HANDOUT 1.1 HIV PERSONAL RISK ASSESSMENT

1. Have you ever had sexual intercourse?  Yes ☐  No ☐
2. Have you ever had unprotected sex (sex without a condom)?  Yes ☐  No ☐
3. Are you 100% sure that your partner has been faithful to you?  Yes ☐  No ☐
4. Do you know the sexual history of your partner?  Yes ☐  No ☐
5. Do you know if your partner has used a condom (every single time he had intercourse) with every sexual partner he or she has ever had?  Yes ☐  No ☐
6. Do you know the sexual history and condom use of your partner’s old sexual partners?  Yes ☐  No ☐
7. And the sexual history of their old sexual partners?  Yes ☐  No ☐
8. Has your partner ever had an HIV test?  Yes ☐  No ☐
9. Have you ever had sex with a commercial sex worker without a condom?  Yes ☐  No ☐
10. Have you ever had a blood transfusion?  Yes ☐  No ☐
11. Have you ever shared needles with another person?  Yes ☐  No ☐
12. If you are circumcised, have scarification or tattoos, do you know if the instruments or razor blades used were properly sterilized?  Yes ☐  No ☐

RATE YOUR RISK:

1) If you answered “yes” give yourself 1 point.
2) If you answered “yes” give yourself 1 point.
3) If you answered “no” give yourself 1 point.
4) If you answered “no” give yourself 1 point.
5) If you answered “no” give yourself 1 point.
6) If you answered “no” give yourself 1 point.
7) If you answered “no” give yourself 1 point.
8) If you answered “no” give yourself 1 point.
9) If you answered “yes” give yourself 1 point.
10) If you answered “yes” give yourself 1 point.
11) If you answered “yes” give yourself 1 point.
12) If you answered “no” give yourself 1 point.
IF YOU HAVE EVEN ONE POINT, YOU MAY BE AT RISK OF HIV INFECTION.
TAKE YOUR LIFE INTO YOUR OWN HANDS!
BE SAFE AND GET AN HIV TEST TODAY.

HANDOUT 1.2
Myths and Misconceptions: True and False Activity

- TB directly causes AIDS. (F)
- There is a cure for AIDS. (F)
- I can protect myself from HIV infection. (T)
- People who are infected with HIV can safely have sex with partners if they use a condom. (T)
- Condoms are coated with the HIV virus. (F)
- Condoms have invisible holes in them (large enough for the HIV virus to get through). (F)
- People with HIV should be isolated from the community in order to prevent transmission. (F)
- Mosquitoes can transmit HIV. (F)
- You can get HIV from oral sex with an HIV+ person. (T)
- You can get HIV from kissing an HIV+ person. (F)
- You can get HIV from sharing food and utensils with an HIV+ person. (F)
- You can get HIV from eating uncooked meat prepared by someone with HIV. (F)
- You can get HIV from sharing towels with someone who has HIV. (F)
- You can get HIV from eating a raw egg from a chicken that has ingested a condom used by an HIV+ person. (F)
- A person with HIV can live a long and healthy life if they receive the necessary drugs. (T)
- Ethiopia has the highest number of PLWHA in Africa. (F)
- The first cases of HIV in Ethiopia were found in the 1990s. (F)
- HIV and AIDS are not the same thing. (T)
- Sleeping with a virgin can cure you of HIV infection. (F)
• Male circumcision is a way to decrease risk of HIV infection.  (T)

• A healthy looking person can be HIV positive.  (T)

• Taking anti-retroviral drugs during childbirth can help to prevent an HIV+ mother from passing on the virus to her child.  (T)

• I can become infected with HIV if I have sex with an HIV infected person one time (without a condom).  (T)

• I am safe from HIV infection if I only have sex (without condom) with one faithful partner.  (F)

• Wearing two condoms during sex gives you double protection against HIV transmission.  (F)

Handout 1.3 Ethiopia’s Response to HIV/AIDS

Insert table here

Handout 1.4 Gender-based Vulnerabilities to HIV

**FEMALE BIOLOGICAL VULNERABILITIES:**

• Larger surface area of mucous membranes, which are exposed during sex, can increase a woman’s exposure to the HIV virus.

• Younger women have undeveloped sexual organs that may tear easily during sex (especially when forced).

• Forced sex can cause lesions and tearing in the vagina (which can serve as an entry point for the virus).

• Women are less likely to be symptomatic while infected with STI and therefore are less likely to seek treatment. People w/ STIs are more likely to get infected with HIV (2-9x more likely).

**MALE BIOLOGICAL VULNERABILITIES:**

• While heterosexual men have less biological risk of infection than women, men who have sex with men are at greater risk. Due to the rough nature of homosexual sex, there is often anal tearing, which can serve as an entry point for the HIV virus.

• Because of the oftentimes hidden nature of homosexual sex, MSM may not access healthcare services; and those who do may have STIs that go undetected by untrained healthcare workers.

• Males who are not circumcised are at a higher risk for HIV infection. (Circumcised men are 50% less likely to be HIV+).

**FEMALE SOCIO-CULTURAL VULNERABILITIES:**

• In many cultures women are supposed to be “pure” and not know of sexuality. This may impede their health services and information seeking.
Women feel they should consult their partners before receiving an HIV test; this may impede them from getting tested.

Women seeking to protect their “virgin” status may engage in high-risk anal sex.

Women’s pressure (oftentimes religious) to be “mother”, first and foremost, may prohibit them from using condoms.

Violence against women (or the threat of violence) prevents them from getting tested and disclosing their status.

**MALE SOCIO-CULTURAL VULNERABILITIES:**

- Cultural notions of masculinity often pressure men to have high-risk sexual behavior including unprotected sex, visits to commercial sex workers, multiple partners and infidelity.
- Men are expected to dominate sexual relationships and are socialized to be aggressive; this can lead to forced sexual relationships and violence against women.
- Men are socialized to “tough out” illnesses and therefore may not seek out necessary medical services and information.

**FEMALE ECONOMIC AND STRUCTURAL VULNERABILITIES:**

- A women’s economic dependence decreases her ability to negotiate safe sex and to leave violent relationships that may put her at risk to HIV.
- A woman’s subordinate economic status oftentimes forces her to carry out commercial sex work or trade sex for money, goods, or protection.

**MALE ECONOMIC AND STRUCTURAL VULNERABILITIES:**

- Societal pressure on men to be the primary breadwinners of families places undue strain on them. This pressure may lead to increased high-risk behavior like drug and alcohol abuse, multiple sex partners, and violence.

1) What role does poverty/economics/migration play in regards to HIV transmission?
- Correlation between external debt of underdeveloped nations and higher HIV prevalence rates.
- Poverty leads to poor nutrition and poor health which leads to increases in HIV.
- Poverty limits access to mass media and health information.
- Poverty limits access to healthcare services.
- Poverty leads to migration, which increases people’s risk to infection through increased risk taking behaviors.
- Migration leads to separation from family, increased sexual risk behavior, lack of legal protection, limited access to healthcare services, and HIV information, counseling and testing.

