



Psychosocial Assessment Guide for use in PMTCT Settings

How to Use the Psychosocial Assessment Guide

This psychosocial assessment guide was developed to support a range of providers (trained counselors, lay counselors, peer educators, expert clients, mother mentors, doctors, nurses, pharmacists, community health workers, and others) who work with pregnant women living with HIV and their families, as well as caregivers of HIV-exposed and HIV-infected children. Conducting a psychosocial assessment with each client helps to learn more about his or her specific situation, to prioritize needs, and to give direction to ongoing counseling and psychosocial support. This includes referrals for needed community and home-based services. The psychosocial assessment guide should be adapted to reflect national PMTCT and pediatric care and treatment guidelines, as well as the specific clinic, community, and cultural contexts in which they are used. It may be helpful to translate the guide into the local language.

A psychosocial assessment should be conducted with **each client after enrollment in PMTCT services**. Health workers may want to conduct another psychosocial assessment or revisit specific psychosocial issues when a client's situation changes in a significant way, such as after a client gives birth. Always respect client confidentiality and conduct sessions in a space that offers visual and auditory privacy. Key information from the psychosocial assessment should be recorded on the form and kept in the client's file. A template to record follow-up counseling notes is also included.

Completed psychosocial assessment forms should be kept in the client's file and referred to during follow-up visits. While many ANC and PMTCT programs do not keep client files, psychosocial assessments and documentation of psychosocial issues are very important parts of quality, continuous care and client-centered counseling. If individual client files are not maintained at the clinic, this guide can also be used as a job aide to help providers assess psychosocial needs and provide follow-up counseling and referrals.

Basic information: Write down the client's name and file number. Be sure to sign and date the form at the end of each session and ensure that the form is kept in the client's clinic file.

Questions to ask the client/caregiver: The questions in these sections allow the health worker to discuss and assess the client's psychosocial issues and needs. Different questions are suggested for different topic areas, including: coping, support system, and disclosure; plans for the mother's and baby's care; and partner and family testing. It is important to allow time for the client to respond to each question. Clients should always be made to feel comfortable expressing psychosocial challenges and should never be judged or punished. Write down any important information from their responses, as this will help decide on effective next steps, important areas for follow-up, and in supporting the client's psychosocial wellbeing over the long term.

Questions, summary, and next steps: Ensure that the client has time to ask questions and that the health worker has time to summarize the session and agreed upon next steps. Record key next steps in the space provided.

Additional notes: Write any additional notes about the session, the client's psychosocial needs, or next steps in the space provided.

Referrals made: Linkages and referrals to psychosocial support services are important elements of quality PMTCT programs and the ongoing support of clients and their families. Each clinic should have an up-to-date list of community support services (such as mother's support groups, home-based care programs, adherence supporters, PLHIV associations, food support, legal support, etc.) and formal two-way referral systems to these organizations and services. Clients with severe psychosocial and psychological issues (such as depression, use of drugs and alcohol, feeling suicidal) will require careful follow-up and immediate referrals and linkages to ongoing professional counseling and other services. Record any referrals made to the client in the space provided. At the next session, follow up to determine if the client accessed these referral services.

Date of next counseling session/clinic appointment: Schedule a follow-up counseling appointment with the client and record this date, as well as any clinic appointments, in the space provided.

PMTCT Psychosocial Assessment Guide and Recording Form

Client's Name: _____

Client's File#: _____

Coping, Support System, and Disclosure

1. Now that you know your HIV-status, what feelings or concerns do you have?	
2. Can you tell me how things have been going since you learned your HIV-status? How are you coping? <i>Explore and discuss client's coping strategies</i>	
3. Who can you go to for emotional support? <i>Counsel on importance of social support</i>	
4. How often in the last week have you used cigarettes, alcohol, or other drugs to help you cope? <i>Assess for harmful coping strategies, such as drug/ alcohol use, and provide counseling/ referrals</i>	
5. Have you disclosed your HIV-status to anyone? <i>Counsel on full and partial disclosure</i>	Yes No
5a. If yes, to whom? What was their reaction?	
5b. If no, how do you feel about disclosing to someone you trust? What support do you need?	
6. Do you belong to a community organization, support group, or religious group that gives you the support you need?	Yes No Name/location of organization or group:
6a. Would you be willing to join a support group at this clinic or in the community? <i>Give information about support groups</i>	Yes No
7. Have you experienced or do you fear stigma, discrimination, or violence because of your HIV-status or other reasons? <i>Counsel and discuss available support services</i>	Yes No Details:
7a. If you experience stigma, discrimination, or violence, or are afraid you will, what do you think you will do? <i>Counsel on available support services</i>	
8. Do you have a regular source of income or do you receive help, such as social grants, food parcels, or anything else? <i>Counsel and refer to social worker and community-level support</i>	Yes No Sources of income/support: Receiving social grant? Yes No

