TRAINING MANUAL
for
Auxiliary Nurse Midwives (ANM)




NACO

INDIAN NURSING COUNCIL

Strengthening Institutional Capacity for Nursing Training on HIV/AIDS (GFATM R7)

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for
Auxiliary Nurse Midwives (ANM)

National AIDS Control Organization
Indian Nursing Council
With Support From Futures Group

First Edition 2012

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FOREWORD

Based on various studies and independent assessments, it is seen that the National AIDS Control Program is progressing steadily towards the objective of halting and reversing the HIV epidemic in India over the period 2007- 2012.As per NACO Annual report statistics, at the of 2009,23.9 lakh people are living with HIV with an adult prevalence of 0.31%. This makes India, the country with the third largestpopulation living with HIV. The mainstay of the NACP Strategy will continue to be prevention since more than 99% of the people are HIV negative.

On the other hand, It, has been, observed that over the years the virus has moved from urban to rural and from high risk to general population disproportionately affecting women and the youth.There is also an urgent need to improve access to HIV Counselling, screening ,testing & PPTCT services, at the grass root , to reduce the missed opportunities of early detection of HIV infection, promote birth of HIV free children etc.

The ANM workforce,by virtue of their numbers and their close andcontinuous contact with individuals, families in villages , have been identified as an ideal resource for managing with the HIV/AIDS epidemic at the primary level. Therefore, ANMs need to be trained onthe requisite knowledge,attitudes and skills for HIV/AIDS prevention and care in the community.

The Training manuals (Facilitator's Guide and Nurses' Manual) , based on the existing,NACO training module, "Shaping Our Lives"for ASHAs/ANMs, has been developed by Indian Nursing Council. It includes topics relevant to the working of the ANM in these facilities and focus on –

- Basic Information on HIV/AIDS, including disease progression, diagnosis and ART
- Prevention of HIV transmission
- Counselling on Treatment adherence
- PPTCT and EID
- Infection Control
- Stigma & Discrimination
- Record keeping and reporting
- Sexually transmitted infections

This module will enable ANMs tocontribute meaningfully towards providing comprehensive, holistic and-compassionate care for people living with HIV/AIDS and educating the communityon how to prevent HIV transmission.

(Mr. T. Dileep Kumar)
President Indian Nursing Council

ACKNOWLEDGEMENT

Under the Global Fund Round 7 project, one of the mandates, is to train the Auxilliary Nurse Midwife positioned in the Facility integrated ICTCS (FICTCs). These are mostly located in 24x7 PHCs. A totalof 4071 ANMs in these facilities need to be trained within this project.

The 2 day training for the ANMs,is being conducted by the locally identified ANM school tutors, who have been trained by Trainers from the existing Trainers' pool of the GFATM project. The trainings will be held at select SR/SSRs, already involved under the said project.

I would like tothank Mr. SayanChatterjee, Secretary and DG, NACO for the leadership and guidance in initiating thistraining program to ANMs posted at FICTCs .

I would like to express my gratitude to Dr. RadheyShyam Gupta,DDG,Basic Services Division, NACO, for his guidance and support.

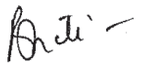
My sincere thanks to all Core Committeemembers, Experts from NACO, Nursing Experts and tutors from select ANM schools, who have put in great efforts in the development of the Facilitator's Guide and Nurses'Manual.

I would also acknowledge the support of Futures Group (MSU), in putting this manual together while taking in all inputs

Lastly, I would like to thank allmy colleagues in the Indian Nursing Council and other project staff who have worked

tirelessly in completing the manuals in the shortest possible time.

I hope the manuals will be equally appreciated by the trainers and participants and would helpbetter equipping ANMs in provided quality care for people with HIV/AIDS.



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LIST OF ABBRIVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Midwife Nurse
ART	Anti Retroviral Therapy
CSW	Commercial Sex Worker
DOTS	Directly Observed Therapy Shortcourse
EID	Early Infant Diagnosis
ELISA	Enzyme-Linked Immunoflourescent Assay
FICTC	Facility Integrated Counseling & Testing centre
HIV	Human Immunodeficiency Virus
HCP	Health Care Provider
ICTC	Integrated Counseling and Testing Centre
IDU	Injecting Drug User
IEC	Information Education Communication
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NGO	Non-Government Organization
OI	Opportunistic Infection
PHC	Primary Health Centre
PCP	Pneumocystis Carinii Pneumonia
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV/AIDS
PPTCT	Prevention of Parent To Child Transmission
RNTCP	Revised National Tuberculosis Control Programme
SACS	State AIDS Control Societies
STI	Sexually Transmitted Infection
TB	Tuberculosis
WBC	White Blood Cell
WHO	World Health Organization

SECTION 1
ABOUT THIS COURSE

Background of the Global and Indian HIV Epidemic

Globally there were estimated 33million people infected with HIV in 2009 with 2.6 million new infections and 1.8 million HIV related deaths. Nearly an estimated 5 million people infected with HIV lived in Asia in 2009 and about 3,80,000 people were newly infected [2010 UNAIDS Global Epidemic Update].

In India, the estimated number of HIV infections as of 2009 is 2.2 million. The distribution of HIV infection and mode of transmission varies by state. Most HIV infections in India (86% of reported AIDS cases) are due to unprotected heterosexual transmission (UNAIDS, 2008 Report on Global AIDS Epidemic).

HIV prevalence tends to be higher in the industrialized, peninsular states. The six states with the highest HIV prevalence are: Maharashtra, Andhra Pradesh, Tamil Nadu, Karnataka, Manipur, and Nagaland.

In India, more than 4,28, 638 people living with HIV/AIDS are accessing ART from public sector hospitals/clinics as of June 2010. NACO proposes to deliver ARV therapy through effectively functioning health infrastructure and properly trained and motivated staff. Building capacity to train all cadres of health professionals in HIV/AIDS care and simplified, standardized ARV therapy is urgent in the Indian context.

This training programme was developed to address the need for training ANMs in HIV/AIDS care and support as part of the overall NACO training agenda.

Goals of the Training

At the end of the course, it is expected that participants will be able to have:

- Basic Knowledge of HIV, its transmission, prevention, comprehensive care, and antiretroviral treatment for adults, pregnant women and children
- Skills and confidence to provide care to the HIV positive pregnant women
- Skills to educate, counsel and provide referrals to people at risk and PLHIV
- Recognize the KEY role of the ANM at the grass root level in HIV prevention and care

Training Schedule
Day 1

Time	Topic	Duration	Resource Person(s)
8.30- 9.00 AM	Registration	30 Min	
9.00–10.00 AM	Unit 1-Introduction & Pre Test	60 Min	
10.00-11.00 AM	Unit 2- Basics of HIV/AIDS (I)	60 Min	
11.00-11.30 AM	Tea	30 Min	
11.30 AM-12.30 PM	Unit 2- Basics of HIV/AIDS (II)	60 Min	
12.30-1.30 PM	Lunch	60 Min	
1.30-2.30 PM	Unit 3- Stigma & Discrimination-Legal & Ethical Issues in HIV/AIDS	60 Min	
2.30-4.00 PM	Unit 5- Prevention of HIV Transmission (I)	90 Min	

Time	Topic	Duration	Resource Person(s)
4.00-4.30 PM	Tea Break		
4.30 - 5.30 PM	Unit 5- Prevention of HIV Transmission(II)	60 Min	
	Day 2		
9.00-11.00 AM	Unit 4- Counseling In HIV/AIDS Care	120 Min	
11.00- 11.30 AM	Tea	30 Min	
11.30 – 1.00 pm	Unit 6- Prevention of Parents to Child Transmission of HIV(PPTCT) & Early Infant Diagnosis (EID)	90 Min	
1.00- 2.00 PM	Lunch	60 Min	
2.00 PM- 4.00 PM	Unit 7- Infection Control & PEP	120 Min	
4.00 – 4.30 PM	TEA		
4.30 - 5.30 PM	Unit 8- Documentation & Reporting	60 Min	
	Day 3		
9.00 – 11.00 AM	Unit 9-Sexually Transmitted Infections(I)	120 Min	
11.00- 11.30 AM	Tea	30 Min	
11.30 - 1.00 PM	Unit 9-Sexually Transmitted Infections (II)	60 Min	
1.00 – 2.00 PM	LUNCH	60 Min	
2.00 – 3.00 PM	Unit 9-Sexually Transmitted Infections (III)	60 Min	
3.00 – 4.00 PM	Post Test & Issue of Certificates	60 Min	

Organization of the HIV/AIDS Training for Nurses Course

This course has been designed for the ANMs. This is a facilitator-led program and consists of 8 units focusing on HIV prevention, care and support with an emphasis of the role of ANM in each of these areas. Each unit has clearly stated unit objectives and session plans which include the following teaching/learning methods:

- Lecture
- Case studies
- Role plays
- Large and small group discussions
- Worksheets
- Individual work and discussions
- Brainstorming sessions
- Videos

How to Use this Manual

This manual was developed to assist you as you participate in the training. The manual contains the following information to support your success in the training:

- Unit – wise summary of content covered during the three days training
- Annexures
  - Worksheets to facilitate individual and group work during the training
  - Guidelines, checklists and other referral information which could aid your day to day work after the training

SECTION 2
UNITS

Introduction

National AIDS Control Program

HIV/AIDS prevention activities were undertaken immediately after the first case of HIV infection was detected in Chennai (formally Madras).

A comprehensive National AIDS Control Program (NACP) was started in 1992 with the setting up of the National AIDS Control Organization (NACO) within the Ministry Of Health and Family Welfare, Government Of India. The first phase of the program, NACP I , was implemented by NACO and State AIDS Cells were set up in all the states between 1992-2004. In the second phase between 1999 to 2006., establishment of State AIDS Control Societies took place.

Under NACP III, (2007-2012), the goal is to stop and bring down the HIV infection in India over the next five years.

The goal of NACP III is being achieved by following four ways:

- To prevent HIV infection among High Risk Groups(HRGs) and general population
- Provide greater care, support and treatment to larger number of PLHIV
- To make the health set ups, and healthcare workforce, working in treatment, care and support programs at national, state and district levels, strong
- To make the management of health information/data strong

Red Ribbon

The red ribbon is, created in 1991,is the universal symbol of awareness and support for those living with HIV or for those who are ill, for those who have died and for those who care for and support those directly affected.

The Red Ribbon offers a symbol of hope and support for those living with HIV, for the continuing education of those not infected, for maximum efforts to find effective treatments, cures or vaccines and for those who have lost friends, family members or loved ones to AIDS.

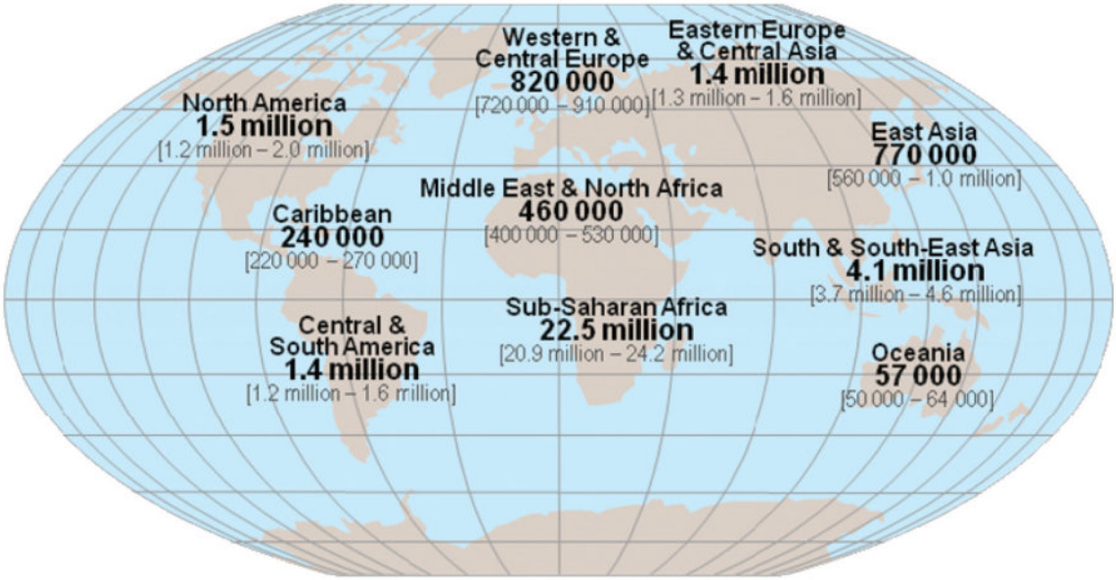
UNIT 1– HIV/AIDS & ANMs' ROLE

Unit Objectives

- ☛ Understand spread of HIV/AIDS at Global & India level
- ☛ Explain role of the ANMs in prevention of HIV/AIDS

HIV/AIDS across the world

Adults and children estimated to be living with HIV I 2009



Total: 33.3 million [31.4 million – 35.3 million]

UNAIDS estimates

- Over 7000 new HIV infections a day in 2009
- About 97% are in low and middle income countries
- About 1000 are in children under 15 year of age
- About 6000 are in adults aged 15 years and older, of whom:
  - almost 51% are among women
  - about 41% are among young people (15-24)

Indian Scenario

In India, the adult prevalence has declined more than 50 % during the last decade i.e. from 2.7 lakh in year 2000 to 1.2 lakh in year 2010. Total no. of people living with HIV were 23.9 lakhs. Out of this, Children accounted for 35 %. and women accounted for 39 % of all the infections.

There were 1.72 lakhs AIDS related deaths in 2009.

3.84 lakh PLHIV (including 22,837 children) received ART through 292 ART & 550 Link ART Centres.

Evolution of HIV in India

- First HIV case in India was reported from Chennai in 1986
- First case of AIDS was reported from Mumbai in 1987
- HIV cases are now in all states of India approximately 2.27 million PLHIV in India (NACO 2008-9)
- All districts across the country are classified into categories A, B, C and D based on prevalence in antenatal women and high-risk groups

Prevalence

For the purpose of planning and implementation of NACP-III, all the districts in the country are classified into four categories based on HIV prevalence in the districts among different population groups for three consecutive years.They are as follows:

1. High Prevalence - i.e. > 5 % in High Risk groups and > 1% in Antenatal women
2. Moderate Prevalence - i.e. > 5% in High Risk groups and < 1% in Antenatal women
3. Low Prevalence - i.e. < 5% in High Risk Groups and < 1% in Antenatal women

ANMs and HIV/AIDS Care

The ANMs posted at "Facility-integrated" ICTC (FICTC) are a part of a multidisciplinary team member, such as, staff nurse/health visitor/laboratory technician (LT)/pharmacist, is expected to undertake HIV counseling and testing.

"Facility-integrated" ICTC is one which does not have full-time staff and provides HIV counseling and testing, as a service along with other services. Such ICTCs will usually be established in facilities that do not have a very large client load and where it would be uneconomical to establish a stand-alone ICTC. Typically, such facilities are 24-hourPrimary Health Centres (PHCs)/Community Health Centres(CHCs)/First Referral Units(FRUs)/Sub District Hospitals, /private sector/not-for-profit hospitals, Such ICTCs will be supported by the National AIDS Control Organization (NACO) through State AIDS Control Societies (SACS).

Terms of Reference of the ANM at the FICTC :

Preventive and Health Education

- Being available in the FICTC as per the specified timings
- Providing pre-test information/counseling, post-test counseling and follow-up counseling in a friendly atmosphere; maintaining confidentiality of such cases
- Displaying all IEC materials such as posters, etc. prominently in the ICTC
- Making available various communication aids in the form of flip books and condom demonstration models, fliers, etc. in the ICTC

Psychosocial Support

- Provide psychosocial support and guidance to help HIV-positive clients and family members to cope with HIV/AIDS and its consequences
- Referral and Linkages
- Maintain effective coordination with the RCH, TB and Antiretroviral Therapy (ART) programmes/ Linked ICTCs as, and visit important persons in the facilities run by these programmes once in a fortnight so as to maintain linkages/Networking and minimize loss of clients during referrals

Supply and Logistics

- Report to the SACs/Linked ICTC on the adequacy of stocks of condoms and prophylactic Nevirapine tablets and syrup available in the FICTC as well as in the facility

Monitoring

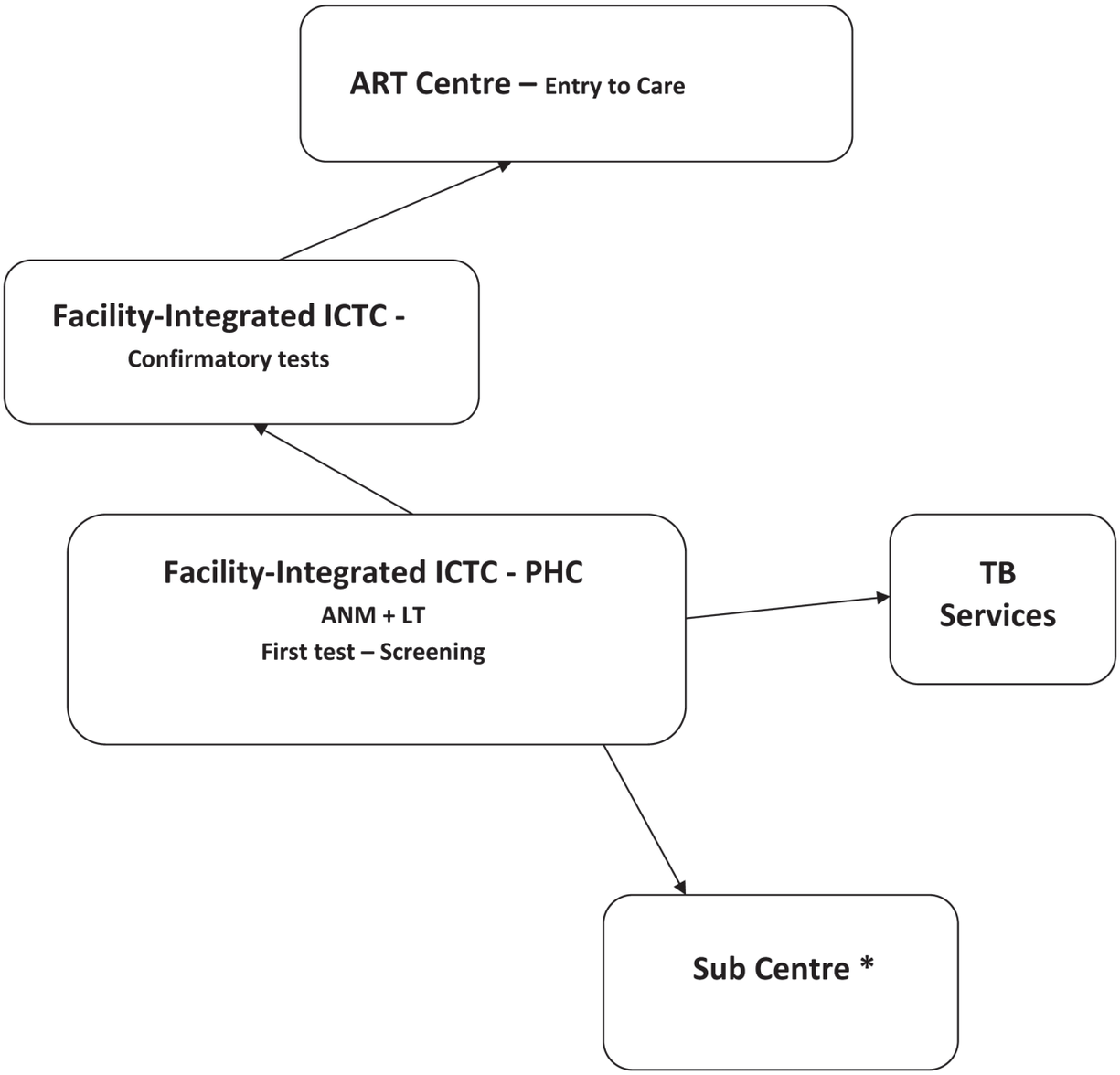
- Maintain counseling records and registers, and prepare monthly reports which are to be sent to the SACs/Linked ICTCs

At the Sub Centres, ANMs

- Health Education regarding prevention Of HIV Transmission
- Conduct HIV screeningTest (i.e.Rapid Test)
- Conduct Pre & Post Screening and Follow Up Counseling
- Providing Referrals to clients and family to support programs (e.g. ICTCs/ART Centres/ PPTCT Centres/STI Clinics/Positive People Networketc.)
- Educate & supervise other co-workers (ASHAs, Outreach Workers etc.)
- Compilation of monthly record & register
- Assisting doctor in management of cases
- Providing drugs to patients as recommended by doctors

- Prepare and sterilize instruments
- Visit the field once a week for Follow-up with patients

The system of Referral at various levels



*Supervise ASHAs & Conduct Rapid HIV testing

If a client's first screening test is positive, ANM can refer him/her to

- ICTC for a confirmatory test. Apart from testing, the client is also provided with basic information on transmission and transmission of HIV/AIDS and referral for other HIV prevention, care and treatment services
- Further to ART Centre, for more care & management, if Confirmatory test is positive
- Recommend the HIV testing for the partner/spouse
- TB services (District Microscopic Centre/DOTS Program etc.) as TB is one of the most common infection found among HIV+ people

Key Messages :

☛ ANMs play a vital and diverse role in the care and treatment of the patient with the aim to

- Provide comprehensive HIV care
- Support patients and families in HIV treatment
- Provide many opportunities for teaching and counseling
- Link patients to appropriate medical and social services

☛ ANMs should understand their importance and believe in their ability to be leaders in HIV care and treatment

UNIT 2 – BASICS OF HIV/AIDS

Unit Objectives

- ☛ Define HIV and AIDS
- ☛ Describe how HIV causes AIDS
- ☛ Describe the various stages of HIV disease
- ☛ Explain transmission of HIV and factors that increase the risk
- ☛ Understand the linkage between Sexually Transmitted Infections (STIs)/Reproductive Tract Infections (RTIs)/Tuberculosis (TB)/Opportunistic Infections(OIs) and HIV/AIDS
- ☛ Explain different types of HIV tests
- ☛ Understand the role of Anti retroviral Therapy in managing HIV infection

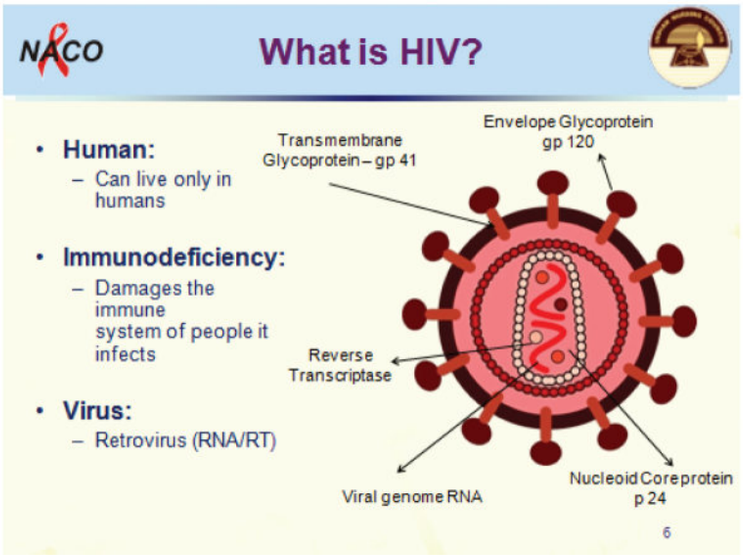
We need to know what the immune system is and how it works in order to fully understand how HIV affects the body

- Immune system protects and defends the body from infections
- White blood cells (WBCs) are the most important part of the immune system, which fight and destroy harmful bacteria, fungi, and viruses that enter the body
- CD4 cells a type of white blood cell (WBC) which fights infections
- The number of CD4 cells in a sample of blood is an indicator of the health of the immune system. HIV infects and kills CD4 cells, leading to a weakened immune system
- Based on the level of CD4 Count, the Health Care Providers know what Opportunistic Infections (OIs) and other conditions,a PLHIV might have and what treatment (OI Prophylaxis/AntiRetro Viral Treatment-ART) to start
- Opportunistic Infections (OIs) are the main cause of death among HIV infected people
- Most OIs can be prevented and treated well in time
- A CD4 Count < 200 is defined as AIDS (Acquired Immuno Deficiency Symdrome)

What are HIV and AIDS?

H - Human
I - Immunodeficiency
V - Virus

- HIV stands for Human Immunodeficiency Virus
- A person infected with HIV is known as HIV positive person
- HIV attaches to the White Blood Cells in the body and slowly kills them
- HIV cannot be destroyed by the body. An infected person carries HIV for life
- There are medicines (AntiRetroViral Treatment- ART) available, which can prolong life, if taken regularly



AIDS

A – Acquired (not inherited - contracted by direct contact with body fluids that have high concentrations of HIV, either from high risk behaviour or exposure)
I – Immune (weakens the immune system)
D – Deficiency (of certain white blood cells -T4 lymphocytes in the immune system)
S – Syndrome (a group of symptoms or illnesses as a result of HIV infection)

How HIV causes AIDS?

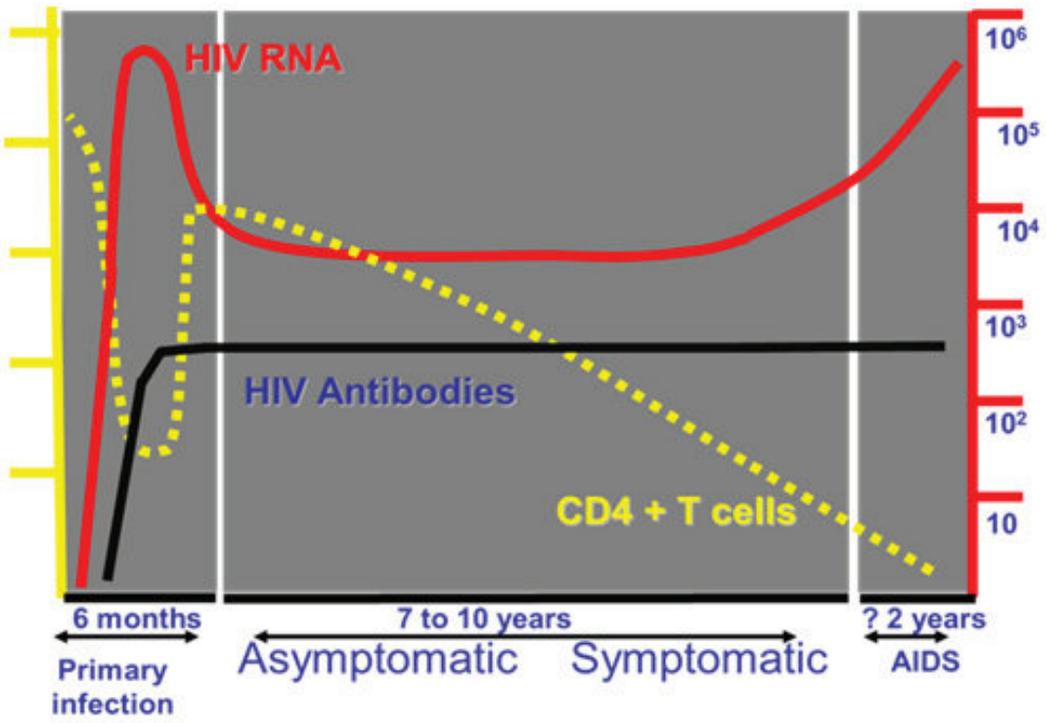
- Viral replication leads to decrease in CD4 cells
- As viral replication continues, there is further impairment of the immune system reducing the body'scapacity to fight infections
- The individual becomes more susceptible to opportunistic infections
- AIDS is characterized by the presence of opportunistic infections

Opportunistic Infections (OIs):

HIV attacks the immune system, the body's "security force" that fights off infections. When the immune system breaks down, patient looses this protection and can develop many serious, often deadly infections and cancers. These are called "Opportunistic Infections" (OIs) because they take advantage

of the body's weakened defenses. You have heard it said that someone "died of AIDS." This is not entirely accurate, since it is the opportunistic infections that cause death.

Many people with HIV/AIDS first learn they are HIV infected when they are diagnosed with an OI.



Stages of HIV Disease

Primary HIV Infection	When HIV first enters the body, the immune system" and causes flu-like symptoms. During this time, HIV viral load is high and therefore infected person is highly infectious and can easily transmit virus to others during this time. Common Symptoms: Fever, Rash, Lymphadenopathy, Many may not have any external symptoms or face any ill health
"Window period"	Once body is infected it usually takes 2 to 12 weeks for it to develop HIV antibodies. During this "window period" the person although infected, tests negative for HIV antibodies.The test needs to be repeated after 3 months He/she can still spread infection to others
Asymptomatic Period	Immunity slowly goes down CD4>500. Level of virus is low. Generally lasts 5 years or more.. Usually no other symptoms except . Generalised persistent lymphadenopathy During this time the person may still look healthy

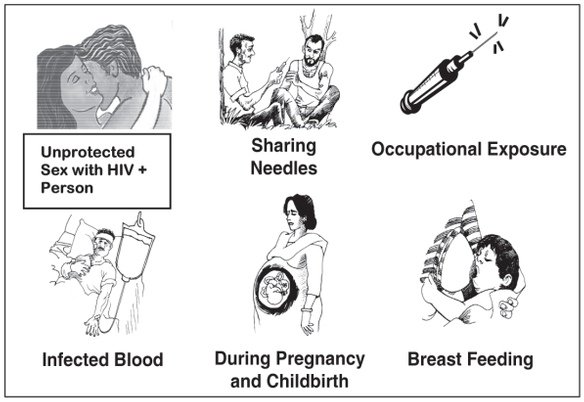
Symptomatic HIV Infection	– Immunity starts falling quite fast.CD4 between 200-500. Infections like TB,Oral Candidiasis,Herpes,Pneumocytis Carini etc. start and persist as CD4 count decreases. ART and OI prophylaxis considered
Advanced HIV Infection/AIDS	Very low level of immunity.– CD4<200. Case definition of AIDS is having a CD4 count of <200. OIs develop

What is the difference between HIV and AIDS?

- HIV is a virus and AIDS is a disease
- AIDS is deficiency in the body's defence mechanism or immune system
- AIDS is acquired, not hereditary
- HIV infection leads to AIDS, depending on the body's defence mechanism

HIV Transmission

How is HIV Transmitted?



Contaminated Blood, Semen, Breast milk, Vaginal secretions Infected Internal bodily fluids & Other fluids contaminated with visible blood

How HIV is NOT transmitted

Body fluid considered *"not at risk" exposure* *(*Unless contaminated with visible blood)

- Tears
- Sweat
- Urine and faeces
- Saliva

HIV **cannot** be transmitted by:

- Kissing
- Hugging
- Swimming in the same pool/pond
- Sharing cooking utensils, same toilet, clothing and bed linen
- Cooking/Eating food cooked by a PLHIV
- Having daily contact with PLHIV
- Insect bites

Women & HIV Infection

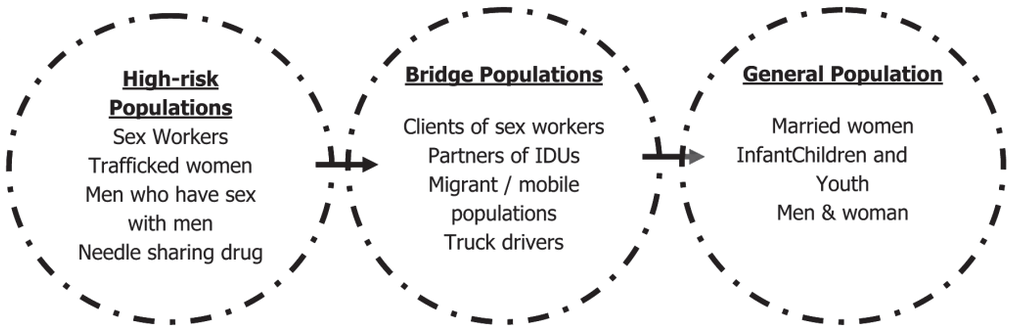
Women at higher risk for HIV infection because

- The internal reproductive organs,in women are such that a large amount of mucosal surface is exposed during sexual intercourse
- Women are the "Receiving Partner" and therefore semen gets collected during sexual intercourse
- Women are especially vulnerable to HIV through sexual contact:
  - When they are young – because of an immature Reproductive organs
  - When they have STIs/RTIs
  - When they undergo menopause leading to fragile vaginal tract
- Women are not able to encourage their spouses/partners to use condoms
- Women often face sexual abuse (i.e. rape/forced sex/Trafficking etc.)
- They are also at risk if they are in relationships with partners who use drugs through needle exchange or are alcoholics
- Due to lack of independence, women are not able to get access to information/treatment for STIs/RTIs/HIV infection
- Women still bear the major responsibility of caring for sick at home, including HIV infected men folk, while they themselves might be sick or HIV infected

Socioeconomic factors that affect HIV transmission

Initially, HIV infection in India was largely observed in high-risk populations: Sex Workers, Trafficked Women, or men having Sex with Men. (MSM) and Injection Drug Users. (IDUs). But HIV today is no longerfound in, any particular group. It has reached the general population - which includes married women, babies and children, youth, and men who have never had any high-risk behaviour.

Infected individuals can transmit HIV infection through unsafe contact (e.g. unprotected sex(having sex without using condoms), needle sharing etc.) to individuals who belong to the "bridge population". Once a member of the bridge population (e.g. truck drivers, clients of sex workers, migrants, etc.) gets back to their home, they can infect their wives/partners, who in turn can transmit infection to on their babies.



Although HIV infection is coming down in many parts of the country,its rate of incidence among group of people practicing high risk behavior (Commercial Sex Workers-CSWs/Men Having Sex With Men-MSMs/Injecting Drug User-IDUs),still is a matter of concern.

Sexually transmitted infections (STIs) / Reproductive Tract Infections (RTIs) and HIV/AIDS

Sexually transmitted infections (STIs)

- Infections that spread from person to person during sexual contact
- More than 50% of people with an STI do not present with any major sign or symptom that could make them suspect they have an infection
- Referred to as Sexually Transmitted Diseases(STDs) previously

Reproductive tract infections (RTIs)

- Infections of the reproductive tract that occur due to:
  - Poor personal hygiene
  - Poor Asepsis at the Health facilities (Lack of conditions in which no disease causing organisms are present)

Link between Sexually Transmitted Infections (STIs) & HIV Transmission

- A person with a STI has a higher risk (2-8 times more) of getting HIV
- Treatment of STI could reduce risk of sexual transmission of HIV as the treatment of STIs is fairly simple. So it is extremely important that ANMs recognize them early and refer patients to STI clinics for diagnosis and treatment
- Prevention strategies for HIV and STIs are the same. ANMs should take time to educate patients about these Strategies (e.g. condom use)

Indian Scenario

- It is estimated that the prevalence of symptoms suggestive of STI/RTI in women was in the range of 23% to 43%, while in men, it is in the range of 4% to 9%.
- Awareness of STI/RTI in men is 53% while in women is only 44%.

Factors Affecting STI Transmission

It is important for ANMs to understand the factors affecting STI transmission so that they can provide appropriate support/make referrals and linkages to other organizations.

Biological	Behavioral	Social
• Age- younger more vulnerable • Gender- women more prone to infection than men • Immune status	• Personal sexual behaviors – unprotected sex with multiple partners • Other behaviors associated with risk-alcohol and/or substance use predisposing to high risk behavior • Partner's behavior – multiple partners, injecting drug user	• Lower status of women in most societies • Men's reluctance to use condoms • Sexual violence • Limited access to health care facilities • Lack of knowledge of STIs

Women are more prone to getting STIs compared to men because:

- Women are the receptive partners during sexual encounters which makes it easier for organisms to enter their bodies
- Large amount of mucosal surface area in vagina, which stays in contact with sperm/semen for longer duration of time
- Women may have STIs and not even know it because: They have internal reproductive organs, which makes it difficult for them to inspect themselves and detect if they have a problem
- Woman may not have the privacy required to examine herself (such as a toilet or bathroom)
- More than 50% of STIs in women are asymptomatic
- Symptoms, e.g. white discharge, may be considered natural and therefore ignored

Common Signs & Symptoms of STIs

ANMs should recognize and observe patients for common signs and symptoms of STIs to facilitate early treatment.

Males	Females
Ulcers / sores	Ulcers/sores
Urethral Discharges	Vaginal discharge
Swellings/growths – warts (groin/scrotum)	Swellings/growths-warts (groin/labia)
Pain / burning when passing urine	Burning when passing urine
	Pain (low abdominal/back ache)

HIV Diagnosis

Who Should Undergo HIV Testing?

- Any person who wants to be tested (voluntary)
- All pregnant women and women considering pregnancy
- Those with high risk behaviours (e.g. Mutiple partners, sexual/drug abuse etc.)
- Men who have Sex with Men–MSMs
- Persons with multiple sexual partners or who trade sex for money, pleasure or drugs
- Sexual partners of people who have high risk behaviors
- Injecting drug users (IDUs) and their partners
- Recipients and donors of blood, organs and semen
- Persons with Sexually Transmitted Infections (STIs)
- Hepatitis B & Hepatitis C
- Tuberculosis infected persons

- Persons with AIDS like illness or illness consistent with AIDS
- Infants born to HIV infected or high risk mothers

HIV Testing

There are two types of tests which are used to diagnose HIV infection. They are :

– HIV Antibody tests
– HIV Antigen Tests

Antibody: A substance that is produced by the immune system to help the body fight infection and foreign substances.

HIV Antibody Tests are:

- Most commonly used tests for diagnosis (age > 18 months)
- Economical
- Rapid
- Can be performed easily in most laboratories

Three tests are done before declaring whether a person is HIV positive or negative. In case of indeterminate results or if the person is in the window period, the person is advised to return for HIV testing again after a period of 3 months and is counseled to stay HIV negative

They are:
- HIV Rapid test
- ELISA
- Western Blot Test (Confirmatory Test)

Antigen: Any substance that stimulates the immune system to produce antibodies (i.e. proteins that fight antigens).

