Community Counsellor Training Toolkit

Module 6

Counselling and PMTCT

Participant Manual

LifeLine/ChildLine Namibia

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

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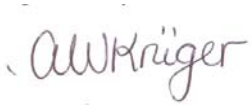
Foreword

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.



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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 Heath 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.

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COUNSELLING AND PMTCT: PARTICIPANT MANUAL
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LIST OF BASIC COUNSELLING SKILLS

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

Empathy*

Listening Skills*

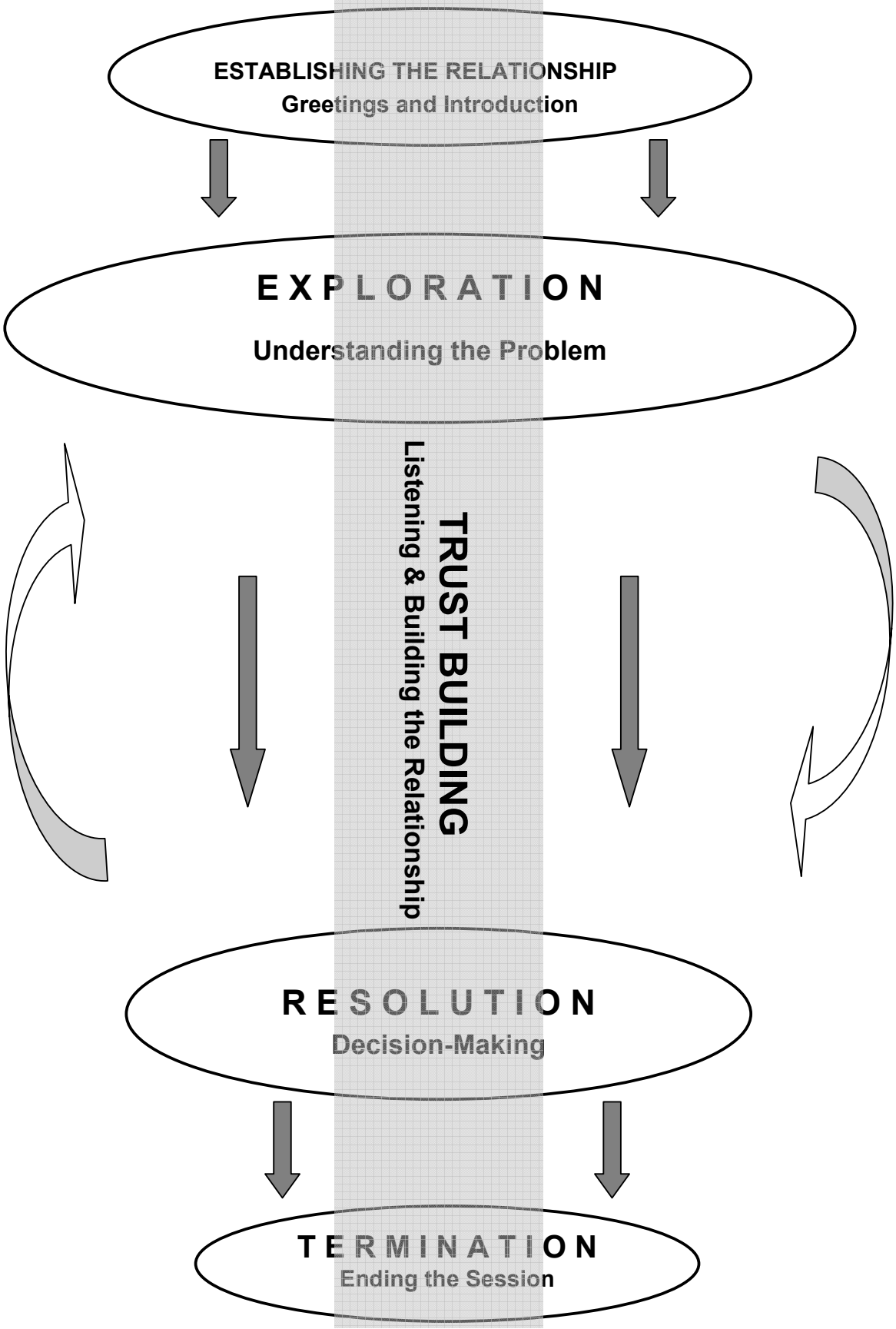
Reflecting Skills:
- **Reflecting Feelings***
- Restating/Reframing
- **Affirmation***
- **Summarising***

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**.

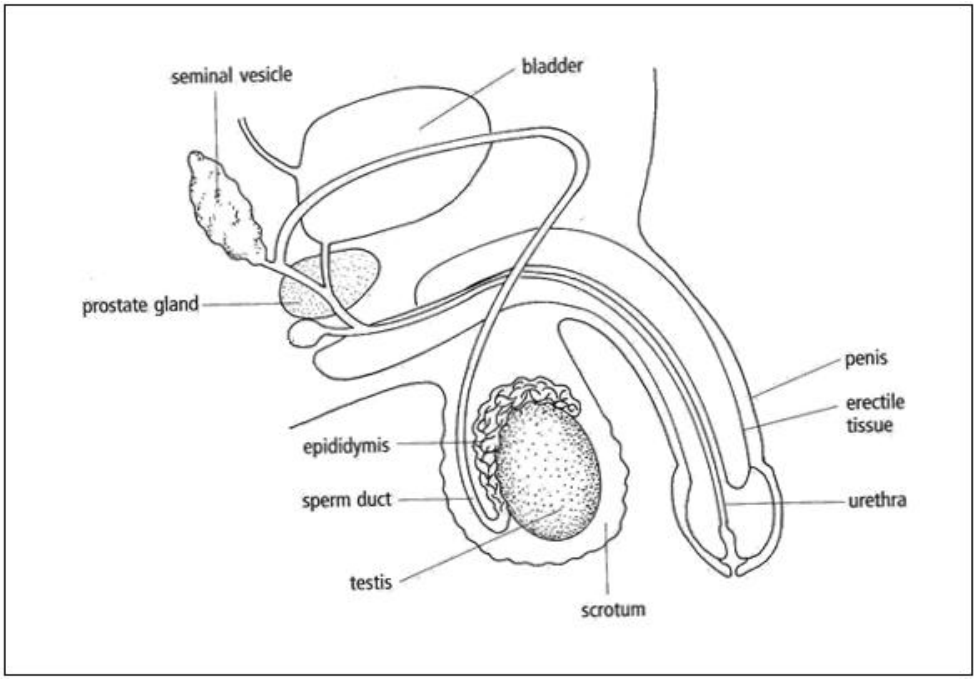
MODEL OF A COUNSELLING SESSION



SEXUAL ANATOMY & REPRODUCTION REVIEW

Male Reproductive Anatomy:

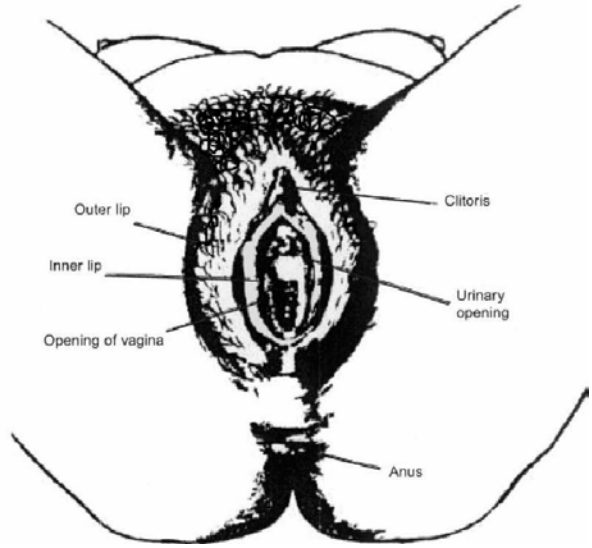
- The penis is the main male sex organ.
- The penis is usually soft and limp. When sexually aroused, the blood vessels swell with blood and the penis gets stiff or hard. This is called an erection.
- Below the penis near the body is the scrotum; it hangs below the penis.
- The scrotum is a sack of skin 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.

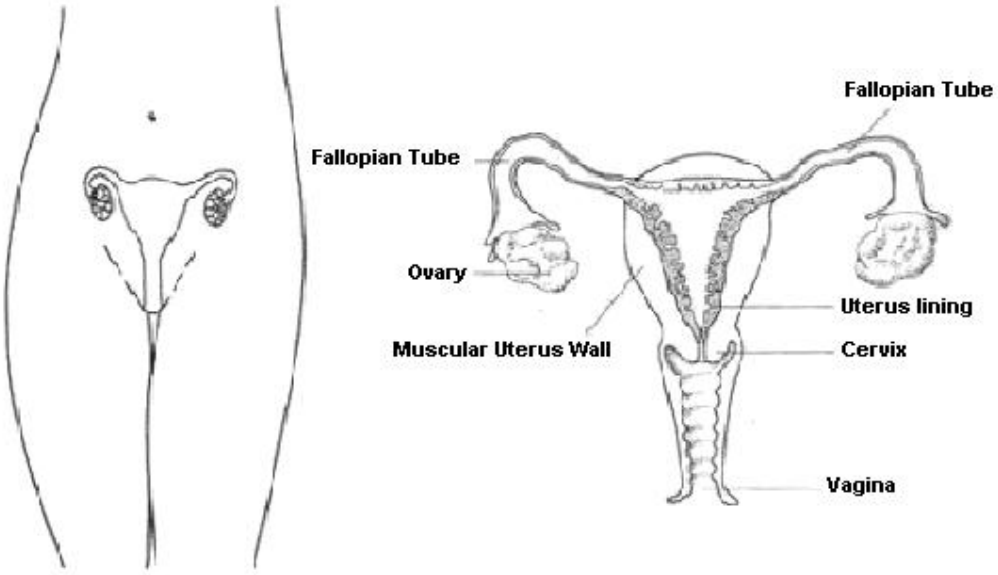


Female Reproductive System (Internal)

- 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 is 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.

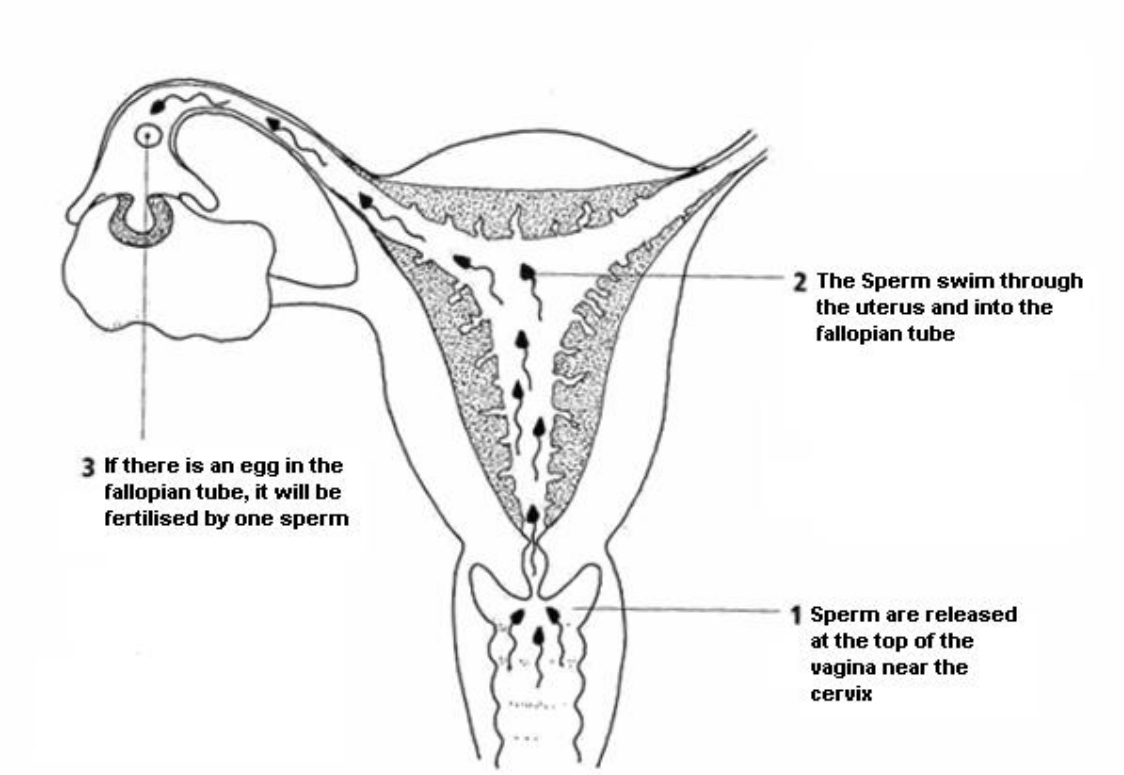
- In the case of mutual consent, the vagina shows its readiness by softening and opening up. It also produces body liquids, or vaginal fluids, which makes it easier for the man to insert his penis.

- 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.

Reproduction/Pregnancy

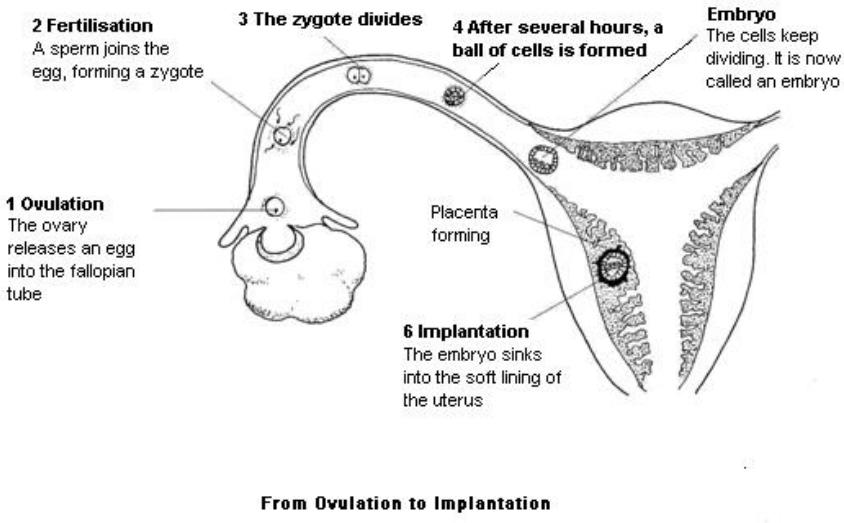
Ejaculation to Fertilisation

- When the man ejaculates during sexual intercourse, he releases millions of sperm into the woman's vagina.
- The sperm swim through the uterus into the fallopian tubes.
- If there is an egg (ovum) in the fallopian tube, when it meets the sperm, it will be fertilised.
- If the sperm penetrates, or joins, the egg, **fertilisation** occurs.



Fertilisation to Implantation

- After the woman's egg is fertilised by the sperm, it moves down the fallopian tubes into the uterus.
- Then the embryo sinks or embeds into the soft lining of the uterus. This is called implantation. At this point, the woman is pregnant.
- The fertilised egg is called an embryo for the first two months of development. After that, it is called a foetus.



From Ovulation to Implantation

Key Terms:

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

Foetus: the name of the developing baby from 2 months until birth.

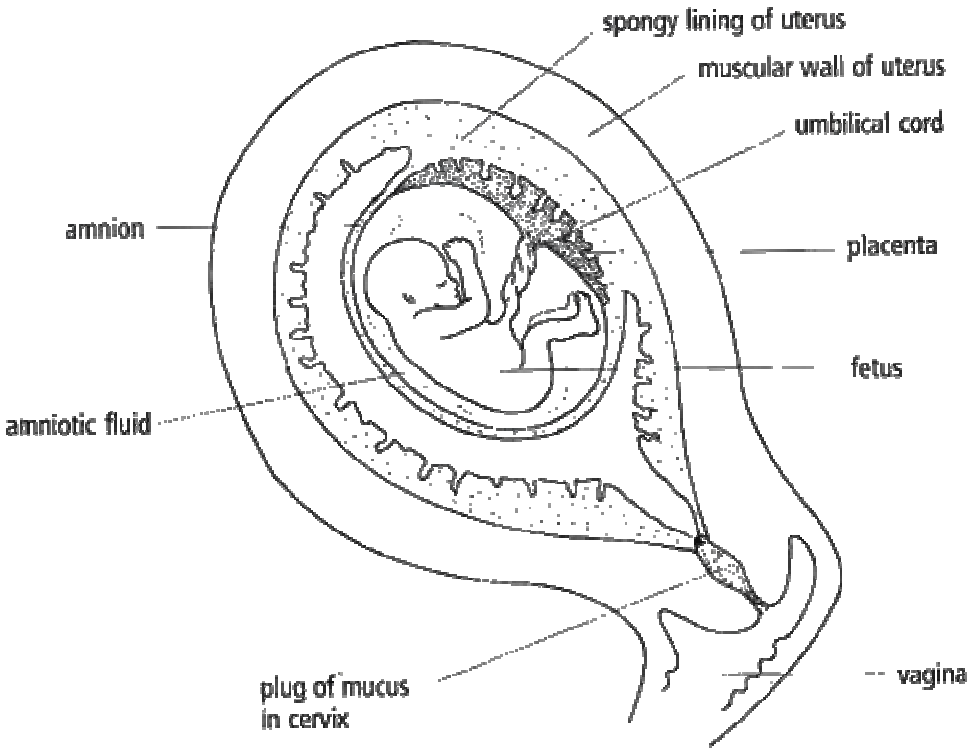
Umbilical cord: connects the foetus (unborn baby) to the placenta. The umbilical cord carries oxygen and nutrients from the mother to the baby. The umbilical cord is cut after the baby is born and forms the belly button.

Placenta: Filters the mother's blood that has oxygen and nutrient and then carries it to the foetus through the umbilical cord. The foetal (baby's) blood and the maternal (mother's) blood are completely separate in the placenta.

Amniotic fluid: the foetus floats in the amniotic fluid, contained by the uterus. The amniotic fluid acts as a protection for the foetus.

