National AIDS Control Organisation
India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
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सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

Azadi Ka Amrit Mahotsav

HANDBOOK FOR HIV & STI COUNSELLORS

OCTOBER 2023

NATIONAL AIDS CONTROL ORGANISATION
Ministry of Health and Family Welfare
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HANDBOOK FOR **HIV & STI COUNSELLORS**

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वी. हेकाली झिमोमी, भा.प्र.से.
अपर सचिव एवं महानिदेशक
V. Hekali Zhimomi, IAS
Additional Secretary & Director General

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
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Foreword

The National AIDS and STD Control Programme (NACP) has evolved over the years, effectively providing HIV and STI prevention, treatment and care services to the at-risk, high-risk, vulnerable population and People Living with HIV (PLHIV). Counselling services for our target population has been the entry point for early detection followed by timely referrals and linkages to HIV and STI services.

Under NACP Phase V, in line with the guiding principles of 'Breaking the Silos and Building Synergies', the terms of reference for all counsellors of the NACP facilities have been revised with the goal of standardizing their roles and responsibilities across various NACP programmes under the NACP-V'. This is aimed towards ensuring provision of an integrated approach for upscaling and effective patient centric service delivery. Up until now, the counsellors have worked in isolation focusing on their respective priority groups, therefore, this approach has been designed to ensure optimization of resources to achieve the common goal of reaching the targets as envisioned for accelerating the efforts for bridging the gaps in the 95-95-95 cascade.

The *Handbook for HIV and STI Counsellors* is developed as an integrated training handbook which will cover all the aspects of NACP, including references to the latest initiatives, guidelines and revised ToRs. The objective is to equip the counsellors with the knowledge and skills to provide standardized high-quality counselling services in accordance with the evolving requirements of NACP-V. This will also enable them to provide ethical and high standards of care towards provision of a single window service delivery approach to our priority population.

It is also envisioned that the training of all counsellors will be conducted in a mix batch, ensuring counselors from different NACP facilities are trained together. Thereby, guaranteeing cross learnings, sharing of experiences and standardization for knowledge development.

The handbook will serve as a reference document for all counsellors under NACP in providing comprehensive, complete, rightful, and quality care to all the individuals 'Infected' and 'Affected' with HIV. I commend the efforts of all involved in developing the *Handbook for HIV and STI Counsellors*, which will make a significant difference in NACO's efforts to combat HIV and provision of quality care.

(V. HEKALI ZHIMOMI)

6th Floor, Chandralok Building, 36 Janpath, New Delhi-110001 Tel.: 011-23325331 Fax : 011-23351700
E-mail : dgoffice@naco.gov.in

निधि केसरवानी, भा.प्र.से.
निदेशक
Nidhi Kesarwani, I.A.S.
Director

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
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Preface

For progress on the Sustainable Development Goal to achieve the end of AIDS by 2030, the National AIDS and STD Control Programme Phase V is set optimize existing programs, adopt newer strategies, and scale up to respond to the geographic and community specific needs and priorities. The programme aims to provide comprehensive service package delivery system by ensuring implementation of programs for "at-risk" and "high risk" population groups including people living with HIV (PLHIV) towards progress on prevention of new HIV and STI infections, testing, treatment and care.

Provision of counselling for HIV and STIs is the first critical step in detecting and linking people with HIV services. Counselling is not merely the provision of information or advice. It is a process of enabling an individual to take personal decisions in the context of HIV/ AIDS prevention, testing as well as preparation for adherence to lifelong treatment. At present, the counsellors under the National AIDS Control Programme (NACP) work at Integrated Counselling and Testing Centres (ICTC), Targeted Interventions (TI) programmes, Anti-retroviral Therapy (ART) centres, Designated STI/RTI Clinic (DSRCs), Opioid Substitution Therapy (OST) Centres, Sampoorna Suraksha Kendras (SSKs), One Stop Centres (OSCs) and for 1097 helpline.

Aligned with the above, this "**Handbook for Counselors"** under the Counselor Training Module was specifically developed to serve as a comprehensive guide and reference manual for counsellors placed at the various service delivery points in the NACP facilities. This document will also work as easy reference for all counsellors to access information on the existing service delivery models as well as the newer approaches being implemented under phase V of NACP. This will also support the vision of NACO of providing a unified approach to counselling, ensuring that all counsellors adhere to the same high standards of care and ethics while establishing a single window service delivery to all our priority populations including PLHIV.

The *Handbook for HIV and STI Counsellors* is envisioned to support the counsellors in providing comprehensive, complete, rightful, and quality care to all the individuals infected and affected by HIV. With the development of this document, NACO in its vision has taken a crucial step towards building capacities of the counsellors to bring efficiencies and improve provision of service delivery to achieve the goal of 95-95-95.

(Nidhi Kesarwani)

Dr. Saiprasad Bhavsar
M.B.B.S, M.D (PSM)
Deputy Director
Tel: + 91-11-43509989
Fax: + 91-1123731746
E-mail: sp.bhavsar84@cghs.nic.in
spbhavsar.phs@yahoo.com

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छठा तल, चंद्रलोक बिल्डिंग, 36, जनपथ
नई दिल्ली – 110001

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation
9th Floor, Chandralok Building
36 Janpath, New Delhi-110001

Acknowledgement

Handbook for HIV and STI Counsellors has been meticulously crafted to serve as a comprehensive guide for counsellors under NACP-V. This handbook stands as a convenient reference document, faciiitating access to information on both established service delivery models and the innovative approaches introduced under NACP –V.

I extend my deepest gratitude to Ms. V. Hekali Zhimomi, Additional Secretary & Director General - NACO, for her dynamic leadership and steadfast guidance. I am also appreciative of the invaluable technical input, guidance, and timely directions provided by Ms. Nidhi Kesarwani, Director-NACO, Dr. Anoop Kumar Puri, DDG-NACO and Dr. U.B. Das, Sr. CMO (SAG)-NACO.

I express my sincere thanks to Dr. Shobini Rajan (DDG, Basic Services Division and Prevention) for her conceptualization and leadership in the design and development of this handbook.

Heartfelt appreciation goes to all members of the National Working Group (NWG) for their significant contributions and support in the development of this Handbook for HIV & STI counsellors.

The technical support provided by the National Working Group (NWG), comprising of NACO officials from all divisions, national technical/programme experts from State AIDS Control Societies (SACS), Strategic Expertise Technical Unit (SETU), Community Representatives and NACP counsellors and other stakeholders and development partners is greatly acknowledged.

Special thanks are due to Dr Melissa Neyndek & Dr Sudheer Chawla (CDC), Dr. Asha Hegde and Mr. G. S. Shreenivas (PATH), Dr. Sai Subhashree Raghavan and Mr Hedvees (SAATHII), Mr. Aditya singh & Dr Subhash Ghosh (JHU), Mr. Nilesh Gawde (TISS), Dr. Vanita Gupta (Public Health Expert for providing valuable inputs.

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I extend my gratitude to the I-TECH India team - Dr. Madhuri Mukherjee, Ms. Divya Gulati and Ms. Garima Sharma - for their continuous support in the development and printing of the handbook.

(Dr. Saiprasad Bhavsar)

डॉ. शोभिनी राजन
मुख्य चिकित्सा अधिकारी (एसएजी)
Dr. Shobini Rajan, M.D. (Pathology)
Chief Medical Officer (SAG)
Tel. : +91-11-23731810, 43509956
Fax : +91-11-23731746
E-mail : shobini@naco.gov.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
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9वां तल, चन्द्रलोक बिल्डिंग,
36, जनपथ, नई दिल्ली-110 001

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation
9th Floor, Chandralok Building,
36, Janpath, New Delhi - 110 001

Message

The National AIDS and STD Control Programme (NACP) - Phase V is set to optimize existing programs, adopt newer strategies, and scale up to respond to the geographic and community specific needs and priorities towards ending AIDS as a public health by 2030. The programme aims to promote coordinated actions, through single window delivery systems along with functional and measurable referrals and linkages, within NACP and across national health programmes and related sectors, for efficient service delivery.

Counselling is one of the key pillars of provision of HIV services, wherein they are situated at all service delivery points. Therefore, the *Handbook for HIV and STI Counsellors* is specifically developed as an easy reference document for all counsellors to access information on the existing service delivery models as well as the newer approaches being implemented under the NACP - Phase V. This handbook aims to ensure that counsellors are well-equipped with the necessary knowledge, skills, and resources to effectively contribute to the prevention and management of HIV/AIDS in their respective communities. The handbook is also envisioned for use by both experienced as well as entry-level counsellors to improve their knowledge and skills for providing effective service delivery across the prevention-to-treatment continuum.

Each chapter in the handbook provides technical information regarding the topic along with key messages for easy reference. The handbook has been written in simple and easy-to-understand language for the convenience of all counsellors. At the end of each chapter, a reference list is also provided for further reading and reference.

This Handbook for counsellors will promote standardized, high-quality counselling services by empowering counsellors, and emphasizing the client-centered approach. I believe this document will contribute significantly to the overall success of NACP in its mission to prevent and control the spread of HIV and STI to achieve the highest attainable standards of health in our communities.

(Dr. Shobini Rajan)

GUIDANCE NOTE

The Handbook for Counsellors is designed to serve as a comprehensive guide and reference manual for counsellors who are involved in the delivery of counselling services within the framework of National AIDS Control Program (NACP). This handbook aims to ensure that counsellors are well-equipped with the necessary knowledge, skills, and resources to effectively contribute to the prevention and management of HIV/AIDS in their respective communities. Counselling is one of the key pillars of HIV services. Under NACP, the counsellors work at Integrated Counselling and Testing Centres (ICTC), Targeted Interventions (TI) programmes, Anti-retroviral Therapy (ART) centres, Designated STI/RTI Clinic (DSRCs), Opioid Substitution Therapy (OST) centres, Sampoorna Suraksha Kendras (SSKs), and for 1097 helpline.

Breaking the Silos and Building Synergies is one of the important guiding principles of NACP-V (2021-26). Break the silos, and build the synergies aims to promote coordinated actions, through single window delivery systems along with functional and measurable referrals and linkages, within NACP and across national health programmes and related sectors, for efficient service delivery. This will ensure a suitable, functional, and sustainable model.

The handbook aims to empower counsellors by equipping them with up-to-date knowledge, practical skills, and resources. This handbook will serve as a reference document for all counsellors under NACP, providing a unified approach to counselling, ensuring that all counsellors adhere to the same high standards of care and ethics and establish a single window service delivery to all PLHIV as well as at-risk populations. The document guides the counsellors in providing comprehensive, complete, rightful, and quality care to all the individuals “Infected” and “Affected” with HIV. The handbook is a ready reckoner for both experienced as well as entry-level counsellors to improve their knowledge and skills for providing effective service delivery across the prevention-to-treatment continuum. The Handbook covers various aspects of the NACP, such as HIV counselling & diagnosis, STI treatment & management, ART initiation, OI management, special populations, monitoring, community engagement strategies, data recording and reporting mechanisms etc. It also mentions the recent initiatives undertaken by NACO under NACP V for providing a comprehensive package of services as well as reaching the population at risk, which is not covered under TI or other prevention programmes, thus boosting the national level progress on HIV prevention. Each chapter in the handbook provides technical information regarding the topic along with key messages for easy reference. The handbook has been written in simple and easy-to-understand language for the convenience of all counsellors. At the end of each chapter, a reference list is also provided for further reading.

By promoting standardized, high-quality counselling services, empowering counsellors, and emphasizing a client-centred approach, this handbook contributes to the overall success of NACP in its mission to prevent and control HIV/AIDS in communities.

ABBREVIATIONS

AIC	Airborne Infection Control
AIDS	Acquired Immune Deficiency Syndrome
Al, A2, A3	Assays 1,2,3
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Anti-retroviral Therapy
ART Centre	Anti-retroviral Therapy Centre
ART Plus	Anti-retroviral Therapy Plus Centre
ARV	Anti-retroviral Drugs
ASHA	Accredited Social Health Activists
AWW	Anganwadi Worker
BCC	Behaviour Change Communication
CABA	Children Affected by AIDS
CB NAAT	Cartridge-Based Nucleic Acid Amplification Test
CBS	Community Based Screening
CBO	Community Based Organization
CDC	Centres for Disease Control and Prevention
CHC	Community Health Centre
CSC	Care & Support Centre
DAPCU	District AIDS Control and Prevention Unit
DISHA	District Integrated Strategy for HIV/AIDS
DMC	Designated Microscopy Center
DNA	Deoxyribonucleic Acid
DPM	District Programme Manager
DR TB	Drug Resistant TB
DSRC	Designated STI/RTI Clinic
EID	Early Infant Diagnosis
ELISA	Enzyme Linked Immunosorbent Assay
ELM	Employee-Led Model
Emtct	Elimination of Mother-To-Child Transmission
EQAS	External Quality Assessment Scheme
F-ICTC	Facility-Integrated Counselling and Testing Centres
FIDU	Female Injecting Drug Users
FSW	Female Sex Worker

HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
HCTS	HIV Counselling and Testing Services
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
IPT	Isoniazid Preventive Therapy
IQC	Internal Quality Control
IVD	In Vitro Diagnostic Medical Device
JSY	Janani Suraksha Yojana
LAC	Link ART Centre
LAC +	Link ART Plus Centre
LPA	Line Probe Assay
LT	Laboratory Technician
LWS	Link Workers Scheme
MARPs	Most At Risk Populations
MMR	Maternal Mortality Rate
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MSM	Men Who Have Sex with Men
MTB	Mycobacterium Tuberculosis
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NASBA	Nucleic Acid Sequence-Based Amplification
NAT	Nucleic Acid Testing
NGO	Non-Governmental Organization
NHM	National Health Mission
NRL	National Reference Laboratory
OI	Opportunistic Infection
OPD	Out-Patient Department
ORW	Outreach Worker
OST	Opioid Substitution Therapy
PCR	Polymerase Chain Reaction

PE	Peer Educator
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Centre
PHN	Public Health Nurse
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PPP-ICTC	Public Private Partner ICTC
POC	Point of Care
PrEP	Pre-Exposure Prophylaxis
PW	Pregnant Women
PWID	People Who Inject Drugs
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement
QMS	Quality Management System
RCH	Reproductive Child Health
RDT	Rapid Diagnostic Test
Rif	Rifampicin
RNTCP	Revised National Tuberculosis Control Programme
SACS	State AIDS Control Society
SA-ICTC	Stand-Alone Integrated Counselling and Testing Centre
SHG	Self Help Group
SOP	Standard Operating Procedure
STI/RTI	Sexually Transmitted Infection / Reproductive Tract Infection
TB	Tuberculosis
TI	Targeted Intervention
TNA	Total Nucleic Acid
TG	Transgender
ToR	Terms of Reference
USP	Universal Safety Precautions
UWP	Universal Work Precaution
WBFPT	Whole Blood Finger Prick Test
WLHIV	Women living with HIV

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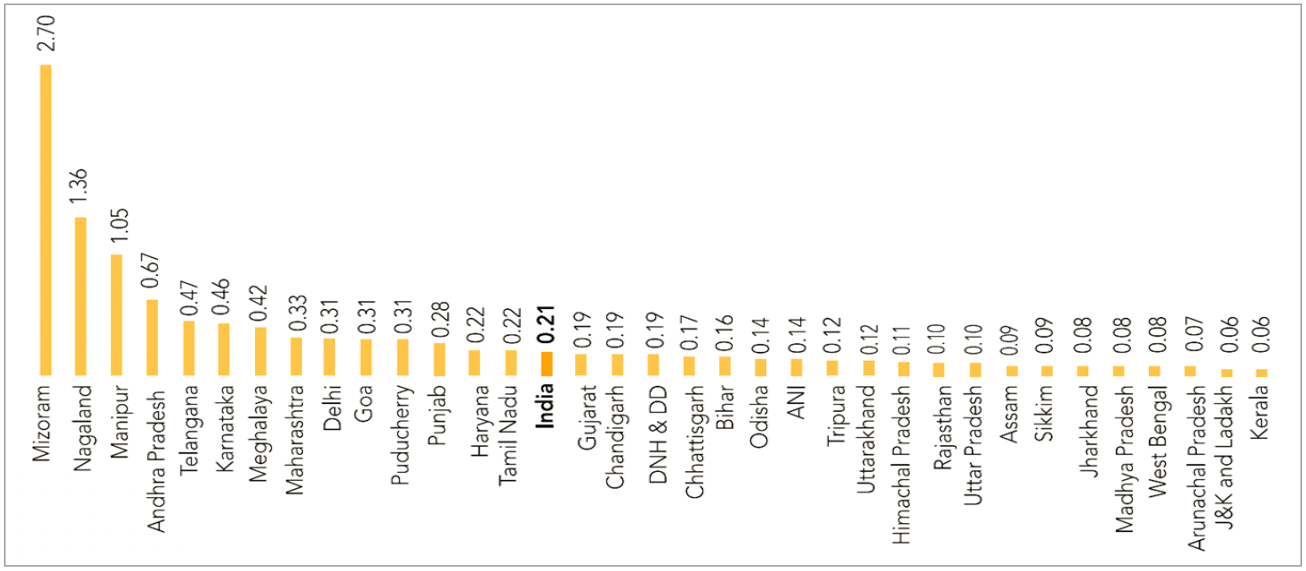
1 Introduction to the National HIV/AIDS Control Program and National AIDS Control Organization

HIV Epidemic in India

As per the 2021 epidemiological data, India is estimated to have around 24.01 lakh (19.92 to 29.07 lakh) people living with HIV/AIDS (PLHIV) with an overall adult prevalence of 0.21% (0.17–0.25%).

Around 63 thousand (36.72–104.06 thousand) new HIV infections were estimated in 2021. Almost 92% of total new infections were reported to be among the population aged 15 years or older, including around 24.55 thousand (14.27–40.69 thousand) among women. Around 42 thousand PLHIV died of AIDS-related mortality in the same reference period.

Figure 1 - Adult prevalence (%) in India by state, 2021



HIV Prevalence in riskgroups

In 2021, the 17th round of HIV Sentinel Surveillance was implemented across eight population groups comprising pregnant women, single male migrants (SMM), long-distance truckers (LDT), prisoners, female sex workers (FSW), men who have sex with men (MSM), hijra/transgender (H/TG) people and injecting drug users (IDU) collecting almost five lakh bio-behavioural samples. Pregnant women are considered as a proxy for general population while SMM and LDT are proxy for bridge population. FSW, inmates, MSM, H/TG people and IDU represent high-risk groups in the disease transmission dynamics in India. As per the preliminary analysis of data from HSS 2021, there is an increasing trend of HIV infection among high-risk and bridge population.

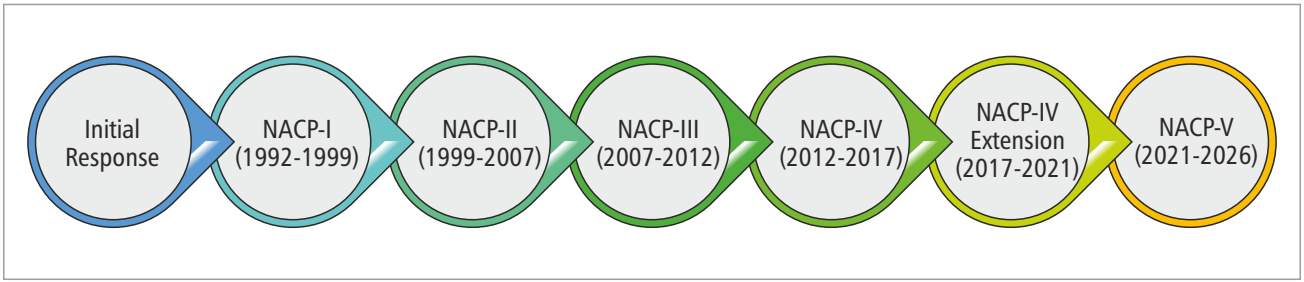
Genesis of NACP

In 1986, following the detection of the first AIDS case in the country, the National AIDS Committee was constituted in the Ministry of Health and Family Welfare. As the epidemic spread, the need was felt for a nationwide programme and an organization to steer the programme. In 1992 India's first National AIDS Control Programme (1992–1999) was

launched, and the National AIDS Control Organization (NACO) was constituted to implement the programme.

The first phase contained initial interventions focused on understanding modes of transmission and on prevention, blood safety and information, education and communication (IEC) strategy to increase awareness. This was followed by NACP-II (2000–2005), NACP-III (2006–2011) and NACP-IV (2012–2017), which was extended for a further four years till March 2021.

Figure shows different phases of NACP implementation in India

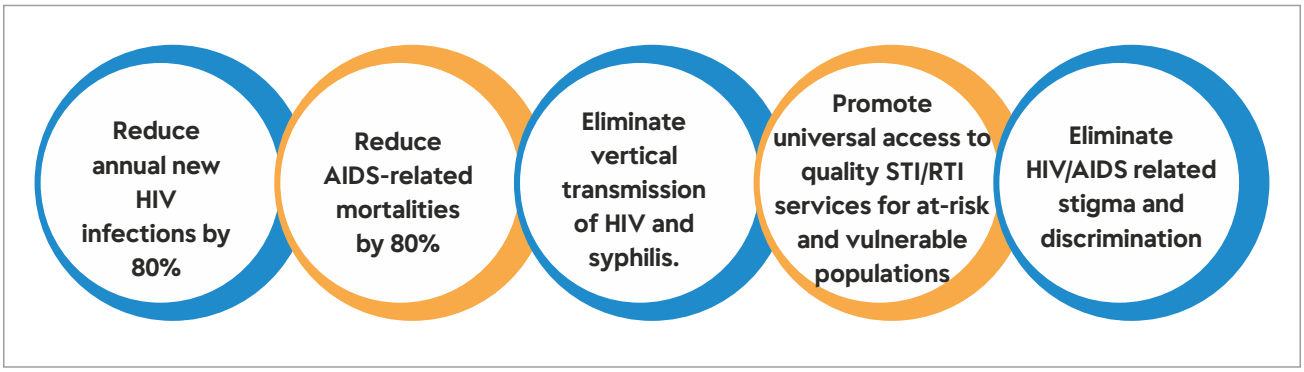


NACP-V (2021 to 2026)

Currently, NACP is in its fifth phase, which started in 2021.It aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-2026 from the baseline value of 2010. It also aims to attain dual elimination of vertical transmission of HIV and syphilis and elimination of HIV/AIDS-related stigma while promoting universal access to quality STI/RTI services for at-risk and vulnerable populations.

Goals of NACP V

Figure 1.3 - Goals of NACP V



The specific objectives of the NACP Phase-V are as below:

a. HIV/AIDS prevention and control

I. 95% of people who are most at risk of acquiring HIV infection use comprehensive prevention.

ii. 95% of HIV-positive people know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment have suppressed viral load.

iii. 95% of pregnant and breastfeeding women living with HIV have suppressed viral load towards attainment of elimination of vertical transmission of HIV.

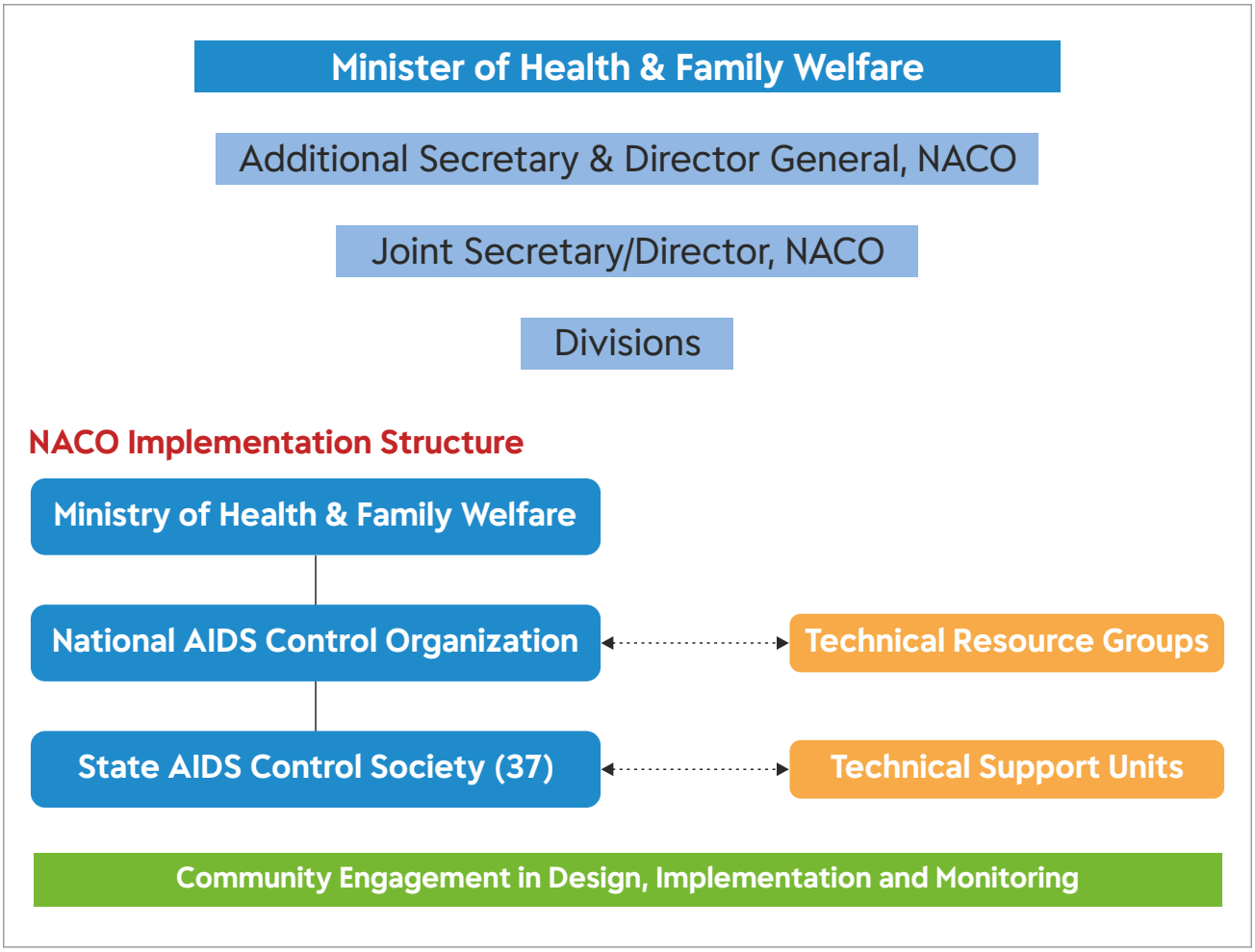
iv. Less than 10% of people living with HIV and key populations experience stigma and discrimination.

b. STI/RTI prevention and control

   i. Universal access to quality STI/RTI services to at-risk and vulnerable populations

   ii. Attainment of elimination of vertical transmission of syphilis

NACO Organogram



Key Messages

- India is estimated to have around 24.01 lakh PLHIV. Around 63 thousand new HIV infections were estimated in 2021. Almost 92% of total new infections were reported to be among population aged 15 years or older, including around 24.55 thousand among women.
- HIV prevalence is high among high-risk groups and bridge population.
- India is committed to ending the AIDS epidemic as a public health threat by 2030 by working towards ensuring that 95% of those who are HIV positive in the country know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment experience effective viral load suppression.
- India's response to HIV/AIDS started in 1985 and from 1992, the NACP was launched and we are currently in NACP Phase V which started in 2021.

- Starting from NACP Phase I to NACP IV (Extension), the HIV/AIDS programme has evolved from large-scale awareness generation campaigns to game-changing initiatives such as, to name a few, enactment of the HIV/AIDS (Prevention and Control) Act, 2017, mission Sampark to bring back lost-to-follow-up PLHIV on antiretroviral therapy (ART), universal viral load testing for on-ART PLHIV, differentiated service delivery models (DSDMs) for PLHIV to strengthen follow-up, ART adherence and retention and interventions in prisons and other closed settings
- NACP-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025–2026. Additionally, it seeks to eradicate the vertical transmission of both syphilis and HIV and the stigma associated with HIV/AIDS.
- To respond to the challenge, the Government of India established the National AIDS Control Organization (NACO, a division of the Ministry of Health and Family Welfare) in1992 to oversee the policies for prevention and control of the HIV infection through 35 HIV/AIDS Prevention and Control Societies across India.

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2 Basics of HIV and AIDS

What is HIV and AIDS

Table 2.1- What is HIV and AIDS

HIV	AIDS
H - Human, **I** - Immunodeficiency, **V** - Virus A virus that attacks the immune system and makes a person more vulnerable to other infections. **PLHIV/HIV positive: people infected with HIV virus.**	**A** - Acquired (meaning to get from someone) **I** - Immune (meaning body's defence to fight diseases or body's resistance) **D** - Deficiency (meaning lack of resistance or decreased level of functioning) **S** - Syndrome (meaning signs and symptoms of disease AIDS is a group of diseases resulting from HIV infection left untreated for a long time. It can be fatal. Being diagnosed with HIV does not mean the person has AIDS. Healthcare professionals diagnose AIDS only when people with HIV infection begin to get severe opportunistic infections (Ois), or their CD4 cell counts fall below a certain level.

Immune System - It defends the body against infections.

- White blood cells (WBCs) are the most important part of this system.
- WBCs fight and destroy bacteria, fungi and viruses that may enter the body.

Progression from HIV to AIDS (without ART)

AIDS is a disease (syndrome) caused by HIV, which on entering the human body, attacks the WBCs, multiplies and infects the other WBCs. The infected WBCs are eventually destroyed, which leads to a reduction in the number of WBCs and finally to greatly reduced immunity. This opens the gateway to various infections (UNODC & TISS, 2011).

1. 80–90% of HIV infected are typical progressors with survival time of approximately 11 years.
2. 5–10% are 'rapid progressors' with median survival time of 3–4 years.
3. 7–10% of HIV-infected individuals do not experience disease progression for extended period of time and are called 'long-term non progressors' (LTNPs).

Signs and symptoms of HIV and AIDS

The symptoms of HIV depend on the stage of infection. As the infection progressively weakens the immune system, an individual can develop other co-infections.

Table 2.2 - Co-infections developed with HIV progression

During the first few weeks after the initial infection:	After the infection progressively weakens the immune system:	Without treatment, develop severe illnesses such as:
• No symptoms or • Influenza-like illness including fever • Headache • Rash • Sore throat	• Swollen lymph nodes • Weight loss • Fever • Diarrhoea • Cough	• Herpes Zoster • Tuberculosis (TB) • Oral candidiasis • Pneumocystis jiroveciipneumonia • Cryptosporidiosis • Progressive multifocal leukoencephalopathy (PML)

How does HIV spread?

Main causes of the spread are as follows:

a) Unsafe sexual intercourse

b) Sharing of needles and injecting equipment

c) Unsafe blood transfusion

d) Vertical transmission: from infected mother to child during pregnancy, labour, delivery or breastfeeding

HIV must be present for transmission

Transmission can occur only from an HIV-infected individual to another individual. A small amount of blood is enough to infect. Healthy, unbroken skin does not allow HIV to get into the body.

HIV survival outside the body

For transmission to occur, the body fluid which contains the virus must enter the body of another individual. It must be noted that in an infected individual, not all body fluids contain enough HIV to be able to infect another. Both infectious and non-infectious body fluids are explained further.

How is HIV not transmitted?

HIV virus does not spread in the following ways:

- **Kissing and touching:** Social kissing and hugging pose no risk of transmission.
- **Sharing living space:** Any casual contact with someone who has HIV, including sharing bathrooms and toilets, is safe.
- **Sharing food or utensils:** The virus cannot survive on surfaces, so sharing utensils and other household items will not spread HIV.

- **Saliva, sweat or tears:** An infected person's saliva, sweat and tears do not put anyone at risk.
- **Helping an injured person with HIV:** Wearing gloves while doing so is ideal; but even if the person's blood comes into contact with your intact skin, you should not worry.
- **Mosquitoes and other insects:** The virus is not viable in insects or ticks.

HIV survival outside the body

Length of time HIV can survive outside the body: HIV is very fragile, and many common substances, including hot water, soap, bleach and alcohol will kill it.

Exposure to air: Air does not 'kill' HIV, but exposure to air dries the fluid containing the virus, which destroys and breaks up the virus very quickly.

Needles: HIV can survive for several days in the small amount of blood that remains in a needle after use. Thus, for transmission to occur, the body fluid which contains the virus must enter the body of another individual. It must be noted that in an infected individual, not all body fluids contain enough HIV to be able to infect another, as listed below.

Risk of HIV transmission

Table 2.3- Risk of HIV Transmission

Exposure route	Risk of transmission
Blood transfusion	>98 %
Perinatal	20–40%
Sexual intercourse	0.10–10%
- Vaginal	0.05–0.10%
- Anal	0.065–0.50%
- Oral	0.005–0.01%
Injecting drug use	0.67%
Needle stick exposure	0.30%
Mucous membrane splash to eye, oronasal	0.09%

(NACO, 2021 – National Guidelines for HIV Care and Treatment)

Prevention of HIV Transmission:

The following care should be taken for prevention:

- **Regular and consistent use of condom:** Regular use of condom at every sexual encounter provides protection from transmission of HIV virus as well as unwanted pregnancy and other sexually transmitted infections.
- **Correct use of condoms:** The use of condom has to be accurate and consistent. A new condom after the due check of its expiry date should be used before every sexual encounter.
- **Non-usage of used syringe:** The reuse of a HIV infected blood-contaminated needle or syringe by another drug injector has some quantity of the HIV-infected blood present in the hollow of the needle and the base of the syringe cylinder. Hence the reuse of such needles and syringes carries high risk of HIV transmission or any other blood-borne virus when pushed into the blood stream of the next user.

- **Proper and just use of post-exposure prophylaxis (PEP):** PEP is a regimen where antiretroviral medicines are taken after potential exposure to HIV to prevent being infected by HIV. PEP should be used as early as possible and definitely within a stipulated time of 72 hours (3 days).
- **Know your status and that of the partner:** It is imperative to know one's HIV status in order to assure speedy access to treatment and medication. Timely testing and treatment can ensure a healthy life. With Government of India's (GoI's) 'Test and Treat' programme in place, a person tested positive for HIV is immediately put on ART, which suppresses the virus and stops the progression of HIV disease.
- **Obtaining blood and components from a licensed blood bank:** Only registered medical practitioners should procure and transfuse blood/blood components that has been screened for HIV and other infections to any patient who needs it.

Everyone should remember that

- HIV can affect anyone;
- HIV infection is largely silent except when OIs/AIDS set in;
- There is no cure for AIDS and it is the responsibility of each one of us to prevent and stop HIV transmission. We should stay away from high-risk behaviours that put us at risk of HIV infection;
- One has a right to get oneself tested without disclosing one's identity;
- People infected with HIV can also lead a positive and productive life by adopting a healthy lifestyle and by taking anti-retroviral medicines;
- Women are more vulnerable to HIV because of biological and social factors;
- Adolescents/youth are much more vulnerable to HIV because of lack of correct information, experimentation in risk taking and peer pressure (NACO, 2019).

Stages of disease progression:

Typically, PLHIV go through the following stages of disease progression:

Primary HIV infection	Clinically asymptomatic stage	Symptomatic HIV infection and AIDS
• Infected person is highly infectious but looks healthy • High viral load • Flu-like symptoms • Window period	• HIV-infected person may take from 6 months to 10 years to develop AIDS • HIV antibodies are detectable • May have swollen glands • Healthy, positive living can make this stage last a long time	• Over time, HIV multiplies in the body. • CD4 count decreases • Immune system weakens • Skin, nail and mouth infections develop • Lose weight

Link between HIV/AIDS and STIs

STIs, especially genital ulcer disease (with 10 times higher chances) and genital discharges (five times more chances), are strongly associated with the occurrence of HIV infection. ,. Early diagnosis and effective treatment of such STIs isan important strategy for the prevention of HIV transmission (NACO, 2019).

Myths and Misconceptions:

Some common myths and misconceptions about HIV are listed below:

- HIV always leads to AIDS.
- HIV can be transmitted through hugs and kisses.
- HIV can spread by breathing the same air
- HIV can spread via infected water or food.
- HIV cannot spread through a needle.
- HIV can be contracted by touching a toilet seat or door handle touched by a HIV-positive person.
- HIV can spread by sharing eating utensils with a HIV-positive person.
- HIV can spread by using exercise equipment used by a HIV-positive person at a gym.
- HIV can spread through touching, shaking hands, hugging, making friends, eating, drinking, studying, working, sharing clothes, toilets, towels or a house with a HIV-positive person.
- HIV can be cured but not AIDS.
- HIV-positive people cannot safely have children.
- Blood donation can lead to HIV infection.
- It is not good for women to ask for condoms. It shows that she is unfaithful and also does not trust her partner.
- Caring for people with HIV/AIDS is risky.
- HIV will not be contracted if one has sex once or twice with anyone without a condom.
- There is no risk of HIV if anal sex and oral sex happen without a condom.
- HIV risk is there only for the receiver during sex, not for the inserter.
- HIV will not be contracted if private parts are cleaned with Dettol immediately after sex.
- If you and your partner seem healthy, then it is not necessary to know the HIV status of either of you.
- I do not require HIV testing as I have not done any such thing.
- If I take any type of blood test, I can get to know HIV automatically.
- HIV is transmissible via infected insects and pets.
- If my HIV test returns negative the first time, then I do not need HIV test ever again.

- If I have committed any mistake unknowingly that leads me to believe I could get HIV, then I should get HIV tested as soon as possible.
- HIV test is too costly.
- My HIV test will come to the knowledge of everyone.
- Condom reduces sexual pleasure.
- Use of condom is not necessary while on ART.
- Nothing will happen if ART dosage is stopped.
- Use of double condom provides more safety from HIV.
- HIV cannot spread if syringe is shared only once.
- If I'm HIV positive, I'll have to take dozens of pills every day.

Key Counselling Messages

Counsellors should know the basics of HIV AIDS. This will help them to educate clients about it. This is an important part of pretest counselling. Counsellors may use visual material like booklets/flipcharts or a drawing of a human figure to explain the details. Ensure that the following points are explained to the clients:

- HIV stands for **H**– **H**uman, **I** - **I**mmunodeficiency, **V** – **V**irus.
- This is a virus that attacks the immune system (which defends the body against infections) and makes a person more vulnerable to other infections.
- WBCs are an important part of the immune system that protect the body from external infections by destroying bacteria, fungi and viruses that may enter the body. Thus, they work as soldiers. HIV kills these WBCs. So, the person succumbs to various infections like TB, severe bacterial infections, cryptococcal meningitis and cancers such as lymphomas and Kaposi's sarcoma.
- AIDS is a group of diseases which results due to HIV infection if left untreated.
- AIDS stands for **A**-Acquired (meaning to get from someone) **I** - Immune (meaning body's defence to fight diseases or body's resistance) **D** - Deficiency (meaning lack of resistance or decreased level of functioning) **S** - Syndrome (meaning signs and symptoms of disease).
- HIV infection is life threatening if not treated.
- HIV can affect anyone. There is no cure for AIDS, and it is the responsibility of each one of us to prevent and stop HIV transmission. We should stay away from high-risk behaviours that put us at risk of HIV infection.
- **Routes of transmission:** Main causes of the spread are unsafe sexual intercourse (without condom use), sharing of needles and injecting equipment, unsafe blood transfusion (blood not tested for HIV) and vertical transmission i.e., from parent to the child during pregnancy, during birth or through breastfeeding. Reiterate that breastfeeding is still a safer option because there are multiple benefits of breast milk.
- **How HIV does not spread:** It does not spread through mosquito bites, social

interaction, by eating together, by touch or by using toilets used by HIV-infected person. It does not spread by donating blood.

- **Signs and symptoms of HIV infection** are swollen lymph nodes, weight loss, fever, headache, diarrhoea and cough. Co-infections are TB, cryptococcal meningitis, severe bacterial infections, cancers such as lymphomas and Kaposi's sarcoma, among others. **However, some clients with infection do not experience any symptoms for a longer time. So, though the person is looking healthy she/he may be infected. So, it is always advised to use condoms and follow safe sex practices.**
- Infectious fluids are blood (including menstrual blood), semen, vaginal secretions, breast milk and pre-seminal fluids. Non-infectious fluids are saliva, tears, sweat, faeces and urine.
- **Methods of protection from HIV infection** are abstaining from casual and unprotected sex, being faithful to your partner, consistent and correct use of condoms, obtaining blood or blood products only from licensed blood banks, ensuring the use of disposable/disinfected injecting equipment and surgical blades, ensuring HIV test during pregnancy and timely initiation of treatment to prevent transmission to the child.There is a strong association between the occurrence of HIV infection and the presence of certain STIs.

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3 Drivers of the HIV epidemic

Determinants of health

The determinants of health are a range of social, economic and environmental factors that determine the health status of individuals or populations. These are the conditions and circumstances into which people are born, grow and live. Determinants of health play a role in HIV infection and the ability of PLHIV to seek care, support and treatment.

HIV epidemic by High-risk groups

Certain populations are more vulnerable to HIV infection because of sexual practices, poverty, physical and sexual abuse, lack of education, homelessness, stigma, addiction, violence, untreated mental health problems, lack of employment opportunities, powerlessness, lack of choice and lack of social support. As per the HIV sentinel surveillance (HSS), 2021 data HIV prevalence among high-risk groups [FSWs, hijra/transgenders (H/TG), MSM, IDU, prisoners] and bridge population [single male migrants (SMM), and long-distance truckers (LDT)] remains very high.

Route of HIV transmission (self-reported)

Analysis of the self-reported route of HIV transmission (RoT) indicates that the HIV epidemic in India, 2019–2020 is still primarily driven through the heterosexual route (84%). Around 6% of the positive cases were reported to have acquired the infection through infected syringes and needles. Rest of the transmissions are acquired through homosexual/bisexual route, parent to child transmission, blood and blood products etc.

Factors affecting the HIV epidemic

a) Multiple Partners

Multiple sexual partnerships are a major driver of the HIV epidemic. Multiple partnerships can be **concurrent** (someone initiates a new sexual relationship before a previous sexual relationship has ended) or **sequential** (when a person completely stops having sex with one partner before starting to have sex with another).

Concurrent relationships increase the number of people who are connected in a 'sexual network' where new HIV infections might still be transmitted rapidly.

Counsellors should advocate during the counselling sessions that reduction in number of sexual practices reduces the risk of HIV/STI infection. Consistent and correct use of condom with every single partner reduces the risk of HIV/STI infection even more.

b) Substance Use

Drug use and sharing of contaminated injecting equipment/sex work has fuelled the spread of HIV epidemic among injecting drug users (IDUs) and onwards to the general population. Injection is the most efficient route for transmission of HIV. Later on, it can spread through sexual transmission to spouses and other sexual partners.

Challenges and Difficulties of Female Injecting Drug Users (FIDUs): Women as IDUs have separate and more challenges than their male counterparts. These are:

- Social factors like inequality towards providing education, healthcare and employment, little or no power status in society or social expectations;
- Biological factors like being physically less strong than men make women vulnerable to physical violence.
- Studies show that FIDUs have a higher risk of getting HIV due to sharing needles and syringes and due to unsafe sex. Many female drug users have IDU partners, and many of them sell sex to finance their own and their partner's drug use. Many sex workers use drugs in order to forget the problems in their lives.

c) Changing Pattern of Networking/Solicitation – High-risk Groups or Other At-risk Population Operating through Virtual platform

- With the advent of mobile and newer communication technologies, the patterns of sex work have also changed and evolved. Mobile phones act as a tool for networking and soliciting. So, there are difficulties to connect with them.
- Similarly, the MSM population is also using virtual platforms for solicitation, and they are becoming all the more unreachable by the traditional peer-led approach, as they are congregating less at physical hotspots/locations to meet sexual partners.
- Less visibility of SWs and MSM in hotspots has become a challenge in the traditional hotspot-focused peer-led outreach model.

d) Gender-Sex-Sexuality and Vulnerability to HIV

Table 3.1- Gender, Sex, Sexuality and Vulnerability to HIV

Definition of gender	It is a societal construct with roles and behaviours assigned by the society. A gender is assigned to the individual at the time of birth. Then society starts treating them as males/females. E.g., society decides how females/males should dress, what responsibilities they should fulfil (such as women should cook and take care of children and men should be the bread earners of the family, etc.) and how they should behave. Thus, social norms are developed.
Difference between sex and gender	Sex refers to biological make-up of a person, usually determined based on external and internal parts, hormones, tissues and chromosomes. Gender is a social construct. Gender roles and behaviours are assigned by society and are learned rather than innate. These vary from society to society, and at different times in history.
Why should we understand gender	Understanding gender norms and gender inequality is essential to reduce HIV risk among men, women and T/G people. Though there are similarities in HIV risk factors and behaviours across genders, differences exist, and some gender groups are far more affected than others.
Gender roles	Gender roles are not inherited. Socialization towards gender roles begins early in life. Children are systematically taught gender differences. Through institutions, society prescribes specific roles for girls and boys but values them differently. Roles can be unlearned. Unequal value is the source of discrimination and oppression for women and accounts for the inferior status given to women in society.

Gender identity and gender expression	• Gender identity refers to how people perceive their own gender: whether they think of themselves as men, women, both or as a different gender. • Gender identities are not static. Individuals can change their gender identity throughout their lives. • Gender expression are the ways in which a person manifests masculinity, femininity, both, or neither, through appearance.
Sexual identity	An individual's conception of themselves
Sexual behaviour	A person's actual act of having sex and/or stimulation (with a person of the same gender or opposite gender or both or none) for pleasure

Sexual Orientation

To whom the person is attracted to romantically, emotionally, and sexually. There are various types of sexual orientations: e.g.,heterosexual, homosexual, gay, lesbian, asexual, bisexual, pansexual.

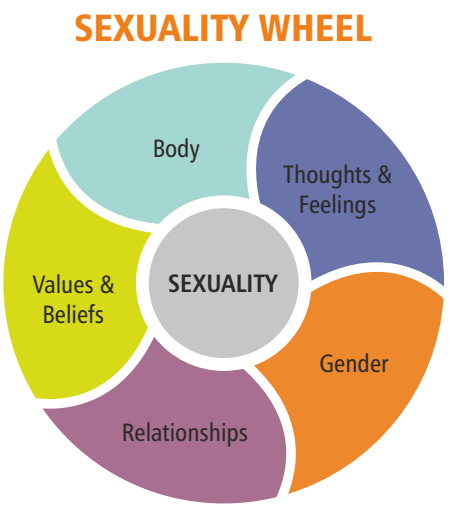
Types of sexual orientation

- **Heterosexual:** An individual who is sexually attracted to people of sex other than their own and/or who identifies as being heterosexual
- **Homosexual:** An individual who is sexually attracted to people of the same sex as their own, and/or who identifies as being homosexual
- **Lesbian:** A woman who is sexually attracted to other women and/or identifies as a lesbian
- **Gay:** A man who is sexually attracted to other men and/or identifies as gay. This term can also be used to describe any person (man or woman) who experiences sexual attraction to people of the same gender.
- **Asexual:** An individual who is not sexually attracted to other individuals
- **Bisexual:** Identity corresponding to significant (not necessarily equal) attraction to more than one gender
- **Pansexual:** Similar to bisexual, sometimes used to denote identity corresponding to attraction INDEPENDENT of gender.

Sexuality

Sexuality is not about who the person has sex with, or how often he/she has it. Sexuality is about a person's sexual feelings, thoughts, attractions and behaviour towards other people. Sexuality is diverse and personal, and it is an important part of a person's personality. Discovering one's sexuality can be a very liberating, exciting and positive experience. However, Human sexuality = Sexual behaviour + Sexual identity + Sexual orientation.

Figure 3.1 - Sexuality Wheel

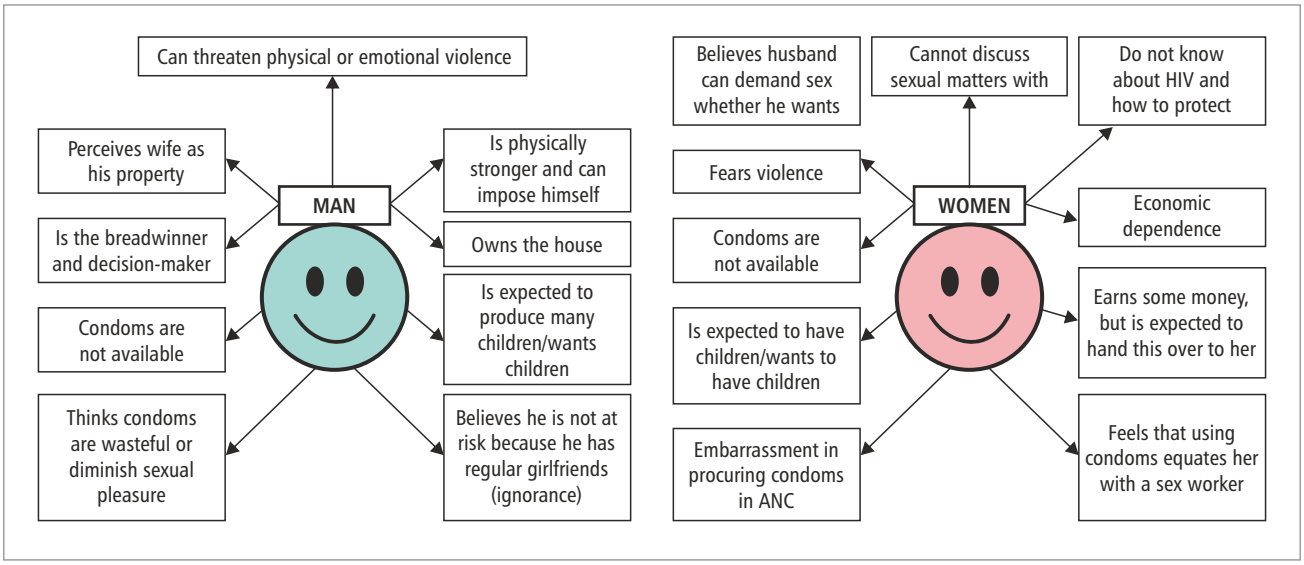


Gender-Sex-Sexuality and Vulnerability to HIV

Several norms and attitudes related to gender roles and relations have been critical in determining an individual's vulnerability to infection.

- **Physiological vulnerability:** The risk of HIV transmission during sexual intercourse is almost twice for women because women have a larger mucosal surface where micro-lesions can occur and facilitate the transmission of HIV.
- **Gender norms related to sexuality:** Common gender norms in our country require women/girls or any feminine person to remain ignorant, passive, subordinate and faithful in sexual relations. The dominant ideal of masculine behaviour and sexuality promotes men and boys as assertive, independent and strong. These notions of gender and sexuality make it very difficult for women/girls and men/boys to access reliable information about sexuality and reproductive health services, openly discuss sexual matters, practise safer sex and promote more gender-equitable relations.
- **Gender power equation in accessing SRH services:**

Figure 3.2- Gender power Equation in accessing SRH services



- **Lack of negotiation power regarding safer sex measures:** Women have less negotiation power in sexual relations.
  - **Promote ABCD model:** A stands for abstinence, B for be faithful, C for correct and consistent condom use and D for do not penetrate.
  - **Address misconceptions** such as condoms reduce sexual pleasure, sex means peno-vaginal penetration, men can get sex whenever they want, customer can decide on anything during paid sex.
- **Gender-based violence (GBV) increases the possible risk of HIV infection:**
  - GBV is any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering that is directed against a person because of their biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity.
  - GBV includes intimate partner violence and can be physical, sexual, emotional, economic or structural where that violence targets someone because of their gender or non-compliance with gender norms.

- It can be experienced by women and girls, men and boys, and transgender T/G and intersex people of all ages and has direct consequences on health, social, financial and other aspects of their lives.
- GBV increases the risk of HIV infection as sexual violence can lead to HIV infection directly and trauma increases the risk of transmission. Trauma of forced sex of any kind – rape, dry sex or lack of readiness – with an infected partner increases the risk of transmission, but the fear and power differentials associated with GBV also limit the ability to negotiate safer sex.
- It increases the gender inequalities and is an important cause of 'choice disability'. Victims of childhood sexual abuse are more likely to be HIV positive, and to have high-risk behaviours.

Role of migration in increasing HIV-related vulnerability

Poverty and the lack of economic opportunities often result in migration of men, women and transgender persons in search of income and employment, which disrupts stable social and familial relationships and exposes them to increased risk of infection. In case of transgender people, domestic violence and familial discrimination causes them to leave their houses. Migrant populations are often socially marginalized.

(I) Possible reasons behind migration

Poor economic situation; PLHIV migrate in fear of disclosure of their HIV status; temporary migration of pregnant women during and after pregnancy; queer people migrate in fear of family pressure for marriage; transgender individuals migrate after they are thrown out of their families.

(ii) How migration enhances the risk of HIV infection

- People who migrate without family due to limited home visits resorting to paid sex. They experience loneliness. Also, there is reluctance to discuss sexual health.
- Truckers are mobile by trade and engage with flying sex workers and companions. They are untraceable due to constant travel.
- Young girls migrate to cities to work as maids in households. Their chances of sexual abuse and harassment increases because the perpetrators know the girl is needy and stays alone.
- Transgender/effeminate boys who are thrown out/disowned by their families. They may earn money through sex work.
- Among MSM and transgender transgender women, pressure to marry leads them to migrate for work and exposes them to higher sexual risk in new locations.

(iii) How to address the issues of increasing HIV risk among migrants

- Understand migration reasons and risks.
- Improve outreach to overcome sexual health discussion avoidance.
- Provide effective counselling for connecting to sexual health services.
- Scaling up primary prevention awareness campaigns.
- Link migrants to other services for motivation (e.g., entitlements, welfare schemes).
- Strengthen referral system and coordination with TI agencies for tracking the cases and connect them with Sampoorna Suraksha Kendras.

Key Counselling Messages

Social, economic and environmental factors impact the health status of individuals or populations. Such determinants play a vital role in HIV infection and the ability of PLHIV to seek care, support and treatment. Because oflower socio-economic conditions, people do not have the resources for better health. For example, it is difficult to access healthcare due to the cost of treatment, travelling expenses, missing daily wages, not getting facilities like leave etc. The socio-economic status impacts the level of education which leads to a lack of awareness about health issues. They cannot afford expenses on preventive health (e.g., having nutritious food, boiling drinking water, etc.). Housing also plays an important role in health. Unclean areas, lack of facilities like water and electricity and high density of population makes the environment vulnerable to various illnesses and epidemics. The counsellor's role is to understand these issues and counsel while considering the clients' situation. For instance, while talking about nutrition, the counsellor should take into consideration what they can afford. In the first session itself, the counsellor should gather information about the client's socio-economic condition. They may ask some questions like what is the source of income, how much is the monthly/annual income, who all are there in the family, what is the education, where do you stay etc. This will help to assess the socio-economic status of the clients.

Gender-Sex-Sexuality and Vulnerability to HIV in social structures like marriage and family, men have more power than women. This affects the overall health status of women. Many women have no control over finances. Hence, healthcare access is difficult. Women have less exposure. So, they are dependent on others to access the health facilities. As per traditional roles, they are expected to give priority to other family members and take a secondary role themselves. So, they tend to neglect health. Traditionally, they hardly have any role in decision making. Because of this and social norms, they cannot make decisions in their own life. Thus, they have less power in sex. So, it is difficult for them to negotiate for condoms or safe sex practices

- People from non-conforming gender and queers face discrimination. They do not have social acceptance and so they hardly have any power or control over their own situation.
- People with other sexualities are not accepted by society. They face a lot of stigma and discrimination; e.g., MSM. They cannot discuss their issues in society, with family or with healthcare providers. Their relationships are hidden, their behaviour is hidden. Thus, access to healthcare is difficult.
- Gender power dynamics affect the accessibility of treatment, support and care. Counsellors should understand these factors when women or queers come for counselling.

Counselling for gender-based violence -Be with the client and be empathetic. Offer water and ask them to relax. Let the client express their feelings. Ask whether they would like to speak. However, do not force them to speak. Assess the symptoms. Send for a medical check-up if the client is ready. Consult your medical officer. Refer to the trained psychologist and legal expert for legal support.

Migration-Due to poverty, lack of resources and other reasons, people from some locations and people from marginalized sections migrate to other places for better opportunities. The process of migration enhances the risk of HIV infection for such populations: e.g., migrant workers, truckers, transgenders, MSM and young girls working as maids are vulnerable and are at high risk.

Migrants are away from home for many months. They must earn and send money to their native place.Their living conditions are not suitable for good health. They are considered 'outsiders'. Many a time, no awareness about health facilities, no connection with local people, loneliness and feeling of isolation makes them vulnerable. Girls and other gender people may experience sexual abuse because social support is not available in the new place.

- Counsellors should encourage the clients to speak freely about their issues. Understand their life challenges. Be empathetic. Provide emotional support. Show acceptance through behaviour. Discuss various possibilities with them with reference to their problems. Do not impose anything on them or do not blame them: e.g., "You never come on time"; "Every time I tell you but you don't improve!"; "Last time I told you and still you have not understood this simple thing!" Never make such statements. Inform them that you/your centre is there to help them. Scale up awareness programmes, strengthen outreach services, provide a referral system and coordinate with TI agencies for tracking the cases. Connect them with Sampoorna Suraksha Kendras. Connect them with various social protection schemes.

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4 The HIV and AIDS (Prevention and Control) Act, 2017

Genesis of the HIV and AIDS Act

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Bill, 2014 was passed by the Parliament the HIV and AIDS (Prevention and Control) Act came into force from September 10, 2018. The objective of the HIV and AIDS (Prevention and Control) Act is to prevent and control the spread of HIV and AIDS and for reinforcing the legal and human rights of persons infected with and affected by HIV and AIDS. It also seeks to protect the rights of healthcare providers.

Figure 1: HIV and AIDS Act timeline

Under the HIV and AIDS (Prevention and Control) Act 2017, the central government has notified the **HIV and AIDS policy for establishments, 2022** to generate awareness on HIV and AIDS in establishments, prevent transmission of HIV infection among workers, protect rights of those infected with and affected by HIV to ensure safe, non-stigmatized and non-discriminating environment. This policy guides employer and worker organizations to establish a better workplace for people affected by HIV. **The Act consists of 50 sections, divided into 14 chapters.**

Table 4.1 - Chapters of HIV and AIDs Act

- Chapter I – Preliminary
- Chapter II – Prohibition of Certain Acts
- Chapter III – Informed Consent
- Chapter IV – Disclosure of HIV Status
- Chapter V – Obligation of Establishments

- Chapter VI – Anti-Retroviral Therapy and Opportunistic Infection Management for People Living with HIV
- Chapter VII - Welfare Measures by the Central Government and State Government
- Chapter VIII – Safe Working Environment
- Chapter IX – Promotion of Strategies for Reduction of Risk
- Chapter X – Appointment of Ombudsman
- Chapter XI – Special Provisions
- Chapter XII – Special Procedure in Court
- Chapter XIII – Penalties
- Chapter XIV – Miscellaneous

Figure 4.2- Highlights of HIV and AIDS Act

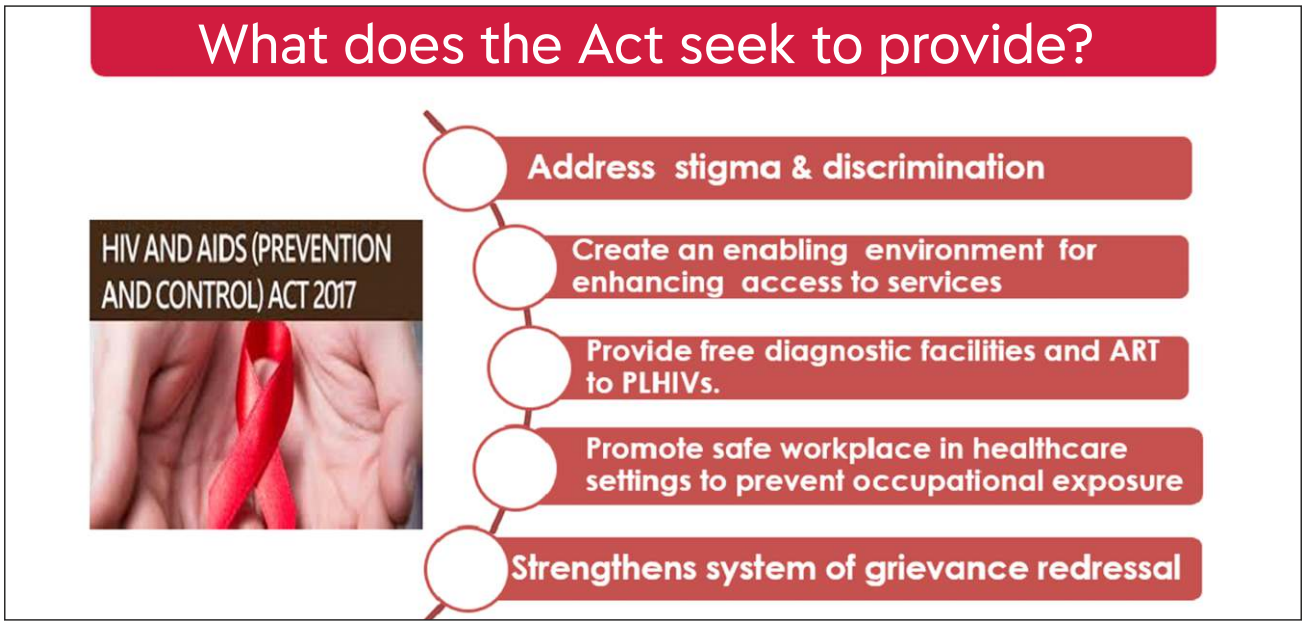

Figure above shows the highlights of the Act

Important provisions of the Act (Referring to relevant sections from the Act)

(I) Address stigma and discrimination

Section 3: Prohibition of discrimination

For the purpose of this section, the definitions of 'protected person' and 'discrimination' need to be referred to.

As per section 2 (d) of the Act, discrimination is defined as any act or omission which directly or indirectly, expressly or by effect, immediately or over a period of time,

(i) imposes any burden, obligation, liability, disability or disadvantage on any person or category of persons, based on one or more HIV-related grounds;

or

(ii) denies or withholds any benefit, opportunity or advantage from any person or category of persons, based on one or more HIV-related grounds.

As per section 2 (s) of the Act, protected person means a person who is HIV-Positive; or ordinarily living, residing or cohabiting with a person who is HIV positive; or ordinarily lived, resided or cohabited with a person who was HIV-positive.

Section 3 of the Act provides that no person shall discriminate against the protected person on any ground including any of the following:

The denial of, or termination from, or unfair treatment in, employment or occupation unless, in the case of termination, the person who is otherwise qualified, is furnished with a copy of the written assessment of a qualified and independent healthcare provider competent to do so that such protected person poses a significant risk of transmission of HIV to other persons in the workplace, or is unfit to perform the duties of the job; and a copy of a written statement by the employer stating the nature and extent of administrative or financial hardship for not providing them reasonable accommodation.

Section 2(t) defines reasonable accommodation as minor adjustments to a job or work that enables an HIV-positive person who is otherwise qualified to enjoy equal benefits or to perform the essential functions of the job or work as the case may be.

iii. The denial or discontinuation of, or unfair treatment in, healthcare services, educational establishments and services;

iv. The denial or discontinuation of, or, unfair treatment with regard to, the right of movement, the right to reside, purchase, rent, or otherwise occupy, any property;

v. The denial of access to, removal from, or unfair treatment in, Government or private establishment in whose care or custody a person may be

vi. The denial of, or unfair treatment in, the provision of insurance unless supported by actuarial studies the isolation or segregation of a protected person;

vii. HIV testing as a prerequisite for obtaining employment, or accessing healthcare services or education, or for the continuation of the same, or for accessing or using any other service or facility.

Section 5: Informed consent for undertaking HIV test or treatment

As per section 2 (n) of the Act, informed consent means consent given by any individual or his representative specific to a proposed intervention without any coercion, undue influence, fraud, mistake or misrepresentation and such consent obtained after informing such individual or his representative, as the case may be, such information, as specified in the guidelines, relating to risks and benefits of, and alternatives to, the proposed intervention in such language and in such manner as understood by that individual or his representative, as the case may be.

The section mandates obtaining informed consent of such person or his representative for

a) undertaking or performing an HIV test;

b) performing any medical treatment, medical interventions or research.

The informed consent for HIV test includes pre-test and post-test counselling of the person being tested or such person's representative.

Section 6: Informed consent not required for conducting HIV tests in certain cases

The section provides certain instances where seeking informed consent for conducting an HIV test is not required:

a) where a court determines, by an order, that the carrying out of the HIV test of any person either as part of a medical examination or otherwise is necessary for the determination of issues in the matter before it;

b) for procuring, processing, distribution or use of a human body or any part thereof including tissues, blood, semen or other body fluids for use in medical research or therapy: Provided that where the test results are requested by a donor prior to donation, the donor shall be referred to counselling and testing centre and such donor shall not be entitled to the results of the test unless he has received post-test counselling from such centre;

c) for epidemiological or surveillance purposes where the HIV test is anonymous and is not for the purpose of determining the HIV status of a person: Provided that persons who are subjects of such epidemiological or surveillance studies shall be informed of the purposes of such studies; and

d) for screening purposes in any licensed blood bank.

Section 8: Disclosure of HIV status

a) The section states that no person can be compelled to disclose their HIV status except by the order of the court that the disclosure of such information is necessary in the interest of justice for the determination of the issues in the matter before it;

b) It further provides that no person shall disclose or be compelled to disclose the HIV status or any other private information of other person imparted in confidence or in a fiduciary relationship, except with the informed consent of that person or a representative of such other person.

Provided that, in case of a relationship of a fiduciary nature, informed consent shall be recorded in writing.

The section also discusses certain exceptions to seeking informed consent for disclosure of HIV-related information:

a) by a healthcare provider to another healthcare provider who is involved in the care, treatment or counselling of such person, when such disclosure is necessary to provide care or treatment to that person;

b) by an order of a court that the disclosure of such information is necessary in the interest of justice for the determination of issues and in the matter before it;

c) suits or legal proceedings between persons, where the disclosure of such information is necessary in filing suits or legal proceedings or for instructing their counsel;

d) disclosure of HIV-positive status to partner of HIV-positive person;

e) if it relates to statistical or other information of a person that could not reasonably be expected to lead to the identification of that person; and

f) to the officers of the central government or the state government or state AIDS Control Society of the concerned state government, as the case may be for the purposes of monitoring, evaluation or supervision.

Section 9: Disclosure of HIV-positive status to partner of HIV-positive person

(1) No healthcare provider, except a physician or a counsellor, shall disclose the HIV-positive status of a person to his or her partner.

(2) A healthcare provider, who is a physician or counsellor, may disclose the HIV-positive status of a person under his direct care to his or her partner, if such healthcare provider

a) reasonably believes that the partner is at the significant risk of transmission of HIV from such person; and

b) such HIV-positive person has been counselled to inform such partner; and

c) is satisfied that the HIV-positive person will not inform such partner; and

d) has informed the HIV-positive person of the intention to disclose the HIV-positive status to such partner:

Provided that disclosure under this sub-section to the partner shall be made in person after counselling;

Provided further that such healthcare provider shall have no obligation to identify or locate the partner of an HIV-positive person: Provided also that such healthcare provider shall not inform the partner of a woman where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health or safety of such woman, her children, her relatives or someone who is close to her.

(3) The healthcare provider under sub-section (1) shall not be liable for any criminal or civil action for any disclosure or non-disclosure of confidential HIV-related information made to a partner under this section.

Section 22: Strategies for reduction of risk

Any strategy or mechanism or technique adopted or implemented for reducing the risk of HIV transmission, or any act pursuant thereto, as carried out by persons, establishments or organizations in the manner as may be specified in the guidelines issued by the Central Government shall not be restricted or prohibited in any manner, and shall not amount to a criminal offence or attract civil liability.

'Strategies for reducing risk of HIV transmission' means promoting actions or practices that minimize a person's risk of exposure to HIV or mitigate the adverse impacts related to HIV or AIDS including

(i) the provision of information, education and counselling services relating to prevention of HIV and safe practices;

(ii) the provision and use of safer sex tools, including condoms;

(iii) drug substitution and drug maintenance; and

(iv) the provision of comprehensive injection safety requirements.

(ii) Provide free diagnostic facilities and ART to PLHIV

Section 14: Anti-retroviral Therapy and Opportunistic Infection Management by Central Government and State Government

The Central Government and the State Government shall provide, as far as possible, diagnostic facilities relating to HIV or AIDS, Anti-retroviral Therapy and Opportunistic Infection Management to people living with HIV or AIDS.

Section 15: Welfare Measures by Central Government and State Government

The Central Government and the State Government shall take measures to facilitate better access to welfare schemes to persons infected or affected by HIV or AIDS.

Section 19 and 20: Promote safe workplace in healthcare settings to prevent occupational exposure.

Every establishment, engaged in the healthcare services and every such other establishment where there is a significant risk of occupational exposure to HIV, shall ensuring safe working environment to provide in accordance with the guidelines and inform or educate all persons working in the establishment of the availability of Universal Precautions and Post Exposure Prophylaxis,

(a) Universal Precautions to all persons working in such establishment who may be occupationally exposed to HIV; and

(b) training for the use of such Universal Precautions.

(c) Post Exposure Prophylaxis to all persons working in such establishment who may be occupationally exposed to HIV or AIDS; and

This is applicable on healthcare establishments consisting of 20 or more persons.

Grievance redressal mechanism

- **Complaints Officer (Section 21):** All establishments consisting of 100 or more persons (in the case of healthcare establishments, consisting of 20 or more persons) shall designate a Complaints Officer, whether as an employee or officer, member, director or trustee or manager, every person, who is in charge of an establishment for the conduct of the activities of such establishment, shall ensure compliance of the provisions of this Act.
- **Ombudsman (Section 23,24,25,26)**

  (a) **Appointment of Ombudsman:** Every state government shall appoint one more Ombudsman possessing such qualification and experience as may be prescribed or designate any of its officer not below such rank, as may be prescribed, by state government.

  (b) **Powers of Ombudsman:** The Ombudsman shall, upon a complaint made by any person, inquire into the violations of the provisions of this Act, in relation to acts of discrimination mentioned in section 3 and providing of healthcare services by any person, in such manner as may be prescribed by the state government.

  1) The ombudsman should carry all the processes as per the legal framework.

  2) All records should be maintained as mentioned in the legal document.

  3) All complaints shall be made to the Ombudsman in writing in accordance with the form as specified in respective state rules. Provided that where a complaint cannot be made in writing, the Ombudsman shall render all reasonable assistance to the complainant to reduce the complaint in writing.

  Orders of Ombudsman

  4) The Ombudsman shall pass order within a period of 30 days of the receipt of the complaint, and after giving an opportunity of being heard to the parties.

  5) In cases of medical emergency of HIV positive persons, the Ombudsman shall pass such order as soon as possible, preferably within 24 hours of the receipt of the complaint.

Guardianship (section 32)

A person below the age of 18 but not below 12 years, who has sufficient maturity of understanding and who is managing the affairs of his family affected by HIV and AIDS, shall be competent to act as guardian of other sibling below the age of 18 years for admission to educational establishments, care and protection, treatment, operating bank accounts, managing property.

Confidentiality and use of pseudonyms

The Complaints Officer shall, if requested by a protected person who is part of any complaint, ensure the protection of the identity of the protected person.

Key Messages

It is important for the Counsellors to be familiar with the provisions of the **HIV and AIDS Prevention and Control Act (2017)** which came into force with the purpose to control the spread of HIV and to mitigate discrimination against PLHIV in work and social, medical and financial settings.

References:

- *The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 NO. 16 OF 2017 [20 April, 2017.]*
- *The HIV & AIDS Policy for Establishments, 2022, NACO*

Annexures - placed at the end of the handbook

- Annexure 1 - HIV/AIDS Act English
- Annexure 2 - HIV/AIDS Act Hindi
- Annexure 3 - Gazette notification HIV/AIDS Act

5 Introduction to Prevention Programme under NACP

Targeted Intervention (TI) projects and Link Worker Schemes (LWS) are the major prevention interventions under the National AIDS Control Programme (NACP). These interventions focus primarily on providing services to the high-risk groups (HRGs) and bridge populations who are at risk of acquiring HIV/STI infections. HRGs include female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU) and hijra/transgender (H/TG) people whereas migrants and truckers are covered as a proxy of bridge population. The projects are implemented in defined geographies through a peer-led, outreach-based service delivery model in partnership with non-governmental organizations (NGOs) and community-based organizations (CBOs) contracted through State AIDS Control Societies (SACS) under the social contracting mechanism of NACP.

These programmes help the HRGs and the vulnerable population to reduce the harm associated with their behaviours such as sex work and injecting drug use, improve the quality of life, reach the overall goal of NACP and reduce the infections.

Table 5.1 - Groups covered by TI programmes

High-risk Groups	Bridge Populations
• Sex workers (Sws) • Men who have sex with men (MSM) • Injecting drug users (IDUs) including female injecting drug users (FIDUs) • Hijras and transgender people (H/TG) • Prison population*	• Migrants • Transport workers • Other vulnerable population

** It may be noted that 'Prison population' consists of other groups of HRGs covered under NACP. The modalities of service delivery for prison population are different from TI projects. Prison intervention is an SACS-owned activity which is in close collaboration with state home department, prison authorities and the partners engaged under the programme.*

Importance of Counselling in Prevention Programmes

- Prevention is the first purpose of HIV counselling.
- It decides whether the clients' lifestyle puts them at higher risk and helps clients to recognize and distinguish their high-risk behaviours.
- It allows people to make informed choices about their future practices and behaviours.
- It enhances their ability to reduce their risk of acquiring or transmitting the infection to others.
- It enhances behavioural change.
- HIV counselling and testing service is a key entry point to prevention of HIV infection and to treatment and care of people infected with HIV.
- After the test, if a person is HIV negative, the counselling provides information and

material that can help them remain HIV negative.

- It supports the HRGs and at-risk populations to access accurate information about HIV prevention and care, thereby reducing the risk of acquiring the infection.
- It provides information on spouse/sexual partner testing.
- It helps with symptomatic screening for STIs/RTIs.

High-risk Groups

(i) Sex Workers

- Sex worker is a gender-neutral term which covers adult men/women/hijra/transgender people who are into sex work. For the purpose of TIs, an FSW is an adult woman who engages in consensual sex for money or payment in kind as her principal means of livelihood. In any given geography, sex workers are not a homogeneous group.
- FSW can be categorized into various sub-categories based on where they work and more specifically where they recruit or solicit clients and not where they live or entertain the clients.
- The major typologies of FSW in India are street-based, brothel-based, lodge-based, dhaba-based, home-based, highway-based and mobile/virtual space-based.
- The higher risk faced by the SWs is reflected in a substantially higher prevalence of HIV among them than in the general population.
- SWs have multiple sexual partners concurrently. Generally, full-time SWs have at least one client per day, or at least 30 clients per month, and nearly 400 per year. Some SWs have more clients than others, having several clients per day and 100 or more clients in a month.
- As in Sankalak 2022, while the overall adult prevalence remains low (0.21% in 2021), HIV prevalence among HRGs remains very high. HIV prevalence among Sex Workers (FSW) is nine times of the overall adult prevalence.

Table 5.2- Sex Workers (SWs): Issues, Risk behaviours and Vulnerability factors

Specific Issues of SWs	Risk Behaviours	Vulnerability Factors
• A high number of sexual partners • Unsafe sex and high rates of STIs • Regular partners, lovers, spouse and children • Alcohol or injecting drug use • Unwanted pregnancy	• Unprotected sex: vaginal, anal and oral	• Lack of knowledge and poor risk perception • Exposure to violence from clients • Entertain clients in unknown locations • Lack of immediate support mechanisms • Chances of unwanted multiple partners during mobile/virtual-based sex • Forced sex without condom use

(ii) Men who have Sex with Men

- The term 'Men who have Sex with Men' is used to denote all men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women or not.

- As per the Sankalak report, 2022 (4th edition), around 3.20 lakh MSM (90% of the estimated size) were covered under TI interventions in 2021–2022.
- A total of 4.36 lakh HIV tests were done among MSM and seropositivity was 0.25%.
- In 2020–2021, 93% of the HIV positives were linked to ART vis-a-vis 86% in 2021–2022.
- Fluctuating HIV positivity among MSM has been an area of concern. However, ART linkage has been constantly above 85% in the last three years, which will definitely contribute towards the achievement of the third 95.

Table 5.3- MSM: Issues, Risk behaviours and Vulnerability factors

Specific Issues of MSM	Risk Behaviours	Vulnerability Factors
• Receptive or insertive anal sex • Multiple partners • Unsafe sex and high rates of STIs • Alcohol or injecting drug use or abuse • Stigma and discrimination • Pressure to marry a female by the family	• Unprotected anal and oral sex	• Fear of exposure and therefore quick sexual encounters that may be high risk • Unavailability of condoms at urinals, parks, railway stations, bus stands, etc. where these quick encounters take place • Exposure to violence from goons

(iii) Injecting Drug Users (IDUs) including Female Injecting Drug Users (FIDUs)

- HIV is highly transmissible among IDUs and FIDUs by sharing used needles and other injecting equipment. HIV spreads very quickly due to the unsafe practice.
- Some IDUs also engage in sex work, due to which the vulnerability increases of the IDUs and FIDUs especially which can quickly link HIV transmission in the IDUs networks. FIDUs face more challenges than their male counterparts. Many female drug users have IDU partners, and many of them sell sex to finance their own and their partner's drug use. Apart from all the vulnerabilities that exist for IDUs, getting engaged in unsafe sex work expose them to HIV and STI infections and violence too.

Table 5.4 - IDUs and FIDUs: Issues, Risk behaviours and Vulnerability factors

Specific Issues of IDUs and FIDUs	Risk Behaviours	Vulnerability Factors
• Unsafe injecting practices • Sharing of needles and equipment with peers • FIDUs taking care of IDU partners/spouses • Some FIDUs are sex workers • Legal and ethical factors create challenges	• Sharing of needles/syringes • Unprotected sex: vaginal, anal and oral sex	• Lack of financial resources to get new needles/syringes for each encounter • Drug-induced state leading to high-risk sexual behaviours • Stigma faced from society, family members

(iv) Hijra/Transgender Persons

- Transgender is used as an umbrella term for persons whose gender identity or expression (feminine, masculine, other) is different from their sex (male, female) at birth. It includes transsexuals, cross dressers, intersex persons and other gender-variant persons.
- Hijras: Individuals who voluntarily seek initiation into the hijra community, whose traditional professions are badhai (giving blessings) and chhalla (seeking alms), but due to the prevailing socio-economic and cultural conditions, a significant proportion of them also practise sex work for survival. These individuals live in accordance with the hijra community norms, customs and rituals, which may vary from region to region.
- The average age of sexual encounter by TGs was estimated as 15 years. More than one-fourth of H/TG mapped were sexually active (IBBS, 2014–15), while another 30% were active before turning 18 years. However, the HIV programmes reached TG women and hijras after they turned 18 years of age.
- HIV seropositivity was at 0.38% and 92% of the identified positives were linked to ART centre.
- Efforts are being initiated to ensure reactive H/TG people for linkage of H/TG people with ART, and adherence to viral load suppression.
- Following are the issues, risk behaviours and vulnerability factors that make the transgender people susceptible to HIV/STI:

Table 5.5- Hijra/ Transgender persons: Issues, Risk behaviours and Vulnerability factors

Specific Issues of Hijra/Transgender People	Risk Behaviours	Vulnerability Factors
• Receptive or insertive anal sex • Multiple partners • Unsafe sex and high rates of STIs • Alcohol or injecting drug use or abuse • Stigma and discrimination • Pressure to marry a female by the family	• Unprotected anal and oral sex	• Fear of exposure and therefore quick sexual encounters that may be high risk • Unavailability of condoms at urinals, parks, railway stations, bus stands, etc. where these quick encounters take place • Exposure to violence from goons

Bridge Populations

The bridge population is defined as population that has potential exposure to HRG groups (sexual and injecting) and has a propensity to transmit HIV/STI to the low-risk population/general population. The bridge population is primarily identified as migrants, transport workers and other vulnerable population including clients or partners of male and female sex workers, trans-sex workers and MSM. Bridge and other vulnerable populations (above 18 years of age) covered under the Targeted Intervention are defined as below:

(i) Migrants

- India is characterized by widespread and fluid migration and mobility. Hence an important source of HIV-related vulnerability is mobility and migration. Due to change in language and other difficulties faced in other states, migrants get involved in sexual practices to overcome their loneliness, which results in risk of HIV and STI. This reinforced by a lack of HIV/AIDS awareness, information and social support networks at both source and destination points, which cumulatively contribute to a migrant's vulnerability.

- Back home, spouses of migrants are also vulnerable to HIV if their husbands return on a regular basis and have become infected with HIV. Some wives also have their own sexual network during the absence of their husbands.
- It is important to note that not all migrants are at equal risk of HIV. It is those men who are part of sexual networks at their destinations – either with FSWs, MSM or transgender – who are more prone to HIV infection. Similarly, those female migrants who take up transactional sex at destination locations are at greater risk of HIV.

Issues specific to migrants:

- Relative freedom in the new setting as well as peer pressure to experiment with new norms;
- Distress migration driven by seasonal drought/disasters;
- Loneliness, drudgery and long periods of separation from spouse/sexual partner;
- Having disposable income, clubbed with limited choices for affordable entertainment and recreation;
- This usually means drinking and, sometimes, drugs as well as sex with SWs and other casual sexual relationships.
- Poverty (usually the reason for migrating in the first place) makes women migrants more vulnerable to being pushed into sex work at their destination to supplement their earnings.
- Women migrants lack information and social support networks at both source and destination points more than male migrants.

(ii) Transport Workers

Transport workers spend a considerable amount of time staying away from their home and family members. Thus, they are more likely to engage in high-risk sexual behaviours than short-distance truckers. They may have multiple sexual partners, including SWs, MSM and transgender women on the highways, or have other fixed partners enroute or at places where they stop for rest or food. This results in a higher prevalence of STIs among truckers than among the general population.

Issues specific to transport workers:

- Transport workers sometimes get separated from their regular partners for extended periods of time due to their occupation due to which they get engage with sexual networks to fulfil their sexual desire and long distance driving relief, consumption of alcohol/ substance use leads to the vulnerability to HIV.
- One can find lots of highly active and easily accessible sexual networks operators along the highways and at halt points / dhabas.
- While the driver has money to access services of the sex workers, this can leave him or his partner vulnerable to infection if his information about sexual health is minimal and they engage in unprotected sex.
- Senior truckers may use younger ones, especially cleaners, for sex. Power dynamics within the community are such that the cleaner or younger trucker is largely helpless, and ignorance about the risks of sex between men can lead to STIs or HIV infection.

(iii) Others vulnerable population

Any person, who is a part of sexual and injecting network of the HRG population will be covered under the bridge population interventions. In order to reach out to this population, it is

important to reach out to the sexual network of HRGs in the intervention area. This includes spouse and partners of PLHIV. Snow balling technique or social networking model is to be used to reach out to these populations. Outreach micro plan should be prepared considering the availability of the population to optimize access to services by them.

Prisoners

People living in prisons are particularly vulnerable to increased risk of HIV infection. Low access to preventive and care services, overcrowding and poor prison conditions, neglect and denial, gang violence and lack of protection for younger inmates significantly increase the vulnerability of prison inmates to HIV transmission. Prison conditions can enhance the spread of TB due to overcrowding, poor ventilation, poor nutrition and inadequate or inaccessible medical care, among others. Over-representation of key populations contributes to making the settings a high-risk environment for HIV transmission.

The prevention packages provided to the prison population includes the following:

- HIV testing and counselling
- Care support treatment for PLHIV
- Prevention, diagnosis and treatment for TB
- Elimination of vertical transmission of HIV/Syphilis
- Prevention and treatment of STIs
- Drug dependence treatment including opioid substitution therapy (OST)
- Referral or diagnosis of viral hepatitis
- Raising awareness on HIV transmission through medical or dental services
- Raising awareness on HIV transmission through tattooing, piercing and other forms of skin penetration
- Counselling/IPC (individual and group)

Issues specific to prison population:

- Lifestyle of many inmates prior to incarceration includes unprotected sexual intercourse, drug and alcohol abuse, poverty, homelessness, under-education and unemployment, all of which are associated with risk of HIV/AIDS.
- Drug users are often over-represented in prison populations, usually incarcerated for drug-related crimes, and may continue to use drugs during their incarceration (United Nations Office on Drugs and Crime; UNODC).
- Frequent sharing of contaminated drug injection equipment is the predominant mode of HIV transmission among prisoners.
- HIV is also transmitted in prisons through unsafe sexual behaviour, sometimes associated with sexual violence (UNODC).
- High turnover of prison inmates fuels the spread of HIV and other infections such as TB.
- After release, infected prisoners return to their social networks in the general community, facilitating the spread of HIV and TB infection in the non-incarcerated community.

