guiding principles. Ethical code on the other hand is a system of moral principles governing the appropriate conduct for a person or group (in this case HTS providers).

The code of ethics outlines the fundamental values of counselling. Counsellors should understand these values so as to maintain a professional relationship with clients. The standards followed by counsellors serve to safeguard integrity, impartiality and respect, with regard to both parties. The following section outlines the main features of an ethical code of conduct for social workers, counsellors, clinical psychologists and other health professionals engaged in HTS delivery.

Core Principles for HTS

Counsellors shall be guided by the core principles, known as the "5Cs" which include: Consent, Confidentiality, Counselling, Correct test results and Connection with prevention, treatment, care, and support services.

Consent

- Persons receiving HTS must give informed consent for this service.
- Consent may be given verbally; written consent is not required.
- Persons receiving HTS should be informed of the process for HTS, and should understand their right to decline testing, even if they have already provided a sample for testing.
- For persons who are not able to give their own consent (i.e. mentally challenged, children), a capable representative of the client may give consent on their behalf.
- Non-consented HIV testing cannot be justified in any circumstance.

Confidentiality

- HTS must be confidential, which means that what is discussed by the HTS provider and the client shall not be disclosed to anyone else without the expressed consent of the person being tested.
- Confidentiality should be respected, but should not reinforce secrecy, stigma, or shame.
- HTS providers should discuss with clients, among other issues, whom the person may wish to inform about their test results, and how they would like this to be done. Shared confidentiality with partners, family members, or other trusted persons—as well as with healthcare providers—can be highly beneficial for the health and well-being of the client.
- Medical records, including those with HIV-related information, must be managed in accordance with appropriate standards of confidentiality. Only persons with a direct role in the management of the client should have access to these records. Clients should be assured that their records will be stored in a secure and confidential location, and should understand who will have access to them.
- Confidentiality of the client must not be breached except in unique situations such as when the provider has reason to believe the client will commit suicide or otherwise harm themselves, believing that the client is no longer able to take responsibility for his or her decisions and actions and when a court orders the disclosure of such information.

Counselling

- Pre-test information can be provided in a group setting, but all people should have the opportunity to ask questions in a private setting if they request it.
- Following the HIV test, all clients should have the opportunity to receive appropriate and high-quality post-test counselling based on their HIV test result and their HIV status reported.
- Quality assurance (QA) mechanisms including supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.
- Counsellors are responsible for their own physical safety, effectiveness, competence and conduct, thereby avoiding any compromise of the counselling profession
- Counsellors must ensure that they have received the required training in counselling skills and techniques
- Counsellors should regularly monitor their competence through supervision or consultative support, and by seeking the views of their clients and other counsellors
- Counsellors must recognize their boundaries and limitations of competence, and provide services, skills and techniques for which they are qualified by training and practice
- Counsellors must refrain from any claim that they possess qualifications or expertise that they do not
- Counsellors must make appropriate referrals to others with expertise that they do not possess
- Counsellors must refrain from making exaggerated claims about the effectiveness of the intervention offered by their services in relation to HIV prevention and care

Correct Test Results

- HTS providers should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis.
- QA includes both internal and external measures, supported by the national reference laboratory.
- All persons who receive an HIV-positive test result should be retested to verify their diagnosis before, or at the time of, initiation on HIV treatment.

Connection with Prevention, Treatment, Care, and Support Services

- All persons tested should be connected with appropriate prevention, treatment, care, and support services based on their situation and their test results.
- Providers should support clients to access follow-up services by actively linking them with these services.
- This includes identifying barriers to accessing follow-up services and identifying strategies with clients to overcome these barriers.
- Providing HTS without linkage to treatment has limited benefit for persons with HIV.

Respect for Human Rights

The following principles of human rights should be understood and adhered to by all HTS providers and programme managers in their client interactions:

- The right to comprehensive and accurate information for making choices about one's health and well-being
- The right to education
- The right to privacy
- The right to non-discrimination, equal protection and equality before the law
- The right to marry and establish a family
- The right to the highest attainable standard of physical and mental health
- The right to live
- The right to shelter
- The right to employment or a means of a livelihood
- The right to safer sex practices
- The right to dignity

- The right to participate in economic activities, including obtaining a loan to set up a project (socio-economic support)
- • The right to health care without discrimination
- • The right to freedom of worship
- • The right to vote and be voted for
- • The right to freedom of speech

Counsellors must recognise the fundamental human rights, dignity and worth of all people. Like any other health professional, counsellors are expected to provide services to people irrespective of their race, culture, religion, values, or belief systems. Counselling is not about forcing people to conform to certain "acceptable" standards. Rather, it is a process in which clients are challenged to honestly evaluate their own values and behaviour, and then decide for themselves in what ways they will modify them.

Effective counselling must take into account the impact of culture on a client's perception of the world. Specifically, counsellors should conform as follows:

- Be aware of socio-cultural differences of gender, age, race, ethnicity, religion, sexual orientation, disability and socio-economic status
- Be aware of personal prejudices and biases based on the above-mentioned human differences.
- Refer clients to another counsellor if socio-cultural differences of gender, age, race, ethnicity, religion, sexual orientation, disability and socio-economic status interfere with the counselling in any way
- Refrain from participating in or condoning any discriminatory practices based on the above mentioned human differences
- Take necessary steps to ensure that clients suffer no physical or psychological harm during counselling
- Strive to promote clients' control over their own lives, and respect clients' ability to make decisions and change in the light of their own beliefs and values

ETHICAL CODES FOR HTS COUNSELLORS

Personal Conduct

- Counsellors must conduct their counselling activities in a way that does not jeopardise the interests of their clients or undermine public confidence in their service or that of their colleagues

- Counsellors must maintain respect for clients in the counselling relationship by not engaging in activities that seek to meet counsellors' personal needs at the expense of clients.
- Counsellors should not exploit any counselling relationship for the gratification of personal desires. Sexual harassment, discrimination, stigmatisation, and derogatory remarks must be avoided.
- Counsellors should refrain from use of alcohol, drugs or other substances that can impair judgement at work.
- Counsellors should appear professional and presentable in dressing and manner.

Integrity

- Counsellors must seek to promote integrity through honesty, fairness and respect for others.
- They should not engage in a personal or sexual relationship with clients.
- They should not accept to counsel clients with whom they have engaged in former sexual relationship or with whom they have a current personal relationship.
- They should not engage in any relationship (including counselling) with a client in another service facility except on referral.
- Counsellors have a responsibility both to individual clients and to the institution within which counselling services are performed, in order to maintain high standards of professional conduct.

Disciplinary Measures

- Counsellors and Counsellor Supervisors have a responsibility to other counsellors and must take measures to correct them when wrong doing is observed.
- Counsellors who breach the code of ethics would face disciplinary measures in line with the local policy in their facilities
- Erring counsellors would be sanctioned by the National HIV/AIDS Counselling Professional Association when established, but in the interim the National HTS Task Team can perform that function.

ETHICAL DILEMMA

HIV/AIDS counsellors should be aware that they may face a number of ethical dilemmas, including issues of:

- Confidentiality
- Client dependence
- Disclosure of test results to partners
- Provision of services to minors
- Appropriateness of gifts received or offered

Counsellors may encounter situations not covered in this manual. When facing an unfamiliar situation, counsellors should remain calm, use their judgment and call on the

techniques of counselling to help the client. If counsellors are unsure of how to respond in any given situation, they should seek help according to the rules in place at their counselling centre. Knowing when to ask for help, and being able to accept it, are essential qualities of a counsellor.

When a Client's problem is beyond a counsellor's capabilities, it is far more effective and useful from the client's point of view if the counsellor refers the problem to an experienced counsellor (with client's consent) rather than attempting to solve it by him or herself.

Scenario for exercise

Case study 1

Ene (24 years old) had diarrhoea for two weeks, loss of weight and fever. Her mother took her to the doctor who took some blood specimens for investigations. After two days, he informed Ene's mother that Ene was HIV positive. Ene threatened to sue the doctor.

- What grounds does Ene have for suing the doctor?

Case study 2

You are conducting a counseling session with a male client who has received a positive test result. He is extremely anxious and defensive. He has told you he has many partners and is married. His wife does not know about his other relationships. He refuses to tell her about his HIV status and about his other relationships. He tells you that she is probably already infected and that informing her or getting her tested would only add to his stress at this time: " What's the point of letting her know the test results? It would only cause her extreme agony. Also, I don't know how she is going to handle knowing I have had sexual relations outside of our marriage. It would mean the end of our marriage and the break up of our family. I can't handle that on top of my positive test result."

1. What are the issues?
2. How do you respond?
3. What are the rights of the client? What are the rights of the wife?
4. What are your obligations as his counselor?
5. What do you see as the central ethical and cultural issues in this case?

Case study 3

A fifteen-year old girl from a nearby secondary school came to you in confidence for counseling and testing two weeks ago. She informed you that she had been sleeping with a teacher who threatened to hold her back if she did not have sexual relations with him. She told you if you informed any one she would not come back for the test results.

1. What are the legal and ethical issues in this case?
2. What are her rights? What are the rights of her parents or guardians?
3. What are you going to tell your client?
4. How do you handle the whole situation?

Case study 4

An eighteen-year old girl from a nearby high school came to you in confidence for counseling and testing two weeks ago. In the last session the girl said clearly that if her test results were positive she would kill herself. You are giving her the results today- they are positive.

1. What are the legal and ethical issues in this case?
2. What are her rights? What are the rights of her parents or guardians?
3. What are you going to tell your client?
4. How do you handle the whole situation

SESSION 4: COMMUNITY MOBILIZATION

LEARNING OBJECTIVES

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

- Define Community and community mobilization
- Discuss the benefits and challenges of involving the community in HTS
- Discuss the community mobilization process

INTRODUCTION

HTS has been promoted through mass media. Additionally, demand for HTS has also been generated by engaging community gatekeepers and influential network leaders to communicate key messages about HTS. Community mobilization is therefore important to scale up HTS.

DEFINITION OF COMMUNITY AND COMMUNITY MOBILIZATION

A community is a group of people who have something in common and will act together in their common interest.

Community Mobilization is a means to define and put into action the collective will and shared concern of the community and to decide together in order to create shared benefits.

Mobilization is the art of Informing, Sensitizing, Educating and Motivating towards realization of desired goals. Community mobilization in HTS is the process of involving and motivating key stakeholders such as; General public, Health workers, Home-based care givers, planners, Policy makers, Leaders etc. to organize and take action against HIV. Mobilization of communities should focus on increasing knowledge and enabling community members to participate.

