

Annexure 1

Checklist for planning training

1. Setting the agenda

What to do	Required on which day of training	Date of task completed	Remarks
Decide training objectives Identify trainees Decide number of training days <ul style="list-style-type: none">• For 12 days• For 5 days Decide day-to-day schedule Identify resource persons Type and print the schedule			

2. Accommodation

What to do	Required on which day of training	Date of task completed	Remarks
Name of the hotel Address Telephone number Fax number Cost per room Single room Double room No. of rooms required Date required: From....To... Transport from hotel to training venue			

3. Training venue

What to do	Required on which day of training	Date of task completed	Remarks
Number of training days (12/5) Spacious enough to conduct activities Electrical outlets, lighting, microphone Furniture, availability of photocopier machine, fax, telephone Comfortable seating Wall space for displaying charts Does the venue provide for flip charts, white board, marker pens, projector, computer/laptop Vehicle parking space available Check for break time facilities <ul style="list-style-type: none"> • Tea/Coffee • Lunch 			

4. Provide the training centre/hotel/venue with the following information

What to do	Required on which day of training	Date of task completed	Remarks
Start and finish time on each day Coffee, tea and lunch break time Contact names and number of senior staff Information on specific requirements Copy of training schedule			

5. Letters to be sent to resource persons/trainees should contain

What to do	Required on which day of training	Date of task completed	Remarks
Name of training programme Objective of training Training schedule Date(s) of training Time Address of venue Contact person—name, address, phone number Is confirmation required? Travel directives (information on transport/ payment for travel)			

6. Checklist for Training Coordinator

What to do	Required on which day of training	Date of task completed	Remarks
Resource person's contact number Copy of letters sent Brief note on speaker Thank you note to speaker Extra handouts Activity sheets Activities for ice breaking, energizers, fillers Pre-/Post-knowledge questionnaire Evaluation of training questionnaire Stationery required <ul style="list-style-type: none"> • Pens/pencils • Notepad • Paper • Masking tape • Stapler/staples • Scissors 			

(contd)

What to do	Required on which day of training	Date of task completed	Remarks
<ul style="list-style-type: none"> • Scotch tape • Two-sided tape • Flip cards • Index cards • Chart paper • Transparency sheets • Marker pens 			

7. Audiovisual aids required

Item	Required on which day of training												
	1	2	3	4	5	6	7	8	9	10	11	12	
White board LCD projector Overhead slide projector Computer/laptop Extension cord													

8. Preparing for field visit

- √ Select site(s) for visit as per guidelines provided in Annexure 3
- √ Arrange for transport
- √ Send letters to the centres informing
 - i. Date and time of visit
 - ii. Background and number of participants visiting
 - iii. Objectives of visit
 - iv. Name and contact details of officials visiting the centre with the trainees
 - v. Requirements from the centre

9. On the first day of training

- √ Provide information on housekeeping rules
- √ Mention ground rules for training
- √ Introduce the training team
- √ Introduce the trainees
- √ Introduce concepts such as question box and parking lot
- √ Review training schedule
- √ Administer pre-training knowledge questionnaire
- √ Provide information on handouts/activity sheets
- √ Introduce the concept of trainee summary

10. On each day of training

- √ Check for questions in the question box and answer the same at the start of the day or through experts (resource persons).
- √ Keep handouts and activity sheets ready.
- √ Be prepared with fillers and energizers.
- √ Have the nominated trainee summarize the previous day's sessions.
- √ Ask for feedback, if any.
- √ Send reminders to resource persons for the next day.

11. Final day of training (in addition to the above point 10)

- √ Post-training knowledge evaluation
- √ Evaluation of training

12. Post-training work

- √ Score the evaluation forms
- √ Prepare report
- √ Submit Statement of Expenditure (SOE), if required

Annexure 2

Guidelines for conducting role-plays

Overview of the role-play process

1. Divide trainees into groups of three (triads).
2. Each triad nominates a 'counsellor', a 'client' and an 'observer'.
3. Give the case study to all clients.
4. Role-play the case provided.
5. Debrief within the triad for five minutes.
6. Debrief within small groups of all counsellors, all clients and all observers for 5–10 minutes. Discuss the following:
 - What made clients feel comfortable?
 - What skills were particularly important for counsellors to employ?
 - How did counsellors manage to balance provision of information with being responsive to the needs of the client's emotions?
7. As per number of case studies provided swap roles
 - Counsellors become observers
 - Observers become clients
 - Clients become counsellors
8. Repeat the process until all case studies are completed

Implementing HIV Counselling role-plays

Ideally, role-plays should be arranged by dividing the trainees into triads. Each triad should nominate a 'counsellor', a 'client' and an 'observer'. These three roles should be rotated between trainees so that they have an opportunity to experience each role. Accordingly, there should be three rounds of cases with one case being conducted per round. The trainer should hand the cases only to the trainees who are playing a client. The counsellors and observer should not be permitted to read the cases. The trainer should inform clients that ideally they **should not** share the cases with either counsellors or observers to make the role-play as real as possible.

