

Testing and Counselling for Prevention of
Mother-to-Child Transmission of HIV (TC for PMTCT)

Reference Guide



Protect Yourself, Your Baby and Your Family from HIV/AIDS

Reference Guide

Centers for Disease Control and Prevention Rights in Trademark and Copyright

Certain text and graphic content included in these materials is the property of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (CDC), and is protected by international copyright laws. The CDC design element (logo) is protected under United States and international trademark law and may not be used in connection with any product or service that is not CDC's, in any manner that is likely to cause confusion among viewers or in any manner that disparages or discredits CDC. The presence of the CDC logo on this material is not intended as an endorsement of any commercial entity or product/service.

WHO Library Cataloguing-in-Publication Data

Testing and counselling for prevention of mother-to-child transmission.

1. AIDS - serodiagnosis. 2. HIV infections - diagnosis. 3. HIV infections - prevention & control. 4. Disease transmission, Vertical - prevention & control. 5. HIV infections - in infancy and childhood - transmission. 6. Counselling. 7. Resource guides. I. World Health Organization. II. Centers for Disease Control and Prevention (U.S.)

ISBN 92 4 159384 9 (NLM classification: WC 503.6)

© World Health Organization 2006

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for non-commercial distribution – should be addressed to WHO Press at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The US Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID) and PMTCT implementing partners have developed the "Protect Yourself, Your Baby and Your Family from HIV/AIDS" *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools*, a job aid package for healthcare workers in PMTCT programmes. **In addition to this Reference Guide**, the other components in this package are:

- **Protocol wall charts** for antenatal, labour and delivery and post-delivery settings
- **Client information brochures** for antenatal, labour and delivery/post-delivery clients
- **Flipcharts**
 - Antenatal Pre-Test Session (20"x24") for large groups
 - Antenatal Pre-Test Session (11"x13") for small group or individuals
 - Antenatal Post-Test Counselling (11"x13")
 - Labour and Delivery Pre- and Post-Test Counselling (4"x5")
 - Post-Delivery Pre-Test Session (11"x13")
 - Post-Delivery Post-Test Counselling (11"x13")

The *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools* can be downloaded at <http://www.womenchildrenhiv.org/wchiv?page=vc-10-00>. Hard copies may be ordered through the website or by mail: NPIN/Aspen Warehouse, 9015 Junction Drive, Suite 2, Annapolis Junction, MD 20701, USA.

For further information contact:

- **Centers for Disease Control and Prevention (CDC)**, NCHSTP/ Global AIDS Program/ PMTCT Team
1600 Clifton Road, MS E-04, Atlanta, GA, 30333, USA
Email: tcpmtct@cdc.gov
http://www.cdc.gov/nchstp/od/gap/pa_pmtct.htm
- **World Health Organization**, Department of HIV/AIDS
20, Avenue Appia, CH-12111 Geneva 27, Switzerland
Email: hiv-aids@who.int
<http://www.who.int/hiv/en>

Acknowledgements

The *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools* were developed by the United States Department of Health and Human Services, Centers for Disease Control and Prevention (HHS-CDC), Global AIDS Program (GAP), in collaboration with the Department of HIV/AIDS at the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United States Agency for International Development (USAID).

Omotayo Bolu, Cristiane Costa, Beth Dillon, Jenelle Norin and Alison Surdo (CDC) were the primary team responsible for supervising the development and field-testing the support tool package. Donna Higgins, Peggy Henderson, Constanza Vallenias, Tin Tin Sint and Isabelle de Zoysa (WHO); Moazzem Hossain, Ngashi Ngongo and Chewe Luo (UNICEF); and Matt Barnhart (USAID) provided technical reviews and input into various drafts. Nathan Shaffer and Jan Moore (CDC) provided overall guidance and support for this project.

CDC would like to thank the following persons, institutions and groups for their helpful suggestions and contributions to the development of the tools: Pam Bachanas, Tracy Creek, Halima Dao, Thomas Finkbeiner, Sara Jacenko, Dorothy Mbori-Ngacha, Michelle McConnell, Odylia Muhenje, Winfred Mutsotso, Joseph Nnorom, Monica Smith, Andrea Swartzendruber (CDC); Ellen Piwoz of the Academy for Educational Development (AED), Ted Greiner of the Program for Appropriate Technologies in Health (PATH) and Gloria Sangiwa of Family Health International (FHI). Acknowledgements are also due to the US President's Emergency Plan for AIDS Relief (PEPFAR) Interagency PMTCT/Pediatric HIV Technical Working Group and Prevention Technical Working Group, WHO, USAID, UNICEF, US government PMTCT Partners Forum and CDC/GAP Field Offices in Kenya, Nigeria, Botswana, Uganda, Democratic Republic of Congo, Zambia, Namibia and Mozambique for their technical contributions.

CDC would like to thank the ministries of health, CDC/GAP offices and US government partners including University of Maryland, Pathfinder International and FHI in Nigeria, Kenya and Botswana for hosting the field tests.

CDC would also like to acknowledge the significant contributions of Mori Taheripour and Luther Knox (Innovative Health Solutions, Inc.), who led the creative development and design of the tools and Virginia Allread, Monica Reiss, Nancy Lerner-Weiss, Mary Boland, Linda Podhurst, Sahai Burrowes and Mona Moore (François-Xavier Bagnoud (FXB) Center at the University of Medicine and Dentistry of New Jersey), who led the development of the *Reference Guide* and coordinated the review and medical editing of the entire package.

Table of Contents

Abbreviations and Acronyms	vii
Introduction.....	1
Overview of <i>TC for PMTCT Support Tools</i>	1
Introduction to TC for PMTCT.....	5
Key Elements of TC for PMTCT	5
Using this Reference Guide.....	8
Chapter I: Testing and Counselling in PMTCT Settings.....	11
Section 1 Overview of Testing and Counselling for PMTCT in ANC, L&D and PD Settings	12
Section 2 Pre-Test Session.....	13
Section 3 Post-Test Counselling Session.....	22
Section 4 Subsequent Visits	29
Chapter II: HIV Test Declined	33
Section 1 Reasons for Declining HIV Testing in PMTCT Settings	34
Section 2 Counselling Approaches for Clients Who Decline HIV Testing	37
Chapter III: Flipchart Cards: Suggested Scripts and Complementary Messages	39
Section 1 Overview of the Flipchart Cards, Suggested Scripts and Complementary Messages.....	39
Section 2 Pre-Test Session Messages.....	40
Section 3 Post-Test Counselling Session Messages.....	49
Section 4 Test Declined Counselling Session Messages	66
Chapter IV: Essential Skills for TC for PMTCT Programmes	71
Section 1 Skills for Pre-Test Information Sessions	71
Section 2 General Counselling Qualities	74
Section 3 Skills for Individual Counselling	76
Section 4 Skills for Couple Counselling.....	78
Chapter V: Rapid HIV Testing in PMTCT Settings	83
Section 1 Introduction to HIV Testing.....	83
Section 2 Algorithms and Specimens for Rapid HIV Testing	85
Section 3 Rapid HIV Tests—Operational Issues	88
Chapter VI: Implementation Issues.....	93
Section 1 Improving Access to PMTCT Services	93
Section 2 Improving Service Provision	96

Chapter VII: Appendices	101
Appendix 1 <i>TC for PMTCT Support Tools</i>	101
Protocol wall chart for ANC Settings	
Protocol wall chart for L&D Settings	
Protocol wall chart for PD Settings	
ANC client information brochure	
L&D and PD client information brochure	
Appendix 2 Guidance for Adapting the <i>TC for PMTCT Support Tools</i>	109
Appendix 3 Provider-Initiated, Opt-Out HIV Testing and Counselling in PMTCT Settings	115
Appendix 4 Risk-Reduction Messages.....	117
Appendix 5 Guidance on Condoms and Condom Use	119
Appendix 6 Window Period.....	125
Appendix 7 Infant Feeding Counselling and Support.....	127
Appendix 8 WHO Recommendations: Antiretroviral (ARV) Regimens to Treat and Prevent MTCT.....	135
Appendix 9 Infection Prevention and Universal Precautions	137
Appendix 10 Healthcare for Mothers with HIV and Their HIV-Exposed Children	141
Appendix 11 Reading Results for the Three Rapid HIV Test Methods	145
Appendix 12 <i>TC for PMTCT</i> Trainer Guidance.....	147
References	159

Abbreviations and Acronyms

AFASS	Acceptable, feasible, affordable, sustainable and safe
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARV	Antiretroviral drugs
CDC	United States Centers for Disease Control and Prevention
ELISA	Enzyme-linked immunosorbent assay
FBO	Faith-based organization
GAP	Global AIDS Program (CDC)
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
L&D	Labour and delivery
MCH	Maternal-child health
MTCT	Mother-to-child transmission of HIV
NGO	Nongovernmental organization
OI	Opportunistic infection
PCP	<i>Pneumocystis jiroveci</i> (formerly <i>carinii</i>) pneumonia
PD	Post-delivery
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
RTI	Reproductive tract infection
STD/I	Sexually transmitted disease/infection
TB	Tuberculosis
TBA	Traditional birth attendant
TC	Testing and counselling
TC for PMTCT	Testing and counselling for prevention of mother-to-child transmission of HIV
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

Introduction	1
Overview of TC for PMTCT Support Tools	1
Introduction to TC for PMTCT	5
Key Elements of TC for PMTCT	5
Using this Reference Guide	8

Introduction

Overview of *TC for PMTCT Support Tools*

Evidence and experience have shown that acceptance of HIV testing increases when healthcare workers recommend testing and counselling (TC) to clients and when programmes are tailored to meet the needs of clients and providers in prevention of mother-to-child transmission of HIV (PMTCT) settings. Well-designed educational materials and job aids can help healthcare workers confidently deliver efficient and effective TC for PMTCT messages.

PMTCT Settings

“**PMTCT settings**” include antenatal (ANC), labour and delivery (L&D) and post-delivery (PD) facilities, sites, or clinics.

TC for PMTCT

“**TC for PMTCT**” refers to the process of providing a Pre-Test session, HIV testing and Post-Test counselling to women, their partners and families in ANC, L&D and PD settings.

The Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID) and their PMTCT implementing partners developed the *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools* for healthcare workers.

The *TC for PMTCT Support Tools* address the need for educational materials, job aids and training resources to support key TC messages in PMTCT programmes. The design of the tools, including the simplicity of the messages, builds on research and experience in resource-constrained settings. The first draft of the tools was pilot-tested in Nigeria, Kenya and Botswana to ensure appropriateness and utility across varied settings.

Goal of the *TC for PMTCT Support Tools*

The goal of the *TC for PMTCT Support Tools* is to facilitate the delivery of essential PMTCT messages to:

- Improve the uptake of HIV testing among pregnant women and their partners.
- Increase the number of women who know their HIV status.
- Promote and provide appropriate PMTCT interventions. (See definition of PMTCT interventions in box on page 2.)

Objectives

The objectives of the *TC for PMTCT Support Tools* are to:

- Improve capacity of healthcare workers to effectively deliver accurate HIV testing and counselling services to PMTCT clients. (See definition of PMTCT clients in box.)
- Ensure that PMTCT clients receive essential testing and counselling information at first contact with the healthcare system.
- Provide both HIV-negative and -positive clients with appropriate PMTCT messages, interventions and referrals to treatment, care, prevention and support services.
- Ensure that HIV-exposed infants are provided (or referred for) care and treatment, infant diagnosis and follow-up services.
- Increase partner testing by involving partners in PMTCT counselling and programmes.

Target Audience

The *TC for PMTCT Support Tools* were developed as a resource for:

- PMTCT healthcare workers—clinical (nurses, midwives, doctors) and non-clinical (HIV counsellors, peer or lay counsellors and outreach workers)
- PMTCT programme managers
- PMTCT trainers

The tools are intended to enhance the expertise of healthcare workers providing these services and to support existing training materials and job aids. The user should have some working knowledge of PMTCT technical content and experience in a PMTCT setting. The flipcharts, protocol wall charts and brochures can also serve as orientation tools for new healthcare workers. As healthcare workers become familiar with the critical messages, they can use the messages as reference and the graphics to guide their discussion and engage clients.

Components of the *TC for PMTCT Support Tools*

The *TC for PMTCT Support Tools* include:

1. **Reference Guide:** This *Reference Guide* provides detailed background information to enhance the use of the *TC for PMTCT Support Tools*. The *Reference Guide* contains essential technical content for delivering testing and counselling services in PMTCT programmes, as well as current recommendations for programme implementation. It uses a

PMTCT Interventions

“**PMTCT interventions**” refers to the interventions focusing on the prevention of HIV transmission from mother to child. These interventions include:

- HIV testing and counselling (including risk-reduction messages)
- ARV treatment and/or prophylaxis
- Safe delivery practices
- Counselling and support for safer infant feeding
- Provision of (or referral to) treatment, care, prevention and support services for women infected with HIV, their infants and their families

PMTCT Clients

“**PMTCT clients**” refers to women, their partners and children who use services in ANC, L&D and PD settings.

“how to” approach; while it is not a training course, it can be readily integrated into ongoing PMTCT training activities.

This *Reference Guide* is divided into seven chapters:

- *Chapter I: Testing and Counselling in PMTCT Settings*
- *Chapter II: HIV Test Declined*
- *Chapter III: Flipchart Cards: Suggested Scripts and Complementary Messages*
- *Chapter IV: Essential Skills for TC for PMTCT Programmes*
- *Chapter V: Rapid HIV Testing in PMTCT Settings*
- *Chapter VI: Implementation Issues*
- *Chapter VII: Appendices*

2. **Protocol wall charts:** The protocol wall charts summarize the steps a healthcare worker follows to deliver TC for PMTCT services (see Appendix 1). The protocol wall charts are designed to be posted on the clinic, delivery room and maternity ward walls as a reference for healthcare workers.
3. **Flipcharts:** The flipcharts provide the healthcare worker with simple scripts containing essential messages, open-ended questions to guide discussion and responses to commonly asked questions (see Chapter III). The flipcharts standardize messages provided by PMTCT staff. The graphics and captions on the front of the cards serve as a visual focus and reinforce essential PMTCT messages for the client. There are six flipcharts:
 - Flipcharts for ANC settings:
 - Pre-Test Session (20”x24”) for large groups
 - Pre-Test Session (11”x13”) for small group or individuals
 - Post-Test Counselling (11”x13”)
 - Flipcharts for L&D settings:
 - Pre- and Post-Test Counselling (4”x5”)
 - Flipcharts for PD settings:
 - Pre-Test Session (11”x13”)
 - Post-Test Counselling (11”x13”)
4. **Client information brochures:** The brochures are single-page take-home leaflets for clients (see Appendix 1). Their purpose is to reinforce the PMTCT messages discussed during counselling sessions. The two brochures are:
 - ANC client information brochure
 - L&D and PD client information brochure

To preserve confidentiality and avoid creating stigma, both brochures include information for clients testing HIV-positive and HIV-negative. The brochures include space to record individual information about follow-up care and referrals.

Additional Training

The *TC for PMTCT Support Tools* are designed to provide healthcare workers with the basic information and skills necessary to deliver TC for PMTCT services. In addition to mastering the material in this package, healthcare workers need to know PMTCT technical content and have experience working in PMTCT settings. Although not necessary to provide basic TC services, healthcare workers are encouraged to pursue additional PMTCT training so they can expand the expertise available in their facility or region. Examples of specialized training include:

- **Prevention of mother-to-child transmission of HIV:** WHO/CDC PMTCT Generic Training Package, available online at <http://www.womenchildrenhiv.org>
- **Infant feeding:**
 - A 40-hour WHO/UNICEF Breastfeeding Counselling: A training course (available at: <http://www.who.int/child-adolescent-health/publications/NUTRITION/BFC.htm>)
 - A 3-day WHO/UNICEF/UNAIDS HIV and Infant-feeding Counselling: A training course (available at: <http://www.who.int/child-adolescent-health/publications/NUTRITION/HIVC.htm>)
 - The newly developed 5-day infant and young child feeding counselling: an integrated course, which combines breastfeeding, complementary feeding and HIV and infant-feeding counselling training. (This course is expected to be available online in the near future; see <http://www.who.int/child-adolescent-health/> for additional information.)
- **Rapid testing:** WHO/HHS-CDC *HIV Rapid Testing Training Package*: Participant Manual and Trainer's Guide. Current Laboratory Practice Series (available at: <http://www.phppo.cdc.gov/dls/ila/hivtraining/>).
- **Couple counselling:** CDC Couple HIV Counselling and Testing curriculum¹
- **Basic antiretroviral treatment (ART):** WHO. *Chronic HIV Care with ARV Therapy*, Integrated Management of Adolescent and Adult Illness (IMAI), available online at <http://www.who.int/3by5/publications/documents/imai/en/>

Adapting the *TC for PMTCT Support Tools*

The *TC for PMTCT Support Tools* can be used without adaptation. However, the flipcharts, protocol wall charts and client information brochures may be more acceptable and useful to both healthcare workers and their clients if adapted to include national policies and protocols and edited to reflect local culture and referral services. The adaptation process is described in Appendix 2.

¹ On the web as of late 2006.

Introduction to TC for PMTCT

Increasing the availability and quality of TC services to pregnant and peripartum women is the critical initial step in implementing PMTCT interventions on a wide scale. Determining the HIV status of clients is a key component of PMTCT programmes and enables healthcare workers to provide the appropriate PMTCT interventions. For this reason, HIV testing is considered the “gateway” to PMTCT interventions.

TC for PMTCT services provide:

- An entry point for women to be referred for appropriate reproductive health services, provided with HIV risk-reduction messages and encouraged to bring their partners for testing and counselling.
- An opportunity for women to know their HIV status and, for those who test HIV-positive, to be provided or referred for PMTCT interventions including ARV prophylaxis and safer infant-feeding counselling and support.
- An entry point to comprehensive HIV/AIDS prevention, care, treatment and support services for women who test HIV-positive.

PMTCT programme managers should seek to integrate PMTCT services into the settings where pregnant women or those who have recently delivered already receive health services, including:

- Antenatal care settings, i.e., where routine care for healthy pregnant women is provided, including first-line management and referral, if necessary.
- Labour and delivery settings.
- Post-delivery settings. Although the focus is on the first 72 hours after delivery (when the infant can receive ARV prophylaxis), PMTCT services should ideally be offered in all settings where a woman may seek healthcare during the first 12 months after the infant's birth. Examples of post-delivery settings include:
 - Maternity or postpartum wards
 - Postpartum clinics that offer services to women who have recently delivered
 - Maternal Child Health (MCH) facilities, including well-baby and immunisation clinics
 - Well-woman, family planning or community health clinics or facilities
 - Sexually transmitted infection (STI) clinics
 - Hospital inpatient wards
 - Paediatric outpatient

Key Elements of TC for PMTCT

Successful PMTCT programmes should be flexible and offer a range of PMTCT testing and counselling approaches to meet their clients' needs. This guide and accompanying support tools build on four key elements of effective PMTCT programmes, including:

1. Provider-initiated, opt-out HIV testing and counselling during ANC, L&D, or post-delivery.
2. Essential PMTCT messages on first contact between client and healthcare worker.
3. Group PMTCT Pre-Test information session during ANC, with a follow-up option for individual Pre-Test counselling, where feasible and available.
4. Rapid HIV testing with same-day results.

These elements should be integrated into ongoing PMTCT services as appropriate and feasible. These key elements are recommended by several countries as well as by WHO, UNICEF, CDC and /or USAID.

1. **Provider-initiated, opt-out HIV testing and counselling in PMTCT settings:** The conventional voluntary counselling and testing (VCT) model relies on the client to request the test (client-initiated) whereas the provider-initiated, opt-out approach encourages healthcare workers to routinely offer HIV testing and counselling to all clients as part of the standard package of care. Clients have the right to refuse or decline the routinely recommended HIV test (i.e., the client has the right to “opt-out” of the test). The basic principles of confidentiality, consent and counselling apply. See Appendix 3 for a comparison of provider-initiated and client-initiated testing.

Routine Testing, an Example from Botswana

The PMTCT programme in Botswana assessed the impact of routinely recommending HIV testing (i.e., opt-out testing) on the uptake of HIV testing. They evaluated routine antenatal HIV testing at four clinics in Francistown, the second largest city in Botswana, where HIV prevalence has been approximately 40% since 1995. Between February and April 2004, the first 3 months of routine testing, 90.5% (314 of 347) of pregnant women were tested for HIV, compared with 75.3% (381 of 506) of women during October 2003–January 2004, the end of the client-initiated testing period. These findings underscore the potential of routine, rapid HIV testing to increase the number of people with access to PMTCT services.

The provider-initiated, opt-out HIV testing and counselling approach is recommended in the context of PMTCT because it helps to “normalize” HIV testing as a routine component of ANC. Additionally, the increasing global demand to scale-up access to care, treatment, prevention and support, including PMTCT services, reinforces the importance of routinely recommending HIV testing since this approach helps to identify a larger number of women who need interventions to reduce MTCT and who need comprehensive HIV care.

2. **Essential PMTCT messages on first contact between client and healthcare worker:** In many resource-constrained settings, pregnant women may make only one ANC visit, often late in pregnancy. Many women present to L&D or PD settings without knowing their HIV status. Therefore, providing essential PMTCT messages on the first encounter is recommended. Routine TC for PMTCT at the first ANC, L&D, or PD visit enables all pregnant and peripartum women to learn their HIV status and make informed decisions about PMTCT. Subsequent visits should be used to reinforce counselling messages and provide appropriate PMTCT interventions.
3. **Group Pre-Test information session:** Group information sessions save time, optimize human resources, allow for group interaction and can be easily integrated into the ANC and PD settings. These sessions are particularly useful where the client-to-provider ratio is high, because healthcare workers can provide basic testing and counselling messages to a large number of clients at one time. Conducting group Pre-Test information sessions as part of routine ANC is already standard practice in many resource-constrained settings.

Group Pre-Test information sessions provide clients with standardized information about HIV and HIV testing. The goal of the group Pre-Test session is to provide information the client needs to give informed consent to testing, including:

- The importance and benefits of HIV testing.
- HIV testing procedures, including the right to refuse.
- The importance of partner testing and disclosure.
- Risk-reduction and available PMTCT interventions (including HIV prevention services).
- The benefits of continuous healthcare, including antenatal, delivery and post-delivery care (including follow-up and care for the infant).

Where available, clients who attend the group Pre-Test session who have additional concerns or questions should be offered the option of individual or couple Pre-Test counselling.

4. **Rapid HIV testing with same-day results:** Rapid HIV testing is highly recommended for PMTCT settings. Rapid testing yields test results within 20–40 minutes, so clients can receive their results during the same visit they are tested, maximizing the opportunity to take advantage of all available PMTCT interventions. In comparison, obtaining results using standard ELISA tests takes hours or days. (See *Chapter V: Rapid HIV Testing in PMTCT Settings*.)

Four Guiding Principles

As mentioned above, TC for PMTCT follows the same guiding principles as conventional VCT. These guiding principles are

1. **Voluntary:** HIV testing must be truly voluntary. In settings where the test is routinely recommended, the client must be made aware of the right to decline testing. WHO and UNICEF do not support mandatory testing of individuals. Mandatory HIV testing is considered unethical because it violates an individual's freedom of choice and right to privacy. Mandatory testing also may discourage ANC attendance.
2. **Informed consent:** Informed consent is the process during which clients receive clear and accurate information about HIV testing in order to make an informed decision about whether to accept or decline testing. In the context of PMTCT, written informed consent is not required; consent may be verbal. Prior to obtaining informed consent, the client must understand the purpose and benefits of the test, and the testing and counselling process, including their right to refuse testing (opt-out). The healthcare worker must respect the client's testing decision.
3. **Confidentiality:** Maintaining confidentiality is the responsibility of all healthcare workers and is essential for establishing and maintaining client trust. A private space should be used for all discussions of HIV-related matters, particularly HIV test results. Healthcare workers should reassure the client that only those who are directly involved in her care will have access to her records—and only on a “need-to-know” basis. *All medical records and registers should be kept confidential and stored in a safe, secure (locked) place.*

4. **Post-Test counselling support and services:** HIV test results must always be provided in person as part of an individual (or couple) Post-Test counselling session. The healthcare worker should offer clear information and help both HIV-positive and HIV-negative clients make decisions about next steps.

Using this Reference Guide

The first three chapters of this *Reference Guide* provide information supporting the development of skills for healthcare workers who deliver TC services in PMTCT settings. These initial chapters provide information to support healthcare workers using the *TC for PMTCT* flipcharts, protocol wall charts and client information brochures.

- *Chapter I: Testing and Counselling in PMTCT Settings*
- *Chapter II: HIV Test Declined*
- *Chapter III: Flipchart Cards: Suggested Scripts and Complementary Messages*

The last four chapters of this *Reference Guide* (plus the References section) provide information supporting the development of a facility or organization's overall capacity to support TC for PMTCT services. These background chapters are as follows:

- *Chapter IV: Essential Skills for TC for PMTCT Programmes*
- *Chapter V: Rapid HIV Testing in PMTCT Settings*
- *Chapter VI: Implementation Issues*
- *Chapter VII: Appendices*
- *References*

Introduction: Key Points

- A key challenge for PMTCT programmes is determining the HIV status of clients.
- HIV testing is the critical first step in implementing PMTCT interventions.
- The *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools* were developed to facilitate the delivery of essential PMTCT messages to improve the uptake of HIV testing, increase the number of women who know their HIV status and provide appropriate PMTCT interventions.
- The recommended key elements of TC for PMTCT are:
 - **Provider-initiated opt-out HIV testing and counselling.** The routine offer of Pre-Test information and HIV testing to all clients as part of the standard package of care helps “normalize” HIV testing.
 - **Essential PMTCT messages on first encounter.** In some settings pregnant or peripartum women may make only one visit.
 - **Group Pre-Test information sessions.** These save time, optimize human resources, allow for group interaction and can be integrated into the ANC and PD settings.
 - **Rapid HIV testing with same-day results.** Clients can receive their results during the same visit they are tested, maximizing opportunity to take advantage of available interventions.
- The guiding principles of TC for PMTCT are:
 - **Voluntary:** Clients must agree to take the test.
 - **Informed consent:** Before giving verbal or written consent, clients must receive clear and accurate information about HIV testing including the right to decline testing.
 - **Confidentiality:** The HIV test and all HIV-related discussions are private and shared only on a “need-to-know” basis.
 - **Post-Test support and services:** Test results should be offered in person as part of an individual or couple Post-Test counselling session; referrals for care, treatment, prevention and support should be offered at this time.

Chapter I:	Testing and Counselling in PMTCT Settings	11
Section 1	Overview of Testing and Counselling for PMTCT in ANC, L&D and PD Settings	12
Section 2	Pre-Test Session	13
Section 3	Post-Test Counselling Session	22
Section 4	Subsequent Visits	29

Chapter I: Testing and Counselling in PMTCT Settings

Section 1	Overview of Testing and Counselling for PMTCT in ANC, L&D and PD Settings
Section 2	Pre-Test Session
Section 3	Post-Test Counselling Session
Section 4	Subsequent Visits

Introduction

In recognition of the public health and individual benefits of widespread implementation of PMTCT services, the overall goal of HIV testing in the PMTCT setting is to identify women in need of PMTCT services. The Pre-Test session offers an opportunity to explain the benefits of testing and the services available depending on HIV status and to encourage uptake of testing. The purpose of the Post-Test session is to present the results, discuss what the results mean and for those who test HIV-negative, how to stay HIV-negative. For clients who test HIV-positive, the Post-Test counselling session will also include how to live positively and how to reduce the likelihood of transmission to their infants and partners.

This Chapter provides guidance on implementing PMTCT services at a facility-level including: the integration of the Pre- and Post-Test sessions into clinic flow, the objectives of the Pre- and Post-Test sessions, who can conduct the sessions and how long they might take.

Background

Without intervention, during pregnancy or labour about 20–25% of women with HIV will transmit the virus to their infants. Another 5–20% of infants will become infected with HIV during breastfeeding. The antenatal care (ANC) setting is ideal for identifying the HIV status of pregnant women and providing prompt interventions for both HIV-positive and HIV-negative clients. Early identification of HIV infection in a pregnant woman allows her to:

- Maintain or improve her health through continuous access to treatment, care and support as well as risk-reduction counselling and services to “live positively” with HIV.
- Reduce the risk of transmitting the virus to her partner who may be HIV-negative.
- Take advantage of all available PMTCT interventions to reduce the risk of transmitting the virus to the baby.

However, for women who do not receive ANC or are not tested during ANC, routinely offering testing during labour and delivery (L&D) to women whose HIV status is unknown provides an opportunity to identify women who are HIV-positive and reduce transmission to the infant. Although the opportunity for some interventions will be missed if testing occurs during labour rather than ANC (see Table I.1 below), ARV prophylaxis, when initiated during labour and when given to the infant within 72 hours of birth, can still reduce MTCT by as much as 50%.

Table I.1 – PMTCT Interventions by Setting

Intervention	Setting		
	ANC	L&D	PD
• ARV treatment during pregnancy (if available)	✓		
• ARV prophylaxis for mother	✓	✓	
• Interventions during delivery that are known to reduce MTCT	✓	✓	
• ARV prophylaxis for infant (if within 72 hours after birth)	✓	✓	✓
• Counselling and support for safer infant feeding	✓	✓	✓
• Provision of (or referral to) treatment, care, prevention and support services for women infected with HIV, their infants and their families	✓	✓	✓
• Provision of (or referral to) prevention and support services for women who test negative to help them stay uninfected.	✓	✓	✓

Table I.1 shows that the maximum number of strategies to prevent MTCT are available to the woman diagnosed with HIV in the ANC setting. There are fewer interventions available to prevent HIV transmission if testing is delayed until labour or post-delivery (PD). However, the strategies that are available at L&D or PD can still significantly reduce transmission from mother to baby.

The testing and counselling process is similar regardless of stage of pregnancy or healthcare setting. This Chapter describes the steps to provide TC for PMTCT in ANC, L&D and PD settings, including

- Pre-Test session
- Post-Test counselling
- Follow-up, or subsequent, visits

Section 1: Overview of Testing and Counselling for PMTCT in ANC, L&D and PD Settings

Section 1 provides an overview of

- The steps in TC for PMTCT in antenatal care (ANC), labour and delivery (L&D) and post-delivery (PD) settings

Steps in Testing and Counselling for PMTCT

The steps in TC for PMTCT are outlined in the following table. The protocol wall charts, which can be found in Appendix 1, provide setting-specific algorithms² for TC in each of the PMTCT settings.

² An algorithm gives step-by-step instructions to accomplish a task.

Table I.2 – Steps in TC for PMTCT

Step	Chapter/ Section
1. Conduct Pre-Test session with individual client (all settings), couples (all settings), or groups (ANC and possibly PD settings). This session is abbreviated if conducted in the L&D setting.	Chapter I, Section 2
2. Offer HIV test at end of the Pre-Test session. The client accepts or declines testing.	
3. Perform HIV test by collecting blood or saliva from the client. The sample is tested using a rapid or ELISA antibody test according to the national testing algorithm.	Chapter V
OR	
4. Provide counselling to client who declines HIV test and encourage future testing.	Chapter II
5. Conduct Post-Test counselling for all clients who were tested. (In the L&D setting, there may be two Post-Test sessions: a brief one before the infant's birth during which only the essential information is provided and a more in-depth followup counselling session after delivery.) Interventions and referrals are provided during the Post-Test counselling session.	Chapter I, Section 3
6. Suggest client return for a subsequent healthcare visit for followup counselling, education, support and referrals.	Chapter I, Section 4

Section 2 Pre-Test Session

Section 2 provides an overview of

- The purpose and key messages of the Pre-Test session in all settings
- The primary models of delivery for the Pre-Test session: group information session, individual counselling and couple counselling
- Who can conduct the session
- Pre-Test session presentation and length
- Special issues for L&D settings
- Special issues for PD settings

What is the Purpose of the Pre-Test Session?

The purpose of the Pre-Test session in all PMTCT settings is to provide the woman or couple with adequate information to make an informed decision about HIV testing.

What are the Pre-Test Session Key Messages?

The following are the Pre-Test session messages in all PMTCT settings:

1. Help the client understand HIV/AIDS.
2. Explain the importance and benefits of HIV testing.
3. Explain HIV testing procedures.

Additional messages for ANC and PD settings include³:

4. Explain importance of partner testing.
 - Discordance
 - Disclosure and partner referral
5. Explain risk-reduction and available services.
 - Prevention of sexual transmission of HIV
 - PMTCT interventions, including ARV prophylaxis and safer infant feeding
 - Referral for prevention, care, treatment and support
6. Encourage continuous healthcare attendance (and delivery care⁴).

The information presented about PMTCT interventions focuses on the prevention methods still available to the woman or her infant (see Table I.1, “PMTCT Interventions by Setting”).

How Should Pre-Test Information be Delivered?

The delivery model selected for the Pre-Test session depends on many factors, including national and facility policy, client volume, staff availability and PMTCT setting. All models should:

- Optimize the human resources available (See box “Time Required for the Pre-Test” on page 17)
- Integrate HIV testing and counselling into clinic routine without disrupting client flow (see *Chapter VI: Implementation Issues*)
- Maximize the number of women tested for HIV and counselled on PMTCT services during their first visit

The three primary models and the settings where each is appropriate are as follows. (Regardless of the model used, the content of the session is similar.)

Table I.3 – Pre-Test Session Models

Model	Setting		
	ANC	L&D	PD
Model 1: Group information	✓		✓
Model 2: Individual counselling	✓	✓	✓
Model 3: Couple counselling	✓	✓	✓

Model 1: Group Information Session

Group information sessions for testing and counselling are efficient because they optimize human resources, allow for interaction among participants and can be easily integrated into the clinic flow. Group information sessions enable healthcare workers to provide the basic testing and counselling messages to many women at one time. Group information sessions are recommended for ANC settings but can be used in PD settings as well; however, group sessions are not practical or recommended for the L&D setting.

ANC settings: Staff in many ANC settings already conduct general health talks for groups of pregnant mothers. HIV information can be integrated into these health talks.

³ The latter three objectives are covered during the Post-Test session for the woman tested during labour.

⁴ For women who are pregnant (ANC settings).

PD settings: If not part of the routine already, PD clinic staff may also consider health talks similar to those already offered to ANC clients. The PD health talk would be appropriate to all clients in the waiting area and include the HIV Pre-Test information. Those whose HIV status is unknown would be offered the test when they see the healthcare worker.

The logistics of organizing group sessions depend largely on the local setting and procedures. Groups can be formed as women arrive for services or after their examinations. Group sessions may be held in waiting areas, meeting rooms, or outdoors.

Group Information Session in a PD Setting, Zambia

At the Matero Clinic in Zambia, women who come for postpartum clinic and well-child clinic are provided Pre-Test information in the waiting area. This talk includes topics such as general well-child care, nutrition and HIV. Those who do not know their HIV status are offered testing when they see the healthcare worker. Integrating TC into postpartum care at this facility has worked well, particularly because the Pre-Test information is provided to groups of clients, thereby decreasing burden on the providers.

Group information sessions may be large (more than 15 people) or relatively small (10–15 people or less); target size for group session is 5–15 clients. The advantage of the smaller group is that participants can feel more comfortable interacting and asking questions, whereas the large group allows the dissemination of information to more clients faster.

Group Pre-Test Information and Routine Testing in Botswana

In Botswana, a nurse or PMTCT counsellor gives health talks in the ANC clinics every morning. The counsellor conducts a 10–15 minute group information session covering HIV transmission, PMTCT, antiretroviral (ARV) therapy and the importance of testing for all mothers and infants. The counsellors encourage group participation and use an illustrated flipchart to help teach about HIV and PMTCT.

Since February 2004, all prenatal clinics in Botswana have offered routine (opt-out) HIV testing during ANC, increasing HIV testing uptake to about 90%. As part of the discussion, the counsellor informs women that they will be tested for HIV, although they have the right to refuse testing. All women who do not refuse HIV testing have blood drawn for the HIV test. Clients who do not want the test are encouraged to talk with a counsellor individually.

Small Group Pre-Test Session in Nigeria

In Abuja, Nigeria, one large secondary care facility registers all new ANC clients before 9:00 a.m. The women are then divided into four groups according to their preferred language. A counsellor provides each small group with Pre-Test information and offers HIV testing, which is performed in an adjacent lab on the same day. Daily registers from this facility show that uptake for HIV testing over a four-month period was over 90%.

Model 2: Individual Counselling

Individual Pre-Test counselling is a one-to-one session during which the healthcare worker offers the same messages delivered during a group Pre-Test session. Although individual counselling provides women with an opportunity to privately discuss their concerns and allows for individual risk assessment, it is time-consuming.

HIV Counsellor versus Healthcare Worker

The term “healthcare worker” is used instead of “counsellor” to reflect the range of staff and levels of counselling expertise involved in providing Pre- and Post-Test information and counselling sessions.

Ideally, individual Pre-Test counselling should be available in all PMTCT settings. In the ANC setting, individual counselling should be available either immediately or by appointment, to any woman who attends the group Pre-Test session and requests individual counselling. If it is not practical to offer individual counselling, clients who request it may be referred to a voluntary counselling and testing (VCT) site for individual Pre-Test counselling. The following are examples of mechanisms that may facilitate referrals:

- A counsellor from the VCT site comes to the PMTCT site to provide individual counselling once a week.
- The PMTCT healthcare worker makes an appointment for the client to receive VCT at another clinic.

If the client is referred off-site for Pre-Test counselling:

- Discuss with her any barriers to attendance, since many women are not willing or able to follow through.
- Communicate the importance of returning to the original site for follow-up.
- Ensure there is a mechanism to communicate test results from the referral site to the original site.

Model 3: Couple Counselling

Healthcare workers should encourage clients to invite male partners to participate in HIV testing and counselling services. Testing men, either together with their female partner or separately, is essential to:

- Gain the male partner’s support for PMTCT interventions.
- Support adherence, since HIV-positive pregnant women who are tested with their partners are more likely to adhere to PMTCT interventions. If the male partner is HIV-positive also, the couple can be referred together for treatment, care, prevention and support services.

Discordant Couple

A “discordant couple” is a couple in which one partner tests HIV-positive and the other tests HIV-negative. In many countries, discordance is common. As many as 3 out of 10 couples tested are likely to be discordant, especially in PMTCT settings.

- Identify discordant couples (see box) and support the HIV-negative partner to stay negative through risk-reduction. The HIV-negative partner in a discordant couple is at extremely high risk of acquiring HIV infection.
- Support women and men who test HIV-negative to stay negative through risk-reduction.

In couple counselling, partners receive HIV counselling together. The healthcare worker provides the same messages as in a group Pre-Test session and specifically addresses the couple's concerns. The advantages of couple counselling and testing include:

- Partners hear information and messages together, enhancing the likelihood of a shared understanding.
- The environment is safe for couples to discuss concerns.
- The counsellor has the opportunity to ease tension and diffuse blame.
- Post-Test counselling messages reflect the test results of both the man and the woman.
- Neither partner is burdened with the need to disclose results and persuade the partner to be tested.
- Couple counselling facilitates the communication and cooperation required for risk-reduction such as condom use.
- Prevention, care and treatment decisions can be made together, including decisions about PMTCT interventions such as infant feeding.

Couple counselling is appropriate in all PMTCT settings. If it is not available on-site, it should be available by referral.

Couple counselling in L&D and PD settings: Where possible, couple counselling should be available in maternity and post-delivery wards. Healthcare workers may need to be innovative, particularly if the woman was tested during labour, to develop ways to test and counsel the male partner.

Time Required for the Pre-Test

The math behind the models...

To choose the most appropriate model for their clinics, the following formula can guide PMTCT managers. Divide the number of healthcare workers available to conduct the Pre-Test session by the total number of new clients per day. For example, if a clinic averages 100 new clients each clinic day and has 2 trained staff members to conduct the Pre-Test session, each healthcare worker will provide Pre-Test counselling to an average of 50 clients per day. In this scenario:

- If each client were Pre-Test counselled individually (approximately 15 minutes with each client), each of the 2 healthcare workers would spend 12.5 hours/day in Pre-Test sessions.
- If the Pre-Test session were offered in small groups of 10 people per group, the healthcare worker would need to hold 5 groups. Assuming each group lasts 20 minutes, the healthcare worker would spend 1 hour and 40 minutes/day in Pre-Test sessions.
- If the Pre-Test were offered in 2 groups of 25, each healthcare worker would spend a total of 40 minutes per day in Pre-Test sessions.

In this scenario, conducting small or large group sessions is a more feasible option to expose more women to TC and PMTCT messages. Individual counselling may be too resource-intensive to be practical and should be reserved for clients with specific concerns.

The skills needed to provide individual and couple counselling are discussed in Chapter IV of this *Reference Guide*.

Who can Conduct the Pre-Test Information Session?

Healthcare workers with basic training in HIV counselling and some PMTCT knowledge can conduct the Pre-Test information session, including:

- Trained lay or peer counsellors, with or without a background in health
- People living with HIV/AIDS (PLHIV)
- Professional counsellors
- Nurses and midwives
- Doctors

Using nonclinical staff to provide this essential service may lighten the clinician's workload. In the L&D setting, staff qualified to provide counselling should be available on all shifts, day and night. Inform the client during the Pre-Test session if another healthcare worker will be providing the test results and Post-Test counselling.

Peer Counsellors in South Africa

At PMTCT sites where there are personnel shortages and heavy workloads, lay or peer counsellors have been trained to deliver Pre-Test sessions. In South Africa, the Mother-to-Mothers-to-Be (M2M2B) program recruits and trains HIV-infected mothers who recently participated in PMTCT programs to educate, counsel and support HIV-infected women who are receiving ANC.

How can the Pre-Test Session and Key Messages be Presented?



The ANC, L&D and PD flipcharts from the *TC for PMTCT Support Tools* package provide the essential messages that healthcare workers should cover during the Pre-Test session. These messages also appear in Chapter III of this *Reference Guide*.

In ANC and PD settings, videos or DVDs may also be used to present content or reinforce key concepts if working with small or large groups. Skills needed to provide a group information session are discussed in Chapter IV.

How Long Might the Pre-Test Session Take?

In ANC settings: It may take approximately 10–20 minutes to provide the basic information on HIV in the group Pre-Test session. Allow additional time for discussion and questions. The individual or couple Pre-Test session may take 10–20 minutes.