HIV Antigen Tests

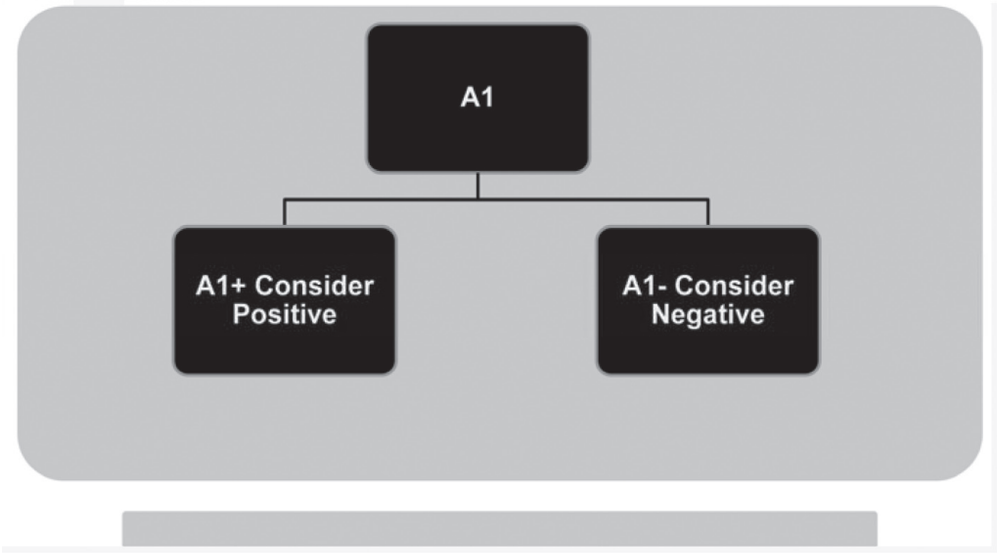
- Detect HIV sooner than antibody test
- Usually used for
  - Diagnosis: age < 18 months
  - Monitoring HIV disease progression
  - Monitoring response to ARV therapy
- Expensive
- Require expertise to perform and interpret

They are:

- DNA PCR
- P24 Antigen

HIV Rapid Test is a highly sensitive, most easy and commonly performed test, used for initial screening of HIV infection. It can easily be performed at Sub Centres/Primary Health centres by the ANMs.

This test is based on the NACO Testing Strategy I where, if the test result is negative, the sample is considered Negative for HIV infection. But if the result is positive, the sample is considered positive for HIV infection and the client is referred to ICTC for counseling, testing and confirmation of test results.



Please refer Annexure 1 for more on HIV Rapid Test

AntiRetroViral Therapy (ART)

HIV antiretroviral treatment is the main type of treatment for HIV or AIDS. It is not a cure, but it can stop people from becoming ill for many years and increase the body's ability to fight disease by keeping the levels of HIV, low in the blood.

It helps both the adults and children in managing the HIV infection.

The drugs are often referred to as:

ART – Anti Retroviral Therapy
ARVs – Anti Retro Virals
HAART – Highly Active Anti Retroviral Therapy

} ***These terms are all used interchangeably!***

For antiretroviral treatment to be effective for a long time, it has been found that you need to take more than one antiretroviral drug at a time. This is what is known as Combination Therapy, also known as **Highly Active AntiRetroViral Therapy (HAART).**

ART is available at various ART/Link ART Centres across the country where PLHIV are referred by ICTCs.

Goals of AntiRetroViral Therapy(ART)

- To help the PLHIV to have a longer and better quality of life

- To reduce the level of HIV in the blood as long as possible
- To increase the level of CD4 count & immunity of the PLHIV
- To reduce the chances of HIV transmission from one person to another
- To decrease the need to get admitted in the hospital

ARVs transform HIV infection from a terminal (fatal) disease to a "chronic" disease.

b) **Benefits of ART**

- Treats existing Opportunistic Infections (OIs)
- Decreases hospitalizations by treating OIs
- Increases survival
- Restores hope
- Improves quality of life
- Reduces HIV transmission
- Benefits both adults and children

c) **Limitations of ART**

Although ART dramatically improves the health and life expectancy for PLHIV

- ART is not a cure for AIDS
- HIV is never entirely eliminated from the body
- HIV can still be transmitted to others, even when the PLHIV is healthy and taking his/her medication regularly
- ART is to be taken life long

Common ARV Drugs

Zidovudine (AZT, ZDV)
Lamivudine (3TC)
Stavudine (d4T)

Efavirenz (EFZ)
Nevirapine (NVP)

ARVs must be given in a 3-drug combination.

- This combination is referred to as the ARV regimen – also known as a drug cocktail
- Giving only 1 or 2 ARVs to treat HIV disease is incorrect & leads to resistance of drugs

Starting ART :

a) Factors to consider when starting ART

There are many factors that affect how a person will do on ART, and all of these need to be considered carefully before starting ART. Some of the important factors are :

- whether the PLHIV is eligible for it, based on CD4 count levels
- What is the general health condition of the PLHIV and stage of infection
- ART has many side effects and requires proper management
- PLHIV (and the family) have to be mentally ready to take ART life long, cope with its side effects; should be able to visit ART /Link ART Centre on regular basis

Starting antiretroviral medication is not an emergency!!

Common side effects of ART are:

Headache, Nausea & vomiting, skin rash , diarrhoea, fatigue, anaemia etc.

ANM should educate the PLHIV and their families about :

- Benefits & limitations of ART
- It should ALWAYS be taken as a 3 drug combination
- Never to miss dose of ART (AT LEAST NOT MORE THAN 3 doses in a month)
- If ART doses are missed, they no longer would be effective in keeping the infection under control
- ART should NEVER be shared among the PLHIV
- Side effects of ART; & that they are temporary
- Seek medical help,in case they are serious
- Not to stop ART, WITHOUT discussing with the Medical Officer

Key Messages :

- ☛ HIV is a virus that destroys the immune system
- ☛ It uses the CD4 cells for its replication
- ☛ AIDS is the end-stage of HIV infection
- ☛ HIV is transmitted through
  - Unprotected sexual contact with a HIV+ person
  - Transfusion of infected blood/blood products
  - Sharing needles
  - Infected mother to child during pregnancy, child birth and breast feeding
- ☛ Women are at greater risk of acquiring HIV/ STIs due to various biological and social factors
- ☛ A person with a STI has a higher risk of getting HIV through sex than a person without an STI
- ☛ Accurate knowledge of HIV disease progression will enable the ANMs to:
  - Recognize a person with a possible HIV infection
  - Refer people at risk for HIV infection for HIV testing
  - Educate and counsel patients and families on:
    - The importance of early testing and diagnosis
    - What the patient can expect
    - A healthy lifestyle
    - The importance of taking ART according to doctor's instructions
    - Prevention of HIV transmission

UNIT 3 – STIGMA AND DISCRIMINATION: LEGAL & ETHICAL ISSUES ON HIV/AIDS

Unit Objectives

- ☛ Define HIV/AIDS-related stigma and discrimination
- ☛ Discuss the causes and consequences of HIV-related Stigma & discrimination
- ☛ Identify ways to address stigma and discrimination in the context of providing HIV care
- ☛ How to handle dilemma causing situations appropriately
- ☛ Understand the legal and ethical issues that relate to PLHIV
- ☛ Identify ANMs' role in reducing stigma and discrimination

Introduction

Stigma and discrimination are major "road blocks" to universal access to HIV prevention, treatment care and support. These are present throughout society: within individuals, families and communities ANMs play a key role in reducing stigma and discrimination.

Defining HIV related stigma and discrimination

Stigma refers to negative attitudes and beliefs directed toward someone or something.

Discrimination refers to an act or behaviour, the treatment of an individual or group with partiality or prejudice.

Examples of discrimination

- A person with HIV is denied medical services/kept in isolation/labeled by a healthcare worker
- An individual loses his job because it becomes known that he/she is HIV-infected
- A person finds it difficult to get a job once it is revealed that he/she is HIV-infected
- A woman who decides not to breastfeed is assumed to be HIV-infected and is rejected by her community
- Rejection by the society e.g. a Positive woman being thrown out by her In laws

What are the causes of stigma & discrimination?

- Moral judgments about people and assumptions about their sexual behavior
- Associations with 'illicit' sex and/or drugs

- Links with religion and the belief that AIDS is a punishment from God
- No training of managing HIV (Healthcare staff)
- Lack of information (including myths) regarding HIV/AIDS
- Fear of the unknown (Fear of contracting the virus & fear of dying)

What is the the impact of stigma & discrimination on the PLHIV and their families?

- Mental and Psychological Disturbance
- Stigma and discrimination can be perceived as "seriously as the illness itself"
- If PLHIV disclose their HIV status or seek treatment, they are likely to face stigma and discrimination, like
  - Abandonment by their spouses and or family members
  - Denial of Care, Support & Treatment by health-care services
  - Difficulty in getting, or loss of jobs
  - Denial of admissions to schools/colleges or expulsion from schools/ colleges
  - Violence
  - Rejection, isolation and depression
  - Denial of insurance viz. medical and others
  - Denial of property rights
  - In Prevention of Parent to Child Transmission (PPTCT) Programmes, it discourages pregnant women from:
    - ✓ Using antenatal care services and accept PPTCT interventions
    - ✓ Following PPTCT safer infant-feeding practices (Replacement feeding or early cessation of breastfeeding)
    - ✓ Follow up of mother- baby pair for testing & treatment

How can we reduce from stigma and discrimination in the health care set up?

Identify and recognize stigma

- We must look at how our own behavior/attitudes/ beliefs that lead to stigmatizing certain individuals based on their HIV-status or their perceived HIV status
- In a health care setting:
  - Accept responsibility for challenging stigma & discrimination
  - Avoid non-verbal communication that shows disrespect and disgust (e.g. Inappropriate facial expressions)
- In community
  - Educate general population regarding HIV/AIDS; its transmission, prevention, and ART, regarding the impact of stigma & discrimination on PLHIV and their families
  - Teach PLHIV regarding positive living and link them to support groups; encourage them and their families to fight stigma & discrimination

- Provide psychosocial support to PLHIV and their families
- Involve PLHIV and their families in plan of care and support services

5. Introduction to Legal & Ethical Aspects

Awareness on legal and ethical issues that relate to PLHIV, could help you take care of such persons more effectively.

Protect, respect, and fulfill human rights in relation to HIV

- All children,women and men, irrespective of their HIV status, have a right to have access to information and services that allow them to protect their own and their family's health
- They have the right to access to HIV/AIDS counseling and testing to know their HIV status
- They have a right to choose not to be tested or to choose not to be told the result of an HIV test
- Women have a right to make decisions about having children/infant feeding, on the basis of full information, and to receive support for the course of action they choose

6. Legal Issues Related to HIV

- According to Drugs and Cosmetic Rules-1993, blood and blood products MUST be tested for HIV (and other Infectious diseases) before transfusion
- According to Right to privacy of a person- Article 21 of the Constitution of India, every individual has a fundamental right to receive medical treatment
- According to Bio-medical Waste Management Regulations (1998)- Any institution producing bio medical waste MUST take all steps to ensure-that such waste is handled without any harm to the human health and the environment
- According to Organ Donation ACT (1994)- Appropriate medical tests of the organ donor MUST be conducted before the actual transplant process
- According to Artificial Insemination Human Act 1995, person MUST be tested for HIV, before the procedure
- Consumer Protection Act (1986) – Ensures the protection of consumers against medical malpractices
- Medical practitioners have the responsibility to diagnose, treat, counsel the patients and no patient can be denied care and treatment on the basis of their HIV positive status

Legal Action can be taken ,in the case of negligence,which could lead to cancellation of the practice

- HIV Positive people
  - Have Right to inherit property
  - Have Right to have custody of children
  - Cannot be terminated from job

7. Ethical Issues

There are certain important ethical principles which ANMs need to follow, while caring for HIV infected patients. These are:

HIV testing and screening

- Screening for Safe blood supply is allowed
- Screening for Sero Prevalence study: This is unlinked anonymous screening that helps to collect quantitative data to understand whether the epidemic is worsening or under control
- Counseling and informed consent are essential requirements of HIV testing
- No individual should be made to undergo mandatory (compulsory) testing for HIV, even as a precondition for employment or for seeking medical treatment
- In India ALL antenatal mothers are provided counseling to get tested for HIV. They can only be tested after they have given voluntary informed consent
- HIV Test Results should be kept strictly confidential
- Provider Initiated Counseling is done for persons having following conditions
  - STI
  - TB
  - Chronic diarrhea
  - Weight loss
  - Chronic fever
  - Chronic cough
  - Herpes Zoster
  - Oral Candidiasis
  - Recurrent oral ulcers and
  - Lymphadenopathy
  - Pregnant women

Privacy & Confidentiality

- Health care Providers (ANMs /Staff Nurses/Doctors/Laboratory Technicians etc.) should protect patient confidentiality, including the HIV test results
- Maintain anonymity (not to be able to link to information about one person to the same person)
- Treating health care team should have access to his HIV status. PLHIV informed to whom Health Care Providers (HCPs) will reveal their HIV status and what the benefits of doing so will be. Thishas to done with the consent of PLHIV (i.e. Shared Confidentiality)
- PLHIV/ IDUs must be counseled on the need for disclosure to the sexual or Needle sharing partner/ Spouse/family/any other important person identified by PLHIV as it will facilitate Partner Testing and Home Based Care
- After repeated counseling, if a PLHIV still does not agree to disclose HIV status to the sexual partners/Spouse, the ANM should refer him/her to her immediate Supervisor

- Identification of HIV status should not be marked on the person's medical record
- It is mandatory for Health Care facilities to Report the status of Notifiable Diseases to health authorities as per prescribed government format

HIV and pregnancy

- HIV-positive women and couples should have complete choice in making decisions regarding pregnancy and childbirth
- The risk involved of getting re-infected and also with a different strain of HIV during sexual contact is high and the couple must be counseled when they plan to have a child
- Couples should be counseled for prevention of Parent to Child HIV Transmission
- Educate on the following aspects:
  - Risks of HIV transmission to the baby
  - Preventive services available to reduce risk of transmission under the PPTCT programme
  - Possibility of adoption
  - consequences of having their own child
  - Various Family planning options,especially the need to practice safe sex i.e. the use of condoms in order to prevent re-infection with HIV

Responsibilities of PLHIV

Educate the PLHIV on his/her responsibilities to : -

- To preserve human life
- Not to infect others deliberately with any disease dangerous to life. According to Supreme Court Ruling it is a punishable offence with imprisonment for a term which may extend to two years, or with fine, or with both"
- To inform their sexual partners about their HIV Status
- To take steps, while they are able, to contribute to family and community

Key Messages :

☛ Stigma and discrimination are evident by the following
  - Treating people differently
  - Naming/labeling a person as HIV positive
  - Placing a sticker on the bed to show that the person is HIV seropositive

☛ Stigma and discrimination discourages
  - People coming forward for HIV testing
  - People from disclosing their HIV status to their partners, leading to spread of HIV

- PLHIV from accessing services – treatment for OIs/STIs/RTIs or ART
- People from caring for PLHIV

☛ ANMs can reduce stigma in the health care setting by:

- Identifying stigma in health settings by staff, doctors & try reducing it as much as possible
- Speaking up on the rights of PLHIV
- Educating all health care personnel other co-workers (ASHAs, Outreach Workers etc) on HIV causes, transmission and prevention
- Training all health care personnel on infection control measures
- Educating the public about HIV, its causes, transmission, prevention and management
- Taking measures to ensure confidentiality of the PLHIV

☛ The fundamental rights of PLHIV need to be respected by

- Providing counseling and obtaining informed consent for HIV testing
- Protecting patient confidentiality
- Encouraging disclosure of HIV status to partner/ family
- Counseling couples for prevention of parent to child HIV transmission
- Providing quality care and treatment

☛ HIV positive persons have a right to live with the same dignity as others

☛ ANMs could play a vital role by referring PLHIV to appropriate Support Groups/NGOs to solve their legal and ethical issues

UNIT 4 – COUNSELING IN HIV/AIDS CARE

Unit Objectives

- ☛ Describe the key elements of Counseling
- ☛ Describes areas of Counseling related to HIV infection
- ☛ Discuss the importance of Counseling in context of HIV
- ☛ Discuss the various types of HIV counseling
- ☛ Learn the Counseling skills through role-plays with simulated cases
- ☛ Describe roles & responsibilities of ANMs when Counseling PLHIV & their families and people at risk of acquiring HIV infection

1. HIV and Counseling

Counseling services are one of the most important services provide for the PLHIV and their families under the HIV program.

At the grass root levels, ANMs have a significant role to play in helping the positive people the as well as people at risk,to prevent & manage the HIV infection,in an effective manner, by providing counseling.

2. What is Counseling?

Counseling is a dialogue between the client and Care provider aimed at enabling him/her to cope with stress and make personal decisions e.g. decisions relating to HIV/AIDS- undergoing HIV testing; sharing the positive test results with family; having children etc. The process involves identification of the problemsof client, gaining understanding, knowledge and skills to cope with the problem and ultimately, behavior change leading to positive living.

ANMs can provide counseling in the following areas related to HIV:

Medical Areas	**Relationships**
Basic HIV/AIDS Knowledge Transmission & Prevention of HIV infection Symptoms of HIV Infection HIV Infection & Pregnancy Adhering to ART regimen Positive Living	Sexual Family & Friends Keeping Others safe from HIV infection
Personal	**Practical issues**
Fear, Anxiety & Depression Isolation & Rejection	Referrals & Networking

Different Counseling Settings their Target Group and Main Counseling Goals:

Counseling Setting		Target Group	Main Counseling Goal
ICTC (Voluntary Clients)	**Pre test**	General population, voluntary & referred	• Decision re. HIV testing • Risk reduction
	Post test negative	HIV negative clients	• Risk Reduction & prevention, • Partner testing
	Post test positive	HIV positive clients	• Psychological support • Risk Reduction • Disclosure & partner testing • Positive Prevention • Referral to care, support & treatment
PICT (Provider Initiative Counseling and Testing) (eg: Pregnant women)	Pre test	– Persons having symptoms of HIV infection/STI/TB – Pregnant women (ANC attendees) – Unbooked cases at Emergency Labor Room	• Education about HIV Infection & Testing • Decision re. HIV testing • Education about Nutrition, Hygiene • Importance of institutional Delivery • Risk reduction • Opt-Out option
	Post test negative	HIV negative mothers	• Prevention • Safe motherhood • Regular Follow up
	Post test positive	HIV positive mothers	• Psychological support • Safe motherhood • Nevirapine prophylaxis • Institutional Delivery options • Infant feeding practices • Referral to care & treatment • Regular Follow up
ART		PLHIV on ART	• Treatment preparedness • Treatment adherence • Treatment support

Provider Initiated Counseling (Opt Out)

Clients are Referred by Health Care Providers to the ICTC where they are given basic information on HIV and are educated about HIV testing & are informed about the advantages of being tested.

The Counseling personnel, then make a routine offer of HIV testing and are the client: – Do you wish to be tested for HIV or not?

The client has a right to accept or to refuse testing and – **Opt Out**.

If the client agrees, he/ she are tested for HIV. Testing is followed by Post-test Counseling.

Client Initiated Counseling (Opt In)

Clients who visit themselves the ICTC of their free will and want to be tested.They are counseled for HIV testing and then they agree or **"Opt In"** for it.

3. How is Client Education different from Counseling?

Client Education	Counseling
Assesses understanding of health related information	Includes client education
Gives valuable information about disease and treatment	Helps PLHIV identify feelings, risk behaviours, readiness to change behaviour etc.
Facilitates confidence in self care	Guides PLHIV to establish a plan
	Facilitates clear thinking and decision making

4. How to be a effective Counselor

In order to be effective counsellors, we need to put into practice effective communication. As HIV infection has many implications on the physical, emotional, social, and spiritual well being of a person, this communication needs to occur within a supportive environment.

The components of Effective Communication are:

Message

- Be positive & focused
- Make the listener comfortable
- Ask for a feedback
- Emphasize important points
- Use positive statements
- Appreciate and encourage positive behavior/action

Listening/Non verbal communication

- Maintain eye contact and smile
- Lean toward the person, say “yes” “hmm” and “OK”
- Do not hesitate to touch the person when needed

Tone

- Use a soft tone of voice that encourages the client to talk about his/her problems
- Utilize praise and encouragement more

Questioning technique

- Ask questions in a manner, which encourages the client to provide more information about the problems
- Wait for answers rather than speaking immediately
- Repeat questions when not understood

Using positive messages while communicating with PLHIV is more effective than using negative messages. When giving messages, always try and frame them so that they are positive rather than negative.

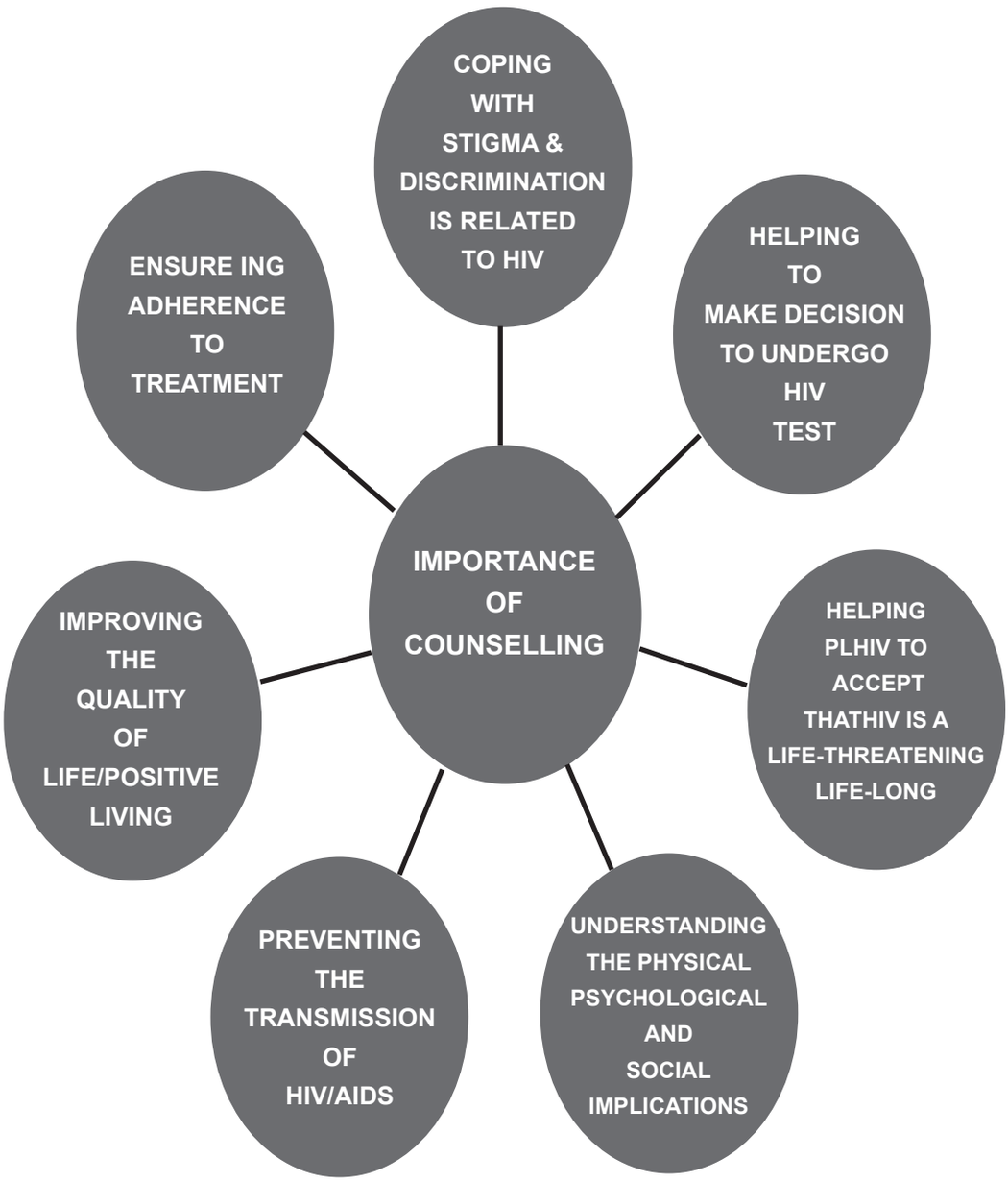
Examples of "Positive" and "Negative" messages

Positive Messages	Negative Messages
Using condoms will help you be free of STIs	Not using condoms could put you at risk of getting STIs
Safe sex practices will help protect yourself as well as protect others	If you do not practice safe sex, you could get an STI and you could transmit HIV to others
Taking your ART exactly as prescribed every day will prevent you from developing resistance to the medications and keep you healthy for a longer period of time	If you do not take your ART exactly as prescribed every day, you will get resistance to HIV, and the medications will not work for you

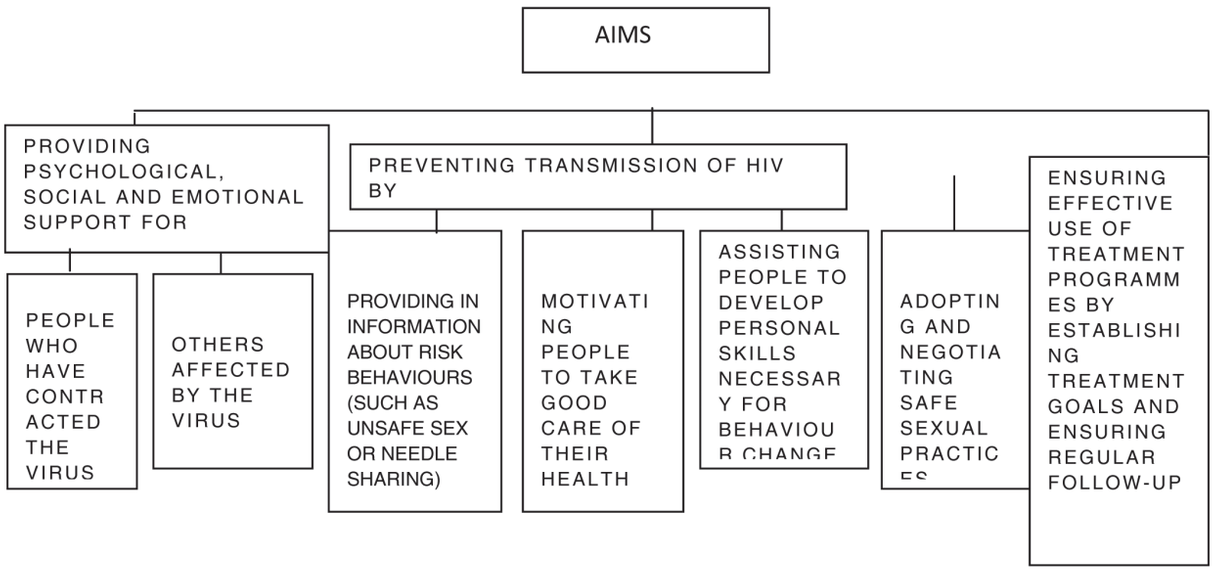
Other Important things to remember are:

- Be sure client is ready for the information and Counseling
- Schedule at a convenient time for the client
- Ensure privacy and comfort
- Assess and address the main concerns of the client, based on his/her need
- Start with topics that the client is comfortable discussing, e.g. his/her work rather than the sexual history
- Provide support to have a positive attitude
- Help to identify risk behaviors i.e behaviors that increase the chances of transmission/retransmission of HIV and reasons due to which client is not able to change thenegative behavior
- Link to the resources which can help to bring positive behavior change
- Assist/support individuals during the process of behavior change

5. In context of HIV Care Counseling can Help in the following manner:



Aims of Counseling in HIV care



Types of HIV Counseling

1. **Pre Screening, Post Screening & Follow up (at FICTCs)**
2. **Pre & Post Test Counselling (at ICTCs)**
3. **PPTCT Counseling**
4. **Family & Relationship Counseling**
5. **Adherence Counseling**
6. **Crisis Counseling**
7. **On going Counseling**

1. Pre Screening/Post Screening & Follow Up Counseling

(a) Pre Screening Counseling

Based on the history taken of the client ANM can identify the behaviors(having multiple partners/ injecting drugs etc.) that put the client under the risk of getting HIV infection.Further he/she is counseled to undergo HIV testing. Informed Consent is taken from the client after explaining about the HIV test and its benefits.The client is also given an option of not taking the test,if he/she is not ready for it (Opt Out). The client is also assured that his/her results would be kept confidential

This counselling also includes discussing the fear/reluctance which the client/family, may be having regarding taking the HIV test.

It is also important to provide education on the modes of transmission of HIV infection and counselling on safe sex (correct & consistent use of condoms) and maintaining healthy life style.

(b) Post Screening Counseling

If the result of Screening test is positive,the client is counselled to undergo Confirmatory test and referral to near by ICTC is provided.It is also important to provide support to the client and address his/her fear/anxiety.

In case of negative results, the client is explained about Window Period and counseled to undergo HIV test after the Window Period.

and He/she is also encouraged to continue following safe sex and other precautions.

(c) Follow Up Counseling

ANM must conduct a Follow up of cases,during her home visits,which were referred for Confirmatory HIV testing. If the client has not done so,he/she will need more counselling and encourage to go for it as soon as possible.

In cases, where the client has undergone testing, the ANM must counsel the client to follow the instructions provided by the ICTC counselor and do repeat visits,as and when required.

2. Pre & Post test Counseling

Pre Test Counseling

The client is provided information on the purpose of testing,its procedure and meaning of the test results. Informed Consent if taken from the him/her before administering the test.The client is also assured that his/her results would be kept confidential.

Post test Counseling

In case of positive results,the client is informed about his/her HIV status and provided emotional support;informed regarding the care & treatment services;encouraged to get the partner/spouse for testing.

In case of negative results, the concept of Window Period is explained and the risk of infection.The Counselor stresses on the importance of safe sex and leading healthy life style.

3. PPTCT Counseling

PPTCT counseling can benefit pregnant women or women wanting to become pregnant who are either HIV-positive or unaware of their HIV status. It consists of promoting safer and responsible sexual behaviours which include, where appropriate, delaying the onset of sexual activity, practising sexual abstinence, reducing the number of sexual partners and using condoms. Secondly, it helps women to make an informed decision about whether to become pregnant; if HIV-infected whether to take a test before pregnancy; and, if pregnant, whether to terminate the pregnancy, where abortion is legally available.

For those already pregnant, counseling can also help to reduce the risk of transmitting HIV to the unborn child, and breastfeeding and other infant feeding options. Where possible, and when the woman agrees, it is advantageous to involve the father in the counseling sessions.

The strategies here include condom provision, early diagnosis and treatment of STIs/RTIs, HIV counseling and testing, and suitable counseling for the uninfected so that they remain HIV negative.

4. Family & Relationship Counseling

This counseling aims at providing Supportive counseling to the PLHIV and their families according to their needs and problems(e.g.sharing their HIV status with family; facing stigma & discrimination in the family/society etc).and encouraging them to follow positive life style,safe sex practices,regularly visiting the STI Clinic/DOTS Centre/ICTC/ART Centre for treatment /Follow up.

ANM also guides PLHIV and their families about the disease management and helping them to have a positive outlook.

5. Adherence Counseling

Adherence Counseling is done at the ART/Link ART Centre and it aims to improve the PLHIV's regular and timely following of the ART regimen for the maximum treatment benefit. It consists of providing knowledge of the treatment regimen, knowledge of side effects and ways to manage side effects.

It also helps the client to assesses the problems due to which the client is not able to take ART in the prescribed manner, discuss ways to solve the same.

6. Initial Counseling in Crisis Situations

The time of diagnosis of HIV could be a crisis for any person. Some possible reactions to an HIV positive result are shock, anger, denial, disbelief, guilt, blame, depression, suicide etc.

How can ANM help

- Assessing the situation and helping the family to deal with any urgent issue/emotion
- Ensuring the safety of PLHIV and the family
- Referring them to the possible source (s) of support, that can help them out of the current crisis e.g. Local Self Help Groups/NGOs/ Hospital/ District Mental Health Program(incase a PLHIV is suicidal) etc.

7. On-going Counseling

Goals:

To provide support for the PLHIV with regards to

- Improve the capacity to cope with HIV infection
- Reduction of risk for re-infection
- Reduction of risk for transmission to others
- Prevention or treatment of OIs/STIs/RTIs
- Improve nutrition(Nutrition Counseling)
- Encouraging the PLHIV to follow ART regimen
- Positive living

Client and family may require ongoing counselling any time during the course of the disease progression.

Key Messages :

- ☛ Maintain confidentiality
- ☛ Develop a relationship of trust
- ☛ Be sensitive to patient & family needs
- ☛ Make a plan for counseling from the point of screening of HIV infection
- ☛ Prioritize needs as per the client's/PLHIVs needs and the situation
- ☛ Counsel on one aspect at a time
- ☛ Never miss an opportunity to counsel a person with risk behaviors/positive results
- ☛ Take an interest to learn about new trends to counsel clients appropriately
- ☛ Be aware of the significance of counseling in reducing stigma and disease transmission
- ☛ Be aware of local services for referral
- ☛ Update oneself on counseling issues
- ☛ Counselling helps PLHIV/people at risk learn to deal with the problems of the daily living
- ☛ Equips them to reach their self-determined goals through meaningful, well-informed choices, and through the resolution of emotional or interpersonal problems
- ☛ Aims to help PLHIV in leading a meaningful & satisfying life

UNIT 5 – PREVENTION OF HIV TRANSMISSION

Unit Objectives

- ☛ Describe primary and secondary HIV prevention
- ☛ Explain HIV prevention programmes under NACP
- ☛ Discuss various HIV prevention interventions with regards to:
  - ABC Approach & Safe Sex
  - Drug use
  - Blood management
  - Awareness Campaigns
  - Traditional practices
  - Prevention for Positives

1. Prevention of HIV

Prevention is the only way to stop HIV transmission. Looking at the magnitude of the problem, 34 million people living with HIV worldwide and approximately 23.9 Lakhs PLHIV are in India. (NACO 2010)

ANMs are in an ideal position to educate patients, families and communities about HIV and how to prevent it.

"THERE IS NO CURE"

Primary and Secondary Prevention

Primary Prevention: targets people at risk for HIV to ***prevent acquiring the infection***

Examples : Safe Sex, Use of safe blood, free from HIV, not sharing needles)

Secondary Prevention: targets people known to be HIV infected, to ***prevent spread of the infection to others***

Examples : ***Prevention of transmission of HIV from HIV infected mother to the child; prevention of HIV transmission from HIV positive drug user to his partner)***

HIV Prevention Programmes Under National Aids Control Programme (NACP)

The NACP III (2007 – 2012) programme's overall objective is to reduce the spread of HIV infection, and to strengthen the capacity of central and state governments, civil society and private sector to

respond to AIDS on a long term basis. The activities for prevention under NACP include:

- Integrated counselling & Testing Services- e.g.Early detection of HIV Infection ,Counselling & Testing for pregnant women, TB patients, etc.
- Targeted Interventions with Commercial Sex Workers (CSWs), Men Having Sex with Men(MSMs), Injecting Drug Users(IDUs) and Trans genders (e.g.Condom promotion, Harm reduction, provision of STI services, encouraging behavior change etc.)
- Promoting access to safe blood
- Creating awareness about symptoms, spread, prevention, and treatment of HIV/AIDS
- Positive prevention i.e.
  - Promotion of safe sexual practices and Infection control
  - Screening and treatment of STIs and RTIs
  - Prevention of Parent to Child Transmission (PPTCT)
  - Provide Care Support & Treatment (CST) services including HIV/TB co-infection

Creating Awareness under NACP III

Reducing the risk of HIV transmission	Mass media
Outdoor hoardings Reducing the Stigma in society	Local events
Impact mitigation	Interpersonal communication
Demanding for better services for Positive People	Mobile vans/community radio; Innovative methods

HIV Prevention Programs

ABC Approach

It is a comprehensive approach for prevention of HIV transmission. It means:

A Abstinence-Denial of or delaying sexual activity

B Be Faithful-Remaining loyal to one's partner or spouse;not to have causal sex or multiple partners

C Correct & Consistent use of Condoms

Safe Sex

- Safe sex refers to the precautions (e.g. correct & consistent use of condoms) to be taken so as not to transmit or acquire sexually transmitted infections including HIV
- Safe sex practices prevent bodily fluids, which can carry viruses or bacteria, from being transmitted between partners

What is condom?

- A condom is sheath made of latex and is available in a rolled form, packed in a sterile aluminum foil
- Condoms act as a wall and prevent the sperms and STI/HIV causing organisms from entering the vaginal Cavity/penis to cause pregnancy and STI/HIV infection
- The closed lower end of the condom has teat which collects the seminal fluid

When one should use condoms?

- When partners feel that one of them may have ST/HIV infections
- When one partner has more than one sexual partner
- When having casual intercourse
- The partner could either be a male or a female

Benefits of condom use:

- Reduces transmission risk
- Reduces re-infection risk
- Reduces risk of getting other sexually transmitted infections (STIs)
- Prevents unwanted pregnancies

Who should use condoms?

Anyone (even if both partners are HIV+) who wants to protect themselves from

- HIV infection
- Re infection of HIV
- STIs
- Pregnancy

Availability

Free condoms

Free condoms are available at Primary Health Centers (PHCs), Government Hospitals and NGOs

Priced condoms

Priced condoms are available at Medical shops, Provision shops, Grocery, Fancy stores, Supermarkets and even in petty shops

Special Varieties of condoms

Plain, dotted, ribbed ultra thin, plain contoured condoms are available in many colors with different flavors

Brands available in the market

- Kohinoor, Kamasutra, Moods, Durex, Nirodh, Nirodh Delux, Fiesta, Ustad, Sajan, Midnight Cowboy, Spiral etc.