Instructions to be given to each group

Counsellors are to practice applying the knowledge and skills learned through the lectures and other activities by completing the nominated task. If during the role-play become confused or uncertain, they should be instructed to refer to their notes, review their material and re-commence when ready. They should not ask for

assistance from their client or observer. If necessary, they should be instructed to put up their hand for assistance from a facilitator. At the conclusion of the role-play, the counsellor should discuss what they were happy with in their practice and what they would have liked to have done differently.

Clients are to play the role of the case outlined in the case study. They should attempt to allow the counsellor to practice obtaining the information rather than simply reading out what is written in the case study. Facilitators should instruct the clients to inform the counsellor if they are role-playing a person of the other gender, e.g. if the trainee is a female and playing a male client she should inform the counsellor that she is playing a male client. Clients should provide feedback to the counsellor at the conclusion of the role-play.

Observers are to observe the process of the role-play and provide feedback to the counsellor at the conclusion of the role-play. Observers should be asked to first give positive feedback and then constructive criticism. This helps in increasing confidence and avoiding discontent among trainees. Facilitators should remind observers that they should not interrupt the role-play.

Conclusion of each round

At the conclusion of each round, five minutes should be allowed for discussion and feedback within the triad. This exercise is to be followed by requesting the class to form three small groups. One small group should comprise all the trainees who played counsellors for that round, another group should comprise all the trainees who played clients and the third group should comprise all the trainees who played observers. A facilitator from among the trainers should be nominated to debrief each small group. One facilitator will debrief the counsellors, the other will debrief the clients and the third will debrief the observers. The small group facilitators should ask the trainees to share their role-play experiences and guide the discussion to the following three questions:

- What made clients feel comfortable?
- What skills were particularly important for counsellors to employ?
- How did counsellors manage to balance provision of information with being responsive to the needs of the client's emotions?

The small group debriefing should last no longer than 10 minutes following each round. Trainees should then return to their triads and swap roles. Different case studies should then be provided to the trainees who swap to being counsellors.

If only one or two facilitators are available then the debriefing should be performed as one large group following each round. Following the triads debriefing each other,

the trainees should be asked to return to one large group. Trainees should be asked to share their role-play experiences and the discussion should focus on the above three questions.

Finally, it is important to remind the trainees that they are in the process of learning. While they may feel overwhelmed at the beginning, each time they use the knowledge and skills they acquire, they will become more confident and improve their abilities.

Annexure 3

Guidelines for field visits

Field visit should be organized to provide the trainees with hands-on understanding of the operation and day to day functioning of VCT/PPTCT/ART centres. Field visits should include observation of activities at the centre, interaction with staff members and with clients visiting the centre. It should be followed by a debriefing session during which trainees discuss their observations and lessons learnt.

Planning and conducting a training field visit by the training coordinator

Ideally **one month before** the training, start to plan and organize the visit to a VCT/PPTCT/ART centre.

1. Contact one or more centres to gain permission for trainees to visit and meet with staff members.
2. Ideally, if there are several VCT/PPTCT/ART centres near the training venue, the trainees should break up into groups of 5 to 12 people each and visit different sites. Try not to send more than 20 trainees to any single facility.
3. In each centre organize meetings with the following groups:
 - Health-care worker (counsellors, technicians, I/C, nurse and/or physician)
 - Support staff
 - Programme manager and/or clinic director
 - Clients/patients visiting the centre

4. Send confirmation letter to the centres.

Once you have permission for the visit from the centre, follow up with a letter confirming the date and timing of the visit and the visit objectives. It may be a good idea to include the following in the letter:

- A brief description of the training (how many trainees, the disciplines of the trainees, etc.)
- The training content and how the field visit supports the overall goals of the training
- The geographic area from which the trainees come
- Information on how long you expect the visit to last
- Information on what the centre should share with the visiting trainees
- Other information you feel the centre should know
- Consider attaching a copy of the training agenda.

The day before the field visit

Call the I/C of the centre and reconfirm the visit. Provide important updates on the

training that you had not anticipated when you first spoke to them (for example the final number of visitors).

On the day of the visit

Field visit teams:

Divide trainees into teams and assign trainees to the different centres. Select a team leader for each team from among the trainees by asking the team to appoint a team leader. The team leader will be responsible for speaking on behalf of the group, when only one voice is necessary. For example they should ask trainees to introduce themselves, explain the objective of the visit and how long it will take, take the lead on asking questions, ensure that the other trainees in the group have an opportunity to ask their questions, conclude the visit and ensure the staff of the centre are thanked for their time and expertise. The leader should, on no account, dominate the meeting; instead they should simply facilitate, guide the discussion to ensure that it achieves its objectives, ensure that everyone in the group has a chance to speak and ensure that the group keeps to time. Ask the trainees to return to the training room at a pre-designated time.