In L&D settings: The Pre-Test session should not take more than 5 minutes (possibly as little as 1–2 minutes), with information presented between contractions. Present only the most critical information during labour; the level of detail in the message should depend on how much the woman wants to know as suggested by her nonverbal and verbal cues. For the woman in the later stages of labour, the messages can be covered in 1–2 minutes. The noncritical information is then saved for the Post-Test session.

In PD settings: The group Pre-Test session typically takes 10–20 minutes. The individual or couple Pre-Test session may take 10–20 minutes. In both hospital and nonhospital (or community-based) PD settings, the Pre-Test session may need to be shortened. The woman in an inpatient setting may be distracted or exhausted by the birth experience and the needs of the new baby. In community-based PD settings, the session may need to be shortened to minimize staffing requirements and disruption to patient flow.

What are the Special Issues for L&D Settings?

The L&D environment presents unique challenges for the healthcare worker and the woman in labour. L&D settings are typically busy and privacy is limited. Women are often anxious and in pain. A woman in labour deserves the right to be as comfortable as possible and to receive counselling in a confidential manner as her labour permits.

Timing: The Pre-Test session should take place as soon as possible after the woman has registered in L&D and has been identified as HIV-status unknown. The approach and timing of the Pre-Test and Post-Test sessions will be guided by the stage of labour in which the woman presents. Following are some common scenarios for women of unknown HIV status arriving in labour:

- **Woman presents to L&D in early labour:** Typically, this woman is provided Pre-Test information while in labour. Her blood (or saliva) sample is then tested using rapid HIV test. She should be provided with her results as soon as they are available (whether positive or negative). If she is HIV-positive, she should be offered emotional support and ARV prophylaxis according to national policy. Any component of the Post-Test session not discussed during labour is completed after childbirth, when she can better consider the information and ask questions.
- **Woman presents to L&D in advanced labour with time for the Pre-Test session but insufficient time to give results:** Depending on the woman's comfort level, conduct the Pre-Test session and draw the blood for testing as early as possible during labour. Every attempt should be made to obtain the results before delivery and provide the mother with ARV prophylaxis. Even if the results are not back before the infant is born, they should arrive in time to inform decisions about infant feeding and infant ARV prophylaxis. Infant ARV prophylaxis will still reduce risk of transmission of MTCT if provided within 48–72 hours of birth. However, for women who did not receive ARVs before delivery, the infant prophylaxis should be given as soon as possible after birth (within one hour).
- **Woman presents to L&D late in labour with insufficient time for the Pre-Test session:** If the woman cannot be given Pre-Test information and tested during labour, the Pre-Test session, rapid testing and Post-Test counselling should be done after delivery. In this scenario, use the Post-Delivery Pre- and Post-Test Flipcharts, since the Labour and Delivery Pre- and Post-Test Counselling Flipchart is used only when an abbreviated Pre-Test session is necessary.

Obtaining consent to provide ARVs: Written or verbal consent (in most settings verbal consent is appropriate) to administer ARV prophylaxis should be obtained at the same time that consent for HIV testing is sought, so there is no need to ask again. It is always important for the healthcare worker to explain any side effects and purpose of the medication she or he is giving.

Conducting the L&D Pre-Test session: The following is guidance on conducting the Pre-Test session, including practical tips to help protect confidentiality in a busy L&D ward.

- Before beginning the Pre-Test session, ensure that the woman is between contractions and comfortable. Agree on a signal that the woman can use to indicate when a contraction begins and when it ends; wait until the contraction is over before resuming the session.
- If there is no record that the client had an HIV test during this pregnancy, inform her that she will receive information about HIV testing.
 - Ask her whom, if anyone, she would like present for the session.
 - If she would like to be alone, ask the family to leave the room for just a moment. If a physical exam is required, for example to assess progress of labour, then the healthcare worker can excuse the family for the physical exam and then conduct the Pre-Test session before the family is given permission to return.
 - Ask whom she would like to be present when she receives the test result.
- Speak in soft tones, but make sure she can hear.
- Use a temporary screen or curtain around the bed for privacy, if available,
- The session can be conducted in a corridor, waiting area, or any other quiet place where some degree of privacy is possible.

Confidentiality in the L&D Setting: An Example from the United States

In the large, multi-site Mother-Infant Rapid Intervention at Delivery (MIRIAD) study in the United States, study coordinators often found it difficult to see women alone for the HIV counselling session. Family members often felt that they should be allowed to hear all the information given to the client in labour, making the topic of HIV testing difficult to address. In those instances, MIRIAD researchers brought a doctor into the room to perform a “physical exam” on the woman in labour, for which family members were willing to leave the bedside. The “physical exam” provided privacy for a Pre-Test session and an opportunity for the client to accept or refuse testing.

What are the Special Issues for PD Settings?

Inpatient settings (such as a maternity or postpartum wards): Testing and counselling for PMTCT after delivery but before discharge from the maternity ward is slightly more relaxed than in the L&D setting. Nevertheless, there are often major challenges, including:

- Lack of sufficient private space to assure confidentiality.
- Maternity staff who are often very busy providing maternity care.
- New mothers who are distracted by the baby, visitors or experiences surrounding the recent birth. (See example of how to handle confidentiality issues in box above.)

Community-based PD settings (postpartum, well-child, family planning, or community health clinics): A woman who goes to a healthcare setting for her own or her infant’s follow-up care (or for another reason), may not expect an invitation to be tested for HIV.

When raising the topic of HIV in an environment where the client does not expect a recommendation of HIV testing:

- Ensure client knows that the offer is routine; in other words, that she has not been singled out for this test.
- Ensure the client understands the benefits of testing to herself, her baby and family.
- If client appears hesitant to accept testing, address her reservations. “You appear to be [*use a word that summarizes client’s reaction, e.g., surprised, offended, hesitant, unconvinced*] by the suggestion of testing. Would you like to discuss your reaction?” If the client declines testing, refer to Chapter II for guidance.

Infant Eligibility for ARV Prophylaxis

Early timing of post-delivery testing and counselling should be a priority, particularly if the infant is less than 72 hours of age (the age at which infants are eligible for prophylaxis). Infants over 72 hours of age are not given ARV prophylaxis because it is not effective.

Note: If the woman did not receive ARV prophylaxis or treatment prior to delivery, the infant ARV dose should be administered as soon as possible, ideally within 1 hour of birth.

Timing: In each of these settings, the Pre-Test session should take place as soon as feasible during the first visit. For inpatient settings (e.g., maternity or postpartum ward), the Pre-Test session should be offered so results will be available at least an hour before discharge, allowing time for the Post-Test counselling session.

Summary of Pre-Test Session

1. The purpose of the Pre-Test session in all PMTCT settings is to provide the client or couple with adequate information to make an informed decision about HIV testing. Messages include the basics about HIV, benefits of testing and explanation of HIV testing procedures. In ANC and PD settings, the Pre-Test session also includes information on partner testing, risk-reduction and encouragement to seek continuous healthcare.
2. There are three primary models for delivering the Pre-Test session: group information sessions, individual counselling, and couple counselling. In the ANC setting, group sessions are recommended. In the L&D and other hospital-based settings, Pre-Test information is usually provided individually; couple counselling should be offered when possible. In community-based PD settings, Pre-Test counselling may be presented in groups, individually, or as couple counselling.
3. Healthcare workers should encourage male partners to test for HIV.
4. Healthcare workers with basic training in HIV counselling and PMTCT, including doctors, nurses and midwives, and trained counsellors (professional, lay or peer), can conduct the Pre-Test information session.
5. The ANC, L&D and PD flipcharts provide the essential messages that should be communicated during the Pre-Test session.
6. The Pre-Test session should take approximately:
 - 10–20 minutes for the group session and 10–20 minutes for individual or couple sessions in the ANC setting.
 - No more than 5 minutes in the L&D setting (feasibly 1–2 minutes).
 - 10–20 minutes in the PD setting.

Section 3 Post-Test Counselling Session

Section 3 provides an overview of

- The purpose and key messages of the Post-Test counselling session in all settings.
- Approaches to the Post-Test session
- Who can conduct the session
- Post-Test counselling session presentation and length
- Tailoring HIV prevention messages to client need
- Special issues for L&D and PD settings
- Disclosure, partner referral and discordance in Post-Test counselling

What is the Purpose of the Post-Test Counselling Session?

The purpose of the Post-Test session is to provide the woman or couple with the HIV test result and to offer counselling, prevention education (including risk-reduction messages and safer infant feeding counselling) and support and referrals to appropriate services. The Post-Test session is crucial for explaining and encouraging the client with HIV infection to accept the PMTCT interventions that will benefit her and her infant.

What are the Post-Test Counselling Key Messages?

The following are the essential Post-Test counselling messages for clients who test HIV-negative:

1. Explain negative test results.
2. Discuss importance of partner testing and discordance.
3. Explain importance of HIV prevention and risk-reduction steps.
4. Encourage continuous healthcare attendance and delivery in health facility⁵, and promote exclusive breastfeeding.

The following are the essential Post-Test counselling messages for clients who test HIV-positive:

1. Explain positive test result and provide support.
2. Discuss available PMTCT services, including
 - PMTCT interventions, including ARV prophylaxis, safer birth⁵ and safer infant feeding
3. Discuss importance of partner testing and prevention of sexual transmission.
 - Discordance
 - Disclosure and partner referral
 - Prevention of sexual transmission of HIV
4. Provide information on available treatment, care, nutrition, family planning and support services.
5. Encourage healthcare visits and return visit.
 - Cotrimoxazole prophylaxis for the infant
 - Infant testing
 - Referral of older children for HIV testing

What are the Approaches to the Post-Test Session?

All HIV test results, whether positive or negative, must be given in person and tailored to the woman's situation. Post-Test counselling sessions are conducted in private, either individually or as a couple.

During Post-Test counselling, it is important to put the woman or couple at ease. The counsellor should make every effort to provide a quiet and private room for the discussion.

Post-Test Counselling Session

- In resource-limited settings where there is limited access to healthcare services, the first Post-Test counselling session is often the only Post-Test counselling session clients attend.
- **It is important that healthcare workers provide *all* of the essential information appropriate for the test result during this first session.**
- Use the *TC for PMTCT Support Tools* flipcharts or messages to ensure all critical messages are covered.

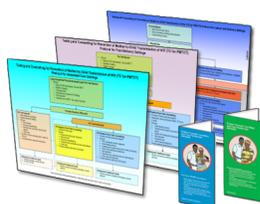
⁵ For women who are pregnant (ANC settings).

It is important for the woman or couple to have time to reflect on the test result and understand the options. Ideally, couple and/or family follow-up counselling should be arranged. It is critical to provide a message of hope and support and to help the woman or couple recognize that they are not alone. Where available, encourage her (them) to attend subsequent counselling sessions for support and for reinforcement of critical messages. Additional information about the couple session can be found in Chapter IV of this *Reference Guide*.

Who can Conduct the Post-Test Counselling Session?

Ideally, the same healthcare worker who conducted the Pre-Test session will also conduct the Post-Test counselling session (see page 18 in Section 2 of this Chapter). In reality, this may be difficult due to shift changes and workload. Healthcare workers who conduct the Post-Test counselling session should be trained in this area and have a thorough understanding of the importance of confidentiality.

How can the Post-Test Session and Key Messages be Presented?



As with the Pre-Test session, the *TC for PMTCT Support Tools* flipchart (available for ANC, L&D and PD settings) can be used to guide the Post-Test session. These messages also appear in Chapter III of this *Reference Guide*.

If available, provide clients with a leaflet, such as the client information brochure, to reinforce Post-Test counselling messages.

Tailoring HIV Prevention Messages to Client Need

Prevention messages are most effective when the counsellor tailors them to a client's situation and experience. To assess HIV risk, ask the client the following key questions.

- How many sexual partners have you had in the past 12 months?
- How often do you use condoms with your partner(s)?
- Have you ever been diagnosed with a sexually transmitted infection (STI)?
- Do you know how many sexual partners your partner(s) has had in the past 12 months?
- Has (have) your partner(s) ever been tested for HIV?
- Have you or your partner(s) ever injected drugs, vitamins, or anything else with a needle (self-administered or administered by someone who is not a healthcare worker)?
- Have you or your partner(s) ever had tattoos, body piercing, or scarification?
- Did you recently receive a blood transfusion that may not have been screened for HIV?

The information provided by the client will allow the healthcare worker to customize the prevention messages. For example, if the client has two regular partners, the healthcare worker knows to refer to the plural "partners". If the client has never injected drugs, then the healthcare worker can skip prevention messages applicable to injecting drug use.

Appendix 4 includes risk-reduction messages appropriate for individual and couple HIV Post-Test counselling. If the healthcare worker determines that the client is at high risk for HIV and needs extensive support in developing a prevention plan, the healthcare worker should refer the client to a local VCT site for counselling.

Disclosure and Partner Referral

Disclosure is an important component of the Post-Test counselling session, particularly for the client who has just tested HIV-positive. Disclosure of HIV status to family and partner can be the first step in seeking support for adherence to PMTCT interventions, partner testing and acceptance of referrals for HIV-related care, treatment and support. Fear of stigma and discrimination prevents many women from disclosing their HIV status, even to their partner.

Approaches that may help clients deal with stigma and encourage disclosure include:

- Encourage male involvement in PMTCT activities as key to increasing women's uptake of services: male participation in couple counselling increases uptake of PMTCT interventions, particularly HIV testing. Clinic staff may have to recruit men through personal invitations and publicity campaigns and may have to rearrange their clinic hours and patient flow to make it more conducive to having men attend clinic.
- Ensure that disclosure is addressed as part of the Post-Test counselling session.
- Encourage women to disclose to a trusted female; a woman is often more likely to disclose to another woman before disclosing to her partner.
- Set up ways to identify and support women who are likely to experience negative outcomes from disclosure; this may include, for example, couples counselling, accompanying women when they disclose to their partners, domestic violence screening of all women and the establishment of referral networks with women's shelters.
- Encourage clients to attend support groups.
- Support and participate in community-level interventions that increase knowledge about HIV and PMTCT, encourage disclosure and reduce stigma.
- Use the Post-Test counselling session to provide all clients with individual counselling and education to support their adherence to PMTCT interventions.

Table I.4 – Disclosure and Partner Referral: Guidance for Healthcare Workers

Protocol	Content
Explore client's feelings about telling partner(s).	<ul style="list-style-type: none"> • Have you thought about telling your partner(s) about your test result? • What are your feelings about talking to your partner(s) about your test result? What are your concerns?
Remind them that result does not indicate partner's HIV status.	<ul style="list-style-type: none"> • Your test result does not indicate what your partner's result will be. • Your partner must be tested in order to know his or her result.
Identify partners who need to be informed.	<ul style="list-style-type: none"> • Whom do you believe may need to know about your result? It is your personal decision to choose whom to tell. (Encourage client who tested HIV-positive to disclose to past sexual partners so that they can be tested.)

Protocol	Content
Discuss possible approaches to disclosing HIV status.	<ul style="list-style-type: none"> • When should you tell them? Disclose when you are ready. In most situations, you can take your time to consider whom to tell and how to tell them. • Where is the best place to have this conversation? Pick a private place to tell the person, at a time when the person is relaxed. <p>For clients who tested HIV-positive:</p> <ul style="list-style-type: none"> • What do you want to tell them about your HIV infection? Learn what you can about HIV so that you can answer their questions. Be prepared to discuss how HIV is and is NOT transmitted. • What are you expecting from the person to whom you are disclosing your HIV status? What is the worst consequence that might happen if you were to tell him? How would you deal with this? • Accept their reaction. You cannot control the fears and feelings of others. • Stay calm, even if the other person gets angry or emotional. If the person does react badly, it is better to wait for the person to calm down. Once the person is calm, ask him/her to explain why he or she is feeling this way. Try to address the person's concerns. If you do not feel that the person will listen to you, suggest talking with the HIV counsellor together. • Be patient. It may take some time for those you tell to process the information.
Support client to refer partner for testing.	<ul style="list-style-type: none"> • Are there particular partners you are worried about? • Tell me your feelings about asking your partner to be tested. • How would you and your partner handle it if he or she were HIV-negative? How about if he or she were HIV-positive?
Practise.	<ul style="list-style-type: none"> • Let's imagine that I am your partner. Tell me about your results and I will respond. It is good to practise this conversation.
Anticipate partner reactions.	<ul style="list-style-type: none"> • How do you believe your partner will react to your telling her or him? • How have you and he handled difficult conversations in the past?
Provide support.	<ul style="list-style-type: none"> • There has been a lot we have talked about today. It is a challenge to deal with being HIV-infected. With time and support, you will adjust and be able to live "positively."

Language to Encourage Partner Referral

While some women receive negative reactions when they tell people about their HIV status, many others get positive reactions. Even if someone reacts badly at first, they may be supportive once the initial shock wears off. The following statements may help the woman introduce the topic of HIV testing with her partner:

- To make sure we're both doing as much as we can to protect each other and our baby from HIV, I'd like (or the nurse wants) you to come with me to the clinic to get an HIV test.
- At the clinic, they now encourage HIV testing for everyone. I don't know my result yet, but the nurse told me that you need to get an HIV test, too. She expects you to come with me next Friday.
- *No mention of purpose of clinic visit:* The nurse said that you need to come to the ANC (or PD) clinic with me the next time. So, can you join me next Tuesday?
- *If she tested HIV-positive:* I have something to tell you. I have HIV.
- *If she tested HIV-positive:* I was tested at the clinic today and my test was HIV-positive. I would like (or the nurse wants) you to be tested as well. I need your support now more than ever. Together we can do everything possible to reduce the likelihood that the baby will get HIV and deal with this ourselves. They'll tell us more when we go in.

How Long Might the Post-Test Counselling Session Take?

ANC and PD settings: The Post-Test session for the woman or couple who tests HIV-negative typically lasts about 5–10 minutes. This time is used to review prevention of HIV transmission, reinforce key safe motherhood messages and answer any questions. This is an important opportunity to provide primary prevention messages. The Post-Test session for the person who is HIV-positive generally takes from 15–30 minutes or longer, depending on the need for support. The Post-Test session messages should be reinforced during subsequent visits (see Section 4 of this Chapter). The Post-Test session messages for the client or couple testing HIV-negative and those testing HIV-positive may be found in the flipchart as well as in Chapter III of this *Reference Guide*.

L&D setting: The amount of time allocated and the messages presented during the Post-Test session will differ, depending on the timing (during labour or post-delivery) and the test result (HIV-negative or HIV-positive).

- **During labour:** The Post-Test session during labour should be as brief as possible and include essential messages only. This session is for the provision of the HIV test result and, if HIV-positive, PMTCT interventions.
- **After delivery:** The Post-Test session after delivery is when the client is provided with further information about her test result, counselling, education and support, as well as referrals. This session is provided to all women who were tested during labour, whether or not they received their results before delivery.

Table I.5 – Time Required for Post-Test Session

Test Result	Post-Test Session during Labour	Post-Test Session after Delivery
HIV-negative	1–2 minutes	About 5–10 minutes
HIV-positive	Rarely more than 5 minutes (presented between contractions); follow-up required after delivery	15–30 minutes or longer

What are the Special Issues for L&D Settings?

Timing: The test results should be given to the client as soon as available to alleviate anxiety and maximize time for maternal and infant prophylaxis. If it is too close to delivery for the mother to take prophylaxis, test results can be provided after delivery.

Confidentiality: The same challenges that face the healthcare worker and the woman in labour during the Pre-Test information session are present during Post-Test counselling as well, such as high levels of noise and activity and limited privacy. Due to the sensitive nature of the information, privacy must be ensured and confidentiality preserved. In some facilities, there is a designated room close to the postpartum ward for confidential discussions about test results and safer infant feeding practices.

Referrals for care: Women who receive HIV testing and counselling during L&D have not been tested during ANC, which suggests that either they did not seek care or that PMTCT was unavailable. It is especially important that healthcare workers make referrals for treatment, care, prevention and support for these women and their infants. Before discharge, all clients, regardless of HIV status, should be given appointments for postpartum and well-baby visits and referred for follow-up care. Referrals should include the name of the clinic, contact person, contact information and the date and time for the first post-natal visit.

Innovative Country Practice: Lay Counsellors in South Africa

At a hospital in South Africa, lay counsellors conduct Pre- and Post-Test counselling, as well as pre-discharge counselling, to all mothers who were not tested prior to delivery. The programme provides rapid HIV testing and offers women who are HIV-infected infant feeding information and ARV prophylaxis for their infants. The lay counsellors have achieved an HIV test acceptance rate of 63% and the clinic staff has accepted lay counsellors working in the wards post-delivery.

What are the Special Issues for PD Settings?

Table I.6, below, shows how the Post-Test counselling session for the client who was tested in the PD setting differs from that in other settings.

Table I.6 – Special Issues for PD Settings

Topic	HIV-Negative Women	HIV-Positive Women
Infant ARV prophylaxis	Not applicable	If less than 72 hours after birth, give (or refer for) infant ARV prophylaxis. ARV prophylaxis should be taken immediately or as soon as possible after birth. (If the infant was born more than 72 hours ago, either do not mention infant ARV prophylaxis or state that it is too late for infant prophylaxis and offer other services.)
Infant feeding	Tailor counselling to a woman who has already started feeding her infant.	Tailor counselling to the woman who is already feeding her infant. Assess the woman's feeding choice to ensure it is the most acceptable, feasible, affordable, sustainable and safe (AFASS) for her situation.

Section 4 Subsequent Visits

Section 4 provides an overview of

- The purpose and key message of the subsequent healthcare visit session
- Who can conduct the subsequent visit session?
- Subsequent visit presentation and length

Why are Subsequent Healthcare Visits Important?

An important component of the Post-Test session is the offer of subsequent healthcare visits and referrals for treatment, care, prevention and support services. Referrals to facilities, groups, or organizations offering support services are important for all clients. However, they are particularly important for the woman who has just found out that she is HIV-positive. The organizations to which she is referred will be instrumental in providing treatment, care, prevention and support services to the woman, her partner, her children and other family members.

“Subsequent healthcare visit” refers to any session conducted after the initial Post-Test session (when the test results were given). The client may attend subsequent sessions alone, with her partner, or with another close friend or family member. Invite all women to return for subsequent healthcare visits, particularly those who test HIV-positive. The subsequent sessions may take place several hours, days, weeks, or months after the initial session. To avoid the inconvenience of multiple return visits, the timing of the subsequent visit can coincide with the next regular ANC or other follow-up visit.

What is the Purpose of a Subsequent Visit?

The purpose of a subsequent healthcare visit is to provide the woman or couple with:

- An opportunity to ask questions about the previous Pre- and Post-Test sessions.
- Partner counselling and testing (if this has not occurred previously).
- Emotional support.
- Reinforcement of messages and referrals provided during the first Post-Test counselling session such as ARV prophylaxis regimens, safer infant feeding, partner referral and referrals for HIV-related treatment, care, prevention and support.
- An opportunity to re-test, if there is concern that the client's HIV status may have changed since the previous HIV test.

Subsequent sessions are confidential, like the original Post-Test session. As such, these sessions should be conducted in a quiet and private space.

Who can Conduct the Subsequent Visit Session?

Like the Pre-Test and Post-Test sessions, the subsequent healthcare visit can be conducted by a healthcare worker with basic training in HIV counselling and PMTCT. See page 18 in Section 2 of this Chapter for additional information. The session may also be conducted by a healthcare worker with specific expertise; for example, a nurse trained in infant feeding may provide further counselling on infant feeding options, a doctor or pharmacist may counsel the client further on ARV adherence, and a nurse may provide supportive counselling.

What are the Key Messages for the Subsequent Visit Session?



As most of the material to be covered in the subsequent visit session was included in the initial Post-Test session, the *TC for PMTCT Support Tools* flipcharts for Post-Test sessions include the essential messages. These messages also appear in Chapter III of this *Reference Guide*.

The client (and her partner) should be allowed to take the lead during the subsequent visit, with the healthcare worker responding to the client's (and partner's) concerns or questions. Once the client has finished asking questions, if time permits, the healthcare worker may want to reinforce the important messages communicated during the initial Post-Test session. The healthcare worker also should emphasize the importance of following-up the referrals for treatment, care, prevention and support.

Topics for the Subsequent Healthcare Visit Session

- PMTCT interventions (ARV treatment and prophylaxis; safer delivery practices; infant feeding; referrals for treatment, care, prevention and support).
 - Developing a plan to accept and adhere to the ARV prophylaxis regimen
 - Developing a plan to safely feed her infant
- “Positive living,” including her (and his) intention to seek regular healthcare services.
- The potential for discordance and the need for disclosure and partner referral, if she has not yet done so.
- HIV prevention and risk-reduction practices such as safer sex and condom use.
- Referrals for ongoing treatment, care, prevention and support (see Chapter VI for information about developing a referral network).

The above topics are described in detail in the *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools* flipchart (available for ANC, L&D and PD settings).

How Long Might the Subsequent Visit Session Take?

Whether the subsequent visit is part of the consultation or a follow-up Post-Test counselling session, it may last from 15–30 minutes or longer, depending on the need for support and number of questions.

Summary of Post-Test Session and Subsequent Visit

1. The purpose of the Post-Test session is to provide the woman or couple with the HIV test result; to offer counselling and prevention education including risk-reduction messages as well as support and referrals to services. For those who test HIV-positive, the Post-Test session should also provide a summary of PMTCT interventions including ARV prophylaxis and infant feeding options.
2. All HIV test results, whether positive or negative, must be given in person, conducted in private and tailored to the woman’s or couple’s HIV status.
3. The healthcare worker should provide all of the essential information during this Post-Test counselling session, since this session may be the only Post-Test counselling session for a woman with limited access to healthcare services.
4. In the ANC and PD settings, the Post-Test session for a client who tests HIV-negative is brief, typically 5–10 minutes; the session can last about 15–30 minutes for a client who tests HIV-positive. In the L&D setting, the Post-Test session during labour should be as brief as possible and include essential messages only. The Post-Test session that takes place after delivery reinforces and elaborates on messages provided during labour.
5. The “subsequent healthcare visit session” takes place after the initial Post-Test session. Its purpose is to provide the opportunity to ask questions, and receive support and partner testing.

Chapter II: HIV Test Declined	33
Section 1 Reasons for Declining HIV Testing in PMTCT Settings	34
Section 2 Counselling Approaches for Clients Who Decline HIV Testing	37

Chapter II: HIV Test Declined

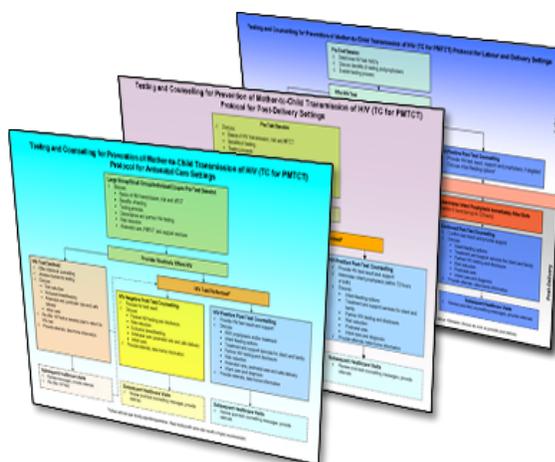
Section 1	Reasons for Declining HIV Testing in PMTCT Settings
Section 2	Counselling Approaches for Clients Who Decline HIV Testing

Steps for Clients Who Decline HIV Testing

This Chapter reviews some of the reasons why PMTCT clients decline HIV testing and discusses the actions that healthcare workers can take to facilitate consent to make testing possible. The following steps provide an overview of the protocol for clients who decline testing.

- **Offer individual counselling** either on-site or by referral, if not offered previously (such as ANC settings that use the group Pre-Test model).
- **Identify and address barriers to testing.**
- **Discuss risk-reduction** including exclusive breastfeeding, antenatal care, safer delivery, postnatal care and infant care.
- **Re-offer HIV test** or develop a plan for client to return for HIV test.
- **Provide referrals** to family planning, VCT and other healthcare services. Provide written information such as the client information brochure that is included with the *TC for PMTCT Support Tools* package.
- **Suggest subsequent visits to:**
 - Review the messages discussed during the previous sessions. Enquire if she followed up with referrals.
 - Re-offer HIV test or develop a plan for client to return for HIV test.

The *TC for PMTCT Support Tools* protocol wall charts for ANC, L&D and PD settings provide guidance on the HIV Test Declined session.



Section 1: Reasons for Declining HIV Testing in PMTCT Settings

Section 1 provides an overview of

- The reasons clients decline HIV testing
- Approaches to supporting and encouraging clients to reconsider and accept testing

What are the Reasons for Declining HIV Testing in PMTCT Settings?

The client who declines HIV testing...

...should be provided all other routine services as part of her care; *she should never be coerced into testing nor tested without her consent.*

Often a client's concerns about testing are rooted in family, culture and community. This section includes some of the most frequently stated reasons for declining testing in PMTCT settings, followed by suggested approaches to addressing the barriers.

1. **Needs permission to get tested:** As HIV testing becomes part of routine care, it is increasingly likely that women will be offered testing and will know their HIV status before their partners. Some women are uncomfortable being tested for HIV without their partner's or extended family members'

knowledge. When counselling a woman who needs approval before consenting to being tested:

- Review the benefits of learning her HIV status during her current visit.
 - Suggest that the client discuss testing with her partner and return for testing later.
 - If couple testing and counselling is available, reschedule or refer the client and her partner for a couple counselling and testing session.
 - Ask if the client would like her extended family included in the testing and counselling process. If she would, then encourage family members to attend the Pre-Test session.
 - Conduct the Post-Test session individually or with a couple (the couple may be the client and her partner or a family member). Where feasible, consider a subsequent visit for the extended family to answer questions.
2. **Perception of low-risk for HIV infection:** Some clients feel they do not need to be tested because they do not think they are at risk for HIV, or they believe none of their partners has been at risk for HIV. When counselling a woman who perceives she is at low-risk of acquiring HIV:
 - Review sexual transmission of HIV. Remind her that HIV is common in the community and that since every pregnant woman has had unprotected sex she is potentially at risk for HIV infection.
 - Explain that her risk is closely associated with both her sexual history and her partner's sexual history.
 - Mention that an HIV-infected person may look and feel healthy but is still able to transmit the virus.
 - Reiterate that testing is especially important in pregnancy to prevent HIV transmission to the baby.

3. **Prior HIV-negative test results:** Some clients who have tested negative for HIV previously or whose partner recently tested negative for HIV may not recognize the need for re-testing. It is common for people to think that a negative test result from months or years ago is still valid. Others assume that a negative HIV test suggests immunity or that a partner's recent negative test result reflects their own. When counselling a woman who previously tested HIV-negative:
- Praise the woman for having been tested.
 - Explain that though she was HIV-negative in the past, she could have been infected since her last test.
 - Inform her that a negative HIV test does not imply immunity; unfortunately, no one is immune to HIV.
 - Remind her that repeating an HIV test during the current pregnancy is important to prevent HIV transmission to the baby.
 - If her partner has tested HIV-negative, explain discordance and stress that her partner's result does not mean that she is HIV-negative.
4. **Fear of testing and learning the results:** Another reason clients may decline HIV testing is that they fear their results will not be kept confidential or they fear stigma, discrimination, abuse or blame for bringing HIV into their family. Healthcare workers should try to identify the source of fear in order to provide appropriate counselling. When counselling a woman who fears testing or learning her result:
- Reassure the client that records are kept private and not shared with anyone except healthcare workers involved in their direct care. As always, ensure confidentiality is strictly observed.
 - Suggest that the client consider inviting a relative or friend to accompany her when she is tested.
 - Find out if the client would want couple HIV counselling. If so, reschedule or refer the client and her partner for couple HIV counselling and testing.
- Studies have shown that most HIV-infected women who disclose their status to their partners *do not* experience physical violence or abandonment. However, for women whose partners do react negatively, the consequences can be severe.
5. **Fear of illness or infecting others:** When counselling a client who is afraid of illness and of infecting others:
- Remind client that most people test HIV-negative and that regardless of status, most people report relief just to know their HIV status.
 - Remind the client that if she does test HIV-positive she can be referred for HIV treatment, care, prevention and support services that will prolong her life. She can also take steps to protect her partner and infant from HIV.
6. **Assumed to be HIV-positive:** When counselling a woman who assumes she is HIV-infected even though she has not yet tested:
- Explain that learning her HIV status will relieve her anxiety about not knowing.
 - Explain that if confirmed that she has HIV, she can take steps to lower the chance of passing HIV to her infant and partner. She can also seek the care and treatment she will need to live a healthier life with HIV. This will help her take care of her baby and family.

- If her partner has tested HIV-positive, explain discordance and stress that her partner's result does not mean she is HIV-positive too.
7. **Unable to protect herself from HIV:** When counselling a woman who feels she cannot change the behaviours that put her at risk for HIV, in addition to the approaches above:
- Review sources of family and community support.
 - Discuss creative ways that she can negotiate condom use.
 - Consider discussing alternative income-generating schemes.
 - If it is likely that she exchanges sex for money, refer her to an HIV prevention program that targets sex workers, if available.
8. **Institutional barriers:** Clients may decline testing because their healthcare worker did not strongly recommend testing or because their healthcare worker had a judgemental attitude. Healthcare worker attitudes, particularly their attitudes towards PLHIV, can dramatically affect the uptake of PMTCT services. A study in Côte d'Ivoire found that many of the HIV-infected women did not return for PMTCT interventions because they had negative experiences with healthcare staff. Usually the women stated that they were afraid of being admonished by staff members for doing something wrong. The researchers concluded that having a positive, service-oriented staff is important for retaining women in PMTCT programmes.

Other institutional barriers to HIV testing include lack of on-site Pre-Test counselling, lack of on-site testing and long waits for test results. Institutional barriers are covered in more detail in *Chapter VI: Implementation Issues*.

What are the Reasons for Declining Testing during L&D?

Delivery is a stressful and hectic time for women and healthcare workers. Women who are focused on pain relief and preparing themselves for delivery may not be able to focus on counselling messages. Other women may decline HIV testing because they do not want to receive "bad news" before the birth. When counselling a woman who declines the initial offer of HIV testing during labour because she does not want to receive "bad news":

- Remind client that most people test HIV-negative.
- Re-frame the possible HIV-positive result as:
 - Bringing with it the good news that PMTCT interventions, if initiated during labour or immediately after birth, can lower the chance of passing HIV to her baby.
 - Providing an opportunity to seek care and, if eligible, treatment to live a healthier life and to help her take care of her baby and family.

When counselling a woman who declines the initial offer of HIV testing during labour because she does not want to lose focus on the birth:

- Suggest that HIV testing is now a routine part of labour and delivery. The testing process is simple and will not distract her from the birth experience any more than any other routine procedure in labour. Let her know that you will try your best to ensure she is not distracted more than necessary. Ask her if there is anything else you can do to ensure labour proceeds as she would wish.
- Re-frame her focus on labour as interest in her infant's well-being. If she finds out now that she is HIV-infected, there are PMTCT interventions available to reduce the likelihood that she will pass HIV to her infant. Specifically, if tested now she can take advantage of ARV prophylaxis, which can reduce HIV transmission by 50%.

If, even after discussion, she decides not to test for HIV despite understanding the advantages of knowing her HIV status, then this decision must be respected. Labour is a stressful time. Ensure that the HIV test is re-offered to her after delivery when she is more comfortable and rested.

Section 2: Counselling Approaches for Clients Who Decline HIV Testing

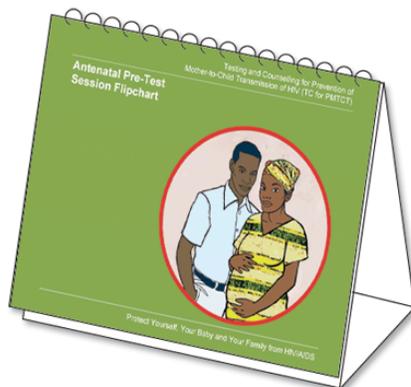
Section 2 provides an overview of

- The purpose and key messages of the Test Declined counselling session
- Approaches to the Test Declined counselling session, including who can conduct the session and length

What is the Purpose of the Test Declined Session?

The purpose of the Test Declined session is to provide the client or couple who has refused testing with more information to make an informed decision about HIV testing.

How can the Test Declined Counselling Session be Presented and What are the Key Messages?



The *TC for PMTCT Support Tools* flipcharts provide the essential messages that should be covered during the Test Declined session. Note that the Test Declined cards in the flipcharts do not have pictures. If the flipchart is not available, the messages in Chapter III can be used to guide the counsellor.

The Test Declined messages focus on addressing barriers to testing, restating the reasons for taking the HIV test, reoffering the test, and for those who continue to decline:

- Risk-reduction steps
- Importance of exclusive breastfeeding
- Antenatal and postnatal care

When and Where Should Test Declined Counselling Occur?

The session for clients who decline the HIV test should take place during an individual or couple counselling session in a private area conducive to confidential discussion. **ANC or PD clients**

who decline HIV testing should be counselled again during the same visit and, if they continue to decline testing, should be followed-up during subsequent visits.

L&D clients: The healthcare worker should only attempt follow-up counselling during labour if the client is physically comfortable. If the client is not comfortable, the Test Declined counselling should be postponed until after the delivery but before discharge.

Who can Conduct Test Declined Counselling and How Long Might the Session Take?

Healthcare workers with basic training in HIV counselling and PMTCT can conduct the Test Declined session. (See page 18 in Chapter I of this *Reference Guide* for additional information.) The session for the client who declined testing may take approximately 5 minutes. Allow additional time for discussion and questions.

Summary of the “Test Declined” Counselling Session

1. A client may decline HIV testing in a PMTCT setting for many reasons, including:
 - Need to discuss testing or get approval from partner and family
 - Low perception of risk for HIV infection
 - Prior HIV-negative test results
 - Fear of testing and/or learning their results
 - Institutional barriers
2. The healthcare worker should explore with the client her reasons for not wanting HIV testing, address barriers, and review the benefits for the client and her baby of learning her HIV status. In some cases, the client may need more information about HIV transmission, or she may have misconceptions about her previous test result or her partner’s test result. As appropriate, she should be reassured about confidentiality and the services available to her.
3. The purpose of the follow-up session with the client who declines HIV testing is to provide the client (or couple) with information to make an informed decision about HIV testing.
4. The “Test Declined” session, which may take about 5 minutes, should take place in a private area and occur as soon as possible after the Pre-Test session.

Chapter III: Flipchart Cards:	
Suggested Scripts and Complementary Messages	39
Section 1 Overview of the Flipchart Cards, Suggested Scripts and Complementary Messages	39
Section 2 Pre-Test Session Messages	40
Section 3 Post-Test Counselling Session Messages	49
Section 4 Test Declined Counselling Session Messages	66

Chapter III: Flipchart Cards: Suggested Scripts and Complementary Messages

Section 1	Overview of the Flipchart Cards, Suggested Scripts and Complementary Messages
Section 2	Pre-Test Session Messages
Section 3	Post-Test Counselling Session Messages
Section 4	Test Declined Counselling Session Messages

Section 1: Overview of the Flipchart Cards, Suggested Scripts and Complementary Messages



This Chapter includes the scripts for all of the cards in each of the flipcharts (available for ANC, L&D and PD settings).

Chapter III is organized as follows:

- Section 2 Contains the flipchart cards for the Pre-Test session for all PMTCT settings
- Section 3 Contains the flipchart cards for the Post-Test counselling session for all PMTCT settings
- Section 4 Contains the flipchart cards for the HIV Test Declined counselling session in all PMTCT settings

- **“Script”** is the standard suggested message for the Pre-Test, Post-Test or Test Declined sessions, to guide the group, individual or couple sessions.
- **“Complementary messages”** are the background information the healthcare worker requires to fully understand the material, accurately answer questions and address concerns. The complementary messages are not part of the routine session, but may be discussed with clients who would like additional information.

Each table in the following sections includes the “scripts” from all of the flipchart cards. The script is then further explained by the “complementary messages,” which provide additional information for the healthcare worker.

In addition to the scripts, the flipchart cards for ANC and PD settings also include “objectives” that correspond with each topic. (These objectives have not been reproduced here.) The scripts are designed for healthcare workers who prefer guidance on what to say during the session. The objectives as they appear on the flipchart cards are for the experienced healthcare worker who needs only an outline of the session.

If the actual flipcharts are not available, a healthcare worker can read the script from the tables in this Chapter. Similar cards for all three settings have been combined into a single table to conserve space and highlight the minimal differences between the counselling sessions in ANC, L&D and PD settings.

The healthcare worker needs to adapt the scope and depth of the information to the client’s level of understanding. Skills for conducting group discussions and individual counselling are discussed in Chapter IV.

Section 2: Pre-Test Session Messages

Section 2 provides an overview of

- The suggested scripts and complementary messages for the HIV Pre-Test sessions in the ANC, L&D and PD settings

The cards that follow include the scripts for the Pre-Test session in ANC, PD and L&D settings. The Pre-Test session for L&D is an abbreviated version (of the ANC and PD Pre-Test sessions) during which only the most critical information is presented. During labour, the level of detail should depend on the woman’s stage of labour, her comfort and the level of privacy in the labour ward.

Key to tables

Text = appears only in the ANC flipchart

[Text] = appears only in the PD flipchart

To review the key messages for the Pre-Test session, see Section 2 (starting on page 13) of Chapter I.

Table III.1 – Introduction Cards

Antenatal Care and Post-Delivery		Labour & Delivery
Card 1: HIV is in the community and it can affect anyone.		Card 1: Introduction
Suggested Script	<ul style="list-style-type: none"> Welcome, my name is _____. I am a _____ (<i>title</i>) here at the clinic. [Before you leave, it is important to make sure you received all the tests you need. There is no record that you received an HIV test during this pregnancy or during labour.] Today, as part of your visit, we will be discussing HIV, HIV testing and ways you can protect your health, the health of your baby and your family. HIV affects families and our community. HIV is an infection that can lead to a serious illness called AIDS. _____ (<i>number</i>) out of 100 adults in the country have HIV. As you can see in this picture, you cannot tell who has HIV. Most people who have HIV do not feel or look sick. Everyone should learn if he/she has HIV, <u>especially pregnant women, because if a pregnant woman has HIV, she can pass it to her baby.</u> [including women who have had a baby. A woman who has or gets HIV while breastfeeding her baby, can pass HIV to her baby.] The only way to know if you have HIV is to be tested. If you are tested and do <i>not</i> have HIV, you will learn how to protect yourself and your baby from getting HIV. If you are tested and <i>have</i> HIV, you will learn how to lower the chance of passing HIV to your baby and how to get care and treatment for yourself, your baby and your family so you can live healthy lives. 	<ul style="list-style-type: none"> Hello. My name is _____. I am a _____ (<i>title</i>) here on the maternity ward. I am checking to make sure you had all the tests you need for this pregnancy. Your card shows that you have not been tested for HIV during this pregnancy. Do you know what HIV is? If NO: HIV is an infection that can lead to a serious illness called AIDS. Not everyone who has HIV looks or feels sick, but if you have HIV you can pass it to your baby.
Complementary Messages	<ul style="list-style-type: none"> The “immune system” is a collection of cells and proteins that protect the body from potentially harmful infections caused by bacteria, viruses and fungi. HIV breaks down or destroys the body’s immune system. When the immune system becomes weak, the body loses its protection against illness. As time passes, the immune system is unable to fight the HIV infection and many other serious and deadly infections such as TB, pneumonia, oral thrush and some types of cancer. HIV = human immunodeficiency virus AIDS = acquired immunodeficiency sndrome, the most advanced stage of HIV infection. People who are HIV-infected may develop AIDS within several months to more than 15 years after getting the infection. The sooner a person is tested for HIV and receives treatment, the longer the person will be able to live a healthy life. 	

