Counsellor's Reference Guide

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ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti – Retroviral Therapy
ARV	Anti- Retroviral Drugs
AZT	Azidothymidine (Zidovudine)
BCC	Behaviour Change Communication
BSS	Behaviour Surveillance Survey
CA	Community Agents
CBO	Community Based Organization
CDC	Centres for Disease Control
CHAMP	Comprehensive HIV and AIDS Management Programme
CHW	Community Health Worker
CHS	Community Health Services
CSH	Communication Support for Health
CMV	Cytomegalovirus
DHMT	District Health Management Team
DATF	District AIDS Task Force
FBO	Faith Based Organization
FSW	Female Sex Worker
GBV	Gender Based Violence
HBC	Home Based Care
HCBC	Home and Community Based Care
HIV	Human Immuno-deficiency Virus
ICBT	Informal Cross Border Trade
IDU	Injecting Drug User
IUD	Intra Uterine Device
IEC	Information Education and Communication
IPT	Intermittent Presumptive Treatment
ITN	Insecticide Treated Mosquito Net
IRS	Indoor Residual Spraying
MC	Male Circumcision
MDG	Millennium Development Goals
MDRTB	Multiple Drug Resistance Tuberculosis
MOH	Ministry of Health
MOT	Modes of Transmission
MOU	Memorandum of Understanding
MSM	Men having Sex with Men
MSW	Male Sex Worker
NAC	National AIDS Council
NFNC	National Food and Nutrition Commission
NGO	Non-Governmental Organization
NMCP	National Malaria Control Programme

NRDC	Natural Resources Development College
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PATF	Provincial AIDS Task Force
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PID	Pelvic inflammatory Disease
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RDT	Rapid Diagnostic Test
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
UA	Universal Access
UNAIDS	Joint United Nations Programme for AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
ZDHS	Zambia Demographic and Health Survey

PREFACE

This 990 Talkline Counsellor's Reference Guide has been revised from the 2003 version that was initially developed by CHAMP. The revision includes new health thematic areas beyond HIV and AIDS including reproductive health and family planning, maternal newborn and child health, nutrition, malaria, and gender based violence.

The revised Reference Guide will help Talkline counsellors share accurate and valuable information with the Talkline callers. As with all counselling services, 990 Talkline counsellors must maintain the highest professional and ethical standards, especially when it comes to caller confidentiality. This is important because health issues are personal and sensitive and callers want assurance that their privacy is respected. As information and service providers, counsellors are reminded to uplift the credibility of the service. In addition, they must provide complete and accurate information at all times, be honest when they do not know the answers to certain questions, and either seek the support of fellow counsellors or supervisors or simply admit to the caller that they do not know the answer.

The tenets of confidentiality and complete and accurate information for callers have been the hallmarks of successful health talklines worldwide. It should also be emphasized that teamwork supersedes all individual brilliance and it is hoped that this will help CHAMP contribute significantly to the improved health outcomes for the callers.

ACKNOWLEDGMENT

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This revised manual now called the 990 Talkline Counsellor's Reference Guide includes adaptations from FHI Telephone Counsellors' curriculum, the Ministry of Health 2010 Prevention of Mother to Child Transmission (PMTCT) and ART Guidelines, Facts for Life (Fourth Edition, 2010) by UNICEF, National Malaria Communication Strategy 2011-2014, National Malaria Control Action Plan 2012 (Ministry of Health), Community Infant and Young Child Feeding Counselling 2011 by the National Food and Nutrition Commission, Zambia Demographic and Health Survey 2007 by the Central Statistical Office and Ministry of Health, and the Integrated Technical Guidelines for Frontline Health Workers (Third Edition, 2009) by Ministry of Health among other national documents.

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Part 1: Telephone Counselling

COUNSELLING

Counselling focuses on addressing and resolving specific problems, making decisions, coping with crises, working through feelings and inner conflict, or improving relationships with others. The counsellor's role is to help a client better understand or solve a perceived problem or situation while respecting the client's values, personal resources and capacity for self-determination.[1] This demands that a counsellor becomes more self-aware and able to understand and appreciate given situations without being influenced by his/her own personal values and attitudes.

SELF-AWARENESS

The concept 'self-awareness' means more than simply being aware of oneself. It has three components:

1. Being aware of one's own feelings, thoughts, attitudes, beliefs, values and reactions and how these can help or hinder counselling.
2. Acknowledging and appreciating the client's feelings, thoughts, attitudes, beliefs, values and reactions and how these help or hinder their ability to address their current concerns.
3. Monitoring and enhancing one's own development as a counsellor and addressing issues related to counselling performance.

Counsellors who are self-aware are in a better position to focus on clients' needs than those who are not self-aware.

VALUES AND ATTITUDES

Attitudes and values consist of feelings, beliefs and emotions regarding a fact, thing, behaviour or person. They can seriously impact counsellor's behaviour towards clients, especially when clients have different attitudes and values. It is important for counsellors to be aware of their own attitudes and values so that they can "subdue" them during counselling sessions. In other words, the counsellor's values and attitudes should not have any impact on the way he/she serves the client.

Values

The aim of re-visiting values is because of the important role they play in defining how we relate to people and talk to them. It is extremely important for a counsellor to keep his or her values to him/herself when attending to a client, no matter how emotional the counsellor may be about a particular issue. Counsellors must not in any way show their differences while talking to clients.

Values are what you believe in. They are the things you assign importance to and things you are against. Individuals derive their values from:

- Family - Family is the primary source of value formation. In fact the basic role of the family is to teach their children the norms, beliefs and culture of the society as well as the family's personal opinion about life.
- Society - Despite the fundamental values formed by youth from different family backgrounds, society has a great impact on the outlook of its members.
- Formal education - Exposure to formal education greatly influences people's beliefs and consequently their values. The things that we are taught directly build up our knowledge. This knowledge influences our desires directly or indirectly.

1 Kara Counselling and Training Trust, Foundation Course in Psychosocial Counselling Skills Part One, March 2006

Values Clarification

This is an educational approach to help people think through, identify and clarify their own values in order to lessen conflict and confusion experienced in decision-making. The "valuing process" has three components: -

1. Choosing one's beliefs and behaviours
2. Prizing one's beliefs and behaviours; and
3. Acting on one's beliefs.

COUNSELLING PROCESS

This section reviews the counselling process and provides an overview of basic phone counselling skills.

Counselling is a client-centred, interactive communication process in which one-person helps others make free, informed decisions about their personal behaviour and provides support to them to act on their decisions. In other words, counselling can be defined as the process of helping a client explore the nature of a problem so that they can determine what to do, without feeling pressure from the counsellor on how to act.

Counselling can take place either individually or in a group. Talkline counsellors do individual or one-on-one counselling. Although most of the 990 callers will probably request information and not counselling, counsellors need to have a well-defined counselling process for helping those who do call with problems. The following is a summary of the process, which was developed by The AIDS Support Organization (TASO) in Uganda. It has been modified slightly for use by telephone counsellors. There are three stages in this process:

Stage 1	Stage 2	Stage 3
Welcoming and building a relationship The goal of this step is to establish a relationship with the client through putting him/her at ease and building his/her trust.	**Gathering information about the clients' situation** The goal of this stage is to learn about the client's "story". The counsellor helps the client to talk about his/her problem, explore his/her feelings and reflect on his/her situation.	**Gathering information about the clients' situation** The goal of this stage is to learn about the client's "story". The counsellor helps the client to talk about his/her problem, explore his/her feelings and reflect on his/her situation.

Stage one is very important, because it sets a good atmosphere and builds a foundation for the rest of the call. Specific things that a counsellor does during this stage include:

- Greet the client in a friendly manner that conveys that you are willing to listen in a non-judgmental way.
- Explain the types of services that the 990 Talkline can offer.
- Inform the client that everything said will be confidential.
- If necessary, set boundaries for the call (i.e. for repeat callers).

Stage two is the "heart" of the counselling process. The counsellor tries to get the client to talk as much as possible in order to explore his/her situation and express his/her feelings. Things that the counsellor does during this stage include:

- Encourage dialogue
- Probe for more information
- Actively listen
- Reflect
- Speak simply
- Affirm

This is the stage when the counsellor invites the client to share what problems he/she is facing. The counsellor helps the person by listening carefully, checking understanding, and asking open-ended questions to help the person explore and clarify fully. This is also the time when the client explains how he/she is trying to cope with the problem.

Stage three is the final stage; the counsellor helps the client to evaluate options and make a plan for resolving the problem. This is done by helping the client to:

- Select a problem which needs to be worked out.
- Explore all the possible ways that the problem could be resolved.
- Consider carefully all the implications and possible outcomes of each option.

If necessary, the counsellor makes a referral to other resources. And only when the client feels comfortable that his/her problem has been addressed, does the counsellor summarise the conversation and terminate the call.

COUNSELLING SKILLS

Greeting - establishing contact with the caller in a way that is warm and welcoming. Greet the caller with respect and in a way that conveys that you are ready and willing to listen, in an unhurried manner, and therefore establishing a good rapport with them.

Empathizing - seeing the world through other people's eyes without judging them. Empathy is not the same as sympathy; empathy means feeling with a person, while sympathy means feeling sorry for a person.[2] Sympathy creates a dead end in the conversation. Empathy involves understanding and acknowledging a person's feelings in order to open up a conversation, encouraging dialogue.

Accepting - valuing another person unconditionally as a human being; it involves a genuine effort to understand another person in a non-judgmental way and being open to new knowledge, ideas and behaviours.

Active Listening - attending to both a client's verbal and non-verbal messages, and listening in a way that conveys respect, interest and empathy, Active listening involves more than just hearing what other people say. It involves paying attention to both the content of the caller's message and words, as well as the things that might go "unsaid," such as feelings or worries.

Active listening can be harder to do over the phone than in person, because the counsellor cannot use body language to show that he/she is listening. Phone counsellors must demonstrate active listening through verbal cues.

Examples of verbal cues :
"I am with you……"
"Tell me more about it……"
"I am following, did you say that……"

It can also be helpful to repeat one or two key words that the caller has just said.

For example:
Caller: "I am so upset with my husband…."
Counsellor: "Upset?"
Caller: "Yes, it makes me so mad that he won't use condoms when he knows that they can protect us."

2 CONNECT (Zimbabwe Institute of Systemic Therapy). 1993. *Basic Telephone Counselling Skills*

Using Silence - Silence is used most effectively when you allow the conversation to stop for a few seconds in order to encourage more dialogue. While many people are uncomfortable with silence in a conversation, silence can actually help clients talk more. When a client falls silent, he/she will often begin to talk again after a few seconds if the counsellor does not say anything.

Also, silence is sometimes necessary if a caller becomes upset and needs a few minutes to calm down or collect his/her thoughts. Counsellors can use this silence as a way of demonstrating active listening.

Sometimes a client may be silent while on the phone with the counsellor because he/she is confused or very stressed with his/her situation. Therefore, the counsellor must know when to use 'restating' so that there is clarity in what the client is trying to explain.

Questioning and Probing - Asking questions in a way that encourages callers to express their feelings and share information about their situation is another tactic that can encourage dialogue. This is accomplished through asking open-ended questions and probing for more information when a superficial answer is not enough.

What can we learn through questions?

The general situation	What did you want to talk about?
The facts	What happened?
Feelings	How did you feel?
Reasons	What made you do that?
Specifics	Please could you explain a bit more about that issue?

Open-ended questions are questions that require more than a one-word answer. They usually begin with words such as "How?", "What?" or "Why?" Probing is necessary when the counsellors need more information about a person's feelings or situation.

The following are some helpful probing phrases:
"Can you tell me more about that?"
"What happened after that?"
"Please describe the symptoms."
"Yes, explain how you felt."

Closed-ended questions usually requiring one or two word answers are sometimes helpful to clarify or confirm issues or statements that the counsellor needs specific information on.

Some examples are:
How old is your friend? 19
Is your friend with you now? Yes
Are you still very afraid? Not so much…
How far away are you from the clinic? About 5 kilometres

Counsellors should use a combination of open-ended questions and some closed-ended questions when they need to probe about two things:

- The caller's experiences or "story"
- The caller's feelings.

Callers may have trouble expressing their feelings and may need help from counsellors to verbalize them.

Focusing - Having the caller choose the most pressing problem that they would like to resolve; often callers have many problems, especially if they are faced with a disease like AIDS, which can impact many different areas of their lives. They may feel overwhelmed and feel the need to address all of their problems at once. It

is not realistic to expect 990 Health Talkline counsellors to be able to meet a caller's every need. Therefore, counsellors need to help callers focus on the issues that are most important to them at the time of the call.

For example:
Counsellor: "It sounds like you are going through a lot right now and you feel overwhelmed. We won't be able to solve everything tonight, but I can help you to start. Which problem is the most important for you right now?"

The issues that are most important to the callers may seem less important to the counsellors than other issues. It is important to respect the caller's feelings, however, and address the issues that they feel are most important. Once they have resolved the important issues, they will be more likely to call back to address the other ones.

Affirming - Congratulating or complimenting callers on the positive actions that they have been able to implement. e.g. "I am pleased to hear that you have been reading about HIV testing." Complimenting callers helps them to feel respected and valued, and it encourages them to share more information. If a caller feels that he/she has already accomplished something, even if it is small, then he/she may be more willing to take some larger actions.

Reflecting - Repeating the key points of what a caller has said back to him/her is known as reflecting. This is also known as "paraphrasing." Reflecting serves many purposes, including:

- The counsellor can make sure that he/she has understood the client correctly.
- The counsellor can show the caller that he/she has been listening actively.
- The caller can gain greater clarity about his/her situation or feelings.

Accurate reflection and acknowledgement of feelings are necessary and critical to the counselling process. Callers must first believe that the counsellor hears and understands their feelings and individual needs and concerns before they are ready and willing to deal with the situation, listen to options, and make an informed and appropriate decision.

The following is an example:
Caller: "I'm really scared. My daughter is going around with all types of boys. She won't talk to me about it. I think she could get AIDS."
Counsellor: "So you're scared that your daughter is exposing herself to AIDS because she has several boyfriends, and you're worried that she won't talk to you about it."

It is important to reflect both the content of what the person has said and their feelings. Emotions form the base of much of life experience. Noting key feelings and helping the caller clarify them can be one of the most powerful things the counsellor can do.

SPEAKING SIMPLY

Using language that is simple enough for a person to understand; counsellors need to adjust their language to accommodate to the callers vocabulary. If a client's speaking abilities are not obvious, it is better to start with simple language and adjust along the way if necessary to make sure that the information is understood. The following is an example of a difficult explanation that has been rephrased to make it simpler:

Caller: "I don't understand AIDS. How does it kill you?"
Counsellor: "AIDS kills you because the virus, HIV, attacks and weakens your immune system. With a weak immune system your body is unable to fight off diseases like it normally would. It is these diseases that eventually kill you."

Difficult Explanation: "AIDS results from infection by HIV. HIV is a retrovirus, which inserts its genetic code into T4 cells, which co-ordinate the body's immune defences. HIV replicates and destroys the T4 cells.

When this happens a person becomes vulnerable to opportunistic infections."
Simple Explanation: "AIDS kills you because the virus attacks and weakens your immune system. With a weak immune system your body is unable to fight off diseases like it normally would. It is these diseases that eventually kill you."

Practice Speaking Simply

Technical Language	Speaking Simply
Biological transmission of HIV	AIDS is caused by a virus called HIV
Sexual orientation	Male or female
Positive HIV diagnosis	He/she is positive
Fear of disclosure	Afraid to disclose results

CORRECTING MISCONCEPTIONS AND MYTHS

There are many misconceptions and myths about health related issues; it is the counsellor's role to correct them. However, this needs to be done in a way that does not make the caller feel embarrassed or defensive. Counsellors should acknowledge misinformation and then correct it. For example; "You mentioned that it is possible to cure AIDS by having sex with a virgin. Many people believe this, but it is not true. Currently, there is no cure for AIDS."

Sometimes counsellors have doubts about certain information. It is advisable for counsellors to first clarify his or her own doubts by consulting a supervisor or consulting information materials available on the topic from a reputable source.

Counsellors, who are faced with a request for information regarding a topic they are not familiar with, should acknowledge that they do not have the answer. They may tell the caller to wait while they find out where the caller can obtain the answer to their request or transfer the caller to other counsellors who can provide the appropriate answers.

SUMMARIZING

Summarizing is similar to reflecting, but the counsellor does not repeat exactly what the client has said. The counsellor takes the main points of the conversation and presents them to the caller. Summarizing is appropriate when:

- The counsellor wants to check that he/she has understood the client's story.
- When it is time to move onto another topic.
- When it is time to end the call.

Summarizing can also help the caller to gain perspective on his/her situation.

Supporting

Supporting: Offering encouragement and help to callers in order to give them confidence for taking action. For example: "We can discuss some options of how to talk to your girlfriend. What would you like to talk about"

Closing

Closing: Asking if the caller has any questions; before hanging up, the counsellor thanks the caller for calling.

TELEPHONE COUNSELLING

Advantages of Telephone Counselling

Telephone Counselling is different from face-to-face counselling, where a client meets a counsellor in person to discuss a problem. It is important to note that there are both advantages and limitations to telephone counselling, however, where available many clients prefer telephone counselling for the following reasons:

- It is anonymous. (This is particularly important when dealing with personal sensitive subjects like illnesses, especially AIDS).
- It is accessible and available several hours a day.
- It can be less expensive than face-to-face counselling (does not require transport money; calling 990 is free).
- It often takes less courage to call a telephone talkline than to visit a counsellor in person.

Limitations of Telephone Counselling

- The caller can terminate the conversation if he/she becomes uncomfortable.
- Limited responding abilities by the counsellor e.g. can only listen and not be able to touch, see or smell anything.
- Some rural areas may have limited cell phone network access.

Challenges to Telephone Counselling

- The counsellor and caller cannot see each other, some types of non-verbal communication, which are important in face-to-face counselling (i.e. body posture, eye contact, facial expressions, etc.) are less important in telephone counselling.
- The quality of the counselling can be affected by the quality of the telephone connection. If the telephone line is bad, then the counsellor and caller will not be able to communicate clearly. This can result in misinformation, frustration and termination of the call by the client.
- The immediate circumstances of the caller are unknown. The counsellor does not know what type of environment the client is calling from. The client could possibly be in danger, or at the very least, could be in a situation where he/she is not able to talk freely for fear of being overheard by others.
- Building trust is hard: It is more difficult for a client to build trust in the counsellor when he/she cannot see the counsellor.
- Callers may place "hoax" calls (these are calls that are meant to be a joke or are not sincere). Face-to-face counsellors rarely have to deal with "hoax clients." In other words, most people who make the effort to visit a counsellor face-to-face are honestly seeking help.

The counsellor's voice and speaking patterns are extra-important in phone counselling. This includes the tone of the voice, breathing patterns, pauses, pace of speaking and hesitation.

How to deal with Difficult Counselling Situations

Counsellors may often be faced with difficult situations or questions when dealing with callers. Health problems, especially HIV and AIDS, can cause crisis situations for a variety of reasons, both among those suffering from the disease and those whose loved ones are affected by it. The following are some suggestions for dealing with problem callers:

Situation/Scenario	Suggested Response
The caller asks the counsellor for personal information	Counsellors should not give out any personal information about themselves
Caller has just tested HIV-positive; he/she may want to know whether or not the counsellor is also HIV-positive	I understand why you might be curious about my HIV status, but that knowledge really won't help your own situation. Let's talk about how you are feeling right now…
A caller is uncomfortable with the counsellor because of his/her gender, age, ethnicity or other unchangeable characteristics	The counsellor could acknowledge the caller's discomfort and say that even though they are of a different gender/ethnic group, the counsellor is still able to listen to what the caller has to say and try and help him/her in an objective way. If the caller is still uncomfortable, the counsellor could offer to transfer him/her to another counsellor (if there is another one available).

A counsellor is not able to establish rapport with the caller, and it is unclear why	The counsellor should acknowledge the caller's discomfort and try to discover the reason behind it. If possible, the counsellor should then use the caller's response to improve the rapport. If this is not possible, the counsellor should offer to transfer the caller to someone else or invite the caller to call back at another time.
A counsellor and caller know each other	It is not appropriate for a counsellor to counsel someone that he/she knows. Sometimes a counsellor may recognize a caller but the caller may not recognize the counsellor. Sometimes a caller may recognize the counsellor, and ask for his/her full name in order to verify this fact. In either case, the counsellor should not reveal his/her full name. He/she should explain to the caller that it would be best for him/her to speak with another counsellor who would be better equipped to handle his/her situation and proceed to transfer the call. If no other counsellor is available, the counsellor can take the call, but he/she should be sure to respect the caller's confidentiality.
A caller asks for information that the counsellor does not know	It is perfectly okay for a counsellor to say, "I don't know" if he/she does not know the answer to a question. Counsellors are not expected to know everything, and they should inform the callers that they might not have all of the information that they are seeking, but that they will try to find it. If the information can be obtained quickly from other Talkline staff, then the counsellor can put the caller on hold. If it will take more time to find the information, the counsellor can ask the client to call back later.
A caller talks continuously or inappropriately	If the caller talks non-stop without giving the counsellor a chance to speak, or the caller does not seem to be making sense, the counsellor should try to redirect the conversation. This can be done through interrupting the caller in a polite way, such as stopping him/her to summarize what he/she said and make sure that it has been understood. (e.g. "Let me just stop you for a minute to make sure that I have understood what you have told me….”).
A caller becomes offensive or aggressive	Callers may use offensive language or speak to the counsellor in a threatening way, especially if they feel frustrated with the conversation or are very upset by information that a counsellor has given them. Some callers may also place "hoax" calls just to be malicious. If this happens, one strategy is for the counsellor to acknowledge the feelings behind the caller's language and state that such behaviour will prevent you from helping him/her. (e.g. "It seems like you are very angry about your problem. I will not be able to help you until you calm down"). If this does not work, or if the caller is extremely verbally abusive, then the counsellor should terminate the call in a polite way. (e.g. "I can tell that you are angry, but I am afraid that I will have to end this call if you are not able to calm down. Good bye").

A client calls back repeatedly for one particular counsellor.	Callers may repeatedly call a particular counsellor if they like him/her and feel comfortable with him/her. While this is a sign that the counsellor is doing a good job, it can also encourage the caller to become overly dependent on the Talkline. It is important to remember that the Talkline cannot provide psychological counselling for serious problems, and that the main function is to provide information and counselling. Counsellors who receive repeat calls from a client should clearly state the Talkline's limitations and refer the caller to services that can best meet their needs.
A caller expects a service that the Talkline cannot provide.	Callers may misunderstand the role of the health Talkline and may call to demand services that cannot be provided. For example, a caller may call to report that his/her neighbour has AIDS, and demand that the Talkline inform the proper authorities. Or a caller may expect to be able to have a face-to-face meeting with a counsellor. Whatever the case, the counsellor should clearly state the services that the Talkline is able to provide, and he/she should refer the caller to other services that can best meet his/her needs.