Counsel on safer sex and reducing risk of transmission

- Counsel on partner reduction while emphasizing consistent condom usage during all sexual encounters i.e. vaginal,anal and oral intercourse
- Counsel on less risky sex—choose sexual activities that do not allow semen, vaginal fluid, or blood to enter the mouth, anus or vagina of the partner.(i.e. mutual masturbation)
- Emphasize that even if a client is on ART, HIV transmission can still occur
- Educate on symptoms of STIs and counsel to receive prompt treatment if they suspect a STI
- Remove any prevailing myths on cleansing of HIV infection through sexual intercourse with minors or virgin. Discuss any other local myths that may impact on positive prevention, for example, belief that condoms transmit HIV
- Respond to concerns about sexual function. Encourage questions from clients. Emphasize that normal sexual activity can continue, with above stated precautions
- Help client to decide whether he/she is at risk of HIV transmission and what can be done to prevent /reduce it

Counsel on consistent and correct use of condoms during every sexual encounter

- Educate that it is essential to consistently use condoms even if already infected with HIV or if both partners are HIV positive
- Use condoms for vaginal, anal and oral intercourse
- Demonstrate how to use both male and female condoms
  - Use model to demonstrate correct use
  - Educate to put condom on before penetrative sex, not just before ejaculation
  - Request client to demonstrate correct use of condoms
- Educate on advantages/disadvantages of both male and female condoms
- Advise to use water-based lubricants
- Provide condoms and discuss how client will assure a regular supply of condoms

Some examples of safe sex practices are:

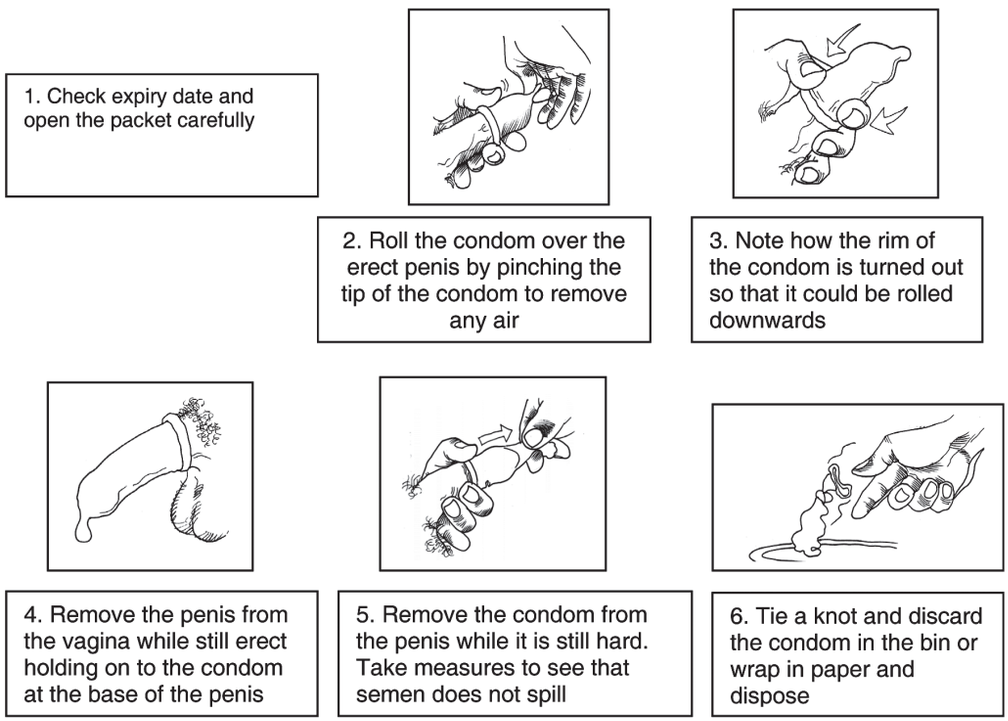
- Avoiding penetrative sex
- Being faithful to one partner/reducing partners
- Regularly being tested and treated for STIs
- Using condoms

- Masturbation
- Mutual masturbation

Steps in male condom use

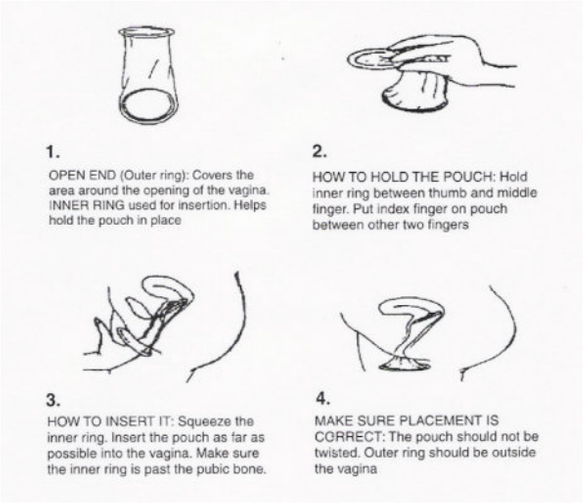
Check the expiry date and make sure condom is not damaged, by

- Reading the date
- If the individual is illiterate, check by moving the condom from side to side and bending it before opening the packet
- Checking if the packet is damaged
- Tear the packet carefully without damaging the condom and remove the condom
- Hold the space at the end of the condom to squeeze out air, and then gently roll it onto the penis model
- Check to make sure there is space at the tip and that the condom is not broken
- Hold the condom at the base of the penis model (This presumed to be during penetration to ensure that the condom does not slip out)
- The condom, should be removed carefully, without spilling the semen,BEFORE the penis gets soft.
- A knot should be tied in the used condom, and it needs to be wrapped in a tissue or newspaper and thrown in a covered dustbin or pit
- **Never Re-use the condom**



Step in Female condom use

- It is used for vaginal sex
- It is advisable to decide on the use of a condom with your partner beforehand as you may forget in the heat of the moment
- Always check the expiry or manufacture date on the condom package to make sure it has not expired
- Make sure it is not more than 4 years old
- Using your fingers, carefully open the condom at the indicated place. Make sure your fingernails do not damage the condom. DO NOT use sharp objects, such a scissors or a razor as they may cut the condom
- Inspect the condom to make sure it is intact
- Rub the outside of the condom to evenly spread the lubricant inside the condom. Add the lubricant as desired
- Find a comfortable position for inserting the condom
- Hold the condom at its closed end. Squeeze the inner ring (the ring at the closed end of the condom) between the thumb and the middle finger with the forefinger between the two
- Spread the vaginal lips with the other hand, and insert the condom in the vagina
- Use your forefinger to push the inner ring all the way up in the vagina until you feel the pubic bone with your finger
- Make sure the outer ring (at the open side of the condom) lies against the outer lips
- Guide and insert the penis inside the condom. Make sure the penis does not go underneath or beside the condom
- If during intercourse the penis does not move freely, there is a sound, or the condom is moving in and out with the penis, add lubricant (to the penis or inside the condom)
- If the outer ring is pushed in the vagina or the penis goes beneath or to the side of the condom, stop and put on a new condom
- Keep the condom on during intercourse. After ejaculation and after the penis is pulled out, squeeze and twist the outer ring to avoid spilling semen and pulling the condom out of the vagina
- Wrap the condom in toilet paper and, as soon as possible, throw it away out of reach of others. Do NOT flush the condom down the toilet



- **NEVER reuse the condom**

ANMs' role

- Counsel on safe sex practices
- Motivate on condom use
- Demonstrate condom use
- Provide condoms to clients
- Clarify doubts and misconception of sexual practices/Refer to higher facilities
- To Counteract Myths Related to Condom Use

Myth	What ANMs could do
Condoms fail to protect us from HIV	Teach that condoms are 95% effective if used consistently and correctly
Condoms break during intercourse	Demonstrate correct condom use Reinforce the Dos and Don'ts of condom use
Use of condoms decreases pleasure	Inform that most condoms come with some lubricant base Discuss use of additional water based lubricant if necessary
Condoms are reusable	Reinforce that a condom can be used only once, and needs to be discarded correctly when the sexual act is over
Using condom during sex is irritating	Not knowing how to use condom Condoms are soft and lubricated Proper use of condom will not cause irritation

Myth	What ANMs could do
Condom is sticky and oily	Sexual intercourse also is sticky due to the vaginal and seminal fluids
Women do not like it	Women may not be aware of benefits of condom usage. They will accept the condom usage once they are convinced about its benefits
The gained erection may be lost	Educate by demonstrating practical tips during condom manoeuvre
Using both male and female	Both male and female condom should not be used condom will provide more protection simultaneously as this can cause condom to break

Harm Reduction (Injecting Drug Users & HIV)

IDUs are the third HRG for which targeted interventions are of critical importance.

HIV is highly transmissible through the sharing of needles and other injection equipment, so it can spread very rapidly within networks of IDUs who share injecting equipment with each other.

Once HIV prevalence is high in the IDU population, it can expand quickly into their sexual networks. Some IDUs are also sex workers, which can quickly link HIV transmission in the IDU networks to transmission in the larger high risk sexual networks.

What ANMs can do in Harm Reduction Strategies

- Abscess Management
- Teach patients NOT to share their needles and syringes
- Inform and encourage participation of needle and Syringe Exchange Programmes; if available,
  - Refer them to Centres from where IDUs can exchange fresh needles and syringes;Oral Substitution Drugs, free of cost
- Refer for rehabilitation – Detoxification Centres

Remember that non- injecting drug use can be just as dangerous in the context of HIV transmission as under the effect of drugs ,IDUs could may indulge in high risk behaviors.

Promoting Access to Safe blood

It is estimated that between 5% and 10% of all HIV infections worldwide have been acquired through transfusion of contaminated blood and blood products.

Ensuring the widespread availability of safe and quality blood is an important part of the National AIDS Prevention and Control Programme.

To prevent the spread of HIV infection, following steps are followed:

Blood units found to be HIV+ve need to be destroyed.

All blood banks follow national guidelines on screening donor blood for transmissible diseases. This includes HIV, Syphilis, Hepatitis B, Hepatitis C, and Malarial Parasite.

If screening at a blood bank reveals HIV positive blood – the blood bank must refer the donor to an ICTC for counselling and testing. The blood banks are not allowed to reveal the status to the donor.

What ANMs can do :

- Promote Voluntary Donation
  - Spread awareness in the community regarding the risk of HIV transmission through HIV infected blood & blood products
- Refer them to ICTC for counseling and testing

Creating Awareness about HIV Prevention through Campaigns:

NACO and State AIDS Control Societies (SACS) run regular campaigns to create awareness not only amongst target populations such as CSWs, MSMs, and IDUs, but also amongst those who are vulnerable to HIV infection, and the general population.

What ANMs can do in Awareness campaigns

- Participate in awareness campaigns
- Create HIV awareness in high risk groups
- Motivate for HIV testing
- Explain available treatment options of HIV i.e, ART therapy, art, mime, SMS
- Educate the general population with HIV awareness

Creating awareness around traditional practices

ANMs can advise patients and communities to practice traditional customs safely by educating them about the need for

- Safe sex and condoms with regards to:
  - Wife sharing/wife inheritance/multiple sex partners/Devdasi
- Use of disposable/sterilized instruments with regards to:
  - Circumcision – ensure that equipment used is sterile
  - Scarification (tattooing): ensure needles are disposable/properly disinfected
  - Skin piercing practices (ears, nose, cheek etc) ensure needles are disposable/properly disinfected.

Positive Prevention

Most prevention strategies, to date, have been targeted at uninfected people to prevent them from becoming infected with HIV. On the other hand a change in the risk behavior of an HIV positive person, is equally important to prevent the spread of HIV.

Strategies for Positive Prevention should aim to support people with HIV to protect their sexual health, to avoid new STIs, to delay HIV/AIDS disease progression and to avoid passing their infection on to others. Strategies for Positive Prevention are not stand alone, but work in combination with one another.

What ANMs can do

ANMs can educate and counsel the PLHIV and their families regarding following aspects of Positive Prevention:

- Counsel on safe sex practices(discussed earlier)
- Healthy life style practices
    1. Food and nutrition-
        - ✓ taking adequate and regular,well cooked meals,in small quantities
        - ✓ Eating Highly nutritious food with right type of fibre
        - ✓ Maintaining fluid intake to maintain hyderation
        - ✓ Avoiding spicy or fried foods, coffee, colas and foods high in fibre to prevent diarrhoea
        - ✓ Qutting alcohol& smoking
        - ✓ Throughly wash fruits and raw vegetables with salt before eating
        - ✓ Drinking safe(boiled) water and storing it properly
        - ✓ Eating foods with stimulate weight gain e.g. It should have high protein, fat and carbohydrate content.

          Examples: Coconut, Full-cream millk Powder, Yoghurt or Sour millk Soya products, Meat, Fish, Chicken, Nuts and Seeds, Dried fruit, Eggs, Beans, Dal, Potatoes, Sweet Potatoes (Shakarkand), Bananas, Tapioca (shimla Aloo), Millet, Sorghum, Oats, Rice Barley, Wheat, Maize etc.
        - ✓ **Avold** sugar and sweets as these increase the risk of dental and/or oral problems.
    2. Oral hygiene
        - ✓ Important to maintain as ART /Anti depressants /Anti blood pressure drugs lead to dry mounth
        - ✓ Limiting the intake of tea, coffee, soft drinks, alcohol etc.
        - ✓ Brushing the teeth regularly with soft brush

3. Personal hygiene
    - ✓ Keeping external genitals clean by washing with gentle soap and water
    - ✓ Changing cloths, especially, underwear at least once in 24 hrs.
    - ✓ Washing hands thoroughly after using toilet
    - ✓ Having bath daily
    - ✓ Maintaining short nails
4. Regular Exercise
    - ✓ Doing simple,light exercise after talking to the doctor
    - ✓ Going for short walks
5. Establish a positive outlook
    - ✓ Accepting the HIV diagnosis
    - ✓ Accepting and following the treatment
    - ✓ Joining some spiritual/religious group or activity
    - ✓ Joining Positive People Network or Support Group

- Educate on HIV disease progression
- Explain OI management and treatment options
- Stress on importance of adherence
- Family planning options
- Regular follow up
- Emphasize on the regular and correct use of condoms
- Explain the harms of reusing the condom (Male & Female)
- Explain the proper method of disposal of used condom (Male & Female)
- Emphasize on the important of using insectside treated bednets to prevent Malaria/Dengue/ Chickunguniya etc.

Key Messages :

- ☛ Provide primary and secondary prevention messages to stop the spread of HIV/AIDS
- ☛ Educate and counsel PLHIV on
  - Safer sex practices
  - Condom use
  - Healthy lifestyle practices
  - Family planning options
  - Harm reduction if they are IDUs
  - Blood safety
  - Practice of traditions safely
- ☛ Support prevention for positives and facilitate positive living by educating and counselling them on the following issues
  - Protection of their sexual health
  - Prevention and early treatment of STIs,/RTIs
  - Delay of HIV disease progression
  - Prevention of passing their infection onto others

UNIT 6 – PREVENTION OF PARENT TO CHILD TRANSMISSION OF HIV (PPTCT) & EARLY INFANT DIAGNOSIS (EID)

Unit Objectives

- ☛ Explain the Prevention of Parent to Child Transmission (PPTCT) Programme
- ☛ List risk factors and appropriate interventions for:
  - HIV transmission during pregnancy
  - HIV transmission during labour and delivery
  - HIV transmission postpartum and during infancy
- ☛ Describe the ANMs role in PPTCT & Early Infant Diagnosis

1. Prevention of Parent to Child Transmission (PPTCT) of HIV

In India mother to child transmission is by far the most significant route of transmission of HIV infection in children below 15 years. Without interventions, the risk of transmission from infected mother to her child ranges from

15-25% in developed countries

25-45% in developing countries

It is estimated that nearly 5% of HIV infections are attributable to parent to child transmission.

The epidemic is more noticeable in urban areas than rural ones, decreases with increasing education levels and is found to be the highest among women whose spouses, work in the transport industry.

What is PPTCT or Prevention of Parent to Child Transmission?

Mothers may transmit HIV to infants during

- Pregnancy
- Labour and delivery
- Breast feeding

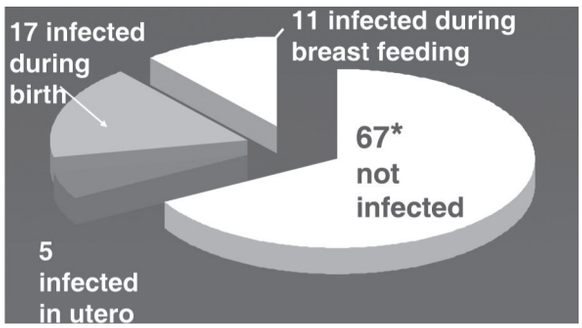
PPTCT program is a very effective method to reduce the vertical transmission of HIV infection from the mother to her baby and improvement in their health. It is also a good opportunity to include men in understanding the issues related to safe childhood, safe sex etc.

Through this program, women can be educated on how to protect themselves from acquiring HIV and other Sexually Transmitted Infections.

For the well being of the mother and child, it is beneficial for both parents to participate in PPTCT programme.

Risk of Parent to Child HIV Transmission

The highest risk is during birth, then during breast feeding and then during pregnancy.



Of 100 Babies born to HIV Infected Mothers 33 may get HIV either during pregnancy, birth or by breast feeding may get HIV either during pregnancy.

Factors That Increase Risk for Transmission of HIV

During Pregnancy

- High viral load
- Recent in3 fection of HIV
- Infected with HIV during pregnancy
- Advanced HIV disease
- Viral, bacterial, and parasitic (esp. Malaria) placental infection
- Concurrent STIs
- Malnourishment
- IDU-Substance use leading to risky behaviors
- Alterations in the integrity of placenta, chorion
- Chorioamnionitis
- Invasive procedures on the uterus

During Labour and Delivery

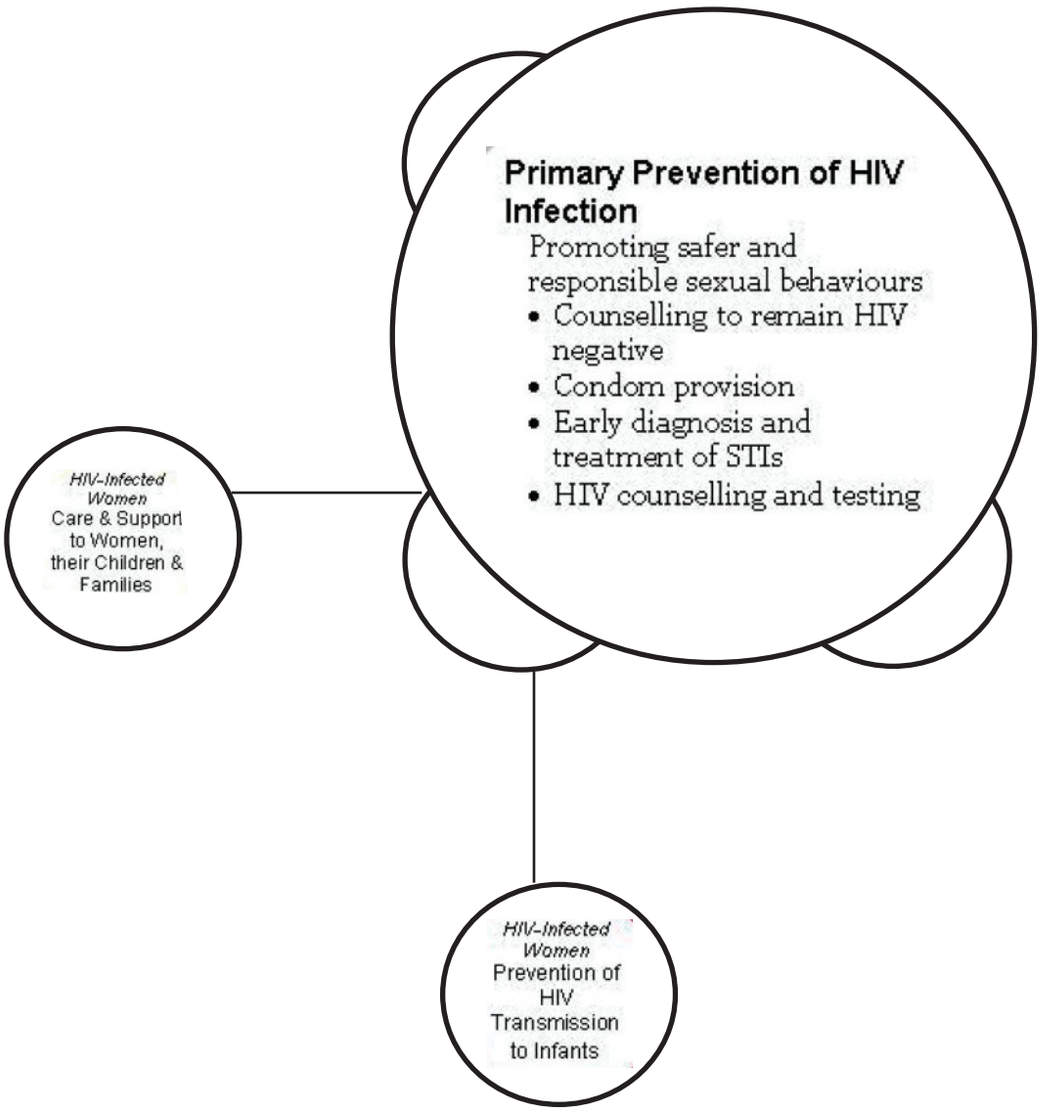
- High viral load
- Rupture of membrane > 4 hours
- Intrapartum haemorrhage
- Invasive procedures
- Invasive foetal monitoring
- ARM (artificial rupture of membranes)
- Episiotomy
- Vacuum cups
- Forceps deliveries
- Preterm birth
- Low birth weight
- First infant of multiple birth
- Altered skin integrity

During Infant Feeding

- High viral load
- Reinfection
- Primary infection
- Advanced disease
- Breast pathologies
- Engorgement
- Cracked nipples
- Mastitis/ abscess
- Poor maternal nutrition
- Mixed feeding (breast milk along with other foods)
- Feeding beyond 6 months
- Mouth sores in infant

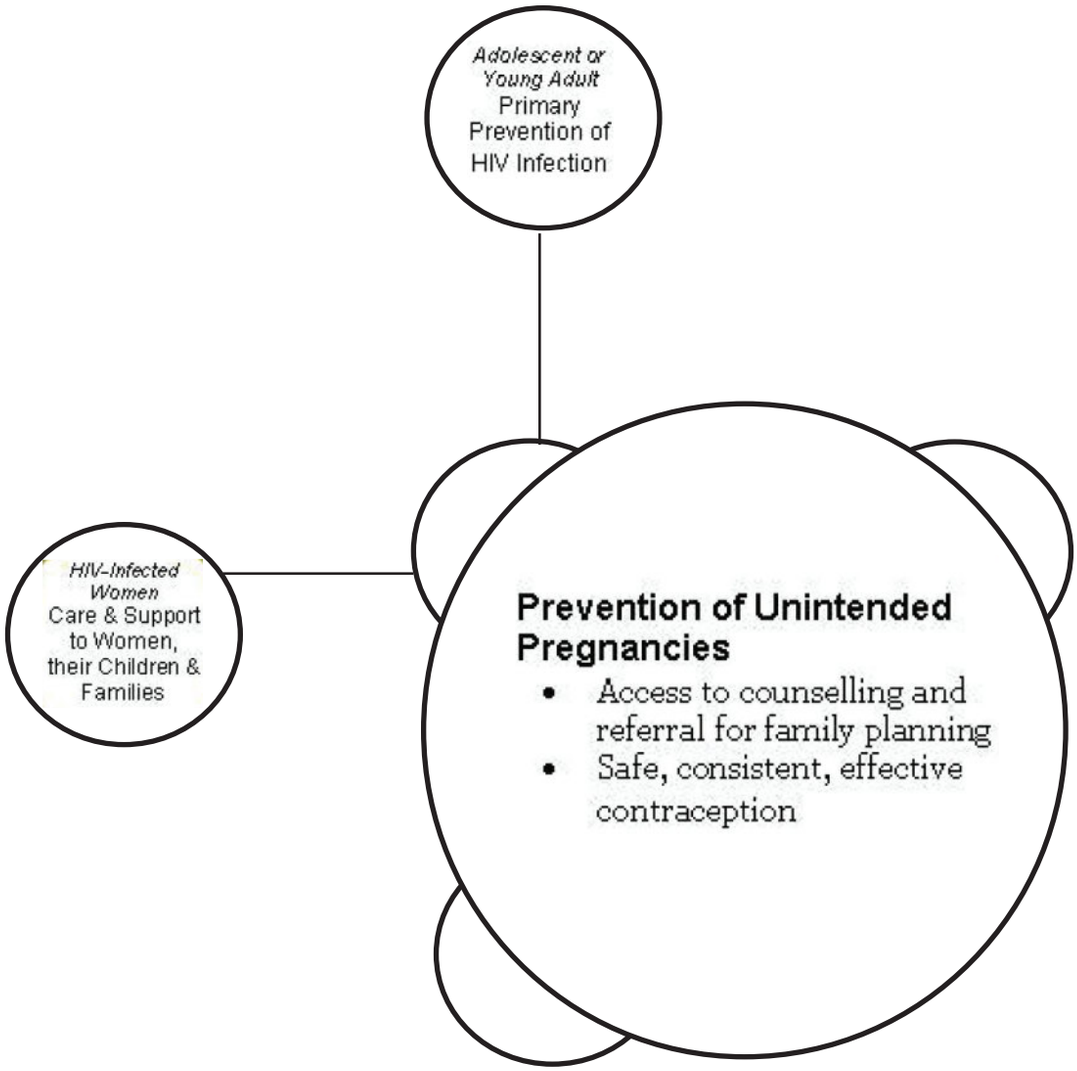
NACO'S 4 Prong PPTCT Strategies

Prong 1 of the PPTCT Strategy: Primary prevention of HIV infection



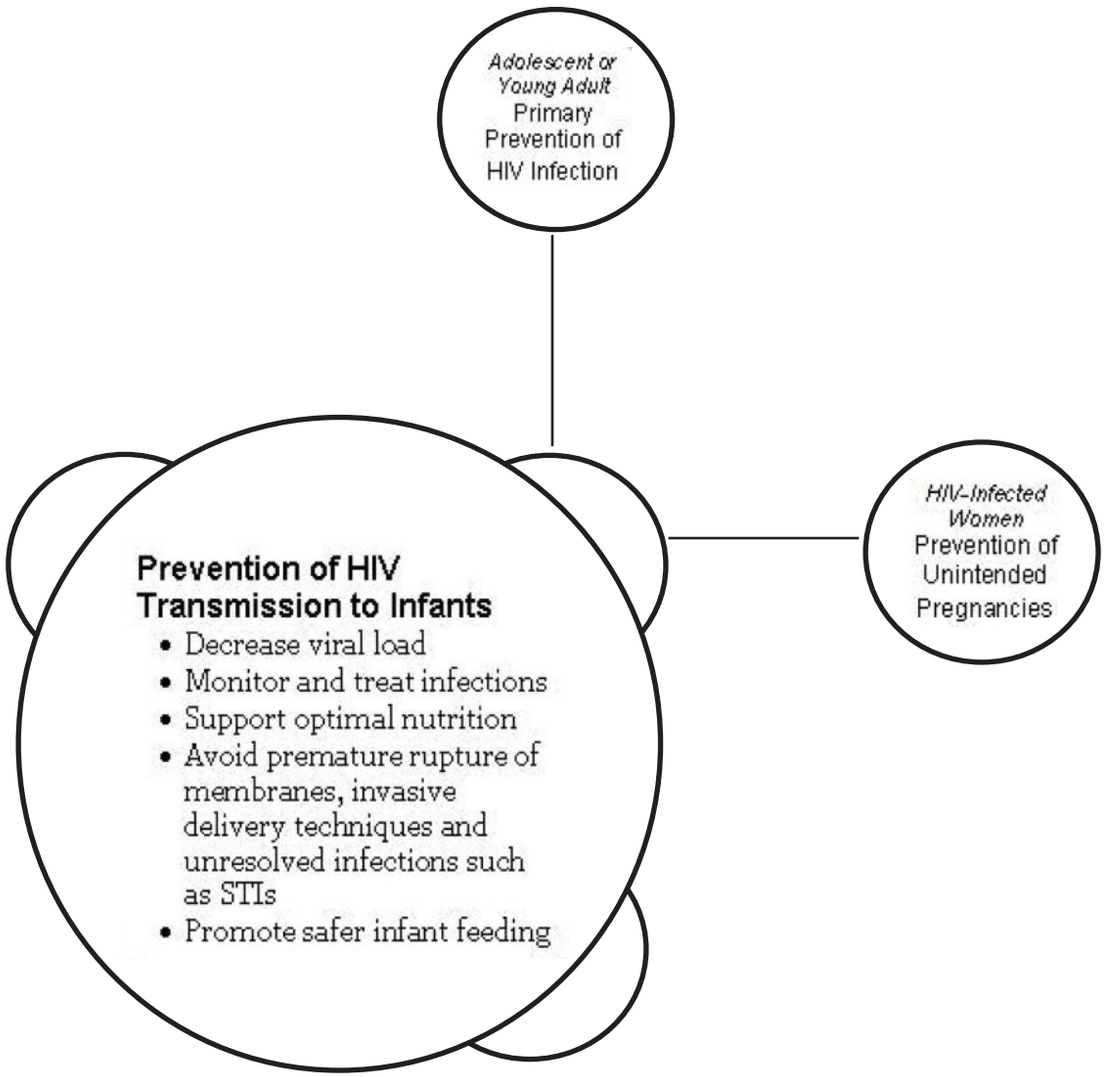
This prong focuses on the parents-to-be. HIV infection cannot be passed on to Children if their parents are not infected with HIV. The strategies here include condom provision, early diagnosis and treatment of STIs, HIV counselling and testing and suitable counselling for the uninfected so that they remain HIV negative.

Prong 2 of the PPTCT Strategy: Prevention of unintended pregnancies among HIV-infected women



This prong looks at the family planning needs of the HIV infected women. With appropriate support, women who are aware of being sero-positive can plan their pregnancy and therefore reduce the possibility of passing the virus, to their future children. They can also take measures to protect their own health. The strategies here include high-quality reproductive health counseling and providing effective family planning measures such as effective contraception, and early and safe abortion, in case, the woman decides to end the pregnancy.

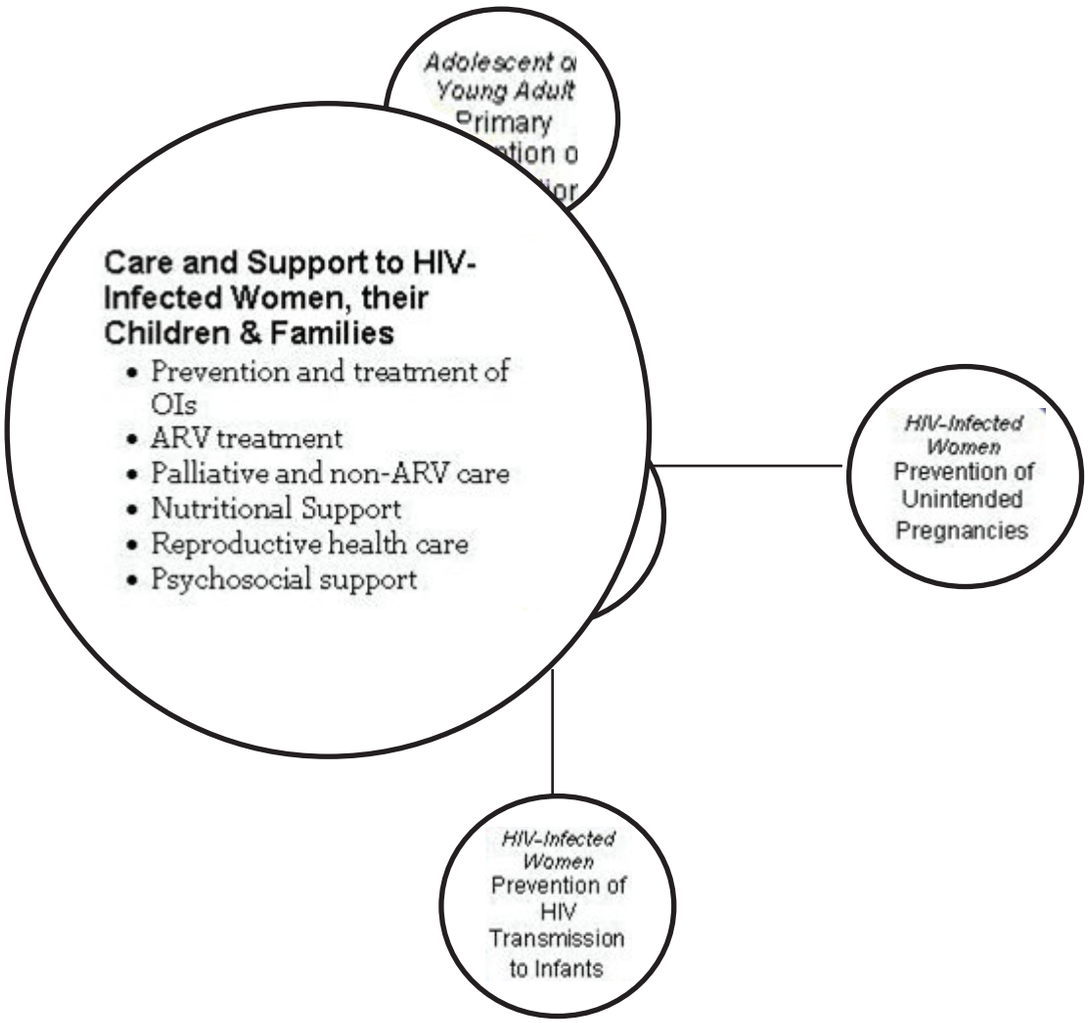
Prong 3 of the PPTCT Strategy: Prevention of HIV transmission from HIV-infected women to their infan



Specific interventions to reduce transmission from a woman living with HIV to her child include HIV counselling and testing, ARV prophylaxis and treatment, safe delivery practices, and safer infant feeding practices.

When an ARV drug is given to prevent transmission from the mother to the infant, it is referred to as ARV prophylaxis. This is different from ARV treatment for the mother the mother which is used to treat her HIV disease.

Prong 4 of the PPTCT Strategy: Provision of care and support to HIV-infected women, their infants and their families



Medical care and social support are necessary to help the woman living with HIV to address and manage her worries about her own health and that of her family.

The service elements here include prevention and treatment of OIs, ARV treatment, palliative (pain-reducing) and non-ARV care, nutritional support, reproductive health care and psychosocial support.

Ways to Prevent Parent to Child Trasmission of HIV (Role of ANMs)

A. What can be done before pregnancy?- Primary Prevention

- **Education** on STIs and pregnancy prevention (usage of Condoms and Oral contraceptives to prevent pregnancy especially for women who already have STIs or who have partners with STIs)
- **Counselling** pregnant or lactating HIV negative women on HIV & early testing
  - HIV prevention during pregnancy and lactation due to high viral load during primary infection and increased chances of parent to child transmission.
- **Referrals** to STI clinic, ICTC, or PPTCT during pregnancy or lactation

B. What can be done during and after pregnancy in HIV positive women?

Secondary Prevention: ANMs and patients can take many steps during pregnancy, labour, delivery, and postnatal period to prevent an HIV positive mother from passing on the virus to her child.

Steps to be taken during pregnancy

Educate the woman on the importance of:

- Screening for HIV
- Testing for HIV at PHC/Confirmatory Test at the ICTCs
- Antenatal visits
- Diet + Vitamin & Iron supplements
- Avoiding invasive procedures
- Practicing safe sex
- Treating ANY infection/STI/RTI
- Importance of hospital delivery: indications for Vaginal versus Caesarean section
- Continuing to monitor the progress of her HIV infection: CD4 counts/presence of OIs
- HIV Screening of the spouse, if he is positive

What is the role of ARVS in PPTCT?

ARVs reduce risk of PPTCT by

- Improving the overall health of the mother through a reduction of viral replication and viral load
- Treating maternal infection
- Protecting the HIV-exposed infant

ART is initiated in ALL HIV Positive pregnant women if CD4 $\leq$ 350 cells/ mm3 OR Irrespective of staging

A single dose of Nevirapine, under the GOI PPTCT intervention programme, reduce the risk of MTCT, with and without breastfeeding, to 5-25%.

Steps to be taken during Labour and Delivery

ANMs should assess whether mothers have already:

- Had regular Antenatal checkups
- Had HIV Testing done
  - If not, offer pre Screening -test counseling for emergency testing (Single Rapid Test)
  - If + ve, consult physician/administer single dose of NVP (Nevirapine) to mother and baby
- Conduct/ facilitate safe delivery
- After delivery, refer the mother for confirmatory test and Counseling to FICTC/ICTC, as applicable

Other Critical Issues in Labour Include:

- Disclosure & shared confidentiality
  - To women, if HIV + status just diagnosed
  - To delivery team
  - To spouse and other family members
- Emotional support
- Administer Nevirapine to mother (PPTCT programme), if prescribed by physician
- Mode of delivery
  - Vaginal delivery in the hospital
  - Caesarean section indicated electively only after 38 weeks ,when viral load is high or as an emergency for obstetrical causes/foetal distress

Dos' & Donts' For Delivery of HIV + woman

Dos'	Donts'
• Use appropriate Personal Protective Equipment (PPE) • Minimize splash of blood and fluids by using clamps and gauze when cutting the cord • If assisting to express breast feeds, stand on the same side as mother • Soak all used linen in bleach solution for 2 hours • NVP 200 mg is given at the onset of labour (observe untoward reaction-e.g. skin rash) • Perform vaginal cleansing with 0.25% Chlorhexidine/Povidine Iodine • Take measures to prevent Episiotomy/Tear • Cut cord under cover of light gauze with a fresh blade	• Isolate • Shave pubic area • Give an enema • Perform frequent PV exams • Rupture membranes • Use instrumental deliveries unless absolutely necessary • Use mouth-operated suction • Suction newborn with Nasogastric tube unless Meconium-stained

Dos'	Donts'
• Clean baby thoroughly of secretions • Determine mother's feeding choice before latching to breast • Provide/Refer for single dose NVP 2mg/kg for the baby within 72 hours of birth (observe untoward reaction-e.g. skin rash)	

If these precautions are taken, there is no need to be fearful of conducting or assisting in a normal delivery for HIV positive women!

What are the options for feeding infants of HIV+ mothers after delivery?

- **Exclusive Breast feeding**
- **Avoid mixed feeding at all costs!**

Option1: Breast Feeding

- Good hygiene
- Good position
- Give Colostrum
- Duration-shorter the better (NOT BEYOND 6 months)
- Never to mix feeds (never give breast milk along with other feeds such as cow's milk or formula)
- Option of expressing breast feed compared to direct feed

Option 2: Replacement Feeding

- If Acceptable Feasible Affordable Sustainable Safe (AFASS criteria)

Please see Annexure 4 for more on "PPTCT: Three Safe Infant Feeding Options – Some Important Points You Could Keep In Mind When Counseling Mothers On Feeding Options

Please see Annexure 5 for more on "Replacement Feeding Checklist"

Follow up care

Follow up care of mother should include:

- Routine postnatal care
- Referral for further Evaluation to decide eligibility for ART and continuing ART
- Monitor and refer for any signs of infections
  - chest, urinary, puerperal, episiotomy or breast infections, and OI's

  - Reinforcement of safer sex (condom use) for prevention of further transmission of HIV,STIs and pregnancy
- Discussion of family planning hormonal contraception(e.g. oral pills) is less effective with ARVs
  - Access to emergency contraception

Follow up care of baby born to HIV positive women:

Educate the parents on the following:

- DNA PCR HIV testing for infants (where available)
  - 6 weeks
  - 6 months
  - 12 months
  - 18 months
- Routine well baby visits
- Follow standard Immunisation schedule
- Cotrimoxazole (CPT/CTX) prophylaxis dose per kg body weight
  - All HIV exposed infants start at 4-6 weeks of age till detected as HIV negative
- HIV antibody testing at 12 months & 18 month visits

Role of the ANMs in PPTCT

It is important for the ANMs to

- Provide correct, non-judgmental information on PPTCT to
  - Patients
  - Families
  - Communities
  - Colleagues
- Educate positive women (and their partners)on risk factors and ways to reduce risk of PPTCT during antenatal, intranatal and postnatal period (safe sex practices, even for discordant couple i.e. when the partner is HIV negative) periods
- Support safe infant feeding practices
- Conduct routine Post Natal visits

Early Infant Diagnosis

Children under one year old are among those most vulnerable to HIV and AIDS. It is also seen that early start of antiretroviral treatment in infants with HIV can save lives. Yet very few children under age one are currently receiving such treatment.

In India, Early Infant Diagnosis programme to closely monitor HIV-exposed infants to identify their HIV status and provide them appropriate treatment to reduce HIV related mortality and morbidity has been rolled out through 766 ICTCs and 181 ART centres; 9,016infants and children under 18 months of age were tested under this programme till January 2011.

