- Note where people stand: What does this tell us about opportunity vis-á-vis the role we were playing?

➢ Now ask the participants to run and grab a space for themselves against the wall.

➢ Following this, ask the participants to assemble back into the training hall.

➢ Ask the participants to share their experiences of doing this activity :

- How did they feel when they had to take a step backwards?
- How did it feel to leave hands?
- At the end of all the questions, who was nearest to the wall and who was the farthest?
- What does this say about the opportunities that are available to some and not to others?
- Who could grab the wall? Who could not?
- Did anyone try to accommodate others so that they could also touch the wall?
- Do we take our privileges for granted?
- Where there any participants, who did not try to run toward the wall at all? If yes, why?

➢ At the end of the discussion ask the participants to 'de-role'. They could say the following – "I am (name of the participant), I am not a policeman" (the role the participant was playing).

➢ Ask the participants if they could draw any connections between this exercise and the previous discussion on marginalisation?

➢ Invite them to share their feelings about being in a marginalised position without doing anything to be in this position?

➢ Ask the participants if they could identify some factors that further marginalise individuals? Some of them could be education, socio-economic status, religion.

➢ Introduce the topic of marginalisation in the context of HIV/AIDS and ask the participants to name the marginalised groups in the context of HIV/AIDS.

(This activity is adopted from the 'Car Park' activity developed by CARAT, TISS and 'Power Walk' activity developed by TARSHI)*

Key points to emphasise:

- Those with greater opportunity owing to either the social groups, family or caste they belong to, enjoy more benefits and power to make choices in their lives. Those people who lack access to opportunities may be 'left behind'.
- One particular person may also have multiple advantages – for example in India, a person who is an educated upper-middle class Hindu, male living in a metropolitan city has multiple advantages over a lower-middle class Muslim woman who has very little education and lives in a village or small town.
- Often the more 'different' a person appears from 'normal' in the society, the greater the discrimination and marginalisation faced.
- A person can experience stigma without any experiences of marginalisation. For example, a person may be stigmatised for being lesbian but she may not be marginalised because of other factors in her life (income, class, caste, and race).
- Marginalisation has many interpretations and is experienced differently by each person. These experiences can further vary due to the influence of structural factors like age, class, caste, gender, educational status, disability and access to services.
- Structural factors and marginalisation contribute to increasing vulnerability of a particular group and community.
- Refers to the likelihood of being exposed to HIV infection because of a number of factors or determinants in the external environment, which are beyond the control of a person or particular social group.

Tips to the facilitator:

- ✓ Manage your time effectively from the beginning.
- ✓ Make sure participants do not see this activity as a judgment of them being fortunate or unfortunate, but rather a chance to examine opportunities and privileges individuals have in society.
- ✓ Encourage participants to get into the role.
- ✓ There is a possibility that the participants will not imbibe the identity to the fullest and will answer based on what they feel. If such a situation arises, the facilitator will have to discuss the same and address issues of the perceptions of the participants regarding a particular community/ identity.
- ✓ The participants (in the role) might not perceive themselves as marginalised or vulnerable. You as a facilitator will have to address this.
- ✓ De- rolling is extremely important for this activity.
- ✓ The facilitator is free to add or subtract more identities and frame more questions for this activity.

Activity 3: Cause and effect (Understanding vulnerability, stigma and discrimination in the context of the social drivers and structural factors) – 25 minutes

- ✓ Start the activity by suggesting that many of us have either witnessed or heard stories about cases of stigmatising and discriminating treatment of PLHIV. Explain them that this activity will provide opportunity for sharing some of them.
- ✓ Divide the participants into 4 groups and assign each with a setting where marginalised communities viz. female sex workers, men who have sex with men, intravenous drug users and migrant populations are vulnerable to HIV and face stigma and discrimination. The participants can also show the linkages between stigma, discrimination and vulnerability.
- ✓ At the same time the participants will have to discuss structural factors that add to the vulnerability and discrimination. Encourage the participants to recall the discussions on social drivers undertaken in the previous session on social drivers of the epidemic. In case the participants need more clarity, *you could tell them how individuals are forced to migrate due to poverty and how isolation and alienation in a new city can put them at a risk to HIV. Further they face stigma and discrimination at the public health centres because of their migrant and HIV positive status.*
- ✓ The settings could be family, local community, workplace, care setting, education and media.
- ✓ Ask each group to develop it as a case study.
- ✓ Ask them to identify the particular expressions of stigma, discrimination and vulnerability in terms of attitude, language and actions.
- ✓ Ask the participants to come back to the larger group. Ask a volunteer from the group to readout the case study for the larger group and list out the manifestations the group has listed out.
- ✓ Ask the other groups to supplement with a few more examples of stigma and discrimination within the particular setting.

Key points to emphasise:

- The term driver relates to the structural and social factors, such as poverty, gender inequality and human rights violations that increase people's vulnerability to HIV infection. These factors operate at different societal levels and different distances to influence individual risk and shape social vulnerability to infection.
- Structural factors can be understood as the factors external to individual. These factors arise out of political, employment or economic conditions such as poverty and migration.
- Recently the term *driver* is also used to describe those risk factors which are so widespread as to account for the increase and maintenance of an HIV epidemic at the population level.
- It is important to understand that it is not just individual behaviour or choices that put people at risk to HIV infection. Choice is never absolute.
- There is ample epidemiological and demographic evidence from the trajectory of the HIV pandemic to show that certain populations are more vulnerable to infection because of the particular social, cultural, economic and legal circumstances to which they are subject.
- In India, it has been seen that marginalised populations that live in an environment of inequity, criminalisation, oppression and violence have an increased vulnerability to HIV and AIDS, and have been disproportionately affected by it.
- Stigma and discrimination can result in violence, abuse or denial of services and information for individuals.
- Stigma and discrimination increases the vulnerability of individuals to HIV. Being infected with HIV further increases the stigma and discrimination, thus creating multiple layers of stigma and discrimination.

Tips to the facilitator:

- Request the participants to go through the leaflet on structural factors and vulnerability.
- Inform them the leaflets are provided to them as a quick reference when they have to conduct the session.
- The participants also need to go through the handout on 'Marginalised population outside the pale of human rights' and stigma and discrimination for further clarity.

Encourage participants to give examples from their practice.

Activity 4: Making the connections (Developing strategies to reduce marginalisation and vulnerability at the structural level) – 25 minutes

- Ask the participants to reconvene in the groups which were formed for the previous exercise. Provide each group with a case study prepared by another group.
- Ask the groups to identify the impact of stigma and discrimination given in the particular case study and then in the particular setting.
- Ask the groups to discuss upon the possible measures to mitigate stigma discrimination at the structural level and reducing vulnerability.
- Ask the group to come back to the larger group. Ask a volunteer from each group to present the discussion findings and their suggestions.
- Record the suggestions on white board or chart paper and compile them to common suggestions.
- Ask the participants to find out measures which they can initiate or advocate from the ICTC/ART/STI and work out plans for them.
- At the same time ask the groups to also discuss strategies that can make the counselling centres (ICTC, ART and STI) sensitive to the needs of marginalised population and reach out to marginalised groups thereby reducing vulnerability.
- This plan can be given as an extra home work for the participants, if time is limited. Alternatively , in case the time is not enough, immediately after the after the " Piece of the sky" activity , the facilitator can ask the participants to discuss strategies that can make the counselling centres (ICTC, ART and STI) sensitive to the needs of marginalised population and reach out to marginalised groups thereby reducing vulnerability and the end the session there itself.

Key points to emphasise:

- HIV prevention and care efforts cannot succeed in the long term without addressing the underlying drivers of HIV risk and vulnerability in different settings.
- Linking clients with government schemes or livelihood programmes can be some of the options to mitigate the vulnerabilities arising out of poverty or loss of livelihoods.
- Sensitising the judicial system, the police force and the public health system about needs of persons belonging to alternate sexuality can be another option of reducing marginalisation and vulnerability of HRGs. Participants can read the handout on 'Law and the marginalised population' for further clarity.
- Stigma, marginalisation and a sense of being different from the normative model can lead to clients experiencing unique stressors and challenges in their lives. Counsellors should know about these challenges and adapt their counselling and counselling centres (ICTC, STI and ART) to provide affirmative services to their clients. For more information on affirmative approach to counselling, please go through the manual developed by Saksham.
- Counsellors at the ART centres need to develop different adherence strategies for sex workers keeping in mind their working hours. For migrant workers, counsellors can suggest and include the 'transfer out' option to enable migrants to seek services at their desired location.
- The ICTC centres can be kept open till late evening to provide services to populations that are unable to access services in regular time, for example, persons who are engaged in daily wage work, MSM or FSW clients.
- Counsellors at the STI clinic need to be sensitive to and include partners of MSM and regular partners of FSW in partner treatment plans.