The training coordinator should provide

1. The team leader with contact details (name, phone number, location) of the in-charge of the centre the team is visiting.
2. The trainees with information on what they should observe during visit.
3. The centres with information they should share with the trainees.

Once the team arrives at the VCT/PPTCT/ART centre, the team leader should contact the in-charge of the centre. After introductions, the team leader should initiate the discussion using the following questions as a guide:

1. Describe the flow of clients to your centre.
2. How many clients/patients visit the centre each day? How are they managed?
3. Describe the process on how clients/patients move through the centre—from when they enter the centre to the time they receive reports.
4. List the different registers and records maintained.
5. How are records maintained? Where are they stored?
6. Who prepares the monthly reports? Where is data extracted from the monthly report?
7. Describe the role and responsibility of each staff member in the centre.
8. What are the changes the centre has undergone since its inception?
9. Where are the monthly reports sent?
10. What does the centre do with the client data they collect?
11. What linkages and referrals have been set and how?
12. Who supervises the staff and how?
13. Is information, collected on clients, shared with the staff? when and how?

14. Are regular meetings held within the centre? Who attends the meeting, what are the issues discussed in these meetings?
15. In case the counsellor needs help whom do they go to?
16. Is there a DOTS/DMC centre within the hospital?
17. What are the different IEC materials you use?
18. What other monitoring data do you collect (clients satisfaction surveys, information received from staff during review meeting)? How are they used?
19. Are any other test offered at the centre?
20. Is emergency testing performed at the centre? What is the procedure followed?

Adapt these questions as appropriate keeping in mind the objective of the field visit. Feel free to re-arrange the questions to allow the discussions to flow and delete questions that seem inappropriate. Try not to ask questions that seem inappropriate. Try not to ask questions that were answered earlier.

Information which the team at the centre could share;

- Clinician (counsellor, nurse and or physician)
 - For how long have they been working with the VCT/PPTCT/ART centre?
 - How many clients/patients visit their centre each day?
 - Describe the client/patient flow at the centre?
 - Share information on forms, records, registers and reports that you complete at the VCT/PPTCT/ART centre.
 - When do they complete these records (eg. when the patient is in front of you or after the clinical visit)?
 - Do they record information for each client/patient?
 - What other reports do each staff member write or contribute to?
 - To whom do they submit the reports/forms?
 - What comments do they have on the process of completing the forms and reports?
 - Do you feel like the effort they put into reporting is worth it?
- Support staff:
 - Explain their role in the centre
 - What are the records they maintain (if any)
 - What thoughts/feedback do they have around this entire process of running the centre?
- Programme manager and/or clinic director;
 - Share their responsibility in reference to the VCT/ PPTCT/ART centre.
 - How do they supervise their staff?
 - What VCT/PPTCT/ART reports are they responsible for submitting? Who do you submit them to?
 - Share the most recent report submitted to SACS

- Do you try to interpret any of the data collected at their centre? What additional information do they get from this data? What do you do with the data here at a local level?
- Share examples of initiatives they have undertaken using the data from the monitoring process
- What other monitoring data do you collect? For example do they have clients/patients?
- Fill in satisfaction surveys? Do they interview clients/patients to find out about their experience with your service?
- How do you get monitoring feedback from their staff?

Debrief following field visit:

- Have each team leader summarize observations from field visit.
- Ask the larger group of trainees if they have any other observations they would like to share or questions to ask.
- Ask the trainees to prepare a brief action plan on changes they would like to bring about at their centre based on lessons learnt from field visit.

After the training is completed

It may be appropriate to send a short note to the centre, thanking the in-charge and the staff for their time and readiness to share their experiences. A thank you note is especially important if the training coordinator plans to send further teams of trainees to the centre.