Table III.2 – Getting or Passing HIV

Antenatal Care and Post-Delivery	
Card 2: How can I get or pass HIV?	
Suggested Script	<ul style="list-style-type: none"> • One of the main ways you can get HIV is by having unprotected sex (sex without a condom). <u>All pregnant women</u> [All women with children] have had unprotected sex and are therefore at risk for HIV. • You can also get HIV when receiving a blood transfusion, if the blood has not been tested for HIV. • You can also get or pass HIV by sharing sharp objects such as razor blades or piercing equipment that puncture or cut the skin. It can also be transmitted by sharing needles and syringes, to inject drugs or any other substance. • HIV <i>cannot</i> be passed in the following ways: <ol style="list-style-type: none"> 1. Mosquito bites 2. Sharing food and utensils 3. Hugging and holding 4. Shaking hands 5. Using toilets <p>Probing Questions:</p> <ul style="list-style-type: none"> • What do you know about how HIV is passed from one person to another? • What questions do you have about how HIV is passed? • Do you have some HIV risks or concerns you would like to talk about today? (<i>for individual or couple counselling only</i>)
Complementary Messages	<ul style="list-style-type: none"> • HIV is transmitted by semen, vaginal secretions, blood and breastmilk. For HIV to be transmitted, one of these four body fluids needs to go from a person with HIV into the body of another person. • There are three main ways that HIV can be passed from one person to another: <ul style="list-style-type: none"> ○ Sexual transmission: through exchange of semen or vaginal secretions. Unprotected sexual intercourse is the most common mode of transmission. ○ Blood-to-blood transmission: <ul style="list-style-type: none"> ▪ Blood transfusion, if the blood has not been screened for HIV ▪ Using needles/syringes previously used by someone who is HIV-infected ▪ Sharing any other sharp object such as blades or needles used in scarring or tattooing, that were used by someone who is HIV-infected. ▪ An infected mother can pass HIV to her baby during pregnancy and labour/delivery ○ Breastmilk transmission: HIV can be transmitted from a mother to her baby during breastfeeding. • Blood to blood transmission of HIV can be prevented by: <ul style="list-style-type: none"> ○ Education about the risks of infection through the re-use of needles, syringes or other sharp objects (such as knives or scalpels) previously used by a person with HIV. ○ Refer women and/or partners with suspected drug or alcohol abuse/misuse for counselling and treatment.
(See Chapter I, page 24, “Tailoring HIV Prevention Messages to Client Need,” for questions to assess client risk.)	

Table III.3 – Mother-to-Child Transmission of HIV

Antenatal Care and Post-Delivery		Labour & Delivery
Card 3: If I have HIV, can I pass it to my baby?		Card 2: HIV can be passed to my baby.
Suggested Script	<ul style="list-style-type: none"> A mother with HIV can pass HIV to her baby during pregnancy, labour and delivery and breastfeeding. <p>Probing Question:</p> <ul style="list-style-type: none"> What questions do you have about how HIV is passed from a mother to her baby? 	A mother with HIV can pass HIV to her baby during pregnancy, labour and delivery and breastfeeding. That is why we always recommend that all pregnant women have an HIV test.
Complementary Messages	<ul style="list-style-type: none"> HIV testing is routinely recommended for all pregnant women. Women and men who are newly infected with HIV and those in late stages of the disease have a high viral load. In other words, they have a lot of virus in their blood. This high viral load makes it easier to transmit HIV to the infant during pregnancy, labour and delivery and breastfeeding. In addition to high viral load, the following factors also increase risk of MTCT. <ul style="list-style-type: none"> During pregnancy: Viral, bacterial or parasitic placental infection (e.g., malaria); sexually transmitted infection; and maternal malnutrition. During labour and delivery: Rupture of membranes more than 4 hours before labour begins, invasive delivery procedures that increase contact with mother's infected blood for body fluids (e.g., episiotomy, foetal scalp monitoring), first infant in multiple birth and chorioamnionitis (from untreated STI or other infection) During breastfeeding: Duration of breastfeeding, early mixed feeding (e.g., food or fluids in addition to breastmilk), breast abscesses, nipple fissures, mastitis, poor maternal nutritional status and oral disease in the baby. 	

Table III.4 – Why Test for HIV

Antenatal Care and Post-Delivery		Labour & Delivery
Card 4: Why should I test for HIV?		Card 3: Why should I test for HIV?
Suggested Script	<ul style="list-style-type: none"> Not all women who have HIV will pass it to their babies. Without care, 1 out of 3 women with HIV will pass HIV to her baby. This is why it is important to get tested for HIV and receive medical care to lower the chance of passing HIV to your baby. There are many benefits to testing. If you are tested and you do <i>not</i> have HIV, you will learn how to protect yourself and your baby from getting HIV. Most women who are tested will not have HIV. <u>If you are tested and you have HIV, you will learn how to lower the chance of passing it to your baby and how to get treatment and care services so you and your baby can both live healthy lives.</u> [If baby was born within the past 72 hours (and rapid testing is available): If you are tested and you have HIV, the baby will receive medicine to lower the chance of getting HIV. You will also learn how to feed your baby more safely and how to get treatment and care services so you and your baby can both live healthy lives. 	If the test shows that you have HIV, we can give you medicine immediately to lower the chance of passing HIV to your baby. After you give birth, the baby will also receive medicine

	<ul style="list-style-type: none"> • If baby was born more than 72 hours ago: If you are tested and you have HIV, you will also learn how to feed your baby more safely and how to get treatment and care services so you and your baby can both live healthy lives.] • We will give you more information after the test to help you make these choices. <p>Probing Question:</p> <ul style="list-style-type: none"> • Before we continue, what questions do you have about how to protect your baby from HIV? 	and we will provide or refer you to where you can get care and treatment services for you and your family.
Complementary Messages	<p>Healthcare workers should be prepared to respond to questions about the advantages and disadvantages of testing for HIV.</p> <p>Advantages of testing:</p> <ul style="list-style-type: none"> • If a woman tests HIV-negative, she can learn how she can remain uninfected. • If a woman tests HIV-positive, she will be offered services and information on: <ul style="list-style-type: none"> ○ Living longer and healthier including referrals for comprehensive HIV treatment, care and support. ○ Reducing the chance that she will pass HIV to her infant. • Not all women who have HIV will transmit the virus to their babies. Without intervention, during pregnancy or labour about 20–25% of women with HIV will transmit the virus to their infants. Another 5–20% of infants will become infected with HIV during breastfeeding. The likelihood that HIV will be transmitted from mother to infant can be reduced with: <ul style="list-style-type: none"> ○ HIV testing and counselling ○ ARV prophylaxis and treatment for the mother and baby ○ Safer delivery practices ○ Counselling and support for safer infant feeding ○ Provision or referral for prevention, treatment, care and support <p>Disadvantages of testing:</p> <ul style="list-style-type: none"> • A woman might experience a little discomfort or bruising during the blood sampling process (a fingerprick or blood taken from the arm). • Prevention, care, treatment and support programmes for people with HIV may not be readily available. • Some people who test HIV-positive may face stigma and discrimination. <p>For most people, particularly pregnant women with access to PMTCT interventions, the advantages far outweigh the disadvantages of testing.</p>	

Table III.5 – How the Test is Done

Antenatal Care and Post-Delivery		Labour & Delivery
Card 5: How will the HIV test be done?		Card 4: How will the HIV test be done?
Suggested Script	<ul style="list-style-type: none"> • HIV testing will be offered as part of the basic services you will receive today. • HIV testing is private. This means that only healthcare workers who are caring for you will know your HIV test result. • You have the right to refuse HIV testing, but we strongly recommend you are tested for HIV to help protect your baby. Unless you refuse, we will test you for HIV along with the other tests we do today. <p><i>Read only the option below that applies.</i> As shown in the first poster, the HIV test will be done by drawing blood.</p>	<p><i>Instructions: Read only the option below that applies.</i></p> <ul style="list-style-type: none"> • As shown in the first poster, the HIV test will be done by drawing blood. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • As shown in the second poster, the HIV test will be done by a simple fingerprick. <p style="text-align: center;">OR</p>

	<p style="text-align: center;">OR</p> <p>As shown in the second poster, the HIV test will be done by a simple fingerprick.</p> <p style="text-align: center;">OR</p> <p>The HIV test will be done by swabbing your mouth.</p> <p><i>Read only the option below that applies.</i></p> <p>You will be tested here and get your result today.</p> <p style="text-align: center;">OR</p> <p>You will be tested _____ (state when and where). You will get your result _____ (state date).</p> <ul style="list-style-type: none"> If your HIV test result is negative, it means you do not have HIV. If your HIV test result is positive, it means you have HIV. <p>Probing Question:</p> <ul style="list-style-type: none"> Before we go any further, what concerns or questions do you have about HIV testing? 	<ul style="list-style-type: none"> The HIV test will be done by swabbing your mouth. HIV testing is private. This means that only healthcare workers who are caring for you will know your HIV test result. You have the right to refuse HIV testing, but we strongly recommend you are tested for HIV to help protect your baby. Unless you refuse, we will test you now and give you and your baby the best care based on your test results. <p>Probing Question:</p> <ul style="list-style-type: none"> Before we go any further, what concerns or questions do you have about HIV testing?
(See Chapter V: Rapid HIV Testing in PMTCT Settings.)		

The L&D Pre-Test cards end here.

Table III.6 – Discordant HIV Tests (ANC and PD)

Antenatal Care and Post-Delivery	
Card 6: My partner's test result could be different from mine.	
Suggested Script	<ul style="list-style-type: none"> • Regardless of your HIV test result, it is very important for your partner to get tested for HIV. In couples, it is common for one person to have HIV (i.e., HIV-positive) while the other person does not have HIV (i.e., HIV-negative). • In this picture, there are four couples: <ol style="list-style-type: none"> 1. In one couple, both partners are HIV-positive. 2. In another, both partners are HIV-negative. 3. In the other two couples, the partners' results are different: one partner is HIV-negative and the other is HIV-positive. • When couples have different test results, the HIV-negative partner is at high risk of getting HIV. Sometimes couples have been together for years, have been faithful, have had children and still have different HIV test results. If an HIV-negative partner continues to have unprotected sex with a partner who is HIV-positive, then he or she is very likely to get HIV. <p>Probing Questions:</p> <ul style="list-style-type: none"> • Do you understand how one partner can have HIV and the other not have it? <p>Suggested Response: Similar to how you may not get pregnant every time you have sex, HIV transmission may not happen every time you have sex with an HIV-positive person. It is not possible to know when HIV will be passed, but every time you have sex with an HIV-positive person there is a chance that you could become infected.</p> <ul style="list-style-type: none"> • What questions or concerns do you have?
Complementary Messages	<ul style="list-style-type: none"> • Women in antenatal clinics who are tested for HIV often assume incorrectly that their partner's HIV status will be the same as theirs. For this reason, it is important to explain discordance. The only way a woman can learn her partner's HIV status is for him to be tested. • A concordant couple is one in which both partners have the same HIV status: they are both negative or both positive. • A discordant couple is when one tests HIV-positive and the other, HIV-negative. Discordance is common in countries with a high prevalence of HIV. As many as 2–3 out of 10 couples tested are likely to be discordant. • It is not possible to know when HIV will be passed, but every time you have sex with an HIV-positive person there is a chance that you could get infected. As an analogy, think of a family that sleeps in the same home and are all exposed to mosquitoes, one person may get malaria while the others do not. • Discordant couples are not protected by remaining faithful. They need to take precautions to prevent transmission from the infected partner to the uninfected partner.
(See Chapter I, pages 25-27, for information on disclosure and partner referral.)	

Table III.7 – Importance of Partner Testing

Antenatal Care and Post-Delivery	
Card 7: Why should my partner test for HIV?	
Suggested Script	<ul style="list-style-type: none"> The only way to know your partner's status is for him to get tested for HIV. Your partner should be tested so you can protect each other and your baby from HIV. Another important reason why your partner should get tested is because if you are HIV-negative now and get HIV later in your pregnancy, or while you are breastfeeding, the risk of passing the virus to your baby is very high. If you prefer to be counselled and tested as a couple, you can be tested together at _____ (name of site). Your partner can also be tested at _____ (name of site). <p>Probing Questions: (for individual or couple counselling only)</p> <ul style="list-style-type: none"> Are you comfortable asking your partner to be tested for HIV? How do you believe he will react? What do you think about receiving HIV testing and counselling with your partner? What questions or concerns do you have?
Complementary Messages	<ul style="list-style-type: none"> If a pregnant woman tests negative, but her partner is HIV-positive, the woman is at high risk of becoming infected during pregnancy or breastfeeding. An infant is at particularly high risk of HIV infection if the mother gets HIV during pregnancy or breastfeeding.

Table III.8 – HIV Prevention

Antenatal Care and Post-Delivery	
Card 8: How can I protect myself from HIV?	
Suggested Script	<ul style="list-style-type: none"> There are three main ways to protect yourself and your partner from HIV. If you and your partner are both tested for HIV and are both HIV-negative, you can protect each other from HIV by being faithful and only having sex with one another. If either of you has sex with anyone else, you could become infected with HIV and pass it to your partner. Another way to protect yourself is by using condoms. When used correctly every time you have sex, condoms help protect against HIV. It is particularly important to use condoms if your partner is HIV-positive, if you don't know if your partner has HIV or if your partner has other partners. We can provide you with condoms and information on how to use a condom correctly. You and your partner can also get additional information about condoms at _____ (name of site). Another option is not to have sex, particularly until your partner is tested for HIV. This can be difficult, but it is the most effective way to protect each other from HIV. <p>Probing Questions: (for individual or couple counselling only)</p> <ul style="list-style-type: none"> Have you taken steps to protect yourself from getting HIV? What methods have you used? What questions or concerns do you have?
Complementary Messages	<ul style="list-style-type: none"> Alcohol and drug abuse may increase the risk of HIV infection by increasing the likelihood of engaging in risky behaviours. Even occasional use of alcohol, marijuana and other "recreational" drugs may increase risk of HIV infection.
(See Appendix 5: Guidance on Condoms and Condom Use.)	

Table III.9 – Protecting Baby from HIV

Antenatal Care	
Card 9: If I have HIV, how do I protect my baby?	
Suggested Script	<ul style="list-style-type: none"> • <u>If you are HIV-positive, there are medicines that we will give you and your baby to lower the chance of passing HIV to your baby.</u> • <u>Your healthcare provider will decide with you when you need to take medicines for HIV (antiretrovirals), which can help protect you from becoming ill and can help you have a long, healthy life.</u> <p>Probing Question:</p> <ul style="list-style-type: none"> • Before we continue, what questions do you have about how to protect your baby from HIV?
(See Table III.19 Preventing MTCT pages 55-56, for additional information on ARV prophylaxis and treatment.)	

Table III.10 – Help for People Testing HIV-Positive

Antenatal Care and Post-Delivery	
ANC Card 10/PD Card 9: If I have HIV, what help can I get?	
Suggested Script	<ul style="list-style-type: none"> • More and more services are becoming available to help HIV-positive people and their families stay healthy. • If you are HIV-positive, there are medicines available to help you live a long and healthy life. • Additional counselling, prevention, nutrition and support services are also available. • After the test, we will give you more information about the services available to help you. • [No matter what your test result is, it is very important for you and your baby to continue receiving healthcare services.]
(See Table III.19 Preventing MTCT, pages 55-56, for additional information on ARV prophylaxis and treatment.)	

Table III.11 – Importance of Healthcare Visits

Antenatal Care	
Card 11: Why is it important to continue with my healthcare visits?	
Suggested Script	<ul style="list-style-type: none"> • <u>No matter what your test result is, it is very important for you to continue receiving antenatal care.</u> • <u>You should also plan to deliver your baby in a health facility, where there are skilled providers who can help in case of problems. This is especially important if you are HIV-positive because there are steps we can take at the health facility to help protect your baby from HIV; steps that might not be available if you have your baby outside of a health facility.</u> <p>Probing Questions: (for individual or couple counselling only)</p> <ul style="list-style-type: none"> • <u>Do you plan to continue antenatal care?</u> • <u>How likely is it that you will deliver your baby in a health facility?</u>
Complementary Messages	<ul style="list-style-type: none"> • Continuing to receive antenatal care is the most effective way to safeguard a baby's health, whether the mother is HIV-positive or HIV-negative. The purpose of antenatal care is to help a woman and her infant stay healthy during pregnancy and childbirth and to prevent or find and treat conditions that may put the health of the baby and mother in danger. • During labour and delivery, it is essential that safer delivery practices are used to protect the health of the woman and her infant. In the postpartum period, continuing to visit the well-baby clinic will enable her baby to receive immunizations and other preventive health services.

	<ul style="list-style-type: none"> • For all women, the goal of safer delivery practices is to promote health and prevent complications and infections. For HIV-positive women, safer delivery practices and infection control are particularly important to reduce exposure to maternal fluids during labour and delivery. Both will reduce the likelihood that HIV will be transmitted to the baby or to healthcare workers during L&D. • During labour and delivery, healthcare workers will minimize cervical examinations, avoid prolonged labour, avoid premature rupture of membranes, prevent unnecessary trauma during delivery, minimize the risk of postpartum haemorrhage and use safe transfusion practices.
--	---

Table III.12 – Summary

Antenatal Care and Post-Delivery	
ANC Card 12/PD Card 10: By testing for HIV, I will have a good chance to have a healthy child and a healthy life.	
Suggested Script	<ul style="list-style-type: none"> • We have talked about five main points today: <ol style="list-style-type: none"> 1. It is important that you test for HIV. 2. If you are HIV-negative, you will learn how to stay negative. 3. If you are HIV-positive there are <u>medicines and ways to feed your baby</u> to lower the chance of passing HIV to your baby. You and your family can also receive care, treatment and support services to stay healthy. 4. Whether your test result is positive or negative, your partner needs to be tested for HIV since your result could be different from his. 5. You should continue with your <u>care during pregnancy and plan to deliver in a health facility</u> [postnatal and well-baby care]. • Remember, by taking the HIV test, you can protect your baby and family from HIV and you can stay healthy. • <u>If you have specific questions or concerns, we can discuss them privately.</u> <p>Probing Questions:</p> <ul style="list-style-type: none"> • What additional questions or concerns do you have?
Complementary Messages	<ul style="list-style-type: none"> • Clients with additional concerns or questions should have the option of follow-up individual Pre-Test counselling, if it is available.

Section 3: Post-Test Counselling Session Messages

Section 3 provides an overview of

- The suggested scripts and complementary messages for the HIV Post-Test counselling sessions for HIV-negative and HIV-positive women in the ANC, L&D and PD settings

Post-Test Counselling Session Messages: HIV-Negative

Post-Test counselling provides an opportunity for a woman who is HIV-negative to learn how to protect herself and her infant from HIV infection. Even for those who test negative for HIV, Post-Test counselling provides women with a powerful incentive to adopt safer sex practices, discuss family planning, understand the issue of discordance and encourage partner testing. The cards that follow include the script for the Post-Test counselling session for the client who tested HIV-negative in the ANC, PD and L&D settings.

Key to tablesText = appears only in the ANC flipchart

[Text] = appears only in the PD flipchart

The messages for the Post-Test counselling sessions in ANC, L&D and PD settings are quite similar, with the exception that those for L&D include some of the messages that would have been provided in the Pre-Test session had the setting been more conducive. Additional

information about the HIV-negative and HIV-positive Post-Test counselling messages can be found in Chapter I, starting on page 22.

Table III.13 – HIV Test Result

Antenatal Care and Post-Delivery		Labour & Delivery
Card 1: What is my HIV test result?		Card 5: What is my HIV test result?
Suggested Script	<ul style="list-style-type: none"> As we discussed earlier, the HIV test result can be positive or negative. Your test result is negative; this means that you do not have HIV. What do you think the negative test result means? There is a very small chance that this test did not find HIV in your blood if you became infected with HIV during the last 6 weeks. If you recently had sex without a condom (unprotected sex) with a partner who is HIV-positive, or if you do not know whether your partner has HIV, you should consider getting another test after 6 weeks. 	<ul style="list-style-type: none"> Your test result is negative; this means that you do not have HIV. By being tested, you have taken a big step to protect yourself and your baby from HIV. If woman is in labour: After you have your baby, we will talk about how you can protect your health and the health of your baby and family. If after delivery, continue with script below. There is a very small chance that this test did not find HIV in your blood because you became infected with HIV during the last 6 weeks. If you recently had sex without a condom (unprotected sex) with a partner who is HIV-positive, or if you do not know whether your partner has HIV, you should consider getting another test after 6 weeks.
Complementary Messages	<ul style="list-style-type: none"> A client who has had unprotected sex within the last 6 weeks with someone who is HIV-positive or whose HIV status is unknown may be in the window period. This client should be advised to be retested 6 weeks from the date of her initial test. The window period is the period of time between becoming infected with HIV and the appearance of detectable antibodies to the virus. The client in the window period is actually HIV-positive even though his/her test came back HIV-negative. Because the HIV antibody tests are very sensitive, the likelihood of a client being in the window period is very low. 	
(See Appendix 6 for additional information on the window period.)		

Table III.14 – Discordant HIV Tests (ANC, PD and L&D)

Antenatal Care and Post-Delivery		Labour & Delivery
Card 2: My partner's test result can be different from mine.		Card 6: My partner's test result can be different from mine.
Suggested Script	<ul style="list-style-type: none"> Remember that your test result does not tell us if your partner has HIV. To protect yourself and your baby from HIV, your partner should also get an HIV test. Knowing if your partner has HIV is also important for the health of your baby. If you are HIV-negative now and get HIV <u>later in your pregnancy or</u> while breastfeeding, the risk of passing the virus to your baby is very high. We recommend that you talk to your partner about your test result, because he could support your goals of staying HIV-negative and protecting your baby from HIV. How do you feel about talking to your partner about your test result? You can tell him that at the clinic, we recommend HIV testing for all <u>pregnant women</u> [clients] and that is why you were tested. We can assist you with talking to your partner about your HIV status. Your partner can get HIV testing services _____ (<i>name of site</i>). <p>Probing Questions:</p> <ul style="list-style-type: none"> Are you comfortable asking your partner to be tested for HIV? How do you believe he will react? What do you think about receiving HIV testing and counselling with your partner? What questions or concerns do you have? 	<ul style="list-style-type: none"> It is very important for your partner to get tested for HIV. In couples, it is common for one person to have HIV (i.e., HIV-positive), while the other person does not have HIV (i.e., HIV-negative). <p>In this picture, there are four couples:</p> <ol style="list-style-type: none"> In one couple, both partners are HIV-positive. In another, both partners are HIV-negative. In the other two couples, the partners' results are different: One partner is HIV-negative and the other is HIV-positive. <ul style="list-style-type: none"> When couples have different test results, the HIV-negative partner is at high risk of getting HIV. Sometimes couples have been together for years, have been faithful, have had children and still have different HIV test results. If an HIV-negative partner continues to have unprotected sex with a partner who is HIV-positive, then he or she is likely to get HIV. <p>Probing Questions:</p> <ul style="list-style-type: none"> Do you understand how one partner can have HIV and the other not have it? Suggested Response: Similar to how you may not get pregnant every time you have sex, HIV transmission may not happen every time you have sex with an HIV-positive person. It is not possible to know when HIV will be passed, but every time you have sex with an HIV-positive person there is a chance that you could become infected. What questions or concerns do you have?
(Se Table III.6, Discordant HIV Test (ANC and PD), and Table III.7, Importance of Partner Testing, for information on discordance. See Chapter I, pages 25-27, for additional information on disclosure and partner referral.)		

Table III.15 – Partner Referral (L&D)

Labour & Delivery	
Card 7: Why should my partner test for HIV?	
Suggested Script	<ul style="list-style-type: none"> Because your partner's HIV result could be different from yours, he should get tested to learn if he has HIV. Another important reason why your partner should get tested is because if you are HIV-negative now and you get HIV while you are breastfeeding, the risk of passing the virus to your baby is very high.

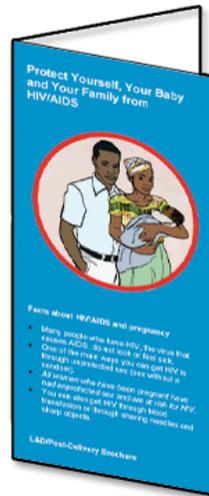
	<ul style="list-style-type: none"> • We recommend that you talk to your partner about your test result because he could support your goals of staying HIV-negative and protecting your baby from HIV. • How do you feel about talking to your partner about your test result? You can tell him that at the maternity ward we recommend HIV testing for all women who are having a baby and that is why you were tested. • We can assist you with talking to your partner about your HIV status. • If you prefer, you can be counselled together at _____ (<i>name of site</i>). Your partner can also get tested at _____ (<i>name of site</i>). <p>Probing Questions:</p> <ul style="list-style-type: none"> • Are you comfortable asking your partner to get tested for HIV? How do you believe he will react? • What do you think about receiving HIV counselling with your partner? • What questions or concerns do you have?
--	---

Table III.16 – HIV Prevention

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC and PD Card 3/L&D Card 8: How can I protect myself from HIV?	
Suggested Script	<p>As we mentioned before, there are three main ways to protect yourself and your partner from HIV.</p> <ul style="list-style-type: none"> • If you and your partner are both HIV-negative, you can protect each other from HIV by being faithful and only having sex with one another. If either of you has sex with anyone else, you could become infected with HIV and pass it to your partner. • Another way to protect yourself is by using condoms. When used correctly every time you have sex, condoms help protect against HIV. It is particularly important to use condoms if your partner is HIV-positive, if you do not know if your partner has HIV, or if your partner has other partners. • We can provide you with condoms and information on how to use a condom correctly. You and your partner can also get additional information about condoms at _____ (<i>name of site</i>). • Another option is not to have sex, particularly until your partner is tested for HIV. This can be difficult, but it is the most effective way to protect each other from HIV. <p>Probing Questions:</p> <ul style="list-style-type: none"> • What questions or concerns do you have? • <u>Which choice do you think will be best while you are pregnant?</u> • <u>Which choice do you think will be best [for you] after you have the baby?</u>
Complementary Messages	<ul style="list-style-type: none"> • Drug use in any form may increase the risk of HIV infection by limiting judgement and facilitating engagement in risky behaviours. Even occasional use of alcohol, marijuana and other “recreational” drugs may increase risk of HIV infection.
(See also Table III.2, Getting or Passing HIV, and Appendix 5: Guidance on Condoms and Condom Use.)	

Table III.17 – Staying HIV-Negative

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC and PD Card 4/L&D Card 9: How can my family and I stay healthy and HIV-negative?	
Suggested Script	<ul style="list-style-type: none"> • Now that you know your HIV status, you have taken a big step to protect yourself and your baby from HIV. There are other things we can talk about during future visits that you can do to keep yourself and your baby healthy. • Attend all of your <u>antenatal</u> [postnatal and well-baby] care appointments so you have a healthy pregnancy. Your next appointment is on ___/___/____. • [Your baby's next appointment is on ___/___/____.] • <u>Plan to deliver your baby in a health facility because there are steps we can take to help you during labour and to have a safe birth.</u> • [How are you feeding your baby? • Other than milk, is your baby receiving any other liquids or foods?] • [It is important that you] Exclusively breastfeed your baby. For the first 6 months, give your baby <i>only</i> breastmilk and no other liquids or foods, not even water. However, you may give your baby drops or syrups consisting of vitamins, mineral supplements or medicine. Breastfeeding has many benefits. It provides all of the nutrients a baby needs and protects the baby from illnesses such as diarrhoea. • <u>After your baby is born</u>, continue with HIV prevention services to reduce your risk of acquiring HIV and get family planning to help plan future pregnancies. We can provide you with further information on family planning. OR You can get additional information about family planning at: _____ (name of site). • Here is the information we have talked about today for you to take home. • What questions do you have? • If you have any further concerns, please contact us so we can help.
Complementary Messages	<ul style="list-style-type: none"> • ANC settings: It is important that all women attend all of their antenatal care appointments and plan to deliver at a health facility. Continuous antenatal care is the most effective way to safeguard a baby's health. • L&D and PD settings: Any time the infant becomes ill or the mother suspects a problem, seeking early medical intervention is strongly encouraged. • If wet nursing (breastfeeding of an infant by a woman other than the infant's mother) is common, stress that the infant should be exclusively breastfed. If mother wants another woman to breastfeed her infant, the wet nurse must be tested and found HIV-negative and must protect herself from HIV infection during the entire time she is breastfeeding. • Provide participants with written information about HIV and HIV testing, if available, as well as referrals for follow-up care for the woman, her infant and family.
(See Appendix 7: Infant Feeding Counselling and Support.)	



If available, provide clients with a leaflet, such as the client information brochure, to reinforce information provided during the Post-Test counselling session.

Post-Test Counselling Session Messages: HIV-Positive

Counselling a woman who tests HIV-positive is a challenge. The healthcare worker must remain nonjudgemental, supportive and confident throughout the counselling process. With skill and experience, the healthcare worker can successfully provide the necessary information and support that an HIV-positive woman needs. Experienced healthcare workers can draw on skills and experiences from other clinical contexts. New healthcare workers should be given an opportunity to shadow more experienced clinicians. (See Chapter IV for additional information about skills for counselling.)

Because women may present late in pregnancy and attend ANC only once, key PMTCT messages as well as emotional support will need to be provided during the Post-Test counselling session. Referral for HIV treatment, care and support is also necessary. Pregnant HIV-positive women should be encouraged to deliver at a healthcare facility and the woman who is receiving test results in L&D or a post-delivery setting should be encouraged to attend postpartum and well-baby clinics for ongoing healthcare. During subsequent visits, key PMTCT messages can be reinforced and follow-up counselling provided. The cards that follow include the script for the Post-Test counselling session for the client who tested HIV-positive in the ANC, PD and L&D settings.

Key to tables

Text = appears only in the ANC flipchart

[Text] = appears only in the PD flipchart

Table III.18 – HIV Test Result

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC and PD Card 5/L&D Card 10: What is my HIV test result?	
Suggested Script	<ul style="list-style-type: none"> As we discussed earlier, an HIV test result could be positive or negative. Your test result is positive; this means you have HIV. What do you think the positive test result means? This result does <i>not</i> mean that you will soon become ill. We can teach you how to stay healthy and how to protect your baby from HIV. How are you feeling? Knowing you are HIV-positive may be difficult at first. There is a lot to think about, but there are many steps you can take to stay healthy and to protect your baby from HIV. We are here to help you take this one step at a time. We will first talk about what you can do to protect your baby from HIV. Then we will discuss the treatment and healthcare available to keep you and your family healthy.
Complementary Messages	<ul style="list-style-type: none"> Both the rapid HIV test and the ELISA are at least 99% accurate. In other words, errors are rare. A positive result means the woman has HIV infection, it does not mean that she has AIDS, nor does it give any indication if or when she may develop AIDS. AIDS is the abbreviation for acquired immunodeficiency syndrome and refers to the most advanced stage of HIV infection. ARV treatment allows people to live long and productive lives with HIV.

Table III.19 – Preventing MTCT

Antenatal Care	
Card 6: There are medicines that can help lower the chance that my baby will get HIV.	
Suggested Script	<ul style="list-style-type: none"> We mentioned before that there are medicines you can take to lower the chance that your baby will get HIV. The medicine does not completely protect your baby but it lowers the chance that your baby will get HIV. The medicine does not treat your HIV infection. You can get care, treatment and support for your HIV infection at _____ (name of site). We will give you _____ (names of drug(s)). You will get your medicine(s) at _____ (tell her when and where). You will take them _____ (tell her when she should start the drug(s), how often she will take it). <p>For multi-drug regimens:</p> <ul style="list-style-type: none"> We will give you _____ (names of drugs) for your baby. You will get the baby's medicine at _____ (tell her when and where). You will give the medicine to the baby _____ (tell her when she should start giving the drug(s) to the baby and how often she will give each drug). <p style="text-align: center;">OR</p> <p>For nevirapine-only regimens: After delivery, your baby will receive medicine in syrup form.</p> <ul style="list-style-type: none"> All clients: If you cannot deliver in a health facility, you should bring your baby to the health facility immediately after birth (but before 48–72 hours), so we can give medicine to the baby. For most women, the medicine is safe and will not harm you or your baby. However, a few women may not feel well after they take the medicine and a few women may feel tired. If you start to have these problems, please contact us immediately so we can help.

	<ul style="list-style-type: none"> • To make sure the medicine works, it is important that you take it exactly as we tell you and that you do not share it with anyone. • Do you have concerns about taking the medicine(s)? • (If applicable) Can you come back to pick up _____ (item to be picked up, e.g., prescription or more medicine) in _____ (number) of weeks? • Will you be able to take the medicine as we have taught you? • Is there someone who can remind you to take your medicine(s)? • What can we do to help make sure that you take the medicine(s)? • What questions or concerns do you have before we continue? If you have any problems taking your medication, please contact us immediately.
<p>Complementary Messages</p>	<p>ARV Prophylaxis:</p> <ul style="list-style-type: none"> • The medicines for PMTCT are referred to as ARV <i>prophylaxis</i>. ARV prophylaxis does not treat maternal HIV infection; it reduces (but does not eliminate) the chances of MTCT. There are several recommended PMTCT regimens. Specific regimens for PMTCT are typically decided by each country. • The infant will also receive medication immediately after birth to prevent the chances of MTCT. • It is important that the medicine be taken exactly as directed. Healthcare workers should counsel clients on how to take PMTCT-related medicines according to national protocol. • Where allowable, dispense the medications in advance (some countries allow women to take one or more doses of ARV prophylaxis home with them to take when labour starts or according to protocol). • If the woman cannot deliver in a health facility, she should be instructed to bring the baby to the health facility within 72 hours of the birth so that the ARVs can be given to the infant. <p>ARV Treatment:</p> <ul style="list-style-type: none"> • The mother must be referred for comprehensive HIV treatment, care and support to find out if she qualifies for ARV <i>treatment</i>. • National policy determines eligibility for ARV treatment. One of the criteria, where available, may be CD4 count. In settings where it is available, HIV-positive pregnant women receive a CD4 test to determine if they should be on ARV prophylaxis or treatment; ARV treatment also prevents MTCT. <p>Adherence:</p> <ul style="list-style-type: none"> • The woman should be encouraged to ask questions about the medication during the Post-Test counselling session. Discuss any difficulties she thinks she may have with the regimen. • Inform her that she may experience side effects such as an upset stomach, fatigue, or a skin rash. Tell her that she should not stop taking her medication and should return to the clinic if this occurs. Discuss how these side effects can be minimized. • Assess the woman's ability to adhere to the drug regimen. This may mean asking the woman to identify an adherence partner or "buddy" and assessing her ability to return to the clinic for medication. • If possible, provide instructions in writing, as well as other tools that can help her remember to take medications (such as the client information brochure that accompanies this package or other client reminder cards that require the woman to cross out each dose as she takes it).
<p>(See Appendix 8 for additional information on ARV regimens to treat and prevent MTCT and Appendix 7: Infant Feeding counselling and support.)</p>	

Table III.20 – ARVs for PMTCT (PD)

Post-Delivery	
Card 6: There are medicines that can help lower the chance that my baby will get HIV.	
Post-Delivery Infant born in last 72 hours	<p>Suggested Script</p> <ul style="list-style-type: none"> • We mentioned before that there are medicines that we can give to your baby to lower the chance that your baby will get HIV. • The medicine does not treat or completely prevent HIV infection; it lowers the chance that your baby will get HIV. • The medicine is safe and will not harm your baby. • We will give that medicine to your baby now. • FOR INFANTS RECEIVING MULTI-DRUG ARV REGIMENS: In addition to the medicine your baby will receive right now, you will also need to give the baby _____ (<i>name of ARV medication</i>) _____ (<i>number of times/day</i>) for _____ (<i>number of days</i>). • To make sure the medicine works, it is important that you give your baby this medicine exactly as we tell you and that you do not share it with anyone. • Do you have concerns about giving medicine to your baby? • Is there someone at home who can remind you to give the medicine to your baby? • What can we do to help make sure that you give the medicine to your baby? • What questions or concerns do you have before we continue? If you have any problem giving the medication to your baby, please contact us immediately. <p style="text-align: center;">(See Table III.19, Preventing MTCT)</p>

Table III.21 – ARVs for PMTCT (L&D)

Labour & Delivery	
Card 11: There are steps I can take to protect my baby from HIV.	
Suggested Script	<p>If woman is within 2 hours of delivery, she may not be eligible for maternal prophylaxis.</p> <p>If woman is eligible for maternal prophylaxis:</p> <ul style="list-style-type: none"> • We will give you medicine now to lower the chance that your baby will get HIV. <p>For all HIV-positive women:</p> <ul style="list-style-type: none"> • After you have your baby, we will give your baby medicine to protect him or her from HIV. • We will talk about how you can feed your baby now or just after delivery.** <p>**Note: If labour is not imminent and the woman agrees, discuss infant feeding now. (Turn to cards 13, 14 and 15.) If labour is imminent, start with Card 12 after delivery.</p>
Complementary Messages	<ul style="list-style-type: none"> • Advise the woman if she is eligible for prophylaxis, based on national guidelines and her stage of labour. Reassure her that additional counselling will be offered after the delivery. <p style="text-align: center;">(See Table III.19, Preventing MTCT)</p>

Table III.22 – Transitional Encouragement

Labour & Delivery	
Card 12: Transitional Encouragement	
Suggested Script	<ul style="list-style-type: none"> • As we discussed, your HIV test result is positive; this means you have HIV. • How are you feeling? You have already taken the first step to lower the chance of passing HIV to your baby. We will later discuss how you can stay healthy and get the care and treatment services you and your family will need. • Now let's talk about how you can also protect your baby from HIV by choosing how you will feed your baby.

Table III.23 – Safe Delivery for PMTCT

Antenatal Care	
Card 7: What can I do to have a safe birth and protect my baby from HIV?	
Suggested Script	<ul style="list-style-type: none"> • You should plan to deliver your baby in a health facility, where there are skilled healthcare workers who can help in case of a problem. This type of help may not be available if you have your baby outside of a health facility. • At _____ (<i>name of site</i>), we can help deliver your baby and make sure your baby receives medicine after birth to lower the chance that he or she will get HIV. If you cannot deliver in this health facility, it is still very important to bring your baby to _____ (<i>name of site</i>) immediately after birth. • Do you think you will be able to deliver your baby at a health facility or hospital? • What could make it difficult for you to deliver at a health facility? • How can we help you solve these problems?
Complementary Messages	<ul style="list-style-type: none"> • It is important that all women, particularly women who are HIV-positive, attend all of their ANC appointments and plan to deliver at a health facility. • There are a number of interventions that can reduce MTCT during labour and delivery: <ul style="list-style-type: none"> ○ Administer ARV prophylaxis to the woman during labour and to the infant after birth. These medicines will be administered in accordance with national protocols. ○ Always adhere to good infection prevention practices, including use of protective gear, safe use and disposal of sharps, sterilization of equipment and safe disposal of contaminated materials. ○ During labour and delivery, minimize cervical examinations, avoid prolonged labour, avoid premature rupture of membranes, prevent unnecessary trauma during delivery, reduce risk of postpartum haemorrhage and use safe transfusion practices. • In the postpartum period, the mother should take her baby to the clinic to receive immunizations and other preventive health services.
(See Appendix 9 for additional information on infection control.)	

Table III.24 – Infant Feeding

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC Card 8/L&D Card 13/PD Card 7: How can I feed my baby?	
Suggested Script	<ul style="list-style-type: none"> • [How are you feeding your baby now? • IF MOTHER IS ALREADY REPLACEMENT FEEDING: GO TO Post-Delivery CARD 10. • IF MOTHER IS ALREADY BREASTFEEDING: How is breastfeeding going for you and your baby? Are you able to exclusively breastfeed? (<i>continue below</i>) • IF MOTHER HAS NOT CHOSEN A FEEDING METHOD:] To protect your baby from HIV, you will need to think about the best way to feed your baby. You can choose exclusive breastfeeding OR replacement feeding with infant formula or _____ (<i>other options</i>). It is very important that you make the choice that is best for you and your baby. • Let us discuss these choices further. First, we will discuss exclusive breastfeeding. • FOR BREASTFEEDING and UNDECIDED MOTHERS: Exclusive breastfeeding means that the baby receives <i>only</i> breastmilk and no other liquids or foods, not even water. However, you may give your baby drops or syrups consisting of vitamins, mineral supplements or medicine. Breastfeeding has many benefits: it provides all of the nutrients a baby needs, and protects the baby from illnesses such as diarrhoea. • However, with breastfeeding there is a chance of passing HIV to your baby through your breastmilk. You can lower this chance if you exclusively breastfeed. You can make breastfeeding even safer if you stop breastfeeding completely after the first few months of life, when you are able to begin safely feeding your baby another way such as replacement feeding with formula or _____ (<i>other options</i>). • You will need help with how and when to stop breastfeeding, because it depends on the availability of other safe options. Once you are ready to stop breastfeeding, come back so we can help you choose a new feeding method. <p>(See Appendix 7: Infant Feeding Counselling and Support.)</p>

Table III.25 – Replacement Feeding

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC Card 9/L&D Card 14/PD Card 8: How can I feed my baby?	
Suggested Script	<ul style="list-style-type: none"> • The other way you can feed your baby is by replacement feeding. • Replacement feeding means giving no breastmilk and using only infant formula or _____ (<i>other options</i>), until your baby is old enough to eat nutritious and safe foods. • With infant formula or _____ (<i>other options</i>), there is <i>no</i> risk of passing HIV to your baby. However, using infant formula or _____ (<i>other options</i>), could increase the chance that the baby will get serious illnesses such as diarrhoea. • Infant formula or _____ (<i>other options</i>) can be expensive, needs to be prepared often and safely and may make other people wonder why you are not breastfeeding. You will need a number of supplies such as a regular supply of formula or milk, clean water, fuel (e.g., kerosene, firewood), soap, a cooking pot and a cup. • The cost for infant formula or _____ (<i>method</i>) is about _____ for _____ (<i>cost and time period</i>).