Development of the Baby (Foetus)

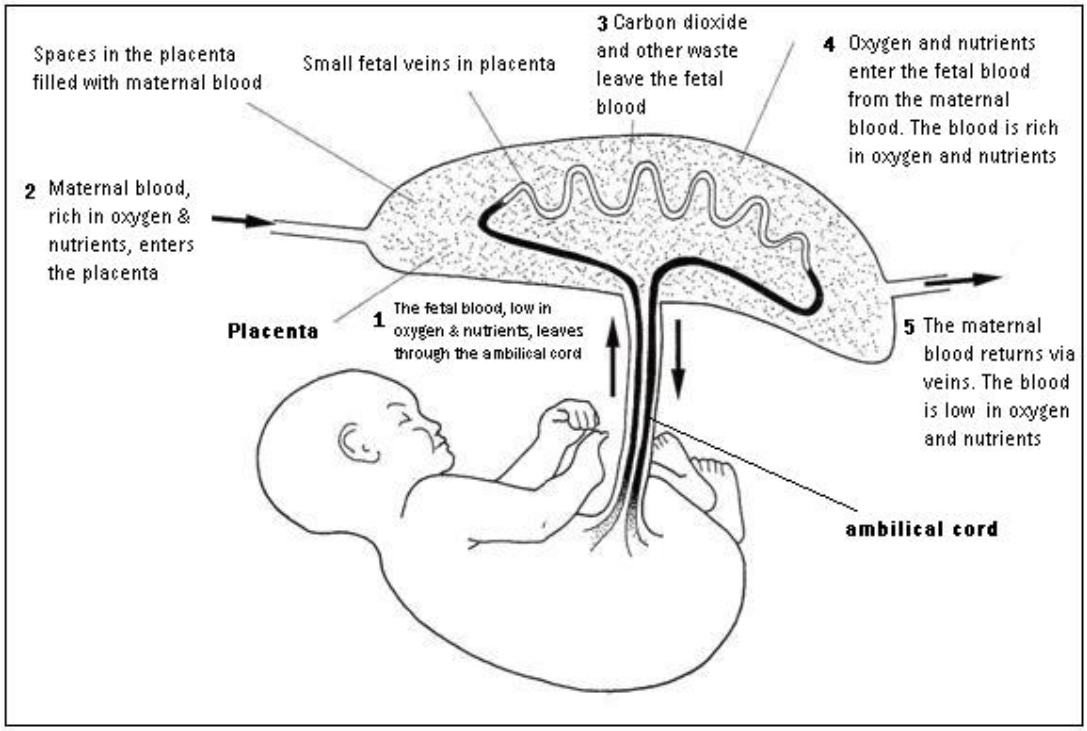
- Development of the body happens for nine months, from fertilisation until birth.
- The fertilised egg is called an embryo until about two months of development.
- From two months until birth, the baby is called a foetus.
- The foetus is protected by amniotic fluid, contained within a sac within the uterus.
- The placenta acts as a filter, and provides oxygen and nutrients from the mother to the foetus while removing wastes from the foetus.
- The foetus is connected to the placenta by the umbilical cord. The umbilical cord carries nutrients and oxygen from the mother to the foetus.



How the Placenta Works

In this diagram, you can see how the baby's blood and mother's blood are kept completely separate in the placenta.

- The placenta filters the mother's blood, providing the baby with oxygen and nutrients.
- Nutrients (food) and oxygen are absorbed into the baby's blood from the mother's blood that is in the placenta.
- At the same time, waste from the baby leaves the baby's blood and is absorbed into the mother's blood.



Birth (Labour and Delivery)

- Birth occurs approximately 9 months after fertilisation.
- Contractions of the muscles around the uterus push the foetus towards the cervix.
- Labour begins when contractions occur.
- These contractions are gentle at first and become stronger and more frequent.
- The sac containing the amniotic fluid breaks. This is also called the rupture of membranes or when the mother's "water breaks."
- As the muscles of the uterus continue to contract, they push the baby out of the uterus through the cervix and vagina and out of the mother's body.
- The placenta is also pushed out of the body.
- The umbilical cord is clamped and cut since the baby can now eat and breathe on his/her own.

Pregnancy and HIV: A Few Facts

- Being HIV-positive makes it more difficult for a woman to become pregnant.
- Being pregnant does not affect the natural course of HIV disease, i.e. it will not speed up the progression of the disease.
- HIV may cause birth defects or miscarriages. Women who are HIV-positive usually have lower birth-weight babies.
- The risk of problems or complications during pregnancy is higher in HIV-positive women who have malaria or STIs. Malaria causes an infection in the placenta; as a result, the placenta cannot filter the mother's blood as it should, which therefore increases the risk of transmission to the baby.

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, including menstruation, family planning, pregnancy, STIs and HIV.

Sexual health is…	**Sexual health is NOT…**
▪ Having the freedom of sexual expression	▪ Being forced to do things
▪ Being well-informed about sexual matters	▪ Doing things that are not pleasurable to you
▪ Enjoying sexual behaviours	▪ Being afraid about becoming pregnant
▪ Having a positive approach to sex	▪ Being afraid that you are at risk of getting HIV or an STI
▪ Feeling safe at all times during sexual behaviours	▪ 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.

MTCT: How is HIV Transmitted from Mother to Child?

MTCT stands for **M**other-**T**o-**C**hild **T**ransmission (of HIV).

PMTCT stands for **P**revention of **M**other-**T**o-**C**hild **T**ransmission (of HIV).

What are the chances of a mother transmitting HIV to her baby?

According to the Ministry of Health and Social Service's PMTCT guidelines published in May 2004, without any intervention, the rates of mother-to-child transmission (MTCT) of HIV range from 21% to 43% in various African settings.

What does this mean for Namibia?

An estimate of the magnitude of transmission to newborn babies in Namibia every year is summarised in the table below. Each year, an estimated 4,620 newborns acquire HIV infection as a result of mother-to-child transmission.

Estimated number of infants infected with HIV every year	
Population (Census 2001)	1.8 million
Births per year, 2002 (estimated HIS 2001)	70,000
HIV prevalence in mothers, 2002	22%
Total number of births to HIV-positive mothers at risk of MTCT, assuming no multiple pregnancies	15,400
Number of newborns infected with HIV during 2002 in Namibia, assuming a 30% risk of transmission and no intervention provided	4,620 (approximately 5,000)

Table adapted from Ministry of Health and Social Services. May 2004. Guidelines for the Prevention of Mother-to-Child Transmission of HIV. First edition.

For every 300 children born to HIV-infected women in Namibia, about 100 will be infected with HIV without any PMTCT intervention.

> **Key Point:** About one-third of all children born to HIV-infected women in Namibia would be infected with HIV if no intervention is provided.

When can mother-to-child transmission happen?

There are three ways that HIV can be transmitted from the mother to the child:

- During pregnancy, in the womb (before delivery)
- During labour and delivery (while the baby is being born)
- During breastfeeding (after delivery)

Transmission Rates:

If the mother does not take any steps to prevent mother-to-child transmission, the estimated risk of HIV transmission to newborn babies exposed to HIV is:

- 5-10% during pregnancy
- 10-20% during labour and delivery
- 2-20% from breastfeeding, depending on how long the mother continues to breastfeed her baby and whether she mixes in water or any other food

> **Key Point:** The higher the mother's viral load (the amount of HIV in her body), the higher the risk of HIV transmission to her baby.

How can HIV be transmitted during pregnancy?

The placenta lines the uterus (womb) of a pregnant woman. Food and oxygen for the baby pass through the placenta from the mother. The placenta usually protects the baby from many things that may happen in the mother's body.

The placenta is also key in protecting the developing baby from getting HIV; it acts as a barrier or filter between the mother and baby.

However, there are some things that increase the risk of the mother transmitting HIV during pregnancy. These include:

- STIs or malaria during pregnancy weaken the placenta and increase the risk of transmission.
- High viral load of the mother, a low CD4 count or advanced HIV disease
- HIV infection occurring while the mother is pregnant, because the viral load is very high right after infection before the body develops antibodies. *Refer to the chart illustrating the Progress of HIV.*
- Poor nutrition of the mother also increases the risk of transmission.

How can HIV be transmitted during labour and childbirth?

As the baby is born, it passes through the birth canal (cervix and vagina) and is exposed to the mother's blood and other fluids that contain HIV. Remember that HIV is contained in blood and vaginal fluids. HIV can be transmitted to the baby through the baby's nose or mouth, or through little scratches or sore patches on the baby's skin.

The following factors increase the risk of transmission during labour and delivery:

- If labour is long, there is more risk of exposure.
- If the water breaks (membranes rupture) more that four hours before the baby is born, there is increased risk of transmission. The longer the labour and delivery, the greater the baby's exposure to infected fluids because when the mother's water breaks, the placental barrier is gone.
- If there is any bleeding during labour and delivery.
- If the baby swallows any of the mother's blood or secretions as it is born.
- If the mother's placenta comes away from the wall of the uterus, the baby's blood and the mother's blood may mix.
- If forceps are used or if the mother's vagina is cut, this increases the exposure to HIV through blood and other body fluid.
- If the baby is born prematurely (early) and weighs less than 2.5 kilos.
- When a baby is one in a multiple birth, i.e. a twin, one of three or four, chances of infection are greater.

How can HIV be transmitted during breastfeeding?

HIV is present in breast milk, although the viral concentrations (amount of the virus) are significantly lower than in blood. However, even with the risk of transmission, exclusive breastfeeding is best.

Exclusive breastfeeding is giving the child breast milk ONLY, NOT ANY other liquids or food, not even water.

The following factors increase the risk of transmission during breastfeeding:

- If a baby is given breast milk and other food, known as mixed feeding. The food may cause an infection in the baby's stomach. This infection then provides an easy way for the HIV in the mother's milk to get into the baby's blood. Breast milk alone will not cause an infection in the baby's stomach.
- If the mother has a breast infection.
- If the baby has sores in his/her mouth.
- If the mother breastfeeds for a long time; the longer a woman breastfeeds, the higher the risk of HIV transmission to the baby.
- If the mother's viral load is very high, which is common with advanced HIV disease (AIDS) or a new HIV infection.

Overall Factors Increasing Risk of Mother-to-Child Transmission

- High HIV viral load of mother
- Severely weakened immune system of mother, i.e. presence of infections or advanced HIV disease (AIDS)
- Poor nutrition of mother
- Premature delivery
- Early rupture of membranes during labour
- Prolonged (long) labour
- Breast infection
- Untreated STIs

Key Point:

Through Namibia's PMTCT programme, an HIV-infected mother can **significantly** reduce the chance of her baby becoming infected.

We believe that every pregnant woman wants the best for her child. This programme can empower pregnant women to take control of their situations and to do **the best they can** to make sure their babies will be healthy. As community counsellors, **your help is needed** in order to help educate and support pregnant women and their partners to make the best decisions for themselves and their families. Also, you will provide the women with emotional support and encouragement to help them negotiate any difficulties or problems they might face along the way.

Factors Impacting Mother-to-Child HIV Transmission
(For reference)

Factors Related to the Mother	Factors Related to the Delivery	Factors Related to the Baby	Factors Related to Infant Feeding
High viral load Due to recent infection or Advanced HIV disease	Prolonged rupture of membranes (over 4 hours before delivery)	Prematurity (early birth)	Breastfeeding
Poor nutrition	Episiotomy (cutting of vagina)	First infant of multiple birth, i.e. twins	Mixed feeding: breastfeeding & other food
Presence of STIs	Invasive foetal monitoring	Immature GI tract (digestive system)	Breast infections of the mother
Infection of the placenta, especially due to malaria	Bleeding during the birth		Longer duration of breastfeeding
	Delivery using instruments		HIV infection of mother during breastfeeding
	Vaginal versus caesarean section		Mouth sores in infant

PMTCT OVERVIEW

In Namibia, the number of pregnant women with HIV varies from region to region. In some regions, 1 out of 10 pregnant women is HIV-positive, while in other regions, it may be 3 out of 10.

Now, let us look at a region where 3 out of 10 women are HIV-positive. Without PMTCT, how many of the children will be infected with HIV?

- On average, 1 out of the 3 women will have a baby who is HIV-positive. This baby may have been infected during pregnancy (inside the womb), during delivery or through breastfeeding.

There are different strategies to reduce the number of HIV-infected infants:

1. Prevention of HIV infections in women is the most important strategy.
2. Prevention of unintended pregnancies is another important strategy. Women can plan to become pregnant when they are ready, wait until they feel they are old enough, or wait until the previous child is strong enough. This is particularly important for women who know they are infected with HIV.
3. Specific strategies exist to reduce the transmission of HIV from a positive mother to her baby during pregnancy, delivery and breast feeding. These strategies are the components of PMTCT.
4. The last strategy is comprehensive care for HIV-positive women, their partner(s) and children.

Basic Facts:

1. HIV is a family infection; both mothers and fathers have an impact on transmission of HIV to the baby.
2. If a woman becomes infected with HIV while she is pregnant or breastfeeding, the risk of transmission to the baby increases.
3. Both parents must understand the need to have a role in safer sex.
4. Women diagnosed with HIV during pregnancy need additional attention to assess the stage of their illness and to prevent opportunistic infections such as TB.
5. Some women will receive only single dose Nevirapine for PMTCT, while others will receive referral to HIV treatment, which is known as PMTCT-plus.

Just as transmission from mother-to-child of HIV (MTCT) can take place in three different ways, the prevention (PMTCT) is directed towards these three different modes of transmission. In this session, we will be looking at the basic concepts of PMTCT and how it works.

1. Before delivery
    - PMTCT introduced to all pregnant women
    - All pregnant women offered Counselling and Testing (VCT)
    - Antenatal care for the mother
    - Explore infant feeding options with the mother

2. During labour and delivery
    - Single dose Nevirapine for mother at start of labour
    - Single dose Nevirapine syrup given to infant
    - Caesarean section delivery, which reduces the baby's contact with blood and vaginal fluids

3. After delivery
    - Support for infant feeding choices

Key Point: Worldwide, the most successful intervention in the HIV epidemic is the prevention of mother-to-child transmission. Transmission of HIV from mother to child can be reduced by 50% through PMTCT programs.

It is important to note that no one knows at what point a baby may become infected. We can only talk about the risk of infection and look at ways to reduce that risk. We can reduce the risk of transmission by 50% by intervening during labour, delivery and breastfeeding.

Ideas for Prevention of Mother-To-Child Transmission

1. Prevention of HIV infection
    - Behavioural change communication (Abstinence, Be faithful, Condom use) targeted towards youth, who are future parents
    - Education about HIV transmission and prevention
    - VCT services at hospitals, clinics and New Start Centres
    - Treatment of STIs, because STIs increase the risk of HIV transmission

2. Prevention of Unintended Pregnancies
    - Education about pregnancy and birth control
    - Availability of birth control options, including condoms, femidoms and other contraceptives.
    - Encouraging male involvement in reproductive health
    - Develop adolescent-friendly reproductive health services.

3. Prevention of Transmission from Mother to Child
    - VCT: encourage awareness of HIV status
    - Education about possibilities and options for transmission prevention
    - Counselling on options
    - Education on nutrition for mother
    - Medical interventions/ARVs
    - Explore infant feeding options
    - Medical monitoring of labour and delivery

4. Provision of Comprehensive Care for HIV-infected women, partners and children
    - Infant feeding counselling in clinics
    - Provide support to the whole family through counselling
    - Routine, follow-up doctor visits for new mother and infant.

Infant HIV testing:

Currently, there are two ways of testing an infant who has been exposed to HIV during pregnancy, labour and delivery, or breastfeeding.

1. ELISA test: This is the same test used for HIV testing in adults. It detects the antibodies in the person's blood. It doesn't actually test for the virus itself. Therefore, the child cannot be tested at birth or soon after birth because the baby acquires the mother's antibodies. This test is done at 18 months, or 3 months after stopping breastfeeding.

2. PCR Test (polymerase chain reaction test): This test can be done at 6 weeks.

Key Points about PMTCT Intervention:

1. Know one's HIV status: HIV counselling and testing is available for mothers at antenatal clinics. There are also group health information sessions offered at ANC.
2. Nevirapine: single-dose NVP for the mother at the start of labour and single-dose NVP given to the baby after birth help prevent transmission of HIV from mother to child.
3. Safer infant feeding options: mothers must choose between exclusive breastfeeding and exclusive replacement feeding for their infants prior to giving birth.

PMTCT AND ART (HIV TREATMENT)

Relationship of PMTCT to ART

- Women can be on ART before they become pregnant and then during their pregnancy. In this case, ART is for the **treatment of the mother**.
- Women can also begin ART when they become pregnant for the treatment of the mother. In this case, ART is called PMTCT-plus and is for the **treatment of the mother**.
- ART can also be given to **prevent transmission** from the mother to the baby. This can be called **ART prophylaxis**.

ART can be used in two ways in PMTCT:

1. As treatment for the mother or woman. ART can be started or continued during pregnancy.
2. As prophylaxis, or prevention, for the baby. ART can we given has prevention of mother-to-child transmission. ART in PMTCT for prevention are given to both the mother and child.

ART as Treatment for Pregnant Women

The majority of women who have HIV and are pregnant do not need HIV treatment. However, there are two situations where women who are HIV-positive will be put on ART:

1. If a woman has a CD4 count below 250 (CD4<250) or has symptoms of WHO stage III or IV, she can be started on ART while she is pregnant.
2. If a woman is already on ART, she can continue on her treatment while pregnant. However, she cannot take Efavirenz (EFV). If she is taking Efavirenz, the doctor will change to Nevirapine.

ART as Prophylaxis (Prevention)

According to the Namibian MoHSS Protocol for PMTCT, ART prophylaxis is for pregnant women diagnosed with HIV who do not need ART for themselves, but do need to prevent transmission to their baby.

