

ICTC TEAM TRAINING

TRAINEE'S HANDBOOK

April 2010



National AIDS Control Organisation

Prepared with support from

Population Council and UNICEF



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Foreword

HIV counselling and testing services have seen a remarkable scale up in recent years. Today, there are more than 7000 Integrated Counselling and Testing Centres (ICTC) providing Voluntary Counselling and Testing (VCT) services as well as Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) services in the country. The cost effective facility integrated model of ICTCs has proven to be highly useful in delivering HIV counselling and testing services to the rural hinterlands of the country and these are expected to be further scaled up in the next two years. Similarly, ICTCs under public private partnerships (PPP) are also expected to be scaled up so as to provide services to clients who access the private health care system. In all by 2012, it is expected that nationwide there will be 10,700 ICTCs under the stand alone, facility integrated as well as PPP models combined.

The remarkable scale up of ICTCs has resulted in an equally remarkable improvement in client uptake. In 2009-10 more than 14 million clients were counselled and tested in the ICTCs throughout the country. Today, more than 64% of the people living with HIV/AIDS in India are aware of their HIV+ve status. Nevertheless, there is still plenty of work to be done. There is an urgency to detect more people and link them with care, support and treatment services. Linkages between ICTCs and various other services within and outside the health system need to be strengthened. There is also a felt need to improve quality of counselling and testing services in ICTCs. All this can be achieved only through a clear understanding of roles and responsibilities by staff of the ICTC and through good team work. With these goals in mind NACO had requested UNICEF to develop a team training manual for ICTCs. This manual which consists of a trainers guide and trainees handbook is the result of 2 years of concerted effort on the part of Population Council, UNICEF and NACO and replaces the earlier PPTCT team training manual. In terms of content, presentation and methodology adopted, the manual is very comprehensive and user friendly. The manual will bring in role clarity for the Medical Officer in charge of an ICTC, the Counsellor as well as the Lab Technician. Further, it will usher in a standardized approach for training of staff in the health facility where an ICTC is located.

I take this opportunity to acknowledge the contribution made by Population Council and UNICEF in the production of this manual. I would like to particularly acknowledge the contribution of Dr. Melita Vaz, Programme Officer (Counselling) who while working in Population Council had written the first draft of the manual. During her stint in NACO, the manual was further fine tuned and field tested. I also acknowledge the contribution of Dr. Suresh K. Mohammed, National Programme Officer (ICTC) from NACO, Dr. Maharajan Muthu from UNICEF and Dr. Mary Sebastian from Population Council in the development of this manual. I would also like to thank the officers of the Basic Services Division in both Maharashtra and Uttar Pradesh SACS for the support given in the field testing of the manual. I hope the manual will help in budding a cadre of professionals who will deliver the highest quality of counselling and testing services in ICTCs across the country.


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अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ

Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing

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List of Abbreviations

AEB	Accidental Exposure to Blood
AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Treatment
ARV	Antiretroviral
AZT	Zidovudine
BCC	Behaviour Change Communication
BCG	Bacillus Calmette Guerin
CBO	Community-Based Organisation
CCC	Community Care Centre
CDC	Centers for Disease Control
CHC	Community Health Centre
CMV	Cytomegalovirus infections
CPT	Cotrimoxazole Preventive Treatment
CST	Care, Support and Treatment
CSW	Commercial Sex Worker
DAPCU	District AIDS Prevention and Control Unit
DBS	Dried Blood Spot
DHO	District Health Officer
DMC	Designated Microscopy Centre
DOTS	Directly Observed Treatment – Short course
DPT	Diphtheria, Pertussis, Tetanus
d4T	Stavudine
EID	Early Infant Diagnosis
ELISA	Enzyme-Linked Immunosorbent Assay
EQAS	External Quality Assessment Scheme
FBO	Faith-Based Organisation
FOGSI	Federation of Obstetricians and Gynaecologists Societies of India
FSW	Female Sex Worker
HBV	Hepatitis B Virus
HCP	Health Care Personnel
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IAP	Indian Association of Paediatricians
I/C	In-Charge
ICT	Integrated Counselling and Testing
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting/ Intravenous Drug User
IEC	Information, Education and Communication
IMA	Indian Medical Association
IND	Indinavir
LPV	Lopinavir
LT	Laboratory Technician
MAC	Mycobacterium Avium Complex
MCH	Maternal and Child Health Services