Annexure 4

Bibliography

1. Early neuropsychological impairment in HIV-seropositive intravenous drug users: Evidence from the Italian Multicentre Neuropsychological HIV Study. *Acta Psychiatrica Scandinavica* 1997;**97**:132–8.
2. 'It is recommended that countries consider broadening the goals and methods of drug treatment from an abstinence-only goal to encompass treatment and prevention strategies that are more accepting of interim goals.' A recommendation of the Task Force on Drug Use and HIV Vulnerability, 2000. Drug use and HIV vulnerability policy research study in Asia; UNAIDS/UNODCCP, 6.
3. Aisu T, Raviglione M, Van Prasag E, *et al.* Preventive chemotherapy for HIV-associated tuberculosis in Uganda: An operational assessment at a voluntary counselling and testing centre. *AIDS* 1995;**9**:267–73.
4. Anglaret X, Chene G, Attia A. Early chemoprophylaxis with trimethoprim- sulphamethoxazole for HIV-1 infected adults in Abidjan, Côte d'Ivoire: A randomised controlled trial. *The Lancet* 1999;**353**:1463–8.
5. Badri M, Wilson D, Wood R. Effect of highly active antiretroviral therapy on incidence of tuberculosis in South Africa: A cohort study. *Lancet* 2002; 15;**359**:2059–64.
6. Benton, Parnell. Facilitating sustainable behaviour change. *Burnet Centre* 1999. (Available from URL: from <http://www.burnet.edu.au>).
7. Burd MC. Assessing HIV-related cognitive impairment among incarcerated chronic substance abusers. [Dissertation abstract]. *Dissertation abstracts international: Section B: The Sciences & Engineering*. 2001;**61**(7-B):3833. US: University Microfilms International.
8. Burman WJ, Jones BE. Treatment of HIV-related tuberculosis in the era of effective antiretroviral therapy. *Am J Respir Crit Care Med* 2001;**164**:7–12.
9. Carroll KM, Libby B, Sheehan J, *et al.* Motivational interviewing to enhance treatment initiation in substance abusers: An effectiveness study. *American Journal on Addictions* 2001;**10**:335–9.
10. Casey K. HIV counselling in Thailand: The relationship between training, work and locus of Control. University of Wollongong, Australia (in press).
11. CDC. Revised guidelines for counselling, testing and referral, 1999. Available from URL: <http://www.cdc.gov/hiv/pubs/guidelines.htm#counseling>.
12. CDC. Technical guidance on HIV counselling, 1993. Available from URL: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00020645.htm>.
13. Centers for Disease Control and Prevention (CDC). Administration of zidovudine during late pregnancy to prevent perinatal HIV transmission—Thailand 1996–1998, *MMWR* 1998;**47**:151–3 and UNAIDS/WHO recommendations on the safe and effective use of short-course zidovudine for the prevention of mother-to-child transmission of HIV, 1998.
14. Centre for Harm Reduction and Asian Harm Reduction Network (1999) <http://www.ahrn.net/manual.html>. (Thai and Indonesian versions can be downloaded. English versions are available in hard copy).
15. Chequer P, Sudo EC, Vitfria MAA, *et al.* The impact of antiretroviral therapy in Brazil. Abstract MoPpE1066 presented at the XIII International AIDS Conference, Durban, South Africa, 2000.
16. Coninx R, Maher D, Reyes H, *et al.* Tuberculosis in prisons in countries with high prevalence. *BMJ* 2000;**320**:440–2.

17. Connor EM, Sperling RS, Gelber R, *et al.* Reduction of maternal–infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. *Pediatric AIDS Clinical Trial Group Protocol 076 Study Group. N Engl J Med* 1994;**331**:1173–80.
18. Coovadia H. Access to voluntary counselling and testing for HIV in developing countries. *Annals of the New York Academy of Science* 2000;**918**:57–63.
19. Cranfield DA. *Drug training, HIV and AIDS in the 1990s. A guide for training professionals.* London UK: Health Education Authority; 1999.
20. Dabis F, Msellati P, Meda N, *et al.* 6-month efficacy, tolerance, and acceptability of a short regimen of oral zidovudine to reduce vertical transmission of HIV in breastfed children in Côte d'Ivoire and Burkina Faso: A double-blind placebo-controlled multicentre trial. *Lancet* 1999;**353**:786–92.
21. Daley CL. Tuberculosis recurrence in Africa: True relapse or re-infection? *Lancet* 1993;**342**:756–7.
22. De Cock K, Johnson A. From exceptionalism to normalization: A reappraisal of attitudes and practice around HIV testing. *British Medical Journal* 1998;**316**:290–3.
23. De Cock KM, Fowler MG, Mercier E, *et al.* Prevention of mother-to-child HIV transmission in resource-poor countries: Translating research into policy and practice. *JAMA* 2000;**283**:1175–82.
24. Des Jarlais D, Perlis T, Friedman S. The roles of syringe exchange and HIV counselling and testing in the declining HIV epidemic among IDUs in New York City. Abstract D1124, presented at the 13th International Conference on HIV/AIDS, Durban, South Africa; 2003.
25. Des Jarlais DC, Hagan H, Friedman SR. Preventing epidemics of HIV-1 among injecting drug users, drug injecting and HIV infection. In: Stimson G, Des Jarlais DC, Ball A (eds). WHO; 1998:183–200.
26. Desenclos J, Papaevangelou G, Ancelle-Park R. Knowledge of HIV serostatus and preventive behaviour among European injecting drug users *AIDS* 1993;**7**:1371–7.
27. DiPerri G, Cruciani M, Danzi MH, *et al.* Nosocomial epidemic of active tuberculosis in HIV infected patients. *Lancet* 1989;**2**:1502–4.
28. Family Health International. HIV/AIDS interventions with men who have sex with men (MSM); 2002.
29. Family Health International. *Zimbabwe HIV Counselling Training Manual*; 2001.
30. Fitzgerald DW, Desvarieux M, Severe P, *et al.* Effect of post-treatment isoniazid on prevention of recurrent tuberculosis in HIV-1-infected individuals: A randomised trial. *Lancet* 2000;**356**:1470–4.
31. Friedman S, Jose B, Neaigus A. Consistent condom use in relationships between seropositive injecting drug users and sexual partners who do not use drugs. *AIDS* 1994;**8**:375–381.
32. Girardi E, Antonucci G, Vanacore P, *et al.* Impact of combination antiretroviral therapy on the risk of tuberculosis among persons with HIV infection. *AIDS* 2000;**14**:1985–91.
33. Glick ID, Berman EM, Clarkin JF, *et al.* *Marital and family therapy.* 4th ed. Washington: American Psychiatric Press; 2000.
34. Godfrey-Faussett P, Baggaley R. Exceptionalism in HIV, challenges for Africa too. *British Medical Journal* 1998;**316**:1826.
35. Gray G, for the PETRA Trial Management Committee. The Petra study: Early and late efficacy of three short ZDV/3TC combination regimens to prevent mother-to-child transmission of HIV-1. Abstract LbOr5, presented at the 13th International AIDS Conference, Durban, South Africa; 9–14 July 2000.
36. Green J, McCreaner A. *Counselling in HIV infection and AIDS.* 2nd ed. Blackwell: London; 1996.
37. Guay LA, Musoke P, Fleming T, *et al.* Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in