- Nevirapine (NVP) is the ART prophylaxis drug used in Namibia. It is used as a single dose, meaning it is taken one time).
- Advantages of single-dose Nevirapine:
  - Easy to take, can be taken at home
  - Inexpensive
  - Safe; no side effects with a single dose
  - Effective: it works quickly and produces a rapid drop in viral load
- Nevirapine for mother:

- One tablet when labour starts, i.e. regular contractions and/or ruptured membranes, when the water breaks
- Must be taken more than 2 hours before delivery in order for it to be most effective.

- Nevirapine for baby:
  - Single dose of Nevirapine within 12-72 hours after the baby is born.
  - If the baby was born less than 2 hours after Nevirapine was taken, the baby should be given a dose immediately after delivery and another dose 48-72 hours later.

- Note that with a home delivery, the mother can still take her Nevirapine at the beginning of labour and then bring the baby to the clinic or hospital 48-72 hours (2 – 3 days) after the baby is born for the baby to receive his/her single dose of Nevirapine.

> Note: Nevirapine (NVP) can be given to the mother to take home. Then she can take it when she starts labour or when her water breaks.

INFANT FEEDING GUIDELINES

Key Point: Breastfeeding is best for infants.

Feeding Options

How long should a woman breastfeed?

Key Point: Exclusive breastfeeding for at least the first six months, but especially the first 3 months, is best for infants.

Note: Exclusive (only) breastfeeding is best for an infant up to 6 months, when the child needs supplemental or complementary food (additional food). Where HIV is not an issue, it is good to breastfeed until the child is up to 2 years old, even after the child is also given additional food.

Why breastfeeding is best for infants:

- Breastfeeding also naturally enhances the bonding between mother and child, which meets the emotional needs of the child, including touch.
- Given the risks of HIV transmission through breastfeeding on the one hand, and the risks of not breastfeeding on the other hand, there are many challenges in counselling mothers with HIV about appropriate infant feeding options.

Key Terms:
- Exclusive breastfeeding
- Mixed feeding
- Replacement feeding
- Complementary food

Key Point: All women are encouraged to exclusively (only) breastfeed their infants for the first six months of life. Breastfeeding not only provides all the nutrition a baby needs but also is associated with better health of the infant, i.e. fewer infections. Breast milk protects against common childhood infections such as diarrhoea.

Infant feeding options:

1. Exclusive replacement feeding: use infant formula or modified (changed) cow's or goat's milk.
2. Exclusive breastfeeding for the first 4 – 6 months, followed by early abrupt weaning and feeding the infant using other feeding options.

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

NOTE: Mixed feeding always involves mixing breast milk with other foods. It does not include mixing replacement feedings, such as infant formula, with porridge.

Exclusive replacement feeding

- This is feeding the infant with infant formula or with modified cow's or goat's milk only, usually for the first 6 months of life.
- This option does not have a risk for HIV transmission through breastfeeding. This option, however, increases the risk of the baby becoming sick or dying from diarrhoea, pneumonia or other infections.
- Important things to consider before choosing exclusive replacement feeding:
    - Acceptable? No social or cultural barriers or fear of stigma or discrimination for not breastfeeding.
    - Affordable? Costs include the cost of purchasing formula or milk and fuel (wood, electricity or gas) to boil water.
    - Reasonable/Possible? The mother or caregiver will have to prepare the replacement milk 8-12 times a day. This will take time, knowledge, skills, resources and support from others.
    - Safe/Hygienic? The replacement milk will have to be hygienically stored, prepared and fed to the infant. Hygiene includes clean hands, cups and other utensils.
    - Sustainable/Able to continue? Availability of continuous and uninterrupted supply of all the ingredients for replacement feeding.
    - Disclosed to others for support? The mother's ability and willingness to disclose her status to her partner, family and community. She does not have to disclose her status to everyone, but she will need support from those close to her, especially those with whom she lives.
- Very specific instructions on how to prepare replacement feedings, both infant formula and modified cow's or goat's milk, are included here for reference.

Exclusive Breastfeeding

- A mother who is HIV-positive may choose to breastfeed her baby.
- It is best if the mother exclusively (only) breastfeeds without giving any other foods or drinks to the infant, not even water. Exclusive breastfeeding is very important, particularly when the baby is very young.
- Other foods and fluids may cause infections in the baby's digestive tract that increase the risk of HIV transmission.
- The mother can breastfeed exclusively for up to 6 months. This is recognised by the World Health Organisation (WHO) as the best practice for HIV-positive women who have limited or no access to safe replacement feeding.

- Stopping breastfeeding early reduces the risk of HIV transmission by reducing the length of time the infant is exposed to the virus in breast milk.
- However, before stopping breastfeeding, the mother must have a plan for feeding the baby: see the suggestions below.

Advantages and Disadvantages of PMTCT Infant Feeding Options

Option	Advantages	Disadvantages
1. Exclusive breastfeeding for up to 6 months. Breastfeeding may be stopped earlier, i.e. at 4 months, if the mother has access to safe replacement feeding.	• Complete nutrition for the baby for the first 6 months. • Provides protection against infection with antibodies. • Contains growth factors that enhance brain development. • Promotes bonding • It is less time-consuming than replacement feeding.	• Risk of HIV transmission. • Mothers need more support in order to achieve this option, particularly those who return to work. • Mothers may get pressure to give the baby water or other liquids, which promotes mixed feeding and increases risk of HIV transmission and other infections.
2. Replacement feeding	• No risk of HIV transmission	• May not be affordable; an infant needs about 50 tins of formula for 6 months. • Formula does not contain the antibodies that breast milk does to protect against infections. • The conditions needed to make it safe may not be available, i.e. clean water, fuel to boil the water, utensils, and sanitation • Stigma associated with not breastfeeding can lead to discrimination and isolation. • Significant time is required for preparing formula. • During hot months, bacteria may grow more rapidly if formula is not kept cold. • The mother may get pregnant again too soon.

Case Studies

Case Scenario 1: Loide is a 26-year-old mother of two children. She lives in the informal settlements on the outskirts of Katutura, has been married to her husband for 3 years, and is not employed. She walks about 10 minutes to get water for her one-room household. She shares a toilet with 10 neighbours. Her husband is a day labourer who makes about N$60 per day.

At her first antenatal visit, Loide wonders why she should be tested for HIV. She has had 2 sexual partners in her life and she feels that her husband is faithful. Her risk seems low. The counsellor suggests taking the HIV test because many people in Namibia have HIV, even if their risk factors seem low. Before HIV testing, the counsellor recommends that Loide go home and talk with her husband before returning for testing. Loide goes home and introduces the topic of HIV, and then says to her husband that she needs to be tested for HIV because she is pregnant and the test is recommended for all pregnant women. She also tells him that the clinic offers testing for partners if they are interested. Loide's husband gets angry and says he thinks HIV is a joke, but she can do whatever she wants.

Loide gets tested and discovers that she has HIV. She does not want to tell her husband about her diagnosis because of his previous reaction, but she gets ideas from counsellors about how she may introduce the topic to him in the future.

Case Scenario 2: Madene is a schoolteacher in Katutura. Her husband, Lucas, is also school teacher. They are currently in the process of building a house in Katutura. Madene just found out that she is HIV-positive when she and Lucas were tested together. Lucus' test was negative. Lucas has been very supportive and usually attends her doctor's appointments with her. Madene's CD4 count is quite high, ranging between 300 and 400.

Madene is now 7 months pregnant, and she and Lucas are very excited about the baby. They have been talking about baby names and discussing whether it will be a girl or a boy, though they are very concerned about Madene passing HIV to the baby. They set up an appointment with the counsellor to discuss different ways of feeding the baby.

Discussion Questions:

- What are the key issues regarding feeding for the baby?
- What are the main issues related to breastfeeding or replacement feeding for Loide or Madene?
- List the advantages and disadvantages of breastfeeding or replacement feeding in the situation.
- What do you think her best choice would be?

Key Points about Infant Feeding:

- Breast milk protects infants against common infections. When mothers are not HIV-infected, exclusive breastfeeding is the best form of feeding for an infant during the first 6 months of life.
- Transmission of HIV through breastfeeding is well-documented. However, it is not clear exactly what the rate of transmission is.
- When replacement feeding is feasible, affordable, sustainable and safe, HIV-infected mothers should avoid breastfeeding completely.
- If replacement feeding is not feasible, affordable, sustainable and safe, HIV-infected mothers should exclusively breastfeed, followed by abrupt stopping as early as possible, and no later than 6 months.
- Factors that will affect a mother's ability to safely replacement feed her infant include:
    - Cost of the replacement feeding
    - Access to a constant supply of the replacement formula
    - Availability of clean water to prepare the formula
    - Access to basic sanitation facilities
    - Availability of fuel to prepare the replacement formula
    - The mother's health
    - Local community infant feeding norms and the level of stigma surrounding replacement feeding
    - The mother's ability and willingness to disclose her status to her partner, family and community
- Women should be allowed to choose the infant feeding option most appropriate for them and their circumstances. Counsellors should support mothers in their choices.
- The rates of HIV infection in breastfed infants increase with the duration of breastfeeding. Rates of HIV infection also increase if the mother has advanced HIV disease, i.e. low CD4 count, high viral load and/or opportunistic infections.
- Other factors that can increase the risk of HIV transmission though breast milk include breast problems or infections.
- Breastfeeding among HIV-infected mothers does not increase the progression of the disease, but some mothers will need nutritional support.
- Women who choose to breastfeed need counselling on how to manage exclusive breastfeeding and abrupt stopping, as well as how to avoid HIV re-infection by their partners.
- Women who choose to replacement feed need advice on safely preparing the formula and avoiding mixed feeding.
- Mixed feeding (breast milk combined with other foods) is NOT recommended because it increases the risk of HIV transmission.

Important Considerations:

- Mixed feeding should be avoided at all times for all mothers, regardless of HIV status, because it carries both a risk of HIV transmission to the baby and illness or death from diarrhoea or other infections.
- HIV transmission to the infant may be higher with mixed feeding than the risk from exclusive breastfeeding.
- It may be difficult for mothers to change from exclusive breastfeeding to replacement feeding; therefore, this should be recognised early so that health workers and counsellors can help the mother avoid mixed feeding.
- HIV-positive women who have difficulty in stopping breastfeeding at 4 months should be supported to continue exclusively breastfeeding until it is safe to stop, which is up to 6 months, when the infant can receive unmodified animal's milk and complementary foods.
- Women should be careful not to breastfeed other children or allow their children be breastfed by another woman.

Breast milk expression: Expressing breast milk is important because it helps mothers maintain milk production even if they are separated from their infants. *See the included reference sheet on breast milk expression.*

- Breast milk can also be boiled. This kills any viruses in the milk.

How to Prepare Infant Formula

(for reference)

*Community counsellors may reinforce what the mother has learned and support her to consistently provide replacement feeding for her baby.

Health workers should teach the mother the important steps for how to prepare formula:

1. Wash hands thoroughly with soap and water before preparation.
2. Use clean utensils washed in soap and water, boiled and kept covered.
3. Boil water for 5 minutes and cool to room temperature before mixing.
4. Make sure the water and the powder are correctly measured. Place the feeding bottle or measuring cup on a levelled surface (kitchen counter or table) and add the correct amount of water according to instructions. Powder should be measured using a levelled scoop.
5. Mix the powder and water well.
6. Prepare only one feeding at a time.

7. Use a cup to feed the baby, and hold the baby close to foster bonding.

8. Discard any left-over formula.

NB: In addition to the above, teach the mother to:

- Not store prepared formula in a thermos/flask, as this will help bacteria to multiply.
- Always check the expiry date on the formula tin.
- Store infant formula in a cool, dry place.
- Use the manufacturers' instructions on the infant formula label in order to ensure safe preparation of formula and to reduce increased rates of infection and death from malnutrition.

Remember: Safe formula feeding might not be possible in conditions where sanitation, hygiene and resources are poor. Follow-on milks such as Nan 2 and Lactogen 2 are not suitable for infants under the age of six months, as they are less modified. At six months, infants who are taking complementary foods do not need modified animals' milk.

Table 1:
Requirements and costs of infant formula for the first six months

400 Gram Tins

Baby's Age	Quantity	Cost N$ per 400gm
1 month	2kg (5 tins/month)	N$35 x 5 = N$175.00
2 months	3kg (7.5 tins/month)	N$35 x 7.5 = N$262.50
3 months	3.5kg (9 tins/month)	N$35 x 9 = N$315.00
4 months	3.5kg (9 tins/month)	N$35 x 9 = N$315.00
5 months	4kg (10 tins/month)	N$ 35 x 10 = N$350.00
6 months	4kg (10 tins/month)	N$ 35 x 10 = N$350.00
	TOTAL	**N$1767.50**

The cost per tin is an estimate based on current prices during the time of this curriculum's publication. The cost is only for the formula, and does not include the cost of utensils, soap, water and fuel needed for the cleaning and preparation.

How to Modify Cow's and Goat's Milk

(*for reference*)

Animal milk contains twice as much protein and about six times as many minerals as human milk. It is therefore difficult for a baby under 6 months to digest the milk and discard the unused protein and minerals. To reduce the protein and mineral content of cow's or goat's milk, making it safe and digestible for the baby, the milk must be diluted with water and boiled. In addition, animal milk has a lower carbohydrate content than breast milk, so sugar should be added to increase the energy content. The baby should also be given multi-vitamin supplements to prevent micronutrient deficiencies. Milk should be prepared one feeding at a time, and any leftover milk should be discarded.

If a mother chooses to use cow's or goat's milk for replacement feeding, teach her to:

Boil the milk after it is milked, then cover and store in a cool, dry place.

1. Wash hands thoroughly with soap and water before preparation.
2. All utensils should be clean, washed in soap and water, boiled, and kept covered.
3. Boil water for 5 minutes and cool to room temperature before mixing.
4. Bring the milk to a rolling boil and cool it to room temperature for no more than one hour to prevent bacterial contamination.
5. Measure the correct amount of water, milk and sugar based on the infant's age, according to Table 2.
6. Mix well in a clean container.
7. Use a cup to feed the baby.
8. Hold the baby while feeding.
9. Discard leftover milk.

In addition, teach the mother that from six months on, the baby can be given full-strength milk. She should offer the baby clean, boiled water to drink 2 – 3 times a day to avoid constipation.

In most parts of Namibia, fresh cow's and goat's milk may not be available year-round. The only milk that may be available is long-life milk, which is more expensive in comparison to fresh cow's milk. Once it is opened, it should be stored the same way as fresh milk.

In addition, the modification of animal milk is more complicated than preparation of infant formula, which is already modified. Infants given modified animal's milk will also need vitamin supplementation. Therefore, this option is relatively expensive.

Table 2: Baby's minimum requirements using modified animal milk* (in household measures, i.e. cups and spoons)

Baby's Age	Dilution per feeding			Approximate number of feeds / day	Total volume / day	Total volume (L) / month
	Milk	Water	Sugar			
1 month	40ml	20ml	4g (slightly less than 1 teaspoon)	8 x 60ml	480ml	14.4 L
2 months	60ml	30ml	6g (1¼ teaspoon)	7 x 90ml	630ml	18.9 L
3 months	80ml	40ml	8g (slightly more than 1½ teaspoon)	6 x 120ml	720ml	21.6 L
4 months	80ml	40ml	8g (slightly more than 1½ teaspoon)	6 x 120ml	720ml	21.6 L
5 months	100ml	50ml	10g (2 full teaspoons)	6 x 150ml	900ml	27.0 L
6 months	100ml	50ml	10g (2 full teaspoons)	6 x 150ml	900ml	27.0 L
Total						**130.5 L**

*adapted from FANTA 2004

The baby requires about 131 litres for the first six months as the actual intake.

The cost is **± N$8.00 per litre x 131 = N$1,048.00**. As in the case with infant formula, this cost does not include the cost of utensils, soap, water and fuel for preparation and cleaning. The cost of milk is an estimate based on prices at the time of this curriculum's publication.