MO	Medical Officer
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NACO	National AIDS Control Organisation
NACP III	National AIDS Control Programme Phase III
NGO	Non-Governmental Organisation
NLF	Nelfinavir
NNRTI	Non-nucleoside Reverse Transcriptase Inhibitors
NRHM	National Rural Health Mission
NVP	Nevirapine
OI	Opportunistic Infection
OPD	Out-Patients Department
OPV	Oral Polio Vaccine
PCP	Pneumocystis Carinii Pneumonia
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Centre
PID	Patient Identification Digit
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnership
PPTCT	Prevention of Parent-to-Child Transmission
RMP	Registered Medical Practitioner
RNTCP	Revised National Tuberculosis Control Programme
RRC	Red Ribbon Club
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SOP	Standard Operating Procedure
SRL	State Reference Laboratory
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targetted Intervention
UNAIDS	Joint United Nations Programme on HIV/AIDS
USP	Universal Safety Precaution
VCT	Voluntary Counselling and Testing
VCTC	Voluntary Counselling and Testing Centre
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organisation
ZDV	Zidovudine
3TC	Lamivudine

Introduction to the Training Module

Introduction to the Training Module

Who does this training module address?

This training module is developed to meet the advanced training needs of health care personnel (HCP) working in the Integrated Counselling and Testing Centres all over the country. An ICTC team comprises a medical officer (MO), one or two counsellors, a laboratory technician (LT) and sometimes a nurse or an outreach worker. As the model of the ICTC is evolving into a facility-integrated model, it is likely that there will be health care personnel (HCP) who perform various different tasks. For instance, we already see trained nurses undertaking patient education and counselling after they have been suitably trained in HIV counselling. This training package use the term counselling personnel and testing personnel in recognition of this reality. The counselling personnel, testing personnel and medical officer will attend this team training together.

At this workshop, you will have an opportunity to meet colleagues from other ICTCs. Even though the ICTCs may be situated in different locations- some may be mobile ICTCs while others may be based at district hospitals or at Community Health Centres (CHCs)- the purpose of providing quality counselling and testing to help people identify their sero-status is common to all. In addition, your reporting formats too are the same.

What is the purpose of this training module?

As an ICTC team member you have probably already undergone induction training to your work. If you have been employed longer than a year, you have also attended refresher training. As per the Training Matrix in the Operational Guidelines for the ICTCs, this team training is scheduled to be held annually for ALL members of the team.

The purpose of this training, therefore, is not to repeat the information provided at the induction (though some overlap is unavoidable). Rather this training module aims to train you as ICTC staff about the day-to-day activities of the ICTC and the specific procedures to be followed. Moreover, since the ICTCs have been set up by integrating the Prevention of Parent to Child Transmission (PPTCT) services into what used to be Voluntary Counselling and Testing Centres (VCTCs), you would find some new information.

You may find, for example, that some information in your handbook is very basic. For advanced information related to your particular work function, you should refer to the participant's materials from your induction programme. At this ICTC team training programme, you will benefit from identifying what daily procedure materials are recommended for your work.

If you have not yet undergone an induction programme, please continue to read your training materials and ask questions during the training. Also, remember that this training workshop offers you a great opportunity to interact with colleagues from other ICTCs who have many years of experience can be very good resources for you. In this context, it is important to remember that as individuals with different professional backgrounds, we all have much to learn from each other. This is also an opportunity to get to know other members of your team, a task that is sometimes difficult given the quantum of work in some ICTCs.

