

IMCI COMPLEMENTARY COURSE ON HIV/AIDS

# **MODULE 3: COUNSEL THE HIV POSITIVE MOTHER**

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## **1.0 INTRODUCTION**

HIV positive mothers need special counselling and support around infant feeding and their own health.

This module assumes that you have completed the Counsel the Mother module of the IMCI case management course. Before starting this module, remember that counselling on infant feeding options requires skill and practice. This current module provides you with the knowledge you will need to give HIV-positive mothers basic information about safer infant feeding, when a health worker fully trained on HIV and infant feeding counselling is not available. It does not provide you with all the skills you need to counsel pregnant or newly-delivered HIV-positive women on infant feeding options.

If you regularly need to counsel pregnant women on infant feeding options, you should participate in one of the courses that include HIV and infant feeding counselling, for example the WHO/UNICEF Infant and Young Child Feeding Counselling: An Integrated Course.

The current module will firstly build upon the communication skills learnt in the IMCI course and then take you through the processes involved in counselling the HIV positive mother about infant feeding options. The module also provides information on feeding options for orphans, issues related to the mother's own health and counselling the mother about taking the child for an HIV test.

## **2.0 LEARNING OBJECTIVES**

By the end of this module you should be able to:

- Describe how to effectively communicate with the HIV positive mother
- Describe different feeding options for HIV exposed children and children with confirmed HIV and the processes involved in counselling the HIV positive mother about feeding, including:
  - explaining the advantages and disadvantages of each option
- Describe how to counsel the mother of an HIV exposed child:
  - about her own health
  - about taking her child for an HIV test

## 3.0 COMMUNICATION SKILLS

The following section builds upon the communication skills that you learnt in the IMCI case management course. Even though you may feel hurried, it is important to take time to counsel the mother carefully and completely during every visit. When counselling a mother, it is important to use good communication skills, including **ask and listen, praise, advise and check understanding**.

In practicing good communication, you should focus on:

- giving relevant advice to each mother
- using simple language that the mother can understand
- using a Mother's Card as a communications tool

In addition to what you learnt in the IMCI case management course, below are a few important skills which will help you in counselling the mother on infant feeding.

### 3.1 Listening and learning skills

#### **Skill 1: Use helpful non-verbal communication**

Non-verbal communication means showing your attitude through your posture and your expression: in other words, everything except speaking. Some important non-verbal skills are listed below:

- Posture – keep your head level
- Eye contact – pay attention
- Timing – take time to explain without rushing
- Physical contact – any physical contact with the mother should be conducted in a culturally appropriate manner
- **No barriers – make sure that you are seated in such a way that the mother can see you clearly**

#### **Skill 2: Ask open questions**

When you ASK a mother questions, use open questions in a way that encourages a mother to talk and give you more information. Open questions usually start with How? What? When? Where? Why? For example, 'How are you feeding your baby?'

The IMCI feeding assessment includes open questions as well as closed questions, to ensure that you record specific information to adequately assess feeding. You may decide to ask only the open questions, or you can ask the questions in your own way to obtain the information.

**Skill 3: Use Responses and gestures that show interest.**

If you want a mother to continue talking, you must show that you are listening. Ways to do this are to look at her, nod and smile or to provide simple and appropriate responses, for example ‘Aha’, ‘Mm’, ‘Yes’, etc.

**Skill 4: Reflect back what a mother says**

It is often useful to repeat back or reflect back what a mother says. It shows that you understand and she is more likely to say more about what is important to her. It is best to say it in a slightly different way, so it does not sound as though you are copying her. You cannot continue to reflect back everything the mother says as it may begin to sound rude, so mix reflecting back with other responses.

An example of what to do:

<u>Example:</u>	<u>Reflect back what a mother says</u>
Health worker:	“How has your child’s feeding changed during his illness?”
Mother:	“I am so worried because he is refusing to take any porridge; he only wants to drink from the breast.”
Health worker:	“You are concerned that he is not eating any food.”

**Skill 5: Avoid words that sound judgmental**

Judging words are words like: ‘right’, ‘wrong’, ‘well’, ‘badly’, ‘good’, ‘enough’, ‘normal’, ‘properly’. If you are using judging words when you talk to a mother about feeding, especially when you ask questions, you may make her feel that she is doing something wrong, or that something is wrong with her baby.

An example of what NOT to do:

<u>Example:</u>	<u>Using judging words</u>
Health worker:	“Good morning, are you breastfeeding <i>normally</i> ?”
Mother:	“Well – I think so”
Health worker:	“Do you think that you have <i>enough</i> breast milk for him?”
Mother:	“I don’t know, I hope so”
Health worker:	“Has he gained weight <i>well</i> this month?”

The health worker is not learning anything useful, but she is making the mother worried. Note that mothers may use judging words and this is acceptable. When a mother does use judging words, don’t agree with her but instead try to build her confidence through praise.

A better example, using non-judging words, could be as follows:

<u>Example:</u>	<u>Using non- judging words</u>
Health worker:	“Good morning, how is the breastfeeding progressing?”
Health worker:	“Does your baby seem to be satisfied with the number of feeds?”