	OR
	<ul style="list-style-type: none"> We will provide infant formula or _____ (other options), for the next _____ weeks/months. You will need to pick it up at _____ (where) _____ (how often).
(See Appendix 7: Infant Feeding Counselling and Support.)	

Table III.26 – Infant Feeding AFASS Assessment

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC Card 10/L&D Card 15/PD Card 9: How can I feed my baby?	
Suggested Script	<p>I would like to ask you some questions to help you decide what choice is best for you and your baby:</p> <ul style="list-style-type: none"> How will your family and community react if you decided not to breastfeed? If you wanted to feed your baby with formula, how would you find time to prepare the feeds (day and night)? How would you pay for and find the supplies you will need, including fuel and clean water? <ul style="list-style-type: none"> Based on your answers and what we have discussed, what do you think would be the best way to feed your baby? If the woman chooses to [(or continues to)] breastfeed: Do you understand how to exclusively breastfeed your baby? What might make it difficult to exclusively breastfeed your baby? You can receive additional counselling on how to exclusively breastfeed now or at _____ (name of site). <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> If the woman chooses to [(or changes to)] replacement feed: What might make it difficult to provide infant formula or _____ (method) to your baby? We will show you how to prepare infant formula now (or we will refer you to _____ (name of site) where someone will show you how to prepare formula). It is important to follow the choice you make and not “mix feed.” Mixed feeding is giving the baby both breastmilk and other liquids or foods. Mixed feeding increases the chance that the baby will get other diseases such as diarrhoea. It may also increase the chance that you will pass HIV to the baby. We recommend that you talk more about your infant feeding method with _____ (who and name of site). If you change your feeding method or if there are any problems at all, please contact us immediately and we will help you. What questions or concerns do you have? <p>[If mother has chosen to (or continues to) breastfeed, or has just decided to replacement feed, or has not chosen a feeding method: Go to Post-Delivery Card 11.]</p>
(See Appendix 7: Infant Feeding Counselling and Support. AFASS is defined in Appendix 7, Table A-8.)	

Table III.27 – Replacement Feeding (PD)

Post-Delivery	
PD Card 10: How can I be sure I am replacement feeding correctly?	
Post-Delivery Replacement feeding mother	<p>Suggested Script</p> <ul style="list-style-type: none"> • How do you think replacement feeding is going for you and your baby? • Are you breastfeeding at all? It is important that you do not “mix feed”. Mixed feeding is giving the baby both breastmilk and replacement feeding or other liquids or foods. Mixed feeding increases the chance that the baby will get other diseases such as diarrhoea. It may also increase the chance that you will pass HIV to the baby. If you are replacement feeding, you should stop breastfeeding completely. • How much milk are you preparing for your baby? How much is the baby taking? How often do you feed the baby? • Have you ever run out of replacement feeding supplies? <p>Please show me how you prepare the feed.</p> <ul style="list-style-type: none"> • How often do you prepare infant formula? (If she does NOT have a refrigerator, she should make formula fresh at every feeding and discard after one hour. If she has a refrigerator, she can make a day’s supply once a day and store in the refrigerator.) • What do you use to boil the water (for preparing formula) or milk (if she is making home-modified animal milk)? How long do you boil the water? (Encourage her to bring water to rolling boil briefly, until surface of the water is moving vigorously for 1-2 seconds.) • How do you clean the cup (or bottle) and utensils used for preparation? (<i>Ensure she is washing feeding cups and utensils with soap and clean water or boiling them.</i>) • What do you use to measure the ingredients? How much formula/milk/sugar/ are you adding? How much water? • IF THE MOTHER IS USING HOME-MODIFIED ANIMAL MILK: Are you giving your baby a micronutrient supplement? IF YES: How often? • What do you use to feed your baby (bottle or cup)? (<i>If she is bottle feeding: support her in switching to cup feeding.</i>) • What, if any, problems might you be expecting in the near future? • We will refer you to _____ (<i>name of site</i>), who will review how you are preparing the formula or _____ (<i>other option</i>) and see if you are having problems with getting or preparing the formula (<i>or other option</i>). <p style="text-align: center;">(See Appendix 7: Infant Feeding Counselling and Support.)</p>

Table III.28 – Staying Healthy When HIV-Positive

	Antenatal Care and Post-Delivery	Labour & Delivery
	ANC Card 11 and PD Card 12: What steps can I take to stay healthy?	Card 16: Why is it important to continue with my healthcare visits?
Suggested Script	<ul style="list-style-type: none"> • Now let us talk about you and your health. There are many people who have HIV and are healthy. • There are many steps you can take to protect your health. You will 	<ul style="list-style-type: none"> • It is important to attend all of your post-delivery and other healthcare visits so we can help you, your baby and your family with any health problems. Remember to bring your health cards to each visit so you and your family get the care you need. • We will not know if the baby is infected

	<p>need to come for regular healthcare visits.</p> <ul style="list-style-type: none"> • There are medicines you can take to prevent or treat illnesses you can get with HIV, such as TB and malaria. It is also important to make sure the water you drink is safe and that you have adequate nutrition. • Your healthcare provider will decide with you when you need to take medicines for HIV (antiretrovirals), which can help protect you from becoming ill and can help you have a long, healthy life. • What questions do you have about HIV care and treatment? • We encourage you to get family planning so that you can make the best decisions about future pregnancies. • You can receive the family planning, care and treatment services we have discussed at _____ _____ (name of site(s)). 	<p>with HIV until we test the baby at _____ (number) months of age.</p> <ul style="list-style-type: none"> • (If applicable) Until we know if your baby has HIV, you will give medicine (cotrimoxazole) to him/her every day. This medicine will help protect the baby from illnesses he/she can get if infected with HIV. • Because we do not know when you became HIV-infected, it is important to bring your other children in for HIV testing. <p>Now let us talk about you and your health. There are many people who have HIV and are healthy.</p> <ul style="list-style-type: none"> • There are medicines you can take to prevent or treat illnesses you can get with HIV, such as TB and malaria. It is also important to make sure the water you drink is safe and that you have adequate nutrition. • Your healthcare provider will decide with you when you need to take medicines for HIV (antiretrovirals), which can help protect you from becoming ill and can help you have a long, healthy life. • What questions do you have about HIV care and treatment? • We encourage you to get family planning to help plan future pregnancies. • You can receive the family planning, care and treatment services we have discussed at _____ (name of site(s)).
<p>Complementary Messages</p>	<ul style="list-style-type: none"> • Continuing to receive healthcare regularly is the most effective way to safeguard the health of the mother and baby, irrespective of HIV status. 	
<p>(See Appendix 7: Infant Feeding Counselling and Support.)</p>		

Table III.29 – Discordant HIV Tests (L&D)

<p style="text-align: center;">Labour & Delivery</p>	
<p style="text-align: center;">Card 17: My partner’s test result can be different from mine.</p>	
<p>Suggested Script</p>	<ul style="list-style-type: none"> • It is very important for your partner to get tested for HIV. In couples, it is common for one person to have HIV (i.e., HIV-positive) while the other person does not have HIV (i.e., HIV-negative). <p>In this picture, there are four couples:</p> <ol style="list-style-type: none"> 1. In one couple, both partners are HIV-positive. 2. In another, both partners are HIV-negative.

	<p>3. In the other two couples, the partners' results are different: one partner is HIV-negative and the other is HIV-positive.</p> <ul style="list-style-type: none"> When couples have different test results, the HIV-negative partner is at high risk of getting HIV. Sometimes couples have been together for years, have been faithful, have had children and still have different HIV test results. If an HIV-negative partner continues to have unprotected sex with a partner who is HIV-positive, then he or she is likely to get HIV. <p>Probing Questions:</p> <ul style="list-style-type: none"> Do you understand how one partner can have HIV and the other not have it? Suggested Response: Similar to how you may not get pregnant every time you have sex, HIV transmission may not happen every time you have sex with an HIV-positive person. It is not possible to know when HIV will be passed, but every time you have sex with an HIV-positive person there is a chance that you could become infected. What questions or concerns do you have?
<p>(See Table III.6, Discordant HIV Tests (ANC and PD), and Table III.7, Importance of Partner Testing, for information on discordance. See Chapter I, pages 25-27, for additional information on disclosure and partner referral.)</p>	

Table III.30 – Partner Referral (ANC, L&D and PD)

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC Card 12 and PD Card 13: My partner's test result can be different from mine. L&D Card 19: Why should my partner test for HIV?	
Suggested Script	<ul style="list-style-type: none"> Remember that your test result does not tell us if your partner has HIV. It is important that he is also tested for HIV. If you decide to tell your partner your test result, it may help him decide to be tested. How do you feel about talking to your partner about your test result? We recommend that you talk to your partner about your test result if you feel safe doing so. You can tell him that at the clinic, we recommend HIV testing for all <u>pregnant</u> women and that is why you were tested today. What would you say? How do you believe he will react? He could be supportive of you in dealing with HIV, help you protect your baby from HIV and help you maintain your health. We can assist you with talking to your partner about your HIV status and about him being tested. <p>If you prefer, you can be counselled together at _____ (name of site). Your partner can also be tested at _____ (name of site). Remember how you can protect your partner from HIV.</p> <ul style="list-style-type: none"> You and your partner should use condoms, particularly until your partner is tested for HIV. When used correctly every time you have sex, condoms help protect against HIV. It is very important that you and your partner know how to use a condom so you do not pass HIV to your partner. We can provide you with condoms and information on how to use a condom correctly. You and your partner can also get additional information about condoms at _____ (name of site). Another option is not to have sex, particularly until your partner is tested for HIV. This can be difficult, but it is the most effective way to protect your partner from HIV. What questions or concerns do you have about these choices?
Complementary	<ul style="list-style-type: none"> By disclosing her HIV status to her partner and family, the woman may be in a

Messages	<p>better position to: encourage her partner to be tested for HIV, to prevent transmitting HIV to him and to receive support from her partner and family for protecting her health and protecting her baby from getting HIV.</p> <ul style="list-style-type: none"> • It is important to respect the woman's choice regarding the timing and process of disclosure. If the woman has indicated that her partner and family may react negatively to her HIV status, the healthcare worker can help the woman problem-solve and build skills to use when she is ready to disclose her HIV status.
<p>(See Chapter I, pages 25-27, for additional information on disclosure and partner referral. See also Appendix 6: Guidance on Condoms and Condom Use.)</p>	

Table III.31 – Treatment, Care and Support Services

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC Card 13 and PD Card 14/L&D Card 19: What treatment, care and support services are there to help my family and me?	
Suggested Script	<ul style="list-style-type: none"> • How are you feeling right now? • Do you have any family members or friends who can provide support to you? • It is important to have someone that you can talk with. Please think about who can support you in dealing with HIV. Consider telling them about your test result. • There are counselling, nutrition and other support services that can help with concerns that you might have. • <i>(If available)</i> Would you like to know more about a local support group? A support group is a group of clients who, like yourself, are living with HIV. The clients attend the group to talk with each other about how to cope and live positively with HIV. • Here is a list of services for additional support: _____
Complementary Messages	<ul style="list-style-type: none"> • HIV infection affects all dimensions of a person's life: physical, psychological, social and spiritual. Counselling and social support can help people and their caregivers cope more effectively with each stage of the infection and enhance quality of life. • With adequate support, PLWHA are more likely to be able to cope with the stress of being infected and are less likely to develop serious mental health problems. • HIV infection often can result in stigma and fear for those living with the infection, as well as for those caring for them and may affect the entire family. Infection often results in loss of employment, income, housing, healthcare and mobility. Psychosocial support can assist people in making informed decisions, coping better with illness and dealing more effectively with discrimination. It improves the quality of their lives and may prevent further transmission of HIV infection. • For people with HIV/AIDS who must adhere to TB treatment, long-term prophylaxis or antiretroviral therapy, ongoing counselling can be critical for enhancing adherence to treatment regimens.

Table III.32 – Summary

Antenatal Care, Labour & Delivery and Post-Delivery	
ANC Card 14/L&D Card 20/PD Card 15: There are steps I can take to keep my baby, my family and myself healthy.	
Suggested Script	<ul style="list-style-type: none"> • It is important to attend all of your <u>antenatal</u>, post-delivery and other healthcare visits so we can help you, your baby and your family with any health problems. • We will not know if the baby is infected with HIV until we test the baby at ____ (<i>number</i>) months of age. • [Whether or not your baby is HIV-infected, s/he should be encouraged to live an active life and play like other children whenever possible.] • Until we know if your baby has HIV, you will give medicine (cotrimoxazole) to him/her every day. This medicine will help protect the baby from illnesses he/she can get if infected with HIV. • Do you have other children? • IF THE MOTHER HAS OTHER CHILDREN: Because we do not know when you became HIV-infected, it is important to bring your other children in for HIV testing. <p>Remember, by knowing your HIV status, you have taken a big step to protect your health and your baby's health. We have spoken with you about the following:</p> <ul style="list-style-type: none"> • Your test result shows you have HIV. • <u>You will get medicines to reduce the chance of passing HIV to your baby.</u> • [(If your baby was born within the past 72 hours): Your baby received medicine to reduce the chance of getting HIV.] • You <u>expect to</u> [will] feed your baby by _____ (<i>selected method</i>). Do not mix feed, that is, do not give breastmilk along with any other liquids or foods, not even water. However, you may give your baby drops or syrups consisting of vitamins, mineral supplements or medicine. • [If applicable: Until we know if your baby has HIV, you will give medicine (cotrimoxazole) to him/her every day. This medicine will help protect the baby from illnesses he/she can get if infected with HIV.] • If you have other children, you should bring them in for HIV testing. • Your partner should be tested for HIV. • <u>You should plan to deliver in a healthcare facility.</u> • Attend all of your [and your baby's] healthcare visits. Your next appointment is __/__/__. [Your baby's next appointment is __/__/__.] • Your first postnatal visit will be _____ (<i>date</i>) at _____ (<i>name of site</i>). • [You can receive family planning at _____ (<i>name of site</i>).] • Your plan is to seek additional support from _____ (<i>name of site, support group or person</i>). • What questions do you have? If you have further concerns, please contact us, so we can help.
Complementary Messages	<ul style="list-style-type: none"> • Review the key messages discussed in the Post-Test counselling session. • ANC: It is important that all women attend all of their antenatal care appointments and plan to deliver at a health facility. Continuing to receive antenatal care is the most effective way to safeguard a baby's health. • L&D and PD: It is important that all women attend all of their postpartum and their baby's well-child appointments. Continuing to receive healthcare is the most effective way to safeguard the mother's and baby's health. • Ask the woman if she has any questions or concerns. Let her know that she should contact the health facility in the future if questions or concerns arise.



If available, provide clients with a leaflet, such as the client information brochure, to reinforce information provided during the Post-Test counselling session.

Section 4 Test Declined Counselling Session Messages

Section 4 provides an overview of

- Suggested scripts and complementary messages provided during the counselling session with clients who initially declined HIV testing

The Test Declined scripts are designed to address barriers to HIV testing and to encourage the client to get tested for HIV. The cards that follow include the scripts for the Test Declined counselling sessions in ANC, PD and L&D settings.

Table III.33 – Barriers to Testing (Test Declined)

Antenatal Care, Labour and Delivery and Post-Delivery⁶	
ANC Card 13/L&D Card 21/PD Card 11: Address barriers to testing.	
Suggested Script	<ul style="list-style-type: none"> • What are some of your reasons for not wanting to have an HIV test today? (<i>Briefly acknowledge and discuss issues and concerns.</i>) • How could we help you with your concerns? What would help you to be ready for an HIV test? • It is very important that you get tested for HIV <u>with every pregnancy.</u>

⁶ ANC and L&D cards are the same.

	<ul style="list-style-type: none"> • If you are tested and do not have HIV, you will learn how to protect yourself and your baby from getting HIV. • <u>If you are tested and have HIV, there are medicines for you and your baby, and ways to feed your baby, to lower the chance of passing HIV to your baby. You and your family can also receive prevention, treatment, care and support services to stay healthy.</u> • [If baby was born within the past 72 hours (and rapid testing is available): If you are tested and have HIV, there are medicines for your baby and ways to feed your baby, to lower the chance of passing HIV to your baby. You and your family can also receive prevention, treatment, care and support services to stay healthy. • If baby was born more than 72 hours ago: If you are tested and have HIV, we will provide you counselling and support on how to feed your baby to lower the chance of passing HIV to your baby. You and your family can also receive prevention, treatment, care and support services to stay healthy.] • Would you like to test for HIV today? • If NO, continue to the next cards. • If YES, stop and refer or perform HV test according to clinic policy.
Complementary Messages	<ul style="list-style-type: none"> • If a pregnant woman tests negative, but her partner is HIV-infected, the woman is at high risk of becoming infected during pregnancy or breastfeeding. An infant is at particularly high risk of HIV infection if the mother gets HIV during pregnancy or breastfeeding.

Table III.34 – Risk-Reduction (Test Declined)

Antenatal Care, Labour and Delivery and Post-Delivery⁷	
ANC Card 14/L&D Card 22/PD Card 12: Review risk-reduction.	
Suggested Script	<p>Without knowing if you have HIV, there are still some steps you can take to protect yourself and your partner from getting or passing HIV.</p> <ul style="list-style-type: none"> • You and your partner should use condoms. When used correctly every time you have sex, condoms help protect against HIV. It is particularly important to use condoms if you or your partner do not know your HIV status or if your partner has other partners. • We can provide you with condoms and information on how to use a condom correctly. You and your partner can also get additional information about condoms at _____ (name of site). • Another option is to not have sex, particularly until you and your partner are tested for HIV. This can be difficult but it is the most effective way to protect each other from HIV. • If you and your partner are both tested for HIV and are both HIV-negative, you can protect each other from HIV by being faithful and only having sex with one another. If either of you has sex with anyone else, you could become infected with HIV and pass it to your partner. • What questions or concerns do you have about any of these choices for preventing HIV? Which choice do you think will be best for you and your partner?
(See Table III.2, Getting or Passing HIV, and Appendix 5: Guidance on Condoms and Condom Use.)	

⁷ ANC, L&D and PD cards are the same.

Table III.35 – Summary (Test Declined)

Antenatal Care, Labour and Delivery and Post-Delivery⁸	
ANC Card 15/L&D Card 23/PD Card 13: Explain exclusive breastfeeding, encourage antenatal [continuous] healthcare and encourage testing.	
Suggested Script	<p>Without knowing if you have HIV, there are some steps you can take to protect your health and the health of your baby.</p> <ol style="list-style-type: none"> 1. Exclusively breastfeed your baby. Give your baby <i>only</i> breastmilk and no other liquids or foods, not even water. However, you may give your baby drops or syrups consisting of vitamins, mineral supplements or medicine. Breastfeeding has many benefits. It provides all of the nutrients a baby needs and protects the baby from illnesses such as diarrhoea. 2. Attend all of your <u>antenatal</u> [you and your baby's health] care appointments so <u>you have a healthy pregnancy, and so we can help you and your partner make good decisions</u> [so that you and your baby stay healthy]. 3. <u>Plan to deliver your baby in a health facility because there are steps we can take to help you through labour and to have a safe birth.</u> <ul style="list-style-type: none"> • <u>After you deliver your baby, you should</u> continue with HIV prevention services to reduce your risk of acquiring HIV and get family planning to help plan future pregnancies. • Remember, we strongly encourage you and your partner to test for HIV. If you know you have HIV, you can lower the chances of passing HIV to your baby. You can also get care and treatment for yourself and your baby so you can both live healthy lives. • Would you like to be tested for HIV today? • We would like you to continue thinking about being tested. When do you think you will be able to come back and take the HIV test? • You can also talk with your partner about couple counselling and testing. If you prefer to be counselled and tested as a couple, you can be tested together at _____ (name of site). Your partner can also be tested at _____ (name of site). • What questions do you have? • If you have any further concerns, please contact us so we can help you.
Complementary Messages	<p>Provide final encouragement for the client to get tested for HIV:</p> <ul style="list-style-type: none"> • Not all women who have HIV will pass it to their babies. Without taking steps to prevent HIV transmission, 1 out of 3 women will pass HIV to their babies. This is why it is important to get an HIV test and receive care—to lower the chance of passing HIV to your baby. • HIV testing is a confidential service. Only healthcare workers providing direct care will know the woman's test result and even then, on a "need to know" basis. <p>Re-offer HIV testing before the client leaves.</p> <ul style="list-style-type: none"> • When the client agrees to testing, the healthcare worker may then describe the method of testing and the process for being tested and receiving results. • If the client continues to decline testing, develop a plan to meet with the client at a future time. Provide referrals to HIV counselling and testing for both the client and for her partner. (<i>If applicable</i>) Inform the client about availability of couple HIV counselling and testing services and offer referral. • Let the client know that: <ul style="list-style-type: none"> ○ You accept her decision and assure her that she will not be tested for HIV without her consent, although she will receive other tests that are part of standard antenatal or labour and delivery care.

⁸ PD and L&D cards are the same (except for a minor difference in title).

	<ul style="list-style-type: none">○ If she declines testing, it will not affect the quality of future care for her or her infant.○ She will be offered the opportunity to test for HIV at a later date.○ She may contact your facility if she needs additional information or support before deciding to take an HIV test, or if she or her partner has other questions.
<p>(See Chapter II: HIV Test Declined for additional information on the Test Declined counselling session. See also Appendix 7: Infant Feeding Counselling and Support.)</p>	

Chapter IV: Essential Skills for TC for PMTCT Programmes	71
Section 1 Skills for Pre-Test Information Sessions	71
Section 2 General Counselling Qualities	74
Section 3 Skills for Individual Counselling	76
Section 4 Skills for Couple Counselling	78

Chapter IV: Essential Skills for TC for PMTCT Programmes

Section 1	Skills for Pre-Test Information Sessions
Section 2	General Counselling Qualities
Section 3	Skills for Individual Counselling
Section 4	Skills for Couple Counselling

Introduction

There are many models of communication, counselling, health education and information sharing that can support a healthcare worker's skill in delivering TC for PMTCT messages in group and one-to-one settings. This Chapter reviews many of the skills needed to facilitate Pre-Test group information sessions and to carry out individual and couple counselling in the PMTCT setting. Guidance for training healthcare workers to use these tools and understand the underlying concepts can be found in Appendix 12.

Section 1: Skills for Pre-Test Information Sessions

Section 1 provides an overview of

- Basic skills needed to conduct effective Pre-Test information sessions
- Techniques used to facilitate groups

Background

This section provides guidance on the presentation of the Pre-Test information session to a group of clients.

In any learning situation, whether it is a formal training or casual health talk, adults absorb new information best when they:

- Are actively involved in the process of learning.
- Can share their knowledge and experiences and learn from others.
- Can apply the new information to everyday life.
- Are in a safe, respectful and comfortable atmosphere.

Group Sessions

As the group Pre-Test session is a core activity of TC in the PMTCT setting, it is important that healthcare workers master the skills necessary to facilitate the group Pre-Test session.

The skills needed to facilitate the Pre-Test group session are very similar to those needed for any group presentation. Throughout the presentation, keep in mind that the goal of the Pre-Test

session, as noted in Chapter I, is to provide clients with adequate information to make an informed decision about HIV testing.

What are the Basic Presentation Skills?

Preparation

- Review the flipchart in advance. The healthcare worker must know the subject matter well and feel comfortable talking about it in front of a group.
- Tailor the presentation to the specific audience. Review the presentation outline for linguistic and cultural appropriateness.
- Ensure there are an adequate number of handouts such as client information brochures (see Appendix 1).
- Set up and check presentation tools such as flipcharts before the session starts.
- Arrange the room so there is sufficient seating and all clients are able to see the healthcare worker and the flipcharts.

Movement

- Stand near the front of the room and face the group when speaking.
- Move around the room when presenting. Approaching clients will help get their attention and encourage them to respond to questions.
- Make appropriate eye contact with all clients.
- Use natural gestures and facial expressions during the presentation. The goal is to appear relaxed and confident.

Speaking

- Speak slowly, clearly and in a voice loud enough for clients to hear. This is particularly important for those whose first language is different from the language spoken by the healthcare worker.
- Use simple and appropriate language.
- Speak in an enthusiastic, natural voice.

Content

- Follow the flipchart or presentation guide closely, making sure that the important points are covered.
- Use stories and analogies to explain complex concepts.
- Encourage participation by inviting questions and comments.
- Keep to the allotted time-frame.
- Try not to rush or spend too much time on any one concept.
- Reiterate key messages at the end of the session.
- Answer all questions correctly. If you do not know the answer, admit that you do not know, or refer the question to a colleague.

What are Some Key Facilitation Skills?

Group facilitation skills are used to create rapport among group members and the healthcare worker. Effective facilitators promote discussion among group members and encourage sharing

and learning. Doing this requires skills that are similar to the counselling skills described in the next section. In particular, good facilitators should:

- Use open-ended questions.
- Set the ground rules at the beginning of the session, such as:
 - We will raise our hand to ask questions or make comments.
 - It is up to the individual if she wants to contribute to the session.
 - We will use language and tone of voice that is respectful of others.
 - We will speak one at a time and avoid whispering or having side conversations.
 - We will protect each other's confidentiality ("What's said here stays here.").
- Pay close attention to what clients say.
- Adopt a nonjudgemental attitude toward group members who are from different cultural or religious backgrounds, or whose opinions and experiences are different from those of the other group members.
- Ensure that all clients, even those who are shy, have an opportunity to participate.
- Deal with clients who tend to dominate the group.

Techniques for active listening

- Listen carefully when clients talk and show that you are listening by nodding, asking follow-up questions and summarizing the main points made by the clients.
- Look at the person who is speaking; but also note the reaction of others.
- Pay attention to what clients say **and** how they say it (e.g., tone of voice, nonverbal cues).

Techniques for managing talkative clients

- If one talkative client is dominating the discussion:
 - Acknowledge the talkative client and thank her for her contribution and expertise, but state, "May I hear from somebody else?"
 - If the talkative client appears to be a lay expert, enlist her help. Ask her to assist by handing out leaflets, by sharing her experiences, or by answering some of the more difficult questions.
- If a number of people in the group are talking with each other:
 - Speak in a lower voice (so clients are required to stop talking to hear).
 - Move near to the talkers (the healthcare worker's proximity should remind them that their conversation is disruptive).
 - Suggest that the talkers share their experiences with the entire group.

Techniques to increase participation

- Rather than lecturing, intersperse the presentation with group discussion, and questions and answers. The flipchart includes questions on many of the cards that can guide the discussion.
- Ask open-ended questions.
- When asking questions, allow the group sufficient time to answer. Use silence to encourage clients to respond.
- Give encouraging responses to all clients who answer. Be sensitive in correcting wrong answers. For example, start the response with "A lot of people think that, but..."
- Steer clients' conversations back to the topic when they drift off the point.
- Try to involve all clients in the discussion. When a few people have dominated the discussion, ask the group if anyone else has an opinion.

Additional techniques for managing difficult clients

- Ignore the behaviour. This might be particularly appropriate at the start of the session. However, the longer the behaviour persists unchecked, the more difficult it may become

to confront the client and the greater the likelihood that the healthcare worker may be seen as implicitly supporting unproductive behaviour.

- Have a quiet chat with the “difficult” individual to explain the impact she is having on the group, find out if there is an underlying reason for the disruption and ask that she discontinue the unproductive behaviour.
- If the behaviour breaks the ground rules, remind the group of the ground rules as a way to bring attention to the fact that the behaviour is inappropriate.

Section 2: General Counselling Qualities

Section 2 provides an overview of

- Counselling skills
- Self-awareness:
 - Its implications for counselling
 - How healthcare workers can build self-awareness
- The importance of empathy in HIV counselling

Introduction

HIV counselling is often defined as a “helping relationship” in which healthcare workers help clients find solutions to their problems. Although healthcare workers have specific HIV/AIDS messages they expect to share with their clients during a counselling session, counselling is not the same as providing health information. Instead, it is a healthcare worker-led process that is client-focused. “Client-focused” means that the counselling is tailored to the risk behaviour, circumstances and special needs of the client. The counselling session enhances the client’s understanding of HIV/AIDS and helps the client make informed choices about HIV prevention, treatment, and care. The healthcare worker’s role is to inform and assist with this decision-making process.

What is the First Step in Counselling?

A good counselling relationship is based on trust and respect. Therefore, the first step in effective counselling is to build a relationship that encourages the client to share feelings and experiences without fear of being judged. In order to build rapport, healthcare workers need skills that will help them to engage the client and manage the flow of the counselling session.

Counselling Skills to Engage Clients

- Be aware of your beliefs, values and assumptions.
- Respect clients and treat them with dignity even when their beliefs and behaviour are different from your own.
- Adopt a nonjudgemental attitude toward clients.
- Be aware of your verbal and nonverbal communication skills and how these may affect the counselling session.
- Listen actively, including the ability to verbally reflect back to the client the issues raised during the session.

- Ask supportive, nonjudgemental questions that encourage clients to discuss important issues related to HIV infection.
- Manage the counselling session in a way that encourages the client or the couple to make their own healthcare decisions.

Why is “Self-Awareness” Important in Counselling?

“Self-awareness” is the ability of healthcare workers to understand how their personal beliefs and experiences affect how they react and respond in a counselling session. Being self-aware, or knowing one’s own beliefs, fears and values, is one of the most important qualities healthcare workers need to counsel effectively. There are many ways in which healthcare workers’ beliefs, feelings and personal situations may influence their counselling. For example, a healthcare worker may:

- Be uncomfortable discussing sexual behaviours or drug use.
- Have prejudices that lead to discomfort when working with some clients (e.g., commercial sex workers).
- Have personal problems that affect her ability to listen and respond to the client.
- Want to be praised or liked, leading her to give clients only comforting, reassuring responses rather than advice the client needs to hear.

The ability to recognize these feelings, biases and motivations and how they affect the counselling session is crucial to the productive interaction between healthcare worker and client. Self-awareness improves the healthcare worker’s ability to ensure their values, beliefs and experiences do not influence client interactions. Self-awareness also enables healthcare workers to communicate, empathize with clients and offer support. For example, the healthcare worker who is aware of her own fears about getting tested for HIV may be better able to counsel a client with similar fears.

Developing self-awareness takes time. Analysing answers to questions such as those in the box below can help the healthcare worker develop self-awareness.

Self-Awareness: Consider Your Responses to These Questions

- What are my expectations of my clients?
- How do I feel about discussing HIV infection and AIDS?
- What are my feelings about people with HIV infection or AIDS?
- What are my feelings about people whose behaviour has placed them at risk?
- Which sexual practices would I find most difficult to talk about?
- Will I be judgemental of clients whose values, beliefs, attitudes, fears and views differ from mine?
- Am I ready to let clients make their own decisions?

What is “Empathy”?

Empathy is the ability to identify with and understand another person’s situation, feelings and motives. To empathize, the healthcare worker must listen to the client carefully, paying close

attention to verbal and nonverbal cues. This information should be used to understand the client's situation and feelings without being judgemental. Empathy should not be confused with sympathy, which involves feeling sorry for someone.

Section 3: Skills for Individual Counselling

Section 3 provides an overview of

- The importance of attentive listening in counselling; nonverbal cues to communicate careful listening
- Reflective listening and paraphrasing
- Questioning techniques that increase client participation in the counselling process

In addition to the general counselling skills discussed in the previous section, healthcare workers involved in individual counselling should also be skilled listeners and know how to encourage dialogue through paraphrasing and use of open-ended questions.

Why is Listening Important in Counselling?

During the counselling session, it is important that clients know that the healthcare worker is paying close attention to what they are saying. Careful listening helps the healthcare worker establish a rapport with clients and encourages clients to share their feelings. It also helps the healthcare worker to gather information. By listening closely to clients instead of leading the counselling conversation, healthcare workers allow clients to take responsibility for making their own healthcare decisions. The following practices support listening:

- Before the counselling session starts, close the door to the counselling room, turn off phones and take any other steps necessary to limit interruptions and distractions.
- Focus on the client when the client is speaking.
- Avoid interrupting the client.
- Give frequent verbal and nonverbal signs. These signs will reassure the client that the healthcare worker is listening. Examples of these behaviours include nodding, gesturing and using encouraging words.

The acronym SOLER can be used to remember nonverbal listening cues.

Table IV.1 – Nonverbal Listening Cues

S	S it squarely facing the client.
O	Adopt an o pen posture.
L	L ean forward towards the client when this is appropriate.
E	Maintain culturally appropriate e ye contact with the client.
R	Be r elaxed and natural.

What are “Reflective Listening” and “Paraphrasing”?

Reflective listening and paraphrasing are additional techniques that healthcare workers can use to encourage dialogue and let clients know that the healthcare worker is paying attention.

In order to listen reflectively, the healthcare worker often has to “paraphrase.” Paraphrasing is taking what the client has said and summarizing it in a nonjudgemental way, using introductory phrases like, “So you feel...” or “It sounds like you...” For example, if the client says, “I don’t want to tell my partner that I have tested HIV-positive,” the healthcare worker might say, “It sounds like you are worried about telling your partner you are HIV-positive.” Using this technique helps the client know that the healthcare worker has heard and understood the client’s perspective.

Why Ask Open-Ended Questions?

An open-ended question requires more than a simple “yes” or “no” answer and encourages clients to talk openly and to influence the direction of the counselling session. Table IV.2, below, includes examples of open- and closed-ended questions.

Table IV.2 – Examples of Open- and Close-Ended Questions

Open-ended questions	Closed-ended questions
What do you think your partner’s reaction will be if you ask him to use a condom?	Will your partner use a condom?
How do you plan to feed your baby now that you know you are infected with HIV?	Will you breastfeed your baby?
Where does your partner live?	Does your partner live with you?

There are situations when it is appropriate to use close-ended questions. Close-ended questions may be appropriate in the L&D setting, where there is limited time and it is more important to provide basic information than to counsel. Closed-ended questions can also be used when asking for consent to test the client for HIV.

Some other ground rules for asking questions during counselling sessions are

- Keep questions short and to the point.
- Ask only one question at a time.
- Use polite imperatives to clarify the client’s statements, get additional information and let the client know you want him or her to keep talking. An example of a polite imperative is “Please tell me more about your concerns about your partner’s HIV risk behaviours.”

Section 4: Skills for Couple Counselling

Section 4 provides an overview of

- The alliances healthcare workers must form and maintain to counsel couples effectively.
- How communication should be directed during the couple counselling session.
- Techniques to ease tensions and diffuse blame during couple counselling.

Introduction

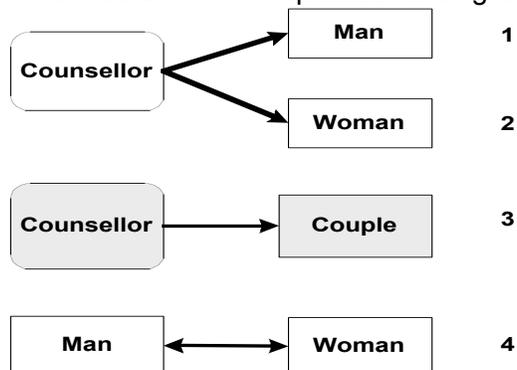
Couple counselling has unique challenges and opportunities that healthcare workers must manage in order to help couples make informed decisions about HIV testing. Because there is more than one client involved in the counselling session, the healthcare worker must be aware of the dynamics and how best to handle them. Having multiple clients also requires that the healthcare workers be skilful in directing the conversation so that all parties can participate fully. Healthcare workers need techniques to diffuse potential blame and tension that may be present when discussing personal or sensitive issues such as concerns about HIV risk.

The following are basic recommendations when counselling couples.

- Create a trusting relationship with the couple.
- Communicate that the opinions of both partners are important.
- Remain neutral.
- Give each partner the opportunity to share feelings and ask questions.
- Obtain consent for testing from each partner and encourage him or her to agree to “shared confidentiality,” which means that the couple will make decisions together about to whom they will disclose their test results.

How are Alliances Built?

The healthcare worker’s first task is to build an alliance, or partnership, with the couple. This alliance serves as the foundation that encourages the couple to participate in the session and discuss HIV-related issues. The first step in forming an alliance is conveying warmth and compassion. There are four main alliances in couple counselling as shown in this figure.



The way the healthcare worker communicates with the couple will influence the strength of the alliances she is able to build. The healthcare worker should pay attention to the different types

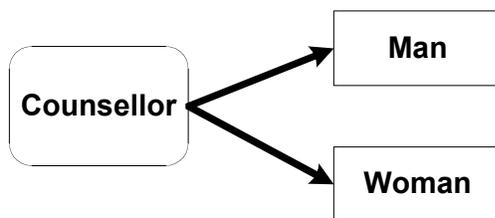
of communication that occur during the counselling session, making sure that she directs communication in such a way as to support each of the four alliances she hopes to form.

Alliances 1 & 2: The relationship between the healthcare worker and each of the individuals. In the first two alliances, each partner should feel acknowledged, valued, respected, engaged and understood. The healthcare worker should convey genuine interest in each of the individuals.

Alliance 3: The relationship between the healthcare worker and couple. In the alliance between the healthcare worker and the couple as a unit, the healthcare worker should convey respect for the couple's relationship.

Alliance 4: The relationship between the individuals in the couple. The healthcare worker should encourage the couple to speak to and engage each other. The more the couple is supported by the healthcare worker for addressing issues and concerns as partners—in terms of “we” rather than as individuals—the more likely they will be able to cope with the challenges of HIV.

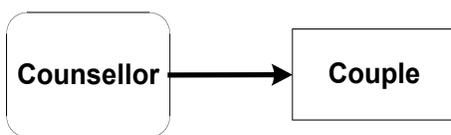
Communication between the healthcare worker and each member of the couple:



It is important for the healthcare worker to engage in conversation with each member of the couple. This gives each person an opportunity to share his or her perspective on issues and allows the silent partner to listen to his or her partner. Questions that are easy to answer and important to the relationship are good for encouraging both partners to talk freely during the counselling session. An example of this kind of question is,

“Tell me about your family and how many children you have.”

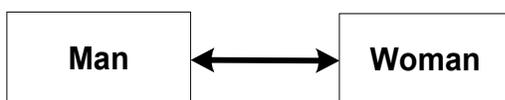
Communication between the healthcare worker and the couple as a unit:



By directing conversation to the couple, the healthcare worker recognizes the couple as a unit with its own history and dreams for the future. In the session, the healthcare worker should invite the couple to talk about their shared perspectives on issues. This demonstrates concern for both members of the couple. An example of a question

directed to the couple as a unit is, “What brings you two in today?”

Communication between each member of the couple:



By directing the partners to speak to each other, the healthcare worker facilitates conversations between them about HIV-related issues. The healthcare worker encourages the couple to work as a team and to bring their expertise about their

shared life and their strengths into the process. This strengthens the couple's alliance, builds communication skills and facilitates dialogue, cooperation and mutual decision-making. An example of this kind of communication would be asking, “How do you think the two of you would want to tell your families if one or both of you were HIV-positive?”

Healthcare workers should remember that communication can be both verbal and nonverbal. In addition to questioning the clients, the healthcare worker should use nonverbal signs such as eye contact, nodding and smiling to encourage communication.

What are Some Tips to Ease Tension and Diffuse Blame?

While all HIV counselling is emotionally difficult, counselling couples can be particularly challenging. One partner may suspect HIV infection is a sign of a partner's infidelity. A woman may fear her partner's reaction to learning she is HIV-infected. For couples who are HIV-infected, partners may feel grief and may be worried about the future of their family. It is therefore crucial that healthcare workers have the ability to prevent blaming and ease tension. The following strategies can help healthcare workers during particularly turbulent sessions.

- **Normalize feelings, reactions and experiences.** Help the couple recognize that what they are feeling is normal and that many others have had similar experiences. Remind the couple that HIV infection is affecting many in their community.
- **Use silence effectively while maintaining a supportive and calm demeanour.** During difficult moments, allow the couple time to be silent so they can collect their thoughts and respond or comment accordingly.
- **Focus on the couple's present and future.** Avoid and deflect questions aimed at identifying the potential source, as this is neither helpful nor relevant to the couple's present situation. Help the couple focus on their present and future together and on ways to support one another. Emphasize that the past cannot be changed. Remind them of PMTCT interventions that are available for them and their infants.
- **Express confidence in the couple's ability to deal with HIV-related issues constructively.** Reflect on their shared history and how they have effectively addressed challenges together in the past.
- **Reinforce positive actions taken by the clients.** Praise the couple's willingness to be counselled and to contend with the challenges that HIV presents. Remind the couple that their willingness to come into counselling together and to discuss these challenges will help them enormously.
- **Acknowledge the feelings the couple expresses and displays.** Let them know that over time the intensity of these feelings will probably change and they will begin to be able to adapt and move on.
- **Redirect and reframe questions and discussions that are placing blame or are hostile.** Help the couple identify the feelings that underlie this hostility. Fear, anxiety and uncertainty may be expressed as anger, aggression, or hostility.
- **Use reflective listening and gently acknowledge the behaviour being observed.**
- **Remind both members of the couple of their roles and responsibilities in the relationship.**
- **Focus on solutions, not problems.** While it is important to acknowledge each partner's feelings, the healthcare worker should focus the couple's attention and energy on generating solutions.

Additional Information on Counselling Skills and Qualities

This *Reference Guide* provides the basic information needed on counselling in PMTCT settings. Additional information may be found in either of the following resources:

- CDC, Global AIDS Program (GAP). 2003. Voluntary Counselling and Testing (VCT) Training curriculum. <http://www.womenchildrenhiv.org/wchiv?page=vc-05-02>
- CDC, Global AIDS Program (GAP). 2006. Couple HIV Counselling and Testing curriculum. Available in late 2006.