Basic Structure of the Training

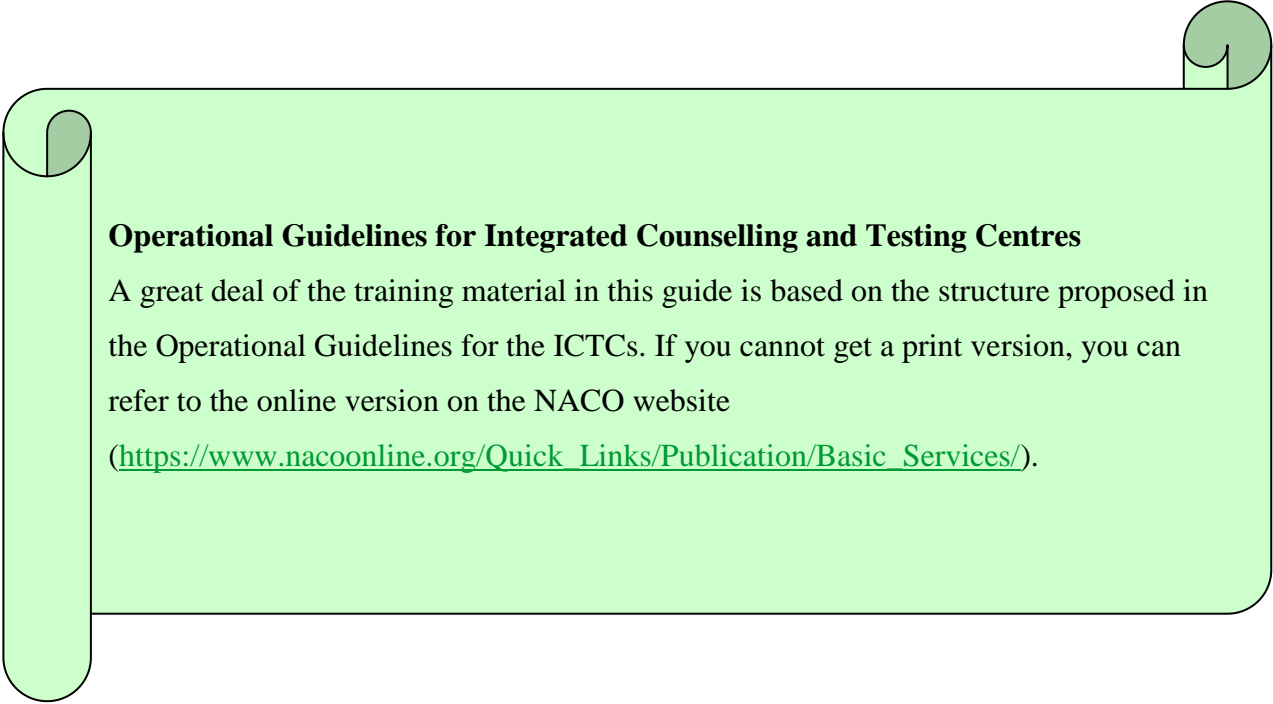
This training module covers 3 days.

- Day 1
 - Introduction to the workshop
 - ICTC Referrals and Linkages in the light of the National AIDS Control Plan III (NACP III)
 - Basic Information about Counselling
- Day 2
 - Basic Information about HIV Testing
 - ICTCs and the National TB Programme
 - Stigma and Discrimination, Universal Safety Precautions and Post-Exposure Prophylaxis
- Day 3
 - ICTCs and PPTCT Services
 - Enhancing the Work of the ICTC Team Including Documentation

The Trainee's Handbook contains write-ups that go along with each session in the workshop. The slides for each session is also included for your reference.