Health worker: "He looks like he has gained weight this month – let's weigh him and find out"

### 3.2 Building Confidence and Giving Support Skills

When you praise a mother, you may use the following skills to help to build her confidence:

#### **Skill 1: Acknowledge how the mother thinks and feels**

Try not to contradict a mother, but also don't agree with a mistaken idea. You may want to suggest something quite different. That would be difficult if you have already agreed with her. Instead, you just accept how she thinks or feels. To acknowledge (or accept her thoughts and feelings) means responding in a neutral way, and not agreeing or disagreeing.

Example:	Acknowledge mother's opinion
Mistaken idea:	'My milk is weak and thin.'
Contradicting:	'Oh no! Milk is never weak and thin'
Agreeing:	'Yes, thin and weak milk can be a problem'
Acknowledge:	'I see, you are worried about your milk' or 'Ah-ha'

#### **Skill 2: Recognize and praise what a mother and baby are doing right.**

We are trained to look for problems. This means that we see only what we think people are doing wrong, and try to correct them. If you tell a mother she is doing something wrong, you will make her feel bad, and that will reduce her confidence. As counsellors we must look for what mothers and babies are doing right. We must recognize what they do right and then we should praise or show approval of the good practices. Praising good practices is highly beneficial: it builds the mother's confidence, encourages her to continue those good practices, and makes it easier for her to accept suggestions later.

Example:

A mother brings her baby for a regular check up and to be weighed. He is exclusively breastfed. He has gained some weight in the last month, however his growth line shows that he is growing too slowly.

No praise:	'Your baby's growth line is going up too slowly'
No praise:	'I don't think your baby is gaining enough weight'
Praising:	'Your baby gained weight last month just on your breast milk'

### **Skill 3: Give practical help**

Sometimes practical help is better than saying anything - for example, when a mother is tired, hungry or thirsty or when she has a clear practical problem.

Some ways to give practical help include: Give the mother a drink or something to eat, hold her baby yourself while she gets comfortable.

Practical help also includes showing caregivers how to prepare feeds rather than just giving them a list of instructions. It also includes practical help with breastfeeding such as helping a mother with positioning and attaching, expressing breast milk, relieving engorgement or preparing complementary feeds.

### **Skill 4: Give relevant information**

Give the mother information that is relevant to her situation now. Try to give her only one or two pieces of information at a time, especially if the mother is tired and has already received a lot of advice. Give the information in a positive way, so that it does not sound critical or make her feel she is doing something wrong. This is especially important if you want to correct a mistaken idea. Wait until you have built the mother's confidence by acknowledging what she says, and praising what she does well.

### **Skill 5: Use simple language**

Health workers often use technical terms when they talk to mothers, and mothers do not understand them. Use simple, familiar terms to explain things to mothers.

Example:

You just finished measuring the weight and height of the child. You want to inform the mother about your assessment:

Technical: "Your child's growth curve is under the third percentile..."

Simple: "Your child is small for his age..."

### **Skill 6: Make one or two suggestions – do not command the mother**

When you counsel a mother, suggest what she could do. Then she can decide if she will try it or not. This leaves her feeling in control, and helps her to feel confident. Be careful not to tell or order her to do something. This does not help her feel confident, and makes it less likely she will do it. Avoid commands which use the 'imperative' form of verbs ('give', 'do', 'bring') and words like 'always', 'never', 'must', or 'should'.

Suggestions include:

Have you considered...?  
Would it be possible...?  
What about trying...to see if it works for you?  
Would you be able to...?  
Have you thought about... instead of ...?  
You could choose between... and ....  
Usually...  
Sometimes...  
Often...

### **3.3 Communication with Children**

When communicating with a child, it is useful to be at the same level as he or she is, for example, sitting or lying on the floor. A child who has been traumatised by any situation may find it difficult to trust others and particularly adults. In order to win a child's trust, adults require patience and must be consistent in their dealings with the child. The child's feelings must be acknowledged as his/her right.

Children speak three "languages" - the language of the body, the language of play, and spoken language. Children often tell their story through their play, their behaviour, and their body language. Through observing the different "languages" of children and how children express their meaning, you can learn about what has happened to the child.

Good communication with children is important for many reasons:

- It promotes understanding of the emotional and physical problems being experienced
- It instils confidence, hope, value, respect and relief amongst children
- It helps children come to terms with real-life experiences

Several factors hinder good communication with children. Some of these are listed in the table below.

### Factors that hinder communication with children

Related to communicator	Related to child	Both
<ul style="list-style-type: none"> <li>• Cultural norms</li> <li>• Attitudes</li> <li>• Lack of skills</li> <li>• Being critical and judgemental</li> <li>• Lack of time</li> <li>• Stress</li> <li>• Burn-out</li> </ul>	<ul style="list-style-type: none"> <li>• Shame</li> <li>• Mistrust</li> <li>• Fear</li> </ul>	<ul style="list-style-type: none"> <li>• Sensitivity of the issue</li> </ul>

It is important to try and work through these issues so that communication with children can be improved.