It may be noted that under the prison intervention, other incarcerated population who are in other closed settings like Swadhar, Ujjala homes and other state-run homes are also covered under the programme.

Key components of TIs

- Behaviour change communication
- Clinical services
- Referrals & linkages
- Provision of commodities
- Enabling environment
- Community mobilization

Table 5.6 - Key Components of TIs

Behaviour change communication	It includes development of context-specific strategies/activities to address the risk of infection through peer counselling and creating an enabling environment to reinforce safer practices: • Interpersonal communication (IPC) by peer educators (PEs) and outreach workers (ORWs) • Counselling for behavioural change • Field-level events/melas • Awareness generation workshops • Training on condom usage, negotiation skills and usage of needles (IDUS only) • Multimedia advertisements • Use of social behaviour change communication (SBCC) materials • National toll-free helpline
Clinical services	• Syndromic case management for STIs • Regular medical check-ups • Community-based screening for HIV • Opioid substitution therapy (OST) • Abscess management
Referrals & linkages	• Integrated counselling and testing centres (ICTCs) • Anti-retroviral therapy (ART) centres • DSRC, Preferred Providers • TB centres • Screening and treatment for Hepatitis B/Hepatitis C • Other referrals as per the demand of the community
Provision of commodities	• Free condom and lubricant distribution • Social marketing of condoms • Clean needle/syringe exchange (IDUs only) • TIs ensure safer practices by providing choices and options of easy accessibility, availability and acceptability
Enabling environment	• Creation of an environment that facilitates easier access to information, services and commodities by the HRGs
Community Mobilization	• Reach out to the community through ORWs and PEs • Capacity building of communities to own the TI programme • Strengthening community systems

The Revamped TI strategy:

Table 5.7: Recommended strategy for core populations

Principal components	Sub-components	Purpose
Programmatic mapping and population size estimation (p-MPSE)		To estimate the sizes of HRGs
Community outreach	Strengthen outreach activities	To increase coverage and cover HRGs by reaching out to the sexual and social networks of HRGs
Service delivery	Differentiated prevention	To optimize human and financial resources, decongest TIs and provide a client-centred package of services
	Navigation	To improve linkages and adherence to ART and ensure viral-load monitoring
	Index testing	To test spouses and sexual/injecting partners of all PLHIV and biological children
	Community-based screening	To test at-risk populations living in hard-to-reach and unreached locations
Commodity distribution	Secondary distribution of needles and syringes	To improve access to needle and syringe exchange
	Satellite OST centres	To improve access and adherence to OST
	Community-based ART dispensing	To improve ART adherence through decentralized care
Community systems strengthening	Community scorecards	To seek feedback from beneficiary communities to continuously improve the quality of TI services

Other strategies

a) **Reaching out to Female IDUs:** Includes the single-window approach for providing needles and syringes, condom, screening for HIV/Syphilis, OST, the collocation of ART dispensation by TI, referrals and treatment of hepatitis B and C, TB etc. Strategies also include formation of self-help/support groups, linkages to mental health services, social protection schemes and provision of legal aid services. Their specific additional needs should be recognized.

b) **Spouses and female partners of IDUS:** Active involvement of female spouses and partners will enhance service uptake, regular clinical check-up, treatment adherence, etc. among the IDUs.

c) ***Dera/gharana/jamath*-based services:** These services are for reaching the hard-to-reach/unreachedtransgenders women where there is a strong network of *dera/gharana/jamath* leaders.

d) **Event-based services:** This strategy is for identifying new transgender women/ hijras who are not part of the existing TI. It proposes to recruit community mobilizers to mobilize HRGs to avail HIV prevention services. Considering the geographical location of the districts wherein the H/TG people are scattered, it establishes leadership, smart outreach, community-based testing, mobilizing them through cultural events combined with different outreach approaches, leaders' messages etc.

Link Workers Scheme(LWS)

LWS is implemented to cover HRGs and other vulnerable populations (antenatal mothers, spouses and partners of HRGs, migrants and truckers, youth, people with TB and PLHIV) in rural areas. This scheme envisages the creation of demand for various HIV/AIDS-related services, linking the target population to existing services, creation of an enabling and stigma-free environment, increasing access to information and services by linking them to other departments/programmes through ASHA volunteers, Anganwadi Workers, Panchayat heads, etc. It may be noted that the scheme itself does not create any service delivery points.

The services provided to the beneficiaries under LWS primarily considered three components: Behavioural, biomedical and structural.

Major activities conducted are as follows:

- Interventions at rural hotspots/congregation points;
- Referral and linkages with services delivery points like ICTC /FICTC /DOTS / ART Centre/ DSRC etc.
- Mid media/mass media activities;
- Conducting health camps;
- Promoting volunteers/ volunteerism;
- Social marketing of condoms.

For more information on the LWS, please refer to the "Link Workers Scheme Operational Guidelines", TI Division, developed in April 2015.

Opioid Substitution Therapy (OST) for IDUs/ PWID/PWID

OST is provided as a key harm reduction strategy to prevent HIV infections among PWIDs under NACP. The OST service involves treating opioid-dependent PWIDs with a long-acting opioid agonist medication for an extended duration of time through the sublingual route, which effectively minimizes craving and withdrawals, and thereby enables the PWIDs to stop injecting drugs. NACP provides OST primarily as a 'Directly Observed Treatment' in a clinic-based setting known as OST Centre under the supervision of a Medical Officer.

There is also a provision for take-home dosage for clinically stable clients satisfying all the criteria provided. The OST programme is provided through three models: the collaborative model at public health facilities, the NGO-based model provided at TI NGOs and the satellite model which includes prison and closed settings.

Communication activities under NACP

Communication activities are directed towards enhancing awareness and knowledge levels among general population to promote safe behaviour, generating demand for services, motivating and sustaining behaviour change in a cross section of populations at risk and strengthening enabling environment.

Following communication activities are conducted under NACP:

Mass Media

- Television and radio campaign
- Cinema theatre
- Effective use of social media through Facebook, Twitter, Instagram, YouTube, etc.

Mid Media

- Posters, hoardings, public displays, bus panels etc.
- National folk media campaign
- Special events on World AIDS Day, International Youth Day, NVD, WBDD, NVBD

On Ground Mobilization and Interpersonal Communication (Youth Interventions)

- Adolescent Education Programme in more than 54,000 schools
- Red Ribbon Clubs in more than 13,000 colleges
- Out of school youth/college at state level

Flagship Initiatives

- National Toll-Free AIDS Helpline1097
- North East Campaign in all eight states

National Toll-Free AIDS Helpline1097

National Toll-Free AIDS Helpline 1097 was launched on the occasion of World AIDS Day on 1 December 2014. 1097 is a 24x7 toll-free service run by NACO for use by the general public and key populations. The short code 1097 can be dialled and reached from any mobile/landline across India. The helpline currently offers call support in 16 languages: Hindi, English, Punjabi, Gujarati, Bengali, Assamese, Odia, Telugu, Tamil, Kannada, Malayalam, Marathi, Mizo, Manipuri, Khasi and Nagamese.

Services offered by 1097 helpline are information, counselling, referral and feedback/ grievances redressal.

Key Messages

I. Targeted Intervention (TI) is the prevention programme being implemented under NACP. This is an approach where evidence-based systematic interventions are implemented for specific target groups who are at high risk of HIV.

ii. The HRGs covered by TI are SW, MSM, PWID, Transgenders/Hijras s and prisoners. The bridge population groups covered are truckers, migrants and other vulnerable populations.

iii. The main principle for the revised and revamped TI strategy was a differentiated approach to prevention that cautions against following a one-size-fits-all approach while carefully segmenting the key populations to enhance an emphasis on risk and vulnerability that would help mitigate the transmission of HIV with greater impact.

iv. Counselling is an essential part of prevention strategies. It helps people to get support and allows them to make informed choices about their future practices and behaviours. It enhances their ability to reduce their risk of acquiring or transmitting the infection to others. It enhances behavioural change. It supports the HRGs and at-risk populations to access accurate information about HIV prevention and care, thereby reducing the risk of acquiring the infection. Following points should be considered while counselling:

a) Understand the marginalization: All HRGs face stigma and discrimination, even violence, from the family and society. They are criminalized. Many are rejected by family and community. They face many challenges in getting their fundamental rights including healthcare.

b) Counsellors should use all basic counselling skills effectively while counselling HRGs: Listen to their story. Do not just talk about HIV risk and infection. Make use of empathy, reflection and paraphrasing as much as possible. Express unconditional acceptance. This is very important because they are facing rejection, and this will help you to establish a rapport with them.

c) Understand the factors making them vulnerable: E.g., MSM hide their sexuality and have sexual encounters at unsafe places like urinals; a new and young sex worker may not have any say in demanding the use of condoms; a TG thrown out of the house after their identity is disclosed.

d) Ensure support while making referrals. Personally talk with the stakeholders and sensitize them.

e) Involve peer educators wherever possible. Get the support of the NGO.

f) Ensure confidentiality, especially while making referrals.

g) Community-based and outreach services are important for the groups while considering various challenges they face to access health services.

h) Make a list of the top priority issues of the HRGs and plan for the interventions.

- Bridge population – Adapt same counselling strategies as above.
- It is important to understand the feeling of loneliness among migrant workers and the fatigue and stress of transport workers. The issues which make them vulnerable should be addressed in counselling.
- Support should be provided through counselling to address the barriers in accessing the services.
- Index testing is a highly recommended strategy to increase the reach and testing coverage of sexual partners, spouses, social and injecting networks of the index client
- Community-based screening (CBS) is important for improving early diagnosis, reaching first-time testers and people who seldom use clinical services.
- Link workers scheme LWS is implemented to cover HRGs and other vulnerable population in rural areas. The services provided under the scheme primarily cover behavioural, biomedical and structural components of the services being provided.
- National Toll-Free AIDS Helpline1097 provides support in counselling, referral, feedback or grievance redressal and any general information related to HIV/AIDS in 16 Indian languages.

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6 Substance Use in the Context of HIV/AIDS

Different definitions and terminologies have been used for categorizing the population of drug users. The following terms are used universally to refer to the population of drug/substance users.

Table 6.1 - Terms used to refer population of drug/ substance users

PWUD	The term 'people who use drugs' is accepted to denote the population of drug users who have used any psychoactive substance for non-medical or recreational purpose through any route of intake.
PWID/IDU	The term refers to people who inject drugs and injecting drugs users, which are used interchangeably. Both refer to any person who has used any psychoactive substance through the injecting route for non-medical purposes.
FIDU	The term refers to female injecting drug users who have used any psychoactive substance through the injecting route for non-medical purpose. In general, the term PWID/IDU is inclusive of all injecting drug users regardless of gender or sexual orientation and can also be used to denote all injecting drug users.

The National AIDS Control Programme (NACP) defines a PWID as ***"People with injecting drugs (PWID) are persons who have used any psychoactive substance through the injecting route for non-medical purposes at least once in the last three months."*** The terms PWID and IDU are used interchangeably in many references and refer to the same populations.

Basic Concepts in Understanding Substance Use

Drugs/Psychoactive substance: Any substance that when taken by a person modifies perception, mood, cognition, behaviour or motor functions. This definition includes legal and illegal substances that can lead to dependence.

The majority of drugs/psychoactive substances can be broadly classified into eight categories as alcohol, opioids, cannabis, sedative-hypnotics, cocaine and other stimulants, hallucinogens, tobacco and volatile solvents.

Concepts in Substance Use/Addiction

Table 6.2 - Concepts used in substance use / addiction

Use	The ingestion of alcohol or other drugs without the experience of any negative consequences. *E.g. If a student had drunk one beer at a party and his parents had not found out, we could say he had USED alcohol.*
Misuse	When a person experiences negative consequence from the use of alcohol or other drugs, it is clearly misuse. *E.g. A 40-year-old man uses alcohol occasionally; his boss throws a party, the man drinks more than usual and on the way home he is arrested by police.*

Abuse/ Harmful Use	Maladaptive pattern of use resulting in physical, social, legal harm and continued use in spite of negative consequences. *E.g. The same 40-year-old man continues drinking alcohol after the incident.*
Dependence	Dependence or addiction is said to have occurred when the following symptoms are manifested. These criteria are important for determining treatment goals and suitability to the different services such as opioid substitution therapy or acute withdrawal management/detoxification.

Dependence criteria are as follows:

- Drug taken in larger amounts or over a longer period;
- Persistent desire or unsuccessful efforts to cut down;
- A great deal of time is spent in obtaining the drug, using the drugand recovering from its effects.
- Important social, occupational or recreational activities given up or reduced;
- Continued use despite harm;
- Tolerance;
- Withdrawal.

Common Progression Pattern of substance use

In general, the progression of substance use follows a common pattern from experimentation with less dependence producing a more socially acceptable substance such as tobacco, alcohol or cannabis to more dependence producing illicit and harmful forms of substances. The role of the counsellor is to understand at what stage the patient is in and determine the appropriate messages accordingly.

Drugs Commonly Injected by PWIDs in India

A vast majority of PWID in India use opioids and opioid derivatives from the poppy plant (Papaver Somniferum) as their primary drug of choice. These opioids include heroin (pure, or the impure smack or brown sugar) as well as pharmaceutical opioids such as buprenorphine, pentazocine and dextropropoxyphene. The opioids may be injected either alone or in combination with other substances including benzodiazepines such as diazepam, or antihistamines such as chlorpheniramine1 or promethazine. The other substances are combined with opioids to enhance the pleasure of opioids or due to some perceptions existing among PWID regarding their positive effects.

Risk and VulnerabilitiesAssociated with Injecting Drug Use

A person who injects drugs faces multiple risks and vulnerabilities due to the cycle of daily drug habit. The role of the counsellor is to help them understand the risks that they face, the resultant harms and counsel them in reducing those risks.

The risks are encountered at multiple stages:

- At the time of procuring of illicit drugs;
- Obtaining money for procurement of drugs;
- Drug intake through unsafe injecting practices;
- During intoxication;
- During withdrawals faced when the effect of the drug starts to wear out.

Table 6.3 - Risks and vulnerabilities associated with injecting drug use

Risk/Vulnerability	Description
Injecting-related risky behaviours	• PWID are highly prone to sharing of used or infected needles, syringes and other injecting paraphernalia such as cookers, water, swabs etc. These behaviours lead to a number of clinical complications including abscesses, blocked veins and transmission of blood-borne viruses such as HIV and hepatitis B and C. • An additional vulnerability among PWIDs is of 'overdose',which is a potentially fatal, medical emergency. • PWID face injecting related risks due a number of reasons. The reasons may vary from the injecting practices themselves or due to the circumstances around injecting: peer influence, injecting in hazardous places, non-availability of injectable drugs, non-availability of adequate needles/syringes and other injecting paraphernalia andinjecting after a period of abstinence.
Sex-related risky behaviours	• PWID may occasionally engage in high-risk sexual behaviours without condoms including sex with female sex workers and sex with spouses or other sexual partners. • The FIDUs are also highly vulnerable to engage in unsafe sex in exchange for drugs or money. • These behaviours put PWIDs at high risk of acquiring and transmitting HIV, hepatitis B and C as well as other STIs.
Drug-related vulnerabilities	• Aside from the physical complications discussed above, PWIDs also suffer from various psychological, legal, social and financial harms resulting from injecting drug use. • They might get into trouble with law enforcement agencies and get arrested for possession of illicit drugs; they might commit theft to pay for their drug habit and get arrested; they might develop marital/family problems, become ostracised by their family and society and be rendered homeless. • They might lose their employment and have financial problems as their daily life is now preoccupied with the drug habit. • Chronic abuse of drugs can affect their mental faculties.

Harms Associated with Injecting Drug Use

An injecting drug user faces multiple risks on a daily basis due to his drug habit leading to various harms that manifest as physical, occupational or financial harms, family or social harms, psychological harms and legal harms as given in Table 6.1.

Table 6.4 - Harms associated with injecting drug use

Physical harms	Infections; poor nutrition, debility, weight loss, overdose, death
Occupational / financial harms	Absenteeism from work, frequent changes of job, loss of job; losses suffered/debts incurred
Familial / Social harms	Marital disharmony, separation/divorce; loss of reputation, social outcast; stigma and discrimination
Psychological harms	Guilt/Shame, lack of motivation, depression, anxiety, other mental disorders
Legal harms	Involvement in illegal activities leading to arrest or imprisonment, drug dealing (NDPS Act)

Drug use is therefore associated with a wide variety of adverse consequences or harms across multiple domains. These harms adversely affect not only the drug-using individual but also their family, community, society and nation.

Drug Abuse Management Strategies

Design of policy and programmes to reduce demand, supply and reduce the harms from drug use

Table 6.5 - Drug abuse management strategies

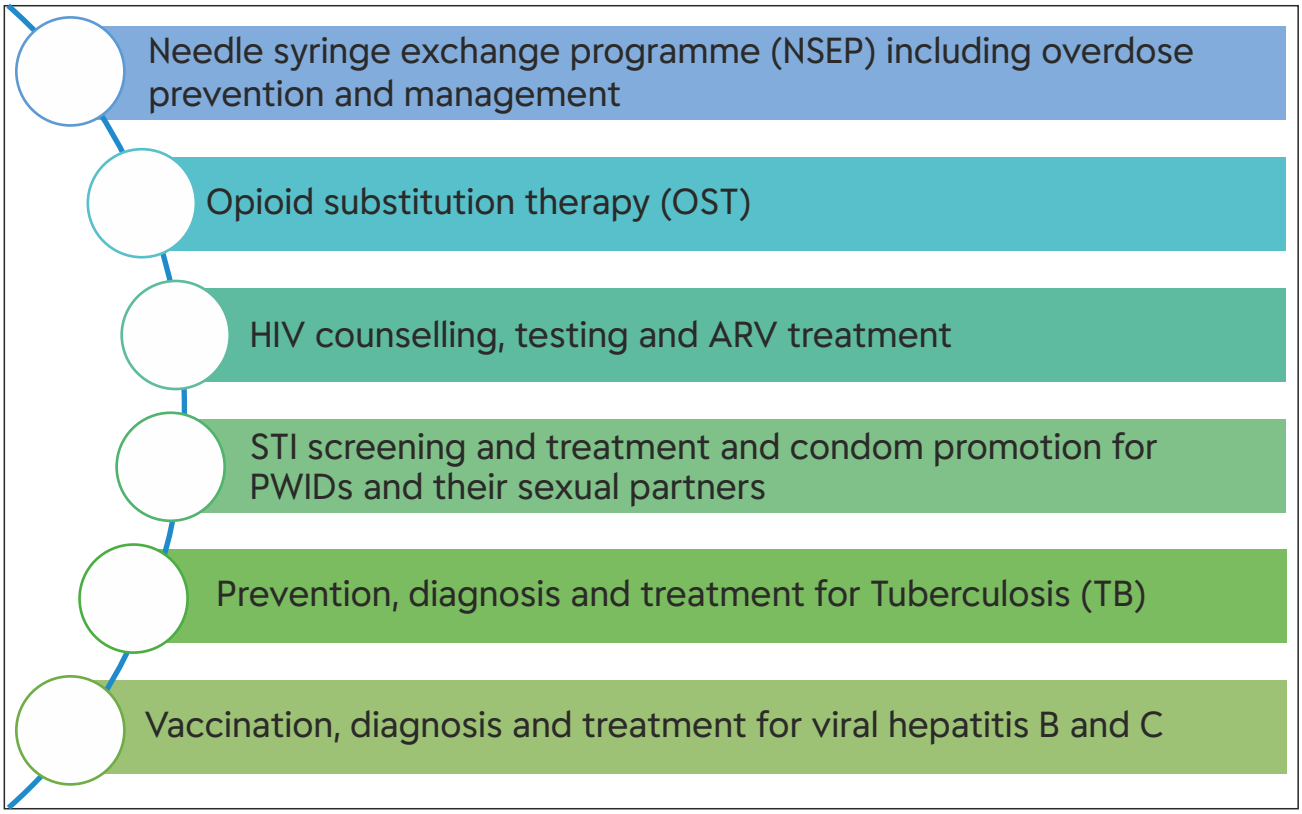
Approach	Description
Demand reduction	**Primary prevention:** Interventions aim at young individuals to discourage initiation of drug use; includes awareness campaigns, teaching life-coping skills and drug-refusal skills. **Treatment and rehabilitation:** Identifying drug users, especially those with abuse or dependence, and providing acute withdrawal management/detoxification and psychosocial intervention and long-term rehabilitation
Supply reduction	**Regulated supply of legal drugs:** Along with certain regulations of consuming alcohol, strategies like imposing duties/taxes should be used to discourage alcohol consumption. **Total prohibition of illegal drugs:** Declaring certain drugs entirely illicit, making all related activities illegal (manufacturing, trafficking, possession). Enforced through laws (e.g., Narcotic Drugs and Psychotropic Substances Act 1985).
Harm reduction	Policies and programmes to minimize or reduce harms resulting from drug use without necessarily stopping drug use per se. This strategy is based on the following universal truths:

	a) While drug use cannot be eradicated completely, it is still possible to reduce the harms arising from injecting drug use. b) Reducing the harms is more important than stopping drug use per se. c) This is the most viable and pragmatic approach to drug use based on a human rights approach. d) This seeks to achieve realistic suboptimal objectives rather than setting up to fail to reach utopian goals.

Harm Reduction Strategy under the National AIDS Control Program

As discussed in the previous section, to reduce the harms resulting from injecting drug use, particularly HIV/AIDS and other blood-borne viruses, NACP has adopted the Harm Reduction Strategy for designing and implementing the Targeted Intervention for People Who Inject Drugs. As part of the commitment to end HIV/AIDS as a public health threat by 2030, comprehensive harm reduction services for people who use drugs are provided under NACP V.

Figure 6.1 - Comprehensive Harm reduction services for people who inject drugs



Needle Syringe Exchange Programme

Under this programme, PWIDS are provided new/sterile needles and syringes to cover every injecting episode in exchange for the return of the used needle syringe along with condoms as per demand. In addition, the PWIDs are provided education on HIV, body to body virus (BBV) and the risks of sharing injecting equipment, are taught safer injecting practices and are counselled for HIV, HBV, HCV testing etc.

Goal: The goal of the needle syringe exchange programme is to ensure that every injecting act is covered with a new needle/syringe to reduce transmission of HIV and BBVs.

Key objectives: The key objectives of the needle syringe exchange programme are as follows:

1. To facilitate safe injecting practices by
    - Providing sterile/new injecting equipment;
    - Practicing safe disposal option;
    - Removing contaminated needles/syringes from circulation.
2. To educate and inform PWIDs and injecting partners about safe injecting practices for prevention of HIV transmission and other BBVs, thereby minimizing the hazardous consequences of unsafe injection.
3. To build a rapport with the PWIDs for establishment of a line of communication that ultimately links them with other services and assists in reduction of high-risk practices/ behaviour.

The Needle Syringe Exchange Programme (NSEP) is currently implemented at the TI NGO facility under the NACP. The services are provided through both outreach using peer educators from the PWID community and at the static TI drop-incentre. In general, the services under the NSEP program include:

Table 6.6 - Services under NSEP

• Information, education, communication • Behaviour change communication • Commodity distribution of needle syringes and condoms • Counselling • Abscess management	• Overdose prevention and management • HIV testing and treatment • STI screening and treatment • Referrals to ARTC, TB DOTs, NVHCP, NMHP facilities • Referrals to OST, detoxification and rehabilitation facilities

Opioid Substitution Therapy

Opioid Substitution Therapy (OST) is the second most integral component of harm reduction services for PWIDs under the NACP. OST involves treatment of PWIDs who are dependent on opioids with a substitution i.e., a long-acting opioid partial agonist medication administered through the sublingual route for a prolonged duration of time under the direct supervision of a trained medical officer and nurse. The philosophy of OST is to replace the illicit substance of abuse with a safer, legal and long-acting alternative that effectively minimizes cravings and withdrawals and enables the patient stop to injecting and lead a normal productive life. Combined with extensive psycho-social intervention, the OST program is successful in reducing drug-related harms including HIV/HCV transmission and in long-term treatment for opioid dependency.

Benefits of OST: The benefits accrued from OST range from HIV/HBV/HCV prevention to treatment of opioid dependence, and improvements in the well-being at the individual, family and society levels. Some of the benefits include the following:

a. Reduction in injecting behaviour (able to stop injecting);

b. Improved adherence to other treatments, especially treatment for HIV, TB and viral hepatitis;

c. Reduction in illicit opioid use;

d. Reduced overdose-related deaths;

e. Reduction in criminality;

f. Reduction in domestic violence;

g. Improved childcare and family ties;

h. Improved productivity and gainful employment.

Models for OST dispensation under NACP

a) **Collaborative model:** In this model, the OST centre is located in a government healthcare facility (medical college hospital, district hospital, sub-divisional hospital, CHC, etc.). It is a full-fledged stand-alone OST centre.

b) **NGO model:** In this model, The OST centre is located within an existing IDU TI project offering the HIV prevention package such as NSEP and other clinical and outreach services.

c) **Satellite OST model:** The satellite OST centre is not a stand-alone centre as the previous two models but is basically a sub-centre (s) of the full-fledged OST centres usually located away and at a distance from the full-fledged main/parent centre. The purpose of a satellite OST centre is to (a) provide OST services to clients residing/congregating at remote locations (more than 15–20 kms from the existing parent OST centre, clients having difficulty in access with a longer travel time, e.g., at least an hour or more) and (b) to decongest existing OST centres having high daily client load of more than 200 so as to ensure quality service delivery to each individual patient.

Counselling for People who Inject Drugs

This section deals with the type of assistance and counselling that can be provided at different stages of drug use. As given in the previous sections, the counselling for people who inject drugs is based on the principles of harm reduction, which state that complete eradication of drug use is impossible and it is possible to systematically reduce and minimize the harms from injecting drug use. Further, it is not necessary for the drug user to be abstinent before seeking assistance and it is possible to offer help at each and every stage of drug use.

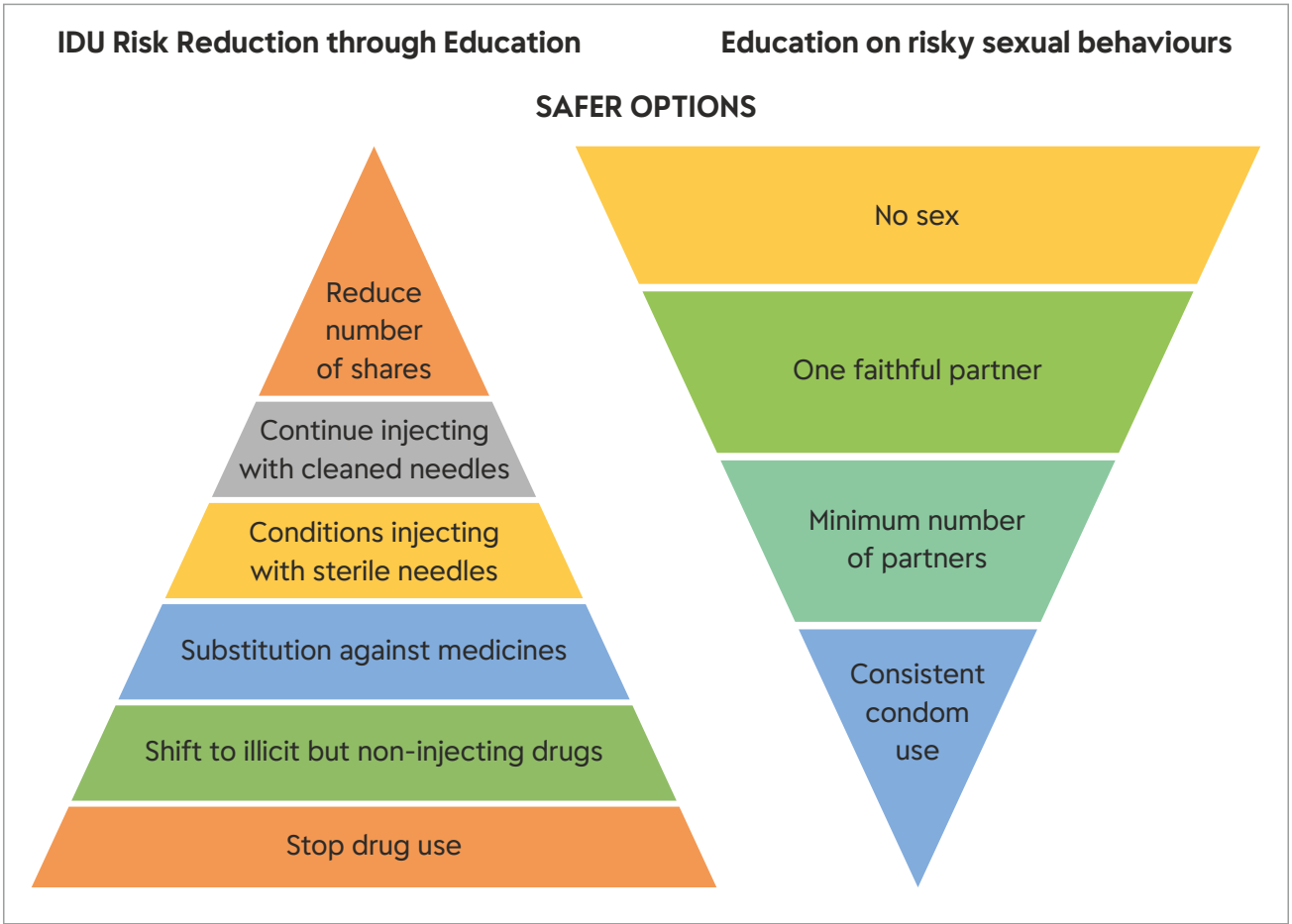
As shown in Fig.6.1, the counsellor can provide assistance to the drug user to reduce the risk and harms of injecting drug use at every stage.

Figure 6.2 - Hierarchy of harm reduction strategy

- Never start using drugs
- Even if using drugs, don't inject
- If injecting, assistance to stop injecting drugs
- If not able to stop injecting, don't share
- If not in a position to stop sharing, ensure clean equipment before every use

- Preventive education to at-risk and general community
- Education to drug users on harms with injection use including HIV, HBV, HCV, abscess, etc.
- Opioid substitution therapy, medically assisted treatment
- Needle syringe exchange, education on safe injecting practices, vein care, abscess, overdose
- Educate; provide cleaning materials, disinfect with bleach as last resort

Figure 6.3-Risk Reduction for injecting and sexual risk behaviours



The counsellor is primarily and directly responsible for individual client well-being and progress throughout the HIV prevention and treatment cascade. Behaviour change communication is an important component in the counselling module for PWID. The role of the counsellor is to ensure that PWID receive adequate information on HIV, BBVs and STIs, is regularly accessing needle syringe exchange and condom services, regularly adheres to the HIV and syphilis testing and repeat testing and maintains adherence and retention on ART if PLHIV.

The counsellor has the following responsibilities:

- Providing different forms of psychosocial counselling to NSEP clients and their spouses/family members and their sexual partners;
- Arranging referrals of clients to ICTC, ARTC, DSRC, OSTC, NTEP and NVHCP facilities;
- Planning and implementation of strategies to reduce dropouts;
- Making field visits or visiting clients in the community and in the hotspots in the field as required.

The counsellor will be expected to cover the following topics as appropriate:

- HIV and other blood-borne viruses such as viral hepatitis B and C
- STIs and condom promotion
- Risk reduction counselling
- Safer injecting practices
- Safer sex practices
- Abscess prevention and management
- Overdose prevention
- Opioid substitution therapy
- Detoxification and rehabilitation
- NDPS Act Section 64, 64 A immunity
- Pre- and post-test counselling
- Crisis intervention and problem solving
- Problem-solving skills
- ART and co-morbidities

Risk Reduction Counselling for Safer Injecting

In conducting risk reduction counselling, the counsellor will explore current injecting practices followed by the PWID client:

a. Understand the risky and safe practices;

b. Reinforce the safe practices followed;

c. Point out risky practices for modification;

d. Summarize the important practices at the end of assessment as feedback to the client.

(i) Counselling for before injecting:

a. Choose a safe place where you are not anxious as this helps in relaxing the muscles.

b. Do not inject alone; injecting in the presence of someone else will ensure availability of help.

c. Keep the immediate surroundings clean: use a clean newspaper or magazine to lay down the injecting equipment.

d. Choose the smallest bore needle possible.

e. Use sterile water; if not, use cooled freshly boiled water.

f. Use an acidifier such as vitamin C tablets or citric acid for dissolving brown sugar use small doses of acidifier, as large dose will injure the vein.

g. Do not heat the drug too much as doing so will cause injury to the tissue where the drug is being injected.

h. Filters such as cotton swabs and cigarette butts are often used to filter out undissolved particulate matters. Cigarette filter ends are preferable, as cotton swabs have loose fibres that may enter the injection.

i. Do not touch the cooker (metal cap, spoon used for mixing and heating) with needle tip, as doing so will make the needle tip blunt.

(ii) Counselling for 'during injecting'

a. Intravenous route is preferable to subcutaneous injection.

b. Clean the area where the drug is to be injected.

c. Best way is with plenty of soap and water.

d. If not possible, use alcohol swabs.

e. Ensure that alcohol dries off before injecting, otherwise the site will not be sterile.

f. Best area for injecting – cubital fossa (front of elbow)

g. Dangerous sites for injecting: Groin veins, neck veins, veins on the face, veins of the hand and legs, breast veins and penile veins

h. Differentiating an artery from vein

i. Vein care techniques are tabulated below:

Table 6.7 - Vein care techniques

• Rotate sites. • Avoid missing the vein. • Avoid infections. • Don't inject in smaller veins. • Use smaller bore needle " larger bore needle will damage the vein. • Tie a tourniquet that can be easily released; do not tie the tourniquet tightly; release tourniquet soon after the needle enters the vein. • Do not repeatedly push the blood back and forth.	• Use the smallest size needle that you can. • Avoid 'flushing' after injecting. • Don't inject tablets/capsules. • Don't make the tourniquet too tight. • Hold the needle at 45-degree angle. • Once you hit a vein, stop further puncture and draw some blood in vein to confirm that it has hit the vein; the blood should be dark red in colour. • Administer the drug slowly

(iii) Counselling after injecting

- Slowly remove the needle from vein.
- Immediately apply pressure on the injected site with a dry cotton swab. DO NOT use alcohol swabs.
- Apply pressure for at least one minute.
- Allow time for injected vein to heal.
- Use another site to inject → rotate veins.

Opioid overdose

Overdose on drugs, particularly opioid overdose, is very common and can often be fatal. The counsellor should explain the risk factors for overdose, the early warning symptoms and what to do in case of overdose such as the administration of naloxone. Teaching the patient first aid for an overdose may also lead to the client helping their friends out during an overdose episode. Refer to the handout for details of overdose management.

Table 6.8- Overdose: Symptoms, Emergency aid and Prevention counselling

Symptoms of overdose: Seemingly awake, but no response elicited on giving any stimulus (such as calling out name), skin becomes pale in colour, body goes limp, slow pulse/no pulse, bluish coloration of fingernails, vomiting, choking noise, shallow breathing.

Emergency aid for overdose: Emergency/first aid should be given before medical help arrives.

1. Shout the name and shake the person. And press the breastbone with your knuckles.
2. If the person does not respond to noise, call the emergency helpline and/or ambulance. Put the client in recovery position. Do not leave the person alone.
3. Make sure nothing is blocking their airway, and there is nothing in the mouth. If necessary, use your finger to get the stuff out.
4. Rescue breathing if no or slow breathing: mouth-to-mouth resuscitation

Explain to the participants that the following points need to be kept in mind during overdose management:

- Don't leave someone who is overdosing alone, except if you absolutely must leave the area to call for help. The person could stop breathing and die.
- Don't put the person in the bath, this could result in death.
- Don't give the person anything to drink or to induce vomiting, this could cause choking.
- Do not make the person drink salt water or put salt in their mouth. This could cause choking too.
- Do not inject salt water as this is dangerous and can cause sudden death.

Counselling for preventing overdose

- The client should be educatedon what the risk factors are for overdose. The client should be made aware that reusing just after a period of abstinence of more than three days

would put them at the greatest risk for overdose. During abstinence, the client has lost the tolerance to drugs, and using the same dose as before would place them at risk of an overdose.

- The client should be warned that though they are buying the heroin from the same dealer, the purity of the sample may not be the same. This may lead to overdose.
- The client should be told to take a small dose first before taking the full dose to test purity.
- The client should be told to take injections in the presence of someone else, so that help is readily available if something goes wrong.
- The client should be educated that mixing drugs, especially other brain-depressing drugs such as alcohol, sedatives/hypnotics, along with heroin or other opioids would place them at a greater risk for overdose.
- The client should also be educated about some myths associated with treating overdose that would not help: inducing vomiting, drinking water, drinking coffee/tea, taking cold showers.
- The clients and their friends should be educated on the recovery position as part of first aid and on administration of naloxone for opioid overdose.

Counselling for Opioid Substitution Therapy

At the OST centre, the counsellor is primarily and directly responsible for individual clients' treatment and adherence, retention and overall progress in therapy and has the following responsibilities:

- Assisting the doctor in assessment and induction of new OST clients as well as follow-up;this includes taking case history of the new client and determining eligibility for OST.
- Providing different forms of psychosocial counselling to OST clients and their spouses/family members;
- Arranging referrals of clients to ICTC, ARTC, DSRC, NTEP and NVHCP facilities;
- Planning and implementation of strategies to reduce loss to follow-up in coordination with link IDU TI;
- Making home visits or visiting clients in the community and in the field as required.

The counsellor at the OST centre will be expected to be familiar with the following topics and techniques besides having adequate knowledge and comprehension of the technical aspects of agonist maintenance therapy using buprenorphine and buprenorphine-naloxone. Different techniques such as role play and simulation exercises will be used. The NACO OST Training Manual 2021 will be used as a reference for the relevant training materials.

Table 6.9 - Techniques for counsellors for OST clients

Motivation enhancement	Decision balancing, adherence counselling, supporting self-efficacy and feedback
Psychological education	Treatment modality, treatment duration and need for active participation in treatment
Relapse prevention	High-risk situations, warning signs of relapse and coping strategies
Support/Self-Help groups	Handling dropouts, benefits of OST and spouse/family counselling
Co-morbidities	HIV/HBV/HCV/TB testing and treatment

Legal Provisions under Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985

The counsellor should be familiar with certain provisions under the NDPS Act, 1985 and provide basic information on the rights available to PWIDs in case of arrest or detention:

Table 6.10 - NDPS Act 1985

- **Section 4 of NDPS Act:** Central Government can take measures with respect to identification, treatment, education, after care, rehabilitation and social re-integration of addicts.
- **Section 71 of NDPS Act:** Gives the government power to establish centres for the purpose outlined in Section 4 AND the power to provide narcotic drugs and psychotropic substances to addicts registered with it. Government-funded OST centres operate within Section 71 of NDPS Act.
- **PWIDs rights on arrest and detention:** Right to know reason for arrest;right to inform one person - friend, relative of your arrest;right to be taken to magistrate within 24 hours
- **Immunity from prosecution:** If an addict is arrested with small quantity (e.g.up to 5gmsheroin or up to 100gmscharas), they can avoid prosecution if they volunteer for drug dependence treatment at government-recognized centre. (Section 64A; added in 2001).
- **Have to complete treatment:** If treatment is left incomplete, then sent back to court.

Key Messages

- NACO defines PWID as people who have used any psychoactive substance through the injecting route for non-medical purposes at least once in the last three months.
- People inject drugs for various reasons:e.g. to enjoy the sense of detachment or euphoria, peer pressure, family environmentor to avoid withdrawal symptoms.
- Opioid dependence syndrome (ODS) is a pattern of opioid drug use in which an individual uses opioid on a daily/almost daily basis and fulfils the criteria for dependence on opioid drugs.
- Drug use problems are addressed with approaches such as supply reduction, demand reduction and harm reduction.

Counsellors' Role

- Detailed risk assessment should be done. Clients may not directly inform counsellors that they use drugs. Counsellors will have to elicit the information. Start the conversation and use the counselling skills discussed in the previous chapters. Rapport establishment is very important. Assure confidentiality.
- The funnelling approach of questioning (beginning with a broad question, then specific question) is useful to elicit information on drug use. E.g.

  "Have you ever smoked?
  What have you smoked?
  Have you ever sniffed any substance?
  What have you sniffed?"

- You may ask the following questions:

  a) *"Some people like to smoke, some people like to inhale substances. They may use tobacco or sniff glue or use medical drugs in a combination form. Have you ever done anything like this?"*

  b) *"We know that one route for the spread of HIV is through the sharing of needles. Have you ever had any instance where you have had to use a syringe/ needle?"*

  c) *If the client responds "Yes", follow up with an open-ended question: "Could you tell me more about that please?"*

- Show a chart with pictures of different substances and ask clients to point to the substances they may have tried out in their lives.
- A comprehensive risk assessment will cover the following:
  - Basic details: age, sex, marital status, education
  - Details of drug use: type of drug, frequency and amount, mode of use, time of last dose
  - Complications with drug use: physical, legal, occupational, financial, marital/familial, social, psychological
  - High-risk behaviour
  - HIV-related knowledge and belief
  - History of medical and mental illness
  - Current living status
  - Motivation leve
- lUnderstand the factors making the PWID vulnerable:

- Stigma and discrimination, rejection from the family, society
- Criminalization
- Lack of access to support services

- Unsafe sex and needle exchange

- Counsellor should assess if there is any harmful use or dependence and refer the client to the clinician for further management. Counsellor can continue with the counselling for behaviour change.Counselling should be provided even to the individuals who might have just used injecting drugsonce in a while.
- PWID face injecting risk due to lack of knowledge, lack of adequate time for injecting, injecting in hazardous places, non-availability of injecting drugs, non-availability of needles and syringes and reuse of needles and syringes. Understand these factors.
- Other than acquiring HIV, faulty injecting practices increase the risk of other blood-borne infections (Hepatitis B&C, syphilis), local skin infections, sclerosis of veins, scarring of tissue, septicaemia, infection of internal organs and risk of injection into the artery.
- Explain substance use disorders to the clients
    - Make your clients aware about the harms, risks and vulnerabilities associated with drug use.
    - PWID have greater risks of acquiring HIV not only because of injecting drugs but also having more sexual partners.
    - Allow PWID to select the options available to reduce the harm and its related risks.
    - Talk to the clients about the OST centres available in their area.
    - Inform them that overdosing from opioid drugs is common and can be fatal.
    - Explain the symptoms and management of overdose.
    - Explain how drugs not only cause deterioration of health, but also create other challenges for the family and society.
- Give the information on overdose and its effects. Counsel for managing overdose.
- The first thing to do in the case of overdose management is to call the ambulance and take the client to the emergency ward of a hospital. Naloxone is administered immediately in cases of opioid overdose.
- NSEP is provided for injecting drug users to ensure that every injecting act is covered by a new/sterile needle-syringe and to stop any further transmission of HIV or other BBVs by reducing sharing of used infected needle syringes.
- The counsellor should accept and internalize the following facts related to injecting drug use:
    - It is not possible in a practical world to eradicate drug/intoxicant use.
    - It is not required for the drug user to be abstinent before getting help.
    - Not every drug user responds to counselling in the same manner and degree.
    - It is possible to offer help at each and every stage of drug use as mentioned below.

Table 6.11- Suggestions for different scenarios related to IDUs

Client is not able to stop sharing	A PWID may not be able to access clean needles and syringes every time they want to inject. So,ask the client to be prepared for such an eventuality and carry one set of new needles and syringes all the time.
Client is not able to stop injecting, but is in a position to avoid sharing	For various reasons, the client may not be in a position to stop injecting drugs. Educate the client about the risks of sharing and reusing syringes, inform about NSEP, educate how to inject safely, explain overdose prevention and management and offer OST if needed. Enhancement therapy may be given to enhance the motivation of the client.
Client has stopped injecting	Clients should be motivated to remain away from injecting drug use; relapse prevention should be taught.
Counselling for preventing overdose	Educateon risk factors of overdose.

References:

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7 Counselling and Testing for HIV

Knowing HIV status enables people to make informed decisions about their life in a timely manner and adopt healthy behaviour. People who have been engaged in high-risk behaviour for HIV or have been exposed to HIV infection should receive necessary information about HIV/AIDS through adequate and correct counselling sessions. HIV counselling and testing services (HCTS) provide a vital gateway to early diagnosis and linking of the clients with preventive treatment, care and a cascade of other support services.

The benefits of knowing your HIV status are listed below:

- **Staying HIV free:** A negative HIV test result opens the door to accessing information about the range of HIV prevention options available depending on the various risk factors to keep the client HIV free.
- **Knowing the HIV-positive status earlier, starting treatment earlier:** The earlier that someone is diagnosed as living with HIV, the earlier life-saving treatment can be initiated. The earlier HIV treatment is initiated after detection, the better the outcome.
- **Looking after loved ones:** Early initiation of HIV treatment reduces the load of HIV virus in a person's blood to undetectable levels. The undetectable viral load levels in the blood have near to zero chances of HIV transmission.
- **Stopping transmission to babies:** A pregnant or lactating woman diagnosed with HIV can access a range of options that ensures her and her babies' health to prevent vertical transmission of the infection.
- **Claiming the right to health:** By deciding to know their HIV status, people are empowered to make choices about their right to health.
- **Staying alive and well:** Taking a HIV test can also provide an opportunity to screen and test for other illnesses, such as TB, STIs, hepatitis, high blood pressure, diabetes and other communicable and non-communicable diseases.

HIV Counselling and Testing Services (HCTS)

HIV Counselling and Testing Services HCTS continues to envisage the provision of comprehensive services in an integrated manner, not limited to HIV testing. HCTS comprises of the following:

- Counselling (pre-test counselling, informed consent and post-test counselling);
- Testing and prompt delivery of test results with embedded quality assurance;
- Ensuring audio-visual privacy and confidentiality;
- Linkages to appropriate HIV prevention, care, support and treatment services.

Five Cs for HIV Testing:

Consent, which is obtained in verbal form from people undergoing testing in order to access testing and counselling services.

Confidentiality refers to the non-disclosure of discussions between the healthcare provider and the receiver until the receiver has their own will.

Counselling is a confidential dialogue between an individual and a counsellor. Its aim is to educate people about HIV/AIDS and allows the individual to make an informed decision about HIV testing and to comprehend the implications of the test results.

Correct diagnosis and test result: HIV testing providers should strive to provide high-quality testing services and quality assurance mechanisms for correct diagnosis.

Connection to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support.

HIV Testing

HIV infection is diagnosed largely under the programme by the detection of antibodies against HIV in the blood of infected patients. HIV infection in any individual can be detected by laboratory tests that demonstrate either the virus or viral products, or antibodies to the virus in blood/serum/plasma. In children below 18 months of age, due to persistence of maternal antibodies, diagnosis of HIV is made by PCR tests that detect HIV total nucleic acid (NACO, 2016).

What are antibodies?

The human body produces certain specific type of proteins in response to detecting some foreign antigens (i.e., infections). These proteins are called antibodies. After HIV enters the body, it infects CD4 type of T cells and is recognized by our immune system as 'foreign'. In response to this foreign invasion, our body produces antibodies. After the window period, these antibodies are detectable through laboratory tests in our blood. When these antibodies can be detected in someone's blood, it is regarded as a 'Positive HIV Test'.

What is the window period?

Window period represents the period between infection with HIV and the time when HIV antibodies can be detected in the blood (6–12 weeks). A blood test performed during the window period may yield a negative test result for HIV antibodies. These cases may require repeat testing after 12 weeks (HCTS Guidelines, 2016). Therefore, it is important to know that the person under window period remains infective and can transmit the infection to others. The history of window period should be elicited in such patients through proper counselling and assessing the duration of exposure. The patient in window period should be counselled about the negative HIV test result,motivated and followed up for repeat testing after 12 weeks.

HIV tests strategies and algorithm

- All testing facilities should ensure reliable, accurate and reproducible results using well-defined strategies and diagnostic algorithms in view of the varying prevalence of HIV infection in different populations and the availability of a variety of different diagnostick its in the market.
- HIV testing strategies should involve a logical sequence of performing two or more tests, one after the other (serial) or simultaneously (parallel) to arrive at a conclusion on the HIV status of a person being tested.

- A testing algorithm with combination and sequence of specific tests that are used to fulfil the testing strategy should be followed.
- The three principles of the HIV testing as per the programme are as follows:
  - Enzyme immune assay (dot-blot), immunofiltration and immunoconcentration are the three principles for HIV testing.
  - As per the recommendation of the TRG, any of the testing principles can be utilized in sequence for confirmation of the diagnosis of HIV.
  - ELISA can be used to replace the enzyme immunoassay when there is shortage or non-availability of three rapid tests.

HIV Testing Strategies

The following strategies are to be used for HIV testing in adults and children above the age of 18 months:

Strategy 1: Blood Banks & HCTS Screening Facilities

Single Test (enzyme-linked immunosorbent assay [ELISA] or rapid)

Mandatory for screening donated blood; if found reactive, the donated blood should not be used for transfusion/transplantation. After informed consent, the donor should be promptly referred for confirmation of the HIV diagnosis at the nearest SA-ICTC for further confirmation and linkage to the cascade of treatment and care services.

Strategy 2 (A): HIV Sentinel Surveillance

Two rRapidt Tests done by using two test kits

Mainly used in case of HIV sentinel surveillance where two test kits are being used. The patient is declared HIV-negative if the first test is non-reactive and as HIV-positive when both tests show reactive results. When there is discordance between the two tests (first reactive and the second non-reactive), it is interpreted and reported as negative.

Strategy 2 (B): Clinically Symptomatic and Suspected Individuals

A patient who is clinically symptomatic and suspected to have an AIDS indicator condition/disease should be tested at SA-ICTC twice using kits with either different antigens or principles

- The patient is declared HIV-negative if the first test is non- reactive.
- The patient is declared HIV-positive when both tests show reactive results.
- When there is discordance between the first two tests (first reactive and the second non-reactive), a third test is to be done. When the third test is also negative, it is reported as negative.
- When the third test is reactive, it is to be reported as indeterminate and the individual is retested after 14–28 days.

Strategy 3: Diagnosis of Clinically Asymptomatic Individuals

Screening is done at F-ICTC/CBS/VHSND using a single rapid test kit.

- If the test is found non-reactive, the individual is to be considered HIV-negative and needs to be followed up if the patient is high risk.
- If the test result is found reactive, the individual should be promptly referred for confirmation of the diagnosis at the linked SA-ICTC and further cascade of services.

The type of strategy to be adopted would depend on the ultimate purpose for which HIV testing is being carried out. One of the essential prerequisites for the use of this algorithm is that the first, second and third tests (A1, A2 and A3) employed are based on different serological principles and/or use of different HIV antigens in the assay. Samples within determinate results are to be sent to higher laboratories for confirmation.

An HIV positive person should be encouraged through counselling to share the positive test result with his or her spouse, sexual or needle sharing partner(s) and bring the spouse or partner for testing.

Universal precautions should be followed while handling blood and body fluids – including all secretions and excretions (serum, semen, vaginal secretions) – by all healthcare providers at all times. The facilities should have provision of providing post-exposure prophylaxis (PEP) in case of accidental exposure in the form of needle stick injury or spill of infected specimen.

Confirmation

In asymptomatic individuals, confirmation should be done using three rapid tests of three different antigens or principles. The individual is considered HIV-negative if the first test is non- reactive and as HIV-positivewhenall three tests show reactive results.

Early Diagnosis in Children below 18 Months

HIV-1 qualitative virological assay should be used for testing at 6 weeks of age or at the earliest opportunity there after. The testing algorithm as defined needs to be followed for children after 6 months of age up to 18 months. Parallel antibody testing needs to be performed followed by qualitative PCR if any of the antibody tests is positive to understand the HIV status.

HIV Counselling and Testing Services

NACO has made significant advances in terms of how HCTS will be offered across the country.

Facilities for HIV Counselling Testing Services

- **Facility-based HCTS:** Facility-based HCTS (screening or confirmation) are offered to individuals accessing healthcare facilities functioning of the institution where the HCTS facility is located.
- **Community-based HCTS:** Community-based screening (CBS) is an important approach for improving early diagnosis, reaching first-time testers and people who seldom use clinical services, including men and adolescents in high-prevalence settings and HRG populations. To improve HCTS access and coverage, community-based HIV screening is carried out through various approaches such as the following:

Mobile HCTS

The main functions of this mobile SA-ICTC are to mobilize pregnant women and vulnerable populations in the community. The mobile ICTC can also be leveraged for the promotion of IEC for HIV/AIDS, condom and other commodity distribution, dispensation of ARV in remote areas and OST dispensation to the peripheral areas. The mobile ICTC can be combined with the general heath camp to provide the range of services to the people who are residing in far-flung areas.

There are two types of mobile HCTS:

a) **Mobile HCTS for HIV confirmatory test:** A mobile SA-ICTC is a vehicle (van, boat, etc.) with facilities to conduct HCTS and regular medical and ANC check-up.

b) **Mobile HCTS for HIV screening test:** As per the MoHFW/GoI decision, the existing mobile medical units (MMU) serving hard-to-reach areas under the NHM should be leveraged as mobile F-ICTCs, as per the prescribed norms, for conducting HIV screening services (pre-test counselling, informed consent, HIV screening test and post-test counselling) in addition to routine activities.

Screening by ancillary healthcare providers

To enhance the outreach and coverage of priority populations for HIV testing, the following nursing and paramedical functionaries have been identified to be trained to conduct HIV screening (Ref: National HIV and Counselling Testing services, guideline of 2016):

- Public health nurse (PHN)
- Lady health visitor (LHV)
- Auxiliary nurse midwife (ANM)
- Counsellor
- Pharmacist
- Multipurpose worker (MPW)-male
- Peer educator (PE)
- Outreach worker (ORW)
- Other trained ancillary health cadre.

Screening for HIV by Targeted Intervention

To increase the HIV testing coverage among HRGs, screening for HIV by TI should be implemented to ensure that HCTS are easily available and accessible to high-risk (core and bridge) groups and priority populations. This HIV screening is undertaken by TI in the community setting or in the TI setting with the help of staff present in the TIs.

External Quality Assurance System (EQAS)

Quality is an absolute requirement for any testing laboratory. A false-positive or false-negative result from an HIV testing laboratory is associated with social, ethical, medical and legal implications. The National External Quality Assurance System (EQAS) ensures quality in HIV testing by implementing SOPs and hierarchical laboratory networks. Each SA-ICTC is linked to an SRL, conducting retesting and panel testing for quality assurance.

Each SA-ICTC is linked to an SRL, which is responsible for mentoring and monitoring quality at the SA-ICTC. Additionally, once in 6 months, as part of a periodic assessment of quality of testing at the SA-ICTC, a panel of four blinded samples is sent by the linked SRL to the SA-ICTC for testing. The SA-ICTC reports back the panel testing report to the linked SRL. In turn, the SRL provides feedback to the SA-ICTC.

Key Messages

a) Knowing their HIV status enables people to make informed decisions about their future. If the status is known, all required care can be taken. E.g. if the report is positive, ART can be initiated. It enhances the quality of life of the client. Not doing the test leads to many complications. If the test report is negative, precautions can be taken to stay negative. So, counsellors should discuss the importance of HIV testing with the clients (especially those who are reluctant to test).

b) HIV infection is diagnosed largely by the detection of antibodies against HIV in the blood of infected people.

c) A person in the window period remains infective and can transmit the infection to others. This is a very important point during counselling. Explain to clients that the infection might be there but the antibodies are not found in the blood. So the test report is negative but the person is infected. Therefore, safe sex practices should be always followed.

d) It is recommended that HIV testing should be done using highly sensitive and specific rapid tests in HCTS, which provide reliable and accurate results. This point also should be explained during counselling. This will help the clients to trust the test results. Inform the clients that three tests with different principles are done for the most accurate results.

e) 'Five Cs' of HIV testing mean consent, confidentiality, counselling, correct test results and connection (linkage to prevention, care and treatment services) – these apply to all HIV testing services.

   Consent: Informed consent must be obtained from individuals undergoing testing to access testing and counselling services.

   Confidentiality: Discussions between the healthcare provider and receiver remain undisclosed until the receiver makes their own choice.

   Counselling: Confidential dialogue between individual and counsellor to educate about HIV/AIDS and contribute to behaviour change.

   Correct test results: Striving for high-quality testing services, ensuring correct diagnosis and test results through quality assurance

   Connection to services: Linking individuals to prevention, treatment and care services, including effective follow-up and support

f) Counsellors have a greater role in the group/individual counselling, especially at the community-based HCTS.

g) It is important to follow the EQAS guidelines to ensure the quality of testing. Counsellors should ensure that samples are sent for EQAS.

h) Some clients do not trust the test results because they cannot accept the fact that they are HIV positive. The quality of the testing process should be explained to the clients. In addition to this, emotional support should be extended.

i) In the pre-test counselling, all clients should be informed that the test quality is very good at the HCTC.

References

- *Guidance note from the National Guidelines for HIV Testing, 2015*
- *National HIV Counselling and Testing Services Guideline, Chapter 3 – Counselling for HIV Testing*
- *National Operational Guideline for ART Services, NACO, 2021*
- *National Guidelines for HIV Care and Treatment, NACO, 2021*
- *Integrated training module for ICTC, ART, and STI Counsellors, NACO, Nov 2014*
- *Statutory Orders and Notifications Issued by the Ministries of the Government of India (Other than the Ministry of Defence), The Gazette of India, July 9, 2022/ASADHA 18, 1944*

8 Basic Counselling Skills

Counselling is a professional relationship between a client and a counsellor to empower the client in dealing with issues in life and choosing the most suitable option from the available alternatives. The counsellor facilitates the process in such a way that empowers clients to make constructive decisions for their lives and become resilient and well-functioning individuals. The goal of counselling is to lead the clients in making constructive changes in beliefs, behaviour and emotional distress.

Counselling is not advice-giving. Counselling also is not Health Education.

"Counselling is a confidential dialogue between an individual and a counsellor. It aims to provide information on HIV/AIDS and bring about behaviour change in the individual. It also enables the individual to take a decision regarding HIV testing and to understand the implications of the test results". (National HIV Counselling and Testing Services Guideline, Chapter 3 – Counselling for HIV Testing).

The Basic Principles of Counselling

Table 8.1 - Counselling Principles

Principle of Acceptance	A counsellor accepts the client as they are and with all their limitations. They believe that acceptance is the crux for all help. They do not condemn or feel hostile towards the client just because their behaviour differs from the approved one.
Principle of individualization	No two persons are alike in all qualities and traits. Their problems may be the same but the cause of the problem, the perception towards the problem and ego strength differs in every individual. Therefore, each individual client should be treated as a separate entity and complete information is required to establish close relations in order to solve their problem from the roots.
Principle of non-judgmental attitude	The counsellor should avoid making assumptions or judgements about the client from their appearance, profession, age or the purpose of seeking help. E.g., a client in her 60s may approach you to get information on HIV, STI and safe sex or a healthcare professional may approach you for help in getting rid of drug use. So, you cannot judge them on the basis of age or profession and the reason for seeking help. Always remember that people have the right to make their own choices.
Principle of confidentiality	The counsellor should not reveal any information gathered from the client without the client's permission. It is important to maintain confidentiality and trust in a counselling relationship. In addition, the counsellor should communicate clearly to the client that confidentiality/secrecy will be maintained. At all times, respect the

	confidentiality of what is disclosed to you. Do not fall into the trap of gossip, which is unprofessional conduct.
Principle of empathy	The counsellor places themselves in the client's shoes and tries to feel what they are feeling. Empathy is known to increase prosocial (helping) behaviours.
Principle of controlled emotional involvement	The counsellor tries to understand the client's feelings and emotions but does not get involved emotionally in the client's problems. The counsellor's over involvement will not help the client. On the contrary, if you are stable, you will be in a better position to help them. Over-involvement is one of the causes of burnout. It is important that you care for your own mental health.
Principle of communication	It is the road to the identification of the client's problem. The function of the counsellor is to create an environment in which the client will feel comfortable in expression of their feelings. Use simple language. Do not use jargon. Use local terms.
Principle of expression of feelings	Safe environment for the expression of feelings is the recognition that you understand them. Clients have the need to express their feelings freely without being judged, especially their negative feelings. Allow clients to express feelings freely. Say that it is okay to cry, to feel disappointed or angry. Never say,"Don't cry. Things will be fine/There is nothing so scary."
Principle of self-awareness	Counsellors should know their own strengths and limitations. If they feel that the problems of the client are beyond their capacity, the client should be referred to the appropriate authority. Counsellors also should be aware of their own values, attitudes and psychological state. They should ensure that this does not interfere in the counselling process.

Importance of counselling in the context of HIV

- Most of the HIV infections in India are through sexual transmission. Discussion on sexual issues is considered a taboo. So, clients need a safe environment to discuss the issues.
- Counselling PLHIV is important because HIV infection is lifelong.
- Prevention of HIV transmission and supporting those affected directly or indirectly by HIV are the dual aims of HIV counselling because changes in behaviour can prevent the spread of HIV.
- Through counselling, the counsellor creates awareness and prepares a person for both the seropositive and seronegative status.
- HIV/AIDS is associated with stigma and discrimination, which leads to mental health issues of anxiety, depressed feelings, denial, anger and guilt, which a person is likely to go through on knowing their seropositive status.

Table 8.1 - Qualities of a counsellor

Knowledgeable Should have knowledge of the field and should be updated with latest information	**Skilful** Should be well equipped with skills required for the role to perform. Here training, practice and feedback on the skills play an important role.	**Observant** Should be a keen observer of the client's verbal and non-verbal behaviours. E.g.,even if the client is not speaking, can guess their state of mind by observing. However, it always advisable to cross check this understanding before coming to conclusions.	**Communication skills** Should communicate clearly without barriers. Use simple language and terms that the clients will understand. Keep silence when the client is not speaking anything. It may help the client to contain the feelings. Non-verbal communication also is important in counselling.
Ethics and values Should know the ethical code of conduct of the community they serve. Should be aware of the values in counselling like confidentiality, freedom of the individual, not imposing your own values on the client etc. Other important values are considering the well-being of the client and not asking for any information to satisfy own curiosity.	**Personal integrity** Should have a high degree of personal integrity and credibility. Honest with self and clients. They know their limitations and will not mislead clients. E.g., they refer the clients to medical officers or another counsellor if they do not know anything.	**Organized** Should be good at time management, well equipped with the skills required for optimal executive functioning, record maintenance of cases and keeping a focus on which client to get shifted to follow-up sessions and which client's case needs to be closed.	**Flexible** Should accept any new challenging behaviours from the clients and mould the session structure according to the needs of the client. A good counsellor does not rigidly assume the diagnosis in the first few sessions.

Open-Minded Should have acceptance for all types of clients, acknowledge both negative and positive feelings	**Patience** Counsellor has to practice tolerance because clients come with various issues, they express various feelings even aggression, negative attitude. Still, counsellors work with them.	**Active listening** They provide a listening ear to the client. They even read the non-verbal cues of the clients.	**Unconditional positive regard and non-judgmental attitude** Accepting all clients and not being biased towards any specific caste, religion, community or clients with specific behaviour, which is different from social norms.
Reflection of feeling and questioning Should recognize client's feelings and let them know you have understood their feelings; ask open-ended questions that allow for more explaining. Help the client to go deeper into their problems and gain insight.	**Paraphrasing** The counsellor attempts to give 'feedback' to the client by stating the essence or content of what the client has just said.	**Interpretation** (Giving back to the client the core issue that they are struggling with.) The counsellor helps to establish what is relevant, emphasizing the important points. When people avoid focusing on the real problem and talk around the issue, this skill should be used. Interpretation goes beyond what is explicitly expressed.	**Repeating and summarizing** Should help clients understand everything they are told, highlighting decisions which have been made and need to be acted on, providing guidance and direction to both, counsellor and client.
Empathy Counsellors try to understand the client's feelings and the situation from the client's point of view. Being empathetic never means that the counsellor agrees with the perspective of the client. It means that the counsellor puts self in the shoes of the client to learn about the scenario from the client's perspective.		**Confidentiality** Client should be informed before the start of counselling about their right to confidentiality. A counsellor guides the client so that whatever information is shared in the session will remain confidential. The information shall not be shared with anyone unless there is a risk to the life of the client.	

Points to consider while counselling high-risk groups:

Table 8.3 - Counselling high-risk groups: Points for consideration

Counselling Sex Workers	Counselling PWID
• Stigma and discrimination • High number of sexual partners • Unsafe sex and high rates of STIs • Regular partners, lovers, spouse and children • Alcohol or injecting drug use or abuse • Unwanted pregnancy and EVTHS services may be needed	• Stigma and discrimination • Unsafe injecting practices • Sharing of needles and equipment with peers • Care for partners/spouses of PWID • Some female PWID are sex workers. • Legal and ethical factors create challenges to enabling environment
Counselling MSM and Hijra/transgender people	**Counselling clients during the index testing**
• Stigma and discrimination • Pressure of marriage from family • Receptive or insertive anal sex • Multiple partners • Unsafe sex and high rates of STIs • Alcohol or injecting drug use or abuse	• Index testing is voluntary service to all clients who are HIV-positive. • With consent, tests for their sex and needle-sharing partners and biological children <19 with unknown HIV status • Approaches for partner referral i.e., client referral and provider-assisted referral. • Preferred method of partner notification or child testing for each named partner/ child. • Intimate partner violence (IPV) risks • Appropriate service for partner(s) and children based on HIV status
Counselling sero-positive pregnant woman	**Counselling PLHIV**
• Partner/spouse testing • Term of pregnancy • Treatment (ARV) history of PW • Linkage with ART services • EVTHS services including VL testing at 32–36 weeks of pregnancy • Infant feeding guidelines • Nutrition • Treatment adherence	• Insight about the diagnosis (denial/ partial insight/acceptance) • Partner/spouse testing • Screening of OIs e.g., 4S screening for TB • Education about HIV/AIDS including prevention and treatment • Identify barriers to treatment • Treatment (ARV/Prophylactic) - counselling including side effects • Adherence/Follow-up counselling

Stigma and discrimination as well as alcohol and injecting drug use or abuse make a person vulnerable to HIV infection. This point should be considered while doing the risk assessment of all HRGs especially – Sex Workers, PWID, MSM and H/TG.

Counselling Room

HIV counselling is a confidential dialogue between a client and a counsellor. The counselling process includes evaluating the personal risk of HIV transmission and discussing how to prevent infection. During the counselling process, the clients may want to discuss their personal lives and problems, so it is important for the counsellors to create a comfortable counselling environment where clients can relax, trust, feel at ease and open up about thoughts or emotions.

List of Referral Services

A counsellor's role does not end with the end of counselling session; counsellor should have a holistic approach encompassing health, family life, social life and empowerment of the client. Counsellor should be able to provide possible solutions to client's worries and concerns. Client concerns may not always be related to health, HIV or treatment.

A counsellor should be able to link clients up with appropriate service provider, government schemes and try to resolve their problem and empower them. This is the way to demonstrate empathy. To be able to do so, a counsellor should be knowledgeable about government programmes, NGO schemes and new policies. He/she should be able to establish linkages with such service providers. A list of these referral services can help the counsellor to providethe best possible service to clients.

Key Messages

- HIV counselling informs and guides behavioural change, aiding decisions on testing, understanding results, initiating treatment and ensuring adherence.
- Counselling is a private, empowering dialogue fostering self-made decisions in life, not advice-giving. Its goal is constructive changes in beliefs, behaviour and emotional well-being.
- Counsellors focus on the client as a whole, considering their background, struggles and vulnerabilities beyond the infection. Personalised support is vital for understanding unique life contexts.
- Every client is unique; personalized, respectful care is essential. Complete client information is crucial, respecting their personality, choices and right to live autonomously.
- Effective counselling builds trust through acceptance and understanding. This alliance is maintained throughout the counselling process, ensuring continuous support.

  Basic counselling principles –

  - **Accepting and Non-Judgmental:**
  - Encourage openness: "Feel free to share; no judgment here."
  - Reassure confidentiality: "Your privacy is ensured; relax and talk freely."

- **Empathy and Clear Communication:**
  - Show understanding: "I understand your situation and concerns."
  - Use simple language: "Explain clearly; use local terms for better comprehension."
- **Expression of Feelings:**
  - Allow emotional expression: "Express fears and feelings openly; it's a safe space."
- **Self-awareness and Sensitivity:**
  - Be mindful: "Stay aware of your attitudes; ensure they don't affect counselling."
- **Aims of HIV Counselling:**
  - Raise awareness: "Our goal is HIV prevention and support for all affected."

Basic counselling skills (qualities of a counsellor) -

- **Active Listening:** Pay attention, nod, show interest, and notice nonverbal cues.
- **Effective Questioning:** Use open-ended questions for clients to express themselves fully.
- **Empathy:** Show understanding and acknowledgment.
- **Paraphrasing and Reflection:** Repeat client's thoughts for validation and deeper understanding.
- **Knowledge and Awareness:** Stay informed about government programs, NGO schemes, and policies.
- **Targeted Intervention Sensitivity:** Conduct thorough risk assessments and address stigma, discrimination, and vulnerability issues during sessions.

- *Counselling Room:* It is important for the counsellors to create a comfortable counselling environment where clients can relax, trust, make patients feel at ease and create an environment where it is possible to open up about thoughts or emotions.
- *List of Referral Services:* The counsellor should be able to link the clients with appropriate service providers and government schemes.

References:

- *National HIV Counselling and Testing Services Guideline, Chapter 3 – Counselling for HIV Testing*
- *National Operational Guideline for ART Services, NACO, 2021*
- *National Guidelines for HIV Care and Treatment, NACO, 2021*
- *Integrated training module for ICTC, ART, and STI Counsellors, NACO, Nov 2014*

Annexure: Ambience of the Counselling Room

HIV counselling is a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counselling process includes evaluating the personal risk of HIV transmission and discussing how to prevent infection. During the counselling process, the clients may want to discuss their personal lives and problems, so it is important for the counsellors to create a comfortable counselling environment where clients can relax, trust, make patients feel at ease and open up about thoughts or emotions.

Suitable environment for counselling is as follows:

- A direction sign board and a name board in local language to make it easier for clients to find the counselling room;
- The counselling room should have a calm and quiet environment where the client can feel secure and protected. At the same time, he/she should feel confident about confidentiality. Privacy should be demonstrated to the client.
- The room should be free from any kind of disturbance like outside noise, ringing telephones, people disturbing in between.
- A suitable environment for counselling will feel like neutral ground to both the counsellors and the clients. If you display too many personal items, it could make the patient feel as if they are visitors in someone else's home. You can avoid this by not keeping personal items.
- Keep your space clean and organized. This type of environment is better for counselling sessions for several reasons. First, it sends the message that you care about your work and pay attention to detail. Second, while a messy office can generate feelings of anxiety, a clean and organized space will have a calming effect on your patients. Third, it can help keep your clients from feeling distracted when their eyes are wandering around all over your office. You want them focused on what you are saying, not on all of the clutter.
- Using natural elements in your office can also help create an environment that is suitable for counselling. You could start by adding some natural elements like plants, scenic photos, or painted landscapes. They help patients feel less stressed, which makes counselling sessions flow more smoothly.
- Have adequate lights in the counselling room.
- Total privacy should be observed at the time of counselling.
- The chairs and tables should be arranged in a way that ensures adequate space and an environment for the clients to feel secure.
- IEC materials should be available at all HCT sites to provide education to waiting clients.

Make the counselling centre child friendly. While a separate room for counselling of children is ideal, this is not always possible in a crowded hospital. Alternatively, you could plan a child-friendly corner with the following:

- A small blackboard at the child's level;
- Drawing paper and other art material;
- Inexpensive games and toys for children;
- Noticeboard with paintings by children such as calendars with complete adherence marked by children, or pictures drawn by them. (Here, remember to use first names only to protect their identity.)
- Storybooks
- Some festival decorations;
- Coloured pictures from magazines/newspapers of popular sports persons or animals.

You can mobilize these resources from places such as toy shops, publishers/distributors of children's magazines, service organizations/clubs like Rotary Club and Lion's Club, local philanthropists and NGOs/CBOs/Networks.

9 Risk Assessment, Pre-and Post-test Counselling and Index Testing

Risk assessment

The client flow at HCTS confirmatory facilities has been revised to enhance focus on priority clients. The clients are prioritized on the basis of referrals. All direct referrals are prioritized and assessed for risk of HIV, while all provider referral clients are fast tracked. However, counsellors may administer risk assessment to provider referral clients at the time of pre-test or post-test, if they feel the need, based on their interaction with client. The risk assessment is documented in SOCH.

"At risk" populations/priority population:

- Self-initiated clients at ICTC with risky behaviour;
- Social and sexual networks of self-initiated clients/individuals;
- Clients motivated from helpline 1097/IEC material;
- Youth and adolescents at risk;
- Individuals having casual sexual relations with regular/non-regular partner/s;
- STI/RTI clients visiting DSRC/STI Clinics with STI complaints;
- HIV-negative but at-risk clients identified through virtual outreach, NACO Helpline 1097 etc.
- Regular and non-regular partner/s/spouse of HRG (FSW, MSM, TG/TS) who are not associated/covered with TIs, LWS & OSC;
- Needle/Syringe-sharing partners (IDU/FIDU) and their sexual partners (who are not associated with TIs/ LWS/OSC);
- HIV-negative partners of discordant couples;
- Screened reactive referrals for confirmatory test and screened reactive from blood banks (BB);
- Pregnant women;
- Exposed babies.

The priority clients will be assessed for risk of HIV based on seven risk assessment questions listed below:

Q.1 : Do you have the habit of using/sharing injecting drugs? (Response: Used/ Shared/ Refusal to answer)

Q.2 : What kind of sexual partner(s) do you have? (Response: Male/ Female/ TG/ No sexual partner/ Refuse to answer)

Q.3 : Do you have any sexual relationship beyond your spouse/partner? (Response: Yes/ No/ Refusal to answer)

Q.4 : Have you bought sex in the past from a man, woman or TG using money, goods, favours or benefits? (Response: Yes/ No/ Refusal to answer)

Q.5 : Have you provided sex in the past in exchange for money, goods, favours or benefits? (Response: Yes/ No/ Refusal to answer)

Q.6 : Any STI symptoms in the last three months? (Response: Yes/ No/ Refusal to answer)

Q.7 : Is your spouse or partner a PLHIV? (Response: Yes/ No/ Refusal to answer).

It should be emphasized that HIV risk assessment should be undertaken in a sensitive and non-judgmental manner, so that clients are encouraged to openly discuss their concerns. In addition, sensitive information is confidential and the HIV risk behaviour or infection status should not result in any discriminatory treatment to the client.

All the clients identified as 'at-risk'on the basis of risk-assessment and whose HIV test result is negative will be linked to the comprehensive prevention services under SSK. In case the clients cannot be linked to SSK for any reason, they will be followed up at the existing confirmatory facility for prevention services.

At SSK, additional details related to client history and demographics will be recorded to better understand client profile and requirements. The details of their social/sexual/injecting partners will also be elicited to generate awareness around HIV and STIs and encourage their partners to access NACP services. The needs (health and non-health) and risk categories of clients (basis risk-assessment) will be assessed by the SSK staff, and a holistic package of services will accordingly be provided to clients in line with SSS Operational Guidelines and States' Implementation Plan (Sampoorna Suraksha Strategy, Operational Guidelines (2nd Cut), 2023).

Table 9.1 - Risk categorization at SSK

Questions	Interpretation basis on response
Q1	If "Used and Shared" or "Shared">>High risk If "Used">> Moderate risk If "Refuse to answer">> Low risk If "No">> Not at risk
Q2	If Client is Male and Sexual Partner is Male>> High risk If Client is Male and Sexual Partner is TG>> High risk If Client is TG and Sexual Partner is Male>> High risk If Client is TG and Sexual Partner is TG>> High risk For other scenarios >> Not at risk
Q3	If "Yes">> High risk
Q4	If "Refuse to answer">> Low risk
Q5	If "No" >>Not at risk
Q6	If "Yes">> Moderate risk If "Refuse to answer">> Low risk If "No" >>Not at risk
Q7	If "Yes">> High risk If "Refuse to answer">> Moderate risk If "No" >>Not at risk

A) Pre-test Counselling:

- Pre-test counselling is provided to the individual before HIV testing using posters, flip charts, brochures and short video clips so as to prepare him/her for the HIV test and to address myths and misconceptions regarding HIV/AIDS.
- This can be done in two ways: (a) one-on-one counselling and (b) group counselling. One-on-one counselling should be done for all individuals accessing HCTS services where risk has been elicited. Group counselling can be done when the counsellor is addressing a group such as pregnant women at ANC clinics.
- At screening facilities, any paramedical staff designated for HIV screening (PHN/ LHV/ANM/MPW male/pharmacist/LT) in the health facility should provide the pre-test counselling.
- At screening and confirmatory facilities, prescribing physician or any paramedical staff designated for HIV screening shall provide pre-test counselling for all provider referral clients. However, for all priority clients, pre-test counselling shall be provided by the counsellor after administering risk assessment.

Table 9.2 - Content of pre-test counselling

a. Provide information on HIV and AIDS: What is HIV, what is AIDS, window period, route of transmission, prevention message, care, support and treatment services.

b. Explain the benefits of HIV testing and risk assessment.

c. Assure confidentiality.

d. Explain that the individual has the right to opt out of HIV testing.

e. Explain the implication of a positive test result, including availability of treatment.

f. Explain the implications of a negative test result including preventive services.

g. Disclosure if positive and avail Index Testing Services.

h. Provide information on genital, menstrual and sexual hygiene.

i. Demonstrate the use of a condom using a model.

j. Provide information on spouse/sexual partner testing.

k. Extend the opportunity to the individual to ask and clarify doubts.

l. In addition, explain to all pregnant/breastfeeding women regarding EVTHS.

m. Additional counselling for patient who has declined the test:

- they can return at any time for further information and or testing;
- information on other health facilities that can offer HIV counselling and testing services;
- information that can be used in prevention and risk reduction for that individual;
- that declining the test does not affect any other health service provision.

n. **Informed consent:** After pre-test counselling, informed consent of the client must be taken for the HIV test. Informed consent remains one of the essential five Cs.

Table 9.3 - Informed Consent

Informed consent by an adult at HCTC	It should always be obtained individually and in private. Even if pre-test counselling is provided in a group setting, everyone should give informed consent for testing with an opt-out option.
Consent for individuals below the age of 18 years	Informed consent has to be obtained from the parents/guardians/ caretaking institutions or NGO concerned. In case there is a difference of opinion on consent for testing between the parents/guardians and the individual below 18 years of age, the counsellor may further counsel the individual/parent/guardian to prepare for testing. In case such individuals are unwilling to involve parents/guardians in their HIV testing process, they should be counselled again. If there is no parent/guardian, then the local legal authorities may grant permission for testing.
Consent for non-ambulatory individuals	The blood sample of such a patient should be sent to the nearest HCTS facility and the healthcare provider should sign the register in lieu of the patient, after obtaining verbal informed consent.
Consent for patients in coma	Informed consent has to be obtained from their family/ parents/ guardians/ caretaking institution, or NGO. If there is no parent/ guardian, then the local legal authorities may grant permission for testing. The relevant person/organization providing consent will also be responsible for signing the counselling register. In certain circumstances where HIV testing is warranted, the decision to test lies with the concerned medical healthcare provider.

B) Post-test Counselling:

- All efforts must be made to provide same-day test results and post-test counselling to all those accessing HIV services at the HCTS facilities.
- Individual post-test counselling must be conducted for all HIV reactive/indeterminate/ positive at confirmatory facilities and wherever risk has been elicited, irrespective of whether the result is HIV non-reactive/reactive at the screening facility.
- At screening facilities, any paramedical staff designated for HIV screening (public health nurse/lady health visitor/auxiliary nurse midwife/Multipurpose worker male/pharmacist/ laboratorytechnician) in the health facility should provide post-test counselling.
- At confirmatory facilities, post-test counselling shall be provided by the counsellor.
- However, the post-test counselling and the follow-up counselling sessions shall be customized to the patients being tested, such as pregnant women, adolescents, at-risk, HRG etc
- Content of the post-test counselling is detailed in Table 9.3.

Table 9.4 - Content of the post-test counselling

HIV result	Content of post-test counselling
All results (screening as well as confirmatory sites) including negative/non-reactive	• An explanation of the test result; • Risk education counselling, condom demonstration and provision of condoms; • Emphasis on the importance of disclosure and partner testing; Information about the availability of partners'/couples' testing and counselling services; • Information on genital, menstrual and sexual hygiene; • Linkages to TB/STI/ANC services, TI programmes, etc. • An opportunity for additional counselling of the individual, clarification on myths and misconceptions.
Additional counselling messages based on test result:	
Negative (confirmatory site and at-risk clients)	• Importance of safe practices and preventive measures; • Importance of follow-up services and retesting at prescribed intervals;
Reactive (screening site)	• This is only a screening test for HIV. With this result, it is not possible to confirm the HIV status. • Explain the need for confirmation of HIV diagnosis at an SA-ICTC and the process followed. • Fill the linkage form and provide directions for reaching the nearest SA-ICTC.
Positive (confirmatory site)	• Explain the test results and diagnosis. • Avoid information overload. • Listen and respond to needs (the patient may be overwhelmed and hear little after being told the positive result). • Discuss the immediate implications and treatment options if the patient is in the condition to receive further information. • Review immediate plans and support. • Assess and address concerns, denial, fear, risk of suicide, depression and other mental health consequences of diagnosis of HIV infection. • Provide clear information on free ART (where it is offered, when ART will start, for how long it has to be taken, how many times it has to be taken, who will provide ART, what tests are required for starting ART, etc.) and reducing the risk of HIV transmission. • Discuss possible disclosure of the result and encourage index testing. • Assess the risk of violence by partner/spouse and discuss existing support system to help such individuals, particularly women, who are diagnosed HIV positive. • **An HIV-positive diagnosis is a life-changing event. Post-test counselling should always be responsive and tailored to the unique situation of each individual or couple.**

	• Link to District Level Network (DLN)/peer support groups
Indeterminate (confirmatory site)	• All individuals with an indeterminate test result should be encouraged to undergo follow-up testing in two weeks to confirm their HIV status. Emphasize the need for and ensure follow-up testing. • Discuss immediate concerns and help the individual. • Assess the risk of suicide, depression and other mental health consequences of a diagnosis of HIV infection.
Pregnant WLHIV	• Potential risk of transmitting HIV to the infant • Benefits of early HIV diagnosis and treatment for mother and infant • Infant-feeding practices
Victims of sexual assault	• Counselling on the need for baseline HIV, other STI and pregnancy testing; • Post-exposure prophylaxis (PEP) for HIV and STI and counselling for its adherence; • Follow-up HIV counselling and testing after 3 months and 6 months (as applicable);
High-risk group (HRG)/bridge population	• Address stigma and discrimination-related issues. • An individual may have more than one type of risk behaviour. Explore and address it. • Need for follow-up counselling (if applicable); • Connect with social protection schemes and services from support structures as applicable: e.g., crisis response team, legal support, etc., when needed; • Linkages to Targeted Interventions or LWS.

C) Follow-up Counselling:

Follow-up counselling is required in the management of a person who has tested positive, or in the situation where a person who tested negative is continuing to participate in high-risk behaviours for HIV. Follow-up counselling is recommended for the following individuals:

- Individuals who have not accepted their HIV-positive report;
- Individuals who have not been linked to care, support and treatment services;
- Individuals in need of services from support structures such as legal, socio-economic welfare, etc.

For further details, please refer the following NACO guidelines:

- **For at-risk negative clients: Please refer page nos. 24–25** (Sampoorna Suraksha Strategy, Operational Guidelines (2nd Cut), 2023)
- **For newly identified PLHIV: Please refer page nos. 57–59** (National Guidelines for HIV care and treatment, 2021)
- **For repeat HIV testing: Please refer page no. 59** (HIV Counseling and Testing Services, 2016)

Index Testing Services (Partner notiofication services/Contact tracing services)

(Refer Index Testing Services SOP, 2020)

Index testing services (ITS), or partner notification services, is a voluntary case-finding approach where trained providers, with the consent of the HIV-positive client, focus on the elicitation of the sexual and/or needle-sharing partners and biological children and offer them HIV Counselling and Testing Services (HCTS).