BENEFITS OF COMMUNITY MOBILIZATION

- To create awareness about available resources within the community
- To assist people to understand their environment
- To make full use of local community resources to improve people's quality of life
- To demonstrate, guide and assist people to do things for themselves at little or no cost using locally available resources
- To persuade and encourage people towards social awareness and behavior change
- To encourage community efforts and activities based on voluntary participation and action
- To identify the problems and seek means of solving the problems together
- To gather information

CHALLENGES OF COMMUNITY MOBILIZATION

- General lack of sustainable strategies to assist families and communities to access HTS.
- Inability of the support NGOs to build the family and community structures for people to address their own problems
- Lack of commitment of key stakeholders in the community to own the HTS programme
- Widespread household poverty that hinders the efforts of the families, communities and volunteers
- Over – dependency by communities on external support

COMMUNITY MOBILIZATION PROCESS

STEPS IN COMMUNITY MOBILIZATION

The steps in community mobilization are;

1. Assess needs
2. Develop plans
3. Mobilize resources
4. Implement actions
5. Monitor activities involving the community at every stage using various mechanisms and tools

In the Process;

- Ensure that the community members take ownership using internal resources
- Recognize the fact that community members are already dealing with the issue of HIV and AIDS and they can be more effective if they work together
- Identify internal community resources and acknowledge individual skills and talents

PRINCIPLES OF COMMUNITY MOBILIZATION

- Ensure active participation by involving as broad and representative a group of community members as possible
- Uphold the rights and dignity of people living and affected by HIV
- Provide for equal partnership and mutual respect between the community and external facilitators
- Build on realities of living with HIV while maintaining hope based on potential community collective action

KEY MESSAGES

- Share the vision and purpose of the community mobilization program
    - Hold meetings with key individuals and community groups
    - Make announcements through mosques, churches, schools etc
    - Arrange group community talks
- Once mobilized, grassroots' group or organization should try to engage the entire community in responding to its shared concerns, e.g. everybody should participate in HTS. It is effective only when the community and family are involved and informed i.e. not just health workers
- For sustainability of the program, work with structures already active in the community

SESSION 5: SUICIDE RISK ASSESSMENT AND MANAGEMENT FOR PATIENTS WITH HIV/AIDS

Session Objectives

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At the end of the training session, trainees will be able to:

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- Understand some of the reasons for suicide and various methods of suicide
- Conduct a suicide risk assessment
- Identify the referral sources for suicidal clients
- Understand counselling issues for suicidal clients
- Apply effective management strategies for counselling a suicidal client

Introduction

The act of suicide is a communication that implies that there is a problem which needs resolution. Death may be seen as a way out of difficult circumstances. Frequently, people who feel miserable and think of suicide will share that feeling and confide in someone. They are often amenable to intervention and eventually find alternative means to structure their lives, although this process may be interrupted by cries for help. However, the belief that people who threaten to kill themselves *never* do so is wrong!

All suicide threats should be taken very seriously.

Common myths

- People who think or plan to commit suicide keep their thoughts to themselves, and the suicide occurs without warning
- Those who talk about suicide will not do it
- People who talk about suicide are just attention seekers
- Suicidal people have the intention of dying
- Talking openly about suicide may cause a suicidal person to end their life
- Suicidal acts reflect a disturbed mind or mental illness

Suicide Risk in HIV-Positive Patients

There are two periods during which HIV-positive individuals are most likely to attempt suicide. The first is when the person is initially diagnosed; suicide may occur as an impulsive response to the emotional turmoil that follows. The second period of high risk occurs late in the course of the disease when the central nervous system complications of AIDS develop, the capacity to earn declines, and the feeling of being a burden on family members and care-givers arises. During the late stage of the disease, patients experience adjustment issues associated with the stage of the disease, impairment of thinking and the possible complications of underlying changes in brain chemistry.

Other factors which may contribute to suicide risk are:

- A pre-existing mood disorder (depression, anxiety or mania)
- A current psychiatric disorder such as schizophrenia or bipolar disorder
- Presence of other psychosocial stressors, e.g. relationship breakdown
- Substance use or withdrawal
- Inadequate support network
- Discomfort with sexuality and/or gender

Classification of Suicide Methods

- Violent methods: This is when the client uses or thinks of using violent means as a way of killing themselves, e.g. hanging, shooting, burning, planned accidents, jumping from heights, etc.
- Nonviolent: When the client uses nonviolent methods such as drug overdose, poisoning, exhaust fumes, suffocation, etc.
- Passive methods: Suicide can also occur in a passive form as patients may choose to die by refusing to accept treatment. This can be distressing for care-givers and raises many ethical considerations. While this may be considered an informed and reasonable decision on the part of the individual, it may also reflect an underlying masked mood, inappropriate guilt or a response to poor palliative care.

Suicide Risk Assessment

A good assessment interview is part of the therapy. It is often enough to change suicidal thoughts. In most cases, the client comes in during a crisis and requires urgent attention. They can be accompanied by a relative but the counsellor should first see them alone. This is because many para-suicidal clients feel powerless and are often unwilling to be frank and open about their problems in front of others who may be part of the problem.

When a counsellor is dealing with a case of para-suicide, it is important to first have the client medically examined. Always check whether they have taken anything poisonous before beginning counselling. Do not be too quick to sit down and counsel

when in fact the client could have taken some poison and could collapse during the session. Suicide ideation or attempted suicide is closely related to feelings of hopelessness. It is important to determine the individual's thoughts about the future and his or her beliefs about improvement in the current circumstances. If the individual believes that a positive change is unlikely, the counsellor can try to restore hope by reassuring the individual that everything possible will be done to help and by teaching them the structured problem-solving method. The counsellor will also need to be on the lookout for other symptoms that may suggest the presence of clinical depression. Specialist referral may be necessary.

Assessing risk level

- The counsellor should explore and assess whether the risk of suicide is high or low.
- A detailed risk assessment summary should be sourced and used as a guide.
- Assessing the risk level is essential as it will determine the further steps the counsellor should take.

Referral Indications

Suppressed emotions, an 'already dead' feeling, are the most dangerous sign. Often the client is frank enough about the intention to eventually kill themselves, but sometimes they deny this in order to be released from the HTS centre. Some clients are in total denial or in anger. These clients need to be referred to a psychotherapist, clinical psychologist, psychiatrist, etc. if necessary. Other clients may need referral to specific helping agencies, e.g. legal aid, welfare organizations supporting unmarried mothers and single parents, etc. Many suicide attempts are made in the context of a family row. Para-suicide is more often connected with anger and perceived helplessness than with depression. The angry client must be challenged to think of new ways to vent their anger. If the clients claim that they never become angry, you know that anger seems so dangerous to them that they refuse to recognize it. There is no human being who never becomes angry. Dealing with denied anger is a different task and therefore an indication for referral.

At-a-glance risk determination

High-risk

- Current suicidal thoughts
- Client reports feeling of hopelessness
- Use of maladaptive coping strategies
- Multiple attempts; lethal means used
- The attempt was made when others were not present
- The client says they will try again

- The client says they will not try again but cannot give a good reason as to what is now different
- Declining health and limited treatment options
- Client feels they are a burden

Low-risk

- Only one attempt. Less lethal means used
- Client expresses some feelings of hope
- Client displayed well-developed coping responses to past crises
- The client gives a valid reason for not wanting to repeat the experience, e.g. the pain made them realize that death was not the answer
- Single attempt, which was made impulsively
- Someone else was informed immediately
- Client indicates they have mixed feelings about suicide. Can provide a good reason why they may not commit suicide, e.g. against their religion, will upset the family
- Client may express concern that they are a burden but feel suicide would place a greater burden on others

Steps for the Management of Suicidal Clients

These are determined by whether the client is at the pre- or post-suicidal attempt stage, although these stages have some similarities. *Always assess the risk in both stages.*

Guidelines for assessing and managing suicide

1. Pre-attempt stage
   - Determine the severity of the problem and assess the need for hospitalization
   - Negotiate for voluntary hospitalization or refer to the client's doctor
   - Do not leave a suicidal person alone while arrangements are being made for referral
   - Help develop alternative mechanisms for coping and decreasing stress
   - Mobilize a support system for the client
   - Initiate (verbally or in writing) a no-suicide contract to ensure the short-term safety of the client

2. Steps for high suicide-risk individuals
   - Ensure appropriate supervision or hospitalization for the individual.
   - Do not leave the individual alone for any length of time.
   - Refer to a psychiatrist or mental health specialist
   - Family and friends may be able to provide suitable supervision

3. *Steps for low suicide-risk individuals*

- Ensure the client has access to suitable clinical care when required (e.g. crisis team, extended hours team, general practitioner, hospital, telephone support).
- Develop a suicide contract—try to delay the individual's suicidal impulses. For example, make a 'contract' with the individual in which they promise not to attempt suicide within an arranged (short) period of time. Also, provide other options for the individual to use at times when he or she is on the verge of attempting suicide (e.g. suggest that the individual calls someone reliable for help, such as yourself, a trusted family member or friend, a doctor, or a crisis hotline).
- Restore hope in the client. Encourage the view that all problems can be solved. Identify, explore and validate the client's ability to cope with past crises or difficulties. Recommend learning a structured problem-solving method as an important skill to the individual.
- Environmental intervention may be required. Encourage the client's active participation in the current situation. Involve family members in caring for the individual. Encourage a supportive network away from the counsellor (e.g. family, friends, and agencies). Encourage the use of community resources (e.g. crisis hotlines, police, medical centres). Refer to services as appropriate (e.g Support Groups). Help the individual resolve any immediate conflicts with others who are contributing to the problem. Help the individual structure time between therapy sessions, and ensure that sessions are frequent, regular and planned in advance.

Some special problems counsellors may encounter with clients

Individuals who refuse to talk. An individual may refuse to discuss their previous suicide attempt or current thoughts or plans because:

- They may be afraid that they will be prevented from committing suicide
- They may be embarrassed or ashamed of having the suicidal thoughts or of their previous suicide attempt/s
- They may be afraid of being labelled 'mentally ill'
- They may be afraid that they will be sent to a hospital
- They may doubt the confidentiality of the interview
- They may be oppositional or manipulative

Questions Used to Probe for Suicidal Thoughts

Whenever any client is angry or depressed, the counsellor should determine whether they are contemplating suicide. Do not be afraid of putting ideas into their head; they are probably there already and your asking will not make any difference.

Some questions that can be asked to determine if the client has suicidal thoughts are:

- Do you sometimes feel it is not worth staying alive?

- Do you ever think of killing yourself? (If the answer to above question was yes)
- How would you do it? (If the above answer is yes)
- Have you ever tried to kill yourself?
- What happened on that occasion? (And so on)

SESSION 6: OVERVIEW OF NATIONAL HTS GUIDELINES

LEARNING OBJECTIVES

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

- Explain importance of National HTS guidelines in service delivery.
- Discuss the different sections of the National HTS guidelines.

IMPORTANCE OF HTS GUIDELINES IN SERVICE DELIVERY

With the country's high HIV infection rate, the need for increased access to HIV Testing Services (HTS) is becoming more compelling. It is common knowledge that knowing one's HIV status influences behavioural change.

HIV Testing Services is the entry point to prevention, treatment, care and support services. It contributes to reduction of the stigma and discrimination that surrounds HIV and AIDS. In Nigeria, access to knowledge of one's HIV status has mainly been through the provider-initiated approach, whereby patients with HIV-related signs and symptoms are tested for HIV for diagnostic purposes. With the new opportunities for prevention, treatment, care and support, especially the availability of Anti-retroviral drugs (ARVs) for PMTCT and AIDS treatment, there is need to scale-up both the client-initiated and provider-initiated approaches. However, in order to offer quality HIV counselling and testing services, there is the need to have guidelines for these services.

The guideline provides a framework and standards for implementation of HIV Testing Services (HTS) in Nigeria, and acknowledges recent advances in HTS delivery approaches. The guideline shall be the basis for the establishment and provision of HTS in Nigeria, and will inform the implementation of the UNAIDS global 90-90-90 HIV targets, which Nigeria has adopted.

SECTIONS OF THE NATIONAL HTS GUIDELINES

The purpose of these guidelines is to provide national standards that must be adhered to by all institutions, organisations and individuals for the provision of high quality HIV counselling and testing services in Nigeria. The HTS National Guidelines has eleven chapters.