Guidelines for Telephone Counselling

- All calls to be answered within three (3) rings.
- Always use your counsellor name.
- Do not disclose the location of 990 call centre.
- Do not give out personal information. This includes your full name, your telephone number, where you work, where you live, etc.
- Never take a call from somebody you recognize.
- Remember your limitations. You are a counsellor and not a therapist, psychologist or medical doctor. Callers with severe problems should be referred to other services.
- It is okay to tell a caller that you do not have the information they are seeking right there, but you can try and find it for them or you can refer them to someone who knows.
- Never meet a caller. Meeting a caller is strictly forbidden, both for safety reasons and also because it compromises the anonymity of the Talk line.
- Never force callers to give details they are not comfortable with.
- Keep it confidential. All conversations with callers must be kept strictly confidential.
- Handover a call to a different counsellor, if you feel uncomfortable with the call.
- If your identity is compromised by a caller DENY your true identity.
- Do not judge or moralise. Accept callers as they are. Clients have a right to their own value systems. He/she does not want to be told what is right and what is wrong from the counsellor's perspective.
- Do not prescribe treatment for any ailment. It is not the counsellor's role to give medical advice.
- Do not reassure. Never say, 'Everything will come right' to a caller. You cannot see the future, and this may not be true. False assurances will not help a caller to deal with his/her situation in a realistic manner.
- Do not block strong emotions. One of the main purposes of counselling is to help a client express their emotions.
- Stay centred on the client. Remember that the counselling session is about the client, not about the counsellor. This includes their feelings, attitudes, beliefs and opinions.

CRISIS COUNSELLING

A crisis is a temporary emotional state of deep distress caused by some kind of unexpected threat. A crisis can be dangerous when a person's normal coping skills fail. A crisis is a subjective experience. What may be a mildly difficult situation to one person may be a crisis to another. A crisis therefore is not the situation itself, but the person's response to this situation.

Crisis counselling is a short-term intervention to help people experiencing psychological difficulties after a traumatic event. Crisis counselling is based on the goals and process of classic counselling, including helping them to understand their situation, express their feelings, review options for actions and get referrals to other sources.

In crisis counselling, the assistance focuses on dealing with the immediate situation as opposed to solving underlying causes of distress. Some examples of events that could cause a crisis situation are:

- Attempted or contemplated suicide
- Rape
- Domestic violence
- Unemployment
- Depression
- Alcohol and drug abuse
- Death of a loved one
- Anger
- Natural or man-made disasters (e.g. bombs, fires, floods, earthquakes)
- Imprisonment or disappearance of a loved one
- Child abuse

If and when a 990 Talkline counsellor receives a crisis call that they do not feel capable of handling, they should immediately refer the caller to the appropriate service, and:

- Remain calm and stable. Encourage the client to express his/her feelings.
- Allow the client full opportunity to speak.
- Attempt to determine the type of crisis, what caused it and how severe it is.
- Deal with the immediate situation rather than its underlying causes that may be left for later.
- Help the client break down the problem into smaller parts and identify which parts of the problem that he/she can do something about. Help him/her to set realistic goals.
- Help him/her decide exactly what he/she is going to do when he/she hangs up.
- Stay focused on the basic practical issues and immediate needs.
- Use the Referral Network Directory to identify other available resources.

Example of Crisis Counselling

Suicide

If someone tells you that he/she is contemplating suicide or shows signs of being suicidal, don't be afraid to talk about it. Your willingness to discuss suicide shows the person that you don't condemn him/her for having such feelings.

Ask questions about how the person feels and the reasons for those feelings. It can be helpful for a person under stress to hear someone say, "You seem really down. Why have you thought of killing yourself?"

Also ask questions about suicide, about the idea itself. "Do you have a specific plan about how you would do it?" "Have you taken any steps to carry out the plan?"

Determine whether the person has access to a gun or pills. The more specific and detailed the plan is, the higher the risk. Don't worry that your discussion will encourage the person to go through with the plan. On the contrary, it will help him/her know that someone cares and is willing to be a friend.

Be calm. Discuss suicide as you would any other topic of concern. Don't offer advice such as, "Think about how much better off you are than most people. You should appreciate how lucky you are."

Such comments only increase feelings of guilt and make the suicidal person feel worse.

Convey hope. Prevent isolation (tell the person that you are available). However, it is important to recognize what you can't do for another person (e.g. you can't bring back a lover, talk someone out of depression, change someone's bad home life, or turn an ugly duckling into a swan).

DEATH AND GRIEVING

Talkline counsellors may receive calls from clients who have lost a loved one or who are dying themselves. While it is not possible to provide intensive psychological counselling, counsellors need basic knowledge about issues that are related to death and grieving.

Cultural Perceptions of Death and Grieving

Death is perceived differently across cultures, and different cultures have their own traditions for grieving. These differences can be based on religion, ethnic group or other factors. For instance, the funeral related activities highlighted in the table below may vary across cultures.

Before burial of the body	Grieving by Family and Friends
• Preparation and dressing of the body • Displaying of the body prior to burial • Length of time before burial • Place of burial • Role of religious figures • Payment of funeral costs • Type of memorial service	• Party to celebrate the person's life • Length of mourning period • Dress during mourning • Beliefs about life after death • Wife/husband and property inheritance • Way that people are spoken of after death • Shrines or altars in memory of a dead person

The Grieving Process

The grieving process is often complicated because everyone deals with grief differently. It is not easy to predict how a person will react, and one person may react differently to two different deaths. There is no one general model, with phases of the Grieving Process that a person may go through when grieving.

STAGE 1: Shock and Denial

Immediately after the death, people may experience numbness and a sense of unreality. They may have a hard time accepting that a death has actually occurred. Denial is a defence mechanism which allows people to protect themselves and avoid their grief. They may believe that there was a mistake in identifying the body or some sort of mix-up.

Denial can be harmful because it isolates the person and keeps him/her from getting the emotional support that he/she needs. A person cannot begin to grieve and heal himself until he/she moves out of this stage.

STAGE 2: Anger

Anger can be a very strong emotion after experiencing a death. A person may feel angry with the person who died if he/she feels that the death could have been prevented (i.e. a person who was killed because he/she was driving while drunk). A person may also feel angry at God or at another spiritual power if he/she feels that the person was unfairly taken away. Finally, a person may feel angry with him/herself or others who played a role in the death (i.e. a murderer or the driver of a car who caused an accident).

STAGE 3: Guilt
People may feel guilty after a death for a variety of reasons. They may replay the period of time before the death over and over in their minds while thinking of things that should have been said or done. People might feel guilty if:

- There was unfinished business between them and the deceased.
- There was a fight or quarrel right before the person died.
- They wished the person dead.
- They did not say goodbye properly.

STAGE 4: Depression, despair and intense pain
This stage can be the longest and most difficult. People in this stage may suffer from insomnia (inability to sleep), depression, acute sadness, crying spells, pangs of longing, loss of appetite and personal feelings of inadequacy.

They may have difficulty functioning on a day-to-day basis and feel hopeless about their situation. They may miss the person so much that they lose the desire to live.

STAGE 5: Re-establishment of balance
In this final stage, life begins to return to normal. The pain gradually lessens, and people recover their desire to live. People regain their appetite and are able to sleep normally again. They feel that they can say goodbye to the deceased and cope with their grief. They reintegrate themselves into their families, work and social lives.

> Many people who have gone through the grieving process say that the most difficult period comes about six months after the death, when others are no longer sympathetic to their grief and expect them to have healed.

Grief Counselling

990 Talkline counsellors can offer some basic help to callers who have lost loved ones due to various causes. They should remember that callers who are grieving due to loss of a loved one should seek professional counselling. Following are some simple suggestions for helping a caller deal with grief. The steps do not necessarily have to be carried out in this order.

1. **Give the caller permission to grieve**

Reassure the caller that grief is a normal reaction to death. Encourage him/her to express he/she feelings and cry if he/she wants to. This is especially important for men, who are often raised to appear strong and hide their emotions.

2. **Assess and support the grieving process**

Ask the caller to tell you his/her story, and assess where he/she is at in the grieving process. Once this is determined, offer the appropriate support for that stage:

> **Stage 1: Shock or Denial**
> - Ask the person what they fear the most about the death.
> - Encourage them to look at photos of the deceased or visit the grave site.
> - Encourage them to talk with someone they can trust.
>
> **Stage 2: Anger**
> - Encourage the caller to express his/her anger by talking to others, beating a pillow with a stick, kicking the rubbish can or screaming in a private place.

Stage 3: Guilt
- Reassure the caller that everyone makes mistakes, and nobody is perfect.
- Life is not all happiness, and it is normal for people to disagree and hate.
- Explore ways that the caller can use to relieve his/her guilt.

Stage 4: Depression, despair and intense pain
- Reassure the caller that it takes time to recuperate from a death and that expressing their feelings can help.
- Encourage them to cry in order to express their pain.

Stage 5: Re-establishment of balance [Acceptance of situation]
- Congratulate the person for reaching this stage.
- Be sure to acknowledge how difficult it must have been.
- Encourage him/her to express his/her feelings, because people in this stage are not fully healed yet.

Help the caller to express their feelings and acknowledge the client's sense of loss. Ask open-ended questions to help a caller explore and verbalize feelings. (e.g. "How did you feel watching him/her die?"). Ask what the hardest thing is to deal with on a daily basis. Acknowledge these feelings.

3. **Explain what the caller can expect next**

For some callers, it may help to explain the stages of the grieving process, so that they know what to expect and understand that they will eventually be able to conquer their grief.

For example, a counsellor might say to a client who is in denial: "I know that your wife's death is hard to accept. Once you are able to accept that she is gone then, you will be able to heal yourself. While you are recovering from your loss you may experience feelings of guilt or anger, and you will feel a lot of pain. Eventually, though, you will be able to cope with your grief."

Such information may be too much for other callers to handle, especially if they want their grief to disappear overnight. The counsellor will need to make this decision on a case-by-case basis.

4. **Encourage the caller to seek support and develop a coping plan**

Ask a caller how he/she has dealt with losses in the past, and help him/her assess whether this strategy would be appropriate for the present situation. Encourage the caller to seek support from friends, family members or professional sources. Provide referrals if necessary.

STRESS AND BURNOUT

Talkline counsellors may suffer from stress and burnout, due to the fact that their work can be emotionally draining.

Causes and Effects of Stress

There are infinite causes of stress. Stress can result from problems at work, at school, at home and with friends. Stress can be caused by major events, such as a death or minor events such as being stuck in traffic. Stress can also be self-imposed. In other words, a person may cause himself to be stressed by having unrealistic expectations or goals.[3]

As this section focuses on stress for health Talkline counsellors, it is beneficial to help counsellors explore sources of stress at the workplace. These can include the following: ever increasing workload, fear of job redundancy, layoffs due to an uncertain economy, petty politics, and just the pressure to perform.

3 Specter, P.; Chen, P. and O'Connel, B. , 2000

Too much stress can have both negative mental and physical effects on a person.[4] All of these effects are also symptoms of stress. Counsellors need to be able to analyse their own behaviour and feelings in order to see if they are suffering from stress. These symptoms can serve as a checklist to see how well a person is coping when in a stressful situation.

COPING WITH STRESS

A person's ability to cope with stress is affected by many different factors, including lifestyle. There are several short-term and long-term solutions to dealing with stress.

Sources of Stress	Physical Effects	Mental Effects
• Heavy workload • Constant deadlines • Organizational problems • Poor status, pay and promotion prospects • Unnecessary rules and procedures • Job insecurity (e.g. If a company is forced to close in the near future) • Unclear role specification • Unrealistically high expectations • Disagreements with superiors or colleagues • Poor communication • Isolation from colleagues and time pressure	• High blood pressure • Muscle tension • Disturbed sleep • Knots in stomach or nausea • Headaches • Increased use of cigarettes • Sweating spells • Heart palpitations • Restlessness	• Trouble concentrating • Lower self-confidence • Memory lapses • Poor judgment • Resentment, cynicism • Anger and irritability • Feeling "on edge" • Feeling down, blue or hopeless • Moodiness • Withdrawal from others • Non-stop talking • Fidgeting

Short-Term Solutions

Laughter - Laughter is one of the best ways to reduce stress. If you can't make yourself laugh, then visit or talk to a friend who makes you laugh.

Flexibility - Loosen up a bit and be more flexible in the way that you interact with the world around you. Do things according to what the situation demands, and not according to the way that you are accustomed to doing them. Try different ways of talking to people and dealing with events.

Set reasonable goals - Don't set goals for yourself that are overly ambitious. Nobody is perfect, and it can be stressful to try and achieve perfection.

Take care of your body - People often neglect their health and well-being when they are stressed. Eat well, exercise, sleep enough and avoid stimulants such as caffeine.

Talk to others - Share your feelings of stress with someone you can trust. Talking about stress can make you feel better, and it may help you to look at your situation differently.

Write in a journal - Writing your feelings down on paper is an excellent way to release stress. This can also help you to develop a plan for improving your situation.

Breathing - Breathing deeply and slowly helps your body to relax. Expand your abdomen while inhaling, count to four, and then exhale.

4 Wallace, S. 1998. Stress. http://www.virtualpsych.com/stress/fancyindex.htm

Long-Term Solutions

The above suggestions are helpful for dealing with stress in the short term. To deal with stress in the long term, you must choose one of the following three options:

- Change the situation
- Change how you react to the situation
- Change how you look at the situation

BURNOUT

Burnout is a state of emotional, mental and physical exhaustion caused by excessive stress. Unchecked stress can lead to burnout, especially in a Talkline counselling situation. It is possible to prevent burnout by being aware of the signs and taking action to improve the situation. How can a counsellor tell if he/she is at risk of burnout?

Dealing with Burnout

Burnout can be prevented by:

- Recognizing that it happens (especially in Talkline situations)
- Learning to recognize the signs in yourself
- Developing a plan for dealing with it

Health Talkline Debriefing Programme

The Talkline aims to provide an enabling environment for the counsellors and supervisors. This includes preventing burnout. To do this, there should be need to hold debriefing meetings with the following elements:

- All counsellors will work shifts. It is recommended that debriefing with shift supervisor or team leaders be held on a regular basis. The session should focus on what experiences the counsellor had during the shift.
- During every shift, one team leader or supervisor should be present. The role of this team leader is to provide both technical and emotional support to the counsellors. The counsellor can call upon the team leader for assistance at any time during the shift.

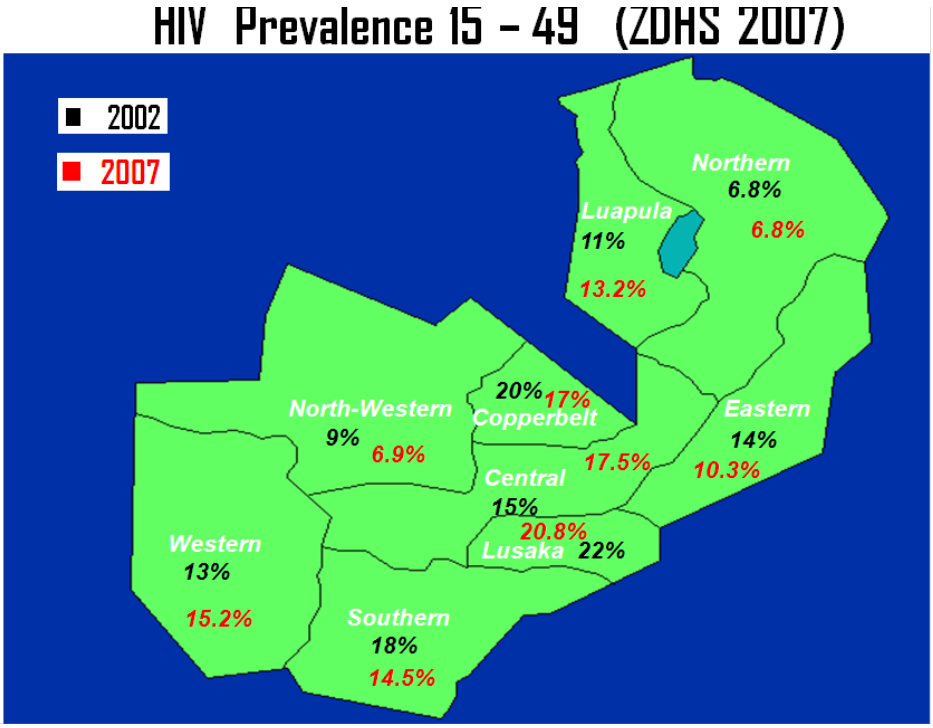
A group debriefing should take place on a weekly basis. All counsellors will attend these sessions. During these sessions, the mentor will assist with building skills for identifying stressors and dealing with stress. Individual sessions can be arranged with the mentor.

Part 2: HIV & AIDS

HIV AND AIDS IN ZAMBIA

In 2007, the national adult HIV prevalence (incidence) was estimated at 14.3% (ZDHS, 2007).[1] The epidemic has a gender bias with more women (16.1%) living with HIV and AIDS compared to men (12.3%). However, for women above 40 years, prevalence is lower than men in the same age bracket.

In children and adolescents aged 0-14 years, the number of new infections has declined dramatically since peaking at 21,189 in 1996 to 9,196 in 2009, a decrease of almost 12,000 over 13 years. Similarly, HIV prevalence levels in ANC clients have shown signs of decline. The female to male prevalence for young people aged 15-24 has dropped from 3.7% in 2004 to 1.6% in 2007, implying fewer new infections in women than men.



CSO, Zambia Demographic and Health Survey, 2007

MODES OF HIV TRANSMISSION AND EPIDEMIC DRIVERS

In Zambia, the main ways in which HIV is transmitted from one person to another are:

1. **Unprotected sex** - The main mode of HIV transmission in Zambia is unprotected sex. An estimated 90% (MOT, 2009)[2] of adult infections are related to unprotected heterosexual activity either with a casual partner, a long-standing partner, or with a concurrent sexual partner. Stable relationships, such as marriages or people living together, have the highest HIV prevalence rates estimated at 16% and 15%, respectively.

   Women are at greater risk of HIV infection through vaginal sex than men, although the virus can also be transmitted from women to men. Sexually transmitted infections also increase the risk of HIV transmission because of broken skin which creates entry points for the virus.

2. **Mother to Child Transmission (MTCT)** - The second mode of transmission of HIV is from mother to child (MTCT) during pregnancy, birth or breastfeeding and it is believed to account for 10% of new infections in Zambia. The transmission of HIV from mother to child can happen in the following ways:
   - during pregnancy
   - delivery
   - breastfeeding

However, it is important to note that Prevention of Mother to Child Transmission (PMTCT) services are now available country wide for all males and females in the reproductive age group.

The spread of HIV is further compounded by other structural factors that are underpinned by social and cultural norms, and limitations in service delivery. Among them are stigma and discrimination; gender

1 CSO, 2007 Zambia Demographic Health Survey (ZDHS)
2 MOH Modes of Transmission, 2009

inequalities; low levels of education; rural-urban differences in accessing services; inadequate focus on most at risk populations (MARPS); vulnerable groups including women and girls with disabilities; low medical male circumcision and VCT uptake.

FACTORS IN THE SPREAD OF HIV IN ZAMBIA

Zambia has a mature HIV epidemic which is driven by a combination of behavioural, structural and biomedical factors commonly known as the drivers of the pandemic. These are drivers include multiple and concurrent sexual partnerships, low and inconsistent condom use, and low levels of male circumcision.[3]

Multiple and Concurrent Sexual Partners

Multiple and concurrent partnerships (MCP) are prevalent among all sexually active age groups. A person is engaged in MCP when they have more than one sexual partner they frequent at the same time, this often includes people involved in extramarital affairs, transactional sex, or with multiple girlfriends/boyfriends. According to the 2009 MOT Report 71% of new infections were a result of casual heterosexual behaviours including people with multiple and concurrent sexual partnerships. Given that viral loads are higher during the first 6-8 weeks of infection, persons (especially among concurrent partnerships) with newly acquired infections are more likely to pass infection to additional sexual partners. Concurrent partnerships raise the number of individuals who become infected over a very short period of time– thus accelerating the spread of HIV. Risk perceptions, norms and behaviours regarding multiple partners are difficult to change because they are so ingrained in culture. However, the barriers can be tackled through targeted health messaging.

Low and Inconsistent Condom Use

Condom usage remains low especially among key populations such as sex workers, people having casual sex, people with MCP, and discordant couples. Condoms are also not easily accessible to vulnerable and most at risk populations such as prisoners or students in primary and secondary schools. Although significant efforts have been made to empower women to take care of their sexual and reproductive health (SRH), they are not adequately empowered to effectively negotiate and or demand the use of condoms with male partners.

Low Levels of Male Circumcision

Male circumcision (MC) in Zambia remains low with only 13% of men aged 15- 49 years reporting (2007) having been circumcised. Eastern (3.2%), Southern (4.4%), and Central (5.7%) have the lowest levels of MC compared with North Western (71%) and Western (40.2%) provinces that have among the highest levels of MC. MC can prevent female to male HIV infection by up to 60%. However, MC still does not provide 100% protection and condom use is still important. HIV prevalence among circumcised men was 10% compared to 12% among uncircumcised men.

Mobility and Labour Migration

Labour migration is common in Zambia, and people often move within and between provinces in search of employment. Provinces with highly mobile populations and many migrant labourers, such as Lusaka and Copperbelt, have higher HIV prevalence than provinces with less labour migration. Informal cross border traders (both men and women) are highly vulnerable to exploitation and abuse, in part because of their irregular migration status.

Informal cross-border trade (ICBT) is estimated to make up about 30-40% of intra-Southern African Development Community (SADC) trade. Sexual exploitation puts traders at a greater risk of contracting sexually transmitted infectious (STIs) including HIV.

Commercial Sex Workers and Men who have Sex with Men

There currently exists little information about the risks of HIV infection for commercial sex workers and men who have sex with men in Zambia As a result, there is an urgent need for research regarding these populations and their behaviours in order to better design programs that can meet their needs.

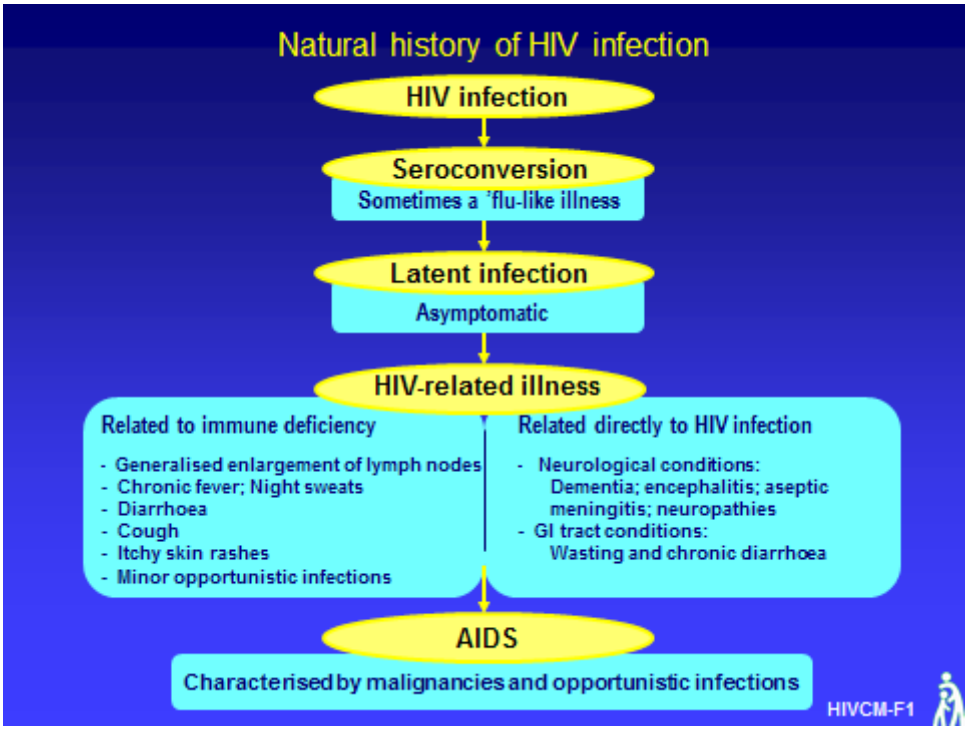
3 NAC, National AIDS Strategic Framework 2011 - 15

Mother to Child Transmission

Mother to child transmission of HIV accounts for 90% of HIV infection in children aged 0-14 years. In the initial phase of the roll-out of services, uptake remained low due to stigma associated with HIV, gender based violence (GBV), inadequate male involvement in PMTCT and opt-in approach to counselling which relied on women consenting to an HIV test . Today, Zambia operates under an "opt-out" policy which assumes the health facility will perform an HIV test unless the woman clearly states she does not want the test.