Implemented appropriately and safely, index testing can link HIV-positive individuals to life-saving treatment, break the chain of transmission and link HIV-negative people to other appropriate prevention services (e.g., SSK, TI, OST etc.)

- **Index client:** All PLHIV (newly diagnosed and known HIV positive person who have had an interruption in treatment or who are identified as having high viral load), including high-risk groups (FSW, MSM, TG and IDU), adults, adolescents, children and bridge population (Truckers and Migrants)
- **Contact:**
  - Sexual contacts should include ALL persons they have had sex with (even if it was just a single encounter and even if they always use condoms with this partner).
  - Needle-sharing contacts including ALL persons they have shared needles or injection equipment (even if it was just one time and even if they cleaned the needle before sharing);
  - All biological children who are less than 19 years of age:
    - In case of woman newly diagnosed with HIV
    - In case of a male index case, if the wife is HIV positive, deceased, or her status is unknown

For Index Case who are children (<19 years), the contacts will include:

- Biological mother
- Biological father, if the child's mother is HIV positive, deceased, or her status is unknown.
- Biological sibling/s
- Sexual and needle sharing partners if elicited in the history taking

Approaches to index testing services

Index testing can be delivered by many approaches, including client (or patient) referral and provider-assisted referral. Client-centred counselling should be used to assist the index client to determine which approach is best for each named partner. Clients may choose different approaches for different partners. Ensuring client consent, confidentiality and safety are critical. According to WHO terminology and definitions:

- In **Client referral** (also called passive referral), a trained provider encourages HIV-positive clients to voluntarily disclose their status to their sexual and/or drug-injecting partners and encourages their partner to get tested. HIV-positive clients may also inform their partner(s) through anonymous means, such as web-based messaging services (emails, web-based applications, etc.), if they do not want to disclose their identity.
- **Provider-assisted referral** consists of three sub types:

- **Provider referral:** Counsellor or other healthcare provider calls or visits the index client's partner(s) and recommends that they test for HIV.
- **Contract referral:** Index client and counsellor work together to refer index client's partner(s). They agree on a time (e.g., within 14 days) in which the client will tell partner(s). If client does not tell within agreed time, counsellor contacts partner(s).
- **Dual referral:** Counsellor/provider sits with index client and partner(s) to support index client in telling partner(s) about HIV status (if they choose to disclose); or provides a safe space for testing together.

Implementing quality and ethical index testing services

The following section provides detailed information about the where, who, to whom, how and what of ITS.

Table 9.5 - Summary of index testing services

Where should ITS be offered	To whom should ITS be offered	Who can offer ITS
HCTC confirmatory sites)	All newly diagnosed HIV-positive individuals including children <19 years	HCTS counsellor
ART/Link ART Centre	• All ART clients (including children <19 years) who have not been offered ITS at the ICTC • All ART clients (including children <19 years) with an unsuppressed viral load • All ART clients reporting a change in relationship • All ART clients returning to care after treatment interruption (LTFU) • All ART clients with an incomplete 'family tree' status documentation • For PLHIV with an unsuppressed viral load • At least bi-annually as a part of HIV treatment services for discordant couple	Counsellor, staff nurse, care coordinator
Care and Support Centre (CSC)	All PLHIV registered at CSC who have never undergone index testing	Peer counsellor or outreach worker
Sampooran Suraksha Kendra (SSK)	• All PLHIV registered in the SSK who have never undergone index testing • All at-risk negative clients who turned out positive on subsequent visit	Master counsellor, peer counsellor, SSK manager or outreach worker, as applicable
One Stop Centre (OSC)	All active HRG PLHIV registered in the OSC who have never undergone index testing	Master counsellor, peer counsellor or outreach worker, as applicable

Targeted Intervention	All active HRG PLHIVs registered in the TIs who have never undergone index testing	Counsellor, outreach worker, peer educator/peer navigator as applicable
OST/satellite OST Centre	All HIV-positive PWIDs, not offered ITS at any of the other facilities	Counsellor, nurse, outreach worker, peer educator/peer navigator as applicable
Mobile Outreach	All PLHIV from hard-to-reach areas or who could not reach any of the above facilities (not offered or not opted for ITS at any facility).	Outreach worker or peer educator/peer navigator

Notes:

i. Children without an ongoing or new HIV exposure do not need re-testing if status is known.

ii. To avoid duplication, all the KP PLHIVs registered with TI/OST/SSK/OSC programme may be referred to the concerned facility to avail ITS.

Core Principles of Index Testing Services

The WHO 5 Cs (Consent, Confidentiality, Counselling, Correct test result and Connection to treatment services) are principles that apply to all HCTS including ITS.

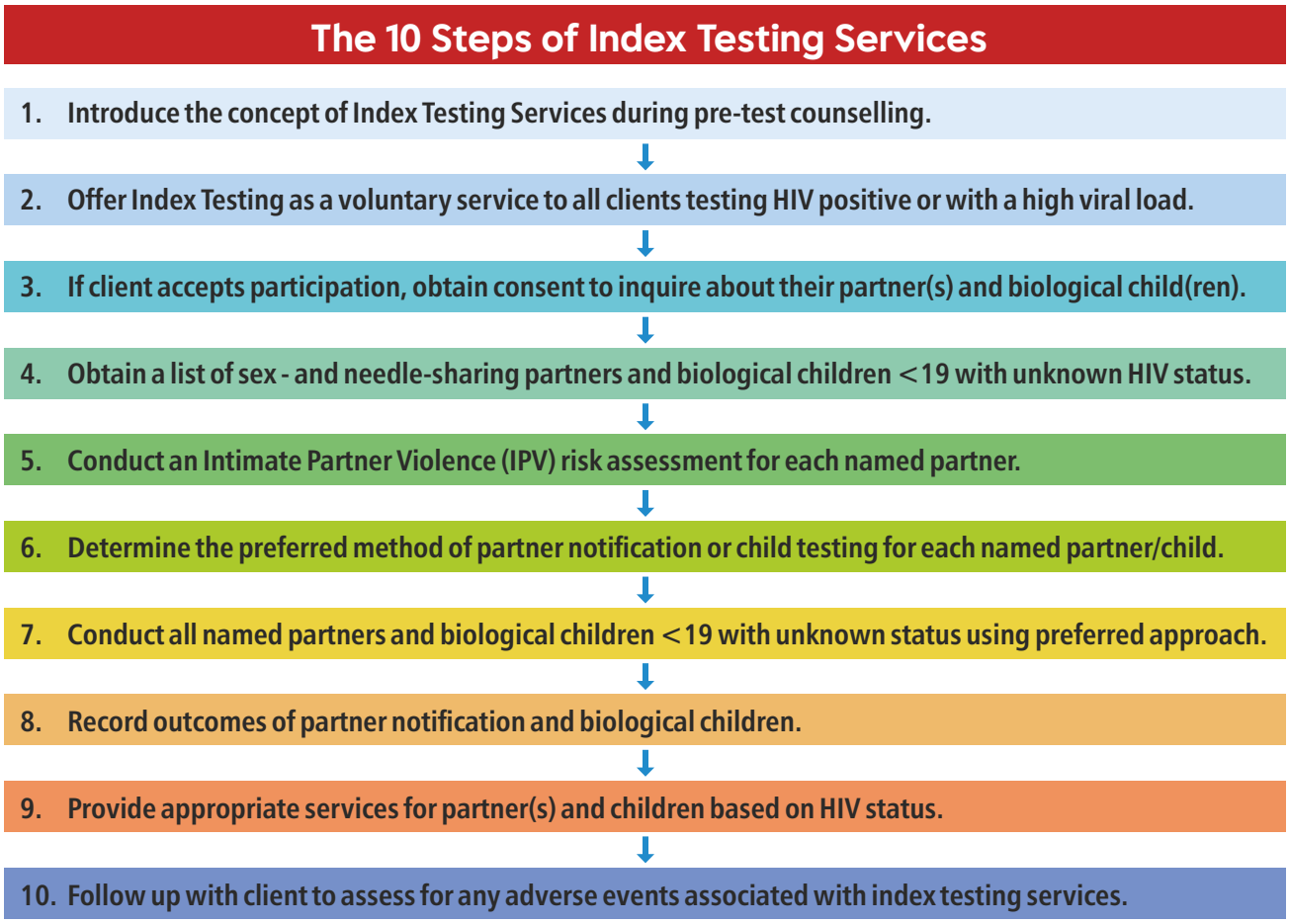
- **Consent:** Clients must provide their informed consent before HIV testing; coerced testing is never appropriate, regardless of where the coercion comes from. If found HIV positive, a second informed consent is to be obtained for participation in Index Testing services before moving ahead. No pressure should ever be placed on anyone being tested for HIV to disclose their partners if they choose not to. Clients may opt out of Index Testing services for any reason, and for no reason at all, at any time and not limited to fear of Intimate Partner Violence (IPV) with no impact to their receipt of HIV prevention, care and treatment services.
- **Confidentiality:** Index testing services must be confidential; the name of the index client should never be shared with the partner and the partner's HIV status should never be shared with the index client (unless consent is obtained from both parties). Programmes should have standard operating procedures (SOPs) such as protection of personally identifiable data, access to data and secure storage space in place to protect the confidentiality of both the index clients and their partner(s) and children. Confidentiality of index client and all named partners and children must be maintained at all times.
- **Counselling:** Index testing services must include appropriate and high-quality pre-test information and post-test counselling. These counselling messages should include discussion on the benefits and risks of ensuring that all partners and biological children of HIV-positive individuals receive an HIV test.
- **Correct test results:** Index testing must be performed according to National Counselling and Testing guidelines, testing strategies, norms, and standards including communication of the correct result.

- **Connection:** Connection or referral to treatment services for newly diagnosed HIV-positive partner(s) and children and to HIV prevention services for HIV-negative partner(s) and children must be supported by index testing programme through concrete and well-resourced patient referral, support, and/or tracking systems.

All index testing services must be client-centred and focused, confidential, voluntary and non-coercive, free of cost, non-judgemental, culturally/linguistically appropriate, accessible, available to all and comprehensive and integrative.

How to provide Index Testing Services ?

Figure 9.1 - 10 Steps of Index Testing Services



Intimate Partner Violence (IPV) risk assessment is done to ensure no harm comes to the index client, their partner (s) or family members as a result of participating in ITS. IPV assessment should rule out any form of physical, emotional or sexual violence by the partner.

If client discloses violence:

- Index testing should not be carried out if the client has high risk of IPV or does not feel comfortable with any of the notification approaches. All decisions about partner notification should ultimately be up to the client. At the same time as first line of response the client could be informed about how they could protect themselves from potential violence. The WHO defined "first-line support" using the acronym "LIVES" should be followed wherever possible (Listen, Inquire, Validate, Enhance Safety and Support Through Referrals).

The repeat Index Testing Services may be offered to the Index Case after certain time period which is mutually agreed upon and noted for follow up.

Key Messages

- Risk assessment: Ask explicit questions about sexual practices, drug-using practices, occupational practices, receipt of blood products, organs or donor semen. It is very important how counsellors ask the questions. Preferably open-ended questions should be asked first, followed by specific questions. E.g."What made you come to us today?" Then after listening to the narration, ask "How long have you had this symptom/ problem?"Again if you need details, ask "Can you please tell me more about this?".
- Preferably, the pattern of asking questions should be as follows:
  - Introduce topic: "The symptoms you mention are often related to sexual behaviour. So I will now ask you some questions about this. I request you to be truthful so that I can help you. What you say to me is only known to me and the doctor."
  - Broad and specific question:"Have you ever had anal sex?"
  - More specific but open-ended question: "Please tell me when and with whom."
  - Some clients tells too many things that may not be relevant for risk assessment but you may get important information through it. E.g. Who are all staying with the client? What is his/her support system? Note down all such important details which may be useful later.

  It is also a skill of the counsellor to bring back the client to the topic if they are sharing too many details.
- Refer to the questions in the risk assessment tool and ensure that all information is collected. Counsellors will have to ask multiple sub questions to get the answers for the questions in the risk assessment tool. Clients may not disclose everything in the first session. Continue to maintain rapport so that they may disclose it in a while or perhaps in the next session. So, counsellors will have to keep on updating the client's details.
- Remember, following persons are at high risk:
  - Multiple partners/more than one partner;
  - High-risk sexual behaviour – high frequency of unprotected sexual intercourse, anal sex;
  - Women, all groups covered under TI;
  - Girls, if they have started their sexual activity early i.e., before 18 years of age.
- Pre-test counselling is the first contact of the client with the counsellor. So, establish rapport and trust. Assure confidentiality. Remember to use counselling skills while talking with the client. Only then the clients may feel like disclosing personal information. Listen to the story of the client. This may help counsellors to know the reasons for HIV infection and the vulnerability factors of the client.
- One of the objectives of pre-test counselling is to prepare the client for the possible test report.
- Post-test counselling is provided after HIV testing to help the individual understand the diagnosis and implications of the result. It also helps the individual cope with the HIV test result. The counsellor assesses the mental health of the client and supports the client until they understand and accept the result. Managing emotional responses after disclosure is important.

- Partner disclosure and testing: Assess whether the client is stable. If yes, talk about disclosure. Offer support. Discuss the challenges. If the client finds it difficult, rehearse on doing it. If the client still needs support, ask him/her to come with the partner. Then counsellor can disclose it in front of the client. Manage the emotions and reactions of partners too. Then advise for partner testing when you feel that they are ready. This readiness assessment is important at various stages of pre- and post-test counselling.
- Index testing is a very sensitive issue. A client may not be ready due to several reasons like fear of disclosure, rejection from the partner and possible violence from the partner. Counsellors need to understand the client's perception of this. They might be thinking that their life has become complicated after HIV diagnosis. It is quite stressful and burdensome. By doing partner testing, they may not want to complicate it further. So, counsellors should play an important role in addressing these issues. Explain how testing will help the client in the life ahead.
- Strict adherence to 5Cs (Consent, Confidentiality, Counselling, Correct test results and Connection to prevention/treatment).

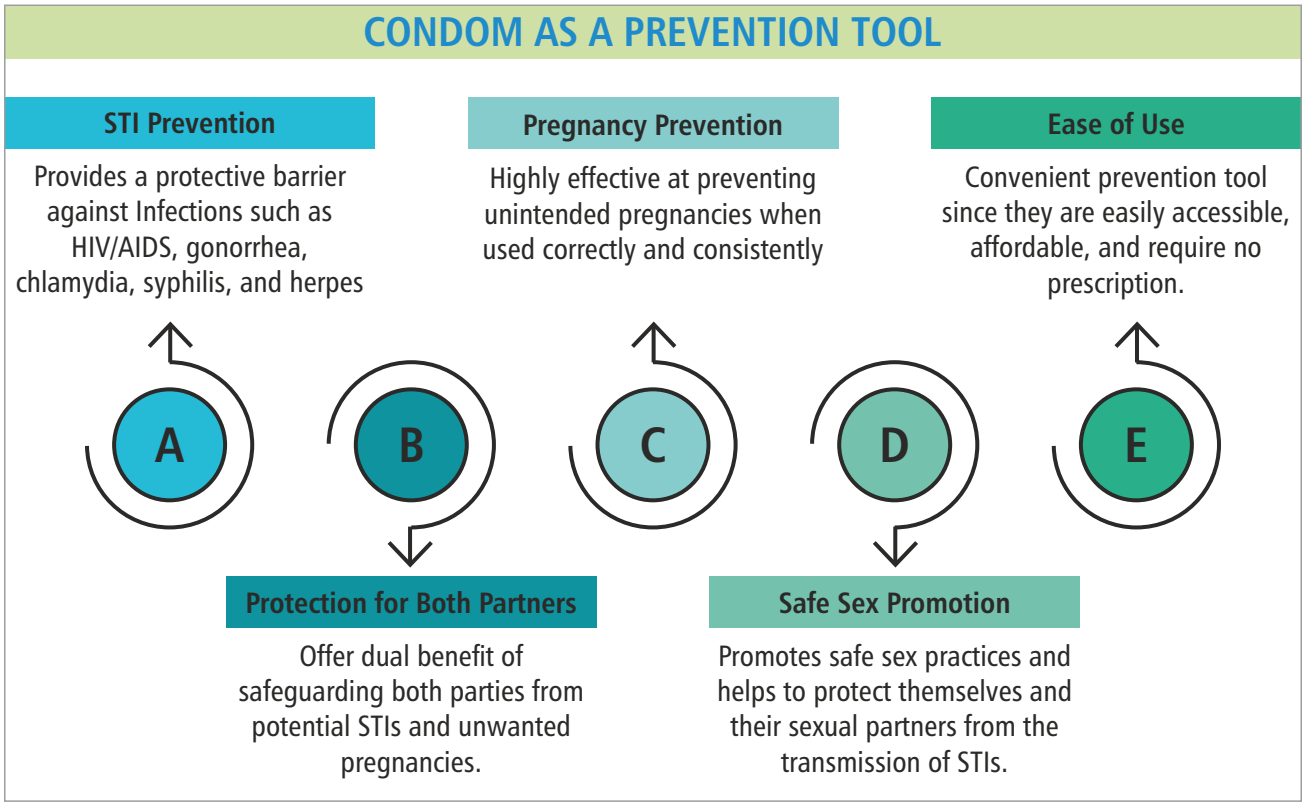
References

- *HIV Counseling and Testing Services, (2016), NACO*
- *Index Testing Services SOP, (2020), NACO*
- *National Guidelines for HIV care and treatment, (2021)*
- *Sampoorna Suraksha Strategy, Operational Guidelines (2nd Cut), (2023), NACO*

10 Condom Use

A condom is a widely used prevention tool in sexual health. It is a type of barrier contraceptive that helps reduce the risk of HIV, sexually transmitted infections (STIs) and unintended pregnancies. It gives protection to both the partners .

Figure 10.1 - Condom as prevention tool



Note: *It is important to note that while condoms are highly effective, they are not 100% fool-proof. They can break or slip if not used correctly or if they are past their expiration date. However, when used consistently and properly, condoms are considered one of the most reliable and accessible prevention tools available for sexual health.*

Risk Reduction Method

There are many effective methods for reducing the risk of HIV transmission through sex. The most widely known strategies for the prevention of HIV transmission through the sexual route are often known as the **ABC rules**:

- **A** stands for abstinence, which means refraining from premarital sexual intercourse.
- **B** stands for 'Be faithful', which means maintaining faithful relationships with a long-term partner.
- **C** stands for 'Condom use', which means correct and consistent use of condoms in sexual intercourse.

Non-penetrative Sex

Some people may choose to have non-penetrative sexual contact instead of penetrative intercourse (oral, anal or vaginal). Non-penetrative sexual practices constitute an alternative way to satisfy sexual needs without being at risk of HIV infection. These alternative practices to sexual intercourse include hugging, kissing, massaging, rubbing or other romantic touches and masturbation, which are all considered to have an extremely low risk of transmitting HIV infection.

This is because HIV is not transmitted from skin-to-skin contact. Only the relatively thin tissues in a person's rectum and vagina are vulnerable to HIV, and even then, they would have to be directly exposed to the wet blood or sexual fluids of an HIV-positive person who does not have an undetectable viral load. Non-penetrative sex, where the penis does not enter the vagina, anus or mouth, and when penetrative sex toys are not shared, is a safer sex method that greatly decreases the risk of getting infected with HIV (however it must be remembered that non-penetrative sex may be 'low risk' but it is not 'no risk'). It still may be a risk factor for the transmission of other sexually transmitted diseases.

Overview of condoms

A condom is a sheath-shaped barrier device used during sexual intercourse to reduce the probability of pregnancy or an STI. Condoms are the only type of contraception that can both prevent pregnancy and protect against HIV and other STIs.There are two types of condoms:

External condoms, worn on the penis, also called the male condoms.

Figure 10.2 - Male Condom

Wallet Pack (Frontside) | Wallet Pack (Backside)

Female condoms (femidom) worn inside the vagina

Female condoms allow a woman to be able to choose an effective means of protection for herself against STIs and HIV, without even asking her partner's opinion. The female condom is made of polyurethane, which eliminates allergy problems connected with latex and it can be put in place at any time.

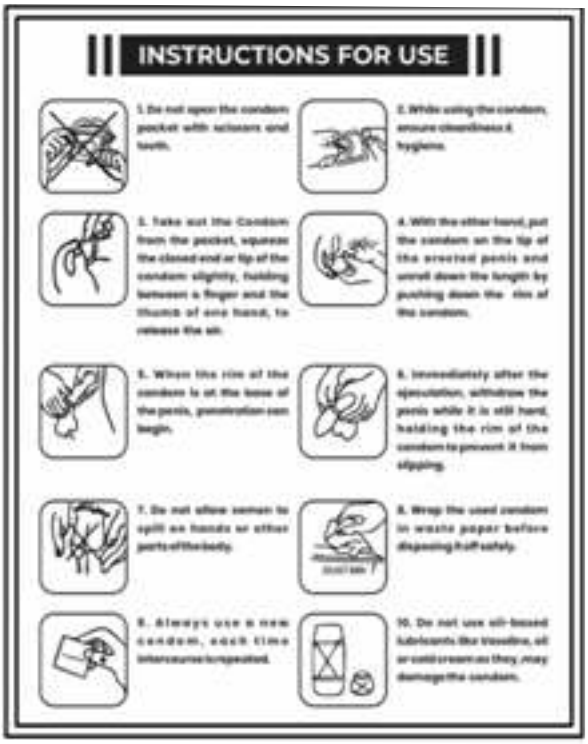
Figure 10.3 - Female Condom

- Condoms are the only type of contraception that can both prevent pregnancy and protect against HIV and other STIs.
- Female condoms allow a woman to be able to choose an effective means of protection for herself against STIs and HIV, without even asking her partner's opinion.
- The female condom is made of polyurethane, which eliminates allergy problems connected with latex and it can be put in place at any time.

Condoms come lubricated to make them easier to use, but one may also like to use additional lubricant (lube). This is particularly advised for anal sex to reduce the chance of condom splitting.

Table 10.1 - Instructions of using male and female condom

Instructions for using male condom	Instructions for using female condom
Take the condom out of the packet, being careful not to tear/damage it with jewellery or fingernails. Do not open the packet with your teeth.	Put yourself in a comfortable position, either lying, sitting or standing with one foot resting on a chair. Open the individual female condom pack and take it out carefully, especially be careful not to damage the lining if you are wearing jewellery or have long nails.
Place the condom over the tip of the erect penis. If there is air in the teat (end) of the condom, use your thumb and forefinger to squeeze the air out of it.	Make sure that the inner ring is at the bottom of the condom. Hold the female condom by this ring by squeezing it with your thumb and index finger. Insert the ring inside the vagina and push it in as far as possible.

Gently roll the condom down to the base of the penis.	Next, place your index finger inside the female condom and push the femidom to the back of the vagina by pushing on the ring. When the femidom is in place, the external ring must be outside the vagina.
After sex, take out the penis while it is still erect: hold the condom at the base of the penis while you take the penis out. Remove the condom from the penis, careful not to spill semen.	To remove the female condom, turn the external ring to close the opening completely and to stop the sperm from pouring out. Now pull it gently.
Tie up the condom and throw it away in a bin, not down the toilet. Make sure your penis does not touch your partner's genital area again.	Put the used femidom back in its pack and throw it in the bin. Do not throw it down the toilet.
If you have sex again, use a new condom.	If you have sex again, use a new condom.
	

Use of lubricants

Only water-based lubricants are recommended for use with condoms. To use a water-based lubricant with a condom, simply apply a small amount to the outside of the condom once it is already in place. Avoid using excessive amounts, as this can reduce the effectiveness of the condom or create a slippery sensation that may interfere with sexual activity. The use of lubricants is recommended for several reasons like compatibility with latex, reducing friction, easy to clean and safe.

What to do if a condom breaks

It is very rare for a condom to break when it is used properly. However, take the following measures if the condom breaks:

- Withdraw the penis immediately.
- Remove as much semen as you can.
- Gently wash the outside of your genitals: avoid washing inside your vagina or anus (douching); if you were having vaginal sex, go to the bathroom and urinate to flush away any semen.
- If you were not using any other contraceptive to prevent pregnancy,you may need to access emergency contraception within 72 hours to prevent pregnancy.
- If you were having oral sex, spit out any semen and rinse your mouth with water.
- The person should be assessed for eligibility of non-occupational post-exposure prophylaxis (PEP).

Myths and Misconceptions

Many people have incorrect information about condoms, which is not true and which should be corrected to continue using condoms as a safer sexual practice. Some myths and misconceptions which counsellors should address are as follows:

Table 10.2 - Condom myths and misconceptions

Condoms are unreliable and can break or slip off easily.	Sex does not feel as good with a condom.
Two condoms are better than one.	Female condoms are reusable.
Female condoms can get lost inside the women's body.	Condoms are indicative of sexual promiscuity by people who use them.
Condoms do not fit.	Condoms are only for penises.

Availability and accessibility of condoms

- Under the NACP's Targeted Intervention (TI) projects, condoms are made freely available for use among the HRG individuals.
- Condoms are also available and easily accessible at/with
  a) Family planning clinics
  b) Primary health centres/community health centres/district hospitals
  c) Sampoorna Suraksha Kendras, ICTC, DSRC, One-stop centres, opioid substitution therapy (OST) centres and ART clinics
  d) NGOs and CBOs working on sexual health, etc.
  e) Medical stores/Pharmacies/Vending machines/Non-traditional outlets
  f) Frontline health workers like the ASHAs and ANMs
- Condom social marketing (CSM) is a type of intervention in which condom brands are developed, marketed with a promotional campaign and sold to a specific target population. This is an innovative approach at field level to increase condom availability and use; other approaches include public, free and private distribution of condoms.
- CSM can help communities overcome social and cultural resistance to practising effective prevention of HIV and other STIs.

Barriers to condom use

Some common barriers to condom use include

- Lack of knowledge
- Misconceptions and myths
- Stigma and social norms
- Accessibility
- Partner disapproval
- Lack of negotiation skills
- Substance abuse

It is important to address these barriers through education programmes, promoting condom accessibility and destigmatizing condom use to encourage widespread and consistent use for safer sexual practices.

Condom negotiation

There can be negotiations between an FSW and her clients on using condoms. For successful negotiation, the following points are essential:

- Communication is the backbone of negotiation. The way you communicate decides the impact of the negotiation.
- It involves identifying non-verbal cues, using the right words and expressing your thoughts in a compelling and engaging way.
- Often, negotiators are active listeners that help them understand the message from another person.
- Negotiation is not about what you say; it is more about how you say it. Therefore, it is imperative to speak confidently to make the person believe that your solution is beneficial.

How to say NO to unsafe sex?

There are five steps during condom use negotiation that will help say NO to sex without condoms in ways that work:

- Say NO! Use the word. Say it in a firm tone of voice.
- Use actions and body language that support the NO message.
- Repeat. One may need to say NO more than once.
- Suggest an alternative. Offer something that is safer and healthier to do instead, if this is someone you still want a relationship with.

Be sure your words and actions are real for the situation and are likely to work with the sexual partner concerned.

Key Messages

- Condom is a barrier against infections such as HIV/AIDS and STIs. It helps to prevent pregnancy.
- Regardless of gender, condoms offer protection to both sexual partners. They can be used for a variety of sexual activities, including oral, anal and vaginal sex.
- Only water-based lubricants are recommended for use with condoms. They are

hypoallergenic, less prone to irritate or trigger allergic reactions and simple to remove from the body and sex toys due to their water solubility.

- Condoms are easily available at government health centres, family planning clinics, OSC and OST centres, SSKs, medical stores, ASHAs and ANMs, NGOs and CBOs working on sexual health.
- Condoms should be kept in a cool, dry place at room temperature, typically at 20–25 degrees and away from sharp objects.

Important points to be discussed in counselling

It is important that the counsellors are comfortable in talking about condoms and demonstrating.

Table 10.3 - Key points for the counsellors to explain condom usage to their clients

- Motivate the client to use a condom every time they have sex with anyone.
- Only correct and consistent use condom can keep a person safe from HIV/AIDS/STI.
- Clarify the myths and misconceptions around condom usage.
- It is very rare for a condom to break when it is used properly; but if it does split, break or something else goes wrong like the condom slips off, there are some simple things that can be done:
  - Withdraw the penis immediately.
  - Remove as much semen as you can.
  - Gently wash the outside of your genitals: avoid washing inside your vagina or anus (douching) as this can spread the infection further or cause irritation.
  - If you were having vaginal sex, go to the bathroom and pee to flush away any semen.
  - If you were not using any other contraceptive to prevent pregnancy, you may need to access emergency contraception to prevent pregnancy. This should be done within 72 hours of having sex.
  - If you were having oral sex, spit out any semen (or swallow it) and rinse your mouth with water.
  - Contact a doctor for assessment for eligibility of non-occupational PEP.
- Build the skill of condom use: teach the client how to wear a condom and ask them to repeat the process to check their learning.
- Tell them about the places where condoms are available and accessible.
- Provide the condoms, if available.
- Remind them that every time they choose not to use a condom, they increase their risk of contracting HIV and other STIs.

- Barriers in accepting the condoms - There are barriers that may make it difficult for some people to use condoms regularly or at all. Individual circumstances, cultural values and societal influences can all influence these barriers in different ways.

How to address the barriers: Identify the barriers. Counsel while considering the issues.

- There may be some myths. Discuss the same. For example, there is a myth that condoms are used while having sex with a sex worker or outside the marriage and it is not used among married couples/in stable relationships. Address this myth. There is another myth that condom should not be used while expressing true love. There should not be any barrier. But it may be explained to the client that love can be expressed by caring for each other.

a) Lack of knowledge: Many people may not have accurate information about the benefits of condom use and how to use them effectively.

b) Stigma and social norms: Condom use may be seen as a sign of promiscuity or a lack of trust in a partner, leading to a reluctance to use them. Some people feel shy to buy condoms. Guide them on condom availability.

c) Accessibility: If there is limited access to condoms, particularly in low-income or rural areas, guide them on condom availability.

d) Partner disapproval: This is one of the most important reasons for not using condoms. Fear of rejection, negative reactions or accusations of infidelity from partners can contribute to a reluctance to use condoms.

e) Counsellor should discuss this point in detail. Discuss various strategies to convince the partner e.g., it is advised for better health, to avoid pregnancy etc. Offer partner counselling.

f) Lack of negotiation skills: Some individuals may feel uncomfortable discussing condom use with their partner or may lack the communication skills necessary to negotiate condom use effectively. Gender plays a vital role in sex. Women, persons from HRGs are vulnerable because they do not have power in sexual relations. It is a common practice that the decisions are taken by men. So, empowerment of the clients should be the goal of counselling. Also, advocacy with men should be done.

g) Another important point to remember is that many individuals, though they have sex, do not openly discuss about it. They do not communicate their concerns, likes, dislikes, etc. So, encourage clients to have an open dialogue about it with their partners and convince them for condom use.

h) Substance abuse: Alcohol or drug use can impair judgment and decision-making abilities, leading to a decreased likelihood of using condoms during sexual encounters. Make the clients aware of this and ask to take due precautions.

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11 Screening and Management of Sexually Transmitted Infections and Reproductive Tract Infections

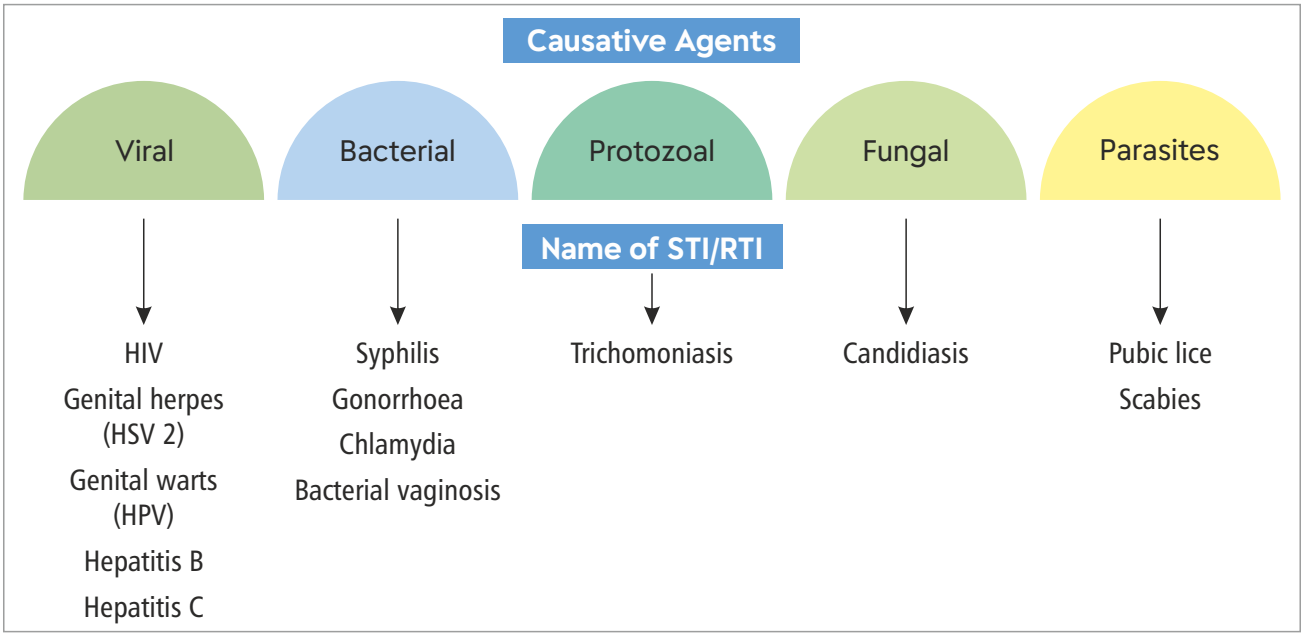
What is STI and RTI?

Table 11.1 - What is STI and RTI

Sexually Transmitted Infection (STI)	Reproductive Tract Infection (RTI)
• STI spread primarily through person-to-person sexual contact. • Most of the STIs can also be transmitted from an infective mother to her infant during pregnancy, atlabour and through blood products and tissue transfer. • It is very common to have STI and not have any symptom. More than 50% of cases of all STIs may be asymptomatic (without any symptom). • Therefore, absence of signs/symptoms does not guarantee that a person is free from STI. • A person may be infected with more than one STI at a time. • HIV can also be transmitted through sexual route and is an STI.	• RTI is any infection of the reproductive tract. • In women, it includes the infection of vagina, cervix, uterus, fallopian tubes and/or in ovaries. • In men, it may involve testes, scrotum and/or prostate but may also involve external genitalia. • Some RTI are caused in the same way as STI. But RTI could also be caused by overgrowth of normal organisms in the reproductive system (e.g.,bacterial vaginosis) or they could be infections caused by improper medical procedures such as catheterization, termination of pregnancy or IUD insertion. • Practices like douching, multiple sexual partners and inconsistent condom use are also associated with increased risk of RTI.
Not all reproductive tract infections are sexually transmitted, and not all sexually transmitted infections are located in the reproductive tract.	
The term 'sexually transmitted infection' is usually used in place of STD (sexually transmitted diseases) to indicate that infections do not always result in a disease. However, all cases of STIs are important.	

Epidemiology of STI/RTI

India has an estimated annual STI prevalence of 6% among the adult population. This would amount to around 33 million STI episodes in the current scenario.Women living with HIV are more likely to develop persistent HPV infections with multiple high-risk HPV types at an earlier age. They also have a more rapid progression to pre-cancer and cancer and four to five times greater risk of developing cervical cancer than women who are not living with HIV.



Signs, Symptoms and Syndromes of STI/RTI

- A symptom is what a client/patient complainsabout or reports to a doctor or a counsellor.
- A sign is the observation of a doctor or a counsellor on examination of a client/ patient.
- A syndrome refers to a set of medical signs and symptoms that are correlated with each other and often associated with a particular disease or disorder.

Asymptomatic patient: A person who shows no symptoms but still has an infection is called asymptomatic. Even when asymptomatic, their health may become worse, and they can transmit the infection to another person, such as their sexual partner or to the unborn child in the case of a woman. They require to be diagnosed and treated timely.

Table 11.2 - Signs and Symptoms of STI/RTI in Men, Women and Transgender persons

Anatomical Part	Symptom
Oral (With history of oral sex)	• Blisters or ulcers in mouth, tongue and lips • Sore throat • Voice changes, difficulty in speaking or shortness of breath
Male Genitalia	• Urethral Discharge • Burning/pain during urination • Increased frequency of urination • Genital itching • Swelling in groin area/scrotal swelling • Blisters or ulcers on the penis, foreskin, urethral meatus and urethra • Genital warts
Female Genitalia	• Unusual discharge from vagina • Abnormal or heavy vaginal bleeding • Genital itching

	• Pain while having sex (dyspareunia) • Lower abdominal pain (below belly button/ pelvic pain) • Blisters or ulcers on internal/external genitals • Genital warts
Anal/peri-anal area	• Anal discharge (with history of receptive anal sex) • Blisters or ulcers on anus or surrounding area • Pain while passing stools • Anal or peri-anal itching • Anal/peri-anal warts
Generalized symptoms/ presentation	• Fever, body ache, muscle pain, dark-coloured urine,infertility

Note:

- *The signs, symptoms and syndromes of STI/RTI among transgender persons correspond to their current anatomy and physiology as well as their engagement in risky behaviour.*
- *Adequate history taking is important to understand the symptoms of transgender persons. The history should involve the sexual behaviour as well as the details of the gender affirmation procedures.*

Relationship between STI and HIV infection

The predominant mode of transmission of both HIV infection and other STIs is the sexual route.The presence of STIs increases the risk of HIV transmission and acquisition in sexual exposure. There could be a 2–9-fold increased chance of HIV transmission in the presence of genital ulcer and a 2–5fold increase in the presence of genital discharge. Management of STIs reduces HIV transmission.

Concurrent HIV infection alters the natural history and manifestations of STIs.STIs are a marker for high-risk behaviour that could also lead to HIV infection.STI/RTI in HIV-positive people can increase viral load and shedding of virus in genital fluids.A higher viral load increases the efficiency of HIV transmission risk to others.Sexually active PLHIV are also at risk for STIs, and they will have to be screened for STI/RTI regularly.

Syndromic Case Management (SCM)

Syndromic case management of STI/RTI is a public health approach to treatment. In this approach, the healthcare provider uses the symptoms reported by the patient as well as the signs that he/she observes during the physical and internal examinations to identify the syndrome affecting the patient and gives treatments for all infections (if not the most common ones) that could possibly cause that particular syndrome.

The syndromic approach has been considered as the backbone of these services at the designated STI/RTI clinics (DSRCs)alongwith optimum utilization of available on-site diagnostics facilities without delaying the prompt treatment of patients.

Advantages of Syndromic Case Management	Limitations of Syndromic Case Management
• Prompt treatment: Patient is diagnosed and treated in one visit. • Highly effective for selected syndromes • Relatively inexpensive since it avoids the use of laboratory tests • Scientifically tested • Easy to learn and practise • Easy integration into primary healthcare systems • Standardized treatment regimens	• Not useful in asymptomatic patients • Over treatment if a patient has only one STI that causes a syndrome • Increases chances for the development of antibiotic resistance

STI/RTI syndromes

1. Urethral Discharge
2. Vagino-cervical Discharge
3. Genital Ulcer Disease – Non-Herpetic
4. Genital Ulcer Disease – Herpetic
5. Painful Scrotal Swelling
6. Inguinal Bubo
7. Lower abdomen Pain
8. Anorectal Discharge

Treatment kits

Treatment kits, containing various drugs, are prepared as per the clients' symptoms. After clinical examination and counselling, the kits are given to the clients. The kits are colour coded. Refer to Annexure for more details.

Table 11.3 – Important considerations for STI/RTI management

Important considerations for management of all STI/RTI
• Educate and counsel client and sexual partner/s regarding STI/RTI, safer sex practices and importance of taking complete treatment. • Sexually active PLHIV are also at risk for STI and they will have to be screened for STI/RTI regularly. • Treat partner/s. • Advise sexual abstinence or condom use during the course of treatment. • Provide condoms, educate about correct and consistent use. • Refer all patients to an integrated counselling and testing centre (ICTC) for HIV/STI counselling and testing. • Follow up after 7 days for all STI; 3rd, 7th and 14th day for lower abdominal pain (LAP); and 7th, 14th and 21st day for inguinal bubo (IB). • If symptoms persist, assess whether it is due to re-infection or treatment failure and advise prompt referral. • Consider immunization against Hepatitis B.

Syphilis

Table 11.4 - Key points about Syphilis

Syphilis	Key Points
Causative agent	Caused by the bacterial spirochete Treponema pallidum
Stages	**Primary Syphilis:** The infected person may present with a painless ulcer that may last up to 2 to 6 weeks and heal even without treatment. **Secondary Syphilis:** Skin rashes, fever, muscle pain, lasts 2–6 weeks. This stage may be followed by a **latent stage** for a few years. The stage is characterized with no signs and symptoms. The bacteria may circulate in blood during this phase leading to infection of all the organs in the body. **Tertiary Syphilis:** The stage occurs after several years of infection and can manifest as neurosyphilis (when brain/spinal cord is affected), cardiovascular syphilis (when heart and aorta are affected) or late benign syphilis (when the skin is primarily involved). The complications can develop in 40% of people with latent infection in absence of treatment.
Serological testing	Two types of tests: Treponemal (detect antibodies to T. pallidum proteins) and non-treponemal (detect antibodies against lipoidal antigens, damaged cells): • Treponemal tests: TPHA, TPPA • Non-treponemal tests: RPR, VDRL *Note: Both tests used for screening, confirming active infection or determining disease activity and treponemal tests can remain positive even in inactive or resolved cases.*
PoC/Rapid Tests	Many Point-of-Care (PoC) or rapid tests use treponemal tests for syphilis detection
Treatment	Syphilis can be successfully treated using injection Benzathine Penicillin or STI colour coded kit -3 or 4

Refer to the national EVTHS (Elimination of vertical transmission of HIV and Syphilis) guidelines for more information (Chapter 16 in handbook).

Coordination among Facilities and STI Services for Sex Workers, MSM, TS and TG, PWID

- Under the TI programme, linkages with DSRC for quarterly routine medical check-up (RMC) are highly promoted as part of the Differentiated Prevention Strategies.
- Camp-based approach is adapted for STI assessment and treatment at prioritized hotspots.

- TIs are currently providing referrals and linkages to various other facilities for the treatment of STI and Syphilis.
- Inter-referrals have been promoted between DSRC, SSKs, ART centres and TI programmes for STI, HIV and Syphilis testing and monitoring.

Clinical Management of STI/RTI in High-Risk Groups

Effective prevention and treatment of STI/RTI among these core groups requires attention to both symptomatic and asymptomatic infections and have the following two components:

Points	Component
Treatment of Symptomatic Infections	• As per the national syndromic case management guidelines
Screening and treatment of Asymptomatic Infections	• Regular medical check-ups should be conducted at least once every three months, where the healthcare provider (HCP) takes history and carries out a clinical examination including internal examination to detect presence of infection/s. • Presumptive treatment for asymptomatic gonococcal and chlamydial infections. This should be administered only to sex workers, MSM and TS/TG during their first clinic visit and should be repeated ONLY if there is no regular check-up for six months consecutively. • Biannual serologic screening for syphilis for sex workers, MSM, TS/TG and PWID.

Important points to consider

- Sex workers and MSM, TS&TG should be encouraged to attend the STI clinic for periodic routine health check-ups.
- During the visit, the clinic staff should take a detailed history and perform an examination.
- Regular medical check-up should include oral, rectal and genital examinations including proctoscopy for all those who have a history of receptive anal intercourse.
- All high-risk groups should be counselled at every opportunity (in the clinic and in the community) on the importance of using condoms.
- Service providers should be sensitive to the needs of the MSM, TS/TG population groups and be empathetic and non-judgemental while providing services.
- As part of the Differentiated Prevention Strategies of the TI programme, quarterly routine medical check-up (RMC) is highly promoted among the core groups and referred to DSRC and camp-based approach for STI in prioritized hotspots/populations for high-priority HRGs.

Key Messages

- Sexually transmitted infections (STIs) are spread primarily through person-to-person sexual contact. HIV and syphilis can be transmitted from an infective mother to her infant during pregnancy, atlabour (vertical transmission) and through blood products and tissue transfer.
- The term 'reproductive tract infection' (RTI) refers to any infection of the reproductive tract.
- The presence of STIs increases the risk of HIV transmission and acquisition in sexual exposure.
- The syndromic case management (SCM) approach has been considered as the backbone of the services at Designated STI RTI Clinics (DSRCs).
- Counselling plays a vital role in the management of STI /RTI..
- Women and STI- Women are more prone to get STI because of biological and social vulnerability.
- Partner management is needed to prevent STI reinfection and possible long-term effects of untreated STI for the partner.

  Clients need to feel convinced that
  - The benefits are greater than the possible problems.
  - Partner notification and treatment is needed even if the partner does not show any symptoms.
  - The partner will be provided with confidential STI treatment services.
- Under the TI programme, linkages with DSRC for quarterly routine medical check-up (RMC) are highly promoted as part of the Differentiated Prevention Strategies. For pregnant women, the national EVTHS guidelines can be referred for information and details.

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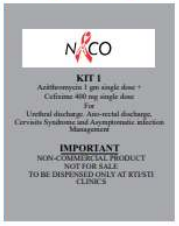
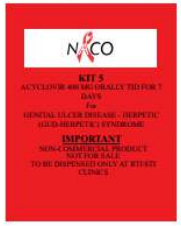
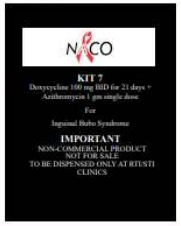
Annexure: RTI/ STI Syndromic Case management

Urethral discharge	Cervical discharge	Painful scrotal swelling	Vaginal discharge	Genital ulcer-non herpetic		Genital ulcer - herpetic	Lower abdominal pain (LAP)	Inguinal bubo (IB)
• Urethral discharge (Pus or muco-purulent) • Pain or burning while passing urine • Increased frequency of urination • Systemic symptoms like malaise, fever	• Nature and type of discharge (quantity, color and odor) • Burning while passing urine, increased frequency • Genital complaints by sexual partners • Low backache (Take menstrual history to rule out pregnancy)	• Swelling and pain in the scrotal region • Pain or burning while passing urine • Systemic symptoms like malaise, fever • History of urethral discharge	• Nature and type of discharge (quantity, color and odor) • Burning while passing urine, increased frequency • Genital complaints by sexual partners • Low backache (Take menstrual history to rule out pregnancy)	• Genital ulcer, single or multiple, painful or painless • Burning sensation in the genital area • Enlarged lymph nodes		• Genital ulcer or vesicles, single or multiple, painful recurrent • Burning sensation in the genital area	• Lower abdominal pain • Fever • Vaginal Discharge • Menstrual irregularities like heavy, irregular vaginal bleeding • Dysmenorrhoea, dysparenunia, dysuria, tenesmus • Lower backache • Cervical motion tenderness	• Swelling in inguinal region which may be painful • Preceding history of genital ulcer or discharge • Systemic symptoms like malaise, fever etc
Tab. Azithromycin 1 gm OD Stat + Tab, Cefixime 400 mg OD Stat	Tab. Azithromycin 1 gm OD Stat + Tab, Cefixime 400 mg OD Stat +	Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat	Tab. Secnidazole 2 g OD Stat + Cap. Fluconazole 150 mg OD Stat	Inj. Benzathine penicillin (2.4 MI-I) - 1 vial Tab. Azithromycin (1 gm) - Single dose	**If allergic to Inj. Penicillin:** Doxycycline 100 MG (Bid for 15 days) Azithromycin 1GM (Single dose)	Tab. Acyclovir 400 mg TDS for 7 days	Tab. Cefixime 400 mg OD stat + Tab. Metronidazole 400 mg BDX 14 days + Doxycycline 100 mg BD X 14 days	Tab. Azithromycin 1 gm OD Stat + Tab. Doxycycline 100 mg BD for 21 days
Kit 1/Grey	**Kit 1/Grey**	**Kit 1/Grey**	**Kit 2/Green**	**Kit 3/White**	**Kit 4/Blue**	**Kit 5/Red**	**Kit 6/Yellow**	**Kit 7/Black**
								
Treat all recent partners	**Treat partners when symptomatic**	**Treat all recent partners**	**Treat partners when symptomatic**	**Treat all sexual partners for past 3 months**		**No partner treatment**	**Treat male partners with Kit 1**	**Treat all sexual partners for past 3 weeks**

12 Post-Exposure Prophylaxis, Universal Work Precautions and Pre-Exposure Prophylaxis

Post-Exposure Prophylaxis

Post-Exposure Prophylaxis (PEP) for HIV refers to comprehensive management instituted to prevent the transmission of HIV following a potential exposure. The potential exposure for HIV can be broadly categorized as occupational or non-occupational.

Occupational Exposure

Occupations exposure refers to exposure to blood-borne infections (HIV, Hepatitis B & C) during performance of job responsibility in workspaces. Healthcare providers are prone to accidental exposure to blood and other body fluids or tissues while performing their work duties. Standard workplace precautions are likely to mitigate the occupational risk of blood-borne pathogens like HCV, HBV, HIV in healthcare personnel.

Health Care Personnel

Healthcare personnel (HCP)are defined as people, paid or unpaid, working in healthcare settings who are potentially exposed to infectious materials (e.g., blood, tissue and specific body fluids and medical supplies, equipment or environmental surfaces contaminated with these substances). Occupational exposure includes percutaneous injury (with needlestick or cut with a sharp instrument), contact with mucous membranes of mouth/eyes and non-intact skin (chapped skin or dermatitis) with blood and body fluids of a HIV-infected person.

Non-occupational exposure

Non-occupational exposure refers to exposure to blood-borne infections (HIV, Hepatitis B & C) outside occupational settings. This includes unsafe sexual exposures and sexual assault.

Risk of exposure from different body fluids

Exposure to body fluids considered 'at risk'	Exposure to body fluids is considered 'not at risk' unless these fluids contain visible blood
Blood, semen, vaginal secretions, cerebrospinal fluid, synovial, pleural, peritoneal, pericardial fluid, amniotic fluid Other body fluids contaminated with visible blood	Tears, sweat, urine and faeces, saliva, sputum, vomitus *Note: Unless these secretions contain visible blood*

Any direct contact (i.e., contact without barrier protection) to the concentrated virus in a research laboratory requires clinical evaluation. Transmission of HIV infection after human bites has been rarely reported.

Average Risk of Acquiring HIV, Hepatitis B, Hepatitis C after Occupational Exposure

The average risk of acquiring HIV infection following different types of occupational exposure is low compared to the risk of acquiring infection with HBV or HCV. In terms of occupational exposure, the important routes are needlestick exposure (0.3 % risk for HIV, 9–30% for HBV, and 1–1.8% for HCV) and mucous membrane exposure (0.09% for HIV).

Standard Workplace Precautions (SWP)

Universal precautions mean control measures that prevent exposure to or reduce the risk of transmission of blood-borne pathogenic agents (including HIV) and include education, training, use of personal protective equipment such as gloves, gowns and masks, hand washing practices and employing safe work practices.These include the following:

- Handwashing before and after all medical procedures;
- Safe handling and immediate safe disposal of sharps: avoid recapping of needles; use special containers for sharps disposals; use needle cutter/destroyers; use forceps instead of fingers for guiding sutures; use vacutainers where possible.
- Safe decontamination of instruments;
- Use of protective barriers whenever indicated to prevent direct contact with blood and body fluids such as gloves, masks, goggles, aprons and boots. Healthcare personnel with a cut or abrasion should cover the wound before providing care.
- Safe disposal of contaminated waste;
- Always use protective gear: consider all blood samples as potentially infectious.
- Follow universal precautions. Practise safe handling of sharp instruments. Use needle destroyers.

Standard of care for individuals exposed to HIV

PEP services should be provided for all occupational/non-occupational exposures. Written **informed** consent needs to be obtained for HIV testing from the person concerned. PEP should be taken in accordance with the national HIV counselling and testing guidelines. Everyone possibly exposed to HIV should be assessed by a trained healthcare worker assessing eligibility for PEP, examination of any wound and first-aid treatment.

Practices that influence risk and how to reduce risk of occupational exposure

- Certain work practices increase the risk of needlestick injury such asrecapping needles, transferring a body fluid between containers, handling and passing needles or sharps after use, failing to dispose of used needles properly in puncture-resistant sharps containers, poor healthcare waste management practices etc.
- Strict compliance with universal safety precautions will help the staff to stay safe.
- All hospital staff members must know whom to report to for PEP and where PEP drugs are available in case of occupational exposure.

Management of the Exposed Person

PEP includes first aid, counselling, risk assessment and relevant baseline laboratory investigations and depending on the risk assessment, the provision of short term (28 days) of antiretroviral drugs, with follow-up and support including maintaining confidentiality.

The first dose of PEP should be administered ideally within 2 hours (but certainly within the first 72 hours) of exposure and the risk evaluated as soon as possible. If the risk is insignificant, **PEP** could be discontinued if already commenced.

Management of Exposure Site–First Aid (in case of occupational exposures)

<table>
<tr><td colspan="2">

- Do not panic.
- PEP must be initiated as soon as possible, preferably within 2 hours of exposure.

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For skin: If the skin is pierced by a needle stick or sharp instrument

- Immediately wash the wound and surrounding skin with water and soap and rinse.
- Do not scrub.
- Do not use antiseptics or skin washes.
- Do not use bleach, chlorine, alcohol, betadine.
- Do not put pricked/cut finger in the mouth, a childhood reflex.

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For the eye

- Irrigate the exposed eye immediately with water or normal saline.
- Sit in a chair, tilt the 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.

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After a splash of blood or body fluids and for unbroken skin

- Wash the area immediately.
- Do not use antiseptics.

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For the 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.

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Establish Eligibility for PEP

The exposed individual should have confidential counselling and assessment by an experienced physician. The exposed individual should be assessed **for pre-existing HIV infection** as PEP isintended for people who are HIV negative at the time of their potential exposure to HIV. Exposed individuals who are known or discovered to be HIV positive should not receive PEP. They should be offered counselling and subsequently link to comprehensive HIV services. **Consult the designated physician of the institution for management of the exposure immediately.**

Counselling for PEP

For an informed consent, exposed persons (clients) should receive appropriate information about what PEP is and the risks and benefits of PEP. It should be made clear that PEP is not mandatory. The client should understand details of the window period, baseline test, drugs that are used, their safety and efficacy and issues related to these drugs during pregnancy and breastfeeding. He/ she should be counselled on safe sexual practices.

Psychological support: Many people feel anxious after exposure. Every exposed person needs to be informed about the risks and the measures that can be taken. This will help to relieve part of the anxiety, but some may require further specialized psychological support.

Considerations for non-occupational exposures

In cases of sexual assault, PEP should be given to the exposed person as a part of the overall package of post-sexual assault care. The cases of unsafe risky sexual exposures should be evaluated for eligibility of PEP and can be advised PEP if eligible. The cases should be evaluated for STI and managed according to the national STI algorithms. For children who have suffered assault must be administered PEP, the dosage should be as per age and weight bands and haemoglobin levels. In all cases, appropriate and adequate counselling must be provided regarding possible side effects, adherence and follow-up protocol.

The victims of sexual assault should additionally receive the following services:

- Emergency contraception for non-pregnant women;
- Tetanus toxoid for any physical injury of skin or mucous membranes;
- Referral to appropriate authority.

Expert opinion may be obtained in situations like any delay in reporting exposure (> 72 hours),unknown source, known or suspected pregnancy (do not delay PEP initiation), breastfeeding issues, source patient is on ART or possibly has HIV drug resistance, major toxicity of PEP regimen etc. Refer/consult if in doubt or complicated cases (e.g., major psychological problem).

Follow-up

Follow up the client at 7 days, 14 days, 28 days and 12 weeks after starting PEP; follow up HIV testing at 4 weeks, if negative, test again at 12 weeks; management of side effects due to PEP.

Pre-Exposure Prophylaxis

Pre-exposure prophylaxis (PrEP) refers to the use of antiretroviral medication to reduce the chances of getting infected by people at risk of acquiring HIV infection. It is highly effective and provides significant protection against HIV infection.

Eligibility for PrEP

PrEP shall be offered to sexually active HIV-negative individuals who are at substantial risk of acquiring HIV. It is important that a careful evaluation is done for assessing the risks and benefits before prescribing PrEP to individuals. To be eligible for PrEP, persons must meet all the following criteria:

- **Confirmed HIV negative,** using rapid antibody testing, following the HCTS algorithm on the day of PrEP initiation;
- **At substantial risk** of acquiring HIV infection;
- **No contraindication** to use of any medication used for PrEP;
- Does not have a current or recent (within the past one month) illness suggestive of acute HIV infection along with a history of probable exposure to HIV.
- Assessed as **ready to adhere** to PrEP and willing to attend follow-up evaluations including repeated HIV testing and monitoring.

Benefits of PrEP

PrEP adds another effective HIV prevention option to the list of prevention strategies. It can be provided as an additional method to help protect people who are unable to negotiate condom use with their partner(s), or people who inject drugs but are not able to obtain new injection equipment, or people who do not use condoms or new injection equipment consistently.

PrEP does not eliminate the risk of HIV infection and it does not prevent STIs or unintended pregnancies. It should, therefore, be offered as part of a combination prevention package that includes risk reduction counselling, HIV testing, condoms and lubricants, STI screening and treatment, contraception, needle exchange and opioid replacement therapy. It is not to be consumed lifelong, but can be started during periods of higher risk and stopped during lower risk periods.

Special Situations

There are situations that call for special attention and care of clients under PrEP. Patients with certain clinical/ special conditions require special attention and follow-up by the clinician such as the following:

Pregnancy

PrEP may be initiated or continued during pregnancy in women at substantial risk of HIV acquisition. If a sero-discordant couple desires pregnancy, PrEP can be one of the strategies for safer conception. Clinicians should educate HIV-discordant couples who wish to have a child about the potential risks and benefits of all available alternatives for safer conception and if indicated, make referrals for assisted reproduction therapies.

The clinicians should also discuss with them about the available information related to potential risks and benefits of beginning or continuing PrEP during pregnancy so that an informed decision can be made. Once the decision of taking PrEP is made, the clinician must ensure that

- The HIV positive partner is on ART and virally suppressed;
- PrEP is initiated at least 20 days ahead of unprotected sex;
- Most fertile period may be advised to the couple for increasing chances of conception.

Breastfeeding

PrEP may be initiated or continued during breastfeeding in women at substantial risk of HIV infection. If a woman becomes infected with HIV during breastfeeding, the risk of transmission to the infant may be higher because of high viral load during sero-conversion. Therefore, PrEP should be initiated or continued in women who are at substantial risk.

Hepatitis B

Hepatitis B vaccination is recommended for people at substantial risk of HBV or HIV infection. Vaccination should be considered if there is no documented history of a completed vaccine series for HBV. PrEP can be provided whether or not HBV vaccination is available. For clients with HBV infection, care should be taken as per the National Technical Guidelines for PrEP.

PrEP Regimens

A combination of two anti-retroviral drugs is recommended:

Tenofovir disoproxil fumarate (TDF) + emtricitabine (FTC)/ lamivudine (3TC) daily

Important Considerations for PrEP

- Consistent and correct condom use should be promoted along with PrEP.
- PrEP should be initiated only after eligibility assessment.
- It should be taken as prescribed by the doctor. If the client is not willing to take PrEP as per advice, the HCP can choose not to provide PrEP.
- PrEP can be used to reduce the risk of HIV transmission in high-risk sexual encounters and injecting drug use. It may also be used for safer conception in HIV-discordant couples.
- Follow-up should be continuous and as per the advice of the doctor. Regular investigations (e.g., HIV screening, KFT etc.) should be ensured for continued prescription. The first follow-up should be after 30 days. Regular follow-up should be after 90 days.

Key Messages

- Awareness about PEP: Counsellors should provide information to the healthcare staff that post-exposure counselling and HIV testing facilities are available at the ICTC. Information on PEP should also be given.
- In case of exposure, do the pre-test counselling to the client. The client might be anxious/ panic due to the exposure. Address the concerns and provide support. Discuss first aid. Ensure that first aid is taken care of.
- Explain that the chances of HIV infection are low (compared to infection through other sources) in case of injuries at the hospital. Give information on PEP and discuss how this measure may help him/her.Also discuss details like eligibility assessment, how many days to take it, side effects etc.
- Do not assume that all healthcare workers have adequate information about the spread and consequences of HIV, HBV and HCV. Provide the information. Discuss the window period. Counsel as you do it for other clients.

- Correct the myths about HIV, HBV and HCV, if any. Assess if the client has any misconceptions about PEP. If yes, correct them.
- Send all the clients for occupational/non-occupational exposure to the medical officer for clinical assessment. If the client is put on PEP drugs, do adherence counselling.
- Discuss universal safety precautions.
- Some people are always prone to injuries and accidents. So, if some clients are coming again and again due to injuries, assess the reasons and address them. E.g., Some people are always anxious and so prone to injuries as they cannot focus on the tasks; some people do not care for self, some people are overconfident and do not perceive the risk etc.
- **Common PrEP Myths**
    1. You do not need to use condoms on PrEP.
    2. You can start taking PrEP after you've been exposed.
    3. PrEP is only for gay men.
    4. You do not need to take PrEP every day.

These myths should be addressed in counselling.

References

- *National Technical Guidelines for Pre-Exposure Prophylaxis, NACO*
- *National Operational Guideline for ART Services, NACO, 2021*
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- *WHO. (2014). Guidelines on Post-Exposure Prophylaxis HIV and the use of CO-TRIMOXAZOLE Prophylaxis for HIV Related Infections among Adult, Adolescents and Children: Recommendation for a Public Health Approach. Geneva, Switzerland: World Health Organization.*
- *Statutory Orders and Notifications Issued by the Ministries of the Government of India (Other than the Ministry of Defence), The Gazette of India, July 9, 2022/ASADHA 18, 1944*
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13 Anti-retroviral Treatment and Management of PLHIV

Objectives of ART centre

The main objective of an ART Centre is to provide a comprehensive package of care, support and treatment services that are effective, inclusive, equitable and adapted to the needs of PLHIV.

Functions of ART centres

ART centres are mandated to give comprehensive and holistic care to PLHIV. Functions of ART centre can be categorized as medical, psycho-social and programmatic as indicated below:

Category	Key Functions
Medical Functions	• Provide ART to all PLHIV • Provide baseline and follow-up investigations to PLHIV, including CD4 cell count and viral load testing • Provide prophylaxis and management of opportunistic infections • Provide TB preventive and management services as per guidelines • Identify PLHIV with advanced HIV disease for appropriate management and refer to higher level of care as needed to reduce mortality • Monitor, manage and follow up PLHIV for adherence, retention and adverse effects (if any) • Referral/e-referral of PLHIV with treatment failure to SACEP for review for second line/third ART and complicated adverse effects
Psycho-social Functions	• Provide linkages with other health services, including non-communicable diseases and other comorbidities • Provide psychological support to PLHIV and caregivers • Provide counselling for adherence to ARV drugs • Educate PLHIV on proper nutrition and healthy living • Assist in the disclosure of HIV results to spouse/family • Counselling for testing of spouse/partners/children • Step up counselling to PLHIV who have poor adherence and are virally unsuppressed • Provide appropriate counselling to PLHIV belonging to special groups (key population, children, adolescents, migrants, pregnant women etc.) Facilitate linkages to access social protection schemes

Programmatic Functions	• Contribute to achieving goal of 95:95:95 to 'End the AIDS' epidemic as a public health threat by 2030 in line with Sustainable Development Goals (SDG) • Proper recording and timely reporting as per national guidelines • Tracking of missed for ART refill (MIS) and lost to follow-up (LFU) cases in coordination with DAPCU, CSC, ICTC, link workers, TI NGO and other NGO approved by NACO/SACS • Coordination with National Tuberculosis Elimination Programme (NTEP) for management of HIV-TB co-infected patients and to ensure availability of drugs for anti-TB treatment (ATT) and TB preventive treatment (TPT) • Mentoring the LAC and coordination with LAC staff for ARV drug indent, monthly reporting CD4 and viral load test • Sensitize hospital staff on care support and treatment (CST) services

Link Art Centres

This is a differentiated service delivery model for decentralized ART services near the patient's residence rolled out in 2008.

The goal of this model is to make treatment services easily accessible to PLHIV and promote adherence by addressing the barriers associated with inconvenience due to frequent visits, need for long-distance travel and cost to the patients. These main functions of LACs include

- Monitoring PLHIV on ART;
- Drug refill to patients on ART;
- Treatment of minor OIs;
- Identification and management of adverse effects and reinforce adherence on every visit.

Anti-Retroviral Treatment for HIV

The primary goals of ART are maximal and sustained reduction of plasma viral levels and restoration of immunological functions. The reduction in the viral load also leads to reduced transmissibility and a reduction in new infections. The defined goals of ART are depicted in Table 13.1:

Clinical goal: Increased survival and improvement in quality of life
Virological goal: Greatest possible sustained reduction in viral load
Immunological goal: Immune reconstitution, that is both quantitative and qualitative
Therapeutic goal: Rational sequencing of drugs in a manner that achieves clinical, virological and immunological goals while maintaining future treatment options, limiting drug toxicity and facilitating adherence
Preventive goal: Reduction of HIV transmission by suppression of viral load.

Principles of Anti-retroviral Therapy

A continuous high level of replication of HIV takes place in the body right from the early stages of the infection. At least one billion viral particles are produced during the active stage of replication. Anti-retroviral drugs act on various stages of the virus replication in the body and interrupt the viral replication process. The ARV drugs act on viral replication and are labelled according to the site of their action.

Benefits of ART	
• It prolongs life. • It improves the quality of life. • It decreases occurrences of OIs. • Livelihood can stay intact. • Households can stay intact. • HIV transmission is lowered.	• It reduces mother-to-child transmission of HIV. • There are fewer orphans. • There is a decreased stigma surrounding HIV infection since treatment is now available.

Side-effects of ARV drugs

Counsellor may also explain ART to client in the following manner:

- *As a counsellor, you can advise your client to begin ART as soon as they are diagnosed with HIV.*
- *ART does not cure HIV. Therefore, the body will need the medications every day in order to stay healthy.*
- *Healthy behaviours such as a good diet, exercise, adequate rest and abstaining from drugs/smoking/alcohol are important habits to begin adopting.*
- *Drug side effects are unwanted and undesirable effects to a drug. These happen in some patients and can be mild, but rarely severe.*
- *As a counsellor, you should tell the patients about the very common sideeffects and suggest ways that these can be managed by the patient.*
- *It will help if you tell them what they can expect. This is called anticipatory guidance.*
- *You should also help them understand how they can get advice on managing other sideeffects or any worries they have. Teach them how to use the Treatment Education Leaflets.*
- *Explain to the patient that many patients experience an adjustment period when starting a new therapy.*
- *Tell them that this period usually lasts about four to six weeks when the body adapts to the new drug. During this time, some patients may experience headache, nausea, muscle pain and occasional dizziness.*
- *Tell your client that most of these sideeffects lessen or disappear as the body adjusts to medication. As the stable patients on ART for at least six months are linked out to LACs, it*

is unlikely that a counsellor at the LAC will come across short-term or medium-term toxicities. Thus, counsellors need to educate the clients about chronic toxicities.

- *A counsellor may be able to identify signs of treatment failure and refer the client to a physician in a timely manner so that necessary changes in treatment may be made.*

Considerations before Initiation of ART

All people with confirmed HIV infection should be referred to the ART centre for registration in HIV care. The following principles need to be kept in mind:

Principles	Details
Preparedness counselling	The patient should be adequately prepared, and informed consent should be obtained before HIV care and ART.
Caregiver support	Each patient should have an identified caregiver. Caregivers must be counselled and trained to support treatment, adherence, follow-up visits, and shared decision-making.
Co-trimoxazole preventive therapy (CPT)	Patients with clinical stages 3 and 4 or CD4 count < 350 cells/mm3 must be put on CPT.
TB screening and preventive therapy	All patients should be screened for TB using the 4S-symptom tool (cough, fever, night sweats, weight loss) and those who do not have TB need to be started on preventive therapy (TPT) in addition to ART.
OI Treatment before ART	**ART should not be started in the presence of an active OI.** All PLHIV are clinically evaluated and existing active OIs should be treated or stabilized before commencing ART. The OIs and HIV-related illnesses need treatment or stabilization before commencing ART.

All persons diagnosed with HIV infection should be initiated on ART regardless of the CD4 count or WHO Clinical Staging or age group or population sub-groups.

The current NACO guidelines (2021) on when to start ART

Ensuring good adherence to treatment is imperative for the success of the treatment as well as for the prevention of drug resistance. To achieve this, counselling must start from the first contact of the patient with the clinical team. Counselling should include preparing the patient for treatment and providing psycho-social support through an identified caregiver/guardian/treatment buddy and support networks. All patients should undergo counselling sessions (preparedness counselling) and co-trimoxazole prophylaxis, TPT (after assessment of patients, when prescribed by MO ART centre).

All efforts should be made to trace the patients who have defaulted on their visits or are lost to follow- up to initiate ART in all PLHIV registered at the ART centres. NGOs and positive network linkages should be established by each ART centre for its respective locality.

Counsellors should use seven-point counselling tool for ART preparedness (attached as annexure) to guide them through the process.

- **Step 1:** Education about HIV and ART
- **Step 2:** Identify the patient's motivation to stay alive and healthy
- **Step 3:** Identification of caregiver
- **Step 4:** Identify the potential barriers to adherence or retention
- **Step 5:** Identify strategies to ensure good adherence
- **Step 6:** Devise a treatment plan that suits the patient the best
- **Step 7:** Plan for the next appointment

Rapid ART Initiation for Newly Diagnosed PLHIV at ART Centre

The introduction of the 'Treat All' recommendation supports the rapid initiation of ART, including the offer of same-day initiation where there is no clinical contraindication. Rapid ART initiation is defined as "ART initiation within seven days from the day of HIV diagnosis". Following a confirmed HIV diagnosis and clinical assessment, same day/rapid ART initiation should be offered to all PLHIV adequately prepared and ready for initiation. However, if an active OI is present, ART initiation may be deferred as required.

- PLHIV who do not have any such conditions can be fast tracked for ART initiation.
- PLHIV who have any such symptoms would require further evaluation for diagnosis and management of common OIs/advanced HIV disease/comorbid conditions before ART initiation.

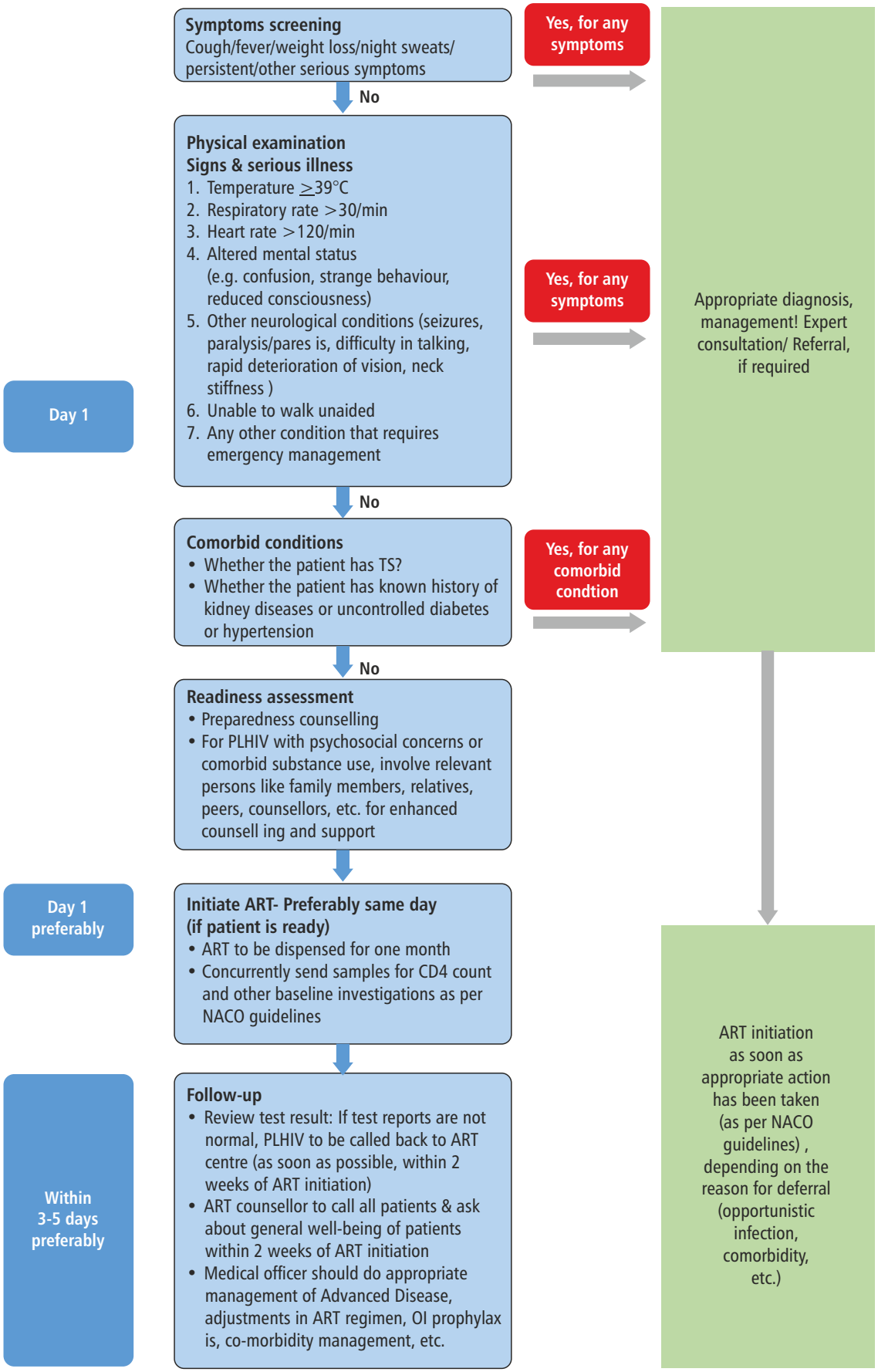
CD4 recovery

CD4 cells are the soldiers of our body, who fight germs from causing infection in the body. HIV virus makes a home in the CD4 and reduces its number and function.

A baseline CD4 count before ART initiation is essential to determine the need for starting co-trimoxazole prophylaxis therapy (CPT) and the baseline immunological status of PLHIV. Even when the viral load testing is routinely done, CD4 monitoring remains relevant in certain situations. CD4 counts are essential for diagnosing IRIS, stopping CPT, monitoring PLHIV with HIV-2 and HIV-1 and 2 co-infection. Timing of testing should be adjusted so that samples for both CD4 and VL testing can be collected by a single prick

CD4 monitoring can be stopped for any HIV-positive patient, aged more than 5 years, if the CD4 count is greater than 350 cells per cubic millimetre and viral load count is less than or equal to 1000 copies per ml, when both tests are conducted at the same time. CD4 testing should be restarted if the patient has suspected treatment failure that is virological failure (more than 1000 copies/ml) or suspected clinical failure or if the patient has undergone a switch in regimen.

Figure 13.1 - Rapid ART initiation algorithm in PLHIV
(Adopted from national guidelines for HIV Care and Treatment 2021)



Viral Load

- Section 2.2.7 of National Guidelines for HIV Care and Treatment says "Dolutegravir causes rapid viral suppression: It helps in achieving rapid viral suppression. It has been found to reduce the viral copies to <50 copies/ml within 4 weeks and this helps reduce the chances of transmission."
- Chapter 2.7, under Timing of Viral Load testing: "For all patients on first-line ART, plasma viral load testing should be done at 6 months and 12 months after ART initiation and thereafter annually."
- For all patients on second-or third-line ART, plasma viral load testing should be done every 6 months after initiation of second- or third-line ART.
- The medical officer can request for additional plasma viral load test when deemed necessary for clinical management (e.g., during one drug substitution, new clinical event).
- Plasma viral load testing is recommended for all HIV-positive pregnant women during 32 to 36 weeks of pregnancy (regardless of duration of ART) to determine the risk of HIV transmission to the baby.
- When to Suspect Treatment Failure:
- Suspect treatment failure when viral load is more than 1000 copies/ml.
- CD4 counts are monitored in PLHIV with HIV-2 infections, or combined HIV-1 and 2 infections.

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Factors contributing to treatment failure

Table 13.1 - Factors contributing to treatment failure

Contributing Factor	Explanation
Not taking medications as prescribed *(Daily at a fixed time, without missing even one dose)*	• HIV virus is an error-prone virus and makes errors during replication. With poor adherence, virus replication increases, the new virus is a mutant virus similar to COVID virus (delta variant etc.) and ART may not work on the new virus. • Drug interactions can also reduce the drug levels and make ART ineffective, especially since DTG interacts with multi-vitamins, antacids, iron, calcium etc. DTG should be given 2 hours before or 6 hours after these medications. • As frequency of missing doses increases, number of mutant viruses increase leading to ART regimen not being effective and leads to treatment failure.

Follow-up and Monitoring

Step up adherence counselling in patients with poor adherence and unsuppressed viral loads (VL>1000 copies/ml)

Step-up adherence counselling is important in understanding possible reasons for non-adherence in a patient and then providing guidance to form an adherence plan. The counsellors should try to review psychological, behavioural, emotional and socio-economic factors that may lead to non-adherence in a patient and provide customized counselling with the objective of improving adherence to treatment.

A minimum of three sessions are recommended for step-up adherence counselling but additional sessions can be conducted as needed. (Table below provides details of each session.) If the adherence of the patient is found to be adequate, a repeat viral load test is conducted 3 months after the suspected treatment failure point to assess the benefits of step-up adherence counselling. It is preferred that all counselling sessions are done by the same counsellor to ensure consistency, continuity, and proper documentation of issue resolution. These sessions can be conducted when the patient visits to collect his/her medication.

Table 13.2: Overview of step-up adherence counselling sessions

Counselling Session	Counselling Issues to be handled
Session 1 (Just after test results indicating suspected treatment failure)	Review patient's understanding of viral load and discuss possible reasons for high viral load i. Assess possible barriers to adherence: • Knowledge of medication – dosage and timing • Motivation to take medicines • Patient response to side effects (if any) • Mental health (check for depression and other reasons) ii. Discuss the patient's support systems. iii. Check the patient's history with referral services such as support groups, medical clinics and evaluate their response to such services. iv. Support patient in developing an adherence plan that addresses the identified issues. v. Check the patient treatment adherence (both pill adherence and appointment adherence) in the treatment card to create a baseline.
Session 2 (15 days or 1 month – as deemed fit by the counsellor at ART centre after Session-1)	Review patient adherence between first and second sessions and discuss any emerging issues or gaps. i. Follow up on any referral services that the patient undertook post the first session. ii. Support patient in modifying the adherence plan to tackle the identified issues.

	iii. Check patient treatment adherence again, and record it in the white card on a regular basis.
Session 3 (15 days or 1 month as deemed fit by the counsellor at ART centre after Session- 2)	Review patient adherence between second and third sessions and discuss any emerging issues or gaps. i. Support patient in modifying the adherence plan to tackle the identified issues. ii. Decide next course of action based on adherence: • If adherence is good, plan a repeat plasma viral load test post 3 months of good adherence. • If adherence is not adequate, plan further sessions with the patient before repeating plasma viral load test. Explain the importance of adhering to the treatment and risk of treatment failure due to non-adherence.
Session after repeat plasma viral load test	Discuss results of the repeat plasma viral load test. I. Decide next steps based on repeat plasma viral load test results: If plasma viral load count <1000 copies/ml, appreciate the patient for his/her success and suggest continuation of current regimen; repeat plasma viral load as per the scheduled frequency of the patient.* ii. If plasma viral load count ≥1000 copies/ml, prepare the patient for a change in regimen.

Note: *On a case-by-case basis, in critically ill patients with high plasma viral load, all the counselling sessions may need to be completed over a shorter span of time.*

- *Next Viral load test to be done after 12 months of the last viral load test in PLHIV on first-line ART*
- *Next Viral load test to be done after 6 months of the last viral load test in PLHIV on second-line ART*

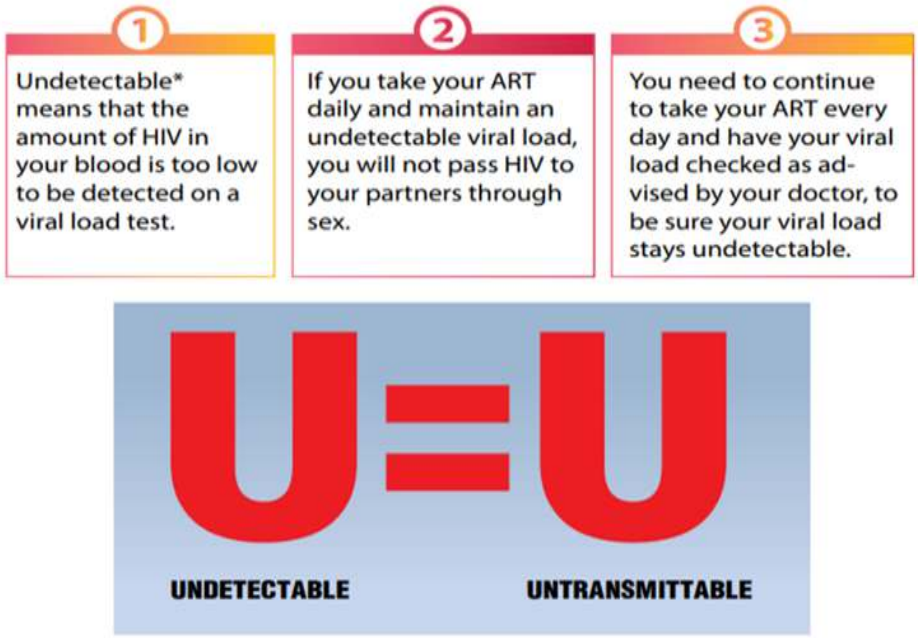
Substitution versus Switch

Substitution refers to replacement of ARV drug(s) in PLHIV due to adverse effects of drug, drug–drug interactions or programme policy. This does not indicate change of regimen due to treatment failure.

Switch refers to the loss of antiviral efficacy to the current regimen. When the entire regimen is changed because of treatment failure, it is referred to as the switch. Currently, the national HIV programme provides free first line, second line and third line ARVs to more than 16 lakh patients through these ART Centres. (NACO, 2023)

What is U=U

Undetectable means the amount of HIV in the blood is too low to be detected in viral load test and report comes as TND (Target Not Detected). It means that PLHIV who achieve and maintain an undetectable viral load by taking ART daily as prescribed cannot sexually transmit the HIV virus to others.



Undetectable = Untransmittable is applicable only for sexual and vertical route of transmission but not for the people sharing needle and blood transfusion.

U=U (TND) has the power to dismantle HIV stigma and discrimination by giving life with HIV a new face; because ART helps PLHIV have long, healthy lives, achieve viral suppression and prevent transmission to people they have sex with, HIV no longer needs to be viewed as a death sentence and people with HIV shouldnot be viewed as posing a risk to other people. As such, the stigma and discrimination associated with fears of death and transmission can be alleviated.

There are specific challenges in adapting U=U (TND):

- It may take as long as six months of treatment to achieve viral suppression, and viral suppression must be maintained to ensure that the virus is not transmitted to a sexual partner.
- U=U does not mean that the person living with HIV is cured of HIV.
- **Adherence to daily treatment:** Taking HIV medicine as prescribed is required to achieve and maintain an undetectable viral load. Poor adherence, such as missing multiple doses in a month, increases a person's viral load and their risk for transmitting HIV.
- **TND or undetectable viral load results:** Virus migrates from blood vessels and settles down and rests in reservoirs and hence blood test does not show the viral count. As virus is not present in blood and secretions, patient does not transmit the virus to sexual partner. If patients stops/misses the medicine, the virus will wake up and start replicating and reappear in the blood vessels.
    - **Knowledge of viral load:** Regular viral load testing is critical to confirm that an individual has achieved and is maintaining an undetectable viral load. Ensuring that demand generation is in place and increasing knowledge among the PLHIV is needed and remains a challenge.

- **Protection against other STIs and pregnancy:** Maintaining an undetectable viral load does not protect from getting other STIs or pregnancy. Other prevention strategies, such as condom use, are needed to provide protection from STIs and pregnancy.
- **Low awareness about the benefits of viral suppression:** Knowledge of the prevention benefits of viral suppression may help motivate people with HIV and their partners to adopt this strategy.
- If you inject drugs, never share needles or injection equipment with anyone else. Even if the amount of HIV in your blood is so low that a test cannot detect it, you can still pass HIV to someone if you share needles or injection equipment with them.

