***Moderate risk, Poor option for safe sex as the couple may 'forget to withdraw; also virus present in the pre-ejaculate; risk for STIs, high risk in the presence of fresh ulcers or wounds in the genitals.***

- Oral sex–man entering a woman's mouth: Risk to woman?
  ***Low–moderate for woman***

- Vaginal sex—no condom, no ejaculation: Risk to woman?
  ***Moderate risk, Poor option for safe sex as the couple may 'forget to withdraw; also virus present in the pre-ejaculate; risk for STIs, high risk in the presence of fresh ulcers or wounds in the genitals.***

- Oral sex—with ejaculation (between men): Risk to the receptive man?
  ***Low–moderate risk***

- Sharing injecting equipment (e.g. swabs, water, mixing bowls)
  ***Low for HIV; high for HBV and HBC***

- Needle stick injury: 'suture' needle
  ***Low risk, solid bore needle, often a subcutaneous injury***

- Sharing syringe/needle
  ***High risk***

- Vaginal sex—no condom, withdrawal then ejaculation: Risk to man?
  ***Moderate risk, poor option for safer sex as the couple may 'forget to withdraw'; also virus present in the pre-ejaculate; risk for STIs and parasites, high risk in the presence of fresh ulcers or wounds in the genitals.***

- Penetrative anal intercourse—no condom, withdrawal then ejaculation
  ***Moderate to high risk, poor option for safe sex as the couple may 'forget to withdraw'; also, virus present in the pre-ejaculate; risk for STIs and parasites.***

- Vaginal sex—no condom, ejaculation: Risk to the woman?
  ***High risk***

- Receptive anal intercourse—no condom, no ejaculation
  ***High risk—poor option for safe sex as the couple may 'forget to withdraw' also, virus present in the pre-ejaculate; risk for STIs and parasites.***

- Needle stick injury: 'venepuncture' needle
  ***Moderate-level of risk dependent on factors such as depth of the puncture Emphasise the need to collect detailed information on exposure.***

- Sharing sex toys
  ***Low–moderate, more information required on the type of the sex toy and circumstances.***

- Oral sex—with ejaculation (between men): Risk to the penetrating partner?
  ***No risk for HIV, avoid if the receptive person has oral herpes.***

- Oral sex—male to male, no ejaculation: Risk to the receptive man?
  ***No risk for HIV; possible risk for STIs parasite.***

- Oral sex—man entering a woman's mouth: Risk to the man?
  ***No risk; possible risk for herpes lesions.***

- Deep kissing
  ***Low risk for HIV***

- Mosquito bite
  ***No risk***

- Crying—getting someone's tears on yourself
  ***No risk***

- Sharing a toothbrush
  ***No risk.***

- 'Rimming'—contact between the mouth and the anus: Risk to the person performing?
  ***No risk.***

- Mutual masturbation: Risk to either?
  ***No–low risk depending on the context and behaviour***

- Sex during menstruation—with a condom, without a condom.
  ***With condom low; without high***

- Tattooing
  ***High for ritual 'group' tattooing***

**Risk reduction (30 min)**

Lecture using slide no. 19-23

**Activity 3: Slide no. 24-26**

**Customised Risk Reduction Plan**

**The Right and Wrong Way**

Here are some risk behaviours. Explain which risk reduction dialogues are more suitable. You can choose more than one option. Explain also why you did not choose certain suggestions. Try to think of suggestions which have been missed.


***Discuss the risk reduction options for each profile. Cover the following points:***

a) "Stop having anal sex" or "Don't have sex," **are poor messages** because they prohibit behaviour but do not provide an alternate action.

b) "Have safer sex" **is a vague message** which assumes that patients understand safer sex.

c) Messages related to replacing a risky behaviour with a non-risky behaviour are better options.

d) Discuss other options not mentioned for lack of space such as use of KY jelly for anal sex.

**Pre-test counselling** (20 minutes)

Lecture using slide No. 27-34

# Annexure

**Risk game: (Statements for risk assessment) (To be translated in the local language and printed / written on separate cards for distribution among participants).**

Blood splash to the eye during a delivery

---

Cleaning up vomit

---

Sharing spoons and forks

---

Using drugs before sex; using alcohol before sex

---

Withdrawal (before ejaculation) - an option for safe sex

---

Oral sex – man entering a woman's mouth: Risk to woman?

---

Vaginal sex - no condom, no ejaculation: Risk to woman?

---

Oral sex – with ejaculation (between men): Risk to the receptive man?

---

Sharing injecting equipment (e.g. swabs, water, mixing bowls)

Needle stick injury: 'suture' needle

Sharing syringe / needle

Vaginal sex – no condom, withdrawal then ejaculation: Risk to man?

Penetrative anal intercourse – no condom, withdrawal then ejaculation

Vaginal sex – no condom, ejaculation: Risk to woman?

Receptive anal intercourse – no condom, no ejaculation

Needle stick injury: 'venepucture' needle

Sharing sex toys

Oral sex – with ejaculation (between men): Risk to the penetrating partner?

Oral sex – male to male, no ejaculation: Risk to the receptive man?

Oral sex – man entering a woman's mouth: Risk to the man?

Deep kissing

Mosquito bite

Crying – getting someone's tears on yourself

Sharing a toothbrush

'Rimming'—contact between the mouth and the anus: Risk to the person performing?

Mutual masturbation: Risk to either?

Sex during menstruation—with a condom, without a condom

Tattooing

# SESSION 13
# Post Test Counselling

## Session Overview:

- General principle of HIV post- test counselling (20 minutes)
- Guidelines for the provision of negative test results (20 minutes)
- Provision of positive test result (30 minutes)
- Other important issues and follow-up counselling (20 minutes)

## Session Objectives:

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

- Apply knowledge of basic counselling techniques for post-test counselling.
- Understand the basic requirements for the provision of HIV results.
- Conduct post-test counselling for HIV negative result.
- Conduct post-test counselling for HIV positive result.

## Time allowed:

- 1 hour 30 minutes

## Material required:

- PPT presentation
- Post test form

## Method :

**Activity 1**

Prepare chits – 'HIV Positive' and 'HIV Negative'. Make equal number of HIV positive and negative chits as per the number of participants. Distribute the chits randomly among the participants. Explain to them saying, "We have taken your blood sample for HIV testing and now you have the result in your hands. Please check your result." Maintain silence for 2 minutes. Observe the expressions and reaction

of the participants. Now ask the participants: How many are HIV negative and how they feel. The expected answer would be: they were confident that it would be negative, they are happy to receive negative result. Then ask how many are HIV positive and how do they feel. The expected answers would be: unbelievable; it can't be my report or depressed. Then explain the objective of the activity. One should know how one would feel when one receives a HIV test report. Counselling should be to empathise with the client and accordingly give result, understand the emotion of the client and provide psychosocial support. At the end of the activity, explain about HIV positive and HIV negative test results.

- HIV tests detect the antibodies that the body produces to fight HIV, once infection has occurred.
- A positive result means that HIV antibodies are present in the blood. In other words, a person is infected with HIV and can infect others.
- A negative result means that no HIV antibodies were found in the blood at the time it was drawn.
- It ordinarily takes three weeks to three months (the window period) for people infected with HIV to develop enough antibodies for HIV to be accurately detected. This may mean that a person needs to be tested again even if the first test results are negative.