PROGRESSION FROM HIV TO AIDS

Below is a diagram that shows the progression of HIV infection into AIDS.



HIV PREVENTION METHODS

HIV can be prevented by practicing the following:

- Abstain from sex
- Be faithful to one uninfected partner (monogamy)
- Use a male or female condom correctly every time you have sex
- Follow prevention of mother to child transmission treatment
- Do not share sharp instruments (e.g. needles, razors)
- Avoid alcohol and substance abuse as there is likelihood of unsafe sexual activities when a person is under the influence of these substances
- Use post exposure prophylaxis after potential exposure to HIV
- Seek immediate medical treatment if you have a sexually transmitted infection (STI)
- Go for male circumcision (MC)

How to prevent Mother to Child HIV Transmission

When an HIV-positive woman becomes pregnant, there are three ways she can pass the virus to her baby. This type of transmission is called "Vertical Transmission."

1. **During pregnancy (antenatal)** - The virus can be passed to the child through the placenta, especially if it is damaged in any way.
   - The mother should know her HIV status early so that she can seek medical advice.
   - Taking antiretroviral drugs such as Zidovudine (AZT) or Niverapine from the 36th week of pregnancy.

Some service providers are now commencing mothers who test positive during pregnancy on ARVs as soon as they test positive.
- Taking multivitamins and eating a balanced diet during pregnancy in order to keep the placenta healthy.
- Recognising and treating any sexually transmitted infections (STIs).

2. **During childbirth (Intrapartum)** - An HIV pregnant woman should:
   - Deliver at a hospital or health centre facility.
   - Clean the vagina before delivery with antiseptic solution.
   - Take antiretroviral drugs such as AZT or Niverapine from the onset of labour or as advised at the health centre facility.
   - Avoid unnecessary vagina examinations (hands off technique).
   - Clean the vagina before and after every vagina examinations with antiseptic solution.
   - Avoid episiotomies (increasing the vagina opening during delivery by cutting).
   - Avoid the use of forceps or other instruments that can break the baby's skin during birth.
   - Remove the mother's blood and secretions immediately after birth by washing the baby gently. It is especially important to clean the face, where HIV can enter the baby through the mucous membranes.

3. **Through breastfeeding (postpartum)** - The following are possible options for preventing HIV transmission to a baby from an HIV positive mother after child birth:
   - Giving antiretroviral drugs to the baby after birth.
   - Considering alternatives to breastfeeding; exclusive breastfeeding up to 6 months is recommended while the mother continues taking ARVs.
   - Using commercial formula milk (if clean drinking water is available).
   - Breastfeed infant exclusively for the first 6 months, introducing appropriate complementary foods thereafter, and continue to breastfeed for the first 12 months of life.

The World Health Organization recommends that HIV-positive women consult health care providers in order to evaluate the best option for their individual situations.

Universal Precautions

There are a number of precautions a healthcare providers and anyone else who cares for an HIV-positive person can take to protect themselves from contracting the virus. These universal precautions are designed to prevent the caretakers from coming in contact with blood and other body fluids that may be infected. Following are some examples:
- Wearing gloves whenever coming into contact with blood or body fluids.
- Washing hands with soap immediately after coming into contact with blood or body fluids.
- Taking extra precautions when disposing off needles in special containers that cannot be punctured. These are called sharp boxes.
- Taking special precautions when cleaning up blood spills and disposing of cleaning materials. Wearing protective clothing is advised.

Safe Sex

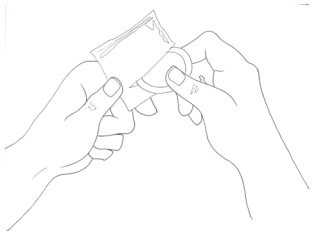
The first step to safe sex is talking about it. Learn to communicate effectively with your sexual partner. Women should not feel guilty talking about sex and expressing what gives them pleasure. Here are some tips for safe sexual practices:
- Reduce the number of sexual partners, practice monogamy (only one partner).
- Both men and women should carry condoms and insist that they be used correctly every time.
- Be sure to check the condom's expiration date before using it.
- Lubricants are especially important for anal sex, as the anus is much more fragile than the vagina and tears more easily.
- Do not have sex when drunk or after taking drugs because these impair judgment, and may cause you

to take more risks than normal.

- Engage in lower-risk sexual activities that do not involve the exchange of body fluids. These include masturbation, massage, thigh sex, armpit sex and breast sex.
- Condoms are very effective for preventing pregnancy and sexually transmitted infections (including HIV and AIDS) if they are used correctly and consistently.
- Sometimes condoms break because they are used incorrectly, are expired, or damaged because of improper storage such as the back pocket of trousers (do not sit on condoms in your pack pocket), or exposure to sunlight, especially for small roadside stands.
- The counsellor's voice and speaking patterns are extra-important in phone counselling.

How to Use a Male Condom

1. Discuss and decide to use condoms with your partner.



2. Carefully tear the edge of the foil pack and open the package so that you do not damage the condom. Do not use teeth, nails, or sharp objects to open the package because this may rip the condom.

3. Place the condom on your erect penis before intimate contact. Hold the tip of the condom to allow room for the semen.

4. With the other hand, unroll the condom over your erect penis right down to the base. You are now ready for intimate contact with your partner.

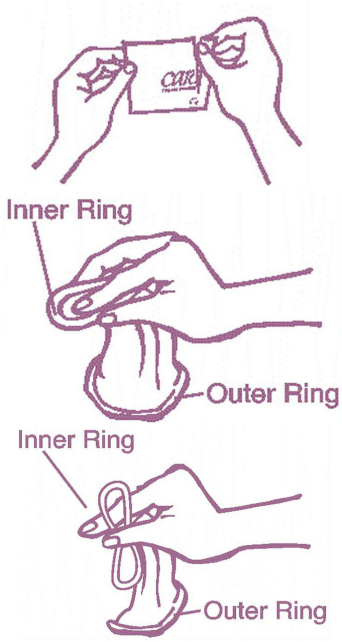
5. After ejaculation (discharge), hold the condom at the base of your penis and pull out of your partner before the penis becomes soft. Slide the condom off the penis without spilling any semen.

6. Dispose of the condom immediately into a trash bin, pit latrine, burn or bury it. Do not put into a flash toilet.

Remember: use one condom for every one sexual act!

How to Use a Female Condom

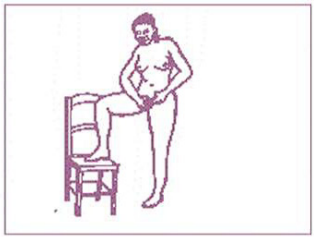
1. Carefully tear open the packet along the edge and remove the condom. Do not use teeth, nails, or sharp objects to open the package because this may rip the condom.



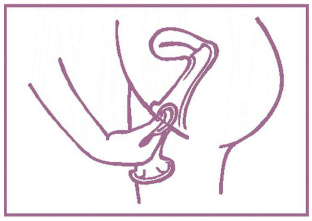
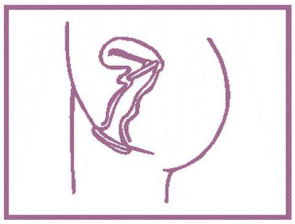
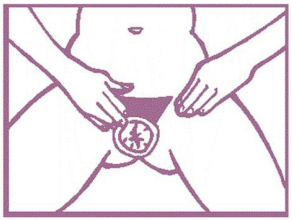
2. The female condom is a thin plastic sheath/tube with flexible rings at both ends. One ring is smaller and closed (inner ring) to facilitate insertion and keep the condom in place. This end of the sheath is closed to protect the cervix from contact with the penis. The other ring is larger and open (outer ring), and rests outside the woman's vagina. Hold the sheath with the open end hanging down.

3. With your hand on the outside of the condom, use your thumb and index finger to pinch the sides of the inner ring together to form a figure "8".

4. Find a comfortable position to insert the condom. You can stand with one foot on a chair, sit on the edge of a chair, lie down, or squat. Use your fingers to guide the sheath into the vagina.



5. Push the ring up the vagina using your index finger. Use the other hand to help widen the opening of the vagina. When your finger cannot push any further up the vagina, the condom is in place. Remove your finger. The inner ring will hold the condom in place inside of the vagina.

6. When you and your partner are ready for intercourse, secure the outer ring and ensure that your partner's penis enters the condom. Make sure that the penis enters into the female condom, not between the condom and the side of the vagina and that the outer ring remains flat against your outer vagina area. If you feel the outer ring being pushed into the vagina during intercourse, stop and pull the outer ring back into the original position.

Unlike the male condom, the use of the female condom does not rely on an erect penis. Therefore, your partner doesn't have to withdraw immediately after intercourse. You can remove the condom when it suits you both.

To remove the condom, twist the outer ring to keep the semen inside and gently pull the condom from the vagina. Use a paper or tissue to pull out the condom.

Wrap the condom in the paper/tissue and throw it in the bin, pit latrine, bury or burn it. Do not flush down toilet as it might cause blockage.

Remember: use one condom for one sexual act!

Condom Tips

- Condoms (male or female) are the best form of protection against STIs and HIV.
- Condoms have expiration dates, just like some food items. The expiration date is usually printed on the condom package. It should be checked before using the condom.
- Condoms should be opened carefully. Do not open condoms with your teeth or any other sharp objects, as this can tear them.
- Do not unroll condoms before checking for flaws. This can make it difficult to put the condom on and can result in tearing.
- Lubricants are fluids or creams that can be used during sex, because sometimes sex can be uncomfortable or painful when the penis or vagina is dry. Some condoms already have a lubricant on them. Extra lubricant can be put on the outside of the condom in order to make it easier to insert the penis in the vagina or anus.
- Only water-based lubricants are safe to use with condoms. Oil-based lubricants (such as cooking oil or Vaseline) can cause condoms to break. Some condoms are coated with spermicide, which kills sperms. Some women may experience vaginal irritation from spermicides.

Why Condoms Break

Condoms are very reliable form of protection from STIs and unplanned pregnancies when used correctly. Here are some reasons why a condom may break. However, all of these can easily be avoided.

- The condom is too old and past its expiring date. This can be prevented by checking the expiration date.
- The condom has been damaged by heat or cold. This can be avoided by storing condoms in a cool, dry place. Do not keep them in a wallet, trouser pocket or car for a long period of time. A good place to store condoms is in a cabinet/drawer by your bedside.
- The condom has not been put on properly. Make sure to leave room at the tip of the condom for semen once it is placed on the penis. All of the air should be squeezed out of the tip.
- The condom has been used before. Never re-use condoms. Use a fresh condom for each round of intercourse.
- Long finger nails may pierce the condom and cause it to break.
- Opening the condom pack with teeth or other sharp objects resulting in accidental piercing of the condom.

HIV TESTING

In Zambia, there are two types of HIV tests that are currently being used – Determine and Confirm.

The first line test a person receives is Determine. If the result is negative, the client is released without need for follow up. If the test comes back positive, another test is recommended to confirm the positive status.

The confirming second line test is known as Uni-Gold. If the test results come back positive, the client is confirmed to be HIV positive. In rare cases, if the test results come back negative, the client will be asked to take third test that will ultimately determine their HIV status. The third line test, called SD Bioline, is the most sensitive of all HIV tests and can identify even the smallest amount of HIV in the blood. This third line test take place 6 weeks after the second line test.[4]

Although a 990 Talkline counsellor will not be administering the HIV test, he/she will need to be able to explain the process to callers who are considering taking the test and refer them to testing centres. Counsellors may also need to explain results to people who have tested but have not received an adequate explanation of the results. A person can get an HIV test done at a fixed facility (hospital or clinic) or mobile facilities. There are now many Non-Governmental Organizations (NGOs) in the country that have HIV testing centres.

4 MOH, June 2009, Integrated Technical Guidelines for Frontline Health Workers, Page 165

An HIV test cannot tell:

- If a person has AIDS (only a doctor can make this diagnosis)
- How the person became infected with HIV
- How long the person has been living with HIV
- Who infected the person

Results

A **positive result** means that…

- A person has been infected with HIV and can infect others through exposing them to infectious body fluids (blood, semen, pre-cum, vaginal fluids or breast milk). All positive results are confirmed with another test (called a "confirmatory test"). However, it is unlikely that a positive result will be false.

A **negative result** can mean one of two things…

- The person has not been infected with the HIV virus.
- The person has been infected within the last 3-6 months, and the body has not yet developed antibodies. If this is the case, then the person should be tested again in another 3 months, during which time they should avoid putting themselves and others at risk of HIV infection. This time is known as the window period.

An **indeterminate result** means that it is not possible to tell if the person has been infected with HIV based on the test results. In other words, the results are inconclusive. This does not occur very often, but it can happen to people who:

- Suffer from other autoimmune diseases, such leukemia.
- Suffer from some types of cancer.

People who receive indeterminate results should be re-tested again in three months if they have engaged in risk behaviors putting them at risk of HIV infection. Those who are at low risk of HIV infection may not need to be re-tested.

The Window Period

The window period is measured from the time when a person is first infected with HIV to when HIV antibodies are detectable in the person's body. During this time the HIV test will be falsely negative because HIV antibodies are not yet present in the blood. In other words, a person is actually infected with HIV but the test will show up negative. A person in the window period may not show antibodies in their blood, but may already have very high levels of HIV in their blood, sexual fluids or breast milk. In fact, people with HIV are most infectious during this window period before their own immune system has tried to control the virus. However, depending on the test used, it can take anywhere from three weeks to 6 months for the antibodies to show up in the blood. If a person who has received a negative test result has recently engaged in risky behaviour, he or she should be tested again 3-6 months after the last time they participated in a risky activity (For example, if he/she had unprotected sex one month ago, he/she should be tested again in 2-5 months).

To Test or Not to Test?

The decision to get tested for HIV can be a difficult one. Some People may call the Talkline in order to get help making this decision.

While the benefits of getting tested may seem obvious, it is important to realize that many people may not want to get tested for a variety of reasons.

There are many advantages to getting tested:

- Early treatment for HIV can help a person live longer, and the use of AZT and Niverapine by pregnant women can reduce the chances of mother-to-child transmission.

- HIV-positive women who are not pregnant can use family planning to prevent pregnancy, if they are not already doing so.
- A person can inform his/her sexual partners so that they can get tested.
- A person can protect his/her sexual partners from infection through practicing safe sex or abstaining from sex.

Why people do not get tested:

- Fear of a positive result and the perceived lack of confidentiality
- Perceived poor quality service/false results
- Low health risk perception , and low understanding of the benefits of knowing their status
- Lack of sufficient information
- Lack of personal risk perception (it will never happen to them)
- Fear of social stigma/possible rejection and discrimination by colleagues and family
- Fear of possible dismissal from work
- Lack of good communication between couples (e.g. having to keep their status a secret from their partner)

Fears about a positive HIV test result:

- Fear of dying
- Fear of infecting spouses, partners or others
- Fear of abuse by spouses or sexual partners
- Fear of being rejected by family, friends and peers
- Fatalistic beliefs (i.e. "There is no cure anyway, so why should I find out?")
- Inability to obtain HIV treatment

Keep in mind that for some people, a negative result may be bad news. For example, if a man's wife is HIV-positive while his test turns out negative. Then this means that someone else infected her. This could have negative consequences for his marriage and for his wife.

Pre-Test Counselling

All clients who decide to go for HIV counselling engage in a pre-test counselling session. This is a short counselling session that happens immediately before someone gets tested for HIV. It explores the client's sexuality, relationships, and possible risky behaviours to assess the client's potential risk of HIV infection. It is usually conducted at the testing site by a qualified counsellor. It may be done in a group session or individually. Counselling plays a very important role in testing. This session is important to:

- Help prepare the client for the HIV test.
- Explain the implications of different test results.
- Explore ways of coping with one's HIV status.

The 990 Talkline Counsellor's role is to:

- Provide information in a manner easily understood by the caller.
- Support the caller's decision-making process by inviting them to call back or helping them to find alternate sources of support, such as partners or other services ("The Referral Network Directory" will be helpful here).
- Refer callers to appropriate services (Referral Network Directory).
- Avoid coercing the caller or the caller's partner or children into getting tested.

Though a Talkline counsellor cannot perform official pre-test counselling, they can still walk a caller through a similar process. The objectives of pre-test phone counselling are to:

- Assess the caller's risk of HIV infection.
- Inform the caller about the HIV testing process and the meaning of positive, negative and indeterminate results.

- Explore the implications of the test for the caller.
- Help the caller decide whether or not to take the test.
- Help the caller to adopt safer behaviours.

TALKLINE HIV COUNSELLING

Since the 990 Talkline is not an HIV Testing Site, the telephone counsellors will not be able to do actual face-to-face pre-test counselling. However, the Talkline counsellors should have basic knowledge of the pre-test counselling process in case they receive a call from someone who has not received proper counselling at a testing site. The 990 Talkline counsellors should adhere to the following steps for people who are either thinking of being tested or who have been tested but have not yet received their results:

a)Assess the caller's risk of HIV infection

- Ask why he/she is considering being tested or has been tested.
- What did he/she do to put himself at risk of HIV?
- What has he/she heard about how HIV is transmitted?
- Correct any misinformation and review the ways that HIV is transmitted with the caller to ensure that he/she is aware of the various risky behaviours.
- Assess whether or not the caller has actually put himself/herself at risk or not. Some people may feel that they have put themselves at risk, but they have not. For example, someone may feel at risk from mosquito bites or from sharing a toilet with an HIV-positive person.
- If a person did engage in risky behaviour, then confirm this fact and suggest that it would be a good idea to get tested. If they did not engage in risk behaviour, confirm this information and tell them that they are welcome to get tested, but that they seem to be at low risk of HIV infection.

b) Inform the caller about the HIV Testing Process

Ask the client what he/she has heard about the HIV testing process. Correct any misinformation. Be sure to discuss all of the following issues:

- Where to get tested
- What the test measures (antibodies, not the virus)
- How the test is conducted (blood or oral test)
- How long it takes to get results (this will depend on the testing site, some sites may offer rapid testing)

c) Explain the meaning of different results

What the different types of results mean (positive, negative, and indeterminate).

d) Help the caller explore the implications of getting tested

The counsellor helps the person to explore the advantages and disadvantages of getting tested. This can be done through asking questions such as the following:

- How will knowing your HIV status be helpful to you?
- What would a positive result mean for you?
- What would a negative result mean for you?
- Who will you tell about your results if they are positive? If they are negative?
- Who could you talk to while you are waiting for your test results if you feel nervous?

e) Help the caller decide whether or not to take the test (if he/she has not already done so)

Ask the caller how he/she feels about being tested after everything that you have discussed together. If the client does want to be tested, then provide him/her with information about where it can be done. Also help the caller identify a friend, family member or other person to talk to if he/she gets nervous while waiting for the results.

For some callers, the disadvantages of getting tested will outweigh the advantages. For example, an abusive husband may pose a serious threat to a woman who learns that she is HIV-positive. She may choose to wait to get tested until she is in a safer domestic situation.

If a caller does not want to be tested, respect this decision and reassure him/her that he/she can call back again if he/she changes his/her mind and would like more information. It is okay for a client to refuse testing, and counsellors should not pressure clients to be tested if they are not willing or ready for it.

f) Help the caller adopt safe sex behaviours
Based on the caller's behaviours, ask him/her what he/she would like to do to protect him/herself from HIV. Be sure that he/she gives his/her own ideas before you present him/her with options. If the client does not have any ideas, then you can present several options to choose from. Remember to ensure that the options are realistic for the client. Once a client has chosen an option, help him/her to develop an action plan.

POST-TEST COUNSELLING IN THE CONTEXT OF THE 990 TALKLINE

Post-test counselling helps the caller to understand and cope with their HIV test result. This includes preparing the caller for the result, getting the result, and providing further information or referrals as required.

Although 990 Talkline counsellors will not be giving medical advice or HIV test results themselves, they may receive calls from people who have a health problem or those that have just received test results and are in need of counselling or are seeking information about treatment and care. Therefore, counsellors need to be prepared to help callers deal with the different types of questions and HIV test results (positive, negative and indeterminate).

Callers may experience a range of emotions upon learning their test results. Many of these emotions will be very strong and should be acknowledged by the counsellor. A caller who is very emotional, either in a positive or negative way may be too distracted to hear information that is given to them.

Therefore, it is important to help the caller explore his/her emotions and "vent" them. Once a caller has released his/her feelings, he/she will be more receptive to receiving other information regarding prevention, treatment and referrals.

Counsellors should always acknowledge a caller's feelings – both those that are directly expressed and those that are "unsaid". Have counsellors refer back to the Focus on Feelings in order to identify feelings which might accompany the three types of test results. Following are examples of feelings which callers might experience upon receiving the different types of test results:

Test Results	Feelings
Negative	Relieved; happy; ecstatic; unburdened; sad (if partner is infected and the caller feels guilty)
Positive	Devastated; angry; shocked; broken; shaken; alone; crushed; despairing; hurt; anxious; overwhelmed; worried; or suicidal
Intermediate	Confused; distressed; impatient; perplexed; suspicious; unsure; or worried

Counselling for people who have recently received their results is similar to pre-test counselling, because both of them involve HIV risk assessment and the promotion of safe behaviours, or "risk reduction" behaviours. The difference between pre-test and post-test counselling is that in post-test counselling callers need to:

- Deal with the reality of their situation (not imagining it in the future).
- Have a clear understanding of what their results mean.
- Know the options that are available to them.

Dealing with callers who have recently received test results

Listen to their story

Encourage callers to tell you their story. Many people have not been able to talk to anyone about their experiences. It can be a big relief to share their story, even if they have received a negative test result.

Focus on feelings

- Ask how they feel about the results and how the results will affect their lives.
- Make sure that they understand the meaning of their results.
- Assess HIV risk.
- Why did they take the test?
- What behaviours did they engage in to put them at risk for HIV?

For positive results:

- Treatment options
- Who to notify of the results
- How to keep from infecting others

For negative results:

- How to stay uninfected (risk reduction behaviours)
- Re-testing if the test was done in the window period

For indeterminate results:

- Re-testing options
- Risk reduction behaviours

Read and think through the following pre-test and post-test counselling scenarios. If possible practice **role play** with a colleague.

1. *You are a 16-year old man. You are calling the 990 Talkline because one of your buddies just tested positive for HIV. You sometimes share drugs with him, and you are worried about getting AIDS. You want to get tested, but you're afraid that your family will kick you out of the house if they find out that you are HIV positive. You began having sex two years ago, and you have never used condoms with any of your partners. The last time you shared drugs with your friend was one year ago, but the last time you had unprotected sex was just last weekend. You want to find out more about getting tested before you make a decision.*

2. *You are a 25-year old woman who went to get tested for HIV three days ago. Your results will not be ready for another week, and you are very nervous. You think that you might be pregnant, but you are not sure. You got tested because you suspect that your boyfriend has been having sex with other women. You are worried about passing HIV along to your baby if you are infected. You are so scared that you are thinking about not returning to the clinic to get your results. You have called the 990 Talkline to talk to someone about your fears.*

3. *You are a 30-year old man named John, who is in a committed relationship with a woman named Julie. Jessy has been having a persistent cough and diarrhoea. She had several sexual partners before meeting you, and she tested HIV positive two weeks ago. You were very scared about Julie's test result and decided to get tested too. You just received your results, and they were positive. You were in such a state of shock when you received your results that you didn't pay much attention to what the clinic counsellor told you. Now you are calling the 990 Talkline to see what you and Jessy can do about your situation. You are not sure whether or not you want to stay with her. You are angry that she may have infected you, but at the same time, you are not 100% sure that she was the one who did it, since you also had many sexual partners before meeting Jessy.*

4. *You are an 18-year old domestic worker named Dabwiso. You don't make very much money, so sometimes you have sex with older men who buy you nice things and take you to restaurants. You recently heard a*

rumour that one of the men has AIDS. You took a test to be sure that you were okay, and it came back negative. You are very relieved and believe that you are "safe" from AIDS. You are worried, though, because this man is pressuring you for sex and doesn't understand why you don't want to see him any more. He forced you to have sex when you went to see him last weekend. You gave in to him and had sex last weekend, but you don't want to do it again. You call the CHAMP 990 Talkline to get some advice about what to do.

STIGMA AND DISCRIMINATION

All over the world, the epidemic of HIV/AIDS has had a profound impact, bringing out the best and worst in people. It triggers the best when individuals or groups act together in solidarity, combating government, community or individual denial and offer support and care to people living with HIV and AIDS. It brings out the worst when individuals are stigmatized and discriminated by their loved ones; their families and communities.

Stigma is having negative attitudes and perception against an individual, community or institution based on ones values and attitudes. Discrimination is the unfair or unjust treatment of an individual, community or institution. HIV and AIDS related stigma builds upon and reinforces existing prejudices.

Why do people stigmatize and discriminate against those with HIV/AIDS?

- Fear of getting infected
- Status is viewed as evidence of sexual misconduct
- Status is viewed as evidence of being a homosexual, commercial sex worker, or intra-venous drug user

Negative effects of stigma:

- Results in denial, rejection, and discrediting of testing results
- Leads to discrimination which inevitably leads to violation of human rights, particularly those of women and children
- Fuels the spread of HIV because it undermines prevention activities, care and support of infected individuals

OPPORTUNISTIC INFECTIONS

Opportunistic Infections (OIs) are infections that take advantage of a body's weakened immune system. When the immune system is not working correctly, the body is left defenceless to the invasion of other diseases. Healthy people are exposed to many of these infectious germs every day, but they do not easily get sick from them because their immune systems are working properly. HIV weakens a person's immune system and makes them very vulnerable to opportunistic infections. Tuberculosis is one of the most common opportunistic infections that affect AIDS patients, and because of AIDS, TB has become a major public health problem.

A person with AIDS can have more than one opportunistic infection at the same time. The table below shows common opportunistic infections, their symptoms and treatment. This is for informational use only. Health Talkline counsellors should not attempt to diagnose opportunistic infections of callers nor should they attempt to prescribed any medication to them. Any caller with a suspected infection should be referred to a healthcare provider.

Infections	Symptoms	Treatment
Chest Opportunistic Infections		
Bacterial Pneumonia	Fever; cough that produces yellow-green sputum; trouble breathing; chest pain	Antibiotics; severe pneumonia may require IV antibiotics
Pneumocystic Carinii Pneumonia (PCP)	Shortness of breath; fever; fatigue; weight loss; cough that produces white sputum or no sputum	Antibiotics; sever cases may also require IV drugs and/or oxygen therapy
Tuberculosis (TB)	Chronic cough; fever; weight loss; night sweats	Antibiotics
Gut Opportunistic Infection		
Diarrhoea (Bacteria, fungi, viruses or parasites)	Chronic passing of loose stool (watery stool) with or without blood or mucus; dehydration (feeling thirsty)	Oral Rehydration Therapy to combat dehydration; antibiotics; diet/food supplements; avoiding roughage foods
Oral Candidiasis (Thrush)	White plaques on the tongue, palate or inner cheek; difficult or painful swallowing if the thrush spreads to the throat	Antibiotics; avoiding roughage foods
Hairy Leukoplakia	White discoloration on the surface and sides of the tongue	Gentle and regular brushing of the tongue with a soft toothbrush
Skin Opportunistic Infection		
Herpes Simplex	Blisters or sores on the mouth, lips or genitals	Keep blisters clean with soap and water; apply antiseptic agents; antibiotics and betadine dressings if sores become infected; antibiotics
Herpes Zoster (shingles)	Small, painful blisters on one side of the body	Keep blisters clean with soap and water; apply antiseptic agents; antibiotics and betadine dressings if sores become infected; antibiotics; antibiotics for pain
Molluscum Contagiosum	Small, pearl-coloured bumps with dimples on the face, anus and genitals	Antibiotics; pricking the bumps with a needle
Folliculitis	Red, itchy or painful bumps that often have a hair in the middle, occurs most often on the face, torso, buttocks and groin	Antibiotics
Fungal Infections	Scaling and cracks on the feet; hair loss and sores on the head; ring-like patches on the body; destruction of the nails; light patches on the skin; redness and irritation on moist areas of the body	Antifungal creams; antibiotics for nail infections, scalp infections and resistant infections
Seborrhoeic Dermatitis	Patches of fine, white/yellow greasy scales on the scalp, eyebrows, moustache, chest, upper back, underarms, and groin or behind the ears	Steroid creams, lotions or shampoos; liquid paraffin applied to the scalp to loosen the crusts; anti-fungal drugs for severe cases

Psoriasis	Red to blue-gray plaques with silvery scales and sharply defined edges, usually found on the elbows, knees and lower back; may be found in the underarms and groin if patient has AIDS	Steriod creams or pills
Kaposi's Sarcoma (Skin cancer)	Black blotches 1-2cm in size, found anywhere on the skin, in the mouth or internally, the lesions may or may not be painful	Radiotherapy for lesions that are painful, large, or found in the mouth or sole of the foot; chemotherapy for severe, generalized or internal lesions
Vaginal Opportunistic Infection		
Vaginal Candidiasis (Yeast Infections)	Vaginal discharge and itching	Vaginal tablets or creams; oral antibiotics for severe cases
Nerve and Brain Opportunistic Infection		
Nerve and Brain Opportunistic Infection	Fever; headache; fatigue; stiff neck; nausea; vomiting; confusion	Antibiotics
Nerve problems in the arms and legs (Neuropathy)	Burning sensation, tingling, pain, weakness, inability to move the arms or legs	Discontinuation of ARV drugs if they are causing these symptoms; better nutrition and vitamins; pain-killers
HIV Dementia	Personality changes; confusion; forgetfulness; depression; loss of coordination and mobility	Care and support of loved ones; referral to psychiatric specialists

Granich, R. 1999. HIV, Health & Your Community. A Guide for Action. Stanford (USA) : Stanford University Press ; and 2) Evian, C. 2000. Primary AIDS Care. Houghton (South Africa) : Jacana Education.

Treatment of Opportunistic Infections

Even though there is no cure for HIV or AIDS, there are drugs that can prevent and treat opportunistic infections. A person who has AIDS should see a doctor on a regular basis in order to get proper treatment. A person with AIDS dies from an opportunistic infection and not the AIDS virus itself.

CARE AND SUPPORT

990 Talkline counsellors may receive calls from people who require information on care and support for either themselves or family members or friends with AIDS.

This session introduces counsellors to a holistic approach to HIV care and support which includes nutrition, safe sexual practices, positive living, monitoring of the disease process, prophylaxis against opportunistic infections, treatment of opportunistic infections and antiretroviral therapy.

The aim of care and support:

- To obtain information on how to live positively and continually get monitored and updated on one's HIV positive status.
- To develop a network of support that is both professional and practical.
- Develop relationships early on with professionals, peers and personal circle (family, close friends, church groups, etc) who will be able to provide support if/when HIV progresses into AIDS.
- To understand the processes leading to positive living.
- To maintain a healthy status, including access to treatment.

Things to think about when seeking care and support:

- What services are available within one's community and the associated cost with the various levels of

care and support?

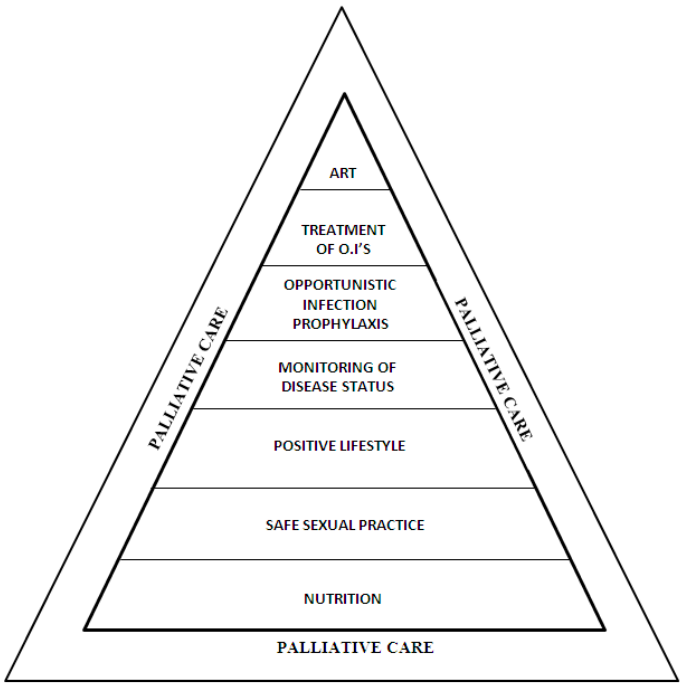
- Why it is important to access care and support?
- Understanding the process of care and support within a service delivery site.
- Where information can be accessed (e.g. from VCT centres, radio shows).

Care and Support for an HIV Positive Person

Care – this is the process of actively seeking medical and social services for one's HIV positive status.

Support – this is the process of actively seeking support services outside of the health system that can provide additional support to the HIV patient as well as friends and family such as partner and family support, psychosocial support, community support, faith based support, and home-based care. Support includes things a person should do for themselves, including self-education which leads to self-empowerment.

Positive Lifestyle - Living positively with HIV includes a number of lifestyle choices a person makes to delay the onset of AIDS. This includes specific behaviours to prevent infecting others as well as re-infecting themselves, eating a healthy diet, and having a positive attitude.



Palliative care is the total active care of patients whose disease is not responsive to curative treatment.

Positive thinking - Positive thinking is a key part of living positively, and begins with coming to terms with and accepting one's HIV status regardless of how the disease was acquired. It does not matter whether one was infected through sexual contact, blood transfusions or any other transfer method. The care and support mechanism remains the same. A person's goal should be to accept their status and move-on living a healthy and productive life.

Accepting One's HIV Status

Before accepting their HIV status, a person may go through all or some of the stages below. These stages may happen at different times in different people. A counsellor, close friend, or family member can provide support.

- **Denial** - It common for someone to deny their HIV status the first time they get their results.
- **Anger** - It is normal to be angry, and look for someone to blame. It is also normal for people to blame and hate themselves.
- **Depression/Withdrawal** - Sometimes a person may go into withdrawal and not want to talk to anyone.
- **Acceptance** - A person accepts his or her HIV positive status.

Once a person reaches acceptance, positive living can begin. It includes:

- **Exercise** - Regular exercise is good for oxygen and blood circulation and to strengthen the muscles. Exercise should focus on maintaining some level of activity as opposed to over exertion (e.g. walking briskly for 20 minutes as opposed to running marathons).
- **Rest** - It is important to take enough rest to allow for tissue repair and proper digestion of foods. Appropriate rest and relaxation will also lead to mental rejuvenation. Both physical and mental rest is necessary. Mental rest is not sitting doing nothing, this is physical rest. Mental rest may include undertaking activities that allow you to focus on alternate routine activities (e.g. cooking, listening to music, casual conversation, and gardening) that does not allow for much thought process. This will

unburden and unclutter your mind from your daily worries and anxieties.

- **Avoiding stress** - Stress is the mental strain or "pull" that you feel when you are challenged by everyday events. Stress can be healthy and stimulating, because it motivates us to live fully. Without any stress in our lives, we don't feel challenged. However, stress can be unpleasant and dangerous when we are not able to control it. Avoiding stress includes staying away from situations, people and environments that can cause stress. Where stressful situations cannot be averted, it is important to make time to de-stress through relaxation and exercise. A person under stress can be helped through counselling, spiritual or pastoral support as well as material and support with chores.
- **Manage emotions** - Positive emotions, including laughter can augment the immune system and help reduce stress and negative energy. The environment that is likely to lead to positive emotions is supportive of a positive frame of mind. Negative emotions (worry, anger, hate, fear, etc.) make the body produce hormones which weaken the immune system.These negative emotions are common with people diagnosed with HIV, but they can be overcome (e.g. talking to friends or seeking counselling). A person should not allow these feelings to overwhelm their ability to live positively with HIV.

MONITORING OF DISEASE PROGRESSION

Prior to initiating any treatment for HIV, it is important to establish the 'level' of disease and to monitor HIV progression. Treatment should only begin when indicated by test results. Treatment is initially aimed at prevention of opportunistic infections.

Opportunistic infections are curable when treated early. It is therefore vital to seek medical care at the earliest onset of symptoms. When untreated, these infections can be fatal. When the viral load has decreased to a pre-determined level, antiretroviral therapy (ART) is considered. Once started, ART must continue for the rest of a person's life. Therefore, ART is the last step in the continuum of care for an HIV positive person.

Routine Medical Examinations

People living with HIV and AIDS (PLHIV) must have regular medical check-ups. These visits are important because they monitor the progression of the HIV infection and provide early diagnosis and treatment of disease. These medical visits will include laboratory tests such as full blood counts, CD4 tests, viral load tests, and chest x-rays.

The health care provider will recommend the frequency of medical check-ups, which can change based on test results. The World Health Organization (WHO) has established guidelines used to determine the stage of disease progression and appropriate intervention at each stage, including use of medical drugs.

Self-Monitoring

HIV affects individuals differently and each stage has its own impact. It is important to monitor and keep track of symptoms. If HIV positive, a person should keep regular contact with a care provider for regular health checks.

ANTIRETROVIRALS

A person who is diagnosed as HIV positive is treated with antiretroviral medicines (ARVs). These medicines fight HIV and enable a person to live a healthier life. ARVs do not cure HIV or AIDS, but simply reduce the amount of HIV in the blood. By doing so, this allows a person's immune system to remain strong and fight disease better. When taken correctly, ARVs can help people living with HIV live longer and healthier lives.

It is important that a person on ARVs follow instructions given to them by their health provider and take the right pills every day at a similar time. He/she should also ensure good nutrition.

Antiretroviral Therapy (ART) is started when:

- CD4 count is less than or equal to 200
- Viral load is more than 50,000 copies
- There is an AIDS defining disease
- Mother to child-transmission is a concern

Before starting ART, a health care provider also considers the following:

- Nutritional status of the patient
- Overall physical condition and exercise
- Risk factors including opportunistic infections
- Smoking, alcohol and drug use
- Laboratory results (full blood count, liver function test, chest X-ray)

ARV's have side effects like any other drugs. Some side effects of ARVs include the following:

- Skin rash
- Fevers
- Redistribution of body fat
- Nausea
- Vomiting
- Diarrhoea
- Blood thinning
- Bleeding

The treatment needs monitoring to see if:

- Treatment is working, by checking the patient's well-being and nutrition, translated in weight gain, increase in appetite, etc.
- CD4 count has increased.
- Viral load has reduced.

Post Exposure Prophylaxis (PEP)

Post exposure prophylaxis (PEP) is a preventative measure using antiretroviral therapy to prevent HIV infection if someone r one has been exposed to the virus. This therapy needs to be initiated within 72 hours of exposure (best results occur when therapy is commenced 1 to 2 hours after exposure) and lasts one month.

PEP is only effective for people who are HIV negative and are newly exposed to HIV. Once HIV is active in the body, PEP has no effect. A negative HIV test result is needed in order to get the full benefits of PEP therapy.

PEP therapy is offered to:

- Rape survivors
- Health care providers
- Other person that may have had accidental exposure to HIV (e.g. coming into contact with infected blood while helping accident victims)

PALLIATIVE CARE

Palliative care is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems. Palliative care:

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten nor postpone death.

- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help the family cope during the patient's illness and in their own bereavement.
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.
- Will enhance quality of life, and may also positively influence the course of illness.

Why is palliative care important?

Palliative care is an essential component of a comprehensive care package for people living with HIV and AIDS because of the variety of symptoms they can experience - such as pain, diarrhoea, cough, and shortness of breath, nausea, weakness, fatigue, fever, and confusion.

Palliative care is an important means of relieving symptoms that result in undue suffering and frequent visits to the hospital or clinic. A lack of palliative care can result in untreated symptoms that hamper an individual from continuing with his or her active daily life. At the community level, lack of palliative care places an unnecessary burden on hospital or clinic resources.

Providing Palliative Care

Palliative care can be provided by:

- **Health workers:** Health workers can provide basic medical and psychological support including necessary drugs to control pain and other symptoms that occur as a result of HIV related disease.
- **Family and community caregivers:** when patients choose to be at home, caregivers can be trained by health workers to effectively provide the prescribed medications and other physical and psychological support that they may need. Friends, relatives and others in the community can be trained to ensure that the patient is comfortable.
- **Medical attention from health facility workers:** home visits to support the patient and to assist the caregiver should be available as needed. Families and friends should provide support even after the death of the patient. Bereavement counselling is an opportunity to support the loss of affected loved ones and to consider future plans.

Trained family members, community volunteers or health care workers will be required in sufficient numbers to provide adequate care without overburdening individual cares. Ideally a mix of all three should be used, with hospital or clinic based health care workers used for initial teaching and periodic follow-up in the home.

HOME-BASED CARE

990 Talkline counsellors may receive calls from people who are taking care of family members or friends with AIDS. This section introduces counsellors to the advantages and disadvantages of home-based care, in addition to an overview of how home-based care providers can protect themselves from infection.

Home-Based Care by Non-Health Professionals

Home-based care is the care of a sick person at home. Family members or volunteers in collaboration with professional health care providers, provide this care. Home-based care is common in Zambia as it is a way to decongest health facilities and is more affordable for patients who cannot afford prolonged hospital care.

The aim of home-based care is to:

- Ensure that people receive basic nursing care as well as social and emotional support.
- Promote acceptance of people with HIV.
- Reduce the demand for AIDS care in hospitals.
- Integrate care with HIV education.
- Mobilise other people to provide support.
- Reach sick people who are not using health services.

- Enable health workers to make home visits.
- Train volunteers, families and people with HIV in basic nursing care and infection control.

AIDS patients need not to be in a hospital. However, home-based care given to a person with AIDS (PLHIV) is not the only care that the person will need. It is part of a continuum of care, which includes clinics, hospitals and other health professionals.

Family members and volunteers cannot provide the same level of care as trained health professionals, but they can be taught to provide good nutrition and to help with hygiene and personal care. If possible, the volunteers should receive some basic training before beginning to care for an AIDS person.

Personal Care

Home-based care providers can help with a patient's personal care in the following ways:

- Giving medications.
- Changing bed sheets.
- Bathing patients and helping them to go to the bathroom.
- Feeding patients.
- Preventing stiff joints and bedsores by helping bed-ridden patients to change positions frequently and by adjusting their pillows and blankets.
- Helping patients to do simple arm, leg, hand and foot exercises. These help to prevent stiff, sore joints and improve blood circulation.
- Treating basic ailments, such as diarrhoea, sore throat, headaches, skin sores and coughing.
- Providing emotional support.
- Maintaining a hygienic environment to prevent the spread of infections.
- Obtaining professional medical help when needed.

The home-based care family provider must remember that he/she is not alone in this care. He/she must be in contact with the doctor, nurse, social worker and other health care workers who are also providing care.

Clear, written information about medicines should be given by the medical team, and the changes expected in the PLHIV should also be understood by the family health care providers. For example, the beginning of a cough, diarrhoea, or confusion may mean an infection or problem that needs a new medicine or hospital care.

Useful Supplies

Following are some supplies that are helpful to have in the home when caring for an HIV-positive person who is very sick and bedridden:[5]

- Plastic for the bed
- Rubber gloves
- Radio/television
- Bedpan or bedside commode chair
- Urinal which could be made from an old container

Self-Protection for the Home-Based Care Provider

Providing care to PLHIV means guarding against infections, both for the PLHIV and for the caretaker. It is unlikely that a caregiver will contract HIV, as long as he/she is following universal precautions. It is possible to get other infections, however.

Home-based care providers should make sure that their immunizations are in order. This is not only to prevent contracting an illness from an AIDS patient, but also to prevent spreading illness to the person with

5 Granich, R. 1999. HIV, Health & Your Community: A Guide for Action. Stanford, CA (USA): Stanford University Press.

AIDS. Children or adults who live with someone with AIDS and who need to get vaccinated against polio should get an injection with the "inactivated virus" vaccine or be separated from the AIDS patient for some time. The regular oral polio vaccine contains the live poliovirus, which can easily spread from the person who got the vaccine to the person with AIDS. Everyone living with a PLHIV (not only caregivers) should get a flu shot every year, if possible. This will reduce the chances of spreading the flu to the person with AIDS. Everyone living with a person with AIDS should also be checked for tuberculosis (TB) every year.

Gloves and hand washing play an important role in protecting caregivers from both transmitting and receiving infections. Gloves should be worn in the following scenarios:

- Whenever the caregiver is exposed to body fluids of a PLHIV, including blood, urine, saliva and sexual fluids.
- Whenever caring for a PLHIV with diarrhea.
- Whenever the PLHIV has fever blisters or cold sores around the nose or mouth.
- When the caregiver has a skin rash, such as eczema.

Many persons with or without AIDS are infected with a virus called cytomegalovirus (CMV), which can be spread in urine or saliva. Washing hands or wearing gloves is extremely important after touching urine or saliva from a person with AIDS. This is crucial for a person who is pregnant because a pregnant woman who gets infected with CMV can also infect her unborn child. CMV causes birth defects such as deafness.

Any liquid waste such as vomit must be flushed down the toilet or thrown down a latrine. Items that cannot be flushed down the toilet (i.e. paper towels, sanitary pads and tampons, wound dressings, bandages and diapers) should be put in plastic bag or wrapped in enough newspapers to stop any leaks. These should then be burnt, buried or thrown in a pit latrine.

If the home-based care provider is also a sexual partner of the PLHIV, he/she should be tested for HIV, and the couple should always use condoms when having sex.

Emotional Support

Home-based care providers should consider talking with close relatives, children, and parents to prepare them for the death of their loved one. This is a difficult topic to discuss as many times denial is the main obstacle.

Addressing the topic of death with the person affected by AIDS might be a topic of discussion especially regarding the fate of children and loved ones in case of death. Home-based care providers can offer an opportunity for loved ones to prepare and discuss about death and make appropriate arrangements.

Part 3: Sexual Reproductive Health

SEXUAL REPRODUCTIVE HEALTH

The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

On the other hand, reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.

Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. (ICPD, 1994, Cairo).

SEXUAL REPRODUCTIVE HEALTH RIGHTS (SRHR)

Sexual and reproductive health and rights (SRHR) can be understood as the right for all, whether young or old, male or female, HIV positive or negative, to make choices regarding their own sexuality and reproduction, providing these respect the rights of others to bodily integrity. This definition includes the right to access information and services needed to support these choices and optimize health such as access to safe, effective, affordable and acceptable methods of family planning. This also includes a woman's right to access the appropriate health-care services needed to go safely through pregnancy and childbirth.

The many sexual reproductive rights individuals should be aware of include:

- Everyone has the right to life, and this should not be put at risk by pregnancy and child birth.
- Everyone has the right and freedom to control their own sexual and reproductive lives.
- No one should be discriminated against because of their race, ethnicity, poverty, sex or sexual orientation, whether they are married or not, or because of religious or political opinions. Everyone has the right to access SRH services.
- Everyone has the right to privately and confidentially make their own decisions about their sexual and reproductive life, and to have these decisions respected.
- Everyone has the right to information and education on SRH and this includes the right to know about the benefits and availability of sexual and reproductive health services.
- Everyone has the right to choose when and whether they want to marry or not.
- Each one has the right to decide on the number, timing and spacing of their children, if they choose to have children. This includes the right to choose contraception and whether or not to breastfeed.
- Everyone has the right to the best possible sexual health. This includes avoiding unwanted pregnancies, STIs, including HIV, and sexual violence.
- Everyone has the right to use new technologies that have the potential to improve their health.
- Any individual or organization has the right to advocate for SRHR issues.
- Everyone has the right to be treated with respect and consideration when accessing SRH services.
- Everyone has the right to have a satisfying, safe and pleasurable sex life.

Source: SAFAIDS Sexual Reproductive Health Rights Kit

GROWING UP - ADOLESCENCE

As young people grow up, there are some important changes and common concerns that happen to them at different ages. Puberty marks the beginning of adolescence, the age between 10 and 19. During this stage, boys and girls experience growth related changes influenced by some chemicals in their bodies called hormones.

Changes During Puberty

	Boys	Girls
Hair Growth	Around the penis, under the arms, and at the face, legs and chest areas	Around the vagina and under the arms
Acne & body odor	Skin gets oilier and acne may occur; perspiration increases and may cause body odour	
Shapes and sizes	Height, weight and muscles increase; shoulders broaden	Height, weight and width of hips increase; fat at the abdominal, buttock and thigh areas increases.
Unique changes	Penis and testes enlarge and lengthen; erections and ejaculations occur more frequently; voice cracks	Breasts develop; menstruation occurs

Adolescents may call the Talkine to express their concerns over different changes they are seeing or not seeing in their body. Counsellors should reassure callers that changes during puberty are natural and that everyone develops at a different time (e.g. no need to compare yourself against your friend's bodies). Examples of such changes include:

- Start of menstruation in girls.
- Differences in hip size among girls of same age.
- Development of pimples in both girls and boys.
- Voice deepening in boys.
- Attraction to opposite sex.

A counsellor needs to remember the following things when attending to an adolescent:

- Educate young people about their bodies. They may have simple questions like "Why do I have pimples? Why is my voice changing? Can I get pregnant? Can I make a girl pregnant?"
- Listen for wrong information that they have picked up. Even those who are sexually active at this stage are not sure of how their bodies work.
- Inform and reassure youth who are confused and fearful about the changes in their bodies. These can be things like breast development, menstruation or erections.

Early Adolescence: 10-14 years

As children undergo puberty (physical body) changes, they also start experiencing adult emotions, such as sexual desire. A girl at this time starts to develop into a woman and a boy into a man. At this age, youth do the following things:

- Begin to identify more with their peers and less with their family.
- Begin to develop their own identity and want independence from adults.
- Become more aware of their bodies.
- Likely to experience sexual arousal.
- Start play acting sexual games with their own gender.

Late Adolescence: 15-19 years

At this age, young people begin to form their own set of values. They explore new ideas about themselves and the world around them. Many young people begin to experiment with sex. Youth at this age are unlikely see the results of their actions. This means that they may take sexual risks and not understand that negative

experiences may result from them. Youths mayneed help to make responsible choices and to understand what will happen when they make these choices. At this age, young people sometimes do the following things:

- Want more freedom, which can mean going against their parents.
- Have loyal friendships with one or two friends of the same age.
- Compare themselves to their friends and peers. This can lead to low self-esteem and lack of confidence. Their emotions go from happiness and joy to sadness as they start their first love relationships.

ADOLESCENCE, TEENAGE SEXUALITY AND PREGNANCY

At adolescence, boys and girls begin to admire each other and have romantic feelings for each other. At this stage, boys and girls may start experimenting sexually. Sex at young age makes those involved even more vulnerable to unplanned pregnancies. An unplanned pregnancy at a young age may result in:

- Loss of education
- Psychological or mental illness disorders if not provided with necessary support
- Being stigmatised by community – considered as social misfit
- Forced into marriage
- Unwanted baby
- Inadequate parenting
- Unsafe abortion
- Child abandonment
- Infanticide (intentional killing of one's baby)
- Reduced access to antenatal, natal and postnatal care
- Obstructed labour/delivery related complications, death, fistula (leaking stool or/and urine) due to damaged wall between rectum and bladder and the vagina during delivery
- Premature childbirth, stillbirth or low weight baby
- Can lead to cycle of poverty (mother and child)

SEXUALLY TRANSMITTED INFECTIONS (STIS) AND HIV INFECTION

STIs, if not treated may result in infertility or death. Other than risks of pregnancies and infections, the adolescents at this stage suffer a lot of worries relating to their body changes that occur at different times in different individuals of the same age and may call 990 Talkline for help on these concerns.

PARENT CHILD COMMUNICATION

Parents should prioritize building open and friendly communication habits early on with their child. This will help build the child's confidence and self-esteem and establish the parent as a safe confidant (a person the child can talk to about his/her sexuality and other growing up related concerns).

> Parents, fathers included, should make time to talk to their children about the changes they will see in their body and what will be expected of them as they continue to grow up.

COUNSELLING ADOLESCENTS

Adolescents are a special and sensitive group of a society. Counsellors should be mindful to adjust to the needs of a younger caller.

Tips for counselling adolescents:

- Use clear and simple language that the youth can understand.
- Listen to what a young person is saying. For a younger child, encourage him or her to tell a story.
- Make sure that the young person understands what you say. Ask them to repeat what you have said in their own words. Young people may find it difficult to ask questions when they do not understand.
- Treat a young person with respect. You must be reliable and act the same way you would act with any adult client.

- Give young people as much time as they need. At the same time make sure they talk about the concerns that they have. A youth may feel confused and change his or her mind as new ideas are explored.

Growing up is joyous, but at times could be filled with worries. Advise adolescents to talk to their parents or any other trusted adult in their community about their concerns.

FAMILY PLANNING

Knowledge of any contraceptive method is almost universal in Zambia, with 97%of women and 99%of men knowing at least one method of contraception. Current use of any contraceptive method among all women is 30%, while use of modern contraceptive methods is at 25%. Among married women, more than two in five (41%) are using contraception in Zambia.[1]

Too many births, births too close together, and births to adolescent girls under 18 and women over 35, endanger the lives of women and adolescents and their infants. Family planning is one of the most effective ways to improve women and children's health and survival. This is because family planning services provide women and men with information, education and the means to plan when to begin having children, how many to have, how far apart to have them and when to stop.[2]

Family Planning Counselling

Counselling is a vital part of family planning. It helps the client to arrive at an informed decision of reproductive options and to use the chosen method safely and effectively. Good counselling should focus on the individual client's needs and situation because every client is unique and has different needs.

During counselling, the provider should assess the needs of each client by asking profiling questions. Profiling is a way of grouping clients according to their reproductive needs during a counselling sessions, in order to meet each individual client's specific needs. Profiling also helps providers to integrate information on other reproductive health issues, such as breastfeeding, STIs and especially HIV/AIDS, as the needs are identified.

Family Planning Methods

Family planning (contraceptive) methods are grouped into permanent, hormonal, barrier and scientific natural methods.

Hormonal: Implants (Jadelle) are a set (two) of small silicone rods filled with hormones and inserted just under the skin in a woman's arm to prevent pregnancy. The rods release a hormone that causes temporary changes in the woman's reproductive system. It stops ovulation and also thickens the cervical mucus that makes it difficult for sperm to reach the egg.

- Highly effective.
- Immediate return of fertility upon removal.
- Decreased menstrual flow/or no menses at all.
- Does not affect quality of breast milk.

Injectable: An **injection**, such as (Noristrat or Depo Provera), can prevent pregnancy for three months. A new injection must be given every three months. The injectable is appropriate for women who want highly effective pregnancy protection. It is appropriate for breast-feeding women and women who have any cardiovascular disorders.

- Highly effective when taken on schedule.
- Easy to use.
- Reduces menstrual flow.
- Does not affect sexual intercourse.

1 CSO, 2007, ZDHS
2 UNICEF, 2010, Facts for Life, Fourth Edition

Pill: There are two types of pill, the regular combined oral pill (microgynon) and the mini pill (projesterone only pill).

Regular Microgynon (combined oral pill)

- A small tablet that women take every day to prevent pregnancy.
- The pill works in three ways: the hormones inside the pill prevent a woman's body from releasing an egg every month; the pill thickens the cervical mucus making it difficult for the sperm to enter the womb to fertilise the egg; the pill changes the lining of the womb so that an egg could no longer attach there.
- Highly effective when taken everyday.
- Easy to use - many women have less menstrual cramping.
- Menstrual periods are usually regular and lighter.

Mini Pill (Progesterone only pill) – used by breastfeeding mothers

It is a tablet taken everyday by a woman to prevent pregnancy. However the hormone in the mini pill is different from the regular family planing pill, it contains a hormone called progestin and can be used by breastfeeding mothers.

- Highly effective when taken everyday.
- Easy to use.
- Reduce menstrual flow.

Intrauterine Contraceptive Device (IUD): The IUD is a small plastic device that fits inside the uterus (womb) to prevent pregnancy. Most of them have a copper wire around the plastic to increase effectiveness. It is also called the loop. The loop prevents pregnancy by causing temporary, reversible changes inside the womb and fallopian tubes, that keeps the sperm and egg from meeting, therefore preventing fertilization.

- Highly effective.
- Long term protection (up to 12 years).
- Does not interfere with sexual intercourse.
- Low maintenance.
- Can be inserted immediately after childbirth.
- Immediate return to fertility after removal.

Barrier Methods: Condoms (male and female) prevent pregnancies by creating a barrier between the penis and vagina during sexual intercourse. The male condom is a close fitting latex rubber that a man wears over his erect penis before penetration to prevent the sperm from entering the woman's vagina during intercourse. The female condom is a soft, thin pouch made of polyurethane with flexible rings at the top and bottom ends. It lines the vagina during sexual intercourse to prevent the sperm from entering the woman's vagina.

- The only contraceptive which also prevents STDs and HIV.
- Effective when used with every act of sexual intercourse.
- Women controlled method (Female Condom).
- Cheap to purchase.

Permanent Methods: A **vasectomy** is a permanent method of family planning for men who do not want to have anymore children. The procedure is done through an operation by a small cut in the scrotum that clips the tubes so that the body no longer releases any sperm in the semen during ejaculation. It is a simple and safe procedure that takes no more than 30 minutes. It is extremely effective and irreversible once done.

Tubal ligation is a permanent method of family planning for women who do not want to have anymore children. A small cut is made in the lower abdomen by a trained health care provider who blocks the fallopian tubes. This prevents a woman's eggs from reaching her uterus for fertilization. The procedure is highly effective.

Fertility Awareness Methods: Fertility awareness methods are based on avoidance of intercourse (practicing abstinence) at times when the woman is in the fertile time of her menstrual cycle. There are namely three methods:

- Symptothermal method – based on observing mucus and temperature.
- Basal body temperature method – observing changes in the body temperature only.
- Cervical mucus method – observing mucus only.

Benefits:

- No drugs, chemicals or surgery needed.
- Little or no cost.
- Improves woman's knowledge of her reproductive system.
- No health risks.
- No side effects.

Lactational Amenorrhoea Method (LAM): The Lactational Amenorrhoea Method utilises temporary infertility that occurs during breastfeeding. When a baby suckles frequently at the breast, it stimulates the nipple, sending signals to the brain which then releases hormones. These hormones prevent the release of the woman's egg. To be effective, breast milk must be the only food or drink the baby receives. For this method to work, the baby must be less than six months old and exclusively breastfed.

- Highly effective.
- No cost or supplies.
- No health risks and improves mother and child bonding.

Possible Side Effects of Family Planning

As a counsellor, when discussing contraceptive with a client, there is a need to provide full information including side effect if any. This will help the client make an informed choice of the method. The table below provides some side effects of some of the contraceptives.

Method	Side Effects
Condoms	Some men and women may react to rubber
Some men and women may react to rubber	Nausea, dizziness, mild breast tenderness, headaches, spotting or light bleeding (usually decreases after 2-3 cycles), can delay return to fertility Serious but rare side effects such as heart attack, stroke, blood clots in lung or brain.
Intra-utrine devices	Increases menstrual bleeding and cramping during the first few months following insertion May be spontaneously expelled (rarely) May increase risk of Pelvic Inflammatory Disease (PID) and subsequent infertility if genital tract infection is present at the time of insertion.
Lactational Amenorrhoea Method	Lactational Amenorrhoea Method
Female sterilisation	Usually none. Post-operative wound bleeding, pain and haematoma, infection is possible if the procedure is not properly carried out.
Male sterilisation - vasectomy	Usually none. Post-operative wound bleeding, pain and haematoma, infection is possible if the procedure is not properly carried out.
Natural Family Planning	Unintended pregnancy.

Types of Family Planning Client Profiles

Family planning methods are better recommended by trained providers on the basis of profiling. There are four profile categories a client can fit:

1. **Multi-Partners** – clients who have multiple partners or who know/suspect that their partners have other sexual partners. Recommended method for them is:
   - Condom (male/female)

2. **Breastfeeders** – clients are currently breastfeeding a child of less than 6 months of age exclusively. Recommended methods for them are:
   - Condoms (male/female)
   - Mini-pill
   - Injectable
   - Implants (Jadelle)
   - Lactational Amenorrhea Method (LAM)
   - Scientific Natural Family Planning (SNFP)

3. **Spacers/Delayers** – clients who want to wait before having a first or another baby. Recommended methods for them include:
   - Condoms (male/female)
   - Oral contraceptive pills
   - Injectables
   - Implants (Jadelle)
   - Scientific Natural Family Planning (SNFP)
   - IUD

4. **Limiter** – Clients who do not wish to have any more children. Recommended methods for them are:
   - Injectables
   - Inplant (Jadelle)IUD
   - Tubal Ligation
   - Vasectomy
   - Family Planning Counselling skills.

When counselling clients, the provider needs to:

- Understand and respect the client's rights.
- Earn the client's trust.
- Understand the benefits and limitation of all the contraceptive methods
- Understand the cultural and emotional factors that affect a woman's (or couple's) decision to use a particular contraceptive method.
- Encourage the client to ask questions.
- Use a non-judgemental approach which shows respect and kindness towards the client.
- Present complete and accurate information in an unbiased, client sensitive manner.
- Actively listen to the client's concerns.
- Understand the effect of non-verbal communication.
- Recognize when he/she cannot sufficiently help a client and refer the client to someone who can.

FAMILY PLANNING AND POSITIVE LIVING

Positive living individuals and couples have the right to sexual intercourse, but for the purpose of maintaining good health, they are encouraged to use family planning methods to avoid unplanned pregnancies – as pregnancy can be a health risk to a positive woman if not well managed. Male and female condoms are recommended for discordant or HIV positive couples to prevent re-infection or infecting the

partner who is negative. For family planning services, advise clients to go to the nearest health facility in their area.

SEXUALLY TRANSMITTED INFECTIONS (STIS)

Sexually Transmitted Infections (STIs) are infections that come through sexual intercourse. They are also more commonly referred to as Sexually Transmitted Diseases (STDs). They are infections passed during vaginal, anal or oral sex. STIs can also be passed from an infected mother to child during pregnancy, child birth, or while breast-feeding. Many STIs that are passed to children are very dangerous and can cause serious health problems.

People are at risk of getting an STI if they:

- have unprotected sex with an infected person (sex without a condom).
- have unprotected sex with many sexual partners.
- have sex while drunk (which could impair their ability to protect themselves).
- do not know the symptoms of an STI (and therefore cannot tell if they or their partner has an STI).

Common STI Symptoms	
Women	Men
• Unusual discharge or smell from the vagina. • Abdominal pain. • Burning or itching around the vagina. • Bleeding between menstrual periods or after sexual intercourse. • Pain deep in the vagina during sex. • Ulceration on the genitals that may start with a rash	• Discharge from the penis. • Pain or burning sensation when urinating. • Ulceration on the penis that may start with a rash

Some of the most common STIs include the following in the table below:

STI Description	Cause	Signs and Symptoms	Complications
Chancroid	Bacterial	Genital ulcer	
Chlamydia	Bacterial	Genital discharge, eye discharge in new born, pain on passing urine, pain during sex	Tubal abscess, infertility, swelling of testicles, arthritis
Syphilis	Bacterial	Painless genital ulcer, swollen glands, non- itchy skin rash	Insanity, skin ulcers, losing of hair on scalp, infertility, still birth
Human Papilloma Virus	Viral	Warts in cauliflower like growth	Cancer of the cervix
Gonorrhoea	Bacterial	Genital discharge, pain on passing urine, lower abdomen pain	Pelvic Inflammatory Disease (PID), infertility, swollen testicles, arthritis, bleeding in between periods, neonatal conjunctivitis
Herpes simplex	Viral	Painful genital ulcer	Can be transmitted to unborn baby, keep on reoccurring
Trichomoniasis	Parasitic	Abnormal vaginal discharge, abdominal pain, discomfort during intercourse, itchy burning genitals, and genital redness	

Hepatitis B	Viral	Flu like illness with fatigue, nausea, vomiting, loss of appetite, fever, yellowing of eyes, mouth, palms and dark urine	
Candidiasis	Fungal	Vaginal itchiness and discharge, genital rashes	
LGV (bola-bola)	Bacterial	Severe genital ulceration, swollen painful nodes in between thigh and genitals that will burst and form deep ulcers.	Severe damage to genitals
HIV	Viral	Flu-like symptoms may occur early or late, most infected people look and feel well for years, skin and lung infections common in later years	Chronic illness until death

Long-Term Consequences of STIs

If left untreated, STIs can cause serious health problems, including the following:[3]

- Damage to the reproductive organs, resulting in infertility.
- Bladder infections.
- Damage to other body organs, such as the liver (Hepatitis B), brain (Syphilis), and heart (Gonorrhoea).
- Arthritis.
- Breakdown of the immune system and death.
- Cancer of the reproductive organs (genital warts caused by the Human Papilloma Virus).
- Premature labour and stillbirths (Gonorrhoea).
- Blindness and birth defects in new-born babies (Syphilis).
- Pelvic Inflammatory Disease (PID) in women. This is a severe infection of the reproductive organs that can result in infertility, ectopic pregnancy and chronic pain. It is often, but not always caused by an STI. Gonorrhoea and Chlamydia are the most common causes.

Link between STIs and HIV Transmission

Having an STI increases a person's chances of becoming infected with HIV and transmitting the virus to a sexual partner. This is because sores or inflammation in the genital areas can serve as both entry points for HIV into the body (when they come into contact with infected semen or vaginal fluids) and exit points for HIV to leave the body (through blood). Prevention and control of STIs helps in the prevention and control of HIV. Therefore, it is very important for people that are infected with STIs to get treatment for themselves and their partners.

Treatment

A person with an STI must get treatment because the infection/disease will not go away on its own. Some STIs, such as syphilis and gonorrhoea, are caused by bacteria and can be cured. Other STIs, such as herpes and HIV, are caused by viruses. These cannot be cured, but their symptoms can be treated with medication.

A person infected with an STI should inform all of his/her sexual partners about it, so that they can get treated also. If a person's partner does not get treated, then he/she will continue to get re-infected by that person and will also infect other sexual partners. It is very important for both partners to finish the treatment completely, even if the symptoms disappear. It is possible for the STI to still be in a person's body even without symptoms.

Prevention

Not having sex is the only 100% effective way to prevent STIs. If a person chooses not to abstain from sex, it is

3 Planned Parenthood (New York City, USA). 1997. Sexually Transmitted Infections: The Facts. (Brochure)

safe for them to have protected sex with another person as long as that person is not having sex with anyone else. It is advisable for partners to talk to each other about past sexual partners (which could put someone at risk of HIV). It is best to use condoms if a person is unsure about his/her partner's past risk of STIs.

It is also advisable for partners to look for any signs of an STI on each other's bodies, for example, a rash, a sore, redness or discharge on or near the genital areas. If any of these are visible, the couple should not have sex, even if condoms are available. People should keep in mind that an STI could be present even if there are no signs or symptoms.

Condoms should be used each and every time a person has vaginal, anal, or oral sex. In addition to condoms, birth control jelly, cream or foam can offer extra protection against STI during vaginal sex. They do not protect against all STIs, however, such as HIV. A person should get checked for STIs every time he/she has a health check-up. If he/she has more than one sexual partner, it is advisable to get regular check-ups, even if he/she doesn't have any symptoms.

Part 4: Nutrition

NUTRITION

Nutrition is a broad term referring to the body's process of taking in, digesting, and utilising food for growth, energy production, and maintenance of health. It helps to describe the relationship between food and the body. Nutrition is more than eating food. It also includes the quantity, quality, frequency and variety of food.

FOOD COMPOSITION

Food is made up of nutrients or substances which the body needs for growth, repair, protection from diseases, and energy. Nutrients can be taken in through different foods including carbohydrates, proteins and fats as well as vitamins and minerals. Most people in Zambia eat mainly carbohydrates, mostly because they are cheaper than meat, fruit and vegetables. This leads to deficiencies, particularly of vitamins, minerals and proteins, often leading to malnutrition. Malnutrition arises from inadequate intake, poor absorption and utilisation of nutrients resulting in a weak poorly functioning immune system.

ROLE OF FOOD IN THE BODY

Food is the main way nutrients enter the body to bring about development, growth, maintenance, replacement and repair of cells and tissues. Food also helps the body produce energy for warmth, movement and work. Lastly, nutrients from the food also help the body resist and fight infections.

NUTRIENTS AND FOOD SOURCES

Carbohydrates

Carbohydrates are obtained from starches and sugars that provide the body with energy. Good sources of carbohydrates include **rice, maize (nshima), wheat (bread), millet, sorghum, cassava, bananas, sugar cane, sweet and Irish potatoes, and honey**.

Proteins

Proteins build and repair the body. Good sources of protein include **beans, soya, meat, milk, cheese, eggs, fish, Kapenta, chicken, groundnuts, mice, caterpillars and other edible insects such as termites (Inswa)**.

Fats and Oils

Fats and oils are good sources of energy and help the body absorb vitamins A, D and E. Good sources of fats and oils include **palm oil, coconut oil, margarine, butter, cooking oil, fatty meat, bottle and barbell fish, milk and cheese, ground nuts, soya beans, and sunflower seeds**.

Vitamins and Minerals

Vitamins and minerals are necessary to support proper body function. They help repair body cells, produce blood and bone, and enhance muscle coordination and brain function. They also help the body resist infection and recover from illnesses quickly. Fruits and vegetables are major sources of vitamins and minerals. Good sources of vitamins and minerals include **avocado, pawpaw, guava, banana, orange, apple, pear, lemon, tomato, pumpkin, spinach, carrot, beetroot, cabbage, sweet potato leaves, pumpkin leaves and rape**.

Fibre

Fibre is good for digestion; essential because of its ability to attract and hold water as it passes through the intestines. Fibre and water helps make the stools soft and stimulate intestinal movement therefore preventing constipation and abdominal discomfort. Good sources of fibre include **wheat, cabbage, rape, oranges, guava, mango, carrots, pineapple, apple, pear, spinach, tomato, pumpkin, sweet potato and bean leaves**.

Water

Water is an essential in keeping the body hydrated. Water helps with digestion, transportation and absorption of nutrients to relevant body organs. It is important to drink a lot of clean safe water every day. To ensure that water is safe, all drinking water should be boiled or chlorinated.

FACTORS THAT COULD LEAD TO POOR NUTRITION

Sickness

Some people may need help in managing symptoms such as loss of appetite, mouth sores, constipation, diarrhoea, nausea and vomiting, taste changes, stress and depression, poor liver function and mal-absorption.

Cultural and Religious Beliefs

Culture defines what should be considered as food. What should and shouldn't be eaten is often transmitted through myths and legends, rules and folk stories, outlining consequences of being disobedient. In most cases culture prescribes food taboos (foods you shouldn't eat), usually targeted at women and children. Examples include, pregnant women should not eat eggs or this will lead babies to be born with bald heads, or women should not to eat rabbit meat otherwise there baby will be born with a hare lip.

Religion, also a part of culture, also influences people's food choices, in addition to food sharing, preparation and cooking practices. For example, (we can use the Zambian example people from the SDA church do not eat pork on account of pigs being not clean..

Other Factors

Poorly prepared foods, alcohol consumption, drug effects and food-drug interaction, food intolerance, poor condition of the intestinal lining decreases digestion and absorption of nutrients. Infections have a negative effect on metabolism, lack of exercise and alcohol consumption can keep the body from processing nutrients effectively. Metabolism is a chemical reaction in the body's cells that converts the fuel from food into the energy we need to do everything from moving to thinking to growing.

Food and Water Hygiene

It is important to take specific actions to keep food and water away from bacteria and disease. Some of those actions include:

- Washing hands and maintaining hygiene around the home.
- Keeping raw food separately from cooked or prepared food .
- Cooking food such as meat, poultry, eggs, fish, stews and other soups thoroughly to ensure their safety.
- Storing food at room temperature or in a cool place such as a refrigerator or cooler if foods are perishable.
- Keeping food and water away from dirty areas.

PLANNING A BALANCED OR MIXED MEAL

A balanced or mixed meal includes a variety of foods containing all nutrients in the right amounts and combinations to meet the body's needs. No single food, except breast milk in the first six months of life, provides all nutrients needed by the body to work well.

A balanced or mixed meal includes at least one food from each of the following food groups:

- **Cereals, roots and tubers** (staples) such as maize, rice, sorghum, millet, cassava and potatoes.
- **Animal foods** (protein) such as fish, rabbits, mice, pork, goat meat, game meat, chicken, beef, doves, ducks, edible insects (inswa, caterpillars), crabs, eggs, , milk and dairy products.
- **Legumes** (protein) such as cowpeas, beans, bambara nuts, and groundnuts.
- **Fruits** (minerals and vitamins) such as guavas, oranges, mangoes, pawpaw, granadilla, lemons, bananas, mulberry.
- **Vegetables** (minerals and vitamins) such as sweet potato leaves, pumpkin and pumpkin leaves, spinach, cassava leaves, rape, kanunka (black jack), bondwe (amaranthus), carrots, tomatoes.

- **Sugars, fats and oils** such as oil seeds, butter, margarine, sugary foods such as cakes.

PRINCIPLES OF DIET PLANNING

There are six principles used to guide diet planning as outlined below:

1. **Adequacy**: adequacy means that the diet provides sufficient energy and enough of all nutrients to meet needs of healthy people.
2. **Balance**: the art of balancing diet involves using enough but not too much of each type of food.
3. **Energy control**: designing an adequate, balanced or mixed diet without overeating requires careful planning. The key to energy control is to select foods of high nutrient density. Nutrient density is the amount of energy and nutrients contained in a given portion of food.
4. **Nutrient density**: to eat well without overeating, select foods that deliver the most nutrients for the least food energy. Foods that are low in nutrient density are sometimes called empty-calorie foods. The energy that these foods provide are "empty" in that they deliver only energy (from sugar, fat or both) with little or no protein, vitamins or minerals.
5. **Moderation**: foods rich in fat and sugar provide enjoyment and energy but relatively few nutrients. In addition, they promote weight gain when eaten in excess. A person practicing moderation should eat such foods only on occasion and regularly select foods low in fat and sugar, a practice that automatically improves nutrient density.
6. **Variety**: A diet may have all qualities described above but still lack variety, if a person eats the same food day after day. People should select foods from each of the food groups daily and vary their choices within each food group from day to day.

Other factors to consider in meal planning include age, sex, physical activity and health status of an individual.

WHAT TO CONSIDER WHEN PREPARING FRUITS AND VEGETABLES

Most fruits and vegetables can be grown easily in a small home garden. Mix vegetables and fruits of different colours (dark green, yellow, orange, purple and red). Vegetables lose some of their nutrient values if soaked or boiled for too long. Wash vegetables before cutting and cook immediately. Cook vegetables for as short a time as possible with a small amount of water, there is no need for oil. Use the left over cooking water in soups and other foods as it is rich with nutrients. Wash fruits thoroughly or peel them before eating.

GOOD EATING HABITS

- Eat a variety of food from all food groups every day. Nutrients work as a team and need each other. The body cannot work properly even if only one nutrient is missing.
- Make staples (starchy foods) the largest part of your meal and eat these at every meal. When planning meals, make the staple food the main part and plan the rest of the meal around the staple food.
- Eat legumes such as peas, beans, lentils, nuts and seeds, if possible every day. These foods are cheaper sources of protein than animal food sources. Legumes need thorough cooking to improve digestion.
- Eat animal and milk products regularly. Poultry, meat, fish, eggs, milk and milk products are useful for growth and repair, making new blood and strengthening muscles and the immune system to fight infection.
- Eat fats, oils, and sugar in small amounts to improve energy intake and add flavour. A sick person with a poor appetite may eat better if small amounts of sugar or fats are added to food. Eating 1-2 teaspoons of fats or sugar more than the usual intake may help the patient gain weight.
- Where possible eat foods that are fortified with essential nutrients. Fortified foods have nutrients added to improve their nutritional value. Examples of fortified foods are salt with iodine, sugar with vitamin A, oil and margarine with vitamin A and D. Read food labels to look for added nutrients and expiry dates. Like fruits and vegetables, fortified foods should not be overcooked because this can result in loss of the added nutrients.
- Drink plenty of clean safe water to keep your body hydrated. If you are dehydrated (not enough water in your body) your body cannot function properly. A person needs about 2 litres or 8 large (250 ml)

cups of water every day, and even more when it is very hot, or the person has diarrhoea, is vomiting, or has a fever, to replace the water lost. Breastfeeding women especially need extra water.

- Do not rely on tea, coffee and alcohol as sources of water, as these can interfere with the absorption of nutrients and may interact poorly with the medicines. Alcoholic drinks remove water from the body, therefore enhancing dehydration.

CRITICAL NUTRITION PRACTICES FOR PEOPLE LIVING WITH HIV AND AIDS

People Living with HIV and AIDS need counselling and support to improve their nutrition at all stages of HIV infection. Good nutrition helps strengthen the immune system and can delay the progression of HIV to AIDS, making it possible for PLHA to remain productive. The goals of the nutrition practices are to ensure adequate nutrient intake by improving eating habits, prevent nutritional deficiencies, prevent weight loss and muscle mass, improve response to ART and manage HIV related symptoms and medication side effects that affect food intake. It is very important that PLHA observe the following practices:

- Have periodic nutrition assessments, at least every 2nd month if symptomatic (signs/symptoms) and every 3rd month if asymptomatic (not showing signs/symptoms).
- Increase energy consumption according to disease stage. PLHA can meet these additional energy needs by eating sufficient amounts of balanced meals, including one or more snacks a day.
- PLHA but with no AIDS symptoms require 10% more energy (equivalent to one extra snack) a day. For example a mug of porridge with sugar, milk and oil..
- PLHA with AIDS symptoms require 20-30% more energy (equivalent to two-three additional snacks) a day depending on the severity of the symptoms. .
- Symptomatic HIV-infected children with declining or faltering weight need 50 – 100% more energy than HIV – negative children of the same sex.
- Eat foods rich in iron to increase hemoglobin levels and blood making factors to prevent anemia and is also responsible for transporting oxygen in the blood and help in energy production: red meat, liver, eggs, peanuts, lentils, dark green leafy vegetables and kapenta.
- Eat foods rich in calcium to strengthen bones and body tissues as well as helping the heart to function well and prevent blood clots: milk, kapenta, dark green leafy vegetables, nuts legumes and groundnuts.
- Eat foods rich in magnesium is needed for muscle and nerve function, release of energy from fats proteins, and carbohydrates and for strengthening the bones and body tissues: cereal, dark green leafy vegetables, nuts, legumes and groundnuts.
- Eat foods rich in vitamin C to strengthen bones and body tissues and boost the immune system: oranges or other citrus fruits, tomatoes and Irish potato.
- Eat smaller, more frequent meals if unable to consume normal amounts.

CARE AND SUPPORT FOR POSITIVE LIVING

- Maintain high levels of sanitation, food hygiene and water safety at all times. People living in hookworm-endemic areas should be dewormed semi-annually.
- Practice positive living behaviours e.g. avoidance of alcohol, cigarettes and other tobacco products. Limit consumption of junk foods and manage depression and stress.
- Engage in regular physical activity to strengthen or build muscles and increase appetite and improve health. Physical activity may include normal household work, walking and gardening.
- Drink plenty of clean safe water (at least 8 glasses a day). Use only filtered, boiled or chlorinated water to swallow medicines and to prepare juices.
- Seek prompt treatment for all opportunistic infections and other diseases especially those that interfere with food intake, absorption, and utilisation.
- Manage food-drug interactions and diet-related side-effects of medicines by following a drug-food schedule and using dietary approaches to manage side-effect symptoms. Inform clinicians if taking traditional remedies/medicines (herbs,) or other nutritional supplements.
- Give 50,000 I.U of Vitamin A to children less than 6 months old born to HIV positive mothers, whose mothers or care givers have opted for exclusive replacement feeding.

- Adherence to prophylaxis and treatment regimens. Good adherence to RVV prophylaxis and treatment facilities maximum viral suppression and reduce the risk of HIV transmission from mother to child.

NUTRITION DURING PREGNANCY AND BREASTFEEDING

Monitoring energy and nutrient balance has important implications for the nutrition and health status of women throughout the life cycle, but especially so during pregnancy and breastfeeding when nutritional demands increase.

Good nutrition before pregnancy, during pregnancy and breastfeeding is important for the survival and well-being of the mother and developing infant. Pregnant and breastfeeding women need more energy, protein, and various micronutrients to meet the demands for growth and development of the foetus and milk production.

A pregnant and breastfeeding woman needs to mix the kind of foods she eats so as to get a good variety as shown in the table below. This can be done through diet diversification (eat a variety of foods) and micronutrient supplementation which include iron, folate and vitamin A.

Staples Nshima, Rice, Potatoes, Cassava, sorghum, millet, (other cereals)	**Seeds, Pulses and Legumes** Beans, cowpeas, pumpkins seeds, groundnuts
Vegetables Rape, spinach, carrots, pumpkin leaves, sweet potato leaves, bondwe, cassava leaves	**Foods from animal sources** Meat, fish, chicken, inswa, caterpillar
Fruits Mango, banana, orange, pawpaw, pumpkin, guava, tomato, mulberry	**Fats and Oils** Margarine, butter, cooking oil, fat from meat, palm **Sugars** Use Vitamin A fortified sugar, honey

Source: MOH, Maternity Counselling Tool for Safe motherhood, June 2004

Good Nutrition Practices in Pregnancy

Pregnant women, HIV positive or not, need extra nutrients because of the changes in their bodies and needs of the growing baby. Pregnant women should:

- Eat a variety of foods.
- Eat small frequent meals.
- Eat more animal foods which are valuable sources of iron that is well absorbed by the body.
- Eat foods rich in vitamin C e.g. guava, oranges, lemons, mabuyu.
- Eat plenty of vegetables, fruits and whole grain cereals such as roller meal.
- Take iron, folic acid, vitamin A and other recommended supplements.
- Eat an extra meal or snack a day.
- Do physical activity and get fresh air.

Nutritional Care for HIV Positive Pregnant and Breastfeeding Women

Nutritional status of an HIV positive woman before, during and after pregnancy may influence her own health and influence the risk of transmitting HIV to her baby. HIV causes increased nutrient needs, excess loss and mal-absorption (e.g. through diarrhoea and vomiting). As a result, an HIV positive woman has a higher risk of malnutrition, anaemia and death. HIV positive pregnant women need additional food to meet the extra energy demands of HIV and maintain good health.

The tips below are important for all pregnant and breastfeeding women, but especially for HIV positive women whose health is particularly delicate.

- Monitor weight gain from time to time during pregnancy. Gain at least one kilogram per month during the second and third trimesters.
- Encourage to eat a variety of foods especially those rich in energy and iron. Eat at least one extra small meal of staple food per day.
- Get additional rest, particularly in the third trimester (last 3 months) of pregnancy.
- Eat food that is not harmful to the body. Advise to avoid harmful cultural practices like not eating eggs.
- Store food and water safely.
- Take iron and folic acid supplements during pregnancy and vitamin A when breastfeeding and to use iodated salt.
- Take malaria prevention medicines, seek prompt treatment for malaria and use Insecticide Treated Nets (ITNs).
- Get de-wormed.
- Seek family planning advice for the breastfeeding woman.
- Encourage the pregnant woman and her family to prepare a birth plan.

ANAEMIA IN PREGNANCY

Anaemia (not enough blood) is common in pregnant women. Anemia contributes to women dying during pregnancy, poor pregnancy outcome such as pre term deliveries, low birth weight babies, decreased work productivity and mild bleeding can lead to serious consequences.

Causes of Anaemia

Iron deficiency is often the primary cause of anemia in pregnancy, as it is needed for rapid growth of the foetus. In Zambia, anemia is due to multiple causes such as malaria, intestinal hookworm infestation, Bilharzia, chronic diseases (HIV), closely spaced pregnancies, and dietary deficiencies in iron, Vitamins A and C, folate and vitamin B-12. Consuming diets low in meat and having high intake foods containing substances that inhibit iron absorption (tea, coffee, cereals with bran) can lead to iron deficiency.

Signs and symptoms of anaemia include pale eyes, gums, nails and skin, breathlessness, rapid pulse, palpitations, headaches, oedema (swollen feet and arms), fatigue, weakness, dizziness and drowsiness. Currently the Ministry of Health has a policy to provide iron and folic acid supplements to all pregnant women. However, the uptake is low owing to the following reasons:

- Counselling for side effects of iron supplements is weak or absent. In many instances, when mothers complain of side effects from iron supplements (nausea and dark stool), health workers reduce the amount of pills given to mothers or give folic acid supplements only, instead of explaining the temporary nature of side effects.
- Many pregnant women do not understand the need for iron and folic acid supplementation.
- Many pregnant women do not know the health consequences of anaemia. Some fear having a big baby because they believe if causes difficult labour.

All these reasons singly or together lead to poor compliance to iron and folic acid supplementation.

Prevention and Control of Anaemia during Pregnancy

- Taking of iron or iron/folate supplements daily.
- Practicing preventive measures such as taking preventive malaria medicines, early treatment of malaria and using ITNs.
- Take de-worming medicines in order to prevent any worms inside the body from competing with the mother and foetus for nutrients.
- Encourage consumption of animal sources of Iron.
- Encourage consumption of dark green leafy vegetables.

CHILD HEALTH AND NUTRITION

The period from birth to six months is a very important development stage for the baby. If the baby is not fed adequately during this period, it becomes stunted and can experience ill-health for the rest of its life. This is common among babies born from mothers with little knowledge about nutrition.

In Zambia, malnutrition is one major factor that contributes to ill-health especially in children less than five years of age. According to Zambia Demographic Health Survey (2007), 45% of under-five children are stunted (short for their age); indicating chronic malnutrition. The problem is not just about the height but poor brain development. Stunting is evident even among children less than 6 months of age (18%). Stunting is a serious problem in children in the first two years of life.

The First 1000 Most Critical Days campaign addresses stunting or chronic malnutrition during pregnancy (270 days) and the baby's first two years of life (730 days). These first 1,000 days are critical in establishing strong nutritional and hygienic practices that will contribute to reducing stunting in children below the age of 2 years.

NUTRITION FOR CHILDREN

Breastfeeding

Breast milk is the very first food a baby should have. The milk contains all the necessary nutrients including energy, protein, vitamins and minerals a baby needs for the first 6 months of life. Breastfeeding is very common in Zambia, with 98% of children being breastfed. Breastfeeding is a key strategy for child survival. Breastfed babies are generally healthier; achieving optimal growth and development compared to those fed formula milk. Mothers should consider using formula milk if they are unable to breastfeed due to a health condition and always have access to safe clean water.

Benefits of breastfeeding:

- Helps mother-child bonding and development.
- Helps delay a new pregnancy within the six months of birth.
- Protects mothers' health.
- Costs less than artificial feeding.
- Provides perfect nutrients.
- Breast milk is easily digested and is efficiently used.
- Protects against infection.
- Helps the uterus return to its normal size.
- Helps to reduce bleeding, and may help to prevent anaemia.
- Reduces the risk of ovarian and breast cancer in the mother.

Exclusive Breastfeeding

Exclusive breastfeeding requires mothers to feed their baby only breast milk, without giving any other foods or liquids including gripe water, for the baby's first six months of life unless advised by the health provider. Exclusively breastfed infants (less than 6 months old) do not need any water as breast milk contains plenty of water on its own. Mothers who choose to breastfeed exclusively should be supported and helped to do so by:

- Counselling them on the need to put the baby to the breast within the first hour of birth.
- Counselling them on the need for continued exclusive breastfeeding.
- Supporting mothers with how to hold the baby and put it to the breast (positioning and attachment).

If the mother wants to use other feeding methods, explain the importance of exclusive breastfeeding and to avoid mixed feeding at all costs. Mixed feeding is the giving of breast milk and other types of feed e.g. porridge, water, juices, commercial milks etc., before the baby turns six months. Feeding the baby anything besides breast milk (or formula) can be very harmful to the baby's health.

Complementary Feeding

Feeding children (6 to 24 months old)

Complementary foods should be introduced only when a child is six months old in order to reduce the risk of malnutrition. Like adults, all children need a variety of foods, including a staple food, animal products, vegetables and fruits and some high-energy or enriched foods. Continue breastfeeding the baby and introduce adequate, safe and nutritious complementary food. Children have small stomachs so they need to be fed small amounts more frequently. To ensure that children get all the nutrients they need, at each meal select different foods from the different food groups.

Staple foods such as cereals (rice, wheat, maize, millet, sorghum), roots (cassava, yams, and potatoes), and starchy fruits (plantain) give energy but do not contain enough nutrients. Feed children other foods in addition to these. Make sure to mash up the food so the baby is able to easily eat and digest the food.

As children get older, increase the variety and quantity of foods:

- Feed infants milk to meet their growth and developmental needs. Infants continue to need breast milk or any other milk until the age of two.
- Feed children small frequent meals. When infants reach the age of 24 months, feed three-four main meals (one meal = 1 cup) and two nutritious snacks in between in addition to milk. Encourage finger foods, foods children can pick up easily such as sliced fruit or bread with butter or margarine for snacking.
- Feed children enriched foods that are full of energy and nutrients. Enrich foods by adding 1–2 teaspoon of oil, butter, margarine, milk or groundnut paste to each cup of food.
- Feed children finely flaked fish, eggs, beans, ground-up nuts, finely sliced meat or other soft and easily digestible foods from the family pot.
- Feed mashed fruits and vegetables such as ripe banana, pawpaw, avocado and pumpkin as often as possible.
- Consider feeding fermented, germinated or fortified products.
- Children who are not receiving breast milk or animal foods may need a multi micronutrient supplement with vitamins and minerals. These are food supplements where some vital nutrients have been added such as energy, proteins, minerals, Vitamin A and carbohydrates and are usually given at the health centres or hospitals.
- Children older than 6 months need water even when they are drinking milk. To find out if children are still thirsty, offer safe drinking water after eating.
- Do not feed infants glucose drinks or soft drinks (fizzy drinks).
- Do not feed infants spicy foods which may make them wary of other foods that contain a variety of nutrients.
- If necessary, hide a child's medication/vitamins in a teaspoon of mashed fruits. This will disguise the taste of the medicine/vitamin and help the child swallow the medicine/vitamin without hesitation.

The chart below provides recommended feeding practices for infants and young children:

Age in Months	Types of Feed
0 – 6	• Breastfeed exclusively at least 8 times within 24 hours. • Do not give water, traditional medicines, glucose, gripe water, other milks, porridge or any other liquids or foods unless medically indicated. • If the child is not gaining weight and is being breastfed properly, refer for medical check-up for any underlying illnesses.