State AIDS Clinical Expert Panel (SACEP)

Table 13.3 – About SACEP

Need for SACEP	Patients with suspected ARV treatment failure, severe adverse effects and complicated clinical cases are referred for review by a panel of experts called State AIDS Clinical Expert Panel (SACEP) at Centre of Excellence /ART plus centres for further evaluation and timely switch/substitution to appropriate ART.
Constitution andmeeting schedule	SACEP is constituted at Centre of Excellence (CoE) and at ART plus centre by the Programme Director of CoE and the Nodal Officer of the ART plus centre respectively. SACEP meets weekly at the Centre of Excellence (CoE) or paediatric CoE (pCoE) or ART plus centre to review all cases referred in that week and in case of high backlog, SACEP may meet more than once a week
Functions of SACEP	1. Review and determine eligibility for switching to an appropriate ART regimen for cases referred by attached ART centres. Prescribe the new regimen if required. 2. Review and decide on the substitution of appropriate alternative ART regimens if necessary for cases referred by attached ART centres. Prescribe the new regimen if substitution is decided. 3. The SACEP coordinator organizes meetings, coordinates with panel members, communicates recommendations to referring ART centres and ensures patient follow-up according to SACEP guidance. SACEP reports will also sent to SACS and NACO.
When should a patient be referred to SACEP?	1. Patients with suspected ARV treatment failure (If VL ≥1000 copies/ml even when treatment adherence is more than 95% for three consecutive months) 2. Patients with suspected moderate to severe ARV adverse effects to decide for substitution of one/more ART drugs of different class 3. PLHIV with drug-related complications or management of severe OIs that cannot be managed at ART centres

	4. Patients from private sector on a regimen other than preferred regimen under NACP can be referred to SACEP after enrolment under care at the ART centre for opinion about most suitable regimen under the programme for them.
Step-up adherence counselling and e-referral to SACEP for review for second/third line	PLHIV with viral load ≥1000 copies/ml should undergo stepwise adherence counselling for three months. Repeat viral load testing (along with other lab investigations) must be done once treatment adherence is >95% for three consecutive months. Patient should be simultaneously informed that in case VL is not suppressed, e-referral will be done to SACEP and he/she would be called back to ART centre for switch (based on SACEP recommendation).

Key Messages

- ART includes drugs that act at various stages of the HIV life cycle to interrupt HIV multiplication. It delays the progression of HIV by reducing viral load, improving CD4 count and thus the immune system, prolongs life and improves its quality.
- The counsellors should advise PLHIV to begin ART as soon as they are diagnosed with HIV. ART should be started as early as possible after the HIV diagnosis and continued for life, following the national guidelines and the advice of the healthcare provider.
- Before initiating ART, the patient should be prepared, consented, screened for TB and OIs and prescribed CPT and TPT as needed.
- Preparedness counselling is vital before initiating the ART. Explain the role of ART medicine in managing HIV. Explain how ART works (Refer Annexure).
- High degree of adherence is essential for optimal virological suppression and therefore counsellors should identify PLHIV having risk factors associated with poor adherence or poor retention such as financial/distance-related issues, migration, lack of understanding, mental health, comorbidity/co-infection, advanced HIV disease, alcoholism, substance abuse etc., and must provide individualized focused counselling.
- Quality counselling sessions for preparedness should be continued even after ART initiation, especially, during the first three months of starting ART. A minimum of four sessions should be done as part of preparedness counselling. Peer counselling should also be a part of the initial counselling.
- Counsellors should explain U=U policy to the clients. Undetectable =Untransmittable (U=U) means that persons with a consistently undetectable viral load have minimal chance of transmitting the virus sexually to their contacts, if adherent to ART. Explain, *"If you are taking the treatment as directed, the virus will be supressed and not detected in the blood. This means that you have achieved an important milestone in your treatment. Though the virus is not eradicated, there are less chances that the virus is transmitted to another person."*
- Patients with suspected ARV treatment failure, severe adverse effects and complicated clinical cases are referred for review by a panel of experts called SACEP. A counsellor may

be able to identify signs of treatment failure and refer the client to a physician in a timely manner so that necessary changes in treatment may be made.

- How Counsellors Can Explain Adherence to PLHIV

  Explain how ART works and prepare the client to initiate ART.

  - Our body has an immune system that protects us from getting sick, just like a house protects us from the rain and cold.
  - If left untreated over time, the HIV virus will take over a body's immune system, leaving a person ill with OIs, just like a house that is left uncared for.
  - If a person is sick from HIV, he/she can begin taking medicines called anti-retroviral treatment. These medicines reduce the amount of HIV in the body. As a result, the body's immune system can fight off disease and the person can become healthy again. Therefore, taking ART is like repairing a house. Based on several factors including the CD4 count, a doctor prescribes ART to such people.
  - ART is several different medications. A person must take all of them, every time, every day for the rest of his/her life for the treatment to be effective.
  - ART does not cure HIV. Therefore, the body will need the medications every day in order to stay healthy. Going without medications, even for a short time, is like not repairing the house.
  - If a person does not take his/her medicine, HIV will multiply in the body and continue to damage the immune system and taking ART in the future will not be able to stop it.

- Explain the effects of non-adherence.

  - Discuss drug resistance (Annexure

    "Think of your body as a pot with a tap. When you take ART medicine regularly, the body has enough medicine to fight the virus. After a while, however, usually about 24 hours, the level of medicines decreases. Therefore, you have to take the medicine as per the prescribed doses to keep the medicine in the blood. If you do not do this, resistance to ART medicines will develop. The medicines will not work against the HIV virus. Then HIV continues to grow in the body and will destroy CD4 cells (the soldier), leading to weakening of the immune system, opportunistic infections, weight loss etc."

  - Ensure regular follow-up.
  - If clients are not adhering to the treatment, assess the reasons, discuss the challenges and take appropriate measures. E.g.See if any support is available from family members/community members NGOs; if clients have mental health issues, refer to the psychiatry department.
  - If clients have problems of side effects, help address them(refer Annexure for details).
  - Do not blame or scold the clients. This will be discouraging.

- Discuss simple tips to remember about tablets: e.g., set alarm, associated with some activity such as after meals while drinking water.

- Assess adherence fatigue. Usually clients say these statements if they have fatigue. *"It is not helping me. I am going to stop the medicine"; "I am tired of eating the tablets. How much a person can eat it?"; "...I forgot to take them." Explain to clients, "This phase is called fatigue and it is experienced by many clients. Though it looks difficult, people can overcome it."* In such cases, reinforce the adherence messages. Use case studies, experience-sharing, support group, interactive methods to encourage the clients. Seek the help of caregivers.

References:

- *Integrated training module for ICTC, ART, and STI Counsellors, NACO, Nov 2014*
- *National Operational Guideline for ART Services, NACO, 2021*
- *National Guidelines for HIV Care and Treatment, NACO, 2021*

Annexure: Antiretroviral Therapy (ART)

These are the main groups of antiretroviral drugs available at present:

1. Nucleoside reverse transcriptase inhibitors (NRTIs)
2. Non-nucleoside reverse transcriptase inhibitors (NNRTIs)
3. Protease inhibitors (PIs)
4. Integrase inhibitors (Integrase strand-transfer inhibitor – INSTI)

Principles of Anti-retroviral Therapy

- A continuous high level of replication of HIV takes place in the body right from the early stages of the infection. At least one billion viral particles are produced during the active stage of replication. Anti-retroviral drugs act on various stages of the virus replication in the body and interrupt the viral replication process. The ARV drugs act on viral replication and are labelled according to the site of their action.

How ART Works

HIV virus enters the CD4 cell of the human body and multiplies rapidly leading to the surge in viral load. The Anti-retroviral therapeutic drugs help to obstruct the passages or pathways of virus entry thus preventing their attachment and multiplication thereby resulting in a decreased viral load. ART drugs are classified based on the nature of the drugs to obstruct specific pathways inside the CD4 cell. The current regimen consists of TLD; i.e. Tenofovir and lamivudine- Nucleoside reverse transcriptase inhibitors (NRTIs), Dolutegravir – Integrase inhibiter.

Annexure: Seven-Point Counselling Tool for ART Preparedness

Seven-point counselling tool for ART preparedness	
Explain the purpose of the session: Acknowledge that as facility staff you are there to support patients. Explain that you will assist them by discussing together any barriers they may have and assist them in creating an individualized adherence plan to help them take their treatment correctly. Be open and alert to any personal difficulties and struggles with aspects of the information	
STEP-1: Education about HIV and ART	• Ask questions to assess understanding of HIV and ART. • Provide education on HIV and ART using the pointers provided in the checklist (HIV is a chronic manageable disease that requires lifelong medication). • Explain benefits of ART (ART stops HIV from making more virus, allowing you to be healthier, U=U). • Explain importance of adherence and lifelong treatment.

STEP-2: Identify patient's motivation to stay alive and healthy,	• Ask patient to think about things that make them want to stay healthy and to live fully. • Ask them to think about the important people in their lives. • Ask them to identify specific things that they really want to have in life, for example, to go to school or work, take care of family or anything that is specific to the person
STEP-3: Identify caregiver.	Assist the patient to identify support system by asking the following questions: • Who could support you in taking your treatment? Family/friends or others • How important do you think it is to disclose your health status? • Counsel the caregiver about importance of treatment adherence and follow-up visits. • Discuss any social or personal issues that the patient may have and support the patient to address the same.
STEP-4: Identify the potential barriers to adherence or retention.	• Encourage the patient to be frank about personal issues (as per checklist) that may affect their adherence and help them to address those issues. • Acknowledge common barriers that other patients have experienced to make the space safe and avoid judgements. • Invite patient to express beliefs or concerns that may interfere with their treatment. • Provide patient with appropriate information/support (counselling, peer support, treatment buddy, need-based referral) which will help them address the issue/s that have been identified.
STEP-5: Identify strategies to ensure good adherence.	• Ask: What could help you to remember to take the treatment? • Discuss treatment reminders and adherence options based on the specific needs of the patient: phone calls by treatment buddy, SMS, ICT-based tools, alarm, calendar, TV shows etc.
STEP-6: Devise a treatment plan that suits the patient the best.	• Advise the patient to take ART at a fixed time everyday, preferably at night. However, if this is not feasible, ask for the best time to take ART as per the schedule of the patient. • Many PLHIV do not have any private place to store their medicines and are not able to take them in privacy. Ask: What safe place could you identify to store your ART? How can you always carry one or two doses with you?

	• How will the patient remember or who will remind him/her to take the medication if he/she forgets? What reminder tools will the PLHIV use? • What will you do in case you **forget to take a dose?** If the pill of the once-daily regimen of TLD is missed, then it should be taken as soon as patient remembers within 12 hours. Missed doses can be taken up to 6 hours later in a twice-daily regimen. Are any other **family members** on ART? If yes, try to align the due dates for family-centric approach. • Is the patient on **medication** (including prevention or management of OI) for any other illness? If yes, explain about the adherence, duration, drug–drug interactions and timing/spacing of medications. • Visit/contact the ART centre if you have new symptoms (IRIS/adverse effects).
STEP-7: Plan for the next appointment.	• Schedule due date for next visit in consultation with the patient. • Remind PLHIV about the next due date to visit the ART centre and explain the importance of regular clinic attendance for monitoring of efficacy, adverse effects and adherence.

ART Preparedness Counselling Checklist/Form

Pre-ART No:_____ ART NO: _____

Mobile/Phone number verified: ☐ Yes ☐ No

Complete Address documented on White Card: ☐ Yes ☐ No

STEP 1: Education about HIV and ART:

☐ PLHIV acceptance of HIV positive status ☐ What is HIV? ☐ Routes of HIV transmission

☐ Positive living ☐ Meaning of viral load (U=U)

ART Awareness: *The following basic information about ART has been provided:*

☐ What is ART? ☐ ART is a lifelong treatment ☐ Benefits of ART ☐ Importance of adherence (>95%)

STEP 2: Identify patient's motivation to stay alive and healthy

What is the most important thing for you in life?

☐ Other .....

STEP 3: Identification of caregiver

☐ Family Career Studies Getting married

☐ Caregiver identified-Family member/ Friends/Others/ None

☐ Have you disclosed your status to the caregiver?

☐ Caregiver counselled on adherence and follow-up visits

☐ Any other family/personal issues.....

STEP 4 and 5: Identify the potential barriers to adherence/retention and strategies to overcome

☐ Adherence to ART is important to avoid development of drug resistance

☐ Strict adherence required (>95%)

Potential Barriers:

☐ Beliefs/Myths	☐ Physical illness	☐ Substance use	☐ Depression
☐ Pill burden	☐ Social functions	☐ Fear of disclosure	☐ Lack of knowledge about ART
☐ Financial/travel issues	☐ Feeling healthy	☐ Forgetfulness	☐ Adverse effects
☐ Child behaviour/refusing	☐ Timing	☐ Caregiver	☐ Drug stock out
☐ Long wait	☐ Stigma	☐ Others _____	

Interventions:

Services

☐ Counselling (individual)	☐ Counselling (group)	☐ Peer support	Treatment buddy
☐ Link to Govt. schemes/NGOs	☐ Home visits by ORWS	☐ Need-based Referrals _____	

Reminder Tools

☐ Written instructions	☐ Phone calls	☐ SMS	☐ ICT-based tools
☐ Alarms	☐ Calendar	☐ TV shows	

☐ Other _____

STEP 6: Devise a treatment plan that suits the patient the best

Timing ☐ Morning ☐ Afternoon ☐ Evening Dosage ☐ OD ☐ BD

Storage of ARV drugs ☐ Safe place (.....)

☐ Always carry additional pills with you when you go out/travel

Annexure: Opportunistic Infections and HIV-related conditions and ART initiation

Clinical Picture	Action
Any undiagnosed active infection with fever	Diagnose and treat first; start ART when stable or simultaneously, based on clinical assessment by MO/SMO of ART centre
TB	Start ART as soon as possible within 2 weeks of initiating TB treatment, regardless of CD4 cell count. Caution is needed for PLHIV with TB meningitis since immediate ART is associated with more severe adverse events.
PCP	Treat PCP first; start ART when PCP treatment is completed.
Invasive fungal diseases: Oesophageal Candidiasis, Penicilliosis, Histoplasmosis	Start treatment for oesophageal candidiasis first; start ART as soon as the patient can swallow comfortably. Treat penicilliosis and histoplasmosis first; start ART when patient is stabilized or OI treatment is completed.
Cryptococcal Meningitis	Treat cryptococcal meningitis first. ART initiation should be deferred until there is evidence of sustained clinical response to anti-fungal therapy due to risk of life-threatening Immune Reconstitution Inflammatory Syndrome (IRIS). After 4–6 weeks of induction and consolidation treatment, ART can be initiated.
Bacterial Pneumonia	Treat pneumonia first; start ART when treatment is completed.
Malaria	Treat malaria first; start ART when treatment is completed.
Acute diarrhoea that may reduce absorption of ART	Diagnose the cause and treat diarrhoea first; start ART when diarrhoea is stabilized or controlled.
Non-severe anaemia (Hb< 9 g/dl)	Start ART if no other causes for anaemia are found (HIV is often the cause of anaemia).
Skin conditions such as PPE and Seborrhoeic Dermatitis, Psoriasis, HIV-related Exfoliative Dermatitis	Start ART (ART may resolve these problems).
Suspected MAC, Cryptosporidiosis and Microsporidiosis	Start ART (ART may resolve these problems).
Cytomegalovirus Retinitis	Start treatment for CMV urgently and start ART after 2 weeks of CMV treatment.
Toxoplasmosis	Treat toxoplasmosis; start ART after 6 weeks of treatment and when the patient is stabilized.

Annexure: Commonly used NRTIs and Adverse Effects

Generic Name	Dose	Adverse effects
Tenofovir Disoproxil Fumarate (TDF)	300 mg once daily	Renal toxicity, bone demineralization
Zidovudine (AZT)	300 mg twice daily	Anaemia, neutropenia, bone marrow suppression, gastrointestinal intolerance, headache, insomnia, myopathy, lactic acidosis, skin and nail hyperpigmentation
Lamivudine (3TC)	150 mg twice daily or 300 mg once daily	Minimal toxicity, rash (though very rare)
Abacavir (ABC)	300 mg twice daily or 600 mg once daily	Hypersensitivity reaction in 3% to 5% (can be fatal), fever, rash, fatigue, nausea, vomiting, anorexia, respiratory symptoms (sore throat, cough, shortness of breath); Rechallenging after reaction can be fatal.

Types of Side Effects of ARV:

ARV Drugs	**Very common side effects:** Warn patients and suggest how to manage.	**Potentially serious side effects:** Warn patients and tell them to seek care.	**Side effects occurring later during treatment:** Discuss with patients.
Tenofovir		Nephrotoxicity (low incidence), Fanconi's syndrome and rarely acute renal failure, can reduce bone mineral density	
Dolutegravir	Nausea, diarrhoea, insomnia, rashes, hepatotoxicity		
Zidovudine (AZT)	▪ Nausea ▪ Diarrhoea ▪ Headache ▪ Fatigue ▪ Anaemia ▪ Skin pigmentation	**Seek urgent care:** ▪ Anaemia = pallor, fatigue, shortness of breath, muscle pain	

ARV Drugs	**Very common side effects:** Warn patients and suggest how to manage.	**Potentially serious side effects:** Warn patients and tell them to seek care.	**Side effects occurring later during treatment:** Discuss with patients.
Stavudine (d4T)	Nausea, diarrhoea	**Seek care urgently:** ▪ Pancreatitis (infection in pancreas)/Lactic acidosis, severe abdominal pain ▪ Fatigue and shortness of breath, persistent nausea and vomiting ▪ Seek advice soon: ▪ Peripheral neuropathy = Tingling numbness or painful feet or legs or hands	Changes in fat distribution: Lipodystrophy: arms, legs, buttocks, cheeks become thin; breast, belly, back of neck become fat
Lamivudine (3TC)	▪ Nausea ▪ Diarrhoea	**Seek care urgently:** ▪ Yellow eyes ▪ Skin rash with involvement of mucosa and exfoliation	
Nevirapine (NVP)	▪ Nausea ▪ Diarrhoea ▪ Mild skin rash		
Efavirenz (EFV)	▪ Nausea ▪ Diarrhoea ▪ Strange dreams ▪ Difficulty sleeping ▪ Memory problems ▪ Headache	**Seek care urgently:** ▪ Psychosis or mental confusion ▪ Skin rash	

Annexure 6: What to do for side effects?

Side Effect	What to Do	Go to the Clinic if
Headache	• Rub the base of your head and temple with your thumbs gently. Rest in a quiet dark room with your eyes closed. • Place a cold cloth over your eyes and forehead. • Avoid things with caffeine such as coffee, string tea and carbonated drinks. • Take 2 tablets of paracetamol every 4 hours with food.	• Your vision becomes blurry or unfocussed • Aspirin or paracetamol does not stop pain • You have frequent or very painful headaches
Dry Mouth	• Rinse your mouth with clean, warm water and salt. • Avoid sweets. • Avoid things with caffeine such as coffee, string tea and carbonated drinks.	• You have white spots on your tongue or in your mouth • You have trouble swallowing food
Skin rashes	• Wash often with unscented soap and water. • Keep the skin clean and dry. • Use calamine lotion to soothe itching. • Avoid the sun when you have a rash.	• If side effects persist, visit your doctor
Diarrhoea	• Eat small meals more frequently each day. • Eat easy-to-digest food such as bananas and rice. • Drink clean, boiled water. • Boil water for 20 minutes to make it safe. • Take oral rehydration solution(ORS). • Avoid spicy or fried food.	• There is blood in the stool • You have diarrhoea more than 4 times a day • You also have fever • You are thirsty but cannot eat or drink properly
Anaemia (Signs that you have anaemia include pale palms and fingernails)	• Eat fish, meat, chicken, legumes. • Eat spinach, asparagus and dark, leafy greens. • Take iron tablets as prescribed by a doctor.	• You have been tired for 3 to 4 weeks, and you are feeling more and more tired. • If your feet swell

Side Effect	What to Do	Go to the Clinic if
Feeling dizzy (These side effects may occur when taking Efavirenz. They usually go away after a few weeks.)	• If you feel dizzy, sit down until the dizziness goes away. • Try not to lift anything heavy or move quickly. • Take Efavirenz right before you go to sleep.	• If the side effects persist visit your doctor
Tingling feet and hands	• Wear loose-fitting shoes and socks. • Keep feet uncovered in bed. • Walk a little, but not much. • Soak your feet in warm water/ massage with a cloth soaked in warm water. • Try ibuprofen to reduce pain and swelling (you can take up to 400 mg every 8 hours with food. Do not take ibuprofen for more than two days without visiting the clinic.)	• The tingling does not go away or gets worse • The pain is preventing you from being able to walk
	• Ask your doctor if you can take drugs with food. • Eat lots of small meals rather than big meals. • Take sips of clean, boiled water, weak tea, or ORS until the vomiting stops. • Avoid spicy or fried foods. • Try to do something that makes you happy and calm right before you go to sleep.	• You also have fever • You have sharp pains in the stomach • There is blood in the vomit • Vomiting lasts more than a day • You are very thirsty but cannot eat or drink properly
Unusual or bad dreams	• Avoid alcohol and street drugs as these will make things worse. • Avoid food with a lot of fat.	
Feelings of sadness or worry (This is common with Efavirenz.)	• Talk about your feeling with others.	• You have serious, sad or very worrying thoughts • You are thinking about killing yourself • You are very aggressive or scared

Annexure: How to explain to client how ART works

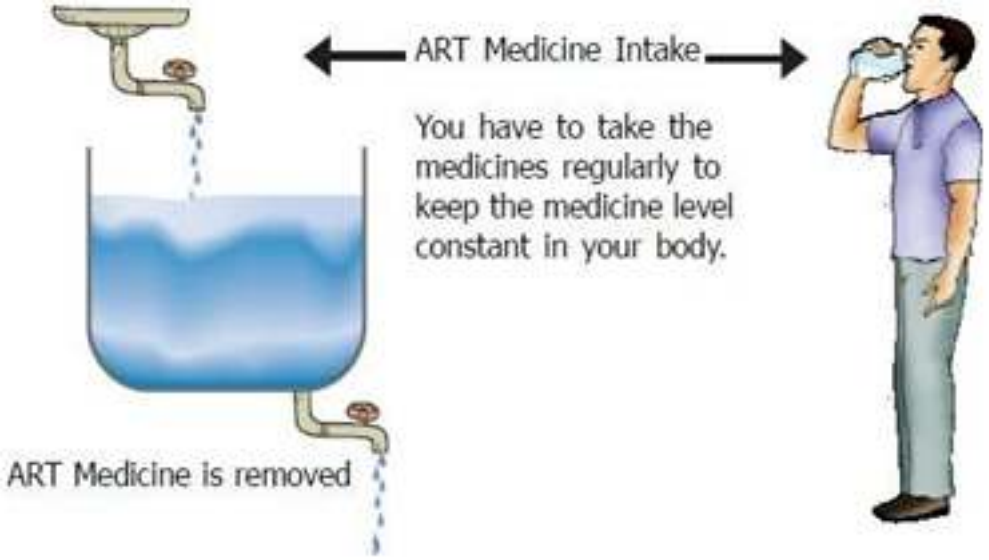
- Our body has an immune system that protects us from getting sick, just like a house protects us from the rain and cold.

- If left untreated over time, the HIV virus will take over a body's immune system, leaving a person ill with opportunistic infections, just like a house that is left uncared for.
- If a person is sick from HIV, he/she can begin taking medicines called anti-retroviral treatment. These medicines reduce the amount of HIV in the body. As a result, the body's immune system can fight off disease and the person can become healthy again. Therefore, taking ART is like repairing a house. Based on several factors including the CD4 count, a doctor prescribes ART to such people.

- ART is several different medications. A person must take all of them, every time, every day for the rest of his or her life for the treatment to be effective.
- ART does not cure HIV. Therefore, the body will need the medications every day in order to stay healthy. Going without medications, even for a short time, is like not repairing the house.
- If a person does not take his/her medicine, HIV will multiply in the body and continue to damage the immune system and taking ART in the future will not be able to stop it.

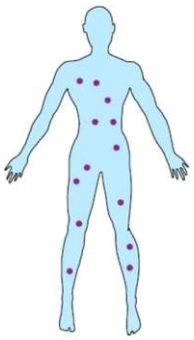
Annexure: How to explain drug resistance to the client

- Resistance to ART medicines develops, most commonly due to poor adherence and the medicines will not work against the HIV virus. Then HIV continues to grow in the body and will destroy CD4 cells (the soldier), leading to weakening of the immune system, opportunistic infection, weight loss, diarrhoea, cough, fever etc.
- Think of your body as a pot with a tap. When you take ART medicine regularly, the body has enough medicine to fight the virus. After a while, however, usually about 24 hours, the level of medicines decreases. Therefore, you have to continuously take the medicine (usually every 24 hours, but it depends on the medicine and recommended dose) to keep the medicine in the blood.

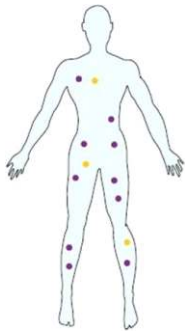


- But medication only stays in our bodies for a short time, like a bottle that has a leak in the bottom. Therefore, we must continue to take medication to keep enough of it in our body at all times.

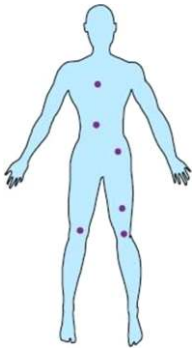
- When a person is infected with HIV, there are viruses that live inside the body. The virus can be seen in the body in the figure as purple dots. As long as we keep enough medication in our body, the medicine can keep the virus from reproducing.



- But if we do not take medicines on time, the HIV virus gets an opportunity to develop resistance against HIV medicine. Resistance is the ability of the virus to oppose the effect of the medicine. If you miss the medicine more than two times, the chances of HIV viruses developing resistance to HIV medicine are very high. These resistant viruses can be seen in the body as yellow dots.



- These resistant viruses then reproduce in our bodies. When a person returns to taking medicine on time, the drugs cannot kill the resistant virus. So, the medicine no longer works, and HIV takes over the body.
- In order for ART to work properly, it must remain in our body at all times. However, over time, the level of medicine decreases in our body.



Therefore, we need to continue taking ART medicine every day at a fixed time (medicine taking time must be fixed as per convenience and prescribed by the doctor) to keep enough in our body.

Annexure: Calculating Adherence

There are a number of ways to measure adherence like self-reporting by patient, pill count, home visit, patient diary etc. Pill count is the most used method to assess adherence. In each follow-up visit, the patient should be asked to bring the pill box with the unconsumed remaining pills. For more than one type of pill, adherence needs to be calculated for all drug combinations separately and reasons for different adherence patterns to different drugs should be explored.

The following formula is used to calculate adherence:

$$\text{Adherence (in \%)} = \frac{\text{Total number of pills the patient has actually taken}}{\text{Total number of pills that the patient should have taken in that period}} \times 100$$

$$\text{This is equal to } \frac{\text{Number of pills given to the patient – Number of pills balance in the bottle}}{\text{Number of pills the patient should have taken}} \times 100$$

Examples

- Tab TLD (Single pill daily) = Number of pill balance 9, patient returns on 28th day.
  Adherence calculation: (30 – 9) / 28 X 100 = 75%
- ALD Regimen: Tab AL (one tablet once a day) + Dolutegravir (one tablet once a day)
  Number of pill balance AL 5; Dolutegravir 5; patient returns on 25th day.
  Adherence calculation: (30 – 5)/(25x1) x 100 = 25 / 25 x 100 = 100%
- TL+ATV/r Regimen: TL once a day; ATV/r once a day; patient returns on 32nd day;
  Pill box: Remaining tablets TL: Nil; ATV/r 1
  TL Adherence = (30 - 0) / 32 x 100 = 30 / 32 x 100 = 94%
  ATV/r adherence = (30 - 1) / 32 x 100 = 29 / 32 x 100 = 91%

  Whenever a combination of two separate drugs is given, calculation has to be done for individual tablet and whichever adherence is lower, that has to be considered for reporting purpose as 'overall adherence'.

  Overall adherence in this patient is 91%.
- Tab ZL +LPV/r (ZL one pill twice daily and LPV/r two pills twice daily dose) = Number of pill balance = 11 ZL and 25 LPV/r, patient returns on 25th day.
  ZL Adherence = (60 - 11) / (25x2) x 100 = 49 / 50 x 100 = 98%
  LPV/r adherence = (120 – 25) / (25x4) x 100 = 95 /100 x 100 = 95%

  Adherence calculation: Individual drug combination adherence needs to be calculated and whichever is lower can be considered for reporting purpose.

  Overall adherence in this patient is 95%.

Step-up adherence counselling form

ART No. | ART Regimen: | Date of ART initiation

Date of viral load | Viral load result: | Due date for next VL

Session-1

Name of counsellor..... Date: ..... ART adherence (last 3 months) 1..... 2.....3.....

		Yes/No	Comments
Does patient have adequate knowledge about	ART adherence & risks of poor adherence		
	VL results		
	ART drug dosage (No. of pills and timing)		
Support system	Name and relation of the caregiver		
	Address and phone no. of caregiver		

Barriers:

- ☐ Forgot
- ☐ Physical illness
- ☐ Social functions
- ☐ Fear of disclosure
- ☐ Long wait
- ☐ Beliefs/Myths
- ☐ Substance use
- ☐ Feeling healthy
- ☐ Caregiver
- ☐ Stigma
- ☐ Lack of knowledge about ART
- ☐ Depression
- ☐ Child behaviour/refusing
- ☐ Financial/travel issues
- ☐ Other
- ☐ Adverse effects
- ☐ Pill burden
- ☐ Timing
- ☐ Drug stock out

Interventions:

Services

- ☐ Counselling (individual)
- ☐ Counselling (group)
- ☐ Peer support
- ☐ Treatment buddy
- ☐ Link to Govt schemes/NGOs
- ☐ Home visits by ORWs
- ☐ Need-based referrals

Tools

- ☐ Written instructions
- ☐ Phone calls
- ☐ SMS
- ☐ ICT-based tools
- ☐ Alarms
- ☐ Calendar
- ☐ TV shows
- ☐ Other

Remind that goal is to achieve suppressed VL

Adherence plan..... .....

Next due date to visit ART centre is ..... Counsellor's Signature

Session-2

Name of counsellor..... Date: ..... ART adherence of previous month.....

		Yes/No	Comments
Follow-up of session 1	Appreciate if adherence>95% and motivate him/her to maintain the same		
	Were strategies discussed in session 1 implemented? If not, Why?		

Barriers:

- ☐ Forgot
- ☐ Physical illness
- ☐ Social functions
- ☐ Fear of disclosure
- ☐ Long wait
- ☐ Beliefs/Myths
- ☐ Substance use
- ☐ Feeling healthy
- ☐ Caregiver
- ☐ Stigma
- ☐ Lack of knowledge about ART
- ☐ Depression
- ☐ Child behaviour/refusing
- ☐ Financial/travel issues
- ☐ Other
- ☐ Adverse effects
- ☐ Pill burden
- ☐ Timing
- ☐ Drug stock out

Interventions:

Services

☐ Counselling (individual) ☐ Counselling (group) ☐ Peer support
☐ Treatment buddy ☐ Link to Govt schemes/NGOs ☐ Home visits by ORWs
☐ Need-based referrals

Tools

☐ Written instructions ☐ Phone calls ☐ SMS
☐ ICT-based tools ☐ Alarms ☐ Calendar
☐ TV shows ☐ Other

Remind that goal is to achieve suppressed VL

Adherence plan.....

Next due date to visit ART centre is .....

.....
Counsellor's Signature

Session-3

Name of counsellor..... Date: ..... ART adherence of previous month:.....

		Yes/No	Comments
Follow-up of session 1	Appreciate if adherence>95% and motivate him/her to maintain the same		
	Were strategies discussed in session 1 implemented? If not, Why?		

Barriers:

☐ Forgot ☐ Beliefs/Myths ☐ Lack of knowledge about ART ☐ Adverse effects
☐ Physical illness ☐ Substance use ☐ Depression ☐ Pill burden
☐ Social functions ☐ Feeling healthy ☐ Child behaviour/refusing ☐ Timing
☐ Fear of disclosure ☐ Caregiver ☐ Financial/travel issues ☐ Drug stock out
☐ Long wait ☐ Stigma ☐ Other

Interventions:

Services

☐ Counselling (individual) ☐ Counselling (group) ☐ Peer support
☐ Treatment buddy ☐ Link to Govt schemes/NGOs ☐ Home visits by ORWs
☐ Need-based referrals

Tools

☐ Written instructions ☐ Phone calls ☐ SMS
☐ ICT-based tools ☐ Alarms ☐ Calendar
☐ TV shows ☐ Other

Remind that goal is to achieve suppressed VL

Adherence plan.....

Next due date to visit ART centre is .....

.....
Counsellor's Signature

Repeat Viral Load

Date of repeat viral load test:..... Viral load result:.....

If VL<1000 copies/ml	☐ Appreciate ☐ Reminder for next due date to visit ART centre ☐ Reminder for next VL testing date.....
If VL≥1000 copies/ml	☐ SACEP procedure explained ☐ SACEP e referral/referral initiated ☐ SACEP recommendations implemented

Annexure: Programmatic Definitions

First Line ART	The initial regimen prescribed for an ART-naive patient
Second line ART	The subsequent regimen used in sequence immediately after first line therapy has failed
Third line ART	The subsequent regimen used in sequence immediately after second line therapy has failed
Substitute	Refers to replacement of ARV drug(s) for PLHIV due to adverse effects of drug, drug–drug interactions or programme policy:.This does not indicate change of regimen due to treatment failure.
Switch	Refers to the loss of antiviral efficacy to the current regimen: when the entire regimen is changed because of treatment failure, it is referred to as the switch.
Pre-ART l(LFU)	PLHIV not initiated on ART and with no clinical contact or visit to health facility for more than or equal to 28 days
MIS	A patient 'On-ART' will be labelled as 'Missed (MIS)' if the patient does not turn up for pill pickup any time within 90 days of due date.
On ART LFU	PLHIV on ART with no clinical contact or ARV pickup for 90 days or more since last due date (missed appointment)
Stopped treatment	PLHIV on ART whose treatment is stopped on medical advice (in discussion with the clinical team)
Opted out*	If a PLHIV is contacted through outreach (home visit) and expresses his/her unwillingness to continue ART services under national programme (after adequate counselling) and provides in writing about the same*
Died	If death of a patient is confirmed by family members/relatives/local authorities during outreach and valid documentation is provided
Transferred out	Transferred out refers to a situation when a patient seeks transfer from one ART centre to another. PLHIV will be labelled as 'transferred out' only when patient reaches recipient ART centre and transfer has been accepted in IMS by recipient ART.

Annexure: 'MIS'

- A patient 'On-ART' will be labelled as 'Missed (MIS)' if the patient does not turn up for pill pickup any time within 90 days of due date.
- The patient can be labelled as 'MIS' consecutively for three months:M1, M2, M3.
- Patients coming any time during that month are not termed as MIS. PLHIV missing an appointment date but coming during the same month will not be termed as MIS.

Example: Raju is on TLD and collected his ARV drugs on 6 January 2023, next scheduled visit is 6 February 2023. He did not turn up in the month of February.

1. If Raju does not come for pill pickup by 28th February, then he should be termed as MIS-1 (if he comes on 22nd February, he will not be termed as MIS).
2. If he does not come by 31st March, then he should be termed as MIS-2.
3. If he does not come by 30th April, he should be termed as MIS-3.
4. If he does not come for pill pickup by the end of 31st May, he should be termed as 'LFU''.
5. As Raju collected pills on 21st May, his on-ART status will change from MIS to on-ART.

14 Prevention and Management of Opportunistic Infections and Comorbidities

Introduction to Comorbidities and Opportunistic Infections

An opportunistic infection (OI) is a disease caused by a microbial agent in a person with a compromised host immune system like PLHIV. PLHIV with low CD4 cell counts are more susceptible to a multitude of opportunistic micro-organisms including protozoa, fungi, viruses and bacteria, which are generally innocuous in healthy individuals. OIs have been the major cause of morbidity and mortality among PLHIV.

PLHIV who are on ART and virally suppressed are living longer and require a comprehensive health and well-being approach that extends beyond HIV care. While significant progress is made in the control of HIV/AIDS, the country is also undergoing a major epidemiological transition non-communicable disease (NCD). NCDs are increasingly contributing to overall disease burden. An NCD is a non-infectious health condition that cannot be spread from person to person. These diseases generally last for a long period of time and are chronic in nature.

Opportunistic infections	• Tuberculosis • PCP • Cryptococcal meningitis
Comorbidities (NCD)	• Hypertension • Diabetes • Cardiovascular disease • Cancer • Depression

Opportunistic Infections

Many of the common OIs are preventable, especially with early/rapid ART initiation. Since opportunistic events tend to recur, sometimes prophylaxis or preventive therapy needs to be continually given even after previous successful treatment until the patients achieve immune restoration.

With early ART initiation, appropriate prevention and management of OIs make an additional and desirable impact to reduce the incidence of OIs along with the use of simple preventive measures such as eating properly cooked food, drinking boiled water, handwashing after toilet use, avoiding situations with a high risk of infection and appropriate and timely immunizations.

The prophylaxis or preventive therapy of preventable OIs is recommended based on the prevalence of OIs, immune status of the patient as well as access to ART.

Prevention of OIs under NACP: The incidences of OIs have markedly declined in recent years because of the widespread availability of ART and early ART initiation in PLHIV. Along with ART, appropriate prevention and management of OIs make an additional and desirable impact.

Prevention can be either primary or secondary.

- **Primary prevention:** Prophylactic or preventive drug given before the appearance of an OI is called 'primary prophylaxis/prevention'.
- **Secondary prevention:** Prophylactic or preventive drug given after the successful completion of treatment of OI is called 'secondary prophylaxis/prevention'.

Table 14.1 - Prevention of OIs under NACP

Type of Prevention	Opportunistic Infection	Drug
Primary	To prevent PCP	Cotrimoxazole
	To prevent tuberculosis (TB)	Isoniazid
	To prevent cryptococcal infection (if CrAg test is not available in PLHIV with CD4 count <100 cells/mm^3	Fluconazole
Secondary	To prevent recurrence of PCP	Cotrimoxazole
	To prevent recurrence of TB	Isoniazid
	To prevent recurrence of cryptococcal infection	Fluconazole

Tuberculosis

Tuberculosis (TB) is caused by bacteria Mycobacterium tuberculosis *(M. tuberculosis)* that most often affect the lungs **(pulmonary TB)**, however it is curable and preventable. TB is spread from person to person through the air. TB can also affect other organs, including bones and joints, kidneys, brain, genitals, urinary tract, spine, lymphatic system, intestines, etc. In other words, it could affect all organs except hair and nails. When TB affects any organ other than the lungs, it is called **extra-pulmonary TB (EPTB)**. The symptoms and signs of EPTB will depend on exactly which organ is involved (e.g., headache if TB meningitis, effusion if joint involvement, etc.).

Breakdown of TB infection into active TB disease is most likely to happen in first two years after infection, more likely when a person is immune-compromised (e.g., HIV infected). 10% of individuals with TB infection will develop TB disease in their lifetime. Each individual with active but untreated TB can infect 10–15 people per year. 60% of HIV-positive individuals with TB infection will develop TB disease. TB patients may stay infected for many years, probably for life. The vast majority (90%) of people without HIV infection who are infected with M. tuberculosis do not develop the disease. Patients who do not take regular treatment and complete it properly may develop more dangerous forms of TB, known as drug-resistant TB, which they can spread to others.

Multidrug-resistant TB (MDR TB) is caused by an organism that is resistant to at least isoniazid and rifampin, the two most potent drugs for TB. These drugs are used to treat all people with TB. Extensively drug resistant TB (XDR TB) is a rare type of MDR TB that is resistant to isoniazid and rifampin, plus any fluoroquinolone and at least one of three injectable second-line drugs (i.e., amikacin, kanamycin, or capreomycin). Because XDR TB is resistant to the most potent TB drugs, patients are left with treatment options that are much less effective. XDR TB is of special concern for people with HIV infection or other conditions that can weaken the immune system. These persons are more likely to develop TB disease once they are infected, and also have a higher risk of death once they develop TB.

Types of TB:

- **Microbiologically confirmed TB:** Presumptive TB patient with biological specimen positive for AFB, or positive for MTB on culture, or positive for TB through Quality Assured Rapid Diagnostic molecular test.
- **Clinically diagnosed TB:**
  - A presumptive TB patient who is not microbiologically confirmed but diagnosed with active TB by a clinician on the basis of X-ray, histopathology or clinical signs with a decision to treat the patient with a full course of anti-TB treatment.
  - In children, this is based on the presence of abnormalities consistent with TB on radiography, history of exposure to an infectious case, evidence of TB infection (positive TST) and clinical findings suggestive of TB in the event of negative or unavailable microbiological results.

TB Case definitions as per NTEP

Microbiologically confirmed TB case	Presumptive TB patient with biological specimen positive for AFB, or positive for MTB on culture, or positive for TB through Quality Assured Rapid Diagnostic molecular test
Clinically diagnosed TB case	Presumptive TB patient who is not microbiologically confirmed but diagnosed with active TB by a clinician on the basis of X-ray, histopathology or clinical signs with a decision to treat the patient with a full course of anti-TB treatment
Pulmonary TB	Any microbiologically confirmed or clinical diagnosed case of TB involving lung parenchyma or trachea – bronchial tree
Extra-Pulmonary TB	Any microbiologically confirmed or clinically diagnosed case of TB involving organs other than lungs such as pleura lymph node, intestine, joints, bones, etc.
• Miliary TB is classified as PTB because there are lesions in the lungs. • A patient with both pulmonary and extra-pulmonary TB should be classified as a case of PTB.	

Screening of Presumptive Pulmonary TB patients

A person at ICTCs, TIs and SSKs and OSCs with cough for more than 2 weeks, with or without other symptoms suggestive of TB, should be promptly identified as presumptive pulmonary TB patient. They are to be referred to a designated microscopy centre (DMC) for sputum examination using the request form for examination of biological specimen. Patients with EPTB, HIV and Paediatrics (after X-ray screening in case of children) can be directly referred for CBNAAT.

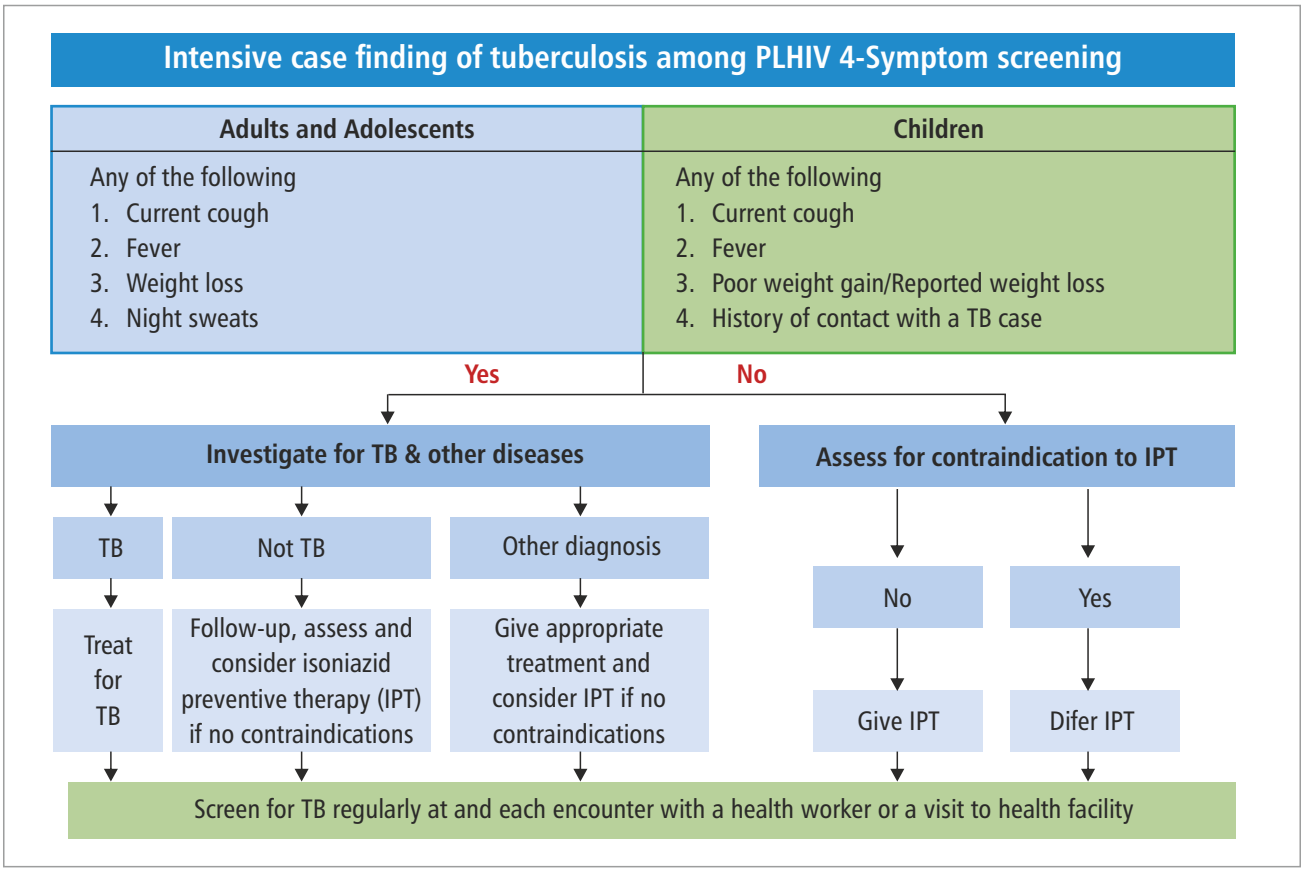
4S (symptoms) Screening

4S screening is to be done for all clients at all NACP facilities, such as ICTCs, TIs, other closed settings like prisons, SSKs and ARTC. At ARTC, all PLHIV, during every visit, should be

screened for 4S in all the health facilities without fail. PLHIV/CLHIV found positive for any of the four symptoms (4S+), should be considered presumptive TB and fast-tracked for TB diagnostic work-up.

The four symptoms are current cough, fever, weight loss and night sweats. For CLHIV, the four symptoms are current cough, fever, weight loss/poor weight gain and history of contact with TB case.

Figure 14.1 - Algorithm of ICF – four-symptom (4S) screening at the ART centre



Understanding of dual disease impact

Impact of HIV on TB	Impact of TB on HIV
Increases susceptibility to TB disease	Most common opportunistic infection in PLHIV
An HIV-infected person who is newly infected with TB bacilli has higher likelihood of developing TB as compared to anon-HIV-infected person.	Major cause of morbidity and mortality in PLHIV
Higher TB recurrence in HIV-infected people	The immune response to TB bacilli increases HIV replication. As a result of the increase in viral load in the body, there may be more rapid progression of HIV infection and patient starts developing symptoms of various opportunistic infections.

Impact of HIV on TB	Impact of TB on HIV
Increased death risk in HIV-TB co-infected patients than HIV non-infected TB patients.	Dual infection accelerates deterioration. Interaction of the diseases may result in difficulties in diagnosing TB among PLHIV due to atypical clinical presentation of TB disease.
The risk of recurrence of TB even after successful TB treatment is much higher in HIV-infected persons.	There is high risk of TB transmission in HIV care settings, due to high TB load and concentrated presence of vulnerable patients.

Strategies for Prevention and Management of TB in PLHIV

- Intensified TB Case Finding (ICF) with timely ATT (to cut TB transmission): Intensified case finding using 4-symptom complex for TB screening; fast-tracking and referral of symptomatic patients for testing (NAAT) and other appropriate investigations, as required, for TB diagnosis;
- Prompt and effective treatment of active TB in PLHIV in accordance with the NTEP guidelines;
- Early ART initiation among PLHIV;
- TB preventive therapy (TPT);
- Airborne infection control in healthcare facilities

Fixed Dose Combinations

Management of PLHIV co-infected with drug-sensitive TB case is being provided at ARTC under **single window services**. Fixed dose combinations (FDCs) refer to products containing two or more active ingredients in **fixed doses,** used for a particular indication(s). In NTEP, treatment will be given as per the **weight bands** for

- Adults: 4FDC (given in IP) consists of HRZE and 3FDC (given in CP) consists of HRE.
- Paediatric TB: Intensive phase has 3FDC + tab ethambutol.
- Continuous phase has 2FDC + tab ethambutol.

Care, Support and Treatment

- TB is a curable disease
- The average course of the treatment for drug-sensitive TB is six months.
- For those with a drug-resistant form of TB, the duration of treatment is often longer, up to two years.
- **Drug-sensitive TB** is treated with a combination of drugs (Isoniazid, Rifampicin, Ethambutol and Pyrazinamide)
- It is very important that people who have TB are treated, finish the medicine and take the drugs exactly as prescribed.

- If they stop taking the drugs too soon, they can become sick again; if they do not take the drugs correctly, the TB bacteria that are still alive may become resistant to those drugs. TB that is resistant to drugs is harder to treat.
- A pregnant woman diagnosed with drug-sensitive TB can start treatment during pregnancy.
- A Direct Benefit Transfer (DBT) scheme called *'Nikshay Poshan Yojana'*, nutritional support for Rs. 500/- every month to TB patients can be availed once they are notified on the Nikshay platform.

Sideeffects of anti-tuberculosis drugs

In most TB patients, ATT is well tolerated. However, some patients may experience some sideeffects to these anti-tuberculosis drugs. These side effects may be classified as minor or severe.

- **Minor side effects** include mild gastrointestinal upset, mild itching, joint aches and drowsiness. Most of these will go away within a short time.
- **Serious side effects** are rare but also occur. These include burning sensation in the hands and feet, impaired vision, ringing in the ears, loss of hearing, dizziness, loss of balance, ongoing nausea or jaundice and require to be immediately reported to the medical officer for evaluation.

  Counsellors should encourage clients to promptly seek medical opinion in case of side effects and not to stop medicines on their own.

TB HIV collaboration

PLHIV are 18 (15–21) times more likely to develop TB than people without HIV. TB is a leading cause of hospitalization and death among adults and children living with HIV, accounting for one in five HIV-related deaths globally. The prevention, diagnosis and treatment of TB and HIV-associated TB are key elements of the internationally endorsed comprehensive package of services given under a single window delivery mechanism at the health facility level.

National TB Elimination Programme (NTEP) and NACP

- Reduce the dual burden of both the diseases
- Early identification and treatment of both the diseases (TB among PLHIV and HIV among TB patients)
- Prevention of TB as an OI
- Prevention of deaths to reduce mortality in co-infected patients

Linkage of HIV-Infected TB Patients to CPT and ART

Cotrimoxazole preventive therapy (CPT) has been shown to reduce morbidity and mortality of HIV-infected patients in general and HIV-infected TB patients in particular. **As per National guidelines, all HIV-infected TB patients are to be linked to CPT and ART services irrespective of CD4 count.**

ART is highly effective at reducing mortality among HIV-infected TB patients. All PLHIV diagnosed with active TB are to be initiated on ART regardless of CD4 count, after initiation of TB treatment in accordance with the NTEP guidelines.

Fast Tracking of Symptomatic TB

- Ensure that any TB suspect at the ART centre should be attended by the MO (ART) on priority and should also be prioritized for testing and laboratory investigations.
- Instigating practices of good cough hygiene for all patients, with any duration of cough, at all ART centres for airborne infection;
- **Diagnostic and treatment services for MDRTB patients:** PLHIV identified as presumptive DR-TB/MDR cases at ARTC may be referred to DR-TB sites under NTEP for further diagnosis and management of the same.

> The key to reducing the risk of tuberculosis transmission at health facilities is early diagnosis and prompt initiation of NTEP treatment regimens until cure. Infectious TB patients become rapidly non-infectious once they are started on directly observed treatment under NTEP.

Drug-resistant TB: Drug-resistant TB can occur when the drugs used to treat TB are misused or mismanaged. Examples of misuse or mismanagement include the following:

- People do not complete a full course of TB treatment or are exposed to DRTB with someone known;
- Healthcare providers prescribe the wrong treatment (the wrong dose or length of time);
- Drugs for proper treatment are not available;
- Drugs are of poor quality.

Multidrug-resistant TB is caused by TB bacteria that are resistant to at least isoniazid and rifampicin, the two most potent TB drugs. These drugs are used to treat all persons with TB disease.

Eligibility for TB Preventive Therapy

- Isoniazid is one of the most effective bactericidal anti-TB drugs that protect against progression of latent TB infection (LTBI) to active disease (against endogenous reactivation). It also prevents TB reinfection post exposure to an open case of TB.
- The effects of TPT augment the effects of ART on reducing the incidence of TB. With the concomitant administration of both ART and TPT, there is a likelihood of restoration of TB-specific immunity by ART and the beneficial effect of TPT may be prolonged. TPT does not promote INH resistance when used to treat LTBI.
- All adults and adolescents living with HIV should be screened for TB with a clinical algorithm. Those who do not report any one of the four symptoms of current cough, fever, weight loss and night sweats are unlikely to have active TB and should, therefore, be assessed for TPT initiation.
- All children living with HIV more than 12 months of age, who do not report with current cough, fever, poor weight gain and history of contact with a TB case, are unlikely to have active TB and should, therefore, be assessed for TPT initiation.
- Infants aged <12 months living with HIV who are in contact with a person with TB and who are unlikely to have active TB on an appropriate clinical evaluation or according to national guidelines should receive TPT.
- If there is any doubt about the TB status of a patient, TPT should be delayed.

Contraindications to Isoniazid or INH

TPT should not be provided to patients in the following conditions:

- Active TB disease
- Active hepatitis
- Signs and symptoms of peripheral neuropathy such as persistent tingling, numbness and burning sensation in the limbs; regular and heavy alcohol consumption and symptoms of peripheral neuropathy
- Concurrent use of other hepatotoxic medications
- Contact with MDR-TB case
- PLHIV who have completed DRTB treatment

TPT with IsoniazidInitiation and Follow-up

All the 4S -ve patients should be assessed by SMO/MO to determine eligibility for TPT. TPT should be considered for both on-ART and pre-ART patients (if found 4S -ve). TPT should be initiated if not contraindicated. TPT drugs must be provided monthly (30 days) to all eligible patients.

4S screening should be done for all the patients (on ART and pre-ART) on TPT during every visit to exclude active TB. In case a patient becomes 4S +ve during the TPT course, he/she should be investigated for TB and if found positive, TPT should be stopped, and appropriate anti-TB treatment should be initiated.

Airborne Infection Control Measures

- Well-ventilated waiting and seating arrangements
- Fast-tracking of screening of patients with respiratory symptoms/chest symptoms for early referral, diagnosis and treatment initiation;
- Health education on cough etiquette (IEC material to be displayed).

Viral Hepatitis

Viral hepatitis is inflammation of the liver due to viral infection. Viral hepatitis can be caused by the five known hepatitis viruses namely A, B, C, D and E (HAV, HBV, HCV, HDV and HEV). Chronic HBV and HCV are silent diseases, but if left untreated may lead to cirrhosis and liver cancer. Therefore, prevention, early diagnosis and treatment are essential to combat viral hepatitis. The co-infection may lead to rapid progression and complications and affect the management of hepatitis and require a modification in the regimen of ARV drugs.

Testing for hepatitis B and C

Screening serological tests and molecular tests are required to establish a diagnosis of hepatitis C (HCV) and hepatitis B (HBV) for evaluation for further management.

(i) Screening test: Rapid diagnostic test

- HCV: Anti-HCV antibody test (anti-HCV)
- HBV: HBV surface antigen test (HBsAg)

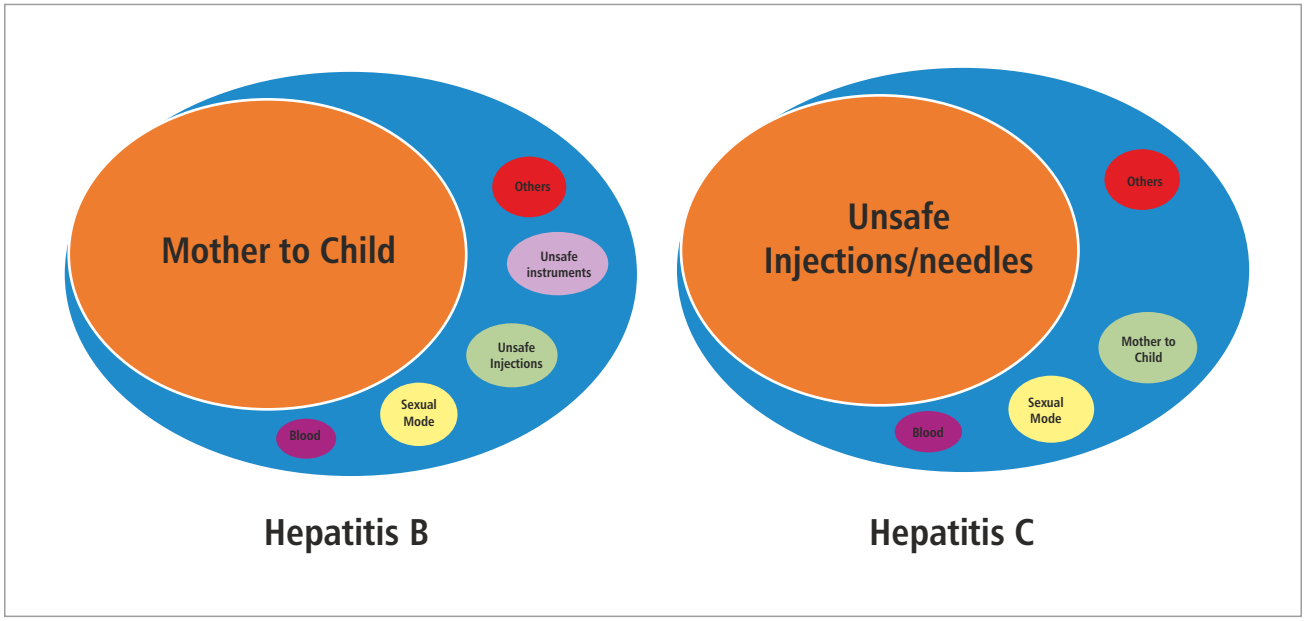
(ii) Molecular test: Viral load testing

- HBV DNA: For decision on treatment
- HCV RNA: For confirmatory test

Routine investigations like complete blood count, including platelets, estimation of liver enzymes alanine transaminase and aspartate aminotransferase are essential to decide whether a client is cirrhotic (complicated) or non-cirrhotic (uncomplicated). Apart from these, renal function tests also must be done before treatment is initiated.

Modes of transmission: Parenteral transmission of viruses occurs following exposure through transfusion of contaminated blood or blood products, unprotected sex, in utero transmission from a pregnant woman to her baby and possible horizontal transmission.

Figure 14.2 - Hepatitis B and C



Counselling and screening for HBV and HCV

The clients who attend the facilities may be at risk for HBV or HCV disease due to high-risk behaviours, especially the IDUs. The counsellor needs to inform the clients about the significance of getting tested for HBV and HCV.

(i) **Pre-test counselling:** Explain the details about HBV and HCV.

- What they are; how they spread; symptoms; consequences; prevention
- All clients should be assessed by the counsellor for the presence of the risk factors of both HBV and HCV. Risk factors:Child of HBV-positive mother; history of injecting drug use; needle stick injury; recipient of transfusion of blood/blood product; history of repeated tattooing; occupational exposure to blood/bodily fluids; history of dental treatment; history of surgery; high-risk sexual behaviours; history of receiving unsafe injection
- All clients (direct walk-in and referred) must be informed that testing for HBV and HCV at the ICTCsis conducted through a simple, easy-to-do rapid diagnostic test that provides the result within 30 minutes.
- HCV is a curable disease and HBV is a vaccine-preventable disease and can be managed with lifelong treatment.

- Inform that HBV and HCV diagnosis and treatment services are available at the government health facilities free of cost under the NVHCP.
- Informed consent must be obtained for testing.

(ii) **Post-test counselling**

- Explain the results of the screening of HBV and HCV.
- Inform that HBV and HCV diagnosis and treatment services are available at the government health facilities free of cost under the NVHCP and that molecular testing must be done if clients are reported as positive.

(iii) **Post-test counselling and linkages to treatment services for clients who are HBV or HCV positive**

- Explain the meaning of the antibody-positive HCV test or antigen-positive HBV (HbsAg) test and counsel on the need for quantitative HBV DNA and HCV RNA testing.
- Explain the need for a haemogram with platelets, liver and kidney function tests for staging and management of the disease.
- Explain that the client may be chronically infected or have cleared the virus in the past in case of antibody-positive HCV test.
- Provide basic HBV and HCV disease, prevention and treatment information.
- All HBV- and HCV-positive clients screened positive need to be linked to treatment sites (treatment centres/model treatment centres) under the NVHCP. Encourage voluntary disclosure of HIV status by the client to the treating physician.
- Explain HCV is a curable disease with treatment of 12 weeks (84 days), extendable to 168 days in severely complicated cases.
- Explain HBV is manageable with lifelong treatment and all clients who are positive may not require treatment.
- Discuss the importance of minimizing risk behaviours to avoid transmitting HBV and HCV infection to others, and encourage notification and screening of needle sharing and other risk factors.
- Encourage and offer HBV testing for bloodline relatives after confirmation.
- Encourage HCV testing among family members in case of evidence of unsafe injection practices from unregistered medical practitioners.
- Discuss healthy life practices, including stopping or reducing alcohol intake.

(iv) **In case of clients diagnosed with HIV and HBV and/or HCV**

- In case a client has co-infection of HIV and HBV and/or HCV, they should be referred to the ART centre. Further, it will be the responsibility of the ART centre to link the client to a model treatment centre under the NVHCP.
- Explain to the client how co-infection of HIV with HBV or HCV may deteriorate their health despite taking ART regularly and lead to rapid deterioration in liver function. Also, inform the client that their ARV regimen may need modification in case of co-infection.

- Give information about infection control practices to prevent the spread of infection to other household members.
- Clients must be provided with the NVHCP referral slip available at the ICTCs and ART centres.
- Confidentiality/shared confidentiality of HIV status must be ensured.
- Ensure posters on the NVHCP are displayed at the NACP service delivery centres and provide any other IEC material on HBV and HCV that is available for distribution to clients.

(v) **Designated health facilities (treatment centres/model treatment centres)**

- HBV- or HCV-positive clients should be referred to the treatment centres/model treatment centres under the NVHCP depending on their condition. The treatment centres are located at district hospitals and designated sub-district hospitals, CHCs and PHCs, while the model treatment centres are in designated medical colleges/tertiary care hospitals. All co-infected cases of HIV–HBV, HIV–HCV and HIV–HBV and HCV should be referred to the model treatment centres as it is important for a hepatologist to evaluate the condition and function of the liver before treatment.
- Once a client reaches the relevant centre, they should meet with the physician/MO and they will be managed as per NVHCP guidelines.

Prevention of HBV and HCV

(I) Vaccination for HBV:

- All infants born to HBV-positive pregnant women need to be immunized within 24 hours of birth followed by routine vaccination under the immunization programme.

- Vaccination of all healthcare workers with HBV vaccine at 0, 1 and 6 months.

(ii) Safety of blood and blood products:

- Promote information regarding the availability of safe blood and blood products at licensed blood banks and referral of donors screened positive for HBV and HCV to a treatment centre for further management.

(iii) Injection safety and infection control:

- Safe injection practices such as universal precautions while respecting socio-cultural practices like tattooing, religious ceremonies (like mundans) and ear/body piercing, etc.
- Inspection of use of new packaged needles/syringes for therapeutic injections.

Comorbidities

Non-communicable diseases (NCDs), also known as chronic diseases, do not spread from person to person. These illnesses take a long time to develop and do not present symptoms in the early stages. They require treatment for several years, and some require lifelong treatment. The main types of NCDs are diabetes, coronary heart disease, stroke, cancers and chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma). Some of the major risk factors include unhealthy /unbalanced diets, lack of physical activity,

smoking/tobacco use and excessive use of alcohol. NCDs are now becoming one of the leading causes of non–AIDS-related morbidity and mortality in PLHIV.

The following five components are recommended for prevention and management of NCDs in PLHIV:

- Health promotion (primordial prevention)
- Screening for early detection
- Diagnosis
- Management (including lifestyle changes and pharmacologic therapy)
- Regular follow-up: Monitoring achievement of treatment goals and monitoring adherence, side effects and drug–drug interactions

I) Health Promotion

Health promotion is critical to promote a healthy lifestyle and reduce specific risk behaviours, e.g., unhealthy diets, physical inactivity, tobacco use and harmful drinking for prevention of NCDs. All PLHIV should be counselled on health behaviours and comprehensive healthy lifestyles.

Table 14.1 - Health Promotion Counselling Messages for PLHIV

Health Behaviour	Counselling Messages
Physical activity	• Aim for an active lifestyle with moderate physical activity (at least 150 minutes/week). • Consider yoga and meditation for overall well-being.
Weight control	• Manage weight to maintain a healthy BMI. • Encourage overweight/obese individuals to lose weight through a mix of diet and dynamic activity.
Diet	• Choose a balanced diet with whole grains, vegetables, fruits and pulses. • Adapt diet based on local food availability. • Limit salt intake to less than 5 grams (1 teaspoon) daily. • Reduce consumption of sugar, fatty meat, dairy fat and fried foods.
Tobacco cessation	• Emphasize the multiple benefits of quitting tobacco. • Discourage non-smokers/chewers from starting tobacco use. • Support and strongly advise current users to quit tobacco.
Avoidance of alcohol	• Encourage avoiding alcohol consumption whenever possible. • Provide counselling support for those with alcohol use disorder or excessive drinking.
Adherence to treatment	• Explain medication doses and frequency, especially in relation to ART and additional medications. • Stress the importance of adhering to NCD medicines alongside ART. • Highlight the need to continue medication even when there are no symptoms. • Educate about potential side effects and prompt reporting of any adverse reactions.

ii) Screening, Diagnosis, Management for early detection and regular follow-up: Adult PLHIV will have to undergo screening, diagnosis and initial management of hypertension, diabetes mellitus, cardiovascular disease, common cancer and mental health.

1. Hypertension

- All PLHIV above the age of 18 years should undergo screening by healthcare providers through blood pressure (BP) measurement at the time of registration into HIV care or ART initiation and every 6 months after ART initiation
- The diagnosis of hypertension should be done by a physician, using a validated device, and following a standardized BP measurement procedure.
- Hypertension for patients below 80 years of age is systolic blood pressure less than 140 mm Hg and diastolic blood pressure less than 90 mm Hg.
- Hypertension for patients 80 years or older is systolic blood pressure less than 150 mm Hg and diastolic blood pressure less than 90 mm Hg.
- Immediate referral to appropriate facility and provider shall be done in cases of hypertensive urgencies and hypertensive emergencies

2. Diabetes

- All PLHIV should undergo screening, through random blood glucose test at
  - registration into HIV care or ART Initiation
  - 1–2 months after ART initiation and then at every 6 months
  - at change of regimen (substitution or switch).
- Screening, diagnosis and management through lifestyle modification can be provided by trained MO.
- Initiation of oral hypoglycaemic agents shall be done by physician.
- Continuation of treatment can be provided by trained MO in PLHIV with controlled diabetes.
- Management and follow-up by physician are recommended in patients with uncontrolled hyperglycaemia despite maximum doses of metformin and sulfonylurea, patients with foot ulcers and patients with vision impairment.

3. Cardiovascular disease

Cardiovascular diseases like ischemic heart disease, coronary heart disease and stroke are one of the major causes of mortality and morbidity among the general population. With changes in lifestyle, the incidence is increasing and PLHIV are also affected by these ailments.

While diagnosis and management of ischemic heart disease (narrowed heart arteries) and stroke are best done at facilities with advanced interventions,

- Assessment shall be done at time of registration in HIV care or ART initiation, at 3 months and 6 months of ART and shall be repeated every 6 months thereafter.
- All patients with history of angina (chest pain), breathlessness on exertion and lying flat, numbness or weakness of limbs, loss of weight, increased thirst, polyuria (urinates more than usual), puffiness of face, swelling of feet, passing blood in urine, pitting oedema (swollen part of the body has a dimple (or pit) after you press it for a few seconds) and tenderness in abdomen need to be referred to a physician for further assessment and management.

4. **Common Cancer (Oral,Breast, Uterine and Cervical)**
   - Create awareness about the early warning signs of cancer like the following:
     - Change in bowel or bladder habits;
     - Wound that does not heal;
     - Unusual bleeding or discharge;
     - Thickening or lump in the breast or elsewhere;
     - Indigestion or difficulty swallowing;
     - Obvious change in a wart or mole;
     - Nagging cough or hoarseness of voice;
   - Educate patients on self-examination and reporting for unusual signs/symptoms.
   - Women should be counselled on breast awareness. The first person to detect any lump in the breast is the woman herself, which is by teaching a woman to be aware of any of the following signs at the earliest possible:
     - Change in size
     - Nipple that is pulled in or changed in position or shape
     - Rash on or around the nipple
     - Discharge from one or both nipples
     - Puckering or dimpling of skin
     - Lump or thickening in the breast
     - Constant pain in the breast or armpit
   - Symptomatic screening for common cancers and their risk factors and appropriate referrals for diagnosis and management shall be done for all PLHIV.
     - Screen all women and girls living with HIV who have initiated sexual activity for cervical cancer symptoms during the time of ART initiation.
     - Ask for tobacco use and counsel on adverse effects of tobacco and encourage to quit tobacco use.
     - Refer for clinical screening within 3 years if the initial test is negative.
     - Ask all women living with HIV above 30 years of age for breast cancer symptoms
     - All PLHIV of age >30 years should be screened using oral visual examination at the time of ART initiation.
     - PLHIV receiving radiotherapy or surgical intervention shall continue taking ART.

Referrals

- If symptoms told by the client pertain to cervical cancer, refer to a gynaecologist/lady MO wherever available or NCD clinic at CHC/DH for confirmation and further management.
- If any positive findings are noted during clinical breast examination, refer to surgeon for further evaluation (USG, biopsy, etc.), diagnosis and management.
- If any abnormality is noted during oral visual examination, PLHIV need to be referred to a surgeon/ENT specialist for further evaluation, diagnosis and management.

Mental health screening, diagnosis and management of depression among PLHIV

PLHIV are prone to psychological ailments due to HIV per se as well as opinions and experiences regarding HIV in their surroundings. They may face multiple types of

psychological issues like depression, anxiety, internalized stigma, etc. Any such issue can significantly hamper adherence and mental well-being.

Depression is a common mental disorder, which presents as persistent sadness or loss of interest or pleasure in daily living accompanied by disturbed sleep or appetite, feelings of guilt or low self-worth, tiredness, poor concentration, difficulty making decisions, agitation, hopelessness and suicidal and self-harm thoughts or acts.

Depression is two to three times more prevalent in PLHIV than in the general population. It is a significant contributing factor to poor adherence to ART and poor HIV treatment outcomes including treatment failure.

Screening for depression:

All PLHIV should receive basic screening for depression before initiating ART and thereafter every 6 months using the following two questions:

- During the past two weeks, have you often been bothered by feeling down, depressed or hopeless?
- During the past two weeks, have you often been bothered by little interest or pleasure in doing things?

Any patient who answers 'yes' to either of the above questions, and all patients with a detectable viral load after 6 or more months on, should undergo a more thorough screening for depression using the PHQ-9 screening tool(Refer Annexures).

At the time of ART initiation, the patient shall also be screened for history of manic symptoms (feeling very happy, elated or overjoyed, talking very quickly, feeling full of energy, being easily distracted, being easily irritated or agitated, being delusional, hallucinating and disturbed or illogical thinking), suicidal ideation or homicidal ideation. If any signs/symptoms suggestive of bipolar disorder/suicidal/homicidal tendencies are identified, the client should be referred to a psychiatrist.

Mental health in children and adolescents living with HIV

Childhood and adolescence are critical periods in development. The environment where children and adolescents grow up shapes their well-being and development. Early negative experiences at home, at school or with peers, such as exposure to violence, mental illness of a parent or other caregiver, bullying and poverty, increase the risk of mental illness.

Mental health disorders during childhood and adolescence are defined as delays or disruptions in developing age-appropriate thinking, behaviours, social skills or regulation of emotions. These problems are distressing to children and disrupt their ability to function well at home, at school or in other social situations.

Thus, there is a need to screen children and adolescents for mental health-related issues. This need is more urgent in children/adolescents with HIV.

The assessment of mental health issues of children and adolescentsis important and should be done. If they have one or more signs suggestive of a mental health condition, they need an evaluation by a paediatrician, psychiatrist and a clinical psychologist.

Table 14.2: Warning signs indicating presence of a mental health condition in children/ adolescents

1.	Persistent sadness for two or more weeks
2.	Withdrawing from or avoiding social interactions
3.	Hurting oneself or talking about hurting oneself
4.	Talking about death or suicide
5.	Outbursts or extreme irritability
6.	Out-of-control behaviour that can be harmful
7.	Drastic changes in mood, behaviour or personality
8.	Changes in eating habits
9.	Loss of weight
10.	Difficulty sleeping
11.	Frequent headaches or stomach aches
12.	Difficulty concentrating
13.	Changes in academic performance
14.	Avoiding or missing school.

Key Messages

- Opportunistic infections (OIs) are intercurrent infections that occur in PLHIV. OIs are common in PLHIV due to immunosuppression. So, they become prone to various OIs.
- The incidence of OIs has markedly declined in recent years because of the widespread availability of ART, early ART initiation in PLHIV as well as appropriate prevention and management of OIs.
- Management of OIs is based on syndromic evaluation and treating the cause. Vaccinations and good personal hygiene will help prevent OIs.
- HIV and TB are two diseases that have a synergistic impact on each other, increasing the risk of morbidity and mortality for co-infected patients. TB is an infectious disease that spreads through air. When a patient with untreated pulmonary TB coughs, sneezes or talks, they involuntarily throw TB germs into the air in the form of tiny droplets.
- There are two types of TB mainly affecting the lungs, causing lung (pulmonary) TB. In some cases, other parts of the body may also be affected, leading to extra-pulmonary TB ('extra' here means outside).
- To reduce the dual burden of HIV and TB, four strategies are recommended: intensified case finding, TB preventive therapy, infection control and ART for all PLHIV.
- Persons with cough for more than 2 weeks, with or without other symptoms suggestive of TB, should be promptly identified as presumptive pulmonary TB patients. They are to be referred to designated microscopy centre (DMC) for sputum examination.
- 4-symptom screening to find TB among PLHIV; assess if PLHIV have cough, fever, weight loss and night sweats.
- Ensure that any TB suspect at the ART centres should be attended by the MO (ART) on priority and should also be prioritized for testing and laboratory investigations. Instigate practices of good cough hygiene for all patients, with any duration of cough, at all ART centres for airborne infection.

- Isoniazid Preventive Therapy (TPT), for prevention of TB among PLHIV, was launched in India on World AIDS Day 2016. HIV/TB collaborative activities in India aim to reduce the dual burden of disease by providing prevention, diagnosis and treatment services for both infections.
- Treatment adherence is very important for TB. To assess and foster adherence, a patient-centred approach to administration of drug treatment should be planned.
- Treatment failure will lead to drug resistance. The patients develop multi-drug-resistant TB (MDR TB). It is contagious if not treated.
- Non-communicable diseases (NCD) are non-infectious health conditions that cannot be spread from person to person. These diseases generally last for a long period of time and are chronic in nature. NCDs are increasingly contributing to overall disease burden. PLHIVs are at high risk for NCD. Hypertension, diabetes, cardiovascular disease, common cancer, arthritis, and depression are some common examples of NCDs.
- They are influenced by risk factors such as unhealthy diet, lack of exercise, smoking and alcohol.
- PLHIV are more prone to NCDs due to immune activation, medication side effects, co-infections and aging.
- PLHIV need health promotion, screening, diagnosis, management and follow-up to prevent and treat NCDs.
- India has launched a national programme to eliminate HCV by 2030 and reduce the burden of other types of viral hepatitis.
- The programme provides free diagnostics and drugs for HCV and HBV at government health facilities.
- Testing for hepatitis B and C requires screening tests (anti-HCV and HBsAg) and molecular tests (HCV RNA and HBV DNA) to confirm the diagnosis and decide the treatment.
- Pre- and post-test counselling and screening for HBV and HCV at the ICTCs involve educating patients about the nature, transmission, symptoms, consequences, prevention and treatment of viral hepatitis.
- NCDs, also known as chronic diseases, are now becoming one of the leading causes of non–AIDS-related morbidity and mortality in PLHIV.
- The main types of NCDs are diabetes, coronary heart disease, stroke, cancers, and chronic respiratory diseases. Some of the major risk factors include unhealthy/unbalanced diets, lack of physical activity, smoking/tobacco use and excessive use of alcohol.
- Five components are recommended for prevention and management of NCDs: Health promotion, screening for early detection, diagnosis, management (including lifestyle changes and pharmacologic therapy),regular follow-up: monitoring achievement of treatment goals and monitoring adherence, side effects and drug–drug interactions.
- PLHIV are prone to have mental health issues like depression, anxiety, internalized stigma, etc. Any such issue can significantly hamper adherence and mental well-being. Regular screening and referral to psychiatry is required in such cases.

Role of the counsellors

- Educate PLHIV about OIs and and NCDs. Do preliminary assessment for OIs and NCDs and make appropriate referrals.
- Address concerns, clarify doubts. Provide guidance and support while availing services of other centres.
- OIs/NCDs are additional psychological and financial burden for the client.It creates stress and the life of the person gets affected. This results in poor adherence. So, provide support and address various concerns clients are experiencing due to the illness. For instance, clients may experience helplessness and hopelessness. It such a situation, a counsellor may say, "I know you are going through a difficult situation. But it is not going to be like this forever. If you follow the treatment properly, you will experience the difference in your health"; "Here many people come with various health issues. Some have similar issues like you, some have more complications. Still, those who follow the instructions and take proper treatment experience good health." Show confidence in the client by saying, "You will be able to do this". The clients may feel that the illness and the treatment are a burden. You may say, "Iunderstand. It is challenging/difficult, but not impossible. After a few days, you will get used to the new lifestyle". These messages are crucial to enhance adherence.
- Adherence counselling should be done for all OIs/NCDs.
- Mental health assessment of all PLHIV must be done. PHQ 2 should be administered before starting ART. Screening for other mental illnesses also should be done. In case of mental health issues,the client should be referred to the psychiatry department.

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Annexure: Ten-point counselling tool

Integrated 10 points counselling tool on TB/drug resistant TB

1. Tuberculosis (TB) is the most common opportunistic infection in people living with HIV (PLHIV) and leading cause of death in PLHIV.
2. TB is an infectious disease caused predominantly by Mycobacterium tuberculosis. The infection occurs most commonly through droplet nuclei generated by coughing, sneezing etc., inhaled via the respiratory route. TB usually affects the lungs, but may affect other parts of the body as well.
   - *An HIV-negative person infected with TB has a 10% lifetime risk of developing TB disease.*
   - *HIV increases the risk of progression from TB infection to TB disease and PLHIVs have a 60% lifetime risk of developing TB disease.*
3. People having cough of 2 weeks or more, with or without other symptoms, are referred to as pulmonary TB suspects (presumptive TB case). They should have 2 sputum samples examined at designated microscopy centre (DMC).
4. A person with extra-pulmonary TB may have symptoms related to the organs affected along with symptoms like enlarged cervical lymph modes, chest pain, pain and swelling of the joints, etc. Extra-pulmonary TB can be confirmed by other investigations.
5. All PLHIV should be regularly screened for TB using a clinical symptom-based algorithm consisting of any one of the symptoms of cough of any duration, fever, weight loss or night sweats at the time of initial presentation for HIV care and at every visit to a health facility or contact with a healthcare worker afterwards.
6. Diagnosis and treatment services for TB are available free of cost through National Tuberculosis Elimination Program (NTEP)
   - *2 sputum smear examinations are necessary for the diagnosis of pulmonary TB. During the course of treatment, the progress is monitored by means of follow-up sputum examinations.*
   - *Anti-TB drugs are provided as fixed dose combinations (FDCs) as per weight band.*
   - *Treatment is provided by 'Treatment Provider' at a place near the patient's home.*
   - *Cure from TB can only be ensured by taking complete and regular treatment. Without correct and complete treatment, a patient can become very ill or develop drug-resistant TB.*
7. PLHIV diagnosed with TB should be linked to ART services at the earliest, irrespective of CD4 count. Cotrimoxazole preventive therapy should be provided to all HIV–TB co-infected patients to prevent OI.
8. An HIV–TB co-infected patient should be referred to nearest NTEP certified culture and drug sensitivity laboratory facility/CBNAAT facility for diagnosis of drug-resistant TB. These cases will be managed as per latest guidelines on 'Programmatic management of drug-resistant TB in India under NTEP'.
9. The client's information is to be kept confidential and this information is not furnished under any circumstances to any other person except 'Shared confidentiality' with the treating physician and public health system DOT provider for better case management and to get benefit of prophylactic/treatment options available for him/her.

Annexure: Patient health questionnaire-9

S. No.	Patient Health Questionnaire-9 (PHQ-9)				
	Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total score	**Patient Health Questionnaire: Scores and Conditions**	
	Conditions	**Recommendations**
0–4	Depression unlikely	• Repeat screening as per schedule.
5–9	Mild depression	• Provide supportive counselling and continue to monitor. • If patient is on EFV, substitute with a different ARV after ruling out treatment failure.
10–14	Moderate depression	• Provide supportive counselling through trained counsellor.
15–19	Moderate to severe depression	• If patient is on EFV, substitute with a different ARV after ruling out treatment failure; and
20–27	Severe depression	• Referral to psychiatrist for further assessment and antidepressant medication

Annexure

Key supportive counselling messages to PLHIV with depression

Component	Key message
Psycho-social support	• Explain about depression and assure that it can be managed. • Feeling of hopelessness, worthlessness, negative emotions are part of depression and will revert with proper counselling and treatment. • Inform about course of counselling and treatment. • Identify supportive family members and involve them as appropriate. • Involve peers and community support groups.
Self-management skills	• Continue ART as prescribed. • Identify activities that they used to find interesting and pleasurable: encourage participation in these activities. • Get regular and sufficient sleep (appx. 7 to 8 hours). • Physical activities to be increased. • Contact ARTC/ healthcare facility immediately if thoughts of self-harm occur.
Reduce stress	• Identify and try to reduce stress points. • Identify and discuss stress-increasing points such as health issues, family and relationship problems, gender-based or partner violence, finances, stigma and discrimination. • Identify and discuss problem-solving techniques. • Suggest stress management such as meditation and relaxation techniques.

15 Nutrition in the Context of HIV and Adherence

Nutrition in context of HIV/AIDS

Nutrition assessment is one of the important components of ART preparedness counselling. Nutritional assessment helps counsellors understand the dietary habits, nutritional status and needs of the patients and advise nutritional interventions accordingly. Based on the needs, the counsellors facilitate linkages with nutritional supplementation schemes of government departments and NGOs.

- HIV and frequent opportunistic infections increase the use of energy and nutrients in the body.
- Proper nutrition helps in the process. It helps in dealing with side effects of medicine, managing HIV-related symptoms and hence leads to a productive life. Proper nutrition keeps the immune system stronger so PLHIV can better fight disease.
- If the increased energy and nutrient needs are not met in PLHIV, they may lose weight and become undernourished.
- This undernourishment can weaken the body's immune response even more.
- The weakened immune system results in repeated infections, which can make the PLHIV develop AIDS more quickly.
- HIV also impacts the digestive system and liver, thus leading to poor absorption of nutrients. Hence, it is important to consider the right quantity and quality of frequent meals.
- Repeated infections further increase nutritional needs, leading to poor nutritional status, and so the cycle continues.

Strategies to meet nutritional requirements of PLHIV

Consuming a variety of foods from each of the main groups daily is important to maintain good nutritional status to help fight illness.

What can the HIV counsellor do?

The HIV counsellors can provide suitable nutrition counselling that helps in breaking the vicious cycle between HIV and malnutrition. Counsellors are also expected to refer children and adults with malnutrition to specialists such as paediatricians, internists and dieticians.