You can encourage the participants to watch the movie, "My brother Nikhil" and "68 pages". Both the movies cover the issue of stigma and marginalised communities very well. The movies can be screened post dinner. The movies are available in "Visual Voices" *(A compilation of videos on Gender, Sexuality and HIV/AIDS.)*

Key messages:

- Marginalisation refers to being on the margin (not in the centre) of the society, and thus having reduced power or importance in the society.
- The social process of marginalisation (especially as a group within the larger society) is a means to keeping or taking away power from someone, because of their identities, practices or appearance. The process of marginalisation makes the marginalised person or group feel left out.
- Stigma is associated with disfiguring or incurable diseases, in particular, diseases that society perceives to be caused by the violation of social norms, including norms about sexual behaviour.
- A person can experience stigma even without any experiences of marginalisation. For example, a person may be stigmatised for being lesbian but because of other factors in her life (income, class, caste, race) she may not be marginalised.
- Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group.
- There is ample evidence that certain populations are more vulnerable to HIV infection because of the particular social, cultural, economic and legal circumstances to which they are subjected.
- Stigma and discrimination increases the vulnerability of individuals to HIV. Being infected with HIV further increases the stigma and discrimination, thus creating multiple layers of stigma and discrimination.
- Stigma, marginalisation and a sense of being different from the normative model can lead to clients experiencing unique stressors and challenges in their lives. Counsellors should know about these challenges and adapt their counselling and counselling centres (ICTC, STI and ART) to provide affirmative services to their clients.

Annexure

Annexure I Activity 1: Identities for piece of the sky

(Please cut along the dotted lines and fold the same into small chits)

Heterosexual married woman who is a house wife. Her husband works as a taxi driver

---

Heterosexual Hindu male, who is married, is an engineer and works in a government undertaking

---

Female sex worker who operates from a brothel

Hindu policeman who is single

MSM who works in a massage parlour

Gay man who works in a multinational company

Female IDU who is Catholic

Unmarried Muslim male who works as an embroider

Unmarried Hindu girl who is a teacher in a public school

Transgendered person who begs for a living

Transgendered person who works as a dancer in a dance bar

Home based female sex worker who is married

Muslim male who has migrated from his hometown, lives in Delhi and works at a construction site

Lesbian woman who works as a receptionist in a five star hotel

Male who is undergoing the sex reassignment surgery procedure and works in an NGO

Bisexual man who works as a watchman

Hindu male who works as a rag picker

Muslim girl who holds a doctoral degree and works as a professor in a university

Catholic female who works in a bakery

Parsi female who runs a boutique

List of questions for the facilitator: (Not to be photocopied)

1. **Will you get a loan?**
2. **Can you make your passport?**
3. **Can you hold your lover's hand in public?**
4. **Can you go abroad for further studies?**
5. **Can you marry your lover / lovers?**
6. **Will you get respect in a public health setting?**
7. **Can you adopt a child?**
8. **Can you get a job in the government sector?**
9. **Does your family know about your profession?**
10. **If yes, is your family proud of your profession?**
11. **Do you get promotions at your work place?**
12. **Will you get medical insurance?**
13. **Does the majority of the country celebrate your festivals?**
14. **Can you afford an IVF?**
15. **Can you contest in an election?**

SESSION 6

Understanding Vulnerability and Risks of High Risk Groups (Core Groups and Bridge Population)

Session Overview:

- Activity 'Truth of the Matter' – 20 minutes
- Case study presentation by groups
- Power point presentation by the facilitator on each case study
- Summarisation – 5 minutes

} 1 hour 50 minutes

Session Objectives:

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

- Describe the reasons of vulnerability of various high risk groups i.e. core groups (FSW, MSM, TG, IDU) and bridge population (Migrants and Truckers).
- Get information on counselling strategies for High Risk Groups (HRGs).
- Apply the knowledge and skills learnt in the session, while counselling HRGs.

Time allowed:

- 2 hours 15 minutes

Material required:

- Two posters, one with the term TRUE and the other FALSE
- Chart papers
- Sketch pens/markers
- PPT / Projector
- Photocopies of case studies

Method:

Preparation before the session:

Activity I - You, as the facilitator, will place two posters, one on either side of the training hall with the terms TRUE and FALSE.

Activity II – (to be done as a homework assignment the previous day and presented by the group on the day of the session). Prepare sufficient photocopies of case studies so that each participant will get a case study of his/her group. Distribute the case studies the evening prior to the session and ask the respective groups to make a presentation on the same on a chart paper for discussion on the next day. Each case study shall be presented for 8-10 minutes by each group before the topic on the PPT and you can explain the slides post discussion of the case for 10 minutes.

The participants can add on points they might have missed or not known before and refresh the presentation of the case study.

If time permits the groups can present their cases once again at the end of the session as a refresher.

Activity I: Truth of the Matter – 20 minutes *

1. Ask the participants to stand in the middle of the training hall, with the posters saying 'True' and 'False' on their either side. Inform them that you will read out a statement. When they hear the statement, they have to individually decide whether it is true or false, and according to their view, they have to move towards the respective poster.
2. Read out each of the statements given in Annexure 1and give the participants a moment to move towards the poster of their choice. You may ask some participants why they elected to move towards 'True' or 'False'. But do this briskly.

After all the statements have been read out, ask the participants briefly what they thought of the exercise. Each participant should be given an opportunity to express their views.

Politely inform them that every single statement you read is false and discuss the details. You may focus on one or two particular statements. However, inform the group that more details follow in the session. If some participants try to force their opinions on others, inform them politely to avoid it and engage in proper discussion.

**(The above activity is adapted from Refresher Training Programme for ICTC Counsellors – second edition developed by NACO, April 2011)*

Activity II: Group presentation on cases studies and PPT (1hr 50 minutes)

1. Divide the participants in 5 groups. Give one case study to each group the day prior to the

session. Ask them to read the case study and note down major points in terms of various issues faced by the key persons, reasons of their vulnerability and counsellor's role with reference to that case.

Refer to annexure II for case studies.

2. On the day of the session ask each group to make a presentation for 8-10 minutes on the above points. Ask other participants to add points, if missing, in the presentation. Facilitator needs to explain the topic on the PPT and debrief after each case presentation. **(Total time for case presentation – 50 minutes i.e., 10 minutes for each group) Power Point Presentation (60 minutes) – (10 minutes for each topic in the case study)**

Activity III: Summarisation (5 minutes):

Ask participants to narrate key points discussed during the session.

The following points need to be emphasised –

- HRGs are vulnerable to HIV because of various reasons e.g. marginalisation, poverty, gender issues, living conditions, lack of awareness, lack of education, limited choices, limited or no access to services and various other systemic and structural factors as well as psychological factors.
- The categories of Core groups and Bridge population may not be exclusive. Many persons belong to various categories at the same time e.g. a person can be a truck driver as well as IDU and MSM. A young girl can be an IDU as well as a sex worker. MSM can be in sex work.
- While counselling, the counsellor need to understand the reasons of vulnerability of the clients.
- Marginalisation is one of the major reasons of vulnerability.
- The counsellor needs to carry out the detailed risk assessment of each client.
- HRGs may find it difficult to utilise various services due to various reasons like systemic issues, stigma and discrimination, or lack of information about services. The counsellor needs to address these issues and make appropriate strategies so that these groups can avail the services.
- Counsellors need to be sensitive about the needs of these groups and should have unconditional positive regard for all clients.
- While considering the language difficulties and literacy level, counsellors need to make use of simple language and also utilise visual material to make the information simpler.
- Counsellor need to link the clients with STI and TB services as per the NACP guidelines.
- Apart from HIV services, counsellors need to link the clients with TI NGOs and other social protection schemes.

