



COUNSELLING TRAINING MODULES

for VCT, PPTCT and ART Counsellors

Handouts



National AIDS Control Organization

Ministry of Health and Family Welfare • Government of India

with technical support from
WHO • UNICEF • CDC

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Technically edited, designed and typeset by
Byword Editorial Consultants
email: editbyword@gmail.com

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
APCASO	Asia Pacific Council of AIDS Service Organizations
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
AS	Activity sheet
ATS	Amphetamine-like stimulants
BCC	Behaviour change communication
BSS	Behavioural surveillance survey
CARAM	Coordination of Action Research on AIDS and Mobility, Asia
CBO	Community-based organization
CIRR	Client information record and result
CMV	Cytomegalovirus
CSW	Commercial sex worker
CT	Computerized tomography
DOT	Directly observed therapy
DOTS	Directly Observed Treatment, Short-course
EBE	Exotic becomes erotic (theory)
ELISA	Enzyme-linked immunosorbent assay
EQA	External quality assurance
EQAS	External quality assurance scheme
FACS	Fluorescent activated cell sort
FSW	Female sex worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HAART	Highly active antiretroviral therapy
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCW	Health-care worker
HIV	Human immunodeficiency virus
HO	Handout
HRB	High-risk behaviour
HST	Humsafar Trust, Mumbai
HSV	Herpes simplex virus
HZV	Herpes zoster virus
ICAAP	International Congress on AIDS in Asia and the Pacific
ICMR	Indian Council of Medical Research
IDU	Injecting drug use/user
IVDU	Intravenous drug user
IEC	Information, education and communication

LFT	Liver function tests
MCH	Maternal and child health
MRI	Magnetic resonance imaging
MH	Mental health
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NACP	National AIDS Control Programme
NEP	Needle exchange programme
NGO	Non-governmental organization
NRTI	Nucleoside reverse transcriptase inhibitor
NNRTI	Non-nucleoside reverse transcriptase inhibitor
OI	Opportunistic infection
ORW	Outreach worker
PCR	Polymerase chain reaction
PEP	Post-exposure prophylaxis
PHC	Primary health centre
PI	Protease inhibitor
PID	Personal identification digit
PLHA	People living with HIV/AIDS
PPD	Purified protein derivative
PPTCT	Prevention of parent-to-child transmission
PPT	PowerPoint presentation
PT	Proficiency test
PTSD	Post-traumatic stress disorder
QA	Quality assurance
QC	Quality control
RNTCP	Revised National Tuberculosis Control Programme
SACS	States AIDS control societies
SEARO	South-East Asia Regional Office
SHG	Self-help group
SOP	Standard operating procedure
SP	Session plan
STI	Sexually transmitted infection
SWAM	Society Welfare Association for Men, Chennai
TB	Tuberculosis
ToT	Training of trainers
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly
VCTC	Voluntary counselling and testing centre
VDT	Voluntary diagnostic testing
WHO	World Health Organization

Background

HIV COUNSELLING

Counselling in the context of HIV has become important in the provision of prevention, treatment and care services over the past years. HIV counselling initially focused on prevention of HIV infection, HIV testing and dealing with the emotional and social impact of a positive HIV test. HIV counselling expanded to include counselling on prevention of parent-to-child transmission (PPTCT) of HIV, and on care for the baby. Most recently, with the introduction of antiretroviral therapy (ART), the scope of counselling further expanded to include preparedness and adherence counselling for people on ART.

As part of the third phase of the National AIDS Control Programme (NACP-III), NACO will further roll out access to ART. Voluntary counselling and testing (VCT) centres and PPTCT services will be expanded from the current district and tertiary care level to CHC and PHC levels especially in rural areas. Integrated counselling and testing centres (ICTC) will be established to provide clients with a comprehensive package of information and counselling.

The planned expansion requires a large cadre of qualified and skilled counsellors and peer counsellors to be available in the VCTCs, PPTCTs and ICTCs. Therefore, a set of comprehensive standardized HIV counselling training modules using a combination of teaching techniques (from lectures to hands-on demonstrations, role-plays, etc.) and regular HIV counselling trainings are important.