2) Give some examples of how culture and society can increase vulnerability to HIV infection. Be sure to include the different ways in which gender-based violence is linked to HIV infection.
- Culture impacts gender roles, sexual behavioral patterns, and migratory patterns all of which may increase a person’s risk to HIV infection.
- Harmful traditional practices like female genital cutting, widow inheritance, polygamy etc. are some examples of how cultural practices can increase HIV infection.
Gender-based violence can increase HIV vulnerability in many ways including:

- Intimate partner violence: women are afraid of violence if they seek HIV testing.
- Women who are victims of violence and rape are more likely to use condoms inconsistently than women who haven’t experienced violence.
- Women who have been raped have increased sexual risk behaviors.
- Children who have been abused have higher adult risk taking behavior (more sexual partners, earlier sexual debut, less condom use, higher drug and alcohol abuse).
- Rape can be used as a weapon of war and military personnel have higher rates of HIV transmission than the general population.
- Commercial sex workers, trafficked and sexually exploited women and girls, as well as women in economically dependant relationships are often victims of sexual violence and have limited access to health services and HIV information, counseling and testing services.

3) What are some psychological states (or perceptions) and behavioral patterns that may affect a person’s risk to HIV infection?

- Personal Risk perception: whether or not the person considers himself or herself to be at risk, will impact their behavior;
- Ability to negotiate condom use;
- Beliefs about whether or not HIV/AIDS can be cured;
- Attitudes about people living with HIV and AIDS;
- Use of drugs and alcohol;
- Self-esteem levels;
- Number of partners; and
- Age of first sexual intercourse

Handout 1.4 Determinants of HIV/AIDS

Poverty and Economics as a Determinant of HIV Transmission:

There is a by-causal relationship between poverty and HIV/AIDS and HIV/AIDS and poverty. This means that poverty makes individuals more susceptible to HIV infection and once people have been infected with HIV there are also more likely to become impoverished. This creates a vicious cycle of poverty and HIV infection as illustrated in the diagram below.
Some Critical Linkages Between Poverty and HIV Transmission:

- Poverty leads to poor nutrition and poor health, which leads to increased vulnerability to HIV infection.
- Poverty limits access to mass media, sources of information on HIV and AIDS, and HIV counseling and testing services.
- Poverty related migration causes people to spend time away from home where they are more likely to engage in risky unprotected casual or commercial sex.
- PLWHA return to rural areas for care and support which puts undue strain on a family’s food security and increases their poverty.
- There is a clear correlation between the debt crisis of African countries and their HIV prevalence rates.
- As external debt increases so does the prevalence of HIV/AIDS.

Social Factors as a Determinant to HIV/AIDS:

Culture shapes our knowledge, attitudes and behaviors towards many aspects of life including issues like HIV/AIDS. More specifically, culture impacts gender roles, migratory patterns, and sexual practices, among many others, all of which may increase a person’s risk to HIV. Some social determinants to increased HIV transmission include:

Migration:

HIV related vulnerability and risk factors specific to migration include: poverty, separation from family, which can lead to an increase in sexually risky behaviors, lack of legal protection, and lack of access to health information, and HIV counseling and testing services.

For example, in Ethiopia the large extent of seasonal migration in workers and the dislocation of people due to the civil war are considered to be significant contributing factors to the spread of HIV (Kebede et al.).

Harmful Traditional Practices Place Certain Populations at Higher Risk of HIV:

Harmful traditional practices like female genital cutting, scarification, widow inheritance, and polygamy are a few examples of how culture can increase a person’s risk to HIV infection.

Gender-Based Violence Can Increase HIV Vulnerability in Many Ways Including:

- Intimate partner violence: women are afraid of suffering violence from their partners if they seek out HIV testing.
- Many people (men and women) do not disclose their HIV positive status out of fear of violence.
- Women who are victims of violence and rape are more likely to use condoms inconsistently than women who haven’t experienced violence.
- Women who have been raped have increased sexual risk behaviors in their future.
- Children who have been abused have higher adult risk taking behavior (more sexual partners, earlier sexual debut, less condom use, higher drug and alcohol abuse).
- Rape can be used as a weapon of war, and military personnel have higher rates of HIV transmission than the general population.
- Commercial sex workers, trafficked and sexually exploited women and girls, and women in economically dependant relationships are often victims of sexual violence and have limited access to health services, HIV information and testing services.
Psychological Determinants of HIV/AIDS:

It has been proven that higher levels of self-efficacy and self-esteem make it easier to negotiate safe sex and healthy relationships. It has also been reported that a later sexual debut and non-dependence on drugs and alcohol help to minimize HIV transmission.

Some Risk Factors Include:

- Low personal risk perception;
- Lack of self-efficacy in condom negotiation;
- Beliefs about HIV/AIDS and whether or not it can be cured;
- Negative attitudes surrounding HIV and people who might be at risk; and
- The use of drugs and alcohol.

Handout 1.5 Sectoral Impact of HIV/AIDS

**Impacts of HIV and AIDS on the Health Sector:**

- Shortage and over-burden of healthcare services and professionals (leads to staff absenteeism and poor quality of care).
- Increases in healthcare workers lost to AIDS.
- Increased demand for healthcare. AIDS patients occupy almost half of Ethiopia’s hospital beds.
- Increases in healthcare expenditure leads to increases in prices, strained government health budgets and quality of service provision suffers.

**Impact of HIV and AIDS on the Education Sector:**

- Hampers the supply of education;
- Increases education sector costs;
- Decreases pool of educators/teachers/school administrators. “During 1998-2000, AIDS mortality [in Ethiopia] grew by 5 percent among teachers, and a third were absent for one or more weeks due to AIDS-related illnesses or deaths in the family” (PEPFAR report 2005);
- Increases in absenteeism and death among teachers and administrators;
- Decreases access to education;
- Decreases in quality of education provided;
- Girl’s educational enrollment suffers as the burden of care for ill HIV/AIDS patients generally falls on females; and
- HIV related poverty might cause girls to exchange sex for educational advancement.

**Impact of HIV and AIDS on the Agricultural sector and the economy at large:**

- AIDS results in income losses to patient and family
- Increased spending on health leads to depletion of household assets
- Switch from cash crops to food crops.
- Reduction in labor supply, limited crop variety, less land cultivated, less production.
- Loss of traditional farming knowledge
- Loss of household, community, and national income levels.
Handout 1.6 Societal and structural Impacts of HIV and AIDS

**Societal and structural Impacts of HIV and AIDS:**

- Increased populations infected and affected by HIV 1.32 million people are living with HIV in Ethiopia.
- In 2005, AIDS decreased life expectancy by 5 years.
- Population rates are in decline due to AIDS.
- Increased orphans 744,100 in Ethiopia in 2005.
- Orphans are less likely to go to school, have higher illness and malnutrition, and riskier sexual behavior.
- Government budgets become strained by the epidemic and funding is taken from other key issues.
- Fiscal deficit increases.
- HIV disproportionately affects military personnel, which threatens national security.
- Negatively impacting hard earned socio-economic gains and preventing progress on the millennium development goals.
- Great losses in civil society workers (health, ed, environmental etc).
- Losses in social capital, social networks eroding etc.