Aspects of nutrition counselling

The counsellor should always remember that nutrition counselling should be simple, practicaland tailored to the client's needs. It should consider the patient's socio-economic status, religious and cultural beliefs. To assess and identify the client's needs, the counsellor should collect the following information about the client:

- Dietary intake (amount and kind of food eaten);

- Presence of HIV-related symptoms or illnesses (e.g., oral thrush, mouth sores, dental problems, vomiting, diarrhoea, depression, appetite loss, altered taste) that may affect food intake of the client;
- Methods of food preparation;
- Food access (availability) to the client i.e., food security;
- Sanitation and hygiene conditions in which food is prepared, i.e., food safety.

Counselling on dietary intake

Counselling on dietary intake simply refers to the question of 'what to eat?'. The counsellor should help the client to understand the need to have a diet which is diverse enough to provide him/her with the necessary nutrients.

The daily diet for a healthy PLHIV adult should include all three food groups:

- **Energy-giving food** like whole cereals, sugar, starchy vegetables and fruits;
- **Body-building food** like pulses, eggs, nuts, milk and milk products;
- **Protective food** like fruits, vegetables and water.

Consuming a variety of foods from each of the main groups daily is important to maintain good nutritional status to help fight illness.

Table 15.1 - Aguidefordailydietfor adults

Cereals	Rice, roti, bread, dalia and upma, i.e.,energy-giving foods. (6–11 servings) 1 serving cereal = 1 roti/1 bread slice/ ½ katori rice
Pulses	Soyabean, rajma and green gram dal, which provide protein, vitamins and soluble fibre – that is body-building foods. (2-3 servings) 1 serving pulse = 1 katori cooked dal
Milk products and animal foods	Milk products and animal foods are body-building foods. These are rich in fat and cholesterol. So, encourage clients to make a careful selection (2–3 servings). 1 serving milk products = 1 cup milk/1katori curd;
	1servingmeat= 1 egg/ 2 pieces of meat/ chicken approximately 100g per piece
Fruits and vegetables	Rich in minerals, vitamins, antioxidants and fibre, i.e., protective foods. Fruits (2–4 servings) and vegetables 1 serving fruit = 1 medium-sized fruit 1 serving vegetables = vegetables
Sweets and oil	Should be consumed sparingly

Note: *Avoid high fat and fried food. Consume healthy food and eat in small and frequent meals (5–6 meals/day), drink plenty of water and liquids at least 7–8 glass per day, Avoid caffeine, alcohol and smoking. Exercise regularly.*

For more details, refer to annexure.

Eight critical nutrition practices to prevent malnutrition among PLHIV:

i. Regularly monitor weight.
ii. Increase energy intake by eating a variety of foods, especially energy-rich foods. This is critical for periods of illness.
iii. Drink plenty of boiled or treated water.
iv. Practice a healthy lifestyle by avoiding alcohol, tobacco, sodas and other coloured, sweetened or carbonated drinks.
v. Maintain hygiene and sanitation.
vi. Exercise regularly.
vii. Seek early treatment of infections and manage symptoms with dietary practices when possible.
viii. Return to the usual eating patterns when HIV-related symptoms or illnesses resolve.

Managing HIV-related symptoms through diet, weight loss and food safety

The counsellor can help PLHIV to select those foods and nutrition practices that help in managing the effects of HIV-related symptoms.

Table 15.3 - Symptom management through diet

Symptoms	Symptoms Management through Diet
Diarrhoea	• Eat small amounts of food more often. • Eat bananas, mashed fruit, soft boiled white rice, rice kanjee and porridge (daliya) to help slow down the diarrhoea. • Eat food at room temperature; very hot or very cold foods stimulate the bowels and make diarrhoea worse. • Drink a lot of fluids (soups, diluted fruit juice, clean boiled water, weak tea and oral rehydration solution). • Avoid high-fat or fried foods. • Avoid coffee and alcohol. • Avoid foods that cause gas or stomach cramps, such as beans, cabbage or onions. • Limit or eliminate milk and milk products such as yoghurt (dahi) to see whether the symptoms will improve. • Remove the skin from fruits and vegetables.
Loss of appetite	• Eat small, frequent meals (5–6 meals/day);eat nutritious snacks. • Add flavour to food and drink. • Drink plenty of liquids. • Exercise lightly and do light activity. • Take walks before meals: Fresh air helps to stimulate appetite. • Having family or friends assist with food preparation and sharing a meal provides a psychological ambience that aids appetite.
Mouth sores	• Eat foods cold or at room temperature. • Eat soft and moist food such as porridge (daliya), mashed potatoes or mashed non-acidic vegetables or fruit.

Symptoms	Symptoms Management through Diet
Nausea and vomiting	• Avoid caffeine, alcohol and smoking, which can irritate mouth sores. • Avoid citrus fruits, tomatoes, spicy foods and very sweet, sticky or hard foods. • Soften your food by soaking it in liquid (milk, broth, juices, soup). • Drink fluids with a clean straw to ease swallowing. • Clean and rinse your mouth after each meal. • Eat small, frequent meals (5¬–6 meals/day);eat bland food. • Avoid food with strong or unpleasant odours. • Avoid an empty stomach as this makes nausea worse. Avoid lying down immediately after eating. • Avoid coffee and alcohol. • Drink plenty of liquids.
Constipation	• Eat fibre-rich fruits (mangoes, guavas, jackfruit), vegetables (beans, peas, pumpkin, carrots, green vegetables) and sprouts. • Drink at least eight glasses of fluids a day, especially boiled water. • Drink a cup of warm water in the morning before eating to help the bowels move. • Do light exercises like taking frequent short walks.
Anaemia	• Eat organ meat, fish and eggs. Eat cereals like ragi and bajra. • Eat a variety of green leafy vegetables (radish greens, mint, chaulai, cauliflower leaves and sundaikai). The best way for the body to utilize iron from plant sources is to combine food rich in vitamin C like amla, guava, oranges and lemons. • Take jaggery and dates between meals.

Counselling on dietary intake

Number of meals the client eats each day: Normally, the client should take 4–5 meals per day (breakfast, lunch, dinner and one or two snacks a day). But during acute illness, the client should be served small frequent meals on a 2-hourly basis (that is 5–6 small meals) as the bodily requirements for food increase. Palatable snacks like sooji, idli, dhokla or vegetable sandwich should be incorporated. Each meal should be made nutrient-dense as the appetite is poor.

- Counsel the client to eat a variety of food items.
- Assess whether the client's diet is nutritious or not. Counsel the client that diet can be made nutrient-dense by adding locally available ingredients such as milk powder to kheer; adding honey/jaggery (gud) to drinks and food; adding vegetables to roti, rice and pulse preparations; adding dal to soups and rasams; adding besan to paratha/chapati to make paustik roti; adding peanuts to upma, poha or pulao.
- Check whether the client has habits like smoking or drinking alcohol and encourage the client to avoid alcohol or smoking as they affect the appetite.

When counselling on dietary intake, it is critical to remember that the dietary needs of PLHIV are greater than those of non-infected people.

Counselling PLHIV for weight loss

The counsellor should inform the client that weight change over a given period indicates how his/her nutritional status has changed. Unintentional weight loss indicates poor food intake or disease that affects food digestion, absorption or utilization. For an average adult, serious weight loss is indicated by a 10% loss of body weight or 6–7 kg in one month. Refer to the appropriate health provider as needed.

Following points are communicated to clients to gain weight:

- Increase the quantity of food. Increase intake of cereals, pulses and nuts.Eat four to six small meals instead of two or three big meals.
- Make meals energy dense by adding peanuts, gingelly seeds, jaggery and oil/ghee/butter.
- For stimulating appetite, have vegetable clear soups, rasam, jaljeera or chicken soup. Eat fruits like mango, banana, chikkoo, grapes, papaya etc.
- Prepare mixed flour laddoos or til/peanut chikki/laddoo made with jaggery. Consume these foods between meals.
- Chew food well before swallowing.
- Prepare some premixes with roasted cereals and pulses. Cook them in milk/water with sugar/jaggery to a consistency of porridge or sheera/halwa and consume them in between meals. The addition of cardamom can enhance the flavour.
- If affordable, consume a boiled egg every day.

Counselling on food safety

Food safety is very important. Food should be stored and prepared with proper hygiene. The consequences of food-borne illness are more severe for people with low immunity such as PLHIV.

- Maintain clean surroundings and cooking utensils to stop food-borne illnesses from spreading.
- Protect food from rodents, insects and animals.
- Wash hands thoroughly before and after cooking. Use clean water for cooking.
- Keep raw and cooked foods separate to stop germs from spreading. This is particularly important for raw meat.
- Wash all fresh fruits and vegetables thoroughly.
- Cook food thoroughly to kill germs, but avoid overcooking vegetables.
- Eat cooked food immediately.
- Store food carefully.
- Eating outside food is generally discouraged. This is particularly true for raw vegetables, fruits or curd. Fresh home-made food is the safest because the client would have taken adequate care to ensure it is free from infective agents.

Nutritional Care of HIV-Exposed and Infected Children (>6 months)

For all infants more than 6 months of age, complementary feeding should be started irrespective of HIV status and initial feeding options. The guiding principles for complementary feeding are as follows:

Table 15.4- Guiding principles for complimentary feeding

Sr. No.	Guiding Principle
1	Introduce complementary foods at 6 months of age (180 days) while continuing to breastfeed.
2	Start at 6 months of age with small amounts of food and increase the quantity and frequency as the child gets older while maintaining frequent breastfeeding.
3	Gradually increase food consistency and variety as the infant grows older.
4	Feed a variety of nutrient-rich and energy-dense food from the family pot to ensure that all nutrient needs are met.
5	Practise responsive (active) feeding, applying the principles of psychosocial care, good hygiene and proper food handling.
6	All breastfeeding should stop only when a nutritionally adequate and safe diet, without breast milk, can be provided by complementary feeds.
7	Assess the child's nutritional status regularly. HIV-positive children: Classify appropriately as one of the three – growing, poor weight gain/conditions with increased nutritional needs or severe acute malnutrition.
8	In addition to age-specific needs, HIV-positive children who are growing appropriately will require additional 10% energy based on actual weight.
9	In addition to age-specific needs, HIV-positive children who have poor weight gain or have conditions with increased nutritional needs will require additional 20–30% energy based on actual weight.
10	In addition to the age-specific needs, HIV-positive children with severe acute malnutrition (SAM) will need therapeutic feeding to provide 50–100% additional calories and should be referred to appropriate facility for management of SAM.

Management of children with severe acute malnutrition

The major causes of morbidity and mortality among CLHIV less than 5 years of age are pneumonia (including PCP), TB, bloodstream infections, diarrhoeal disease and SAM. Children with SAM have signs of visible wasting, bilateral oedema (build-up of fluid in the body) and severely impaired growth. They must be identified and managed correctly since they are at a very high risk of mortality. These children should be evaluated at an ART centre for the following:

a) Anaemia

b) Opportunistic infections including TB

c) Drug side effects

d) Treatment adherence

e) Treatment failure

f) Immune reconstitution inflammatory syndrome (IRIS).

Unless associated complications are appropriately managed, improvement in diet alone may not result in normal growth, weight recovery or improvement in clinical status.

As per the Nutrition Guidelines for HIV-Exposed and Infected Children (0–14 years of age), children with SAM require 50%–100% extra energy every day after the period for stabilization till nutritional recovery (usual duration 6–10 weeks). They should be treated with therapeutic feeding. Children with no medical complications may be managed at home if they still have a good appetite. They can receive good supervision at home and therapeutic feeds can be provided.

Children who are sick and have associated complications like infections, have a poor appetite or are unable to eat **must be referred** for inpatient care by trained staff with experience in nutritional rehabilitation.

PLHIV who are well-nourished are likely to

- Have a better quality of life and be able to work;
- Enjoy good health, remain active, care for themselves and help with the care of children and other dependents;
- Have fewer illnesses and recover more quickly from infections, thus reducing costs for healthcare;
- Maintain a good appetite and stable weight.

A table of some **common myths and misconceptions about nutrition for PLHIV**, along with the facts and explanations.

Table 15.5 - Myths and misconceptions about nutrition for PLHIV

Myth	Fact
There is one, single food that can ensure good health and protect from HIV.	No single food can provide all the nutrients that the body needs. A balanced diet that includes a variety of foods is essential for good health and immunity.
PLHIV need to eat more protein than other people.	PLHIV do not need to eat more protein than the recommended amount for their age, sex and activity level. Too much protein can strain the kidneys and liver, which may already be affected by HIV or ART.
PLHIV should avoid fats and oils.	Fats and oils are important sources of energy and essential fatty acids, which help the body absorb fat-soluble vitamins (A, D, E and K). PLHIV should not avoid fats and oils, but choose healthy types such as olive oil, canola oil, nuts, seeds, avocados and fatty fish. These fats can help lower cholesterol and inflammation and improve heart health. PLHIV should limit saturated fats (found in butter, cream, cheese, fatty meats, etc.) and trans fats (found in processed foods, baked goods, margarines, etc.), as these can increase the risk of cardiovascular disease.

Myth	Fact
PLHIV should eat more sugar to gain weight.	Sugar provides empty calories that do not have any nutritional value. Eating too much sugar can lead to weight gain, tooth decay, diabetes and other health problems.
PLHIV should avoid raw fruits and vegetables since	Raw fruits and vegetables are rich sources of fibre, vitamins, minerals and phytochemicals that can boost immunity and digestion. Wash before eating. Cooking fruits and vegetables can destroy some of their nutrients and reduce their benefits.
PLHIV should drink alcohol to cope with stress or improve appetite.	Alcohol can interfere with the absorption and metabolism of ART drugs and other medications. It can also damage the liver, which is responsible for processing drugs and toxins. Alcohol can also impair the immune system, increase inflammation, dehydrate the body and affect mood and mental health.

Key Counselling Messages

- Nutrition assessment is one of the important components of the ART preparedness counselling. Nutritional counselling helps counsellors understand the dietary habits, nutritional status and needs of the patients and advise nutritional interventions accordingly.
- For the purpose of nutritional assessment, the counsellor should ask the client to recall the 24-hour menu the client is following:
  - "Can you tell me what your daily meal is like on an average day (An average day is a day on which you might go to work or to school.)?"
  - "What do you have in the morning when you get up? Do you have breakfast? At what time? When do you have lunch and dinner?"
  - "What do you eat in each meal? What is the quantity?"
  - "Can you tell me what your meal is like on a special day (e.g., a Sunday or a religious festival)?"
  - "Can you tell me what your meal is like on a day when you fast?"

If needed, the counsellor should discuss how the client could modify existing meal patterns to make them more nutritious. Take care to make suggestions that are affordable to the client. E.g., some clients do not eat breakfast due to lack of time and cost. So, suggest some cost-effective and less time-consumingfood to include in the breakfast e.g.eggs/sprouts/ banana etc.

- Assess why some clients do not have anutritious diet. Explore the possible reasons and address the same as follows:

Table 16.6- Reasons of non-nutritious diet and possible counselling points

Myth	Counselling points
No awareness	Give information. Discuss the importance of nutrition. Use BCC material to explain in simple language.
Clients think that it is not affordable	Suggest some low-cost but nutritiousdiet. Include eggs/sprouts/bananasin the meals. Make use of jaggery/gud, and add vegetables to the roti,rice,dal etc.
No time	Simple ways can be suggested e.g.instead of making roti–subji, make paratha/khichadi with dal and vegetables. Have salad and curd with it.
No energy to make	Simple food can be cooked. Inform the clients thatif they start having nutritious food, their energy levels will increase. Also find out the reasons for low energy. Refer the client to the medical officer.
Do not like the food which is advised or not used to follow meals pattern suggested	One has to develop the habit of eating specific food and following the pattern (4–5 meals a day). Initially, it is difficult to follow but later on clients may get used to it.

Explore if any other reason is there. E.g. family members may not be supportive. These issues should be addressed.

- Counsellors should check with the clients what is doable, what is not doable and suggest accordingly. Try to understand the possible hurdles. Discuss how to address them.
- Nutrition counselling should include not only the person infected with HIV/AIDS but also the family.
- Counsel for critical nutrition practices to prevent malnutrition.
- Referrals and linkages: Guide the patients about various programmes and schemes that provide direct nutritional support or monetary benefit for the nutritional support: e.g., anganwadi. Patients may avail of nutrition services from other health programmes or from NGOs as per eligibility.
- Nutrition counselling is not one-time counselling. It should be done every time clients visit the centre. Follow up on whether the nutrition plan is being followed, what are the challenges etc. Modify it as per need. Every time, motivate them to follow it. Otherwise, after a few days they go back to the old pattern. So, encouragement is very important.
- Community-based activities can be conducted with support from NGOs (where possible) e.g., competition for nutritious food cooking, quiz on nutrition, etc.

References:

- *Nutrition Guidelines for HIV-Exposed and Infected Children (0-14 Years of Age)*
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- *Fenneld. (2023, May 15). 8 common myths about HIV and AIDS. Cleveland Clinic. https://health.clevelandclinic.org/myths-about-hiv/*
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Annexure: Nutrients, their functions and commonly available sources

The table below shows the category of foods/nutrients, their function in our body and commonly available sources of such nutrients. The daily diet for a healthy adult PLHIV should include all three food groups:

Around 63 thousand (36.72–104.06 thousand) new HIV infections were estimated in 2021. Almost 92% of total new infections were reported to be among the population aged 15 years or older, including around 24.55 thousand (14.27–40.69 thousand) among women. Around 42 thousand PLHIV died of AIDS-related mortality in the same reference period.

Table - Nutrients, their functions and available sources

Nutrients	Function	Commonly Available Sources
Energy-giving foods: (Carbohydrate and fat)	To provide energy to our body To maintain body temperatures, for metabolic purposes	Carbohydrate-rich foods are rice, wheat, potato, sugar, honey, bajra, jowar etc. Rich sources of fat are fish, walnuts, corn, soyabean and sunflower oil. Similarly, nuts, mustard, olive oil and fish are the sources of monounsaturated fat.
Body-building foods (Protein)	Proteins are the building blocks of our body.	Protein-rich foods are pulses, peas, nuts, beans, soyabeans, milk, egg, fish and meat.
Protective foods (Iron, calcium, zinc, iodine, sodium)	Minerals are needed for bones, teeth, healing of wounds, fighting infections, converting food into energy and body repair.	Green leafy vegetables, egg yolk, jaggery and organ meat are good sources of iron. Milk products, methi leaves and almonds are good sources of calcium. Whole grains, yeast, nuts, seafood (lobster, salmon) and pulses are rich sources of zinc. For sodium and iodine, intake of iodised salt is very important.
Vitamins (e.g., Vitamin A, B, C, D, E, K)	Prevent infections, develop antibodies, healthy skin, eyesight, absorption of calcium and antioxidants against ageing	Intake of green and leafy vegetables, pulses, eggs, milk and milk products, fruits (citrus fruits for Vitamin C), fish, nuts, seeds, grain and cereals and exposure to sunlight is essential for the maintenance of different types of vitamins in our body.
Fibres	Important in the process of digestion and absorption	Rich sources of fibre are vegetables, grains, oats, pulses and fruits with skins like apples and plums

16 Elimination of Vertical Transmission of HIV and Syphilis (EVTHS)

India's commitment to the dual elimination of HIV and Syphilis

India has programmatically moved towards achieving the global 95:95:95 targets by 2025. These targets aim to ensure that 95% of all pregnant women diagnosed with HIV are aware of their status, 95% of pregnant women diagnosed with HIV are on treatment and 95% of all infants born to women living with HIV have HIV-negative status. However, achieving these targets requires sustained commitment and action to address the scale of challenges ahead.

Despite this, the progress in EVTHS has also been significant. While the registration of pregnant women in ante-natal care (ANC) services was 95% in 2021–2022, the HIV testing reported in pregnant women for HIV was 84% and for syphilis was 57%. ART coverage in pregnant mothers with HIV infection was 64% against a target of 95%. Adequate treatment coverage in pregnant women seropositive for syphilis was 78% against a target of 95%.

What is vertical transmission?

Vertical transmission refers to the transmission of infection from mother to child, which can take place during pregnancy (in-utero), during labour and delivery (perinatal) or postpartum through breastfeeding. In recent years, substantial efforts have been made to prevent vertical transmission of HIV and syphilis.

Newer four prongs of EVTHS under NACP-V

Prong 1: Primary prevention of HIV and syphilis among women of childbearing age. This can be achieved by providing sexual and reproductive health services and other relevant health services to women at an early age. It is important to engage with the community structures and work collaboratively to increase awareness and improve access to prevention services.

Prong 2: Preventing unintended pregnancies among women living with HIV by offering suitable counselling, guidance and contraception to women living with HIV, to address their unmet needs for family planning and birth spacing. This will help in improving the health outcomes for these women and their children.

Prong 3: Prevent HIV and syphilis transmission from pregnant women to their children by providing pregnant women with HIV testing and counselling services, as well as access to ARV drugs during pregnancy, delivery and breastfeeding. Additionally, it is crucial to ensure that screening and management services for syphilis are readily available and accessible to pregnant women.

Prong 4: Providing care, support and treatment to infected pregnant women, their partners and HIV-exposed infants (HEIs) and management of syphilis-exposed infants (SEIs). This includes ensuring access to ART to manage HIV. Additionally, it is essential to ensure adequate management of syphilis in pregnancy and screening and management of SEIs. Adequate management of infants diagnosed with congenital syphilis is also essential.

The newer four prongs of EVTHS under NACP V

Table 16.1 - Newer four prongs of EVTHS under NACP-V

	Prong 1	Prong 2	Prong 3	Prong 4
HIV	Primary prevention of HIV, especially among women of childbearing age	Preventing unintended pregnancies among WLHIV	Prevent HIV and syphilis transmission from pregnant women to their children	Provide care, support and treatment to infected pregnant women, their partners and HIV-exposed infants; management of syphilis-exposed infants
Syphilis	Primary prevention of syphilis, especially among women of childbearing age			

Table 16.2 - Risk of HIV transmission from mother to child with and without ARV interventions

ARV intervention	Risk of HIV transmission
No ARV; breastfeeding	30–45%
No ARV; no breastfeeding	20–25%
Short course with one ARV; breastfeeding	15–25%
Short course with one ARV; no breastfeeding	5-15%
Short course with two ARVs; breastfeeding	5%
3 ARVs (ART) with breastfeeding	2%
3 ARVs (ART) with no breastfeeding	1%

Primary Prevention

This includes a mix of commodity services (like differential HIV testing, STI screening), non-commodity services (like counselling and risk reduction) and referral services to engage women who are 'atrisk' of acquiring HIV/syphilis to ensure that they stay negative and healthy.

Counselling

- Inform, educate and counsel adolescents on adolescent health issues and refer clients to health facilities, HCTS confirmatory facilities, de-addiction centres, non-communicable disease clinics etc.
- Counsellor at ART centre should counsel the adolescents living with HIV for safer sex practices, positive and healthy living and prevention of transmission of HIV/syphilis.
- Counsellor should provide counselling services to high-risk populations regarding safer sex practices, behaviour change and condom promotion for the reduction of STI/RTIs.

- Women in the reproductive age group should be encouraged to establish and maintain routine gynaecological care, nutritional care and management of NCDs through regular visits to health facilities.

Essential package of services for the prevention of vertical transmission of HIV

Table 16.3 - Essential package of services for prevention of vertical transmission of HIV

Essential Services	Key Points
Routine HIV counselling and testing	Offered to all pregnant women; involve partners and family members
Provision of ART for all HIV+ pregnant/breastfeeding women	Regardless of CD4 count, for prevention
Ensuring institutional deliveries for HIV+ women	Reducing stigma and discrimination among healthcare workers; ensuring safer childbirth environment
Comprehensive care for various conditions	STIs, RTIs, TB, opportunistic infections, hypertension and diabetes
Provision of plasma viral load testing at 32–36 Weeks	Determines HIV transmission risk
Nutrition counselling	Provision of nutrition counselling and psychosocial support to HIV-infected pregnant women
ARV prophylaxis for infants	Administered within 72 hours of birth
Follow-up care for HEIs and immunization	Integrated into routine healthcare services
Co-trimoxazole prophylactic therapy (CPT)	Administered from six weeks of age
Enhance community follow-up and outreach	Support for HIV+ pregnant women and families, through local networks
Management of HIV-Exposed Infants	
Immediate care and ARV prophylaxis for newborns	Based on national guidelines: At birth, ARV prophylaxis should be provided, preferably within one hour or within 72 hours of delivery.
Coordination for newborn ARV prophylaxis	For infants of newly identified HIV+ mothers during labour. Labour room nurse should coordinate for ARV prophylaxis.
Infant feeding	Infant feeding should be started based on the counselling provided during the ANC period. Mothers who are identified HIV positive during labour should be counselled for infant feeding options by the labour room nurse.

Essential Services	Key Points
Monitoring ARV prophylaxis adherence	Initiated and monitored for newborns
CPT initiation and monitoring	Begins at six weeks for prophylaxis
Follow-up of infant growth, development monitoring, clinical assessment	It should take place at the ART centre at 6 weeks, 6 months, 12months and 18 months from birth. Early infant diagnosis should take place at a collocated HCTS confirmatory site.
Additional monitoring of growth and development	Regular monitoring at specific intervals (10 weeks, 14 weeks, 9months and 15 months from birth at healthcare centres
ART Initiation for HIV+ Infants	If HIV+ status is confirmed
Confirmatory testing and regular follow-Up	At 18 months or after 3months breastfeeding cessation
Referral of infant for syphilis care if mother is co-infected	Appropriate care for co-infected mothers

Note: *When an infant cannot be taken to an ART centre, care can be provided at a linked ART centre under the supervision of the medical officer. In a few cases, if the child cannot be taken to a linked ART centre as well, the medical officer of the centre may coordinate with the nearest health facility (preferably one which has a medical officer trained to manage HEIs) or through teleconsultation for providing essential HIV care.*

Dual Prophylaxis of HEI

Dual prophylaxis for high-risk infants is considered when:

- Infants born to HIV-positive mother not on ART;
- Maternal viral load not done after 32 weeks of pregnancy;
- Maternal plasma viral load not suppressed after 32 weeks of pregnancy;
- Mother newly identified HIV positive within 6 weeks of delivery.

Dual prophylaxis includes Syrup Nevirapine and Syrup Zidovudine. The duration of the dual prophylaxis is as follows:

- In case of exclusive replacement feeding: From birth till 6 weeks of age;
- In case of exclusive breastfeeding: From birth till 12 weeks of age.

Early Infant Diagnosis

Children who contract HIV while in the womb or during birth tend to experience a rapid progression of the HIV disease within the first few months of their life, which often results in death.

The goal of Early Infant Diagnosis (EID) is to detect HIV infection in infants who were exposed to the virus and initiate ART as soon as possible to reduce their chances of morbidity and mortality.

Infant Feeding Guidelines

a) **Counselling mothers on feeding strategy**

Antenatal counselling for infant feeding is vital, starting early after HIV diagnosis. HIV-positive mothers should be informed about exclusive breastfeeding (EBF) or exclusive replacement feeding (ERF) options with education on pros and cons. Healthcare providers must be trained to assist parents in making informed choices. Discussions should occur before delivery, emphasizing ART adherence for EBF and explaining both strategies. Family context should guide decisions, tailored to each mother's needs. Counsellors play a key role in supporting successful implementation of chosen feeding option.

b) **Exclusive Breast Feeding (EBF)**

- The recommended feeding option, as per WHO and national guidelines, is exclusive breast feeding for a minimum of 6 months.
- After 6 months of EBF, mothers should introduce appropriate complementary feed while continuing to breastfeed their infants.
- Even if practising mixed feeding, EBF is still recommended during the first 6 months. This is not a reason to stop breastfeeding in the presence of ARV drugs.
- Breastfeeding can be continued for up to 24 months or beyond, regardless of the child's HIV status.

c) **Exclusive replacement feeding (ERF):**

The six criteria to be used to assess suitability for ERF are as follows:

Table 16.4 - Six criteria to assess suitability for ERF

Mothers known to be HIV infected should give replacement feeding to their infants **only when ALL** the following conditions are met:

1. **Safe water and sanitation** are assured at the household level and in the community.
2. The mother or any other caregiver can **reliably afford** to provide sufficient and sustained replacement feeding (milk), to support the normal growth and development of the infant.
3. The mother or caregiver can **prepare it frequently enough in a clean manner** so that it is safe and carries a low risk of diarrhoea and malnutrition.
4. The mother or caregiver can, in the first six months, **exclusively give replacement feeding**.
5. The **family is supportive** of this practice.
6. The mother or caregiver can access **healthcare** that offers comprehensive child health services.

d) Benefits and Risks of Exclusive breastfeeding and Exclusive Replacement Feeding

Table 16.5 - Benefits and risks of EBF and ERF

	Exclusive breastfeeding (EBF)	Exclusive Replacement feeding (ERF)
Benefits	• Breast milk contains all the nutrients the baby needs in the first six months. • Breast milk is easy to digest. • Breast milk protects the baby from diarrhoea, pneumonia and other infections. • Breast milk is readily available and does not require preparation. • Breastfeeding helps in developing mother–infant bonding. • Exclusive breastfeeding helps the mother to recover from childbirth early. • Exclusive breastfeeding protects the mother from getting pregnant again too soon. • It prevents postpartum depression.	• No risk of HIV transmission through feeding • Other family members may be involved in feeding when mothers need help • The expense of obtaining appropriate milk, water, fuel, the added task of cleaning utensils
Risks / Demerits	• Risk of acquiring HIV infection if the baby is breastfed	• Babies are at higher risk of contracting diarrhoea, pneumonia and other infections • The mother may be questioned about not breastfeeding her baby.

Elimination of Vertical Transmission of Syphilis

Table 16.6 - Elimination of vertical transmission of Syphilis

Introduction	• Syphilis is an STI caused by Treponema pallidum. • It may be transmitted through the following routes: - Unsafe sex with an infected person (oral/vaginal/anal sex) - From an infected mother to her child during pregnancy and labour - Transfusion of infected blood and blood products • Syphilis is an easily preventable, diagnosable and curable disease.
Syphilis in pregnancy	• Syphilis can be transmitted from an infected pregnant woman to her child during pregnancy and labour. • The infection is associated with various adverse birth outcomes, including early foetal loss, stillbirths, neonatal deaths, low birth weight, prematurity and transmission of infection to the infant (also known as congenital syphilis). • Congenital syphilis is a serious but preventable disease that can be prevented through effective screening of pregnant women; timely and

	appropriate treatment of infected women should be initiated without delay.
Screening and management of syphilis in pregnancy and treatment monitoring	• Pregnant women should be screened for syphilis during their first ANC visit (preferably in the first trimester). • It can be screened using dual rapid diagnostic test (RDT) kits or rapid plasma reagin (RPR)/VDRL kits. • **Re-testing criteria:** If a woman is serologically non-reactive for syphilis and/or HIV during pregnancy, the screening should be repeated if she lives in areas with a high prevalence of syphilis among pregnant women (>1% seropositivity), where women are at risk of getting infected with syphilis during pregnancy in the third trimester (32–36 weeks) and during labour. • Syphilis screening at screening sites (facility integrated ICTCs, VHND, PMSMA, etc.) can be conducted using dual RDT kits or rapid plasma reagin, while the screening at confirmatory sites (standalone ICTCs) can be conducted using RPR/VDRL kits. When facility for RPR/VDRL testing not available, pregnant woman may be referred to nearest SA-ICTC or DSRC.
Linkages of syphilis reactive cases	• If any pregnant woman is found reactive for syphilis, then the ANM should write on the MCP card for the pregnant women "Reactive for Syphilis" and refer the pregnant woman to the nearest PHC. She must also share details with the linked In-charge PHC MO. • Ensure atleast one dose of injection benzathine penicillin to all the pregnant women screened reactive for syphilis at the nearest treatment facility (including DSRC). • Link all screened syphilis-reactive pregnant women to confirmatory sites for confirmation. All women screened reactive with RPR/VDRL should be provided with complete treatment with 3 doses of injection benzathine penicillin at the nearest treatment facility (including DSRC).
Screening and management of SEIs	• The term 'syphilis-exposed infants'(SEIs) is used to refer to infants born to mothers infected with syphilis until congenital syphilis infection can be reliably excluded or confirmed. • Infants might be born without clinical signs of syphilis but go on to develop late-stage manifestations of untreated congenital syphilis that include developmental delays, neurologic manifestations and physical signs of late congenital syphilis (like swelling of joints, skin lesions, jaundice, anaemia, changes in long bones, etc.). • All SEIs at birth should be referred to the nearest special newborn care unit/neonatal intensive care unit/paediatric treatment facility at a medical college/district hospital/sub-district hospital. • The infants should be screened and managed by a paediatrician at the facility using crystalline penicillin. • The RPR titers of both mother and infant at birth should be compared and the infant should be managed using the guidelines for scenario-based case management.

Hepatitis B

Hepatitis B is the inflammation of the liver caused by Hepatitis B virus. The virus is most commonly transmitted from mother to child during birth and delivery, through contact with blood or other body fluids during sex with an infected partner and unsafe injections or exposures to sharp instruments.

a) **Symptoms:** May not show any symptoms in the infected person in the initial stages. The symptoms include but are not limited to the following:

- Fatigue
- Poor appetite
- Stomach ache
- Nausea/vomiting
- Dark urine and jaundice-like symptoms.

b) **Screening of Hepatitis B:** The risk of Hepatitis B (HBV) infection may be higher in HIV-infected adults, and therefore all people newly diagnosed with HIV should be screened for HBsAg. HBV infection also negatively impacts the progression of HIV infection leading to faster immune deterioration and higher mortality. Screening serological tests and molecular tests are required to establish a diagnosis of hepatitis B (HBV) for evaluation for further management.

Routine investigations like complete blood count, including platelets, and estimation of liver enzymes alanine transaminase and aspartate aminotransferase, are essential to decide whether a client is cirrhotic (complicated) or non-cirrhotic (uncomplicated). Apart from these, renal function tests also must be done before treatment is initiated.

c) **Treatment**

Designated health facilities (treatment centres/model treatment centres)

- HBV-positive clients should be referred to the treatment centres/model treatment centres under the NVHCP depending on their condition. The treatment centres are located at district hospitals and designated sub-district hospitals, CHCs and PHCs, while the model treatment centres are in designated medical colleges/tertiary care hospitals.
- Once a client reaches the relevant centre, they should meet with the physician/medical officer and they will be managed as per the NVHCP guidelines.

In case of clients diagnosed with HIV and HBV

- In case a client has co-infection of HIV and HBV, they should be referred to the ART centre. Further, it will be the responsibility of the ART centre to link the client to a model treatment centre under the NVHCP.
- Explain to the client about how co-infection of HIV with HBV may deteriorate their health despite taking ART regularly and lead to rapid deterioration in liver function. Also, inform the client that their ARV regimen may need modification in case of co-infection.
- The counsellor also needs to give information about infection control practices to prevent the spread of infection to other household members.

- Clients must be provided the NVHCP referral slip available at the ICTCs and ART centres.
- Confidentiality/shared confidentiality of HIV status must be ensured at all levels by all staff members.
- Ensure posters on the NVHCP are displayed at the NACP service delivery centres and provide any other IEC material on HBV that is available for distribution to clients.

d) **Vaccination for HBV:** Hepatitis B has a vaccine and can be prevented by vaccination.

- All infants born to HBV-positive pregnant women need to be immunized within 24 hours of birth followed by routine vaccination under the immunization programme.
- It is recommended that all the TI staff should work closely with SACS and National Hepatitis Control Program to get their staff and core groups vaccinated for Hepatitis B.
- Besides this, all infants born to hepatitis B-positive women need to be immunized within 12 hours of birth (dose - 0) followed by 1, 2 and 6 months (dose – 10 µg IM) and HBIG – 0.5 ml IM.

Key Messages

- Vertical transmission is the transmission of HIV, syphilis, Hepatitis B of a child by the mother during pregnancy, delivery or breastfeeding.
- Elimination of vertical transmission of HIV, syphilis and Hepatitis B is focused upon, leading to triple elimination.
- All women attending the ANC clinic should be offered HIV counselling and encouraged for HIV testing.
- Care should be taken while disclosing HIV positive report. If the woman is HIV positive, the counsellor should disclose the news with utmost care and support. The news may be shocking and there might be a lot of concerns about the baby to be born. There might be relationship and other issues that should be addressed.
  - Discuss the importance of disclosure and partner testing. But, do not force or pressurize.
  - She should be guided for ART registration and preparedness counselling. Adherence counselling should be provided as per the guidelines.
- Family counselling: In case of ANC, other family members too are involved in the care of the woman, e.g., her mother, mother-in-law and others. In such cases, it might be important to disclose the status to them as well but that decision should be taken by the woman. If she needs any support, it should be provided. Family members also should be counselled if required.
- Infant feeding options should be discussed with the woman during ANC period well in advance. Explain the benefits and risks of both options and let the woman take the decision. It is not easy to make the decision because a lot of emotional and cultural issues are attached to it. E.g. if a woman opts for replacement feeding, she may be pressured by family members to breastfeed the baby. Culturally, there is a lot of importance to breastfeeding and women who do not do it are stigmatized. If she opts for breastfeeding, there will be always the concern of HIV transmission.

- Participation of spouse in care: Ensure the involvement of spouse in caring of the woman. At most places, the participation of men in the care of women is less. Most of the time, ANC women come to the centre with other women in the family. Encourage the participation of spouses in the decision-making process.
- For ANC women: The woman should get proper rest and nutritious food. All medicines, supplements and regular check-upsshould be done as per timelines.
  - Insist on hospital delivery. Carry all documents while making a visit to the hospital. Do the delivery at the same hospital where the client is registered. In case of a new hospital, make sure to give all information to the doctors and show the documents.
  - In the labour room, the infant should be given ARV prophylaxis. Labour room nurse should support feeding as per the option exercised by the client. Counsellor should document the details on the client's papers.
  - Further management of the client and the infant is to be done as per protocol.
  - The client will need support and guidance from time to time while the child is growing up. The ART team should ensure that the client gets all necessary support.
  - Some women experience postpartum depression. Counsellor should assess the symptoms and make referrals if needed. Consult with the gynaecologist too.
- Counselling messages for parents/caregivers for testing of the HIV-exposed infant/child

  Counselling parents regarding the timing for HIV testing for their baby begins during the antenatal period. This should be emphasized by the various staff at the health facilities where pregnant women are being followed, including ART centres, health centres, antenatal clinics and maternity wards. Counselling messages should include the following:
  - Importance of HIV testing and postnatal care for the infant/child
  - Availability of tests that can diagnose HIV in the infant/child
  - Availability of a comprehensive package of care and treatment for the HIV-exposed infants and children
  - Need for follow-up visits and regular monitoring
  - Timing for testing and report collection
  - Final testing would be at 18 months of age or 3 months after stopping breastfeeding, whichever is later.
  - Pre- and post-test counselling will be provided for mothers and caregivers by counsellors, MOs and/or nurses at the EID testing sites.
- **Counselling mothers regarding choosing feeding strategy**
  - Expectant mothers who test positive for HIV must be informed about the available feeding options, including EBF or ERF during the ANC period well before delivery. The healthcare team and counsellors must educate and guide the parents about the benefits and drawbacks of both options to enable them to make an informed decision. Since each mother's circumstances are unique, counselling and the final decision on

feeding options must be tailored to their specific needs. The counsellor's crucial role is to support the family in successfully implementing their chosen feeding option.

- Counsellor should emphasize the importance of ART adherence especially if the mother has opted for breastfeeding.

- **Counselling messages related to EVTHS**

  Speak to the mothers during pregnancy and after delivery on the importance of the following activities as part of the counselling sessions:

  - Screening for TB, syphilis, Hepatitis B and other STIs
  - Testing the partner for HIV
  - Regular hospital visits
  - Viral load testing
  - ART adherence
  - Practicing safe sex and viral suppression
  - Appropriate ways to disclose HIV status to other children and caregivers in the family
  - Institutional delivery
  - Exclusive breastfeeding for the first six months
  - Introduction of appropriate complementary foods after 6 months
  - ART given to the mother makes breastfeeding safe (Undetectable = Untransmissible)
  - Mothers living with HIV should breastfeed till at least 12 months and may continue breastfeeding till up to 24 months or beyond (like in the general population), while being fully supported for ART adherence.
  - Administration of ARV drugs to all HEIs immediately after delivery, within 72 hours
  - Administration of CPT to all HEIs from the age of 6 weeks
  - Vaccination as per the standard immunization schedule
  - Dried blood spot testing for HEIs at 6 weeks, 6 months, 1 year and 18 months
  - Final testing of HEIs at 18 months or three months after stoppage of breastfeeding (whichever is later)
  - Mothers must bring their children immediately to hospital, whenever they fall ill.

17 Family Planning Methods for PLHIV

India took pioneering steps by launching its national family planning programme in 1952. The programme's primary objective was to regulate fertility and reduce birth rates to a level that aligns with socio-economic development and environmental sustainability, as stated in the Family Planning Insurance Manual of the National Health Mission.

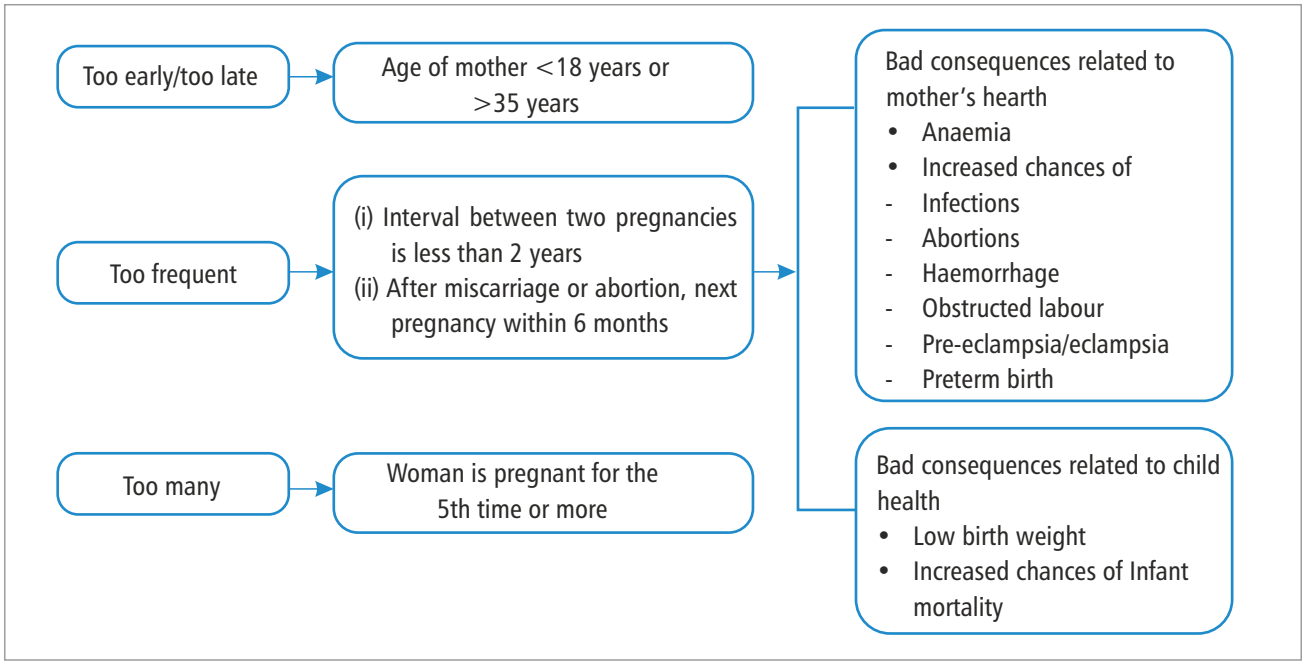
According to the WHO "family planning enables individuals and couples to plan and achieve their desired number of children while controlling the spacing and timing of their births. This is achieved through the use of contraceptive methods and addressing involuntary infertility. The ability of women to manage the timing and spacing of their pregnancies has a profound impact on their overall health and well-being, as well as the outcomes of each pregnancy.

Source: (WHO, https://www.publichealth.com.ng/who-definition-of-family-planning/)

By framing family planning in a comprehensive manner, individuals and couples can make informed decisions that align with their life circumstances, health and well-being, as well as contribute to responsible population growth and sustainable development.

Importance of family planning

Figure 17.1- Importance of Family Planning



Various family planning methods

Figure 17.2 - Family planning methods

Various Commodities available in India and who provides them at what level	PHC and Above	Sub Centre	VHSND	FLW
All Sterilization Services	✓			
PPIUCD (Only at Delivery Points)	✓	✓		
IUCD	✓	✓		
Injectable (Antara)	✓			
Condoms (Free)	✓	✓	✓	
Condoms (Paid)	✓			✓
Mala D/ Mala N	✓	✓	✓	✓
ECP (Ezy Pill)	✓	✓	✓	✓
Centchroman (Chhaya)	✓	✓	✓	✓

Table 17.1- Contraceptive methods and their use

Contraceptive Methods	Key Points about Contraceptive Methods and Their Use
Male condoms (Nirodh)	A condom, when used consistently and correctly during sexual activity, is a simple yet highly effective method for men. It acts as a barrier, preventing sperm from reaching and fertilizing the egg by blocking ejaculated semen from entering the vagina. In addition to contraception, condoms also provide protection against sexually transmitted infections (STIs), reproductive tract infections (RTIs) and HIV. They can also be used in combination with other contraceptive methods for dual protection.
Oral contraceptive pills	Two types: 1) Hormonal (combined oral contraceptive pills: COC i.e. Mala N and progestin-only pills) 2) Non-hormonal: Centchroman non-hormonal pill (Chhaya) For women, taken to prevent pregnancy, no protection against STIs.
Intra-uterine contraceptive device (IUCD)	An intra-uterine contraceptive device (IUCD) is a small, flexible plastic frame containing coiled copper with two nylon strings at its lower end. It can be easily inserted in the uterus by a healthcare or trained service provider even just after delivery for effective spacing. There are two types of IUCDs available: • IUCD 380 A that is effective for 10 years • IUCD 375 that is effective for 5 years **Three types based on time of insertion:** Interval IUCD, postpartum IUCD and post-abortion IUCD

Contraceptive Methods	Key Points about Contraceptive Methods and Their Use
Injectable contraceptive	Medroxyprogesterone acetate (MPA) - Antara Programme: • A three-month injection which needs to be repeated every three months • Safe, highly effective, convenient method of contraception • Can be taken intramuscularly or subcutaneously • It does not affect breastmilk, hence can be injected to breastfeeding mothers at 6 weeks. • It is a reversible method.
Sterilization	Either partner can choose this method when they decide that their family is complete, and they do not wish to have any more children in the future. Two types: **(i) Female sterilization:** One-time surgical procedure where tubes carrying the eggs from the ovaries to the uterus are blocked. **(ii) Male sterilization:** One-time surgical procedure where the two vasa deferentia carrying the sperms to the urethra are blocked.
Emergency Contraception	Sexually active individuals may encounter emergencies such as incorrect condom use, condom breakage, missed contraceptive pills, IUCD expulsion, coerced sex or situations where a contraceptive method is not used during intercourse. In such circumstances, levonorgestrel tablets (commonly known as Ezy Pill) containing progestin hormones can be taken within three days (72 hours) following unprotected sex.

Table 17.2 - Types of contraception for different needs/reproductive intents

Why is Contraception Needed?	Contraceptive Options
For delaying the first child	✿ Condoms ✿ Oral contraceptive pills (Mala N, Chhaya) ✿ Intra Uterine Contraceptive Devices (IUCD 380A & 375) ✿ Injectable contraceptive MPA (Antara Programme) ✿ Emergency contraceptive pills (Ezy Pill, not to be used routinely)
For healthy spacing between two pregnancies	✿ Condoms ✿ Oral contraceptive pills – (Chhaya, Mala N) Mala-N pills – not to be given until the breastfed baby is 6 months old ✿ Intra Uterine Contraceptive Devices (IUCD 380A & 375) ✿ Injectable contraceptive MPA (Antara Programme)
For limiting family size*	✿ Male Sterilization (Conventional/ Non – Scalpel Vasectomy) ✿ Female Steriliazation (Minilap tubectomy/ Laproscopic tubal occlusion) ✿ Long – acting reversible methods – ■ Intra Uterine Contraceptive Device (IUCD 380A & 375) ■ Injectable contraceptive MPA (Antara Programme) *Oral pills & condoms can also be used to limit the family size; however, the client should be counselled about the importance of correct & consistent use of the method as incorrect or inconsistent use may lead to failure.

Family planning services for PLHIV

Couples have both the right and the responsibility to plan their families by taking necessary steps to achieve the desired family size. PLHIV have similar fertility desires and intentions as those who are not infected, and with advances in treatment, most WLHIV can realistically plan to have and raise children to adulthood. Although HIV may have adverse effects on fertility, recent studies suggest that ART may increase or restore fertility.

Ensuring that PLHIV have access to stigma-free family planning services to prevent unintended pregnancies is one of the important services provided to the PLHIV. Counsellors are expected to prepare a line list of eligible PLHIV in reproductive age groups based on records available at the ART centre and counsel on pregnancy planning if desiring pregnancy and provide preconception care.

a) **Preconception Care (PCC)**

Preconception care should be provided to all WLHIV who desire pregnancy as well as negative partner of HIV-positive male who desires pregnancy. The viral suppression of the HIV-infected partner before pregnancy is a key factor in addition to optimal health conditions.

The goals of PCC for WLHIV are as follows:

- Prevent unintended pregnancy;
- Optimize maternal health prior to pregnancy;
- Improve maternal and foetal outcomes in pregnancy;
- Prevent perinatal HIV transmission;
- Prevent HIV transmission to an HIV-uninfected sexual partner when trying to conceive.

PCC counselling ensures the following:

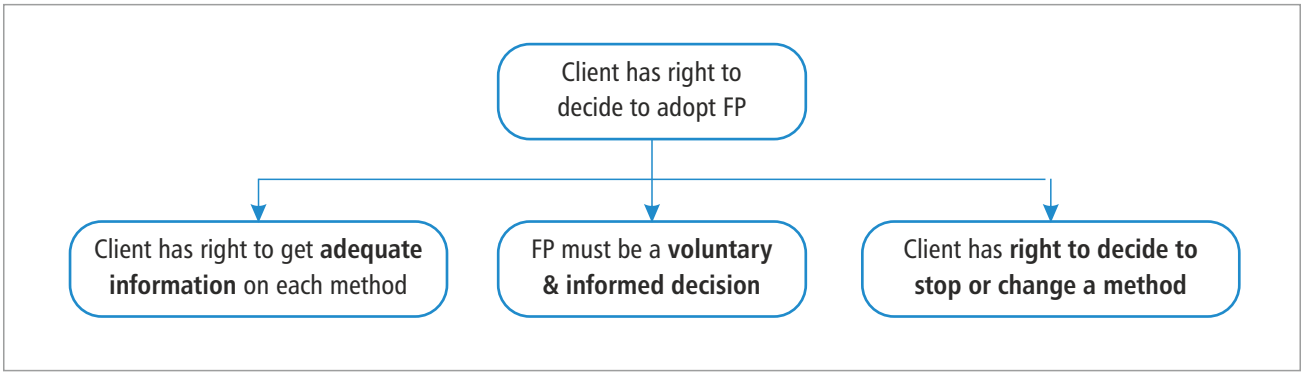
1. Prepare line list of couple where one or both partners are infected with HIV and desire to have child.
2. Ensure viral load suppression before planning pregnancies and optimal ART adherence.
3. Ensure optimal health of the couple. Anaemia and malnutrition may be treated by ART medical officer as PLHIV nutritional requirements and drug-induced anaemia needs special care.
4. Screening and management of STI/RTI of both the partners.

b) **Birth Planning Counselling for PLHIV**

The birth planning counselling should be tailored to the individual needs and preferences of WLHIV and their partners, and should involve shared decision making. Counselling should be offered at multiple points of contact with the health system, such as antenatal care clinics, labour wards, postnatal wards, ART centres, etc.

Birth planning counselling for PLHIV should be provided in a respectful, non-judgemental and confidential manner. Reproductive rights of Women living with HIV include respecting fertility, sexuality and contraceptive method choices, which do not force or coerce women into abortion or sterilization.

Figure 17.3-Clients' rights and voluntary decision of family planning



There are three key messages to be followed by couples to have healthy timing and spacing of pregnancy:

- First pregnancy should be planned only after 20 years of age in order to avoid complications in teenage pregnancy.
- After a live birth, another pregnancy should be planned at least after two years, with an ideal spacing of 3–5 years.
- After a miscarriage or abortion, a new pregnancy should be planned only after six months or later to avoid the occurrence of abortion again.

c) **Counselling sero-discordant couples for family planning**

Many sero-discordant couples may want to have a child. This may be a strongly felt need even among couples who already have one or more children. One or both members of the couple may experience a desire for parenthood even knowing that this carries the possibility of HIV transmission.

The desire to be a parent is also often mixed with the fear of transmitting infection to the child. Some experts have even suggested that the wish for parenthood may explain, to some extent, why there is a high transmission rate between sero-discordant partners.

Factors that influence the desire to have children:

- **Availability of PPTCT and ART:** PLHIV who have access to ART feel more confident about parenthood. They feel more confident about the chances that their children may be born without HIV, and that they will live long enough to parent them.
- **Family support:** If the sero-discordant couple feels stigmatized by family, or if they feel that the family will not support the child after their death, they may not want to bear children. When they feel the family will look after the children, they want to have children. When you counsel a sero-discordant couple, you should probe for the family's attitude.
- **Stigma of infertility:** Sometimes couples may report that they want to have children because they believe the stigma of being infertile is worse than the stigma of being HIV positive. This is more likely when the couple has not shared the HIV diagnosis with family members.
- **Completing the family:** Some couples may want to have children in order to complete their family. Some have stated that having a second or third child may provide the other children with some companionship after they (the parents) have died. Some couples may want to have children in order to cement their relationship.

PrEP for Safer Conception

HIV-discordant couples in which one partner is living with HIV and one partner is HIV-uninfected, often desire pregnancy, despite risk of sexual HIV transmission during pregnancy attempts. HIV prevention counselling for the desiring HIV-discordant couples will have to discuss safer and more effective conception strategies. For HIV-discordant couples, an integrated approach with PrEP use limited to the time prior to ART-induced HIV viral suppression in the HIV-infected partner can virtually eliminate sexual HIV transmission and can be used when pregnancy is desired.

Clinicians should educate HIV-discordant couples who wish to have a child about the potential risks and benefits of beginning or continuing PrEP during pregnancy so that an informed decision can be made. Once the decision to take PrEP is made, the clinician must ensure that

- The HIV-positive partner is on ART and virally suppressed;
- PrEP is initiated at least 20 days ahead of unprotected sex.

The most fertile period may be advised to the couple for increasing chances of conception.

Counselling of pregnant women when one or both partners are HIV positive

Table 17.3 - Counselling guidance when one or both partners have HIV

Considerations	Counselling Guidance
When both partners have HIV	• Ensure both are on ART with sustained viral suppression before attempting conception. The risk of HIV superinfection or infection with a resistant virus is negligible when both partners are on ART and have fully suppressed plasma viral loads. • This underscores the importance of achieving and maintaining viral suppression to ensure the health and well-being of both partners and to minimize the risk of transmission during conception and throughout their relationship. • By following this approach, couples with HIV can confidently pursue their desire for parenthood while safeguarding their health and reducing the risk of further transmission.
Couple who wants to conceive when one or both partners have HIV	• Expert consultation is recommended to tailor guidance to an individual's specific needs. • People with HIV should achieve sustained viral suppression before attempting conception to maximize their health, prevent HIV sexual transmission and minimize the risk of HIV transmission to the infant, especially for pregnant individuals with HIV • Ensure sustained clinical stability of the HIV-positive partner to ensure their overall health during the conception process. • Both partners should be screened and treated if any genital tract infections are there, before conceiving. Treating such infections is essential as genital tract inflammation is associated with increased genital shedding of HIV. • When individuals have different HIV statuses, sexual intercourse without a condom allows conception with effectively no risk of sexual HIV transmission to the person without HIV if the person with HIV is on ART and has achieved sustained viral suppression.

Additional guidance might be required in the following scenarios:

- If the person with HIV has not achieved sustained viral suppression or their HIV viral suppression status is unknown, OR
- If concerns exist that the person with HIV might be inconsistently adherent to ART during the peri-conceptional period.

If a sero-discordant couple desires pregnancy, PrEP can be one of the strategies for safer conception. Clinicians should educate HIV-discordant couples who wish to have a child about the potential risks and benefits of all available alternatives for safer conception. If indicated, referrals for assisted reproduction therapies can also be made. The clinicians should discuss with them the available information related to the potential risks and benefits of beginning or continuing PrEP during pregnancy so that an informed decision can be made.

Table 17.4 - Counselling scenarios

Scenario	Counselling
Before PrEP initiation, clinician must ensure	• Ensure HIV-positive partner is on ART and virally suppressed. • Start PrEP at least 20 days before unprotected sex. • Advise on the most fertile period for increasing chances of conception.
Partners with different HIV statuses	• Partner without HIV can choose to take PrEP even if HIV-positive partner is virally suppressed. This will provide an extra layer of protection as a prevention.
Condomless sex timing	• Consider advising timing condomless sex to coincide with ovulation (peak fertility) for safer conception and HIV risk reduction.
Home insemination (HIV-infected female partner) by using needleless syringe	• Sero-discordant couples with an HIV-infected female partner may consider home insemination during the most fertile period of the menstrual cycle using a needleless syringe, while continuing consistent condom use. Home insemination can be a safer alternative to unprotected sexual intercourse for conception purposes, providing a way for sero-discordant couples to pursue pregnancy while still maintaining preventive measures against HIV transmission.

Around 63 thousand (36.72–104.06 thousand) new HI+V infections were estimated in 2021. Almost 92% of total new infections were reported to be among the population aged 15 years or older, including around 24.55 thousand (14.27–40.69 thousand) among women. Around 42 thousand PLHIV died of AIDS-related mortality in the same reference period.

Table 17.5 - Approaches to reduce risk of horizontal HIV transmission

Approaches to reduce risk of horizontal transmission for HIV-affected couples who want to have children		
	Low technology	**High technology**
Male HIV +ve	• Screening and pre-treatment for STI	• Sperm washing
Female HIV –ve	• Delay until viral load controlled • Limited, timed, unprotected sexual encounters • PrEP to negative partner	• IUI – Intra uterine insemination • ICSI – Intra cytoplasmic sperm injection
Female HIV +ve **Male HIV –ve**	• Screening and pre-treatment for STI • Delay until viral load controlled • Limited, timed, unprotected sexual encounters • Male circumcision • PrEP to negative partner	• Artificial insemination

Key Messages

- Family planning for PLHIV involves preventing unintended pregnancy, optimizing maternal health, improving pregnancy outcomes and preventing HIV transmission to the partner or the child.
- Integrating family planning into HIV counselling involves asking clients about their fertility intentions, contraceptive methods and HIV prevention concerns, and providing them with information and support on their choices.
- Counsellors should prepare a line list of eligible couples (couples of childbearing age) where one or both partners are infected with HIV and desire to have child. Family planning counselling should be offered to the couples irrespective of the HIV status.
- Family planning counselling for PLHIV should be provided in a respectful, non-judgemental and confidential manner. Respect the reproductive rights of the couple. Do not force to make use of contraception or abortion or sterilization. Couples should take their own decision after counselling.
- Counsellor's responsibilities include affirming the right of WLHIV and couples to make informed decisions, providing preconception care, discussing dual protection and disclosure, and following up on contraceptive use.
- Counselling sero-discordant couples for family planning involves providing information and support on the factors, methods and risks of conceiving and preventing HIV transmission.
- Sero-discordant couples should also consider screening and treatment for STIs, viral load control, male circumcision and ART prophylaxis to prevent vertical transmission.
- Counsellor should respect the family planning need of PLHIV. Refer to gynaecologists for the right choice of family planning methods for PLHIV.

- Understand the challenges couples face while making pregnancy-related decisions. When one or both persons in the couple are HIV positive, decision making for pregnancy is not easy. Various health-related, psychosocial, cultural and financial factors impact the decision. A woman/couple may want to have a child for various reasons like natural wish, cultural factors, fear of stigma of childlessness, children being perceived as old age support etc. At the same time, they might consider this as a burden because of their own health condition and finances. They may have concerns like who will look after their child when they passaway, fear that their child will be HIV positive and so on.
- Facilitate decision-making process. Counsellors' role is to understand this dilemma, provide information on various options about conception and support the couple while they are in the decision-making process. The couple's decision also may not be unanimous. So, facilitate to have a consensus between the couple.
- Initial dialogue-When the couple/woman expresses the wish to conceive, be empathetic and listen carefully. Understand their point of view about the infection and life in general. Assess whether they have an understanding of the risks involved while planning for the pregnancy. Do not assume anything. Cross check if they have any misconceptions or inadequate information and counsel accordingly. Explain the risk of HIV and STI in case of unprotected sex. Discuss pros and cons of various options. Discuss safe sex practices.
- Follow-up session - Ask about the decision taken. If the decision is to opt for pregnancy, give information on all dos and don'ts. Offer various options with benefits and risks involved and ask them to select.
- Explain proper adherence to ART and its efficiency in preventing horizontal transmission. The concept of U=U (HIV undetectable = untransmittable) needs to be explained along with its risks and exceptions.
- If the decision is "no", provide information on safe sex and for the negative partner to stay negative. Positive partner – ART adherence and viral load suppression.
- Provide detailed information on various contraception methods to all the couples and support in choosing a suitable option.

  Counsellors can present a range of contraceptive options to the couple. However, it is important to emphasize that the guidance for the most suitable contraceptive method should be provided by the clinician. So it is essential to refer the woman/ couple to a clinician.
- Explain the difference between temporary and permanent methods. If the couple has one or more living children, then a permanent sterilization method can be recommended.

References:

- *Preconception and Contraceptive Care for Women Living with HIV. Mary Jo Hoyt, Deborah S. Storm, Erika Aaron, and Jean Anderson*
- *Commonly available family planning methods under NHM at various levels of health system: https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=821&lid=222*
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- *WHO: https://www.publichealth.com.ng/who-definition-of-family-planning/*
- *Manual for Family Planning Insurance Scheme (nhm.gov.in)*
- *National Technical Guidelines for Pre-Exposure Prophylaxis, NACO*
- *Final Draft EVTHS Guidelines (Version 1) Chapter 3: Technical & Operational Guidelines for EVTHS*

18 Counselling of Children and Parent/Guardian

The estimated children living with HIV (CLHIV) in India are 69,808 (Sankalak,2022). Of these, about 90% have been infected through mother-to-child transmission (MTCT) i.e., during pregnancy/ childbirth/breastfeeding. The remaining 10% have acquired through other modes like blood transfusion, sexual contact or sexual abuse. The information about the route of transmission is significant when addressing sexually active children as well as to understand the effects of positive status on the physical and psychosocial growth of the children.

The child client and his/her parent/guardian must be supported through sensitive and caring counselling.

Challenges Faced While Counselling Children

Table 18.1 - Challenges of Counselling children

Parent/Guardian-related Challenges	Child-related Challenges	Home Environment-related Challenges
• Frequent sickness/mortality • Frequent changes in parent/guardian • Attitudes, beliefs and habits	• Dependency on adults • Poor attention span, poor physical growth • Difficulty in communication • Changing understanding of the child with age	• Higher chance of sickness • Economic constraints, • Stigma and discrimination

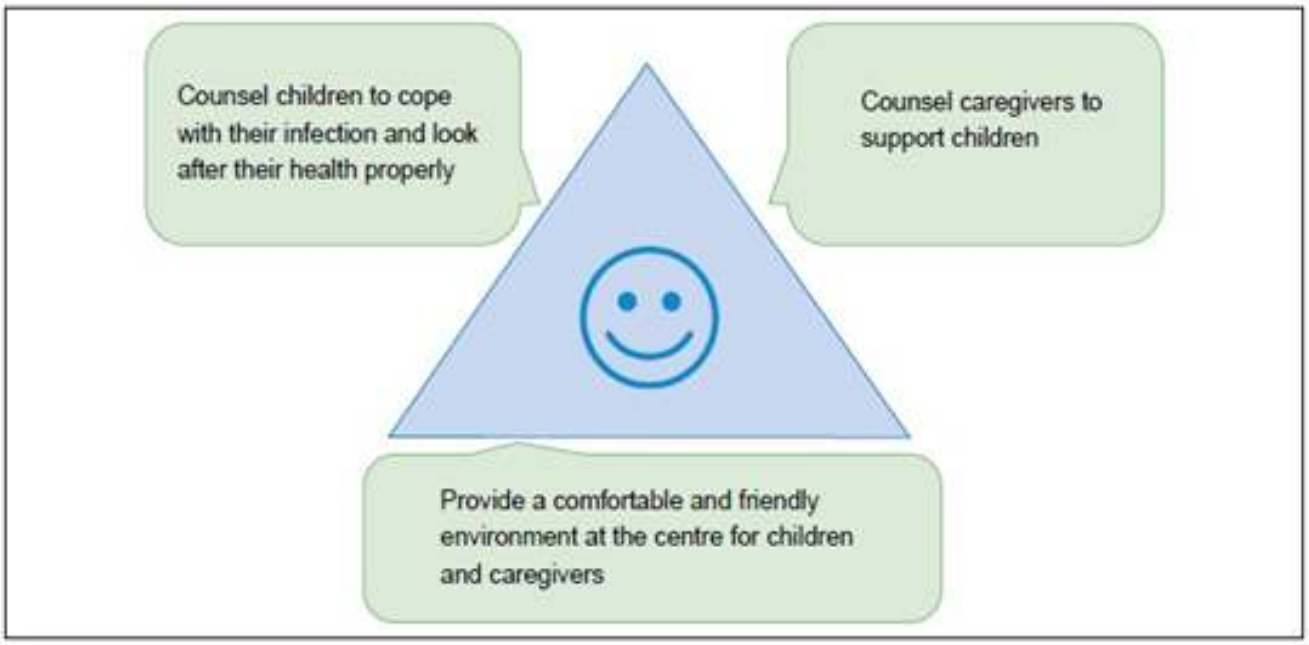
Addressing Challenges in Counselling CLHIV

1. Both the child client and his/her parent/guardians need to be supported through sensitive and caring counselling.
2. Counselling messages should be tailored as per child's age, developmental status, ability to understand HIV disease and treatment and his/her social circumstances.
3. Counselling messages should be adapted to changing needs as the child grows older and progresses through various stages of child development.
4. Essential to identify the primary caregiver and a back-up secondary caregiver if the primary caregiver is not available.
5. Challenges of coping with adherence to lifelong treatment; issues of disclosure, confidentiality, stigma and discrimination in their immediate environments, issues related to education, career, relationships, etc., all need to be sensitively addressed at appropriate times. These may vary from child to child.

Creating Child-friendly ART Centre

A child-friendly environment is necessary in the centre to support children and make them feel comfortable. The atmosphere at the ART centre is crucial for strengthening the trust between the ART team and the child, and to support adherence to treatment. This can change the perception of the child from viewing the ART centre as a 'hospital' to a 'friendly centre' that can help find solutions to the issues he/she is facing.

Figure 18.1- Child Friendly ART centre



Ideas for a Child-friendly ART Centre

- Separate room for counselling of children is ideal. If it is not available, then plan a child-friendly corner.
- The room should have small chairs, art materials, toys, drawing papers, crayons and art materials.
- The wall should have a display of paintings done by CLHIV.
- Blackboard and chalk placed at the child's eye level in a corner of the waiting area so that they may express their creativity.

Child-Centred Counselling

Children have distinct physical, emotional, and social needs that demand a different approach from adults. Although the core counselling skills apply to both groups, when working with children, it is vital to use words they can understand and encourage them to share their emotions. The messages related to various aspects of their illness are best conveyed using tools like stories, drawings and games.

Talking to children effectively relies on their developmental stage and how well they can share their feelings and concerns. Young children struggle with using words to describe their thoughts or emotions. So, it is important to find practical methods to connect with them and help them express themselves. Holding their attention can be challenging. Therefore, using tools like stories, drawings and games works best to convey messages about their illness.

Table 18.2 - Child centered counselling

Principles of Child-centred Counselling	Essential Counselling Skills	Description of Skills
Develop rapport, focus on child's needs	Rapport building	Introduce yourself/your role to the child. Clear fears, set context, assure confidentiality.
Tailor the messages according to physical, psychological development	Listening	Pay attention to the child's verbal and non-verbal communications, validate, support. This encourages them to share their stories and challenging experiences. It also means being supportive, refraining from arguing and providing instant solutions as the child unfolds his/her narrative.
Promote potential, build self-esteem	Recognizing and acknowledging emotions	Validate feelings, experiences. Empathize, understand. This helps children feel supported and comfortable. This demonstrates your understanding and empathy.
Respect identity, emotions	Acceptance and non-judgemental attitude	Refrain from judgement, provide space for reflection. Creating a space where children can analyse and contemplate their actions is crucial. Such introspection forms the foundation for them to make more thoughtful decisions about their lives and choices.The counsellor's role is to empower and facilitate the child's decision-making process.
Always involve the child and the child's parent/guardian in counselling. Involve them in the decision making.	Questioning	Make use of more open-ended questions for detailed perspectives. Allow them to tell their stories in ways that are descriptive, detailed and non-threatening.
Protecting the 'best interest' of the child Maintain confidentiality. Ensure non-discrimination	Paraphrasing	Summarize accurately to validate their narratives and experiences.

Disclosure of HIV Diagnosis to Children Living with HIV

Disclosure of HIV diagnosis to infected children is a challenge for both the parents/guardians and the healthcare providers. A prevalent obstacle to disclosure arises from feelings of guilt and discomfort among mothers/parents/guardians, coupled with apprehension about the potential outcomes of revealing the truth. Frequently, parents/guardians are unsure how to broach the subject with the child, often aiming to shield them from distressing information. Another hurdle stems from the fear that the child might inadvertently disclose their HIV status to others. In certain instances, the absence of a parent/guardian poses a challenge to the disclosure process, as seen in the case of orphans.

Timing of Disclosure

Counsellors and doctors are often concerned about the right age for disclosure to the child. The optimal approach is to initiate this conversation when children are between 5 and 7 years old, gauging their comprehension and obtaining parental approval. This process can unfold gradually, progressing until the child reaches 12–14 years of age.

Table 18.3 - Type and timing of disclosure

Type of Disclosure	Time of Disclosure
Initiating disclosure (Age 4 to 6 years)	When the child is curious about many issues and concepts of illness and wellness can be introduced
Partial disclosure (Age 7 to 11 years)	When the child is aware that he/she or the parent has a chronic illness and is taking daily medications for it.
Full disclosure (Age 12 and above)	When the child can understand full disclosure of illness

How to Explain HIV and ART to Children

Disclosure must be done together with the child and the parent/guardians. Disclosure to a child needs to be age appropriate and according to the level of understanding. Table18.2 gives an example of utilizing the understanding about child's growth in counselling using age-appropriate counselling messages about HIV infection.

Table 18.2 - Age-appropriate counselling messages about HIV infection

Age Groups		Messages
3–6 years		"You are not well. If you want to play, you should be well and for that you need to take medicine."
6–9 years		"You have got germs inside your body. That germ is making you fall sick often. To kill that germ, you need to take medicine every day. The germ will become strong if you don't take medicine."
9–12 years		"There is a germ in your body. It reduces your body's ability to fight other infections. We cannot remove it from your body. But we can control it so that you stay healthy. For that, you must take medicine regularly."

Preparing the parents/guardians for providing HIV disclosure

Parents/guardians play a vital role in the disclosure of a child's HIV status, offering the most appropriate and supportive environment for this important conversation. Encouraging and assisting parents in this process is crucial, allowing them to choose the right time and place to share this sensitive information with their child. Preparing parents to gently communicate the news, address inquiries and guide the child in comprehending and managing the illness is essential.

In certain cases, parents may seek the guidance of a counsellor or medical officer to facilitate the disclosure. In such instances, it is advisable to arrange joint counselling sessions involving both the child and the parent or guardian. The parents' input regarding the child's readiness for disclosure counselling holds significance and should be taken into consideration. The counsellor can also provide their expert assessment of the child's emotional readiness to receive this life-changing news.

One common concern shared by parents, guardians and even counsellors is the fear that children who are informed of their status might accidentally reveal this information to others, potentially leading to stigma. There is also the apprehension that the child might experience feelings of depression and even contemplate self-harm. To address these concerns, the counselling team should propose a gradual disclosure approach based on the child's ability to grasp the implications of the diagnosis. Additionally, the team can normalize the situation by drawing parallels between HIV and chronic illnesses like diabetes, underscoring the necessity for consistent health-promoting behaviours.

A legitimate worry parents and guardians may have is the reluctance to divulge the child's HIV status to others. This apprehension could inadvertently affect the child's treatment journey. It might result in refusals to fill prescriptions locally, concealing or relabelling medication containers to maintain secrecy within the family and missed doses when the parent is unavailable. These potential challenges must be openly discussed during counselling sessions, providing parents with a safe space to express their concerns and explore solutions.

Counselling the Child and Caregiver for Lifelong ART

Table 18.4 - Three Stages of counselling

	Preparedness Counselling	Adherence Counselling	Follow-up Counselling
Key objectives	It should start before beginning of ART. Disclosure of the HIV status of the child Prepare child andparent/guardian for treatment	Identifying barriers and ensuring adherence to treatment.	Providing ongoing psychosocial support Monitoring of adherence Monitor the growth of child Nutrition counselling

	Preparedness Counselling	Adherence Counselling	Follow-up Counselling
Counselling child and parents/guardians	Educating and making ready both the children and their parents/guardian for lifelong therapy: this groundwork is pivotal for strong adherence and successful treatment results. Explain ART and its advantages/ limitations.	Educate on ART adherence. Counselling for nutrition	Address adherence fatigue in CLHIV
	Evaluate child's social environment. Discuss lifelong therapy. Emphasizeon adherence to treatment.	Provide reminder tools (alarms, calendars, SMS, refill boxes and pill charts) Build rapport with child for reporting about doses missed	Assist with disclosure of HIV status. Prepare child for disclosure.
Counselling parents/ guardian	Help them to deal with personal guilt and worry. Support in accepting the illness and its implications before initiating treatment. Identify the main caregiver(s).	Identify and address barriers to adherence. Nutrition counselling	Prepare parents/guardians for disclosure.
	Educate about ART implications, adherence and drug toxicities.		Address concerns about disclosure.
	Sensitize about HIV status disclosure to child.		Normalize HIV as chronic illness.
Medication information	Explain medicine details (appearance, dosage).	Specify timing and administration of medicines.	Suggest disclosure in stages.
	Discuss who will administer the medicines.	Address caregiver changes.	Address concerns about secrecy.
	Educate about possible side effects and measures to take.	Address barriers in adherence.	Address concerns about stigma.

Treatment Preparedness Counselling

Preparedness counselling for children shares similarities with that for adults. The main distinction is that since children rely on their parents/guardians for treatment, counselling for children involves including the parents/guardian as well.

The 5 As method is a useful approach for preparing both the child and parents/guardian for treatment.

1) **ASSESS** the child's and parent's/guardian's comprehension of their HIV status, and knowledge of its treatment, evaluate potential obstacles to adherence and the social support systems.
2) **ASSIST** the child and parents/guardian in developing a treatment and adherence plan
3) **ADVISE** about how ART works and the importance of adherence. It is important to advise the child and parents/guardian to aim for 100% adherence, ensuring not skipping even a single dose or visit.
4) **ARRANGE:** the ART team can arrange for medical investigations and appropriate referrals.
5) **AGREE** means that the patient and parents/guardian both understand, accept and agree to the formulated treatment.

The counsellors should explain the What, When, How and Who of ART medicines as part of the preparatory counselling.

- Explain WHAT medicines will be given.
- Specify WHEN the medicines should be given or taken.
- Provide details on HOW the medicines will be given or taken.
- Identify WHO will administer the medicines to the child.

Side effects: Prepare the parents/guardians for the possibility of minor side effects of ARV drugs like nausea, headache and abdominal discomfort and explain to them about home-based care for these common adverse events. Counsel that mild side effects will recede over time or respond to changes in diet or method and timing of medication administration.

Treatment Adherence Counselling

Adherence to ART is essential to achieve viral suppression. Hence, it is essential to educate both the CLHIV and the parents/guardian about adherence to ART.

Barriers to adherence: It is essential to monitor adherence during each visit and identify and address any unidentified barriers to adherence. The four broad categories of potential barriers to adherence in CLHIV are child-related, treatment related, provider-related and environmental and social factors. This categorization helps the counsellor in addressing each barrier.

Treatment-related adherence issues could occur due to long-distance travel to and from the hospital, loss of daily wages for travel, frequent changes in ART staff, high pill burden, etc. These issues can be addressed by the counsellor while designing the customized adherence plan. Issues related to social factors may be stigma, discrimination at home and school, if living in an orphanage or with relatives, and poor access to medical care facilities, etc. In issues related to society, the ART team may have limited scope for intervention. However, CLHIV should be helped to minimize the impact of the barrier on them and encouraged to continue treatment.

Table 18.5 - Child and Parent/ guardian related factors in treatment adherence

Child-related Factors	Parents/Guardian-related Factors
Dependency on adults	Knowledge and understanding of treatment and its implications
Likes/dislikes for medicines	Misconceptions regarding treatment and health beliefs
Emotional issues	Relationship with the child, daily routineand nature of job
Other infections and medications	Attitude towards adherence; repeated changes in parent/guardians

Follow-up Counselling

Adherence fatigue

It is essential to monitor adherence during each visit and identify and address any unidentified barriers to adherence. Monitor adherence fatigue in CLHIV and address the same.

Nutrition and Safe Food Handling

Dietary counselling is another important component of paediatric HIV-related counselling. It is important to instruct the parent/guardian and the child to include a variety of nutritious food items in the diet of CLHIV to eat small frequent meals and have plenty of fluids.

Counselling for personal hygiene and measures for personal safety must also be given to the child and the parents/guardian. This includes advice to always wash their hands with soap and water, cover the nose and mouth while coughing, covering wounds and avoiding direct contact with other people's open wounds. Mosquito nets can be used to avoid infections such as dengue or malaria. Garbage should be always kept in covered bins to avoid flies.

Immunization Advisory

The counsellor should encourage and ensure timely immunization of children with HIV. Asymptomatic CLHIV with CD4 count above 15% can be safely immunized even with live vaccines. The SMO/MO should assess the child for the safety of immunization with live vaccines.

Child Abuse

Sexual abuse victims are among the most vulnerable members of our society, including children and adolescents. We have a collective responsibility to listen to their experiences, protect them from further harm and ensure they have ongoing access to specialist counselling support.

Table 18.6 – Overview of Child abuse

Child Abuse and Sexual Assault Overview	Impact of Childhood Sexual Abuse in Adulthood	How to Support Someone Who Has Been Sexually Assaulted	Sexual Abuse Trauma Recovery Counselling
Sexual abuse can happen to anyone, any age. For legal purposes, all children till the age of 18 years are covered under this.	Long-lasting problems in many areas of adult life	Listen, validate their feelings.	Process what has happened. Reduce distressing after-effects.
Often involves close relations and people in position of authority	Damage to the sense of self/negativeself-perception	Respect boundaries, help with tasks.	Strengthen resilience, rebuild self-esteem.
Offender is often known to victim(family members, foster parents, family friends);frequentl y repeated abuse	Interpersonal and emotional difficulties; Avoidance of intimacy; Numbness; Re-experiencing abusive patterns in adult relationships	Make sure they are aware that you are there for them.	Emphasize blame on perpetrator, not victim. Leave them alone if requested.
Abuser uses promises, threats, bribes for control	Intense shame, anger, depression, suicidal thoughts, despair, isolation	Donot push them to explain their experience.Leave them alone if they so request.	Enhance coping, well-being. Guide on how to ensure safety.
Disclosure can lead to disbelief, trauma.	Fear of speaking up	Help them with basic tasks.	**Refer the victim for professional help.**
Vulnerable victims need ongoing support	Counselling helps accept it is not victim's fault	Be present, believe them.	Assist in filing case against perpetrators. (POCSO Act, 2012).

Counsellors should get familiar with POCSO Act 2012 (Refer to Annexure). The act has been enacted to protect children from offences of sexual assault, sexual harassment and pornography and provide for the establishment of special courts for the trial of such offences and related matters and incidents.

Key Messages

- Counselling skills required for counselling CLHIV are the same as for adults but the child's developmental stage should be considered while counselling.
- Counsellors should be able to effectively communicate with children using various verbal and non-verbal methods and actions.
- CLHIV often have issues with self-esteem. Expressing acceptance is most important. It helps in self-acceptance.
- Counselling messages should be adapted to changing needs as the child grows older and progresses through various stages of child development.
- Children like being treated as 'grown-ups'.

Refer following examples:

Age 3–6 years	Age 6–9 years	Age 9–12 years
Understand concepts such as size, shape, direction and time. • Use this to help them fix the time of their pills. **Enjoy doing most things independently.** • You may ask caregivers to place the tablet and water in the child's hand rather than feeding the tablet. Explain how to swallow the tablet to 5–6-year-old child. • Explore whether children have an aversion to any particular pill colour. **Follow directions.** • You can take them around the ICTC and explain what happens there. You can create a small demo (not real) for the actual testing process by asking them what a brave soldier would do: e.g., not mind a little pain which comes from being pricked. This will help them in acceptance of the situation and normalize feelings associated with HIV.	**Peer recognition starts.** • Ask them to name their various pills. Designate them as friends who help them to stay fit and healthy and be able to go to school to meet other friends. • Ask them about their friends. This will help you identify any issues that they face, like difficulty with friends, and avoidance from friends as a result of stigma and the emotional issues associated with it. • A good counsellor will recall the names of the child's friends because this is one way of entering their world. She/he will patiently listen to the stories of "what Adi said" and "what Kirti did." This is important for child-centred counselling because it gives importance to those things that are important for the child.	**Understand and are able to follow sequential directions.** • Explain them their treatment regimen. • Reading and verbal communications are very well developed. • Help them to maintain a record of their pill consumption on a calendar or diary. • This age group has a lot of influence of peers. So, talk about their friends and interest. It will help you to understand the stigma and discrimination issues if any. • Remember to ask them about their physical milestones related to puberty.

- Disclosure of HIV status to a child is a continuous and progressive process. It is important that the disclosure be done by the caregiver, the role of the counsellor is to support this process. If the caregiver really cannot do it, then the counsellor can help to do it in the presence of the caregiver.
- Three types of disclosure: **Initiating disclosure** (Age 4–6 years) is done when the child is curious about the illness. **Partial disclosure** (Age 7–11 years) is done when the child is aware that the medicines are being taken for some chronic illness. Full disclosure (Age 12 and above) is done when the child can understand and cope.
- Expression of emotions:
  - Help the child express their emotions. Often children are told not to express emotions, especially negative ones such as anger and sadness.
  - Enabling the child to express emotions in a safe environment is an important task for the counsellor.
  - Normalize the feeling. Normalization helps people to feel that what they are experiencing is acceptable.
  - Explore the reason(s) for the feeling. Assist the child to manage the feelings.
  - Assess adherence fatigue and counsel to overcome it. Some statements that a counsellor may hear from the CLHIV are "I can't take these medicines"; "I don't like the taste of these pills"; "My friends are not taking it, why should I?"; "My head is paining" or "I feel like vomiting".
- Discuss the parenting skills with parents/guardians. Many parents neglect the child's feelings, thoughts and opinions. It is important to understand children and guide them. This will help them become independent and develop decision-making ability.
- Counsellors will have to understand the acts of the perpetrators that are considered as sexual abuse under the POCSO Act 2012 and support the affected children.

References

- *Reference Manual for Integrated RMNCAH+N, Ministry of Health and Family Welfare, Government of India, September 2021*
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- *National HIV Counselling and Testing Services (HCTS) Guidelines, NACO, December 2016*
- *WHO (2010), 'IMAI one-day orientation on adolescents living with. HIV. Participants' manual and facilitator guide'; accessed at http://whqlibdoc.who.int/publications/ 2010/9789241598972_eng.pdf*
- *The Protection of Children from Sexual Offences Act, 2012.*

19 Counselling for Adolescents Living with HIV (ALHIV) and Adolescents at Risk

Adolescents, aged 10–19, are a unique group transitioning from childhood to adulthood. This phase encompasses physical, emotional and behavioural changes. Physically, they experience the emergence of secondary sexual characteristics, rapid height growth, voice modulation and sexual interest. Emotionally, surging sex hormones lead to mood swings, impulsivity, a sense of invincibility and idealistic thinking. Behavioural shifts may involve self-consciousness, sensitivity to bodily changes, a strong craving for peer approval, risk-taking tendencies, identity confusion and vacillating between child and adult behaviours. Adolescents often grapple with the ability to make and bear responsibility for their decisions.

