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Government of India

Induction Training Module for Counsellors under National AIDS Control Programme

An Integrated Training Module for ICTC, ART and STI Counsellors

Facilitator Guide

November, 2014

Prepared by

NACO

and

saksham

TISS

National AIDS Control Organization,
(Basic Services Division)
Ministry of Health & Family Welfare,
Government of India, New Delhi.

GFATM-Project Saksham,
(HIV/ AIDS Counselling under NACP)
Tata Institute of Social Sciences,
Mumbai.

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Government of India

INDUCTION TRAINING MODULE FOR COUNSELLORS UNDER NATIONAL AIDS CONTROL PROGRAMME

An Integrated Training Module for ICTC, ART and STI Counsellors

November, 2014

R.K. JAIN
Additional Secretary
& Director General (CGHS)
Tel. (O) : 011-23062985
Telefax : 011-23062579

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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

FOREWORD

The National AIDS Control Programme (NACP) was launched in 1992 and presently is in its Phase IV (2012-17). Due to rigorous implementation of NACP, there has been a reduction of 57% in the new HIV infections over the last decade in the country. The adult HIV prevalence has also witnessed a fall from 0.41% (2001) to 0.27 % (2013). Raising awareness, behavior modification and psychosocial support through skilled counsellors constitute a vital part of our strategy to combat HIV/AIDS in India.

The National AIDS Control Organization (NACO) has expanded the HIV counselling services by making counsellors available up to the sub-district level of public health facilities providing Integrated Counselling and Testing (ICTC), Sexually Transmitted Infection (STI) prevention, and Anti-Retroviral Treatment (ART) services. The number of counsellors continuously increased to more than 8000 at present, which highlights the importance being given to the prevention and control of HIV in the country.

NACO with the support of 36 State AIDS Control Societies (SACS) regularly undertake well designed trainings and capacity building of the counsellors at the induction as well as refresher levels in order to ensure quality counseling services under NACP.

NACO has been continuously involved in planning, implementation, monitoring, evaluating and improvising of counsellors training modules. In this context, during the current year NACO in collaboration with TISS has developed an Integrated Induction Training Module for all the counsellors working in ICTC, ART & STI facilities. The joint efforts of Basic Services Division (BSD) along with Care, Support and Treatment (CST) and Sexually Transmitted Infections (STI) Divisions of NACO as well as Tata Institute of Social Sciences (TISS) for bringing out this module are greatly appreciated. All the SACS need to ensure an efficient implementation of the training module.

(R. K. Jain)
Addl. Secretary
National AIDS Control Organisation

Dr. Ashok Kumar, M.D.
F.I.S.C.D & F.I.P.H.A
Dy. Director General
Tele :91-11-23731956
Fax :91-11-23731746
E-mail :ddgak.dac@gmail.com

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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
एड्स नियंत्रण विभाग
6वां तल, चन्द्रलोक बिल्डिंग, 36 जनपथ, नई दिल्ली -110001
Government of India
Ministry of Health & Family Welfare
National AIDS Control Organization
6th Floor, Chandralok Building, 36 Janpath, New Delhi - 110 001

PREFACE

The project Saksham at Tata Institute of Social Sciences (TISS) was initiated with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) support under its counselling component. This project is functioning with the objective to strengthen the capacities of the institutions and counsellors to meet the long term goals of the National AIDS Control Programme (NACP) in India. The National AIDS Control Organisation (NACO), Government of India (GOI) works in close collaboration with TISS to address the training needs of HIV/AIDS counsellors in India.

Under NACP, the counsellors work at Integrated Testing and Service Centers (ICTC), Sexually Transmitted Infections (STI) Units and Anti-Retroviral Treatment (ART) Centers throughout India. These counsellors provide information regarding HIV/AIDS and enable behavior change in the clients. In addition to this, they also offer necessary psychosocial support required for addressing HIV/AIDS related stigma and discrimination faced by People Living with HIV/AIDS (PLHIV). Thus, counselling forms the backbone of NACP in providing comprehensive care to the PLHIVs. Quality training plays a crucial role in building and sustaining the counsellors' capacity to effectively meet the varied needs and expectations of clients.