The training modules provide hands-on training for counsellors to develop and fine-tune their skills, to increase their sensitivities and to be able to reach out to their clients. These training modules help counsellors in enhancing their counselling skills and in providing state-of-the-art counselling to their clients.

NACO, with technical support from WHO, UNICEF and the Centers for Disease Control and Prevention (CDC), has developed the current HIV counselling training modules (2006) with an aim to provide standardized trainings to all cadres of HIV counsellors in the country. The training modules support the NACO's VCT, PPTCT and ART programmes.

THE DEVELOPMENT OF THE HIV COUNSELLING TRAINING MODULES

The NACO HIV Counselling Training Modules have been developed through six regional consultations and field-testing of the WHO South-East Asia Regional Office (SEARO) Voluntary HIV Counselling and Testing: Manual for training of trainers

between 2003 and 2005 held at Imphal, Chennai, Panchgani (Maharashtra), Ranchi, Delhi and Lucknow. A total of 235 teaching faculty from 111 institutions in 30 states, who were selected as master trainers (ToTs), underwent counselling training and provided technical inputs.

In May 2004, a three-day national consultation conducted by NACO, and supported by WHO, with 38 master trainers and senior experts reviewed the comments and provided technical inputs for the development and standardization of the modules. Each topic had been assigned to two to three experts for review. Their comments and suggested modification were discussed by experts in small groups. Further, the content of modules from CDC, FHI, BPNI, UNICEF and NIMHANS were reviewed for inclusion.

Dr Sushma Mehrotra (formerly Consultant Counselling, NACO) was the chief coordinator of the zero draft supported by Professor B.L. Barnes and her team from Mumbai including Ms Rohini Ramamurthy and Ms Tasneem Raja who edited the modules and gave the document its final shape.

UNICEF took the lead in field-testing the zero draft of the HIV counselling modules during a 12-day training in Mumbai in October 2004 with 30 participants from six high-prevalence states and three moderate-to-low prevalence states primarily to validate the appropriateness of the modules for counsellors in HIV settings.

The contents of the module were found to be extensive with clear session instructions and PowerPoint (PPT) presentations for trainers/facilitators and detailed handouts for trainees. The modules were considered useful as a standardized training tool to conduct uniform HIV counsellor trainings across the country.

SOME HIGHLIGHTS OF THE PRESENT MODULES

The VCT and ART parts of the current modules are based on the WHO-SEARO Manual which was developed for the Asian context by experts from Bangladesh, Bhutan, India, Indonesia, Sri Lanka and Thailand.

The PPTCT parts of the modules are based on UNICEF training modules. UNICEF has been a key partner in the national PPTCT programme and works closely with NACO and State AIDS Control Societies (SACS) to ensure quality in PPTCT services of which counselling is an important part.

The modules cover VCT issues including counselling for risk reduction and facilitating HIV test decision. The PPTCT parts address issues related to HIV testing, care of pregnant women and infant feeding. The ART parts provide training in basic counselling skills on treatment preparedness, adherence and follow-up counselling. The ART module further includes specific issues when providing HIV counselling

for high-risk and vulnerable groups such as CSW, MSM, IDU and young people. Additional topics are introduced in the current modules to enrich the contents of training:

- Crisis intervention and problem-solving counselling
- Family counselling
- Infant feeding counselling
- Mental health issues and suicide prevention in HIV
- Role of PPTCT in HIV prevention
- Group counselling
- Managing psychological distress
- Grief counselling
- Counselling for occupational stress and burn-out
- Legal and ethical issues
- Nutrition counselling
- ART counselling
- Home-based care

Organization of the HIV Counselling Modules

The material for the HIV Counselling Training Modules is divided into two folders. The folder titled **Facilitator's Guide** is meant for training organizers, trainers and facilitators. It contains, for each training session (submodule), a detailed session plan with information on the content of the session, materials required, and instructions on how to conduct the session in a logical manner. The folder also includes 'ready to use' PowerPoint presentations and specific session activities which need to be conducted with the trainees. Some activity sheets will need to be photocopied beforehand for use by the trainees during the training.