Key messages:

- HRGs (Core groups and bridge population) are vulnerable to HIV because of various reasons e.g. marginalisation, poverty, gender issues, living conditions, lack of awareness, less or no education, limited choices, limited or no access to services and various other systemic and structural factors.
- The categories of Core Groups and Bridge Population may not be exclusive. Many persons belong to various categories at the same time e.g. a person can be a truck driver as well as IDU and MSM. A young girl can be an IDU as well as a sex worker.MSM can be in sex work.
- While counselling, the counsellor needs to understand the reasons for vulnerability of clients.
- Marginalisation is one of the major reasons of vulnerability.
- The counsellor needs to carry out a detailed risk assessment of each client.
- HRGs (Core groups and bridge population) may find it difficult to utilise available services due to various reasons like systemic issues, stigma and discrimination, or lack of information about services. The counsellor needs to address these issues and make appropriate strategies so that all clients who need these services can avail them.
- Counsellors need to be sensitive about the needs of people from HRGs and should have unconditional positive regard for all clients.
- In case of language difficulties and lower literacy level, counsellors need to make use of simple language and also utilise visual material to convey the necessary messages.
- Counsellors need to link the clients with STI and TB services as per the NACP guidelines.
- Apart from HIV services, counsellors also need to link the clients with TI NGOs and other social protection schemes as and when needed.
- **Counselling process should not be limited only for providing HIV related information and services but it should also aim to empower the client.**

Annexure

Annexure I: Statements for Activity I 'Truth of the Matter' –

1) Counsellors should advise MSM clients to become heterosexual for their own well being.
2) Some boys become transgender /hijras (TG) because their parents grow them like a girl child.
3) All MSM have anal sex.
4) All MSM clients have feminine look and they behave in a feminine manner.
5) All hijras sell sex.
6) All sex workers enjoy sex and so they are in this profession.
7) Sex workers should take more responsibility to control the HIV/AIDS epidemic.
8) Migrants are irresponsible as they bring back the HIV epidemic to their homes.
9) All migrants have sex with sex workers.
10) Long distance truck drivers are careless. They drink and have accidents.

Annexure II: Cases for Activity II 'Discussion on case studies'

1. Case study for MSM Counselling

Sohaib was a 24-year-old matriculate belonging to an orthodox Muslim family in a district of North India. He was soft spoken, with fair complexion and fairly good looks. At the age of 17, he came to Mumbai and started working in his uncle's garage to make a living and to learn the trade of a motor mechanic. His uncle was married and used to stay with a few other migrants from North India. His wife lived away in the village with their three children. The uncle soon started asking Sohaib for sexual favours against the obligation of keeping him in the job. Sohaib felt helpless and had no other support in the city except his uncle. His initial resentment and pain slowly turned into silent submission. After about two years he found himself being recognised by other boys who had the same sexual orientation. By this time, Sohaib had started identifying himself as homosexual and developed relationship with two other men.

Once, while visiting a friend in another village, he happened to see a campaign organised by SACS for migrants. He met a counsellor there who gave him information about the routes of HIV transmission. Sohaib was frightened and decided to get himself tested. He gathered the courage to visit the ICTC at his district despite the fear of being found out. During the counselling session he disclosed his sexual identity to the counsellor. He was tested negative for HIV. Counsellor counselled him and further suggested that he should undertake HIV test regularly i.e. quarterly or at least once in six months.

Presenting problem:

After a few months Sohaib came back to the ICTC once again for his regular HIV testing. Sohaib had gotten married a month back because of immense family pressure. He informed the counsellor that he had sexual intercourse with his wife a few times without condoms. He also informed the counsellor that after a few months there will be family pressure to have a child.

After a few months he was tested for HIV and found positive. Sohaib was shocked and was full of remorse. He said that Allah was punishing him for his deeds and that he had been suffering since he was young.

Questions for discussion:

- What are the major issues to be discussed in this case?
- What were the reasons of Sohaib's vulnerability?
- What is the role of a counsellor in this case?
- How should the counsellor handle various emotions expressed by Sohaib?
- How are the categories of HRGs not exclusive but overlapping?

2. Case study for FSW counselling

A 29-year-old woman Neela is into home based sex work. She has been in the profession for over 10 years. She is married and has children and engages in this work purportedly without the knowledge of her family. The husband does not support the family economically and is an alcoholic. She belongs to a family from the lower economic strata and has received very little education.

She has used condoms occasionally saying that some customers do not want to use condoms and are willing to give more money for that. She has the apprehension that if she keeps the condoms, her husband may doubt that she is into sex work and so it is risky for her to keep condoms. She was tested negative for HIV last month but has come to the counsellor as her white discharge is not getting cured. She also informs the counsellor that she will not be able to come to the hospital regularly for HIV testing because her family members may ask her the reasons for visiting the hospital.

Questions for discussion:

- What are the major issues in this case?
- What are the reasons of Neela's vulnerability?
- How can the counsellor address her issues?
- What are the difficulties faced by home based sex workers?

3. Case study for IDU Counselling

Sunny was a 24-year-old male from a Sikh family. He had 12 years of schooling. His father was no more. He had a sister and a brother. His mother was a school teacher in a North Indian city. He had never liked to study or to be bound by rules. Unable to handle his indiscipline any longer, he had been sent by his mother to another city, where he lived with his uncle and continued his schooling, but also made friends with some miscreants. He also started to take intravenous drugs. When his uncle discovered this, he took him out of the school and put him to work in his transport business.

There he got himself to the ways of the transport operators and was also soon engaging in sex with an FSW. He was convicted of a criminal offence and was put behind bars. His drug addiction continued even in the jail. He used to steal used injections discarded by the jail doctors for injecting, and the drugs were smuggled into the jail. He also began having sex with men. He was tested positive for HIV and started on ART, however, he did not disclose this to his mother and siblings. He decided to go back to his home town as he was severely sick. He consulted a local doctor for severe cough, and was found to have TB. Meanwhile Sunny was extremely unwell, depressed, and did not want to live any more.

Presenting Problem:

A friend brought him to the IDU Targeted Intervention NGO in the city. The counsellor in the TI counselled him and also took him to the sanatorium for treatment of his persistent cough. Meanwhile Sunny did not disclose either his high risk behaviour or his HIV positive status to the TI counsellor. The TI counsellor referred him to the ICTC for testing, where he also accompanied him. On the way, Sunny disclosed his high risk behaviour and his HIV status to the counsellor. However, he was counselled and tested again at the ICTC and tested positive.

The issue was now of referral and continuation of ART and also of disclosure of the test result to his mother and family members. His siblings asked their mother to throw him out of the house immediately. His mother felt helpless and hopeless. However, after she was counselled by the TI counsellor, she decided to take care of the son. After requisite follow up by the ICTC and TI counsellors, Sunny produced his papers of ART for starting the treatment afresh at his hometown. His ART began soon after his TB treatment.

Presently, Sunny has recovered significantly. He has also shown tremendous behaviour change. He has opened his own small business. From a regular injector, he has turned into a low volume injector. He also picks up condoms from the TI NGO regularly and says that he practices safer sex.

Questions for discussion:

- What are the major issues in this case?
- What are the factors which are making Sunny vulnerable?
- What can a counsellor do if a client does not disclose the source of infection or some other crucial information like sexual history or history of taking drugs?

- Besides referring him to the TI NGO, what else could the counsellor do while dealing with this client?
- How are the categories of HRGs not exclusive but overlapping?

4. Case study for counselling migrant population

Soman was a 37-year-old unmarried male from a lower socio economic class family in Kerala. He had been working as a cook in a circus for the last 16 years, but did not have sufficient savings. Once in a year or so he used to visit his family.

Presenting problem:

Soman went to the counsellor at the STI clinic through the public relation officer (PRO) of the circus because he had been having an itching sensation in the genital region. While the PRO waited outside, the counsellor heard the client patiently. As part of history taking, Soman revealed that the pain, itching and ulcers in the genital region were there for the last few months, and it was never treated. When the counsellor took his sexual history, Soman reported engaging in high risk sexual activities with multiple partners - men and women. Soman was then referred to the Medical Officer who carried out a careful examination, and sent Soman to the counsellor with a kit medicine. The counsellor provided essential guidelines on use of the medicine, regular follow up, partner notification, safer sex practices and so on. Thereafter Soman was referred to the ICTC for VDRL and HIV tests.

Soman approached the ICTC counsellor the next day itself with the results. He was tested positive for HIV. Soman was a bit nervous about the result that was disclosed by the ICTC counsellor. The STI counsellor prepared the client to cope with the results as an initial step. Subsequently he described the importance of the regular usage of STI medicine and ART registration and advised Soman to visit the STI clinic after 7 days. The counsellor also showed and handed over relevant IEC material among the circus artists and other employees with the help of Soman and PRO without disclosing the HIV status of Soman.

After a week, Soman visited the counsellor again. The counsellor noticed that the client got registered at the ART centre and his STI symptoms were consistently reducing. Later he was referred to a clinician to continue the treatment. The counsellor also linked Soman to the network of positive people associated with the STI clinic. As Soman was HIV positive, he was invited to be an outreach worker in the positive people's network, and he joined them.

Questions for discussion:

- What are the issues faced by Soman?
- Why migrant population is vulnerable?
- How have counsellors played a supportive role in this case?
- What role can a peer play in creating awareness among migrant population?