Objectives of providing care for HIV exposed Infant and Children are:

- To closely monitor HIV-exposed infants and children for symptoms of HIV infection
- To prevent opportunistic infections by providing Cotrimoxazole prophylaxis to all HIV-exposed infants from six weeks of age
- To identify HIV status early through early diagnosis of infant/child and final confirmation of HIV status at 18 months by HIV antibody test
- To provide appropriate treatment including ART as early as possible
- To reduce HIV related morbidity and mortality and improve survival

The diagnosis of infants and children below the age of 18 months is done by using HIV-1DNA PCR

Testing through Dried blood spot (DBS) and Whole blood (WB) sample

This sample type, which can be taken from a heel prick, requires a reasonably small amount of blood and is therefore appropriate for routine testing in infants, where blood volumes are small and it is difficult to draw blood

The carefully packed samples are transported to certain designated centres to conduct the DNA PCR Test

ANMs' Role

It is very important for ANMs to have knowledge on Early Infant Diagnosis so that they can educate, counsel and refer the parents, for further evaluation and management of the possible HIV infection, in their infant, as early as possible.

Primary Care of HIV Exposed Infants

- Suspect recognize and refer HIV exposed infants to higher facility
- Ensure that the parents are giving PCP prophylaxis (Cotrimoxazole-5 mg/kg/OD For 6 Months) to their infant/child if prescribed by doctor
- Monitor the infant/child for signs and symptoms of TB and refer to the ART Centre
- Make prompt referral for needed services
- Educate parents to
  - Give immunizations as per schedule
  - Bring infant for routine evaluation of growth and development to health facility

- Report any illnesses,which the child might have, for prompt treatment

- Providegood nutrition to the baby

Some important points regarding Nutritional Education which ANM must convey to parents:

- Feeding options during infancy:
  - Exclusive Breast Feeding 6 months & then on top feeds with complementary foods (Mashed softdiet)

    OR

  - Exclusive artificial (replacement) feeding
- Well balanced diet
- Small frequent feeds
- Food hygiene
- Hygienic Feeding practices

– Continuing Care

Educate the parents regarding:

- Regular Growth monitoring at the health facility(Refer to **Annexure 6** for **WHO Growth Monitoring Charts**
- Appropriate Diet to support growing needs
- Preventing injuries and infections
- Bringing the child for Regular check - ups
- Recognizing and reporting signs of infections
- Long term care-involving other Care Takers
- Joining Support Groups
- School- admission;disclosing the HIV status of the child to teachers etc.

Key Messages :

- ☛ In the absence of any intervention, there is a high risk of HIV transmission from positive pregnant women to her unborn childin peripartum period- especially during labour and delivery
- ☛ PPTCT strategies and ART reduce this risk to a large extent
- ☛ A positive couple or pair having only one HIV positive partner should practice safe sex throughout pregnancy and breastfeeding
- ☛ Educate and counsel mothers with HIV exposed infants to
  - Follow safe infant feeding practices
  - Come for regular follow up
  - Give all immunizations for the infant
  - Report any signs of infection
  - Refer the parents for Early Infant Diagnosis (for baby fo > 18 months)
  - Give Cotrimoxazole prophylaxis(if prescribed bythe physician) for all infants till diagnosed as HIV – ve or up to 5years if HIV +ve
  - Assess and refer for ART
  - Follow ART regimen as prescribed by the doctor
- ☛ Support children as they grow to cope with the various psychosocial issues of living with HIV
- ☛ Link HIV+ children and their families to support groups

UNIT 7 – INFECTION CONTROL AND POST EXPOSURE PROPHYLAXIS

Unit Objectives

- ☛ Describe the basic principles of Infection Control and Standard Precautions
- ☛ Demonstrate how to prevent infections
- ☛ List measures to safeguard against TB and blood-borne pathogens
- ☛ Manage Post Exposure Prophylaxis
- ☛ Discuss ANMs' role in Infection Control

Infection Control and Post Exposure Prophylaxis (PEP)

Basic Principles of Infection Control

Patients' blood and other body fluids can pass on infections such as HIV, Hep B, and Hep C, with those who come into contact with those fluids. In order to avoid such spread of infections, precautions must be taken

- All patients are potentially infectious**. Precautions must be taken at all times with all patients**
- Follow Standard Precautions for all patients

Standard work precautions

"Universal Precautions" as defined by CDC (Centre For Disease Control), are a set of precautions designed to prevent transmission of Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV), and other blood borne pathogens when providing first aid or health care.

Standard safety precautions, if carefully followed, will prevent spread of HIV, Hep. B, and Hep C infections in the health setting.

The routes of HIV infection in the hospital setting are from:

- Patient to Health care Personnel
- Patient to patient
- Through hospital wastes
- From Health Care personnel to patients

All blood and body fluids, substances, secretions and excretions must be considered to be potentially infectious regardless of the perceived risk of the source!

Precautions to be taken to control infection

- Hand Hygiene
- Disinfection and Sterilization of equipments
- Use of Personal Protective Equipment (PPE)based on the risk of the procedure
- Standard precautions against air borne pathogens
- Standard precautions against blood borne pathogens

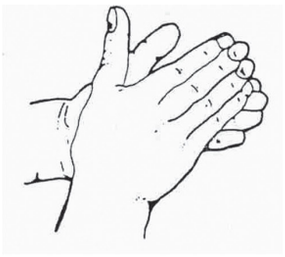
1. Hand Hygiene

Hand washing is one of the simplest, but often overlooked procedures that can be followed to prevent infection from spreading.

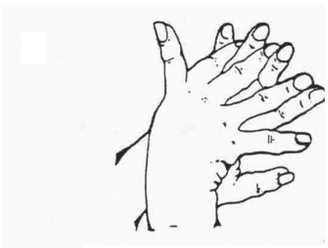
Hand washing could help in reducing risk of transmission of pathogens within the healthcare setting among patients, and health care workers, and to caregivers and family members of the patient.

Ensure patients and caregivers to follow the simple Hand washing practice.

	When to use	Effect on germs	How to use
Soap and water	Use this technique when hands have back visible dirt and fingers, whenever you come in contact with a patient.	Removes germs	Wet hands to wrist 1. Apply soap on the palms, of the hands, between around the thumb 2. Clean the nails 3. Rub for at least 15 seconds 4. Rinse with running water 5. Dry by air or single use towel
Alcohol rub (if available)	If no visible dirt on hands and before or procedures needing aseptic technique	Kills germs	1. Place 3-5 ml on dry hands 2. Rub until dry No water towels needed
Surgical scrub	Done before surgery or stick procedures needing sterile technique.	Kills germs	1. Clean under nails with 2. Wet up to elbow; 3. Use antiseptic, long acting and rub all surfaces for 2-6 minutes. 4. Rinse with running water 5. Dry with sterile towel

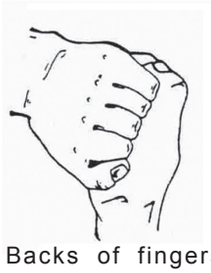


1. Palm to palm

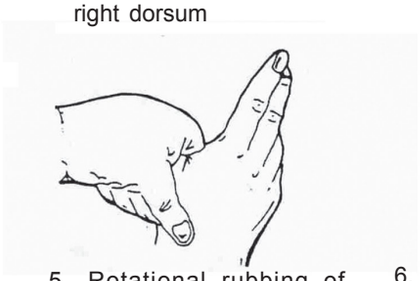


2. Right palm over left dorsum and left palm over right dorsum

3. Palm to palm fingers interlaced



4. Backs of fingers to opposing palms with fingers interlocked



5. Rotational rubbing of right thumb clasped in left palm and vice versa

6. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

2. Disinfecting and Sterilizing

Disinfection:

It is the use of specialized cleansing techniques that destroy or prevent growth of organisms capable of infection from a surface,body part,equipment,instruments etc. It does not necessarily kills these organisms and is less effective than Sterlization.

Sterlization:

It is the killing of all microorganisms in a material or on the surface, body part,equipment,instruments etc.

Decontamination

It is the process of removal of infection causing microorganisms from surface, body part,equipment,instruments by a process of sterilization or disinfection.

The level of decontamination should be such that there is no risk for infection when using the equipment. The choice of the method depends on a number of factors, including type of material of object, number and type of organisms involved and risk of infection to patients or staff.

Disinfectants in use:

Name of Disinfectant	Method of Dilution	Contact Time	Effective time Span
Glutaraldehyde 2% e.g. Cidex	Add activator powder/liquid to the liquid in the 5 L jar & use undiluted	Disinfection: 20 to 30 minutes Sterilization: 10 hrs	14 to 28 days (see manufacturer's instructions) Span will be reduced if solution is diluted so utilize in-use testfor confirming efficacy
Combination of Glutaaldehyde & chemically bound Formaldehyde e.g. Korsolex, Bacilloid	Korsolex : water 1 part : 9 parts	Disinfection 15 minutes.	14 days
	Bacillocid : water 1 part : 49 parts (20 ml : 980 ml)	Sterilisation 5 hrs 30 minutes	24 hrs
Phenol 5% (Carbolic acid 100%)	Phenol : water 5 ml : 95 ml	10–15 minutes in 5% solution	24 hrs 24 hrs
Ethanol Isopropyl Alcohol 70% eg. Bacillol – 25	Do not dilute	2 – 10 minutes	24 hrs
Hydrogen Peroxide 6% (available as 30% stabilized solution)	20ml H_2O_2 –with 80ml Normal saline = 6% H_2O_2 – (use freshly prepared)	6 – 8 minutes	Use immediately after preparation
Sodium Hypochlorite solution 1% e.g. Polar bleach available in 5% & 10% concentrations	5% : 80ml water +20ml bleach solution 10% : 90ml water + 10ml bleach solution	20 – 30 minutes	8 hrs
Calcium Hypochlorite eg. Bleaching Powder (70% available Cl_2)	14 gm / L dissolved properly for visibly contaminated articles. 1.4 gm per L for clean objects.	20 – 30 minutes	24 hrs
Formaldehyde 40%		30 minutes then open the area after 6 hrs	15 – 30 days

Source: Infection control manual- AIIMS

Ensure all the above disinfectants are available

Antiseptics (iodine, etc) are ineffective against HIV

Please see Annexure 7 on "Disinfection of Needles and Syringes with Bleach Solution"

Please see Annexure 9 on "Hospital Disposal of used disposable Needles

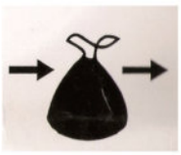
Please see Annexure 10 for more on "Guidelines for Disinfection and Sterilization"

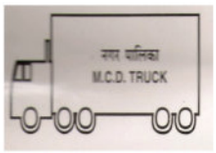
Safe Disposal of Non-infectious and Infectious in Health Care Setting/Hospital Waste Peels

A) HOUSEHOLD WASTE (NON-INFECTIOUS).

LEFT OVER FOOD, FRUIT PEELS, VEGETABLES, WASTE PAPER, PACKING MATERIAL, EMPTY BOX & BAGS ETC.

VIII. USE BLACK DRUM / BAG





I. THIS WASTE TO BE SENT FOR INCINERATION

V. B) INFECTED WASTE

i) HUMAN ANATOMICAL WASTE, ORGAN, TISSUE, BODY PARTS, BLOOD, BODY FLUID, PLACENTA ETC.

ii) SOLID WASTE: USED COTTON, GAUZE, DRESSINGS, PLASTER, POP CAST ETC.

iii) ANIMALS USES IN RESEARCH DEAD ANIMALS, THEIR BODY PART OR TISSUES.

VII. USE YELLOW DRUM / BAG

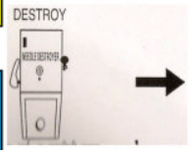
XI. USE BLUE DRUM / BAG

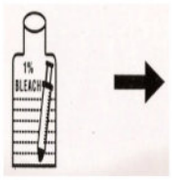
VI. C) INFECTED PLASTIC WASTE

i) USED DISPOSABLE SYRINGE & NEEDLE

ii) USED SHARPS: BLADE & BROKEN GLASS ETC.

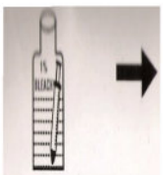
iii) PLASTIC ITEMS USED ON PATIENTS: IV. SET, B.T. SET, E.T. TUBE, RYLE'S TUBE, CATHETER, URINE BAG ETC.

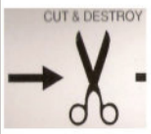




III. PUT IN TRANSLUCENT CONTAINER WITH 1% BLEACH

IV. DOCTOR, NURSE & TECHNICAL STAFF





II. THIS WASTE WILL BE AUTO CLAVED TO MAKE IT NON INFECTIOUS.

THIS WILL THEN BE SHREDDED

BEFORE FINAL DISPOSAL.

ANMs' role in Waste Management

- Be up-to-date on infection control practices
- Segregate Health care setting/ wastes appropriately
- Teach/train other staff in the Health care setting/ward with regards to waste segregation and disposal
- Teach, train and supervise junior staff and cleaning staff

Guidelines for Bio Medical Waste Management

- Classify and segregate waste
- Use colour-coded bags for segregation of waste
- Disinfect waste before disposal
- Incinerate when appropriate
- Deep burial of the waste, as needed
- Disinfect & destroy disposables before discarding
- Personnel handling the wastes, to be provided with appropriate protective cover and these staff are to be adequately trained in handling the wastes

Disposal of dead body of AIDS patients

ANM must educate the the family regarding:

- not opening the body bag, once it is closed
- Disinfecting the plastic cover with bleach powder and bury it deep in the ground
- Cremation is the best procedure for disposal of the dead. However, with due respect to religion and tradition, when cremation is not practiced, suggest deep burial

Use Personal Protective Equipment (PPE)

PPE is designed to protect employees from workplace injuries or serious illnesses resulting from contact with chemical, radiological, physical or mechanical or other workplace hazards.

Using Appropriate PPE during Common Nursing Procedures

Protection required	Common nursing procedures	Type of exposure
Gloves helpful but not necessary	Bed making, Back care, Sponge bath, Mouth care, Minor wound dressing, Perineal care, Taking temperature, BP	**Low risk** (Chances of direct contact with infectious body fluids is minimal)

Protection required	Common nursing procedures	Type of exposure
Use gloves with waterproof aprons, For intubation, wear gloves, mask, goggles and apron	Injections, Lumbar puncture, Insertion and removal of IV needles, PV examination, Dressing large wounds, Handling blood spills or specimens, Intubations, Suctioning, Collecting blood	**Medium risk** (Chance of direct contact with infectious body fluid is moderate i.e. probable contact with blood, splash unlikely)
ALL PPE (Surgical gloves, Apron, Masks, Protective eyewear, Foot wear)	Vaginal delivery, Uncontrolled bleeding, Surgery, Endoscopy, Dental procedures	**High risk** (Chance of direct contact as well as splash of infectious body fluid is high, uncontrolled bleeding)

Points to keep in mind while using PPE:

1. While using gloves

- Wash hands
- Slip each hand into glove, pulling it snuglyover the fingers to ensure a good fit
- Pull glove over the wrist as far as it will go tomaximize coverage
- Grasp the glove by the other gloved hand andremove first glove by turning the glove inside out as it is pulled over the hand (This will keep the contaminated areas away from your skin)
- During removal of the second glove, avoidtouching the outer surface by slipping the fingers of the ungloved hand under the glove and pulling it inside out as it is pulled over the hand, effectively sealing the first glove inside
- Dispose of the used gloves in a lined wastecontainer or disinfect as per standard protocol
- Sterilize gloves before re-use for invasiveprocedures
- Wear utility gloves when Cleaning or managing waste
- Do not use them to touch patients, patient care items, or anything near patients
- Wash with detergent and bleach and leave to dry at the end of the shift

2. For Eye Wear:

- It should cover the whole eye, without any gap
- It should be washed thoroughly before re use; should be disinfected if there is slash of infectious fluid on it

3. For Gowns & aprons:

- They should be made of thick Plastic (not cotton as they absorb dirt)
- They should be disinfectedby soaking in bleach solution (1%) for 20 minutes and sterilized in case they have been used during surgery or delivery

4. For Masks (cloth or paper)

- It should be well fitted over the nose and mouthand below the jaw
- Wet masks should be changed immediately as *it allows the bacteria to pass and wet surfaces attract dirt and pathogens*
- It should not be left around the neck after use
- It should be used when having a respiratory infection herself or interacting with patients with cough

5. Cap

- It should be large enough to cover all the hair

6. Foot wear

- It should cover the whole feet;if not then,wear a plastic cover & tied with a rubber band
- It should be easily washable and disinfected

Note:

1. All the used PPE should be properly discarded and disinfected according to the guidelines
2. Hands must be washed thoroughly after disposing off the PPE

Do's and Don'ts for Use of PPE

Do's	Dont's
Use PPE based on risk of procedure	Share PPE
Change PPE completely after each procedure	Use same gloves between patients
Discard the used PPE in appropriate disposal bags	Reuse disposable gloves, eyewear, masks
Dispose PPE as per the policy of the hospital	Use eye wear that restricts your vision
Always wash hands after removing PPE	Use masks when wet
Educate and train all junior and auxiliary staff in the use of PPE	

Educate people in the community about early detection and treatment of TB

- Encourage persons with chronic coughs (>2 wks) to get evaluated at a TB centre
- Start and complete treatment (DOTS) without delay

Instruct coughing/sneezing patients to

- Turn their heads opposite to you

- Cover the mouth with a cloth or rag
  - Wash hands regularly
  - Wash/burn the cloth used
- At home, good air circulation should be maintained by opening windows and the air flow from patient to the window

Standard Work Precautions against Blood borne Pathogens

In addition to the Standard Work Precautions detailed above, there are also specific infection control measures that can be taken against blood borne pathogens.

Blood borne pathogens are microorganisms such as viruses or bacteria that are carried in blood and can cause disease in people. e.g. Hepatitis B/C. Hepatitis B-Stable virus, can survive outside the body after the body fluid dries.

Hepatitis C-Stable virus, can survive outside the body after the body fluid dries

HIV—Fragile virus, usually dies outside the body after the body fluid dries)

- Disinfect surfaces contaminated with body fluid or blood.
- Follow the policy for waste management.(See picture on Safe Disposal Of Hospital Waste)
- Get vaccinated against Hepatitis B (No other vaccine is available)

Please see Annexure 10 for more on Situational Guide - Cleaning up a Blood Spill on the Floor

Reducing Risks of Sharp Injuries

Sharps refer to instruments such as needles, knives, and scissors etc which have sharp edges with potential for puncturing or tearing skin. Naturally, as risk of acquiring blood borne pathogens increases with severity of exposure, it is best to avoid sharps injuries by taking simple steps as listed below.

Do's	Don'ts
• Use needle cutter/destroyer immediately after use. • Separate sharps from other waste • Use rigid, puncture proof disposal bins • Empty sharps containers when they are ¾ full	• Do not recap needles before disposal • Do not collect the used needles. • Burn immediately- to reduce chances of getting the needle stick injury • Handle, empty, or transfer used sharps between containers

Protect yourself

- Be aware of the PEP policy
- Take three doses of hepatitis B vaccine. It gives you life long protection

- Take measures to prevent accidental needle stick and other sharps injuries
- Talk to designated physician about taking Post Exposure Prophylaxis (PEP) in the event of any occupational exposure
- Follow standard precautions at all times
- Carry out all the procedures meticulously.

Occupational Exposure and Post Exposure Prophylaxis (PEP)

Occupational Exposure refers to exposure to harmful substances/material that occurs during the course of one's work.It can place healthcare workers at risk for contracting HIV, Hepatitis, and other pathogens., while handling the patients.To tackle such situations, Post Exposure Prophylaxis is practiced

Post Exposure Prophylaxis (PEP)

- The term Post Exposure Prophylaxis refers to treatment of occupational exposures using Antiretroviral Therapy. Post-Exposure Prophylaxis, if initiated immediately after exposure to HIV,HBV and HCV may control the infection.

Which Body Fluids Have Risk for HIV Transmission?

Body fluids* considered *"at risk"* exposure exposure	**Body fluid considered *"not at risk"* (Unless contaminated with visible blood)**
Blood	Tears
Semen	Sweat
Breast milk	Urine and faeces
Body fluids with blood	Saliva
Vaginal secretions Internal body fluids Amniotic fluids	

How does a person becomes infected

- Source body fluids,* if infected
- From infected person (injury, needle stick etc.)
- Into susceptible person (break in the skin, mucus membrane-nose, mouth, eyes)

Factors that Influence Risk for Acquiring HIV

- Type and extent of exposure
  - Size and type of needle
  - Depth of injury
  - Amount of blood

- Types of procedures that carry a higher risk of transmission:
  - Procedures involving a needle placed in artery or vein
  - Use of invasive devices visibly contaminated with blood
- Amount of virus present in the contaminated fluid
- Whether PEP is taken or not within the specified time

It is absolutely essential that ANMs are aware of the Occupational Exposure protocol followed by their health centre and follow them routinely. Below are the basic steps which need to be observed following occupational exposure to HIV.

Crisis management

Remain Calm

Dispose the sharp appropriately

First aid

For skin – if skin is broken after a needle-stick or sharp instrument:

- Immediately wash the wound and surrounding skin with water and soap. Do not scrub.
- Do not use antiseptics or skin washes (Bleach/Chlorine/Alcohol/ Povidone Iodine)

After a splash of blood or body fluids

- To unbroken skin:
  - Wash the area immediately
  - Do not use antiseptics
- For the eye:
  - Irrigate exposed eye immediately with water or normal saline
  - Sit in a chair, tilt head back and ask a colleague to gently pour water or normal saline over the eye
  - If wearing contact lenses, leave them in place while irrigating, as they form a barrier over the eye and will help protect it. Once the eye is cleaned, remove the contact lenses and clean them in the normal manner. This will make them safe to wear again
  - Do not use soap or disinfectant on the eye
- For mouth:
  - Spit fluid out immediately
  - Rinse the mouth thoroughly, using water or saline and spit again
    Repeat this process several times
  - Do not use soap or disinfectant in the mouth

Report to the appropriate authority as soon as possible

Get evaluated for PEP should be started within 2 hours of exposure, and not later PEP and baseline than 72 hours. PEP must be taken for 4 weeks (28 days) testing for IV

Basic Regimen: Zidovudine/Stavudine (AZT or d4T)

300mg BD + Lamivudine (3TC) - 150mg BD

Access and Availability to PEP at a Health Care Facility

In order to ensure that an exposed person has access to prophylactic therapy in a timely manner, it is recommended that PEP drugs be kept available round-the-clock .All health staff should know through trainings where to get PEP, as required.

For the full course of drugs, this can be purchased locally to complete 4 weeks of drugs or refer to nearest ART centre. In case these drugs are not available on site at the healthcare facility, the hospital can purchase it locally and it shall be reimbursed by SACS .

Drug stock at the Health care Facility

Level of health care facility	Designated person/team in chargeof PEP	Minimum drug stock of PEP exposure-response kits
Primary – CHC	The medical officer of the CHC is thereference person for PEP	2 kits of 3 days supply. Ie FDC* (AZT/3TC) 2 tabs/day x 3days x 2 kits = 12 tabs
Primary Health centers (PHC)	The PHC medical officer is in-charge ofreferring for PEP to CHC or district level	Link to CHC or district level for PEP

*FDC- Fixed Dose Combination

Key Messages :

- ☛ Standard precautions are
  - for ALL patients and health workers
  - to reduce the risk of blood borne and airborne infections
- ☛ Standard precautions against blood borne infections include
  - Practice of hand hygiene
  - Use of personal protective equipment based on risk of exposure
  - Disinfection and Sterilization techniques
  - Appropriate separation and disposal of waste
  - Proper sharps disposal

☛ Standard precautions against airborne infections include

- Identification of smear positive patients and using masks when interacting with them
- Educate and counsel the families on
  - recognition of signs and symptoms of TB
  - need for seeking and taking complete treatment (DOTS)
  - cough hygiene
  - Maintaining good ventilation at home

☛ ANMs must educate all junior staff/Cleaning staff on standard precaution protocols and ensure that these protocols are followed

☛ Occupational exposure

- Report the exposure to the Medical Officer In Charge
- Wash the area with soap and water, or irrigate mucous membranes with clean water Seek counselling and advice on the need for PEP at the PHC/District Hospital/ART Centre
- Take PEP for 28 days as prescribed
- Report any side effects that are not manageable
- Repeat HIV test at 6weeks, 3 months, 6 months and then 1 year
- Ensure availability of bleaching solution

UNIT 8 – DOCUMENTATION & REPORTING OF HIV DATABASE

Unit Objectives

- ☛ To understand the data definitions in the Monthly Progress Report(MPR)
- ☛ To understand the data definitions in the FICTC/PPP ICTC Register
- ☛ To understand the correct documentation of data in MPR and FICTC/PPP ICTC Register through practical Excercise

Data definition for the Monthly Progress Report of F-ICTC/PPP ICTC **Section A Identification**		
Indicator	**Data Definition**	**Data Source**
F-ICTC/PPP ICTC Code	To be provided by the SACS after registering the unit. SACS BSD/ICTC division to prov ide the basic information required to register the F-ICTC in SIMS to the respective SACS M&E Division or SIMU and accordingly the auto generated code to be shared with the respective F-ICTC/PPP ICTC. The F-ICTC should mention the code provided by SACS/ DAPCU	To be provided by the SACS
1. Name of Centre	Write the name of the health facility where the F-ICTC is located	To be provided by the F ICTC
Type of F-ICTC	Write the type of F-ICTC/PPP ICTC whether Fixed or Mobile. If the F-ICTC/PPP ICTC has been established in a fixed health facility write “Fixed” or if the F-ICTC established in Mobile Medical Units/Mobile Van write “Mobile”	
2. Address	Write the complete address of the centre	To be provided by the F ICTC

Indicator	Data Definition	Data Source
Pin Code	Write the Pin code of the place where the F-ICTC/PPP ICTC is located or from where it operates in case of Mobile"	To be provided by the F ICTC
Block/Mandal/Taluka	Write the name of Block/Mandal/ Taluka where the F-ICTC/PPP ICTC is located or from where it operates in case of Mobile"	To be provided by the F ICTC
District	Write the name of District where the F-ICTC/PPP ICTC is located or from where it operates in case of Mobile"	To be provided by the F ICTC
State	Write the name of the State	To be provided by the F ICTC
3. Reporting Period Month Year	Write the month of reporting Write the year of reporting	To be provided by the F ICTC To be provided by the F ICTC
4. Name of the Officer In-Charge (F-ICTC/PPP ICTC)	'Write the name of the Medical Officer In-Charge of the F-ICTC/PPP ICTC	To be provided by the F ICTC
5. Contact Number	Write the contact number of the Medical Officer In-Charge of the F-ICTC/PPP ICTC	To be provided by the F ICTC
6. Email Address	Write the email address of the Medical officer In-Charge of the F-ICTC/PPP ICTC	To be provided by the F ICTC
7.	F-ICTC/PPP ICTC Location Write the location of the F-ICTC/ PPP ICTC where it is situated e.g:- Medical Hospital, Maternity Home, CHC, 24X7 PHC, PHC, etc	To be provided by the F ICTC
Section B Basic Indicator		
1. Progress Made During the Month		
Indicator	**Data Definition**	**Data Source**
1. Total ANC Clients regis	Write the total number of ANC tered during the month registered during the month of reporting in the health facility. For eg: 100 Pregnant registered under Women then write 100 in the box	ANC registeration Register of the Centre

Indicator	Data Definition	Data Source
2. Number of Clients provided pre-test counseling	Write the number of pregnant women (ANC) provided pre-test counseling during the month of reporting in the specified boxes for the format. E.g:- if 80 out of the 100 Pregnant Women registered under ANC are provided with pre-test counseling then write "80" in the box below ANC. Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male,female(non pregnant) and TS/TG))	F-ICTC RegiserColoumn No. 7
3. Number of Clients] tested for HIV	Out of the above write the number of clients tested during the month of reporting in the specified boxes for the format. E.g:- if 80 Pregnant Women register under ANC are tested for HIV 1st test write "80" in the box below ANC. Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male, female(non pregnant) and TS/TG))	F-ICTC RegiserColoumn No. 8
4. Number of Clients provided post-test counseling	Out of the above, write the number of clients provided post-test counseling during the month of reporting in the specified boxes for the format. E.g:- if 80 Pregnant Women register under ANC are provided with post-test counseling write "80" in the box below ANC. Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male, female(non pregnant) and TS/TG))	F-ICTC RegiserColoumn No. 10
5. Number of Clients	Out of the clients tested for HIV,	F-ICTC RegiserColoumn

Indicator	Data Definition	Data Source
detected HIV reactive after 1st Test	write the number of clients detected HIV reactive after 1st test during the month of reporting in the specified boxes for the format. E.g:- if 10 Pregnant Women register under ANC are detected HIV reactive after 1st test write "10" in the box below ANC.Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male, female(non pregnant) and TS/TG))	No. 9
2. Linkage & Referral		
In Referral		
Indicator	**Data Definition**	**Data Source**
1. OBG/GYN(ANC)	Write the number of ANC cases referred in, during the month of reporting, for HIV testing, by the Obstetrics and Gynaecology Department or medical officer	F-ICTC RegiserColoumn No. 2
2. Targeted Intervention NGOs	Write the number of clients being referred in, during the month of reporting, for HIV testing, by the NGOs working under Targeted Intervention Projects.	F-ICTC RegiserColoumn No. 2
3. Link Worker	Write the number of clients being referred in, during the month of reporting, for HIV testing, by the Link Workers working under Link Worker Scheme.	F-ICTC RegiserColoumn No. 2
4. RNTCP	Write the number of clients being referred in, during the month of reporting, for HIV testing, by the staff working under Revised National TB Control programme (MO/STS/STLS etc)	F-ICTC RegiserColoumn No. 2
5. STI Clinic	Write the number of STI clients being referred in, during the	F-ICTC RegiserColoumn No. 2

Indicator	Data Definition	Data Source
	month of reporting, for HIV testing, by the STI Clinic or medical officer	
6. Others	Write the number of clients coming in during the month of reporting for HIV testing from any sources other than those mentioned above	F-ICTC RegiserColoumn No. 2
Out Referral to Stand Alone ICTCs for confirmation		
Indicator	**Data Definition**	**Data Source**
1. OBG/GYN(ANC)	Write the number of those referred in clients from OBG/GYN (ANC) or medical officer, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
2. Targeted Intervention NGOs	Write the number of those referred in clients from NGOs working under Targeted Intervention Projects, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
3. Link Worker	Write the number of those referred in clients from Link Worker working under Link Worker Scheme, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
4. RNTCP	Write the number of those referred in clients by the staff working under Revised National TB Control programme (MO/STS/STLS etc), found HIV 1st test reactive and further referred to Stand Alone ICTC for	F-ICTC RegiserColoumn No. 11

Indicator	Data Definition	Data Source
	confirmation of HIV status during the month of reporting.	
5. STI Clinic	Write the number of those referred in STI clients from STI Clinic or medical officers found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
6. Others	Write the number of those referred in clients from sources other than mentioned above, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
3. Stock Status of HIV Test (Number of Tests)		
Indicator	**Data Definition**	**Data Source**
1. HIV 1st Test	Write the information pertaining to the HIV 1st Test like Name of Kit, Batch No., Expiry Date (in DD/MM/YYYY format like 1st April, 2012 as 01/04/2012), Opening Stock, Number of Test received, Number of Test consumed, Control, Was tage/Damage, Closing Stock and Quantity indented in the specified boxes, for the month of reporting.	Stock Register of the Facility
2. Whole Blood Test	Write the information pertaining to the HIV 1st Test like Name of Kit, Batch No., Expiry Date(in DD/MM/ YYYY format like 1st April, 2012 as 01/04/2012), Opening Stock, Number of Test received, Number of Test consumed, Wastage/Damage, and Quantity Facility indented in the specified boxes for the month of reporting.	Stock Register of the Closing Stock

Data definition for FICTC/PPP ICTC Register

Name of the FICTC		Mention the name of the Health Facility providing Counseling and Testing services
Month		Mention the current month at the space provided
Year		Mention the current year at the space provided
Coloumn No.		
1	Serial Number (Sr.No.)	This is the number given to individuals coming to ICTC for counseling and Testing. The number should be started from 1 onwards
2	Referral From	Write the source/point of referral from where the client has been referred to your facility. A Client may be referred from O&G(ANC), Direct in labour, NGOs working under Targeted Intervention project, staff of RNTCP, link worker working under Link Worker Scheme, STI Clinics or others.
3	Full Name	Write the Full Name of the Client
4	Full Address with contact No-	Write the Full Address including Taluka/Block , Pin code and contact number of the client.
5	Age In Years	Write the age of the client in years
6	Sex: Male, Female, TS/TG	Write the Sex of the client whether Male, Female or Trans-sexual/ Trans-gender
7	Pre Test Counseling (Yes/No)	The person coming for testing is provided with HIV pre-test counselling/information involving provision of basic information on HIV/AIDS and risk assessment. Write "Yes" if pre test counselling is done or write "No" if it is not done
8	Date of HIV Test (dd/mm/yyyy)	Mention the Date of HIV test done. E.g. client tested on 1st February, 2012 write 01/02/2012 in the space provided
9	HIV Test Result (Reactive , Non Reactive)	Mention the HIV test result here whether Reactive or Non Reactive
10	Post Test Couseling (Yes/No)	Post test counseling is provided to the client helping him/her to understand and cope with the HIV test result. Write "Yes" if post test counselling is done or write "No" if it is not done
11	Referred to Stand Alone ICTC for confirmation (Yes/No)	If the client's HIV Test is reactive, refer him/her to the nearest stand Alone ICTC where three test will be conducted for confirmation of HIV status. Write "Yes" if client has been referred or write "No" if not referred and write the details like name of ICTC centre referred to, or reasons for not referring, etc in remarks coloumn
12	Remarks	Any other information not captured may be mentioned here

F-ICTC Code							
MONTHLY REPORTING FORMAT: FACILITY INTEGRATED / PPP ICTC							
SECTION A. IDENTIFICATION							
1. Name of Centre:					**Type of F-ICTC**		
2. Address:							
Pin Code:		**Block/ Mandal/ Taluka:**		**District:**		**State:**	
3. Reporting Period:		**Month:**		**Year:**			
4. Name of Officer In-charge (F-ICTC):							
5. Contact number (phone):							
6. Email Address:							
7. F-ICTC Location:							

SECTION B. BASIC INDICATORS

1. PROGRESS MADE DURING THE MONTH

	Pregnant Women			**General Clients**			
	ANC	**Direct in Labour**	**Total**	**Male**	**Female**	**TS / TG**	**Total**
1. Total ANC clients registered during the month							
2. Number of clients provided pre-test counseling							
3. Number of clients tested for HIV							
4. Number of clients provided post-test counseling							
5. Number of clients detected HIV reactive after 1st Test							
6. Number of ANC Client tested for Syphlis (VDRL/RPR Test)							
7. Number of ANC Client found reactive for Syphlis							

2. LINKAGE & REFERRAL

Department/ Organisation	**In Referral**	**Out Referral to Stand Alone ICTCs for confirmation**
1. OBG / GYN (ANC)		
2. Targeted Intervention NGOs		
3. Link Worker		
4. RNTCP		
5. STI Clinc		
6. Others		

3. STOCK STATUS OF HIV TEST KITS (Number of Tests)

Consumables	**Name of Kit**	**Batch No.**	**Expiry Date dd/mm/yyyy**	**Opening Stock**	**Received**	**Consumed**	**Control**	**Wastage / Damage**	**Closing Stock**	**Quantity Indented**
1. HIV 1st Test										
2.Whole Blood Test										

SECTION C. STI/RTI MONTHLY INDICATORS

	Male	**Female**	**Total**
1. Number of patients diagnosed and treated for various STI/RTI			
2. Number of STI/RTI patients tested for Syphlis (VDRL/RPR Test)			
3. Of Above, Number found reactive for syphilis			
4. Availability of essential STI/RTI drugs (Yes/ No)			

Signature of In Charge	
Date:	

Register for Facility Integrated/PPP ICTC

Name of the Health Facility……..								Month	……	Year	……
Sr.No.	Referred from (O&G)ANC/ Direct in Labour/RNTCP/ STI/ TI/ LWS/ Others	Full Name	Full Address with contact No-	Age In Years	Sex: Male, Female, TS/TG	Pre Test Counselling (Yes/No)	Date of HIV Test (dd/mm/yyyy)	HIV Test Result (Reactive , Non Reactive)	Post Test Couselling (Yes/No)	Referred to Stand Alone ICTC for confirmation (Yes/No)	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)

UNIT 9 – SEXUALLY TRANSMITTED INFECTIONS (STIS)

Unit Objectives

- ☛ To gain more knowledgeable and awareness about the magnitude of STI/RTI problem in the country
- ☛ To understand the seriousness of complications of common STI/RTI, if left untreated and its long term implications on health including reproductive health
- ☛ To gain awareness about the approaches to STI/RTI management
- ☛ To be able to define risk assessment and describe the steps for patient referral
- ☛ To educate and counsel STI/RTI clients about prevention, successful treatment of STI/RTI and partner treatment
- ☛ To understand their role in promoting community awareness and prevention of

Stigma and discri What are Sexually Transmitted Infections (STIs)/Reproductive Tract Infections(RTIs)

Sexually Transmitted Infections (STIs) are infections caused by germs such as bacteria, viruses, or protozoa that are passed from one person to another through sexual contact. Sexually transmitted organisms may be sometimes transmitted by nonsexual modes of transmission.

Reproductive Tract Infections (RTIs) refers to any infection of the reproductive tract. In women, this includes infections of the outer genitals, vagina, cervix, uterus, tubes, or ovaries. In men, RTI involve the penis, testes, scrotum, or prostate.

STDs versus STI

Historically, the terminology used to describe infections and diseases acquired through sexual contact has demonstrated the social stigma and moral judgments attached to these infections. Therefore,medical and public health professionals began to see the need for a more accurate, technical description, the term STI was approved by WHO and hence became the standardized term.

STIs & HIV Infection

HIV, which causes AIDS, is a viral STI that is a leading cause of death in many countries. It is transmitted through the same behavior that transmits other STI. Therefore, whenever there is a risk of STI, there is a risk of HIV infection as well. An understanding of these differences is essential in order to provide effective care and to give good advice to patients with reproductive tract complaints.

Studies have shown that the spread of HIV and other STI are closely related, STI are identified as a co-factor for the causation of HIV infection and promiscuous behavior puts people at risk for any

sexually transmitted infections as well as HIV infection (90%). A person with an STI has a much higher risk of acquiring HIV from an infected partner. A person infected with both HIV and another STI has a much higher risk of transmitting HIV to an uninfected partner.