- Kampala, Uganda: HIVNET012 randomised trial. *Lancet* 1999;**354**:795–802.
38. Gulick RM, Mellors JW, Havlir D, *et al.* Treatment with indinavir, zidovudine, and lamivudine in adults with human immunodeficiency virus infection and prior antiretroviral therapy. *N Engl J Med* 1997;**337**:734–9.
 39. Hammer SM, Squires KE, Hughes MD, *et al.* A controlled trial of two nucleoside analogues plus indinavir in persons with human immunodeficiency virus infection and CD4 counts of 200 per cubic millimeter or less. *N Engl J Med* 1997;**337**:725–33.
 40. Harries AD, Maher D, Nunn P. Practical and affordable measures for the protection of health care workers from tuberculosis in low-income countries. *Bull World Health Organ* 1997;**75**:477–89.
 41. Hayman J, Buhrich N. *Psychiatric aspects in the Albion Street Centre: The AIDS Manual*. 1994.
 42. Inter-agency. Clinical management of survivors of rape: A guide to the development of protocols for use in refugee and internally displaced persons situation. An outcome of the Inter-Agency Lessons Learned conference: Prevention and Response to Sexual and Gender-based Violence in Refugee Situations. Geneva; 27–29 March 2001.
 43. Inter-agency. Inter-agency field manual on reproductive health in refugee situations; 1999.
 44. Johnson SM. Emotionally focused couple therapy with trauma survivors. New York: Guilford Press; 2002.
 45. Jordan B. Mbeki investigates declaring a national emergency on HIV/AIDS to secure cheap drugs. *Sunday Times*. 11 February 2001.
 46. Kalichman S. *Understanding AIDS: A guide for mental health professional*. Routledge: London; 1995.
 47. Kamenga M, Ryder R, Jingu M, *et al.* Evidence of marked sexual behaviour change associated with low HIV-1 seroconversion in 149 married couples with discordant HIV-1 serostatus: Experience at an HIV counselling centre in Zaire. *AIDS* 1991;**5**:61–7.
 48. Kelan G, Shahan J, Quinn T. The Project Educate Work Group. Emergency department-based HIV screening and counselling: Experience with rapid and standard serological testing. *Ann Emergency Med* 1999;**33**:47–155.
 49. King M. *AIDS, HIV and mental health*. University of Cambridge Press; 1993.
 50. Lallemand M, Le Coeur S, Kim S, *et al.* Perinatal HIV Prevention Trial (PHPT), Thailand: Simplified and shortened zidovudine prophylaxis regimens as efficacious as PACTG076. Abstract LbOr3, presented at the 13th International AIDS Conference, Durban, South Africa; 9–14 July 2000.
 51. Lambouray J-L. HIV and health care reform in Phayao. From crisis to opportunity. UNAIDS Best Practice Publication; 2001 [unpublished].
 52. Lienhardt C, Rodrigues LC. Estimation of the impact of the human immunodeficiency virus infection on tuberculosis: Tuberculosis risks revisited? *Int J Tuberc Lung Dis* 1997;**1**:196–204.
 53. Lourdes M, Marin S. The impact of HIV/AIDS policy and programme implications: Case studies of Filipino migrant workers living with HIV/AIDS. Abstract 0432, presented at the Sixth International Congress on AIDS in Asia and the Pacific, Nutbeam and Harris (1998) Theory in a Nutshell, University of Sydney, <http://www.achp.health.usyd.edu.au>.
 54. Magura S, Shapiro J, Grossman J. Reactions of methadone patients to HIV antibody testing. *Adv Alcohol Subst Abuse* 1990;**8**:97–111.
 55. Magura S, Siddiqi Q, Shapiro J. Outcomes of AIDS prevention programme for methadone patients *Int J Addiction* 1991;**26**:629–55.
 56. Marder K, Stern Y, Malouf R, *et al.* Neurologic and neuropsychological manifestations of human immunodeficiency virus infection in intravenous drug users without acquired immunodeficiency syndrome. Relationship to head injury. *Archives of Neurology*. 1992;**49**:1169–75.

57. Ministry of Health and Family Welfare, National AIDS Control Organisation, Government of India, HIV/AIDS Counselling Training Manual for Trainers, pp. 82–83 and Family Health International (2001), Zimbabwe HIV Counselling Training Manual, pp.49–51.
58. Minuchin S. Families and family therapy. Cambridge: Massasuchetts, <Harvard University Press; 1974.
59. Mitsuyasu RT, Skolnik PR, Cohen SR, *et al.* Activity of the soft gelatin formulation of saquinavir in combination therapy in antiretroviral-naïve patients. *AIDS* 1998;**12**:F103–9.
60. MMWR. Update: HIV counselling and testing using rapid tests United States 1998;**47**:11.
61. Montaner JS, Reiss P, Cooper D, *et al.* A randomized, double-blind trial comparing combinations of nevirapine, didanosine, and zidovudine for the HIV-infected patients. The INCAS Trial. Italy, The Netherlands, Canada and Australia Study. *JAMA* 1998;**279**:930–7.
62. Morar N, Ramjee G. Impact of voluntary counselling and testing among sex workers Abstract C1030, presented at the 13th International Conference on HIV/AIDS, Durban South Africa; 2000.
63. Murphy RL, De Gruttola V, Gulick RM, *et al.* Treatment with amprenavir alone or amprenavir with zidovudine and lamivudine in adults with human immunodeficiency virus infection. *J Infect Dis* 1999;**179**:808–16.
64. Mwingwa A, Hosp M, Godfrey-Faussett P. Twice weekly tuberculosis preventive therapy in HIV infection in Zambia. *AIDS* 1998;**12**:2447–57.
65. Nelson-Jones R. *Practical Counselling and Helping Skills*, 2nd ed. Sydney. Holt, Rinehart and Winston; 1988:141.
66. Nicolosi A, Molinari S, Musicco M, Saracco A, Zilliani N, Lazzarin A. Positive modification of injecting behaviour among intravenous heroin users form Milan and Northern Italy 1987–89. *Br J Addict* 1991;**86**:91–102.
67. Nunn P, Mungai M, Nyamwaya J, *et al.* The effect of human immunodeficiency virus type 1 on the infectiousness of tuberculosis. *Tubercle Lung Dis* 1994;**75**:25–32.
68. O'Brien WA, Hartigan PM, Martin D, *et al.* Changes in plasma HIV-1 RNA and CD4+ lymphocytes counts and the risk of progression to AIDS. *N Engl J Med* 1996;**334**:426–31.
69. O'Connor M (ed). *Treating the consequences of HIV*. Jossey-Bass: San Francisco; 1997.
70. OHCHR. HIV/AIDS and Human Rights International Guidelines Second International Consultation on HIV/AIDS and Human Rights Geneva; 1998.
71. Population Services International. 'New Start' VCT Training Manual. Zimbabwe; 2001.
72. Prochaska JO, DiClemente CC. *The theoretical approach: Crossing boundaries of therapy*. Homewood Ill, Dow Jones Irwin; 1984.
73. PSI 'New Start' Zimbabwe VCT Training package. The documented has been updated and review for use in South Asia by Dr Ruangpung Sutthemt from Mahidol University Thailand, Dr Mark Kelly and Kathleen Casey of the International Health Services Unit Albion Street Centre Sydney Australia.
74. Raviglione MC, Harries AD, Msiska R, Wilkinson D, Nunn P. Tuberculosis and HIV: current status in Africa. *AIDS* 1997;**11** (Suppl B): S115–S123.
75. Rieder HL, Cauthen GM, Comstock GW, Snider DE. Epidemiology of tuberculosis in the United States. *Epidemiologic Reviews* 1989;**11**:79–98.
76. Shaffer N, Chuachoowong R, Mock PA, *et al.* Short-course zidovudine for perinatal HIV-1 transmission in Bangkok, Thailand: a randomised controlled trial. *Lancet* 1999;**353**:773–80.
77. Staszewski S, Morales-Ramirez J, Tashima KT, *et al.* Efavirenz plus zidovudine and lamivudine, efavirenz plus indinavir, and indinavir plus zidovudine and lamivudine in the treatment of HIV-1 infection in adults. *N Engl J Med* 1999;**341**:1865–73.
78. Sumich, H., Andrews, G., Hunt, C. *The Management of Mental Disorders Vol. 1*. WHO Training and Reference Centre, Sydney; 1995:28–31.