5. Case study for counselling Truckers

Rambabu, a 32-year-old man is a long distance truck driver. He is from a farmer family but because of consistent drought, his father left the village and came to a city to make a living. Rambabu became a truck driver and began earning enough to feed his family, but it was not sufficient because of pressing needs in the family like clearing debts, father's illness, sisters' marriages and so on. Rambabu used to work quite hard to earn more and more money. Since the last year he had not been feeling well. He felt very tired and his health was deteriorating. He had developed the habit of drinking. He had gotten married a few months back but his wife left him. Now he was sexually involved with a dhaba based sex worker.

Presenting Problem:

Rambabu consulted a clinic run by an NGO and as per the outreach worker's advice, and got tested for HIV at an ICTC. The result came out to be positive. He informed the counsellor that he did not have any hope in his life and he was not interested in registering for ART. He also informed that he had to reach somewhere early next morning and that he could not wait further at the clinic.

Points for discussion:

- What are the issues faced by Rambabu?
- What are the reasons of his vulnerability?
- How can the counsellor address his issues?
- Why truckers are vulnerable?
- What strategies of linkages need to be followed for truckers as they cannot wait at one centre for a long time?

Following TV show/ films can be shown if time permits –

https://www.youtube.com/watch?v=mHr87BxZYcw (Satyamev Jayate episode 'Accepting Alternate Sexualities', duration 1 hr 11 minutes)

https://www.youtube.com/watch?v=vT7W8vOb7Cc (Film 'In The Flesh' by Magic Lantern. 2 minute film on lives on women and TG in sex work)

SESSION 7
Enhancing Counsellor Competence

Session Overview:

- Objectives and instructions – 10 minutes
- Preparation time – 50 minutes
- Demonstration and discussion – 2 hours 20 minutes
- Summing up – 10 minutes

Session Objectives:

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

- List the skills and competences required for counsellors.
- Practice the competence required for counsellors.
- Know when and how to apply counselling skills in HIV counselling setting.

Time allowed:

- 3 hours 30 minutes

Materials required:

- Chart paper
- Papers
- Markers

Method:

Preparation before the session:

You as the facilitator will photocopy the handout "Enhancing Counsellor Competence" for all the participants. Because the session requires a lot of reading, it would be ideal to translate the handout into the local language in advance.

- Divide the participants into 5 groups; distribute the handout to all the participants.
- Each group will be given one set of skills, namely:
  - Group 1 – Inter personal relationships
  - Group 2 – Gathering information
  - Group 3 – Giving information
  - Group 4 – Handling special circumstances
  - Group 5 – Counselling skills
- Inform the participants that each group has to go through their set of skills in the handouts and prepare a role play demonstrating that particular set of skills. The verbatim statements given in the handout can be used in the role play.
- The facilitator will have to play an active role in this activity and may need to step in to clarify, correct or demonstrate a particular skill as and when required.
- Facilitator needs to emphasise that participants need not present any case in detail. Only demonstration of the skill is required.
- For the role plays, follow the 'instructions to the training institutes' given in the beginning of the manual.
- The groups will be given 50 minutes to prepare for skill demonstration. After this, each group will get about 25-30 minutes for demonstrating the skill through role plays.

Key points to emphasise:

- ✓ It would be best if an experienced and practicing counsellor / psychotherapist facilitates this session.
- ✓ These are the basic skills required for counsellors to undertake HIV counselling.
- ✓ The information gained and attitudes developed by the counsellors during the training programmes have to be translated into practice by using these sets of skills.

Tips to the facilitator:

- The skills partly overlap with each other. Kindly communicate the same to the participants as well.
- The handout is given as an aid for the participants to develop their role plays. Please feel free to substantiate the description of the skill or the verbatim mentioned in the handout during the course of the session.

Key messages:

- The counselling skills and competences covered in this session **are very crucial to effective counselling.**
- Counsellors need to practise and internalise these proficiencies. With practice these skills becomes more natural.
- Skilful counselling does not necessarily require more time. Counsellors need to understand when and how to use the skills even in a five minute interaction with the client.
- Skills cannot be considered in isolation. Appropriate attitude (as discussed in the session on self awareness) and subject knowledge are also MUST for effective use of any skill.
- Empathy is a key skill in counselling, wherein a counsellor is able to put oneself in the client's position and understand what the client must be thinking and feeling; and then conveying to the client what has been understood.
- Certain skills and techniques like use of silence, confrontation, disclosure, handling defensiveness are important and need practice. Practice of different skills can also be done through discussion and role play during supervisory visits.

SESSION 8
Body Basics and Family Planning

Session Overview:

- Discussion of body mapping -10 minutes
- Lecture session using slides -50 minutes

Session Objectives:

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

- Describe the structure and functions of male and female external and internal reproductive/ sexual organs.
- Understand where STI/RTI occur.
- List different family planning methods available in India and their use in the context of people with HIV/ STI/RTI.
- Address issues related to family planning in the context of sero-discordant couple.

Time allowed:

- 1 hour

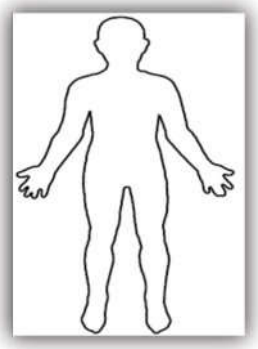
Material required:

- Body map
- Drawings/ cut outs of pictures of external and internal male and female reproductive / sexual organs
- Power-point Presentation
- Different methods of contraception

Method:

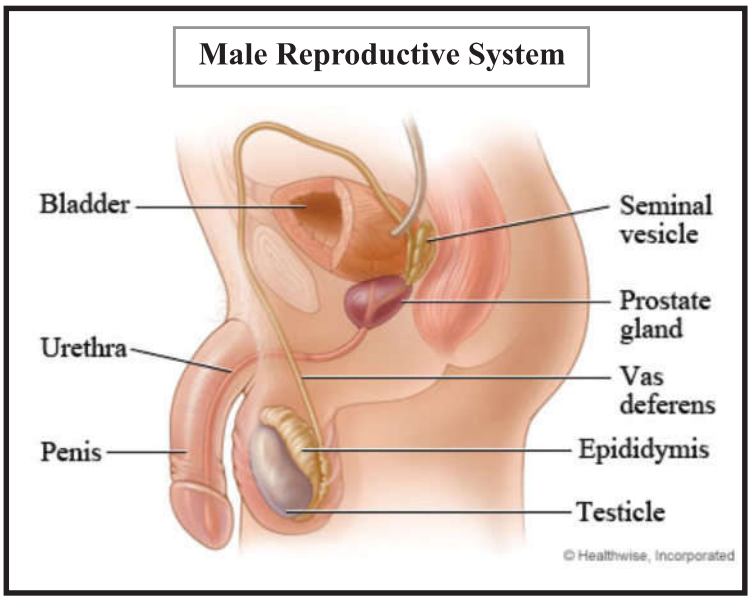
Preparation before the session:

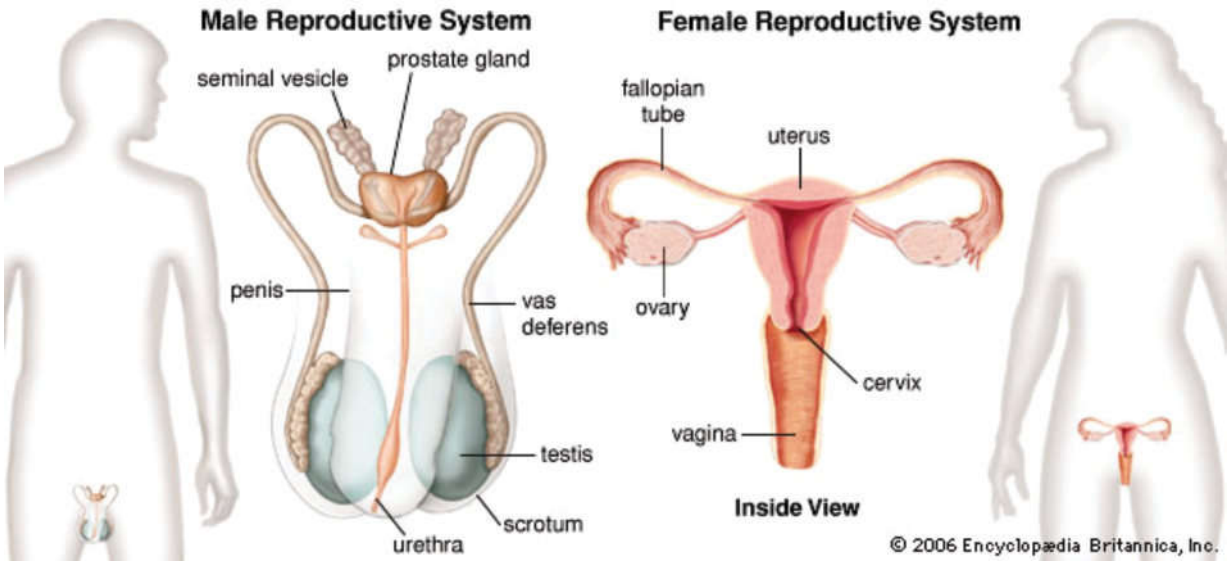
1. The training institute needs to prepare a body map in advance. To prepare a body map three chart papers may be stuck with each other using tape or glue. A body outline of any volunteer / staff needs to be drawn on the chart paper as shown in the figure below:

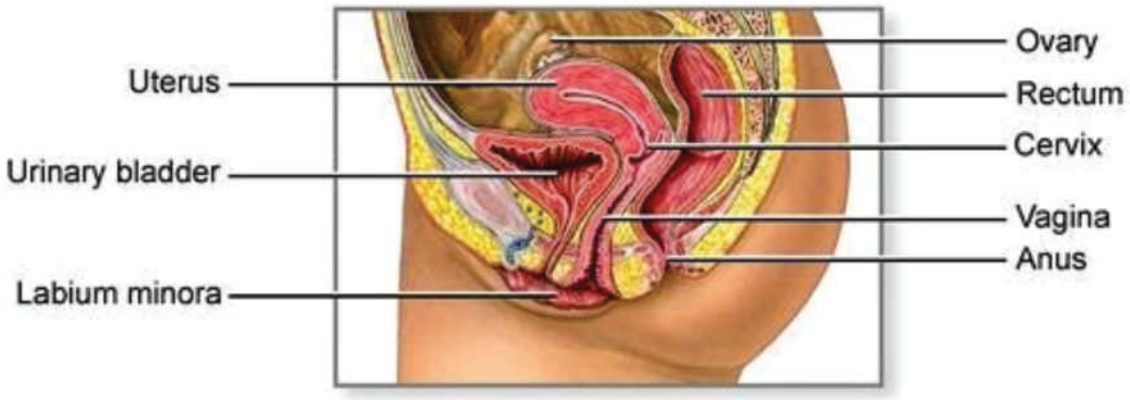


2. The session needs to be facilitated by a medical professional.

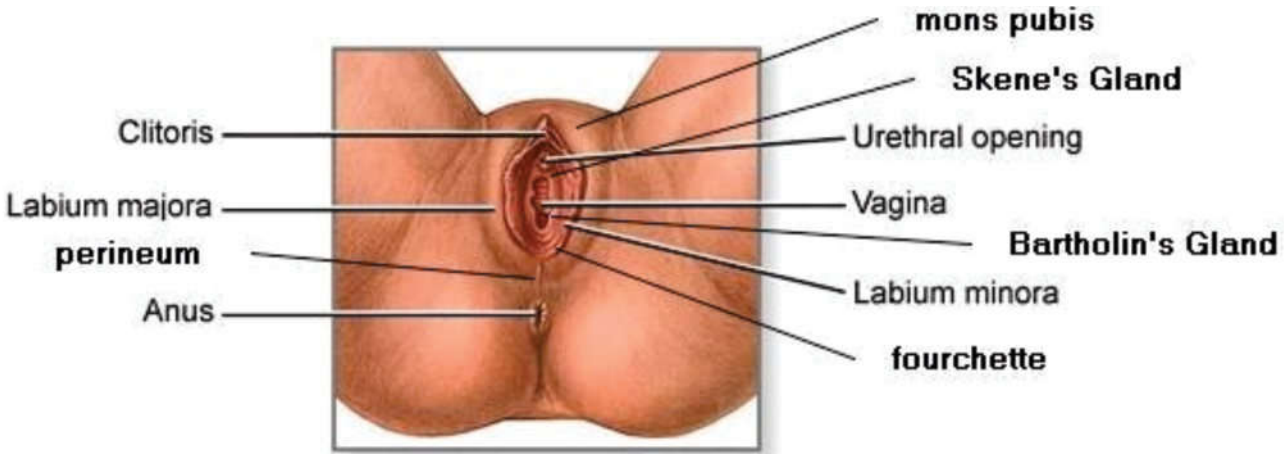
3. Drawings / cut outs of pictures of internal and external male and female reproductive / sexual organs may be either prepared by the training institute or the facilitator may be requested to bring the same. (In case the drawings / cut outs are not available, the facilitator can photocopy and use the figures given below.)







Female Reproductive System



Female Reproductive System

1. **Discussion of body mapping (10 minutes)**

   Using the body map and the drawings / cut outs of pictures of body parts, the facilitator needs to clarify the structure and function of different sexual and reproductive organs. The drawings / cut outs need to be placed at the appropriate places on the body map, and the participants need to be made familiar and comfortable with the names of all the body parts.

Tip to the facilitator:

Please ensure to not disclose the name of the person who has volunteered to be the model for body mapping to avoid embarrassment and to stay focused.

2. **Lecture using slides (50 minutes)**

   - The facilitator needs to explain the key points in the session using slides.
   - The facilitator needs to demonstrate a sample of different contraceptive methods to familiarise the participants with the same.

Key Messages:

- Understanding one's own body, especially sexual organs, is essential for everyone.
- Poor knowledge and lack of sanitation facilities lead to poor genital hygiene, especially in women, resulting in Reproductive Tract Infections (RTI). This increases their vulnerability to other genital infections and illnesses including STI and HIV.
- It is important to understand social norms associated with maleness and femaleness as well as the various facets of gender inequality in sexual relationships. This knowledge provides the counsellor with confidence in dealing with clients' sexuality issues in the context of HIV.
- Counselling on family planning methods discusses two aspects:
  - How well the method works to regulate pregnancy.
  - How well the method works to prevent transmission of HIV and other STI.
- Not all methods are suitable for everyone. A family planning method may be at times useful or may cause additional harm in PLHIV with an underlying medical condition.
- Ask every client who is married or in a committed relationship about the number of children they would like to have, and what method they use to plan their family. Planning a family can mean delaying pregnancy as well as limiting the number of children.
- Be gender-sensitive – do not discuss only the female contraceptive methods.
- Address HIV prevention concerns clearly.
- Guide the clients clearly about where and when they may access family planning services.

SESSION 9
Basics of STI / RTI

Session Overview:

- Lecture using slides (45 minutes) or
- Modular reading (45 minutes)
- Discussion (15 minutes)

Session Objectives:

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

- Define STI and RTI.
- Name some common STI and RTI.
- List the modes of transmission of STI and RTI.
- Describe conditions that put people at greater risk of STI and RTI.
- Correct common misconceptions related to transmission of STI.
- Counsel clients on getting diagnosed and treated for STI/RTI.
- Refer clients for further follow up to the STI clinics.

Time allowed:

- 1 hour

Material required:

- Slides related to the session
- Participants handout

Method:

Lecture using Slides (45minutes)

1. Explain the key points in the session using the slides and the dialogue given for your convenience.

Optional: Modular Reading (45 minutes)

- You, as the facilitator, will ask counsellors to open their handouts titled Basic Fact Sheet on STI/RTI.
- Invite a volunteer with a loud and clear voice to read out a section.
- Stop the reading and explain that section. Remind participants to make notes on their handouts.
- Invite another volunteer to read the next section and follow the same pattern till all sections are read.
- There are facilitator notes in the PPT slides for your assistance. Use them at your discretion.

Note: In case some participants are not comfortable reading in English, they should be given the choice to refuse.

Discussion (15 minutes):

Answer any queries or doubts of the participants during or after the modular reading / slide presentation.

Key messages:

- **Sexually Transmitted Infections** (STI) are infections that are spread primarily through person-to-person sexual contact. STI reflects **modes of transmission of infection**.
- **Reproductive Tract Infections** (RTI) are infections which are present in the reproductive tract of males or females. RTI represents **site of infection**.
- Not all reproductive tract infections are sexually transmitted and not all sexually transmitted infections are located in the reproductive tract.
- STI often, **but not always** cause discomfort and pain to people who have them.
- STI can **spread** quite easily to other people.
- STI can cause **serious health problems** such as infertility, stillbirth, ectopic pregnancy and blindness in newborns.
- Shame and guilt over STI / RTI make people delay treatment or visit quacks for help. So it is important for the counsellor to be **respectful and nonjudgmental** with every client to get the required treatment and emphasise the importance of **complete treatment**.
- Make sure that during counselling you address any **misconceptions** such as, "patients cannot have more than one STI at a time," or "sex with a menstruating woman causes STI."
- Some forms of sex like **anal sex** make the transfer of STI organisms easier. But **all forms of sexual contact** can transmit infection.
- Women and adolescents are more prone to get STI.