**Strategies to Minimize the Socio-Economic Impacts of HIV/AIDS:**

- Provide basic education to children and ensure girl’s education.
- Strategic and long-term planning to maintain and replace teachers and healthcare workers.
Handout 2.1 Strengths and Weaknesses of the ABC Approaches

**Abstinence:**

**Strengths:**
- Appropriate for youth;
- 100% protective against HIV infection;
- Allows youth to avoid early pregnancy as well as to plan for their future (educational advancement);
- Youth need information and life skills to enable them to negotiate and maintain positive behaviours;
- Sets positive behavioural patterns for adulthood; and
- Youth who have been sexually active but wish to abstain can also benefit.

Point out that there are absolutely no health disadvantages of abstaining from sexual intercourse. Also note that some people who have had sexual intercourse could also decide to abstain. It is ok to choose not to have sexual intercourse any more. If you decide to return to abstinence, know that:

- it is ok to say no now;
- You should communicate with your partner ahead of time about your decision;
- You have the right to choose to have sexual intercourse or not—even if you’ve had sexual intercourse in the past.

**Weaknesses:**
- Behaviour can be difficult to practice in face of intense peer pressure and desires to experiment sexually; approach does not consider gender imbalance of power in some sexual relationships.

**Being faithful (or reducing number of partners):**

**Strengths:**
- Targets married people & common-law relationships and people with steady partners who may reject condom use; reconciles values for relationships with practices.
Weaknesses:
Must know partner’s HIV status in order for ‘faithfulness’ to provide protection against HIV infection; serial monogamy (series of short-lived, exclusive relationships) common among young people may be perceived as ‘faithfulness’ but is not a safe practice; a woman who is being faithful to an unfaithful husband also needs to be advised to use condoms.

Point out if one or both partners are not faithful to one another, then they should use condoms to protect themselves and their other partners.

Among some groups the practice of negotiated safety has developed. Negotiated safety is when regular sex partners make an agreement that they will not use condoms with each other, but will always practice safe sex in outside relationships.

Condom use:

Strengths:
Can offer protection for anyone who is sexually active; particularly effective strategy for young men, people who practice casual sex, and sex with commercial sex workers.

Weaknesses: Major barriers to use include stigma attached to condom use; misconceptions about effectiveness; relatively high rate of misuse on part of the user.

Handout 2.2 Abstinence, Be Faithful, Condom Use

The ABCs of HIV Prevention

Abstaining from sexual activity, mutual monogamy, and condom use are three key behaviors that can prevent or reduce the likelihood of sexual transmission of the AIDS virus. These behaviors are often included together under a comprehensive “ABC” approach - A for abstinence (or delayed sexual initiation, especially among youth), B for being faithful (or reduction in number of sexual partners), and C for correct and consistent condom use, especially for casual sexual activity and other high-risk situations.

Understanding and effectively promoting these behaviors are crucial elements in combating the spread of HIV and AIDS. Based on a growing body of evidence from a number of developing countries, USAID supports the ABC approach because it can target and balance A, B, and C interventions according to the needs of different at-risk populations and the specific circumstances of a particular country confronting the epidemic.

Background: The Decline of HIV Prevalence in Uganda

As one of the world’s earliest success stories in confronting AIDS - and probably the most dramatic - Uganda experienced substantial declines in HIV prevalence during the 1990s. According to estimates by the U.S. Census Bureau and UNAIDS, national prevalence peaked at around 15 percent in the early 90’s and fell to 5 percent by 2001. Among pregnant women in Kampala, prevalence declined from a high of approximately 30 percent to about 10 percent, while among pregnant women in other areas it fell from more than 10 to less than 5 percent (figure A). Uganda’s vivid decline in HIV prevalence remains unique worldwide. In other sub-Saharan African countries with epidemics of comparable severity and longevity, similar declines have yet to occur. Accordingly, Uganda’s
success has been the subject of intense study and analysis. It appears that Uganda’s decline in HIV prevalence was associated with positive changes in all three ABC behaviors:

- increased abstinence, including deferral and considerably reduced levels of sexual activity by youth since the late 1980s;
- increased faithfulness and partner reduction behaviors;
- increased condom use by casual partners.

The most significant of these appear to be faithfulness or partner reduction behaviors by Ugandan men and women, whose reported casual sex encounters declined by well over 50 percent between 1989 and 1995 (figure B). This conclusion is supported by comparisons with other African countries.

Uganda’s successful combination of ABC strategies was rooted in a community-based national response in which both the governmental and nongovernmental sectors (including faith-based, women’s, and other grassroots organizations) succeeded at reaching different population groups with different messages and interventions appropriate to their need and ability to respond. Young persons who had not yet begun to have sex were cautioned to wait, and if a young person had just begun to have sex, then he or she should return to abstinence. If a person was already sexually active, he or she should adopt the practice referred to locally as “zero grazing” faithfulness in marriage or partner reduction outside of marriage. For those who continued to engage in risky behavior, condom use was urged to reduce their risk.

**Evidence From Other Countries**

While Uganda provides the most dramatic example of the effect of ABC behavior changes on slowing the spread of HIV infection, there is growing evidence from other countries as well. In Thailand, the first Asian country to face a serious AIDS epidemic, prostitution was the main source of HIV infection. In the early 1990s, the government instituted a “100 percent condom use” policy in brothels, which was widely credited with sharply reducing the spread of HIV infection.

Between 1990 and 1995, the proportion of men reporting paying for sex declined by more than 50 percent (figure C). In this more concentrated epidemic, therefore, partner reduction along with condom use for commercial sex undoubtedly had a substantial effect on slowing HIV transmission. As in Uganda, the government’s willingness to address the epidemic openly was also essential.

Zambia, Cambodia, and the Dominican Republic are other countries in which various combinations of ABC behavioral changes appear to have contributed to declines in HIV prevalence. In Zambia, a decline in prevalence seems to have occurred among urban youth during the 1990s, during which time national surveys reported clear, positive changes in all three ABC behaviors. The grassroots involvement of faith-based and other community based organizations was crucial in promoting these changes. As occurred in Uganda, the main reported change was a large decline in casual sex among both men and women.

Cambodia is replicating Thailand’s success in applying a 100 percent condom policy in brothels. Similar to Thailand, the country has experienced a steep decline in the number of men paying for sex (from 27 to 11 percent between 1996 and 2000). In the Dominican Republic, partner reduction by men and increased condom use with prostitutes and other non-regular sexual partners also appear to have slowed the spread of HIV.

**Communication Strategies for HIV/AIDS**
Balancing and Targeting a Comprehensive ABC Approach

The findings of a recent extensive review of survey data are consistent with the need for appropriately balanced and targeted ABC approaches. This study analyzed how ABC behaviors appear to have affected HIV prevalence in three developing countries where prevalence declined (Uganda, Zambia, Thailand) compared to three countries where there had been little evidence of a decline (Cameroon, Kenya, Zimbabwe). In the case of the five African countries, it found that significant delays in the onset of sexual activity, declines in premarital sex, and large declines in extramarital sex and multiple sexual partnerships occurred in Uganda and Zambia during the 1990s, while comparable changes did not occur in Cameroon, Kenya, or Zimbabwe. Condom use increased greatly in all of the countries.