Programme Schedule

	Day 1	Day 2	Day 3
9.00 a.m.	Inauguration	Self-assessment Quiz on HIV/AIDS (20 minutes)	Here’s what we do at the ICTC (Presentation by Counselling personnel –PPTCT) (15 minutes)
	Tea	Tea	Tea
	Pre-workshop Questionnaire (15 minutes)	Planning Presentations for “Here’s what we do at the ICTC” sessions in Day 2 and 3 (30 minutes)	Prevention of Parent to Child Transmission Starter quiz (10 minutes) Lecture (45 minutes) Exercise (1 hour 30 minutes) Lecture on Documentation (20 minutes)
10.00 a.m.	Introduction of Trainees (20 minutes)	Here’s what we do at the ICTC (Presentation by testing personnel) (15 minutes)	
	Team-wise Introduction Exercise (30 minutes)	HIV testing at the ICTC (20 minutes)	
	Brief overview of programme (10 Minutes)	Here’s what we do at the ICTC (Presentation by Counselling personnel – non PPTCT) (15 minutes)	
11.00 a.m.	ICTC-Roles, Referrals and Linkages Ecomap (25 minutes) Large group discussion (20 minutes) Lecture (30 minutes)	Module: ICTC-TB Integration Lecture (30 minutes) Case discussion (30 minutes) Large Group discussion (1 hour)	
12.00 p.m.	Cases profile on ‘Do I need HIV testing’: discussions (45 minutes)		Here’s what we do at the ICTC (Presentation by MOs) (15 minutes)
1.00 p.m.	Lunch	Lunch	Lunch
2.00 p.m.	Wheels on the bus go round & round: Activity before session (1 hour)	Picture Perfect team: Team Exercise (1 hour)	Working as an ICTC Team Starter (25 minutes) Lecture (25 minutes) Documentation exercise (25 minutes) Team resolution (1 hour)
3.00 p.m.	Why do Patients Need Counselling? Starter exercise (20 minutes) Discussion (15 minuts) Lecture (25 minutes) Role plays on Provider Initiated Testing (1 hour)	Understanding and Managing Stigma and Discrimination People search (20 minutes) Discussion (20 minutes) Discussion of Discrimination Case Note (25 minutes) Lecture (35 minutes) Tree and its Branches: Activity (20 minutes)	
4.00 p.m.			
5.00 p.m.	Final Comments and Announcements	Final Comments and Announcements	Valedictory Session



Operational Guidelines for Integrated Counselling and Testing Centres

A great deal of the training material in this guide is based on the structure proposed in the Operational Guidelines for the ICTCs. If you cannot get a print version, you can refer to the online version on the NACO website

(https://www.nacoonline.org/Quick_Links/Publication/Basic_Services/).

ICTC: Roles, Referrals and Linkages

ICTC: Roles, Referrals and Linkages

Since HIV was first detected in 1986 in India, it has moved from urban to rural areas and from people who were regarded as “high-risk” due to their lifestyles the general population. Most affected are young people. Estimates show that in 2007 there were about 2.31 million people infected with HIV in India (data from NACO). The general HIV/AIDS prevalence rate is 0.34% – that is 34 persons in every 10,000 Indians are infected (data from NACO). However, about one-third of the districts in the country have high HIV prevalence, namely more than 1 in a 100 women using ANC services is infected with HIV. The number of districts categorised as A,B, and C would change from year to year. Please check NACO website for most recent information.

Table 1: Categorisation of districts based on HIV prevalence

Category	Criteria	Stage of Epidemic
A	HIV prevalence in more than 1% of ANC attendees in district	High Prevalence
B	HIV prevalence in more than 5% of any key population in the district and STI clients	Concentrated Epidemic
C	Increased presence of key populations	High vulnerability
D	No presence of key populations OR No data available	Low or unknown vulnerability

(Source: data from NACO, 2009)

What is the ICTC and what is its Role?

It is important for an individual who is infected with HIV to become aware of his/her status. Otherwise, he/she

- Could unknowingly transmit the virus to others
- Will not receive timely treatment.

The infected person can detect the presence of HIV through a simple blood test. However this diagnosis has many implications for the person, which underscores the need for counseling while testing for HIV. People who are found to be HIV-negative must be supported with information and counselling to reduce risks and remain HIV-negative while those who are found to be HIV-positive need psychosocial support and linkages to treatment and care services.

An Integrated Counselling and Testing centre is such a service where a person is counselled and tested for HIV, on his/ her own free will or as advised by a medical provider. The main functions of an ICTC include:

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

Types of ICTCs

At present, there are two models of ICTCs operating in the country:

- **Stand alone ICTCs:** These are centres with a full-time counselling personnel and testing personnel who undertake HIV counselling and testing. Such facilities exist in medical colleges, district hospitals and 30-bedded CHCs throughout the country.
- **Facility-integrated ICTC:** This type of ICTC does not have full-time staff and provides HIV counselling and testing as a service along with other services in the facility. The existing staff such as the auxiliary nurse midwife (ANM), staff nurse or health visitor undertake HIV counselling and testing. Such ICTCs are usually established in facilities that do not have a very large client load and where it would be uneconomical to establish

a stand-alone ICTC. Typically, such facilities are established in India in integration with the National Rural Health Mission (NRHM) in 24-hour Primary Health Centres (PHC).

