Ministry of Health

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Strengthening Ethiopia's Urban Health Program (SEUHP)

John Snow Inc. Addis Ababa, Ethiopia

Core Public Health Training for Ethiopia's Urban Health Extension Professionals

HIV Module

2015

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
BMI	Body mass index
CHCT	Couple HIV counselling and testing
HAART	Highly active antiretroviral treatment
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
IPC	Interpersonal communication
LGV	Lymphogranulomavenerum
MARP	Most-at-risk-population
MTCT	Mother-to-child transmission
PEP	Post-exposure prophylaxis
PLHIV	Person/people living with HIV
PMTCT	Prevention of mother-to-child transmission
STI	Sexually transmitted infection
UHE-p	Urban health extension professional
UHE-P	Urban Health Extension Program

INTRODUCTION

The HIV and AIDS module prepares Urban Health Extension professionals (UHE-ps) to provide HIV-related services including reaching vulnerable populations with key HIV prevention messages, HIV counseling and testing(HCT), care and support, and referrals to services. This module will help UHE-ps understand the social ecology of HIV issues as they offer tailored services to vulnerable populations.

General objectives:

By the end of this module, UHE-ps should be able to:

- Analyze social ecology and interconnections between factors.
- Identify risks and vulnerabilities and explain their connection.
- Explain the importanceof prevention of maternal-to-child transmission (PMTCT) of HIV, national strategies for PMTCT, and UHE-p role in PMTCT.
- Explain how to screen for Sexually Transmitted infections(STIs) and refer for treatment.
- Enhance skills on HIV risk assessment, testing, and helping clients develop risk-reduction and follow-up plans.
- Identify factors that reduce adherence to treatment, retention, and how UHE-ps can help clients overcome them.
- Explain the relation between HIV and nutritionand Water, Sanitation and Hygiene(WASH).

Note for the facilitator:

The facilitator displays the module objectives on a flip chart or slides.S/he shall explain the sessions to be covered by this module and the overall expected time to complete it. (15 min)

Table 1. ASK analysis of HIV module

ATTITUDE	SKILL	KNOWLEDGE
▪ Non-judgmental ▪ Respectful ▪ Self-worth ▪ Flexible ▪ Empathetic ▪ Equitable ▪ Open-minded ▪ Confidential	▪ Effective inter-personal communication (IPC) ▪ Knowledge for problem solving ▪ HIV counseling skills	▪ Social ecology ▪ UHE-p role in HIV and AIDS prevention and care ▪ Risk and vulnerability ▪ Infection prevention ▪ Post-exposure prophylaxis(PEP) ▪ PMTCT strategy ▪ Gender issues ▪ HCT protocol and algorithm ▪ Adherence and retention in care ▪ HIV and nutrition ▪ HIV and WASH

TIME ALLOCATED: 18 hours (3 days)

Module contents:

Session 1: Social ecology in the context of HIV risk and vulnerability

Session 2: Prevention of HIV

Session 3: Care, support, and treatment

Session1.Social ecology in the context of HIV risk and vulnerability

Session objectives:

- Enhance the problem-solving skills of UHE-ps by using the social ecology theory to explain complicating factors to accessing services.
- Explain risk and vulnerability and connections between them for different groups.

ACTIVITY1.1. SOCIAL ECOLOGY

PURPOSE

The purpose of this activity is to help UHE-ps understand the social ecology of HIV and the possible barriers to accessing services. Based on this, they will be able reduce these barriers to help clients access high-quality HIV related services.

TRAINING METHOD: Group work and plenary discussion

MATERIAL REQUIRED/PREPARATION:

- Printed care scenarios
- Flip chart
- Marker
- Prepared social ecology model

TIME ALLOCATED: 90 MIN

STEP 1: Group brainstorm on what social ecology means.

STEP 2: Show the definition/concept of social ecology and solicit participants' reflections of what it means to them.

SOCIAL ECOLOGY:

Ecology is a descriptive term applied to complex relationships between organisms and their environment).social ecology is characterized by an interdisciplinary approach to the study of social and environmental problems that are examined at multiple levels of analysis and that involve analysis of interdependence.

Source: Hawley, 1950

UNDERLYING PRINCIPLES OF SOCIAL ECOLOGY:

- Identify a phenomenon as a social problem.
- View the problem from multiple levels and methods of analysis.
- Utilize and apply diverse theoretical perspectives.
- Recognize human-environment interactions as dynamic and active processes.
- Consider the social, historical, cultural, and institutional contexts of people-environment relations.
- Understand people's lives in an everyday sense.

STEP 3: Divide participants into four groups.(5min.)

STEP 4: Give each groups a copy of the case scenario below.

STEP 5: Assign the first group to individual factors, the second to community factors, the third to institutional factors, and the fourth to policy factors.(20 min.)

STEP 6: Once the groups discuss and list the factors, put them in the spaces of social ecology diagram already prepared where the factors belong to.(10 min.

STEP 7: Participants approach the social ecology diagram and discuss how the factors at individual level are linked with community, institution, and policy levels. (40 min.)

STEP 8: Seat people in pairs ask them to talk about how understanding social ecology can help them improve their performance and quality of services they provide as UHE-ps.(10 min.)

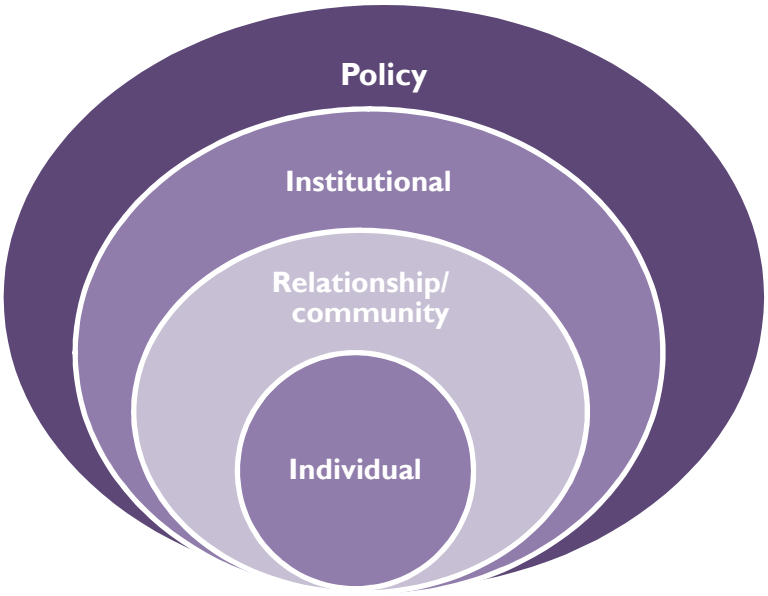


Diagram 1: Social Ecology

CASE SCENARIO:

Aster is 15 year-old-girl who came to Bahir Dar from rural area a year ago. She lives with her two friends in a dormitory. She was married for 3 years when she was in her village but left because her husband frequently hit her. Because she had no work experience, aster has been supporting herself through sex work. She is sick all the time and is worried and doesn't know what to do.

Activity1.2. Risk and Vulnerability to HIV

PURPOSE:

The purpose of this activity is to help UHE-ps identify vulnerable and at-risk groups in the community and understand how vulnerability increases risk. They also will explore their role in helping clients become aware of their situations and reduce vulnerability and risks.

TRAINING METHODS: Group work, presentation, and discussion

MATERIAL REQUIRED:

- Printed story
- Prepared definitions of risk and vulnerability
- Prepared risk and vulnerability cards
- Flip chart
- Marker

TIME ALLOCATED: 90 MIN.

STEP 1: Explain the purpose of this activity.(5 min.)

STEP 2: Ask if anyone can explain what meant by "risk of HIV infection"and **"**vulnerability to HIV infection"and discuss.(5 min.)

STEP 3: Distribute randomly to each participant the following cards (it is fine if several participants receive the same card).(5 min.)

- Lack of alternative jobs.
- Insufficient social security.
- Inadequate occupational health and safety conditions.
- Gender norms that disempower women.
- Peer pressure.
- Insufficient self-risk perception.
- Alcohol and substance abuse.
- Unsafe sex with casual partners.
- Lack of information about personal rights.
- Stigma and discrimination.

(Facilitators are encouraged to adapt cards or create additional ones as needed)

STEP 4: Post two heading cards with **"Risk of HIV infection"** and "**Vulnerability to HIV infection**" next to each other on a wall.

STEP 5: Explain that you will read the story below twice. As you read it, the participants will decide which cards are about risk and which are about vulnerability and post them under the corresponding sign. (5 min.)

STORY:

I am a 20-year-old girl living in Bahir Dar. I am a waitress at a hotel that tourists visit. I started working here when my parents died a year back because as the elder in the family I am responsible for supporting my siblings. The income is not enough to support the family and I am worried about how I can fulfil our needs.

I meet many guests in the hotel and some of them are interested in me. One who comes from Addis for business frequently told me he will support me to have a private business if I become his sexual partner. My friends and colleagues advised me to accept his request so I can become rich. On his next visit he asked me to stay with him for a night party. I accepted and I drank whisky for the first time. I did not exactly remember except I knew I found myself in his room in the morning. I think we had unsafe sex, but I am not sure and I do not know what to do.

STEP 6: Gather participants by the wall where the risk and vulnerability signs are posted.

STEP 7: Discuss how the participants categorized the cards. If the same cards are posted under both signs, ask the participants to explain their reasoning.(15min.)

STEP 8: Post the definitions of risk and vulnerability (shown below) near the already posted cards and discuss the definitions.(5 min.)

Risk of HIV infection: constitutes direct exposure that increases the probability that a person will acquire HIV infection.

Vulnerability to HIV: considers how social environment may increase risk of exposure.

STEP 9: Ask if the participants want to shift the placement of any cards following the discussion and posted definitions of risk and vulnerability. (30min.)

- How do the issues on the cards affect risk in real life for a girl like the one in our story?
- How do these issues interconnect and increase risk?
- Let's imagine that the girl in the story begins to practice safer sex. What vulnerability issues would make it difficult for her to sustain safer sexual behavior? Why? As UHE-ps, how could you help her?
- Do certain people experience these issues more than others in our society? Who? What barriers can you reduce to increase access to services for these people?How?

Note for facilitators: In the sample set of cards above, only unsafe sex with casual partners fits the definition of 'risk'.

STEP 10: Use the following questions and social ecology diagram to conclude discussions.(20 min.)

- If you met a girl like the one in the story, how could you help her to decrease her vulnerability? What could you do to help her decrease her risk?
- Do you see any relation to social ecology? How? (For example,alcohol abuse and peer pressure: her friend's encouragement and getting drunk made it easier for her to become the man's sexual partner).

Why is it important for UHE-ps to understand risk and vulnerability issues and their connection?

SESSION 2: Prevention of HIV

Specific objectives:

At the end of this session, UHE-ps will be able to:

- Define who vulnerable groups to HIV are.
- Explain the magnitude of maternal-to-child HIV transmission.
- Explain the PMTCT strategies and UHE-p role in them.
- Explain basic facts of common STIs (symptoms, transmission modes, complications, prevention activities).
- Demonstrate the HIV counseling and testing (HCT) protocol (pre-test, test and post-test).

Activity 2.1.Defining and reaching vulnerable groups with HIV prevention

PURPOSE: The purpose of this activity is to enable UHE professionals to be able to identify MARPs and other vulnerable groups and provide them with HIV prevention services.

TRAINING METHODS:

- Paired discussion and reflection

MATERIALS REQUIRED:

- Reach protocol hard copies for all participants

TIME ALLOCATED: 50 MIN.

STEP 1: Describe the purpose of the activity. (5min.)

STEP 2: Ask participants to list the MARPs and other vulnerable groups in the community (15 min.)The co-facilitator will write responses on a flip chart.

STEP 3: Show the participants the list of MARPs and vulnerable groups according to GOE HIV prevention guide (listed below), including prevention with positives. Discuss the similarities and differences with the list of vulnerable groups mentioned in the guide of FHAPCO developed in 2011 to reach MARPs and vulnerable populations.

Note for the facilitator: Display the following list of vulnerable groups on a flipchart.

- Sex workers
- Drivers
- Daily laborers
- PLHIV and household members
- People who have STIs
- TB patients
- Partners of the above target groups
- Pregnant women

STEP 4: Ask participants how they are currently providing HIV-related services to these groups of people. What tools are the UHE-ps using to reach MARPs and vulnerable groups with HIV prevention interventions and how are they using them?

STEP 5: Distribute the "Reach protocol" to participants, let them discuss in pairs with next person (15min.).

REACH PROTOCOL

"To Reach" an individual/group with HIV prevention services	
In HIV prevention intervention, service providers can only say someone is "reached" when an individual/group is identified as a vulnerable person/group, supported by a self-assessment using the vulnerability/risk assessment tool, and after developing an informed risk reduction plan that includes the provision of targeted service(s).	
Criteria to report an individual/group "is reached" with HIV prevention service	
▪ Individual/group must be identified as a vulnerable person/group using occupational proxy, through model household interaction and through household visits ▪ Vulnerability/risk assessment should be conducted, however it is critical that rapport is establishedwith the identified individual/group to facilitate the assessment; the risk assessment should be conductedusing the standard checklist/guide ▪ An individual risk reduction plan should be developed that includes referral &linkages; ▪ A follow up plan should be developed with the individual/group to ensure implementation of the risk reduction plan	
Rapport Building	▪ Rapport building is one of the most important characteristics of communication. Building rapport includes certain techniques such as maintaining eye contact with a client; mirror posturing (matching a client's posture), emotional mirroring/understand, etc. to gain a client's trust and confidence. Rapport makes service providers and clients comfortable with each other to disclose sexuality or discuss HIV vulnerability issues.
Risk Assessment	▪ The HIV risk assessment is an interactive process, i.e. the health worker or provider is a "facilitator" to help develop awareness of how the person might have been at risk. It is critical that the person "owns" his/her assessment. This process takes the person through denial, fear, and a deep-seated self-perception of risk that may take time to be re-assessed. This assessment process may happen in more than one visit.
Risk Reduction Plan	▪ It is an action plan that an individual develops after assessing her/his risk level with the support of the health provider to reduce the risk of contracting HIV.
While Assessing the risk, discus the following issues	1. How the person is protecting him/herself from HIV/STI. If she/he is using condoms correctly and consistently 2. If an individual is involved in unprotected vaginal, anal, or oral sex 3. If an individual has untreated sexually transmitted infections 4. If an individual is sharing sharp materials such as razors and needles with others 5. If an individual is in contact at any time with blood or other bodily fluids of someone who is HIV+ or has AIDS
The risk reduction plan has to include the following actions:	
1. Being faithful to your partner or reducing the number of partners 2. Getting tested for HIV 3. Correct & consistent use of condoms and 4. Positively living to reduce further risk	

STEP 5: One of the pairs presents the reach protocol and discuss at a plenary. (15 min.)
STEP6: Conclude the session by asking participants how they will use the reach protocol when providing HIV prevention activities like Health education on HIV, and what its importance is.(5 min.)

Activity 2.2. TRUE or FALSE exercise on basics of HIV and AIDS

PURPOSE: The purpose of this activity is to enable participants to reflect on their perceptions of basic HIV service standards. It will also help them become aware of their beliefs, values, attitudes, and behaviors and how that affects the quality of the services they provide.

Note for the facilitator: The role of the facilitator is to stimulate thinking and reflection by asking effective questions. Suggested questions are indicated under each statement, but the facilitator should add and alter to the particular context. Once the UHE-ps decide TRUE or FALSE, the facilitator must avoid right/wrong debate and ask probing questions. S/he also should consider the overall session/activity allocated time to discuss all the statements and clarify misconceptions.

MATERIALS REQUIRED:

- Two cards; one written with "**TRUE,**" the other "**FALSE.**"
- Already prepared statements to initiate discussion.

TIME ALLOCATED: 80MIN.

STEP 1: Explain purpose of the exercise to participants. Post cards with words of "**TRUE**" or "**FALSE**" side-by-side on the wall.
STEP 2: The participants stand in a semi-circle around the facilitator, who is in front of the two posted cards.
STEP 3: The facilitator reads one statement and asks UHE-ps to stand by one or the other cards depending on which they think is the answer. Every participant must choose one or the other.
STEP 4: Ask a participant who said false why s/he chose that answer. Ask at least three more participants same question.
STEP 5: Ask a participant who said TRUE why s/he chose that answer. Ask at least three more participants to explain why.
STEP 6: If participants shift from one answer to another after hearing another person's reasoning, ask them to explain.

TRUE/FALSE statements and suggested follow-up questions for steps 4, 5, and 6 above.

1. **HIV IS MORE CONCENTRATED IN CERTAIN GROUPS OF PEOPLE THAN OTHERS.(10 MIN.)**

Possible probing questions:

- If yes, who are these groups?
- Why are these sub-populations particularly vulnerable to HIV? Can you link the reasons with the social ecology? How?
- Are you currently reaching these vulnerable populations and with what services?
- What are the challenges to providing services to these groups of people?

- Is it possible to reduce barriers and help these people access services? How?

NOTE FOR THE FACILITATOR: The purpose of this question and discussion is to enable them to recognize that there are groups of people who are more affected by HIV than others. The UHE-ps are expected to provide tailored services to these groups of people and link them to other facilities for extra services in line with combination prevention services.

Combination prevention coordinates behavioural (condom promotion, life skills, risk reduction counseling, peer education); biomedical (condom provision, clinical services, STI screening and treatment, PMTCT); and structural (economic strengthening, legal support, addressing stigma and discrimination, access to health services) intervention to maximize efforts to prevent HIV transmission.

2. **Women are more affected by HIV than men. (10 min.)**

Possible probing questions:

- If yes, why are women more affected than men?
- Are certain groups of women more vulnerable than others? If yes, why?

NOTE TO FACILITATOR: If the issue below was covered in the previous session, you may skip to the statement #4.

3. **Using two condoms during sexual intercourse gives double protection from STI and HIV transmission (10 min.)**

Possible probing questions:

- What issues do we need to consider while promoting and demonstrating condom?
- Who are our target groups to demonstrate condom? Why?

Note for the facilitator: The "two condoms are better than one" myth was created when it was reported that condoms aren't perfect and occasionally break. That led some people to believe that using two condoms (also known as "double bagging") is safer than using one. This is not true. If you use two condoms, they will rub against each other during penetration, create friction, and may could break or slide off.

4. **STIs occur because of sexual contact out of marriage. (10 min.)**

Possible probing questions:

- What are STIs?
- What causes them?
- Are there symptoms? If yes, what are some?
- What is your role as a UHE-p to prevent and manage STIs?

5. **Some people are less prone to HIV. (8 min.)**

Possible probing questions:

- What is discordance?

- How does discordance happen in couples?
- How long will the discordant result continue?
- What can you do to prevent infection of the uninfected partner?

Note for the facilitator: Discordant couples are those in an ongoing sexual relationship in which one partner is HIV-positive and the other is not. Both people in the relationship are referred to as a "partner."

How does discordance happen? The causes are still largely unknown. Some causes have been traced to the interrelation of the several factors ranging from transmission rates due to anatomical structure of male and female genitals where men are less vulnerable to contracting the virus than women; virulence of HIV strains; circumcision factors; and numbers of sexual partners and encounters.

What key messages should we give discordant couples?

- HIV discordance is common.
- Couples can remain discordant for a long time.
- HIV discordance is not a sure sign of infidelity.
- HIV is not transmitted in every exposure.
- Viral load is important in transmission, but it changes over time.
- No one is immune to HIV.
- HIV-negative partners in discordant couples are at very high risk of infection.
- Effective risk reduction options exist. (Don't forget about condom promotion, demonstration, and distribution).
- HIV transmission within discordant couples can be prevented

Source: http: //www.aidstarone.com/sites/default/files/AIDSTAROne_Technical_Brief_Serodiscordant_Couples.pdf and WHO guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in sero-discordant couples. Recommendations for a public health approach, April 2012

6. **There is no reason for partners who are both HIV positive to practice safer sex. (7 min.)**

Possible probing questions:

- What is the risk of having unsafe sex between concordant (positive) partners?
- What messages would you give to concordant HIV positive partners? Why?

7. **Infection prevention precautions are more useful for facility-based services than UHE-p services. (8 min.)**

Possible probing questions:

- What are the principles of infection prevention?

- What are you doing to prevent infection while providing services like HCT, FP-Depo? How do you manage waste generated during service provision?

Note for the facilitator: Infection prevention and control is required to prevent the transmission of communicable diseases in all health care settings. Infection prevention and control demands a basic understanding of the epidemiology of diseases; risk factors that increase patient susceptibility to infection; and the practices, procedures, and treatments that may result in infections. The basic principle of infection prevention and control is hygiene.

Standard precautions

Standard precautions are the minimum infection prevention measures that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These evidence-based practices are designed to protect health care personnel and prevent the spread of infections among patients. Standard precautions replace earlier guidance relating to universal precautions and body substance isolation. They include:

A. Hand hygiene

Hand hygiene can be undertaken using soap and water or hand sanitizers, namely alcohol hand gels. When used appropriately, alcohol hand gels are an efficient and effective way to disinfect hands.a considerable amount of gel needs to be used so that hands are wet. The entire procedure should last at least 20 seconds and calls for the same rubbing movements as hand washing. Hand sanitizers are not better than washing with water and soap, and if used incorrectly, they can be much less effective.

It is important that health workers perform hand hygiene:Before patient contact

- Before contact with a susceptible patient site (such as an invasive device or wound)
- Before an aseptic task
- After exposure to body fluids (blood, vomit, feces, urine,etc.)
- After glove removal
- After patient contact
- After contact with the patient's immediate environment

B. Use of personal protective equipment (e.g., gloves, gowns, facemasks) depending on the anticipated exposure

C. Respiratory hygiene and cough manners

D. Safe injection practices

E. Safe sharps best practices

Ensure that:

- Syringes or needles are disposed as a single unit and not dismantled by hand.

- Sharps are put in a sharps container for disposal.
- Sharps containers are readily available as close as possible to the point of use
- Needles are never re-sheathed, recapped, or reused.
- Needles are not broken or bent before use or disposal.
- Ensure safe disposal and transport of sharps used in a community setting such as patients' homes.
- Sharps containers (safety box) are not filled more than two-thirds.
- Sharps bins are stored away from the public and out of children's reach (e.g., not stored on the floor or at low levels).
- Staff report sharps injuries in line with local reporting procedures/policies.

Source: http: //www.cdc.gov/hai/settings/outpatient/basic-infection-control-prevention-plan-2011/fundamental-of-infection-prevention.html

8. **Post-exposure prophylaxis (PEP) service is provided within 3 months after exposure. (7 min.)**

Possible probing questions:

- What is PEP?
- Who is eligible for PEP?
- How is the service provided to the eligible persons?

Note for the facilitator: Post-exposure prophylaxis (pep) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, whether at work or during 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.

The aim of pep is to allow a person's immune system a chance to provide protection from the virus and to prevent HIV from becoming established in someone's body. It usually consists of a month-long course of two or three different types of the antiretroviral drugs that are also prescribed as treatment for people living with HIV. Because it is not 100 percent effective, post-exposure prophylaxis should only be used as a last resort.

Who is eligible for pep?

There is general consensus that the provision of pep should be judged on a case-by-case basis, and the decision about whether to administer pep should be made on a confidential and non-discriminatory basis, with informed consent. Some believe that the increasing availability of pep will lead to negative behavioural changes. The assumption is that if pep is readily available, people will be less likely to use condoms or will be less cautious because there is potential back up.

The following groups of people are eligible for pep:

1. People exposed to blood,bloody fluid, or needles sticks at work
2. Victims of sexual assault or rape

Post-exposure prophylaxis is not indicated:

- If the exposed person is HIV-positive from a previous exposure;
- If the exposure does not pose a risk of transmission, that is, after exposure of intact skin to potentially infectious body fluids; sexual intercourse using a condom that remains intact;exposure to non-infectious body fluids (such as feces, saliva, urine and sweat); exposure to body fluids from a person known to be HIV-negative, unless this person is identified as being at high risk for recent infection and thus likely to be within the window period.
- If the exposure occurred more than 72 hours previously.

Source : http: //www.avert.org/post-exposure-prophylaxis-pep.htm and POST-EXPOSURE PROPHYLAXIS TO PREVENT HIV INFECTION joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection (2007)

STEP 7: Close the session by having participants play the carousel game to talk about what they learned in the session and how it applies to their work. (10 min.)

NOTE FOR FACILITATOR: Carouselis a game/method of reflection. Divide participants in to two groups and sit them parallel rows in front of one another. Each person from the first group takes 1 minute to discuss new learning points and their professional importance with a person in the front row. One of the rows will shift to the right by one seat and proceed with the same discussion with each person for 1 minute.

Activity2.3.Prevention of mother-to-child transmission (PMTCT)

PURPOSE: The purpose of this session is to enable UHE-ps understand the importance of preventing maternal transmission of HIV to newborns, and to clarify their role in providing PMTCT services at each level of the National PMTCT strategy.

TRAINING METHODS:

- Group presentation and discussion

MATERIALS REQUIRED:

- Flip chart
- Marker
- Prepared tables

TIME ALLOCATED: 70 MIN.

STEP 1: Divide participants into four groups.(5min.)

STEP 2: Each group receives Tables 1 and 2 (shown below) and completes the information missing in the tables. (15 min.)

STEP 3: When the groups complete the tables, give them Tables 3 and 4 with full information and ask them to compare what they wrote on Tables 1 and 2 with what is written on Tables 3 and 4. Encourage them to discuss the differences. (10 min.)

STEP 4: Once the groups compared, ask the groups to continue discussing and filling the roles of UHE-ps at each prong in the National PMTCT strategy using the fourth column of table 4(15 min.)

STEP 5: Post their flipcharts on the wall. Gather the participants around the flipcharts and discuss responses one group at a time. (15 min.)

- How important is your role to the national strategy? What if you do not have any activity in PMTCT?

STEP 6: Provide additions and address misconceptions, if any, and ask them what they have learned from the session and how it will help them do a better job with PMTCT. (10 min.)

Table 1: Estimated risk of MTCT

Timing	Transmission rate without intervention
During pregnancy	
During labor and delivery	
During breastfeeding	

Table 2: National strategies for PMTCT

Prong	National strategy
Primary prevention of HIV infection	
Prevention of unintended pregnancies among HIV-positive women	
Prevention of HIV transmission from infected women to their infants	
Treatment, care, and support of HIV-positive women and their infants and families	

Table 3: Estimated risk of MTCT

Timing	Transmission rate without intervention
During pregnancy	5-10%
During labor and delivery	10-15%
During breastfeeding	5-20%

Table 4: National Strategies for PMTCT

Prong	National strategy	UHE-p role and why it is important
1. Primary prevention of HIV infection.	▪ Explain the Abstain, Be faithful, or Condom approach to protect reproductive-age people from becoming infected with HIV and other STIs. ▪ Provide voluntary counseling and testing services following the National HIV Counseling and Testing Guidelines. ▪ Promote correct and consistent use of condoms. ▪ Early diagnosis and treatment of STIs.	▪
2. Prevention of unintended pregnancies among HIV-positive women.	▪ Integrate family planning counseling at potential PMTCT and VCT service sites.	▪
3. Prevention of HIV transmission from infected women to their infants.	▪ Ensure availability of antiretroviral drugs and other appropriate supplies for PMTCT. ▪ Provide counseling services integrated with ANC, labor, and delivery and postnatal care. ▪ Safer obstetrical practices. ▪ Provide appropriate counseling on infant feeding and support. ▪ Promote exclusive breastfeeding.	▪
4. Treatment, care, and support of HIV-positive women, and their infants and families	▪ Provide pregnant women ART. ▪ Ensure appropriate follow-up of infants born to HIV-positive women including: OI prophylaxis and early infant diagnosis. ▪ Provide HIV testing for family. ▪ Link PMTCT with care and support initiatives organized for infants and HIV- positive women	▪

Activity 2.4.HIV counseling and testing

PURPOSE: The purpose of this session is to improve the capacity of UHE-ps to help clients self-assess their vulnerability to and risk of HIV infection.
UHE-ps help clients make informed decisions about what they can do to reduce their vulnerability and risk. All trainees should participate in the group work and role play to build communication, counseling, condom demonstration, and couple counseling skills so they can provide context-appropriate services.

TRAINING METHODS:

- Group work, role play, structured feedback, discussion

MATERIALS REQUIRED:

- HCT protocol for pre- and post-test
- Scenarios of different type
- Observer's checklist
- Flip chart, marker

TIME ALLOCATED: 9 HOURS (1.5 DAYS)

HIV PRE-TEST GROUP WORK (60 MIN.)

STEP1: Divide participants into four groups. (5 min.)

STEP2: Each group brainstorms the process of pre-HIV test counseling. Write the steps in a flip chart (15min.)

STEP 3: Distribute National HIV pre-test counseling guidelines to each group and ask them to compare what they wrote with it. Ask the groups to respond to the following discussion questions. (20min.)

- What benefits do the steps in the protocol have for the client?
- What would happen if you did the process without these steps?
- What differences are there between individual and couple counseling?
- Who should receive HIV counseling and testing?

Note for the facilitator: The purpose of the discussion question "Who should receive HIV testing and counseling?" is to remind UHE-ps to encourage MARPs and other vulnerable groups listed below to get HCT service.
(Sex workers, mobile populations, in-school youth, uniformed services, PLHIV, partners of these groups, and other critical practices including HCT before marriage, all TB patients, families of PLHIV)

STEP 4: One group will present the above two questions and the other groups will contribute (15 min.).

STEP 5: Conclude the session by asking what new information they have gained from the activity and its importance for providing HCT services to the community. (5 min.)

PRE-TEST HIV COUNSELING ROLE PLAY: 105MIN.

STEP 1: Distribute prepared observer checklist and let them discuss in pairs (10 min.)

STEP 2: Ask each pair to read one indicator and explain what they discussed. Why are these issues important to the counseling process? What negative consequences might arise if we did not address these issues?(15min.)

STEP 3. If any issue is not properly explained by the participants, facilitator will do so.

STEP 4: Divide participants into four groups. Each group will select a member to be a UHE-p, and one/two clients depending on the scenario. Remaining members will observe and hold all questions and comments until the role play is complete.

STEP 5: Describe how structured feedback avoids debates and enhances learning. Feedback is not to attack; it is to help the provider assess and improve performance. The person playingthe client will also offer constructive feedback. (5 min.)

STEP 6: Provide each group with an unfinished case scenarios (below)and begin the role play (25 min.).

STEP 7: Ask a group to volunteer to perform their role play for the rest of the participants. (20 min.)

STEP 8: Using the structured feedback model, the observers begin with what was done well and what could be improved. ("If I were the provider, I would do this and also include...") (5 min.)

STEP 9: When the role play and discussion is completed, use the following questions to debrief. (25 min.)
Ask the 'service provider' the following questions:

- Which part of the counseling process did you do best?

- Which part of the counseling process did you find challenging? Why? What did you do to overcome your challenges?
- If given the chance to do it again, how do you like to improve it? Why?

After the service provider self-assesses her performance, ask the 'client' the following question:

- Which part of the counseling process was most helpful for you? Why?
- Which part of the counseling process did not meet your needs? Why?
- Solicit feedback of the larger group by asking:
  - Did the UHE-p meet the needs of the client?
  - If you were the service provider, what would you do differently to address the client's needs?

Finally, ask the service provider about the feedback she received from the plenary:

- Which suggestions were help you do a better job of pre-HIV test counseling?

POST-TEST HIV COUNSELING PROTOCOL: GROUP WORK (50 MIN.)

STEP1: Divide participants into four groups. (5min.)
STEP 2: Each group brainstorms the process for post-HIV test counseling. (15 min.)
STEP3: Distribute official guidelines to each group and ask them to compare, using the following discussion questions. (15min.)

- What benefits do the steps in the protocol have for the client?
- What would happen if you did the process without all the steps?

STEP 4: One group will present the above two questions and the other groups will contribute. (10 min.)
STEP 5: Conclude the session by asking what new information they have gained from the activity and its importance for providing HCT services to the community. (5 min.)

POST-TEST HIV COUNSELING ROLE PLAY(105 MIN.)

STEP 1: Distribute prepared observer checklist and let them discuss in pairs. (10 min.)
STEP 2: Ask each pair to read one indicator and explain what they discussed. Why are these issues important to the counseling process? What negative consequences might arise if we did not address these issues?(15 min.)
STEP3: If any issue is not properly explained by the participants, facilitator will do so.
STEP 4: Divide participants into four groups. Each group will select a member to be a UHE-p, and one/two clients depending on the scenario. Remaining members will observe and hold all questions and comments until the role play is complete.
STEP 5: Provide each group with an unfinished case scenarios (below)and begin the role play preparation (25 min.)
STEP 6: Ask a group to volunteer to perform their role play for the rest of the participants. (20 min.)
STEP 7: Using the structured feedback model, the observers begin with what was done well and what could be improved. ("If I were the provider, I would do this and also include...") (5 min.)
STEP 8: When the role play and discussion is completed, uses the following questions to debrief. (25 min.)

Ask the 'service provider' the following questions:

- Which part of the counseling process did you do best?
- Which part of the counseling process did you find challenging? Why? What did you do to overcome your challenges?
- If given the chance to do it again, how do you like to improve it? Why?

After the service provider self-assesses her performance, ask the 'client' the following question:

- Which part of the counseling process was most helpful for you? Why?

- Which part of the counseling process did not meet your needs? Why?

Solicit feedback of the larger group by asking:

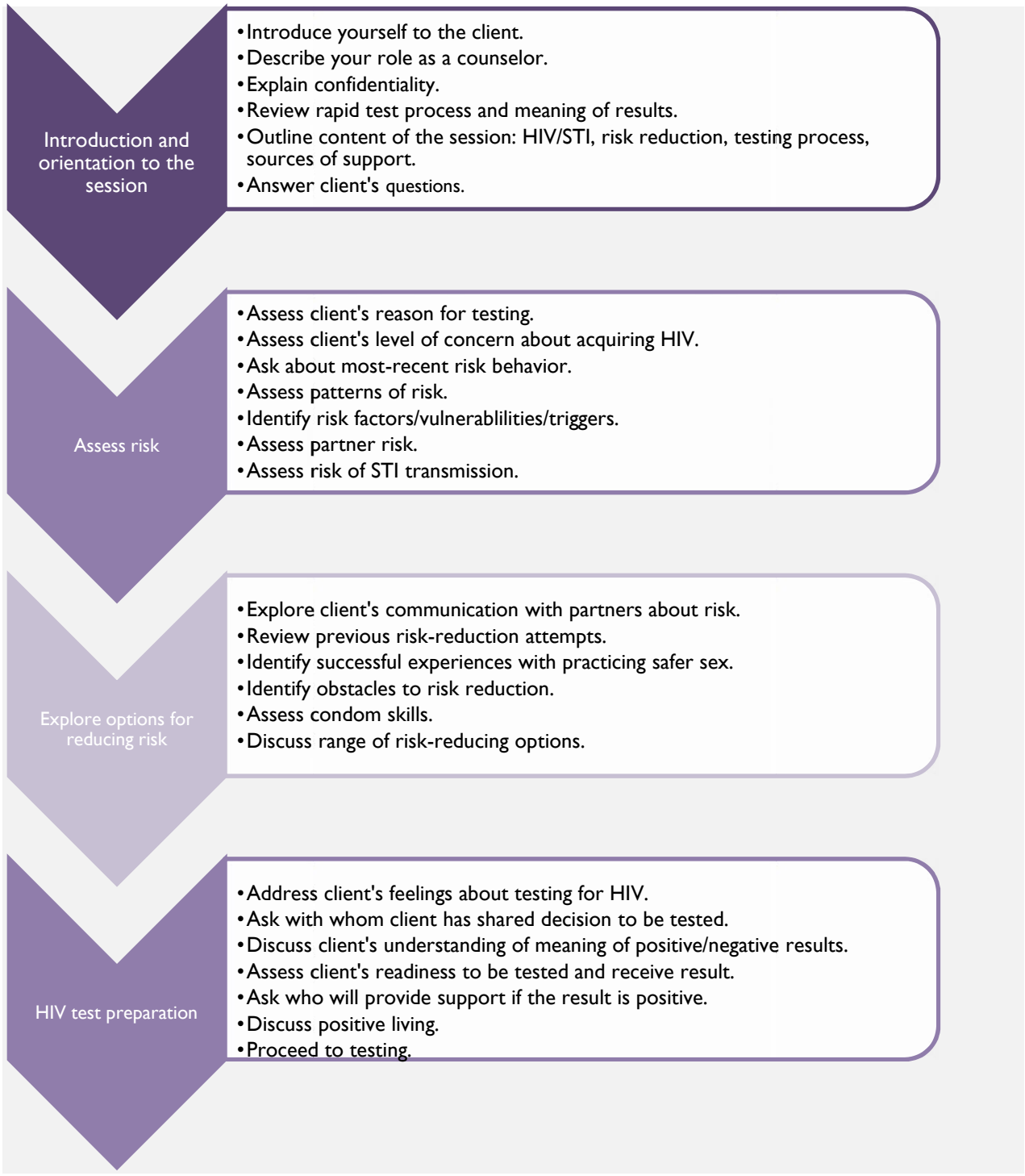
- Did the UHE-p meet the needs of the client?
- If you were the service provider, what would you do differently to address the client's needs?

Finally, ask the service provider about the feedback she received from the client and the plenary:

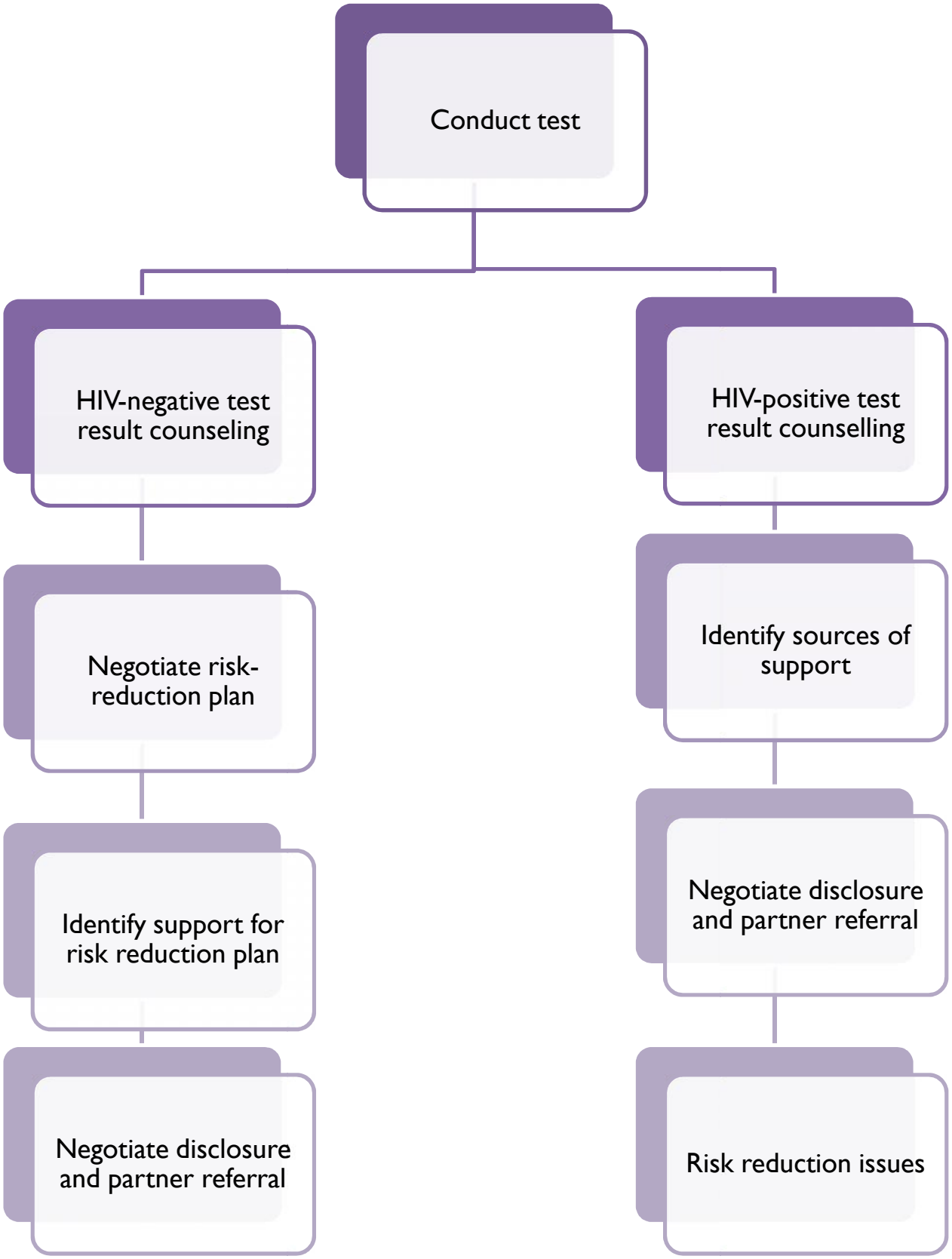
- Which suggestions were help you do a better job of post-HIV test counseling?

STEP 9: Close the session by playing the "hot potato" game to summarize key learning points. Ask participants to stand in a circle around you. Give a ball to one of the participants. The ball represents a potato, and participants pass it around the circle. Close your eyes and start saying "Faster and faster!" and, "The potato is getting warmer and warmer!" and then "It is hot!" When you say the word "hot," the person who is holding the ball at that moment will share something she has learned through the role play in particular and HIV session in general. Then *she* goes in the middle and replaces you as the leader, continuing the game until ideas saturate.

HCT PRE-TEST SESSION COMPONENTS

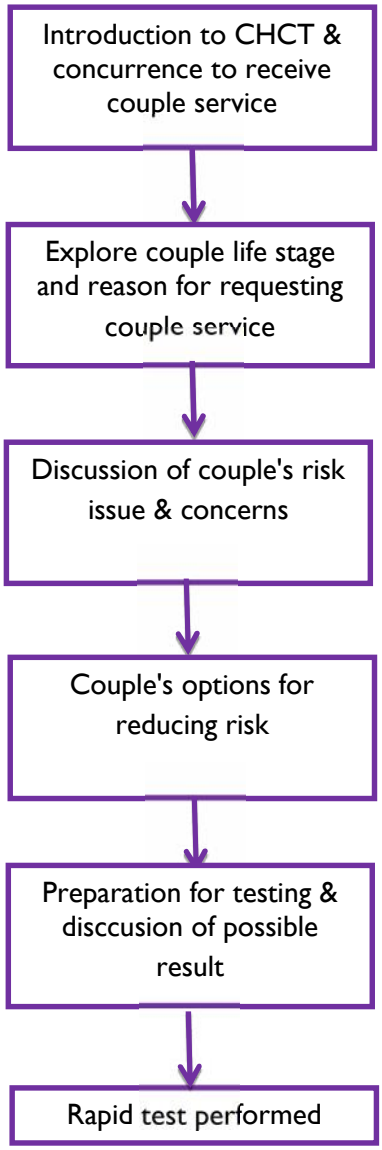


Post-test section of HIV testing and counseling protocol

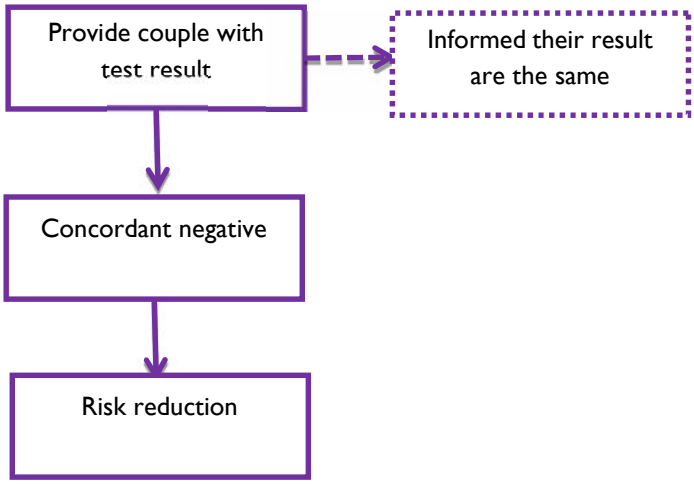


Couple HIV counseling and testing intervention

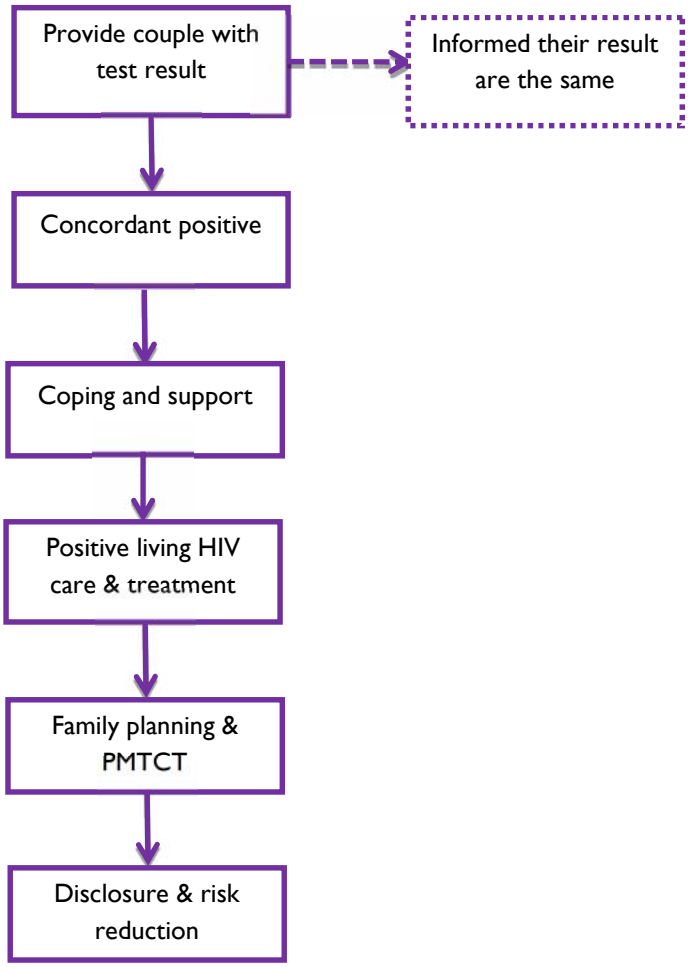
Initial session



Result session: Concordant negative

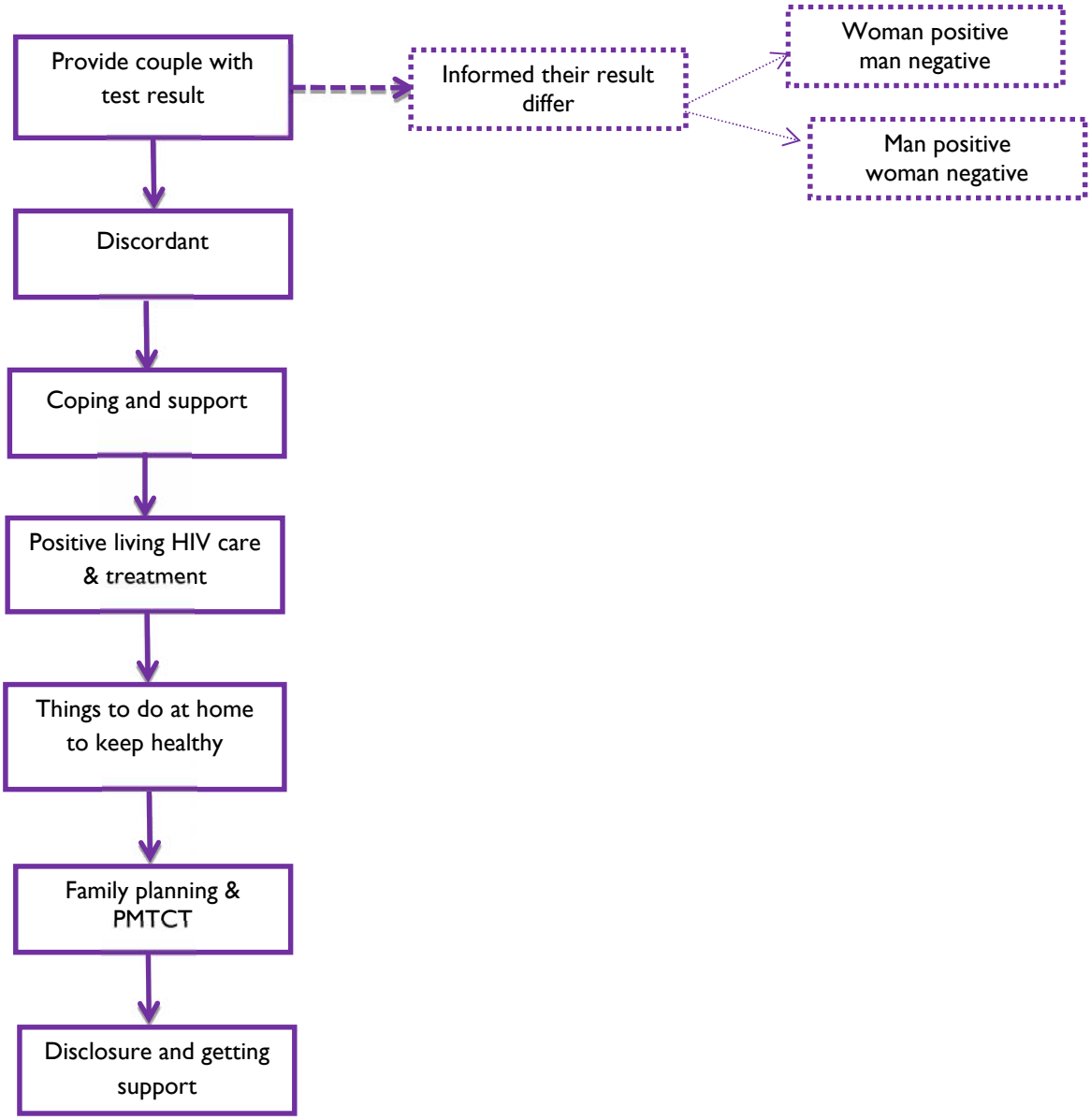


Result session: Concordant positive



Result session: Discordant

First explain that test results are different, then provide HIV result for infected partner.



Individual HTC and couple HTC compared

INDIVIDUAL HTC	COUPLE HTC
▪ Individual learns only his/her HIV status.	▪ Individuals learn own HIV status and that of their partner.
▪ Individual assumes burden of disclosing topartner.	▪ Mutual disclosure is immediate.
▪ Couple must cope with issues of tension and blame alone.	▪ Counselor can help ease tension and diffuseblame.
▪ Only one partner hears the information.	▪ Partners hear information together, enhancing likelihood of shared understanding.
▪ Counseling messages take into account onlyone partner's status; individuals may wronglyassume that partner has same status.	▪ Counseling messages are based onthe test results of both partners.
▪ Counselor is not present to facilitate thecouple's discussion about difficult issues.	▪ Counselor creates a safe environment andhelps couple talk through difficult and new issues.
▪ Prevention, treatment, and care decisions aremore likely to be made in isolation.	▪ Prevention, treatment, and care decisions canbe made together.
▪ Individual bears burden of getting partner, family members tested.	▪ Decisions about family/child testing,as well as family planning, can be made together.

Source: WHO guidance on couples HIV testing and counseling including antiretroviral therapy for treatment and prevention in sero-discordant couples:recommendations for a public health approach, April 2012.

Pre-test HIV counseling observer's checklist

Put tick mark (√) if the task is completed and "X" if not. Provide comments for those marked with "X."

TASK	COMPLETED	COMMENTS
Introduce yourself to the client		
Described role as a counselor		
Explain confidentiality		
Review the rapid test process		
Outline content of session		
Assess client's reason for testing		
Assess client's level of concern about acquiring HIV		
Ask about most-recent risk behavior		
Assess patterns of risk		
Identify risk factors/vulnerabilities		
Assess partner risk		
Assess risk of STI		
Review previous risk reduction attempts		
Identify successful experience with practicing safer sex		
Identify obstacles to risk reduction		
Assess condom skills		
Discuss range of risk-reducing options		
Discuss client's HIV test history and results		
Ask with whom client has shared decision to test		
Make sure client understands the meaning of positive/negative test result		
Assess client's readiness to test and receive result		
Ask who will provide support if positive		
Discuss positive living		

Post-test HIV counseling observer's checklist: HIV-negative test result

Put tick mark (√) if the task is completed and "X" if not. Provide comments for those marked with "X."

TASK	COMPLETED	COMMENTS
Inform client that the test results are available		
Provide results clearly and simply		
Explore client's reaction to the result		
Review meaning of the result		
Note the need to consider the result in relation to most-recent risk exposure		
Identify priority risk-reduction behavior		
Explore behavior the client is motivated to change		
Identify supports or barriers to the risk-reduction step		
Identify a person to whom the client feels comfortable to disclose		
Explore clients feelings about telling partner about HIV-negative result		
Remind him/her that result does not indicate partner status		
Support client to refer partner for testing		

Post-test HIV counseling observer's checklist: HIV-positive test result

Put tick mark (√) if the task is completed and "X" if not. Provide comments for those marked with "X."

TASK	COMPLETED	COMMENT
Inform client that the test results are available		
Provide results clearly and simply		
Review meaning of the result		
Allow the client to absorb the meaning of the result		
Explore the client's understanding of the result		
Assess how the client is coping with the result		
Acknowledge the challenges of dealing with an initial positive result		
Discuss living positively		
Ask who client will tell about the result		
Identify people who can help the client cope with being HIV-positive		
Identify health care resources		
Explain the importance of client'shealth care providers knowing test result		
Explore client's access to medical services		
Identify needed medical referral		
Discuss support groups/post-test clubs		
Explore client's feeling about telling partner about his/her HIV status.		
Remind the client his/her status does not indicate the partner HIV status		
Identify partners who need to be informed of their risk to HIV		
Discuss possible approaches to disclosure of HIV status to partners		
Help client to refer partner for testing		
Assess client's plan to reduce risk of transmission to partners		

CASE SCENARIOS:

SCENARIO 1: TEST WIFE AND FAMILY OF BEKELE.

Bekele complained of repeated infections and was referred to HCT by UHE-p. He agreed to and was tested at the UHE-p office. He turned out positive. He has a wife and two children, ages 7 months and 5 years. He also has hidden sexual relations with another woman.

SCENARIO 2: TESTING COUPLES WHO ARE AT RISK OF HIV TRANSMISSION.

Abebech and Abera have been married for six years and have three children. She is 5 months pregnant and has never attended anc. Last year, the couple separated for approximately 4months. During that time, Abera had unsafe sexual relations with someone who he later found out was HIV-positive.

SCENARIO 3: DISCLOSING RESULTS TO DISCORDANT COUPLES.

A couple came to UHE-p to get HCT service because they planned to have a child. The UHE-p tested them and found out that the husband is negative and the wife is positive.

SCENARIO 4: STI

While visiting a household, Sr Demeshi came across a woman who had STI. The woman is 23 years old, married, and lives with husband and her four children. She is uneducated and unemployed. For the last seven days, she has been ashamed and worried about unusual, thick yellowish vaginal discharge.

Sub-activity 2.5.1.HIV testing algorithm

PURPOSE: The purpose of this activity is to explore UHE-p use of algorithm to provide HCT service and avoiding false results because of poor procedure.

TRAINING METHODS: Group work, demonstration, practice, discussion

MATERIALS NEEDED:

- Rapid tests: KHB, stat pack, buffer
- Glove
- Blood samples
- Safety box
- Alcohol
- Cotton
- Flip chart, marker

TIME ALLOTTED: 3hrs

STEP 1: Ask participants to individually write the procedure they use in conducting HIV testing.

STEP 2: Randomly select five participants to explain what they wrote

STEP 3: Ask if others have a different approach to the algorithm.

STEP 4: Ask a few UHE-ps to demonstrate the algorithm.

STEP5: Demonstrate the algorithm using the already known samples brought from the facility.

STEP 6: Ask a UHE-p to demonstrate the procedure again.

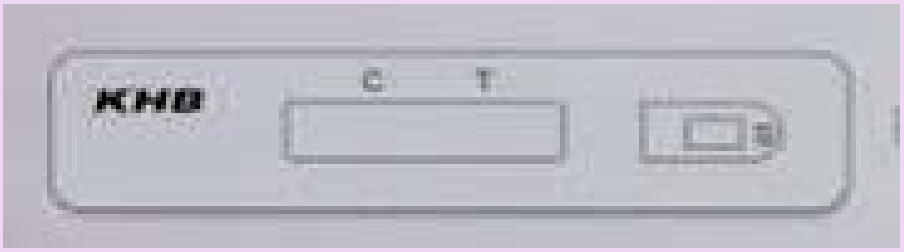
STEP 7: Address questions and close the session.

FACILITATOR RESOURCE:

HIV Test Algorithm

KHB Rapid HIV test

STEP 1: Remove the test cassettes from foil pouch and place on a flat surface.



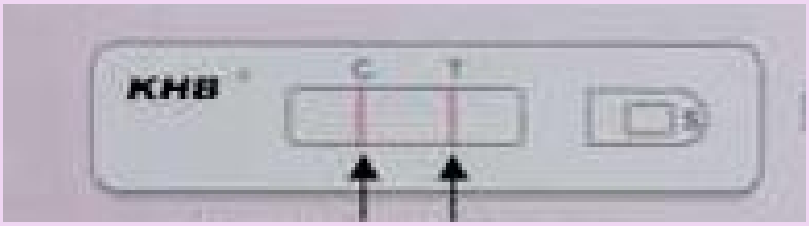
STEP 2: Label it with client ID number/code.

STEP 3: Use a sample serum, plasma, or whole blood and add 40 µl of whole/plasma/serum.

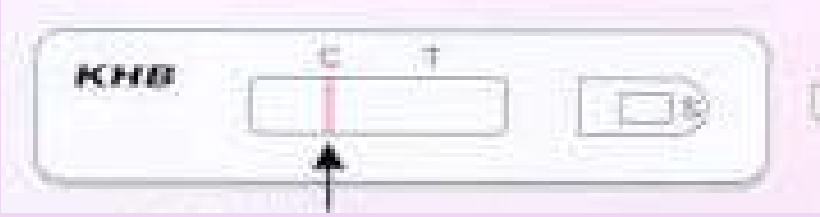
STEP 4: Add 1 drop of running buffer to the sample area.

STEP 5: Test interpretation at 30 minutes.

POSITIVE TEST RESULT:



NEGATIVE TEST RESULT:



INVALID TEST RESULT:

STAT-PAK

STEP 1: Collect test items and other necessary laboratory supplies.

STEP 2: Remove device from package, place it on flat surface, and label with client identification number.

STEP 3: Collect specimen.

STEP 4: Fill the 5µl loop provided with the kit with whole blood, plasma, or serum.

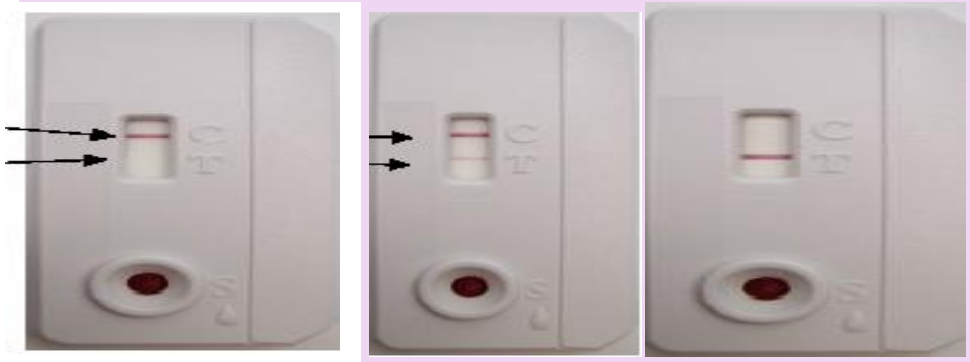
STEP 5: Holding the sample loop, vertically apply the 5µl of sample to the sample pad.

STEP 6: Add 3 drops (150 µl) of buffer slowly into the sample well.

STEP 7: Read the results 15-20 minutes after addition of running buffer.

TEST INTERPRETATION:

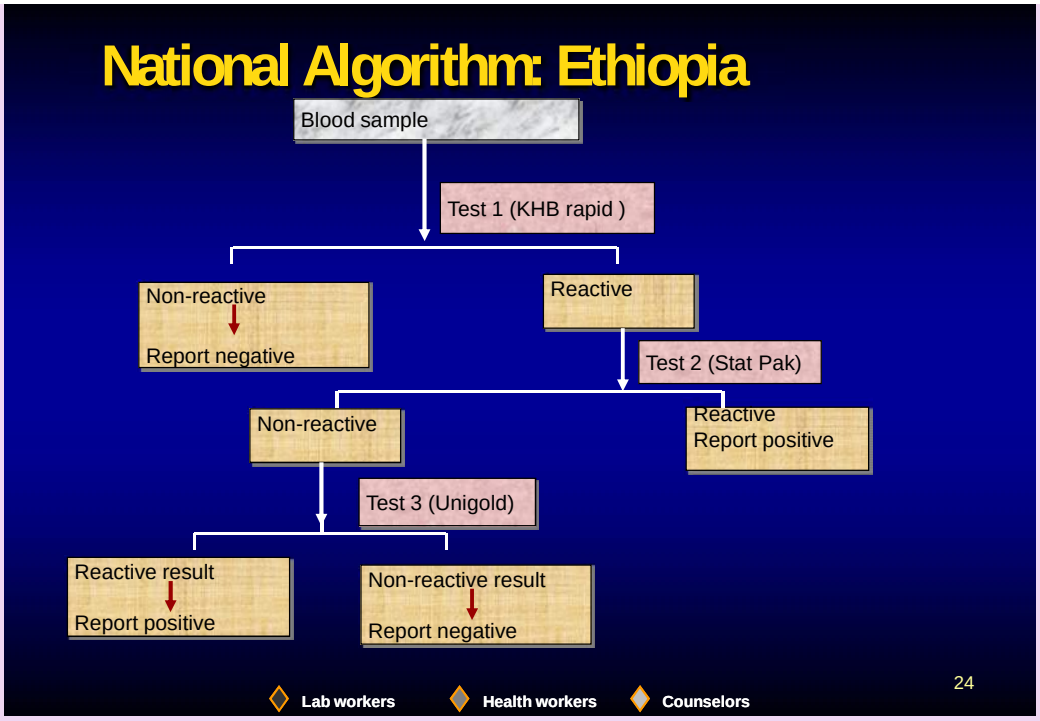
Non-reactive **Reactive** **Invalid**



STEP 8: Record results and other pertinent information on the worksheet.

UNIGOLD

When the KHB test is positive and STAT-PAK negative, there is a need for the third test-UNIGOLD. The UHE-ps should refer the client to a health facility in this case. Results are disclosed after the tie-breaker test is completed.



POSSIBLE OUTCOMES IN A SERIAL ALGORITHM:

NON-REACTIVE			NEGATIVE
Reactive	**Reactive**		**Positive**
Reactive	**Non-reactive**	**Non-reactive**	**Negative**
Reactive	**Non-reactive**	**Reactive**	**Positive**

Session3. Care, Support & Treatment

SPECIFIC OBJECTIVES:

At the end of this session, UHE-ps will be able to:

- Define **adherence** to treatment and **retention in care.**
- Explain challenges and factors influencing adherence and retention in care.
- Describe strategies to enhance adherence and retention in care.
- Explain the relation between HIV, nutrition, and WASH.

Activity3.1. Adherence and Retention in HIV & AIDS care

PURPOSE: This activity will provide UHE-ps with the relevant knowledge, attitude, and skills to retain clients in care and help them adhere to treatment PLHIV as prescribed by the health service providers from ART clinics.

TRAINING METHODS: Brainstorming, pair works

MATERIALS REQUIRED:

- Flip chart

- Marker
- Written definitions and handout

TIME ALLOCATED: 90min.

STEP 1: Brainstorm what **adherence** means with the large group. Discuss the definitions suggested and compare them to the following definition (show on flipchart)(10 min.)

> **Adherence** is a patient's ability to follow a treatment plan, take medications at prescribed times and frequencies, and follow restrictions regarding food, behavior, and other medications.

STEP 2: Brainstorm the definition of retention in care. Discuss the definitions suggested and compare them with the following definition (show on flipchart)(10 min.)

> **Retention** in care begins with the moment of initial engagement in care when a person with HIV is linked to services, assessed for eligibility, initiated on ART, and in care for rest of life.

STEP 3: Organize participants in to four groups and ask them to answer the following questions. Provide three questions for each group. (Questions "a" and "b" are given toall groups; the rest are divided, one each, among the four groups (e.g., one group works on questions a, b, and f)(30 min.)

a. WHAT factors affect adherence to HIV treatment? Retention in care?
b. How can UHE-ps enhance adherence?
c. What supportive attitudes should providers develop in patients to enhance adherence?
d. What essential knowledge should the providers have about adherence? Why?
e. What essential knowledge should the patient have? Why?
f. In which other ways might we support adherence and retention?

STEP 4: Use the diagram for factors affecting adherence and ask them to link it in the social ecology they already discussed. (Note for the facilitator: Prepare the diagram, post beside social ecology diagram and discuss how factors are inter-connected. E.g., how clinical settings as an adherence factor is linked to social ecology).(20 min.)

STEP 5: Provide the participant resources and read in pair. (15 min.)

STEP 6: Conclude by asking participants the following questions. (10 min.)

- What new information did you learn in this activity?
- Will it help you improve patient's adherence and retention in care? How?

HANDOUT ON ADHERENCE AND RETENTION IN CARE FOR PARTICIPANTS.

Adherence to ART and retention in care

Adherence is defined as a patient's ability to follow a treatment plan, take medications at prescribed times and frequencies, and follow restrictions regarding food, behavior, and other medications.

How much adherence is required for successful therapy?

- Goal of Highly Active Anti Retroviral Treatment(HAART) = maximal and durable viral suppression (undetectable levels)
- Successful HIV therapy requires adherence > 95%
- Failure rates increase sharply as adherence decreases

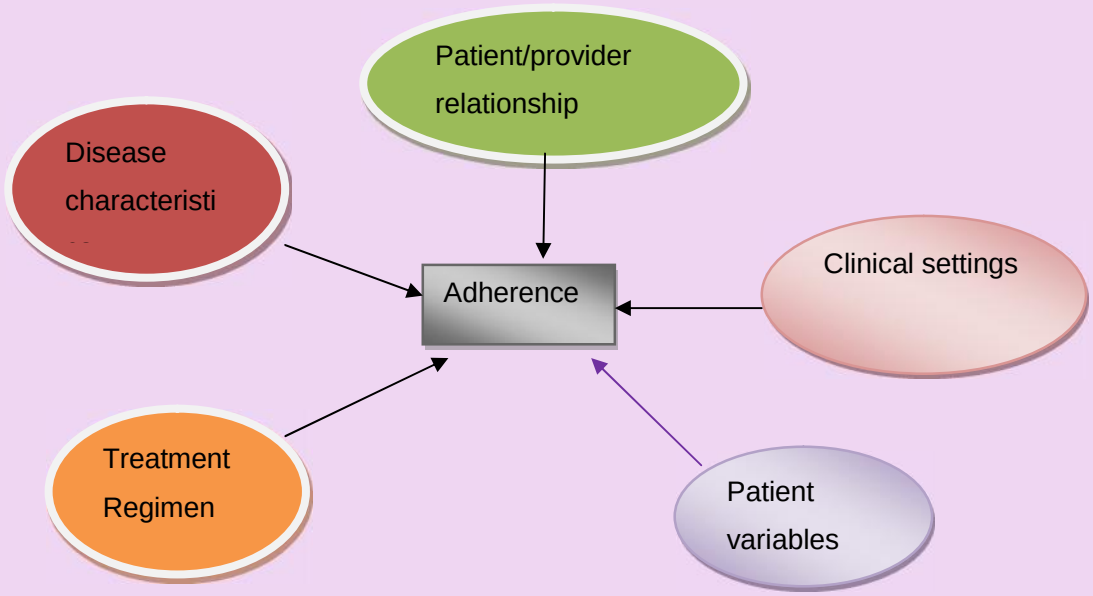
Forms of non-adherence:

- Missing one dose of a given drug
- Missing multiple doses of one or more prescribed medications
- Missing whole days of treatment
- Not observing the intervals between doses
- Not observing the dietary instructions

Consequences of poor adherence:

- Incomplete viral suppression
- Continued destruction of the immune system-CD4 cell counts
- Disease progression
- Emergence of resistant viral strains
- Limited future treatment options
- Higher costs to the individual and ARV program

FACTORS INFLUENCING ADHERENCE



1. Patient variables:

- **Socio-demographic factors**:
  - Gender
  - Ethnicity
  - Age
  - Employment
  - Income
  - Education and literacy

- **Psychosocial factors**:
  - Active drug or alcohol use
  - Degree of social support
  - Social stability
  - Depression and other psychiatric illnesses

2. Patient/provider relationship:

The patient/provider relationship has an important role in improving adherence to prescribed medications in chronic disease and is believed to be a motivating factor for adherence to HAART. Trust and confidence in providers has been found to influence adherence positively.

3. Disease characteristics:

Prior opportunistic infections (OI) contribute to increased adherence. Patients who have had serious opportunistic infections may perceive their illness to be severe and adhere better to their treatment.

4. Treatment regimen:

- The higher the pill burden, the lower the adherence.
- When patients experience treatement side effects, they tend to stop treatment or take it irregularly. Common side effects include:
  - Diarrhea, fatigue, nausea, and vomiting; peripheral neuropathy, physical changes in body appearance, metabolic changes.

5. Clinical settings:

A friendly, supportive, and nonjudgmental attitude of health care providers, including UHE-ps, convenient appointment scheduling, and confidentiality contribute to better adherence.

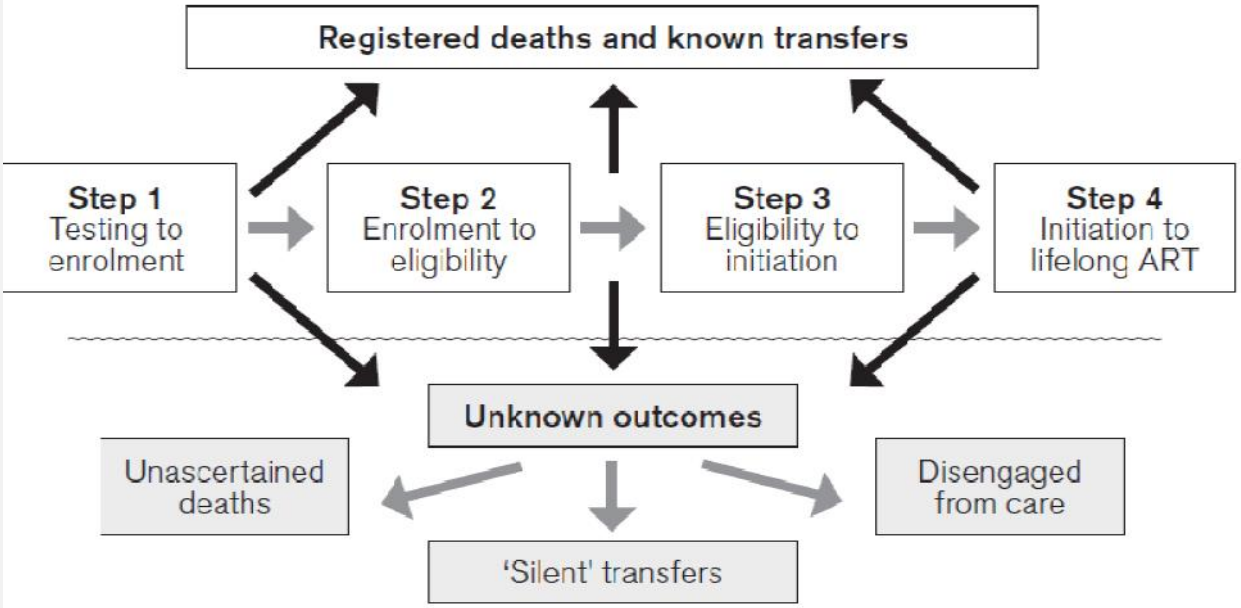
ADHERENCE COUNSELING:

- Knowledge
  - Infections, CD4 counts
  - Medications and side effects
- Attitudes
  - Positive belief and perceptions
  - Self-efficacy and commitment
- Practices and support systems
  - Disclosure to buddies, family
- Identifying and addressing barriers
- Integrating treatment regimen into patient daily routine
- Providing reminder cues

RETENTION IN CARE

'**Retention in care'** can be defined from the moment of initial engagement in care, when a person with HIV is linked successfully to services, to assessment for eligibility, initiation on ART and retention in lifelong ART care.

Fig 1: The 4 steps along the continuum of HIV care and treatment. Patient loss may occur at all 4 steps along this continuum.



BARRIERS TO RETENTION IN CARE:

The most common reasons for missed appointments are thought to be:

- Patient barriers:
  - Forgetfulness, sickness/illness, disbelief in ARV efficacy, and traditional and religious beliefs.
- System barriers:
  - Clinic distance resulting in transport difficulties and cost; schedule conflicts including inability to take time from work (both in the formal and informal sector); long wait times;poor hospital staff attitude; and poor knowledge about ART.
- Transferring to another health care provider or migration due to different reasons:
  - stigma, poor clinical environment.

Activity 3.2 HIV and nutrition

PURPOSE: Increase UHE-ps' awareness of how AIDS affects nutritional status and how the nutritional status of PLHIV affects HIV progression.

TRAINING METHODS: Plenary and paired discussions

MATERIALS REQUIRED:

- Flip chart
- Marker

TIME ALLOCATED: 45MIN.

STEP 1: Organize participants in pairs and ask each pair to discuss the following questions (15 min.)

- What is the link between malnutrition and PLHIV?
- How do you assess nutritional status of PLHIV at household level?

STEP 2: Discuss views with plenary (25 min.)

STEP 3: Conclude the session by asking (5 min.)

- What new information did they get at the session?
- How will they apply it to PLHIV when providing service at household level?

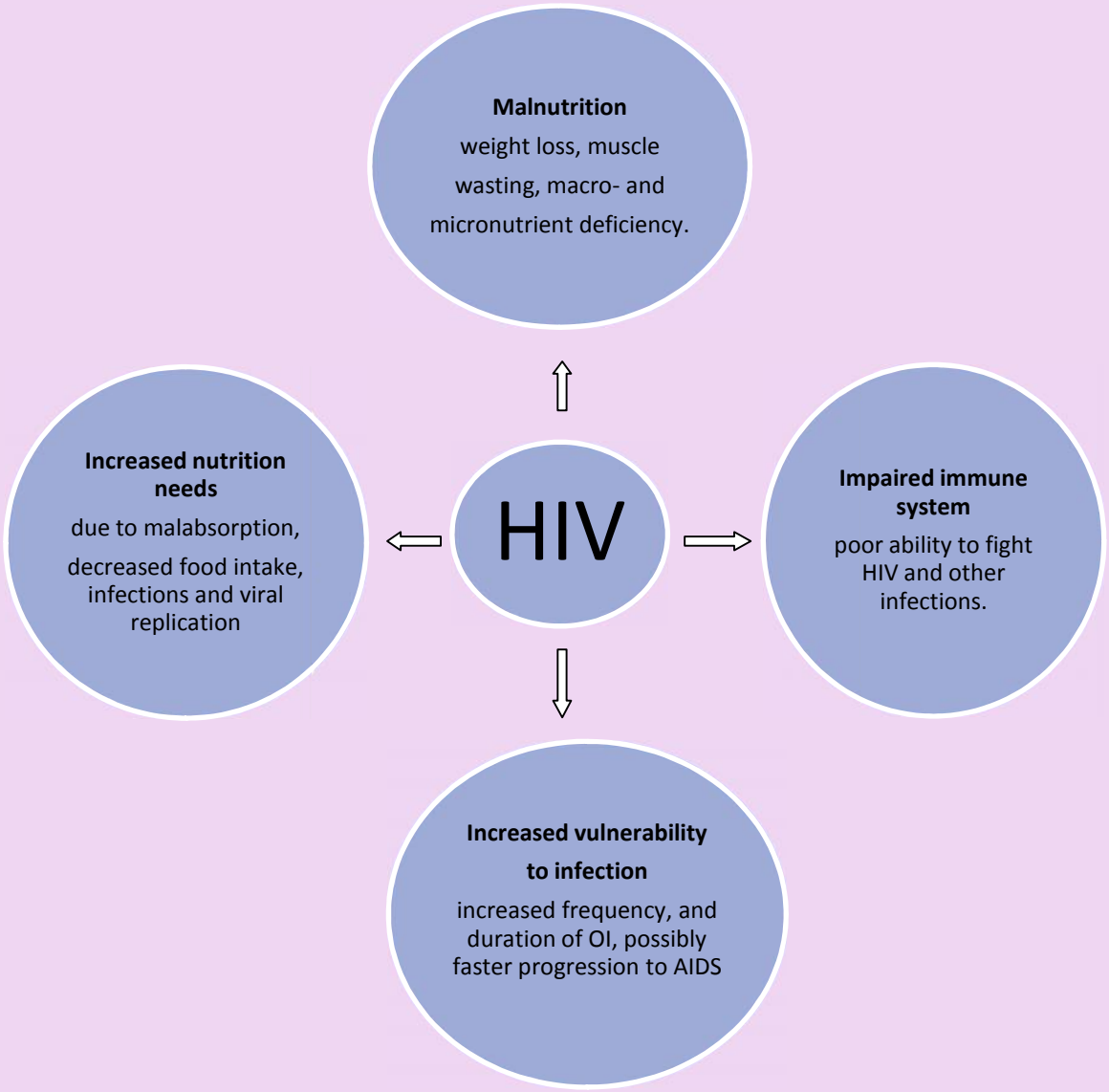
HIV and nutrition resources to be printed and distributed to participants:

Links between HIV and AIDS and nutrition

Malnutrition and HIV and AIDS exacerbate one another. PLHIV are more likely to become malnourished because of the following:

- Reduced food intake resulting from appetite loss and difficulty eating, possiblyas a result of infections, side effects of medication, or depression.
- Poor absorption of nutrients that may be the result of recurrent or chronicdiarrhea and HIV-caused intestinal cell damage.
- Increased energy needs as a result of virus replication and opportunisticinfections (OIs).
- Changes in the way the body uses the nutrients it receives or has stored.

INTER-CONNECTION BETWEEN HIV AND NUTRITION



HIV-positive adults and adolescents:

Measure weight in kilograms to the nearest 100 grams and height in meters to the nearest centimeter at every visit and also calculate BMI(= weight in kg/square of height in meter).

Advise clients to be weighed at these intervals:

- If asymptomatic, at least every 3–4 months
- If symptomatic, at least every 2 months
- If BMI < 18.5, every month

Always check a patient's palms. Those of anemic patients are often noticeably pale. Also, ask about any illness, symptoms, or medications the client is taking and refer client to a clinician as necessary. If the client's BMI is < 18.5 or MUAC is < 18.5 cm, or palm is pale, refer him/her to appropriate food and nutrition interventions or supplements.

What is the link between malnutrition and PLHIV?

When you have diarrhea, some of the nutrients you have eaten are lost before you can absorb them, so it is as though you never ate them. You lose the protein, carbohydrates, vitamins, minerals, and whatever else you ate. Frequent diarrhea means frequent loss of nutrition.

Activity 3.3. HIV and WASH

PURPOSE: Increase UHE-p awareness of how PLHIV are affected by problems related to WASH and enable UHE-ps to help PLHIV reduce associated risks.

TRAINING METHOD: Group work

MATERIALS REQUIRED:

- Flip chart
- Marker

TIME ALLOCATED: 45 min

STEP 1: Divide participants into four groups.

STEP 2: Provide discussion questions and the groups write their responses on a flip chart. (20 min.)

- How is WASH related to reduced immunity among PLHIV?
- How does diarrhea lead to the poor absorption of medications, such as antiretroviral drugs?
- How can social stigma be minimized with stronger WASH actions?

STEP 3: One group presents and others comment and discuss. (20 min.)

STEP 4: Summary questions for all (5 min.)

- What did you learn from this activity?
- How will you use what you learned to provide services for PLHIV?

HIV and WASH resources to be printed and distributed to participants:

How does diarrhea lead to the poor absorption of medications, such as antiretroviral drugs?
In order for oral medications to be effective, they need to stay in the digestive system long enough to be absorbed into the body. As in the case of nutrients, diarrhea can eliminate medications from the body before they are absorbed. It is like you never took the medication.

How is WASH related to reduced immunity among PLHIV?
Dehydration, malnutrition, and poor absorption of medications all reduce immunity. Immunity is the body's ability to fight infections, and PLHIV have, by definition—*human immunodeficiency virus* —lowered immunity. This means they can get infections such as TB and malaria more easily than people who are healthy.

Reference:National Guidelines for HIV/AIDS and Nutrition in Ethiopia

Resources for WASH:

Priority WASH practices to integrate into HIV and AIDS programs (USAID/WHO 2010):

- Treat drinking water
- Store treated drinking water safely
- Promote hand washing
- Handle and dispose of feces safely
- Manage menstruation
- Prepare, handle, and store food safely
- Promote personal cleanliness of people living with HIV and their environment

A better life for PLHIV

1. Diarrhea is a major threat to PLHIV—it affects 90% of patients.

2. WASH can reduce diarrhea by 25-65%.

3. PLHIV will have better lives with stronger WASH practices in place at home and at the facility level.

Why is dehydration risky for PLHIV?

You lose body fluids with diarrhea. Your body starts to dry out. In extreme cases, even healthy people can become gravely ill or die. You must get fluids into your body rapidly, or better yet, avoid diarrhea in the first place.

Why is weight loss risky for PLHIV?

Diarrhea can lead to weight loss. PLHIV may already be below a healthy weight, and losing more weight is harmful to their health. Their bodies do not have the energy reserves they need, and they lose strength.

What are some dangerous infections to PLHIV that can be avoided?

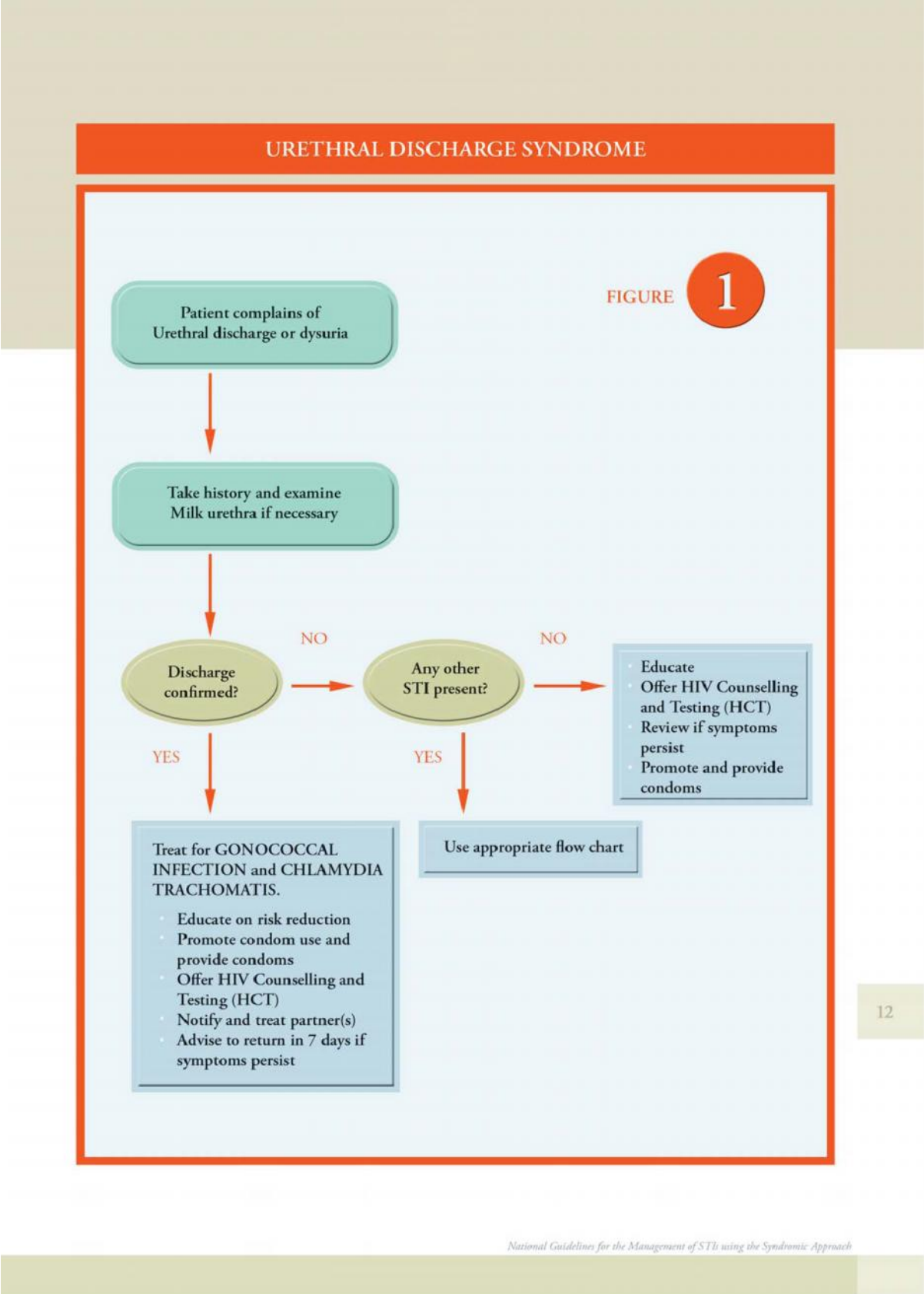
With weaker immune systems, People who are HIV-positive are highly susceptible to infections including certain types of TB, bacterial meningitis, candidiasis, *Pneumocystis jiroveci* pneumonia, cryptosporidiosis, and herpes.

How can social stigma be minimized with stronger WASH actions?

PLHIV are often the victims of stigma. People in their community, in their family, or even at health facilities sometimes shame them, avoid them, and treat them as if they were no longer real people. When PLHIV suffer from diarrhea, the discrimination can get worse, especially when they have frequent bowel movements, have "accidents," or cannot keep themselves clean.