In September 2002, USAID hosted a meeting of technical experts from HIV and AIDS programs and research institutions to consider the evidence regarding ABC behavior change approaches to HIV prevention. The meeting identified areas of consensus that may have important implications for program planning and decision-making:

- There is a clear need for a balance of A, B, and C interventions. Approaches should be combined as appropriate based on the local cultural context as well as the state of the AIDS epidemic. In Southeast Asia, HIV is still largely confined to high-risk populations, in which correct and consistent condom use is relatively easy to implement. In many African countries, the epidemic is more generalized and thus requires an appropriate mix of A, B, and C approaches.

- Interventions need to be targeted for efficiency and respond to crucial differences among target groups. For example, balanced ABC approaches might be implemented in the form of A interventions emphasizing sexual deferral to youth; B interventions promoting partner reduction to those not in monogamous relationships; and C interventions promoting condom use to highly sexually active groups, especially sex workers and their clients, as well as people living with HIV and AIDS.

- Political leadership and community involvement is key. There is a critical need for government and community leaders to promote open communication about the problem of HIV and AIDS, address stigma, help empower women and girls to avoid sexual coercion, and develop a multi-sectoral response to enhance the success of ABC behavior changes.

- Partner reduction is emerging as a key element of successful HIV prevention. Amid the debate over abstinence versus condoms, partner reduction and fidelity have been an often-neglected component of behavior change efforts. Yet, as suggested by the experience of the very different epidemics in Uganda and Thailand, “B” could become the centerpiece of a unifying, evidence-based ABC approach. As partner reduction becomes an expected “normative” collective social behavior (as seems to have occurred in both Uganda and Thailand), the impact of B could become even more significant in many countries.

- Further research is needed. Continuing studies in other countries will yield more evidence of the most effective balance of ABC approaches in different settings. Senegal, for example, has achieved Uganda-like Behavior change with a balanced ABC program in a low-prevalence setting. Further study of such successes is needed to consider their potential application elsewhere.

The USAID meeting also noted that the ABC approach to HIV prevention has ample room for the
participation of a diverse range of partners in the global fight against HIV and AIDS. The approach helps clarify the complementary roles of program partners in overcoming the epidemic, and all partners - governments, international organizations, donor agencies, faith-based and other non-governmental organizations, and many others - can contribute to ABC programming according to their particular organizational orientation, capacity, and strengths. This enhanced collaboration will serve to broaden the ABC strategy and maximize its impact across a wide spectrum of program and national needs.

Handout 2.3 Correct Condom Use

Condoms

- **Most penises are not too big or too small for a condom.** Condoms can be stretched to fit over a forearm. (Facilitator should blow up a condom like a balloon and tie it in a knot).

- **Condoms do not leak unless torn by the user and the virus (HIV) cannot get through.** Have one person hold the condom and the facilitator pours a bottle of water into it. Tie it up and put it aside. Tell the participants to check it tomorrow and see that it has the same amount, and that it hasn’t leaked."

- **Condoms do not eliminate sensation, although they do change it.** Remind participants that the idea of sex and sexual pleasure is in the mind and the pleasure from the sex act, with the man wearing a condom, can be just as great and rewarding. Also note that since partners get pleasure from knowing they are protecting each other from STIs and HIV infection as well as an unintended pregnancies.

- **Asking a partner to use a condom does not mean you do not trust them.** You are making a responsible statement about both of your futures by using condoms.

- **Most condoms are lubricated.** However, if extra lubrication is desired, use a water-soluble lubricant such as KY Jelly. Water and saliva are good substitutes. *Never* use petroleum jelly products such as Vaseline and body lotions because they can cause the condom to tear tiny holes that you can’t see but still let the virus through.

- **Condoms are tested thoroughly and should not break with proper use and storage prior to use.** Never leave condoms in warm places like on a windowsill or in a wallet in your back pocket or under a fluorescent light. All these places will accelerate condom deterioration.

- **Emphasize that even when condoms are used, if they are not used correctly and consistently each time a person has sex, a pregnancy or an STI may occur.**

How to use a condom correctly:

- **Check expiration date to make sure condom is still good.**

- **Open the package carefully.** Be careful of long fingernails tearing the latex;

- **Hold tip of condom, squeeze out the air and roll it down over penis model;**

- **Roll the condom down to the base of the model.** Be sure you leave a reservoir at the tip, so
that the ejaculated semen can be captured there;

- Explain that once ejaculation has occurred, withdraw from your partner;

- Be sure to hold the base of the penis model (explain that to prevent spilling of the semen, the condom must be held at the base while withdrawing from the partner’s body). The condom should be removed before the penis goes limp;

- Remove the condom, tie it in a knot, wrap it in tissue or other paper, and discard it in a place where children will not find or play with it.

**Handout 2.4 HCT Case Studies**

1) A young married couple has been married for two years and has been faithful to one another throughout the entirety of their marriage. The young couple does not use condoms when they have sex, as they are in a committed relationship and are faithful to one another. The wife is pregnant with their first child.

   1) Are these people at risk to HIV infection? Why?
   2) If they haven’t been tested, should they be tested for HIV? If so, why?
   3) What are some of the reasons and/or benefits for them to seek testing?

Yes these two may be at risk to HIV infection. While they may be faithful to each other during their marriage we do not know the sexual history of either person before marriage. They could have had unprotected sex with others prior to this relationship.

It is especially beneficial for the women to get tested for HIV. Because if she is HIV+ she can be counseled on the modes of mother-to-child transmission of HIV as well as receive antiretroviral drugs in order to prevent the transmission of HIV to their child.

2) A twenty year-old girl named Mare has been dating the same boy, Mesfin, for the last three years. Mesfin is the only boy Mare has ever had sexual intercourse with and she is faithful to him. When they have sex they use condoms fairly consistently, but not every time. Unfortunately for Mare, Mesfin has several sexual relationships on the side without Mare’s knowledge (including some visits to commercial sex workers when he goes out of town for the weekend). He does not always use condoms with his non-regular sex partners.

   1) Are they at risk for HIV infection? Why?
   2) If they haven’t been tested, should they be tested for HIV? If so, why?
   3) What are some of the reasons and/or benefits for them to seek testing?

Yes, they may both be at risk of HIV infection. Even though Mare believes Mesfin to be faithful, and vice versa, neither one can be one hundred percent sure that the other is faithful. It is better to get an HIV test and be sure! Even if you have sex once without a condom you can be at risk of HIV infection.

3) A couple that has been dating each other for a few months decides to take their relationship to the next level and have sexual intercourse. They decide to play it safe and get an
HIV test before they have sex. When the results of the HIV test come back they find out that one of them is HIV+ while the other is HIV- (this is what we call a “discordant couple”).

Q: As a counselor or a friend what advice would you give this couple and why?

- First you should congratulate them on their initiative to get an HIV test and to be safe. This shows they really love and respect each other.
- They should be advised to have protected sex every time they have sexual intercourse (if they decide not to abstain from having sex).
- You should be sure to demonstrate correct condom use.
- Give advice on healthy living including good nutrition, exercise, stress management, ART adherence and opportunistic infection control.
- Advise HIV- person in the couple to get regularly tested for HIV and how to remain negative.
- Advise HIV- person on how to provide psychosocial support for their HIV+ partner.
- Make sure you restate the definition of “Discordant Couple” and make sure that it is understood by all.