### 3.4 Informing a child of their HIV test result

Testing a child for HIV and informing him or her of their status is a sensitive issue and, if the child is HIV-infected, one that many healthcare providers may find difficult. The benefits of disclosure, however, significantly outweigh the drawbacks. Disclosure has been shown to positively impact treatment adherence and a child's coping strategies as well as result in fewer psychosocial problems. It is also fundamental to a child's need for autonomy. The process of informing a child of their HIV status (particularly if their test result is positive) is a process rather than a single event. As children grow, they undergo both physical and psychological changes. In general, children and adolescents of different ages will have different emotional needs, fears and expected behaviours that need to be considered in the process.

Information should be given to a child in a manner that he understands and at a pace that he can cope with. The parent or guardian has the prime responsibility for informing the child of the result; the healthcare worker should be guided by the primary caregiver in what to say to the child about his HIV status or treatment. Information provided should be truthful, coherent and consistent and in a language that is understandable and age-appropriate. You should be prepared to give support to the caregiver in this process. Some caregivers are very protective of their children and need counselling around the importance of informing the child of their HIV status. This process is often made easier if it is adapted to a child's needs, expectations and requests.

## 4.0 FEEDING OPTIONS FOR HIV POSITIVE WOMEN (HIV-EXPOSED INFANT 0-6 MONTHS)

In Module 2 you learnt about the risks of mother-to-child transmission during pregnancy, labour and delivery and through breastfeeding. All pregnant women have a potential risk of HIV infection since they have engaged in unprotected sex in order to get pregnant. For this reason, all pregnant women should be offered HIV testing and counselling as part of routine antenatal care.

Counselling around feeding options will depend upon the mother's HIV status:

All women who are **HIV-negative or who do not know their HIV status** should be counselled to exclusively breastfeed their babies for the first six months of life, followed by complementary feeding with continued breastfeeding for up to two years or beyond. Women who do not know their HIV status should be encouraged to have an HIV test.

All **HIV positive women** should receive counselling on infant feeding options as part of antenatal and postnatal care, in order to reduce the risk of transmission of HIV to their child during breastfeeding.

- The most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances, including her health status and the local situation, but should take greater consideration of the health services available and the counselling and support she is likely to receive.
- Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.
- When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended

The main recommended infant feeding options for HIV exposed infants 0-6 months who have not been confirmed as HIV-infected are shown in the box below:

**Main recommended feeding options for HIV exposed infants aged 0-6 months not confirmed HIV infected**

- Replacement feeding using a suitable breast-milk substitute
- Exclusive breastfeeding during the first 6 months

NOTE: Other options - wet nursing and heat treated breast milk - are used when the main options are not feasible and if the mother is interested.

NOTE:

For the purposes of this part of this manual, HIV-exposed infants are assumed to be HIV-negative unless they have been confirmed to be HIV-infected (see section 6.0).

If a child is confirmed HIV infected there is no reason to avoid breastfeeding because the child already has HIV. Thus, the HIV positive mother should follow the feeding recommendations for HIV negative women or women of unknown HIV status i.e. exclusive breastfeeding for the first 6 months with continued breastfeeding thereafter and the addition of complementary foods at 6 months.

If a child below 6 months is confirmed HIV uninfected (e.g. with a virological test) and the mother is breastfeeding, the same feeding recommendations as for HIV exposed children will apply (since the child could still become infected through breastfeeding).

There are advantages and disadvantages associated with each of the feeding options available to the HIV positive mother, as outlined in the table on page 14. If there is no trained infant feeding counsellor, you could explain these advantages and disadvantages to the mother, before exploring her home and family situation using the AFASS criteria (explained in more detail below). These processes will guide the final decision on which feeding option to choose.

## **AFASS**

**Acceptable:** The mother perceives no problem in replacement feeding. Problems may be cultural or social, or be due to fear of stigma and discrimination.

**Feasible:** The mother (or family) has adequate time, knowledge, skills, resources and support to correctly mix formula or milk 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 replacement feeding without harming the health and nutrition of the family.

**Sustainable:** Availability of a continuous supply of all ingredients needed for safe replacement feeding for up to one year of age or longer.