How to Express Breast Milk by Hand

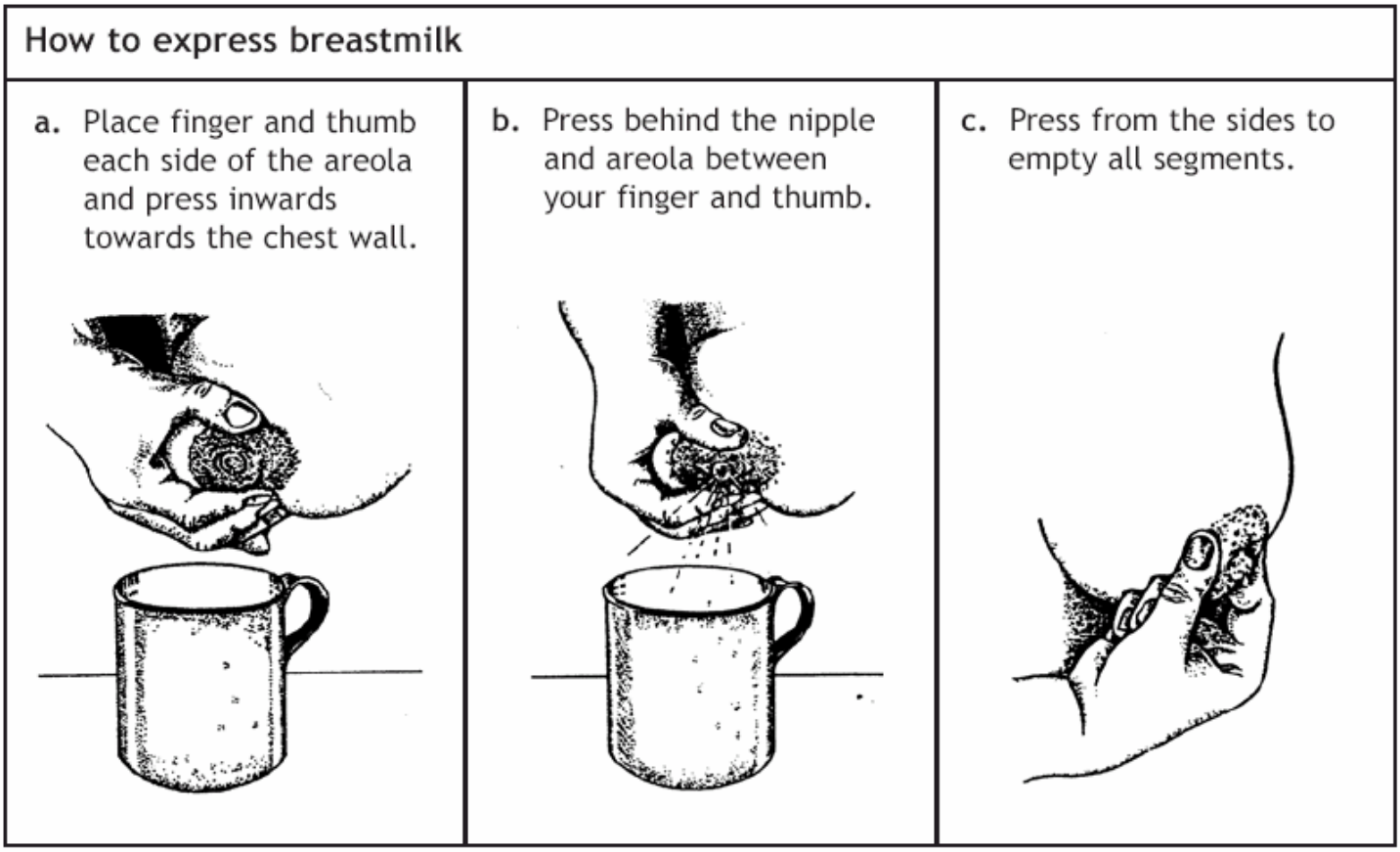
(for reference)

Teach mothers to:

- Wash their hands thoroughly with soap and water.
- Use clean containers washed in soap and water and kept covered.
- Sit comfortably and hold the container near the breast.
- Put the thumb on the breast above the nipple and areola and the first finger on the breast below the nipple and areola, opposite the thumb. Support the breast with the other fingers.
- Press the thumb and first finger slightly inwards towards the chest wall. Avoid pressing too far because that can block the milk ducts.
- Press the breast behind the nipple and areola between the first finger and thumb. Press on the lactiferous sinuses beneath the areola. Sometimes it is possible to feel the sinuses in a breast; they are like pods or peanuts.
- Press and release, press and release. This should not hurt; if it hurts, the technique is wrong. At first, milk may not appear, but after pressing a few times, milk should start to drip out. It may flow in streams if the oxytocin reflex is active.
- Press the areola in the same way from the sides to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding the fingers along the skin.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple will not express the milk. It is the same as the baby suckling only the nipple.
- Express one breast for at least 3-5 minutes until the flow slows, then express the other side and then repeat both sides. Use either hand for both breasts and change when one becomes tired.

Health workers should explain that to express breast milk adequately takes 20-30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.

Figure 4: How to express breast milk (UNCEF/WHO, 1993)



To heat treat breast milk:

- Express breast milk into a clean cup.
- Place the cup directly on the stove or in a pot of water on the stove.
- Bring breast milk to a boil.
- Cool breast milk either by placing the container of boiled breast milk in a larger pot of cool water or letting the milk stand until it cools, but no more than 1 hour.
- Feed heat treated milk to the infant with a cup.

Unheated breast milk can be stored for up to 8 hours at room temperature or up to 24 hours in the refrigerator. Once the milk is heat treated, it must be used within one hour.

Adapted from: Government of the Republic of Namibia. Draft 2006. *Infant and Young Child Feeding: National Guidelines for Health Professionals*. Ministry of Health and Social Services. Windhoek, Namibia.

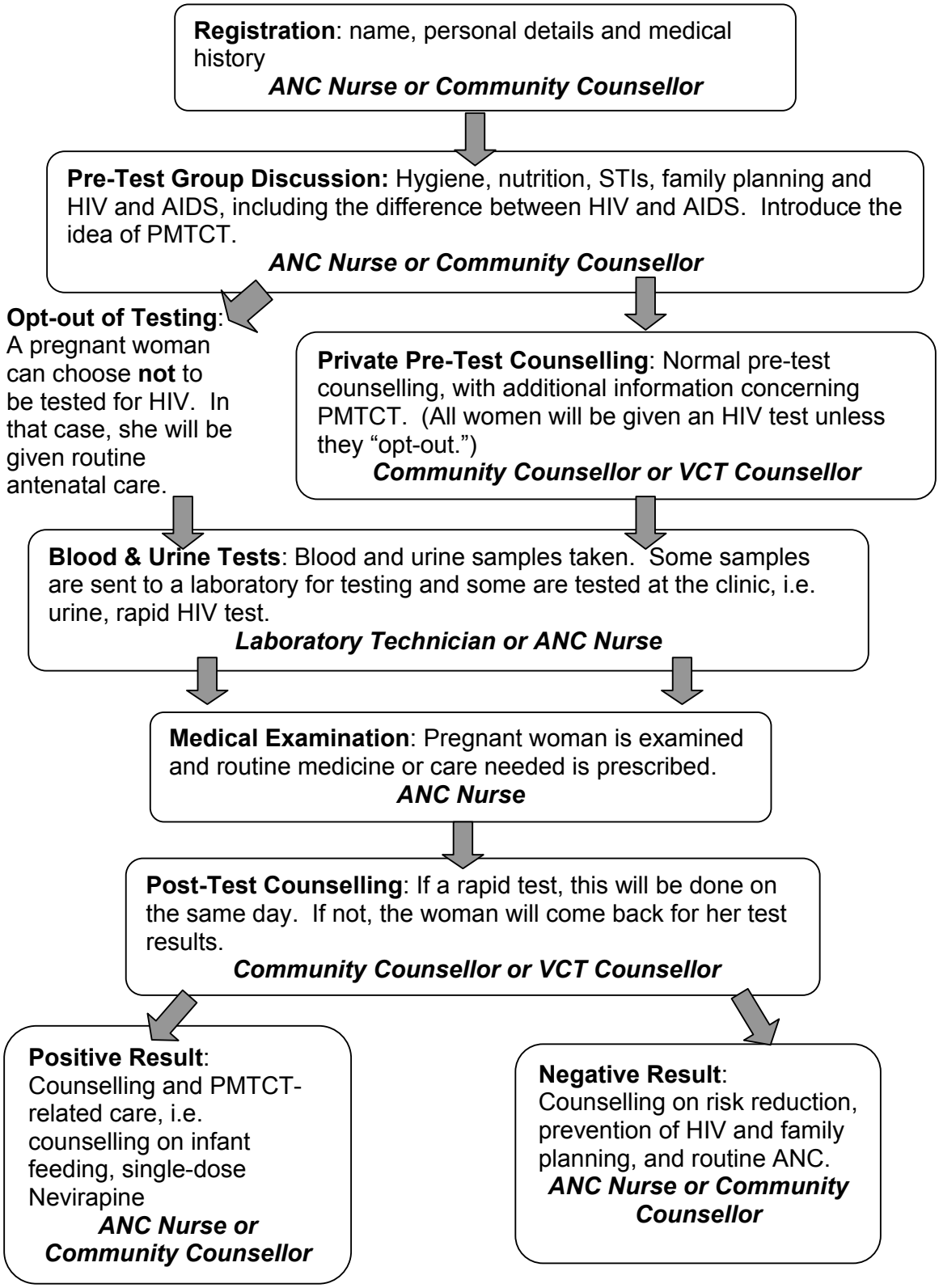
ANTENATAL CARE

Antenatal care is care for a woman who is pregnant, looking after the health of a mother and her baby during a normal pregnancy and childbirth.

Goals of Antenatal Care and What Happens at the Antenatal Clinic

1. Early detection and treatment of illness
    - Some women may have health problems that they are not aware of, or that may develop during pregnancy.
    - It is important to treat these problems as early as possible in order to keep mother and child in good health.
    - Some examples of common illnesses during pregnancy: anaemia, hypertension, syphilis, other vaginal infections, or HIV.
2. Prevention of illness
    - Give vaccinations or other treatments to prevent illnesses in pregnant women: these include tetanus injections, iron tablets, medicine to prevent malaria or extra vitamins.
    - If the mother has HIV, she will be given medicine (Nevirapine) to take once labour begins.
3. Being prepared for the birth and complications
    - Pregnant women should be helped to make plans for when the baby comes.
    - She many need to make arrangements for transport and for normal delivery at a health facility, i.e. clinic or hospital. She may need to arrange for traditional birth attendants to be with her if the baby will be born at home.
4. Promote good health in general
    - When a woman visits an antenatal clinic, it is also an opportunity to discuss a variety of health issues. This will help women take good care of themselves and their babies during and after pregnancy.
    - Health issues that may be discussed at the ANC:
        - Care for common discomforts
        - Good nutrition and a balanced diet
        - Hygiene
        - Rest and activity
        - Prevention of diseases
        - Use of harmful substances, i.e. alcohol, tobacco, etc.
        - Voluntary counselling and testing for HIV
        - Early, exclusive breastfeeding
        - Techniques for successful breastfeeding
        - Sexual relations and safer sex
        - Family planning
        - Newborn care

What happens at the Antenatal Clinic?



Ideally, these steps will take place during a woman's first visit to the ANC:

- **Pre-Test Group Discussion:** During this group discussion, women are given basic information about pregnancy, hygiene, nutrition, STIs, family planning, HIV and AIDS, and PMTCT. This can be done by a nurse and community counsellor together, with the nurse focussing on medical issues and the counsellor focussing on the HIV and PMTCT portion of the discussion. In different clinics it is handled in different ways, depending on the staff, the number of patients and the facilities.
    - Include the following information on HIV: what it is, how it is transmitted (highlight transmission from mother to child), impact on pregnancy, PMTCT, including ART or single-dose Nevirapine, and infant feeding.
    - Include HIV testing procedure and confidentiality of results.

- **Opt-out Testing**: "opt-out" testing in practised in Namibia's ANC clinics. This means that the standard practice is for every pregnant woman to be counselled and tested for HIV. However, a woman can choose not to be tested if she wants, which is called "opt-out." *Note: For statistical reasons, every pregnant woman is tested for HIV in order to track the prevalence of the disease. This is how HIV prevalence rates are calculated around the world. This test is done without including identifying information such as the woman's name with the sample; it only includes her age and the clinic where the test was done. What women are choosing is whether or not to receive their HIV test results.

- **Private Pre-Test Counselling**: Those women who have not "opted-out" of testing should each be counselled individually. This pre-test counselling is similar to pre-test counselling in VCT, with additional exploration of issues related to PMTCT.

- **Blood and Urine Tests**: These are routine tests for all pregnant women. As already mentioned, all women are tested for HIV. For those who have "opted-in," they receive counselling and their test results. For women who "opt-out," their HIV test is "blind" or "unlinked anonymous" (meaning without any identifying information so the test result cannot be traced back to the client who provided the blood sample) for national and worldwide prevalence statistics.

- **Post-Test Counselling**: This is very similar to when the test results are given in VCT post-test counselling. However, with pregnant women, there are additional issues to discuss. For women who test negative for HIV, prevention of HIV transmission to the baby will involve protection for the mother, i.e. safer sex practices. For women who test HIV-positive, issues should be discussed concerning the prevention of transmission to the baby; these include care for the baby during pregnancy, labour and delivery, as well as infant feeding.

PMTCT EDUCATION AT ANTENATAL CLINICS

In discussing antenatal care, we looked at what happens at the Antenatal Clinic. Ideally, the health education and information sharing can happen during the Pre-Test Group Discussion. Since there is a lot of information to give to pregnant mothers, it would be easier to do this in a group setting. Then during individual pre-test counselling, the counsellor can explore personal issues with the woman.

Pre-Test Group Discussion at Antenatal Clinics

(Key points from the Antenatal Pre-Test Session Flipchart)

1. **HIV is in the community and it can affect anyone**.

Objective	Script
Explain the purpose of the discussion.	As part of your visit, we will be discussing HIV, HIV testing and ways you can protect your health, the health of your baby and your family.
HIV/AIDS is a community issue.	HIV affects families in our community. HIV is an infection that can lead to a serious illness called AIDS. About 20 out of 100 adults in Namibia have HIV. You cannot tell by looking at someone whether they have HIV. Most people who have HIV do not feel or look sick. Everyone should learn if he/she has HIV, especially pregnant women, because if a pregnant woman has HIV, she can pass it to her baby.
General benefits of knowing HIV status	The only way to know if you have HIV is to be tested. If you are tested and do not have HIV, you will learn how to protect yourself and your baby from getting HIV. If you are tested and have HIV, you will learn how to lower the chance of passing HIV to your baby and how to get care and treatment for yourself, your baby and your family so you can live healthier lives.

2. How can I get or pass on HIV?

Objective	Script
Explain how HIV is transmitted.	One of the main ways you can get HIV is by having unprotected sex, which is sex without a condom. All pregnant women have had unprotected sex and are therefore at risk of HIV. You can also get HIV by receiving a blood transfusion from blood that has not been tested* and from blood-to-blood contact, such as sharing needles or syringes or sharp objects like razor blades.
Address myths about HIV transmission.	HIV cannot be passed in the following ways: ▪ Mosquito bites ▪ Sharing food and utensils ▪ Hugging and holding

	▪ Shaking hands ▪ Using toilets

*__Note__: All blood in Namibia is screened and the blood supply is safe, so the risk of HIV infection through a blood transfusion is extremely low.

Potential Questions:

- What do you know about how HIV is passed from one person to another?
- What questions do you have about how HIV is passed?

3. If I have HIV, can I pass it to my baby?

Objective	Script
Explain HIV transmission from mother to baby.	A mother with HIV can pass HIV to her baby during pregnancy, labour and delivery and breastfeeding.

Potential Question:

- Do you have questions about how HIV is passed from a mother to her baby?

4. Why should I test for HIV?

Objective	Script
Explain risk of mother-to-child transmission of HIV.	Not all women who have HIV will pass it to their babies. Without care, 1 out of 3 women with HIV will pass HIV to their babies. This is why it is important to get tested for HIV and receive medical care: you can lower the chances of passing HIV to your baby.
Explain the benefits of HIV testing.	There are many benefits to HIV testing: ▪ If you are tested and you do not have HIV, you will earn how to protect yourself and your baby from getting HIV. ▪ Most women who are tested will not have HIV. ▪ If you are tested and you have HIV, you will learn how to lower the chance of passing it to your baby and how to get treatment and care services so you and your baby can both live healthy lives.

5. How will the test be done?

Objective	Script
Explain availability of HIV testing services.	HIV testing will be offered as part of the basic services you will receive today.
Explain confidentiality.	HIV testing is private. This means that only healthcare workers who are caring for you will know your HIV test result.

Explain that the HIV testing is routinely recommended and she has the right to refuse.	You have the right to refuse HIV testing, but we strongly recommend that you be tested for HIV to help protect your baby. Unless you refuse, we will test you for HIV, along with the other tests we do today.
Describe the method of testing used by the clinic.	[*You will describe either the rapid test where they will receive the results in 20-30 minutes OR you will tell them how long the test takes and when they will return for their results.]*
Explain the meaning of the test results.	If you HIV test result is negative, it means you do not have HIV. If you HIV test result is positive, it means you have HIV.

6. My partner's test result could be different from mine.

Objective	Script
Define discordance and the risk to the uninfected partner of acquiring HIV.	Regardless of your HIV test result, it is very important for your partner also to get tested for HIV. In couples, it is common for one person to have HIV (HIV-positive) while the other person does not have HIV (HIV-negative). When couples have different test results, the HIV-negative partner is at high risk of getting HIV. Sometimes couples have been together for years, have been faithful, have had children, and still have different HIV test results. If an HIV-negative partner continues to have unprotected sex with a partner who is HIV-positive, then he/she is very likely to get HIV.

Probing Questions:

- Do you understand how one partner can have HIV and the other not have HIV?
- Do you have any questions or concerns?

Suggested Response: Just as you may not get pregnant every time you have sex, HIV transmission may not happen every time you have sex with an HIV-positive person. It is not possible to know when HIV will be passed, but every time you have sex with an HIV-positive person, there is a chance that you could become infected.

7. Why should my partner test for HIV?

Objective	Script
Encourage partner testing.	The only way to know your partner's status is for him to be tested for HIV. Your partner should be tested so you can protect each other and your baby from HIV.
Explain the increased risk of MTCT if she is infected during pregnancy or while breastfeeding.	Another important reason why your partner should get tested is because if you are HIV-negative now and are infected with HIV later in your pregnancy or while you are breastfeeding, the risk of passing the virus to your baby is very high.
Inform women where they and their partners can be tested for HIV.	If you prefer to be counselled and tested together as a couple, you can be tested together at _____ (name of site).

8. How can I protect myself from HIV?

Objective	Script
Introduce HIV prevention methods.	There are three main ways to protect yourself and your partner from HIV.
Define and describe being faithful.	If you and your partner are both tested for HIV and are both HIV-negative, you can protect each other from HIV by being faithful and only having sex with one another. If either of you has sex with anyone else, you could become infected with HIV and pass it to your partner.
Define and describe condom use.	Another way to protect yourself is by using condoms. When used correctly every time you have sex, condoms help protect against HIV. It is particularly important to use condoms if your partner is HIV-positive, if you do not know if your partner has HIV, or if your partner has other partners. *You may want to give a condom demonstration to show the correct use of condoms, and provide information about where condoms are available, i.e. at the hospital.*
Describe abstinence.	Another option is not to have sex, particularly until your partner is tested for HIV. This can be difficult, but it is the most effective way to protect each other from HIV.

