Voluntary HIV Counselling and Testing

Manual for Training of Trainers

Part I

World Health Organization
Regional Office for South-East Asia
New Delhi, India
2004

Voluntary HIV Counselling and Testing

Manual for Training of Trainers
Part I

World Health Organization
Regional Office for South-East Asia
New Delhi, India
July 2004

WHO Library Cataloguing-in-Publication Data

World Health Organization, Regional Office for South-East Asia.
Voluntary HIV counselling and testing: manual for training of trainers part I & II with CDs, 2004.

1. HIV infections – diagnosis - prevention and control
2. Counselling 3. Education 4. Manuals I. Title

ISBN 92 9022 233 6 (NLM classification: WC 503)

Printed in India

Trainer's Manual Contents

Acknowledgements

This training package was prepared on behalf of the World Health Organization (Regional Office for South-East Asia), by the Albion Street Centre, International Health Services Unit, Sydney, Australia, and other experts from the South-East Asia Region.

Kathleen Casey, Albion Street Centre, Australia
Charmaine Turton, Albion Street Centre, Australia
Alexandra Wilson, Albion Street Centre, Australia
Rachel Musson, Albion Street Centre, Australia
Nicholas Bates, Albion Street Centre, Australia
Prawate Tantipiwattanasakul, Department of Mental Health, Thailand
Pahsuvadn Kongsin, Bangkok Metropolitan Medical College, Thailand
Duangta Graipaspong, Kalayarajanakarindh Institute, Thailand
Paritas Silpagij, Suan Prung Psychiatric Hospital, Thailand
Ruengpung Sutthent, Mahidol University, Thailand
Achara Teeraratkul, Thai MOPH-US CDC Collaboration (TUC), Thailand
Greg Carl, UNICEF EAPRO, Thailand
Kulasiri Buddhakorala, National STD/AIDS Programme, Sri Lanka
Maya Ramachandran, South India AIDS Action Programme, India
Ying-Ru Lo, WHO Regional Office for South-East Asia, India
Magdalene Jeyarathnam, South India AIDS Action Programme, India
Sushma Mehrotra, National AIDS Control Organisation (NACO), India
This document was edited by Ying-Ru Lo, WHO Regional Office for South-East Asia

Many individuals and organisations have contributed to the development of this voluntary counselling and testing (VCT) training of trainers package. Sincere thanks are due to following people and organizations for their technical input and reviews:

Rachel Baggaley, WHO consultant, United Kingdom
Suchada Sakornsatian, Department of Mental Health, Thailand
Kanyarat Klumthanom, Thai MOPH-US CDC Collaboration (TUC), Thailand
Thanada Naiwatanakul, Thai MOPH-US CDC Collaboration (TUC), Thailand
Kalaya Unchuen, Prasrimahapo Psychiatric Hospital, Thailand
Somsri Tantipaibulvut, The Thai Red Cross AIDS Research Centre, Thailand
Phongphan Vannakit, The Thai Red Cross AIDS Research Centre, Thailand
Scott McGill, Family Health International, USA
Pema Rinzin, Dermatologist, Thimphu, Bhutan
Rohini Ramamurthy, Counsellor, Mumbai, India
Population Services International "Lighthouse" Counselling and Testing, India
Ratna Mardiati, Ministry of Health, Indonesia
Chad Hughes, WHO Myanmar
Patrick Osewe, USAID, Zimbabwe
Buhle Ncube, WHO/AFRO
Population Services International "New Start" Counselling and Testing, Zimbabwe

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
APCASO	Asia Pacific Council of AIDS Service Organisation
ART	Antiretroviral Therapy
ARV	Antiretroviral
AS	Activity Sheet
CBO	Community-Based Organisation
CIRR	Client Information Record and Result
CSW	Commercial Sex Worker
DOT	Directly Observed Therapy
ELISA	Enzyme Linked Immunosorbent Assay
EQA	External Quality Assessment
EQAS	External Quality Assessment Scheme
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HO	Handout
ICAAP	International Conference on AIDS in Asia and the Pacific
IDU	Injecting Drug Use/User
IEC	Information, Education and Communication
IOM	International Institute for Migration
MCH	Maternal and Child Health
MSM	Men who has sex with Men
MTCT	Mother-to-Child Transmission
NEP	Needle Exchange Programme
NGO	Non-governmental Organisation
OI	Opportunistic Infection
PCR	Polymerase Chain Virus
PEP	Post Exposure Prophylaxis
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother–to–Child Transmission
PPT	Power Point Presentation
PT	Proficiency Test
PTSD	Post Transmitted Stress Disorder
QA	Quality Assurance
QC	Quality Control
SEARO	South-East Asia Regional Office
SOP	Standard Operating Procedure
SP	Session Plans
STI	Sexually Transmitted Infection
TB	Tuberculosis
ToT	Training of Trainers
UNAIDS	Joints United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly
VCT	Voluntary Counselling and Testing
VDT	Voluntary Diagnostic Testing
WHO	World Health Organization

1. Introduction and how to use

The Asia and Pacific region, with around seven million people estimated to be living with HIV/AIDS, ranks second in the world, after sub-Saharan Africa for HIV prevalence. The region is vast and diverse. Countries have varied epidemiological patterns of HIV and AIDS with generalised versus concentrated, versus low level epidemics. Regional trends indicate dramatic increases in infectious diseases such as HIV/AIDS and other sexually transmitted infections (STIs).[1] Asia and Pacific currently account for about 20% of new annual HIV infections globally. Transmission routes vary country by country, with unprotected commercial sex, heterosexual sex, homosexual and bisexual sex, and sharing of injecting equipment among injecting drug use all playing a greater or lesser part.

Particular challenges include the emergence of modern socially and sexually liberal youth populations who are poorly informed of the attendant risks; the link between commercial sex and the trafficking of humans; and the likelihood that rising rates of syphilis and other STIs will form a bridge by which HIV can spread rapidly through sexual contact from injecting drug users to the wider population. A number of interventions, as for example condom use, STI control, preventing mother-to-child transmission and harm reduction among injecting drug users, have been proven effective in decreasing HIV transmission. High quality voluntary counselling and testing (VCT) not only enables and encourages people with HIV to access appropriate care but has been demonstrated to be effective in HIV prevention. Equitable access to VCT services should be considered a priority intervention in the fight against HIV.[2]

There is clear evidence that VCT has several benefits such as facilitating planning for the future; orphan care; will making; acceptance and coping with one's serostatus; facilitating behaviour change in sero-negative and sero-positive people thus keeping HIV negative those who test negative; and reducing mother-to-child transmission. VCT is also the platform for facilitating early management of HIV-related infections and STIs, identifying the need for prophylaxis and effective/safe use of HIV antiretroviral therapies.[3] It also enables psychosocial support through referral to social and peer support and increases the visibility of HIV in the communities. This fosters the enhancement of destigmatisation of those with HIV/AIDS as HIV will be seen as a problem faced by many normal people in the community. This process can promote normal attitudes to the disease, which is known as 'normalisation' of HIV/AIDS. It is therefore important that VCT services be made available on a much larger scale than at present.

1.1 Overall objectives of the training

1	Describe the HIV/AIDS situation in the South-East Asia region
2	Describe the rationale to scale up VCT services
3	Demonstrate that VCT is an effective HIV transmission reduction strategy
4	Demonstrate the role of VCT as an entry point to HIV treatment and care
5	Improve the technical capacity of health workers to provide VCT
6	Train a cohort of counsellors for VCT

1.2 How to use this training package

While no training manual can be exhaustive, this package attempts to outline the key activities and information involved in training VCT counsellors and also provides guidance on how to train trainers.

[1] UNAIDS/WHO AIDS Epidemic Update, December 2002, Geneva. UNAIDS/02.46E
[2] UNAIDS, The Joint United Nations Programme on HIV/AIDS, The global strategy framework, UNAIDS. Geneva 2001
[3] UNAIDS, The impact of voluntary counselling and testing: A global review of the benefits and challenges. Geneva 2001, http://www.unaids.org/publications/documents/health/counselling

2. The trainer's manual

The printed trainer's manual is divided into separate parts:

Part I: Training of VCT counsellors

Part I contains essential information for training HIV/AIDS counsellors and is intended for use as a resource by those conducting such training. It is also designed as a reference book and provides information to help build the skills and expand the scope of those who already provide HIV/AIDS counselling.

This part contains five modules organised into sub modules with clearly stated objectives and session plans. The printed manual contains all the training resources detailed in the training resources outline. This form provides the module and sub module numbers, the title of the sessions and the corresponding numbers of the associated:

SP	**Session plans**
PPT	**PowerPoint presentations**
HO	**Handouts**
CS	**Case studies**
AI	**Activity instructions**

The appendix of the trainer's manual contains sample training evaluation materials.

The PowerPoint presentations, handouts and case studies for course participants, referred to in the manual, can be found on the CD ROM under the various module and sub module numbers.

Part 2*: Training VCT counsellors to train others in VCT counselling

Part 2 contains only one module and is designed to assist trained and experienced VCT counsellors in the development and delivery of training. Again, the printed manual contains all training resources detailed in the training resources outline. The PowerPoint presentations and handouts for course participants, referred to in the manual, can be found on the CD ROM.

We would like to suggest that, prior to the commencement of any training programme, you refer to the preparation for training section that follows.

Disclaimer: *The training programme requires supervised skills rehearsal. Therefore, the manual is not suitable for use as a self-directed learning tool. You are further advised that only persons who have successfully completed the course should use this manual. It is not recommended that this manual be used by clinicians/trainers who have not participated in the specific training activities—to do so may compromise the quality of training provided.*

* to be distributed before the second half of the course

3. Plan of training

The time required for training

Part 1: Training of VCT counsellors

This is a **12-day training programme** (including one day as holiday suggested for day 7) that may be adapted as appropriate to longer or shorter periods of training. However, sessions, or 'modules' should be added or subtracted according to their relevance to the culture and epidemic profile of the country in which the training is happening, the time available for training, and the level of practical experience in hands-on patient management of the participants.

Specific suggestions on how to adapt the programme to different time frames and training contexts are outlined in the manual for Part 2. In general, with limited time and special groups, core modules should be included and activities and case studies should be selected that will highlight the issues specific to the objectives of the training and the epidemiology of the local area. For example, in settings where transmission is associated with injecting drug use (IDU), then it will be important to include the module on IDU; if training is being conducted for health care workers providing antenatal care then the module of Prevention of Mother-to-Child Transmission (PMTCT) will be imperative. Reading material and/or follow-up training programmes could be offered to address the content omitted from a shorter training programme.

The 12-day programme is very comprehensive and is designed to address all VCT training requirements.

An example of a five-day curriculum incorporating the core modules is provided below. With careful selection of activities and case studies this shorter programme could be used in a variety of contexts.

DAY ONE
Introduction and orientation
Epidemiology and implications for VCT
Overview of HIV
Introduction to HIV testing
Role of VCT in HIV prevention and care

DAY TWO
Orientation to counselling
Counsellor values and attitudes
Counselling microskills

DAY THREE
Behaviour change communication

DAY FOUR
Prevention of mother-to-child transmission
Pre-HIV test counselling

DAY FIVE
Post-HIV test counselling
Evaluation and closing activities

Part 2: Training VCT counsellors to train others in VCT counselling

This is a six-day training programme that may be adapted as appropriate to longer or shorter periods of training.

It is recommended that new graduates of Part 1 complete at least six months of post-training clinical practice before undertaking Part 2 training. In order to conduct high quality training it is recommended that all course trainers have recent or current clinical experience in VCT counselling.

4. VCT training programme – 12 day schedule

**The schedule begins each day at 08.30 and concludes each day at 17.00 hours.
The schedule assumes strict adherence to the specified break times:
10.15 – 10.30 morning tea; 12.30 – 13.30 lunch; 15.00 – 15.30 afternoon tea.
The schedule includes one day as time off on day 7.**

DAY 1 - Monday

08.15	08.30	Registration
08.30	08.45	Official welcome
08.45	10.15	Introduction and orientation (Module 1- Sub module 1)
10.15	10.30	**Morning tea**
10.30	11.30	Epidemiology and implications for VCT (Module1- Sub module 2)
11.30	12.30	Overview of HIV (Module 1 - Sub module 3)
12.30	13.30	**Lunch**
13.30	14.00	Overview of HIV/*continued* (Module 1 - Sub module 3)
14.00	15.00	Introduction to HIV testing (Module 1 - Sub module 4)
15.00	15.15	**Afternoon tea**
15.15	16.45	Role of VCT in HIV prevention and care (Module 1 - Sub module 5*)*
16.45	17.00	Questions and answers/Closing

DAY 2 - Tuesday

08.30	08.45	Participant summary
08.45	10.15	Orientation to counselling (Module 2 - Sub module 1)
10.15	10.30	**Morning tea**
10.30	12.30	Counsellor values and attitudes (Module 2 - Sub module 2)
12.30	13.30	**Lunch**
13.30	15.00	Counselling microskills (Module 2 - Sub module 3)
15.00	15.15	**Afternoon tea**
15.15	16.45	Counselling microskills/*continued* (Module 2 - Sub module 3)
16.45	17.00	Questions and answers/Closing

DAY 3 - Wednesday

08.30	08.45	Participant summary
08.45	10.15	Behaviour change communication - HIV transmission (Module 2 - Sub module 4.1)
10.15	10.30	**Morning tea**
10.30	11.30	Behaviour change communication – Models of behaviour change (Module 2 - Sub module 4.2)
11.30	12.30	Behaviour change communication - Models of behaviour change: safe sex and safe injecting (Module 2 - Sub module 4.2)
12.30	13.30	**Lunch**
13.30	15.00	Behaviour change communication - Problem solving (Module 2 - Sub module 4.3)
15.00	15.15	**Afternoon tea**
15.15	16.45	Behaviour change communication - Case activities (Module 2 - Sub module 4.3)
16.45	17.00	Questions and answers/Closing

DAY 4 - Thursday

08.30	08.45	Participant summary
08.45	9.00	Pre-HIV test counselling – Overview (Module 2 - Sub module 5.1)
9.00	10.15	Clinical risk assessment (Module 2 - Sub module 5.2)
10.15	10.30	**Morning tea**
10.30	11.30	Clinical risk assessment/*continued* (Module 2 - Sub module 5.2)
11.30	12.00	Pre-HIV test counselling – Lecture (Module 2 - Sub module 5.3)
12.00	12.30	Pre-HIV test counselling – Role-play (Module 2 - Sub module 5.3)
12.30	13.30	**Lunch**
13.30	14.00	Pre-HIV test counselling – Role-play (Module 2 - Sub module 5.3)
14.00	15.00	Pre-HIV test counselling – Debriefing (Module 2 - Sub module 5.3)
15.00	15.15	**Afternoon tea**
15.15	16.45	Pre-HIV test counselling – Sexual assault (Module 2 – Sub module 5.4)
16.45	17.00	Questions and answers/Closing

DAY 5 - Friday

08.30	08.45	Participant summary
08.45	10.15	Pre-HIV test counselling – Occupational exposures (Module 2 – Sub module 5.5)
10.15	10.30	**Morning tea**
10.30	11.30	Pre-HIV test counselling – Occupational exposures/*continued* (Module 2 – Sub module 5.5)
11.30	12.00	Post-HIV test counselling – General principles (Module 2 - Sub module 6)
12.00	12.30	Post-HIV test counselling – Negative results (Module 2 - Sub module 6)
12.30	13.30	**Lunch**
13.30	15.00	Post-HIV test counselling – Positive results: Lecture (Module 2 - Sub module 6)
15.00	15.15	**Afternoon tea**
15.15	16.15	Post-HIV test counselling – Positive results: Role-play (Module 2 - Sub module 6)
16.15	16.45	Post-HIV test counselling – Positive results: Debriefing (Module 2 - Sub module 6)
16.45	17.00	Questions and answers/Closing

DAY 6 - Saturday

08.30	08.45	Participant summary
08.45	10.15	Suicide – Risk assessment in HIV, role-play and debrief (Module 2 - Sub module 7)
10.15	10.30	**Morning tea**
10.30	12.30	Suicide – Management strategies (Module 2 – Sub module 7)
12.30	13.30	**Lunch**
13.30	15.00	Counselling issues across the HIV disease continuum (Module 4 - Sub module 1)
15.00	15.15	**Afternoon tea**
15.15	16.45	Counselling issues across the HIV disease continuum (Module 4 - Sub module 1)
16.45	17.00	Questions and answers/Closing

DAY 7 - Sunday (Holiday)

DAY 8 - Monday

08.30	08.45	Participant summary
08.45	10.15	Targeted VCT intervention – IDU (Module 3 – Sub module 1)
10.15	10.30	**Morning tea**
10.30	11.30	Targeted VCT intervention – IDU/*continued* (Module 3 – Sub module 1)
11.30	12.30	Targeted VCT intervention – Sex workers (Module 3 – Sub module 2)
12.30	13.30	**Lunch**
13.30	14.30	Targeted VCT intervention – Sex workers/*continued* (Module 3 – Sub module 2)
14.30	15.00	Targeted VCT intervention –Youth and children (Module – Sub module 3)
15.00	15.15	**Afternoon tea**
15.15	16.45	Targeted VCT intervention –Youth/*continued* (Module 3 – Sub module 3)
16.45	17.00	Questions and answers/Closing

DAY 9 - Tuesday

08.30	08.45	Participant summary
08.45	10.15	Targeted VCT intervention – Males having sex with males (Module 3 – Sub module 4)
10.15	10.30	**Morning tea**
10.30	12.30	Targeted VCT intervention – Prevention of mother-to-child transmission (Module 3 – Sub module 5)
12.30	13.30	**Lunch**
13.30	17.00	Field visit (Module 5 – Sub module 8)

DAY 10 - Wednesday

08.30	17.00	Field visit (Module 5 – Sub module 8)

DAY 11 - Thursday

08.30	08.45	Participant summary
08.45	10.15	Counselling for treatment adherence (Module 4 – Sub module 2)
10.15	10.30	**Morning tea**
10.30	11.30	Adaptations to the standard VCT model (Module 5 – Sub module 1)
11.30	12.30	Models of VCT service delivery (Module 5 – Sub module 2)
12.30	13.30	**Lunch**
13.30	14.30	Referral and network development (Module 5 – Sub module 3)
14.30	15.00	Counselling supervision and support (Module 5 – Sub module 4)
15.00	15.15	**Afternoon tea**
15.15	16.45	Counselling supervision and support/*continued* (Module 5 – Sub module 4)
16.45	17.00	Questions and answers/Closing

DAY 12 - Friday

08.30	08.45	Participant summary
08.45	10.15	Counsellor ethics (Module 5 – Sub module 5)
10.15	10.30	**Morning tea**
10.30	12.00	Monitoring, evaluation and quality assurance (Module 5 – Sub module 6)
12.00	12.30	Counsellor records and data management (Module 5 – Sub module 7)
12.30	13.30	**Lunch**
13.30	14.30	Counsellor records and data management/*continued* (Module 5 – Sub module 7)
14.30	15.00	Other targeted VCT interventions - Mobile populations and prisons* (Module 3 – Sub modules 6 & 7)
15.00	15.15	**Afternoon tea**
15.15	16.45	Evaluation and post-course knowledge questionnaire
16.45	17.00	Closing activities

* These topics have not been included in the timetable, but they are included as optional topics in the training manual. Trainers can use this time to discuss when and how these optional topics can be considered for other courses where these targeted interventions may be a priority.

5. Guidelines for preparation for training

5.1 Key considerations for the development and delivery of effective training[1]

It is important to identify the combination of skills that counselling staff and supervisors will need in order to support each other, so that together the entire staff at a VCT site will be able to deliver high quality services to their clients.

Making sure that supervisors also receive counselling training as well as counselling supervision training is critical to maintaining the quality of clinical service and to strengthening the management of the programme. Supervisors must see their roles as educative and supportive (as well as being able to provide appropriate challenges where necessary), but not interrogative.

Training for counsellors should be ***competency-based,*** bearing in mind the realities of the field situation. This means that before training programmes can be designed, the relevant competencies must be defined. Careful consideration must be given to the procedures which counsellors should follow and the skills they require.

The most important method in any situation depends on the nature of the learning objectives (the learning of facts requires different teaching methods from the learning of communication skills); local cultural factors; and the style of teaching which learners are familiar with and capable of using.

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

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

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

5.1.1 Group size

Group size for classroom counselling training should not exceed 24 participants. An ideal number is between 12 and 21. The smaller the group, the more quality time and opportunity is afforded for trainees to practise their skills. As a number of group activities require splitting the trainees into groups of three's, it is suggested that course trainee numbers are divisible by three.

5.1.2 Interactive training strategies

This course employs interactive training methodologies, allowing instruction, practice and feedback to take place as it is crucial to address the sensitive and confidential issues discussed during HIV pre- and post-counselling.
The methodologies include:

[1] This material was adapted with permission from PSI Zimbabwe training.

1	Role-play exercises (including those which can be audio or videotaped)
2	Focused discussions
3	Educational games
4	Case-based small group learning activities

Trainers can consider using any of the following strategies:

Visual aids

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

Equipment required for training includes

1	Whiteboard or large sheets of paper (e.g. flip chart)
2	Photocopied trainee handouts arranged in a folder
3	Transparencies used with an overhead projector
4	PowerPoint and LCD projector
5	Videotapes
6	Posters/photographs

Presentation

A presentation is used to give information. Key points can be illustrated using visual aids. Trainers can promote interaction by:

- the use of partially individual/group exercise handouts which trainees complete
- encouraging questions from the group following the presentation
- group work to discuss and answer questions or
- assigning issues or tasks to small groups

Rapporteur sessions

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

Large group discussions

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

- The trainees are involved in problem-solving
- The trainees are active participants, which stimulates interest
- The learning process becomes more personal, requiring the trainer to provide feedback on individual opinions and ideas
- The trainer is able to evaluate the trainees' understanding and absorption of material
- The trainees have an opportunity to share already established expertise and skills

Large group discussions require a skillful trainer who:

- asks questions or suggests topics, maintains objectivity, and directs the discussion to keep it relevant to the learning objective
- stresses confidentiality
- ensures that all group members have equal opportunities to participate and that no one person (including the trainer!) dominates the discussion
- perceives and responds to differences in the group, such as skill level, education, and comfort with the topic
- is aware of cultural and gender issues
- encourages trainees to answer questions and share expertise
- needs to be flexible if the group begins to explore other relevant issues
- is respectful and non-judgmental of the trainees' ideas and opinions in order to allow for open expression of concerns
- keeps to the time, leaving adequate periods for discussion
- obtains feedback and responses from the group to provide evaluation mechanisms for the session and
- provides an appropriate balance of supportive and challenging facilitation in which to foster learning

Small group discussions

These are usually groups of four to six. Some of the advantages of such discussions are:

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

The trainer does not lead the group, but must be skillful in structuring the discussions so that the trainees accomplish the stated objectives. It is important to provide clear guidelines at the beginning of the discussion such as:

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

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

Working in pairs

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

Role-play

Role-play can be organised to play the parts of identified people and act out a scene. This is useful when practising skills such as counselling, and for exploring how people react in specific situations. Role-play has the following advantages:

- It allows for safe rehearsal of skills and activities and provides practical preparation for genuine situations
- The trainees are able to experience activities and to relate theory to practice
- It allows for full expression and interpretation of concepts

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

- keep the role-play appropriate to the learning context
- emphasise that the characters are "in role" and that group observers are looking at the character and their reactions, not the individual people playing them

Implementing role-plays

Ideally, role-plays should be arranged by dividing trainees into triads. Each triad should nominate a "counsellor", a "client" and an "observer". Trainees should be rotated between these three roles so that they have an opportunity to experience each role. Accordingly, there should be three rounds of cases with one case being conducted per round.

The trainer should only hand the cases to the trainees who are playing a client. Counsellors and observers should not be permitted to read the cases. The trainer should inform clients that they do **not** wish them to share the cases with either counsellors or observers in order to make the role-play as realistic as possible.

Counsellors are to practice applying the knowledge and skills learned through the lectures and other activities by completing the nominated task. If during the role-play they become confused or uncertain they should be instructed to refer to their notes, review their material and recommence when ready. They should not ask for assistance from their client or observer. If necessary, they should be instructed to put up their hand for assistance from a facilitator. At the conclusion of the role-play the counsellor should discuss what they were happy with in their practice and what things they would have liked to have done differently.

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

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

Five minutes should be allowed at the conclusion of each round for discussion and feedback within the triad.

This is to be followed by requesting the class to form three small groups. One small group should comprise all the trainees who played counsellors for that round, another group should comprise all the trainees who played clients and another group should comprise all the trainees who played observers.

A facilitator should be allocated to debrief each small group. One facilitator will debrief the counsellors, one facilitator will debrief the clients and one facilitator will debrief the observers.

The small group facilitators should ask the trainees to share their role-play experiences and guide the discussion to the following three questions:

i. What made clients feel comfortable?
ii. What microskills were particularly important for the counsellor to employ?
iii. How did counsellors manage to balance provision of information with being responsive to the needs of the client's emotions?

The small group debriefing should last no longer than 10 minutes each round.

Trainees should then return to their triads and swap roles. Different case studies should then be provided to the trainees who swap to being counsellors.

If only one or two facilitators are available then the debriefing should be performed as one large group following each round. Following the triads debriefing each other, the trainees should be asked to return to one large group. Trainees should be asked to share their role-play experiences and discussion should focus on the three questions above.

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

Overview of role-play process

Trainees divide into triads

↓

Each triad nominates a "counsellor", a "client" and an "observer"

↓

ROUND ONE

Clients receive case study 1.
Conduct the role-play exercise.
Debrief within the triad for five minutes.
Debrief within small groups of counsellors, clients and observers for 10 minutes.

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

Trainees should then return to their triads and swap roles.

- Counsellors should become observers
- Observers should become clients
- Clients should become counsellors

↓

ROUND TWO

Clients receive case study 2.
Conduct the role-play exercise.
Debrief within the triad for five minutes.
Debrief within small groups of counsellors, clients and observers for 10 minutes.

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

Trainees should then return to their triads and swap roles.

- Counsellors should become observers.
- Observers should become clients.
- Clients should become counsellors.

↓

ROUND THREE

Clients receive case study 3.
Conduct the role-play exercise.
Debrief within the triad for five minutes.
Debrief within small groups of counsellors, clients and observers for 10 minutes

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

Case studies

The case studies are designed to give counselling trainees an understanding of the effect of HIV infection on the individual, and to enable them to deal with problems they may encounter in the practice setting. The trainers need to develop case studies that are specific to the local setting. Where included, case studies are located in the session plan for each individual sub module, some of these are followed by a discussion of key points pertaining to the case study. Case studies for printing and providing to trainees are found in a separate section of this trainer's manual.

The case studies provide a detailed description of an event, different characters and settings. The case studies may be followed by a series of questions that will challenge the trainees to discuss the positive and negative aspects of the event.

> *The case studies prepared for use in the individual clinical risk assessment and pre-HIV test counselling sessions* ***should not*** *be included in the participant folders. They have been designed to be handed out to the trainees during the activities. (Refer to session plan).*
>
> Trainees who role-play "counsellors" in these activities should not see the cases prior to the commencement of the activities. This will ensure that the "counsellor" gains experience in acquiring information from "clients". In "real life" situations clients do not send all their details to the counsellor in advance; rather the counsellor uses counselling microskills to gain information from the client. Conducting role-plays in this way ensures that training approximates real life situations.

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

5.1.3 External trainers/guest speakers

Use of a range of external trainers or guest speakers presents both advantages and disadvantages. Some of the advantages include:

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

Some of the disadvantages of using external trainers or guest speakers include:

- When inadequately briefed, speakers may launch into their standard lecture response
- Speakers may present non-evidence based or erroneous information
- Speakers may pitch their presentation inappropriately in terms of language used and target audience
- Some speakers may be uncomfortable with the use of more interactive learning methodologies
- Speakers may not adhere to the time frame provided.

To maximise the use of external trainers or guest speakers:

- Ensure they are adequately briefed, verbally as well as in writing, in terms of what is expected of them. Provide a guideline that specifies the content to be covered, the style of methodology to be used, the level and type of language, and the time frame by which to adhere. In addition, clearly describe the type of trainees they are working with and the overall aims of the training programme

- Choose speakers who are known to be effective for your goals. Alternatively, "groom" them to attain the desired outcome.
- Ensure that the regular trainer remains present where possible whilst the external speaker presents. This ensures continuity if there are any issues arising. In addition, regular trainers are also able to observe and provide useful feedback to the external trainer/guest speaker
- Always ensure that external trainers/guest speakers are given feedback from both the organisation and trainee evaluations in order to continue to improve their sessions

5.2 Assessing knowledge levels

Prior to the training sessions, the trainees' knowledge of HIV/STDs and the counselling process should be assessed with a pre-test using objective questions. This information can be used to tailor the training sessions to the understanding of the trainees. After the sessions are completed, these same questions can be used to determine how much trainees have learned and how effective the training has been. For populations that are not familiar with questionnaires or where some of the trainees may be illiterate, focus groups may also be utilised to assess knowledge levels.

5.3 Assuring quality

However, for these training sessions to be successful, the trainees must use this knowledge in the actual counselling setting. Consequently, it is important to observe whether the guidelines are implemented in the actual practice situation to assure quality of service to the client.

5.4 Checklist of what is needed for the training (supplies and space)

Sample checklist of materials/advance preparation

- Timetable
- Room
- Adequate seating
- Personnel (trainers, resource persons, administrative support)
- Participant notebooks and pens
- Flipchart paper and stand
- Markers
- "Sticky stuff"/cellotape
- Newsprint/handouts
- Manuals/resource books
- Copies of activity sheets to hand out to each trainee
- Overheads
- Overhead projector and markers
- Box for collecting written questions trainees feel unable to ask
- Box for collecting evaluation forms
- Condoms (allow 2 per trainee)
- Penis and vagina models for condom demonstrations
- Injecting equipment (needle, syringe, two small bowls, red food colouring and water)

5.5 Key considerations for ensuring successful training

- **Ensure that the Training Materials Outline is close at hand for easy reference.** This will prevent usage of wrong handouts or case studies for accompanying presentations.

- **All trainees must be present for the ENTIRE training.** It is suggested that certificates not be provided to trainees who do not attend the entire course. In the event of an emergency arising and trainee cannot complete the course, the trainer should negotiate with the trainee to complete the missed segments at a future course and then hand over the certificate. Note that this is critical to ensuring quality of counselling. If a trainee misses any segments, the trainer should brief the trainee when they return about the missed segments. This will ensure that they do not disadvantage their role-playing partner when they do role-plays or other activities.

- **Ensure training sessions commence on time. Request all trainees should arrive on time.** There is much material to be covered each day, and it can be very disruptive to have trainees arrive at the training sessions once the sessions have already begun.

- **Discussion of sensitive issues.** Trainers must recognise that discussions of sex, sexuality, HIV and STIs can be difficult. It is important for trainers to make a statement about this potential discomfort to trainees at the commencement of the course and invite the course trainees to discuss their concerns with you on an individual basis. The training group must respect a trainee decision to pass on a specific question or activity.

- **Encourage trainees to use the question box.** Questions of a sensitive nature can be written down on a piece of paper and placed in the question box. The questions shall be drawn out at the end of each day and discussed during the “question and answer” session before the close of the day.

- **It is important to maintain confidentiality at all times**. This should be the case especially if counsellor trainees refer to their own personal experiences or those of their clients. Trainers are urged to ask all trainees to agree to maintain the confidentiality of all fellow trainees.

- **Encourage trainees to respect individual differences.** Trainees frequently come from different ethnic and cultural and lifestyles, beliefs, personal experiences and expertise.

- **Encourage trainees to listen carefully and with empathy, and respect each other’s contributions, opinions, and experiences.** Explain that it is important in the training, and as professionals, to practise active listening by allowing each other to share their own experiences and opinions with the group.

- **Create an environment in which each participant feels comfortable asking questions.** Trainees need to be able to ask questions about what they do not understand. Again the question box can be a useful tool.

- **Due to the constant change in transmission patterns, treatment, perceptions, attitudes, etc., trainees should be reminded to consistently update their information regarding HIV/AIDS.** As providers, it is important that we keep abreast of changing information. With

the latest information, resources and treatments available, we can provide better services to our clients.

- **Ensure you get the right trainees**. Establish clear criteria for participation and communicate these criteria not only to the trainees but also their employers.

- **Ensure an evaluation form is distributed to trainees at the end of every session.** These need to be completed by the trainees and placed in the 'evaluation box' to be collected by the trainer once all forms have been submitted. These evaluation forms can help provide valuable feedback to the trainer about their styles, presentation skills and apparent knowledge of the subject area.

- **Consider the advantages of providing meals to the trainees.** The training course follows a very strict timetable. It is therefore essential that the sessions commence and conclude at the nominated times. The provision of morning tea, lunch and afternoon tea at the site of the training has the advantage of ensuring all trainees promptly return from breaks. It also creates flexibility within the programme should there be a need to shorten breaks or complete work within a break. Further, it tends to contribute to the general satisfaction of trainees and allows them to focus on the material being learned to a greater degree.

6. Training resources outline

Module	Sub module	Title	Session plans (SP)	Power Point Presentation (PPT)	Handout (HO)	Activity sheet (AS)
MODULE 1	**BACKGROUND INFORMATION ON HIV AND VCT**					
1	1	Introduction and orientation	SP1	N/A*	N/A	N/A
1	2	Epidemiology and implications for VCT	SP2	PPT01	H01	N/A
1	3	Overview of HIV	SP3	PPT02	H02	AS01
1	4	Introduction to HIV testing	SP4	PPT03	H03	AS02
1	5	Role of VCT in HIV prevention and care	SP5	PPT04	H04	AS03
MODULE 2	**VCT FOR HIV**					
2	1	Orientation to counselling	SP6	PPT05	H05	AS04 AS05
2	2	Counsellor values and attitudes	SP7	PPT06	H06	AS06 AS07 AS08 AS09
2	3	Counselling microskills	SP8	PPT07	H07	AS10a AS10b AS11
2	4.1	Behaviour change communication – HIV transmission	SP9	PPT08	N/A	N/A
2	4.2	Behaviour change communication – Models of behaviour change	SP10	PPT09	H08	N/A
2	4.3	Behaviour change communication – Problem solving	SP11	PPT10	H09	AS12
2	5.1	Overview of pre- and post-HIV test counselling	SP12	PPT11	H010	
2	5.2	Clinical risk assessment	SP13	PPT12	H011	AS13a AS13b
2	5.3	Pre- HIV test counselling	SP14	PPT13	H012	AS14
2	5.4	Pre- HIV test counselling– Sexual assault	SP15	PPT14	H013	AS15
2	5.5	Pre- HIV test counselling– Occupational exposures	SP16	PPT15	H014	AS16
2	6	Post- HIV test counselling	SP17	PPT16	H015	(AS14)
2	7	Suicide – Risk assessment in HIV and management strategies	SP18	PPT17	H016	AS17 AS18
MODULE 3	**TARGETED VCT INTERVENTION**					
3	1	Targeted VCT intervention - IDU	SP19	PPT18	H017	AS19
3	2	Targeted VCT intervention - Sex workers	SP20	PPT19	H018	N/A
3	3	Targeted VCT intervention - Youth and children.	SP21	PPT20	H019	N/A
3	4	Targeted VCT intervention – Men who have sex with men (MSM)	SP 22	PPT21	H020	N/A
3	5	Prevention of mother-to-child transmission	SP23	PPT22	H021	AS20
3	6	Targeted VCT intervention – Mobile populations (optional)	SP24	PPT23	H022	AS21
3	7	Targeted VCT intervention – Prisons (optional)	SP25	PPT24	H023	AS22
MODULE 4	**PSYCHOSOCIAL CARE**					
4	1	Counselling issues across the disease continuum	SP26	PPT25	H024	AS23
4	2	Counselling for treatment adherence	SP27	PPT26	H025	AS24

N/A=not available

MODULE 5		ESTABLISHMENT AND MANAGEMENT OF VCT SERVICES				
5	1	Adaptations to the standard VCT model	SP28	PPT27	H026	N/A
5	2	Models of VCT service delivery	SP29	PPT28	H027	AS25
5	3	Referral and network development	SP30	PPT29	H028	AS26
5	4	Counselling supervision and support	SP31	PPT30	H029	AS27
5	5	Counsellor ethics	SP32	PPT31	H030	AS28
5	6	Monitoring, evaluation and quality assurance	SP33	PPT32	H031	N/A
5	7	Counsellor records and data management	SP34	PPT30/33	H032	AS29
5	8	Field visits	SP35	N/A	H033	N/A

Cover and acknowledgements - Part I and part II	OTHER folder
Table of contents	OTHER folder
Introduction and how to use the manual for facilitators	OTHER folder
Introduction and how to use the manual for participants	OTHER folder
Guidelines for preparation of training	OTHER folder
Training programme	OTHER folder
Training resources outline	OTHER folder
Pre- and post- training knowledge questionnaire	OTHER folder
Pre- and post- training knowledge questionnaire answer sheet	OTHER folder
Pre- and post- training knowledge questionnaire result sheet	OTHER folder
Evaluation post-session	OTHER folder
Evaluation post-course	OTHER folder
VCT service forms	VCT SERVICE FORMS folder
Recommended reading	OTHER folder