- Describe the general principle of HIV post- test counselling using slide no. 6-10
- Describe frequent HIV–negative testers using slide no.11
- Describe post test counselling using slide no. 12-14
- Describe other important issues and follow-up counselling using slide no. 15-16

**Key messages: (slide 17)**

- Avoid giving false reassurance.
- Clarify misinformation about the meaning of the test result and its implications.
- Reinforce information on transmission, safe sex/drug use.
- Assess the support available to the client.
- Make appropriate referrals and accompany referred client wherever possible.
- Refer to a specialist for psychological /psychiatric / mental health related issues if needed.

# SESSION 14
# Behaviour Change Communication and Condom Demonstration

## Session Overview:

- Lecture using slides (20 minutes)
- Behaviour change stories (40 minutes)
- Condom demonstration and practice (45 minutes)
- Optional: Lecture using slides (15 minutes)

## Session Objectives:

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

- Describe the trans-theoretical model of behaviour change.
- List appropriate counselling techniques for each stage of behaviour change.
- To understand and apply the principles of 'Behaviour Change Communication'.
- Demonstrate how to use a condom.

## Time allowed:

- 2 hour

## Material required:

- Slides related to the session
- Behaviour Change Story 1 (already printed in the handouts)
- Behaviour Change Story 2 (already printed in the handouts)
- Condoms (Sufficient pieces so each participant has one)
- Penis model

## Method:

**Lecture using slides** (25 minutes)

- Explain the key points in the session using the BCC slides and the dialogue given for your convenience.
- Ask the participants to open their handouts to Behaviour Change Story 1. Read this story paragraph by paragraph and help the participants to relate the story to the behaviour change stages: *Pre-contemplation, Contemplation, Preparation, Action, and Maintenance*. A key is provided for your convenience.
- Variation: Alternatively, you could begin the session by reading the first part of the story and then showing the slides.

**Activity 1: Behaviour Change Story 2** (35 minutes)

- Divide the participants into 8 groups. Ask the groups to read the handout titled Behaviour Change Story 2 and answer the questions after the story. Give them 20 minutes for the task.
- Discuss the story in the larger group. An answer key is given for your convenience.

**Condom demonstration and practice** (45 minutes)

- You, as the facilitator, will invite a participant to demonstrate condom usage on penis model.
- When they have demonstrated, ask another participant to suggest how to improve the condom demonstration. Encourage all the participants to actually do the demonstration.

**Optional lecture using slides** (15 minutes)

- You, as the facilitator, will cover the key points of the session using the slides and the notes given in the note view for your convenience.

**Key messages:**

- Behaviour change is not easy either for oneself or for the client.
- Only knowing the need for behaviour change does not actually lead to change in behaviour.
- Repeated efforts of the counsellor through identification of the different stages of change and communicating the various techniques at those stages can cause behaviour change to happen in a client.
- Keep a penis model in the clinic and ask the client to demonstrate how to use a condom correctly. Most people are ignorant about correct use of a condom.
- No matter how well done, explaining and demonstrating are not sufficient to ensure correct condom use. It is necessary that the person practices doing what you have done. This process is called return or re-demonstration.
- Stress the use of a condom for family planning and prevention of STI.

# Annexure

## Behaviour Change Story 1

**This is an exercise to apply the Transtheoretical Model. Read the story and identify statements which show the different stages of change the person is at:**

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

*'I have been gaining weight for some 10 years now ever since the age of 28. Then I was slim. But the weight gain began very slowly. At first my family would tell me that I was putting on weight. But I would ignore their comments. Once I actually threw and broke a china cup when my father went on and on about how he could not distinguish between my mother and me in the dark as we were the same size. When professional colleagues mentioned my weight, I would joke, "I usually skip meals when I am depressed. Therefore, the fact that I am getting fat means that I am happy," or simply "Now there is more of me for you to appreciate." I would dismiss their comments by saying that I was eating healthy.'*

*'But a lot of this changed three years ago. My father passed away from a heart condition. He had been a little on the stout side. I began to realise just how out-of-shape I was. As he also had diabetes, I began to worry about family history issues. I even took a blood sugar test and breathed with relief when I was found to be in the normal range. I noticed how breathless I would become after climbing a few stairs. I noticed that a favourite sari could not be worn till I made a new blouse as I had already altered the seams once. Whereas before I did not mind people clicking my photographs, I suddenly became conscious that certain angles made me look fat. I began to dislike having my photograph taken.'*

*'Still I did not do much. But then I met with a colleague who had experienced good outcomes with a brand new diet. I was impressed. I thought wistfully about how nice it would be if I could also do so. I began to read about the diet. I liked the book so much that I went out and bought it. I even began experimenting with the recipes.'*

*'When I felt ready to make the change, I went out and brought some of the foods necessary for my new diet. I opened my diary and measured my weight. I was 78 kilos at that time. I started my new diet from the first of January. I would weigh myself every Monday morning and note it on the calendar. I felt really happy when I had dropped 10 kilos at three weeks of dieting. At this point my clothes began to hang on my body. So I went out and bought a new suit. I felt lighter and more energetic. I began to walk about more. This was something I had lost the habit for as I used to get breathless. The more I walked of course, the more I lost weight.'*

*'Now it is August. I am 18 kilos lighter. I have had to buy new clothes. But I feel good.'*

# Answer Key

1. **Identify the different stages-**

   a. Stage of pre-contemplation: *But I would ignore their comments... I would dismiss their comments by saying that I was eating healthy.'*

   Here the person displays a complete lack of readiness to change her behaviour or lifestyle. Well-meaning comments from friends are ignored.

   b. Stage of preparation: *I began to read about the diet. I liked the book so much that I went out and bought it. I even began experimenting with the recipes.*

   Here the individual begins making tentative steps towards changing the behaviour but has not yet made a full commitment.

   c. Stage of maintenance: *Now it is August. I am 18 kilos lighter.*

   Here the individual has lost weight and has managed to maintain it for more than 6 months.

2. **Some ways to help the person move from precontemplation to contemplation of behaviour change-**

   a. **Consciousness raising:** Presenting facts and figures linking over-weight with heart disease and other health problems.

   b. **Dramatic relief:** Presenting stories about how good people feel after they have managed to lose weight, how their personal well-being improves; Role-playing during counselling about how other people might respond to the "new and reduced You."

   c. **Self re-evaluation:** Encouraging the client to think of how being fat negatively impacts her life (e.g., she has to endure nicknames, she is no longer comfortable to have her photo taken, she has difficulty finding clothes that fit, she does not have energy to play with her children, she tires easily, she is at greater risk of heart disease, her boss has overlooked her for a promotion as he/she prefers a smart looking employee.)

   d. **Environmental re-evaluation:** Encouraging the client to think about how her fat stature negatively impacts other people in her life (e.g., her children miss playing with her, her family is embarrassed.)

3. **An example of counter conditioning for this individual-**

   One example of counter-conditioning for this individual is to substitute unhealthy eating with healthy eating, that is green salads in place of high-cholesterol foods which are deep fried. As the person may enjoy deep fried items, the replacement foods should provide comparable enjoyment to her. Another example is to bake or steam food items instead of frying them.

**4. An example of contingency management for this individual-**

The individual mentions: *I would weigh myself every Monday morning and note it on the calendar. I felt really happy when I had dropped 10 kilos at three weeks of dieting. At this point my clothes began to hang on my body. So I went out and bought a new suit.*

Here the individual is using the technique of contingency management on herself. She rewards herself when she has reached a level of behaviour change that is meaningful to her. She also uses a calendar to track her progress.