SESSION 10
STI Syndromic Management Counselling

Session Overview:

- Lecture using slides (5 minutes) (slides1-5)
- Sorting exercise (5 minutes) (slides 6-18)
- Modular reading assisted with slides (55 minutes) (slides19-43)
- Processing exercise (20 minutes) (slides 44-48)
- Quiz (20 minutes) (slides 49-60)
- Lecture using slides (10 minutes) (slides 61- 65)
- Role play (15 minutes) (slide 66)
- Lecture using slides (20 minutes) (slides 67-80)

Session Objectives:

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

- Differentiate between signs and symptoms.
- Explain the concept of syndromic case management.
- Apply the information sheets for management of common syndromic conditions in India.
- Carry out patient education relevant to each of the syndromic conditions.
- Understand what a counsellor in the STI/RTI service should do in relation to HIV.
- Explain the importance of partner management.
- Make appropriate referrals for STI/RTI clients.

Time allowed:

- 2 hour 30 minutes

Material required:

- Flipchart
- Markers
- PPT slides / Projector

Method:

Lecture using slides (5 minutes)

You, as the facilitator, will begin the session by explaining the difference between a sign and a symptom using the slides.

Sorting exercise (5 minutes)

Ask counsellors to turn to the Sorting exercise in their handouts and ask them to sort out the various terms given into two categories: Signs or Symptoms

> Syndromic management of STI relies heavily on the doctor recognising the signs and eliciting the symptoms from patients. So let us do an exercise. Look at the exercise in your handout. Sort the statements into the columns for Sign and Symptom. You have 5 minutes for the job.

Debrief using the slides (Slide 6 to 18 are related to the exercise)

Slide 6 is the instruction slide. Slides 7 to 18 are the debriefing slides which contain the answers. They are animated slides. A mouse click will highlight the answer.

Answer key to the exercise-

(Clue is underlined)

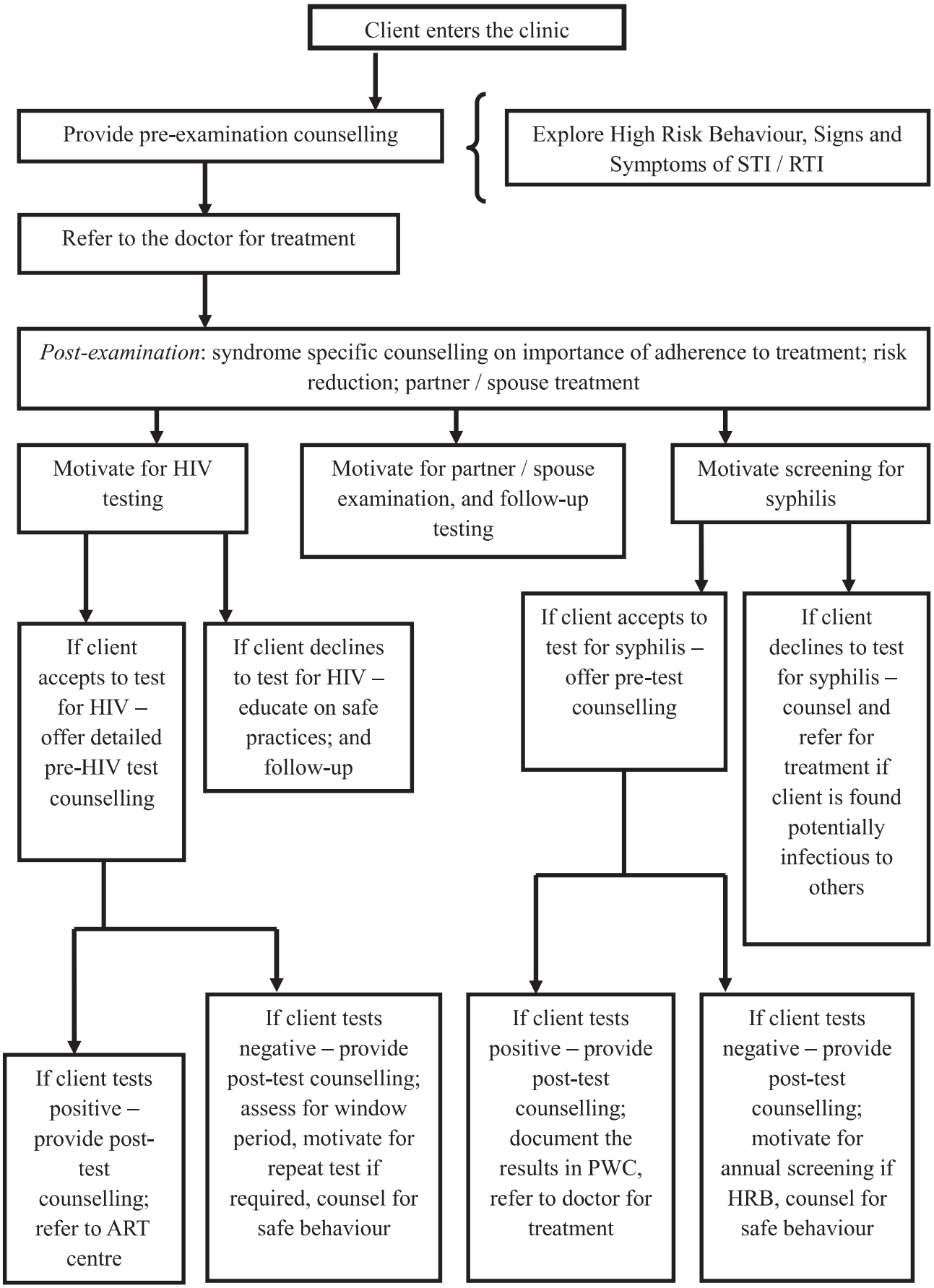
- Woman says, "I have a discharge from my vagina." - SYMPTOM
- Discharge is seen from the anus. - SIGN
- On physical examination, sores, ulcers, blisters, small hard lumps or rashes are seen in and around the sexual organs. - SIGN
- Man says, "Oh! I have a discharge from my penis." - SYMPTOM
- Teenager says, "My mouth burns when I have to eat food." - SYMPTOM
- Doctor examines teenager's mouth and finds blisters or sores inside the mouth. - SIGN
- Sore throat sensation - SYMPTOM
- Pain in vagina while having sex - SYMPTOM
- Burning sensation in vagina - SYMPTOM
- Lower abdominal pain - SYMPTOM
- Frequent urination - SYMPTOM
- Patient complains of swelling of scrotum/ groin area - SYMPTOM

Modular reading assisted with slides (55 minutes)

Continue the lecture using the slides (Slides 19-43). Ask counsellors to continue reading the section on Syndromic Management in their handouts. Discuss each syndrome listed on the slides while pointing to the handouts when necessary.

Slide 43: Below is the Standard Operating Procedure (SOP) for STI/RTI Counsellors to ensure quality counselling services:

FLOW CHART FOR STI/RTI COUNSELLORS



Processing exercise (20 minutes)

As an energiser, ask the counsellors to stand in order of when they have joined the SACS as a counsellor. Some might have earlier worked as an ICTC counsellor. Please see diagram:

1year 3mths | 2 years | 2 years 5 mths | 3 years 2 mths | 5 years

Ask 4 senior-most counsellors to come forward and let each of them choose an equal number of people to join their team.

Inform them that each group will have 20 minutes to review a certain section of the handouts and to answer the following questions **(Slide 44)**:

a. What do you notice is common in these syndromes?

b. What do you notice is different in these syndromes?

c. What are the implications for patient education and counselling?

Ask 3 groups to read the handout pages related to Urethral Discharge Syndrome, Painful Scrotal Swelling Syndrome, Inguinal Bubo Syndrome, Genital Ulcer Syndrome (Non-herpetic) and Genital Ulcer Syndrome (Herpetic).

Ask the other 3 groups to read the handout pages related to Vaginal Discharge Syndrome, Cervical Discharge Syndrome, Lower Abdominal Pain and Oral/Anal STI.

After 20 minutes, stop the group reading and record the answers on a flipchart. Participants should be able to recognise that:

a) Many of the complications from untreated STI are similar.

b) They cause damage to body organs.

c) Sexual partners also get affected.

d) There are many contra-indications during pregnancy. Full and complete treatment is required.

e) The symptoms of different syndromes are quite distinct – especially in males and females.