Chapter 1: Introduction - This covers background, rationale, goal, objectives and target audience. The background deals with the HIV and AIDS situation in Nigeria and the efforts of Government in combating the epidemic. The goal of this guideline is to inform the establishment and delivery of HTS in Nigeria. While the target audience for the guideline include healthcare workers in facility, community and private sector settings who will read and use this document.

Chapter 2: Guiding Principles – This chapter describes the core principles that guide HTS known as the "5Cs" These are; Consent, Confidentiality, Counselling, Correct test results and Connection with prevention, treatment, care, and support services. This chapter also includes the ethical and legal considerations and operational requirements.

Chapter 3: Service Delivery Approaches – There are multiple approaches for delivering HTS in Nigeria. These are generally categorized into health facility-based approaches, community-based approaches, new or innovative strategies, and private sector.

Chapter 4: Priority populations – Chapter 4 places special attention on reaching populations at highest risks and/or who do not utilize HTS. They include; Adolescents, Infants and Children, Pregnant women, Men, Couples and partners, Key Populations and other special category populations (people with disabilities, survivors of sexual and gender based violence, orphans and vulnerable children, people in incarceration (prisoners), migrants, refugees and internally displaced populations and other vulnerable populations).

Chapter 5: Pre-test information and Post-test Counselling Services - This chapter addresses demand creation among the target population. It addresses pre and post-test counselling processes aimed at preparing an individual for the test as well as coping with

the result. It also deals with counselling scenarios like Requesting Testing Only, Requesting Counselling Only and linkage to appropriate follow-up services.

Chapter 6: Conducting the HIV test – HIV testing is carried out in public and private health facilities including NGOs/FBOs at the following tiers of care; tertiary, secondary and primary health facilities/clinics. This chapter describes basic principle for performing HIV testing; window period; HIV tests (HIV test for infants and children less than 18 months, Rapid Diagnostic Tests RDT, ELISA, HIV Self-Test, and Recency test); HIV Rapid Testing Strategy; Test for triage strategy and National HIV testing algorithm.

Chapter 7: Quality Assurance for HTS – Ensuring correct HIV test results is a priority and a crucial component of the 5Cs for HTS. Misdiagnosis of HIV must be prevented, and robust quality management systems should be established to deliver high-quality and accurate reporting of HIV status. QA is not a one-off activity or something that is undertaken by only one person. Rather, QA is an integral part of the ongoing roles and responsibilities of every staff member who is engaged in HTS. QA systems should be in place not only for ensuring the accuracy of test results, but also to ensure the quality of pre-test information and post-test counselling.

The chapter includes the; Nationally approved algorithm and test kits, Quality Management Systems, Training and Certification of Staff, Registration, Certification and Accreditation of HTS sites, Documentation and Record keeping, Universal safety precautions, Forecasting, quantification and procurement systems, Monitoring and improving HTS performance, and Quality Assurance for Pre-test information and Post-test counselling.

Chapter 8: Human Resources – HTS providers are the backbone of high quality HTS delivery. This Chapter addresses qualifications, training, mentoring, certification, staffing for results, and preventing burn-out.

Chapter 9: Logistics Management – Logistics Management issues are discussed in this chapter. Logistics and supplies take into account several factors such as; quantification and forecasting, effective procurement, distribution, warehousing, recording and reporting, and quality logistics management.

Chapter 10: Monitoring and Evaluation – Monitoring and evaluation (M&E) for HTS includes data collection, analysis, reporting, and use. Whereas monitoring involves the regular, routine assessment of ongoing activities, evaluation is episodic and examines large scale impact and achievements to answer specific management and epidemiologic

questions that will guide future actions, planning, and decision making regarding HTS. Both monitoring and evaluation are critical components of Nigeria's national HIV and AIDS framework. This chapter includes; Routine programme monitoring, Evaluation activities, and One M&E framework.

Chapter 11: Coordination and Scale Up – HTS coordination is multi-faceted and multi-level, with responsibilities spanning national, state, and lower level structures. At each level, various bodies are responsible for various functions. This chapter addresses HTS responsibilities and coordination in Nigeria and supporting scale up.

SESSION 7: LOGISTICS MANAGEMENT

OBJECTIVES:

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

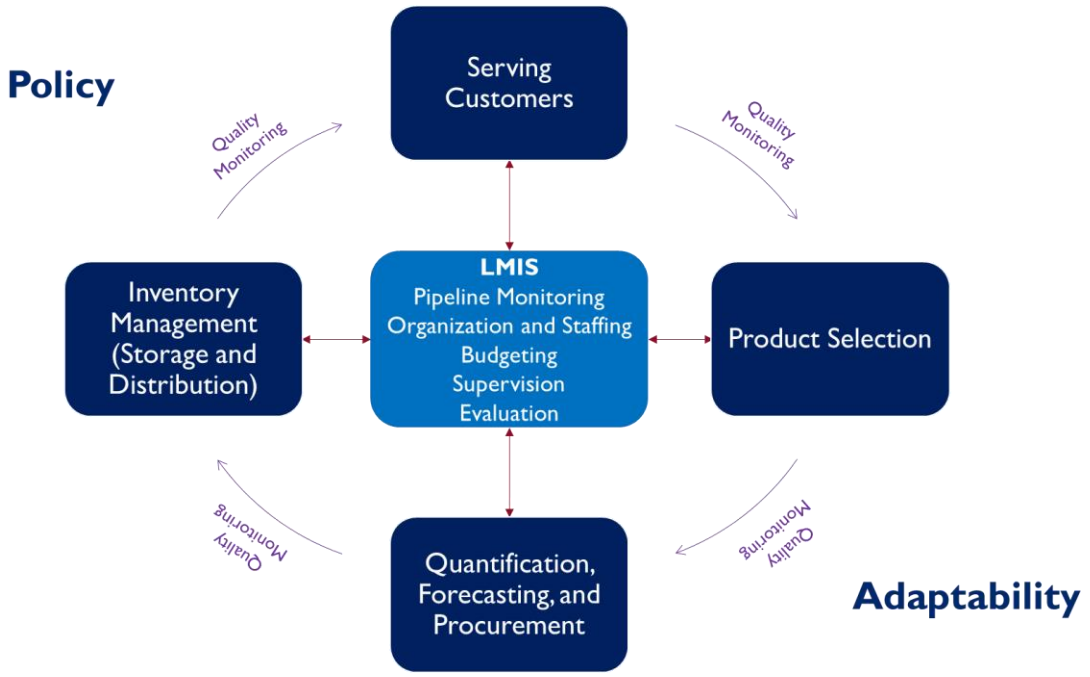
- Define and explain Logistics Management for HTS.
- Understand the goal of logistics system
- Discuss the components of HTS Logistics Management
- Understand the right storage conditions for HIV Test kits
- Understand how to determine SOH, AMC and MOS
- Fill the different HTS Logistics Management Tools

LOGISTICS MANAGEMENT

Logistics management deals with the efficient and effective process of managing, coordinating sourcing, procurement warehousing, distribution and rational use of supplies. Supplies in this context refer to the various commodities used in the HTS programme.

Goal of Logistics system

The goal of HIV/AIDS logistics system is to ensure a secure and dependable supply of HIV/AIDS commodities for diagnosing and treating people living with HIV and AIDS. To successfully address the HIV/AIDS pandemic in Nigeria, the HIV/AIDS logistics system must ensure that all commodities needed are made available. In essence, the logistics system must be capable of providing the following six rights:



Product selection:
Product selection is the first activity in logistics cycle. In any logistics system, product must be selected. For HTS product selection is based on national algorithm

Quantification and Procurement:
Quantification is the process of estimating the quantities and cost of .the product required for a specific period of time.
Following product selection the quantity required for HTS commodities must be determined and procured.

Inventory management and Distribution:
Once the product has been procured it is now the role of inventory management to store and distribute. The product must be stored under the right storage condition using storage guideline. Inventory management gives the data for informed decision making.

Serving the customer:
Each activity in the logistics system is set to ensure excellent customer service.

Logistics Management Information System (LMIS)

LMIS is the motor that drives the logistics cycle; without information the logistics system will not be able to run smoothly

Issues of logistics and supplies must take account of several factors, namely:

- Source(s) of funds for the implementation of the logistics programme
- Scope of the programme
- Effective forecasting
- Effective quantification
- Effective procurement
- Warehousing/Storage and distribution
- Rational use
- Monitoring and evaluation
- Feedback mechanism

To ensure non-interruption of supplies, it is important to establish procurement and distribution system for test kits, consumables and equipment to be used in HTS facilities. HIV test kits selection and testing protocol will be in conformity with the national interim algorithm. Forecasting, quantification, budgeting, financing, procurement and distribution of test kits will be evidence based.

Procurement of test kits

All test kits for the public sector will be procured centrally at the national level. Other service providers must only procure test kits recommended by the FMOH (HIV/AIDS Division). All procured kits will be in line with the agreed national algorithm in the standard operating procedure manual. Simple/rapid test kits that do not require refrigeration will be more appropriate for HTS sites located in areas where constant electricity supply is not guaranteed. Test kits with long shelf life should be used in remote areas and sites performing smaller numbers of tests.

Distribution of Test Kits

The FMOH will distribute test kits to public health sector facilities and will also maintain an emergency or buffer stock of rapid HIV test kits for distribution when needed. However, where central/national procurement is not feasible, states and other service providers must only procure test kits recommended by the FMOH (HIV/AIDS Division-NASCP) and distribute to all facilities within their area of jurisdiction.

Storage Guidelines

In general, supplies should be protected from sun, heat, and water. Follow manufacturer recommendations for storing supplies. This information is usually printed on the product carton and boxes. Good storage practices save time, storage space, and prevent waste.

The following are storage guidelines that should be followed at all facilities:

Storage Procedures	Why This Procedure is Important
1. Limit storage area access to authorized personnel and lock up controlled substances.	HIV/AIDS commodities are very costly. Prevent theft and pilferage by keeping stocks in locked enclosures and using what is deemed "appropriate security measures" during storage, reception, and transport. Physical counts should be conducted on a regular basis to verify inventory records and identify any problems as soon as they occur.
2. Clean and disinfect the storeroom regularly and take precautions to discourage harmful insects and rodents from entering the storage area.	Insects and rodents can damage product packaging as well as the products themselves.
3. Store HIV test kits and lab consumables in a dry, well-lit, and well-ventilated room at room temperature	Keep products out of direct sunlight. Extreme heat and exposure to direct sunlight can dramatically shorten shelf life.

4. Protect the storeroom from water penetration.	Water can destroy both supplies and their packaging. If the packaging is damaged, the product is still unacceptable to the patient even when the drugs themselves are not damaged. Repair the storeroom so that water cannot enter. HIV/AIDS commodities are particularly sensitive to moisture.
5. Check expiration dates of incoming HIV Test kits and lab consumables and store them to facilitate "first-to-expire, first-out" (FEFO) procedures and stock management.	FEFO guidelines require that HIV Test kits and lab consumables that will expire first are issued first, regardless of when they were received at the health facility. The shelf life of some HIV Test and laboratory consumables in particular, can be as short as three months from the date of manufacture, so it is especially important to follow FEFO for these products.
6. Store all health commodities away from insecticides, chemicals, flammable products, hazardous materials, old files, office supplies, and equipment; always take appropriate safety precautions.	Exposure to insecticides and other chemicals can damage products and affect the shelf life of commodities. Storing old files and other office supplies reduces space needed for storing health commodities. "Dejunk" the storeroom regularly to make more space available for the storage of HIV/AIDS commodities.
7. Store flammable products separately from other products. Take appropriate safety precautions.	Some medical procedures use flammable products, such as alcohol, cylindered gas, or mineral spirits. Such products should be stored away from other products and near a fire extinguisher.
8. Separate from usable commodities and dispose of damaged or expired products. Remove them from inventory immediately and dispose of them using established procedures.	Do not use expired HIV test kits and lab consumables for testing. Designate a separate part of the storeroom for damaged and expired commodities. Subtract damaged or expired products from the Inventory Control Card/Bin Card, and return them to the Central Medical Stores using the Record for Returning/Transferring Commodities.