For example, a person who has chancroid, chlamydia, gonorrhoea, syphilis, or trichomonas infection can have as much as four times the risk of getting HIV from a sexual partner as a person who is not infected with one of these STI. An ulcerative STI (such as genital herpes, syphilis, or chancroid) increases the risk of HIV transmission per exposure significantly more than a nonulcerative STI (such as gonorrhoea or chlamydia) since HIV can pass more easily through genital ulcers. But STI that do not cause ulcers also increase risk because they increase the number of white blood cells (which have receptor sites for HIV) in the genital tract, and because genital inflammation may result in damage that can allow HIV to enter the body more easily.

Routes of transmission of STIs/RTIs

STIs are caused by bacteria, viruses, or protozoa that are passed from one person to another through sexual contact. While RTIs, which are not sexually transmitted, can be caused by disturbances of the normal micro organisms, living within the reproductive organs i.e. Endogenous Infections (e.g. Unsafe sex) and by medical procedures like unsafe procedures like unsafe abortions, unsafe delivery, etc. that may provoke infections i.e. Iatrogenic infections.

In men, STIs are much more common than endogenous or iatrogenic infections. While in women RTIs include mainly sexually transmitted diseases as well as infections caused by disturbances of the normal vaginal flora containing bacteria and fungi and due to infections caused while doing medical procedures related to pregnancy, birth, or abortion under unsafe conditions.

Some RTI can be easily cured by using antibiotics or other drugs, while few others are incurable. HIV, which causes AIDS, is a viral STI that is a leading cause of death in many countries. An understanding of these differences is essential in order to provide effective care and to give good advice to patients with reproductive tract complaints

Fig 1 RTIs/STIs and HIV infection

Factors that increase the risk of RTIs

Poor general health

- Poor genital hygiene
- Poor menstrual hygiene
- Unhygienic practices by service providers during delivery, abortion, and IUCD insertion in women

Factors that increase the risk of STIs

- Unprotected sex
- Multiple Partners

- Sex with Partner having sore on the genital region, urethral discharge or infected vaginal discharge
- Previous STI infection(s) in the past year
- Special concerns for STIs/RTIs in women

Although STIs affect both women and men, women are more susceptible to them and are less likely to seek treatment than are men. It gives rise to potential complications such as infertility; ectopic pregnancy, cervical cancer, Pelvic inflammatory disease ,transmission of infection to the offspring etc.

Risk groups

In most communities there are certain people who may be more vulnerable to STI. These may vary in different communities, but they usually include:

- Adolescent girls and boys who are sexually active and indulging in unsafe sex
- Women who have several partners for earning money.
- Female and male sex workers and their clients
- Men and women whose jobs force them to be away from their families or regular sexual partners are away for long periods of time.
- Men having sex with men including trans genders.
- Street children, prison inmates, etc.

Where STIs/RTIs occur in females?

In women, RTIs involve the outer genitals, vagina and cervix are referred to as lower reproductive tract infections. Infections in the uterus, fallopian tubes, and ovaries are considered upper reproductive tract infections.

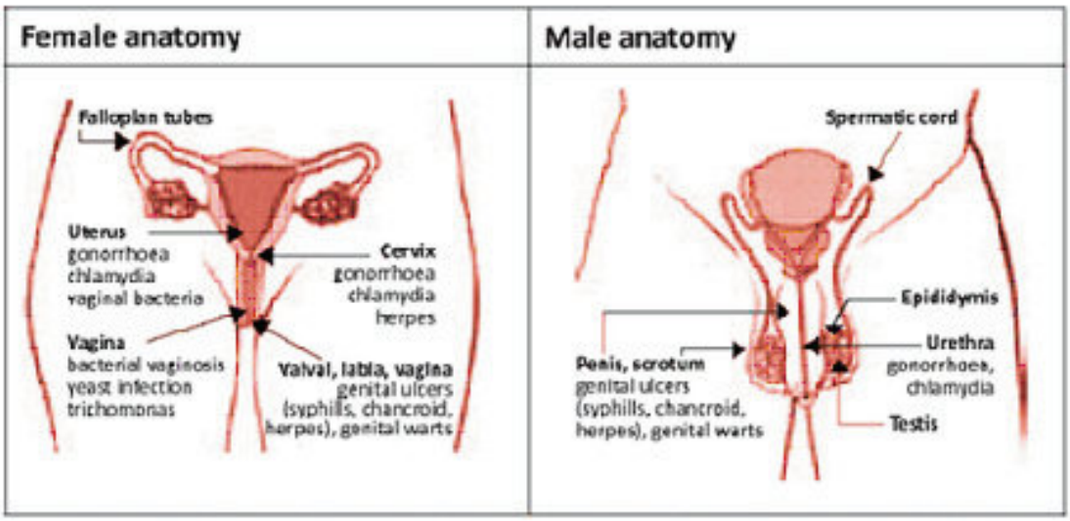
Note: Infections of the cervix are considered more severe than vaginitis because they much more commonly result in upper reproductive tract infection with its serious consequences. Unfortunately

Where STIs/RTIs occur in males?

RTIs generally begin in the lower reproductive tract (the urethra). If untreated, they may ascend through the vas deferens (sperm tube) to the upper reproductive tract (which includes the epididymis and testes). It also leads to prostatitis and epididymitis.

In general, RTIs in men are easier to identify and treat, as they are more likely to be symptomatic.

Different body sites where STI/RTI occur in females and



males

Source: Adopted from "Integrating STI/RTI care for reproductive health, sexually transmitted and other reproductive tract infections, A guide to essential practice-2005 WHO"

RTIs that are most common but may not always be sexually transmitted are:

1. Bacterial Vaginosis (BV) - A RTI in women that is caused by an imbalance in the vagina's normal environment and overgrowth of bacteria in the vagina.
2. Vaginal yeast infection- A RTI in women that occurs when the normal environment in the vagina changes and there is overgrowth of yeast, commonly candida albicans.

There are over 20 STIs. But the most common are:

1. Syphilis- A STI due to infection by Treponema Pallidum that initially causes sores that will heal on their own but, if left untreated, can cause serious complications or even death.
2. Gonorrhoea- A STI due to infection by Neisseria gonorrhoea that can cause infertility in both men and women. It includes ophthalmia neonatarum.
3. Chlamydial infection- A STI due to infection by Chlamydia trachomatis in both men and women. It is often asymptomatic.
4. Trichomonas infection- A STI due to infection by Trichomonas vaginalis in both men and women. It is often asymptomatic.
5. Chancroid- A STI due to infection by Haemophilus ducreyi, that causes lymph node swelling and painful ulcers in the genital area.
6. Genital herpes- A STI due to Herpes simplex virus that causes painful genital ulcers.
7. Genital and cervical warts due to Human papilloma virus (HPV) -Growth or warts in the genital area caused by some forms of HPV. Other forms of HPVs can lead to cervical cancer.

8. HIV infection – is caused by (Human immunodeficiency virus) a retrovirus that weakens the immune system and causes AIDS.
9. Hepatitis B and Hepatitis C infection- A virus that can cause liver damage, and possibly even liver failure.
10. Donovanosis - A STI due to infection by Calymmatobacterium granulomatis or Kleibsella granulomatis that can cause serious ulcers at the site of infection. These ulcers can grow together and cause permanent scarring and genital destruction.
11. Lymphogranuloma venereum (LGV) - A STI due to a subtype of Chlamydia trachomatis that causes inflammation of and prevents drainage of the lymph nodes in the genital area. LGV can cause destruction and scarring of surrounding tissue.
12. Molluscum contagiosum - A STI due to a virus that causes relatively benign skin infections.It can also lead to secondary bacterial infections.
13. Genital scabies- A STI in both men and women caused by itch mite, sarcoptis scabiei.
14. Pubic lice- A STI in both men and women caused by pubic lice (phthirus pubis).

5. Signs and Symptoms of STI/RTI

The following list identifies signs and symptoms of the most common RTI and STI:

In men:

- Urethral discharge: chlamydia, gonorrhoea and trichomonas infection
- Genital ulcer: T. Pallidum, H. Ducreyi.
- Genital itching: chlamydia, gonorrhoea and trichomonas infection
- Swollen and/or painful testicles: chlamydia, gonorrhoea

In women:

- Unusual vaginal discharge: BV, Chlamydia, gonorrhoea, trichomonas infection, vaginal yeast infection
- Genital itching: BV, trichomonas infection, vaginal yeast infection
- Abnormal and/or heavy vaginal bleeding: chlamydia, gonorrhoea (Note: This symptom is often caused by factors other than STI.)
- Bleeding after intercourse: chlamydia, gonorrhoea, chancroid and genital herpes
- Lower abdominal pain (pain below the belly button; pelvic pain): chlamydia, gonorrhoea
- Persistent vaginal candidiasis: HIV/AIDS
- Dyspareunia

In men or women:

Blisters or ulcers (sores) on the mouth, lips, genitals, anus, or surrounding areas: chancroid, genital herpes, and syphilis

- Burning or pain during urination: chlamydia, genital herpes, trichomonas infection and gonorrhoea
- Itching or tingling in the genital area: genital herpes, candidiasis
- Jaundice (yellowing of the eyes and skin) and/or fever, headache, muscle ache, dark urine: Hepatitis B & C,
- Warts or bumps on the genitals, anus, or surrounding areas: HPV (genital warts)
- Flu-like syndromes (fever, fatigue, headaches, muscle aches), mild liver inflammation: CMV
- Small, dimpled bumps or lesions on the skin that usually do not hurt or itch and are flesh colored, but can vary from white to yellow to pink: molluscum contagiosum
- Small, red lesions or ulcers in the genital or anal area; lymph node swelling in the genital area; chronic ulcers on the genitals or anus: LGV (Lympho Granuloma Venereum)
- Red nodules or bumps under the skin on the mouth, genitals, or anus that ulcerate, become tender, and often bleed easily: donovanosis

6. Complications of STI/RTI

STIs/RTIs, if left untreated, can cause serious complications in males, females and neonates, which are serious, long-term, and sometimes deadly, particularly for women. Some STIs/RTIs can also cause pregnancy-related complications or congenital infections. Unfortunately, symptoms and signs of many infections may not appear until it is too late to prevent serious consequences and damage to the reproductive organs.

Complications of STI/RTI in males

1. Phimosis , paraphimosis and urethral stricture
2. Inflammation of testes
3. Infertility- Infections of the upper reproductive tract can occasionally result in partial or complete blockage of the sperm ducts, and disorders in sperm production. This can cause low sperm counts in semen or abnormal sperm, which contribute to male infertility.
4. Carcinoma of the penis

Complications of STI/RTI in Females

1. Pelvic inflammatory disease (PID)

Some of the most serious consequences of RTI in women occur when an infection of the lower genital tract (cervix or vagina) or outside organisms reach the upper genital tract (uterus, fallopian tubes, ovaries and surrounding structures). Infection may become generalized and life threatening,

and resulting tissue damage and scarring may cause infertility, chronic pelvic pain and increased risk of ectopic pregnancy.

Untreated gonococcal and chlamydial infection in women results in pelvic inflammatory

disease in upto 40% of cases. One in 4 of these will result in infertility.

2. Adverse outcomes of pregnancy

RTI such as chlamydia, gonorrhoea, syphilis, genital herpes etc. are responsible for the adverse outcomes of pregnancy. In addition to ectopic pregnancy, other poor pregnancy outcomes that are linked to RTI include:

- Fetal wastage - spontaneous abortion or stillbirth.
- Low birth weight due to premature delivery or intra-uterine growth retardation.
- Congenital or perinatal infections - eye infections causing blindness, infant pneumonias and mental retardation.

3. Infertility

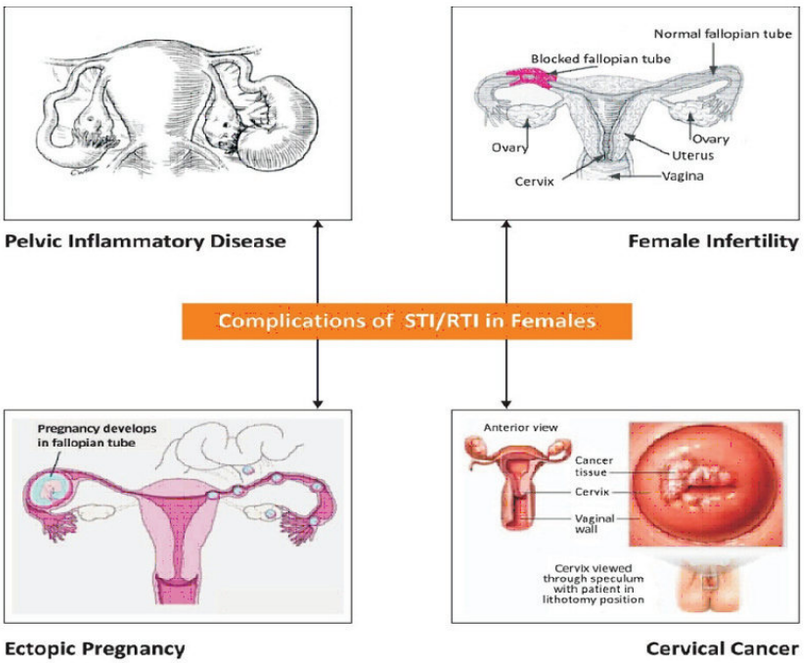
Infertility often follows after untreated pelvic inflammatory disease in women, and epididymitis and urethral scarring in men. In fact, complications of RTIs are the most important preventable causes of infertility in regions where childlessness is most common. Repeated spontaneous abortion and stillbirth often due to STI such as syphilis are other important reasons why couples are unable to have children.

4. Ectopic pregnancy

The tubal scarring and blockage that often follows PID may be total or partial. Fertilization can still occur with partial tubal blockage but risk of implantation in the fallopian tubes or other site outside the uterus (ectopic pregnancy) is high. Ruptured ectopic pregnancy, along with complications of abortion and postpartum infection, is a common preventable cause of maternal death in places with high prevalence of STI/RTI and PID.

5. Cervical cancer

Infection with Human papilloma virus (HPV) appears to be strongly associated with the development of cervical cancer, which is the most common genital cancer among women in India. Cervical cytological screening (Papanicolaou smears) facilities are still not available in the primary health care facilities and therefore majority of diagnosed cases are detected in advanced stages when treatment has lower successful outcome.



Complications of STI/RTI in newborn babies

1. Perinatal and neo-natal infections

(i) Congenital syphilis –

It results from the transmission of treponema pallidum infection from an infected pregnant woman to her fetus. Maximum transmission (up to 100%) occurs if the mother herself is in the primary or secondary stages of the disease and this transmission rate drops to 10% to 30% if the mother is in the late latent stage. The symptoms and signs of the congenital infection may not be evident till the infant is about 3 months old when hepato- splenomegaly, conjugated hyperbilirubinemia, skeletal lesions, skin and mucus membrane lesions and other features are detectable. If untreated, late manifestations appear in the second year of life.

(ii) Gonorrhoea

An untreated Neisseria gonorrhoea infection in pregnant woman results in its transmission to her neonate. The neonate may present with only conjunctivitis, which usually appears within the first four days of life and may progress to panophthalmitis unless treated. The newborn may also have systemic disease, which may present as sepsis, arthritis or meningitis.

(iii) Chlamydia

Chlamydia trachomatis can be vertically transmitted from an infected pregnant woman to her neonate and may cause only conjunctivitis or have systemic infection like pneumonitis.

(iv) Human immunodeficiency virus (HIV)

Most of the HIV transmission takes place during delivery but it must be remembered that HIV is also transmitted through breast milk (14%).

(v) Herpes simplex viruses 1 & 2 (HSV1 & HSV2)

Herpes simplex virus has a very high intrapartum transmission rate (75% to 90%) and can lead to localized or central nervous system or disseminated disease in the affected neonates with a very high rate of long-term residual sequelae.

(vi) Hepatitis B virus

Hepatitis B virus infection in the mother can be transmitted to the neonate. Neonatal infections result in higher carrier rates with more chances of long-term sequel. There are a number of other infections like cytomegalovirus, candida, trichomonas and other organisms that are transmitted from the mother to the neonate and can cause serious morbidity.

2. Prematurity

STI/RTI in pregnancy especially bacterial vaginosis and trichomoniasis may result in preterm delivery, which can lead to prematurity and associated complications in the neonate.

3. Low birth weight

Low birth weight can be a result of prematurity or intrauterine growth retardation caused due to associated STI/RTI in pregnancy.

4. Systemic complications

Systemic complications are common to all & include renal, cardiac, gastrointestinal, neurological, complications of skin and Septicaemia.

Situation in India

The STIs/RTIs are becoming a rapidly growing problem in our country and has serious impact. Transmission and prevalence of STI/RTI are influenced by social and economic factors as well as by biological and behavior pattern.

It is estimated that the prevalence of symptoms suggestive of STI/RTI in women was in the range of 23% to 43%, while in men, it is in the range of 4% to 9%. The STI clinic based data indicates syphilis as the major prevalent STI among men (31%-57%). This is followed by chlamydia (20%-30%), chancroid (10%-35%), and gonnorhoea (8%-26%). The hospital based studies report a varied prevalence for HSV (3%-15%) and HPV (5%-14%) among men in India. Awareness of STI/RTI in men is 53% while in women is only 44%.

STIs/RTIs control strategies

There are two main elements of STI/RTI control:

- Prevention, such as , community education is the primary strategy to preventSTIs/RTIs from occurring. It should include information about various STIs/RTIs and their consequences, reducing the number of sex Partners, using condoms, and having safer sex.
- Effective case management means correctly diagnosing and treating symptomatic patients, and providing patient education and partner management to prevent reinfection and transmission to others.

Control strategies are often different for those who are at high risk and those at lower risk of contracting and transmitting infection. Reaching those at high risk will provide the greatest overall reduction of STIs/RTIs in the community.

8. Prevention of STI/RTI

Primary prevention	Secondary prevention	Tertiary prevention
• Creating awareness and imparting knowledge about safer sex and STI/RTI • Advising on practicing safe sex • Use of condom-Correct and consistent use of condom • Having single partner, avoiding multiple partners • Maintaining sexual hygiene • Removing stigma and bias in community and health care provider for improving the treatment seeking behavior • Improving access to safe delivery and safe abortion services	• Early diagnosis and prompt treatment by trained health care personnel prevents spread of infection • Correct and adequate treatment • Treatment of both the partners simultaneously • Strengthening the referral system • Accessible and affordable STI/RTI services in locality	• Prevention of late complications, complications of infertility and children

Prevention and control of STI/RTI in India is difficult because of:

- Very few cases are symptomatic; mostly they are asymptomatic, chronic or vaguely symptomatic. People do not seek treatment easily but they can transmit infection even when not having symptoms
- Sex is a taboo subject. So people, especially women do not discuss problems they think are related to sexual activity and avoid seeking treatment

- Often treatment is taken from quacks
- Treatment, even when taken, is often inadequate, incomplete, left halfway
- Partners often do not take treatment which results in reinfection
- Overburdened and under-trained health care workers
- Stigmatizing attitudes of health care workers towards marginalized high risk groups i.e. Most at Risk Population (MARP).
- Inadequate referral systems
- Limited and inadequate preventive startegies , especially for youth

It is important for health care providers to remember that STI affect men and women of all ages, backgrounds, and socioeconomic levels. Providers of STI services and counseling must avoid judgmental and moralistic attitudes that can deter clients from seeking treatment, especially in the case of clients (who might be particularly susceptible to social stigma and bias, such as adolescents, sex workers, unmarried women, and homosexuals).

STIs/RTIs Case management

The main objectives of STI/RTI management at the grass root level is to assess the risk of clients attending sub-centre facilities for STIs/RTIs and send them to higher facilities for diagnosing the infection and availing appropriate treatment, at an early stage.

High quality management of STI/RTI is important because it:

1. Prevents the development of long-term complications
2. Reduces the length of time a person is infected and therefore, the further spread of STIs/ RTIs
3. Reduces the level of STIs/RTIs in the population that present an increased risk for sexual transmission of HIV
4. Allows for education and counseling on risk reduction and health-seeking behaviors
5. Generally improves the quality of people's lives
6. Management of STIs/RTIs involves more than simply diagnosis and treatment of the infection

The 7 steps of comprehensive STI/RTI case management are:

1. Take history
2. Conduct physical examination
3. Provide treatment
4. Provide health education on prevention
5. Provide condoms and demonstrate use
6. Offer Partner treatment

7. Follow up or refer as needed

The Syndromic Case Management (SCM)approach to STIs/RTIs

The patient is diagnosed and treated based on groups of symptoms or syndromes, rather than for specific STI/RTI. All possible STIs/RTIs that can cause those symptoms are treated at the same time.

Advantages:

- Fast—the patient is diagnosed and treated in one visit
- Highly effective for selected STI/RTI syndromes
- Relatively inexpensive since it avoids use of laboratory
- No need for patient to return for lab results.
- Avoids the wrong treatment since all possible STIs/RTIs causing signs and symptoms are treated at once
- Can be used by Health Care Providers at all levels

How ANMs can help doctors in case management?

They can help doctors by:

- Referring patients whose clinical history suggests symptoms of STIs/RTIs
- Referring patients or clients who are at risk of developingSTIs/RTIs or screening of asymptomatic clients
- Providing Client education and counseling for prevention, treatment adherence and follow up
- Partner management and Notification
- Providing Condom Demonstration/instruction for their correct and consistent use

Action points for management of STs/RTIs

ANMs should consider following important factors when managing men and women with STIs/ RTIs:

- Unawareness of the consequences of STIs/RTIs
- Shyness/embarrassment to talk about STIs/RTIs, especially among adolescents and women
- Difficulty in eliciting the sexual health related information
- Privacy and Confidentiality issues

RISK ASSESSMENT, PROMPT REFERRAL AND PARTNER MANAGEMENT

1. **Risk Assessment**
   Importance of History taking

A client history is taken to get the information needed to make an accurate risk assessment of the problem for the appropriate and timely referral to the higher services. It is one of the most important and sensitive parts of the patient encounter.

Goals of history

- To establish the patient's risk of contracting or transmitting a STIs/RTIs
- To efficiently collect essential information that will help in diagnosis, treatment and prevention of STIs/RTIs
- To determine if the patient has had any Partners who may have been infected

General tips for History Taking

- History must be taken in a language, which the client understands well
- Ensure privacy (both visual and auditory) by having a separate room for history taking and examination
- Encouraging him/her to talk about their complaints by establishing eye contact and by being attentive
- Maintaining a high index of suspicion about STIs/RTIs as the client, out of embarresment , may not mention it specifically
- Screening for Antenatal Care and Family Planning services clients
- Assuring the partner that STIs are not necessarily acquired through sexual contact but they can also be acquired through unhygienic conditions. This is absolutely essential to get partner confidence and co- operation.
- Awareness of the commonly used culturally appropriate STI/RTI related terminology as well as those used for high-risk behavior
- Information to be collected in history taking
- General information: age, sex, address, marital status-married or single, number of children, employment, contraceptive method if any, date of last menstrual period and information of partner/s
- **Present illness:** signs, symptoms, and their duration previous treatment and response to therapy
- **Medical history:** STI/RTI in the past, other illnesses, and drug allergies
- **Sexual history:** Currently sexually active, age at first intercourse, new Partner, risky sexual behaviors, sexual preference (homosexual, heterosexual or bisexual) and use of condoms with each partner)

Risk Assessment For Women

- Husband/ Partner is a migrant worker or is having multiple partners
- Sex work
- Husband/partner having STIs/RTIs

Risk assessment in men:

- Having multiple or casual partners
- Is a truck driver/migrant worker
- Wife/ Partner is having STI

Common problems encountered when taking history related to STIs/RTIs:

- Limited time with the Health care Provider
- Provider/Patient is uncomfortable talking about sex
- Provider is of opposite gender

Assessing risk may be improved by:

- Ensuring confidentiality
- Questions are specific to local needs and conditions
- Assisting clients assess their own risk (self-assessment)

STI (Genital infections) symptoms checklist

For men

- Discharge or pus (drip) from the penis
- Urinary burning or frequency
- Genital sores (ulcers) or rash or itching
- Scrotal swelling
- Swelling in the groin
- Infertility

For women

- Abnormal vaginal discharge (increased amount, abnormal odor, abnormal color, consistency)
- Genital sores (ulcers), rash or itching
- Urinary burning or frequency

- Pain in lower abdomen
- Dysmenorrhoea, menorrhagia, irregular menstrual cycles
- Infertility
- Obstetric history and contraceptive history

High risk sexual behavior

- For all adolescents: Have you begun having any kind of sex yet?
- If sexually active, do you use condom consistently?
- Do you have any reason to think you might have a sexually transmitted disease? If so, what reason?
- Have you had sex with any man, woman, with a gay or a bisexual?
- Have you or your Partner had sex with more than one Partner?
- Has your sex Partner(s) had any genital infections? If so, which ones?
- Do you indulge in high risk sexual activity like anal sex
- Do you practice correct and consistent condom usage while having sex? If yes, whether every time or sometimes?

STI history

- In the past have you ever had any genital infections, which could have been sexually transmitted? If so, can you describe?

STI treatment history

- Have you been treated in the past for any genital symptoms? By whom? (qualified or unqualified person)
- Did your Partner receive treatment for the same at that time?
- Has your Partner been treated in the past for any genital symptoms? By whom? (qualified or unqualified person) Injection drug use
- Have you had substance abuse? (If yes, have you ever shared needles or injection equipment?)
- Have you ever had sex with anyone who had ever indulged in any form of substance abuse?

Referral

When to refer a patient:

- If history suggests symptoms of STI/RTI including HIV/AIDS
- Patient is a known case of STI/RTI and gives symptoms suggestive of reinfection
- If there is Partner history of STI/RTI

- If there is history of risky sexual behavior
- ANC cases having symptoms
- History of recent abortion and symptoms like fever or pain abdomen
- Post natal women with symptoms of infection

Where to refer a patient:

- Nearest center where facilities for managing STIs/RTIs are available i.e. to PHC or Rural hospital, District hospital
- ICTC centers for voluntary testing for HIV/AIDS

How to refer a patient:

- With complete Patient record having history, symptoms, diagnosis
- With proper address of the centre and directions
- Referral slip to be given
- Partner should ideally accompany the patient
- Patient should be advised for follow up visit
- Patient should carry the old records with them

Partner Management

What is Partner management?

Partner management is an activity in which the Partners of those identified as having STIs/RTIs are located, informed of their potential risk of infection, motivate and offer them treatment and counseling services. Timely Partner management serves following purpose:

- Prevention of re-infection
- Prevention of transmission from infected Partners and
- Help in detection of asymptomatic individuals, who do not seek treatment

General principles for Partner Management

- The Partners of clients having STIs/RTIs must be referred even if they do not have symptoms suggestive of STIs/RTIs.
- Couple must be explained that some of these infections are acquired through unhygienic conditions like unclean toilets, fomites, swimming pools etc.
- STIs/RTIs cannot be treated fully unless the Partner is also treated, as there is a definite chance of reinfection through sexual transmission. This ensures compliance from both Partners.
- A two-step strategy can be used where Clients are first asked to contact Partners themselves. If

no response till one or two weeks, clinic or health department staff can attempt to trace the contact for treatment.

Note: Efforts needed to trace the Partner but whether the Partner should be treated, the choice to be rested with the patient.

Important issues in Partner management

- Confidentiality: Partners should be assured of confidentiality. Many times Partners do not seek services, as they perceive confidentiality as a serious problem. It will promote Partner management
- Voluntary reporting: Providers must not impose any pre-conditions giving treatment to the index client. Providers should counsel client several times to emphasize the importance of client-initiated referral of the partners.
- Gender issues Providers should understand that because of prevailing gender inequities, woman may not be in position always to communicate adequately to her husband/partner regarding need for partner management.
- Availability of services: STI/RTI diagnostic and treatment services should be available to all Partners.

Approaches for Partner management

- **Referral by Index Client**

This approach, appears to be a feasible approach, because it does not involve extra personnel, is inexpensive and does not require any identification of Partners. This approach may also include use of Client-initiated therapy for all contacts.

- **Referral by Providers**

Service provider contacts Client's Partners through issuing appropriate Partner notification card. The information provided by Client is used confidentially to trace and contact Partners directly. This approach needs extra staff and is expensive.

Client Education on STIs/RTIs

Client education is the corner stone for the management of STIs/RTIs and includes information not only on various STIs/RTIs, their transmission, recommended treatment and Partner referral but also on prevention, risk reduction and behavior change,. This information can be communicated one-on-one, in group settings in the clinic; and via posters, videos, and brochures. It should involve all possible staff. Client education requires teaching and group facilitation skills

What the client needs to know

Prevention of STI/RTI

- Risk reduction

- Using condoms, correctly and consistently, availability of condoms
- Limiting the number of partners
- Alternatives to penetrative sex
- Negotiating skills

Education on STIs/RTIs

- How they are spread between people
- Consequences of contracting STIs/RTIs
- Links between STIs/RTIs and HIV

STIs/RTIs treatment

- How to take medications
- Symptoms that call for a return visit to the clinic
- Importance of Partner referral and treatment

Principles of effective client education

- Shows respect and concern being attentive to and acknowledging clients feelings, and taking sufficient time with them
- Is client-centered
- Provides messages that are tailored for each individual–different message for married men, women, and adolescents
- Involves 3 kinds of learning: through ideas, actions, and feelings (cognitive, psycho- motor, and affective)
- Uses multiple channels (eyes, ears and face-to-face/visual, auditory, interpersonal)
- Delivers messages via the eyes, ears, and face-to-face communication

Education on safe sex

One of the most effective ways of prevention and management of STIs/RTIs is the practice of safer sex by the clients and their partners as reduces the risk of passing STI and HIV from one person to another . It is an integral part of any Client Education activity.

What is Safe Sex

It refers to the precautions being taken so as not to transmit or acquire STIs, including HIV infection. Safe Sex practices prevent the transmission of body fluids (e.g. vaginal secretions/semen etc.) from one partner to the other.

Some safer sex practices

- Mutually faithful relationship between two uninfected partners
- Reducing the number of sex partners
- Using a barrier such as a condom for all types of intercourse
- Non-penetrative sexual practices such as kissing, hugging, rubbing, and masturbating
- Avoiding sex when either partner has signs of a STI
- Abstinence

Some practices that make sex risky

- Unprotected vaginal sex if one don't know whether the partner is infected
- Sex with a partner who has signs of a STI
- Sex with multiple / casual partners
- Unprotected anal/oral sex.
- Use of alcohol or drugs with sex.
- Sex with an intravenous drug user.
- Douching or use of vaginal drying agents

Guidelines for communicating with clients on safer sex methods

- Use of protection (condom or other barriers) every time one has sex unless it is with only one faithful Partner who is uninfected
- Keeping away from unsafe practices like "dry sex" that may break the skin—vagina should be wet inside during the intercourse
- Avoiding anal sex, but if one has to, it should always be with lubricated condoms to prevent skin tear so that HIV can't pass
- Using non sexual practices such as massage, rubbing, touching, dry kissing, hugging, or masturbation
- Having oral sex with a male or female condom
- NOT having sex when either Partner,who has genital sores or abnormal discharge **Guidelines for communicating with clients on negotiating safer sex**

- **Focus on safety**

  It is easier to reach agreement around safety because both people benefit from it

- **Use other people as examples**

  Knowledge that others are practicing safer sex can make it easier to start.

- **Ask for help if you need it**

  Inviting another trusted person to help discuss safer sex with a Partner may make it easier. Importance of Condoms and its correct usage technique

  Condom is one of the barrier method of contraception and are made of latex, polyurethane, which can't be penetrated by sperms,HIV or STI/RTI causing oraganism. Therefore it provides dual protection, by helping to avoid unwanted pregnancy as well as STIs/RTIs.

  Therefore promotion of the use of condoms and ready accessibility of condoms is important for the control of STI and HIV. Management of STI includes counseling on preventive measures and use of condoms. All health facilities providing STI services must always have in stock the essential drugs and condoms. The necessity of using condoms must be explained to the Clients along with the advice on the treatment schedule and important for compliance of the full course of medicines prescribed.

  For details regarding the type of condoms and their correct usage, refer to Unit 5 on "Prevention of HIV transmission"

  Integrated counseling and testing centers (ICTCs) and their role in STI prevention and management

  In Integrated Counseling and Testing Centers, the STI client will receive comprehensive and accurate information on HIV/AIDS and HIV counseling to facilitate an informed choice regarding a HIV test. The integrated centers serve as single window system by pooling all counselors and laboratory technicians working in ICTCs, PPTCT Centres, , STI, ART Centres, and HIV - TB together to offer round the clock counseling and testing services. This common facility will remove fear, stigma and discrimination among the clients, PLHIV and the referrals.

In STI settings, the following is recommended

- HIV testing should be recommended for all STI clients after pre-test counseling and informed consent. There should be a guarantee for confidentiality. HIV counseling and testing can either be performed in the STI clinic (if counselor is available) or clients can be referred to the nearest ICTC.
- In some cases of STI in the presence of HIV infection, larger doses and longer treatment duration of the drugs listed under the different STI may be required. These clients should be followed up regularly for longer duration.
- Excessive use of anti-microbial should be avoided, as it is likely to lead to more rapid development of antibiotic resistance.

  Note: It is important that counseling of individual clients on risk reduction, and prevention of STI transmission to the partners should be done in all clients of STIs

PREVENTING STI/RTI AMONG SPECIAL POPULATIONS

- **Male Participation in Prevention and Control of STI/RTI**

Often men are the bridging group who acquire infection from and transmit STI/RTI to high- risk Partners such as sex workers and who then carry it home to their regular Partners. In this way, STI/RTI spread even to women who have only one Partner. Reaching men with prevention messages and condoms and treating their STI/RTI early and correctly are very effective ways to prevent the spread of STI/RTI in their regular Partners.

Two important reasons why men should be involved in STIs/RTIs prevention programs

To encourage men with STIs/RTIs to bring or refer their partners for treatment. Since STIs/RTIs are more often symptomatic in men than in women, partner management is an important way to identify asymptomatic women who need treatment.

To reach men with information about prevention, especially use of condoms in casual and commercial sex encounters. This will reduce the chance that they will take STIs/RTIs home.

Ways to Involve Men in Awareness, Prevention, and Treatment

There are many ways to involve men in the awareness, prevention, and treatment of STIs/RTIs. The following are only a few examples:

- Public information campaign on STIs/RTIs directed to men receiving early treatment and informing their partners of the need for treatment
- Condom promotion for men with casual partners in addition to primary partners
- Posters in local bars, pan shops where men gather, that address STIs/RTIs
- Drug treatment packets/kits with information on STIs/RTI sfor female partners.
- Partner referral cards for a men to give to their primary partners
- Linking FP/MCH services with STIs/RTIs services for partner referral
- Public information campaign on Syphilis and HIV focused on STIs/RTIs prevetion to protect both their wives and newborns by decreasing the number of casual partners and using condoms
- Adverting ANC services that promote male partnership in pregnancy and birth
- Trained peer educators in the workplace

Men may be more receptive to STI prevention messages if they understand that STIs threaten their health and fertility, and may endanger the lives of their wives, girlfriends and children.

The challenge of reaching Men and how to address these challenges

Challenges	How to address
• Men may not feel comfortable using services mainly used by women.	• Establish men only clinic or have dedicated hours for men services • Ensure privacy and confidentiality
• Men may feel shame or embarrassment about seeking information or treatment for STI/ RTI.	• Create general public awareness • Provide better experiences to those attending the clinic so they recommend others to seek services • Provide adequate information to those attending the clinic which might help in spreading the word in the peers and community
• There is a lack of confidentiality for men if their partners are with them.	• Have proper arrangements for privacy to men and women in the clinic • Assure then and maintain • Try couple counseling rather than individ-
• Treating men may take time and resources away from women.	• Assign adequate time to men as well as women • Make available enough resources and manpower for handling the load of STI/RTI clinic/RH clinics
• Treating men requires new skills from providers.	• Train providers to respond to STI/RTI management needs of both men as well as women
• Treating men may require different facilities and more male providers	• Establish men only clinic or have dedicated hours for men services

2. Preventing STI/RTI in Adolescents

Adolescent girls are particularly vulnerable to STIs/RTIs since they are less likely to have access to health services and to recognize symptoms. Health services for adolescent boys are also extremely limited. Lack of education about sexual health for both boys and girls leaves them ill equipped to make important choices to protect themselves against unwanted sex, pregnancy, and STIs.

The data from various Indian studies reveal that

Adolescents indulge in pre-marital sex more frequently and at an early age.

- More than half of the currently married illiterate females are married below the legal age of marriage. Nearly 20% of the 1.5 million girls married under the age of 15 are already mothers. Nearly 27% of married females adolescents have reported unmet need for contraception.
- STIs, including HIV, are most common among young people aged 15-24 years and more so in young women. Over 35% of all reported HIV infections in India occur in this age group ,indicating that young people are highly vulnerable. The majority of them are infected through unprotected sex
- Deaths due to pregnancy and its outcomes in married female adolescents of 15-19 yrs are higher than adult females who are in the reproductive age group **Barriers to information and services for youth**
- Lack of services: little access to family planning or services for treatment or prevention of STIs
- Lack of access to condoms
- False belief that young people are not sexually active, and that information will increase sexual activity
- Lack of messages targeted to youth
- Lack of providers trained to deal with youth

Overview of the adolescent reproductive and sexual health strategy

Adolescent Reproductive and Sexual Health (ARSH) has been developed and in the National Rural Health Mission (NRHM) ARSH strategy has been approved as a part of the Reproductive and Child Health Phase II (RCH II) and has been adopted by many states as a part of the national strategy. This strategy is now to be implemented in the districts in the Primary Health Care setting.

It focuses on re organiazing the existing public health system in order to meet the service needs of adolescents. Steps are to be taken to ensure improved service delivery to adolescent during routine check ups at sub centers clinics and to ensure service availability on fixed days and timings at the PHC and CHC levels.A core package of services would include preventive, promotive, curative and counseling services

ANMs should give the following information on STIs/RTIs prevention to adolescents

- Abstinence or Delay the onset of sexual activity
- Avoid multiple partners and stick with one partner.

- Correct and consistent use of condoms
- Avoid high-risk partners.
- Recognize symptoms of STIs/RTIs. If burning with urination and/or discharge from the penis, or there are genital sores, young men and their partners should not have sex, but both should come to the clinic for treatment.

Key issues to be communicated are:

A - Abstinence

B - Be faithful to your partner

C - Use condoms

D - Early diagnosis

E – Ensure cure

3 Preventing STI/RTI among High Risk Group Population (HRG)

High risk group population comprises the people who sell sex for money or favors, the sex workers, men having sex with men (MSMs), transgender and intravenous drug users (IDUs).

What all HRG have in common is that their work puts them at high risk for STI/RTI. HRG population can transmit infections at a higher rate than others in the population. Due to their high potential to transmit infections to others, the high risk group population especially sex worker needs effective treatment whenever and wherever they present for care, as well as knowledge and skills to promote condom use with their regular partners and customers. Female sex workers, MSMs, IDUs have the highest rates of transmission of HIV.

