



Community Counsellor Training Toolkit

Module 3

General HIV and Sexuality

Participant Manual

LifeLine/ChildLine Namibia



In July 2011, FHI became FHI 360.



FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

Visit us at www.fhi360.org.

© 2006 Family Health International (FHI) and LifeLine/ChildLine, Namibia

All rights reserved.

This manual may be freely reviewed and quoted provided the source is acknowledged. This book may not be sold or used in conjunction with commercial purposes.

Developed by Lisa Fiol Powers, Family Health International (FHI), Namibia, in collaboration with staff from LifeLine/ChildLine, Namibia.

The development of this manual was funded by the President's Emergency Plan for AIDS Relief, through Family Health International (FHI) under its Cooperative Agreement (No. HRN-A-00-97-00017-00) with the U.S. Agency for International Development (USAID). The information contained in this publication does not necessarily reflect the views of the U.S. Government, FHI or USAID.

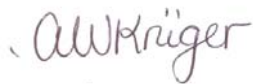


Foreword

In 1988, I started working as a young community liaison officer for a Namibian non-profit organisation. This experience opened my eyes to the tremendous gaps between the values, norms and cultural influences of the country's different ethnic and racial groups and between those living in urban and rural settings. These differences in experience and perspective added to the tension amongst people, leading to a lack of trust and an inability to work together.

Fortunately, Namibians have experienced tremendous social growth since then, as these manuals for training community counsellors demonstrate. They include such sensitive subjects as stigma, coercion and cultural practices detrimental to health. These pioneering learning tools reflect the significant progress made as a result of the great partnerships developed throughout Namibia over the last 18 years. It is heart-warming to witness the openness and trust people from different cultures have achieved by offering counselling to a neighbour, a friend, a stranger.

I am proud to be associated with these manuals. I am proud of every trainer of LifeLine/ChildLine Namibia and every Namibian trainee who contributed. Thanks go to the many partners in faith-based organisations, non-governmental organisations, and the Ministry of Health and Social Services, especially NACOP—Special Programmes Division, which made such important contributions. Ms. Lisa Fiol Powers, a consultant seconded by Family Health International to upgrade and develop these manuals, deserves special thanks. In addition to these dedicated partners, we also want to thank the U.S. President's Emergency Plan for AIDS Relief, which provided funding. We will forever be grateful to you all.



Amanda W. Krüger
NATIONAL DIRECTOR

LifeLine/ChildLine Namibia

director@lifeline.org.na



Acknowledgements

Over the last eight months I have lived, breathed and dreamt about community counselling, training and curricula. Developing the Community Counselling Training Toolkit has been an incredible experience for me. It enabled me to share my passion and concern to provide psychosocial support and counselling to meet the needs of so many around the world, particularly those affected by and infected with HIV. For me, it has been an honour to live and work in Namibia and to share in the lives of so many who are tirelessly working to fight HIV and its effects.

As is true with all curricula development, the entire team creates the finished product. The team I have worked with at Family Health International (FHI) and LifeLine/ChildLine has been especially generous, delightful and supportive.

Let me start by thanking the training team at LifeLine/ChildLine. The training team includes staff trainers Nortin, Frieda, Maggy, Angela and Cornelia, and volunteer trainers Dube, Christine, Hilarie, Emmy, Emelle and Jonas who have been absolutely fabulous to work with. When I rushed to complete drafts of Facilitator Manuals just days before a training workshop, the trainers never lost patience, even though it meant they had limited time to prepare for their sessions. Their enthusiasm and willingness to try new material has never ceased to amaze me. They have welcomed new ideas and significant changes to both the training materials and the methodology. The encouragement and feedback I have received from the trainers has been invaluable! You have been a delightful group of people to work with on this project.

I would also like to thank Amanda Kruger, Hafeni Katamba and Simon Kakuva at LifeLine/ChildLine for recognising the need to make substantial changes in the Community Counsellor Training Toolkit and for their support throughout the process of curricula development, encompassing piloting and testing new material as well as training trainers in process facilitation.

None of this would have been possible without the incredible support from the entire staff at Family Health International/Namibia. You are all a truly talented, dedicated and fun group of people. I would specifically like to thank Rose de Buysscher for making this whole project possible, not only through the allocation of funds, but also for her support in turning what began as a "harmonisation" into a more extensive project involving significant changes to existing curricula and the design and development of new material. The technical contributions and support for person-centred counselling offered by Dr. Fred van der Veen enabled me to challenge some of the rigid tenets of HIV counselling, and encourage counsellors to focus on their client's emotional needs rather than adhering to fixed protocols.

Finally, I would like to express my deepest gratitude to Patsy Church for her inspiration and generosity in providing so many resources, for engaging in so many stimulating conversations, for being a cheerleader at times, and for always believing that these materials could make a difference. Patsy tirelessly read through drafts and offered valuable feedback and encouragement. Patsy has not only become a role model, she has become a dear friend.

My hope is that, with this Training Toolkit, community counsellors in Namibia will be better equipped to support their clients emotionally, offering them hope as they wrestle with so many difficult issues such as stigma, loss, coping with their HIV status, death and treatment, as well as financial and emotional uncertainty.

Lisa Fiol Powers, MA (Clinical Psychology)
Family Health International, Namibia



GENERAL HIV AND SEXUALITY: PARTICIPANT MANUAL
TABLE OF CONTENTS

LIST OF BASIC COUNSELLING SKILLS	6
MODEL OF A COUNSELLING SESSION	7
SEXUAL ANATOMY	8
SEXUALITY AND GENDER ROLES	14
GENDER AND COUNSELLING	15
BELIEFS ABOUT SEXUALITY	19
HEALTHY SEXUALITY	20
KNOWING ABOUT SEXUALLY TRANSMITTED INFECTIONS (STIs).....	22
HIV/AIDS DEFINITIONS	25
STIGMA & DISCRIMINATION	26
TRANSMISSION OF HIV	28
PREVENTION OF HIV TRANSMISSION	33
COMMUNITY BELIEFS AND MYTHS ABOUT HIV/AIDS	42
THE IMMUNE SYSTEM AND HIV	43
NATURAL COURSE/PROGRESSION OF HIV	45
UNDERSTANDING BEHAVIOUR CHANGE.....	54
RISK-TAKING.....	57
STRESS AND HIV	64
LOSS & GRIEF.....	66
LIVING POSITIVELY	70
NUTRITION	72
NEEDS & RESOURCES FOR PEOPLE LIVING WITH HIV.....	75
PERSONAL STRENGTHS & WEAKNESSES	78
HOMEWORK ASSIGNMENT:.....	79
PERSONAL VALUES AND FEELINGS ABOUT HIV	79
THE HIV RULE OF THREE	84
NAMIBIAN HIV/AIDS CHARTER OF RIGHTS	85
GLOSSARY	94
REFERENCES: GENERAL HIV AND SEXUALITY MODULE	99



LIST OF BASIC COUNSELLING SKILLS

Below is a list of the basic counselling skills. You will need to continuously remind yourself of these skills as you are practising structured types of counselling.

Empathy*

Listening Skills*

Reflecting Skills:

Reflecting Feelings*

Restating/Reframing

Affirmation*

Summarising*

Probing/Action Skills:

Asking Questions (Clarifying)*

Interpretation or Making Statements

Confrontation or Challenging

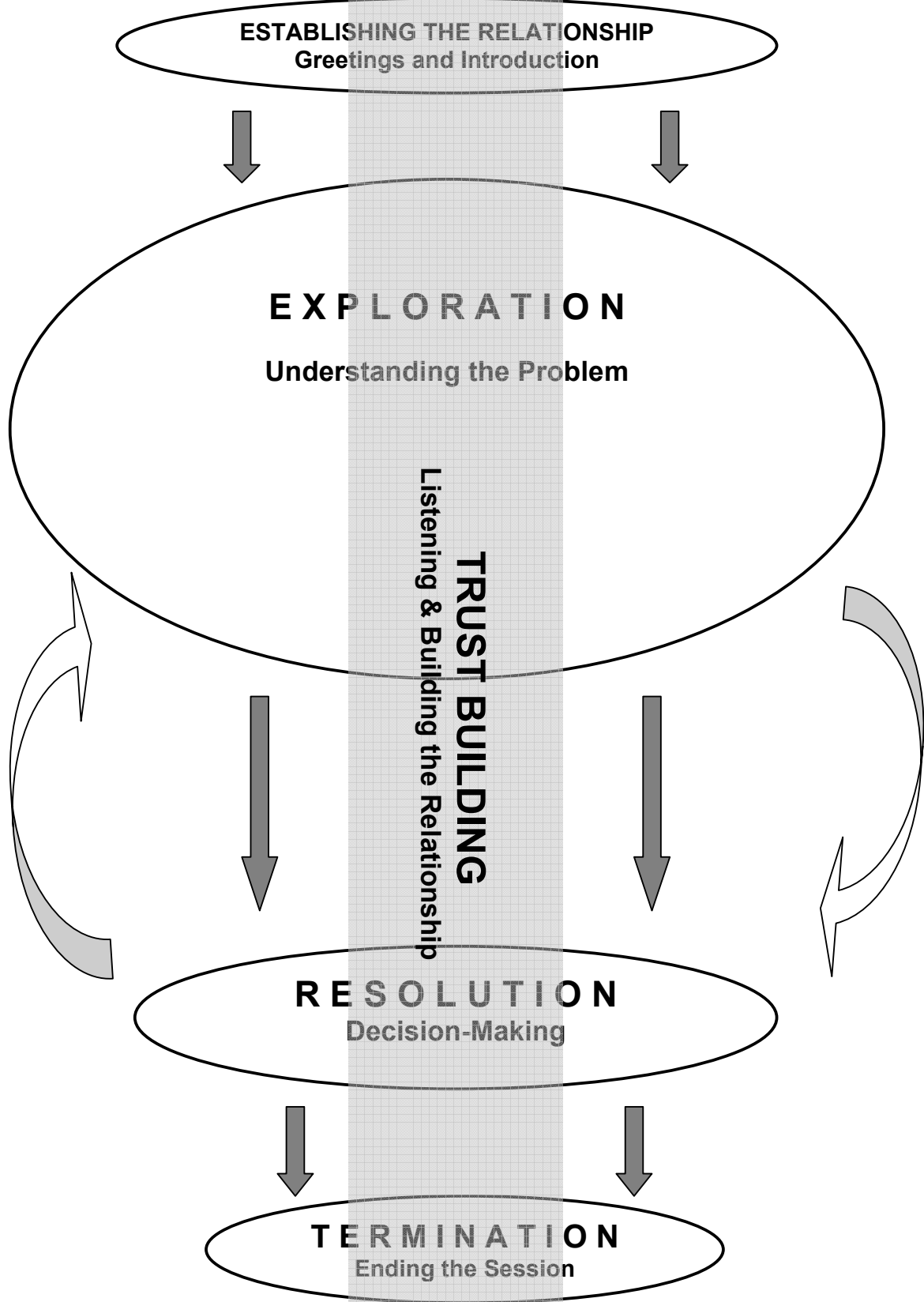
Information Sharing and Education

Problem-Solving/Problem Management

* These are the **essential counselling skills**.



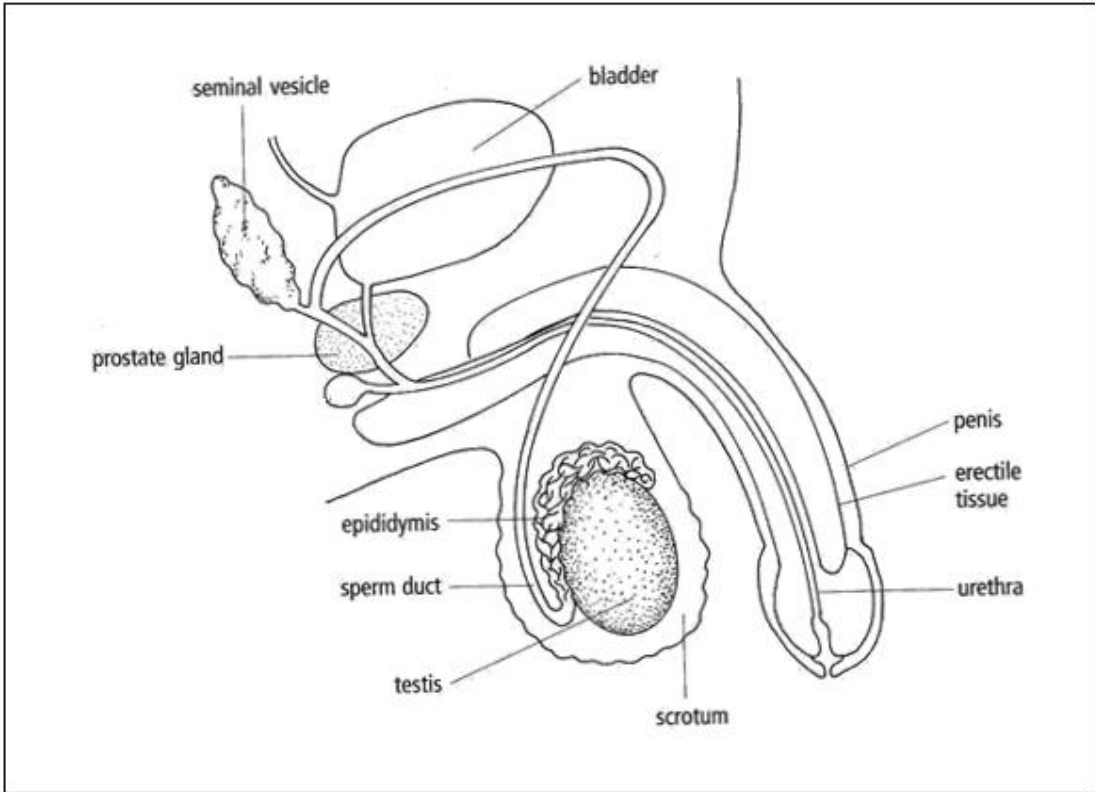
MODEL OF A COUNSELLING SESSION



SEXUAL ANATOMY

Male Reproductive Anatomy:

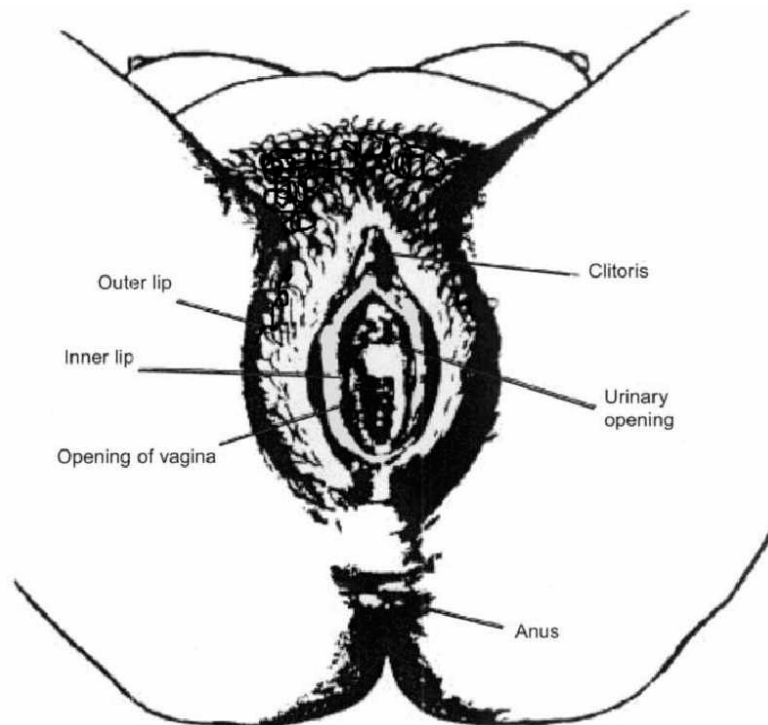
- The penis is the main male sex organ.
- The penis is usually soft and limp. When sexually aroused, the blood vessels swell with blood and the penis gets stiff or hard. This is called an erection.
- Below the penis near the body is the scrotum; it hangs below the penis.
- The scrotum is a sack of skin that holds the testes or testicles.
- The testicles produce sperm cells at all times.
- Sperm are the man's "seeds" that need to join with a woman's egg for fertilisation (to make a baby). Sperm are stored in the epididymis.
- Semen combines with sperm in the urethra to help sperm move easily.
- Semen is the liquid that comes out of the penis when a man ejaculates. In one-half teaspoon of semen, there are between 250 and 500 million sperm cells. About half a teaspoon of sperm spurts out during ejaculation.
- Sperm does not only come out of the body during ejaculation; some semen and sperm leaves the penis before and after ejaculation.



Female Reproductive Anatomy:

Female External Genitalia

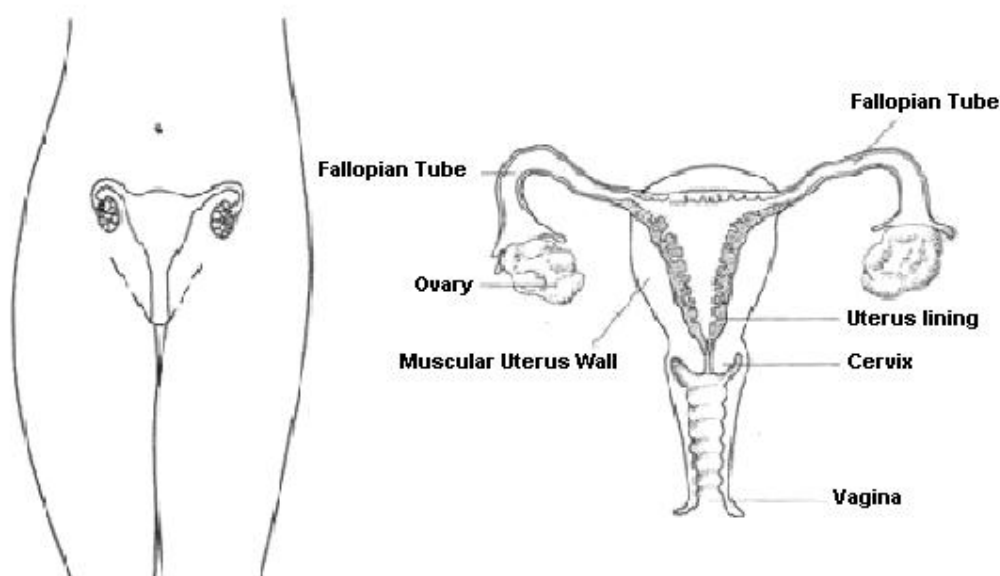
- The clitoris is outside the body and important for sexual stimulation.
- The clitoris is covered with a soft fold of skin that is located above the opening where urine comes out.
- The inner and outer lips cover the clitoris and vaginal opening.
- The urinary opening is between the clitoris and the vaginal opening.



Female Reproductive System (Internal)

- The vagina is the female's main sexual organ. The vagina is the passage that connects the uterus with the outside of the body.
- The cervix is the narrow neck of the uterus that connects the uterus with the vagina.
- The uterus is inside the body where the baby grows; it is also called the womb.

- Fallopian tubes and ovaries are on either side of the uterus. The ovaries contain the eggs. Each month one or more eggs are released from the ovaries and travel down the Fallopian tubes to the uterus.
- The fallopian tubes connect each ovary with the uterus.
- The uterus develops a soft lining of tissue that will feed and protect the egg if it becomes fertilised. Fertilisation happens when a sperm joins the egg.
- If the egg is not fertilised, the lining is not needed. The uterus lining breaks away and passes through the vagina. This is called menstruation or a woman's period.



Sexual Intercourse:

- During sexual intercourse, the man inserts his *penis* into the woman's vagina.
- In the case of mutual consent, the vagina shows its readiness by softening and opening up. It also produces body liquids, or vaginal fluids, which makes it easier for the man to insert his penis.
- Eventually the man ejaculates, which releases semen and sperm from his penis. Some semen also comes out of the man's penis before, during and after ejaculation.

Male Reproductive Anatomy

1. Bladder
2. Penis*
3. Erectile tissue
4. Urethra
5. Scrotum
6. Testis
7. Sperm*
8. Semen*
9. Epididymis
10. Erection*
11. Ejaculation*

Female Reproductive Anatomy

External Genitalia:

1. Clitoris*
2. Urinary opening
3. Anus*
4. Inner lip/outer lip (Labia)

Internal Reproductive System:

1. Fallopian tube*
2. Uterus lining
3. Cervix*
4. Vagina*
5. Muscular uterus wall
6. Ovary*
7. Egg*
8. Menstruation/period*
9. Vaginal fluids*

*Key Words



Sexual Behaviours

1. Sexual intercourse (sex)*
2. Oral sex
3. Anal sex
4. To get excited/sexually aroused*
5. Orgasm*
6. *Key Words

SEXUALITY AND GENDER ROLES

Sex: The word “sex” has different meanings. Sex can be used to refer to a person’s gender: if they are male or female. Another meaning of sex can refer to sexual intercourse. In this second meaning of the word, sex refers to the body, something that is physical.

Sexuality has a broader meaning than the word “sex.” Sexuality relates to our full personhood. It is the total expression of who we are as male and female human beings. It includes the physical, emotional and spiritual parts of us. It encompasses our personality, values, attitudes, gender, race, sexual orientation, etc. Sexuality involves much more than a physical sensation and includes our mental experiences as well.

Sexuality means:

- You are aware of what it means to be male or female.
 - You are aware of some of the expectations and gender roles imposed by society and culture.
 - You are aware of your own and other people’s bodies.
 - You feel sexually attracted to other people.
 - You are able and have a need to be emotionally close to somebody else.
- Gender: Gender is the fact that someone is male or female. There are actions, roles and expectations that we associate with being a man or a woman. We often call these gender roles.

Discussion Questions:

- What do you think are the implications for this exercise and during the process of negotiation with a partner for safer sex?
- How do beliefs about men’s or women’s sexuality affect how people approach the issue of condom use with a partner?
- What dynamics are different when a person is negotiating with a man rather than a woman?
- How does negotiation for specific sexual behaviour differ from negotiation in other circumstances? What makes it different?
- Can you think of any strategies for addressing the specific concerns of either gender in negotiation situations?
- *Focus on communication*: What factors might hinder communication when negotiating sexual behaviour?

Adapted from AIDSTECH/Family Health International. AIDS/STD Education and Counselling: Training Manual.



GENDER AND COUNSELLING

Discussion Questions:

- Do you think that working with women is any different from working with men in counselling? If so, what do you think the differences might be?
- In your cultures, what might it be like for a man to counsel a woman? Will establishing the relationship be the same or different? If it is different, what do you think the differences might be?
- What about the other way around: if a woman counsels a man? How might establishing the relationship be different? .
- What about counselling someone of the same gender? .
- How might the expectations of men and women in counselling be different?

Working with Men in Counselling

Counsellors who work with men in counselling often want more training on how to talk to men in counselling sessions. Many are aware that there may be a difference between how to talk with men and how to work with women, especially in counselling that is related to sexuality. While it is impossible to generalise communication approaches that work best for all men, an understanding of men's needs and roles might help counsellors engage and establish relationships with men for effective and productive counselling sessions, particularly when they involve sexuality and sexual health.

In this session we are going to discuss some very general tips for building relationships and working with men in counselling.

NOTE: Keep in mind that these tips may not apply to all men. They are NOT hard and fast rules, but suggestions for working with men in counselling.

1. Men are usually decision-makers. They are socialised to act decisively and be in control. This can cause conflict when a man goes to a health facility, especially when urged to go by his partner.
 - Be careful to allow men to make as many decisions as possible, just as it is important to let all our clients make their own decisions. Start by affirming his decision to come into counselling and then ask probing questions to find out what decisions he is considering.

Scenario: A man has come to your health facility because he had unprotected sex. He is concerned about HIV infection or other STIs.

What might not work: the provider might simply tell the man that unprotected sex puts him at risk for STIs, show him how to use a condom, give him condoms, and then tell him that he needs to use one every time he has sex.

What might work: The provider might say: “You made a really good decision to come here today for help. You have told me that there are times you have successfully used condoms in the past. What do you think worked for you when you used condoms? How might you make sure you use condoms every time you have sex in the future?”

2. Men may not want to appear ignorant (as if they do not know something). Men are often socialised to know all about sex. Admitting that they do not know something, especially something related to sex, creates anxiety for men. In a counselling session, this may be a problem if the counsellor is expecting a man to ask questions or ask for clarification when he does not understand something. Men are not likely to ask questions or to admit that they do not understand.
 - One technique counsellors can use is to make it OK for men not to know. Instead of asking men to acknowledge what they do not know, providers can take the burden off a man by proactively giving information without making it appear like he does not know something.

Scenario: A counsellor is about to do a condom demonstration for a man.

What might not work: The counsellor might ask the man if he knows how to correctly use a condom. The man might say “yes,” and the counsellor would not do the demonstration. Or the counsellor might do a condom demonstration and then ask, “Do you have questions?”

What might work: The counsellor might say, “I am sure you already know how to use a condom correctly, but I will just review a few important points about what some men struggle with...”

3. Men may be more comfortable with thoughts and action than with feelings. In general, women tend to be more comfortable discussing feelings than men. In a counselling session, the counsellor might focus on thoughts, options and decision-making steps rather than on a discussion of emotions. If you ask a man how he felt when he found out that his partner was pregnant, he might not be quick to describe his feelings, but if you ask him what thoughts were going through his mind, he may be more likely to talk about those.



Scenario: A man comes to the health facility to be tested for HIV. The man is there because he just found out that his girlfriend has tested positively for HIV.

What might not work: The counsellor might ask the man, “Your girlfriend just told you that she tested positive for HIV. How are you feeling about that?”

What might work: The counsellor might say, “I really appreciate the fact that you came in for counselling and testing given the difficult news you have received. That was not an easy thing to do, but it was a good idea to come here and talk about it. It sounds as if you have been doing a lot of thinking. What sorts of things have you been thinking about?”

4. Men like to know that other men share their fears and concerns. A man may be more comfortable discussing his feelings if the counsellor validates that his fears or concerns are normal and that other men have similar feelings.
 - If the counsellor suspects that the client has a concern he is not communicating, the counsellor can talk about that issue in terms of what other men like him have shared in the past.

Adapted from EngenderHealth. 2003. Comprehensive Counselling for Reproductive Health: An Integrated Curriculum, Trainers' Manual and Participants' Manual.

Helpful Phrases to Use When Working with Men in Counselling

Need or Role	Sample Phrase
Men are decision-makers and want to solve their own problems.	<ul style="list-style-type: none"> ▪ You made a good decision to come here today. ▪ You made a good decision to use a condom that time. ▪ How do you plan to talk to your partner about this?
Men are supposed to know it all when it comes to sex.	<ul style="list-style-type: none"> ▪ You may already know this, but... ▪ You have probably heard this before, but I have to tell all my clients that... ▪ I am sure you already know how to put on a condom correctly, but why don't we just review a few important points about...
Men might not ask questions about sex.	<ul style="list-style-type: none"> ▪ You seem to understand in general how to use condoms, but are there any points you would like to know a little more about? ▪ As long as you are here today, are there any things you would like to ask or tell me about? ▪ Even when we have dealt with a problem we sometimes have a few doubts afterwards. Is there anything more you would like to discuss with me?
Men want to know that they are "normal" and as good as, or better than, other men.	<ul style="list-style-type: none"> ▪ Many men are concerned about the same thing. ▪ Many men have asked that question before. ▪ A lot of men wonder about that.
Men may need validation for asking questions about sex.	<ul style="list-style-type: none"> ▪ That is a really good question. ▪ I am glad you asked about that. ▪ You are really brave to ask that question. ▪ It is great that you came here to be tested and to ask the questions you did.

Adapted from EngenderHealth. 2003. Comprehensive Counselling for Reproductive Health: An Integrated Curriculum, Trainers' Manual and Participants' Manual.

BELIEFS ABOUT SEXUALITY

Beliefs Worksheet

Directions: Consider each item carefully, and then write the number that best describes how much you agree or disagree with the statement on the line before the statement. This worksheet will not be collected.

- 1 – Strongly Agree
- 2 – Agree
- 3 – No Opinion
- 4 – Disagree
- 5 – Strongly Disagree

- _____ 1. Men always want to have sex.
- _____ 2. Women do not think much about sex.
- _____ 3. Women should wait for their partners to start sexual activity.
- _____ 4. Men are always ready to have sex.
- _____ 5. A woman who is prepared for sex is “easy.”
- _____ 6. Having sex is like performing for an audience.
- _____ 7. Women have difficulty having orgasms.
- _____ 8. When a woman says “no” to having sex, she really means “yes.”
- _____ 9. If a man goes too long without having sex, it is bad for him.
- _____ 10. If a man loses his erection, he will not be able to have sex.
- _____ 11. Women have sex just for the relationship.
- _____ 12. All physical contact must lead to sex.
- _____ 13. Men are turned off by aggressive women.
- _____ 14. Women need to be in the mood to have sex.
- _____ 15. “Good” sex must end in orgasm.
- _____ 16. Once a man has an erection, he must have sexual intercourse to achieve satisfaction.
- _____ 17. Women are always passive during sex.
- _____ 18. Sexual health care and family planning are a woman’s responsibility.
- _____ 19. It is the woman’s responsibility to introduce condom use.



HEALTHY SEXUALITY

Definition of Sexual Health:

Being able to express yourself sexually without any negative risk to yourself. Sexual health may be physical, but it also includes psychological or mental aspects. Having good sexual health includes having a positive approach to sexual relationships and interactions, feeling free to express oneself sexually, and being well informed about sexual issues (these include menstruation, family planning, pregnancy, STIs and HIV).

Sexual health is...	Sexual health is NOT...
<ul style="list-style-type: none"> ▪ Having the freedom of sexual expression 	<ul style="list-style-type: none"> ▪ Being forced to do things
<ul style="list-style-type: none"> ▪ Being well-informed about sexual matters 	<ul style="list-style-type: none"> ▪ Doing things that are not pleasurable to you
<ul style="list-style-type: none"> ▪ Enjoying sexual behaviours 	<ul style="list-style-type: none"> ▪ Being afraid about becoming pregnant
<ul style="list-style-type: none"> ▪ Having a positive approach to sex 	<ul style="list-style-type: none"> ▪ Being afraid that you are at risk of getting HIV or an STI
<ul style="list-style-type: none"> ▪ Feeling safe at all times during sexual behaviours 	<ul style="list-style-type: none"> ▪ Being afraid that you have HIV

You can achieve good sexual health by:

- ❖ Informing or educating yourself about sexual matters
- ❖ Only engaging in sexual behaviours when you are willing
- ❖ Ensuring that your partner is considerate in his/her sexual relations with you
- ❖ Informing your partner when sexual relations are uncomfortable, unpleasant or painful
- ❖ Avoiding or preventing sexual relations that violate your human rights
- ❖ Seeking relationships in which you can freely express and enjoy your sexuality
- ❖ Protecting yourself from STIs, HIV and unwanted pregnancy



Guide to Safer Sexual Relations (For reference)

- Remember that vaginal, semen and sexual fluids have high concentrations of HIV if you or your partner has HIV. You need to protect yourself from coming into contact with these fluids. The safest way to do this is by using a barrier method, such as a male or female condom.
- Find out your HIV status as well as your partner's HIV status on a regular basis. Knowing this will either put your mind at ease or help you to take the necessary precautions against infection or re-infection.
- Try to be faithful to one sexual partner who is also faithful to you. If two healthy partners are faithful, there is no chance of an infection taking place. A risk exists only when one partner contracts HIV or an STI from someone else.
- Have regular check-ups at a clinic, particularly if you are a woman, to confirm your reproductive health.
- Engage in sexual activities that are pleasurable but present either low or no risk to you. It may be healthy for you and your partner to get to know each other by exploring each other's bodies, for example, engaging in foreplay (such as kissing, touching and even oral sex) and masturbating each other, before you have penetrative sex.
- Say "no" to partners who are disrespectful, intimidating or manipulative; who present a possible risk; or whom you feel you cannot trust. You may have to pay a high price for a brief moment of pleasure.
- No matter your gender, religion, culture or community, in the eyes of the law it is your right to decide who you would like to have sex with, when you would like to do it and how.

Adapted from HIVSA. April 2005. Education and Support Group Materials Toolkit.



KNOWING ABOUT SEXUALLY TRANSMITTED INFECTIONS (STIs)

Relationship between STIs and HIV:

- Like HIV, STIs are also transmitted by the same route.
- HIV and STIs can be prevented with the same behaviours and methods.
- The presence of an STI increases the chances of transmission of HIV.
- Risks of getting HIV increases if there are open sores in a person with an STI.
- Many STIs can be cured, but HIV cannot be cured.
- Usually the partner of a person with a STI also needs to be treated.
- Consistent condom use is the best prevention method for HIV and STIs.
- STIs may be harder to treat in people who have HIV due to their weak immune systems.
- STI prevention is one way to fight the HIV epidemic.

Key Points:

- HIV is an STI. STIs “like to travel together” and are therefore closely linked to HIV. People with HIV can get STIs more easily and these may be more difficult to cure. STI such as syphilis may speed up the “natural course of HIV disease.” This means that they reduce the time that a person with HIV feels well without treatment.
- Talking about STIs and HIV can often be difficult for people since they are related to sex. Because of the relationship you have established with your client as a counsellor, he/she may be comfortable talking with you about STIs, so you should be familiar with them and help refer the client to a doctor if he/she has any signs or symptoms.

Activities and material in this session adapted from UNESCO Bangkok. 2005. Reducing HIV/AIDS Vulnerability Among Students in the School Setting: A Teacher Training Manual.



Knowing About STIs

Questions	Answers
What does STI stand for?	Sexually Transmitted Infection
What are STIs? Give a correct description.	Infections that are transmitted (passed) through sexual contact. Sexual contact includes intimate body contact (without clothes), vaginal sex, anal sex and oral sex.
What is another name for STI?	Can also be called STD (sexually transmitted disease) or venereal disease.
Name at least three (3) STIs.	Gonorrhoea, Syphilis, Herpes, HIV, Genital Warts, Chlamydia, Crabs, Scabies, Hepatitis B, Chancroid
Are all STIs curable?	No, but most are curable. Viral STIs such as HIV, Herpes and Hepatitis B are not curable.
List at least three (3) possible symptoms of STIs.	Burning sensation while urinating Increased frequency of urination Blisters, ulcers or swelling on or around the genitals (penis or vagina) Warts around the penis vagina or anus Itching in the genital area Men: clear or creamy discharge (fluid) from the penis Women: unusual vaginal discharge (fluid), lower abdominal pain, irregular bleeding (not with menstruation/period), painful intercourse
Do you know immediately if you have an STI?	Not always. You may have an STI but have no symptoms for a long time. (Symptoms may be there, but these may be caused by an infection that is NOT sexually transmitted. This is very common in women who have vaginal discharge.)
Why are some STIs dangerous? OR What can happen if an STI is not treated?	If not treated, the infection can spread and cause sterility (or infertility) in men and women (where they cannot have children). Syphilis can even lead to death. An STI also increases the risk of HIV transmission.
Is HIV an STI?	Yes, when it is transmitted sexually. But HIV can also be transmitted non-sexually, such as from a mother to a child or from contaminated blood (i.e. shared needles or blood transfusion).
Name the most effective ways to protect yourself from an STI.	Abstinence: no sex Be faithful to one partner: both partners are faithful to each other and as long as they are both free of infection. Condom use: use a condom correctly and consistently every time you have sex

What is the first thing you should do when you think you have an STI?	Go to a health facility and see a doctor or nurse. Inform your sexual partners to go for treatment. Remember that not all infections are sexually transmitted. This is not a “proof” that someone has been “cheating.” The partner only receives treatment to prevent possible complications or re-infections.
Your doctor prescribed medicines for 7 days, but the symptoms disappear after 5 days. Can you stop taking the medicines?	No, some STI germs are hard to kill. The medicines must be taken as the doctor prescribed them, for as long as the doctor prescribed them.
Why are people who have an STI at a higher risk of HIV infection?	Many STIs may cause sores around the genitals or discharge that contains lots of viruses. This makes it easier for HIV to enter the body.
Can you have sex while you are being treated for an STI?	No, you can infect your partner even while you are being treated. Therefore, you should not have sex until you are completely cured, or always use a condom during treatment and thereafter! Be sure to finish your medicines.

Adapted from UNESCO Bangkok. 2005. Reducing HIV/AIDS Vulnerability Among Students in the School Setting: A Teacher Training Manual.



HIV/AIDS DEFINITIONS

What is **HIV**?

- **HIV** means Human Immuno-deficiency Virus.
 - **H: Human** means that the virus affects only humans and lives only in humans. It does not live in animals, in toilets, in food, etc.
 - **I: Immuno-deficiency** means a break-down or lessening of the immune system, which decreases the body's ability to fight disease. The **immune system** is the body's defence for fighting off infections. The immune system usually helps to defend the body against infections.
 - **V: Virus**. A virus is a germ that invades the body and causes diseases.
- HIV is a virus that weakens the body's ability to fight disease.
- HIV is the virus that causes AIDS.
- A person with HIV is often healthy without any symptoms.
- This virus attacks the very cells (the immune system) that our body uses to fight HIV. This means that it weakens the immune system so that the body cannot fight infections.

What is **AIDS**?

- **AIDS** means Acquired Immune Deficiency Syndrome.
 - **A:** Acquired means to get or develop over a period of time.
 - **ID:** Immune Deficiency means a decrease in the body's ability to fight diseases. It affects the immune system and breaks it down or makes it deficient, or weaker. The immune system does not break like an egg; it breaks down gradually over time. It gets deficient, or less and less efficient, under the attack of the multiplying numbers of the HIV virus in the body.
 - **S:** Syndrome refers to a group or collection of signs and symptoms of disease in a person who has AIDS. These signs and symptoms include unusual weight loss, fever, dry cough, excessive tiredness, diarrhoea for a long time, etc.
- **AIDS** is an advanced stage of HIV disease. It usually takes years, sometimes over 10 years, for the HIV virus to progress to the stage of AIDS.
- AIDS develops because the body's immune system can no longer cope because it has been weakened by the virus. A person with AIDS is often sick.

STIGMA & DISCRIMINATION

Dictionary Definitions of Stigma:

- ❑ “The strong feeling in society that a type of behaviour is shameful.” *Longman Dictionary of Contemporary English*
- ❑ “A mark of shame or discredit to a person or group.” *Merriam-Webster Dictionary*
- ❑ “A brand.” *Oxford English Dictionary*
- ❑ An attribute of a person that is considered unacceptable.

Stigma comes from two sources:

- External: this comes from others in our communities, such as friends, neighbours, doctors, nurses and even counsellors. This type of stigma is a judgement on our own personal behaviour.
- Internal: this comes from within us. It normally shows itself as feeling rejected and ashamed. It can also be from blaming oneself, judging oneself and not accepting oneself.

Stigma is a **process**:

1. Point out or label differences: “He is different from us – he coughs a lot.”
2. Attribute differences to negative behaviour: “His sickness is caused by his sinful and promiscuous behaviour.”
3. Separate “us” and “them”: e.g. shunning, isolation, rejection
4. Loss of status and discrimination: loss of respect and isolation

Dictionary Definitions of Discrimination:

- ❑ “The practice of treating one particular group in society in an unfair way.” *Longman Dictionary of Contemporary English*
- ❑ “Prejudiced or prejudicial outlook, action, or treatment.” *Merriam-Webster Dictionary*
- ❑ Discrimination happens when a person is treated unfairly because of a particular attribute, such as race, religious affiliation, health status, or economic status.

3. Relationship between stigma and discrimination:

- Stigma is the thought or feeling that influences the way you act or behave.
- Discrimination is a behaviour or an act.
- Stigma can result in discrimination.

- Discriminating between two things is not always bad, but where stigma and discrimination work together, it is negative. For example, a person is likely to say to himself, “That person has HIV and they could have prevented it. I am not like that. I am different from that person and better than her too.” This gives people a false sense of security that they are invulnerable to HIV. It unjustly separates a person from others.

Disclosure: the primary step in breaking down stigma.

“We are not victims, we are not patients, and we are not sufferers. These names are both derogatory [negative] and disempowering. We are people living with HIV. We laugh, we cry, we dance, we sing, we play, we argue, we pay tax, we are parents and children. We belong to families. We are all in communities. Above all these things we are part of human nature. That is the second challenge: de-stigmatizing ourselves and HIV/AIDS.”

Thanduxolo Doro, *speaking at the First National Summit for People Living with HIV/AIDS, held in Midrand, South Africa, October 2002*

Source: SAfAIDS

Stigmatisation involves:

- Judging or blaming people.
- The judging is based on assumptions about people’s sexual (and other) behaviour.
- As humans, we often believe or assume the worst about other people.
- We assume that certain categories of people are more at-risk because of their occupations or behaviours, i.e. sex workers, alcoholics, truck drivers, soldiers, etc.
- We are all at risk, so we should stop judging each other.
- HIV is not limited to certain groups or occupations. It is in every community.



TRANSMISSION OF HIV

Ways HIV is Transmitted:

Make sure the list of ways that HIV is transmitted includes the following:

1. Unprotected sex with an infected person: this includes unprotected sex of any kind where penetration is involved: vaginal, oral and anal. HIV is a sexually transmitted infection (STI).
2. Blood-to-blood contact: includes sharing of needles used to inject drugs, knives or needles for tattoos, ritual scarring, or piercing, or a prick from a needle used to give an infected person an injection. Note: in some places, HIV has been transmitted through blood transfusions. However, in Namibia, the blood supply is safe, because all blood is tested for HIV and all HIV-positive blood is destroyed.
3. Mother-to-child transmission: an infected mother can pass on the virus during pregnancy, during delivery or breastfeeding.

Ways HIV is Not Transmitted:

This is not a complete list.

1. Handshakes, hugging and touching with an infected person.
2. Swimming or bathing with an infected person.
3. Eating together or sharing utensils (i.e. cup, plate, spoon) with an infected person.
4. Toilet seats, or sharing towels, clothes or a bed with an infected person.
5. Mosquitoes.
6. Hugging and kissing (if there are no bleeding gums or broken skin).
7. Massages.
8. Masturbation, including self-massage, or mutual massage (rubbing and stroking the genitals by two partners). If one or both partners are infected, care must be taken to ensure that there are no openings in the skin where the virus can enter.

*Note: The virus is easily destroyed by heat, drying, soap and disinfectant (i.e. Jik).



Key Point: The HIV virus cannot live outside the body. The virus needs the cells of the body to stay alive and to replicate (multiply or make more copies of itself).

Body fluids that can transmit HIV:

Blood

Vaginal fluids (female sex fluids)

Semen (male sex fluid)

Breast milk

Principal ways HIV is transmitted:

- Through sexual intercourse: 75-85%
- Mother-to-child transmission: Up to 10%
- Intravenous drug use: Up to 10% (starting to become a problem in Africa)
- Blood transfusion: Up to 5% globally, but not an issue in Namibia because all blood is tested for HIV
- Exposure through needles, etc.: 0.01%

Infection Route	Risk of Infection
Sexual Intercourse	
Female positive to male negative	1 in 700 to 1 in 3,000
Male positive to female negative	1 in 200 to 1 in 2,000
Male-to-male transmission	1 in 10 to 1 in 1,600
Fellatio: oral sex	Not really known
Through Other Means	
Needle stick (i.e. in a hospital)	1 in 200
Needle sharing (i.e. drug users)	1 in 150
Transfusion of infected blood (blood transfusions)	95 in 100
Transmission from Mother to Infant	
Without treatment	1 in 3.5
With AZT or Nevirapine treatment	<1 in 10
With combination anti-retroviral therapy	1 in 50

* Note: Females are at a much higher risk of becoming infected through unprotected sex than men are.



Risk of Infection from Highest Risk to Lowest (from above chart):

1. Infected blood transfusion
2. Transmission from mother to infant without treatment
3. Transmission from mother to infant with Nevirapine
4. Transmission from mother to infant if mother is on ART
5. Male-to-male transmission
6. Needle sharing (intravenous drug users)
7. Male positive to female negative sexual transmission
8. Needle stick
9. Female positive to male negative sexual transmission
10. Oral sex

Risk of HIV transmission is increased by:

- Number of partners
- Presence of other STIs (sexually transmitted diseases)
- The menstrual cycle
- The stage of the disease in the positive person: the risk of transmission is highest during acute infection (right after infection before antibodies are produced, also known as the window period) and advanced disease.

During unprotected vaginal intercourse (sex), a woman's risk of becoming infected is four times higher than that of a man. Why are women at a higher risk for becoming infected through unprotected sex than men are?

There are three biological reasons:

1. The vaginal wall has a much larger surface area and is much more fragile (very thin skin) than the penis.
2. Men produce and leave more secretions (fluids) than women, as semen is deposited into the woman's body during sex.
3. HIV-infected semen typically contains higher viral concentrations that do vaginal secretions.

Source: Peter R. Lamptey, Jami L. Johnson, and Marya Khan. March 2006. The Global Challenge of HIV and AIDS, Population Bulletin, Vol. 61, No.1.

Vulnerability of women: why women are at a greater risk of HIV infection:

- Difference in power: men have more power (male dominance)
- Difference in social : men are usually the ones to make decisions
- In marriage, women are expected to do what their husbands say, i.e. not use a condom



- Women tend to depend on men financially
- Women's lack of access to education or personal income
- Unequal property rights
- Women fear their husbands will abandon them if they try to control how and when they have sex and whether their partner uses a condom.
- Poverty drives some women into sex work.
- Men control the primary mode of prevention: use of the male condom
- Older men prefer young women
- Violence against women

Transmission Risk Quiz

Below is a list of different scenarios. Please identify if each of the scenarios involves no risk, low risk or high risk.

- **No risk:** there is no risk of HIV infection in this activity.
 - **Low risk:** there is a low risk of HIV infection in this activity.
 - **High risk:** there is a high risk of HIV infection in this activity.
1. You are bitten by a mosquito.
 2. You use a public toilet.
 3. You take somebody's razor blade to shave your face or armpits.
 4. You use someone else's toothbrush.
 5. You have vaginal sex without a condom.
 6. You donate blood to the Namibian Blood Transfusion Service.
 7. You have multiple sexual partners.
 8. You do deep kissing with an infected partner.
 9. You share clothes with a person who is HIV-positive.
 10. You share needles for ear piercing that you have carefully cleaned with water.
 11. You rub your partner's penis to the point of ejaculation.
 12. An AIDS patient coughs near you.
 13. You have sex with a person you do not know well, but you use a condom properly.
 14. You sleep in one bed with an HIV-infected person without having sex.
 15. You are a homosexual and have anal intercourse without a condom.
 16. You touch and comfort someone living with AIDS.
 17. You eat food prepared by an infected person.
 18. You give your baby to a friend to breastfeed while you are at the market.
 19. You come in contact with someone's faeces.
 20. You have a sexually transmitted infection but continue having sex.
 21. You are a virgin and have unprotected sex the first time you have sex.
 22. You use a borrowed syringe for intravenous drug use.
 23. You engage in oral sex without using a condom.
 24. You share a drink, using the same cup as an infected person.
 25. A mosquito bit you after it bit an HIV-positive person.

Adapted from Ghana Red Cross. Session Manual, p. 7 – 8.



PREVENTION OF HIV TRANSMISSION

Prevention of Sexual Transmission of HIV

There are three main ways to prevent transmission of HIV sexually:

A: Abstinence

B: Be Faithful to a partner who is faithful to you

C: Consistent Condom Use

Abstinence

- Delay onset of sexual behaviour. Encourage teenagers to wait to have sex.
- Intermittent abstinence: this can include abstaining from sex when you do not have a regular partner, and can also be an aspect of being faithful.

Be Faithful: protecting a couple's relationship from HIV

- Refer one's partner for HIV counselling and testing. Remember, being faithful is only effective if both partners have been tested and are known to be HIV-negative.
- Both partners being faithful is the only sure way to protect your relationship and your future from HIV.
- Affirm both privately and publicly your mutual commitment to the relationship.
- Develop a shared vision of your future together.
- Establish shared goals and priorities.
- Demonstrate genuine respect for each other.
- Be both supportive and forgiving.
- Maintain open and honest communication. Talk through problems as they come up; remember conflict management and "I" statements.
- Know that there will be difficult and challenging times for both partners. Commit to working through these times together.
- Act as a role model to family, friends and co-workers in making your relationship a priority by sharing social occasions and family events together and openly acknowledging your shared commitment.

"Be Faithful" adapted from Department of Health & Human Services, Centers for Disease Control and Prevention. October 2004. Voluntary Counselling and Testing (VCT), Training Course. Participant's Manual, USA.

Use a Condom

- Learn how to use a condom, both male and female.
- Use a condom correctly.
- Use a condom consistently: use a condom every time you have sex.



An Alternative to ABC: the SAVE Model of HIV Prevention

Recently, some organisations have realised that the ABC model is not always realistic for people, and may actually contribute to stigma at times.

A new model for HIV prevention and response has been developed that encompasses the ABC ideas but is also broader: **SAVE**.

- Safer practices
- Available medications
- Voluntary counselling and testing (VCT)
- Empowerment through education

S refers to **safer practises** covering all the different modes of HIV transmission. For example, safe blood for blood transfusions, barrier methods for penetrative sexual intercourse, sterile needles and syringes for injecting, safer methods for scarification, and adoption of universal medical precautions.

A refers to **available medications**. Antiretroviral (ARV) therapy is by no means the only medical intervention needed by people living with HIV or AIDS. Long before it may be necessary or desirable for a person to commence ARV therapy, some HIV-associated infections will have to be treated. Treating these infections results in better quality of life, better health and longer-term survival. Every person needs good nutrition and clean water, and this is doubly true for people living with HIV and AIDS.

V refers to **voluntary counselling and testing**. Individuals who know their HIV status are in a better position to protect themselves from infection, and if they are HIV-positive, from infecting another. Someone who is HIV-positive can be provided with information and support to enable them to live positively. People who are ignorant of their HIV status, or who are not care for, can be sources of new HIV infections.

E refers to **empowerment through education**. It is not possible to make informed decisions about any aspect of HIV or sexual behaviour without access to all the relevant facts. Inaccurate information and ignorance are two of the greatest factors driving HIV- and AIDS-related stigma and discrimination. Correct, non-judgemental information needs to be disseminated to all. This will assist people to live positively, whatever their HIV status. Education also includes information on good nutrition, stress management, and the need for physical exercise.

SAVE model from ANERELA+. Information adapted from: Christian AID. www.christian-aid.org.uk/news/media/pressrel/060321p.htm



Prevention of Blood-to-Blood Contact: Universal Precautions

(For reference)

1. Blood, especially in large spills such as from nosebleeds, and old blood or bloodstains, should be handled with caution. Skin exposed accidentally to blood should be washed immediately with soap and running water. All bleeding wounds, sores, breaks in the skin, grazes and open skin lesions should ideally be cleaned immediately with running water and/or other antiseptics. If there is a biting or scratching incident where the skin is broken, the wound should be washed and cleansed under running water, dried, treated with antiseptic and covered with a waterproof dressing. Blood splashes to the face (mucous membranes of eyes, nose or mouth) should be flushed with running water for at least three minutes.
2. Disposable bags must be made available to get rid of sanitary wear.
3. All open wounds, sores, breaks in the skin, grazes and open skin lesions should at all times be covered completely and securely with a non-porous or waterproof dressing or plaster so that there is no risk of exposure to blood.
4. All persons attending to blood spills, open wounds, sores, breaks in the skin, grazes, open skin lesions, body fluids and excretions should wear protective latex gloves or plastic bags over their hands to eliminate the risk of HIV transmission effectively. Bleeding can be managed by compression with material that will absorb the blood, e.g. a towel.
5. If a surface has been contaminated with body fluids and excretions which could be contaminated with blood, i.e. tears, saliva, mucus, phlegm, urine, vomit, faeces and pus, the surface should be cleaned with running water and household bleach (1:10 solution), and paper or disposable cloths. The person doing the cleaning must wear protective gloves or plastic bags on his/her hands.
6. Blood-contaminated material should be sealed in a plastic bag and incinerated, sent to an appropriate disposal firm, or otherwise properly disposed of. Tissues and toilet paper can be readily flushed down a toilet.
7. If instruments (i.e. scissors) become contaminated with blood or other body fluids, they should be washed and placed in a strong household bleach solution (1:10) for at least one hour before drying and re-using.

Recommended Contents of First Aid boxes:

- Two large and two medium pairs of disposable latex gloves
- Two large and two medium pairs of household rubber gloves for handling blood-soaked material in specific instances (for example, when broken glass makes the use of latex gloves inappropriate)
- Absorbent material
- Waterproof plasters
- Disinfectant (such as hypochlorite, Savlon/Jik)
- Scissors
- Cotton wool
- Gauze tape
- Tissues
- Water containers
- Resuscitation mouthpiece or similar device with which mouth-to-mouth resuscitation can be administered without any contact being made with blood or other body fluids
- Protective eyewear
- Protective facemask to cover nose and mouth

Alternatives: Universal precautions are, in essence, barriers to prevent contact with blood or body fluids. Adequate barriers can also be established by using less sophisticated devices than those described above, such as:

- Unbroken plastic bags on hands where latex or rubber gloves are not available
- Common household bleach for use as disinfectant (diluted one part bleach to ten parts water)
- Spectacles instead of protective eyewear
- Scarf instead of protective facemask

Used items should be dealt with as indicated in paragraphs 6 and 7 above.

Adapted from Namibian Training Curriculum for Community Counsellors. August 2004. Prevention of Mother-to-Child Transmission of HIV, final draft

PREVALENCE OF HIV

Prevalence rate: the percentage of people in a population at a given time who have a disease such as HIV.

Incidence: new cases (i.e. of a disease). HIV incidence is the number of new cases of HIV infection.

The overall HIV prevalence rate from the 2004 serosentinel survey in Namibia was 19.7%.

- What do you think contributes to the high rates of HIV prevalence in Namibia and in Sub-Saharan Africa? *Answers may include:*
 - Less access to health care (for instance, STIs are not treated as quickly and contribute to the rate of transmission)
 - Multiple concurrent partners are common
 - Migration, transport, and sexual networking
 - Work-related, shipping and trucking, war, refugees
 - Back-and-forth migration between rural areas and cities
 - Poverty
 - Lack of access to prevention information
 - Economic vulnerability and the low status of women reduces opportunities to negotiate safer sex
 - Delayed national and international response
 - Lack of timely change of societal norms
 - Biological factors
 - Lack of male circumcision
 - High prevalence of STIs
 - Other unknown factors

Additional Statistics:

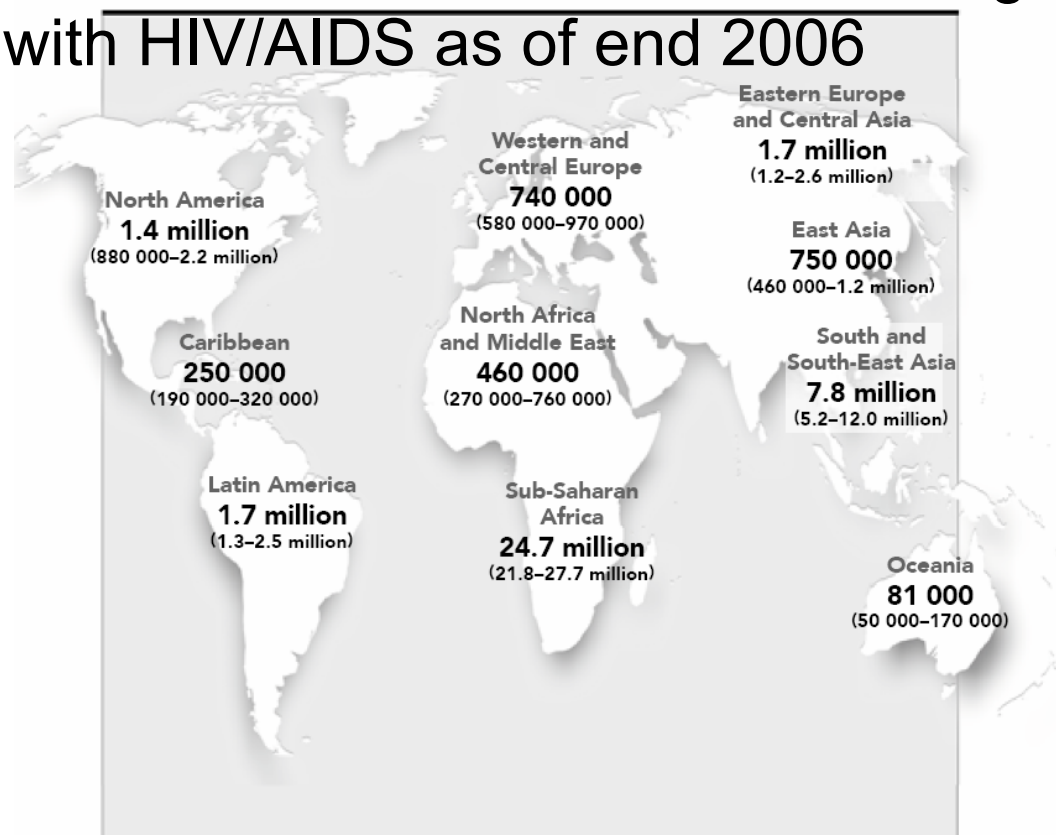
Globally, by the end of 2005:

- 25 million people have died of AIDS.
- At least 40 million people are now living with HIV.
- In 2005, an estimated 6.5 million people needed anti-retroviral treatment; only about 15 percent – 1 million people – had access to treatment.
- An estimated 4.9 million people were newly infected with HIV in 2005. Most of those people in Sub-Saharan Africa.
- More Africans die of AIDS-related illnesses than of any other cause.
- UNAIDS estimates that 2.3 million children were living with HIV at the end of 2005.
- At the end of 2003, 15 million children had lost at least one parent to AIDS; of these, 12 million are in Sub-Saharan Africa.

Additional Statistics from Peter R. Lamptey, Jami L. Johnson, and Marya Khan. March 2006. The Global Challenge of HIV and AIDS, Population Bulletin, Vol. 61, No.1.



Adults and children estimated to be living with HIV/AIDS as of end 2006



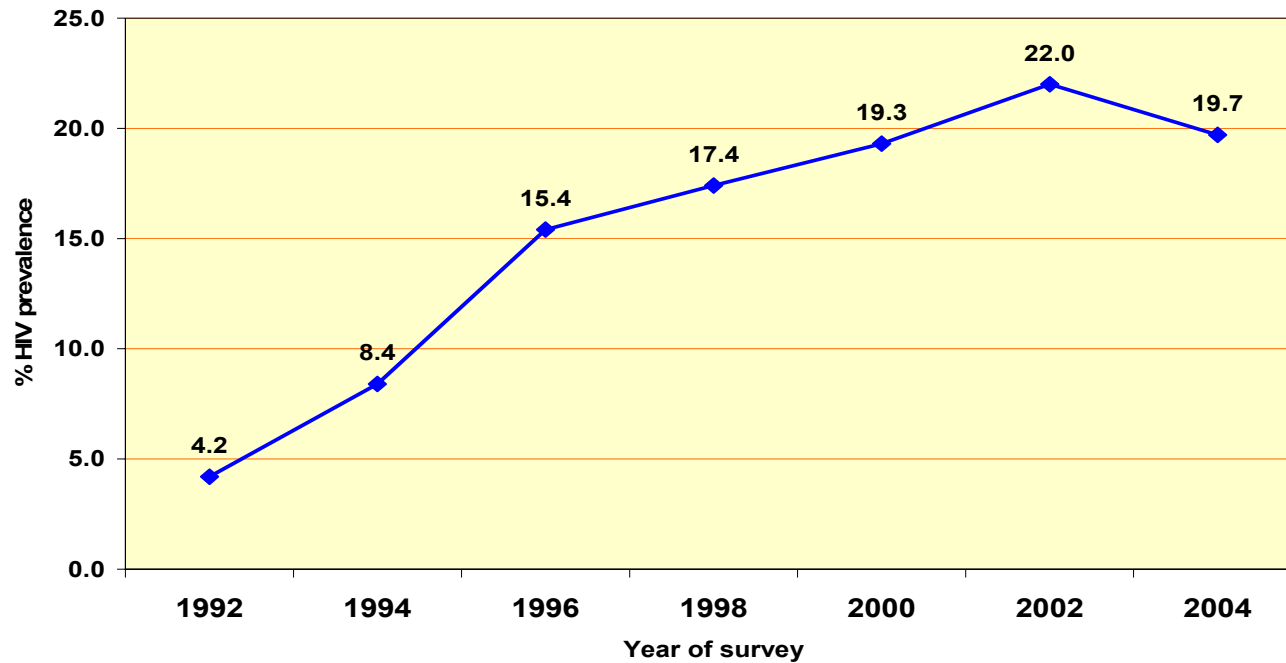
Source: Joint United Nations Programme on HIV/AIDS (UNAIDS). 2006.
http://data.unaids.org/pub/EpiReport/2006/12-Maps_2006_EpiUpdate_eng.pdf



Source:

HIV prevalence rate in pregnant women, biannual surveys 1992-2004, Namibia

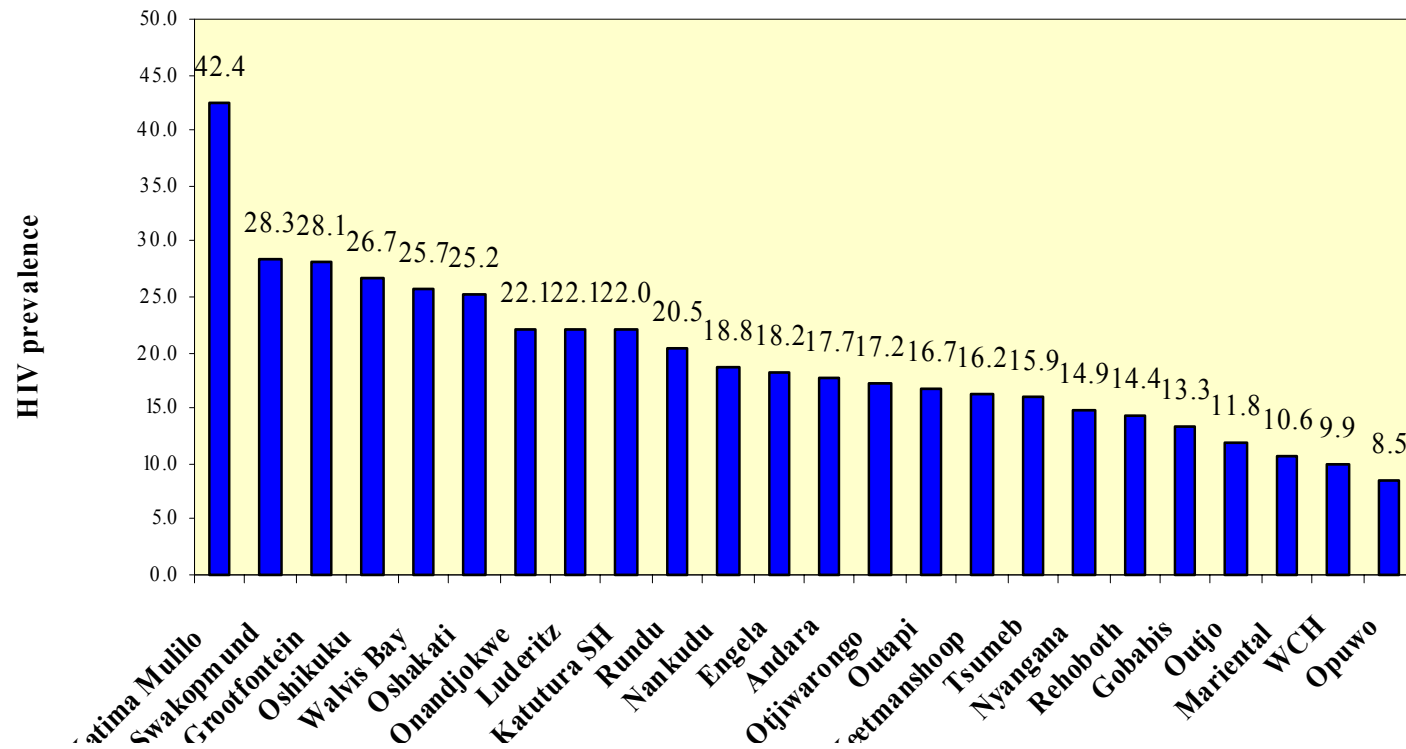
Source:



Government of the Republic of Namibia. July 2005. *Report of the 2004 National HIV Sentinel Survey*. Ministry of Health and Social Services, Directorate of Special Programmes, Windhoek, Namibia, p. 10.



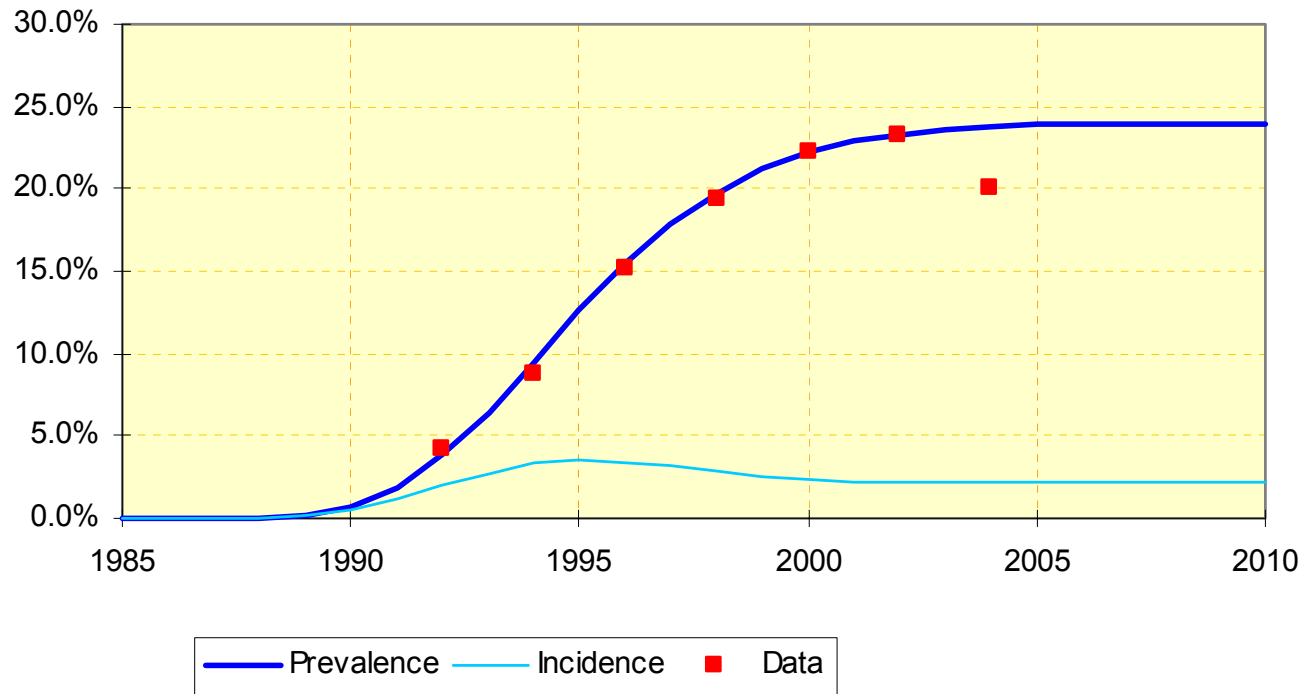
Figure 1: HIV prevalence in Namibia among ANC attendees by site (2004)



Source: Government of the Republic of Namibia. July 2005. *Report of the 2004 National HIV Sentinel Survey*. Ministry of Health and Social Services, Directorate of Special Programmes, Windhoek, Namibia, p.7.



Trend in HIV Prevalence in Pregnant Women, Namibia



Note the rise in prevalence.
Notice that the incidence rate has remained about the same.



COMMUNITY BELIEFS AND MYTHS ABOUT HIV/AIDS

Myth: incorrect belief held by a community

- Small group discussion questions:
 - What do people in your community believe causes illness such as HIV/AIDS?
 - What do people in your community call HIV and AIDS?
 - What do people think about people with HIV?
 - Who are recognised as healers in your community? What types of treatment do they provide?

Key Points:

- False beliefs and myths about HIV/AIDS are widespread in our communities. These beliefs can negatively affect prevention and treatment of HIV/AIDS.
- Education can combat these beliefs.
- In counselling, first listen to your client's beliefs before providing information.

THE IMMUNE SYSTEM AND HIV

What is the immune system?

- The immune system is the body's defence against infection. It protects the body against viruses and diseases. It keeps your body from getting sick.
- Protecting the body is a difficult and complex job that involves many cells with many different functions.
- In order to understand the immune system, it helps if we think of it as an army of soldiers who all have different jobs or functions.

Antibody: the substance that the body makes to fight a virus or infection. Its purpose is to protect the body from disease by not allowing the disease to reproduce (or multiply).

Our immune system army consists of 3 main groups of cells (or army soldiers):

1. CD4 cells: the head of the army, or the Major-Generals. They are the most important immune system cells because they control how the whole immune system works. They give orders or instructions to the other immune system cells. They also are responsible for making more cells (replicating). They produce more immune system cells.
2. B cells: These Sergeants develop and produce an antibody (or the correct weapon) to fight infections. Antibodies help to neutralise the virus or infection. NOTE: B cells are also called T cells.
3. Killer cells: the Privates, or the soldiers who fight and kill infections.

HIV and the Immune System

Why is HIV so hard for the immune system to fight?

- The HIV virus attacks the key components of the immune system. It goes after the head of the immune system army, the CD4 cells, by becoming part of the CD4 cells. This means that the virus replicates or multiplies in the CD4 cells. So, as the CD4 cell is doing its work and leading the immune system, it is also spreading HIV in the body.
- HIV infects CD4 cells, uses them to replicate, and eventually kills the CD4 cells.



- When the HIV virus grows or replicates, it changes, or makes mistakes that are called mutations. Some of these mutations change the structure of the virus.
- This means that the antibody that was used before to stop the virus from growing no longer works because the virus has changed.
- Therefore, the body has to restart the process of making a new antibody to fight the changed HIV. Remember that making a new antibody takes some time. While the B cells are developing the new antibody, the HIV keeps growing and replicating (multiplying).
- The body tries to replace the lost CD4 cells, but over time, the number of CD4 cells decreases and the immune system is weakened. The process continues over the years until the immune system becomes exhausted as more and more CD4 cells are destroyed by the virus.
- Eventually the body, or the CD4 cells, are no longer able to fight infections. This happens at the advanced stages of the disease.

Key Point: HIV's ability to mutate so quickly and its ability to evade the immune response makes it particularly difficult for the immune system to fight.

NATURAL COURSE/PROGRESSION OF HIV

Progression of HIV usually follows a predictable course of phases from infection to AIDS.

HIV is measured in two main ways:

- CD4 Count
- Viral Load

1. CD4 Count

- Currently the best monitor for HIV disease progression
- Number of CD4 cells per cubic millimetre of blood
- Normal range: 600 – 1,200 CD4 cells per cubic millilitre of blood (mL^3), and is generally higher than 500 in uninfected people
- Normal range of CD4 count varies from person to person, day-to-day, and hour to hour.
- As the HIV virus progresses, the number of CD4 cells decline and the CD4 count goes down.
- The CD4 count is one of the measures used to determine when a patient should start antiretroviral treatment.
- When the CD4 count falls below 200 cells per cubic millilitre of blood, the body can develop life-threatening illnesses from other infections, which are called opportunistic infections.

Percentage of CD4: In addition to counting the number of CD4 cells in the blood, there are tests that can also measure the percentage of CD4 cells.

- Measures CD4 cells to total immune system cell (white blood cell) population.
- Normal range: approximately 40%
- If below 15%, the person is at serious risk of being sick or getting an opportunistic infection such as TB or malaria.

2. Viral Load

- Another measure of disease progression is viral load, or the amount of the virus in the body.
- A viral load counts the number of HIV particles in a sample of blood.
- It is expressed as the number of “copies” of HIV RNA per millilitre of blood. Below 10,000 copies or less is considered low and above 50,000 copies is high.
- Viral load does not measure the virus present in the brain and genital fluids, where the effects of ARVs may vary.
- Currently, viral load tests are not done in the public sector in Namibia.

Key Point: As a person becomes sicker, his/her immune system is more damaged (CD4 cell count drops) AND the amount of virus in the blood increases (viral load rises).

Relationship between CD4 Count and Viral Load:

- The higher the viral load, the faster the CD4 count reduces.
- The lower the viral load, the slower the CD4 count reduces.
- However, this relationship is not always clear.

Key Point: As a community counsellor, you do not need to memorise the phases and stages of HIV. Just become familiar with how HIV progresses.

- HIV progresses from infection to AIDS in a predictable manner.
- The length of time for this progression varies from one person to another.
- There are times when a person with HIV may not have symptoms or even test positive.

Progression of HIV Infection

HIV Infection	Initial infection with HIV virus
Window Period (Acute Phase) <i>Usually 2 - 6 weeks, but can last up to three months</i>	No signs or symptoms of disease and no detectable antibodies to HIV. An HIV antibody test would be negative even though the virus is present.
Sero-conversion (production of antibodies) <i>Brief period after 2 – 6 weeks, may last up to three months</i>	Development of antibodies: may include flu-like symptoms. About 25% of people experience no illness during this stage and most do not visit health care facilities.
Asymptomatic HIV <i>Lasts from less than one year to 10-15 years or more</i>	Antibody tests show up positive but there are no signs or symptoms of illness. (incubation period)
HIV/AIDS – Related Illnesses (Symptomatic Phase) <i>Lasts months or years</i>	Signs and symptoms of disease increase because HIV is weakening the immune system. Illnesses are usually not life-threatening at first, but become more serious and longer lasting.
AIDS <i>Usually less than one to two years without treatment.</i>	Terminal Stage: life-threatening infections and cancers occur because the immune system is severely damaged. The patient dies when an untreatable illness develops. Life expectancy depends on many factors, including antiretroviral treatment, medication for opportunistic infections and holistic health care, especially nutrition.

Adapted from Helen Jackson. 2002. AIDSAfrica: Continent in Crisis, SFAIDS, Zimbabwe.

- Patients can live for many years after being infected with HIV.
- Progression of the disease to the advanced stage of AIDS varies in time and from person to person.
 - A small proportion of patients may develop AIDS (advanced HIV disease) in less than 5 years.
 - Another small proportion of patients can live over 15 years without any signs and symptoms of the disease.
 - Most people take an average of 10 years to progress from infection to AIDS (advanced HIV) without any treatment.



Window Period:

- The period between the time of infection and when an HIV test result will be positive. It can range from 2 weeks to 3 months.
- This is because the HIV test does not actually test for the HIV virus in the body; instead, it tests for the antibodies. Remember, it takes a while for the B cells to produce the antibody. This time can vary from person to person.
- The amount of HIV virus in the body is very high right after infection because the B cells have not produced the antibodies that defend against the HIV virus.
- A person can infect another person from the moment he/she is infected with HIV.

How quickly HIV progresses in a person varies from person to person and depends on many factors, including:

- Regular health care
- Other infections
- Nutrition
- Alcohol/drug use
- Stress
- Depression

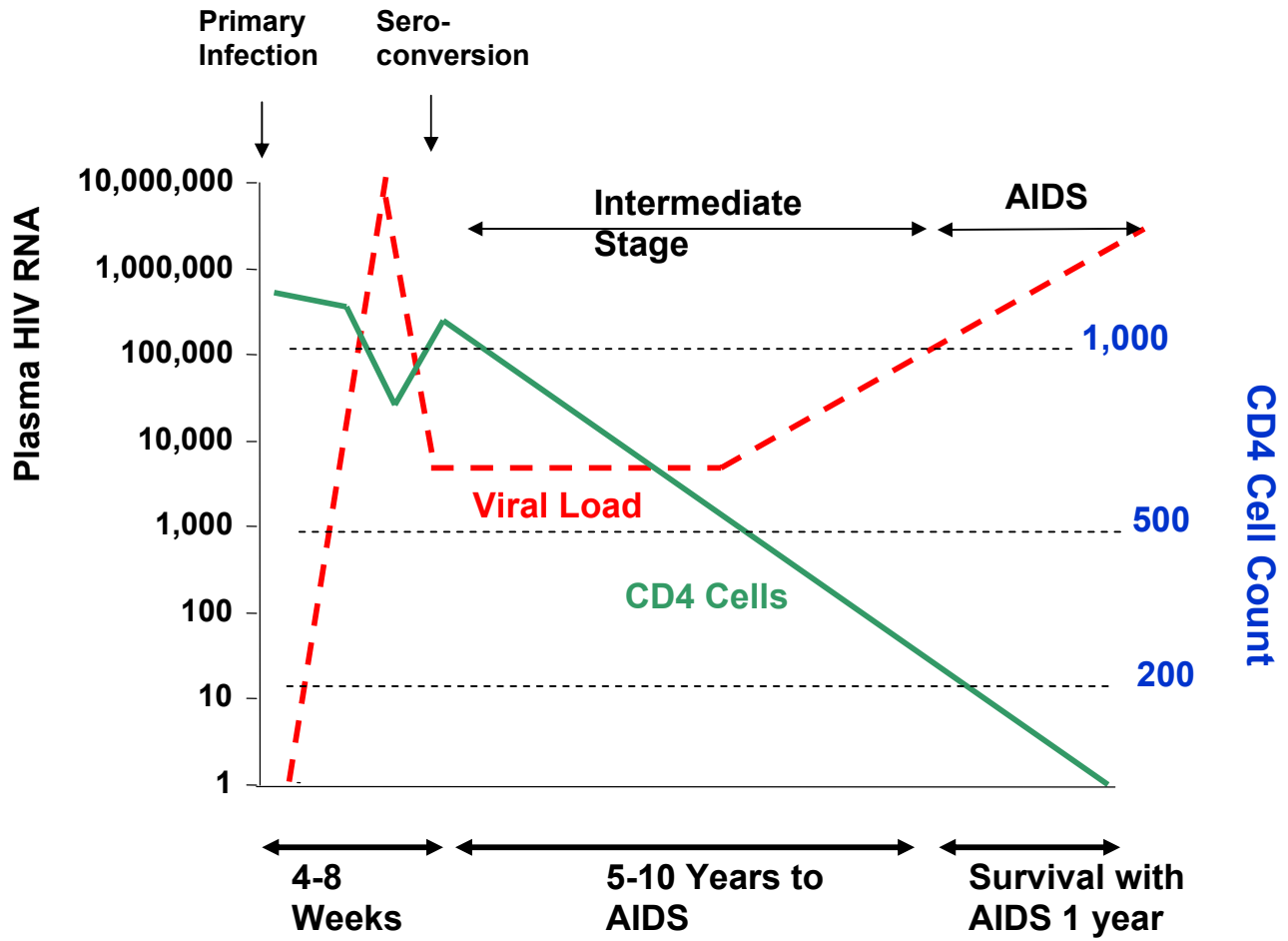
Additional Factors that contribute to HIV infection developing into AIDS (HIV-related disease):

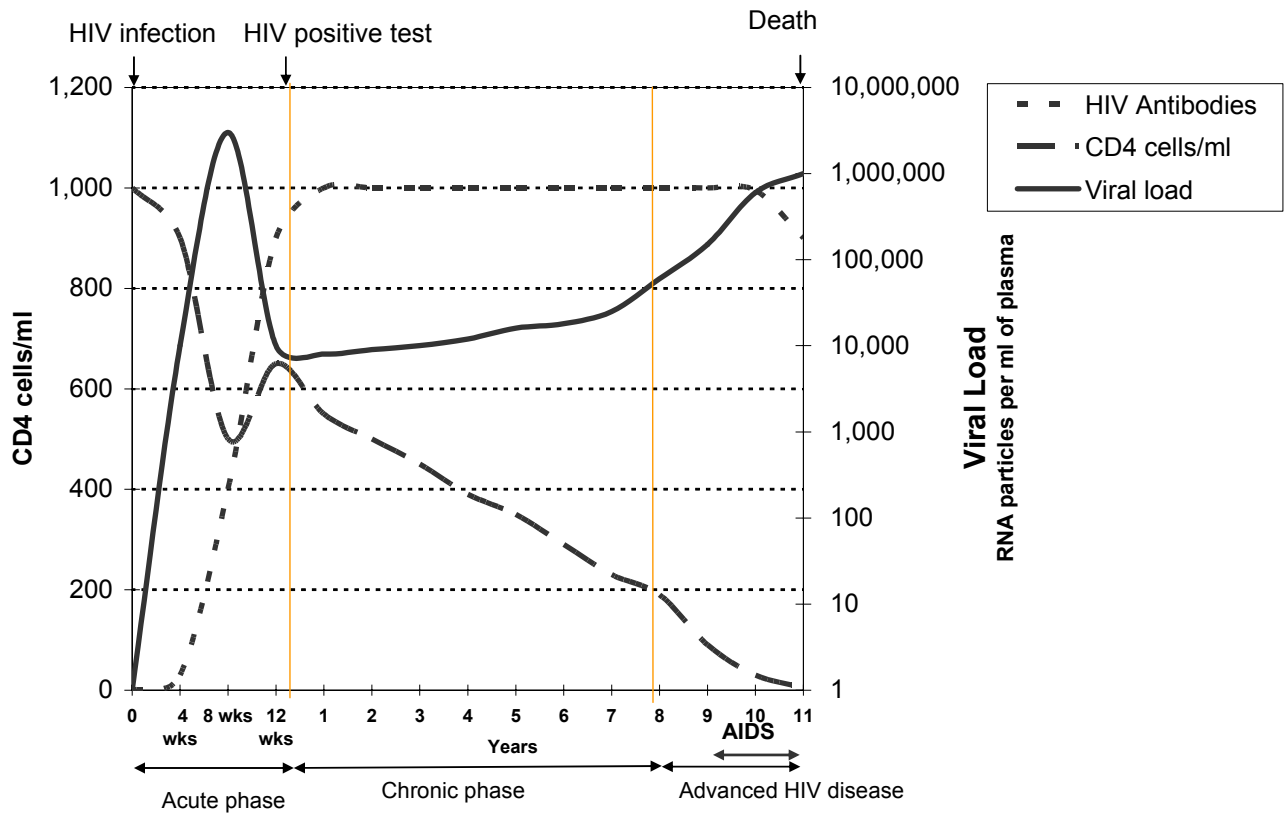
- Infection with different types of HIV virus (multiple strains)
- Natural genetic or biological differences in individuals' immune systems
- Stress on the immune system from general lack of fitness and exposure to other infections, such as parasites
- Repeated STIs (sexually transmitted infections) that keep the immune system busy and appear to speed up HIV replication or growth.
- State of mind, such as anxiety and depression
- Other health stressors such as overtiredness, poor diet or nutrition and heavy drinking.

Case Study: A friend tells you that she has tested HIV-positive. She knows very little about HIV. She states that she does not believe that she has HIV because she does not feel sick.

- In your pairs, role play how you would talk to your friend. Make sure you include the following:
 - What HIV is
 - How HIV is spread
 - How HIV affects the body
 - How HIV progresses
 - The difference between HIV and AIDS

CD4 Count, Viral Load and Clinical Course of Untreated HIV Infection in Adults





REVISED WHO CLINICAL STAGING OF HIV/AIDS FOR ADULTS AND ADOLESCENTS

(Interim African Region version for persons aged 15 years or more with positive HIV antibody test or other laboratory evidence of HIV infection)

Table 1. Revised WHO Clinical Staging of HIV/AIDS for adults and adolescents

Primary HIV Infection

Asymptomatic
Acute retroviral syndrome

Clinical Stage 1

Asymptomatic
Persistent generalized lymphadenopathy (PGL)

Clinical Stage 2

Moderate unexplained weight loss (<10% of presumed or measured body weight)
Recurrent respiratory tract infections (RTIs, sinusitis, bronchitis, otitis media, pharyngitis)
Herpes zoster
Angular cheilitis
Recurrent oral ulcerations
Papular pruritic eruptions
Seborrhoeic dermatitis
Fungal nail infections of fingers

Clinical Stage 3

Conditions where a presumptive diagnosis can be made on the basis of clinical signs or simple investigations:

Severe weight loss (>10% of presumed or measured body weight)
Unexplained chronic diarrhoea for longer than one month
Unexplained persistent fever (intermittent or constant for longer than one month)
Oral candidiasis
Oral hairy leukoplakia
Pulmonary tuberculosis (TB) diagnosed in last two years
Severe presumed bacterial infections (e.g. pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteraemia)
Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis

Conditions where confirmatory diagnostic testing is necessary:

Unexplained anemia (<8 g/dl), and/or neutropenia (<500/mm³) and/or thrombocytopenia (<50,000/mm³) for more than one month



Clinical Stage 4

Conditions where a presumptive diagnosis can be made on the basis of clinical signs or simple investigations:

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent severe or radiological bacterial pneumonia
- Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration)
- Oesophageal candidiasis
- Extrapulmonary TB
- Kaposi's sarcoma
- Central nervous system (CNS) toxoplasmosis
- HIV encephalopathy

Conditions where confirmatory diagnostic testing is necessary:

- Extrapulmonary cryptococcosis including meningitis
- Disseminated non-tuberculous mycobacteria infection
- Progressive multifocal leukoencephalopathy (PML)
- Candida of trachea, bronchi or lungs
- Cryptosporidiosis
- Isosporiasis
- Visceral herpes simplex infection
- Cytomegalovirus (CMV) infection (retinitis or of an organ other than liver, spleen or lymph nodes)
- Any disseminated mycosis (e.g. histoplasmosis, coccidiomycosis, penicilliosis)
- Recurrent non-typhoidal salmonella septicaemia
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Visceral leishmaniasis

UNDERSTANDING BEHAVIOUR CHANGE

from Basic Counselling Skills

Our Attempts to Change: Questions for Discussion

1. What habit or behaviour did you try to change?
2. What made you decide to change? OR Why did you want to change?
3. Were there good things you thought would happen if you changed? If so, what were they?
4. What steps did you take to change? OR What did you do to change?
5. Were you able to change? If yes, how long did it take to change?
6. Did you ever go back to the old behaviour?
7. What happened that made you slip back into the old behaviour?
8. Were there any times when it was harder than others? What was happening that made it more difficult?

Adapted from Ministry of Health & Child Welfare Zimbabwe. Integrated Counselling for HIV and AIDS Prevention and Care, Primary Care Counsellor Training.

Key Points:

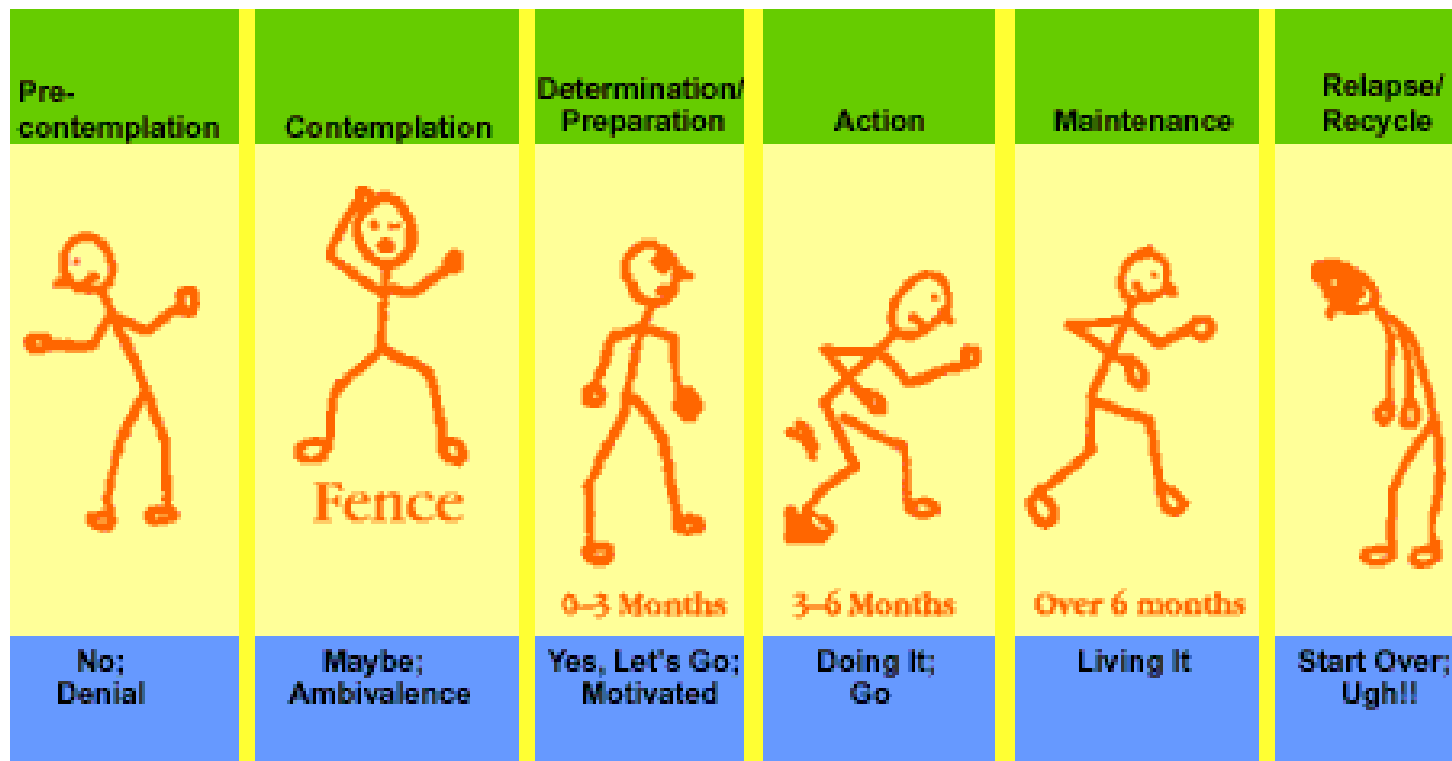
- Change takes time; change is a process.
- It takes more than information to change.
- People around us can help us or make it harder to change.
- We will experience setbacks when we try to change.

Key Point: Behaviour change is rarely a simple, single event. Usually, a person moves from being uninterested to considering a change to deciding and preparing to make a change. Behaviour change happens gradually over time; it is a process.

Stages of Behaviour Change

Stage	Description
1. Pre-contemplation (not aware or thinking about change)	<p>The person is not thinking about change. Believes there is no problem. Answers questions with “yes, but...” Possible feelings/thinking:</p> <ul style="list-style-type: none"> ▪ resigned or hopeless (this is just the way things are) ▪ no control ▪ denial (this does not apply to me, there is not a problem) ▪ argumentative; believes consequences are not serious
2. Contemplation (thinking)	<p>Acknowledges that there is a problem Increased awareness and knowledge related to the problem Weighs advantages and disadvantages of behaviour Begins to think about behaviour change</p>
3. Preparation	<p>Develops commitment to change Makes a detailed plan for change Perceives more benefits than barriers to change Experiments with small changes</p>
4. Action	<p>Takes action to change Takes six months before person moves to maintenance</p>
5. Maintenance and Relapse Prevention	<p>Maintains new behaviour over time</p>

*Note: these stages do not happen in a linear pattern. A person usually slips backwards and goes between the stages like a spiral.



Adapted from UCSF AIDS Health Project. 1998. Building quality HIV prevention counselling skills: The Basic I training.

Why is understanding the stages of behaviour change important for you as counsellors?

- Communicating a realistic view of the work involved in behaviour change can prepare clients for the work and commitment required to make changes.
- To help clients gain an awareness of themselves in order to sustain the behaviour change.
- To distinguish between a relapse and a setback. Setbacks are normal and part of changing behaviour.
- To understand that changing any behaviour is a process. It does not happen overnight, and as counsellors, we must be patient with our clients as they are attempting to change their behaviours.

RISK-TAKING

Risk: embarking on a behaviour in which you are not certain of the outcome, or choosing to do something when you do not know what will happen as a result of your actions.

- Think through the following:
 - What factors influenced your decision to take a risk? What made you take the risk? Why did you take the risk?
 - What were your feelings at the time?
 - What was the outcome of taking that risk? Was it positive or negative?
 - Are you generally a risk-taker?

Risk-Taking and HIV: Discussion Questions

- How do we view our own risk-taking behaviour? i.e. Is risk-taking a good thing?
- How do we view the risk-taking behaviour of others?
- Are there certain areas in our lives where risk-taking is better than others?
- Can you make any general observations about risk-taking behaviour?
- Why are we talking about risk-taking in a workshop on HIV? OR What does risk-taking behaviour have to do with HIV counselling?
- Why is it important to look at our own risk-taking behaviour before talking about the risk-taking behaviours of others?
- What implications does our view towards risk-taking have on our attitudes towards HIV and AIDS?
- Do we have different standards for risk-taking when it comes to sexual behaviours? If so, why?

To think about...we often feel that it is OK to take risks if they turn out well. We might be praised for our courage. However, we tend to blame others if they take risks and things go wrong.

We are also usually much less harsh in judging ourselves than we are in judging others. Remember that we are all taking risks all of the time: when we walk through a field (snakes and scorpions), when we cross the road (traffic), when we have a baby, etc.

Conclusion:

When we conduct counselling related to HIV, we will talk a lot about risk of infection (or risk of transmission), risk behaviours, risk reduction, risk triggers and risk reduction plans. A great deal of prevention counselling addresses what people do that puts them or others at risk of HIV infection. In counselling, you will be helping people assess (determine) whether they are at risk of infection and what they can do to reduce that risk.



CRISIS COUNSELLING FOR HIV/AIDS

Key Point: A crisis is an emotionally stressful event or change in a person's life. Everybody experiences crises in their lives.

Crisis Counselling as part of HIV Counselling

Refer to the Crisis & Recovery/Behaviour Change Model on page 60.

Crisis Counselling Model

Refer to the Crisis Counselling Model.

1. **EXPRESSION:** Express support and reflect feelings.
2. **CONTROL:** Help the client gain emotional control.
3. **CLARIFY:** Determine and clarify what the crisis is for the client.
4. **FOCUS/PRIORITISE:** Work on one aspect of the crisis.
5. **IDENTIFY SUPPORT:** Identify strategies for emotional support.
6. **PLAN NEXT STEPS:** Create a next step plan.

Skills and Techniques for Working with Clients in Crisis

1. **EXPRESSION:** Express support and reflect feelings.
 - Tell the client that you want to help and that you can talk about how the client is feeling.
 - Use open-ended questions to find out more about the client's feelings.
 - Give permission for the client to express his or her feelings.
 - Use reflecting skills to reflect the client's feelings.
 - "Begin where the client is."
 - Comment on the strength of the client's feelings, fears and efforts to deal with the problem. Provide affirmation.
 - Accept and validate the client's fears as genuine.
 - Focus on the client's expression of current feelings and anxieties.
2. **CONTROL:** Help the client get control.
 - Assess whether the client has the ability to make decisions or is feeling helpless and out of control.

- Sometimes giving a client an assignment can help them gain control. This can be as simple as getting a glass of water or taking a deep breath.
 - *Example:* “Take a deep breath. Now let it out slowly. I want to help you, but first it may be helpful to relax.”
3. CLARIFY: Identify/determine what the crisis is for the client.
- Help the client identify what the most troubling issue is for them at this time. For instance, if they have just received a positive HIV test result, what is it about the result that is most upsetting? It could be that he/she is afraid of dying soon, it could be a fear of telling a partner, or for a pregnant woman, it could be the fear of transmitting HIV to her child.
4. FOCUS/PRIORITISE: Work on one aspect of the crisis.
- Start working on one aspect of the crisis that can be addressed easily. This will build the client’s confidence that he/she can deal with future problems.
 - Focus on what you can do to help the client.
 - Discuss what others could do to help.
 - *Example:* “Let’s work on one step at a time.”
5. IDENTIFY SUPPORT: Identify strategies for emotional support.
- Use open-ended questions to help the client identify resources he/she may not have thought about.
 - *Example:* “Who have you turned to in the past when you have had something difficult to deal with?” OR “Who have you talked with in the past?”
6. PLAN NEXT STEPS: Create a next step plan.
- Talk with the client about the next step he/she plans to take that day. Be very specific. For instance, if he/she just received a positive test result, ask what he/she will do when he/she leaves the counselling session.
 - Repeat some information if the client is in denial or too distressed to understand what is being said.
 - If the client has regained control and it able to make decisions, next steps may extend to future days and up to a week.
 - Next steps may include a future appointment day and time.

What the counsellor should NOT do:

- Play down the seriousness of the client's challenge or crisis, e.g. by saying, "You are over-reacting" or "It is not that bad."
- Panic.
- Offer false assurances, e.g. by saying, "It will all work out" or "Everything will be OK."
- Give advice.
- Take offence. A client may express some of their feelings, i.e. anger, towards the counsellor; do not get defensive.

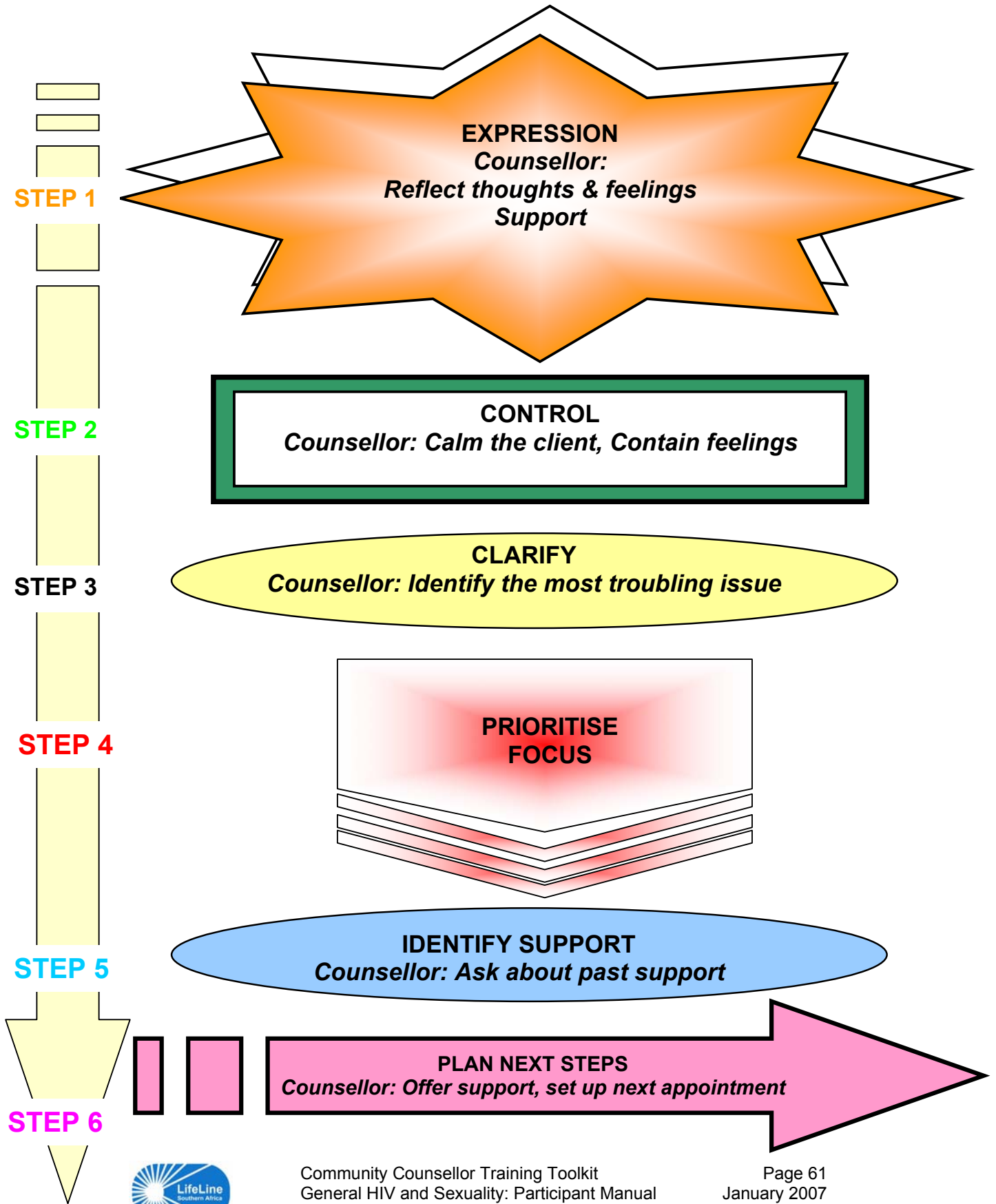
Guidelines for Crisis Counselling

- Remain calm and show confidence.
- Listen.
- Be accepting and non-judgemental.
- Provide empathy and reflect the client's feelings.
- Provide a calm and relaxing atmosphere.
- Allow the client to speak freely with minimal interruptions.
- Allow the client to vent his or her feelings and express all feelings.
- Explore the immediate crisis rather than underlying causes.
- Do not minimise the crisis.
- Prioritise: agree on aspects of the problem that can be dealt with most readily.
- Agree on a plan of action, but do not tell the client what to do.
- Assess suicide risk: ask whether the client has had suicidal thoughts.
**Remember that asking about suicidal thoughts does not make suicidal behaviour more likely. Instead, if the client has already thought about suicide, he/she may feel better if the counsellor raises the issue, and it may actually reduce the risk of suicide.

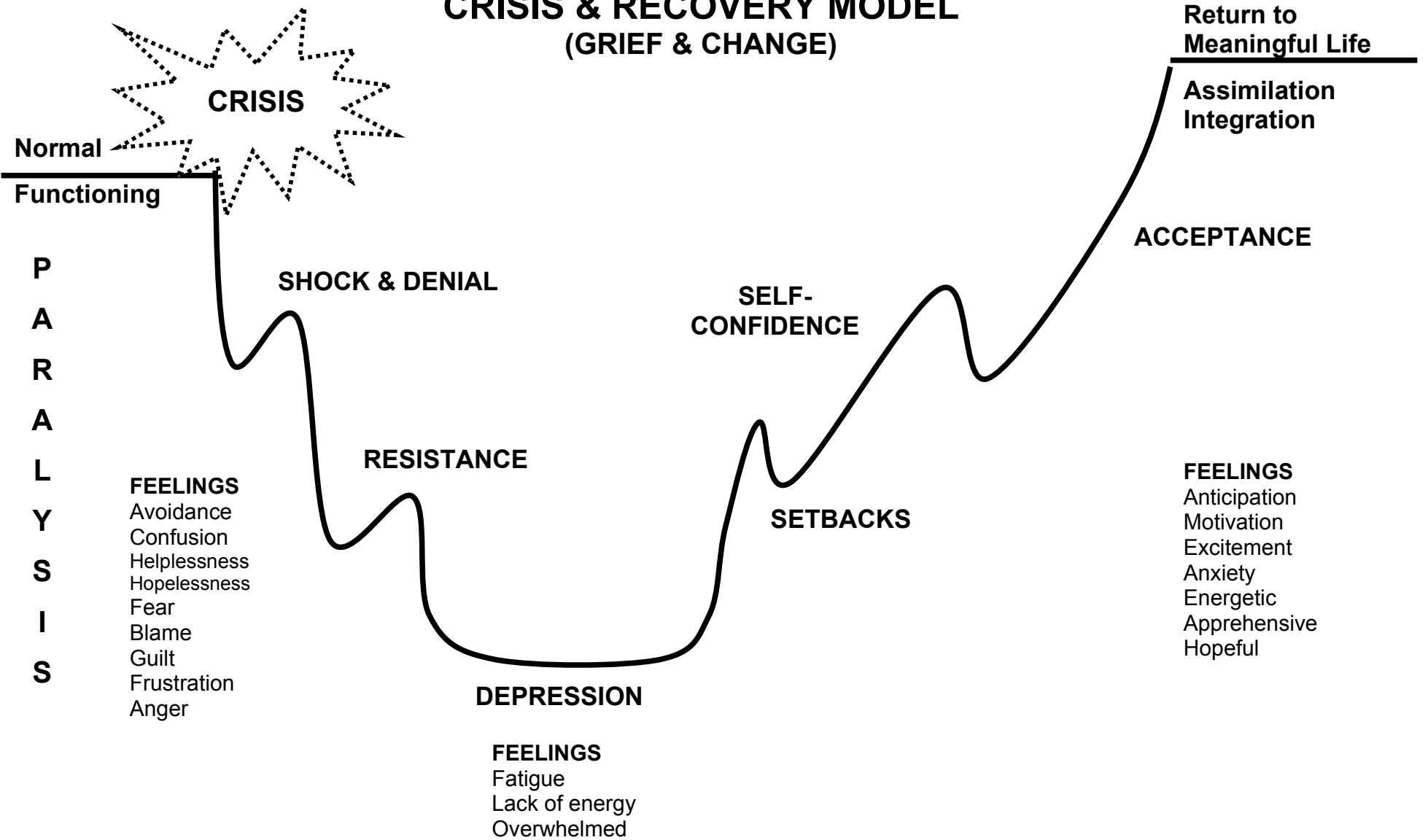
Adapted from Family Health International. January 2004. VCT Toolkit. HIV Voluntary Counselling and Testing: A Reference Guide for Counsellors and Trainers. January 2005. HIV Voluntary Counselling and Testing: Skills Training Curriculum, Facilitator's Guide.



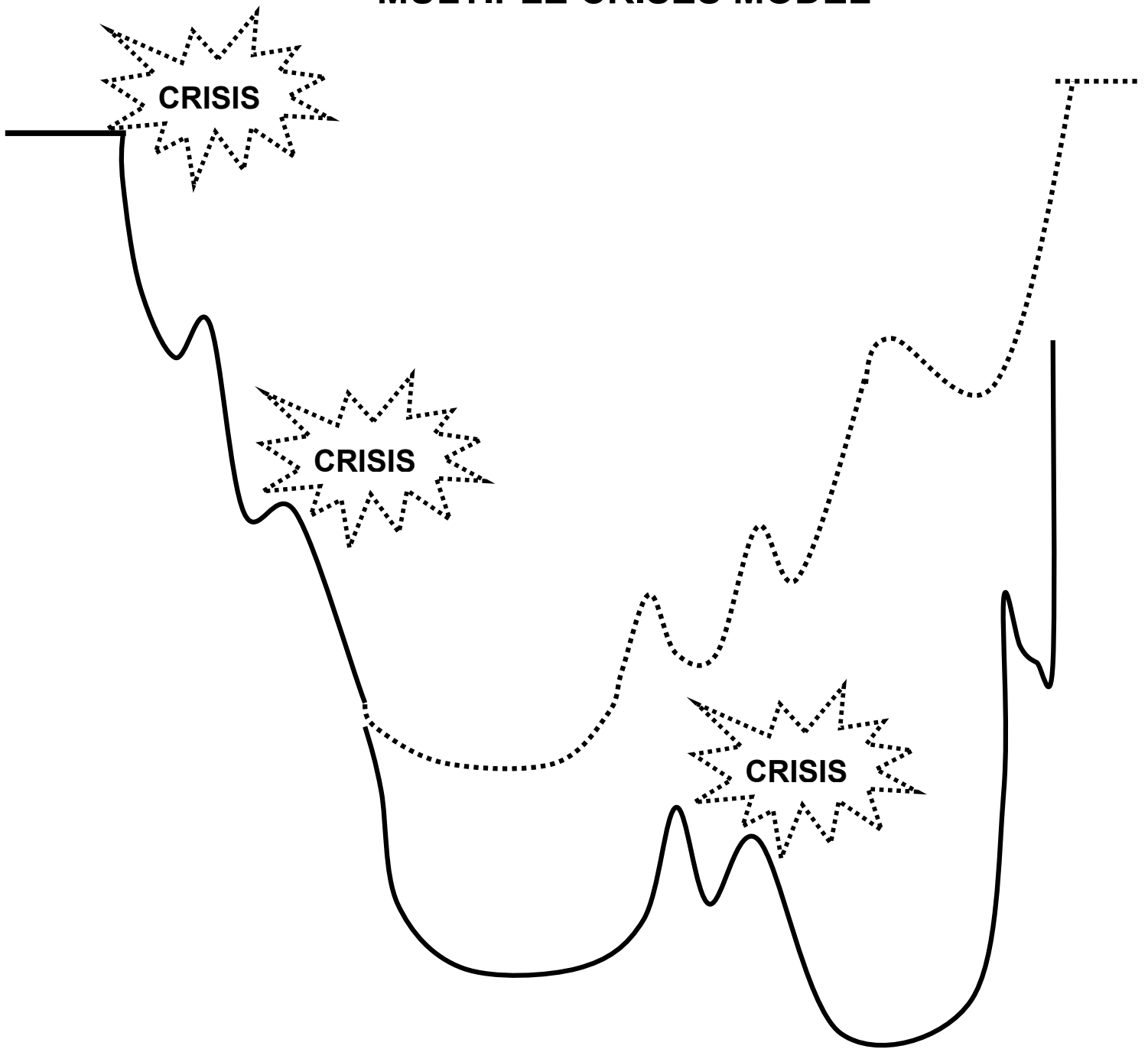
CRISIS COUNSELLING MODEL



CRISIS & RECOVERY MODEL (GRIEF & CHANGE)



MULTIPLE CRISES MODEL



————— **Functioning with multiple crises**

..... **Functioning with just one crisis**

STRESS AND HIV

Refer to the Major Areas of Psychosocial Stress Diagram on page 64.

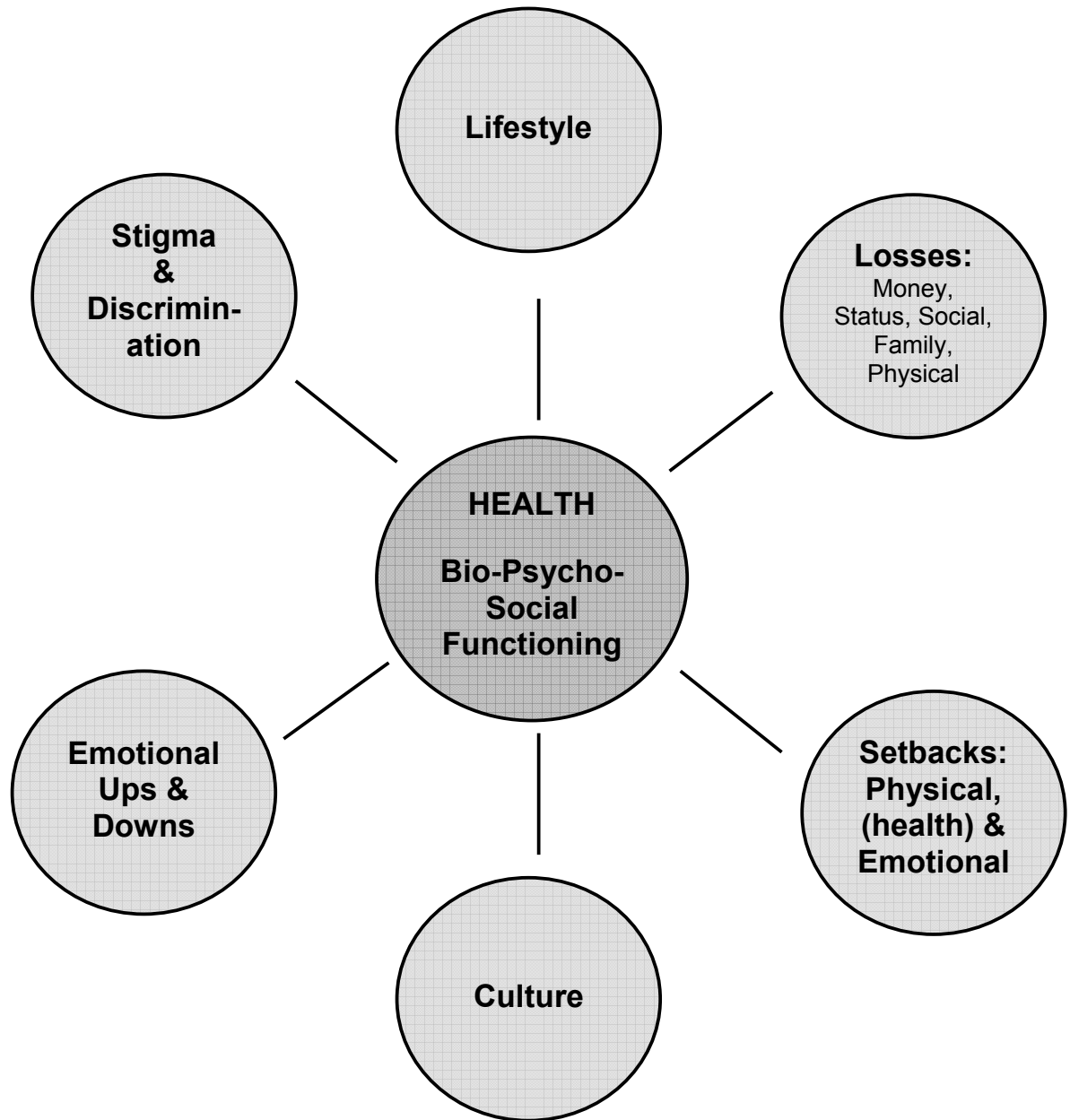
Define the centre circle: Bio-Psycho-Social Functioning

- Bio: refers to the body. This is your physical health.
- Psycho: refers to the mind or emotions (psychology). This is your mental health.
- Social: refers to your interactions or relationships with others. These are your connections with others or your interactions with the community.
- Bio-Psycho-Social Functioning is the physical (body), mental (mind and emotions) and social (community, family) health of an individual.
- Bio-psycho-social functioning is basically a person's complete health or how he/she is coping.

The circles on the outside are different types of stresses.

- Lifestyle
- Culture
- Stigma & discrimination
- Emotional ups and downs
- Setbacks: emotional and physical, such as health
- Losses i.e. money, job, family, status, community, home, etc.

Major Areas of Stress with HIV



Adapted from Kerry Saloner, Centre for the Study of AIDS, University of Pretoria, and Perinatal HIV Research Unit, University of the Witwatersrand. 2005. Adherence Resource Pack for Anti-retroviral Treatment (ART) Adherence Counselling and Support.

LOSS & GRIEF

Definitions:

Grief: an intense feeling of sorrow or sadness people experience when they go through a personal loss, such as the loss of a loved one, one's health or a financial loss. Grief is a normal personal process, and an emotional response to one's loss.

Mourning: the actions and manners of expressing grief, including cultural reactions to loss. Mourning is the process that occurs after a loss.

- The primary difference between grief and mourning is that grief is a personal, normal process and mourning is usually a process largely influenced by the culture.

Because there is no cure for HIV, people often experience grief when they learn that they, their partner or a friend is HIV-positive. People experience grief when a loved one dies of AIDS, but the grief often starts long before a person dies.

Grief is experienced emotionally (feelings), mentally (mind), spiritually and physically (body). People experiencing grief need nurturing, compassion and patience.

The Stages of Grief

There is no single way to grieve. However, people generally experience several common stages of grief. An individual may move in and out of these stages and back and forth between the stages.

1. **Denial** (numbness): Denial is usually the first reaction ("it cannot be true" or "no"). This stage can last for a few hours or for many days. It can be a problem if it lasts too long.
2. **Anger** (yearning and searching): Anger can include blaming others for the loss, getting easily irritated or agitated, finding it hard to concentrate, relax or sleep, and emotional outbursts. People often feel deep guilt about arguments they had with the person who died, or about failing to express emotions and wishes.
3. **Bargaining**: The bargaining stage is most likely when people themselves are dying. After the dying person or family member has vented his/her anger at friends, family and possibly a higher power (i.e. God), he/she begins the bargaining phase. During the bargaining stage, the affected person often makes promises to God, agrees to change his/her life if allowed to live, and/or asks for an opportunity to do something special before he/she dies.



4. **Depression:** Bouts of depression and sadness are set off by reminders or memories of the dead person or of the dying person's good health. People who are grieving often feel very tired because the process usually requires significant physical and emotional energy.
5. **Acceptance:** The final stage is acceptance, letting go and moving on with life. This may mean resignation, not necessarily contentment. This stage helps remaining depression to lift and for sleep and energy patterns to return to normal.

Key Point: These stages of grief are not linear; one does not go through these stages one after the other. People usually go back and forth between the different stages in a cyclical pattern.

Individual Differences in Grieving

Each person grieves in a different way because each person has his/her own unique combination of past experiences, different personalities, attitudes, styles and ways of coping. For some people, grief is an intense experience, while for others it is milder. For some people, grief begins the moment they hear of the loss, but for others, grief is delayed. In some cases, grieving is fairly short, whereas in others it seems to go on forever.

Below are some factors that affect how a person responds to a loss:

- Past experiences: Losses experienced in a person's life and how the person has grieved.
- Relationship with the person who died/lost object/lost health, etc: What was the grieving person's relationship like with the person who died/what was lost? How important to the grieving person was the loss (of job, health, freedom, etc.)?
- Role the person/object/health played in life: The more important role a person's loved one or own health played in his or her life, the more difficult the grieving process.
- Circumstances surrounding the death/loss object/lost health: The cause of death, illness or loss is also important, as is where and how the death or loss occurred.
- Influences in the present: The current state of a person's life, including stress level, ability to manage feelings, social aspects of life, religious faith, support system, etc. greatly affects how he/she grieves.

Key Point: Each person grieves in their own way; the mourning process can be months or years. As counsellors we should allow clients to express their thoughts and feelings, giving them time and permission to grieve.

Grief Counselling

The goals of grief counselling:

- Help the client accept the loss by talking about it.
- Help the client identify and express spoken and unspoken feelings, i.e. anger, guilt, anxiety, helplessness and sadness.
- Allow the client to experience all of their hurt, sorrow, resentment, anger, fear, anxiety, guilt or pain without expectations of what is “right.”
- Help the client overcome difficulties in readjusting to life after the loss; encourage the client to make decisions on his/her own or with other family members.
- Encourage the person to say goodbye; sometimes this happens before or during the loss.
- Allow time for and give permission to grieve.
- Describe normal grieving and the differences in grieving between different individuals; allow for individual differences, understanding that there are many ways to grieve.
- Provide continuous support, identify coping methods and identify any coping problems.
- Avoid clichés, as these “pat answers” or glib comments can be hurtful to your client. These comments often minimise the loss by providing simple solutions to difficult situations. Clichés include the following:
 - “You are holding up so well.”
 - “Time will heal all wounds.”
 - “Think of all you have to be thankful for.”
 - “Just be happy he is out of pain.”
 - “He is in a better place now.”
 - “She is at peace now.”

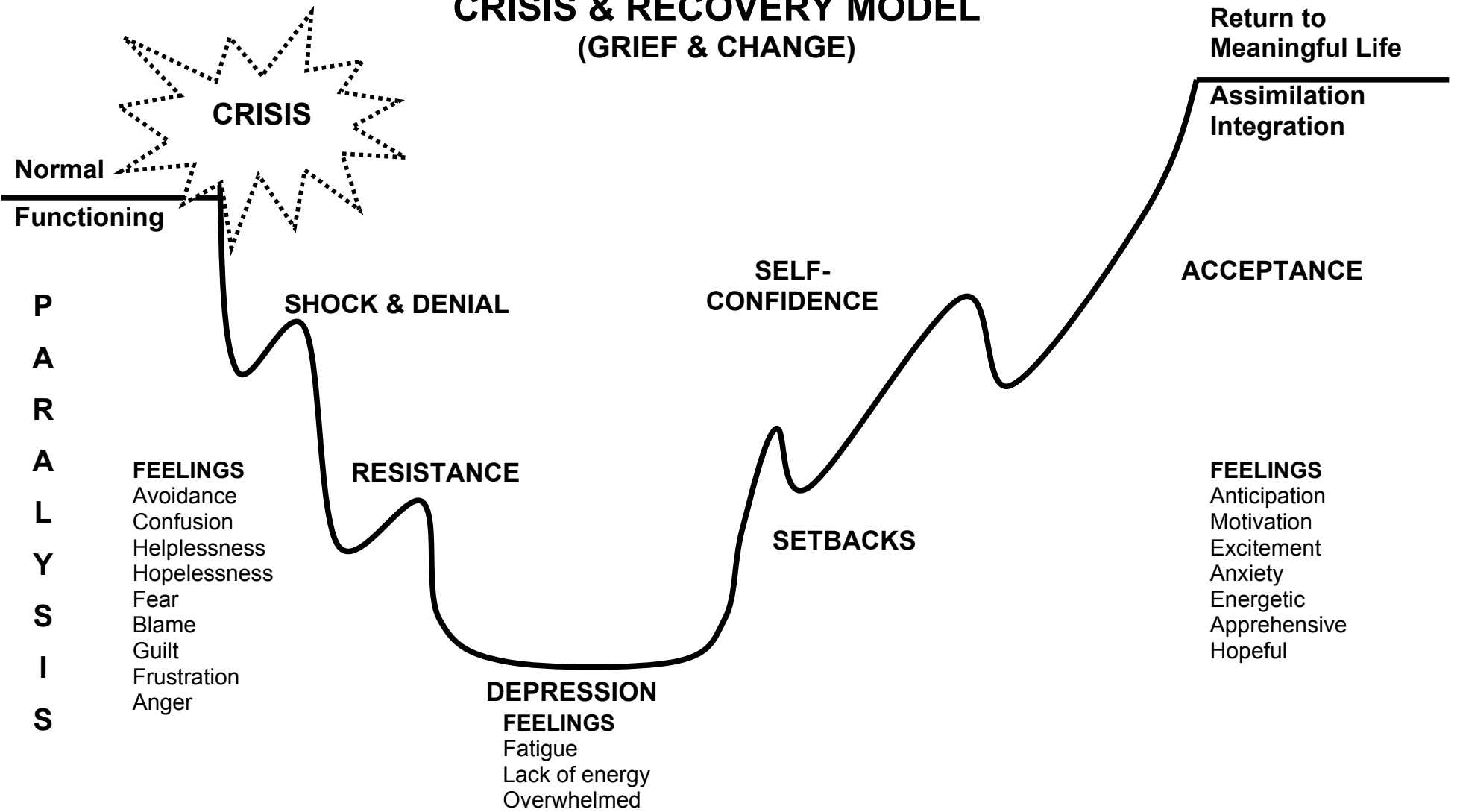
Counsellor’s Grief: our own experiences with grief influence our ability to help someone through the grief process. Have we allowed ourselves to experience and work through our own losses?

- If we have not adequately dealt with losses in our own lives, it may be difficult to help and relate to the client who is experiencing his/her losses.

Adapted from Family Health International. January 2004. VCT Toolkit. HIV Voluntary Counselling and Testing: A Reference Guide for Counsellors and Trainers



CRISIS & RECOVERY MODEL (GRIEF & CHANGE)



LIVING POSITIVELY

A diagnosis of HIV affects all areas of a person's life including physical, emotional, social and spiritual.