Adolescents are at higher risk of HIV due to engaging in high-risk practices. Economic hardship can drive adolescents into early employment, increasing street living, and exposure to high-risk activities, alcohol and drugs. The increased awareness among paediatricians, early diagnosis in infancy and the widespread availability of free ART have led to a growing number of adolescents living with HIV.

Adolescents Living with HIV

Depending on the mode of acquisition of HIV, ALHIV may be classified into two distinct populations:

1. **Vertically infected adolescents:** Those who have acquired HIV through vertical route: The diagnosis of HIV infection in these children may be through the 'early infant diagnosis' protocol if maternal HIV exposure is known during pregnancy/delivery. Alternatively, their diagnosis may occur later when symptoms manifest or through contact tracing if their parents or siblings are found to be infected. Whether they are on antiretroviral therapy (ART) by the time they enter adolescence varies.
2. **Horizontally infected adolescents:** Those who have acquired HIV infection horizontally during childhood or adolescence through sexual transmission due to unprotected sex or sexual abuse, or through injectable drug use, unsafe surgical procedures or injections or blood transfusion. These two groups differ in some important characteristics.

Table 19.1 Characteristics of adolescents with HIV

Characteristics	Vertically Infected Adolescents	Horizontally Infected Adolescents
Stage of HIV infection	Likely in advanced stage of infection	Usually in early stages of infection
Occurrence of opportunistic infections	More likely	Less likely
Impact on growth and development	Usually affected, especially if ART started late or not started	Lower impact on growth and development

Characteristics	Vertically Infected Adolescents	Horizontally Infected Adolescents
Mortality rate	Higher	Lower
Knowledge of HIV status	May not be fully disclosed or not disclosed at all	Likely to know their HIV status if they have accessed HIV care services
ART experience	Likely to be highly ART-experienced with multiple changes in ARVs and multiple mutations	N/A (as they are usually in early stages)
HIV-related losses	More likely	N/A (as they are usually in early stages)
Stigma experience	Usually experience stigma early in life, at school, home and healthcare	Usually face stigma later, possibly exacerbated by stigma related to drug use and sexuality
Detection age	Diagnosed during childhood at different ages, some may present during adolescence	Infection usually detected during adulthood
Medical problems and developmental delay	Likely to have chronic medical problems and developmental delay	N/A (as they are usually in early stages)

Challenges Faced by ALHIV

ALHIV face challenges of both adolescence and HIV infection. They feel the need to identify themselves with peers and are often pre-occupied with self-image. This leads to risk-taking behaviour.

Table 19.2 - Challenges faced by ALHIV

Challenges Faced by Vertically Infected Adolescents	Challenges Faced by Horizontally Infected Adolescents
• Poor/stunted physical growth due to delay in ART initiation • Delayed puberty • Impaired bone health • Delayed cognitive and physical development • Academic struggles, leading to a high dropout rate • Long-term morbidities involving metabolic, renal, cardiovascular or central nervous system.	• Hidden identities: Many conceal their sexuality, occupation or gender identity from family and peers. • Difficult/hard to reach due to the criminalization of behaviours such as drug use, sex work and consensual same-sex relations, along with the fear of arrest and abuse • Disclosure dilemma • Transgender youth and those with sexually transmitted infections (STIs) face difficulties in navigating their HIV status. • Challenges in ART adherence and retention

Challenges Faced by Vertically Infected Adolescents	Challenges Faced by Horizontally Infected Adolescents
• Psychiatric and behavioural problems • Lack of knowledge about their own HIV status or that of their parents, leading to incomplete or incorrect information about the disease • Transition challenges from adult-supervised care to self-led care • Adherence issues • Treatment complications, failure, and/or side effects • Stigma and discrimination • Socio-economic challenges • Mental health issues	• Delayed HIV detection in largely asymptomatic adolescents and due to limited youth-friendly voluntary testing facilities and the requirement of parental/caregiver consent for HIV testing before the age of 18 • Challenges to linkage to care due to high rate of loss to follow-up between diagnosis and ART initiation • Familial constraints due to disclosing their HIV status, which can further delay their access to care • Lack of emotional and financial support • Late entry into care with significant immune dysfunction, which can impact their long-term health outcomes
Common challenges faced by both groups: • Increased likelihood of adverse family and social environment with poor support • Difficulty in accepting and learning to cope with their diagnosis and its impact on various aspects of their life • Increased mental stress and risk of acquiring deviant and aggressive behaviour • Higher chance of hindered education and career-related challenges • Difficulty in coping with relationships, following protected sexual practices and a greater risk of unwanted pregnancy	

ALHIV and Mental Health

The relationship between HIV infection and mental health issues is bidirectional. ALHIV are more susceptible to develop mental health problems due to social stressors. Conversely, adolescents with pre-existing mental health problems are more prone to acquire HIV because they are more likely to engage in risky behaviours like unprotected sex and substance abuse, and they may also be vulnerable to sexual abuse.

Counselling for ALHIV

Adolescents living with HIV require ongoing counselling and support not only to accept their diagnosis but also to navigate the challenges of living with HIV. Involving adolescents actively in the counselling process is crucial. While parents or guardians may be involved, it is essential to prioritize the adolescent's needs. However, permission from the parent or guardian is necessary before discussing certain issues with an adolescent under the age of 18.

Key Counselling Areasfor ALHIV

Counselling needs of ALHIV can be grouped under three areas which are tabulated below.

Table 19.3 - Key counselling in ALHIV

Care and Treatment	Sex and HIV	Life Skills
• Understanding HIV • Importance of lifelong ART • Treatment adherence • Disclosure of HIV status • Healthy living with HIV and nutritional guidance	• Involves discussion about growing up and changing behaviour • Maintaining healthy sexual relationships • Methods of preventing pregnancy	• Guidance in essential life skills like effective communication skills • Coping with stigma and discrimination • Decision making • Planning for future

ALHIV need to have understanding about HIV and how it spreads. It is important to give details about HIV infection and AIDS and discuss the need for lifelong therapy. Adolescents need to know about drug side effects and the importance of adherence to drug regimens.

A strong rapport with the adolescent clients is essential, which helps counsellors to be responsive towards the ever-changing concerns the adolescent may have as he/she goes through this phase of life.

Table 19.4 - Key principles of communicating with adolescents

Principles	Key Points
Understand their interests	Understand their interests, assure confidentiality, ask about friends, acknowledge their identity, be open and non-judgemental
Address their concerns	Acknowledge their concerns and validate their feelings. One common concern voiced by most adolescents is “Nobody understands me”.
Constructively respond to their feelings	Adolescents may feel shy, helpless, anxious, scared, defensive, resistant, embarrassed or worried. The counsellor should explain to them that it is normal to feel this way and overcome the barriers to communication.
Help with adherence to ART	Build trust and rapport, address alcohol/substance use and depression, connect with peers facing similar issues and emphasize consistent medication.

Table 19.5 - What to Do and What to Avoid When Communicating with Adolescents

Dos	Avoid
• Be truthful about what you know and what you do not know. • Be professional and technically competent. • Use words and concepts that they can understand and relate toto assess if they understand. • Use pictures and flip charts to explain. • Treat them with respect in terms of how you speak and act. • Give all the information/choices and help them decide what to do • Treat all adolescents equally. • Be understanding and supportive even if you do not approve of their behaviour. • Accept that they may choose to show their individuality in dress or language.	• Giving inaccurate information (to scare them or make them "behave") • Threatening to break confidentiality "for their own good" • Giving them only the information that you think they will understand • Using medical terms they will not understand • Talking down to them, shouting, getting angry or blaming them • Telling them what to do because you know best, and they "are young" • Being judgemental about their behaviour, showing disapproval or imposing your own values • Being critical of their appearance or behaviour, unless it relates to their health or well-being

Source: WHO (2010), 'IMAI one-day orientation on adolescents living with. HIV. Participants' manual and facilitator guide'; accessed at http://whqlibdoc.who.int/publications/ 2010/9789241598972_eng.pdf

Nutritional Counselling for ALHIV

Since adolescence is the phase of sudden and rapid growth, counselling on nutrition becomes important. Assess and discuss the following points:

- Weigh adolescent clients at each visit and record their weight.
- If malnourished, discuss if nutritional problems exist: if so, the severity and probable causes.
- Assess eating habits, such as eating a lot of 'junk food' or skipping meals and the reason for skipping meals.
- Encourage a well-balanced diet that includes a variety of fresh foods and that is based on what is locally available and affordable.
- Discuss the ability of the client and his or her family to buy or grow enough healthy foods to eat.
- Refer the clients for appropriate nutritional support programmes.

Table 19.6 - 5As in ALHIV

A series of steps used in the integrated management of adult illness (IMAI) approach to chronic HIV care with ART, to guide health workers at each consultation

Assess	Goals for the consultation, physical and mental status, treatment adherence, sexual activity and contraception use, pregnancy (for young women, risk behaviours/factors, knowledge, beliefs and concerns about HIV, support structures and disclosure
Advice	Use plain, neutral, non-judgemental attitude, correct inaccurate knowledge, advise on living with HIV (relationships, sex, substance use, discuss sexual activity, condom use, contraception, couple counselling and HIV status disclosure, peer support from other ALHIV, adherence advice, treatment options and regimen. Consider developmental phase for ART prescription.
Agree	Choose treatment and support location, decide whom to disclose status to, plan for status disclosure, define roles in care and treatment, agree on treatment plan and goals. Decide on clear, measurable and limited goals.
Assist	Provide written or pictorial plan summary, referrals to adolescent-friendly services, links to support services, provide medications and treatments, condoms and contraception, self-management tools and skills, address adherence obstacles, predict and strategize barriers, psychological support if needed, strengthen social connections and support.
Arrange	Plan for time between visits, set next appointment date, arrange for group counselling or support group referral.

Disclosure in ALHIV

Disclosing an adolescent's HIV status is a crucial step, significantly impacting adherence to treatment and clinical outcomes. Adolescents require counselling and support to navigate when, how and to whom to disclose their HIV status. This process encourages them to take more responsibility for their health and increases their participation in care, ultimately improving retention in care. Ongoing support is essential for both disclosing their own status and learning about their parents' status.

Counselling for disclosure should encompass a thorough discussion of the risks and benefits associated with disclosing their HIV status to others. Support should be readily available as adolescents make decisions about when, how and to whom they will disclose their status.

It is paramount to ensure that the adolescent is emotionally prepared for the disclosure process. Encouraging parents or caregivers to assume responsibility for disclosure can be a more effective approach. The disclosure process should be tailored to align with each adolescent's developmental stage and understanding, taking their age into consideration. Overcoming barriers to disclosure is crucial and should be undertaken with the active support of caregivers.

Counsellors and healthcare staff should maintain accessibility and openness, ready to address any questions or concerns that may arise during and after the disclosure. Disclosure is an ongoing process, evolving as the adolescent's understanding of the disease deepens.

Linking with required services: Counselling centres cannot address all the needs of adolescent clients. Hence there is a need to connect them with respective service facilities or providers.

Facilities under National Health Mission

Adolescent-Friendly Health Clinics (AFHCS):

Rashtriya Kishor Swasthya Karyakram (RKSK) highlights the need for strengthening Adolescent Friendly Health Clinics (AFHC) under its facility-based approach. This approach was initiated in 2006 under RCH II in the form of Adolescent Reproductive Sexual Health (ARSH) Clinic to provide counselling on sexual and reproductive health issues.

Now under RKSK, AFHC entails a whole gamut of clinical and counselling services on diverse adolescent health issues ranging from sexual and reproductive health (SRH) to nutrition, substance abuse, injuries and violence (including gender-based violence), non-communicable diseases and mental health. AFHS are delivered through trained service providers: MO, ANM and counsellors at AFHCs located at primary health centres (PHCs), community health centres (CHCs),district hospitals (DHs) and medical colleges.

Facilities under NACP

- ARTcentrefor pre-ARTregistration and/or treatment
- STI clinic or STI care providers in case of STI/RTI symptoms
- TI projects if the adolescentisan IDUor does sex work
- Community care centres
- Drop-in centres for ALHIV

Other Facilities and Providers

- Designated Microscopy Centre for TB diagnosis
- De-addiction centres
- Legal help cells/advocates
- Other agencies providing care and support services.

It is advisable to furnish adolescents and their parents/guardian with essential information about the services available at the facility before referring them there. As previously mentioned, adolescents may harbour reservations about accessing services alongside adults. Therefore, it is important to proactively prepare the adolescent and their parents/guardian for this arrangement. Clarify that directing them to another facility is not a form of abandonment; rather, it is a proactive step taken to ensure they receive the specific help and support they require.

Follow-Up for ALHIV

Follow-up counselling sessions offer an opportunity for the adolescent and parents/guardian to express and share these concerns in a supportive environment.

Follow-up counselling includes:

- Ensure the adolescent's registration at the ART centre.
- Facilitate disclosure of HIV status to the adolescent.
- Facilitate reduction in identified risk behaviours of the adolescent.

- Help the adolescent to deal with identified particular situations in his/her life such as sickness in the family, stigma and trafficking.

The adolescent or parents/guardian may seek professional assistance to deal with particular problems related to HIV in their life. This can again relate to stigma, problems with peers, issues related with knowing one's own HIV status and anxiety about life.

Table 19.7 - Addressing other issues with adolescents

Issues	Suggested guidance
Stigma	Discuss experiences of stigma, assist in overcoming effects of stigma. Support parents/caregivers in handling situations and disclosing status. Work in dealing with 'self-stigma'.
Difficulty in identifying with HIV-negative peers	Peers are important for adolescents. Due to HIV infection, they may themselves stay apart from HIV-negative peers or experience rejection from them. Encourage healthy relationships with HIV-negative peers, educate them that HIV does not spread through casual contact. Boost self-esteem. Work with peers during outreach sessions to appreciate positive qualities in individuals.
Anxiety about sexual relationships and future planning	Talk about delaying and safe sex practices, emphasize honesty in relationships, discuss legal obligations to disclose to potential partners; highlight importance of honesty and trust in relationships.
Concerns about the care of sick family members	Address care giving challenges for sick family members, provide emotional support, guidance and links to social support systems, assist in accessing medical services
Concerns about heading family	Address responsibilities and challenges of heading the family after parental death; offer follow-up support sessions, link to relevant support networks and resources.

It is important to connect adolescents with one-stop centres and networks for PLHIV to access the support they need during these challenging times.

Counsellors should get familiar with POCSO Act 2012. The Act has been enacted to protect adolescents from offences of sexual assault, sexual harassment and pornography and provide for the establishment of special courts for the trial of such offences and related matters and incidents.

Key Messages

- ALHIV need long-term counselling and support not only to come to terms with their diagnosis but also to discuss what it means to live with HIV, if and when to disclose their status and how to envision their future.
- Counsellors should understand the developmental characteristics of the adolescents. They are neither children nor adults. This is a period of physical growth. Sexual characteristics develop. There are many psychological changes e.g., preoccupation with body image, desire to establish own identity and freedom, distancing from parents, rapid

mood changes, attraction towards the opposite sex, self-exploration, influence of peer group etc. These features put them at risk for HIV.

- Be empathetic and try to understand the issues from their point of view. Give them the confidence that you understand them.
- Involve them in the counselling process. Discuss separately with them. Do not talk only with parents.
- Treat them as adults (though legally they are not adults, they do not like to be treated like children).
- Do not preach to them. Instead, have a discussion with them on various issues and ask for their opinion.
- Respect their point of view. Show trust.
- Adolescents have peer influence on them and they may not be getting along with parents. Handle the situation carefully. Do not take sides, stay neutral. Explain both sides to both of them and ask what will be beneficial for the ALHIV.
- Adolescents may not want their family to be involved in counselling, especially when sensitive matters are discussed. But the family may insist on being part of counselling. In such cases, conduct separate as well as joint sessions and have a discussion on various points including points of disagreement.
- Maintain confidentiality. If the counsellor feels the need to inform certain things to parents, ask the consent of the client.
- Normalization can be used to reassure clients that the feelings they experience(e.g. guilt, anger) are common or normal reactions.
- Normalize feelings of shyness, anxiety and embarrassment. Explain that it is normal to feel this way. The feelings of shame and guilt are associated with HIV infection. Address these feelings.
- The options decided on by the adolescents may not always be right and benefit them. Help them to understand the risks and benefits of each solution.
- Self Esteem: This is a very crucial area for focused in counselling. Adolescents' self-image is based on acceptance by the peers. ALHIV face many issues like self-stigma, negative attitude towards self due to the difference between self and others. Discuss self-acceptance.
- Encourage them to explore their own good qualities. Encourage them to mix with peers. If they stay aloof, they will not experience belongingness with the peer group.
- Discuss how they can deal with the stigma. They should also work on the self-stigma with the help of the counsellor.
- Discuss self-care. This is one strategy to deal with low self-esteem.
- Communication: Key principles of communicating with adolescents are understanding their interests, addressing their concerns, constructively responding to their feelings and helping them with adherence to ART.

- Ensure that you are not communicating in a way that reminds them of a dominating parent.
- Ask direct questions.
- Avoid judgemental and evaluative statements.
- Assess mental health issues: Mental health issues are very common among adolescents and they remain neglected most of the time. If necessary, make psychiatric referral.
- Provide anticipatory guidance while making referrals: For instance, prepare for what might happen at the facilities they are referred to: e.g., "It may be crowded. You may have to wait a long. Better to go in the morning/noon."; "The people over there might ask you some questions. They may ask for your reports and I card. So, please carry it with you."
- Counsellors will have to understand the acts of the perpetrators that are considered as sexual abuse under the POCSO Act 2012 and support affected adolescents.

References

- *Reference Manual for Integrated RMNCAH+N, Ministry of Health and Family Welfare, Government of India, September 2021*
- *Nutrition Guidelines for HIV-Exposed and Infected Children (0-14 Years of Age)*
- *National Operational Guideline for ART Services, NACO, 2021*
- *National Guidelines for HIV Care and Treatment, NACO, 2021*
- *National HIV Counselling and Testing Services (HCTS) Guidelines, NACO, December 2016*
- *WHO (2010), 'IMAI one-day orientation on adolescents living with. HIV. Participants' manual and facilitator guide'; accessed at http://whqlibdoc.who.int/publications/ 2010/9789241598972_eng.pdf*

20 Newer Interventions in NACP-V

A number of initiatives have been launched by NACO recently like Sampoorna Suraksha Strategy (SSS), One Stop Centre (OSC), Community Systems Strengthening (CSS) and virtual interventions to reach the population at risk that is not covered under Targeted Interventions (TI) or other prevention programmes.

Sampoorna Suraksha Strategy (SSS)

As per the HIV Estimations 2021 report, annual new HIV infections declined in India by 46% between 2010 and 2021. While this is significantly higher than the global average of 32%, it is evident that there is a need to further arrest the spread of HIV to reach the programme targets.

While the programme has made a huge leap in preventing HIV among key populations (KP) through its TI programme, new infections among 'at risk' individuals who do not identify themselves as part of any high-risk group (HRG) are target beneficiaries who are still being missed out.

Sampoorna Suraksha is a strategy aimed at reaching out to those not self-identifying as HRGs but are at risk, and providing them with a clinical, need-based and comprehensive package of supportive services that help them stay negative and healthy.

Objectives of Sampoorna Suraksha Strategy:

- Identify individuals who are at risk HIV-negative clients.
- Ensure evidence-based comprehensive prevention service package customized to geographies and vulnerable populations to maintain their HIV-and STI-negative status.
- Sustain focus on all at-risk HIV-negative clients.
- Drive the development and roll-out of new generation communication strategies tailored to the current context.

What is a Sampoorna Suraksha Kendra?

- SSS is being implemented as an evidenced-based 'Immersion Learning Model' to identify the best path forward and adapt strategies, by leveraging feedback, field experiences and learnings.
- The SSS is being implemented through existing identified NACP facilities i.e., ICTCs or DSRCs functional at the districts by remodelling into SSKs.
- The national programme has selected **150 districts** in **20 states** for the implementation of SSS in the country till 2024 based on a detailed data analysis.
- The SSKs will deliver a comprehensive service package under one roof and address the 360-degree health needs of the beneficiaries.
- The service package is designed to include a holistic set of services customized as per clients' needs, with strong linkages and referrals to other services and social security schemes, and

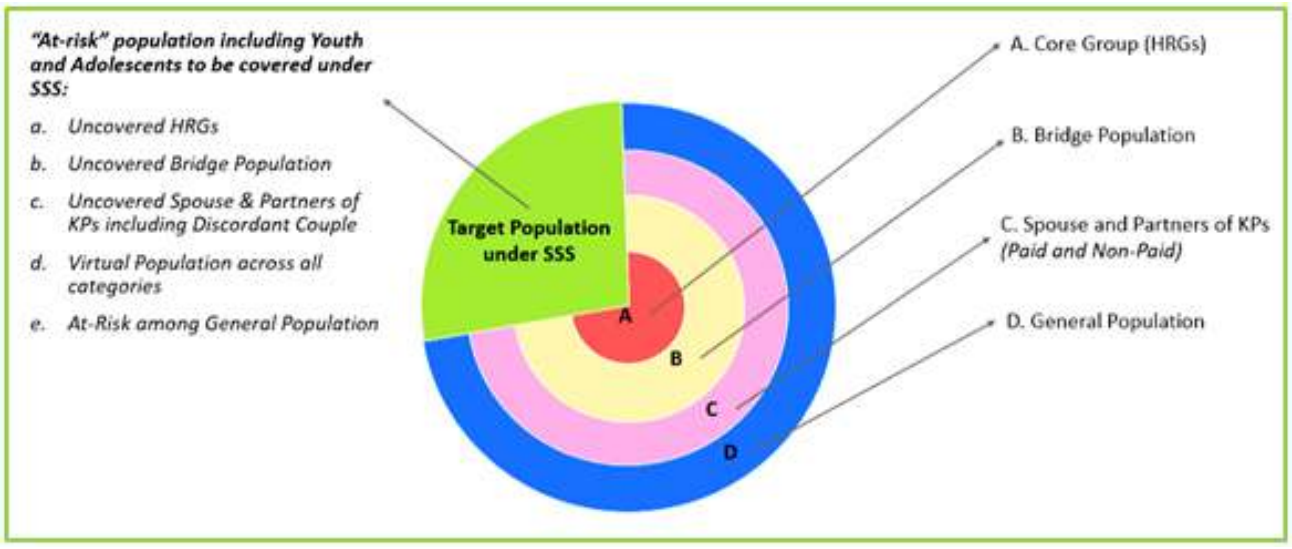
rigorous client outreach and follow-up by using different modalities that may include virtual platforms through various apps and other strategies.

Target population

The population 'At Risk' for HIV and STIs is defined as "any individual who is at risk of acquiring HIV or STI due to risky behaviours of self or partner(s)". This includes the core population, the bridge population, their spouses/partners and other populations who are engaging in risky behaviours. 'At risk'populations to be covered through SSS are the following:

- Self-initiated clients at ICTC with risky behaviour;
- Social and sexual networks of self-initiated clients/individuals;
- Youth and adolescents;
- Individuals having casual sexual relation with regular/non-regular partner/s;
- STI/RTI clients visiting DSRC/STI Clinicswith STI complaints;
- HIV-negative but at-risk clients identified through virtual outreach, NACO Helpline 1097 etc.;
- Regular and non-regular partner/s/spouse of HRG (FSW, MSM, TG/TS) who are not associated/covered with TIs, LWS and OSC;
- Needle/Syringes-sharing partners (IDU/FIDU) and their sexual partners (who are not associated with TIs/ LWS/OSC);
- HIV-negative partners of discordant couples.

Figure 20.1 – "At Risk" Population Chart



Risk Assessment Questionnaire

The risk assessment can also be leveraged to assess whether the client is atrisk or not. Further, at-risk clients can be categorized into low, moderate and high-risk in the manner given below. These categorizations will help in prioritization and facilitating follow-up of priority clients.

Interpretation of Risk Assessment Questionnaire

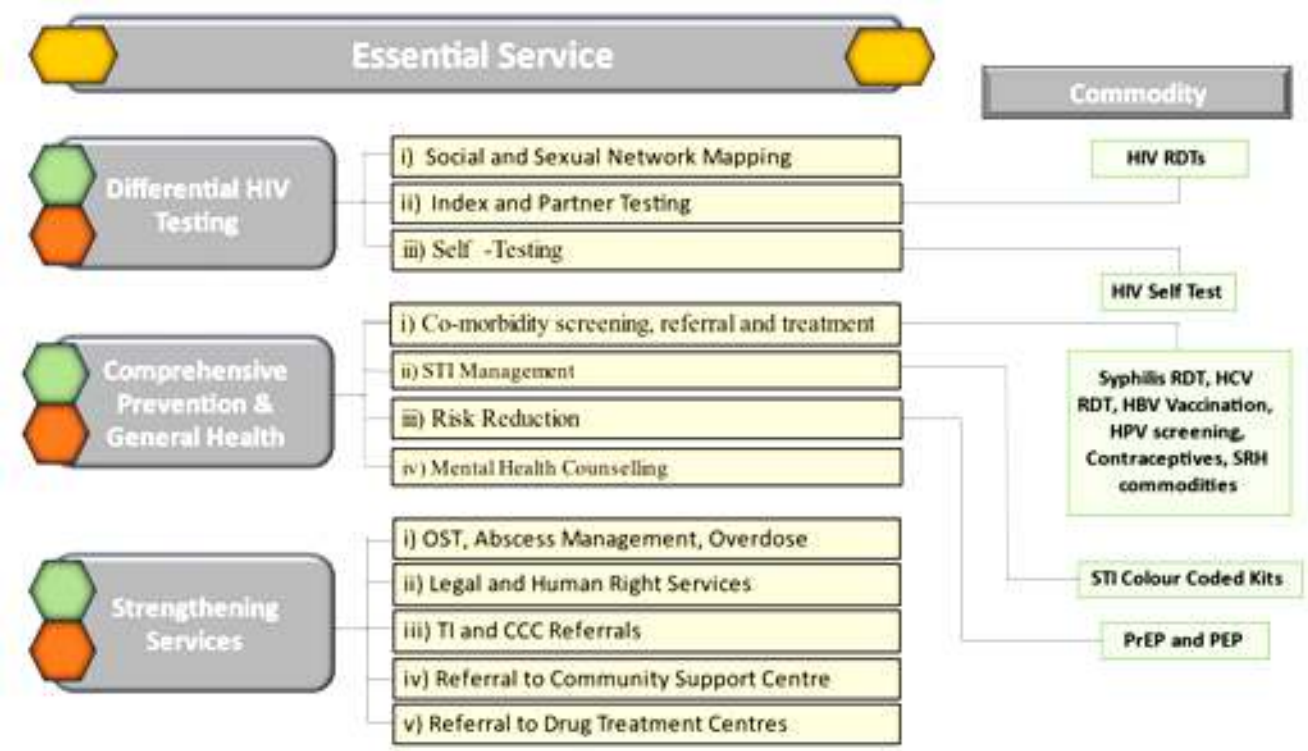
Table 20.1 – Risk assessment questionnaire

Question No.	Response	Interpretation
1. Do you have the habit of using/sharing injecting drugs?	Used, Shared, No, Refuse to answer	If (a) "Shared" or (b) "Used AND Shared">> High risk; If "Used">> Moderate risk; If "Refuse to answer">> Low risk; If "No">> Not at risk.
2. What kind of sexual partner(s) do you have?	Male, Female, TG, No sexual partner, Refuse to answer	If client is Male AND sexual partner is Male>> High risk; If client is Male AND sexual partner is TG>> High risk; If client is TG AND sexual partner is Male>> High risk; If client is TG AND sexual partner is TG>> High risk; For other scenarios >> Not at risk; If refuse to answer>> Low risk.
3. Do you have any sexual relationship beyond your spouse/partner?	Yes/No/Refuse to answer	If "Yes">> High risk; If "Refuse to answer">> Low risk; If "No" >>Not at risk.
4. Have you bought sex in the past from a man, woman or TG using money, goods, favours or benefits?	Yes/No/Refuse to answer	
5. Have you provided sex in the past in exchange for money, goods, favours or benefits?	Yes/No/Refuse to answer	
6. Any STI symptoms in the last three months?	Yes/No/Refuse to answer	If "Yes">> Moderate risk (AND in case of "Yes" in any of these questions (Q No. 2 to 5) >> High risk; If "Refuse to answer">> Low risk; If "No" >>Not at risk.
7. Is your spouse or partner a PLHIV?	Yes/No/Refuse to answer	If "Yes" >> High risk; If "Refuse to answer" >> Moderate risk; If "No" >> Not at risk.
Basis combination of questions		If "Yes" OR "Refuse to answer" in Q6 AND "Yes" OR "Refuse to answer" in any of these questions (Q2/Q3/Q4/Q5/Q7) >> High risk.

Comprehensive Service Package under SSS

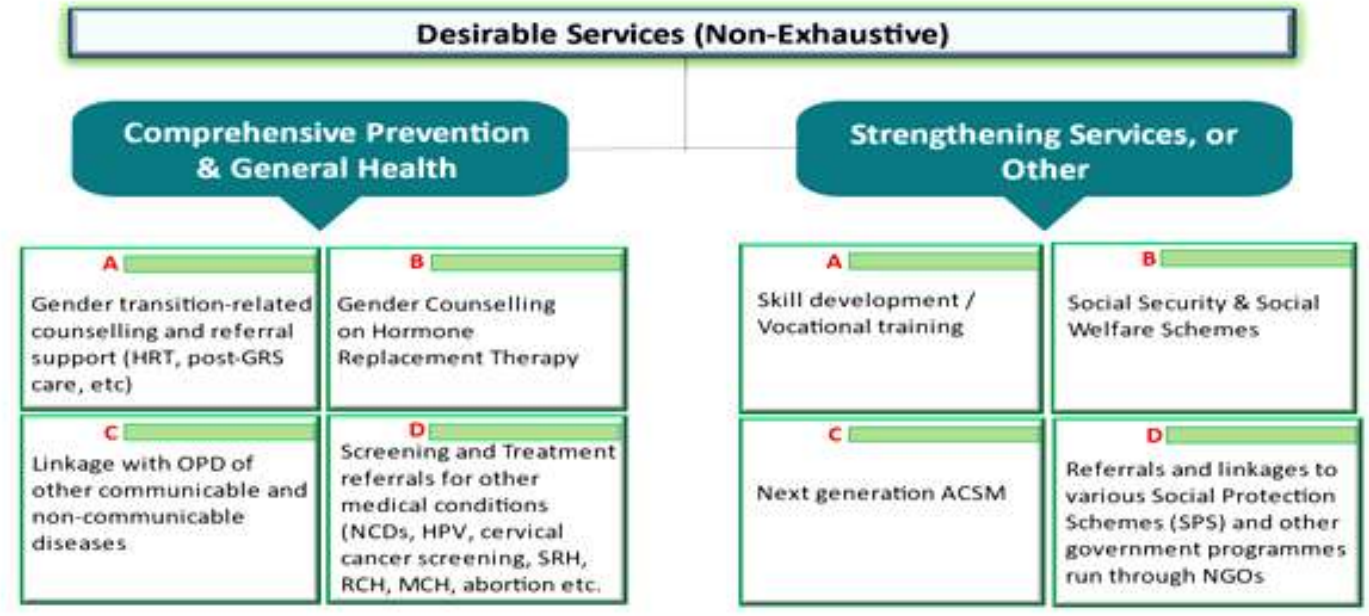
Essential Services: These are essential services that are to be provided across all SSKs and their linked centres uniformly.

Figure 20.2 - Essential services under SSS



Desirable Services (Non-exhaustive): These are heterogeneous services tailored to client-based needs at each SSK.

Figure 20.3 – Desirable services at SSK



Commodities to be available at SSK

Table 20.2 – Commodities available at SSK

Kits/Drugs/Commodities	Purpose
HIV/Syphilis Dual RDT kits	For testing at SSK
Needle/Syringe	For dispensation to relevant clients through ORWs or from SSK
HIV WBFP kits and HIV Confirmatory Test kits (A1/A2/A3)	For screening at field and confirmatory tests
Buprenorphine	For dispensation to clients at SSK
STI/RTI Colour-Coded kits	
SRH Commodities (Condoms/Lubes etc.)	
PEP	
RPR kits	For syphilis testing at SSK
Injectable Benzathine Penicillin G	For treatment at SSK through DSRC
HIV self-test kit	***Proposed (when approved)***
PrEP	***Proposed (when approved)***
Hepatitis screening test kits	***Proposed (when approved)***

One Stop Centre

Over the last decade, evidence shows the changing landscape of risk due to sexual and injecting behaviours among the HRGs, bridge populations and special groups. To effectively respond to the evolving epidemic and to saturate the coverage of KPs, revamping efforts are needed to reach out to hitherto unreached HRGs living outside the TI geographic areas. So, the TI revamped strategies are recommended.

One Stop Centre – An Integrated Service Delivery Model at Community Settings

- One Stop Centre (OSC) is designed as a person-centred and resource-effective approach to deliver integrated HIV preventioncare cascade services in settings with low-level and concentrated HIV epidemics to the hard-to-reach segment of the at-risk population who are still out of national HIV control response due to high stigma, discrimination and lack of awareness i.e Transgender persons, People who Inject Drugs and Bridge Populations (including clients of sex workers, truckers and allied population).
- OSCs provide comprehensive services based on the risk assessment, HIV screening, subsequent linkages for HIV/STI preventive and treatment services along with required social support to improve general health and wellbeing of the clients by helping them reduce the harm associated with risk behaviours.

The specific objectives of establishing OSCs are as follows:

- Promote screening and linkage for HIV and other essential health services.
- Promote screening and referral to requisite holistic care services.
- Ensure completion of referrals/linkages among different service providers.
- Increase access to HIV, other essential health services and social welfare services.
- Increase awareness and reduce stigma and discrimination.

Comprehensive Service Delivery Package

- The project is mandated to establish integrated service delivery models through OSCs for medical and behavioural aspects of HIV and social protection services. The proposed package of services for each typology is as follows:

Figure 20.4 – Current package of services in OSC

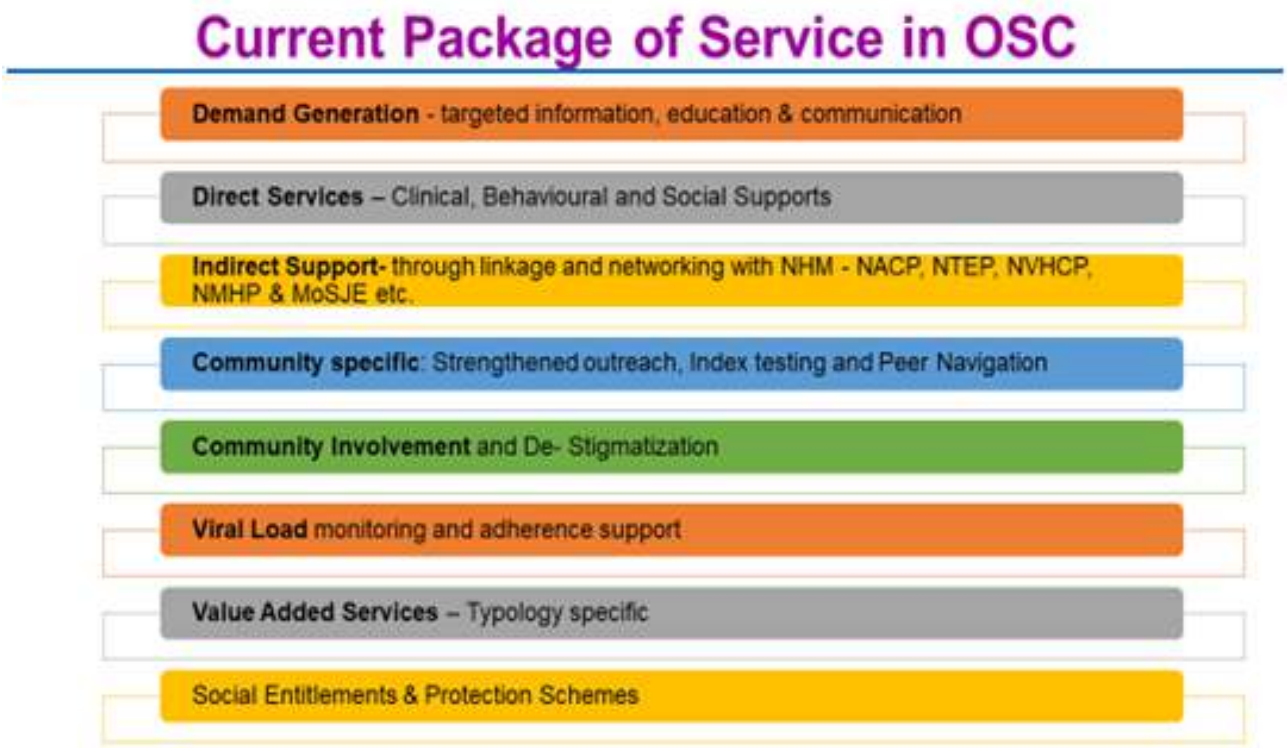
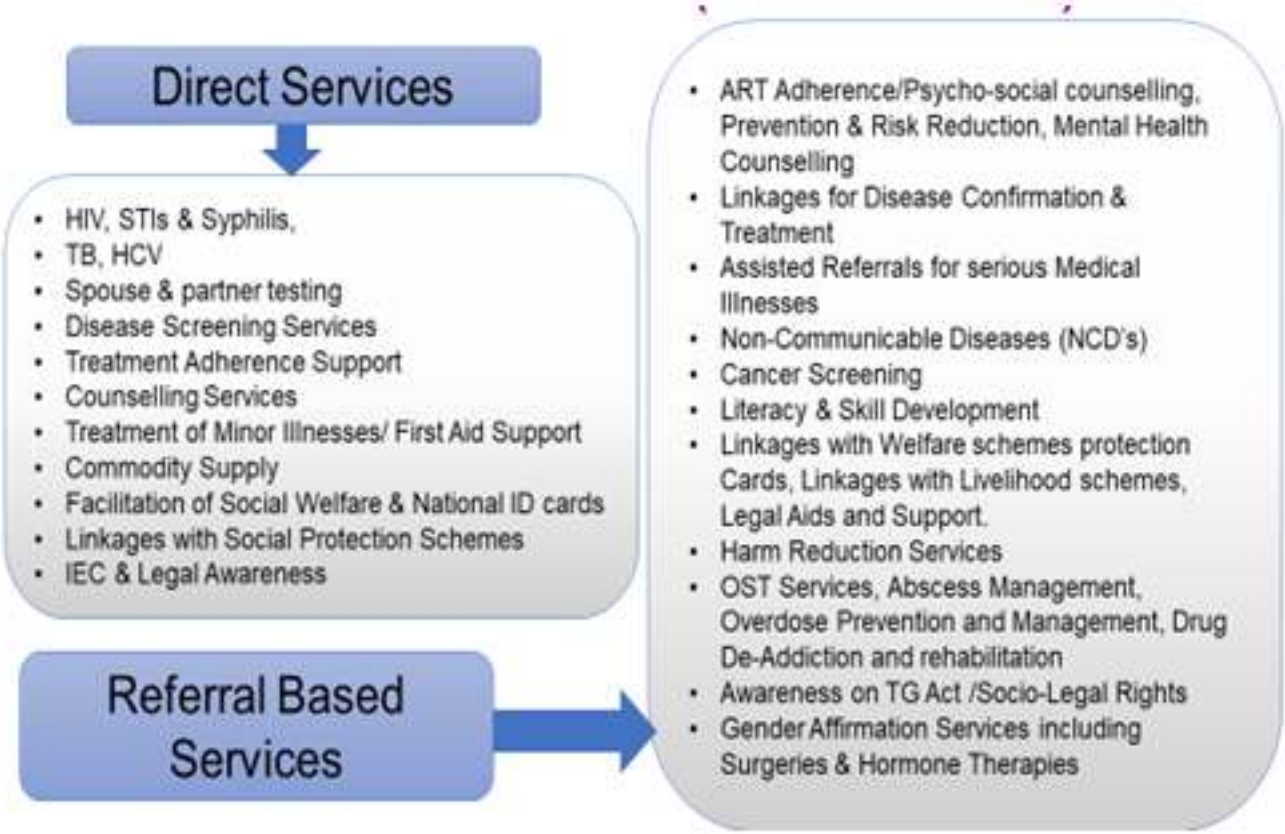


Figure 20.5 – Direct and referral based services

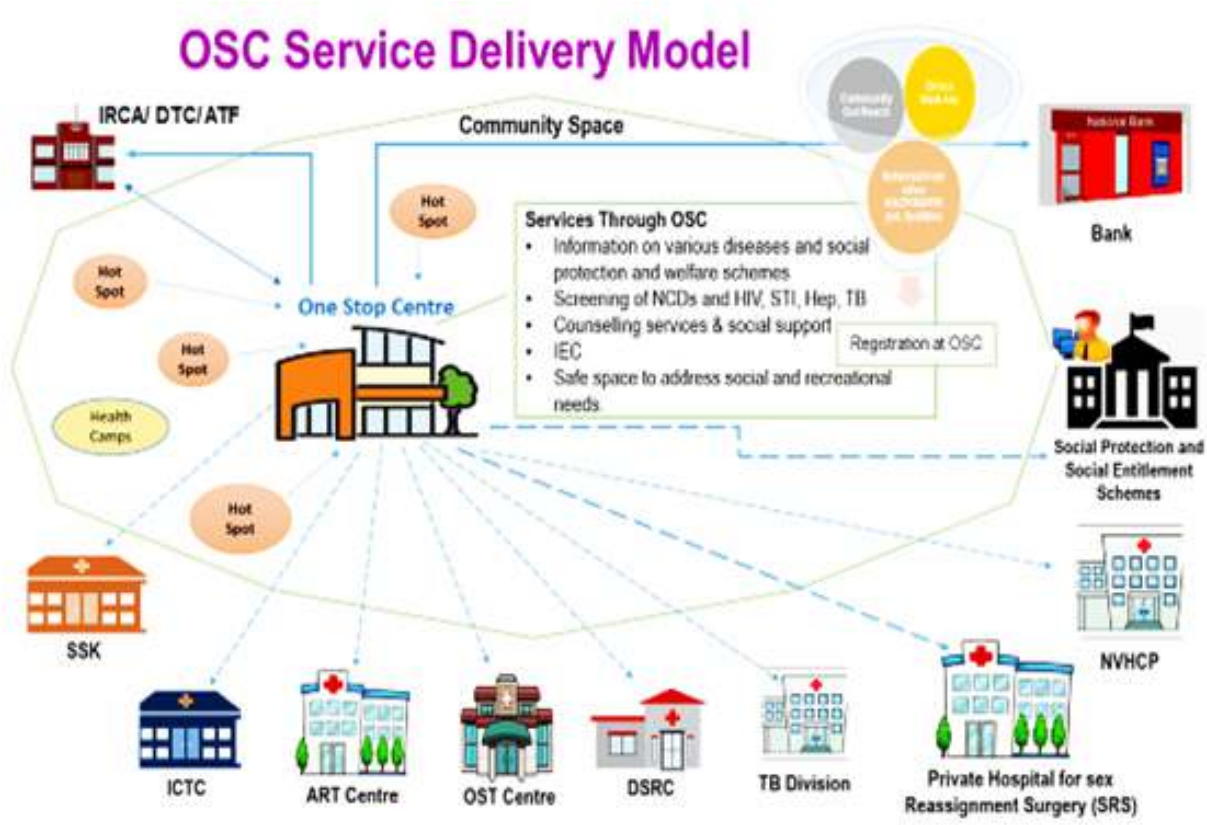


Commodity and Consumables for OSCs

OSCs are a resource-effective way to implement HIV prevention and care programmes in settings with a concentrated burden of hidden and hard-to-reach populations. They are also a cost-effective method of reaching people who are most at risk in more generalized epidemics.

OSC Service Delivery Model

Figure 20.6 – OSC service delivery model



Community System Strengthening

NACP-V institutionalizes community engagement and meaningful participation at the most granular level in the form of community system strengthening (CSS). This is expected to lead to improved health outcomes under the NACP, specifically through strengthened TI programmes and greater involvement of communities in decision making, and finally developing structured systems of community-led monitoring (CLM).

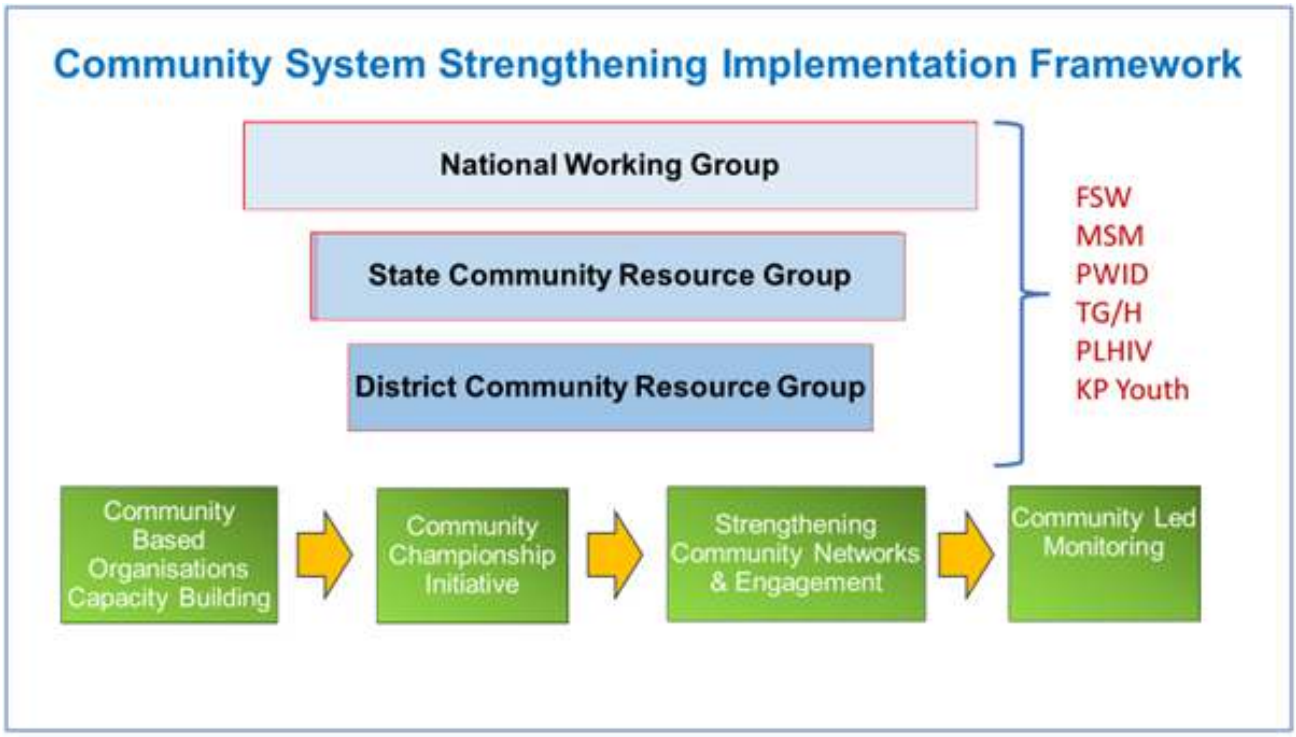
CSS is an approach that promotes the development and reinforcement of informed, capable, coordinated and sustainable structures, mechanisms, processes and actions through which the KPs, their organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. It increases both the reach and sustainability of programmes.

CSS aims to achieve the goals of the NACP through the following objectives:

- Support an enabling environment;
- Demand generation for prevention and increasing testing;
- Care and support for those on ART including social protection, treatment literacy, adherence;
- Community monitoring and ensuring effective and quality programme delivery.

CSS Implementation Framework

Figure 20.7 – CSS Implementation Framework



The National Youth Policy of India (2014) defines youth in the country as people belonging to the age group of 15–29 years.

Community structures at the national, state and district levels

Initiative	Summary
Community Resource Group (CRG)	CRG is a formal structure anchored in the national response at the district, state and national levels to **identify, understand, resolve and address** the community's concerns with their **meaningful representation** (HRGs - FSW, MSM, H/TG, PWID, PLHIV and Youth communities). • It facilitates and **augments community** participation in planning, implementation and supportive supervision. • It establishes **formal structures** for meaningful engagement and involvement of KPs, PLHIV and youth community members. • It promotes meaningful engagement and involvement of KPs, PLHIV andyouth community members. • It ensures timely identification and **redressal** of issues of stigma and discrimination.
Community Championship Initiative	Community champions are KPs with influence in local area. They address the needs of KPs, stigma and discrimination, are trained in advocacy, mobilization, leadership, information dissemination, are expected to empower local communities and become a resource.

Initiative	Summary
Strengthening Community Engagement	Community mobilization for effective HIV prevention, formal/informal networks for partnerships, collaborative solutions through stakeholder engagement, communities voice concerns via CLM.
Community-led Monitoring (CLM)	Specific objectives include collecting regular feedback from the KPs and PLHIV on improvement of service delivery. This feedback will help in increasing ownership as well as ensuring services access among the communities. Feedback from community is collected systematically via scorecards, discussions, data analysis, solutions generated with community and providers. Involvement of community in making and implementing action plans.

Virtual Interventions

With internet users in India expected to surpass 658 million by 2022, online platforms are changinghow Indians communicate, seek information and identify sex partners. Higher risk groups for HIV, particularly men who have sex with men, transgender individuals and sex workers, are increasingly using virtual channels to find sex partners as well as to build and maintain communities. In recent times, sex work patterns have also undergone a change owing to technology and social media. Mobile phones act as a tool for networking and soliciting.

Hence the programme has initiated various efforts to close the existing gaps due to newer risk behaviours like soliciting partners through virtual platforms, through new spaces like spa and massage parlours, etc.It has emerged as a programmatic focus under NACP V.

Virtual Strategy Advancement in India

For engaging with the virtual population, it is essential to expand approaches to reach all population groups at risk for HIV, especially groups involved in high-risk behaviours. The possibility of remote care through virtual strategies can overcome barriers of social stigmatization that impede these groups from accessing conventional in-person HIV services. Many organizations in India have responded to the increase in digital communication and information sharing through novel digital interventions for HIV care and prevention.

The NACP V will work to incorporate online communication-based strategies, considering evolutions in the technology industry and digital platforms in India as well as strive to understand the size of target virtual population; explore differences among users in demographics, preferences and context to facilitate tailored virtual approaches; design effective online messages to generate awareness about HIV prevention, care and service options; and link virtual populations to comprehensive HIV services tailored to the needs of communities.

(Refer annexure for the details of virtual interventions being implemented across the country).

Key Messages

- Various initiatives like Sampoorna Suraksha Kendra, One Stop Centre, Community System Strengthening and Virtual Interventionhave been initiated under NACP V to reach the population at risk that is not covered under TI or other prevention programmes.
- Counsellors' role is to identify and link the 'at risk' (non-TI) population with these initiatives.
- Community members can play an important role for effective linkages.
- Rapport establishment and communication skills should be used effectively for linkages. It is important to connect with the client'as a person'and not just as 'client came for HIV services'.So, discuss other concerns as well with the client along with HIV-related issues. E.g., you may talk with an adolescent about their family issues, their interests. Many festivals are celebrated in the community. Discuss that. Explore your own ways to connect with the communities.
- Counselling and education of the target audience on prevention measures, testing and treatment of HIV, STIs and related co-infections.
- Undertake risk assessment of the target audience and offering of suitable follow-up services.
- Promoting comprehensive prevention models (Condom, Contraception, Pre-Exposure Prophylaxis, Post-Exposure Prophylaxis etc.)
- Undertake HIV and Syphilis screening services in facility and field settings.
- Counsel people found reactive/positive for HIV, STIs and related co-infections, counselling for ART, opportunistic infections management, management of NCD, lifestyle modification, positive prevention, index testing, psychosocial support, family counselling, suitable linkage and referrals etc.
- Provide an enabling environment to fight against stigma and discrimination.
- Undertake family planning counselling and follow-up referral and linkages among eligible HIV-positive clients.
- Counsel adolescents and youths for sexual and reproductive health.
- Counsel and follow-up services for 'at-risk' non-reactive/negative clients.
- Follow-up for HIV and STIs reactive/positive people through field visit/outreach ensuring uptake of suitable services like confirmatory testing, registration to treatment facilities and adherence counselling.
- Coordinate with various outreach workers/field functionaries/ANM/ASHA workers/Anganwadi workers etc. in context of HIV/STI-reactive/positive individuals ensuring uptake of suitable services.
- Perform the role of nodal point for Sampoorna Suraksha Strategy.
- Counsel on harm-reduction services for people who inject drugs (PWIDs).

- Ensure the suitable use and maintenance ofkits/commodities/consumables/equipment provided under NACP including the cold-chain maintenance of kits/drugs as per guidelines.
- Undertake data recording and reporting as required.
- Criteria for at-risk HIV-negative clients:

  In order to ensure that the target population is continuously engaged with the SSK and is prioritized, a graduation criterion has been devised. Upon meeting such criteria, the client can be graduated from the system, or in other words, may not be followed up actively. However, such clients should be provided services/commodities if they voluntarily ask for the same. Additionally, the client may visit the SSK on yearly or half-yearly basis as advised by the counsellor and/or subject to the risk perceived by the client in future.

References:

- *White Paper on Strategies for Engaging with HIV at-risk populations in Virtual Spaces*
- *Technical Brief on Changing trends in sex work, IDENTIFYING CHANGING TRENDS IN THE SEX WORK DYNAMICS AMONG FEMALE SEX WORKERS (FSWS) IN INDIA- Bal Rakshase, Priyanka Dixit, P. Saravanamurthy, Vinita Verma, Shobini Rajan*
- *Available at: https://naco.gov.in/sites/default/files/Technical%20Brief%20on%20Changing%20trends%20in%20sex%20work.pdf*
- *White Paper on Comprehensive Health-Related Services for Transgender Persons., 2023, NACO, New Delhi*
- *The Guidance Document on Integrated Package of Services for People Who Use Drugs in 2023, NACO, New Delhi*

Annexure: Examples of Virtual Strategies for HIV Care in India

Featured Virtual Strategies for HIV Care in India		
Intervention Name/ Organization/ Population Group	**Intervention Name/ Organization/ Population Group**	**About the Intervention**
Virtual DIC, Delhi SACS, FSW/MSM/TG	Risk awareness, prevention, testing, service linkage	Virtual drop-in centre for KPs in Delhi to identify and link the virtual network-based HRGs with service provisions. An interactive web portal managed by the community and TI team allows KPs to log in with their ID and password and seek services/book appointments to seek HIV services as per their choiceand time in Delhi. • Web Page • Virtual Mapping • Training of the TI staff • Online Outreach • Service provision • Monitoring &Evaluation (M&E)
MDACS/HST, ITECH-CDC, Young MSM	Risk awareness, prevention, testing, service linkage	Enhanced Peer Outreach • To reach the unreached • Through social media platforms For individuals above 18 years who have accessed social media platform for sex with a man in last 3 months; had sex with a male in the last one month; not associated with any TI
Maharashtra SACS, HRGs (FSW)	Knowledge, awareness, feedback, planning	WhatsApp groups for awareness generation; committee awareness generation activities –feedback from HRGs. Also, hotspots/health facilities' Google Map for ease of planning by field workers
Love Zodiac – Twistle	Risk awareness, prevention and treatment support	Risk profiling quiz on safe sex, relationship health, social stigma and HIV testing promoted via targeted advertising on social media. Clients can then optin 45-days educational SMS.
Game Set Match –One Key Care Ventures	Prevention, testing, stigma reduction	Incentive-based model rewards dating app users to play short games promoting HIV prevention behaviours and stigma reduction.
IRA - Jubi.AI	Knowledge, awareness, service linkage	Powered by artificial intelligence, IRA is a one-to-one conversational platform where users can talk to a chatbot offering information and emotional support in response to HIV/AIDS queries.

Featured Virtual Strategies for HIV Care in India		
Intervention Name/ Organization/ Population Group	**Intervention Name/ Organization/ Population Group**	**About the Intervention**
Ujwala project - Alliance India, FSW	Prevention, testing, treatment and care support	To improve uptake of HIV services among FSW in urban areas in India, Ujwala sends informational videos over smartphone apps with links to a helpline.
Yes4Me – USAID, General and KPs	Risk assessment, prevention, testing and service linkage	Yes4Me uses advertising and outreach workers on social media and dating apps to engage users. They are directed to a website with a risk assessment and appointment booking for HIV services.
Safe Masti – Elton John AIDS Foundation, Young MSM	Awareness, prevention, stigma reduction	Promotion of visuals and videos raising HIV/STI awareness over social media using influencers, links to HIV testing sites, chat-based counselling
Dr Safe Hands, General and KPs	Awareness, testing, treatment, counselling, retention	Dr Safe Hands is a website promoted through social media offering information, telemedicine counselling, booking support for HIV/STI testing and treatment, as well as free home sample pick-up.
Virtual Outreach, Nagaland, ITECH-CDC, MSM and TG	Outreach, awareness messaging on HIV/AIDS, STIs and safe practices, linkage to harm reduction services, HIV testing and treatment services, distribution of commodities	Reaching MSM & TG population through virtual interventions for harm-reduction services and linkage to HIV testing, prevention and treatment services through various social media platforms including Blued, Grindr and Facebook.

21 Mobile Outreach Services

Mobile and outreach activities are critical in order to ensure that need-based services are delivered. In 2007, access to counselling and testing services expanded to provide HIV Counselling and Testing (HCT) outreach services and Mobile ICTCs. Subsequently, mobile facility-integrated counselling and testing centres (FICTCs) were also introduced to expand HIV screening services.

At present, a mobile ICTC consisting of a team of paramedical healthcare providers (an ANM/ counsellor and LT) is used to set up a temporary clinic with flexible working hours in hard-to-reach areas, where services include regular health check-ups, syndromic treatment for STI/RTIs, antenatal care, immunization, as well as HIV counselling and testing services (Operational Guidelines for Integrated Counselling and Testing Centres , 2007). Introduction of NACP V and launch of newer strategies such as client prioritization, rationalization of confirmatory facilities, introduction of Sampoorna Suraksha Kendras, and integration with other health programmes such as National TB Elimination Programme (NTEP) and National Viral Hepatitis Control Programme (NVHCP) demand change in strategies related to outreach services.

Objectives of Mobile Outreach Services

To increase access to NACP and other related health services for the at-risk/vulnerable/high-risk or unreached populations in under served areas to minimize the gap of 95-95-95 by 2025 to end HIV AIDS as a public health threat by 2030.

Intended Beneficiaries/Priority Populations for Mobile Outreach Services

- Difficult-to-reach populations, HRGs, at-risk populations;
- Inmates of prisons and other closed settings (OCS);
- Population that is unable to access regular, stand-alone HIV/STI services or displaced due to natural/manmade disasters;
- Populations in vulnerable areas who are at risk of transmission of HIV/STI/Hepatitis B/Hepatitis C/TB infections.

Type of Services Provided

- **Comprehensive prevention and treatment services:** Risk reduction counselling and risk assessment, distribution of needle syringes, lubricant jelly and condoms, camp-based induction and dispensation of OST medication to stable clients and follow-up counselling, comorbidity (STI, hepatitis, TB, substance use) screening, referral and treatment, awareness generation/IEC activities;
- **Differential HIV screening/testing:** Disclosure counselling, index testing, social and sexual network mapping and testing, HIV confirmation of pending HIV-reactive cases;
- **HIV and STI treatment services:** ART pill dispensation and refill, adherence counselling, follow-up of missed cases (MIS) and LFU, STI/RTI testing, diagnosis and treatment, partner

counselling and testing for HIV/STI, other need-based services such as viral load or CD4 sample collection and transportation and DBS samples for EID.

- **Other health services:** Screening and referral for TB, hepatitis B and C, diabetes, hypertension and other non-communicable diseases.

Selection of Geographies for Mobile Outreach Services:

SACS should select the districts for implementation based on the below suggested criteria:

1. Districts or areas with high gaps in achievement of the first 95;
2. Districts or areas with high numbers diagnosed, and documented clustering of uncovered at-risk, bridge and HRG populations, unreached pregnant women;
3. Districts or areas with high HIV prevalence or identification of new HIV infections, high STI/RTI or high AIDS-related deaths;
4. Districts or areas with vast geographies and hilly terrain, scattered location of health facilities, limited public transportation and with scarce HIV-related service provision including CD4 and viral load testing;
5. Districts or areas with high load of pending HIV confirmation, high rate of MIS/LFUs or linkage loss;
6. Padas/villages/blocks within districts where HIV screening at Health and Wellness Centres (HWC)/other NHM facilities are not initiated or are limited.

SACS may additionally deploy the outreach camp based on epidemiological intelligence and interactions with at-risk clients/PLHIV and other key stakeholders.

Strategy of Outreach Activities:

The various strategies that could be used for mobile outreach services include the following:

i. **Static camp-based approach:** HIV-related services and outreach activity can be delivered through use of SACS/state-hired or owned vehicles (bus, van or even a two-wheeler), which can move from place to place, or by organizing outreach camps to provide the required services to those at-risk or HIV-positive individuals who have difficulty in accessing facility-based services. The counsellors (SA-ICTC, ART, OST, SSK), laboratory technicians and additional workforce including outreach workers or staff nurse of nearby ART, OST, SSK, CSCs, TI NGO can provide various HIV and STI services according to the roster prepared and approved by the district nodal officer (DISHA official, DACO), Chief District Health Officer (CDHO) or Chief District Medical Officer (CDMO) and competent SACS authority, as deemed fit.

ii. **Alignment of mobile vans/bike outreach plan with the following activities for better integration with health systems:**

   - Coordination with other campaigns: Coordination with integrated health campaigns/ ISHTH campaign/IEC campaigns/observance of any special day/ health programmes conducted by District Health Society;
   - Collaboration with other stakeholders: The route map should be aligned with NHM's Medical Mobile Units (MMU). Coordination meeting should be held with the Block Medical Officer to discuss the utilization of services and seek further support.

iii. **Extended outreach component under the Integrated Health Campaigns of health systems:**

The staff engaged in conducting the camp will coordinate and carry-out extended outreach (EOR) at the hotspots or sites where the HRGs are available and feel comfortable. This will include index testing with HIV/STI screening.

Social networking strategy (SNS) will be implemented to reach at-risk or high-risk behaviour populations who are hidden with HCT services. SNS utilizes peers to reach their network members and motivate them to undergo HCT. The peer educators and outreach workers under the TI-NGO will play an important part in this strategy.

Suggested Models for Operationalization of Mobile Outreach Services

1. Operation of mobile vans on outsourcing basis: Mobile vans and human resources are provided on outsource basis. Drugs and supplies are provided by SACS/DISHA.
2. State-owned mobile vans: Mobile vans and human resources are deployed by SACS. Drugs and supplies are provided by SACS/DISHA.
3. Mobile bikes with driver: Procured/hired by the SACS for undertaking camps in remote and hilly terrains where reach by mobile vans is not possible.

a. **Human resources required:**

The human resources requirements are classified as essential and desirable.

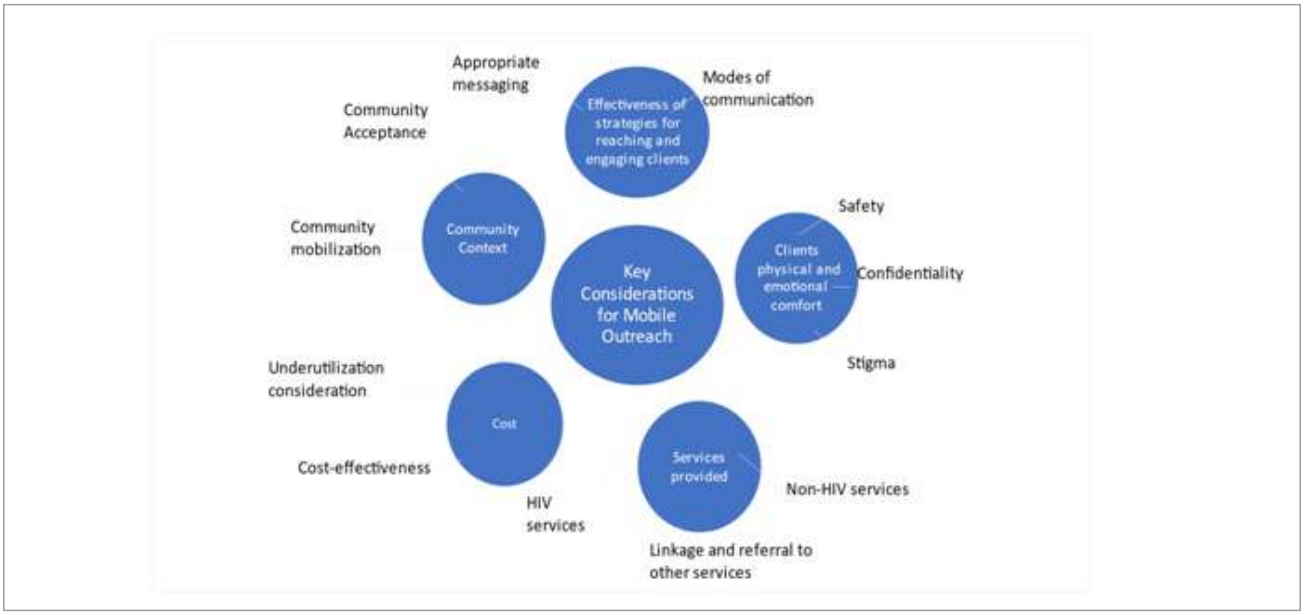
Essential: Driver/rider, counsellor, laboratorytechnician (if facilities for confirmation are available in camp)

Desirable: Medical doctor, nurse, ORW

These human resources are from within the existing programme facilities and there are no new recruitments, or they are mobilized from health system. In addition, in the districts where there are existing TIs or LWS, the staff of the TI/LWS will provide necessary support to the mobile intervention team for mobilizing KPs and making necessary arrangements as required.

Operationalization of Mobile Outreach Services

Figure 21.1 - Mobile outreach services



KEY CONSIDERATIONS FOR PLANNING MOBILE OUTREACH SERVICES

I. Preparatory Planning and Initiation Phase

Approvals and coordination: The SACS in coordination with the DISHA unit will be responsible for operationalization of Mobile Outreach Services, supervision and monitoring of these units. The Mobile Outreach plan may be prepared by mobile van counsellor or DISHA officials (who will act as a nodal officer).Only after approval can the roster be implemented.

- Day-wise and week-wise plans will be prepared for each unit of mobile camp. For each day, there should be a facilitator preferably from the nearest health facility/public health administrator. The format of road map is below in Table 21.1.
- The necessary coordination and approval of the DTO/DHO/CMHO is to be undertaken to ensure that the camps are convened smoothly. The necessary approvals of the prison and other closed settings are to be undertaken.
- Infection prevention measures and biomedical waste disposal guidelines must be followed.

Table 21.1 - Format for Road Map of Mobile Outreach Unit

Name of the State						**Unique ID of Mobile Unit:**		
S. No.	Weeks	District	Date	Facilitator	Location/ Area/Site 1	Location/ Area/Site 2	Location/ Area/Site 3	Location/ Area/Site 4
1	Week-1							
2								
3								
4								
5								
6	Week-2							
7								
8								
9								
10								
11	Week-3							
12								
13								
14								
15								
16	Week-4							
17								
18								
19								
20								

Community Engagement and Collaboration: NACP counsellors under the leadership of DISHA will arrange initial meetings with local government authorities, local community leaders and HIV-positive networks to engage communities and carry out community mobilization as needed.

Conduct IEC activity: IEC or advocacy activities will be conducted prior to organizing the camps. This will help in spreading information and awareness about camps well in advance and will help in mobilizing people when the camps are organized. Community sensitization activities will be conducted for members of the general population as well as HRGs. Support from community champions will be taken for reaching out to key populations. The mobile unit will be painted and decorated with key messages on health including HIV to ensure stigma-free services.

ii. **Implementation of Outreach Camps at Service Delivery Points**

- A district route map and service delivery points will be prepared based on a mapping of HRG/at-risk populations, pending reactive cases for HIV confirmation, OST patients, PLHIV not linked to ART services etc.
- The visit date, service time and the possible parking points for the vehicle need to be shared with the local health team (ANM, ASHA) in advance.
- If possible, the services in rural areas could be conducted in any adequate building with one or two rooms and toilets, such as an Anganwadi centre or Panchayat Bhavan or primary school. Adequate arrangements for waiting area should be made in coordination with the Gram Panchayat/VHSNC.

iii. **Equipment and Inventory Management**

- The expected number of beneficiaries or clients in the camp should be identified and counsellors should prepare a list of the equipment based on diagnostics and treatment services provided.
- The list of drugs and consumables required along with required quantity will be prepared and shared with DISHA. The supply shall be provided from the nearest NACP facility or from district stores. The drugs and consumables required for integrated health camps will be mobilized in planned coordination with the health systems like NTEP, NVHCP and NCD at the state and district levels.
- Regular inventory should be maintained in the physical format and shared from time to time and as per national guidelines.

iv. **Effective Referral Mechanism**

In order to keep identified at-risk negative clients negative, an effective referral with appropriate services will play a very crucial role. Counsellors should understand the requirement of the at-risk clients and refer them for the required service/s.

The confirmed HIV-positive cases will be linked with the nearby ART centre for initiation of treatment. The staff will ensure effective referral and linkages for diagnosis and management of TB, Hepatitis B/C and non-communicable diseases during the camp. The line list should be maintained for effective referrals, linkages and follow-up.

v. **Reporting and Documentation**

Reporting will be done in NACO's existing SOCH as a separate facility. Monthly and quarterly reports will be prepared and shared with DISHA. A logbook should be

maintained by the mobile camp driver and supervised by DISHA and be available for verification. The mobile camp shall adhere to all the provisions of Motor Vehicle Acts and other applicable acts in this regard.

vi. **Post Camp Follow-up**

Post camp follow-up will help counsellors and/or other personnel to ascertain that the clients have availed the services for which they were referred.

Monitoring and Supportive Supervision

The IMS data management system of NACP must be regularly updated every time after the completion of the camp. The data below should be updated with DISHA and SACS every month:

- Number of mobile units in the district (sanctioned andoperational);
- Units managed by outsourced or owned by state (disaggregate);
- Number of trips/day in a month;
- Number of villages/habitations visited with route map;
- Number of patients servedper trip and per month;
- Number of individuals screened for HIV, syphilis and other diseases (TB/ Hepatitis B & C, blood sugar levels, BP etc.) and identified positives/reactive;
- Number of patients screened for STI, screened reactive and number of patients treated for STI;
- Number of patients who receive follow-up care like adherence counselling, follow-up for sputum test etc.
- Number of patients provided ART refill, OST refills;
- Number of patients referred to other health facilities for any services;
- Details of commodities distributed under prevention services.

Key Messages

- Field activities are to support the client in order to ensure that need-based services are delivered.
- Based on the client's needs and programmatic needs, field activities are to be planned and prioritized.
- For the counsellors, field activities indicate going out of the facility/institution to meet clients at their homes or common places for various follow-ups to ensure service uptake.
- Counsellor posted at the Mobile Outreach Van shall be responsible for ensuring referral and follow-ups of the clients.
- Attending coordination meetings, meetings with SACS officials or nodal medical officers, coordination with other departments regarding service referralsand linkages or performing any administrative activities are not considered as field activities.
- Types of services provided by mobile ICTCs include comprehensive prevention and treatment services, differential HIV screening/testing services, HIV and STI treatment services and other health services.
- Various strategies that can be used for outreach activities includestatic camp-based approaches, coordination with other campaigns and stakeholders for better integration with health systems.
- The DISHA unit will be responsible for operationalization, supervision and monitoring of Mobile Outreach Services.

References

- *Operational Guidelines for Integrated Counseling and Testing Centres, 2007*

22 Linkages and Referrals for PLHIVs and At-Risk Negative Clients

In HIV and AIDS programme, it is important to establish linkages with both NACP programme and other health, social welfare programmes, connect with local leaders/groups, organizations for referrals and linkages both with various government and civil society service providers.

Linkages and Referrals with Health Services

Mechanisms for establishing linkages and referral systems are necessary to meet the immediate and long-term needs of PLHIV and at-risk negative clients of SSKs. Each NACP facility must establish the following programmatic linkages with other health services, social welfare and protection services within the institute as well as within district. The counsellor must also be aware of the services available at each of these units and guide clients appropriately. Following are the referral and linkage services required for the clients accessing various health facilities:

- Referrals/linkages is to be done with appropriate prevention, care and treatment services.'
- Referrals/linkages of the clients to be done to other social welfare and social protection services.
- Counsellors at SA-ICTCs and ART centre also should collect information on the services available for the mental health issues for HRGs, at-risk population and PLHIVs. If and when counsellors feels that the clients require enhanced and/or special mental health services, they should be able to refer such clients for the special services.
- Referrals to DSRC for screening for presence of STI signs and symptoms and early diagnosis and treatment of STI and syphilis. If tested negative, link to SSK for prevention services;
- Referrals to NGOs/CBOs for psychosocial support, support groups, legal support, socio-economic support and nutritional support;
- The CSC serves as a comprehensive unit for treatment support, retention, adherence, positive living and referral linkages to need-based services and strengthening enabling environment for PLHIV.
- For comprehensive care, PLHIV need access to various departments/services within the health facility depending upon disease stage and occurrence of opportunistic infections to the departments of medicine, microbiology, obstetrics & gynaecology, paediatrics, dermatology/venereology, chest diseases, non-communicable diseases (NCD), screening for Hepatitis B and C free of cost under the National Viral Control Programme (NVHCP) or other OPDs.
- To provide nutrition counselling and psychosocial support to HIV-infected pregnant women, Linkages should be made with ANMs, ASHAs, community outreach workers district-level networks to advise them on the right foods to take and go to Anganwadi centres for

nutritional support, and to the district-level network of Positive People for peer counselling and psychosocial support.

- Due to lifelong ART, PLHIV need to undergo several follow-up investigations for monitoring purpose and for the early diagnosis of comorbid conditions (blood and urine tests, molecular tests for TB, radiological investigations etc.).
- Patients with suspected treatment failure, severe adverse effects and complicated clinical cases of drugs are referred for review by the panel of experts called State AIDS Clinical Expert Panel (SACEP) at Centre of Excellence/ART plus centres for further evaluation and timely switch/substitution to appropriate ART.
- For non-PLHIVs, at-risk negative population, SSK counsellors are required to identify the comprehensive service needs from such clients to provide them the referrals and link them to the other health services as per need so that such clients remain associated with the programme and receive services from SSK as per the guidelines.

Figure 22.1 - Referrals and linkages under NACP

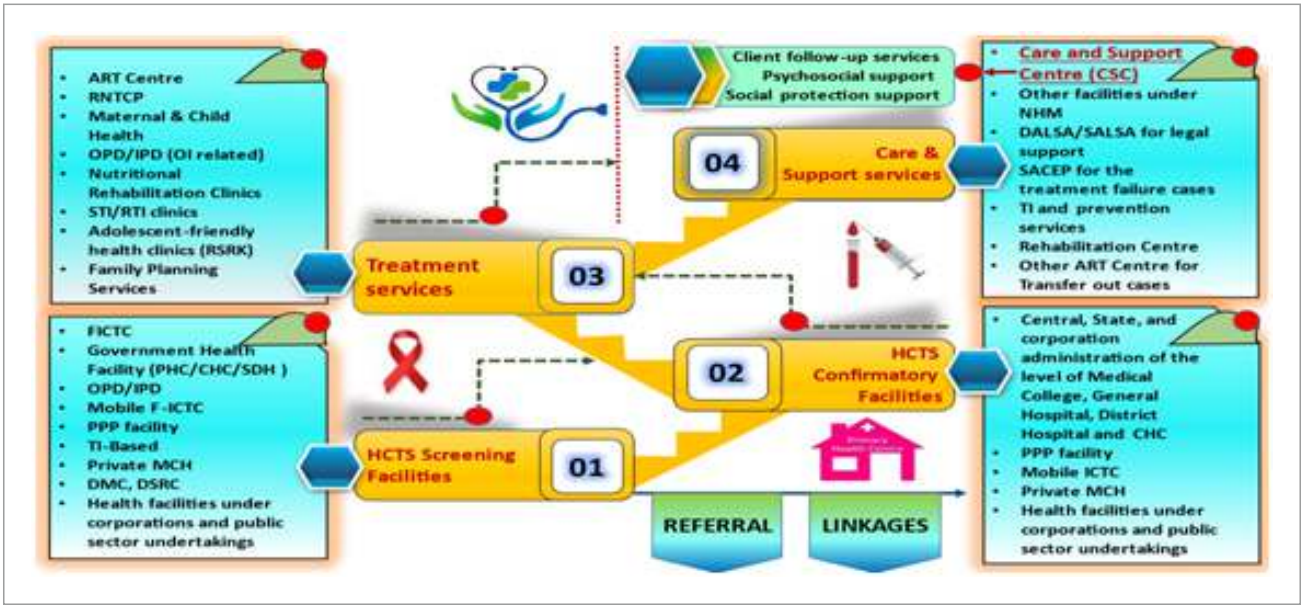


Table 22.1 - Referrals and Linkages to Social Protect Schemes

Need for Social Protection for PLHIV	• The medical and social reality of HIV/AIDS pushes people and households into poverty in part by reducing household labour capacity and by increasing medical expenses. • HIV-related stigma and discrimination marginalize PLHIV, and households affected by the HIV epidemic and exclude them from essential services. • The impact is felt on income, employment, consumption expenditure (especially nutrition, education and healthcare) and savings. • PLHIV face various vulnerabilities such as job insecurity, loss of livelihood, poor access to healthcare facilities, low access to nutritional support, loss of education for children, issues of identity and lack of support for orphan and semi-orphan children, losing a house and/or family if WLHIV. • Self and social stigma and discrimination diminish the social support

	system. The burden of increased illness, loss of jobs and income, rising medical expenses, depletion of savings and other resources, food insecurity, psychological stress and social exclusion further worsens the socio-economic condition of PLHIV. • It has been recognized that PLHIV, CABA, their families and MARPs have needs beyond HIV prevention and treatment services. In these circumstances, social protection (including legal aid) is imperative.
Social protection in the context of HIV	• Social protection in the context of HIV may be understood as a set of policies, schemes and entitlements or legislations that help those infected or affected by HIV and the most-at-risk populations to mitigate the impact of HIV, reduce further vulnerability and lead life with dignity. • The strategy behind social protection is to reduce the impact of HIV by ensuring social entitlements and benefits of various welfare schemes to PLHIV, CABA, their families and MARPs. It reduces the burden on households as well as vulnerabilities of people to infection.
Social welfare schemes	• The Indian government, at all levels, announces welfare schemes for a cross section of the society from time to time. These schemes could be either central, state specific or a collaboration between the centre and the states. An easy and single point of access to information about several welfare schemes and their various aspects (eligibility, types of benefits, other scheme details) are given here: https://www.india.gov.in/my-government/schemes. • The schemes are also compiled and presented by NACO and there are schemes that are different for different states. A compendium of schemes available during 2017 can be seen here (these schemes may have been modified and new schemes may have been added by the governments concerned): http://naco.gov.in/sites/default/files/Social%20Protection%20Compendium%20%20Version%202%20.pdf. • The Government of India jointly with the state governments implements several welfare schemes for the poor and deprived to provide them with direct benefits. PLHIV, CABA, MARPs and tribals living in geographically remote areas, people from disadvantaged castes and the economically vulnerable category and people who do not have a substantial source of income are dependent on these schemes to support their livelihood. Hence, the basic objective of the welfare scheme is to support and improve the standard of living of the above-mentioned groups of people and provide them with equal opportunities.

Table 22.2 - Some centrally sponsored welfare schemes

Name of the schemes	Implementing agency/department
Job card under the Mahatma Gandhi National Rural Employment Scheme (MGNREGS)	Ministry of Rural Development
Pradhan Mantri Awas Yojana (PMAY)	Ministry of Housing and Urban Affairs
Pradhan Mantri Ujjwala Yojana (PMUY)	LPG connection for women
Pre- and post-matric scholarships for OBC and SC students	Ministry of Social Justice and Empowerment
Entrepreneurial schemes for OBC women	Ministry of Social Justice and Empowerment
Pradhan Mantri Suraksha Bima Yojana (PMSBY)	Ministry of Finance
Pradhan Mantri Jan Arogya Yojana (PMJAY) under Ayushman Bharat	National Health Protection Mission
Rashtriya Swasthya Bima Yojana (RSBY)	Ministry of Labour and Employment
Support for Marginalized Individuals for Livelihood and Enterprise (SMILE)	Ministry of Social Justice and Empowerment
HIV/AIDS Act 2017	NACO, Ministry of Health & Family Welfare

Additionally, individuals can be directed to the State/District Legal Services Authorities and the State Ombuds person for HIV/AIDS for legal assistance with matters related to discrimination against PLHIV.

Key Messages

- One of the functions of the HIV counselling services is to link clients with various services under NACP and other health services. Only counselling will not help to mitigate the response of HIV and so connections with health services and social protection schemes are important.
- PLHIV and their families face poverty, stigma and exclusion due to HIV and need social protection to cope and live with dignity. Social protection for HIV includes policies, schemes and legislations that help mitigate the impact of HIV and reduce vulnerability.
- Mechanisms for establishing linkages and referral systems are necessary to meet immediate and long-term needs of PLHIV.
- Counsellors should be aware of the services available at each facility and guide clients appropriately to access them. Counsellors should also coordinate with other service providers and follow up on the referrals and linkages.
- Various services under NACP aim to provide comprehensive and holistic care for PLHIV and their partners, including prevention, diagnosis, treatment, counselling, support and legal aid.
- In addition to the linkages with services under NACP, it is important to establish linkages with other health services e.g., services under National Health Mission.

- The Indian government offers various welfare schemes for the poor and deprived, including PLHIV, CABA, MARPs and tribals, to support their livelihood and rights. These schemes provide direct benefits such as food, education, healthcare, disability assistance and skill development, and are implemented by different ministries and departments at the central and state levels, such as rural development, social justice, tribal affairs, agriculture, etc.
- Counsellors are expected to make a list of various schemes in their own district/corporation area with details of the scheme, the eligibility norms, documents required, contact details and other information, if any. They should develop a booklet that has state-specific schemes that help PLHIV access them.
- Counsellors should establish rapport with the respective persons of various departments/NGOs who are implementing the schemes.
- Counsellors should link clients with various such services and schemes. Give a referral slip if convenient. However, if there is any fear of stigma, make the referral in the most convenient manner; e.g., instead of giving a referral slip, you may want to speak to the respective person. Maintain a register for referrals and linkages.
- Provide anticipatory guidance to the client before sending them to another service provider: e.g., advise them about the documents to carry, where to go, whom to meet and other information.
- If there are challenges in referrals and linkages, find out the reasons and address them. Contact respective stakeholders like collector office/corporation office/NGO for further guidance.
- Counsellors should encourage clients to keep the documents like Aadhar card, pan card, bank account details, ration card, income proof, photograph etc., ready, which will help them avail various schemes. Help of local authorities may be availed for this.
- Counsellors may invite government officials, NGO representatives in the community camps/ events to guide people about the schemes and preparing the documents. This may help in strengthening the bond between the officials and community members.

References:

- *Integrated training module for ICTC, ART, and STI Counsellors, NACO, Nov 2014*
- *National Operational Guideline for ART Services, NACO, 2021*
- *National Guidelines for HIV Care and Treatment, NACO, 2021*
- *Operational Guidelines 2nd cut for Sampoorna Suraksha Strategy, August 2023*

Annexure: Worksheet for Mapping the Social Welfare and Social Protection Schemes in the State/District of the Participants

Age group (years)	Aadhaar card	Voter ID card	Ration card Nutrition support	Bank account	Legal aid	Liveli-hood support MNERGA	Educa-tion support	Pension (old age, widow, ART)	Health Insurance Health services	Transport support	Housing schemes
0–15											
16–18											
18+ (Female)											
18+ (Male)											
More than 60											

23 Breaking Silos – Counselling Needs and Terms of Reference of the NACP Counsellors

Counselling services are an essential component for achieving the objectives of NACP V (2021–2206).

Counselling is a type of therapy that helps individuals work through personal, mental health and emotional issues.