## Behaviour Change Story 2

### Practice Time

*I began smoking when I was 14 years old. I used to steal cigarettes from my father's pocket. Later I began to also "borrow" money from my mother's purse to buy cigarettes. In college I found out that for the same money I could buy a small 'pudi' of stuff that was better. I enjoyed myself.*

*My best friend warned me that I was going down the wrong track. I laughed at him. I told him that I was not like those "druggies," "smackiyas" or "charasis". I could stop at any time. Yes! I could stop. I had tried to stay away from the stuff during exams. The longest I could do was 7 days. But soon I was back to taking the "stuff" again.*

*When I began working at the age of 21, I had already begun taking a cocktail of pharmaceutical stuff. You crush it together, dissolve it and inject it. This was clean stuff, not like those "charasis." I worked in sales. It was difficult to keep my focus. But I managed. More than half my salary would disappear.*

*My mother started to notice my behaviour patterns. She would grumble that I was not the good child she had known before. Then one day she found me injecting myself in the bathroom. The whole family started harassing me. By now I knew I was hooked. The family tried many things. They took me to a "baba" who prayed over me. They began accompanying me to work but I would find a way to escape. They locked me in the house one day. But my withdrawal pain was very great. I started screaming and cursing. This frightened them and they let me out.*

*A friend came over to talk to me. She tried to make me see the light. But all I could think of was how to avoid the withdrawal pain. I looked forward to my "nasha," my "intoxication."*

*My family left me alone. But they would leave pamphlets about drug NGOs around the house. I would throw them in the waste-paper basket.*

*Then one day my mother came to me and in tears asked me if I could give her a birthday gift. She said I could afford this one. I loved my mother. So I said, "Yes." She took me to a support group meeting. I did*

*not like the idea of being in Narcotics Anonymous. But I had promised my mother. So I decided to wait for 20 minutes. There were two speakers who had to speak. I kept looking at my watch.*

*Five minutes before I was ready to walk out, an older man got up to speak. He had a soothing voice. I began to listen to his testimony. His words were very familiar to me. He could have been saying my life story. He described his own trouble with drugs. I realised how much I had sunk down. My mother looked over at me and held my hand. I had no thought now to leave.*

*After the meeting she requested that man to speak to me. I was now starting to get twitchy. I needed my fix. But I spoke to that man a little. He took my telephone number. He would call me every week and speak to me gently about turning my life around. His message slowly sunk in.*

*One day, I decided that I would go to a drug agency to get straight. I told my friend from Narcotics Anonymous. He told me that he would go along with me as a support. I agreed. I knew that if I was alone, I would be tempted to give up.*

*My first week at the drug centre was like sitting in a fire. There are no words to describe it for you. But later it got better. I learned to control my need for the drugs through yoga prayer and hard work. I was allowed to smoke cigarettes because I still got twitchy. When I went out, I was encouraged to go with another addict friend so we could support each other to remain sober. I still have the certificate that the centre gave me for remaining sober for 50 days. Even Sachin's half-century could not be better!*

*It has been 8 months since I have taken drugs. I am with my family now. We spend a lot of time together because I still worry about meeting my old friends who would lead me back to my bad habits. I still think about the drugs. So I began learning how to paint as a distraction. This works sometimes.*

*I look forward to the future. The centre has warned me about sliding back, about relapse. I go to Narcotics Anonymous meetings. Being around other ex-addicts helps.*

- **Read the story and identify sentences in the story which show the person passing through the different stages of behaviour change according to the Transtheoretical Model: Precontemplation, Contemplation, Preparation, Action, and Maintenance.**

- **Identify the different types of techniques used in this story.**

# Answer Key

**Comments on Behaviour Change Story 2**

For facilitator's guidance only: not intended for verbatim use.

- **Identify the different stages.**
- **Identify the different techniques used.**

**a. Stage of pre-contemplation:**

Paragraphs 1, 2 and 3 are stage of pre-contemplation because the person does not see any need to change.

**b. Stage of contemplation:**

This individual went through a long phase of contemplation. We recognise this from the fact that though many people told him about the need to change, all he could see were the disadvantages of withdrawal pain.

The technique mentioned here is 'Dramatic Relief' (when the speaker at the Narcotics Anonymous meeting tells his life-story).

**c. Stage of preparation:**

Paragraph 10 is the stage of preparation: "One day I decided…" In the case of this individual, it is a very brief moment. He decides to go in for de-addiction. He informs his friend. He agrees to the concrete plan of going to the centre with his friend. (Contrast this with the earlier description of throwing the pamphlets into the waste-paper basket in Paragraph 6.)

**d. Stage of action:**

Paragraph 11 describes the person in the stage of action. – He has taken actions to be drug-free but has not yet maintained it for 6 months.

The techniques mentioned here are 'Stimulus Control' (being in the company of new friends. yoga, prayer) and 'Counter-Conditioning' (smoking cigarettes instead of using harder drugs).

**e. Stage of maintenance:**

Paragraph 12 describes the person in the stage of maintenance – He has been drug-free for more than 6 months. (Contrast this with the earlier description in Paragraph 2 where he could not stay without drugs for more than 7 days).

The technique mentioned here is 'Stimulus Control' (being in the company of friends, painting, going to Narcotics Anonymous meetings) to avoid relapse prevention.

# SESSION 15

## Managing Mental Health Issues in the Context of HIV

### Session Overview:

- PPT presentation – 1 hour 15 minutes
- Role plays – 1 hour 45 minutes

### Session Objectives:

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

- Learn the meaning of mental health and mental illness.
- Understand the relevance of mental disorders in the context of HIV.
- Enhance counselling competence for a few common mental health issues in the context of HIV.
- Learn to plan a referral to a mental health professional.

### Time allowed:

- 3 hour

### Material required:

- PPT slides and Projector
- White board markers
- Translated handouts
- 2 copies of cases for role plays

**Tips to the facilitator:** 

- Participants' reading the handouts in advance is crucial to completing the session in time.
- Do translate the handouts in the local language to increase the chances of participants reading the handouts in advance, and understanding them enough to utilise the learning in the role plays and in the actual counselling setting.

## Method:

**Preparation before the session:**

You as the facilitator:

- Translate the handouts in the local language.
- Go through all the handouts in advance
- Divide the participants into three groups in advance, to read the translated handouts **before the session,** with the instructions that "you need to read and understand the handouts thoroughly, such that each of you comes prepared in the session to demonstrate your learning through a role play in the session". Thus, each individual participant (and not just one or two members of the group) needs to be able to do the role play. The division of groups is as follows:
  - **Group 1**: Dealing with suicidal clients and
    - Grief Counselling
  - **Group 2**: Crisis intervention and
    - Anger Management
  - **Group 3**: Dealing with anxiety, and
    - Helping a client with sleep difficulty
- In addition, if possible, the handout "Making a referral to a mental health professional" may also be given to all the participants to read in advance.
- Make 2 copies of each case for role plays – one for the 'client' and one for the facilitator (not to be handed over to the person playing the role of the counsellor).

**I. Sessions 1-3 (1 hour 15 minutes)**

- Present the PPT slides in an interactive manner.
- Make the session participatory; keep the participants involved by explaining and asking them questions, but stick to the time.