Conduct a group discussion on the following questions **(Animated slides 45- 48)**:

a) How easy is it for a person with an STI to come for treatment?
Answer: It is not easy. There are many barriers.

b) When are they likely to come?
Answer: When their symptoms become unbearable.

c) Who might not be likely to come?
Answer: People who are asymptomatic. Women: because they do not want to speak to a male provider.

d) What makes it easier for a person with STI to seek treatment?
Answer: Caring, non-judgmental health care providers.

Review with the quiz on the **Animated slides 49 – 60 (20 minutes)**

a) Imran Khan comes to your STI/RTI centre. After seeing the doctor, he comes to you with his patient-wise card which reads under diagnosis "LAP." What's wrong with this scenario?
Answer: Imran is a man. LAP is a woman's complaint.

b) What is DOTS-STI? Which drugs/ drug kits come under the category of DOTS-STI?
Answer: DOTS-STI stands for Directly Observed Treatment – STI. It includes Kit 1 which contains drugs like sd-Azithromycin and sd-Cefixime (stat) which are taken in the presence of the health worker.

c) Name a syndrome which is seen only in males.
Answer: Urethral discharge syndrome, Painful scrotal swelling syndrome.

d) Which disease when passed on from a mother to her baby during delivery can affect the baby's eyes and even lead to loss of eyesight?
Answer: Gonorrhoea and Chlamydia.

e) Name a drug which should not be taken during pregnancy.
Answer: Doxycycline (Kit no.6 and 7) and Podophylin.

f) Name one condition that can be linked with cervical cancer in women.
Answer: Certain types of warts.

g) One syndromic drug when taken with alcohol can cause nausea, vomiting, flushing and sinking feeling. The counsellor will advise the client not to take any alcohol until 24 hours have passed after the last dose is taken. Which drug is this?
Answer: Secnidazole and Metronidazole. So counsellors should clearly advise patients who take this medicine to avoid taking it along with alcohol.

h) Which syndromic condition may recur during stressful periods?

Answer: Genetic ulcer disease syndrome (Herpetic). So counsellors advise such clients to find ways to reduce stress.

i) For which drug does the client have to make repeat visits to the clinic on the 7th day, the 14th day and the 21st day?

Answer: Doxycycline (100 mg) BID for 21 days which is used for treating Inguinal Bubo Syndrome. This is part of patient education when dealing with this Drug Kit (Kit 7)

j) Which syndromic condition is sometimes treated with an injection of penicillin?

Answer: Genetic ulcer disease syndrome (non-herpetic) which can be cured with an injection of Benzathine penicillin in each buttock.

k) When counselling pregnant women, information about STI is very important. What are some of the consequences of the mother's untreated STI to a new-born baby?

Answer: Still-birth, eye infection.

l) If a client with herpes argues with a counsellor that herpes sores heal on their own after10-14 days and therefore there is no need to get treated, how should the counsellor respond convincing the person to take treatment till the end?

Answer: The counsellor can explain to this client that the medicines for herpes shorten the time of healing. Further, if the client's herpes cures faster, it may be possible to resume sexual relations that much faster.

Role Play (15 minutes)

- Invite 2 volunteers to role play a situation of a counsellor preparing a patient with Genital Ulcers-non-herpetic to bring their partner for treatment. (See slide 65)

- Ask the group to make sure that the volunteers cover all the arguments in favour of referral by client.

Lecture using slides: Referral services for STI/RTI patients (Slides 68-77)

Key messages:

- A symptom is what the client / patient complains of or reports to a doctor.
- A sign is that which the doctor /counsellor observes on examination of the client / patient.
- People with no symptoms (asymptomatic) should also be treated.
- Most of the STI/RTI are asymptomatic.
- Syndromic management is to identify the syndrome affecting the patient with the help of signs and symptoms and to treat all infections that could possibly cause that syndrome.
- Treatment for STI/RTI is:
  - ✓ To be taken from a trained doctor.
  - ✓ To be taken for the duration prescribed.
  - ✓ To be taken in the dosage prescribed.
  - ✓ To be also given to the sexual partner.
  - ✓ To use condoms during treatment.
- More than 50% of STI in women are without symptoms!
- Women are more easily infected than men.
- STI/RTI in women can lead to a number of complications like infertility, cancer and so on.
- Untreated STI/RTI in women can affect her child: still born, abortions, eye infections at birth.
- Presence of an STI can increase risk of acquisition and transmission of HIV 5 to 10 times!
- Explain and encourage HIV testing to a client presenting with STI/RTI.
- Establish referral services to other centres.
- Network for expanded STI and HIV care and support - general laboratory, ICTC, PPTCT, ART, CCC, and TB-HIV, for example.
- All STI are curable except HIV, Herpes and Hepatitis B.
- **Partner management is needed in case of STI to prevent:**
  - ✓ STI re-infection.
  - ✓ Further spread of STI.
  - ✓ Possible long term effects of untreated STI for the partner.
- Encourage the patient to take his/ her prescribed STI/RTI treatment.
- Help him/her understand how to avoid re-infection.
- Help him/her understand the importance of possible transmission that might have occurred and further transmission.
- Help him/ her on how and what to communicate with partner(s).

SESSION 11
Basics of PPTCT and Programme Guidelines

Session Overview:

- Reading the PPTs – 90 minutes
  - Cause and occurrence of HIV in children.
  - Factors that increase and decrease transmission of HIV from Mother to Child.
  - Four prongs for PPTCT.
  - Importance of lifelong ART for HIV positive pregnant mothers.
  - Choice of ART regimen for pregnant mothers / PPTCT scenarios.
  - Standard Operating Procedures (SOPs) during event of labour.
  - Care for the HIV exposed infant.
- Case studies – 25 minutes
- Discussion – 50 minutes

Session Objectives:

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

- Gain knowledge about the cause and occurrence of HIV in children.
- Enumerate the factors that increase and decrease the transmission of HIV from mother to child.
- Understand the four prongs of the PPTCT Program.
- Understand the importance of lifelong ART for HIV positive pregnant mothers.
- Gain knowledge on the SOPs during the event of labour and care for the HIV exposed infant.
- Practice methods of prevention of transmission of HIV from infected mother to her child.

Time allowed:

- 2 hour 45 minutes

Material required:

- Paper / pen
- PPT slides and projector

Method :

You as the facilitator:

- Read the PPTs and explain to the participants.
- Mail a copy of the handout on 'Basics of PPTCT and programme guidelines' to the participants one week prior to the training programme.
- Keep copies of handout ready in-case the participants need to refer to it again.
- Photocopy the case studies and the answer key (1 copy for each facilitator).

Activity 1:

- At the end of the session on ART regimen for pregnant women, the facilitator can give each group a case study to read aloud and select the correct answer.
- Explain the right answer to the participants and also clear their doubts if any.

Key messages:

- Mother-to-child transmission is the main cause of HIV infection in children. It can occur during pregnancy, delivery and breast feeding.
- Four prongs of PPTCT program are as follows:

  1. Primary prevention of HIV (HIV negative, general population (ARSH)).
  2. Prevent unintended pregnancies (HIV positive, not pregnant, family planning counselling in ICTC and more importantly at ART centres).
  3. Prevention of MTCT (HIV positive and pregnant).
  4. Care, support and treatment (HIV positive mother and child).

- All pregnant women at the ART centre need to be seen on priority.
- **India National Technical Resource Group (TRG) recommendation on PPTCT:**

  1. All HIV positive pregnant women including those presenting in labour and breast-feeding women should be initiated on a triple ART irrespective of CD4 count, for preventing mother-to-child transmission risk and should continue life-long ART.
  2. The duration of NVP to infant should be for 12 weeks, especially if ART to mother was started late in pregnancy, during labour or after delivery and the mother has not been on ART for adequate duration (which is at least 24 weeks) to be effective to achieve optimal viral suppression.
  3. This recommendation on extended NVP duration applies to infants who are breast - fed and not those who are receiving exclusive replacement feeds.

Annexure

CASE STUDIES

Case study 1:

- A HIV positive pregnant women comes to the ART centre at 12 weeks with CD4 count >700 mm3. Will you start ART?

  Answer: Yes.

Case study 2:

- Rizwana 24 years old, HIV positive, came directly-in-labour, she is reactive to HIV whole blood finger prick test done by a nurse.
- Do you give ART to the mother?

  Answer: Yes. (Make sure the medical officer in Labour room prescribes ART)

Case study 3:

- Uma 26 years old, HIV positive, no prior ART, breast feeding with CD4 count 1000 mm3. Will you start ART?

  Answer: Yes.