9. If I have HIV, how do I protect my baby?

Objective	Script
Inform women that there are medications and infant feeding choices for PMTCT.	If you are HIV-positive, there are medicines that we will give you and your baby to lower the chance of passing HIV to your baby. Your doctor/nurse will decide with you when you need to take medicines for HIV (anti-retrovirals, or ARVs), which can help protect you from becoming ill and help you have a long, healthy life. We will also discuss ways to feed your baby that lower the chance of passing HIV to the baby so you can choose which one will work for you. We will give you more information after the test to help you make these choices. You will have plenty of opportunities for counselling and getting information from the nurses at the ANC.

10. If I have HIV, what help can I get?

Objective	Script
Explain that HIV-positive women will receive referrals for care and treatment.	More and more services are becoming available to help HIV-positive people and their families stay healthy. If you are HIV-positive, there are medicines available to help you live a long and healthy life.

11. Why is it important to continue with my health care visits?

Objective	Script
Encourage women to continue receiving antenatal care.	No matter what your test result is, it is very important for you to continue receiving antenatal care.
Encourage women to deliver in a health facility.	You should also plan to deliver your baby in a health facility, where there are skilled providers who can help in case of problems. This is especially important if you are HIV-positive, because there are steps we can take at the health facility to help protect your baby from HIV. These steps may not be available if you have your baby outside of a health facility.

12. By testing for HIV, I will have a good chance to have a healthy child and a healthy life.

Objective	Script
Summarise ANC services. Provide motivation and support for receiving HIV test.	We have talked about five main points today: 1. It is important that you test for HIV. 2. If you are HIV-negative, you will learn how to stay negative. 3. If you are HIV-positive, there are medicines and ways to feed your baby that lower the chance of passing HIV to your baby. You and your family can also receive care, treatment and support services to stay healthy. 4. Whether your test result is positive or negative, your partner needs to be tested for HIV since your result could be different from his. 5. You should continue with your care during pregnancy and plan to deliver in a health facility. Remember, by taking the HIV test, you can protect your baby and family from HIV and you can stay healthy.
Offer individual counselling.	If you have specific questions or concerns, we can discuss them privately. *[Give specific instructions for counselling.]*

Adapted from "Protect Yourself, Your Baby and Your Family from HIV/AIDS" Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools. 2005. US Centers for Disease Control (CDC), World Health Organization (WHO), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID) and PMTCT implementing partners.

WARNING

- NEVER ask a group of people if anyone is willing to be tested.
- NEVER be rigid about the best infant feeding options. Each situation should be looked at separately and decided based on those specific circumstances. Each person's situation and life circumstances are different.
- NEVER make judgemental comments. Each person has the right to choose to be tested or not. It is their choice, NOT yours.

PRE-TEST COUNSELLING AT ANTENATAL CLINICS

Refer to the PMTCT: Pre-Test Counselling Model.

ESTABLISH THE RELATIONSHIP

1. Introduce yourself and describe your role as a counsellor.
2. Explain confidentiality, length of the session and give an overview of what will be discussed.
3. Ask if there are any questions from the education group discussion.

EXPLORATION

1. **Listen to the client's story.**

   - Tell me a little bit about yourself. *Find out about family and children. Start with easy questions: think of Johari's Window, and focus on things that would fall into the Free Self Window.*
     - What brought you here today?
     - Can you tell me a little bit about yourself?

2. **Assess HIV knowledge**

   - Important points for the client to understand about HIV:
     - Transmission of HIV, both sexually and from mother to child
     - Natural course of the disease

   - Possible questions to assess the client's understanding from the group discussion:
     - Can you explain how a mother can pass HIV to her child?
     - Can you tell me what you understand about your results and your partner's results? Will they be the same?

3. **Risk Assessment**

   - Determine risk behaviours, including recent risk behaviours and patterns of risk behaviour.
     Example questions:
     - How concerned are you about your risk of acquiring HIV?
     - Can you tell me a little about your most recent risk behaviour?
     - Can we look at how often these risk situations happen? *Explore number of partners, type of partners, frequency of new/different partners, and condom use.*
     - Can you tell me about what may be going on in your life that could be increasing your risk behaviour? *Explore risk triggers or circumstances.*
   - Costs/benefits of risk behaviour: what are the advantages and disadvantages of this behaviour for the client?

Example questions:

- What are the advantages of this behaviour [specify the behaviour, i.e. having sex without a condom] for you?
- What do you gain by do this behaviour [i.e. having sex without a condom, or having multiple partners]?
- What are the disadvantages of this behaviour?
- How do you view your risk behaviour? *Determine the client's view of her own risk and if her risk behaviours are a problem for her. Does the client want to change? At what stage of behaviour change is the client?*

- Past successes and abilities: explore any changes to risk behaviour that the client has made in the past, or the skills and abilities she has to make those changes).

  Example questions:

  - Have you ever tried to change these risk behaviours in the past?
  - How did you try and change them? Were you successful?
  - What have you done to try and reduce your risk of acquiring HIV?
  - What has been or what could be the most difficult part of changing your behaviour to reduce your risk?
  - Can you tell me about your experiences using condoms?

4. **Risk Reduction Options/Strategies**

- Determine options for reducing risk. *Explore what options the client has to reduce her risk and what falls into the client's circle of influence. Refer to Decision Making, Circles of Concern and Influence Session in Personal Growth*.

  Example questions:

  - Can you think of anything you might be able to do to reduce your risk of being infected with HIV?
  - Tell me about what would be easiest for you to change and what would be most difficult for you. Why?
  - What options do you have to reduce your risk of HIV infection?
  - Have you thought about what you might be able to do to reduce your risk of becoming infected with HIV?

- Identify barriers: what are problems your client might experience with her risk reduction options?

  Example questions:

  - What kinds of things might keep these options from working?
  - What might get in the way of making these options work for you in reducing your risk of infection?

- Develop strategies to overcome the barriers: problem-solve ways that the client can overcome the identified barriers.

Example questions:
- Can you think of any ways or strategies to overcome these barriers?
- Is there anything you can do to make these barriers less of a problem?

5. **Partner Communication**

NOTE: Many of the issues related to partner communication may have already been discussed when exploring risk behaviours and discussing risk reduction options and strategies. It is best if this topic is integrated throughout the discussion rather than explored separately.

- Explore the client's relationship with partner/s.
- Assess communication with partner/s.
- Explore barriers.
- Identify strategies for overcoming barriers.
  Example questions:
  - Tell me about your concerns about your partner's risk. Has your partner had sex with anyone else?
  - What have you and your partner talked about concerning STI and HIV risk?
- Explore partner's willingness to be tested.
- Practise skills: you may even want to role play a conversation with client and her partner.

6. **Identify Support**: Find out who the client relies on, or who she has talked to in the past. It is important to identify people who have been supportive in the past and could be supportive in the future.
   Example questions:
   - Who have you gone to when you have had problems in the past?
   - Does anyone know that you are here for testing? Is that person someone to whom you could or would tell your results?
   - Who do you talk to about personal things in your life? Who would you tell if you found out your test results were positive?

RESOLUTION

1. **Develop a personalised risk reduction plan**: the plan does not need to be comprehensive, but should at least take into account next steps. Remember that change takes time and does not happen all at once.
2. **Explain the HIV Test**. Explain the window period, especially if the client's risky behaviour has occurred within the last 3 months.
   - Explain the test, i.e. if blood will be drawn or if it will be a finger prick. Also explain when the test results will be ready.

3. **HIV test preparation**
   Example questions:
   - How are you feeling about having an HIV test?
   - Have you thought about bringing your partner for a test?
   - What would a positive HIV test result mean to you?
   - How would you understand an HIV-negative test result?
   - What test result are you expecting?
   - Have you thought about how you would deal with each of the possible test results?
   - Do you have any questions before we go for the test?

TERMINATION

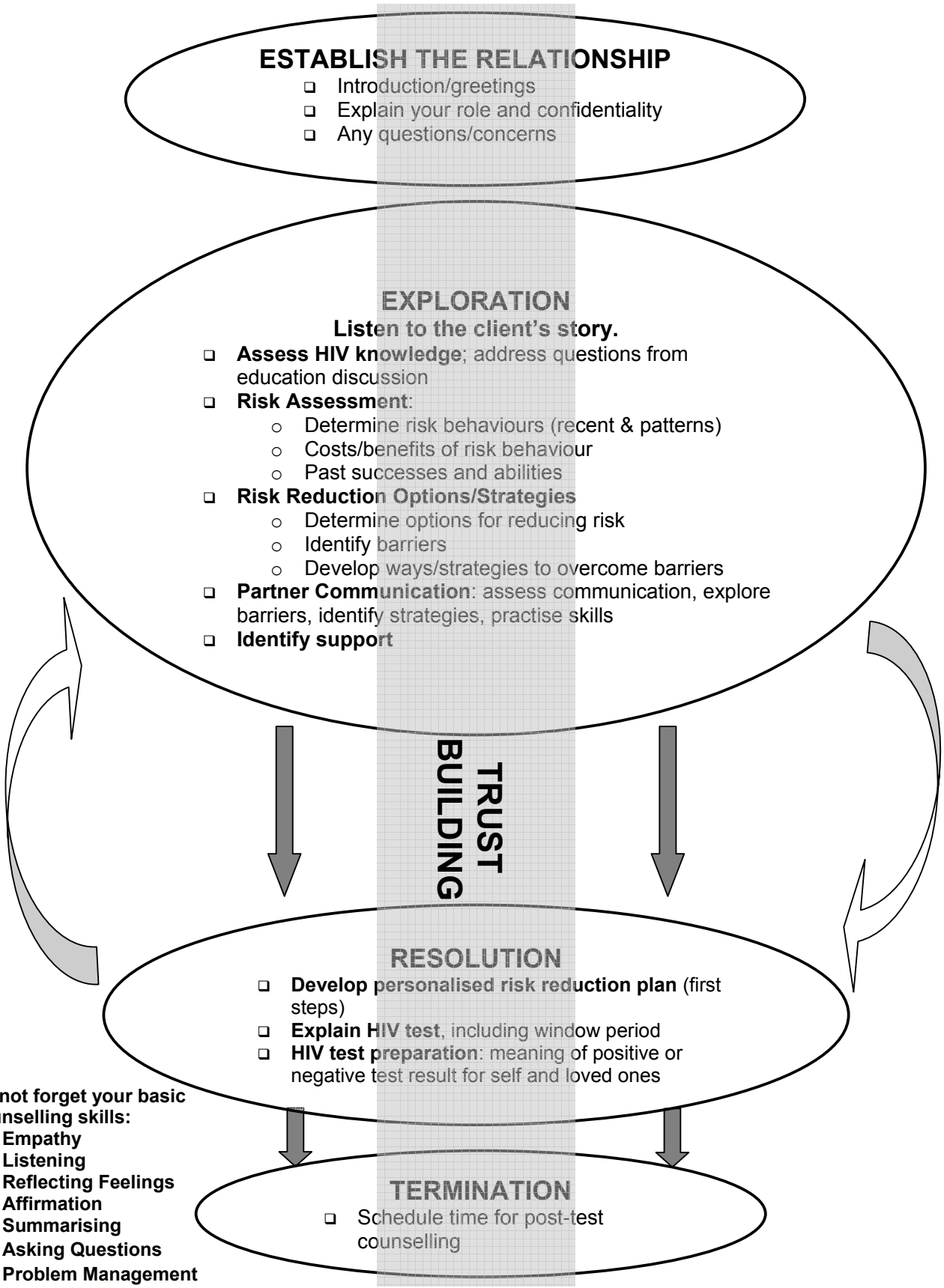
1. Set up time for post-test counselling, either same day with rapid testing or schedule a day when the test results will be back.

2. Take the client in for the test.

NOTE: It is important to remember what was discussed during Pre-Test Counselling, because you will need to refer to it during Post-Test Counselling. You are encouraged to take notes right after the counselling session so that you can read through your notes before conducting the Post-Test Counselling.

Role Play Scenario: Nangula is a 26-year-old woman who has come to the antenatal clinic for her first visit. She has taken part in the group discussion about overall antenatal care, hygiene, nutrition and HIV information related to mother-to-child transmission. Now, she is coming for individual pre-test counselling.

PMTCT: PRE-TEST COUNSELLING



Do not forget your basic counselling skills:

- **Empathy**
- **Listening**
- **Reflecting Feelings**
- **Affirmation**
- **Summarising**
- **Asking Questions**
- **Problem Management**

HIV TEST DECLINED AT ANC

Despite the fact the HIV testing is a normal, standard procedure at the ANC, you may sometimes encounter women in counselling who do not want to be tested. Ideally, after the group education session, all women will be seen in individual counselling. However, there may be occasions where women simply leave instead of declining the HIV test in a counselling session.

Key Point: Respect the woman's right to choose to be tested or not. Balance this with the importance of making sure that she is making an informed choice, as well as understanding the reasons and possible fears behind her choice.

Counselling at ANC for Client who "Opts-Out" of HIV Test

ESTABLISH THE RELATIONSHIP

This is the first session with the client, so make sure you spend some time with greetings, explaining your role as the counsellor, confidentiality and begin to build trust by making the client feel comfortable.

EXPLORATION

1. Explore the reasons why the client is declining the test.
    - Discuss her concerns and fears, i.e. is she afraid of what her partner/husband would do if she was positive, is she afraid that if she was positive it would confirm her fears that her husband has other women, etc.
    - Listen and empathise with the woman's situation; usually she will have mixed feelings. Make sure that you explore both sides of the woman's concerns and feelings.
    - *Possible questions:*
        - What are some of your reasons for not wanting to have an HIV test today?
        - What are the fears and concerns you have about taking an HIV test today?
        - How could we help you with your concerns?
        - What would help you to be ready for an HIV test?
2. Explore the advantages of getting tested and knowing one's status. Re-state the reasons why HIV testing is very important for pregnant women.
3. Continuously rely on trust building and establishing the relationship.
    - It often will be more difficult to establish a relationship with a client who wants to refuse the test. She may be distant, hesitant or suspicious.

- Remember to make her feel comfortable and welcome.
- Respect her opinions, beliefs and feelings. Listen to her and encourage her to think through her decision by exploring all her options and possible outcomes.

RESOLUTION

1. Ask the client if she wants to be tested.
    - Declines test: If she has not changed her mind, review prevention of the sexual transmission of HIV and how to protect herself. Encourage exclusive breastfeeding, ANC attendance, delivery at a medical facility and use of family planning.
    - Decides to be tested: She may have changed her mind and want to be tested, in which case you proceed with pre-test counselling.
    - Wants to think about it: She may want to think about it. In this case, review topics from declining the test, i.e. transmission, exclusive breastfeeding, ANC attendance, delivery at a health facility and use of family planning.

TERMINATION

1. Offer on-going support and encouragement.
    - This is especially important for a woman who has decided not to be tested today but is still thinking about it. If you connected well with her, building trust and establishing the relationship, she will be more likely to return if she has questions or wants to explore the option of testing further.

Key Point: Remember that it is the woman's choice to be tested or not. Respect her choice, even though you may disagree with her. Focus on the relationship and encourage her to return if she has doubts or concerns.

POST-TEST COUNSELLING AT ANTENATAL CLINICS (NEGATIVE RESULT)

Refer to the Model of PMTCT: Post-Test Counselling with a Negative Result.

ESTABLISH THE RELATIONSHIP

1. The relationship has already been established: the same counsellor should always do pre and post-test counselling with one client.
2. Affirm and congratulate the client for returning for the result if it is not a rapid test.
3. Ask if the client has any questions before you discuss the results.

EXPLORATION

1. **Give HIV-negative test result.**
    - State the test result clearly and simply.
2. **Explore client's reaction** to the test result.
    - *Example questions:*
        - What does this test result mean to you?
        - Can you tell me some of what you are thinking and feeling right now?
        - How does it feel?
        - What does this test result mean for your future?

Note: Your client may feel happy, relieved, disbelieving or even worry that the results were wrong. Validate any and all of these feelings; they are all normal reactions to a negative test result.

    - If the client's risky behaviour occurred within the past three months, discuss the window period. Encourage the client to be tested again three months after the risky behaviour.
3. **Explore Risk Reduction Options/Strategies.**
    - Discuss any risk patterns that came up during pre-test counselling.
      Example questions:
        - What have you done in the past to reduce your risk of becoming infected with HIV?
        - What will you do to maintain (or keep) your HIV-negative status?
    - Discuss ways of reducing her risk of infection in the future.
      Example questions:
        - If you become infected with HIV while you are pregnant, the risk of passing HIV to your baby is very high. Do you have ideas for how you will protect yourself from becoming infected in the future?

- Are there any behaviours you would like to change in order to reduce your risk of becoming infected with HIV?
- Are there any people in your life who can help you change the behaviour you wish to change? *OR* Who can support you?

- Discuss barriers or potential challenges to reducing risk. Refer to what was discussed in Pre-Test Counselling.

- Discuss what might be especially difficult about the different options. Explore way to overcome these barriers; be realistic. Refer to Pre-Test Counselling.

4. **Discuss Partner Communication**. This test result does not indicate whether or not your sex partner is infected with HIV.

    - Discuss disclosure to partner and partner referral for testing.
      Example questions:
      - How would you feel about talking with your partner about your test results?
      - Tell me your thoughts about asking your partner to be tested.

    - Practise skills for disclosure or partner referral. You can do a role play or use the empty chair technique.

RESOLUTION

1. **Discuss Personalised Risk Reduction Plan.**
   When doing post-test counselling at the ANC, it is important to emphasise continued attendance at the ANC, both for medical exams and counselling. Also, encourage healthy living, i.e. nutrition, rest, exercise, sleep, etc., for all pregnant women.
   Example questions:
   - We have discussed ways to reduce your risk of becoming infected. Now can we discuss what you will do and how you will do it?
   - We discussed a number of risk reduction options. Can you choose any of those that you think you will be able to change in your life?

2. **Summarise** the client's risk reduction plan.