**Safe:** Replacement foods are correctly and hygienically prepared and stored, and fed preferably by cup.

## Advantages and disadvantages of the main feeding options available to HIV positive mothers

<b>Feeding option</b>	<b>Advantages</b>	<b>Disadvantages</b>
<b>Commercial infant formula</b>	<ul style="list-style-type: none"> <li>• Giving only formula carries no risk of transmitting HIV to the baby</li> <li>• Most of the nutrients a baby needs have already been added to the formula</li> <li>• Others can help feed the baby</li> </ul>	<ul style="list-style-type: none"> <li>• Formula does not contain antibodies. These are substances that protect the baby from infections</li> <li>• A formula-fed baby is more likely to get seriously sick from diarrhoea, chest infections and malnutrition</li> <li>• To prepare formula there is a need for a sustainable supply of fuel and clean water (brought to a rolling boil)</li> <li>• People may wonder why the mother is not breastfeeding</li> <li>• Formula takes time to prepare</li> <li>• Formula is expensive</li> <li>• Need to learn how to feed by cup</li> <li>• The mother may get pregnant again too soon</li> </ul>
<b>Exclusive breastfeeding</b>	<ul style="list-style-type: none"> <li>• Breast milk:               <ul style="list-style-type: none"> <li>• is the perfect food for babies and protects them from many diseases</li> <li>• gives babies all of the nutrition and water they need</li> <li>• is free, always available and does not need any special preparation</li> </ul> </li> <li>• Exclusive breastfeeding for the first few months may lower the risk of passing HIV, compared to mixed feeding</li> <li>• People will not ask why the mother is breastfeeding</li> <li>• Exclusive breastfeeding protects the mother from getting pregnant again too soon</li> </ul>	<ul style="list-style-type: none"> <li>• As long as a mother is breastfeeding, her baby is exposed to HIV</li> <li>• People may pressure her to give water, other liquids, or food to the baby while she is breastfeeding. This practice, known as mixed feeding, may increase the risk of HIV transmission, diarrhoea and other infections</li> <li>• The mother will need support to exclusively breastfeed until it is possible for the mother to use another feeding option</li> <li>• It may be difficult for the mother to do if she works outside the home and cannot take the baby with her</li> </ul>

## **5.0 FEEDING RECOMMENDATIONS FOR HIV EXPOSED CHILDREN UP TO 2 YEARS OF AGE**

The table on the following page summarizes the feeding recommendations for children aged:

- 0 <6 months
- 6 <12 months
- 12 <24 months

The table also includes recommendations for the safe transition from exclusive breastfeeding to replacement feeding.

Supplementary information relating to the table is provided in sections 5.1 to 5.3.

# Feeding recommendations: children classified as HIV exposed

<p>(see supplementary notes 5.1)  <b>Up to 6 Months of Age</b></p> <p><b>Breastfeed exclusively</b> as often as the child wants, day and night.</p> <ul style="list-style-type: none"> <li>• Feed at least 8 times in 24 hours</li> <li>• Do not give other foods or fluids (mixed feeding increases the risk of HIV transmission from mother to child when compared with exclusive breastfeeding)</li> <li>• Stop breastfeeding as soon as this is AFASS</li> </ul> <p><b>OR (if feasible and safe)</b></p> <p><b>Formula feed exclusively</b> (no breast milk* at all)</p> <ul style="list-style-type: none"> <li>• Give formula</li> <li>• Other foods or fluids are not necessary</li> <li>• Prepare correct strength and amount just before use. Use milk within two hours and discard any left over (a fridge can store formula for 24 hours)</li> <li>• Cup feeding is safer than bottle feeding</li> <li>• Clean the cup and utensils with hot soapy water</li> <li>• Give these amounts of formula 6 to 8 times per day</li> </ul> <p>* Exception: heat-treated breast milk can be given</p> <table border="1"> <thead> <tr> <th>Age mos</th> <th>Average amount and times/ day</th> </tr> </thead> <tbody> <tr> <td>0 up to 1</td> <td>60 ml x 8</td> </tr> <tr> <td>1 up to 2</td> <td>90 ml x 7</td> </tr> <tr> <td>2 up to 3</td> <td>120 ml x 6</td> </tr> <tr> <td>3 up to 4</td> <td>120 ml x 6</td> </tr> <tr> <td>4 up to 5</td> <td>150 ml x 6</td> </tr> <tr> <td>5 up to 6</td> <td>150 ml x 6</td> </tr> </tbody> </table>	Age mos	Average amount and times/ day	0 up to 1	60 ml x 8	1 up to 2	90 ml x 7	2 up to 3	120 ml x 6	3 up to 4	120 ml x 6	4 up to 5	150 ml x 6	5 up to 6	150 ml x 6	<p>(see supplementary notes 5.2)  <b>6 months up to 12 months</b></p> <p>If still breastfeeding, breastfeed as often as the child wants</p> <p>Give 3 adequate servings of nutritious complementary foods plus one snack per day (to include protein, mashed fruit and vegetables). Each meal should be 3/4 cup*. If possible, give an additional animal-source food such as liver or meat.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If breastfed, give adequate servings 3 times per day plus snacks          If an infant is not breastfeeding, give about 1-2 cups (500 ml) of full cream milk or infant formula per day</p> <p>Give milk with a cup, not a bottle          If no milk is available, give 4-5 feeds per day</p> <p>* one cup = 250 ml</p> <p style="text-align: center;"><b>(insert picture)</b></p>	<p><b>12 months up to 2 years</b></p> <p>If still breastfeeding, breastfeed as often as the child wants</p> <p>Give adequate servings of:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>or family foods 5 times a day.</p> <p>If breastfed, give adequate servings 3 times per day plus snacks          If an infant is not breastfeeding, give about 1-2 cups (500 ml) of full cream milk or infant formula per day</p> <ul style="list-style-type: none"> <li>• If no milk is available, give 4-5 feeds per day</li> <li>• Feed actively with own plate and spoon</li> </ul> <p style="text-align: center;"><b>(insert picture)</b></p>	<p>(see supplementary notes 5.3)  <b>Stopping breastfeeding</b></p> <p><b>Stopping breastfeeding</b> means changing from all breast milk to no breast milk (over a period of 2-3 days to 2-3 weeks)          Plan in advance to have a safe transition.</p> <p>Stop breastfeeding as soon as this is AFASS. This would usually be at the age of 6 months but some women may have to continue longer.</p> <p><b>Help mother prepare for stopping breastfeeding:</b></p> <ul style="list-style-type: none"> <li>• Mother should discuss (and plan in advance) stopping breastfeeding with her family if possible</li> <li>• Express milk and give by cup</li> <li>• Find a regular supply of formula or other milk, e.g. full cream cows milk</li> <li>• Learn how to prepare and store milk safely at home</li> </ul> <p><b>Help mother make the transition:</b></p> <ul style="list-style-type: none"> <li>• Teach mother to cup feed her baby</li> <li>• Clean all utensils with soap and water</li> <li>• Start giving only formula or cows milk once the baby takes all feeds from a cup</li> </ul> <p><b>Stop breastfeeding completely:</b>          Express and discard enough breast milk to keep comfortable until lactation stops</p>
Age mos	Average amount and times/ day																
0 up to 1	60 ml x 8																
1 up to 2	90 ml x 7																
2 up to 3	120 ml x 6																
3 up to 4	120 ml x 6																
4 up to 5	150 ml x 6																
5 up to 6	150 ml x 6																