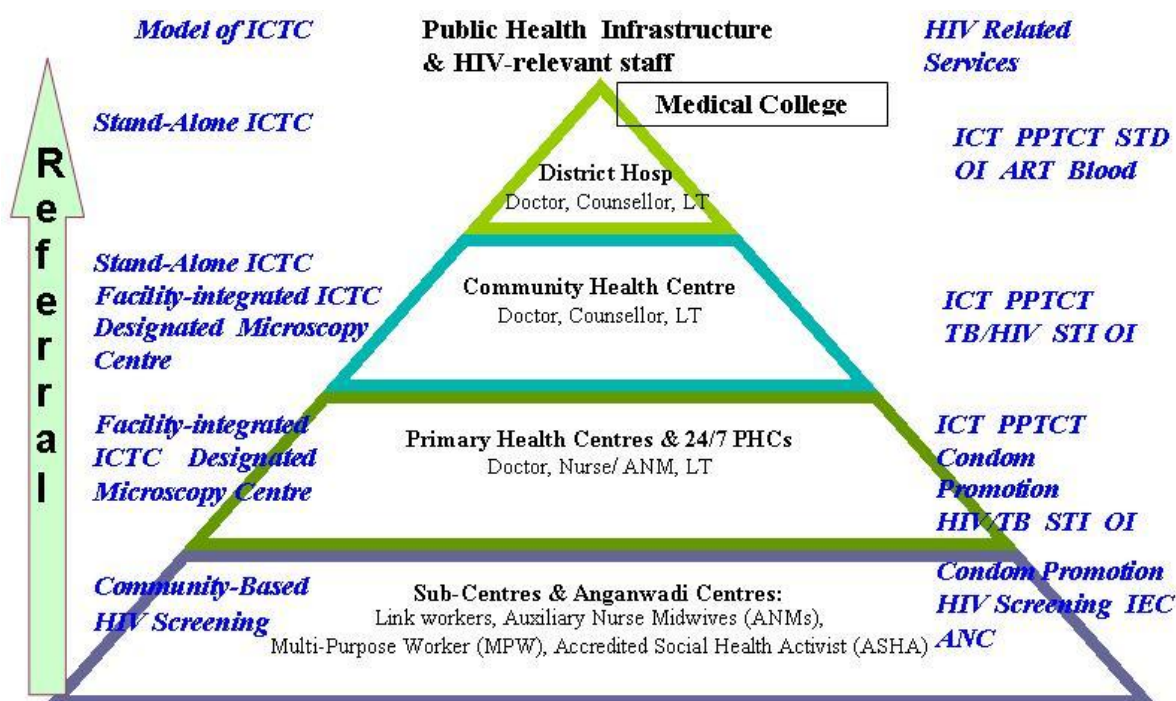
Less visible are **mobile ICTCs** which provide services to high-risk or vulnerable populations. These individuals are less likely to access ICTCs which are geographically fixed due to impediments such as distance and timing. Mobile ICTCs carry health services nearer to such groups. These centres consist of a temporary clinic with flexible working hours in hard-to-reach areas, where services cover regular health checks, syndromic treatment for STI/reproductive tract infection (RTI) and other minor ailments, antenatal care, immunization, as well as HIV counselling and testing services.

Where are ICTCs located?

Earlier, many ICTCs were located at big hospitals such as those attached to medical colleges. Now, ICTCs also exist at the district and block level so that more people can get the services which they provide. This need is reinforced by the fact that the epidemic has spread beyond urban communities and seeks to reduce travel time.

The diagram below also shows how NACP III aims to integrate HIV services with existing health facilities. The future expansion of ICTCs will be in the direction of more facility-integrated ICTCs at all levels of the health system which means that existing personnel provide HIV counselling and testing services. This is why the current training material uses the terms counselling personnel and testing personnel in place of counsellor and lab technician. It indicates that health care personnel in future may perform other functions in addition to testing or counselling.