Providing services to sex workers such as distributing free condoms, STI treatment and enabling them to adopt safer behavior can have the greatest impact on slowing STI transmission in the larger community.

COMMUNITY EDUCATION FOR PREVENTION OF STI/RTI

Good management of STIs/RTIs in the clinic is necessary, but it alone will not prevent the spread of STI/RTI. An urgent need to increase community awareness of STIs/RTIs and AIDS exists because of the general lack of knowledge and motivation for behavior change and the stigma associated with STI/RTI, particularly HIV

Need for community education on prevention and control of STIs/RTIs

- **To increase awareness of the symptoms and consequences of STIs/RTIs:**

Awareness of the signs of STIs/RTIs, knowledge about STIs/RTIs transmission and the serious consequences of STIs/RTIs, and perception of risk is low in many communities, especially among certain populations. Increasing knowledge and awareness is the first step toward changing behavior.

- **To counter myths and misconceptions:**

Myths and misconceptions about AIDS and STIs/RTIs abound, often causing stigmatization of people known to be infected. Negative community attitudes based on misunderstandings prevent people from openly seeking information and health care and using condoms to protect themselves.

- **To encourage risk-reducing behaviors:**

People need to know which behaviors are safe and how to reduce unsafe behavior. Awareness of the consequences of unsafe behavior can lead to motivation for change.

- **Increase use of available health services:**

Adverting availability of services at the health centers with clear messages about services offered and populations served can increase the use of available services. The quality of an individual's experience can be greatly improved by creating a welcoming, supportive, educational atmosphere.

- **Start a process of social change:**

Organized community groups can help both men and women to discuss their concerns about about health problems, including STI/RTI and AIDS, in an open and non judgemental environment and explain hoe early detection and treatment of STI/RTI help prevent HIV infection.

- **Gain public support for STI/RTI services:**

If community members see that prevention efforts are backed up by quality health services, they will be more willing to support such services. Make sure condoms are available in your community and at the health centers.

- **Increase community leaders' support for STI/RTI services:**

Active engagement of the community in STI/RTI prevention that yields positive results can make it easier for leaders to support STI/RTI control efforts publicly, continuing a positive cycle of prevention activities

Developing Strategies for BCC in the Community

Define target groups: Understand that different messages are required to reach different groups. Sex workers, youth, men, rural and urban women, community leaders, and religious leaders—all need messages and information tailored to their different situations.

Understand community beliefs and practices to make sure that relevant messages are conveyed

Set communication objectives and activities: developing education materials according to their levels of information, their attitudes and prejudices about STI/RTI etc.

Develop strategies to reach target groups:

Evaluate the strategies impact:

Can you use peer educators to reach marginal groups? Can you attract people by offering clinical services?

Glossary of STI/RTI Related Terminology

S. No.	Terms	Meaning
1	Sexual Aberration	A sexual activity, which differs from those generally, practiced, or considered 'right' or 'moral'; also called
2	Adultery	Sexual intercourse between a married person and an
3	Anal intercourse	Sexual intercourse in which the penis is inserted into the Partner's anus; sometimes termed sodomy or
4	Anilingus	The act of using the mouth or tongue in erotic stimulation of the anus (the rim)
5	Aphrodisiac or Zoophilia	Anything, such as drug or perfume, that is believed to
6	Bestiality	Sexual relations between a human and an animal
7	Celibacy	a. The state of being unmarried, usually implying sexual abstinence b. Abstaining from sexual intercourse
8	Clap	A layman's expression for gonorrhoea
9	Coitus/Copulation (To engage in coitus, to bang, to fuck, to lay, to	Sexual intercourse between a male and a female, in which the penis is inserted into the vagina
10	Coitus interruptus (premature withdrawal, pulling out)	The practice of withdrawing the penis from the vagina just before ejaculation;
11	Condom (French letter or FL, rubber sheath, Nirodh) In females the condom is placed in the	A contraceptive commonly used by males and recently introduced for females. For males it consists of a rubber or gut sheath that is drawn over the erect penis before sexual intercourse

14.	Fellatio (penilingus) (a blow job; to blow, to go down on, to eat, to suck)	The act of taking the penis into the mouth and sucking it for sexual pleasure
15.	Fidelity	Being faithful to one's chosen or given sexual Partner(s) and having sexual intercourse only with that/those
16.	Fondling	Touching or stroking lovingly; caressing
18.	French kissing (deep kissing or wet kissing)	Use of the tongue in kissing; thrusting of the tongue into the Partner's mouth during a kiss
19.	Gay	Another term for male homosexual
20.	Glans	The head of the clitoris or the penis; comes from the
21.	High-risk behaviour	Term used to describe certain activities which increase the risk of transmitting an STI; includes frequent change of sex Partners, anal and vaginal intercourse without using a condom, oral-anal contact, semen or urine in the mouth, sharing intravenous needles or syringes, intimate blood contact and sharing of sex toys contaminated by body fluids; often referred to
22	Impotence (Erectile dysfunction)	Inability of a man to have sexual intercourse; usually refers to inadequacy of penile erection
23	Incest	Sexual intercourse between close relatives, such as father and daughter, mother and son, or brother and
24	Labia majora	The major or outer lips of the vulva
25	Labia minora	The minor or inner lips of the vulva
26	Lecherous	Being very lustful
27	Lesbian	A female homosexual
28	Libido	Sexual drive, interest or urge
29	Masturbation (Hand practice, playing with oneself)	Self stimulation of the genitals through manipulation; autoeroticism; self gratification
30	Monogamy	A marital arrangement in which a person has only one spouse

31	Nymphomania	The constant, extreme and irrepressible desire of a woman for sexual satisfaction
32	Oral-genital sex	Application of the mouth or tongue of one Partner to the genitals of the other
33	Oral-sex (head job, come down on, eat each	Sexual activity which involves mouth contact with another person's genitals or anus; contact may include kissing, sucking or licking of the sexual organs
34	Orgasm (The big O, to experience orgasm, to come)	The peak or climax of sexual excitement in sexual activity
35	Paedophile	An adult who engage in or desires sexual activity with a child
36	Partner exchange (Swinging, swapping)	The planned exchange of sexual Partners between four or more individuals
37	Pederasty	1. Male sexual relations with boy, often-anal intercourse 2. Sexual relations via the anus
38.	Petting (Making out, necking, dry fuck, dry lay)	Sexual contact that excludes coitus
39	Polyandry	The form of marriage in which a woman has several husbands
40	Polygamy	A marital arrangement in which a person has more than
41	Polygyny	The form of marriage in which a man has several
42	Pornography	The explicit description or exhibition of sexual activity in literature, photographs, films, etc, intended to stimulate erotic rather than emotional feelings
43	Promiscuous	Engaging in sexual intercourse with many persons; engaging in causal sexual relations
44	Prostitute	A person who engages in sexual relationships for payment (hooker, streetwalker, whore, pros); nowadays referred to as a commercial sex worker to avoid a negative bias
45.	Prostitution	Engaging in sexual activity for money
46	Sadism	The achievement of sexual gratification by inflicting physical or psychological pain upon the sexual Partner
47	Sado-masochism	A form of behaviour in which sex and pain become pathologically attached bondage, discipline

48.	Safe- sex	Term used currently to describe sexual activities mostly to reduce the risk of transmission of STD; includes
49.	Vaginal lubrication	A clear fluid (like sweat) that appears on the walls of the vagina within a few seconds after the onset of
50	Virgin	A woman or girl who has never had sexual intercourse

SECTION 3
EXCERCISES

Unit 1: INTRODUCTION

Trainer's Notes :

The **purpose** of this exercise is **to stimulate the participants to think about HIV/AIDS.**

Instructions:

– Ask all the participants to stand up and form one group.

– Designate **three areas** in the room – one area will be for "***Agree***", the second will be for "***Disagree"*** and the third for ***"Not Sure".***

– Project each statement slide and ask participants to quickly go stand in the area designated for their response.

– Ask the participants in each group to discuss for two minutes why they chose that response.

– Then ask one member from each group to share their reasons.

– Use the trainer's notes to help facilitate a short discussion, correcting any misinformation at this time, **but do not attempt to teach the subject fully.**

– Proceed in this manner with all statements.

Statement No.1

One can generally identify a person with HIV infection just by looking at him or her.

Explanation:

Disagree. People with HIV can appear (and actually can be) very healthy. They can also have illnesses (opportunistic infections) that HIV negative individuals have, such as TB or pneumonia. Thus, although there are certain infections and symptoms associated with HIV disease, it is impossible to tell just by looking at someone if they are HIV positive. Confirmation can be got only through blood tests.

Statement No. 2

HIV and AIDS are the same

Explanation

Disagree. HIV is a virus that weakens Immune system. AIDS is a disease caused by HIV and is characterized by the presence of various illnesses (Opportunistic Infections and /or cancers) , caused by the weak immune system.

A person may be infected with HIV for many years before his/her immune system is damaged sufficiently to cause these infections/cancer. Hence the person may not show any symptoms and look healthy during this period.

Statement No. 3

Once the immune system has been restored to normal function, antiretroviral therapy can be stopped.

Explanation

Disagree.Antiretroviral treatment should not be stopped unless issues of toxicity or poor adherence develop

Statement No. 4

Once a patient starts antiretroviral treatment, he or she can no longer transmit HIV infection to others

Explanation

Disagree.This statement is a wrong and dangerous assumption! Although viral loads in HIV positive individuals may become so low that they cannot be detected, this does not mean that the virus cannot be passed to another person. The virus still exists because there is no cure for HIV. There is also the possibility that an individual can pass a resistant virus or a new strain of virus on to someone.

Statement No. 5

A woman who is HIV infected should not get pregnant.

Explanation

Debatable. This statement may generate a lot of discussion because of people's assumptions about passing the virus on to an unborn child. The goal is to find out what participants know about HIV and their assumptions about people who live with HIV, and NOT to judge them. An HIV-positive woman who is pregnant will not necessarily pass the virus on to her child. There are interventions available to further reduce the risk. It is her and her family's choice whether or not she should get pregnant.

Statement No. 6

Sex with a virgin / younger womencan protect a man from STI infections, including HIV infection.

Explanation

Disagree. Sex with minors or virgins cannot protect a man from STIs including HIV. It is a crime to engage in sex with a minor. It leads to greater risk of injury to the immature sexual organs of the young boys and girls along with psychological/ emotional trauma that the person is left to deal with later in life.

Statement No. 7

People belonging to certain community / profession are responsible for spreading HIV/AIDS

Explanation

Disagree.HIV is spread due to practicing high risk behavior e.g. having multiple sex partner, having unprotected sex with a HIV infected person , using & sharing of unsterilized needles etc. And NOT by people of any community or profession. It is the high risk BEHAVIOR and not the PERSON/PROFESSION, which is responsible for spread of HIV infection.

Role Play: Typical Patient Questions

Patients often have many questions about HIV/AIDS and nurses need to know how to answer these questions. Nurses will get better as they learn more and with experience. This exercise is to participants practice their knowledge and communication skills.

1. What is the difference between HIV and AIDS?

2. Will my family members also get infected?

3. How does HIV make me sick?

4. How much time do I have to live now that I have HIV infection?

5. How could I have gotten HIV infection if I had sex with no one else but my wife?

Unit 3 : STIGMA AND DISCRIMINATION : LEGAL AND ETHICAL ISSUES IN HIV/AIDS CARE

Break up the participants into 5 groups and refer them to Case Scenarios Worksheet.

Assign each group a case and give them 5-10 min to go over the case, brainstorm, and note down their answers. Each group will present their answers to the large group for a discussion.

Ask one representative from the first group to stand up and read out the case from the slide.

Then ask another representative of the group to read out their group's responses.

Give the large group 2 minutes to discuss and give feedback before moving on to the next slide.

Case Scenario 1:HIV Testing & Screening

Mr. A suffering from fever, diarrhoea and cough for the past 8 weeks

The Medical Officer at the PHC examines her and orders some tests. One of the tests, is an HIV test

- What two important things should have been done before the HIV test?
- What thing(s) the doctor should keep in mind while informing Mr. A of his test report?

Case Scenario 2: Confidentiality

Mr. Y suffering from TB, was prescribed HIV test. He was explained about the purpose and need of the HIV test and his consent was taken The doctor informs him that his test results are positive , in front of his brother.

- What right things were done before the HIV test?
- What wrong thing(s) the doctor did while informing Mr. A of his test report?

Case Scenario 3: Partner Notification

Mr. X, an IDU, was tested positive for HIV recently at the FICTC. He was counseled to disclose to his wife He is not willing to do so.

- What must be done first?
- Can the HIV status be disclosed to the partner by a doctor?
- What other measures must the doctor/health care worker take?

Case Scenarios 4: HIV and Pregnancy

Mr. and Mrs. X, a married couple, tell you that they wish to have a child. They are both HIV positive

- What information would you give them?

Case Scenario 5: Refusal of Treatment

Mrs. A came to the PHC with labor pains. The doctor noticed that she had severe vaginal infection and ordered a rapid HIV test. The result was positive and she was sent away with the pretense that no bed was available.

- What are the ethical issues in this scenario?
- What opportunity is being lost here?

Divide participants into three small groups5-6 participants and assign each group all five role plays scenarios.

Each group needs to perform one role play ,either as a Client or as a Counselor.

Inform participants that during role play patient and counselor will meet as if they are having a regular visit.

- Give the groups 05 minutes to plan and practice their role play amongst themselves.
- Give each pair 5-7 minutes to perform the role play in rotation and take feedback from other group members
- Role Players (e.g., How do you think it went ?How did it feel taking on the role ?)
- Stop the role play when the Trainer feel the important points have been covered (in each group)
- Each Trainer would present the positive and the negative points of the role plays performed by their respective group members.

Each Trainer observes the performance of all the groups with the help of the Answers provided& Check List for Counselling Skills Assessment.

After all groups finish all five role plays bring them to the big group and project all the slides of correct answers of the case scenarios.

Trainers remember the following points while giving feedback to the group:

- -Be respectful to each of the trainees. Remember, it is hard to be in the counsellor position in public.
- -Emphasize the positive aspects of the counselling session.
- -Offer gentle, constructive suggestions to improve what didn't work so well.
- -Be cautions when critically analyzing the role plays and giving suggestions.
- -Avoid using terms like 'should have' 'must have' etc.

Evaluate each of them for taking active role in the group sessions and reassure them that practice can make them better counselor so they should practice these skills in day to day situations.

Counselling Case Scenarios

1. ARV Adherence Counselling

Mrs. A,35 yr. old, HIV+ woman, having CD4 Count 180. The Medical Officer has advised her to start ART. She is reluctant to take ART as she is scared of its side effects. Also the ART Centre is very far from her place and it will not be possible for her to visit it regularly.

How will you counsel her?

PPTCT Intervention- Ante Natal

During one of your home visits, you meet Mrs. Y, 23 yr. old, HIV+, 8 weeks, pregnant woman. While talking to her, you come to know that she has not registered herself in the local Ante Natal Clinic.

Her Mother- in-law does not feel it is necessary for Mrs. Y to go to Ante Natal Clinic, as in their family, the delivery is conducted by "dai".

What points you will keep in mind, while counselling Mrs. Y & her mother in-law ?

2. PPTCT Intervention – Post Natal

Mrs. S, 25 yr. old, HIV+, woman, has recently given birth to a baby girl, through Normal Vaginal Delivery at the PHC. The baby has a slight low birth weight.

She is worried about baby's growth and passing on her infection to her.

How would you help her?

3. RTI Prevention & Care

Mrs. X brings her 18 yr. old daughter Ms Y to PHC. She tells ANM on duty that Ms Y is continuously having smelly white discharge for the past 6 weeks. She does not have any appetite and is losing weight.She also reveals that the family is planning to get her married soon.

How would you counsel her?

4. HIV/AIDS- Education & Management

Mr. A, a 22 yr. old, daily wager, has recently being diagnosed with HIV infection. He is very scared, as he does not much information about HIV infection. He has not told about his positive status to anyone in the family, due to fear of rejection. He says," I am having AIDS and I am going to die soon".

How will you help him?

Counseling Skills and Techniques	Done
• Creates comfortable environment • Uses culturally appropriate greeting gestures that convey respect and caring • Offers seat • Uses pleasant & gentle tone of voice • Makes eye contact • Looks at client when speaking • Attentive body language and facial expression • Continuous eye contact (but NOT staring) • Occasional gestures, such as nods to acknowledge client • Uses open ended questions to elicit information • Asks relevant questions • Reflects statements back to client for conformation • Takes time to summarize information obtained from client • Checks with client to ensure understanding of important concerns and issues	

Unit 5 : PREVENTION OF PARENT TO CHILD TRANSMISSION (PPTCT) & EARLY INFANT DIAGNOSIS (EID)

Exercise 1 : Patient Educaiton on Prevention of Parents to Child Transmission

– Divide participants into 5 groups, with each group being assigned one case

– Give them 5 minutes to discuss and write out main points they would consider to prevent PTCT of HIV for their particular situation

– One representative would have to come forward and present the points to the large group

– Other groups will be asked to provide feedback to the responses.

– Make sure to clarify any questions participants have

Group 1:

An 18-year-old girl comes to you. She says she is likely to get married in a year's time but she is scared about HIV. Her friend had got married last year and was discovered to be positive after her marriage during her antenatal checkup. What points would you keep in mind when counselling her?

Group 2:

A 23 years old, HIV positive woman, comes for her first antenatal checkup. She is 6 weeks pregnant. What key points would you keep in mind while counselling her to prevent MTCT?

Group 3:

A 22 years old, HIV positive woman , comes to the PHC with labour pains since half an hour. What will you assess and do for her, if you were present throughout her labour period to reduce MTCT?

Group 4:

A 24 years old, HIV positive woman, delivered her baby asks you about feeding her baby. You have not seen her in the past, during her prenatal period. What points would you keep in mind while counselling her to reduce MTCT?

Group 5:

A 26 years old, HIV positive woman has doubts about her and her baby's follow up care after delivery. What key points would you keep in mind while counselling her to reduce the risk of PTCT?

Exercise 2 – Patient Education on Early Infant Diagnosis

You are visiting a HIV positive woman, who has delivered baby few days ago, at your centre. She has concerns about baby's HIV status. How would you help her?

- Involve the father & extended family (if required)
- Provide education on the importance of early diagnosis

- Provide referral to near PPTCT / ICTC
- Stress on Exclusive breast feeding for the first 6 months
- Timely immunization
- Good nutrition for the mother
- Stress on Safe Sex practice to avoid reinfection & pregnancy
- Emphasis on the importance of regular & timely Follow up

UNIT 7: INFECTION CONTROL AND PEP

Exercise 1: Hand Washing Technique

Split the participants into pairs .Ask each pair to act out the steps of hand washing techniques, using the guidelines.

Exercise 2: Use of Personal Protective Equipments

Ask for a volunteer and ask her or him to demonstrate how to put on and remove Personal Protective Equipments.

Exercise 3: Preparation of Bleach Solution

Ask for a volunteer and ask her or him to demonstrate how to prepare the Bleach Solution.

Exercise 4 : Proper Needle Disposal

Ask for a volunteer and ask her or him to demonstrate the proper disposal of a needle.

SECTION 4
ANNEXURES

Annexures

ANNEXURE 1: HIV TESTING-RAPID TEST

HIV can be detected in the laboratory by the detection of either HIV antibodies or virus.

The various HIV antibody tests are :

- Rapid Test
- ELISA (Enzyme Linked Immunosorbent Assay)Rapid Test
- Western Blot (Confirmatory Test)

Out of these, Rapid Test is a highly sensitive, most easy and commonly performed test, used for initial screening of HIV infection.

This type of HIV testing makes it possible for the clients to get pre-test and post-test counselling , their test results(within 5 to 30 minutes), and any medical referrals they may need all in one visit and in a very short amount of time.

The Rapid Test can be performed at Primary Health centres, Out Patient Clinics,Blood Banks, ICTCs, PPTCT Centres etc.

The advantages of Rapid test are

- It is easier to use as no equipment is required to perform the test
- The test kits can be stored at room temperature
- Can be performed at remote health facilities (e.g. Sub Centre/Primary Health Centre etc.) and where same day results are needed (e.g. ICTCs/Blood banks etc.)
- Can be used on whole blood or serum
- Reading is visual to naked eye
- Easier management of the waste
- The results are as accurate as a traditional Elisa test
- Almost all people tested will get post-test counseling and their results because only one visit is necessary
- Since results are delivered quicker, positive people get into medical care quicker

Method

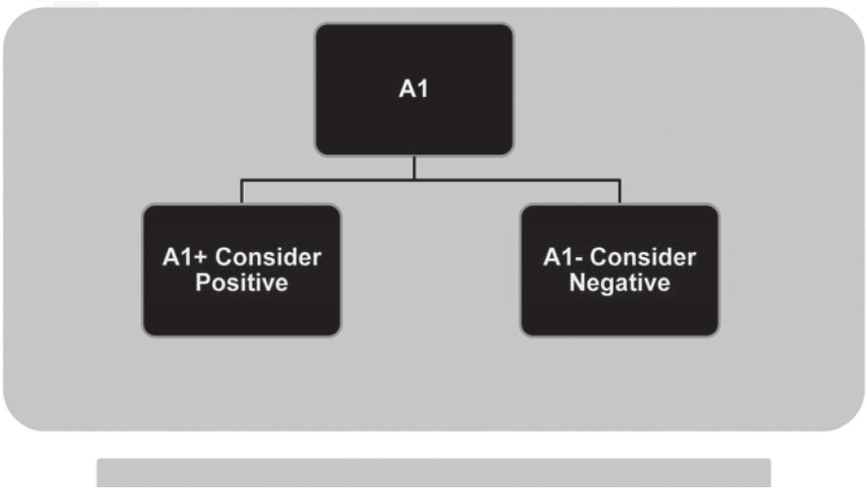
To perform the Rapid Test, Whole blood (Finger prick) /serum of the client is diluted and is applied to a plate to which HIV antigen has been attached.

Possible outcomes of the test

- Reactive or Positive :Appearance of 2 lines of any intensity on the control area and the patient area
- Non-Reactive : Appearance of line only in the control area and no line on the patient area
- Invalid : No line appears on the control area. The test needs to be repeated with new kit, even if the line appears on the patient

This test is based on the NACO Testing Strategy I where, if the test result is negative, the sample is considered Negative for HIV infection. But if the result is positive, the sample is considered positive for HIV infection and the client is referred to ICTC for counselling, testing and confirmation of test results.

The Health care Provider must offer Pre Test counselling and take an Informed Consent from the client before administering the test; and results should be delivered, followed by Post test counselling.



It is utmost important to maintain the confidentiality of the test results.

By maintaining confidentiality, not only the client will have faith in the health care system, it will encourage other people, practicing high risk behaviors , to come forward for HIV testing.

ANNEXURE 2: COUNSELING CHECKLISTS

Counseling Checklists For ANMs, for various Counseling sessions

Checklist No.1: SELF ASSESSMENT OF EFFECTIVE COUNSELING

Counseling Skills and Techniques	Done
• Creates comfortable environment • Uses culturally appropriate greeting gestures that convey respect and caring • Offers seat • Uses pleasant & gentle tone of voice • Makes eye contact • Looks at client when speaking • Attentive body language and facial expression • Continuous eye contact (but NOT staring) • Occasional gestures, such as nods to acknowledge client • Uses open ended questions to elicit information • Asks relevant questions • Reflects statements back to client for conformation • Takes time to summarize information obtained from client • Checks with client to ensure understanding of important concerns and issues	

Checklist No 2 (a) Pre-Screening Counseling Form

Note : Confidentiality of the client information should be strictly maintained at all times.

1. Age: ___ years
2. Sex: M / F / Transgender
3. Education: standard: illiterate/1.5/6.8/8.10/11.12/Graduate/Post-graduate
4. Occupation: _____ (Migrant/ Non-migrant)
5. Monthly income in Rs: 0.2,500/2,501.5,000/5001.7,000/7,001.10,000/ more than 10,000
6. Marital status: unmarried/ married/widowed/divorced/separated/living together
7. Medical history: (Does your client currently have any medical problems or symptoms?]

   Nil/Recurrent fever/weight loss/cough/diarrhoea/STIs/TB/OIs/Others _____

Please explore the following issues with your client:

8. Risk assessment of the past six months:

Q: Reason for counselling and testing?

_____

_____

(a) Contaminated blood through:

Blood transfusion / IDU

Organ transplant / Tattoo

Needle stick injury

Unprotected sex: Vagina/Anal/Oral

(b) Partner or family member infected Yes/ No

(c) Explained about the following:

i. What is HIV/AIDS

ii. Modes of transmission

iii. Myths & Misconceptions

iv. Information about HIV test

v. Nature of test and testing process

vi. Benefits and consequences

vii. What does a positive result mean

viii. What does a negative result mean

ix. Window period

9. Counseling provided on:

i. Safe Sex (including Condom Demonstration)

ii. Nutrition

iii. Personal Hygiene

iv. Positive living

v. Safe Needle use (For IDUs)

10) Assessment of OIs/ STIs/ RTIs done Yes/No

11) Support System at home

12) Willingness to reveal the HIV Status to family/Spouse (in case of positive result) (Yes/No)

Checklist No 2 (b) Post-Screening Counseling Form

Note : Confidentiality of the client information should be strictly maintained at all times.

1. Date: ___ /___ /___ 2. Age: _____

3 Sex: M/F/Transgender

4. In case of positive result, provided referral to nearest FICTC/ICTC

5. Provided Counselling on:

(a) Increase condom use (b) Reduce number of sexual partners

(c) Reduce needle sharing (d) Reduce alcohol or drug use

(e) Nutrition (f) Others

6. Provided education and/or referral for management/ treatment of STIs/RTIs/OIs Yes/No

7.. Need to share positive HIV Test result with partner/family discussed Yes/No

Checklist No 2 (C) Follow up Counseling

Note : Confidentiality of the client information should be strictly maintained at all times.

1. Date: ___ /___ /___ 2. Time: (start of session): _____

3 Age: ___ years 4 . Sex: M/F/Transgender

5. Whether the client went for the HIV testing Yes/No

6. If No, further counseled on the need to go for testing Yes/No

7. Discussed client's concerns/fears regarding the HIV testing Yes/No

8. For clients, who have received results

   I whether the client clearly understood the significance of results Yes/No

   Ii whether the client following the instructions provided by the ICTC Counselor Yes/No

   Iii whether the client has been paying Follow up visits to the ICTC, as and when required Yes/No

   Iv If no, discussed the reasons for the same and encouraged the client to do so Yes/No

9. Provided counselling (a) Increase condom use (b) Reduce number of sexual partners (c) Reduce needle sharing (d) Reduce alcohol or drug use (e) Discussion with

Checklist No 3 Home Care Counseling form

HOME VISIT DATA SHEET

Name of the patient Registration No

Sex: M/F

Purpose of home visit

Locality and neighbourhood

Socioeconomic situation of the family as observed

Observed emotional and physical status of the patient

Chief caregiver

Observed behavior and attitude of the caregiver/family members towards the patient

Observed behavior and attitude of the family members towards each other

Expressed concerns/issues/opinions

Home visit conducted by

Visit requested by

Date of request

Date of visit

ANNEXURE 3: PPTCT TRUE OR FALSE STATEMENTS AND ANSWERS

1. Pregnancy makes HIV disease worse.

False - Pregnancy does not accelerate the progression of HIV disease.

2. HIV-infected sperm can directly infect the infant even if the mother does not have HIV infection.

False- Although there is HIV in male semen, there is no HIV in the sperm. Therefore, the mother could get HIV infection from the male semen but the foetus could not get HIV infection from the male's sperm. The foetus can only acquire HIV infection from exposure to the mother's blood or vaginal/cervical secretions during pregnancy, birth, or breast milk during breast feeding. Remember that about 70% of time, the foetus will not get HIV infection at all.

3. If a woman is HIV+, there are medications she can take to reduce the likelihood of passing the virus to her infant

True- If a woman is HIV+, she can be prescribed ART depending on clinical criteria either during her pregnancy. She should be given ART during labour, and the baby must be given ART within 72 hours of birth. Details of ART to prevent mother to child transmission will be dealt with in this unit. If she is on ART and her viral load is suppressed, her risk of transmission is very low, about 1 or 2%

4. If both parents are HIV +, using condoms during pregnancy isn't necessary

False - One partner may transmit a resistant virus to the other through sexual intercourse so it is essential that the couple practice safe sex with use of condoms.

5. If a woman is HIV positive, all her babies will be HIV-infected because they share the same blood.

False - The mother and baby do not share the same blood. The mother's blood is filtered by the placenta so the baby gets oxygen and nutrients without exchange of blood. The baby can only become infected if she/he is exposed to the mother's blood. This may happen from an infection in the placenta, a maternal abruption or abdominal trauma causing bleeding into the amniotic sac, or during birth. It is also important to note that even with exposure to the mother's blood during pregnancy and birth, there is only about a 30% chance of the baby becoming infected.

6. Procedures during delivery that may cause exposure of the newborn to maternal body fluids should be avoided whenever possible

True - This includes artificial rupture of membranes, forceps or vacuum delivery, episiotomy, or vigorous suctioning of the infant.

7. If an HIV positive woman has a Caesarean section (C/S), her risk of having a baby with HIV is 0%.

False - Although in some cases, when the woman's virus is not suppressed or she has advanced HIV disease, a C/S may reduce the risk of infection, it will never reduce it to 0%. The actual risk depends on the severity of disease and the actual viral load. When a woman is on ART and her viral load is fully suppressed, there does not appear to be an advantage to C/S. Also, there is a higher risk of maternal infection and mortality with C/s and the higher cost to consider.

8. Giving Nevirapine to babies after they are born is like giving a nurse post-exposure prophylaxis after a needlestick injury.

True. Giving Nevirapine is like giving PEP to a nurse after a needle stick injury.

ANNEXURE 4 : PPTCT: THREE SAFE INFANT FEEDING OPTIONS – SOME IMPORTANT POINTS YOU COULD KEEP IN MIND WHEN COUNSELING MOTHERS ON FEEDING OPTIONS

	No Breastfeeding at all – Providing Cows/Tinned milk	Breastfeed Exclusively For 6 Months – Stopping Abruptly – Switching to Weaning Foods	Continue breastfeeding if at 6 months replacement feed is not acceptable, affordable, feasible, safe and sustainable with complementary foods
Advantages	• Breast milk increases PTCT risk by up to 20%. • Not breastfeeding at all eliminates this risk completely	• Breastfeeding provides infants with optimal nutrition, reduces morbidity and mortality associated with infections other than HIV, and delays the mother's return to fertility. • Baby would have received all the anti-infective available in breast milk • Bonding between the mother and baby is better • The baby's gut is safe from any mucosal injury reducing the chance of infection • It is economical and considerably more safe to breast feed than to bottle or spoon feed the baby • At 6 months of age, breast milk alone may not be enough to meet the nutritional needs of the baby, hence complementary or weaning foods could be introduced	
Disadvantages	• Infant gets no colostrum • It is an expensive option • In India the chance of baby dying due to gastroenteritis (because of poor hygienic practices, ignorance of mother about sterilizing feeding bottles, etc.) is higher than it dying of HIV! • Risk of over dilution of formula could result in malnutrition of the baby • Microscopic mucosal injury of the gut is very high with formula feeds • Social stigma if mother does not breastfeed	• Baby is exposed to virus in breast milk • Colostrum along with its advantages is also considered to be highly infectious	• Baby is exposed to virus in breast milk • Colostrum along with its advantages is also considered to be highly infectious • The longer the duration of the breast feeding the higher the risk of transmission

	No Breastfeeding at all – Providing Cows/Tinned milk	Breastfeed Exclusively For 6 Months – Stopping Abruptly – Switching to Weaning Foods	Continue breastfeeding if at 6 months replacement feed is not acceptable, affordable, feasible, safe and sustainable with complementary foods
What to Assess to Help Mother Decide Option	Formula feeding will be • acceptable • affordable • feasible • safe • sustainable	Formula feed is considered to be • expensive • unsustainable over the long term • unsafe • cause for social problems • risk for mixed feeds • unacceptable	• All under second option plus • If socio-economic situation is such that safe and sustainable exclusive alternate feeds cannot be provided even after 6 months
Additional Information to Provide to Mothers	Why never to give mixed feeding. • With formula feeds microscopic mucosal injury to gut is high • If mixed feeds (i.e. breast milk and other milk such as cow's milk) are given the chance of HIV to enter the increases risk of HIV transmission. • Infant feeding hygiene. • Preparation of formula milk • References to NGOs/ support centres which may provide free/ subsidized alternate	• Teach mothers how to express breast milk and give it safely if there is risk for cracked nipples, mastitis that could increase the risk of HIV transmission • Reinforce feeding hygiene if expressed breast milk is given • Good breast feeding practices: position of the mother and the baby as well as breast hygiene • How to stop breast-feeding abruptly - it is important if mother has been feeding directly to teach mother how to express breast milk at least two weeks before stopping abruptly. • Baby gets used to feeding with a cup/spoon/ palada • Amount of breast milk supply reduces • To practice safer sex while breastfeeding to prevent reinfection and higher viral load	

Annexure 5 : REPLACEMENT FEEDING CHECKLIST

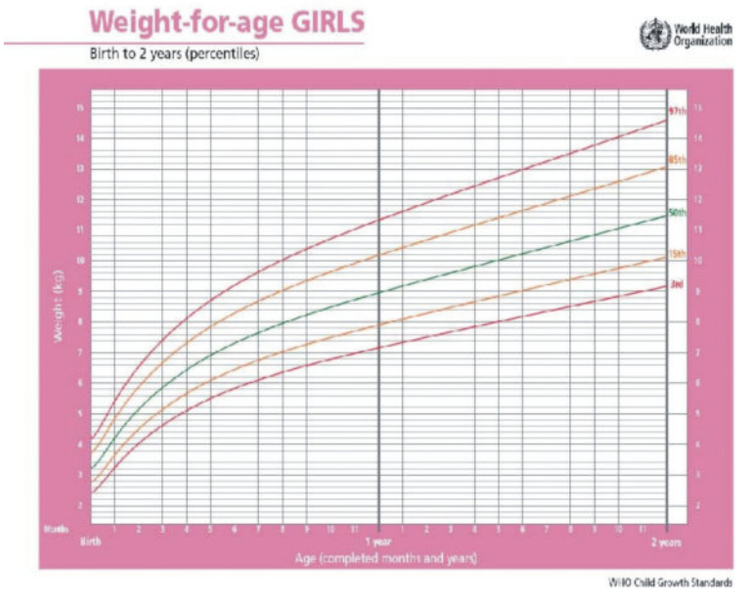
	Yes	No
• Can she afford to buy enough milk/milk powder?		
• Does she have access to clean water?		
• Can she prepare milk safely? Boil the water • Make the correct concentration of milk if using the tin milk		
• Can she clean and sterilize the feeding articles?		
• Will she have enough support from significant others in the family?		
• Does she know how much of milk the baby can be given – each time – for a day – how often		

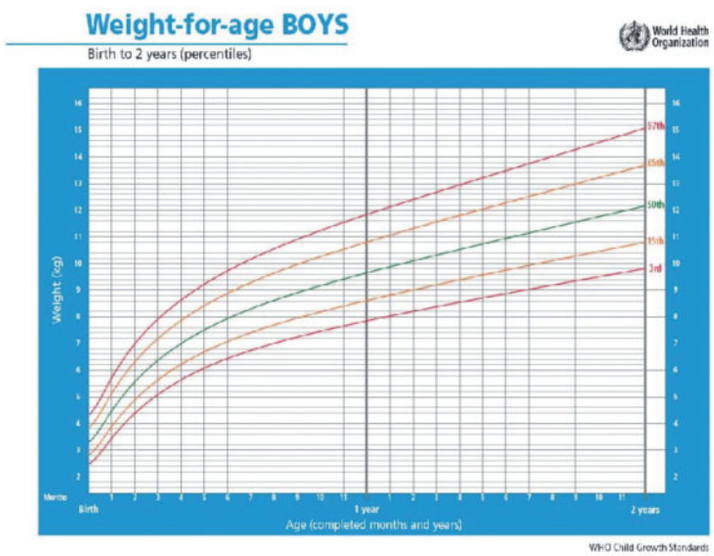
If answers are "No", see what patient education/ linkages can be provided to support replacement feeding OR advise safe breastfeeding.

ANNEXURE 6 : WHO GROWTH MONITORING CHARTS

Using growth charts Infants and children who are well and healthy should gain weight and length/height. Infants and children who are growing normally follow a growth curve parallel to one of the standard growth curves. Weight loss or failure to gain weight can be identified by observing the child's weight over time.

When the growth curve 'flattens' and is no longer parallel to the chart line, this indicates the need for clinical assessment, management and nutritional intervention and possibly ART.