Case study 4:

- Mary, 25 years old, came to know that she is HIV positive at 36 weeks of pregnancy. She was initiated on ART immediately. She is breast-feeding post delivery. How long the new born child should continue on ARV prophylaxis (NVP)?

  A. Till 6 weeks

  B. Till 12 weeks

  Answer: B

Case study 5:

- Suman, 35 years old, came to know that she is HIV positive at 30 weeks of pregnancy. She was initiated on ART immediately. She has decided to do exclusive replacement feeding. How long the new born child should be given ARV prophylaxis?

  A. Till 6 weeks

  B. Till 12 weeks

  Answer: A

SESSION 12

Basics of HIV-TB co-infection and Programmatic Linkages

Session Overview:

- Power point presentation: 1 hour and 30 minutes
- Role Play: 30 minutes

Session Objectives:

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

- Provide correct information on modes of transmission and available diagnosis and treatment for TB.
- Explain the effect of TB disease on HIV status and effect of HIV on TB infection.
- Clarify the myths and misconceptions related to TB.
- Identify patients with symptoms suggestive of TB.
- Refer the TB suspects to RNTCP Unit for TB investigations and further management.
- Be able to keep a record of patients referred to RNTCP Unit.
- Motivate patients with symptoms suggestive of TB to undergo sputum examinations and any necessary examinations.
- Provide adherence counselling for TB treatment, and explain the importance of ART evaluation and treatment.
- Maintain the standard records and reports (as provided by the national programme) on TB-HIV collaborative activities.

Time allowed:

- 2 hour

Material required:

- Computer
- Projector
- Copies of the handout

Method:

Preparation before the session:

You as the facilitator:

-- Keep copies of handout ready.

Activity 1: (one and half hours)

– The facilitator will use power point presentation to explain various aspects of HIV-TB interaction and linkages.

-- To make the presentation interactive, the facilitator will ask questions during the presentation before discussing a particular slide.

-- The facilitator should remind participants to refer to relevant guidelines of NACO.

Activity 2: (half hour)

Role plays

Role Play key for the facilitator

1. Pavani needs to be counselled for HIV and TB. She should be assessed for risk of TB. Explain about TB and then probe for symptoms.

Some questions to discuss the role play:

- You told me that you are having diarrhoea for last 6 months. Apart from this have you been experiencing any other problems? Can you tell me what problems?
- Were you suffering from cough? For how long?
- Can you tell me whether you have any other symptoms which I am going to tell you: Fever, weight loss, night sweats, chest pain on breathing, blood in cough, breathlessness, loss of appetite, tiredness?
- Do you have anybody at your home diagnosed with TB or having cough persistent for more than two weeks?

2. Nidhi is in a shocked situation. She is thinking that she is going to die and is worried about her child. She is also feeling that her husband will hate her. She is not accepting that she may have TB. The counsellor has to counsel Nidhi on why it is important to get tested for TB. Counsellor also needs to tell the implications of HIV on her TB, and what she needs to do now with regards to her TB treatment, and any additional HIV-related care and support.

Sample questions for initiating discussion

"I understand that you are concerned about your child and relation with your husband. I also understand that you do feel that you may die soon. Let me tell you the fact. You can live healthy and look after your child. For that you have to take some steps like taking ARV drugs if required and getting your illnesses treated." Explain to her about ART, need of nutrition and so on.

"I heard from you that you are having cough for last one week. Hope you remember what I told you about TB. Let me once again brief you what TB is and how important this information is for you. Then you can tell me whether there is any chance of you having TB."

Key Messages:

- TB is caused by Mycobacterium tuberculosis and is spread through air.
- HIV infection makes persons:
  - much more susceptible to developing TB disease,
  - more likely to die of TB, and
  - more likely to develop TB again.
- All clients who have symptoms or signs of TB disease, irrespective of their HIV status, should be referred to the nearest facility providing RNTCP diagnostic and treatment services.
- Cough of more than two weeks duration could be TB and all such clients should be referred to RNTCP.
- Among HIV positive persons, cough of ANY duration could be TB, refer them to RNTCP.
- Tell the clients that the TB tests available under RNTCP are adequate to diagnose TB and are accurate. If they do undergo testing at the government facilities, they can also avoid unnecessary expenses.
- Patients with sputum-positive pulmonary TB are the most infectious to others, and priority is given to their care for this reason.
  - Ensure that information on cough hygiene is strongly reinforced.
  - Also inform the patient that if he/she is diagnosed with sputum positive TB, they should get their contacts (family and friends) tested for TB at the nearest health facility.
- Any child in the family aged less than 6 years should also be provided with chemoprophylaxis for TB from the nearest DOTS centre.
- TB is curable.
- TB is curable among HIV positive patients as well.
- Taking complete treatment is the key to success of treatment.
- DOTS is the recommended strategy for treatment in adults and children.
- DOTS ensures that patients complete the treatment.
- DOTS improves survival in HIV positive individuals.
- The key to reducing the risk of tuberculosis transmission at health facilities is early diagnosis and prompt initiation of RNTCP treatment regimens until cure.
- Infectious TB patients become rapidly non-infectious once they are started on directly observed treatment under RNTCP.

SESSION 13
Pre Test Counselling

Session Overview:

- Assessing personal risk (20 minutes)
- Risk assessment (30min)
- Risk game (20 minutes)
- Risk reduction (30min)
- Pre-test counselling (20 minutes)

Session Objectives:

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

- Conduct a pre HIV test information session.
- Manage discussing sensitive issues.
- Conduct a risk assessment interview.
- Assess risks within the HIV test window period.
- Assess and individual's coping strategies and psychosocial support system.
- Integrate risk assessment, HIV prevention education, and counselling into HIV pre test counselling.

Time allowed:

- 2 hour

Material required:

- Risk assessment cards
- PPT presentation
- Pre test form

Method:

Preparation before the session:

You as the facilitator will:

1. Keep handouts ready to be distributed to the participants.
2. Translate the risk cards given in Annexure 1 in the local language and keep them ready for the game on risk assessment.

Lecture using slide no. 3-6

- Give introduction to HIV testing.
- Explain process of HIV pre test counselling.
  (Notes are provided under each slide).

Activity 1: Slide 7

Assessing personal risk (20 min)

This activity helps counsellors reflect on how they handle risk in their own lives. It increases their understanding of why other people take risks and helps them to examine their feelings about this. Before deciding to take an HIV test, people need time to think about what it may mean to discover they are HIV-positive. Many people are anxious about discussing their personal risk of HIV infection (often for the first time) and are worried about being judged.

1. Invite participants to consider the following on their own for a few minutes:

'Think back on your own life and identify any occasion when you took a risk, related to sex and relationships, work or money. It may have been a small risk or a big one, but was very important to you at the time.'

- What factors influenced your decision to take a risk?
- What were your feelings at the time?
- What was the result of taking that risk?
- Do you generally take risks?
- How do you view risk-taking in others? How does risk-taking among your friends affect you?
- How does this affect your attitude towards the risk of HIV infection? It may be useful to write these questions down.

After a few minutes, ask everyone to choose a partner and share as much of their situation as they wish. Each person should talk for a few minutes and then listen to the partner's story.

2. Invite everyone to join the full circle. Encourage them to explore links between how people deal with risk and ways in which it may affect their responses to HIV. It may be useful to make the following points:

   - We often feel that it is all right to take risks if they turn out well. But we tend to blame others if things go wrong.
   - We are generally less harsh in judging ourselves than we are in judging others. Is this fair?
   - We all take risks all the time.

3. Then invite participants to link this discussion with their counselling work. How can they introduce the subject of risky sexual behaviour without being judgemental? How can this be linked to information about safe sex and reducing the risk of HIV infection?

   (Source: Working with uncertainty. Published by FPA, England)

Risk assessment (30 min)

Lecture using slide no. 8 -10

Activity 2: Slide 18

Risk game (20 min)

Prepare cards indicating the following risks. Randomly distribute the cards to the participants. Place three cards with high risk, medium risk and low risk indicated on them on the floor. Ask the participants to place their cards on the one indicating the appropriate level of risk. Have the group discuss the correct answers.

[The answers in italics are only to assist facilitators—DO NOT include these on the cards given to the participants.]

- o Blood splash to the eye during a delivery.
  Low risk only—only one case in the world, which was concentrated virus in a laboratory.
- o Cleaning up vomit.
  No–low risk for HB, HCV without gloves
- o Sharing spoons and forks.
  No risk
- o Using drugs before sex; using alcohol before sex
  Moderate–high risk, less likely to be safe sex
- o Withdrawal (before ejaculation)—an option for safe sex?