Earlier, the training modules for counsellors working at ICTC, STI and ART units were separate and their induction training was of 12 days, each. Because of significant similarities in the job responsibilities and the programme needs, it was felt desirable to sensitize and train counsellors from all these three settings on a common standardized module. The matter related to integrated induction training for counsellors working in ICTC, STI and CST was deliberated with the subject specialists, programme managers and training experts, who unanimously agreed that the existing induction training to be remodeled while not sacrificing the desired objectives of the comprehensive induction training. It also called for reducing the duration of the induction training to 7 days.

The outcome of continued efforts of over the last nine months has resulted in bringing out this integrated training module which will make a significant contribution in fulfilling the goals and objectives of National AIDS Control Programme. This integrated induction training module will ensure that counsellors are oriented and sensitized during the training, while the consolidation of the learning happens at the service delivery settings.

(Dr. Ashok Kumar)

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1. Ms Annie Shajan, Sr. Programme Officer, Saksham-TISS, Mumbai.
2. Ms Dharmishtha Nanawati, Capacity Building Officer, Saksham-The Maharaja Sayajirao University of Baroda, Vadodara.
3. Dr Neelam Sukhramani, Faculty-in-charge, Saksham-Jamia Millia Islamia, Delhi.
4. Dr Nilesh Gawde, School of Health Systems Studies, TISS, Mumbai.
5. Dr Sudhir Chawla, JD CST, SACS, Gujarat
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9. Dr Shalini Anant, Technical Specialist – Counselling, Saksham-TISS, Mumbai.
10. Ms Shivranjani Kulkarni, Capacity Building Manager, Saksham- TISS, Mumbai.
11. Ms Shweta Bajaj, Zonal Program Manager, Saksham-TISS, Mumbai.
12. Dr Veena Yardi, Assoc. Prof., Dept of Foods, Nutrition and Dietetics, Nirmala Niketan, Mumbai.
13. Ms Nurith Samuel, Ex-Capacity Building Officer, Saksham-TISS, Mumbai.
14. Dr Poonam Sharma, Capacity Building Officer, Saksham-TISS, Mumbai.
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CONTENTS

LIST OF ABBREVIATIONS

ABC	Abacavir
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ARS	Acute Retroviral Syndrome
ARSH	Adolescent Reproductive and Sexual Health Programme
ART	Anti Retroviral Therapy
ARV	Anti retroviral
ASHA	Accredited Social Health Activist
ATT	Anti Tubercular Therapy
ATV/r	Atazanavir / Ritonavir
AZT	Zidovudine
BCC	Behaviour Change Communication
BP	Bridge Population
BPL	Below Poverty Line
CBT	Cognitive Behaviour Therapy
CCC	Community Care Centre
CD4	White Blood Cells which are part of Immune system / Cluster of Differentiation 4
CDC	Centre for Disease Control
CLHA	Children living with HIV/ AIDS
CLHIV	Children living with HIV
CMV	Cytomegalo Virus
CNS	Central Nervous System
CP	Clinical Psychologist
CPT	Co-trimoxazole Prophylactic Treatment
CRC- UN	United Nations Convention for Child Rights
CSF	Cerebrospinal Fluid
CST	Care, Support and Treatment
D4t	Stavudine
DAC	Department of AIDS Control
DIC	Drop-in-Centre
DLN	District Level Network
DMC	Designated Microscopy Centre
DNA	Deoxyribonucleic Acid
DOTS	Directly Observed Treatment - Short course