Summary of Essential Skills for TC for PMTCT Programmes

1. Essential presentation skills for conducting effective Pre-Test information sessions in the PMTCT setting include:
 - Be well-prepared: bring all needed equipment and materials, know the flipchart or other material. Follow the flipchart, invite questions, summarize key points.
 - Be mindful of movement: stand near the front, move around, make eye contact.
 - Speak slowly and clearly.
2. Group facilitation skills are used to create rapport among group members and between group members and the healthcare worker. There are a number of skills for managing difficult clients and ensuring that everyone in the group has an opportunity to participate in the session.
3. HIV counselling is often defined as a “helping relationship” in which healthcare workers help clients find solutions to their problems. Counselling is a healthcare worker-led and client-focused interactive process.
4. Self-awareness is the ability of healthcare workers to understand how their personal beliefs and experiences affect how they react and respond in a counselling session. Healthcare workers develop self-awareness through an ongoing process of introspection, questioning and self-reflection.
5. Empathy is the ability to identify with and understand another person’s situation, feelings and motives without being judgemental.
6. During the counselling session, it is important that clients know that the healthcare worker is paying close attention to what they are saying. Careful listening helps the healthcare worker establish a rapport and encourage clients to share their feelings.
7. Open-ended questions encourage clients to talk openly, give detailed responses and influence the direction of the counselling session.
8. Couple HIV testing and counselling is when both partners in a couple are counselled together. Having two clients also requires that the healthcare worker be skilful in directing the conversation so that both parties can participate fully and the healthcare worker use techniques to diffuse blame and tension.

Chapter V: Rapid HIV Testing in PMTCT Settings	83
Section 1 Introduction to HIV Testing	83
Section 2 Algorithms and Specimens for Rapid HIV Testing	85
Section 3 Rapid HIV Tests—Operational Issues	88

Chapter V: Rapid HIV Testing in PMTCT Settings

Section 1	Introduction to HIV Testing
Section 2	Algorithms and Specimens for Rapid HIV Testing
Section 3	Rapid HIV Tests—Operational Issues

Section 1: Introduction to HIV Testing

Section 1 provides an overview of

- HIV testing in PMTCT settings
- The benefits of rapid HIV testing in PMTCT settings

When HIV enters the body, the body responds by making a protein called an antibody, which can be detected in blood, serum/plasma or oral fluid/saliva⁹ by HIV antibody tests, such as the rapid HIV test, the enzyme-linked immunosorbent assay (ELISA) and the Western blot test. ELISA and the rapid HIV tests are the most commonly used HIV antibody tests. When properly administered, both the ELISA and the rapid HIV test yield results that have a high degree of accuracy. The primary difference between the standard ELISA and the rapid test is that the ELISA requires lab equipment and trained technicians, whereas the rapid test can be performed in the clinic setting by healthcare workers with basic training. The ELISA test results may take days or weeks to be returned to the clinic site, whereas the rapid test results are available in 20–40 minutes. When properly performed, both the ELISA and the rapid HIV test yield results that have a high degree of accuracy.

Several factors influence the decision about which HIV test will be used in PMTCT sites, including:

- National testing policy
- Availability and expertise of laboratory or other trained personnel
- Availability of supplies and laboratory support
- Cost of test kits and supplies

⁹ Although some rapid testing technologies utilize oral fluid or saliva samples, this Chapter refers to blood samples, as most HIV testing technologies require a whole blood sample. This is not meant to preclude use of oral fluid/saliva antibody testing.

Point-of-care testing

“**Point-of-care**” or “near-patient” testing refers to performing a medical test at a location near the client and outside the facility’s clinical laboratory. Locations may include nursing stations, examination rooms, counselling room, blood drawing stations, or small “satellite” laboratories.

Rapid HIV antibody testing performed at the point-of-care yields results within 20–40 minutes, allowing clients to receive their test results on the same day the sample is taken. Rapid HIV testing with same-day results, using a two-test algorithm, is the preferred approach for TC in a PMTCT setting.

What are the Advantages of Rapid HIV Testing?

The rapid HIV test has many benefits that make it practical for use in PMTCT settings.

In Kenya, women who underwent rapid testing were much more likely (96%) to receive their test results than were women who had been tested using an ELISA test (73%).

- **Onsite testing and same-day results:** Clients can receive their test results the day they are tested. This is important if clients present late in pregnancy, do not return for a second visit, or do not know their HIV status at L&D.

- **Lower risk of administrative error:** When the specimen is drawn, tested and results provided at the point-of-care, there is less risk of delay, specimen loss or mix-up, all of which are more likely to occur when samples are sent to a lab.
- **Accepted by clients:** Availability of same-day results increases the uptake of HIV testing substantially, reduces transportation time and costs for clients, and reduces the anxiety of waiting for the result.
- **Easier to perform:** Rapid HIV tests are simple and easy to perform because fewer steps are required to conduct the test.
- **Fewer resources required:**
 - **Human resources:** Any healthcare worker who has received training can perform the rapid test. Trained laboratory technicians are not required.
 - **Resources at the facility:** Most rapid test kits can be stored at room temperature (up to +20 to 30°C), but the ELISA reagents require refrigeration (2–8°C). If testing volume is low, a single specimen can be analyzed with rapid testing. ELISA testing is most economical when 40–90 specimens are run at a time; this batching increases the time clients have to wait for results.
 - **Financial resources:** Rapid tests have a lower cost per client who receives results, in part due to the fact that the proportion of clients who are post-test counselled tends to increase after the introduction of rapid testing. The lower cost is also due to the fact that rapid tests do not require investment in and maintenance of equipment or hiring of skilled laboratory technicians.
- **Lower risk of occupational exposure:** Because rapid testing requires only a few drops of whole blood, a fingerprick is sufficient. Fingerprick samples are easy to obtain, require

Rapid test accuracy

The diagnostic accuracy of the ELISA and rapid testing are comparable, but rapid testing makes it possible to provide essential post-test counselling PMTCT messages to the client on the same day that she was tested.

minimal equipment and can be carried out by an appropriately trained healthcare worker. The risk of occupational exposure is substantially reduced with fingerprick blood collection, as most occupational exposure to blood occurs during venipuncture. Additional information about preventing occupational exposure to HIV can be found in Appendix 9, “Infection Prevention and Universal Precautions.”

How does the ELISA Test Compare with the Rapid HIV Test?

ELISA is also used to identify antibodies to HIV in blood, urine, or saliva. Generally, a technician takes a blood sample with a needle from a vein in the arm and sends the sample to a laboratory for testing. Positive results are confirmed either with another ELISA (using a test kit from a different manufacturer) or by Western blot. The Western blot is a highly “specific” antibody test; it is particularly accurate in providing a negative test result on samples from people who are truly HIV-negative. Both tests can be done on the initial blood sample.

Because the sample is tested in a laboratory (ELISA testing requires trained technicians as well as special equipment), reporting of results may take several days or weeks and women may not return for test results or may give birth before the results are ready.

What are the Disadvantages of Rapid HIV Testing?

There are relatively few disadvantages of rapid HIV testing. They include:

- **Decentralized quality assurance and quality control:** Because the testing is decentralized, each facility has to establish its own quality assurance and control measures for the point-of-care testing.
- **Small test run:** Because rapid HIV tests are usually performed in small numbers, busy facilities with high client turnover may find the testing process inefficient.

See Section 2 of this Chapter for a summary of the advantages and disadvantages of the oral fluid/saliva rapid HIV test.

Section 2: Algorithms and Specimens for Rapid HIV Testing

Section 2 provides an overview of

- Rapid HIV testing algorithms for serial and parallel testing
- Specimens used for rapid HIV testing

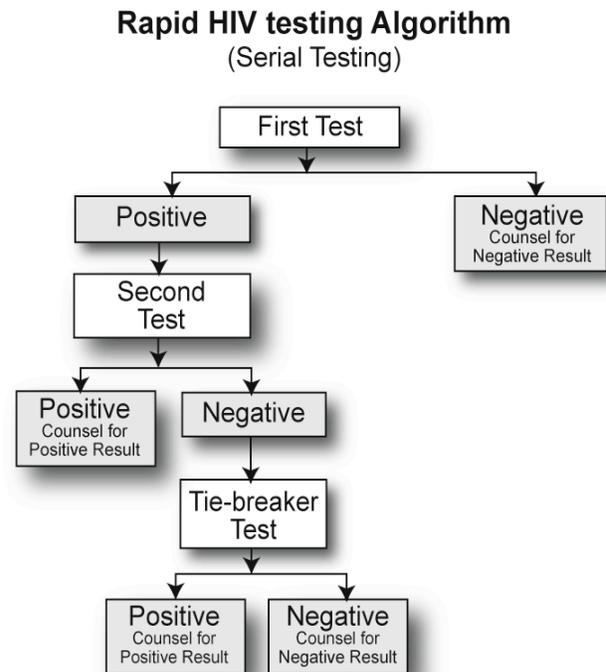
There are many rapid HIV testing technologies. Two or more rapid tests can be used serially or in parallel (see description below), to increase the accuracy of the test results. The WHO and other international guidelines recommend serial testing in most settings because it is more economical, i.e., a second test is required only when the first test result is positive. National policy determines the rapid test technology and algorithm used.

Serial Testing

In serial testing, as shown in this algorithm, a blood sample is taken and tested with a rapid HIV test.

- If this first test result is nonreactive, it is considered HIV-negative and there is no need to perform a second test. The result is given to the client as HIV-negative.
- If the first test result is reactive, the blood sample is tested again using a different brand of rapid HIV test:
 - If the second test is reactive, the result is given to the client as HIV-positive.
 - If the second test is negative, a third test (usually with a different rapid test kit) known as a “tie-breaker” is performed. The result of the tie-breaker is the final HIV result.

In the L&D setting, a single positive rapid test is adequate to start ARV prophylaxis for the woman during labour and for the infant upon delivery. The test should be repeated and the result confirmed after delivery.

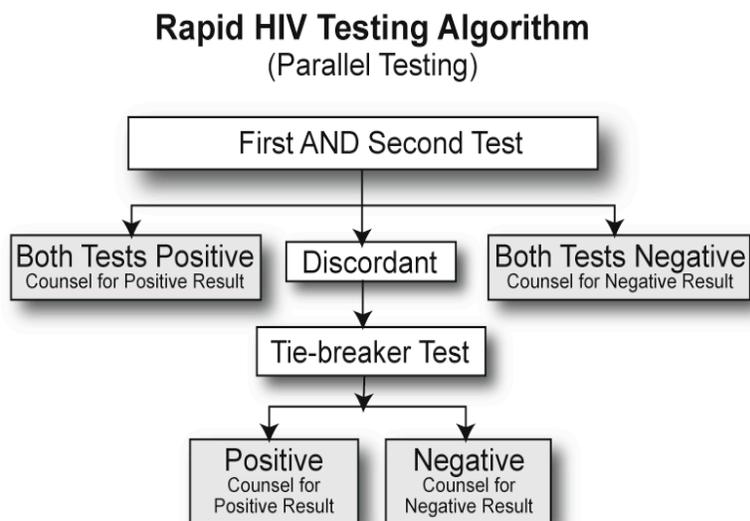


Parallel Testing

Parallel testing involves testing a blood sample with two HIV tests performed at the same time.

- If both test results are nonreactive, the result is HIV-negative.
- If both test results are reactive, the result is HIV-positive.
- If one test is reactive and the other nonreactive, a third test (usually with a rapid test kit manufactured by a third company) known as a “tie-breaker” is performed. The result of the tie-breaker is the final test result.

Parallel testing is shown in the figure on the next page.



In the L&D setting, when the test result is either positive or discordant, it is advisable to start ARV prophylaxis for the woman during labour and for the infant upon delivery. The testing should be repeated and the results confirmed after delivery.

Performing and interpreting the rapid HIV test: Appendix 11 provides an overview of the interpretation of the three most common rapid HIV test methods.

Which Specimens are Used for Rapid HIV Testing?

Decisions on specimen for rapid HIV testing are usually based on country policy. Rapid HIV tests can be done using any of the following types of specimens:

- Whole blood
- Serum¹⁰
- Oral fluid/saliva

Rapid tests that use oral fluid/saliva rather than blood are becoming more available. The oral fluid/saliva tests share the advantages of the rapid blood tests: the specimens can be stored at room temperature, the tests require no specialized equipment and they take the same amount of time to process (20–40 minutes). The additional *advantages* of the oral fluid/saliva rapid test are:

- It is generally better accepted by clients, as the sample collection does not require a blood draw or fingerprick. Instead, a device is gently swabbed once completely around the upper and lower outer gums and inserted into a vial containing a developer solution.
- Healthcare workers do not face the risk of occupational exposure to blood.

The two notable *disadvantages* of the oral fluid/saliva rapid HIV test are:

- It can cause confusion about HIV transmission. Many clients who are tested for HIV using oral fluid/saliva sometimes assume wrongly that HIV can be transmitted through saliva. If using the oral fluid/saliva rapid test, the counsellor should include in the pre-test session information to correct misconceptions about HIV transmission via saliva.

¹⁰ In contrast to whole blood fingerprick specimens, serum specimens require blood to be drawn with syringes or vacutainers and centrifugation or time to clot, and, therefore, require more time and staff with a higher level of training.

- Currently, these tests tend to be more expensive and are less available.

Section 3: Rapid HIV Tests—Operational Issues

Section 3 provides an overview of

- Who should perform the rapid HIV antibody test
- Location for rapid HIV test administration
- Quality assurance systems and quality control for HIV testing, including steps to prevent and detect errors

Who is Qualified to Perform Rapid HIV Tests?

National and clinic policy will determine who can perform the HIV rapid test. In addition to laboratory personnel, trained healthcare workers including doctors, nurses, midwives and lay or peer counsellors with little or no previous laboratory experience can learn to perform most rapid tests.

Using nonlaboratory staff to perform the rapid HIV test improves access to testing and counselling where laboratory personnel are unavailable. Training, regular supervision and periodic assessment of skills should be provided to ensure the quality of testing is maintained.

Additional Information on Rapid HIV Test Training

Training resources include:

- Rapid testing: WHO/HHS-CDC HIV Rapid Testing Training Package: Participant Manual and Trainer's Guide. Current Laboratory Practice Series (available at: <http://www.phppo.cdc.gov/dls/ila/hivtraining/>).
- Guidelines for Assuring the Accuracy and Reliability of HIV Rapid Testing: Applying a Quality System Approach (available at: [http://www.phppo.cdc.gov/dls/ila/documents/HIVRapidTest%20Guidelines%20\(Final-Sept%202005\).pdf](http://www.phppo.cdc.gov/dls/ila/documents/HIVRapidTest%20Guidelines%20(Final-Sept%202005).pdf))

Where Should Rapid HIV Test be Performed?

Set up the rapid testing area as near to the point-of-care as possible. The rapid test may be performed in any number of places, keeping in mind the "Safety Rules for Rapid Testing Areas" (Appendix 9) and the need for a private space. Examples include:

- Side lab near the clinic or ward.
- Examination room.
- Healthcare facility's general laboratory.
- Central but conveniently located mobile rapid testing unit that can meet the testing needs of all of the PMTCT and VCT sites in the area.

Lessons from the Field, Point-of-Care Rapid Testing

Hospitals in several large US cities participating in the MIRIAD study set up a small counter space or worktable in the nurses' station for performing rapid tests for clients on the labour and delivery ward. This enabled the nurses to perform the tests, return to caring for their patients and then go back to read test results at the recommended time.

How Should Rapid HIV Tests be Processed?

The rapid tests can be processed one-by-one as clients have their blood drawn, or in batches, with many tests processed at once. The best method for a particular setting will depend on several factors, including the number of clients tested and the model used for the pre-test session. Large clinics and sites that provide group pre-test counselling may favour batching tests for processing.

Although it may be more efficient to batch the tests, the advantage of processing them one at a time is that there is less chance of specimen mix-up and the results can be made available to the individual more quickly. Efficiency is especially important in the L&D setting, where it may be advantageous to process samples one-by-one to provide PMTCT interventions.

What about a Quality Assurance System for Testing?

Because of the critical implications of the test results, it is extremely important to ensure accurate testing of all specimens and reporting of all results. Maintaining a quality assurance (QA) system is crucial for a laboratory to detect and reduce errors, improve consistency among testing sites and help contain costs. A quality assurance system includes the following components:

- System to hire, retain, train, supervise and manage staff.
- Procedures to select, purchase, install, calibrate, maintain, service and repair equipment.
- Procedures to manage inventory.
- Procedures, including standard operating procedures, to manage specimens.
- Procedures for developing, approving, distributing forms and for storing records.
- System and staff to manage information including data and assure client privacy and confidentiality.
- Procedures for reporting, addressing and recording errors.
- System for external quality assessment and internal audit or self-evaluation.
- Method for monitoring customer satisfaction and improving the process.
- System for ensuring safety procedures and practices.

Quality Assurance: Preventing and Detecting Errors

Steps that healthcare workers can take to prevent and detect errors are shown in the tables below.

Table V.1 – Preventing and Detecting Errors *before* Testing

Preventing and detecting errors— <i>before</i> testing	
Do	Common errors
<ul style="list-style-type: none"> • Check storage and room temperature. Test kits should be stored as recommended (usually between 4°C–30°C); if refrigerated, test kits must be brought to room temperature, 15°C–30°C, before opening. • Select an appropriate testing workspace. • Check inventory and expiration dates. • Review testing procedures. • Record pertinent information and label test device with client identifier. • Collect specimen. • Store and transport specimen appropriately. Specimens should be tested immediately but can be tested within 8 hours of collection if stored between 15°C–27°C. 	<ul style="list-style-type: none"> • Test kits stored inappropriately. • Outdated kits used for testing. • Quality control procedures not performed or performed incorrectly. • Specimens mislabelled or not labelled.

Table V.2 – Preventing and Detecting Errors *during* Testing

Preventing and detecting errors— <i>during</i> testing	
Do	Common errors
<ul style="list-style-type: none"> • Perform and review quality control procedures (QC). • Follow safety precautions. • Conduct test according to written directions. • Correctly interpret test results. 	<ul style="list-style-type: none"> • Did not follow country algorithm. • Failed to read the test results within the recommended time. • Reported results when control results out of range. • Measured specimen or reagents improperly. (Reagents are compounds that are part of the test kit. When added to the blood sample, the reagents produce a characteristic chemical reaction, which indicates the presence of HIV antibody.) • Stored reagents inappropriately and/or used them after expiration date. • Made errors when diluting and pipetting. • Used incorrect reagents.

Lessons From the Field, Quality Control

In a country in Africa, counsellors were reporting a very high percentage of discordant rapid HIV test results. (They were using the nationally approved parallel testing algorithm.) After evaluating the problem, it was found that counsellors were not following many quality control procedures:

- Outdated test kits were being used; the counsellors were incorrectly informed by hospital laboratory personnel that kits could be used for 3 months after the expiration date.
- Few counsellors understood that the test control procedures needed to be repeated every morning.
- Temperatures in testing spaces often exceeded the recommended temperature range.

To address the problem, one individual in the region was appointed to be responsible for HIV rapid testing quality control. This quality assurance supervisor made visits to each testing site to evaluate testing procedures and re-train counsellors. Procedures were formalized for periodic re-evaluation of counsellors' rapid testing skills.

Table V.3 – Preventing and Detecting Errors After Testing

Preventing and detecting errors—after testing	
Do	Common errors
<ul style="list-style-type: none"> • Re-check client identifier. • Write test report legibly. • Clean up and safely dispose of contaminated waste. • Package external quality assessment specimens for re-testing, if needed. 	<ul style="list-style-type: none"> • Made transcription error. • Sent report to the wrong location. • Did not maintain information system.

Rapid HIV Testing in PMTCT Settings

1. Rapid HIV antibody testing yields results within 20–40 minutes, allowing clients to receive post-test counselling—and their test results—on the same day, usually within 1 or 2 hours after the blood or oral fluid/saliva sample is taken.
2. The diagnostic accuracy of the ELISA and rapid testing are comparable.
3. Benefits of rapid testing include:
 - Onsite testing and same-day results
 - Increased uptake of HIV testing by clients; increase in percentage of clients receiving results
 - Lower risk of specimen mix-up, loss or delay
 - Less human, facility and financial resources required
 - Lower risk of occupational exposure
4. There are two commonly used algorithms for rapid testing—serial and parallel testing. WHO recommends serial testing because it is economical; with serial testing, a second test is required only when the first test result is positive.
5. Decisions on the type of specimen used for rapid HIV testing are usually based on country policy. Rapid HIV testing can be done using whole blood, serum / plasma or oral fluid/saliva.
6. After appropriate training, healthcare workers with little or no laboratory experience can perform most types of rapid tests. However, regular supervision, periodic assessment of skills and a quality assurance system should be maintained to ensure the quality of testing.
7. In ANC and PD settings, the rapid test may be conducted at any time after the pre-test counselling session has been completed and informed consent given. In L&D settings, the rapid test should be performed as soon as consent has been given.
8. Maintaining a QA system is crucial. The QA system detects and reduces errors, improves consistency among testing sites and helps contain costs.

Chapter VI: Implementation Issues	93
Section 1 Improving Access to PMTCT Services	93
Section 2 Improving Service Provision	96

Chapter VI: Implementation Issues

Section 1 Improving Access to PMTCT Services
Section 2 Improving Service Provision

Introduction

The early implementation phase of establishing a PMTCT programme can be challenging. These challenges are a normal part of the process of establishing a new service and ensuring that the service is acceptable to clients and that it meets its goals.

If PMTCT activities are to be successful in the long-term, many areas need to be strengthened, including the following:

- Accessibility
- Uptake of PMTCT interventions
- Staffing levels
- Training
- Procurement systems
- Communication networks
- Monitoring and evaluation systems

In the short-term, when TC for PMTCT services are added to the standard MCH package, an initial investment in infrastructure will be needed so that PMTCT activities do not compromise existing services. This chapter summarizes some of the approaches that established PMTCT services have implemented to meet these challenges. The issues are divided into two sections:

- Factors that affect access to services
- Factors that affect service provision

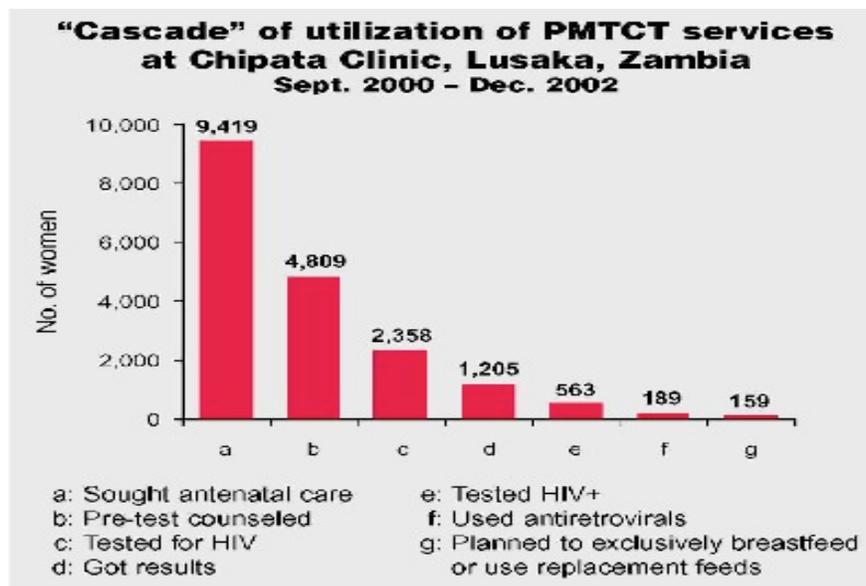
Section 1: Improving Access to PMTCT Services

Section 1 provides an overview of

- Some of the factors limiting client access and adherence to PMTCT services
- Strategies for addressing these factors

Background

Although progress has been made toward increasing PMTCT coverage worldwide, the uptake of PMTCT services has, to date, remained inadequate. Many pilot PMTCT programmes experience a “cascade of attrition,” shown in the graph below, which dramatically weakens the impact and cost-effectiveness of PMTCT services.



The graph shows the number of women who dropped out of PMTCT services at each stage of the PMTCT process in a clinic in Zambia: not all women who sought antenatal care received Pre-Test counselling and testing and even fewer (about 13% of those who sought ANC) received their test results. Of those who tested HIV-positive, only one-third used antiretroviral (ARV) prophylaxis. Many factors influence the rate of attrition experienced at the clinic in Zambia and in other PMTCT programs worldwide. This Chapter provides an overview of some of these factors.

How can we Improve Access to Services?

There are many factors that can influence a client's access to healthcare services; some of which are listed below.

- **Limited clinic hours:** Extend MCH clinic hours into the afternoon, evening or weekends for the convenience of clients and partners who work during the day.
- **Transportation:** Establish mobile or satellite clinics or health outreach initiatives in outlying areas to support trained community health workers or traditional birth attendants in carrying out basic PMTCT interventions and referrals.
- **Cost of care:** Provide free or subsidized MCH and PMTCT services including testing, counselling and ARV prophylaxis to increase access for clients who are unable to pay. MCH managers could consider seeking partnerships with NGOs or multinational organizations to encourage funding of incentives, such as food supplements, to offset the costs of care.
- **Limited access to ANC:** Provide testing and counselling (TC) to all pregnant or peripartum women at first point of contact including women with unknown status who present for the first time at labour or immediately post-delivery (see Introduction and Chapter I for additional information).
- **Home births or delivery at another facility:** Approximately 54% of African women give birth without the assistance of trained healthcare workers. Women should be urged to return for all ANC and healthcare visits and to give birth in a health facility. Healthcare workers should develop linkages with other L&D and PD facilities to facilitate shared care and reduce duplication of testing. If a client plans to deliver at home or at a different health facility, where permitted by national policy, provide HIV-positive clients ARV prophylaxis (such as single dose nevirapine) to take home for self-administration. Traditional birth attendants (TBAs) can be trained to help women adhere to PMTCT interventions and to identify women whose HIV status is unknown. With training, TBAs may also be able to support PMTCT programmes by providing HIV/AIDS education, including risk-reduction strategies, encouraging women to get HIV tested, using safer obstetrical practices, observing the administration of ARV prophylaxis and referring mothers and infants to post-delivery care. This is currently being done in Cameroon in West Africa, where TBAs provide support to PMTCT programs with great success.

Refer to Chapter II for a summary of some of the barriers to accepting HIV testing and how healthcare workers can help clients overcome them.

What if a Client Says she has Already been Tested?

Deciding to retest a woman for HIV will depend on national policy. In general, unless there is proof of HIV status, repeat the HIV test. For clients who tested HIV-negative, the test must have been performed during the current pregnancy or it should be repeated.

Section 2: Improving Service Provision

Section 2 provides an overview of

- Strategies to assess and address challenges to service provision
- Quality data collection for programme monitoring
- Suggestions for developing a referral network

How can we Improve Service Provision?

To improve the quality and accessibility of services, PMTCT managers and healthcare workers may start by assessing the strengths and weaknesses of their own services in any number of ways:

- Reviewing monitoring and evaluation data.
- Implementing client satisfaction surveys.
- Interviewing clients.
- Setting management policy that encourages staff to discuss service provision issues and suggestions with management.
- Sharing service implementation successes and lessons learned with staff and management of neighbouring PMTCT sites.

Common challenges to the provision of TC for PMTCT services include the following.

1. Staff shortage

The shortage of skilled counsellors and other trained healthcare workers is one of the main barriers to providing TC for PMTCT. Nurses and midwives are often overburdened with existing responsibilities and making HIV testing and counselling a routine part of MCH will further increase their workload unless human resource issues are addressed. Possible approaches to addressing the staffing shortage are as follows:

- Develop a system for integrating PMTCT activities including testing and counselling into clinic activities and flow. For example, designate staff members to implement the PMTCT interventions, or distribute responsibility for providing these services among all staff. Managers should emphasize that PMTCT activities are a routine and permanent part of ANC, L&D and PD care, not a special project or an optional activity.
- Conduct pre-test counselling in small or large groups rather than having individual pre-test counselling sessions (see Chapter I).
- Allow nurse-midwives to counsel and conduct health talks on their day off for extra pay.
- Use dedicated counsellors instead of MCH staff to conduct the pre- and post-test sessions. A study of PMTCT programmes in Uganda found that having more counsellors increased testing uptake.
- Use HIV-infected mothers, other peer or lay counsellors to provide counselling (see description of M2M2B on page 18, Chapter I). Develop clear policies on required skill level, training, supervision and pay.

2. Long waits

One challenge of introducing TC for PMTCT is ensuring that the additional services do not cause long waits in the ANC or PD facility. For example, in a PMTCT programme in Zimbabwe, the addition of PMTCT services required clients to spend an additional 1½ hours in the ANC clinic. Finding innovative ways to minimize waiting times is important, not only for client convenience but also for improving the uptake of testing and counselling services.

Approaches to addressing long waits might include:

- Use group pre-test sessions instead of individual counselling in order to improve patient flow and reduce waiting time (see Chapter 1).
- Incorporate HIV information into the general ANC or PD health talk given to all clients, eliminating the need to have a separate HIV information session.
- Use rapid HIV tests at point-of-care so that women are tested and are given their results during the same visit. Maximize the staff cadres (e.g., counsellors and nurses) who are able to perform the rapid tests.
- Explore the possibility of extending MCH clinic hours.
- Ensure sufficient counselling staff.

3. Inadequate space

The lack of private rooms for one-to-one counselling can also be an obstacle to offering testing and counselling services in PMTCT settings. Unfortunately, most facilities are already quite crowded and funding for building additional rooms is often scarce. Possible approaches to dealing with the lack of space may include:

- Use other rooms as part-time counselling rooms, since counselling rooms are usually not used continuously. Sharing rooms can be made easier by scheduling counselling appointments and using signs to indicate when the room is in use so that counselling sessions are not interrupted.
- Partition existing rooms to create additional counselling space.
- Consider asking community groups, NGOs or local business to either donate money for or assist with building additional rooms or installing modular or portable buildings.

4. Lack of supplies

HIV testing supplies and drugs for PMTCT must be consistently available. When supplies for testing are not available, women may be required to return later or go to another clinic. Many of these women will not return for testing. Commodity issues are not typically resolved at the facility level. However, below are some approaches that programme managers can consider.

- Develop accurate estimates of the quantity of supplies that will be needed. Three methods can be used to make these estimates:
 - Review data on past consumption of commodities.
 - Take into account the current inventory, delivery time and quantity expected to be lost to waste or theft.
 - Use data from other PMTCT programmes in similar facilities to estimate quantities needed.
- When necessary, prioritize the use of commodities in short supply: If HIV test kits are scarce, test women in the later stages of pregnancy first; reserve personal protective equipment for higher risk procedures (e.g., if gloves are in short supply, use them for childbirth and suturing instead of routine injections).
- Designate commodity storage areas, with inventory and stock control systems, that are secure from theft and protected from the elements.
- Develop a system to safely dispose of expired commodities.

- Coordinate the purchase and delivery of test kits with other PMTCT and healthcare facility supplies, as well as with the supplies for other VCT centres, HIV surveillance centres and blood transfusion services in the area.

How can we Ensure Quality Data Collection?

Ongoing monitoring and evaluation of PMTCT services is important to determine if a programme is achieving its goals and objectives. Most PMTCT sites already have client registers and forms for data collection on the number of women tested, counselled and offered PMTCT services. These forms and registers are the primary source of monitoring how well the program is working and changes that need to be made. For example, if programme monitoring suggests that the number of clients tested is lower than expected, a programme may decide to initiate opt-out (rather than opt-in testing) and implement intensive staff training to increase the numbers tested.

Monitoring information is only as useful as the quality of the data recorded. The following are suggestions for healthcare workers responsible for recording PMTCT service and client health information:

- Record the data each time you perform a procedure, provide a group or individual pre-test session, examine or counsel an HIV-infected client, prescribe an ARV drug, receive and provide a test result, or engage in any other PMTCT activity.
- Provide all the information requested on the monitoring form. Doing so might even require noting when you did not provide a service.
- Record the data in the same way every time. Use the same definitions and the same rules for reporting the same piece of information over time. Guidance on recording data can usually be found in national or facility policies or guidelines.
- Clearly document errors when they are made.

How can we Develop a Referral Network?

Testing and counselling serves as a gateway to a network of HIV prevention, treatment, care and support services. Functioning referral networks require that healthcare workers be fully versed in the range of clinics, departments and organizations that provide services to clients with HIV, their partners and families. It is important to link the ANC facility, nearby maternity sites, post-delivery services and TBAs in the referral network. An additional benefit of referral linkages is that they advertise and create support for PMTCT activities.

Referral networks take time and commitment to create and maintain. The first step in creating a network is to map all possible referral resources (for example, government health facilities, community health organizations, faith-based organizations (FBOs), hospitals and TBAs), and create a directory of these services. A referral network can include the following components:

- A lead organization to coordinate the referral system.
- Regular meetings of network providers or another way to communicate (e.g., e-mail, telephone, newsletter).
- A designated referral person at each of the organizations, who will be the first contact for people referred. This person will handle any paperwork involved in processing referrals and attend network meetings.
- A standard referral form that all network members can give to clients and use for managing referrals.

- A system that tracks referrals and lets network members know when a referral has been successfully completed.

Suggested Referrals

Referrals for HIV-negative women and women of unknown HIV status:

- Postpartum care
- Nutrition
- Routine well-baby or well-child care, including immunizations
- Testing and counselling sites (partner and family testing)
- Family planning, reproductive health, including condoms and safer sex advice
- Infant-feeding counselling and support
- Treatment and support for drug and/or alcohol abuse

Referrals for HIV-positive women:

- Postpartum care
- Nutrition
- Routine well-baby or well-child care, including immunizations, treatment, care and support for HIV-exposed infants; and infant or young child HIV testing
- HIV treatment, care, prevention and support including ARV treatment
- Testing and counselling sites (partner and family testing)
- Family planning, reproductive health, including condoms and safer sex counselling
- Infant-feeding counselling and support
- Self-help groups for PLWHA (support groups and positive mothers' clubs)
- Tuberculosis, malaria, hepatitis, or other speciality disease-specific clinic
- Sexually transmitted infection (STIs) treatment programmes
- Organizations providing ongoing counselling
- Faith-based organizations and community organizations that offer psychosocial care or that help PLWHA with specific needs such as housing, transportation, food assistance, legal assistance and advice and income-generating
- Nutritional support programmes for mothers and children
- Treatment and support for drug and/or alcohol abuse

Summary of Implementation Issues

1. Many factors can influence a woman's access to healthcare services. The most frequently mentioned are a lack of transportation, inconvenient clinic hours and the high cost of services. Other barriers to adherence to PMTCT interventions, such as home birth or delivery at another facility, can be minimized through creative solutions such as self-administration of ARV prophylaxis, liaison with TBAs and linkages with neighbouring L&D and PD sites.
2. Issues affecting service provision include:
 - Staffing levels
 - Long waits for services
 - Limited space for counselling
 - Lack of supplies

With collaboration from the community, staff, clients and funders, creative solutions can enable programmes to keep services functional and of high quality.

3. Testing and counselling serves as a gateway to HIV prevention, treatment, care and support services. As testing and counselling is integrated into PMTCT services, formal referral networks to other health organizations, clinics, and departments will need to be developed to ensure that clients have access to the full continuum of care. Referral networks take time and commitment to create and maintain.

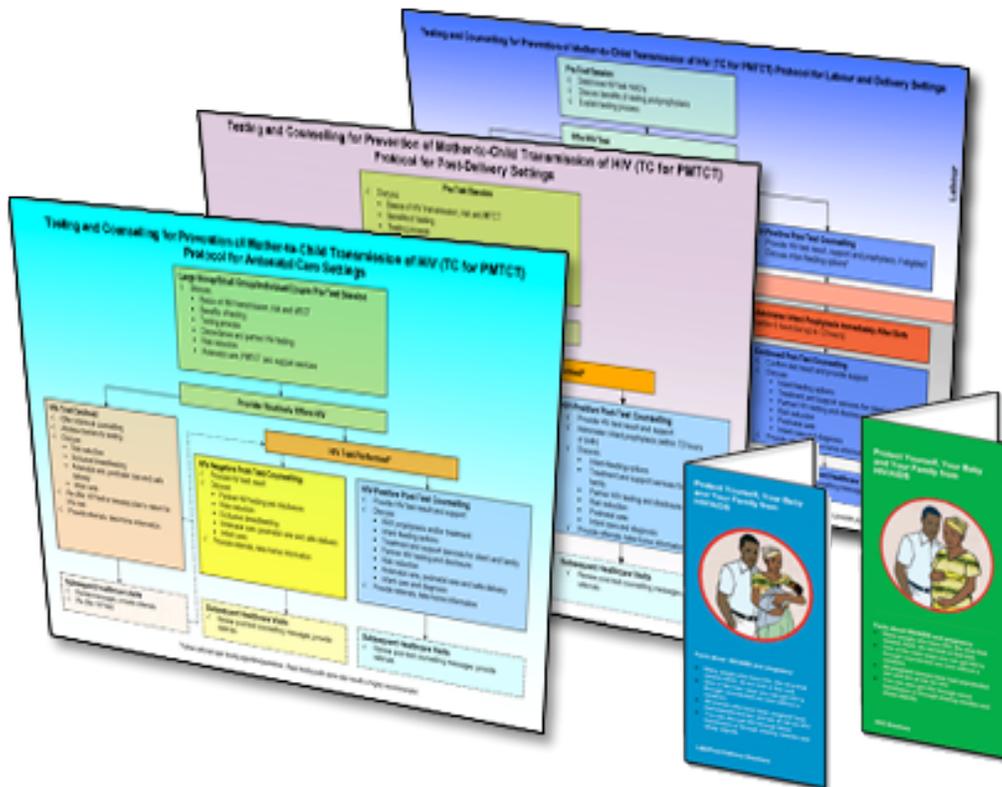
Chapter VII: Appendices	101
Appendix 1	101
TC for PMTCT Support Tools	
Protocol wall chart for ANC Settings	
Protocol wall chart for L&D Settings	
Protocol wall chart for PD Settings	
ANC client information brochure	
L&D and PD client information brochure	
Appendix 2	109
Guidance for Adapting the TC for PMTCT Support Tools	
Appendix 3	115
Provider-Initiated, Opt-Out HIV Testing and Counselling in PMTCT Settings	
Appendix 4	117
Risk-Reduction Messages	
Appendix 5	119
Guidance on Condoms and Condom Use	
Appendix 6	125
Window Period	
Appendix 7	127
Infant Feeding Counselling and Support	
Appendix 8	135
WHO Recommendations: Antiretroviral (ARV) Regimens to Treat and Prevent MTCT	
Appendix 9	137
Infection Prevention and Universal Precautions	
Appendix 10	141
Healthcare for Mothers with HIV and Their HIV-Exposed Children	
Appendix 11	145
Reading Results for the Three Rapid HIV Test Methods	
Appendix 12	147
TC for PMTCT Trainer Guidance	