Handout 2.5 Counseling and Testing

Effective counseling and testing calls for discretion and sensitivity to a nervous or embarrassed client. It is therefore essential that there is an appropriate physical environment for comfort, privacy, and confidentiality; good client reception, greeting and introduction; rapport, respect, interest and empathy; non-judgmental attitude; and engagement of the client in conversation.

Other skills a counselor requires include active listening (verbal and non-verbal); emotional warmth and support; sensitivity to and accommodation for language barriers; talking about sensitive issues plainly and appropriately to the client; and flexibility to involve partner(s) when appropriate or requested.

HIV Tests

There are currently two main types of HIV tests:

a) Antibody tests (e.g., ELISA, simple/rapid, saliva and urine, and Western blot);

b) Virologic tests (e.g., HIV antigen test, polymerase chain reaction test, and viral culture).

Antibody Tests

HIV antibody tests look for antibodies against HIV; they do not detect the virus itself. When HIV enters the body, it infects white blood cells known as T4 lymphocytes, or CD4 cells. The infected person’s immune system responds by producing antibodies to fight the new HIV infection. Presence of the antibodies is used to determine presence of HIV infection.

The most commonly used antibody tests are the enzyme immune assay (EIA) or ELISA, including the rapid HIV test. The less commonly used Western blot antibody test is used mainly in industrialized countries to confirm a prior test. The Western blot is better than other tests at identifying HIV infection, but is more expensive than other tests. In addition, the radioimmununoprecipitation assay (RIPA), a confirmatory antibody test, is used when antibody levels are very low or difficult to
detect, or when results of the Western blot are uncertain. RIPA is an expensive test and requires time and expertise to perform.

**Rapid HIV Testing**
Rapid tests usually produce results in five to 30 minutes. Some of these tests do not require a blood sample from the client. HIV tests based on urine or oral fluid samples offer an alternative to blood-based tests.

Testing urine for HIV is not as sensitive or specific as testing blood. Available urine tests include the EIA and the Western blot, which can confirm the EIA results. These tests must be ordered by a physician. Results usually are sent back to the ordering physician or his or her assistant.

Saliva-based tests (e.g., OraSure HIV-1) collect oral fluid, which is tested for the presence of HIV antibodies. A trained specialist usually collects the sample from between the lower cheek and gum. Testing an OraSure HIV-1 specimen for HIV antibodies is accurate, but testing blood is more accurate. When both tests are available, clients may be allowed to choose.

**Virologic Tests**
The antibody tests discussed above are the most commonly used in HCT settings. But under special circumstances (e.g., in a recently infected individual, during the window period, or in the case of a child born to an HIV-positive mother), more direct diagnostic methods may be used. Unlike antibody tests, virologic tests determine HIV infection by detecting the virus itself. There are three virologic (direct) tests:

- Viral antigen detection test (also known as the P24 antigen test);
- Nucleic acid-based tests (specialized tests that look for genetic information on HIV using polymerase chain reaction or PCR);
- Virus culture, which isolates the virus.

Virologic tests are rarely used to diagnose HIV in developing countries since they require sophisticated laboratories. But they may be used to monitor progress of infection or response to therapy (e.g., by measuring viral load).

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**The “Window Period”**
In some cases, HIV tests may come back negative, even though the person is infected with HIV. This can happen during the “window period,” the time between initial HIV infection and when the body builds a measurable immunologic (antibody) response to it. During the window period, HIV is not detected by most HIV tests though it is replicating in the blood and lymph nodes. The virus can be detected during this phase only by laboratory tests used to identify the virus itself.

The window period can last from as little as two weeks to as long as six months. Thus, if a person tests negative to HIV antibody tests, one possible explanation is that they are still in the window period, in which their immune system has not yet begun making antibodies to the virus. A person in the window period will only test positive for HIV if a virologic test is used.
Pre-test Counseling

In pre-test counseling, the counselor should as much as possible help clients to decide whether or not to be tested and to address the following issues:

• Reason for coming for HIV testing
• Knowledge of HIV and transmission and misconceptions
• Assessment of personal risk profile
• The test process itself
• The meaning of the result and implications (who to inform)
• Coping with test results
• Development of personal risk reduction plan
• Potential needs and available support
• Informed consent/dissent given freely

This flowchart shows the process of pre-test counseling and testing.

Pre-test Counseling and Testing
Getting Test Results

HIV Test Results
Negative: A negative test result indicates that no antibodies to HIV were detected in the blood.

This result can have one of two meanings:

∑ The person may not be infected with HIV.

∑ The person may be infected with HIV, but his or her body has not had time to produce antibodies to the virus. In this case, the person is in the window period.

A negative test result means that HIV antibodies were not detected in the person’s serum sample, either because the person is not infected or because the person is still in the window period. It is imperative that the client understands that a negative result does not mean that the person is uninfected or immune to HIV infection. An HIV-negative person is still vulnerable to HIV infection if he or she engages in risky behavior. A person who tests negative but has practiced safe behaviors during the window period may be (or become) infected with HIV and infectious to others.

Positive: A positive test result indicates that antibodies to HIV were detected in the person’s blood. This result indicates the person has been infected with HIV; it does not necessarily mean the person has AIDS. A positive test result means that HIV antibodies were detected in the person’s serum sample. It means the person is infected with HIV and that he or she can transmit the virus to others if he or she engages in risky behaviors. It does not necessarily mean the person has AIDS.

Indeterminate: An indeterminate test result means one of the following:

∑ The person may be infected with HIV and in the process of developing antibodies to it (acute seroconversion).

∑ The person has antibodies in his or her blood that are very similar to antibodies to HIV. These antibodies are reacting to the HIV test.

An indeterminate test result means that the presence or absence of HIV antibodies could not be confirmed. This means one of three possibilities:

∑ The person may be in the process of sero-converting.

∑ The person might have had an earlier inoculation that is cross-reacting with the HIV antibody test (cross-reactivity does not necessarily mean HIV is present).

∑ The person may have a prior medical condition that is affecting the test (for example, arthritis or autoimmune problems).

HIV tests have been developed to be especially sensitive. Consequently, a positive result may be obtained even when there are no HIV antibodies in the blood. This result is known as a “false positive.” Because of this possibility, all positive results must be confirmed by another testing method. False positives have many causes, including:

∑ Technical errors,
∑ Serologic cross-reactivity,
∑ Repeated freezing and thawing of specimens,
∑ “Stickiness” of stored sera in malaria-endemic regions in Africa.

HLA cellular antigens may cross-react and cause a false positive on an ELISA or rapid HIV test. There is risk of false positive results in persons with:

- Rheumatoid arthritis;
- Multiple sclerosis;
- Systemic lupus erythematosus;
- Type I diabetes mellitus;
- Addison’s disease;
- Ankylosing spondylitis;
- Chronic hepatitis;
- Cancer (particularly lympho-proliferative malignancies);
- Severe kidney disease.

And in persons who have had a:

- Flu shot within the past 30 days;
- Gamma globulin injection;
- Recent transfusion or organ transplant

Confirmatory tests usually rule out false-positive results. A false negative occurs in an infected person when the blood tested gives a negative result for HIV antibodies, even though it should have showed positive. The likelihood of a false-negative test result must be discussed with clients if their history suggests they have engaged in behavior likely to put them at risk of HIV infection.