TERMINATION

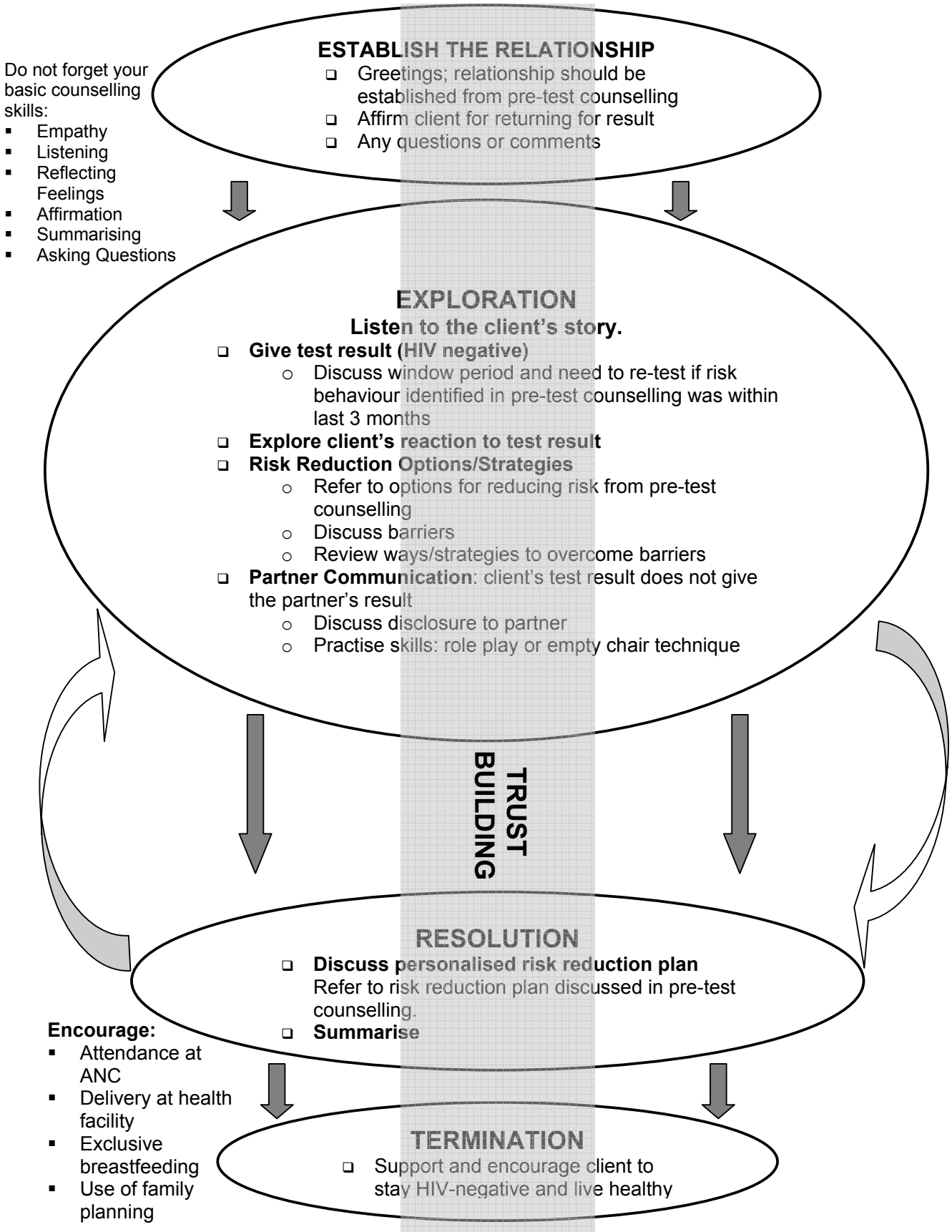
1. **Support and encourage** the client to stay healthy and HIV-negative.

    - Healthy living
    - Safer sex: use a condom, abstain and/or be faithful
    - Partner disclosure and/or referral for testing
    - Encourage continued attendance at clinic appointments during pregnancy.
    - Encourage delivery in a medical facility, i.e. clinic or hospital.
    - Encourage exclusive breastfeeding.
    - Encourage use of family planning.

2. Offer ongoing support.

> **Suggested Role Play Scenario:** We will continue with Nangula, the 26-year-old woman we saw in pre-test counselling.

PMTCT: POST-TEST COUNSELLING (negative result)



Do not forget your basic counselling skills:

- Empathy
- Listening
- Reflecting Feelings
- Affirmation
- Summarising
- Asking Questions

Encourage:

- Attendance at ANC
- Delivery at health facility
- Exclusive breastfeeding
- Use of family planning

POST-TEST COUNSELLING AT ANTENATAL CLINICS (POSITIVE RESULT)

Refer to the Model of PMTCT: Post-Test Counselling with a Positive Result.

ESTABLISH THE RELATIONSHIP

1. The relationship has already been established: the same counsellor should always do pre and post-test counselling with one client.
2. Affirm and congratulate the client for returning for the result if it is not a rapid test.
3. Ask if the client has any questions before you discuss the results.

EXPLORATION

1. Give the HIV-positive test result.

- State test result clearly and simply.

2. Explore the client's reaction to the test result.

- *Refer to the Crisis & Recovery/Behaviour Change Model and Skills and Techniques for Working with Clients in Crisis (from Crisis Counselling & HIV).*
  Example questions:
  - What does this test result mean to you? *Make sure the client understands what the test result means.*
  - How are you feeling?
  - Can you tell me some of what you are thinking and feeling right now?

Key Point: Testing positive for HIV is a crisis for most people. Keep in mind that different people respond to crises in different ways. Allow the client to express her emotions.

Crisis Counselling Steps:

Refer to the Crisis Counselling Model.

Step 1: **Expression**

- Express support and reflect feelings.
- Tell the client that you want to help and you can talk about how she is feeling.
- Give permission for the client to express her feelings.
- Sit quietly; silence is OK.

Use **reflecting skills**; do not be afraid to sit in silence. Reflect the client's non-verbal communication if she is not talking.

- Focus on the client's expression of her current feelings and anxieties.
- Do NOT rush the client through this stage. It can take 10 – 15 minutes.

Step 2: **Control**

- Help the client regain control.
- Assess whether the client has the ability to make decisions or is feeling helpless and out of control.
- Give the client a task to help her gain control, i.e. give her a glass of water and ask her to drink the water slowly OR taking some deep breaths.

Step 3: **Clarify**

- Determine what the crisis is for the client.
- Help the client identify what the most troubling issue is for her at the time. For instance, it could be that she is worried about passing HIV on to her child, worried about dying, scared to tell her partner, or scared that her family will reject her, etc.
- Validate the fear and feelings, and offer information that may support and encourage her, i.e. "There are many things that you can do to prevent your child from getting HIV." *OR* "Having HIV does not mean that you have AIDS and will die soon; most people who have HIV live for many years. There are many things you can do to live a positive and healthy life."
- You can reassure your client with simple information; DO NOT give a lot of information!

Key Messages:
- There are many things you can do to live positively, longer and healthier.
- Not every child born to a woman who is HIV-positive has HIV. There are many things a woman can do to prevent transmission of HIV to her child.
- Practise safer sex for prevention of HIV and STIs: Abstain, Be faithful or use a Condom.
- Return to the clinic for health care and counselling.

Step 4: **Focus/Prioritise**

- Focus on one aspect of the crisis. Pick the aspect that is most troubling to the client or most urgent, i.e. safety.
- Focus on an aspect that is manageable to change.

Step 5: **Identify support**. Refer to support that was discussed during Pre-Test Counselling.

- Identify strategies for emotional support; this usually involves disclosure.
- Use open-ended questions to help the client identify people and resources that can be supportive. DO NOT tell the client who she should disclose to: this is a decision that the client must make for herself.
- Remember that you addressed the issue of support in the pre-test counselling session. Refer to the person that your client identified in that session.
- *Example questions:*
  - Who have you turned to in the past when you have something difficult to deal with? *OR* Who have you talked with in the past?
  - Often people who find out they are HIV-positive find it helpful to share their status with someone in order to get support. Can you think of anyone you could share your status with?
  - Does anyone know that you are here?
  - Is there anyone that you can share your status with?

RESOLUTION

1. **Plan next steps**.

- *Note: This is step 6 in the Crisis Counselling model*.
- Create a next step plan. Try to involve people who can offer emotional support.
  Example questions:
  - What do you plan on doing when you leave the clinic?
  - How will you cope with this news over the next couple of days?
- Tell the client that you can discuss an overall plan for positive living during the next session.

2. Summarise the session, and focus on the client's next step plan.

Key Point: DO NOT try to give too much information. SUPPORT the client and leave her with a sense of HOPE.

TERMINATION

1. Support and encourage the client; offer hope.

- Remind the client that there is much she can do to live a healthy life.

- Remind the client that there are many things she can do to prevent transmission to her child.
- Mention that you will discuss this in the next session.

2. Schedule another appointment to talk more about positive living and prevention of mother-to-child transmission.

3. Offer ongoing support.

NOTE: Due to the fact that you are focussing on only the most pressing crisis in this counselling session, you may want to write down the other issues that come up for the client. You can let the client know that you are holding all the other issues for her and you will talk about them in future counselling sessions. You may either write down the issues during the session or take notes immediately following the counselling session. Refer to these notes before the follow-up counselling session.

Do not forget about the possibility of suicide risk for a client who finds out she is HIV-positive. You may want to review the suicide risk assessment, as well as the suicide checklist included in this session.

Key Point: Remember that receiving a positive test result is a crisis for most clients. Focus on letting the client express all of her thoughts and feelings.

SUICIDE RISK REVIEW

ARE YOU HAVING THOUGHTS OF SUICIDE?	YES	√
CURRENT FACTORS:		
➢ **Current Suicide Plan**		
How? How Prepared? How soon?	YES	√
➢ **Pain**		
Do you have pain that sometimes feels unbearable?	YES	√
➢ **Resources**		
Do you feel you have few, if any, resources?	YES	√
BACKGROUND FACTORS:		
➢ **Prior Suicidal Behaviour**		
Have you ever attempted suicide before?	YES	√
➢ **Mental Health**		
Are you receiving or have you received mental health care?	YES	√

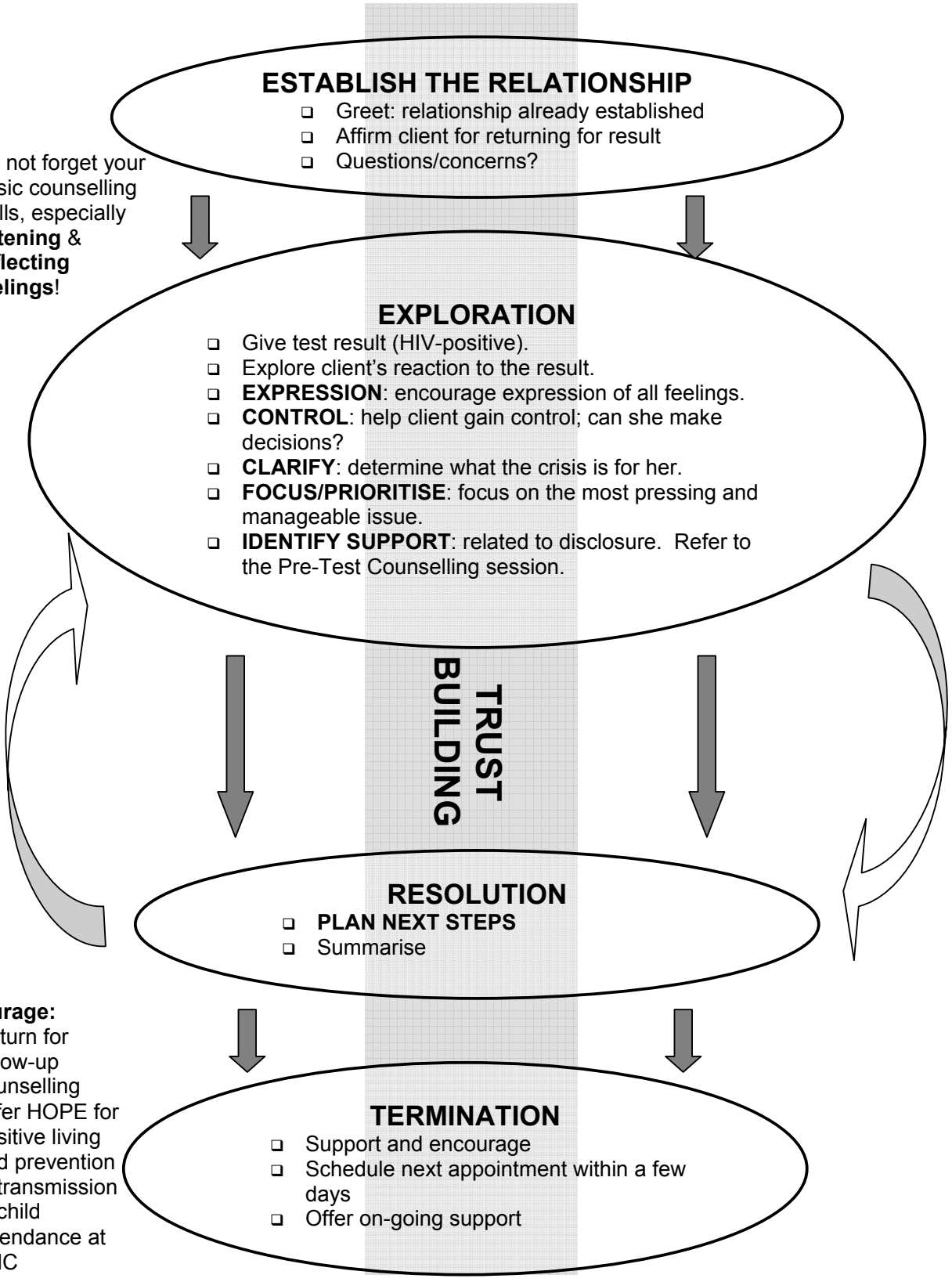
Suicidal Checklist

A person may be suicidal if he/she:

- Talks about committing suicide
- Feels and expresses hopelessness
- Appears depressed or sad most of the time
- Has trouble eating or sleeping
- Withdraws from family and friends and/or social activities
- Loses interest in work, school, hobbies, etc.
- Makes out a will and final arrangements
- Gives away prized possessions
- Has attempted suicide in the past
- Takes unnecessary risks
- Is preoccupied with death and dying (thinks and talks about death and dying a lot)
- Neglects personal appearance
- Increases use of alcohol or drugs
- Recently experienced severe losses, which can include loss of health, job, home, relationship, etc.
- Recently experienced a perceived “failure” or “humiliating” situation
- Irritable

Note: a suicidal person may not display all these characteristics, but the list can offer some guidelines of what to look for.

PMTCT: POST-TEST COUNSELLING (positive result)



Encourage:

- Return for follow-up counselling
- Offer HOPE for positive living and prevention of transmission to child
- Attendance at ANC

FOLLOW-UP POST-TEST COUNSELLING AT ANTENATAL CLINICS

We have talked about post-test counselling with a client who has a positive result. Remember that post-test counselling with a positive result is one type of crisis counselling. You should schedule another session with the client to take place within a few days of that first counselling session. There is no rule about when that counselling session should take place. It could be the next day if the client is not able to cope, or it could be within two or three days. However, the follow-up counselling session should be no more than a week after the post-test counselling session.

Establish the Relationship

1. Relationship has already been established: the same counsellor should always work with a client from pre-test counselling through the whole counselling process, if at all possible.

2. Affirm the client for returning for follow-up counselling: by returning, the client is already making choices to take care of herself, her baby and her family.

3. Summarise the previous session: briefly review what you discussed, what the crisis was for the client and what her next step plans were.

4. Ask how the client is doing: assess how the client is functioning, how she has been since you last saw her, whether or not she followed the next step plans, and how it worked. *These questions should talk you into the Exploration Stage.*

Exploration

1. Explore the client's current feelings about her HIV status: explore whether her thoughts and feelings have changed from when she first found out her positive status.

2. Assess client's functioning: how is she doing? Is she able to go about her normal routine? At what stage is she in the Crisis and Recovery Model? Is she in denial or shock, resisting the diagnosis, or depressed?

    - Your assessment should determine how you proceed. If the client is still in denial, then you must focus on her status and what that means: help her to understand the risks to her health, her baby's health and the impact on her loved ones. It may take several counselling sessions before the client is ready to look at PMTCT or positive living. Remember to meet the client where she is.

    - However, if the client has accepted her status and wants to know what she can do, you can proceed.

3. Address the client's main crisis and other issues mentioned from the previous session. Follow-up on the main crisis for the client: how did the

next step plan work? Is she ready to move on to subsequent steps or to develop a larger plan?

- If the client is ready, you can start to look at some of the other issues that came up in the previous session. It is helpful if you have notes taken either during that session or immediately after it.
- If the client is still barely coping, focus on the main crisis and look at more options for functioning and getting support.

4. Assess support: find out if the client has disclosed her status to anyone. Who can she go to for support? Explore issues of disclosure.
5. Explore partner disclosure and referral for testing: has the client disclosed to her partner? How would the client feel about disclosing her status to her partner?
   - You may want to address discordant results, i.e. that the client's positive result does not mean that her partner's result will be the same.
   - You may want to role play disclosure to the partner during the counselling session.
   - Provide a referral for the partner to be tested.
6. Health education and information: Ideally, these topics will come up during other exploration and assessment.
   - If the client asks about these topics, it is much easier to address them in the natural course of counselling.
   - However, if the client is not ready to make a plan, hope can be offered by talking about positive living in general.
   - Health education topics that can be addressed by asking about the client's knowledge or answering her questions:
     - Understand transmission of HIV (both MTCT and sexually)
     - Medicines for PMTCT: ART if the mother is sick or single-dose Nevirapine (NVP) for mother during labour and baby after birth.
     - Safe delivery at a health facility if possible
     - Introduce infant feeding options; more detailed counselling for infant feeding can come later.
     - Positive living, including:
       - nutrition
       - avoid smoking, alcohol and drugs
       - hygiene
       - safe drinking water
       - getting plenty of rest
       - light exercise, like walking
       - family planning
       - safer sex

- continued attendance at the ANC for a healthy pregnancy and to prevent infections. This includes follow-up appointments, both medically and for counselling.