## 5.1 Supplementary information: Feeding children aged 0 to 6 months

Each time you see the mother and child for follow up:

- Check how the mother is feeding the baby
- Check the child's growth and health
- Check how the mother is coping with her own health and with any difficulties

If she is breastfeeding:

- Check that she breastfeeds exclusively and gives no other milk or water or food to the baby
- Help her with any feeding problem she may report, such as “not enough milk”, “baby crying a lot”, or sore nipples.
- Check if she breastfeeds as often as the baby wants and for as long as the baby wants
- Observe a breastfeed and check the mother's breasts
- If the mother's circumstances would enable her to replacement feed, discuss the possibility of stopping breastfeeding early

If she is replacement feeding, check that she:

- Is not breastfeeding
- Is using a suitable breast-milk substitute
- Is able to get new supplies of milk before she runs out
- Is measuring the milk and other ingredients correctly, including micronutrients if she is using home-modified animal milk
- Is giving an appropriate volume and number of feeds
- Is preparing the milk cleanly and safely
- Is cup feeding - suggest that the mother feeds the baby by cup and offer practical help with cup feeding. The cup and utensils need to be cleaned with hot soapy water. They do not have to be sterilized.

Watch the mother prepare a replacement feed and, if there are any problems, demonstrate how to prepare and give the feed to the baby

If she is using other breast-milk feeding options (wet-nurse, expressed, heat-treated breast milk), check to see whether she has any problems and assist/advise her as necessary.

## **5.2 Feeding an HIV-exposed infant from 6-24 months**

### **5.2.1 If a baby is still breastfeeding**

Once they reach 6 months of age, babies need other foods and liquids in addition to breast milk, formula or animal milk. These foods should include:

- Staple foods - cereals, roots, starchy fruits

Staple foods do not include enough nutrients by themselves, so the baby also requires a variety of other foods along with the staple:

- Animal products - meat, liver, chicken, fish and eggs
- Milk products - milk, cheese, yoghurt and curds
- Green leafy and orange coloured vegetables
- Pulses - chickpeas, lentils, kidney beans, lima beans
- Oils and fats
- Ground nut paste, other nut paste
- Fruits

### **5.2.2 If a baby is not breastfeeding**

Milk is still important for the health and growth of a baby, even when he/she is old enough for solid foods. In addition to the foods listed above, a baby will need the amounts of milk shown in the feeding recommendations table above on page 16. Make sure the baby also receives any locally-recommended micronutrients.

## 5.3 Stopping breastfeeding

For the HIV positive mother whose child is classified as HIV EXPOSED, provide counselling on stopping breastfeeding if this is AFASS.

Counsel the mother on how to stop breastfeeding:

- While you are breastfeeding teach your baby to drink expressed breast milk from a cup
- This milk may be heat-treated (brought to the boil) to destroy HIV
- 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 member of the family to help with cup feeding
- Stop putting your baby to your breast completely as soon as your baby is accustomed to frequent cup-feeding. From this point on it is best to heat-treat your breast milk
- Gradually replace the expressed breast milk with commercial infant formula or home-modified animal milk if baby is below 6 months, or with boiled milk if 6 months or over..
- If your baby needs to suck, give him / her one of your clean fingers instead of the breast
- To avoid breast engorgement (swelling) express a little milk whenever your breasts feel full. This will help you feel more comfortable. Use cold compresses to reduce inflammation. Wear a firm bra to prevent discomfort
- Do not begin breastfeeding again once you have stopped. If you do you may increase the risk of passing HIV to your baby. If your breasts become engorged express breast milk by hand.
- Begin using a family planning method of your choice, if you have not already done so, as soon as you start reducing breastfeeds.

## 5.4 Feeding orphans

Abandoned children or maternal orphans require special consideration. Their feeding options are as follows:

From 0 – 6 months:

- breast-milk from confirmed HIV negative women or
- breast milk from a breast milk bank (milk banks should pasteurize milk always), or
- a safe and appropriate breast-milk substitute

If the child receives breast milk from a wet nurse it will be crucial to determine that this wet nurse is confirmed HIV negative, is not in the window period where she might still become HIV positive and is not at risk of becoming HIV positive.

If the child receives breast milk from a milk bank, the milk bank should pasteurize the milk according to standard procedures.

If the child receives formula milk, make sure that the milk given is appropriate. Follow the feeding recommendations for a child on formula milk in the Counsel the mother section on page 40 of the chart booklet.

From 6-24 months:

Infants from six months to 2 years who are not breastfed should be given milk or some other animal-source food every day, in addition to other complementary foods.

## **ROLE PLAY**

### **Infant feeding options**

Lungile Dladu is 26 years old. She is 37 weeks pregnant. She has just found out that she is HIV positive. Lungile lives in a tin shack in the centre of the city. She gets water from the tap in the street 200 metres from her home. She lives alone. Her partner works in another city and comes home at weekends. Her mother lives on the farm. Lungile visits her mother during Christmas. Lungile is working – she has temporary jobs.

After the baby is born she does not know whether she will go back to work. Maybe she will go back to the farm for a while before she returns to work. When she returns to the city her mother will look after her baby. Neither her mother nor her partner knows that she is HIV infected. She wants to tell her partner but she is scared as maybe he will get angry with her and he will not give her any money for this baby.

**HEALTH WORKER:** Counsel Lungile on how she might feed her baby once he or she is born

**LUNGILE:** Try to behave as Lungile would in a real situation.

**OBSERVERS:** Watch the role play and note anything that may be important in the group discussion that will follow the role play.

#### **DISCUSSION**

After the role play you should have a group discussion about the issues around counselling on infant feeding options.

## **6.0 FEEDING CHILDREN CLASSIFIED AS CONFIRMED HIV INFECTION**

This section provides additional information on feeding a child classified as CONFIRMED HIV INFECTION.

### **Should breastfeeding continue?**

Children with the above classification can still be breastfed. There is no reason to avoid breastfeeding at this stage because the child already has HIV. Giving breast milk will help protect the child from common infections such as ear infections and recurrent diarrhoeal disease.

For a child with CONFIRMED HIV INFECTION, follow the feeding recommendations for the general population. .

### **Are there any special feeding requirements?**

Children over 6 months with confirmed HIV infection, but still asymptomatic, should increase their energy intake by 10% to maintain growth. HIV-infected children who are experiencing weight loss need to have energy intake increased by 50-100%. Children should receive Vitamin A and other micronutrient supplements according to current WHO or national recommendations.

HIV positive children may experience special feeding problems. These are explained below.

### **Child has a poor appetite:**

This is especially common with HIV infection, and may be made worse if the child has mouth lesions such as ulcers or oral thrush:

- Use soft, varied favourite foods to encourage the child to eat as much as possible
- Keep up fluid intake
- Give foods that are not too thick or dry
- Offer small, frequent feeds. Feed the child when he is alert and happy. Give more food if he shows interest
- If the child has mouth lesions, offer foods that do not burn the mouth such as eggs, mashed potatoes, sweet potato, pumpkin or avocado. Do not give spicy or salty foods. Paracetamol may be used for pain relief before each meal
- Ensure that the spoon is the right size, that food is within the reach of the child and that he is actively fed e.g. sits on the mother's lap while eating

**What situations may impair the nutrition of the HIV infected child?**

Further nutritional, counselling and care and support interventions for children living with HIV will vary according to their nutritional status and the extent of disease progression. HIV-related illness, such as tuberculosis and diarrhoea, occur in malnourished children; however they also have severe nutritional consequences because they precipitate appetite loss, weight loss and wasting.

Study the table on the next page for clinical situations when the nutrition of an HIV-infected child is affected. Always follow the feeding recommendations in sections 4.0 and 5.0 of this module and the feeding recommendations in your chart booklet.

The table suggests what additional action you should take for these children.

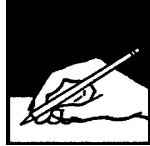
## FEEDING THE HIV INFECTED CHILD IN SPECIFIC CIRCUMSTANCES

Clinical situation / symptom that may impair the nutrition of HIV-infected children	Consequence	What action should you take?
<b>Recurrent or chronic infection</b>	Increased metabolic needs Significantly higher caloric demands	<ul style="list-style-type: none"> <li>• Offer feeds more frequently than before:</li> <li>• If the child is breastfeeding breastfeed at least 8 times in 24 hours</li> <li>• If the child is on complementary foods, offer small meals at least 5 times a day. Increase the energy value of these feeds by adding, for example oil / margarine / ground nuts</li> <li>• Follow the feeding recommendations in your IMCI chart booklet</li> </ul>
<b>Intestinal infections</b>	Increased nutrient requirements Impaired absorption and loss of appetite may decrease food intake	<ul style="list-style-type: none"> <li>• Follow the same feeding recommendations for the child with recurrent or chronic infection</li> <li>• Treat for worms if the child has not been treated during the previous 6 months</li> <li>• Give Vitamin A if the child has not been treated during the past 6 months</li> </ul>
<b>Oral or oesophageal thrush</b>	Potential pain with swallowing may result in decreased oral intake primarily for solids, but also for liquids	<ul style="list-style-type: none"> <li>• Offer foods that have been mashed up or pureed</li> <li>• Avoid spicy foods</li> <li>• Paracetamol half an hour before feeds may be helpful in extreme cases</li> </ul>
<b>Persistent diarrhoea caused by cryptosporidia or other parasites</b>	Impaired absorption of nutrients	<ul style="list-style-type: none"> <li>• Follow the feeding recommendations for the child with recurrent or chronic infection (above); the child with intestinal infections (above) and the child with persistent diarrhoea (in the chart booklet)</li> </ul>
<b>Nausea and vomiting as a result of ARV drugs</b>		<ul style="list-style-type: none"> <li>• Encourage small frequent sips of fluids and give food that the child likes</li> <li>• Let the child eat before medication</li> </ul>

It is important to identify local nutrient-rich foods that are available and affordable and to advise the mother on how to increase the energy content of foods.

Always advise the mother to continue feeding and continue giving fluids during any illness.

## WRITTEN EXERCISES



### WRITTEN EXERCISE A

In this exercise you will answer questions about the feeding recommendations that you have learnt about in this module.

1. Write a "T" by the statements that are True. Write an "F" by the statements that are False.
  - a. \_\_\_\_ Children should be given fewer feeds during illness.
  - b. \_\_\_\_ A 3-month-old HIV positive child should be exclusively breastfed.
  - c. \_\_\_\_ A 2-week-old child of unknown HIV status, born to an HIV positive mother should never be breastfed.
  - d. \_\_\_\_ A breastfeeding child born to an HIV positive woman must continue breastfeeding for as long as the mother wants to breastfeed.
  - e. \_\_\_\_ A 5-month-old child whose mother is HIV negative should be breastfed as often as he wants, day and night.
  - f. \_\_\_\_ A 9-month-old child who is HIV positive on virological tests should continue breastfeeding.
  - g. \_\_\_\_ All breastfeeding HIV positive women transmit HIV to their infants.
  - h. \_\_\_\_ A child born to a mother with unknown HIV status should be given formula
  
2. When should complementary foods be added to the diet of a child born to an HIV-positive mother? What foods should be added and what quantity?

3. What is meant by stopping breastfeeding early? When should it be practiced? By whom?
  
4. An HIV positive mother lives in an urban environment. She has access to piped water, a flush toilet and a refrigerator with a constant power supply. She also has a stove. She and her partner have a stable income. She lives with her partner and her mother. They both know that she is HIV positive. They are keen to help her and are very supportive. What would you say to the mother about the different infant feeding options?
  
5. An HIV positive mother lives alone in an informal settlement. She has access to piped water, but only has a pit latrine and no toilet. She does not have a regular power supply / fuel and no stove. She does not have a stable source of income. No-one else knows that she is HIV positive. What would you say to the mother about different infant feeding options?



## **WRITTEN EXERCISE B**

In written exercise A of Module 1 you met 4 children (Ebai, Henri, Mishu, and Dan). In Module 2 you assessed and classified these children for HIV.

*Go back to the recording forms that you used in Written Exercise A Module 1 and Written Exercise B of Module 2. Look at your classifications for each child, including the classifications for HIV.*

Based on these classifications, write down the feeding advice and counselling that you would give to each mother.

When you have completed the exercise, discuss your answers with the facilitator.

## **7.0 COUNSEL THE HIV POSITIVE MOTHER ABOUT HER OWN HEALTH**

During a sick child visit, listen for any problems that the mother (or caregiver) herself may have. The mother may need treatment or referral for her own health problems. Do not force mothers to queue twice or attend different places for simple problems. Write down her health concerns at the bottom of the recording form. This will remind you to help the mother after attending to her child.

Ask her about family planning and if she is happy with the method she has chosen. Discuss the alternatives with her and prescribe contraception as you have been taught in family planning. Offer barrier contraception as well, and ensure that the mother has enough contraception for at least 3 months.

Ask about any lower abdominal pain, vaginal discharge or sores. Assess and treat these according to the National STI protocols.

Encourage the mother to discuss any social problems. Provide ongoing counselling and care if she is HIV positive. If necessary, refer her appropriately.

### **Mother too sick to breastfeed:**

If the HIV positive mother who has chosen to breastfeed develops symptomatic AIDS, she may no longer be able to manage the physical burden of breast-feeding. Help the mother to make a safe and complete transition to replacement feeds. For poor women, you may have to arrange for a secure supply of formula milk (under six months) or plain milk (older children). The mother should be assessed and referred for ART and she should be placed on co-trimoxazole.