Repeated testing over time may be necessary before the client can be reassured that he or she is not infected with HIV. The most frequent reason for a false-negative result is that the individual is newly infected and is not yet producing HIV antibodies.

The benefits of knowing one’s HIV status
At Individual level

- Creates more realistic self-perception of client’s vulnerability to HIV;
- Promotes or maintains behaviors to prevent acquisition or further transmission of HIV;
- Alleviates anxiety, and facilitates understanding and coping;
- Facilitates entry to interventions to prevent mother to child transmission of HIV;
- Helps client to plan and make informed choices for the future;
- Leads to early referral to HIV specific clinical care, treatment, and support.

At community level

- Creates peer educators, and mobilizes support for appropriate responses;

Communication Strategies for HIV/AIDS
• Reduces denial, stigma and discrimination and normalizes HIV and AIDS.

The most difficult part of learning one’s status is deciding whether or not to disclose their status to family, friends, and/or partner(s). There is no right or wrong thing to do. Some individuals disclose while others do not. However, it is important for the client to understand the consequences of his/her decision and the new behavioral limitations s/he will face if the test result is HIV positive.

Post-test counseling
The aim of post-test counseling is to help clients understand and emotionally accept their test results. During a post-test counseling session with an HIV positive client, the counselor should address the following:

∑ Referral for follow-up care and support;

∑ Importance of taking care of ones health and seeing a doctor immediately even for minor illnesses;

∑ Need to maintain ideal weight by eating a balanced diet, preventing diarrhea diseases, exercising regularly, and taking rest;

∑ Importance of practicing safer sex to avoid infecting ones partner by (personalized risk reduction plan);

∑ Importance of protect unborn child if ones partner is pregnant.

Positive clients should be encouraged to make a short term coping plan, share it with a spouse or partner and return to discuss it with the counselor. Positive clients are encouraged to make a risk reduction plan as well.

Clients should be asked to make a risk reduction plan.

∑ The counselor asks the client to propose some ideas about how to reduce his or her risk of HIV exposure;

∑ The counselor may initiate a discussion of risk reduction by listing several alternative risk reduction strategies for the client to consider.

∑ For each risk-reduction behavior, the counselor assesses internal and external obstacles to change, perceived efficacy in enacting the new behavior, readiness to change, and availability of resources to support change.

∑ In supporting a client to enact his or her personalized risk-reduction plan, the counselor acknowledges and supports the client’s strengths (e.g., social support, self-efficacy, previous success in changing behavior) and assists problem solving in areas of concern or expected difficulty.

∑ If condom use is part of the risk-reduction plan, the counselor asks the client to tell what he or she knows about condoms and invites the client to practice putting a condom on a penis/vagina model before the counselor conducts the condom demonstration.

∑ If the client does not mention condoms, the counselor may introduce the subject, whether or not the client is planning to use them.
The counselor elicits a commitment from the client to try to implement specific behavioral changes before the next counseling session.

Post-Test Counseling for the Sero-negative Client
Post-test counseling for an HIV negative client should address the following:

- The challenges of remaining negative
- Negotiation and persuasion skills to encourage the partner(s) to go for HCT and to practice safer sex
- The promotion and advocacy of the female condom if appropriate.
- The importance of being tested periodically.

Negative clients should be encouraged to return for testing. Clients whose results are indeterminate should be told to practice safe sex and prevent the transmission of the virus in case they have it.

Handout 3.1 Positive Prevention Issues

Handout 3.2 Case Study-Positive Prevention

Taken from: Positive Prevention: HIV Prevention for People Living with HIV-A Guide for NGOs and Service Providers, AIDS Alliance, 2007

Handout 3.3 Prevention of Mother to Child Transmission of HIV

Prevention of mother-to-child transmission of HIV has become an important intervention in the prevention and control of HIV and AIDS in developing countries, with commitment being made to improve maternal and child health and survival.

In recent years, MTCT rates have fallen to as low as 2% to 5% of births among HIV-infected mothers in developed countries. This reduction in transmission was made possible by the intro-
duction of comprehensive services including HIV counseling and testing, antiretroviral therapy, elective caesarean section delivery, and the safe use of infant feeding formula instead of breastfeeding. In Africa where these interventions have generally not been available and prolonged breastfeeding is the norm, about 25-35% of HIV-infected mothers pass on HIV to their infants.

The severity of the MTCT problem in Sub-Saharan Africa is due to high rates of HIV infection in women of reproductive health, a large total population of women of reproductive age, high birth rates, and the lack of effective MTCT prevention interventions.

MTCT prevention requires more than provision of drugs and commodities. Systems must be strengthened and communities need to be prepared for these programs. Therefore, commitment to providing a range of core MTCT interventions is required to reduce the incidence of MTCT of HIV.

AIDS related deaths are reversing gains made in child health and survival. Caring for HIV infected children carries heavy costs for families and health systems. At the national level, preventing MTCT has the potential to increase the understanding and acceptance of the HIV and AIDS epidemic and those living with HIV and AIDS. Counseling, testing and community sensitization can contribute to reducing stigma.

The benefits of PMCT include:

∑ It can promote behaviour change
∑ It can encourage the use of dual methods of family planning
∑ There is improved antenatal care (attending 4 times)
∑ Infant feeding options can be discussed
∑ It promotes access to early medical care
∑ ARVs
∑ STD treatment
∑ Malaria treatment
∑ TB therapy
∑ Obstetric care
∑ It enables preventive therapy
∑ Gives time to plan for the future e.g. infant feeding support systems

Reduction of MTCT of HIV:

∑ Decreases numbers of HIV infected children;
∑ Increases child health and survival;
∑ Decreases the load on the health system;
∑ Gives an opportunity to improve, expand health services and strengthen the health infrastructure.

Breastfeeding transmission of HIV

In Africa, 3 to 4 out of every 10 infants born to an HIV infected woman acquire HIV infection. Thirty to 50% of these infants acquire infection thorough breastfeeding. Overall _ of the breast milk transmission takes place by 6 weeks, and _ by 6 months. The standard in infant feeding is breast milk. Babies should be exclusively breastfed for the first 6 months of life. There is early evidence that mixed feeding increases the risk of breast milk transmission of HIV.

In most cases, the pregnant woman will not have HIV infection, and this reassuring news offers an opportune time to discuss prevention of HIV infection. Knowing the HIV infection status of the
partner is also critical. Only by knowing a person’s HIV status can the health worker make appropriate health care management recommendations and the pregnant woman make appropriate decisions about maintaining her health.

Figure 1: Guidelines for counselling on HIV and infant feeding

1. What should a pregnant woman who is HIV positive understand about the risks of breastfeeding her newborn child? What alternatives are there in your community for women who cannot breastfeed?

Notes on breastfeeding:

∑ Breastfeeding carries a risk of HIV transmission to the infant.

β Women with HIV infection have the virus in both their blood and breast milk.

∑ The risk of transmission increases if the mother becomes infected with HIV while breast-feeding, as the HIV virus is active throughout the body during the initial infection.