6 – 12	• Continue breastfeeding 8-10 times within 24 hours. • Feed at least three times a day if breastfed, five times with 1-2 cups of milk per day if not breastfed. • Introduce a variety of locally available foods. Give about half to three quarters cup of food (150-180ml) per feeding of: • Thick porridge enriched with sugar, oil, pounded groundnuts or Kapenta, mashed beans or avocado, soya flour, pounded dried caterpillars or green leafy vegetables, or • Nshima with mashed relish of green leafy vegetables, beans, fish, or pounded Kapenta, caterpillar or meat cooked in oil or pounded groundnuts • Between main meals, give other foods, such as fruits (banana, pawpaw, avocado, mango or orange juice), chikanda, mashed pumpkin, beans, groundnuts, cassava, boiled sweet potatoes or pumpkins with pounded groundnuts, sugar, milk or oil, whenever possible. Mash these foods and feed to the child. • Serve and feed child separately in their own plate to allow close monitoring of how much is eaten.
12 – 24	• Continue breastfeeding as much as child wants. • Feed at least five to six times a day about 1 to 1½ cups (200-300ml) of the following per feeding: • Nshima with mashed or pounded relish. Do not feed only the gravy. • Thick porridge enriched with one or more of the following: sugar, oil, pounded Kapenta, groundnuts, dried caterpillars, mashed beans, egg and milk. • In between main meals, give other foods such as fruit, samp, boiled cassava, mashed beans or groundnuts, porridge, bread, pumpkin, sweet potato or rice with sugar, milk or oil. • Serve the child separately and supervise the eating.
24 months or more	• Milk remains important in the child's diet. • Feed the child from the family meals at least three times a day. • Two times a day, between family meals, give fruit (such as banana, orange, mango, pawpaw and guava), samp, sweet potato, bread, rice with sugar or oil, eggs or beans. • Portion size should be increased with age of the child.

Source: Ministry of Health 2009.

FEEDING HIV POSITIVE CHILDREN

In Zambia HIV positive pregnant women are counselled and supported to breastfeed and receive ARVs. WHO (2010) made the following recommendation on HIV and infant feeding: Mothers who are HIV positive and whose infants are HIV negative or ofr unknown status should breastfeed their infants exclusively for the first six months, introducing appropriate complementary foods thereafter, and continue to breastfeed for the first 12 months of life. Where available, both mothers and infants should receive ART to reduce the risk of HIV transmission during the breastfeeding period. Breastfeeding should stop only when mothers can provide a nutritionally adequate and safe diet without breast milk.

Infants 0-6 months old

Prevention of HIV transmission during breastfeeding should be considered in a broader context, taking into account the need to promote breastfeeding of infants and young children in the general population. In Zambia exclusive breastfeeding is promoted for all mothers regardless of their HIV status. The policy supporting breastfeeding in Zambia states that "as a general principle, in all populations, irrespective of HIV infection rates, breastfeeding should continue to be protected, promoted and supported."

Women who do not know their HIV status, or HIV testing is not available, should be counselled on infant feeding, including on the possibility of transmission through breastfeeding. Mothers are advised to

exclusively breastfeed their babies (no other liquids or solids, not even water) in their first six months of life; unless prescribed by the health provider. To help HIV positive mothers breastfeed exclusively the health providers should do the following:

- Support them to position and attaché their infants properly
- Counsel them on the importance of continuing exclusive breastfeeding for 6 months
- Counsel them to seek immediate medical care for sore or cracked nipples or mouth lesions or thrush in their infants to help reduce the risk of cracked nippples association with HIV transmission during breastfeeding
- Help them solve common breastfeeding difficulties such as insufficient milk
- Help them make breastfeeding safer
- Encourage them to seek medical advice immediately for any illness
- Counsel them to stop breastfeeding gradually over one month and continue taking ARV prophylaxis along with their infants until 1 week after breastfeeding is fully stopped.

Exclusive Replacement Feeding using Commercial Formula

Replacement feeding refers to feeding an infant who is not receiving any breast milk with a diet that provides all the nutrients he/she needs until he/she is fully fed on family foods. HIV infected mothers can feed commercial infant formula milk as a replacement feed only when the following conditions are met (WHO 2010):

- Safe water and sanitation are ensured in the household and in the community
- There is a reliable source of milk and sufficient formula milk to support normal groth and development of the infants
- Mothers and caretakers can prepare formula cleanly and frequently enough so that it is safe and carries no risk of causing diarrhea
- Mothers or caregivers can use the formula milk exclusively for the first 6 months and can also access health care that offers comprehensive child health services.

Mothers who choose to provide replacement feeding should be counselled that their infants face increased risk of infection and death, unless replacement feeding meets AFASS (Affordable, Feasible, Acceptable, Sustainable and Safe) conditions.

The disadvantages of replacement feeding:

- High risk of serious diarrhoeal infections. **To reduce this risk, use a cup and NOT a feeding bottle to feed the baby.**
- Increased risk of malnutrition because of diluted feeds (increased cost of formula in low income settings).
- Risk of improper mixing of formula.
- Risk of using of unclean water.
- Missing out on the general health benefits of breast milk.
- Mixed feeding (giving formula and breastfeeding) leads to increased HIV transmission from HIV positive mothers.

Infants 6-24 months old

Regardless of their HIV status, all children need complementary foods from the age of 6 months onwards. HIV affects the nutritional status of children just as it does with adults. Stunted growth and failure to thrive are common in HIV infected children. Children with HIV also have frequent common childhood infections such as diarrhea, ear infections, pneumonia, fever, chronic gastroenteritis and TB. All these infections can affect nutrient intake, leading to malnutrition and higher risk of death.

Children with HIV need extra calories, which they can get from approximately one extra snack per day. Caregivers need to work on a meal plan with health service providers to achieve this but the guidance need not be very strict. Encourage caretakers or mothers to prepare the child's food using locally available foods to allow a wide range of meal options.

Meal planning should be done using guidance on the various food groups. Children that are HIV positive need more calories than children that are not affected. This means giving an HIV positive child an extra meal in a day. However, HIV infected children who are loosing weight need even more energy (50 to 100% more energy than un-infected children of the same age and sex). The following factors in children with HIV may lead to poor growth, frequent illness and under nutrition:

- Difficulty eating because of poor appetite, difficulty swallowing, nausea and vomiting.
- Difficult feeding relationship between caregiver and child.
- Intolerance of foods.
- Illness of parents.

Replacement Feeding

Replacement feeding is feeding an infant who is not receiving any breast milk with a diet that provides all nutrients the infant needs until s/he is fully fed on family foods.

Mothers who choose to provide replacement feeding should be counselled that their infants face increased risk of infection and death, unless replacement feeding meets AFASS (Affordable, Feasible, Acceptable, Sustainable and Safe) conditions.

Disadvantages of replacement feeding:

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- Missing out on the general health benefits of breast milk.
- Mixed feeding (giving formula and breastfeeding) leads to increased HIV transmission from HIV positive mothers.

FEEDING CHILDREN DURING ILLNESS

Mothers and caregivers need guidance and support for appropriate feeding practices and improved food intake for children during illness and recovery. The following factors are important:

- Actively feed infant directly.
- Help older children to feed themselves.
- Help child learn the skills associated with eating.
- Be sensitive to hunger cues or signs.
- Feed slowly and patiently, encouraging but not forcing child to eat.
- Try different food combinations, tastes, textures and methods of encouragement if the child refuses foods.
- Reduce distractions during meals if child loses interest easily.
- Talk to child during feeding ensuring eye-to-eye contact.

Children need extra food to recover during illness. HIV positive children particularly need much more energy and nutrients to recover completely. Very ill children with HIV take longer to recover from illness than HIV negative children and may die if they do not get additional feeding. During an illness, children may face difficulties feeding. A child may eat less during illness if:

- S/he does not feel hungry or is weak.
- S/he is vomiting or has a sore mouth or throat.
- S/he has a respiratory infection which makes eating and suckling more difficult.
- S/he is difficult to feed and the care giver is not patient with him or her.
- Caregivers withhold food thinking that this is best during illness.
- No suitable foods are available in the household.

- Someone has advised the mother to stop feeding the child.

The following points are important when feeding a child during illness, especially if they are HIV positive:

- If on exclusive breastfeeding, breastfeed more frequently.
- Make the child more comfortable.
- Be patient and feed slowly.
- Feed the child food he or she likes.
- The child needs small, frequent meals.
- Give a variety of foods and extra fluids.
- Pay attention and make feeding a happy time.
- Feed the child a variety of nutrient-rich foods.
- Continue to breastfeed. Ill children need to breastfeed more frequently.

FEEDING CHILDREN DURING RECOVERY

A child's appetite usually increases after illness, so it is important to continue to give extra attention to feeding after the illness. This is a good time for families to give extra food so that lost weight is quickly regained and growth continues. Young children need extra food until they have regained all the lost weight and are growing at a healthy rate.

The following points are important for feeding a child during recovery:

- If exclusively breastfeeding, offer breast milk more frequently.
- If the child is older than 6 months, increase the number of meals per day.
- If the child's appetite is good, give more food.
- Give fruits and foods with extra rich energy and/or nutrients such as enriched porridge.
- Make the child comfortable and encourage him/her to eat patiently.
- Offer the child water and other liquids besides breast milk.

Part 5: Maternal, Newborn & Child Health

MATERNAL, NEW-BORN AND CHILD HEALTH

Every pregnant woman hopes for a healthy baby and uncomplicated pregnancy. For every 100,000 women who give birth in Zambia, 591 of them will die, and 30 will have severe complications that affect their life, such as fistulas. But almost all of these women can be kept alive and healthy (ZDHS 2007).

The process of becoming a mother can be made safer and it starts before a woman gets pregnant and ends when she and her child are safe and healthily living their lives. It involves the entire community – husband or partner, the extended family, plus neighbours and friends. The specific steps to safe motherhood include:

1. Creating a birth-plan
2. Accessing antenatal care as soon as a woman knows she is pregnant
3. Going for antenatal care at least 4 times during pregnancy
4. Facility based delivery
5. Adequate post-delivery care
6. Family planning

This section focuses on the following components of safe motherhood:

- Antenatal Care
- Safe Delivery
- Postpartum and Newborn Care

ANTENATAL CARE

According to the 2007 ZDHS report, 94% of women in Zambia received antenatal care (ANC) from a skilled service provider (Doctor, clinical officer, nurse, or midwife) during their last pregnancy. Antenatal care involves the regular monitoring of the mother and baby by a trained health care provider, midwife or obstetrician (or by a combination of these professionals). The primary goal of antenatal care is to establish contact with the mother and identify and manage current and potential risks and problems that may occur during pregnancy. At least four antenatal visits are recommended throughout a pregnancy, with the first visit ideally early in the pregnancy (during the first three months – the first trimester) as soon as the woman knows she is pregnant.

The major objective of antenatal care is to achieve the optimal health outcome for the mother and the baby. Specifically, the following should be accomplished by a skilled health care provider:

1. Health promotion and disease prevention by providing health messages and counselling to pregnant women. This helps to promote and maintain the physical, mental and social well-being of both the mother and baby by providing education on warning and danger signs, the benefits of improved nutrition, diet, and health, rest, sleep and personal hygiene as well as the environment of the pregnancy and birth.
2. Early detection of complications and prompt treatment (e.g. detection and treatment of sexually transmitted infections).
3. Prevention or treatment of diseases through immunization, micronutrient supplementation, and other services (Tetanus, anaemia, malaria, HIV). If a woman is found to be HIV positive, she will receive the necessary advice from the health worker on how to care for herself and how to prevent passing the virus to her unborn baby.
4. Birth preparedness: This is when a pregnant woman and her family prepare for a normal birth and for complications that may arise during pregnancy and childbirth. It involves coming up with an action plan arising from the family discussion.

Birth Plan

All pregnant women should be encouraged to create a **birth plan**. A birth plan is a document that includes all the details about what the woman and her family will do during pregnancy, during delivery, or in the case of an emergency.

The birth plan should answer the following questions:

- When will the baby be born? - Know when to expect the baby to be born, and when you should be at the place you plan to deliver.
- Where are you planning to have your baby? - Decide where to have the baby, and where to go in case of an emergency.
- How will you get there? - A plan should be made about how to get to the place of delivery in time, especially in the case of an emergency.
- Who will be there to help? - Plans should be made ahead of time as to who will be the skilled attendant to assist the delivery; who will accompany the woman to the place of delivery and support her during childbirth; who will be available to help in the case of an emergency or complication.
- What will you need to have ready? - It is important to know what money and supplies will be required, and when. Set aside the money and supplies required well before the time of delivery or in case of any complication or emergency.

Pregnant women and their families should also make plans in the case of complications or an emergency during the pregnancy. For example:

- **Who** will be available to recognise danger signs?
- **Where** will you go in an emergency?
- **How** will you get there quickly?
- **Who** will be there to help?
  - A skilled health worker to help manage the emergency
  - Someone to support you
  - Potential blood donor where possible
- **Who** will stay to help the family?
  - Family to identify person to help.
- **What** things would you need, and will you have them ready at short notice?
- **Transportation**
  - Money to get to the clinic.
  - Money to get from the clinic to the hospital, if need be.
  - Money for medication and other supplies.

Vaccination against Tetanus

Tetanus is an infection that kills. Tetanus can enter the body when an instrument that is not properly disinfected is used during delivery on the mother or is used to cut the baby's cord.

All girls and pregnant women should be vaccinated against tetanus. A pregnant woman, who has not been vaccinated, should have an injection of Tetanus Toxoid (TT) at her first prenatal check-up and subsequent injections as per schedule below.

Tetanus Immunization Schedule:	
TT 1	At first contact
TT 2	At least 4 weeks after TT 1
TT 3	At least 6 months after TT 2
TT 4	At least one year after TT 3
TT 5	At least one year after TT 4

DELIVERY AND POSTNATAL CARE

Less than half (48%) of Zambia's births occur in health facilities, 43% in the public sector and 5% in private sector facilities. Fifty-two percent of births occur at home. Home births are more common in rural areas (67%) than urban areas (16%). Only 47% of births are assisted by a skilled provider (doctor, clinical officer, or nurse/midwife). Another 23% are assisted by a traditional birth attendant and 25% by an untrained relative or friends.[1]

It is advised that women give birth in a health facility where they have access to skilled service providers (midwives or doctors) in the case of any emergency. Access to trained health workers is particularly important if a woman:

- Is under 18 or over 35 years of age
- Has had close pregnancies - less than two years in between
- Has had more than four pregnancies
- Has had a previous difficult birth or Caesarean section
- Has had a miscarriage or still birth
- Is less than 1.5 meters tall
- Has HIV or other STIs

Danger Signs

Danger signs are serious conditions during pregnancy, labour or after delivery that show that a pregnant woman and/or her baby are in serious danger. In the case of any danger sign, a woman and her baby should be given immediate medical attention by trained health workers. It is important for women and their families to be able to recognize these signs quickly, and know what to do if they occur.

Common signs are summarized below:

Danger Signs		
During Pregnancy	During Childbirth	After Delivery
• Anaemia (symptoms include paleness of the tongue and inside the eyelids, very tired and shortness of breath) • Unusual swelling of legs, arms or face • Bleeding from private part • Severe headache • Little or no movement of the baby • Baby lying crossways or head up • Spotting or bleeding from the vagina • Convulsions (fits) • Severe abdominal pain • Fever and weakness • Fast or difficult breathing • Labour pains for more than 12 hours	• Heavy much bleeding • Severe headache • Body hotness or feeling cold • Labour lasting more than 12 hours • Having fits • Placenta not delivered within 30 minutes after baby is born	• Continued heavy bleeding • Severe headache • Body hotness or feeling cold • Severe increasing stomach pain or pain in private parts • Bad smelling discharge from private parts • Extreme sores or pain in breasts

1 CSO, 2007, ZDHS, Key findings

Danger signs in a baby after delivery:

- Breathing difficulties, or not breathing
- Fever, chills, fits, rash
- Yellowness of the skin or eyes
- Poor sucking or feeding problems
- Vomiting
- Not active
- Diarrhea or constipation
- Red, swollen eyes
- Redness, pus or blood from the umbilical stump

Labour

Labour is a process by which any time after the 28th week of pregnancy the uterus prepares to deliver the baby and the placenta. Labour between 28-36 weeks is considered premature, but after 37 weeks and beyond is full term and normal labour.

Signs of Labour

The following three signs indicate that labour has started:

- Painful and strong abdominal pains occurring every 20 minutes or less.
- Mucus discharge mixed with blood from the birth canal.
- A gush of water from vagina– indicating that the bag that carries the baby has broken.

Postnatal Care

Post-natal care helps to identify, treat and prevent complications after child birth. It supports mothers and fathers or other caregivers to help their new baby get a healthy start in life. The mother and child should be checked regularly during the first 24 hours after childbirth, in the first week, and again six weeks after birth. If there are complications, more frequent check-ups are necessary.

Postnatal care tips for women:

- **Rest** – a woman should rest and limit her activities until fully recovered at around six weeks. It is important for the woman not to lift heavy loads until she has fully recovered.
- **Nutrition** – a woman should continue eating variety of foods regularly, to help with recovery and producing breast milk.
- **Fluids** – a woman should drink plenty of fluids to stay hydrated and encourage breast milk production.
- **Sexual Activity** - a woman should Delay any sexual activity until she is fully recovered and feels comfortable. Even when sexual activities resume, the couple should take measures to prevent conception by using a family planning method of their choice.
- **Cleanliness** – a woman should keep herself clean to prevent any infections.
- **Breast Care** – a woman should wash her breasts before each feed, and feed the child from both breasts (changing from one to the other). Any feeling of hardness of the breast, a lump in the breast, redness, tenderness or hotness or cracked or bleeding nipples should be reported to a health provider.

Postnatal care tips for the baby:

- **Clean Birth** – a clean birth is very important for preventing infection for the baby.
- **Keep baby warm** – right after birth and in the first days of life, babies are at risk of getting cold.
- **Keep dry** - Dry the baby with a clean dry cloth immediately after birth and ensure it is warm. Do not bathe the baby for 24 hours after birth. Keep the baby in skin-to-skin contact with the mother so that the mother's body heat will keep the baby warm.
- **Hand washing** –all who care for the baby must wash their hands often, especially before handling the baby, and after cleaning the soiled baby, to avoid infecting the baby.

Umbilical cord care:
The umbilical cord should only be cut with a new, unused razor and tied with a clean tie.
The cord should be cleaned with a clean cloth and clean, boiled, cooled water.
Do not put anything on the cord. If cord shows signs of infection (red, hot to touch, or oozing pus) the baby should immediately be taken to the clinic.

Growth Monitoring, Immunization, and Vitamin A Supplementation

The mother and family of the baby should follow the recommended child immunization and growth monitoring schedule. All of these services are very important to make sure the baby continues to grow healthy.

Zambia's recommended schedule for childhood immunization:

Vaccine	Minimum Age at First Dose	Number of Doses	Minimum Interval between Doses
BCG	Birth	1	none
Polio (OPV-0)	Birth-13 days	1	none
Polio (OPV-1,2,3)	6 weeks	3	4 weeks
DPT-HepB-Hib (DPT-HepB-Hib-1,2,3)	6 weeks	3	4 weeks
Rotavirus vaccine	6 weeks	2	4 weeks
Measles = OPV-4 if OPV-0 was missed	9 months	1	none
Vitamin A (if not breastfeeding)	0-5 months	1	none

Source: MOH, Integrated Technical Guidelines for Frontline Health Workers, June 2009

Malaria prevention– Babies, and all children under five years of age, should sleep under Insecticide Treated Mosquito Nets (ITNs). Their skin should also be kept covered from sundown to sunrise, to avoid bites from malaria-causing mosquitoes.

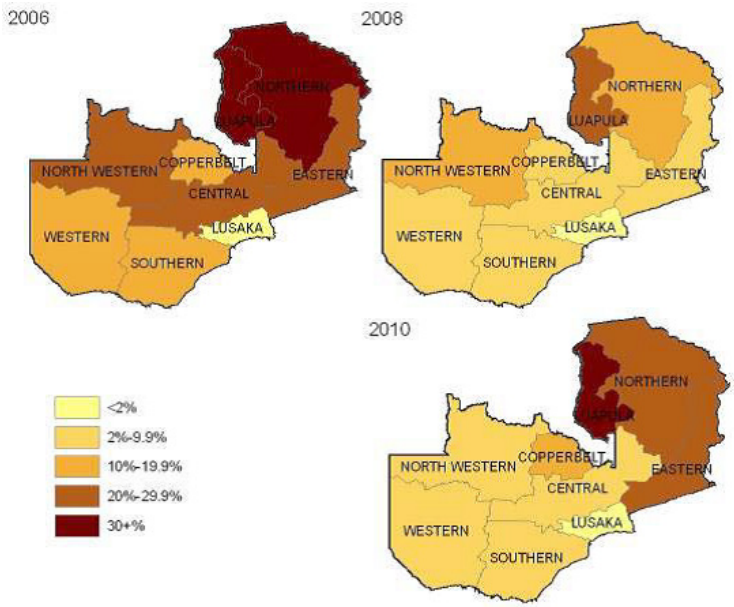
Part 6: Malaria

MALARIA

What communities need to know about malaria:

- Malaria is a serious illness spread by mosquitoes. A mosquito picks up the malaria parasite when it bites an infected person, and then passes it to another person as it bites them afterwards.
- Malaria can kill, and the longer you wait to diagnose and treat the deadlier it becomes. At the first signs of the disease go for immediate testing.
- Malaria is preventable and treatable.
- The only way to know if you have malaria is through a blood test. Insist on one.
- The only way to treat malaria is to follow treatment prescribed by a health provider after a malaria test and to finish the entire treatment, even if a person feels better before finishing treatment.

Malaria is particularly dangerous in pregnant women. Malaria during pregnancy contributes to nearly 20% of low-birth weight babies in endemic areas. Other consequences of malaria in pregnancy are anemia, stillbirths and maternal deaths. During pregnancy, a woman may have malaria, but not know it. This is because the parasites tend to be concentrated in the placenta and not in the blood stream. This can be very dangerous for the unborn baby.



Parasitemia rates by Province by MIS in 2006, 2008 and 2010

MALARIA TRANSMISSION

Malaria is spread by a bite from a female Anopheles mosquito which feed predominantly at night. The mosquito transfers the malaria parasite (Plasmodium) from person to person. Out of all the malaria cases in Zambia, 98% are caused by Plasmodium falciparum, the most serious type of malaria and which causes nearly all malaria deaths.

SIGNS AND SYMPTOMS OF MALARIA

The main symptoms of malaria include: persistent high fevers, shivering, profuse sweating, joint pains, diarrhea, repeated vomiting, headache, flu-like illness, cough, lassitude (severe weakness, general body pains), and fatigue. At the first sign of any of these symptoms it's important to go to the nearest health facility for immediate testing. As the situation worsens, a malaria sufferer can also experience convulsions, confusion, hallucinations and unconsciousness.

In children, malaria at times presents itself with loss of appetite (refusing to eat), vomiting, drowsiness and fits. In young children the disease can worsen rapidly, causing unconsciousness (coma) and death. Children under 5, pregnant and breastfeeding women, and people living with HIV can easily get attacked by malaria because their immune system is developing or overly burdened.

Complications in Malaria

As the disease progresses it kills more and more red blood cells, seriously affecting the brain and kidneys. If left untreated malaria can lead to death. It can also result in kidney failure, hypoglycemia, anemia, pulmonary

edema, shock and coma. At this stage malaria is an emergency and requires immediate medical attention. In pregnant women malaria can result in:

- Anaemia
- Death
- Abortion
- Stillbirth
- Premature-delivery
- Intra-uterine growth retardation
- Low birth weight

MALARIA DIAGNOSIS AND TREATMENT

Malaria Diagnosis

There is only one way to know if a person havs malaria: a blood test. The main symptoms of malaria (headache, fever, sweating, chills, joint pains) are also associated with other conditions. Therefore, it's important to confirm if the person has malaria to make sure a person gets correct treatment for whatever illness they have. In 2008 to 2009, Zambia adopted a policy that all suspected malaria cases must be confirmed through a test before treatment. Previously, diagnosis of malaria was done through the mere observation of symptoms a patient presented with.

The most common and readily available test for malaria in Zambia is the Rapid Diagnostic Test (RDT). The advantages of RDTs are that they are inexpensive, easy to use and are increasingly available even in the remotest areas of the country. Another test is the laboratory diagnosis involving the examination of the person's blood under a microscope. However, this method of testing is limited to a few health facilities with medical laboratories. Universal laboratory diagnosis has resulted in better patient care, better planning and cost saving on the scarce drug resources and has enhanced the effective use of malaria medicines.

Malaria Treatment

Malaria can be cured if promptly diagnosed and adequately treated. In Zambia the first line treatment is Coartem, an ACT or Artemisinin Combination Therapy that is very effective. Coartem is a brand name; be sure the medicine has artemether and lumefantrine, the combination that kills the malaria parasite. It's important to take the medicine with food, and to take the full three-day course as directed. It is not unusual to feel better after one day, but a patient must complete the entire treatment (no sharing or saving medication for next time you get sick) or they will not be cured. If the situation has become a medical emergency, or the patient is unable to keep the medicine down, then Quinine is the preferred drug.

MALARIA PREVENTION

Many lives can be saved by preventing malaria and treating it early. The Government of the Republic of Zambia is implementing several strategies aimed at fighting malaria. Some of the ways to prevent malaria include:

Insecticide Treated Mosquito Nets (ITNs)

The distribution of ITNs is one of the interventions being implemented by the National Malaria Control Centre (NMCC). NMCC aims to have universal ITN coverage, meaning that all sleeping spaces in all households are covered by an ITN. NMCC prioritizes children under five and pregnant women as they are the most vulnerable populations to malaria attacks. Similarly, PLHA and the elderly require consideration.

It is important to note that ITNs are one of the most effective methods of preventing malaria; they are easy to use and can last for 2-3 years; they offer year round protection; reduce exposure to mosquito bites for the whole community.

There are many myths and misperceptions around ITNs. For example, many people think that sleeping under an ITN will lead to suffocation, respiratory tract infections, premature births (they actually can help to

prevent them), death, or cause bad dreams, infertility, or impotence. ITNs do not contribute to any of those risks. ITNs simply repel mosquitos and provide a barrier between the person sleeping under the net and the mosquitos outside.

NMCC usually distributes ITNs through what is referred to as mass distribution. This is a campaign that aims to reach all households in targeted communities. The other method of ITN distribution is focused on pregnant women and children under five through antenatal and under-five clinics.

Indoor Residual Spraying (IRS)

Household residue spraying is based on mosquito behaviour. Scientists observed that after biting, the female anopheles frequently chooses to rest on a wall for a few hours to digest the blood. By applying a small amount of insecticide to walls and ceilings, a mosquito will absorb the chemical when it lands on the wall and will die eventually, thereby preventing it from spreading malaria.

IRS is widely used in urban and peri-urban areas where houses are close together and most of the structures are made of brick walls. Household residual spraying is done with an internationally approved and effective insecticide that is applied once a year before the rainy season. IRS is safe for the entire family. Always follow the directions from the trained spray operators. For example, they will frequently ask you to remove items from your house prior to spraying and open windows after spraying to air the house out from the smell of the chemicals.

Intermittent Presumptive Treatment (IPT) or Malaria Prophylaxis during Pregnancy

Malaria prevention in pregnant women is very important in saving women's lives because pregnant women are more vulnerable to the disease. Their bodies work hard to facilitate the growth of the unborn baby and this weakens the body's defence system to fight not only malaria, but other diseases as well. Furthermore, a pregnant woman can have malaria without showing signs and symptoms. It is estimated that malaria is responsible for 20% of deaths of pregnant women in Zambia.

Unlike ITNs, IRS or case management, Intermittent Presumptive Treatment (IPT) does not stand on its own; it is embedded in another public health service – antenatal care (ANC). It is therefore important that counsellors use every opportunity to inform clients about the importance of booking for ANC early and taking anti-malarial medicine. This must be done immediately they know they are pregnant. Ideally a pregnant woman will take three doses of IPT during her pregnancy.

Environmental Management

Environmental management means undertaking one or more activities to modify or manipulate a community's surroundings to reduce mosquito breeding areas. Mosquitoes breed in stagnant or slow moving water. These could be open wells, empty tins and packs, drainages and pot holes—even foot or hoof print pools on the ground. Activities that can be undertaken to reduce mosquito breeding areas include:

- filling standing water pools, drainages and ditches
- removing piles of rubbish
- introducing living organisms like fish that eat mosquito larvae
- putting chemicals in the water that kill mosquito larvae (larviciding)

Environmental management is important for malaria control and prevention because it reduces breeding areas or kills mosquitoes in their early stages of life. This reduces the number of mosquitoes in communities and consequently reducing malaria transmission.

NMCC also promotes the screening of doors, windows and the eaves of buildings, particularly in households and public places (schools, health facilities, hotels, restaurants and places of work). This involves covering a window or door way with thin wire mesh that will prevent mosquitoes from entering.

MALARIA IN CHILDREN

Malaria can cause a high fever and chills. As noted above, with fever or any other symptom of the disease, it's essential to go for immediate testing. Try to keep a child's fever down by giving him/her treatment with antipyretics (medication that prevents or reduces fever), such as paracetemol or ibuprofen, but not Aspirin (for fear of Reyes syndrome i.e. a severe reaction resulting into convulsions and coma). Keeping the fever from going too high is important to prevent convulsions, which could lead to disabilities.

A child, like anybody else with confirmed, malaria needs to take the full course of treatment, even if the fever disappears. Only a full course of malaria can ensure that all the malaria parasites inside the body have been killed. If the treatment is not completed, the malaria could rebound and become more severe. Failing to complete treatment regimes can also lead to developing drug resistance.
If malaria symptoms continue after correct treatment, the child should be taken to a health centre or hospital. The problem may be that the child is not receiving enough medicine, under dosing or poorly adhering to treatment, or that the child has an illness other than malaria. If the child is not responding to the first line treatment and his/her condition worsens then the clinic may shift the medicine to Quinine.

MALARIA IN PEOPLE LIVING WITH HIV AND AIDS

Untreated malaria can further compromise the immunity of PLHA. Therefore, it is very important for people who HIV positive to strictly observe malaria prevention measures. PLHA on Septrin have partial protection against malaria.

Part 7: Gender Based Violence

GENDER

Gender is a psychological or cultural concept which refers to one's subjective feeling of femaleness or maleness. It defines women's roles and responsibilities in relation to those of men.[1] Gender refers to the behavioural, cultural, or psychological characteristics typically associated with one sex.[2]

Gender Socialization

The different roles that men and women play in the family, community and workplace, as well as in sexual relationships, are mainly based on society's beliefs about what women and men should and shouldn't do, meaning their gender roles. Girls and boys are taught by society that they have different roles to play in the family and in the home. For example, usually it is girls not boys who must help with housework like cleaning and cooking. Or boys learn that men, in general, have more privilege and status than women. Gender norms sometimes encourage harmful behaviour. For example, men should have multiple sexual relationships with women to show they are strong

Gender is rooted in culture, tradition, and religion

Gender norms and gender roles do not come from nature or biology, but from a society's beliefs in the differences between females and males. Culture, tradition, and religion play a critical role in creating and maintaining these beliefs about and definitions of gender. Culture, tradition and religion are all important elements of the social 'glue' that binds a society together, giving a sense of shared identity and a source of resilience.

As much as culture and tradition play a positive role in people's lives, it is important to challenge those aspects of culture, tradition, and religion that need to change to bring about fairer gender relations. For example, campaigns against early marriages aim at protecting girl children's rights and enhance their prospects for a better future. These cultural and traditional practices can be very difficult to change as they will face resistance from those who benefit from them.

Gender is not fixed, but changing and changeable

Society's definitions of what women and men can and should change over time. Being a 'woman' or 'man' was different for our great grandparents; these changes can be seen in many areas of life, such as the workplace, schools, home, and in the law.

Changes in the job market mean more women are working now as breadwinners than ever before. This change in economic roles also affects relationships between women and men, in the community and the family.

GENDER-BASED VIOLENCE

Violence is a tool of oppression used to claim and reinforce power and control. Gender-based violence (GBV) refers to violence that targets individuals or groups on the basis of their gender. The act of aggression intended to cause physical, psychological, or emotional harm to the victim.[3] Women and girls are most often the targets of GBV, but men and boys can also be victims.

GBV reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. GBV encompasses a wide range of human rights violations, including sexual abuse, rape, domestic violence, sexual assault and harassment, human trafficking, and harmful traditional practices. These abuses can leave victims with deep psychological and physical scars for the rest of their lives.

1 Zambia, National Gender Policy, March 2000
2 MoH, Men's Health Kit, Reference Manual, January 2009
3 A Safer Zambia (ASAZA) Partners, Gender Based Violence Brochure

People usually think of violence in terms of physical violence, but there are other forms of violence that are used to harm people and maintain power over them. Violence is an everyday experience for many people, especially women. It is accepted as a normal part of life. Street-level sexual harassment of women, such as whistling in a suggestive manner, is one form of everyday violence that is not only widespread but also widely ignored. Everyday violence also includes the violence in relationships, especially those between young women and much older men ("sugar daddies"). The power inequalities of both gender and age, and frequently economic status, within such relationships make violence almost an inherent part of them.

Types of Sexual and Gender-Based Violence

There are five types of sexual and gender-based violence, namely:

- Sexual Violence
- Physical Violence
- Emotional and Psychological Violence
- Harmful Traditional Practices
- Socio-Economic Violence

Sexual Violence

Rape and marital rape

The invasion of any part of the body of the victim by the perpetrator with a sexual organ or object by force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent (International Criminal Court).

Child sexual abuse, defilement and incest

Any act where a child is used for sexual gratification; any sexual relations or interaction with a child.

Sexual abuse

Sexual abuse is the actual or threatened physical intrusion of a sexual nature of one person by another. This includes inappropriate touching, either by force or under unequal or coercive conditions.

Sexual exploitation/Forced prostitution

Any abuse of a position of vulnerability, differential power, or trust for sexual purposes. This includes profiting momentarily, socially or politically from the sexual exploitation of another. Forced/coerced sex trade in exchange for material resources, services and assistance, usually targeting highly vulnerable women or girls unable to meet basic human needs for themselves and/or their children.

Sexual harassment

Any unwelcome, usually repeated and unreciprocated sexual advance, unsolicited sexual attention, demand for sexual access or favours, sexual innuendo or other verbal or physical conduct of a sexual nature, display or pornographic material, when it interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment.

Sexual violence as a weapon of war and torture

Crimes against humanity of a sexual nature, including rape, sexual slavery, forced abortion or sterilization to prevent birth, forced pregnancy, forced delivery, and forced child rearing, among others.

Sexual violence as a form of torture is a defined as any act or threat of a sexual nature by which severe mental or physical pain or suffering is caused to obtain information, confession of punishment from the victim or third person, intimidate him/her or a third person or to destroy, in whole or in part, a national, ethnic, racial or religious group.

Physical Violence[4]

Physical Assault

Beating, punching, kicking, biting, burning, maiming or killing, with or without weapons; often in combinations with other forms of sexual and gender-based violence.

Trafficking, Slavery

Selling and/or trading in human beings for forced sexual activities, forced labour or services, slavery or practices similar to slavery, servitude or removal of organs.

Emotional and Psychological Violence[5]

Abuse/Humiliation

Non-sexual verbal abuse that is insulting, degrading, demeaning; compelling the victim/survivor to engage in humiliating acts, whether in public or private; denying basic expenses for family survival.

Confinement

Isolating a person from friends and family; restricting their movements; depriving them of liberty, or obstructing and restricting their right to free movement.

Harmful Traditional Practices

Female Genital Mutilation (FGM)

Cutting of genital organs for non-medical reasons, usually done at a young age; ranges from partial or total cutting, removal of genitals stitching whether for cultural or non-therapeutic reasons; often undergone several times during life-time, i.e., after delivery or if a girl/woman has been a victim of sexual assault.

Early marriage

Arranged marriage under the age of legal consent (sexual intercourse in such relationships constitutes statutory rape, as the girls are not legally competent to agree to such unions).

Forced marriage

Arranged marriage against the victim's/survivor's wishes, which is exposed to violent and/or abusive consequences if he/she refuses to comply.

Honour killing and maiming

Maiming or murdering a woman or a girl as a punishment for acts considered inappropriate with regards to her gender, and which are believed to bring shame on the family or community (e.g. pouring acid on a young woman's face as punishment for bringing shame to the family for attempting to marry someone not chosen by the family), or to preserve the honour of the family (i.e. as a redemption for an offence committed by a male member of the family).

Infanticide and/or neglect

Killing, withholding food from, and/or neglecting female children because they are considered to be of less value in a society than male children.

Denial of education for girls or women

This is the removal of girls from school, prohibiting or obstructing access of girls and women to basic, technical, professional or scientific knowledge.

Socio-Economic Violence

Discrimination and/or denial of opportunities, services

This is the exclusion, denial of access to education, health assistance or remunerated employment; denial of property rights.

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4 Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, UNHCR, May 2003

5 It is in our hands Stop the Violence Against Women, Amnesty International publication, 2004

Social exclusion/ostracism based on sexual orientation
This is the denial of access to services or social benefits, prevention of the exercise and enjoyment of civil, social, economic, cultural and political rights, imposition of criminal penalties, discriminatory practices or physical and psychological harm and tolerance of discriminatory practices, public or private hostility to homosexuals, transsexuals or transvestites.

Obstructive legislative practice
This is when individuals (especially women) are prevented from the exercise and enjoyment of civil, social, economic, cultural and political rights.

HUMAN RIGHTS APPROACH TO GBV

The reality and extent of violence is often down played or denied. Some people may blame "bad" men for the violence, but say that it has nothing to do with them; others may blame women or argue that violence is justified. These attitudes are dangerous to victims, especially women, because they diminish the seriousness and prevalence of violence and allow it to continue. But there is no excuse for violence.

While Talkline counsellors may not have been trained to deal with this problem, women or children may call and say that they have been or are victims of gender based violence and want help. It is important for Talkline counsellors to understand the value of a human rights-based approach when dealing with gender-based violence and to be specific about the rights of men, women, and children in relation to gender-based violence. These rights include:

- The right to sex free from coercion or violence
- The right to life
- The right to dignity
- The right to move and associate freely
- The right to decide where, when and under what conditions to have sex
- The right to decide on the number and spacing of children

A key principle of a human rights-based approach is the indivisibility of rights which means that to be fully human we need to have all of our rights recognized at all times.

MEN AND GBV

Men are often socialised into violence and commit the vast majority of violent acts. Men learn violence as a result of experiencing it in childhood or as adults. Violence is a learned behaviour that can be unlearned. Men can choose not to behave violently toward women, children, and other men, thus contributing to stopping GBV. They can do this by:

- Acknowledging that they (men) choose to use violence and should stop belittling violence on an excuse of "loss of contro.l. They should learn to be accountable for their decisions and actions. This principle of accountability is central to any programme focussed on stopping GBV.
- Choosing not to use violence and to live in equal relationships with women. This will help in breaking the negative gender norms. They need support as well as the pressure of accountability to do this. Support from women and other men can help men break the gender rules and end GBV.
- Using their privileged decision making positions in their work places to advocate and set the policies and budgets that can provide more help to prevent and intervene in cases of GBV.
- Intervening (as family and community members) with perpetrators to stop the violence and provide support to the victims of GBV especially children and women with whom they are in contact with.
- Serving as role models of gender equality for other men and work with women as allies for gender equality.

Though women and children suffer more violence than men and cases of GBV have increased, few of such cases are brought to light as battered women often are frightened and unaware of their alternatives.

Such women should be made to understand that the battering behaviour is not acceptable under any circumstances.

CHARACTERISTICS OF GBV

GBV is often progressive. It's usually characterized by periods of tension build-up followed by tension release through physical violence. GBV often times results in mental health problems and/or serious harm or death to the victim. It is the most common type of violence seen in health care settings.

Factors that contribute to GBV:

- Increased use of alcohol or illicit drugs
- Gender inequalities (e.g. subordinate position of women)
- Cultural values that glamorize violence
- High levels of unemployment, poverty and homelessness among women

COUNSELLING GBV VICTIMS

If a woman calls the Talkline and wants to share her GBV experience, as a counsellor you should do the following:

- Listen to her in a sympathetic manner. Listening can often be of great support.
- Reassure her of guaranteed confidentiality.
- Do not blame her or make a joke of the situation. She may defend her partner's actions.
- Reassure her that she does not deserve to be abused in any way.
- Help her to assess her present situation. If she thinks that she or her children are in danger, try and explore together the options to ensure her immediate safety (e.g. can she stay with her parents or friends? Does she have, or could she borrow money?).
- Explore her options with her. Help her identify local resources for support, either within her family, friends and/or community, or through non-government organizations (NGOs), shelters or social services, if available. Remind her that she has legal recourse if needed.
- Offer her an opportunity to call again. Violence by partners is complex, and she may not be able to resolve her situation quickly.
- Provide her with information on where she can find help or meet with a counsellor face-to-face or agencies where she can find help. E.g. YWCA has hostels for temporal residence for abused spouses, Victim Support Unit within the Police structures also attends to GBV cases.

Dealing with Sexual Abuse

As a counsellor, it is important to:

- Be prepared for possible disclosure of sexual abuse before it happens. Think about what you will do if a young person tells you that he or she has been abused.
- Know the law around sexual abuse.
- Find out if there are people or services that can give you or the youth more support.
- Listen and show empathy. Do not make someone give you the information unless he or she wants to. Tell the client he or she is not responsible for the abuse.
- Be positive. You can do this by listening to and valuing a young person's experiences. The young person will feel that he or she counts and is important. This also builds self-esteem.
- Talk with the caller about what they can do in this situation. Write down any information so that if other people become involved, you have the right information.

If unprotected sex has taken place, he or she will need to know about the risk of pregnancy, STIs or HIV infection. Give the person information, and encourage him or her to seek medical care.

Remember!

Sexual abuse of youth is an abuse of power. It can be hard, and sometimes dangerous, for the young person to stop the abuse. Here are five sentences you can use as a counsellor to show the caller you are here to support them:

1. "I am glad that you told me."
2. "I am sorry that this happened to you."
3. "It's not your fault."
4. "I believe you."
5. "We will get you help."

As a counsellor you must listen and believe the caller, show empathy and give them support to stop the abuse.

References

PART 1: COUNSELLING

1. CHAMP, 990 Talkline Manual, 2003
2. Kara Counselling and Training Trust, Foundation Course in Psychosocial Counselling Skills Part One, March 2006
3. CONNECT (Zimbabwe Institute of Systemic Therapy). 1993. Basic Telephone Counselling Skills.
4. Wallace, S. 1998. Stress, http://www.virtualpsych.com/stress/fancyindex.htm

PART 2: HIV AND AIDS

5. CSO, Zambia Demographic and Health Survey, Central Statistical Office, Lusaka, 2007
6. NAC, National AIDS Strategic Frame Work, 2011 – 2015, 25th November, 2010
7. Erhardt, A. "Sexual Behaviour among Heterosexuals"
8. CSO, Zambia Sexual Behaviour Survey, Central Statistical Office, Lusaka, 2009
9. Granich. R. And Memin, J. HIV, Health and Your Community. Stanford, CA (USA): Stanford University Press.
10. U.S. Centers for Disease Control and Prevention, The Deadly Interaction Between TB and HIV, November 1999.
11. World Health Organization (WHO), Tuberculosis Fact Sheet, No. 104, April, 2000.
12. Planned Parenthood (New York City, USA), 1997. Sexually Transmitted Infections: The Facts (Brochure).
13. Gay Men's Health Crisis (New York City, USA), 1992. The Safer Sex Condom Guide for Men and Women.
14. The Female Health Company, Insertion Diagrams. http://www.female health.com/insertiondiagrams.html.
15. CHAMP, HIV/AIDS Peer Educator Manual, 2006
16. MOH, Modes of Transmission, 2009
17. Evian, C. 2000. Primary AIDS Care. Houghton, South Africa: Jacana Education.
18. WHO, UNICEF, UNAIDS Statement on Current Status of WHO/UNAIDS/UNICEF Policy Guidelines. September 1, 1999.
19. MOH, June 2009, Integrated Technical Guidelines for Frontline Health Workers, Page 165

PART 3: SEXUAL REPRODUCTIVE HEALTH

20. CSO, Zambia Demographic and Health Survey, 2007
21. WHO, Geneva, 2003, Managing Complications in Pregnancy and Childbirth
22. Gill Gordon, 1999, Choices, A guide for Young People
23. National Food and nutrition Commission, The First 1000 Critical Days Leaflet
24. MOH, Maternal, Newborn and Child Health Communication Strategy, 2009
25. CSH, Live Today, Your Health Is In Your Hands, Volume2, Issue 4 June2012
26. National Food and nutrition Commission, Community Infant and Young Child Feeding (IYCF) Counselling, March 2011UNICEF, Facts for Life (Fourth Edition), 2010Planned Parenthood (New York City, USA). 1997. Sexually Transmitted Infections: The Facts. (Brochure)

PART 4: NUTRITION

27. National Food and Nutrition Commission, 1000 Critical Days Brochure2007 ZDHS Page 160
28. MOH, Integrated Technical Guidelines for Frontline Health Workers, June 2009, page 56
29. Chainama College of Health Sciences, Department of Counselling Studies, PSYCHOSOCIAL COUNSELLING TRAINING MATERIALS.
30. MOH, Nutrition Guidelines for Care and Support of People Living with HIV and AIDS, 2011

PART 5: MATERNAL, NEWBORN AND CHILD HEALTH

31. CSO, 2007, ZDHS
32. MOH, 2009, Integrated Technical Guidelines for Front Health Workers
33. CSO, 2007, ZDHS, Key findings
34. MOH, Integrated Technical Guidelines for Frontline Health Workers, June 2009

PART 6: MALARIA

35. National Malaria Communication Strategy 2011 – 2014
36. Integrated Technical Guidelines for Health Workers, June 2009
37. National Malaria Programme, Performance Review 2010 (MPR-Zambia 2010)
38. National Malaria Control Action Plan 2012
39. UNICEF, Facts for Life (Fourth Edition), 2010
40. CSH, Brochure on "Facts about Malaria"
41. CSH, Live Today, Your Health Is In Your Hands, Volume 2, Issue 4 June2012

PART 7: GENDER BASED VIOLENCE

42. SAT, Guidelines for Counselling Youth on Sexuality, series No. 11, 2006
43. Ministry of Health, Integrated Technical Guidelines for Front line Health Workers, June 2009
44. MoH, Pregnancy, Childbirth, Postpartum and Newborn Care Guidelines, (Agenda for Essential Practice in Zambia)
45. A Safer Zambia (ASAZ) Partners, Gender Based Violence Brochure.
46. Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons, UNHCR, May 2003,
47. It is in our hands Stop the Violence Against Women, Amnesty International publication, 2004.

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