The folder titled **Handouts** is meant to provide detailed background information on each topic and complement the information provided by the facilitator/trainer during the session presentations. It is therefore important that facilitators/trainers are familiar with the content of the handouts. Ideally, to enable them to prepare beforehand, the trainees should be given the respective handouts a day before the session presentations are to be conducted. At the end of the training, each trainee has a complete set of handouts which they can take back with them for future use and easy reference.

However, as is the case with all training materials, the contents of these modules need to be revised and updated periodically and should always be reviewed and updated by the trainers before conducting trainings.

HIV COUNSELLING TRAININGS

The modules can be used as a complete 12-day training package when providing induction training to counsellors or these can be used in parts during refresher trainings to meet the specific needs of the counsellors. The proposed 12-day and 5-day training schedules have been included as guidance for training course organizers. These need to be adapted to the specific training requirements and availability of resource persons.

NACO envisions that the standardized HIV counselling trainings will support the scale up of quality VCT, PPTCT and ART services. The modules will allow the states to build the capacity of local institutions for regular training (induction and refresher trainings) of counsellors. The same institutions can be engaged to provide ongoing support for counsellors which includes mentoring, supervision and monitoring. The goal is to make available quality HIV counselling services close to people's doorsteps as entry points to HIV prevention and care for all segments of society in all parts of the country.

Introduction

CONTEXT

Within the South and South-East Asia Region, an estimated 7.4 million are people living with HIV/AIDS (PLHA) (as of December 2005). This region ranks second in HIV prevalence, after sub-Saharan Africa, and accounts for about 20% of new annual HIV infections globally.

The epidemic in India is varied, with areas of generalized epidemic in the South and North-east, and with pockets of concentrated epidemics and highly vulnerable regions with low-levels of HIV infection. At the end of 2004, 5.3 million Indians were estimated to be infected with HIV. A hundred and eleven districts in the country are classified as high HIV prevalence districts. Transmission of HIV is predominantly through the sexual route (86%). Other routes include injecting drug use (IDU) (2.4%), vertical transmission from mother to child (3.6%) and transfusion of blood and blood products (2%), and others (6%) (as of July 2005).

HIV transmission is on the increase among both adults and children in most parts of the country. Regional trends indicate increases in the occurrence of sexually transmitted infections (STIs). The extent of HIV infection in many states and rural areas is currently unclear.

Increasing the reach of voluntary counselling and testing (VCT), prevention of parent-to-child transmission (PPTCT) and antiretroviral therapy (ART) interventions enables and encourages people with HIV to access appropriate care and treatment early and strengthens prevention of HIV infection in the community. In NACP-III, VCT, PPTCT and ART services will be expanded up to the sub-district level.

VCT AND PPTCT—GATEWAYS TO PREVENTION, TREATMENT AND CARE

Both VCT and PPTCT provide important entry points to prevention, care and treatment services, and have the following benefits. They

- Increase awareness about HIV/AIDS and its modes of transmission
- Strengthen prevention and facilitate behaviour change (risk reduction)
- Facilitate behaviour change in both HIV-negative and HIV-positive people. It supports HIV-negative clients to remain negative and HIV-positive clients to prevent the further spread of HIV (positive prevention)
- Help in acceptance and coping with one's serostatus
- Provide psychosocial support through referral to social and peer support
- Identify the need for prophylaxis and effective ART

- Reduce parent-to-child transmission of HIV
- Facilitate early management of HIV-related infections and STIs
- Facilitate planning for the future
- Encourage orphan care
- Promote ‘will’ making
- Increases the visibility of HIV in communities, thus ‘normalizing’ HIV/AIDS.

Factors that contribute to high-quality VCT and PPTCT services include easy accessibility; a non-threatening environment; confidentiality of client information; skilled, sensitive counsellors and experienced laboratory technicians.

TRAINING AND EDUCATION

High-quality and skilled counsellors are not born, nor is basic orientation and skill-building for counselling sufficient to deal with all aspects of HIV/AIDS. Training forms the cornerstone for developing competent and effective HIV counsellors who can support the various aspects of the programme.

Counselling is not merely the provision of information or advice. Counselling is a process of enabling an individual to take personal decisions in the context of HIV/AIDS. Thus, counselling can include facilitating a client’s decision whether or not to undergo an HIV test or preparing clients for lifelong ART.

The conviction held by NACO is that clients accessing a VCT, PPTCT or ART centre need to understand the context of HIV/AIDS from prevention to treatment and care. The HIV counsellor needs to equip the client to prevent HIV infection, to make an informed choice about HIV testing, to cope with an HIV test result and to understand the implications of lifelong treatment. Thus, HIV counsellors are challenged not only to keep abreast with new trends in HIV/AIDS prevention, treatment and care but also to continually fine-tune their skills and to equip themselves to address the various needs of their clients in the most comprehensive and sustainable manner. The objective of these training modules is to provide HIV counselling skills to health-care workers, especially ‘counsellors’. The modules address an array of knowledge and skills required for effective HIV counselling in VCT, PPTCT and ART settings.

OBJECTIVES OF THE HIV COUNSELLING TRAINING

The objectives of the HIV Counselling Training are:

- To train a cohort of HIV counsellors
- To provide knowledge on prevention, treatment and care issues in HIV/AIDS
- To build and strengthen the skills of counsellors and health workers to provide quality VCT, PPTCT and ART counselling to their clients.

Key points for conducting trainings

While no training can be exhaustive, these modules outline the key activities and information involved in training HIV counsellors.

The training consists of seven modules organized into submodules with clearly stated objectives and session plans (SPs). Each submodule is divided into up to four sections which provide the content of the submodule and the detailed training resources:

- Session plan (SP), which provides an overview of the training content
- PowerPoint (PPT) presentation, which aids the trainer during the session
- Handout (HO), which provides background information for the trainees
- Activity sheet (AS), which provides information on the activities that are to be conducted

Modules 1–6 contain the core HIV counselling content. Module 7 includes supplementary content providing advanced counselling skills.

The section ‘evaluation forms’ includes formats to evaluate the trainee’s knowledge level before and after the training, and forms to assess the training and the trainers.

The annexure contains guidelines, checklists and references.

The complete training material is available on a CD-ROM for easy duplication and training preparation.

Disclaimer

The training programme requires supervised skills rehearsal; therefore, it is not suitable for use as a self-directed learning tool. Trainers are further advised that only those who have been trained as trainers should use the modules. It is not recommended that these modules be used by clinicians/trainers who have not participated in the specific training activities; doing so, may compromise the quality of the training.

1. SETTING THE STAGE FOR TRAINING

No training is complete without the necessary preparation, in spite of the best training modules and resources. The preparation has to set the stage for learning and for achieving the training objectives. This includes:

- Adult learning styles must be planned for to ensure involvement of all trainees.
- Local language and terminology should be used during the trainings in settings where trainees are more conversant with the local language.

- A conducive environment should be established for learning through discussions, role-plays, brainstorming sessions and games. This helps to increase the trainees' receptivity and learning potential. It also helps the trainer to understand the knowledge level and experience of the trainees.
- Field visits to VCT, PPTCT or ART centres can further illustrate key points and support the learning. A detailed guideline for conducting field visits is included in Annexure 3.
- An introduction and a conclusion to every topic helps the trainees recapitulate the main messages from the modules.

Although the modules have been designed to address all aspects of the training, the ultimate success lies with the trainers and the training coordinator. This includes assigning modules to trainers/resource persons with appropriate experience and assuring that trainers familiarize themselves with the handouts, activities and presentations before the training. A detailed checklist for planning and organizing HIV counselling trainings is given in Annexure 1.

2. TRAINING SCHEDULE

The complete set of modules cover a 12-day programme (including field visits and a day of holiday suggested on the sixth day of training), which may be adapted as appropriate for longer or shorter periods (see proposed 12-day and 5-day training schedules at the end of this section). However, sessions or 'modules' should be added or subtracted according to their relevance to the culture and epidemic profile of the location where the training is conducted, time available for training and the level of practical experience of the trainees in hands-on patient management.

3. KEY CONSIDERATIONS FOR TRAINING

It is important to identify the combination of skills that counselling staff and supervisors will need to support each other so that, together, the entire staff at a VCT, PPTCT or ART centre will be able to deliver high-quality services to their clients. Making sure that supervisors also receive counselling training as well as counselling supervision training is critical to maintain the quality of clinical services and to strengthen the management of the programme. Supervisors must see their roles as educative and supportive (as well as being able to provide appropriate challenges, where necessary), but not interrogative.

Training for counsellors should be *competency-based*, bearing in mind the realities of the situation in the field. This means that the relevant competencies must be defined before training programmes are designed. Careful consideration must be given to the procedures that counsellors should follow and the skills they require. The most important method of training in any situation depends on the nature of the learning objectives. (The learning of facts requires different teaching methods from

the learning of communication skills; local cultural factors; and the style of teaching that learners are familiar with and capable of using.)

Example: Even though trainees may be most familiar with lectures, this method cannot be used to teach communication skills.

The competencies identified with regard to training in counselling depend on communication skills. There will also be a need to develop attitudes and skills for coping with fear, anger and embarrassment. Learning objectives in these areas can be achieved only when the teaching methods are interactive and involve the trainees in practising communication skills and in expressing their feelings.

Effective training of counsellors always has a closely supervised *practical* component. Therefore, counselling training programmes should be designed in such a way that ample opportunity is provided for this practical training in the field as well as in the classroom.

3.1 Group size

The group size for classroom counselling training should not exceed 30 trainees. The smaller the group, the more quality time and opportunity are afforded for trainees to practise their skills. As a number of group activities require splitting the trainees into groups of threes, it is suggested that the number of trainees be divisible by three (*see also* ‘Group discussions’ later in this section).

3.2 Interactive training strategies

These modules use interactive training methodologies, allowing instruction, practice and feedback to take place as these are crucial to address the sensitive and confidential issues discussed during HIV pre- and post-test counselling. Each session of training involves one or more of the following strategies:

- Role-play exercises
- Group discussions
- Educational games (card game for risk assessment, the ‘trust walk’)
- Case-based small group learning activities
- Brainstorming sessions

Presentations

A PowerPoint (PPT) presentation can be used to highlight key points. The duration of each presentation should not exceed 30 minutes. Trainers can promote interaction by:

- the use of individual/group exercise HOs that trainees complete
- encouraging questions from the group following the presentation

- conducting group work to discuss and answer questions
- by assigning issues or tasks to small groups

Visual aids

Visual aids can be used to highlight oral presentations or points. For example, key points can be noted on the blackboard and questions for debate or discussion (and responses) can be written on the board. The use of the board in this way promotes discussion and interaction. Visual aids should be clear, readable and should not be filled with too many details.

Rapporteur sessions

Following group discussions, the trainer can develop a list of the points made, which can be used to summarize the presentation. Alternatively, the trainer can call upon a trainee to be a rapporteur to document a list of summary points that can be derived from brainstorming lessons learnt from the presentation.

Role-plays

Role-plays should be used to ‘act out’ specific roles of identified people or to act out a scene. This is useful when practising skills such as counselling and to explore how people react to specific situations. The time limit for a role-play is 15–20 minutes. (For more information on how to conduct role-plays see Annexure 2.)

Role-plays have the following advantages:

- They allow for safe rehearsal of skills and activities, and provide practical preparation for genuine situations
- The trainees are able to experience activities and to relate theory to practice
- They allow for full expression and interpretation of concepts

Some individuals may feel intimidated by role-playing. The trainer must be skilful in ensuring that they are relaxed and should:

- keep the role-play appropriate to the learning context, and
- emphasize that the characters are ‘in role’ and that group observers are looking at the characters and their reactions, not the individual people enacting the role.

Group discussions—large group discussions

These should be led by the trainer and involve the entire group. The advantages of such discussions include the following:

- The trainees are involved in problem-solving
- The trainees are active, which stimulates interest

- The learning process becomes more personal, requiring the trainer to provide feedback on individual opinions and ideas
- The trainer is able to evaluate the trainees' understanding and absorption of material
- The trainees have an opportunity to share their acquired expertise and skills

Large group discussions require a skilful trainer who:

- Asks questions or suggests topics, maintains objectivity and directs the discussion to keep it relevant to the learning objectives
- Stresses confidentiality
- Ensures that all group members have an equal opportunity to participate and that no one person (including the trainer!) dominates the discussion
- Perceives and responds to differences in the group, such as the skills level, education and comfort with the topic
- Is aware of cultural and gender issues
- Encourages trainees to answer questions and share expertise
- Is flexible if the group begins to explore other relevant issues
- Is respectful and non-judgmental of the trainees' ideas and opinions to allow open expression of concerns
- Keeps to the time, leaving adequate periods for discussion
- Obtains feedback and responses from the group to provide evaluation mechanisms for the session
- Provides an appropriate balance of supportive and challenging facilitation in which to foster learning

Group discussion—small group discussions

These are usually conducted in groups of four to six persons. The advantages of small group discussions include the following:

- Trainees have more opportunity to talk and are less likely to be embarrassed than in a large group
- The atmosphere is more conducive to a discussion of feelings
- Trainees gain self-confidence through sharing of information
- More ideas come from the group

The trainer may also ask the group to appoint a facilitator and a rapporteur. Small group discussions and/or work with pairs should be followed by a large group discussion so that general conclusions can be drawn.

The trainer does not lead the group, but must be skilful in structuring the discussions so that the stated objectives are accomplished.

It is important to provide clear guidelines for group discussions, such as the ones below, at the beginning of the discussion.

- Which topics are to be discussed?
- Will the group draw conclusions or make decisions?
- Can opinions or feelings of the trainees be shared beyond the small group?
- Will the group be expected to report its discussions to the larger group?

Working in pairs

Working in pairs is effective when in-depth sharing or analysis of particularly personal or sensitive issues is required. Individuals may feel more free to disclose their attitudes and opinions with one trainee rather than within the larger group.

Case studies

Case studies are designed to give counselling trainees an understanding of the impact of HIV infection on the individual, and to enable them to deal with problems trainees may encounter in real-life settings. The trainers need to develop case studies that are specific to the local setting. Where included, case studies are introduced in the Session Plan for each individual submodule, some of these are followed by a discussion of key points pertaining to the case study. Case studies should be printed and provided to trainees as part of the activity. These case studies provide a detailed description of an event, different characters and settings. The case studies may be followed by a series of questions that will challenge the trainees to discuss the positive and negative aspects of the event.

The advantages of case studies are that they allow an examination of a real or simulated problem that mirrors the outside world, and help trainers to develop confidence and problem-solving skills.

The case studies prepared for use in the individual clinical risk assessment and HIV pre- test counselling sessions should NOT be included in the trainees' folders. They have been designed to be handed out to the trainees during the activities. (Refer to the session plan.)

Trainees who role-play 'counsellors' in these activities should not see the cases before the commencement of the activities. This will ensure that the 'counsellor' gains experience in acquiring information from 'clients'. In 'real-life' situations, clients do not send all their details to the counsellor in advance; rather the counsellor uses counselling skills to gather information from the client. Conducting role-plays in this way ensures that training approximates real-life situations.

4. USE OF RESOURCE PERSONS/EXTERNAL TRAINERS

Using a range of resource persons or external trainers presents both advantages and disadvantages. Advantages include:

- Trainees have access to ‘experts’ in their respective fields
- Trainees establish important linkages with external individuals and agencies that will assist them in their clinical work
- External presenters add variety to the programme of regular trainers

Some disadvantages of using external trainers or guest speakers are as follows:

- Inadequately briefed speakers may not focus on the topic
- Speakers may present nonevidence-based or erroneous information
- Speakers may pitch their presentation inappropriately in terms of language used and target audience
- Some speakers may be uncomfortable with the use of more interactive learning methodologies
- Speakers may not adhere to the time frame provided

Follow these guidelines to maximize the use of external trainers or guest speakers:

- Ensure that the speakers are adequately briefed, verbally as well as in writing, in terms of what is expected of them. Provide a guideline that specifies the content to be covered, the methodology to be used, the level and type of language, and the time frame. In addition, clearly describe the type of trainees they will be working with and the overall aims of the training programme
- Choose speakers who are known to be effective for your goals. Alternatively, ‘groom’ them to attain the desired outcome
- The regular trainer should be present where possible when the external speaker makes their presentation. This ensures continuity in case an issue arises. In addition, regular trainers are also able to observe and provide useful feedback to the resource persons/guest speaker
- Always ensure that external trainers/guest speakers are given a feedback from both the organization and that based on trainee evaluations to continue improving their sessions

5. ASSESSING TRAINEES KNOWLEDGE LEVELS

Before beginning the training, assess the trainees’ knowledge of HIV and the counselling process with a pre-training knowledge questionnaire (see section ‘evaluation forms’). This information can be used to fine-tune the training to the knowledge level of the trainees. At the end of the training, the same questionnaire can be administered to determine how much knowledge and skills the trainees have gained and how effective the training has been. For trainees who are not familiar with questionnaires or are illiterate, use focus groups to assess the knowledge levels.