Store Test Kits Using FEFO (First Expiry First Out) Principles

- As a general rule do NOT use expired test kits
- At regular intervals, check all stock for expiry dates. Place test kits with shorter expiry dates in front of those with longer expiry dates.

This method is referred to as first expiry first out (FEFO). FEFO procedures reduce waste caused by test kits expiry.

Logistics Management Information System (LMIS)

Stock Management of Test Kits

An effective logistics system is supported by timely logistics data that will enable HTS managers to account for and ensure adequate supplies of HIV test kits. The following information will be collected in this system:

Stock on hand: data on the usable quantities of stock held at the central and the facility level

consumption/usage: data on the quantities of products given to clients/patients during a particular period.

Losses and adjustments: Losses are the quantity of stock removed from the system for reasons such as expiration, damage, etc; adjustments are made when commodities are transferred from one service delivery point to another.

How much we have (stock on hand)	÷	How much we have used in a month (rate of consumption)	=	How long supplies will last (months of stock on hand)

Inventory Management

Inventory Management entails properly maintaining adequate stocks to ensure uninterrupted service, It also:

- Leads to high quality testing
- Ensures availability of materials and kits when needed
- Avoids the use of expired kits
- Minimizes wasting

Inventory Management Involves

- Performing a "stock count"
- Maintaining proper inventory records

- Determining when to re-order
- Determining how much to re-order
- Placing orders properly
- Inspecting delivery of new orders
- Ensuring proper storage of inventory

Relevant forms to collect and report the above-mentioned information are included in the annex.

SESSION 8: MONITORING AND EVALUATION

LEARNING OBJECTIVES

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

- Define M&E and explain its importance in HTS
- Discuss the components of HTS M&E, including the reporting mechanisms and data flow
- Fill the different HTS M&E tools
- Describe the M&E indicators for HTS

Definition

Monitoring and evaluation (M&E) for HTS includes data collection, analysis, reporting, and use. Strategic information from HTS programs can be used for the effective management and improvement of HTS, for tracking progress toward achieving program targets, and for tailoring service delivery approaches to maximize HTS coverage and uptake in order to achieve the UNAIDS 90-90-90 HIV goals.

Whereas monitoring involves the regular, routine assessment of ongoing activities, evaluation is episodic and examines large scale impact and achievements to answer specific management and epidemiologic questions that will guide future actions, planning, and decision making regarding HTS. Both monitoring and evaluation are critical components of Nigeria's national HIV and AIDS framework

Monitoring and evaluation for HTS services should be in line with the NHMIS and feed into DHIS.

The HTS database would be used to monitor and evaluate HTS services at the site, LGA, state, and national levels. The data should be used to identify programme areas that need to be strengthened for effective and efficient programme implementation. Special studies may be required for specific issues but in general, the emphasis should be on using the HTS database for program planning

Data Management

FMOH provides National HTS M&E tools, including forms, registers, and summary reports on key indicators, to be used by all programmes offering HTS. Furthermore, FMOH will provide guidance and training on how to complete these forms and registers, and the process of reporting. All data shall be submitted into the National Health Management Information System (NHMIS), and feed into the District Health Information Management System (DHIS) platform, a web-based data repository that contains facility-level aggregate data and is housed in the Department of Health Planning, Research and Statistics (DHPRS) of the FMOH.
Handling of HTS records and data requires confidentiality and efficiency. This will give the clients a sense of security.

- **Data Collection System:** The national HTS data collection and analysis system developed by HIV/AIDS Division of the Federal Ministry of Health will be in conformity with M&E guidelines
- **Data Entry and Transfer**: At each HTS site, the data collection forms should be completed and forwarded to the LGA, where the data are collated and in turn forwarded to the State Ministry of Health (SMOH). At the state level, all HTS data should be collated, analysed and forwarded to the FMOH.

- **Data Collection Tools:** The following instruments are used to collect HTS data;
    - Client intake form
    - Request and result form
    - HTS register HTS monthly summary form
    - Daily HIV and Syphilis testing worksheet
    - Client referral form
    - Referral register

- **Coding System**: A standardised system of assigning codes or reference numbers to clients for identification purposes should be used within each institution

- **Record Keeping:** A filing system for HTS records should be used within each institution. All records must be kept confidential and stored in a secure room with lockable cabinets

- **Data Entry and Transfer**: At each HTS site, the data collection tools (see annex) should be completed and forwarded to the LGA, where the data are collated and in turn forwarded to the SMOH. At the state level, all HTS data are collated, analysed and forwarded to the FMOH

- **Data Analysis and Reporting**: Data collected should be analysed and findings should contribute to programme planning and implementation. Feedback mechanisms should ensure that each level of service and management is informed on a quarterly basis regarding HTS

Quality Assurance

Staff competency, client satisfaction and adherence to counselling and testing protocols should be assessed periodically. Quality assurance measures and examples of selected tools can be found in the annex. Periodic external data quality checks should be conducted by HIV/AIDS Division of the FMOH and other stakeholders. These checks will include a review of site registers and reporting forms for completeness and accuracy.

Monitoring Activities

The FMOH in collaboration with partners ensures the availability of HTS M&E at the HTS sites. . Guidelines and training manuals/materials will also be provided to support sites in their HTS while the FMOH in collaboration with partners and other stakeholders will support training on data collection and reporting.

Evaluation Activities

Process and outcome evaluations should be periodically conducted before HTS scale-up to assess current programme success and inform future revisions of the National HTS guidelines and strategic plans.

HIV Testing Services Programme Reports

1. "Best practices" should be documented by all facilities
2. All facilities/sites should produce monthly, quarterly and annual reports of HTS
3. National annual HTS reports should be produced by the NASCP/FMOH and feedback given to the facilities

4. The annual reports should be discussed in annual meetings where progress on data, challenges faced in service provision, "best practices" and the way forward will be agreed upon

For this session, you will need to make reference to the copy of your national HTS guidelines or the HTS M&E tools will be distributed to you. The facilitator will explain each of them and you can add your own notes to facilitate your understanding. The following forms will be discussed:

- Client intake form
- Request and result form
- HTS register
- HTS monthly summary form
- Daily HIV and Syphilis testing worksheet
- Client referral form
- Referral register

National HTS Indicators

Indicators for the National HTS programme include those that measure Coverage, Quality of service, Quantum of Service provided and Outcome.

These are listed in the table below. Details on them can be found in the HTS Performance Indicator Reference Sheet (PIRS) "

HIV Testing Services (HTS) National Indicators

Programme Area	Indicator Type	Indicator	Periodicity of reporting	Source
HTS 1	**Output indicator**	**Number of people tested HIV negative and received their results**	**Monthly**	**HTS Register**
HTS 2	**Out put indicator**	**Number of people tested HIV positive and received their results**	**Monthly**	**HTS Registe r**

HTS 3	**Output indicator**	**Number of people tested for HIV and received their results more than once within the present year**	**Monthly**	**HTS Register**
HTS 4	**Output indicator**	**Number tested HIV Positive that were identified as previously Known HIV positive during post–test counselling**	**Monthly**	**HTS Register**
HTS 5	**Output indicator**	**Number of couples counseled, tested and received their results**	**Monthly**	**HTS Register**
HTS 6	**Output indicator**	**Number of couples counseled, tested for HIV and received discordant results**	**Monthly**	**HTS Register**
HTS 7	**Output indicator**	**Number of Index contact Tested for HIV**	**Monthly**	**HTS Register**
HTS 8	**Output indicator**	**Number of Index contact Tested HIV positive**	**Monthly**	**HTS Register**
HTS 9	**Output indicator**	**Number of HTS clients clinically screened for TB**	**Monthly**	**HTS Register**
HTS 10	**Output indicator**	**Number of HTS clients identified as presumptive TB**	**Monthly**	**HTS Register**

HTS 11	**Output indicator**	**Number of HTS clients clinically screened for STI**	**Monthly**	**HTS Register**
HTS 12	**Output indicator**	**Number of HTS clients screened for syphilis**	**Monthly**	**HTS Register**
HTS 13	**Output indicator**	**Number of HTS clients screened for Hepatitis**	**Monthly**	**HTS Register**
HTS 14	**Output indicator**	**Number of donated blood units screened for HIV, HBV, HCV and syphilis using ELISA**	**Monthly**	**HTS Register**

REMEMBER
DATA COLLECTION AND MANAGEMENT ARE KEY TO EFFECTIVE MONITORING AND EVALUATION OF THE HTS INTERVENTION AND SUBSEQUENT FUNDING. ENSURE THAT THE SYSTEMS ARE IN PLACE AT YOUR HTS FACILITY

MODULE 9: HIV DIAGNOSTICS

Session Objectives

At the end of the training session, trainees will be able to:

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- Give an overview of HIV Diagnostics and define relevant terms
- Give examples of Programmes using HIV Diagnostics
- Describe the equipment required for HIV Diagnostics and identify relevant Supplies and Kits needed for HIV Diagnostics
- Know the importance of safety at Test Sites and describe the importance of assuring quality of HIV Diagnostics
- Demonstrate the procedure for blood collection using finger prick or other blood collection methods safely and correctly
- Demonstrate the process of HIV Diagnostics including interpretation of results
- Demonstrate good understanding of medical waste management

INTRODUCTION:

Identification of individuals infected by HIV can only be achieved through laboratory investigations. There are many types of HIV testing techniques such as serologic (antigen/antibody) detecting assay or Genetic Material Polymerase Chain Reaction (PCR). The group of tests used in serology is ELISA and rapid testing. These tests involve the use of blood, blood products, saliva, semen or other body secretions. However, the best way to know whether someone is infected with HIV is to test his/her blood for the presence of the virus or its genetic material. These tests for viral antigens or its genetic materials are very expensive, time consuming and difficult to perform. The alternative option, which is more widely used, is the rapid testing. It is easy to perform, less expensive and sensitive.

The following terms should be noted in HIV testing:

Window period: This is the period of time between initial infection with HIV and the time HIV antibody can be detected in the blood stream. This varies from 2 to 6 months (or more) depending on the sensitivity of the test kit used and the immune system of the individual.

Sensitivity: This is the accuracy with which a test can confirm the presence of an infection i.e. identifies HIV antibodies in appropriate specimen (detects true positive specimens as positive). Because test kits with high sensitivity show few false negatives, they are recommended to be used to screen blood prior to transfusion to ensure blood safety and as the first line assay screening tests in HIV testing algorithm (in the absence of more accurate tests).

