National Comprehensive HIV Testing Services Training

Participant Manual

Federal Ministry of Health

Ethiopia

April 2018

Foreword

In Ethiopia, HIV Testing Services (HTS) have been provided for clients at health facilities and at community level for more than a decade with strong attention from the government and partner organizations as these services are important entry points to all other HIV prevention, treatment, care and support interventions. Accordingly the Federal Ministry of Health and regions have been doing impressive jobs to scale-up HTS to ensure service availability across the country for all clients who demand the service. To effectively guide the national endeavors while expanding and strengthening HTS, the country developed national guidelines for HIV testing and counseling in 2007 and National Guidelines for comprehensive HIV prevention care and treatment in 2014 and 2017. These guidelines helped to standardize HTS and ensure availability of quality services at all testing and counseling sites in the country.

HIV testing is the critical first step in identifying and linking PLHIV to HIV care and treatment services. It is also an opportunity to reinforce HIV prevention services among clients who have ongoing behavioral risk. Ethiopia has revised the HIV counseling and testing guideline to support the implementation of targeted testing. The focus of HIV Testing Service guideline revision is to guide programs towards identifying and linking new HIV infections by targeting population groups who are at risk of acquiring HIV in locations and sites with the highest HIV burden. To efficiently identify and link HIV positive clients to care and treatment services. , targeted HTS should be implemented across the range of community and facility-based settings (using PITC, VCT and CBTC approaches).The Ministry is guiding towards a focused approach to test people more likely to be infected with HIV who are identified using epidemiological or population based survey evidences.

To effectively implement the current HTS strategies, it is imperative to revise the existing training materials according to the updated recommendations. The FMOH believes that this comprehensive HTS training material will play an instrumental role in building the capacities of service providers and ensure that the services are available for targeted population groups as well as for any individual or couples who requested for HIV testing and counseling in the country and eventually achieving the national commitment towards the three 90 targets (90% diagnosed, 90% on treatment and 90% has viral suppression).

APPROVAL STATEMENT OF THE MINISTRY

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of In-Service Trainings (IST) at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As part of the national IST quality control process, this national Comprehensive HIV Testing Services IST training package has been reviewed based on the standardization checklist and approved by the Ministry in June, 2018.

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List of abbreviation and acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
CHCT	Couple HIV Counseling &Testing
CPD	Continuous Professional Development
DTS	Dry Tube Specimen
EDHS	Ethiopian Demographic and Health Survey
EIA	Enzyme Immunoassay
EPHI	Ethiopian Public Health Institute
EQA	External Quality Assessment
HAPCO	HIV/AIDS Prevention & Control Office
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HTS	HIV Testing Service
IgG	Immunoglobulin G
IP	Infection Prevention
IQA	Internal Quality Assurance
IQC	Internal Quality Control
IST	In Service Training Center
MOH	Ministry of Health
MTCT	Mother - To -Child Transmission

OGHC Ongoing HIV Counseling

OPD Out Patient Department

PCR Polymerase Chain Reaction

PEP Post Exposure Prophylaxis

PITC Provider Initiated HIV Testing & Counseling

PLHIV People Living with HIV

PMTCT Prevention of Mother-To- Child Transmission

PrEP Pre exposure Prophylaxis

PT Proficiency Testing

QA Quality Assurance

QC Quality Control

SOP Standard Operating Procedure

STI Sexually Transmitted Infections

TB Tuberculosis

TOT Training of Trainers

UNAIDS Joint United Nations Program on HIV/AIDS

VCT Voluntary HIV Counseling &Testing

WB Western Blot

WHO World Health Organization

Table of Contents

Introduction to the Course

This introduction to comprehensive HTS training course gives details of the target audiences, rationale to the training, course goal, objectives, competencies, participant selection criteria, trainer qualification criteria/ requirement, training methods, learning materials including teaching aids, course evaluation, trainee assessment and certification criteria, general guidance for the trainer, daily and end course evaluation and pre and post course assessments.

Rationale of the manual

Ethiopia is one of the most severely affected countries by the HIV epidemic. The HIV epidemic in Ethiopia is becoming more concentrated in urban areas and along major transport corridors. According to the 2016 Ethiopia Demographic and Health survey report the national prevalence of HIV infection was 0.9 % (1.2% for women and 0.6% for men) among adult population.

HIV testing service (HTS) is a key strategic entry point to prevention, treatment, care and support services. This is critically important for individuals and couples to learn about their HIV status and make informed decisions about their future. The ongoing developments in HIV Prevention, Care and treatment has necessitated the revision and updating of the HIV testing and counseling training materials.,. Improved availability of antiretroviral medications and better treatment of opportunistic infections have created the opportunity to expand HTS, Particularly provider-initiated testing and counseling in health facilities thereby increasing access. HIV testing and counseling, refers to the process of giving people professional counseling before and after the HIV test. The process helps people prepare for and understand their test results. Those whose test result is negative can learn ways

to avoid becoming infected, and those who are positive can learn how to live longer, healthier lives and prevent transmission to others. In this way, HTS offers an important entry point to HIV prevention, care, and support.

This competency based 12 days Comprehensive HTS training is designed to build the capacity of service providers on provision of quality HTS for targeted population groups. It will enable service providers to early identify, timely link to care and treatment and, improve retention. This course has more of practical extent that gives emphasis for quality**,** to acquire and apply new knowledge and skills using competency-based assessment instruments, develop clinical experience sharing through demonstrations and role plays and conduct a comprehensive HTS training course for service providers. Hence the training course will support the provision of quality Comprehensive HTS in an integrated manner.

Course competencies

The following are the competencies expected to be acquired and executed after the completion of the training:

- Express the current global, regional and national distributions of HIV
- Provide HTS at point of care testing service for the targeted groups
- Demonstrate basic communication skills in counselling
- Conduct Pre and Post-test counselling through VCT and CHCT services
- Provide pre -test information for identified target groups through PITC approach
- Perform appropriate sample collection and HIV rapid testing
- Provide successful referral and linkage to Comprehensive HIV care, treatment and support services.

COURSE SYLLABUS

Course Description

This twelve days training course is developed for health care professionals to deliver HIV testing services for different target groups using different approaches (Client and provider initiated testing and counseling) following the standard national protocols and algorithms.

Course Goal

The goal of this course is to enable health professionals acquire HIV testing and counseling knowledge and skills in order to provide the service following national HTS protocols.

Course Objectives

By the end of this course, the participants will be able to:

- Describe basic facts of HIV/AIDS and overview of HTS
- Demonstrate basic HIV counselling skills
- Provide client initiated HTS for individuals
- Provide client initiated HTS for couples
- Employ provider initiated testing and counselling for the target groups following the national guidelines
- Practice point of care HIV testing according to national testing algorithm
- Describe the Standard Operating Procedures(SOP) of HIV testing and Counselling
- Practice appropriate HTS data recording and reporting

Description of training methods and materials

Methods

- Interactive presentation and Discussion
- Group work
- Buzz group Discussion
- Brainstorming
- Demonstration
- Role play
- Case studies
- Guided clinical practice
- Recap

Materials

- Participant manual
- Facilitators guide
- Standardized Power point slides
- Cue cards, protocols and test algorithms
- Role play scenarios and observer check-lists
- Job aid for HIV rapid tests and finger prick procedures
- Course evaluation formats
- Knowledge assessment questionnaire
- Penile model
- Condoms
- HIV rapid test kits
- Timer
- IP Kits (gowns, gloves, capillary tubes, lancets, disinfectants, safety box, waste bags)
- Flip charts and Markers
- LCD projectors, Laptops computers

Participant selection criteria

For basic training, health care professionals will be selected from health care facilities that are actively involved on the day to day health service activities and have an interest to be trained and provide the HTS after training. For TOT training participants will be selected from health facilities, training centers, higher education institutions and HIV program managers at different levels of the health system that are health care professionals and have the basic HTS training. The participants need to be involved in HIV service delivery or HIV program management and have proven experience and facilitation skills.

Trainer Qualification criteria/ requirement

. In selecting HTS trainers to use this training package, the following criteria should be considered:

- Demonstrated proficiency in HTS. The trainer must have Basic training on HTS and training facilitation skills
- The trainers must be health professionals at least with first degree or BSC and have received training of trainers' course on Comprehensive HTS.
- The Comprehensive HTS trainer must have experience using the master learning approach to provide the training, which is conducted according to adult learning principles:

- Learning is participatory,
- Relevant, and practical and uses behavior modeling,
- Competency-based and incorporates humanistic training techniques.

- HTS trainers for this course must be aware of basic principles of transfer of learning to help the participants translate the new knowledge and skills in to comprehensive HTS provision at their workplaces, and improve job performance.
- It is strongly recommended that at least two clinical trainers per class of trainees conduct this HTS course.
- The trainers can divide roles and responsibilities according to their expertise, such as sharing the roles of "coach" and "facilitator" throughout the course.

Methods of course evaluation

Participant evaluation

- Pre- and post-course knowledge assessment
- Skill assessment of observed practice during role plays and practicum
- Skill assessment of rapid HIV testing during classroom demonstrations
- Facilitators daily evaluation
- Strict attendance (100%)
- In addition to full attendance and appropriate assessment findings during role plays and practical sessions, Participants need to score more than 70% for Basic training and more than 80% for TOT in the post course knowledge assessment to qualify for certification.

Course evaluation

- Daily evaluation will be done at the end of each day except the last day
- End course evaluation we be conducted at the completion of the course

Post training evaluation or follow up

- Supportive supervision and mentoring will be done

Course Duration

- The total duration for this training is twelve days, which includes a one day practical session.

Training Venue Selection and Suggested class size

Comprehensive HTS training need to be delivered in ISTC, CPD or other designated center and Assuming role plays and other group activities, the recommend number of participants need to be 20-25 participants per class.

National Comprehensive HIV Testing Services course schedule
DAY 1 (Monday)

TIME	ACTIVITY
8:30-10:30 AM	Registration (50 min.) Opening speech (10 min.) Participant's introduction (15 min.) Participant's expectation (15 min.) Establish group rules (15 min.) Course overview (goals, objectives, course (15 min.)
10:30-10:50 AM	**HEALTH BREAK**
10:50-11:30 AM	Pre-test (40 min.)
11:30-12:30 AM	**BASICS OF HIV/AIDS** Epidemiology of HIV (20 min.) Ways of HIV transmission (10 min) Window period (10 min.) Discussion (20 min.)
12:30-2:00 PM	**LUNCH BREAK**
2:00-2:25 PM	HIV Prevention methods (25 min)
2:25-3:00 PM	HIV Prevention methods continue (35 min.)
3:00- 3:35 PM	**OVERVIEW OF HTS** Overview of HTS in Ethiopia (10) Targeted HTS (10) HTS as an essential component of HIV prevention, care and treatment (15)
3:35-3:55 PM	**HEALTH BREAK**
3:55-4:20 PM	**INTRODUCTION TO HIV COUNSELING** Definition of HIV counseling (5 min.) HIV counseling involves (10 min.) Qualities of a good counselor (10 min)
4:20-4:35 PM	Common errors in counseling. (15 min.)
4:35-5:15 PM	Day summary

5:15- 5:30 PM	Daily evaluation

DAY 2 (Tuesday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 1
9:00- 10:10 AM	**SELF CONCEPT, SELF-AWARENESS, ATTITUDES, VALUES AND PREJUDICES and CULTURE** Definition of self- concept Model (5 min.) Elements of self-concept Model (20 min.) Concepts of self- awareness (10 min.) Concept of attitude, values, prejudices (10 min.) Concept of culture in relation to counseling (10 min.) Summary (15 min.)
10:10-10:30 AM	**BASIC COMMUNICATION AND COUNSELING SKILLS** Definition & importance of Communication (10 min.) Communication skills (10 min.)
10:30-10:50 AM	**HEALTH BREAK**
10:50-12:30 AM	Communication skills continued (45 min.) Elements of good Counseling (15 min.) Basic counseling skills (40 min.)
12:30-2:00 PM	**LUNCH BREAK**
2:00-3:30PM	Skills and attributes of the couples counselor (30min.) Solution- focused model of couples counseling (40 min.) Blame Mediation Skills for Easing Tension and Diffusing (20 min.)
3:30- 3:50 PM	**HEALTH BREAK**
3:50-5:20 PM	Counseling Process (10 min.) HIV counseling room Setting (20 min.) Role-play (45 min.)

	Daily summary (15 min)
5:20- 5:30 PM	Daily evaluation (10 min.)

DAY 3 (Wednesday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 2
9:00-10:30 AM	**Ethical and Policy considerations for HIV Testing and Counseling In Ethiopia** Key ethical principles for HIV counselors (35 min.) Client rights during counseling and testing (20 min.) HTC Policy statements in Ethiopia (35 min.)
10:30-10:50 AM	**HEALTH BREAK**
10:50-12:30 AM	**VCT** Introduction of VCT (15) Structure of VCT Protocole (15) Benefits of VCT (10) Introduction of Counseling Protocol (20) Component 1: Introduction and Orientation to the Session (30 min.) Summary (10 min)
12:30- 2:00 PM	**LUNCH BREAK**
2:00- 3:30 PM	Component 2: Risk Assessment (40 min.) Component 3: Explore Options for Reducing Risk (50 min.)
3:30- 3:50 PM	**HEALTH BREAK**
3:50- 5:20 PM	Component 4: HIV Test Preparation (25 min.) Role-play Components 1- 4 (45 min.) Large group process (Role play presentation & Discussion) (25 min.)
5:20-5:30	Daily evaluation (10 min.)

DAY 4 (Thursday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 3
9:00- 10:30 AM	**Counseling a Client with HIV-Negative Result** Component 5: Provide HIV Negative Test Result (20 min.) Component 6: Negotiate a Risk Reduction Plan (15 min.) Component 7: Identify Support for Risk Reduction Plan (10 min.) Component 8: Negotiate Disclosure and Partner Referral (20 min.) Role-play Components 1- 8 (25 min.)
10:30-10:50 AM	**HEALTH BREAK**
10:50- 11:55 AM	Role-play Components 1- 8 continued (20 min.) Large group process (Role play presentation & Discussion) (30 min.) Summary (15 min)
11:55- 12:30	**Counseling a Client with HIV- Positive Result** Review Exercise (30 minutes)
12:30-2:00 PM	**LUNCH BREAK**
2:00- 3:30 PM	Component 9: Provide HIV Positive Test Result (20 minutes) Component 10: Provide Linkages to Care, Treatment, and Support Services (20 minutes) Component 11: Negotiate Disclosure and Partner Referral (10 minutes) Component 12: Risk Reduction Issues (10 minutes) Role play: Component 1-4 & 9-12 Small group (30 min)
3:30- 3:50 PM	**HEALTH BREAK**
3:50- 5:20 PM	Role play: Component 1-4 & 9-12 Small group continued (30 min)

	Large group process Role play (presentation & Discussion) (30 minutes) Summary (30 min)
5:20- 5:30 PM	Daily evaluation (10 min.)

DAY 5 (Friday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 4
9:00- 10:30 AM	**Introduction to Couple HIV Testing and Counseling** Definition to couple HIV Testing and Counseling (5 min.) Dynamics of couple Group exercise (15 Min) Advantage of couple HIV Testing and Counseling (15 min.) Concept of Couple HTC (5 min) Importance of couple HTC (10 min.) Discordance of couple HTC (10 min.) Myth about discordance (5 min.) Facts about discordance (5 min.) Forming an alliance b/n the counselor & couple (10 min.) Summary (10 min)
10:30-10:50 AM	**HEALTH BREAK**
10:50- 12:30 PM	**Initial Session of the CHTC Intervention** Conditions for Receiving CHTC Services (10 min.) Roles, responsibilities, and expectations (5 min.) Realities of Couples HIV Testing and Counseling (10 min.) Introduce CHTC Protocol (10 min.) **Component 1:** Introduce the couple to CHTC and obtain concurrence to receive couple services (40 min.) **Component 2:** Explore the Couple's Life Stage and Reason for Seeking CHTC Services (20 min.) **Summary** (5 min.)
12:30-2:00PM	**LUNCH BREAK**
2:00- 3:30 PM	**Component 3:** Discuss the couple's HIV risk concerns (20 min.) **Component 4**: Prepare the couple for testing and discuss possible results (10 min.) **Role play small group**: Initial session (30 min.) Role play presentation & discussion (20 min) Summary (10 min)

3:30- 3:50 PM	**HEALTH BREAK**
3:50- 5:25 PM	**Second Session Providing Concordant Negative Results** Component 5-A Provide concordant negative result (10 min.) Component 6 -A Discuss risk reduction with couple (15 min.) **Role play small group:** Concordant negative (20 min.) Role play presentation & discussion (10 min) Summary (5 min)
5:25- 5:30 PM	Daily evaluation (5 min.)

DAY 6 (Saturday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 5
9:00- 10:30 AM	**Providing Concordant Positive Results** Provide the concordant positive results -Component 5-B (10 min) Discuss coping and mutual Support -Component 6-B (10 min) Discuss positive living , HIV Care and Treatment Component 7-B (20 min) Discuss risk reduction - Component 8-B (20 min) Discuss children, family planning, & PMTCT options - Component 9-B (30 min)
10:30-10:50 AM	**HEALTH BREAK**
10:50-12:30 AM	Discuss disclosure and getting support Component 10-B (20min) **Role play small group:** Concordant Positive (30min) Role play presentation & discussion (30 min) Summary (10 min)
12:30- 2:00 PM	**LUNCH BREAK**

2:00 - 3:30 PM	**Providing Discordant Results** Factors influence the transmission of HIV (10 min) Essential counselor responsibilities (10 min) Provide discordant test result 5-C (10 min) Discuss coping and mutual support 6-C (10 min) Discuss positive living and HIV care and treatment 7-C (10 min) Discuss risk reduction 8-C (10 min) Discuss family planning & PMTCT options for discordant couples 9 - C (10 min) Discuss Disclosure –10 -C (10 min), Summary (5 min)
3:30- 3:50 PM	**HEALTH BREAK**
3:50- 5:30 PM	**Role play: Small group** (30 min) Large group: role play presentation & discussion (30 min) Summary (30 min) Daily evaluation (10 min)

DAY 7 (Monday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 6
9:00- 10:30 AM	**Provider -Initiated HIV Testing and Counseling for adults** Introduction (10 min.) Initial Provider-Client encounter (45 min) **Role play& presentation** (35 min.)
10:30- 10:50 AM	**HEALTH BREAK**
10:50- 12:30 PM	Providing HIV Negative result (60 min) Providing HIV Positive (40 min.)
12:30- 2:00 PM	**LUNCH BREAK**
2:00- 3:10 PM	Providing HIV Positive continued (70 min)
3:10 -3:30 PM	**HEALTH BREAK**
3:30- 5:15 PM	**Role play small group:** Providing HIV Positive & Negative (60 min) Large group: Role play presentation & discussion (30 min)

	Summary (15 min)
5:15- 5:30 PM	**Daily evaluation**

DAY 8 (Tuesday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 7
9:00-10:30 AM	**Provider -Initiated HIV Testing and Counseling for Infants, Children and Adolescents** Rationale for testing infants, children and adolescents (30 min.) Testing of Adolescents (20 min.) Testing Infants and Children (40 min.)
10:30-10:50 AM	**HEALTH BREAK**
10:50-12:30 AM	Testing Infants and Children continued (100 min.)
12:30-2:00 PM	**LUNCH BREAK**
2:00- 2:35 PM	Testing Infants and Children continued (20 min.) Disclosing Children their HIV Status (15 min.)
2:35- 3:30 PM	**MONITORING & EVALUATION** SOPs (25 min) Recording and reporting (20 min) Quality Assurance (15 min)
3:30:- 3:50 PM	**HEALTH BREAK**
3:50:- 5:25 PM	Referral and linkage (30 min) Monitoring and evaluation, Indicators (20 min) Exercise on Recording and reporting (40 min) Summary (5 min)
5:25- 5:30 PM	**Daily evaluation**

DAY 9 (Wednesday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 8
9:00- 9:45 AM	**OVERVIEW OF HIV TESTING TECHNOLOGIES** Unit Introduction (5 min.), Expansion of HIV Testing (5 min.), Spectrum of HIV Tests (5 min.), EIAs, Rapid and Complexity (10 min.), HIV Rapid, Advantages and Disadvantages (10 min.), Interpreting Individual HIV Rapid Test Results (10 min.)
9:45:- 10:35 AM	**HIV TESTING STRATEGIES AND ALGORITHMS**

	Strategies and Algorithms (15 min.), Evaluating Test Performance (15 min.), Testing Algorithms (10 min.), Interpreting HIV Status Using Testing Algorithm (5 min.), Possible Outcomes of HIV Testing (5 min.)
10:35:- 10:55 AM	**HEALTH BREAK**
10:55:- 11:50 AM	**SAFETY AT THE HIV RAPID TESTING SITE** Safety Practices (50 min.), Summary (5 min.)
11:50:- 12:30 AM	**PREPARATION FOR TESTING— SUPPLIES, KITS AND WORKING SPACE** Supplies and Materials (10 min.), Identifying Supplies and Materials (10 min.), Examining Test Kits (10 min.), Organizing Work Area (10 min.) Summary (5 min.)
12:30-2:00 PM	**LUNCH BREAK**
2:00-2:40 PM	**BLOOD COLLECTION—FINGER PRICK** Overview of Initial Steps and Finger Prick Procedures (15 min.) Finger pricking (20 min.), Summary (5 min.)
2:40:- 3:30 PM	**PERFORMING HIV RAPID TESTS** Overview of Testing Procedures (30 min.), National Testing Algorithm (10 min), Possible Outcomes in Serial Algorithm (10 min)
3:30-3:50 PM	**HEALTH BREAK**
3:50-4:50 PM	**ASSURING THE QUALITY OF HIV RAPID TESTING** What Is Quality? Why Quality? Who Is Responsible for Quality? (10 min.) Quality Assurance vs. Quality Control (10 min.), Why Do Errors Occur? (10 min.), What Is Quality Control? Internal versus External Quality Control (10 min.), Troubleshooting Invalid Results (5 min.), Maintaining QC and Periodic Review of Records (5 min.), EQA: Definition and Methods (5 min.), Summary (5 min.)
4:50- 5:25 PM	**DOCUMENTS AND RECORDS** Documents Vs. Records (10min), SOPs (10 min), Recordkeeping (10 min) Summary (5 min)
5:25-5:30 PM	Daily evaluation

DAY 10 (Thursday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 9 and Agenda of day 10
9:00- 10:30AM	HIV rapid testing practical session (90 min.)
10:30:- 10:50 AM	**HEALTH BREAK**
10:50: - 12:30 AM	HIV rapid testing practical session continued (100 min.)
12:30-2:00 PM	**LUNCH BREAK**
2:00- 3:30PM	HIV rapid testing practical session continued (90 min.)
3:30- 3:50 PM	**HEALTH BREAK**
3:50- 5:25 PM	Summary and discussion
5:25- 5:30 PM	**Daily evaluation**

DAY 11 (Friday)

TIME	ACTIVITY
8:30-9:00 AM	Recap of Day 10 and Agenda of day 11
9:00- 12:30 AM	**PRACTICAL ATTACHMENT**
12:30-2:00 PM	**LUNCH BREAK**
2:00- 3:30PM	**PRACTICAL ATTACHMENT**
3:30- 3:50 PM	**HEALTH BREAK**
3:50- 5:30 PM	Compile report and lesson learned in each practicum group

Day 12 (Saturday)

TIME	ACTIVITY
8:30- 10:30 AM	Practicum group presentation, Discussion & Feedback
10:30- 10:50 AM	**HEALTH BREAK**
10:50- 12:30 AM	Practicum group presentation, Discussion & Feedback continued
12:30-2:00 PM	**LUNCH BREAK**
2:00- 3:30PM	HTC course summary, Post test, Course end evaluation
3:30- 3:50 PM	**HEALTH BREAK**
3:50- 4:30 PM	The way forward and Certificate and closing

Module 1
Basics of HIV and HTS

CHAPTER 1: BASICS OF HIV

Learning objectives: By the end of this session the participants will be able to:

- Describe the current global, regional and national distributions of HIV
- Explain modes of transmissions of HIV
- Interpret the concept of window period
- Explain about combination HIV prevention methods

Contents

- Epidemiology of HIV
- Ways of HIV transmission
- Window period
- Combination HIV Prevention methods

1.1 EPIDEMIOLOGY OF HIV

Updates of global, Regional & national estimates of HIV/AIDS

HIV is one of the pandemic diseases which is distributed all over the world. The pandemic has affected all regions of the globe although there are variations among regions on the level of burden of the epidemic. Over 35 years after its discovery, human immunodeficiency virus (HIV) is still a major public health threat. HIV ranked the third largest pandemic after the 14th century Black Death and the 1918 influenza pandemic. HIV continues to spread and currently 37 million people are living with HIV (PLHIV) globally. After coming to our attention in 1981, the pandemic has infected over 70 million people, caused over 39 million deaths, and has had a devastating impact. There were around 2.1 million new infection and 1.1 million HIV related deaths in 2016 globally.

Ethiopia has a generalized epidemic with an estimated national adult 15+ prevalence of 0.9% according to EDHS 2016. The epidemic is heterogeneous by sex, geographic areas and population groups. Women are more infected with HIV compared with their men counterparts (women 1.2%, men 0.6%). By geographic location; Gambella has the highest HIV prevalence (4.8%) followed by Addis Ababa (3.4%) while Oromia (0.7) and SNNPR (0.4%) regions have the lowest. HIV prevalence increases

markedly with the number of life time sexual partners among both men & women. Among women, HIV prevalence increases from 0.8% among those with one life time sexual partner to 7% among those t. increase from 0.3% among men having one life time partner to 2.9% among those with 10 or more.. Key populations are disproportionally infected compared with the national average: 23% among Female Sex Workers (FSW), 4.9% long distance truck drivers and 4.2% among inmates.

Ethiopia has made tremendous progress in fighting the HIV epidemic. The HIV prevalence declined by more than 65% in both women and men age 15-49 (from 4.1% for women and 3% for men) in 2004 to (1.4% for women and 0.9% for men) in 2016. New HIV infection has dramatically declined by more than 80% from its peak (141,000) in 1994 to 27,000 in 2016. HIV related deaths fell from 82,000 where it had reached its peak in 2004 to 22,000 in 2016. Similarly, Mother to Child Transmission (MTCT) rate including through breast feeding has fallen by 50% from 35% in 2001 to 16% in 2014. MTCT rate at six week reduced from 19% to 9% in 2001 and 2014 respectively.

Different innovative strategies and recommendations have been developed and adopted to maximize the response and to sustain the gains. In 2015 Ethiopia adopted the UNAIDS "90-90-90" targets. These ambitious targets have the potential to end the AIDS epidemic by 2030. In line with these in 2016, there were an estimated 718,000 People Living with HIV (PLHIV) in Ethiopia of whom 16% (114,000) were young people (15-24). Of the total estimated number of PLHIV, 72% (646,000) knew their status; 59% (426,472) were receiving ART and 47.2% (201,293) had accessed viral load tests, among whom 86% had suppression (<1000 copies/ml). These shows the wide gap in achieving the three 90 targets especially for the second and third 90's. The average national ART unmet need is 41% with wide sub-national variation ranging from the highest (92%) in Ethiopian Somali region followed by Afar (58%) to the lowest (8%) in Benishangul Gumuz.

With the goal of achieving the 90-90-90 targets, (90% of the total estimated number of PLHIV know their HIV status, 90% of total PLHIV received ART and Third 90 is among those who received ART 90% achieved viral suppression among those who took ART,) the country plans to test around 10 million people annually over the next years through targeted approach. To facilitate this, with the support of the development partners, the FMoH launched a "Catch-up Campaign" for HIV testing in 2016. This has showed a promising result and taking the lessons in to account, the implementation will continue as a catch up initiative for the upcoming years. The country has also adopted different treatment recommendations and service delivery models. The most important ones include adoption of

the treat all recommendation, implementing the appointment spacing model of differentiated service delivery, piloting of HIV self-testing and pre exposure prophylaxis (PreP) in confidential clinics and Drop in Centre (DIC).

1.2 WAYS OF HIV TRANSMISION

How Is HIV transmitted?

It is very important for you to understand how HIV is transmitted as you learn how to talk with clients who will be tested for HIV. Part of HIV testing and counseling is providing your clients who test HIV-positive with information about not spreading HIV to their partners and children, and also talking with those who are HIV-negative about how to remain uninfected.

1.2.1 Modes of HIV transmission:

- People can be infected with HIV by having unprotected sex with an infected partner. Unprotected sex is sex that does not involve the correct and consistent use of a condom.
- HIV can be transmitted from mothers to their babies during pregnancy, labour and delivery, or through breastfeeding.
- People can also be infected by an exposure to infectious blood and body fluids through accidental cuts with sharp instruments and needles.
- Transfusion with HIV-infected blood.
- Exposing an uninfected person’s broken skin or wound to blood or bodily fluids that are infected.

1.2.2 How HIV is Not Transmitted, HIV is not transmitted through:

- Coughing, sneezing and any other airborne exposure
- Insect bites
- Touching or hugging
- Drinking water
- Preparing or eating food
- Kissing (Social kissing)
- Going to a public bath or swimming pool
- Shaking hands

- Working or going to school with and HIV-positive person
- Using telephones
- Sharing cups, glasses, plates or other meal and beverage utensils
- Using the same toilets

1.3 WINDOW PERIOD

The window period represents the period between HIV infection and the detection of HIV-1/2 antibodies using serological assays, which signals the end of the seroconversion period. The period prior to detection of HIV-1/2 antibody is often referred as "acute infection' where by HIV viral particle in the body is very high associated with higher infectivity and rate of transmission.

The detection of HIV-1/2 antibodies by serological assay signals the end of the window period for diagnosis. Seroconversion is a term used to describe the change that occurs when antibodies are produced and the blood tests positive. The length of the window period is determined primarily by the type of serological assay used and by an individual's immune response. In most people, it takes the body three to five weeks, maximum up to six week to three month to make enough antibodies to be detected by laboratory tests. The type of the body fluid that can be used for detection of the antibody has also some influence on the duration of window period. Oral fluid specimen exhibiting longer window period compared to venous or capillary blood and serum plasma. It is important to explain the definition of the window period to your clients who test negative but may have had a recent HIV exposure. The definition of the window period can be confusing and hard to explain. We will practice talking with clients about the window period later in the training.

In many settings post-test counseling messages recommend that all people who have a non-reactive (HIV-negative) test result should return for retesting to rule out acute infection that is too early for the test to detect – in other words, in the window period. However, retesting is needed only for HIV-negative individuals who report recent or ongoing risk of exposure. For most people who test HIV-negative, additional retesting to rule out being in the window period is not necessary and may waste resources.

1.4 HIV PREVENTION METHODS/ STRATEGIES

There is no single magic bullet for HIV prevention. However, a Combination HIV prevention Strategies including Behavioral, Biomedical and Structural interventions have shown promising result in protecting against HIV transmission and acquisition that includes knowledge of sero-status, adoption

of behavioral risk reduction, proper use of condoms, male circumcision, treatment of curable sexually transmitted infections, and use of antiretroviral medications .Some of HIV prevention methods are discussed as follows:

1.4.1 Abstinence, Being faithful, use Condom (ABC) and Dialogue &Discussion

- **A**: Abstain sexual activity before testing
- **B**: Being faithful after testing
- **C**: Consistent and correct condom use
- **D**: Dialogue OR discussion on HIV risk issues ,need for Periodic test, and concern

1.4.2 Prevention of Mother To Child Transmission (PMTCT)

Mother-to-child transmission (MTCT) is the transmission of HIV from an infected pregnant woman to her offspring. The majority of children infected with HIV acquire the virus through MTCT. Mother to child transmission of HIV occurs during pregnancy (antepartum transmission), labor and delivery (intrapartum transmission), and through breastfeeding (postnatal transmission).

Among 100% of HIV-infected mothers, around 20 - 40% of them transmit the virus to their babies without any intervention. Below are percentages of babies who become infected by HIV by mode of MTCT.

Without intervention:

- During pregnancy: 5–10% become infected with HIV
- During labor and delivery: about 10 -15% become infected with HIV
- During breastfeeding: 5–15% become infected with HIV

The four prongs of PMTCT

Ethiopia has adopted the WHO PMTCT strategy with 4-pronged approach as a key entry point to HIV care for HIV positive pregnant, laboring and lactating women and their infants.

1. **Primary Prevention of HIV**: for the general population with a focus on women in the reproductive age group, since remaining HIV-negative is obviously the best option.
2. **Prevention of Unintended Pregnancies:** among HIV-infected women.
3. **Preventing HIV Transmission:** from HIV-infected women to their infants.
4. **Provision of Care and Support:** to women infected with HIV, their infants and their families.

1.4.3 Prevention and treatment of STIs

As their name implies, the main mode of transmission of STI is through unprotected penetrative sexual intercourse. Link between STIs and HIV/AIDS are very strong as they share the same behavior and mode of transmission. The presence of an untreated inflammatory or ulcerative STI increases the risk of transmission of HIV during unprotected sex between an infected and an uninfected partner. Preventing and treating other STIs reduce the risk of sexual transmission of HIV.

1.4.4 Anti-retro viral Therapy (ART)

Antiretroviral is often abbreviated as ARV. ARV drugs stop HIV from multiplying in the body. When these drugs are given to clients, their viral loads decrease and their CD4 cell counts increase with an ultimate goal of immune function improvement. Early treatment initiation is associated with clinical and HIV prevention benefits, improving survival and reducing the incidence of HIV infection at the community level, improve the quality of life of HIV positive clients restore hope, reduce vertical transmission, prevent the opportunistic infections, and reverse the course of existing opportunistic infections.

ART should be initiated for all individuals (children, adolescents and adults) living with HIV immediately after HIV diagnosis, regardless of WHO clinical stage and CD4 cell count.

1.4.5 Infection prevention (IP)

Infection prevention (IP) is defined as an intervention that protects clients, providers and staff from infection and minimizes the risk of transmitting serious diseases such as hepatitis B and HIV infection.

Standard precautions mean placing physical, mechanical or chemical barriers between microorganisms and an individual in order to prevent infections.

It includes:

- Hand washing,
- Wearing gloves
- Proper handling of sharps
- Proper handling of specimen

- Using physical barriers (personal protective equipment)
- De-contaminating all instruments and surface, using antiseptic reagents
- Washing and rinsing of all instrument
- Proper sterilization or high-level disinfection
- Proper storing and handling of processed instrument
- Safely disposing infectious waste materials
- Using safe workplace
- Process instruments and other items after use

1.4.6 Post Exposure Prophylaxis (PEP)

It is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

Things to be done:

Immediately after the injury:

Wash exposed wounds or skin sites to blood or body fluids with soap and water, and mucous membranes flushed with water. For needle or sharp injury, allow to bleed for few seconds before washing but do not squeeze. The exposure should be evaluated for potential transmission of HIV infection (based on body substance and severity of exposure).

PEP for HIV should be provided when exposure to a source person with HIV or (the likelihood that the source person is infected with HIV) within 72 hours (three days) of exposure. Immediate initiation of PEP (during the 1st two hours of exposure) is more beneficial. If patient/client is HIV negative, discontinue PEP and re-test at 6 weeks, 3 months and 6 months.

If patient/client is HIV positive, council, support and refer for follow up. The exposure source should be evaluated for HIV infection. Testing of source persons should only occur after obtaining informed consent, and should include appropriate counseling, care and referral. Confidentiality must be maintained. Clinical evaluation and baseline testing of the exposed health care worker should proceed only after informed consent.

Exposure risk reduction education should occur with counselors reviewing the sequence of events that preceded the exposure in a sensitive and non-judgmental way

Emphasize: The risk of acquiring HIV after being stuck with a needle from an HIV-positive patient is 0.3% (Note: with PEP it would reduce to 0.1%) that is 1 in 1000.

1.4.7 Pre Exposure Prophylaxis (PrEP)

Pre exposure prophylaxis (PrEP) is one of the new innovative approaches for prevention of HIV. PrEP is the use of ARV drugs before HIV exposure by people who are not infected with HIV in order to block the acquisition of HIV. This initiative will be piloted in selected targeted groups in Ethiopia for future considerations.

CHAPTER 2: OVERVIEW OF HIV TESTING SERVICES

Learning Objectives: By the end of this session the participants will be able to:

- Discuss overview of HTS
- Describe the targeted groups for HTS at point of care testing service Discuss models of HTS
- Discuss models of HTS
- Elaborate Innovative HTS approaches & tools to strengthen targeted HIV testing
- HTS as an essential entry component of HIV Prevention, Care, and Treatment Services

Contents

- Overview of HTS
- Targeted HTS
- Models of HTS
- Innovative HTS approaches & tools to strengthen targeted HIV testing
- HTS as an entry point of prevention, treatment and care services

2.1 OVERVIEW OF HIV TESTING SERVICES IN ETHIOPIA

HIV Counseling and Testing started in Ethiopia in1987 to provide pre and post- test for the participants of the first surveillance carried out in 1988 and 1989. In 1989 the first in country training conducted for hospital health professionals.

HIV Counseling and Testing service was provided to patients suspected of having HIV related diseases and visa applicants. In 1996 the first HIV/AIDS Counseling and Testing guidelines was developed to help counselors to have well-structured approach.

Voluntary Testing and Counseling (VCT) made available following the launch of the National HIV/AIDS Policy in 1998. VCT guidelines developed by HAPCO and MOH in 2000 and revised 2002. Same day VCT service using rapid testing introduced in 2002. VCT services become widely available in 2003 and onwards, In 2006/7 the VCT guideline is updated and launched to improve both the facility and community based HIV Counseling and Testing Services in the country.

HTS should focus more on Post-test counseling for those who tested positive, but it does not mean that pretest counseling is totally avoided. However the pretest counseling can be tailored, or done as a form of PITC for targeted testing.

2.2 TARGETED HIV TESTING SERVICES

HIV testing is the critical first step in identifying and linking PLHIV to HIV care and treatment services. It is also an opportunity to reinforce HIV prevention services among clients who have ongoing behavioral risk. Ethiopia has revised the HIV Testing and Counseling guideline to support the implementation of targeted testing. The focus of the HTS guideline revision is to guide programs towards identifying and linking new HIV infections by targeting population groups who are at risk of acquiring HIV in locations and sites with the highest HIV burden. Referral and linkage of clients must get necessary attentions to maximize the number of identified HIV infected persons that are linked to care and treatment services. .

In order to achieve **the goal of providing treatment for 90% of all people living with HIV, it is important to identify and link all HIV positive clients who know their status to care and treatment services.** Targeted HTS should be implemented across the range of community and facility-based settings through different approaches (including PITC, VCT and CBTC approaches). The ministry is guiding towards a focused approach to test people more likely to be infected with HIV who are identified through targeted approaches. By targeting high burden geographic areas and focusing on high risk population groups will be expected to improve the overall HIV testing yield and linkage to care.

2.2.1 The eligible Target clients for routine HTS by using PITC approach are:

1. All pregnant, laboring and postpartum women with unknown HIV status; and partners of HIV positive pregnant/lactating women and Partners of HIV high risk* pregnant and post- partum women.
2. Family members (siblings under 15 years old and their parents) and sexual networks of index PLHIV.
3. Commercial sex workers and their clients.
4. All TB patients with unknown HIV status and presumptive TB cases.
5. All sexually transmitted infections (STI) patients with unknown HIV status, their partners and sexual networks.
6. Discordant couples.
7. Children orphaned by AIDS and vulnerable** children.
8. Children with malnutrition.

9. Patients coming with clinical signs and symptoms of HIV/AIDS visiting health facilities (outpatient and inpatient).
10. Long distance truck drivers, mobile workers and daily laborers.
11. Widowed, divorced & remarried.
12. Vulnerable** adolescents / youth clients (15-24 years).
13. All under five children visiting health facilities.
14. Refugees and inmates.
15. Family planning clients with identified risk (history of having multiple sexual partner, inconsistent condom use and their partners).

*High risk includes having multiple partners, divorced and recently married, newly married, sex worker, waitress, daily laborer, mobile worker and age between 15-24 years.

**Vulnerable adolescents include those living in the street, orphans, adolescents in child headed household, girls engaged in sex with elder men or in multiple and concurrent sexual partnership, out of school youth, and adolescents who are sexually exploited.

2.3 MODELS OF HIV TESTING SERVICE IN ETHIOPIA

1. Facility Based HTS

This could be given as Client Initiated or Provider Initiated (VCT or PITC) service at static public, private and NGO's health facilities

2. Community Based HTS

- Home-based testing targeting specific sub-group or family members of Index case
- Outreach HTS services- high prevalence areas(hot-spots).
- Work-place VCT service- Big farms, factory or construction sites

2.4. Innovative HTS approaches and tools to strengthen Targeted HIV Testing Service

2.4.1. Index case testing

The index case is primary case, or patient zero who is the starting point (individual) in the population of an epidemiological investigation. The index case is defined as the individual who is found HIV positive on HIV Testing and Counselling (HTC) provided at the health facility. Counsellors provide HTS and identify HIV infected individuals and then provide HTS to their family members and partners.

Index case testing is also a high yield, targeted testing approach for identifying and linking new HIV-infected individuals to treatment services. This approach needs to be optimally utilized for case detection and to break the HIV transmission cycle. Some of the PLHIV might have not yet disclosed their HIV status to their partners while others have partners with ongoing risk, including none spouse partners. Clients concerns should be addressed to improve disclosure and testing service uptake among index partners (spouses and none spouse partners) and HIV exposed children.

2.4.2 Respondent Driven HIV testing or Snow ball

Respondent Driven HIV testing is a ***network-based technique*** for reaching out the hard-to-reach populations through facilitating/addressing, such a key populations, via a ***chain - referral procedure*** in which participants recruit one another.

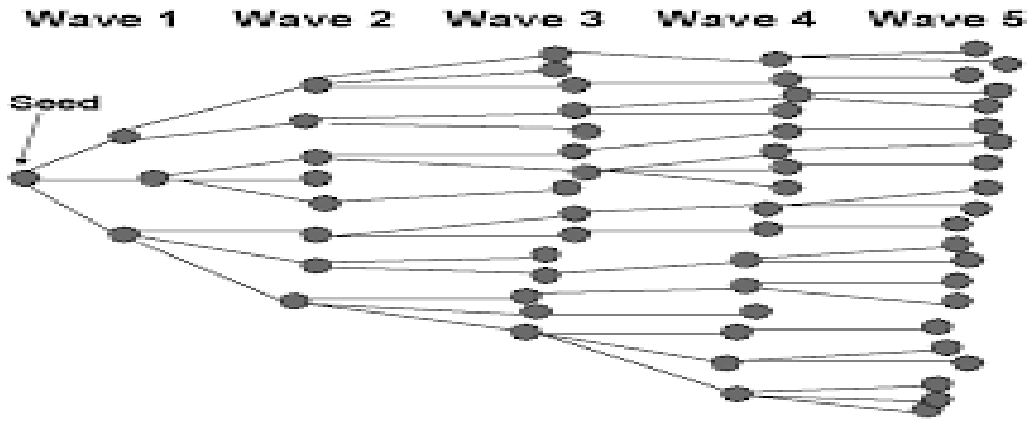


Fig. 1.1. Respondent Driven HIV testing or Snow ball testing

2.4.3 HIV Self-Test

As part of improving targeted HIV testing for hard to reach population groups, FMOH is introducing HIV Self-Test (HIVST). It is an innovative approach to deliver HIV testing services and contribute more for the national testing targets goal of reaching 90-90-90 and specifically the first target of diagnosing 90% of all people with HIV. WHO recommends HIV self-testing should be offered as an additional approach to HIV testing services.

HIV self-testing (HIVST) refers to a process in which a person collects his or her own specimen (oral fluid or blood) and then performs an HIV test and interprets the result, often in a private setting, either alone or with someone he or she trusts. As with all approaches to HIV testing, HIVST should always be voluntary, not coercive or mandatory. The approaches of HIVST are:

Directly assisted HIVST refers to trained providers or peers giving individuals an in-person demonstration before or during HIVST of how to perform the test and interpret the test result.

Unassisted HIVST refers to when individuals self-test for HIV and only use an HIVST kit with manufacturer-provided instructions for use.

Both directly assisted HIVST and unassisted HIVST may supply additional support tools, such as telephone hotlines, mobile phone text messages, videos, social media and Internet-based applications, which provide technical support, counselling and referrals for further HIV testing services, HIV prevention, care and treatment and other services. For instance currently assisted self-testing has been piloted as one modality of testing on female sex workers in Ethiopia. The pilot finding will be used to scale up this initiative for different target groups in the future.

2.4.4 Applying risk screening for high risk groups or individuals, for more targeted PITC

A risk screening based HIV testing which enables service providers to identify risky groups during counseling & gives opportunity for being targeted HIV testing. HIV risk screening tool is a tool, having a set of questions, used to identify the clients with specific risks for HIV transmission. Risk screening tool could be used among patients in OPD setting for more consistent targeted testing services to identify at risk adolescents, youth and adults and test them for HIV focusing on case detection. Risk screening tools have been utilized in other countries to identify who needs to be tested and maximize HIV case detection and increase efficient utilization of the limited RTKs. The following major questions can be asked to assess their risky behavior:

- Have you ever tested for HIV in the past 12 month?
- Have you had unprotected sex?
- Did you drink a lot during night time & have sex with clients?
- Have you ever experienced symptoms of sexually transmitted infections?

2.4.5. Partner Services

Partner services, sometimes also called Partner Notification Services (PNS) are a comprehensive array of services offered to persons diagnosed with HIV or another sexually transmitted infection (STI) and individuals they may have exposed to HIV infection (e.g. spouses, none spouse partners). A critical function of PNS is partner elicitation, a process through which index patients (i.e. an individual newly diagnosed as HIV-positive and/or an individual who is enrolled in HIV treatment services) are interviewed to elicit information about their partners, counseled and assisted on disclosure , and will be continuously supported to bring their partner for HIV testing. Partner notification services are

voluntary, based on the decision of the index patient, and are provided confidentially, at no cost, in a patient-centered framework. The role of the service providers here need to be providing counseling on the risk of HIV transmission and importance of disclosure, assisting on disclosure, educating on the benefits of early treatment and better outcome.

2.5. HTS AS AN ESSENTIAL COMPONENT OF HIV PREVENTION, CARE AND TREATMENT SERVICES

The HIV epidemic is a complex problem that is having a devastating impact on communities and families worldwide. Ethiopia designed many tools in order to turn the tide of this epidemic. HTS is one tool that is primarily a prevention intervention. HTS is also an essential component of HIV prevention, care and treatment services and it can serve as an entry to care, treatment and support services for infected persons.

HTS is an essential component of a comprehensive HIV/AIDS program. It is from the foundation of HTS that other prevention, care, treatment and support services emerge. Providing treatment and care for people who are infected with HIV requires careful thought, planning, and hard work. It also requires that those who are HIV-positive become aware of their infection.

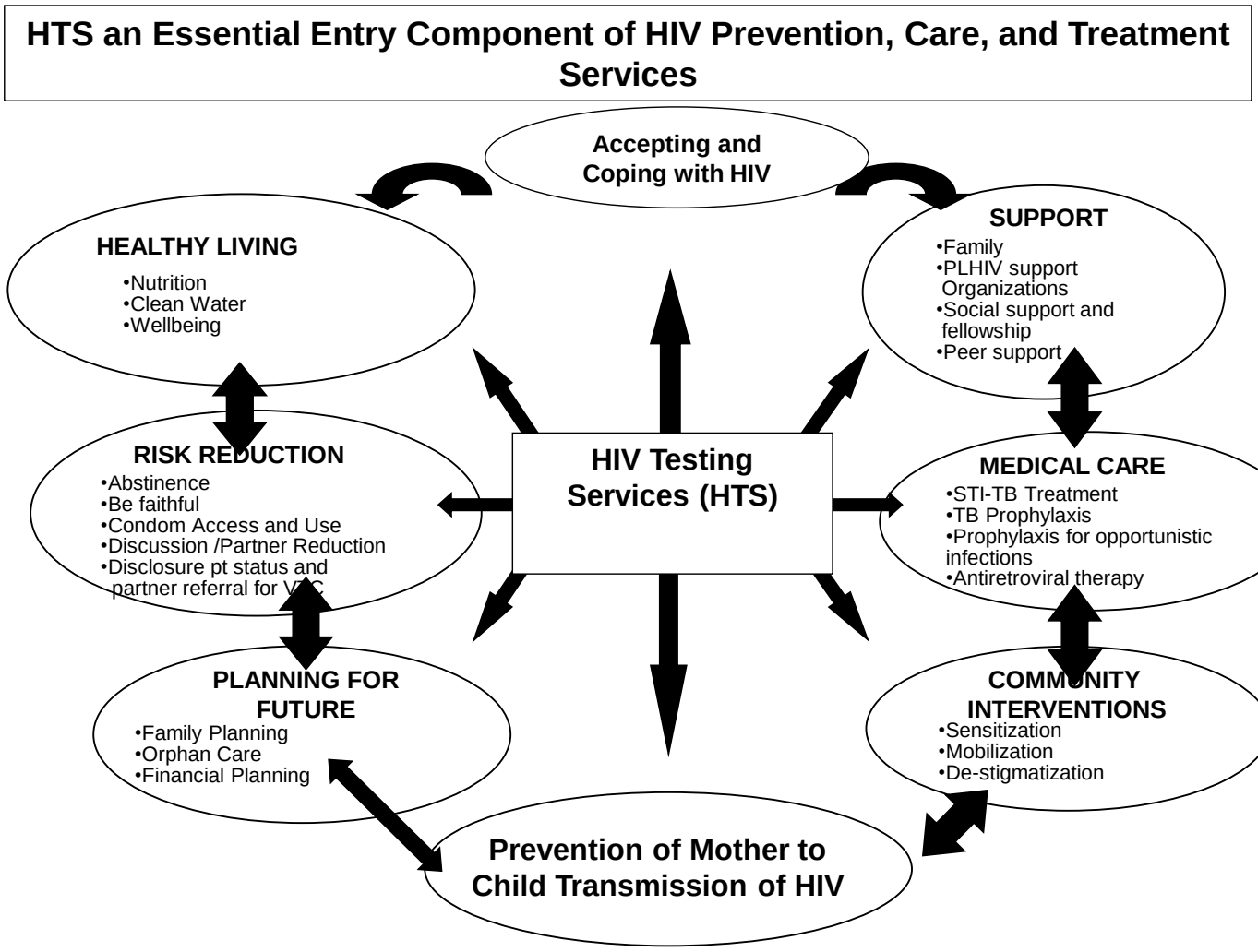


Fig 1.2. HTS as essential entry components of HIV Prevention, treatments, Care and Support Services

Module Summary

- Standard Precautions mean placing physical, mechanical or chemical barriers between microorganisms and an individual in order to prevent infections
- STIs facilitate the transmission of HIV
- Cchildren younger than 18 months of age need a DNA-PCR test for HIV diagnosis confirmation.
- MTCT is the major mode of transmission of HIV in children.
- HIV-infected people will ultimately develop severe HIV-related diseases and AIDS, but the progression from HIV infection to AIDS can be delayed with OI prophylaxis and ARV drugs.
- ARV drugs stop HIV from multiplying in the body.
- Great attention should be given to high risk population with targeted intervention
- HTS is an essential entry component of HIV prevention, care and treatment services
- Innovative HTS approach like self-testing can be offered as an additional approach to strengthen targeted HIV testing services and improve the yield of HIV positive result.

Module 2

Basics of Counselling

CHAPTER 1: INTRODUCTION TO HIV COUNSELING

Learning objectives: By the end of this course, Participants will be able to:

- Define HIV counseling
- Elaborate benefits of HIV counseling
- Describe qualities of a good counselor
- Explain common errors in counseling

Contents

- Definition of HIV counselling
- Benefit of HIV counselling
- Qualities of a good counsellor
- Common errors in counselling

1.1. 1.1. DEFINITION OF COUNSELING

Counseling is a two-way communication process that helps individual to:

- Examine personal issues
- Make decisions
- Make plans for taking action

In the context of HIV/AIDS, counseling is a confidential two-way communication between a counselor and client (s) aimed to make personal decisions related to HIV/AIDS.

1.2. 1.2. BENEFITS OF HIV COUNSELING INCLUDES THE FOLLOWING:

- Helps to listen the clients concern;
- Helps to respect clients' rights, needs, values, culture, religion and lifestyle;
- It helps to ask questions that help counselors to identify behaviors which put clients at risk of HIV infection;
- It also helps to explore options for risk reduction that can help clients to choose for their situation.
- Helps to answer clients' questions and correcting misconceptions;
- Helps to discuss with clients about the advantages and disadvantages of HIV testing;
- Allow clients to make their own decisions about HIV prevention and testing;

- Help clients to understand their HIV test result after they get tested;
- Help those clients whose test results are negative, to select ways that help them to reduce their chances of getting infected with HIV;
- Help those clients whose test result is positive, to discuss ways to avoid transmitting HIV to others and get referral for treatment and other services;
- Help clients to disclose their HIV status and refer partners and exposed family members; and
- Helps to refer clients to other care and support services they need, such as treatment and family planning, antenatal and childbirth care drug abuse treatment service and other social support.

1.3. 1.3. QUALITIES OF A GOOD COUNSELOR

A good counselor must have the following qualities:

- **Self-confident:** certain of having the ability.
- **Empathetic:** not disregarding nor detached.
- **Accepting:** warm and friendly
- **Genuine:** not artificial e.g. behaving like he/she is perfect or knows every thing
- **Trustworthy:** deserving trust or able to be trusted
- **Competent:** having enough skill or ability to do something well

1.4. 1.4. COMMON ERRORS IN COUNSELLING

Counseling involves quite a bit of talking and listening. Almost all of us have done this too. Hence it might seem that counseling and the application of the skill might appear simple and easy to follow. But experience shows that there are a large number of errors which are made by “counselor”.

The following are some of the common errors in counseling:

- Interrupting the client
- Looking away frequently or not maintaining eye contact
- Frowning, scowling or yawning
- Speaking too quickly or too slowly
- Finishing off the sentences of clients

- Controlling rather than encouraging the clients' spontaneous expression of thought, feeling and needs
- Judging as shown by statements that indicate the client does not meet the counselors' standards
- Moralizing, preaching and patronizing – telling clients how they ought to behave or lead their lives, labeling and diagnosing the client into a category rather than trying to find out the person's motivation, fears and anxieties
- Providing unwarranted reassurance, diverting a client's attention from an issue and inducing undue optimism by claiming that the problem is easy
- Not accepting the client's feelings – saying that they should be different
- Advising before the client has had enough information to arrive at a personal solution
- Interrogation, using question in accusatory "why'' questions often sound accusatory'
- Encouraging dependence-inflating the client's need for the counselors continuing presence; support and guidance
- Using unacceptable paraphrasing, or suggestions like
  "You should'', "will tell you what to do'' "must try ", "the only way out is'' "It is a must "etc...

CHAPTER 2: SELF CONCEPT, SELF- AWARNESS, ATTITUDE, VALUES, PREJIDUCES AND CULTURE

Learning objectives: By the end of this course, participants will be able to:

- Define the self-concept model in relation to HIV counselling
- Describe the Core elements of self-concept model
- Understand the three concentric self- domains in relation to the four core elements of self-concept model
- Describe how providers' self-awareness, attitudes, values and prejudices might affect interaction with their clients
- Explain the influence of culture on people's feelings and beliefs.

Contents

- Definition of self- concept
- Core elements of self-concept Model
- The three concentric self-domains
- Concepts of self- awareness, attitude, values, prejudices and culture
- Counselling in different culture

2.1 DEFINITION OF SELF-CONCEPT

An individual's self-concept is the way in which some body thinks about him/her.

Counseling is about helping people make decisions and act upon those decisions. It is essential that provider understands client's strengths, weaknesses, doubts and uncertainties. This understanding needs focus

- Who somebody is?
- What his/her problems are?
- How the problems will change overtime?

2.2 THE FOUR CORE ELEMENTS OF SELF-CONCEPT MODEL

The four core elements of self-concept are:

1. **The self-image**: The way in which the individual perceives himself /herself.
   - Gender
   - Age
   - family back ground
   - Occupation.

   sometimes the statement is not definite and can change depending whether the individual decides he or she is: -
   - Clever/stupid
   - Ugly or beautiful
   - Confident or insecure
   - Introvert or extrovert
   - Honest or dishonest

2. **Self-esteem**: Self-esteem is a set of statements regarding the value an individual put upon themselves, such as: -
   - I am less respected
   - I am a respected person

3. **Ideal self**: It is the way a person would most like to be
   - I would like to be more tolerant
   - I wish I was wealthy
   - I wish I were more attractive
   - I wish I had more friends.

Often people imitate someone who is older. Age has attraction of being associated with i.e. usually people don't want to have an ideal self of an individual who is smaller than their age.

- Liberty
- Freedom
- Respect
- Veneration
- Authority

4. **Body image**: Body image compromises a set of statements about the way in which people imagine they look.

The core elements make up the base of self-concept- they are things that make an individual singular and unique.

Each of the four elements has parity of space, because they are all equal importance. In which case the core elements usually pursue a common aim and then the person is: -

- Well adjusted.
- Happy and
- Self-fulfilled.

If the core elements are not interacting harmoniously then person will be: -

- Insecure
- Uncertain
- Lack of self-direction.

General truths about core elements of self-concept:

- The closer the self-image approaches the ideal self, higher is the self-esteem.
- If the body image corresponds with the ideal self, the self-esteem tends to be high.
- If there is little difference between public and private self, then the self-esteem is relatively high.

2.3 The three concentric self-domains

Each Self Concept core element has three domains: the public, private and hidden. The size of the domain represents how important that domain is for the individual.

The three concentric self domains which super imposed over the four self-concept circles are:-

1. **The public domain:** Open and accessible. It is information that the individual doesn't have much control over. The public domain information concerns items such as: -

- Name
- Gender
- Age (although some try to hide it)
- Family
- Where the person lives.
- Occupation

2. **The Private domain:** It is the information which the individual has control over and select to whom he/she wishes to disclose it. The information includes items such as who he/she hate/detests. When someone tries to get closer to the centre of the self-concept, he/she guards the information more closely and, is very particular about whom they admit to this area.

   Somebody may be comfortable disclosing some of the HIV risks to his/her counsellor but he /she makes a tight control over this information to other colleagues.

3. The Hidden domain: This is the area that contains information, which makes the individual feel uncomfortable.

E.g. A lady may be raped by four men when she was a child. And she may feel so anxious sharing this information and even she doesn't want to remember it for herself

2.3. THE THREE SELF DOMAINS: CONCENTRIC CIRCLES

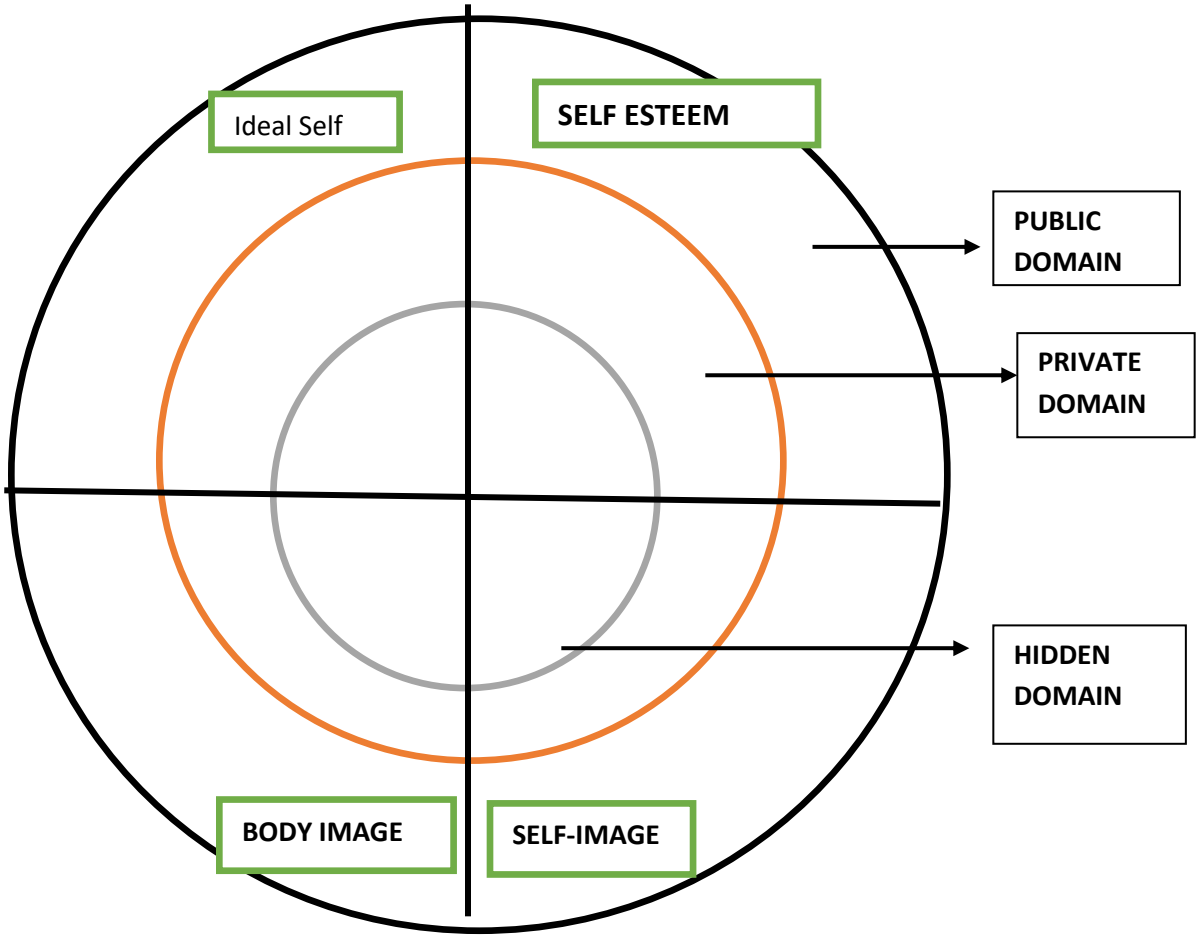


Fig 3; Model of self-concept and the three Concentric Self Domain

FACTORS TO BE CONSIDERED BY COUNSELORS DURING HTC SERVICE

2.4. SELF-AWARNESS, ATTITUDES, VALUES , PREJUDICE AND CULTURE

Each clinician has her/his own strengths, weaknesses, beliefs, attitudes, fears, values and worries; all of these can affect how a clinician works with clients. Clinicians should think about the issues related to r own and client attitudes, values, prejudices and culture. How these affect counselors ability to provide effective counseling and testing services to clients.

2.4.1 SELF-AWARENESS

Being self-aware means knowing yourself, how other people affect you and how you affect other people. Clinicians who have self-awareness:

- Comprehend their own feelings, thoughts, attitudes and beliefs, and how they can affect counseling in positive and negative ways
- Understand that clients have their own feelings, thoughts, attitudes and beliefs and how they can affect their ability to talk about their concerns
- Look at their behaviors and attitudes and ask: How am I doing? How can I improve?

Clinicians who have self-awareness can focus on clients and respond to their needs. Self-aware clinicians are also more willing to learn and improve their performance. Clinicians should watch for physical and emotional signs of stress in themselves. Counseling and testing can be difficult and it's normal for clinicians to get stressed. If a clinician notices signs of stress in themselves such as headaches, problem sleeping, fatigue, lack of caring, irritability or anger, they may want to talk with a supervisor or another clinician to get support.

Strategies to develop self-awareness

1. Self-disclosure: Sharing something about one's self the person doesn't know.
2. Introspection: Reflecting one's own feelings & reactions
3. Accepting feedback: Learning from others how one's behaviour affects them another ways. Counselor becomes more self-aware, conducting Value exploration by doing: -

- Disconnect exercise (E.g. Experience of grief to others OR Self, HIV Infection to others OR Self). The Possible response to the Cause/Effect may not wide, Counsellors should near too.
- Ranking exercise (Money, Family, Power, Profession, Sexuality, Religion), Any order can be accepted because the value given to each of the case may be different from person to person

- Stereotyping exercise (Fixed ideas cannot be the explanation for things)

2.4.2 VALUES

Values are defined as principles or standards that lead to judgments of either relative or absolute utility, goodness, or importance or that guide choices among alternate means or actions.

Values are learned in the socialization process. They are products of society and they act on the members of the society.

In all cultures, the elders, educators, churches and mosques, the family, the mass media, correctional institutions, and the community at large attempt to transmit the culturally "approved" values to the younger generation.

Values are relatively stable and resist changes, since these institutions struggle to maintain the basic values of the society.

2.4.3 ATTITUDES

An Attitude is a relatively enduring tendency to respond to someone or something in a way that reflects a positive or a negative evaluation of that person or thing.

It is natural for people to evaluate other people or groups in the light of their own attitudes and also includes individuals, social groups, behaviours, inanimate objects etc.

Attitudes are learned predispositions or social orientations to act in accordance to the evaluation - favourably or unfavourably.

2.4.4 PREJUDICE

A Prejudice is a negative opinion or judgment made about a person or group of people before knowing the facts. Often, prejudices are caused by a lack of information. For this reason, the more people know about something, the less likely they are to be prejudiced against it. Prejudices can prevent providers and clients from having open and honest discussions about sensitive issues. It is important for providers to be aware of their own prejudices regarding the cultures and groups of people with whom they work. Providers can help lessen their prejudices by getting information about those cultures or groups of people. This process will help providers work with clients in a more respectful way. It is very important for clinicians to be aware of their attitudes, values and prejudices, as well as the fact that different

people have different attitudes, values and prejudices. Clinicians should ultimately respect clients' attitudes

2.4.5 CULTURE

Culture is the totality of the customs, arts, science, religious and political behavior taken as an integrated whole that distinguishes one society from the other.

WHO defines culture as the habits, expectations, behaviors, rituals, values and beliefs that human groups develop over time.
It is the product of the interaction of people, ideas and the physical environment.

NOTE

Culture influences people's feelings and beliefs about life, death, health, illness, caring for the infirm and healing. There are some differences between cultures in the way they look at the above phenomena. For example, one culture may see illness as punishment from God, while another culture considers it as a fate. There are strong indications that culture influences the way people interpret, explain and respond to HIV infection and to AIDS disease. Through culture people learn acceptable behavior, what is right and wrong.

2.4.6 COUNSELING AND DIFFERENT CULTURES

Counselors must develop awareness and competencies that will enable them to contribute to the development of all individuals, regardless of their social backgrounds or life styles.

A large number of counselors, throughout the world recognize that attempts should be made to accommodate cultural diversities among various social groups.

Multicultural or cross-cultural counseling refers to counseling that deals with clients whose values and perceptions of reality (culture) are different from the counselors

CHAPTER 3: BASIC COMMUNICATION AND COUNSELING SKILLS

Learning objective: By the end of this course, participants will be able to:

- Define Communication
- Elaborate basic communication skills in counseling
- Describe the elements of good counseling
- Describe basic counseling skills
- Discuss essential skills attributes of the couple counseling
- Employ Solution- focused model of couples counseling
- Practice Mediation Skills for Easing Tension and Diffusing Blame
- List the stages of Counselling process
- Setting the environment for Counseling

Contents

- Definition of Communication
- Communication skills in counselling
- Elements of good counselling
- Basic Counselling skills
- Skills and attributes of the couple counselling
- Solution- focused model of couples counselling
- Mediation Skills for Easing Tension and Diffusing Blame
- Process of counselling
- Setting environment for Counselling

3.1. DEFINITION OF COMMUNICATION

Communication is a process by which information is exchanged between or among individuals through a common system of symbols, signs, and behavior.

Communication helps to establish a common ground where two or more people meet and discuss their views. It allows feelings, ideas and views to flow freely and to be understood. Communication can only take place in a climate of acceptance and understanding, where a relation of respect and friendship exists.

3.2 . COMMUNICATION SKILLS USED IN COUNSELING

- Active listening
- Attending
- Paraphrasing
- Reflection of feelings
- Summarizing
- Questioning
- Reframing
- Confrontation
- Self-disclosure

1. ACTIVE LISTENING

Listening involves not only receiving sounds but, as much as possible, accurately understanding the meaning. As such it entails hearing words, being sensitive to vocal cues, absorbing movements and taking into account the context of communication.

A helping conversation emphasize meeting the psychological need of clients. Listening in counseling session is an active process, which requires effort and concentration as well as the ability to keep our own concerns aside temporarily at least.

Hearing is like sound waves striking the ear drum, while listening is involvement of brain in hearing. Whereas active listening is letting the other person knows that you are listening. This could be nodding head, repeating what the other person has just said, or asking questions etc.

Example:

The patient is biting her nails and looking very nervous but tells the healthcare providers she is fine.

Clinician: "Sometimes when we think we are relaxed, we can still feel quite anxious inside. I see you are biting your nails. Perhaps there is something bothering you that you do not know how to express. Do you have any idea what that might be?"

Purposes of Listening

Each of the following purposes one by one using the note given below

- Creating rapport
- Creating an influence base

- Creating a knowledge base
- Helping clients to talk
- Helping clients to express their feelings
- Helping clients to own responsibility and to solve problem

The following are non-verbal aspects of behavior that facilitate good listening

- Maintaining eye contact
- Head movements to indicate encouragement
- Mirroring the client's expressions in order to show empathy
- Adopting a warm, open posture by leaning slightly forward towards the client
- Giving appropriate verbal encouragement when natural pauses occur in the client's speech

Note

- Creating rapport: - develop an effective working relationship with the clients.
- Creating an influence base: - listening actively to the client is one way counselors can build their position as an influence. It contributes to their perceiving the counselor as trustworthy and reliable.
- Creating a knowledge base: - clients collaborate in providing relevant information about them if the counselor actively listens to them.
- Helping clients to talk: - Active listening helps them to feel affirmed, safe, accepted and understood. This in turn helps them to make choices that allow them to share their thoughts with the counselor.
- Helping clients to express their feelings: - active listening can help clients to acknowledge and express their feelings freely.
- Helping clients to own responsibility and to solve problem: - Clients who are listened actively are more likely to assume responsibility for working on their problems than those who are not. One reason is that good listening may reduce defensiveness and this may increase their willingness to focus on their own behavior. Furthermore active listening provides client with psychological space and support for their self-exploration and problem solving.

Barriers to Listening

There are barriers or distractions which can affect our quality of listening. These include extraneous noise, interruptions, discomfort, and emotions such as anger, sadness, anxiety etc. Interference to listening can occur when someone is using unfamiliar language and counselor is thinking about other matters while counseling. Prejudice, preconceived ideas and judgmental attitudes act as barriers to good listening. Mentally trying to solve a client's problem will interfere with the counselor's listening ability.

2. ATTENDING

Attending refers to the behavioral skills of paying attention to the client by limiting distractions and equalizing the power between the counselor and the client.

The following are the attending (both Verbal and non-Verbal) skills.

- Availability
- Relaxed and open body posture, appropriate facial expression
- Good eye contact
- Active listening (Use of head nods, Use of minimal words such as **"uh-hum"** and **"yes"**, when appropriate

3. PARAPHRASING

Paraphrasing is a verbal statement that is interchangeable with the client's statement and is concerned with the cognitive (thought) content of the client.

In other words, the counselor repeats back the essence of the client's main words and thoughts in response to what client shares with the counselor.

The use of paraphrasing reflects the level of the counselor's ability to actively and attentively listen to the client's story.

Paraphrasing is ineffective if the counselor:

- Repeats exactly what the client says;
- uses technical words (jargons);
- is judgmental (evaluative);
- debates with the client;

- Fails to summarize (mirror) the client's message.

4. REFLECTION OF FEELINGS

Reflection of feelings is similar to paraphrasing, but the focus is more on feelings (emotions) of the client. Emotions are considered basic to cognitive and intellectual life and a clear understanding of the client's feelings provides an important basis for understanding the client's decisions, thoughts and attitudes. In learning the skills of reflection of feelings, it is first helpful to label emotions.

Words to express feelings include: angry, glad, sad, happy, proud, disappointed, worried, anxious, surprised, pleased, ashamed, afraid, relieved, delighted, depressed, guilt, irritated, excited, bored, annoyed, rejected and confused.

Counselors need to learn to correctly label emotions. An experienced counselor continuously identifies his client's feeling and reflects them at the appropriate times. With practice it is easy to identify feelings such as tension, distress and sadness from a person's body posture, facial expressions and movements.

5. SUMMARIZING

Summarizing is the gathering together of a client's verbalizations, behavior, and feelings and presenting them to the client in an outlined form. Summarization involves attending to the client, and integrating and ordering the contents of the interview.

Purpose of summarizing includes:

- Acting as a bridge or stepping stone during a session.
- Checking the accuracy of your understanding.
- Providing closure-at the end of a session
- As a bridge between sessions

6. QUESTIONING

Questioning is one of the most important tools the counselor uses to guide the client through the counseling process.

Purposes of Questioning

- To help clients state their problems and feelings.
- To gather information, to facilitate client's self-exploration during the discussion, and to clarify understanding.
- To help the client explore his/her problem more fully and better clarify the issues
- To help the client look more about his/her situation or behavior that is troublesome,
- To facilitate understanding and to facilitate decision making ability.

Judicious questioning can also help client explore, clarify and understand their frame of reference better.

There are two major categories in to which questions fall. They are:

- Close ended questions
- Open ended questions

Close ended questions

Closed questions are questions that lead to a specific answer. Usually the answer to a closed question is very short. It may be an answer like "Yes" or "No".

They are used when specific information is sought or needed and they have the disadvantage that they do not elicit or require reflective or elaborate communication.

Example:

- Do you use condom?
- Do you feel angry?
- Are you married?

Open ended questions

Open ended questions give clients an opportunity to express themselves freely and make it easier for the counselor to identify their needs and priorities. Open ended questions are useful in starting

dialogue, finding a direction, and/or exploring a client's concern. Open questions begin with the words like "how", "what", "who" and "why".

Questions that are used to gather information, increase clarity, stimulate thinking or elicit further discussion. These questions often lead to wide self-exploration into the "what" and "how" of behavior.

Questioning Errors

- Too many questions
- Conducting an interrogation that may lead to either defensiveness or dependence or both,
- Leading questions.
- Questions that put the answer into your client's mouth.
- Too probing questions
- The questions that are likely to create anxiety and resistance
- Poorly timed questions.
- Not being Sensitive to your and the client's similarities and differences in gender, sexual orientation social economic status.

7. REFRAMING

Reframing refers to the client's individual experience pictured from the counselor's point of view. Clients interpret events as they see them, but often from a position of depression or low self-esteem. The counselor needs to listen very carefully to the client's description of the events or situations, and then try to look from the client's point of view and picture what the client has described. The client's picture, painted from his own perspective, will have a frame, which is appropriate for the client with his own particular mood and perspective.

A skillful counselor can change the way a client perceives events and the orientation by **"reframing**" the picture, which the client has described. The counselor puts a new frame around the picture so that the picture looks different.

Example:

A client says, "You can't feel anything when you wear condoms"

Counselor says" You're right, condoms can reduce sensation; and you know, lots of men find that when they use condoms they stay erect longer, and they do not have to worry about unplanned pregnancies, STIs, and HIV".

8. CONFRONTATION

Confronting is a communication technique used to reflect a contradiction expressed by a client. Contradictions include differences between self-perception and behavior; between verbal and non-verbal messages; or between two different verbal messages.

A confrontational message should be given in a neutral tone.

Example
"Based on what you told me, is that you have multiple partners and you do not use condoms with all of them, I am really concerned that you could get HIV. If this is the case, are you aware that you are putting yourself at risk of HIV infection?"

9. SELF-DISCLOSURE

This is a situation where the counselor communicates to the client his/her feelings or perceptions about the client and also reveals something about him/ her.

Note: The disclosures might be feelings at the moment, facts about the counselor, similarities between them, or strategies used in counseling.

Positive disclosures are reassuring in that they support, reinforce, or legitimize the client's perspectives, while negative disclosures tend to be challenging in that they confront the client's perspectives, and ways of behaving.

Self-disclosure is used with few clients and the counselor should raise the following questions if he/she is planning to disclose:

a) Has the client received enough support to make his/her decision?
b) Is it appropriate to shift the focus away from the client?
c) Should I disclose this experience, feeling, or observation with this and other clients?

Example:

- I feel sad as I listen to your continual attacks on yourself.
- I feel that we had a good discussion (interview, interaction), but we have to end it soon.
- If someone did that to me, I would have been angry.
- One of the things that have worked well for me is listening to people seriously.

3.4. ELEMENTS OF GOOD COUNSELING

1. RESPECT: Respect for the client's beliefs, attitudes, values and culture should be maintained all the time even if they differ from that of the counselor.

2. GENUINENESS: The counselor should be open minded, authentic, honest and congruent during the entire process of counseling. Genuineness promotes trust and positive relationship between the client and the counselor.

3. CONFIDENTIALITY: This forbids any reference to, or discussion about a client, except within a professional relationship, and then only with the consent of the client. The counseling environment should also provide privacy for the client.

SHARED CONFIDENTIALITY: This is a form of confidentiality in which the discussion matters will be limited to the counselor, the client and to those individuals who will be involved in the care and management of that specific client.

4. PRIVACY: This refers to the need for privacy in the counseling interaction. This includes:

- Location (conducive, maintain confidentiality)
- Understanding the fact that the client request for counseling help in a personal capacity.

5. UNCONDITIONAL POSITIVE REGARD: This is another attitude the counselor must adopt to express empathy. Counselors should view clients as individuals with problems, and respect them without judging or condemning their past behavior. The counselor should not add to the self-blame or guilt which is characteristic of many clients.

6. ACCEPTANCE: Counselors should not be judgmental of clients, but rather should try to accept clients, regardless of their socioeconomic, ethnic or religious background, occupation, sexual orientation or personal relationships.

7. AUTONOMY: This refers to the liberty to choose one's own course of action, to take full responsibility of the outcome of action and it is the cornerstone of the client's right of participation. Counselors promote the client's control over his/her own life, respect client's ability to choose, decide, and change in the light of his/her own beliefs, values and circumstances.

8. EMPATHY: Empathy is showing warmth, concern and caring attitudes and responses. It understands the other person's point of view. It is being able to think and feel through the other person's (client's) perspective. It is an active process that needs to be practiced by the counselor by clarifying communication, reflection of feeling, and imagining others' thoughts. So empathy involves **'being with the client'.** Empathy is not synonymous with "sympathy".

3.5. BASIC COUNSELING SKILLS

The following are the most important counseling skills that counselors use in HIV counseling:

1. Establishing rapport
2. Showing empathy
3. Acknowledging difficult feelings
4. Affirming
5. Correcting false information
6. Using third-person technique / Impersonal Statements

1. ESTABLISHING RAPPORT

Establishing rapport ("joining") with clients is crucial in all counseling situations and is a key in developing a trusting relationship. Developing rapport demonstrates the counselor's interest in and respect for a client's issues and concerns.

Building rapport is an ongoing process that can be facilitated by:

- Greetings and introduction appropriate to culture and context;
- Respect;

- Presence of common or complementary goals;
- Open verbal and non-verbal communication;
- Mutual trust

2. SHOWING EMPATHY

The ability to empathize is one of the most essential counseling skills. Empathy involves understanding client's thoughts and feelings, and communicates from their point of view.

Example*:*

A patient may say: "I am coughing the whole night and feeling week and cannot work hard but my employer wants me to work in this department which includes a lot of laborious work."
Clinician's empathic response: "So you feel very tired at the end of the day. That must be very difficult for you."

3. ACKNOWLEDGING DIFFICULT FEELINGS

The presence of difficult feelings is a substantial and unavoidable component of counseling. To help address difficult feelings, counselors should:

- Be aware of their own feelings;
- Acknowledge clients' feelings and realities;
- Understand that it is not the counselor's job to take feelings away or to fix them;
- Articulate and respond to non-verbal messages;
- Normalize and validate client's feelings

4. AFFIRMING

Affirming is congratulating or complimenting clients on the positive actions that they have been able to take. It is important to encourage success.

Complimenting client helps them feel respected and valued, and it encourages them to make decisions about testing for HIV, and take a better care of themselves.

They also may be more willing to share information about other actions they have taken.

Example:

- ***Client says:*** *"I have recently started using condoms each time I have sex"*
- ***Counselor responds:*** *That's a really positive step in protecting yourself against HIV and sexually transmitted infections. Well done!"*

5. CORRECTING FALSE INFORMATION/MISCONCEPTION:

Providing correct information to a client and correcting any myths and false information is important. There are many incorrect facts about HIV, AIDS, and sexually transmitted infections, and they should be corrected.

This need to be done in a sensitive way that does not make the client feel stupid or defensive. Counselor should acknowledge false information and then correct it quickly. It is not necessary to give a detailed explanation of the facts.

6. USING THIRD-PERSON TECHNIQUE / IMPERSONAL STATEMENT

In making a general point, using third person technique, also known as using impersonal statement, can be helpful in reflecting clients' feelings that are unspoken but nonetheless perceived.

This technique is very useful in acknowledging, reflecting on, and normalizing the client's feelings and helps to avoid defensiveness in a client.

Example:

"Some people decide to abstain from sex, while others choose to remain faithful to one partner. Still others prefer to use condoms and some never use them. To avoid becoming infected from HIV, you must decide which of these options suits you best".

3.6. ESSENTIAL SKILLS AND ATTRIBUTES OF THE COUPLES COUNSELOR

Couples counseling is different from working with individuals in the approach that the counselor takes and in the techniques the counselor uses. The following are five skills or attributes that couples counselors need to keep in mind in order to work successfully with couples:

1. COUNSELOR SELF-AWARENESS

Counselors should be aware of their own beliefs, biases, feelings, perceptions, and reactions and how their perspectives may affect the counseling session. The counselor who is in tune with personal attitudes, biases, and emotions has the ability to gauge his or her responses to the couple. Self-awareness also allows the counselor to provide unbiased empathy, understanding, and support to the couple. This is important, and we will be discussing the issue of self-awareness in detail.

2. CAPACITY TO TOLERATE INTENSITY

Couple relationships are dynamic and complex, and HIV-related issues may be emotionally intense. The counselor must be able to tolerate this intensity while maintaining a consistent and supportive stance with the couple. The counselor will need to facilitate conversation and encourage the couple to deal with challenging issues. The couple's confidence in the counselor's ability to manage the session enhances their ability to relate to and deal with important issues.

In both individual and couples counseling, the counselor must be able to tolerate strong emotions and feelings. However, in CHTC, the situation is more dynamic and complex because the counselor is dealing with two individuals who have a relationship with each other.

A counselor's capacity to tolerate intensity is a skill often acquired over time and with experience and maturity.

3. ABILITY TO BOTH VALIDATE AND CHALLENGE

The counselor must have the ability to validate the couple's feelings and perceptions. At the same time, the counselor must challenge the couple to address the realities of HIV in their lives and their community. The counselor must also encourage the couple to take action to reduce the transmission of HIV.

4. RECOGNITION THAT RELATIONSHIPS ARE FULL OF CONTRADICTIONS

The couples' counselor must understand the couple's strengths and weaknesses. For example, the counselor should acknowledge the wish of the couple to preserve the relationship even while they struggle to accept the behavior changes required to protect one another. Engaging in behaviors that increase the risk of HIV transmission may be both pleasurable and painful.

5. **UNDERSTANDING RELATIONSHIPS IN THE CONTEXT OF CULTURAL VALUES AND NORMS**

Culture, gender dynamics, religious background, and economic status shape a couple's relationships. The counselor must understand and recognize that these dynamics exist while respectfully engaging both partners in the session and valuing equality and human dignity.

6. **UNDERSTANDING PERCEPTIONS AND CONCERNS ABOUT THE DIFFICULTIES AND CHALLENGES OF WORKING WITH CHTC**

Counselors may imagine consequences for couples that are far worse than the reality of how couples handle HIV results and disclosure.

3.7. ADDITIONAL COUPLES COUNSELING SKILLS

The following counseling skills will help maintain a positive atmosphere and balanced couples interactions during the CHTC session.

- Demonstrate neutrality and nonbiased concern for both members of the couple.
- Convey respect for the couple's relationship.
- Facilitate balanced participation of both partners during the session.
- Model appropriate listening and communication skills.
- Facilitate dialogue between members of the couple.
- Raise difficult issues that the couple may need to address.
- Ease tension and diffuse blame.

3.8. SOLUTION- FOCUSED MODEL OF COUPLES COUNSELING

This training emphasizes a *solution-focused model* of couples HIV counseling.

Effectively delivered, brief couples interventions make a difference.

- **Couples who volunteer for CHTC are invested in the process.**

Most couples constructively engage in the CHTC session. Generally, couples who request CHTC have identified HIV as an issue of concern and have decided to deal with it together. The couple has entrusted the counselor to skillfully guide and support them throughout the process.

- **It is the couple's present and future that is the most important.**

The CHTC process is not about blame. It is not about identifying the behavior or the individual that is the source of the infection. It is about helping the couple address the reality of HIV in their shared life. It is about the present and helping them deal with and prepare for their future.

One analogy that may help is to think about HIV as a snake in the house. It does not matter how the snake got into the house—front door, back door, basement, or roof—what matters is that the snake is in the house and needs to be dealt with. By focusing on solutions, couples HIV Testing and Counseling helps couples move on with their lives and make positive changes in their attitudes and behaviors.

- **It is most effective to build on strengths rather than weaknesses.**

The couple's strengths, such as their ability to adapt, their flexibility, and their resilience, are the resources that will help the couple deal effectively with HIV.

- **Focus on solutions, not problems.**

Attention and energy is best directed toward generating solutions. The couple should be helped to identify possibilities, options, and alternatives. The couple's skills, strengths, and resources are maximized when they are directed toward creating solutions together.

- **The couple understands how to use their strengths to address HIV-related issues in their relationship.**

In CHTC sessions, the counselor brings in expertise about HIV, behavior change, and counseling skills. The couple brings expertise about their relationship, their life together, and their strengths and resources. The couple uses their strengths and resources to address issues; the counselor skillfully supports them through the process.

- **The counselor validates feelings, but the focus is on positive actions.**

Attending to emotions is important, but action generates hope, optimism, and confidence. The counselor should help the couple to imagine and believe in possibilities and empower them to take action.

- **Small behavior changes lead to bigger ones.**

Life is about changes. From the moment the couple decided to receive CHTC services, they realized on some level that some form of change in their lives became inevitable. The goal of CHTC is to help the

couple to build on this momentum and to initiate changes that will reduce their risk of acquiring or transmitting HIV.

3.9. MEDIATION SKILLS FOR EASING TENSION AND DIFFUSING BLAME

Another important skill of a CHTC counselor is the ability to ease tension and diffuse blame between the couple. The following skills can help.

1. **Normalize feelings, reactions, and experiences**.

Help the couple recognize that what they are feeling is not uncommon and many others have had similar experiences.

2. **Effectively use silence while conveying a supportive and calm demeanour**.

Allow the couple a moment of silence so that they can collect their thoughts and respond or comment accordingly.

3. **Remind the couple that HIV infection is common**.

Reinforce that the couple HIV Testing and Counseling session focuses on the couple's present and future. The past is the past and cannot be changed.

4. **Focus on the couple's present and future**.

The past is the past and cannot be changed. Your CHTC session is not marriage counseling. Your goal is to keep the couple from dwelling too much on the source of the infection and how it came about. Instead, you should try to focus them on their present and future together and ways to support one another and their dreams.

5. **Avoid and deflect questions aimed at identifying the potential source of infection.**

Discussing the source of the infection is neither helpful nor relevant to the couple's present situation. Again, encourage the couple to focus on their present situation and how they plan on dealing with it.

6. **Express confidence in the couple's ability to deal with HIV-related issues constructively.**

Reflect on their strengths and history together and how they have effectively addressed challenges in their shared lives.

7. **Admire the couple's willingness to contend with the challenges of HIV in their lives.**

Make sure the couple knows that their willingness to come into counseling together and to discuss the issues will help them enormously.

8. **Acknowledge the feelings expressed and observed. Predict that in time their intense emotions will likely change or shift.**

Recognize the feelings expressed during the session. Let the couple know that the intensity of these emotions will lessen over time and they will begin to be able to adapt and cope.

9. **Redirect and reframe questions and discussions that are blaming or potentially hostile**.

Identify underlying non-hostile feelings. Fear, anxiety, and uncertainty may be expressed as anger, aggression, or hostility. Help the partners to identify their underlying emotions.

10. **Calmly and gently name and acknowledge the behaviour being observed.**
11. **Remind both members of the couple of their roles and responsibilities.**

3.10. COUNSELING PROCESSES

The counseling process can be divided into three stages as outlined below. The outlined stages are only a guide and there is no fixed time or number of sessions required to complete each stage. Counseling is a process whose pace is determined by the client.

3.10.1. The Beginning Stage/Relationship building

Relationship building starts when a counselor meets a client and it continues right through the session. The way the counselor welcomes the client, her body language and even tone of voice, all assist in establishing a relationship which will determine how the client will open up to you.
Some do's that will help in establishing a relationship:

- Greet the client; shake their hand if appropriate
- Offer them a seat
- Ensure that there is no barrier e.g. table
- Lean forward when talking to them
- Look them in the face during your conversation (do not stare)
- Let your face show that you are interested and that you care.

At this stage the counselor also:

- Establishes the reason client has come
- Clarifies the client’s expectations
- Confirms what the counselor can and cannot do
- Assures the client of confidentiality

- Set the rules for the session e.g. duration of the session

3.10.2. The Middle Stage/Information gathering

Once the client fells the counselor can be trusted and will be able to offer information, guidance and support counseling enters the middle stage.

During this stage, the counselor should:

- Help client to share own feelings and views about problem at hand. The meaning that the client attaches to the problem should be discussed.
- Counselor explores the problematic behavior patterns of the client and the belief systems that support them
- Information is provided where necessary
- Talk about behavior change
- Plan action toward behavior change
- Discuss available resources

3.10.3. The End Stage/coping and problem solving

- Summarize proceedings on session
- Work on tasks for behavior change
- Review plans on management of health or illness
- Check on support systems
- Refer client if necessary and when ready
- Assure client that your door is always open for them to come back if they want to come back.

3.11. ENVIRONMENT SETTING

The environment should:

- Be easily accessible
- Ensure audio visual privacy
- Have appropriate seating arrangement with Counselling Job aids

Maintaining "SOLER"

The concept of SOLER is very important in communicating clients who come for Counseling.

SOLER stands for as follows:

S: Sit Squarely

O: Open Gesture

L: Lean Forward

E: Eye Contact

R: Relax

CHAPTER 4: ETHICAL AND POLICY STATEMENTS IN COUNSELING IN ETHIOPIA

Learning objectives: By the end of this unit, participants will be able to:

- Describe the key ethical principles of HIV counselors
- Demonstrate client's right during Counseling and Testing
- Review Policies related to HTS in Ethiopia

Contents:

- Ethical principles for HIV counselling
- Clients' rights during counseling and testing
- Policies related to HTS in Ethiopia

4.1. ETHICAL PRINCIPLES FOR HIV COUNSELLORS

Ethical principles are outlines the fundamental values of counseling. Counselors should understand these values so as to maintain a professional relationship with their clients.

The standards followed by counselors serve to safeguard integrity, impartiality and respect, with regard to both parties.

The following section outlines the main features of ethical principles for social counselors engaged in HIV testing and counseling.

General ethical principles include:

4.1.1. COMPETENCE

Counselors:

- Are responsible for their own physical safety, effectiveness, competence and conduct, thereby avoiding any compromise of the counseling profession.
- Must ensure that they have received the required training in counseling skills and techniques.
- Should regularly monitor their competence through supervision or consultative support, and by seeking the views of their clients and other counselors.
    - Must recognize their boundaries and limitations of competence, and provide services, skills and techniques for which they are qualified by training and practice.
- Must refrain from any claim that they possess qualifications or expertise that they do not;
- Must make appropriate referrals to others with expertise that they do not possess; and

- Must refrain from making exaggerated claims about the effectiveness of the intervention offered by their services in relation to HIV prevention and care.

4.1.2 The 5 C's of HTC Guiding Principles

1. CONSENT

- Counselors must obtain their clients' consent to engage in the counseling and/or HIV testing process.
- Unless sanctioned by legal authorities on criminal or mental health grounds, counseling is to be voluntarily undertaken by clients, and should take place in a private and confidential setting.
- It is the counselor's responsibility to inform clients about the nature of counseling offered and contractual obligations such as timing, duration and confidentiality
- All people taking an HIV test must give informed consent prior to being tested. This consent must be obtained or provided in the counseling relationship.
- Counselors are expected to ensure that clients have adequately understood all of the issues involved in HIV testing and counseling before giving informed consent for HIV testing.
- Counselors must recognize the rights of those whose ability to give valid consent to HIV testing may be diminished because of age, learning disabilities or mental illness.
- Counselors must recognize the right of clients to withdraw their consent at any time, even after their blood has been taken for HIV testing.
- Non-consented HIV testing cannot be justified in any circumstance. The risk of occupational transmission of HIV is extremely small and elementary precautions can eliminate it.

2. CONFIDENTIALITY

- Counselors must maintain adequate records of their work with clients or patients and take all reasonable steps to preserve the confidentiality of information obtained through client contact.
- They should take steps to protect the identity of individuals, groups and others revealed through counseling without the individual's permission.
- Confidentiality should be upheld and no information concerning the client or patient given away without the permission of the client. The results of HIV tests must be kept absolutely confidential.

- However, having consent from the HIV positive clients, shared confidentiality with family members, loved ones, care givers, and trusted friends is encouraged
- Although results of HIV tests should be kept confidential, other professionals such as counselors and health workers might also need to be aware of a person's HIV status in order to provide appropriate care
- Counselors must take all reasonable steps to communicate clearly the extent of confidentiality they are offering to clients. Normally this should be made clear in the pre-counseling information or initial contracting.
- Counselors must work within the current confidentiality agreement. Any agreement between the counselors and the client or patient about confidentiality may be reviewed and changed by joint negotiation.
- Counselors are responsible to the community and should be aware of laws governing counseling in the community and ensure that they work within the law.
- Counselors must not disclose any information about a client or patient to colleagues not directly involved in their care or their patients without first seeking consent of the client.
- Counselors must make provisions for maintaining confidentiality in the storage and disposal of client or patient records.

Counselors may break the confidentiality agreement only if there are sound reasons for doing so, such as:

- ✓ Believing that a client will cause serious physical harm to himself or herself, or to other persons; or that the client will be harmed by someone else;
- ✓ Believing that a client is no longer able to take responsibility for his or her decisions and actions.

The decisions to break confidentiality agreed upon between a counselor and client should be made only after consultation with a counseling supervisor, an experienced counselor or immediate management staff.

3. CORRECT TEST RESULT

In conducting HIV testing and interpretation of the test results, at each time for each client follow the national HIV testing algorithms, testing protocols and use HIV testing job aids**.** Providers of HIV testing should strive to provide high-quality testing services, and QA mechanisms should ensure that

people receive a correct diagnosis. QA may include both internal and external measures and should receive support from the national reference laboratory.

4 COUNSELING

HIV Counseling is mandatory and needed for those who test HIV negative and positive. Pretest counseling should be done for VTC and CHTC clients. In the case of PITC, pre-test information should be providing to all clients or patients who undergo HIV testing. Provide Post-test counseling in such a way that the client understands the benefits of ART; develop trust and confidence on the provider and reaches to informed decision on linkage.

5. CONNECTION TO SUCCESSFUL REFERRALS AND LINKAGES

Clients with HIV positive result should be linked to treatment, care and support services through accompanied referral or using referral formats. It is mandatory to ensure that all HIV positives are linked to treatment services.

4.1.3. RESPECT FOR HUMAN RIGHTS

Counselors must recognize the fundamental rights, dignity and worth of all people.
Like any other health professionals, counselors are expected to provide services to people irrespective of their race, culture, religion, values, or belief systems.
Counseling is not about forcing people to conform to certain "acceptable" standards to live by. Rather, it is a process in which clients are challenged to honestly evaluate their own values and behavior, and then decide for themselves in what ways they will modify these things.

4.1.4. PERSONAL CONDUCT

- Counselors must conduct their counseling activities in a way that does not damage the interests of their clients or undermine public confidence in their service or their colleagues.
- Counselors must maintain respect for clients in the counseling relationship by not engaging in activities that seek to meet counselors' personal needs at the expense of clients, and not attempt to secure financial or other benefits other than those contractually provided for or awarded by salary.

- Counselors should not exploit any counseling relationship for the gratification of personal desires. Sexual harassment, unfairness, discrimination and stigmatization, remarks must be avoided.

4.1.5. EMPHASIZE

- Counselors should refrain from counseling when their physical or psychological condition is impaired through the use of alcohol or drugs, or when their professional judgment and abilities are impaired for any other reason.
- Counselors should appear professional and presentable in dress and manner, and be clearly identified by a badge detailing their name, professional status and facility.

4.1.6. INTEGRITY

- Counselors must seek to promote integrity through honesty, fairness and respect for others, and avoid improper and potentially harmful dual relationships with clients.

- They should not engage in a personal or sexual relationship with current clients.
- They should not accept to counsel clients with whom they have engaged in former sexual relationship or with whom they have a current personal relationship.
- They should not engage in any relationship (including counseling) with a client in another service facility.

4.1.7. DISCIPLINARY MEASURES

- Counselors have a responsibility to other counselors and must take measures to correct them when wrong doing is observed.
- Counselors have a responsibility both to individual clients and to the institution within which counseling services are performed, in order to maintain high standards of professional conduct.

Counselors may encounter situations not covered in this training material. In unfamiliar situation, counselors should remain calm; use their judgment and call on the techniques of counseling to help the client. If counselors are unsure of how to respond in any given situation, they should seek help according to the rules in place at their counseling center. Knowing when to ask for help, and being able to accept it, are essential qualities of a counselor.

When a client ‘s problem is beyond a counselor’s capabilities, it is far more effective and useful from the client’s point of view if the counselor refers the problem to an experienced counselor rather than attempting to solve it by him or herself.

4.2. CLIENTS’ RIGHTS DURING COUNSELING AND TESTING

Clients have the right to:

- Confidentiality
- Privacy
- Refuse testing
- Be treated with respect
- Information
- Ask Question

Confidentiality is an important characteristic of HIV Testing and Counseling (HTC) services.

Counselors should keep all client information private and respect client’s wish to decide carefully when and whom to tell about her/his HIV status.

Other reasons confidentiality is so important in CT are the negative feeling many people have about HIV/AIDS and the possible harmful consequences of someone’s HIV status being known.

Sometimes, other caregivers need to know the client’s HIV test result to help ensure that the client receives appropriate care. The counselor should tell the client about the possibility during counseling.

4.3. POLICIES RELATED TO HTS IN ETHIOPIA

The following policy and ethical statements reflect existing National Comprehensive HIV Prevention, Care and Treatment guideline.

4.3.1. GENERAL HTC SERVICES

Policy objectives:

To promote and provide standard HTC services to individuals, couples, and community groups of all ages especially to vulnerable and high-risk groups regardless of gender.

Policy Statements

- HTC services shall be integrated into existing health and social welfare services and promoted in all settings: government, non-governmental, private sector, cooperatives, workplace, faith based organizations etc.
- HTC services shall be strengthened through effective networking, consultation and collaboration among stakeholders.
- HTC services shall be standardized nationwide and shall be authorized, supervised, supported and regulated by appropriate government health authorities.
- Informed consent for testing shall be obtained in all cases, except in mandatory testing
- Adequate pre-test information, post-test counseling shall be offered to all clients
- Test results, positive or negative, shall be declared to clients in person and must be provided with post-test counseling.
- No results will be provided in certificate form, however referral will be offered to access post-test services (prevention, care, treatment and support).
- Clients' confidentiality will be maintained at all times. Results can be shared with other persons only at clients' request or agreement, and with those involved in clinical management of clients. Clients can be referred if required or upon request.
- Mandatory HIV testing is a violation of human rights, only permissible in exceptional cases by order of a court of law. Mandatory testing will be done on all voluntary blood, tissue and organ donors, who shall be informed about HIV testing and given opportunity to learn their test results.
- Provider-initiated testing and counseling (PITC) shall be promoted to all eligible person as part of standard clinical management and care in all health facilities.

4.3.2. COUPLES

Policy Statements

• Couples shall be encouraged to be counseled, tested and receive results together. Partner notification shall be encouraged in cases where one partner receives the results alone.

• The privacy and autonomy of the couple and individual must be respected. Informed decisions shall be encouraged among discordant couples to protect negatives and support positives.

• Pre-engagement, premarital, and preconception counseling and testing will be promoted.

4.3.3. WOMEN

Policy Statements

• Women shall be routinely offered HTC during pregnancy, labor, post-natal and at family planning with the right to refuse testing.

4.3.4. CHILDREN AND YOUTH

Policy Statements

• HIV testing for children under the age of 15 shall only be done with the knowledge and consent of parents or guardians, and the testing must be done for the benefit of the child. However children aged 13-15, who are married, pregnant, commercial sex workers, street children, heads of families, or sexually active are regarded as "mature minors" who can consent to HIV testing

• Persons 15 years and above are considered mature enough to give informed consent for themselves.

• In some special cases, such as child adoption, a counselor may refuse a testing request when not in the best interest of the child

- Children who have been sexually abused and put at risk of HIV infection shall receive counseling, be encouraged to test for HIV and helped to access appropriate services.
- The result of HIV testing is the property of the child tested and shall not be disclosed to third parties unless clearly in the best interest of the child.
- Youth-friendly counseling and testing services shall be made widely available for youth population.

4.3.5. PHYSICALLY DISABLED AND MENTAL IMPAIRED INDIVIDUALS

People with physical disabilities and mental impairment require special care when providing counseling and testing services, particularly regarding communication.

Policy Statements

- HTC service shall accommodate the special needs of people with visual and hearing impairments by adopting appropriate media of communication.
- Individuals under the immediate influence of alcohol or addictive drugs (substance use) shall not be offered HIV testing due to a mental inability to provide informed consent.
- HTC for a mentally impaired individual requires the knowledge and consent of his/her guardian, and should be for the benefit of the individual or patient.

4.3.6. ETHICS IN COUNSELING

Policy Statements

- All service providers shall abide by the rules, regulations and protocols contained in this document and other related national guidelines.
- All service providers shall observe the ethical requirements of confidentiality, informed consent, proper counseling, anonymity and privacy.
- Shared confidentiality shall be promoted as an avenue to demystify and destigmatize HIV/AIDS.

ANNEXS

Annex 1: Types and forms of counseling

Apply the different types of HIV counseling (*Crisis counseling, Problem solving counseling, Decision making counseling, and ongoing counseling)*

The type of counseling is usually based on the client's need and problems, the stage of the problem at which counseling begins, and the overall circumstances.

Here are some types of counseling

- *Crisis counseling*
- *Problem solving counseling*
- *Decision making counseling*
- *Ongoing counseling*

Here we will focus only on the crisis, problem solving, decision making and ongoing counseling as they are forms of counseling most related with HIV/AIDS counseling.

1. CRISIS COUNSELING

Crisis counseling is a means by which a counselor is working to alleviate HIV related painful situation or period, especially a time when action must be taken to avoid complete disaster or breakdown

Crisis counseling is the most frequently required form of counseling related to HIV infection.

The implication of the infection, with regards to survival and social stigma can induce feelings of helplessness, hopelessness, and loss of control.

NOTE: A crisis is made of four elements.

1. **The Blow:** is the shock of fearing or realizing that something is wrong.
2. **The Recoil:** occurs as the person struggles emotionally to come to grips with the full implications of the crisis (denial).
3. **Withdrawal:** to be alone with their sorrow or anger, and isolate themselves. Others suffer depression.
4. **Acceptance:** clients with their own psychological resources and with skillful counseling can come out of the crisis.

A client in a crisis situation might feel and perceive all efforts to resolve the problem or to reduce the suffering as useless and hopeless. The counselor has to accept the feeling of the client and start work from where the client is. He/she should be reassuring and supportive as the client discusses the crisis. Some clients might appear to be overwhelmed and the counselor should respect them and accept their feelings. The counselor should remain calm and accept the fear as genuine. He/she should recognize the need for denial, shock or anger. The counselor should not panic, offer false assurance, give advice or take offence.

Techniques for crisis counseling

Using the following brief techniques would help to define the crisis and restore a sense of control of life (the present and the future):

Guided questioning: asking direct and clear questions about the situations and feelings. Check that the client understands the situation and future possibilities.

Showing acceptance – the expressed feelings and ideas are understandable. Talk about them and show willingness to listen.

Emotional support – indicating that one would be frightened on such situation: one should take some time and talk about.

Agree on courses of action- check that the client has the decision-making ability; focus on the current or present feeling, and agree on a course of action to take starting from then on.

2. PROBLEM SOLVING COUNSELING

Crisis counseling and Problem solving counseling often take place at the same time.

Crisis counseling focuses directly on the present issues; problem solving is concerned with the future planning together with the methods of coping with the reaction to HIV/AIDS, medical care and the prevention of transmission of HIV.

Problem solving counseling is concerned with the clear definition of what the problem is, risk factors, planning of prevention of transmission, methods of coping with the reactions to HIV/AIDS, and the necessary support and care.

In general, the following principles are recommended for using the problem solving model.

- Explore the problem by responding to the client;
- Understand the client's problems in relationship to the outside world;
- Define the problem in specific terms and consequences;
- Define a goal to be achieved;
- Generate several courses of action;
- Evaluate the options pf action and make a decision for action;
- Implement the choices and if conditions allow, follow up the outcomes.

Encouraging open discussion about all aspects of the problem, coming up with a plan of action (what to do next), and discussing abort the resources (personal and other) available are the major activities of the approach.

3. DECISION MAKING CONSELING

Based on the awareness of risk behavior or a diagnosis of infection the client must make decisions about behavior and other possible changes.

In making decisions people usually consider alternative courses of action, assess the objectives and goals, weigh costs and risks, obtain the relevant information and examine the consequences of the alternative choices.

Such criteria are not explicitly applied in most situations, but with better understanding of the situation and growing emotional control, most clients would be able to make acceptable decisions.

It is highly recommended that decision making counseling should help the client to focus on the following decisions:

- What behavioral and attitudinal changes are necessary?
- Who will provide the care and support in the event of progressive illness?
- Who will provide the emotional support?
- Who will need to be told of the condition; how and when will they be told?
- Who will care for the children and the family?
- What kind of change can be made in diet and lifestyle in order to stay as healthy as possible?

Please note that crisis counseling, problem solving and decision making counseling are interrelated. They can be selected and applied according to the client's needs at any given time. Each could also be used many times with the same client or the family.

4. ONGOING COUNSELING

Ongoing HIV counseling can be defined as counseling clients on an ongoing basis to support them in their desire to address their needs as related to their HIV status.

GOALS AND OBJECTIVES OF OGHC:

The overarching goal for ongoing HIV counseling is to provide clients with a higher quality and improved access to ongoing HIV counseling services with a gender perspective that can better serve their ongoing and expressed needs.

Specifically, some of the objectives of OGHC include, but are not limited to:

- Improve the base of knowledge and skills that both facility and community-based HIV and AIDS providers have, so that they can better address and understand the needs of their clients.
- Provide gender sensitive OGHC services to address the different issues of clients and also ensure equal opportunity in recruiting female and male counselors
- Provide individuals seeking ongoing support with holistic ongoing HIV counseling services
- Increase the number of HIV tested individuals who opt to disclose and refer people they believe to be at risk for HIV infection, and thereby increase the number of individuals who seek out HIV testing services.

- Improve the quality of life of people living with HIV (PLWH) and those affected by HIV and AIDS, by providing them with problem-solving and decision-making counseling sessions.
- Encourage HIV negative clients to remain negative by reducing their risk behavior.
- Improve HIV related referral linkages between the clients in need and the community and facility-based services that can provide them with care and support.
- Increase the psychosocial support network for people living with, or affected by, HIV and AIDS.
- Assist clients to cope with stigma and discrimination within their communities.

Module Summary

- Counseling is a two-way communication, totally different from advice or education
- The purpose of counseling is accepting the client and providing target oriented information to the client and assists the client in making realistic informed decision
- The Four core elements of self-concept and equally important and are mutually supportive
- Being self-aware means knowing yourself, how other people affect you, and how you affect other people
- Culture influences the way people interact, interpret, explain and respond to HIV infection and to AIDS disease
- Counselors should attempt to learn the main values of the people with whom they are working with and must develop awareness and competencies that will enable them to contribute to the development of all individuals, regardless of their social backgrounds or life styles.
- Communication helps to establish a common ground where two or more people meet and discuss their views. Relationship building starts when a counselor meets a client and continues right through the session.
- Counseling process has three stages (Beginning /Relation building, Middle stage/Information gathering & Concluding or End stage/Coping and Problem Solving)
- HIV counselors should be aware that they may face a number of ethical dilemmas, including

Issues of confidentiality, client dependence, disclosure of test results to partners, provision of HTC to minors, appropriateness of gifts received or offered. & they need to manage ethically.

- Confidentiality is an important characteristic of HIV Testing service

Module 3

Voluntary Counseling and Testing (VCT)

CHAPTER ONE: INTRODUCTION TO VCT

Learning Objectives: By the end of this session the participants will be able to:

- Apply required knowledge and commitment to conduct VCT
- Demonstrate skills required to conduct a quality VCT session
- Conduct VCT session using protocol components

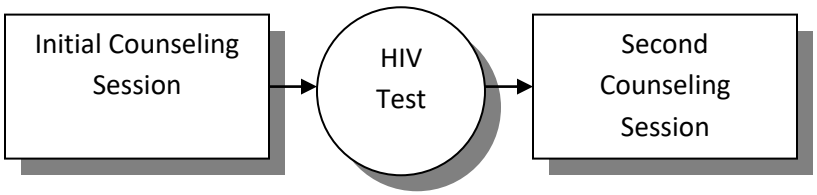
Content:

- Definition of VCT
- Benefits and Challenges of VCT
- Structure and Protocol of VCT
- Introduction of VCT Cue Cards

What is Voluntary Counseling and Testing?

Voluntary Counseling and Testing (VCT) is an HIV prevention intervention which gives the client an opportunity to confidentially explore his or her HIV risks to learn his or her HIV test result.

Through VCT, clients learn their HIV status. Most people who access VCT find they are not infected with HIV! Clients who go through VCT become ambassadors for HIV prevention. They reduce their risk and encourage partners, family members and friends to access VCT**.**



A VCT intervention includes two counseling sessions; the initial counseling session followed by the HIV test; and a second counseling session to provide the client with his/her test result.

VCT INTERVENTION

- VCT is designed to be a brief and focused intervention. With practice, each of the two sessions can be accomplished in 15 to 20 minutes (sessions with HIV+ clients will take longer).
- The VCT intervention is "client-focused" to the extent that you focus on the client's unique issues and circumstances related to HIV risk.

- The VCT intervention is based on a risk reduction model and the intervention is designed to reduce, not necessarily eliminate risk. The emphasis is on the initiation of small incremental behavior change steps to reduce risk. VCT is an HIV Prevention intervention that builds on success!

What is HIV Prevention Counseling?

HIV Prevention Counseling is a counselor-led and client-focused two way communication designed to help individuals make behavior changes that will reduce their risk of acquiring or transmitting HIV.

Benefits of VCT

- **Benefits to the Individual**
  - Empowers the uninfected person to protect himself/herself from becoming infected with HIV.
  - Assists infected persons to protect others and to live positively
  - Offers the opportunity for the treatment of HIV & other opportunistic infections associated with HIV.
- **Benefits to the Couple and Family**
  - Supports safer sexual relationships – enhances faithfulness
  - Encourages family planning and treatment to prevent mother-to-child HIV transmission
  - Allows the couple/family to plan for the future
- **Benefits to the Community**
  - Generates optimism as large numbers of persons test HIV-negative
  - Impacts community norms (HIV testing, risk reduction, discussion of status, condom use)
  - Reduces stigma as more persons "go public" about having HIV
  - Serves as a catalyst for the implementation of care and support services
  - Reduces transmission and changes the tide of the epidemic

Challenges of VCT

HIV/AIDS presents many challenges to communities, families, and individuals. Some people still practicing unsafe and unprotected sex and they think that HIV is not no more a problem to their community they may assume that the HIV epidemic is over and only a few group of people like FSW and their clients are at risk of getting HIV. There are people in the community who have HIV in their blood but do not know their HIV status, however, still practicing unsafe and unprotecting sex that might contribute for further spread of the virus. Therefore any person who is sexually active and don't know his/her HIV status, better to look for HTS.

STRUCTURE OF VCT

- The VCT protocol consists of 12 components.
- Each component has a goal and specific tasks to achieve the goal and complete the component.
- Each component builds on the previous component.
- The protocol is a series of questions based on each component's goals that direct the counselor-client discussion.
- The counselor selects questions relevant to the client.
- The protocol questions help guide the counselor during the sessions.
- The questions are intended to guide the client's thought process.

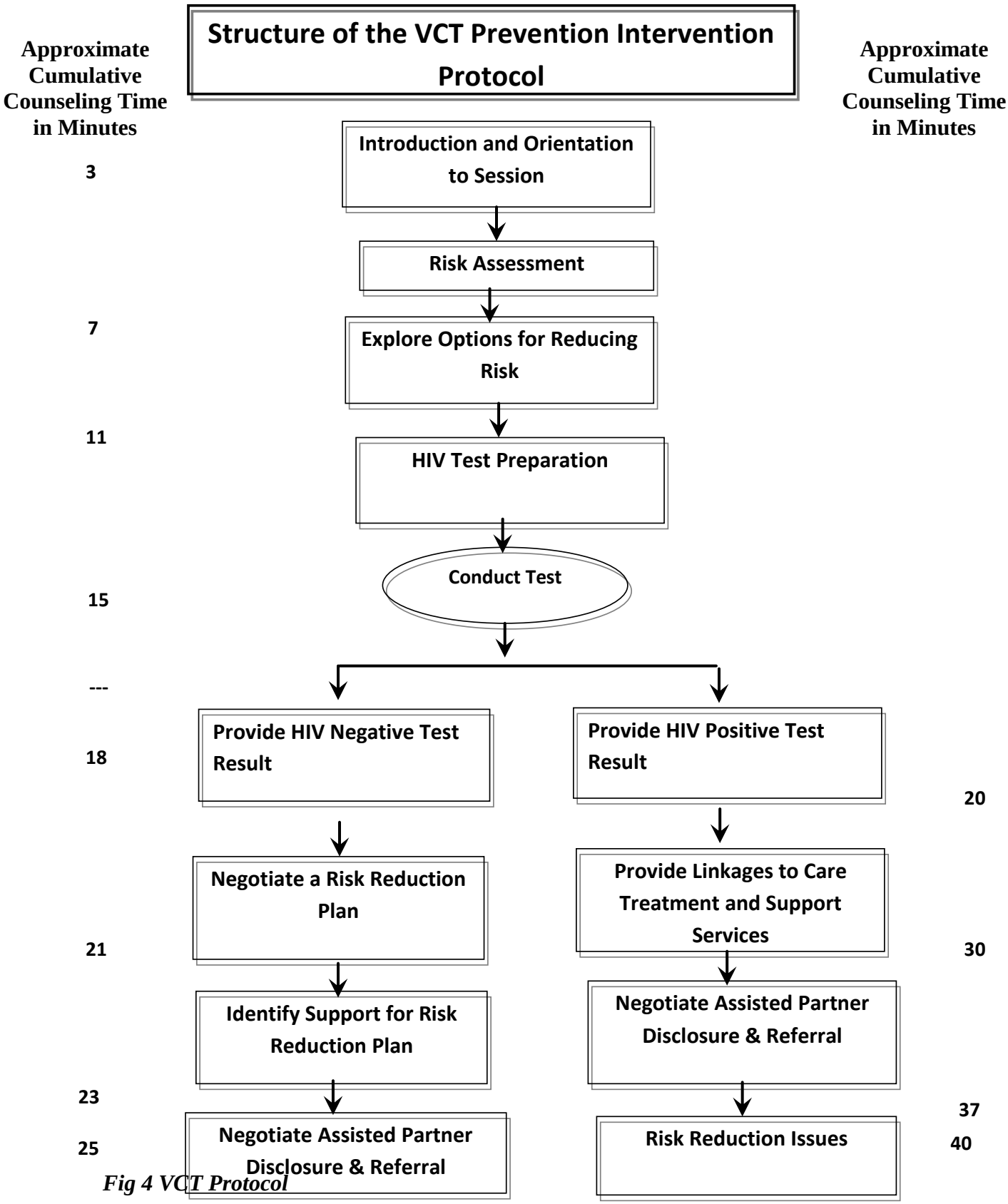


Fig 4 VCT Protocol

CUE CARD: a consecutive guides /tool of the counseling session with the client and these cards will help you stay organized in the VCT session and help you redirect clients to keep them on task.

PROTOCOL
An organized series of content areas and activities covered by the counselor with an individual or couple that in combination accomplish a prevention intervention. **Examples:** VCT, CHCT, and PITC Protocol

COMPONENT
A sequence of related tasks that comprise a specific and important topic area to be addressed in delivering the prevention intervention. **Examples:** Introductions and Orientation to the Session

OBJECTIVE	**TASK**	**SCRIPT**
Provide the rationale for focusing on and achieving each of the Component/tasks to be completed **Examples:** To mutually agree on the session's objectives.	A series of ordered activities to be fulfilled in order to accomplish each component **Examples:** Introduce self to client	Assist the counselor to solicit the essential information from the client to accomplish specific tasks **Examples:** “Good morning/afternoon”, my name is _____. I’ll be talking with you today about what brought you to the VCT site.

CHAPTER TWO: VCT PRETEST COUNSELING

Learning objectives: By the end of this course, participants will be able to:

- To apply the first four components of Pretest counseling of the VCT session

Contents

- **Component 1** :Introduction and Orientation to the VCT Session
- **Component 2**: Risk Assessment
- **Component 3**: Explore Options for Reducing Risk
- **Component 4**: HIV Test Preparation

Component 1: Introduction and Orientation to the VCT Session

Learning Objectives: By the end of this session the participants will be able to:

- Mutually agree on the session's objectives
- Orient the client to the VCT procedures
- Reduce client anxiety and emphasize that in the session they will explore his/her HIV risks and
- Develop a plan to reduce his/her risk of infection or, if infected, to reduce risk of transmitting the virus to others.

In order to establish rapport with the client, the counselor needs to convey positive regard, and genuine concern and empathy. This connection will help build trust and will set the tone of the session. The counselor must be professional and respectful to every client. The client should be helped to feel comfortable with the counseling and testing procedures, understand the role of the counselor, and be clear about the content and purpose of the session. It is also essential that the counselor needs to explain confidentiality. If the client is clear about the expectations and the process, the counselor has reduced the client's anxiety and increased the client's ability to focus on the session. In this component of the session, the counselor should establish the collaborative nature of the session and the commitment of the counselor to supportively address the client's HIV concerns and to explore risk issues.

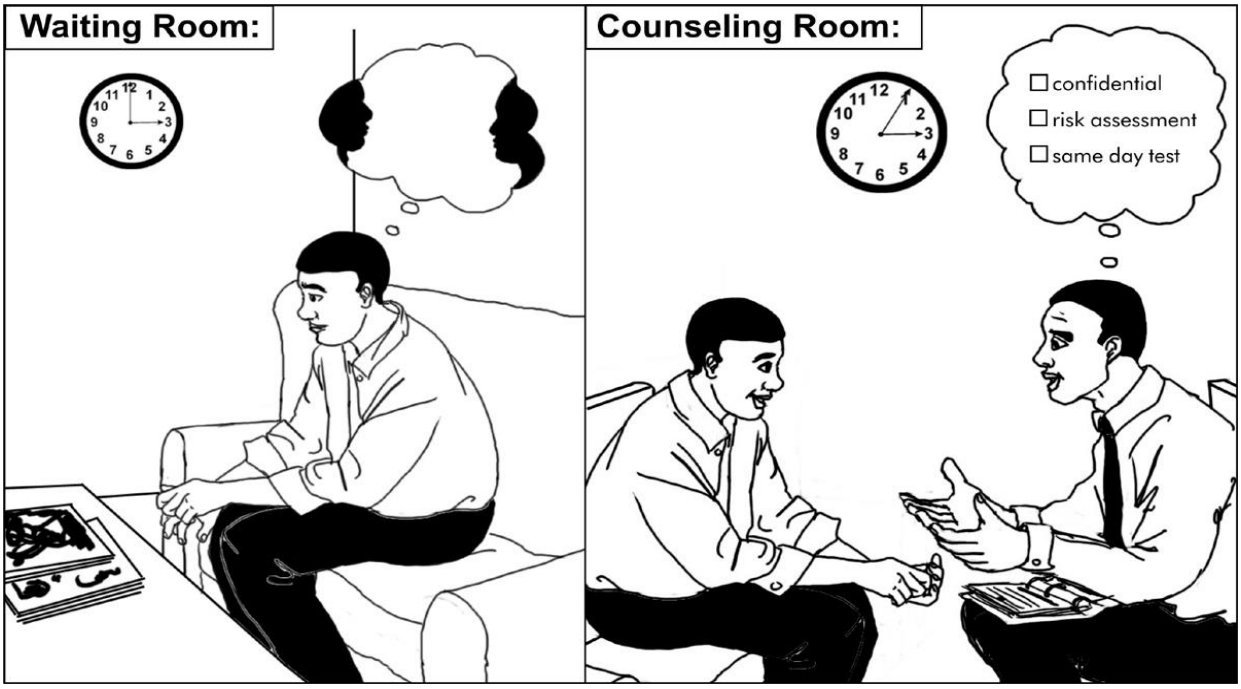


Fig 5: Importance of Introduction & orientation to VCT, with privacy and confidentiality .

This figure is intended to demonstrate that a client is often anxious when coming in for VCT. As a client he/she may be thinking: what's going to happen to me today, who will I be talking to, what will they ask me, and how long will all of this take? However, if you are clear about the content and purpose of the session, you will reduce your client's anxiety and increase his/her ability to focus on the session. **Notice the use if the cue cards on the counselors lap. Nothing else.**

Examples of <u>Client</u> Questions and Possible <u>Counselor</u> Responses

Client says	**Counselor answers**
Will my boss find out about my test result?	No, your test result and counseling sessions are all confidential.
I have to get back to my job and I've been waiting for a long time.	I understand you have been waiting for quite a while. You will be entirely finished here in about 45 minutes. Will you be able to stay that long?
Should my partner be tested?	I promise we will talk about that later in the session, but first let's begin by understanding your risk situation.

If I have HIV, is there a cure?	No cure for HIV, but I will explain more about that to you in a few minutes, but it would be helpful if first we talk about some important issues.
How much does the test cost?	It is free of charge.
Will I receive a copy of my test result	It is not our policy to provide clients with documentation of their result. However, in case, if your test result is HIV positive, I will give you a referral paper in order to get the necessary care and support services
If I am infected does that mean my wife/husband also has HIV?	That is a very good and important question, your test result doesn't indicate your wife test result. However, I can better respond to your concern if I first understand your situation a little better.
I might have HIV from the barber, I'm not sure he cleaned the razor blades or not.	The risk of getting HIV from your barber in most cases should be very low. There are other behaviors that may put you higher risk, so let's start there.
In case, if I am HIV positive, I need to decide whether I should marry my girlfriend/ boyfriend or not but I don't know what to do?	Let me ask you a few questions in order to begin to understand your situation better. Once we talk about these issues it may be clearer to you how to make your decision.
What should I do if I have HIV?	Based on your test result we will talk about what you should do next. Let's first start by understanding your HIV risk.

(Refer cue cards for the VCT component 1)

Component 2: Risk Assessment

Learning Objectives: By the end of this session the participants will be able to:

- Engage the client in an initial exploration of his/her HIV risk behavior
- Explore the client's HIV concerns and risk issues
- Enhance the client's understanding of HIV and his/her risk behavior

In assessing the client's risks, the questions asked by the counselor are directed at eliciting the entire range of factors that may have contributed to the risk behavior. A discussion of the most recent risk behavior may help the client clarify how the risk behavior occurs. What may have initially seemed like an accident or an unusual incident begins to have concrete circumstances that contributed to the client's decision to engage in high-risk behavior. Through this process the client begins to understand and gain insight into his/her own behavior. The counselor should be aware client's emotions, recent life events, alcohol and drug use, self-esteem, and other issues that might influence a particular risk incident or pattern of risk behavior. The aim of this exploration is to help the client gain an understanding of the complexity of factors that influence his/her risk behavior.

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Fig 6 Analogy of conditions of Client HIV Conerns or risk , identifies during VCT Intial session

This figure illustrates that as the counselor asks questions to assess the client's risk, the client begins to actually think about her risk, maybe for the first time. Most of our clients have busy lives. Some do not think beyond day-to-day survival. Therefore, VCT offers your client an opportunity to take time to reflect on and begin to understand his/her personal risks. As the counselor, you should encourage your client to reflect on and examine his/her strengths and resources and mobilize the client to change his/her behavior and reduce risk.

What is Risk Assessment?

- Risk assessment is the exploration of the factors that influence the client's behaviors that place him/her at risk for HIV infection.

- This exploration of risk helps the client understand his/her risk behavior.

- During risk assessment, the counselor seeks to understand the client's HIV concerns and develop an understanding of the client's risk.
- The questions asked are intended to clarify how risk behavior occurs and what client characteristics, issues, and circumstances lead to risk behavior.

Exploration of Recent Risk

- Discussion of a client's most recent risk behavior will help clarify how his/her risk behavior occurs.
- A client needs to gain an understanding of how he/she gets into risky situations in order to begin to reduce risk.

Assessing Client's Risk

In this component of the VCT counseling protocol, the counselor's role changes:
In the introduction and orientation to the session, the counselor did most of the talking.
From this point forward, the counseling session will be more interactive.

- The client will be talking more than the counselor.
- The counselor will actively engage the client in exploring the client's risk behavior and help the client gain an understanding of the many factors that influence his/her risk behavior.
- The counselor will also keep the session focused on risk issues.

Risk Circumstances, Triggers, Vulnerabilities and Pattern

Risk Circumstances

The client's circumstances influence patterns of risk. A risk circumstance is a situation in which the client finds himself or herself in that may lead to engaging in risky behavior.

For Example, lack of money for school fees or food could be a risk circumstance that could lead to exchanging sex for financial support.

Risk Triggers

A risk trigger is an event that leads the client to engage in risky behavior.

For example, being separated from a spouse could be a risk trigger that could lead to seeking out other sexual partners.

Risk Vulnerabilities

Risk vulnerability is an emotional or psychological state that leads the client to engage in risky behavior.

For example, a person in love might believe that his or her partner could not be infected with HIV.

Risk pattern

Patterns of risk are recurring situations in which the client is more likely to engage in risky behavior...

For Example: A male client travels for work. When he travels he is lonely and often stops at a bar for the evening to be with other people. He drinks alcohol at the bar. When he drinks too much, he is more likely to seek out a sexual partner and because of the alcohol, often doesn't think to use a condom. As a result, when the client travels for work he often has unsafe sex.

- *The following figure gives examples of a risk pattern, trigger, vulnerability, and circumstance by matching the woman's risk factors to a specific example on the man. Just as in this figure the counselor in collaboration with the client attempts to understand, organize and put together the fragment of factors that contribute to the client's risk.*

(Refer cue cards for the VCT component 2)

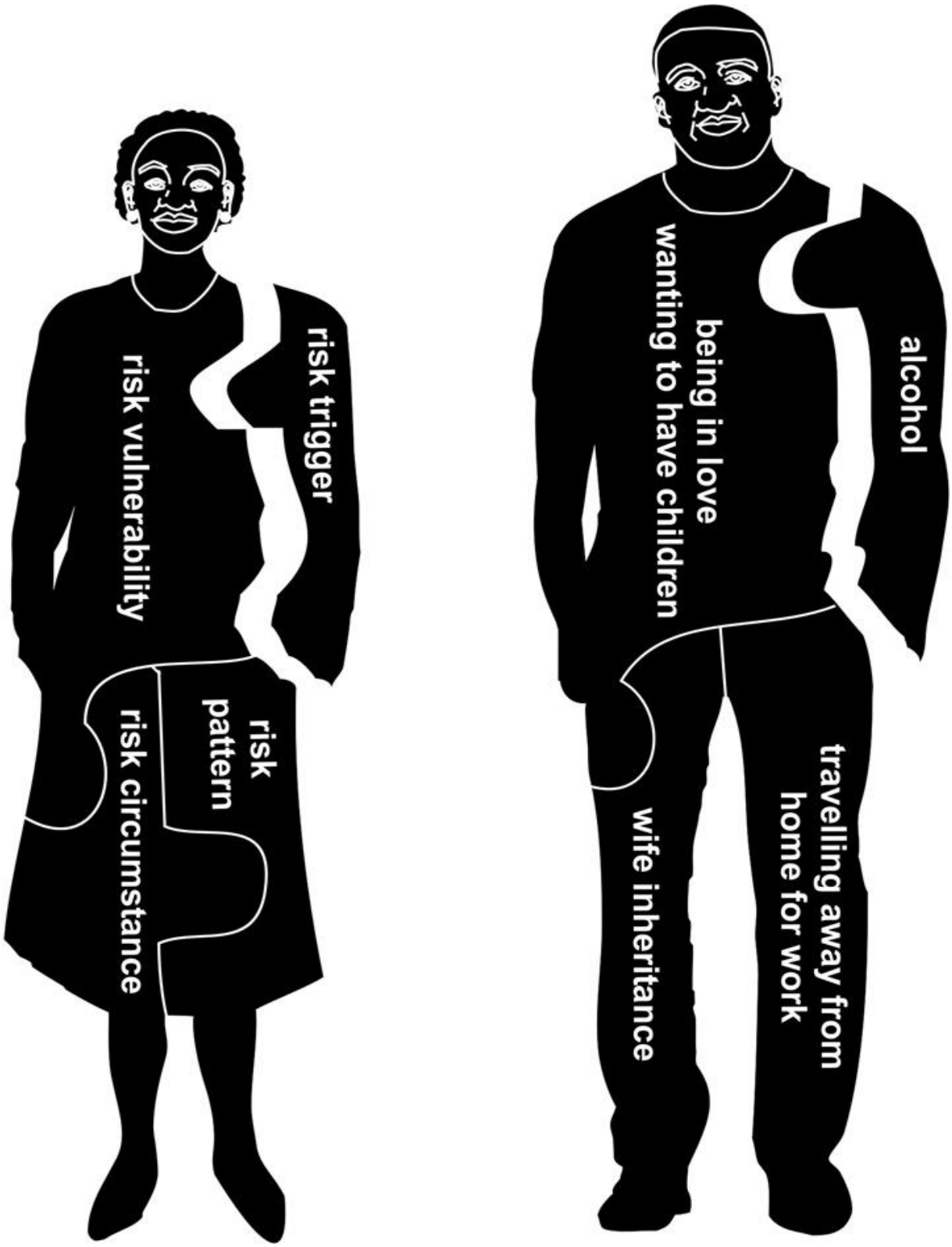

Fig 7. HIV Risk Circumstances, Triggers, Vulnerabilities and Pattern

Component 3: Explore Options for Reducing Risk

Learning Objectives: By the end of this session the participants will be able to:

- Identify client's constructive risk reduction attempts
- Explore barriers toward behavior change, and provide understanding and support regarding these issues
- Empower the client to take action to protect him/herself and others through skills building, role plays, problem solving, communication enhancement and condom skills

The component of the session is intended to be very interactive and meant to engage the client in a focused exploration of risk reduction and support options. The counselor should have an open and inquisitive approach to this portion of the session. This approach will encourage the client to reflect and examine his/her strengths, resources and options. The counselor's aim is to have the client fully engaged in the session and invested in reducing his/her HIV/STI risk. Skill building and role-playing are essential aspects of this component of the session. This discussion is the foundation on which the risk reduction plan will be developed.

The counselor should explore any changes initiated by the client to reduce his/her HIV risk(s). This provides the counselor with an essential opportunity to **support** and **reinforce** the client. The counselor should note all of the client's intentions, communication and actions concerning HIV risk reduction. The counselor should elicit obstacles encountered by the client in attempting behavior change. The counselor should gently and sensitively discuss the challenges the client has encountered or perceived. It is important to acknowledge that behavior change is a complex, difficult and challenging process. It is helpful, particularly if the client has difficulty of talking about his/her experiences with risk reduction, to explore his/her perception of community and peer norms concerning HIV prevention. Further, encouraging the client to articulate his/her attitudes and beliefs about HIV risk behavior may provide additional insight. This process allows the client to verbalize the extent to which he/she has addressed HIV issues and provides the counselor with insight into the client's strengths and difficulties in initiating and sustaining behavior change.

The counselor's approach to this component of the session will achieve client's particular issues in addressing HIV risk by:

1. Enhance self-perception of risk;

2. Address disagreement (examples when beliefs and behavior are at odds) and ambivalence (mixed feelings) about risk reduction;

3. Increase self-efficacy (belief in one's power or ability to do something);

4**. Raise peer pressure and community norms;**

5. Role-play and develop skills;

6. Explore and identify support resources.

Fig 8 Analogy of Client HIV risk reduction options , identifies during VCT Intial session

This young woman on the above Picture is looking at her options on the menu. She knows that she cannot eat Gomen Wat because it causes stomach upset. Kitfo is too expensive for her. However, she likes Shiro Wat, it's not expensive and it's served with her favorite fresh vegetables. After exploring all options on the menu, she chooses Shiro Wat.

As a VCT counselor, it will be your responsibility to engage your client in a focused discussion of risk reduction options. Like the items on the menu, options and choices will vary from client to client. Clients need to explore options that are realistic and reasonable for them to pursue.

What are Male Condoms?

A sheath that fits over a man's erecting penis. Most made of thin latex rubber Variety of sizes, colors, flavors, and textures are available. It protects against both pregnancy and STIs including HIV. Condom can be used alone or with another family planning method. **Correct and consistent use of condoms has significantly reduced the risk of HIV infection among men and women.**

Factors that affect the effectiveness of condoms

- Incorrect or inconsistent use
- Using oil-based lubricants available at household products
- Storage condition (i.e., exposure to heat or sunlight or moisture)
- Torn by teeth or fingernails/sharp materials

What are quality condoms?

- Need to fit penis properly
- Free from holes
- Adequate physical strength
- Correctly packaged to protect them during storage
- Correctly labeled
- Condom, packing material and lubricants should not be toxic ,not locally irritating and harmful

What are quality condoms?

- Need to fit penis properly
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- Condom, packing material and lubricants should not be toxic ,not locally irritating and harmful

How do we verify quality?

Condoms are tested in: Manufacturers' laboratories, Independent laboratories and National regulatory laboratories

How is the laboratory testing done?

DRAFT

Assessing Client's Condom Skills

Sample Dialogue

State to Client:

- "Using condoms is an effective way to reduce the risk of HIV infection and other STIs. Generally, people have a lot of different thoughts and beliefs about using condoms."

- "I'd like to take a few minutes to focus on what you think and know about using condoms when you have sex."
- "To be certain that you are using condoms properly, would you like me to demonstrate for you, or would you like to demonstrate for me the proper use of a condom?"

State to client at the beginning of the condom demonstration:

"A condom as you might know is very effective protection against sexually transmitted infections, unplanned pregnancy including HIV. But, you must use a new condom the right way in each sexual act for the condom to be effective in preventing disease transmission and unplanned pregnancy This demonstration will allow you to practice proper condom use."

Remember:

If you conduct a condom demonstration for the client it should not dominate the counseling session!

Condom Demonstration Steps

You will need a penis model for the demonstration

1. Show how to inspect the condom by checking the condom package to make sure it is not punctured and not expired. (If the condom package is punctured or expired, throw the condom away and repeat inspection with a new condom.)
2. Open the condom package carefully with your fingers. (Stress that you should never use a sharp object because it may puncture the condom.)
3. Find the tip of the condom with the forefinger and hold it so that the ring hangs down like a little hat.
4. Hold the tip with the forefinger and thumb as you place the condom on the penis model, ring on the outside.
5. Roll the condom down to the base of the penis with the other hand.
6. Tell the client that after sex, hold the condom at the base and pull the hard penis away from the partner. Do not spill any liquid on the partner.
7. Slide the condom off.
8. Dispose immediately in proper waste container.

Female Condoms

Female condoms are becoming more widely available and have the advantage for women that their use is more in their control than use of male condoms. One type of female condom is currently in the market, under various names. It is made of polyurethane plastic, which is sturdier than latex. Only one size is made and fitting by a health care provider is not required. Unlike male latex condoms which are weakened by oiled based lubricants the female condom may be used with any type of lubricant without its strength being affected. It is pre-lubricated but users may add more lubricant.

Female condoms offer a similar level of protection as male condoms, but they are more expensive.

Exercise others High-Risk Behavior and Possible Risk Reduction Options

What are some examples of possible **Risk Reduction Options? High Risk Behaviors?**

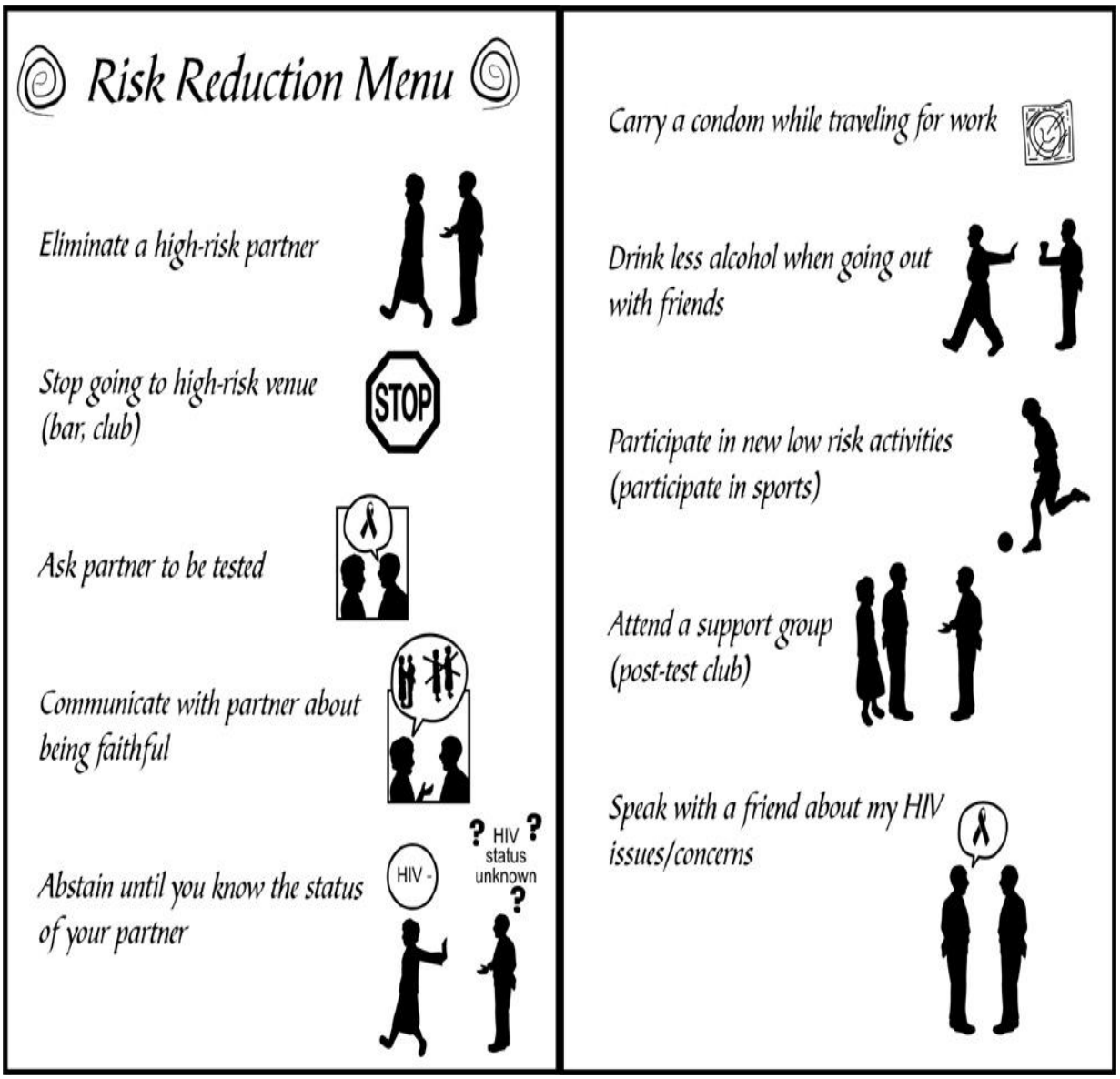


Fig 9 Options / Menu of HIV Risk reduction

Regardless of what a client chooses off of the risk reduction menu (e.g. Abstaining, Being faithful or using Condoms, ongoing Discussion among Sexual partner …) it is important for the counselor and the client to think through Role Plays how to implement the risk reduction plan into action to make it a reality.

Component 4: HIV Test Preparation

Learning Objectives: By the end of this session the participants will be able to:

- Ensure that the client understands the meaning of the possible HIV test results
- Reinforce the benefits of testing and underscore the importance of accessing care and treatment services should the clients' result indicate infection with HIV

In this component of the session, it is essential for the counselor to explore the client's understanding of the meaning and implications of the HIV test result in an unbiased professional manner. The counselor should be aware of and convey the benefits of knowing one's serostatus. A client who is aware of his/her HIV infection can protect partners and future children from HIV, prepare for his/her family's future and protect his/her health.

The counselor should keep in mind that although receiving a positive test result may be quite difficult, clients are generally resilient and, after dealing with their feelings of fear and loss, are generally able to cope well and enhance the quality of their lives. The counselor should explain and underscore the importance of receiving preventative and clinical care for persons infected with HIV. Correspondingly, the counselor should assess the client's plans for constructively coping and obtaining needed support should he/she test positive.

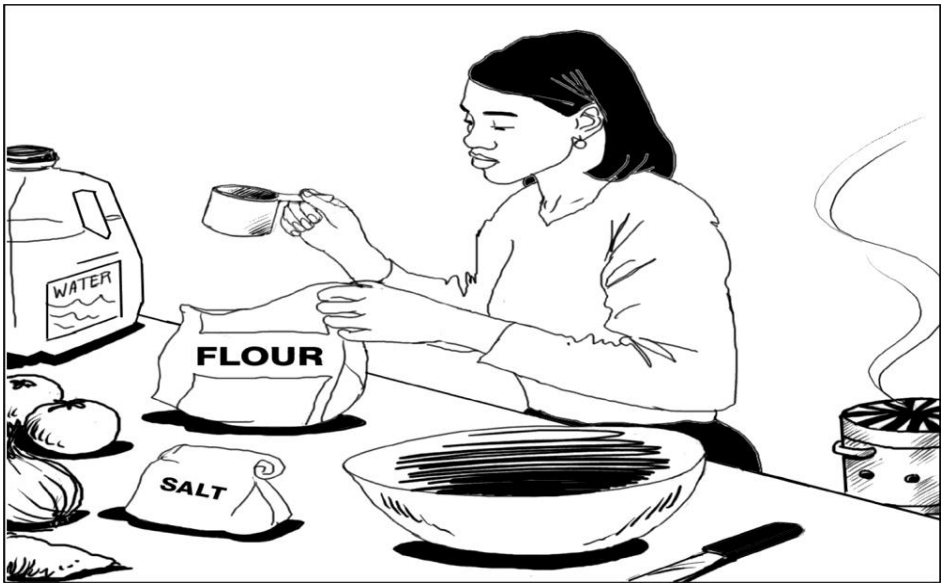


Fig 10 Analogy of the benefit of HIV Test preparation before conducting the HIV Test

Before making a meal for her family, a mother must be prepared with the appropriate ingredients and utensils. Once she is confident that she is properly prepared, she will combine the ingredients and prepare the meal. The result will be a delicious and nutritious meal enjoyed and appreciated by her family.

Just as the mother was prepared to make the meal, in most cases the client will have come to the VCT site prepared to be tested. The counselor should assess the steps that the client has taken to prepare him or herself for taking the test and receiving the result.

Role-Play Number 1

COMPONENT 1: INTRODUCTION AND ORIENTATION TO VCT SESSION

COMPONENT 2: RISK ASSESSMENT

COMPONENT 3: EXPLORE OPTIONS FOR REDUCING RISK

COMPONENT 4: HIV TEST PREPARATION

General directions for conducting role-plays

You will be partnered with two other people for the role-play. Your instructor will be assign each of you to conduct a role play as a counselor, a client, or an observer. Your group will sit together and conduct the role-play.

Directions for each role

Counselor:

- Quickly review the main points of the counseling protocol section using cue cards before the role-play begins.
- Take your time.
- Use the questions that are clearly stated in you cue cards
- Stay organized

Client:

- Before the role-play, read through the client scenario. No need you to have cue cards. Refer to the scenario when responding to the counselor. Although the information given in the scenario does not cover all the questions you may be asked, try to make an appropriate response that does not contradict the facts outlined for you. Try to be a very reasonable and uncomplicated client;

this is a learning experience not a test of the counselor's skills and abilities. So be simple and cooperative.

Observer:

- Before the role-play, read through the observation checklist. Also read the client scenario. No need you to have cue cards. During the role-play, quietly observe **"do not interfere while he/she is conducting a role play"** and make notes but, if the counselor is having difficulty or is not using the protocol, you may offer suggestions to the counselor. You may also offer suggestions to the client if his or her responses do not follow the client scenario. At the end of the role play you will give feedback to the counselor using the checklist.

The role paly will be conducted from component 1 to 4. After played one round of role play you will rotate clockwise to change your role and will continue conducting the role play till your facilitator inform you to back to your place for a large group processing.

(PLEASE REFER THE VCT CUE CARDS, VCT CASE SCENARIOS, & OBSEREVER CHECLIST)

CHAPTER 3: The HIV Negative Test Result

Learning Objectives: By the end of this session the participants will be able to:

- Provide an HIV negative test result clearly and simply with an emphasis on the need for the client to initiate risk reduction in order to remain negative
- Develop a realistic risk-reduction plan that addresses the behaviors that places the client at risk for infection
- Help client identify resources for support with his/her risk reduction plan
- Encourage the client to discuss his/her HIV status with current and future partner and refer to VCT

Contents

- Component 5: Provide HIV Negative Test Result
- Component 6: Negotiate a Risk Reduction Plan
- Component 7: Identify Support for Risk Reduction Plan
- Component 8: Negotiate Assisted Partner Disclosure and Referral

Reasons for providing an HIV-negative test result in the VCT protocol

- Most people who come in for VCT are low risk and they will test HIV- negative!
- It helps to Empower them to remain HIV Negative
- Enable the individual to practice behavioral change

Component 5: Provide HIV Negative Test Result

Learning Objectives: By the end of this session the participants will be able to:

- Provide an HIV negative test result clearly and simply with an emphasis on the need for the client to initiate risk reduction in order to remain negative.

The counselor should provide the test result in simple terms, avoiding technical jargon. In case if the client he/she wants to see his/her actual test(s) results (the strip and the dots or lab result) please show and stating the result at same time increases the client's confidence that the result is actually his/hers and may help the client accept the accuracy of the result. The client may be very relieved to receive the negative test result. The counselor should allow the client to experience his/her reaction at not being infected while gently underscoring the need for behavior change in order for the client to remain negative. The counselor should explore feelings and beliefs the client has about his/her negative test

result, particularly in the context of the risk behavior(s) the client has described thus far in the session. The counselor should be alert to the possibility that the client may feel more inclined to engage in risky behavior in response to the result. The client may believe the test result is an indication that he/she has, thus far, made the "right choices." It is often helpful for the counselor to underscore the fact that the **negative test result does not indicate that the client's sex partner(s) is not infected.**

There is a slight possibility that a recent risk behavior (especially in the last month) may have resulted in the client becoming infected without the infection being indicated in this test result. However, both counselor and client should be reminded that the current result represents all other, sometimes years' of previous risk behavior. Counselors must be very careful with their "retest message." If there is no significant risk in the previous 6 weeks to 3 months, then no additional test is indicated unless the client has a subsequent risk. If there is a very recent and significant risk exposure, there is a small chance that the client could have been infected by that exposure and it was not detected on the current test. The counselor should avoid technical discussions of this information and recommend, when necessary, a specific time for possible retest linked to the specific previous date of the risk exposure. In summary, a brief explanation of the possible need for retesting is sometimes, with some clients, important, but this should not be over-emphasized.

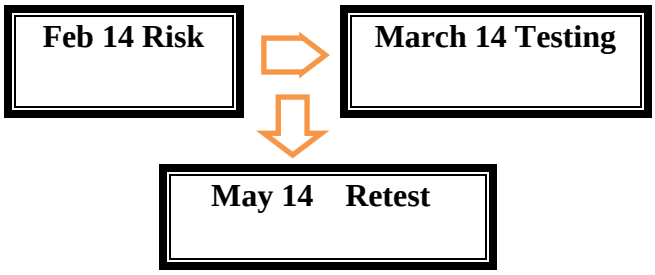


Fig 11 possibility of considering Repeat test for HIV Negative test result, with known recent risk

(Refer the VCT HIV Negative Session, Component 5)

Component 6: Negotiate a Risk Reduction Plan

Learning Objectives: By the end of this session the participants will be able to:

- Develop a realistic risk-reduction plan that addresses the behaviors that places the client at risk for infection.

The risk reduction plan is a fundamental component of the prevention counseling session. The counselor should assist the client in identifying a behavior corresponding to his/her risk and that he/she is invested in changing risky behavior. It is essential that the plan match the client's skills and abilities with his/her motivation to change a specific behavior. The counselor should challenge the client to go beyond what he/she has previously attempted in terms of risk reduction. The plan must be **specific** in that it describes **who, what, when, where and how** the risk reduction process is applied. It must be **concreted** in that it details the successive actions required of the client to implement and complete the risk reduction plan.

Global risk reduction messages such as "always use condoms," "remain monogamous," or "abstain from sex" **do not** meet the criteria for an appropriate risk reduction plan. The counselor should ensure that the client agrees with the plan and is committed to its implementation. The client should be asked to critique the plan and identify problems with the plan. The counselor may even quiz the client on the plan or provide plausible examples of obstacles the client may encounter in initiating the plan. These obstacles should be problem-solved with the client and may require revising the plan. The process of developing a plan represents the client's movement toward risk reduction. In fact, it is the second step in reducing risk (the first being the client's decision to come for counseling and testing), for which he/she should be provided encouragement and considerable.

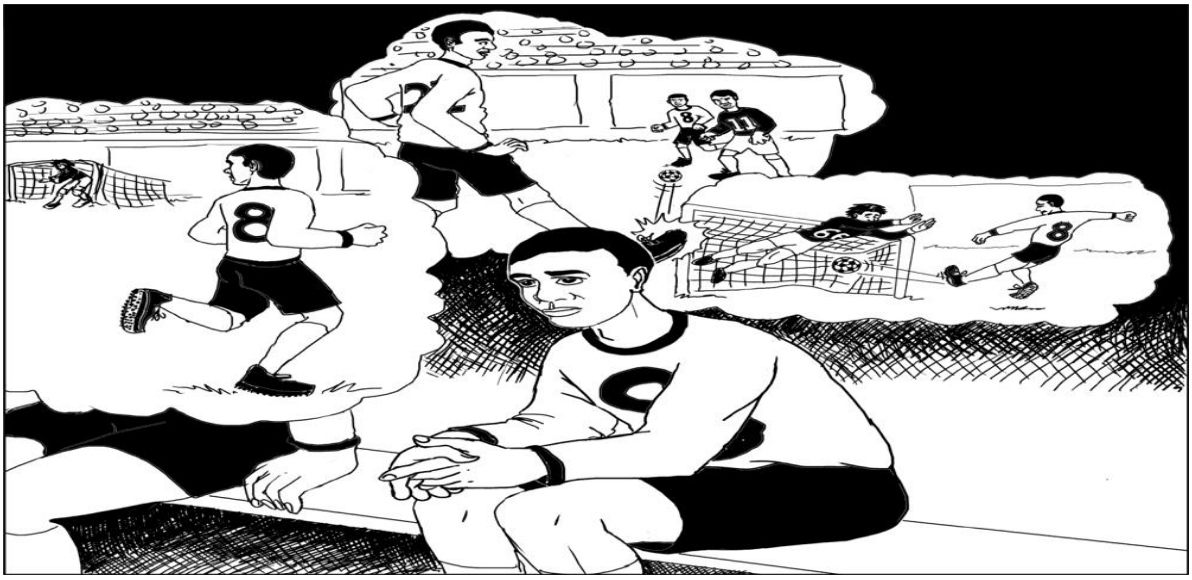


Fig 12 Analogy of visualize on Option for Reduce HIV risk & plan for non-risky behavioral change

A successful football player must visualize in great detail how he will perform in a game. He must see the field, the ball, and the goal. He must be able to imagine exactly how he will move down the field, how his foot will hit the ball, the movement of his opponent, where the ball will go, and at what angle the ball will enter the goal cage.

Similarly, a client must be able to visualize in specific and detailed terms his/her plan to change behavior to reduce his/her HIV risk.

(Refer the VCT HIV Negative Session, Component 6)

Component 7: Identify Resources to Support for Risk Reduction Plan

Learning Objectives: By the end of this session the participants will be able to:

- Help client to identify resources for support with his/her risk reduction plan.

This component of the session is intended to identify or develop for the client peer and community support for HIV risk reduction, as well as to provide referral to professional services directed at addressing specific issues the client may have identified. The priority for this component of the session is to identify a specific friend or relative with whom the client will discuss his/her risk reduction plan and report to regarding the implementation and completion of the plan. This step is critical because in the rapid test scenario there is no second session for the counselor to review with

the client his/her experience in implementing the plan. The process of the client checking in with someone about the plan is important because it gives enhanced meaning to the plan and increases the client's personal expectations about completing the plan. The client must trust this person and feel comfortable with his/her ability to keep the client's confidence. It is reasonable that the trusted person be the same person with whom the client is trying to initiate the behavior change plan. The counselor should discuss the process of confiding the risk reduction plan with a similar level of detail as that devoted to developing the plan. The counselor and client should establish a time frame during which this will occur. When will the client disclose the plan to this person? When will the client report the progress or completion of the plan to this person?

Fig 13 Analogy of identifies support for successful completion of non-risky HIV behavioral change

Just as this woman is receiving help carrying her heavy load, the client needs help and support to accomplish his/her risk reduction plan. The counselor's task is to help the client identify someone with whom he/she can share the plan, talk about his/her attempts(s) to complete the plan, and receive feedback and support.

(Refer the VCT HIV Negative Session, Component 7)

Component 8: Negotiate Assisted Partner Disclosure and Referral

Learning Objectives: By the end of this session the participants will be able to:

- Encourage the client to discuss his/her HIV status with current and future partners to assist disclosure and referral others to VCT.

An important personal issue for the client and an important public health issue for the community is what, whom, when, where, and how to tell others, particularly (partners), about being tested for HIV and to disclose the result. Sometimes, client may directly address to the counselor his/her thoughts and feelings about disclosure; however, it is more common for the counselor to first discuss the disclosure. With the HIV negative client, the counselor should discuss and assist client on how to disclose and refer partner for HIV testing service who are not aware of their HIV status. The client should be reminded that in order to remain negative he/she must be confidant that his/her partner is uninfected or always use condoms correctly and consistently. If the client is in a long-term relationship, the counselor should discuss the possibility and consequences should the couple's HIV test results be discordant.

(Refer the VCT HIV Negative Session, Component 8)

Essential Messages to Convey when Counseling an HIV Negative Client

- Reinforce that the client's test result does not indicate the HIV status of his/her partner(s) and that it is common for long-term, steady partners, even couples with children, to have different test results.
- Underscore that HIV negative individuals with a HIV positive partner or partner of unknown status are at highest risk for becoming infected with HIV.
- Prioritize assisted disclosure of the client's HIV status to partner(s) and referral of his/her partner(s) to HIV testing and counseling services.
- Address communication issues, engage in skill building and role-play approaches to partner disclosure and referral.
- Emphasize that assisted disclosure of HIV status to partner enhances the client's ability to negotiate risk reduction with partner(s).

- Remind the client that his/her HIV negative test result offers the client an opportunity to serve as a community ambassador advocating HIV Testing and Counseling and reinforcing risk reduction.

Role-Play : 2 (Component 1 to 8)

Component 1: Introduction and Orientation to Session

Component 2: Risk Assessment

Component 3: Explore Options for Reducing Risk

Component 4: HIV Test Preparation

Conduct Test

Component 5: Provide HIV Negative Test Result

Component 6: Negotiate a Risk Reduction Plan

Component 7: Identify Support for Risk Reduction Plan

Component 8: Negotiate Assisted Partner Disclosure and Referral

General directions for conducting role-plays

You will be partnered with two other people for the role-play. Your instructor will assign each of you a role – as a counselor, as a client, or as observer. Your group will sit together and conduct the role-play. The role paly will be conducted from component 1 to 8. After played one round of role play you will rotate clockwise to change your role and will continue conducting the role play till your facilitator inform you to return back to your place for a large group processing.

Directions for each role

Counselor:

- Quickly review the main points of the counseling protocol section before the role-play begins.
- Take your time.
- Use the questions.
- Stay organized.

Client:

- Before the role-play, read through the client scenario. Refer to the scenario when responding to the counselor. Although the information given in the scenario does not cover all the questions you may be asked, try to make an appropriate response that does not contradict the facts outlined

for you. **Try to be a very reasonable and uncomplicated client; this is a learning experience not a test of the counselor's skills and abilities.**

Observer:

- Before the role-play, read through the observation checklist. Also read the client scenario. During the role-play, quietly observe and make notes but, if the counselor is having difficulty or is not using the protocol, you may offer suggestions to the counselor. You may also offer suggestions to the client if his or her responses do not follow the client scenario.

For this Role-Play

For this role play, you will begin with the section **"Introduction and Orientation to the Session"** and immediately follow with **"Risk Assessment" "Explore Options for Reducing Risk," "HIV Test Preparation,"** conduct simulated rapid test and then you will move on to **"Provide HIV Negative Test Result", "Negotiate a Risk Reduction Plan", "Identify Support for Risk Reduction Plan", "Negotiate Assisted Partner Disclosure and Referral"** and end with **"Risk Reduction Issues"** if applicable.

(Please Refer to VCT Cue cards, VCT Negative session case Scenarios, & Initial with negative sessions observer checklists)

CHAPTER 4: The HIV Positive Test Result

Learning Objectives: By the end of this course, participants will be able to:

- Provide the client with an HIV-positive test result in a clear, compassionate and supportive manner
- Provide the HIV positive client with linkages to essential preventative health, clinical care and treatment services and to identify appropriate support services
- Assist the client to inform partners about his/her HIV status
- Arrange an approach for assisted partner referral to VCT
- Assist the client in exploring his/her feelings about telling friends and family about his/her test result
- Agree and address any other risk reduction issues that the client may need to discuss

Contents:

Component 9: Provide HIV Positive Test Result

Objective: To provide the client with an HIV Positive test result in a clear, compassionate and supportive manner.

The priority for this component of the session is to ensure that the client understands the test result, expresses his/her feelings about being infected with HIV, receives empathy and compassion from the counselor, and is helped to cope. The counselor should provide the test result in simple terms, avoiding technical jargon. As simple statement such as, "The test indicates that you have been infected with the HIV virus." will provide the essential information. Showing the client his/her code number and then indicate the test result using the lab request. The counselor should allow for silence in the session to provide the client with time to absorb the test result. The counselor should acknowledge that receiving this result can be difficult, elicit feedback from the client as to how he/she is feeling about the result and provide appropriate support.

(Refer the VCT HIV Positive Session, Component 9)

Component 10: Provide Linkages to Care, Treatment and Support Services

Objective: To provide the HIV Positive client with linkages to essential preventative health, clinical care and treatment services and to identify appropriate support services.

HIV positive clients should have access to preventative health services, clinical care and antiretroviral treatment using a test and treat approaches. It is essential that the counselor ensure that the HIV infected client understands the benefits of accessing medical care and other services. The counselor should help client to understand the need of informing his/her HIV status to other health professionals who will going to evaluate or treat him/her for any other HIV related medical conditions. Whenever possible the client should rehearse how he/she will tell to the provider about his/her HIV status. The counselor should give emphasis about the importance of screening, diagnosing and treating sexually transmitted infections including evaluation for tuberculosis. The counselor should discuss family planning and antenatal care intervention options. If the client is not emotionally prepared for a comprehensive discussion on these issues, a follow-up appointment or referral to care and treatment services need to be arranged.

For the HIV positive client it is essential that he/she identify at least one person with whom he/she can share the test result and receive support. Isolation and loneliness in dealing with HIV is detrimental to the client. The client's health and emotional wellbeing is enhanced proportionate to the extent he/she is accepted by family and friends, continues to live an active and productive life and is integrated into the community. However, the client and counselor should anticipate that there may be negative consequences associated with disclosure of his/her HIV status. It is the role of the counselor to help the client weigh and assess where and how to obtain support. It is helpful if the client can identify a close family member or friend to help him/her through the process of dealing with his/her HIV infection. This person can assist the client in planning for the future, initiating positive living and completing medical follow-up. In addition, HIV positive persons often find support and fellowship through association with other positive persons. The counselor should encourage the client to attend at least one support group, posttest club or other organization who provide psychological support to the HIV infected persons.

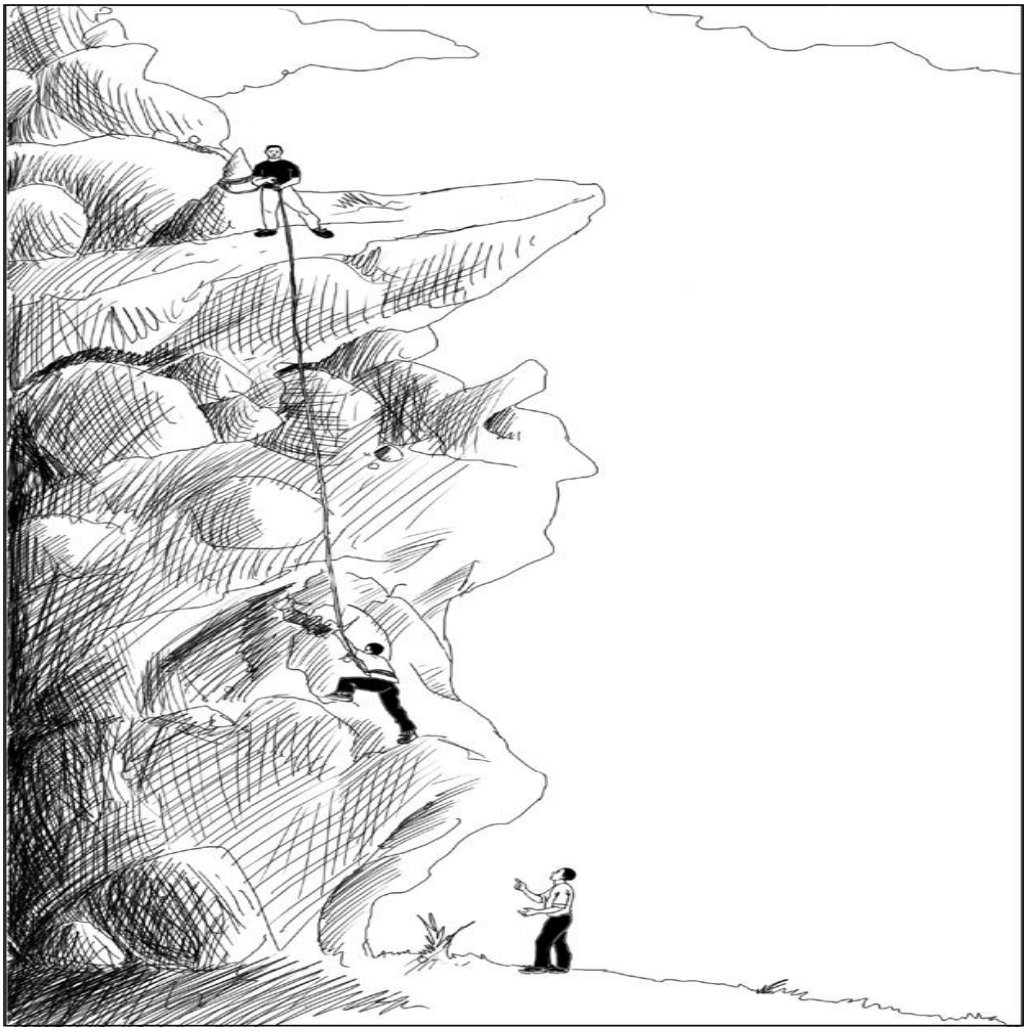


Fig 14 Analogy of linkage, support, need for continuous HIV Follow up care for positive livening

When you climb a mountain, the path is made easier if someone is with you each step of the way to lend a helping hand, listen, console, provide support and encourage you. When dealing with the potential stigma of being HIV positive, an HIV-infected person needs a trusted confidant and guide throughout the journey of dealing with being HIV-positive.

(Refer the VCT HIV Positive Session, Component 10)

Benefits of Successful Linkage to care and Treatment

Essential care and treatment services for HIV infected persons

- Package of HIV positive living, including HIV care follow up , prophylactic treatment with co-trimoxazole to prevent: pneumonia, diarrhea, other bacterial infections, malaria, toxoplasmosis and intestinal parasites
- Safe water precautions
- Practicing safe sex
- Malaria prophylaxis- insecticide-treated bed netting (especially for pregnant women and young children) and treatment
- Evaluation, diagnosis and treatment, or prophylaxis for tuberculosis (TB)
- Nutritional support and vitamin supplements
- Personal hygiene/skin care,
- Up to date immunizations (especially for children)
- Screening , diagnosis and treatment of STI's, and referral of partners
- Treatment/ managing for other opportunistic infections: Like
    - Oral thrush, Fungal infections, Vaginal candidiasis, , Herpes zoster)

ARV treatment service and essential messages

- Treatment is initiated immediately as soon as possible after adherence preparation and exclusion of OI's or any other medical reason without considering WHO HIV Clinical stage Or CD4 levels or low total lymphocyte counts.
- ARVs are medications used to treat HIV – "ARV" is the abbreviation commonly used to refer to these drugs.
- ARVs help infected persons feel better and delay the effects of HIV on their health – prolong quality of life by significantly reducing the viral load.
- ARVs do not cure HIV and must be taken for live long
- A person taking ARVs is still infected and can transmit the virus to others.
- Treatment of HIV consists of a combination of three different ARVs - sometimes two or more antiretroviral may be combined in one pill with different mechanisms to attack the virus.
- It is essential that a patient should take his/her medication every day as directed

Family planning and reproductive health services for PLHIV

- Recognize that the reproductive choices of a woman and her partner are a matter of personal choice and a human right
- Acknowledge that cultural, community and family expectations have a strong influence on the decisions about having children and the number of children a woman "should" have
- Ensure an understanding of the HIV transmission risk associated with becoming pregnant:
    - From infected male to uninfected female
    - From infected female to uninfected male
    - From infected female partner to infant
- Address options for reducing risk of HIV transmission:
    - Prevent unintended pregnancies
    - Reduce the number of pregnancies – fewer children
    - Reduce risk of transmission through condom use – unprotected sex only during monthly cycle of increased fertility
    - Access programs to prevent mother to child transmission
- Encourage HIV infected persons and their partners to use dual contraception:
    - Condom to prevent transmission of HIV and STI
    - Other contraceptive method to prevent pregnancy
- Educate about safer reproductive choices:
    - Maternal age (over 18 and under 35)
    - Birth spacing (greater than 2 year intervals)
    - Four or fewer pregnancies
    - Adequate prenatal care
- Ensure linkage to family planning services

Component 11: Negotiate Assisted Disclosure or Partner Notification and Referral

Objective:

- To assist the client in exploring his/her feelings about disclosing to partner his/her HIV status.
- To help the client his partner has got information about potential risk for HIV.
- To encourage client partner(s) for testing to VCT.

An important personal issue for the client and a public health issue for the community is what, whom, when, where, and how to tell others, particularly (partners), about disclosing the HIV test result of client. Sometimes, client may directly address to the counselor his/her thoughts and feelings about disclosure; however, it is more common for the counselor to first discuss the disclosure or partner notification.

Therefore, assisted discloser or partner notification and referral service should be offered as part of comprehensive package of testing service to be provided to individual diagnosed with HIV. It should **only occur with informed consent** of HIV positive client and be made to their partner alone or preferred, trusted family.

Assisted discloser or partner notification and referral methods include face-to-face conversation and invitation letters, Note that care is needed to ensure the correct person is receiving the message and that anonymity of both the HIV positive client and provider have been ensured. Assisted discloser or partner notification improves HTS uptake and new diagnosis of high proportion of people with HIV compared to passive referral. However passive referral can also result in HIV test uptake among partners of PLHIV.

The major benefits of assisted discloser or partner notification are: It increase uptake of HTS among partners of PLHIV, results in high proportion of HIV positive people being newly diagnosed, results in increased linkage to treatment and care among partners of PLHIV.

Despite all these facts, the HIV infected client may have numerous concerns about the potential repercussions of partner getting information about his/her HIV status. These include anger, blame, rejection, and abandonment. The counselor must explore these concerns with the client. Sometimes these are real and relevant issues in the client's life and other times they represent unfounded anxiety and guilt. Regardless, it is the role of the counselor to work through the client's concerns and develop a plan that maximizes the quality and extent of partner notification. Together the counselor and client should identify at least one person, other than a partner, the client can tell about the test result and receive comfort and support.

(Refer the VCT HIV Positive Session, Component 11)

Component 12: Risk Reduction Issues

Objective:

- To address, any outstanding risk reduction issues

The counselor should be aware that the most important first steps toward reducing the likelihood that an HIV infect client will transmit HIV to his/her partner(s) have already been addressed. The first action of the counselor is accessing preventative health and available care and treatment services. The second is to make assisted disclosure, notification and referral of his/her partner(s) to HIV testing and counseling services. If the partner tested for HIV and uninfected, she /he is at high risk of becoming infected. So need to provide adequate counseling on how to protect herself/ himself from acquiring HIV.

Furthermore, when both partners are aware of each other's HIV status, the negotiation of safer behaviors will be easier and more collaborative. A third important step to obtain assistance with coping and social support in dealing with the client's HIV status and reducing stigma the counselor should be aware that the client may not be prepared for further behavior change and risk reduction discussion. However, the client may have some immediate issues or concerns in this regard that he/she would like to address with the counselor. For these reasons, the counselor should address his/her immediate need and give appointment for follow up counseling.

(Refer the VCT HIV Positive Session, Component 12)

ROLE-PLAY: 3

COMPONENT 1: INTRODUCTION AND ORIENTATION TO SESSION

Component 2: Risk Assessment

Component 3: Explore Options for Reducing Risk

Component 4: HIV Test Preparation

Conduct Test

Component 9: Provide HIV Positive Test Result

Component 10: Provide Linkages to Care, Treatment and Support Services

Component 11: Negotiate Assisted Disclosure or Partner Notification and Referral

Component 12: Risk Reduction Issues

General directions for conducting role-plays

You will be partnered with two other people for the role-play. Your instructor will assign each of you a role – as a counselor as a client, or as observer. Your group will sit together and conduct the role-play. The role paly will be conducted from component 1 to 4 and 9 to 12 After played one round of role play you will rotate clockwise to change your role and will continue conducting the role play till your facilitator inform you to back to your place for a large group processing.

Directions for each role

Counselor:

- Quickly review the main points of the counseling protocol section before the role-play begins.
- Take your time.
- Use the questions.
- Stay organized.

Client:

- Before the role-play, read through the client scenario. Refer to the scenario when responding to the counselor. Although the information given in the scenario does not cover all the questions you may be asked, try to make an appropriate response that does not contradict the facts outlined for you. Try to be a very reasonable and uncomplicated client. This is a learning experience not a test of the counselor's skills and abilities.

Observer:

- Before the role-play, read through the observer checklist. Also read the client scenario. During the role-play, quietly observe and make notes but, if the counselor is having difficulty or is not using the protocol, you may offer suggestions to the counselor. You may also offer suggestions to the client if his or her responses do not follow the client scenario.

This Role-Play

For this role-play, you will be begin with the section **"Introduction and Orientation to the Session"** and immediately follow with **"Risk Assessment", "Explore Options for Reducing Risk", "HIV Test Preparation",** Conduct Simulated Rapid Test**,** and you will move on to **"Providing Client with HIV Positive Test Result", "Provide Linkages to Care, Treatment and Support Services", "Negotiate Disclosure and Partner Referral"** and end with **"Risk Reduction Issues"** if applicable.

Module Summary

- VCT is one of the models of HTS serving as "an entry point" for HIV prevention, care and support services. The basic, guiding & ethical principles of VCT should be respected.
- VCT Has a total of 12 component, which comprises of 4 initial , 4 Negative Sessions and 4 positive sessions
- **HIV Risk Reduction Options Includes** : (Abstain from sex, Avoid having sex with a person whose HIV status is unknown, testing together with partner, Having only one partner whose HIV status is known, Consistent and appropriate Condom use , Reduce number of partners and Use alternative means of sexual expression (touching each other and other forms of non-penetrative sex)
- **Positive** living means taking care of client's **health** and **emotional well-being** in order to enhance his/her life and stay well longer. It involves: having positive attitude, sense of optimism and well-being, understanding the disease, and follow prescribed nutrition, and medications. And follow-up medical care, and advice
- When providing HIV Positive test results, Counselor should allow a brief period of supportive silence and acknowledges the difficulty of receiving it for first times and should focus the need to have focused and brief medical care follow up.

ANNEXS:1

Scenario 1: Initial / Pre-test counseling

Male Client: Role Play – Protocol Components 1, 2, 3 and 4

Duguma, who is 23 years old, moved to the city from his village about two years ago. He works very hard at his teaching job and coordinates a boy's football club's games after work and weekends. Until he met his girlfriend, Elfnesh, he and his friends used to have fun, especially on pay day, hanging out at clubs, drinking a few beers, dancing and meeting girls. Sometimes he would have sex with these girls, but he usually would wear condoms. A couple of times he had too many beers and forgot to use a condom. Then about six months ago Duguma began dating Elfnesh, who is 21 years old and also a teacher. He quickly fell in love with Elfnesh, and felt the relationship was getting serious. Because he felt in "love and committed" to Elfnesh, he did not use a condom when they first had sex four months ago. As time went on and Duguma thought about his past and the future he was imagining with Elfnesh, he became terrified that he may have exposed himself and Elfnesh to HIV. As a youth in his village, he had a couple of girlfriends. Duguma wasn't too worried about these girls as he knew them and their families all his life and he usually used condoms to prevent pregnancy. But he was very concerned about the two club girls he had sex with without condoms. The more he thought about it, he realized he did not know if Elfnesh has had sex with anyone else. They have never talked about HIV/AIDS, but he has talked with his brother about getting tested and may talk with Elfnesh after he finds out his HIV test result.

Female: Role Play – Protocol Components 1, 2, 3 and 4

Elfnesh is 21 years old and a teacher. She loves working with children and hopes to have a family of her own someday. When Elfnesh was in teacher's training, she dated a nice man for over a year. They stayed together often, and usually used condoms to prevent pregnancy. She thought he would someday become her husband. Their relationship ended after his father died in an accident and he needed to return to his village to care for his brothers and sisters. After finishing her training, Elfnesh moved to the city to find a teaching position. She was new to the city and lonely. She eventually made some friends and would go out with them. Once she met a man she thought was nice and she dated him a few times. They eventually had sex, but she ended the relationship because he usually drinks too much. He refused to wear a condom whenever he drinks, and she was frightened she might get pregnant.

She was transferred to a new school and met Duguma, a teacher at the same school. Duguma is a wonderful man, a fine teacher and wonderful with the children. He even coaches a boy's football club on the weekends. They began dating about six months ago and first had sex about four months ago. He has told her he loves her and is committed to her. They are talking about their future together. When they first had sex, they did not use a condom. Elfnesh thinks this was because it was a way to be really intimate and demonstrate their mutual love. As they have begun to talk about their future together, Elfnesh has been thinking about her past and wonders about Duguma' past. They have never talked about their previous partners. She wants to get herself tested for HIV before she asks him to be tested.

Scenario 2: Initial and Negative post-test counseling

Female Client: Role Play 2 – Protocol Components 1 - 8

Mebrat is 22. She moved from her village to the city for work about one year ago. She stays with her aunt and her family. She had a steady boyfriend in her village, but they both went different directions after completing school. She and the boy from her village had sex, but they almost always used condoms to prevent pregnancy. When she first came to the city, she was lonely and went out most weekends with the other young people from her work. They would drink and dance. About four months ago, she had sex two times with a friend from work who went to the club with her. They did not use condoms the first time they had sex because they had both been drunk. The second time she insisted he better use condom. She soon found out this man had another girlfriend and stopped dating him.

About three months ago, Mebrat became close to a man named Ayalew. He works with her cousin. Ayalew l is a very serious person and has a good job with the government. They have begun to talk about having a future together. Recently, they began having sex and use condoms each time, but he really doesn't like using condom and is pressuring her to let him stop use it. She knows little about his previous partners.

Mebrat and Ayalew have never really talked about HIV, AIDS or STIs. They have not talked about other people they have had sex with.

Male Client: Role Play 2 – Protocol Components 1 - 8

Ayalew is a 24 year old who recently graduated from the university and now has a good position in the government. He has recently started dating a very nice girl who just moved from her village to the city about a year ago. This girl, Mebrat, is 22 years old and is also very serious about her work. Ayalew and Mebrat have recently started having sex. They have used condoms every time because Mebrat has insisted. Ayalew doesn't like the condoms and is trying to convince Mebrat that since they have a serious relationship, they can stop using condoms. Ayalew had several girlfriends at the university, but he had no serious relationship with anyone of them. He sometimes used condoms with these girls but not always. He sometimes reluctant to use condom, assuming that the girls are from good families or when he had too much to drink,. Now he is committed to Mebrat however, once in a while he goes out with his old friends and has sex with a bar girl, but he usually uses condoms with these women. However, about two months ago he was celebrating his new-job post, had too much to drink and forgot to use a condom.

He has never really thought about his past partners until recently. Mebrat's insistence that they should always use condoms has made him begin to wonder about his and her previous partners. He thought maybe he should get an HIV test before he goes any further in this relationship.

Scenario 3: Initial and Positive post- test counseling

Female Client: Role Play 3 – Protocol Components 1-4 and 9-12

Mihiret is 26 years old and has two children (4 year-old twins, girls). Her husband Dawit was a businessman and died in an automobile accident three years ago. He used to be away from home for several weeks at a time on business trips. She believes that he may have had sex with other women while away on these trips. This always concerned her.

Mihiret is thinking more and more about all this because she has been seeing a man named Yohannes for about six months. She met Yohannes at the church she is attending and they both sing in the choir. Yohannes is 30 years old and works for a company that repairs computers. She and Yohannes have always used condoms. They are getting serious, and Yohannes has suggested that they better stop using condoms. Yohannes is a very good man, he helps her with school fees, and he is kind to the children. His wife died almost two years ago from pneumonia. Yohannes has one 3-year-old son, who is very close to Mihiret's twins. She is not sure if Yohannes is having sex with anyone else, as they didn't talk of such things.

Male Client: Role Play 3 – Protocol Components 1-4 and 9-12

Yohannes is a 30-year-old man whose wife died two years ago from what the doctors said was pneumonia. Yohannes has a three-year-old son. Yohannes works for a company that repairs computers. Yohannes is seeing a woman named Mihiret; he met her about six months ago at the church he is attending. This woman's husband, a businessman, died in an automobile accident a few years earlier. He is very fond of this woman and she is very good to his son. Mihiret is 26 years old and has 4-year-old twins (girls).

Yohannes and Mihiret started having sex but have always used condoms. He would rather not use condoms, but he is very much concerned because during the first year after his wife's death he was in deep grief and feels lonely, and sometimes he used to go to clubs and occasionally have sex with women he would meet at the club. He usually, but not always used condoms with these women. Yohannes didn;t have sex with another woman since he met Mihiret. Yohannes would like a future with Mihiret. He wants to ask Mihiret and the two little girls to live with him and his son. He would first like to get himself tested for HIV because he loves Mihiret but does not know what he will do if he is infected. He and Mihiret have not yet talked about this, but he senses it is weighing on both of their minds.

VCT Observer Check list

Observer Checklist Role Play 1

Introduction and Orientation to the Session		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Introduce self to client.		
Describe your role as counselor.		
Explain confidentiality.		
Explain Benefits of VCT		
Review the rapid test process: o Detects HIV infection o Accurate o Negative – not infected o Positive – infected with HIV o Same day test result		
Outline content of session: o **Explore HIV/STD risks** o Address options for reducing risk o Provide test o Develop risk reduction plan o Provide referrals to care and support		
Review "map" of client stops/activities during this counseling and testing visit.		
Address immediate questions and concerns.		

General comments:

Observer Checklist (continued), Role play 1

Risk Assessment		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Assess client's reason for coming in for services.		
Assess client's level of concern about having/acquiring HIV.		
Explore most recent risk exposure/behavior o When? o With whom? o Under what circumstances?		
Assess client's feelings about his/her risk behaviors		
Assess pattern of risk (e.g., happening regularly, occasionally, due to an unusual incident) o Number of partners? o Type of partners? o Frequency of new/different partners? o Condom use?		
Identify risk triggers, vulnerabilities, and circumstances		
Assess partner's risk		
Assess communication with partner(s)		
Assess for indicators of increased risk		
Summarize and reflect back client's story and risk issues o Risk pattern o Prioritize risk issues		

○ Risk triggers and risk vulnerabilities		

General Comments

Observer Checklist (continued), Role Play 1

Explore Options for Reducing Risk		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore client's communication with friends about risk reduction.		
Review previous risk reduction attempts.		
Identify successful experiences with practicing safer sex.		
Identify obstacles to risk reduction.		
Explore triggers and situations which increase the likelihood of high risk behavior.		
Place risk behavior in the larger context of client's life.		
Assess condom skills.		
Identify entire range of options for reducing risk.		
Role play, skill build, problem solve.		
Address examples when client's beliefs and behavior are at odds or when feelings are mixed about changing behavior.		
Summarize risk reduction options/ discussion.		

General Comments:

_____

_____

Observer Checklist (continued), Role Play 1

HIV Test Preparation		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore with whom client has shared his/her decision to come for VCT services. o Partners, family and friends		
Discuss the client's understanding of the meaning of positive and negative HIV test results.		
Assess client's response to the potential results. o Positive result o Negative result		
Assess who will provide the client support if he/she is infected.		
Discuss the importance of follow-up health care and positive living: o Medical care and follow-up o Staying well living longer o Obtaining support		
Review the benefits of knowing your serostatus (knowledge is power).		
Affirm client's test decision.		
Describe the tests and the interpretation/reading of the test.		
Direct client to lab to receive test and instruct him/her to return to the counselor or where to wait should the counselor be with another client.		

General Comments:

Observer Checklist Role Play 2

Introductions and Orientation to the Session		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Introduce self to client.		
Describe your role as counselor.		
Explain confidentiality.		
Explain benefits of VCT		
Review the rapid test process: o Detects HIV infection o Accurate o Negative – not infected o Positive – infected with HIV o Same day test result		
Outline content of session: o **Explore HIV/STI risks** o Address options for reducing risk o Provide test o Develop risk reduction plan o Provide referrals to care and support		
Review "map" of client stops/activities during this counseling and testing visit.		
Address immediate questions and concerns.		

General Comments:

Observer Checklist (continued). Role play 2

Risk Assessment		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Assess client's reason for coming in for services.		
Assess client's level of concern about having/acquiring HIV.		
Explore most recent risk exposure/behavior o When? o With whom? o Under what circumstances?		
Assess client's feelings about his/her risk behaviors		
Assess pattern of risk (e.g., happening regularly, occasionally, due to an unusual incident) o Number of partners? o Type of partners? o Frequency of new/different partners? o Condom use?		
Identify risk triggers, vulnerabilities, and circumstances		
Assess partner's risk		
Assess communication with partner(s)		
Assess for indicators of increased risk		
Summarize and reflect back client's story and risk issues o Risk pattern o Prioritize risk issues o Risk triggers and risk vulnerabilities		

General Comments:

Observer Checklist (continued), Role play 2

Explore Options for Reducing Risk		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore client's communication with friends about risk reduction.		
Review previous risk reduction attempts.		
Identify successful experiences with practicing safer sex.		
Identify obstacles to risk reduction.		
Explore triggers and situations which increase the likelihood of high risk behavior.		
Place risk behavior in the larger context of client's life.		
Assess condom skills.		
Identify entire range of options for reducing risk.		
Role play, skill build, problem solve.		
Address examples when client's beliefs and behavior are at odds or when feelings are mixed about changing behavior.		
Summarize risk reduction options/ discussion.		

General Comments:

Observer Checklist (continued), Role play 2

HIV Test Preparation		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore with whom client has shared his/her decision to come for VCT services. o Partners, family and friends		
Discuss the client's understanding of the meaning of positive and negative HIV test results.		
Assess client's response to the potential results. o Positive result o Negative result		
Assess who will provide the client support if he/she is infected.		
Discuss the importance of follow-up health care and positive living: o Medical care and follow-up o Staying well living longer o Obtaining support		
Review the benefits of knowing your serostatus (knowledge is power).		
Affirm client's test decision.		
Describe the tests and the interpretation/reading of the test.		
Direct client to lab to receive test and instruct him/her to return to the counselor or where to wait should the counselor be with another client.		

General Comments:

Observer Checklist (continued), Role play 2

Provide HIV Negative Test Result		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Inform client that the test result is available.		
Provide result clearly and simply (show the client his or her result).		
Explore client's reaction to the result.		
Note the need to consider the test result in relation to most recent risk exposure.		
If client has ongoing risk, convey concern and urgency about client's risks (as appropriate).		

Role play 2

Negotiate a Risk Reduction Plan		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Identify priority risk-reduction behavior.		
Explore behavior(s) that the client will be most motivated about/capable of changing.		
Identify a reasonable yet challenging incremental step toward changing the identified behavior.		
Break down the risk reduction action into specific and concrete steps.		
Identify supports or barriers to the risk reduction step.		
Problem-solve issues concerning the plan.		
Role-play the plan.		
Confirm with the client that the plan is reasonable and acceptable.		
Ask the client to be aware of strengths and weaknesses in the plan while trying it out.		

Recognize the challenges of behavior change.		
Document the risk reduction plan with a copy to counselor.		

Observer Checklist (continued), Role Play 2

Identify Support for Risk Reduction Plan- HIV Negative		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Emphasize the importance of the client discussing with a trusted friend or relative the intention and content of the plan.		
Identify a person to whom the client feels comfortable disclosing the plan.		
Establish a concrete and specific approach for the client to share the plan with his or her friend or relative.		
Convey confidence in the client's ability to complete the plan.		

Role Play 2

Negotiate Assisted Disclosure and Partner Referral		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore client's feelings about telling partner(s) about his/her HIV negative test result.		
Remind the client that his/her result does not indicate partner's HIV status.		
Support client to refer partner for testing.		
Anticipate potential partner reactions.		
Practice and role-play different approaches to disclosure.		
End session, providing the client with motivation and encouragement.		

Observer Checklist for Role Play Number 3

Introduction and Orientation to the Session		
Key counselor tasks	**Task addressed ?**	**Comments and recommendations**
Introduce self to client.		
Describe your role as counselor.		
Explain confidentiality.		
Explain Benefits of VCT		
Review the rapid test process: o Detects HIV infection o Accurate o Negative – not infected o Positive – infected with HIV o Same day test result		
Outline content of session: o **Explore HIV/STI risks** o Address options for reducing risk o Provide test o Develop risk reduction plan o Provide referrals to care and support		
Review "map" of client stops/activities during this counseling and testing visit.		
Address immediate questions and concerns.		

General Comments:

Observer Checklist (continued), Role play 3

Risk Assessment		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Assess client's reason for coming in for services.		
Assess client's level of concern about having/acquiring HIV.		
Explore most recent risk exposure/behavior o When? o With whom? o Under what circumstances?		
Assess client's feelings about his/her risk behaviors		
Assess pattern of risk (e.g., happening regularly, occasionally, due to an unusual incident) o Number of partners? o Type of partners? o Frequency of new/different partners? o Condom use?		
Identify risk triggers, vulnerabilities, and circumstances		
Assess partner's risk		
Assess communication with partner(s)		
Assess for indicators of increased risk		
Summarize and reflect back client's story and risk issues o Risk pattern o Prioritize risk issues o Risk triggers and risk vulnerabilities		

General Comments:

Observer Checklist (continued) Role play 3

Explore Options for Reducing Risk		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore client's communication with friends about risk reduction.		
Review previous risk reduction attempts.		
Identify successful experiences with practicing safer sex.		
Identify obstacles to risk reduction.		
Explore triggers and situations which increase the likelihood of high risk behavior.		
Place risk behavior in the larger context of client's life.		
Assess condom skills.		
Identify entire range of options for reducing risk.		
Role play, skill build, problem solve.		
Address examples when client's beliefs and behavior are at odds or when feelings are mixed about changing behavior.		
Summarize risk reduction options/ discussion.		

General Comments:

Observer Checklist (continued), Role play 3

HIV Test Preparation		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore with whom client has shared his/her decision to come for VCT services. o Partners, family and friends		
Discuss the client's understanding of the meaning of positive and negative HIV test results.		
Assess client's response to the potential results. o **Positive result** o Negative result		
Assess who will provide the client support if he/she is infected.		
Discuss the importance of follow-up health care and positive living: o Medical care and follow-up o Staying well living longer o Obtaining support		
Review the benefits of knowing your HIV status (knowledge is power).		
Affirm client's test decision.		
Describe the tests and the interpretation/reading of the test.		
Direct client to lab to receive test and instruct him/her to return to the counselor or where to wait should the counselor be with another client.		

General Comments:

Observer Checklist (continued), Role Play 3

Provide HIV Positive Test Result		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Inform client that the test result is available.		
Provide result clearly and simply.		
Allow the client time to absorb the meaning of the result		
Review the meaning of the result		
Explore client's understanding of the result.		
Assess how client is coping with result.		
Acknowledge the challenges of dealing with positive result and provide appropriate support.		

Role play 3

Provide Linkages to Care, Treatment and Support Services		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Discuss living positively.		
Identify current access to health care services.		
Address the need for the health care provider to know about the HIV positive test result.		

Address the need for preventative health care:
• STI exam/treatment
• Prevention of opportunistic infections
• Environmental precautions
  ○ Safe water
  ○ Mosquito netting
• Nutritional support and vitamin supplements		

Determine if immediate referral for TB treatment is needed.		
(If available) Explain basic information about ARV treatment.		
Address client's questions and concerns about ARV treatment.		
Address PMTCT and family planning services.		
Identify needed medical referrals.		
Assess whom the client would like to tell about his/her positive result.		
Identify a family member or friend to help the client through the process of dealing with HIV A. Coping and support B. Planning for the future C. Positive living		

Assess the client's willingness to seek support, complete a referral.		
Discuss options of support groups (Posttest Club).		
Evaluate what types of referral the client would be most receptive to.		
Provide appropriate referrals.		

Observer Checklist (continued), Role play 3

Negotiate Assisted Disclosure, Partner Notification and Referral		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Explore client's feelings about telling partners about his/her HIV positive test result.		
Remind client that his/her result does not indicate the partner's HIV status.		
Identify partners that are at risk and need to be informed of their risk for HIV infection.		
Discuss possible approaches to disclosure of HIV status to partners.		
Practice and role-play different approaches to disclosure.		
Anticipate potential partner reactions.		
Support client to refer partner for testing		
Identify other friends/family members the client might want to disclose his/her result to.		
Discuss situations in which the client may want to consider protecting his/her own confidentiality.		

Observer Checklist (continued), Role play 3

Risk Reduction Issues		
Key counselor tasks	**Task addressed?**	**Comments and recommendations**
Elicit transmission risks the client may need/want to address.		
Address issues raised by the client		
Recognize the important risk reduction issues already addressed in the session.		
Remind client of need to re-visit risk reduction issues in the future		
Explore client's immediate plans after leaving the test site		
Inquire as to additional issues the client may like to address		

Module 4

Couples HIV Counseling and Testing (CHCT)

CHAPTER 1: INTRODUCTION TO COUPLE HIV COUNSELING AND TESTING

Learning objectives: By the end of this course, Participants will be able to:

- Defining Couple
- Defining Couple HIV Counseling and Testing
- Describe shared vision Couple Counseling and Testing
- Explain advantage of Couple HIV Counseling and Testing
- Describe concepts and importance of Couple HIV Counseling and Testing
- Discuss HIV discordance in Couple HIV Counseling and Testing
- Identify the importance of forming alliances during a couples HIV counseling
- Describe about discordance and Myth

Content

- Definition of Couple
- Definition of Couple HIV Counseling and Testing
- Shared vision of Couple HIV Counseling and Testing
- Advantage of Couple HIV Counseling and Testing
- Concept of Couple HIV Counseling and Testing
- Importance of Couple HIV Counseling and Testing
- Discordance of Couple HIV Counseling and Testing
- Myth about discordance
- Facts about discordance
- Forming an alliance between the counselor and couple

1.1. Definition of Couple HIV Counseling and Testing

Couple Definition –Two person in an ongoing sexual relationship; each of these persons is referred to as “a partner “in relationship.

Couple HIV Counseling and Testing:-When two or more partners are counseled, tested and receive their results together. When couples receive their results together, there can be mutual disclosure of HIV status, and the couple can receive appropriate support and be linked to follow-up services by a counselor, health care provider or community-based worker.

1.2. Shared vision of Couple HIV Counseling and Testing

- In many parts of the world, people speak their own regional language and one other widely shared language.
- Couples counseling is a variation of this in couples counseling there are four views: those of each partner, the couple together, and the counselor.
- In HIV couples counseling and testing, the goal is to bring together these views and to create a shared vision and a shared language.
- This shared vision is the couple's acceptance of the realities of HIV in their lives, being empowered to prevent acquiring and transmitting HIV, and sharing their support and compassion for each other.

1.3. Advantage of Couple HIV Counseling and Testing

- Environment is safe for couple to discuss risk concerns.
- Partners hear information and messages together, enhancing likelihood of a shared understanding.
- Counselor has the opportunity to ease tension and diffuse blame.
- Counseling messages are based on the results of both individuals.
- Individual is not burdened with the need to disclose results and persuade partner to be tested.
- Counseling facilitates the communication and cooperation required for risk reduction.
- Treatment and care decisions can be made together.
- Couple can engage in decision-making for the future.

1.4. Concept of Couple HIV Counseling and Testing

- Counselors should focus on solutions—not problems.
- Counselors must assist in diffusing blame and tension.
- Counselors should focus on the present and the future.
- Remember, the past is in the past and cannot be changed.

1.5. Importance of Couple HIV Counseling and Testing

Participating in couples HTS has a number of benefits these include adoption of prevention strategies by the couple (for example, condom use, immediate ART), safer conception, improved uptake of and adherence to practices for PMTCT as well as to one's own ART (thus reducing transmission risk as well as morbidity and mortality).

- To contend with HIV and plan for their future, both partners must know their status.
- Couples HIV services enhance opportunities to prevent mother-to-child transmission of HIV.
- In countries with high HIV prevalence, it is fairly common for one partner to be HIV infected and the other uninfected—meaning that they are HIV sero-discordant, or simply "discordant."
- Promote for early identifying of couple discordant result since couples can remain discordant for a long time—even more than 10 years.
- Helps to confirm each individuals HIV status rather than assumptions.
- Individual rates of disclosure are very low therefore CHCT encourage mutual disclosure
- Before knowing their HIV status, most discordant couples do not use condoms; however, CHCT has been shown to increase condom use.

1.6. Discordance of Couple HIV Counseling and Testing

It is important to understand the different types of HIV test results that are possible during a couples counseling session. The majority of people living in stable relationships are unaware of their partner's status, and many people with an HIV-positive partner are not aware of their own status. Despite growing evidence of its importance, the concept of "sero-discordance" and the frequency of its

occurrence are poorly understood in most communities. Discordance is common in countries with high prevalence of HIV

- Discordant couple has one HIV-positive partner and one HIV-negative partner
- Concordant couple is one where both partners have the same HIV status—they are both either negative or both positive.

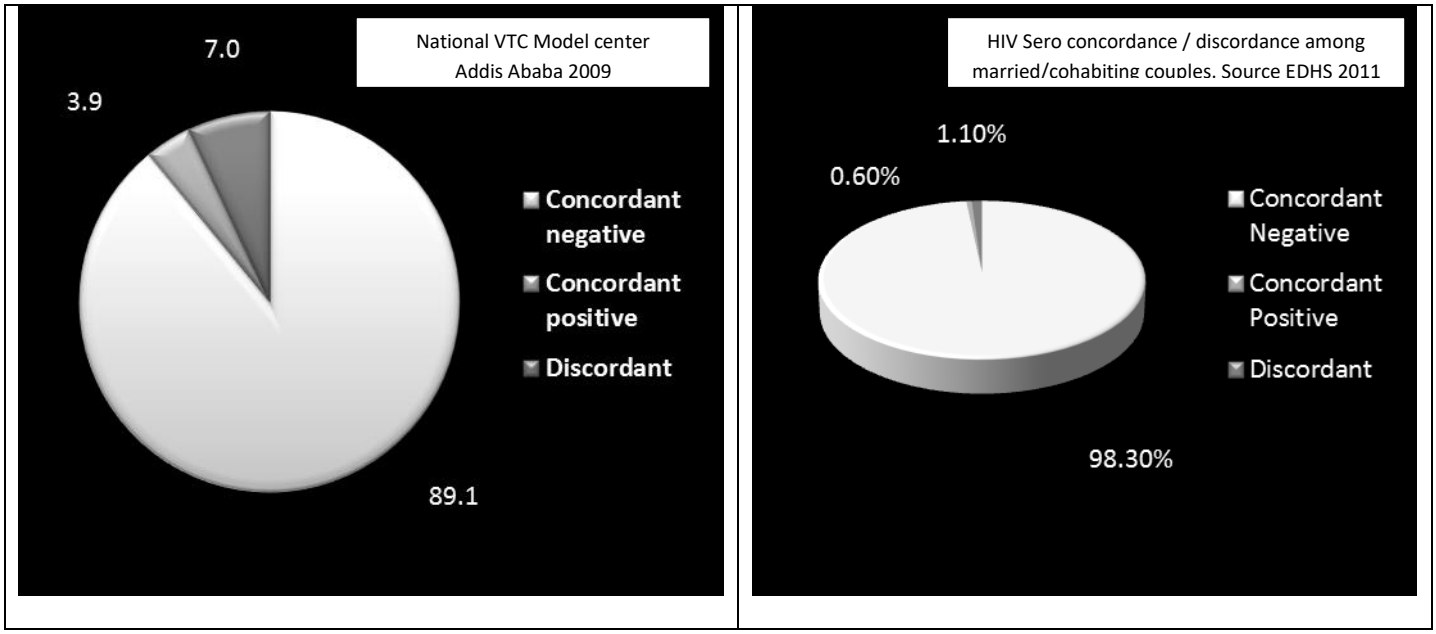


Fig 4.1 – National Concordant Negative, Concordant Positive and Discordant Couple results data

. 1.7 Myths about Discordance

Many people do not understand the facts about discordance. Many myths about discordance exist that need to be corrected. The following are some of the most common myths about discordant

- Many people believe discordance is not possible.
- When tested individually, many people assume that their partner's HIV status is the same as their own.

(Source: National VTC Model Center Addis Ababa 2009)

- e discordance is a sure sign of infidelity (may be non-sexual or premarital).

It is important that counselors make sure that discordant couples understand the facts about discordance:

- It is important for couples to understand that the HIV-positive partner may have entered the relationship already infected or may have acquired HIV non-sexually. The most important thing to focus on is to protect the HIV-negative partner from getting infected.

1.8 Facts about discordance

- The negative partner in a discordant couple is not protected only by remaining faithful. Couples need to take precautions such as using condoms to prevent transmission from the infected partner to the negative partner.(Being faithful with Consistent & proper use of condom)
- When couples are discordant, infection could have occurred in different ways:
    - The positive partner may have been infected before they became a couple.
    - The positive partner may have other partners outside the relationship or may have acquired HIV non-sexually.
    - Transmission risk through sex is extremely high among steady discordant couples who do not take preventive measures such as using condoms.

1.9 Forming an alliance between the counselor and couple

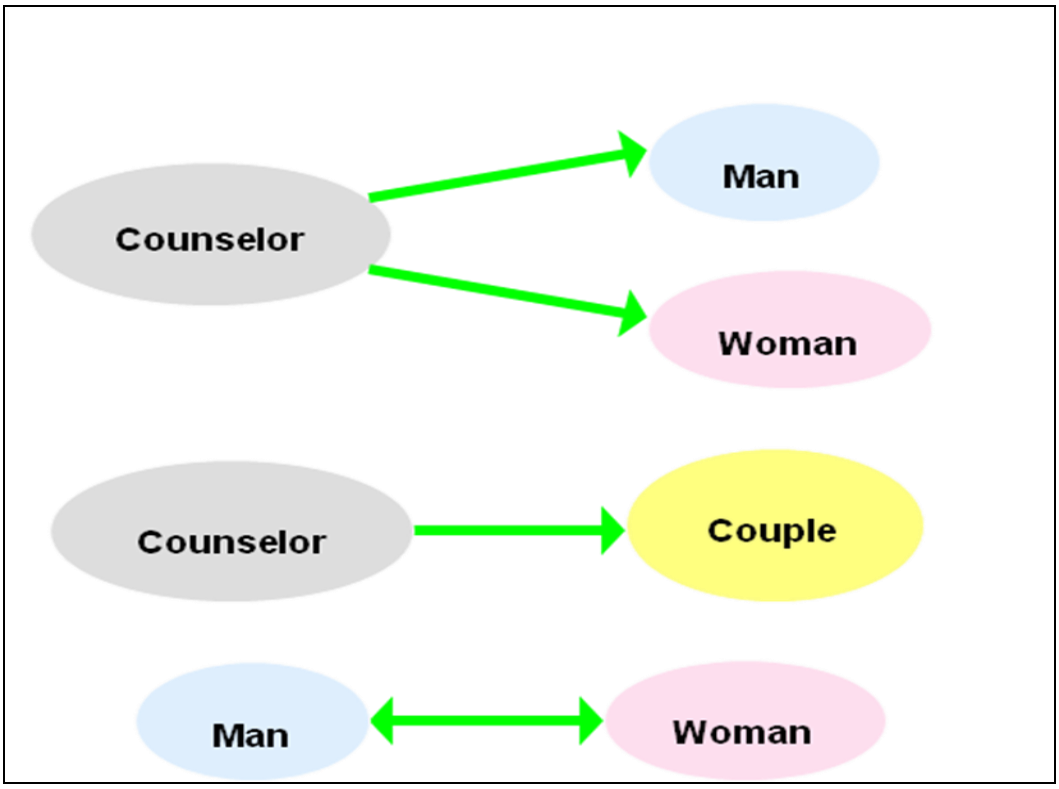
The counselor's first task is to build an alliance, or a partnership, with the couple. This alliance serves as the foundation that permits the couple to engage in the session and to be willing to discuss HIV-related issues. The first step in forming an alliance is offering a genuine attitude that conveys warmth and compassion.

The acronym A.C.E. explains three important elements of an alliance

***Acknowledgment*—**Describes the couple's awareness that the counselor acknowledges their strengths, courage, and experience.

***Competence*—**The couple senses that the counselor has the skills and experience to guide and support them through the CHCT process.

***Empathy*—**The counsellor genuinely understands and appreciates the couple's experience and feelings.



Fig, 4.2---: Essential Alliances in Couple HIV Counseling and Testing

1 and 2. Counselor and each individual

In the first two alliances, each partner should feel acknowledged, valued, respected, engaged, and empathetically understood. The counselor should convey genuine interest and investment in each individual.

3. Counselor and couple

In the alliance between the counselor and the couple as a unit, the counselor should convey respect for the couple's relationship. The counselor should recognize the bond between the members of the couple and validate their mutual commitment. The couple should feel that the counselor values their relationship.

4. Individuals in the couple

In the alliance between the couple as partners, the counselor should encourage the couple to speak to and engage each other. The counselor should help the couple recognize their shared values, mutual history, and future aspirations. The counselor should recognize that the strength and resilience of the couple's alliance influence how they will deal with challenges and build their future together.

The more the couple can be supported in addressing their issues and concerns as partners—in terms of "we" rather than as individuals—the more likely they will be able to cope with the realities of HIV in their shared life.

An important thing for counseling to remember is that forming an alliance with a couple is as much of an attitude as it is a technique.

CHAPTER 2: CHCT PRE TEST COUNSELING INTERVENTION

Learning objectives: By the end of this session the participants will be able to:

- Describe conditions of CHCT
- Discuss the roles, responsibilities and expectation of couples
- Explain the realities of CHCT
- Introduce the couple to CHCT and obtain concurrence to receive couple services
- Explore couple's life stage and reason for seeking CHCT
- Discuss the couple's HIV risk concerns
- Prepare the couple for testing and discuss possible results

Content

- Conditions for receiving CHCT Services
- Roles, responsibilities, and expectations
- Realities of Couples HIV Testing and Counseling
- The Initial Session
- Introduce the couple to CHCT and obtain concurrence to receive couple services
- Explore couple's life stage and reason for seeking CHCT
- Discuss the couple's HIV risk concerns
- Prepare the couple for testing and discuss possible results

2.1 Conditions for Receiving CHCT Services

There are several conditions the couple should agree upon, in order to receive couples HIV Testing and Counseling services. These conditions include:

- **Partners agree to discuss HIV risk issues and concerns together.**
- **Couple is willing to receive results together.**
  This means that the couple will know each other's test results.
- **Couple commits to shared confidentiality.**
  The couple should make decisions together about sharing their test results with other people.
- **Disclosure decisions are made mutually.**
  The couple should agree not to tell anyone their test results unless both partners agree.

2.2 -Roles, responsibilities, and expectations for how the couple should interact during the CHCT session include:

- Each partner participating equally in the discussion
- Listening carefully and responding to each other
- Treating each other with respect and dignity
- Being as open and honest as possible
- Providing understanding and support to each other

These roles, responsibilities, and expectations are addressed in the initial session when the counselor introduces the couple to CHCT and obtains their concurrence to receive couple services.

2.3 -Realities of Couples HIV Testing and Counseling

Couples counseling is different from individual counseling in the approach that the counselor must take and in the issues that may be raised. The counselor should keep the following points in mind when working with couples:

- Remember that CHCT is **NOT** marriage counseling.
- The **couple's issues are more important than individual issues** during a CHCT session.
- If the counselor forms alliances and creates a safe and open atmosphere, the couple **may reveal feelings that have not been discussed previously within the couple**.
- **Couples may attempt to use CHCT to address longstanding issues in their relationship** or as a lifeline for a failing relationship.
- **Couples may have issues and problems in their relationship unrelated to HIV** or made worse by HIV issues and concerns.
- **The couple—not the counselor—is ultimately responsible for what happens in the relationship**. The couple's counselor is neither "binder" nor "breaker".

Remember, research shows that with support, couples do make it through the difficulties and challenges that may arise from being tested for HIV together.

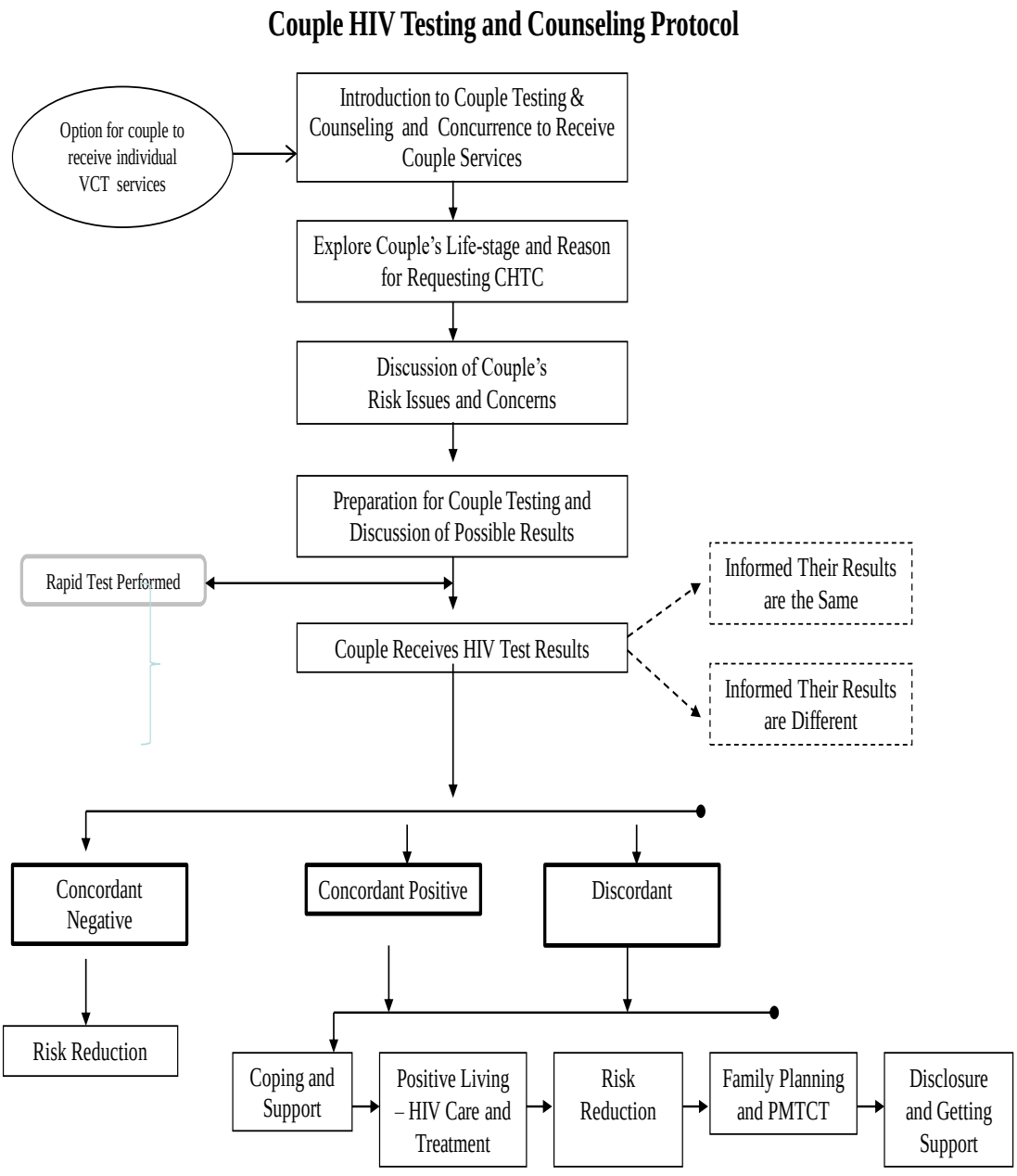


Fig 4.3: Couple HIV Counseling and Testing Protocol Components

2.4 The Initial Session

The CHCT intervention is divided up into sessions: the initial session and the second session. A significant and vital portion of the counseling session takes place before the HIV test is performed. This portion of the counseling session is referred to as the initial session.

The initial session consists of four important components that guide the counselor through the session.

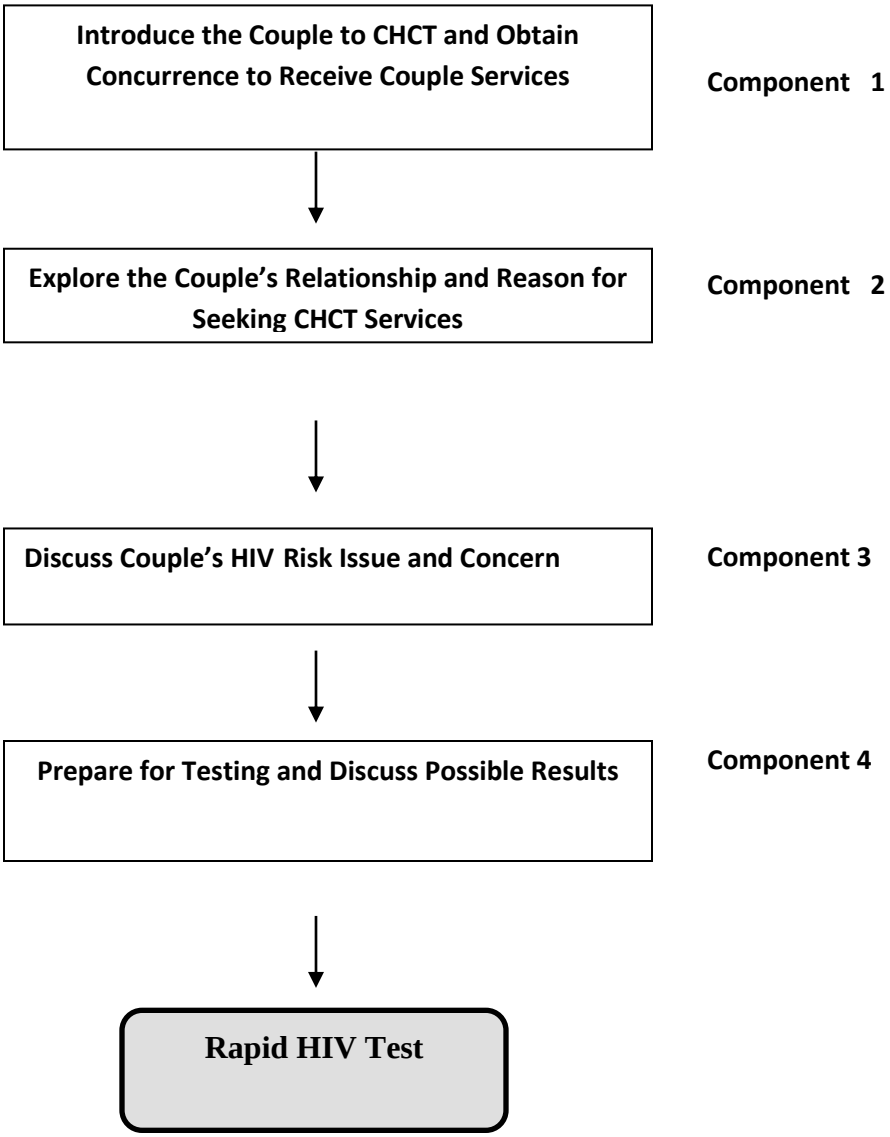


Fig.4.4-Couple HIV Counseling and Testing Initial session protocol components

Component 1 : Introduce the Couple to CHCT and Obtain Concurrence

The aim of Component I is to clarify the purpose and content of CHCT for the couple. The counselor's objective is to ease the couple's anxieties and concerns and set a collaborative tone for the session.

From the moment the counselor first interacts with the couple, he or she should competently apply the specific counseling skills we addressed in Basics of counseling skills module 2

- Demonstrating neutrality and balance
- Facilitating dialogue between the couple
- Modeling calm, open, and reasoned discussion

An important aspect of this component is discussing the conditions for receiving CHCT services and determining if the couple is ready to receive services. These conditions include:

- Partners agree to discuss HIV risk issues and concerns together.
- Couple is willing to receive results together.
- Couple commits to shared confidentiality.
- Disclosure decisions are made mutually.

In addition the counselor should address the couples roles, responsibilities and expectations to interact both during the CHCT session.

The initial session is the only practical point in the CHCT session when the counselor may, based on assessment, decide to refer the couple to individual counseling and testing services instead of couple's services. However, if the couple is able to agree to the above terms, they should be encouraged to continue with couples services because of the many benefits of receiving HIV Testing and Counseling together.

Component 2: Explore the Couple's Life Stage and Reason for Seeking CHCT Services

The aim of Component II is to learn about the couple's relationship status and history while assessing their communication style and decision-making process.

This unit has history, experiences, expectations, resources, and dynamics that will have an impact on the CHCT session. The couple's relationship exists in an interpersonal and socio-cultural context that extends beyond the particular characteristics of the individuals within the couple. The counselor should encourage the partners to deal with their HIV-related issues together and to embrace CHCT as a couple,

rather than as individuals. This will increase the likelihood that they will respond positively to the experience.

Types of Couples Seeking HIV Testing and Counseling Services

Pre-sexual Couples

Pre-sexual couples may be using CHCT to decide whether to pursue a long-term relationship based on their test results. This is a prudent course of action, and the couple should be commended for their commitment to acting responsibly and getting tested. However, it presents the counselor with some challenges. If the couple is discordant, it's possible the relationship will dissolve. Also, the HIV-positive partner may be concerned about confidentiality and whether the HIV-negative partner will disclose the test results. Therefore, the counseling session may focus on how the couple will supportively manage changing the course of their relationship.

Engaged Couples

Engaged couples have often been recognized publicly by family and friends as in a serious relationship. Elaborate plans for a wedding may have been made. There are numerous confidentiality and disclosure implications if the couple decides to alter their plans based on their test results. Discordant, engaged couples may have difficulty continuing their relationship. However, it may be quite difficult for the couple to initially acknowledge this, since emotions at this point in a relationship are very intense. The partners may make testimonials to their commitment and the power of their love. Young couples receiving concordant positive results are faced with difficult psychological and interpersonal challenges at a time in their lives when they thought their future was full of dreams and promise. Many engaged couples have limited skills and experience in dealing with stressful and difficult circumstances as a couple.

Married or Cohabitating Couples

Couples that are married or cohabitating generally define their lives collectively, as a partnership. They may be more interdependent socially, financially, and emotionally. Married or cohabitating couples may have more skills and experience coping together with problems. However, these couples may also have pre-existing conflicts and issues in their relationship that impede their communication and their ability to work together to address HIV issues in their lives.

Polygamous Couples

Polygamous couples have many complex dynamics. The wives may not be equal partners with the husband. If all partners are receiving CHCT together, the dynamics may be challenging. If only one wife is present, there are significant implications for the absent wife or wives who are also affected by the counseling session and the test results.

Reuniting Couples

For reuniting couples, the circumstances behind their separation may influence the dynamics of the CHCT session and have a substantial impact on the partners' ability to deal with their test results. Couples who separate because of marital discord often have struggled with issues of trust, faithfulness, and communication. If the couple has not addressed these issues before reuniting and seeking CHCT services, it may be difficult for the partners to deal supportively with concordant positive or discordant test results. In other instances, the couple may have been separated for a long time because of employment, educational opportunities, or family responsibilities. When working with reuniting couples, the counselor may want to facilitate the partners' acknowledge of the existence of past issues and that their time apart may have had both benefits and potential risks. The counselor should keep the couple focused on the present and future.

In general the duration of the couple's relationship, their marital status, childbearing history, living arrangements, future plans, and extended family relationships will influence the issues addressed in this session. This information will allow the counselor to tailor the CHCT session to the couple's unique circumstances. Further, the couple's life stage may substantially influence how the couple deals with their test results and risk behaviors, as well as the future of the relationship.

Component 3: Discuss Couple's HIV Risk Issues and Concerns

Engaging the couples in a discussion of their HIV risk issues and concerns enhances the couple's ability to communicate about HIV risk behaviors and related issues. The capacity to communicate about sensitive issues is crucial to the couple's ability to reduce risk after receiving CHCT services. It is important for the counselor to understand the extent to which the couple has discussed their HIV risk behaviors and concerns. Discussion of Couple's HIV Risk Issues and Concerns: Dealing with Issues in the Abstract

Knowing when and how to address risk issues and concerns is an important part of couples counseling.

Fig: 4.5- Discussion of Couple's HIV Risk Issues and Concerns: Dealing with Issues in the Abstract

When discussing the couple's risk issues and concerns, keep in mind the following points:

- Focus on the couple's present and future

It's not the counselor's job to pull out past issues. The past cannot be changed and should be left in the past.

- Diffuse blame
- Discussion of risk is not about blame—it is about prevention. Discussion of when and by whom one or both partners became infected is discouraged. In countries where HIV is widespread, anyone could be HIV-positive. Being HIV-positive does not mean that a person did something wrong.
- Address risk issues each partner is capable of disclosing

Again, it's not the counselor's job to pull out past issues.

- Emphasize communication and cooperation
- Deal with undisclosed potential risk issues in the abstract way

During the CHCT session, the exploration and discussion of past sexual relationships is not relevant to the couple's current situation beyond the recognition that past history may influence the partners'

respective test results. Therefore, the counselor should not force disclosure of risk behaviors. If one or both partners acknowledge past risk, the counselor may facilitate partner disclosure of past behavior. The counselor should normalize this and indicate it is not uncommon. If the couple has current risks they disclose and choose to discuss, then the counselor should be willing to address these in a constructive, nonjudgmental manner. Often, the counselor's simple acknowledgement in general terms of the possibility of HIV infections occurring before the relationship (which is the reality in most couples) may ease tension and diffuse blame should one or both partners be infected. This situation becomes more complicated when one or both partners deny any previous partner or partners. If possible, the counselor should attempt to redirect testimonials concerning virginity and fidelity because these are difficult to reconcile with positive test results. Should the counselor have an inclination that other partners exist currently, he or she should address this risk in hypothetical terms.

Component 4: Prepare for Testing and Discuss Possible Results

This component provides the opportunity for the counselor to review the meaning of positive and negative test results with the couple. This ensures that both partners clearly understand the results. It also provides an opportunity for the couple to prepare for the test results they may receive and to anticipate the implications of these results. The counselor should talk through potential test result scenarios and help the couple identify issues they will need to address. This will require the counselor to normalize the possibility of any combination of test results. The counselor should also encourage mutual support and diffuse blame. Since discordance is often difficult for couples to understand, the counselor should address issues specific to this potential outcome.

To help contain the couple's anxiety, the counselor should explain the testing process. This includes how long it will take, when results will be available, and how the counselor will deliver the results to the couple. Because the couple as a unit is seeking services, their results are provided as a summary of their combined results: First the counselor tells the couple if their results are the same or if they are different; then they are told their individual results.

Counselors should prepare the couple to receive their test results by making sure they clearly understand when and how the results will be provided to them. Counselors can do that by explaining to the couple that the results are provided at the same time to the couple together. The results are given as a summary of the couple's combined results.

How to deliver HIV test result to the couples

- If the couple is concordant, the counselor should say: First “Your test result are Same”

Then: EITHER: “Both of you has tested HIV-positive.”

OR: “Both of you has tested HIV-negative.”

- If the couple is discordant, the counselor should say:

FIRST: “Your test results are different.”

THEN: Provide the HIV-positive result to the infected partner.

For detail providing initial counseling session please refer , the CHCT cue card.

CHAPTER 3: PROVIDING CONCORDANT NEGATIVE RESULTS

Learning Objectives: By the end of this session the participants will be able to:

- Provide the couple with concordant negative results
- Discuss risk reduction with the couple

Content

- Component 5-A -Provide Concordant Negative Results
- Component 6-A -Discuss Risk Reduction

This chapter explains how to deliver concordant negative test results to couples and how to discuss strategies for remaining HIV negative with the couple. The module introduces two components that guide counselors through the steps and skills needed for the post-test session with concordant negative couples:

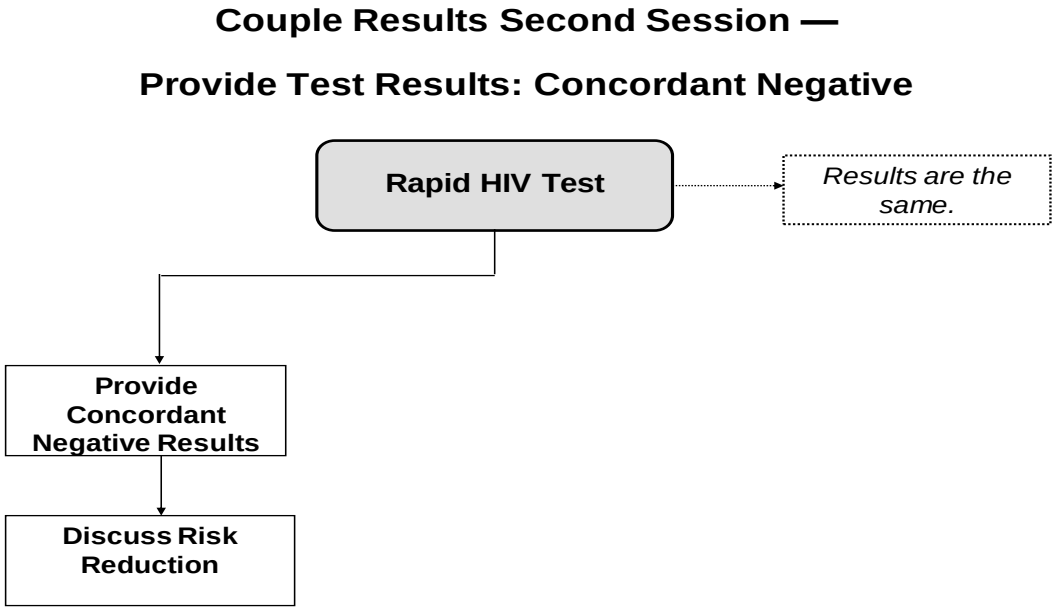


Fig.4.6-Couple HIV Counseling and Testing concordant negative test result protocol components

Component 5-A: Provide Concordant Negative Results

Overall, the aim of the counselor in the concordant negative post-test session is the same as in the initial session that is, to ease tension, diffuse blame, and emphasize the importance of the couple's collaboration and commitment to protect their relationship from HIV.

Component 6-A: Discuss Risk Reduction

In this component, the counselor helps the couple to fully embrace and appreciate the implications of their HIV-negative status.

For detail providing concordant negative test result please refer the CHCT cue card .

CHAPTER 4: PROVIDING CONCORDANT POSITIVE RESULTS

Learning objectives: By the end of this course, Participants will be able to:

- Provide the concordant positive results
- Explore coping , mutual Support
- Explain positive living ,HIV Care and Treatment
- Review risk reduction
- Discuss children, family planning, and PMTCT options
- Discuss disclosure and getting support

Content

- Provide the concordant positive results -Component 5-B
- Discuss coping and mutual Support -Component 6-B
- Discuss positive living, HIV Care and Treatment -Component 7-B
- Discuss risk reduction -Component 8-B
- Discuss children, family planning, and PMTCT options -Component 9-B
- Discuss disclosure and getting support -Component 10-B

This chapter examines how to provide an HIV-positive concordant couple with their test results. The six components of this chapter guide the counselor through providing the results and the subsequent counseling for coping, support, and positive living. The components include:

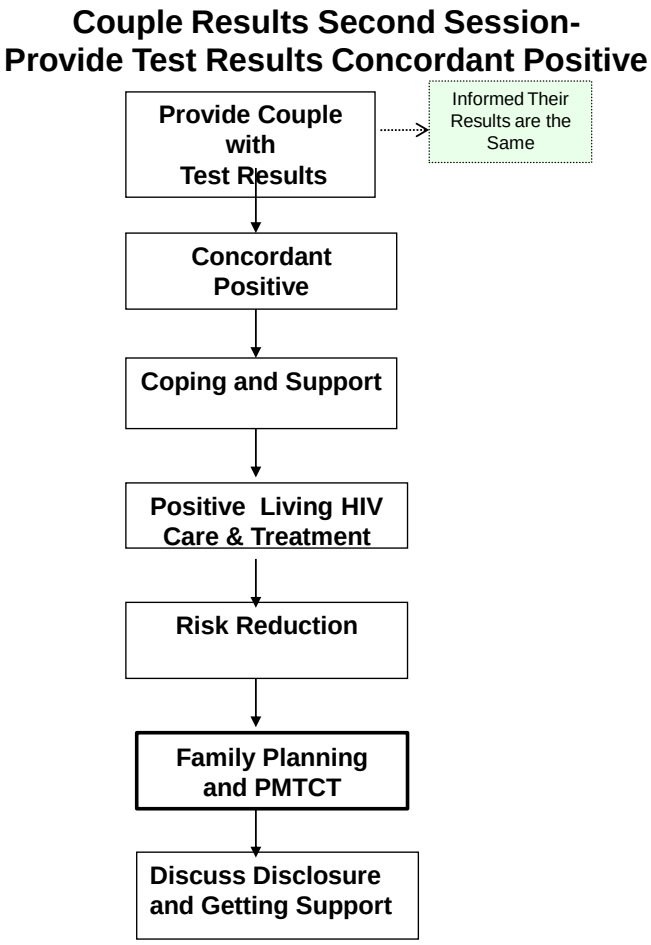


Fig.4.7-Couple HIV Counseling and Testing concordant positive test result protocol components

4.1 PROVIDE CONCORDANT POSITIVE RESULTS (Component 5-B)

The counselor is responsible for providing the test results in a straightforward, clear, and succinct manner. First, the counselor should provide the couple with a summary of both of their test results by saying, "Your results are the same." This should be immediately followed by, "Your test results are HIV-positive, which indicates that both of you are infected with HIV." This approach reaffirms that the partners have sought to learn their HIV status as a couple and that they will be coping with their shared test results together.

The counselor should allow a moment of silence in the session to provide the couple with time to absorb the meaning of the test results. The counselor should make sure that the couple clearly understands the test results. As much as possible, the counselor should diffuse any discussion about

one partner being unfaithful or bringing HIV into the relationship. The counselor may need to assist the couple in understanding that it is not possible to determine when or by whom either partner became infected, and in reality, this is neither relevant nor helpful. The counselor should attempt to focus the partners on how they can support each other and cope with their results.

4.2 DISCUSS COPING AND MUTUAL SUPPORT (Component 6-B)

In this component, the counselor should delicately balance the couple's expression of feelings—often of distress and loss—with supportive encouragement and understated but genuine optimism about the couple's ability to adapt to and cope with the results. The counselor's demeanor should be somber yet supportive. The counselor should refrain from labeling the couple's feelings for them. For example, the counselor should avoid saying, "You must be upset," or "This is difficult for you." The partners should first be supported to define the meaning of the results for themselves and identify their own thoughts, reactions, feelings, and emotions. The counselor can then supportively reflect back and normalize the couple's experiences.

As appropriate, the counselor may remind the couple of their resources and strengths, which they identified earlier in the session. The partners should be encouraged to be supportive of each other. At the same time, the counselor should help the couple recognize the potential need for additional support from others.

4.3 DISCUSS POSITIVE LIVING AND HIV CARE AND TREATMENT (Component 7-B)

The counselor should gently transit the session away from addressing the couple's feelings and emotions associated with dealing with HIV infection toward the clinical care, treatment, and preventive services required to manage HIV infection. Counselors should emphasize that there are many preventive treatments that can enhance the quality of the partners' lives. The goal is to motivate and empower the couple to seek needed care and treatment services and to advocate for their own health. To do this, the counselor should provide information at the couple's level of understanding to educate them about the essentials of HIV care and treatment. The aim is for the couple to fully understand and value the importance of accessing appropriate care.

4.4 DISCUSS RISK REDUCTION (Component 8 –B)

For HIV-infected couples, the issue of risk reduction may be delicate and complex, especially when talking about outside partners. Discussing the risks of having partners outside the relationship should be handled diplomatically and in general terms.

Reasons to talk about outside partners include:

- Outside partners could be HIV-negative.
- Outside partners could have STIs that would make the couple sicker.
- Individuals in the couple are HIV-positive and need to use condoms with outside partners.

Using of third person technique or in abstract way in this protocol component is basic the counseling skill

- **Example we can use some words such as in some married couples, in some relationship, polygamy ..**

The counselor should emphasize the importance of avoiding STIs. If there is any sexual exposure outside of the relationship, condoms must be used to protect the couple from STIs and to prevent the transmission of HIV.

4.5 DISCUSS CHILDREN, FAMILY PLANNING, AND PMTCT OPTIONS (Component 9-B)

There are a number of issues to address regarding the couple's family planning and reproductive choices. In terms of public health, the objective is to prevent unintended pregnancies and to reduce the risk of transmission of HIV to infants born to infected mothers. The most effective way to prevent HIV transmission to an infant is for the couple not to have additional children by having protected sex only. However, in terms of human rights, the couple should be supported to make informed reproductive choices and then their choices should be respected.

When discussing family planning and reproductive health issues with the couple, the counselor's aim is to make sure that the couple understands PMTCT, has access to family planning services, and understands the importance of accessing PMTCT services if the woman is currently pregnant or if the couple conceives in the future. The counselor should aim at least to address the essential information

and to provide appropriate referrals. If the couple is interested and time permits, the counselor can discuss their choices more fully.

4.6 DISCUSS DISCLOSURE AND GETTING SUPPORT (Component 10 – B)

It is important for the couple both to understand the benefits of disclosing their HIV status to friends, family, and community members who will support them. It is also important for the couple to understand how to approach disclosing their status.

Disclosure Benefits and Basics

1. **Potential benefits of disclosure to the HIV-infected person:**

- May build a network of social and emotional support—may reduce sense of isolation and anxiety
- May enhance opportunities for HIV-infected person to receive support in obtaining proper medical care and treatment
- Assists HIV-infected individuals in taking medication properly by
    - ✓ Allowing the individual to take medication openly
    - ✓ Allowing the individual to acknowledge HIV status
    - ✓ Allowing the individual to receive support during treatment

2. **Potential benefits of disclosure to sex partners:**

- Allows sex partner to know about exposure risk
- Allows sex partner to seek testing and to reduce his or her risk of acquisition or transmission of HIV
- Enhances the sex partner's ability to understand and support the behavior changes needed to reduce risk

3. **Potential benefits of disclosure to family and community:**

- Helps infected individuals, couples, and families prepare for the future
- Allows an opportunity to address children's fears and anxieties

- Provides a role model to friends, family, and community
- Allows health care providers to take appropriate precautions

4. **Potential benefits of disclosing to children:**

- Not knowing can be stressful for children.
- Children can be highly perceptive. Children (especially older ones) often know something is wrong even if the parent has not disclosed.
- Parents can relieve the stress of uncertainty as well as communicate trust and openness by talking about their status.
- Parents should be the ones to disclose their status. It's best for children to learn about their parents' HIV status from the parents themselves.
- Disclosure opens communication between parents and children and allows the parents to address the children's fears and misperceptions.
- Disclosure lowers parents' stress. Parents who have shared their HIV status with their children tend to experience less depression than those who do not.

Approaches of disclosure

Discussing disclosure to people and partners outside of the couple relationship is an issue that must be approached with sensitivity. Some guidelines to help couples with disclosure include:

- Identify the person most likely to be supportive and understanding to disclose to first.
- Find a private and quiet place and time for the discussion.
- Request that the discussion be kept confidential.
- Mentally frame the issues to be addressed beforehand.
- Develop a script of what to say and how and when to say it.
- Practice, practice, practice.
    - Anticipate both supportive and non-supportive responses and how they may feel to the couple
    - Imagine possible counter-responses.

- Focus on and share feeling avoid blame.
- Be clear and specific about what support is needed and what would be helpful.
- When finished, review the experience; revise the approach as necessary for disclosure to the next person.
- When deciding which sex partners to disclose to, prioritize those who may have been exposed to HIV (if the HIV-positive person feels it is safe to disclose to that person).

Once couples and individuals decide to disclose and decide to whom to disclose, practicing the disclosure is a useful way to develop strategies to make the process easier.

Considerations for disclosing to children:

- The decision to tell a child that a parent or parents are HIV-infected should be individualized to the child's age, maturity, family dynamics, social circumstances, and health status of the parent.
- How a child reacts to learning that a parent (or parents) has HIV usually depends on the relationship the parent has with the child.
- Young children should receive simple explanations about what to expect with their parent's HIV status. The focus should be on the immediate future and addressing fears and misperceptions.
- Older children have a better capacity to cope with their parent's status and to understand the implications of being HIV-positive.
- It is possible that in some cases, disclosure may initially cause stress and tension. Parents should anticipate that their children might need time to adjust to and accept their parents' HIV status.
- If a parent discloses his or her HIV status but requires the children to keep it a secret from others, it can be stressful and burdensome to the children.
- Parents should consider disclosing their status to other adults who are close to their children. This creates a support network of adults who can help the children cope with and process their feelings.
- Parents who are experiencing intense feelings of anger or severe depression about their HIV infection may want to wait to disclose to their children until after they have learned to cope with their status.

HIV-affected children and families need ongoing support beyond disclosure for coping with HIV and planning for the future.

For detail providing concordant positive test result please refer , the CHCT cue card .

CHAPTER 5: PROVIDING DISCORDANT RESULTS

Learning objectives: By the end of this session the participants will be able to:

- Describe the factors Influencing the Transmission of HIV
- Explain essential counselor responsibilities to disclose test result
- Provide discordant test result
- Discuss risk reduction

Content

- Factors that influence the transmission of HIV
- Essential counselor responsibilities
- Provide discordant test result -5-C
- Discuss coping and mutual support –6-C
- Discuss positive living and HIV care and treatment –7-C
- Discuss risk reduction –8-C
- Discuss family planning and PMTCT options for discordant couples –9-C
- Discuss Disclosure –10-C

This chapter clarifies the implications of discordance and will explain the couples HIV Testing and Counseling (CHCT) procedure for counseling discordant couples, including:
The component below shows some of the issues that we will discuss, such as providing the test results and informing the couple that their test results differ. We will discuss the implications of discordance when the woman is HIV-positive and the man is HIV-negative. We will also discuss issues when the man is HIV-positive and the woman is HIV-negative.

We will then cover issues that are very important for discordant couples, such as coping and providing each other support; positive living, care, and treatment; risk reduction; family planning, disclosure; and getting support.

CHCT Results Session: Discordant

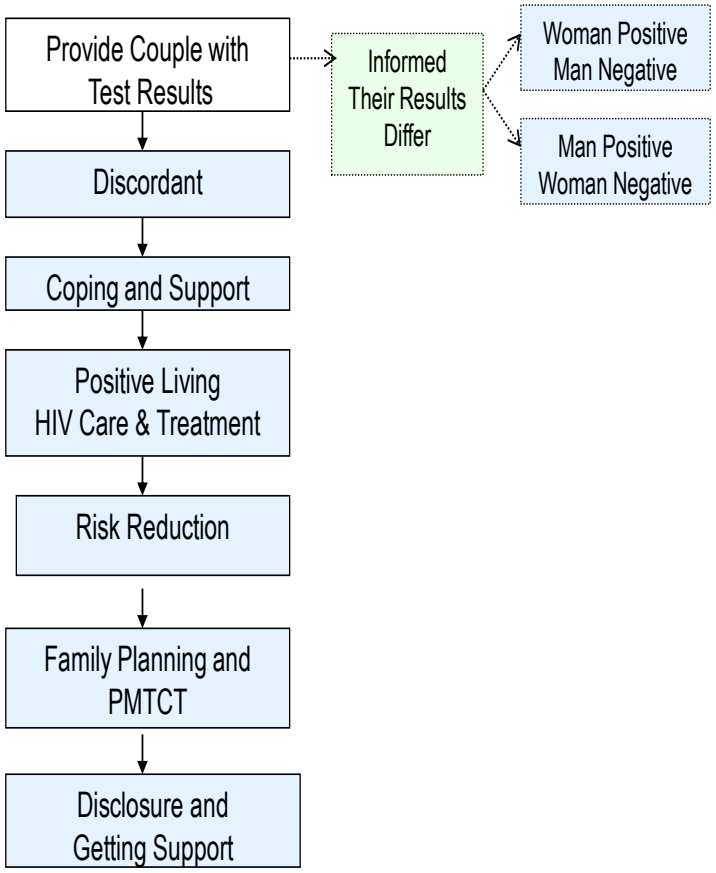


Fig.4.8-Couple HIV Counseling and Testing Discordant positive test result protocol components

Preventing transmission within a discordant couple is one of the most critical reasons for offering couples HIV Testing and Counseling services. We will discuss in-depth the counselor's most important responsibilities in working with a discordant couple and how to communicate effectively with the couple.

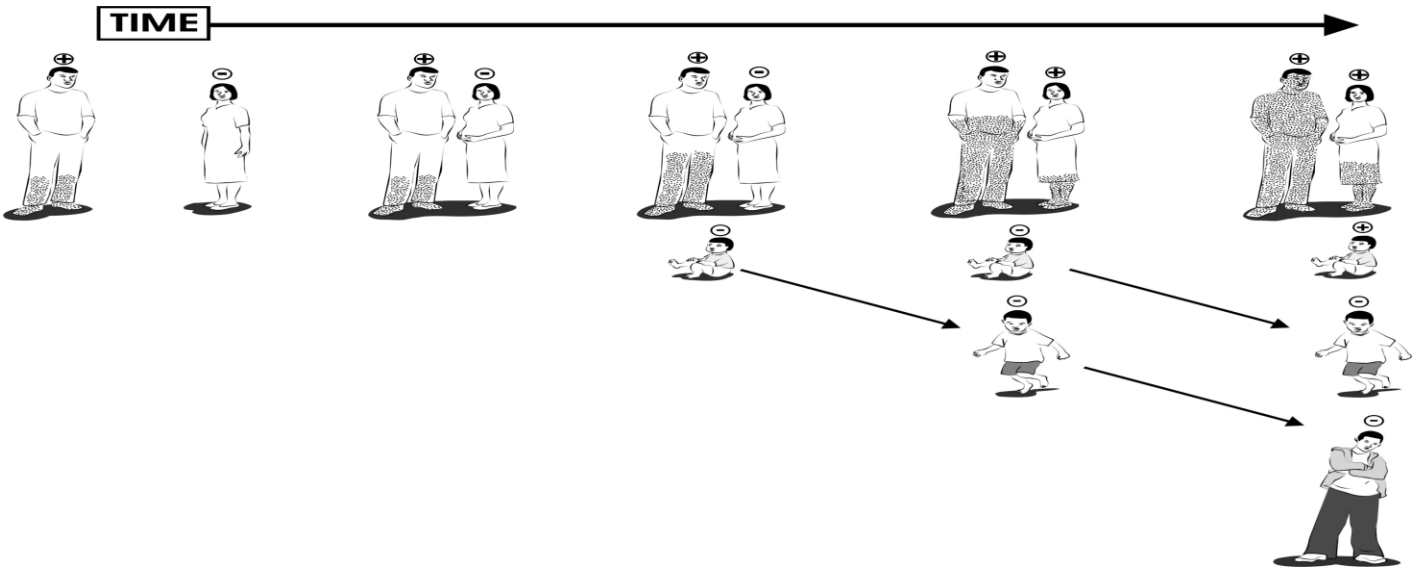


Fig 4.9: *Possible HIV Sero status condition in Couple and benefit of CHCT to avoid HIV transmission*

When this couple met, the man was young and healthy and unaware he was infected with HIV. When the couple married, they were unaware they were discordant. Like most couples, they soon had a child, and the child was not at risk for HIV because the mother had not yet become infected with HIV. When they had their second child, the woman had become infected with HIV, but fortunately she did not transmit the virus to the child. Unfortunately when the couple had their third child, this child was infected with HIV.

Factors that Influence Transmission of HIV

Once an individual has engaged in risk behaviors, several factors influence the likelihood of the transmission and acquisition of HIV. These factors make it more likely for a person to transmit HIV or for a person to acquire HIV. All of these factors underscore the importance of counseling couples about how to minimize their risk in order to protect the HIV-negative partner.

Even though, these factors influence whether the partners are discordant and how long they may remain discordant, the chance or probability of HIV transmission is unpredictable. Whether or not the virus is passed during a specific exposure relies partly on chance.

The following factors can influence HIV transmission and can also affect the health of the infected person:

Sexually transmitted infections

HIV-infected persons with STIs are more likely to transmit HIV than people without STIs**.** Sexual partners are more likely to acquire HIV if they have STIs.

Level of virus

The more virus (HIV) the HIV-positive person has in his or her body, the more likely it is that he or she will pass HIV to a sexual partner. When individuals develop AIDS, they are ill because they have very high levels of HIV in their body and low numbers of immune system cells. Patients who take their ARVs as directed will have a lower level of virus, but are still able to transmit the virus.

Recent infection with HIV

When someone is recently infected with HIV, he or she will initially have a higher amount of virus in his or her body. This increases the chance of passing HIV to others.

Frequency of sexual exposures

Each time an HIV negative person has sex with someone who has HIV, he or she is at risk of getting HIV. The more exposure to HIV he or she has, the more likely it is that he or she will become infected.

Injury of the genital tract

Partners with cuts or abrasions of the membranes of the genital track are more likely to acquire HIV than partners with intact membranes.

Farmer's Crop the First Year

Farmer's Crop the Second Year

Fig 4.10: Analogy of how chances may be temporal explanations for couple discordant HIV result

Imagine this farmer invested the same amount of time and effort into tilling, planting, cultivating and harvesting his crops each year. However, the first year the farmer had a bountiful harvest while the second year the harvest is poor. What factors caused the farmer's harvest to be so different each year?

Essential Counselor Responsibilities to disclose test result

Because couples may have difficulty understanding their discordant results, counselors need to be very clear. Their messages should emphasize the very high risk of the uninfected partner becoming infected unless the couple adopts behaviors to protect the uninfected partner. It is extremely important that counselors fulfill the following responsibilities:

- Facilitate understanding and acceptance of results.
- Provide clear and accurate explanation of discordance.
- Dispel any beliefs that might undermine prevention. Examples of false beliefs that can place a couple at greater risk include:

  Belief #1: One partner has been unfaithful and deserves to be abandoned or punished. **Answer: The infected partner could certainly have acquired HIV well before the partners became a couple.**

  Belief #2: The couple believes the virus is sleeping and cannot be transmitted. **Answer: HIV-infected persons can transmit the virus at any time, even if they have no signs or symptoms of the disease.**

  Belief #3: There has been a mistake in the lab.

  Answer: While this is a possibility, it is very rare, and the lab has many procedures in place to prevent any mistakes.

  Belief #4: We have been having sex all this time and never transmitted the virus. Why do we need to take precautions now?

  Answer: HIV may be transmitted in the future, particularly as the person gets sicker and has higher levels of the virus.

- Empower the couple to commit to risk reduction. During your counseling session, you will be giving couples the knowledge and skills to prevent transmission from the positive partner to the negative one. This will empower them to stay healthy.

- Discuss mutual disclosure decisions. Discrimination and stigma are unfortunately very common. Couples need to be careful about to whom they disclose their results. This should be a mutual decision.

- Help the couple develop adaptive coping strategies. HIV is very stressful. Your counseling will involve helping these couples cope with this stress.

The counselor has a crucial opportunity to help discordant couples deal with their results and, most importantly, take steps to reduce the risk of transmission.

Provide Discordant Test Results – Component 5

The aim of this component is to emphasize that the counselor is responsible for providing results to the couple in a straightforward, clear, and succinct manner. It is essential for the counselor to help discordant couples accept the accuracy and reality of their test results. Discordance must be explained in simple terms that clearly address any misconceptions the couple may have. The following five tasks guide counselors through this portion of the post-test session: Remember that the words a counselor chooses to say in the session affect each client in different ways and on many levels. Words, information, and explanations can have several meanings and interpretations. A counselor should listen carefully to his or her own choice of words and phrases and assess how the messages may be heard, perceived, and interpreted.

For detail providing discordant test result please refer CHCT cue card.

Discuss Protecting the Negative Partner from HIV

For a discordant couple, it is very important for the HIV-negative partner to stay negative. The negative partner can be a source of support for the positive partner, both emotionally and with HIV care and treatment. Should the HIV-positive partner become ill or die, having an HIV-negative, healthy partner can help ensure the well-being of any children or the household.

Couples may remain discordant for a long time without knowing their HIV status or reducing their risk. However, if they do not take steps to protect the negative partner from HIV, that partner is at very high risk for becoming infected. By taking steps to protect the negative partner, such as not having sex or

always using condoms during sex, the couple should be able to remain discordant for much longer, if not indefinitely.

Helping discordant couples protect the negative partner from HIV is among the most important goals of CHCT. Counseling greatly reduces the transmission of HIV within discordant couples by delivering risk reduction messages and discussing the couple's choices. The following four tasks and objectives outline how to discuss risk reduction effectively with discordant couples:

Discussing the Likelihood of an HIV Test

Not Detecting Recent HIV Infection— "Window Period"

It is possible during CHCT Chapter 3: Concordant Negative or during Chapter 5: Discordant that the issue of the "window period" will come up. The window period describes the period when an HIV test does not detect HIV infection because the body has not yet produced antibodies to a very recent infection. This briefing paper should assist the trainer in facilitating discussion on this issue and dispelling myths.

1) Explain to participants that as counselors they should try to avoid using the term "window period" when explaining HIV test results to clients. The phrase is misleading, poorly understood, and essentially jargons. Instead, counselors should tell couples that a recent exposure to HIV may not be detected by the HIV antibody test. If either partner has had a recent exposure that they are concerned about then they should consider re-testing **4-6 weeks** or more after the last risk exposure to an HIV-infected person or someone with unknown status.

2) Explain to participants that they should be careful when explaining the likelihood of being in the window period to couples. The actual likelihood of being in the window period is quite low. The counselor therefore has an ethical responsibility to mention the risk but should also emphasize their confidence in the negative test result(s) and convey this to the couple.

3) Some participants may believe that discordant couples are actually concordant positive, and that one partner is in the window period. If so, explain to the participants that this is not likely. Remind them that discordance is not only possible, but that it is also fairly common in Africa, occurring in about 13%-30% of couples, whereas the risk of being in the window period is very small **(<3%)**.

Module Summary

- CHCT is one of the models of HTC serving as "an entry point" for HIV prevention, care and support services for different type of couple and family. And the basic guiding ethical principles and additional CHCT Counseling (conditions) should be respected
- CHCT protocols were comprises of 4 initial , 2 concordant Negative Sessions and 6 concordant positive or Discordant sessions
- CHCT HIV Risk Reduction Options Includes : (Abstain from sex, Avoid having sex with a person whose HIV status is unknown, Testing with partner, Having only one partner whose HIV status is known, Consistent and appropriate Condom use , Reduce number of partners and Use alternative means of sexual expression (touching each other and other forms of non-penetrative sex)
- Positive living means taking care of client's health and emotional well-being in order to enhance his/her life and stay well longer. It involves: having positive attitude, sense of optimism and well-being, understanding the disease, and follow prescribed nutrition, and medications. And follow-up medical care, and advice
- When providing Concordant HIV Positive or HIV discordant test results, Counselor should allow a brief period of supportive silence and acknowledges the difficulty of receiving it for first times and should focus the need to have focused medical care follow up, also disclosure issues may have same implications for both partners and on continuing risk reduction.
- In discordant HIV Couple test result, need to protect uninfected partner from becoming infected with HIV and support the infected for continuous medical follow up , also bring them together for any further action, as HIV-infected partner may have greater disclosure concerns and on continuing risk reduction.
- During the whole process of CHCT, the focus is on the couple strength, present and

future HIV issues, the past is past, & remain there, as not able to change it any more.

- Enhanced, ongoing CHCT sessions for HIV-positive individuals or Discordant couples
- Create and regularly maintain a resource Medical Service directory, Which comprises of

(Name of Service referral, Location/directions , Hours of operation, …)

ANNEXS

Annex 1. ***Johari's Window for Couple*** **Counseling**

OPEN	**PRIVATELY DISCUSSED** **Issues that are understood, acknowledged, or privately discussed**
NOT DISCUSSED **Issues that are imagined or believed, and rarely, if ever, discussed**	**HIDDEN** **Issues that are hidden, protected, and kept secret**

Table 1: The Johari's Window for Couples

The **"OPEN" box** represents things that you are proud of and that you share and discuss openly with your family and extended family. For example:

- Your child's accomplishments
- Professional goals and ambitions
- Relationship status (such as engaged or married)

The **"PRIVATELY DISCUSSED" box** represents things that you share in your home between you and your partner. For example:

- Financial circumstances
- Detailed information regarding personal family situations

The **"NOT DISCUSSED" box** represents things in your relationship you know about but do not talk about. For example:

- Believing your partner drinks when away from home on business
- Believing your partner dislikes your mother or relatives

The **"HIDDEN" box** represents things that cause you to feel guilty, ashamed, or embarrassed. For example: A sexual encounter or fantasy, something you did under the influence of alcohol

- Having been in an abusive relationship
- Having been sexually assaulted or forced to have sex

Annex 2:

Initial Session Role Play

Couple: Petros age 29, accountant, and Marta age 25, primary school teacher

Relationship: Together 1 year and Engaged couple

The couple met during Marta second year at the university, the same year Petros was finishing his educational training. They acknowledge that student life at the university was somewhat carefree and groups of classmates routinely had parties, went to the Night clubs to dance, and generally had a good time. They never really talked very much about relationships they had with other people, but it was understood between them that they both dated before meeting each other. Once they met though it was clear they were meant for each other. They used condoms to prevent HIV & pregnancy, as they wanted to plan their future together. A cousin of Petros who probably had AIDS recently died after being ill for some time and left behind a wife and three children. This caused Petros and Marta to talk more openly about their HIV AIDS concerns. They decided it was important for them to go together for couple counseling

You are Petros

Petros is the prime of his life. He has a beautiful girl friend His career as an accountant is going quite well and he has been able to provide nicely for his Girlfriend & his family. In his work he travels occasionally to visit other manufacturing facilities run by his company in neighboring countries. There is also discussion that he may be sent away for a six-week course in auditing. This is the opportunity of a lifetime. However, he thinks that he must be careful especially if he goes out to a club and has a few beers with his co-workers. He loves his girlfriend and would not want to jeopardize their dreams and their future.

Initial Session Role Play

Couple: Petros age 29, accountant, and Marta age 25, primary school teacher

Relationship: Together 1 year and Pre marital couple

The couple met during Marta second year at the university, the same year Petros was finishing his educational training. They acknowledge that student life at the university was somewhat carefree and groups of classmates routinely had parties, went to the Night clubs to dance, and generally had a good time. They never really talked very much about relationships they had with other

people, but it was understood between them that they both dated before meeting each other. Once they met though it was clear they were meant for each other. They used condoms to prevent HIV & pregnancy, as they wanted to plan their future together. A cousin of Petros who probably had AIDS recently died after being ill for some time and left behind a wife and three children. This caused Petros and Marta to talk more openly about their HIV AIDS concerns. They decided it was important for them to go together for couple counseling

You are Marta:

Mata is from a small village and is the eldest in her family. As a young girl she was quite bright and did well in school. Since she was a good student, her parent's supported her to go to the university to become a teacher. It is their hope that in time she will be in a position to help out her brothers and sisters. Marta enjoys the life she shares with Peter and feels he is very supportive. Petros has done well at work and has an opportunity to go for six-week training in a neighboring country. Although this is a very promising opportunity, Marta is concerned about what can happen when a man travels and gets lonely.

Couple counseling role play (Concordant Negative)

Couple: Petros, age 29, accountant

Elsa, age 25, primary school teacher Child: 2 years old daughter

The couple met during Elsa's second year at the university, the same year Pawulos was finishing his educational training. They acknowledge that student life at the university was somewhat care free and groups of classmates routinely had parties, went to the local clubs to dance and generally had a good time. They never really talked very much about relationships they had with other people, but it was understood between them that they both dated before meeting each other. Once they met though, it was clear they were meant for each other. In the beginning, they used condoms to prevent pregnancy, as they wanted to plan their future together. About the same time they were getting married, Elsa found out she was pregnant. Although it wasn't planned, they were thrilled as were their families.. These days they no longer use condoms as Pawulos never really like them and they would like to have another child. Both couple attends radio dramas concerning prevention of HIV /AIDS one day they decided it was important for them to go together for couple counseling.

You are Pawulos:

Pawulos is at the prime of his life. He has a beautiful wife and a healthy 2 years old baby girl. His career as an accountant is going quite well and he has been able to provide nicely for his family. In his work he travels occasionally to visit other manufacturing facilities run by his company in neighboring countries. There is also discussion that he may be sent away for six-week course in auditing. This is the opportunity of a life time. However, he thinks that he must be careful especially if he goes out to a club and has a few beers with his co-workers. He loves his wife and do not want to jeopardize their dreams and their future.

You are Elsa:

Elsa has a husband she loves and a 2 years old daughter she adores very much. Her husband earns a good income and including of her salary, they are able to live comfortably. She thinks of attending a night school once her daughter grows into a certain age. She is recently feeling discomfort when Pawolos is being sent for a trip away from the country. She wants the development of her husband career, but fears he may commit a mistake during his stay far away from his family.

Role Play - Concordant Positive

Elias age 31, driver for an aid organization

Jember age 28, House wife

Children: 5-year-old son, 2-year-old daughter

Jember and Elias are a very close couple and after years of hard work they feel like their life is going pretty well. Jember met Elias at a friend's wedding. He was very charming and she liked him immediately. He seemed to be a good man. He had a good job and was building a house for his mother. Elias and Jember never talked in detail about their past relationships. Jember is aware that prior to the time they met; Elias drove a truck for another aid organization and delivered supplies to programs in various neighboring countries. He was away for weeks at a time and she imagines he may have met girls along the way. Elias knows that for a brief time Jember had a boyfriend who she was serious about but the relationship ended long before they met. Since they married they have built a nice home for their family.

Elias and Jember are considering having another child. Elias, in particular, would like another son. The nurse midwife, a family friend, who delivered their youngest daughter, recommended to Jember that the couple receive CHCT service prior to adding another child to their family. Elias has a coworker who has been ill and Elias is concerned that this friend may have AIDS. Elias' concern about his coworker has caused him to talk to Jember a little more about his worries about HIV. The youngest child of Elias and Jember has had some minor health problems and this has added to their worries. As a result, they decided to go together to receive couple HIV testing.

You are Elias:

Prior to his current position Elias delivered construction and food commodity supplies for another aid organization. He would be gone for several weeks at a time. This was a lonely time for Elias and he would sometimes go to the bars in the evenings. Occasionally he would meet a girl and have sex with her. He would usually use condoms but not always. For awhile he had a steady girlfriend in the border of the country. He was fairly serious about her and thought they might marry. Initially he used condoms with this girl to prevent pregnancy but eventually they stopped. This relationship ended when the girl moved to the city to live with her sister to find a better job. Not long after that Elias met Jember and they later married. Elias is very happy with his life. He is dedicated to his wife and children. Elias feels that he and Jember have a strong bond and have worked together toward building a better future for their family. Although Elias is worried about going for an HIV test, he feels a bit reassured that his employer is scaling-up a program to provide access drugs to treat HIV as part of the employee health package. He doesn't know a lot about these drugs but thinks they may offer some hope.

Role Play - Concordant Positive

Elias age 31, driver for an aid organization

Jember age 28, House wife

Children: 5-year-old son, 2-year-old daughter

Jember and Elias are a very close couple and after years of hard work they feel like their life is going pretty well. Jember met Elias at a friend's wedding. He was very charming and she liked him immediately. He seemed to be a good man. He had a good job and was building a house for his mother. Elias and Jember never talked in detail about their past relationships. Jember is aware

that prior to the time they met; Elias drove a truck for another aid organization and delivered supplies to programs in various neighboring countries. He was away for weeks at a time and she imagines he may have met girls along the way. Elias knows that for a brief time Jember had a boyfriend who she was serious about but the relationship ended long before they met. Since they married they have built a nice home for their family.

Elias and Jember are considering having another child. Elias, in particular, would like another son. The nurse midwife, a family friend, who delivered their youngest daughter, recommended to Jember that the couple receive CHCT service prior to adding another child to their family. Elias has a coworker who has been ill and Elias is concerned that this friend may have AIDS. Elias' concern about his coworker has caused him to talk to Jember a little more about his worries about HIV. The youngest child of Elias and Jember has had some minor health problems and this has added to their worries. As a result, they decided to go together to receive couple HIV testing.

You are Jember:

While in secondary school Jember had a boyfriend. This boy really pressured her to have sex with him. Jember only had sex with this boy twice. Later, Jember met a boy from her village and was involved with him for awhile. He ended their relationship when he got the opportunity to go away to a technical school for training. She was hurt and disappointed when this young man left. About a year later she met Elias and finally found the relationship she was looking for. Jember feels that she and Elias have a strong bond. Elias is a responsible and kind husband, a good father, and works hard to provide for the family.

Role Play—Discordant

Yohannes: 28 year's old, computer technician

Eyerusalem: 25 years old, secretary

Married: 3 years

Children: 3-year-old twins (one girl and one boy)

Yohannes and Eyerusalem met a little over 4 years ago when they travel 500km.by public transport to visit their family. They met for lunch a few times and found they had quite a lot in common. Soon they were seeing each other regularly and it was clear that they had a strong bond and similar dreams. When they first had sex they used condoms but as their relationship became

more committed and as their wedding plans moved along they became more relaxed. They never really talked about it but somehow they simply stopped using condoms. Not long after the wedding they found out that they were having twins. This news was exciting to their families and brought them closer. With the help of her mother-in-law, who lives nearby and cares for the twins while she is at work, Eyerusalem returned to work when the twins were 1 year old.

Yemane and Eyerusalem are dedicated to each other and happy together. Eyerusalem sister lives close by and they are best friends. They both listen to a radio drama while at work and talk and laugh endlessly about the characters. Recently a couple in the drama has been considering going for a HIV test. Eyerusalem decided she was going to talk to Yemane about getting a test. Yohannes too had been thinking about HIV as a friend and co-worker has been ill and the rumor was that he had HIV. His friend really looked bad for a while but lately he had been looking better. Yohannes heard he was taking some new medications to treat HIV. Yohannes and Eyerusalem both have their worries but decided to go ahead and go for couple HIV counseling and testing.

Although Yohannes and Eyerusalem never talked specifically about it, they both knew there may have been other partners in their pasts. In fact, Yohannes knew that Eyerusalem went with someone from her work for a while when she first moved to town. Eyerusalem knows Yohannes is a handsome man and he must have had girlfriends while at the university. Her only hope is that he had been careful. What is important is that she knows that he is now committed to her and their family and she is proud to have such a handsome and responsible husband.

You are Eyerusalem:

When Eyerusalem was young and lived in the village she had a boyfriend for a brief time. He persuaded her that he loved her and convinced her to have sex. The first time he used a condom; the second time he did not. She was so relieved not to become pregnant that she stopped seeing him. Eyerusalem was eager to find a career, so 6 years ago she moved to the city to live with her sister. Eyerusalem went to technical school to become a secretary. After her training, she found a good job in a large company. She and her co-workers would go out evenings to dance and have fun. An older supervisor from another unit took an interest in her. They saw each other for a while and then he seemed to lose interest. They had sex a few times and he used a condom every

time except once. Six months later she felt for Yohannes. In him she found a companion, a supportive husband, and a dedicated father.

You are Yohannes:

Yohannes has some concerns about HIV as he had a few girlfriends while in training at the university. That was a carefree time in his life and he often went out to clubs with friends. There was one girl he was a bit serious about for a while, but as time went on it was clear they were not meant to be together. She later moved to another country to pursue an advanced degree. Of course as a boy in secondary school he had also played with a couple of girls. He usually used condoms but not always; he wasn't perfect. Besides he really didn't like condoms that much as it didn't seem as close or pleasurable. Once he met Eyerusalem he knew he met the woman who would be his wife. Although he has at times been tempted, he has been faithful to Eyerusalem. He cherishes their beautiful children and the life they share together.

Annex 3:

CHCT OBSERVER CHECKLISTS FOR CHTC Services					
Component 1: Introduction the Couple to CHCT and Obtain Concurrence to Receive Couple Services					
		Not Achieved	**Partially Achieved**	**Well Achieved**	**Comment**
	1. Introduce yourself and describe your role as the counsellor.				
	2. Discuss the benefits of CHCT: • Learning about their HIV status together • Providing an opportunity for both partners to deal with their HIV concerns together				
	3. Describe the conditions for receiving CHCT services. Conditions include: • Discussing risk concerns • Willingness to receive results together • Commitment to shared confidentiality • Mutual disclosure decisions				
	4. Address expectations, roles and responsibilities of the couple in CHCT. • Partners participate equally. • Listen and respond to each other. • Treat each other with respect and dignity. • Engage in open and honest discussion. • Provide understanding and support.				
	5. Obtain concurrence to receive CHCT.				
	6. Give a session overview. Include what will be covered and estimate how long the session will take. The session includes: • Reviewing the couple's situation • Discussing HIV risk issues and concerns • Preparing for the HIV test and discussing possible results • Taking the rapid HIV test • Receiving results • Counselling based on results				
Component 2 : Explore the Couple's relationship and Reason for Seeking CHCT Services					
	1. Establish the nature and duration of the couple's relationship, including: • Living arrangements (including if couple have been separated due to employment) • Marital status (ask if in polygamous relationship)				

	• Plans for the future				
	2. Address family planning and childbearing issues and choices.				
	3. Review how the couple came to the decision to seek CHCT services: • Decision process				
	4. Assess the couple's feelings associated with receiving CHCT. Be sure to get input from both partners.				
	5. Summarize and reflect on the couple's history and current situation.				
Component 3 : Discussion the Couple's HIV Risk Concerns					
	1. Discuss possible HIV risks in the abstract and remind the couple to focus on the present and future.				
	2. Address indicators of increased risk. • Note factors frequently associated with risk behaviour, such as a history of illnesses, STIs, or TB. • Listen for possible risk circumstances, such as: o Separation because of travel or work o Alcohol or drug use o Second wife or other partners				
	3. Summarize the risk reduction discussion and provide motivation and support.				
Component 4 : Prepare for testing and Discuss Possible Results					
	1. Explain the meaning of positive and negative results.				
	2. Explain that the couple could have the same results: • Concordant positive • Concordant negative				
	3. Discuss discordance: • Discordance occurs frequently • Does not mean uninfected partner is immune • Uninfected partner remains at risk				

	4. Guide the couple through the testing process and describe how the test results will be provided: • The couple will have results that are either the same or different. • Individual results will be provided. • Counselling is provided based on the test results.				

CHCT – Results Session: Concordant Negative : 5 A

Component 5 - A: Provide Concordant Negative Test Results –					
		Not Achieved	**Partially Achieved**	**Well Achieved**	**Comment**
	Inform couple that their test results are available				
	State that the couple‘s test results are the same/shared				
	Provide a simple summary of the couple’s results				
	Both test results are negative - indicating each partner is not infected				
	Inquire as to the couple’s understanding of their results				
	Explore couple’s reaction to their results				
	Note the need to understand the result in the context of any recent risks outside of their relationship				
Component 6 - A: Discuss Risk Reduction					
	Discuss commitments and communication required of the couple to remain uninfected				
	Encourage couple to preserve their future by remaining uninfected				
	Discuss commitments and communication required of the couple to remain uninfected				
	Encourage couple to preserve their future by remaining uninfected				
	Address the risk associated with other partners (past or present)				
	Remind couple that their results do not indicate the status of other partners				
	Partner’s status will only be determined through				

	HIV testing				
	Identify behaviour most likely to place couple at risk of becoming infected				
	Discuss plan should either partner engage in risk behaviour				
	Develop a plan to ensure the couple remains negative				
	Identify potential obstacles to accomplishing the plan				
	Encourage the couple practice the communication skills required to successfully accomplish the plan				
	Encourage couple to become ambassadors for testing and particularly couple services				
	Provide needed referrals (STI, FP, ANC, support etc.)				

CHCT – Results Session: Concordant Positive : 5 B

Component 5 - B: Provide Concordant Positive Test Results –					
		Not Achieved	**Partially Achieved**	**Well Achieved**	**Comment**
	Inform the couple that their results are available				
	State that the couple's test results are the same/shared				
	Provide a simple summary of the couple's results – both test results are positive, indicating the couple is infected				
	Allow the couple to absorb the meaning of their results				
	Inquire as to the couple's understanding of their results				
	Encourage mutual support and avert blame				
Component 6- B: Discuss Coping and Mutual Support					
	Invite both partners to express their feelings and concerns				
	Validate and normalize the couple's feelings and acknowledge the challenges of dealing with a positive result				
	Inquire as to how the couple could best support each other				

	Recall couple's strengths and covey optimism that the couple will be able to cope and adjust to living with HIV				
	Address the couple's immediate concerns				
Component 7 - B: Discuss Positive Living and HIV Care and Treatment					
	Discuss positive living.				
	Address the need for preventive health care.				
	- Encourage immediate visit to the Care and treatment clinic/ART				
	-Dispel myths about treatment eligibility				
	Encourage the couple to access appropriate care and treatment services.				
	Provide needed referrals to the Care and treatment clinic/ART and other services. Identify and problem-solve obstacles.				
	Discuss with the couple the need to live a healthy lifestyle. Discuss things that they can do right away to keep healthy.				
	Discuss the importance of having safe drinking water to prevent diarrhoea. Inform the couple about where to get more information or obtain supplies.				
	Discuss the importance of using bed nets to prevent malaria (when applicable). Inform couple about where to get more information or obtain supplies.				
	Discuss the importance of good nutrition. Inform couple about where to get more information.				
Component 8 - B: Discuss Risk Reduction					
	Discuss the importance of being faithful and not having sex with outside partners.				
	Inform couple of the need to protect partners if they choose to have sex outside their relationship. Provide condom demonstration.				

Component 9 - B: Discuss about Children, Family Planning and PMTCT Options					
	Discuss the issue of HIV testing of children				
	Revisit the couple's intentions concerning having children. Discuss the couple's reproductive options				
	Prevent unintended pregnancies – family planning – dual contraception				
	Limit the number of children				
	When pregnant access antenatal and PMTCT services				
	Describe PMTCT programs and services and identify where the couple can access services.				
	Address the couple's questions and concerns regarding PMTCT services.				
	Provide needed referrals.				
	Family planning				
	ANC clinics (if woman is pregnant)				
	MCH clinic (if woman has young children and/or if he is breastfeeding)				
Component 10 - B: Discuss Disclosure and Getting Support					
	Explain the benefits for the couple to disclose their HIV status to others.				
	Explore the couple's feelings about sharing their results with a trusted friend, relative, or clergy.				
	Discuss disclosure basics.				
	Reinforce that the decision to disclose is mutual.				
	Explore the possibility of participating in a support group and additional counselling sessions.				
	Answer remaining questions and provide support.				

	Summarize.				

CHCT – Results Session: Discordant Result : 5 C

Component 5 C: Provide Discordant Results					
	Inform the couple that their results are available.				
	State that the couple has received results that are different. Pause briefly for the couple to absorb the implications of the results.				
	Convey support and empathy.				
	Ask the couple if they understand their results.				
	Review the explanation of how couples can have different results.				
Component 6 C: Discuss Coping and Mutual Support					
	Invite both partners to express their feelings and concerns.				
	Validate and normalize the couple's feelings and acknowledge the challenges of dealing with different results.				
	Ask the uninfected partner how he or she could best support his or her partner.				
	Recall the couple's strengths. Convey optimism that the couple will be able to cope and adjust to the situation.				
	Address the couple's immediate concerns				
Component 7 C: Discuss Positive Living and HIV Care and Treatment					
	Discuss positive living and the importance of getting care for the HIV-infected partner.				
	Discuss positive living.				
	Address the need for preventive health care.				
	Encourage immediate visit to the HIV clinic				

	Dispel myths about treatment eligibility				
	Encourage the infected partner to access appropriate care and treatment services.				
	Encourage the uninfected partner to serve as an advocate for the infected partner.				
	Provide needed referrals to the HIV clinic and other services. Identify and problem-solve obstacles.				
	Component 8 - C: Discuss Risk Reduction				
	Discuss the importance of being faithful and not having sex with outside partners.				
	Inform couple of the need to protect partners if they choose to have sex outside their relationship. Provide condom demonstration.				
	Component 9 - C: Discuss family planning and PMTCT options for discordant couples				
	Revisit the couple's intentions concerning having children.				
	Address the risk to the uninfected partner should the couple decide to have a child.				
	Discuss the couple's reproductive options.				
	Describe the country's PMTCT programs and services and identify where couples can access services.				
	Address issue of testing of young children if the woman is HIV-positive.				
	Provide needed referrals.				
	· Family planning				
	· ANC clinics (if woman is pregnant)				
	· MCH clinic (if woman has young children, is breastfeeding, or both)				

	Component 10 - C: Discuss Disclosure and Getting Support				
	Explain the benefits for the couple to disclose their HIV status to others.				
	Explore couple's feelings about sharing their results with a trusted friend, relative, or clergy.				
	Identify who could provide additional support.				
	Address confidentiality and disclosure concerns.				
	Discuss disclosure basics.				
	Reinforce that the decision to disclose is mutual.				
	Explore the possibility of participating in a support group and additional counselling sessions.				
	Answer remaining questions and provide support and summarize				

Module 5

PROVIDER-INITIATED HIV TESTING AND COUNSELING (PITC)

CHAPTER 1: PROVIDER-INITIATED HIV TESTING AND COUNSELING FOR ADULTS

Learning objectives:

By the end of this session the participants will be able to:

- Discuss the similarities and differences of VTC and PITC
- Perform initial provider-client encounter
- Provide HIV negative test results
- Provide HIV positive test results

CONTENTS

- Similarities and differences of VCT and PITC
- Initial Provider-Client encounter
- Providing HIV Negative result
- Providing HIV Positive result

Similarities between VCT and PITC, Both of them:

- Voluntary and Confidential
- Require the consent of the client/patient
- Test for the benefit of the client/patient
- Require the results be given to the client/patient
- Preferably done using a rapid test with same-day results

The differences between PITC and VCT include:

- Patients can receive PITC services only within a health facility.
- Patients come to the clinic for a wide variety of reasons; consequently, they may not expect to get tested for HIV.
- Providers in these clinical settings are trained as clinicians and are providing HIV testing in addition to medical services.

- The primary focus is on identifying HIV-infected patients and linking them to prevention, care, and treatment and support services.
- Pre-test information is limited to a brief discussion about the need for HIV testing. Providers recommend the test as standard practice for anyone coming to the clinic. However, HIV testing is still voluntary and patients may refuse the test.
- Providers spend little time with those who test negative. Instead, the primary focus is on those who test positive and their medical care, referral and prevention counselling.

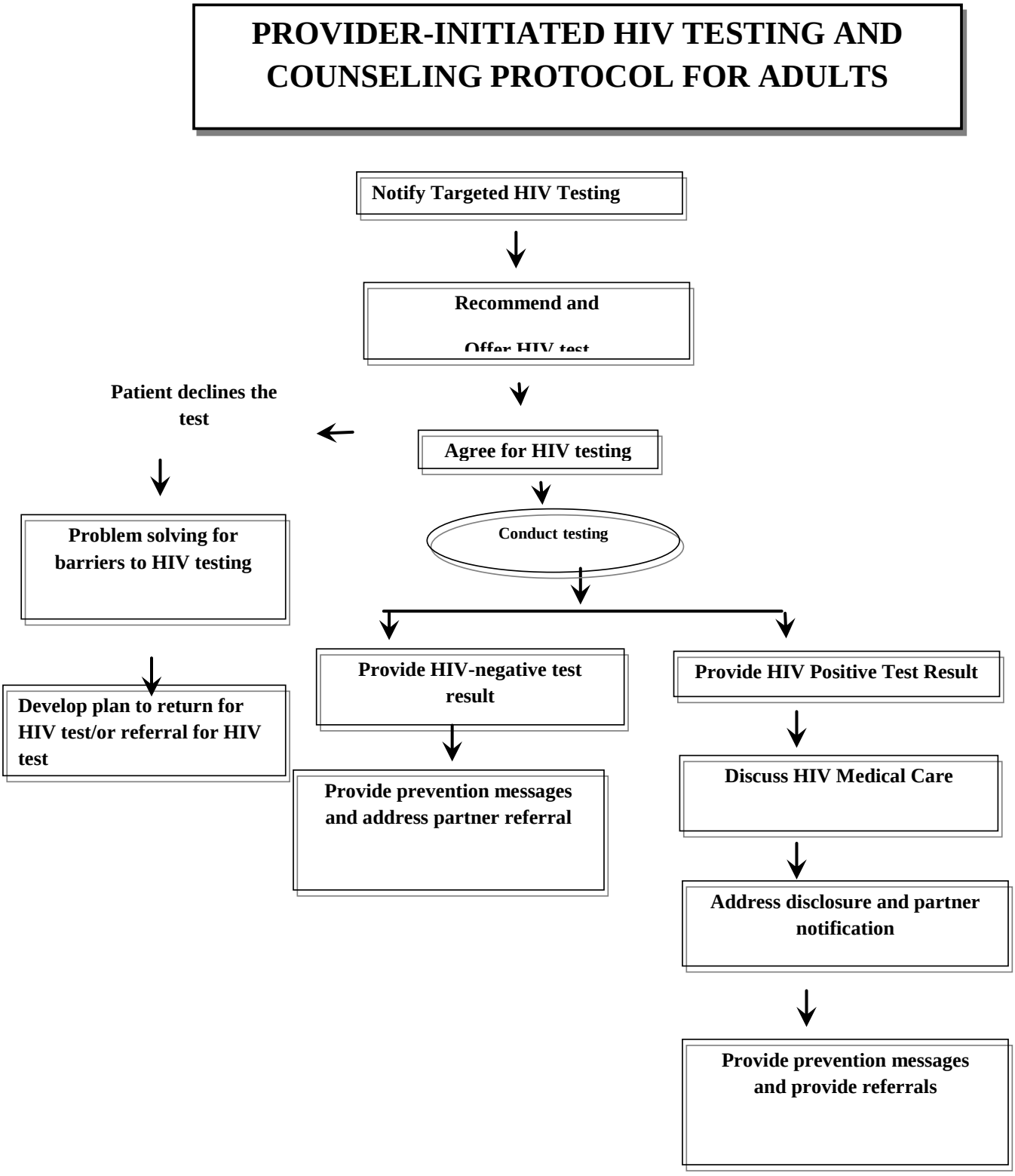


Fig. PITC Adult Protocol

INITIAL PROVIDER-CLIENT ENCOUNTER

The Provider's Initial Encounter with the Patient

All Eligible patients should undergo testing unless they refuse. They have the right to refuse. Testing is not mandatory.

The best time to talk to new patients about the HIV test is usually after the provider discusses the patient's current condition.

In the first part of the script, you will help patients understand:

- That people in the community have HIV
- That some people admitted to the hospital have HIV
- The importance of treatment for HIV-infected patients

Introduce the Topic of HIV

Once you have introduced the topic of HIV and explained the importance of knowing one's HIV status, you should tell the patient

- It is recommended that all eligible patients be tested for HIV.
- The patient will be tested today unless he or she refuses.
- The patient will receive the result of their HIV test today.

Provider offers and recommends the Test

Providers should not ask the patients directly if they want to be tested. Instead, they should use the recommended script, "For these reasons, we advise that all target patients/Clients be tested for HIV."HIV testing is among the services we provide in this facility and I advise you to be tested today " "Opt out" approaches.

"Opt out" approaches

Patients have a right to refuse the test, but your task is to help the patient understand that knowing his or her HIV status will help the provider provide better care.

If the Patient Refuses the Test

The first thing to do if the patient refuses the test is to explain that the care they receive will not be as good as it could be if you knew their complete medical condition, including their HIV status.
Also, if patients come to the clinic with an HIV-related disease or symptoms of HIV, explain to them how this increases their need for an HIV test. Ask patients if they have additional questions or concerns that you can address for them.
Providers will not be able to overcome all their patients' fears or objections in a short clinic visit. Acknowledge patients' fears or concerns.
However, you should focus on reminding patients of the benefits of knowing their HIV status, including:

- They can be treated for their possible HIV infection.
- Treatment for HIV will make the treatment for other illnesses more effective.

If the patients say they have had a recent negative HIV test, encourage them to repeat the test so the clinic will have a record of it.
If patients continue to refuse, repeat the reasons to be tested and give them the following option:

You can give patients a referral to another HIV testing site if they do not want to be tested in the clinic.

Patient Agrees to an HIV Test

The first thing you will do is explain to the patient what will happen:

- Depending on the process set up in individual hospitals or clinics, the test will be done by the provider during the patient's visit at point of care. Either the provider or the lab technician will take blood from a small prick of the patient's finger or from vein puncture of the arm. The patient's blood will then be tested using HIV rapid test, as per the National HIV testing Algorithm.
- If the first rapid test result is positive, a second and third test will be conducted to confirm that result.
- If the testing is performed in the lab, the result should be sent back to the provider..
- The patient waits in the waiting area while the test is performed. You may answer questions the patient may still have about the test, HIV treatment or other treatment the patient is receiving.

PROVIDING THE HIV TEST RESULT TO THE PATIENT: NEGATIVE RESULT

Inform Patient of the Negative HIV Test Result

Once you have finished testing the blood or the lab has given you the result of the patient's HIV test, you will give the result to the patient.

When giving the patient an HIV-negative result, there are two important issues you need to discuss: repeat testing and prevention.

First you will tell the patient that the test result is negative; this means that the test did not detect HIV in the patient's blood. At this point, you should pause for a moment to let the patient absorb what you have said.

It is very important that you inform your HIV-negative patients about sexual behavior that will prevent them from getting infected with HIV. The messages are about:

Prevention Messages for HIV-negative Patients, Includes

Partner testing: The patient should ask his or her partner to be tested for HIV. It is possible that the patient's sex partner is positive even though the patient is negative. If one partner in a couple is negative and the other is positive, we say the couple is discordant.

Being faithful: If the patient's partner does not have HIV, both partners can protect each other from getting HIV by being faithful and not having any other partners.

Abstaining from sex: The patient should not have sex until the partner has been repeat tested.

Using condoms: Patients who do have sex with HIV-infected partners or with partners whose status is unknown can protect themselves by using condoms properly every time they have sex. Condoms should be available in your clinic. There should also be brochures on how to use condoms and on all the ways to prevent HIV infection.

Finally, emphasize the importance of getting the patient's partner tested in the very near future. For clinics that provide partner testing, providers can encourage the patient to return with their partner for testing.

PROVIDING THE HIV TEST RESULT TO THE PATIENT: POSITIVE RESULT

Inform the Patient of the Positive HIV Test Result

It will be important when you give patients their HIV-positive test result, that you remember what we talked about earlier in this unit:

You must remember to focus on their understanding the situation.

You should acknowledge that these results may be difficult to hear, but express confidence in their ability to adjust and cope. You need to stress the importance of their getting care and treatment for HIV.

You should ask if there is someone they can talk to about what they have learned.

If your clinic has an on-site counsellor offers them the opportunity to talk with that person. If not, you will give them information about support from organizations in the community.

You will give the patient a referral to the HIV care clinic. If you are working in an in-patient ward at a health facility that has an HIV care clinic on-site, you will try to arrange for a HIV care clinic counsellor to come to the ward and meet with your patient for additional supportive counselling and to talk more specifically about treatment options.

You will advise the patient that if she (or a male patient's partner) is pregnant or planning to get pregnant that they should tell the health care provider at the HIV care clinic so that they can talk about how to protect the unborn child from HIV.

You will urge the patient to go to the HIV care clinic as soon as possible.

Confidentiality is particularly important at this time. Patients will be very concerned about others knowing about their HIV status, and they will need time to figure out who to disclose to and how to manage their situation.

You can help in two ways: Advice the patient to keep their referral form in a private place until they take it to the HIV care clinic. The result of the patient's test will be recorded in the medical record and clinic register or logbook.

Prevention Messages for HIV-positive Patients

Finally, it is very important to talk with the patient about preventing transmission of HIV to the patient's partner or partners, and preventing the patient from getting other STIs and/or re-infection with different strains of HIV.

It will be important that you make sure the patient understands that HIV can be spread through sex and that his or her partner may not have the same HIV status. The prevention messages for HIV-positive patients are similar to those for HIV-negative patients:

Partner and HIV exposed children/household members should be tested: Because the patient is infected with HIV, the patient's partner must be tested, as soon as possible, to determine if he or she is infected. The patient/client is counseled and assisted on disclosure and interviewed to elicit information about their partners, who can then be confidentially notified, referred and provided HTS. Partner notification services are voluntary, at the discretion of the index patient, and are provided confidentially, at no cost, in a patient-centered framework.

The patient may inform you that his/her partner has already been tested. Acknowledge this is a good thing, but go on to discuss the need to prevent transmission of sexually transmitted infections and HIV, regardless of the testing status of the partner.

If the partner tested positive, note that protection from other strains of HIV and sexually transmitted infections is important for both individuals.

If the partner tested negative, be sure to emphasize the importance of protecting the negative partner.

Abstaining from sex: Tell the patient that the best way to assure that his/her partner does not get HIV is not to have sex.

Using condoms: If the patient does have sex, he or she should be advised to use condoms properly every time.

Advise the patient that there are condoms in the clinic and that the VCT center also has condoms.

Finish by making sure the patient has his or her referral letter for the HIV clinic and condoms provisions as appropriate.

The news that they are HIV-positive will, of course, be difficult for patients, even if they suspect they are infected.

Some patients may want to talk about fears or concerns they have, such as disclosing their HIV status to their partner.

If someone brings up an issue of safety, do not press for disclosure or assisted partner testing. Refer a patient with difficult issues to the HIV care clinic and on-site counselor.

CHAPTER 2: PROVIDER-INITIATED HIV TESTING AND COUNSELING FOR INFANTS, CHILDREN AND ADOLESCENTS

Learning objectives: By the end of this session the participants will be able to:

- Describe the different approaches needed for testing infants, children and adolescents
- Use recommended scripts with target groups
- Describe the significance of HIV antibody-based test results in infants under 18 months of age
- Conduct Paediatric PITC using cue card
- Address disclosure issues related to the HIV status of children

CONTENTS

- Rationale for Testing Infants, Children and Adolescents
- PITC Protocol for Paediatric clients
- Testing of Adolescents
- Testing Infants and Children
- Disclosing Children their HIV Status

RATIONALE: DIFFERENT APPROACH, IF THE PATIENT IS AN INFANT, CHILD OR ADOLESCENT?

Why Different Approach for Children (Rationale*)*

If your patient is an infant, child or adolescent, you will need to change what you say and do in this situation. For example:

Diagnosis of HIV in young children less than 18 months of age presents unique challenges, as we have discussed in Unit One.

If young children test HIV-positive, it is very likely that their mothers are also infected and

Need to be tested.

Children and adolescents below the age of 15, unless they are "mature minors" between the age of 13–15, are not responsible for making decisions about medical treatment or procedures for themselves; their parents or guardians will be responsible for refusing the test for their children. Because issues related to HIV testing differ between young children and adults, this training discusses each of these age groups separately.

PROVIDER-INITIATED HIV TESTING AND COUNSELING PROTOCOL FOR PEDIATRIC CLIENTS

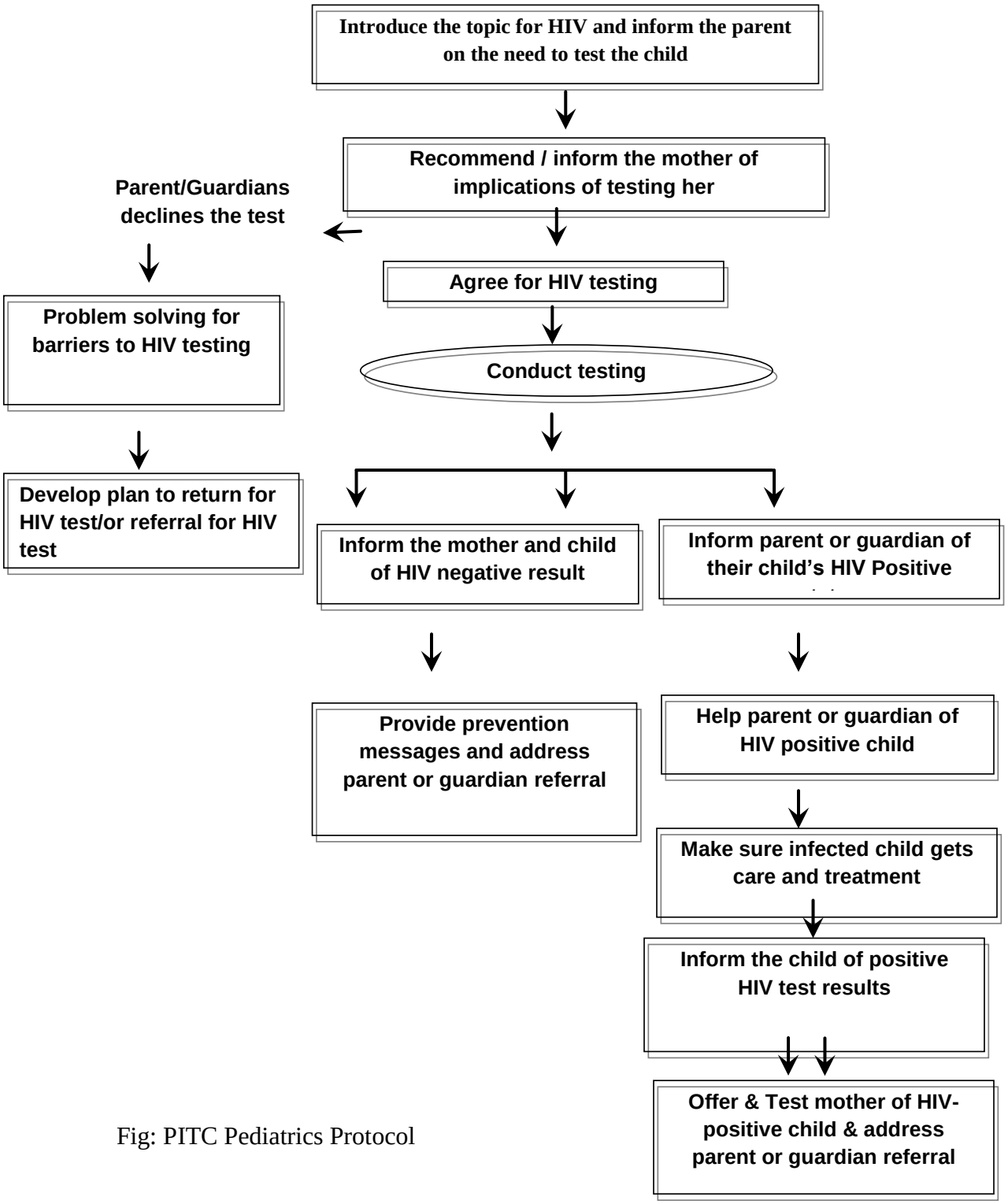


Fig: PITC Pediatrics Protocol

Testing of Adolescents

As children become adolescents, many of them may become sexually active. Once this happens, adolescents can acquire HIV the same ways as adults, which is primarily through sexual contact with an infected partner. For this reason, the script for adolescents is similar to the script used for adults.

However, you may need to speak with the adolescent's parents or guardians about HIV testing recommendations or guidelines because it may be the parents' or guardians' responsibility to make decisions regarding testing for the adolescent. Let's talk about this situation.

At What Age are Adolescents Legally Responsible for Their Own Health Care Decisions?

In Ethiopia, the legal age at which an adolescent may be considered an adult is 18. However, adolescents 15 years and older are allowed to make their own decisions regarding HIV testing.

Adolescents, aged 13–15, who are married, pregnant, commercial sex workers, street children, heads of households or sexually active are referred to as emancipated or mature minors.

For Adolescents 15 Years of Age or Older

Adolescents who meet these criteria also do not need parental permission for HIV testing and counseling, but can make this decision on their own. In this case, use the same script as you are using for adults.

The adolescent may not have had sex, just as some adults may not be currently sexually active. You do not necessarily need to ask adolescents or adult patients whether or not they are having sex. The script is designed to inform patients how HIV is transmitted and how they can prevent the spread of HIV, regardless of their current sexual activity.

Involving the Under-Age Adolescent

Adolescents younger than the age of 15 must have permission from their parents or caregivers to undergo HIV testing, unless they are considered independent from their parents/caregivers.

In our country, an adolescent between the ages of 13–15 can legally make decisions about his/her HIV testing if they are married, pregnant, commercial sex workers, street children, heads of households or sexually active. Again, in this case, use the same script as you are using for adults.

If the under-age adolescent does not meet these criteria, you will need to speak to his/her parent or caregiver about the recommendations regarding HIV testing, in addition to discussing this with the adolescent.

Involving the Under-Age Adolescent in Health Care Decisions

If the parent or guardian is not present, do not introduce PITC. If the adolescent patient requires parental consent for HIV testing, have the parent/guardian present when introducing PITC.

Although the parent has responsibility for deciding whether HIV testing can be done, the adolescent should be able to voice an opinion about his or her health care, and have the adults who are responsible for him or her take that opinion into account when making decisions.

In other words, ideally, the adolescent should participate in the decision making about HIV testing even though the final decision rests with the parent.

For the adolescent to be able to participate fully, he/she must be educated along with the parent about the need for HIV testing as part of their diagnostic work-up, the benefits and so on.

Participation of adolescents in this process may have benefits for their clinical care. Being active participants in their own care may support the adolescents' better decision making in the future.

In addition, open communication may build trust between the adolescent and the health care provider, which may lead to the adolescent patient's better adherence to future treatment.

For these reasons, it is better to involve both the parent and adolescent in the PITC process. The script advises that you speak primarily to the adolescent while acknowledging the role of the parent.

It is best if the adolescent and parent can sit next to each other so you can look at both of them while you are talking.

You may want to explain to the parent first that you will be talking to the adolescent so that you do not seem disrespectful.

Why Parents Refuse

Parents may refuse because they think their child is not at risk or is too young. Acknowledge this, but remind the parents that it is recommended to test all patients with their son or daughter's condition, even if they are at low risk for HIV.

You could say something like, "We want to be absolutely sure about the HIV status of all our patients because this is very important for their health, particularly because there are several

treatment options that are used to prevent other infections and treat HIV that were not available before."

Some parents may want to consult the other parent; acknowledge that this is not legally required. If the parent insists on getting permission, encourage the parent to bring the other parent in as soon as possible if your clinical judgment suggests that the adolescent patient needs a test immediately. If the adolescent patient's medical condition is not life-threatening, encourage the parent to bring the other parent along when the adolescent returns to the clinic.

The other important reason why parents refuse HIV testing for children is a fear that will indicate their HIV status as well.

Why Adolescents Refuse

Reasons why adolescents mat refuse testing include:

- Embarrassed
- Feeling guilty about sexual activity
- Fearful of needles
- Mistrust of the test
- Feeling unable to cope with the result
- Worried about stigma/discrimination from peers and others in the community

Providers can reassure adolescents who are refusing a test by:

- Reassuring adolescents about the confidentiality of the result
- Asking parents' permission to speak to the adolescent alone
- Reassuring adolescent that the pain is minimal
- Ensuring availability of treatment for the disease and for preventing other infections

In the event that the HIV test is positive, you may encounter parents who are quite upset, even crying. Some parents may be angry and disappointed in their adolescent. Adolescents are also likely to be upset and may feel ashamed.

Handling the Reactions of Parents and Adolescents

Providers can handle the reactions from parents and adolescents by:

- Reassuring adolescents and parents that this does not mean that their life is over. With treatment, HIV-positive persons can live long and lead productive lives.
- Reassuring the adolescents that while their parents may be visibly upset, their reaction is normal because they are worried about their children. Have the parents acknowledge that they will be supportive to the adolescent.
- Reassuring the parents that the HIV test does not indicate HOW a person got HIV only that they have the virus. Remind the parent that their support of their adolescent is critically important at this time.
- Reminding adolescents and parents that there are community resources that can help the family deal with the situation.
- Referring the adolescent and parent(s) to local support groups or youth friendly services that may be available in your community.

In rare cases, parents may abandon their adolescent or even throw him or her out of the home to live on the street; this happens especially when the parent is not around and the adolescent is accompanied by guardians.

It will be important to make sure that the adolescent knows that they can come to the clinic at any time to address concerns or questions.

TESTING OF INFANTS AND CHILDREN

Children can acquire HIV from: infected mothers during pregnancy, labor and delivery; breastfeeding; blood transfusions with HIV-infected blood; HIV-contaminated medical injections or harmful traditional practices; and, on occasion, through sexual abuse.

The most common way that children get HIV is from their mothers during pregnancy, labor and delivery, or through breastfeeding. Thus, the mothers of children who have HIV are very likely to have HIV as well.

For this reason, when a pediatric patient tests positive for HIV, you will also recommend and offer testing to his or her mother.

If the mother tests HIV-positive, then the child became infected through exposure to the virus at some point during pregnancy, labor and delivery, or through breastfeeding.

If the mother is HIV-negative, the child most likely contracted HIV from a blood transfusion, breastfeeding from another HIV-positive woman (wet nursing), medical injection, harmful traditional practices, or (rarely) sexual abuse.

Meaning of the HIV Test Results in Infants

As discussed, the most commonly used HIV tests are those that detect HIV antibodies, not the actual virus.

All HIV-infected mothers will pass their antibodies to their babies while they are in the womb. Thus, all babies born to HIV-infected mothers will have antibodies and will test positive using the antibody test for several months.

Remember that not all babies born to an HIV-infected mother will become infected; this is true even if the mothers do not receive ARV treatment during pregnancy, labor or delivery.

In the event that the infant is sick or appears ill, and the antibody test is positive, it will be important for the health care provider to conduct other tests to define the status of HIV in the infant (DNA PCR) as soon as possible.

Counselling Parents and Children about PITC

In giving the baby's result to the mother, you will need to be able to explain the meaning of a positive result to the mother. The scripts provided may help providers explain this as simply as possible.

Because parents make the decisions about health care for their children, you will be discussing the testing of the child with the parent/guardian.

You will also need to talk to the child who is being tested, but this must be done in a **developmentally appropriate manner**; this means that what we say and how we say it when talking to a three-year-old will be quite different from when we are talking to a 10-year-old.

What Can Children Understand?

As with adolescents, some older children may be able to understand what you are saying to their parents about HIV testing and the results of their tests.

The age at which children are likely to be able to understand most of the words you are saying is probably around four to five years of age. Although children this young may understand the words, they may not grasp the significance or meaning. However, younger children, while not understanding all your words, can be very good at reading your tone and feelings on a subject.

Children older than 4–5 years may understand more of the meaning of the words but lack the maturity to understand the significance of HIV testing and HIV test results.

Most adults will keep the HIV status of the child private to protect the child's confidentiality and to prevent discrimination.

Children may not understand the concepts of confidentiality or discrimination and may freely share their HIV-positive status, which can harm the family.

Regardless of the child's age, most children are keenly aware of the emotions and actions of the adults around them, particularly the parent. This is true even of very young children; children will sense the parent's emotional stress upon learning of his or her child's HIV infection.

All these issues need to be kept in mind when considering what information to share with children.

THE INITIAL PITC DISCUSSION

What Is the Process for Providing PITC to Paediatric Patients?

To facilitate the discussion with both the parent and the child, ideally you should first talk with the parent about the need for HIV testing **without the child being present.**

Children older than five years of age should be able to wait in a separate area of the clinic or the ward while the provider discusses PITC with the parent.

However, children five years of age and younger should not be left unattended. If the parent has come alone to the clinic and there is no responsible adult or older child to attend to the child, then the young children can remain with their parent during the PITC discussion, as they are not likely to understand or be interested in the discussion.

Young children will likely be reactive to the emotions of the adults in the room, particularly the parent. Parents may be upset when they are told their children need an HIV test.

TAKING THE BLOOD SAMPLE

If the parent agrees to an HIV test for his or her child, you may then bring the child into the exam room/area to discuss the need for drawing blood. Most children are afraid of pricks and needles, so you will need to reassure the child by telling him/her that his/her parent will be close by.

INFORMING THE PARENT OF THE CHILD'S RESULTS

Once the result is back, you will be giving the child's HIV test result to only the parent, again **without the child being present** (if the child is 6–12 years). If the child's result is HIV-negative, you may have the child return to the exam room/area and reassure him/her that the blood tests were "normal." The parent may never have a reason to tell the child that he/she was tested for HIV. There is no reason to encourage this disclosure.

If the child's test result is HIV-positive, you may need to give the parent some time to adjust before bringing the child back into the room. The parent may be upset when given the news that his/her child has been exposed to HIV or is HIV-positive. Thus, the provider may need to reassure the frightened child until the parent can gain emotional control.

It will be the parent's responsibility to decide when to tell the child about his/her result. Providers should not tell children less than 12 years of age their HIV diagnosis unless specifically requested by the family.

DISCLOSING CHILDREN THEIR HIV STATUS

Informing Children of Their HIV-positive Results

Because telling a child about his or her HIV status is likely to be very difficult for parents, assistance from trained counselors in the HIV clinic can be very helpful.

Since HIV is a life-long infection, at some point (age) the child will need to know his or her HIV-positive status. Although there is no exact "right" time to tell children, most parents and professionals feel that children need to know at least by 10–11 years or sooner if the child is very sick, requires a lot of medical care or ARVs, or is very curious about his or her condition.

If the child asks questions about their illness, the responses should always be truthful and age-appropriate.

How Should Children be informed of Their HIV Status?

In addition to using language and words that children of different ages will understand, we must also consider what information children need to know and the appropriate times and settings to share that information with the child.

It is important to note that telling a child about their HIV status is a process that does not need to be done immediately after testing, but can be done over time.

In general, an initial understanding between the health care provider and the parents about how and when to disclose a child's HIV status can be defined.

Settings where HIV testing occurs (out-patient departments, pediatric in-patient wards) may not be the best setting for disclosure. Usually, disclosure of a child's HIV status to the child will be done over time in the clinic where they receive their HIV care and treatment.

A good general rule is to respond truthfully to the questions a child may ask about their illness in an age-appropriate manner.

Children should be given information about issues that will affect their lives and should be able to voice their opinions. They need information and support to understand the things that are happening to them; this approach is important to minimize fear.

Children need to be told their diagnosis, but it is important to share information with them:

In an age-appropriate manner,

At the appropriate time

In a supportive environment or setting where they can be emotionally reassured

As part of a process that will begin in the clinic where they will receive HIV care and treatment

While parents have the responsibility to provide both information and support to their child, they may need the assistance from professionals in helping to know what to say and when to say it.

Providers working in busy clinics or wards may have limited time to provide counseling to parents. It is important to keep this in mind as we consider how best to provide PITC to our pediatric patients.

Within the context of PITC, the information that is shared with children during the initial encounter is best limited to informing them that they need a blood test because you are trying to find out why they are sick. If the child tests HIV-negative, they can simply be told that the blood test was “normal” or “okay.”

Parents can decide when and if they want to tell the child that they were tested for HIV and found to be negative.

If the child asks specifically about his/her HIV or other test results, answer them simply and truthfully.

What Information Should Children be given About Their HIV Status*?*

It is suggested that providers limit the information given to young children about testing because they can easily misunderstand what you are saying about HIV. Many children will not be HIV-infected, so providers do not want to cause unnecessary emotional distress.

The situation of a child who tests positive is more difficult. In a busy clinic, where the parent is first learning the child’s HIV diagnosis, is not the appropriate time or setting to properly inform a child about his/her HIV status.

The parent needs the time to adjust to this information before he or she is able to properly inform the child and provide the necessary support. The parent may also want time to discuss the diagnosis with the other parent or family members for support or guidance.

The child who tests HIV-positive can be informed that the blood test showed they have a germ in the body, and that the parent will be taking the child to another clinic where he/she will receive special care and treatment.

When the parents and the HIV-infected child are followed in the HIV clinic, the issue of when to inform the child of their HIV diagnosis can be discussed. Some parents may want to inform their children within the setting of the home. Others may need assistance from the providers or counselors.

Since you will provide acute medical care and HIV diagnoses, you will likely not be the health care provider responsible for in-depth family counseling. Parents will be able to access supportive counseling for themselves and their children at the HIV clinic.

Advantages of Telling Children Their HIV Diagnosis

Some advantages to telling children their HIV diagnosis include:

- To help children cope with their illness, addressing their fears, concerns and questions in an honest and supportive manner, and allowing them to participate in support groups or other coping activities.
- To facilitate involvement of children in their care (preventive therapy and ARVs), especially the issue of adherence.

Disadvantages of Telling Children Their HIV Diagnosis

- Some disadvantages to telling the children about their HIV diagnosis include:
- Children may not fully understand the situation and become emotionally distressed.
- Children may reveal their status without realizing the possible negative consequences.

Although most children will be told about their HIV diagnosis at the HIV care clinic, it might still be beneficial for us to think about children's feelings during this time.

Think about what might happen if children are not told about their HIV-positive status. Pretend you are a 10-year-old with HIV infection. You are frequently tired and often too sick to play with other children in your village/neighborhood. Your mother says you have to take pills every day that make you sick to your stomach. You have to go to the clinic every month, and the clinicians frequently stick you with needles for drawing blood. The needles hurt and you feel faint at the sight of blood. Although your mother says you are sick, you don't know why or what's wrong with you. And the clinicians are vague when you ask questions.

If children are not told about their HIV status, they may be more anxious and depressed about their illness. And if children are not told the truth, they may become angry and resentful. They may be relieved to find out the cause of their illness, even if it is HIV.

Children also need to know their HIV status as they may become sexually active adolescents. It is imperative that they know how to prevent spreading HIV to others.

Module Summary

- Target Clients will undergo testing unless they refuse.
- It is recommended that all target clients/clients be tested for HIV.
- Giving HIV-negative test result is simple, but it is necessary to raise issues of retesting and future prevention.
- Partner testing, being faithful, abstinence and using condoms are important preventions messages in HIV for both HIV negative and positive clients.
- Providers of PITC must be well aware of the legal age and criteria that allow adolescents to make their own heath care decisions
- Diagnosis of HIV infection in children less than 18 months of age may require further testing
- All HIV-infected children will need to be told about their HIV status before adolescence and readiness ongoing counseling is needed, as disclosure of HIV is a process. .
- Mothers of children less than 12 years of age who test positive should also be offered for an HIV test
- Providers need to be sensitive to the emotional needs of infants, children and adolescents, as well as adults, during the PITC process.

Annex: 1

ROLE PLAY SCENARIOS

Role Play Scenario 1
Aster is a 32 year old secretary working in one of the shoe factories in Addis. She has two children and her husband died two years ago. Three days before she was feeling chest pain, this became severe last night. Girma has diagnosed her and put her on a treatment. While Girma is offering her an HIV test she was very surprised and asked him several times why he wants her to have an HIV test. Girma continues explaining the need of having the test.

Role Play Scenario 2
It has been around 30 minutes since Bekele sat in a waiting area waiting to hear his HIV test result. He was very anxious and cannot imagine what his HIV test result could be. The provider called and gave him his HIV test result. Bekele became very happy when he received his HIV-negative result and want to hear what the provider will say next.

Role Play Scenario 3
Sr. Senait called one of her clients, Fatima, who was tested for HIV 30 minutes ago. Sr. Senait told Fatima that the result is available and was positive. This was shocking news for Fatima; she was silent for several minutes and started to deny the result. Sr. Senait helps Fatima to cope and continues the post-test counseling and provides her information on where she can get care and support.

Role Play Scenario 4
Abebech has a 14 month old baby that has had a fever and cough for four days. She took leave form her work place and took her child to a private clinic. The doctor in the clinic has managed all the acute problems and wants to test the baby for HIV.

But the mother was not well convinced with the need of testing her if the baby is HIV positive. The provider is explaining the need for testing the baby and it's relation to the HIV status of the mother.

Role Play Scenario 5
After getting appropriate pre-test information, Chaltu was very happy when she received HIV-negative result for her three year old son. The provider is expressing the need to test Chaltu for HIV in another testing center and partner referral. Chaltu thinks she will have difficulty with bringing her husband to a counseling and testing site. The provider is explaining to her the importance of partner referral along with other prevention messages.

Role Play Scenario 6
Meselech was very angry when Dr. Abebe politely informed her that it is good to test mothers of HIV-positive children. Meselech was very worried that she will be HIV-positive if she gets tested. The test for the baby was done and turned out to be positive. The provider continued explaining how to cope with the baby's HIV-positive result and the need of testing the mothers of HIV-positive children.

Annex: 2

CHECKLIST: INITIAL PROVIDER ENCOUNTER FOR ADULTS

KEY COUNSELOR TASKS	TASK ADDRESSED	COMMENTS AND RECOMMENDATIONS
Introduce the topic of HIV		
Inform patient/client of need to test for HIV		
Recommend and Offer HIV Test		
Recommend and offer HIV test		
Explain procedure to safe guard confidentiality		
Patient Declines or Defers Testing		
Problem solve barrier to testing		
Develop plan to return for HIV test or referral for HIV test		
Patient Agrees to be Tested		
Explain the process of getting the HIV test		
Prepare patient for HIV testing		

CHECKLIST: HIV-POSITIVE RESULT, ADULT

KEY COUNSELOR TASKS	TASK ADDRESSED	COMMENT AND RECOMMENDATION
INITIAL PROVIDER ENCOUNTER		
Introduce the topic of HIV		
Inform patient of need to test for HIV		
Recommend and Offer HIV Test		
Recommend and offer HIV test		
Explain procedure to safe guard confidentiality		

Patient Declines or Defers Testing		
Problem solve barrier to testing		
Develop plan to return for HIV test or referral for HIV test		
Patient Agrees to be Tested		
Explain the process of getting the HIV test		
Prepare patient for HIV testing		
POST-TEST COUNSELING SESSION: HIV-POSITIVE		
Inform HIV tests results is positive		
Provide support		
Discuss Medical Care and Provide HIV Clinical Care Recommendation		
Provide HIV clinical care recommendation		
Address assisted Disclosure or assisted Partner notification and referral		
Address assisted disclosure		
Discuss assisted partner notification		
Provide preventive messages and referrals		
Provide preventive message for HIV-positive patients		
Provide referral		

MODULE 6

HIV RAPID TESTING

CHAPTER 1: OVERVIEW OF HIV TESTING TECHNOLOGIES

Learning objectives: By the end of this session the participants will be able to:

- Discuss settings where HIV testing will be part of service delivery during an era of expanded services
- Understand the spectrum of testing technologies for HIV
- Explain the advantages and Drawbacks of HIV rapid tests
- Accurately recognize individual test result as reactive, non-reactive or invalid

Contents

- Expansion of HIV Rapid Testing
- Spectrum of HIV Diagnostic Tests
- Challenges with HIV Testing
- Advantages and Drawbacks of HIV Rapid Testing
- Three Formats of Rapid Tests
- Reading Individual Test Results

HIV Testing Occurs in a Variety of Settings

HIV testing occurs in a variety of settings outside of the laboratory. The testing will likely to occur testing and counselling centers (T&C), antenatal care (ANC) clinics, blood banks, surveillance programs, TB clinics, and sexually transmitted infections (STIs) clinics.

While all settings where testing occurs can triage persons to treatment and care, TB clinics and hospitals will be the primary venues for providing antiretroviral treatment to HIV-infected persons, and for providing care to HIV-affected persons. T&C, ANC, blood banks and surveillance are the primary venues for providing prevention programs.

Expansion of Testing Services

Testing will need to be integrated at all levels of testing services, and testing must be linked to referral services, e.g., ANC and VTC. To facilitate the expected high volume of testing, non-traditional test sites will need to be incorporated with the national testing strategy. These non-traditional sites must however be linked back to the laboratory referral network and a quality management system.

Use of HIV Testing Technologies in the Continuum of Care

A variety of tests are performed at different stages. HIV rapid tests play an important role in initially identifying those who are infected with the HIV virus.

Other tests, e.g., CD4 and viral load, play an important role to monitor the therapy whether the drugs are working or not.

Spectrum of HIV Tests

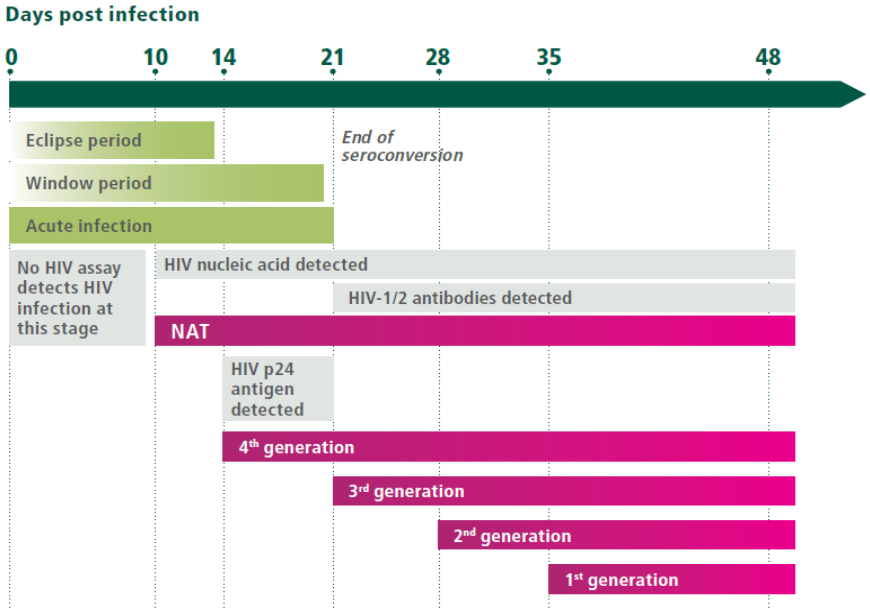
The list below reflects commonly performed test associated with HIV. Some tests are for diagnostic purposes, e.g., EIAs, rapid tests, Western blot and p24. Other tests are supplemental in monitoring disease progression, such as CD4 and viral load.

- HIV diagnosis (antibody/antigen testing)
  - Enzyme immunoassays (EIAs)
  - Rapid tests
  - Western blot (WB)
- Early diagnosis in infants
  - p24
  - DNA/RNA PCR
- Initiation and monitoring of ART
  - CD4
  - Viral load
  - Chemistry and hematology tests

Enzyme Immunoassays (EIAs)	EIA is a quantitative assay that measure HIV antibodies. Most EIAs can detect antibodies to HIV-1 and HIV-2. Here is how EIA works: • Sample is added to micro well plate that has been coated with HIV antigen(s). • After a series of reagent additions, incubations and washings, the plate is placed in reading device. • The reading device measures the optical density of color that develops if HIV antibody is present in the client's sample. Multiple factors can affect testing such as a skilled lab technician, large-volume testing and properly maintained equipment. A certain level of technical skill and functioning equipment is a must.
HIV Rapid Tests	HIV rapid tests are qualitative assays that detect HIV antibodies. Most of them can detect HIV-1 and HIV-2. These tests are as reliable as EIAs.

Detecting HIV-infection with various formats and generations

The picture below illustrates the types of assays that can be used at different points in the natural history of HIV infection.



Source: Rosenberg et al., 2015 *(1)*.

Challenges of HIV Testing

There are several challenges associated with HIV testing:

- The ability of some tests to detect early infections is sub-optimal.
- Specialized testing is required to diagnose HIV infection in infants younger than 18 months. However, people have limited access to this testing.
- Some tests may not be able to detect antibodies produced against specific HIV subtypes. For example, early generation of HIV test kits could not detect antibodies produced against strains of sub type O.
- Cross-reactivity with other health conditions or infections decreases performance of the assay, e.g., cytomegalovirus and Epstein-Barr virus.
- Some kits need equipment that requires specific maintenance.
- Personnel need a certain level of skill to accurately perform and interpret tests; this level of skills varies from minimal to high level.

Complexity of HIV Tests Varies

Four levels of complexity for HIV tests have been described in a number of WHO reports. The complexity of tests varies, from minimal (level 1) to complex (level 4), in terms of equipment and technical skill.

- Level 1: No additional equipment and little or no laboratory experience needed
- Level 2: Reagent preparation or a multi-step process is required; centrifugation or optimal equipment
- Level 3: Specific skills such as diluting are required
- Level 4: Equipment and trained laboratory technician are required

HIV rapid testing provides an excellent tool for expansion of services. The remaining portion of this unit will focus on HIV rapid tests.

HIV Rapid Tests: Advantages

HIV rapid tests have the following advantages:

- Increase access to prevention (VTC) and interventions (PMTCT)
- Support increased number of testing sites (PITC)
- Same-day diagnosis and counseling
- Robust and easy to use
- Test time under 30 minutes
- Most require no refrigeration
- None or one reagent (a substance used in a chemical reaction to detect or produce other substances)
- Minimal or no equipment required
- Minimum technical skill

One advantage of an HIV rapid test is its ability to use whole blood. While HIV rapid tests in general are considered to be low in complexity, all tests must be appropriately evaluated prior to use and personnel be properly trained. It is equally important that the test be validated for use in the environment where testing will occur.

Drawbacks of HIV rapid testings

- Monitoring testing practices
- Subjective interpretations
- Adherence manufacturer insert

Body Fluids Used for HIV Rapid Testing

HIV tests could be performed on a wide range of body fluids. Serum, plasma, whole blood and oral fluids are used the most. The samples used for HIV rapid testing will most likely be whole blood drawn from clients' fingertips.

Three Formats of HIV Rapid Tests

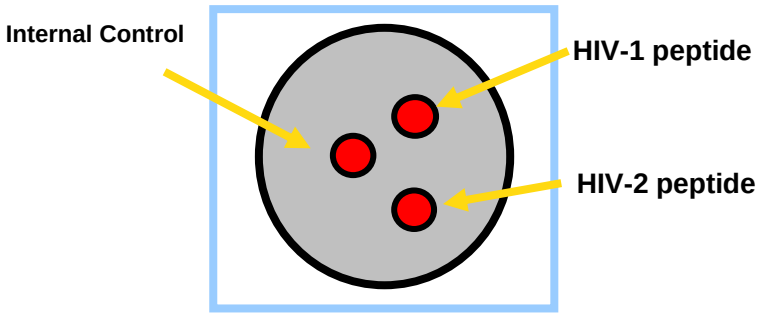
There are three main formats or types of rapid HIV tests:

- Immuno-concentration (flow-through device)
- Immuno-chromatography (lateral flow)
- Particle agglutination

Read on to find out more about each format.

How Immuno-concentration Works

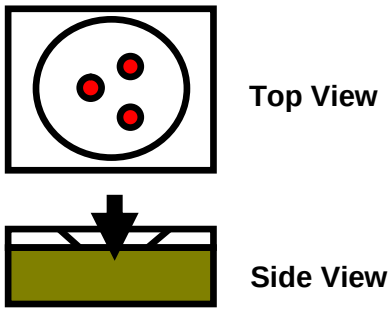
HIV antibody links to bound HIV peptide antigens forming the color spot.



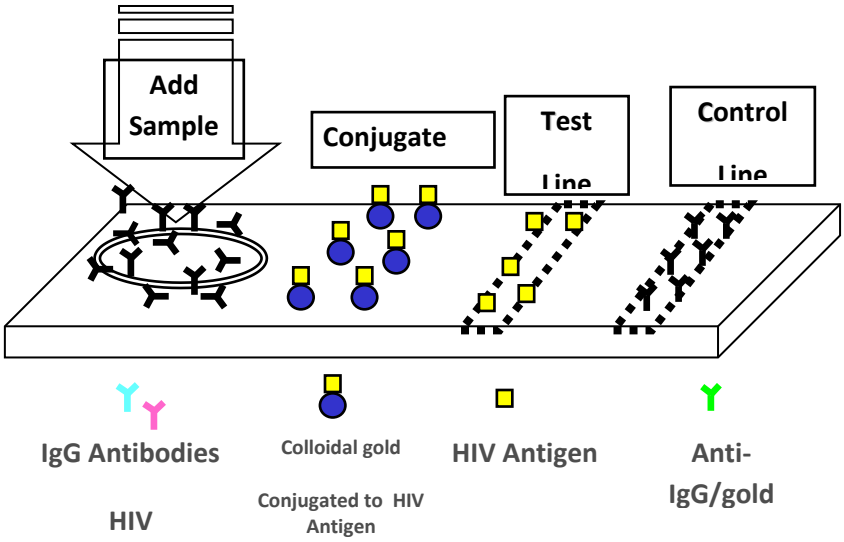
Flow-through (or immuno-concentration) devices are usually cartridges with HIV antigen attached to a membrane. The specimen and individual reagents are each added to the cartridge in a series of steps. Presence of HIV antibodies is indicated by the development of a colored spot or line.

Tests Based on Immuno-concentration

Some examples of flow-through devices are the Multi-Spot and Genie II.



How Immuno-chromatography Works



Specimen is applied to a pad (filter) where it mixes with gold or selenium colloid-antigen conjugate. This mix migrates through the nitrocellulose strip to immobilized recombinant antigens and synthetic peptides at the patient window. If HIV antibodies are present then a red line will form in the test area of the strip.

Tests Based on Immuno-chromatography

Some examples of lateral flow devices include:

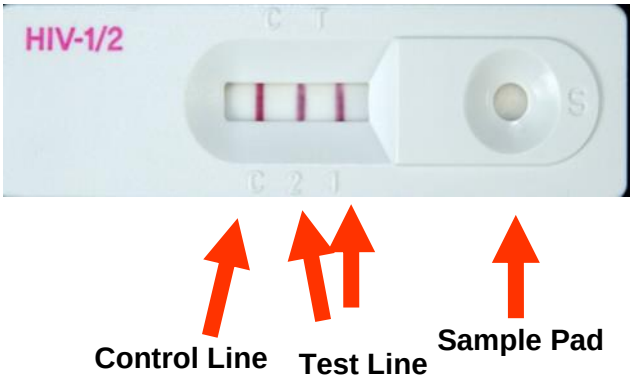
- SD Bioline ½ 3.0
- Stat- pak
- Abon HIV 1.2.0
- Vikia HIV 1/2

Capillary flow (lateral flow) devices resemble dipsticks. All of the necessary reagents are usually incorporated with the test strip embedded in the device. Specimen (and sometimes a buffer or a reagent) added to the strip flows across the reagents, and a coloured line develops in the presence of antibodies. Most lateral flow devices also have an internal control that detects human IgG. This internal control indicates that specimen was added to the test strip. If no human IgG is detected, an internal control line does not develop indicating an invalid test.

Reading Results:

HIV RTK:

Reactive

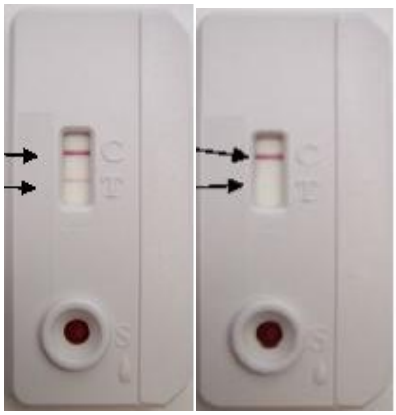


The reactive result shows two lines: one for the control band and the other for the test. A band in the test area means a reactive result. A non-reactive reaction will show a control band only. The control band (line) must always be present for the test results to be valid.

If the result is non-reactive, you will only see one visible dot in the control region

If the result is reactive, you will see either one or two visible dots. One dot for HIV-1, and the other for HIV-2.

At the control dot, human IgG links to membrane-bound anti-human IgG.



Reactive **Non-reactive**

Besides reactive and non-reactive, there is a third possible result—the control line is not present. When the control line fails to show, it indicates that the test has failed. The result is therefore called “invalid.”

There Are Only Three Possible Outcomes for Single HIV Antibody Tests

In summary, the three possible outcomes for a single HIV antibody test are:

- Reactive or "Positive": when both test band and control band are present.
- Non-reactive or "Negative": when only the control band is present.
- Invalid: when no control band is present.

If a test yields an invalid result, the test has failed. The test MUST be repeated using a new test device.

Exercises

Interpreting Individual HIV Rapid Test Results

At the end of this unit, you will find an exercise handout. Study the examples and write your interpretation of the test results in the space provided.

EXERCISE #1: INTERPRETING INDIVIDUAL HIV RAPID TESTS

Instructions: Interpret the test results in the following examples. Write your interpretation of the test result on the line provided below each example.

CHAPTER 2: HIV TESTING STRATEGIES AND ALGORITHMS

Learning objectives: By the end of this session the participants will be able to:

- Understand national testing algorithm
- Explain how sensitivity, specificity and positive/negative predictive value relate to development of an HIV rapid testing algorithm
- Explain the approved HIV rapid testing algorithm in our country
- Determine HIV status following a particular algorithm

Content

- Testing Strategies and Algorithms
- Developing National Testing Algorithm
- Measuring Performance of HIV Rapid Tests
- Interpreting HIV Status

Strategies and Algorithms

Testing strategies are defined as the testing approach used to meet a specific need, such as for blood safety, surveillance and diagnosis. For a given strategy, multiple algorithms may be used depending on the needs of testing settings.

Algorithms are defined as the combination and sequence of specific tests used in a given strategy. The number of algorithms used should be limited.

HIV Testing Strategies

Parallel and serial testing can be part of any testing strategy. Parallel testing means that samples are tested simultaneously by different tests. Serial testing means that samples are tested by a first test; and the results of the first test determine whether additional testing is required.

Before any test is adopted in-country for use, a series of key steps must be taken. These steps include:

- Identifying appropriate tests
- Developing an algorithm
- Building consensus
- Developing policy
- Bringing into national scale
- Reviewing testing algorithms annually

Testing Algorithms Should be Developed at National Level

Because multiple tests are marketed and available in-country, each country must identify the appropriate tests for use within given environment. A standardized approach to developing an algorithm must be taken. This involved building consensus and developing a policy before a test is brought to national scale.

After testing algorithms are adopted and implemented nationally, they must be reviewed annually to determine if they are performing as expected, and to determine if any changes need to be made to the algorithms.

Advantages of National Testing Strategies and Algorithms

Nationally adopted testing strategies and algorithms facilitates:

- Country-level standardization of tests used in-country—supporting a limited number of tests is more feasible and practical than many different tests.
- Procurement and supply management—using standardized tests allows for bulk procurement that facilitates controlling costs.
- Training—implementation of a national training program is eased when test sites follow the same testing algorithm. This facilitates pre-planning of workshops, as well as assuring that staff who move from one test site to another will not require total re-training.
- Quality Assurance—national oversight of quality of testing operations is easier when test sites use the same tests and have similar operations.

Evaluating Test Performance: Basic Terms

Sensitivity (Se) and ***Specificity*** (Sp) relate to the performance of the test capacity. Sensitivity of a test is its capacity to correctly identify people who are infected with HIV.

Testing Algorithms

Testing algorithms describe the sequence of tests to be performed. An HIV-positive status should be based upon the outcome of two or more tests.

National HIV Testing Algorithm

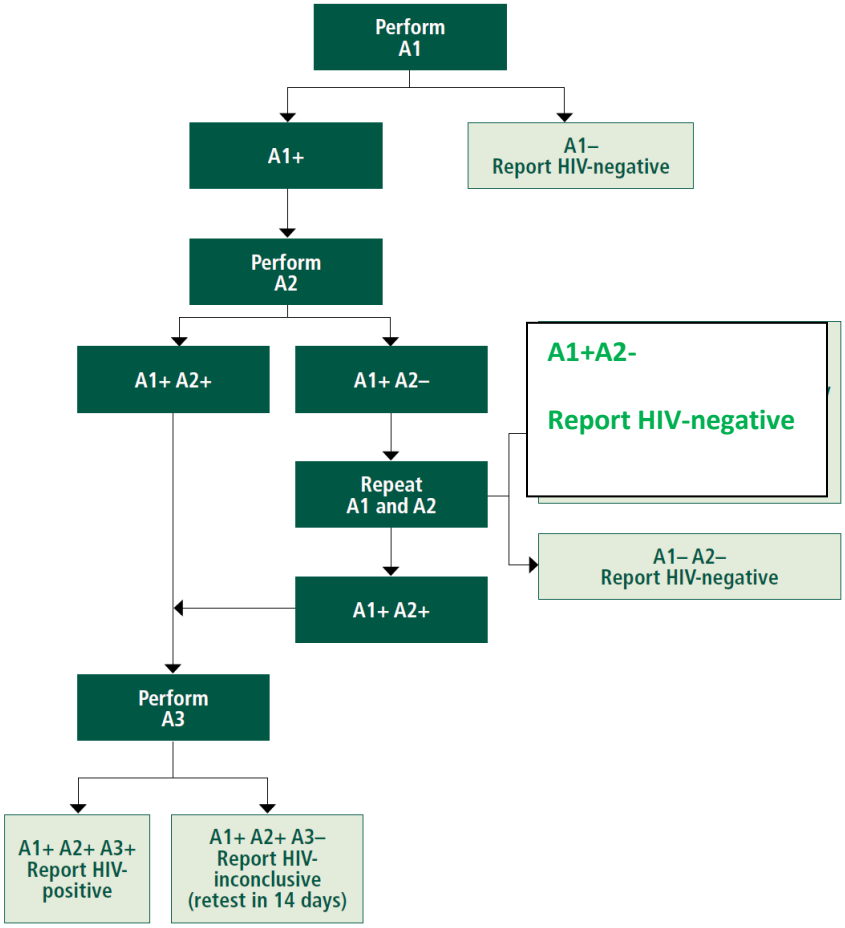
The ideal algorithm used is one in which tests are highly sensitive and highly specific. Both tests should not share the same false negatives and false positives. Always follow the sequence of the tests in the algorithm.

Serial Testing Algorithm

Ethiopia is currently using serial algorithm (three test algorithm instead of tie-breaker). In a serial testing algorithm, the samples are tested by a first test. The results of the first test determine whether additional testing is required.

- When the first test is non-reactive, then the final HIV result is negative. When the first test (T1) is reactive, the result will be tested by a second test (T2); and if the result of the second test is reactive, then the third test (T3) will be done and if the result is again reactive, the final HIV status will be positive. This test will be repeated at ART clinic for confirmation.
- When the first test is reactive, the result will be tested by a second test; and if the result of the second test is non-reactive, then repeat both test one (T1) and test two (T2). After repeating the tests if T1 is reactive and T2 is non-reactive, report HIV negative. After repeating the tests if T1 is non-reactive and T2 is non-reactive, then report HIV negative. After repeating the tests if both T1 and T2 are reactive, then conduct test three (T3). If T3 is reactive, report HIV positive. If T3 is non-reactive, report HIV inconclusive and retest in 14 days.

National HIV Testing Strategy (three test algorithm instead of tie-breaker test)



CHAPTER 3: SAFETY AT THE HIV RAPID TESTING SITE

Learning objectives: By the end of this session the participants will be able to:

- Adhere to personal health and safety practices
- Maintain a clean and organized workspace
- Disinfect and dispose of infectious materials
- Take appropriate actions following accidental exposure to potentially infectious specimen
- Follow written safety procedures and keep proper safety records

CONTENTS General safety practices on:

- Work habits (personal, work space, material)
- Proper disposal of sharps and waste
- Disinfection of work areas
- Appropriate measures for accidental exposure to potentially infectious specimen
- Safety documentation

Why Is Safety Important?

Performing HIV tests poses a potential health hazard to the tester. Coming in contact with human blood or blood products is potentially hazardous. Safety involves taking precautions to protect you, other staff and clients, and the community against infection.

What Else Needs Protection?

Besides the tester and client, we need to protect other people from infection:

- Never leave blood spills that could infect others.
- Never leave used lancets lying around for anyone else to pick up—they could prick themselves with HIV contaminated lancets.
- Always seal contaminated waste—you don't want to risk infecting the person who removes contaminated waste from the rapid testing site.

In addition, it is important to protect the integrity of test products. Shield unused tests from any contamination. If a new or unused kit is contaminated by a drop of blood from a previous client, the test may not yield accurate result when used on the next client.

It is also important to protect the environment from hazardous material. Avoid transferring contaminated materials into areas outside of the testing area.

Universal or Standard Precautions

Every specimen should be treated as though it is infectious. Why? Because harmful agents/organisms may be present in a client's blood. If a person comes into direct contact with the blood, that person could be infected. We must follow safety practices in every step of the testing process.

Apply Safety Practices Throughout the Testing Process

During testing, follow the safety rules when performing finger-prick and actual testing of the client's blood. After testing, remember to clean up working area and properly dispose of contaminated waste.

Develop Personal Safe Work Habits

It is important that you:

- **Wash hands between testing each client**—to wash away any germs that might be present on the tester's hands; this will ensure that no infections are passed from the tester or previous client onto the next, new client.
- **Wear fresh gloves for each new client**—to protect the client and tester from cross-infection (that is, the transfer of infection from one person to another).
- **Wear lab coat or apron** —to protect the tester from reagent spills and client's blood.
- **Get rid of used sharp objects** such as needles or lancets—Sharp objects can cut human skin. Any germs or pathogens present on the lancet can be passed from the lancet into that person's blood through the cut.
- **Never eat, drink or smoke in the test area**—Harmful germs or pathogens can be an entry point to the mouth from touching contaminated objects followed by contact with your mouth.
- **Keep food away from the testing area or a refrigerator that *contains blood samples***—Infectious agents/pathogens can be carried in food and transmitted to people.
- **Never go to the restroom wearing gowns/aprons.**
- **Remember to never let your mouth touch anything from work, such as pens, pencils, etc.**

Maintain Clean and Orderly

It is important to:

- **Keeping work areas uncluttered** – So there is less chance for accidents.
- **Disinfecting daily** – Just because a work area was disinfected yesterday, it does

Work Space

not mean it is still free of germs today.

- **Keeping supplies locked** – To prevent unauthorized persons having access to potentially dangerous objects such as lancets.
- **Collocate all necessary supplies** in orderly manner in working station
- **Keep emergency eye wash units** in working order and within expiry date
- **Allocate specific site** and chair/table for testing
- **Always perform testing at designated work station**

The eye wash unit is used to clean one's eyes when they are accidentally splashed with any type of specimen). If an eye wash unit is not available, please consult your local infection control personnel for alternate procedures to follow in the event of an accidental splash.

- The left container is a plastic bag for contaminated waste. It should not be used for sharp objects as they can pierce the bag and injure someone.

- The red plastic container on the right is suitable for sharp objects as the plastic is thick enough so that sharp objects cannot puncture the container. It also has a lid.

Answers:

What is wrong with the Picture on the left?

- It is an open container with a mixture of blood, sharps and other contaminated waste.
- It has no lid.

- It has no label to warn people of biohazardous waste.
- It is placed on the floor and prone to spill.

What is right with the Picture on the right?

- The container is made of thick plastic. This is appropriate for disposing of sharps.
- The bottle has a lid and sealed.

Remember: waste should be segregated based on the nature of the wastes in to infectious, non-infectious and sharp.

Never Place Needles or Sharps in Office Waste Containers

Plastic bags must be securely tied once filled. This is appropriate for disposing of contaminated waste such as used gauze. This type of container is NOT appropriate for disposal of sharps.

Contaminated waste should be kept separate from office waste. It is the tester's responsibility not to put any other persons at risk of infection.

Below, the image of the right illustrates improper disposal of objects. And on the left, sharps are mixed with non-sharp items and the opening is exposed, posing a potential hazard.

Sharps Containers Must be…

Sharps containers must be:

- Placed near workspace
- Closed when not in use
- Sealed when ¾ full

Policy for Handling Sharps

Important rules about handling sharps:

- User responsible for disposal of sharps
- Must dispose of sharps after each test
- Must place sharps in sharps boxes
- Do not drop sharps on the floor or in the office waste bin
- Place sharps container near your workspace
- Seal and remove when box is ¾ full
- Incinerate all waste

Burial of Waste

For burial waste disposal:

- Access to the disposal site should be restricted
- Burial site must be lined with material of low permeability
- Selected site should be 50 meters away from any water source

Incineration of Waste

Incineration is the burning of contaminated waste to destroy and kill micro-organisms. Contaminated waste should be burned to completion (that is, beyond re-use). It protects the environment and must be supervised. Care should be taken in transporting waste from one site to another for incineration.

Disinfect Work Areas with Bleach

To keep a clean and orderly work area, disinfect your work surface on a daily basis. It is part of the general safe practice that you need to follow. Remember, disinfection:

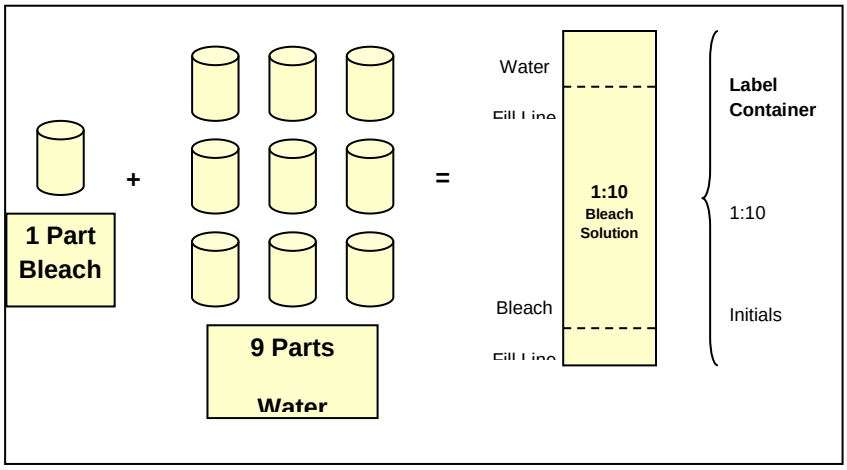
- Kills germs and pathogens
- Keeps work surface clean
- Prevents cross-contamination
- Reduces risks of infection

Different Cleaning Jobs Require Different Bleach Solutions

The WHO Laboratory Bio safety Manual recommends that:

- For spills, you should use a 10% bleach solution (1 part bleach + 9 parts water). The larger the spill, the longer the contact with the 10% bleach solution.
- For general disinfection purposes such as wiping down all surfaces at the end of the day, use a 1% solution (1 part bleach + 99 parts water).

You should have 10% bleach readily available at your test site. Make bleach solutions at the beginning of each week. Disinfect work surfaces, at a minimum, at the end of each day.



In Case of A Spill or Splash

Follow these steps in case of a spill or splash:

- Wear clean disposable gloves.
- Immediately and thoroughly wash any skin splashed with

	blood. • Large spills: Cover with paper towels and soak with 10% household bleach and allow to stand for at least five minutes. • Small spills: Wipe with paper towel soaked in 10% bleach. • Discard contaminated towels in infectious waste containers. You should never leave any spill unattended.
In Case of an Accident	There are three types of accidents that may happen: • Potential Injury, i.e., needle-pricks, falls • Environmental, i.e., splashes or spills • Equipment damage In case of an accident, you should report to your supervisor immediately. Assess the situation and take action accordingly. Record the accident using appropriate forms, and continue to monitor the situation.
Consult In-Country Safety Manuals for Policy and Guidelines	It is important to follow Standard Operating Procedures (SOP). If an SOP is available, get a copy and review the sections related to the safety procedures in a test site. Does it cover the following safety procedures? • Housekeeping • Personal protection • Personnel responsibilities • Decontamination and waste disposal • Emergency procedures – In-lab first aid – Accidental injury – Post-exposure prophylaxis (PEP) – Contacts

CHAPTER 4: PREPARATION FOR TESTING SUPPLIES, KITS AND WORKING SPACE

Learning objectives: By the end of this session the participants will be able to:

- List and identify all the supplies required for HIV rapid testing
- List and identify all the components of test kits for HIV rapid testing
- Identify appropriate working space for HIV rapid testing

CONTENTS

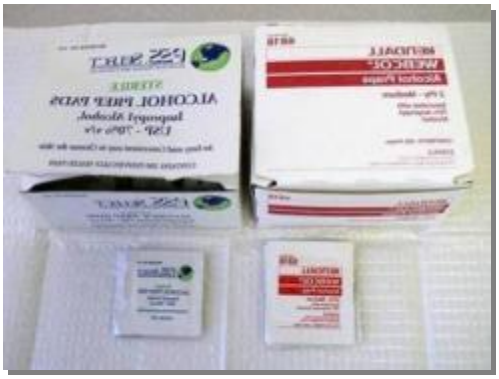
- Supplies for HIV Rapid Testing
- Components of Test Kits
- Organizing Working Area

GLOVES

Gloves come in latex or polypropylene—consider latex allergies when selecting the type of glove to use. Gloves are used for safety reasons—to protect both you and the client or client. It is important that the proper size gloves are used. Wearing gloves that are too large may pose a safety hazard and make it cumbersome to work. Keep in mind that long nails may puncture gloves, making them ineffective.

Gloves must be changed between clients, and disposed of in a container labelled as biohazardous waste. Never use gloves that have been previously used or are torn.

Alcohol Swabs



Alcohol is used to cleanse the client's finger before performing a finger-prick. Alternatively, use a bottle of rubbing alcohol and cotton wool.

Cotton Gauze or Cotton Balls

Cotton balls are used to: wipe away the first drop of blood and to stop bleeding after specimen is collected. They are for single-use only. Contaminated cotton gauze or cotton balls should be disposed of with other hazardous waste.

Sterile Lancets

There are a variety of lancets available for use. Some are easier to use than others. One difference in the types of lancets is the depth of the puncture made by the retractable blade.

Timer

Shown above are two types of timers that can be used for waiting the specified time to elapse before test results are read. You may also use a watch or clock.

Standard Operating Procedures and Forms

Each site will also need to follow standard operating procedures (SOPs) and use standard forms for recording test results. Every responsible personnel in a facility should check the availability and utilization of SOPs.

Labeling and Writing Pens

A permanent marker as seen on the left is best used for labeling test devices. Ball point pens (seen on the right) are used to fill in forms. Never use pencils, especially for recording client results, as results can be erased and changed.

Safety materials

- Infectious and non-infectious waste container,
- Biohazard bag,
- Sharp container,
- Household bleach

Check Test Kits

Examine the test kits that are approved in your country. Pay attention to the components of each test kit. In addition, notice the following two components:

- Desiccant packet—this is not used when performing the test. It only serves to keep the packet contents dry before use. It should be discarded when the test kit packet is opened.
- Buffer solution—Required by some kits

Organize Your Work Area

Having an organized workspace is key to produce quality results. It is important to keep working area neat, clean and organized.

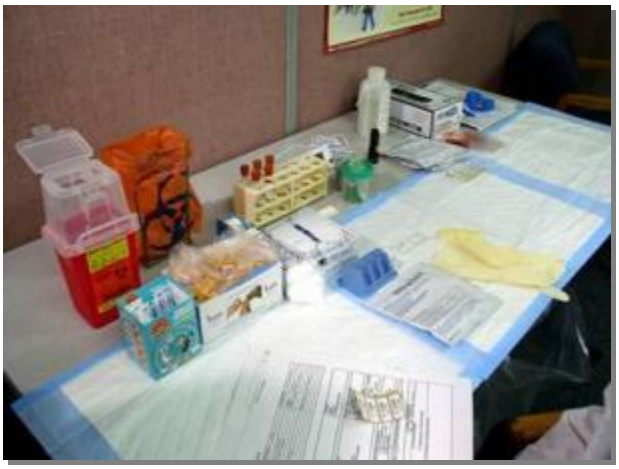
Each site or set-up where HIV rapid testing is performed must have an appropriate physical space for testing. Appropriateness of the physical space includes that for the storage of test kits and QC samples and other supplies used for testing. Facility appropriateness should include:

- ❖ Adequate and labelled bench surface to perform testing
- ❖ Test kits and consumables storage cabinet
- ❖ Adequate lighting for interpreting results
- ❖ Environmental control: adequate temperature controlled storage space

and room

- Hand washing facility
- Proper waste disposal facility (infectious and non-infectious), chemical and paper waste and sharps.

Supplies and Materials Checklist



Refer to the checklist at the end of this unit for a list of materials and supplies required for HIV rapid testing in **annex A.**

CHAPTER 5: BLOOD COLLECTION - FINGER PRICK

Learning objectives: By the end of this session the participants will be able to:

- Explain the preparation tasks required for rapid tests
- Put a client at ease while collecting blood
- Collect blood from a finger prick accurately and confidently

CONTENTS

- Preparation for Testing
- Introducing Your Client
- Performing a Finger Prick
- Demonstration and hands-on practice.

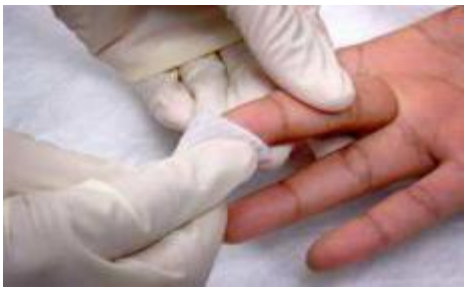
Introduce the client and reassure for blood collection

Introduce the client that you are going to collect a blood sample from his/ her ring finger (preferably) and reassure that the volume of the sample is small and the procedure is not painful.

Initial Steps of Finger Prick Procedure

Position hand palm-side up. Choose whichever finger is least calloused.

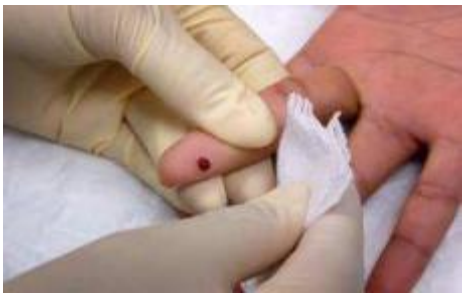
Apply intermittent pressure to the finger to help the blood to flow.



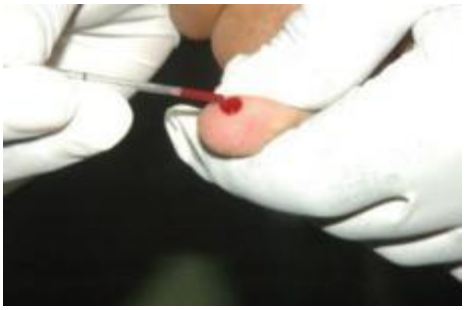
Clean the fingertip with alcohol. Allow the area to dry. Never touch cleaned area of the finger.

Hold the finger and firmly place a new sterile lancet off-center on the fingertip.

Firmly press the lancet to puncture the fingertip.



Wipe away the first drop of blood with a sterile gauze pad or cotton ball. Put intermittent pressure on the base of the punctured finger several times.



Blood may flow best if the finger is held lower than the elbow. Touch the tip of the EDTA Capillary Tube to the drop of blood.

Avoid air bubbles, fill the tube with blood between the two marked lines. After you've collected all the blood that's needed for the test, give the client a gauze pad or cotton ball to place on his/her finger until the bleeding stops. And finally, properly dispose of the gauze before the client leaves the testing area.

The above finger prick procedure explains the important steps for taking blood samples from a client's fingertip.

Demonstrations and Questions

You are expected to be able to answer these questions after you have demonstrated:

- How do you …
  - Position the hand?
  - Decide which finger to use?

  - Clean the fingertip?
  - Use a lancet?
  - Ensure blood flow from your client's fingertip?
- Do you …
  - Use a previously used lancet on a client?
  - Collect the first drop of blood?

Space is provided below for you to take notes during or after the demonstration.

How do you position the hand?

_____

How do you decide which finger to use?

_____

How do you clean the fingertip?

_____

How do you use a lancet?

_____

How do you ensure blood flow from your client's fingertip?

_____

Do you use a previously used lancet on a client?

_____

Do you collect the first drop of blood?

_____

CHAPTER 6: PERFORMING HIV RAPID TESTS

Learning objectives: By the end of this session the participants will be able to:

- Perform three types of HIV rapid tests according to standard operating procedure (SOP)
- Perform multiple tests simultaneously
- Accurately interpret individual test results
- Accurately determine HIV status

Contents

- Types rapid HIV testing kits in Ethiopia
- Interpretation of test results
- Demonstration and
- Hands-on practice on HIV rapid tests.

Performing HIV rapid tests

Each procedure explains the important steps you need to take for performing the test. You are expected to be able to answer these questions after you have demonstrated:

- What preparation is required for the test kit before testing?
- What are the components in the test kit?
- What information needs to be recorded, and where?
- How do you collect samples? What device do you use?
- How long do you set the timer?
- How many results are possible? How do you read them?

Space is provided in the unit for you to take notes during demonstration.

Job Aid

Refer to the SOPs and colour job aids for procedures of the tests used in your country. These job aids are laminated so you may post them in your test site.

Hands-on practice should be rigorously done……

Test 1

What preparation is required for the test kit before testing?

_____

What are the components in the test kit?

_____

What information needs to be recorded, and where?

_____

How do you collect samples? What device do you use?

_____

How long do you set the timer?

_____

How many results are possible? How do you read them?

_____

Test 2

What preparation is required for the test kit before testing?

_____

What are the components in the test kit?

_____

What information needs to be recorded, and where?

_____

How do you collect samples? What device do you use?

_____

How long do you set the timer?

Test 3

How many results are possible? How do you read them?

What preparation is required for the test kit before testing?

What are the components in the test kit?

What information needs to be recorded, and where?

How do you collect samples? What device do you use?

How long do you set the timer?

How many results are possible? How do you read them?

CHAPTER 7: ASSURING THE QUALITY OF HIV RAPID TESTING

Learning objectives: By the end of this session the participants will be able to:

- Explain the systems approach to test quality and its benefits
- Recognize key factors that may compromise the quality of HIV rapid testing
- Describe your responsibilities in preventing and detecting errors before, during, and after testing
- Differentiate between internal and external controls
- Use external quality controls at designated frequencies
- Analyze common problems associated with invalid test results

Contents

- The Approach We Take to Achieve Quality
- Quality Assurance Procedures at the HIV Rapid Testing Site
- How You Can Contribute to Quality Before, During and After Testing
- What Is Quality Control (QC)?
- Benefits of QC in Rapid Testing
- Internal Versus External Quality Control
- Troubleshooting Invalid Results
- Quality Control Records

What is "Quality"?

Quality is the ability of a product or service to satisfy the needs of a specific customer. You may achieve it by conforming to established requirements and standards.

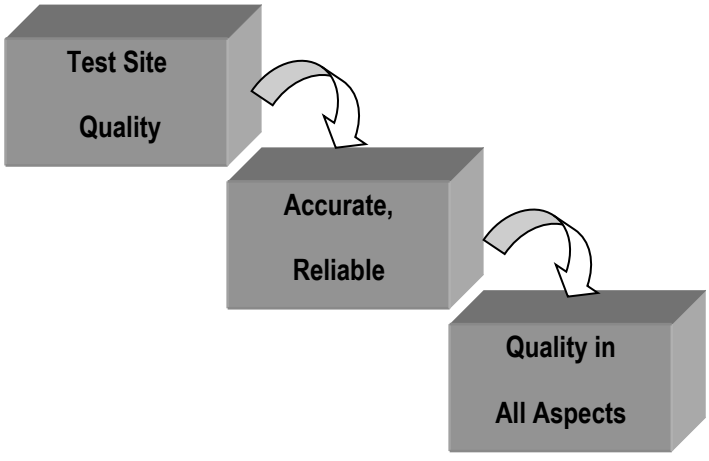
What is Quality about?

Quality is about:

- Knowing what you want to do and how you want to do it

- Learning from what you do
- Using what you learn to develop your organization and its services
- Seeking to achieve continuous improvement
- Satisfying your customer

Why Quality?



Quality at a testing site will result in accurate and reliable test results, which

are essential to all aspects of client health, including prevention, care and treatment.

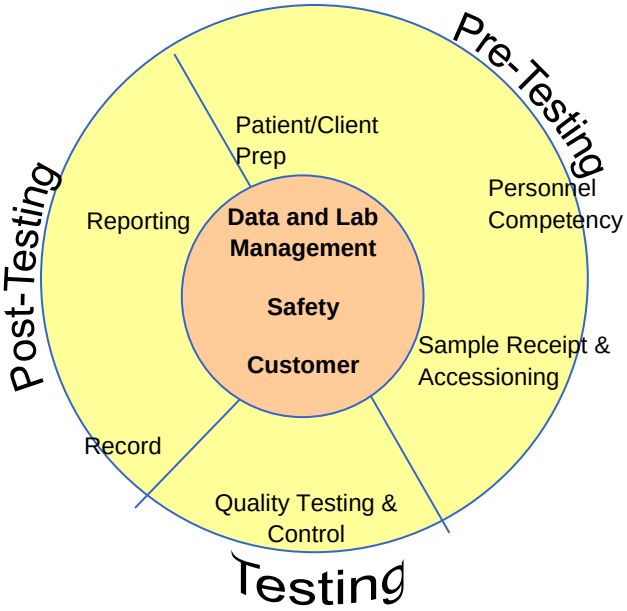
Who Is Responsible for Quality?

Quality is everyone's responsibility. For example, laboratory management and program staff establish quality assurance procedures, and test site personnel implement the quality assurance procedures.

Quality Assurance vs. Quality Control

Quality assurance (QA) is the activities that ensure process are adequate for a system to achieve its objectives. Quality control (QC), on the other hand, is the activities that evaluate a product or work result.

The Quality Assurance Cycle



QA is applied throughout the testing process at all testing sites. It is not a one-time event. As you can see in the graphic above, this is a continual process comprising three phases, and there are multiple activities associated with each phase of testing.

Why Do Errors Occur?

Errors can occur throughout the testing process. Some causes include:

- Individual responsibilities unclear
- No written procedures
- Written procedures not followed
- Training is not done or not completed
- Checks not done for transcription errors
- Test kits not stored properly
- QC, external quality assessment (EQA) not performed

The table below provides the examples of errors that may occur during the three phases of the Quality Assurance Cycle, and what you can do to prevent them.

	BEFORE TESTING	DURING TESTING	AFTER TESTING
Common Errors	•Testing device mislabeled or unlabeled •Specimen stored/ kept inappropriately before testing •Test kits stored and transported inappropriately	•Country algorithm not followed •Incorrect timing of test •Results reported when control results invalid •Improper measurements of specimen or reagents •Reagents stored inappropriately or used after expiration date •Incorrect reagents used (i.e., using buffers from a different kit)	•Transcription error in reporting •Report illegible •Report sent to the wrong location •Information system not maintained
How to Prevent/ Detect Errors	•Check storage and room temperature •Select an appropriate testing workspace •Check inventory and expiration dates •Review testing procedures •Record pertinent information, and label test device •Collect appropriate specimen	•Perform and review Quality Control (QC) •Follow safety precautions •Conduct test according to written procedures •Correctly interpret test results	• Re-check client/client identifier • Write legibly • Clean up and dispose of contaminated waste • Package EQA specimens for re-testing, if needed

REMEMBER, EVERY TESTER IS RESPONSIBLE FOR PREVENTING AND DETECTING ERRORS BEFORE, DURING AND AFTER TESTING.

What Is Quality Control?

QUALITY CONTROL

Quality control (QC) seeks to monitor the quality of the test itself. QC ensures that the test is working correctly and the tester can report accurate test results with confidence.

Sources of Controls

There are two types of quality control for HIV rapid testing: internal and external to the test kit.

Internal and External Quality Control

Internal quality control:

- Control samples with known reactivity may be included with the test kit that you would test as you would client/client specimens.
- Another type of internal control is an area or region within the individual testing device. This area or region is also termed the procedural or in-built control. This type of control verifies the flow of either specimen and/or buffer through the test device resulting in an appearance of a line or dot in the control region. In other words, in some test devices, a line in the control area may appear even if a specimen is not added, unlike other test devices with an anti-IgG control. In this instance, a control line will not appear if IgG is not detected.
- Since it is not always known if the test device includes a true IgG control, it is important to test an external control sample.

External quality control:

- Control samples that do not come with the test kit. They are provided by an external source such as your regional reference laboratory or a facility laboratory.
- This type of control should also be tested in the same manner as you would test a client or client specimen.

Sources of External Quality Control Samples

Control samples are often received in tubes called cryovials. This photo illustrates control samples neatly stored in a Styrofoam container.

It is important to store controls appropriately. For in-house prepared controls, these should be refrigerated upon receipt.

For both internal and external control samples, you already know whether the control is positive or negative. Once tested, you should receive the expected results. If not, this is one sign that there is a problem with your testing operation.

For all controls, you must:

- Label vial with date when first used
- Test before expiration date
- Take care as to not contaminate the control materials

Frequency of Use: When Should You Test External Control Samples?

At a minimum, test your external control samples:

- Once a week
- When a new shipment of test kits are received at the testing site
- In the beginning of a new lot number

If you get an invalid result, you must repeat the test. In addition, you should identify the cause of the problem, inform your supervisor and take corrective actions.

Invalid Results – What Do You

It is important to always follow the standard operating procedure (SOP) for each

Do?

type of test used, as the following may differ from kit to kit:

- Sample volume – This may differ from kit to kit, and might differ depending on the sample type (e.g., whole blood vs. serum).
- Buffer volume – Some kits require different volumes of buffer.
- Incubation time – This time may also differ from kit to kit. Always follow the time required by the manufacturer.

Troubleshooting Invalid Results

Use the following table to help you troubleshoot invalid results.

PROBLEM	POTENTIAL CAUSE	ACTION
No control line or band present	Damaged test device or controls	• Repeat the test using new device and blood sample
	Proper procedure not followed	• Follow each step of testing according to SOP • Re-check buffer and/or specimen volumes • Wait for the specified time before reading the test
	Expired or improperly stored test kits or controls	• Check expiration date of kits or controls. Do not use beyond stated expiration date • Check temperature records for storage and testing area
Positive reaction with negative external control, i.e., false positive	Incubation time exceeded	• Re-test negative control using a new device and read results within specified time limit
Extremely faint control line	The control line can vary in intensity	• No action required. Any visible line validates the results

Maintaining Quality Control

Why are these records important? Because they help with troubleshooting and provide proof of reliable test results.

Records

How are the records maintained? By using standard worksheets.

When should you maintain QC records? Every time when you test QC materials. You should also record all invalid results and inform supervisor.

Periodic Review of Records

During a review of QC results, it is easier to have one log of all QC results rather than going from page to page in a logbook. A format such as this also provides an easy glance at consistent frequency in testing QC samples, and readily identification of problems.

You should review QC results periodically to detect any problems early.

This review involves:

- Daily review of internal control results before accepting test results
- Review of external control results by test performer
- Weekly or monthly review of external quality control results by testing site supervisor
- Periodic audits or assessments

Keep in mind that if problems are detected, you must take corrective actions immediately.

EXTERNAL QUALITY ASSESSMENT

External Quality Assessment: Definition

External Quality Assessment (EQA) is the objective assessment of a test site's operations and performance by an external agency or personnel.

Why EQA?

EQA allows comparison of performance and results among different test sites offering not only an opportunity for performances checks, but an opportunity to systematically identify problems with kits or operations.

Additionally, EQA also provides objective evidence of testing quality, indicates areas that need improvement and identifies training needs.

Testing Personnel's Responsibilities

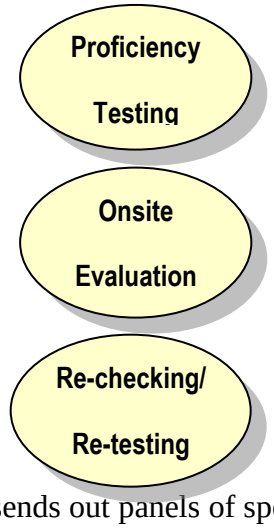
Test providers' EQA responsibilities include:

- Participating in the EQA program
- Taking corrective actions
- Maintaining EQA records
- Communicating outcomes to supervisors

EQA Methods

There are three main EQA methods:

- Proficiency testing (PT) – Proficiency panel may be used during on-site visits.
- On-site evaluation, which is sometimes referred to as onsite monitoring visits or audits.
- Re-checking or re-testing of specimens. Now a day, this method is not relevant for HIV rapid testing.



What Is Proficiency Testing?

In proficiency testing (PT), a reference laboratory sends out panels of specimens to multiple test sites, which in turn perform tests on these panels and report results. Dry tube specimen (DTS) is used in HIV PT program in Ethiopia for all testing points. The reported results indicate quality of personnel performance and test site operations. Results are often compared across several testing sites.

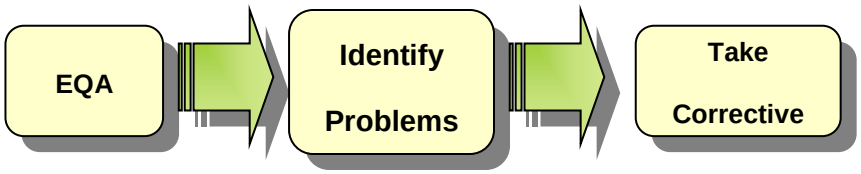
What is Onsite Evaluation?

Onsite evaluation is periodic site visits to systematic assessment of laboratory practices. These visits focus on how the lab monitors its operations and ensures testing quality. They also provide information for internal process improvement. Onsite evaluation is also referred to as audits, assessments and supervisory visits.

These site visits enable us to learn "where we are" so we may measure gaps or deficiency. From the visits we can collect information for planning and implementation, monitoring and continuous improvement. They are part of every laboratory quality system.

These visits should be instructional rather than punitive. The main purpose of onsite visits is to observe the testing site under routine conditions to check that it is meeting quality requirements.

EQA should Lead to Corrective Actions



A corrective action is an action taken to correct a problem or non-conformance/ deficiency within the quality management system. Examples of a non-conformance include:

- Production of an incorrect result
- Test performed by untrained personnel
- Not following SOPs
- When the quality system does not meet the requirements of quality standards or requirements

Problems May Occur Throughout the Testing Process

Problems may lie anywhere in the testing process: pre-testing, testing and post-testing. Most problems occur in the pre- and post-analytic phases of testing. The integrity of the specimen may have been compromised during preparation, shipping or after receipt by improper storage or handling.

Problems such as with reagents, test methods, quality control or competency of staff may occur during testing. Due to the large number of specimens collected and transported by numerous test sites, care must be taken to ensure proper transcription of data throughout the testing process.

Take Corrective Actions

Whenever problems are detected, corrective actions must be taken:

- Use problem-solving team
- Investigate root causes and develop appropriate corrective actions
- Implement corrective actions
- Examine effectiveness
- Record all actions and findings
- Check the sample corrective action log book/form

Chapter 8: Documents and Records

Learning objectives: By the end of this session the participants will be able to:

- Explain the difference between a document and a record
- Explain the rationale for following documents and keeping records
- Provide examples of documents and records kept at a test site
- Follow the procedures as prescribed in SOPs
- Describe how to properly keep and maintain test site documents and records

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Contents

- Definition of documents and records?
- Why are they important?
- What documents and records should you keep?
- Why is it important to follow SOPs?
- What is the proper way to keep and maintain documents and records?

Definition of Documents and Records?

Documents are written policies, process descriptions and procedures used to communicate information. They provide written instructions for HOW TO do a specific task.

Records are generated when written instructions are followed. In other words, after data, information or results are recorded onto a form, label, etc., then it becomes a record.

Documents and records may be paper or electronic.

Examples of Documents and Records

Examples of documents include: country testing algorithm, safety manual, SOPs for an approved HIV rapid test, manufacturer test kit inserts, and quality control record (blank form).

Examples of records include: client test results, summary of findings form onsite evaluation visit, report of corrective actions, stock cards and stock book (completed), and EQA result submission form (completed).

Documents Are the Backbone of the Quality System

Verbal instructions often are not heard, misunderstood, quickly forgotten and ignored. Policies, standards, processes and procedures must be written down, approved and communicated to all concerned.

SOPs are Documents

SOPs are documents that describe how to perform various operations in a testing site. They provide step-by-step instructions and assure consistency, accuracy and quality. SOPs are one type of document. Using SOPs results in reliable and consistent results.

SOPs Are Controlled Documents

"Controlled" documents means that documents must be approved for use in-country, have document control features and be kept up-to-date. Key features of SOPs include:

- Cover page
- Descriptive title
- SOP number
- Version number
- Date when SOP become effective
- Signature of person responsible for writing the SOP
- Signature of person authorizing the SOP

What SOPs Should You Keep at a Test Site?

Each test site should have on hand current/approved SOPs. Typical SOPs kept at a test site include:

- Daily routine schedule
- National HTC guideline and algorithm
- Safety manuals (for example, safety precautions, preparation of 10% (vol/vol) bleach solution and post-HIV exposure prophylaxis management and treatment guidelines)
- Blood collection (for example, finger prick, venipuncture and DBS)
- Test procedures
- Reordering of supplies and kits

SOPs Must Be Followed

SOPs must be followed. Not following safety precautions poses unnecessary risk to you, the client and the environment.

Do Not Rely Solely on Manufacturer Product Inserts

Manufacturer product inserts do not provide specific information for test sites. Examples include:

- Materials required, but not in kit
- Specific safety requirements
- Sequence of tests in country algorithm
- External quality control requirements

Proper Record-Keeping Makes Quality Management Possible

Recordkeeping allows a test site to:

- Communicate accurately and effectively—Recordkeeping enables sites to be timely in reporting to program managers and site supervisors.
- Minimize error—All records must be written.
- Monitor quality system—Records allow for periodic review of testing operations. Only through the review of records can improvements be identified.
- Assist management in developing policy and plans and M&E programs.

What Records Should You Keep at a Test Site?

It is recommended that you keep these records at your test site:

- HIV positive referral feedbacks
- HIV test request/client test result
- IQC records
- PT feedbacks
- HTC register
- Inventory records/ IFRR forms(completed)

Tips for Good Recordkeeping

Here are some tips for good recordkeeping:

- Understand the information to be collected. Before you record any information, make sure that you understand what is to be collected
- Record the information every time. Record on the appropriate form each time you perform a procedure.
- Record all the information. Make sure that you have provided all the information requested on a form.
- Record the information the same way every time. Be consistent in how you record information.

Client Test Records

Types of information captured on test records when testing is requested by different units includes:

- Client/Client ID number
- Date of test
- Results from Test 1, Test 2 and Test 3
- Repeat results
- HIV status
- Kit name and lot number
- Person performing test

(Refer to standard HIV test recording form in **Annex C**)

How Long Should You Retain Client Records?

Records must be maintained secure storage. The length of time you will need to store test site records will depend on national policies and the availability of secure storage space at your test site.

Logbooks Are Cumulative Records of Test Site Operations	Storage of logbooks and records should be kept in a manner that will minimize deterioration. Although many sites uses paper-based logbooks and records, they should be indexed so that they will be accessible while they are needed.
Records Should be Permanent, Secure, Traceable	Facilities where records are kept should be secure to maintain client confidentiality. Procedures and mechanisms should prevent unauthorized access. Records should be permanent, secure and traceable. Examples of keeping records permanent include: keep books bound, number pages, use permanent ink and control storage. To keep records secure, you need to maintain confidentiality, limit access and protect them from environmental hazards. To keep records traceable, make sure every record is signed and dated.
Information Recorded will Feed into M&E System	Records must be kept permanent, secure, and traceable because they will be used for reporting and monitoring purposes. Monitoring is the routine tracking of program information. Accurate facility records provide essential information for providing high-quality health care and monitoring HTS programs. It is recommended that you analyze on a monthly basis the number of clients served and summarize the test results.

Module Summary

- HIV rapid tests can be as reliable as EIAs.
- All tests require attention to training, supervision and monitoring at points of service.
- As testing is expanded and decentralized, training, supervision and monitoring must follow accordingly and become all the more important.
- Before any test is adopted in-country for use, a series of key steps must be taken to evaluate the tests before they are fully adopted for use countrywide.
- The ideal algorithm used is one in which tests are highly sensitive and highly specific.
- No test is 100% sensitive or 100 % specific when compared to the "gold standard."Always follow the sequence of the tests in the algorithm
- Report any accidents immediately and take appropriate actions
- Always apply safety work practices throughout the testing process.
- Do not break, bend, re-sheath or reuse lancets, syringes or needles.
- Dispose of contaminated waste in the appropriate container.
- Disinfect your work surface on a daily basis.

- Having an organized workspace is key to producing high-quality results.
- Be sure to have all the supplies you need in reach before beginning a test.
- You must prepare your workstation and client prior to performing a finger prick.
- Always follow universal safety precautions to protect your client and yourself when performing finger prick.
- Follow standard operating procedures when performing a finger prick.
- An accurate HIV rapid test result is dependent in part on the quality of the sample collected.
- Always follow universal safety precautions when performing any laboratory procedure.
- Always follow your country's testing algorithm.
- EQA provides early warning for systematic problems associated with kits or operations.
- Onsite visits are designed to be instructive, not punitive.
- Corrective actions should be implemented and recorded for any problems identified.
- A test result is only as good as the specimen received for testing.
- Always follow standard operating procedures (SOPs) for each test performed.
- If problems or errors occur, you must immediately take corrective actions before you give results to clients.
- If an invalid result is obtained at any point, corrective actions should be taken prior to reporting test results.
- QC results must be documented and reviewed periodically for early detection of problems.
- Quality is the foundation of everything we do.
- The simplest rapid test is not fool-proof.
- Errors can occur throughout the testing process.
- Quality is everyone's responsibility.
- Written policies and procedures are the backbone of the quality system.
- Complete quality assurance records make high-quality management possible.
- Keeping records facilitates meeting program reporting requirements.

Annexure

Annex A: Checklist for HIV Rapid Testing Supplies and Materials

_____ HIV rapid test kit(s)

_____ Alcohol or alcohol prep pads

_____ Laboratory coats or aprons

_____ Sterile lancets

_____ Paper towels

_____ Leakproof bag

_____ Band-Aids or plasters

_____ Positive and negative controls

_____ Spray/wash bottle

Capillary tubes

_____ Disposable gloves

_____ Cotton gauze/wool

_____ Timer, clock or watch

_____ Lancet bin or disinfectant jar

_____ Pens for labeling

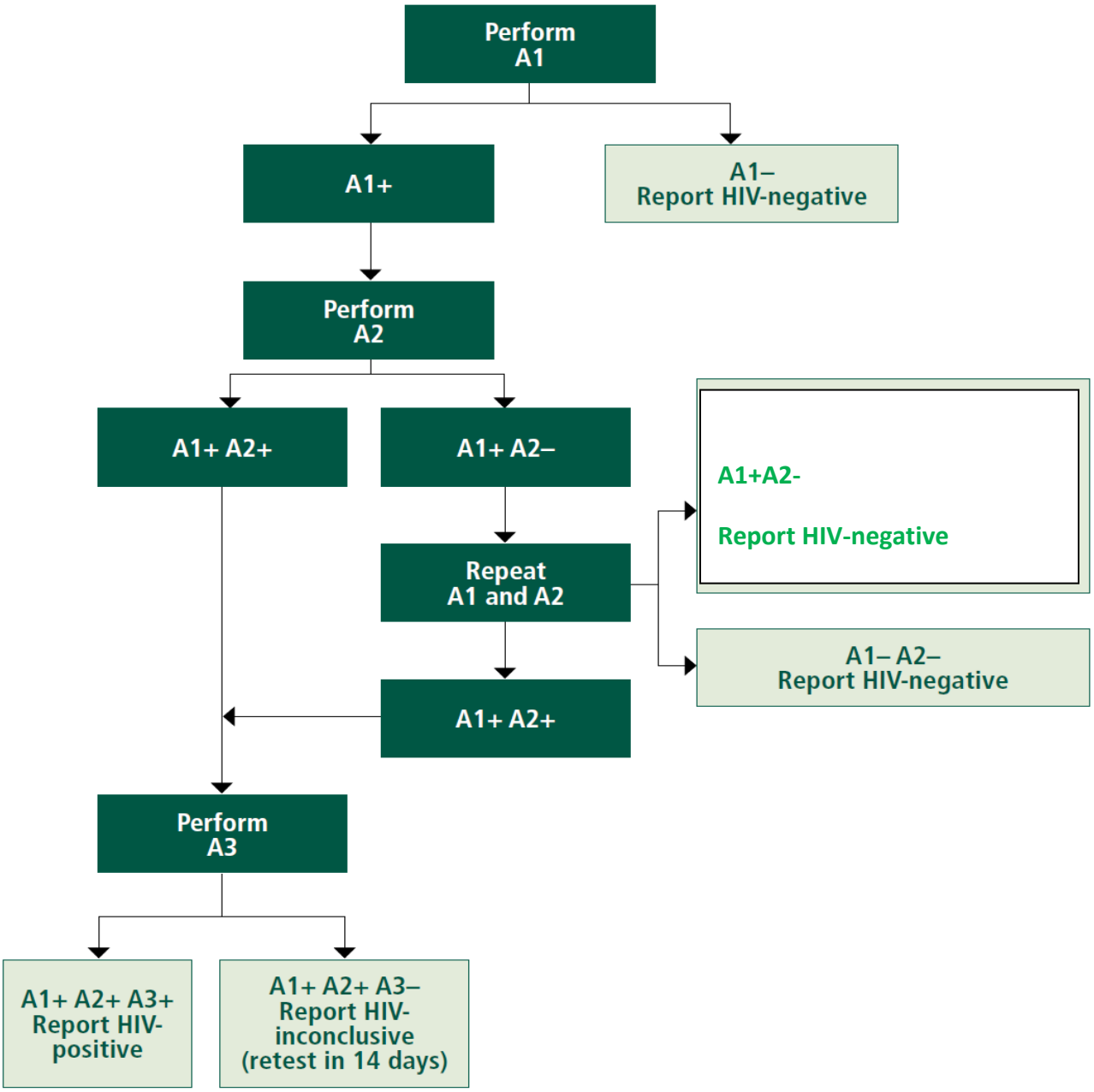
_____ Handwashing soap

_____ Disinfectant

_____ Standardized Logbook or register

_____ Standard operating procedures

Annex B: Job Aid for HIV Rapid Testing Algorithm



Annex C: Practical Exercise Recording Worksheet

	Rapid HIV Test		
	Test 1	**Test 2**	**Test 3**
Test Name			
Lot Number			
Expiration Date			

Patient Identifier	**Results Test 1**	**Results Test 2**	**Results Test 3**	**Final Status**	**Comments**
	NR R INV	**NR R INV**	**NR R INV**	**NEG POS IND**	
	NR R INV	**NR R INV**	**NR R INV**	**NEG POS IND**	
	NR R INV	**NR R INV**	**NR R INV**	**NEG POS IND**	
	NR R INV	**NR R INV**	**NR R INV**	**NEG POS IND**	
	NR R INV	**NR R INV**	**NR R INV**	**NEG POS IND**	
	NR R INV	**NR R INV**	**NR R INV**	**NEG POS IND**	

Circle the results of the individual test results and final status, once the testing is completed for each sample

NR – Non reactive R – Reactive INV – Invalid

NEG – Negative POS – Positive IND – Indeterminate

	Signature/Date	**Additional comments**
Supervisor		

Annex D: Job Aid for HIV ½ Stat-Pak Rapid Testing

HIV 1/2 Stat-Pak

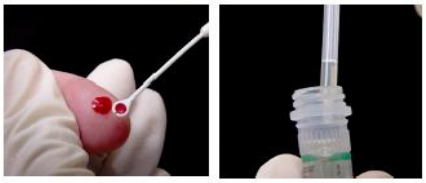
For use with whole blood, serum, or plasma
Store Kits: 8 - 30° C

- Check kit before use. Use only items that have not expired or been damaged.
- Bring kit and previously stored specimens to room temperature prior to use.
- Always use universal safety precautions when handling specimens. Keep work areas clean and organized.

This outline is not intended to replace the product insert or your standard operating procedure (SOP).

1. Collect test items and other necessary lab supplies.

2. Remove device from package and label device with client identification number.



3. Collect approximately 5 µl of specimen using a new disposable loop or pipette.

4. Dispense the sample in the center of SAMPLE well.

5. Add 3 drops of buffer, holding vial vertically over the SAMPLE well.

6. Wait for 10 minutes before reading the results.

7. Read and record the results and other pertinent info on the worksheet.

HIV 1 / 2 Stat-Pak Test Results

Reactive
2 lines of any intensity appear in both the control and test areas.

Non-reactive
1 line appears in the control area and no line in the test area.

Invalid
No line appears in the control area. Do not report invalid results. Repeat test with a new test device even if a line appears in the test area.

WHO

Use of trade names and commercial sources is for identification only and does not imply endorsement by WHO, the Public Health Service, or by the U.S. Department of Health and Human Services (2005).

CDC

Annex E: Job Aid for SD Bioline ½ 3.0 HIV Rapid Testing

SD BIOLINE HIV-1/2-3.0
(STANDARD DIAGNOSTICS, INC).

SD BIOLINE HIV-1/2 3.0 is an immunochromatographic rapid diagnostic test for the qualitative detection of HIV-1 and HIV-2 antibodies in human serum/plasma and capillary/venous whole blood specimens.

KEY INFORMATION:

Shelf life: 24 months
Storage conditions: 1-30 °C
Volume of specimen needed: 10µL (serum/plasma); 20 µL (whole blood)
Time to test one specimen: 10 minutes

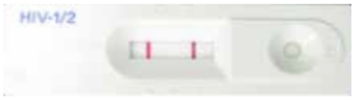
EQUIPMENT REQUIRED BUT NOT SUPPLIED:

- personal protection equipment such as gloves, lab coat or gown
- timer
- appropriate biohazard waste containers
- precision pipette + tips, when using serum/ plasma
- for capillary blood collection: cotton wool.
  Certain kit configurations require capillary pipettes, lancets, alcohol swabs
- for venous blood collection: venipuncture apparatus and appropriate blood collection tubes.

Non-reactive for HIV-1&HIV

Reactive for HIV-1 antibodies

Reactive for HIV- 2 antibodies



Reactive for HIV- 1+2 antibodies

TEST PROCEDURE:

1) Remove the test device from its pouch and place it on a flat surface.
2) Label the test device with patient or specimen ID number.
3) For serum or plasma specimens:
   a. Using a precision pipette, apply 10µl of specimen to the specimen well (S).
4) For venous whole blood (venipuncture) specimens:
   a. Using a precision pipette, apply 20µl of specimen to the specimen well (S).
5) For capillary whole blood (finger stick) specimens:
   a. Clean fingertip with alcohol swab, place lancet off-centre and puncture the finger tip. Wipe away first drop of blood with cotton wool.
   b. Using capillary tube provided within the test kit, draw specimen. Apply 20µl of specimen to the specimen well (S).
6) For all specimen types, add 4 drops (120µl) of buffer to the same specimen well (S).
7) Read results at 10 minutes after adding the assay diluent, but no later than 20 minutes.
8) Interpret results as follows:

Non-reactive for HIV-1 & HIV-2: Presence of only control line (C) within the result window.

Reactive for HIV-1 antibodies: Presence of two lines as control line (C) and test line 1 (T) within the result window

Reactive for HIV- 2 antibodies: Presence of two lines as control line (C) and test line 2 (T) within the result window

Reactive for HIV- 1 and 2 antibodies: Presence of three lines as control line (C), test line 1 (T) and test line 2 (T) within the result window

Invalid: No presence of control line (C) within the result window

Annex F: Job Aid for Abon HIV 1.2.0 HIV Rapid Testing

ABON™ HIV 1/2/O TRI-LINE HUMAN IMMUNODEFICIENCY VIRUS RAPID TEST DEVICE (ABON BIOPHARM (HANGZHOU) CO., LTD).

ABON™ HIV 1/2/O Tri-line Human Immunodeficiency Virus Rapid Test Device (Whole Blood/Serum/Plasma) is an immunochromatographic rapid diagnostic test for the qualitative detection of HIV-1 and HIV-2 antibodies in human serum/plasma and capillary/venous whole blood specimens.

KEY INFORMATION:

Shelf life: 24 months
Storage conditions: 2-30 °C
Volume of specimen needed: 25µL (serum/plasma); 50µL (whole blood)
Time to test one specimen: 11 minutes

EQUIPMENT REQUIRED BUT NOT SUPPLIED:

- personal protection equipment such as gloves, lab coat or gown
- timer
- appropriate biohazard waste containers
- for capillary whole blood: heparinised capillary tubes with 50µl fill line
- for capillary blood collection: lancet, cotton wool, alcohol swab
- for venous blood collection: venipuncture apparatus and appropriate blood collection tubes.

Non-reactive HIV-1 & 2 antibodies

Reactive for HIV-1 antibodies

Disclaimer: These instructions were prepared based on the instructions for use submitted as part of the WHO Prequalification of In Vitro Diagnostics assessment. These may change over time and so it is recommended to always refer to the most current instructions for use when developing standard operating procedures and/or job aids.

TEST PROCEDURE:

1) Remove the device from protective foil pouch, use within 1 hour.
2) Label the test with patient or specimen ID number
3) For serum or plasma specimens:
   a. Using the dropper provided within the test kit, apply 1 drop (25µl) of specimen to the specimen well (S).
   b. Add 1 drop (40µl) of buffer to the same specimen well (S).
   c. Read results at 10 minutes, do not read after 20 minutes.
4) For venous whole blood (venipuncture) specimens:
   a. Using the dropper provided within the test kit, apply 2 drops (50µl) of specimen to the specimen well (S).
   b. Add 2 drops (80µl) of buffer to the same specimen well (S).
   c. Read results at 10 minutes, do not read after 20 minutes.
5) For capillary whole blood (finger stick) specimens:
   a. Clean fingertip with alcohol swab, place lancet off-centre and puncture the finger tip. Wipe away first drop of blood with cotton wool.
   b. Using capillary tube, take specimen until the fill line. Apply 50µl of specimen to the specimen well (S).
   c. Add 2 drops (80µl) of buffer to the same specimen well (S).
   d. Read results at 10 minutes, do not read after 20 minutes.
6) **Interpret results as follows:**

Non-reactive for HIV-1 & HIV-2 antibodies: One coloured line appears in the control region C and no apparent coloured lines in the test line regions T1 and T2.

Reactive for HIV-1 & HIV-2 antibodies: Two or three distinct coloured lines appear, one on the control line 'C' and other one or two coloured lines in the test line region(s) **T1** and or **T2**

Reactive for HIV-1 antibodies: Two distinct coloured lines appear, one in the control line 'C' and one other coloured line in the test region T1.

Reactive for HIV-2 antibodies: Two distinct coloured lines appear, one in the control line 'C' and one other coloured line in the test region T2.

Invalid: Control line fails to appear in control region, even if coloured lines appear in any of the test regions T1 or T2.

Annex G: Standard Operating Procedure for HIV ½ stat-Pak Rapid Testing

Purpose

This test is suitable for use in multi- test algorisms designated of the statistical validation of rapid HIV test result.

Principle

The specimen/buffer mixture migrates along the test strip by capillary action, reconstituting the conjugate. If present, the antibodies bind to the colloidal gold conjugated antibody binding protein. In a reactive sample, the dye conjugated immune complex migrates on the nitrocellulose membrane and is captured by the antigens immobilized in the TEST (T) area producing a pink/purple line. In the absence of HIV1 and HIV2 antibodies, The sample continues to migrate along the membrane and produces a pink/purple line in the CONTROL (C) area containing immunoglobulin G antigens.

Materials

Reagents list
• HIV (1+2) antibody cassettes • Sample diluents • Sodium hypochlorite solution (5 %) or other suitable disinfectant. **Reagents, stability and storage:** At room temperature

Supplies
• Disposable gloves • biohazard waste containers • Timer • Pipette tips and pipettes

Sample

Sample type	**Amount required**	**Stability**
EDTA, Litium Heparin or Sodium Citrate Whole Blood	4-5ml	Up to 4 hour at 15-37ºC Do not freeze Whole Blood samples
Capillary blood (Finger prick)	5 µL	Should be tested immediately

Serum/ plasma	2.0 ml	One week at 2-8 ^{O}c For log period at >-20 ^{O}c

Safety Precautions	Using universal persecution(gloves, lab coat, washing hands) when handling infectious materials refer to the national health and safety guideline for standard safety procedure

Maintenance

Step	Action
	Daily Cleaning

Quality Control

Control	Level	Stability	Frequency	Preparation (y/n)
Internal kit control	Sero-04	Room temperature	Each run	N
In house control	------	-20 or colder	Weekly	Y

Procedure

Step	Action
1	Remove the Chembio HIV 1/2 STATPAK test device from its pouch and place it on a flat surface
2	Label the test device with patient name or identification number
3	Touch the 5 µL sample loop provided to the specimen, allowing the opening of the loop to fill with the liquid
4	Holding the sample loop vertically, touch it to the sample pad in the center of the SAMPLE (S) well of the device to dispense ~5 µL of sample (serum, plasma or whole blood) onto the sample pad.
5	Add 3 drops (~ 105 µL) of buffer slowly, drop wise, into the sample well.

	6	Read the Test Result between 15 and 20 minutes after the addition of the Running Buffer.

Result Interpretation

1. Reactive result (two bands)
A reddish-purple band appears both on control line (C-line) and test line (T-line) of the cassette.

2. Non-reactive result (one band)
A reddish-purple band appears only at the control line (C-line) of the cassette.

3. Invalid result

- No reddish-purple band appears neither at the control line nor the test line of the cassette
- If there is no distinct pink/purple line visible in the CONTROL (C) area
- Any lines that appear outside of the Control (C) Area or Test (T) Area

Limitation

1. The HIV-1/HIV-2 test is designed to detect antibodies to HIV-1 and HIV-2 in human serum, plasma and whole blood. Other body fluids or pooled samples may not give accurate results.
2. No test absolutely guarantees that a sample does no contain low level of antibodies to HIV-1 and HIV-2 which may occur at a very early stage of infection. Therefore a negative result should not exclude the possibility of exposure to or infection by HIV-1 or HIV-2 viruses.
3. Positive samples should be retested, and additional testing using other clinical methods is recommended.

Annex H: Standard operating procedure for SD Bioline ½ 3.0 HIV Rapid Testing

Purpose

This procedure provides instructions on a laboratory method used to qualitatively detect antibodies to all isotypes (IgG,IgM, IgA) specific to HIV-1 including subtype 0 and HIV-2 Using SD BIOLINE HIV-1/2 3.0 kit

Principle

The SD BIOLINE HIV-1/2 3.0 test contains a membrane strip, which is pre-coated with recombinant HIV-1 capture antigen (gp41, p24) on test band 1 region and with recombinant HIV-2 capture antigen (gp36) on test band 2 region, respectively. The recombinant HIV-1/2 antigen (gp41, P24 and gp36)-colloid gold conjugate and the specimen sample move along the membrane chromatographically to the test region (T) and form a visible line as the antigen antibody-antigen gold particle complex forms with high degree of sensitivity and specificity. This test device has a letter of 1,2 and C as Test Line 1(HIV-1), Test Line 2(HIV-2) and control line on the surface of the device. Both the Test Lines and Control Line in result window are not visible before applying any sample. The Control Line is used for procedural control. Control Line should always appear if the test procedure is performed properly and the test reagents of Control Line are working.

Materials

Reagents
SD BIOLINE HIV-1/2 3.0 (25 test devices individually foil pouched with a desiccant)
Assay diluents(1x4ml/Vial)

Reagents preparation: Ready to use

Reagents stability and storage:

- The test device should be stored at 1-30°C. Do not freeze the kit or components
- Protect the test kit from humidity as well as to heat
- The test device is stable until the expiration date printed on the test kit and/or sealed test device pouch.
- Do not use the kit if the pouch is damaged or the seal is broken
- The reagents should be used before expiry date
- The test device must remain in the sealed pouch until use
- The test device is recommended to use at room temperature (15-30°C)

Supplies
Capillary pipettes
Alcohol Swab
Single use Lancet
Timer
Biohazard waste containers for sharps and non-sharps
Marker

Equipment
Centrifuge
Specimen collection equipment and containers

Sample

Sample type	Amount required	Stability
Fingerstick whole blood	20 µl	It should be done as soon as possible
Venipuncture whole blood	20 µl	If the blood is not tested immediately, it should be stored at 2-8^{0}c and should be tested within 3 days of collection
Serum and plasma	10 µl	If plasma or serum specimens are not tested immediately, they should be refrigerated at 2-8^{0}c For storage period longer than 2 weeks, freezing is recommended plasma or serum specimens containing a precipitate may yield inconsistent test results

Safety Precautions	Using universal persecution(gloves, lab coat, washing hands) when handling infectious materials refer to the national health and safety guideline for standard safety procedure
Quality control	The SD BIOLINE HIV-1/2 3.0 test device incorporates the characters "1","2" and "C" on the surface of the device to identify the adjacent location of the Test Line (HIV-1), Test Line (HIV-2) and Control Line in the result window. These lines are not visible before applying the sample. The Control Line is used for procedural control. A visible Control Line confirms that the diluents has been applied successfully and that the active ingredients on the strip are functional, but is not confirmation that the sample has been properly applied; it is not a positive sample control.

Procedure

Specimen collection

Step	Action

1	**Whole blood**
	• **Collection by venipuncture**
	  • Using venipuncture, collect whole blood into the collection tube (containing anticoagulants such as heparin, EDTA and sodium citrate).
	• **Collection by lancet**
	  • Clean the area to be lanced with an alcohol swab
	  • Squeeze the end of the fingertip and pierce with a sterile lancet provided.
	  • Take a 20µl capillary pipette provided, immerse the open end in the blood drop and then release the pressure to draw blood into the capillary pipette to black line.

2	**Plasma or Serum** • (Plasma) collect the whole blood into the collection tube (containing anticoagulants such as heparin, EDTA and sodium citrate) by venipuncture and then centrifuge blood to get plasma specimen. • (Serum) collect the whole blood into the collection tube (NOT containing anticoagulants such as heparin, , EDTA and sodium citrate) by venipuncture, leave to settle for 30 minutes for blood coagulation and then centrifuge blood to get serum specimen of supernatant.

Testing procedure

Step	Action
1	Remove the test device from foil pouch, place it on a flat, dry surface.
2	**Using a capillary pipette** Add 20µl of drawn blood specimen with a 20 Capillary pipette into the sample well (s) **OR,** **Using a micropipette** Add 10µlof plasma or serum specimen (20µl of blood specimen) into the sample well (s)
3	Add 4 drops (about 120µl) of Assay diluents vertically into sample well (s) **Caution**: if you do not hold the bottle vertically, it can lead to inaccurate results.
4	As the test begins to work, you will see purple color move across the result window in the center of the test device.
5	Time to result is 10 to 20 minutes. After adding the diluents, read the result after 10 minutes but not more than 20 minutes. **Caution**: If test result is not legible after 10 minutes due to high background colour read again later but within 20 minutes of adding the diluents. Do not read after 20 minutes.

Result

Interpretation

1. A colour band will appear in the left section of the result window to show that the test is working properly. This band is control line (C)
2. Colour bands will appear in the middle and right section of the result window, these bands are test line 2 and test line 1 (2,1).

Negative Result

The presence of only control line (C) within the result window indicates a negative result.

Positive Result

1. The presence of two lines as control line (C) and test line 1 (1) within the result

window indicates a Positive result for HIV-1.

2. The presence of two lines as control line (C) and test line 2 (2) within the result window indicates a Positive result for HIV-2.
3. The presence of three lines as control line (C), test line 1 (1) and test line 2 (2) within the result window indicates a Positive result for HIV-1 and/or HIV-2.
    - If the color intensity of the test line 1 is darker than one of test line 2 in the result window, you can interpret the result as HIV-1 positive.
    - If the color intensity of the test line 2 is darker than one of test line 1 in the result window, you can interpret the result as HIV-2 positive.

    Caution: Dual infection of HIV-1 and HIV-2 within one individual is quite rare. Dual reactivity observed in SD Bioline HIV-1/2 3.0, i.e HIV-1 line and HIV-2 line both reactive, is more likely to be caused by cross-reactivity given certain homology in the amino acid sequences of HIV-1 and HIV-2. To determine the virus type or diagnose a co-infection, confirmatory testing must be performed.

Invalid Result

No presence of control line (C) or/and pink/purple smear observed in the result window indicates and invalid result. The directions may not have been followed correctly or the test may have deteriorated. It is recommended that the specimen be re-tested.

Limitations

1. Although a positive result may indicate infection with HIV-1 or HIV-2 virus, a diagnosis of AIDS can only be made on clinical grounds, if an individual meets the case definition for AIDS established by the centers for Disease Control. For samples repeatedly tested as positive, more specific supplemental tests must be performed.
2. Immuno chromatographic testing alone cannot be used to diagnose AIDS even if the antibodies against HIV-1 and/or HIV-2 are present in patient's specimen.
3. A negative result does not eliminate the possibility of HIV-1 and/or HIV-2 infection. The specimen may contain low levels of antibodies to HIV-1 and/or HIV-2.

Annex I: Standard operating procedure for Abon HIV 1.2.0 HIV Rapid Testing

Purpose

This procedure provides instructions on a laboratory method used to qualitatively detect antibodies to Human Immunodeficiency Virus (HIV) type 1, including sub type 0 and 2 using ABON HIV 1/2/0 tri-line HIV rapid test device

Principle

The HIV 1/2/O Tri-line Human Immunodeficiency Virus Rapid Test Device (Whole Blood/Serum/Plasma) test strip is pre-coated with HIV-1 and subtype O antigens on T1 test line and HIV-2 antigen on T2 test line. Firstly, specimen and then buffer is added to the specimen well, thus starting the migration of the specimen/buffer. The specimen/buffer passes the conjugate pad which contains a mixture of HIV-1 envelope and core antigens and HIV-2 envelope antigen. These detection antigens are conjugated to latex particles. If present, the HIV-1 of HIV-2 antibodies react and bind to the detection antigen-conjugate. The antibody/antigen-conjugate mixture then migrates further and binds to antigens present on the test lines. If the specimen contains antibodies to HIV-1, the specimen will bind to the T1 test line and produce a line, if specimen contains antibodies to HIV-2, the specimen will bind to the T2 test line. As liquid continues to migrate down the test strip, the control line will appear. If the control line is present, in addition to either or both test lines, then the test is reactive for HIV1/2 antibodies. If the specimen does not contain HIV-1 or HIV-2 antibodies, no colored lines will appear for either of the test lines region indicating a non-reactive result. Please note that the appearance of colored lines at T1 and T2 is highly unlikely to be indicative of co-infection with HIV-1 and HIV-2 but rather is a result of cross-reactivity between antigens. A colored line will appear in the control line region if the migration of liquid has been successful, and must be present for the test to be valid. Its presence does not confirm sufficient specimen addition.

Materials

Reagents
ABON HIV 1/2/0 tri-line HIV rapid test device
3ml buffer

Reagents preparation: Ready to use

Reagents stability and storage:

- The test kit should be stored as packaged sealed pouch at 2-30°C at all times to avoid deterioration (storage in refrigerator at 2-8°C permitted). **Do not store in the freezer**
- Protect the test kit from humidity.
- The test device is stable until the expiration date printed on the test kit and/or sealed test device pouch.
- The reagents should be used before expiry date
- The test device must remain in the sealed pouch until use

Supplies
Specimen dropper (for Serum, Plasma, Venipuncture Whole blood
Alcohol Swab
Single use Lancet
Specimen dropper (for Fingerstick Whole blood)
Cotton wool or gauze pad(for fingerstick whole blood only)
Timer
Biohazard waste containers for sharps and non- sharps
Marker

Equipment
Centrifuge
Specimen collection equipment and containers

Sample

Sample type	Amount required	Stability

Finger stick/ Venipuncture whole blood	2 drops (approximately 50 µl)	Whole blood collected by finger stick should be tested immediately. Whole blood collected by venipuncture should be stored 2-8^{0}c if the test is to be run within 2 days of collection
Serum and plasma	One drop (approximately 25 µl)	Prepare serum or plasma as soon as possible to avoid haemolysis Do not use turbid or haemolysed specimens May be stored 2-8^{0}c for up to 3 days For long term storage specimen should be stored at -20^{0}c

Safety Precautions

- Using universal persecution(gloves, lab coat, washing hands) when handling infectious materials refer to the national health and safety guideline for standard safety procedure

Quality control

A control line is included in the test as an internal control. The test must absorb liquid and allow it to migrate along the membrane for the control line to appear. The control line doesn't control for the addition of adequate volume of specimen

Quality control specimens are not supplied with this kit; however, it is recommended that quality control specimens be tested as a good laboratory practice.

Procedure

Specimen collection and preparation

Step	Action
1	To collect **finger stick whole blood** specimens: • Wear gloves. • Clean entire fingertip (preferable 3rd or 4th finger from non-dominant hand) with alcohol swab. Allow to dry (30 seconds). • Puncture the skin just aside the centre of the fingertip with a new lancet

	each time, if required. Wipe away the first blood drop and dispose of lancet in sharps box.
2	To collect a **fingerstick whole blood specimen by using a capillary tube:** • Immerse the open end of the capillary tube into the blood drop and allow for the blood to draw into the capillary tube up to mark line. Avoid air bubbles. • Place the bulb onto the top end of the capillary tube, then squeeze the bulb to dispense all whole blood on the specimen well (S) of the test device for testing.
3	To collect **serum or plasma** specimens: • Collect according to safe phlebotomy procedures, using vacuum technique into tubes for serum or plasma preparation. • Prepare serum or plasma from whole blood as soon as possible to avoid hemolysis. Don't use turbid or haemolysed specimens

Test procedure

Step	Action
1	**Allow the test device, buffer and specimen to reach room temperature (15-30 °C) prior to testing.**
2	Remove the test device from the foil pouch and use it as soon as possible (within one hour). For **serum or plasma** specimens: Hold the dropper vertically and **transfer 1 drop of serum or plasma (approximately 25 µL)** to the specimen well (S) of the test device, then **add 1 drop of buffer** (approximately 40 µL) and start the timer. For **venipuncture whole blood** specimens: Hold the dropper vertically and **transfer 2 drops of whole blood** (approximately 50 µL) to the specimen well (S) of the test device, then **add 2 drops of buffer** (approximately 80 µL) and start the timer.

		For **fingerstick whole blood** specimens: Take whole blood specimen with a 50 μL capillary tube until mark line. And **add drawn specimen** (about 50 μL) on the specimen well (S) of the test device, then **add 2 drops of buffer** (approximately 80 μL) and start the timer
	3	Wait for the colored line(s) to appear. **Read results at 10 minutes. Do not read results after 20 minutes.**

Result Interpretation

REACTIVE: Two or three distinct colored lines appear. One line should always appear in the control line region (C), and another one or two apparent colored line(s) should appear in the test line region(s) (T1 and/or T2).

NOTE 1: The intensity of the color in the test line region (T1 and/or T2) will vary but any shade of color in the test line region (T1 and/or T2) should be considered reactive.

NOTE 2: Dual infection of HIV-1 and HIV-2 is quite rare. Dual reactivity observed in Abon HIV 1/2 /O Tri-line HIV Rapid Test Device, i.e. HIV-1 line and HIV-2 line both reactive, is more likely to be caused by antibody cross-reactivity. Any specimen with dual reactivity should be referred for specific HIV-2 confirmatory testing, if a discretionary result is required.

NON-REACTIVE: One colored line appears in the control region (C). No apparent colored lines appear in the test line regions (T1 and/or T2).

INVALID: No line appears in the control line region (C). If this occurs, read the test procedure again and repeat the test with a new test device. If the result is still invalid, stop using the test kit immediately and contact your local distributor.

Limitations

1. HIV 1/2/O Tri-line Human Immunodeficiency Virus Rapid Test Device (Whole Blood/Serum/Plasma) is for *in vitro* diagnostic use only. This test should be used for the detection of antibodies to HIV-1/2 in human whole blood, serum or plasma. The concentration of antibodies to HIV-1/2 can be determined by this qualitative test.

2. HIV 1/2/O Tri-line Human Immunodeficiency Virus Rapid Test Device (Whole Blood/Serum/Plasma) will only indicate the presence of antibodies to HIV-1/2 in the specimen and should not be used as the sole criteria for the diagnosis of HIV-1, HIV-2, and/or HIV-1 subtype O infection.

3. For confirmation of reactive test results, specimens should undergo further testing using different assays, such as rapid diagnostic tests, EIA and/or Western blotting in accordance with

a validated HIV testing algorithm.

4. As with all diagnostic tests, all results must be interpreted together with other clinical information available to the physician.

5. Results should not be used to determine the serotype of HIV infections.

6. Due to possible antibody cross reactivity, the appearance of lines in both T1 and T2 does not necessarily indicate co-infection from HIV-1 and HIV-2.

7. False reactive results may arise due to rheumatoid factors, antinuclear antibodies, other viral infections (i.e. hepatitis B or hepatitis C), parasitic infections (i.e. schistosomiasis and trypanosomiasis), damage to test components by heat or humidity, when other test kit components (e.g. buffer or droppers) are substituted between test kits.

8. False non-reactive results may arise when titers of antibodies to HIV1/2 are very low, titers of antibodies to HIV1/2 are very high (high-hook effect), insufficient specimen volume added, excess of buffer added, damage to test components by heat or humidity.

9. False-negative results may be observed in individuals who are receiving effective antiretroviral therapy

Annex J: HIV Rapid Testing Quality Control Log Sheet

NAME OF FACILITY: _____

MONTH: _____

WEEK	Operator Name	DATE TESTED	Quality Control	Name of Test 1: _____				Name of Test 2: _____				Na
				Kit information *(Provide information for each week)*	**Result** *(Circle one)*			**Kit information** *(Provide information for each week)*	**Result** *(Circle one)*			**Kit** *(Pro each*
1			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Exp *(yyy*
2			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Exp *(yyy*
3			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Exp *(yyy*
4			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Exp *(yyy*
5			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Exp *(yyy*

KEY: NR-Non Reactive R- Reactive INV- Invalid NEG- Negative POS-Positive

TESTING INSTRUCTIONS

1. Controls should be performed by each individual who are performing are client testing
2. The positive control and Negative control are run at the same time.
3. Test both positive and negative controls on HIV rapid tests 1, 2 and 3 (if applicable).
4. When the controls give unexpected results (Positive control being negative/invalid or negative control being positive/invalid) the necessary investigations should be carried out before commencement of client testing.
5. Record the quality control results in the table above (circle the correct results).
6. The facility shall order Quality Control supplies as need arises from their supervisor.

Supervisor Signature: _____

Annex N: HIV Rapid Testing Quality Control Log Sheet

NAME OF FACILITY: _____

MONTH: _____

WEEK	Operator Name	DATE TESTED	Quality Control	Name of Test 1: _____				Name of Test 2: _____				Name of Test 3: _____			
				Kit information *(Provide information for each week)*	**Result** *(Circle one)*			**Kit information** *(Provide information for each week)*	**Result** *(Circle one)*			**Kit information** *(Provide information for each week)*	**Result** *(Circle one)*		
1			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV
2			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV
3			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV
4			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV
5			Positive	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV	Lot No _____	POS	NEG	INV
			Negative	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV	Expiry Date _____ *(yyyy/mm/dd)*	POS	NEG	INV

KEY: NR-Non Reactive R- Reactive INV- Invalid NEG- Negative POS-Positive

TESTING INSTRUCTIONS

7. Controls should be performed by each individual who are performing are client testing
8. The positive control and Negative control are run at the same time.
9. Test both positive and negative controls on HIV rapid tests 1, 2 and 3 (if applicable).
10. When the controls give unexpected results (Positive control being negative/invalid or negative control being positive/invalid) the necessary investigations should be carried out before commencement of client testing.
11. Record the quality control results in the table above (circle the correct results).
12. The facility shall order Quality Control supplies as need arises from their supervisor.

Supervisor Signature: _____

Annex O: HIV Rapid Testing Log Book Template

4	5	6	7	8	9	10
Sex	Ethiopian Date (dd/mm/yy)	HIV Test-1* Kit Name ____________ Lot No. ____________ Expiration Date ____/____/____	HIV Test-2* Kit Name ____________ Lot No. ____________ Expiration Date ____/____/____	HIV Test-3* Kit Name ____________ Lot No. ____________ Expiration Date ____/____/____	Final Results**	Tester Initials
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	
M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND	

	M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
	M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
	M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
	M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		

3. PAGE TOTALS

Total non-reactive/negative				
Total reactive/positive				
Total invalid*				
Total indeterminate**				
Total tests				

Examples of freq
A *– kit expired an*
B *– IND specimen*
C *– asked patient*

alid, please record and repeat using the same test on a new row.
eaker) is not available.

MODULE 7
STANDARD OPERATING PROCEDURES, Monitoring and Evaluation

CHAPTER 1: STANDARD OPERATING PROCEDURES

Learning objectives: By the end of this session the participants will be able to:

- Discuss the standard operating procedures of counselling

CONTENTS

- Standard operational procedure for counselling

STANDARD OPERATIONAL PROCEDURE for counselling

Definition of Standard Operating Procedures (SOPs)

SOPs are documents that describe how to perform various operations while providing a particular service. Using SOPs results in reliable and consistent results of health services like HTS. Regarding HTS, it is provided with step-by-step instructions using protocols, cue cards and testing procedures and algorism to assure consistency, accuracy and quality of service..

SOP for HIV Testing and Counseling Services (HTS)

HIV testing and counseling services can be provided using client initiated approach (Voluntary Testing and Counseling and Testing (VCT)) and Provider Initiated Testing and Counseling (PITC) approaches for individual client or couples. The standards and procedures of these services are outlined below:

Voluntary Counseling & Testing (VCT)

- All hospitals and health centers should provide VCT service
- All health facilities should have separate VCT room
- VCT service should be provided at least 8 hours a day and 5 working days in a week
- VCT services should be provided only by trained health worker or nurses as counselors
- Strengthen posttest counseling for HIV positive clients on prevention with positives [positive living]
- All HIV positive clients should be encouraged on result disclosure and partner HIV testing

- All clients diagnosed as HIV positive should be immediately linked to HIV chronic care/ART
- Strengthen post-test counselling for HIV negative clients on primary prevention
- Encourage all ongoing high risk HIV negative clients to be re-tested for HIV as per the national guidelines
- Encourage couple counselling and testing for all VCT client

Provider Initiated Testing & Counselling (PITC)

- PITC services shall be integrated and delivered into all health services of the health facility and encouraged to be done at point of services
- PITC services need to be delivered 24 hours and seven days in a week
- PITC services should be provided by all trained health care professionals [nurses, health officers and physicians]
- PITC service provided to targeted clients/patients with HIV unknown status coming to the health facility and be offered as an opt-out service
- It provides pre-test information and strong posttest counseling for HIV negative clients on primary prevention
- Encourage all ongoing high risk HIV negative clients to be re-tested for HIV as per the national guidelines
- Strengthen posttest counseling for HIV positive clients on prevention with positives [positive living] and RH services
- Provider encourage HIV positive status disclosure and partner HIV testing
- All HIV positive clients diagnosed as HIV positive at all service units should be immediately linked to HIV chronic care/ART
- All providers should have to use PITC cue card for every client.
- All diagnosed HIV positive clients should be referred by escort and has to be linked.

Chapter 2: MONITORING AND EVALUATION

Learning objectives: By the end of this session the participants will be able to:

- Discuss recordkeeping and reporting needs of HTS
- Practice recording and reporting on HTS data and reports
- Describe the quality assurance in counselling
- Discus the referral and linkage system and good practice of linkage
- Describe HTS programs monitoring and evaluation

CONTENTS

- Recording and reporting of HTS
- Quality assurance on counselling
- Overview referral and linkage system and good practice
- Monitoring and evaluation including indicators for HTS

Definition of Records

- Records are generated when written instructions are followed. In other words, after data, information or results are recorded onto a form, label, etc., and then it becomes a record.
- Documents and records may be found as paper or electronic.
- Examples of documents include: country testing algorithm, IPC manual, SOPs for an approved HIV rapid test, manufacturer test kit inserts, temperature log (blank form) and quality control record (blank form).
- Examples of records that needs to be completed include: client test results, daily maintenance log book, stock cards and stock book, EQA specimen transfer log book, quality control record format, summary of findings from onsite evaluation visit and report of recommended corrective actions.

Practice of Recording

- Keeping accurate records of critical medical information is an important function of the clinic staff. The records are used for tracking clients' clinical care, public health surveillance purposes and evaluating program performance.
- Currently, most clinics record data about each client visit using client record card. Some clinics use logbooks or registers to record client information and others use both. Information about HTC and other HIV activities needs to be added to client record cards as well as logbooks/registers.
- The best method for assuring accurate information at *woreda*, zonal, regional or national level is to supply preprinted logbooks with labeled columns for each required data item and also periodic monthly or quarterly report forms.
- In the absence of these preprinted logbooks, clinics will need to determine how they will record the additional information. As with all client information, clinic staff must do their best to ensure complete confidentiality of client cards and logbooks—particularly with the inclusion of HIV-related information that could prove harmful to clients if improperly released.

HIV Testing Services Recording

Documents are written policies, process descriptions and procedures used to communicate information. They provide written instructions for HOW to do a specific task.

Records are generated when written instructions are followed. In other words, after data, information or results are recorded onto a form, label, etc., and then it becomes a record.

Documents and records may be paper or electronic.

Examples of documents include: country testing algorithm, safety manual, SOPs for an approved HIV rapid test, manufacturer test kit inserts, and quality control record (blank form).

Examples of records include: client test results, summary of findings from onsite evaluation visit, report of corrective actions, stock cards and stock book (completed), and EQA result submission form (completed).

Verbal instructions often are not heard, misunderstood, quickly forgotten and ignored. Policies, standards, processes and procedures must be written down, approved and communicated to all concerned.

It is recommended that you keep these records at your test site:

- HIV positive referral feedbacks
- HIV test request/client test result
- IQC records
- Post Test client feedbacks
- HTS register
- Inventory records/ IFRR forms (completed)

Types of information captured on test records when testing is requested by different units include:

- Client/Client MR number
- Date of test
- Results from Test 1, Test 2 and Test 3
- Repeat results
- HIV status
- Kit name and lot number
- Person performing test

Storage of logbooks and records should be kept in a manner that will minimize deterioration. Although many sites use paper based logbooks and records, they should be indexed so that they will be accessible while they are needed.

7.1 Recording and Reporting of HTS

Documents are written policies, process descriptions and procedures used to communicate information. They provide written instructions for how to do a specific task. Blank forms are also considered documents. Forms are used to capture data or information from performing a procedure.

There are a number of items that need to be recorded and reported on a regular basis, daily or monthly. There is a reporting and monitoring checklist provided as a handout for you.

Here are some tips for good record-keeping:

- Understand the information to be collected. Before you record any information, make sure that you understand what is to be collected
- Record the information every time. Record on the appropriate form each time you perform a procedure.
- Record all the information. Make sure you have provided all the information requested on a form.
- Record the information the same way every time. Be consistent.

The health facility providing HTS need to assign responsible persons at different service points for the following:

- Making sure logbooks are being filled out correctly.
- Making sure all posters are in place and not worn out.
- Checking supply of brochures.
- Checking the supply of condoms.
- Making sure that all providers are using a private space for discussion with clients.
- Checking with providers to see how things are going. (Discuss any problems.).

7.1. Quality assurance on counseling

Quality assurance (QA) is the activities that ensure processes are adequate for a system to achieve its objectives

Sample monthly quality assurance checklist

Name of person completing this form:

Date:

_____ Are all registers and logbooks being filled out correctly?

_____ Are all posters, HTC protocols in place and not worn out?

_____ Is there a sufficient supply of brochures?

_____ Is there a sufficient supply of condoms?

_____ Are all providers using a private space for discussion with clients and use cue cards?

_____ Are providers comfortable with the way things are going? Discuss any problems.

Below, list any problems identified and the solutions you will implement.

_____
_____
_____
_____

Purpose of HTS Quality Assurance

- Ensure consistent and disciplined delivery of the intervention components
- Enhance HTS providers skills in delivering the intervention
- Provide feedback and support to HTS counselors
- Create a collaborative and competent counseling team

Recommended HTS quality assurance measures

The following are essential HTS Quality Assurance Activities:

1. Use HTC Session Guide Cue Cards
2. Observe HTC Session and Provide Feedback
   - The counselor obtains permission from the client. The counselor explains to the client that the supervisor is assisting the counselor in enhancing the quality of services he or she provides.
   - The supervisor sits where he or she can observe the counselor but can avoid obstructing the client-counselor interaction.
   - Counselor/providers should be supervised at least every month, and the supervisor does not participate in the session. He or she quietly observes the session and takes brief notes on the "VCT Session Quality Assurance Guide."

7.2. Overview referral and linkage system

Definition of Client referral

Client Referral: It is a process by which client's immediate need for care and support services are assessed and get helped to access services, such as setting up appointments or giving directions to facilities. Referral should include reasonable follow-up efforts to facilitate contact between service providers and solicit feedback to clients and service providers. Referral is also a process of sending HIV positive clients from the point of testing to care and treatment with referral form.

Definition of linkage to care and treatment

Linkage is the process whereby client refereed from point of testing service to care and treatment service and the engagement of newly diagnosed clients when enrolled (undergo for retesting , formats are field up like intake form in to care and treatment service attaining at least one service during a visit.

It is critical for people living with HIV to enrol in care and treatment service as early as possible. This enables both early assessment of their eligibility for ART and timely initiation of ART as well as access to RH interventions to prevent the further transmission of HIV, prevent other infections and co-morbidities and also to minimize loss to follow-up.

Good practices for linkage to care from HTS sites

The following are recommended good practices to improve linkage of HIV positive person to care and treatment services after the person is found positive at HTS provision sites: This can be achieved by iimplementing standardized service delivery system that will improve referral and linkage between HTS and HIV chronic care service sites through the following recommended priority interventions:

- Prepare SOP for inter and intra- facilities service outlets referral linkage system
- Establish site level support groups to improve escorting and feedback practices for intra-facility referral
- Mapping and establishing network between available HTS, chronic care, and other support services in the area

- Develop and use standardized documentation, reporting and feedback system to priority intervention
- Harmonize site level HTS and chronic care registers, reporting formats, referral and feedback formats (in line with HMIS)
- Ensure the availability and sustainability of recording and reporting formats
- Ensure a referral and linkage feedback mechanism in health facilitate
- Ensure standardization of HTS guidelines and training materials on referral and linkage issues,
- Ensure utilization of both VCT and PITC implementation manuals with referral and linkage issues
- Improve the involvement of Health Extension Workers (HEW), PLHIVs in awareness creation activities as to improve referral and linkage to Priority interventions
- Support HEWs in their day to day IEC/BCC activities in relation to facilities that provide HIV related care and treatment services
- Establish and strengthen PLHIV associations and support groups to be involved on the facilitation of referral and linkage through escorting and other mechanisms
- Develop IEC/BCC materials focusing on stigma and discrimination that will help linkage of clients to services
- Advocate gender equality that reduce linkage
- Increase media utilization focusing on referral and linkage
- Take a visible leadership role in community activities to address stigma and discrimination through contextually available values and norms of the community
- Identify and analyze the root cause of stigma and discrimination.

  Involve PLHIV to reduce stigma and discrimination and to be part of prevention and care services.
- Promote health seeking behaviour and encourage HIV positive people for service utilization through Priority interventions
- Educate clients on benefits of chronic care and other misconception

- Involve local officials, political leaders, community and Faith based organization leaders to advocate the advantage of standard referral and linkage
- Involve HEWs and other sectors such as agricultural extension workers, education workers, youth associations, women's associations, PLHIV and their associations and etc. to aware the problem of referral and linkage and collaborate to resolve it.

DISCUSSION POINTS

- Determine the process for contacting the ART clinic and who is responsible for contacting the ART clinic and setting up a meeting?
- Review the list of issues to be discussed at the meeting with the HIV care clinic and make any additions. (Prepare a sample list.)
- Where and how to get medications the client is taking for other conditions
- Discuss the use of a referral note that the client will give to the HIV care provider. (See sample provided.)
- Review the sample referral note and make any necessary changes.
- Discuss possible list of support services that the client needs to get both in the facility and outside.
- Discuss possible list of support organizations and associations in the community that the client may be referred other than the HIV care clinic.

Key points:

- The clinic doing the HIV testing will need to notify the HIV care and treatment clinic of the intent to test all clients (those who require HIV testing) for HIV. Discussions with the HIV care clinic will be necessary to ensure that referrals of HIV-positive clients will be handled properly by the HIV care clinic. For clients who are referred, the HIV care clinic will need to know that an HIV test has been performed and is positive. The HIV clinic will also need to know the client's medications.

- HIV-positive clients, particularly when they become sick, need different support. Many clients also need support when they first learn that they are HIV-positive. They may need help in discussing their HIV status with their family and adjusting to the results.
- Although the clinic where the HIV testing is done may not be able to provide this support, the clinic needs to inform clients about services that are available in the community or connected with the HIV clinic.

7.3. Monitoring and evaluation

Monitoring:

- **Monitoring** is the use of assessment techniques to measure the performance of an organization, person or specific intervention (e.g., HTS intervention) in order to:
    - Make improvements or changes by identifying those aspects that are working according to plan and those that are in need of mid-course corrections
    - Track progress toward the performance standards that were set
- Monitoring of program activities is a critical function. Data from monitoring activities can be used for a variety of purposes.
    - Data from monitoring help clinics know and document what they have done. For example, how many clients did the clinic test for HIV this month?
    - Data from monitoring help clinics know how well they are achieving program objectives. For example, did a lot of clients refuse?
    - Data from monitoring help with program management. For example, by monitoring the number of clients tested, clinics will know how many HIV test kits need to be ordered each month.
    - Data from monitoring help determine the impact of programs on the health of clients. For example, by monitoring the number of people tested at the clinic, they can measure the success of HIV testing programs.

Evaluation:

- **Evaluation** is the process of using the data that clinics collect through their monitoring activities to guide program improvement. For example, if one clinic sees

a total of 300 clients each month, but they have only tested 50 of them the next months, they need to find out the reason and should try to solve the problem.

Clinics might then have a meeting to discuss the reasons that most clients are not being tested and decide how to change their program to facilitate greater numbers of clients being tested. For monitoring and evaluation purposes, clinics will need to collect data on a number of indicators.

Indicators: are data items that are being monitored. In many cases, the *woreda*, zonal health office or the regional health bureau request the clinic to report indicators on a regular basis (monthly or quarterly).

Below is a table with a list of sample indicators and data sources. These indicators represent the minimum amount of information. Your clinic may want to collect additional indicators for better program monitoring and evaluation.

Indicators that can be identified for HTS

INDICATOR	**SOURCE OF DATA**
Number of clients got pre-test HIV Counselling	Clinic or lab logbook and tally sheet
Number of clients tested for HIV	Clinic or lab logbook and tally sheet
Number of clients received post-test HIV counseling	Clinic log book
Number of clients who tested HIV-negative	Clinic or lab logbook and tally sheet
Number of clients who tested HIV-positive	Clinic or lab logbook and tally sheet
Number of HIV-positive clients who are referred and linked	Clinic log book
Proportion of couples received HIV Testing and Counseling	Clinic log book

Module Summary

- The clinic doing the HIV testing will need to notify the local HIV care and treatment clinic of the intent to test all eligible clients for HIV.
- Keeping accurate records of critical medical information is an important function of the clinic staff.
- Monitoring is the use of assessment techniques to measure the performance of an organization, person or specific intervention.
- Evaluation is the process of using the data collected through monitoring activities to guide program improvement.

Annex: 1

Case Scenarios for HTC Record / Report and (M / E) Part

1. Selam, 28 Years of age, was living in A.A for more than 7 years with her husband who was a driver. They came to your health center, Selam and Her husband, Moges, 38 Years of age, together received couple HIV test, found both Negative.

2. Meseret is a 19 year-old who dropped out from grade 11 last year. She lives in A.A City in a rental house with her two friends who are working at the same bar. The bar that Mesret and her friends working at are of the famous and known bar in the town .She received, HIV test and found positive. Agreed to follow a medical care in your facility. For Mesesret even though it is she seldomely use condom correctly, get condom demonstration, ready to disclose to her steady partner, Elias and consensus to have test for him too. .

3. Yohannes, Age 14 was living in A.A with his parents. He and His Mother, 40 years of age, received HIV test, found positive and his mother negative. Now, Yohannes and his mother ready to continued care and follow up.

4. Addeszemen, 30 years of age, lives in A.A, a taxi driver. He is divorced about 6 months ago. Now Addeszemen came to your clinic to get HIV test because his girlfriend, 34 years of age, who has been tested a week ago disclosed him, her test, found negative on your Counseling and HIV Testing. Addeszemen and his girlfriend now came to receive CHTC, he founds to be positive, discordant couple, and they agreed to continue with their relationship, by using condom continuously and correctly. Got condom demonstration, agreed to continuum care and follow up at your health center, not reach consensus in disclosing the result to other and post pone to disuss the issue well with themselves. .

5. Selamawit a 28-year-old woman, finance officer, lives in A.A came to your health center, C/C of headache, cough, chest pain, You provide and offer her, HIV test well, found negative test, ready to disclose to her husband and will make him also to get HIV test.

Federal Democratic Republic of Ethiopia
Ministry of Health

VOLUNTARY COUNSELING AND TESTING (VCT) REGISTRATION

Serial No.	Date (DD/MM/YY)	Client Code	Couple Code	Age	Sex (M/F)	PreTest Counseling Offered (√)	HIV Test Accepted (√)	Final HIV Test Result (R or NR or I)	Received HIV Test Result (√)	Post-test Counseled (√)	If positive and linked to care and treatment (Write MRN)	Screened for STI (√)	Result of STI screen (P or N)	Positive& referred for STI (√)	Screened for TB (√)	Result of TB screen (P or N)	Positive& referred for TB (√)	Target population Category*	Referral (enter the Code)**	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)

Column 19 Targeted population category *

A. Female Commercial Sex workers

B. Long distance drivers

C. Mobile workers/daily laborers

D. Prisoners

E. OVC/Children of PLHIV

F. Other MARPS

G.General Population

Column 20 Referral **

1=Referred to other facility for care and treatment

2= Psycho -Social services

3 = ANC (PMTCT)

4 =PLHIV Association

5 = Family Planning

6 = Post Test Club

7 =Other (Specify)

VCT TALLY SHEET

Target population Category	Male																													
	<1 years				1-4 years				5-9 years				10-14 years				15-19 years				20-24 years				25-49 years				50+			
	HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received	
	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count
	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)
Female Commercial Sex workers																																
Long distance drivers																																
Mobile workers/daily laborers																																
Prisoners																																
OVC/Children of PLHIV																																
Other MARPS																																
General Population																																
	sum tests performed		sum tests positive		sum tests performed		sum tests positive		sum tests performed		sum tests positive		sum tests performed		sum tests positive		sum tests performed		sum tests positive		sum tests performed		sum tests positive		sum tests performed		sum tests positive		sum tests performed		sum tests positive	

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. Female Sex workers

B. Long distance truck drivers

VCT TALLY SHEET

Target population Category		<1 years				1-4 years				5-9 years			
		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received		HIV Test Result Received		Positive Result Received	
	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally	Count	Tally
	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Female Commercial Sex workers													
Long distance drivers													
Mobile workers/daily laborers													

Logbook for HIV Rapid Testing

Federal Ministry of Health

Testing Site Name: _____

Region:_____

Log book Start Date : _____/_____/

Logbook End Date : _____/_____/_

Testing Site Type (Check)

- **VCT**
  - ☐ Integrated
  - ☐ Stand alone
  - ☐ Mobile
- **PITC**

☐ TB clinic

☐ STI clinic

☐ PMTCT

☐ L&D ☐ PNC

☐ General OPD

☐ Inpatient

☐ ART clinic

☐ Emergency

Algorithm (circle)

- **Serial**
- **Parallel**

Logbook Number (1, 2, …) : _____

☐ Other (specify)_____

_____

_____

Instructions for Using Standardized Logbook to Reco

1. Introduction and Background

This logbook is being tested as a tool to streamline the work pro
workload lighter and more efficient. Additionally this log book is
For example, never use "white-out" if a mistake is made. Inste
Quality Assurance purposes. Everyone makes mistakes. Knowing
TOTALS at the bottom of each page will be used to evaluate the
same test kit repeatedly for Test-1, Test-2, and Test-3. When
TOTALS are restricted to one test kit. Please use black or blue i
below for each of the data fields (columns) in the logbook. The gu
please be aware of differences in kits and follow manufacturer gui

2. Columns in the Logbook

1. Serial Number

Print consecutive numbers in each row. Each row is associated wit
more than one row. For example, if one of the tests is invalid (I
made in the Comments field and results of the repeat test are re
form).

2.2 Patient/Client Code.

Transfer client code or patient code – might be known as IP (inpa
if available. Most sites have intake registration forms that conta
names on this Rapid Test logbook for confidentiality reasons.

2.3 Age

Print age in years. If exact age is not known, please estimate.

2.4 Sex

Circle **M** for male and **F** for female.

2.5 Date Tested – Ethiopian Date

Print exact date when test was performed, using this format: day/m

2.6 Test-1 Kit Name, Lot Number, Expiration Date

Write the kit name, lot number, and expiration date in the space pr
a new page so that PAGE TOTALS are restricted to one test kit. K

Test-1 Results

Record results of the FIRST test performed in this section – accord

For **NON-REACTIVE** result, circle **NR**. No SECOND
For **REACTIVE** result, circle **R**. For all reactive FIRST
results are recorded in the Test-2 section).
For **INVALID** result, circle **INV.** The test is invalid if th
patient/test window. If this happens, record this result (c
on the next row (see sample form, rows 1 & 2).

2.7 Test-2 Kit Name, Lot Number, Expiration Date

Same as 2.7.

Test-2 Results

Record results of the SECOND test performed in this section – acc

For **NON-REACTIVE** result, circle **NR**.
For **REACTIVE** result, circle **R**.
For **INVALID** result, circle **INV.**

Is a THIRD (Tie-Breaker) test needed? If results of the FIRST a
not needed. Proceed to the section on **Final Results**.

If results of the FIRST and SECOND

For **INVALID** result, circle **INV.**

2.9 Final Results

Use the following table as a guide for interpreting Final Results:

SERIAL Scenario	Test-1	Test-2	Test-3 (Tie-Breaker)	Final Results
1	NR	Not Needed	Not needed	**NEG**
2	R	R	Not needed	**POS**
3	R	NR	R	**POS**
4	R	NR	NR	**NEG**

2.10 Tester

Print Name of Person performing this test.

2.11 Comments

Use this section for recording additional information. For example, if a test is recorded as invalid (INV) – this field can be used to indicate the row number below on which results of the repeat test is performed (see sample form). Another example: if the person tested should return for additional testing (such as repeated indeterminate results or the window period), please write this in the comments field. Can use coded list at bottom. PT/EQA samples coming from external body will also be treated as patient samples so that all the necessary data which are required by the log sheet (except Age, sex, couple code etc..) will be completed after performing the test. For example in lieu of client code , tester should write PT code number and indicate a remark on the comments column of the same row.

3. Page Totals

This feature is meant to assist with preparing montly reports. **Page totals should be tallied after each page is completed.** This will help identify higher than normal levels of indeterminate/discrepant results where Test 1 is R and Test 2 is NR.

4. Supervisor

This space is for an onsite or external supervisor to monitor work of testers.

MONTHLY SUMMARIES

Specify Month and Year ___________________________________ Specify Month and Year ___________________________________

TOTAL POSITIVE __________ MALE __________ FEMALE __________ TOTAL POSITIVE __________ MALE __________ FEMALE __________
TOTAL NEGATIVE __________ MALE __________ FEMALE __________ TOTAL NEGATIVE __________ MALE __________ FEMALE __________
TOTAL INDETERMINATE __________ MALE __________ FEMALE __________ TOTAL INDETERMINATE __________ MALE __________ FEMALE __________

Specify Month and Year ___________________________________ Specify Month and Year ___________________________________

TOTAL POSITIVE __________ MALE __________ FEMALE __________ TOTAL POSITIVE __________ MALE __________ FEMALE __________
TOTAL NEGATIVE __________ MALE __________ FEMALE __________ TOTAL NEGATIVE __________ MALE __________ FEMALE __________
TOTAL INDETERMINATE __________ MALE __________ FEMALE __________ TOTAL INDETERMINATE __________ MALE __________ FEMALE __________

Specify Month and Year ___________________________________ Specify Month and Year ___________________________________

TOTAL POSITIVE __________ MALE __________ FEMALE __________ TOTAL POSITIVE __________ MALE __________ FEMALE __________
TOTAL NEGATIVE __________ MALE __________ FEMALE __________ TOTAL NEGATIVE __________ MALE __________ FEMALE __________
TOTAL INDETERMINATE __________ MALE __________ FEMALE __________ TOTAL INDETERMINATE __________ MALE __________ FEMALE __________

Specify Month and Year ___________________________________ Specify Month and Year ___________________________________

TOTAL POSITIVE __________ MALE __________ FEMALE __________ TOTAL POSITIVE __________
MALE __________ FEMALE __________
TOTAL NEGATIVE __________ MALE __________ FEMALE __________ TOTAL NEGATIVE __________
MALE __________ FEMALE __________
TOTAL INDETERMINATE __________ MALE __________ FEMALE __________ TOTAL INDETERMINATE
__________ MALE __________ FEMALE __________

Specify Month and Year ______________________________ Specify Month and Year
____
TOTAL POSITIVE __________ MALE __________ FEMALE __________ TOTAL POSITIVE __________
MALE __________ FEMALE __________
TOTAL NEGATIVE __________ MALE __________ FEMALE __________ TOTAL NEGATIVE __________
MALE __________ FEMALE __________
TOTAL INDETERMINATE __________ MALE __________ FEMALE __________ TOTAL INDETERMINATE
__________ MALE __________ FEMALE __________

Specify Month and Year ______________________________ Specify Month and Year
____
TOTAL POSITIVE __________ MALE __________ FEMALE __________ TOTAL POSITIVE __________
MALE __________ FEMALE __________
TOTAL NEGATIVE __________ MALE __________ FEMALE __________ TOTAL NEGATIVE __________
MALE __________ FEMALE __________
TOTAL INDETERMINATE __________ MALE __________ FEMALE __________ TOTAL INDETERMINATE
__________ MALE __________ FEMALE __________

Specify Month and Year ______________________________ Specify Month and Year
____
TOTAL POSITIVE __________ MALE __________ FEMALE __________ TOTAL POSITIVE __________
MALE __________ FEMALE __________
TOTAL NEGATIVE __________ MALE __________ FEMALE __________ TOTAL NEGATIVE __________
MALE __________ FEMALE __________
TOTAL INDETERMINATE __________ MALE __________ FEMALE __________ TOTAL INDETERMINATE
__________ MALE __________ FEMALE __________

Specify Month and Year _____

_____

TOTAL POSITIVE _____ MALE _____ FEMALE _____

MALE _____ FEMALE _____

TOTAL NEGATIVE _____ MALE _____ FEMALE _____

MALE _____ FEMALE _____

TOTAL INDETERMINATE _____ MALE _____ FEMALE _____

_____ MALE _____ FEMALE _____

Specify Month and Year

TOTAL POSITIVE _____

TOTAL NEGATIVE _____

TOTAL INDETERMINATE

Specify Month and Year _____

_____

TOTAL POSITIVE _____ MALE _____ FEMALE _____

MALE _____ FEMALE _____

TOTAL NEGATIVE _____ MALE _____ FEMALE _____

MALE _____ FEMALE _____

TOTAL INDETERMINATE _____ MALE _____ FEMALE _____

_____ MALE _____ FEMALE _____

Specify Month and Year

TOTAL POSITIVE _____

TOTAL NEGATIVE _____

TOTAL INDETERMINATE

Specify Month and Year _____

_____

TOTAL POSITIVE _____ MALE _____ FEMALE _____

MALE _____ FEMALE _____

TOTAL NEGATIVE _____ MALE _____ FEMALE _____

MALE _____ FEMALE _____

TOTAL INDETERMINATE _____ MALE _____ FEMALE _____

_____ MALE _____ FEMALE _____

Specify Month and Year

TOTAL POSITIVE _____

TOTAL NEGATIVE _____

TOTAL INDETERMINATE

Couple Code	Counselor Code	Target population Category*	Requesting Unit	Reason for Testing	Age (Specify if not in years)	Sex	Ethiopian Date (dd/mm/yy)	HIV Test-1* Kit Name ____ Lot No. ____ Expiration Date ____/____/____	HIV Test-2* Kit Name ____ Lot No. ____ Expiration Date ____/____/____	HIV Test-3* Kit Name ____ Lot No. ____ Expiration Date ____/____/____	Final Results**	Referred to	Tester Initials
(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		
						M F	/ /	NR R INV	NR R INV	NR R INV	NEG POS IND		

umn 5 Targeted population category *

emale Commercial Sex workers
ong distance drivers
obile workers/daily laborers
risoners
VC/Children of PLHIV
ther MARPS
eneral Population

Column 6 Requesting Unit:

A *– VCT*
B *– TB*
C *– STI*
D *– PMTCT*
E *– Outpatient*
F *– Inpatient*
G *– Emergency*
H *– Other (specify)* _____

3. PAGE TOTALS

Total non-reactive/negative				
Total reactive/positive				
Total invalid*				
Total indeterminate**				
Total tests				

est is considered invalid (INV) if control line does not develop, irrespective of presence or absence of client line. If invalid, please record and repeat using the same test on a new row.
Final interpretation is considered indeterminate (IND) if Test-1 and Test-2 results are not the same and a 3rd Test (tie-breaker) is not available.

4. **Supervisor Signature and Date** _____

REFERENCES

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- UNAIDS 2015/16 Global updates
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