6. ASSESSING TRAINING QUALITY

It is important for the training coordinator to assess the quality and effectiveness of the HIV counselling training. This feedback will help in conducting future trainings, improving sessions and identifying appropriate resource persons for trainings. Forms for evaluating the overall training and for evaluating the trainers is included in section 'evaluation forms'.

7. SUMMARY OF KEY CONSIDERATIONS FOR SUCCESSFUL TRAININGS

1. **Ensure that the Training Materials Outline is close at hand for easy reference.** This will prevent usage of wrong HOs or case studies for accompanying presentations.
2. **Encourage all trainees to be present for the ENTIRE training.** It is suggested that certificates may not be given to trainees who do not attend the entire course. In the event of an emergency, in which case a trainee cannot complete the course, the trainer should negotiate with the trainee to complete the missed segments at a future course and then hand over the certificate. Note that this strategy is critical to ensuring the quality of counselling. If a trainee misses any segments of the training programme, the trainer should brief the trainee about the missed segments when they return. This will ensure that they do not put their role-playing partner to a disadvantage when they do role-plays or other activities.
3. **Ensure that the training sessions commence on time.** Request all trainees to arrive in time. Inform them that there is much material to be covered each day, and it can be very disruptive to have trainees arrive late at the training sessions.
4. **Discussion of sensitive issues.** Discussions on sex, sexuality, HIV and STIs can be difficult. It is important for trainers to make a statement about this potential discomfort to trainees at the commencement of the course and invite the course trainees to discuss their concerns with the trainers on an individual basis. The training group must respect a trainee's decision to pass on a specific question or activity.
5. **Encourage trainees to use the question box.** Questions on sensitive issues can be written down on a piece of paper and dropped in a question box. The questions should be drawn out at the end of each day and discussed during the 'question-and-answer' session before the close of the day.
6. **Maintain confidentiality at all times.** This should be the case, especially if counsellor trainees refer to their own personal experiences or those of their clients. Trainers are urged to ask all trainees to agree to maintain the confidentiality of all fellow trainees.
7. **Encourage trainees to respect individual differences.** Trainees frequently come from different ethnic and cultural groups, and their lifestyles, beliefs, personal experiences and expertise may differ.
8. **Encourage trainees to listen carefully and with empathy, and respect each**

other's contributions, opinions and experiences. Explain that it is important in the training, and as professionals, to practice active listening by allowing each other to share their own experiences and opinions with the group.

9. Create a congenial environment in which each trainee feels comfortable asking questions. Trainees need to be able to ask questions about what they do not understand. Again, the question box can be a useful tool.
10. Due to the constant change in transmission patterns, treatment, perceptions, attitudes, etc., trainees should be reminded to consistently update their information regarding HIV/AIDS. With the VCT training programme in the 12-day schedule, latest information, resources and treatments available, we can provide better services to our clients.
11. **Ensure you get the right trainees.** Establish clear criteria for participation and communicate these criteria not only to the trainees but also to their employers.
12. **Ensure that an evaluation form is distributed to trainees at the end of the training.** These need to be completed by the trainees and placed in the 'evaluation box' to be collected by the trainer once all the forms have been submitted.
13. **Consider the advantages of providing meals to the trainees.** The training course follows a very strict timetable. It is therefore essential that sessions commence and conclude according to the schedule. The provision of morning tea, lunch and afternoon tea at the site of training has the advantage of ensuring that all trainees promptly return from breaks. It also creates flexibility within the programme should there be a need to shorten breaks or complete work within a break. Further, it contributes to the general satisfaction of trainees and allows them to focus on the study material to a greater degree.