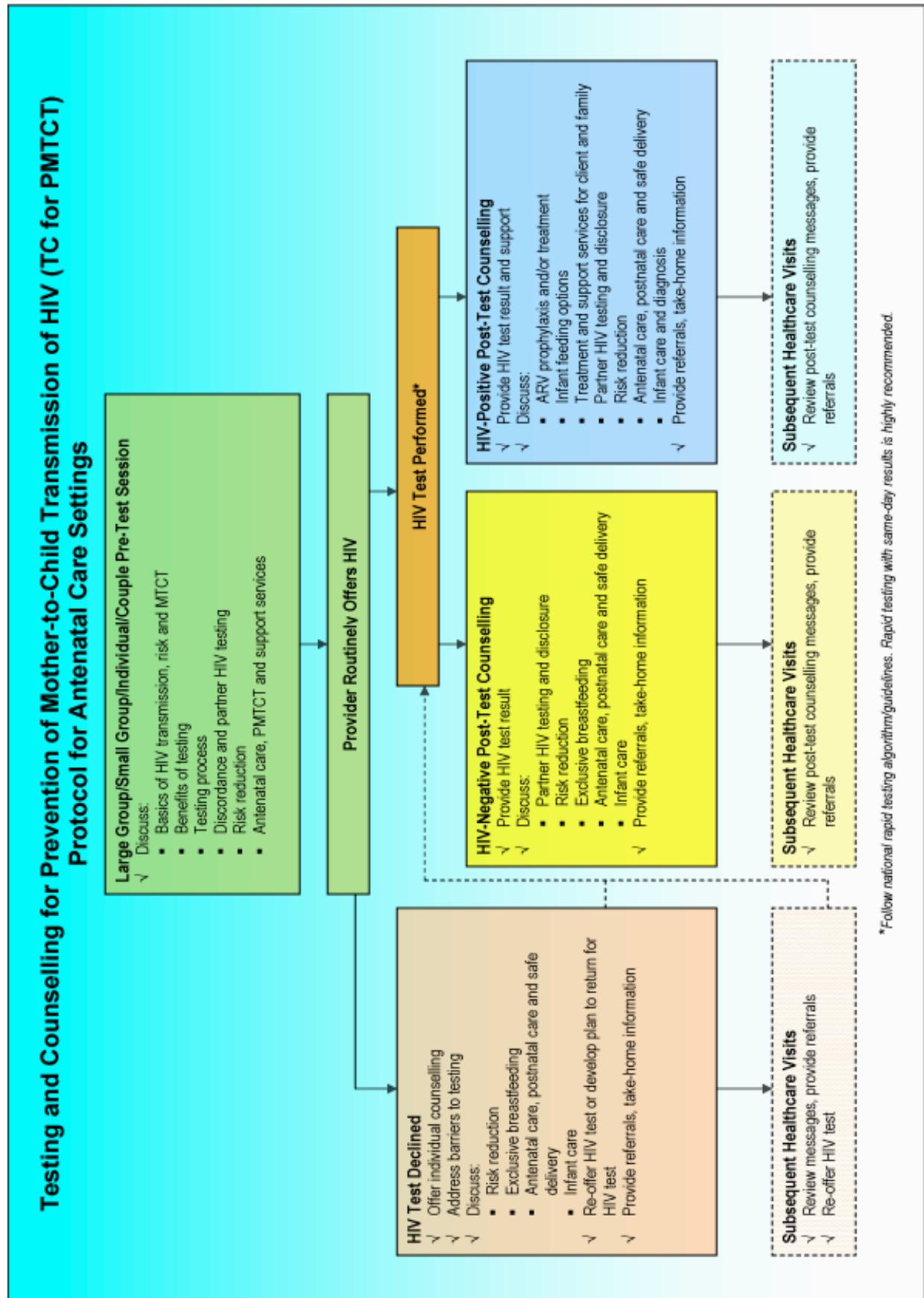
Chapter VII: Appendices

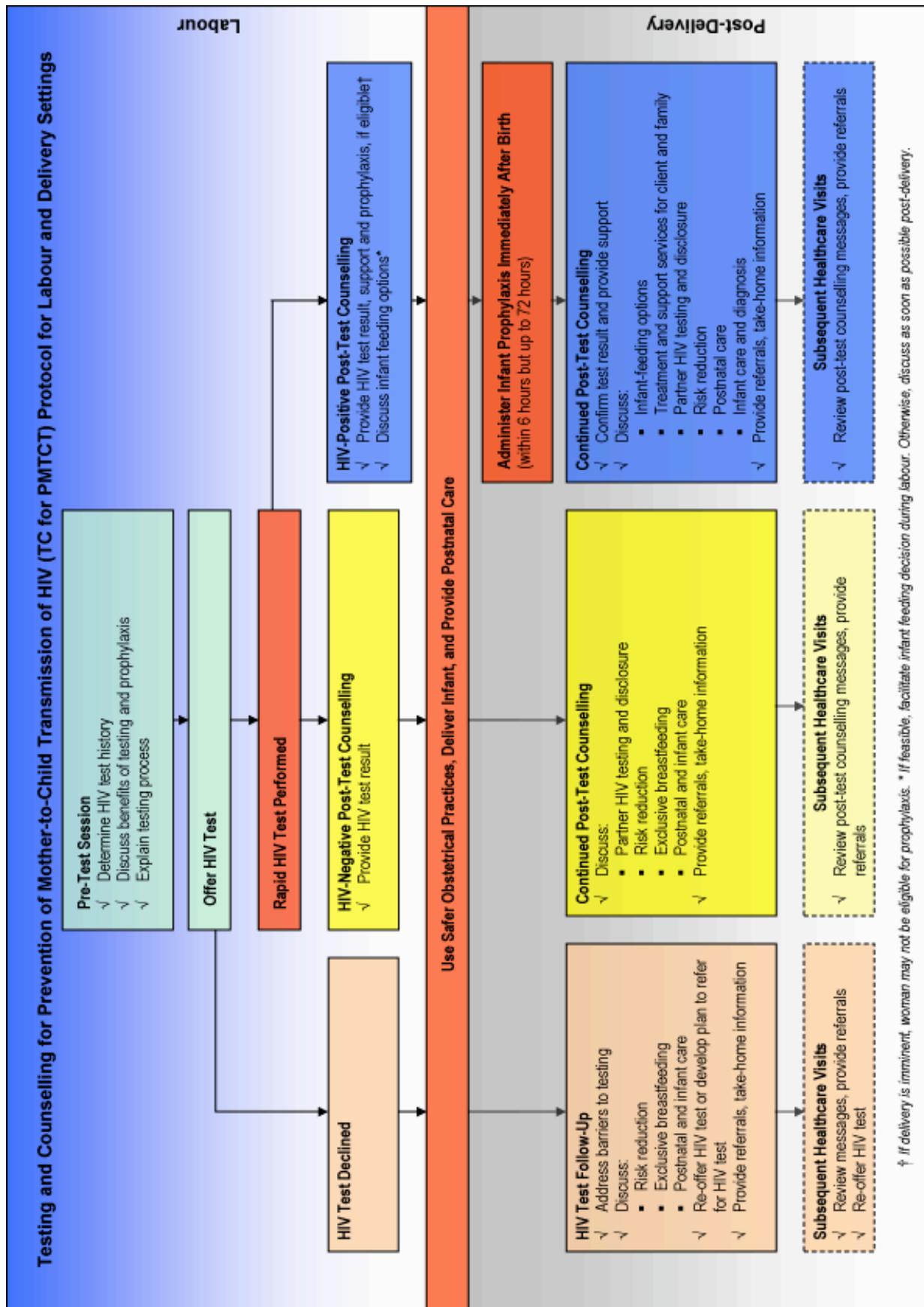
Appendix 1: *TC for PMTCT Support Tools*

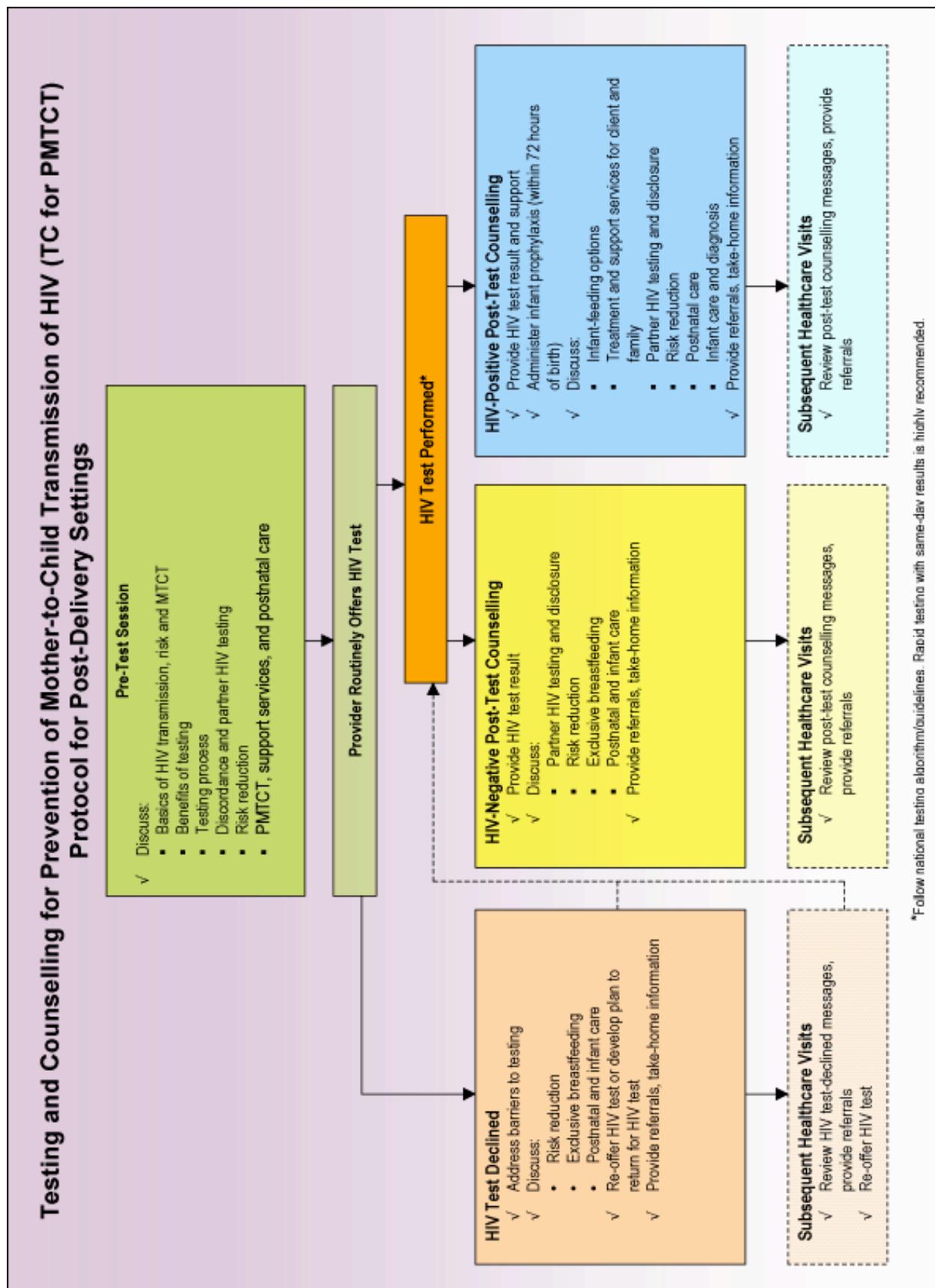
This Appendix includes the following *TC for PMTCT Support Tools*:

- **Protocol wall charts** for antenatal (ANC), labour and delivery (L&D) and post-delivery (PD) settings.
- **Client information brochures** for antenatal, labour and delivery/post-delivery clients.









I can lower the chance that my baby will get HIV by taking my medicine correctly.

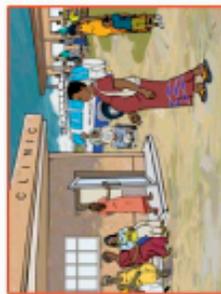


Name	When to take	How to take

I will pick up the medicine on ___/___/___ at _____.

My baby will also receive medicine to lower the chance that he/she will get HIV. (If applicable) I will pick up the medicine on ___/___/___ at _____.

There are many steps I can take to protect my health.



I will need to receive regular health care. There are medicines to prevent or treat illnesses that I can get with HIV, such as TB and malaria.

I can get care and treatment services at:
 Location: _____
 Day and time: _____

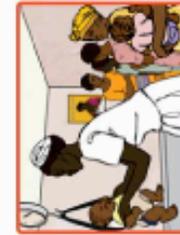
There are support services that can help me.



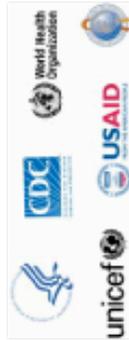
I can attend support and counselling groups at:
 Location: _____
 Day and time: _____

I can get other community services at:
 Location: _____
 Day and time: _____

I can get other community services at:
 Location: _____
 Day and time: _____



My baby will need to be tested for HIV when he/she is ___ month(s) old. Until we know if the baby has HIV, he/she will be given a medicine (cotrimoxazole) every day. This medicine will help protect the baby from illnesses he/she can get if infected with HIV.



Protect Yourself, Your Baby and Your Family from HIV/AIDS



- Facts about HIV/AIDS and pregnancy**
- Many people who have HIV, the virus that causes AIDS, do not look or feel sick.
 - One of the main ways you can get HIV is through unprotected sex (sex without a condom).
 - *All pregnant women have had unprotected sex and are at risk for HIV.*
 - You can also get HIV through blood transfusion or through sharing needles and sharp objects.

AMC Brochure

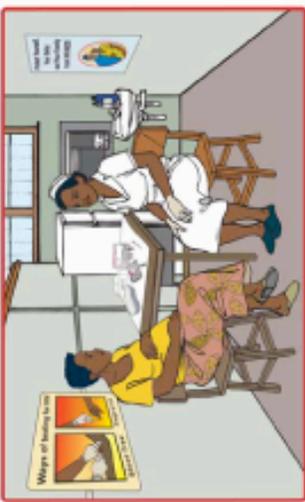
Positive Clients

HIV can be passed from a mother to her baby during pregnancy, labour and delivery, or breastfeeding.



Taking an HIV test is the only way to know if I have HIV.

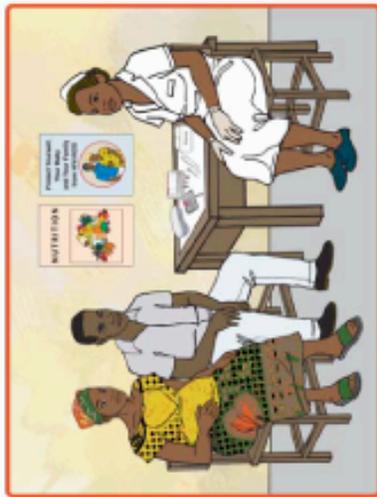
HIV testing is confidential. This means that only healthcare workers who care for you will know your HIV test result.



If I do not have HIV:
I will learn how to protect myself and my family from HIV.

If I have HIV:
I will learn how to lower the chance of passing it to my baby and get treatment and healthcare services for my family and me to live a healthy life.

My partner's test result can be different from mine, so he should get an HIV test. When couples have different test results, the HIV-negative partner is at very high risk of getting HIV. If an HIV-negative partner continues to have unprotected sex with a partner who is HIV-positive, he or she is very likely to get HIV.



My partner (and I) can go for HIV testing at:
Hospital/clinic: _____
Other location: _____
Day and time: _____

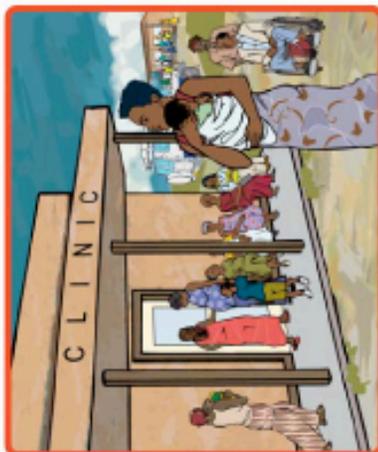
Until my partner has an HIV test: We can help protect each other from HIV by using condoms correctly every time we have sex.



To keep my baby and myself healthy, I will keep all of our antenatal, postnatal and child health appointments.

My next antenatal appointment is ____/____/____.
My due date is ____/____/____.
I will deliver my baby at _____.

I will only _____ feed my baby.
If I have any problems, I can go to _____ for help, but I will not mix feed, that is, I will not give both breastmilk and other liquids or foods.



I can get family planning services at:
Location: _____
Day and time: _____

Protect Yourself, Your Baby and Your Family from HIV/AIDS



Facts about HIV/AIDS and pregnancy

- Many people who have HIV, the virus that causes AIDS, do not look or feel sick.
- One of the main ways you can get HIV is through unprotected sex (sex without a condom).
- *All women who have been pregnant have had unprotected sex and are at risk for HIV.*
- You can also get HIV through blood transfusion or through sharing needles and sharp objects.

L&D/Post-Delivery Brochure

I can get care and treatment services at:
 Location: _____
 Day and time: _____

There are support services that can help me.
 I can attend support and counselling groups at:
 Location: _____
 Day and time: _____

I can get other community services at:
 Location: _____
 Day and time: _____

I can get other community services at:
 Location: _____
 Day and time: _____



My baby will need to be tested for HIV when he/she is _____ month(s) old. Until we know if the baby has HIV, he/she will be given a medicine (cotrimoxazole) every day. This medicine will help protect the baby from illnesses he/she can get if infected with HIV.



My baby will receive medicine to lower the chance that he/she will get HIV.



Name	When to take	How to take

(If applicable) I will pick up the medicine on _____ at _____.

There are many steps I can take to protect my health.



I will need to receive regular health care.
 There are medicines to prevent or treat illnesses that I can get with HIV, such as TB and malaria.

Positive Clients

HIV can be passed from a mother to her baby during pregnancy, labour and delivery, or breastfeeding.



Taking an HIV test is the only way to know if I have HIV.

HIV testing is confidential. This means that only healthcare workers who care for you will know your HIV test result.



All Clients

If I do not have HIV:
I will learn how to protect myself and my family from HIV.

If I have HIV:
I will learn how to lower the chance of passing it to my baby and get treatment and healthcare services for my family and me to live a healthy life.

My partner's test result can be different from mine, so he should get an HIV test.

When couples have different test results, the HIV-negative partner is at very high risk of getting HIV. If an HIV-negative partner continues to have unprotected sex with a partner who is HIV-positive, he or she is very likely to get HIV.



My partner (and I) can go for HIV testing at:

Hospital/clinic: _____

Other location: _____

Day and time: _____

Until my partner has an HIV test:

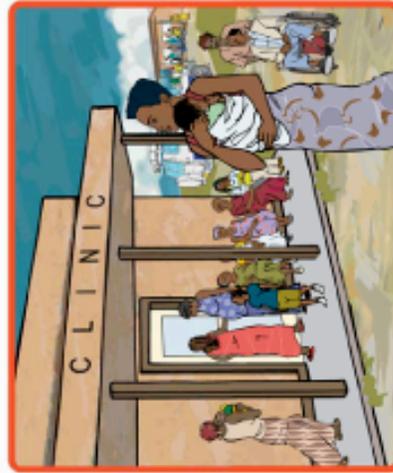
We can help protect each other from HIV by using condoms correctly every time we have sex.



I will only _____ feed my baby.

If I have any problems, I can go to _____ for help, but I will not mix feed; that is, I will not give both breastmilk and other liquids or foods to my baby.

To keep my baby and myself healthy, I will keep all of our postnatal and child health appointments.



My (next) **postnatal** appointment is on _____ / _____ / _____ at _____

My baby's first/next **immunisation** is _____ / _____ / _____ at _____

I can get **family planning services** at: _____

Location: _____

Day and time: _____

Appendix 2: Guidance for Adapting the *TC for PMTCT Support Tools*

The *TC for PMTCT Support Tools* flipcharts, protocol wall charts and client information brochures do not necessarily *require* adaptation. However, if adapted to include national guidelines, policies and protocols, and edited to reflect local culture, the *TC for PMTCT Support Tools* will be more acceptable and useful to both healthcare workers and their clients. An additional advantage of adapting nationally or locally is that it provides stakeholders with an opportunity to have input into the final product, creating support for their eventual dissemination and use. This Appendix provides guidance on adapting the flipcharts, protocol wall charts and client information brochures.

Adapting the *TC for PMTCT Support Tools*

There are two levels of adaptation for the flipcharts:

- **National level:** Editing of the scripts and objectives to reflect national policies and protocols should be done by a Technical Working Group, which would include key national stakeholders and experts from the following fields:
 - PMTCT
 - HIV testing and counselling (including experts in antibody testing and testing procedures such as algorithms)
 - Infant and young child feeding
 - Maternal-child health (ANC, L&D and PD care)
 - Health education
- **Local level:** Once the scripts have been adapted to support national policy, edit messages to ensure they will be understood locally and add the names and addresses of local referral organizations.

National Policies to Support the Adaptation

Have available national policies to support the adaptation process as follows:

- HIV testing and counselling guidelines including policies on confidentiality, consent, opt-in vs. opt-out strategy.
- HIV and AIDS epidemiology.
- Infant and young child feeding policy and recommendations, including HIV.
- Guidelines on routine antenatal package of care.
- Guidelines on ARVs for treatment and PMTCT prophylaxis; postpartum care of the mother with HIV infection.
- Guidelines on HIV care and treatment for adults, including ARV treatment and treatment of opportunistic infections such as PCP and TB.
- Guidelines on the care and treatment (including ARV treatment) of infants and children who are HIV-exposed or HIV-infected.
- Guidelines on treatment of symptoms, nutritional support, social and psychosocial support and palliative care.
- Resource list of local agencies providing clinical and social support services for mothers and families living with HIV/AIDS.

Adaptation Tips

The following tables provide guidance on adapting the flipcharts. Although these tables include the most important areas where national policy can be included and text edited to reflect local practices, countries adapting the *TC for PMTCT Support Tools* should feel free to also consider the following:

- Change the wording of the document to:
 - Ensure it can be easily understood and reflects general levels of HIV and PMTCT knowledge.
 - Reflect local terminology.
- Adapt the overall content to support national priorities for PMTCT client education.
- Add local analogies to explain complex concepts (e.g., disclosure).
- Add probing questions.

Once the adaptation is completed, consider testing the materials at a few sites in different geographic areas to ensure that they are appropriate for the target population and accepted by healthcare workers. Consider the suggestions made during the testing phase by both clients and healthcare workers when finalizing the documents.

Note that all of the Pre-Test flipcharts (for ANC, L&D and PD settings) are in the first table (Table A-1), reflecting the similarity of the adaptation process. Likewise, the Post-Test flipcharts are in Table A-2 and the Test Declined flipcharts are in Table A-3. (If there are no specific recommendations for adapting a card, it is not included in the tables below.)

The last two tables provide guidance on adapting the protocol wall charts (Table A-4) and client information brochures (Table A-5).

Table A-1 – Pre-Test Session Flipcharts, *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT)*

Number and Name of Card			National-level Suggestions for Adaptation	Local-level Suggestions for Adaptation
ANC	PD	L&D		
Card 1: HIV is in the community and it can affect anyone.	Card 1: HIV is in the community and it can affect anyone.		<ul style="list-style-type: none"> • Insert approximate number of people and/or pregnant women out of every 100 who are HIV-infected, based on national data. 	
Card 2: How can I get or pass HIV?	Card 2: How can I get or pass HIV?		<ul style="list-style-type: none"> • Include national information on screening the blood supply. For example, if all blood has been screened since 1985, note that transmission through blood transfusion is rare. • Edit sentence on transmission by “sharing sharp objects, such as razor blades or piercing equipment....” to reflect local customs such as circumcision, scarification, or injection of drugs, vitamins, or other substances. 	Amend paragraph that starts: “HIV <i>cannot</i> be passed in the following ways:” to add any other common local myths about HIV transmission.

Number and Name of Card			National-level Suggestions for Adaptation	Local-level Suggestions for Adaptation
ANC	PD	L&D		
	Card 4: Why should I test for HIV?		<ul style="list-style-type: none"> Edit: "If baby was born within the past 72 hours (and rapid testing is available)" to reflect availability of rapid testing and national policy on infant prophylaxis. 	
Card 5: How will the HIV test be done?	Card 5: How will the HIV test be done?	Card 4: How will the HIV test be done?	<ul style="list-style-type: none"> ANC Card only: Add names of the blood test(s) typically requested during the first ANC visit (e.g., syphilis, haemoglobin, CBC, hepatitis B.) L&D Card only: Modify "Unless you refuse, we will test you now" if it does not reflect national policy on informed consent and HIV testing. Edit text on method of testing to reflect only those methods used. <i>Note: the testing method for ANC, L&D and PD settings may be different; adapt these cards separately.</i> 	<ul style="list-style-type: none"> Edit text on process for being tested and receiving results to reflect local practices.
Card 7: Why should my partner test for HIV?	Card 7: Why should my partner test for HIV?			<ul style="list-style-type: none"> Include name of site where couples can go for couples testing and counselling
Card 8: How can I protect myself from HIV?	Card 8: How can I protect myself from HIV?			<ul style="list-style-type: none"> Include name and address where condoms can be obtained.
Card 9: If I have HIV, how do I protect my baby	Card 9: If I have HIV, what help can I get?		<ul style="list-style-type: none"> Include the names of the ARV drug(s) used for HIV prophylaxis. 	

Table A-2 – Post-Test Session Flipcharts, Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT)
Post-Test Negative

Number and Name of Card			National-level Suggestions for Adaptation	Local-level Suggestions for Adaptation
ANC	PD	L&D		
Card 1: What is my HIV test result?	Card 1: What is my HIV test result?	Card 5: What is my test result?	<ul style="list-style-type: none"> Edit phrase "you should consider getting another test after 6 weeks" to reflect national policy on re-testing if client could be in the window period. 	
Card 2: My partner's test result can be different from mine.	Card 2: My partner's test result can be different from mine.	Card 7: Why should my partner test for HIV?		<ul style="list-style-type: none"> Add the name and address of the venue where client can go for individual or couple counselling and testing.
Card 3: How can I protect myself	Card 3: How can I protect myself	Card 8: How can I protect myself		<ul style="list-style-type: none"> Include name and address where condoms can be obtained.

from HIV?	from HIV?	from HIV?		
Card 4: How can my family and I stay healthy?	Card 4: How can my family and I stay healthy?	Card 9: How can my family and I stay healthy?	<ul style="list-style-type: none"> • ANC Card only: Include the ANC schedule as per national protocol so that the date of the next visit can be calculated. • L&D and PD Cards only: Include the post-natal, well-baby, and immunization visit schedules as per national protocol, so that the date of the next visit for mother and baby can be calculated. 	<ul style="list-style-type: none"> • PD and L&D Cards only: Include the names and addresses of agencies that can provide the mother with infant feeding support and family planning.

Post-Test Positive

Number and Name of Card			National-level Suggestions for Adaptation	Local-level Suggestions for Adaptation
ANC	PD	L&D		
	Card 5: What is my HIV test result?		<ul style="list-style-type: none"> • PD Card only: Change “If the infant was born within the past 72 hours” to state the maximum age when an infant qualifies for ARV prophylaxis (if national policy is different from 72 hours) 	
Card 6: There are medicines that can help lower the chance that my baby will get HIV.	Card 6: There are medicines that can help lower the chance that my baby will get HIV.	Card 11: There are steps I can take to protect my baby from HIV.	<ul style="list-style-type: none"> • Edit to reflect national policy on maternal and infant prophylaxis regimens. • PD only: Edit “We will give that medicine to your baby now.” to reflect national policies on consent to ARV prophylaxis, if necessary. • L&D only: Modify the statement at the top (“If woman is within 2 hours of delivery, she may not be eligible for maternal prophylaxis.”) to correspond with national policy. 	<ul style="list-style-type: none"> • ANC Card only: Add the name, address and date when the mother should return for her own ARV prophylaxis (if applicable). • ANC Card only: Add the name, address and date when the mother should return for the infant’s dose of ARV prophylaxis if she should deliver at home.
Card 7: What can I do to have a safe birth and protect my baby from HIV?				<ul style="list-style-type: none"> • Add the name and address of the site where the mother can receive the baby’s dose of ARV prophylaxis immediately after birth should the infant be delivered at home.
Card 8-10: How can I feed my baby?	Card 7-9: How can I feed my baby?	Card 13-15: How can I feed my baby?	<ul style="list-style-type: none"> • Include available infant feeding options. • Integrate national recommendations on breastfeeding cessation for HIV-infected women. 	<ul style="list-style-type: none"> • Include the name and address of agencies where woman can meet with an infant feeding counsellor. • Include information on where to obtain infant formula as well as cost of infant formula and size of tins available. Use the table in Appendix 7 to calculate the cost to feed an infant formula for 6 months. • Where available, include information on infant feeding support and availability of free or low cost formula through the PMTCT programme.

	Card 10: How can I be sure I am replacement feeding correctly?		<ul style="list-style-type: none"> Edit questions and answers under "Please show me how you prepare the feed" to reflect national recommendations on the preparation and storage of infant formula including the cleaning of utensils. 	<ul style="list-style-type: none"> Include site where further support can be obtained.
	Card 11: What can I do to keep my baby healthy?		<ul style="list-style-type: none"> Insert the age (in weeks or months) at which HIV testing of infants is recommended as per national policy. Edit well-baby advice to reflect national policy. 	
Card 11: What steps can I take to stay healthy?	Card 12: What steps can I take to stay healthy?	Card 16: Why is it important to continue with my healthcare visits?	<ul style="list-style-type: none"> L&D only: Insert the age (in weeks or months) at which HIV testing of infants is recommended as per national policy. Adapt content on "There are many steps you can take to protect your health" to reflect national guidelines on care, treatment and support of people with HIV infection. 	<ul style="list-style-type: none"> Include the name and address of the agency where she can get family planning services after delivery.
Card 12: My partner's test result can be different from mine.	Card 13: My partner's test result can be different from mine.	Card 17: My partner's test result can be different from mine. Card 18: Why should my partner test for HIV?		<ul style="list-style-type: none"> Add the name and address of the venue that provides individual or couple counselling and testing. Add the name and address of the venue where clients can get condoms as well as information about condoms.
Card 13: What treatment, care and support services are there to help my family and me?	Card 14: What treatment, care and support services are there to help my family and me?	Card 19: What treatment, care and support services are there to help my family and me?		<ul style="list-style-type: none"> Include the name and address of the venues where she can go for additional counselling, prevention, nutrition, support groups and other support services.

Table A-3 – Test Declined Session Flipcharts, Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT)

Number and Name of Card		National-level Suggestions for Adaptation	Local-level Suggestions for Adaptation
ANC	PD and L&D		
Card 13: Review	Card 12/22: Review		<ul style="list-style-type: none"> Add name/address of venue where clients can get condoms as well as

Risk-Reduction.	Risk- Reduction.		information about condoms.
Card 14: Explain exclusive breastfeeding, review ante-natal care, and encourage testing.	Card 13/23: Explain exclusive breast-feeding, encourage continuous health-care/postnatal care and encourage testing.	<ul style="list-style-type: none"> • Include ANC, post-natal, well-baby, immunization (as applicable) visit schedules as per national protocol so that date of next visit can be calculated. 	<ul style="list-style-type: none"> • Include name/address of agency where she can get family planning. • Add name/address of venue where client can go for individual or couple counselling and testing

Table A-4 – Protocol Wall Charts, Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT)

ANC and PD Protocol Wall Charts Suggestions for National or Local Policy Adaptation	L&D Protocol Wall Chart Suggestions for National or Local Policy Adaptation
Review the following to ensure consistency with guidelines and practice:	Review the following to ensure consistency with guidelines and practice:
<ul style="list-style-type: none"> • Process for providing HIV information and counselling (large group, small group, individual or couple counselling as well as components of Pre-Test session) • Type of test performed (rapid or ELISA) • Components of HIV Test Declined, HIV-Negative and HIV-Positive Post-Test counselling sessions as well as subsequent healthcare visits 	<ul style="list-style-type: none"> • Components of Pre-Test session • Timing of Post-Test counselling session (before / after delivery or both) • Timing of infant prophylaxis administration (within 6 hours but up to 72 hours) • Components of HIV Test Declined, HIV-Negative and HIV-Positive Post-Test counselling sessions as well as subsequent healthcare visits

Table A-5 – Client Information Brochures, Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT)

Panel number	National-level Suggestions for Adaptation	Local-level Suggestions for Adaptation	Client-specific additions
Front, panel 1 "I can lower the chance that my baby will get HIV by taking ..." OR "My baby will receive medicine to lower..."	Add names of medicines for ARV prophylaxis as per national policy		Add name/address of venue where medicine can be obtained.
Front, panel 2	Add age at which infant is tested for HIV		Add name/addresses of local referrals
Front, panel 3 Brochure cover	4th bullet point: Include national information on screening of the blood supply; e.g., if all blood has been screened since 1985, then state this and note that transmission through blood transfusion is now rare.		
Back, panel 2 "My partner's test result can be different from mine..."		Add name/ address of places for HIV testing	
Back, panel 3			Add plan for infant feeding and family planning. Record next appointment.

Appendix 3: Provider-Initiated, Opt-Out HIV Testing and Counselling in PMTCT Settings

Provider-initiated, opt-out testing is strongly recommended in the context of PMTCT, especially for resource-constrained settings where client-provider ratio is low. It helps normalize the process and ensures that many more women are tested. **Provider-initiated** refers to the healthcare worker routinely initiating an offer of HIV testing in a context where the provision of, or referral to, effective prevention and treatment services is assured. Provider-initiated HIV testing and counselling moves beyond the conventional voluntary counselling and testing (VCT) model, which relies on the client to request the test (**client-initiated**). (See Table A-6, below, for a comparison of these two models of testing and counselling.) The opt-out approach is described below and illustrated with a comparison to the opt-in approach:

- **Opt-out (also referred to as “routine”):** The client is offered HIV testing as a routine part of a standard package of care. The client is informed during the Pre-Test information session that the HIV test will be performed and that she has the right to refuse or decline the routinely recommended HIV test. In other words, she may opt-out of testing, just as she has the right to refuse any other tests that are part of her care. The client must specifically refuse or decline the HIV test if she does not want it to be performed.
- **Opt-in:** After the woman receives information about HIV and testing, she is given the choice of refusing or consenting to an HIV test. The healthcare worker asks all clients in a neutral, supportive manner, if they would like an HIV test. The opt-in approach requires an active step by the woman to agree to be tested; that is, the client requests the HIV test if she wants it.

The approach used in any setting is guided by national policy. Regardless of testing approach, the basic principles of confidentiality, consent and counselling apply; testing must be voluntary. The healthcare worker should reassure each woman that declining an HIV test will not affect her access to ANC or related services. The increasing demand to scale-up access to care, treatment and prevention, including PMTCT, reinforces the importance of testing all clients as the gateway to these services.

Table A-6 – Traditional VCT vs. Provider-Initiated Testing and Counselling in PMTCT Settings

	Client-Initiated TC	Provider-Initiated TC for PMTCT
Clients	<ul style="list-style-type: none"> • Clients come to facility specifically to get HIV test. 	<ul style="list-style-type: none"> • Clients come to facility for a health-related reason (e.g., pregnancy, to deliver a baby, infant immunisation). • Clients may or may not expect to be tested for HIV. With time and community education, clients will learn that this is a regular part of MCH.
Provider	<ul style="list-style-type: none"> • Usually trained counsellors. 	<ul style="list-style-type: none"> • Usually healthcare workers trained to provide testing and counselling. In some settings, counsellors are also used.
Purpose	<ul style="list-style-type: none"> • Primary focus is to reduce HIV transmission by providing risk- 	<ul style="list-style-type: none"> • Primary focus is to reduce risk of MTCT and link client with HIV care and treatment

	reduction counselling and referrals for HIV care and treatment services.	services.
Pre-Test	<ul style="list-style-type: none"> Client-centred individual counselling 	<ul style="list-style-type: none"> HIV information session is routinely provided to groups of clients. In some facilities, group session is followed by individual counselling for clients who have additional questions or concerns. In a few settings where resources are available, individual counselling is done routinely.
Testing procedure	<ul style="list-style-type: none"> Rapid testing, although standard ELISA HIV test is still done in some settings. 	<ul style="list-style-type: none"> Rapid testing, although standard ELISA HIV test is still done in some settings.
Post-Test	<ul style="list-style-type: none"> Clients with positive results discuss coping, referrals for PMTCT, care and treatment, partner testing and risk - reduction. HIV-negative clients are provided with information on partner testing, risk-reduction. 	<ul style="list-style-type: none"> Clients with positive results are offered/provided PMTCT interventions: ARV prophylaxis or treatment, safer obstetric practices and safer infant-feeding options; partner testing and referral to other services. HIV-negative clients are provided with information on partner testing, risk-reduction and healthy behaviours during pregnancy, delivery and postpartum.
Follow-up	<ul style="list-style-type: none"> HIV-positive clients referred for PMTCT, clinical care, treatment and support services. 	<ul style="list-style-type: none"> HIV-positive clients provided with PMTCT interventions. Mothers, infants and family members referred to clinical care, treatment and support services. Follow-up to determine HIV status and provide prophylaxis and care to HIV-exposed infants.

Appendix 4: Risk-Reduction Messages

Healthcare workers should provide clients with messages to reduce their risk of HIV transmission or acquisition. Table A-7 includes messages that healthcare workers can use in individual or couple counselling sessions to guide the discussion around risk-reduction. The messages presented in this table should follow the client risk assessment (see Chapter I, page 24: “Tailoring HIV Prevention Messages to Client Need”) and be tailored to the individual client(s) and their situation.

The messages in this table focus on sexual risk, which is the most common HIV-related risk in PMTCT settings. Discussion of risk-reduction for injecting drug users or those at risk through occupational exposure is beyond the scope of this document. The risk-reduction messages presented below are based on the three most common risk-reduction strategies: abstinence, faithfulness and condoms.

Table A-7 offers a number of questions to guide the conversation. It is up to the healthcare worker to decide which questions are appropriate and which are inappropriate for that individual. As a general guidance:

- If the risk assessment suggests that “abstinence” is an appropriate prevention strategy, consider asking the questions in Steps 1 and 7.
- If the risk assessment suggests mutual monogamy (“being faithful” to one partner) is an appropriate risk-reduction strategy, consider asking the questions in Steps 2, 3 (maybe Step 6) and 7.
- If the risk assessment suggests that client is at risk of HIV infection either because she or her partner has more than one partner, she is in a discordant relationship, or her partner has declined HIV testing, then condoms may be the most appropriate risk-reduction strategy. Consider using the questions in Steps 4, 5, 6 and 7 to guide the conversation.

Table A-7 – Risk-Reduction Counselling Messages

Step	Strategy	Messages
1.	Discuss abstinence .	<ul style="list-style-type: none"> • What would happen if you said “no” to sex? • How would you tell him that you do not want to have sex? • What would your partner say if you said that you didn’t want to have sex until he is tested? • Let me tell you a bit more about nonpenetrative sex, which carries no risk of HIV or STI transmission or pregnancy.
2.	Assess partner communication.	<ul style="list-style-type: none"> • What have you and your partner talked about concerning HIV/STD risk? • When risk-reduction has come up with your partner, how did that discussion go? • Have you discussed HIV testing with your partner? • How did you and your current partner decide to stop using condoms?
3.	Discuss mutual monogamy/faithful .	<ul style="list-style-type: none"> • Tell me about your concerns about your partner’s risk. • Has your partner had sex with anyone else? • What plans for the future do you and your partner have?
4.	Assess risk-taking.	<ul style="list-style-type: none"> • Tell me a little about the last time you put yourself at risk. • How did you meet this person? • How long did you know this person? • How did you decide to have sex? • How does alcohol affect you having high-risk sex?

	<ul style="list-style-type: none"> • What makes it more likely that you'll put yourself at risk? • In what particular situation or with which type of partners do you find it difficult to negotiate or ask for safer sex? • Tell me about what may be going on in your life that could be increasing your risk behaviour.
5. Discuss risk-reduction.	<ul style="list-style-type: none"> • What is your thought about eliminating all high-risk partners (those who have other partners)? • If risk taking is related to alcohol or drug use: What do you think of avoiding places where you tend to drink too much? Have you ever tried to reduce your drinking? What help do you need to stop or reduce your drinking? • Based on what you know as the circumstances when you are vulnerable to sexual risk taking, what would you suggest to help you avoid these situations? • Alternatively, if you can't avoid these situations, how can you at least prepare for them to make these encounters safe?
6. Suggest condom use.	<p>Assess condom use</p> <ul style="list-style-type: none"> • Using condoms is an effective way to reduce the risk of HIV infection and other STDs. What do you think of condoms? When was the last time you used one? • How well do condoms work for you? • Tell me about times you have had problems using condoms. • To be certain that you are using condoms properly, would you like me to demonstrate for you, or would you like to demonstrate for me the proper use of a condom? <p>Role-play</p> <ul style="list-style-type: none"> • Imagine that I am your partner, what would you say to me about wanting to reduce your risk? • Let us switch roles. I'll be you and you will be your partner. I'll ask you to be tested and you will respond as you imagine he would. • What would you say to suggest using a condom? • What do you think your partner's reaction would be? • How do you think you'd deal with his reaction?
7. Summarize	<ul style="list-style-type: none"> • It seems like you have identified several ways in which you are comfortable in reducing your risk (list them). Can you think of any other ways?

Appendix 5: Guidance on Condoms and Condom Use

Condoms are the only form of contraception that protect against HIV and other sexually transmitted infections. A condom is a thin, flexible tube that is closed at one end. Condoms provide a barrier covering for the penis or vagina. Male and female condoms are used during sex to prevent semen, vaginal fluid and blood from passing from one partner to the other.

Condoms are only effective if used correctly and consistently *each time* during sex. It is important to know all the facts about condoms, such as which substances are safe to use for lubrication and the correct way to put on a condom. If used incorrectly, a condom may leak or break during sex and there will be no protection.

This Appendix provides information about male and female condoms. Healthcare workers should discuss these facts with all clients and encourage a woman to discuss safe sex with her partner before she engages in sex. In the clinic setting, a healthcare worker can review negotiation strategies with a client through:

- Role-play
- Discussion of obstacles to and suggestions for practising safer sex

Male Condoms

Male condoms are used during sex to prevent contact with semen. They are made of either latex rubber, polyurethane or lambskin. Latex condoms are the safest to use; they are the most durable and are readily available in most countries. Lambskin condoms contain small pores through which viruses can travel and do not provide safe protection from sexually transmitted infections. Polyurethane condoms are associated with a higher frequency of breakage and slippage. Pre-lubricated condoms are less likely to tear during handling or use. Latex condoms are best for protecting against HIV. *Never use an oil-based lubricant with a latex male condom.*

Safe lubricants:		
<ul style="list-style-type: none"> • Any water-based lubricant such as K-Y Jelly[®] or glycerine 		
Unsafe lubricants:		
<ul style="list-style-type: none"> • Baby oil • Burn ointments • Butter • Coconut butter • Coconut oil 	<ul style="list-style-type: none"> • Edible cooking oil • Fish oil • Haemorrhoid ointment • Insect repellent • Margarine 	<ul style="list-style-type: none"> • Mineral oils • Palm oil • Petroleum jelly • Rubbing alcohol • Suntan oil

Male Condom Checklist

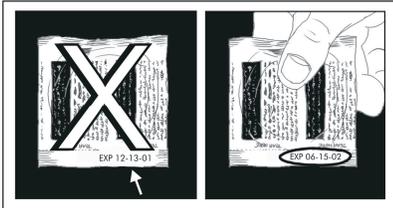
- √ Put a new condom on the penis each time you have sex and before entering the vagina, rectum or mouth. **DO NOT REUSE CONDOMS.**
- √ Put the condom on when the penis is erect.
- √ Do not pull the condom tightly against the tip of the penis but pinch the end of the condom when unrolling it—this leaves a small, empty space to hold the semen.
- √ If the condom tears during sex, withdraw the penis immediately and put on a new condom.

The following tips will help prevent condoms from breaking or leaking:

- √ Store condoms in a cool, dark, dry place (a wallet or purse/handbag is not a good place for long-term storage). Avoid exposing condoms to direct sunlight or storing them for prolonged periods at temperatures above 100°F (38°C). Also, always check the date on the package to make sure the condom is not out-of-date.
- √ If possible, choose pre-lubricated condoms that are packaged so that light does not reach them.
- √ Do not use condoms that are sticky, brittle, discoloured or damaged in any way.

How to Use Male Condoms

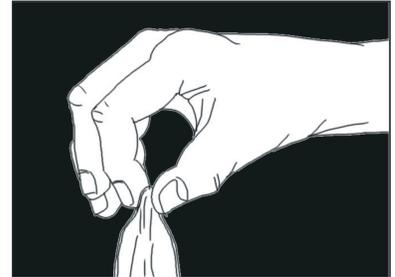
1. Check the date on the condom before you have sex.



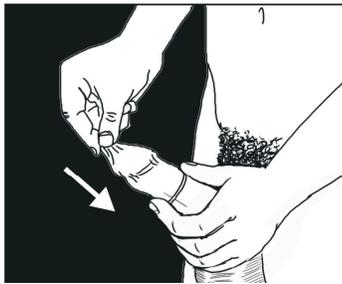
2. Open package with fingers. Never use teeth or fingernails as they could put a hole in the condom.



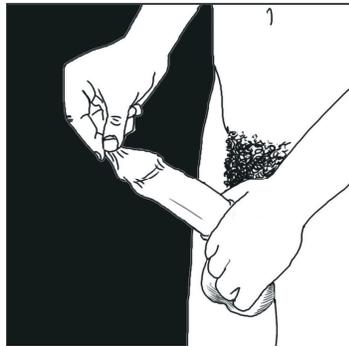
3. Find the tip of the condom with the forefinger and hold it so that the ring hangs down like a little hat.



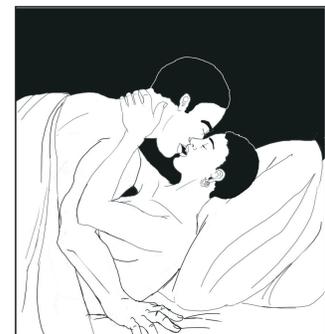
4. Hold the tip with the forefinger and thumb as you place the condom on the penis, ring on the outside.



5. Roll the condom down to the base of the penis with the other hand.



6. Check to make sure the condom is on right.



7. After sex, hold the condom at the base and pull penis away from the partner. Do not spill any liquid.



8. Slide the condom off without spilling the liquid inside.



9. Tie the condom in a knot and dispose properly.



Female Condoms

Female condoms are a polyurethane sheath that lines the entire vaginal canal. There is a flexible ring at each end of the condom; the ring at the closed end of the condom is inserted into the vagina to keep the condom in place. The female condom has no side effects and can be used by women of all ages.

The female condom is a viable contraceptive alternative for sexually active women who:

- Have a male partner or partners who will not use condoms.
- Have sex with more than one partner or have partners who have sex with more than one partner.
- Want a barrier method of contraception.
- Are allergic to latex rubber.

Healthcare workers should provide information and education to both women and their partners about how to properly use the female condom and its effectiveness and safety.

Female Condom Checklist

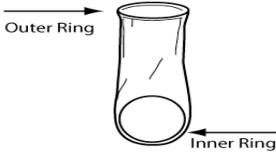
- √ Make sure the condom is completely lubricated on the inside. The condom comes with lubricant, but extra lubricant may be necessary.
- √ During sex, gently guide the penis into the vagina. Make sure that the penis is not entering to the side of the condom.
- √ If the condom is pulled out or pushed in, there is not enough lubricant. Add more to either the inside of the condom or to the outside of the penis.

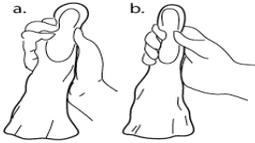
Other important points to remember:

- √ The female condom can be placed in the vagina up to 8 hours before sexual activity or immediately before intercourse.
- √ The female condom does not have to be removed immediately after intercourse.
- √ Practise inserting the condom several times prior to having sexual intercourse to feel comfortable with how it works.
- √ For protection against STIs, the female condom can be used at the same time as the IUD, hormonal methods and sterilization.
- √ The female condom can also be used as a barrier method for anal intercourse.
- √ The female condom should not be used at the same time as the male condom, because friction will cause the male condom to slip off and the female condom to be pushed in.
- √ No special storage conditions are required: the female condom is made of polyurethane, which is not affected by differences in temperature or humidity.
- √ All types of lubricant can be used with the female condom, including oil-based.

How to Use Female Condoms

Instructions on how to use the female condom





1. Open end (Outer Ring). The open end covers the area around the opening of the vagina. The inner ring is used for insertion, and to help hold the sheath in place. Rub condom to spread lubricant.
2. How to hold the sheath.
 - (a) Hold inner ring between thumb and middle finger. Put index finger on pouch between other two fingers, or
 - (b) Just squeeze.





3. How to insert condom. Squeeze the inner ring. Insert the sheath as far as it will go. It's in the right place when you can't feel it. Don't worry, it can't go too far, and it won't hurt!
4. Make sure placement is correct. Make sure the sheath is not twisted. The outer ring should be outside the vagina.



5. Removal. Remove before standing up. Squeeze and twist the outer ring. Pull out gently. Dispose with trash, not in toilet.

Source: THE FEMALE HEALTH COMPANY

Appendix 6: Window Period

Definition of “Window Period”

The “window period” is the time between the onset of infection with HIV and the appearance of antibodies to the virus detectable by an antibody test. A person in the window period will test HIV-negative, even though she is actually HIV-infected. The window period lasts for 4–6 weeks after HIV exposure.

- When explaining HIV test results to clients, try to avoid using the term “window period.” The phrase may be misleading. Instead, tell them that a recent exposure to HIV may not be detected by the antibody test (whether rapid test or ELISA).
- The likelihood of being in the window period is quite low.
- Despite common belief, it is rare for a discordant couple to in fact be concordant positive, with the partner who tested HIV-negative being in the window period. Discordance is fairly common in Africa, occurring in about 13–30% of couples, but the risk of being in the window period is very small. If the couple is discordant, it is important that they practise safer sex to protect the HIV-negative partner from being infected with HIV.
- The risk of an individual being infected during a recent exposure depends on whether the partner was HIV-infected. (If the partner was not HIV-infected, then there is no risk.) The possibility that the partner was HIV-infected depends on the prevalence of HIV in the country and how often the partner engaged in risky behaviours.
- If the partner was HIV-infected, the healthcare worker should recommend that all of the infected partner’s other sex partners are tested.
- It is important to link the risk of HIV infection to specific risk behaviours (and *not* to time-frames). Linking risk to behaviour reinforces risk-reduction messages.
- In theory, re-testing should be recommended 6 weeks from the client’s most recent exposure to an HIV-infected person or a person of unknown HIV status. For the sake of simplicity, the *TC for PMTCT Support Tools* recommend retesting 6 weeks from the Post-Test counselling session if there has been exposure within the previous 6 weeks.

Appendix 7: Infant Feeding Counselling and Support

Mother-to-Child HIV Transmission through Breastmilk

Antiretroviral (ARV) treatment and prophylaxis substantially reduces mother-to-child transmission (MTCT) of HIV. ARV prophylaxis alone, however, does not provide long-term protection for the infant who is breastfed.

Without intervention, 5–20% of infants breastfed by mothers who are HIV-positive may acquire HIV-infection through breastfeeding. Infant-feeding practices that follow national or UN guidelines can reduce the likelihood of MTCT through breastfeeding and reduce the risk of infant death from diarrhoea and other childhood infections.

WHO and Other UN Agencies' Recommendations on Infant Feeding for:

(a) Mothers who are HIV-negative and mothers with unknown HIV status

- Breastfeed exclusively for the first 6 months of life. Exclusive breastfeeding is when the mother gives her infant *only* breastmilk and no other liquids or foods, not even water. However, drops or syrups consisting of vitamins, mineral supplements or medicine may be given to the baby.
- Continue breastfeeding for up to 2 years or longer.
- After the infant reaches 6 months of age, introduce complementary foods that provide sufficient nutritional balance and are safe.
- All mothers with unknown HIV status should be encouraged to be tested for HIV.

(b) Mothers who are HIV-infected

- When replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), mothers who are HIV-infected should avoid all breastfeeding. (See Table A-8, "AFASS Definitions," below.) Replacement feeding includes commercial infant formula and home-modified animal milk.
- Otherwise, exclusive breastfeeding is recommended during the first months of life.
- To minimize the risk of HIV transmission, HIV-infected mothers who are breastfeeding should discontinue breastfeeding as soon as feasible, taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (which include malnutrition and infections other than HIV).
- To minimize HIV transmission risk, cessation of breastfeeding with safe transition (over a period of 2–3 days to 2–3 weeks) is recommended.
- The timing of early cessation of breastfeeding should depend on the mother's individual situation.
- All mothers who are HIV-infected should receive counselling, which includes general information about the risks and benefits of infant-feeding options and specific guidance on selecting the option most likely to be suitable for their situations.
- Whatever choice a mother makes, she should be supported.

It is recommended that countries establish their own guidelines taking into account these replacement feeding recommendations.

Table A-8 – AFASS Definitions

<ul style="list-style-type: none"> • Acceptable: The mother perceives no barrier to replacement feeding. Barriers may have cultural or social causes, or be due to fear of stigma or discrimination. • Feasible: The mother (or family) has adequate time, knowledge, skills and other resources to prepare the replacement food and feed the infant up to 12 times in 24 hours. • Affordable: The mother and family, with community or health-system support, if necessary, can pay the cost of purchasing/producing, preparing and using replacement feeding, including all ingredients, fuel, clean water, soap and equipment, without compromising the health and nutrition of the family. • Sustainable: The mother has access to a continuous and uninterrupted supply of all ingredients and products needed for safe replacement feeding for as long as the infant needs it, up to one year of age or longer. • Safe: Replacement foods are correctly and hygienically stored, prepared and fed in nutritionally adequate quantities with clean hands using clean utensils, preferably by cups.

Table A-9 – Commercial Infant Formula in First 6 Months

Table 4.2 Commercial infant formula requirements in first 6 months		
Month (Age of infant)	500 g Tins/Month**	450 g Tins/Month**
First month	4	5
Second month	6	6
Third month	7	8
Fourth month	7	8
Fifth month	8	8
Sixth month	8	9
Total	40	44

**As commercial infant formula tin sizes vary from place-to-place, this table will need to be revised according to tin size of locally available brands and the number of tins needed per month re-calculated. Healthcare workers should carefully review preparation instructions printed on formula tins in case messages given by manufacturers are inconsistent with the educational messages provided by clinic staff.

This table shows number of tins of infant formula required during the first 6 months of life. Use this table to assess whether or not formula feeding is affordable and sustainable.

Infant Feeding Counselling, Education and Support is:

- Based on country or local guidelines and includes an understanding of the resources accessible to the mother and her family.
- Based on the individual woman's circumstances, including her health, social and financial status as well as customs and beliefs.

Infant Feeding Counselling during Clinic Visit:

Every clinic visit is an opportunity to provide women with counselling and support. Mothers and mothers-to-be should receive comprehensive counselling, including infant-feeding counselling, over the course of several sessions according to HIV status. At least one counselling session should take place during the antenatal period and reinforced during subsequent visits.

Overview of Infant Feeding Counselling for Women with HIV

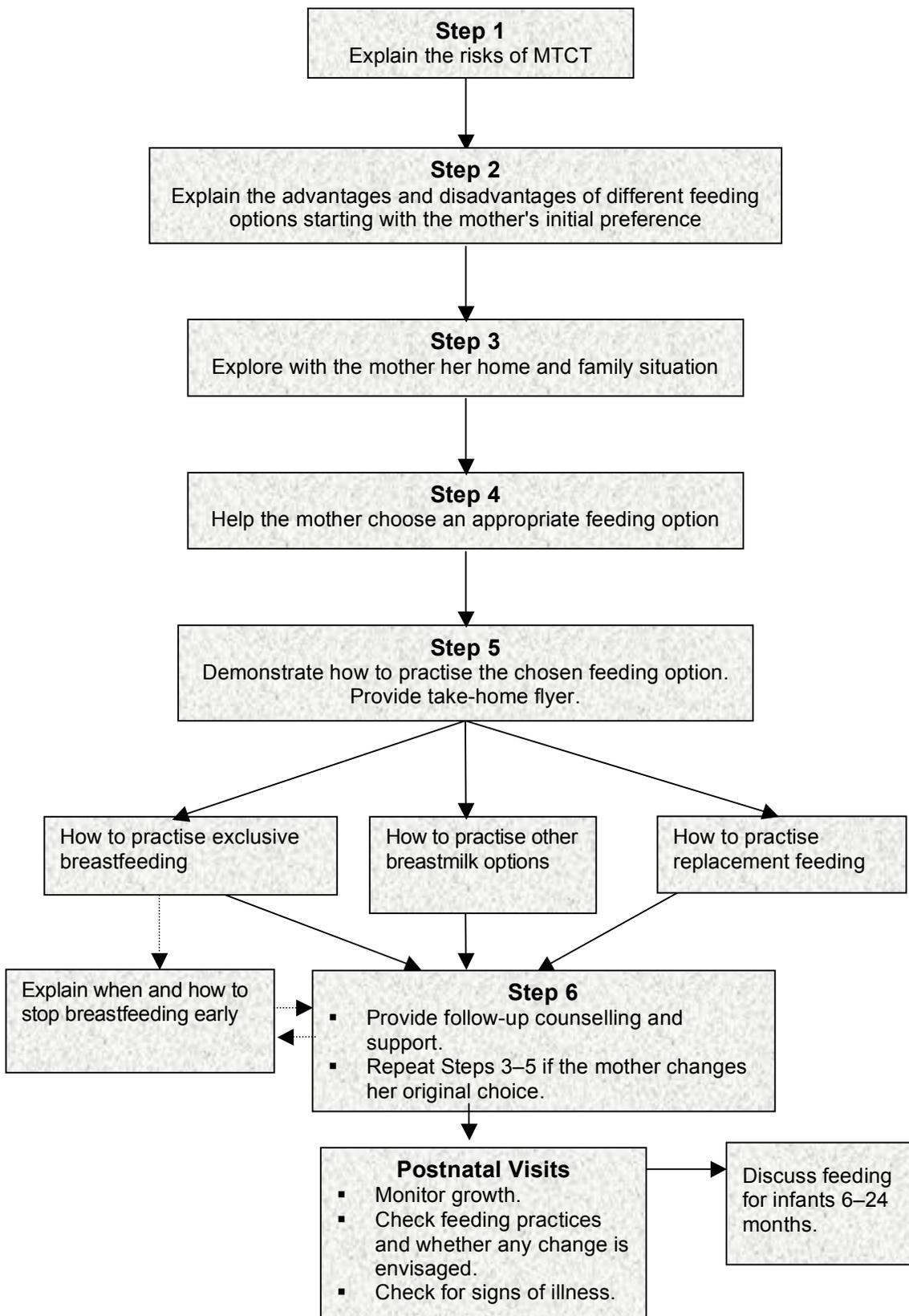
An HIV-infected woman who is attending ANC and PD services should receive infant feeding counselling that includes:

- Information about the risk of HIV transmission through breastfeeding.
- Information about the advantages and disadvantages of various infant-feeding options.
- Guidance selecting and adhering to the feeding method most suitable for her situation.

To support a woman to adhere to her chosen infant-feeding method, infant-feeding counselling also:

- Provides women with the skills needed to feed their infants safely.
- Includes demonstrations and/or opportunities for practice.
- Encourages women to seek partner or family involvement.

Table A-10 – Infant Feeding Counselling Flowchart for HIV-Positive Women



Overview of Infant Feeding Counselling Steps

The infant feeding counselling flowchart on the previous page illustrates the six steps for counselling mothers infected with HIV about infant feeding. Use the flowchart as follows:

Table A-11 – Using the "Infant Feeding Counselling Flowchart for HIV-Positive Women"

If this is the mother's first infant feeding counselling session and...
<p><i>She is pregnant:</i></p> <ul style="list-style-type: none"> • Follow Steps 1–5. • If she needs time to decide which feeding option to choose, follow Steps 1–4 and ask her to return to discuss Step 5. • If she is early in her pregnancy, counsel her but also ask her to return again closer to her delivery date to review how to implement the feeding method. <p><i>She already has a child:</i></p> <ul style="list-style-type: none"> • Follow Steps 1–4. If the mother is not breastfeeding at all, however, do not discuss the advantages and disadvantages of breastfeeding. • Continue with Steps 5 and 6.
If the mother has already been counselled and chosen a feeding method, but has not yet learned how to implement it and....
<p><i>She is pregnant:</i></p> <ul style="list-style-type: none"> • Do Step 5 only. <p><i>She already has a child:</i></p> <ul style="list-style-type: none"> • Begin with Step 5 and then continue with Step 6.
If this is a follow-up visit...
<ul style="list-style-type: none"> • Begin with Step 6. • Review how to implement the feeding method.

Assessing the Mother's Situation

Use this with all HIV-infected women who are being counselled for the first time or who are thinking of changing their feeding option.

Ask the question in the left-hand column. Her replies to these questions can help the woman choose the most suitable method for her situation, after she has learned the advantages and disadvantages of each method.

Table A-12 – Assessing the Mother’s Situation

	Breastfeeding or wet-nursing	Unclear	Replacement feeding or expressed and heat-treated breastmilk
Where do you get your drinking water?	River, stream, pond or well	Public standpipe	Piped water at home or can buy clean water
What kind of latrine/toilet do you have?	None or pit latrine	VIP latrine	Waterborne latrine or flush toilet
How much money could you afford for formula each month?*	Less than _____* available for formula each month	_____ * available for formula most months	_____ * available for formula each month
Do you have money for transportation to get formula when you run out?	No	Yes, usually	Always (unless expressing and heat-treating breastmilk)
Do you have a refrigerator with reliable power?	No, or irregular power supply	Yes, but not at home	Yes
Can you prepare each feed with boiled water and clean utensils?	No	Yes, but with effort	Yes
How would you arrange night feeds?	Preparation of milk feeds at night difficult	Preparation of milk feeds at night possible but with effort	Preparation of milk feeds at night possible
Does your family know you are HIV-positive?	No	Some family members know.	Yes
Is your family supportive of milk feeding and are they willing to help?	Family not supportive and not willing to help, or don't know — can't discuss	Family supportive but not willing to help	Family supportive and willing to help

*Add local monthly cost of formula.

If breastfeeding is the most appropriate option for the mother, reinforce her choice and provide her with support. The questions in the box below provide guidance.

Breastfeeding: Progress Check

Breastfeeding has many benefits: It provides all of the nutrients a baby needs, protects the baby from illnesses such as diarrhoea and is relatively easy to do.

- How do you think breastfeeding is going for you and your baby?
- How often do you feed your baby?
- For how long does the baby feed?
- Have you had any breast discomfort?
- (Optional) Would you be so kind to breastfeed your baby now, so that I can observe that the baby is latching on correctly?
- What, if any, problems might you be expecting with breastfeeding in the near future?

Transitioning from Exclusive Breastfeeding to Replacement Feeding

In areas where early cessation of breastfeeding is an option, assess the woman's situation to explore if this is a feasible option for her. Consider asking: "Would you consider stopping breastfeeding early to reduce the risk of passing HIV to your baby?"

- Rapidly stopping breastfeeding can be traumatic for the woman and can cause several problems for the baby, such as dehydration (i.e., not having enough liquid), refusal to eat, the loss of sucking comfort, weight loss and malnutrition. Common problems for the woman include breast engorgement, mastitis, depression, increased risk of pregnancy and stigmatization. Support from the woman's family members may make the transition easier. The following guidelines can help women to make the transition easier.

Tips for Transitioning from Exclusive Breastfeeding to Replacement Feeding

How do you think you will go about stopping breastfeeding? Here are some tips:

- While you are breastfeeding, teach your baby to drink expressed, unheated breast milk from a cup.
- Once the baby is drinking comfortably, replace one breastfeed with one cup feed using expressed breast milk.
- Increase the frequency of cup feeding every few days and reduce the frequency of breastfeeding. Ask an adult family member to help cup-feed the baby.
- Stop putting your baby to the breast completely, as soon as you and your baby are accustomed to frequent cup feeding. From this point on, it is best to heat treat your breastmilk to destroy the HIV.
- If your baby is only receiving milk, check that your baby is passing enough urine—at least 6 wet nappies/diapers in every 24-hour period. This means that the baby is getting enough milk.
- Gradually replace the expressed breastmilk with formula or home-modified animal milk.
- If your baby needs to suck, give the baby one of your clean fingers instead of the breast.
- To avoid breast engorgement (swelling) express a little milk whenever your breasts feel too full. This will help you to feel more comfortable. Use cold compresses to reduce the inflammation. Wear a firm bra to prevent breast discomfort.
- Do not begin breastfeeding again once you have stopped. If you do, you can increase the chances of passing HIV to your baby. If your breasts become engorged, express the milk by hand.
- Begin using the family planning method of your choice, if you have not already done so, as soon as you start reducing breastfeeds.
- What questions or concerns do you have? What difficulties might you have with stopping early? How can you deal with those difficulties?

Provide support to women who are replacement feeding their infants. (See box below for guidance.)

Replacement Feeding: Progress Check

- How do you think replacement feeding is going for you and your baby?
- What type or brand of replacement feed are you feeding your baby?
- Have you ever run out of replacement feeding supplies?
- Please show me how you prepare the feed. What do you use to warm the water/milk? What do you use to measure the ingredients? What do you use to feed your baby (bottle or cup)? (If she is bottle feeding: support her in switching to cup feeding.)
- How do you clean all of these supplies? (If cleaning methods seem inadequate, educate her to clean supplies thoroughly.)
- How much milk are you preparing for your baby? How much is the baby taking? How often do you feed the baby? (Troubleshoot if feeding frequency or amount is inappropriate.)
- What, if any, problems might you be expecting in the near future?
- What support do you need to continue replacement feeding?

Assess for mixed feeding if this was not broached during the Pre-Test session. If the client is breastfeeding, consider asking: "Other than breastmilk, what else do you/does anyone else feed your baby?" If the client is replacement feeding, consider asking: "Other than replacement milk, what else do you/does anyone else feed your baby?"

If woman has been mixed feeding, consider asking: "What are your thoughts about exclusive breastfeeding (or replacement feeding)? Are you able to exclusively breastfeed (or replacement feed)? What might make it difficult to exclusively breastfeed (or replacement feed) your baby?"

Additional Information on Infant Feeding

The *Testing and Counselling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools* provide the basic information needed to support infant-feeding counselling. Additional tools for healthcare workers include:

UNICEF, WHO and USAID. 2005. *HIV and Infant Feeding Counselling Tools. Counselling Cards and Reference Guide*. For further information: Department of Child and Adolescent Health and Development (CAH) World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland. Email:cah@who.int.

http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm

The *HIV and infant feeding counselling tools, Counselling Cards* can be viewed and downloaded from: http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_IF_CT/ISBN_92_4_159249_4.pdf

Appendix 8: WHO Recommendations: Antiretroviral (ARV) Regimens to Treat and Prevent MTCT

HIV-related treatment, care and support must be provided during the antenatal and postpartum periods. All HIV-exposed infants should be followed-up for diagnosis of HIV, prophylaxis of opportunistic infection and treatment, care and support.

All regimens are administered by mouth. Paediatric formulations are available for the main drugs used in current prophylactic regimens to prevent MTCT (AZT, NVP, 3TC). Effort must be made to monitor for side effects and support maternal and infant adherence.

WHEN HIV TREATMENT IS CONSIDERED OR INDICATED FOR MATERNAL HEALTH AND HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART) IS AVAILABLE ¹				
COURSE	ANTENATAL	INTRAPARTUM	POSTPARTUM	POSTPARTUM
HAART ²	Mother: HAART	Mother: Continue antenatal dosing schedule	Mother: Continue antenatal dosing schedule	Infant: AZT 4 mg/kg twice a day for 7 days ²
FULL RANGE OF ARVS FOR PMTCT AVAILABLE AND HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART) NOT YET INDICATED FOR MATERNAL TREATMENT OF HIV				
COURSE	ANTENATAL	INTRAPARTUM	POSTPARTUM	POSTPARTUM
AZT and lamivudine (3TC) and NVP³	Mother: AZT 300 mg twice a day starting at 28 weeks or as soon as possible thereafter	Mother: AZT 300 mg every 3 hours until birth <u>and</u> 3TC 150 mg every 12 hours until delivery and single-dose NVP 200 mg at onset of labour	Mother: AZT 300 mg <u>and</u> 3TC 150 mg twice a day for 7 days	Infant: NVP 2 mg/kg oral suspension immediately after birth or within 72 hours <u>and</u> AZT 4 mg/kg twice a day for 7 days ⁴
Zidovudine (AZT) and nevirapine (NVP)⁵	Mother: AZT 300 mg twice a day starting at 28 weeks or as soon as possible thereafter	Mother: AZT 300 mg at onset of labour and every 3 hours until delivery <u>and</u> single-dose NVP 200 mg at onset of labour ----- <u>OR</u> AZT 600 mg at onset of labour <u>and</u> single-dose NVP 200 mg at onset of labour	Mother: None	Infant: NVP 2mg/kg oral suspension immediately after birth or within 72 hours <u>and</u> AZT 4 mg/kg twice a day for 7 days ⁴

MINIMUM ARV AVAILABLE FOR PMTCT: NEVIRAPINE ONLY				
COURSE	ANTENATAL	INTRAPARTUM	POSTPARTUM	POSTPARTUM
Nevirapine (NVP)	Mother: None	Mother: Single-dose NVP 200 mg at onset of labour	Mother: None	Infant: NVP 2 mg/kg oral suspension immediately after birth or within 72 hours
REGIMENS FOR WOMEN KNOWN TO BE HIV-POSITIVE WHO PRESENT IN LABOUR WITHOUT PREVIOUS ARVS AND ADDITIONAL ARV MEDICATIONS ARE AVAILABLE ⁶				
COURSE	ANTENATAL	INTRAPARTUM	POSTPARTUM	POSTPARTUM
AZT and 3TC³	Mother: None	Mother: AZT 300 mg and 3TC 150 mg at onset of labour followed by AZT 300 mg every 3 hours <u>and</u> 3TC 150 mg every 12 hours until delivery	Mother: AZT 300 mg <u>and</u> 3TC 150 mg twice a day for 7 days	Infant: AZT 4 mg/kg <u>and</u> 3TC 2 mg/kg twice a day for 7 days
AZT and NVP	Mother: None	Mother: AZT 300 mg at onset of labour and every 3 hours until delivery <u>and</u> single-dose NVP 200 mg at onset of labour	Mother: None	Infant: NVP 2mg/kg oral suspension immediately after birth or within 72 hours <u>and</u> AZT 4 mg/kg twice a day for 4 weeks
		OR		
AZT and NVP for infant (when mother has received no ARV prophylaxis and presents late in labour)	None	None	None	Infant: NVP 2 mg/kg oral suspension immediately after birth or within 72 hours <u>and</u> AZT 4 mg/kg twice a day for 4 weeks

¹ The revised WHO adult antiretrovirals guidelines recommend HAART be considered for patients with clinical stage I and II with CD4 counts below 350 cells/mm³, particularly if closer to 200-250 cells/mm³. Maternal HAART is indicated for clinical stage III or IV and/or when CD4 count is less than 200 cells/mm³. Toxicity related to initiation of long-term nevirapine-containing HAART may be a concern in pregnant women with a CD4 count between 250-300/mm³. Recent data from resource-constrained settings suggest a low toxicity in this context and the issue continues to be followed carefully.

² Efavirenz (EFV)-containing HAART should only be taken in the 2nd and 3rd trimesters and adequate contraception must be made available postpartum. Avoid using EFV in women of childbearing potential unless adequate contraception is available and used. Counsel women about the importance of avoiding pregnancy while taking EFV.

³ A 7-day tail of AZT and 3TC can be given to the mother after delivery to reduce the emergence of NVP resistance and is advised if HAART is expected to be started soon after delivery.

⁴ If the mother receives less than 4 weeks of AZT or HAART during pregnancy, the infant AZT dosing should be extended to 4 weeks.

⁵ If the woman receives AZT during pregnancy for at least 4 weeks or more, omission of the intrapartum maternal NVP dose may be considered.

⁶ Mothers should be assessed postpartum about their need for therapy if indicated.

Source: Adapted from *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants in Resource-Limited Settings, Towards Universal Access, Recommendations for a Public Health Approach* (2006 Version). Retrieved (August 17, 2006) from <http://www.who.int/hiv/pub/guidelines/WHOPMTCT.pdf>

Appendix 9: Infection Prevention and Universal Precautions

Blood is the primary fluid associated with HIV transmission in the healthcare setting. HIV transmission to healthcare workers is almost always associated with needlestick injuries that occur while performing an invasive procedure (i.e., a procedure that breaks or pierces the skin, including a blood draw) on a client who is HIV-infected. Healthcare workers should consider the blood and body fluids of all clients as potentially infectious, not just those of clients being tested for HIV or suspected to be HIV-positive.

Universal precautions are a simple set of effective practices used when caring for all clients, regardless of diagnosis. These practices are designed to protect healthcare workers and clients from becoming infected with a range of pathogens (disease-causing organisms).

Universal Precautions

- Wash hands before and after direct contact with clients.
- Disinfect or sterilize all devices and equipment used during invasive procedures.
- Avoid needle recapping, especially two-handed needle recapping.
- Use lancets, needles or scalpel blades on one client only.
- Safely dispose of needles (hypodermic and suture) and sharps (scalpel blades, lancets, razors and scissors) in puncture- and leak-proof safety boxes (“sharps” containers) that can be covered and are difficult to open or break.
- Use gloves when in contact with body fluids, non-intact skin or mucous membranes.
- Use masks, eye protection and gowns (or plastic aprons) when blood or other body fluids could splash.
- When possible, avoid wearing sandals, thongs or shoes made of soft materials.
- Apply waterproof dressing to cover all cuts and abrasions.
- Promptly and carefully clean spills involving blood or other body fluids.

Universal Precautions When Collecting Blood for HIV Testing

Step 1: Wash hands for 20 seconds with clean water and soap.

Step 2: Put on latex gloves.

Step 3: Clean the area to be punctured (arm or finger) with alcohol swab or as directed by the site’s policy.

Step 4: Obtain specimen in accordance with approved procedure.

Step 5: Perform rapid test following approved procedure.

Step 6: Remove and discard latex gloves.

Step 7: Wash hands for 20 seconds with clean water and soap.

Strategies for Resource-Constrained Settings

Universal precaution measures are difficult to practise when supplies are low and protective equipment is not available. Use resources cost-effectively by prioritising the purchase and use of supplies, e.g., if gloves are in short supply, use them for childbirth, suturing and blood drawing instead of routine injections and bed-making.

Handling and Disposal of Sharps

Most injuries that transmit HIV in the workplace setting occur when sharps are recapped, cleaned or inappropriately discarded. Recommendations for using injection equipment include the following:

- Use a sterile syringe and needle to reconstitute each unit of medication and for each injection.
- If single-use syringes and needles are unavailable, use equipment designed for steam sterilisation.
- Use new, quality-controlled, disposable syringes and needles.
- Avoid recapping and other manipulations of needles by hand.
- Collect used lancets, syringes and needles at the point of use in a sharps container that is puncture- and leak-proof; seal the container when $\frac{3}{4}$ full.
- If plastic or metal containers are unavailable or too costly to use for sharps, use dense cardboard containers (cardboard safety boxes) that meet WHO specifications. If cardboard safety boxes are unavailable, use a tin with a lid, a thick plastic bottle or a heavy plastic box.
- All sharps containers should be clearly marked "SHARPS" and/or have illustrated instructions for using and disposing of the container.
- Place sharps containers away from high-traffic areas and as close as possible to where the sharps will be used.

Tips for Careful Handling of Sharps

- Always point the sharp end away from yourself and others.
- Pass scalpels and other sharps with the sharp end pointing away from others; or place the sharp on a table or other flat surface (i.e., a receiver) where it can then be picked up.
- Pick up sharps one at a time.

Hand Washing

Hand washing with plain soap and water is one of the most effective methods for preventing transmission of bloodborne pathogens and limiting the spread of infection. To reduce transmission of bloodborne pathogens and other infectious agents use:

- Soap and water hand washing, rubbing hands together vigorously under running water for at least 15 seconds.
- Alcohol-based hand rubs or antimicrobial soap and water

Hand Hygiene Recommendations	
Wash before <i>and after:</i>	<ul style="list-style-type: none"> • Putting on gloves • Examining a client • Performing any procedure involving contact with blood or body fluids • Handling contaminated items such as dressings and used instruments • Eating
Wash after:	<ul style="list-style-type: none"> • Making contact with body fluids, mucous membranes, non-intact skin or wound dressings • Handling soiled instruments and other items • Using a toilet

Tips for Effective Glove Use

- Wear gloves that are the correct size.
- Use water-soluble hand lotions and moisturizers often to prevent hands from drying, cracking and chapping. Avoid oil-based hand lotions or creams because they will damage latex rubber surgical and examination gloves.
- Do not wear rings; they may serve as a breeding ground for bacteria, yeast and other disease-causing microorganisms.
- Keep fingernails short (less than 3 mm [1/8 inch] beyond the fingertip). Long nails may provide a breeding ground for bacteria, yeast and other disease-causing microorganisms and are more likely to puncture gloves.
- Store gloves in a place where they are protected from extreme temperatures, which can damage them.

Risk-Reduction in Testing Areas

Safety Rules for Rapid Testing Areas

The following rules should be observed when performing the rapid HIV antibody test:

- Close doors when testing is in progress. Allow only persons advised of the potential hazards into testing areas. Do not permit children to enter testing areas.
- Do not pipette by mouth; do not place any other testing materials in the mouth and do not lick labels.
- Do not eat, drink, smoke, store food or apply cosmetics in the testing area.
- Keep the testing area neat, clean and free of materials that are not pertinent to the work being done.
- Decontaminate work surfaces after any spill of infectious or dangerous material and at the end of each working day.
- Do not recap needles. Do not reuse sharps such as needles and lancets. Dispose of them in a special waste container.
- Before taking a fingerprick sample, swab the client's finger with alcohol. After obtaining the sample, cover the wound with a plaster/band-aid.
- Wash hands after handling infectious materials and before leaving the testing area.
- Separate potentially contaminated waste from ordinary office waste and clearly label the container.
- Decontaminate all potentially infectious equipment or other materials before cleaning or disposal.

Risk-Reduction in the Obstetric Setting

The potential for exposure to HIV-contaminated blood and body fluids is greatest during labour and delivery. Healthcare workers should work in a manner that ensures safety and reduces the risk of occupational exposure for themselves and their colleagues.

Tips for Reducing the Risk of Occupational Exposure in the Obstetric Setting

- Cover broken skin or open wounds with watertight dressings.
- Wear suitable gloves when exposure to blood or body fluids is likely, e.g., long, cuffed gloves during manual removal of a placenta.
- Wear an impermeable plastic apron during the delivery.
- Place all sharp instruments onto a receiver, rather than passing them hand-to-hand.
- Modify surgical practice to use needle holders. Avoid using fingers for needle placement.
- Workers with dermatitis should not work in obstetrics.
- When episiotomy is necessary, use an appropriate-size needle (21-gauge, 4 cm, curved) and needle holder during the repair.
- When possible, wear an eye shield during vaginal deliveries, caesarean section and episiotomy suturing.
- If blood splashes on skin, immediately wash the area with soap and water. If it splashes in the eye, wash the eye with water only.
- Dispose of solid waste (e.g., blood-soaked dressings and placentas) safely.

Appendix 10: Healthcare for Mothers with HIV and Their HIV-Exposed Children

Healthcare for the Mother with HIV

- “Living positively” refers to taking responsibility for one’s self to maintain mental, emotional, physical and spiritual health. For people living with HIV, “positive living” refers to proactively seeking services and a lifestyle that will affirm life and preserve mental and physical health.
- Support for antiretroviral (ARV) treatment for women who are HIV-infected is becoming increasingly available. Women initially followed in PMTCT settings should be linked to treatment services for themselves and their families.
- Although ARV prophylaxis during pregnancy reduces the risk of MTCT, it does not provide any long-term benefit to the mother. When indicated, (i.e., when the woman meets clinical criteria), antiretroviral treatment to suppress viral replication and promote a better quality of life should be initiated.
- Combination ARV therapy to reduce HIV viral load as much as possible—and for as long as possible—is the standard of care for HIV treatment. A combination of three or more ARV drugs slows replication of HIV most effectively. The advantages of ARV therapy are:
 - Improved health status
 - Lower MTCT rates
 - Fewer HIV-related hospitalisations
 - Fewer deaths from AIDS
- In addition to referrals for HIV care, treatment, prevention and support, the healthcare provider can support positive living by linking people with HIV to the following services:
 - Prevention and treatment of opportunistic infections, including TB, PCP and malaria. (WHO recommends cotrimoxazole for prevention of PCP. Cotrimoxazole also may reduce the risk of other bacterial infections, including toxoplasmosis, diarrhoeal disease and malaria.)
 - Early treatment for STIs
 - Family planning to plan future pregnancies and prevent unplanned pregnancies
 - Treatment of symptoms
 - Palliative care
 - Nutritional support
 - Social and psychosocial support
 - Faith-based support
 - Home-based care

Healthcare facilities and healthcare workers should strive to establish formal connections with the range of complementary services in the continuum of care for clients with HIV.

Postpartum Care for Women with HIV

Each visit should include the following:

- Assess healing: check wound healing, monitor uterine involution, confirm cessation of postpartum bleeding.
- Assess infant feeding and provide support.
- Discuss sexual and reproductive healthcare: condom use as dual protection (against STIs, including HIV and for family planning), safer sex to prevent the spread of HIV and other STIs, advice regarding early STI treatment, including how to recognize symptoms and where to go for STI assessment and treatment.
- Provide or refer for HIV treatment, care and support:
 - Prevention and treatment of PCP (with cotrimoxazole)
 - Prophylaxis, screening and treatment for TB
 - Prevention and treatment of malaria
 - Prevention and treatment of other opportunistic infections
 - ARV treatment when indicated and available, as per national guidelines
 - Symptom management and discomfort relief
 - Palliative care
 - Nutritional support
 - Social and psychosocial support
 - Immunisations as per national or WHO guidelines for adults who are HIV-infected.
- Nutritional counselling, care and support

Healthcare for Infants and Children Exposed to HIV

PMTCT interventions reduce, but do not eliminate, the risk of HIV transmission from mother to infant. Regular follow-up care is critical for an infant born to a mother with HIV/AIDS and for the infant whose mother's HIV status is unknown. This includes infants born to an HIV-infected mother, because HIV exposure increases an infant's risk of illness and failure to thrive, whether or not the infant has HIV infection.

During antenatal visits, the healthcare worker should recommend that all women return to the clinic for post-natal care and counselling, to ensure that infants receive essential care, adequate nutrition and support for feeding. Newborns can be seen either in the healthcare facility or at home. The recommended schedule for infant visits should be in accordance with national policy or as suggested below:

- If the infant was born in a healthcare facility, a visit within 7–10 days of delivery to assess infant feeding.
- If the infant was born at home, a visit to a healthcare facility as soon as possible after birth (preferably within the first 72 hours) so that the infant can receive ARV prophylaxis and infant-feeding counselling and support.

Testing of HIV-Exposed Infants and Children

There are two types of tests: those that identify antibodies (the rapid HIV test and the ELISA) and those that detect the presence of HIV in blood (viral assay).

Antibody Testing

Where breastfeeding is common, initial antibody testing is recommended at 18 months due to the persistence of maternal antibodies that cross the placenta during pregnancy and the risk of infection during breastfeeding.

For children who are *not breastfeeding* or where breastfeeding cessation occurred at least 6 weeks previously:

- A negative HIV antibody test result for a child 18 months or older indicates that the child is not infected with HIV.
- A positive HIV antibody test at 18 months or older indicates the child is infected with HIV.

For children who *are* breastfeeding:

- If the test is negative at 18 months of age or older and the infant was breastfeeding in the last 6 weeks, the antibody test should be repeated 6 weeks after complete cessation of breastfeeding.
- A positive HIV antibody test result at 18 months indicates that the child is HIV-infected.

In countries with capacity for multiple testing and where replacement feeding or early weaning is common, testing can be done at 9–18 months.

- A negative HIV antibody test result for a child age 9–18 months indicates that the child is not infected with HIV (unless the infant was breastfeeding in the last 6 weeks, in which case the antibody test should be repeated 6 weeks after complete cessation of breastfeeding).
- A positive HIV antibody test at 9–18 months indicates either that the child is infected or may still have antibodies from the mother and the test should be repeated at 18 months.

HIV Viral Assays

Viral assays that detect HIV in the infant's blood, such as the DNA PCR or RNA PCR test, may be used to diagnose HIV infection in infants at a younger age than antibody tests. For children who are *not breastfeeding*, consider testing the infant from age 6 weeks.

- If a DNA PCR or RNA PCR test is positive, the child is HIV-infected.
- If a DNA PCR or RNA PCR test is negative, the child is not HIV-infected.

For children who *are breastfeeding*, consider testing the child from 6 weeks to 6 months.

- If a DNA PCR or RNA PCR test is positive, the child is considered HIV-infected.
- If a DNA PCR or RNA PCR test is negative, repeat viral assay 6 weeks after complete cessation of breastfeeding.
- If a DNA PCR or RNA PCR test is negative 6 weeks after complete cessation of breastfeeding, the child is not HIV-infected.
- If a DNA PCR or RNA PCR test is positive 6 weeks after complete cessation of breastfeeding, the child is HIV-infected.

- The signs and symptoms most commonly associated with HIV infection in infants are low weight and/or growth failure; pneumonia, including PCP; oral candidiasis (thrush); lymphadenopathy; parotid gland swelling; recurrent ear infections; persistent diarrhoea and TB. Healthcare workers should teach mothers and other caregivers to recognize early signs of these conditions and to seek early care for the child.
- PCP, which is short for *Pneumocystis jirovecii* (formerly *carinii*) pneumonia, is a serious infection of the lungs and the most common opportunistic infection among children with HIV

infection. It is a leading cause of death in infants with HIV. Every infant born to a mother with HIV infection should receive cotrimoxazole to prevent PCP, beginning at 6 weeks and continuing at least through 6 months of age, unless a viral assay shows the infant is not HIV-infected. PCP prophylaxis should continue in infants who are HIV-exposed until they are 1 years old or virologic testing shows the infant is not infected.

Well-Child Visit Checklist Infants and Young Children Exposed to HIV

It is recommended that subsequent visits be scheduled to coincide with a country's recommended schedule for immunisations. WHO recommends subsequent visits as follows:

- At ages 6, 10 and 14 weeks.
- Once a month from 14 weeks to 1 year.
- Every 3 months from the ages of 1 to 2 years.

Additional counselling sessions may be required during high-risk periods, such as when the:

- Child is sick.
- Mother returns to work.
- Mother decides to change feeding methods.

Any time the infant becomes ill or the mother suspects a problem, seeking early medical intervention is strongly encouraged.

During each visit:

- Assess for common illnesses and manage appropriately as directed by the Integrated Management of Childhood Illness (IMCI) guidelines.
- Identify non-specific symptoms or conditions that could be related to HIV infection using the HIV-adapted IMCI algorithms, if available.
- Provide HIV testing as indicated by national policy.
- Provide PCP prophylaxis based on WHO guidelines or national policy.
- Promote health and prevent illness.
 - Monitor growth and assess causes of growth failure, if observed.
 - Check immunization status and immunize as indicated.
 - Treat for helminth infection if the parasite load in the environment is high or as recommended by IMCI guidelines.
 - Screen and provide prophylaxis for TB; treat TB if indicated.
 - Prevent and treat malaria, as indicated, based on national policy or guidelines.
- Treat anaemia, as indicated, based on national policy or guidelines.
- Counsel caregivers on infant feeding, nutrition, ARV treatment when indicated and other care as appropriate.
- Ensure that the mother has access to family planning and support for maintaining her health.

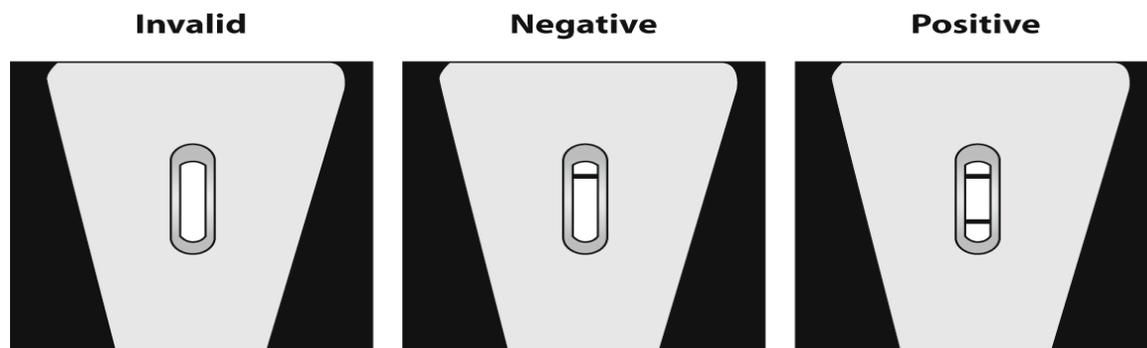
Because the health of mother and child are so closely related, assessment of maternal health and nutrition should be concurrent with assessment of the infant and appropriate referrals for maternal care should be made during infant checkups.

Appendix 11: Reading Results for the Three Rapid HIV Test Methods

There are many rapid HIV tests on the market and most of them use three main techniques or methods.

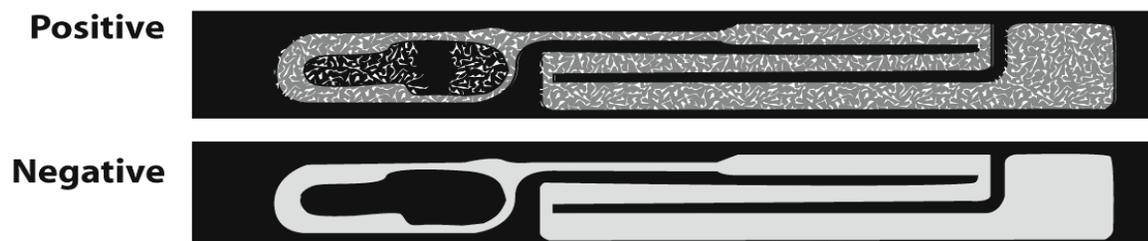
Method 1 (lateral flow): When Reading a Rapid HIV Test Result for Determine[®], Hema-Strip[®], Unigold[®] or OraQuick[®]:

- Check to see if the test is working properly. (This is also called determining if the test is valid.)
 - If there is a line in the **control area**, the test is working.
 - If there is no line in the **control area**, the test has failed (even if there is a line in the client area, the test is not working). Do not report this result. Repeat the test with a new test kit.
- If the test is **negative**, **1 line** will appear in the **control area** and **no line** in the **client area**.
- If the test is **positive**, **2 lines** of any intensity appear in the **control and client areas**.



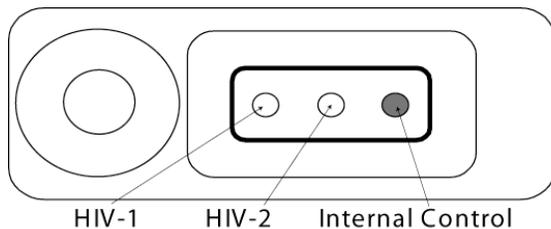
Method 2 (agglutination): When reading a Rapid HIV Test Result for Capillus[®] or Serodia[®]:

- If the **test** is **positive**, there will be **white clumping**.
- If the **test** is **negative**, there will be **no white clumping**.



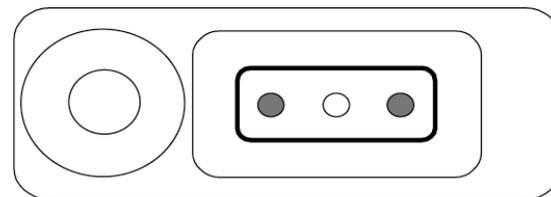
Method 3 (immunoconcentration): When Reading a Rapid HIV Test Result for Multi-Spot[®] and Genie II[®]

- Check to see if the test is working properly. (This is also called determining if the test is valid.)
 - If the **internal control spot** is darkened, the test is working.
 - If the **internal control spot** does not appear, the test has failed or is “invalid.” Do not report this result. Repeat the test with a new test kit.
- If the **test is negative**, only the internal control spot will appear
- If the **test is positive**, the control spot as well as the HIV-1, HIV-2, or both HIV-1 and HIV-2 spots will darken.

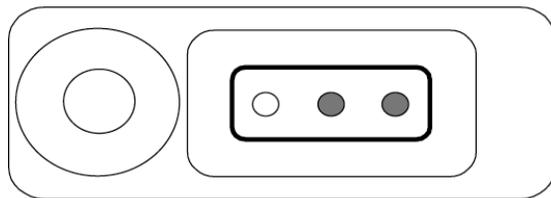


HIV-1 HIV-2 Internal Control

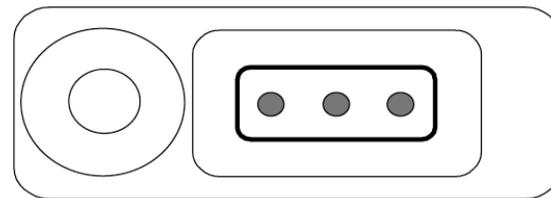
Negative



Positive, HIV-1



Positive, HIV-2



Positive, HIV-1 and HIV-2

Appendix 12: TC for PMTCT Trainer Guidance

Training on the use of the *TC for PMTCT Support Tools* should be integrated into all in-service PMTCT-related HIV testing and counselling training courses.

The following guidance is designed to support trainers responsible for training healthcare workers who will be implementing *TC for PMTCT* at a facility-level. It is assumed that participants attending this course have already attended a core PMTCT or are otherwise skilled in PMTCT.

The goal of this training is to increase PMTCT healthcare worker skill in implementing TC for PMTCT and using the *TC for PMTCT Support Tools*. The training focuses on the

content in the Introduction, Chapters I, II, III and IV of this *Reference Guide*.

This training is not meant to teach all of the skills needed to provide TC for PMTCT services. As noted in this *Reference Guide*, this training is meant to complement the training provided in other areas such as rapid HIV testing.



Advance Preparation

The trainer should be familiar with *TC for PMTCT Support Tools* including the *Reference Guide* and able to refer trainees to the relevant resources where there are questions.

- **Exercises 1, 2 and 3:** Review the cases and modify scenarios and names to ensure that they are typical of clients in your area. If possible, meet with local PMTCT healthcare workers to find out more about the typical client as well as the difficult client.
- **Exercise 1:** Either the trainer or someone identified by the trainer should be prepared to model the group Pre-Test session.
- **Large group discussion in Session 5:** Familiarize yourself with the implementation issues faced by local PMTCT programmes. If possible, obtain a copy of reports summarizing progress around key indicators such as percentage of women tested for HIV in ANC, and percentage of those with HIV accepting PMTCT interventions.

Materials Needed

- The flipcharts used in your area (ideally, one copy of each flipchart for each participant; if necessary, one copy for each small group will be sufficient).
- Client information brochures (one for each participant).
- Wall charts for ANC, L&D and PD settings (one set per participant).
- Flipchart or whiteboard and markers or blackboard and chalk.
- Pencil or pen for each participant.



Total Time 4 hours 30 minutes to 5 hours 45 minutes (depending on the exercises used)

Note to Trainer: Start the training as you usually would, i.e., with introductions, discussion of ground rules and overview of the day.

1. Background (30 minutes)

The objective of this session is to:

- Introduce the *TC for PMTCT Support Tools*

“Background” information is covered in more depth in the Introduction to this Reference Guide.

This part of the training could include:

- Background on the *TC for PMTCT Support Tools* (see pages 1-3 in this *Reference Guide*).
 - Goals of the *TC for PMTCT Support Tools*
 - Objectives
 - Listing of the *TC for PMTCT Support Tools* available locally.
- Introduction to TC for PMTCT:
 - Provides an entry point to other services.
 - Provides an opportunity for women to know their HIV status and for those with HIV to be referred for PMTCT interventions.
 - Provides an entry point to comprehensive prevention, care treatment and support.
- Key Elements of TC for PMTCT, which provide trainees with background information on the overall approach and premises upon which the *TC for PMTCT Support Tools* are based. The following elements are generic and based on global policies; they should be edited to reflect national policy.
 - Provider-initiated, opt-out HIV testing and counselling during ANC, L&D, or post-delivery.
 - Essential PMTCT messages on first contact between client and healthcare worker.
 - Group PMTCT Pre-Test information session during ANC, with a follow-up option for individual Pre-Test counselling where feasible and available.
 - Rapid HIV testing with same-day results.

2. Group Pre-Test Session (120 minutes)

The objectives of this session are to:

- Provide a brief overview of the Pre-Test counselling session.
- Provide participants with an opportunity to observe and facilitate the group Pre-Test session using the *TC for PMTCT Support Tools*.

The “Pre-Test Session” information is covered in more depth in Chapter I and “Test Declined” in Chapter II of this *Reference Guide*. The scripts from all the flipcharts are in Chapter III.

Provide participants with copies of the Wall Charts for ANC, L&D and PD settings as an overview to the Pre- and Post-Test process. Refer to the Wall Charts as you progress through the Pre- and then the Post-Test sessions.

Present the following (see Section 2 in Chapter I of this *Reference Guide*):

- Purpose of the Pre-Test session
- Objectives of the Pre-Test session
- Models of delivery for the Pre-Test session (group information session, individual counselling and couple counselling). The trainer should review the skills needed for the models of counselling used in participants’ settings. See Chapter IV.
- Length of the Pre-Test session

As an introduction to the essential skills to provide Pre-Test information to a group of clients, refer to Chapter IV of this *Reference Guide*. Provide participants with background on basic presentation skills including the following:

- Preparation
- Movement
- Speaking
- Content

Summarize some of the key facilitation skills, including:

- Use of open-ended questions
- Setting ground rules
- Techniques for active listening
- Techniques for managing talkative clients
- Techniques to increase participation
- Techniques for managing difficult clients

Use Exercise 1 as an introduction to using the TC for PMCT flipchart in front of a group. This exercise should be adapted if protocol requires individual or couple counselling rather than the group Pre-Test session. See Chapter IV for information on providing individual or couple counselling.

Table A-13 – Pre-Test Session Information

Exercise 1: The Group Pre-Test Session, Role-Play	
Purpose	To provide participants an opportunity to use the flipcharts while providing Pre-Test information to a group
Duration	Approximately 100 minutes (total) as follows: <ul style="list-style-type: none"> • 15 minutes to model the group presentation • 15 minutes feedback • 10 minutes for instruction and break into two small groups • 30 minutes to practise • 10 minutes for small group debrief • 20 minutes for the large group feedback and closeout)
Introduction	In many areas, the biggest barrier to using a flipchart for a group session is the lack of comfort with group presentations. The objective of this exercise is to provide trainees with a chance to speak before a group of peers and practise using the flipcharts.
Activities Part 1	<ul style="list-style-type: none"> • The trainer or someone experienced in providing the group Pre-Test session should model Pre-Test counselling using the appropriate flipchart. All participants should take roles as client participants in a busy ANC setting. To make the exercise more interesting, the trainer may distribute the client roles that follow this exercise (allow the presenter to review the roles beforehand so that he or she can be prepared to respond appropriately). • Once the presentation is complete, debrief as described below.
Activities Part 2	<ul style="list-style-type: none"> • Divide participants into 2 groups. • Ensure each group has at least one copy of the ANC Pre-Test session flipchart (large, if available). • Ask the groups to agree on one person to start as “presenter”; the other members of the group will role-play “clients.” • Inform the presenters that they are the ANC healthcare worker assigned to the group Pre-Test information sessions today. Twenty women are sitting in the ANC waiting room and you need to present the Pre-Test session to them immediately. • (Optional) Assign roles to the clients (see below); advise them to interpret their role in a way that duplicates an ANC clinic as closely as possible. They should not be inappropriately disruptive. • Ask the presenters to position themselves with the flipchart in front of their clients. • The first presenter should present about half of the flipchart cards (approximately 6 cards) pretending that he or she is in front of a large ANC waiting area. • Clients should be polite and listen but should feel free to become their role as appropriate to give the “presenter” practice dealing with a range of participants.
Debriefing	<p>At the end of each Pre-Test session and within small groups, debrief as follows:</p> <ul style="list-style-type: none"> • Ask the presenter to state how the session went, what went well and what will he or she change the next time? <p>Participants should, in turn, provide each of the presenters with feedback on:</p> <ul style="list-style-type: none"> • What were each presenter’s strengths?

Exercise 1: The Group Pre-Test Session, Role-Play	
	<ul style="list-style-type: none"> • Did the presenter's movements and speech help the presentation? • Did the presenter involve the clients in discussion and answer questions clearly? • Did the presenter explain the content clearly? • Did the presenter include all of the important content? • Did the presenter handle difficult participants appropriately? <p>When 2 or 3 other participants have had a chance to be presenters, reconvene into the large group. Invite participants to discuss:</p> <ul style="list-style-type: none"> • How did the exercise go? How did it feel to be a presenter? • How did it feel for the clients? • How was the role-play different from group presentations in the real world? • How did the flipchart work out? What were the strengths of the flipcharts? What skills do presenters need to develop to make the best use of the flipcharts? • What were the primary learning points you took from this exercise? <p>The trainer should record important points on the flipchart/board.</p>

Client Roles (optional)

Roles, distribute to participants	Notes for trainer, Do NOT distribute to participants
<p>Client 1: Rosa is 32 weeks pregnant. She is anxious to learn about HIV, she doesn't think she is infected but is interested to learn more. Her main barrier to listening as closely as she would like is her very active 18-month-old toddler who keeps running to play on the clinic stairs.</p>	<p>Participant responses could include:</p> <ul style="list-style-type: none"> • Have toys available in your desk to keep children busy: paper and crayons/pencils, cups or other small toy. • If there is another client or member of staff who is trustworthy and willing to babysit, take advantage of this offer.
<p>Client 2: Precious is 36 weeks pregnant and only vaguely familiar with HIV. This is her first pregnancy and she wants to learn more about HIV; she has so many questions but is afraid to speak in public.</p>	<p>Participant responses could include:</p> <ul style="list-style-type: none"> • Once Precious seems comfortable in the group, gently encourage her to participate: ask her and other clients questions (use the probing questions on the flipchart or your own open-ended questions) to encourage discussion and find out what Precious knows. • Give Precious time to answer questions; don't be afraid of silence between your question and her response.
<p>Client 3: Lucky is 30 weeks pregnant. She is very excited to finally learn more about HIV and has a lot of questions that she is not afraid to ask.</p>	<p>Participant responses could include:</p> <ul style="list-style-type: none"> • Allow Lucky to lead the session with her questions. When Lucky has finished asking her questions, the healthcare worker should fill in any information that was missed using the flipchart as her checklist. • If Lucky's questions are disruptive offer to discuss her issues privately after the group session.
<p>Client 4: Pakirani is 39 weeks pregnant and uncomfortable. Her lack of comfort is showing itself in her impatience with the material that is being presented about HIV. She thinks it is all a waste of</p>	<p>Participant responses could include:</p> <ul style="list-style-type: none"> • Healthcare worker should acknowledge that Pakirani is uncomfortable and promise to make the session as quick as possible. If possible,

<p>time; she knows that she can't have HIV as she has always been a religious woman and thinks that people with HIV probably deserve it.</p>	<p>offer her a comfortable chair or the option of standing so she is as comfortable as possible.</p> <ul style="list-style-type: none"> • Recognize that Pakirani thinks this is a waste of time, but remind her that the information is important. • Let her know that nobody with HIV deserves to have been infected; and that everyone who has had sex without a condom is actually at risk; even she could be at risk depending on her husband's sexual history.
<p>Client 5: Maya is 32 weeks pregnant and has had several partners over the past year, one of whom she heard recently is not feeling very well. So Maya has a lot of questions, all of which focus on her own risk (What are the symptoms of AIDS? How would I know if my partner had AIDS? What are the chances that I would have gotten HIV if we only had sex twice?).</p>	<p>Participant responses could include:</p> <ul style="list-style-type: none"> • Go through the flipchart with the group. Give all clients including Maya time to ask their questions; try to answer each in turn. If you can't answer her questions, refer her to someone who can. • Offer Maya one-to-one counselling.

3. Pre-Test Session in L&D (Optional, 75 minutes)¹¹

The objectives of this session are to:

- Provide a brief overview of the Pre-Test session in the L&D setting.
- Provide participants with an opportunity to practise the L&D Pre-Test session using the *TC for PMTCT Support Tools*.

Introduce the special issues for L&D settings, which can be found in Chapter I, Section 2 (pages 19-20). Discussion should include the following topics:

- Timing
- Most common scenarios
- Obtaining consent
- Conducting the L&D Pre-Test session

Exercise 2 will provide participants an opportunity to practise these skills.

Exercise 2: The Pre-Test Session in L&D, Role-Play	
Purpose	To prepare participants to conduct the Pre-Test session in the L&D setting using the <i>TC for PMTCT</i> flipchart
Duration	Approximately 60 minutes (total) as follows: <ul style="list-style-type: none"> • 10 minutes for instruction and break into two small groups • 15 minutes to practise • 15 minutes for small group debrief • 20 minutes for the large group feedback and closeout)

¹¹ This training is intended for PMTCT staff working in areas where HIV testing in L&D settings is supported by national policy.

Exercise 2: The Pre-Test Session in L&D, Role-Play (cont.)	
Introduction	The Pre-Test session in the L&D setting takes place in an environment in which the woman is typically uncomfortable, she may not be expecting to be tested for HIV and confidentiality may be challenging. This exercise gives participants a chance to use the flipcharts, discuss various scenarios and share experiences.
Activities	<ul style="list-style-type: none"> • Divide participants into groups of 3–4 participants each. • Ensure each group has at least one copy of the L&D Pre- and Post-Test Session Flipchart. • Give each group one case study (the case studies appear below). • Ask the groups to assign participants to the following roles: <ul style="list-style-type: none"> ○ Healthcare worker/counsellor ○ Client ○ Observer to assist client; this observer will be responsible for timing the contractions and reminding the group that the client is going through contractions ○ Any remaining small group members may assist the healthcare worker. • Using the flipchart, the healthcare worker should proceed with the L&D Pre-Test session. The client should respond as she thinks her client would in this situation. Where appropriate and time-permitting, consider broaching the infant feeding counselling and/or Test Declined messages. • In small groups, participants should discuss: <ul style="list-style-type: none"> ○ How did the session go? ○ What would you do if this client refused testing? ○ Were you able to discuss infant feeding? ○ How did the flipchart work out? What were the strengths of the flipcharts? What skills do healthcare workers need to develop to make the best use of the flipcharts? ○ Was the conversation confidential? How could it have been made more confidential? Did the flipchart affect privacy? • Give the groups about 10–15 minutes to discuss their cases and then ask the groups to re-convene.
Debriefing	<p>In the large group, invite participants to discuss:</p> <ul style="list-style-type: none"> • How did the exercise go? • What were the primary learning points you took from this exercise? <p>The trainer should record important points on the flipchart/board.</p>

Client Roles

Roles, distribute to participants	Notes for trainer, Do NOT distribute to participants
Client 1: Daisy just arrived in the L&D department, 6 cm dilated. She was never tested for HIV because she comes from a village where there is no ANC clinic. Her contractions are about 5 minutes apart and lasting about 30 seconds each. As this is her first baby, she is anxious. She is accompanied by her husband who seems	<p>Participant responses could include:</p> <ul style="list-style-type: none"> • Ask husband if he can wait outside of the delivery room while the initial exam is conducted. • Broach the issue of HIV as soon as the exam is completed and ask if she would like her husband to be present. • If Daisy gives consent for her husband to take part in the Pre-Test counselling, invite the husband in and

unwilling to leave her side.	then provide couple Pre-Test counselling. If she does not consent, then provide one-to-one counselling—upon completion of the session, invite husband back into the labour room. <ul style="list-style-type: none"> • Use the L&D flipchart to guide the session.
Client 2: Beatrice never attended ANC because she could afford neither the time nor the modest fee for pregnancy care. She has arrived at L&D 8 cm dilated. She is accompanied by her mother. As this is her 3 rd pregnancy, the labour is progressing quickly with contractions 4 minutes apart but 90 seconds long. The contractions are extremely painful now. As the midwife, you estimate that she is probably 30–45 minutes from delivery, at most.	Participant responses could include: <ul style="list-style-type: none"> • As appropriate, suggest to Beatrice’s mother that she should leave for the physical exam. While the mother is still outside of the labour room, provide the Pre-Test information and take blood. • If possible, draw blood before birth, even if it may not be possible to get the results back before delivery. • If Beatrice is in too much pain for even the very short Pre-Test session or declines to be tested, re-offer testing after delivery. • Use L&D tools or PD flipcharts depending on the timing of the Pre- and Post-Test sessions.
Client 3: Shanti is a primigravida who had arrived at L&D 3 cm dilated. She refused HIV testing at ANC because she didn’t want to risk getting bad news while pregnant. She has been accompanied by her partner and mother-in-law.	Participant responses could include: <ul style="list-style-type: none"> • See Client 1 but ask both the mother-in-law and husband to leave the room for the physical exam. Either the mother-in-law and/or husband can be invited back into the room for the Pre-Test session as per Shanti’s request. • Counselling can focus on her fear of “bad news” whilst pregnant: remind her that most people test HIV-negative; but even if HIV-positive, this brings with it the good news that PMTCT interventions can be initiated to reduce the likelihood that HIV will be passed to the child.

4. Post-Test Session (75 minutes)

The objectives of this session are to:

- Provide a brief overview of the Post-Test counselling session.
- Provide participants with an opportunity to practise giving HIV test results using the *TC for PMTCT Support Tools*.

The “Post-Test Session” information is covered in more depth in Chapter I of this *Reference Guide*.

1. Provide a summary of the following (refer to Section 3 of Chapter I in this *Reference Guide* for additional information):
 - Purpose of Post-Test session
 - Objectives of Post-Test session
 - Models of delivery for Pre-Test session (individual counselling and couple counselling)
 - Length of Post-Test session

Exercise 3 is an opportunity to practise using the TC for PMCT flipcharts as a tool in the Post-Test session.

Exercise 3: The Post-Test Session, Role-Play	
Purpose	To prepare participants to conduct the Post-Test session using the <i>TC for PMTCT</i> flipchart
Duration	60 minutes
Introduction	This exercise will provide participants with an opportunity to use the flipcharts to guide the post-test session and (if available) give the client information brochures to reinforce take-home messages.
Activities	<ul style="list-style-type: none"> • Divide participants into groups of 4-6 participants each. • Ensure each group has at least one copy of either of the following flipcharts: ANC Post-Test counselling, PD Post-Test counselling or L&D Pre- and Post-Test session. • Ensure groups have copies of the client information brochures. • Give each group one case study (the case studies appear below). • Ask the groups to assign participants to the following roles: <ul style="list-style-type: none"> ○ Healthcare worker and/or counsellor ○ Client ○ Observers • Using the flipchart, the healthcare worker should proceed with the Post-Test session. The client should respond as appropriate for the situation. • The groups should conduct the Post-Test negative session first. Then a new healthcare worker and new client should role-play the Post-Test positive session. • If either the healthcare worker or client is unsure of what to say, the observers should feel free to assist. • Encourage the healthcare worker to use the client information brochure to reinforce important points. • After each session and while still in small groups, participants should discuss: <ul style="list-style-type: none"> ○ How did the session go? ○ How did the flipchart work out? What were the strengths of the flipcharts? What skills do “healthcare workers” need to develop to make the best use of the flipcharts? ○ Were the client information brochures helpful to reinforce important points? How could healthcare workers make best use of the brochures? • Give the groups about 10–15 minutes to discuss their cases and then ask the groups to re-convene.
Debriefing	<p>In the large group, invite participants to discuss:</p> <ul style="list-style-type: none"> • What were the primary learning points you took from this exercise? • The case studies were from all PMTCT settings, ANC, L&D and PD. Was there a difference in the implementation of the <i>TC for PMTCT Support Tools</i> in these settings? How about the acceptability? <p>The trainer should record important points on the flipchart/board.</p>

Client Roles, HIV-Negative

Client 1: Rosa is 32 weeks pregnant and tested in the ANC clinic. She is accompanied by her oldest child, an active 18-month-old toddler. She tests HIV-negative.

Client 2: Precious refused testing during ANC. She arrived at the post-delivery ward with her infant who is 2 days old. She tests HIV-negative.

Client 3: Lucky refused testing during ANC, but did test for HIV while in labour. She was told that she

was HIV-negative just before the delivery but now needs the follow-up counselling.

Client Roles, HIV-Positive

Client 4: Pakirani is 39 weeks pregnant and physically uncomfortable. She was very impatient during the ANC group Pre-Test session and was certain that she was not infected as she is a religious woman. She tested HIV-positive.

Client 5: Maya, refused testing during ANC. She accepted HIV testing yesterday during labour, at which time she tested HIV-positive. She was provided with her results and given ARV prophylaxis but now it is time to provide her with the full Post-Test counselling session. This is her 2nd child.

Client 6: Nikhita lives in a remote village; she never accessed ANC and delivered her baby at home. Now she is attending the child health clinic where she is requesting routine immunisations for her 6 week old infant. She also brought her two older children (ages 3 and 5). She listened to the group Pre-Test session, but now needs to be told that her HIV test is positive. She is breastfeeding the baby.

5. Implementation Issues and Summary (40 minutes)

The objectives of this session are to:

- Discuss implementation issues focusing on ways to address common problems affecting accessibility and acceptability.
- Summarize the session.

Explain that in the last hour of this training we will discuss issues that affect accessibility and acceptability of services and how this can affect uptake. Start the discussion by asking participants the following:

- Approximately what percentage of the clients who attend your clinic accept HIV testing?
- Of those who accept testing, how many get their results?
- Of those who test HIV-positive, how many will take ARV prophylaxis?
- Of those testing HIV-positive, how many will follow infant feeding advice?

The trainer should focus on what he or she knows are the problem areas, for example if routine testing is going well and virtually all clients are tested, then discussion should focus on uptake of PMTCT interventions. The trainer should be familiar with the evaluation data from the local PMTCT programs to focus the discussion on areas where improvement should be targeted.

As they are discussed, record the issues noted by participants on flipcharts under the following headings:

- “Client-level factors” (This could include nonattendance, home births, fear of stigma.)
- “Facility-level factors” (These factors might include, for example, staff shortage, long waits, patient flow, inadequate space, lack of supplies.)

Add any other factors that participants may not have considered. Then ask participants for ideas on how we can address each of these issues using Chapter VI of this *Reference Guide* for ideas on how to address client and facility-level factors.

Summarize the session, focusing on the important points from the exercises and group discussion (which should have been recorded on flipchart paper or the white/black board). Finally, thank all participants for attending the session and provide them with information on resources should they have questions.

For Additional Information on Training

- World Health Organization, UNAIDS, UNICEF. 2000. *HIV and Infant Feeding Counselling: A Training Course, Director's Guide*. Retrieved November 2005, from http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_Inf_Feeding/Directors_Guide.pdf
- World Health Organization, UNAIDS, UNICEF. 2000. *HIV and Infant Feeding Counselling: A Training Course, Trainer's Guide*. Retrieved November 2005, from http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_Inf_Feeding/Trainers_Guide.pdf
- WHO, CDC. February 2005. *Prevention of Mother-to-Child Transmission of HIV Infection Generic Training Package*. Retrieved November 2005, from <http://www.womenchildrenhiv.org/wchiv?page=wx-resource&rid=784-41902&topic=if&type=prtm>

References

Key General Resources

- CDC. 2004. *Couple HIV Counseling and Testing Training Manual* Draft document 29 December 2004.
- CDC. 2004. Introduction of Routine HIV Testing in Prenatal Care—Botswana, 2004. *MMWR* 2004;53(46):1083-1086. Retrieved 27, July 2005, from <http://www.cdc.gov/mmwr/PDF/wk/mm5346.pdf>
- CDC, Global AIDS Program (GAP). 2003. *Voluntary Counseling and Testing (VCT) Training Curriculum*. Retrieved May 2005, from <http://www.womenchildrenhiv.org/wchiv?page=vc-05-02>
- Farquhar C, Kiarie JN, Richardson BA, Kabura MN, John FN, Nduati R, et al. Antenatal couple counseling increases uptake of interventions to prevent HIV-1 transmission. *J Acquir Immune Defic Syndr* 2004;37:1620–1626. Retrieved May 2005, from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15577420&query_hl=1
- Ginwalla, SK, Grant AD, Day JH, Dlova TW, Macintyre S, Baggaley R, et al. 2002. Use of UNAIDS tools to evaluate HIV voluntary counselling and testing services for mineworkers in South Africa. *AIDS Care* 14(5):707–726.
- USAID/Synergy. *Women's Experiences with HIV Serodisclosure in Africa: Implications for VCT and PMTCT*. Meeting Report. Washington, DC: USAID: Mar 2004. Retrieved 15 June 2005, from <http://www.synergyaids.com/documents/VCTDisclosureReport.pdf>
- UNICEF, WHO. 2005. *HIV and Infant Feeding Counselling Tools Reference Guide*. Retrieved 21 June 2005, from http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm.s
- UNICEF, WHO, and USAID. 2005. *HIV and Infant Feeding Counselling Tools*. Counselling Cards. For further information Department of Child and Adolescent Health and Development (CAH) World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland. Email:cah@who.int.
- WHO, CDC. February 2005. *Prevention of Mother-to-Child Transmission of HIV Infection Generic Training Package*. Retrieved May 2005, from <http://www.womenchildrenhiv.org/wchiv?page=wx-resource&rid=784-41902&topic=if&type=prtm>

Introduction

- UNAIDS, WHO. 2004. UNAIDS/WHO Policy Statement of HIV Testing. Retrieved 21 June 2005, from www.unaids.org/html/pub/una-docs/hivtestingpolicy_en_pdf.pdf
- WHO. 2003. The Right to Know New Approaches to HIV Testing and Counselling. Retrieved 21 June 2005, from <http://www.emro.who.int/ASD/backgrounddocuments/egy0703/RighttoKnow.pdf>

Chapter I: Testing and Counselling in PMTCT Settings

- AIDS Med.com, "To Tell or Not To Tell: Disclosing Your HIV Status" Retrieved 5 August from <http://www.aidsmeds.com/lessons/Disclosure.htm>
- The Republic of Botswana. 2004. *The Botswana Prevention of Mother-to-Child Transmission of HIV Programme Handbook*. Pp 117–119.
- CDC. 2003. *Voluntary Counseling and Testing (VCT) Training Course*, Participant's manual. Revised March 2003; Unit 5 p. 111. Retrieved 30 June 2005, from <http://www.womenchildrenhiv.org/wchiv?page=vc-05-02>
- Rabkin M, El-Sadr W, Abrams E. 2005. *The Columbia Clinical Manual*. Retrieved May 2005, from <http://www.womenchildrenhiv.org/wchiv?page=wx-resource&rid=703-8402&type=prcl&topic=ch1>
- Solomon V, van Rooyen H, Griesel R, Gray D, et al. Critical review and analysis of voluntary counselling and testing—Literature in Africa. Durban: Health Systems Trust 2004. Retrieved 21 May 2005, from <http://www.hst.org.za>
- UNAIDS. 2001. *Counselling and voluntary HIV testing for pregnant women in high HIV prevalence countries. Elements and issues*. Geneva: Switzerland. Retrieved 21 June 2005, from <http://www.emro.who.int/asd/backgrounddocuments/egy0703/CounselingPregnantWomen.pdf>
- UNICEF, WHO, and USAID. 2005. *HIV and Infant Feeding Counselling Tools*. Reference Guide. For further information Department of Child and Adolescent Health and Development (CAH) World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland. Email:cah@who.int.
- US Office Global AIDS Coordinator, Guyana Ministry of Health, Maternal Child Health, & Family Health International. *Healthy Mothers Healthy Babies*. Retrieved 15 July 2005, from http://www.fhi.org/en/HIVAIDS/country/Guyana/res_guyanapmtct.htm
- WAVE, Women and AIDS Virtual Education, HIV library and resources website. Retrieved 5 August from http://www.pwn-wave.ca/index.cfm?group_id=1221

Chapter II: HIV Test Declined

- Bulterys M, Jamieson DJ, O'Sullivan MJ, Cohen MH, et al. Mother-Infant Rapid Intervention at Delivery (MIRIAD) Study Group. Rapid HIV-1 testing during labor: a multicenter study. *JAMA*. 2004 Jul 14;292(2):219–23. Retrieved May 2005, from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15249571&query_hl=7
- Gray R, Li X, Serwadda D, Kigozi G, et al. Pregnancy and the Risk of Incident HIV in Rakai, Uganda, a Cause for Concern. In: Program and abstracts of 12th Conference on Retroviruses and Opportunistic Infections; February 22–25, 2005; Boston, MA. Abstract 19. Retrieved May 2005, from <http://www.retroconference.org/2005/CD/Abstracts/25618.htm>
- Population Services International. 2003. Working Paper No. 53 "Misconceptions, Folk Beliefs, Denial Hinder Risk Perception among Young Zambian Men." Retrieved 27 July 2005, from <http://www.psi.org/resources/pubs/rb3.pdf>

Sahlu T, Kassa E, Agonafer T, et al. 1999. Sexual behaviours, perception of risk of HIV infection, and factors associated with attending HIV post-test counselling in Ethiopia. *AIDS*. 13(10):1263–1272. Retrieved 27 July 2005, from <http://www.aidsonline.com/pt/re/aids/pdfhandler.00002030-19990709000017.pdf;jsessionid=C11eaglY55PTVNqJZ8wqkkiJAnkr9tZzMQ2Y04DtaEtVsWaNjJJN!-1049669964!-949856032!9001!-1>

Chapter IV: Essential Skills for TC for PMTCT Programmes

FHI. 2005. *Voluntary Counseling and Testing: Skills Training Curriculum—Participant's Manual*. Retrieved May 2005, from <http://www.fhi.org/en/HIVAIDS/pub/guide/vcttrain2.htm>

Keim, J. and Lappin, J. "Structural strategic marital therapy." In Gurman, A.S. and Jacobson, N.S. (Eds.), *The Clinical Handbook of Couple Therapy*. New York: Guilford Press, 2002.

Kenya PMCT Project, Horizons Project, Population Council. 2002. *Prevention of Mother-to-Child Transmission (PMTCT) Training Curriculum*. Retrieved May 2005, from <http://www.popcouncil.org/horizons/pmcttc.html>

WHO. 2000. *Fact Sheets on HIV/AIDS for Nurses and Midwives (WHO/EIP/OSD/2000.5)*. Retrieved May 2005, from http://www3.who.int/whosis/factsheets_hiv_nurses/index.html

WHO Regional Office for South-East Asia. 2004. *Voluntary HIV Counselling and Testing, Manual for Training of Trainers: Part I and II*. Retrieved May 2005, from <http://w3.whosea.org/en/Section10/Section18/Section1562.htm>

WHO CDD Programme, UNICEF. *Breastfeeding Counseling A Training Course, Trainer's Guide*, (WHO/CDR/93.4; UNICEF/NUT/93.2). Retrieved May 2005, from http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/Breastfeeding/Trainers_Guide_Part4.pdf

WHO Regional Office for South-East Asia. 2004. *Voluntary HIV Counselling and Testing, Manual for Training of Trainers: Part I and II*. Retrieved May 2005, from <http://w3.whosea.org/en/Section10/Section18/Section1562.htm>

Chapter V: Rapid HIV Testing in PMTCT Settings

CDC. 2005. Notice to readers: protocols for confirmation of reactive rapid HIV tests. *MMWR Weekly*. March 19, 2004/53(10);221–222. Retrieved 21 June 2005, from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5310a7.htm>

CDC. 2005. Rapid HIV Testing. Retrieved 21 June 2005, from http://www.cdc.gov/hiv/rapid_testing/#training

CDC. 2004. *Rapid HIV-1 Antibody Testing During Labor and Delivery for Women of Unknown HIV Status. A Practical Guide and Model Protocol*. Retrieved 21 June 2005, from http://www.cdc.gov/hiv/rapid_testing/materials/Labor&DeliveryRapidTesting.pdf

Jamieson DJ, O'Sullivan MJ, Maupin R, Cohen M, et al. The challenges of informed consent for rapid HIV testing in labor. *J Women's Health* (Larchmt). 2003 Nov;12(9):889–95. Retrieved May 2005, from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14670168&query_hl=7

OGAC, HHS-CDC, USAID, GHARP, FXB Center. 2005. *Prevention of Mother-to-Child Transmission of HIV: HIV Counselling and Rapid Testing in Labour and Delivery Participant Guide Supplement: Module 6B*.

WHO/HHS-CDC *HIV Rapid Testing Training Package: Participant Manual and Trainer's Guide*. Current Laboratory Practice Series (available at: <http://www.phppo.cdc.gov/dls/ila/hivtraining/>).

WHO, HHS-CDC. 2005. *Guidelines for Assuring the Accuracy and Reliability of HIV Rapid Testing: Applying a Quality System Approach*. Geneva: Switzerland. (Available at: [http://www.phppo.cdc.gov/dls/ila/documents/HIVRapidTest%20Guidelines%20\(Final-Sept%202005\).pdf](http://www.phppo.cdc.gov/dls/ila/documents/HIVRapidTest%20Guidelines%20(Final-Sept%202005).pdf))

WHO. 2004. *Rapid HIV Tests: Guidelines for Use in HIV Testing and Counselling Services in Resource-Constrained Settings*. Geneva: Switzerland. Retrieved 21 June 2005, from www.who.int/entity/hiv/pub/vct/en/rapidhivtests/en.pdf

Chapter VI: Implementation Issues

CDC. 2004. Prevention of Mother to Child HIV Transmission Monitoring System (PMTCT-MS), Reference Version 1.0, November 2004.

Dadian, M, et al. December 2003. *Prevention of Mother-to-Child HIV Transmission, Assessing feasibility, acceptability, and cost of services in Kenya and Zambia*. Horizons Report. Retrieved 19 October 2005, from <http://www.popcouncil.org/pdfs/horizons/hrptdec03.pdf>

Israel E, Kroeger M. 2003. *Integrating Prevention of Mother-to-Child HIV Transmission into Existing Maternal, Child, and Reproductive Health Programs*. Pathfinder International.

Rutenberg N, Kalibala S, Baek C. 2003. *Programme Recommendations for the Prevention of Mother-To-Child Transmission of HIV: A Practical Guide for Managers*. United Nations Children's Fund.

Rutenberg N, Kalibala S, Mwai C. 2002. *Integrating HIV Prevention and Care into Maternal and Child Health Care Settings: Lessons Learned from Horizons Studies*. Population Council Inc. February 2002.

Stuart L, Harkins J, Wigley M. 2005. *Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings*. Family Health International.

Walkowiak H, Gabra M. 2002. *VCT Toolkit: Commodity Management in VCT Programs: A Planning Guide*. Family Health International.

Chapter VII: Appendices

Appendix 4: Risk reduction messages

CDC. 2003. *Voluntary Counseling and Testing (VCT) Training Course*, Participant's manual. Revised March 2003; Unit 2. Retrieved 28 October 2005, from <http://www.womenchildrenhiv.org/wchiv?page=vc-05-02>

Appendix 5: Guidance on condoms and condom use

CDC, Global AIDS Program (GAP). 2003. *Voluntary Counseling and Testing (VCT) Training Curriculum*. Retrieved May 2005, from <http://www.womenchildrenhiv.org/wchiv?page=vc-05-02>

Pan American Health Organization. 1999. *Women and HIV/AIDS: Prevention and Care Strategies*. Retrieved May 30, 2005 from http://www.paho.org/English/AD/FCH/AI/Women_HIV.pdf

WHO. 2002. *Training Course for the 100% Condom Use Programme*. Retrieved May 25, 2005 from http://www.wpro.who.int/NR/rdonlyres/8BC531F0-6370-47E2-AB46-317040E4A65F/0/Training_Course_for_the_100CUP.pdf

Appendix 7: Infant-feeding counselling and support

WHO and UNAIDS. 2003. *HIV and Infant Feeding: Guidelines for Decision-Makers*. Retrieved 29 July 2005, from http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_IF_DM.pdf

WHO and UNAIDS. 2003. *HIV and Infant Feeding: Guidelines for Healthcare Managers and Supervisors*. Retrieved 29 July 2005, from http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_IF_MS.pdf

WHO, UNICEF and USAID. 2004. *HIV and Infant Feeding Counselling Tools*. Retrieved 29 July 2005, from http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm. The HIV and infant-feeding counselling tools, counselling cards can be viewed at http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/HIV_IF_CT/ISBN_92_4_159249_4.pdf

WHO, CDC. February 2005. *Prevention of Mother-to-Child Transmission of HIV Infection Generic Training Package: Participant Manual*. Module 4: Infant feeding in the context of HIV infection. Geneva: WHO.

Appendix 8: WHO recommendations: Antiretroviral prophylaxis regimens for PMTCT

WHO. *Antiretroviral drugs and the prevention of mother-to-child transmission of HIV infection in resource-limited settings Recommendations for a Public Health Approach* (2005 Revision). Retrieved (September 15, 2005) from http://www.who.int/3by5/PMTCTreport_June2005.pdf and http://www.who.int/3by5/PMTCTtable_June2005.pdf.

Appendix 9: Infection prevention and universal precautions

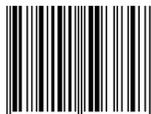
WHO, CDC. February 2005. *Prevention of Mother-to-Child Transmission of HIV Infection Generic Training Package: Participant Manual*. Appendix 8: Guidelines for cleaning, sterilising, and disposing of infectious waste materials. Geneva: WHO.

Appendix 10: Healthcare for mothers with HIV and their HIV-exposed children

WHO, CDC. February 2005. *Prevention of Mother-to-Child Transmission of HIV Infection Generic Training Package: Participant Manual*. Module 6: HIV Testing and Counselling for PMTCT and Module 7: Linkages to Treatment, Care, and Support for Mothers and Families with HIV Infection. Geneva: WHO.



ISBN 92 4 159384 9



9 789241 593847