79. The VCT efficacy study group. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad: a randomised trial. *Lancet* 2000;**356**:103–12.
80. Towards a Regional Strategy, An Analysis of the HIV Vulnerability of Migrant Workers in and from South Asia. UNDP 2001.
81. UNAIDS. Counselling and voluntary counselling and HIV testing for pregnant women in high HIV prevalence countries. UNAIDS/44E; 1999.
82. UNAIDS. Knowledge is power. Voluntary HIV counselling and testing in Uganda. UNAIDS/99.8E; 1999.
83. UNAIDS Prevention of HIV transmission from mother to child. *Strategic options* UNAIDS/40.E; 1999.
84. UNAIDS. Opening Up the AIDS Epidemic. Geneva; 2000.
85. UNAIDS. VCT Technical update. UNAIDS/WC 2000;**503**:6.
86. UNAIDS. Voluntary Counselling and Testing (VCT) UNAIDS Technical Update. UNAIDS Best Practice Collection. Geneva; 2000.
87. UNAIDS. The impact of voluntary counselling and testing. A global review of the benefits and challenges. <http://www.unaids.org>; 2001.
88. UNAIDS Policy on HIV testing and counseling. <http://www.unaids.org/publications/documents/health/counselling/counselepole.html>; 1997.
89. UNAIDS, UNESCO. Migrant Populations and HIV/AIDS, UNAIIDS Best Practice Key Material; 2000.
90. UNAIDS/UNODC/AHRN Preventing HIV/AIDS Among drug users—Case studies from Asia 2002.
91. UNDP 2001, Towards a Regional Strategy, An Analysis of the HIV Vulnerability of Migrant Workers in and from South Asia.
92. UNHCR. 'Prevention and response to sexual and gender-based violence in refugee situations.' Inter-agency lessons learned. Conference proceedings. Geneva; 27–29 March 2001.
93. United Nations General Assembly Special Session. Declaration of Commitment on HIV/AIDS. June 2001:19. '...recognizing that care, support and treatment can contribute to effective prevention through an increased acceptance of voluntary and confidential counselling and testing, and by keeping people living with HIV/AIDS and vulnerable groups in close contact with health-care systems and facilitating their access to information, counselling and preventive supplies.'
94. Vanichseni S, Coopanya K, DesJarlais D, Plangsringarm K, Sonchai W, Carballo M, Friedmann P, Freidman S. HIV testing and sexual behaviour among intravenous drug users, Bangkok, Thailand. *Journal of AIDS*; 1992;**5**:1119–23.
95. Vanichseni S, DesJarlais D, Coopanya K, Friedman P, Wenston J, Sonchai W, Raktham S, Carballo M, Freidman S. Condom use with primary partners among injecting drug users in Bangkok, Thailand and New York City, USA. *AIDS* 1993;**7**:887–91.
96. Velasquez, Mary Marden, Maurer, Gaylyn Gaddy, Crouch, Cathy, DiClemente, Carlo C. Group treatment for substance abuse: A stages-of-change therapy manual. New York: Guilford Press; 2001.
97. Voluntary counselling and testing for HIV infection in antenatal care: *Practical considerations for implementation*. HIS home page <http://www.who.org>.
98. Voluntary HIV-1 counselling and testing efficacy study group. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad: A randomised trial. *Lancet* 2000;**356**:103–12.
99. Watters J, Estilo M, Clarke G, Lovrich J. Syringe and needle exchange as HIV/AIDS prevention for injecting drug users *JAMA* 1994;**271**:115–120.
100. WHO. The importance of simple and rapid tests in HIV diagnostics: WHO recommendations. *Wkly Epidemiol Rec* 1998;**73**:321–8.