DTO	District Tuberculosis Officer
EBF	Exclusive Breast Feeds
EC	Exposure Code
EFV	Efavirenz
EID	Early Infant Diagnosis
ELISA	Enzyme Linked Immunosorbent Assay
ERF	Exclusive Replacement Feeds
FDC	Fixed Dose Combination
FGD	Focussed Group Discussion
FNAC	Fine Needle Aspiration Cytology
FSH	Follicle Stimulating Hormone
FSW	Female Sex Worker
HAART	Highly Active Antiretroviral Therapy
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Worker
HEI	HIV Exposed Infant
HIV	Human Immuno-deficiency Virus
HRB	High Risk Behaviour
HRG	High Risk Group
HSV	Herpes Simplex Virus
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Scheme
ICSI	Intra-Cytoplasmic Sperm Injection
ICTC	Integrated Counselling and Testing Centre
ID	Incidence Density
IDU	Injecting Drug User
IEC	Information, Education, Communication
IIPS	International Institute of Population Sciences
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPC	Indian Penal Code
IR	Incidence Ratio
IRIS	Immune Reconstitution Inflammatory Syndrome
ITP Act	Immoral Trafficking Prevention Act,1986
IUD	Intra Uterine Device
IUI	Intra Uterine Insemination

IVF	In Vitro Fertilisation
LAC	Link ART Centre
LAP	Lower Abdominal Pain Syndrome
LFU	Lost-to-follow up
LGV	Lympho Granuloma Venereum
LH	Luteinising Hormone
LPV/r	Lopinavir / Ritonavir
LWS	Link Worker Scheme
MARP	Most At Risk Population
MCH	Maternal and Child Health
MDR-TB	Multi-Drug Resistant Tuberculosis
MO	Medical Officer
MSM	Men who have sex with men
MTCT	Mother to Child Transmission
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NBSS	National Behaviour Surveillance Survey
NCAER	National Council of Applied Economic Research
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NNRTI	Non-nucleoside Reverse Transcriptase Inhibitor
NRHM	National Rural Health Mission
NRTI	Nucleoside Reverse Transcriptase Inhibitor
NSEP	Needle and Syringe Exchange Programme
NVP	Nevirapine
OI	Opportunistic Infections
OPIM	Other Potentially Infected Material
ORS	Oral Rehydration Salt / Solution
ORW	Outreach Worker
OVC	Orphans and Vulnerable Children
PCP	Pneumocystis Pneumonia
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PI	Protease Inhibitor
PID	Pelvic Inflammatory Disease
PID	Personal Identification Digit

PITC	Provider-Initiated Testing and Counselling
PLHA	People living with HIV /AIDS
PLHIV	People living with HIV
PLWHA	People living with HIV/AIDS
PPE	Personal Protective Equipment
PPTCT	Prevention of Parent- to- Child Transmission
PSW	Psychiatric Social Worker
PTSD	Post Traumatic Stress Disorder
QAP	Quality Assurance Programme
RCH	Reproductive and Child Health
RNA	Ribonucleic Acid
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SC	Source Code
SCC	Short Course Chemotherapy
SIMS	Strategic Information Management System
SLRC	State Level Rehabilitation Committee
SMO	Surveillance Medical Officer
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
STS	Senior Treatment Supervisor
TB	Tuberculosis
TCA	Trichloro Acetic Acid
TDF	Tenofovir
TG	Trans Gender
TI	Targeted Intervention
TISS	Tata Institute of Social Sciences
TRG	Technical Resource Group
UIP	Universal Immunisation Programme
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VAS	Visual Analogue Scale
WBC	White Blood Corpuscle
WHO	World Health Organisation
WLHIV	Women living with HIV
ZDV	Zidovudine
3TC	Lamivudine

INSTRUCTIONS TO TRAINING INSTITUTES

A NOTE TO THE TRAINING ORGANISERS ABOUT CONDUCTING INDUCTION TRAINING USING THIS MODULE

This module is meant for conducting integrated induction training of HIV counsellors working in ICTC, ART and STI settings. The training carried out through this module is not aimed to be exhaustive, but rather to orient counsellors to HIV and STI counselling and to equip and empower them to deal with different issues commonly faced in ICTC, ART and STI settings.