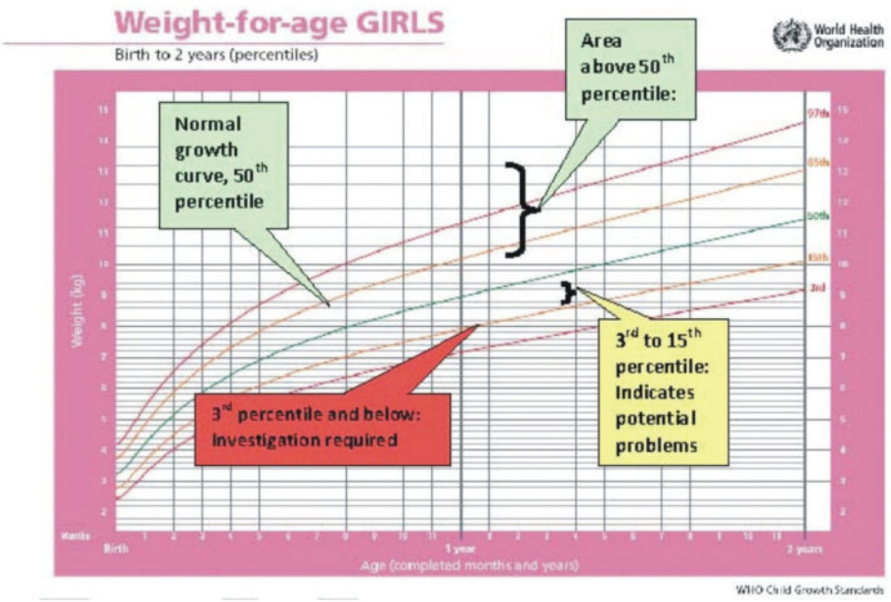




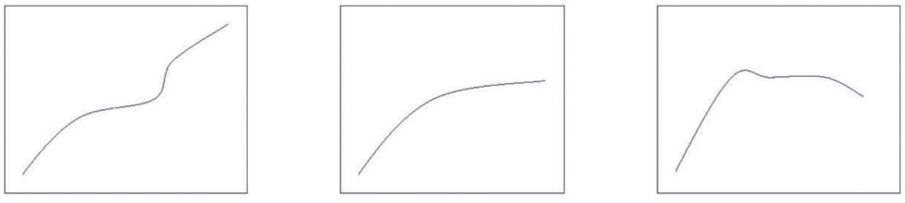
Growth curves are used to follow changes in growth over time for a child – thus, looking at trend of weight is more useful than a single observation. The nurse will take the weight and enter it on the growth chart, in the ICTC HIV-Exposed Infant/Child Card Using gender appropriate charts (different for girls and boys), plot the weight measurement (in kg.) on the vertical axis against the age (in months/year) on the horizontal axis

- Connect the dots for each visit to obtain a growth curve for the child
- Compare the plotted line of the child's growth with the standard curves in the chart
- MO to interpret the growth chart and determine course of action:
    - Child with growth curves lying between the 3rd and 15th percentile need careful history taking to detect feeding problems. A physical assessment must be done and appropriate nutritional advice must be given.
    - Child with growth curves less than the 3rd percentile (growth below the bottom most line) need further

Figure 3: Example of use of growth charts to detect potential problems in growth



Examples of growth curves with weight-for-age charts:



Growing well | Curve flattening (Crossing growth lines) | Losing weight

REFER TO MO FOR ASSESSMENT AND ACTION or
REFER TO NEXT LEVEL OF HEALTH CARE/PAEDIATRICIAN

ANNEXURE 7: GUIDELINES FOR DISINFECTION AND STERILIZATION

Device Classification	Devices Examples	Type of Process	Process Examples
High Risk Enters sterile tissue or vascular system, includes dental instruments	Implants, scalpels, needles, other surgical instruments and Endoscopic accessories	Sterilisation (cycle time per manufacturer)	Steam under pressure, Dry heat, Ethylene oxide gas, Chemical gas sterilizers
Intermediate Risk Touches mucous membranes or broken skin	Flexible Endoscopes, Laryngoscopes, Endotracheal Tubes, Respiratory Therapy and Anaesthesia equipment, Diaphragm fitting rings, and other similar devices.	High-level disinfection (exposure time [3] 20 minutes)	Glutaraldehyde based formulations (2%) Stabilized Hydrogen Peroxide (6%) Household bleach (Sodium Hypochlorite 5.25% 1,000 ppm available Chlorine = 1:50 dilution)
	Thermometers (oral or rectal)	Intermediate-level disinfection (exposure time > 10 minutes)	Ethyl or Isopropyl Alcohol (70% to 90%) (do not mix oral and Rectal Thermometers)
	Smooth, hard surfaces such as Hydrotherapy tanks	Intermediate-level disinfection (exposure time > 10 minutes)	Ethyl or Isopropyl Alcohol (70 to 90%) Phenolic detergent (dilute per label) Iodophor detergent (dilute per label) Household bleach (Sodium Hypochlorite 5.25% 1,000 ppm available chlorine = 1:50 dilution)
Low Risk Touches intact skin	Stethoscopes, Tabletops, floors, Bedpans, Furniture, etc.	Low level disinfection (exposure time > 10 minutes)	Ethyl or Isopropyl Alcohol (70 to 90%) Phenolic detergent (dilute per label) Iodophor detergent (dilute per label) Household bleach (Sodium Hypochlorite 5.25% 100ppm available chlorine = 1:500 dilution)

ANNEXURE 8 : HAND HYGIENE CHECKLIST

Procedure	Done
• Ensure short finger nails	
• Ensure water supply/ alcohol hand - rub solution	
• Remove accessories from hands	
• Pour soap solution / alcohol rub into hand or apply soap uniformly on the hand	
– Scrub both hands – Scrub palms and fingers – Scrub back of hands – Scrub fingers and knuckles – Scrub thumbs – Scrub finger tips and nails – Scrub wrists and up to elbows if needed	
• Wash hands ensuring removal of soap from all applied areas / if using alcohol rub, rub all surfaces till dry (Do not wash with water)	
• Air dry or dry using clean towels	

Keeping the above points in mind, think about what resources are required for regular efficient hand hygiene and make a mental note to check if these are available at your centre.

ANNEXURE 9: DISINFECTION OF NEEDLES AND SYRINGES WITH BLEACH

Injecting drug users often do not have access to a steady supply of disposable syringes, and re-use/share needles with other IDUs. The procedure below can be taught to them to minimize the risk of HIV transmission under such circumstances. Remember, where available – disposable, unshared needles are always the first choice.

Procedure:

It will probably take 5-10 minutes to follow the recommended procedures for cleaning and disinfecting.

- Fill the needle and syringe completely with clean water
- Shake vigorously for 30 seconds, and shoot out the water into the sink or onto the ground
- Repeat the process
- Then, completely fill the needle and syringe (to the top) with full-strength (not diluted) liquid household bleach several times.
- Keep the bleach for at least 30 seconds
- Shoot out the bleach and repeat
- Rinse the syringe and needle by completely filling several times with CLEAN water.

Remember:

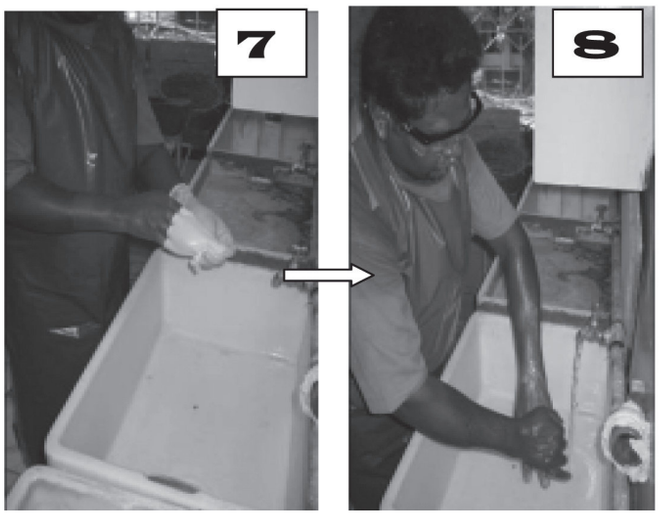
- Cleaning and disinfecting should be done at two points of time—once immediately after use and again just before re-use of needles and syringes.
- ALL used solutions should be disposed of (e.g. by placing in a waste container or pouring down a sink or toilet or on the ground). DO NOT REUSE.
- Every time the cleansing process is repeated, the more likely HIV and other blood borne pathogens will be inactivated
- Taking the syringe apart by removing the plunger may also improve the cleaning/ disinfection of parts that might be hard to reach (e.g., behind the plunger).
- Although it is important to follow all steps in the bleach disinfection procedures to ensure maximum effectiveness, drug users who indicate they may be unable to do so should be encouraged to perform as much of the process as possible.
- The more steps done, the more effective the disinfection process is likely to be in reducing risk of HIV transmission.

ANNEXURE 10: GUIDELINES FOR DISPOSAL OF USED DISPOSABLE NEEDLES AND SYRINGES

No.	Steps / Stages
•	Sever needles from disposable syringe immediately after administering injection using a needle cutter/hub-cutter that removes the needle from disposable syringes or cuts plastic hub of syringe from AD syringes
•	The cut needles get collected in the puncture proof container of the needle cutter/hub-cutter. The container should contain an appropriate disinfectant and the cut needles should be completely immersed in the disinfectant
•	Segregate and store syringes and unbroken (but discarded) vials in a red bag or container
•	Send the collected materials to the common bio-medical waste treatment facilities. If such facilities do not exist, then go to the next step
•	Treat the collected material in an autoclave. If this is unavailable, treat the waste in 1% hypochlorite solution or boil in water for at least 10 minutes. It shall be ensured that these treatments ensure disinfection
•	Dispose the autoclaved waste as follows: (i) Dispose the needles and broken vials in a pit / tank, (ii) Send the syringes and unbroken vials for recycling or landfill
•	Wash the containers properly for reuse
•	Make a proper record of generation, treatment and disposal of waste

ANNEXURE 11: SITUATIONAL GUIDE - CLEANING UP A BLOOD SPILL ON THE FLOOR

- Instruct the hospital worker or cleaner to wear appropriate personal protective equipment: plastic apron, shoes and disposable gloves
- Put a towel / gauze / cotton over the spill area to cover it completely
- Pour hypochlorite solution 10% over the covered cloth to soak it completely
- Leave the solution on the cloth for another 30 minutes without disturbance
- Carefully lift the cloth from the floor, mopping the whole spill onto the cloth and dispose into the yellow bin
- Using a routine mop and soap water solution swipe the area and wash the mop and hang it out to dry
- Remove gloves and dispose into red bin
- Wash hands under running water with soap and dry hands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ANNEXURE 12: ROLE OF ANMs IN HIV/AIDS CARE

Role of ANMs in HIV/AIDS Care

- Prevention Of HIV Transmission
- Patient Education and Counselling
- Assesses the physical, social, and psychological & spiritual needs of the patient
- Links the patient and family to community-based support programs
- Educate & Supervise other co-workers (ASHAs, outreach workers etc.)
- Compilation of monthly record & register
- Assisting doctor in management of cases
- Providing drugs to patients as recommended by doctors
- Prepare and sterilize instruments
- Visit the field once a week for Follow-up with patients
- Ensure referrals to relevant resources (e.g. ICTCs/PPTCT Centres/ STI Clinics etc.)

ANNEXURE 13 : LIST OF STATE AIDS CONTROL SOCIETIES (SACs)

Ministry of Health & Family Welfare
Department of AIDS Control
National AIDS Control Organisation

Details of State AIDS Control Societies/Municipal AIDS Control Societies

Sr. No.	SACS/ MACS	Address	Name of Project Director	STD Code	Office No.	Fax no.	Email id	Website URL (if any)
1	Andaman & Nicobar Islands	AIDS Control Society, G.B. Pant Hospital Complex, Port Blair 744104	Shri Rakesh Bali	03192	236555	231176	andmansacs@gmail.com	
2	Andhra Pradesh	State AIDS Control Society, Directorate of Medical and Health Services, Sultan Bazar Hyderabad - 500059	Shri. C Parthasarthy	040	24657221 24650776	24650776 24652267	sacsandhra@gmail.com	http://apsacs.org
3	Arunachal Pradesh	State AIDS Control Society, Naharlagun, New Itanagar - 791110	Dr. Emi Rumi	0360	2351268 2245942	243388 244178	arunachalsacs@gmail.com	
4	Assam	Assam State AIDS Control Society Khanapara, Guwahati, Assam, 781022	Mrs. Purobi Sonowal, IAS	0361	2360524	2360524	assamsacs@gmail.com	www.assamsacs.org
5	Ahmedabad MACS	Ahmedabad Municipal Corpn. AIDS Control Society, Old Municipal Dispensary, behind Lal Bungalow, C.G. Road, Ahmedabad.	Dr. Umesh.N. Oza	079	26409857 26468653	26409857	ahmedabadmacs@gmail.com	
6	Bihar	Bihar State AIDS Control Society, SIHFW Building, Sheikhpura, Patna-800014 (Bihar)	Shri Sanjeev Kumar Sinha	0612	2290278	8986184695	pd@bsacs.org	
7	Chennai MACS	Chennai Municipal Corpn. AIDS Control Society, 82 Thiru Vi-Ka-Salai, Mylapore, Chennai - 600003	Dr.R.Ananda Kumar I.A.S	044	24980081 24986514	25369444	chennaimacs@gmail.com	
8	Chandigarh	Chandigarh State AIDS Control Society, U.T, Chandigarh, International Hostel, Madhya Marg, (Near PGIMER), Sector 15-A, Chandigarh-160015	Dr. Vanita Gupta	0172	2544563 2783300 2544589	2700171	Chandigarhsacs@gmail.com	http://chandigarhsacs.org/
9	Chhattisgarh	Chhattisgarh AIDS Control Society, Directorate of Health Services, State health Training Centre, Near Kalibari Chowk, Raipur	Dr. Kamal Preet Singh IAS,	0771	2235860 2221624 2221275	2235860	chattisgarhsacs@gmail.com	
10	Dadra & Nagar Haveli	Dadra & Nagar Haveli AIDS Control Society, 1st Floor, Shri Vinobha Bhave Civil Hospital, Silvassa – 396230	Dr.Maganbhai V Dhodia	0260	2642061	2642061	dnhsacs@gmail.com	
11	Daman & Diu	Daman & Diu State AIDS Control Society, CHC Campus, 2nd Floor, Fort Area, Moti Daman, Daman – 396 220	Dr Devendra K Makwana	0260	2230192 2230136		ddsacs@gmail.com	

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Sr. No.	SACS/ MACS	Address	Name of Project Director	STD Code	Office No.	Fax no.	Email id	Website URL (if any)
12	Delhi	Delhi AIDS Control Society , Dr. Baba Saheb Ambedkar Hospital,Dharamshala Block, Sector - 6, Rohini, Delhi - 110 085	Dr Faizi O. Hashmi	011	27055717 27055724 27055725	27055720	delhisacs@gmail.com	
13	Goa	Goa State AIDS Control Society 1st Floor, Dayanand Smruti Building, Swami Vivekanand Road, Panaji, Goa – 403 001	Dr. Dipak Kabadi	0832	2427286/2 421381/24 22519	2422518	goaaids@dataone.in, goaaids@gmail.com	www.goasacs.nic.in
14	Gujarat	Gujarat State AIDS Control Society, 0/1 Block, New Mental Hospital, Complex, Menghani Nagar, Ahmedabad - 380016	Mr. P.K. Taneja, IAS	079	2680211-13 2685210	2680214	cohealth@gujarat.gov.in	
15	Haryana	Haryana State AIDS Control Society, SCO - 10, Sector - 10, Panchkula, Haryana	Dr. Narbir Singh	0172	2585413 2584549(PD)	2585413	haryanasacs@gmail.com	
16	Himachal Pradesh	Himachal Pradesh State AIDS Control Society Hari Villa, Near Forest Rest House, Khalini Shimla-171002	Dr. Shashi Pal Singh	0177	2621608 2625857	221314, 225857	hpsacs@gmail.com	
17	Jammu & Kashmir	J&K State AIDS Prevention and Control Society, 48- Samunder Bagh, Exchange Road, Srinagar (Kashmir) **May to October (Srinagar Office)** J&K State AIDS Prevention and Control Society, 90/3, Trikuta Nagar, Jammu **November to April (Jammu Office)**	Dr. Rakesh Khajuria	0194 0191	2486409 (Srinagar) 2471579	2486409 2475424	jksacs@gmail.com	
18	Karnataka	Karnataka State AIDS Prevention Society, No.4/13-1, Crescent Road, High Grounds, Bangalore - 560001	Smt.Salma K.Fahim,I.A.S.	080	22201438 22201436/7/9	22201435	ksapspdp@gmail.com	
19	Jharkhand	Jharkhand State AIDS Control Society, Sadar Hospital Campus, Purulia Road, Ranchi	Sri, Aboobacker Siddique P. , I.A.S	0651	2309556 2490649 2211018	2562621	jharkhandsacs@gmail.com	

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Sr. No.	SACS/ MACS	Address	Name of Project Director	STD Code	Office No.	Fax no.	Email id	Website URL (if any)
20	Kerala	Kerala State AIDS Control Society,, IPP Building, Red Cross Road, Thiruvananthapuram, Kerala - 695037	Dr.K.Shylaja	0471	2304882, 2305183	2305183 09496020800	keralasacs@gmail.com	http://ksacs.in/
21	Lakshadweep	Lakshadweep AIDS Control Society, Directorate of Medical and Health Services, UT of Lakshadweep, Kavaratti - 682555	Sh. K.P. Hamzakoya	04896	262316, 262317, 262114, 263582,	262817	lakshyadweepsacs@gmail.com	
22	Madhya Pradesh	Madhya Pradesh State AIDS Control Society, 1, Arera Hills, Second Floor, Oilfed Building, Bhopal - 462011	Mr. Ashwini Kumar Rai, I.A.S.	0755	2559629	2556619	mpsacs@gmail.com	
23	Maharashtra	Maharashtra State AIDS Control Society, Ackworth Leprosy Hospital Campus, Behind SIWS Collete, R.A. Kidwai Marg, Wadala(West), Mumbai - 400031	Sh. Ramesh Devkar IAS	022	24113097, 24115791	24113123, 24115825	maharashtrasacs@gmail.com	
24	Manipur	Manipur State AIDS Control Society, Room No.207, Western Block , Annex Building, New Secretariat –Imphal 795001(MANIPUR)	Dr. Shailesh Kumar Chourasia, IAS	0385	2443776	2443776	manipursacs@gmial.com	http://manipursacs.nic.in
25	Meghalaya	Meghalaya State AIDS Control Society, Ideal Lodge, Oakland, Shillong - 793001	Dr. (Mrs) S. Laloo,	0364	2223140/ 2227223		meghalayasacs@gmail.com	
26	Mizoram	Mizoram State AIDS Control Society, MV-124, Mission Veng South, Aizwal - 796005	Dr. Eric Zomawia	0389	2321566	2320922	mizoramsacs@gmail.com	
27	Mumbai MACS	Mumbai District AIDS Control Society, Acworth Complex, Behind SIWS College, R.A. Kidwai Marg, Wadala (West), Mumbai - 31	Dr. A.R. Bamne	022	24100245-49, 24100250	24100245, 24100250	mumbaimacs@gmail.com	http://www.mdacs.org
28	Nagaland	Nagaland State AIDS Control Society, Medical Directorate, Kohima - 797001	Dr Nandira Changkija	0370	2244218, 2241046, 2222626, 2233027	2242224	nagalandsacs@gmail.com	
29	Odisha	Odisha State AIDS Control Society, 2nd Floor, Oil Orissa Building, Nayapalli, Bhubaneshwar-12	Dr. Pramod Meherda, IAS	0674	2395134, 2393235	2407560, 2405105 2394560	orissasacs@gmail.com	

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Sr. No.	SACS/ MACS	Address	Name of Project Director	STD Code	Office No.	Fax no.	Email id	Website URL (if any)
30	Puducherry	Pondicherry AIDS Control Society, Ground Floor, Northern Block, Old Maternity Hospital Building, Victor Simonel Street, Puducherry - 605 001	Dr. D. Gurumurthy	0413	2343596, 2337000	2343596	pondicherrysacs@gmail.com	
31	Punjab	Punjab State AIDS Control Society, 4th Floor Prayaas Building Sec-38B, Chandigarh	Ms. Raji P. Shrivastava, IAS	0172	2743442		punjabsacs@gmail.com	
32	Rajasthan	Rajasthan State AIDS Control Society, DMHS, Swasthya Bhawan Tilak Marg, C - Scheme Jaipur - 302001, Rajasthan	Dr. J.P. Dhamija	0141	2225532/2 222452	2221792	rajasthansacs@gmail.com	
33	Sikkim	Sikkim State AIDS Control Society, STNM Hospital, Gangtok, 737101	Dr. V Singhi	03592	225343, 220898, 32965	220896	sikkimsacs@gmail.com	
34	Tamil Nadu	Tamil Nadu State AIDS Control Society, 417, Pantheon Road, Egmore, Chennai - 600008	Shri.A. C Mohandoss	044	28194917, 28190467	28190261	tnsacs@gmail.com	http://www.tansacs.in/
35	Tripura	Tripura State AIDS Control Society, Health Directorate Building, Gurkhabasti, P.O. Kunjaban, Agartala, West Tripura - 799006	Dr. Tapan Kumar Das	0381	2321614		tripurasacs@gmail.com	
36	Uttar Pradesh	Uttar Pradesh State AIDS Control Society, A block, PICUP Bhawan, Vibhuti Khand, Gomati Nagar, Lucknow - 10	Shri. Ashish Kumar Goel	0522	2721871, 2720360, 2720361, 2283168		upsacs@gmail.com	
37	Uttarakhand	Uttarakhand State AIDS Control Society, Red Cross Bhawan, Near Directorate Medical Health, Dandalakhound, Gujrada, (Opp, I.T. Park), Sahstradhara Road, Dehradun	Mr. Piyush Singh, IAS	0135	2608885	2608745	uttaranchalsacs@gmail.com	
38	West Bengal	West Bengal State AIDS Control Society, Swasthya Bhavan, GN-29, Sector-V, Salt Lake, Kolkatta -700091	Dr. Rashmi Kamal, IAS	033	23330178, 23330526	23570122	wbsacs@gmail.com,	

ANNEXURE 14 : LIST OF ART CENTREs

List of 355 ART Centres		
Month - March, Year -2012		
st_nam	District Name	ART Centre
Andhra Pradesh	Adilabad	District HQ Hospital, Adilabad
	Anantapur	GGH, Anantapur
	Anantapur	Khadri ART center
	Anantapur	RDT ART center
	Chittoor	District Hospital Chittoor
	Chittoor	SVRR GGH, Triupati Chittoor
	Cuddapah	Produtur ART center
	Cuddapah	RIMS, Kadapa
	East Godavari	ART Center, Area Hospital, Amalapuram
	East Godavari	GGH, Kakinada , East Godavari
	East Godavari	Rajahmundry ART Centre
	Guntur	Area Hospital, Tenali,
	Guntur	Govt. Medical College, Guntur
	Guntur	Guntur ART center
	Guntur	Narasaraopet ART center
	Guntur	NRI ART center
	HYDERABAD	DH,King Koti, Hyderabad
	HYDERABAD	Govt. Gen. Chest hospital, Hyd
	HYDERABAD	Nillofer Hospital
	HYDERABAD	Osmania Medical College, Hyderabad
	Karimnagar	Govt. District Hospital, Karimnagar
	Karimnagar	Ramagundem ART center
	Khammam	Bhadrachalam ART center
	Khammam	District Head Quarters Hospital, Khammam
	Krishna	Tandur ART center
	Krishna	DH, Machilipatnam,Krishna
	Krishna	GGH, Vijayawada
	Krishna	OLD GOVERNMENT GENERAL HOSPITAL
	Kurnool	Government General Hospital, Kurnool
	Mahbubnagar	District HQ Hospital, Mehboobnagar
	Medak	District Headquarter Hospital,Medak
	Nalgonda	District HQ Hospital, Nalgonda
	Nellore	District Head Quarters Hospital, Nellore

st_nam	District Name	ART Centre
	Nizamabad	District Head Quarters Hospital, Nizamabad
	Prakasam	Government District Hospital, Ongole
	Prakasam	Markapur ART center
	Rangareddi	Gandhi Med College, Secundarabad
	Srikakulam	District Head Quarters Hospital, Srikakulam
	Visakhapatnam	Government Hospital for Chest & Communicable Diseases, ART center
	Visakhapatnam	ART Center Anakapalli
	Visakhapatnam	Govt. MC (King George Hospital), Vizag
	Vizianagaram	Government Medical College
	Warangal	Medical college, Warangal
	West Godavari	District Head Quarters Hospital, Eluru
	West Godavari	Tadepalligudem ART center
Arunachal Pradesh	Papum Pare	ART Centre, General Hospital, Naharlagun
Assam	Cachar	Silchar Medical College & Hospital
	Dibrugarh	AMC, Dibrugarh
	Kamrup	Guwahati Medical College Hospital
Bihar	Bhagalpur	J L N Medical Collge,Bhagalpur
	Darbhanga	Dharbhanga Med col,Laheriasarai,Darbhanga
	Gaya	ARTC, ANMMCH
	Katihar	ART Centre Katihar
	Madhubani	ART Centre Madhubani
	Motihari	District (Sadar) Hospital, Motihari
	Muzaffarpur	SKMCH, Muzaffarpur
	Patna	ARTC, RMRI
	Patna	PMCH, Patna
	Saran	District (Sadar) Hospital, Saran
Chandigarh	Chandigarh	PGIMER
Chhatisgarh	Bastar	ART Center Jagdalpur
	Bilaspur	ART Centre CIMS Bilaspur
	Durg	ART Centre, District Hospital
	Raipur	Govt Medical Collage, Art Center, Raipur
	Surguja	ART center surguja

st_nam	District Name	ART Centre
Delhi	Central	LNJP Hospital, New Delhi
	NEW DELHI	AIIMS, New Delhi
	NEW DELHI	Kalawati Saran Children Hospital
	NEW DELHI	RML Hospital, New Delhi
	NORTH	Dr. Baba Saheb Ambedkar Hospital
	NORTH EAST	GTB Hospital, Delhi
	South	LRS institute of TB, New Delhi
	South	SAFDARJUNG HOSPITAL
	WEST	DDU Hospital, New Delhi
Goa	NORTH GOA	Government Medical College, Bambolim
Gujarat	Ahmedabad	ART Center V. S. G. Hospital
	Ahmedabad	B.J. Medical College, Ahmedabad
	Amreli	General Hospital, Amreli
	Banaskantha	ART Centre, General Hospital, Palanpur
	Bharuch	ART Center, Genral Hospital, Bharuch
	Bhavnagar	Medical Collage, Bhavnagar
	Dahod	ART Center , Dahod
	Gandhinagar	Himatnagar ART Centre
	Jamnagar	G G HOSPITAL JAMNAGAR
	Junagadh	General Hospital Junagadh
	Kachchh	ART Center Bhuj
	Kheda	ART Center Nadiad
	Mehsana	Medical Collage, Mashana
	Navsari	Navsari ART Center
	Panchmahal	ART Center General Hospital, Godhra
	Patan	General Hospital, Patan
	Porbandar	ART Centre, Bhavsihji Gen. Hospital Porbandar
	Rajkot	Pandit Din dayal Upadhyay Hospital Rajkot
	Surat	Govt. Medical College, Majura Gate, Surat
	Surat	MoraChoriyasi,RELIANCE HIV&TB CONTROL CENTER,Surat
	Surat	SMIMER HOSPITAL SURAT
	Surendranagar	Mahatma Gandhi Smruti (MGS) Hospital Surendranagar
	Vadodara	SSG Hospital ART Center

st_nam	District Name	ART Centre
	Valsad	ART CENTRE VALSAD
Haryana	Rohtak	PGIMS
Himachal Pradesh	Hamirpur	ART Center R.H Hamirpur
	Kangra	ARTC Dr R P Medical College,
	Shimla	IGMC, Shimla
Jammu & Kashmir	Jammu	Govt. Medical College
	Srinagar	Sher-i-Kashmir Institute of Medical Sciences SKIMS
Jharkhand	Daltonganj	Sadar Hospital, Daltonganj
	Deogarh	Sadar Hospital, Deogarh
	Dhanbad	Patliputra Medical College and Hospital (PMCH), Dhanbad.
	Hazaribagh	ARTC Hazaribagh
	Purbi Singhbhum	MGM Medical College, Jamshedpur
	Ranchi	RIMS, Ranchi
	Bagalkot	ART Center Jamakhandi
	Bagalkot	ART Centre, Taluka Hospital MUDHOL
	Bagalkot	District hospital, Bagalkot
	Bagalkot	General Hospital, Hunagund
	BANGALORE	ART Centre, K C General Hospital
	BANGALORE	Bowring & Lady Curzon Hosp., Bangalore
	BANGALORE	IG Inst. Of Child Health, Bangalore, (IGICH)
	BANGALORE	KIMS Bangolare
	BANGALORE	St. John Hospital
	BANGALORE	Victoria hospital
	Belgaum	District hospital, Belgaon
	Belgaum	General Hospital, Chikkodi
	Belgaum	General Hospital, Gokak
	Belgaum	General Hospital, Athani, dist., Belgaum
	Belgaum	General Hospital, Saudatti, dist., Belgaum
	Bellary	Hospet ART Center
	Bellary	VIMS, Bellary
	Bidar	District Hospital, Bidar
	Bijapur	District hospital, Bijapur
	Bijapur	Sindagi ART center
	Chamarajanagar	District Hospital, Chamrajnagar
	Chikballapur	District Hospital, Chikballapur
	Chikmagalur	District hospital, Manglore

st_nam	District Name	ART Centre
	Chitradurga	District Hospital, Chitradurga
	Dakshina Kannada	District Hospital, Chikmagalur
	Davanagere	ART Centre, Channagiri
	Davanagere	District hospital, Davangeri
	Dharwad	District Hospital, Dharwad
	Dharwad	KIMS ART Centre, Hubli
	Gadag	District Hospital ART Center, Gadag
	Gulbarga	District hospital, Gulburga
	Gulbarga	Voluntary Counseling and ART Center, Wadi
	Haveri	District Hospital, Haveri
	Kodagu	District Hospital, Kodagu
	Kolar	District hospital, Kolar
	Koppal	District Hospital, Koppal
	Mandya	District Hospital ART Center ,Mandya
	Mangalore	Kasturba Medical College & Hospital, Mangalore
	Mysore	Asha Kirana
	Mysore	District Hospital, Hassan
	Mysore	Mysore Medical College
	Raichur	District hospital, Raichur
	Raichur	General Hospital, Lingasugur
	Ramanagaram	District Hospital, Ramanagara
	Shimoga	District Hospital, Shimoga
	Tumkur	District Hospital, Tumkur
	Udupi	District Hospital, Udupi
	Uttara Kannada	District Hospital, Karwar
Karnataka	Yadgiri	District Hospital,ART Centre, YADGIRI
	Alappuzha	Medical College Allepy
	Ernakulam	ART Centre,General Hospital Ernakulam
	Kasaragod	General Hospita l Kasargod
Kerala	Kottayam	Medical College Kottayam
	Kozhikode	ART Centre, Kozhikode
	Palakkad	USHUS District Hospital
	Thiruvananthapuram	Hospital Trivandrum
	THRISSUR	ART Centre, Thrissur
	Bhopal	Gandhi Medical College, Bhopal
	East Nimar	ART Center District Hospital KhanDwa

st_nam	District Name	ART Centre
Madhya Pradesh	Gwalior	Department of MEDICINE J.A. Hospital Gwalior
	Indore	M Y Hospital, Indore
	Jabalpur	Medical College, Jabalpur
	Mandsaur	ART Mandsuar
	Rewa	ART centre Rewa
	Sagar	ART Sagar
	Seoni	ART Seoni
	Ujjain	R D G Medical College Ujjain (M.P)
	Ahmadnagar	District Civil Hospital, Ahmednagar
	Ahmadnagar	Pravara Medical Trust, Loni.xls Pravara Medical Trust, Loni
	Aurangabad	District Hospital, Vaijapur, Aurangabad
	Akola	Medical college, Akola
	Amravati	ART Centre, District Civil Hospital
	Aurangabad	Medical college, Aurangabad
	BEED	Medical college, Ambejogai
	Bhandara	Bhandara DH
	Buldana	ART Centre, District General Hospital
	Chandrapur	BILT, Chandrapur
	Chandrapur	District Hospital ART Centre, Chandrapur
	Dhule	Medical college, Dhule
	Gadchiroli	GADCHIROLI ART Center
	Gondiya	ART Centre, Gondia
	Hingoli	ART Center, Civil Hospital, Risala Bazar, Darga Road
	Jalgaon	Civil Hospital, Jalgoan
	Jalna	Jalna DH
	Kolhapur	RCSM Government Medical College
	Kolhapur	Sub District Hospital,Gadhinglaj
	Latur	Civil Hospital and Govt. Medical College
	Mumbai	BLY Nair Hospital
	Mumbai	Godrej Mumbai
	Mumbai	KEM Hospital
	Mumbai	L&T Health Centre
	Mumbai	LTMG Sion Hospital
	Mumbai	LTMG Sion Hospital,Regional Pediatric ART Centre

st_nam	District Name	ART Centre
Maharashtra	Mumbai	NMMC Vashi
	Mumbai	Siddharth Hospital, Goregaon, Mumbai
	Mumbai	Shatabdi Hospital, Govandi, Mumbai
	Mumbai	Sir J. J. Hospital
	Nagpur	Govt. Med. College, Nagpur
	Nagpur	IGMC Nagpur
	Nanded	Govt. Medical College
	Nandurbar	Nandurbar ART Center
	Nashik	ART Centre SDH Malegaon
	Nashik	Civil Hospital, Nashik
	Osmanabad	Osmanabad DH
	Parbhani	Civil Hospital, Parbhani
	Pune	AFMC Pune
	Pune	B.J. Medical college
	Pune	Bajaj Auto ITD YCMH Pimpri
	Pune	NARI, Pune
	Raigarh	Reliance DAH Patalganga
	Ratnagiri	District Civil Hospital, Ratnagiri
	Sangli	Bharati Vidyapeeth - Sangli
	Sangli	Government Medical College, Sangli
	Satara	ART CENTER KARAD
	Satara	District Civil Hospital, Satara
	Solapur	ART CENTER SUB DISTRICT HOSPITAL,PANDHARPUR
	Solapur	Govt. Medical College, Solapur
	Thane	ART Centre. RGMC Kalva- Thane
	Thane	Central Hospital Ulhasnagar-3
	Thane	Vithal Sayanna General Hospital, Thane
	Wardha	ART Centre Civil Hospital, Wardha
	Washim	WASHIM DH
	Yavatmal	Medical college, Yawatmal
Manipur	Bishnupur	District Hospital, Bishnupur
	Churachandpur	ART CENTRE, DISTRICT HOSPITAL CHURACHANDPUR
	Imphal East	J.N HOSPITAL, ART CENTRE, IMPHAL EAST
	Imphal East	J.N. Regional Pediatric ART Centre,Imphal East
	Imphal West	ART CENTRE, RIMS HOSPITAL, Imphal West

st_nam	District Name	ART Centre
	Senapati	District Hospital, Senapati
	Thoubal	ART CENTRE, DISTRICT HOSPITAL Thoubal
	Ukhrul	ART CENTRE, DISTRICT HOSPITAL Chandel
	Ukhrul	ART CENTRE, DISTRICT HOSPITAL UKHRUL
Meghalaya	East Khasi Hills	Shillong
Mizoram	Aizawl	Civil Hospital, Aizawal
	Champhai	Champhai ART Centre
	Lunglei	Lunglei ART Centre
Nagaland	Dimapur	Ditrict Hospital, Dimapur,
	Kiphre	ART Centre, Kiphre
	Kohima	Naga Hospital Authority, Kohima
	MOKOKCHUNG	ART Centern, Imkongliba Memorial Hospital
	Tuensang	Civil Hospital, Tuensang
	Zunheboto	ART Center, Zunheboto
Orissa	Anugul	ART Centre, DHH, Angul
	Balangir	ART Centre,DHH.Balangir
	Baleshwar	ART Balasore
	Cuttack	S C B Medical collage cuttak
	Ganjam	MKCG Medical College and Hospital, Berhampur
	Khordha	ART CENTRE, CAPITAL HOSPITAL,
	Koraput	BILT ART Centre DHH
	Sambalpur	V.S.S. Medical College. ART Centre
	Sundargarh	ART Centre, RGH, Rourkela
Pondicherry	Pondicherry	Govt General Hospital
Punjab	Amritsar	GMC, Amritsar
	Bathinda	ART Centre, Saheed Bhai Mani Singh, Civil Hospital
	Gurdaspur	ART Centre, Civil Hospital, Pathankot
	Jalandhar	Civil Hospital, Jalandhar
	Ludhiana	ART Centre, Lord Mahavir, Civil Hospital
	Patiala	Medical Collage, Patiala
	Ajmer	ART Centre J.L.N. Hospital & Medical College
	Alwar	ART Centre, Alwar
	Bikaner	Bikaner, SP Medical College

st_nam	District Name	ART Centre
Rajasthan	Bhilwara	ART Center Bhilwara
	Jaipur	SMS Hospital, Jaipur
	Jodhpur	SNMC, Jodhpur
	Kota	Medical College
	Pali	Govt. Bangur hospital pali-Marwar
	Sikar	ART Center Sikar
	Udaipur	RNT Medical College, Udaipur
Sikkim	East	STNM HOSPITAL
Tamil Nadu	Ariyalur	Govt. District Headquaters Hospital, Krishnagiri
	Chennai	Govt. Hospital for Thoracic Medicine
	Chennai	ICH
	Chennai	Institute of Obstetrics & Gynecology MMC
	Chennai	Kilpouk Medical College
	Chennai	Madras Medical College
	Chennai	Stanley Medical College
	Coimbatore	Coimbatore medical college
	CUDDALORE	Govt. District Headquaters Hospital, Cudallore
	Dharmapuri	District Hospital
	Dindigul	Govt. District Headquaters Hospital, Dindugal
	Erode	Erode District Headquarters Hospital
	Kancheepuram	Govt. Medical College and Hospital, Chengalpattu
	Kanniyakumari	Medical College
	KARUR	District Hospital
	Madurai	ART CENTRE MELUR
	Madurai	Government Medical College
	Nagapatinim	Nagapattinam District Headquarters Hospital,
	Namakkal	Government Hospital
	Namakkal	Tiruchengode ART Centre
	Perambalur	ART Centre, Govt Hospital, Perambalur
	Pudukkottai	Govt. District Hospital
	Ramanathapuram	Ramanathapuram District Headquarters Hospital
	Salem	Attur ART centre
	Salem	Medical College

st_nam	District Name	ART Centre
	Sivaganga	Sivagangai Medical College & Hospital
	Thanjavur	Thanzavur Medical College
	The Nilgiris	Nilgiris District Headquarters Hospital
	Theni	Theni medical college
	Thiruvallur	Govt. District Headquaters Hospital, Thiruvallur
	Thiruvarur	Govt. Medical College and Hospital
	Tiruchirappalli	ART Center, Manaparai
	Tiruchirappalli	Trichy medical college
	Tirunelveli	Medical College
	Tirupur	ART Centre, Tirupur
	Tiruvanamalai	Govt.District Headquaters Hospital,Thiruvannamalai
	Toothukudi	Jayamkondam ART Center
	Toothukudi	Tuticorin Medical College Hospital, Tuticorin
	Vellore	CMC Vellor
	Vellore	Vellore medical college
	Vellore	Tirupathur
	Viluppuram	District Hospital
	VIRUDHUNAGAR	District Hospital
Tripura	West Tripura	Agartala
	Agra	SN Medical College Hospital
	Aligarh	J N Medical College, Aligarh
	Allahabad	MLN Medical College, Allahabad
	Azamgarh	ART Centre Azamgarh
	Deoria	ART Centre District Hospital Deoria
	Etawah	ART Centre UP RIMS & R, Saifai,
	Gorakhpur	BRD Medical College, Gorakhpur
	Ghazipur	Art centre,District Hospital Ghazipur
	Jaunpur	ART Centre Jaunpur
	Jhansi	MLB Medical College
Uttar Pradesh	Kanpur Nagar	I.D. HOSPITAL, GSVM MEDICAL COLLEGE, KANPUR
	Kushinagar	COMBIND DISTRICT HOSPITAL,KUSHI NAGAR
	Lucknow	ART Center. Dr. Ram Manohar Lohia Combined Hospital
	Lucknow	KGMC, Lucknow

st_nam	District Name	ART Centre
	Meerut	LLRM Medical College
	Partapgarh	ART center Pratapgarh
	Rae Bareli	ART centre, UNCHAHAR
	Sidharth nagar	ART center, Siddharth Nagar
	Varanasi	ART Center Pt. DEEN DAYAL UPADHYAY GOVT HOSPITAL
	Varanasi	Banaras Hindu University, Varanasi
Uttaranchal	Dehradun	Doon Hospital
	Nainital	Dr.SusheelaTiwariMemorial forest Hospital Haldwani
West Bengal	BARDDHAMAN	Medinapur Medical College, Burdwan
	Darjiling	North Bengal Medical College, Siliguri
	Kolkata	M. R. Bangur District Hospital,
	Kolkata	Medical College,Regional Pediatric ART Centre
	Kolkata	R.G.Kar Medical College
	Kolkata	School of Tropical Medicine
	Maldah	Malda District Hospital
	Medinipur	Medinapur Medical College, Medinapur
	Uttar Dinajpur	Islampore SD Hospital, (Room No. 10 & 11)

ANNEXURE 15 : ROLE OF CCCs

- The CCC plays a critical role in enabling PLHIV to access ART as as providing monitoring, follow up and counselling support to those who are initiated on ART, positive prevention, drug adherence, nutrition counselling etc. The monitoring of PLHIV, who do not require ART as yet (Pre ART) will also be a critical function that needs to be carried out by CCC.
- A Community Care Centre (CCC) is a place with facilities for Out Patient and In-Patient treatment where a PLHIV receives the following services:
    - All PLHIV started on ART (at the ART Centre) will be sent to the CCC for a minimum of 5 days of In patient care and be prepared for ART
    - Treatment of OIs
    - Appropriate referrals to ICTC,PPTCT and ART Centres
    - Out Patient Services
    - Home Based Care
    - Some CCCs will serve as Link ART Centres
    - Condom Distribution
- Staff at CCC comprises of;
    - Doctor – 1 Full time or 2 Part time
    - Project Coordinator – 1 Full Time
    - Counsellor – 1 Full Time
    - Out Reach Workers – 4
    - Laboratory Technician – 1 Part Time
    - Nurses – 3
    - Cook – 1
    - Helper – 1
    - Janitor – 2
- Under NACP III, it is proposed to set up 350 CCC over a period of 2007-2012 through PLHIV networks, NGOs and other Civil Society Organizations
- The CCCs are being established on priority,in districts which have high levels of HIV prevalence and high level PLHIV plod and will be linked to the nearest ART centre.