► **Counsel the mother about her own health**

- If the mother is sick, care for her, or refer her for ART.
- If she has a breast problem (such as engorgement, sore nipples, breast infection), provide care or refer her for help.
- Advise her to eat well to keep up her own strength and health.
- Check the mother's immunization status and give her tetanus toxoid if needed.
- Make sure she has access to:
  - Contraception and sexual health services
  - Counselling on STI and AIDS prevention
- Counsel about safe sex and early treatment of STIs

► **Give additional counselling if the mother is HIV positive**

- Reassure her that with regular follow-up, much can be done to prevent serious illness, and maintain her and the child's health
- Emphasize good hygiene, and early treatment of illnesses
- See guidelines for palliative care in chart booklet and Module 4

## **8.0 USE OF A MOTHER'S CARD / THE HIV AND INFANT FEEDING COUNSELLING CARDS**

When you did the IMCI case management course you learnt about the mother's card. Continue to use the mother's card when speaking with HIV positive women. In addition, when speaking with HIV positive women you may use the HIV and infant feeding counselling cards if you have been trained to use them.

## **9.0 COUNSEL THE MOTHER OF AN HIV-EXPOSED CHILD ABOUT AN HIV TEST**

The mother of a child classified as HIV EXPOSED/POSSIBLE HIV INFECTION or SUSPECTED SYMPTOMATIC HIV INFECTION will need to be counseled about an HIV test for the child.

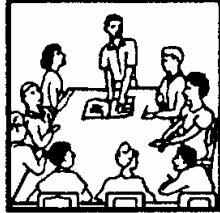
Many mothers, and even health workers, are reluctant to discuss HIV. However HIV is present in the community and the problem will not be solved as long as there is secrecy surrounding the topic. Mother-to-child transmission presents a number of barriers to testing of the child. HIV may provoke feelings of guilt on the part of the mother, as well

as fears of rejection by and of the child and of revealing their own HIV status and how they were infected. All health workers must be equipped with the knowledge and ability to discuss HIV, ask questions and give appropriate counselling.

When you have identified a young infant or child who is in need of HIV testing you should provide the mother with information: tell the mother that the condition of the child makes you think that HIV may be the cause of the illness. Explain that if the child has often been ill, this can be a sign of HIV infection. Allow the mother time to express any feelings of guilt and/or arguments against testing. Help the mother to understand that the reason for HIV testing is so that the child can receive treatment that will improve his quality of life. He should have antibiotics to prevent infections, vitamin supplementation, regular growth monitoring, prompt treatment of any illnesses and antiretroviral therapy if it is needed. If the child is less than about 2 years, the mother may receive counselling on infant feeding.

Once you have explained, allow the mother to ask questions and address her concerns. If she agrees to the test, arrange it in the normal way at your clinic. Since the most common route of HIV infection for a child is by mother-to-child transmission, you may need to discuss testing her and her partner as well perhaps even before testing the child. In some communities, mothers abandon their children when they find that their children are HIV infected, not knowing that mother-to-child transmission was the means by which their children became infected. If a mother does not agree to test the child, the health worker should listen to and address her concerns and reasons against testing. The health worker may be considered an advocate for the child and negotiate with the parent or carer in the child's best interest. Reassurances should be made regarding treatment, care, support and/or preventative interventions that the child may benefit from once diagnosed. It may help for the parent/carer to express their concerns without the child's presence.

After testing, make an appointment for a review of the results and post-test counselling. If a rapid test has been performed, do the post-test counselling immediately if this is agreeable to the mother. Maintain privacy and confidentiality so that the mother can discuss her concerns freely.



## **ROLE PLAY**

### **Counselling a mother about the HIV Test**

Sandile is an 18-month-old boy with cough and fever. He is classified as PNEUMONIA and NOT GROWING WELL. The health worker considers his HIV status and symptoms. Neither the mother nor the child has had an HIV test. Sandile is low weight for age, and has unsatisfactory weight gain. On examination, the health worker finds that Sandile has oral thrush and enlarged glands in the neck and groin. The health worker classifies Sandile as SUSPECTED SYMPTOMATIC HIV.

**HEALTH WORKER:** Counsel the mother that there are signs that Sandile may have HIV infection and that he needs a test. Tell her that you are not sure that he is suffering from HIV infection but that you think it is important he has a test, so that he gets the treatment he needs.

**MOTHER:** Try to behave as a real mother might behave. She may be confused or distressed or she may not understand.

**OBSERVERS:** Watch the role play and note anything that may be important in the discussion.

#### **DISCUSSION**

After the role-play you should have a group discussion about the issues of informing a mother that her child may be HIV infected.

Do the group members feel that they will be able to do this at their own clinics?  
Why is it important that it should be done?

Discuss strategies that could be used to make it easier for health workers to discuss the topic of HIV infection with their clients.

## **10.0 SUMMARY OF MODULE AND CLOSING**

The facilitator will now ask participants to briefly summarize what topics have been covered by Module 3. Participants should call out what this module has taught them and the facilitator will list your responses on a flipchart.

Look back to the learning objectives for the module and provide your feedback as to whether you feel that these objectives have been met.

Participants should highlight any difficult areas, where you need further clarification and ask final questions.

You are now ready to move onto Module 4: Follow up and chronic care of HIV exposed and infected children.