The training consists of one session on orientation to the training and 23 sessions on the topics covered in the training. Each session has clearly stated objectives and session plans. Each session is divided in up to three sections:

- Facilitators' Guide (FG), which provides the session plan and an overview of the training content.
- Power Point (PPT) presentation, which aids the facilitator during the session. This section may or may not be there depending upon its need based on the session plan in FG.
- Handout (HO), which provides background information, homework exercises and additional reading for the participants.

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

1. SETTING THE STAGE FOR TRAINING

No training is complete without the necessary preparation, even if the best training modules and resources are available. The preparation has to set the stage for learning and for achieving the training objectives. This includes:

- **Adult learning styles** must be planned to ensure involvement of all participants. Learning through discussions, role-plays, brainstorming sessions and games helps increase the participants' receptivity and learning potential. It also helps the facilitator understand the knowledge level and experience of the participants.
- **Field visit** to co-located ICTC, PPTCT, STI, ART, DMC, or blood bank can further illustrate key points and support the learning. A detailed guideline for conducting field visit is included in Annexure 1.

- **Local language** and terminology should be used as far as possible during the training in settings where participants are more conversant with the local language. To make the best use of time during the training and to enhance learning, it is advised that the organisers get all the annexure material translated in the local language.
- An introduction and a conclusion to every topic helps the participants recapitulate the main messages from the modules. **Key messages** are added at the end of every session. The facilitator needs to make sure the participants understand and retain these, thus they need to be emphasised.
- **Translate all the material in the annexure** for all the sessions into the local language in advance. This is because the annexure is supposed to be read and used by the participants, and a lot of time can be saved and learning can be significantly enhanced if the language is easily understandable for the participants. **Also translate the handout for Enhancing Counsellor Competence** because that is also to be read and used by participants.

Although the sessions have been designed to address all aspects of the training, the ultimate success of the training lies with the facilitators and the training coordinator. This includes assigning the modules to facilitators/resource persons with appropriate experience and assuring that the facilitators familiarise themselves with the handouts, activities and presentations well before the training.

The organisers must send the relevant session to the facilitator well in advance. The facilitator needs to be asked to follow the session plan and not carry out a session just on one's own. The activities, film viewing, homework assignments and role plays given in the sessions are of utmost importance. **The training organisers must make sure to carry out these activities as per the session plans** to enhance learning and not follow merely a lecture method.

The organisers also need to inform the participants in advance that the training will be **very rigorous** and that the evenings will also be utilised for training related activities. The participants need to thus come prepared to dedicate the entire 7-day period completely for the training and NOT plan any recreational activity for the evenings.

2. TRAINING SCHEDULE

The complete set of modules covers a continuous seven (7) day programme (including half day's field visit and a day of holiday suggested on the third or fourth day of the training). However, more sessions may be added according to their relevance to the culture and epidemic profile of the location where the training is conducted, time available for the training and the participants' level of practical experience in hands-on client management.

To fit the very tight schedule of the training, the training has been made residential even for the local participants. It is suggested that the organisers **insist that all the participants reach the training venue**

on the evening prior to the first day, such that they get ample rest before the training begins, and so that there are no chances of any participant missing any session due to delays in travel. Similarly, the participants' **return journey needs to be planned the next morning after the training is over, or, at the earliest - not before 9 pm** (after dinner) on the last day, to complete the post-training assessment, evaluation and other formalities **after** covering the full day's training on the last day. Participants need to also be requested to return from the breaks (lunch, tea) and be settled well before the next session's time, so as to utilise the time most optimally.