β If HIV positive women have access to breastfeeding alternatives and the means to use them, the risk of death and illness from HIV and other infections can be kept to a minimum.

β If breastfeeding alternatives are not available, then it is better to breastfeed the infant than to use suboptimal feeding practices.

∑ If an HIV positive woman is breastfeeding, then she should:

β Practice exclusive breastfeeding for the first six months. This reduces the risk of transmission.

β Stop breastfeeding if complications develop (e.g., mastitis-breast-related inflammation or cracked and bloody nipples) from poor breastfeeding techniques, as this increases risk of transmission.

∑ Stop breastfeeding after six months, as the risk of HIV transmission increases at that point and
the risk may be greater than the benefits of breastfeeding.

∑ If no other options are available for infant feeding, women should continue breastfeeding, seek prompt treatment for any breast problems, and treat any case of thrush (open soars in mouth) in the infant.

2. Why is it important for a woman to be seen by a trained health care provider early in her pregnancy?

∑ Early prenatal care can ensure that a woman learns of her HIV serostatus. If she is infected with HIV, she can plan accordingly for delivery (C-section if possible) and seek early intervention for any health problem that arises during pregnancy. She also can learn about the risks of breastfeeding and plan accordingly.

β Note that many women give birth at home. Family members and pregnant women themselves can help reduce the chance of HIV transmission during home delivery by using sterile instruments and following good hygiene practices.

3. What are some of the challenges facing prevention of mother-to-child transmission programs?

β Men (resistant to women accessing testing)
β Stigma (fear of discrimination)
β Couple cooperation and communication
β Health illiteracy (lack of knowledge of services)
β Desire for children

THE CASCADING DECLINE IN ACCEPTANCE OF PMTCT SERVICES:

1) First you have to get pregnant women to utilize existing ANC services;
2) Then you have to get them to accept HIV counseling;
3) Then they have to accept to get tested for HIV;
4) Then you have to get them to return for their test results; and
5) Then you have to get them to accept ARV and achieve 100% compliance with their medication.

Handout 3.4 Nutrition and HIV and AIDS

Healthy and balanced nutrition will improve the quality of life of people living with HIV and AIDS, by:

∑ Maintaining body weight and strength;
∑ Improving the function of the immune system and the body’s ability to fight infection;
∑ Extending the period from infection to the development of the AIDS disease;
∑ Improving response to treatment, reducing time and money spent on health care;
∑ Keeping HIV positive people active, allowing them to work, take care of themselves, their family and their children.
People with HIV and AIDS often do not eat enough because:

∑ The illness and the medicines taken for it may reduce the appetite, modify the taste of food and prevent the body from absorbing it;
∑ Symptoms such as a sore mouth, nausea and vomiting make it difficult to eat;
∑ Tiredness, isolation and depression reduce the appetite and the willingness to make an effort to prepare food and eat regularly;
∑ There may not be enough money to buy food.

One of the possible signs of the onset of clinical AIDS is a weight loss of about 6-7 kg for an average adult. When a person is already underweight, a further weight loss can have serious effects. A healthy and balanced diet, early treatment of infection and proper nutritional recovery after infection can reduce this weight loss and reduce the impact of future infection.

Ways to improve the appetite:

∑ Taking smaller meals; eating when hungry rather than waiting for mealtime;
∑ Rinsing the mouth before eating to make the food taste fresher;
∑ Eating with family and friends, socializing;
∑ Taking in fluids such as water, soup, milk, yoghurt, herbal teas or juices throughout the day;
∑ Decreasing the amount of fluid taken at meals to allow more room in the stomach for food;
∑ Eating in a well-ventilated room away from smells of cooking; and
∑ Avoiding alcohol – it reduces appetite and affects medications.

Foods that can boost one’s immunity, eating a balanced diet that includes the following food groups:

Foods rich in carbohydrates:
∑ Grains (e.g., corn, wheat, millet, sorghum, rice, barley), potatoes, sweet potatoes, cassava, yam, beans and peas are rich in carbohydrates (starches and sugars). Carbohydrates provide the body with energy, and they are usually inexpensive and easy to digest.

Foods rich in fats:
∑ Oils, butter, margarine, fatty meats and poultry, fatty fishes, peanut butter, nuts, and seeds are rich in fats. Like carbohydrates, fats provide the body with energy, but they can be harder to digest than carbohydrates.

Foods rich in protein:
∑ Meat, chicken, liver, fish, ants, caterpillars, dairy products, eggs, beans (soy and others), lentils, nuts, peanuts, peas, and seeds are all rich in proteins. Proteins help build and repair the body and play an important role in immune function. Vegetable proteins should be combined with other sources, such as beans and rice.

Foods rich in vitamins and minerals:
∑ Vegetables (spinach, cabbage, tomatoes, pumpkin, etc.) and fruits (mango, orange, banana, papaya, lemon etc.) provide the body with vitamins and minerals. There are at least 17 vitamins and 14 minerals, each with a special use in the body. Each vegetable or fruit is rich only in a few vitamins or minerals, so it is important to eat a variety. Generally, dark green and orange or red vegetables and fruits are best.
What advice would you give to a person living with HIV or AIDS on how to live positively?

∑ There are things you can do to stay healthy for a longer period of time, such as eating a balanced diet, getting enough sleep, exercising, and staying connected to family and friends.

∑ It is important to follow the advice of the health care provider and to follow your treatment plan.

∑ Practicing safe sex (using a condom) with your partner can protect him or her from getting the virus.

∑ You do not have to worry about transmitting the virus via everyday activities, such as sharing food, shaking hands, hugging, etc.

What advice would you offer to a concerned individual who wants to know what he or she can do to help a PLWHA?

∑ Spend time with the person and invite him or her out.

∑ Discuss the foods they need to maintain and gain weight and manage their illness. Get to know what kind of foods they like and do not like. Involve them in planning their meals.

∑ Check the medicines they are taking. Read the instructions to find out when they need to be taken, what foods to be avoided and any side effects.

∑ Keep a watchful eye. Look around to see if the house is clean, that there are no hygiene problems and there is enough food.

∑ Do not coddle or over care for someone just because they are living with HIV/AIDS, this is also a form of stigma.

∑

What advice would you give to the primary caretaker of a PLWHA?

∑ Be sure to take of yourself (good nutrition, getting enough sleep and exercise, spending time with friends) or you will not be able to care for yourself, your family, and the PLHA.

∑ Understand that HIV cannot be transmitted via food or water, or by sharing utensils, or by hugging or shaking hands or other normal body contact.

∑ Visit the health facility or community clinic to find out what resources are available to help you and the person living with HIV and AIDS.

The HIV virus attacks the immune system. In the early stages of infection a person shows no visible signs of illness but later many of the signs of AIDS will become apparent, including weight loss, fever, diarrhea and opportunistic infections (such as sore throat and tuberculosis).

Nutrition education at this early stage gives the person a chance to build up healthy eating habits and to take action to improve food security in the home, particularly as regards the cultivation, storage and cooking of food.

Good nutrition is also vital to help maintain the health and quality of life of the person suffering
from AIDS. Infection with HIV damages the immune system, which leads to other infections such as fever and diarrhea. These infections can lower food intake because they both reduce appetite and interfere with the body’s ability to absorb food. As a result, the person becomes malnourished, loses weight and is weakened.