As counselling can be beneficial for people of all ages and backgrounds, some common reasons why people seek counselling are as follows:

a. Struggling with anxiety or depression;

b. Coping with the aftermath of trauma or abuse;

c. Dealing with relationship problems or conflicts;

d. Adjusting to major life changes or transitions;

e. Struggling with addiction or substance abuse;

f. Coping with grief or loss;

g. Managing stress or stress-related health problems;

h. Working through issues related to self-esteem or self-worth.

In the context of HIV/AIDS, counselling remains one of the key pillars of HIV services. HIV counselling and testing is a package service that supports people to make informed decisions regarding their HIV status and to make informed choices about their future practices and behaviours. The purpose of counselling is to create awareness and prepare a person for both a seropositive and seronegative status,and also to address the issues of anxiety, denial, anger and guilt, which a person is likely to go through upon knowing their seropositive status.

Key objectives and points for consideration across various counselling phases:

Counselling Phase	Objectives and Key Points
Pre-test counselling	• Assess the risk behaviour • Give information on HIV, syphilis and other STIs, routes of transmission. • Give information about tests and the possible results. • Prepare and encourage clients for testing. • Give information on safe sex practices. • Prepare for HIV-negative and HIV-positive test results. • Linkages with necessary services

Counselling Phase	Objectives and Key Points
Post-test counselling	• Prepare clients for test results. • *If positive,* help in coping up with results, educate the client about the condition, available treatment(ART), other assessments (TB,STI, etc.) and supportive services. • Counsel for positive and healthy lifestyle. • Encourage partner testing. • *If negative,* educate them about the risk behaviour, possible sources of HIV/STI infection and preventive measures. • Encourage partner testing. • Linkages with necessary services
For HIV-positive clients	• Inform about options, care, support and treatment services and provide referrals. • The client must be aware of safer sex practices and the risks associated with unprotected sex. • Promote safer sex practices and encourage disclosure of serostatus. • Encourage partner testing.
For HIV-negative clients	• Provide information and materials for remaining HIV negative. • Refer high-risk clients to the relevant care and support services (like injecting drug users can be referred to harm reduction services or drug treatment facilities).

Breaking Silos and Building Synergies

One of the guiding principles of NACP-V is breaking the silos and building synergies. NACP-V recognizes opportunities available within the programme as well as in the other national health programmes to catalyse progress on stated goals.

Break the silos, build synergies promotes coordinated actions through single-window delivery systems along with functional and measurable referral and linkages, within NACP and across national health programmes and related sectors for an efficient service delivery. This will take into account the local contexts to ensure a suitable, functional and sustainable model.It is expected that this approach will help the clients improve their quality of life, which will help in reducing their vulnerability.

The Sampoorna Suraksha Strategy (SSS) is the first step towards breaking the silos and building synergies. It aims to provide a comprehensive package of services to the at-risk HIV-negative population as per their needs to keep them HIV-free, thus boosting the national level progress on HIV prevention.

The eight NACP facilities, which include ICTCs, TI projects, ART centres, DSRCs, OST centres, Sampoorna Suraksha Kendras (SSKs), One Stop Centres (OSCs) and the 1097 helpline, offer HIV/AIDS/STI services. For the clients who attend these institutions, these facilities offer services like HIV/STI/RTI prevention, testing, treatment, care, referrals and linkages.

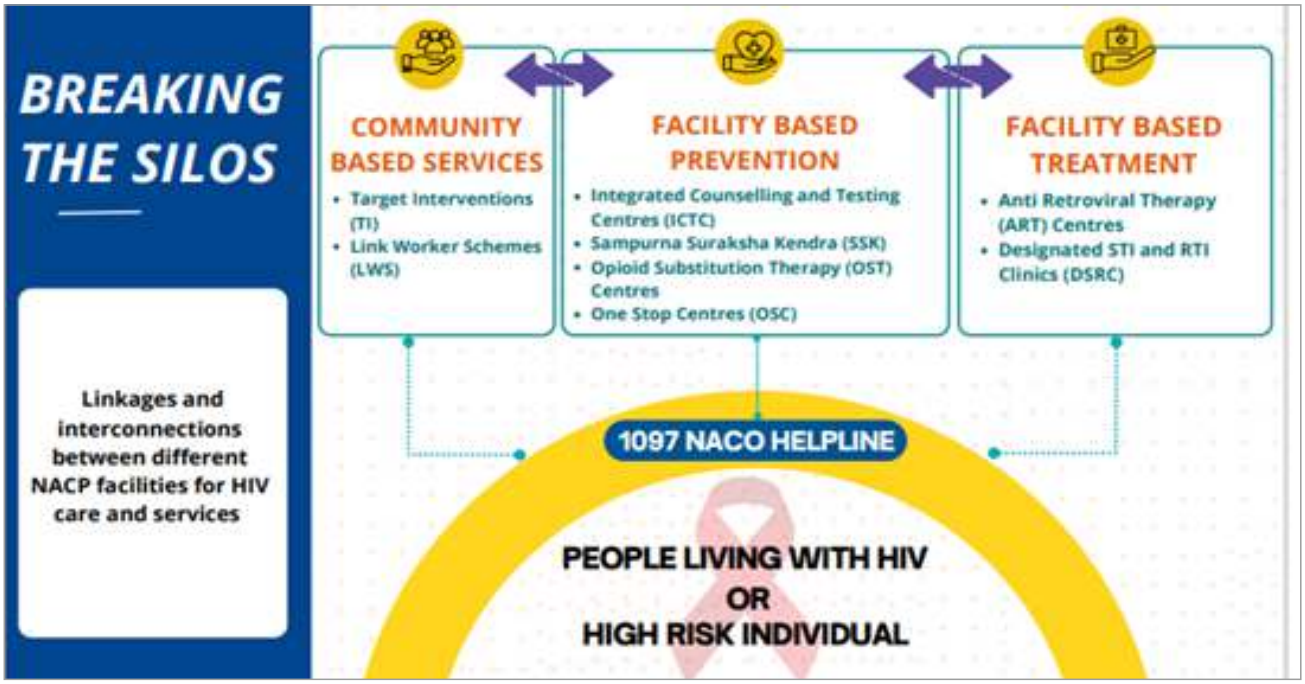
The community-level services by the TI and LWS projects to the high-risk groups and bridge populations include HIV/AIDS/STI/RTI awareness and education, commodities distribution, screening and referrals.

Facility-based prevention services are provided at OST, ICTCs, OSCs and SSKs for high-risk groups as well as for at-risk clients.

Facility-based treatment services are provided at the ART centres and DSRCs to those who have STI and tested reactive for HIV respectively.

The following diagram depicts how the NACP services are interconnected in terms of services provided to the clients visiting any of the centres. Most frequently, a client who visits one of the services needs to be repeatedly referred to a variety of additional facilities. Counsellors must be knowledgeable about the services offered at different NACP sites in order to fulfil this requirement. For example, a person visiting an OST directly for drug-related issues or DSRC with any of the symptoms of STI/RTI should be referred to TI/LWS for comprehensive package of preventive services coupled with risk-reduction counselling; the client should also be referred for HIV screening/testing services and if the client tests positive, then they are further referred to care and treatment services. During all these processes, it is quite possible and normal that a client keeps coming to the OST or DSRC as well. So, all in all, a counsellor will have to understand this inter-dependency among various services in order to effectively cater to the needs of the clients.

Figure 23.1 – Services and linkages in NACP



The counsellors' terms of reference (ToR) have been revised to break the silos and to create synergy in the counselling support provided under NACP. The revised ToR for all counsellors working in various NACP facilities has come into effect from 11 November 2022.

Revised ToR for Counsellors (w.e.f. November 2022)

(i) **Essential qualification:**

- Graduate degree holder in psychology/social work/sociology/ anthropology/human development/nursing with at least three years of experience in counselling/educating under a national health programme

OR

- Post-graduate degree holder in psychology/social work/ sociology/ anthropology/ human development/nursing.

If the candidate is a PLHIV: Graduate degree holder in psychology/social work/sociology/ anthropology/human development/nursing with at least one year of experience in counselling/educating under a national health programme.

Desirable: Experience of working under an NACP facility or community settings.

(ii) **Knowledge and skill set needed:**

- The candidate should be computer literate with working knowledge of MS Office, usage of internet and electronic mail.
- The candidate should be familiar with government health policies and related programmes.
- The candidate should be able to work in teams and have flexible ways of working as per the need of the programme.

(iii) **Roles and responsibilities of a counsellor:** Acounsellor will be performing the following jobs, in facilities (including prisons) and in outreach/community settings through field visits in a confidential and ethical manner, as per the modalities prescribed in the national guidelines and periodic instructions issued under the NACP:

1. Counselling and educating the target audience on preventive measures, testing and treatment of HIV, STIs and related co-infections through one-to-one or group counselling, using suitable media (posters, flip books, flyers, leaflets, audio-visual material, tele-counselling, virtual platform, etc.);
2. Undertaking risk assessment of the target audience and offering of suitable follow-up services as per the risk level of the clients;
3. Promoting comprehensive prevention models (condoms, contraception, PEP, PrEP etc.), including condom demonstrations (using a penis model), for prevention of new HIV infections.
4. Undertaking HIV and syphilis screening in facility and field settings;
5. Undertaking counselling of people found reactive/positive for HIV, other STIs and related co-infections, including but not limited to, ARV medicines, preparedness counselling, adherence counselling, opportunistic infections management, management of non-communicable diseases, lifestyle modifications, positive prevention, disclosures, index testing, psychosocial support, family counselling, suitable linkage and referrals, including to the 1097 helpline, social protection schemes, legal aid, rehabilitation and other relevant services.
6. Promoting benefits of DTG-based regimen or current ART regimen preferred in the programme;
7. Contributing to the creation of an enabling environment to fight stigma and discrimination;
8. Undertaking family planning counselling and follow-up of referral and linkages among eligible HIV-positive clients;

9. Undertaking counselling of adolescents and youth for SRH, including that for prevention, testing and treatment of HIV, other STIs and related co-infections;
10. Undertaking counselling and follow-up of services for at-risk non-reactive/negative clients, including but not limited to comprehensive prevention models, periodic screening for HIV and other STIs, and suitable linkage and referrals, including to the 1097 helpline, as per national guidelines;
11. Conducting follow-up for STI/HIV-reactive/positive people through field visits/outreach ensuring uptake of suitable services like confirmatory testing, registration with treatment facilities and adherence counselling;
12. Conducting follow-up for STI/HIV-reactive/positive children through field visits/outreach ensuring uptake of suitable services like confirmatory testing, viral load tests, registration with treatment facilities and adherence counselling;
13. Conducting follow-up for STI/HIV-reactive/positive children through field visits/outreach for ARVs/prophylaxis/suitable treatment administration;
14. Coordinating with various outreach workers/field functionaries/ANMs/ASHA workers/Anganwadi workers etc. in the context of STI/HIV-reactive/positive individuals ensuring uptake of suitable services like confirmatory testing, registration with treatment facilities and adherence counselling;
15. Promoting institutional delivery among HIV-positive pregnant women;
16. Counselling on exclusive breastfeeding/replacement feeding and counselling the mother for complete EID;
17. Performing the role of a nodal point for the SSS as suitable for the given locality;
18. Counselling on harm-reduction services for PWID, including on OST, viral load testing and viral suppression;
19. Administration of OST drugs to PWID as suitable;
20. Ensuring the suitable use and maintenance of kits/commodities/consumables/equipment provided under the NACP, including the cold-chain maintenance of kits/drugs as per guidelines;
21. Undertaking data recording and reporting, including data entry in IT-enabled platforms, for the services offered as per the system prescribed under the national guidelines;
22. Undertaking specific activities for programme monitoring, surveillance and research as per the instructions issued periodically;
23. Participating in reviews, trainings and capacity-building activities etc., as per the instructions issued periodically;
24. Undertaking any other related activities under the NACP as per the instructions issued periodically.

Key Messages

- HIV counselling plays a major role in achieving the objectives of NACP V,95:95:95 goal, universal access to quality STI/RTI services to vulnerable/at-risk populations and attaining the elimination of vertical transmission of syphilis.
- HIV counselling and testing is a package service that supports people to make informed decisions regarding knowing their HIV status and to make informed choices about their future practices and behaviours.
- One of the guiding principles of NACP-V (2021–2026) is breaking the silos and building synergies.
- Break the silos, build the synergies and promote coordinated actions, through single-window delivery systems is the principle of NACP V. This will be achieved through referrals and linkages within NACP and across national health programmes and related sectors.
- This will help ensure single-window service delivery to the PLHIVs as well as at-risk population, which will help improve their quality of life.
- The Sampoorna Suraksha Strategy (SSS) is the first step towards breaking the silos and building synergies. It aims to provide a comprehensive package of services to the at-risk HIV-negative population as per their needs to keep them HIV-free.
- In order to provide quality services to the clients in a holistic manner, the counsellors' ToR has been revised to break the silos and to create synergy in the counselling support provided under the NACP.
- As per the revised ToR, counsellors' role will not be restricted to one centre. They will have to play diverse roles like counselling at the centre for various services under NACP, referrals and linkages, outreach activities, follow-up and various other activities.
- To perform these roles, counsellors will have to keep themselves updated with knowledge, attitude and skills required for the respective tasks.

References:

- *Strategy document titled National AIDS and STD Control Programme Phase-V (2021-2026).*
- *Revised integrated Terms of Reference (ToR) for the Counsellors under National AIDS Control Programme (NACP) Phase -V, Dated 09/11/2022*

24 Data Safety and Management at Facilities under NACP

The National AIDS Control Programme (NACP) generates considerable amount of data on HIV/AIDS from service facilities across the country through the Information Management Systems, Research Projects, HIV Sentinel Surveillance etc. NACO encourages the use of this data for evidence-based programme planning, research etc., at all levels under the programme. NACO also encourage students to use NACP data for their thesis/dissertation work.

In addition to this, a large number of organizations are involved in fighting against HIV/AIDS across the country and many of them are supporting SACS/NACP facilities in various activities; so there is a need for availability of data to all those who are involved in the programme.

According to section 11 of the HIV and AIDS (Prevention and Control) Act, 2017, it is mandatory for every facility to keep records of HIV-related information. The details of HIV-infected and affected population should be maintained with data protection measures. All the data should be kept confidential.

"HIV-related information" means any information relating to the HIV status of a person and includes

- information relating to the undertaking performing the HIV test or result of an HIV test;
- information relating to the care, support or treatment of that person;
- information which may identify that person; and
- any other information concerning that person, which is collected, received, accessed or recorded in connection with an HIV test, HIV treatment or HIV-related research or the HIV status of that person.

"Protected person" means a person who is

i. HIV positive; or

ii. ordinarily living, residing or cohabiting with a person who is HIVpositive; or

iii. ordinarily lived, resided or cohabited with a person who was HIVpositive.

Data Protection Measures at the Facility Level

A) Composition of Data Management Committee (DMC)

A DMC should be formed at each facility. The concerned DMC is responsible for ensuring data security and also to review and provide appropriate recommendation regarding data security measures. Wherever a facility does not have DMC, the head of the facility should be entrusted with the responsibility and function of DMC. Details of composition as well as roles and responsibilities at the NACP facility level are as follows:

Table 24.1 – Composition of DMC at NACP facility

Composition of DMC At NACP Facility	
Chairperson	Senior and relevant officer of the facility
Members	The committee will have 2 members, one of the members should be a representative from the protected persons and the other from the same facility who deals with the data
Terms of Reference	
• Review of implementation of data protection measures at the facility • Review of data access and data security at the facility • To provide inputs on the disposal of physical files/computer equipment containing HIV-related information at the facility • To consider all adverse events related to NACP data reported to the committee • Any other matter related to NACP data management	

B) Steps for data management at NACO, SACS and NACP facility

It is mandatory for every facility that keeps the records of HIV-related information of protected persons to adopt data protection measures. Data protection measures here include the following steps:

- **Protecting information from disclosure of HIV-related information:** Confidentiality and privacy is to be maintained while collecting HIV-related information. For each facility desirous of collecting HIV-related information, authorized persons or staff should sign an undertaking for data confidentiality.
- **Access to HIV-related information:** Access should be granted only to the authorized persons/ staff after they sign a formal undertaking for confidentiality.
- **Provision for security systems for HIV-related information:**
  i. There should be secured almirahs or cabinet for physical records like registers, reports etc., which should be carefully locked when not being used.
  ii. Facilities should ensure that computer systems having HIV-related information are protected by using appropriate and up-to-date anti-virus and firewall technologies and these should be kept up-to-date to meet emerging threats.
  iii. Personal computers, mobile phones,tablets or any other hardware with HIV-related information should be password protected and should be logged off or 'locked' when not being used.
  iv. Passwords for hardware, software, databases, etc., should be of sufficient strength. Facilities must ensure that passwords are changed on a regular basis.
  v. A strong password must
     - be at least 8 characters in length;
     - contain both upper and lowercase alphabetic characters (e.g. A-Z, a-z);
     - have at least one numerical character (e.g. 0–9);
     - have at least one special character (e.g. ~!@#$%^&*()_-+=).

vi. Any software or applications for maintaining the HIV-related information of protected persons in the facility should be explicitly approved by the competent authority of the respective institution.

- Disposal of HIV-related information: Facility should have standard operating procedures (SOPs) in place regarding the disposal of physical and electronic records/files containing HIV-related information of protected persons.
- Accountability and liability for security of HIV-related information should be with DMCs or the head of the concerned facility where DMC is not constituted.

C) NACP data sharing through shared confidentiality: NACP data is only to be shared by NACO and SACS as per the SOP for NACP data sharing available onthe NACO website.

D) Exemption through shared confidentiality

- By a healthcare provider to another healthcare provider who is involved in the screening/testing, linkage, care, treatment, support or counselling of HIV and other related disease of such person, when such disclosure is necessary to provide appropriate healthcare to that person;
- By an order of a court that the disclosure of such information is necessary in the interest of justice for the determination of issues and in the matter before it;
- In suits or legal proceedings between persons, where the disclosure of such information is necessary in filing suits or legal proceedings or for instructing their counsel;
- To the officials of the central government or the state government/SACS for the purposes of monitoring, evaluation and related activities;
- If it relates to statistical or other information of a person that could not reasonably be expected to lead to the identification of that person.

In all other scenarios, no paper or electronic records containing the HIV-related information of protected persons shall be shared or transferred to other facilities or persons without the written informed consent of the concerned person or his or her representative.

Data sharing and monitoring of shared data at facility level

Consistently monitor data access and security, and in case of any concerns or data breach, proactively report them to the DMC or the head of the institution.

The sharing of data between different facilities or organizations must strictly adhere to authorized channels. It is of utmost importance to ensure that shared data is exclusively utilized for healthcare and monitoring purposes and is not disseminated to any unauthorized individuals or organizations.

Table 24.2 - Dos and Don'ts for NACP Data Management at NACP Facilities

Dos	Don't
• Grant access to authorized personnel. • Maintain confidentiality during data collection. • Implement password protection for devices. • Secure physical records in locked cabinets. • Log off and lock devices when not in use. • Follow SOP for safe physical/electronic file disposal. • Regularly review data access/security; promptly inform the Data Management Committee/Head of Institution of any issues. • Share NACP data through authorized channels.	• Allow unauthorized personnel to access data/records. • Neglect secure storage and protection measures such as leaving paper/ files accessible to unauthorized individuals. • Use weak passwords that do not meet the criteria. • Use software/device for NACP data storage without proper approval. • Dispose of data without following the established procedures. • Share data through unauthorized channels. • Neglect to monitor data access regularly.

Table 24.3 - Dos and Don'ts for NACP Data Sharing at NACP facilities

Dos	Don't
• Share data for appropriate healthcare between healthcare providers. • Share with central government, state government/SACS for monitoring and evaluation. • Ensure shared data is not further shared with other organizations/individuals. • Maintain responsibility for data security and proper use.	• Share NACP data without proper approval of NACO/ SACS. • Share paper/electronic HIV-related data with personal information without informed consent, except for healthcare and monitoring purposes.

Role of Counsellor in NACP Data Safety and Management

As counsellors working in the programme, the following is the list of registers, records and reporting formats to be maintained by the counsellors:

Table 24.4 – List of registers and records to be maintained by counsellors

Registers	• Counselling register for general individuals • Counselling register for pregnant women • Outreach activity register
Forms	• Linkage form in triplicate • Indent form • RNTCP form for referral for diagnosis
Reports	• SOCH monthly report
Cards	• PLHIV card for general individuals • PPTCT beneficiary card • EID card • Discordant couple card • Follow-up HIV testing card

Importance of Client Records

- Client records are intended to ensure continuity and quality of service delivery.
- Benefits of maintaining client records include the availability of information to different counsellors and healthcare workers within the team to ensure emotional support and follow-up management.

Importance of Analysis and Reporting

- Necessary to enter client and clinic data into a system so as to ensure proper analysis and reporting.
- Reporting reflects the overall service provided by the counsellor/s during a specified period.
- Reporting helps to make decisions on the effectiveness and efficacy of services provided.

Barriers to Data Recording Practices

- Individual barriers
  - Leave data field blank in the data collection form
- Occupational barriers
  - Non-availability of forms
  - Power breakdown etc.

Key Messages

- The HIV and AIDS Act, 2017 directs every facility to keep records of HIV-infected and affected population and ensure that the data is protected and confidentiality is maintained.
- According to the section 11 of the HIV and AIDS (Prevention and Control) Act 2017, it is mandatory for every facility to keep records of HIV-related information.
- Data Management Committee (DMC) should be formed at each facility responsible for ensuring data security.
- Consistently monitor data access and security, and in case of any concerns or data breach, proactively report them to the DMC or the head of the institution.
- Client records are intended to ensure continuity and quality of service delivery.
- Counsellors should maintain accurate data. The data can help them to understand the progress being made towards the programme objectives; it helps in modifying interventions if progress is not seen. It helps in evidence-based planning and to assess progress.
- At local, state and national levels, it is useful to get information on various trends and see the impact of the interventions.
- Patient recordshelp in the assessment of the progress made. If a new team member has joined the healthcare team, it helps the person to understand the case history of the patient.
- It is the responsibility of everyone working in NACPto ensure data security.

रजिस्ट्री सं॰ डी॰ एल॰—(एन)04/0007/2003—17 REGISTERED NO. DL—(N)04/0007/2003—17

भारत का राजपत्र
The Gazette of India

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इस भाग में भिन्न पृष्ठ संख्या दी जाती है जिससे कि यह अलग संकलन के रूप में रखा जा सके।
Separate paging is given to this Part in order that it may be filed as a separate compilation.

MINISTRY OF LAW AND JUSTICE
(Legislative Department)

New Delhi, the 21*st April*, 2017/*Vaisakha* 1, 1939 (*Saka*)

The following Act of Parliament received the assent of the President on the 20th April, 2017, and is hereby published for general information:—

THE HUMAN IMMUNODEFICIENCY VIRUS AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (PREVENTION AND CONTROL) ACT, 2017

NO. 16 OF 2017

[20*th April*, 2017.]

An Act to provide for the prevention and control of the spread of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome and for the protection of human rights of persons affected by the said virus and syndrome and for matters connected therewith or incidental thereto.

WHEREAS the spread of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome is a matter of grave concern to all and there is an urgent need for the prevention and control of said virus and syndrome;

AND WHEREAS there is a need to protect and secure the human rights of persons who are HIV-positive, affected by Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome and vulnerable to the said virus and syndrome;

AND WHEREAS there is a necessity for effective care, support and treatment for Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome;

AND WHEREAS there is a need to protect the rights of healthcare providers and other persons in relation to Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome;

AND WHEREAS the General Assembly of the United Nations, recalling and reaffirming its previous commitments on Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome, has adopted the Declaration of Commitment on Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (2001) to address the problems of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome in all its aspects and to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat it in a comprehensive manner;

AND WHEREAS the Republic of India, being a signatory to the aforesaid Declaration, it is expedient to give effect to the said Declaration.

BE it enacted by Parliament in the Sixty-eighth Year of the Republic of India as follows:—

CHAPTER I
PRELIMINARY

Short title, extent and commencement.

1. (*1*) This Act may be called the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act**,** 2017.

(*2*) It extends to the whole of India.

(*3*) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

Definitions.

2. In this Act, unless the context otherwise requires,—

(*a*) "AIDS" means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus, which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions, as may be specified from time to time;

(*b*) "capacity to consent" means ability of an individual, determined on an objective basis, to understand and appreciate the nature and consequences of a proposed action and to make an informed decision concerning such action;

(*c*) "child affected by HIV" means a person below the age of eighteen years, who is HIV-positive or whose parent or guardian (with whom such child normally resides) is HIV-positive or has lost a parent or guardian **(**with whom such child resided) due to AIDS or lives in a household fostering children orphaned by AIDS;

(*d*) "discrimination" means any act or omission which directly or indirectly, expressly or by effect, immediately or over a period of time,—

(*i*) imposes any burden, obligation, liability, disability or disadvantage on any person or category of persons, based on one or more HIV-related grounds; or

(*ii*) denies or withholds any benefit, opportunity or advantage from any person or category of persons, based on one or more HIV-related grounds**,**

and the expression "discriminate" to be construed accordingly.

Explanation 1.—For the purposes of this clause, HIV-related grounds include—

(*i*) being an HIV-positive person;

(*ii*) ordinarily living, residing or cohabiting with a person who is HIV-positive person;

(*iii*) ordinarily lived, resided or cohabited with a person who was HIV-positive.

Explanation 2.—For the removal of doubts, it is hereby clarified that adoption of medically advised safeguards and precautions to minimise the risk of infection shall not amount to discrimination;

(*e*) "domestic relationship" means a relationship as defined under clause (*f*) of section 2 of the Protection of Women from Domestic Violence Act, 2005; 43 of 2005.

(*f*) "establishment" means a body corporate or co-operative society or any organisation or institution or two or more persons jointly carrying out a systematic activity for a period of twelve months or more at one or more places for consideration or otherwise, for the production, supply or distribution of goods or services;

(*g*) "guidelines" means any statement or any other document issued by the Central Government indicating policy or procedure or course of action relating to HIV and AIDS to be followed by the Central Government, State Governments, governmental and non-governmental organisations and establishments and individuals dealing with prevention, control and treatment of HIV or AIDS;

(*h*) "healthcare provider" means any individual whose vocation or profession is directly or indirectly related to the maintenance of the health of another individual and includes any physician, nurse, paramedic, psychologist, counsellor or other individual providing medical, nursing, psychological or other healthcare services including HIV prevention and treatment services;

(*i*) "HIV" means Human Immunodeficiency Virus;

(*j*) "HIV-affected person" means an individual who is HIV-positive or whose partner (with whom such individual normally resides) is HIV-positive or has lost a partner (with whom such individual resided) due to AIDS;

(*k*) "HIV-positive person" means a person whose HIV test has been confirmed positive;

(*l*) "HIV-related information" means any information relating to the HIV status of a person and includes—

(*i*) information relating to the undertaking performing the HIV test or result of an HIV test;

(*ii*) information relating to the care, support or treatment of that person;

(*iii*) information which may identify that person; and

(*iv*) any other information concerning that person, which is collected, received, accessed or recorded in connection with an HIV test, HIV treatment or HIV-related research or the HIV status of that person;

(*m*) "HIV test" means a test to determine the presence of an antibody or antigen of HIV;

(*n*) "informed consent" means consent given by any individual or his representative specific to a proposed intervention without any coercion, undue influence, fraud, mistake or misrepresentation and such consent obtained after informing such individual or his representative, as the case may be, such information, as specified in the guidelines, relating to risks and benefits of, and alternatives to, the proposed intervention in such language and in such manner as understood by that individual or his representative, as the case may be;

(*o*) "notification" means a notification published in the Official Gazette;

(*p*) "partner" means a spouse, *de facto* spouse or a person with whom another person has relationship in the nature of marriage;

(*q*) "person" includes an individual, a Hindu Undivided Family, a company, a firm, an association of persons or a body of individuals, whether incorporated or not, in India or outside India, any corporation established by or under any Central or State Act or any company including a Government company incorporated under the Companies Act, 1956, any Limited Liability Partnership under the Limited Liability Partnership Act, 2008, any body corporate incorporated by or under the laws of a country outside India, a co-operative society registered under any law relating to co-operative societies, a local authority, and every other artificial juridical person**;** 1 of 1956. 6 of 2009.

(*r*) "prescribed" means prescribed by rules made by the Central Government or the State Government, as the case may be;

(*s*) "protected person" means a person who is—

(*i*) HIV-Positive; or

(*ii*) ordinarily living, residing or cohabiting with a person who is HIV-positive person; or

(*iii*) ordinarily lived, resided or cohabited with a person who was HIV- positive;

(*t*) "reasonable accommodation" means minor adjustments to a job or work that enables an HIV-positive person who is otherwise qualified to enjoy equal benefits or to perform the essential functions of the job or work, as the case may be;

(*u*) "relative", with reference to the protected person, means—

(*i*) spouse of the protected person;

(*ii*) parents of the protected person;

(*iii*) brother or sister of the protected person;

(*iv*) brother or sister of the spouse of the protected person;

(*v*) brother or sister of either of the parents of the protected person;

(*vi*) in the absence of any of the relatives mentioned at sub-clauses (*i*) to (*v*), any lineal ascendant or descendant of the protected person;

(*vii*) in the absence of any of the relatives mentioned at sub-clauses (*i*) to (*vi*), any lineal ascendant or descendant of the spouse of the protected person;

(*v*) "significant-risk" means—

(*a*) the presence of significant-risk body substances;

(*b*) a circumstance which constitutes significant-risk for transmitting or contracting HIV infection; or

(*c*) the presence of an infectious source and an uninfected person.

Explanation.—For the purpose of this clause,—

(*i*) "significant-risk body substances" are blood, blood products, semen, vaginal secretions, breast milk, tissue and the body fluids, namely, cerebrospinal, amniotic, peritoneal, synovial, pericardial and pleural;

(ii)"circumstances which constitute significant-risk for transmitting or contracting HIV infection" are—

(*A*) sexual intercourse including vaginal, anal or oral sexual intercourse which exposes an uninfected person to blood, blood products, semen or vaginal secretions of an HIV-positive person;

(*B*) sharing of needles and other paraphernalia used for preparing and injecting drugs between HIV-positive persons and uninfected persons;

(*C*) the gestation, giving birth or breast feeding of an infant when the mother is an HIV-positive person;

(*D*) transfusion of blood, blood products, and transplantation of organs or other tissues from an HIV-positive person to an uninfected person, provided such blood, blood products, organs or other tissues have not been tested conclusively for the antibody or antigen of HIV and have not been rendered non-infective by heat or chemical treatment; and

(*E*) other circumstances during which a significant-risk body substance, other than breast milk, of an HIV-positive person contacts or may contact mucous membranes including eyes, nose or mouth, non-intact skin including open wounds, skin with a dermatitis condition or abraded areas or the vascular system of an uninfected person, and including such circumstances not limited to needle-stick or puncture wound injuries and direct saturation or permeation of these body surfaces by the significant-risk body substances:

Provided that "significant-risk" shall not include—

(*i*) exposure to urine, faeces, sputum, nasal secretions, saliva, sweat, tears or vomit that does not contain blood that is visible to the naked eye;

(*ii*) human bites where there is no direct blood to blood, or no blood to mucous membrane contact;

(*iii*) exposure of intact skin to blood or any other blood substance; and

(*iv*) occupational centres where individuals use scientifically accepted Universal Precautions, prohibitive techniques and preventive practices in circumstances which would otherwise pose a significant-risk and such techniques are not breached and remain intact;

(*w*) "State AIDS Control Society" means the nodal agency of the State Government responsible for implementing programmes in the field of HIV and AIDS;

(*x*) **"**State Government", in relation to a Union territory, means the Administrator of that Union territory appointed by the President under article 239 of the Constitution; and

(*y*) "Universal Precautions" means control measures that prevent exposure to or reduce, the risk of transmission of pathogenic agents (including HIV) and includes education, training, personal protective equipment such as gloves, gowns and masks, hand washing, and employing safe work practices.

CHAPTER II

PROHIBITION OF CERTAIN ACTS

Prohibition of discrimination.

3. No person shall discriminate against the protected person on any ground including any of the following, namely:—

(*a*) the denial of, or termination from, employment or occupation, unless, in the case of termination, the person, who is otherwise qualified, is furnished with—

(*i*) a copy of the written assessment of a qualified and independent healthcare provider competent to do so that such protected person poses a significant risk of transmission of HIV to other person in the workplace, or is unfit to perform the duties of the job; and

(*ii*) a copy of a written statement by the employer stating the nature and extent of administrative or financial hardship for not providing him reasonable accommodation;

(*b*) the unfair treatment in, or in relation to, employment or occupation;

(*c*) the denial or discontinuation of, or, unfair treatment in, healthcare services;

(*d*) the denial or discontinuation of, or unfair treatment in, educational, establishments and services thereof;

(*e*) the denial or discontinuation of, or unfair treatment with regard to, access to, or provision or enjoyment or use of any goods, accommodation, service, facility, benefit, privilege or opportunity dedicated to the use of the general public or customarily available to the public, whether or not for a fee, including shops, public restaurants, hotels and places of public entertainment or the use of wells, tanks, bathing *ghats*, roads, burial grounds or funeral ceremonies and places of public resort;

(*f*) the denial, or, discontinuation of, or unfair treatment with regard to, the right of movement;

(*g*) the denial or discontinuation of, or, unfair treatment with regard to, the right to reside, purchase, rent, or otherwise occupy, any property;

(*h*) the denial or discontinuation of, or, unfair treatment in, the opportunity to stand for, or, hold public or private office;

(*i*) the denial of access to, removal from, or unfair treatment in, Government or private establishment in whose care or custody a person may be;

(*j*) the denial of, or unfair treatment in, the provision of insurance unless supported by actuarial studies;

(*k*) the isolation or segregation of a protected person;

(*l*) HIV testing as a pre-requisite for obtaining employment, or accessing healthcare services or education or, for the continuation of the same or, for accessing or using any other service or facility**:**

Provided that, in case of failure to furnish the written assessment under sub-clause (*i*) of clause (*a*), it shall be presumed that there is no significant-risk and that the person is fit to perform the duties of the job, as the case may be, and in case of the failure to furnish the written statement under sub-clause (*ii*) of that clause, it shall be presumed that there is no such undue administrative or financial hardship.

Prohibition of certain acts.

4. No person shall, by words, either spoken or written, publish, propagate, advocate or communicate by signs or by visible representation or otherwise the feelings of hatred against any protected persons or group of protected person in general or specifically or disseminate, broadcast or display any information, advertisement or notice, which may reasonably be construed to demonstrate an intention to propagate hatred or which is likely to expose protected persons to hatred, discrimination or physical violence.

CHAPTER III

INFORMED CONSENT

Informed consent for undertaking HIV test or treatment.

5. (*1*) Subject to the provisions of this Act,—

(*a*) no HIV test shall be undertaken or performed upon any person; or

(*b*) no protected person shall be subject to medical treatment, medical interventions or research,

except with the informed consent of such person or his representative and in such manner, as may be specified in the guidelines.

(*2*) The informed consent for HIV test shall include pre-test and post-test counselling to the person being tested or such person's representative in the manner as may be specified in the guidelines.

Informed consent not required for conducting HIV tests in certain cases.

6. The informed consent for conducting an HIV test shall not be required—

(*a*) where a court determines, by an order that the carrying out of the HIV test of any person either as part of a medical examination or otherwise, is necessary for the determination of issues in the matter before it;

(*b*) for procuring, processing, distribution or use of a human body or any part thereof including tissues, blood, semen or other body fluids for use in medical research or therapy:

Provided that where the test results are requested by a donor prior to donation, the donor shall be referred to counselling and testing centre and such donor shall not be entitled to the results of the test unless he has received post-test counselling from such centre;

(*c*) for epidemiological or surveillance purposes where the HIV test is anonymous and is not for the purpose of determining the HIV status of a person:

Provided that persons who are subjects of such epidemiological or surveillance studies shall be informed of the purposes of such studies; and

(*d*) for screening purposes in any licensed blood bank.

Guidelines for testing centres, etc.

7. No HIV test shall be conducted or performed by any testing or diagnostic centre or pathology laboratory or blood bank, unless such centre or laboratory or blood bank follows the guidelines laid down for such test.

CHAPTER IV

DISCLOSURE OF HIV STATUS

Disclosure of HIV status.

8. (*1*) Notwithstanding anything contained in any other law for the time being in force,—

(*i*) no person shall be compelled to disclose his HIV status except by an order of the court that the disclosure of such information is necessary in the interest of justice for the determination of issues in the matter before it;

(*ii*) no person shall disclose or be compelled to disclose the HIV status or any other private information of other person imparted in confidence or in a relationship of a fiduciary nature, except with the informed consent of that other person or a representative of such another person obtained in the manner as specified in section 5, as the case may be, and the fact of such consent has been recorded in writing by the person making such disclosure:

Provided that, in case of a relationship of a fiduciary nature, informed consent shall be recorded in writing.

(*2*) The informed consent for disclosure of HIV-related information under clause (*ii*) of sub-section (*1*) is not required where the disclosure is made—

(*a*) by a healthcare provider to another healthcare provider who is involved in the care, treatment or counselling of such person, when such disclosure is necessary to provide care or treatment to that person;

(*b*) by an order of a court that the disclosure of such information is necessary in the interest of justice for the determination of issues and in the matter before it;

(*c*) in suits or legal proceedings between persons, where the disclosure of such information is necessary in filing suits or legal proceedings or for instructing their counsel;

(*d*) as required under the provisions of section 9;

(*e*) if it relates to statistical or other information of a person that could not reasonably be expected to lead to the identification of that person; and

(*f*) to the officers of the Central Government or the State Government or State AIDS Control Society of the concerned State Government, as the case may be, for the purposes of monitoring, evaluation or supervision.

Disclosure of HIV-positive status to partner of HIV-positive person.

9. (*1*) No healthcare provider, except a physician or a counsellor, shall disclose the HIV-positive status of a person to his or her partner.

(*2*) A healthcare provider, who is a physician or counsellor, may disclose the HIV-positive status of a person under his direct care to his or her partner, if such healthcare provider—

(*a*) reasonably believes that the partner is at the significant risk of transmission of HIV from such person; and

(*b*) such HIV-positive person has been counselled to inform such partner; and

(*c*) is satisfied that the HIV-positive person will not inform such partner; and

(*d*) has informed the HIV-positive person of the intention to disclose the HIV-positive status to such partner:

Provided that disclosure under this sub-section to the partner shall be made in person after counselling:

Provided further that such healthcare provider shall have no obligation to identify or locate the partner of an HIV-positive person:

Provided also that such healthcare provider shall not inform the partner of a woman where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health or safety of such woman, her children, her relatives or someone who is close to her.

(*3*) The healthcare provider under sub-section (*1*) shall not be liable for any criminal or civil action for any disclosure or non-disclosure of confidential HIV-related information made to a partner under this section.

Duty to prevent transmission of HIV.

10. Every person, who is HIV-positive and has been counselled in accordance with the guidelines issued or is aware of the nature of HIV and its transmission, shall take all reasonable precautions to prevent the transmission of HIV to other persons which may include adopting strategies for the reduction of risk or informing in advance his HIV status before any sexual contact with any person or with whom needles are shared with:

Provided that the provisions of this section shall not be applicable to prevent transmission through a sexual contact in the case of a woman, where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health or safety of such woman, her children, her relatives or someone who is close to her.

CHAPTER V

OBLIGATION OF ESTABLISHMENTS

Confidentiality of data.

11. Every establishment keeping the records of HIV-related information of protected persons shall adopt data protection measures in accordance with the guidelines to ensure that such information is protected from disclosure.

Explanation.— For the purpose of this section, data protection measures shall include procedures for protecting information from disclosure, procedures for accessing information, provision for security systems to protect the information stored in any form and mechanisms to ensure accountability and liability of persons in the establishment.

12. The Central Government shall notify model HIV and AIDS policy for establishments, in such manner, as may be prescribed. HIV and AIDS policy for establishments.

CHAPTER VI

ANTI-RETROVIRAL THERAPY AND OPPORTUNISTIC INFECTION MANAGEMENT FOR PEOPLE LIVING WITH HIV

13. The Central Government and every State Government, as the case may be, shall take all such measures as it deems necessary and expedient for the prevention of spread of HIV or AIDS, in accordance with the guidelines. Central Government and State Government to take measures.

14. (*1*) The measures to be taken by the Central Government or the State Government under section 13 shall include the measures for providing, as far as possible, diagnostic facilities relating to HIV or AIDS, Anti-retroviral Therapy and Opportunistic Infection Management to people living with HIV or AIDS. Anti-retroviral Therapy and Opportunistic Infection Management by Central Government and State Government.

(*2*) The Central Government shall issue necessary guidelines in respect of protocols for HIV and AIDS relating to diagnostic facilities, Anti-retroviral Therapy and Opportunistic Infection Management which shall be applicable to all persons and shall ensure their wide dissemination.

CHAPTER VII

WELFARE MEASURES BY THE CENTRAL GOVERNMENT AND STATE GOVERNMENT

15. (*1*) The Central Government and every State Government shall take measures to facilitate better access to welfare schemes to persons infected or affected by HIV or AIDS. Welfare measures by Central Government and State Government.

(*2*) Without prejudice to the provisions of sub-section (*1*), the Central Government and State Governments shall frame schemes to address the needs of all protected persons.

16. (*1*) The Central Government or the State Government, as the case may be, shall take appropriate steps to protect the property of children affected by HIV or AIDS for the protection of property of child affected by HIV or AIDS. Protection of property of children affected by HIV or AIDS.

(*2*) The parents or guardians of children affected by HIV and AIDS, or any person acting for protecting their interest, or a child affected by HIV and AIDS may approach the Child Welfare Committee for the safe keeping and deposit of documents related to the property rights of such child or to make complaints relating to such child being dispossessed or actual dispossession or trespass into such child's house.

Explanation.—For the purpose of this section, "Child Welfare Committee" means a Committee set-up under section 29 of the Juvenile Justice (Care and Protection of Children) Act, 2000. 56 of 2000.

17. The Central Government and the State Government shall formulate HIV and AIDS related information, education and communication programmes which are age-appropriate, gender-sensitive, non-stigmatising and non-discriminatory. Promotion of HIV and AIDS related information, education and communication programmes.

18. (*1*) The Central Government shall lay down guidelines for care, support and treatment of children infected with HIV or AIDS. Women and children infected with HIV or AIDS.

(*2*) Without prejudice to the generality of the provisions of sub-section (*1*) and notwithstanding anything contained in any other law for the time being in force, the Central Government, or the State Government as the case may be, shall take measures to counsel and provide information regarding the outcome of pregnancy and HIV-related treatment to the HIV infected women.

(*3*) No HIV positive woman, who is pregnant, shall be subjected to sterilisation or abortion without obtaining her informed consent.

CHAPTER VIII

SAFE WORKING ENVIRONMENT

Obligation of establishments to provide safe working environment.

19. Every establishment, engaged in the healthcare services and every such other establishment where there is a significant risk of occupational exposure to HIV, shall, for the purpose of ensuring safe working environment,—

(*i*) provide, in accordance with the guidelines,—

(*a*) Universal Precautions to all persons working in such establishment who may be occupationally exposed to HIV; and

(*b*) training for the use of such Universal Precautions;

(*c*) Post Exposure Prophylaxis to all persons working in such establishment who may be occupationally exposed to HIV or AIDS; and

(*ii*) inform and educate all persons working in the establishment of the availability of Universal Precautions and Post Exposure Prophylaxis.

General responsibility of establishments.

20. (*1*) The provisions of this Chapter shall be applicable to all establishments consisting of one hundred or more persons, whether as an employee or officer or member or director or trustee or manager, as the case may be:

Provided that in the case of healthcare establishments, the provisions of this sub-section shall have the effect as if for the words "one hundred or more", the words "twenty or more" had been substituted.

(*2*) Every person, who is in charge of an establishment, referred to in sub-section (*1*), for the conduct of the activities of such establishment, shall ensure compliance of the provisions of this Act.

Grievance redressal mechanism.

21. Every establishment referred to in sub-section (*1*) of section 20 shall designate such person, as it deems fit, as the Complaints Officer who shall dispose of complaints of violations of the provisions of this Act in the establishment, in such manner and within such time as may be prescribed.

CHAPTER IX

PROMOTION OF STRATEGIES FOR REDUCTION OF RISK

Strategies for reduction of risk.

22. Notwithstanding anything contained in any other law for the time being in force any strategy or mechanism or technique adopted or implemented for reducing the risk of HIV transmission, or any act pursuant thereto, as carried out by persons, establishments or organisations in the manner as may be specified in the guidelines issued by the Central Government shall not be restricted or prohibited in any manner, and shall not amount to a criminal offence or attract civil liability.

Explanation.—For the purpose of this section, strategies for reducing risk of HIV transmission means promoting actions or practices that minimise a person's risk of exposure to HIV or mitigate the adverse impacts related to HIV or AIDS including—

(*i*) the provisions of information, education and counselling services relating to prevention of HIV and safe practices;

(*ii*) the provisions and use of safer sex tools, including condoms;

(*iii*) drug substitution and drug maintenance; and

(*iv*) provision of comprehensive injection safety requirements.

Illustrations

(*a*) A supplies condoms to B who is a sex worker or to C, who is a client of B. Neither A nor B nor C can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the strategy.

(*b*) M carries on an intervention project on HIV or AIDS and sexual health information, education and counselling for men, who have sex with men, provides safer sex information, material and condoms to N, who has sex with other men. Neither M nor N can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention.

(*c*) X, who undertakes an intervention providing registered needle exchange programme services to injecting drug users, supplies a clean needle to Y, an injecting drug user who exchanges the same for a used needle. Neither X nor Y can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention.

(*d*) D, who carries on an intervention programme providing Opioid Substitution Treatment (OST), administers OST to E, an injecting drug user. Neither D nor E can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention.

CHAPTER X

APPOINTMENT OF OMBUDSMAN

Appointment of Ombudsman.

23. (*1*) Every State Government shall appoint one or more Ombudsman,—

(*a*) possessing such qualification and experience as may be prescribed, or

(*b*) designate any of its officers not below such rank, as may be prescribed, by that Government,

to exercise such powers and discharge such functions, as may be conferred on Ombudsman under this Act.

(*2*) The terms and condition of the service of an Ombudsman appointed under clause (*a*) of sub-section (*1*) shall be such as may be prescribed by the State Government.

(*3*)The Ombudsman appointed under sub-section (*1*) shall have such jurisdiction in respect of such area or areas as the State Government may, by notification, specify.

Powers of Ombudsman.

24. (*1*) The Ombudsman shall, upon a complaint made by any person, inquire into the violations of the provisions of this Act, in relation to acts of discrimination mentioned in section 3 and providing of healthcare services by any person, in such manner as may be prescribed by the State Government.

(*2*) The Ombudsman may require any person to furnish information on such points or matters, as he considers necessary, for inquiring into the matter and any person so required shall be deemed to be legally bound to furnish such information and failure to do so shall be punishable under sections 176 and 177 of the Indian Penal Code.

45 of 1860.

(*3*) The Ombudsman shall maintain records in such manner as may be prescribed by the State Government.

Procedure of complaint.

25. The complaints may be made to the Ombudsman under sub-section (*1*) of section 24 in such manner, as may be prescribed, by the State Government.

Orders of Ombudsman.

26. The Ombudsman shall, within a period of thirty days of the receipt of the complaint under sub-section (*1*) of section 24, and after giving an opportunity of being heard to the parties, pass such order, as he deems fit, giving reasons therefor**:**

Provided that in cases of medical emergency of HIV positive persons, the Ombudsman shall pass such order as soon as possible, preferably within twenty-four hours of the receipt of the complaint.

Authorities to assist Ombudsman.

27. All authorities including the civil authorities functioning in the area for which the Ombudsman has been appointed under section 23 shall assist in execution of orders passed by the Ombudsman**.**

Report to State Government.

28. The Ombudsman shall, after every six months, report to the State Government, the number and nature of complaints received, the action taken and orders passed in relation to such complaints and such report shall be published on the website of the Ombudsman and a copy thereof be forwarded to the Central Government.

CHAPTER XI

SPECIAL PROVISIONS

Right of residence.

29. Every protected person shall have the right to reside in the shared household, the right not to be excluded from the shared household or any part of it and the right to enjoy and use the facilities of such shared household in a non-discriminatory manner.

Explanation.—For the purposes of this section, the expression "shared household" means a household where a person lives or at any stage has lived in a domestic relationship either singly or along with another person and includes such a household, whether owned or tenanted, either jointly or singly, any such household in respect of which either person or both, jointly or singly, have any right, title, interest or equity or a household which may belong to a joint family of which either person is a member, irrespective of whether either person has any right, title or interest in the shared household.

HIV-related information, education and communication before marriage.

30. The Central Government shall specify guidelines for the provision of HIV-related information, education and communication before marriage and ensure their wide dissemination.

Persons in care or custody of State.

31. (*1*) Every person who is in the care or custody of the State shall have the right to HIV prevention, counselling, testing and treatment services in accordance with the guidelines issued in this regard.

(*2*) For the purposes of this section, persons in the care or custody of the State include persons convicted of a crime and serving a sentence, persons awaiting trial, person detained under preventive detention laws, persons under the care or custody of the State under the Juvenile Justice (Care and Protection of Children) Act, 2000, the Immoral Traffic (Prevention) Act, 1956 or any other law and persons in the care or custody of State run homes and shelters. 56 of 2000. 104 of 1956.

Recognition of guardianship of older sibling.

32. Notwithstanding anything contained in any law for the time being in force, a person below the age of eighteen but not below twelve years, who has sufficient maturity of understanding and who is managing the affairs of his family affected by HIV and AIDS, shall be competent to act as guardian of other sibling below the age of eighteen years for the following purposes, namely:—

(*a*) admission to educational establishments;

(*b*) care and protection;

(*c*) treatment;

(*d*) operating bank accounts;

(*e*) managing property; and

(*f*) any other purpose that may be required to discharge his duties as a guardian.

Explanation.—For the purposes of this section, a family affected by HIV or AIDS means where both parents and the legal guardian is incapacitated due to HIV-related illness or AIDS or the legal guardian and parents are unable to discharge their duties in relation to such children.

Living wills for guardianship and testamentary guardianship.

33. (*1*) Notwithstanding anything contained in any law for the time being in force, a parent or legal guardian of a child affected by HIV and AIDS may appoint, by making a will, an adult person who is a relative or friend, or a person below the age of eighteen years who is the managing member of the family affected by HIV and AIDS, as referred to in section 33, to act as legal guardian immediately upon incapacity or death of such parent or legal guardian, as the case may be.

(*2*) Nothing in this section shall divest a parent or legal guardian of their rights, and the guardianship referred to in sub-section (*1*) shall cease to operate upon by the parent or legal guardian regaining their capacity.

(*3*) Any parent or legal guardian of children affected by HIV and AIDS may make a will appointing a guardian for care and protection of such children and for the property that such children would inherit or which is bequeathed through the will made by such parent or legal guardian.

CHAPTER XII

SPECIAL PROCEDURE IN COURT

Suppression of identity.

34. (*1*) In any legal proceeding in which a protected person is a party or such person is an applicant, the court, on an application by such person or any other person on his behalf may pass, in the interest of justice, any or all of the following orders, namely:—

(*a*) that the proceeding or any part thereof be conducted by suppressing the identity of the applicant by substituting the name of such person with a pseudonym in the records of the proceedings in such manner as may be prescribed;

(*b*) that the proceeding or any part thereof may be conducted *in camera*;

(*c*) restraining any person from publishing in any manner any matter leading to the disclosure of the name or status or identity of the applicant**.**

(*2*) In any legal proceeding concerning or relating to an HIV-positive person, the court shall take up and dispose of the proceeding on priority basis.

Maintenance applications.

35. In any maintenance application filed by or on behalf of a protected person under any law for the time being in force, the court shall consider the application for interim maintenance and, in passing any order of maintenance, shall take into account the medical expenses and other HIV-related costs that may be incurred by the applicant.

Sentencing.

36. In passing any order relating to sentencing, the HIV-positive status of the persons in respect of whom such an order is passed shall be a relevant factor to be considered by the court to determine the custodial place where such person shall be transferred to, based on the availability of proper healthcare services at such place.

CHAPTER XIII

PENALTIES

Penalty for contravention.

37. Notwithstanding any action that may be taken under any other law for the time being in force, whoever contravenes the provisions of section 4 shall be punished with imprisonment for a term which shall not be less than three months but which may extend to two years and with fine which may extend to one lakh rupees, or with both.

Penalty for failure to comply with orders of Ombudsman.

38. Whoever fails to comply with any order given by an Ombudsman within such time as may be specified in such order, under section 26, shall be liable to pay a fine which may extend to ten thousand rupees and in case the failure continues, with an additional fine which may extend to five thousand rupees for every day during which such failure continues.

Penalty for breach of confidentiality in legal proceedings.

39. Notwithstanding any action that may be taken under any law for the time being in force, whoever discloses information regarding the HIV status of a protected person which is obtained by him in the course of, or in relation to, any proceedings before any court, shall

be punishable with fine which may extend to one lakh rupees unless such disclosure is pursuant to any order or direction of a court.

Prohibition of victimisation.

40. No person shall subject any other person or persons to any detriment on the ground that such person or persons have taken any of the following actions, namely:—

(*a*) made complaint under this Act;

(*b*) brought proceedings under this Act against any person;

(*c*) furnished any information or produced any document to a person exercising or performing any power or function under this Act; or

(*d*) appeared as a witness in a proceeding under this Act.

Court to try offences.

41. No court other than the court of a Judicial Magistrate First Class shall take cognizance of an offence under this Act.

Offences to be cognizable and bailable.

42. Notwithstanding anything contained in the Code of Criminal Procedure, 1973, offences under this Act shall be cognizable and bailable. 2 of 1974.

CHAPTER XIV

MISCELLANEOUS

Act to have overriding effect.

43. The provisions of this Act shall have effect notwithstanding anything inconsistent therewith contained in any other law for the time in force or in any instrument having effect by virtue of any law other than this Act.

Protection of action taken in good faith.

44. No suit, prosecution or other legal proceeding shall lie against the Central Government, the State Government, the Central Government or AIDS Control Society of the State Government Ombudsman or any member thereof or any officer or other employee or person acting under the direction either of the Central Government, the State Government, the Central Government, or Ombudsman in respect of anything which is in good faith done or intended to be done in pursuance of this Act or any rules or guidelines made thereunder or in respect of the publication by or under the authority of the Central Government, the State Government, the Central Government or AIDS Control Society of the State Government Ombudsman.

Delegation of powers.

45. The Central Government and State Government, as the case may be, may, by general or special order, direct that any power exercisable by it under this Act shall, in such circumstances and under such conditions, if any, as may be mentioned in the order, be exercisable also by an officer subordinate to that Government or the local authority.

Guidelines.

46. (*1*) The Central Government may, by notification, make guidelines consistent with this Act and any rules thereunder, generally to carry out the provisions of this Act.

(*2*) In particular and without prejudice to the generality of the foregoing power, such guidelines may provide for all or any of the following matters, namely:—

(*a*) information relating to risk and benefits or alternatives to the proposed intervention under clause (*n*) of section 2;

(*b*) the manner of obtaining the informed consent under sub-section (*1*) and the manner of pre test and post test counselling under sub-section (*2*) of section 5;

(*c*) guidelines to be followed by a testing or diagnostic centre or pathology laboratory or blood bank for HIV test under section 7;

(*d*) the manner of taking data protection measures under section 11;

(*e*) guidelines in respect of protocols for HIV/AIDS relating to Anti-retroviral Therapy and Opportunistic Infections Management under sub-section (*2*) of section 14;

(*f*) care, support and treatment of children infected with HIV or AIDS under sub-section (*1*) of section 18;

(*g*) guidelines for Universal Precautions and post exposure prophylaxis under section 19;

(*h*) manner of carrying out the strategy or mechanism or technique for reduction of risk of HIV transmission under section 22;

(*i*) manner of implementation of a drugs substitution, drug maintenance and needle and syringe exchange programme under section 22;

(*j*) provision of HIV-related information, education and communication before marriage under section 30;

(*k*) manner of HIV or AIDS prevention, counselling, testing and treatment of persons in custody under section 31;

(*l*) any other matter which ought to be specified in guidelines for the purposes of this Act.

Power of Central Government to make rules.

47. (*1*) The Central Government may, by notification, make rules to carry out the provisions of this Act.

(*2*) In particular, and without prejudice to the generality of the foregoing provision, such rules may provide for all or any of the following matters, namely:—

(*a*) manner of notifying model HIV or AIDS policy for the establishments under section 12;

(*b*) any other matter which may be or ought to be prescribed by the Central Government.

Laying of rules before both Houses of Parliament.

48. Every rule made under this Act shall be laid, as soon as may be after it is made, before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions, and if, before the expiry of the session immediately following the session or the successive session aforesaid, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

Power of State Government to make rules and laying thereof.

49. (*1*) The State Government may, by notification, make rules for carrying out the provisions of this Act.

(*2*) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely:—

(*a*) measures to provide diagnostic facilities relating to HIV or AIDS, Anti-retroviral Therapy and Opportunistic Infection Management to people living with HIV or AIDS and for the prevention of spread of HIV or AIDS in accordance with the guidelines under section 14;

(*b*) qualification and experience for the appointment of a person as an Ombudsman under clause (*a*) or rank of officer of the State Government to be designated as Ombudsman under clause (*b*) of sub-section (*1*) of section 23;

(*c*) terms and conditions of services of Ombudsman under sub-section (*2*) of section 23;

(*d*) manner of inquiring into complaints by the Ombudsman under sub-section (*1*) and maintaining of records by him under sub-section (*3*) of section 24;

(*e*) manner of making the complaints to the Ombudsman under section 25; and

(*f*) manner of recording pseudonym in legal proceedings under clause (*a*) of sub-section (*1*) of section 34.

(*3*) Every rule made by the State Government under this Act shall be laid, as soon as may be, after it is made before the Legislature of that State.

Power to remove difficulties.

50. (*1*) If any difficulty arises in giving effect to the provisions of this Act, the Central Government may, by order published in the Official Gazette, make such provisions, not inconsistent with the provisions of this Act, as may appear to be necessary for removing the difficulty:

Provided that no order shall be made under this section after the expiry of the period of two years from the date of commencement of this Act.

(*2*) Every order made under this section shall be laid, as soon as may be after it is made, before each House of Parliament.

———

DR. G. NARAYANA RAJU
Secretary to the Govt. of India.

———

CORRIGENDUM

THE GOODS AND SERVICES TAX (COMPENSATION TO STATES) ACT, 2017

NO. 15 OF 2017

In the Goods and Services Tax (Compensation to States) Act, 2017 (15 of 2017) published in the Gazette of India, Extraordinary, Part II, Section I, dated 12th April, 2017, issue No. 15, at page 3, in line 20, *for* "onstitution", *read* "Constitution".

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[राज्य सभा द्वारा 21 मार्च, 2017 को पारित रूप में]

2014 का विधेयक संख्यांक 3-सी

मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) विधेयक, 2017

खंडों का क्रम

खंड

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विशेष उपबंध

[राज्य सभा द्वारा 21 मार्च, 2017 को पारित रूप में]

2014 का विधेयक संख्यांक 3-सी

[दि ह्यूमन इम्यूनोडीफिसिएनसी वायरस एंड अक्वाइर्ड इम्यूनोडीफिसिएनसी सिंड्राम (प्रिवेंशन एंड कन्ट्रोल) बिल, 2017 का हिन्दी अनुवाद]

मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) विधेयक, 2017

मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण के फैलाव के निवारण और नियंत्रण के लिए और उक्त विषाणु और संलक्षण से प्रभावित व्यक्तियों के मानव अधिकारों के संरक्षण के लिए तथा उससे संबंधित या उसके आनुषंगिक विषयों का उपबंध करने के लिए

विधेयक

मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण का फैलाव सभी के लिए गंभीर चिंता का विषय है और उक्त विषाणु और संलक्षण के निवारण और नियंत्रण की तत्काल आवश्यकता है;

और उन व्यक्तियों के मानवाधिकारों की संरक्षा और सुरक्षा की आवश्यकता है जो एचआईवी-पोजिटिव हैं, मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण से प्रभावित हैं और उक्त विषाणु और संलक्षण द्वारा भेद्य हैं;

और मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण की प्रभावी देख-रेख, संभाल और उपचार की आवश्यकता है;

और मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण से संबंधित स्वास्थ्य देखभाल प्रदाताओं और अन्य व्यक्तियों के अधिकारों की संरक्षा की आवश्यकता है;

और संयुक्त राष्ट्र महासभा ने मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण पर अपनी पूर्व प्रतिबद्धताओं का प्रत्याह्वान और पुन: अभिपुष्टि करते हुए मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण की समस्या के सभी पहलुओं पर ध्यान देने के लिए और व्यापक रूप में इसकी रोकथाम के लिए राष्ट्रीय, क्षेत्रीय और अंतरराष्ट्रीय समन्वय और तीव्रकरण में वृद्धि करने की वैश्विक प्रतिबद्धता को सुनिश्चित करने के लिए मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण पर प्रतिबद्धता की घोषणा (2001) को अंगीकृत किया है;

और भारत गणराज्य का पूर्वोक्त घोषणा का हस्ताक्षरकर्ता होने के कारण इस घोषणा को प्रभावी बनाना समीचीन है:—

भारत गणराज्य के अड़सठवें वर्ष में संसद् द्वारा निम्नलिखित रूप में यह अधिनियमित हो:—

अध्याय 1

प्रारंभिक

संक्षिप्त नाम, विस्तार और प्रारंभ।

1. (1) इस अधिनियम का संक्षिप्त नाम मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) अधिनियम, 2017 है।

(2) यह संपूर्ण भारत पर लागू होगा।

(3) यह उस तारीख को प्रवृत्त होगा जो केन्द्रीय सरकार राजपत्र में अधिसूचना द्वारा नियत करे।

परिभाषाएं।

2. इस अधिनियम में जब तक कि संदर्भ से अन्यथा अपेक्षित न हो,—

(क) "एड्स" से अर्जित रोगक्षम अल्पता संलक्षण अभिप्रेत है जो मानव रोगक्षम अल्पता विषाणु द्वारा कारित संकेतों और लक्षणों के समुच्चय द्वारा वर्णित दशा है, जो एचआईवी-पोजिटिव व्यक्ति के लिए जीवन विभीषक दशाओं और ऐसी अन्य दशाओं के लिए जो समय-समय पर विनिर्दिष्ट की जाए, खतरा बनते हुए शरीर के रोगक्षम तंत्र पर आक्रमण करती है और उसको कमजोर बना देती है;

(ख) "सहमति की हैसियत" से किसी प्रस्तावित कार्रवाई की प्रकृति और परिणामों को समझने और उसका मूल्यांकन करने और ऐसी कार्रवाई से संबंधित सूचित विनिश्चय करने के लिए उद्देश्य के आधार पर अवधारित किसी व्यक्ति की योग्यता अभिप्रेत है;

(ग) "एचआईवी द्वारा प्रभावित बालक" से अठारह वर्ष से कम आयु का कोई व्यक्ति अभिप्रेत है जो एचआईवी-पोजिटिव है या जिसके माता या पिता या संरक्षक (जिसके साथ ऐसा बालक साधारणत: निवास करता था), एचआईवी-पोजिटिव है या माता-पिता या संरक्षक (जिसके साथ ऐसा बालक साधारणत: निवास करता है), को एड्स के कारण खो दिया है या एड्स द्वारा अनाथीकृत बालकों का पोषण करने वाले किसी गृहस्थ में रहता है;

(घ) "विभेद" से ऐसा कोई कार्य या लोप अभिप्रेत है जो प्रत्यक्षत: या अप्रत्यक्षत: अभिव्यक्त रूप से या प्रभाव द्वारा, तुरंत या कुछ समय पश्चात्,—

(i) कोई भार, बाध्यता, दायित्व, निर्योग्यता या अलाभ अधिरोपित करता है; या

(ii) किसी व्यक्ति या कोटि के व्यक्तियों पर एचआईवी से संबंधित एक या अधिक आधारों पर आधारित किसी फायदे, अवसर या लाभ से इंकार करता है या उसको रोकता है,

और "विभेद करने" अभिव्यक्ति का अर्थ तद्नुसार लगाया जाएगा।

स्पष्टीकरण 1.—इस खंड के प्रयोजनों के लिए एचआईवी संबंधित आधारों के अंतर्गत निम्नलिखित आते हैं,—

(i) एचआईवी-पोजिटिव व्यक्ति होना;

(ii) ऐसे व्यक्ति के साथ सामान्यतया रहना, निवास करना या सहवास करना जो एचआईवी-पोजिटिव व्यक्ति है;

(iii) ऐसे व्यक्ति के साथ सामान्यतया रहा था, निवास किया था या सहवास किया था जो एचआईवी-पोजिटिव था;

स्पष्टीकरण 2.—शंकाओं को दूर करने के लिए यह स्पष्ट किया जाता है कि चिकित्सक दृष्टि से सूचित रक्षोपायों को अंगीकार करना और संक्रमण के जोखिम को कम करने के लिए पूर्वाधानियां विभेद की कोटि में नहीं आएंगी।

(ङ) ''पारिवारिक संबंध'' से घरेलू हिंसा से महिलाओं का संरक्षण अधिनियम, 2005 की धारा 2 के खंड (च) के अधीन यथा परिभाषित संबंध अभिप्रेत है; 2005 का 43

(च) ''स्थापन'' से मालों या सेवाओं के उत्पादन, उनके प्रदाय या वितरण के लिए कोई निगम निकाय या सहकारी सोसाइटी या ऐसा कोई संगठन या संस्थान या ऐसे दो या अधिक व्यक्ति अभिप्रेत हैं, जो प्रतिफल के लिए या अन्यथा एक या अधिक स्थानों पर बारह मास या अधिक की अवधि के लिए संयुक्त रूप से कोई प्रणालीगत क्रियाकलाप कर रहे हैं;

(छ) ''मार्गदर्शक सिद्धान्त'' से केन्द्रीय सरकार द्वारा जारी कोई कथन या कोई अन्य दस्तावेज अभिप्रेत है जिसमें एचआईवी या एड्स के निवारण और नियंत्रण और उपचार के संबंध में केन्द्रीय सरकार, राज्य सरकारों, सरकारी और गैर-सरकारी संगठनों और स्थापनों और व्यष्टियों द्वारा अनुसरण की जाने वाली एचआईवी और एड्स के निवारण और नियंत्रण से संबंधित नीति या प्रक्रिया या कार्यवाही उपदर्शित है;

(ज) ''स्वास्थ्य देख-रेख प्रदाता'' से कोई ऐसा व्यक्ति अभिप्रेत है जिसका व्यवसाय या वृत्ति दूसरे व्यक्ति के स्वास्थ्य की देखभाल से प्रत्यक्षत: या अप्रत्यक्षत: संबंधित है और जिसके अंतर्गत कोई भी चिकित्सक, नर्स, पराचिकित्सीय, मनोविज्ञानी, परामर्शदाता या चिकित्सीय नर्सिंग मनोवैज्ञानिक या अन्य स्वास्थ्य सेवाएं जिसके अंतर्गत एचआईवी निवारण और उपचार सेवाएं भी हैं, देने वाला कोई अन्य व्यक्ति आते हैं;

(झ) ''एचआईवी'' से मानव रोगक्षम अल्पता विषाणु अभिप्रेत है;

(ञ) ''एचआईवी-प्रभावित व्यक्ति'' से ऐसा व्यक्ति अभिप्रेत है जो एचआईवी-पोजिटिव है या जिसका संगी (जिसके साथ ऐसा व्यक्ति साधारणत: निवास करता है) एचआईवी-पोजिटिव है या जिसने एड्स के कारण किसी संगी को (जिसके साथ ऐसा व्यक्ति निवास करता था) खो दिया है;

(ट) ''एचआईवी-पोजिटिव व्यक्ति'' से ऐसा व्यक्ति अभिप्रेत है जिसके एचआईवी परीक्षण में पोजिटिव होने की अभिपुष्टि हो गई है;

(ठ) ''एचआईवी-संबंधी सूचना'' से किसी व्यक्ति की एचआईवी प्रास्थिति से संबंधित कोई सूचना अभिप्रेत है और इसके अंतर्गत निम्नलिखित आते हैं—

(i) एचआईवी परीक्षण करने के उपक्रम या किसी एचआईवी परीक्षण के परिणाम से संबंधित सूचना;

(ii) उस व्यक्ति की देखभाल, संभाल या उपचार से संबंधित सूचना;

(iii) ऐसी सूचना, जिससे उस व्यक्ति की पहचान हो; और

(iv) उस व्यक्ति से संबंधित कोई अन्य सूचना जिसे एचआईवी परीक्षण, एचआईवी उपचार या एचआईवी संबंधी अनुसंधान या उस व्यक्ति की एचआईवी प्रास्थिति के संबंध में एकत्रित, प्राप्त, सुलभ या अभिलिखित किया गया है;

(ङ) ''एचआईवी परीक्षण'' से एचआईवी के किसी रोग प्रतिकारक या एंटीजन की उपस्थिति को अवधारित करने के लिए परीक्षण अभिप्रेत है;

(ढ) ''सूचित सहमति'' से किसी प्रपीड़न, असम्यक् असर, कपट, भूल या दुर्व्यपदेशन के बिना किसी प्रस्तावित मध्यक्षेप के लिए विनिर्दिष्ट किसी व्यक्ति या उसके प्रतिनिधि द्वारा दी गई सहमति अभिप्रेत है और ऐसी सहमति, यथास्थिति, ऐसे व्यक्ति या उसके प्रतिनिधि द्वारा समझे जाने वाली भाषा और रीति में प्रस्तावित मध्यक्षेप को मार्गदर्शक सिद्धांतों में यथाविनिर्दिष्ट जोखिम और फायदों या विकल्पों से संबंधित ऐसी सूचना, यथास्थिति, ऐसे व्यक्ति या उसके प्रतिनिधि को देकर प्राप्त की गई है;

(ण) ''अधिसूचना'' से राजपत्र में प्रकाशित अधिसूचना अभिप्रेत है;

(त) ''संगी'' से पति-पत्नी, वस्तुतः पति-पत्नी या ऐसा व्यक्ति अभिप्रेत है जिसके साथ दूसरा व्यक्ति वैवाहिक प्रकृति का संबंध रखता है;

(थ) ''व्यक्ति'' के अंतर्गत भारत में या भारत के बाहर कोई व्यष्टि, हिंदू अविभक्त कुटुंब, कंपनी, फर्म, व्यक्तियों का समूह या व्यष्टियों का निकाय, चाहे निगमित हो या नहीं, किसी केन्द्रीय या राज्य अधिनियम द्वारा या उसके अधीन स्थापित कोई निगम, कोई कंपनी जिसके अंतर्गत कंपनी अधिनियम, 1956 के अधीन निगमित कोई सरकारी कंपनी भी है, सीमित उत्तरदायित्व भागीदारी अधिनियम, 2008 के अधीन कोई सीमित उत्तरदायित्व भागीदारी, भारत के बाहर किसी देश की विधि द्वारा या उसके अधीन निगमित कोई निगमित निकाय, सहकारी सोसाइटियों से संबंधित किसी विधि के अधीन रजिस्ट्रीकृत कोई सहकारी सोसाइटी, कोई स्थानीय प्राधिकारी और प्रत्येक अन्य कृत्रिम न्यायिक व्यक्ति आते हैं; 1956 का 1 2009 का 6

(द) ''विहित'' से, यथास्थिति, केन्द्रीय सरकार या राज्य सरकार द्वारा बनाए गए नियमों द्वारा विहित अभिप्रेत है;

(ध) ''संरक्षित व्यक्ति'' से ऐसा व्यक्ति अभिप्रेत है जो —

(i) एचआईवी-पोजिटिव है; या

(ii) ऐसे व्यक्ति के साथ सामान्यतया रहता है, निवास करता है या सहवास करता है जो एचआईवी-पोजिटिव व्यक्ति है; या

(iii) ऐसे व्यक्ति के साथ सामान्यतया रहता था, निवास करता था या सहवास करता था जो एचआईवी-पोजिटिव था;

(न) ''युक्तियुक्त वास-सुविधा'' से नौकरी या कार्य में मामूली समायोजन अभिप्रेत है जो ऐसे एचआईवी-पोजिटिव व्यक्ति को जो, यथास्थिति, समान फायदों का उपभोग करने के लिए या नौकरी या कार्य के आवश्यक कृत्य करने के लिए अन्यथा अर्हित है, समर्थ बनाता है;

(प) संरक्षित व्यक्ति के संबंध में ''नातेदार'' से निम्नलिखित अभिप्रेत हैं—

(i) संरक्षित व्यक्ति के पति या पत्नी;

(ii) संरक्षित व्यक्ति के माता-पिता;

(iii) संरक्षित व्यक्ति के भाई या बहन;

(iv) संरक्षित व्यक्ति के पति या पत्नी के भाई या बहन;

(v) संरक्षित व्यक्ति के पति या पत्नी के माता-पिता के भाई या बहन;

(vi) खंड (i) से खंड (v) में उल्लिखित किसी भी नातेदार के अभाव में संरक्षित व्यक्ति के पारंपरिक पूर्वज या वंशज;

(vii) खंड (i) से खंड (vi) में उल्लिखित किसी भी नातेदार के अभाव में संरक्षित व्यक्ति के पति या पत्नी के पारंपरिक पूर्वज या वंशज;

(फ) ''महत्वपूर्ण जोखिम'' से निम्नलिखित अभिप्रेत है—

(क) महत्वपूर्ण जोखिम वाले शारीरिक पदार्थ की उपस्थिति;

(ख) ऐसी परिस्थिति जो एचआईवी संक्रमण को पारेषित करने या उसके संपर्क में आने के लिए महत्वपूर्ण जोखिम पैदा करती है;

(ग) किसी संक्रामक स्रोत और किसी असंक्रमित व्यक्ति की उपस्थिति।

स्पष्टीकरण—इस खंड के प्रयोजनों के लिए,—

(i) ''महत्वपूर्ण जोखिम वाले शारीरिक पदार्थ'' रक्त, उक्त उत्पाद, वीर्य, योनिक स्राव, स्तन दूध, ऊतक और शारीरिक तरल अर्थात् सेरेब्रोस्पाइनल, एम्नियोटिक, पेरिटोनियल, साइनोवायल, पेरिकार्डियल और प्लेयूरल हैं;

(ii) ''वे परिस्थितियां जिनसे एचआईवी संक्रमण के पारेषण या संपर्क से महत्वपूर्ण जोखिम होती है'' निम्नलिखित हैं—

(अ) मैथुन, जिसके अंतर्गत योनिक, गुदा या मुख मैथुन हैं, जिनसे असंक्रमित व्यक्ति को, एचआईवी-पोजिटिव व्यक्ति से रक्त, रक्त उत्पाद, वीर्य या योनिक स्राव में संक्रमण की आशंका होती है;

(आ) एचआईवी-पोजिटिव व्यक्तियों और असंक्रमित व्यक्तियों के बीच औषधियों को तैयार करने और सुई लगाने के लिए उपयोग में लाई गई सुइयों और अन्य साज सामान का एक दूसरे व्यक्ति के लिए उपयोग;

(इ) किसी शिशु की सगर्भता, उसे जन्म देना और उसे स्तनपान कराना, जबकि उसकी मां एचआईवी-पोजिटिव व्यक्ति है;

(ई) रक्त, रक्त उत्पादों का आधान और अंगों या अन्य ऊतकों का एचआईवी-पोजिटिव व्यक्ति से असंक्रमित व्यक्ति को प्रतिरोपण, परंतु यह तब जबकि ऐसे रक्त, रक्त उत्पाद, अंग या अन्य ऊतकों का एचआईवी के एंटीबाडी या एंटीजन के लिए निश्चायक रूप से परीक्षण नहीं कर लिया गया है और ताप या रसायन उपचार द्वारा उसे निष्प्रभावी नहीं बना दिया गया है; और

(उ) अन्य परिस्थितियां, जिनके दौरान एचआईवी-पोजिटिव व्यक्ति के स्तन दूध से भिन्न महत्वपूर्ण जोखिम वाला शारीरिक पदार्थ असंक्रमित व्यक्ति की श्लेष्मा झिल्ली, जिसके अंतर्गत आंख, नाक या मुंह, क्षत त्वचा, जिसके अंतर्गत खुला घाव, त्वचा शोथ स्थिति में त्वचा या खरोंच वाला क्षेत्र या नाड़ी तंत्र भी है,और ऐसी परिस्थितियों के अंतर्गत सूई या चोभ घाव और महत्वपूर्ण जोखिम वाले शारीरिक पदार्थ द्वारा इन शारीरिक सतहों के सीधे संतृप्ति और व्याप्ति आते हैं किन्तु यहीं तक सीमित नहीं हैं:

परन्तु महत्वपूर्ण जोखिम के अंतर्गत निम्नलिखित नहीं हैं—

(i) ऐसे मूत्र, मल, थूक, नासिका स्राव, लार, पसीना, आंसू या उल्टी को अरक्षित छोड़ना जिसमें खुली आंख से दृश्यमान रक्त नहीं हो;

(ii) मानव द्वारा काटना, जहां पर रक्त से रक्त का या रक्त से श्लेष्मा झिल्ली का सीधा संपर्क न हो;

(iii) रक्त या किसी अन्य रक्त पदार्थ से अक्षत त्वचा की उच्छन्नता; और

(iv) उपजीविका जन्य ऐसे केन्द्र जहां पर व्यक्ति वैज्ञानिक रूप से स्वीकृत,

सर्वव्यापी पूर्वावधानियों, प्रतिबंधात्मक तकनीकियों और निवारक कार्य प्रणाली का ऐसी परिस्थितियों में उपयोग करते हैं जिनसे अन्यथा महत्वपूर्ण जोखिम हो और ऐसी तकनीकियों का भंग नहीं हो और वे अविकल हों;

(ब) ''राज्य एड्स नियंत्रण सोसाइटी'' से एचआईवी और एड्स के क्षेत्र में कार्यक्रमों के कार्यान्वयन के लिए उत्तरदायी राज्य सरकार का केन्द्रक अभिकरण अभिप्रेत है;

(भ) संघ राज्यक्षेत्र के संबंध में ''राज्य सरकार'' से संविधान के अनुच्छेद 239 के अधीन राष्ट्रपति द्वारा नियुक्त उस संघ राज्यक्षेत्र का प्रशासक अभिप्रेत है; और

(म) ''सर्वव्यापी पूर्वावधानियों'' से ऐसे नियंत्रण उपाय अभिप्रेत हैं जो रोगोत्पादक कारकों के पारेषण की जोखिम की आशंका का निवारण करते हैं या उसे कम करते हैं (जिसके अंतर्गत एचआईवी भी है) और जिसके अंतर्गत शिक्षा, प्रशिक्षण, व्यक्तिगत संरक्षी उपकरण जैसे दस्ताने, चोगा और मुखावरण, हाथ धोना और सुरक्षित कार्य पद्धतियां लागू करना भी आते हैं।

अध्याय 2

कतिपय कार्यों का प्रतिषेध

विभेद का प्रतिषेध।

3. केन्द्रीय सरकार या राज्य सरकार या कोई भी स्थापन या कोई भी व्यक्ति संरक्षित व्यक्ति के साथ किसी भी आधार पर विभेद नहीं करेगा जिसके अंतर्गत निम्नलिखित कोई आधार भी हैं, अर्थात्:—

(क) नियोजन या व्यवसाय का प्रत्याख्यान या उसकी समाप्ति जब तक कि समाप्ति की दशा में उस व्यक्ति को, जो अन्यथा अर्हित है, निम्नलिखित नहीं दे दिया जाता—

(i) किसी अर्हित और स्वतंत्र स्वास्थ्य देख-भाल प्रदाता, जो ऐसा करने के लिए सक्षम है, के लिखित में निर्धारण की ऐसी एक प्रति कि संरक्षित व्यक्ति से कार्यस्थल में अन्य व्यक्तियों को एचआईवी के पारेषण की महत्वपूर्ण जोखिम है या वह नौकरी के कर्तव्यों का पालन करने के अयोग्य है; और

(ii) नियोक्ता द्वारा उसे युक्तियुक्त वास सुविधा प्रदान नहीं किए जाने के लिए प्रशासनिक और वित्तीय कठिनाई की प्रकृति और विस्तार के कथन वाले लिखित विवरण की एक प्रति;

(ख) नियोजन या नौकरी में या उसके संबंध में अऋजु बर्ताव;

(ग) स्वास्थ्य देखभाल सेवाओं का प्रत्याख्यान या रोक या उसमें अऋजु बर्ताव;

(घ) शैक्षणिक सेवाओं में प्रत्याख्यान या रोक या उसमें अऋजु बर्ताव;

(ङ) साधारण जनता के उपयोग को समर्पित या जनता को रूढ़िगत रूप से उपलब्ध किसी माल, वाससुविधा, सेवा सुविधा, फायदा, विशेषाधिकार या अवसर के उपयोग पर पहुंच या उसकी व्यवस्था या उसका उपभोग करने की बाबत प्रत्याख्यान या रोक या अऋजु बर्ताव चाहे ऐसा फीस देने पर हो या उसके बिना जिसके अंतर्गत दुकानें, सार्वजनिक रेस्तरां, होटल और लोक मनोरंजन के स्थान या कुंओं, तालाबों, स्नानघाटों, सड़कों, कब्रिस्तानों या अंत्येष्टि संस्कारों और लोक समागम के स्थानों का उपयोग आते हैं;

(च) संचलन के अधिकार की बाबत प्रत्याख्यान या रोक या अऋजु बर्ताव;

(छ) निवास, क्रय, किराया या अन्यथा किसी संपत्ति के अधिभोग के अधिकार की बाबत प्रत्याख्यान या रोक या अऋजु बर्ताव;

(ज) सार्वजनिक या निजी पद के लिए उम्मीदवार होने या पद धारण करने के अवसर का प्रत्याख्यान या रोक या उसमें अऋजु बर्ताव;

(झ) किसी राज्य या निजी स्थापन में जिसकी देख-रेख और अभिरक्षा में कोई व्यक्ति हो, पहुंच से प्रत्याख्यान, उसको हटाया जाना या उसमें अऋजु बर्ताव;

(ञ) बीमा व्यवस्था का प्रत्याख्यान या उसमें अऋजु बर्ताव जीवनांकि अध्ययनों द्वारा समर्थित न हों;

(ट) किसी संरक्षित व्यक्ति को अलग करना या पृथक्करण;

(ठ) नियोजन की अभिप्राप्ति या स्वास्थ्य सेवाओं तक पहुंच या शिक्षा या उसके जारी रखे जाने या कोई अन्य सेवा या सुविधा लेने या उसका उपयोग करने के लिए पूर्व अपेक्षा के रूप में एचआईवी परीक्षण:

परंतु खंड (क) के उपखंड (i) के अधीन लिखित निर्धारण देने में असफल रहने की दशा में यह उपधारणा की जाएगी कि उससे कोई महत्वपूर्ण जोखिम नहीं है और यह कि व्यक्ति नौकरी के कर्तव्यों का पालन करने के योग्य है और, यथास्थिति, उस खंड के उपखंड (ii) के अधीन लिखित विवरण देने में असफल रहने की दशा में यह उपधारणा की जाएगी कि ऐसी कोई असम्यक् प्रशासनिक या वित्तीय कठिनाई नहीं है।

कतिपय कार्यों का प्रतिषेध।

4. कोई व्यक्ति, साधारणतया या विशिष्ट रूप से किसी संरक्षित व्यक्ति या संरक्षित व्यक्तियों के समूह के विरुद्ध बोले गए या लिखे गए शब्दों द्वारा घृणा की भावनाओं का प्रकाशन, प्रचार, पक्ष-पोषण नहीं करेगा या संकेतों द्वारा या दृश्यरूपेण या अन्यथा संसूचित नहीं करेगा या किसी भी ऐसी सूचना, विज्ञापन या नोटिस का प्रसार, प्रसारण या प्रदर्शन नहीं करेगा जिससे युक्तियुक्त रूप से घृणा के प्रचार के आशय के निदर्शन का अर्थ लगाया जा सके या जिससे संरक्षित व्यक्ति को घृणा, विभेद या शारीरिक हिंसा की आशंका में डाला जाना संभाव्य हो।

अध्याय 3

सूचित सम्मति

एचआईवी परीक्षण या उपचार कराने के लिए सूचित सम्मति।

5. (1) इस अधिनियम के उपबंधों के अधीन रहते हुए,—

(क) किसी भी व्यक्ति पर एचआईवी परीक्षण; या

(ख) किसी भी संरक्षित व्यक्ति का चिकित्सा उपचार, चिकित्सा मध्यक्षेप या उसके बारे में अनुसंधान,