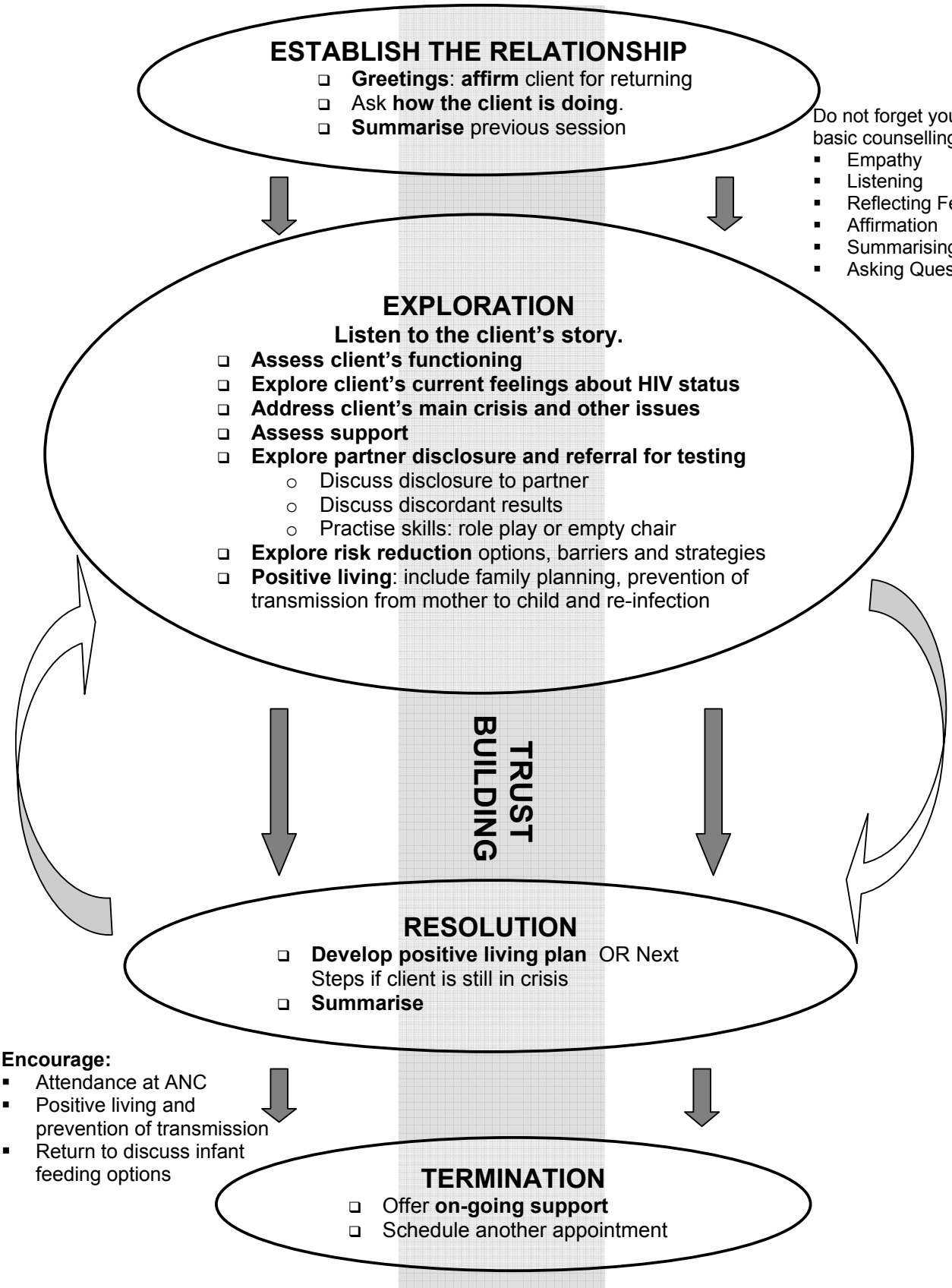
Resolution

1. Develop a positive living plan OR Next Steps Plan if the client is still coping with her status and not able to think beyond the next few days or a week.
2. Encourage and support positive living.

Termination

1. Summarise the counselling session, including key points discussed and the agreed plan, either next steps or a longer-term plan.
2. Offer on-going support, and schedule another appointment: the next counselling session can be either to discuss more issues related to follow-up and support or to focus on infant feeding.

PMTCT: FOLLOW-UP COUNSELLING



INFANT FEEDING COUNSELLING

Purpose or goal of infant feeding counselling:

- Explore the infant feeding options with the mother.
- Help her to understand the risks and benefits of the different options and determine the feasibility of the options.
- Support the mother's decision, help build her confidence, and give her the skills to correctly feed her infant.

While infant feeding options and education will be given by health professionals at the ANC, community counsellors can answer questions, assess the client's understanding, clarify any misconceptions, help the client explore options, and support the mother's choices.

- Women have the right to choose what they believe is best for themselves and their babies.
- Counsellors must support the decisions of mothers, even if the counsellor disagrees with the decisions.

Key Point: There are no "right" answers for helping mothers with HIV to make safer choices for infant feeding.

Infant Feeding Counselling

Refer to PMTCT: Infant Feeding Counselling model.

1. Assess the mother's understanding of the modes of HIV transmission, both from mother-to-child and sexual transmission. The mother should also understand ways to prevent transmission.

   - This is important because:
     - Most babies will not be infected. Without intervention, there is a 30-40% risk of mother-to-child transmission; 60-70% will not be infected.
     - Even with interventions, there is a small possibility that the baby will become infected. Remember, PMTCT reduces the overall risk of transmission by half.
     - Even though breast milk may transmit HIV, the risk of NOT breastfeeding may be more dangerous for the baby because of risks of malnutrition and other infections. Breast milk protects the baby from many infections.
     - It is important that mothers do not count on having a baby who is free of HIV infection.
     - The choice of the best feeding option depends on the mother's circumstances.

2. Be sure to explain that it will be several months (usually 18 months) before it will be possible to know definitely whether the baby is infected or not.

   - This is important because:
     - If mother chooses to breastfeed, she will not know if her child already has been infected or not.
     - If her baby is infected, she will not know when the child was infected.
     - The mother needs to know what to expect in terms of when it is possible to definitely know her child's HIV status.

3. Discuss important factors in making a decision to breastfeed or use replacement feeding. The mother with HIV must weight the benefits and risks of both infant feeding options.

   - Acceptable culturally?
     Ways to ask the mother about this in a counselling session:
     - How are most babies fed in your community?
     - What do people say when a baby is not breastfed?
     - Will people guess that a non-breastfeeding mother has HIV?
     - How will people respond if you do not let your child be given any foods other than breast milk?

   - Affordable? Ways to ask the mother about affordability:
     - How much would it cost to get replacement feed, either formula or cow or goat's milk?
     - How much does your household make in a month?
     - How much money do you usually have left over or extra at the end of the month?

   - Feasible/Possible? (This concerns the time and ability to prepare replacement feedings correctly)
     Suggested questions to explore feasibility:
     - In order to replacement feed your infant, you will need to prepare food 8 – 12 times in a day. How does this sound to you? Is there anyone who could help you with this?
     - In order to exclusively breastfeed, you will have to feed your infant 8 – 12 times in a day. Will you be able to be there to feed your child on demand?

   - Safe/hygienic? Questions to explore issues around safety:
     - Where do you get your water?
     - Do you have any refrigeration?

   - Sustainable/Able to continue? (consistent availability): Possible questions to ask about sustainability:
     - Where would you get the replacement feed? *OR* Where would you buy infant formula? *OR* From where would you get cow's/goat's milk?
     - What kind of fuel do you use to prepare your meals?

- Where do you get your fuel?
- You will need extra fuel to boil water for the baby's replacement food. Will extra fuel be a problem? How much will that cost? *OR* Are their people who can help you gather extra wood to boil water?

- <u>Disclosed to others for support/willingness for mother to disclose her status</u>:
  Ways to ask the mother about her willingness to disclose her status:
  - Who knows about your HIV status?
  - How do you think disclosure of your status to members of your household will help you with infant feeding?

4. In counselling, mothers should be given information about both the risks and the benefits of different feeding options, especially as they apply to the mothers' own situations.

5. These feeding options should be explored with the mother. Counselling should be non-judgemental and non-directive. This is the mother's decision; the counsellor must keep his/her personal feelings separate.

6. The mother's choice should be supported by the counsellor.

7. Additional information should be given about the chosen infant feeding method. Counsellors should also build the mother's skills and confidence in carrying out her infant feeding choice.

HIV and Infant Feeding Counselling Guide
(for reference)

Situation	Counselling Guide
Mother's HIV status unknown	▪ Promote HIV testing ▪ Promote exclusive breastfeeding, which is safer than replacement feeding ▪ Teach mother how to prevent HIV infection, including safer sex
HIV-negative mother	▪ Promote exclusive breastfeeding for 6 months, with the introduction of complementary foods at 6 months ▪ Teach mother how to prevent HIV infection, including safer sex
HIV-infected mother who is considering her feeding options	▪ Refer to ART if needed ▪ Explore acceptability, affordability, feasibility, safety, sustainability and mother's disclosure in relation to infant feeding options ▪ Help mother choose the safest available feeding option. ▪ Build mother's skills for and confidence in feeding her infant ▪ Teach mother to practise safer sex
HIV-infected mother who chooses to breastfeed	▪ Promote exclusive breastfeeding up to 6 months, with abrupt stopping as soon as replacement feeding is safe and feasible. ▪ Build mother's skills and confidence in exclusively breastfeeding her infant ▪ Support mother's choice ▪ Explore and then problem-solve potential difficulties.
HIV-infected mother who chooses replacement feeding	▪ Help mother choose the safest replacement feeding strategy, i.e. modified goat or cow's milk or infant formula ▪ Build mother's skills for and confidence in correctly preparing the infant feeding, i.e. hygienic and correct preparation, cup feeding ▪ Support mother's choice. ▪ Explore and then problem-solve potential difficulties. ▪ Teach mother to practise safer sex to prevent HIV transmission, re-infection, and for pregnancy prevention.

Abrupt Stopping of Breast Feeding

After about 6 months, the balance between the risk of not breastfeeding and the risk of transmission changes. The benefits of breastfeeding are reduced, because protection against infection and malnutrition decreases rapidly after six months. The child also needs additional food beyond breast milk.

How to help a mother achieve abrupt stopping of breastfeeding:

- Find a regular supply of replacement milk BEFORE stopping breastfeeding.
- Begin the transition by expressing breast milk and providing feedings by cup between regular breastfeedings.
- As the baby accepts cup feeding, replace breastfeeding with cup feeding, one feeding at a time. Keep in mind that it is breast milk that is fed with the cup.
- It may help to find someone to assist with feeding the baby with replacement and complementary feedings in the beginning.
- Once all breast milk feedings are accepted by cup, begin feeding only breast milk substitutes, i.e. formula or modified cow's or goat's milk.
- Mothers should use alternative ways of comforting the baby other than breastfeeding. This can include massaging, swaddling, carrying, rocking, singing, sleeping with and talking to the baby.

Taken from: Government of the Republic of Namibia. Draft 2006. Infant and Young Child Feeding: National Guidelines for Health Professionals. Ministry of Health and Social Services. Windhoek, Namibia.

Feeding Young Children (beyond 6 months)

We have discussed feeding for infants. Remember that after 6 months, children no longer need special modified milk. They also need additional food beyond replacement feeding or breast milk.

Complementary foods are foods or liquids given to the child in addition to breast milk or other milk.

Consider the age at which mothers begin to give children something besides breast milk traditionally. Think about what you normally feed children when you start feeding them other things besides breast milk.

For mothers with HIV, it is important that they stop breastfeeding before or by 6 months. When complementary foods are introduced to the child, the mother should no longer be breastfeeding in order to avoid mixed feeding. Remember that mixed feeding increases the risk of HIV transmission to the baby.

Complementary Foods for Young Children (6 months)

- In general, children need complementary foods starting at 6 months.
- In addition to breast milk or other milk, a child should be fed other household foods.
- Complementary foods should include: omahangu, maize meal porridge (pap) and sorghum, well-mashed vegetables (i.e. pumpkin, spinach, carrots, sweet potatoes, potatoes), and well-mashed yellow fruits (i.e. paw-paw, mangoes, bananas).
- Start with only 1 or 2 teaspoons twice a day, and gradually increase the amount of food and how often it is given.
- The baby should be fed slowly with a small spoon.
- Introduce one food at a time.
- At nine months, add other foods such as soft meat, fish, chicken and egg (only yellow part). Enrich staple foods with oil, fats and nuts.

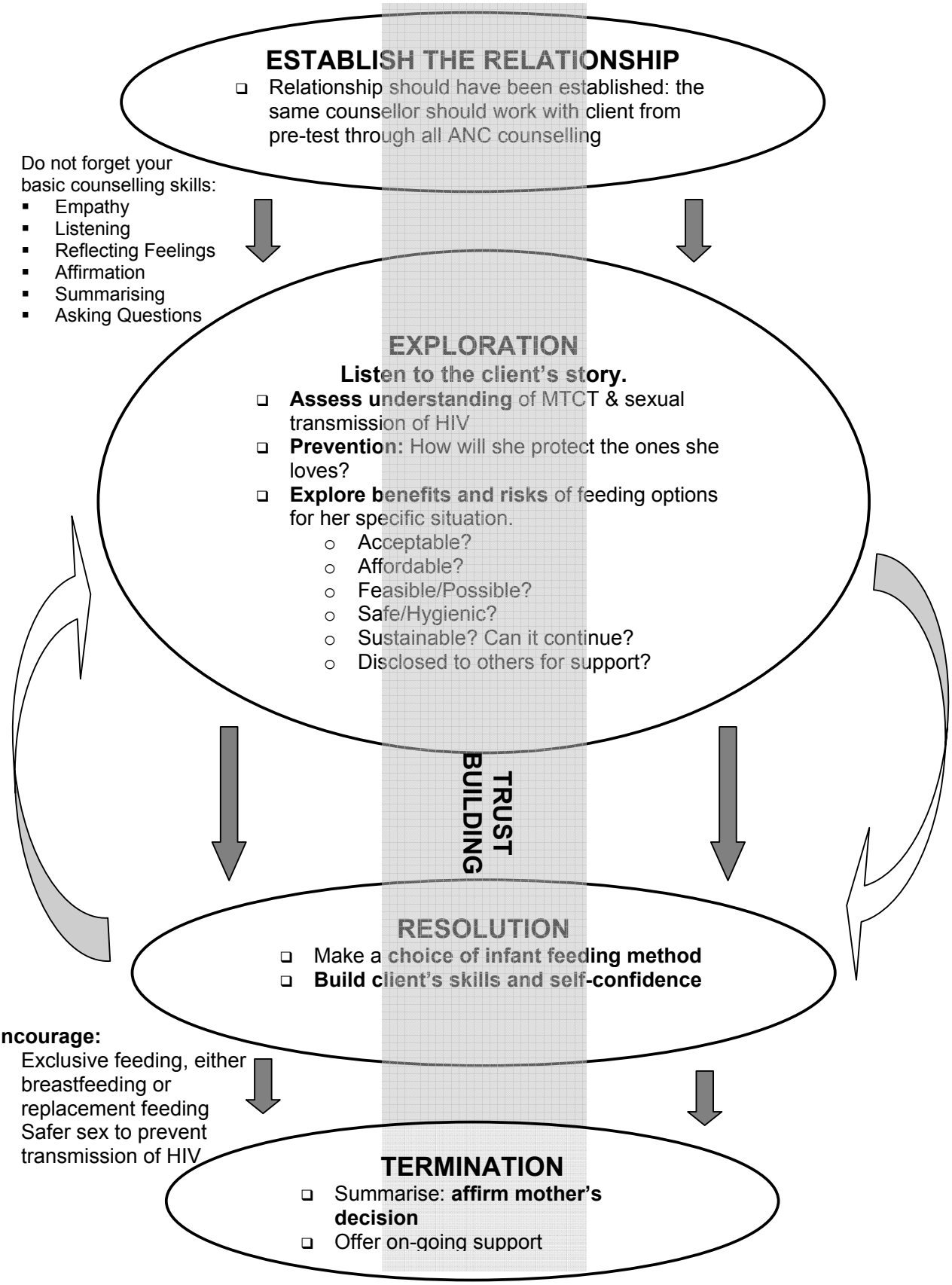
Ways to make porridge more nutritious:

- Use less water and more maize meal or omahangu flour
- Instead of water, use milk to make porridge
- Add extra milk powder, unsifted maize meal or butter to the porridge
- Add cooked, mashed vegetables, such as sweet potato or pumpkin
- If porridge becomes too thick, add butter, margarine (Rama) or oil to make it softer and easier to eat.

What to AVOID:

- Do NOT give your baby cool drinks, such as Fanta or Coke, or other sugary drinks.
- Do NOT give your baby tea or coffee.
- Limit fruit juice to no more than one cup a day, as this can decrease the baby's appetite and may cause diarrhoea.

PMTCT: INFANT FEEDING



POSITIVE LIVING: MOTHER'S HEALTH AND NUTRITION

Nutrition is important for all pregnant women, as it contributes to maternal health as well as the health of the baby. An adequate diet is necessary during pregnancy, but also during breastfeeding.