One of the possible signs of the onset of clinical AIDS is a weight loss of about 6-7 kg for an average adult. When a person is already underweight, a further weight loss can have serious effects. A healthy and balanced diet, early treatment of infection and proper nutritional recovery after infection can reduce this weight loss and reduce the impact of future infection.

A person may be receiving treatment for the opportunistic infections and also perhaps combination therapy for HIV; these treatments and medicines may influence eating and nutrition. Good nutrition will reinforce the effect of the drugs taken.

During this period the family will have the burden of caring for the sick person, paying for health care and absorbing the loss of earnings while the ill person is unable to work. In addition, good nutrition can help to extend the period when the person with HIV and AIDS is well and working.

Food can neither cure AIDS nor treat HIV, but it can improve fitness and quality of life for PLHA. Food is important for everyone. Familiar foods make us feel safe and secure. Food reminds us of our childhood, home country and culture. We celebrate events by eating special foods in the company of people who are important to us. When we eat well we feel well.

Food provides the energy and nutrients that our bodies need to:

Σ Stay alive, move and work;
Σ Build new cells and tissues for growth, maintenance and repair;
Σ Resist and fight infections.

When the body does not get enough food, it becomes weak and cannot develop or function properly.

Eating an adequate and balanced diet can help maintain body weight and muscle mass and improve immune function. To understand what constitutes healthy food, it is important to learn about nutrient composition. Food can be divided into four groups, according to its dominant nutrient content: carbohydrates, fats, proteins, and vitamins and minerals.

Foods rich in carbohydrates
Grains (e.g., corn, wheat, millet, sorghum, rice, barley), potatoes, sweet potatoes, cassava, yam, and legumes (beans and peas) are rich in carbohydrates (starches and sugars). Carbohydrate-rich foods provide the body with energy, and they are usually inexpensive and easy to digest.

Foods rich in fats
Oils, butter, margarine, fatty meats and poultry, fatty fishes, peanut butter, nuts, and seeds are rich in fats. Like carbohydrates, fats provide the body with energy, but they can be harder to digest than carbohydrates.

Foods rich in proteins
Meat, chicken, liver, fish, ants, caterpillars, dairy products, eggs, beans (soy and others), lentils, nuts, peanuts, peas, and seeds are all rich in proteins. Proteins, which are made up of amino acids, help build and repair the body and play an important role in immune function. Consuming animal
proteins provides the range of amino acids the human body needs; individual vegetable proteins do not. Thus, vegetable sources of protein should be varied or combined with other sources. An example of a good combination is legumes and grains.

Foods rich in vitamins and minerals
Green leafy vegetables (including cabbage, green beans and peas, tomatoes, pumpkin and other squash, carrots and avocados) and many fruits (pear, mango, orange, guava, banana, mulberry, baobab, peach, pineapple, apple, paw-paw, plum, passion fruit, and lemon) provide the body with vitamins and minerals. There are at least 17 vitamins and 14 minerals, each with a special use in the body; the body cannot work properly if any of these are missing. Each vegetable or fruit is rich only in a few vitamins or minerals, so it is important to eat a variety (varied in color, shape, and botanical function—leaves, fruits, and roots). Generally, dark green and orange or red vegetables and fruits are best.

Balanced Diet
Good nutrition requires a balance of proteins, fats, carbohydrates, and vitamins and minerals. No single food contains every nutrient. A healthy meal is made up of at least one food item from each of the four food groups.

Food Safety
It is important to avoid ingesting food-borne bacteria and parasites, especially because PLHA are 20 times more likely to contract illnesses from these pathogens than are people without HIV.

Food and Diarrhea in People Living with HIV and AIDS
PLHA, especially those who are in advanced stages of HIV and AIDS, often experience diarrhea. The main causes are infection (viral or bacterial), poor nutrition, and mal-absorption (improper absorption of food in the digestive tract). Proper nutrition can play an important role in both minimizing the causes of diarrhea and treating it. Selecting foods carefully and following the foregoing guidelines for food handling can reduce the risk of infection-related and mal-absorption-related diarrhea significantly.

If diarrhea does occur, practical steps can be taken to prevent dehydration (the biggest danger of severe diarrhea) and/or malnutrition (the biggest danger of long lasting diarrhea).

Handout 3.5 Caring for a Person with HIV and AIDS

The caregiver looking after a person with HIV and AIDS may be a member of the family or, if the person lives alone, a neighbor, relative or friend. It is not easy to care for a person with HIV and AIDS and whoever grows, prepares, cooks food and serves it to a person with HIV and AIDS needs support. The task involves meeting the needs of the sick person and balancing these with the needs of other members of the family. Too much help may be overprotective and take away the dignity, independence and self-respect of the person with HIV and AIDS while too little help may not provide the support that is needed to ensure that the person eats well and has the strength to resist infection.

RECOMMENDATIONS FOR CARERGIVERS:

Spend time with the person living with HIV and AIDS. Discuss the foods they need to maintain and gain weight and manage their illness. Get to know what kind of foods they like and do not like. Involve them in planning their meals.

Keep an eye on their weight. If possible, weigh them regularly and keep a record. Look out for any
unexpected weight loss and take action.

Check the medicines they are taking. Read the instructions to find out when they need to be taken, what foods to be avoided and any side effects.

Be encouraging and loving. If people want to have food of their choice at any time of the day, try to get it for them. They may suddenly stop liking a food, refuse what has been prepared and want something different. They are not trying to be difficult. These sudden changes in taste are a result of their illness.

Be firm about the importance of eating and encourage them to eat frequently, but do not force them to eat. Giving them too much food at one time may cause them to refuse.

If they are too sick to leave their beds, make sure that they have something to drink and a snack nearby.

Keep a watchful eye. Look around to see if the house is clean, that there are no hygiene problems and there is enough food.

If the sick person lives alone, invite them to join your family for a meal.

Encourage others in the community to visit them and invite them out.

Caregivers will have their own concerns and worries, fears for the future, for their families and for their own health. It is important that they take care of themselves, get enough rest and have the appropriate information and support to carry out their difficult task. The important messages given below cannot be emphasized enough.

Handout 3.6 Common Ailments and Treatments for People Living with HIV/AIDS

DIARRHOEA:

® Drink lots of fluids (non-alcoholic) to prevent dehydration.
® Eat soft, mashed, liquid foods that are easy to eat and swallow, like porridge and soup.
® Eat small meals five or more times a day.
® Eat food that is low in fat.
® Eat food high in carbohydrates to provide energy (e.g., rice, potatoes, maize, bread).
® Eat soft fruits and vegetables, such as banana, watermelon, and potatoes.
® Avoid milk and milk products.
® Avoid acidic fruits and vegetables, including onions, tomatoes, and pineapple. Do not use “hot” spices.
® Prepare fresh food from fresh ingredients.

NAUSEA AND VOMITING:

® Sit up when eating. Try not to lie down until one or two hours after eating.
® Drink plenty of fluids after meals.
® Try not to prepare food yourself. The smell of preparing or cooking food may worsen the feeling of nausea.

SORE MOUTH: