HIV/AIDS
Care and counselling

Only study guide for

PYC2605

DEPARTMENT OF PSYCHOLOGY

UNIVERSITY OF SOUTH AFRICA, PRETORIA

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WELCOME TO YOUR HIV/AIDS CARE AND COUNSELLING MODULE

HIV and Aids have changed our world and have touched all of our lives. We hope that this module will empower you with the necessary knowledge, skills and attitudes to make a difference in your own lives, in the lives of your loved ones and in your communities.

At first glance the workload may look daunting! But you will find that the material is written in a very reader-friendly way and that you will be able to manage. Use the Learning Units to guide you through the module.

But first things first: Let's introduce you to your teaching team.

YOUR TEACHING TEAM

You are welcome to contact us during office hours (weekdays from 07:45 to 16:00) or to e-mail us.

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We trust that you are as excited as we are about your HIV/Aids care and counselling module.

Enjoy your studies

Your PYC2605 lecturers.

INTRODUCTION AND OVERVIEW

WORD OF WELCOME

Welcome to the HIV and Aids Care and Counselling course. We hope that studying this course will be one of your most rewarding learning experiences ever! We invite you to join us on a journey through the world of HIV and Aids. Make the best of this opportunity. We wish to challenge you not to study merely to pass the examinations, but to use your newly found knowledge and skills to make a difference in your own life and in the lives of those who are touched by the virus, and to assist your communities in need.

In this module we will guide you to gain the knowledge, understanding and skills to educate, counsel and care for people infected or affected by HIV and Aids. We will also ask you to explore your own attitudes and those of others and to establish a deep empathy for those who suffer from the effects of the HI virus.

PURPOSE OF THE MODULE

The purpose of this course is to empower you with the necessary knowledge, skills and attitudes to:

- Manage your own life in the risky environment posed by the HIV and Aids epidemic, that is, to help you discover how you can protect yourself from the virus, or alternatively, if you are HIV positive, how to live positively and how to curtail the effects of the virus on your life.
- Enable you to help other people in your community by aiding them to manage their lives in the HIV and Aids environment, by facilitating a process of behaviour change, or by curtailing the effects of HIV on their lives.

OUTCOMES OF THE MODULE

When you have completed this module, some of the things you will be able to do are to:

Apply your newly-gained knowledge and skills to keep yourself healthy and safe in an HIV and Aids environment.

- Disseminate correct and relevant information on HIV and Aids within your community to prevent HIV infection.
- Facilitate the breakdown of negative attitudes, stereotypes and misconceptions about HIV and Aids in your community.
- Do basic counselling and care for people living with HIV and Aids.
- Be an advocate for the legal and ethical rights of people living with HIV and Aids.
- Care for yourself as a caregiver to prevent burnout.

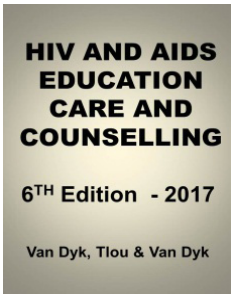
LEARNING APPROACH OF THE MODULE

We have adopted the experiential learning approach in this course, which means that we want to give you the opportunity to be actively involved in the learning process. We do not want you to merely open the prescribed book and learn everything by heart, but rather to evaluate the content of your learning material against real-life situations within your own world and your own contexts. The focus of your learning should be holistic, lifelong learning and not just learning to complete assignments and to pass exams. Remember that learning can be successful only if you take ownership of your own learning and if you change in response to that learning.

WHAT YOU NEED TO COMPLETE THE MODULE

To successfully complete this module you need the following:

- **Tutorial Letter 101.** This tutorial letter contains all the information you need about assessment and examinations. (Use your hard copy or go to "Official study material" in the left hand menu bar of myUnisa).
- **myUnisa and the 23 learning units.** If you have internet access you can work your way through the syllabus on myUnisa by going to the "Learning Unit" section. Alternatively, if you do not want to work constantly on myUnisa (for example, when it is too slow), you can save the 23 Learning Units (in PDF format) on your computer. **Please Note:** If you choose to work from the downloaded PDF documents you still need to be connected to the Internet if you want to follow **external** links (e.g. to YouTube videos). However, all **internal** links (e.g. links to the glossary or assessment) will work even if you are not connected to the internet. (EXCEPTION: links between learning units ["GO TO NEXT LEARNING UNIT"] will not work if you work on the downloaded PDF learning units.)
- **Your prescribed book.** You have to buy the following prescribed book for this module: Van Dyk, A., Tlou, E., & Van Dyk, P. (2017). *HIV and Aids education, care and counselling: a multicultural approach.* 6th Edition. Cape Town: Pearson Education. We will use his icon whenever we refer to the prescribed book.



NB: It is important that you do not buy one of the previous editions of the prescribed book, because the 6th edition (2017 or later impressions) differs substantially from the older editions.

You can get all the details about the book as well as about Unisa's official booksellers by clicking on "Prescribed books" in the left hand menu bar on myUnisa. If you prefer to buy the e-book, go to: http://shop.pearson.co.za and type the title of the book (or part of it, e.g. "education, care and counselling") in the search box.

General information about your assignments and examinations can be obtained in Tutorial Letter 101. (Go to "Official study material" in the left hand menu bar on myUnisa, or use your hard copy.)

STRUCTURE OF THE LEARNING UNITS

To help you to understand the complex nature of HIV and Aids and to acquire a responsible, humane response to it, we have divided the module into five themes.

Each theme focuses on a specific aspect of the disease, such as the challenges posed by the virus, its prevention, counselling in various contexts, care for people living with HIV infection and Aids, and ethical and workplace issues pertaining to HIV and Aids. These issues will be discussed in different learning units.

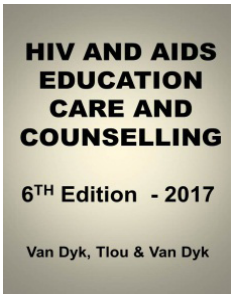
Tip: The Learning Unit number is the same as the chapter number in the prescribed book. For example: Learning Unit 1 (HIV and Aids: A brief history) refers to Chapter 1 in the prescribed book.

Each Learning Unit will consist of the following:

Introduction

In this section we will provide a brief *introduction* as well as some *key questions* to give you an overview of what to expect in the learning unit. We will also highlight all the important (and often new) *key concepts* that you will encounter in a learning unit. If you do not understand a specific concept, consult the glossary (or list of definitions) by simply clicking on the highlighted word. There is also a glossary in PDF format on the "Official study material" site. In this glossary we provide the definitions of the most important concepts in four languages, namely English, Afrikaans, Northern Sotho and isiZulu.

Study



You will immediately recognise the "study" sections in your learning units. The study sections are placed in a box with an icon representing your prescribed book. These sections will refer you to your prescribed book. They will highlight the aspects in the book that you have to give special attention to and will often explain difficult concepts. Please note that the examination questions will come from the prescribed book, so this is one of the most important sections in your learning units.

YouTube videos and electronic resources

In some cases we will provide YouTube videos and electronic resources in a column of the "study" sections or elsewhere. You are welcome to access this material as additional learning material. Please note that there will be no examination questions on the videos or electronic resources.

Activities

With the activities, we hope to inspire you to engage more deeply with the issues and problems associated with HIV and Aids and to discover new perspectives and solutions to problems. We also trust that the activities will lead you to discover more about yourself and your own learning processes. You will probably not have time to do all the activities, but it might be a good idea to read through them and through the feedback provided.

Assessment

The assessment section will consist of two parts:

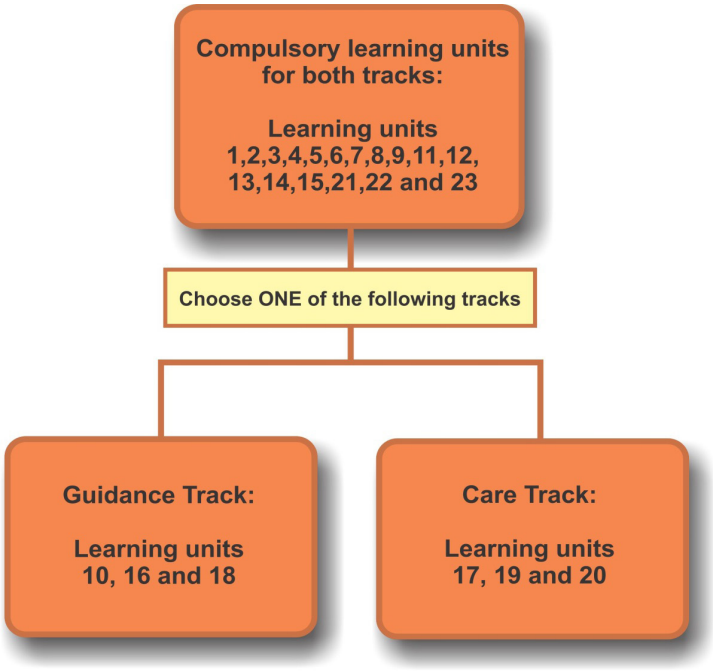
- *Study reflection* consists of a checklist that you can use to see if you understand the main issues after completing a learning unit;

- *Self-assessment* contains tasks to test your knowledge. The self-assessment section will give you the opportunity to do some additional tasks, but please note that these are in addition to your assignments and will not contribute to your year mark.

Word of warning: Your teaching team had a lot of fun looking for as many YouTube videos and websites as possible to make your studies in this module memorable. But please don't get carried away! Make sure that you have enough time to work through the syllabus.

MAKE A SYLLABUS CHOICE

Our student population consists of individuals from all walks of life. We have teachers, nurses, doctors, ministers of faith, academics, social workers, psychologists, counsellors, engineers and human resources personnel, to mention just a few. Other students do the module because they are HIV-infected themselves, or because they care for loved ones with HIV infection or Aids. We appreciate that our students have different needs and we acknowledge these needs by allowing certain choices within the syllabus. To make sure that you all have the same basic understanding of the work, some learning units are compulsory. You can then choose between two tracks: the **care track** OR the **guidance track**. The map below shows the compulsory section as well as the two tracks.



Please choose the track (Guidance Track or Care Track) according to your own interests and needs. The Guidance Track is often the choice of counsellors (lay and professional), psychologists, social workers, teachers, religious workers and some nurses. The Care Track is more often the choice of nurses caring for patients with HIV infection and Aids in hospitals, and for caregivers involved in home-based and hospice care. It might help to page through your prescribed book, *HIV and Aids: education, care and counselling,* to help you make your decision. We, as lecturers, do not need to know which track you choose and you do not need to indicate in the exam the track you have chosen. (Reason: the equivalent questions in the two tracks have the same number and the same alternative will be the correct choice.) Click on "Prescribed books" in the left hand menu bar on myUnisa for a more detailed syllabus (or see Tutorial Letter 101).

Acknowledgments:

All photographs and graphics used in the learning units (except where otherwise indicated) were obtained from the copyright free Britannica Quest website.

YOUR SYLLABUS IN A NUTSHELL

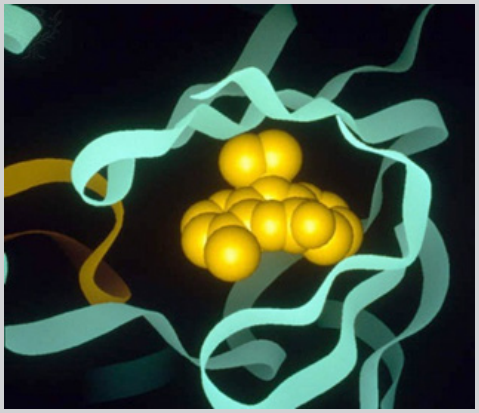
Learning Unit or Chapter	Title	Study category
Part 1 – Fundamentals about HIV and Aids (Outcome 1)		
1	HIV and Aids: A brief history	**Compulsory**
2	HIV and the immune system	**Compulsory**
3	Transmission and Prevention	**Compulsory**
4	HIV-associated symptoms and diseases	**Compulsory**
5	HIV tests	**Compulsory**
6	Antiretroviral therapy	**Compulsory**
Part 2 – Education and empowerment (Outcome 2)		
7	Theories of behaviour change	**Compulsory**
8	Aids education	**Compulsory**
9	Changing unsafe practices	**Compulsory**
10	Aids education for school children	**Guidance Track**
11	Aids education in traditional Africa	**Compulsory**
Part 3 – HIV Counselling (Outcome 3)		
12	Counselling principles and skills	**Compulsory**
13	HIV counselling and testing	**Compulsory**
14	Ongoing counselling	**Compulsory**
15	Bereavement counselling	**Compulsory**
16	Spiritual counselling and the meaning of life	**Guidance Track**
Part 4–Care and Support (Outcome 4)		
17	Home- and community-based care	**Care Track**
18	Orphans and vulnerable children	**Guidance Track**
19	Infection control	**Care Track**
20	Care and nursing principles	**Care Track**
21	Care for the caregiver	**Compulsory**
Part 5 – Legal and policy issues (Outcome 5)		
22	Aids and the law (Only selected sections)	**Compulsory**
23	Aids in the workplace	**Compulsory**

More information on what to study for the examination is in Tutorial Letter 101.

THEME 1

Knowing the Challenge

Throughout history, humans have been challenged by many different health issues. With the development of vaccines for many life-threatening and crippling diseases (such as for rabies, smallpox and polio) and the discovery of antibiotics, humans have gradually become used to the idea that most diseases could be prevented or treated. However, in the last two decades of the 20th century, this false sense of security was shattered by HIV and Aids.



Structure of Nevirapine

So how can we meet the challenge posed by HIV and Aids?

This is the question we investigate in Theme 1. We do this by dealing with six basic questions:

Where does Aids come from?

- What is HIV and how does it attack the body?
- How is HIV transmitted from one person to another and how can we prevent it?
- What are the symptoms and diseases associated with HIV infection?
- How can HIV infection or Aids be diagnosed?
- How can HIV infection and Aids be managed with antiretroviral therapy (ART)?

Each one of these questions will be discussed in a separate learning unit and, in this way, we will start to suggest possible answers to the Aids challenge.

LEARNING UNIT 1

HIV and Aids: A brief history

INTRODUCTION

People **react** differently to challenges. Some choose to ignore them and hope that they will go away. Others feel helpless and disempowered in the face of a huge problem and this makes it difficult for them to meet the challenge effectively. We believe that the best way to meet a challenge like HIV and Aids is to know as much as possible about the threat and to explore as many avenues as possible in combating the spread and effects of the virus. Our first learning unit therefore deals with the following key questions:

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- When and how did the Aids epidemic start?
- Where and when did HIV originate?
- What does it mean when researchers talk about the “prevalence” and the “incidence” of the Aids epidemic?
- What is the response to the Aids epidemic?

KEY CONCEPTS

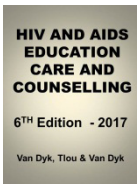
While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used. You can also look up the definitions of

the terms in the glossary. Please note that some of the key words in this list might not be in the glossary.

HIV	HIV prevalence
Aids	HIV incidence
Crossing the species barrier	AZT
Urban legends	

THE BIRTH OF A NEW EPIDEMIC

Where did the HI virus come from, how and where did the epidemic start, and how did it spread to become a pandemic (i.e. spread all over the world)? An equally controversial issue is who first discovered (or isolated) the HI virus? All these questions are discussed in your prescribed book.

Study	Prescribed book: pp. 3–6
	**Section 1.1: The birth of a new epidemic.** Pay special attention to: • The meaning of the acronym "Aids" and what is meant by the term "syndrome". • The outcome of the controversy about the discovery of HIV.

THE ORIGIN OF HIV

FIGURE 1:

Luc Montagnier, Françoise Barré-Sinoussi (for the discovery of HIV) and Harald zur Hausen (for the development of the HPV virus vaccine), won the Nobel Prize in Physiology or Medicine in 2008.

We are sure that you have heard various theories and opinions about the origin of HIV, some more far-fetched than others. So how can you tell fact from fiction? Although we would like you to always consider different views and ideas by consulting the voices of various communities, the news media, colleagues and scientists, you should remember that this is a scientific course and not mere popular speculation.

To uncritically accept rumours, conspiracy theories and alternative views just because you like them is not acceptable within a scientific or university milieu. This is not to say that scientists always agree. For example, in the case of HIV, a large number of different theories were put forward in the earlier years of the epidemic about the origin of the virus.

Let's consider a few so-called urban legends about the origin of HIV. Urban legends regarding the origin of HIV often consist of unsubstantiated conspiracy theories or stories that blame somebody, some organisation or some government agency for manufacturing or spreading the virus. Discover this for yourself by doing the following activity.

ACTIVITY 1.1

Conspiracy theories and urban legends

Conduct an informal survey amongst your friends and colleagues and see how many additional conspiracy theories and urban legends about the origin of HIV you can discover.

If you have access to the internet, use the Google search engine and search using the words "HIV conspiracy theories" or "Urban legends about Aids". The search will probably return hundreds of different types of conspiracy theories. Try to find as many as possible.

Now ask yourself the following questions:

- Who are the villains ("bad guys") in these theories or urban legends?
- Is the source of the virus always attributed to the same "bad" organisation or person, or does it vary according to the storyteller's own perspective or group?
- What proof is offered to support any specific theory, except that "it is generally accepted" or that its acceptance depends on what people wish to believe?

FEEDBACK 1.1

If you paid close attention, you would probably have realised that urban legends and conspiracy theories are widespread in our society, but that they are difficult or impossible to verify. The specific agency to which the conspiracy is attributed also varies greatly (depending on the setting in which the legend circulates). During the Cold War in the 1980s (and today), the US military was and is a popular villain. In South Africa, the previous apartheid government is a popular choice for the "bad guy". On the other hand, within certain religious communities, the New Age movement is seen as the "source of all evil" and therefore also as the possible source of HIV.

It is important to understand the difference between scientific theories and popular conspiracy theories. One of the basic tenets of science is that we should not merely believe everything that we hear, that is, we should develop a critical attitude.

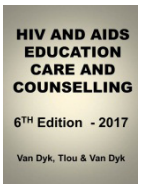
Study  	**Prescribed book: pp. 6–9** **Section 1.2: The origin of HIV.** Pay special attention to: • How scientists gradually became more certain about the exact origin of HIV. Also note the reasons behind the current theory that it crossed the species barrier on several occasions from various primate species, each occurrence resulting in a different group of the HI virus (see Figure 1.2 in your prescribed book). The fact that many pathogens (e.g. viruses) are specific to a species (e.g. one kind of animal), but may in some cases cross over to another species (e.g. humans), is well-known to epidemiologists. Although this crossing of the species barrier by a pathogen is by no means a common occurrence, it is nonetheless common enough so that many of the seasonal flu viruses which plague us during the winter months have their origin in other species such as pigs or birds (thus the popular names such as swine or bird flu).	
	• Type the following link **(http://goo.gl/B8fUVp)** into your web browser to watch a YouTube video about the origin of HIV. • The nature of and reasons behind urban legends and conspiracy theories so that you identify them in future and dismiss them for what they are: unsubstantiated rumours which people wish to believe for various reasons.	

It is now commonly accepted that an ancestor of the HIV-1 group M virus was transmitted from a chimpanzee (*Pan troglodytes troglodytes*).

THE GLOBAL AIDS EPIDEMIC

This section in the prescribed book, about the current global prevalence of HIV infection, is deliberately short, indicating only broad trends. The reason for this is that, by the time you read it, it will already have become outdated. You are therefore referred to the UNAids website (http://goo.gl/ArUSY) for a more detailed and up to date figures about the Aids pandemic. You can also go to http://goo.gl/Opm2ef to access the report on the global HIV infections statistics.

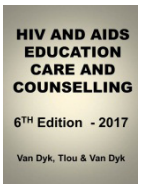
Over and above the global figures of HIV infection, this section also deals with exactly how these figures are calculated and what the difference between prevalence and incidence is.

Study	Prescribed book: pp. 9–11
	**Section 1.3: The global Aids epidemic.** Pay special attention to: Broad trends in global HIV infections and the most recent statistics as reflected on the UNAids website. • The important difference between *prevalence* and *incidence* of HIV. An easy way to remember the difference is to picture prevalence as the frequency (or how common) HIV infection is amongst the population as a whole (either globally or in a specific country or group). Incidence refers to the rate of infection, that is, the number or percentage of new infections in a given year. Why is it important for you to know this difference? If you don't know what the difference is, you will not understand what scientists mean when they use these terms. • How HIV prevalence is measured. People often express doubt (without giving any reasons) about the number of HIV infections in a specific country or group. It is therefore important to be knowledgeable about the process of measurement and that it is done according to the guidelines of UNAids.

You have read about the National Household Surveys that are done by the HSRC (Human Sciences Research Council) on a regular basis in South Africa. Visit the HSRC website (http://goo.gl/FC5Ltj) to familiarise yourself with the amazing work they are doing.

THE WORLD'S RESPONSE TO THE AIDS EPIDEMIC

This section deals primarily with the kind of inaction and denial which featured during the earlier years of the Aids pandemic, especially in South Africa.

Study	Prescribed book: pp. 11–23
	**Section 1.4:** The world's response to the Aids epidemic. Pay special attention to: The psychological reasons why people may tend to deny, blame and moralise when trying to come to grips with a potentially deadly disease. • The current South African government's ARV programme and how it entails a total 180 degree switch from the previous policy. • Table 1.1 for a summary of all major historical events regarding the Aids pandemic and to situate yourself in terms of these events by doing the Activity that follows.

ACTIVITY 1.2

Where were you when Aids happened?

Look at the timetable showing the history of HIV and Aids in Table 1.1 in your prescribed book. Do the following:

- Look at each one of the main incidences on the timetable. Think about what you were doing in your life at that time.

- Take a pencil and draw a circle around the year on the timetable when you first became aware of HIV and Aids.
- What made you aware of HIV and Aids at that time in your life?
- Think back of how you felt about Aids at the time. How do you feel about Aids now? Have your feelings about Aids changed over the years?

FEEDBACK 1.2

We all have our own personal experiences which will influence our answers.

Where was I? Although I had already been working in the Aids field since the mid-1980s, Aids really hit me when Freddie Mercury died on 24 November 1991. What a waste of talent, and how terribly sad that the use of highly active antiretrovirals (HAART) was introduced only in 1995. It was also a time of silence, stigma and prejudice. Do you think things are better now? In what sense? (Alta van Dyk)

Go to the link http://goo.gl/Bv9dzc to watch a video about the people we have lost because of Aids.

Flight MH17 – We mourn our Aids colleagues

The world was shocked and saddened by the loss of so many members of the international Aids community when flight MH17 was shot down over the Ukraine on Thursday 17 July 2014. They were on their way to the 20th International Aids Conference in Melbourne, Australia. One of the victims was Dr Joep Lange from the Netherlands who fought for years to make ARVs available and accessible in developing countries. I will always remember him saying "If you can get Coca Cola to the smallest villages in Africa, you can also get ARVs there." Our thoughts are with the families and friends of all those who died on flight MH17.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 1 (HIV and Aids: A brief history), you should have acquired the following knowledge and understanding and be able to:

- narrate the early history of HIV and its discovery.
- explain how HIV crossed the species barrier from various primates.
- explain the main differences between scientific theories and urban legends and rumours.
- explain the difference between prevalence and incidence of HIV and how prevalence is measured and calculated.
- narrate the main events about the history of HIV and Aids and how people reacted to the epidemic.

These skills will help you to continue reading and discovering more amazing, although often disturbing, facts about HIV and the Aids epidemic, but also may empower you to help fight the disease in your community. We can only succeed in this fight if we stand together and dispel half-truths and ignorance. Are you willing to become part of the solution?

SELF-ASSESSMENT 1

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Go to Self-Assessment 1 to do a few questions on this learning unit. Please note that these self-assessment questions do not contribute to your year mark or your admission to the exams. The feedback to the questions will be given to you immediately after you have completed each question.

SELF-ASSESSMENT QUESTIONS 1

[**NB:** Please note that the feedback to the questions is on the next page.]

QUESTION 1

When did the world first become aware of a new disease that affected the immune systems of young homosexual men?

1. 1981
2. 1985
3. 1991
4. 1995

QUESTION 2

Who won the Nobel Prize in Physiology or Medicine in 2008 for the discovery of HIV?

1. Robert Gallo
2. Louis Pasteur
3. Luc Montagnier
4. Françoise Barré-Sinoussi and Luc Montagnier

QUESTION 3

HIV crossed the species barrier from primates to humans. We now know that HIV-1 (Group M) was originally transmitted from a …… to a human being, probably during hunting.

1. Green monkey
2. Chimpanzee
3. Vervet monkey
4. Gorilla

QUESTION 4

Define the concept "HIV incidence".

QUESTION 5

Define the concept "HIV prevalence".

FEEDBACK SELF-ASSESSMENT 1

FEEDBACK QUESTION 1

The correct answer is 1981 (alternative 1)

FEEDBACK QUESTION 2

The correct answer is Françoise Barré-Sinoussi and Luc Montagnier (alternative 4)

FEEDBACK QUESTION 3

The correct answer is chimpanzee (alternative 2).

FEEDBACK QUESTION 4

It is the annual number of new HIV infections as a proportion of previously uninfected people. (See Section 1.3.1 in your prescribed book for a full explanation of HIV incidence.)

FEEDBACK QUESTION 5

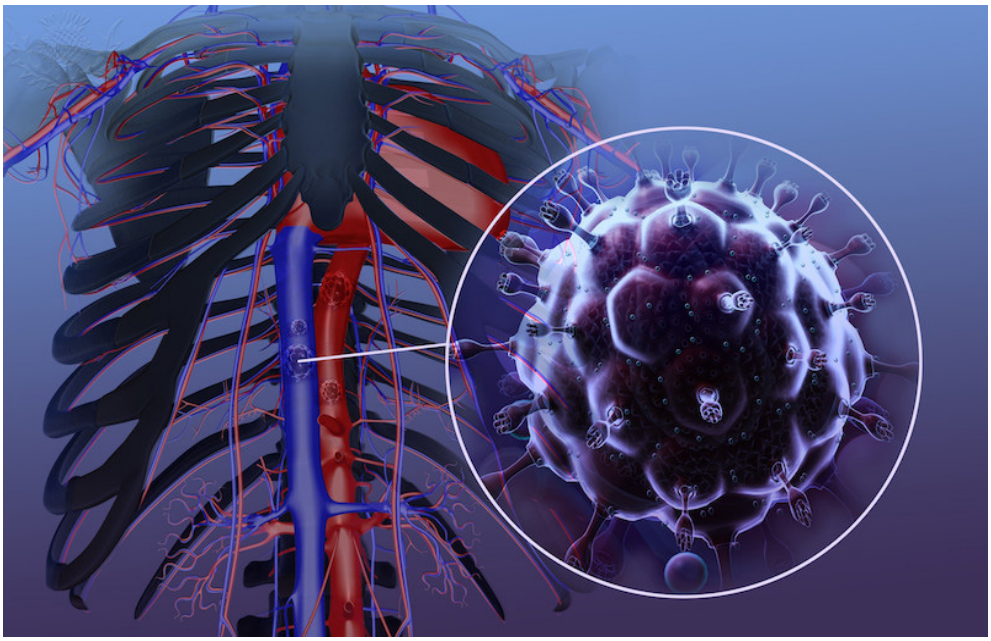
HIV prevalence is the percentage of people living with HIV (as a proportion of the total population) at a specific time. (See p.8 in your prescribed book.)

GLOSSARY

HIV	An acronym for the Human Immunodeficiency Virus – the virus that causes Aids. The predominant form of HIV in central, eastern and southern Africa, North and South America and Europe is HIV-1. HIV-2 is a closely related retro- virus found in western Africa.
Aids	An acronym for: Acquired Immune Deficiency Syndrome. This acronym emphasises that the disease is acquired and not inherited. It is caused by a virus (HIV) that invades the body. This virus then attacks the body's immune system and makes it so weak and ineffectual that it is unable to protect the body from both serious and common infections and pathogens.
HIV Prevalence	The proportion (percentage) of people within a population living with HIV.
HIV Incidence	Refers to the annual number of NEW HIV infections as a proportion (percentage) of previously uninfected people.
AZT (Zidovudine)	AZT is an ARV falling in the class of Nucleoside reverse transcriptase inhibitors (NRTI). NRTIs disturb the life cycle of HIV through interference with the reverse transcriptase enzyme by mimicking the normal building blocks of HIV DNA.

LEARNING UNIT 2

HIV and the immune system



INTRODUCTION

All living things have a natural defence system which protects them from attacks by pathogens (i.e. disease causing agents) such as viruses. This defence system is called the immune system.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

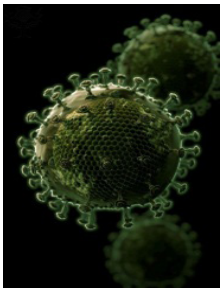
- What are the different lines of defence used by the immune system?
- How does the immune system fail in the case of HIV?
- How do viruses work in general?
- What are the unique features of HIV?
- How does HIV enter the body and how does it replicate?
- What is meant by “the variability of HIV” and how many subtypes of HIV are there?
- What are the different responses of the body to HIV infection?

KEY CONCEPTS

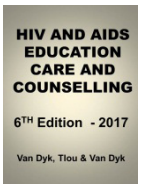
While working your way through this learning unit, look out for the following key terms. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Active and passive immunity	Non-specific and specific defences
Cells and proteins	HIV subtypes (A, B and C)
Antibody	DNA
RNA	Reverse transcriptase
T-cells	B-cells
CD4 cell	Phagocytes
Macrophages	Vaccine
Seroconversion	

THE IMMUNE SYSTEM



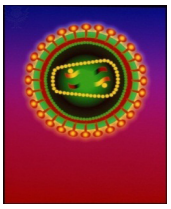
The body's immune system uses various lines of defence to protect the body against pathogens by killing the pathogens (in various ways) and, if possible, by retaining a memory of such pathogens so that they can be killed during future infections by the same pathogen before they can make a person sick (i.e. to make the person immune against a specific pathogen). In the prescribed book, the working of the immune system is described in terms of various lines of defence, involving different immune cells, which can broadly be divided into non-specific and specific defences.

Study		
	**Prescribed book: pp. 26–37** **Section 2.1: The Immune system.** Pay special attention to: • The different lines of defence and their associated cells. The third line of defence is especially important because it involves the specific defences of the immune system and its processes of: 1. recognition and warning; 2. mobilisation and battle; 3. demobilisation; and 4. active and passive immunity. Use Figure 2.4 in your prescribed book to help you understand this specific defence system. **Go to** (http://goo.gl/j5fYex) to watch the YouTube video on the immune system. • The lock-and-key system of attachment. • Reasons why the defence system of the body's immune system fail in the case of HIV infection. • **Go to** (http://goo.gl/49yeVV) to watch the YouTube video on the T-helper Cells.	 

We should hasten to add that not all immune deficiencies are caused by HIV. Other well-known causes of immune system malfunctioning are inherited immune system disorders, or when the immune system has been damaged by radiation. Inherited immune system disorders are diseases in which part of the body's immune system is missing or does not work properly. People with an immune system disorder are therefore less able to fight infections. Various immune deficiencies may affect the immune system in different ways, causing different kinds of opportunistic infections. These inherited immune disorders are rare, with only about 50,000 people in the United States having some type of inherited immune system disorder, ranging from mild to severe.

In contrast to inherited immune disorders, secondary immune deficiencies may be caused by something outside the body, such as a virus or by chemotherapy. Aids is such a secondary immune deficiency, because it is not inherited, but acquired. That is why it is called Acquired Immune Deficiency Syndrome.

THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

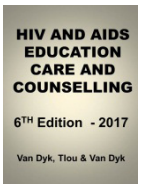


Viruses are important pathogens and cause many different diseases. (Other pathogens such as bacteria, fungi and micro-organisms are responsible for many other diseases.) Viruses are one-cell organisms and differ from all other living organisms in the sense that they cannot replicate (increase) without first infecting a host cell from another organism (e.g. in a human body) and then, by using the host cell's resources and genetic material, creating new copies of themselves.

Although we often talk about the "HI virus" (as if it were a single organism), the number of viruses in the body of an infected person (who is not on ARVs) may exceed 500 000 per one millilitre of blood. This implies that millions of viruses may live in the body, cells and blood of an (untreated) HIV-infected person.

Although the controversy as to whether Aids was really caused by a virus has now greatly fizzled out in both South Africa and the rest of the world, it is still important to clarify a few matters. After initial doubts about the exact cause of Aids in the very early stages of the epidemic (doubts which have, for far too long, been kept alive by some people pretending to be serious scientists) we now not only know for certain that Aids is caused by HIV, but we also know more about this virus than about any other virus that exists.

Unfortunately many people still persist in naming various other supposed causes of Aids, which may spread some more confusion. It is therefore important to clearly distinguish between the primary cause of Aids (i.e. HIV) and some contributing factors which may be driving the pandemic. Factors such as poverty, bad nutrition and disempowerment of women are indeed very important driving forces (contributing factors) behind the Aids pandemic, but they could never be termed the causes of Aids as mistakenly proposed by some.

Study  	**Prescribed book: pp. 37–47** **Section 2.2: The HI virus.** Pay special attention to: • The general structure of viruses. Use Figure 2.6 to help you understand the various components. **Click on the icon** (http://goo.gl/IsCPQq) in the right hand column to watch the YouTube video on HIV and infection. Also use Activity 2.1 below to help you remember the various components of a virus.	
	• How HIV enters the body and infects a cell. Use Figure 2.7 to visualise the process. It is also a good idea to watch the YouTube video (http://goo.gl/8u1494) in the right hand column, which explains the various processes of how a virus infects a cell and how it replicates (i.e. attachment, fusion, injection, reverse transcription, integration of genetic material, replication of genetic material and production of new copies of the virus). It is important to understand these basics so that you can later understand how ARVs interfere with these processes (see Learning Unit 6). • Some common questions about HIV and its functions. • The variability of HIV. If you understand why HIV changes so quickly (is highly variable) you will also understand why the immune system fails in the case of HIV and why it is so difficult to make a vaccine for HIV. • Different responses to HIV infection. It is important to realise that people differ from each other and that, following HIV infection, their responses to the infection may also greatly vary. Make sure that you understand the reasons for this.	

ACTIVITY 2.1

Draw a diagram of a virus

If you really want to understand what a virus looks like it may be a good idea to go to your journal and draw a detailed picture of one. Use the diagram of HIV (Figure 2.6) of your prescribed book to help you.

Draw a rough circle – to represent the loose outer membrane around the virus. Label it: Lipid membrane (loose viral envelope). Lipid refers to the fact that the membrane consists primarily of fat.

(1) Draw another smaller circle inside the first one and label it: Capsule (shell). This is the main membrane around the virus which protects the inside of the virus like a skin.

(2) Next, draw a series of small mushroom-shaped protrusions around the two membranes. Make sure that they go through the first circle (envelope) and are fixed to the inner circle (capsule). Each little mushroom has a small stem and a head that looks like a little suction cup. Label these mushrooms: “Glycoproteins” (gp for short). There are two gp’s: gp120 and gp41. Both the

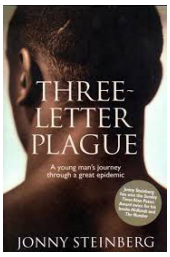
gp120 and gp41 are “envelope proteins” (env for short). These gp’s play an important role in allowing the virus to attach to another cell and penetrate it during infection. When a virus meets a potential host cell, the suction cups attach to the surface of the cell, but only if the suction cups fit the outside of the cell (like a key and lock system). Gp120 does the “sucking” or adherence and is part of the suction cup proper. Gp41 does the penetration. It is part of the stem of the little suction cups.

(3) Complete your picture by also filling in the details about the core of the virus. Draw a third cone-shaped block inside the first two circles (like the pit or stone inside an apricot or peach). Label it: Core. It is inside this core that all the genetic material is stored. It is from the genetic material in the core that the virus receives all its instructions on how to manufacture more copies of itself.

(4) Inside the core, draw three or four single snake-like strands – in the prescribed book there are only two. Label them: Viral RNA. These are elements of the genetic material of the virus. The genetic material of most living organisms consists of double-stranded DNA. However, in some exceptional cases the genetic material consists of single-stranded RNA – as is the case with retro-viruses such as HIV. RNA doesn’t work as well as DNA when dishing out instructions about copying the virus. It therefore makes a lot of mistakes during the process of copying the virus. It is because of these mistakes that retroviruses (like HIV) mutate or change so quickly.

(5) Now for the enzymes. Enzymes can be regarded as biological chemicals which make specific biological or chemical processes in the body possible. Inside the body, enzymes help with digestion and many other biological processes such as cell division or replication. Without enzymes life would not be possible. There are three important enzymes which play a role in the replication of the HI virus: reverse transcriptase, protease and integrase (note that all enzyme names end with “-ase”). Draw a series of dots, crosses and small squares inside the core of your virus – close to the snake-like RNS strands – and give them the names of the three enzymes mentioned above.

(6) Draw the last elements of the virus by including the two gag proteins (p’s), p 24 and p 17.



A “MUST READ” BOOK

One of the most insightful fiction books written in the past few years – about the effects of HIV in a rural community in South Africa – was written by Jonny Steinberg and is called *Three letter plague*.

A “must read”

Three-letter plague is a story by Jonny Steinberg about a young man’s journey through a great epidemic. The following are a few comments about the book:

“When people die en masse within walking distance of treatment, my inclination is to believe that there must be a mistake somewhere, a miscalibration between institutions and people. This book is a quest to discover whether I am right.” – Jonny Steinberg.

Jonny Steinberg’s groundbreaking work or reportage about pride and shame, sex and death, and the Aids pandemic in Africa is a masterpiece of social observation.

At the end of a steep gravel road in one of the remotest corners of Lusikisiki in the old Transkei lies the village of Ithanga. Home to a few hundred villagers, the majority of them unemployed, it is inconceivably poor. In the broader world, most would consider it entirely inconsequential.

It is here that author Jonny Steinberg explores the lives of a community caught up in a battle to survive the ravages of HIV and Aids. He befriends Sizwe Magadla, a young local man who refuses to be tested for HIV despite the existence of a well-run testing and anti-retroviral programme nearby. It is this apparent illogic that becomes the key to understanding the dynamics that run like a thread through this complex and traditional rural community.

In this eye-opening, compassionate, searing and beautifully written book, Steinberg seeks to understand the Aids crisis in South Africa. As he grapples to get closer to answers that remain maddeningly just out of reach, he realises he must look within to unravel some of the enigmas surrounding the epidemic that has corrupted souls as much as bodies.

"In this vivid account of a journey to the frontline in the battle against Aids, Jonny Steinberg portrays with acute perception the impact of the epidemic on village life in a small rural community in South Africa." – Martin Meredith.

(This extract was published by Jonathan Ball.)

If you are interested, try to get the book and start reading it to supplement your more formal study of HIV and Aids. We trust that the book will enrich your life greatly, but please note that the reading of *Three-letter plague* is not compulsory and that no examination questions will be asked on the content of the book.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing your journey through Learning Unit 2 (HIV and the immune system), you should have acquired the following knowledge and understanding and be able to:

- label the different components of HIV.
- explain how HIV attacks the body's immune system.
- imagine how viruses work and replicate.

SELF-ASSESSMENT 2

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Click on the link Self-Assessment 2 to do a few questions on this learning unit. Please note these self-assessment questions do not contribute to your year mark or your admission to the exams. The feedback to the questions will be given to you immediately after you have completed each question.

SELF-ASSESSMENT 2

QUESTION 1

What is the first line of defence for the body's immune system?

1. Antibiotics
2. The skin
3. White blood cells
4. Plasma B-Cells

QUESTION 2

CD4 T+ cells are part of the:

1. Specific defences of the body
2. Acquired immune system
3. Non-specific defences of the body
4. Innate immune system

QUESTION 3

The ..... of a pathogen can be regarded as the unique "insignia" which is used by the body's immune system to recognise the specific pathogen. The missing word is:

1. Antibody
2. Colour
3. Antigen
4. Smell

QUESTION 4

Which kind of immunity can one get by having immunoglobulin injections?

1. Protective passive immunity
2. Active immunity
3. Passive immunity
4. Non-specific immunity

QUESTION 5

Name the four stages of immune system function when the body is attacked by a pathogen.

QUESTION 6

Name the seven steps in the replication of HIV.

QUESTION 7

HIV is called a ..... because it does not have DNA but RNA as genetic code in its nucleus. The missing word is:

FEEDBACK 2

FEEDBACK QUESTION 1

The correct answer is alternative 2. The skin is the first line of defence for the body.

FEEDBACK QUESTION 2

The correct answer is alternative 1. CD4 T+ cells are lymphocytes which form part of the specific defences of the body and the acquired immune system. See Section 2.1.1 in your prescribed book.

FEEDBACK QUESTION 3

The correct answer is alternative 3. The "antigen" of a pathogen is the unique insignia by which it is recognised. Do not confuse the words antigen and antibody – although antigens stimulate the development of antibodies, they have different functions.

FEEDBACK QUESTION 4

The correct answer is alternative 1. Protective passive immunity provides short-term protection through the injection of immunoglobulin (a preparation rich in antibodies) into a person's bloodstream. (Passive immunity is acquired by a baby from his or her mother).

FEEDBACK QUESTION 5

1. Recognition and warning
2. Mobilisation and battle
3. Demobilisation
4. Active and passive immunity

FEEDBACK QUESTION 6

1. Attachment
2. Fusion
3. Injection
4. Reverse transcription
5. Integration of genetic material
6. Replication of genetic material
7. Production of new viruses

FEEDBACK QUESTION 7

"Retrovirus". The usual transcription of genetic material is from DNA to RNA to DNA. HIV is called "retro" because it transcribes in the reverse order.

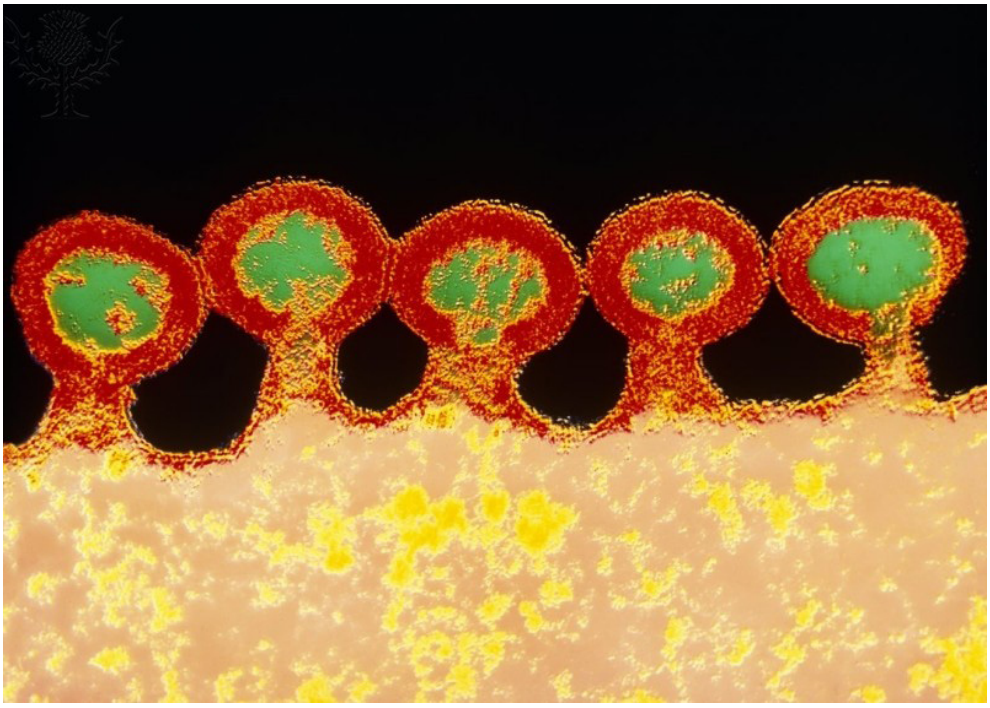
GLOSSARY

CD4 Cells	CD4 T helper lymphocytes (a type of white blood cell). These cells play an important role in keeping the immune system healthy. HIV attaches itself to the CD4 receptors on the outer layer of the CD4 cells. They are also called T4 helper cells.
Macrophages	Types of phagocytes that generally attack cells infected with viruses. Macrophages are antigen presenting cells – they present antigens to the lymphocytes and thus mobilise the lymphocytes (or the specific defence system) to attack the invaders.
Phagocytes	Phagocytes are often referred to as the "scavengers" of the immune system. They are white blood cells that engulf and destroy ("eat") foreign or infected cells. There are two kinds of phagocytes, namely macrophages and neutrophils.
Retrovirus	A type of virus (of which HIV is one) that replicates by changing its genetic RNA into DNA by using the host's cells.
Seroconversion	The point at which a person's HIV status converts or changes from being HIV negative to HIV positive. This coincides with the time when an HIV test will show that a person is HIV positive. Seroconversion usually occurs 4 to 8 weeks after an individual has been infected with HIV.
Vaccine	A substance given to stimulate the immune system to protect the person from infection by a specific microorganism. Vaccines are made from live attenuated pathogens, from killed whole organisms or from purified proteins. The search for an HIV vaccine is based on genetic engineering and protein-based technology.
Active and passive immunity	Active immunity usually follows after infection by a pathogen but it can also be generated by immunisation. Passive immunity is short-term immunity that a new-born baby gets from its mother.
Antibody	Special protein complexes produced by the immune system that attack and neutralise specific disease-causing organisms. The antibodies which the body creates in response to HIV are unfortunately powerless to protect the body against the long-term destructive effects of HIV.
Non-specific and specific defences	Non-specific defences consist of the skin (to keep pathogens out) and an inflammatory reaction (when the skin is broken). These defences are non-specific in the sense that they will attack any pathogen or pollutant to try to protect the body. Macrophages and natural killer cells are examples of non-specific defences. Specific defences "specialise" and they attack specific pathogens that they are made for. For example, CD4 cells have a specific specialisation and that is to stimulate the rest of the immune system to produce more cells to fight off the infection.

Reverse Transcriptase	Reverse transcriptase is a viral enzyme which helps (with the other viral enzymes protease and integrase) in the copying of the virus inside the host cell, and is injected with the viral genetic material into the host cell during infection.

LEARNING UNIT 3

Transmission and prevention



Viruses budding from a cell

INTRODUCTION

In 1981 when the world realised that it was threatened by a serious new disease there was great fear. The fear was caused by the fact that people did not know at that time what caused the disease and also had no idea how the disease spread from one person to another. We can truly say that knowledge is power since we know today that Aids is caused by HI virus, how it is spread and how it can be prevented. We no longer need to harbour unnecessary and harmful fears and we have no excuse to treat people with HIV infection like outcasts. In this learning unit we will look into ways that HIV can be transmitted from one person to another and how it can be prevented.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

How is HIV transmitted from one person to another?

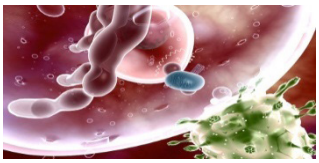
- How do poverty, disempowerment and poor socio-economic conditions contribute to the spread of HIV?
- How does HIV not spread?
- How can HIV infection be prevented?

KEY CONCEPTS

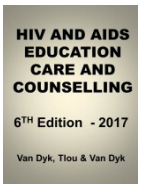
While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary. You have learned by now that to click on the word will take you directly to the glossary):

Transmission of HIV	MTCT (mother-to-child transmission)
Microbicides	Myths

HOW IS HIV TRANSMITTED?



Why is it important to know how a disease is spread? Well, if we know how a disease is spread, we also know how to prevent it. Knowing how a disease is spread also gives us peace of mind because we can then easily distinguish between facts and myths (or misconceptions).

Study  	**Prescribed book: pp. 50–67 as well as pp. 548–550 (Section Universal precautions)** Study the following sections in your prescribed book: **Introduction:** It is not so easy to get infected with HIV. Certain conditions must apply before HIV can be transmitted from one person to another. Let's see if you know what these conditions are: • Name the two things that must happen before HIV will be transmitted from one person to another. • Name the three conditions where transmission is more likely to happen. **Section 3.1: Sexual transmission of HIV.** Will you be able to answer the following questions if a client asks them? • What is the role of other sexually transmitted infections in the spread of HIV? • Why are women more easily infected by HIV than men? • How many instances of sexual contact with an HIV-positive person are necessary before one becomes infected oneself? • Is oral sex safe? • When is an HIV-positive person most infectious to other people? • Which contributing factors influence the spread of HIV? • What is the difference between 'men who have sex with men' and 'being gay'? **Section 3.2: Transmission of HIV through contaminated blood**. You may find that people in your community are often very scared of blood. Do you have the knowledge to share the real dangers with them but also to pacify their fears by giving the correct information? • List all the important points about the transmission of HIV through contaminated blood that you would discuss with a concerned person in your community.
	How would you explain to a person in your community that it is safe to donate (or give) blood? To go to the South African National Blood Services go to http://goo.gl/jTTkYa for a discussion on donor risks. **Section 3.3: Mother-to-child transmission of HIV**. HIV-positive pregnant women are very concerned about the health of their babies. After reading this section, make sure that you will be able to answer the following questions: • What would you tell a pregnant woman about the transmission of HIV from a mother to her child? • How would you counsel HIV-positive pregnant women in your community about breastfeeding their babies? • What implications does the very interesting "exclusive breastfeeding versus mixed feeding" debate have for your community? Keep the socioeconomic as well as cultural beliefs and traditions in community in mind when you think about this question.

ACTIVITY 3.1

Transmission of HIV

This activity gives you an understanding of how HIV can spread from one person to another.

Complete the following questionnaire on how HIV is transmitted. First, read through the list in the left-hand column. Then indicate in the right-hand column if you think that HIV can spread from one person to another through the way mentioned. Answer "yes", "no", or "maybe" in the right-hand column.

HIV infection can be transmitted in the following ways	**Yes/No/Maybe**
1. Swimming in a municipal swimming pool	
2. Being born to a mother who is HIV positive	
3. Donating (or giving) blood	
4. Being bitten by an infected mosquito	
5. Having unprotected sex with an HIV-positive person	
6. A baby drinking the breast milk of her HIV-positive mother	
7. Sharing food with a person with Aids	
8. Receiving a blood transfusion if the blood contains HIV	
9. Extreme poverty and dire living conditions	
10. Having oral sex with a person with Aids without a barrier	
11. Shaking hands with a person with HIV	
12. Kissing an HIV-positive person	
13. Having sex with many partners without using condoms	

When filling in the above questionnaire you may have become aware of the fact that you were uncertain about some of your choices. How do you know if they were correct or not? To assess your own choices consult your prescribed book.

FEEDBACK 3.1

While doing the activity you may have become aware that some practices are more dangerous than others and that others are only dangerous under certain conditions and when viral loads are high.

Did you give a definite "NO" to questions 1 (swimming pools), 3 (donating blood), 4 (mosquitoes), 7 (sharing food), 9 (poverty), 11 (shaking hands) and 12 (kissing)? If you are still wondering about the mosquito, read the enrichment box "Mosquitoes and Aids" in your prescribed book. This will hopefully prove the mosquito's innocence beyond all doubt. If you marked "YES" to questions 5 (unprotected sex), 8 (blood transfusion with infected blood) and 13 (sex with many partners without condoms) you were correct. Note that oral sex without a barrier like a condom (question 10) also carries some risk.

One of the lessons I have learnt about HIV and Aids is that there are some **grey areas** where the answers to questions are not so straightforward. For example, if you gave a definite "YES" to questions 2 (being born to an HIV-positive mother)

and 6 (breastfeeding), and a definite “NO” to question 12 (kissing), think again! Not all babies born to HIV-positive mothers or who are breastfed by an HIV-positive mother become HIV infected. It depends on factors such as the viral load in the mother’s blood or in her breast milk at the time of birth or while breastfeeding her child. An HIV-positive mother on ART will probably have very few viruses in her blood that can be transmitted to her baby. On the other hand, a mother who gave birth or breastfed while she was in the seroconversion phase (the first phase of infection when the viral load is very high) would most probably transmit the virus to her baby.

And kissing? Kissing is generally safe and becomes a problem only with two conditions: open sores in the mouth and a high viral load (in the blood of the person, not in the saliva).

Now do the next activity.

ACTIVITY 3.2

A home experiment on viral load

This activity will help you to understand why the viral load is an important determinant (or deciding factor) in the transmission of HIV.

Do the following home experiment to illustrate the importance of viral load in the transmission of HIV:

You will need the following:

- two long water glasses and two shorter glasses (tumblers)
- tap water
- a marker pen (“Koki” or whiteboard marker)
- polystyrene balls (usually sold at post offices or PostNet shops as packaging material)
- a teaspoon

Now follow the next six steps to conduct your experiment:

Step 1: Mark one long glass with an “A” and the other with a “B” with the marker pen, and mark one short glass “X” and the other “Z”. The four glasses represent four people.

Step 2: Fill glasses A and B with tap water. The water represents a body fluid – let’s say semen in this case.

Step 3: Add 20 polystyrene balls to glass A, and 100 polystyrene balls to glass B. The polystyrene balls represent HIV.

Step 4: Stir the contents of glass A with a teaspoon and pour half of the water into glass X.

Step 5: Stir the contents of glass B and pour half of the water into glass Z.

Step 6: Make your observations (count the polystyrene balls in glass X and in glass Z) and write them down on a piece of paper.

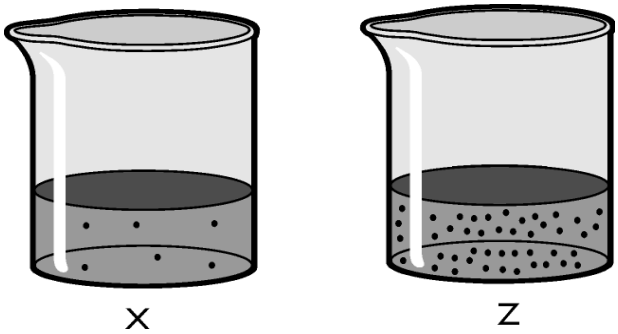
Answer the following questions:

- Which glass (X or Z) had the most polystyrene balls?
- If the glasses X and Z were people exposed to HIV, which one would have the greater chance of getting infected?

FEEDBACK 3.2

The experiment was a practical illustration (by using two glasses of water and small polystyrene balls) of how important viral load is in terms of the chances of HIV transmission.

You will probably find that the container with the most polystyrene balls in it is glass Z. Because there are 100 balls in glass B, chances are so much bigger that more balls will end up in glass Z since there are only 20 balls in glass A. The same applies to the number of viruses in the body fluids of an HIV-infected person. The higher the viral load (or the more viruses) in the body fluid, the higher the chances of transmitting HIV to another person.



The figure above is an illustration of the home experiment.

But what if you found more balls in glass X? Remember what I said earlier about some remaining grey areas and that the answers to HIV and Aids questions are not always straightforward? There are always exceptions to the theoretical rules. If the recipient of a body fluid (e.g. semen) has an STI with open sores, the chances of getting infected with HIV are extremely high – even if the viral load in the HIV-positive person's semen is relatively low!

WHO IS TO "BLAME" FOR THE SPREAD OF HIV?

In Learning Unit 1, you read about the history of HIV and Aids and where it probably came from. In this section we will explore our perceptions and feelings about so-called at-risk individuals and groups. Let's start by doing the following activity:

ACTIVITY 3.3

Perceptions of people at risk of HIV infection

This activity will give you the opportunity to explore your beliefs and perceptions of people at risk of HIV infection.

(1) Fill in the following "at risk" scale.

Instructions: Read through the list of people on the left-hand side of the scale. Indicate to what extent you think each one of them is susceptible to or at risk of getting an HIV infection, and who are the least susceptible. Draw a circle around a number between 1 (least susceptible) and 5 (most susceptible) to indicate your choice for each one of the individuals mentioned.

	Least				**Most**
A medical student	1	2	3	4	5
A sex worker	1	2	3	4	5
A homosexual man	1	2	3	4	5
A travelling businessman	1	2	3	4	5
The businessman's wife	1	2	3	4	5
A Unisa first-year student	1	2	3	4	5
A lesbian woman	1	2	3	4	5
An injecting drug user	1	2	3	4	5
A high school teacher	1	2	3	4	5
A trans-Africa truck driver	1	2	3	4	5

(2) How easy was it for you to do this activity and why?
(3) Search the Internet for stories about hate crimes towards gay and lesbian people. There are many reports in newspapers about senseless killings of gay and lesbian people.

Also think of the horrible xenophobic crimes that shook our country and our communities in 2008 (and that are currently still happening). Xenophobic and gay crimes have one thing in common: fear of and hate for people that are different from us.

Think about the following issues after reading stories of hate crimes and make notes in your journal:

As a student in the human sciences, how and where would you start to address the change of attitudes in your community to prevent hate crimes?

- If you were a school teacher, what would you do to prevent one of your learners from one day becoming part of senseless hate crimes or xenophobia?
- If you explore your own feelings and attitudes towards other people whose beliefs and life choices differ from your own, are you tolerant, or are you also guilty of "passive" hate?

FEEDBACK 3.3

I trust that this activity made you aware of how easy it is to hate people who are different from you and to label groups as high risk instead of rather identifying high risk behaviour.

I hope that this activity made you think about your **own attitudes** and feelings about people with values other than your own, and also about the dangerous consequences of negative attitudes and the "blaming" of others.

Let's look at how easy it was for you to fill in your scale in the first part of activity 3.3. For some of you it might have been an easy, straightforward exercise because you thought that the homosexual man, the sex worker, the injecting drug user and the trans-Africa truck driver should all score high marks. However, I hope that most of you were frustrated by this activity because I did not give you enough information to enable you to make an informed decision on where to draw your circle. For example, if the homosexual man always uses condoms when having sex, he is at a considerably lower risk than the businessman who has unprotected sex with sex workers on his trips. And what if the sex worker always insists on condom use and goes for HIV testing regularly? The medical student is supposed to have all the facts on HIV and Aids, but what if he or she does not apply them and has many sex partners without always using condoms? How at risk is the businessman's wife who has sex only with her husband (who visits sex workers on his travels)?

In conclusion: Can you identify with the following statements?

- There is ***no such thing*** as high-risk people, only high-risk behaviour.
- If you have more than one sex partner – even if you use condoms, there is no such thing as no-risk sexual behaviour, only lower-risk behaviour.
- To automatically see some people as high-risk people is to **blame** them, to stereotype them and to foster negative attitudes which often lead to prejudiced behaviour.

I hope that this activity made you think about your **own attitudes** and feelings your own about people with values other than your own, and also about the dangerous consequences of negative attitudes and the "blaming" of others. We all have our own opinions and attitudes about the world around us, but to be good and helpful counsellors we need to explore and recognise our attitudes and change them when they are hurtful to our clients.

NOBODY IS TO BE BLAMED FOR THE SPREAD OF HIV

POVERTY, DISEMPOWERMENT AND HIV

How do poverty, disempowerment and poor socioeconomic conditions contribute to the spread of HIV? In Learning Unit 2 the meaning of the word "cause" was clarified as well as the role of contributing factors (such as poverty) in a person's vulnerability to HIV infection. Do you agree that poor socioeconomic conditions and poverty are fertile grounds for the spread of HIV infection, but that they in themselves are not causes of HIV infection or Aids?

Study	**Prescribed book: pp. 51–56**
	Study the following sections in your prescribed book: **Contributing factors influencing the spread of HIV.** There are so many aggravating factors in Africa contributing to hardship and vulnerability to diseases. Think about the conditions in your own communities or in the lives of your clients and add these to the aggravating factors described in the prescribed book.

ACTIVITY 3.4

The role of poverty and disempowerment in action

Read the case study about Maria who grew up in a very poor family. The activity will give you hands-on experience of how certain factors in a person's life can contribute to their chances of also becoming infected with HIV. We call them contributing factors to (NOT CAUSES OF) Aids.

Read the case study below and answer the questions that follow.

Maria grew up in a very poor family. Her father was very strict and often hit his wife and young daughters to keep them "in line". It became clear to Maria at a very young age that women were inferior to men and that their only worth in life lay in serving and pleasing men. To escape these living conditions, Maria ran away from home when she was 14 years old. She had no money for food and clothes and would have died on the streets if a group of street children had not taken her in. She became involved in petty crime, glue sniffing and alcohol abuse and, when she was 16 years old, she started having sex with men for money. The drinking continued to help her cope with her difficult circumstances. She often complained of a vaginal discharge and sores (indications of STIs), but she had no access to health services. When she was 18 she got what she thought was a "lucky break" when one of her clients asked her to marry him. But it was not long after the marriage that she realised that he only wanted his own personal slave. He treated her badly and when she asked him to use condoms (to prevent pregnancy) he called her a whore. It was not long after her marriage that Maria went to a mobile clinic and tested HIV positive.

(1) Name the factors that contributed to Maria's HIV infection and explain how these factors made her more vulnerable to HIV infection.
(2) Is there someone like Maria in your community? Share the story (don't use names) with your fellow students in a blog.

FEEDBACK 3.4

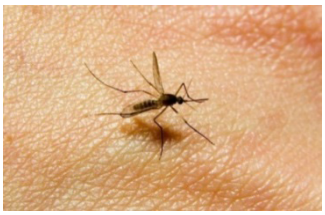
You probably know by now that the only cause of Maria's HIV-positive status is HIV that she contracted by having unprotected sex. There were, however, various factors that **contributed** to this situation and if these *contributing factors* could have been avoided, Maria's life story could have turned out so very differently – for example if she had been an empowered young woman who believed in herself and who also had the means to protect herself. Some of these factors are as follows:

- Maria was a disempowered young girl and woman who did not know how to protect herself. She formed the perception from a young age that women are worthless, and do not have the right to protect themselves. She could not even ask her husband to use condoms.
- Poverty and dire living conditions on the streets drove Maria to prostitution.
- Alcohol abuse is a known factor in compromising decision-making abilities, for example not to insist on condom use.
- Maria contracted STIs on the street and STIs (especially those with open sores) increased her chances of also becoming infected with HIV tenfold.
- Maria had no access to health services and could not empower herself with health knowledge (e.g. to use condoms) or seek help when needed (e.g. to treat her STIs). Health knowledge could have protected her in the end.

You will probably meet people like Maria in the course of your work as an HIV and Aids counsellor. Use the opportunity this course offers you to empower yourself to help them to make better life decisions.

You will probably meet people like Maria in the course of your work as an HIV and Aids counsellor. Use the opportunity this course offers you to empower yourself to help them to make better life decisions.

HOW HIV IS NOT SPREAD



One of the important tasks of Aids educators or counsellors is to eradicate myths (i.e. popular views that are not true) and to correct misconceptions about HIV and Aids in their communities. But to know what these myths and misconceptions are, you need to listen to the voices of the people in your community first.

ACTIVITY 3.5

Myths and misconceptions

The purpose of this activity is to familiarise you with some of the die-hard myths and misconceptions about the transmission of HIV and also to give you the opportunity to find out what myths and misconceptions exist in your community. Different communities often believe different myths.

(1) Listen to what people in your community (church, school, clubs) have to say about Aids by engaging them in a conversation on the topic.
(2) Make a list of some of the things people in your community say, for example how HIV is spread and how it can be prevented.
(3) What do you believe about HIV and Aids?
(4) What do you think is the function of the belief in myths? What role do they play in people's lives?
(5) What harm can there possibly be in believing certain HIV transmission and prevention myths? How can a myth be dangerous?

FEEDBACK 3.5

It is important when you work in your communities to help correct wrong information or myths and convince people of the correct facts. It is also not enough to tell people ***that*** mosquitoes cannot transmit HIV – you also need to tell them ***why*** it is not possible for mosquitoes to transmit HIV. I believe that eradication of HIV myths should start at a young age and that schools should use science classes to explain to children why certain myths are scientifically not possible (e.g. one such myth is that you can get rid of the virus by having sex with a virgin).

Myths are not harmless! Go to your prescribed book (Chapter 10, Section 10.6, Enrichment box) and read what South African adolescents (16 to 18 year olds), who participated in research about South African schoolchildren's perceptions about HIV and Aids, had to say about the so-called virgin cleansing myth.

If you look back at your answers in Activity 3.1, you will see that all the questions where the correct answer is "NO" (swimming pools, donating blood, mosquitoes, sharing food, poverty, shaking hands and kissing) are based on myths and misconceptions.

Adolescent girls expressed extreme concern about the virgin cleansing myth and made the following comments:

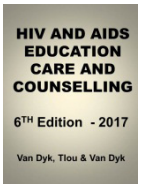
" If this is true, how safe is it to be a virgin?"

- "They give us double messages: They want us to be virgins but it is extremely dangerous to be a virgin – we get raped."
- "My grandmother wants me to go for virginity testing. For what? So that I can be labelled as a 'cure for Aids' and be raped?"

Adolescent boys were intrigued and curious about the myth:

"Our friends say that you can cure yourself from Aids if you have sex with a virgin. Is it true? Can it be that easy?"

As counsellors, we should, however, be empathic and understand the functioning of myths in the lives of people who believe in them. Myths often serve the function of alleviating fear and guilt feelings and of shifting blame. For example: "I'm safe and won't get Aids because I'm not gay", or "It's not my fault that I have Aids, I was bitten by a mosquito".

Study	**Prescribed book: pp. 67–69**
	**Section 3.4: Myths about the transmission of HIV.** After reading this section make sure that you are able to do the following: • List the myths and misconceptions about the transmission of HIV that are mentioned in the book. • Add at least three myths that you have heard in your community to this list. • Understand why you may have believed in some of these myths or misconceptions – and whether you feel any different about what you believed now that you have reading more about myths and misconceptions? • Formulate a way in which you can convince your friends that some beliefs about the spread of HIV are simply not true.

PREVENTION OF HIV INFECTION

Study	Prescribed book: pp. 70–79
	**Section 3.5: Prevention of HIV.** Study this section and give attention to figure 3.1 which provides a nice summary of this section. Make sure that you understand the following: • What are the differences between the following intervention strategies: Behavioural intervention, biomedical intervention and structural intervention? • Give examples of the specific strategies used under each one of the three main intervention methods to prevent HIV. • Which of the interventions are already used in our communities, and which have been researched but not yet implemented? • Do you understand the difference between "ARVs as treatment", and "ARVs as prevention"? • Do you know the different uses of ARVs to prevent HIV? That is the use of ARVs to prevent MTCT of HIV, prevention in heterosexual discordant couples, as post-exposure prophylaxes (PEP as well as nPEP); and pre-exposure prophylaxis (PrEP).

If you are interested in knowing more about male circumcision, click on the link (http://goo.gl/VAfKJ) to see what the World Health Organisation has to say about it.

Important note on circumcision:

Circumcision alone is NOT the ultimate answer! Although male circumcision research indicates that men who have been circumcised have a reduced risk of HIV infection compared to their uncircumcised counterparts, the World Health Organisation (WHO) and UNAids warn that circumcision is not a magic bullet. Although male circumcision reduces the risk of infection for men substantially, it does not eliminate the risk of infection completely. Male circumcision should therefore NEVER replace other known methods of HIV prevention, but should always be considered as part of a comprehensive HIV prevention package. There is also no evidence that male circumcision has any direct impact on the risk of infection

for the woman, on the risk among men who have sex with men, or on the risk for heterosexual anal intercourse.

Also note that male circumcision is very different from female genital mutilation (previously called female circumcision). Female genital mutilation has very adverse effects on the health, sexual pleasure and obstetric outcomes in women and has no medical benefits.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 3 (Transmission and prevention), you should have acquired the following knowledge and understanding and be able to:

- explain what each one of the key terms mentioned under "key concepts" at the beginning of this learning unit means to you.
- explain to a friend why unprotected, penetrative sexual intercourse can transmit HIV as well as other STIs.
- advise women on how to make themselves less vulnerable to HIV infection. (Before you can do this, you will have to list the reasons why women are particularly vulnerable to HIV infection.)
- counsel an HIV-positive couple on condom use and self-protection when they argue that it "surely is not necessary to use condoms since we are both infected with the virus."
- write an article to your local newspaper about the difference between causal and contributing factors to a disease – explain how poverty and homelessness can contribute to the spread of HIV, while it cannot in itself cause HIV infection.
- talk to an HIV-positive pregnant woman about the possible transmission of HIV through her breast milk and counsel her on her choices.
- facilitate a workshop for adolescents where you discuss the following issues:

  - why oral sex is not necessarily safe sex
  - why the virgin cleansing myth is just that: a myth (use scientific arguments you picked up in Learning Unit 1 to explain why this cannot be true)
  - how girls can say "No" and boys can respect the choices of young women.
  - evaluate your own sexual behaviour in terms of what is risky and what is safe.

- explain what we mean by behavioural interventions, biomedical interventions and structural interventions to prevent HIV infections to another.
- understand that nobody is to be "blamed" for the spread of HIV.
- explain how poverty, disempowerment and poor socioeconomic conditions contribute to the spread of HIV.
- explain how HIV is **NOT** spread.
- explain how HIV infections can be prevented.
- explain what we mean by behavioural interventions, biomedical interventions and structural interventions to prevent HIV infections.

You are now finished with this learning unit. Do some self-assessment questions.

SELF-ASSESSMENT 3

Please note that these self-assessment questions do not contribute to your year mark or your admission to the exams. The feedback to the questions will be given to you immediately after you have completed each question.

SELF-ASSESSMENT 3

QUESTION 1

Under which one of the following conditions is HIV transmission the most likely to happen?

1. Kissing an HIV-positive person.
2. Sharing food with a person with Aids.
3. Having sex with many partners without using condoms.
4. Being bitten by an infected mosquito.

QUESTION 2

What is the correct statement about socio-economic factors influencing the spread of HIV?

1. Sexually transmitted infections (STIs) influence sexual transmission of HIV.
2. Shaking hands with a person with HIV can cause HIV infection.
3. Extreme poverty forces women into selling sexual services.
4. Women are more likely than men to become infected with HIV during unprotected vaginal intercourse.

QUESTION 3

Choose the correct statement about the prevention of HIV.

1. HIV prevention programmes are often not well planned and cordinated.
2. Total abstinence from sex cannot bear any fruits in the fight against HIV and Aids.
3. Interventions to prevent HIV infection can broadly be classified into two main categories: Behavioural intervention and biomedical intervention.
4. Behavioural intervention focusing only on faithfulness to one partner.

FEEDBACK 3

FEEDBACK QUESTION 1

The correct answer is having sex with many partners without using condoms. (alternative 3).

FEEDBACK QUESTION 2

The correct answer is that extreme poverty forces women into selling sexual services (alternative 3). Note: although alternatives 1 and 4 are also correct, they are not socio-economic factors.

FEEDBACK QUESTION 3

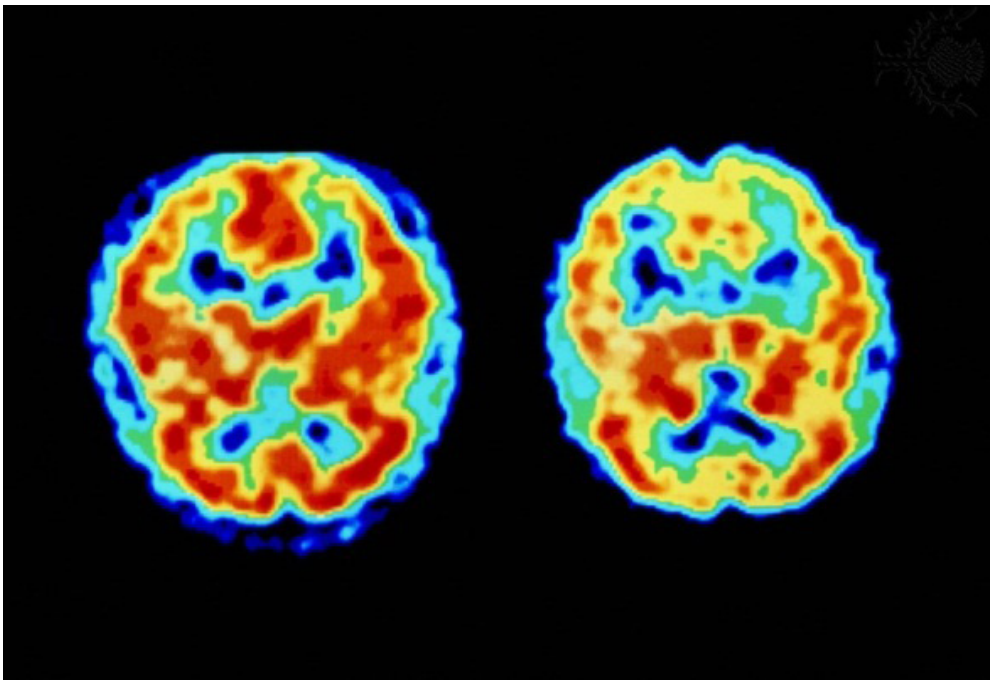
The correct answer is that HIV prevention programmes are not well planned and co-ordinated (alternative 1).

GLOSSARY

Microbicides	A substance that kills microscopic organisms such as bacteria, viruses and parasites. Researchers are currently developing microbicides that can be inserted into the vagina (or rectum) with the aim of destroying infection- causing organisms including HIV.
MTCT (Mother to Child Transmission)	Mother-to-child transmission of HIV. This happens mostly during the birth process or when an HIV-positive mother breastfeeds.
Myths	Generally held beliefs, which are UNTRUE. In the Aids field these mostly refer to false beliefs about how HIV is transmitted and how it originated. Myths are often linked to conspiracy theories and urban legends.
Transmission of HIV	Transmission of HIV from one person to another. Transmission of HIV mostly happens because of exposure to HIV-contaminated blood or other high risk body floods (e.g. semen, vaginal fluids and breast milk). Sexual transmission typically happens during unprotected sexual intercourse with a person who has a high viral load.

LEARNING UNIT 4

HIV-associated symptoms and diseases



Brain scan of patient with Aids dementia

INTRODUCTION

After reading Learning Units 2 and 3, it should be clear to you that Aids is an *immune deficiency* syndrome. In this learning unit we will elaborate on all the different infections and diseases that can attack a person with a broken-down immune system. We will also look at that very fine balance between the immune system (in the form of CD4 cells) and HIV to determine the progress of an infected person's disease.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- What is the relationship between the immune system, the virus and disease progression?
- What are the symptoms of HIV infection? How can opportunistic infections be prevented?
- What does tuberculosis have to do with Aids?
- Why are STIs and Aids such a deadly combination?

KEY CONCEPTS

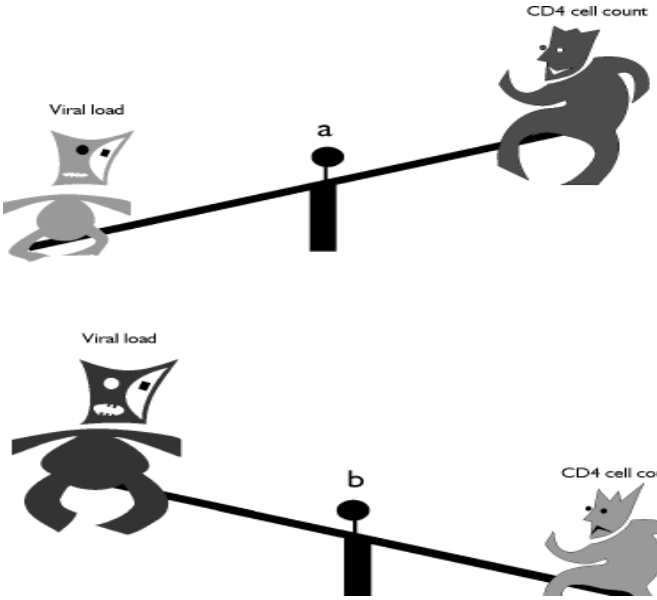
While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

CD4 cell count	*Pneumocystis* Pneumonia (PCP)
Stages of HIV infection	Tuberculosis (TB)
Opportunistic infections	Sexually Transmitted Infections (STIs)
Viral load	Shingles (or herpes zoster)

A SPECIAL RELATIONSHIP

There is a very special relationship (or a fine balance) between the viral load, the CD4 cells (representing the immune system) and the progression of the disease (Aids). If you grasp this relationship, you are halfway there! Everything you read about Aids can be explained by looking at this relationship between CD4 cells and HI viruses. This relationship will explain how healthy or sick a person with HIV infection is, what the effects of positive living are and why ARVs work so well. Let's explore this relationship further:

Study	**Prescribed book: pp. 84–86**
	**Section 4.1: The CD4, the viral load and the stages of HIV infection.** Pay special attention to: • When the viral load is high, the CD4 cell count will be low. • When the CD4 count is high, the viral load will be low.



The relationship between the CD4 count and the HI viral count

To explain the relationship between the CD4 count, HIV and the health of the immune system, I will use the pictures of an HIV-positive man living in a house (the immune system) with creatures lurking around (opportunistic infections). If the man maintains the house properly (e.g. by keeping the door intact) the creatures

cannot come in (to attack the immune system) and the man will stay healthy. If the man neglects his house (immune system) and lets the door fall into disrepair, the creatures (opportunistic infections) will take the opportunity to come into the house and they will kill the man. With this story in mind, do Activity 4.1.

ACTIVITY 4.1

The immune system in pictures

In this activity you will find the pictures below as well as a couple of questions to answer based on the pictures.

Look at the pictures below and answer the questions that follow.

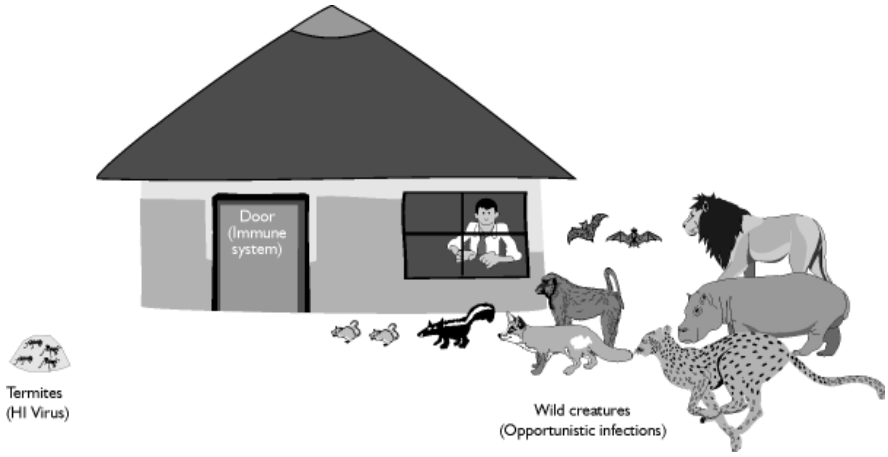


FIGURE 1:
A healthy immune system keeps pathogens out

After looking at Figure 1, answer the following questions:

(1) How many termites are there in this picture?
(2) What percentage of the wooden door is still intact (100%, 80%, 50%, 20%)?
(3) Which of the creatures can get through the door?
(4) What is the general condition of the person behind the door?
(5) What can the housekeeper do to keep the door intact?

Now look at the following picture and answer the questions that follow:

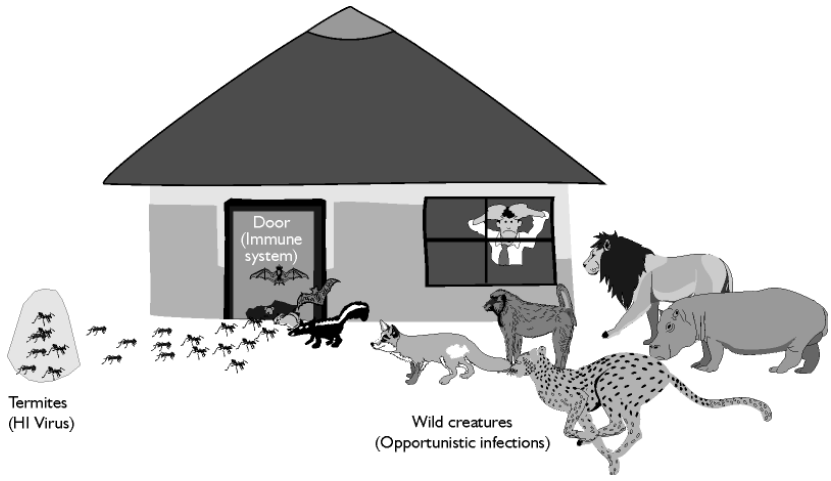


FIGURE 2:

A bigger challenge to the immune system

After looking at Figure 2, answer the following questions:

(1) How many termites are there in this picture?
(2) What percentage of the wooden door is still intact (100%, 80%, 50%, 20%)?
(3) Which of the creatures can get through the door now?
(4) What is happening to the person in the house?
(5) What can the housekeeper do to control the damage?

And now the final picture to look at and questions to answer:

FIGURE 3:
A failing immune system under heavy attack

After looking at Figure 3, answer the following questions:

(1) How many termites are there in this picture?
(2) What percentage of the wooden door is still intact (100%, 80%, 50%, 20%)?
(3) Which of the creatures can get through the door now?
(4) What do you think they are doing to the person in the house?
(5) What can the housekeeper do to control the damage?

FEEDBACK 4.1

I hope that the picture of the termites, the door and the lurking creatures will always be in your mind when you deal with the management of HIV infection and Aids. You will later learn more about all the different things the housekeeper can do to keep a person healthy. But for now, let's concentrate on the creatures which get through the holes in the door. Make the following principles your own:

- Disease progression (the extent to which an HIV-positive person gets sick with opportunistic infections) will depend on the viral load and the CD4 count in the blood.
- The lower the viral load and the higher the CD4 count, the healthier a person with HIV infection will be. (Think of the **seesaw metaphor** used in the prescribed book, and the story about the termites and the door used in this guide).
- The *higher the viral load* and the *lower the CD4 count,* the sicker a person with HIV infection will be.

- Every HIV disease management intervention has only one purpose in mind: to keep the body as healthy as possible. Opportunistic infections and diseases (the lurking creatures) can be kept at bay only by keeping the viral load (the number of termites) as low as possible and the CD4 count (the intact door) as high as can be.
- You will later learn more about all the different things the housekeeper can do to keep a person healthy. But for now, let's concentrate on the creatures which get through the holes in the door.

SYMPTOMS OF HIV INFECTION

You will see that we use a "*stages of disease"* approach in this course. This means that the progression of HIV infection and Aids is explained in terms of four stages of infection. We use the stages approach only because it is a handy theoretical way to understand the disease. The advent of ARVs changed the stage approach to the development of disease dramatically. ART literally brought some people with fully developed Aids back from the brink of death. You only have to read the life stories of great South Africans like Zackie Achmat and Edwin Cameron to realise this. The very sad scenario is, however, that many people all over Africa are not on ARVs (for various reasons) and this stage-like pattern progressing from being infected to death is still often seen.

Study	**Prescribed book: pp. 86–96**	
	**Section 4.2: The stages of HIV infection.** This section will help you to explain to a patient with HIV infection the infections and diseases they are vulnerable to in the different stages of the disease. Pay special attention to: The symptoms and diseases that can make a person sick in the different stages of infection. Click on the link http://goo.gl/eM1tR2 to watch a video on early symptoms. The involvement of the CD4 cell count and the viral load in each one of the infections or diseases. The fact that a person who is in the final stage of Aids (clinical stage 4) is very vulnerable to opportunistic infections and is usually very sick. Be aware of the diseases that the person can be vulnerable to and be able to give a short definition of each. (See the glossary). Click on the link http://goo.gl/x75Xyi to watch a video on the differences between HIV, Aids and opportunistic diseases.	 

If you still have doubts about the CD4/HIV/symptoms seesaw, look at figure 4.3 (p.88 of the prescribed book). Can you see how this picture brings it all together and how it shows how a person with HIV infection and Aids can deteriorate if nothing is done to boost the immune system and to repress the viral load?

ACTIVITY 4.2

The stages of HIV infection

This activity will require from you to link the symptoms and diseases that you read about in the prescribed book to the right stages of HIV infection.

Do you think that you will be able to link the symptoms and diseases that you read about in the prescribed book to the right stages of HIV infection if I mix them up a bit? Well, let's see.

Stages of HIV infection

	Primary HIV infection	**Stage 1 Asymptomatic latent**	**Stage 2 Minor symptomatic**	**Stage 3 Major symptomatic**	**Stage 4 Aids-defining conditions**
(a) Symptoms & diseases	Sore throat Mild fever				
(b) CD4 count					
(c) Viral load					
(d) Health of individual					

(1) Read through the random list of symptoms and diseases (below) and complete the columns in row (a) in the table by placing the symptoms under the correct stage. Was it easy for you to decide which symptoms and diseases belong to which stage of infection? I helped you a bit by placing the first two correct symptoms under the "primary HIV infection" stage.

List of symptoms and diseases

- sore throat for a week or two
- moderate swelling of the lymph nodes
- persistent generalised lymphadenopathy (or severe swelling of the lymph nodes for at least three months)
- persistent and recurrent oral and vaginal candida infections (thrush)
- persistent and unexplained weight loss (more than 10% of usual body weight)
- weight loss up to 10% of usual body weight
- severe and recurrent skin infections such as warts and ringworm
- recurrent herpes infections such as herpes simplex (or cold sores)
- Pneumocystis pneumonia (or PCP)
- mild fever for a week or two only
- occasional, recurring fevers
- unexplained fever that lasts for more than a month
- shingles (or herpes zoster)
- night sweats
- persistent cough
- HIV encephalopathy (or neurological abnormalities)
- meningitis

- lymphoma (or cancer of the lymph nodes)
- recurrent oral ulcerations (or sores)
- Kaposi's sarcoma
- oral hairy leukoplakia (or thick, white patches on the tongue)
- mild feelings of fatigue
- tuberculosis
- recurrent upper respiratory tract infections

(2) Indicate in each column (rows b and c) what the CD4 count and viral load would look like for each stage of infection. You don't have to give the specific numbers of the CD4 count or viral load. Just indicate if it would be high or low, increasing or decreasing.

(3) Complete row (d) by indicating how healthy or sick a person will be in a specific stage.

FEEDBACK 4.2

If you battled to place the symptoms and diseases in the right column, you are welcome to go back to your prescribed book and take a peek. Take note that some of the symptoms or diseases could fit into more than one stage of HIV infection.

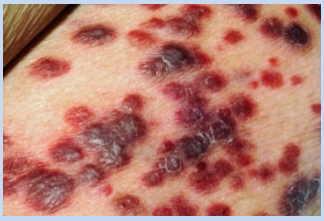
You probably learnt the names of some new diseases in this section. I tried to define them properly in the prescribed book, but if you still battle with some of the words, go to your glossary and look them up. It might also help to Google the word on the internet.

When you filled in your table, did you notice that some of the symptoms or diseases could fit into more than one stage of HIV infection? The distinguishing factor is usually the degree or seriousness of an infection, how long it lasts, how well it responds to treatment, as well as its recurrence. Some symptoms (such as fever, vaginal thrush, diarrhoea, shingles) can occur in more than one stage of infection, but they are much more severe and persistent in the latter stages of infection, and also have the tendency to recur more often.

I hope that your column for stage 1 (the asymptomatic latent stage) is blank (except maybe for one symptom). The only symptom that some people in this asymptomatic stage (meaning "no symptoms") may have is swollen lymph nodes.

If you look back at the table, can you clearly see the relationship between the CD4 cells, the viral load and the seriousness of the symptoms and diseases? Symptoms and diseases become much more severe as the immune system deteriorates and they also tend to recur more often.

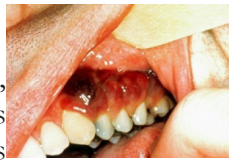
Look at pictures of diseases



You have now learned about a number of diseases and infections but, if you don't know what they look like, they might mean nothing to you. The following online library gives images and photographs of Aids-related diseases. The pictures might help you to put a face to many diseases by looking at them. The images can even be transformed into PowerPoint slides. But be warned: Some of these pictures are not for sensitive viewers!

Go to the following website: http://www.Aids-images.ch . Click on "All diseases" (on the left, under "Search images by disease"). This will bring up an alphabetical list in a popup box. Choose a disease that you would like to view by clicking on it, for example "Candidiasis" or "Kaposi's sarcoma".

PREVENTION OF OPPORTUNISTIC INFECTIONS



I looked up the word "opportunist" in various dictionaries, and came up with this interesting description in an Afrikaans dictionary: "An opportunist is a person without fixed principles who only takes the circumstances into account and waits for an opportunity" (own translation). An opportunistic disease does exactly that: It has no "principles" and awaits the opportunity to attack a weakened immune system. Our only defence is to be proactive and to start treating the patient for a specific opportunistic disease before it attacks. Let's discover together how this is done.

Study	**Prescribed book: pp. 99–106**
	**Section 4.4: Prevention of opportunistic infections.** Pay special attention to: When prophylactic treatment of patients should start, based on the CD4 cell counts for the various diseases. • Which diseases can be prevented by immunisation? • CD4 counts that are no longer used to initiate TB preventative therapy. • You do not need to study Section 4.3 (symptoms of HIV infection in children).

ACTIVITY 4.3

Prophylactic treatment of opportunistic infections

This activity may help you to remember when to start prophylactic (i.e. preventive) treatment. And don't think that you will never need this information. A student told me that she advised her HIV-positive brother to speak to his doctor about TB prophylactic treatment when his CD4 count dropped below 350 cells. The clinic personnel missed this completely because they did not look at his health problem holistically!

Read section 4.4 in your prescribed book again and use the information to fill in the table below to indicate:

- when you would start treating patients prophylactically in terms of their CD4 cell counts for the diseases mentioned
- which of these diseases can be prevented by immunisation? (You don't need to know the names of medications that are used to prevent the opportunistic infections.)

Prophylactic treatment of opportunistic infections

Disease/infection	Prophylaxis when CD4 count drops to below …	Can patient be immunised against disease? (Yes/No)
Tuberculosis	(Be careful! There is a catch here.)	
PCP		
Candidiasis (thrush) – oral – vaginal		
Toxoplasmosis		
Influenza		
Hepatitis B		

FEEDBACK 4.3

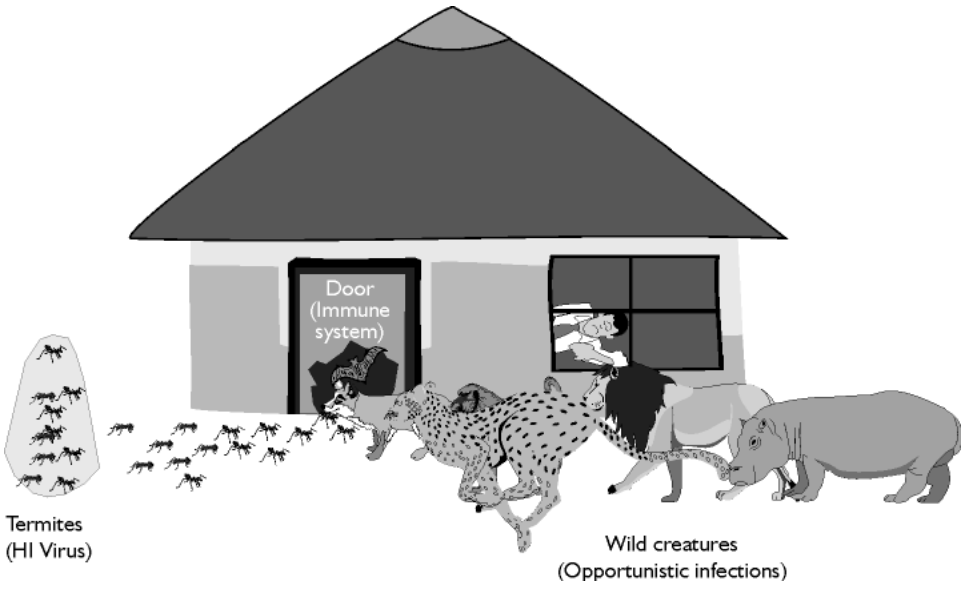
You probably had no problems filling in the table, since the answers are in your prescribed book. Note that it is a good idea for HIV-positive people to be vaccinated against influenza (flu) and hepatitis B. The immune system needs all the support it can get! Did you remember that CD4 counts are no longer used to initiate TB prevention?

Let's go back to our story about the termites, the door and the lion to explore further what opportunistic infections are and how they can be prevented.

ACTIVITY 4.4

Opportunistic infections

Look at the picture and answer a couple of questions based on the picture.



A failing immune system under heavy attack

(1) Look at the picture above (this is the picture where the termites had done quite a bit of damage to the door) and answer the following questions:

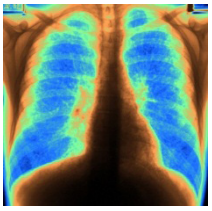
(a) What represents the opportunistic infections in this picture?
(b) Which creatures cannot get through the hole in the door yet?
(c) What can be done to prevent those creatures from getting through the hole in the door?

(2) If you think of your community, your co-workers, or your patients, which disease do you think is the most common opportunistic infection in Africa? Think back to a time when you attended the funeral of a friend who died of Aids, or talk to somebody who attended such a funeral. What did the people say this person died of?

FEEDBACK 4.4

Tuberculosis is one of the most dangerous opportunistic infections to attack HIV-infected people with depressed immune systems – especially in Africa. It usually attacks as soon as the CD4 count starts falling below 350 cells/mm^3 (which opens up a bigger hole in the door). The only way to prevent TB in people with already compromised immune systems is to start treating them prophylactically with TB medication as soon as you know they are infected with HIV. This will make it impossible for the TB germ to get through the hole in the door of the immune system.

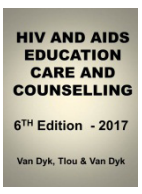
TB/HIV LINK



What does TB have to do with Aids? Marcos Espinal, the head of the WHO's Stop TB Partnership, said the following at a symposium in Cape Town:

> *In Africa TB and HIV run in parallel, they are **married**, with each fuelling the other. The marriage between TB and HIV must be recognised and treated as a union of social – and not medical – diseases if the goal of eliminating tuberculosis in humans is to be achieved* (Beresford, B. (2008). Mail & Guardian Online, 09 February).

What a strange way to describe the relationship between HIV and TB! Take a closer look at the TB/HIV alliance and decide if you agree with Espinal.

Study	**Prescribed book: pp. 106–116**	
	**Section 4.5: Tuberculosis.** Pay special attention to: • The transmission of TB. • The two stages of TB: Primary and post-primary (secondary TB). • The symptoms of TB. • The treatment of a TB. (You do not have to know the names of the medications, but the basic principles of treatment are important).	

	• TB and HIV. • Side-effects of TB medicines. • Adherence to treatment – why it is important. • Drug-resistant TB (multi-drug as well as extremely drug-resistant TB. • Click on the link http://goo.gl/tqYjza to watch a video on 'superbugs'. You may leave out the diagnosis of TB.	

It is extremely important for everybody working in the HIV and Aids field to recognise the importance of screening all people living with HIV for TB and to offer antibiotics to either *prevent* TB or to *treat* TB. It is also important to offer an HIV test to all people with TB and to assess if they should also start taking ARVs.

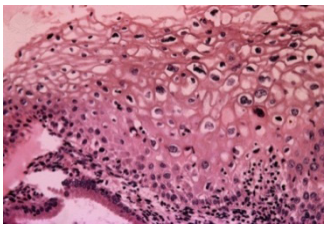
STIS AND HIV – A DEADLY COMBINATION


Kaposi's sarcoma

You have probably realised by now that HIV and Aids have forced us to think holistically. In the previous section we looked at the HIV/TB link. Let's now explore the link between HIV and other STIs.

Study 	**Prescribed book: pp. 116–122** **Section 4.6: Sexually transmitted infections.** Pay special attention to: • Why people who have other STIs are particularly prone to HIV infection. • The difference between the diagnostic versus the syndromic management of STIs. • Why we use the syndromic approach in developing countries like South Africa and not the diagnostic approach which is used in developed countries. • The importance of regular pap smears. • The importance of treating STIs when there is still time. Click on the link http://goo.gl/0R6f5U to watch a general discussion on STIs. • Advising STI clinics on the general points of managing STIs. Although you don't have to know the specific causes, symptoms and treatment of STIs, it is important that you recognise STI-related syndromes – not only in your patients, but also in yourself. Did you know that most STIs can be treated successfully? Click on the link http://goo.gl/L15UB1 to watch a discussion on herpes.	 

If you want to see more pictures of what STIs look like, go to the following website: http://goo.gl/4C8N9D. Type the name of the STI you would like to look at in the search box. Do you appreciate the importance for women to go for their Pap (or cervical) smear tests regularly to make sure that they are not infected with the human papilloma virus (HPV)?


Human papilloma virus

HPV causes cervical cancer. According to WHO estimates, 630 million people have HPV and more than 650 women die from cervical cancer around the world each day. According to the pharmaceutical information on Gardasil, the vaccine should be given to boys and girls between the ages of 9 and 17 years, and to females between the ages of 18 and 26 years. But let's play devil's advocate and ask you to consider the following questions:

- Since HPV is implicated in almost all cases of cervical cancer, why is the vaccine not available in the public sector?
- What can we do to help disempowered women who often need the vaccine most to get it?
- HPV has serious health consequences, but what are the ethical implications of giving a vaccine that prevents an STI to young children?

What are the ethical implications of **NOT** giving a vaccine that prevents a very serious STI to young children – given the fact that we live in a country with a very high crime and rape rate?

Did you know?

In 2014 the South African Minister of Health, Dr Aaron Motsoaledi, announced that all girls of between 9 and 12 years of age would be vaccinated with the HPV vaccine. This will save thousands of women in future from cervical cancer and death. Click on the video link http://goo.gl/apWhLx to watch a video on HPV and the vaccine to protect women.

Dr Harald zur Hausen who received the Nobel Prize in Physiology or Medicine in 2008 for developing the HPV vaccine

ILLNESS FROM ANOTHER PERSPECTIVE – SIZWE'S STORY

This learning unit was written within the Western philosophy of health and illness, but there are also other perspectives that we should acknowledge, for example the traditional African beliefs about health and illness. Although we will deal with the

African perspective in detail in Learning Unit 11, here is an appetizer from your recommended book: Three-letter plague: A young man's journey through a great epidemic (page 29). Sizwe is telling Jonny about the death of his friend Jake.

> *Jake died in 2000. By the end of 2004, the people of Ithanga had, in whispers and behind closed doors, attributed five other deaths among their ranks to the virus. "How did you recognise that these people had Aids?" I asked Sizwe. "The pimples on the body. The person getting thin. The diarrhoea. There is always diarrhoea but the stomach is never sore. It runs and it does not stop."*
>
> *Notably absent from this list are the symptoms of tuberculosis, pneumonia and cryptococcal meningitis, the most common causes of death among Aids sufferers in these parts. Ithanga did not yet have sufficient knowledge of the epidemic to recognise it, for many of its symptoms were identical to illnesses the village had known for many generations to be the work of witchcraft. A person who contracted cryptococcal meningitis or suffered from Aids dementia was said to have had a demon sent to him by an enemy. A person suffering from shingles – a common opportunistic infection triggered by immuno-deficiency – was said to have had a witch's snake crawl over her skin while she slept. It was only much later, when people with shingles went to the clinics and the nurses diagnosed their condition as an Aids-related infection and treated them successfully, that the definition of Aids in Ithanga began to expand.*

It is important for caregivers and counsellors to recognise different viewpoints about the causes and treatment of illness. But as I have said before, more about this in Learning Unit 11.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 4 (HIV-associated symptoms and diseases), you should have acquired the following knowledge and understanding and be able to:

- explain what each one of the key terms mentioned under "key concepts" at the beginning of this learning unit means to you.
- explain to a client or a patient how the relationship between the CD4 cell count, the viral load and the stages of infection works.
- describe the different stages of HIV infection.
- devise a TB symptom checklist that can be used in an HIV VCT clinic to diagnose TB in patients.
- recognise the main symptoms of STIs in your patients as well as in yourself.
- advise the manager of a free counselling clinic for youth on how to offer a youth-friendly service which offers help to youth for STIs.

SELF-ASSESSMENT 4

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

SELF-ASSESSMENT 4

QUESTION 1

Complete the following sentence:

The health of an HIV-infected patient depends on the condition of his/her ……..., and the …….. is the best predictor of how easily the patient maybe infected with opportunistic infections.

QUESTION 2

Disease progression depends on the viral load and on the CD4+T cell count in the blood. The following condition will make it easy for infections to attack the body:

1. A high viral load and a high CD4+T cell count.
2. A high viral load and a low CD4+T cell count.
3. A low viral load and a low CD4+T cell count.
4. A low viral load and a high CD4+T cell count.

QUESTION 3

HIV infection is divided into different stages. Name each of these stages.

QUESTION 4

Which infection is the most serious and common opportunistic infection affecting HIV patients in Africa?

QUESTION 5

Explain the difference between the diagnostic approach and the syndromic approach in the treatment of STIs.

FEEDBACK 4

FEEDBACK QUESTION 1

The sentence should read: The health of an HIV-infected patient depends on the condition of his/her *immune system*, and the *CD4+ cell count* is the best predictor of how easily the patient maybe infected with opportunistic infections.

FEEDBACK QUESTION 2

The correct answer is: A high viral load and a low CD4+T cell count (alternative 2).

FEEDBACK QUESTION 3

The stages are:

Primary HIV infection

- Clinical Stage 1: The asymptomatic latent stage
- Clinical stage 2: The minor symptomatic stage
- Clinical stage 3: The major symptomatic stage
- Clinical Stage 4: The severe symptomatic stage

FEEDBACK QUESTION 4

Tuberculosis

FEEDBACK QUESTION 5

The diagnostic approach involves the identification of the causing organism and precise treatment of the infection. The syndromic approach involves the recognition of the clinical signs and the patient symptoms and treatment of the major causes of the syndrome.

GLOSSARY

CD4 cell count	The laboratory test most commonly used to estimate the level of immune deficiency in HIV-infected individuals by "counting" the CD4 cells.
Stages of HIV infection	HIV infection can be divided into four clinical stages: 1. Asymptomatic stage 2. Mild symptoms 3. Advanced symptoms 4. Severe symptoms Each stage is associated with the lack or presence of certain symptoms and opportunistic diseases.
Opportunistic infections	Infections that would not normally cause disease in a healthy body but which exploit the opportunity presented by an infected person's weakened immune system to attack the body.
Viral load	The amount of viral RNA (or virus particles) detectable in the blood of an infected person. The quantitative PCR technique is used to "count" the HIV particles or viral load in the blood of an HIV- positive person.
***Pneumocystis* Pneumonia (PCP)**	An infection of the lungs caused by a fungus. PCP is often seen in patients with severe immune deficiency (such as patients in the last stages of Aids) and is characterised by a continual dry, non-productive cough, laboured and sometimes painful breathing, as well as shortness of breath.
Tuberculosis (TB)	Tuberculosis is an infectious disease that is caused by the bacillus Mycobacterium tuberculosis, which usually enters the body by inhalation through the lungs. TB is characterised by productive cough, coughing blood (haemoptysis), shortness of breath, weight loss, fever, night sweats and fatigue. TB does not respond to standard broad-spectrum antibiotics, only to anti-TB treatment.

Sexually transmitted infections (STIs)	Sexually transmitted infections are infections transmitted primarily through sexual intercourse. These include (for example) syphilis, gonorrhoea, candidiasis, genital herpes and HIV infection.
Shingles (or herpes zoster)	A condition characterised by an extremely painful skin rash or tiny blisters on the face, limbs or body. Shingles is caused by a virus, and it affects nerve cells.

LEARNING UNIT 5

HIV tests

INTRODUCTION

I want to take you back in history to January 1985. What was your awareness of Aids then? I remember a world of denial and blaming at the one end of the scale, to extreme fear at the other. At the beginning of 1985, we knew that Aids was caused by HIVand that the virus was spread mainly through sexual intercourse and contact with infected blood. By then it had also been firmly established that Aids was not a homosexual disease and that it also spread through heterosexual contact.

People were worried about past sexual behaviour, sex partners and the safety of blood transfusions. And they had reason to worry, because there was no test available to diagnose HIV infection. It was only later that year (1985) that the first kits for HIV antibody testing became commercially available. In the beginning, HIV testing was used mainly to diagnose people who were already showing symptoms of Aids to confirm their diagnoses (and, of course, to test donated blood). It is only in the last decade that testing has become more general and that we hear the motto "know your status".

You will learn about HIV testing in various contexts in this course. In this learning unit we will investigate the tests themselves as well as the testing procedures. We will discuss pre- and post-HIV test counselling in Learning Unit 13.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- Do I need to know my HIV status?
- What test should I take?
- What is the impact of HIV testing on society?
- Which HIV testing algorithms (procedures) are used in South Africa?

KEY CONCEPTS

While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

HIV antibodies	PCR test (technique)
ELISA test	Window period
Western Blot test	Indeterminate test result
Rapid HIV antibody test	HIV testing algorithms
HIV p24 antigen test	False negative

DO I NEED TO KNOW MY HIV STATUS?

Let's start this section on a personal note and do some self-reflection on HIV testing.

ACTIVITY 5.1

Do I need to know my status?

In this activity you will reflect on the "know your status" campaigns and how they have affected you.

A “know your status” billboard

“Know your status” campaigns have become part of many HIV prevention programmes in Africa. These campaigns take many forms, and I am sure that you are familiar with billboards with the “know your status” messages. Reflect on the influence that “know your status” campaigns have had on you personally by answering the following questions:

(1) Do you think a billboard with a “know your status message” can change an individual’s behaviour? Give reasons for your answer. (Think critically about this question!)
(2) Would a billboard with a “know your status message” motivate you to go for HIV testing? Give reasons for your answer.
(3) Do you know your HIV status? *If you know your status, please answer questions 4 to 9. If you do not know your HIV status, answer questions 10 to 12.*
(4) What were your reasons for taking the test?
(5) How did you feel when you walked into the testing site or doctor’s rooms to be tested?
(6) What went through your mind while waiting for your test results?
(7) What positive things came from you knowing your status?
(8) What negative things came from you knowing your status?
(9) If a friend asks you: “Do you think I should go for an HIV test?” what would be your answer? *If you do not know your HIV status:*
(10) What is holding you back from being tested?
(11) Will you consider being tested for HIV in the foreseeable future?
(12) Do you think it is a good thing that people should be “coerced” to go for testing by media campaigns? Why do you think it is a good or a bad thing?

FEEDBACK 5.1

Going for an HIV test is one of the hardest things to do. I remember very well how I felt when I went for testing the first time. No one may be pressured into going for a test. My mind kept telling me: “You have nothing to fear – you know that you are HIV negative”, but my heart said: “What if ...”. People who have been for testing are usually very glad that they did because it gives them a new start: if they are negative, they resolve to stay negative, and if they are positive, they resolve to start living a positive life and access help. But please remember that the decision to go for testing should be a personal one. No one may pressurise you into going for testing. We will further explore your experiences and feelings about testing later on in the course. For now, let’s concentrate on the test itself and the testing procedures.

Demonstration of an HIV home test

https://www.youtube.com/watch?v=epaNjjtyMAU

WHICH HIV TEST SHOULD WE TAKE?

The world of HIV testing sounds a daunting one if you are not involved in the medical profession. Here is a tip to make it easy: There are basically only two main classes of HIV tests:

- those that react to antibodies that have been formed by the immune system in reaction to the virus
- those that react directly to the HI virus in the body

The following metaphor from nature might help you to remember the two main classes of HIV tests. You know that there are animals in the veld when you:

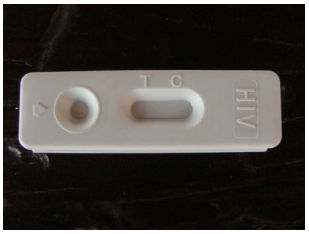
(a) see their spoor (or footprints)
(b) see the animals themselves

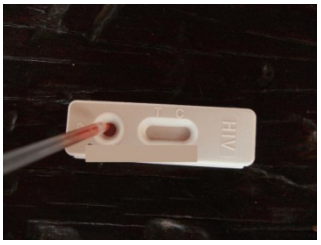
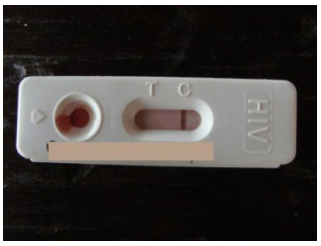
Well, HIV tests work the same. They either look for the spoor (HIV antibodies) or for the animals themselves (HI virus).

After reading the relevant sections in your prescribed book and doing the activity that follows, I believe that you will never again battle to explain the difference between the tests to your clients.

Study	Prescribed book: pp. 129–138
	**Section 5.1: HIV testing as diagnostic tool.** This section will give you a peek into the history of the development of the HIV test, and you will also get to know the uses of the test. Make sure that you know how the use of the HIV test has changed over time. Also remember the differences between sensitivity and specificity of tests. Make sure that you know the various reasons for HIV testing, as well as the two main approaches to diagnosing HIV (identification of the virus and detection of an immune response to HIV. **Section 5.2: HIV antibody tests.** This section will help you to answer patients' questions regarding antibody tests. Pay special attention to: • How an antibody test works. (See the pictures below.) • Well-known HIV antibody tests.What a rapid HIV antibody test is and how it works. • The differences between the rapid and the ELISA antibody tests. • What the window period is. **Section 5.3: HIV virus tests.** Pay special attention to: • How an HI virus test works. • The HIV viral tests available on the market. • The difference between the HIV p24 antigen test, proviral DNA detection and viral RNA detection. • The difference between the qualitative and the quantitative PCR test. • What a dried blood spot test is. Prepare yourself to be able to answer any of the questions (marked with a question mark icon in your prescribed book) if a client asks them. Use Figure 5.1 in your prescribed book to help you to remember the HIV tests and their uses.

WHAT DOES A RAPID HIV ANTIBODY TEST LOOK LIKE?

	
The contents of a rapid HIV antibody test kit	The testing device. Note the two lines marked 'T' and 'C'. T stands for test and C for control.

 Prick the finger with the lancet included in the test kit	 Press the finger lightly to draw a drop of blood
 Press the pipette to absorb the drop of blood	 Place the drop of blood in the circle on the device
 Add the drops of the reagent (chemical substance in clear bottle) in the circle on top of the drop of blood.	 There should always be a red line on the 'C'. This means that the test is working (e.g. it has not expired). If the test is positive, there will be a clear red line on 'T'. If the test is negative, there will be no red line on the 'T'.

You have now completed a difficult chunk of work and it is time for a recap.

I want you to consider what you have read so far about the different HIV tests available. The best way to demonstrate the differences between the HIV antibody test and the HIV viral test is to use a table.

ACTIVITY 5.2

HIV antibody and HI viral tests

This activity will require you to indicate the differences between HIV antibody tests and HI viral tests.

Draw the following table and fill in the missing cells:

Differences between HIV antibody and HI viral tests

	HIV antibody test	HIV viral test
Body fluids used for testing		
Particles detected		
Types of tests (name them)		
Window period		
Cost		
Reliability		
Available in rapid test		

FEEDBACK 5.2

Know the differences between the main HIV tests. You may have to explain this to someone, or assist with decision-making regarding HIV tests.

Your table should clearly illustrate the following:

- Blood is used for both tests, but the HIV antibody test is also available for testing on saliva and urine.
- The window period is much shorter for HI viral tests than for HIV antibody tests.
- The HI viral test is much more expensive than the antibody test.
- Both tests are very reliable, but only the antibody test is available in a rapid format.
- HIV antibody tests react to antibodies, while the HI viral tests react to viral antigens such as p24, or to viral nucleic acid such as viral RNA or viral DNA.

You might now be wondering where exactly the antibodies or the viral particles are that are detected by the HIV tests. The next activity will take you back to some pictures.

ACTIVITY 5.3

What do the antibodies and viral particles look like?

This activity will require you to page to certain figures in your prescribed book in order to see what is detected by HIV tests.

To see exactly what is detected by HIV tests, let's look back at some pictures.

(1) Go to figure 2.4 in your prescribed book and look for the antibodies in phase 2 in the picture. Draw a circle around them. Do you remember that the immune system manufactures these antibodies to fight the HI virus that enters the body? Well, the HIV antibody tests are made to react to or pick up these antibodies.

(2) Go to figure 2.6 in your prescribed book and look for the p 24 antigen in the picture. Draw a circle around this antigen. The p 24 antigen test reacts to this antigen and picks it up. Reflect on the following:

- When do we usually use the p 24 antigen test?

(3) Why is it not a good idea to use this test for a patient who has already been infected with HIV for many years?

(4) Go to figure 2.6 and draw a circle around the viral RNA. Now go to figure 2.7 (where the virus has already infected a CD4 cell) and draw a circle around the viral RNA and around the proviral DNA. These are the viral components that are picked up by the HIV viral test.

FEEDBACK 5.3

I bet you will never again forget the differences between HIV antibody tests and HIV viral tests, and that you cannot wait to explain them to a friend! Let's now put the theory into practice. For the next activity I am using a real-life scenario and I want you to imagine yourself as the counsellor who will have to make decisions that will suit the situation the best.

Study	Prescribed book: pp. 138–144 **Section 5.4: HIV counselling and testing algorithms.** This section will give you some guidelines to the testing and counselling policy used in South Africa for various groups, namely (a) adolescents and adults (including pregnant and breastfeeding women), (b) children younger than 18 months, and (c) children of 18 months and older.

You have probably realised by now that being an Aids counsellor involves so much more than knowing a few basic facts about HIV, Aids and counselling. HIV and Aids challenges us on various levels and we need to get involved in various debates – especially about public and human rights. You will also find that it is almost impossible not to become an activist of one sort or another to fight for the rights of our patients. But more about this in Learning Unit 13. Let's apply what we have learned to a real-life situation in Activity 5.4.

ACTIVITY 5.4

Sizwe's story: Testing day

This activity will require from you to read a piece and to reflect on your emotions.

You are probably already reading the book, *Three-letter plague* by Jonny Steinberg. Listen to what Sizwe told Jonny about testing day in Ithanga (pp 30–31).

The six deaths Sizwe had identified remained his formative experience of Aids until a Saturday morning in early February 2005. On that morning, the Médecins Sans Frontières (MSF) treatment programme came to Ithanga for the first time. By late afternoon, the meaning of the virus in Ithanga had changed forever.

Ithanga is an outlying village, among the most peripheral in Lusikisiki. The nearest clinic is an arduous fifteen-kilometre journey. A group of MSF counsellors visited the local chief to ask his permission to set up a mobile HIV testing centre at Ithanga's school. The chief reluctantly gave his consent. MSF lay workers then spread word across the village that they would be staffing a testing centre at the school for the duration of the following Saturday. The idea was to bring news of antiretroviral treatment to Ithanga. This is not the way Sizwe understood what happened that day. For him, that Saturday had little to do with medicine; it was about shame and fear.

"The whole village knew that people would be coming to test," he told me. "The previous week, the young counsellors had been all around the village telling everyone. They came the next Saturday to set up their testing centre at the school. Many, many people came to test, young people and not such young people. And to know who was positive and who was negative, you just had to stand and watch."

"For what?"

"For how long the people stay. You see, there is counselling before the test, and counselling after the test."

"The counselling before the test, it's the same for everybody: a few minutes. But the counselling after the test, for some it lasts two minutes, for others, it is a long, long, time. They don't come out for maybe half an hour, even an hour. And then you know."

"By the time the day ended, the whole village knew who had tested HIV positive?"

"The whole village."

"You went to the school to watch, not to test? You went to see who was HIV-positive?"

"No. Not to watch. They said that you could come and learn without being tested. There was a room on the side, and if you went there, somebody would answer all your questions, but you would not have to be tested. That is what I did. I stayed in that room for maybe an hour."

The following morning, the people of Ithanga awoke to a different village. In the course of a few hours, eight or nine healthy, ordinary-looking villagers, most of them young women, had been marked with death. In the weeks and months that followed, those who had tested positive were silently separated from the rest of the village. They were watched: whether they coughed, or lost weight, or stayed at home ill; whether they boarded a taxi, and if so, whether that taxi was going to the clinic; above all, with whom they slept. These observations were not generous; they issued from a gallery of silent jeerers.

FEEDBACK 5.4

It is hard to describe the feelings that this text evoked in me. I can't even think of questions to formulate. I only want you to stay in the moment for a while, and think deeply about what you have read. We will talk more about this in Learning Unit 11 when we discuss pre- and post-HIV test counselling.

"Aids is not a death sentence"

Click on the link http://goo.gl/L0PyS4 to watch a video on a South African community talking about Aids.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 5 (HIV tests), you should have acquired the following knowledge and understanding and be able to:

- explain what each one of the key terms mentioned under "picking up useful words" at the beginning of this learning unit means to you.
- explain to a client what the difference is between an HIV antibody and an HIV viral test.
- counsel clients about the implications of negative and positive test results.
- draw a picture to explain to a friend what is meant by the window period.
- explain the various algorithms for testing individuals for HIV infection.

SELF-ASSESSMENT 5

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit. Please note these self-assessment questions do not contribute to your year mark or your admission to the exams. The feedback to the questions will be given to you immediately after you have completed each question.

SELF-ASSESSMENT 5

Read the following scenario (or story) about a clinic in rural KwaZulu-Natal where you have to counsel two clients on testing for HIV and related issues. Fill in the missing word or sentences in the spaces provided.

You are working as a counsellor in a clinic in rural KwaZulu-Natal. Your closest town with laboratory facilities is very far from your clinic. Therefore, you use _____ tests to diagnose HIV infection in your clients. This test reacts to the _____ in the client's blood which can usually be detected in the blood _____ days/weeks after infection with HIV. If this test is HIV positive, your rural clinic's policy is to use _____ to confirm the results and to make sure that you do not give your client a false positive result. Recently, you had two clients, John and Mary, with inconclusive or indeterminate test results. An indeterminate result means that _____ .

Both John and Mary practised unsafe sex in the past, but John shows no symptoms of HIV infection at all, while Mary shows the following symptoms: swollen glands, weight loss, persistent fever and oral as well as vaginal thrush. In John's case you decide to confirm his HIV results by _____ . You further counsel him to _____ . The best course of action in Mary's case is to _____.

Tip: Context is very important when you work in the Aids field. Your first clue in the story that should lead you to the correct answers is that you are working in a rural clinic very far from a laboratory. You will therefore probably only have the rapid HIV antibody test available. Your clue on how to handle Mary and John's cases (which have some similarities) should be the fact that Mary already shows symptoms of Aids, while John has no symptoms.

FEEDBACK 5

The paragraph should read as follows:

You are working as a counsellor in a clinic in rural KwaZulu-Natal. Your closest town with laboratory facilities is very far from your clinic. Therefore, you use *rapid HIV antibody* tests to diagnose HIV infection in your clients. This test reacts to the *antibodies* in the client's blood which can usually be detected in the blood *3 to 6 weeks (or sooner depending on the test)* after infection with HIV. If this test is HIV positive, your rural clinic's policy is to use *a second rapid test* to confirm the results and to make sure that you do not give your client a false positive result.

Recently, you had two clients, John and Mary, with inconclusive or indeterminate test results. An indeterminate result means that *it is not clear if the test result is positive or negative*. Both John and Mary practised unsafe sex in the past, but John shows no symptoms of HIV infection at all, while Mary shows the following symptoms: swollen glands, weight loss, persistent fever and oral as well as vaginal thrush. In John's case you decide to confirm his HIV results by *sending blood to the lab for an ELISA test*. You further counsel him to *practise safer sex and to check his health*. The best course of action in Mary's case is to *treat her opportunistic infections, send blood away for a CD4 count and get her ready for an antiretroviral programme. She should also be educated about safer sex practices and healthy living to boost her immune system.*

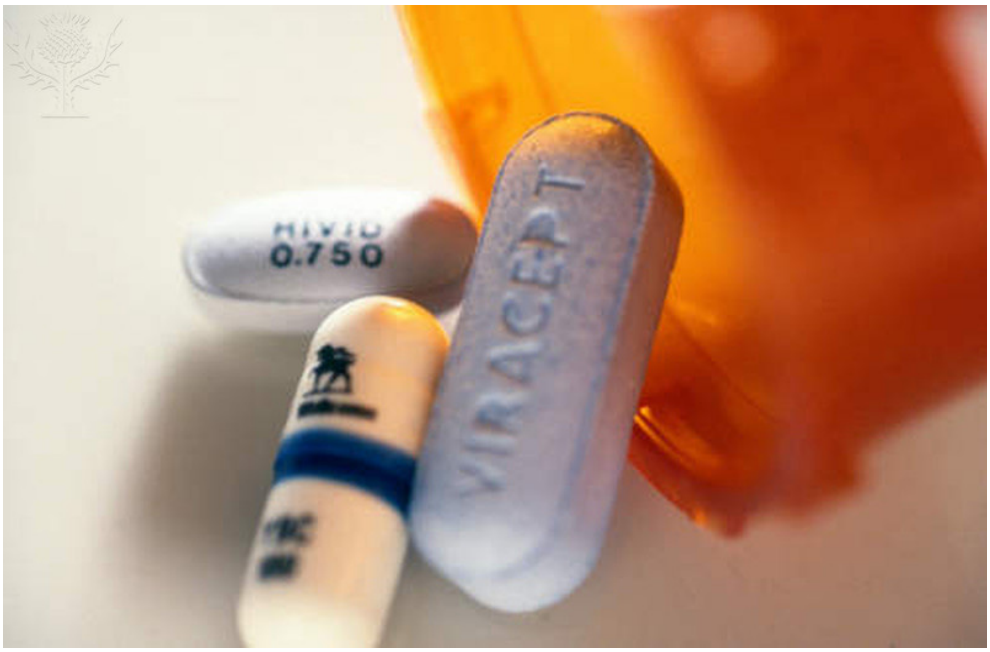
GLOSSARY

HIV antibodies	Special protein complexes produced by the immune system that attack and neutralise specific disease-causing organisms. The antibodies which the body creates in response to HIVare, unfortunately, powerless to protect the body against the long-term destructive effects of the HI-virus.
ELISA test	ELISA stands for "enzyme-linked immunosorbent assay". This is a laboratory test (technique) to detect antibodies in the blood.
Western Blot test	A blood test that detects the antibodies to HIV infection. It is sometimes used to confirm an ELISA test that has produced a (HIV) positive result.
Rapid HIV antibody test	An HIV antibody test that produces rapid or fast results. Rapid HIV tests are relatively easy to use (they involve pricking a finger with a lancet), and the results are usually available within 10 to 30 minutes.
HIV p24 antigen test	A test to detect a core protein found in the HI virus. The presence of this antigen in the blood is evidence that HIVis present in the body. These antigens are usually detectable in the early and very late stages of HIV infection.

PCR test (technique)	A method of testing for the presence of HIV in the body. The PCR technique does not have to rely on the formation of antibodies in order to diagnose HIV infection – it detects the viral DNA and viral RNA itself in the blood. A qualitative PCR is used for diagnostic purposes while a quantitative PCR is used after diagnosis and during treatment to measure the viral load (or amount of viruses in a particular body fluid).
Window period	The time between infection with HIV and the development of detectable HIV antibodies. Any HIV test done during this time will render false negative results (see False negative), even though the person is actually already infected with HIV.
Indeterminate test result	A test result that does not clearly indicate whether a person has an HIV-infection or not.
HIV testing algorithms	A protocol indicating in steps how the process of HIV-testing should take place.
False negative	An HIV test result that is HIV negative when the person is actually HIV positive. A test can show a false negative result when the person is still in the window period or (in rare cases) when the test is faulty.

LEARNING UNIT 6

Antiretroviral therapy



INTRODUCTION

The advent of antiretroviral therapy (ART) was truly a rescue boat launched in a sea of dying people. The tide also turned for many children when ART was used for the first time to prevent mother-to-child transmission in 1994 (though, to our great dismay, only since 2002 in South Africa). The introduction of triple drug therapy or highly active antiretroviral therapy (HAART) in 1995 changed the status of Aids from a disease without much hope to that of a chronic but manageable disease. The lives of thousands of South Africans living with HIV changed for the better when the South African government finally approved the plan to make ART publicly available in 2003. Today, South Africa has one the greatest antiretroviral programmes in the world. At this point it might be a good idea to Google how many people in South Africa are on ARVs.

But what is all the fuss about? In this learning unit you will get the chance to explore the what, why and how of ART. I hope that you will feel empowered enough, after studying this unit, to talk with confidence to an HIV-positive person about ARVs in general.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

What are antiretrovirals (or ARVs)?

- Why are ARVs important, how do they work and when must a person start taking them?
- Why is it important to adhere to ARVs and what is adherence counselling?

- How can ARVs be used to *prevent* HIV infection?

KEY CONCEPTS

While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Nucleoside reverse transcriptase inhibitors (NRTIs)	Drug regime (individualised versus standardised regime)
Non-nucleoside reverse transcriptase inhibitors (NNRTIs)	Drug resistance
Protease inhibitors (PIs)	Drug adherence
Highly active antiretroviral therapy (HAART)	Post exposure prophylaxis (PEP)

WHAT ARE ARVS?

Before we talk about ARVs, look at the bigger picture by doing the following activity:

ACTIVITY 6.1

ART: What will you do if you were HIV positive?

Explore the bigger picture of ARVs and your immune system.

(1) Imagine that you are HIV positive. Based on what you have heard and read, what are the things that you would do to keep yourself and your immune system healthy?
(2) What role would ARVs play in your health plan?

FEEDBACK 6.1

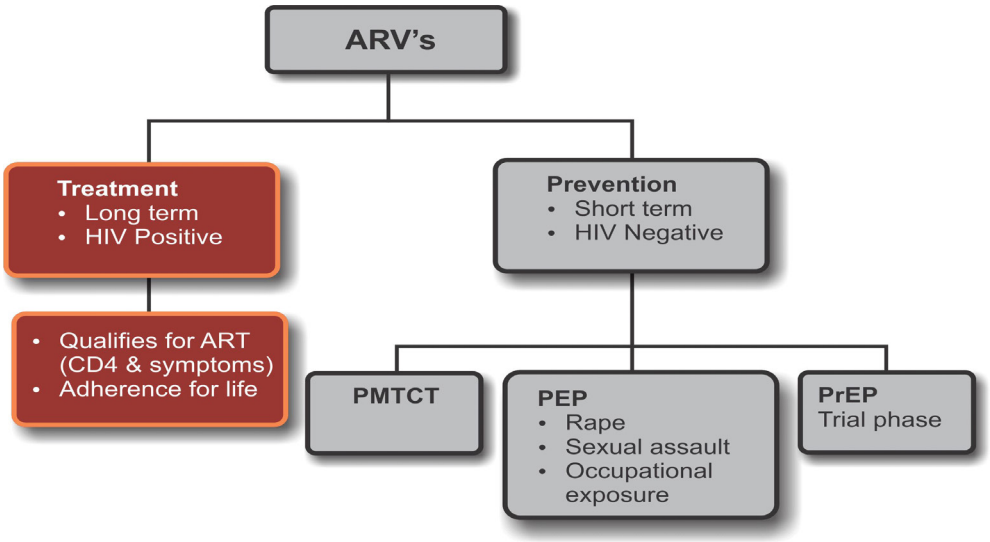
The activity asked you to imagine what you would do to boost your immune system if you were HIV positive. Healthy living and eating are, of course, important, but at some stage ARVs will become necessary.

You probably mentioned many things that you can do to keep your immune system healthy, like eating enough fruit and vegetables, doing exercise, not smoking and limiting alcohol intake, using condoms, going for regular check-ups, and getting treatment for opportunistic infections and diseases. You probably mentioned ART as a last resort when your immune system needs some help to cope. Well, you are correct! There are many things that we can do to keep our immune systems healthy, but there will come a time that the immune system needs a bit of help from ARVs. This learning unit will focus on the help that ARVs can provide to the immune system.

This learning unit will focus on the help that ARVs can provide to the immune system.

But what are ARVs, and what do they do? ARVs are medications that control the level of HIV in the blood. They cannot cure Aids. What they *can* do is to **lower the HIV levels** in the blood to such an extent that they do no harm, or less harm, to the immune system. Lower levels of HIV in the body also mean that there will be fewer viruses to transmit to other people.

There are **two main uses** of ARVs. ARVs are used in the first place to *treat* HIV infection, and in the second place to try to *prevent* HIV infection. The following diagram will help you to remember how Antiretroviral Therapy (ART) is used. We will now discuss ARVs as *treatment* for HIV infection (left hand side of diagram in red).



This diagram (or organisational chart) is an example of a mind map. You can see with one glance how ARVs are used. The organisation of this learning unit is based on this mind map. Use it and page back to it regularly to see where you are.

GOALS AND CLASSES OF ARVS

One of the things that you will most surely have to talk about in your work as a counsellor is ARVs. At this stage of your studies, it probably feels like a daunting and impossible task. Relax! If you really put everything into the next sections, you will be able to talk about ARVs with confidence. You will get the chance to practise your newly-acquired knowledge in a counselling activity later.

We will now go to your prescribed book to learn more about ARVs.

Study

Prescribed book: pp. 146–150

Read the introduction in your prescribed book, then study the following:

Section 6.1: Clinical assessment. In this section you will learn more about the HIV wellness programme for HIV-infected adolescents and adults. You will also learn that there is only one way to see if ARVs are doing their job properly and that is to monitor the CD4 count and the viral load regularly. This section will help you to understand what a CD4 count and a viral load test tell us about a patient. You will also learn what a normal CD4 cell count is, and what it means when the doctor tells you that your viral load is undetectable.

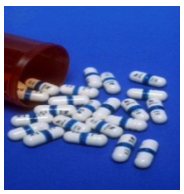
Section 6.2: Goals of ART. This section will give you a general introduction to ARVs and explain the four goals of ARVs. The four goals of ARVs are very simple:

- to reduce the number of viruses in the body
- to boost the immune system
- to improve quality of life
- to reduce the impact of HIV on our society (fewer infections, and less sickness and death)

Section 6.3: Classes of ART and their mechanisms of action. Use figure 6.2 in your prescribed book to help you to understand how ARVs work. Take a red pen and make circles around the enzymes (the reverse transcriptase, protease and integrase enzymes) in figure 2.6 in your prescribed book. Make sure that you understand what the effects of ARVs are on these enzymes. You can also go to http://goo.gl/aZsVod to watch a YouTube video.

The classes of antiretroviral drugs are discussed in this section. Figure 6.2 explains the mechanisms of action of each of the classes of ARVs and it will give you a good idea of exactly what ARVs do to interrupt the replication of the virus. You don't have to know the names of the medicines in each one of the classes, but if you are on ARVs yourself, you might find it interesting to see into what class your ARVs fall. It is not necessary to study Table 6.1.

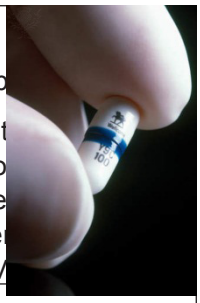
DRUG REGIMES



When students see all the strange names of ARVs, they get such a fright that they don't want to read any further. Relax! We do not expect you to know the names of medications. What is important is to know the *general principles* about ARVs and how they work. Your patients or clients may ask you these questions.

Study

Prescribed book: pp. 151–160



Study the following sections in your prescribed b

Section 6.4: ARVs available in S.A. You do not this section for exam purposes. Nurses and co work with ARVs are welcome to read it. Please information may be outdated. Go to the Southe Clinicians Society website (http://goo.gl/ZI7PZV recent information on ARVs:

Section 6.5: Guidelines for the use of ART. This section will explain why we use HAART or triple combinations of ARV medications, and never only one or two drugs. You will see that maximum viral suppression is of the essence. Use your newfound knowledge of the four classes of ARVs to understand these guidelines better. We will break Section 6.5 down a bit to make it easier.

Section 6.5: When to start ART. The World Health Organisation recommends that people should start ARV treatment as soon as possible after diagnosis, irrespective of their CD4 count. The South African Department of Health follows the WHO guidelines. Make sure that you read the enrichment box on 'New guidelines regarding ART initiation'. Some critics feel that we should get our house in order first and get problems such as stock-outs sorted out first, before starting treatment. What do you think? Click on http://goo.gl/a1LVld to see the WHO guidelines for ARV treatment. Also read what an Aids expert, Prof Francois Venter of Wits, has to say about the WHO guidelines http://goo.gl/3WRStz

Make sure that you understand the guidelines on when to start ART for: (a) adolescents ≥ 15 years and adults; (b) adolescents aged 10 to 15 years; (c) infants, children and early adolescents.

Section 6.5: Counselling before ART initiation.

Section 6.5: Choice of drug regime. Make sure that you know the difference between individualised and standardised treatment plans. Note that South Africa uses the standardised regime (as do most other sub-Saharan countries). You need to study 'ART for adults and adolescents ≥ 15 years. (There will be NO examination questions on *ART for adolescents aged 10 to 15 years, ART for children* and *ART in patients for TB*.)

Section 6.5: Support for children to adhere to ART. You need to study this section on how to support children on ART.

Section 6.5: Drug interactions. It is important to take note of the interactions between ARVs and TB medications.

Before you learn more about ARVs, let's pause for a moment to reflect on what you know so far by doing the following activity.

ACTIVITY 6.2

The threes and fours table of ARVs

Fill in the table to see if you understand the basics of ARVs. This activity provides a convenient summary of the why, what and how of ARVs and it will come in very handy when you do your preparations for the examinations.

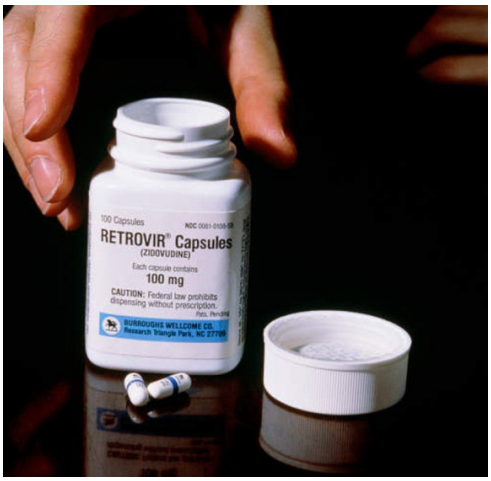
Fill in the following table by answering the questions.

Prompt	Response	Additional information
Give three reasons why it is important to do regular CD4 counts.	1. 2. 3.	
Give three reasons why it is important to do regular viral load tests.	1. 2. 3.	
Name the four goals of ARVs.	1. 2. 3. 4.	
Name the four enzymes targeted by ARVs (including new developments).	1. 2. 3. 4.	
Name four classes of ARVs.	1. 2. 3. 4.	
Give three reasons why we use HAART (triple therapy).	1. 2. 3.	

FEEDBACK 6.2

See your prescribed book pp. 146–160.

Below are a few pictures to show you what some of the ARVs look like.



To help you to remember the individualised and standardised treatment plans, do the following activity.

ACTIVITY 6.3

Individualised vs standardised ARV treatment plans

It is very important that you understand the difference between individualised and standardised treatment plans. Go to Activity 6.3 and fill in the table to indicate the advantages and disadvantages of the individualised and standardised ARV treatment plans. Think of your own community after you have completed the table – and think about which one of the two treatment plans will work best in your community.

Fill in the following table to indicate the advantages and disadvantages of the individualised and standardised ARV treatment plans.

ARV treatment plan	Advantages	Disadvantages
Individualised plan		
Standardised plan		

FEEDBACK 6.3

Individualised treatment plans are, unfortunately, not always practical in resource-poor situations, but standardised treatment plans may nonetheless be very effective.

An individualised treatment plan is based on the principle that ARVs are selected for the needs of a specific individual. A standardised treatment plan is "one-size-fits-all" – though with a few variations. This plan is often used in developing countries,

where there is a lack of sophistication, to run complex individual treatment plans. See prescribed book for the advantages and disadvantages of these treatment plans.

EFFECTS OF ANTIRETROVIRAL THERAPY

We will now look at the effects of antiretroviral medications. What are the side-effects of ARVs? How do we know that they are working, and if they are not working, when to change them?

Let's continue by going back to your prescribed book:

Study	Prescribed book: pp. 160–163.
	**Section 6.6: Adverse effects of ARVs.** It is important for clients on ARVs to know what the possible side effects of the medication they are taking are. Some side effects can have serious consequences for the patient. But not all people on ARVs experience side effects. Many are fortunate and have no side effects at all. If you are on ARVs yourself, do you experience any side effects from your medication? You don't have to study table 6.5, but if you are interested in the common side effects of specific ARVs, you are welcome to look them up there. (You do not need to know Table 6.7.) Give special attention to immune reconstitution inflammatory syndrome (IRIS). What does it mean if we say that 'TB is the most common presenting IRIS in South Africa?' **Section 6.7: How to know if ART is effective.** It is important to understand how the doctor and patient will know if ART is effective. This section highlights some of the laboratory tests that should be done. **Section 6.8: When to change ART.** Study this section to make sure that you understand when it is necessary to change a patient's ARV treatment regime.

To be effective in practice, you really need to understand the basics about ARVs. If you don't feel comfortable with your ARV knowledge yet, please go back and read sections 6.1 to 6.8 in your prescribed book again. Now practise your counselling skills to *communicate* your newfound knowledge to a client.

ACTIVITY 6.4

Role-play: ART knowledge in practice

Increase your knowledge about ART by doing some role-play.

Ask a person who is interested in HIV and ARVs to engage in a roleplay situation with you. Explain to the person that you are studying the HIV and Aids Care and Counselling course and that you need their help to practise your skills to communicate your knowledge about ARVs. Ask the person to play the role of an HIV-positive client who needs information about ARVs. Your role is to be

the counsellor, but warn the person that you might not be able to answer all the questions since you are still busy with your course! Take a notebook and a pen with you so that you can draw pictures to help you explain the what, why and how of ARVs. I am sure that your "client" will have many questions of their own, but to guide you a bit, here is a list of questions that the client can use.

(1) "I have been HIV positive for many years now. I go for regular checkups and my CD4 cell count has recently been 400. When should I start with ARVs?"
(2) "If I go onto ARVs, what exactly do they do in my body? I suppose what I am asking is, how do they work?"
(3) "Will the ARVs make me sick?"
(4) "How will you know that my ARVs are working and that they are really fighting the virus in my body?"
(5) "They say that when you start with ARVs you have to take them for the rest of your life. I am only 30! Does it really mean I can never stop taking them? What about weekends and holidays?"
(6) "Why not? Can you please explain to me what you mean when you said that the virus can become 'resistant' to the medications I take?" (Tip: Draw a picture to explain resistance.)
(7) "Must I still use condoms when I am on ARVs? Why?"
(8) "Can ARVs cure me?"
(9) "My friend Susan is on ARVs and she told me the other day that her viral load is 'undetectable'. What does that mean? Can she now stop her ARVs?

FEEDBACK 6.4

Did your client ask you a question that you could not answer? What did you do? At the beginning of my career I felt terrible if a client asked me something that I didn't know. Now I accept that I am human and I tell the client that I don't know but will find out and get back to them. And I stick to my promise!

Well done! That wasn't too hard, was it? Below is a summary of what you may have discussed with your "client":

- You probably told your client that treatment usually starts when the person is ready to adhere to the medication, irrespective of the CD4 count. Note that private practitioners often start ARVs earlier (higher CD4 counts) than in the public health sector.
- Did you draw a picture to explain how ARVs stop virus reproduction by interfering with its enzymes (question 2)?
- Did you explain that not all people get side effects from ARVs and that the doctor will discuss possible side effects of the specific medication the client is taking in detail with them? (question 3)
- You probably told your client that we will know that the ARVs are doing their job if (*inter alia*) the viral load stays low (question 4).
- This, of course, links up with question 9 where the concept of an "undetectable" viral load is explained as well as the fact that the virus can never be completely eradicated from the body (question 8).
- I suppose you also used a picture to explain to the client why ARVs should be taken for the rest of their life, namely to keep on repressing the viruses and to prevent the development of resistance (questions 5 and 6).
- In your answer to question 7, did you explain to the client that, although chances of transmitting the virus to sex partners are much lower when the viral load is low, that they should still use condoms to protect their sex partner(s) as well as to protect themselves against reinfection with other strains of the virus?

Well done!

Please read the important note on debriefing if you go back to the learning unit.

Allow me to make a comment on role-play in general. Role-play is a very handy tool to practise certain skills in a safe environment before you have to do it in the "real world". However, people often get so involved in the role-play situation that they find it hard to get back to reality. A person who has played the role of an HIV-positive client, for example, often feels depressed after the role-play has ended. It is therefore very important to ***debrief*** after a role-play session. By this I mean that both you and your client should be brought back to the real world by you saying something like the following: "Thank you, Charles, for being the client in our make-believe situation. Now we can get back to our real lives where I am not an Aids counsellor and you are not an HIV-positive client."

The following activity will bring you into contact with the thinking in Sizwe's community:

ACTIVITY 6.5

Responsibility towards your community

Read more about Sizwe's story. Where does this leave you in terms of your responsibility towards your community?

Read the following excerpt from *Three-letter plague*, page 74. Sizwe is telling Jonny about his reluctance to take his niece, who is HIV positive, to the clinic. He rather wants to take her to a young girl in Mthatha who is said to possess extraordinary healing powers.

> *She (the young girl from Mthatha) is your first option," I suggest. "The clinic is your last option."*
>
> *He nods. "A cure is better."*
>
> *"Is that the problem with the clinics? They don't offer a cure?"*
>
> *"I have three problems with antiretrovirals," he replies crisply.*
>
> *"First, people do not know about them. We don't know them here. Second, it seems you must get sick before they give you the antiretrovirals. You must wait until you are sick. I do not like that. Why must you get sick first?"*
>
> *He has been staring at his hands as he speaks. Now he lifts his head and looks me in the face.*
>
> *"The third reason is the biggest reason. I feel terrible for the people living with this disease inside of them. It is there for their whole lives. I think of Thandeka living with this disease inside her for the rest of her life, and I feel so sorry for her. I wonder whether she can cope with that, whether anyone can cope with that. A cure is much better."*
>
> *"We will go together," I say, "to the girl from Mthatha and to the clinics. At the clinics you will meet the doctor who runs the ARV programme. You will ask him everything you want to know."*

This text is rich with complexities around ARVs in our communities. But for now I want you to concentrate on Sizwe's second problem with ARVs: Why start with ARVs when the immune system is already compromised (a low CD4 count) or when the person already shows symptoms? Why not earlier? What would you tell Sizwe?

FEEDBACK 6.5

The Three Letter Plague was written in 2008 when our ARV policy in South Africa was very different from now. So the answer to this question will also be very different now – almost 10 years later. In 2008, your answer would probably contain a combination of the following explanations:

- Taking ARVs for the rest of your life is difficult.
- The immune system should be given the chance to fight on its own for as long as possible (by starting later rather than sooner).
- ARVs sometimes have side effects – these should be delayed for as long as possible.
- A long treatment history may increase the chances of developing resistant viruses.
- Resistant viruses make future treatment more difficult.
- There should thus be a balance between the patient's health and optimum treatment time – a **shorter treatment** history is ultimately the ideal.

Now, your answer will probably be that his niece does not have to wait so long to qualify for ART, because the policies and guidelines about ART have changed since 2008. His niece can now be treated much sooner. It is also so much easier to take ARVs now, because we now have fixed-dose combinations (one tablet containing 3 types of ARVs). But I wonder if this theoretical explanation will really satisfy Sizwe? Can you think of a metaphor or story that will convince Sizwe?

Keep your eyes open and your ears on the ground for new developments in the ART field.

ADHERENCE AND DRUG RESISTANCE

Before we go into adherence to ART, I want you to do think about your own personal experiences with medication in general, by doing the following activity.

ACTIVITY 6.6

Adherence questionnaire

I want you to think back to the times in your life when you had a prescription for a course of medication that you were instructed to complete, such as antibiotics. Now fill in the questionnaire.

Think back to the times in your life when you had a prescription for a course of medication that you were instructed to complete, such as antibiotics. Now fill in the following questionnaire by making a cross in the relevant box, indicating if you strongly agree, agree, disagree or strongly disagree with the statements.

Statement	Strongly agree	Agree	Disagree	Strongly disagree
1. I have been on antibiotics before.				
2. It happened once or twice in the past that I stopped taking my antibiotics before they were finished, because I felt better.				
3. Although I usually take all my pills as prescribed, I often find it hard to take them at the prescribed time because I am busy or because I simply forget to take them.				
4. My situation (work, personal life) is such that I am often not able to take pills exactly at the prescribed times every day.				
5. I will definitely be able to take pills every day for the rest of my life, if necessary.				
6. I stopped taking medication in the past because it made me feel sick, or because I developed side effects.				
7. I think it is a silly idea to get a treatment helper to help me to remember to take my pills, because then I would have to tell this person why I am taking medication – my reasons are private.				
8. It will be easy for me to take medication on a regular basis because I have something that will remind me, such as a cellphone or clock that I will definitely use.				
9. If I have to take pills for the rest of my life, it will be difficult for me to plan ahead to have enough pills – for example if I go on holiday.				
10. I don't want to excuse myself every time from a meeting or a gathering with friends to go and take my pills.				
11. There is nothing wrong with sharing my prescription pills with other people who could not get their pills in time.				
12. I will be able to stop taking alcohol if this is required of me.				
13. I will be able to go for regular check- ups every three to six months for the rest of my life if this is required of me.				
14. I will never be able to give up smoking to take pills. (If you don't smoke, mark "strongly disagree".)				
15. I don't like taking pills and I will probably stop taking them when I feel better.				
16. I was on antibiotics before, and I can honestly say that I took all my pills, at the prescribed times, until all the pills were finished.				

FEEDBACK 6.6

Did you enjoy the exercise? Please note that the purpose of this exercise was to provide a fun way to find out if you are ready to commit to ARV treatment for the rest of your life. Please DO NOT use this questionnaire to test your client's readiness

to go onto ARVs! The message that we wanted to convey with this activity, is that an a**dherence of 95% or more to ARVs is critical for viral suppression.**

Now let's see how you did in your adherence questionnaire. Give yourself the following marks:

- Question 1: no marks (only a test question)
- Questions 2, 3, 4, 6, 7, 9, 10, 11, 14 and 15: 1 mark for strongly agree, 2 marks for agree, 3 marks for disagree and 4 marks for strongly disagree
- Questions 5, 8, 12, 13 and 16: 4 marks for strongly agree, 3 marks for agree, 2 marks for disagree and 1 mark for strongly disagree

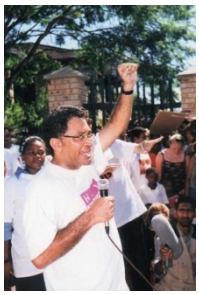
Add up your marks and write the total in this block: [ ]

The minimum mark you could have obtained is 15 and the maximum mark is 60.

Now let's see how you did on your adherence scale.

Adherence of 95% or more is critical for viral suppression.

57 to 60 points: Well done! You would probably be a good candidate for ARVs because you show good intentions to adhere to your medication. Research has shown that ARVs have 81% effectiveness for patients with an ART adherence of 95% or more. Those patients who adhered 100% to their drug regimens had an undetectable viral load in 65% of the cases. Adherence of 95% or more is critical to achieve viral suppression and to slow the time to treatment failure and subsequent development of resistance.



48 to 56 points: This is not good enough for ARV adherence! Research has shown that, of those patients whose adherence was down to 80%, only 36% had undetectable viral loads.

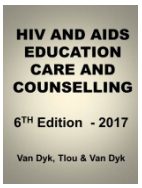
43 to 47 points: This situation is even worse than in the previous scenario. You will probably have to go into a programme first to prepare you for adherence before you can start ARV treatment.

Adherence of 70% or lower – a waste of money, time and energy!

42 points or lower: Patients who have an ART adherence of 70% or lower (42 points on your scale) have only a 6% chance of the medication being effective. The chance of developing resistant viruses is huge!

Did you enjoy the exercise? Please note that the purpose of this exercise was to provide a fun way to find out if you are ready to commit to ARV treatment for the rest of your life. Please DO NOT use this questionnaire to test your client's readiness to go onto ARVs!

How do we get someone with a score of 42 (70%) to a score of 60 (100%)? Let's find out by consulting the prescribed book. But remember that knowledge alone is not enough to get people to adhere to their medications – it needs an attitude change as well.

Study	Prescribed book: pp. 163–166	
	**Section 6.9: The development of drug-resistant viruses.** You were introduced to the concept of drug resistance in Learning Unit 4 where we discussed MDR-TB (or multi-drug-resistant TB). Use figure 6.3 to guide your understanding of how drug-resistant viruses can develop, or go to http://goo.gl/lxlydp to watch a slide-show on the internet. Do you think this can have serious implications for ART in general? **Section 6.10: Adherence to antiretroviral therapy.** This section will explain to you how important it is to adhere to ARVs. It will also share strategies for improving adherence to ARVs. While reading this section, think of ways in which the adherence strategies can be implemented in your community.	

Do you understand what happens when a person does not adhere to his or her ARVs? Drug-resistant viruses develop. This means that HIV has developed ways to resist the medication. The medication will therefore no longer work for this person (it will have no effect on the virus). It is therefore extremely important for people on ARVs to adhere to their medications at all times.

ACTIVITY 6.7

Zackie Achmat: Adherence in practice

Read what Zackie Achmat had to say about his heart attack and the implications for ARV adherence.

Read what Zackie Achmat, a well-known Aids activist, said about his heart attack in March 2005[1] and answer the questions in Activity 6.7

> *I awoke to a stunning pain on the left side of my chest; it was very heavy but dull, and I immediately thought "heart attack". I couldn't move properly, so I couldn't pick up my cell phone to call my housemate, so I rolled out of bed and slid on my stomach to my housemate's room – luckily only five metres away. Emergency services soon arrived. As they were picking me up I said, "Bring my Pablo Neruda poems and biography, and my antiretrovirals", and then lost consciousness.*

What does this passage say about Zackie's adherence to ARVs?

- What kind of relationship do you think Zackie has with his ARVs if you read the sentence "Bring my … poems … and my antiretrovirals …"?
- What can happen to a patient who is admitted to hospital for an emergency if nobody knows that the patient is on ARVs – especially if the patient is to stay in hospital for an extended period?

1 *Heart*. (2008). Interview with Zachie Achmat. pp 19–20.

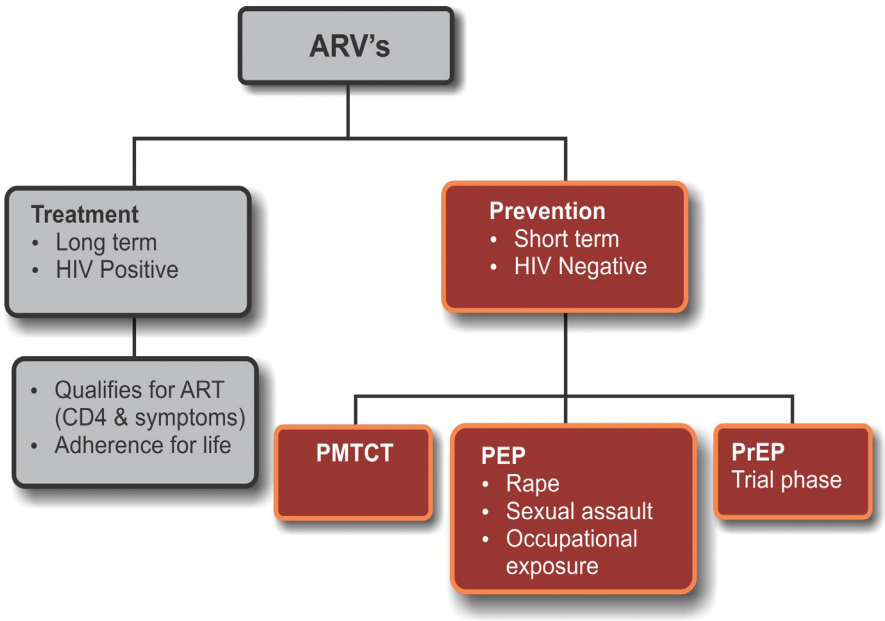
FEEDBACK 6.7

Adherence to ARV is a serious issue.

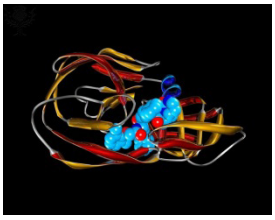
Let's conclude this section with the following excerpt from *Three-letter plague* (p 111):

> *If people are to administer their own life- long treatment, they must have a lively relationship with their medicines, a relationship at once emotional and cognitive. They must know the name of each pill, its shape, its colour, its nickname, all its potential side effects. They are stuck with these tablets for their lives. Their relation to them will at times be hateful and fraught and unhappy. The tablets will perhaps make them sick, fail to stop them from getting sick, change the shape of their bodies. Best to develop a language with which to speak to them.*

If you look at the diagram that we gave at the beginning of this learning unit again, you will see that we have now completed the discussion of the left hand side of the diagram (grey), namely how ARVs are used to *treat* HIV infection once it has occurred and damaged the immune system. In the next section, we will discuss the right hand side of the diagram (red), namely how ARVs can be used to *prevent* HIV infection from occurring in the first place.



USING ARVS TO PREVENT HIV INFECTION



If you look at the right hand side (green) of the figure on the previous page, you will see that ARVs are used to prevent HIV infection in the following circumstances:

- mother-to-child transmission
- occupational exposure
- after rape or sexual assault

Go to your prescribed book to learn more.

Study	Prescribed book: pp. 169–176
	**Section 6.11: Prevention of mother-to-child transmission.** Although it is important to know the basic principles of the prevention of mother-to-child-transmission (or MTCT) of HIV, it is not necessary to know the specific drugs or protocols that are used. We will also not ask detail questions on infant prophylaxis. **Section 6.12: Post-exposure prophylaxis after occupational exposure.** Write down the letters PEP one below the other and write the meaning of each letter next to it. In this section you will read how PEP is used to prevent HIV infection after occupational exposure to the virus. Make a summary of the procedures that should be followed before a person can start taking PEP. Do you know when an exposure warrants PEP and when it does not require PEP? **Section 6.13: PEP after rape or sexual assault.** Although PEP for rape survivors is no different from PEP after occupational exposure, we discuss it separately due to the high incidence of rape and violent crime in South Africa. Please read this section very carefully as you might need the information in the future.

Do you clearly understand the difference between (a) the use of ARVs to treat established HIV infections, and (b) the use of ARVs to prevent HIV from entering the CD4 cells in the first place? It is important to realise that HIV is NOT YET in the body in the case of (b) above.

In the next activity, I have lined up a few issues that often cause heavy debates. It is a great learning experience to reason about topics like this with your colleagues or friends.

ACTIVITY 6.8

Social debates around PEP

Use the topics to debate with your co-students. You can do this on myUnisa.

Debate the following issues with a person who also feels strongly about the issues concerned. The knowledge you have gained so far will assist you with your arguments.

- How can we refuse to give PEP to a health care worker who reports her needle stick injury a week after the accidental exposure to HIV-infected blood?
- Is it not cruel and inhumane to refuse PEP to an HIV-positive woman who has been raped? (Note: she was HIV positive at the time of rape.)
- Is it such a good idea to offer short-term treatment (or PEP) to people after rape or accidental exposure? Will short-term treatment not lead to the development of resistant viruses?

Did you use the following background information to inform your position in the debate?

- PEP has a protective effect only if it is given within 72 hours of exposure to the virus. If it is given too late, it will have absolutely no effect if the virus has

already penetrated CD4 cells and started to replicate. The health care worker should be counselled accordingly.

- PEP won't have any effect on a person who is already HIV positive. If given, it can lead to the development of resistant viruses. Counselling is of the utmost importance in a case like this.
- If PEP is given to a person who is HIV negative, the whole idea is for the ARVs to protect the CD4 cells and to prevent the viruses (that might have entered the rape survivor's body) from entering CD4 cells and from replicating. If everything goes according to plan, there will be no viruses that can develop resistance.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 6 (Antiretroviral therapy), you should have acquired the following knowledge and understanding and be able to:

- explain what each one of the key terms mentioned under "picking up useful words" at the beginning of this learning unit means to you.
- explain to a patient what the four goals of ART are.
- draw a picture to explain to a colleague how a virus can develop drug resistance.
- devise a personal plan for a client to help them to adhere to their ARV treatment plan.
- explain the protocol that should be followed before a rape survivor can receive ARVs as post-exposure prophylaxis.

SELF-ASSESSMENT 6

Do a few questions on this learning unit.

SELF-ASSESSMENT 6

QUESTION 1

Antiretroviral therapy has four primary goals. The virological goal is to:

1. Reduce HIV-related sickness and death
2. Improve quality of life
3. Reduce the HIV viral load
4. Restore the immune system

QUESTION 2

Antiretroviral therapy is usually initiated as follows:

1. As soon as the person can adhere to ART, irrespective of CD4+cell count.
2. In all pregnant women
3. When CD4+cell count ≤ 200 cells/mm3
4. When the patient is ready to commit to treatment

QUESTION 3

What is the difference between an individualised and standardised drug regime approach?

QUESTION 4

Explain what drug resistance is.

QUESTION 5

Read the following paragraph and fill in the missing words in the spaces provided.

It is extremely important to adhere to your ARVs. To adhere to one's medication means that (a) .....

Research has shown that an adherence level of at least (b) ..... is necessary for ARVs to suppress HIV sufficiently.

Non-adherence can lead to (c) .....

When this happens, the problem is that (d) .....

The following can be done to assist people to adhere to their medications:

(e) .....

(f) .....

(g) .....

(h) .....

(i) .....

(j) .....

FEEDBACK 6

FEEDBACK QUESTION 1

The correct answer is (3) – to reduce the viral load.

FEEDBACK QUESTION 2

The correct answer is (1)–When the CD4+cell count is ≤ 500 cells/mm3.

FEEDBACK QUESTION 3

Individualised approach: A combination of ARVs is selected that suits the specific individual patient. Standardised approach: A specific regime of ARVs is prescribed to all patients with HIV infection.

FEEDBACK QUESTION 4

If a patient does not take his or her medication as prescribed, or if an insufficient ART regime is prescribed, the concentration of drugs in the bloodstream will fall too low to keep the pathogen depressed and mutants will develop. The drugs will be ineffective against these mutants. It is therefore important to have enough drugs (e.g. antibiotics, anti-tuberculosis medication or antiretrovirals) in the bloodstream for 24 hours a day to keep the pathogen depressed.

FEEDBACK QUESTION 5

(a) the patient must take his/her medication exactly as prescribed and not skip any doses.
(b) 90% or above.
(c) drug resistant viruses
(d) the ARVs the patient is taking will no longer have any effect on the virus that has developed drug-resistant. The viral load will go up again.
(e) to (j) Any of the strategies to improve adherence to ARVs mentioned in your prescribed book.

GLOSSARY

Nucleoside reverse transcriptase inhibitors (NRTIs)	A class of anti-retroviral drugs that includes drugs such as zidovudine (AZT), lamivudine (3TC) and stavudine (d4T). NRTIs disturb the life cycle of HIV through interference with the reverse transcriptase enzyme by mimicking the normal building blocks of HIV DNA.
Drug regime (individualised versus standardised regime)	A course, schedule, plan or routine of therapy describing what medications a patient should take and how often.
Non-nucleoside reverse transcriptase inhibitors (NNRTIs)	A class of antiretroviral drugs that include drugs such as nevirapine and efavirenz. NNRTIs disturb the life cycle of HIV by directly inhibiting the reverse transcriptase enzyme.
Drug resistance	If a patient does not take his or her medication as prescribed, or if an insufficient ART regime is prescribed, the concentration of drugs in the bloodstream will fall too low to keep the pathogen depressed and mutants will develop. The drugs will be ineffective against these mutants. It is therefore important to have enough drugs (e.g. antibiotics, anti-tuberculosis medication or antiretrovirals) in the bloodstream for 24 hours a day to keep the pathogen depressed.
Protease inhibitors (PIs)	A class of antiretroviral drugs that includes drugs such as saquinavir and indinavir. PIs inhibit the late stages of HIV replication by interfering with the protease enzyme.
Drug adherence	To take medication as prescribed (the right amount and at the prescribed times) without missing any dosages.

Highly active antiretroviral therapy (HAART)	A combination of antiretroviral drugs that efficiently inhibit HIV replication in HIV-infected people. The combination usually includes two nucleoside inhibitors (NRTIs) plus one non-nucleoside inhibitor (NNRTI) or two nucleoside inhibitors (NRTIs) plus one protease inhibitor (PI). Also often referred to as “triple therapy”.
Post exposure prophylaxis (PEP)	Methods for attempting to prevent HIV infection in a person who has been exposed to infected blood or other body fluids, for example, in the case of accidental exposure or rape. PEP with antiretroviral drugs must start as soon as possible (and no later than 72 hours) after exposure.

THEME 2

Aids Education and Empowerment

"Prevention is better than cure."

This has long been one of the best-known slogans in health care. Within the Aids context this truism has become even more important: In this case it should state: "prevention is the only 'cure'." Especially now that an HIV vaccine seems to be much further into the future than previously hoped, prevention is our only defence. This immediately introduces the following issues:

- What do the theories of behaviour change say? Can we change people's behaviour?
- How do we educate people about HIV and Aids?
- How can HIV transmission be prevented?
- What is safe and what is unsafe behaviour?
- How should children of different ages be educated about HIV and Aids?
- The challenge of preventing HIV transmission in traditional African societies

Each one of these issues will be discussed in a separate learning unit and, in this way, we will start to suggest possible answers as to how HIV transmission can be prevented in various contexts. The learning units in Theme 2 are as follows:

- Learning Unit 7: Theories of behaviour change
- Learning Unit 8: Aids education
- Learning Unit 9: Changing unsafe practices
- Learning Unit 10: Aids education for school children (Guidance Track students only)
- Learning Unit 11: Aids education in traditional Africa

LEARNING UNIT 7

Theories of Behaviour Change

INTRODUCTION

"Just give people the relevant facts about HIV and they will take the necessary steps to prevent infection."

This is the naïve view of many people. But, unfortunately, we are **not always rational beings**. Our behaviour is also determined by emotions, by relationships, the wish to be loved and be accepted, and by our ambitions and needs – both physically and emotionally. Humans are much more complex than we often appreciate. For example, how many times have you decided to stop smoking, to eat or drink less, or not to lose your temper again? You know all the rational reasons why you should change these harmful behaviours. But have you always been successful in trying to change them?

ACTIVITY 7.1

The difficulties of changing behaviour

In this activity you will reflect on some challenges preventing behaviour change.

Read or reread the chapter "On the outer edge" in Steinberg's book *Three-letter plague*, pages 104–118. Pay special attention to the following dialogue on pages 111–112:

> *Her new batch of pills in her bag, she makes her way to the door.*
>
> *"Was your boyfriend here for Christmas?" Hermann calls after her.*
>
> *"Yes."*

"Condoms?"

"Sometimes."

He turns to the counsellor. "Have you explained to her the risks of reinfec ..."

"She knows," the counsellor snaps.

(1) List a few possible reasons why you think the girl referred to in this episode did not always use condoms, even though she was fully aware of the risks she was taking?
(2) How easy do you think it would have been for a girl to always insist on condom usage?
(3) Why do you think the counsellor "snapped" when Hermann asked her if she had explained the risks of reinfection to the client?
(4) What did you learn from this incident?

FEEDBACK 7.1

It is not easy to change behaviour, especially when it is a highly pleasurable activity and when we need to be consistent and we cannot afford to slip up. However, the fact that it is not easy to change behaviour does not mean that it is impossible!

Each student will have his or her own opinion of why it is so difficult for the girl to not always insist on condom use. What is important is that you understand that it is not easy to change behaviour. The counsellor was probably irritated or disheartened because she had said the same thing over and over and that her clients just "don't listen".

This learning unit is about changing behaviour, because if we want to prevent the spread of HIV infection, we have to change our behaviour and motivate others to change their behaviour too. As long as there is no vaccine available for HIV (and this still seems to be decades away), the only sure way of prevention is by changing high-risk behaviour.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- When will people change their behaviour?
- What are the three main groups of theories to change behaviour?
- What are the principles of individual psychosocial theories of behaviour change?
- How can these principles be implemented?
- What are the basic principles of social theories?
- What are the basic principles of environmental theories?

Are you ready to become an effective and willing agent in changing people's lives? Let's do it!

KEY CONCEPTS

While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Reasoned action	Subjective norms
Planned behaviour	Internal and external locus of control
Health belief model	Social network theory
Social-cognitive learning theory	Diffusion of innovation theory
Self-efficacy	Empowerment model

Note that many of the above terms have to do with rational and cognitive aspects of behaviour. This is an indication that knowledge about HIV and how it is transmitted is indeed a prerequisite for any prevention programme. How can people change their behaviour if they don't know what kind of behaviour places them at risk of being infected? So, even though we started this learning unit by arguing that knowledge and rational approaches alone are not sufficient to change behaviour, this does not imply that we can get along without knowledge or without appealing to cognitive approaches.

WHEN WILL PEOPLE CHANGE THEIR BEHAVIOUR?

What do the social scientists and psychologists say? How can people change their behaviour and how can you, as an Aids counsellor, facilitate such a process? Let's first consider the various theories.

Study		
	**Prescribed book: pp. 186–198** **Introduction:** When reading the introduction, think about your own difficulty in talking about sex and Aids. What are the secret taboos and prejudices which you may have? **Section 7.1: Individual psychosocial theories**. Good theory is always linked to good practice. Therefore, when studying this section, constantly consider how you can implement the theoretical principles in an HIV and Aids programme. Note that this section combines the insights of various models of behaviour change (Fishbein, Ajzen, Catania, etc.) into nine principles of behaviour change. Make a list of these nine principles and add a brief description to each one as you read through the section. (Tip: The nine principles correspond with the nine subheadings in this section.) The following video http://goo.gl/GHPRBo illustrates the Theory of Planned behaviour very well. **Make sure that you understand the stages of change theories.** Watch the following video http://goo.gl/X6KWgU where the Transtheoretical Model is explained in relation to	 

	exercise. I bet you will never again battle to understand the Transtheoretical Model. Another nice video to watch on behaviour change communication is http://goo.gl/1meBXz .	

Did you note that these principles include cognitive, emotional and social factors which may impact on behaviour change? Behaviour change will not take place if knowledge is not specific and if it is not clear how and why behaviour should be changed (benefits and disadvantages). The way in which knowledge is imparted to people is of the utmost importance.

ACTIVITY 7.2

Exercise in changing your own behaviour

This activity will provide you with the opportunity to change a specific behaviour and to evaluate your progress.

Think about your own situation and a possible behaviour that you would like to change about your health (e.g. stop smoking, eat more healthily, reduce your stress, or start using condoms). Choose one specific behaviour that is important to you, but not too difficult or unrealistic to change, and commit yourself to changing it.

Make a copy of the following questionnaire and complete it by marking the most appropriate choice which describes your view. Try to be as honest with yourself as possible. (Note: The nine questions below coincide with the nine principles of behaviour change discussed in your prescribed book.)

QUESTIONNAIRE

The behaviour I want to change is .....

(1) I really need to change this behaviour.

1. Strongly disagree	2. Disagree	3. Don't know	4. Agree	5. Strongly agree

Why do you need to change this behaviour?

.....

(2) I know exactly how to change this behaviour.

1. Strongly disagree	2. Disagree	3. Don't know	4. Agree	5. Strongly agree

Exactly how are you going to change your behaviour? Give specifics, such as what, how and when.

.....

(3) I have a very strong intention of changing this behaviour.

1. Strongly disagree	2. Disagree	3. Don't know	4. Agree	5. Strongly agree

(4) I have a very positive attitude towards changing this behaviour. (Think about all the positive and negative things which may influence your attitude toward changing this behaviour.)

1. Strongly disagree	2. Disagree	3. Don't know	4. Agree	5. Strongly agree

(5) My family and friends will be positive and strongly support me in changing this behaviour (subjective norm).

1. Strongly disagree	2. Disagree	3. Don't know	4. Agree	5. Strongly agree

How much do you care if you get their support?

.....

(6) I am convinced about my ability to change.

1. Strongly disagree	2. Disagree	3. Don't know	4. Agree	5. Strongly agree

(7) There will be many positive rewards for me if I change my behaviour.

1. Strongly disagree	2. Disagree	3. Don't know	4. Agree	5. Strongly agree

Possible rewards are: .....

Possible stumbling blocks are .....

(8) I am convinced that I have control over my own health to a large extent.

1. Strongly disagree	2. Disagree	3.Don't know	4. Agree	5. Strongly agree

(9) I am convinced that I have the ability and skills to convert my intentions to change into real and lasting change.

1. Strongly disagree	2. Disagree	3.Don't know	4. Agree	5. Strongly agree

Calculate your mark out of a possible 45 by adding up the number of the options you chose for each question. For example, if you marked "4. Agree" your score for that question is 4. The higher your total score, the higher your chances of effecting behaviour change.

Please note: This questionnaire is not a scientific prediction of your success. Its purpose is merely to make you aware of the different factors influencing behaviour change in a fun and personal way.

Fill in the questionnaire every week for the next four to six weeks and notice how your score may change with time. Each time you complete the questionnaire, also answer the following additional question:

(10) How do you rate your success in changing your behaviour during the past week?

20% or lower	40%	60%	80%	100%

FEEDBACK 7.2

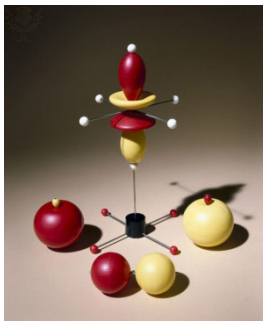
It is often only when we try to change our own behaviour that we really come to understand how difficult it is and how many challenges there are to overcome.

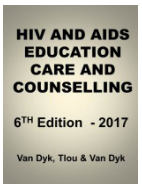
Which tendencies became clear during your experiment? How easy is it to change behaviour? Did your motivation and success rate change with time? Did you lose interest and commitment as time progressed? How easy is it to change, if you really (deep down) don't want to change, because you really enjoy the activity, or it fulfils some kind of important need in your life?

The theories that we have discussed so far have focused on the individual. Read the "critique of theories focussing on the individual" in your prescribed book (paragraph above Section 7.2). The following section discusses theories of behaviour change that take the social context in which individuals function into consideration, as well as the structural and environmental contexts.

BEHAVIOUR CHANGE: BEYOND INDIVIDUAL THEORIES

Theories of change based on the individual's psychosocial and cognitive factors are very helpful, though they do not take the bigger picture, namely the social, cultural, and structural environments in which the individual functions, into account. Learn more about this in your prescribed book.



Study	Prescribed book: pp. 199–206
	**Section 7.2: Social theories and models.** This section looks at the interactive relationship of behaviour in its social and cultural contexts. Make sure that you understand the basic principles of the social network theory, the diffusion of innovation theory and the theory of gender and power. Give special attention to the theories about gender-based violence and abuse, and on intervention strategies to protect women. **Section 7.3: Structural and environmental theories.** This section looks at the wider communal, political and economic environments which often make it difficult for people to change their behaviour. Make sure that you know the basic principles of structural and environmental theories and that you can explain what the empowerment model and the socioecological model for health promotion entail. Give an example of media advocacy in South Africa.

ASSESSMENT

STUDY REFLECTION

In this learning unit you had to cross some difficult terrain. The possibility of lasting behaviour change is a major and problematic issue in the Aids field. After completing Learning Unit 7 (Theories of behaviour change), you should have acquired the following knowledge and understanding and be able to:

- distinguish between (a) individual psychosocial theories, (b) social theories and (c) structural and environmental theories of behaviour change.
- discuss theories or models of behaviour change under each one of the main groups of behaviour change as mentioned above.
- give practical examples of each one of the theories or models discussed in this learning unit.

SELF-ASSESSMENT 7

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills.

SELF-ASSESSMENT 7

QUESTION 1

Name the 3 main groups of theories of behaviour change.

QUESTION 2

Complete the following paragraph:

Theories of behaviour change that focus on the …….. are mainly based on cognitive, …….. and …….. constructs. Social theories work with the principle that …….. can be broken into …….. and that it is the …….. have the most significant influence on the individual's behaviour.

Structural and environmental theories and models see human behaviour as a function of the …….. and his/her ……..., as well as on the wider …….. , ……..., and …….. environment.

QUESTION 3

Link each of the basic principles of individual psychosocial theories with a description:

a. Because Jack does not understand HIV he finds it difficult to change his behaviour.
b. Jeff doubts that he will be able to change his behaviour.
c. Action, target, context and time are important components related to this principle.
d. Joe views the use of condoms as a waste of his money.
e. Julia realises that HIV can affect her whole life.
f. Jill decides to practice safe sex as her movie hero practices safe sex.
g. This is an indication of how hard Jackie will try to change her behaviour.

FEEDBACK 7

FEEDBACK QUESTION 1

The three groups of behaviour change are:

1. Individual, psychosocial and cognitive approaches
2. Social theories and models
3. Structural and environmental theories

FEEDBACK QUESTION 2

The paragraph should read as follows:

Theories of behaviour change that focus on the ***individual*** are mainly based on cognitive, ***attitudinal*** and ***affective*** constructs. Social theories work with the principle that ***society*** can be divided into ***smaller subcultures*** and that it is the ***peer group*** that have the most significant influence on the individual's behaviour.

Structural and environmental theories and models see human behaviour as a function of the ***individual*** and his/her ***immediate social networks***, as well as on the wider ***communal***, ***political*** and ***economic*** environment.

FEEDBACK QUESTION 3

a. Jack: Knowledge
b. Jeff: Self-efficacy or perceived behaviour control
c. Principle: Know what behaviour to change
d. Joe: Attitude
e. Julia: Recognition of the need to change
f. Jill: Subjective norms
g. Jackie: Intention to change

GLOSSARY

Reasoned action	Behaviour determined by intention. Intentions are reflected by the motivational factors (attitudes, subjective norms, perceived behaviour control, beliefs about advantages and disadvantages) influencing specific behaviours.
Planned behaviour	Behaviour that is under the direct management of the person. It is therefore not reactive or reflexive in nature.
Health belief model	An explanation of health-related behaviour of individuals based on a specific model. This usually includes the person's evaluation of an outcome and his/her expectation that specific behaviour will lead to that outcome. It can also be described as a behaviour change model explaining and predicting health-related behaviours.
Social-cognitive learning theory	A theoretical explanation of how people learn through observation.

Self-efficacy	The belief in one's ability to do something, for example, to insist on condom use.
Subjective norms	The influence of important others on our decision-making processes. Subjective norms are influenced by the beliefs of important reference groups or individuals in a person's life; and the desire to please these reference groups or individuals.
Internal and external locus of control	Your locus of control reflects how much you believe you can direct your own behaviour. If you have an internal locus of control you feel in charge of your own behaviour. If you have an external locus of control you believe that other people and outside forces control or direct your behaviour.
Social network theory	Theory that asserts that the attributes of individuals are less important than their relationships and ties with other people or groups within the social network, when trying to facilitate change.
Diffusion of innovation theory (DOI)	Theory that explains how a new practice can diffuse through a given social system to the point that it becomes a social norm. For a new practice to spread it must be adopted by an influential person in the community.
Empowerment model	A model in which the individual takes responsibility for creating solutions for his/her problems.

LEARNING UNIT 8

Aids Education

INTRODUCTION

You were introduced to various theories and models of behaviour change in the previous learning unit. In this learning unit you will get the opportunity to implement some of those principles to develop prevention programmes.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- What should prevention programmes look like in practice?
- How can negative attitudes about HIV be changed?
- What are the basic principles of adult education?
- What teaching and facilitation skills do counsellors and caregivers need?

KEY CONCEPTS

Look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Facilitating empowerment	Discrimination
A holistic approach	Learning Aids
Stereotypes	Facilitation skills
Prejudice	

PRACTICAL ASPECTS OF PREVENTION PROGRAMMES

In this learning unit we will discuss a number of pointers to help you when designing and implementing programmes.

Study	Prescribed book: pp. 209–212
	**Section 8.1: Prevention programmes.** The best way to master this section is to see if you can evaluate an existing programme in terms of the following questions: • Does it have national support from the leaders of the country? • How many partners (different organisations and different kinds of professional people) are involved in the programme? • Does the programme offer peer support, or is it restricted to advice given by people in authority (e.g. doctors, nurses or social workers)? • Are people living with HIV involved in the programme? • Are condoms distributed in an effective and sensitive way? • Is the programme holistic in nature, offering counselling, education, support and care services?

Did you notice that the above practical aspects of prevention programmes mostly have to do with:

- how and by whom information regarding HIV and Aids is disseminated?
- how people can best be motivated to change behaviour?
- how emotional and physical support can be given to HIV-positive people?

We have talked about principles of behaviour change (Learning Unit 7) and practical aspects of implementing prevention programmes, but what about negative attitudes?

NEGATIVE ATTITUDES

Negative attitudes towards HIV-positive people often continually trouble the best-conceived prevention programmes.

Let's consider the following example: You neighbour moves away without selling his house. He has a lovely vegetable garden and he proposes that, if you take care of it, you can have the

vegetables for your own use. There is no water supply to his house which would require of you that you bring water from your own house.

Will you take care of this vegetable garden if you do not like gardening, if you feel that food can be bought from a shop and if you do not want to increase your water bill? The street vendors also have to make a living!

Probably not! If I asked you why not, what reasons would you give? The following may be some of your answers:

- I don't care.
- I have never had a vegetable garden. Why would I now want to take care of one?
- I don't like vegetables.
- Somebody else can do it.
- Good riddance, more work!

On the other hand, if you were a keen gardener and a vegetarian, would you try to take care of the vegetable garden? Probably yes. Why? Because you can practice a hobby and benefit financially from it! What is the difference between the two scenarios? I believe it is a question of negative versus positive attitudes. It doesn't matter which so-called rational reasons we may supply for not wanting to take care of the garden; the real reason can be found in our negative attitudes, in our stereotypes and prejudices. Negative attitudes towards a specific action "give us permission" not to do it. The same goes for people and diseases. If we have negative attitudes towards a specific group of people, or find a specific disease distasteful and scary, we often react either with indifference or hostility.

In the Aids field, negative attitudes often lead to indifference – probably because indifference is socially more acceptable than overt hatred. Unfortunately, the stigma produced by stereotypes and negative attitudes makes it difficult for HIV-positive people to acknowledge and accept their status, to access help and support and to feel positive about themselves. This is a major stumbling block in preventing the further spread of HIV and in helping people who are HIV positive. Negative attitudes are killing people. For this reason, all HIV prevention programmes should consider negative attitudes seriously and deal with them. Watch this video http://goo.gl/Tpei2I in which Nelson Mandela talks about fear, stigma and discrimination killing people because they are too scared to be tested and to access help.

Study	Prescribed book: pp. 212–214
	**Section 8.2: Changing negative attitudes.** While reading this section, try to answer the following questions: • What are the emotional and social reasons for stereotypes and prejudices? • Are stereotypes really reasonable? • How do negative attitudes impact on a society? • How can I combat my own and other people's negative attitudes?

Prejudice and stereotyping may sometimes have serious consequences and make people very angry. It may therefore be a good idea to sometimes add a bit of humour to a situation. If people can laugh about their own prejudices, they may also be willing to recognise them and try and change them.

In the next section we cover the last important aspect concerning prevention programmes: how to facilitate learning.

TEACHING AND FACILITATION

In this section you have a choice, either to learn all the principles of HIV education and facilitation by heart, or to learn as you are attempting to implement them. Although the first method seems to be the shortest and most desirable route, this is a false impression. You will learn much more and remember the principles better if you try to *implement* the theoretical principles. We therefore suggest that you first read the sections, as indicated below, just to give you an idea of the principles of HIV education and facilitation and then to jump in and immediately do the activity of preparing and presenting an educational session. As you go along you will need to constantly refer back to the prescribed book to ensure that your presentation is in accordance with the relevant theoretical principles of education. By doing it this way, your mind will be focused and it won't be easy to forget the basics about HIV education and facilitation.

Study	**Prescribed book: pp. 214–226**	
	**Section 8.3: Aids education.** How do you teach people, especially adults, about HIV? How can you prepare such an educational session in the most interesting way and make sure that your message has the maximum impact? Not by just standing up in front of the group and giving them a sermon! This is the surest way of losing them within a few minutes. This section will teach you the tricks of the trade. Give special attention to the methods of teaching. **Section 8.4: Facilitation skills.** One of the most useful tricks of the trade in education is not to merely tell people about something, but to help them discover it themselves. This is what facilitation is all about. It is especially useful when you wish to use group work as part of your educational workshop. Watch the following YouTube video http://goo.gl/927zSc on seven key skills on workshop facilitation.	

Now that you have a basic idea of what HIV education is all about, it is time to implement the basic principles of Aids education.

ACTIVITY 8.1

Present an educational session

The purpose of this exercise is to prepare an educational session (e.g. a workshop) on any aspect of HIV and Aids, to choose a target group, and to present your lecture or workshop to them.

(1) For this activity do the following:

- Decide on (a) a target group and (b) a topic that you would like to discuss or workshop with your participants. Note: Rather concentrate on

adult education. (Educating schoolchildren has all sorts of complications. For example, you will need the written permission of their parents.) You may ask colleagues or a group of friends to attend your educational session. There should be at least five participants attending your session.

- Decide on your method of teaching (e.g. lecture, group participation, role-play, or a combination).
- Decide what your main message should be (what do you hope to achieve?), how long the educational session should take, what equipment or educational material you will need, etc.
- Study your topic (use your prescribed book as well as additional material) and make brief notes.
- Develop your educational materials, or collect pamphlets, posters and other training materials from your nearest health department, if possible.
- Which evaluation methods are you going to use to evaluate your educational session?
- Think about your role as a facilitator (see section 8.4 in your prescribed book).
- Present your educational session.

(2) Write down your experiences. Answer the following questions:

a. Who was your target group? How many people attended?
b. What was your method of teaching?
c. What was your topic?
d. What was your main message?
e. What educational materials did you use?
f. How did you evaluate the educational session?
g. How did you feel standing in front of a group to facilitate the session? (Concentrate on your feelings.)
h. What did you learn about yourself as a facilitator? What will you do differently next time?

(3) Write a report about your experiences.

- Give an outline of your workshop plan.
- Describe the educational materials you used (e.g. pamphlets, posters).
- Provide a reflection of your experience as a facilitator of the workshop. How did you feel? Did you merely lecture, or did you guide your participants to empower themselves in a safe environment? Were you sensitive to group dynamics and did you do more listening than talking?
- Describe your participants' responses. Did they talk a lot, did they ask many questions, or were they absolutely quiet?

FEEDBACK 8.1

Presenting a workshop for the first time can be a nerve-racking experience. Start, therefore, on a small scale and practice your skills until you feel more comfortable. Teaching can be one of the most rewarding experiences in life.

They say practice makes perfect! Keep on practicing until you get it right.

You are now finished with this learning unit. Click on Assessment to do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 8 (Aids education), you should have acquired the following knowledge and understanding and be able to:

- design prevention programmes in such a way that they include essential practical aspects such as peer group support, support by leaders and the cooperation and involvement of various stakeholders.
- expose and combat negative attitudes and stereotyping in the HIV and Aids field.
- implement the principles and facilitation skills required for HIV and Aids education.

SELF-ASSESSMENT 8

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills.

SELF-ASSESSMENT 8

QUESTION 1

Which one of the following reflects some of the principles/aspects to be kept in mind when developing an Aids prevention programme?

1. Facilitating empowerment, individual approach, partnerships
2. International support, partnerships, a holistic approach
3. Partnerships, facilitating empowerment, a holistic approach
4. National support, peer support, facilitating growth

QUESTION 2

What are the main reasons why people do not go for HIV tests, access ARV drugs, adopt safe feeding methods for their babies, or change sexual behaviour?

QUESTION 3

Name some of the entities who should implement efforts to fight against stigma and discrimination?

QUESTION 4

Link the descriptions below with the corresponding methods of teaching/learning:

1. After a play, the class asks questions of the character played by the actor.
2. The use of posters, leaflets, written information, cartoons, and comic strips.
3. A short account of a person's experience to clarify what is being taught in class.
4. Using the experiences of learners who have achieved something relevant to what is being taught, to teach the other learners.
5. Active involvement of the learners.

QUESTION 5

Indicate whether the following statements on facilitation skills are true or false:

1. Subjectivity is very important.
2. The facilitator should provide many opportunities to ask questions.
3. All people attach the same meanings to concepts.
4. The facilitator should be alert to expressions indicating deep or strong feelings.
5. The four cornerstones of being a good facilitator are empathy, respect, genuineness, and concreteness.

FEEDBACK 8

FEEDBACK QUESTION 1

The correct answer is partnerships, facilitating empowerment and a holistic approach (alternative 3).

FEEDBACK QUESTION 2

The main reasons why people do not access HIV-related services are stigma and discrimination.

FEEDBACK QUESTION 3

Some of these entities are: all leaders; people living with HIV; human rights protectors; governments; the legal environment; prevention and treatment, care and support services.

FEEDBACK QUESTION 4

The corresponding method of learning is:

1. Discussion in character
2. Social marketing and the use of the media
3. Case study
4. Building on successes of learners
5. Group participation

FEEDBACK QUESTION 5

The correct answers are:

1. Subjectivity is very important: False.
2. The facilitator should provide many opportunities to ask questions: True.
3. All people attach the same meanings to concepts: False.
4. The facilitator should be alert to expressions indicating deep or strong feelings: True.
5. The four cornerstones of being a good facilitator are empathy, respect, genuineness, and concreteness: True.

GLOSSARY

Facilitating empowerment	The process of involving and encouraging individuals, groups and communities to address their own health concerns and to find solutions to their own problems (p. 153)
A holistic approach	A combination of various approaches to provide an inclusive continuum of HIV prevention and care.
Stereotypes	Frames of reference or patterns of expectations that strongly influence the processing of incoming social information.
Prejudice	A negative attitude toward members of a group, based solely on their membership of that group.
Discrimination	Negative behaviour or actions based on prejudice.
Learning Aid	Any object used to assist an educator in the teaching process.
Facilitation skills	The skill of helping other people to discover knowledge, to explore their potential, to build upon experience, and to generate their own learning.

LEARNING UNIT 9

Changing unsafe practices

INTRODUCTION

Have you ever been in a position where somebody expected you to change and you desperately wanted to change, but you didn't know exactly what was expected of you? I can still remember, as a pre-school child, how my mom tried to teach me how to be neat.

Pick up your clothes behind you," she instructed, pointing at the clothes strewn across my bedroom floor.

"Yes, mom," I replied obediently. When my mom left the room I picked up all the clothes and promptly deposited them in a bundle on my bed. When she returned a few moments later she looked at my pleased face and then gasped when she saw the clothes on my bed.

"This is not what I meant. Your room is still not neat. I can still see all your dirty clothes," she said in a rising voice, turning on her heel. I was desperately unhappy at having disappointed her. So when she left, I started shoving all the clothes beneath my bed …

So what went wrong? My mother instructed me to change my untidy behaviour, but her instructions were rather vague – at least for a five-year-old kid. What she needed to do was to give me specific instructions of what I should have done with my clothes and why.

"Pick up your dirty clothes and put them in the washing basket. It looks untidy when they are scattered all over the room."

This would probably have done the trick.

The same is true when instructing people on how to change unsafe practices in the HIV and Aids context. Vague instructions about behaviour change won't be effective. In this learning unit we deal with the specifics of unsafe and safe behaviour.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

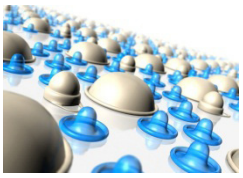
- How can sexual transmission of HIV be prevented?
- How should I talk about sex?
- How can transmission of HIV be prevented in people who inject themselves with drugs?
- How can I promote health and life skills?

KEY CONCEPTS

While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Femidom (female condom)	Oral-anal sex (anilingus)
Anal sex	"Dry sex"
Oral sex (fellatio and cunnilingus)	

HOW CAN SEXUAL TRANSMISSION OF HIV BE PREVENTED?



By far the most common and effective way in which HIV is transmitted from one person to another is through unprotected sexual intercourse. It is therefore of the utmost importance that people should be informed about which sexual practices may increase the risk of transmission. This includes exactly how transmission of the virus during sex can be prevented, or how the risk of infection can be reduced. The problem many people have with talking openly about the details of sex makes this very difficult. Nonetheless, talking about this is essential.

Study	Prescribed book: pp. 230–245 & pp. 248–249
	**Introduction:** Focus on why it is important for Aids counsellors to set realistic goals in terms of sex and behaviour change. High ideals are good, but not if they are not really implemented. **Section 9.1 and 9.2: Prevention of sexually transmitted HIV and barrier methods.** When discussing sex and changes in sexual behaviour, vague statements and general ideas won't do the trick. Specifics and frank discussions are absolute requirements. Focus in this section on exactly which behaviours should be changed and how they should be changed. Never assume that people know how to use condoms, especially not female condoms.
	Leave section 9.3 out for the moment. **Section 9.4: Prevention of HIV in people who inject drugs.** Sharing needles is the major way in which HIV is transmitted in people who inject drugs. Take note of the fact that not all people who use drugs are directly at risk (e.g. those smoking dagga), but only those who inject drugs with non-sterile needles. However, non-injecting drug users are at risk when they have unprotected sex and if they "sell" sex to buy drugs.

What about now doing something practical to practise your skills?

ACTIVITY 9.1

Condom demonstration

The purpose of this activity is to demonstrate the use of a condom to a friend.

Ask one of your close friends to act the part of a client and give a practical demonstration of how a male condom should be used. Use a broomstick or any other appropriate object to illustrate how a condom should be unrolled over a penis. (Note: If you are a counsellor you will probably have a condom demonstrator to use instead of a broomstick.) Be frank and make sure that you don't avoid terms such as penis, vagina, erection and ejaculation.

You can also demonstrate the use of the female condom (femidom) to a friend.

FEEDBACK 9.1

Go back to your main learning unit and watch the YouTube videos illustrating the correct use of the male and female condom.

Go to the following YouTube links to see the correct use of a male as well as a female condom.

Male condom: http://goo.gl/inF0Le

Female condom: http://goo.gl/C88zv2

Go to the following website to see how male condoms are made and tested:

https://www.youtube.com/watch?v=VJTjxFu2nHg

People often wrongly think that they know what high-risk sexual behaviour entails, or they do not want to talk about it. For this reason, the next activity will ask you to rate high and low risk sexual behaviour, to assess your own knowledge.

ACTIVITY 9.2

Rate high- and low-risk sexual behaviour

In this activity, you will rate the risk involved with various sexual activities. You can keep the completed table as a handy reference for the future.

Complete the following table by rating each activity in terms of its risk for transmission of HIV. Use a scale from 0 to 5, with 0 as no risk and 5 as high risk. Also fill in the last column (when relevant) to indicate how the risk of certain activities can be reduced. We have completed the first row (anal sex) for you as an example. Note: Assume that all behaviours mentioned below take place without any protection.

Risk reduction scale

Behaviour	**Rating (0–5)**	**How to reduce risk**
Anal sex	5	Use extra-strength male condom
Vaginal sex		
Vaginal sex where lesions are present (e.g. STIs are present)		
French kissing		
Mutual masturbation		
Anilingus		
Vaginal fisting		
“Dry sex”		
“Thigh sex” with no lesions present		
Cunnilingus		
Erotic massage		
Swallowing semen		
Sharing sex toys		
Drug users: sharing needles		
Sharing razor blades		
Sharing toothbrushes when one person has bleeding gums		

FEEDBACK 9.2

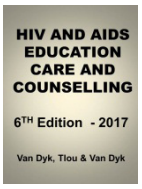
We should always talk about potentially high-risk behaviour within the context in which a specific behaviour takes place.

When completing the table you may have discovered that it was more difficult than it may have first appeared. The reason for this is that we should always talk about potentially high-risk behaviour in a qualified manner. For example, sharing toothbrushes, although an unhygienic practice, may in ordinary circumstances be a low-risk behaviour. But if we take into account that HIV-positive people often have sores in their mouths caused, for example, by thrush, it may become a high-risk behaviour in such a case due to the presence of blood.

It may also have been difficult in some cases to give an exact risk rating, because of many unspecified factors in the table. For example, in the case of an erotic massage: is the skin of both partners intact or not? It may therefore be necessary to expand the above table by qualifying each behaviour and rating each situation separately.

HOW TO TALK ABOUT SEX

Talking about sex to clients is extremely difficult for most people. In most cases it breaks the taboos which surround sexual activities in many societies. However, in the HIV context we don't have a choice. The only way to overcome your own hesitance is to become aware of possible situations which may make it more difficult (e.g. differences in gender and age of counsellor and client) and try to avoid or overcome them, and to practise speaking openly about sex until you become comfortable with the subject.

Study	**Prescribed book: p. 246–247**
	**Section 9.3: Talking to clients about sex. The do's and don'ts:** Remember, one of the purposes of this learning unit is to teach you how to talk to people about safer sex practices. Make a list (while reading through this section) of what should be avoided and how such an education session should be structured in terms of mode, presentation, terminology, etc. Study the enrichment box 'Know your gender terminology'. Can you define and explain the differences between biological sex, gender identity and sexual orientation? Do you know what it means to be 'transgender'? What is the difference between 'men who have sex with men' and being gay? Are all women who have sex with women lesbian?

Do you need more practice to overcome your shyness? Do the following activity:

ACTIVITY 9.3

A fun way to talk about sex

In this activity you will prepare a humorous PowerPoint presentation about sex and present it to your friends.

- Prepare a PowerPoint presentation on your computer about high-risk and low-risk sexual behaviour. Search the internet for humorous pictures and clipart to illustrate your talk. The more outrageous these are, the better.

- Invite two or three close friends (preferably of the same sex) and present the talk to them. Or choose any small group which will be the least “threatening” to you. Some people find it easier to talk about sex to close friends, while others prefer total strangers. You can also present it to your partner first, if you prefer that.
- Present the same talk to group that you do not feel so comfortable with and gradually introduce more “embarrassing” details (e.g. by using a condom demonstrator to show correct condom usage), until you become comfortable talking about sex. Double check yourself that you don’t avoid explicit terms such as penis, vagina, oral sex, anal sex or any word that may embarrass you. Include them in your talks until you are comfortable with them.

FEEDBACK 9.3

Not only may the use of humour calm your nerves, it might make your presentation much more effective.

Did the fact that you used a PowerPoint presentation make it easier to talk about sex? What effect did the use of humour have in the presentation of the talk?

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 9 (Changing unsafe practices), you should have acquired the following knowledge and understanding and be able to:

- clearly inform other people about high-risk and lower-risk behaviours in terms of HIV transmission.
- give detailed advice to clients on how high-risk sexual behaviour can be changed to reduce the risk of HIV transmission.
- demonstrate the use of the male and female condoms.
- talk about sex in an open and frank way without being too embarrassed.

SELF-ASSESSMENT 9

Now is the time to pause briefly and assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

You are now finished with the assessment. Please go to the relevant Learning Unit as indicated below:

Guidance Track -> Learning Unit 10

Care Track -> Learning Unit 11

Please Note: You were asked earlier to choose only ONE of the two tracks available in this course. Up to now, these tracks have been exactly the same, but at this stage they are going to diverge.

SELF-ASSESSMENT 9

QUESTION 1

Complete the following sentences:

a. The most common means of transmission of HIV is via …….. or contact with ……..., ……..., or …….. and ……...
b. The only 100% effective way of protection against the sexual transmission of HIV is ……..
c. Additional sex partners …….. the risk of contracting HIV.

QUESTION 2

Choose the most accurate statement.

Both male and female condoms:

a. can be put in place/inserted after sexual intercourse has started, but before ejaculation.
b. are made from latex, lambskin or polyurethane
c. can be used after the expiry date as long as the condom is not damaged, discoloured, brittle, or sticky.
d. are classified as barrier methods.

QUESTION 3

Name three safe sex practices that are still enjoyable.

QUESTION 4

Which solution can be used to sterilise injecting equipment?

QUESTION 5

Is there a programme in South Africa for registered drug users to swap used needles and syringes for sterile equipment?

QUESTION 6

Define the following gender concepts:

- Biological sex
- Gender identity
- Sexual orientation
- Transgender
- Men who have sex with men
- Women who have sex with women

FEEDBACK 9

FEEDBACK QUESTION 1

The sentences should read as follows:

a. The most common means of transmission of HIV is via ***sexual intercourse*** or contact with ***infected blood***, ***semen***, or ***cervical*** and ***vaginal fluids***.
b. The only 100% effective way of protection against the sexual transmission of HIV is ***total abstinence.***
c. Additional sex partners ***increase*** the risk of contracting HIV.

FEEDBACK QUESTION 2

The correct answer is (d). Both male and female condoms are classified as barrier methods.

FEEDBACK QUESTION 3

You can mention any option provided under 'General safer sex rules' in your prescribed book (hugging, cuddling, erotic massage, using personal sex toys, etc).

FEEDBACK QUESTION 4

A bleach and water solution (Jik) can be used to sterilise injecting equipment.

FEEDBACK QUESTION 5

The answer is no. There is NO programme in South Africa for registered drug users to swap used needles and syringes for sterile equipment.

FEEDBACK QUESTION 6

You will find the answers in your prescribed book in the Enrichment box under Section 9.3.

GLOSSARY

Femidom (female condom)	A strong, soft sheath made of polyurethane plastic or nitrile that is inserted into the vagina before sexual intercourse.
Anal sex	Sex during which penetration of the anus takes place.
Oral sex (fellatio and cunnilingus)	Sexual contact between the mouth and genitals.
Oral-anal sex (anilingus)	Sexual contact between the mouth and the anus.
"Dry sex"	Sex with a woman with a dry vagina, achieved through the use of herbs, snuff, antiseptic solutions, chemical and other substances.

LEARNING UNIT 10

Aids education for school children

(Guidance Track)

INTRODUCTION

It is important that our children learn about Aids from a young age. But we must keep in mind that children go through cognitive, social, emotional and other development phases and that education should always be appropriate to the development phase of any specific child. For example, it is useless to try to convince a four-year-old child that they should regularly wash the puppy's water bowl by explaining the presence of water-borne bacteria and how they may cause the puppy to get sick. A small child cannot conceptualise small unseen pathogens and how they may cause disease because they can't see them and don't understand the basics of cause and effect. It would be far better to merely explain to the small child that dirty water bowls and sickness are "associated", without trying to explain the mechanism of how bacteria cause illness. Even small children can understand associations even though they cannot yet grasp cause and effect.

This learning unit will deal with how children develop and how their Aids education should be adapted to their development phases. The purpose is to ensure that Aids education is aimed at addressing the specific issues of children and has the maximum effect on them.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- How are learners and teachers influenced by HIV and Aids?
- What are the requirements and basic building blocks for HIV, STI and TB education?
- How should middle-childhood development inform teaching in the foundation and intermediate school phases?
- How should adolescent development inform teaching in the senior and further education school phases?
- How can we support adolescent learners with HIV in our schools?

KEY CONCEPTS

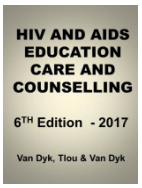
While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Multiple classification	Foundation school phase
Hierarchical classification	Intermediate school phase
Middle-childhood development phase	Senior school phase
Adolescent development phase	Further education school phase

LEARNERS, TEACHERS AND HIV

How are children and teachers influenced by the HIV and Aids pandemic? *"Surely children, especially young children, should not be burdened with Aids? Our children live a clean life".*

The above view is often the unspoken assumption of many parents and teachers. Unfortunately, there is nothing further from the truth. Children, especially in Africa, are constantly **confronted** with HIV and sex from a very early age. To think that smaller children know nothing about sex is extremely naïve. Not only are they often confronted with sex within their communities, but they are also bombarded with sex through the mass media and the internet if they have access to these forms of media. Children therefore need to be knowledgeable about HIV, Aids and STIs from a very early age. They further need to be made aware of TB (tuberculosis) from an early age. Schools should also give special attention to adolescents who are HIV positive – many children who were born with HIV have now reached adolescence.

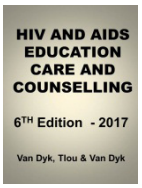
Study	Prescribed book: p. 252–253
	**Introduction:** When reading this introduction, take a moment and contemplate the importance of our children and how easy it sometimes is for a community to neglect their children or speak about a "lost generation". Can we afford to give up so easily? **Section 10.1:** Learners, teachers and HIV: Aids statistics are about people – people who are confronted with HIV every day of their lives. Children are often the most vulnerable, while teachers are one of the groups most severely influenced. Make sure you grasp the extent to which our education systems are in trouble. The Department of Health recommends that sexuality education should be introduced to children at around 12 years. How does the Department of Health define 'sexuality education'? What does the Department of Basic Education mean when they talk about an 'Integrated Strategy on HIV, STIs and TB?

To what extent is your local school influenced by the Aids epidemic? To answer this question is often difficult because of confidentiality issues and denial by school authorities to acknowledge the problem. The possible influence of Aids on schools can often be assessed indirectly by looking at absenteeism among children and teachers and, if possible, the reasons for this. The number of orphans in a school may also be an indication of Aids deaths within the community. If you are involved in your local school, see if you can arrange an interview with the school principal and ask him or her about absenteeism and orphans within the school and to what extent he or she attributes these factors to Aids.

Isn't it shocking to realise the extent to which children and teachers have to deal with Aids issues every day? This fact has changed and will drastically change the childhood years of our children. The only thing we can do is to arm them with the necessary knowledge, skills and attitudes to empower them to protect themselves and to handle the pandemic responsibly and humanely.

THE REQUIREMENTS FOR HIV, STI AND TB EDUCATION

In the previous section we agreed that children (and teachers) are directly influenced by the Aids epidemic and that it is therefore imperative to teach them about HIV and Aids, other STIs and TB–both from an ethical and human rights point of view (the right to knowledge). This section deals with basic requirements and building blocks of HIV, STI and TB education programmes for children, that is, **how** and **when** HIV, STIs and TB education in the school should take place and **by whom** it should be delivered. We further stress the point that all proper education should deal with three basic components: knowledge, attitudes/values and life skills.

Study	Prescribed book: pp. 253–258
	**Section 10.2: Basic requirements for Aids education.** Practice has shown that there are certain preferred ways of dealing with HIV, STI and TB education in schools. Exactly how should it be done? Who should be involved? Here is a convenient summary for you of all the basic requirements. Don't miss the Enrichment box on 'Life skills and life orientation as offered in South African Schools'.

	Section 10.3: Building blocks for successful HIV, STI and TB education. Pay special attention to how knowledge, but also values, norms, attitudes and skills, should be part of any good education programme. Note that we no longer only focus on HIV and Aids education in schools. Programmes should offer an integrated strategy on HIV, STIs and TB to present a holistic response for learners and educators in the school system.

As emphasised previously, when devising an HIV, STI and TB education programme, mere transferal of knowledge (content-driven education) it is not sufficient. Changing behaviour and attitudes should be the ultimate outcome or goal, and this can be achieved only with a holistic and integrated approach in which emotional impact, applicability, ethical aspects and skills all play an integral part.

MIDDLE CHILDHOOD AND HIV, STI AND TB EDUCATION

So far we have not paid any attention to how education programmes should be adapted to and made appropriate for the different development phases of children. As argued earlier, it is not appropriate to treat children (especially young ones) as if they have the cognitive, emotional, social and other abilities of an adult. Our next question is therefore: How does HIV, STI and TB education pan out in practice? In this section we deal with the middle childhood years, which include the two school phases known as the foundation school phase (6–9 years) and the intermediate school phase (10–12 years).

Study	**Prescribed book: pp. 258–283**
	**Section 10.4: The middle childhood years.** Ensure that you read this section with the intention of using it as the broader theoretical background to the next two sections (i.e. the foundation and intermediate school phases). Cognitive, emotional, social, moral, sexual and self-concept development in the middle-childhood years will be discussed, as well as the development of general skills. Give special attention to Jensen's cultural-developmental approach to moral psychology and her three types of ethics. Also study the section on 'Cultural differences in self-concept'. **Section 10.5: Aids education and life-skills training in the foundation phase.** Think about this section as the practical application of the theory of middle childhood years with regard to HIV, STI and TB education in the foundation phase. Ensure that you appreciate the fact that, in the foundation phase, children are still very young and limited in their abilities. This does not, however, imply that they should be kept in the dark about HIV, STIs and TB. **Section 10.6: Aids education and life-skills training in the intermediate phase.** Imagine Aids education as a ladder of increasing abstraction, more complex life skills and emotionally more demanding expectations. The intermediate phase is but the second step in the process. The challenge is to neither give too much, nor too little. Remember there are still two more steps to go.

Although there is a logical progression in complexity and abstraction from one development phase to the next, it may be useful to summarise the development phases and how they inform HIV, STI and TB education in a more visual way. In

the activity below, we suggest that you use a table to do this, but if you prefer you can also construct a mind map or use more visual techniques (pictures and graphics) to present the information.

ACTIVITY 10.1

A summary of middle childhood

This activity provides you with the opportunity to summarise the various aspects of the development of children in the middle childhood phase.

Foundation school phase

The following table is an example of how you can summarise the information about the development of children in the middle childhood years and how it impacts on HIV, STI and TB education in the foundation school phase. (Note that the table below provides only a minimum amount of information which you need to expand.) We suggest that you make your own table and include enough spaces to fill in all the necessary information.

Use your prescribed book to expand on the cryptic details in the table about middle childhood development (left column). Then, fill in more details of how these may influence children's perceptions about disease (second column) and how they should influence Aids education (third column).

Middle childhood development	**Foundation school phase**	
	Perceptions about illness	**Aids education**
Cognitive		
Egocentric	Group unrelated facts together – own subjective point of view	Concrete examples, e.g. not all thin men have Aids
Concrete	Focus on external	Concrete knowledge on how to avoid HIV infection, e.g. avoid blood
Inability to classify	No cause and effect No interest in symptoms	No specifics about causes, symptoms and prevention of HIV infection
Emotional		
Fear	Overwhelming fear: Feel vulnerable and helpless	Reassurance and eradication of irrational fears
Social		
Peer group influence	Friends influence perceptions	Reassurance and concrete knowledge
Prejudice	Association between similar people and similar diseases	Adults' own attitudes and manner of communication important
Moral		
Rules and punishment	See disease as punishment	HIV-positive people are not bad

Sexual		
Curiosity	Don't understand link between sex and STIs	No formal sex education, but answer questions and give practical advice on how to avoid molestation
Self-concept		Positive self-concept to make healthy life choices
General		Teach to help in small ways at home

Intermediate school phase

Use the skills you obtained by completing the table about the foundation phase and fill in as many details as possible in the table below. Please note that the intermediate school phase still falls within the middle childhood development phase. The left column will therefore be mostly the same as that in the table about the foundation phase. The information in columns 2 and 3 will, however, differ to some extent from that in the foundation phase, because the children are further developed in their cognitive, emotional and other abilities.

Middle childhood development	**Intermediate school phase**	
	Perceptions about illness	**Aids education**
Cognitive		
Egocentric		
Concrete		
Inability to classify		
Emotional		
Fear		
Social		
Peer group influence		
Prejudice		
Moral		
Rules and punishment		
Sexual		

Curiosity		
Self-concept		
General		

FEEDBACK 10.1

Isn't it fascinating to discover how children develop and how this influences their cognitive, emotional and social capabilities? This makes us realise that children are not small adults, but that their educational needs differ from those of adults. This is especially true when educating children about Aids.

Use these tables when you prepare for the examinations.

ADOLESCENT DEVELOPMENT AND HIV, STI AND TB EDUCATION

In the adolescent phase, children can increasingly **understand and handle** the social and emotional aspects of HIV, STIs and TB. Education will therefore focus more on causes, symptoms, prevention and ethical and moral aspects.

Study	**Prescribed book: pp. 283–291**
	**Section 10.7: The adolescent years.** Now we have reached the last two steps on the ladder towards a comprehensive Aids education. • It is in the adolescent years that the basis for scientific thinking and individualised moral principles should be established and a positive self-image built. • The development characteristics of the adolescent are discussed in terms of cognitive, emotional, moral, social, sexual, identity and self-concept development. • Give attention to cultural differences in the development of adolescents (e.g. development of the self and moral development.) • Make sure that you understand the behavioural and structural factors that make adolescents vulnerable to HIV ('Adolescents and HIV') The application of the developmental phases of adolescents to Aids education in the senior and further education phases is discussed in the next two sections. • STUDY TIP: Remember, the more you relate or associate facts with each other, the better you will remember them.

ACTIVITY 10.2

A summary of adolescence

Make a summary of development in the adolescent years.

Spend half an hour summarising the details of the adolescent years by filling in the tables below. You will be well rewarded in terms of understanding and remembering the details. You can also use the table later, when you devise an Aids education programme, to check that it is appropriate for the development phases of the children you may be teaching. (Adolescence can be divided into the senior school phase (first table) and further educational school phase (second table).

Senior school phase

Adolescent	**Senior school phase**	
	Perceptions about illness	**Aids education**
Cognitive		
Abstract/operational thinking		
Capacity for decision-making		
Scientific thinking		
Egocentricity (imaginary audience & personal fable)		
Emotional		
Anxiety, guilt, embarrassment		
Social		
Peer group important source of information		
Conformity		
Moral		
Personal value system Principled moral reasoning		
Sexual		
Large role in relationships		
Identity development and self-concept		

Further education school phase

Adolescent	**Further education school phase**	
	Perceptions about illness	**HIV and Aids education**
Cognitive		
Abstract/operational thinking		
Capacity for decision-making		

Scientific thinking		
Egocentricity (imaginary audience & personal fable)		
Emotional		
Anxiety, guilt, embarrassment		
Social		
Peer group important source of information		
Conformity		
Moral		
Personal value system Principled moral reasoning		
Sexual		
Large role in relationships		
Identity development and self-concept		

FEEDBACK 10.2

Use this table when you prepare for the examinations.

Study  	**Prescribed book: pp. 291–305** **Section 10.8: Aids education and life orientation in the senior phase.** Focus on how the older child has now developed. They now: have a more complex understanding of consequences expect a direct and frank approach, but not an overly abstract discussion about Aids have to deal with confusion and stress – it is the beginning of a turbulent period in the child's development can handle more complex and multi-dimensional teaching strategies **Section 10.9: Aids education and life orientation in the further education phase.** Make sure that you don't miss the enrichment block advising you how to use practical activities which will help learners to obtain knowledge and build attitudes and values. Did you grasp the important fact that adolescents in the further education phase now have the ability to plan ahead, which is often a deterrent to unsafe behaviour? Also make sure that you appreciate the role that conspiracy theories play at this stage.	

	Go to http://goo.gl/XhZbLz to watch a video on "Working with vulnerable adolescents in South Africa to prevent HIV/Aids infection". **Section 10.10: Learners living with HIV in school.** It is currently a national priority for the Departments of Health and Education to address the specific needs of perinatally HIV-infected adolescents (infected through MTCT) as well as the needs of adolescents who became infected through sex (behaviourally).	

General comment

In the adolescent years, Aids education becomes even more important because many children become sexually active during these years. In contrast to the middle childhood years, **sexual education is now of prime importance**.

Did you appreciate the fact that the cognitive abilities of adolescents have now reached the stage where the educator can increasingly talk about cause and effect and ways of prevention within a scientific framework? The fact that adolescents depend largely on their peer group for information is also an important consideration when devising adolescent education programmes. Wherever possible, peer group education should be part of an adolescent HIV, STI and TB education programme.

Did you know that The Child Care Act states that a girl child of 12 years or older may ask for oral contraceptives to prevent pregnancy without her parents' permission? And that a child over the age of 12 years can ask for condoms at a clinic or family planning centre without parental consent? Go to the website of the Department of Social Justice: http://goo.gl/vzCAlV and download the Children's Act (at the bottom of the page) to learn more about legal issues and children.

ACTIVITY 10.3

The children who "fall through the cracks"

Read the extract in Steinberg's book *Three-letter plague* (p 23) about children who "fall through the cracks". .

Read the following extract from Steinberg's book *Three-letter plague* (p. 23) and answer the questions that follow. This extract is about Sizwe's friend Jake:

> *It is into this life that Jake makes his entrance. He does not go to school, but he sometimes arrives outside Sizwe's classroom unannounced. He is there waiting when the school day ends. Jake and Sizwe*
>
> *spend the afternoons and the early evenings hunting for girls. Jake arrives at school prepared; he has done sufficient reconnaissance to keep them busy the rest of the day and night.*

This extract from the book makes us think about the children who don't go to school, who don't have the opportunity to learn about Aids in a formal education setting: the children in the rural areas, who have to work in the fields, or look after the goats and cattle; the children in our cities, living on the streets and sleeping on a piece of cardboard at night. What about all these children, the children who fall through the cracks of the education system?

See if you can identify an NGO working in your community with street children (e.g. the Red Cross, the Salvation Army). Phone them and make an appointment to go and visit them.

- Ask them about their programme: Where do they get funds? What services do they provide to the children (e.g. food, shelter, informal education)?
- Also ask them what they do in terms of Aids education.
- If at all possible, volunteer your services to help them with Aids education or to devise an education programme for them.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 10 (Aids education for school children), you should have acquired the following knowledge and understanding and be able to:

- implement the basic requirements and building blocks of any Aids education programme
- tabulate the different development phases and indicate how they should inform Aids education programmes

SELF-ASSESSMENT 10

Now is the time to pause briefly and assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

SELF-ASSESSMENT 10

QUESTION 1

What are the building blocks for successful Aids education?

1. Knowledge
2. Attitudes
3. Values
4. Skills
5. All of the above

QUESTION 2

Name five life skills that children should develop to help them to make the right choices in life.

QUESTION 3

Complete the following sentence: The young child, aged …….. may still use egocentric and …… thinking.

QUESTION 4

How do children in the foundation phase perceive illness?

QUESTION 5

Which age group is most prone to the acquisition of myths?

1. Adolescents
2. Between the ages of 7 and 8 years
3. Young adults in the FET phase
4. Between the ages of 10 and 12 years

QUESTION 6

Which factors, according to Thom et al. (2005), influence adolescents' moral development?

FEEDBACK 10

FEEDBACK QUESTION 1

The correct answer is alternative 5, namely "all of the above" which are: knowledge, attitudes, values and skills.

FEEDBACK QUESTION 2

The skills are: self-awareness, critical thinking, problem-solving, assertiveness and negotiation skills. (Note that there are many more skills listed in your prescribed book.)

FEEDBACK QUESTION 3

The sentence should read: The young child, aged ***six to seven years*** may still use egocentric and ***magical*** thinking.

FEEDBACK QUESTION 4

Children in the foundation phase do not really understand what illness is and they tend to focus on external, observable events.

FEEDBACK QUESTION 5

The correct answer is alternative 4. Children between 10 and 12 years are most prone to the acquisition of myths.

FEEDBACK QUESTION 6

The factors are: cognition, parental attitudes and actions, peer interaction and religion.

GLOSSARY

Multiple classification	Refers to the ability of a child to classify objects on the basis of more than one criterion simultaneously. Children usually develop the ability of multiple classification between the ages of 9 to 12 years old.
Hierarchical classification	Implies class inclusion – which means that a person has the ability to understand that a subclass is always smaller than the more general overall class in which the subclass is included. Children usually develop the ability of hierarchical classification between the ages of 9 to 12 years old.
Middle-childhood developmental phase	The middle childhood years stretch from about 5 or 7 years to 12 years. Children in the foundation school phase as well as in the intermediate school phase fall into this category (middle-childhood).
Adolescent development phase	The adolescent years stretch from about 12 or 13 years to about 18 or 19. Children in the senior school phase, as well as in the further education and training phase (FET), fall into this category (adolescence).
Foundation school phase	The grade 1 to grade 3 child (about 7 to 9 years old) is in the foundation school phase and is in the early stage of the middle childhood years.
Intermediate school phase	The grade 4 to grade 6 child (about 10 to 12 years old) is in the intermediate school phase and is in the later stage of the middle childhood years.
Senior school phase	The grade 7 to 9 adolescent (13 to 15 years old) is in the senior school phase and is in the early adolescent stage.
Further education school phase	The grade 10 to 12 adolescent (16 to 19 years old) is in the further education and training (FET) phase.

LEARNING UNIT 11

Aids education in traditional Africa

INTRODUCTION

Imagine living in a world where disease and ill fortune are not merely the result of random events, or exposure to natural disease-causing agents, but where the cold with which you woke up this morning was sent to you. Imagine it was willed by some magical or supernatural person, or brought down on you by somebody who knows you and is jealous and therefore used supernatural powers (witches) to send the germ to you in order to harm you. Never again would you be able to sleep soundly, knowing that you had taken all reasonable precautions to avoid illness and misfortune. No, there is another set of rules- different powers to which you can fall prey, more powerful than the mechanics suggested by Western science.

This is the world of ancestors, witches, demons and magic. It is a world that ultimately cannot be fought with Western medicine, or as suggested in the Aids field, by merely using condoms. It can be fought only by stronger counter-magic. Powerful magical means that can be attained only by consulting a diviner or traditional healer who can identify the ultimate (supernatural or religious) cause, and prescribe the correct medicine or ritual that will be able to counter the evil which has befallen you.

What is your **reaction** to the above passage? Are you sceptical or disbelieving? Do you think it may be biased in some way, or may be derogatory towards African culture? Or alternatively, do you think it may be a celebration of African culture and the acknowledgement that some traditional African communities may not yet have been "corrupted" by Western thought? How may your own beliefs and culture have influenced your reaction? These are all important factors that you should consider when doing this learning unit.

The following **indicators** may, however, guide you when you make up your mind:

- Various anthropological and scientific studies have strongly suggested that an alternative traditional African worldview does exist in Africa.
- This traditional African worldview is not necessarily shared by all Africans, but is more prevalent in traditional, non-Westernised communities.
- To deny the fact that traditional African communities may share a unique worldview may be an unacceptable form of cultural imperialism. The Western, non-magical worldview is not the only "acceptable" alternative.
- To assume that clients adhere to a specific worldview merely because they belong to a specific cultural group is a form of unacceptable stereotyping.

In view of the above statements, let's think further: How would you feel if another person questioned your traditional or religious views? For example, how would you react if somebody from outside your community were to come and tell you that all your religious beliefs were not true? That you should forget all of them and substitute them with a new set of totally different beliefs – beliefs of which you have little understanding and which fundamentally reject your own traditional or religious beliefs? Would you not find such a suggestion preposterous and, even if you kept quiet, would you not perhaps reject the notion in your heart?

These are the realities Western or Westernised Aids workers, working in traditional communities in Africa, have to deal with. It is never as simple as merely substituting traditional beliefs for a new set of Western beliefs, or merely telling a traditional community that they should use condoms. The purpose of this learning unit is to explain the worldview of traditional African communities and how such a worldview may complicate Aids education.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

How is illness perceived?

- How is sexuality perceived?
- How are condoms perceived?
- What is the importance of community life?
- Can traditional beliefs be used in Aids education?

KEY CONCEPTS

While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Ancestors	Immediate and ultimate causes
Witches and witchcraft	Polygamy
Zamani (Swahili word meaning past)	Ripening of foetus

Exotic cultural behaviour	Virginity testing

HOW IS ILLNESS PERCEIVED?

Jonny Steinberg's book *Three-letter plague* gives an account of how Aids influences a traditional community. It also deals with how illness is perceived: On page 15 the main character, **Sizwe**, explains his own belief of how he may have been infected with HIV:

"Some people have maybe sent a demon to have sex with me: a demon with HIV. That is why I am scared to test. I think I will test positive."

Later (p 26) in a conversation with the author, Sizwe also tells how his friend Jake became infected:

"How did you know it was Aids?" I asked. "The whole village thought his uncle had bewitched him", he replies, "Jake had money and could be generous. He (the uncle) was jealous. And the rash in the crotch – it is a common means of witchcraft. The jealous one slips the muthi into Jake's girlfriend's food. The next time Jake has sex with her, he gets the poison."

Yet another supernatural reason for the cause of disease (i.e. Aids) is given on page 65. Here Sizwe explains to Steinberg a ritual which he observed:

"It is a ritual for Simlindile's cousin," he explained. "He lives in East London. They have especially brought him back to Ithanga, to his ancestors, perform this ritual for him. They are slaughtering a goat up on the hill."

"What is the matter with him?"

"It is believed that the problem is his late wife. She died last year. No sacrifice was made for her after she died. He went on to a new wife, and made no sacrifice for his old wife. There is a belief that if no sacrifice is made for the dead one, her spirit remains trapped. She cannot go to the other world. She possesses her husband and makes him ill."

"What are his symptoms?" I asked.

"I saw him yesterday when he arrived. I know this man has Aids".

Now that you have seen in practice how traditional beliefs may impact on perceptions about diseases such as Aids, it is time to read the discussion in your prescribed book.

Study	**Prescribed book: pp. 310–320**	
	Study the following sections in your prescribed book: **Introduction:** This gives an interesting account of perceptions of where Aids may have started in Africa: Juliana's disease. **Section 11.1: Perceptions of illness.** Try to forget for a moment everything that you may know or believe about the causes of illness. Now submerge yourself in (or rediscover) a totally different set of traditional African beliefs with regard to the possible causes of disease:	

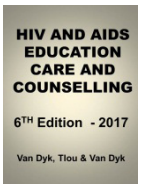
	Ancestors and God, witches and sorcerers, pollution and germs. Click on the link to watch a video on the cleansing rituals of traditional healers http://goo.gl/qDKV99 The important distinction between immediate and ultimate causes (Did you grasp the fact that everything, including diseases and misfortune, in the traditional African worldview, is ultimately related to the religious sphere, that is, attributed to supernatural causes?)	

It is so easy to assume that all people share the same beliefs about the origin of disease. As you can see, this is not necessarily the case. Often people living in traditional African communities do not share the logic assumed by Western medicine and do not share a belief in its underlying principles. This may seriously complicate Aids education.

It is not only illness that is perceived differently – sexuality is also a much more loaded concept in traditional Africa.

HOW IS SEXUALITY PERCEIVED?

What do you think about when you think about sex? It is probably safe to assume that sex means different things to different people. It is seldom seen as merely a mechanical act of procreation. In Africa, sex and sexuality are closely linked to personal immortality. Childlessness is seen as one of the most severe burdens a person can carry, while many children are seen as a blessing. Any call to use condoms or abstain from sex therefore runs into big problems in traditional African communities.

Study	**Prescribed book: pp. 320–323**
	Study the following sections in your prescribed book: **Section 11.2: Perceptions of sexuality.** Do we really understand the context of sexuality in traditional Africa? How much of what we believe is based on stereotyping and prejudice – specially about African masculinity? How important do you think issues are such as personal immortality and the fact that there must be children to help in the homestead and fields? The way in which sexuality is perceived in Africa has important implications for Aids education.

HOW ARE CONDOMS PERCEIVED?

Why are people from all cultures sometimes so reluctant to use **condoms**, especially if their lives may depend on it? This is the question asked again and again by Aids workers worldwide and also in Africa. The simple answer is: condoms are a bother to wear, not always readily available and may reduce the pleasure of the sexual act. But if this were the complete answer, condom campaigns would have been so much easier.

Condom usage is often complicated by urban legends such as the supposed ineffectiveness of condoms in preventing HIV transmission (a belief that is totally untrue!) and by some political conspiracy theories. But what makes pro-condom campaigns even more difficult in Africa are various deep-seated cultural and religious beliefs, taboos and logic, which are often poorly understood by Western or Westernised educators.

Study	Prescribed book: pp. 323–325
	Study the following sections in your prescribed book: **Section 11.3: Perceptions of condoms.** It is important to understand why condom use in traditional African communities is often problematic. Did you take note of the following? • Sex as the gift of oneself • Unfounded fears • The mistaken belief that the foetus needs a constant supply of semen to develop normally.

Although we have constantly advocated respect for traditional beliefs, it is nonetheless sometimes necessary to **challenge** harmful cultural beliefs if they are killing people.

ACTIVITY 11.1

Searching for lesser-known cultural beliefs

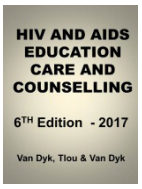
Search the internet for lesser-known cultural beliefs about sex and sexuality. Learn more about other cultural beliefs.

Although our focus in this learning unit is on traditional African beliefs about sex, it may interest you to search the internet for other lesser-known cultural beliefs about sex and sexuality in other traditional cultures. Google the words: "sex cultural beliefs" and link them to "Mediaeval Europe" or the "East" or any other traditional culture. Although it may not be possible for you to access all the sources that you find, it is nonetheless interesting to scan through all the many beliefs which often surround sex in traditional cultures.

IMPORTANCE OF COMMUNITY LIFE

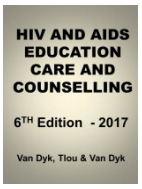
"Through others I am"

This is probably one of the best-known proverbs in Africa. It is considered extremely unhealthy not to be part of a community. Everything, even personal decisions, first needs to be discussed with the community. In South Africa this practice is called **ubuntu**. Click on the link **http://goo.gl/pVVdJT** to watch a video on Ubuntu. No Aids education programme in Africa can ignore the importance of the community and the role it plays in the everyday life of the African individual.

Study	Prescribed book: pp. 325–329	
	Study the following sections in your prescribed book: **Section 11.4: The importance of community life.** While reading this section, make a mental list of how Aids education, which focuses on the individual, may differ from education programmes in Africa, which should involve the community and which often need to use traditional healers as vehicles for change. Do you think that disclosure is still a problematic issue in Africa? Motivate your answer. Video on traditional healer at work. http://goo.gl/3ResVg	

HOW CAN TRADITIONAL BELIEFS BE USED?

One of the biggest challenges in Aids education in traditional African communities is how traditional beliefs can be used in prevention programmes without belittling the beliefs of others – even when you differ from them. Great wisdom is required in accepting positive and even exotic practices and using them in such a way that they can become powerful forces in our fight against Aids. The challenge is to devise more creative ways of bringing the Aids message, with the utmost respect, also to traditional communities.

Study	Prescribed book: pp. 330–334
	Study the following sections in your prescribed book: **Section 11.5: Using traditional beliefs in Aids education.** Cultural beliefs require Aids educators to be more creative and to consider various possibilities of how they can be helpful in conveying the all-important message of prevention. This will most often involve embracing positive and so-called exotic cultural practices and these should be challenged only when they are really harmful or potentially deadly. Songs play an important role in African culture as bearers of messages. How can songs be used as conveyers of the Aids message? How can technology be used to spread Aids health messages in Africa? Think of social media.

One example of where challenging culture may be essential concerns initiation rites which use the same spear (assegai) to circumcise all initiates. In such a case it is undesirable to challenge traditional circumcision as such, but you may, for example, try to persuade initiation schools to ask initiates to bring their own clean spears to the ceremony. Go to http://goo.gl/CJ4KFp to watch a video on circumcision in the Eastern Cape – Xhosa community

ACTIVITY 11.2

Consult focus groups about traditional African beliefs

Answer the questions about traditional African beliefs.

If you have access to and are trusted by a traditional African community, you may make an invaluable contribution by consulting various focus groups within the community about traditional African beliefs. Explain to them that you wish to consult them on possible ways in which existing cultural beliefs can be used in a positive way to convey the message of HIV prevention more effectively. Identifying positive ways in which tradition can be used may really make a big contribution in this field.

Try to answer the following questions:

Which existing beliefs have the potential to be used in the Aids field?

- How widespread are they?
- Exactly how can they be used to prevent HIV transmission? Are they compatible with scientific findings about HIV transmission? (Please note: Many suggestions may be interesting, but may have no real positive effect on preventing transmission.)
- How acceptable will such traditional solutions be to community leaders, traditional healers and members of the community?

You are welcome to blog about interesting cultural beliefs that you read/hear about. Please remember that you should be respectful and not judgemental.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 11 (Aids education in traditional Africa), you should have acquired the following knowledge and understanding and be able to:

- appreciate the unique worldview which is shared by many traditional African communities and which may differ from a Western worldview.
- agree with the fact that differences between cultures should be acknowledged and respected in Aids education and counselling.
- take traditional African beliefs and customs into account in Aids education or counselling.

SELF-ASSESSMENT 11

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

SELF-ASSESSMENT 11

QUESTION 1

Research shows that condoms are not very popular everywhere in Africa, despite an increased awareness and knowledge of Aids. Which one of the following is the reason for resistance to condom use in Rwanda?

1. Ignorance about HIV and Aids.
2. Political conspiracy theories about condoms in Rwanda.
3. Cultural beliefs of Rwandans about condoms.
4. The belief that condoms are not effective.

QUESTION 2

According to some African Christians, Aids is seen as:

1. punishment meted out by the ancestors.
2. God's punishment for immorality and sins.
3. being caused by witchcraft.
4. being caused by sorcerers.

QUESTION 3

Which of the following represents an African perception of sexuality?

1. Sex not only serves a biological function in African societies. Sex also conquers death and symbolises immortality.
2. Sex is part of life.
3. Sex is taboo.
4. Sex means different things to different people.

FEEDBACK 11

FEEDBACK QUESTION 1

The correct answer is "cultural beliefs of Rwandans about condoms". They believe that condoms prevent fertility and also that they cause all sorts of illness (alternative 3).

FEEDBACK QUESTION 2

The correct answer is "God's punishment for immorality and sins" (alternative 2).

FEEDBACK QUESTION 3

The correct answer is "Sex not only serves a biological function in African societies. Sex also conquers death and symbolises immortality" (alternative 1).

GLOSSARY

Polygamy	Plural marriage or the practice of having more than one spouse at one time. “Polygyny” is the specific term used for having more than one wife (as mostly occurs in the African context), whilst “polyandry” refers to a situation where a wife has more than one husband.
Immediate and ultimate causes	The term “immediate causes” usually refers to natural causes, whereas the term “ultimate causes” usually refers to supernatural causes. Supernatural causes may include the action of God, ancestors, or magic.
Witches and witchcraft	Witches and witchcraft are often seen as causes of illness and mishaps in some traditional African communities.
Ancestors	Ancestors are those who came before us and who are deceased. Ancestors play a very important role in the daily lives of many traditional Africans and they are usually seen as benevolent spirits.
Virginity testing	Virginity testing is a traditional practice usually carried out on girls. Various methods are used to test if a girl is still a virgin. Gender activists believe that virginity testing is a violation of human rights. (More on this in Chapter 22 in your prescribed book.)

THEME 3

HIV Counselling

Students often cannot wait to start learning about counselling. Well, you have reached that point now. Allow yourself enough time to master the skills that we provide in Theme 3–there are many people living with HIV and Aids who need your help.

We will approach this part by looking at the expectations and the counselling needs of our clients. The expectations and needs that will emerge can be translated into the following basic questions:

- What can I as a client expect from my counsellor in general?
- What will happen to me during pre- and post-HIV test counselling?
- What counselling support can I expect with special problems such as disclosure, stress management or depression?
- How can my counsellor assist me if my disease progresses and when I need drug treatment?
- What if I have a crisis?
- How will my need for bereavement and spiritual counselling be taken care of?

Counselling entails more than giving psychological support and may cover any of the following areas:

Medical: HIV and Aids knowledge, transmission and prevention of HIV, testing for HIV, symptoms, treatments and ARVs;

Personal and emotional: feelings of isolation and rejection, anxiety and stress, religious and faith problems, suicidal thoughts and problems with body image;

Relationships: partners (sexual), family, friends, employer and colleagues, school;

Practical: referral procedures, finances, accommodation, legal, schooling, funeral and wills.

Some of the counselling needs mentioned above have already been taken care of in themes 1 and 2. We will try to address the rest of the counselling needs of our clients in the next five learning units.

LEARNING UNIT 12

Counselling principles and skills

INTRODUCTION

If I were to ask you why you are doing this course, or why you want to be an HIV and Aids counsellor, what would you say? Most of you would say that you want to help other people because you care about them. If this is your answer, you already comply with the first important requirement of being a counsellor, namely to have *compassion* for another person's struggle to live beyond the confines of Aids. If you also have the *willingness* and the *commitment* to walk the walk with this person and their loved ones, you already have a good foundation to build your counselling skills on. This learning unit will assist you to understand better what counselling entails.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- What is counselling?
- What does the counselling process entail?
- What are the characteristics of an ideal counsellor?
- What counselling skills do I need?
- What counselling skills do I need in Africa?

KEY CONCEPTS

While working your way through this learning unit, look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used (or look up their definitions in the glossary):

Counselling	Confidentiality
Problem solving model	SOLER skills
Congruence	Attending
Genuineness	Empathy
Probing	Respect
Self-disclosure	Referral skills

WHAT IS COUNSELLING?

Before we talk about what the definition and aims of counselling are, first look at your own expectation of counselling by doing the activity below.

ACTIVITY 12.1

What I want my counsellor to do for me

This Activity 12.1 will give you the opportunity to reflect on a problem you have and to think about what you expect from a counsellor.

Think of a problem in your life that you might want to discuss with a counsellor. This problem might be a relationship problem (e.g. with a partner, your parents or with your child), a financial problem (you battle to pay all your bills at the end of the month), a health problem (you are afraid that you are infected with HIV), a behavioural problem (you want to stop smoking) or any other type of problem that you have. Write this problem down. Imagine yourself discussing this problem with a counsellor. Now reflect on what you expect from this counsellor. Start with "I want my counsellor to …". (You are welcome to blog your expectations of the counsellor.)

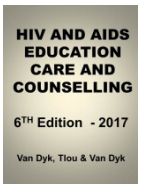
FEEDBACK 12.1

The role of a counsellor is not to tell you what to do or to solve your problems for you. The counsellor will help you to manage your own problems.

Are your expectations of a counsellor realistic if you compare them with what you have read in the prescribed book (or what your peers have shared on the blog)? Do you understand that the role of a counsellor is not to tell you what to do (or to give advice), or to solve your problems for you? The role of the counsellor is to:

- help clients manage their own problems
- guide them to make constructive changes in their lives
- empower them to be more effective self-helpers in their everyday lives.

Let's go to the prescribed book to learn more about what counselling entails.

Study	Prescribed book: p. 342–344
	**Section 12.1: What is counselling?** Write your own definition of counselling after reading this section. Does your definition mention that counselling is a facilitative process in which the counsellor uses specific skills to assist clients to understand themselves better, to help themselves, and to discover ways to better manage their problems in future? In this section we will also look at the purpose of counselling as well as at what can be expected from the counsellor (the role of the counsellor). Focus on the second issue by drawing a table with two columns. In the left-hand column, write down the things that you would expect from your counsellor. In the right-hand column, note the things that should not be expected from a counsellor. Look at the 'Counselling house metaphor' in Figure 12.1 and keep this metaphor in mind when you work through this chapter.

ACTIVITY 12.2

What counselling is and isn't

After considering your expectations of a counsellor, let's also revise what counselling is and what it isn't by doing Activity 12.2.

Draw the following table.

Counselling is …	Counselling isn't …

Read through the following list and place every word or sentence in one of the two columns in the table above. Don't use your prescribed book when you do this activity – trust your intuition.

Listening	Caring
Problem-solving	Spoon feeding
Listening	Caring
Telling someone what to do	Demanding
Helping	Counsellor is in charge
Giving information	Interfering
Client is in charge	Understanding
Giving advice	Judgemental
Sharing	Giving advice
Reflective teaching	Critical Based on trust

Accepting	Social work
Open-minded	Helping person to sort out their own problems
Skilled	Imposing
Only done by professionals	Taking action by counsellor
Genuine	Deal only with facts
Confidential	Based on trust
Supportive	Deal with feelings and facts
"Do-gooding" (to make counsellor feel better)	

FEEDBACK 12.2

What interests me is in which column you placed "giving information". Most books on counselling will tell you that "giving information" has no place in counselling. But is this true in the HIV and Aids context where clients often need information (e.g. how to use condoms, how to take ARVs or the symptoms of TB)? The magic answer is *how* to give information without giving advice!

You probably had no problems at all completing your columns. The words that belonged in the "counselling isn't" column are: Telling someone what to do, giving advice, teaching, social work, imposing, "do-gooding" (it seldom has the client's needs in mind), spoon feeding, interfering, judgmental, critical, taking action by the counsellor, and deal only with facts. Counselling is also not done only by professionals, but by lay people with proper training in counselling.

THE COUNSELLOR

You now have a better idea of what counselling is. This is an opportune time to consider the counsellor.

ACTIVITY 12.3

My Ideal counsellor

What do you personally expect from a counsellor? Share your ideas.

In activity 12.1, you reflected on what you expect from your counsellor. I want you to think about your counsellor's characteristics. With what type of person are you prepared to share the intimate details of your life? Write down your ideal counsellor's characteristics. Start with "My counsellor should …" (blog- your characteristics of the ideal counsellor).

FEEDBACK 12.3

We all have different needs and expectations. What I want in a counsellor is for him or her to respect me and to listen to me.

I personally would go to a counsellor who respects me, who listens to my story and shows real interest in it, who doesn't judge me, who assures me of confidentiality, and who is genuine or real. I also prefer a counsellor with a sense of humour and one who allows me to be myself (and this is a challenge for my counsellor!

Let's go to the prescribed book to compare your ideal counsellor with the values, ethics and attitudes described there.

Study	Prescribed book: pp. 344–349
	**Section 12.2: The counsellor's values, ethics and attitudes.** Underline all the words that describe a good counsellor. Think of a counsellor or person you know with each of these characteristics. Explain the ADDRESSING model that can be used to develop counsellors' competence in ethnic and cultural diversity.

In the next section, we will look at the counselling process.

THE COUNSELLING PROCESS

If you look back at your definition of counselling, you will see that we defined counselling as a *facilitative* process. This means that counsellors only facilitate the change in clients – the real hard work must be done by the clients themselves. Let's go to your prescribed book to learn more about the counselling process. (Don't miss the counselling house in your prescribed book. You can even draw your own house and fill in the process of counselling in the foundation (the four fundamental questions), the four flours (the four phases of counselling and the skills required), and the roof (the counsellor's values, ethics and attitudes).

Study	Prescribed book: pp. 349–361	
	**Section 12.3: The four fundamental questions of counselling.** Apply the four fundamental questions of counselling to your own life by doing the activity at the end of Section 12.3 in your prescribed book. **Section 12.4: The four phases of counselling.** The "bad" news about counselling is that it does not have a recipe because no two clients are the same. Their problems differ, their reactions to these problems differ and a solution that will work for one person will not necessarily work for another. I do, however, have a bit of good news about counselling, and that is that we can provide you with a map that you can use to guide you on your counselling road. This map (or counselling process) consists of four phases. You will learn all about the four phases of counselling in your prescribed book. Watch a video on the counselling process: http://goo.gl/y552Dr–it is a bit boring, but it does illustrate the process well.	

	The problem-solving model: Go to the Enrichment box 'The problem-solving model' in your prescribed book. Counsellors often find this seven-stage problem-solving model useful in their work. To see how it works, you can apply this model to your problem as stated in activity 12.1. Don't miss the section on termination of the counselling session at the end of Section 12.4. Lay counsellors, in particular, often battle with the question of how to terminate a session with a client.	

COUNSELLING SKILLS

Go to your prescribed book to learn more about counselling skills.

Study 	**Prescribed book: pp. 361–375** **Section 12.5: Basic communication skills.** Since counselling is a conversation or a dialogue between you and your client, you need certain communication skills. Read carefully through the communication skills as discussed in this section and practice them this week on your family and friends. Click on this video link to watch a video on counselling skills: http://goo.gl/DEsTP6 **Section 12.6: Advanced communication skills.** It takes a lot of practice to get the advanced communication skills right because you have to "challenge" your client to talk about what is hidden or repressed. These skills are usually practised in practical counselling classes, but reading about them will give you a good idea of what is expected. Make summaries and think of one example that illustrates the following advanced counselling skills: • Advanced empathy • Immediacy • Helper self-disclosure • Information sharing, suggestions and recommendations. **Section 12.7: Referral skills.** After reading this section you should know exactly what it means to refer a client, and also how to refer a client. Watch a video on referral skills: http://goo.gl/fc7wJh **Section 12.8: Record keeping.** This section provides helpful tips on how to keep records of your clients. **Section 12.9: Supervision**. This section provides a very brief introduction to supervision.	 

ACTIVITY 12.4

Basic communication skills

Practice your counselling skills on your friends and family this week.

Apply your knowledge about communication skills by practising them on your family and friends:

Attending: Write the letters S O L E R one below the other and next to each letter write the meaning of that letter. Invite your partner for a cup of coffee and ask about his or her day. Practise your SOLER skills while listening to your partner.

- **Listening:** Write down the four skills of listening. Now do the activity in your prescribed book where you have to listen to a favourite song. Do you also appreciate listening in a whole new light? Your song consists not only of content, but also of emotion and some unsaid messages.
- **Roadblocks to effective listening**: Which one or more of these roadblocks stand in the way of your communication with your loved ones? My roadblock is that I often don't wait for the person's full stop before I respond (jump-the-gun listening)! What is your "red-flag" that you need to be aware of? Write it down or blog about it.
- **Basic empathy:** Practise the skills of basic empathy on your partner this week. If he or she is cross with you, don't attack by starting your sentence with: "You are horrible to me …" Rather say: "I sense that you're feeling cross with me…" The reaction might surprise you. When you know the difference between sympathy and empathy, write an example of each.
- **The use of silence**: Be acutely aware of all your conversations with colleagues this week. Listen for silence and be aware of your reactions to it. Note if the use of silence was comfortable and necessary, or uncomfortable and judgemental. Many people talk so much that they do not use silence appropriately.
- **Probing or questioning:** Practise the use of open-ended and closed questions on your children this week. Note the different answers. Teenagers might, of course, still give you one-syllable answers to open questions ;-).
- **Clarification, reflective commenting and summarising:** These communication skills are very helpful in the counselling context and we can also use them in our day-to-day communication with others. If someone tells you a story this week, practise clarification and also reflective commenting (or paraphrasing). See how surprised this person is by your good listening skills!

FEEDBACK 12.4

This is a bit of a fun exercise, but please note that it is not advisable to counsel your loved ones. It is hard to be objective when you are intimately involved in another person's life.

At this stage of your studies, you probably have a very good *theoretical* knowledge of counselling. But to counsel other people you also need *practical* experience. Empower yourself by enrolling for a practical counselling skills course or workshop. Contact your local LifeLine branch and enquire about training opportunities. LifeLine courses are usually very good and are offered at reasonable prices. You are also welcome to contact the Unisa Centre for Applied Psychology (ucap@unisa.ac.za or 012-429 8544) to enquire about their HIV/Aids practical counselling skills workshop (Module 2) after you have successfully completed this module.

Practice some of the counselling or communication skills that you have learnt by doing the activity below.

ACTIVITY 12.5

Empathic responding

In this activity you are going to practice your skills to reflect feelings and to paraphrase or reflect what a client has said.

In the following exercise you are going to practise your skills to reflect feeling and to paraphrase or reflect what a client has said. Imagine that you are listening to each of the people quoted below. Try to communicate to each person an accurate understanding of their feelings. Then paraphrase what the person has said by writing it down.

(1) "I've been retrenched from my job because I can no longer cope with it after my HIV diagnosis. I don't know what to do. I've been everywhere looking for work and nobody wants to help me. Please, can you tell me what to do?"

(a) How would you reflect feeling? Start with: "You feel …"
(b) How would you paraphrase this statement? ……

(2) "My husband has a lot of girlfriends and there's nothing I can do about it. I mean, you know what men are like, and you just have to accept it. But when I try to talk to him about condoms he beats me up – I want to lay charges against him, I've had enough."

(a) How would you reflect feeling? Start with: "You feel …"
(b) How would you paraphrase this statement? ……

(3) "I met this guy at a club, and we had sex. We should have used a condom, but you know how it is, I mean the condoms were right there, but in the heat of the moment I felt it would be OK. Well, now he tells me he is HIV positive and I am ready to kill him. But how could I have done it? I know better!"

(a) How would you reflect feeling? Start with: "You feel …"
(b) How would you paraphrase this statement? ……

(4) "My wife died of Aids last year, and this year my youngest son went away to university. The other children are married. So now that I'm retired, I spend a lot of time rambling around a house that's really too big for me."

(a) How would you reflect feeling? Start with: "You feel …"
(b) How would you paraphrase this statement? ……

(5) "I want to buy a house and I've approach a bank. Apparently the bank would like life cover but I know I'm HIV positive, I found out three weeks ago. I feel as if I'll never be able to own my own house."

(a) How would you reflect feeling? Start with: "You feel …"
(b) How would you paraphrase this statement? …….

FEEDBACK 12.5

It is often very hard to reflect on a client's feelings. I hope that this activity will make it a bit easier.

In the next section, you will apply what you have learnt about counselling to the traditional African context.

Was it hard for you to reflect your client's feelings? We often have a very limited "feelings vocabulary". A good exercise to do to improve your feelings vocabulary is to take a dictionary and write down all the "feelings" words. For example:

A: abandoned, accepted, aching, accused, adventurous, affectionate, agony, alienated, aloof, aggravated, agreeable, aggressive, alive, alone, alluring, amazed, amused, angry, anguished, annoyed, anxious, apart, apologetic, appreciative, apprehensive, approved, argumentative, aroused, astonished, assertive, attached, attentive, attractive, aware, awestruck, awful.

And these are only the feelings words starting with an A! Now do the same for the rest of the alphabet.

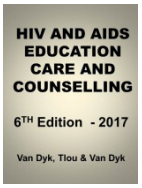
When you paraphrased the clients' statements, did you:

- *listen* to the feelings behind the words?
- include not only the content of what the client said, but also the feelings?
- reflect what the client said in such a way that it facilitated an atmosphere of understanding?
- refrain from being judgmental, giving sympathy, taking sides and giving advice?
- prompt the client to tell you a bit more?

The reason for paraphrasing is to check if you have understood what the client has said. It also helps the client to clarify for themselves what they are thinking and feeling when they hear you accurately paraphrase what they have just said. A paraphrase often brings up new thoughts and feelings that can be explored further. In effect, a good paraphrase says: "I'm with you".

COUNSELLING SKILLS IN AFRICA

In Learning Unit 11 you became familiar with the way traditional African people perceive health and illness. The traditional African worldview has implications for the way we do counselling. In this section you will see how the counselling skills of attending, listening, probing and empathy can be adjusted to accommodate the needs of traditional African clients.

Study	Prescribed book: pp. 377–390
	**Section 12.10: Counselling in Africa.** Read and make a summary of the following: • The African perspective on health, illness and healing. • A philosophy of holism. • Similarities and differences in counselling contexts. • An integrative approach to Aids counselling. • The person-centred approach in Africa.
	• Practical guidelines in multi-cultural counselling. • Counselling families in the African context. • Language barriers.

For the following activity I need you to take everything that you have learnt in this learning unit into account, with particular emphasis on counselling in a traditional African context.

ACTIVITY 12.6

What Sizwe had to say about ARV counsellors

You will be very interested to find out what some people in our communities think of ARV counsellors.

Read what Sizwe had to say about the ARV counsellors in the Activity box 'Sizwe on the ARV counsellors' in your prescribed book (from *Three-letter plague*, p 32) and answer the questions that follow:

In what way (if at all) did the counsellors show openness, respect and empathy for their clients' needs?

- In what way did the counsellors take the traditional African worldview into account? (Think of traditional group customs, the role of secrecy, the role of disclosure, the influence of age and gender in a community, etc.)
- Sizwe saw the counsellors' self-disclosure ("see how healthy we are") as preaching. What should the counsellors have done to bring the same message without it being perceived as "the preaching of a cult"?
- What could the counsellors do to change their tactics from "giving advice" to giving clients all the options and the chance to decide for themselves what to do?
- In all fairness to the counsellors, consider how the important message of testing and ARVs can be brought to a community where it is not always practical to do individual counselling.

FEEDBACK 12.6

Counsellors should be very sensitive about the perceptions of their work in the communities they work in. Counsellors may have the intention of doing good, but is it always perceived like that by people on the receiving end of the counselling?

You are probably going to think about Sizwe's feelings and thoughts about the ARV counsellors in Ithanga for a long time to come. Although it is heart-warming to see that counsellors have so much enthusiasm for their course, it also is an eye opener that such enthusiasm is not necessarily well received in the community.

With your background information of what good counselling entails, what do you think went wrong for Sizwe?

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 12 (counselling principles and skills), you should have acquired the following knowledge and understanding and be able to:

- draw a picture in which you explain the four fundamental questions of counselling as well as the four phases.
- engage in a role-play situation where you practise the following communication skills:
- attending
- listening
- empathising
- probing
- paraphrasing
- summarising

SELF-ASSESSMENT 12

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

SELF-ASSESSMENT 12

QUESTION 1

Counselling consist of four phases, which phase below is the first phase?

1. Helping the client tell his or her story
2. Developing understanding of the problem
3. Relationship building
4. Intervention or action

QUESTION 2

What is another name for reflective commenting in counselling?

1. Summarising
2. Paraphrasing
3. Clarifying
4. Integrating

QUESTION 3

Complete the following sentence: SOLER is the acronym that summarises the ……..used by counsellors when attending to their clients.

1. Listening skills
2. Verbal skills
3. Probing skills
4. Non-verbal skills

QUESTION 4

Define the term "immediacy."

QUESTION 5

What is attending skills?

FEEDBACK SELF-ASSESSMENT 12

FEEDBACK QUESTION 1

The correct answer is Alternative 3. Relationship building.

FEEDBACK QUESTION 2

The correct answer is Alternative 2. Paraphrasing.

FEEDBACK QUESTION 3

The correct answer is Alternative 4. Non-verbal skills.

FEEDBACK QUESTION 4

Immediacy is the skill of communicating what is happening in the counselling relationship while it is happening.

FEEDBACK QUESTION 5

"Attending skills" refers to the ways in which counsellors can be with their clients both physically and psychologically.

GLOSSARY

Attending	A basic communication skill in counselling. This term refers to the way in which counsellors can be "with" their clients, both physically and psychologically. Effective attending communicates to clients that they can share information about their worlds with you.

Confidentiality	Not to disclose any information, such as HIV status, to anyone under any circumstances, without the express permission of the client.
Counselling	A facilitative process in which the counsellor, working within the framework of a special helping relationship, uses specific skills to assist clients to develop self-knowledge, emotional acceptance, emotional growth and personal resources.
Congruence (or genuineness)	This refers to a counsellor's attitudes to and behaviour with clients, e.g. being honest, transparent and authentic in the counselling relationship. According to psychologist Carl Rogers, there should be a match between a person's behaviour (or presentation) and his/her inner experiences.
Empathy	The ability of a counsellor to set aside his or her own frame of reference in order to see the world from the client's point of view — it is an attempt to understand the world of the client by temporarily "stepping into his or her shoes".
Probing	A counselling technique involving statements, questions and interjections from the counsellor. It enables clients to explore their life stories and problems more fully.
Problem-solving skills (Problem-solving model)	Refers to understanding the problem; discussing alternatives and possible solutions to the problem through brain-storming; exploring the consequences of all alternatives discussed; deciding on the best option; looking at how to go about doing it; and taking action.
Respect	An attitude in counselling that portrays the belief that each client is a worthy being who is competent to decide what he or she really wants, has the potential for growth, and has the ability to achieve what he or she really wants from life.
Referral skills	The process of sending a client to another professional or organisation for specialised help. Referral should not be used to "pass the buck" but should be seen as co-opting of additional helpers into the counselling process.
Self-disclosure	This literally means to "disclose yourself to another person". It refers to the ability of the counsellor to share with the client, in an appropriate and constructive manner, information about his or her own feelings, experiences or behaviour.
SOLER skills	These are non-verbal skills that are used by counsellors when attending to their clients to show their inner attitude and values of respect and genuineness.

LEARNING UNIT 13

HIV counselling and testing

INTRODUCTION

Do you remember Sizwe's story about testing day in Ithanga when he said "to know who was positive and who was negative, you just had to stand and watch. If the counselling after the test takes a long, long time – then you know"? He also said that what he learnt from testing day was that "I must never test for HIV in my own village".

In this learning unit we will talk about HIV test counselling and together we will explore ways in which it can be done to accommodate communities like Sizwe's in such a way that people feel safe to be tested.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- What is the difference between client-initiated and provider-initiated counselling and testing?
- What is pre-HIV test counselling?
- What is post-HIV test counselling?
- What is my personal experience of HIV testing?

KEY CONCEPTS

Look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used.

Pre-HIV test counselling	Post-HIV test counselling
Informed consent	Inconclusive test result
Shared confidentiality	Client-initiated counselling and testing (CICT)
Provider-initiated counselling and testing (PICT)	

HIV COUNSELLING AND TESTING – GENERAL ASPECTS

Before we introduce pre- and post-HIV test counselling, it is necessary to look at the legal and ethical aspects around HIV testing. We will also highlight the differences between client- and provider-initiated counselling and testing.

Study		
	**Prescribed book: pp. 396–398** **Section 13.1: Legal and ethical aspects.** Do you know what the five C's are? **Section 13.2: Approaches to HIV counselling and testing.** Make sure that you know the two different approaches to HIV counselling and testing used in South Africa. What are the advantages and disadvantages of each approach? **Section 13.3: The counselling process.** Click on the link http://goo.gl/Fn3GkV to see what South Africa's position is on HIV counselling and testing.	

ACTIVITY 13.1

Discussions about public versus human rights

HIV and Aids lends itself to many public debates. Participate in debates about public versus human rights.

Prepare yourself for the following debates and write down your opinions. Talk to as many people as possible about the issues concerning public versus human rights. Share your opinions with them, but also listen respectfully to their opinions.

(1) Is it possible to ensure human rights, informed consent and confidentiality when *provider initiated* testing and counselling is offered? How can this be done?
(2) If health facilities rely solely on *clients to initiate counselling and testing*, are we not missing many opportunities to diagnose and counsel individuals?
(3) If the *provider initiated* test process is followed, how will informed consent be achieved when people are tested unless they specifically decline the test?
(4) Do people in vulnerable positions – such as prisoners – really have a choice to opt out and refuse testing if it is offered as a matter of course in prisons (*provider initiated testing*)?
(5) If health facilities rely on *provider initiated* testing, what happens to people who do not use formal health services and will never be offered an HIV test? An example is people living in rural areas who are poorly served by the health system, mobile populations and vulnerable communities such as sex workers or drug users who often face stigma and discrimination in health settings.

FEEDBACK 13.1

Did you listen to and respect the viewpoint of other people?

How did the discussion go? Did it end up in huge differences of opinion, or did you agree on most issues? It is important to debate issues like these because it stimulates our thinking and we get new insights by listening to the viewpoints of other people.

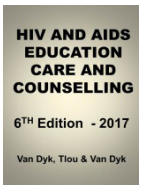
PRE-HIV TEST COUNSELLING

HIV test counselling can be divided into two parts:

- Pre-HIV test counselling (counselling before the test is done)
- Post-HIV test counselling (where the result of the test is shared with the client)

In this section we will discuss **pre-HIV test counselling**. The purpose of this counselling is to give someone who is thinking about being tested for HIV all the necessary information and support to make an informed decision.

Go to your prescribed book and read the sections as indicated. Imagine that you are the client who is thinking about being tested for HIV when you work through the relevant sections in the prescribed book, and write down how you would feel if counselling was done this way.

Study	**Prescribed book: pp. 398–406**
	Introduction paragraph. HIV test counselling is one of the application fields of counselling. This means that you will now get the opportunity to use all the counselling skills that you have acquired so far (e.g. attending, listening, empathy, giving information) by applying them to the HIV testing context. We can say that the HIV test becomes the presenting problem for the client.

	Section 13.4: Pre-HIV test counselling. Read the purpose of pre-HIV test counselling and familiarise yourself with the following guidelines: • Relationship building. Reflect on the following questions: How easy would it be for you to share intimate details of your life with a counsellor? How would you prefer the counsellor to approach you? • Confidentiality. What must the counsellor do to assure you of confidentiality? • Reasons for testing. Explore the reason/s why you would consider HIV testing. Now read about all the other reasons why clients might consider testing. • Assessment of risk. Consider the following questions: Why do you think it is important for the counsellor to ask a client about their risk factors for HIV? How would you feel if the counsellor asked you questions about your sex life? Can you appreciate why he or she needs to know this about you? • Beliefs and knowledge about HIV infection and safer sex. Why is it important for counsellors to make sure that their clients have the correct information about HIV and Aids? • Information about the test. After reading this section, consider if you personally would feel more reassured to take the HIV tests if the counsellor shared this information with you. • The implications of an HIV test. Make a list of all the possible advantages and disadvantages that taking an HIV test may have for you personally. Now read the advantages and disadvantages mentioned in the prescribed book and add to your list. Do you think the advantages outweigh the disadvantages, or does it depend on the circumstances of the individual? Give reasons for your answer. • Anticipate the results. Try to answer each one of the questions in the prescribed book honestly, for example: How would you feel if you tested positive? Who would you tell? • Giving the results and ongoing support. An important part of counselling is telling clients when and how the results will be given to them and what they should do afterwards. Who would you personally approach for support? • Informed consent. What is meant by "informed" consent, and why is it so important to get informed consent before an HIV test is done? How would you feel if a test were to be done on you without anybody asking your consent first?

Some videos:

To watch a video on the effect of a home-based HIV counselling and testing intervention in rural South Africa, go to http://goo.gl/58vOr4.	
Go to http://goo.gl/KKySFc to learn more about HIV counselling and testing in Kenya.	

Let's go back to **Sizwe's experience** of counselling. A special testing day was held in Sizwe's village, and everybody in the community knew exactly who went for the

test and who did not. Focus on this aspect when you do the next activity. (See Sizwe's story on page 279 in your prescribed book.)

ACTIVITY 13.2

Sizwe's experiences with HIV testing

Read about Sizwe's experiences with HIV testing. Answer the questions that follow this activity.

After reading about Sizwe's experiences of counselling in the village where he lives (Enrichment box: Testing day in Ithanga in your prescribed book), answer the following questions:

(1) Were you ever part of a testing day where HIV testing was offered on a grand scale to everybody in your community? If the answer is "yes", were you part of the counselling and testing team, or were you a potential client? Think back to your experiences and feelings of that day. Can you empathise with Sizwe's feelings, or were your experiences different from his?
(2) If you were given the task of organising a testing day in a community like Sizwe's, how would you do it to take the concerns of people like Sizwe into account? Make suggestions as to what changes you would make (if any) to improve testing days in communities.
(3) If you have been tested for HIV in the past, consider how well the pre-test counselling was done. Take each one of the aspects of pre-HIV test counselling as discussed in your prescribed book (section 13.4) and write a critical evaluation of your own experience of pre-test counselling. For example:

- Did the counsellor rush to get the test over and done with?
- Did the counsellor take the time to build a trusting relationship with you? If so, what did he or she do?
- How was confidentiality established, and did you feel that you could trust your counsellor?
- How sensitive was the counsellor about your reasons for testing?

FEEDBACK 13.2

I hope that this story will sensitise you to the challenges and needs of rural communities.

Have your considered the following in your answers?

- Perceptions are unique and no two people will ever experience a specific event (like testing day in Ithanga) the same.
- Health budgets are often very restricted and testing days are more cost effective.
- It is much more sustainable to open a permanent clinic where people can go whenever they need to do so for health services (including HIV testing).
- Testing days increase the visibility of Aids in a community and almost "normalise" the situation – if they are done often enough people will start seeing HIV infection as they do any other manageable disease.
- HIV and Aids will never be accepted as a "normal" disease due to the stigma attached to it and HIV testing should be a private matter.

- Testing days should perhaps concentrate on more than just HIV – they should rather be wellness days where people are tested for and educated about a variety of diseases such as diabetes, high cholesterol and high blood pressure.

POST-HIV TEST COUNSELLING

Post-HIV test counselling is counselling after the **test result** is known. How post-HIV test counselling is done depends on the outcome or the results of the test. The outcome can be negative (the counsellor's dream!), positive or inconclusive. Go to the prescribed book to consider how counselling is done for each one of these outcomes. But before you do, I want you to do activity 13.3 where you will get the opportunity to evaluate the various ways counsellors give clients their HIV results.

ACTIVITY 13.3

"Congratulations, you are HIV negative!"

Imagine you are a supervisor in an HIV clinic who sits in on sessions where the counsellors give HIV results. Evaluate the counsellors' communication with their clients.

To compare your responses in Activity 13.3 with the theoretical principles of post-test counselling, turn to the prescribed book.

Imagine you are a supervisor in an HIV clinic who sits in on sessions (with the informed consent of clients) where the counsellors give HIV results. Listen to the way the following counsellors break the news to their clients. Write an evaluation of each of the counsellors' communications to their clients. What would your feedback to the counsellors entail? (Concentrate on positive points but also give constructive critique for improvement.)

Counsellor A: "Congratulations! You are HIV negative. Now go home immediately and share the good news with your partner."

Counsellor B: "Mmmm, please sit down. Are you comfortable? I have very bad news and I don't know how to share it with you. Are you sure you are comfortable? Should I open the window? Well, you are HIV positive, but don't worry, it's not the end of the world."

Counsellor C: "Your test result came back but it is inconclusive. You will have to come back in two weeks' time so that we can test again."

FEEDBACK 13.3

After working through the **relevant sections** in the prescribed book, you are now welcome to go back to your responses to Activity 13.3 and to add points if necessary. Did you pick up the following?

- The results should be given without delay.

- The counsellor should not attach value to the results by saying that the news is "good" or "bad" or "that it is not the end of the world". Neither is it very comforting to tell a client that they "shouldn't worry".
- It is always pleasant to give negative results, but this should still be accompanied by more information (such as the possibility of the window period, and safer sex tips to stay negative).
- The counsellor should be properly prepared before giving results. Counsellor B is very uncomfortable and just cannot get himself or herself to give the results to the client.
- Counsellor C said the right things, but did not give enough information. Does the client know what is meant by an "inconclusive" test and the possible reasons for it?

Study	**Prescribed book: pp. 406–414**	
	**Section 13.5**: **Post-HIV test counselling.** Read in the introduction how pre- and post-HIV test counselling are interlinked, and not two separate issues. Familiarise yourself with the following guidelines for post-test counselling: • **Counselling after a negative HIV test result:** Make a list of all the important issues that should always be discussed with every client who tests HIV negative. • **Counselling after a positive HIV test result:** There is no recipe or ten- point plan for telling a person that they are HIV positive. It might also be one of the most difficult things that you ever have to do in your life. Be yourself, keep in mind all the counselling skills that you have learned so far, and let the client take the lead in the way you respond to their needs. To assist you, here are some important points. Take a pen and underline the most important words in your prescribed book that will help you to answer the following questions: — How can I prepare myself before giving positive results to a client? — Exactly how do I tell a client that they are HIV positive? — How do clients react to a positive HIV test result? — How do I respond to the client's needs? — What strategies can the counsellor follow to improve linkage to care for the client? — How do I help the client to make a plan for the next 24 hours? — Why is it important to schedule follow-up visits for the client? — How can a client be supported to disclose his or her HIV status? — What do I do if the client is a suicide risk? **Counselling after an inconclusive HIV test result:** Before you can counsel a client about an inconclusive (or indeterminate) test result, it is first of all important	

	that you know what it is, and why it sometimes happens. Now make a list of the aspects you will share with your client. Go to http://goo.gl/S5Tmhq to look at a counselling session where the counsellor tells the client that he is HIV positive.	

COUNSELLING CHILDREN

Counsellors often battle when it comes to counselling and testing children. The guidelines in the next section may help you with this difficult issue.

Study 	**Prescribed book: pp. 414–416** **Section 13.6: Counselling children and adolescents.** Familiarise yourself with the practical, ethical and legal issues around counselling and testing children and adolescents. Remember that children may not be tested without proper pre- and post-HIV test counselling. Go to http://goo.gl/69sdtd to see how a peer educator works with adolescent boys to reduce rates of HIV in South Africa.	

PERSONAL EXPERIENCE OF HIV TESTING

Going for an HIV test can be a very stressful experience. To really show empathy and to try to understand what your clients are going through, it is often a good idea for you as a counsellor to go for HIV testing **yourself**.

Each one of us will experience HIV testing and receiving the results in our own unique ways. If you realise this as a counsellor and allow the client to set the pace of counselling (instead of sticking to your own fixed recipe), you cannot go wrong in your support of the client.

PERSONAL EXPERIENCES WITH HIV TESTING

One of our students gave us permission to share her story with you.

I suspected that my husband was unfaithful in our marriage and I forced him to go with me for testing. It gave me courage that he was there with me, but I was still very scared when I arrived at the clinic.

The waiting room was not user friendly. Everyone there waited to be tested and I saw that as some kind of labelling. I felt like everyone was looking at me and they were aware that I was scared.

The counselling process was confidential since we were alone in a counselling room. But I was not listening to the counsellor. I thought that the counsellor was wasting my time by doing pre-test counselling. All I wanted to know was whether I was HIV positive or negative. All that went through my mind was: "What if I am HIV positive? What about my life, my children? Why did he have sex with that woman without protecting himself?" These questions scared the hell out of me but I tried by all means to be calm and pretend as everything is fine.

During the waiting period for the results (30 minutes) I thought of changing my mind (my husband said I thought of running away). He was also very scared.

The whole HIV testing experience was very traumatic. The waiting period was too long. I stayed in the clinic for more than six hours. The clinic had only one nurse who was qualified for testing and only two counsellors. I was very afraid but I am glad that I now know my status. I even found it in my heart to forgive my husband.

Did Sizwe go for testing in the end?

You might be wondering what happened to Sizwe. Did he go for HIV counselling and testing after all? Let's pick up Sizwe's story about two years later when Jonny phones him one day (from *Three-letter plague*, pp. 324–325).

"I went to Village Clinic in town last week. I went for them to test me." He pauses a long time.

"And?"

"They had no electricity, no running water. It was so crazy there. I waited until after lunchtime. Then I went home."

"But you went back?"

"Yes. Two days later. It was still dark in there. I waited until after lunch again. They couldn't test me."

"The electricity is back now, surely?" "I don't know."

"I am sure it's back."

He chuckles, affectionately, but mockingly. He is laughing at my earnest concern.

"Maybe," he says. "We will see."

But the lightness in his tone suggests that the urgency of his need to know has passed. The restless fear that caused him to phone Sharon (a friend) out of the blue and ask for help, the agitation that had taken him away from work for two days to sit in a clinic waiting room, these are things from last week; they are gone now.

I put down the phone and think of Hermann Reuter. He is right. Sizwe went to test and couldn't. The problem was not one of demand for health care but of supply. "People arrive at a health care facility frightened and unsure," Hermann told me. "If you turn them away, they will not come back."

I discover subsequently that there is no electricity because the clinic has not paid its utilities bill and the municipality has cut its service.

But Sizwe's failure to test is not simply a tale about health-care services: it is a tale about men.

Do you have similar stories to tell about how the health care system failed you or your clients? But, as Steinberg said, it is not simply a tale about health care services. It is also a tale about men. Do you also have stories to illustrate how people have persevered to get tested, or to get their ARVs despite challenges in the health care system? Share them with your co-students via blog or the discussion forum.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 13 (Pre-HIV and post-HIV test counselling), you should have acquired the following knowledge and understanding and be able to:

- list the advantages of knowing your HIV status.
- discuss the difference between provider-initiated and client-initiated counselling and testing, and give the advantages and disadvantages of both.
- explain the rapid HIV test procedure to a client.
- create a form that can be used in a clinic to accompany pre- and post-HIV test counselling.
- role-play a counselling session where you give pre-HIV test counselling to a client.

SELF-ASSESSMENT 13

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

You are now finished with the assessment. Go to Learning Unit 14.

SELF-ASSESSMENT 13

QUESTION 1

What are the three human rights principles that should be taken into consideration during counselling and testing?

QUESTION 2

What are the two main approaches to counselling and testing?

QUESTION 3

Complete the following sentence:

…… counselling is done with a client before the HIV test is done and …… counselling when the test result is given.

QUESTION 4

What is the purpose of pre-HIV test counselling?

QUESTION 5

What is the purpose of post-HIV test counselling?

FEEDBACK 13

FEEDBACK QUESTION 1

The three principles are:

- Counselling
- Informed consent
- Confidentiality

FEEDBACK QUESTION 2

The two main approaches to testing are:

- Provider-initiated counselling and testing
- Client-initiated counselling and testing

FEEDBACK QUESTION 3

Pre-HIV test counselling is done with a client before the HIV test is done and ***post-HIV test*** counselling when the test result is given.

FEEDBACK QUESTION 4

The purpose of pre-HIV test counselling is to give a person who is considering being tested for HIV all the necessary information and support to make an informed decision.

FEEDBACK QUESTION 5

The purpose of post-HIV test counselling is to counsel a person after testing. The nature of the counselling will depend on the outcome of the test which may negative, positive or inconclusive.

GLOSSARY

Pre-HIV test counselling	This is the counselling that is given to a person who is considering being tested for HIV. It includes giving him or her all the necessary information and support to make an informed decision.
Informed consent	This means that the client must have enough information to give permission to be tested.

Shared confidentiality	This refers to sharing of information about the client's HIV status with the sex partner, family, trusted friends and medical staff. It can occur only with the informed consent of the client, specifying to whom such disclosures may be made.
Post-HIV test counselling	This is the counselling given to a person after testing. The counselling will depend on the outcome of the test which may be a negative result, a positive result or an inconclusive result.
Inconclusive test result	When an HIV test result is ambiguous or indeterminate, and when it is therefore not possible to say whether the person is HIV positive or not. A test can be inconclusive when the test is cross-reacting with a non-HIV protein or because there has been insufficient time for full seroconversion to occur after exposure to HIV.
Client-initiated counselling and testing (CICT)	This refers to individuals, couples or sex partners who actively seek HIV counselling and testing at facilities that offer these services.
Provider-initiated counselling and testing (PICT)	This refers to counselling which is initiated and recommended by healthcare providers to all adults, youth and children attending health care facilities as a standard component of medical care.

LEARNING UNIT 14

Ongoing counselling

INTRODUCTION

Counselling is an ongoing process and does not end with post-HIV test counselling. There are many issues to deal with after a positive HIV test result. In this learning unit, we will explore some of these issues, but keep in mind that **people are unique** and the way they perceive and experience their diagnosis is also unique. Therefore, there might be many other issues that a client may want to discuss with you. It sounds like a daunting task, but if you keep the basic principles of counselling in mind (attending to your clients, listening deeply, exploring their story to really come to an understanding of the problem, and assisting them to make a plan to resolve the problem), you cannot go wrong.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

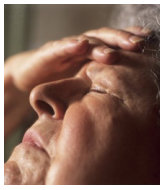
- What is the emotional impact of being HIV positive on a person and their loved ones?
- Which psychological problems are associated with HIV and Aids?
- Should a person disclose their HIV-positive status?
- How can an HIV-positive person live positively? What are the ethical concerns in counselling?

KEY CONCEPTS

Look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used.

Adjustment disorder	Acute stress disorder
Progressive muscle relaxation technique	Post-traumatic stress disorder
Systematic desensitisation	Secondary trauma
Disclosure	Positive living
Crisis intervention	

THE EMOTIONAL IMPACT OF BEING HIV POSITIVE



In the previous two learning units, we concentrated mainly on counsellors and what they need to be able to help a client. In this section we will concentrate on what the HIV-positive person and their loved ones go through while they struggle to come to terms with a life with HIV infection. Go to your prescribed book to read more about this.

Study		
	**Prescribed book: pp. 420–431** **Section 14.1: Ongoing counselling process approaches**. Familiarise yourself with counselling process approaches that can be used in ongoing counselling. Do you understand the difference between counselling and psychotherapy? Can you describe the overlaps and boundaries between the different approaches to the counselling process? **Crisis intervention.** One of the greatest fears of any counsellor is not knowing what to do in a crisis. For example, you have just given an HIV- positive test result to a client and the client suddenly turns violent or threatens to jump out of your window. Well, the first thing you have to do is to stay calm. The second thing is to realise that you will have to take control of the situation and to remember that crisis counselling is directive. This means that the client needs your advice and direction immediately. Now that I have increased your adrenalin levels, read this section in your prescribed book and make notes on how you could handle a crisis situation. Make sure that you mention the following: • the main goal of crisis intervention • the importance of networking and a proper referral system • the nature of crisis counselling (it is OK to give advice) • the role of hospitalisation • the supporting role of family or friends	

	Section 14.2: The emotional impact of HIV infection. This section contains a case study where Mr Palermino shares his emotional turmoil of being HIV positive with us. Reflect on the case study by doing the activity in your prescribed book (the first activity after the case study). Now read more about the psychological, spiritual, socioeconomic and other needs and experiences of a person living with HIV. Watch this YouTube video about living with HIV. http://goo.gl/XAVuTI **The impact of HIV infection on affected significant others.** As counsellors we usually work with the client and we often tend to forget the significant others behind the client. The loved ones of an infected person play a very important role in that person's physical as well as psychological care, and it is important for us to remember them too. This section will make you more aware of the impact of an HIV-positive diagnosis on the lives of the infected person's significant others.	

The following activity is for those of you who have a loved one with HIV infection or Aids.

ACTIVITY 14.1

Think about a loved one with HIV infection

Reflect on your own feelings about a loved one with HIV infection.

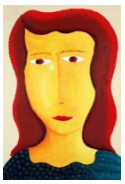
We are often overwhelmed by the HIV diagnoses of a loved one, and we are so busy providing support for that person that we often forget to stand still and think of our own feelings. We can only come to terms with a loved one's diagnosis if we allow ourselves the time to explore our own hurt, guilt, anger and sadness. If you have a loved one, a family member or a close friend who is HIV positive, reflect on your feelings by using the following questions as guidelines:

- How does this person's being HIV positive affect you?
- How did you feel when you first heard the diagnosis?
- How long ago was it?
- How are you coping with it now?

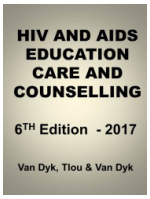
FEEDBACK 14.1

I hope that you feel a bit better after doing this activity. You might also consider talking to a professional counsellor about these feelings if you find it hard to deal with them on your own. We can only really care for our loved ones if we also care for ourselves. But more about this in Learning Unit 21.

ONGOING COUNSELLING IN CONDITIONS PREVALENT IN HIV AND AIDS



There are many psychological problems that can be experienced by people with HIV and Aids and it was very difficult to decide what to include in this module. In the end I decided on a few aspects that you will probably get to deal with most. These are stress, anxiety, depression and suicidal thoughts. We will also discuss how each one of these problems is best managed. The section will conclude with a few notes on ethics.

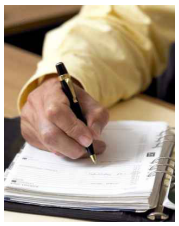
Study		
	**Prescribed book: pp. 432–450** **Section 14.3: Ongoing counselling in conditions prevalent in HIV and Aids.** **Stress:** Answer the following questions as you read through the prescribed material: • What is the effect of stress on our immune systems? Look at this short YouTube animation video http://goo.gl/5QVv1w about the effect of stress on the immune system. • How should we manage stress in our everyday lives? • What are (a) an acute stress disorder and (b) a post-traumatic stress disorder? What are the differences between these two stress-related conditions? • How do we counsel clients who have been through trauma? • What is the effect of stress on caregivers? **Adjustment disorder:** What is an adjustment disorder, and what does intervention in adjustment disorder entail? **Anxiety:** Explain what anxiety entails and discuss intervention methods to alleviate anxiety. **Depression.** Answer the following questions as you read through the prescribed material: • What are the symptoms of depression? • Arrange the symptoms in a table with four columns with the following headings: affective symptoms, cognitive symptoms, behavioural symptoms, and physiological symptoms. • When can depression be diagnosed as a major depressive disorder? • Counselling depressed clients often focuses on cognitive-behavioural therapy or interpersonal counselling. What are the differences between these two approaches? • Now think of someone you know who suffers from depression. Describe the person's symptoms and note if they are affective, cognitive, behavioural or physiological. For how long has this person been depressed, and what triggered the depression (if anything)?	

	Suicide. Counsellors should always be aware of the risk of suicide in their clients. Please make sure that you are able to answer the following questions about suicide – you might need to do so in the future to save a person's life: • What are the mood indicators of suicide? • What is the link (according to research) between HIV infection and suicide? • What are the signs of depression and suicide risk that we should be aware of? • What are the warning signs of depression and suicidal thinking in children and adolescents? • According to Sue and colleagues, the successful prevention of suicide is a three- phase process. Name the three phases in suicide prevention. • Discuss the various aspects of suicide prevention that a counsellor should take into account. **Neurocognitive Disorders:** Explain what neurocognitive disorders (NCDs) are. Also discuss interventions in NCDs. **Substance use and addiction:** Discuss substance use and addiction. How should counsellors dealt with substance use and addition? **Living with a chronic disease:** Discuss the impact of being diagnosed with HIV on a person and his/her loved ones. How can the counsellor intervene?	

We will now focus on one of the above problems that all of us experience from time to time, namely stress. The following activity will help you to keep a stress diary and to practise one technique of stress release. Not only will you personally benefit by doing this relaxation exercise, but you will also learn a new skill to help your clients to relax.

ACTIVITY 14.2

A stress diary and a relaxation exercise



Use this opportunity to take a "stress awareness week" and to keep a stress diary. You will also learn a relaxation exercise.

Decide on a Monday of a typical week in your life that you are taking a stress awareness week and start a stress diary. Be acutely aware of all the factors that stress you this week, as well as your reactions to them. Reflect on these stressors at the end of every day. The following pointers may help to increase your awareness of stress in your life:

Stressor: What happened that caused the stress?

Stress instigator: Who or what caused the stress?

Reaction: How/what did you feel when you experienced the stress? Concentrate on physical (which muscles in your body became tight?) as well as psychological or emotional reactions (e.g. crying, aggression).

Coping: What did you do to cope with the stress (if anything)?

Look at your stress diary at the end of the week. Do you have a lot of stress in your life? Try the following relaxation exercise.

Relaxation exercise

Ask a friend who has a calm and soothing voice to assist you with a relaxation exercise. The instructions for the exercise (called the progressive muscle relaxation technique) are in a Enrichment box in your prescribed book.

Get completely comfortable by sitting in a chair or lying down on a mattress.

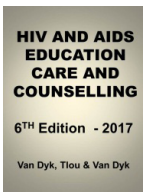
- Close your eyes and imagine a place where you feel absolutely safe, secure and relaxed. (The place I go to in my mind is a secluded beach with only the voice of the mild wind and the sea in my ears.)
- Now ask the friend to follow the instructions of the relaxation technique in your prescribed book.
- How did you feel after the exercise?

Do this exercise regularly until you have learned which muscles to relax in a stressful situation.

FEEDBACK 14.2

Look at your stress diary at the end of the week. If you feel that you have a lot of stress, ask a friend who has a calm and soothing voice to assist you with the relaxation exercise in Activity 14.2.

COUNSELLING SPECIAL GROUPS

Study	**Prescribed book: pp. 450–465**
	**Section 14.4: Counselling special groups.** Make sure that you understand counselling in the following contexts: • Counselling women/couples on pregnancy • Counselling families • Counselling couples • Counselling children • Parents who need to disclose HIV status to children **Section 14.5: Ethical concerns in counselling.** Read the ethical concerns and ask yourself if you honour them when you counsel clients. Remember that ethics is always a primary focus in whatever we do.

Please appreciate that this is only the ears of the hippo regarding counselling couples, families or children. Specialised training is necessary to counsel groups.

TIPS FOR POSITIVE LIVING

The tips for positive living are not for HIV-positive people only. They will benefit all of us who want to keep our immune systems healthy. Note that your prescribed book will take you to chapter 20 to learn more about keeping the immune system healthy.

Study		
	**Prescribed book: pp. 578–585** Go to chapter 20 and read the introduction. **Section 20.1: The promotion of health and positive living.** This section shows how a healthy lifestyle not only improves the quality of life, but also strengthens the immune system's capacity to combat infections. After reading each one of the health promotion aspects, make a list of all the things that you do to care for your immune system. If your list is very short, adopt a few of the recommendations in this section and make time to care for yourself and your immune system. Click on http://goo.gl/oU86bQ to watch a video about "Living positively with HIV." **Section 20.2: Nutrition.** The link between malnutrition and a depressed immune system is so strong that every counsellor should know what constitutes a healthy diet. Make sure that you will be able to assist a client who needs the following information: • Name the three main food groups. • Give examples of generally available foods that fit into each of the three main food groups. • Draw a picture of a plate and divide it into five sections. Now fill each one of the sections with a food group. Explain to a client what foods they should eat at each meal of the day. (Figure 20.1 in your prescribed book will give you a good idea.) • What advice will you give a client about supplements and vitamins? • What does it mean to eat defensively? • Give examples of defensive eating.	

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 14 (Ongoing counselling), you should have acquired the following knowledge and understanding and be able to:

- name the feelings that HIV-positive people may experience after diagnosis.
- recognise the symptoms of depression.
- recognise the warning signs of suicide.
- know how to intervene to prevent suicide.
- assist a client in the decision to disclose their HIV-positive status.
- give an HIV-positive friend tips on healthy and positive living.
- do crisis counselling with a client.
- explain to a client what a healthy meal entails by;
  - explaining the three food groups;
  - giving examples of the types of food under each food group; and
  - showing the client what should typically be on a plate each meal by dividing the plate into five sections, keeping the client's background, culture, taste and financial situation in mind.

SELF-ASSESSMENT 14

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

SELF-ASSESSMENT 14

QUESTION 1

The symptoms of acute stress disorder and post traumatic disorder are similar. Is this statement true or false?

QUESTION 2

Name the four categories that describe the symptoms of depression.

QUESTION 3

Complete the following sentence:

Bereavement often causes a/an …….. disorder in which a person's response to a life stressor is maladaptive, such as when a person is unable to function as usual in his/her social, occupational or academic life.

QUESTION 4

Define the term "crisis intervention"

QUESTION 5

There are many creative ways to communicate with children in counselling. Which of the following work well when communicating with children?

1. Writing memos and reading.
2. Storytelling and dreams.
3. Training and workshops.
4. Teaching and guiding.

QUESTION 6

One of the benefits of disclosure is that the HIV infected person can access support from health services and family members. Is this statement true or false?

FEEDBACK 14

FEEDBACK QUESTION 1

The statement is true. The symptoms of acute stress disorder and post traumatic disorder are similar.

FEEDBACK QUESTION 2

The four categories that describe the symptoms of depression are:

- Affective symptoms
- Cognitive symptoms
- Behavioural symptoms
- Psychological symptoms

FEEDBACK QUESTION 3

The sentence should read: Bereavement often causes a/an ***acute stress*** disorder in which a person's response to a life stressor is maladaptive, such as when a person is unable to function as usual in his /her social, occupational or academic life.

FEEDBACK QUESTION 4

Crisis intervention is a form of emotional first aid or a short-term helping process designed to provide immediate relief in an emergency situation.

FEEDBACK QUESTION 5

Storytelling and dreams will work best (alternative 2).

FEEDBACK QUESTION 6

The statement is true. One of the benefits of disclosure is that the HIV infected person can access support from health services and family members.

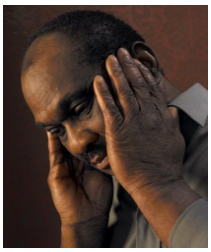
GLOSSARY

Adjustment disorder	A person's maladaptive response to a life stressor, such as when a person experiences excessive distress and is unable to function as usual in his or her social, occupational or academic life.
Progressive muscle relaxation technique	A technique for learning to relax your mind and body by progressively tensing and relaxing muscle groups throughout your entire body. (See pp.289–290 in prescribed book.)
Acute stress disorder	An anxiety disorder that develops in response to an extreme psychological or physical trauma.
Post-traumatic stress disorder	A stress disorder that develops in response to an extreme psychological or physical trauma. A diagnosis of post-traumatic stress disorder is made if symptoms of acute stress disorder persist for more than a month.
Systematic desensitisation	A relaxation technique that relies on the principle that it is impossible to be both anxious and relaxed at the same time.
Secondary trauma	Post-traumatic stress disorder experienced by the family members of trauma survivors as well as by people who witnessed the trauma or were involved in the care of the trauma survivor.
Disclosure	A decision by a person to reveal his/her HIV-positive status to others, whether publicly or by telling only certain people such as a partner, spouse, relative or friend.
Positive living	To do everything in one's power to stay as healthy as possible – not only physically, but also emotionally, psychologically and spiritually.
Crisis intervention	A form of emotional first aid or a short-term helping process designed to provide immediate relief in an emergency situation.

LEARNING UNIT 15

Bereavement counselling

INTRODUCTION



Why do you think bereavement is so often overlooked as an important cause of physical and psychological stress? Except for the death of a loved one, what other factors can cause bereavement? How do we deal with bereavement? These are the questions which are considered in this learning unit.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- How does bereavement relate to loss and attachment?
- What are the stages of bereavement?
- What is the purpose of grief work according to Worden
- How does the Dual Process Model of bereavement attempt to manage stress in bereaved persons through a process of oscillation?
- How should I deal with children and bereavement?
- How should I, as a counsellor, deal with my own grief?

KEY CONCEPTS

Look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used:

Attachment theory	DPM
Worden's tasks of bereavement	Oscillation
Cognitive restructuring	Complicated Grief

BEREAVEMENT AND ATTACHMENT THEORY

How do you feel when you lose something that you were attached to – something like a favourite pair of shoes or a memento of sentimental value? You may feel sad or angry, while in some cases you may even be shocked, or you may be all three. It is interesting that this kind of reaction can even be observed in animals and small babies. Try to hide one of your pet's favourite blankets or toys and see how they react. Often you will see searching behaviour and mild to severe emotional reaction which may include aggression. People (and animals) react to loss in a more-or-less predictable way. This reaction to loss is called bereavement or grieving and it may vary from mild to severe.

ACTIVITY 15.1

Think about a past loss

Do some self-reflection about past losses in your life.

Let's start with a bit of self-reflection. Think about someone or something that you really were attached to and that you lost in the last few years. It can be a person, an object, a pet or something more abstract like your job, health or friendship. The only thing that matters is that it was someone or something that you really held dear. Now sit back in a quiet place, close your eyes and think about the following:

- When exactly did the loss occur?
- Where were you when you realised or heard about the loss?
- What was the first feeling that you experienced?
- Did you at any stage try to avoid thinking about the loss or try to avoid situations or objects which reminded you of the loss?
- Do you still feel the pain of the loss when you think about it?

FEEDBACK 15.1

It is often extremely painful to think about a loss, not only the loss of a loved one through death, but any kind of loss of something which mattered to you. What may have surprised you is the fact that a similar process of grieving may result from very different kinds of losses. The acuteness of the bereavement often does not depend on the type of loss which you have suffered, but how attached you were to

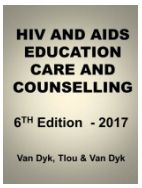
the person, pet or object. We will now further consider the nature of bereavement and attachment theory.

Study	Prescribed book: pp. 470–471
	**Introduction.** Consider the importance of bereavement and bereavement counselling in the Aids context. **Section 15.1: Attachment theory and bereavement.** Separation or loss of a person, pet or object may initiate a process of grief. Pay special attention to Bowlby's theory of attachment and the psychological needs attachments fulfil in our lives. This explains why we are so upset and angry when we lose a person or object of attachment.

To experience a loss is always painful. Understanding which reactions to expect following a loss – and realising that these are not "abnormal" and are often shared by other people – may be comforting.

STAGES OF BEREAVEMENT

How do people grieve? Is the process of bereavement different in each person or are there many similarities? These are the questions considered in this section by introducing the classical bereavement stages .

Study	Prescribed book: pp. 471–472	
	**Section 15.2: Stages of bereavement.** Concentrate on how many similarities there are in the feelings experienced by people during bereavement. Appreciate the fact that the order of the stages of bereavement may sometimes differ from person to person, as may the relative importance of each stage. Go to http://goo.gl/ZtPXb1 to watch a video on the stages of bereavement. Do not fall into the trap of thinking that these stages are completely separate and neatly follow one another. They may overlap and sometimes a person can revert back to a previous stage or even skip a stage.	

ACTIVITY 15.2

Own reaction to losses

Think about the loss that you reflected on in activity 15.1 and then reflect on your own reactions to a loss.

Think about the loss that you reflected on in activity 15.1 and answer the following questions:

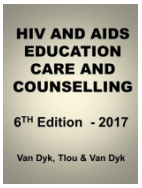
- Which phases of bereavement did you experience after your loss? How did you feel? Did you recognise all your feelings at the time?
- What did you do to get over your loss?

FEEDBACK 15.2

When dealing with bereavement, counsellors should be open and even expect reactions which may sometimes seem extreme. How reactions are expressed may also vary considerably between cultures.

When you know the theories about bereavement you are able to expect and understand certain reactions from the bereaved person. For example, why does the person feel so angry or act so aggressively (also towards the counsellor)? Can you recognise feelings of guilt, even though bereaved persons may be unaware of them?

GRIEF WORK

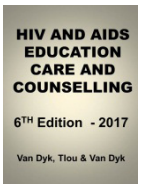
Study	**Prescribed book: pp. 473**	
	**Section 15.3: Grief work.** Take note of the important differences between the stages approach and Worden's tasks of bereavement. • The main difference is the fact that Worden wanted to stress the active aspect of the process. • Worden's approach tries to avoid the idea that a bereaved person just has to passively wait for the bereavement stages to "flow over" them, without any active input in the process. Go to http://goo.gl/kAXHyJ to watch a video on Worden's tasks of bereavement. • Go to http://goo.gl/u8lX7W to watch a YouTube video in which the well-known actor Liam Neeson discusses his grief after the death of his wife	 

THE DUAL PROCESS MODEL (DPM) OF BEREAVEMENT

Study		
	**Prescribed book: pp. 473–481** **Section 15.4: The Dual Process Model (DPM) of bereavement.** Pay special attention to how this model of bereavement: • Improved on previous models; • Manages stress; • Acknowledges that a bereaved person oscillates between loss-orientated and restoration-orientated processes; • Emphasises the importance of reconstructing the meaning of life; • Works towards avoiding complicated grief; and • Stresses the enormous variations which may exist between sub-groups and cultures in the manifestations of grief.	

CHILDREN AND BEREAVEMENT

One of the most common misconceptions is that small children don't experience grief, or else that they experience it to a much lesser extent. If you also think so, consider the next section.

Study		
	**Prescribed book: pp. 481–483** **Section 15.5: Children and bereavement**. Appreciate the similarities in the grieving process between children and adults, but also the differences and how the symptoms of bereavement may sometimes manifest themselves in a slightly different way in children. Go to http://goo.gl/IvC45a to watch a video on child bereavement and grief support.	

Children are special. We must never forget them and the amount of trauma and emotional and physical stress they are confronted with in the HIV and Aids society of today. Not the least of these is the experience of acute grief: grieving for lost parents, for the loss of a loving and secure home and in some cases, grieving for the health and future which they may have lost by being HIV positive.

THE COUNSELLOR'S OWN GRIEF

How can you do bereavement counselling if you are in the process of acute bereavement yourself or if you feel like bursting into tears every time your client speaks about their own losses? The counsellor's own grief can sometimes become a major stumbling block in providing bereavement counselling to other people. It is therefore important that, before attempting to help others, you first recognise and deal sufficiently with your own grief, for example by going for counselling yourself.

Bereavement in counsellors can be caused either by losses of their own, or (and this is often not recognised by people working in the Aids field) by the relentless exposure to the losses of others.

Study	Prescribed book: pp. 483–484
	**Section 15.6: The counsellor's own grief.** Empower yourself by being able to recognise your own grief and protect yourself against burnout and overload. The South African study on the amount of grief experienced by Aids caregivers is particularly tragic, but also enlightening. **Section 15.7: Conclusion.** This section is a recap of what the bereavement counsellor can expect.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 15 (Bereavement counselling), you should have acquired the following knowledge and understanding and be able to:

- Appreciate the link between attachment to animate, inanimate and abstract objects and how their loss or anticipated loss may trigger a process of bereavement.
- Name the stages and tasks of bereavement.
- Explain the Dual Process Model of bereavement and the importance of oscillation.
- help children deal with grieving in their own unique way.
- recognise and deal with your own grief and implement practical ways in which you can prevent burnout.

SELF-ASSESSMENT 15

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. The feedback to the questions will be given to you immediately after you have completed each question.

SELF-ASSESSMENT 15

Read the following story and then answer the questions.

Tracey has Aids and in the last month has contracted tuberculosis as well as various other opportunistic infections that do not react well to treatment. She is 20 years old and lives at home with her parents and her sister Susan, who is 9 years old. Tracey is very sick and everybody realises that she is going to die.

QUESTION 1

When should bereavement counselling be started with Tracey's family and, ideally, which members should be involved in the counselling process? Choose the correct alternative.

1. The moment Tracey dies, all her family members should receive bereavement counselling.
2. Bereavement counselling should start as soon as possible because the anticipated loss of a family member often initiates the bereavement process. Tracey, her sister and her parents should be counselled because of the anticipated loss involved.
3. The best time to start bereavement counselling is one month after the burial of the deceased person and only people with symptoms of complicated grief should be counselled.
4. All the **adult** family members (i.e. Tracey and her parents) should immediately be counselled.

QUESTION 2

Tracey experiences severe bouts of anger and starts to verbally abuse the social worker who counsels her family. How would you handle the situation if you were the social worker? Choose the correct alternative.

1. Explain to Tracey that anger is unacceptable and that she should rather channel her emotional energy towards helping her family.
2. Put an ultimatum to Tracey that if she doesn't stop her verbal abuse you will stop helping her family.
3. Acknowledge her anger as a natural part of bereavement and explore the reasons for her anger.
4. Ask the doctor to give her drugs to suppress her anger.

QUESTION 3

Tracey's mother flatly denies that her daughter has Aids. What might be the reasons for her denial?

a. She lives in a very conservative community and possibly fears stigmatisation of her daughter and family.
b. She understands the link between Tuberculosis and Aids.
c. Denial is a typical reaction to bereavement.

Choose the correct combination:

1. (a), (b) & (c)
2. (c)
3. (a) & (c)
4. (b)

FEEDBACK 15

FEEDBACK QUESTION 1

Alternative 2 is correct, because counselling should start even before a loss occur, that is, when the loss is anticipated and all members of the family (including the child) should be counselled. Alternative 4 is incorrect because it excludes the young sister.

FEEDBACK QUESTION 2

Alternative 3 is correct, because anger is a natural part of the bereavement process. The best is therefore to explore the reasons for this anger rather than reprove Tracey.

FEEDBACK QUESTION 3

Alternative 2 (c only) is correct. Denial is often irrational, but is nonetheless a part of bereavement.

GLOSSARY

Attachment theory	According to the attachment theory of bereavement, grief is a reaction to the loss of something one is emotionally attached to.
DPM	This is the acronym which stands for the Dual Process Model of bereavement proposed by Stroebe and and Schut.
Worden's tasks of bereavement	William Worden adapted the stages of bereavement (suggested by Kübler-Ross) by saying that one should rather talk about "tasks of bereavement". He thereby wished to suggest that bereavement should ideally be a more active process where the bereaved person actively work towards acceptance, rather than merely passively accept that he/she will go through various stages of bereavement.
Oscillation	Within the Dual Process Model of bereavement the term 'oscillation' refers to the constant process of alternating between loss-orientated and restoration-orientated processes.
Cognitive restructuring	This is a process whereby a grief counsellor tries to help a client to get rid of negative or destructive thoughts and adopt healthier and life-affirming thoughts.
Complicated Grief	Complicated grief refers to maladjustment by grieving persons when they do not alternate between loss-orientated and restoration-orientated processes, but either exclusively focus on their loss (chronic grievers) or alternatively focus only on restoration (absent grievers).

LEARNING UNIT 16

Spiritual counselling and the meaning of life

(Guidance Track)

INTRODUCTION

Spiritual and religious counselling is probably, for various reasons, the most neglected aspect of counselling in the HIV and Aids context. What makes this fact so tragic is that many HIV-infected people crave for such counselling as they struggle with the questions of life and death. Even when HIV-infected clients may, in many cases, shy away from directly touching on spiritual matters, or may even be reluctant to discuss these with their priest, minister, imam or religious leader, they nonetheless often have the burning need to discuss spiritual matters. It is in this context that the HIV counsellor has an important role to play.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- What is the task of the spiritual counsellor?
- How can the counsellor operate within different spiritual frameworks?
- Which factors may complicate spiritual counselling in the HIV and Aids context?
- How should one handle spiritual counselling and religion in the case of children?
- What is the role of religious institutions in the Aids context?
- How can religious coping mechanisms be beneficial to HIV-positive people?

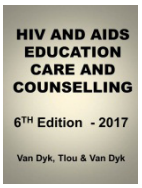
KEY CONCEPTS

Pay attention to the following concepts:

World religions	Spirituality
Secularisation	Traditional religious frameworks in Africa
Sanctity of life	Syncretism

THE TASK OF THE SPIRITUAL COUNSELLOR

In this section, we stress how important it is that the spiritual counsellor should not pretend to know all the answers of life or act as a "life coach" or guru in guiding the client towards ultimate "enlightenment". The task of the spiritual counsellor is much more humble: "to facilitate the client's search for life's meaning".

Study		
	**Prescribed book: pp. 48–489** **Section 16.1: The task of the spiritual counsellor.** Pay special attention to: • Victor Frankl and his logotherapy with regard to the search for the meaning of life. Go to http://goo.gl/Ve9Jyt to watch a video where Victor Frankl explains the basics of his views about the meaning of life. If you are interested in the subject you can search for more videos about the subject on YouTube. • How the broader concept of spiritual counselling differs from more specific religious counselling.	

OPERATING WITHIN DIFFERENT SPIRITUAL FRAMEWORKS

Spiritual and religious counsellors often err by assuming that they and their clients share the same spiritual framework. Such an assumption is often mistaken, especially within the multi-cultural South African society, and may lead to a situation where counsellor and client speak "a different language" and where the client may experience the suggestions made by the counsellor as irrelevant or may misunderstand them.






Study	Prescribed book: pp. 490–493
	**Section 16.2: Operating within different spiritual frameworks.** Pay special attention to: • The specifically religious frameworks of the different world religions as represented in Africa (e.g. Judeo-Christian or Muslim). • Traditional African religious frameworks and their assumptions about disease and death. • A general spiritual framework as opposed to a more specific religious one, which has become increasingly prevalent, especially in South Africa during the past few years. • A secular framework where a client may not, for example, see disease as the result of some higher agent or God.

COMPLICATING FACTORS

The nature of the HIV and Aids context creates a number of complicating factors for the HIV counsellor, which may be especially problematic within spiritual counselling. These include negative attitudes, stigmatisation and stereotyping and the problem of death and how to deal with it.

Study	Prescribed book: pp. 493–496
	**Section 16.3: Complicating factors.** Pay special attention to: • The negative attitudes, double standards and taboos surrounding sexual issues. • The negative function of stigmatisation and stereotyping in dealing with fear and thereby the psychological attempt to separate oneself as far as possible from Aids. • The special challenges of counselling about death-and-dying issues.

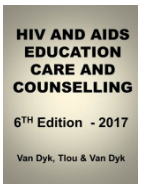
CHILDREN AND RELIGION

As is also suggested earlier in Learning Unit 10, counsellors and educators cannot expect to confront young children with all the complexities of life and death and expect them to deal successfully and like adults with all the knowledge and emotions. The age and life stage of children, and the possibility of their understanding more abstract concepts, should therefore be taken into account when counselling them about religion and death.

Study	Prescribed book: p. 497
	**Section 16.4: Children and religion.** Pay special attention to: The needs, perceptions and ability of children to understand various religious concepts at different ages.

THE ROLE OF RELIGIOUS INSTITUTIONS

Common to all religious communities is the responsibility to preserve the sanctity of life. Within the Aids context this implies that such institutions will avoid their duty if they are indifferent or negative towards HIV infected members. Such indifference is especially sad if it goes hand in hand with negative attitudes and the indiscriminate labelling of all HIV infected people as sinners.

Study	Prescribed book: pp. 497–501
	**Section 16.5: The role of religious institutions.** Pay special attention to: • The general imperative to preserve life because it is sacred. Do the Activity on page 338 to enhance your understanding of how people see the task of religious institutions. • Problems of confidentiality and trust and how counsellors can overcome this barrier. • Capability and willingness of institutions to help people infected and affected by the Aids epidemic and practical ways in which they can help.

RELIGIOUS COPING MECHANISMS

This section wishes to emphasise the potentially beneficial effect of religion and spirituality on the physicial, emotional and psychological health of people. Religious coping mechanisms should therefore be integrated into the interventions of religious leaders when counselling HIV-positive members.

Study	Prescribed book: pp. 501–502
	**Section 16.6: Religious coping mechanisms.** Pay special attention to: • Possible religious styles of coping with a crisis and their potential effectiveness. • Positive and negative coping strategies

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 16 (Spiritual counselling and the meaning of life), you should have acquired the following knowledge and understanding and be able to:

- facilitate a client's search for meaning without offering advice or by suggesting what the meaning of their life may be.
- act as counsellor and educator within different religious frameworks.
- address the possible complicating factors within the Aids context.
- appreciate the special religious needs of children and the role of religious institutions.
- explain the possible positive or negative effects of different strategies of religious coping mechanisms.

SELF-ASSESSMENT 16

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills.

SELF-ASSESSMENT 16

QUESTION 1

Nancy goes to her local priest and confesses to him that she is HIV positive. She asks him what sin she may have committed to deserve such an illness. What would your answer as counsellor be to such a question?

1. She should look into her heart and identify the sin that she committed and confess it (e.g. unfaithfulness to her husband).
2. It doesn't matter which specific sin she has committed, but she should accept that all illness eventually is for the good of the believer.
3. It is not her individual sins, but the sins of her whole family that have caused the crisis in their family.
4. Sin and disease cannot be linked directly. Although we all sin in many ways, God loves us nonetheless if we repent and ask for forgiveness.

QUESTION 2

What are the possible problems, according to your prescribed book, with preaching ONLY morals (e.g. abstinence and faithfulness) while condemning safer sex practises such as condom usage?

1. It is unnecessarily prudish and old fashioned.
2. It does not take the fact that all people are sinners seriously, and it does not take sufficiently into account the ethical principle of the preservation of life.
3. It ignores modern Bible interpretations about acceptable sexual morals.
4. It is in contrast with the view of the majority of church and religious leaders.

QUESTION 3

Nomsa belongs to a Christian church, but believes that her HIV infection was caused by witchcraft. As a religious counsellor, what would you tell her?

1. Witchcraft has nothing to do with it and it is incompatible with Christian beliefs.
2. HIV infection is caused by a virus and not by witchcraft or religion.
3. It is sometimes difficult for believers to understand why bad things happen to them, but if it is important to her, she should consult a traditional healer to help her deal with the disease.
4. She should confess her sins and cleanse herself from thoughts about witches.

QUESTION 4

How would a religious counsellor answer **secularised** clients' questions about why they were infected by HIV?

1. God wanted to punish them for their sins. They should therefore confess their sins (e.g. an immoral lifestyle) and ask God's forgiveness.
2. God often brings illness and pain into life's way to make us better people and to teach us important truths about life.
3. We don't always understand why things happen to us, but "bad things sometimes happen to good people" and being HIV positive doesn't mean that one is a bad person.
4. The devil is constantly trying to attack us and we should therefore expect that illness and pain will sometimes come our way.

FEEDBACK 16

FEEDBACK QUESTION 1

Alternative 4 is correct, because it is taught by most religions that one should not directly link specific sins to specific diseases. Although we all commit sins, diseases have many causes and may have many functions within a religious framework.

FEEDBACK QUESTION 2

Alternative 2 is correct. The preservation of life is always an important ethical consideration. If one therefore takes into account that all people are sinners it is important to teach people about life-saving practices, even if one does not condone the sins they may commit and which put them in danger.

FEEDBACK QUESTION 3

Alternative 3 is correct. It is NOT the role of the religious counsellor to convert a client to his/her own beliefs. In many traditional African churches beliefs in witchcraft and Christian beliefs co-exist. Although the immediate cause of Aids is a virus, this does not preclude the fact that the ultimate cause of Aids may be seen in a religious framework, which may include witchcraft.

FEEDBACK QUESTION 4

Alternative 3 is correct. Within a secularised framework any reference to supernatural powers (God or the devil) as being the primary cause of disease is not accepted.

GLOSSARY

World religions	The term refers to the major worldwide religions. These usually include Buddhism, Christianity, Hinduism, Judaism and Islam.
Spirituality	Spirituality is a broader framework within which specific religious beliefs may function or may not function. Spirituality usually entails the following views: 1) A sense of connectedness to the universe; 2) The belief in some kind of power or spirit outside one's self; 3) The belief that life has a purpose; and 4) The conviction that one can have a relationship with the divine. See p.331 in your prescribed book.
Secularisation	Secularisation refers to a process where the world is increasingly interpreted only in terms of natural causes and effects, while ignoring any possibility of supernatural causes or God as a causal agent. This may be a temporary suspension of beliefs (e.g. in the case of religious scientists) or in its more extreme forms may be equated with agnosticism or atheism. Secularisation often (but not always) is associated with an estrangement from organised religion.
Traditional religious frameworks in Africa	Traditional African religious beliefs usually emphasise belief in and veneration of ancestors and belief in spirits, demons and witchcraft. These beliefs are often combined with other world religions such as Christianity, Judaism and Islam.
Sanctity of life	Many religions emphasise, as an ethical principle, the all-importance and sacredness of life. The taking of human life especially (but also animal life) is therefore condemned in most circumstances.
Syncretism	Syncretism is the mixture of beliefs from more than one religious framework. For example, the mixture of traditional African beliefs with Christian beliefs is often considered as syncretism. The term usually has a negative connotation, although contemporary scholars of religion consider it as a neutral concept and point out that most religions contain forms of syncretism.

THEME 4

Care and Support

Theme 4 is about care and support for people infected with and affected by HIV and Aids. Together we will visit homes, clinics and hospitals and learn how to make a contribution to the lives and health of people with HIV infection or Aids. We will also look at the difficult circumstances of children made vulnerable by HIV and Aids – and how to take care of YOU, the caregiver.

The following issues will be discussed:

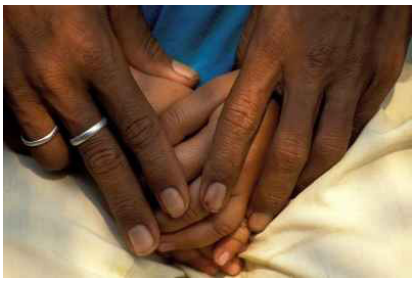
- What does developing a home-based care programme entail?
- What is the best way to care for orphans and other children made vulnerable by Aids?
- What are the infection control measures that should be applied in all care settings to prevent the spread of HIV and other infectious organisms?
- How do I care for a patient with HIV infection and Aids in the various care situations (e.g. home-based care, hospital care, clinic care)?
- How do I take care of myself as a caregiver?

LEARNING UNIT 17

Community and home based care

(Care Track)

INTRODUCTION



Imagine you have a serious chronic disease. Who would you prefer to care for you if you could no longer take care of yourself? Would you prefer to be admitted to a hospital or hospice, or to be cared for in your own home by your loved ones, supported by a community health care team?

Home-based care has become a practical solution in a time when hospitals are often overburdened by the huge demand placed on them, particularly by the Aids epidemic. In this learning unit we will discover what home-based care is, as well as how to develop and implement an integrated home-based care service for your community.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- What is the background to home-based care?
- What is involved in planning and implementing an integrated home-based care programme?
  - Who is the home-based care team?
  - What is the role of volunteers, and how are they selected?

- How should an integrated home-based care programme be planned?
- What services should be offered by an integrated home-based care programme?
- How can home-based caregivers be trained?

KEY CONCEPTS

Please pay special attention to the following concepts:

Integrated home-based care model	Professional caregiver
Primary (or informal) caregiver	Volunteer worker
Community caregiver	

BACKGROUND TO HOME-BASED CARE

What is **home-based** care, why is it important and what are its implications for individuals specifically and for the health care system in general? You will find the answers to these questions in your prescribed book.

Note: In this learning unit we will simply refer to "home-based care" for short, but remember that we usually talk about an integrated community and home based care (CHBC) model.

Study	**Prescribed book: pp. 510–518**
	**Introduction:** Read how Aids has "forced" us to implement home-based care programmes to assist families and communities to look after their own sick members. Do you personally know anyone who receives home-based care in your community? **Section 17.1: Definition of home-based care (HCBC).** After reading this section, write down your understanding of the meaning of home-based care in your journal. Are you aware of any home-based care programmes in your community? If so, write down the name of the agency that provides this service. **Section 17.2: The goals and objectives of HCBC programmes.** Jot down the main goal of home-based care. Now name four important functions of home-based care programmes. You may need this information one day when you are part of a team that needs to develop a new home-based care programme for your community. Name ten types of services delivered as part of a community and home based programme. **Section 17.3: Advantages of CHBC.** This section gives 17 reasons why home- based care is preferable to hospital care. Think of at least three more reasons to add to this section. **Section 17.4: Potential problems associated with HCBC.** We mention five drawbacks of home-based care in this section. If you can think of any other potential problems, add them here.

	Section 17.5: Models of HCBC. In this section you will learn why the integrated home-based care model is preferable to the single-service or the informal home-based care programmes. Make sure that you know what each one of these models entails. Look at figure 17.1 in your prescribed book to see what an integrated home-based care model looks like. Describe the CHBC model followed in South Africa.

You are now familiar with the concept of an *integrated* home-based care model, which means that the patient and family are supported by a *network* of services. I am sure I can hear someone asking: "But where do I get a reference list with resources and services available to the people in my community?" Although reference lists are available in some bigger centres, most of the time it is up to us to develop our own reference lists that are relevant for the community we live in.

The next activity will assist you in developing your own service reference list for your community.

ACTIVITY 17.1

A resource and service reference guide for your community

Draw up a reference guide in the form of a table, listing all the resources and services available in your community to people living with HIV infection.

Draw up a reference guide in the form of a table, listing all the resources and services available in your community to people living with HIV infection. Use the integrated community home-based care model in your prescribed book (figure 17.1) to give you some ideas of possible available services (e.g. hospitals, crisis centres, doctors, counsellors, and social workers in your community). Use the telephone directory or the internet to search for services. If your town does not offer a specific service, who does? Is it close enough for patients to travel there? Visit or phone some of the services on your list to get a personal account of what they offer. Use the following headings for your table (and add to them if you can think of more).

Reference guide of Aids organisations

Name of organisation	Service provided	Contact person	Physical address	Telephone no.	Office hours	Fees

FEEDBACK 17.1

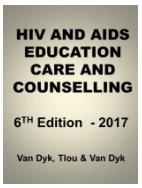
I hope this reference guide will help you in future if you have to refer someone to a specific service.

Now that you know what an integrated community home-based care programme entails, it is time to talk about the development and implementation of such a programme.

PLANNING AND IMPLEMENTING

To plan and implement an integrated home-based care programme, you need to do your homework first. You have to get a clear picture of who you want on your home-based care team, how you plan to select and train volunteers and other caregivers, what services you want to offer, and exactly how you intend setting up your home-based care programme.

While reading through your prescribed book, keep your own community in mind and make notes of how you would apply each one of the principles under discussion if you had to develop and implement a home-based care programme for your community.

Study		
	**Prescribed book: pp. 518–527** **Section 17.6: The HCBC team.** Note that the home-based care team consists of core as well as support team members. Apart from the patient and the family, identify people in your community who can fulfil the role of core and support team members. **Section 17.7: Volunteers in home-based care.** Home-based care can almost not exist without the help of volunteers. But can everyone with the urge to be a volunteer be accepted into a home-based care programme? Go to this YouTube video http://goo.gl/y6Kgfs to see a home-based care volunteer at work. **Section 17.8: Using children in community and home based care.** **Section 17.9: Developing an integrated HCBC programme.** Although professional and volunteer caregivers are the backbone of home-based care, an integrated comprehensive home-based care programme needs much more to be a success. Make sure that you know and understand all the points that should be taken into consideration in developing a home-based care programme that will assist the community for which it is meant. Think of your own community: • Who would you talk to about developing a home-based care programme? • Who would be on the management team? • Who would take responsibility for a community Aids awareness programme? • How would you advertise your services so that the community knows about them? • Who would assist in writing the policy, procedures and training programmes for the home-based care service? How would you evaluate the efficiency of the service?	

Section 17.10: Implementation of a home-based care programme. Any home-based care programme should start with an exploration of the needs of its clients. The services rendered should then be tailored to fit the community needs.

After reading this section, do the following:

- Make a list of all the needs that should be taken into account when a home- based care programme is developed.
- Now think of your own community and identify any needs that are unique to it and add them to your list.

Section 17.11: Training home-based caregivers. It is important that home-based caregivers be trained properly to empower them to offer a helpful service, to experience work satisfaction and to prevent occupational stress and burnout. After reading this section, do the following:

- List the points that should be included in a good training programme for home-based caregivers.
- Think of the needs in your own community and how they impact on volunteer training. Adjust your training programme by adding these additional points.
- Read what should be included in a home-care kit for home-based caregivers in your prescribed book.

Watch this YouTube video http://goo.gl/VUzEg7 on training home-based care volunteers in Africa.

Requirements for a volunteer

A friend of mine (who is a social worker) was very unhappy because a well-known NGO did not want to use her services as a volunteer. She has a very busy life as a full-time social worker with three children still at school. She decided to volunteer after she lost her husband and she felt that volunteering would help her to do something useful for other people in need and that it would also help her to get over her husband's death. She was prepared to give the NGO at least two hours per month of her valuable time. She accused the NGO of being ungrateful and being "beggars who do not realise that they cannot be choosers". Can the NGO be blamed for not wanting to make use of her services? The points under "Selection and management of volunteer workers" will help you to form an opinion on the NGO's "rejection" of her help.

It is not easy to be a volunteer, and you will also read about the problems and frustrations often experienced by volunteers.

The following activities will help you to get some practical experience with home-based care programmes and volunteer work:

ACTIVITY 17.2

Evaluate a home-based care programme and volunteer your services

Get hands-on experience with a home-based care programme in your community. This activity will also give you the opportunity to evaluate your own suitability as a volunteer, and who knows? Maybe you can also volunteer your services.

(1) Phone your local hospice and find out if they offer a home-based care programme in your community. Make an appointment with the manager of the programme and ask him or her to talk to you about the programme. Use the information in the prescribed book (sections 17.1 to 17.10) to make a checklist to indicate what a good integrated home-based care programme should look like. Also use the information to prepare some questions that you would like to ask during the interview. Some of the questions you might ask are listed below:

- What services do you offer?
- Who is part of your home-based care team?
- What are your selection criteria for volunteer workers?
- What training do you offer volunteer workers?
- What do you expect from your volunteers in terms of work ethics?
- How was your home-based care programme developed?
- What problems do you encounter with the home-based care programme, if any?
- Do you have a reference guide that your caregivers can use to refer patients if necessary?
- What services do you offer to the patient's family and loved ones, if any?
- What advice would you offer someone who plans to start a home-based care programme?

After the interview, use your checklist to evaluate the home-based care programme. For example, is it truly an integrated comprehensive home-based care programme? Did they include the community leaders and members when they developed the programme? Do they select their caregivers and train them properly?

(2) Evaluate your own suitability as a volunteer. Make a list of your strengths, knowledge and skills and reflect on what you can offer to lighten the burden of primary and home-based caregivers. Be critical and honest and also list the factors or characteristics that might hinder you from being a good volunteer. Use the list of factors in the section "Selection and management of volunteer workers" in your prescribed book to assist you in your self-evaluation as a volunteer. Keep the bigger picture in mind and remember that patients need more than nursing care. They need volunteers to read to them, to do shopping, to care for their animals or plants, to take children to school and to help the children with their homework.

(3) If you feel that you have the experience, skills, willingness, time, commitment and dedication to volunteer your services to lighten the burden of caregivers, contact an organisation (e.g. a hospice, NGO, or faith-based organisation (FBO)) close to you and volunteer your services. Keep a diary of your experiences and concentrate on your feelings. Ask yourself the following questions:

- How does volunteering make me feel about myself?
- What am I learning about myself?
- How has volunteering changed me as a person?

FEEDBACK 17.2

I said somewhere at the beginning of this study guide that this course will strive to be **different** from any other courses that you will do at university. If you are the same person at the end of the course, I have failed in my objective to make a shift in the way you look at your community and Aids. I want you to "get your hands dirty"; to be an activist and to fight for people who cannot talk for themselves. And you don't have to take part in Aids rallies to be an Aids activist – it can also be in the way you talk about people who are HIV positive to your friends and colleagues. And you will really feel this shift in attitude if you volunteer your services to an organisation which needs it.

Read the chapters entitled "Kate Marrandi" and "Nomvalo" in the *Three-letter plague*. These two chapters tell the story of Kate Marrandi, a community health worker who does community home-based care in Nomvalo village. It tells the story of an extraordinary woman who tirelessly walks the maze of pedestrian paths in Nomvalo to get to the sick. This is how the author, Jonny Steinberg, remembers Kate:

> An image of Kate Marrandi filled my mind. Her rucksack on her back, her nose keenly tuned to the scent of illness, she knocks on every second or third door in the village. She is invited in, and sits in the family living room speaking softly and paging through her ledger. She coaxes the sick into a taxi to visit Dr Hermann.
>
> *"How much does the government pay you to be a community health worker?" I asked.*
>
> *"Five hundred rand per month. So that we can buy soap to be clean when we visit the people."*
>
> It was the first hint of irony I had encountered since meeting her, although her face remained so deadpan it was impossible to tell what she thought of her remark.

You are now finished with this learning unit. Do some self-assessment questions.

ASESSMENT

STUDY REFLECTION

After completing Learning Unit 17 (Home-and community-based care), you should have acquired the following knowledge and understanding and be able to:

- do some self-reflection about your own abilities of what you can offer your community.
- offer your services as a volunteer to an NGO that works in the HIV and Aids field (but only if your self-reflection leads you in that direction).
- assist your community leaders in developing and implementing an integrated community home-based care programme.
- critically discuss the role of volunteers in a home-based care programme.
- offer basic training for volunteer home-based caregivers.

SELF-ASSESSMENT 17

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills.

SELF-ASSESSMENT 17

QUESTION 1

Is the following statement true or false? Home- and community-based care is preferable to hospital care because it promotes a holistic approach to care.

QUESTION 2

What is the definition of home-and community-based care?

QUESTION 3

Complete the following sentence: Two of the important factors to be considered when selecting volunteers are …….. and ……..

QUESTION 4

What are the four important functions of home-based care?

QUESTION 5

Who are the primary caregivers according to the home- and community-based care module? They are mostly:

1. Family or friends caring for patients.
2. Professionals or volunteers trained in community-based care.
3. Non-government organisations assisting in the community.
4. Faith-based organisations giving support to people living with HIV and Aids.

FEEDBACK 17

FEEDBACK QUESTION 1

The statement is true. Home- and community-based care is preferable to hospital care because it promotes a holistic approach to care.

FEEDBACK QUESTION 2

Home-and community-based care is comprehensive health and social services offered by primary and community caregivers in the home and community.

QUESTION 3

Two of the important factors to be considered when selecting volunteers are ***motivation*** and ***availability.***

QUESTION 4

The four important functions of home based care are:

- To empower the community and the family to cope effectively.
- To educate the community about the prevention of HIV transmission.
- To support family members in their caregiving roles.
- To reduce the social and personal impact of HIV.

QUESTION 5

Primary caregivers are mostly family or friends caring for patients. (Alternative 1 is correct).

GLOSSARY

Integrated home-based care model	A model that links all the service providers with patients and their families in a continuum of care.
Primary (or informal) caregiver	A family member or friend caring for a patient – usually the patient's mother, grandmother, partner, friend or a foster or adoptive parent.
Community caregiver	A person from the community trained to help the primary caregiver with direct care and support of the patients. Community caregivers may be professional caregivers or volunteers.
Professional caregiver	A professionally-trained caregiver such as a nurse, community health or TB worker, social worker, medical doctor, psychologist or counsellor, pharmacist, physiotherapist or occupational therapist.
Volunteer worker	A community member offering his or her services without any remuneration and of his or her own free will. Volunteers are trained to do their jobs and usually offer support services such as residential care, respite care services, pastoral care, legal aid and advice and transport services.

LEARNING UNIT 18

Orphans and vulnerable children (Guidance Track)

[Care Track students: go to learning unit 19]

INTRODUCTION

The child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding. The child should be fully prepared to live an individual life in society – in the spirit of peace, dignity, tolerance and freedom, equality and solidarity. Every child has the right to their childhood – a hopeful existence free of exploitation, violence, neglect and extreme poverty. Children need education, health services, and consistent support systems as well as love, hope and encouragement; all these things and more are required in order to experience childhood to the fullest, and to eventually develop into healthy, capable adults. (Excerpt from the United Nations Convention of the Rights of the Child, 1990.)

How often do you pass a street child on your way to work or to the shops? Focus on one specific street child that you often see. When you pass this child again, look at him or her and imagine what this child's life must be like, for example:

- Does he or she still have parents?
- Does the child get any form of education?
- Where does he or she sleep at night?
- Is the child properly dressed for the weather?
- Does the child look healthy and happy?

- What forms of abuses do you imagine the child suffers?

You may even consider stopping and talking to the child.

Read the introductory paragraph of this learning unit again and consider to what extent this child is deprived of what is deemed to be the right of every child. What role do you think Aids has played in this child's situation? What can we do to help?

In this learning unit we will discuss the rights and needs of children, the vulnerability of children affected by HIV and Aids, and the psychosocial support that vulnerable children need to enable them to develop into healthy, capable adults.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- Theory: What are the rights and needs of children?
- Reality: Why are children who are affected by HIV and Aids so vulnerable?
- Support: What psychological support can we offer children to enable them fulfil their fundamental needs.

KEY CONCEPTS

Pay attention to the following concepts:

United Nations Convention on the rights of the child	Singular satisfiers
Transcendence	Synergistic satisfiers
Destroyers	Supported living of orphans
Pseudo-satisfiers	

THE RIGHTS AND NEEDS OF CHILDREN

Before we can talk about the plight of Aids orphans and other children made vulnerable by Aids, we need to consider a few *definitions* (e.g. what an orphan is), what children's *rights* are, as well as the basic *needs* of children that should be fulfilled by parents, society and the government. Go to your prescribed book to read more about this.

Study

Prescribed book: pp. 530–534

Introduction: **Read about the havoc that Aids has caused in the lives of the children of the world.** Make sure you know the definition of an orphan. If you are not a South African citizen, find out how your country defines an orphan.

Section 18.1: The rights of a child. Familiarise yourself with the United Nations Convention on the Rights of the Child. Use the following to guide your reading:

- What are the four guiding principles upon which the convention is based?
- What are the four main categories into which the rights of the child can be grouped?

The United Nations Convention on the Rights of the Child is a legal document that sets minimal acceptance standards for the well-being of all children. (Go to http://www.unicef.org/crc/ to learn more). Note that the South African government adopted the Convention in 1995, which means that it is legally bound to obey the rules as set out in the Convention. Ask yourself if you can see any application of any of these rules in the life of the street child you pass every day on your way to work.

Go to the following website http://www.youthforhumanrights.org/ to download short videos illustrating 30 human rights with specific reference to children and young people. The videos are very useful in schools to make children aware of their rights.

Section 18.2: The needs of the child. Write down the ten fundamental human needs. Indicate if a specific need is physical, emotional, social, spiritual or intellectual. You will get the chance later to apply the theory to the real-life situation of the street child you see on the corner.

Section 18.3: Satisfiers of needs. Name the five types of satisfiers that can be used to satisfy the fundamental needs of a child. Give an example of each satisfier. Can you see that the money or jersey you may give a street child can be classified as a singular satisfier? Can you also see that what the child really needs is a synergistic satisfier? What do you think of Max-Neef's definition of poverty?

Children disrupted by war

Let's go from theory to practice by doing the following activity.

ACTIVITY 18.1

The rights and needs of a street child

This activity will give you the opportunity to apply what you have learnt so far to a street child's situation.

At the beginning of this learning unit we referred to a street child that you may pass on your way to work. Did you by any chance stop your car to have a conversation with the street child? Maybe you know his or her name. Consider the life of this child and think about the following:

- To what extent are this child's ten basic needs fulfilled?
- What are your reasons for saying so?
- Which rights of the child are being violated?

Use the table below to organise your thoughts.

- Column 1 lists the ten basic needs of the child. Start with the need for subsistence.
- Column 2 contains a fulfilment scale ranging from 0 (not at all fulfilled) to 5 (fully fulfilled). Indicate to what extent you think the street child's basic need for subsistence is fulfilled by drawing a circle around the appropriate number (0 to 5).
- Give the reasons/s why you think this need is fulfilled/not fulfilled in column 3.
- In column 4, write down which one or more of the rights of this child are being violated if the need (e.g. for subsistence) is not fulfilled.
- Complete the table for all the needs.

Table on the rights and needs of children

The needs of the child	Fulfilment scale 0 = Not at all; 5 = Fully fulfilled	Reasons why need is fulfilled or not	Right/s violated
Subsistence	0…1…2…3…4…5		
Protection	0…1…2…3…4…5		
Affection	0…1…2…3…4…5		
Understanding	0…1…2…3…4…5		
Participation	0…1…2…3…4…5		
Leisure	0…1…2…3…4…5		
Creation	0…1…2…3…4…5		
Identity	0…1…2…3…4…5		
Freedom	0…1…2…3…4…5		
Transcendence	0…1…2…3…4…5		

Do this same exercise with your own child, or with the child of a family member in mind, and comment on the differences between your child's fulfilment scale and that of the street child.

FEEDBACK 18.1

The street child probably scored very low on most of the needs and you probably did not have any difficulty giving reasons for this. Was it obvious to see which children's rights were violated? If you battled with the activity, this example may help: Let's take the need for *leisure*.

- I would give the street child "1" or maybe "2" for the fulfilment of the need for leisure scale.
- My reason would be that I sometimes see the child playing with other street children, but the kind of play is not very constructive or educational. Most of the time he is standing on the street corner begging for money, food or clothes.
- The children's right that is being violated is the child's right to *development.* Children need ample time, space and stimulation for constructive play and leisure (as well as for education, art and culture) to ensure normal physical, emotional and psychological development.

It was probably obvious for you to see which children's rights were being violated.

We have now looked at the theory concerning the rights and needs of children. In the next section, we look at the reality of Aids orphans and other vulnerable children by investigating their vulnerability.

THE VULNERABILITY OF CHILDREN

Let's assume that the street child you see every day on your way to work is an Aids orphan. What do you think the challenges that this child has faced, and is still facing every day, are? Write down at least three possible challenges before you go to your prescribed book.

Study	Prescribed book: pp. 534–536	
	**Section 18.4:** Vulnerability of children affected by Aids. Read the challenges that orphans and other vulnerable children face, as described by Kluckow. Think of more challenges and add them to Kluckow's list. **Enrichment box 'Stigmatisation of children orphaned by Aids':** Do you agree with Stein that our use of the word "Aids orphan" stigmatises children whose parents have died of Aids? Why do you agree or disagree with her? How can the use of acronyms such as OVCs and CABAs contribute to the stigmatisation of orphans and other vulnerable children? (See grey box in Section 18.4) Watch this YouTube video http://goo.gl/8E8epQ on the plight of Aids orphans.	

If you look back at the United Nations quotation at the beginning of this learning unit, you will see that children need to grow up in an atmosphere of happiness, love and understanding within a family environment to ultimately develop into healthy, capable adults.

ACTIVITY 18.2

The future of the street child

Explore the future that might await a child if they are deprived of the love and care of a family.

If you look back at the United Nations quotation at the beginning of this learning unit, you will see that children need to grow up in an atmosphere of happiness, love and understanding within a family environment to ultimately develop into healthy, capable adults. With the next activity we will explore the future that might await a child if they are deprived of this love and care.

(1) According to Max-Neef's theory, "a child whose needs are not fulfilled lives in poverty, and each poverty has the dire consequences of generating pathologies". What do you think the future holds for your street child if nobody intervenes to offer psychological support?

(2) If you were to advise government on care for Aids orphans and other vulnerable children, what synergistic satisfiers would you recommend to satisfy the needs of these children?

FEEDBACK 18.2

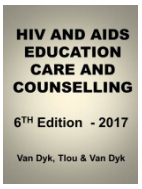
You probably mentioned some emotional, psychological, physical, behavioural and social problems that the child might have in future. Check your answer against the points given in your prescribed book. Were you guilty of stigmatising orphans and other vulnerable children by classifying them as future delinquents, thieves and murderers?

If you cannot remember what a synergistic satisfier is, go back to your prescribed book to read more on the topic.

Were you guilty of stigmatising orphans and other vulnerable children by classifying them as future delinquents, thieves and murderers? Go to http://goo.gl/YhJrT6 to watch this video on the lives of street children in South Africa. Also watch this video http://goo.gl/86eDDS on a day in the life of a street child in Kampala, Uganda.

PSYCHOLOGICAL SUPPORT FOR VULNERABLE CHILDREN

This section will deal with the support we should give orphans and other vulnerable children to satisfy their needs in a synergistic way. We will also look at the models of care and support that are used in South Africa. Note that we look at orphan care in a different way in this course. Instead of asking: "Where should the child be placed?" we ask: "What is the best way of meeting the child's physical, psychological, emotional, educational, spiritual and social needs in a synergistic way?"

Study	**Prescribed book: pp. 537–543**
	**Section 18.5: Psychosocial support.** Table 18.1 in your prescribed book summarises the fundamental needs of the child, the potential deprivation of these needs due to Aids, and the psychosocial support required to fulfil the child's needs in a synergistic way. Study this table carefully. List and give examples of the resources that communities and governments should establish to provide psychosocial support for children. **Section 18.6: Models of care and support.** Critically evaluate each one of the six models of care for orphans and other vulnerable children as identified by the South African Law Commission. Also read the Enrichment box 'The effect that suffering children have on caregivers in South Africa'.

Orphanage in Kenya

If you are interested volunteering your services, do the following activity.

ACTIVITY 18.3

Voluntary projects to support vulnerable children

Get involved in a voluntary project to help Aids orphans and other children made vulnerable by HIV and AIDS.

Would you like to do something to help Aids orphans and other children made vulnerable by HIV and Aids? Then the following activities may be just for you:

(1) Start Saturday morning empowerment workshops for young girls made vulnerable by Aids. See the activity box in your prescribed book (Section 18.5) for instructions.
(2) Devise an experiential learning exercise for teenage boys with the purpose of learning a new life skill in a fun way. See the activity box in Section 18.5 in your prescribed book for an example.
(3) Start a memory book project. Read the enrichment box 'Memory projects' in your prescribed book for ideas on memory books.
(4) Volunteer your services to an organisation that takes care of Aids orphans and other vulnerable children. If you decide to do this activity, go to Learning Unit 17 first and read Activity 17.2, points 2 and 3.

FEEDBACK 18.3

By now, you know that this course strives to be different from any other course that you will do at university. I hope that we are teaching you to be an activist and to fight for the recognition of the basic human needs and rights of children in your community who cannot speak for themselves.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 18 (Orphans and vulnerable children), you should have acquired the following knowledge and understanding and be able to:

- Recognise the shortcomings in our government, health and private systems to support children made vulnerable by Aids in sub-Saharan Africa.
- Think of ways to satisfy the ten fundamental human needs of children made vulnerable by Aids.
- Offer your services as a volunteer to an NGO that works with vulnerable children.
- Assist your community leaders in developing and implementing an integrated community care programme for children made vulnerable by AIDS.

SELF-ASSESSMENT 18

Do a few questions on this learning unit. Please note these self-assessment questions do not contribute to your year mark or your admission to the exams. The feedback to the questions will be given to you immediately after completing each question.

SELF-ASSESSMENT 18

QUESTION 1

Choose the correct statements about the United Nations Convention on the Rights of the Child.

1. The South African government signed the Convention on the Rights of the Child in 1996, which means that it is legally bound to obey the rules as set out by the Convention.
2. The Convention on the Rights of the Child takes into account only the political rights of children.
3. The views of children should be respected and taken into account in all decisions concerning them.
4. There are five guiding principles upon which the convention on the rights of the child is based.

QUESTION 2

Kluckow (2004:24) identified some of the challenges that children affected by AIDS often have to face due to their parents' illness and deaths. Which of the following is one of the challenges that a child faces as their parents become more dependent on them?

1. Role changes.
2. Dropping out of school.
3. Loss of childhood.

4. Loss of learning.

QUESTION 3

According to Max-Neef (1991), human needs are:

1. The same, few and classified.
2. Few, finite and classifiable.
3. Constant
4. Vague.

FEEDBACK 18

FEEDBACK QUESTION 1

The correct answer is the views of children should be respected and taken into account in all decisions concerning them (alternative 3).

FEEDBACK QUESTION 2

The correct answer is role changes (alternative 1).

FEEDBACK QUESTION 3

The correct answer is that human needs are few, finite and classifiable. (alternative 2).

GLOSSARY

Transcendence	The belief that we are part of something bigger than ourselves, and that the world is more than a physical reality. Many people have a need for spiritual awareness and connectedness.
Destroyers	Satisfiers that address one need but end up stifling both that need and other needs as well. Child labour and prostitution are examples of destroying satisfiers. Child labour may provide a vocation and a certain type of identity for children, but it stifles other needs such as affection, participation and freedom as well as the development of a healthy identity.
Pseudo-satisfiers	These are "satisfiers" that are appealing and that promise to fulfil needs – but don't. They generate a false sense of satisfaction. Examples include the allure of the city and freedom, which pull many vulnerable children into prostitution, drugs and alcohol.
Singular satisfiers	Satisfiers that satisfy one need in a child's life while ignoring others. The indiscriminate distribution of food to poor children is an example of a singular satisfier that satisfies the need for subsistence in a non-synergistic way.

Synergistic satisfiers	Satisfiers that satisfy a given need and also stimulate and contribute to the fulfilment of others. Synergistic satisfiers therefore meet several different needs at once. For example, an educational game that satisfies the need for leisure also stimulates and satisfies the needs for understanding and creation.
Inhibitors	Satisfiers that satisfy one need but inhibit another, for example, an overprotective family provider.

LEARNING UNIT 19

Infection control

(Care Track)

INTRODUCTION

The fear of infection should never prevent us from caring for people with HIV. The risk of HIV infection in health care settings is very low if caregivers follow suggested infection control guidelines as drawn up by the Centers for Disease Control and Prevention, WHO and other organisations.

This learning unit will look at these guidelines and their practical application in hospitals, clinics and home-based care situations. These guidelines will protect you and your patients from all kinds of infections. Also use the guidelines to empower your patients and their primary caregivers to protect themselves.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- How can I comply with universal precautions?
- What do I do to ensure a safe and clean environment?
- What precautions should I take with needles and other sharp objects?
- What are the infection control guidelines for childbirth and blood spills?
- Is it safe to resuscitate a person at an accident scene?
- How do I handle laboratory specimens safely?

- How do I handle contaminated equipment, waste and linen?
- What post-mortem procedures should I follow?

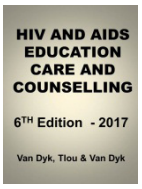
KEY CONCEPTS

Pay attention to the following concepts:

Infection control	Antimicrobial
Antiseptic	Second-person risk
Invasive procedures	Post-partum care
Decontamination procedures	Sterilisation
Disinfection	Infected waste

HYGIENE, PROTECTIVE CLOTHING AND INJECTIONS

In this first section of Learning Unit 19, we will revisit what is meant by universal precautions in terms of infection control. We will also learn that basic hygiene principles are the first step to infection control. Protective clothing that should be worn whenever there is a possibility of contact with blood or body fluids is discussed, as well as precautions to be taken when giving injections and performing invasive procedures. Read all the boxes in your prescribed book, and give special attention to the home-based care boxes.

Study	Prescribed book: pp. 548–561	
	**Section 19.1:** Universal precautions. Read how HIV infection can be prevented in the workplace or care-giving context. Watch this video http://goo.gl/AMkSTK on universal precautions: infection control procedures. **Section 19.2:** The objectives of infection control. Write down the objectives of infection control. **Section 19.3:** Basic principles of hygiene. Study the principles of hand washing, covering skin lesions and ensuring a clean and safe working environment. Don't miss the home-based care box on basic hygiene principles in your prescribed book. Watch this YouTube video http://goo.gl/GeBEpd on hand washing techniques in the health care setting. You can also watch this animation http://goo.gl/tqw2nJ on hand washing. **Section 19.4:** Protective clothing. Read about the use of gloves, eye shields, masks, aprons and footwear to protect yourself and your patients against infection. Look at this video http://goo.gl/7njF6e illustrating how to put disposable gloves on and (very importantly) how to take them off without contamination. **Section 19.5:** Injections and invasive procedures. Make sure that you know exactly how to avoid injuries with needles and other sharp objects such as blades. How will you make the environment safe so as to avoid the second-person risk of sharp injuries? What are the safety procedures to be taken for invasive procedures? Read table 19.1 in your prescribed book to familiarise yourself with which protective clothing should be worn for which hospital procedures.	

ACTIVITY 19.1A

Complete a table on principles of hygiene

While working through the above sections you will have realised that they contain a lot of details, which will be difficult to remember. To help you in remembering all the details and complete the first part of the table pertaining to basic principles of hygiene, protective clothing, injections and invasive procedures. You can complete the rest of the table after you have studied the next units.

Summarise what you have learnt by printing the following table and then filling it in. Note that hospital procedures will often differ from procedures used in home-based care.

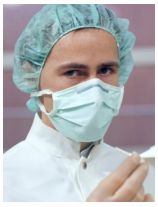
Infection control guidelines

Infection control guidelines	Care facility	
	Hospital care	Home-based care
Basic hygiene principles		

Hand washing		
Covering skin lesions		
Clean & safe working environment		
Protective clothing		
Gloves		
Eye shields		
Masks		
Aprons		
Footwear		
Injections & invasive procedures		
Disposal of needles & sharps		
Reduce 2nd-person risk		
Invasive procedures		

We have now discussed the first three infection control measures, namely basic hygiene principles, protective clothing and how to handle needles and other sharp instruments. Let's continue and discuss three more.

CHILDBIRTH, BLOOD SPILLS AND RESUSCITATION



In this section we will discuss the infection control guidelines that should be followed during childbirth (vaginal or caesarean delivery), cleaning blood and body fluid spills and care that should be taken during resuscitation. Read all the boxes in your prescribed book, and give special attention to the home-based care boxes.

Study	Prescribed book: pp. 562–565
	**Section 19.6:** Vaginal or caesarean deliveries. Make sure that you can answer the following questions: • In which instances should caregivers who assist in deliveries wear protective clothing? • What should caregivers do to keep the risk of transmission of HIV to the baby as low as possible? • What does the post-partum care of the HIV-positive mother and her baby entail? **Section 19.7:** Blood and body fluid spills. It is very important to know the procedure for cleaning up blood and other body fluid spills. Also make sure that you will be able to explain to a home-based caregiver how to prepare a household bleach preparation that will kill HIV. **Section 19.8:** Resuscitation precautions. It is important for health care workers to know what precautions should be taken during mouth-to-mouth resuscitation, as well as at accident scenes where the patient is bleeding. A resuscitation bag in the form of a key ring is very handy to have in your handbag for an emergency situation. The grey box in your prescribed book will tell you where to get hold of it.

ACTIVITY 19.1B

Childbirth, blood spills and resuscitation

Complete middle part of table

Summarise the above sections by completing the middle part of the table.

Infection control guidelines	Care facility	
	Hospital care	Home-based care
Childbirth/deliveries		
In delivery room / home		
Post-partum care		
Blood & body fluid spills		
Cleaning spills		
Disinfectant to use		
Resuscitation		
Mouth-to-mouth		

Bleeding		

LABORATORY, CLEANING AND POST-MORTEM PROCEDURES

This section will deal with the infection control guidelines that should be followed when handling laboratory specimens, decontaminating equipment and disposing of infected waste, linen and rubbish. We will also look at safe post-mortem procedures.

Study

Prescribed book: pp. 565–571

Section 19.9: Handling laboratory specimens. Make a list of all the precautions that should be taken by nurses and laboratory staff when handling laboratory specimens.

Section 19.10: Cleaning contaminated equipment. Make sure that you understand what the differences between the following decontamination methods are:

- cleaning with soap and water
- sterilisation and disinfection
- disinfectants and antiseptics

Section 19.11: Infected waste, linen and rubbish. The following might help you to study this section:

- What is meant by infected waste?
- How would you advise a hospital on how to dispose of infected waste safely?
- How would you explain to the personnel in the hospital laundry room what the difference is between used linen and soiled linen?
- What are the safety procedures to handle soiled linen in a hospital? And at home?
- What precautions should be followed when handling rubbish?
- What would you advise rural home-based caregivers to do with infected waste such as menstrual pads and soiled dressings when they do not have municipal waste removal services?

Section 19.12: Post-mortem procedures. Make a list of the guidelines that should be followed after the death of an Aids patient.

ACTIVITY 19.1C

Completing the summary table (continue D)

You can now complete the activity by filling in the last part of the summarising table.

Laboratory specimens		
Handling procedures		N/A
Equipment decontamination		
Cleaning		
Sterilising		
Disinfection		
Disposal		
Infected waste		
Linen		
Rubbish		
Post-mortem procedures		
Infection precaution		

FEEDBACK 19.1

After completing the whole table you will have a good summary of this learning unit that you can use for revision or as a guide in your workplace. You can also use it as an outline when organising a workshop for cleaning staff – see Activity 19.2 below.

ACTIVITY 19.2

Organise a workshop for cleaning staff

We believe that the best way to remember facts is to teach others and to apply the knowledge.

Cleaning staff are often overlooked in personnel training, but they are very vulnerable to second-person risks of infection. Use the information in your prescribed book and devise a training workshop to teach cleaning staff in hospitals about the following:

- basic hygiene principles to observe in hospitals and homes
- the importance of covering skin lesions
- how to keep their working environment clean and safe
- when to wear protective clothing
- what to do with needles and other sharp instruments
- how to clean blood spills on the floor
- how to make a household bleach solution to clean body fluid spills at home
- how to sort linen into used and soiled linen
- what the procedures to handle the soiled linen of patients in a hospital are
- how to wash used and soiled linen of an Aids patient at home

- how to dispose of infected waste and rubbish
- what to do with the body of a patient who died of Aids at home

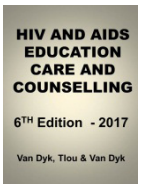
FEEDBACK 19.2

It is a very important principle of learning to not only tell people what they should do, but also *why* and *how*.

The information used in your workshop should be relevant for cleaning staff and the work they do. For example, you will teach cleaning staff to be on the lookout for needles and other sharps, and you will show them how to dispose of needles and other sharps in special containers, but you will not teach them to how to handle vacutainers, because that is not part of their duties or training.

- Did you explain to the cleaning staff why they should be careful when they clean blood and body fluid spills? Do they understand about HIV and that it can live outside the body in blood for a long time?
- Did you encourage them to always wear gloves when they work with body fluids?
- Did you tell the cleaning staff to report any needles and sharp instruments that are lying around to the health care professional in charge?
- Did you start your workshop with basic information about HIV and Aids?
- Do you appreciate that, if the cleaner does not understand how HIV is transmitted (specifically in the hospital setting), she may not bother to cover her skin lesions, or to wear gloves when she cleans bins, or she may not be careful of needles?

CREATING A SAFE WORKING ENVIRONMENT

Study	Prescribed book: pp. 572–575
	**Section 19.13: Creating a safe working environment.** Read about the legal as well as ethical obligations of employers toward their employees. Also make sure that you understand what should be done in the case of accidental exposure to blood or other infectious body fluids. Read how HIV infected staff should be managed in the workplace.

ACTIVITY 19.3

Safety in the workplace

Evaluate an employer's policies or guidelines regarding safety in the workplace.

If you work in a hospital or other type of care facility, get hold of the workplace management or policy plan. Evaluate this plan according to the following guidelines:

(1) Read Section 19.13 "Creating a safe environment" in your prescribed book, where we give 14 safety guidelines. Now read what your workplace policy says in this regard. Take a pencil and make a tick at each one of the 14 guidelines if your workplace policy honours these guidelines. If not, make a cross (X) and discuss it with your employer.

(2) Every health care facility policy should have procedures to deal with accidental exposure to HIV-infected body fluids and blood (e.g. needle stick injuries).

Read what your workplace policy says in this regard, and use the information in your prescribed book to evaluate the policy.

FEEDBACK 19.3

It is your right to work in a safe environment and you may insist that your employer create this safe environment for you to work in. But remember that you also have a responsibility to make use of the safety procedures and training to keep yourself safe. It is also your responsibility to adhere to universal precautions at all times.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 19 (infection control), you should have acquired the following knowledge and understanding and be able to:

- explain what the term “universal precautions” mean, and give examples of the body fluids to which universal precautions apply.
- explain the following infection control measures to volunteers who have no medical background and who look after people with Aids in a home-based care programme:
  - basic hygiene principles
  - how to ensure a clean and safe working environment
  - the use of protective clothing
  - how to safely dispose of needles or other sharps
  - how to take care of an HIV-positive mother and handle her baby after birth
  - cleaning blood spills on the floor
  - helping someone who is bleeding after an accident in the home
  - how to disinfect instruments that you are using in the home
  - disposal of infected waste (e.g. soiled bandages) and rubbish in a landfill
  - how to handle soiled linen
- create a safe working environment where universal precautions are implemented

SELF-ASSESSMENT 19

Complete the questions on this learning unit.

SELF-ASSESSMENT 19

QUESTION 1

The objective/s of HIV infection control in hospitals, clinics and in the home is/are to:

a. ensure that health care workers do not discriminate against people with Aids.
b. protect the patient against opportunistic infections.
c. keep hospitals, clinics and homes sterile and to kill all germs.
d. prevent transmission of infection from one person to another.

The correct answer is:

(1) (d)
(2) (b) & (d)
(3) (a)
(4) (a), (b), (c) & (d)

QUESTION 2

Which of the following statements concerning mouth-to-mouth resuscitation at an accident scene is true?

1. Mouth-to-mouth resuscitation is not safe, and it should never be done without an Ambu Bag or a mouthpiece, since HIV has been detected in saliva.
2. Saliva is one of the body fluids that do not contain HIV, and it is therefore perfectly safe to perform mouth-to-mouth resuscitation.
3. The chance of HIV transmission during mouth-to-mouth resuscitation is extremely low, and it is theoretically only possible if the patient's blood comes into contact with an open lesion in the helper's mouth.
4. There is not enough evidence about the safety of mouth-to-mouth resuscitation, and one should rather not place one's own life at risk by resuscitating people at accident scenes.

QUESTION 3

In which of the following situations is it necessary to wear disposable latex gloves?

a. when you change drainage bags.
b. when you draw a patient's blood.
c. when you give a patient an injection.
d. when you have open sores on your hands.

The correct answer is:

1. (a) & (d)
2. (a), (b) & (d)
3. (b) & (c)
4. (a), (b), (c) & (d)

FEEDBACK 19

FEEDBACK QUESTION 1

The correct answer is 2 (b and d). The objective of infection control in health care settings is to protect the patient against opportunistic infections and to prevent transmission of infection from one person to another.

FEEDBACK QUESTION 2

The correct answer is 3. The chance of HIV transmission during mouth-to-mouth resuscitation is extremely low, and it is theoretically only possible if the patient's blood comes into contact with an open lesion in the helper's mouth.

FEEDBACK QUESTION 3

The correct answer is 2 (a, b and d), namely when you change drainage bags, when you draw a patient's blood and when you have open sores on your hands.

GLOSSARY

Infection control	Measures taken to prevent infection from spreading from one person to another.
Antimicrobial	Antimicrobial means "killing microbes". Products containing antimicrobial ingredients are used in care settings where patients are at high risk of infection.
Second-person risk	Risk of contamination to a person who is not directly involved with patient care, for example cleaning personnel who empty bins (with a used needle in it) or removing dirty linen (with a needle in it) and who are then at risk of infection.
Invasive procedures	Any procedure where the body is "invaded" and where blood is present – such as an operation.
Post-partum care	Care of a mother and her baby after birth. Universal precautions should apply.
Decontamination procedure	Procedures to remove contamination (e.g. blood). Decontamination methods include washing with soap and water, sterilisation, boiling and chemical disinfection. The decontamination procedure will depend on the level of risk of contamination.
Disinfection	A process that eliminates many micro-organisms (excluding bacterial spores) on inanimate objects. Examples of disinfection processes are pasteurisation, boiling and chemical soaking.
Sterilisation	Sterilisation kills micro-organisms. Methods of sterilisation are moist heat (autoclaving), dry heat at certain temperatures, and exposure to chemicals such as ethylene oxide.
Infected waste	Waste that carries the risk of infection, such as bloodied linen, dressings, bandages, liquids, needles and other materials. See the prescribed book for information on how to dispose of infected waste, linen and rubbish.

LEARNING UNIT 20

Care and nursing principles

(Care Track)

INTRODUCTION

You have almost reached the end of your module. I hope that you feel empowered at this stage to talk confidently to your clients about various aspects of HIV and Aids. I am sure that your counselling skills have improved over time and that they will get even better with practice. We have so far concentrated a lot on the social, psychological and emotional aspects of HIV and Aids, and not so much on the physical care of patients. In this learning unit we will learn how to care for patients with very specific HIV and Aids-related health problems and symptoms – not only in formal health care settings, but also in the home.

KEY QUESTIONS

Use the following as pointers to ensure that you retain your focus on the important issues in this learning unit:

- Promotion of health and good nutrition revisited.
- How do I care for patients with general health problems and opportunistic infections in the following care settings?
  - formal care (hospitals, clinics and hospices)
  - home-based care
- How do I care for patients who feel socially isolated?
- What is palliative care and how do I offer it?

KEY CONCEPTS

Look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used:

Anorexia	Electrolyte imbalance
Shingles (herpes zoster infection)	Oral thrush
Respiratory problems	Circulatory impairment
Oedema	Ladder approach to pain management
Dementia	Palliative care

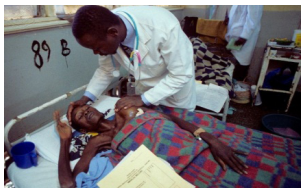
PROMOTION OF HEALTH

In this first section of Learning Unit 20, we will revisit the promotion of health, the strengthening of the immune system and a healthy diet.

Study	Prescribed book: pp. 578–585
	Introduction: Read what the current emphasis is when it comes to the management of HIV infection and Aids. Make a mind map in your journal to remind you of the main points of HIV and Aids care. **Section 20.1:** Promotion of health and positive living. You did this section in Learning Unit 14. Read it again to refresh your memory. Make a list of all the suggested things that HIV-positive people should do to promote good health and strengthen the immune system. Add more tips if you can think of any. **Section 20.2:** Nutrition. You did this section in Learning Unit 14. Refresh your memory by reading it again. Write down what a balanced meal should look like (in terms of food groups and quantities). Look at your own plate at dinner tonight to see if your dinner would fit into a healthy diet. Also make notes of what it means for an HIV-positive person to eat defensively.

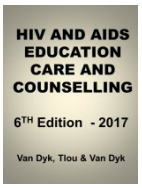
The following section concentrates on the nursing care and management of general symptoms that people with HIV infection and Aids often experience.

CARE OF GENERAL HEALTH PROBLEMS



While writing the prescribed book, I often wondered how to approach this chapter. Should I focus on the nursing care of patients with specific diseases and opportunistic infections, such as tuberculosis, pneumonia or shingles, or should I rather focus on symptoms that often accompany various infections and diseases? An example is fever which is evident in many conditions such as TB, pneumonia, gastro-intestinal infections and others. I spoke to nurses and home-based care workers in the field, and we decided that the best way would probably be to look at the care of symptoms and general health problems that are often experienced by people with HIV infection and Aids. The underlying condition causing the symptom

(for example, tuberculosis) is usually taken care of with medication. The real task of the nurse or home-based caregiver is to make sure that the patient is comfortable and that the symptoms (like fever) are alleviated. Let's get started by going to your prescribed book.

Study	**Prescribed book: pp. 586–617**
	**Section 20.3: Care of general health problems.** Twenty two of the most common problems that people with HIV infection and Aids experience are discussed in this section. It is important that you understand the following about each symptom or health problem: • definition • symptoms or manifestations • causes • general patient care (listed with bullets in text) • additional care in the home-based context (in home-based care boxes) • danger signs (when is it necessary to take the patient to the hospital?): you will find this information in the home-based care boxes • care for children (often the same as adult care, but make notes when special care is to be taken, for example with dehydration and fever): this information is in the text as well as in the home-based care boxes.

ACTIVITY 20.1

Summarise symptoms

I realise that this is a very big chunk of the work, and to help you to organise your thoughts, summarise the symptoms by completing the given table.

Use the following table as a template to draw your own table. Use two (or more) double pages for your table, since you need to fit 19 symptoms or health problems horizontally into your table. To help you a bit, I have filled in some of the information for "fever", but note that it is not by any means complete. You still have to add where necessary. Note that my table consists only of the first three health problems in your prescribed book. You need to add all the rest.

Symptoms and health problems

Symptom/health problem	**Fever**	**Diarrhoea**	**Anorexia, nausea & vomiting**	**Etc.**
Definition	High body temperature Low-grade: 37–38°C High: > 38°C			
Symptoms	Feels hot to the touch Sweaty			

Symptom/health problem	Fever	Diarrhoea	Anorexia, nausea & vomiting	Etc.
Causes	Infections HIV itself Diarrhoea Dehydration Endemic diseases			
General care	Lots of fluid Light clothing Sponge/cool baths Cool, ventilated room Nutritious foods Medication			
Home-based care – additional care	Same as above			
Danger signs	Body temp very high Fever doesn't break Other symptoms (e.g. stiff neck, pain, confusion) Pregnancy or childbirth Malaria in area			
Care of children	Be very careful Take to clinic if fever doesn't break Fever convulsions common (and dangerous) Lukewarm water (not cold)			

FEEDBACK 20.1

It probably took you a while to fill in this table, but look on the bright side: you have done your examination preparations! When you revise this learning unit you only have to read the table. The table might also come in handy when you care for patients with one of the listed problems.

Teaching how to prepare oral rehydration fluid

Now do the next activity.

ACTIVITY 20.2

Organise a practical workshop

It is now time to apply the knowledge that you have learnt by teaching other people within a community setting. Follow the outline to organise a practical workshop for primary health care workers.

If you are a trained nurse, develop a series of one-day practical workshops for primary caregivers involved in home-based care. Include the following activities in your workshops:

- how to bed-bath a bedridden patient
- how to lift or turn a bedridden patient
- how to care for a bedridden elderly patient to prevent the development of bed sores
- how to bath a baby – use a doll to illustrate the procedure
- how to care for a baby with fever – use a doll to illustrate
- how to give medication to a young child
- how to make a rehydration fluid for patients with diarrhoea (take the ingredients with you and see home-based care box in your prescribed book for the recipe)
- how to work out a diet for a patient with diarrhoea
- how to position a patient with respiratory problems in the semi-Fowler's position in bed

FEEDBACK 20.2

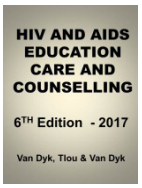
The list of skills that you can teach to primary caregivers involved in home-based care is endless and I am sure that you can add some of your own.

The list of skills that you can teach to primary caregivers involved in home-based care is endless and I am sure that you can add some of your own.

Do you remember who primary caregivers are? Primary caregivers are usually family members (such as mothers or grandmothers) who take care of their sick loved ones in the home – often with very few resources. They often have no formal training in caregiving, and will appreciate your input. Remember to include a session or two on how caregivers can protect themselves against infection by observing universal precautions.

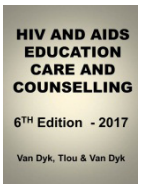
COMORBIDITIES, CO-INFECTIONS AND COMPLICATIONS

'Along with innovations in HIV drug therapies, HIV infection and Aids care has become more complex than ever before due to increasing comorbidities, co-infections and complications that are attributable to HIV treatment and the aging of the HIV-infected population.' This section focuses on some of the most important comorbidities, co-infections and complications that were not discussed elsewhere in the book.

Study	Prescribed book: p. 617–623
	**Section 20.4: Comorbidities, co-infections and complications.** Table 20.1 consist of a list of most of the comorbidities, co-infections and complications associated with HIV infection. In this section, only the following comorbidities, co-infections and complications are discussed in more detail: • Abnormalities of body-fat distribution • Dyslipidaemia • Insulin resistance, hyperglycemia and diabetes • Renal disease • Hepatitis B infection • Hepatitis C infection

PALLIATIVE CARE

Unfortunately there often comes a time when we can do no more for a patient than offer palliative care. Read more about palliative care in your prescribed book.

Study	Prescribed book: pp. 623–625	
	**Section 20.5:** Palliative care of Aids patients. Explain what is meant by palliative care. What do you think is the purpose of palliative care? When does palliative care start? What is the role of the patient and their loved ones in palliative care? Watch the following video http://goo.gl/YUz0sv on what palliative care is and who it is for.	

You have now reached the end of a very long and often tiring road. It is time for a bit of "me-time" or self-care. In the following learning unit we talk about how to care of yourself.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 20 (Care and nursing principles), you should have acquired the following knowledge and understanding and be able to:

- begin a "positive living" group in your community where you facilitate a process as part of which HIV-positive people share their healthy living tips with each other.
- offer practical workshops on a regular basis where you teach home-based caregivers the basic principles of caring for Aids patients in their own homes.
- deal with general health problems such as a fever, diarrhoea, nausea, pain, mental confusion and others.

SELF-ASSESSMENT 20

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Answer the questions on this learning unit. By doing this you can make sure that you understand and know the work.

SELF-ASSESSMENT 20

QUESTION 1

The purpose of palliative care is to:

1. provide relief from pain and other distressing symptoms, without hastening or postponing death.
2. alleviate a patient's suffering by terminating all medical treatment to bring death, and thus relief, to the patient as soon as possible.
3. take care of the physical needs of the patient, because the patient is too sick to care about psychological or spiritual needs.
4. do anything in one's power to preserve life and therefore to try new anti-retroviral medications and other therapies to try to save the patient's life.

QUESTION 2

The basic rules for treating diarrhoea in adults are:

1. Drink more fluids than usual, stop the intake of solid foods for at least 24 hours, and be on the lookout for danger signs such as weight loss.
2. Drink something nutritious like Milo or milkshake after every loose stool, eat small amounts of nutritious foods high in fibre, and be on the lookout for any signs of dehydration such as a rapid pulse.
3. Restrict the intake of fluids as well as solid foods for at least 12 hours, and be on the lookout for danger signs such as fever and irritability.
4. Drink more fluids than usual, eat small amounts of nutritious, low-fat foods and be on the lookout for any signs of dehydration such as a dry skin.

QUESTION 3

Trudy's baby is HIV positive. What advice would you give her about caring for her baby to keep the child as healthy as possible?

1. Trudy's baby should preferably be hospitalised, because a hospital is the best place for sick babies to be.
2. The baby should under no circumstances receive the standard vaccinations such as the polio vaccine, because vaccines are prepared from a weak form of the infecting agent, and to immunise an already sick baby may cause these diseases to occur.
3. Fever is a danger sign in babies with Aids because fever, convulsions and shock can easily develop. Trudy should therefore bathe her baby in ice-cold water when she has a fever.
4. Because babies with HIV can get very sick very quickly, Trudy must take her baby to the clinic immediately if the baby shows symptoms such as dehydration or fever.

QUESTION 4

Olivia is HIV positive and has vaginal thrush. What could she do to alleviate her symptoms?

1. She should douche (or wash out her vagina) with a lemon juice solution, because lemon juice slows down the growth of the fungus that causes thrush.
2. She must wear only tight, nylon panties to contain the infection.
3. She should eat more defensively and avoid foods containing yeast.
4. She must apply a gentian violet solution to the herpes sores that are caused by the vaginal thrush.

QUESTION 5

Some people in the final phase of Aids may experience continuous pain. How should pain preferably be dealt with?

1. Patients with Aids can easily become addicted to pain medication, and it is therefore advisable to avoid pain medication and rather to encourage relaxation exercises.
2. Use the "ladder" approach, and start with the strongest medication the patient can take, rather than giving medication that won't help at all.
3. Encourage patients to take their pain medication on a regular basis as prescribed, before the pain becomes too great.

4. Aspirin and paracetamol should be avoided as pain medication, if possible, because these drugs often cause constipation.

FEEDBACK 20

FEEDBACK QUESTION 1

The correct answer is alternative 1. The purpose of palliative care is to provide relief from pain and other distressing symptoms, without hastening or postponing death.

FEEDBACK QUESTION 2

The correct answer is alternative 4. In the case of diarrhoea, drink more fluids than usual, eat small amounts of nutritious, low-fat foods and be on the lookout for any signs of dehydration such as a dry skin.

FEEDBACK QUESTION 3

The correct answer is alternative 4. Because babies with HIV can get very sick very quickly, Trudy must take her baby to the clinic immediately if the baby shows symptoms such as dehydration or fever.

FEEDBACK QUESTION 4

The correct answer is alternative 3. She should eat more defensively and avoid foods containing yeast to alleviate her symptoms of vaginal thrush.

FEEDBACK QUESTION 5

The correct answer is alternative 3. Encourage patients to take their pain medication on a regular basis as prescribed, before the pain becomes too great.

GLOSSARY

Anorexia	An eating disorder causing severe weight loss.
Electrolyte imbalance	Imbalances in the body of electrolytes that are important for normal functioning – such as potassium and sodium. Electrolyte imbalance is often caused by dehydration. Read more in your prescribed book.
Shingles (herpes zoster)	A condition characterised by an extremely painful skin rash or tiny blisters on the face, limbs or body. Shingles is caused by a virus and it affects nerve cells. A shingles vaccine (called Zostavax) is available in South Africa, but it is recommended only for people over the age of 50 to protect them against the disease.

Oral thrush	Oral thrush caused by a fungus. It is characterised by persistent creamy white to yellow soft small plaques on mucosa, which can often be scraped off. It is also frequently characterised by red patches on the tongue, palate or lining of the mouth and is usually painful or tender.
Respiratory problems	Problems with breathing.
Circulatory impairment	Problems with the blood circulation, often caused by pressure on body parts or by immobility. Circulation impairment often occurs when the patient has oedema or swelling of the extremities.
Oedema	Swelling usually of the legs, knees or ankles. Read more in your prescribed book.
Ladder approach to pain management	Managing pain by increasing pain medication in steps, starting with the mildest pain medications and, if these do not relieve the pain, by moving "up the ladder" to more moderate medications and, when nothing else relieves the pain, to something stronger like morphine.
Dementia	Impaired cognition or mental confusion. In the case of Aids dementia, it is due to the effect of HIV on the brain. Read more in your prescribed book.
Palliative care	The terminal care of patients dying of Aids (or any other disease).

LEARNING UNIT 21

Care for the caregiver

INTRODUCTION

You have learnt how to be a good counsellor and a good caregiver to others. But **who will** be taking care of ***you***? This study unit will *not* be about others. It will be about *you*. I believe that you can take care of others only if you first of all take proper care of yourself. You will soon discover why.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- Are caregivers totally stressed out, and why?
- How should I take care of myself as a caregiver?

KEY CONCEPTS

While working your way through this study unit, look out for the following key terms.

Occupational stress	Boundary problems
Burnout	Grief and bereavement overload
Depersonalisation	Supervision
Over-identification	Mentoring

THE STRESS EXPERIENCED BY CAREGIVERS

Before we take you to the prescribed book, do the following activity and tell your story as caregiver.

ACTIVITY 21.1

My story as a caregiver

This activity will give you the opportunity to write your life story as a caregiver. Caregiving includes not only professional caregiving, but also taking care of loved ones.

Write the following heading on a piece of paper, or blog about it:

"My story as a caregiver"

Now do the following:

(1) Write your life story as a caregiver. Who do you take care of? Your story should include your life as a caregiver on a professional level (e.g. patients, clients, school children, employees, colleagues), but also on a personal level (e.g. partner, children, parents, family, friends). Care involves all types of care, such as emotional care, physical care, financial care and psychological care.

(2) Being a caregiver can sometimes cause a lot of stress, especially if you work in the HIV and Aids context. If you think of your stress levels on a scale of 0 to 10 (with 0 = no stress and 10 = extreme stress), where would you place yourself on the following scale?

1 ……. 2 …..... 3 …..... 4 …..... 5 …..... 6..... 7 …..... 8 …….. 9 ……..... 10

(3) What are the sources of your stress? In other words, what are the factors that contribute to your stress? (Divide your stress factors into personal stress factors and work-related stress factors.)

(4) How do you know that you are stressed? In other words, what symptoms of stress are you experiencing?

(5) What support do you receive from others to alleviate your stress? Divide the support you receive into personal support (from loved ones and friends) and organisational or employer support.

(6) What do you do personally to alleviate your stress and to care for yourself?

FEEDBACK 21.1

After doing this activity, you are probably wondering if the stress that you experience is normal or not, if you are doing enough to alleviate it, and what you can do to care more for yourself. This learning unit is about caring for yourself as a caregiver. Keep your story as a caregiver at hand because we will come back to it.

Go to your prescribed book to read more about stress and to see how other caregivers are doing.

Study	Prescribed book: pp. 627–633	
	**Introduction:** Read about how Aids has changed the medical landscape completely and about the tremendous burden it has placed on the shoulders of caregivers – especially in sub-Saharan Africa. **Section 21.1: Stress, compassion fatigue and burnout.** Make sure that you can define these concepts and discuss the effect of stress on the caregiver. How does stress and burnout in the workplace and in the personal lives of caregivers manifest? It is important that you know the difference between stress and burnout. Burnout can be seen as the end stage of chronic stress, and it is a very serious condition which is hard to treat. It is in your own best interest to recognise stress and burnout in yourself and to do something about it immediately. Watch this video http://goo.gl/Kn8S6f on caregiver burnout. **Section 21.2: Factors associated with occupational stress in the Aids field.** Make your own list of factors that cause stress in a caregiver's life. Compare your list to the list in the prescribed book.	

The following activity will give you the opportunity to talk about the stress factors in your life as a caregiver.

ACTIVITY 21.2

Stress factors in my life as a caregiver

Write an essay about the stress factors in your life and fill in a stress and burnout checklist to measure your stress levels.

Go back to your own story as a caregiver and do the following activity.

(1) Write an essay about the stress factors in your life. If you care for patients with Aids, concentrate on the factors involved in your work as an Aids caregiver (include stressors in your personal life that can be linked to your work as an Aids caregiver). Compare your stress factors to the stress factors experienced by other caregivers as discussed in section 21.3 in your prescribed book. Comment on the similarities and differences. If you do not work in the Aids field, write about the stress factors you experience in your work. Any type of work brings about its own stress factors.

(2) Fill in the stress and burnout checklist in your prescribed book to evaluate your own stress levels (Enrichment box: Stress and Burnout Checklist). Are your stress levels low or high? Look back at the stress scale that you filled in for activity 21.1(2). Now that you know what the symptoms of stress are, and what to look out for, do you want to adjust the scale in activity 21.1, or was your gut feeling about your stress levels about right?

(3) Do you ever ask for help if you feel that you cannot cope? If yes, who do you ask for help?

FEEDBACK 21.2

You are probably wondering why I gave you such a stressful activity to do! Well, you have to know the enemy to fight the enemy. As caregivers, we are very aware of the feelings and emotions of our clients and patients, but when it comes to ourselves, we are often clueless. Awareness of the stress factors in our lives and how our bodies react to them (symptoms) is the first step in DOING something about our stress. Although we often cannot change the *stress factors* in our lives, it is possible to change the way *we cope* with these stress factors. Caregivers are also notorious for *giving* help without being able to *ask* for it. Try to change this and get some support for yourself as well. Let's now talk about coping and self-care.

HOW TO TAKE CARE OF THE SELF

In your *story as a caregiver* (Activity 21.1), you wrote what support you receive from others, and what you do for yourself to better cope with stress. Read more in the prescribed book about the skills that may help caregivers and counsellors to cope with the pressure of working with people living with HIV and Aids. Also read what the workplace can do to support caregivers.

Look at this YouTube video http://goo.gl/aM9DQz on "What is self-care?" and then go to your prescribed book.

Study	Prescribed book: pp. 633–642	
	**Section 21.3: Care for the self.** While you read through this section, make it personal and do the following: • Re-evaluate your own performance expectations and goals. • Start developing an acute self-awareness by asking yourself why you are in the helping profession in the first place. Make a list of the things you do to take care of yourself. • Make a list of your support systems, both personal and professional. Look at this YouTube video http://goo.gl/QSDcNN on care for the caregiver. **Section 21.4: Organisational support.** Read this section and do the following: • Make a list of all the things your employer or manager does to create a supportive working environment for you to work in. What more could your employer do? • Discuss the role of a *mentor* in supporting caregivers. • Discuss the role of emotional support and therapeutic counselling in the workplace. Describe your understanding of the word "coping". • Give guidelines that will help caregivers to cope better with their work stress. • What role does ongoing training play in your life?	

Now that you know, in theory, how to care for yourself as a caregiver, watch this self-care video http://goo.gl/4liyp6 and do the following activity.

ACTIVITY 21.3

My self-care plan

Draw up a self-care plan.

Give your imagination wings and make a list of all the things that you would love to do if you had limitless time. Think big and small. Your wish list may include anything from "New Year's Eve in Cape Town" to "30 minutes every day to work in my garden". The only conditions for your wish list are that your wishes (a) may not be work-related, and (b) must be something that you would do for yourself – but you may, of course, do it together with somebody else.

Instructions:

(1) Choose the one thing on your list that is the most possible to carry out now. Fix a date in your diary to do this activity or have this experience and keep that date! Write a report about how it felt to do something nice for yourself. (Fight the typical caregiver feeling of guilt!) Do this on a regular basis to spoil yourself a bit. You can also fix a date in your diary for one of your long-term dreams to look forward to.

(2) Make a self-care list to use at work. Stick this list somewhere in your office or in your locker where you can see it. Refer to your list regularly to see if you are sticking to your care plan. The type of plans on your list will depend on the type of work you do, and they must obviously be realistic.

(3) If you work in a very stressful situation, start a peer-support group. Use the tips in your prescribed book, and remember to ask permission and support from your employer. Keep patient/client confidentiality in mind at all times and make sure that the group is about support and professional venting, and not about gossiping!

(4) Set aside 10 minutes a day to do the visualisation exercise (or imagery) described in your prescribed book. You will literally feel the tension flow from your body and you will feel refreshed and ready to go on with your day.

(5) After implementing your self-care plan for at least a month, go back to your stress scale in activity 21.1(2). Mark your stress levels on this scale (between 0 and 10) to see if there is any improvement. If not, revise your self-care plan.

FEEDBACK 21.3

Working in the Aids field places a tremendous strain on caregivers, and many caregivers leave the profession because they cannot cope or because they suffer from burnout. I cannot emphasise enough the importance of having a self-care plan. As I said before: you can give quality time to those in your care only if you care for yourself in the first place. In one of our counselling skills workshops, an aeroplane analogy was used to explain this: When the flight attendants explain the safety procedures to passengers, one of the things they do is to show you how to use your oxygen mask. They instruct you to put the oxygen mask on your own face first, and then to assist young children and elderly people with their face masks. If you do not take care of yourself first (by putting on your oxygen mask), you will not be able to assist those who need your help and care.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 21 (Care for the caregiver), you should have acquired the following knowledge and understanding and be able to:

- identify stress factors in your life (both personal and work related).
- know your body to know when you are stressed (symptoms of stress).

SELF-ASSESSMENT 21

Now is the time to pause briefly and to assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit. Please note that these self-assessment questions do not contribute to your year mark or to your admission to the exams. The feedback to the questions will be given to you immediately after you have completed each question.

SELF ASSESSMENT 21

QUESTION 1

Define the term "occupational stress".

QUESTION 2

What does the term "burnout" mean?

QUESTION 3

Which of the following strategies will prevent occupational stress and burnout among Aids caregivers?

1. Over-identification and self-care
2. Professional and role issues
3. Over-involvement and boundary problems
4. Stress reduction and coping skills

QUESTION 4

Is the following statement true or false? "Training does not play a role in the management of stress and burnout in caregivers."

FEEDBACK 21

FEEDBACK QUESTION 1

Occupational stress is the perception of being unable to cope with an internal or external expectation or demand in the workplace.

FEEDBACK QUESTION 2

Burnout is the end stage of a chronic process of deterioration and frustration due to long-term emotional and interpersonal stressors.

FEEDBACK QUESTION 3

The correct answer is "stress reduction and coping skills" (alternative 4).

FEEDBACK QUESTION 4

Training plays an important role in the management of stress and burnout in caregivers. The statement is therefore false.

GLOSSARY

Occupational stress	It is the perception of being unable to cope with an internal or external expectation or demand in the workplace.
Burnout	The end stage of a chronic process of deterioration and frustration due to long-term emotional and interpersonal stressors (often experienced in work situations).
Depersonalisation	An emotional dissociative disorder in which there is loss of contact with your own personal reality or identity, accompanied by feelings of unreality and strangeness.
Over-identification	The situation in which the caregiver can no longer keep his/her life apart from that of the patient and in which he/she identifies so completely with the pain of the patient that he/she can no longer be objective. The caregiver then experiences so much stress him/herself that he/she can no longer be of assistance to the patient.
Boundary problems	The situation in which caregivers can no longer put boundaries in place between themselves and the patients and, consequently, become over-involved in their patients' lives.

Grief and bereavement overload	Grief is a natural response to loss, it is the emotional suffering one feels when something or someone the individual loves is taken away. Bereavement overload is the experience of suffering too many deaths within a certain period of time and not being allowed the opportunity or time to grieve.
Supervision	Supervisors provide guidance and support to caregivers (also see Mentoring). However, the hierarchical, managerial and evaluative nature of supervision often prevents caregivers from openly sharing their feelings and anxieties.
Mentoring	The process by which a counsellor receives guidance and support from an experienced colleague or professional person. This helps the counsellor to develop his/her skills and to grow in self-awareness.

THEME 5

Legal and Practical issues

South Africa's Constitutional Court

Do I hear sighs and see long faces because you now have to study boring law issues? Relax! This is going to be fun. And I promise, no incomprehensible "legalese" rules and regulations. We will focus only on issues that are relevant for your work as an HIV and Aids counsellor, caregiver or educator. In Theme 5, we focus on the following:

- What are the rights of people living with HIV and Aids?
- What are the guidelines on how and when HIV testing should take place?
- What constitutes good practice in the workplace when it comes to employers with HIV infection or Aids?
- Are there any special rights of women and children that should be considered when it comes to HIV and Aids?
- How should the workplace respond to HIV and Aids?

Theme 5 consists of only 2 learning units.

Learning Unit 22: Aids and the law

- Introduction
- The constitutional and legal framework
- The basic rights of people living with HIV and Aids
- National HIV counselling and testing guidelines
- Aids and employment
- Women's rights
- The rights of children
- Assessment

Learning Unit 23: Aids in the workplace

- Introduction
- The impact of the Aids epidemic on the workplace
- The workplace's response to the Aids epidemic
- Assessment

LEARNING UNIT 22

Aids and the law

Former president Nelson Mandela signs the new South African constitution

INTRODUCTION

Legal matters can often seem like impersonal rules and regulations. So let's start this unit by reading the story of Anna.

Anna's story

The day it became known that I had tested HIV positive everything changed. I was desperate. My husband had died recently and I had two children who I had to look after. So I searched for a job. After struggling for more than two months, often going hungry, I finally found a job in a shoe factory. I was so happy. Now I would be able to buy food and clothes for my children and send them to school.

I had been working in the factory for two months when I started to get ill. I lost a lot of weight and started coughing the whole day. I could barely do my work, but I tried my best. But one day I fainted at work and when I came around the boss told me: "Anna you look ill. You'll need to go to the clinic to test for TB and HIV." "No, I'm okay. I think I just have the flu," I told him.

"You have been coughing for a long time. You need to be tested," he insisted. "I don't want to be tested. I'm too afraid," I told him. "I'm sorry, but if you refuse to be tested I will have to fire you," he told me.

So I went with a heavy heart to our local clinic and ask them to test me. I live in a small rural community and I didn't want to go to the local clinic, but I didn't have the money to go to town. I was so ashamed. Soon everybody started regarding me with suspicion and I knew that they all knew that I have taken an HIV test. I was too afraid to go to work, but I went anyway, because I needed the money.

After two weeks I was still coughing and felt weaker every day. One day during our lunch hour the boss called me to his office. When I came to his office I saw that the nurse from the clinic was also sitting there. They had grave expressions on their faces. I just knew. Before they could say anything, I knew. "Anna," my boss said, "we have some very bad news for you. The nurse told me that you have tested positive for both TB and HIV." I started crying. Was I going to die? What will happen to my children? Is the factory going to fire me? I just didn't know what to do.

As I was crying the nurse came to me and held me. In a soothing voice she said: "Don't cry Anna. We will take care of you. We will treat the TB and put you on ARVs and soon you will feel much better." But I kept on crying, because I knew that everything would change, nonetheless. "Yes, you can keep your job," my boss said, "We will give you a separate room in which you can stitch shoes and you will be able to work happily by yourself without anybody bothering you." "You see, everything will be okay," the nurse said.

When I returned to work after six months from the TB hospital in the city, my boss called everybody in the factory together to welcome me back: "We are glad that Anna is back with us and that her TB has disappeared and the ARVs are working well. From today she will be working in one of the back rooms and I ask you to be kind to her and not bother her with anything." So I sat all by myself in a small dark room at the back of the factory, crying while I stitched my quota of shoes.

After the first week, when I received my payment, I noticed that it was less than usual. Thinking that it was a mistake, I went to ask my boss about it. "I'm sorry Anna," he said, "but surely you didn't expect to be paid the same amount as the other healthy people?"

"But I stitch the same number of shoes as everybody," I protested. When I said that, he became angry and he shouted at me and told me that I could always resign if I wasn't satisfied with my job. So I kept quiet and left his office, clinging to the envelope with my meagre payment, knowing that I would not be able to afford my house any longer. I would have to build myself a shack on the outskirts of town.

Two weeks later, after I had erected a shack from cardboard and pieces of rusted corrugated iron, the head mistress of the Kindergarten, where my youngest daughter was, called me. "We're sorry, but we can't take Miriam any longer," she told me. "What's wrong," I asked, "I paid every month, even while I was away." "I'm sorry, one of our teachers is going away, so we cannot accommodate her any longer," she replied. I knew that it wasn't true, but I also knew that I could say nothing to convince her.

As we walked home, I took Miriam's small hand and I wondered how I was going to explain to her that she wasn't going to be able to go to school any longer or see her friends anymore.

Place yourself for a moment in Anna's shoes. How would you feel if you were treated like this, if you were suddenly treated like a second-rate person? How would you feel with no right to privacy, receiving less payment than other workers and with your child being kicked out of school?

That is why human rights, legal issues and Aids policies are so important. They are to protect people like Anna. Think about Anna, as you read through this learning unit and consider how you, if you had the chance, would defend her rights.

To defend other people's rights (and your own) you will need a sound knowledge of HIV and Aids policies and laws. In this study unit we will look at people's rights concerning

- HIV testing
- The workplace
- Women
- Children

Note that this learning unit is based on South African laws and policy. If you are from another country, access the HIV and Aids-related policies in your country, and compare them to South African policies to note similarities and differences. If you have access to the internet, it is very easy to get hold of HIV and Aids policies.

KEY QUESTIONS

Use the following key questions to guide you through this learning unit:

- What are my basic human rights according to the South African Constitution?
- What are the basic rights of people living with HIV and Aids?
- What is the HIV and Aids Charter?
- How do I know that my rights will be respected when I go for HIV testing?
- What are my rights as an HIV-positive employee?
- Are there special legal issues when it comes to the rights of women and children?

KEY CONCEPTS

Look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used.

Constitution	National Policy on Testing for HIV
Bill of Rights	Notifiability
HIV and Aids Charter	

BASIC HUMAN RIGHTS

South African legislation and policies are based on basic human rights that apply to all citizens of the country. Learn more about the Constitution and the application of human rights.

Study	Prescribed book: pp. 648–651	
	**Introduction:** Read this brief introduction to put HIV and Aids laws and policies into perspective. **Section 22.1: The Constitution and the legal framework.** Read about the Bill of Rights as well as the list of basic human rights that apply to all citizens of the country – including those who live with HIV or Aids. You don't have to know names of the laws (Acts) or policies listed in this section. Go to http://goo.gl/VytDmG to read the Constitution of South Africa. This link http://goo.gl/xuT1yz will tell you more about human rights. **Section 22.2: The basic rights of people living with HIV and Aids.** Study the Charter of Rights on Aids and HIV and make sure that you know the rights (but also the responsibilities) of people living with HIV and Aids. Go to http://goo.gl/dNPYYI to go to the homepage of the Aids Consortium. Go to the HIV and Aids Charter of Rights and choose from six South African languages.	

You have now seen that people living with HIV and Aids have the same basic rights and responsibilities as all other citizens. Under no circumstances may any person, group or organisation discriminate against HIV-positive people. It is against the law.

If you think back to Anna's story, can you list those of her basic human rights which were violated by the clinic, employer and school?

Now that you know what the basic rights of people living with HIV infection and Aids are, let's investigate the National Policy on Testing for HIV.

NATIONAL POLICY ON TESTING FOR HIV

The National Policy on Testing for HIV is a guideline on how and when HIV testing should take place. Read more about it in your prescribed book.

Study	Prescribed book: pp. 652–654	
	**Section 22.3: National HIV counselling and testing guidelines.** Read through this section and make sure that you will be able to answer the following questions: • What are the circumstances under which HIV testing may be conducted? • Under which circumstances may HIV testing be conducted without informed consent? • What is meant by proxy consent? • What does the policy say about informed consent, confidentiality and pre- and post-test counselling? • What if a person refuses to receive counselling, or refuses to be tested? Go to http://goo.gl/Qs7h3X to read more about the National HIV counselling and testing guidelines.	

Do you feel confident that you will be able to advise a client on their rights in terms of HIV testing?

The following section will deal with HIV and AIDS and employment. Counsellors and caregivers often work with clients who are disempowered and who do not know their rights in the workplace. This section may help you to give basic assistance to such clients. Note that you do not have to study Section 22.4 – Health Professions Council Ethical Guidelines for Good Practice with regard to HIV. Students who work in the medical field are welcome to read the section for self-enrichment.

AIDS AND EMPLOYMENT: CODE OF GOOD PRACTICE

In this section, we will look at the Code of Good Practice on Key Aspects of HIV and AIDS and Employment, which offers guidelines for employers and employees on how to cope with HIV and Aids.

Study	Prescribed book: pp. 661–666	
	**Section 22.5: Aids and employment: Code of Good Practice.** Read through this section and make sure that you understand the following: • What the Code of Good Practice entails. • What the objectives and policy principles of the Code of Good Practice are. • The promotion of a non-discriminatory work environment. • The Code's position on HIV testing, confidentiality and disclosure – how does this relate to Anna's situation? • The Code's position on the promotion of a safe workplace, compensation and employee benefits. • Employers' rights concerning dismissal and grievance procedures when an employee's rights are violated. Go to http://goo.gl/I1DoH0 to read more about the South African Labour Guide on HIV and Aids in the workplace. You can also learn more here on the Code of Good Conduct (Practice). The following YouTube video http://goo.gl/lgD0DF is about discrimination in the workplace.	 

Do the following activity to test your knowledge on Aids and the law in a practical way.

ACTIVITY 22.1

Critical evaluation of a workplace policy

Get hold of a workplace policy on HIV and Aids and evaluate the policy in terms of the recognition of basic human rights, the policy on HIV testing, and HIV and Aids-related issues in the workplace.

Get hold of your own workplace's HIV and Aids policy, or Google the words "HIV and Aids policy" on the internet to search for workplace policies. To help you a bit, here is one example of a workplace policy: Pfizer: http://goo.gl/QSn3bZ

Print the policies and keep it at hand to answer the following questions:

(1) Read through your workplace policy and give special attention to the recognition of basic human rights in this policy. Make notes and indicate to what extent the workplace policy takes the human rights of its employees or students into account.
(2) To what extent does the policy honour the principles of the National Policy on Testing for HIV? Think back on Anna's story. Could her employer insist that she be tested? What were her rights? Could he have fired her if she refused to be tested?
(3) All workplace policies must deal with HIV testing in the workplace. To what extent does your policy comply with the National Policy on Testing for HIV? Find out by doing the following:

    (a) Take a pencil and underline all the sections in your workplace policy that have to do with HIV testing.
    (b) Go to your prescribed book and make a summary of all the main points in the National Policy on Testing for HIV.
    (c) Go back to your policy and critically evaluate how well it complies with the National Policy.
    (d) Make notes of possible shortcomings in your workplace policy. (For example, does the policy state whether the company offers HCT (HIV counselling and testing)? If it does, does it make provision for referrals and treatment?)
    (e) Would your workplace policy have protected Anna's rights and what difference would it have made?

(4) It is now time to evaluate your workplace policy further to see to what extent it takes the Code of Good Practice into account.

    (a) Does the policy recognise the impact of HIV and Aids on the workplace? How?
    (b) Does it promote a non-discriminatory work environment? If yes, exactly what does it say?
    (c) Is HIV testing addressed in the policy? What does it say about testing?
    (d) Does the policy explicitly say that nobody can be asked to undergo an HIV test?
    (e) What does the policy say about informed consent, confidentiality and disclosure?
    (f) Does the policy include guidelines on the promotion and maintenance of a safe working environment?
    (g) Does the policy have guidelines for compensation for occupationally acquired HIV?
    (h) Does the policy have a non-discriminatory attitude in terms of employee benefits?
    (i) What is the policy on dismissal of employees with Aids?
    (j) How could this policy have made a difference to Anna's situation?

FEEDBACK 22.1

Every workplace, big or small, is affected by the HIV and Aids epidemic, and this fact should be reflected in its own workplace policy.

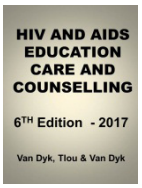
It is important to be very critical when you read a workplace policy. Don't just assume that the policymakers took all the important aspects into consideration.

Could you find any omissions in the policy you evaluated? If so, was it merely an oversight that can be easily corrected, or do you think that there was ill intent based on prejudiced attitudes? How old is the policy? Does it take important developments in the field (like availability of ARVs in the public sector) into account? Does it also make provision for the loved ones of HIV-infected employees? If you found omissions, how can they be corrected in the policy?

The following section will deal with the rights of women and children – often (but not always!) the most disempowered members of our communities. You do not have to study Section 22.6 – National Policy on HIV and Aids for Learners and Educators. If you are a teacher or educator you are welcome to read this section for self-enrichment.

WOMEN'S AND CHILDREN'S RIGHTS

You might wonder why we have a special section for women's and children's rights. Women and children often do not have a voice to fight for their own rights of equality and non-discrimination and, as we know, women are disproportionally affected and infected by HIV. Women's and children's issues are also unique and need separate attention, for example issues such as termination of pregnancy, sterilisation, rape and sex work in the case of women, and the legal age to be tested for HIV or request condoms or termination of pregnancy without parental permission in the case of children, to mention just a few. Go to the prescribed book to learn more.

Study	Prescribed book: pp. 672–678	
	**Section 22.7: Women's rights.** Read through this section and make sure that you will be able to advise clients on the following: • Termination of pregnancy. • Sterilisation. • Rape and sexual assault. • Virginity testing. • Sex workers. Read the history about South African women's struggle for women's rights from 1900 to 1994 here http://goo.gl/t5MNgl **Section 22.8: The rights of children.** Make sure that you understand the following about children's rights: • HIV-related rights of children. • Male-circumcision. Look at this link http://goo.gl/vwOYmn for a workshop outline on children's rights in the Aids context. The following link http://goo.gl/c7uFrf will tell you more about children and adoption or foster care: Who must be tested for HIV under which circumstances?	  

	Go to the following website http://www.youthforhuman-rights.org/ to download short videos illustrating 30 human rights with specific reference to children and young people. The videos are very useful in schools to make children aware of their rights. You will find the Children's Act here: http://goo.gl/weSsBk	

Workplace policies often do not make special reference to women's or children's issues (and in some cases these might not be relevant). Think very critically about these issues when you do the following activity.

ACTIVITY 22.2

Critical evaluation of a workplace policy on women's and children's rights

Critically evaluate the workplace policy that you used for Activity 22.1 on women's and children's rights. Keep Anna's story in mind when you read the policy.

Critically evaluate your workplace policy (see Activity 22.1) to see if it makes any reference to women's and children's rights. Does it, for example, refer to issues such as the following?

- Sexual harassment in the workplace.
- Rape in the workplace.
- Provision for HIV testing and post-exposure prophylaxis.
- Prevention of mother-to-child transmission of HIV.
- Discrimination against women in the workplace.
- Proper care for children of women employees.
- How could the policy be changed, if necessary, to have made sure that Anna would not have been discriminated against in the workplace? For example, does it explicitly prohibit any separation measures? Does it deal with any violations of privacy?

FEEDBACK 22.2

The school where Anna's daughter was clearly did not have a proper workplace policy to protect HIV positive children.

Many workplace policies do not specifically make provision for the rights of women and, although we are all humans, women have certain challenges and needs and provision for these gender-specific needs must be made. Do organisations that look after children have a policy to protect these children in their care?

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 22 (Aids and the law), you should have acquired the following knowledge and understanding and be able to:

- Advise a client or patient about their rights in the following circumstances:
  - when they go for HIV testing
  - in the workplace
  - in their dealings with health care institutions
- Advise women on their rights about the termination of pregnancy.
- Assist children and their caregivers to understand children's rights.
- Assist your workplace in developing or evaluating a workplace policy.

SELF-ASSESSMENT 22

Now is the time to pause briefly and assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

SELF-ASSESSMENT 22

QUESTION 1

Before Mabel was diagnosed as HIV positive she worked as a cashier at the local grocery store. After her HIV positive test result, she was legally obliged to:

1. keep her HIV status unknown to the customers of the shop.
2. immediately inform her employer about her HIV status.
3. take basic hygienic precautions to prevent infecting her co-workers, for example, by properly disposing of menstrual pads and any clothing containing blood.
4. keep quiet about her HIV status to protect her family and children.

QUESTION 2

After a while Mabel decided to inform her employer about her HIV positive status. In terms of the South African law her employer could:

1. discontinue her service as long as he paid her proper compensation – for example, three months' salary.
2. not fire her as long as she could do her work, or continue with other work in the shop if she could no longer do her current job as cashier.
3. immediately transfer her to another part of the shop and offer her a lower salary.
4. fire her if her co-workers refused to work with her because she is HIV positive.

QUESTION 3

When Nwabisa first started to feel sick, she decided to have an HIV test done at her local clinic. On the wall of the clinic was a written notice stating that it would be accepted that all patients coming for treatment had given their consent for an HIV test. According to the law this is:

1. illegal, because not all people can read.
2. legal, because it is the responsibility of all patients to ensure that they take notice of all notices and forms that they sign.
3. illegal, because although the hospital ensured Nwabisa's informed consent through the notice, they did not ask her to sign a consent form.
4. legal, because the patients are formally informed about the tests.

QUESTION 4

What does Section 12 of the Children's Act say about virginity testing? Do you think the law is general knowledge and that people abide by it?

QUESTION 5

Complete the following sentence: A child may consent to his or her own medical treatment if the child is over the age of ……. And if the child is of sufficient ……. and has the ……. This means that this child may consent to ……., ……. , ……... and ……..

FEEDBACK 22

FEEDBACK QUESTION 1

The correct answer is 3. Mabel has no legal obligations to tell anyone that she is HIV positive. As a cashier, there is no possibility that she will infect someone in the course of her work. What the law does require from her is to take basic hygienic precautions to prevent infecting her co-workers, for example, by properly disposing of menstrual pads and any clothing containing blood (if such a situation should ever arise).

FEEDBACK QUESTION 2

The correct answer is 2. The boss could not fire her as long as she could do her work, or continue with other work in the shop if she could no longer do her current job as cashier. All the other alternatives constitute unlawful behaviour.

FEEDBACK QUESTION 3

The correct answer is 1. It is not enough for hospitals or clinics to put a notice on the wall and to assume that all people will read it, or can read it.

FEEDBACK QUESTION 4

A child who is older than 16 years of age must give written and signed consent to undergo a virginity test. The consent form must also be signed by the person conducting the virginity test and official proof of the child's age must be attached to this form.

FEEDBACK QUESTION 5

The paragraph should read:

A child may consent to his or her own medical or surgical treatment if the child is over the age of ***12 years*** and if the child is of sufficient ***maturity*** and has the ***mental capacity to understand the benefits, risks, social implications and other implications of the treatment or surgical procedure.*** This means that this child may consent to ***HIV testing, ARV treatment, treatment for STIs*** and ***may ask for condoms or other forms of contraception.***

GLOSSARY

Constitution	The South African Constitution is the supreme law of the country and all other laws must comply with its provisions.
Bill of Rights	The Constitution includes a Bill of Rights which lists the basic human rights that apply to all citizens.
HIV and Aids Charter	The HIV and Aids Charter sets out basic human rights which should be enjoyed by all people and should not be denied to persons infected with and affected by HIV and Aids.
National Policy on Testing for HIV	The National HIV counselling and testing policy provides guidelines on how and when HIV testing should take place. It gives guidelines on the duties of healthcare workers and the rights of people considering HIV testing.
Notifiability	A notifiable disease is a highly contagious disease with a short incubation period that should be reported to the Department of Health so that further spread of the disease can be prevented (e.g. cholera and ebola). HIV-infection is NOT a notifiable disease.

LEARNING UNIT 23

Aids in the workplace

INTRODUCTION

The workplace is often seen as the gateway to HIV prevention among employees and their families – and, where employees or their families are living with HIV, as the gateway to providing them with care and treatment. Positive outreach from the workplace is extremely important – for humanistic reasons as well as for the retention of skills and productivity.

KEY QUESTIONS

Use the following questions as pointers to ensure that you retain your focus on the important issues in this learning unit:

- What is the impact of the Aids epidemic on the workplace?
- What does a workplace's response to the Aids epidemic entail?
- What are the six tasks for the development of an integrated Aids strategy for the workplace?
- What are the seven steps in developing an Aids workplace policy?

KEY CONCEPTS

Look out for the following key concepts. Make sure that, after you have completed this learning unit, you know what they refer to and how they are used.

Organisational culture	Peer facilitators
Aids management team	Workplace policy on HIV and Aids

THE IMPACT OF THE AIDS EPIDEMIC ON THE WORKPLACE

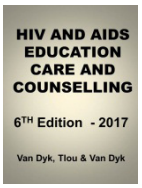
Every workplace in South Africa has been affected by Aids. Go to your prescribed book to read more about the impact of the Aids epidemic on the workplace.

Study	Prescribed book: p. 680–681
	**Section 23.1: The impact of the Aids epidemic on the workplace.** Make sure that you understand the effects that Aids has had on the workplace. Figure 23.1 will assist your understanding.

Now that you know more about the impact of Aids on the workplace, it is time to investigate the workplace's response to the Aids epidemic.

THE WORKPLACE'S RESPONSE TO THE AIDS EPIDEMIC

The most important response to the Aids epidemic in the workplace is to develop an integrated Aids workplace programme. In this section you will learn what the six tasks are for developing such an integrated strategy, and you will also learn more about the development of an Aids policy for the workplace.

Study	Prescribed book: pp. 682–694	
	**Sections 23.2 to 23.9: The workplace's response to the Aids epidemic – An integrated Aids workplace programme.** Pay special attention to: • The six tasks for developing an integrated Aids strategy for the workplace. • How to establish a representative Aids management team. • The seven steps in the development and implementation of an Aids policy. • How to evaluate and review workplace policies and programmes. • What a workplace wellness programme should look like. • You may find the following websites and YouTube videos helpful: • Information on setting up workplace HIV and Aids policies and programmes: http://goo.gl/RJPTQD • South African labour guide on HIV and Aids in the workplace as well as Code of Good Conduct: http://goo.gl/I1DoH0 • Johnson and Johnson's socially responsible workplace programme (East London, South Africa) http://goo.gl/a5pPMy • Labour protection in South Africa: http://goo.gl/28k0ub	   

ACTIVITY 23.1

Develop an Aids-awareness day for your workplace

Develop an AIDS awareness day for your workplace to be presented at World AIDS Day (1 December). Read Chapter 8 of your prescribed book again, and give special attention to "Teaching and learning about HIV and AIDS", "Basic principles of adult education", and "Facilitation skills". Use the ideas in Learning Unit 23 to present your Aids-awareness day.

You are now finished with this learning unit. Do some self-assessment questions.

ASSESSMENT

STUDY REFLECTION

After completing Learning Unit 23 (AIDS in the workplace), you should have acquired the following knowledge and understanding and be able to:

- Explain the impact of the Aids epidemic on the workplace in general, and on your workplace in particular.
- Discuss the six tasks for developing an integrated Aids strategy for the workplace.
- Explain the seven steps in the development of an Aids policy for the workplace.

SELF-ASSESSMENT 23

Now is the time to pause briefly and assess whether you have acquired the necessary knowledge and skills. Do a few questions on this learning unit.

SELF-ASSESSMENT 23

QUESTION 1

Complete the following paragraph.

An Aids management team should consist of a …..., a ….. and ….. facilitators. The steering committee must be ….. of all members of the company. They should further have ….. and influence, and be highly ….. in the organisation.

It is important to assess the direct as well as indirect costs of Aids to the company. Examples of direct cost are: ……..., while examples of indirect cost are ……

Workplace prevention programmes will not work without support from …...

FEEDBACK 23

FEEDBACK QUESTION 1

The paragraph should read as follows:

An Aids management team should consist of a ***steering committee***, a ***coordinator*** and ***peer facilitators***. The steering committee must be ***representative*** of all members of the company. They should further have ***credibility*** and influence, and be highly ***visible*** in the organisation.

It is important to assess the direct as well as indirect costs of Aids to the company. Examples of direct cost are ***employee benefits, medical costs, training and recruitment costs***, while examples of indirect cost are ***increased absenteeism, employee morbidity, loss of productivity, decline in workplace morale***.

Workplace prevention programmes will not work without support from ***top management***.

GLOSSARY

Organisational culture	A culture shared by employers and employees in the workplace where they all share the same vision, follow the same guidelines and adhere to the same rules.
Aids management team	Every workplace should have a representative Aids management team consisting of representatives of all groupings in the work-place. Strong leadership and management support is very important for the management team to succeed.
Peer facilitators	Peer facilitators are volunteers in a company or workplace who wish to help their colleagues manage HIV and Aids. Peer facilitators or peer educators are often the backbone of a successful workplace HIV programme.
Workplace policy on HIV and Aids	An HIV and Aids workplace policy contains an organisation's position on Aids and should comply with all the laws and policies of the land.