Further, it is suggested that the training could be started on a Wednesday, Thursday or Friday so that the participants as well as organisers get a break on Sunday around the middle of the hectic training schedule. The training needs to start everyday at 9:00 am (soon after the breakfast), and go on till around 6:15 pm so that the curriculum can be covered within the stipulated time. The organisers need to also **make sure the evenings are utilised for watching films** on the specific days mentioned in the schedule, and that the **participants are reminded to carry out the group discussions and / or assignments** needed for the next day's training. Thus, the participants need to come prepared that the training period needs to be a time completely dedicated to the training.

3. KEY CONSIDERATIONS FOR TRAINING

A good training program is supposed to equip counsellors with **communication skills** needed in a counselling setting. There will also be a need to develop **attitudes and skills for coping with emotions like fear, anger and embarrassment**. Learning objectives in these areas can be achieved only when the **teaching methods are interactive** and involve the participants in practising communication skills and in expressing their feelings.

Training for counsellors should be **competency-based**, bearing in mind the realities of the situation in the field. The most important method of training in any situation depends on the nature of the learning objectives. For example, the learning of facts requires different teaching methods from the learning of skills. Thus, even though participants and facilitators may be most familiar with the lecture method, this method alone is **NOT** enough to learn communication skills or counselling skills.

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

3.1 Group size

The group size for classroom counselling training should not exceed 25 participants. The smaller the group, the more quality time and opportunity are afforded for participants to practise their skills (see also 'Group discussions' later in this section).

3.2 Interactive training strategies

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

- Role-play exercises
- Group discussions
- Educational games
- Case-based small group learning activities
- Brainstorming sessions

Presentations

A PowerPoint (PPT) presentation can be used to highlight key points. Facilitators need to promote interaction during and in addition to PPT presentations by:

- Explaining in one's own words rather than reading out the slide word-by-word.
- Use of individual/group exercise HOs that participants complete
- Encouraging questions from the group following the presentation
- Conducting group work to discuss and answer questions
- By assigning issues or tasks to small groups

Visual aids

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

Role-plays

Role-plays need to be used to 'act out' specific roles of identified people or to act out a scene. This is useful when practising skills such as counselling and to explore how people react to specific situations. Please refer to Annexure 2 for guidelines for doing role plays.

Group discussions—large group discussions

Group discussion may be carried out in the large group (involving all the participants) or in smaller groups of 3-4 participants each. Please refer to Annexure 3 for guidelines on group discussions.

Case studies

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

The advantages of case studies are that they allow an examination of problem that mirror the real world, and help facilitator build participants' confidence and problem-solving skills.

> The facilitators' guide for each specific module needs to be referred to know what to do in each specific module. In some module the case studies may need to be shared with the participants in advance while in some others they may need to be given only during the session.
>
> Participants who role-play 'counsellors' in these activities should not see the cases before the commencement of the activities. This will ensure that the 'counsellor' gains experience in acquiring information from 'clients'. In 'real-life' situations, clients do not send all their details to the counsellor in advance; rather the counsellor uses counselling skills to gather information from the client. Conducting role-plays in this way ensures that training approximates real-life situations.

4. USE OF EXTERNAL RESOURCE PERSONS/ FACILITATORS

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

- Participants have access to 'experts' in their respective fields.
- Participants establish important linkages with external individuals and agencies that will assist them in their clinical work.
- External presenters add variety to the programme of regular facilitators.

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

- Inadequately briefed speakers may not focus on the topic.
- Speakers may present no 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.

Follow these guidelines to maximise the use of external facilitators or guest speakers:

- **Ensure that the speakers are adequately briefed**, verbally as well as in writing, in terms of what is expected of them. Provide a guideline that specifies the content to be covered, the methodology to be used, the level and type of language, and the time frame. In addition, clearly describe the type of participants present in the training and the overall aims of the training programme. Please ask the facilitator to come half an hour early and take time to brief them clearly about these things. **Do insist that the time frame is followed** under all circumstances, so that the sessions do not keep spilling over into each other.
- While inviting a facilitator who has conducted a session earlier, please ask them to go through the session completely because the **sessions have been modified**, thus they should not assume that they know what the session is like.
- Choose speakers who are known to be effective for your goals. Alternatively, 'groom' them to attain the desired outcome.
- The regular facilitator should be present where possible if the external speaker conducted the session. This ensures continuity in case an issue arises. In addition, regular facilitators are also able to observe and provide useful feedback to the resource persons/guest speaker.
- Always ensure that external facilitators/guest speakers are given a feedback from both the organisation and from the participant evaluations so as to continue improving their sessions.

5. ASSESSING PARTICIPANTS' KNOWLEDGE LEVELS

Before beginning the training, assess the participants' knowledge of HIV and STI and the counselling process with Pre- & Post-Training Assessment Tool.

The information gathered through the tool can be used to fine-tune the training to the knowledge level of the participants. At the end of the training, the same assessment tool can be administered to determine how much knowledge and skills the participants have gained and how effective the training has been.

6. ASSESSING TRAINING QUALITY

It is important for the training coordinator to assess the quality and effectiveness of the HIV counselling training. This feedback will help in conducting future trainings, improving sessions and identifying appropriate resource persons for trainings.

7. KEY CONSIDERATIONS FOR SUCCESSFUL TRAININGS

1. Ensure that the **material** required for each session have been made available well in advance. This will prevent usage of wrong HOs or case studies for different sessions.
2. Encourage all participants to be **present** for the ENTIRE training. It is suggested that certificates may not be given to participants who do not attend the entire course. In the event of an emergency, in which case a participant cannot complete the course, the facilitator should negotiate with the participant to complete the missed segments at a future course and then hand over the certificate. Note that this strategy is critical to ensuring the quality of counselling. If a participant misses any segments of the training programme, the facilitator should brief the participant about the missed segments when they return. This will ensure that they do not put their role-playing partner to a disadvantage when they do role-plays or other activities.
3. Ensure that the training sessions commence on **time**. Request all participants to stay at the venue, as it is a residential training even for the local participants. Those who insist on going home everyday must arrive in time and leave only after all the evening activities are completed. Inform them that there is much material to be covered each day, and it can be very disruptive to have participants arrive late or leave early at the training sessions.
4. The organising team members need to be constantly there in the training sessions, and be ready with ample number of **energisers** to keep the participants interested and alert during the training.
5. **Discussions on sensitive issues** like sex, sexuality, HIV and STIs can be difficult, especially in induction training. It is important for the facilitators to make a statement about this potential discomfort to participants at the commencement of the course and invite the course participants to discuss their concerns with the facilitator on an individual basis. The training group must respect a participant's decision to pass on a specific question or activity.
6. Encourage participants to use the **question box**. Questions on sensitive issues can be written down on a piece of paper and dropped in a question box. The questions should be drawn out at the end of each day and discussed during a 'question- and-answer' session just before the close of the day.
7. Maintain **confidentiality** at all times. This should be the case, especially if counsellor participants refer to their own personal experiences or those of their clients. Facilitators are urged to ask all participants to agree to maintain the confidentiality of all fellow participants. Facilitators need to also instruct participants to never share the clients' names or other identifying information during any discussions, and to follow the same principle even beyond the training programme.
8. Encourage participants to **respect individual differences**. Participants frequently come from different ethnic and cultural groups; and thus their lifestyles, beliefs, personal experiences and expertise may differ.

9. Encourage participants to listen carefully and with empathy, and respect each other's contributions, opinions and experiences. Explain that it is important in the training, and as professionals, to practice **active listening** by allowing each other to share their own experiences and opinions with the group.
10. Create a **congenial environment** in which each participant feels comfortable to ask questions. Participants need to be able to ask questions about what they do not understand. Again, the question box can be a useful tool.
11. Due to the constant change in transmission patterns, treatment, perceptions, attitudes, and so on, participants should be reminded to consistently **update** their information regarding HIV.
12. Ensure that you get **the right participants**. Establish clear criteria for participation and communicate these criteria not only to the participants but also to their employers.
13. Ensure that an **evaluation form** is distributed to participants at the end of the training. These need to be completed by the participants and placed in the 'evaluation box' to be collected by the facilitator once all the forms have been submitted.
14. Consider the advantages of providing **meals** to the participants. The training course follows a very strict timetable. It is therefore essential that sessions commence and conclude according to the schedule. The provision of morning tea, lunch and afternoon tea at the site of training has the advantage of ensuring that all participants promptly return from breaks. It also creates flexibility within the programme should there be a need to shorten breaks or complete work within a break. Further, it contributes to the general satisfaction of participants and allows them to focus on the study material to a greater degree.
15. The organisers could also consider the possibility of **keeping the meals and refreshments light and nutritious**, like home food, rather than heavy. For example, if possible, emphasis could be placed on salads, seasonal / local fruits, buttermilk, lemonade in addition to or if possible instead of heavy desserts, rich and spicy food, biscuits, tea / coffee. This can help in keeping the participants' digestion intact even after 8 days of eating outside food, and could also help them feel alert and prevent lethargy.

ANNEXURE

Annexure 1: Guidelines for field visits

Field visit should be organised to provide the participants with hands-on understanding of the operation and day-to-day functioning of settings like ICTC/PPTCT/ART/STI/Blood Bank. Field visit should include observation of activities at the centre, interaction with staff members and with clients visiting the centre. It should be followed by a debriefing session during which participants discuss their observations and lessons learnt.

Planning and conducting a training field visit by the training coordinator Ideally one month before the training, start to plan and organise the visit to settings where there are 3 or more co-located centres like ICTC/PPTCT/ART/STI/Blood Bank.

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

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

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

The day before the field visit

Call the centre in-charge and reconfirm the visit. Provide important updates on the training that you had not anticipated when you first spoke to them (for example the final number of visitors).

On the day of the visit

Field visit teams:

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

The training coordinator should provide

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

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

1. Describe the flow of clients to your centre.
2. How many clients/patients visit the centre each day? How are they managed?
3. Describe the process on how clients/patients move through the centre—from when they enter the centre to the time they receive reports.
4. List the different registers and records maintained.
5. How are records maintained? Where are they stored?
6. Who prepares the monthly reports? Where is data extracted from the monthly report?
7. Describe the role and responsibility of each staff member in the centre.
8. What are the changes the centre has undergone since its inception?

9. Where are the monthly reports sent?
10. What does the centre do with the client data they collect?
11. What linkages and referrals have been set and how?
12. Who supervises the staff and how?
13. Is information, collected on clients, shared with the staff? When and how?
14. Are regular meetings held within the centre? Who attends the meeting, what are the issues discussed in these meetings?
15. In case the counsellor needs help whom do they go to?
16. Is there a DOTS/DMC centre within the hospital?
17. What are the different IEC materials you use?
18. What other monitoring data do you collect (clients satisfaction surveys, information received from staff during review meeting)? How are they used?
19. Are any other tests offered at the centre?
20. Is emergency testing performed at the centre? What is the procedure followed?

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

Word of caution:

If the participants are visiting a TI centre, **please sensitise them** in advance, so that they do not look at the clients or staff with inappropriate amazement, or ask awkward personal questions.

Information that the team at the centre could share:

- Clinician (counsellor, nurse and or physician)
  - For how long have they been working with the ICTC/STI/PPTCT/ART centre?
  - How many clients/patients visit their centre each day?
  - Describe the client/patient flow at the centre?
  - Share information on forms, records, registers and reports that they complete at the ICTC/STI/PPTCT/ART centre.
  - When do they complete these records (e.g., when the patient is in front of them or after the clinical visit)?
  - Do they record information for each client/patient?
  - What other reports does each staff member write or contribute to?