What does it mean to live positively?

“Dying is not the problem. Our problem is how to continue living while we're still alive.”
~Person Living with HIV

- **Key Point:** With people who are not HIV-positive, we normally call it healthy living, but with people who are living with HIV, we often talk about positive living so that people realise there is a lot they can do to live longer and healthier, even with HIV.
- For a person with HIV, living positively is a lifestyle a person adopts in order to live life as fully as possible while slowing the progression of the disease. It includes:
 - Making positive choices to care for one's mental and physical health
 - Having a positive outlook on life
 - Avoiding risky behaviours

Some quotes from women living with HIV capture what it means to live positively:

“No one has ever said ‘Yes to AIDS’. No one has asked for it. Most of us who have it now had never even heard of it when we caught it. You cannot attach blame or assign guilt to anyone. It doesn't matter who was responsible – the husband or the wife or the blood transfusion. The important thing is to think and live positively.” (Ugandan Counsellor)

“Do I look like a figure or a statistic? I am a person, a woman living with HIV.” (Bridgette, HIV+, Zambia)

“When I first met my husband we did not seem to have a care in the world. But now AIDS is always there in the back of my mind. We make plans and then I think – God what are we doing this for. And he will say ‘you cannot think like that. You've got to make plans for the future.’” (Pat, HIV+, Uganda)

“When I heard of my status I wanted to commit suicide to spare my family from worrying about my health. But then I thought it would hurt them even more. And after all why die sooner. I loved living too much. I am glad I am still here. HIV is a part of me and even if it is not always fun living with it, life is still surprisingly beautiful.” (Isabelle, HIV+, Belgium)

Adapted from the State of Eritrea, Ministry of Health



Suggestions for Positive Living

Emotional Well-Being

- Accept your HIV status.
- Acknowledge your feelings: sadness, anger and hopelessness are normal feelings when you are sick.
- Keep a positive attitude: focus on what you can control or change.
- Reduce your stress, ask others to help you, and seek help from the community.
- Seek counselling.
- Talk to close friends and family members.

Physical Well-Being

- Go to a hospital or clinic for treatment.
- Get plenty of rest; sleep 7-8 hours every night and rest when you are tired.
- Exercise regularly.
- Eat a variety of nutritious foods.
- Keep your body clean and bathe regularly.
- Wash your hands after using the toilet and before eating.
- Brush your teeth regularly.
- Avoid smoking, drugs and alcohol.

Social Well-Being

- Continue to engage in relationships with friends and family.
- Ask for help when needed.
- Show people close to you that you love them, even if you have not done this in the past.
- Spend time with people you love, such as children and friends. Share happy memories.
- Talk with people close to you about your feelings and worries.
- Get involved with community activities and reach out to others who are HIV-positive.

Spiritual Well-Being

- Stay hopeful that you will be able to manage your illness and soon feel better.
- Seek spiritual support and prayer according to your beliefs.
- Be a part of a spiritual community that supports you.
- Seek help from people in your community who have experience with the spiritual aspects of life. They may be pastors, elders or leaders of your church.

General/Overall Well-Being

- Practise safe sex: (ABC) Abstain, Be faithful and use a Condom,
- Use family planning methods
- Engage in activities that you enjoy and that comfort you. These could include praying, walking, reading a book, meditating, etc.
- Keep working as long as possible.
- Plan for the future: where will you be cared for, who will care for you, who will be responsible for your possessions, how will you family manage without you, who will take care of your children, how your family will pay for your funeral, etc. It is better to plan for the future when you are feeling well. Even though you may live for many more months or years, you will find peace in being prepared.
- Make a will.

NUTRITION

Nutrition: Eating foods each day that give you the vitamins and minerals you need to keep your body strong. There is no single food that has everything our bodies need. Good nutrition means eating a variety of foods.

Basic Food Groups:

1. Fruits & vegetables: full of vitamins and minerals that are good for the body
2. Protein: good for muscle development and the immune system
3. Carbohydrates: provide the body with quick energy
4. Fat: how the body stores energy
5. Dairy: this is sometimes included as a food group, and contains some protein and fat

HIV and Nutrition:

When your body fights infection, it needs more energy and you need to eat more than normal. This is sometimes difficult for people living with HIV, because when we are sick, we usually eat less than normal. In addition, many of the opportunistic infections related to HIV as well as the side effects of HIV and/or treatment may reduce a person's appetite or make it difficult to eat.

People living with HIV need to eat:

- Lots of protein, especially low-fat protein such as chicken breasts, fish, lean cuts of pork and beef and low-fat dairy products.
- 5 – 6 servings of fruits and vegetables per day. In order to get all the different vitamins and minerals, eat a variety of different-coloured fruits and vegetables.
- Carbohydrates provide energy. Half of one's diet should consist of carbohydrates such as grains, i.e. maize meal, bread, cereal, porridge, rice, pasta, vegetables and fruits. Try to eat whole grains.
- Eat very little sugar, sweets and cool drinks. They have very few nutrients and the sugar can cause side effects like thrush (Candida) to become worse.
- Have a serving or more of nuts, seeds or beans every day. These include peas and peanuts.

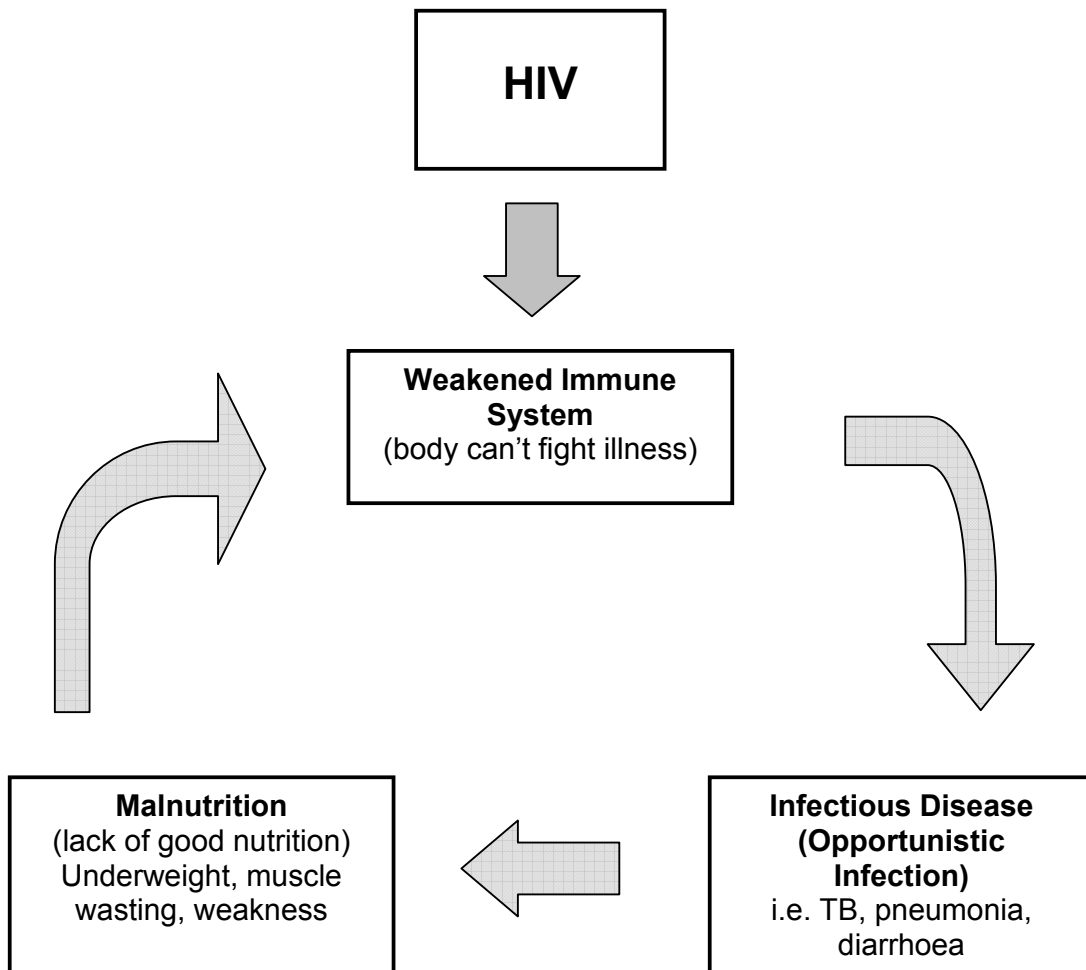
Key Points:

- Eat a variety of foods.
- Eat small but frequent meals.
- Eat starchy food, i.e. bread, porridge, potatoes, rice, pasta, with every meal.
- Eat fruit and vegetables every day.
- Eat meat and dairy foods (milk, yogurt, cheese) every day.
- Drink lots of water every day.

- Eat when hungry; it is good to snack, but make sure they are healthy snacks. Ideally, include protein and some carbohydrates in snacks.
- Drink 1 –2 litres of water every day.
- Yoghurt is good for digestion.
- Avoid: sweetened drinks (cool drinks like Fanta, Coke or sweetened fruit juices), sweets (cookies, candies) and junk food (chips, crisps, fried food).

Vicious Cycle of HIV and Malnutrition

Malnutrition is not having enough food to eat, or not eating nutritious food or food that is good for you.



GETTING THE RIGHT NUTRITION

Fats, Oils & Sweets
USE SPARINGLY

KEY

- Fat (Naturally occurring and added)
- ▼ Sugars (Added)

These symbols show fats and added sugars in foods.

Milk, Yogurt & Cheese Group
2-3 SERVINGS



Meat, Poultry, Fish, Dry Beans, Eggs & Nuts Group
2-3 SERVINGS



Vegetable Group
3-5 SERVINGS



Fruit Group
2-4 SERVINGS



Bread, Cereal, Rice & Pasta Group
6-11 SERVINGS



NEEDS & RESOURCES FOR PEOPLE LIVING WITH HIV

Broad spectrum of needs:

- HIV is a chronic disease (one that lasts lifetime) that affects the whole family and is often associated with stigma.
- Therefore, people who are living with HIV have many needs beyond medical care that need to be addressed.
- These needs will vary with the individual person, the family and circumstances they are experiencing at the time.

Needs may change:

- Needs of the person with HIV and the family will change over time as circumstances and/or disease status change. For example: when first diagnosed with HIV, the person may need support for disclosure. When a patient starts ART, he/she may need support from others with HIV to help adhere to treatment. After the client's health improves, he/she may need help training for and finding a job. Later, if he/she is feeling alone, the client may request spiritual support.

Comprehensive Care and Support

Communities have many different resources. To provide comprehensive care and support to meet the needs of people living with HIV, their caregivers and families, services should include:

- Medical/nursing
- Psychosocial: counselling
- Economic: job training, job searches
- Legal: stigma and discrimination reduction, help making a will, care for children, etc.
- Spiritual: church, pastor and church community

What is a referral network?

- A group of health facilities and community services within a geographic area that communicate regularly and work together to provide a broad range of services for people with HIV and their families.



What kinds of services do you have in your communities? OR What services are available in Namibia for people living with HIV? Think back to your referral file you started at the end of Basic Counselling Skills.

The referral network might include the following services, but they may not all be available:

- Adherence counselling
- ART
- Child care
- Clinical care
- Education/schooling/training
- Family planning
- HIV counselling & testing
- Home based care
- Legal support
- Material support (social grants)
- Mental health services
- Microfinance
- Nutrition counselling
- Antenatal services
- Peer counselling/peer education
- Pharmacy
- PLWHA support (people living with HIV/AIDS)
- PMTCT services
- Post-test clubs or support groups for people who have tested positive
- Prevention services, i.e. free condoms and femidoms
- Psychosocial support services
- Social support, i.e. social workers at Ministry of Health and Social Services or Ministry of Gender Equality and Child Welfare
- Spiritual support
- STI services
- Substance abuse management
- Support for victims of domestic violence



- Treatment support
- TB treatment services
- Youth support groups

Case Scenario: Katia is a 25-year-old mother of two small children, ages 2 and 4. She lives with her husband and children. She also cares for two of her nephews who lost their parents to HIV. She recently found out that she is HIV-positive. She is unaware of the HIV status of her husband or children. She is thin and tells you that she has been ill off and on with diarrhoea for the last few weeks. She has been unable to work.

- Discuss the following in your pairs:
 - What needs do you think Katia has?
 - What referrals might Katia need?
 - If she lived in your community, what resources exist that could help her?



PERSONAL STRENGTHS & WEAKNESSES

List five personal strengths and five personal weaknesses. What are you especially good at and what are your weaknesses? For instance, a strength could be that you are friendly or hard-working. A weakness could be that you are easily distracted or are often impatient.

Key Point: Who you are as a person greatly influences who you become as a counsellor. Remember that knowing who you are also allows you to help others.

HOMEWORK ASSIGNMENT: PERSONAL VALUES AND FEELINGS ABOUT HIV

In order to work effectively with people who are living with HIV, it is important that each of us explores our own personal values and feelings related to HIV.

1. Prior to the next training, you should fill out the “Personal Values and Feelings about HIV Worksheet” in your Participant Manual. Please take time to thoughtfully fill this out.
2. You are encouraged to continue to keep a journal. Remember that personal growth is very important for a counsellor; personal growth should not stop after the course is completed. This should be the beginning of more personal growth in months and years to come.
3. Additional Optional Assignment: This assignment is not required, but you are encouraged to go for an HIV test. You might wonder why we are encouraging you to do this. The rest of the training will be focussed on issues surrounding HIV. We will be talking about HIV counselling and testing (VCT), and it would be helpful if you had experienced what it feels like to be a client before you are trained as a counsellor. It will also help you to have a context for your learning about HIV counselling and testing in the next module.



Part II

Instructions: Read the statements provided below. For each statement, circle the response that most closely reflects your own opinion. Then, in the space below the statement, explain your thoughts and feelings.

SA Strongly Agree	A Agree	D Disagree	SD Strongly Disagree
-----------------------------	-------------------	----------------------	--------------------------------

1. Health providers and counsellors should recommend HIV testing to all patients with any risk factors in their lives.

SA	A	D	SD
-----------	----------	----------	-----------

2. People with HIV have a responsibility to disclose their status to all potential sexual partners.

SA	A	D	SD
-----------	----------	----------	-----------

3. Health workers and counsellors who counsel others about HIV should know their own HIV status.

SA	A	D	SD
-----------	----------	----------	-----------

4. I am comfortable talking with my clients about their sexual behaviours.

SA	A	D	SD
-----------	----------	----------	-----------

5. I have never felt the desire to break the confidentiality of a client's HIV status.

SA	A	D	SD
-----------	----------	----------	-----------



SA **A** **D** **SD**
Strongly Agree Agree Disagree Strongly Disagree

6. I am equally comfortable working with men and women.

SA **A** **D** **SD**

7. I am comfortable working with homosexual clients.

SA **A** **D** **SD**

8. It is a person's right to end his/her life when his/her pain is unbearable.

SA **A** **D** **SD**

9. There is nothing wrong with extramarital sex as long as the parties involved are adults.

SA **A** **D** **SD**

10. Prostitutes are largely responsible for spreading HIV.

SA **A** **D** **SD**

11. All people with HIV must tell their partners and families their status.

SA **A** **D** **SD**



SA **A** **D** **SD**
Strongly Agree Agree Disagree Strongly Disagree

12. Masturbation is an acceptable safer sex strategy.

SA **A** **D** **SD**

13. Women's vulnerability to HIV can be reduced by empowering women through counselling to protect themselves.

SA **A** **D** **SD**

14. It is a woman's duty to have sex when her husband asks for it.

SA **A** **D** **SD**

15. If an adult gets HIV, it is their fault for having many sexual partners.

SA **A** **D** **SD**

Adapted from Ministry of Health & Child Welfare/Zimbabwe. Integrated Counselling for HIV and AIDS Prevention and Care, Primary Care Counsellor Training.



THE HIV RULE OF THREE

Much of the basic knowledge on HIV seems to follow a “rule of three.”

1. HIV: Three letters that stand for Human Immuno-deficiency Virus
2. Three ways of transmitting HIV: Sexual intercourse, exposure to blood (sharing needles) and mother-to-child transmission.
3. Three ways to prevent sexual transmission of HIV: **A, B & C**
Abstinence
Be Faithful to a partner who is faithful to you
Use a **C**ondom: use a condom correctly every time you have sex
4. Three phases in the natural course of HIV disease:
Acute HIV infection (also called the Window Period)
Chronic phase (asymptomatic)
Advanced HIV disease (also called AIDS)
5. In mother-to-child transmission, one baby out of three is infected without any intervention, and two out of three remain uninfected.
6. There are three ways for children of pregnant women to become infected: during pregnancy, during delivery (birth) or through breastfeeding.

NAMIBIAN HIV/AIDS CHARTER OF RIGHTS

Preamble

Recognising that people living with HIV/AIDS continue to face discrimination and prejudice which preclude them from access to services and benefits

And further recognising that a rights-based approach to HIV/AIDS which outlaws discrimination on the basis of HIV status is central to an effective public health response to HIV/AIDS

And further recognising that people living with HIV/AIDS should be involved at all levels of decision-making regarding the design and implementation of HIV/AIDS programmes and policies

And further recognising that people living with HIV/AIDS should be empowered and empower themselves to effectively participate in decision-making processes

And further recognising that the responsibility to effectively prevent the transmission of HIV is not limited to people living with HIV/AIDS but rests on Namibian society as a whole, and that all persons should empower themselves through education and information to gain knowledge about sexually transmitted diseases including HIV/AIDS, that will protect others and minimise the risk of HIV infection and re-infection

And further recognising that an effective response to the AIDS epidemic requires commitment at a political level to implement an effective HIV/AIDS prevention strategy; prevent discrimination and stigmatisation on the basis of HIV status; promote openness and transparency regarding the disease; and provide adequate information that will enable every person to make informed choices and to take responsibility for his or her own choices

NOW THEREFORE this Charter sets out those basic rights which all people enjoy or should enjoy and which should not be denied to persons affected by HIV or AIDS, as well as certain duties.

1. Equal protection of the law and equal access to public and private facilities and benefits

- HIV status cannot be considered as a ground on which to deprive any person of his or her basic human rights.
- Respect for the inherent dignity of all persons and the right to equal protection of the law requires that persons living with HIV/AIDS should have equal access to public and private services, benefits and opportunities. HIV testing should not be required as a precondition for such access.



- Public measures should be adopted to protect persons living with HIV/AIDS, including children and adolescents, from discrimination in employment, housing, education, childcare and custody and the provision of medical, social and welfare services.

2. Liberty, autonomy, security of the person and freedom of movement

- All persons, including persons living with HIV/AIDS, have the same rights to liberty, autonomy, security of the person and freedom of movement in Namibia and should have the same rights between countries.
- Segregation, isolation or quarantine of persons in prisons, schools, hospitals or elsewhere merely on the grounds of HIV/AIDS is unjustified and should therefore not be permitted.
- Persons living with HIV/AIDS are entitled to autonomy in decisions regarding marriage and reproductive health. Adequate counselling, information and education in this regard should be made available to all persons to enable them to make informed decisions.

3. Privacy and confidentiality

Confidentiality in the context of the AIDS pandemic is a concept that is widely misunderstood and is often quite incorrectly labelled as a veil of secrecy that undermines efforts to control the spread of HIV. In the context of HIV/AIDS, confidentiality means that health-care workers are ethically and legally required to keep all patient information to themselves. This means that any information about the patient's illness or treatment can only be given to another person with the patient's consent.

It is crucial to distinguish between the promotion of open discussion about HIV/AIDS and non-discrimination at a community and society level on the one hand, and the need for confidentiality on the other. Both of these contribute positively to the public health interest in reducing transmission and in providing care and support. Therefore:

- Persons living with HIV/AIDS have the right to confidentiality and privacy regarding their health and HIV status. This right endures after death. Information about HIV status may not be disclosed to a third party without the consent of the person with HIV/AIDS, unless legally required.
- The sharing of information regarding HIV status by the person living with HIV with others remains a matter of individual choice. However, this practice should be encouraged through appropriate counselling, education and the creation of a

supportive environment and appropriate services to those affected by this disclosure.

- It should be explained to patients that in order to optimise treatment and care it may be necessary to disclose personal health information to other health-care workers, but that this will only be done with the prior consent of the patient.

4. Counselling and testing

- Voluntary and confidential counselling and testing for HIV should be encouraged.
- The establishment of affordable and accessible voluntary confidential counselling and testing facilities is essential. These facilities should provide quality pre- and post-test and ongoing counselling by qualified and competent counsellors.
- Testing should be done only with informed consent.

5. Partner notification and reporting

- Health-care workers and counsellors are obliged to maintain confidentiality regarding a person's HIV status.
- Disclosure by a health-care worker of a person's HIV status without that person's consent should only take place to an identifiable sexual partner at risk in accordance with the following criteria:
 - The HIV-positive person in question has been thoroughly counselled as to the need for partner notification.
 - The HIV-positive person has refused to notify or consent to the notification of his/her partner(s).
 - A real risk of transmission to the partner(s) exists.
 - The HIV-positive person is given reasonable advance notice of the intention to notify.
 - Follow-up is provided to ensure support to those involved, as necessary.
- Reporting of HIV-positive results to any health information system should take place on an anonymous basis.
- Reporting of HIV-positive results should be undertaken for the sole purpose of gathering epidemiological data to facilitate the management of the HIV/AIDS epidemic.

6. Gender

All females and males are potentially at risk of HIV infection and are affected by HIV/AIDS. Disproportionate numbers of women and girl children are infected with HIV. The predominantly subordinate position of women and girl children in society makes them especially vulnerable to the risk of HIV infection. This is exacerbated by the high prevalence of domestic violence against and sexual abuse of women and girl children.

Therefore:

- The empowerment of women should be promoted through appropriate programmes aimed at raising the status of women and eliminating adverse social, economic and cultural factors that put women at risk of infection, as well as at strengthening men's sense of responsibility in relation to the prevention of transmission.
- Women and men should be equal partners in decision-making and matters of family planning and reproductive health. This includes the right to demand and to take appropriate precautionary measures to prevent transmission of HIV.
- Appropriate counselling and information regarding transmission of HIV should be made available to persons living with HIV/AIDS who wish to exercise the right to marry and/or found a family.
- Women with HIV should have access to adequate information to enable them to make informed decisions regarding their reproductive health.

7. Children, adolescents and HIV/AIDS

- Children and adolescents enjoy the same rights as adults in respect of access to information, privacy, confidentiality, respect, informed consent and means of prevention.
- Quality health care, information and education should be made available to all children and adolescents, including those living with HIV/AIDS. This should include information relating to HIV/AIDS and STD prevention and care, inside and outside school, which is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality and rights.
- Children and adolescents should be ensured adequate access to user-friendly, confidential sexual and reproductive health services. These services should include information on HIV/AIDS and STDs, sexual health advice, counselling, HIV testing and prevention measures including free access to condoms and social support services. The provision of these

services to children/adolescents should reflect an appropriate balance between the rights of the child or adolescent to be involved in decision-making according to his or her evolving capabilities and the rights and duties of parents or guardians for the health and well-being of the child.

8. Supportive and enabling environment for vulnerable groups infected and affected by HIV/AIDS

- A supportive and enabling environment for vulnerable groups should be promoted by identifying and addressing underlying prejudices and inequalities through advocacy, community dialogue, policy formulation and implementation, specially designed social and health services and support to community groups.
- Associations comprising members of different vulnerable groups should be established and supported for purposes of peer education, empowerment, positive behavioural change and social support.
- The development of adequate accessible and effective HIV/AIDS-related prevention and care, education, information and services by and for vulnerable groups should be supported. Such groups should actively be involved in the design and implementation of these services.

9. Children orphaned by AIDS

- Children orphaned by AIDS, regardless of their HIV status, who have lost one or both of their parents due to HIV/AIDS, are entitled to love and care, and a nurturing environment that would enable them to realise their full potential.
- The rights of the child should be respected; therefore children orphaned by AIDS should not be discriminated against. It is recognised that children orphaned by AIDS should be cared for and supported within their communities and that all decisions should be made in their best interests.
- Information on services, grants and benefits for children orphaned by AIDS should be made freely available.
- People employed in childcare agencies as well as informal and formal adoptive and foster care parents and persons providing services to children should receive training in order to deal effectively with the special needs of HIV-affected children, including psycho-social support and protection from mandatory testing, discrimination, abuse and abandonment.

10. Prisoners

- Prisoners should not be discriminated against on the basis of their HIV status. No compulsory HIV testing of prisoners should be carried out. Prisoners living with HIV/AIDS should not be isolated or quarantined.
- Prisoners living with HIV/AIDS are entitled to special care equal to that afforded to other prisoners with serious illnesses.
- Prisoners should be provided with information on HIV/AIDS and preventative measures, such as condoms, as well as with adequate counselling facilities.
- Information regarding the HIV status of a prisoner in the possession of the prison authorities should not be disclosed to any third party without the informed consent of the prisoner.

11. Adequate standard of living

All persons, including those living with HIV/AIDS, have the same right to a standard of living adequate for the health and well-being of themselves and their families, including food, clothing, housing and medical care and necessary social services.

12. Access to education

Persons living with HIV/AIDS should have equal access on a non-discriminatory basis to institutions of primary, secondary and tertiary education, as well as to scholarship schemes.

13. Access to appropriate information and sex education

- Culturally appropriate formal and non-formal education programmes and information on HIV/AIDS should be accessible on a continuous basis to all, to enable people to make informed decisions about their life and sexual practices. Education should also promote respect, tolerance and non-discrimination in relation to persons living with HIV/AIDS.
- Appropriate information regarding parent to child transmission, breastfeeding, treatment, nutrition, change of lifestyle and safer sex should be freely available.

14. Access to health care and appropriate treatment

- HIV status should not be considered as a ground for depriving any person of their right to the highest attainable standard of physical and mental health. To this end, persons living with



HIV/AIDS should have access on a non-discriminatory basis to adequate health care and appropriate and affordable treatment and drugs so that persons living with HIV/AIDS can live as long and as successfully as possible.

- Ethical guidelines and codes of conduct for health-care workers and counsellors should be implemented and reinforced to guarantee the rights to privacy, confidentiality and dignity of persons living with HIV/AIDS. These guidelines and codes of conduct should require health-care workers and counsellors to treat any person living with HIV/AIDS without discrimination.
- Community efforts to provide home-based care to people who are living with HIV/AIDS should be supported. Caregivers should be properly trained to render effective care and counselling.
- Women with HIV who are pregnant should have access to adequate information regarding mother to child transmission and to affordable treatment to reduce the risk of mother to child transmission.
- Rape survivors should have access to adequate information about HIV/AIDS and to affordable and timely prophylactic treatment.

15. Research and clinical trials

- Persons living with HIV/AIDS should have access to clinical trials conducted only in terms of acceptable research protocols, which adequately protect the rights of research subjects prior to, during and after the trials.
- The results should be made available to the community for timely and appropriate action.

16. Employment

Discrimination on the basis of HIV status in access to and continued employment, conditions of employment and employment benefits is contrary to the provisions of the Labour Act.

Therefore:

- People living with HIV/AIDS have the right to work, and should not be excluded from employment solely on the basis of their HIV status.



- Both employers and employees have a mutual responsibility to prevent discrimination on the basis of HIV status in the workplace.
- There should be no compulsory testing for HIV in the workplace. Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with the informed consent of the employee in accordance with normal medical ethical rules and with pre- and post-test counselling.
- Persons living with HIV/AIDS have the legal right to confidentiality regarding their HIV status in any aspect of their employment. An employee is under no obligation to inform his or her employer of his or her HIV status.
- Employees living with HIV/AIDS should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they are unable to continue with normal employment, the normal rules regarding incapacity should apply.
- Employers, in consultation with employees, should develop and implement appropriate workplace policies on HIV/AIDS.
- Employers should provide a safe and healthy working environment for employees, including the provision of the necessary equipment and information, as well as the implementation of universal precautions to prevent transmission of HIV in the workplace.
- Where an employee accidentally contracts HIV in the course and scope of his or her employment, he or she shall be entitled to employee's compensation.

17. Insurance and medical aid

- Persons living with HIV/AIDS and those suspected of being at risk of having HIV or AIDS should be protected from arbitrary discrimination in insurance and medical aid. Insurers and medical aid administrators should explain to the insured or medical aid member what influence HIV/AIDS would have on the validity and effect of the contract of insurance or medical aid.
- If HIV testing is required for life insurance or medical aid, the insurer or medical aid administrator should provide access to adequate pre and post-test counselling. The insurer or medical aid administrator requiring the test should ensure that the results are treated with confidentiality.
- Insurers and medical aid administrators should continue to explore, in consultation with people living with HIV/AIDS, the

development of new products that would provide appropriate cover for people living with HIV/AIDS.

- Insurers and medical aid administrators should be encouraged to play an effective role in HIV/AIDS prevention and education campaigns.

18. Media

- Media programmes should be designed to challenge attitudes of discrimination and stigmatisation associated with HIV/AIDS.
- The media and the advertising industry should be sensitive to HIV/AIDS and human rights issues and should reduce sensationalism in reporting and the inappropriate use of language and stereotypes, especially in relation to disadvantaged and vulnerable groups.
- The public has the right to balanced and informed coverage, information and education on HIV/AIDS, STDs and related issues.
- HIV/AIDS media programmes should be designed to be accessible to all people, including those with audio-visual disabilities.

19. Cultural and traditional practices

- It is recognised that some cultural and traditional practices militate against effective preventive action and place people, especially women and young people, at risk of HIV infection. These practices and traditions should be identified and steps should be taken to address them by way of formal and non-formal education and/or legislation.
- Traditional Authorities should play an important role in HIV/AIDS prevention strategies.
- Traditional healers and traditional birth attendants should be provided with appropriate education and information about HIV/AIDS and its transmission.
- Dialogue and collaboration between traditional and non-traditional health providers on the care and management of HIV/AIDS should be promoted.

AIDS Law Unit. Legal Assistance Centre. Namibian HIV/AIDS Charter of Rights. Available from: <http://www.lac.org.na/alu/Pdf/hivchart.pdf>.



GLOSSARY

Abrupt stopping of breastfeeding/abrupt weaning: Completely stopping breastfeeding with a switch to replacement feeding. Mixed feeding should be avoided during this time.

Adherence: The extent to which a person's behaviour (taking medication, following a treatment regimen, making lifestyle choices, etc.) corresponds with recommendations made by the health-care team. ART adherence is taking the correct dose at the correct time and in the correct way.

AIDS (Acquired Immune Deficiency Syndrome): late-stage HIV infection.

Acquired: obtained or contracted; not inherited.

Immune: the body's defence system that provides protection from most diseases.

Deficiency: a defect, weakness or inability to respond; when linked with the immune system, this refers to the inability of that system to perform its functions and combat antigens or germs.

Syndrome: a group of symptoms and diseases that indicate a specific condition; it is not by itself a disease.

ANC: Antenatal clinic or antenatal care.

Antenatal care: Care of a pregnant woman and her unborn child or foetus.

Antibody: the substance that the body makes to fight an antigen (foreign substance in the body such as a germ). Its purpose is to protect the body from disease by countering or identifying the antigen to be destroyed.

Antigen: any foreign substance that gets into the body and causes the immune system to respond. Antigens include bacteria and viruses such as HIV.

Antiretroviral drugs (ARV): drugs that slow the growth and replication of HIV and the progression of HIV disease.

Antiretroviral prophylaxis (HIV prophylaxis): use of antiretroviral drugs to reduce the likelihood (or possibility) of HIV transmission, for example, the use of single-dose Nevirapine for prevention of HIV transmission from mother to child.

Antiretroviral treatment (ART): Use of antiretroviral drugs to treat HIV infection or AIDS.

Asymptomatic: without symptoms of illness or disease. People who are infected but asymptomatic may transmit HIV or other STIs (sexually transmitted infections).



CD4 cell: The white blood cell within the immune system that is targeted and destroyed by HIV.

CD4 count: The number of CD4 cells in the blood, which reflects the state of the immune system. A normal count in a healthy adult is 500-1,200 cells/mL³. When the CD4 count falls below 200 cells/mL³, there is a high risk of opportunistic and serious infection.

Complementary food: Any food used as in addition to breast milk or to a breast milk substitute when feeding an infant.

Cup feeding: Feeding an infant from an open cut without a lid.

Diarrhoea: illness characterised by loose, watery bowel movements more than three times a day, every day.

Disclosure: sharing personal information, thoughts or feelings with others. In the context of HIV, disclosure is usually used to refer to sharing one's HIV status with others.

Discrimination: treating one particular group in society in an unfair way.

Embryo: fertilised egg (egg & sperm) until 2 months of development.

Exclusive breastfeeding: an infant receives only breast milk and NO other liquids or solids, not even water. The only exceptions are drops or syrups that contain vitamins or minerals, or any medicine prescribed by a doctor.

Foetal (also spelled fetal): connected with a foetus, i.e. foetal blood is the blood of the foetus.

Foetus (also spelled fetus): a baby before birth, while the baby is still in the mother's uterus/womb; from 2 months to birth.

Gender: our maleness or femaleness, often including our social roles.

HIV (Human Immuno-deficiency Virus): the virus that causes AIDS.

Human means that it affects only humans and lives only in humans.

Immuno-deficiency means a deficiency or a breakdown of the immune system; a decrease in the body's ability to fight disease.

Virus: A virus is a germ that invades the body and causes diseases. A virus is a type of antigen.

Health care worker (Health care provider): A doctor, nurse or midwife who work with patients in a health care facility, i.e. hospital or clinic.



Immune system: the body's resistance or the body's defence mechanism for fighting off infections. The immune system defends the body against infections; it includes the white blood cells, which include CD4 cells, T cells and B cells.

Infant: a person from birth to 12 months of age; a baby.

Infant formula: a breast milk substitute that contains the nutrients an infant needs. It is a powder sold in tins.

Intercourse: sex that involves one partner entering another's body. Intercourse may refer to oral, anal and vaginal sex.

Intervention: Specific action or strategy to address a particular problem or issue and to accomplish a specific action or outcome.

Maternal: of the mother, or related to being a mother, i.e. maternal blood is mother's blood.

Mixed feeding: feeding both breast milk and other foods or liquids, including water. Mixed feeding increases the risk of transmission of HIV from a positive mother to her child.

Mother-to-child transmission (MTCT): transmission of HIV to a child from an HIV-infected woman during pregnancy, delivery, or breastfeeding.

Nutrients: substances that come from food and are needed by the body, i.e. carbohydrates, proteins, fats, vitamins and minerals.

Opportunistic infection: infections that occur in the presence of immune deficiency (weakened immune system), or HIV-related diseases. Any disease that occurs more frequently in people with HIV.

Oral thrush: a fungal infection of the mouth that looks like white patches or curdled milk.

PCP (Pneumocystic carinii pneumonia): a severe, life-threatening lung infection that causes fever, dry cough and difficulty breathing. It is an opportunistic infection.

PCR (polymerase chain reaction) test: This test detects HIV in the blood and can be done at 6 weeks following possible exposure; it is also may be used to test infants.

PEP (post-exposure prophylaxis): medicine given after someone has been exposed to a virus or disease, such as HIV, in order to prevent infection.



Placenta: organ in the womb that filters the mother's blood and allows oxygen and nutrients to pass through the umbilical cord to nourish the growing foetus.

Postnatal care: care given to mother and baby after the child is born. It includes medical treatment, services on breastfeeding, immunisations, maternal nutrition and support for the mother and her family.

Prevention of mother-to-child transmission (PMTCT): prevention of mother-to-child transmission of HIV.

Replacement feeding: feeding infants who are receiving no breast milk with a diet that provides all the nutrients they need until they can eat family foods. During the first six months of life, replacement feeding should be with a breast milk substitute such as infant formula or modified cow's or goat's milk.

Replicate: to duplicate or make more copies of something.

Resistance (viral resistance): changes in the genetic makeup of HIV that decrease the effectiveness of antiretroviral drugs (ARVs).

Safer sex: Ways to have sex that reduce the danger of acquiring or transmitting HIV or other sexually transmitted infections (STIs).

Sex: sexual activity or behaviour; sexual intercourse.

Sexual orientation: determined by whom a person is physically and emotional attracted to; common divisions are **heterosexual** (attracted to people of the opposite gender), **bisexual** (attracted to people of either gender) or **homosexual** (attracted to people of the same gender).

Sexuality: the experience of being sexual; this is shaped by behavioural, psychological, emotional, social and orientation factors.

Sexually Transmitted Infection (STI): infection that is spread from one person to another through sex or sexual activity. The unprotected sex may include vaginal, oral and anal sex.

Side effect: unintended action or effect of a medication or treatment.

Stigma: mark of shame or discredit; the strong feeling in a society that a type of behaviour is shameful. An attribute of a person that is considered unacceptable.

Symptomatic HIV infection: the stage of HIV infection when a person experiences symptoms. Common symptoms include fever, weight loss and swollen lymph glands.



Transmit (transmitted): to pass on, as in a disease. To transmit HIV is to pass on the virus to another person.

Tuberculosis (TB): A highly contagious (easy to get) bacterial infection that attacks the lungs and other parts of the body.

Umbilical cord: connects the foetus (unborn baby) to the placenta. The umbilical cord carries oxygen and nutrients from the mother to the unborn baby. The umbilical cord is cut after the baby is born and forms the belly button.

Unprotected sex: sexual intercourse without a condom or other barrier to prevent contact with the partner's body fluids. This can be vaginal, anal or oral sex.

Vaginal fluids: liquids produced by the female reproductive system that provide moistness and wetness in the vagina and serve as lubrication during intercourse.

Viral load: The amount of HIV in the blood as measured by a blood test (usually the HIV RNA polymerase chain reaction test, or PCR).

Viral replication: the process by which a virus makes copies of itself, using genetic material in human cells.

Virus: a type of germ that causes infection.

Wasting (syndrome): condition characterised by loss of more than 10% of body weight, and either unexplained chronic diarrhoea lasting more than a month or chronic weakness and unexplained fever lasting more than a month.

Window period: the time between infection with HIV and a definitive positive result on an antibody test. For HIV, the window period is usually about 3 months.

REFERENCES: GENERAL HIV AND SEXUALITY MODULE

AIDSTECH/Family Health International, *AIDS/STD Education and Counselling: Training Manual*.

Coates, Thomas, PhD. *Principles of Behavior Change*. Centre for AIDS Prevention Studies, University of California, San Francisco.

Department of Health & Human Services, Centres for Disease Control and Prevention. October 2004. *Voluntary Counselling and Testing (VCT) Training Course*. Participant's Manual. USA.

EngenderHealth. 2003. *Comprehensive Counselling for Reproductive Health: An Integrated Curriculum, Trainers' Manual and Participants' Manual*.

Government of the Republic of Namibia. July 2005. *Report of the 2004 National HIV Sentinel Survey*. Ministry of Health and Social Services, Directorate of Special Programmes. Windhoek, Namibia.

HIVSA. April 2005. *Education and Support Group Materials Toolkit*.

Kidd, Ross and Clay, Sue. September 2003. *Understanding and Challenging HIV Stigma: Toolkit for Action, Trainer's Guide*.

Ministry of Health & Child Welfare/Zimbabwe. *Integrated Counselling for HIV and AIDS Prevention and Care, Primary Care Counsellor Training*. Zimbabwe.

Family Health International. *Adherence Worker Training: Facilitator's Guide*. Zambia.

Family Health International. 2005. *Control of Sexually Transmitted Diseases*. Ed. Gina Dallabetta, Marie Laga, and Peter Lamptey.

Family Health International. January 2004. *HIV Voluntary Counselling and Testing: A Reference Guide for Counsellors and Trainers*. VCT Toolkit.

Family Health International. January 2005. *HIV Voluntary Counselling and Testing: Skills Training Curriculum, Facilitator's Guide*. VCT Toolkit.

Lamptey, Peter R., Johnson, Jami L., and Khan, Marya. March 2006. *The Global Challenge of HIV and AIDS*. Population Bulletin, Vol. 61, No.1.

LifeLine/ChildLine Namibia, affiliated to LifeLine International. 23 August 2004, final draft. *Prevention of Mother-to-Child Transmission of HIV. Namibian Training Curriculum for Community Counsellors*.



Pathfinder International. June 2002. Judith Senderowitz, Cathy Solter and Gwyn Hainsworth. *Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 16: Reproductive Health Services for Adolescents, Participant's Manual*.

UNESCO. 2005. *Reducing HIV/AIDS Vulnerability Among Students in the School Setting: A Teacher Training Manual*. Bangkok, Thailand: funded by Japanese Funds-in-Trust.

Welbourn, Alice. June 1998. *Stepping Stones*. Strategies for Hope Training Series: No. 1. London: ActionAID.

Wietersheim, Erika von and Steinitz, Lucy Y. 2005. *Red Window of the Windows of Hope*. Ministry of Basic Education, Sport and Culture, HIV and AIDS Management Unit (HAMU). Windhoek, Namibia.

Winiarski, M. 2004. *Community-Based Counselling for People Affected by HIV and AIDS*. Longman & Catholic AIDS Action. Windhoek.