Plans for Her Own and Baby's Care

9. What are you going to do to stay well during and after your pregnancy, and to reduce the chance that your baby will be HIV-infected? <i>Counsel on ANC and PMTCT services, including ARVs</i>	
10. Other than coming to this clinic, do you go to other places for health services (e.g. other clinics, TBA, traditional healers, etc.)?	
11. How will you remember to take your medications every day? How will you remember when to come back to the clinic? Is there someone who can help you? <i>Counsel on adherence to care and medicines</i>	

12. What do you think are the most important things you can do to care for your new baby? <i>Counsel on care for HIV-exposed infants and bringing the baby back for all clinic appointments</i>	
13. How do you plan to feed your baby? Do you have any questions or concerns? <i>Counsel on safe infant feeding per national guidelines</i>	Exclusive breastfeeding Exclusive formula Not sure Final infant feeding choice:
14. Who will help you take care of the baby and give the baby medicines? <i>Counsel on importance of bringing baby back often and having all caregivers understand the care plan</i>	Name(s) and relationship(s):
14a. If you cannot bring the baby back to the clinic, who else will be able to bring the baby? Have you disclosed to this person?	Name and relationship: Disclosed? Yes No
15. Would it be ok if we called you (or someone you trust) if you miss an appointment at the clinic? Would it be ok if we visited you at home?	Consent for phone call: Yes No Phone number (own/other's?): Consent for home visit: Yes No Detailed address:

Partner and Family Testing

16. Can you tell me who lives with you at home? <i>Counsel on family-testing, care, and treatment</i>	Name: _____ Age: _____ Relationship: _____ Name: _____ Age: _____ Relationship: _____ Name: _____ Age: _____ Relationship: _____ Name: _____ Age: _____ Relationship: _____
17. For the children who live with you, can you tell me if each has been tested for HIV and what the test result was? <i>Counsel on HIV testing for all children, even if they seem well, and importance of early care and treatment for HIV-infected children</i>	Name: _____ Age: _____ Tested: Yes No Result: pos neg If positive, in care and tx: Yes No Name: _____ Age: _____ Tested: Yes No Result: pos neg If positive, in care and tx: Yes No Name: _____ Age: _____ Tested: Yes No Result: pos neg If positive, in care and tx: Yes No
18. Do you have a sexual partner(s) now?	Yes No
18a. If yes, has your partner been tested for HIV? What was the result? <i>Counsel on partner testing and discordance</i>	Partner tested? Yes No Don't know Partner's test result? Positive Negative Don't know If positive, in care and tx? Yes No Don't know
18b. If no, do you think your partner would be willing to come for an HIV test?	Yes No Don't know
18c. If yes, can you tell me how you and your partner(s) practice safer sex?	

Questions, Summary, and Next Steps

19. What other questions or concerns do you want to discuss today?	
20. <i>Summarize the session and review immediate plans and next steps, including the next clinic visit date</i>	Note next steps here and in the space below:

Notes:

Referrals made:

Date of next counseling session/clinic appointment: _____

Counselor's signature: _____ Date: _____

PMTCT Counseling Follow-up Notes

(photocopy additional forms for client's file, as needed)

Client's Name: _____

Client's File#: _____

Date of counseling session: _____

Key issues and concerns discussed:

Next steps and areas for follow-up:

Counselor's signature: _____

Date of counseling session: _____

Key issues and concerns discussed:

Next steps and areas for follow-up:

Counselor's signature: _____