Some benefits of good nutrition:

For the mother:

- Decreases risk of complications during pregnancy and delivery
- Prevents or controls anaemia (low iron), which results in tiredness
- Lowers the risk of mortality during delivery and right after birth because the mother is stronger
- Ensures energy storage for breastfeeding

Benefits for the infant:

- Contributes to healthy growth and development
- Reduces risk of HIV transmission to the baby because nutrition boosts the immune system and raises the mother's CD4 count

Benefits for the household:

- Well-nourished, healthy mothers can contribute more fully to the functioning of the family because they have more energy.
- Improved work productivity when someone is well-nourished

General Nutritional Considerations for Pregnant or Breastfeeding Women

- Eat a variety of locally available and seasonal foods; eat traditional foods.
- Drink at least 3 glasses of dairy products per day, i.e. yoghurt, omaere, fresh milk (cow or goat), omaotekwa (sour milk), etc.
- Eat at least 3 portions of meat/protein per day, i.e. meat, fish, chicken, eggs, etc.
- Eat at least 3 portions of vegetables per day, i.e. spinach, pumpkin, carrots, beans, etc.
- Eat at least 2 portions of fruit per day, i.e. oranges, apples, bananas, marula, oombe, paw-paw, watermelon, etc.
- Eat at least 9 portions of breads and cereals per day, i.e. porridge, bread, omahangu, rice, macaroni, etc.
- Drink plenty of fluids, especially water. You can also drink oshikundu, osopa, fruit juice, oshinwa, etc.

- Groundnuts are also good source of protein, either as a snack or with a meal.

Suggestions for what a pregnant woman can do to remain healthy:

Overall Health

- Get plenty of rest, and encourage family members to assist with household work.
- Exercise regularly by walking, gardening, dancing, etc.
- Avoid alcohol, drugs, smoking, and too much caffeine from coffee, black tea or cool drinks.
- Maintain personal hygiene by washing hands regularly with soap and water, washing all utensils used for eating and drinking, and keeping cooking area clean.
- Practise safer sex with correct use of condoms.
- Go to follow-up visits at the ANC.

KNOWING ABOUT SEXUALLY TRANSMITTED INFECTIONS (STIS)

Relationship between STIs and HIV:

- Like HIV, STIs are also transmitted by the same route: sex.
- 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.

Game: 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.

REPRODUCTIVE HEALTH & FAMILY PLANNING

Reproductive health: Implies that people are able to have a satisfying and safe sex life, physically, mentally and emotionally, and they have the capability to reproduce and the freedom to decide if, when and how often to have children. This means that people must have access to the family planning methods of their choice as well as to health care services.

Effectiveness of Family Planning Methods

For every 100 women who use this method for one year:	This many women will become pregnant:	Protection against STIs
Condom	12	Good
Condom for women (femidom)	20	Good
Diaphragm	18	Some
Spermicide	20	None
Pill (the combined pill)	3	None
Progestin only pill	5	None
Implants	Less than 1	None
Injections	Less than 1	None
Intra-Uterine Device (IUD)	1	None
Breastfeeding (first 6 months)	2	None
Natural family planning	20	None
Sterilisation	Less than 1	None
No method	85	None

**All of these methods can be used safely while breastfeeding except the combined pill and the injections that have estrogen.

Adapted from A. August Burns, Ronnie Lovich, Jane Maxell, Katharine Shapiro. 1997. Where Women Have No Doctor: A Health Guide for Women. The Hesperian Foundation. Berkeley, California.

Key Point: Couples may want to use two types of family planning, one to prevent pregnancy and one to prevent transmission of STIs. For instance, the woman could get injections of Depo-Provera and the couple could also use condoms to prevent transmission of HIV or other STIs.

Information About Family Planning Methods
(For reference)

1. **Condoms** (Male or Female)

    - Prevent both pregnancy and STIs/HIV when used consistently and correctly
    - In real-life situations, correct and consistent (use every time you have intercourse) use may be difficult to achieve.
    - Do not use a female condom with a male condom or two condoms at the same time, as this will cause friction and increase the likelihood of the condom breaking.

Pregnancy Rates

	Male Condom	Female Condom (Femidom)
Perfect Use	2%	5%
Typical Use	15%	21%

Prevents HIV/STI Transmission:
*Condoms are the only method proven to reduce the risk of all STIs, including HIV.

- Typical use: 80% reduction in HIV incidence (transmission)
- Consistent use: infection rate of less than 1% per year in discordant couples
- Inconsistent use with infected partner is as risky as using no condom at all.

Overall: Condoms are the only method that can prevent HIV and STI transmission. However, they are less effective than other methods for preventing pregnancy.

2. **Diaphragm**: a shallow cup made of soft rubber that a woman wears in her vagina during sex. The diaphragm works by covering up the cervix (opening to the uterus), preventing the sperm from entering it. The spermicide jelly used with the diaphragm helps kill the sperm and also protects against some STIs.

    - You can go to a health facility to be fitted for a diaphragm by a health professional (doctor or nurse).
    - NOT recommended for women with HIV

Overall: Diaphragms used with spermicide are not very effective in preventing pregnancy, and offer limited protection from STIs. They are not recommended for use by women with HIV.

3. Spermicide

- Comes in many forms: contraceptive foam, tablets, jelly or cream, and is put into the vagina just before having sex.
- Spermicide kills the sperm before it can get into the uterus.
- It is helpful when used as extra protection with another method, such as the diaphragm or condom.
- May increase risk of HIV with frequent use because it can disrupt the lining of the vagina, which increases the risk of HIV infection.
- NOT recommended for women with HIV

Overall: Spermicides used alone are not very effective in preventing pregnancy, and offer no protection from STIs. They are not recommended for use by women with HIV.

4. Hormonal Contraceptives

- There methods contain hormones, called oestrogen and progestin. They work by preventing the woman's ovaries from releasing an egg. The hormones also work by making the mucus at the opening of the uterus very thick, which helps prevent the sperm from getting inside the uterus.
- There are different forms of hormonal contraceptives:
  - Birth control pills that a woman takes every day
  - Injections that are given every few months, i.e. Depo-Provera/DMPA
  - Implants, which are put into a woman's arm and last for several years, i.e. Norplant, Jadelle, Implanon.
- There are both combination pills and injections (containing oestrogen and progestin) and progestin-only pills (also called the "mini pill"), injections and implants.

Benefits	Limitations
Very effective for preventing pregnancy	ARVs may reduce effectiveness of contraception or increase side effects
Easy to use	Contraceptives may reduce the effect of ARVs
Suitable (work) for short- or long-term use	Contraceptives may affect HIV disease progression
Reversible; not permanent	Offers no protection from STIs & HIV infection
Potentially other health benefits: reduce risk of other diseases	Can experience some side effects (mostly mild)
Serious complications are very rare	

Overall: Hormonal contraceptives are very effective in preventing pregnancy, but offer no protection from STIs and HIV infection. They may also not be the best choice for women on ART. Another method of protection against STIs and HIV should be encouraged.

5. Intra-Uterine Device (IUD)

- An IUD is a small object that is inserted into the uterus by a specially trained health worker. Once inside the uterus, the IUD prevents the man's sperm from fertilising the woman's egg.
- The IUD can stay in the uterus for up to 10 years.

Benefits	**Limitations**
Very effective for preventing pregnancy; failure rate of less than 1%	Offers no protection from STIs & HIV infection
Can remain in place up to 10 years	Not suitable for short-term use
Suitable for long-term use	
Reversible; not permanent	

Overall: IUD is very effective in preventing pregnancy. However, it offers no protection from STIs and HIV infection.

6. Lactational Amenorrhoea Method (LAM)

- This is breastfeeding for the first 6 months after the baby's birth.
- Temporary contraceptive option
- ONLY for women who are:
  - less than six months from getting a child (giving birth to a child) AND
  - are breastfeeding the baby every 6 hours AND
  - have no periods (menses).
- For women with HIV, there is a risk of their child becoming infected through breast milk.
- Offers no protection from STIs, and there is an increased risk of infecting the child with HIV if the mother is infected while breastfeeding.

Overall: There method is only effective for a very limited time for a very limited group of women as pregnancy protection. It offers no protection from STIs, and if a woman is infected with HIV during this time, the breastfeeding child is at a higher risk of being infected.

7. Fertility Awareness-based Methods (also called the mucus method and the rhythm method)

- Identify fertile days in the menstrual cycle and abstain from intercourse during those days
- Can use condoms or other barrier methods during fertile days
- It takes about 3 – 6 months of practise to learn how to use these methods.

Overall: Not very effective in preventing pregnancy, and offers no protection from STIs. Clients wanting more reliable contraceptives should use other methods.

8. Sterilisation (the operation for no more children)

- There are operations that make it almost impossible for a man or a woman to have any (more) children. Since these operations are permanent, they are only suggested for those women or men who are sure that they do not want any more children.
- Vasectomy: the operation for the man, in which the tubes that carry the sperm from the testicles to the penis are cut. It does not change a man's ability to have sex or to feel sexual pleasure.
- Tubal Ligation: the operation for the woman, in which the fallopian tubes that carry the egg to the uterus are cut. It is a slightly more difficult operation than the man's, but does not change a woman's ability to have sex or to feel sexual pleasure.
- Sterilisation does not protect against STIs.

9. Emergency Methods

- Emergency methods are ways for women to avoid pregnancy after having unprotected sex. These methods prevent a fertilised egg from attaching to the wall of the uterus.
- They are only effective if used soon after having sex, generally within 2 or 3 days.
- They do not protect against HIV or other STIs.

Summary of Contraceptive Choices

- Use two methods at the same time, i.e. condoms plus another contraceptive method.
- Use one method and understand its limitations i.e. prevent pregnancy versus prevent transmission
    - Effective pregnancy prevention but no STI/HIV protection
    - Condoms protect from STIs/HIV, but typically are less effective in preventing pregnancy than other methods
- Use no method and abstain from sexual intercourse
- A health professional can provide additional information about family planning and help couples make the best choices for their situation.

Adapted from A. August Burns, Ronnie Lovich, Jane Maxell, Katharine Shapiro. 1997. Where Women Have No Doctor: A Health Guide for Women. The Hesperian Foundation. Berkeley, California.
Family Health International. 2005. Contraception for Women and Couples with HIV.

BURNOUT PREVENTION

Burnout:

- Cumulative stress (stress that builds up); physical, emotional, spiritual and mental exhaustion (extreme tiredness)
- Prolonged (for a long time) exposure to stress over a period of time

Many idealistic and enthusiastic counselling trainees promise themselves that they will never become like some of the counsellors or counsellor supervisors they have known.

- They will not turn into tired, frustrated individuals who no longer seem to care very much about what they do or what others think about them.
- They will not be a burnt-out professional who has lost his/her compassion and carries out HIV counselling as if it were a duty.
- It is important to remember that these burnt-out professionals were just like you. Nobody who starts out as a counsellor plans for the days when work is no longer interesting and exciting.
- This is why we are talking about the important subject of burnout. If we anticipate the predictable stresses and strains of being an HIV counsellor and the difficulties that being a counsellor entails, then we can take steps that allow us to take care of ourselves and minimise the negative effects.

Anyone can experience burnout, but the following people are more likely to experience burnout:

- Highly committed individuals who have high expectations for themselves
- Frontline workers, not those who work "behind the scenes"
- Counsellors dealing with difficult issues such as HIV

Factors Contributing to Burnout Among HIV Counsellors

- The combination of a counsellor's high level of commitment to his/her work, the isolation and stress of the job, and the lack of adequate support can lead to "burnout."
- Some factors that may contribute to burnout:
  - Attempts to accomplish too much
  - Fails to set realistic limits on one's work
  - Lacks sufficient resources to effectively accomplish one's work and assist clients
  - Lacks support
  - Isolation
  - Boredom: talking to clients about similar things every day

- Excessive work
- Increasing responsibilities
- Lacks sufficient access to supportive supervisors and co-workers
- Lacks sufficient education or training to perform his/her work
- Feels the need to "rescue" the client
- Unable to express her/his own feelings, particularly emotions like grief and anger
- Has not learned effective ways of coping with the emotional stress inherent to his/her work
- Feeling unappreciated
- Need for personal or professional support
- Being confronted with chronic illness (HIV), dying and death
- Working with clients who face many challenges
- Working with clients who find it difficult to change unsafe behaviours

Burnout Symptoms

Physical	Behavioural (Doing)	Thinking & Feeling
Exhaustion (severe fatigue) Repeated minor illnesses Frequent headaches and backaches Sleeplessness (cannot sleep) Stomach problems Chronic and vague physical pains General weakness and apathy	Quickly irritated or frustrated Quickness to anger and/or irritation Prone to prejudice Alcohol or drug abuse Marital or relationship problems Rigid (inflexible) in solving problems Impulsive or acting out Inability to concentrate Forgetfulness Procrastination Social withdrawal from friends or family Lack of desire to go to work	Exasperation: "I have had enough" or " I cannot take this anymore" Ruminating: think about the same things over and over Emotional numbness, indifference/apathy Emotional hypersensitivity Over-identification (not objective) Pessimistic (think the worst), helplessness, hopelessness Grief or sadness Anxiety Resentful Apathy (I do not care attitude) Feeling inadequate (like I cannot do my job) Loss of hope Outbursts of anger

Burnout has four stages:

- Stage 1: Physical, mental and emotional exhaustion
- Stage 2: Shame and doubt
- Stage 3: Cynicism and callousness/Apathy
- Stage 4: A sense of failure, helplessness and crisis

Ways to Prevent Burnout

Build Physical Reserves:

- Find something physical, such as walking, playing football (soccer) or dancing, that you enjoy doing. Do that physical activity three or four times a week.
- Eat well-balanced and nutritious meals.
- Avoid smoking and drinking a lot of caffeine, i.e. tea, coffee or cool drinks such as Coke.
- Avoid using alcohol to reduce stress.
- Mix leisure with work, and take breaks when you can. During those breaks, take a short walk or eat a healthy snack.
- Get enough sleep. Be as consistent with your sleep schedule as possible. Go to sleep at the same time and wake up at the same time every day.

Build Emotional Reserves:

- Develop mutually (shared) supportive friendships/relationships.
- Pursue realistic goals that are meaningful to you, not goals that others have set for you.
- Expect frustrations, failures and sorrows as a part of life.
- Practise being kind and gentle with yourself and being a friend to yourself; take care of yourself.
- Make time in your life for the activities and the people that bring you joy.
- Seek supportive supervision and/or peer support, either individual or group supervision.
- Associate/work with committed, concerned colleagues who can help the counsellor identify when he/she is at risk of burnout.
- Seek support from a partner, work team or work environment.

- Share the highlights and successes of your work with others; share your accomplishments without breaking confidentiality.
- Regularly do a self-assessment; identify suggestions of what questions to ask yourself.
- Keep an attitude of hope.
- Make a commitment to periodically change, i.e. find new challenges, learn new ways of counselling, supervision, peer support group, etc.
- “Allow” yourself to forget about your clients when you go home and permit yourself not to feel guilty about the suffering of others.
- Learn to accept what can be controlled and let go of what cannot, remembering your locus of control and circle of influence vs. circle of concern.
- Know when the work is too challenging: when you need help from your supervisor, when you need to refer, when you need to take a break and when to ask for help.
- Periodic assessment of burnout: it can be helpful to do this by yourself, with your colleagues or with your supervisor.

Stress Management Plan Worksheet

Identify Signs and Symptoms of Stress

Physical: I experience these physical symptoms when I feel stressed:

Behavioural/Actions: I do the following things when I feel stressed:

Thinking: I begin to think this way when I feel stressed:

Create New Habits to Reduce Stress

Adopt a Healthier Lifestyle: Create new habits and let go of old ones that are not healthy. Write a habit you plan to create or one you plan to drop for each of the following areas. It is important to keep balance in your life, which means creating time with family and friends that does not involve your work.

Eating:
Example: I will eat at least two vegetables a day.

Sleeping:
Example: I will go to sleep around 22:30 every night.

Communicating:
Example: I will address something that frustrates me while it is happening or immediately after so I do not let it bother me later. I will write all of my frustrations and successes in a personal journal.

Physical Exercise and Recreation:
Example: I will play soccer/football on Saturdays.

Drinking/Smoking:
Example: I will drink no more than three beers when I go out on the weekends.

Relationships:
Example: I will spend Saturdays with my husband and children doing something as a family.

Manage Time More Effectively:
Example: I will schedule time to process my experiences counselling at the end of each day.

Adopt a New Attitude: Occasionally, you will find yourself in a situation that you cannot change. This can be very frustrating and cause a great deal of stress. The one thing you can always control is your attitude and how you perceive things. When you feel the need to change your attitude, try asking yourself some of the following questions:

- What part of this situation upsets me?
- What would it be like to feel peaceful about this situation?
- Where can I take control in this situation? *Note: usually you can begin with how you are reacting.*
- What would it feel like to let go of my anger or frustration in this situation? How would my body feel and what would I think?

We are here to listen…
NOT to work miracles.
We are here to provide honest information…
NOT to tell them what we want them to think.
We are here to help them identify their alternatives…
NOT to decide what they should do.
We are here to discuss steps with them…
NOT to take steps for them.
We are here to empower them to discover their own abilities…
NOT to rescue them and leave them still vulnerable.
We are here to help them access resources…
NOT to take responsibility for solving all of their problems.
We are here to care about their health and well-being…
NOT to judge them for their choices.
We are here to provide support for healthy decisions.

Taken from the American Social Health Association's CDC National AIDS/STD Hotline Training Manual. 2002.

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

Written Exercise: Burnout Prevention/Stress Reduction Plan

Activity: What will you do?	With Whom?	When? How Often?

Self-Assessment and Improvement Worksheet

Strengths:

My strengths as a counsellor or the basic counselling skills I am good at:

Example: I am good at establishing the relationship and making the client feel comfortable in counselling.

How will I use this to build on my skills as a counsellor?

Example: I will expand my ability to make an initial connection with a client to build trust and allow the client to explore very personal things that are often hard to talk about, such as sexual behaviour.

Areas for Improvement:

The areas where I need to improve as a counsellor or the skills I struggle with:

Example: I am uncomfortable when my client is emotional. I try to make her feel better by reassuring her, and then I usually give advice instead of helping the client explore her feelings and options.

How will I work on improving these skills?

Example: I will write in my journal every day about my own feelings to get comfortable with my own emotions. I will role play with my counselling colleagues, focussing on simply validating the feelings and not giving advice.

Date of Assessment_____

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 that 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.

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