- To whom do they submit the reports/forms?
- What comments do they have on the process of completing the forms and reports?
- Do they feel like the effort they put into reporting is worth it?

- Support staff:
  - Explain their role in the centre
  - What (if any) are the records they maintain?
  - What thoughts/feedback do they have around this entire process of running the centre?

- Programme manager and/or clinic director;
  - Share their responsibility in reference to the ICTC/ PPTCT/ART/STI centre.
  - How do they supervise their staff?
  - What ICTC/PPTCT/ART/STI reports are they responsible for submitting? Who do they submit them to?
  - Share the most recent report submitted to SACS—do they try to interpret any of the data collected at their centre? What additional information do they get from this data? What do they do with the data here at a local level?
  - Share examples of initiatives they have undertaken using the data from the monitoring process.
  - What other monitoring data do they collect? For example do they have clients/ patients?
  - Fill in satisfaction surveys? Do they interview clients/patients to find out about their experience with your service?
  - How do they get monitoring feedback from their staff?

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

After the training is completed:

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

Annexure 2: Guidelines for doing role plays

Role plays can serve the important purpose of helping the participants practice skills in a safe environment, where no harm can be caused to a 'real' client, and the presence of the facilitator can provide an opportunity to hone one's skills. However, role plays may sometimes be seen as a way of practicing one's acting skills (!), which might lead to losing a lot of precious time and also take away from the primary purpose of the training. Thus, the organisers as well as facilitators need to guide role plays well.

The time limit for a role-play is 15-20 minutes. The facilitator should **hand over the cases only to the participants playing a client's role.** The 'counsellors' should not be permitted to read the cases. This is to make the role-play as real as possible, just as in the real scenario the counsellor does not know the case in advance. The facilitator needs to emphasise that **the focus is on what a 'counsellor' does** in the role play and **not on the 'client's' acting.** The group observers need to observe and **give feedback on the counselling process;** not on the individual people enacting the role.

Role-plays have the following advantages:

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

Some individuals may feel intimidated by role-playing. The facilitator must be skilful to ensure that they are relaxed and should:

- Tell the participants that we all are bound to make mistakes while learning counselling. It is **better to make mistakes here** rather than in real settings, because here no one is actually harmed, whereas in the real setting the client may get harmed by our mistakes.
- Keep the role-play appropriate to the learning context.
- Always **first give positive feedback** and then constructively suggest what could have been done additionally or differently.

Annexure 3: Guidelines on group discussions

Group discussions—large group discussions

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

- The participants are involved in problem-solving.
- The participants are active, which stimulates interest.
- The learning process becomes more personal, requiring the facilitator to provide feedback on individual opinions and ideas.
- The facilitator is able to evaluate the participants' understanding and absorption of material.
- The participants have an opportunity to share their acquired expertise and skills, and learn from each other.

Large group discussions require a skilful facilitator who:

- Asks questions or suggests topics, maintains objectivity and directs the discussion to keep it relevant to the learning objectives.
- Stresses confidentiality.
- Ensures that all group members have an equal opportunity to participate and that no one person (including the facilitator!) dominates the discussion.
- Perceives and responds to differences in the group, such as the skills level, education and comfort with the topic.
- Is aware of cultural and gender issues.
- Encourages participants to answer questions and share expertise.
- Is able to politely bring the discussion back to the point if the group begins to discuss issues beyond the session's scope.
- Is respectful and non-judgmental of the participants' ideas and opinions to allow expression of diverse concerns.
- Sticks to the time – starting on time, and leaving adequate periods for discussion.
- Obtains feedback and responses from the group to provide evaluation mechanisms for the session.
- Provides an appropriate balance of supportive and challenging facilitation in which to foster learning.

Group discussion—small group discussions

The advantages of small group discussions include the following:

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

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

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

It is important to provide clear guidelines for group discussions in advance. These can include:

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