It is calculated thus:

$$\text{Sensitivity} = \frac{\text{True positive (TP)}}{\text{TP + False negative (FN)}} \times 100$$

Specificity:It is the accuracy with which a test can confirm the absence of an infection i.e. identifies the absence of HIV antibodies in appropriate specimens (detects true negative specimen as negative). Tests with high specificity show few false positives and are to be preferred for the diagnosis of HIV infection in an individual or used as the second assay in a screening algorithm with double ELISA or double rapid test kits. Specificity is determined as follows:

$$\text{Specificity} = \frac{\text{TN (True negative)}}{\text{TN + FP (False positive)}} \times 100$$

Cross-reaction: This is when an antigen not only recognizes its own antibody, but also other antibodies that have certain similarities that may be present in the specimen. This may result in false positive results.

HIV Tests

HIV Tests for Infants and Children Less than 18 Months

For infants less than 18 months, definitive confirmation of HIV infection can only be done with virological testing using Nucleic Acid Testing (NAT) technologies, since maternal HIV antibodies may remain in the infant's blood until 18 months of age. All children less than 18 months should be referred for Early Infant Diagnosis (EID) services.

Rapid Diagnostic Tests (RDTs)

RDTs are recommended for HTS because they are fast, simple and accurate. Results are available between 15-30 minutes (depending on the assay), and they can be performed in all settings without any need for specialised laboratory personnel or equipment. They are easy to use and can be performed with quality by trained lay and healthcare providers.

Enzyme-Linked Immunosorbent Assays (ELISA)

ELISA tests take a longer time process than RDTs. They were originally developed for blood donor screening, and are more suitable for batch testing in settings where large numbers of clients are seen daily. Only trained medical laboratory scientists can perform this test.

HIV Self-Tests

There are currently three commercial HIV RDTs specifically labelled and packaged for HIV self-testing, and more are under development. HIV self-tests use either oral fluid or whole blood specimens. HIV self-tests perform as accurately as provider-delivered RDTs, provided the self-tests meet quality, safety and performance standards. HIV self-tests should include instructions for use that provide detailed and easy-to-interpret guidance on how to perform the HIV self-test. These might also include links to a video where persons using HIV self-tests can watch how to perform an HIV self-test. Persons using HIV self-tests should also understand the meaning of the results, and where and how to access follow-up services including additional testing, if the self-test result is HIV-positive. Anyone distributing HIV self-tests should ensure the assays have been approved for self-test use.

Recency Tests

A select number of emerging testing technologies allow for the ability to detect early HIV infection, for example HIV infection that occurred within the last six months. These tests are only beginning to be evaluated for wide scale use, but may show a lot of promise for breaking the chain of HIV transmission, since early detection of HIV infection may allow you to know where the infection came from and to reach out and also offer HIV testing to those person(s).

Benefit of HIV rapid testing

Rapid tests are recommended for HTS services in all settings. The Rapid tests that are recommended by WHO have been evaluated and have been found to have high levels of sensitivity and specificity comparable to ELISA tests. The rapid test kits being used in Nigeria have also been evaluated by the Federal Ministry of Health (FMOH) NASCP. Their advantages are as follows:

- Easy and quick to perform
- Use a very small amount of blood from the person's fingertip
- Efficient for screening single or small number of tests
- Can be done in clinics without laboratories
- Requires minimum materials and skills,

- Allows for same day result collection.
- Generate minimal medical waste

Disadvantage

- Being antibody based, It cannot detect window period
- Room temperature for storage condition may be misleading (Room temperature in Nigeria varies from zone to zone)
- Cannot be used for children <18 months.

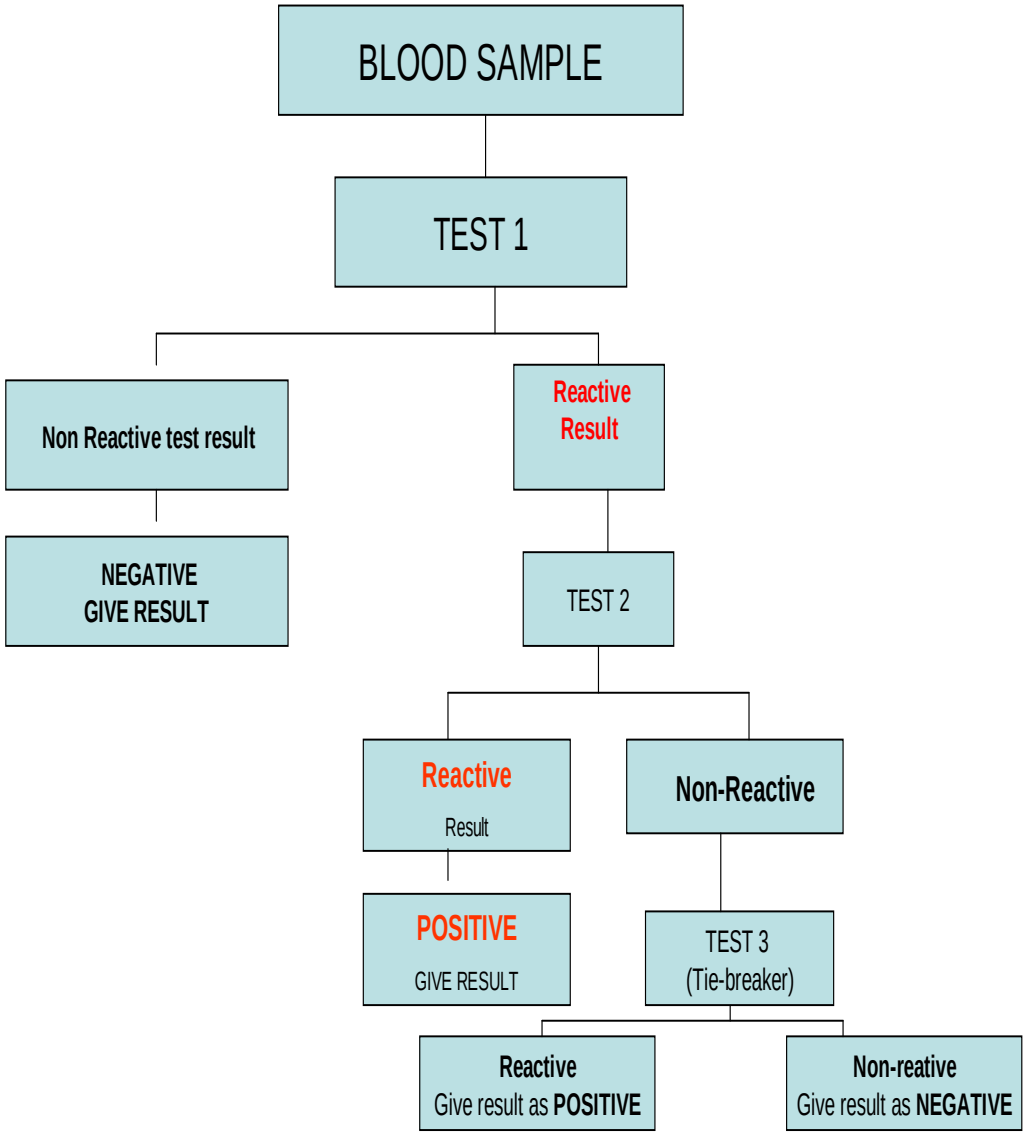
HIV TESTING ALGORITHM

Algorithm is an approved sequence of steps followed in performing HIV tests for the purpose of diagnosing HIV infection. There are two types of algorithms; these are Serial and Parallel algorithm.

The serial testing strategy is currently recommended by the FMOH, which all HTS sites are mandated to follow. This strategy involves three levels of testing. Conduct the initial test with one rapid test kit (screening test). If the result of the first test is non-reactive, interpret the result as negative. Samples that are reactive by the first test are confirmed as positive if second test is also reactive. But if the second test (confirmatory test) is non-reactive, proceed with the third test kit (tie breaker). The result of the third test which usually agrees with either the first or second test results is accepted and given out.

Invalid test result refers to a test situation where internal control does not show or no test reaction is observed.

SERIAL TESTING ALGORITHM



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CRITERIA FOR RECOMMENDING TEST KITS IN THE ALGORITHM:

HIV Test kits recommendation is based on:

- Stability at room temperature
- Use of whole blood

- Visual reading of results
- Availability i.e. currently available and in use in Nigeria
- Performance based on sensitivity and specificity with local samples
- Duration of assay
- Complexity of assay
- Shelf life
- Cost

RECOMMENDED SERIAL ALGORITHM TEST KITS

S/N	Screening test	Confirmation of positive	Tie-breaker
1	**Determine**	**UniGold**	**StatPak**

PRINCIPLE OF TESTING:

A number of rapid assays are based on one of four immunodiagnostic principles: particle agglutination, immunodot (dipstick), immuno-filtration or immuno chromatography. They have been developed for ease of performance and quick results. These assays generally require less than 30 minutes to perform and do not require special equipments. In addition, whole blood, capillary blood, serum or plasma can be used for some of the assays. Many of these rapid tests contain "inbuilt" internal control such as band or spot indicating whether the sample materials or the reagents were added correctly.

Immunochromatography

The test kits in the current algorithm are based on immunochromatography. These assays are rapid, easy to perform do not require sophisticated equipment. The results are read by development of colour. Sensitivity and specificity of most of these assays compare favourably with ELISA.

The assays utilize recombinant or synthetic peptides spotted onto nitrocellulose paper/ micro particles. The antigen containing matrix is housed in a plastic device containing absorbent pads underneath to collect reactants. Each assay contains an immunoglobulin captured control to validate the result. These assays are very good for single test application such as in emergency unit, autopsy room, labour room and peripheral blood banks.

When choosing the type of test to use, their sensitivity and specificity should be considered. The first test must be highly sensitive and the second should be highly specific.

PREPARATION FOR TESTING

Definitions of the supplies included in rapid tes kits:

- **Lancet**: A disposable sterile instrument used to puncture the skin for the finger prick procedure

- **Buffer solution**: The test liquid used to activate the HIV rapid test after the client's blood is placed on the test strip.

- **Test strip**: The rapid HIV test. Where the client's blood from the capillary tube is placed and then the buffer is added. This is where the test result will be determined.

- **Desiccant packet**: A preservative intended to keep the test kit contents dry prior to opening the packet. It should be retained in the packet until the test device(s) are exhausted.

Before starting the test, with the aid of checklist, have all your materials properly arranged at the testing area.

Materials required:

- Test kit: if stored in refrigerator, bring to room temperature.
- SOPs and Job Aids
- Sterile Lancets
- Alcohol swab/gauze
- Dry swabs/gauze
- Sample applicator (some kits come with pipettes for drawing blood)
- Disposable hand gloves
- Waste disposal containers (sharps container and biohazard bags)
- Disinfectants e.g sodium hypochlorite
- Marker
- Timer
- Record forms
- Absorbent bench pad.