**Tips to the facilitator:** 

- The handouts are one the information covered in session 3. The handouts are to be read by the participants in advance, and the presentation is meant to briefly revise what has been learnt through self-study of the handouts, and to clarify any doubts.
- Activity 1 (role plays) needs to be given adequate time, because it is likely to help give practical tips and enhance skills while most of the other things covered in the session can be learnt through reading.

**II. Activity 1 (Role Plays – 1 hour 45 minutes)**

- Invite a participant to act as a client.
- Invite a participant from group 1 and ask them to counsel the client using what they have learnt from the handouts studied by them.
- **The facilitator needs to try and make as many participants as possible, act as the counsellor during the role plays.**
- Alternatively, all the participants from that group can join as 'counsellors' to support each other while counselling on the issue prepared by them.
- Keep one copy of the case (given in the annexure) with you, and give one copy to the person acting as the client.
- You can read out the case aloud once the client and counsellor have already volunteered for the role play.
- Give about 10 minutes for each role play.
- The focus needs to be on mental health counselling and not on the 'client's' acting.
- In the role play, the facilitator needs to be supportive to the person acting as the counsellor and help if they get stuck.
- When a 'counsellor' is stuck, other members from the group may be invited to quickly take over as the counsellor with the same case.
- **Guidelines for role plays (given in the instructions to the training institutes) may be used.**

**Tips to the facilitator:** 

- The facilitator needs to invite different participants to act as counsellors and clients for each role play.
- Encourage the participants to come forward to play the counsellor's role saying that the facilitator will be there to support them.
- This is an opportunity for counsellors to learn that counselling is different from common sense.
- Ideally everyone should be able to counsel with every case if they have read the handouts in advance.
- After the 'counsellor' has completed counselling, the facilitator needs to add, if needed, to demonstrate how the issue can be handled.

**Remember:** 


There is a lot of stigma around mental illness. The facilitator needs to make sure throughout the session to not make fun of mental illness or the mentally ill, and to gently dissuade the participants also from doing so.

**Key messages:**

- There is no 'health' without mental health.
- HIV can lead to a) increased mental stress and b) mental health problems due to ART side effects.
- Mental health problems can indirectly lead to increased chances of HIV infection. Thus, **poor mental health can negatively impact fulfilment of NACP goals.**
- The prevalence of HIV is higher among people with severe mental illness as compared to the general population.
- The counsellor needs to know some general warning signs that require a referral to a mental health professional, and make an appropriate and timely referral.
- Common psychiatric disorders among PHLIV are: mood disorders, anxiety disorders, substance use disorders, delirium, cognitive disturbances, sleep disorders, psychosis, and personality changes.
- A counsellor needs to be sensitive to mental illness and the mentally ill. We must NOT stigmatise people with mental disorders, and thus avoid using terms like 'mad', 'mental', 'paagal', 'lunatic' and 'derailed', for example.
- **Suicide risk is higher** among HIV-positive patients than in general population.
- **A counsellor must ask a client about suicide** if they feel that the person might be suicidal.
- Using common sense can sometimes do more harm than good while dealing with a suicidal client, thus it is important to learn the do's and don'ts about different issues like suicidality; sleep difficulties; dealing with anger, anxiety and grief, for instance. This is important so that we do not do any harm to the client.

# Annexure

## Cases for role plays

**The cases need to be handed over to the person acting as a client and NOT to the person acting as a counsellor.**

The 'client' will summarise to the counsellor and the audience at the same time the brief information given here.

**Case 1 for role play:**

"I am a 23-year-old married woman. I have recently come to the city from a village, where I studied up to 12th class. My husband works as an assistant to an electrician. I got to know that he has TB and HIV, and today I got to know that I also have HIV."

"I feel as if everything is over, as if there is no point living. I will die, my husband will die. No one in the village will accept me. My father also died recently. I want to end my life (begins to cry)."

**Case 2 for role play:**

"I am 34 years old. I have 2 young children, and I run a small business. I got to know of my HIV 2 years back, and I have been on ART.

"I feel very worried about what will happen to my wife and kids if I die. I know that I will not die, but I keep thinking constantly about all the negative things, even though I try very hard not to. I get startled very easily, I just cannot be positive no matter how hard I try. I know I need to eat, but I do not feel like eating. I cannot concentrate on anything, and that is why my work is also affected. I love my family and I do not want to trouble them with my worries. I have also been finding it very difficult to sleep. I take a long time to fall asleep."

**Case 3 for role play:**

"I am 36 years old. I have 2 children, and my husband works in an office. I got to know of my HIV 4 years back, and I have been on ART.

"I sometimes feel so angry that I just cannot control myself. Because of this I sometimes hit my children and then I feel very bad and cry because I love my children a lot."

**Key (Not to be shared with participants before the role plays are over):**

**Case 1** is related to counselling for grief / suicidality.

**Case 2** is related to counselling for anxiety / sleep.

**Case 3** is related to counselling for anger management.

# SESSION 16
# Counselling Children and Adolescents

## Session Overview:

- **Sub session 1: Counselling children in an HIV setting**

  Lecture using slides: (40 minutes)

  Activity 1: Fast forward (5 minutes)

- **Sub session 2: Counselling adolescents in an HIV setting**

  Activity 2: Case discussion from PPT presentation: (10 minutes)

  Lecture using slides (35 minutes)

  Activity 3: Case discussion of child and adolescent cases (50 minutes)

- **Summing up (10 minutes)**

## Session Objectives:

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

- Understand the need to learn advanced counselling skills for counselling children and adolescents.
- Demonstrate strategies required for working with children and adolescents during counselling in the field / clinic.

**The focus of this session is counselling in an HIV counselling setting with -**

- Children
- Adolescents

## Sub session 1: Counselling children in an HIV setting

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

- Identify children with developmental delays and take appropriate actions.
- Match counselling according to the developmental stages in children.
- Explain parental issues in relation to counselling children at the HIV counselling setups.
- Demonstrate interactive strategies for working with children.

## Sub session 2: Counselling adolescents in an HIV setting

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

- List the characteristics of adolescence.
- Analyse the ethical issues related to HIV testing of adolescents.
- Demonstrate skills in counselling adolescents.

### Time allowed:

- 2 hours 30 minutes

### Material required:

- Lecture slides related to the session
- Copies of instructions for the practice session on working with children
- Copies of instructions for the practice session on working with adolescents
- Blackboard or flip chart

### Method:

**Preparation before the session:**

You as the facilitator:

- Translate the handout and annexure in the local language and distribute the same at least one day prior to the session.
- Read the facilitator's guide, PPT slides and the handout before the session.

## Sub session 1: Counselling children in an HIV setting

**Lecture using slides (5 minutes)**

Explain the objectives of the session and sub session 1. Explain the slides on Children and HIV and development milestones and HIV.

**Activity 1: Fast forward (5 minutes)**

Ask the participants to fill in the activity sheet on developmental milestones based on the information received from the previous slide.

**Lecture using slides (10 minutes)**

Explain how to match child counselling to the development stage. Also explain briefly the various emotions a child goes through and how a counsellor can help express and manage that emotion.

**Brainstorm and lecture using slides (15 minutes)**

Brainstorm on what is child centred counselling and what a counsellor can do to make his /her centre child friendly.

Explain how a counsellor can walk the child and parent through the testing process and how he /she can break the news of a positive diagnosis.

**Brainstorm and lecture using slides (10 minutes)**

Explain how communicating with children is different from communicating with adults. Brainstorm on what strategies could be adopted for communicating with children.