101. WHO. Evaluation of simple/rapid tests to determine antibodies to HIV-1 and/or HIV-2 in human whole blood; 2001. (in press).
102. WHO SEARO. Planning and implementing HIV/AIDS care programmes: A step-by-step approach. First edition 1998, reprint in 2000 and 2002.
103. WHO SEARO. The use of antiretroviral therapy: A simplified approach for resource-constrained countries; 2002.
104. WHO. Acquired immunodeficiency syndrome (AIDS). Interim proposal for a WHO staging system for HIV infection and disease. *Wkly Epidemiol Rec* 1990;**65**:221–4.
105. WHO. Scaling up: Antiretroviral therapy in resource-limited settings. Guidelines for a public health approach; 2002.
106. WHO/UNAIDS. Policy statement on preventive therapy against tuberculosis in people living with HIV. WHO/TB/98.255 UNAIDS/98.34; 1998.
107. Wiktor S, Sassan-Morokro M, Grant A, *et al.* Efficacy of trimethoprim-sulphamethoxazole prophylaxis to decrease morbidity and mortality in HIV-1 infected patients with tuberculosis in Abidjan, Côte d'Ivoire: A randomised controlled trial. *Lancet* 1999;**353**:1469–75.
108. Wiktor SZ, Ekpini E, Karon JM, *et al.* Short-course oral zidovudine for prevention of mother-to-child transmission of HIV-1 in Abidjan, Côte d'Ivoire: A randomised trial. *Lancet* 1999;**353**:781–5.
109. Wolffers I. Testing for HIV and Migrant Workers, http://caramasia.gn.apc.org/icaap_hivtesting.html; 1999.
110. Zwi A, Cabral AJ. Identifying “high risk situations” for preventing AIDS. *British Medical Journal* 1991;**303**:1527–9.
111. Glick ID, Berman EM, Clarkin JF, Rait DS. *Marital and family therapy*. 4th ed. Washington: American Psychiatric Press; 2000.
112. Johnson SM. *Emotionally focused couple therapy with trauma survivors*. New York: Guilford Press; 2002.
113. Minuchin S. *Families and family therapy*. Cambridge, Ma: Harvard University Press; 1974.
114. Fazel S, Danesh J. Serious mental disorder in 23,000 prisoners: A systematic review of 62 surveys. *Lancet* 2002;**359**:545–50.
115. Graipaspong D. Psychiatric disorders among the inmates: A study in the jails in Bangkok Metropolitan and the Bangkok Central Prison. *Journal of Mental Health of Thailand* 2002;**10**:77–88.
116. Kantor E. HIV. Transmission and prevention in prisons, HIV insite knowledge-base chapter; 1998.
117. Thies PA. Coping with HIV: A study of HIV positive male inmates in a federal prison. Dissertation Abstracts International: Serton B: the Sciences and Engineering. 2000;60:4913, US: Univ Microfilms International.
118. Lerwitworapong J. HIV/AIDS and pulmonary tuberculosis in a prison, Thailand. *Journal of AIDS Disease (Thailand)* 1997;**9**:215–24.
119. Singh S, Prasad R, Mohanty. A high prevalence of sexually transmitted and blood-borne infections amongst the inmates of a district jail in Northern India. *International Journal of STD AIDS* 1999;**10**:475–8.
120. Beyrer C, Juttiwitikarn J, Teokul W, *et al.* Drug use, increasing incarceration rates, and HIV risks in Thailand, 1992–2000. Abstract MoPeC3396, XVth International AIDS Conference, Barcelona 2002.
121. Paul C, Das Gupta S, Sharma S, *et al.* Awareness, perception and risk behaviours of drug users in the prisons. Abstract WeOrE1323, XVth International AIDS Conference, Barcelona 2002.

122. Aumphornpun B, Page-Shafer K, van Grievsven GJP, *et al.* Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: Case-control study. *BMJ* 2003;**7**:384.
123. Raktham S, Kitayaporn D, Vanichseni S, *et al.* Incarceration as a continuing HIV risk factor among injecting drug users (IDUs) in Bangkok. Mahidol University Annual Research Abstracts 2000.
124. UNAIDS. Prisons and AIDS, <http://www.unaids.org/publications/documents/sectors/prisons/prispve.pdf>; 1997.
125. Okochi CA, Oladepo O, Ajuwon AF. Knowledge and sexual behaviours of inmates of Agodi prison in Ibadan Nigeria. *International Quarterly of Community Health Education* 2000;**19**:353-62.
126. UNAIDS/99.47/E (English original, September 1999). First printed 1993, WHO/GPA/DIR/93.3
127. Laporte J, Bolinni P. Management of HIV/AIDS related problems: Situation in European prisons. Programme and Abstracts of XII World AIDS Conference, Geneva. Abstract 44193.
128. Kantor E. HIV Transmission and prevention in prisons: HIV insite knowledge-base chapter; 1998.
129. UNAIDS/99 (English original, September 1999).

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