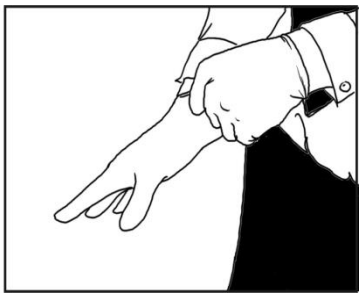
Steps to Perform the Finger-prick Procedure

Before pricking, ask client if there is any issue of bleeding disorder

1. Put on protective clothing e.g laboratory coat.
2. Wash your hand and dry
3. Put on your gloves
4. Explain the procedure to the client first.
5. Choose the finger with the least callus area
6. Clean the finger with alcohol swab, starting in the middle and working out to avoid re-contaminating the area.
7. Allow the alcohol to air dry
8. Take the lancet and show it to the client to assure him/her that it is new
9. Using an auto-lancet, hold the finger firmly, place the lancet on the fingertip and press the lancet against the skin and puncture the skin. If using the standard lancet, hold the finger firmly and make a quick firm prick.
10. Wipe away the first drop of blood with sterile dry gauze/cotton wool
11. To help the blood flow, hold the finger and apply gentle pressure to the base of the finger.
12. Collect the blood specimen according to the manufacturer's instructions.
13. Give the client a dry gauze pad or cotton wool to place on the finger until the bleeding stops.
14. Before the client leaves the testing area properly dispose the gauze pad or cotton wool into non sharps waste containers and lancet into the sharps container.

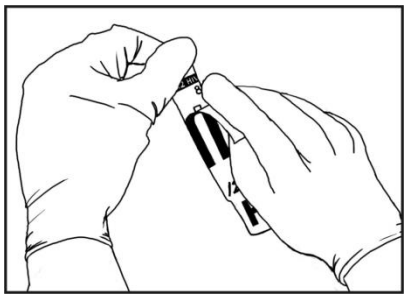
1. Wash hands with antibacterial liquid soap under running water and air dry or use disposable serviette.

2. Put on latex gloves.

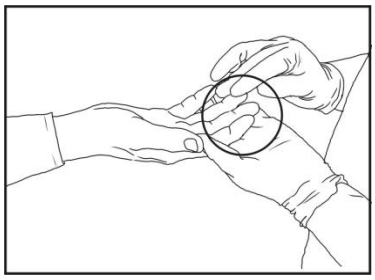


3. Label test in front of client with his or her unique identification number.

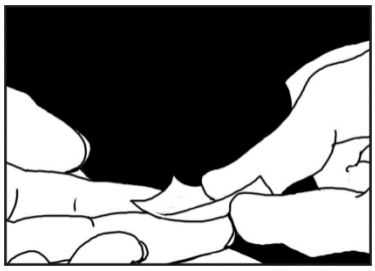
4. Remove test covers and open pouches of test.



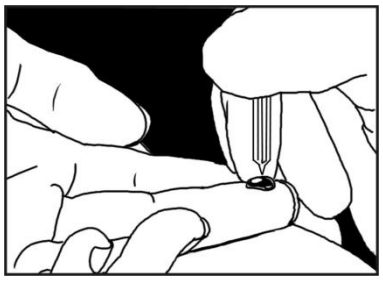
5. Holding the palm up, choose the least calloused fingertip of client



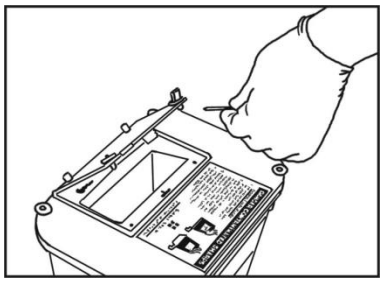
6. Clean client's fleshy area of fingertip with alcohol swab.



7. Tell client that you are going to prick his or her finger, and it may be uncomfortable. Hold finger lower than elbow. Prick cleaned finger with lancet (finger-prick device). Use a swift motion when pricking client's finger. A slower motion is very uncomfortable for the client.



8. Place lancet in sharps container. Never reuse the lancet!



TESTING:

First, record test date, client identification, name of person performing test, type of test kit, lot/batch number and expiry date of the kit on the worksheet

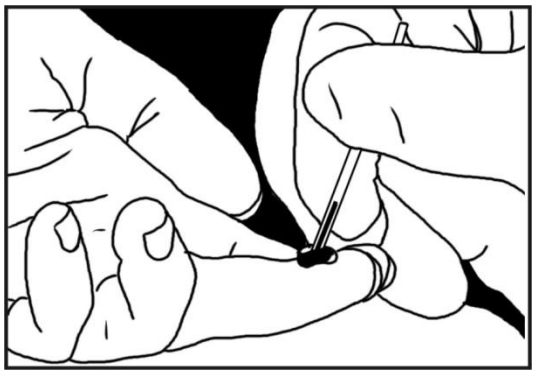
Using a strip based HIV-1/2 test kit as an example

1. Use one strip per test
2. Record the client identification at the top of the test strip
3. Remove the foil covering the test strip
4. Collect blood using 50 micro liter pipette or a capillary tube

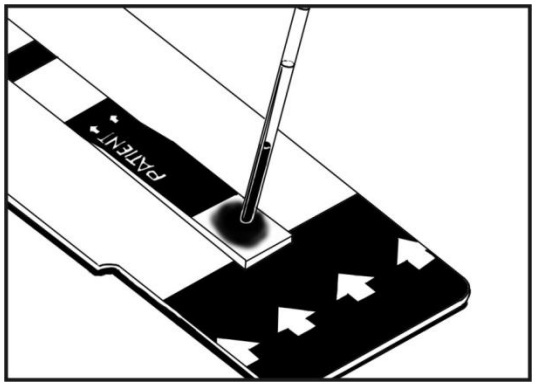
5. If using a pipette add all the blood onto the absorbent pad on the test strip, if using the capillary tube, add one drop of blood to the absorbent pad.
6. Wait thirty seconds to one minute (30 sec – 1 mins.) until the blood is absorbed on the pad
7. Add one drop of chase buffer to the blood specimen on the pad
8. Start the timer and read the results in 15 minutes
9. Discard the used gauze/cotton wool before the client leaves the testing area.

Steps for Conducting strip base HIV Rapid Test

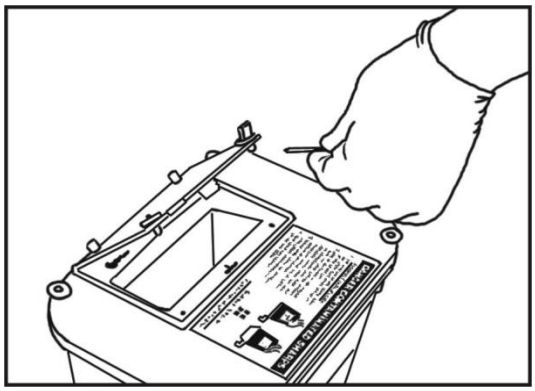
1. Take clean capillary tube and place gently on finger. Keep your thumb on the tube and gently tap so tube can fill up with blood.



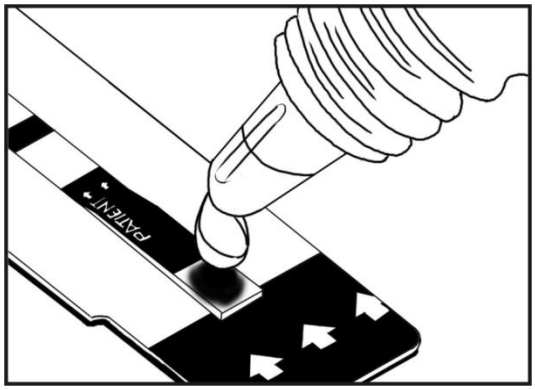
2. Place the required volume of blood sample on the absorbent pad on the strip.



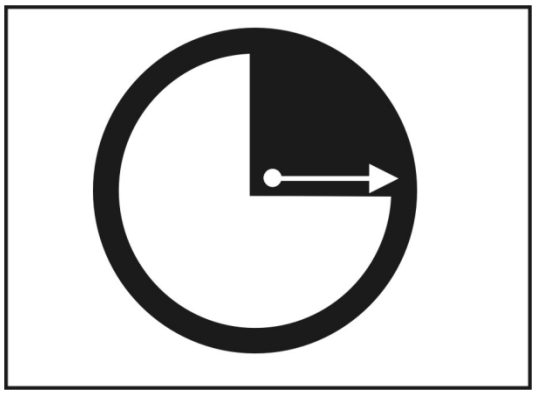
3. Put tube in sharps container. Do not reuse tube!



4. Add one drop of buffer solution over the blood on the strip to activate test.



5. Wait for 15minutes (not longer than 60 minutes) before reading the test result.



<u>Note</u>: Use only the buffer solution made for the HIV rapid test kit you are processing.

INTERPRETATION OF RESULTS:

Reactive: Two red lines/spots on the test strip: one line /spot on the control window and another line/spot on the patient window.

Non – reactive: One red line on the control window only.

Invalid: No line on the control window even if there is a line on patient/ test window.

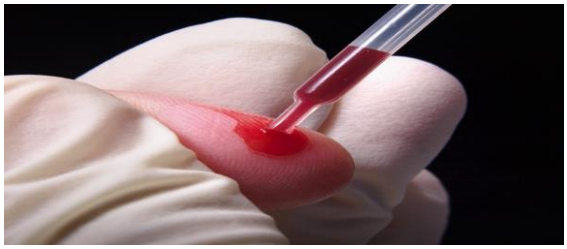
Using a Cassette based HIV-1/2 test kit as an example

- Open a single kit for a patient by removing the protective foil cover.
- Label test cassette with patient identifier and enter intolog book.
- Select the finger that is least calloused and perform a finger prick using a new lancet.
- Using an EDTA capillary tube, or a precision pipette if sample is already in sample bottle, collect about 60uL of blood, and apply to the sample pot of the kit
- Immediately add two drops (approximately 60uL) of wash reagent to sample pot.
- The result should be read at the end of 10 minutes incubation time (up to 20 minutes

Steps for conducting cassette-based HIV Rapid Test

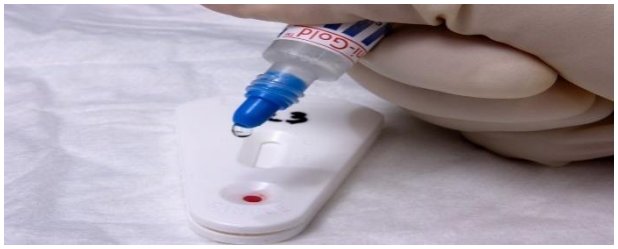
Remove device from package and label device with client identification number

Collect specimen using the disposable pipette



Add 2 drops (approx. 60µl) of specimen to the sample port in the device.

Add 2 drops (approx. 60µl) of the appropriate wash reagent to sample port.



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

Read and record the results and other pertinent info on the worksheet.

Note: Use only the buffer solution made for the HIV rapid test you are processing.

INTERPRETATION OF RESULTS:

Reactive: Two red lines/spots on the test strip: one line /spot on the control window and another line/spot on the patient window.

Non-reactive: One red line/spots on the control window only.

Invalid: No line on the control window even if there is a line on patient/ test window.

QUALITY ASSURANCE (QA)

Quality assessment, QA is the process by which programmes are constantly monitored to ensure that test result are reliable and accurate. It is intended to demonstrate that procedures followed are effective.

The aim of QA is to eliminate errors and ensure credibility of test results.
QA consist of:
Internal quality control (IQC) and
External quality assurance (EQA)
QA is achieved by:

- Adhering to the set standards
- Ongoing training of personnel
- Compliance with proficiency test programme
- **Periodic checks on results and repeat test by supervisors**

There are two levels of QA

Quality control: It involves the following:

- Good laboratory practice with set standards for performing HIV tests.

- Systems for management of HIV tests results
- Inclusion of previously characterized samples in order to identify problems with competence of the person performing the tests and also the test kit.
- Every new batch/lot of test kit must be tested using control sera (negative and positive samples).
- Following universal safety precautions
- Good record management
- Access to post exposure prophylaxis (PEP)
- . Controls (Dried tube specimen – DTS): Provided to testing sites.