## Sub session 2: Counselling adolescents in an HIV setting

**Activity 2: Case discussion: (10 minutes)**

Display the slide with the case study on the projector. Ask the participants the following questions:

a. Explain ALL the ways this boy could have got infected.

b. List 6 risk assessment questions the counsellor should ask the boy.

Discuss the different responses and check for any misconceptions about route of infection.

**Lecture using slides (30 minutes)**

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

**Activity 3: Case discussion of child and adolescent cases (50 minutes)**

**Tips for facilitators:**

- Discuss the 3 cases with the participants in an interactive manner to learn the practical application of the issues covered so far.
- Invite participants to give their suggestions before adding further points for each case.
- If time permits participants can be divided into 3 groups to discuss one case of each of the additional cases given in **Annexure 2**.

**Summing up (10 minutes)**

Read out the key messages and answer any relevant questions from the participants.

## Key messages

### Counselling Children

- Monitor the growth of the child by checking the child for any signs of developmental delay or asking caregivers.
- Address concerns of the caregiver regarding the child's delay in showing the expected motor skills or behaviours and direct them to required services such as special schools.
- Enable the child to express emotions in a safe environment.
- Create a child friendly corner by mobilising toys etc. from schools, NGOs.
- Use drawing, story -telling, puppetry while communicating with children tailored to the age, maturity, level of comprehension and extent of the child's relation with him/her.
- Use sandwich technique to communicate a positive diagnosis.

### Counselling Adolescents

- Normalise feelings of shyness, anxiety and embarrassment. Explain that it is common or normal to feel this way.
- Acknowledge adolescent sexual activity – heterosexual as well as homosexual.
- Maintain a balance between the rights of the adolescent and those of the parent.

# Annexure

## Annexure 1: (Fast forward) (5minutes)

**(Activity 1)**

**Key to the developmental milestones worksheet (Not to be photocopied)**

| Situation | Is this child facing a developmental delay? | When would a "normal child" complete this? |
|---|---|---|
| Ishani is 5 months old. When her grandmother holds her, her head falls to the side. | Yes | 10 weeks |
| Afsaana is 2 years old. She can walk without holding the wall. | No | 12 months |
| Dhanesh is 18 months old. He has just learned to sit up. | Yes | 9 months |
| Balbir Kaur was born 6 weeks ago. She delights her family with her new development – smiling. | No | 6 weeks |
| Bhavna is 3 months old. She has begun sliding around and will learn to turn over in a few days. | No | 14 weeks |
| Kamlesh is 6 months old. He is very pleased at his new trick – moving his rattle from one hand to the next. | No | 6 months |

## Annexure 2: Case discussion of child and adolescent cases (50 minutes)

**(Activity 2)**

**CASE 1 Managing emotions of children/adolescents:**

Shiny is 11 years old. Her parents passed away some time ago due to HIV. She lives with her aunt who brings her to the counselling centre and reports that she has not been eating well recently. She is very restless and has been pulled up in school. She has also become clingy. When the counsellor asks Shiny's aunt, she also reports that Shiny does not get sound sleep nowadays.

**CASE 2 Techniques for child counselling:**

Jaimala is a 7-year-old child on ART. She has been tested at your ICTC and is fond of you. She realises that she is the only one in her school taking medicines. She does not want to be different from her friends. So she is refusing to take medicines.

**CASE 3 Risk assessment:**

Emaan is a 14-year-old girl who is brought by her parents to the hospital for a Medical Termination of Pregnancy (MTP). She was referred from the Gynaecology department to the ICTC. Her parents are very scared that their family secret will be found out and bring them shame. But Emaan knows that she is pregnant through her uncle who is abusing her.

**Additional cases for managing emotions of children/adolescents:**

1. Bipin is feeling very low. He is 13 years old. He has been taking ART since the age of 3. He is fed up of having to take medicines all the time. His mother reports that he has become very irritable and snaps over small things. As compared to earlier, he neither goes to play with his friends nor completes his homework.

2. Sharda is 8 years old. She lost her mother recently to HIV-related illness. Her grandfather who is her caregiver brings her to the counsellor because he is upset over her temper tantrums.

**Additional cases for 'Techniques for child counselling':**

1. Rosy is a 4-year-old child. She is brought to the ICTC for HIV testing. She was missed on the EID protocol because her HIV-positive parents left the district to avoid stigma. Now her health is failing. To check if she is eligible for ART, she must take the HIV test. She does not like hospitals and is crying bitterly when her parents bring her to you. You know that she will be even more scared when it comes to drawing the blood.

2. Jehana is a 4-year-old child. She was brought to the centre for HIV testing because her health is failing. She was missed on the EID protocol because her HIV positive parents left the district to avoid stigma. She tested positive. Her parents took her to the ART centre where she started ART. She came to your hospital today because her father wanted to get checked for his own condition. He brings her to the ICTC just to chat. You learn from him that Jehana does not like taking the medicine and is making a fuss to take it. She has not been very regular in having medicines. You realise how dangerous this is for her health. Her father explains that she tells him to take medicines as he is unwell, but refuses to take the medicines herself because she is currently doing better.

**Additional cases for risk assessment:**

1. Sam is 18 years old. He has been having sex with his college friends. He attended a talk on HIV and got scared. As he does not have much pocket money, he found out the test is done free of cost at the ICTC. So he goes there.

2. Kapil has come from the STI clinic to the ICTC for testing. He is 16 years old. So he is accompanied by his mother. He developed an abscess on his arm which appears to be festering around a needle puncture site. He injects drugs but does not want his family to know. So he resolves not to tell the counsellor anything.

# SESSION 17
# Counselling Sero-discordant Couples

## Session Overview:

- **Counselling sero-discordant couples in an HIV setup**

  Activity 1: Parking lot (20 minutes)

  Lecture using slides (60 minutes)

  Activity 2: Whose line is it anyway? (30 minutes)

- **Summing up (10 minutes)**

## Session Objectives:

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

- Understand the need to learn advanced counselling skills for counselling sero-discordant couples.
- Demonstrate strategies required for working with couples during counselling in the field / clinic.
- Assess and reduce the risk of sero-conversion among discordant couples.
- Carry out fertility planning among sero-discordant couples.
- Use couple counselling techniques with sero-discordant couples.

## Time allowed:

- 2 hour

## Material required:

- Lecture slides related to the session
- Copies of instructions for the practice session on working with Sero-discordant Couples
- Sero-discordant Parking Lot statements
- Whose Line is it Anyway: Complaints
- Whose Line is it Anyway: Appropriate Counselling Lines
- Blackboard or flip chart

## Method:

**The training team must schedule the session on Body Basics and Family Planning BEFORE this session.**

**Preparation before the session:**

You as the facilitator:

- Translate the handout and annexure in the local language and distribute the same at least one day prior to the session.
- Read the facilitator's guide, PPT slides and the handout before the session.

**Activity 1: Sero-discordant Parking Lot (20 minutes)**

*NOTE: This exercise is inspired by the famous Parking Lot Exercise related to Stigma and Discrimination.*

- Ask the participants to stand in an open area free of furniture in the room or in the open.
- The participants have to hold two balloons (one red and one green) in each hand.
- Explain that you will read out an action or behaviour in a discordant couple. For each behaviour you read out, they should SILENTLY raise the hand with the **green balloon** if they think this is safe in terms of risk of transmission from a positive person to their negative partner. If they think the action will increase the possibility of transmission they should raise the hand with the **red balloon**. This is in line with green symbolising safe and red symbolising danger.
- Read out each behaviour statement and allow the participants to raise the hand with the red or green balloon. A participant can also keep both hands down for any statement if he /she find it difficult to make a choice. The participants have to explain the reason behind their raising the hand with the red or the green balloon.
- Ensure that you cover each behaviour statement. Some statements generate more debate, so try to avoid too much time on any one statement, and reassure that it will either get clarified in the session or during a break.