Reference: AIDSTAR-one: improving the lives of people living with HIV (PLHIV) through wash: water, sanitation, and hygiene, trainer guide

Syndromic classification of STI-flow chart



GENITAL ULCERS SYNDROME

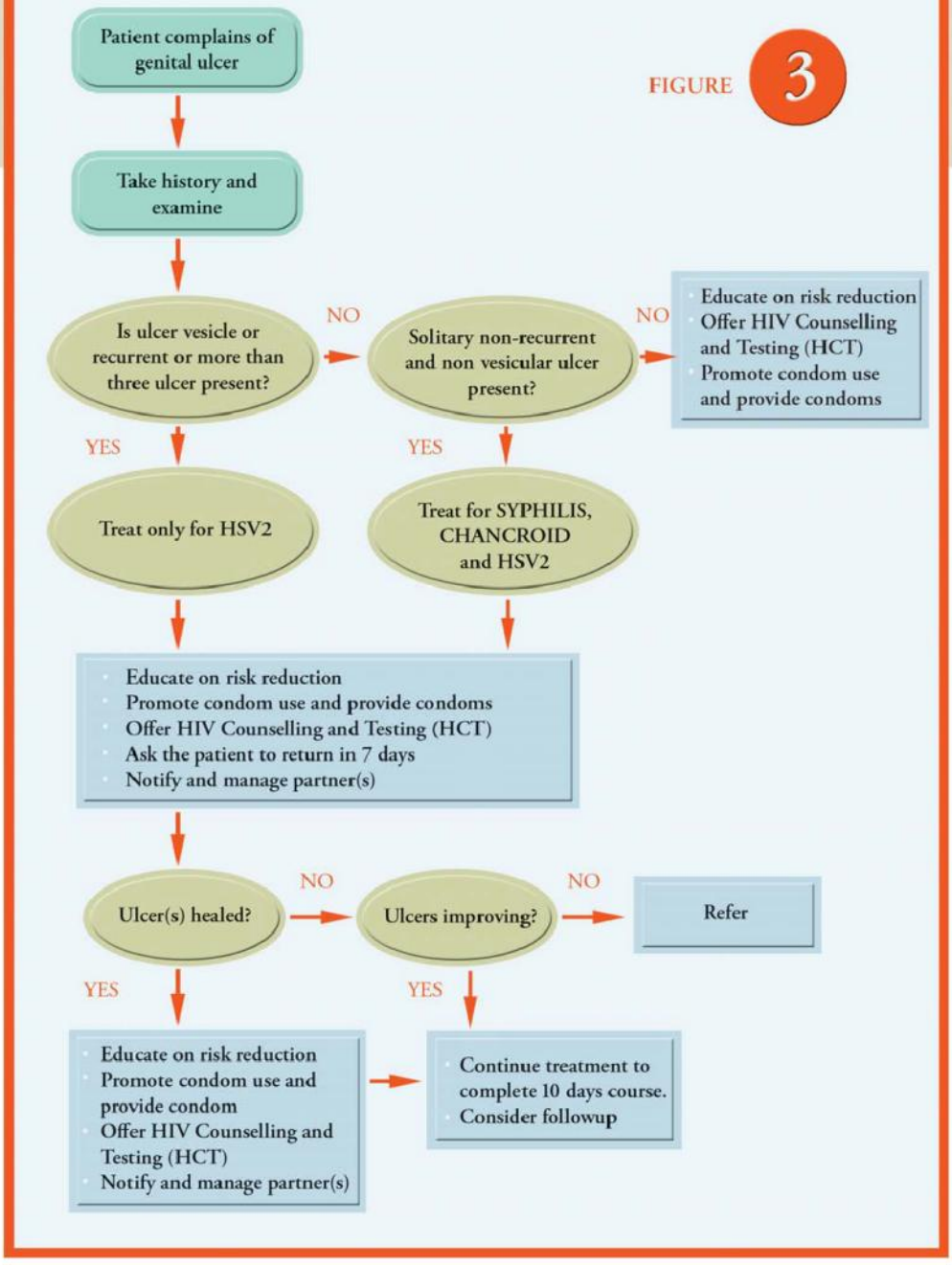


FIGURE 3

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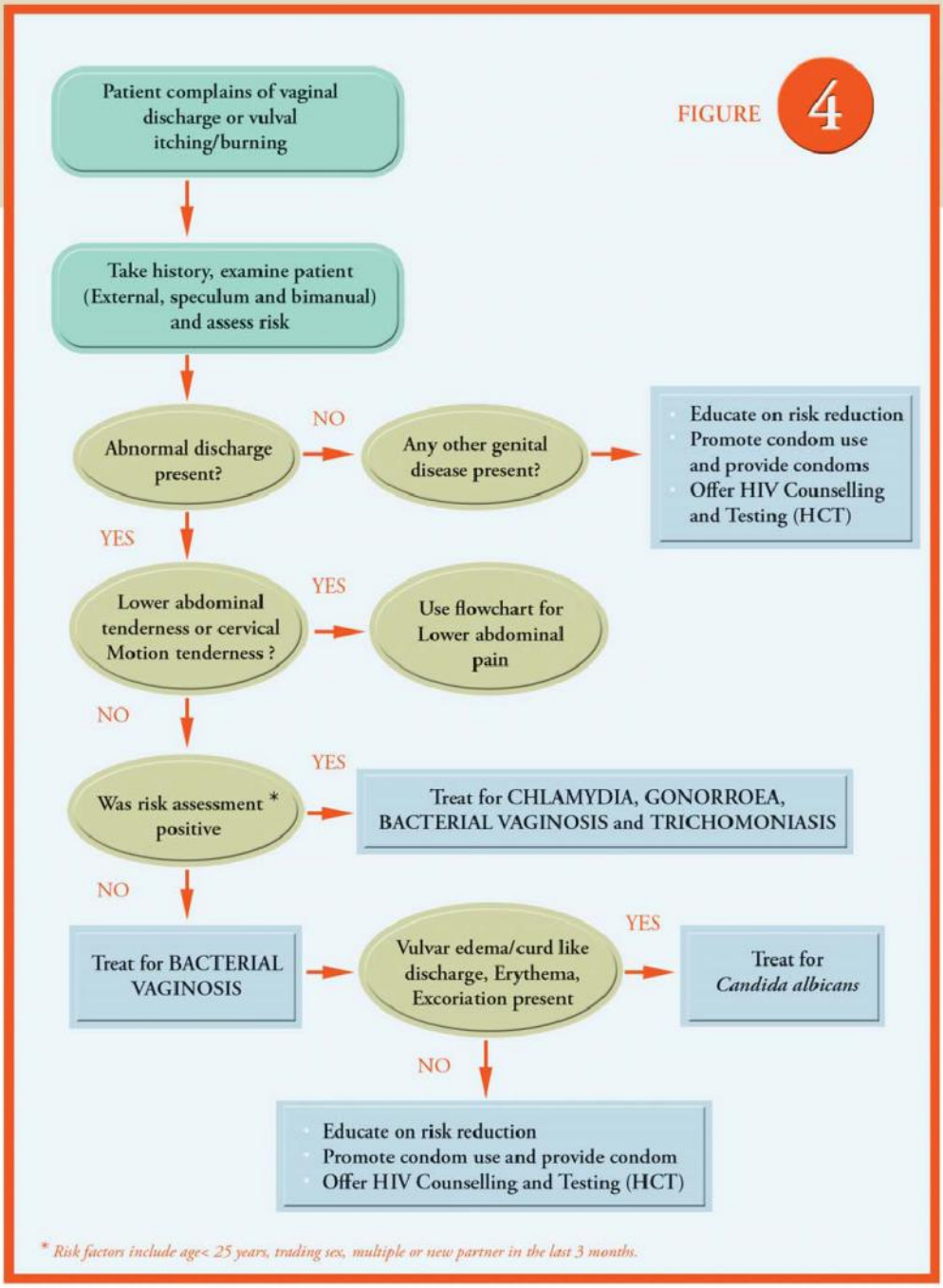
National Guidelines for the Management of STIs using the Syndromic Approach

VAGINAL DISCHARGE (SPECULUM AND BIMANUAL)



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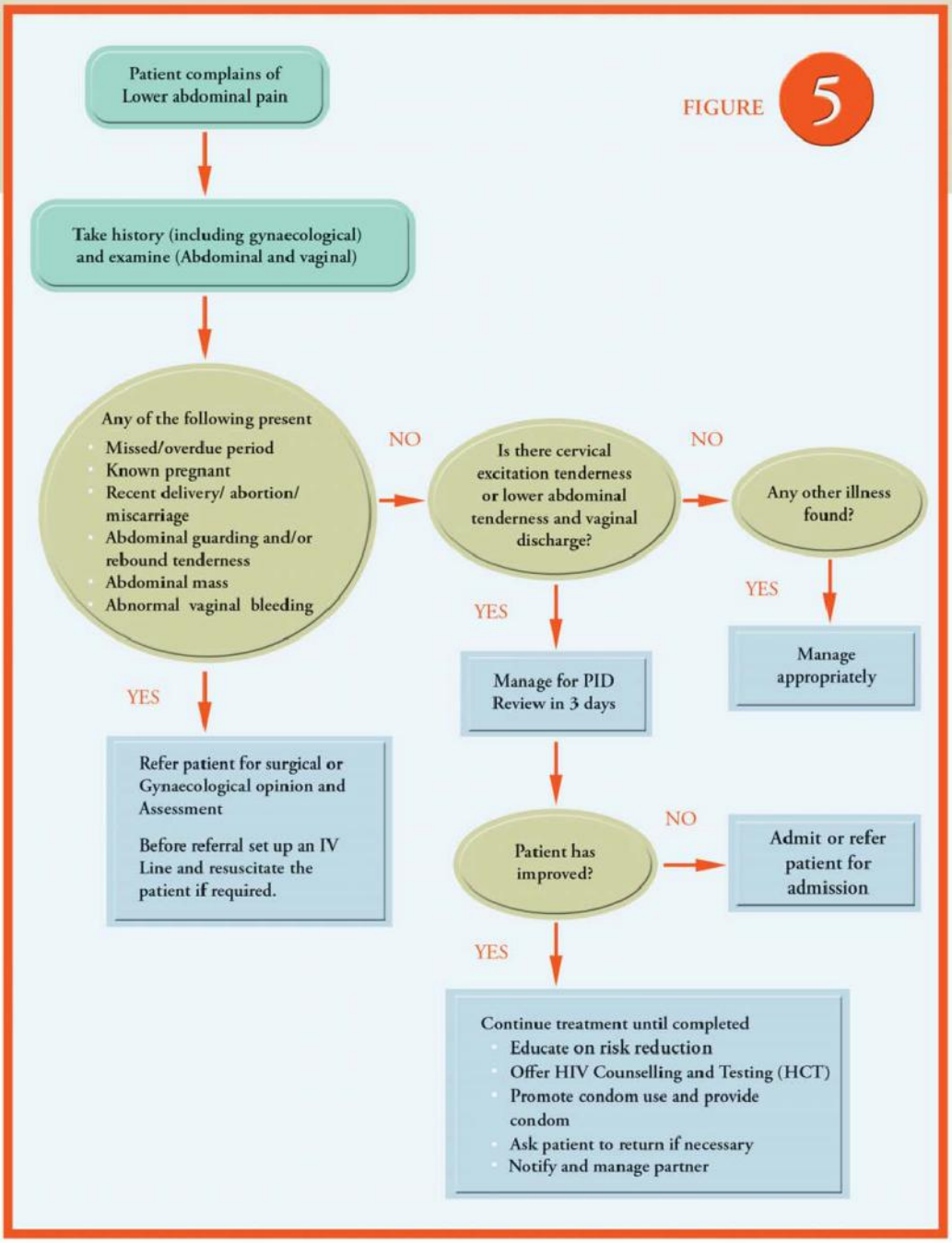
LOWER ABDOMINAL PAIN



Type of STI and symptoms in men and women

Type	Symptoms		Mode of transmission
	Women	**Men**	
Chlamydia	• Asymptomatic in 2/3 women • Unusual vaginal discharge • Burning during urination • Bleeding between periods • Pain during or bleeding after sex • Low abdominal pain	• Asymptomatic in 1/2 men • Cloudy urethral discharge • Pain/burning during urination • Testicular pain and/or swelling	• Having anal or vaginal sex with infected person
Gonorrhoea	• Asymptomatic in 50% women • Foul white, yellow/ greenish vaginal discharge • burning during urination • Abnormal vaginal bleeding • Pain during or bleeding after sex • Abdomen or pelvic pain	• Asymptomatic in 10% men • Foul white, yellow/ greenish urethral discharge • Pain/burning during urination • Urethral itch • Testicular pain and/or swelling	• Anal or vaginal sex with infected person • Close physical contact and touching infected parts • Mother-to-child at birth
Syphilis	• 1st stage:Painless sores or open ulcers on anus, vagina, penis, or inside mouth • 2nd stage:Flu-like symptoms, hair loss, or a rash on the soles and palms and in some cases all over the body • Latent phase: no symptoms		• Anal, oral, or vaginal sex with infected person • Intimate touching or kissing • Mother-to-child (during vaginal birth)
Chancroid	• Sores are not common in women • Vaginal discharge • Painful urination and defecation • Rectal bleeding • Painful intercourse • Inguinal lymphadenopathy	• Painful open sores on penis • Tender and swollen inguinal lymph nodes	• Sexual activity • Skin-to-skin contact with open sores • Contact with hands that have touched a sore
Trichomoniasis	• Genital itching and/or burning • Frothy yellow- greenish vaginal discharge with foul odor • Frequent and/or painful urination • Blood spotting • Abdominal pain	• Usually asymptomatic • Unusual penile discharge • Pain/burning during urination • Burning sensation after ejaculation • Tingling inside the penis	• Sexualcontact with infected person • Sharing infected objects such as sheets, towels, and underwear

Genital herpes (Herpes)simplex)	• Flu-like symptoms • Burning sensation in the genitals • Pain during urination • Painfulblisters around the genitals and on the mouth (lips) • Lower back pain	• Sexual contact with infected person • Kissing or touching any affected area
HPV(Genital warts)	• Many types of HPV have no symptoms • Visible warts in the vagina and/or urethra or on the cervix, vulva, penis, or anus • Flesh-coloredsoft-to-touch often painless (although may itch).	• Oral, anal, or vaginal sex with infected person • Skin-to-skin contact