ऐसे व्यक्ति या उसके प्रतिनिधि की सूचित सम्मति के सिवाय और ऐसी रीति के सिवाय, जो मार्गदर्शक सिद्धांतों में विनिर्दिष्ट की जाएं, नहीं किया जाएगा।

(2) एचआईवी परीक्षण के लिए सूचित सम्मति के अंतर्गत परीक्षण किए गए व्यक्ति या ऐसे व्यक्ति के प्रतिनिधि की ऐसी रीति में पूर्व परीक्षण और पश्च परीक्षण परामर्श सेवा की जाएगी जो मार्गदर्शक सिद्धांतों में विनिर्दिष्ट की जाएं।

कतिपय मामलों में एचआईवी परीक्षण करने के लिए सूचित सम्मति की अपेक्षा नहीं होना।

6. निम्नलिखित मामलों में एचआईवी परीक्षण करने के लिए सूचित सम्मति की अपेक्षा नहीं होगी—

(क) जहां कोई न्यायालय आदेश द्वारा यह अवधारित करता है कि उसके समक्ष मामले में विवाद्यकों के अवधारण के लिए या तो चिकित्सा परीक्षा के भाग के रूप में या अन्यथा किसी व्यक्ति का एचआईवी परीक्षण किया जाना आवश्यक है;

(ख) आयुर्विज्ञान अनुसंधान या चिकित्सा में उपयोग के लिए मानव शरीर या उसके किसी भाग को उपाप्त करने, उसका प्रसंस्करण, वितरण या उपयोग करने के लिए, जिसके अंतर्गत ऊतक, रक्त, वीर्य या अन्य शारीरिक तरल आते हैं:

परंतु जहां पर किसी दाता द्वारा संदान के पहले परीक्षण परिणामों का अनुरोध किया गया है वहां दाता को परामर्श सेवा और परीक्षण केंद्र को निर्दिष्ट किया जाएगा और ऐसा दाता तब तक परीक्षण के परिणाम का हकदार नहीं होगा जब तक उसने ऐसे केंद्र से पश्च परीक्षण परामर्श सेवा प्राप्त नहीं कर ली हो;

(ग) जानपदिकयरोग विज्ञान संबंधी या निगरानी प्रयोजनों के लिए जहां पर एचआईवी परीक्षण अनाम है और किसी व्यक्ति की एचआईवी प्रास्थिति को अवधारित करने के प्रयोजन के लिए नहीं है:

परंतु ऐसे व्यक्तियों को, जो ऐसे जानपदिकय रोग संबंधी या निगरानी अध्ययनों के अधीन हैं, ऐसे अध्ययनों के प्रयोजनों की सूचना दी जाएगी; और

(घ) किसी अनुज्ञप्त रक्त कोष में छानबीन प्रयोजनों के लिए।

जांच केंद्रों आदि के लिए मार्गदर्शक सिद्धांत।

7. किसी परीक्षण या निदान केंद्रों या विकृति विज्ञान प्रयोगशाला या रक्त कोष द्वारा कोई एचआईवी परीक्षण तब तक नहीं किया जाएगा जब तक ऐसा केंद्र या प्रयोगशाला या रक्त कोष ऐसे परीक्षण के लिए अधिकथित मार्गदर्शक सिद्धांतों का पालन नहीं कर ले।

अध्याय 4

एचआईवी प्रास्थिति का प्रकटीकरण

एचआईवी प्रास्थिति का प्रकटीकरण।

8. (1) तत्समय प्रवृत्त किसी अन्य विधि में किसी बात के होते हुए भी,—

(i) किसी व्यक्ति को उसकी एचआईवी प्रास्थिति प्रकट करने के लिए उस दशा के सिवाय विवश नहीं किया जाएगा किसी न्यायालय के आदेश द्वारा यह अवधारित किया जाता है कि ऐसी सूचना का प्रकटीकरण उसके समक्ष मामले में विवाद्यकों के अवधारण के लिए न्याय हित में आवश्यक है;

(ii) कोई व्यक्ति, किसी अन्य व्यक्ति की एचआईवी प्रास्थिति या उसके द्वारा विश्वास में बताई गई या वैश्वासिक प्रकृति के संबंधों में बताई गई किसी अन्य निजी सूचना को, यथास्थिति, ऐसे अन्य व्यक्ति या ऐसे अन्य व्यक्ति के प्रतिनिधि की ऐसी रीति में जो धारा 5 में विनिर्दिष्ट की जाए, प्राप्त सम्मति के सिवाय और ऐसा प्रकटीकरण करने वाले व्यक्ति द्वारा ऐसी सम्मति के तथ्य को लेखबद्ध करने के सिवाय प्रकट नहीं करेगा या उसे प्रकट करने के लिए विवश नहीं किया जाएगा:

परंतु वैश्वासिक प्रकृति के संबंधों की दशा में सम्मति को लेखबद्ध किया जाएगा।

(2) उपधारा (1) के खंड (ii) के अधीन एचआईवी संबंधी सूचना के प्रकटीकरण के लिए उस स्थिति में सूचित सम्मति अपेक्षित नहीं है जहां पर प्रकटीकरण—

(क) किसी स्वास्थ्य देख-भाल प्रदाता द्वारा ऐसे दूसरे स्वास्थ्य देख-भाल प्रदाता को किया गया है जो ऐसे व्यक्ति के देख-रेख, उपचार या परामर्श सेवा में सम्मिलित है जब कि ऐसा प्रकटीकरण उस व्यक्ति की देख-रेख या उपचार के लिए आवश्यक है;

(ख) किसी न्यायालय के किसी आदेश द्वारा जब वह ऐसे आदेश द्वारा यह अवधारित करे कि ऐसी सूचना का प्रकटीकरण उसके समक्ष मामले में विवाद्यकों के अवधारण के लिए और न्यायहित में आवश्यक है;

(ग) व्यक्तियों के मध्य दावों या विधिक कार्यवाहियों में जहां ऐसी सूचना का प्रकटीकरण दावे या विधिक कार्यवाहियां फाइल करने के लिए या उनके काउंसेल को अनुदेश देने के लिए आवश्यक हैं;

(घ) धारा 9 के उपबंधों के अधीन है;

(ङ) यदि यह किसी व्यक्ति की सांख्यिकीय या अन्य सूचना से संबंधित है जिससे उस व्यक्ति की पहचान होने की युक्तियुक्त प्रत्याशा नहीं की जा सके; और

(च) मानीटर, मूल्यांकन या पर्यवेक्षण के प्रयोजनों के लिए, यथास्थिति, केंद्रीय सरकार या राज्य सरकार या संबंधित राज्य सरकार की राज्य एड्स नियंत्रण सोसाइटी के समक्ष है।

एचआईवी पोजिटिव व्यक्ति के संगी को उसके एचआईवी पोजिटिव प्रास्थिति का प्रकटीकरण।

9. (1) चिकित्सक या परामर्शदाता के सिवाय कोई भी स्वास्थ्य देख-भाल प्रदाता किसी व्यक्ति के संगी को उसकी एचआईवी पोजिटिव प्रास्थिति प्रकट नहीं करेगा।

(2) कोई स्वास्थ्य देखभाल प्रदाता जो चिकित्सक या परामर्शदाता है, किसी व्यक्ति की एचआईवी-पोजिटिव प्रास्थिति को उसके संगी को अपने प्रत्यक्ष देख-रेख के अधीन प्रकट कर सकेगा यदि ऐसा स्वास्थ्य देखभाल प्रदाता—

(क) युक्तियुक्त रूप से यह विश्वास करता है कि ऐसे व्यक्ति के संगी को उससे एचआईवी के पारेषण की महत्वपूर्ण जोखिम है; और

(ख) ऐसे एचआईवी पोजिटिव व्यक्ति को ऐसे संगी को सूचित करने के लिए परामर्शित कर दिया गया है; और

(ग) उसका यह समाधान हो जाता है कि एचआईवी पोजिटिव व्यक्ति ऐसे संगी को सूचित नहीं करेगा; और

(घ) एचआईवी पोजिटिव व्यक्ति को उसके संगी को उसकी एचआईवी पोजिटिव प्रास्थिति को प्रकट करने के अपने आशय के बारे में सूचित कर दिया है:

परंतु इस उपधारा के अधीन संगी को प्रकटीकरण परामर्श देने के पश्चात् व्यक्तिगत रूप से किया जाएगा:

परंतु यह और कि ऐसे स्वास्थ्य देखभाल प्रदाता की किसी एचआईवी पोजिटिव व्यक्ति के संगी की पहचान करने या उसका पता लगाने की कोई बाध्यता नहीं होगी:

परंतु यह भी कि ऐसा स्वास्थ्य देखभाल प्रदाता ऐसी परिस्थितियों में किसी महिला के संगी को सूचित नहीं करेगा जहां यह युक्तियुक्त आशंका है कि ऐसी सूचना का परिणाम हिंसा, परित्याग या ऐसी कार्रवाइयां हो सकती हैं जो ऐसी महिला, उसके बालकों, उसके नातेदारों या किसी ऐसे व्यक्ति के, जो उसके निकट है, शारीरिक या मानसिक स्वास्थ्य या सुरक्षा पर तीव्र नकारात्मक प्रभाव पड़ता हो।

(3) उपधारा (1) के अधीन स्वास्थ्य देखभाल प्रदाता, इस धारा के अधीन किसी संगी को की गई गोपनीय एचआईवी संबंधित सूचना के किसी भी प्रकटीकरण या अप्रकटीकरण के लिए किसी भी दांडिक या सिविल कार्यवाही के दायित्वाधीन नहीं होगा।

एचआईवी पारेषण के निवारण का कर्तव्य।

10. प्रत्येक ऐसा व्यक्ति, जो एचआईवी पोजिटिव है और जारी किए गए मार्गदर्शक सिद्धांतों के अनुसार परामर्शित कर दिया गया है या एचआईवी की प्रकृति या उसके पारेषण से अवगत है, अन्य व्यक्तियों को एचआईवी के पारेषण के निवारण के लिए सभी युक्तियुक्त पूर्वावधानियां अपनाएगा, जिसके अंतर्गत किसी व्यक्ति से किसी लैंगिक संपर्क या उस व्यक्ति के साथ सुइयों के एक दूसरे के लिए उपयोग से पहले उसकी एचआईवी प्रास्थिति की जोखिम को कम करने और उसके बारे में पहले से सूचित करने के लिए रणनीतियां अपनाना भी है:

परंतु इस धारा के उपबंध ऐसी परिस्थिति में किसी महिला की दशा में, लैंगिक संपर्क के माध्यम से पारेषण का निवारण करने को लागू नहीं होंगे, जहां यह युक्तियुक्त आशंका है कि ऐसी सूचना का परिणाम हिंसा, परित्याग या ऐसी कार्रवाइयां हो सकती हैं जो ऐसी महिला, उसके बालकों, उसके नातेदारों या किसी ऐसे व्यक्ति के, जो उसके निकट है, शारीरिक या मानसिक स्वास्थ्य या सुरक्षा पर तीव्र नकारात्मक प्रभाव पड़ता हो।

अध्याय 5

स्थापनों की बाध्यता

आंकड़ों की गोपनीयता।

11. संरक्षित व्यक्तियों की एचआईवी संबंधित जानकारी के अभिलेख रखने वाला प्रत्येक स्थापन यह सुनिश्चित करने के लिए कि ऐसी जानकारी प्रकटन से संरक्षित है, मार्गदर्शक सिद्धांत के अनुसार आंकड़ा संरक्षण के उपाय अंगीकार करेगा।

स्पष्टीकरण—इस धारा के प्रयोजनों के लिए, आंकड़ा संरक्षण उपायों में प्रकटन से जानकारी संरक्षित करने के लिए प्रक्रियाएं, जानकारी तक पहुंच के लिए प्रक्रियाएं, किसी रूप में भंडारित जानकारी

के संरक्षण के लिए सुरक्षा प्रणालियों हेतु उपबंध और जवाबदेही तथा स्थापन में व्यक्तियों के दायित्व सुनिश्चित करने के लिए तंत्र सम्मिलित है।

स्थापनों के लिए एच॰आई॰वी॰ और एड्स नीति।

12. केन्द्रीय सरकार, स्थापनों के लिए एचआईवी और एड्स के मॉडल ऐसी रीति में अधिसूचित करेगी, जो विहित की जाए।

अध्याय 6

एचआईवी से ग्रस्त लोगों के लिए प्रतिविषाणु संबंधी चिकित्सा और अवसरवादीय संक्रमण प्रबंधन

केन्द्रीय सरकार और राज्य सरकार द्वारा उपाय।

13. यथास्थिति, केन्द्रीय सरकार और प्रत्येक राज्य सरकार ऐसे सभी उपाय करेंगी, जो वह मार्गदर्शक सिद्धांत के अनुसार एचआईवी या एड्स के प्रसार को रोकने के लिए आवश्यक और समीचीन समझें।

केन्द्रीय सरकार और राज्य सरकार द्वारा प्रतिविषाणु संबंधी चिकित्सा और अवसरवादीय संक्रमण प्रबंधन।

14. (1) धारा 13 के अधीन एचआईवी या एड्स से ग्रस्त लोगों के लिए केन्द्रीय सरकार और राज्य सरकार द्वारा किए जाने वाले उपायों में यथासंभव प्रतिविषाणु संबंधी चिकित्सा और अवसरवादीय संक्रमण प्रबंधन एच आई वी या एडस संबंधी नैदानिक सुविधाओं का उपबंध करने के लिए उपाय सम्मिलित होंगे।

(2) केन्द्रीय सरकार प्रतिविषाणु संबंधी चिकित्सा और अवसरवादीय संक्रमण प्रबंधन नैदानिक सुविधाओं से संबंधित एचआईवी और एड्स के लिए प्रोटोकाल की बाबत आवश्यक मार्गदर्शक सिद्धांत को जारी करेगी, जो सभी व्यक्तियों को लागू होंगे और उनका व्यापक प्रचार सुनिश्चित करेगी।

अध्याय 7

केन्द्रीय सरकार और राज्य सरकार द्वारा कल्याणकारी उपाय

केन्द्रीय सरकार और राज्य सरकार द्वारा कल्याणकारी उपाय।

15. (1) केन्द्रीय सरकार और प्रत्येक राज्य सरकार, दौनों एचआईवी या एड्स द्वारा संक्रमित या प्रभावी व्यक्तियों के लिए कल्याणकारी स्कीमों तक बेहतर पहुंच को सुकर बनाने के लिए उपाय करेंगी।

(2) उपधारा (1) के उपबंधों पर प्रतिकूल प्रभाव डाले बिना, केन्द्रीय सरकार और राज्य सरकारें सभी संरक्षित व्यक्तियों की आवश्यकताओं से निबटने के लिए स्कीमों की विरचना करेंगी।

रेषण के कर्तव्य।

एचआईवी या एड्स द्वारा प्रभावित बालकों की संपत्ति का संरक्षण।

16. (1) यथास्थिति, केन्द्रीय सरकार या राज्य सरकार, एचआईवी या एड्स द्वारा प्रभावित बालकों की संपत्ति का संरक्षण करने के लिए एचआईवी या एड्स द्वारा प्रभावित बालकों की संपत्ति का संरक्षण करने के लिए समुचित कदम उठाएगी।

(2) एचआईवी और एड्स द्वारा प्रभावित बालकों के माता-पिता या संरक्षक या कोई अन्य व्यक्ति, जो उनके हित के संरक्षण के लिए कार्य कर रहा है या एचआईवी और एड्स द्वारा प्रभावित कोई बालक ऐसे बालक को संपत्ति अधिकारों से संबंधित दस्तावेजों को सुरक्षित रखने और जमा करने या बेदखल किए गए या वास्तविक बेदखल वाले ऐसे बालक या ऐसे बालक के गृह में अतिचार से संबंधित शिकायतों को करने के लिए बाल कल्याण समिति के पास जाएंगे।

स्पष्टीकरण—इस धारा के प्रयोजन के लिए, ''बाल कल्याण समिति'' से किशोर न्याय (बालकों की देखरेख और संरक्षण) अधिनियम, 2000 की धारा 29 के अधीन गठित समिति अभिप्रेत है।

एचआईवी और एड्स से संबंधित जानकारी, शिक्षा और संपर्क कार्यक्रमों का संवर्धन।

17. केन्द्रीय सरकार और राज्य सरकार एचआईवी और एड्स संबंधित जानकारी, शिक्षा और संपर्क कार्यक्रमों की विरचना करेंगी, जो समुचित वय, लैंगिक संवेदनशीलता, लांछनरहित और गैर- विभेदकारी हैं। 2000 का 56

एचआईवी या एड्स से संक्रमित स्त्रियां और बालक।

18. (1) केन्द्रीय सरकार, एचआईवी या एड्स से संक्रमित बालकों की देख-रेख, समर्थन और उपचार के लिए मार्गदर्शक सिद्धांत अधिकथित करेगी।

(2) उपधारा (1) की व्यापकता पर प्रतिकूल प्रभाव डाले बिना और तत्समय प्रवृत्त किसी अन्य विधि में अंतर्विष्ट किसी बात के होते हुए भी, यथास्थिति, केन्द्रीय सरकार या राज्य सरकार परामर्श करने

और गर्भावस्था और एचआईवी से संक्रमित स्त्रियों के लिए एचआईवी संबंधी उपचार के परिणाम के संबंध में जानकारी प्रदान करने के लिए उपाय करेगी।

(3) कोई एचआईवी पोजिटिव स्त्री, जो गर्भवती है, उसकी सूचित सम्मति को प्राप्त किए बिना बंध यीकरण या गर्भपात की पात्र नहीं होगी।

अध्याय 8

सुरक्षित कार्यकरण वातावरण

सुरक्षित कार्यकरण वातावरण प्रदान करने के लिए स्थापनों की बाध्यता।

19. स्वास्थ्य देख-रेख सेवाओं में लगा प्रत्येक स्थापन और प्रत्येक ऐसा अन्य स्थापन, जहां एचआईवी के प्रति उपजीविकाजन्य प्रभावन के महत्वपूर्ण जोखिम हैं, सुरक्षित कार्यकरण का वातावरण सुनिश्चित करने के लिए,—

(i) मार्गदर्शक सिद्धान्त के अनुसार उपबंध करेगा,—

(क) ऐसे स्थापन में कार्य कर रहे सभी व्यक्ति जिनका एचआईवी के प्रति उपजीविकाजन्य प्रभावन हो सकता है, के लिए सार्वभौमिक पूर्वावधानियां; और

(ख) ऐसी सार्वभौमिक पूर्वावधानियों के उपयोग के लिए प्रशिक्षण;

(ग) ऐसे स्थापन में कार्य कर रहे सभी व्यक्ति जिनका एचआईवी या एड्स के प्रति उपजीविकाजन्य प्रभावन हो सकता है, के पश्च प्रभावन रोग निरोध; और

(ii) सार्वभौमिक पूर्वावधानियों और पश्च प्रभावन रोग निरोध की उपलब्धता के स्थापन में कार्य कर रहे सभी व्यक्तियों को सूचित और शिक्षित करना।

स्थापनों के साधारण दायित्व।

20. (1) इस अध्याय के उपबंध उन सभी स्थापनों को, जो सौ या अधिक व्यक्तियों से मिलकर बने हैं, लागू होंगे चाहे वे, यथास्थिति, कोई कर्मचारी या अधिकारी, या सदस्य या निदेशक या न्यासी या प्रबंधक हों:

परंतु स्वास्थ्य देख-रेख स्थापनों के मामले में इस उपधारा के उपबंध इस प्रकार प्रभावी होंगे मानो ''सौ या अधिक'' शब्दों के स्थान पर, ''बीस या अधिक'' शब्द रखे गए हों।

(2) प्रत्येक व्यक्ति, जो उपधारा (1) में निर्दिष्ट किसी स्थापन का भारसाधक है, ऐसे स्थापन के क्रियाकलापों के संचालन के लिए इस अधिनियम के उपबंधों का अनुपालन सुनिश्चित करेगा।

शिकायत प्रतितोष तंत्र।

21. धारा 20 की उपधारा (1) में निर्दिष्ट प्रत्येक स्थापन, ऐसे व्यक्ति को, जिसे वह ठीक समझे, शिकायत अधिकारी के रूप में अभिहित करेगा, जो स्थापनों में इस अधिनियम के उपबंधों के अतिक्रमण की शिकायतों का ऐसी रीति से, और समयावधि के भीतर जो विहित की जाए, निपटारा करेगा।

अध्याय 9

जोखिम में कमी के लिए रणनीतियों का संवर्धन

जोखिम की कमी के लिए रणनीति।

22. तत्समय प्रवृत्त किसी अन्य विधि में अंतर्विष्ट किसी बात के होते हुए भी, एचआईवी संचरण के जोखिम को कम करने के लिए अंगीकृत या क्रियान्वित कोई रणनीति या तंत्र या तकनीक या व्यक्तियों, स्थापनों या संगठनों द्वारा उस रीति में जो केन्द्रीय सरकार द्वारा मार्गदर्शक सिद्धांत में विनिर्दिष्ट किया जा सके, के अनुसरण में कोई कार्य किसी रीति में निर्बंधित और प्रतिषिद्ध नहीं किया जाएगा और यह दांडिक अपराध की कोटि में नहीं आएगा या सिविल दायित्व का भागी नहीं होगा।

स्पष्टीकरण—इस धारा के प्रयोजनों के लिए एचआईवी संचरण का जोखिम कम करने के लिए रणनीति से उन कार्यों या व्यवहारों का संवर्धन करना अभिप्रेत है, जो एचआईवी के प्रभावन वाले व्यक्ति के जोखिम को कम करते हैं या एचआईवी या एड्स से संबंधी प्रतिकूल प्रभावों को घटाते हैं, जिसमें सम्मिलित हैं—

(i) एचआईवी रोकने से संबंधित जानकारी, शिक्षा और परामर्शी सेवाएं और सुरक्षित व्यवहारों का उपबंध;

(ii) सुरक्षित यौन साधनों जिसके अन्तर्गत कंडोम भी है का उपबंध और उपयोग

(iii) ओषधि प्रतिस्थापन और ओषधि संकट ; और

(iv) व्यापक इंजेक्शन सुरक्षा अपेक्षाओं का उपबंध

दृष्टांत

(क) **क, ख** को, जो एक यौनकर्मी है या **ग** को, जो **ख** का ग्राहक है, कंडोम प्रदाय करता है। न तो **क**, न ही ख और न ही ग ऐसी कार्यवाहियों के लिए दांडिक रूप से या सिविल रूप से दायी अभिनिर्धारित या रणनीति के क्रियान्वयन या उपयोग से प्रतिषिद्ध, बाधित, निर्बंधित या निवारित नहीं किए जा सकेंगे।

(ख) **ड** उन पुरुषों, जिनका पुरुषों के साथ यौन संबंध है, के लिए एचआईवी या एड्स और लैंगिक स्वास्थ्य जानकारी, शिक्षा परामर्श पर मध्यवर्ती परियोजना पर कार्य करता है, बेहतर सुरक्षित यौन जानकारी, सामग्री और कंडोम **ढ** को प्रदान करता है जो अन्य पुरुषों के साथ यौन संबंध रखता है। न तो **ड**, न ही **ढ** ऐसी कार्यवाहियों के लिए दांडिक रूप से या सिविल रूप से दायी अभिनिर्धारित या मध्यक्षेप के क्रियान्वयन या उपयोग से प्रतिषिद्ध, बाधित, निर्बंधित या निवारित नहीं किए जा सकेगा।

(ग) **भ**, जो सुई लगाने वाले मादक द्रव्य उपयोक्ताओं को रजिस्ट्रीकृत नीडल विनिमय कार्यक्रम सेवाओं को प्रदान करने वाला किसी मध्यक्षेप की जिम्मेवारी लेता है, **म** को स्वच्छ नीडल प्रदाय करता है, सुई से लगाने वाला कोई मादक द्रव्य उपयोक्ता जो प्रयोग की गई नीडल के लिए उसी का विनिमय करता है। न तो **भ**, न ही **म** ऐसे कार्य के लिए दांडिक या सिविल रूप से दायी अभिनिर्धारित या ऐसे मध्यक्षेप के क्रियान्वयन या उपयोग से प्रतिषिद्ध, बाधित, निर्बंधित या निवारित नहीं किए जा सकेगा।

(घ) **घ**, जो औपियाड प्रतिस्थापन चिकित्सा उपचार (ओ॰एस॰टी॰) प्रदान करने वाले मध्यक्षेप कार्यक्रम पर कार्य करता है, ओ॰एस॰टी॰ **ङ** को देता है, जो सुई लगाने वाला मादक द्रव्य उपयोक्ता है, न तो **घ**, न ही **ङ** ऐसे कार्य के लिए दांडिक रूप से या सिविल रूप से अभिनिर्धारित या मध्यक्षेप के क्रियान्वयन या उपयोग से प्रतिषिद्ध, बाधित, निर्बंधित या निवारित नहीं किया जा सकेगा।

अध्याय 10

ओमबड्समैन की नियुक्ति

ओमबड्समैन की नियुक्ति।

23. (1) प्रत्येक राज्य सरकार, ओमबड्समैन की ऐसी शक्तियों का प्रयोग और ऐसे कर्तव्यों का निर्वहन करने के लिए, जो इस अधिनियम के अधीन उसे प्रदत्त किए जाएं, एक या अधिक ओमबड्समैन की नियुक्ति करेगी,—

(क) जो ऐसी अर्हता और अनुभव रखता हो, जो विहित किए जाएं; या

(ख) ऐसी पंक्ति जो उस सरकार द्वारा विहित की जाए, से अन्यून के उसके किसी अधिकारी को अभिहित करेगी।

(2) उपधारा (1) के खंड (क) के अधीन नियुक्त किए गए किसी ओमबड्समैन की सेवा की निबंधन और शर्तें वे होंगी जो राज्य सरकार द्वारा विहित की जाएं।

(3) उपधारा (1) के अधीन नियुक्त किए गए ओमबड्समैन को ऐसे क्षेत्र या क्षेत्रों की बाबत अधिकारिता होगी जो राज्य सरकार, अधिसूचना द्वारा विनिर्दिष्ट करे।

ओमबड्समैन की शक्तियां।

24. (1) ओमबड्समैन, किसी व्यक्ति द्वारा परिवाद करने पर, किसी धारा 3 में वर्णित विभेद संबंधी कार्यों और स्वास्थ्य देखरेख संबंधी सेवाएं उपलब्ध कराने के संबंध में इस अधिनियम के उपबंधों में अतिक्रमण की ऐसी रीति में, जो राज्य सरकार द्वारा विहित की जाए, जांच करेगा।

(2) ओमबड्समैन, किसी व्यक्ति से ऐसे बिंदुओं या मामलों पर जानकारी प्रस्तुत करने की अपेक्षा कर सकेगा, जो वह मामले की जांच के लिए आवश्यक समझे और इस प्रकार अपेक्षित कोई व्यक्ति ऐसी जानकारी प्रस्तुत करने के लिए विधिक रूप से आबद्ध होगा और ऐसा करने में असफल रहने पर वह भारतीय दंड संहिता की धारा 176 और धारा 177 के अधीन दंडनीय होगा।

1860 का 45

(3) ओमबड्समैन ऐसी रीति में अभिलेखों का अनुरक्षण करेगा, जो राज्य सरकार द्वारा विहित की जाए।

परिवाद की प्रक्रिया।

25. धारा 24 की उपधारा (1) के अधीन ओमबड्समैन को शिकायतें ऐसी रीति में की जा सकेंगी, जो राज्य सरकार द्वारा विहित की जाए।

ओमबड्समैन के आदेश।

26. ओमबड्समैन धारा 24 की उपधारा (1) के अधीन शिकायत प्राप्त होने के तीस दिन की अवधि के भीतर पक्षकारों को सुने जाने का अवसर देने के पश्चात् उसके कारण देते हुए ऐसा आदेश पारित करेगा, जो वह ठीक समझे।

परन्तु ओमबड्समैन, एचआईवी पोजिटिव व्यक्तियों की आपात चिकित्सा के मामलों में यथा संभवशीघ्रता से, अधिमानत: शिकायत प्राप्त होने के चौबीस घंटे के भीतर ऐसा आदेश पारित करेगा।

ओमबड्समैन की सहायता के लिए प्राधिकारी।

27. ओमबड्समैन द्वारा पारित आदेशों के निष्पादन में सभी प्राधिकारी, जिसमें उस क्षेत्र, जिसके लिए धारा 23 के अधीन ओबड्समैन की नियुक्ति की गई है, में कार्य कर रहे सिविल अधिकारी भी सम्मिलित हैं, सहायता करेंगे।

राज्य सरकार को रिपोर्ट।

28. ओमबड्समैन, प्राप्त परिवादों की संख्या और प्रकृति, की गई कार्यवाही, ऐसे परिवादों के संबंध में पारित आदेश की रिपोर्ट राज्य सरकार को, प्रत्येक छह मास के पश्चात्, करेगा और ऐसी रिपोर्ट ओबड्समैन की वेबसाइट पर प्रकाशित की जाएगी और उसकी एक प्रति केंद्रीय सरकार को अग्रेषित की जाएगी।

अध्याय 11

विशेष उपबंध

निवास का अधिकार।

29. प्रत्येक संरक्षित व्यक्ति को, साझी गृहस्थी में निवास करने का अधिकार होगा, उस अधिकार को साझी गृहस्थी या उसके किसी भाग से अपवर्जित नहीं किया जाएगा और ऐसी साझी गृहस्थी की सुविधाओं के अधिभोग और उपभोग का अधिकार गैर-विभेदकारी रीति में होगा।

स्पष्टीकरण—इस धारा के प्रयोजन के लिए, ''साझी गृहस्थी'' से ऐसी गृहस्थी अभिप्रेत है, जहां कोई व्यक्ति पारिवारिक संबंध में या तो एकल रूप से या किसी व्यक्ति के साथ रहता है या किसी अवस्था में रह चुका है और इसमें ऐसी गृहस्थी, चाहे स्वामित्व वाली या किराएदारी वाली, चाहे संयुक्त रूप से हो या एकल रूप से, कोई ऐसी गृहस्थी, जिसकी बाबत या तो व्यक्ति या दोनों का, संयुक्त रूप से या एकल, कोई अधिकार, हक, हित या साम्या है या कोई ऐसी गृहस्थी, जो उस संयुक्त कुटुंब से संबंधित हो सकेगी, जिसका व्यक्ति इस बात का ध्यान दिए बिना सदस्य है कि क्या व्यक्ति का साझी गृहस्थी में कोई अधिकार, हक या हित है, सम्मिलित है।

एच॰आई॰वी॰ संबंधी जानकारी, शिक्षा और विवाह से पूर्व संसूचना।

30. केंद्रीय सरकार, एचआईवी संबंधी जानकारी के उपबंध, शिक्षा और विवाह से पूर्व संसूचना के लिए मार्गदर्शन सिद्धांत विनिर्दिष्ट करेगी और यह उनका व्यापक प्रसार सुनिश्चित करेगी।

राज्य की देख-रेख या अभिरक्षा में व्यक्ति।

31. (1) प्रत्येक व्यक्ति का, जो राज्य की देख-रेख या अभिरक्षा में है, इस संबंध में जारी मार्गदर्शन सिद्धांत के अनुसार एचआईवी निवारण, परामर्श परीक्षण और चिकित्सा का अधिकार होगा।

(2) इस धारा के प्रयोजनों के लिए, राज्य की देख-रेख या अभिरक्षा के अधीन व्यक्तियों में, अपराध के लिए सिद्धदोष ठहराए गए और दंडादेश भुगत रहे, विचारण के लिए प्रतीक्षारत व्यक्ति, निवारक निरोध विधियों के अधीन निरुद्ध व्यक्ति, किशोर न्याय (बालकों की देख-रेख और संरक्षण) अधिनियम, 2000, अनैतिक व्यापार (निवारण) अधिनियम, 1956 या किसी अन्य विधि के अधीन राज्य की देख-रेख

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या अभिरक्षा के अधीन व्यक्ति और राज्य द्वारा चलाए जा रहे गृहों और आश्रयगृहों की देख-रेख और अभिरक्षा में व्यक्ति सम्मिलित हैं।

बड़े सहोदर की संरक्षकता की मान्यता।

32. तत्समय प्रवृत्त किसी विधि में अंतर्विष्ट किसी बात के होते हुए भी, कोई व्यक्ति, जो अठारह वर्ष से कम का है, किंतु बारह वर्ष से कम का नहीं है, जो पर्याप्त और परिपक्व समझ रखता है और जो एचआईवी और एड्स द्वारा प्रभावित अपने कुटुंब के कार्यों का प्रबंध कर रहा है, वह निम्नलिखित प्रयोजनों के लिए अठारह वर्ष से कम के अन्य सहोदर के संरक्षक के रूप में कार्य करने के लिए सक्षम होगा, अर्थात्:—

(क) शैक्षणिक स्थापनों में प्रवेश;

(ख) देखरेख और संरक्षण;

(ग) चिकित्सा;

(घ) बैंक खातों का प्रचालन;

(ङ) संपत्ति प्रबंध; और

(च) कोई अन्य प्रयोजन, जो संरक्षक के रूप में उसके कर्तव्यों के निर्वहन के लिए आवश्यक हो।

स्पष्टीकरण—इस धारा के प्रयोजनों के लिए, एचआईवी या एड्स से प्रभावित कोई ऐसा कुटुंब अभिप्रेत है, जहां दोनों माता-पिता और विधिक संरक्षक, जो एचआईवी संबंधित बीमारी या एड्स के कारण असमर्थ है या विधिक संरक्षक और माता-पिता, जो ऐसे बालकों के संबंध में अपने कर्तव्यों का निर्वहन करने में असमर्थ हैं।

संरक्षकता और वसीयती संरक्षकता के लिए विद्यमान उपबंध।

33. (1) तत्समय प्रवृत्त किसी विधि में अंतर्विष्ट किसी बात के होते हुए भी, एचआईवी और एड्स द्वारा प्रभावित किसी बालक के माता-पिता या विधिक संरक्षक वसीयत करके किसी ऐसे वयस्क व्यक्ति को नियुक्त कर सकते हैं, जो नातेदार या मित्र है या अठारह वर्ष की आयु से कम का कोई व्यक्ति, जो, यथास्थिति, माता-पिता या विधिक संरक्षक की अक्षमता या मृत्यु पर तुरंत विधिक संरक्षक के रूप में कार्य करने के लिए, धारा 33 में यथानिर्दिष्ट, एचआईवी और एड्स द्वारा प्रभावित कुटुंब का प्रबंध सदस्य है।

(2) इस धारा की कोई बात, उपधारा (1) में निर्दिष्ट माता-पिता या उनके अधिकारों वाले विधिक संरक्षक को वंचित नहीं करेगी, उनकी क्षमता के बारे में माता-पिता या विधिक संरक्षक द्वारा प्रचालन को बंद नहीं करेगी।

(3) एचआईवी और एड्स द्वारा प्रभावित बालकों के माता-पिता या विधिक संरक्षक ऐसे बालकों की देख-रेख और संपत्ति के संरक्षण के लिए संरक्षक नियुक्त करने हेतु यह वसीयत कर सकेंगे कि ऐसे बालक उत्तराधिकार या जिनको ऐसे माता-पिता या विधिक संरक्षक द्वारा की गई वसीयत के माध्यम से वसीयत की गई हो, प्राप्त करेंगे।

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न्यायालयों में विशेष प्रक्रिया

पहचान का अधिक्रमण।

34. (1) किसी विधिक कार्यवाही में, जिसमें संरक्षित व्यक्ति एक पक्षकार है या ऐसा व्यक्ति कोई आवेदक है, न्यायालय ऐसे व्यक्ति या उसके निमित्त किसी अन्य व्यक्ति द्वारा आवेदन करने पर न्याय के हित में निम्नलिखित में से कोई या सभी आदेश पारित कर सकेगा, अर्थात्:—

(क) कि कार्यवाहियों के अभिलेख में छद्मनाम वाले ऐसे व्यक्ति का नाम प्रतिस्थापित करके आवेदक की पहचान के अधिक्रमण द्वारा कार्यवाहियां या उसके कोई भाग ऐसी रीति में संचालित किए जाएंगे, जो विहित की जाएं;

(ख) कि कार्यवाहियां या उसका कोई भाग बंद कमरे में संचालित किया जा सकेगा;

(ग) आवेदक के नाम या प्रास्थिति या पहचान के प्रकटन को अग्रसर करने के लिए किसी सामग्री को किसी रीति में प्रकाशन से किसी व्यक्ति को रोकना।

(2) किसी एचआईवी पोजिटिव व्यक्ति से संबद्ध या संबंधित किसी विधिक कार्यवाही में न्यायालय पूर्विक्ता के आधार पर कार्यवाहियों को करेगा और व्ययन करेगा।

भरणपोषण आवेदन।

35. तत्समय प्रवृत्त किसी विधि के अधीन संरक्षित व्यक्ति द्वारा या उसके निमित्त फाइल किए गए किसी भरणपोषण आवेदन में न्यायालय अंतरिम भरणपोषण के लिए आवेदन पर विचार करेगा और भरणपोषण के किसी आदेश को पारित करने में, चिकित्सा व्यय और अन्य एचआईवी संबंधित लागत, जिन्हें आवेदक द्वारा उपगत किया जा सकेगा, को ध्यान में रखेगा।

दंडादेश करना।

36. दंडादेश करने से संबंधित किसी आदेश को पारित करने में एचआईवी पोजिटिव प्रास्थिति वाले व्यक्तियों की, जिनकी बाबत ऐसा आदेश पारित किया जाता है, अभिरक्षण स्थान, जहां ऐसे व्यक्ति को ऐसे स्थान पर समुचित स्वास्थ्य देख-रेख सेवाओं की उपलब्धता के आधार पर स्थानान्तरित किया जाएगा, का अवधारण करने के लिए न्यायालय द्वारा विचार करने के लिए सुसंगत कारक होगा।

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शास्तियां

उपबंधों के उल्लंघन के लिए शास्ति।

37. तत्समय प्रवृत्त किसी अन्य विधि के अधीन की जाने वाली किसी कार्यवाही में किसी बात के होते हुए भी, जो कोई धारा 4 के उपबंधों का उल्लंघन करता है, वह ऐसी अवधि के कारावास से, जो तीन मास से कम की नहीं होगी, किंतु जो दो वर्ष तक की हो सकेगी और जुर्माने से, जो एक लाख रुपए तक का हो सकेगा, या दोनों से, दंडनीय होगा।

ओमबड्समैन के आदेशों का पालन करने में असफल रहने के लिए शास्ति।

38. जो कोई धारा 26 के अधीन ऐसे समय के भीतर, जो ऐसे आदेश में विनिर्दिष्ट किया जाए, ओमबड्समैन द्वारा किए गए किसी आदेश का अनुपालन करने में असफल रहता है, जुर्माने का, जो दस हजार रुपए तक का हो सकेगा, और यदि असफलता जारी रहती है तो अतिरिक्त जुर्माने का, जो ऐसे प्रत्येक दिन के लिए, जिसके दौरान असफलता जारी रहती है, पांच हजार रुपए तक का हो सकेगा, संदाय करने के लिए दायी होगा।

विधिक कार्यवाहियों में गोपनीयता भंग के लिए शास्ति।

39. तत्समय प्रवृत्त किसी विधि के अधीन की जाने वाली किसी कार्यवाही में किसी बात के होते हुए भी, जो कोई संरक्षित व्यक्ति की एचआईवी प्रास्थिति के संबंध में ऐसी सूचना का, जो उसके द्वारा किसी न्यायालय के समक्ष किन्हीं कार्यवाहियों के प्रक्रम में या उसके संबंध में प्राप्त की गई है, प्रकटन करता है, जुर्माने से, जो एक लाख रुपए तक का हो सकेगा, दंडनीय होगा, जब तक ऐसा प्रकटन न्यायालय के किसी आदेश या निर्देश के अनुसरण में नहीं होता है।

उत्पीड़न का प्रतिषेध।

40. कोई व्यक्ति, इस आधार पर कि ऐसा व्यक्ति या ऐसे व्यक्ति निम्नलिखित में से कोई कार्यवाही कर चुके हैं, किसी अहित के लिए किसी अन्य व्यक्ति या व्यक्तियों के अधीन नहीं होंगे, अर्थात्:—

(क) इस अधिनियम के अधीन किया गया परिवाद;

(ख) किसी व्यक्ति के विरुद्ध इस अधिनियम के अधीन लाई गई कार्यवाही;

(ग) इस अधिनियम के अधीन किसी शक्ति का प्रयोग कर रहे या कृत्यों का पालन कर रहे व्यक्ति के लिए प्रस्तुत की गई कोई सूचना या पेश किया गया कोई दस्तावेज;

(घ) इस अधिनियम के अधीन कार्यवाही में साक्षी के रूप में उपसंजात हो चुके हों।

अपराधों के विचारण के लिए न्यायालय।

41. इस अधिनियम के अधीन किसी अपराध का संज्ञान न्यायिक मजिस्ट्रेट प्रथम वर्ग के न्यायालय से भिन्न कोई न्यायालय नहीं लेगा।

अपराधों का संज्ञेय और जमानतीय होना।

42. दंड प्रक्रिया संहिता, 1973 में अंतर्विष्ट किसी बात के होते हुए भी, इस अधिनियम के अधीन अपराध संज्ञेय और जमानतीय होंगे। 1974 का 2

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प्रकीर्ण

अधिनियम का अध्यारोही प्रभाव होना।

43. इस अधिनियम के उपबंधों का, तत्समय प्रवृत्त किसी अन्य विधि में या इस अधिनियम से अन्यथा किसी विधि के आधार पर प्रभाव रखने वाले किसी लिखत में उससे असंगत किसी बात के होते हुए भी प्रभाव होगा।

सद्भावपूर्वक की गई कार्रवाई के लिए संरक्षण।

44. इस अधिनियम या उसके अधीन बनाए गए किसी नियम या मार्गदर्शक सिद्धांत के अनुसरण में या केंद्रीय सरकार, राज्य सरकार, केंद्रीय सरकार तथा राज्य सरकार के ओमबड्समैन की एड्स नियंत्रण सोसाइटी के द्वारा या उनके प्राधिकार के अधीन प्रकाशन के संबंध में सद्भावपूर्वक की गई या की जाने के लिए आशयित किसी बात की बाबत या तो केंद्रीय सरकार या राज्य सरकार, केंद्रीय सरकार तथा राज्य सरकार के ओमबड्समैन की एड्स नियंत्रण सोसाइटी या उसके किसी सदस्य या केंद्रीय सरकार या राज्य सरकार, केंद्रीय सरकार या ओमबड्समैन के निदेशन के अधीन कार्य कर रहे किसी अधिकारी या अन्य कर्मचारी के विरुद्ध कोई वाद, अभियोजन या अन्य विधिक कार्यवाही नहीं होगी।

शक्तियों का प्रत्यायोजन।

45. यथास्थिति, केंद्रीय सरकार या राज्य सरकार, साधारण या विशेष आदेश द्वारा, यह निदेश कर सकेगी कि इस अधिनियम के अधीन इसके द्वारा प्रयोक्तव्य कोई शक्ति, ऐसी परिस्थितियों में और ऐसी शर्तों के अधीन, यदि कोई हैं, जो आदेश में उल्लिखित की जाएं, उस सरकार या स्थानीय प्राधिकारी के अधीनस्थ किसी अधिकारी द्वारा भी प्रयोक्तव्य होगी।

केन्द्रीय सरकार की मार्गदर्शक सिद्धांत बनाने की शक्ति।

46. (1) केंद्रीय सरकार, अधिसूचना द्वारा, साधारणतया इस अधिनियम के उपबंधों का क्रियान्वयन करने के लिए, इस अधिनियम और उसके अधीन बनाए गए किसी नियम से संगत मार्गदर्शक सिद्धांत बना सकेगी।

(2) विशिष्टतया और पूर्वगामी शक्ति की व्यापकता पर प्रतिकूल प्रभाव डाले बिना, ऐसे मार्गदर्शक सिद्धांत, निम्नलिखित सभी या किन्हीं विषयों के लिए उपबंध कर सकेंगे, अर्थात्:—

(क) धारा 2 के खंड (ढ) के अधीन प्रस्तावित मध्यक्षेप के लिए जोखिम और फायदे या विकल्पों संबंधी जानकारी;

(ख) धारा 5 की उपधारा (1) के अधीन सूचित सम्मति प्राप्त करने की रीति और उपधारा (2) के अधीन पूर्व परीक्षण और पश्च परीक्षण परामर्श की रीति;

(ग) धारा 7 के अधीन एचआईवी परीक्षण के लिए परीक्षण या निदान केंद्र या विकृति विज्ञान प्रयोगशाला या रक्त बैंक द्वारा अनुसरण किए जाने वाले मार्गदर्शक सिद्धांत;

(घ) धारा 11 के अधीन आंकड़ा संरक्षण उपायों को किए जाने की रीति;

(ङ) धारा 14 की उपधारा (2) के अधीन प्रतिविषाणु संबंधी चिकित्सा और अवसरवादीय संक्रमण प्रबंधन से संबंधित एचआईवी/एड्स के लिए प्रोटोकाल की बाबत मार्गदर्शक सिद्धांत;

(च) धारा 18 की उपधारा (1) के अधीन एचआईवी या एड्स से संक्रमित बालकों की देखरेख, सहारा और उपचार;

(छ) धारा 19 के अधीन सार्वभौमिक पूर्वावधानियां और पश्च प्रभावन रोग निरोध के लिए मार्गदर्शन;

(ज) धारा 22 के अधीन एचआईवी संचरण के जोखिम को कम करने के लिए रणनीति या क्रियाविधि या तकनीकी के कार्यान्वयन हेतु;

(झ) धारा 22 के अधीन ओषधि प्रतिस्थापन, ओषधि अनुरक्षण और नीडल तथा सीरिंज विनिमय कार्यक्रम के कार्यान्वयन की रीति;

(ञ) धारा 30 के अधीन एचआईवी संबंधी जानकारी, शिक्षा और विवाह से पूर्व संसूचना;

(ट) धारा 31 के अधीन एचआईवी या एड्स निवारण, परामर्श, परीक्षण और अभिरक्षा में व्यक्तियों की चिकित्सा की रीति;

(ठ) कोई अन्य विषय, जो इस अधिनियम के प्रयोजनों के लिए मार्गदर्शक सिद्धांत में विनिर्दिष्ट होने चाहिए।

केंद्रीय सरकार की नियम बनाने की शक्ति।

47. (1) केंद्रीय सरकार, अधिसूचना द्वारा, इस अधिनियम के उपबंधों को कार्यान्वित करने के लिए नियम बना सकेगी।

(2) विशिष्टतया और पूर्वगामी शक्ति की व्यापकता पर प्रतिकूल प्रभाव डाले बिना, ऐसे नियम, निम्नलिखित सभी या किन्हीं विषयों के लिए उपबंध कर सकेंगे, अर्थात्:—

(क) धारा 13 के अधीन स्थापनों के लिए माडल एचआईवी या एड्स नीति अधिसूचित करने की रीति;

(ख) कोई अन्य विषय, जो केंद्रीय सरकार द्वारा विहित किए जाएं या विहित होने चाहिए।

नियमों का संसद् के दोनों सदनों के समक्ष रखा जाना।

48. इस अधिनियम के अधीन बनाया गया प्रत्येक नियम, उसके बनाए जाने के पश्चात् यथाशीघ्र संसद् के प्रत्येक सदन के समक्ष, जब वह सत्र में हो, कुल तीस दिन की अवधि के लिए रखा जाएगा। यह अवधि एक सत्र में अथवा दो या अधिक आनुक्रमिक सत्रों में पूरी हो सकेगी। यदि उस सत्र के या पूर्वोक्त आनुक्रमिक सत्रों के ठीक बाद के सत्र के अवसान के पूर्व दोनों सदन उस नियम में कोई परिवर्तन करने के लिए सहमत हो जाएं तो तत्पश्चात् वह ऐसे परिवर्तित रूप में ही प्रभावी होगा। यदि उक्त अवसान के पूर्व दोनों सदन सहमत हो जाएं कि वह नियम नहीं बनाया जाना चाहिए तो तत्पश्चात् वह नियम निष्प्रभाव हो जाएगा। किंतु नियम के इस प्रकार परिवर्तित या निष्प्रभाव होने से उसके अधीन पहले की गई किसी बात की विधिमान्यता पर प्रतिकूल प्रभाव नहीं पड़ेगा।

राज्य सरकार की नियम बनाने और उसे रखे जाने की शक्ति।

49. (1) राज्य सरकार, अधिसूचना द्वारा, इस अधिनियम के उपबंधों को कार्यान्वित करने के लिए नियम बना सकेगी।

(2) विशिष्टतया और पूर्वगामी शक्ति की व्यापकता पर प्रतिकूल प्रभाव डाले बिना, ऐसे नियम, निम्नलिखित सभी या किन्हीं विषयों के लिए उपबंध कर सकेंगे, अर्थात्:—

(क) एचआईवी या एड्स से ग्रस्त लोगों के लिए एचआईवी या एड्स संबंधी मैदानिक सुविधा प्रतिविषाणु संबंधी चिकित्सा और अवसरवादीय संक्रमण प्रबंधन प्रदान करने तथा धारा 14 के अधीन मार्गदर्शनों के अनुसार एचआईवी या एड्स का प्रसार रोकने के उपाय;

(ख) धारा 23 की उपधारा के खंड (क) (1) के अधीन किसी ओमबड्समैन के रूप में किसी व्यक्ति की नियुक्ति या खंड (ख) के अधीन राज्य सरकार के किसी अधिकारी की रैंक ओमबडसमैन के रूप में नामनिर्दिष्ट किए जाने के लिए अर्हता और अनुभव;

(ग) धारा 23 की उपधारा (2) के अधीन ओमबड्समैन की सेवा के निबंधन और शर्तें;

(घ) धारा 24 की उपधारा (1) के अधीन ओमबड्समैन द्वारा शिकायतों की जांच करने की रीति और उसकी उपधारा (3) के अधीन उसके द्वारा अभिलेखों का अनुरक्षण;

(ङ) धारा 25 के अधीन ओमबड्समैन को परिवाद करने की रीति;

(च) धारा 35 की उपधारा (1) के खंड (क) के अधीन विधिक कार्यवाही में छद्मनाम अभिलिखित करने की रीति।

(3) इस अधिनियम के अधीन राज्य सरकार द्वारा बनाया गया प्रत्येक नियम यथाशीघ्र विधान-मंडल के समक्ष रखा जाएगा।

कठिनाइयों को दूर करने की शक्ति।

50. (1) यदि इस अधिनियम के उपबंधों को प्रभावी करने में कोई कठिनाई उत्पन्न होती है तो

केंद्रीय सरकार, राजपत्र में प्रकाशित आदेश द्वारा ऐसे उपबंध कर सकेगी, जो इस अधिनियम के उपबंधों से असंगत न हो, जो उस कठिनाई को दूर करने के लिए उसे आवश्यक या समीचीन प्रतीत हो:

परंतु इस धारा के अधीन ऐसा कोई आदेश इस अधिनियम के प्रारंभ से दो वर्ष की अवधि की समाप्ति के पश्चात् नहीं किया जाएगा।

(2) इस धारा के अधीन किया गया प्रत्येक आदेश, इसके किए जाने के पश्चात्, यथाशीघ्र, संसद् के प्रत्येक सदन के समक्ष रखा जाएगा।

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(राष्ट्रीय एड्स नियंत्रण संगठन)

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नई दिल्ली, 17 सितम्बर, 2018

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अध्याय- I
प्रारंभिक

1. **संक्षिप्त नाम और प्रारंभ.**—(1) इन नियमों का संक्षिप्त नाम मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) नियम, 2018 है।

(2) ये राजपत्र से प्रकाशन की तारीख से प्रवृत्त होंगे।

2. परिभाषाएं—

(1) इन नियमों में जब तक संदर्भ के अनुसार अन्यथा अपेक्षित न हो,

(क) ''अधिनियम'' से मानव रोगक्षम अल्पता विषाणु और अर्जित रोगक्षम अल्पता संलक्षण (निवारण और नियंत्रण) नियम, 2017 (2017 का 16) अभिप्रेत है;

(ख) "समुचित प्राधिकारी" से अभिप्रेत है;

(i) केंद्रीय सरकार के मामले में राष्ट्रीय एड्स नियंत्रण संगठन; और

(ii) राज्य सरकार के मामले में राज्य एड्स नियंत्रण सोसाइटी;

(ग) "उच्च भार जिले" से अभिप्रेत उस जिले से है जहां –

(i) प्रहरी निगरानी में प्रसवपूर्व परिचर्या में एक प्रतिशत से अधिक का प्रचलन हो; या

(ii) प्रहरी निगरानी में उच्च-जोखिम जनसंख्या में पांच प्रतिशत से अधिक का प्रचलन हो; या

(iii) एकीकृत काउंसिलिंग और समय-समय पर केंद्रीय सरकार के अधीन समुचित प्राधिकारी द्वारा अधिसूचित किए गए परीक्षण केंद्र में आम मरीजों में एचआईवी पाजिटिव राष्ट्रीय औसत से अधिक हो।

(2) इसमें उपयोग किए गए शब्दों और अभिव्यक्तियों जिन्हें इन नियमों में परिभाषित नहीं किया गया है परंतु अधिनियम में परिभाषित किया गया है, का अर्थ वही होगा जो अधिनियम में निर्दिष्ट किया गया है।

अध्याय – II

स्थापनों के लिए एचआईवी और एड्स नीति को अधिसूचित किए जाने की विधि

3. केंद्रीय सरकार के अधीन समुचित प्राधिकारी स्थापनाओं के लिए मॉडल एचआईवी और एड्स नीति को अधिसूचित करने से पूर्व इस नीति के संबंध में-

(क) एचआईवी पाजिटिव व्यक्तियों के प्रतिनिधियों सहित सभी पणधारकों;

(ख) एचवाईवी प्रभावित व्यक्तियों और संरक्षित किए गए व्यक्तियों;

(ग) स्वास्थ्य देखरेख प्रदाता;

(घ) शिक्षा, स्वास्थ्य परिचर्या सेवाएं उपलब्ध कर रही स्थापनाओं, विशेषज्ञों और एचआईवी तथा एड्स के क्षेत्र में कार्य रहे संगठनों, नियोजकों, ट्रेड यूनियनों एवं अन्य सुसंगत पणधारकों के साथ परामर्श करेगा।

4. केंद्रीय सरकार के अधीन समुचित प्राधिकारी राजपत्र में स्थापनाओं के लिए मॉडल एचआईवी और एड्स नीति अधिसूचित करेगा।

5. केंद्रीय सरकार के अधीन समुचित प्राधिकारी नियम 3 और 4 के अनुसार स्थापनाओं के लिए समय-समय पर मॉडल एचआईवी और एड्स नीति की पुनर्विलोकन करेगा तथा उसे अद्यतन करेगा।

6. (1) स्वास्थ्य देखरेख सेवाओं के उपबंधों का अनुपालन कर रही स्थापनों तथा एचआईवी के व्यावसायिक खुलासे की अत्यधिक जोखिम वाली दूसरी प्रत्येक स्थापनों में मॉडल एचआईवी और एड्स नीति लागू करने से कार्य करने में तथा अधिनियम के उपबंधों के अनुरूप परीक्षण, उपचार और अनुसंधान के लिए संसूचित सहमति के लिए सुरक्षित वातावरण उपलब्ध होगा।

(2) किसी स्थापना पर लागू मॉडल एचआईवी और एड्स नीति, जिसमें 100 अथवा उससे अधिक व्यक्ति सम्मिलित हों, चाहे कोई कर्मचारी अथवा अधिकारी या निदेशक अथवा न्यासी या प्रबंधक है, जैसा भी मामला हो, द्वारा अधिनियम के उपबंधों और इन नियमों के अनुरूप एक शिकायत समाधान तंत्र की व्यवस्था की जाएगी।

परन्तु स्वास्थ्य देखरेख स्थापनों के मामले में स्थान पर और इस उप-नियम के उपबंध इस प्रकार लागू होंगे जैसे कि "सौ अथवा अधिक" शब्दों के स्थान पर "बीस अथवा अधिक" शब्दों को रख दिया गया हो; और

7. (1) केन्द्रीय सरकार के अधीन समुचित प्राधिकारी द्वारा समय-समय पर लागू संशोधित और अद्यतन मॉडल एचआईवी और एड्स नीति को इसकी अधिसूचना होने पर प्रत्येक स्थापना द्वारा अंगीकार किया जाएगा।

(2) स्थापन में कार्यरत सभी व्यक्तियों को एचआईवी और एड्स नीति के विषय की जानकारी स्थापना के प्रभारी व्यक्ति अथवा उत्तरदायी व्यक्ति द्वारा दी जाएगी।

(3) प्रभारी व्यक्ति अथवा स्थापन हेतु उत्तरदायी व्यक्ति एचआईवी और एड्स नीति के पाठ को अंग्रेजी में अथवा कार्यरत अधिकांश व्यक्तियों द्वारा समझी जाने वाली भाषा में अथवा प्रवेश द्वार पर अथवा उसके समीप, जहां से कार्यरत अधिकांश व्यक्ति आते-जाते हैं, पर इस उद्देश्य हेतु लगाए गए विशेष बोर्डों पर प्रमुखता के साथ प्रदर्शित करेगा।

(4) स्थापन एचआईवी और एड्स नीति को समझने और इसके क्रियान्वयन के लिए कार्य करने वाले व्यक्तियों के लिए वार्षिक प्रशिक्षण सत्रों का आयोजन करेगी।

8. (1) नियम 7 के उप-नियम (3) में विनिर्दिष्ट सूचना उस रीति में कथन करेगा, जिसमें एचआईवी और एड्स नीति की प्रतियां प्राप्त की जाएंगी और स्थापन में कार्यरत अथवा सेवाओं हेतु आने वाले व्यक्ति ऐसी नीति की नि:शुल्क प्रतिलिपि पाने के हकदार होंगे।

(2) स्थापनों की एचआईवी और एड्स नीति की प्रतियां उनके द्वारा पब्लिक डोमेन में उपलब्ध कराई जाएंगी, जिनके लिए नीति उपलब्ध कराई गई है, जिसमें उनकी वेबसाइट, यदि कोई हो, और नाममात्र मूल्य पर हार्डकॉपी उपलब्ध कराना सम्मिलित है।

(3) प्रत्येक राज्य का समुचित प्राधिकारी सभी शैक्षणिक स्थापनाओं के प्रमुखों को एचआईवी तथा एड्स नीति की प्रति उपलब्ध कराएंगे, जो इन स्थापनों में प्रवेश पाने वाले विद्यार्थियों को अथवा उनके माता-पिता अथवा अभिभावकों को इन नीतियों की एक प्रति नि:शुल्क उपलब्ध कराएगा।

अध्याय – III

स्थापनाओं हेतु शिकायत निवारण प्रणाली

9. (1) सौ या इससे अधिक कर्मचारियों वाले प्रत्येक स्थापन, जिसमें कर्मचारी अथवा अधिकारी अथवा निदेशक अथवा न्यासी अथवा प्रबंधक, जैसा भी मामला हो, इस अधिनियम के लागू होने के 180 दिनों के अंदर किसी वरिष्ठ पंक्ति के व्यक्ति को, द्वारा जैसा वह उचित समझे, शिकायत अधिकारी के रूप में नियुक्त किया जाएगा, जो इन नियमों के अनुपालन में स्थापना में अधिनियम के उपबंधों के उल्लंघन की शिकायतों का समाधान करेगा।

परन्तु सौ या इससे अधिक कर्मचारियों वाले स्थापन की प्रत्येक शाखा, जिसमें कर्मचारी अथवा अधिकारी अथवा निदेशक अथवा न्यासी अथवा प्रबंधक, जैसा भी मामला हो, इस अधिनियम के लागू होने के 180 दिनों के अंदर किसी वरिष्ठ पंक्ति के व्यक्ति को, द्वारा जैसा वह उचित समझे, शिकायत अधिकारी के रूप में नियुक्त किया जाएगा, जो इन नियमों के अनुपालन में स्थापन में अधिनियम के उपबंधों के उल्लंघन की शिकायतों का समाधान करेगा।

परन्तु आगे यह कि स्वास्थ्य देखरेख स्थापनों के मामले में, इस नियम के उपबंध इस तरह से लागू होंगे जैसे "सौ अथवा इससे अधिक" शब्दों के स्थान पर "बीस अथवा इससे अधिक" शब्दों को रखा गया है।

(2) स्थापन द्वारा नियुक्ति के 30 दिनों के अंदर, रोकथाम की सूचना, देखरेख, सहयोग तथा एचआईवी संबंधित उपचार, मानव लैंगिकता, यौन अभिमुखता तथा लिंग निर्धारण, नशीले पदार्थ का प्रयोग, सेक्स वर्क, एचआईवी संभावित व्यक्तियों, कलंक तथा भेदभाव, एचआईवी पीड़ितों के साथ घनिष्ठता बनाने के सिद्धांत, जोखिम कम

करने के उपाय आदि सहित इस अधिनियम के उपबंधों पर शिकायत अधिकारियों को प्रशिक्षण दिया जाएगा। प्रशिक्षण के दौरान शिकायत अधिकारी को संरक्षित व्यक्तियों तथा एचआईवी संभावित व्यक्तियों सहित विशेषज्ञों की सहायता प्रदान की जाएगी।

10. (1) कोई भी व्यक्ति स्थापन में अधिनियम के कथित उल्लंघन की जानकारी मिलने के उपरांत तीन माह के भीतर शिकायत अधिकारी को शिकायत कर सकता है:

परन्तु शिकायत अधिकारी, लिखित में कारण अभिलेख करते हुए और तीन मास के लिए शिकायत करने की समय-सीमा बढ़ा सकता है, यदि वह संतुष्ट है कि शिकायतकर्ता कुछ परिस्थितियों के कारण निर्धारित समय में शिकायत नहीं कर सका।

(2) प्रत्येक शिकायत, इन नियमों के साथ उपबद्ध प्ररूप में, लिखित में, की जाएगी:

परन्तु यह कि जहां लिखित में शिकायत नहीं की जा सकती है, शिकायत अधिकारी, शिकायतकर्ता को सभी प्रकार की युक्तियुक्त सहायता प्रदान करेगा जिससे कि शिकायत लिखित में की जा सके।

(3) शिकायत अधिकारी व्यक्तिगत रूप में, अथवा डाक द्वारा अथवा फोन से अथवा इलैक्ट्रॉनिक रूप में शिकायत प्राप्त कर सकता है:

परन्तु यह कि स्थापन शिकायत अधिकारी नियुक्त किए जाने की 30 दिन की अवधि के भीतर समर्पित वेबसाइट, वेबपेज के माध्यम से इलैक्ट्रॉनिक रूप में शिकायत की प्राप्ति अथवा शिकायत अधिकारी को शिकायतें भेजने के लिए सरकारी ई-मेल का पते प्रदान करने की रीति तय करेगी।

(4) शिकायत अधिकारी, शिकायत की प्राप्ति पर, शिकायतकर्ता को पावती देगा और मात्र उस उद्देश्य के लिए रखे गए रजिस्टर में शिकायत दर्ज करेगा।

(5) रजिस्टर में शिकायत की प्राप्ति का समय और की गई कार्रवाई की रजिस्टर में प्रविष्टि की जाएगी।

(6) रजिस्टर में प्रत्येक शिकायत को क्रमिक संख्या दी जाएगी।

(7) शिकायत अधिकारी अधिनियम की अधीन की गई शिकायत पर उद्देश्यपरक और स्वतंत्र रीति से कार्य करेगा।

(8) शिकायत अधिकारी शिकायत पर तत्परता से और किसी भी स्थिति में सात कार्य दिवसों के भीतर निर्णय लेगा:

परन्तु यह कि आपात मामले में अथवा स्वास्थ्य देखरेख के स्थापन के मामले में जहां यह उपबंधों में भेदभाव या फिर स्वास्थ्य देखरेख सेवाओं के पहुँच अथवा सर्वाभौमिक सावधानियों के उपबंधों से संबंधित शिकायत है, शिकायत अधिकारी उसी दिन, जिस दिन उसे शिकायत प्राप्त होती है, निर्णय लेगा।

11. (1) शिकायत अधिकारी यदि संतुष्ट है कि अधिनियम का उल्लंघन हुआ है जैसा कि शिकायत में आरोप लगाया गया है-

(क) प्रथमत:, स्थापना को उल्लंघन सुधार के उपाए करने का निदेश देगा;

(ख) दूसरे, जिस व्यक्ति ने उल्लंघन किया है उसे परामर्श देगा और ऐसे व्यक्ति को एचआईवी और एड्स, अधिनियम के उपबंधों और नियमों तथा दिशा-निर्देशों, विशेषकर कलंक और भेदभाव से संबंधित प्रशिक्षण दिया जाएगा जो एक सप्ताह की अवधि का होगा और सामाजिक सेवा हेतु निर्धारित अवधि तय की जाएगी जिसमें एचआईवी और एक्वायर्ड इम्यूनोडेफिसिएंसी वायरस, संरक्षित व्यक्ति नेटवर्क हेतु कार्यरत

गैर-सरकारी संगठन के साथ कार्य करना सम्मिलित होगा, अथवा राज्य सरकार के अधीन समुचित प्राधिकारी द्वारा निगरानी रखी जाएगी और हो सकता है कि उल्लंघनकर्ता का पर्यवेक्षण करने वाले को भी ऐसा प्रशिक्षण लेना हो।

(2) उसी व्यक्ति द्वारा पुन:अधिनियम का उल्लंघन करने पर शिकायत अधिकारी, स्थापन को विधि अनुसार उसके विरुद्ध अनुशांसनिक कार्रवाई करने की सिफारिश कर सकता है।

(3) शिकायत अधिकारी, शिकायत के संबंध में की गई कार्रवाई की शिकायतकर्ता को जानकारी देगा और यदि शिकायतकर्ता की गई कार्रवाई से असंतुष्ट हो तो उसको अधिकार होगा कि वह ओम्बड्समैन के पास जाए अथवा कोई अन्य उपयुक्त विधि कार्रवाई करे।

(4) शिकायत अधिकारी, शिकायत पर निर्णय के उपरांत निर्णय की तारीख से 10 दिन की अवधि में स्थापना को तथा शिकायत से संबद्ध पक्षकारों को निर्णय के संबंध में लिखित में कारण सूचित करेगा।

12. (1) शिकायत अधिकारी सुनिश्चित करेगा कि शिकायत, इसकी प्रकार संख्या और की गई कार्रवाई की रिपोर्ट केन्द्रीय सरकार के अधीन उपयुक्त प्राधिकारी को अधिनियम की धारा 11 और इसके अधीन नियम 13 के अंतर्गत, हर छ: माह में दी जाए।

(2) शिकायत अधिकारी इस अधिनियम के नियम 13 और धारा 11 के उपबंधों के अध्ययधीन, यह सुनिश्चित करेगा कि शिकायत, शिकायत की प्रकृति, शिकायत की संख्या और की गई कार्रवाई वार्षिक आधार पर संस्थान की वार्षिक रिपोर्ट में अथवा संस्थान की वेबसाइट पर प्रकाशित हो।

13. (1) शिकायत अधिकारी, संरक्षित व्यक्ति जो किसी शिकायत का हिस्सा है, के अनुरोध पर निम्नलिखित रीति से उक्त संरक्षित व्यक्ति की पहचान के संरक्षण को सुनिश्चित करेगा, अर्थात्:

(क) शिकायत अधिकारी ऐसे दस्तावेज की एक प्रति फाइल करेगा जिसमें ऐसे संरक्षित व्यक्ति का नाम, पहचान और पहचान योग्य ब्यौरा दिया गया हो, और इसे बंद लिफाफे में शिकायत अधिकारी की सुरक्षित अभिरक्षा में रखा जाएगा;

(ख) उसके समक्ष आई शिकायतों में संलिप्त संरक्षित व्यक्ति को छद्म नाम प्रदान करेगा;

(ग) शिकायत अधिकारी के समक्ष आई शिकायतों में संलिप्त संरक्षित व्यक्ति की पहचान और उसके पहचान योग्य ब्यौरों को नियम 10 के उप-नियम 4 के तहत शिकायतों के रजिस्टर सहित शिकायतों के संबंध में शिकायत अधिकारी और संस्थान द्वारा सृजित सभी दस्तावेजों और रिकॉर्डों में छद्म नाम से प्रदर्शित किया जाएगा;

(घ) शिकायत अधिकारी के समक्ष आई शिकायत में संलिप्त संरक्षित व्यक्ति की पहचान और पहचान योग्य ब्यौरों को किसी भी व्यक्ति या सहायक और स्टाफ सहित उनके प्रतिनिधियों द्वारा प्रकट नहीं किया जाएगा।

(2) कोई भी व्यक्ति शिकायत अधिकारी के समक्ष आई शिकायत के संबंध में कोई भी मामला तब तक मुद्रित या प्रकाशित नहीं कराएगा जब तक कि शिकायत में संलिप्त संरक्षित व्यक्तियों की पहचान सुरक्षित न की गई हो।

(3) शिकायत अधिकारी इस अधिनियम की धारा 11 के उपबंधों के अनुसार आंकड़ों के संरक्षण के उपायों का अनुपालन करेगा।

14. प्रत्येक स्थापन जिसे शिकायत अधिकारी नियुक्त करने की आवश्यकता है वह-

(क) अपने कर्मचारियों को इस अधिनियम के उपबंधों के प्रति संवेदनशील बनाने के लिए वार्षिक आधार पर कार्यशालाएं और जागरूकता कार्यकम तथा शिकायत अधिकारी के लिए अभिमुखी कार्यक्रम कार्यक्रम संचालित करेगा;

(ख) शिकायत पर निर्णय लेने के लिए शिकायत अधिकारी को आवश्यक सुविधाएं प्रदान करेगा; और

(ग) ऐसी सूचना उपलब्ध कराएगा जो शिकायत अधिकारी द्वारा निर्णय लेने के लिए अपेक्षित है।

15. केन्द्रीय सरकार के अधीन समुचित प्राधिकारी-

(क) अधिनियम के उपबंधों जिसमें अधिकारों के समाधान से संबंधित उपबंध भी शामिल हैं, के प्रति सामान्य रूप से आम जनता और विशेष तौर पर संरक्षित व्यक्तियों, सिविल प्राधिकारियों और स्वास्थ्य देखभाल कर्मियों की समझ को बढ़ाने के लिए सूचना शिक्षा, संचार और प्रशिक्षण सामग्री को तैयार करेगा और इसका प्रसार करेगा;

(ख) ऐसे अभिमुखी और प्रशिक्षण कार्यक्रमों को तैयार करेगा और इनका प्रसार करेगा जिनका संस्थानों द्वारा नियम 9 के उपनियम 2 के तहत शिकायत अधिकारियों के प्रशिक्षण में और इस अधिनियम तथा नियम 11 के उपनियम (1) के खण्ड (ख) के उपबंधों का उल्लंघन करते पाए गए व्यक्तियों के परामर्श में प्रयोग किया जा सकता है;

(ग) उच्च भार वाले जिलों में संस्थानों के लिए राज्य सरकार के अधीन ऐसे जिलों में समुचित प्राधिकारी और उनके शिकायत अधिकारियों के समन्वय में उक्त अधिनियम और नियमों के क्रियान्वयन पर प्रशिक्षण प्रदान करेगा और आगे ऐसे प्रशिक्षण वार्षिक आधार पर प्रदान करेगा;

(घ) उच्च भार वाले जिलों में सिविल प्राधिकारियों और मान्यता प्राप्त सामाजिक स्वास्थ्य कर्मियों (आशा) और आंगनवाड़ी कर्मियों सहित स्वास्थ्य देखभाल कर्मियों के लिए राज्य सरकार के अधीन ऐसे जिलों में उपयुक्त प्राधिकारी के समन्वय में उक्त अधिनियम और नियमों के क्रियान्वयन पर प्रशिक्षण प्रदान करेगा और आगे ऐसे प्रशिक्षण वार्षिक आधार पर प्रदान करेगा।

16. इन नियमों में अंतर्विष्ट कुछ भी अन्य उपचारों के प्रति किसी व्यक्ति के अधिकार को प्रतिसिद्ध, सीमित या अन्यथा प्रतिबंधित करता हो परन्तु इस अधिनियम या इस अधिनियम के उपबंधों के उल्लंघन से निपटने के लिए कुछ समय के लिए बनाए गए किसी अन्य कानून के तहत उपबंधित न किया गया हो।

प्ररूप

नियम 10 के अधीन शिकायत अधिकारी को शिकायत करने के लिए प्ररूप

1. घटना की तारीख .....

2. घटना का स्थान .....

3. घटना का विवरण .....

4. घटना के लिए उत्तरदायी व्यक्ति या संस्थान.....

शिकायतकर्ता के हस्ताक्षर या अंगूठा निशान*

नाम: तारीख:

मोबाइल नं. या ईमेल या फैक्स या पता :

केवल कार्यालय प्रयोग हेतु :

शिकायत संख्या: .....

*जहां शिकायत मौखिक रूप से या टेलीफोन के माध्यम से प्राप्त होती है और शिकायत अधिकारी द्वारा लिख ली गई है वहां शिकायत अधिकारी प्रपत्र पर तारीख सहित हस्ताक्षर करेगा।

[फा. सं. टी-11020/50/1999-नाको (पी एण्ड सी)]
आलोक सक्सेना, संयुक्त सचिव

MINISTRY OF HEALTH AND FAMILY WELFARE

(National AIDS Control Organisation)

NOTIFICATION

New Delhi, the 17th September, 2018

G.S.R. 888I.—In exercise of the powers conferred by section 47 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention And Control) Act, 2017 (16 of 2017), the Central Government hereby makes the following rules, namely:—

Chapter – I

Preliminary

1. Short title and commencement.- (1) These rules may be called the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention And Control) Rules, 2018.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions.-

(1) In these rules, unless the context otherwise requires,—

(a) "Act" means the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention And Control) Act, 2017 (16 of 2017);

(b) "appropriate authority" means;

(i) the National AIDS Control Organisation in case of Central Government; and

(ii) the State AIDS Control Society in case of State Government;

(c) “high burden district” means a district which has-

(i) more than one percent prevalence among antenatal care in Sentinel Surveillance; or

(ii) more than five percent prevalence among high-risk population in Sentinel Surveillance; or

(iii) HIV positivity of more than national average among general clients in Integrated Counselling and Testing Centre notified by the appropriate authority under the Central Government from time to time;

(2) Words and expressions used herein and not defined in these rules but defined in the Act shall have the meanings assigned to them in the Act.

Chapter – II

Manner of Notifying HIV and AIDS Policy for Establishments

3. The appropriate authority under the Central Government shall, before notifying a model HIV and AIDS policy for establishments consult -

(a) all stakeholders including representatives of HIV -positive persons;

(b) HIV -affected persons and protected persons;

(c) healthcare providers;

(d) establishments engaged in providing education, healthcare services, experts and organizations working in the field of HIV and AIDS, employers, trade unions, and other relevant stakeholders on such policy.

4. The appropriate authority under the Central Government shall notify a model HIV and AIDS policy for establishments in the Official Gazette.

5. The appropriate authority under the Central Government shall review and update from time to time the model HIV and AIDS policy for establishments in accordance with rules 3 and 4.

6. (1) The model HIV and AIDS policy applicable to an establishment, engaged in the provision of healthcare services and every other establishment where there is a significant risk of occupational exposure to HIV shall provide for a safe working environment and for informed consent for testing, treatment and research in accordance with the provisions of the Act.

(2) The model HIV and AIDS Policy applicable to an establishment consisting of one hundred or more persons, whether as an employee or officer or member or director or trustee or manager, as the case may be, shall provide for a grievance redressal mechanism in accordance with the provisions of the Act and these rules:

Provided that in the case of healthcare establishments, the provisions of this sub-rule shall have the effect as if for the words "one hundred or more", the words "twenty or more" had been substituted.

7. (1) The model HIV and AIDS policy as may be applicable and as may be amended and updated from time to time by the appropriate authority under the Central Government shall be adopted by every establishment upon its notification.

(2) The text of the HIV and AIDS policy shall be communicated to all persons working in the establishment by the person in charge of or responsible to the establishment.

(3) The person in charge or responsible for the establishment shall prominently post the text of the HIV and AIDS policy as a notice in English and in the language understood by majority of persons working in or accessing such establishment on special boards to be maintained for such purpose, at or near the entrance through which the majority of the persons working in or accessing the services of the establishment enter such establishment.

(4) The establishment shall conduct annual training sessions for persons working in such establishment in understanding and implementing the HIV and AIDS policy.

8. (1) The notice referred to in sub- rule (3) of rule 7 shall state the manner in which copies of the HIV and AIDS policy shall be obtained and persons working in or accessing the services of the establishment shall be entitled to a copy of such policy free of charge.

(2) The copies of the HIV and AIDS policy of establishments shall be made available in the public domain by those to whom the policy has been made available including on their website if any and in case of hard copies for a nominal price.

(3) The appropriate authority of every State shall make available the copy of HIV and AIDS policy to heads of all educational establishments who shall further provide a copy of the policy to the learners and their parents or guardians free of charge immediately upon admission of the learner to the establishment.

Chapter – III

Grievance Redressal Mechanism for Establishments

9. (1) Every establishment having one hundred or more persons, whether as an employee or officer or member or director or trustee or manager, as the case may be, shall within one hundred and eighty days of the commencement of the Act, designate such person of senior rank, as it deems fit, as the Complaints Officer who shall dispose of complaints of violations of the provisions of the Act in the establishment, in accordance with these rules:

Provided that every branch of an establishment having one hundred or more persons, whether as an employee or officer or member or director or trustee or manager, as the case may be, shall within one hundred and eighty days of the commencement of the Act, designate such person of senior rank, as it deems fit, as an additional Complaints Officer for such branch who shall dispose of complaints of violations of the provisions of the Act in the establishment, in accordance with these rules:

Provided further that in the case of healthcare establishments, the provisions of this rule shall have the effect as if for the words "one hundred or more", the words "twenty or more" had been substituted.

(2) The establishment shall within thirty days of appointment, provide training to the Complaints Officer on the provisions of the Act including information on prevention, care, support and treatment related to HIV, human sexuality, sexual orientation and gender identity, drug use, sex work, people vulnerable to HIV, stigma and discrimination, principles of the greater involvement of people living with HIV, strategies of risk reduction, etc. During the training assistance of experts including protected persons and persons vulnerable to HIV may be provided to the Complaints Officer.

10. (1) Any person may make a complaint to the Complaints Officer, within three months from the date that the person making the complaint became aware of the alleged violation of the Act in the establishment:

Provided that the Complaints Officer may, for reasons to be recorded in writing, extend the time limit to make the complaint by a further period of three months, if he is satisfied that circumstances prevented the complainant from making the complaint within the stipulated period.

(2) Every complaint shall be made to the Complaints Officer in writing in the Form set annexed to these rules:

Provided that where a complaint cannot be made in writing the Complaints Officer shall render all reasonable assistance to the complainant to reduce the complaint in writing.

(3) The Complaints Officer may receive complaint made in person, or by post or telephonically or in electronic form:

Provided that the establishment shall within a period of thirty days of appointing the Complaints Officer, establish a method for receipt of complaints in electronic form either through dedicated website, webpage or by providing an official email address for the submission of complaints to the Complaints Officer.

(4) The Complaints Officer shall, on receipt of a complaint, provide an acknowledgment to the complainant and record the Complaint in a register to be kept solely for that purpose.

(5) The time of the complaint and the action taken on the complaint shall be entered in a register.

(6) Every complaint shall be numbered sequentially in the register.

(7) The Complaints Officer shall act in an objective and independent manner while deciding complaints made under the Act.

(8) The Complaints Officer shall decide a complaint promptly and in any case within seven working days:

Provided that in case of emergency or in the case of healthcare establishment where the complaint relates to discrimination in the provision of, or access to health care services or provision of universal precautions, the Complaints Officer shall decide the complaint on the same day on which he receives the complaint.

11. (1) The Complaints Officer, if satisfied that a violation of the Act has taken place as alleged in the complaint, shall-

(a) firstly, direct the establishment to take measures to rectify the violation;

(b) secondly, counsel the person who has committed the violation and require such person to undergo training in relation to HIV and AIDS, provisions of the Act, rules and guidelines, particularly in relation stigma and discrimination, for a period amounting to one week, and a fixed period of social service, which shall include working with a non-governmental organisation working on HIV and Acquired Immunodeficiency Virus, a protected person's network, or the appropriate authority under the State Government that shall be monitored, and may also require that the person supervising the violator undergo such training.

(2) Upon subsequent violation of the Act by the same person, the Complaints Officer may recommend the establishment to take disciplinary action in accordance with the law.

(3) The Complaints Officer shall inform the complainant of the action taken in relation to the complaint and of the complainant's right to approach the Ombudsman or to any other appropriate legal recourse in case the complainant is dissatisfied with the action taken.

(4) The Complaints Officer shall, on deciding a complaint, provide brief reasons in writing for the decision to the establishment and the concerned parties to the complaint within a period of ten days from the date of decision.

12. (1) The Complaints Officer shall ensure that the complaint, its nature and number and the action taken are reported to the appropriate authority under the Central Government every six months subject to the provisions of section 11 of the Act and rule 13 of these rules.

(2) The Complaints Officer shall ensure that the complaint, the nature of the complaint, the number of the complaint and the action taken are published on an annual basis or the establishment publishes annual report or on the website of the establishment or in such annual report , subject to the provisions of rule 13 and section 11 of the Act.

13. (1) The Complaints Officer shall, if requested by a protected person who is part of any complaint, ensure the protection of the identity of the protected person in the following manner, namely:-

(a) the Complaints Officer shall file one copy of the document bearing the full name, identity and identifying details of such protected person which shall be kept in a sealed cover and in safe custody with the Complaints Officer;

(b) the Complaints Officer shall provide pseudonyms to protected person involved in complaints before him;

(c) the identity of protected person involved in complaints before the Complaints Officer and their identifying details shall be displayed in pseudonym in all documentation and records generated by the Complaints Officer and the establishment in relation to the complaints including in the register of complaints under sub-rule (4) of rule 10;

(d) the identity and identifying details of the protected person involved in a complaint before the Complaints Officer shall not be revealed by any person or their representatives including assistants and staff.

(2) No person shall print or publish any matter in relation to a complaint before a Complaint Officer unless the identity of the protected persons in the complaint is protected.

(3) The Complaints Officer shall comply with the data protection measures in accordance with the provisions of section 11 of the Act.

14. Every establishment which requires to appoint a Complaints Officer shall-

(a) on an annual basis, organise workshops and awareness programmes for sensitising its employees with the provisions of the Act and orientation programmes for the Complaints Officer;

(b) provide necessary facilities for the Complaints Officer for deciding the complaint; and

(c) make available such information as the Complaints Officer may require in deciding the complaint.

15. The appropriate authority under the Central Government shall-

(a) develop and disseminate information, education, communication and training materials to advance the understanding of the public generally and in particular of protected persons, civil authorities and healthcare workers of the provisions of the Act including relating to redressal of rights;

(b) formulate and disseminate orientation and training programmes that may be used by establishments in the training of Complaints Officers under sub-rule (2) of rule 9 and in the counselling of persons found to have violated the provisions of the Act and clause (b) of sub-rule (1) of rule 11;

(c) provide training for the establishments in high burden districts, in coordination with the appropriate authority under the State Government and their Complaints officers in such districts on the implementation of the Act and the rules and shall further provide such trainings on an annual basis;

(d) provide training for civil authorities, and healthcare workers including Accredited Social Health Activists and Anganwadi Workers in high burden districts, in coordination with the appropriate authority under the State Government in such districts on the implementation of the Act and the rules and shall further provide such trainings on an annual basis.

16. Nothing contained in these rules prohibits, limits or otherwise restricts the right of a person to other remedies provided under the Act or any other law for the time being in force to address violations of the provisions of the Act.

FORM

Form for making Complaint to Complaints Officer under rule 10

1. Date of Incident ____

2. Place of Incident ____

3. Description of incident _____

4. Person or institution responsible for the incident _____

Signature or Thumb Impression of Complainant*

Name: Date:

Mobile No. or email or Fax or Address:

For Official Use only:

Complaint Number: ____

**Where the complaint is received orally or telephonically and reduced to writing by the Complaints Officer, the Complaints Officer shall sign and date the Form.*

[F. No. T-11020/50/1999-NACO (P&C)]

ALOK SAXENA, Jt. Secy.

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