**Lecture:** Explain the key points in the session using the slides and the dialogue given for your convenience. Refer to the handout wherever necessary. **(45 minutes)**

**Activity 2: Practice exercise in counselling discordant couples: (Discussion of Home Assignment) (45 minutes)**

This exercise has to be done one day prior to the session by the participants as a home assignment. The answers shall be discussed in groups on the day of the session as a practice exercise.

The following exercise aims to help a counsellor put oneself in a client's shoes, so to speak, to help improve empathy. Further the exercise also gives an opportunity to the reader to think what a counsellor needs to say or do in a certain situation.

As you read the following exercise, imagine yourself being a client who is visiting a counsellor. You are one of the partners in a sero-discordant couple relationship or marriage. Imagine yourself saying the following line ('you say') to the counsellor. What might you be thinking? What might you be feeling? What does a counsellor need to say or do to be most helpful to you? Some of the answers are given as examples to the first situation.

You may fill the answers in the practice sheet (Annexure 2).

Refer to Annexure 3 and Annexure 4 for filling the form.

**Tips to the facilitator:**

- Read the first statement ('you say') in the practice sheet and read out the corresponding statements ('you think', 'you feel' and 'the counsellor needs to say / do').
- Read the second statement and ask the participants to respond with what they have filled as part of their home assignment.
- The facilitator may keep adding to the points given by the participants.

**Summing up (10 minutes)**

Read out the key messages and answer any relevant questions from the participants.

**Key messages**

- The counsellor has a duty to protect other persons from HIV infection. For instance if a client does not disclose the sero-status to the spouse, or has sex without informing the sexual partner, the counsellor has a duty to inform. The PLHIV should be informed about this additional duty of the counsellor in a gentle manner and disclosure to the partner needs to be done only in collaboration with the client as far as possible.
- Safer sex between discordant partners is a programme goal. The techniques of couple counselling offer you a way to reach this goal.
- There is some evidence that a good couple intervention may reduce the risk of HIV transmission within a sero-discordant couple from 22% to 6%.

# Annexure

## Annexure 1: Key to sero-discordant 'Parking Lot' statements (Not to be photocopied)

**(Activity 1)**

- **Positive Partner takes ART regularly** (green balloon). But in some cases the partners may become careless about practicing safe sex.
- **Positive Partner treats STI** (green balloon).
- **Negative Partner does not treat STI** (red balloon).
- **Positive Partner is in the window period and has sex with Negative Partner** (red balloon).
- **Positive Partner is in the advanced HIV disease phase and has sex with Negative Partner** (red balloon).
- **Positive Partner has sex using a condom** (green balloon).
- **Partners decide to abstain from sex** (green balloon).
- **Male partner is circumcised** (green balloon). This is not a suggestion that every male should get circumcised. This is a sensitive issue because of religious associations. But all counsellors should be aware of the facts.
- **Discordant couple has sex frequently with a condom** (This is tricky). The more frequent sex, the greater the likelihood of transmission. Using a condom consistently will reduce the risks.
- **Negative partner is a female and the couple has sex frequently** (red balloon).
- **Negative partner is a female aged 15 years and the couple has sex frequently** (red balloon).
- **Positive partner shares their ART medicine with the negative partner** (red balloon). The positive partner needs to take all the medicine for the viral load to remain low.

## Annexure 2: Practice sheet for Activity 2 (Home assignment)

**Please read the following carefully and fill all the columns from item 2 onwards in your own words. Item 1 is already filled as an example.**

| | **Imagine that you are:** | **You say:** | **You think:** | **You feel:** *Please refer to the list of feeling words* | **The counsellor needs to say / do:** *Please refer to couple counselling techniques for an idea* |
|---|---|---|---|---|---|
| 1 | Negative husband of a Positive woman | *"When do you think my partner got infected with HIV?"* | *Maybe she was infected when I got married. She was cheating on me. She must be having a boyfriend I do not know about…* | Confused, upset, sad, worried, betrayed, angry… | • Listen calmly and attentively.<br>• Normalise the feelings. E.g., *"It is common for people to be curious about where their partner got infected. I might have also wondered about this if I were in your situation."*<br>• Deflect the question that is targeted at the source of infection. Then focus on the present and the future. E.g., *"But this question will shift the focus away from dealing with handling the infection. Isn't it better to think about the future right now? Let us try to stabilise your partner's health first."* |
| 2 | Negative wife of a Positive man | *"I don't want to use a condom because I want to get pregnant."* | If you were to be the negative wife of a positive man who said *"I don't want to use a condom because I want to get pregnant,"* my thoughts would be: | My feelings would be: | A good counsellor needs to say / do this in this situation: |
| 3 | Positive husband of a Negative woman | "I don't want to use a condom because I do not feel as much "sex" as I would be able to without wearing it." | | | |

| | Imagine that you are: | You say: | You think: | You feel:<br>*Please refer to the list of feeling words* | The counsellor needs to say / do:<br>*Please refer to couple counselling techniques for an idea* |
|---|---|---|---|---|---|
| 4 | Negative partner of a Positive person | "How could my husband/ wife do this to me? I feel like killing him/ her." | | | |
| 5 | Negative boyfriend of a Positive man | "Please tell me how AIDS came into our life, into our relationship." | | | |
| 6 | Negative partner of a Positive person | "I am so upset and angry and sad and worried. I am upset at my partner for bringing this into my life. I am sad because our child will miss one parent. I am worried that I might also have it." | | | |
| 7 | Negative wife of a Positive man | "I am so angry at him/ her because he/ she had sex with someone else." | | | |
| 8 | Negative partner of a Positive person | "I am so angry at him/ her because he/ she has brought this thing into the family." | | | |

| | Imagine that you are: | You say: | You think: | You feel:<br>*Please refer to the list of feeling words* | The counsellor needs to say / do:<br>*Please refer to couple counselling techniques for an idea* |
|---|---|---|---|---|---|
| 9 | One of the partners in a discordant couple | "We know that one of us is infected. But we want to have a child." | | | |
| 10 | Negative wife of a positive man | "I knew when I got married that my life with this person would be useless. Look at how I am trapped now." | | | |
| 11 | Positive husband of a Negative woman | "I have HIV but my wife does not. What should I do next? She is pregnant. I understand that she should get tested for the sake of the baby. But what if she finds out that I am infected! I am scared about knowing her result. I am also guilty about my own behaviour. Tell me what to do please." | | | |
| 12 | One of the partners in a discordant couple | "I am so confused. I do not know how to react." | | | |

How did you feel doing this exercise?