External QA: External quality assurance should be based on

- Training: Appropriate training of individuals with or without laboratory background
- Competency assessment and Certification: For those performing HIV diagnostic testing
- Supportive supervision and Audit using SPI-RT(Stepwise Process for Improving the Quality of HIV Rapid Testing) checklist: All stand alone or satellite sites must enjoy adequate supervision including observation of new testers
- Proficiency program using dried tube specimen: For each tester
- Test results are recorded in standard logbooks/registers.
- All sites providing HTS should receive HIV proficiency sample panel every four months.
- All sites failing the proficiency tests should receive additional technical supervision and help.

SAFETY MEASURES

Universal (Standard) Safety Precautions is designed to prevent transmission of HIV, hepatitis B virus (HBV), hepatitis C (HCV), and other blood-borne pathogens. Universal safety precaution states that **all blood samples and blood products should be handled as potentially infectious.**

Standard rules should be adhered to when working with blood or any other potentially infectious materials:

1. Smoking, drinking, eating, storing food and applying cosmetics must not be allowed in the testing areas.
2. Work surfaces must be decontaminated before and at the end of the working day. Any spill of potentially dangerous materials must be immediately wiped and the surface decontaminated.
3. Disposable latex Gloves appropriate for the work must be worn for all procedures that may involve accidental direct contact with blood and infectious materials**.**

4. **New hand gloves must be used for each client**. After use, the gloves must be removed aseptically and properly disposed.
5. Labels must not be licked; materials must not be placed in the mouth.
6. The testing area should be kept neat, clean and free of materials that are not pertinent to the work.
7. Hands must be washed after handling infectious materials, and before leaving the working area.
8. All accidents or potential exposures to infectious materials must be reported immediately to the supervisor. A written record of such accidents should be maintained.
9. All technical procedures should be performed in a way that minimizes the formation of droplets.
10. Personal protective equipment should be worn by all persons handling blood and other body fluids.

HANDLING OF MEDICAL WASTE:

Medical wastes should be segregated into sharps and non-sharps materials.

- Sharps (lancets and needles) should be placed in a specially designed sharp container and disposed when 3/4 full.
- Used test kits and other waste generated should be discarded in a separate disposable biohazard bag
- All disposable containers must be handled properly and incinerated or disposed off according to standard safety practices.

CURRICULUM OVERVIEW

This training package has been adapted to be more prescriptive, with emphasis on hands-on activities and the use of simple and practical tools and approaches to complete the quality assurance cycle and ensure the accuracy of testing. This curriculum contains an Introduction section, 10 modules for 2 full days and third day for field practical. The proposed agenda below lists the segments in the curriculum and estimated time requirement for each activity

Session 1. Quality Assurance Cycle for HIV Rapid Testing

Activities		Purpose	Time	Worksheets/Handouts	Resources
1.1	Components of Quality Assurance	Maintaining quality at a testing site will result in accurate and reliable test results, which are essential to all aspects of a client's care and treatment. In this activity, participants will define terminology associated with quality	45 min	N/A	PowerPoint slides: 4-8 Flipchart Markers Flash cards – terms and

		assurance.			definitions Flip chart
1.2	Identifying Errors Throughout the Testing Process	Quality assurance is applied throughout the testing process at all testing sites. Ensuring the quality of testing is not a one-time event. This is a continual process encompassing multiple activities associated with each phase of testing. This activity focuses on how to detect and prevent errors throughout the testing process.	45 min	N/A	PowerPoint slides 9 to 14 Flipchart Markers Flash cards
1.3	Factors Contributing to Quality	To ensure the quality of HIV testing, you need to look at all the activities, direct or indirect, that may contribute to quality. In this activity, participants will identify positive and negative factors that affect quality of testing and which component of quality assurance they refer to.	45 min	N/A	PowerPoint slides: 16-26 Flipchart Markers Cabbage ball
1.4	Completing the Quality Cycle	Quality Assurance encompasses all activities that are fundamental to ensuring the client receives accurate and reliable results. The type of activities implemented are critical to maintaining the quality of HIV rapid testing; however it is also important that the cycle of quality is complete (i.e. from design and development to providing corrective actions)	30 min	N/A	PowerPoint slides: Quality Assurance Activity 5.4 slides Flipchart Timer Markers

Session 2. Overview of HIV Rapid Testing

Activities		Purpose	Time	Worksheets/ Handouts	Resources
2.1	Basic terms and definitions for HIV rapid testing	Basic understanding of terminology will help understand the principle of the HIV rapid testing methodology. In this activity, participants will define HIV terminology associated with rapid testing.	40 min	NA	Flash cards – terms and definitions
2.2	Following the correct testing procedure	In order to get an accurate and reliable test results, it is very essential to follow correct test procedures the same way each time. In this activity, participants will gain knowledge on the order of the correct testing procedures and interpretation results for HIV rapid tests.	75 min	2.2W1 – Paste job aides puzzle in correct testing order	Pre-cut pieces of job aides

2.3	Workstation set-up, familiarizing with testing supplies and performing HIV rapid testing	An organized and clutter free workstation is safe and appropriate for testing. Additionally, proper understanding of each testing procedure and different supplies will allow each participant to perform a test with confidence. In this activity the following will be conducted: • Organize workspace • Understand different supplies • Test known samples (positive and negative control) on a given rapid test	2 hrs 35 min	2.3W1 – Quality Control Log 2.3W2 – Worksheet Recording Incubation Time	Testing supplies

Session 3. Safety at HIV Testing Sites

Activities		Purpose	Time	Worksheets/Handouts	Resources
3.1	Safety in-a box	Laboratory safety begins with proper knowledge/use of safety supplies and will ensure our safety and those around us. Safety equipment allows for a better safeguard for both the testers and the patients. This activity will allow participants to identify safety supplies and their proper use at HIV testing site	30 min	N/A	Box containing PPE and other safety equipment common to HTC settings.
3.2	Identifying unsafe practices	Basic understanding of safe laboratory practices will ensure the safety of lab & health workers as well as counselors; however, knowledge of good laboratory practices does not always result their proper implementation. In this activity, we will define Universal Safety Precautions and steps to take to protect ourselves and those around us.	35 min	N/A	Option 1 PowerPoint 2 slides 2-8 (Photos) Option 2 PowerPoint 1 slides: 12-18
3.3	Assessing and responding to safety incidents	Safety is a primary concern when dealing with blood or bodily fluids. In this activity, we will define what a bio-hazard is and steps taken in the event of a bio-hazard spill and other safety incidents that may happen at the HIV testing site. Through role plays, participants learn to assess, document, correct and follow-up safety incidents.	30 min	Worksheet 3.3W1 – Incident Report Form	Spill box Lancets/Needles Mock specimen

Session 4. Specimen Collection, Storage and Handling

Activities		Purpose	Time	Worksheets/Handouts	Resources
4.1	Practice using a specimen collection device	To provide the participants with necessary knowledge and skills to use a specimen collection device efficiently to collect blood specimens	25 min		Specimen collection device (i.e. transfer pipette, capillary tube, loop, etc.) Small containers of colored PBS/saline buffer PPE Bio-hazard waste container
4.2	Practice finger-prick collection and storage	All tests have specific requirements for sample type and volume. Collection of right amount of required sample is very critical. In this activity, you will learn the following: • how to perform a finger prick, • collect the right amount of whole blood for rapid testing • Learn how to prepare for finger prick and venous draw.	1hr 5 min		Flipchart Job aid Supplies required for finger prick (Lancets, pipette, cotton wool, alcohol swabs/alcohol) PPE Bio-hazard waste container

Session 5. HIV Rapid Testing Algorithm

Activities		Purpose	Time	Worksheets/ Handouts	Resources
5.1	Interpreting HIV Status based on a Testing Algorithm	Testing Algorithm describes the sequence of tests to be performed. An HIV positive status should be based upon the outcome of 2 or more tests. In this activity, participants will learn how to determine a patient's HIV status based on a serial or parallel algorithm using different testing scenarios.	25 min	N/A	PowerPoint slides: 4-8
5.2	Performing HIV rapid testing based on country specific algorithm	Testing Algorithm describes the sequence of tests to be performed. An HIV positive status should be based upon the outcome of 2 or more tests. In this activity, participants learn how to determine a patient's HIV status based on a serial or parallel algorithm using different rapid tests. In this activity all participants will perform HIV rapid testing based on country specific algorithm	1 hr 40 min	5.2 W-1 Results Recording Form	

Session 6. Overview of Record Keeping

Activities		Purpose	Time	Worksheets/Handouts	Resources
6.1	Design a Standardize HIV logbook	HIV test registers are often designed for inventory purposes and do not adequately capture key quality assurance elements. This has presented a significant challenge in identifying problems and targeting areas for improvement. This activity aims to identify important QA elements to be included in HIV test registers.	30 min	N/A	Flip chart and markers
6.2	Enter Data in a Standardized HIV logbook	A standardized logbook is an ongoing quality assurance monitoring tool. Relevant testing information is not always captured accurately or consistently in the logbooks. This activity will focus on how to accurately document HIV testing information in a standardized logbook.	35 min	6.2W1- Logbook Page 6.2H1- Data Entry examples	PowerPoint slides 1: 8-12 PowerPoint slides: Logbook Activity 6.2 slides 2-7 Laminated logbook page (enhanced size) Markers
6.3	Identify Errors in a standardized HIV logbook	A standardized logbook is an ongoing quality assurance monitoring tool. Relevant testing information is not completely captured in the registers. To	30 min	6.3H1- Completed logbook page examples	PowerPoint slides: Logbook Activity 6.3 slides 2-11

		recognize common errors that may be detected while reviewing HIV registers.		6.3W1- Logbook data review	Flipchart Markers
6.4	Review the Agreement Rate Between Two Tests	The page totals at the bottom of each logbook page allows the monitoring of the test performance by determining the agreement rate between the first and second test in the national testing algorithm. This activity aims to aggregate logbook testing data into a monthly summary report, analyze the data manually and identify any issues based on the agreement rate.	2 hrs 10 min	6.4H1- Five Completed Logbook Pages 6.4W1- Monthly Summary Report 6.4W2- Logbook Data Analysis and Review 6.4W3- Assessment of Agreement Rate	PowerPoint slides: 13-17 Calculator
6.5	Logbook Data Management	Standardized logbooks have been implemented in numerous countries an ongoing QA monitoring tool. However, data management has become a huge bottle neck which prevents sites from receiving feedback and implementing corrective actions in a timely manner. This activity will focus on how to use the Data Analysis and Quality Assurance Tool to analyze logbook page total data.	2 hrs	6.5W1- 5 Monthly Aggregate Logbook Page Totals	PowerPoint slides: 18-21 Data Analysis and Quality Assurance Tool Computer/Tablet