ANNEXURE 16 : FACILITY INTEGRATED COUNSELING & TESTING CENTRE$_S$

Background

An integrated counselling and testing centre is a place where a person is counselled and tested for HIV, on his own free will or as advised by a medical provider. The main functions of an ICTC include:

- Early detection of HIV
- Provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioral change and reducing vulnerability
- Link people with other HIV prevention, care and treatment services

"Facility-integrated" ICTC is one which does not have full-time staff and provides HIV counselling and testing, as a service along with other services. Existing health staff such as the auxiliary nurse midwife (ANM)/staff nurse/ health visitor/laboratory technician (LT) are expected to undertake HIV counselling and testing. Such ICTCs are usually established in facilities that do not have a very large client load and where it would be uneconomical to establish a stand-alone ICTC. Typically, such facilities are 24-hour PHCs as well as private sector/not-for-profit hospitals, Such ICTCs will be supported by the National AIDS Control Organization (NACO)/State AIDS Control Societies (SACS) to the extent of:

- Supply of rapid HIV testing kits
- Training of existing staff
- Quality assurance
- Supply of protective kits and prophylactic drugs for post-exposure prophylaxis (PEP) for staff
- Supply of information, education and communication (IEC) material required for an ICTC such as flip charts, posters, etc.

Current status

In the country, a total of 5018 facility Integrated ICTCs (Government) and 964 public private partnership (PPP) model ICTCs are functional and are reporting through CMIS as on 31st March 2011. In the high prevalent states, facility integrated ICTCs have been established up to the 24x7 PHC level and in the majority of the remaining states, the services of Facility Integrated ICTCs have reached up to CHCs.

State wise distribution of different types of ICTCs is detailed below as Table 1

Monitoring & Reporting

In all the A& B category districts, District ICTC supervisors have been appointed and they perform regular visits to the facility integrated ICTCs to ensure quality of services and reporting. In the remaining districts the counselors in the stand alone ICTCs are being instructed to visit the facility integrated ICTCs as part of the regular out reach activities on Saturday afternoons to hand hold the staff for effective service delivery. So far, the "facility-integrated" ICTC sends reports as per the formats prescribed in the operational guidelines of ICTCs. Henceforth, the monthly reporting formats, register to be maintained, etc are revised and will be discussed in this session.

Terms of Reference of the ANM at the F-ICTC:

Preventive and health education

- Ensure that each client is provided pre-test information/counselling, post-test counselling and follow-up counselling in a friendly atmosphere.
- Be available in the ICTC as per the specified timings.

- Ensure that strict confidentiality is maintained.
- Ensure that all IEC materials such as posters, etc. are displayed prominently in the ICTC.
- Ensure that communication aids in the form of flip books and condom demonstration models, fliers, etc. are available and used during counselling sessions in the ICTC.

Psychosocial Support

- Provide psychosocial support to help HIV-positive clients cope with HIV/AIDS and its consequences.
- Ensure that the extended family of the HIV-positive client is sensitized on how to deal with HIV-positive members of the family.

Referral and Linkages

- Maintain effective coordination with the RCH and TB programmes as well as with the antiretroviral therapy (ART) programme, and visit key persons in the facilities run by these programmes once in a fortnight so as to strengthen linkages and minimize loss of clients during referrals.

Supply and Logistics

- Report to the SACS on the adequacy of stocks of condoms and prophylactic PPTCT drugs in the ICTC as well as in the facility.

Monitoring

- Maintain counselling records and registers, and prepare monthly reports which are to be sent to the District HQ / SACS.
- Facilitate the establishment of linkages and referrals to the ICTC from within and outside health-care settings.

Table : Distribution of ICTCs state wise as on 31st March, 2012

NUMBER OF ICTCs FUNTIONING AS ON 31.03.2012

No.	State	Stand alone (Including Mobile)	Facility Integrated ICT Cs (Govt.)	PPP Model	Total
1	Ahmedabad	25	1	0	126
2	Andaman & Nicobar Islands	13	2	0	15
3	Andhra Pradesh	406	1013	198	1617
4	Arunachal Pradesh	36	11	0	47
5	Assam	85	41	9	135
6	Bihar	208	0	5	213
7	Chandigarh	12	2	0	14
8	Chhatisgarh	104	10	0	114
9	Dadra & Nagar Haveli	1	0	0	1
10	Daman & Diu	4	0	0	4
11	Delhi	95	0	0	95
12	Goa	14	0	2	16
13	Gujarat	283	769	132	1184
14	Haryana	88	30	0	118
15	Himachal Pradesh	47	17	0	64
16	Jammu & Kashmir	35	0	0	35
17	Jharkhand	67	21	2	90
18	Kamataka	467	797	136	1400
19	Kerala	164	54	26	244
20	Madhya Pradesh	143	196	17	256
21	Maharashtra	589	757	272	1618
22	Manipur	60	7	3	70
23	Meghalaya	12	3	4	19
24	Mizoram	36	24	4	64
25	Mumbai	72	0	25	97
26	Nagaland	70	12	1	83
27	Orissa	185	16	7	208
28	Pondicherry	12	3	0	15
29	Punjab	73	136	0	209
30	Rajasthan	182	7	6	195
31	Sikkim	13	6	0	19
32	Tamil Nadu	393	932	76	1401
33	Tripura	18	20	0	38
34	Uttar Pradesh	217	20	29	266
35	Uttaranchal	48	101	6	155
36	West Bengal	256	10	4	270
	India	4533	5018	964	10515

ANNEXURE 17 : NACO DOCUMENTATION & REPORTING FORMATS

Data definition for the Monthly Progress Report of F-ICTC/PPP ICTC **Section A Identification**		
Indicator	**Data Definition**	**Data Source**
F-ICTC/PPP ICTC Code	To be provided by the SACS after registering the unit. SACS BSD/ICTC division to provide the basic information required to register the F-ICTC in SIMS to the respective SACS M&E Division or SIMU and accordingly the auto generated code to be shared with the respective F-ICTC/PPP ICTC. The F-ICTC should mention the code provided by SACS/DAPCU	To be provided by the SACS
1. Name of Centre	Write the name of the health facility where the F-ICTC is located	To be provided by the F ICTC
Type of F-ICTC	Write the type of F-ICTC/PPP ICTC whether Fixed or Mobile. If the F-ICTC/PPP ICTC has been established in a fixed health facility write "Fixed" or if the F-ICTC established in Mobile Medical Units/Mobile Vanwrite "Mobile"	
2. Address	Write the complete address of the centre	To be provided by the F ICTC
Pin Code	Write the Pin code of the place where the F-ICTC/PPP ICTC is located or from where it operates in case of Mobile"	To be provided by the F ICTC
Block/Mandal/Taluka	Write the name of Block/Mandal/ Taluka where the F-ICTC/PPP ICTC is located or from where it operates in case of Mobile"	To be provided by the F ICTC
District	Write the name of District where the F-ICTC/PPP ICTC is located or from where it operates in case of Mobile"	To be provided by the F ICTC
State	Write the name of the State	To be provided by the F ICTC
3. Reporting Period Month Year	Write the month of reporting Write the year of reporting	To be provided by the F ICTC To be provided by the F ICTC
4. Name of the Officer In-Charge (F-ICTC/PPP ICTC) 5. Contact Number	'Write the name of the Medical Officer In-Charge of the F-ICTC/PPP ICTC Write the contact number of the Medical Officer In-Charge of the	To be provided by the F ICTC To be provided by the F ICTC

Indicator	Data Definition	Data Source
	F-ICTC/PPP ICTC	
6. Email Address	Write the email address of the Medical officer In-Charge of the F-ICTC/PPP ICTC	To be provided by the F ICTC
7.	F-ICTC/PPP ICTC Location Write the location of the F-ICTC/ PPP ICTC where it is situated e.g:- Medical Hospital, Maternity Home, CHC, 24X7 PHC, PHC, etc	To be provided by the F ICTC
Section B Basic Indicator		
1. Progress Made During the Month		
Indicator	**Data Definition**	**Data Source**
1. Total ANC Clients regis	Write the total number of ANC tered during the month registered during the month of reporting in the health facility. For eg: 100 Pregnant registered under Women then write 100 in the box	ANC registeration Register of the Centre
2. Number of Clients provided pre-test counseling	Write the number of pregnant women (ANC) provided pre-test counseling during the month of reporting in the specified boxes for the format. E.g:- if 80 out of the 100 Pregnant Women registered under ANC are provided with pre-test counseling then write "80" in the box below ANC. Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male,female(non pregnant) and TS/TG))	F-ICTC RegiserColoumn No. 7
3. Number of Clients] tested for HIV	Out of the above write the number of clients tested during the month of reporting in the specified boxes for the format. E.g:- if 80 Pregnant Women register under ANC are tested for HIV 1st test write "80" in the box below ANC. Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male, female(non pregnant) and TS/TG))	F-ICTC RegiserColoumn No. 8
4. Number of Clients provided post-test counseling	Out of the above, write the number of clients provided post-test counseling during the month of reporting in the	F-ICTC RegiserColoumn No. 10

Indicator	Data Definition	Data Source
	specified boxes for the format. E.g:- if 80 Pregnant Women register under ANC are provided with post-test counseling write "80" in the box below ANC. Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male, female(non pregnant) and TS/TG))	
5. Number of Clients detected HIV reactive after 1st Test	Out of the clients tested for HIV, write the number of clients detected HIV reactive after 1st test during the month of reporting in the specified boxes for the format. E.g:- if 10 Pregnant Women register under ANC are detected HIV reactive after 1st test write "10" in the box below ANC.Similarly fill the other boxes (direct in labour under pregnant women and under general clients, male, female(non pregnant) and TS/TG))	F-ICTC RegiserColoumn No. 9
2. Linkage & Referral		
In Referral		
Indicator	**Data Definition**	**Data Source**
1. OBG/GYN(ANC)	Write the number of ANC cases referred in, during the month of reporting, for HIV testing, by the Obstetrics and Gynaecology Department or medical officer	F-ICTC RegiserColoumn No. 2
2. Targeted Intervention NGOs	Write the number of clients being referred in, during the month of reporting, for HIV testing, by the NGOs working under Targeted Intervention Projects.	F-ICTC RegiserColoumn No. 2
3. Link Worker	Write the number of clients being referred in, during the month of reporting, for HIV testing, by the Link Workers working under Link Worker Scheme.	F-ICTC RegiserColoumn No. 2
4. RNTCP	Write the number of clients being referred in, during the month of reporting, for HIV testing, by the staff working under Revised National TB Control	F-ICTC RegiserColoumn No. 2

Indicator	Data Definition	Data Source
5. STI Clinic	programme (MO/STS/STLS etc) Write the number of STI clients being referred in, during the month of reporting, for HIV testing, by the STI Clinic or medical officer	F-ICTC RegiserColoumn No. 2
6. Others	Write the number of clients coming in during the month of reporting for HIV testing from any sources other than those mentioned above	F-ICTC RegiserColoumn No. 2
Out Referral to Stand Alone ICTCs for confirmation		
Indicator	**Data Definition**	**Data Source**
1. OBG/GYN(ANC)	Write the number of those referred in clients from OBG/GYN (ANC) or medical officer, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
2. Targeted Intervention NGOs	Write the number of those referred in clients from NGOs working under Targeted Intervention Projects, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
3. Link Worker	Write the number of those referred in clients from Link Worker working under Link Worker Scheme, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
4. RNTCP	Write the number of those referred in clients by the staff working under Revised National TB Control programme (MO/STS/STLS etc), found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
5. STI Clinic	Write the number of those referred in STI clients from STI Clinic or medical officers found	F-ICTC RegiserColoumn No. 11

Indicator	Data Definition	Data Source
	HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	
6. Others	Write the number of those referred in clients from sources other than mentioned above, found HIV 1st test reactive and further referred to Stand Alone ICTC for confirmation of HIV status during the month of reporting.	F-ICTC RegiserColoumn No. 11
3. Stock Status of HIV Test (Number of Tests)		
Indicator	**Data Definition**	**Data Source**
1. HIV 1st Test	Write the information pertaining to the HIV 1st Test like Name of Kit, Batch No., Expiry Date (in DD/MM/YYYY format like 1st April, 2012 as 01/04/2012), Opening Stock, Number of Test received, Number of Test consumed, Control, Was tage/Damage, Closing Stock and Quantity indented in the specified boxes, for the month of reporting.	Stock Register of the Facility
2. Whole Blood Test	Write the information pertaining to the HIV 1st Test like Name of Kit, Batch No., Expiry Date(in DD/MM/YYYY format like 1st April, 2012 as 01/04/2012), Opening Stock, Number of Test received, Number of Test consumed, Wastage/Damage, Closing Stock and Quantity indented in the specified boxes for the month of reporting.	Stock Register of the Facility

Data definition for FICTC/PPP ICTC Register

Name of the FICTC		Mention the name of the Health Facility providing Counseling and Testing services
Month		Mention the current month at the space provided
Year		Mention the current year at the space provided
Coloumn No.		
1	Serial Number (Sr.No.)	This is the number given to individuals coming to ICTC for counseling and Testing. The number should be started from 1 onwards
2	Referral From	Write the source/point of referral from where the client has been referred to your facility. A Client may be referred from O&G(ANC), Direct in labour, NGOs working under Targeted Intervention project, staff of RNTCP, link worker working under Link Worker Scheme, STI Clinics or others.
3	Full Name	Write the Full Name of the Client
4	Full Address with contact No-	Write the Full Address including Taluka/Block , Pin code and contact number of the client.
5	Age In Years	Write the age of the client in years
6	Sex: Male, Female, TS/TG	Write the Sex of the client whether Male, Female or Trans-sexual/ Trans-gender
7	Pre Test Counseling (Yes/No)	The person coming for testing is provided with HIV pre-test counselling/information involving provision of basic information on HIV/AIDS and risk assessment. Write "Yes" if pre test counselling is done or write "No" if it is not done
8	Date of HIV Test (dd/mm/yyyy)	Mention the Date of HIV test done. E.g. client tested on 1st February, 2012 write 01/02/2012 in the space provided
9	HIV Test Result (Reactive , Non Reactive)	Mention the HIV test result here whether Reactive or Non Reactive
10	Post Test Couseling (Yes/No)	Post test counseling is provided to the client helping him/her to understand and cope with the HIV test result. Write "Yes" if post test counselling is done or write "No" if it is not done
11	Referred to Stand Alone ICTC for confirmation (Yes/No) write reasons for not referring, etc in remarks coloumn	If the client's HIV Test is reactive, refer him/her to the nearest stand Alone ICTC where three test will be conducted for confirmation of HIV status. Write "Yes" if client has been referred or write "No" if not referred and the details like name of ICTC centre referred to, or
12	Remarks here	Any other information not captured may be mentioned

F-ICTC Code							
MONTHLY REPORTING FORMAT: FACILITY INTEGRATED / PPP ICTC							
SECTION A. IDENTIFICATION							
1. Name of Centre:					**Type of F-ICTC**		
2. Address:							
Pin Code:		**Block/ Mandal/ Taluka:**		**District:**		**State:**	
3. Reporting Period:		**Month:**		**Year:**			
4. Name of Officer In-charge (F-ICTC):							
5. Contact number (phone):							
6. Email Address:							
7. F-ICTC Location:							

SECTION B. BASIC INDICATORS

1. PROGRESS MADE DURING THE MONTH

	Pregnant Women			General Clients			
	ANC	**Direct in Labour**	**Total**	**Male**	**Female**	**TS / TG**	**Total**
1. Total ANC clients registered during the month							
2. Number of clients provided pre-test counseling							
3. Number of clients tested for HIV							
4. Number of clients provided post-test counseling							
5. Number of clients detected HIV reactive after 1st Test							
6. Number of ANC Client tested for Syphlis (VDRL/RPR Test)							
7. Number of ANC Client found reactive for Syphlis							

2. LINKAGE & REFERRAL

Department/ Organisation	In Referral	Out Referral to Stand Alone ICTCs for confirmation
1. OBG / GYN (ANC)		
2. Targeted Intervention NGOs		
3. Link Worker		
4. RNTCP		
5. STI Clinc		
6. Others		

3. STOCK STATUS OF HIV TEST KITS (Number of Tests)

Consumables	Name of Kit	Batch No.	Expiry Date dd/mm/yyyy	Opening Stock	Received	Consumed	Control	Wastage / Damage	Closing Stock	Quantity Indented
1. HIV 1st Test										
2.Whole Blood Test										

SECTION C. STI/RTI MONTHLY INDICATORS

	Male	Female	Total
1. Number of patients diagnosed and treated for various STI/RTI			
2. Number of STI/RTI patients tested for Syphlis (VDRL/RPR Test)			
3. Of Above, Number found reactive for syphilis			
4. Availability of essential STI/RTI drugs (Yes/ No)			

Signature of In Charge	
Date:	

Register for Facility Integrated/PPP ICTC

Name of the Health Facility……..								Month	……	Year	……
Sr.No.	Referred from (O&G)ANC/ Direct in Labour/RNTCP/ STI/ TI/ LWS/ Others	Full Name	Full Address with contact No-	Age In Years	Sex: Male, Female, TS/TG	Pre Test Counselling (Yes/No)	Date of HIV Test (dd/mm/yyyy)	HIV Test Result (Reactive , Non Reactive)	Post Test Couselling (Yes/No)	Referred to Stand Alone ICTC for confirmation (Yes/No)	Remarks
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)

ANNEXURE 18 : ICE BREAKERS & ENERZIERS

Remember – these are more fun when the trainers join in!

1. SHAKE ALL HANDS :

Everyone in the room shakes everyone else's hand within a strict time limit of one minute. This gets energy up, and obliges each participant to acknowledge everyone else.

2. SPACE ON MY RIGHT:

Participants are seated in a circle. The facilitator arranges for the space on their right to remain empty. They then ask a member of the group to come and sit in the empty space; for example, "I would like Lili to come and sit on my right". Lili moves and there is now a space on the right of another participant. The participant who is sitting next to the empty space calls the name of someone different to sit on his or her right. Continue until the entire group has moved once.

3. WHAT WE HAVE COMMON:

The facilitator calls out a characteristic of people in the group, such as 'having children'. All those who have children should move to one corner of the room. As the facilitator calls out more characteristics, such as 'likes football', people with the characteristic move to the indicated space.

4. THE SUN SHNES ON……:

Participants sit or stand in a tight circle with one person in the middle. The person in the middle shouts out "the sun shines on..." and names a colour or articles of clothing that some in the group possess. For example, "the sun shines on all those wearing blue" or "the sun shines on all those wearing socks" or "the sun shines on all those with brown eyes". All the participants who have that attribute must change places with one another. The person in the middle tries to take one of their places as they move, so that there is another person left in the middle without a place. The new person in the middle shouts out "the sun shines on..." and names a different colour or type of clothing.

5. BODY WRITIING:

15 Body writing Ask participants to write their name in the air with a part of their body. They may choose to use an elbow, for example, or a leg. Continue in this way, until everyone has written his or her name with several body parts.

6. TIDE'S IN / TIDE'S OUT:

Draw a line representing the seashore and ask participants to stand behind the line. When the facilitator shouts "Tide's out!", everyone jumps forwards over the line. When the leader shouts "Tide's in!", everyone jumps backwards over the line. If the facilitator shouts "Tide's out!" twice in a row, participants who move have to drop out of the game.

7. SIMON SAYS… :

The facilitator tells the group that they should follow instructions when the facilitator starts the instruction by saying "Simon says..." If the facilitator does not begin the instructions with the words "Simon says", then the group should not follow the instructions! The facilitator begins by saying something like "Simon says clap your

hands" while clapping their hands. The participants follow. The facilitator speeds up the actions, always saying "Simon says" first. After a short while, the "Simon says" is omitted.

8. WHAT SOUND IS THIS?

Someone makes a sound and everyone else tries to identify it – the person who guesses right makes another sound. Sounds could include animal and bird noises, machines, vehicles or food preparation.

9. WHERE WERE YOU?

Ask each participant to pull a coin out of their purse and look at the year on the coin. Give them one minute to think about where they were and what significant event took place during that year. Ask few or all participants (depending on time) to share their memories in one or two sentences.

10. REFLECTING ON THE DAY:

To help people to reflect on the activities of the day, make a ball out of paper and ask the group to throw the ball to each other in turn. When they have the ball, participants can say one thing they thought about the day.

11. WRITING ON BACKS:

At the end of a workshop, ask participants to stick a piece of paper on their backs. Each participant then writes something they like, admire or appreciate about that person on the paper on their backs. When they have all finished, participants can take their papers home with them as a reminder

12. TREASURE HUNT

Material Needed: Any object eg Book/ Hand bag/Vase etc. (Treasure) A thin dupatta to blind fold Steps:

- Ask for a participant to volunteer, without telling the purpose of the game (Volunteer should trust the Trainer).
- Take her out of the room and blindfold her.
- In the meantime, come back and ask the other participants to rearrange the furniture in the room to create enough space and to make the game more interesting.
- Bring the volunteer back in the room, make her feel the treasure and put it at some accessible location in the room.
- Instruct her to hunt for it in the room.
- Do not give any explicit instructions to the volunteer or the group on whether she can seek the help from the group or whether the group can guide her.
- Make sure that the volunteer does not hurt herself while hunting for the treasure; If you observe that the volunteer is finding it difficult to locate the treasure ,keep it at a more convenient location.
- Observe the group behavior ie whether they remain silent or assist the volunteer in locating the treasure (by providing her appropriate directions)- both while you are present in the room or when you move out; do they wait for instructions from you to guide the volunteer or do they themselves take the initiative.
- Ultimately, when the volunteer is able to successfully hunt for treasure, congratulate her on her efforts and remove the blindfold.

13. PAPER DANCE (Achieving Maximum with Minimum resources)

Resources Needed**:** Double page or half page same size old news papers, (depending upon the number of participants examples for 30 participants take 15 papers).

Process:

- Make the group count 1,2,1,2……
- Divide all the 1s and 2s in two groups and pair them
- Distribute one paper to each pair and make them stand comfortably and dance on the paper. Instruct them to make sure that their feet remain inside the paper only.
- After few minutes, ask them to fold the paper in half and dance, with their feet remaining inside the paper.
- Ask the participants to repeat the process, as many times as they can, by folding the paper half every time (some would be able to do it by folding the paper 5 or 6 times, where as some would stop at 3 or 4 times only)
- In the end, ask the participants:

  Q 1 qualities needed to do this exercise

  Q 2 their feelings during the excercise, and write them on the flip chart

  Q 3 What made some of the pairs carried on with the exercise for long?

Write their responses on a flip chart

SAMPLE ENERGIZERS:

The following can be carried out to music, with brief stops in the music to signal that the movement/role should change.

- Divide the participants into pairs, one person in the front and the other person behind. Get the person at the back to rub the shoulders of the person in front. The pair turns around and exchange roles.
- Get participants of the same size and preferably same gender, to stand back to back. Each person drops her/his head on the other person's shoulder and relaxes.
- Participants can form a semi-circle with the person at the far end bending forwards from the waist, hands forward and inhaling, and exhaling while coming up, everyone follows suit.
- Everyone does spot jogging while facing her/his partner.
- Get a small group to stand on either side of a person. The person in the middle gets gently pushed from one group to another. The person in the middle should not resist or move voluntarily, but just relax and let others take care of her/him.

ANNEXURE 19 : IMUNIZATION CHART FOR CHILDREN LIVING WITH HIV

Age	Vaccination	Remarks
Birth	BCG + OPV 1 + HBV 1	
6 weeks	DPT 1 + OPV2 + HBV 2	
10 weeks	DPT2 + OPV 3	
14 weeks	DPT 3 + OPV 4	
6-9 months	OPV 5 + HBV 3	Assess clinical status of child before giving live vaccines
9 months	Measles Vitamin A	Assess clinical status of child before giving live vaccines
15-18 months	MMR DPT1 booster OPV 6	Assess clinical status of child before giving livevaccines
5 years	DPT2 booster OPV 7	Assess clinical status of child before giving livevaccines
10 Years	TT3	
15-16 Years	TT4	

Notes:

- Inactivated Polio vaccine (IPV) is now registered in India, and will be available soon.
- Generally, if the HIV-infected child is asymptomatic or mildly symptomatic – vaccinations should be given.
- Withhold vaccine (live vaccines) for HIV-infected children who are symptomatic and severely immuno-compromised.
- Other vaccines not within the normal EPI schedule include: Japanese B encephalitis, chickenpox vaccine, Haemophilus, influenza B, etc

SECTION 5
Glossary & References

Glossary of Terms

Some of the definitions in this glossary were taken from the "Glossary of HIV/AIDS-related Terms" compiled by UNAIDS and available at: http://www.unaids.org/Unaids/EN/Resources/Terminology/glossary+of+hiv_aids-related+terms.asp. Some terms not found in this UNAIDS database were defined by I-TECH trainers for a training held in Namibia. These are indicated with an asterisk (*). Rest of the definitions have been taken up from the website of National AIDS Control Organization (NACO)

Adherence	The process in which a patient follows a prescription and recommendations for a regimen of care. The patient participates and understands plan of care and treatment.
AIDS	Acquired Immune Deficiency Syndrome. The most severe manifestation of infection with the human immunodeficiency virus (HIV).
AIDS Defining Conditions	Numerous opportunistic infections and neoplasms (cancers) that, in the presence of HIV infection, constitute an AIDS diagnosis. Persons living with AIDS often have infections of the lungs, brain, eyes and other organs, and frequently suffer debilitating weight loss, diarrhoea, and a type of cancer called Kaposi's sarcoma.
ANM	Auxiliary Nurse Midwife
ARV	Antiretroviral. Drug used to fight infection by retroviruses, such as HIV infection.
ART or ARVT	Antiretroviral Therapy. A treatment that uses antiretroviral medicines to suppress viral replication and improve symptoms.
Asymptomatic	Without symptoms. Usually used in the HIV/AIDS literature to describe a person who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.
Bridge Populations	Bridge populations comprise people, who, through close proximity to high risk groups are at the risk of contracting HIV. Quite often they are clients or partners of male and female sex workers. Truckers and migrant labours are major bridge populations
CD4 Cells	1. A type of T cell involved in protecting against viral, fungal and protozoal infections. These cells normally orchestrate the immune response, signalling other cells in the immune system to perform their special functions. Also known as T helper cells. 2. HIV's preferred targets are cells with a docking molecule called 'cluster designation 4' (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (or CD4+) cells. Destruction of CD4+ lymphocytes is themajor cause of the immunodeficiency observed in AIDS, and decreasing CD4+ lymphocyte levels appear to be the best indicator for developing OIs

CD4 Receptors	The chemical on the surface of a CD4 lymphocyte to which HIV attaches.*
CD4 Count	A way of measuring ehavi-competency by counting the lymphocytes that carry the CD4 molecule. Normal is well over 1000/ml of blood. A count lower than 200 ml is an indicator of AIDS.*
Compliance	The degree of constancy and accuracy with which a patient follows a prescribed regimen
Chronic	The term chronic means lasting a long period of time. In medicine, an illness may be considered chronic if it has lasted six months or more, or if there is no expectation of improvement.
Client Initiated Counselling	A HIV-prevention intervention initiated by the client at his or her free will
Code Of Ethics	A code of ethics is a set of principles of conduct within an organization that guide decision making and behaviour. The purpose of the code is to provide members and other interested persons with guidelines for making ethical choices in the conduct of their work.
Colostrum	Also known as beestings or first milk,is a form of milk produced by the mammary glands in late pregnancy and the few days after giving birth. In humans, it has high concentrations of nutrients and antibodies, but it is small in quantity. Colostrum is high in carbohydrates, high in protein, high in antibodies, and low in fat (as human newborns may find fat difficult to digest).
Combination Therapy	(For HIV infection or AIDS.) Two or more drugs or treatments used together to achieve optimum results against infection or disease. For treatment of HIV, a minimum of three antiretrovirals is recommended. Combination therapy may offer advantages over single-drug therapies by being more effective in decreasing viral load. An example of combination therapy would be the use of two nucleoside analogue drugs (such as lamivudine and zidovudine) plus either a protease inhibitor or a non-nucleoside reverse transcription inhibitor.
Cough Hygiene	Procedures to contain infectious respiratory secretions in people showing symptoms of disease, beginning at initial point of encounter.Usual respiratory hygiene includes covering the mouth/nose when sneezing or coughing; using tissues and disposing of them in no-touch containers; and careful hand washing.
DNA	Deoxyribonucleic acid. Except for a few viruses, all living cells carry genetic information as DNA.*
DOTS	Directly Observed Treatment-Short Course
DOTS PLUS	Directly Observed Treatment-Short Course For Multi Drug Resistant TB
Efficacy	(Of a drug or treatment). The maximum ability to produce a result, regardless of dosage. A drug passes efficacy trials if it is effective at the dose tested and against the illness for which it is prescribed.
ELISA Test	Acronym for enzyme-linked immunosorbent assay. A type of enzyme immunoassay (EIA) to determine the presence of antibodies to HIV in the blood or oral fluids. Repeatedly reactive (i.e. two or more), ELISA test results should be validated with an independent supplemental test of high specificity, such as the Western blot test.

Epidemiology	The branch of medical science that deals with the study of incidence, distribution and control of a disease in a population.
FICTC	Facility Integrated Counseling & Testing Centre- providing HIV counselling and testing, as a service along with other services. They typically don not have a very large client load and therefore does not have full-time staff and
Fusion	The stage of the HIV lifecycle in which the virus binds to the CD4 receptor, activates other proteins on the surface of the cell, then fuses with the T helper or macrophage cell.*
GFATM	Global Fund For AIDS, TB & Malaria
HAART	Highly Active Anti Retroviral Therapy. The name given to treatment regimens recommended by leading HIV experts to aggressively suppress viral replication and progress of HIV disease. The usual HAART regimen combines three or more different drugs such as two nucleoside reverse transcriptase inhibitors and a protease inhibitor, two NRTIs and a non-nucleoside reverse transcriptase inhibitor or other combinations.
HIV	Human Immunodeficiency Virus. The virus that weakens the immune system, ultimately leading to AIDS.
HIV-1	Human Immunodeficiency Virus Type 1. The retrovirus isolated and recognized as the etiologic (i.e. causing or contributing to the cause of a disease) agent of AIDS. HIV-1 is classified as a lentivirus in a subgroup of retroviruses. Most viruses and all bacteria, plants, and animals have genetic codes made up of DNA, which uses RNA to build specific proteins. The genetic material of a retrovirus such as HIV is the RNA itself. HIV inserts its own RNA into the host cell's DNA, preventing the host cell from carrying out its natural functions and turning it into an HIV factory.
HIV-2	Human Immunodeficiency Virus Type 2. A virus closely related to HIV-1 that has also been found to cause AIDS. It was first isolated in West Africa. Although HIV-1 and HIV-2 are similar in their viral structure, modes of transmission, and resulting opportunistic infections, they have differed in their geographical patterns of infection.
HIV Antibody Test	If positive, the results of this test indicate that the person has been exposed to HIV and has developed antibodies to the virus after the window period of up to 12 weeks has passed.
ICTC	Integrated Counselling & Testing Centre-An ICTC is a place where a person is counselled and tested for HIV, of his own free will or as advised by a medical provider
Immunodeficiency	Breakdown in immunocompetence (i.e. the ability of the immune system to resist or fight off infections or tumors) when certain parts of the immune system no longer function. This condition makes a person more susceptible to certain diseases.
Incidence	The number of new cases within a specific period of time.*
Informed Consent	Process involving all the relevant information, to a Volunteer/patient, his/her proper understanding of the same and willingness to participate in a particular research
Integrase	An enzyme used to integrate HIV DNA into the host cell's own DNA.*

Link ART Centre (LAC)	NACO authorised ARV Drug Distribution Centre, linked to the Nodal ART centre. They are located at the at ICTCs in the district /sub- district level hospitals/CHCs places, within accessible distance.
Lamivudine (3TC)	A nucleoside reverse transcriptase inhibitor antiretroviral medicine used in HIV infection with at least two other antiretroviral medicines.
Mandatory	Required or commanded by authority; obligatory
Maternal Antibodies	Antibodies passed from mother to fetus during pregnancy. Diagnosis of HIV through antibody testing for infants under 18 months is complicated by maternal antibodies.
NACO	National AIDS Control Organization-Nodal organisation for formulation of policy and implementation of programs for prevention and control of HIV/AIDS
NACP	National AIDS Control Program-Nationwide programme to steer the HIV/AIDS prevention and treatment programme.
Nevirapine (NVP)	A non-nucleoside reverse transcriptase inhibitor used in HIV infection in combination with at least two other antiretroviral drugs; used in prevention of mother-to-child transmission in HIV-infected patients.
Occupational Exposure	Occupational exposure refers to exposure to potential blood-borne infections (HIV, HBV and HCV) that occurs during performance of job duties.
Opportunistic Infections (Ois)	Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Opportunistic infections common in persons diagnosed with AIDS include Pneumocystis carinii pneumonia; Kaposi's sarcoma; Cryptosporidiosis; other parasitic, viral and fungal infections; and some types of cancers.
PCR	Polymerase chain reaction. A laboratory method to find and measure very small amounts of RNA or DNA. It is used as the "viral load" test to diagnose HIV in infants and to measure the level of HIV RNA in the blood of infected persons.*
PEP	Post-Exposure Prophylaxis. The use of ARV therapy just after a possible exposure to HIV has occurred. Recommended after rape, an occupational exposure to HIV (e.g. needlestick injury) or just after birth for infants who are born to HIV infected mothers.*
Personal Protective Equipments	A part of standard precautions, personal protective clothing or equipment worn by a health worker, for protection against a hazard, in particular blood-borne pathogens
PLHIV	Acronym for "Person/People living with HIV/AIDS".
PMTCT	Acronym for 'Prevention of Mother-to-Child Transmission'.
PPTCT	Prevention Of Parent To Child Transmission
Prevalence	The number of cases at any time during the study period, divided by the population at risk.*

Prophylaxis	Preventive or Protective treatment taken to prevent disease
Provider Initiated Counselling	Routine, confidential, HIV testing offered to patients visiting health institutions
RNA	Ribonucleic acid*
Rapid Test	HIV blood, saliva, urine, or vaginal secretions test that yields same day results. Only rapid blood (finger stick) tests are currently available in India.*
Red Ribbon	Universal symbol for awareness and support for those living with HIV/AIDS
Resistance	The ability of an organism, such as HIV, to overcome the inhibitory effect of a drug, such as AZT or a protease inhibitor.
Retrovirus	A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme called Reverse Transcriptase. This DNA then becomes part of the cell's genetic material.
SACs	State AIDS Control Societies- Autonomous, decentralized bodies ,implementing National AIDS Control Program at the state levels
Safe Sex	Taking precautions during sex to prevent getting or giving Sexually Transmitted infections ,including HIV, to one's partner
Sentinel Surveys	This form of surveillance relates to a particular group (such as men who have sex with men) or activity (such as sex work) that acts as an indicator of the presence of a disease.
Sero conversion	The development of antibodies to a particular antigen. When people develop antibodies to HIV, they 'seroconvert' from antibody-negative to antibody-positive. It may take from as little as one week to several months or more after infection with HIV for antibodies to the virus to develop. After antibodies to HIV appear in the blood, a person should test positive on antibody tests. See "Window Period".
Side Effects	Medical problems that result from ARV rug toxicities. Common side effects include: peripheral neuropathy, lipodystrophy, hepatitis, pancreatitis, and lactic acidosis.*
STI	Also called Venereal Disease (VD), an older public health term, or Sexually Transmitted Disease (STD). Sexually transmitted infections are spread by the transfer of organisms from person to person during sexual contact.
Sub Centre	Grass root level unit, available at the Village level to take care of the health needs of the community. A Sub centre covers a population of 5000 in plain areas and 3000 in Hilly and difficult terrains. All primary health care services are being provided at the door steps of the community.

Surveillance	The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition. Collecting blood samples for the purpose of surveillance is called serosurveillance.
Symptomatic	Having evident signs of disease: weight loss, fever, diarrhea, enlarged glands, oral candida, herpes, skin problems.*
Viral Load	In relation to HIV: The quantity of HIV RNA in the blood. Research indicates that viral load is a better predictor of the risk of HIV disease progression than the CD4 count. The lower the viral load the longer the time to AIDS diagnosis and the longer the survival time.
WBC	White Blood Cell- a type of cells,involved in protecting the body against infections
Window Period	Time from infection with HIV until detectable Sero Conversion. During this time HIV antibody tests will be negative, even though the person is infected. 90% of infected individuals will test positive within 3 months of exposure and 10% will test positive within 3 to 6 months of exposure.*
Zidovudine (ZVD or AZT)	A nucleoside reverse transcriptase inhibitor antiretroviral medicine, zidovudine was the first antiretroviral drug to be introduced. Used in HIV infection in combination with at least two other antiretroviral drugs, and in monotherapy of maternal-fetal HIV transmission.

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