## Annexure 3: List of feeling words for Activity 2 (Home assignment)

A very short list of feeling words can be:

- Angry
- Happy
- Sad
- Scared

But not ALL our feelings may be described using this tiny list. Sometimes it helps us to know more words that can describe our or others' feelings. Here is a list that you can refer to. The words on top in bold font are the broader categories under which the words in that column describe specific feelings.

| **Pleasant Feelings** | | | |
|---|---|---|---|
| **OPEN** | **HAPPY** | **ALIVE** | **GOOD** |
| understanding | great | playful | calm |
| confident | gay | courageous | peaceful |
| reliable | joyous | energetic | at ease |
| easy | lucky | liberated | comfortable |
| amazed | fortunate | optimistic | pleased |
| free | delighted | provocative | encouraged |
| sympathetic | overjoyed | impulsive | clever |
| interested | gleeful | free | surprised |
| satisfied | thankful | frisky | content |
| receptive | important | animated | quiet |
| accepting | festive | spirited | certain |
| kind | ecstatic | thrilled | relaxed |
| | satisfied | wonderful | serene |
| | glad | | free and easy |
| | cheerful | | bright |
| | sunny | | blessed |
| | merry | | reassured |

| | | | |
|---|---|---|---|
| | elated | | |
| | jubilant | | |
| **LOVE** | **INTERESTED** | **POSITIVE** | **STRONG** |
| loving | concerned | eager | impulsive |
| considerate | affected | keen | free |
| affectionate | fascinated | earnest | sure |
| sensitive | intrigued | intent | certain |
| tender | absorbed | anxious | rebellious |
| devoted | inquisitive | inspired | unique |
| attracted | nosy | determined | dynamic |
| passionate | snoopy | excited | tenacious |
| admiration | engrossed | enthusiastic | hardy |
| warm | curious | bold | secure |
| touched | | brave | |
| sympathy | | daring | |
| close | | challenged | |
| loved | | optimistic | |
| comforted | | re-enforced | |
| drawn toward | | confident | |
| | | hopeful | |
| **Difficult/Unpleasant Feelings** | | | |
| **ANGRY** | **DEPRESSED** | **CONFUSED** | **HELPLESS** |
| irritated | lousy | upset | incapable |
| enraged | disappointed | doubtful | alone |
| hostile | discouraged | uncertain | paralysed |
| insulting | ashamed | indecisive | fatigued |

| | | | |
|---|---|---|---|
| sore | powerless | perplexed | useless |
| annoyed | diminished | embarrassed | inferior |
| upset | guilty | hesitant | vulnerable |
| hateful | dissatisfied | shy | empty |
| unpleasant | miserable | stupefied | forced |
| offensive | detestable | disillusioned | hesitant |
| bitter | repugnant | unbelieving | despair |
| aggressive | despicable | sceptical | frustrated |
| resentful | disgusting | distrustful | distressed |
| inflamed | abominable | misgiving | woeful |
| provoked | terrible | lost | pathetic |
| incensed | in despair | unsure | tragic |
| infuriated | sulky | uneasy | in a stew |
| cross | bad | pessimistic | dominated |
| worked up | a sense of loss | tense | |
| boiling | | | |
| fuming | | | |
| indignant | | | |
| **INDIFFERENT** | **AFRAID** | **HURT** | **SAD** |
| insensitive | fearful | crushed | tearful |
| dull | terrified | tormented | sorrowful |
| nonchalant | suspicious | deprived | pained |
| neutral | anxious | pained | grief |
| reserved | alarmed | tortured | anguish |
| weary | panic | dejected | desolate |
| bored | nervous | rejected | desperate |

| | | | |
|---|---|---|---|
| preoccupied | scared | injured | pessimistic |
| cold | worried | offended | unhappy |
| disinterested | frightened | afflicted | lonely |
| lifeless | timid | aching | grieved |
| | shaky | victimised | mournful |
| | restless | heartbroken | dismayed |
| | doubtful | agonised | |
| | threatened | appalled | |
| | cowardly | humiliated | |
| | quaking | wronged | |
| | menaced | alienated | |
| | wary | | |

**Annexure 4 for Activity 2 (Home assignment): Whose Line is it anyway? Appropriate Counselling Lines using couple counselling techniques:**

1. Normalise feelings , reactions , experiences:

   The effort here is to help the couple to recognise that their feelings such as guilt and betrayal are common and that other couples also feel similar emotions. Learning that their emotional reaction is common or natural gives the clients a sense of reassurance and validation that their emotions are justified – even if they cannot act on their deepest hurt or anger. The counsellor here demonstrates acceptance of the emotion, and not of any harmful or negative behaviour.

- *"Many couples in this situation feel like you do right now."*
- *"You are not the only one who feels this way. Other husbands (or wives) also feel betrayed (or guilty or angry) like you do right now. I can reassure you that many of them also manage to work through their problems."*

2. Effectively use silence while remaining calm and supportive:

   We have already seen that couple counselling involves a high level of intense feeling. Sometimes creating a deliberate moment of silence may bring the emotion to a manageable level. The counsellor may also use this technique when she/ he judges that the couple would benefit from a period of silence so they can collect their thoughts and respond accordingly.

Sometimes, the counsellor's silence may prompt the couple to open up. Many counsellors are uncomfortable with silence or pauses in the conversation. But if used effectively, this is a very effective technique.

- *"It seems like the atmosphere in the room is very hot. I'd like us all to be silent for just a little while so that we can regain our composure."*
- *"Let us pause a bit while I let you think about what I have just explained."*

3. Focus on the present and the future:

   It is common for a couple to recall past deeds and hurts. These may surface during the session. It is, therefore, helpful for the counsellor to gently bring back the focus of the session to the here and now, and to emphasise that the past cannot be altered. But it is also important not to use this technique to avoid an issue or to brush it under the carpet.

- *"It is easy to recall past incidents that have been painful in the relationship. But these cannot be rewritten or undone. All that we really have control over is our current and future direction."*

  Here there are some gender dimensions of which a counsellor should be aware. In India, married women are often expected to suppress their anger and betrayal when their spouse is unfaithful. Counselling personnel should be careful to avoid conveying to female clients that infidelity is acceptable, and thus negate or fail to validate their deepest anguish and hurt. Rather this technique should be used when clients appear to be narrating woeful stories that they have told several times before.

4. Avoid questions aimed at identifying source of infection:

   Related to the point above is the almost inevitable desire of the partners to identify when exactly HIV was transmitted. This is bound up in the possible infidelity of the infected partner and it also moves the focus of counselling to the past which cannot be undone. So the counsellor should point out that any discussion about the source of the infection is neither helpful nor relevant to the couple's current situation and life decisions.

- *"While the question of how and when HIV got in is something that everyone asks, you should also realise that HIV is present and we have to deal with it. Knowing where it came from does not really help our decision-making for the immediate present and the future."*
- *"Let me answer your question about when HIV entered with a short story. If a house is burning down and there are two people still stuck in the building, what is the immediate need? Would you stop to guess how the fire started or would you try to rescue those people and put out the fire? In a similar manner, worrying about where HIV came from, and trying to pin-point the source will distract you from the more urgent concerns before you."*

  Once again it is important to emphasise that this technique should not be used to cover up really important issues such as wife-beating, emotional abuse or spouse's alcohol misuse. This technique is recommended to help client couples progress to concrete decision-making on key

issues such as registering at the ART centre, getting their child or spouse tested. The counsellor should address underlying conflicts during follow-up counselling sessions.

5. Express confidence in couple's ability to deal with issues:

   The counsellor must project a sense of optimism that the couple will be able to deal with their life decisions. She/ he can accomplish this by jointly reflecting with them on their strengths and shared history. By examining how they, as a couple, have effectively addressed challenges in their lives, the counsellor can highlight their strengths. The counsellor should not only acknowledge these strengths but should show appreciation that the couple is willing to deal with HIV.