Session 7. Introduction to Dried Tube Specimen

Activities		Purpose	Time	Worksheets/Handouts	Resources
7.1	Introduction to DTS	Dried Tube Specimen (DTS) samples are a practical alternative to other liquid or dried blood spot (DBS) specimen types commonly used for proficiency testing (PT). This presentation is to provide participants with an introduction to the country's proficiency testing program and dried tube specimen (DTS) technology.	30min		PowerPoint slides 1-18
7.2	Testing DTS panels	Every DTS PT panel is distributed to testing sites with DTS Testing Instructions and a DTS Results Form included. This activity will focus on how end users will process the DTS panel upon receipt.	3 hrs 45 min	7.1H1- DTS Job Aide 7.1H2- DTS Testing Instructions 7.1 W1- DTS Results Form	DTS PT pack
7.3	DTS PT Data Entry and Analysis	Dried Tube Specimen (DTS) samples are a practical alternative to other liquid or dried blood spot (DBS) specimen types commonly used for proficiency testing (PT). Every DTS PT panel is distributed to testing sites with DTS Testing Instructions and a DTS Results Form included. This activity will demonstrate to participants how to manage and analyze the type data typically collected in a DTS PT program.	2 hrs 20 min	7.2H1- Dataset 7.2 H2- Sample Report	PowerPoint Slides 1-9 and 12-20 Computer PT Data Analysis Management Tool (PT DAMT)

Session 8. Professional Ethics

Activities		Purpose	Time	Worksheets/Handouts	Resources
8.1	Examples of Ethical Conduct	The intent is to provide the context and examples of the ethical dilemma that participants will likely face on their job. These examples will help them better grasp the abstract concept of ethics and facilitate discussions around their role as Q-Corps volunteers.	35 min	N/A	Power Point Slides 4-16 Flip Chart Markers

Session 9. Site Assessments

Activities		Purpose	Time	Worksheets/Handouts	Resources
9.1	Review SPI-RT Checklist	The Stepwise Process for Improving the Quality of HIV Rapid Testing (SPI-RT) checklist for use in HIV-related testing is primarily intended for use as a guide to assist and promote consistency in the application of quality management systems to improve healthcare services in resource-constrained settings and in low and middle-income countries. This activity will focus on how to complete the SPI-RT checklist and submit audit findings to MOH.	2hr 30 min	SPI-RT Checklist	PowerPoint Slides 2-16 Handout 9.1H SPI-RT checklist Flipchart Markers
9.2	Conducting a site assessment using the SPI-RT Checklist	Once the SPI-RT checklist is reviewed it is very important to perform the assessment at few sites that is performing HIV rapid testing. In this activity, an audit will be performed by the participants using the standardized SPI-RT checklist.	2 hrs	SPI-RT Checklist 9.2W-1 Inspector's Summation Report	Pens
9.3	Site assessment Summary report	The summary report is a critical of the site assessment as it allows describing best practices and outlining weakness and areas for improvement. This activity is an independent activity for all inspectors to provide a summary of their audit findings.	Overnight	9.3W-1 Site assessment summary report 9.3W-2 Multiple Site Assessment Data Analysis	Computer , data analysis

Session 10. Monitoring and Evaluation Tools

Activities		Purpose	Time	Worksheets/Handouts	Resources
10.1	Review RTCQI Monitoring and Evaluation Assessment Checklist	The Quality Improvement (QI) Initiative is a comprehensive approach to HIV rapid test quality assurance that addresses key areas of HIV rapid testing. This checklist will help gather baseline data of the key areas identified for this initiative serve to develop framework for strategic planning and work plans and determine timelines and budgets. In addition, the checklist will allow monitoring the progress throughout the implementation of activities related to the key QI areas. This activity will focus on how to complete the baseline assessment checklist.	1hr	RTCQI- M&E Assessment Checklist	PowerPoint Slides 2-10 Handout 10.1H RTCQI-M&E Assessment Checklist Flipchart Markers
10.2	Conduct a site assessment using the RTCQI Monitoring and Evaluation Checklist	Once the RTCQI-Assessment Checklist is reviewed it is very important to perform the assessment at few sites that are performing HIV rapid testing. In this activity, an audit will be performed by the participants using the standardized RTCQI-M&E Assessment Checklist.	2hr	RTCQI-Assessment Checklist Summary Report	Pens
10.3	Site assessment Summary report	The summary report is a critical of the site assessment as it allows describing best practices and outlining weakness and areas for improvement. This activity is an independent activity for all inspectors to provide a summary of their audit findings.	Overnight	Site assessment summary report	
10.4	Indicator Reporting Tool	The RTCQI indicators are developed to help monitor the implementation of activities and to demonstrate progress in strengthening country capacity to improve the quality of HIV testing. These indicators will help assess processes, outcomes and impact. The aim of this activity is to learn how to use the indicator reporting tool and understand how the data will impact programs overall.	1 hr	N/A	Indicator Reporting Tool Computer/Tablet

SESSION 11: BLOOD SAFETY AND VOLUNTARY BLOOD DONATION

Session Objectives

:

At the end of the training session, trainees will be able to:

- Understand the concept of blood safety and the concept of a centralised blood service
- Understand the importance of voluntary blood donation
- Develop pre-donation counselling skills
- Understand the importance of identifying low-risk potential blood donors for referral to NBTS for blood donation

Background

Blood is a critical element of medical treatment. Daily, a large number of units of blood are transfused for a variety of illnesses and conditions, including accidents, burns, heart surgery, organ transplants, leukaemia, cancer, sickle cell anaemia, Haemophilia and many others. Unfortunately, blood transfusion itself can be a cause of illness. Currently, the blood supply is much safer than it was in the past due to the importance given to voluntary blood donation, stringent donor selection criteria, and increased testing protocols for donated blood units and strict quality management programmes in blood transfusion services. It should be noted that the quality of blood depends on the selection of blood donors in blood donation sites or service points.

Implementation of blood safety in blood donation sites/service points

Every blood donation site or service point in Nigeria is advised to ensure that safe blood is provided to each patient. The incidence of HIV transmission through blood transfusion can be appreciably reduced by introducing safe blood transfusion practices.

Availability of safe blood is achieved by:

- Promotion of voluntary blood donation programmes and particularly motivating repeat donors
- Proper donor counselling for donor and recipient safety prior to donation
- Proper identification, deferral and counselling of high-risk donors
- Proper screening of donated units for transfusion transmitted infections (TTIs)
- Promoting rational use of blood among clinicians
- Assuring the quality of blood donation by motivating voluntary and repeat

donors.

Despite the existence of strict screening protocols, the incidence of HIV transmission through the use of blood and blood products remains a challenge in the Nigerian health system due to many hospitals and laboratories not adhering to these protocols

Proper donor counselling for donor and recipient safety

The pre-donation counselling of a donor is of great importance for selecting healthy donors whose blood can be considered safe. Pre-donation counselling requires the donors to complete a questionnaire and undergo a thorough medical, physical and laboratory examination to determine their suitability as a donor. The questionnaires help identify high-risk donors, who will be deferred from donating blood.

Proper identification, referral and counselling of high-risk donors

There are situations whereby some repeat voluntary blood donors or a few first-time voluntary blood donors fail to report high-risk behaviours during pre-donation interviews. Counsellors should have adequate skills to carry out interviews with that in mind and to assess the possibility of high-risk factors among the donors by taking them into confidence. Once high-risk behaviours are identified, the clients should be counselled appropriately regarding blood safety norms, deferred from further blood donation and should be referred to the HTS for pre-test counselling, followed by confirmatory testing and post-test counselling.

Proper screening of donated units for TTIs

In Nigeria, screening of each donated blood unit for HIV is mandatory. This protocol does not cover many other viruses/parasites; also, no protection is offered against emerging/unknown pathogens. In these circumstances, a thorough and proper history should be taken from the donor to help eliminate transmission of many of these pathogens. Even with the best possible testing kits available and excellent testing procedures, chances that infections may go undetected either due to window phase of infection or very low level of antigen/antibody in the blood sample still exist. There are many such testing limitations, which may lead to false reporting and transfusion of infected blood. Every counsellor should be aware of such possibilities and discuss the matter in detail with the donor during the pre-donation interview.

Pre-donation counselling in blood donation sites/service points

Pre-donation counselling of blood donors involves all major areas concerning donor and recipient safety. The donor is interviewed with the objective of selecting them as a blood donor, they are told that this will cause no untoward problems during or after

donation. Besides, the safety of the blood unit collected from such a donor is assured by laboratory investigations along with a lifestyle inventory which covers all aspect of donor and recipient's safety. The questionnaire has been designed to ascertain the past and present history of donors for any illness, family history, and any high-risk behaviour, medications, history of travel, and any rejection earlier as a blood donor. Blood donors who are found to be seroreactive for HIV markers in blood banks are referred for further pre-test counselling and confirmation of results to HTS centers.

Counselling in HTS centers stresses more on HIV-related behaviour or practices. It enables and encourages people with HIV to access appropriate care and is also effective for prevention of HIV infection and transmission. This service assesses individual risk factors and behaviour. Clients learn about the major modes of HIV transmission, safe sex and using disposable needles.

Ensuring blood safety and implications for HTS

While the vast majority of HIV infections in Nigeria are due to sexual transmission, the transfusion of unsafe blood and blood products accounts for a significant proportion of the HIV infections in the country. This form of transmission has nothing to do with the behaviour pattern of individuals. Blood safety remains an important component to provide adequate and safe blood and blood products to patients, and to ensure the safety of both donors and recipients. HTS centers can provide their expertise for HIV prevention through safe blood transfusion practice promotion and encouraging HIV negative clients to donate blood voluntarily and prevent new transmission.

Counselling donors on testing of donated blood units

Donors are made to understand that their blood units will be subjected to mandatory tests, which will be kept entirely confidential. All donated blood units are screened for the four mandatory tests of HIV, HBV, HCV and syphilis. The units found to be reactive for any markers are discarded. outrightly. The concerned donor has the right to know the result of the screening test and is consequently informed of his or her status.

HTS and blood donors

Essentially, the results of screening for TTIs can be revealed to blood donors. Donors, if found to be reactive for a particular marker, and who want to know about their status, should be referred to the concerned specialty for further testing and management. If the donor is found to be positive for syphilis, they can be referred to an STI clinic for further management. Donors found sero-reactive for HIV are referred to a HTS for further confirmation of the test and pre-test counselling. In the HTS Centre, the standard protocol of counselling and testing will be followed. After pre-test counselling, a fresh blood sample will be collected, the blood will be tested and the test result will disclosed to the client during post-test counselling. If the donor is HIV-positive, the HTS

counsellor will suggest to the donor not to donate blood again. The counsellors at the HTS should be aware of blood safety norms while counselling donors. They should explain the relationship between unsafe blood and HIV transmission to the donor. Counsellors should restrain them from further blood donation if they are confirmed to be positive for HIV. HTS centers can play a vital role in improving blood safety programmes by targeting high-risk groups and counselling them for HIV prevention.

Promotion of Voluntary Blood Donation Programme

It has been clearly documented that blood from a voluntary donor who is not remunerated is qualitatively superior to that collected from commercial donors. Since voluntary donors do not expect any monetary returns and donate exclusively on altruistic grounds, they do not tend to hide any of their medical problems from the Medical Officer or counsellor during pre-donation counselling. They are fully aware of the quality of their blood as well as the test for TTIs, which will be carried out on their donated blood units. Some problems might still exist while selecting voluntary donors for the first time. Hence, collecting blood from repeat voluntary blood donors is stressed worldwide, as the TTIs status of these donors is already known. There are reservations from some public health quarters in Nigeria on blood collection from commercial donors. Many of these visit hospital blood banks as replacement or related donors, which can be detrimental to safe blood collection. The danger of collecting blood from such donors should be highlighted during mass awareness campaigns or in counselling centres.

REFERENCES

Medical Laboratory Science Council of Nigeria (MLSCN) (2015): EQA Proficiency Testing.