   *"It appears to me that together you have survived some difficult times. I am sure that once you have a chance to catch your breath, the same strength will help you in this current situation also." Together, I believe, the two of you have the strength needed to deal with these difficult events. It might be helpful to make a list of all the difficult times you have faced successfully in the past.*"

6. Project sense of optimism in couple's abilities:

   "It appears to me that together you have survived difficult times. I am sure that once you have had time to catch your breath the same strength will help you in dealing with this problem as well.

7. Work with intense emotions :

   In couple counselling, it is important to acknowledge the feelings expressed by the couple verbally and nonverbally. As these emotions may be overwhelming, it is important to also reassure them that as time passes the intense emotions and reactions will change or shift. This is a common and known pattern.

- *"Many couples show the same initial reactions as you, but I have seen that over time this gradually changes, and they adjust."*
- *"It is normal to feel so upset (or sad or angry). But slowly you will find yourself adjusting and coping."*

8. Reframe questions that are blaming or hostile:

   The emotional intensity between couples is sometimes due to blaming and angry reactions. The counsellor can defuse this situation by identifying underlying softer feelings and helping the couple to recognise that. For instance, fear, anxiety, and uncertainty are sometimes expressed as anger. One way to understand this concept is to recall an instance when you saw a child run towards some danger like a burning stove or a busy road. Your reaction might have been to rush and pull the child away, to express relief ("Thank God, I got you in time.") or to shout at the child

for not being more careful. What is underlying all of this is deep fear at the possibility of hurt to the child. But this is expressed differently.

- "It is common to feel many mixed-up emotions at the same time. Could you list what is going on in your mind right now?"
- "Sometimes people express frustration and anger but they are also experiencing many other things at the same time."

## Annexure 5: Key to 'Whose line is it anyway?' (Not to be photocopied)

1. "When do you think my partner got infected with HIV?"

- First normalise the feelings. Deflect the question that is targeted at the source of infection. Then focus on the present and the future.
- "It is common for people to be curious about where their partner got infected. But this question will shift the focus away from dealing with handling the infection. Isn't it better to think about the future right now? Let us try to stabilise your partner's health first."

2. "I don't want to use a condom because I want to get pregnant."

- First normalise the feelings. Then discuss the issues.
- "Wanting to have a child is a normal human urge. Let us discuss the issues."

3. "I don't want to use a condom because I do not feel as much "sex" as I would be able to without wearing it."

4. "How could my husband/ wife do this to me? I feel like killing him/ her."

- This is an intense emotion that you should work with.
- "Many partners in a sero-discordant couple often feel really strong emotions. These do not stay at the same level. Let us explore what is upsetting you."

5. "Please tell me how AIDS came into our life, into our relationship."

6. "I am so upset and angry and sad and worried. I am upset at my partner for bringing this into my life. I am sad because our child will miss one parent. I am worried that I might also have it."

- Reframe these emotions and responses.

7. "It is common to feel many mixed-up emotions at the same time. Often we are angry with others when we are actually upset with ourselves for not being able to do something?"

8. "I am so angry at him/ her because he/ she had sex with someone else."

9. "I am so angry at him/ her because he/ she has brought this thing into the family."

10. "We know that one of us is infected. But we want to have a child."

11. "I knew when I got married that my life with this person would be useless. Look at how I am trapped now."

12. "I have HIV but my wife does not. What should I do next? She is pregnant. I understand that she should get tested for the sake of the baby. But what if she finds out that I am infected! I am scared about knowing her result. I am also guilty about my own behaviour. Tell me what to do please."
    - First normalise the feelings. Reflect some of the feelings that the client is feeling. Then focus on the present and future.
    - "In such a situation many people feel very confused and have mixed feelings. You have expressed confusion, worry about your wife's sero-status, and guilt about being positive. Let us discuss; what are the important steps you need to take right now."

13. "I am so confused. I do not know how to react."

# SESSION 18
# Basics of Antiretroviral Therapy

## Session Overview:

- Lecture using slides (40 minutes)
- Carousel Activity (30 minutes)
- Debriefing of Carousel Activity (20 minutes)

## Session Objectives:

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

- The relevance of understanding the ART regimen for ICTC and STI/RTI counsellors.
- How counsellors may use the information about ART in their session.
- Describe the progression of HIV infection to AIDS and the WHO clinical staging.
- Explain about ART, its benefits, side-effects and limitations.
- Describe the effects of ARV drugs in relation to the HIV life cycle in the body.
- Identify the reasons for treatment failure and need of 'switch' and 'substitution' of treatment.
- Assess and evaluate these issues jointly with clients.

## Time allowed:

- 1 hour 30 minutes

## Material required:

- Slides related to the session
- Carousel Situations
- Cello tape
- Participants Handbook

## Method:

**Preparation before the Session**

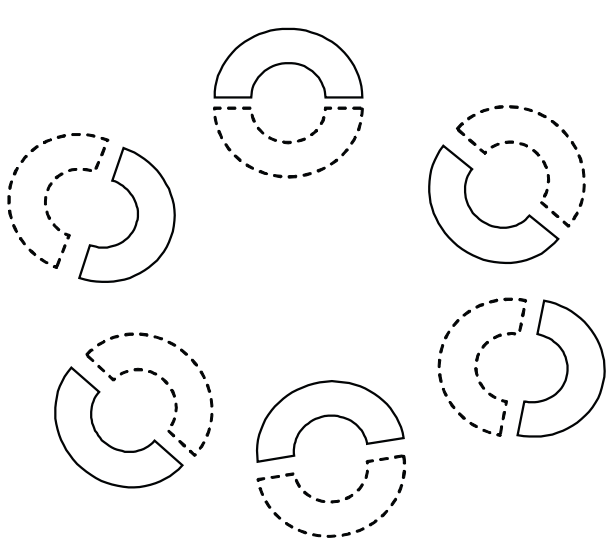
1. You, as the facilitator, will cut up the Carousel Situations and keep them handy BEFORE the session. The Capacity Building Officer will have to assist here.

**Lecture using Slides (40 minutes)**

2. Explain the key points in the session using the slides and the dialogue given for your convenience.
3. For the slides on side-effects, guide the participants to the relevant pages in their hand- outs and permit sufficient time for them to understand the key points.
4. In summary, emphasise the following points: *The client should not stop taking medication OR skip OR reduce doses; and that ART is at present a LIFETIME treatment.*

**Carousel Activity (30 minutes)**

5. For this activity, request the participants to help you arrange their chairs in two concentric circles with the inner circle facing the outer circle. Place the chairs slightly apart such that one can recognise distinct pairs and such that each pair has some privacy. See sample image. The Capacity Building Officer will have to assist here.




6. Use the cello tape to paste the Carousel situations to alternate chairs in the inner and the outer circles (that is the chairs with dashed outline as shown in the above figure). Thus each set of chairs will have one Carousel situation.
7. Explain the activity: Each pair has a situation to role-play. The person who is seated on the chair with the situation has to role-play a client with the problem described on the paper while the opposite person plays the role of a counsellor. "Clients" may take one minute to think about the situation and then describe it to their "counsellor." "Counsellors" have to listen carefully to the situation, ask relevant questions, identify the possible causes of the side-effects, discuss management of the side-effect, and suggest a suitable course of action. "Counsellors" may use their hand-outs for correct information.