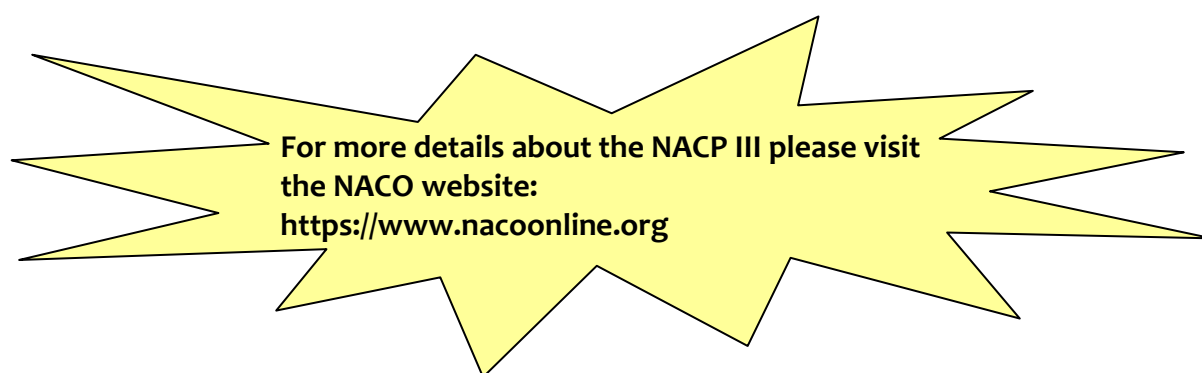
Besides 24-hour Primary Health Centres and Community Health Centres, facility-integrated ICTCs may also be found in the private sector in not-for-profit hospitals and non-governmental



health organisations which have a large clientele. This is in compliance with the national policy related to Public-Private Partnership (PPP). With steady expansion of the private sector into rural areas coupled with subsidies (through the *Janani Suraksha Yojana*), vouchers (in states like Gujarat and Karnataka) and health insurance policies, access to the private sector has increased. It is envisaged that through co-investment, private sector partners will provide space infrastructure, and staff for HIV testing services while NACO will train staff and provide uninterrupted supply of rapid HIV test kits, safe delivery kits, PEP drugs and IEC materials. The private sector partner will adhere to NACO ICTC guidelines and NACO reporting formats.

Further, there has been a great effort to increase the number of testing and treatment facilities in districts with high HIV prevalence. Also a District AIDS Prevention and Control Unit (DAPCU) is established to co-ordinate HIV/AIDS related activities more effectively in Category A and B districts.

Wherever an ICTC may be located – at a medical college, a district hospital, a CHC or a PHC; its mission is to identify people infected with HIV as early as possible and link them with the appropriate services so that they may prevent future illness or treat current illness in a timely manner.



Some Highlights of the National AIDS Control Programme Phase III (NACP-III)

NACP–III is the Government of India’s plan to stop and reverse the epidemic in India over five years by integrating programmes for prevention, care, support and treatment. This will be achieved through a four-pronged strategy:

1. Prevention of new infections in high-risk groups (HRGs) and the general population through:
 - a. Saturation of coverage of high risk groups with targeted interventions.
 - b. Scaled up interventions in the general population.
2. Providing greater care, support and treatment to larger numbers of People Living With HIV and AIDS (PLWHA).
3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.
4. Strengthening the nationwide Strategic Information Management System.

Prevention of new infections in high-risk groups and the general population

Interventions aimed at keeping individuals safe from being infected with HIV are termed **primary prevention**. There are three core High Risk Groups (HRGs). They are female sex workers (FSWs), men who have sex with men and transgenders (MSM and TGs) and injecting drug users (IDUs).

NACP III attempts to do this through programmes for key populations such as commercial sex workers, men who have sex with men and transgenders and injecting drug users. Targeted interventions (TIs) are programmes that recognise the unique vulnerabilities of these individuals and use suitable prevention strategies to effectively reach these individuals. They seek to bring them into the ambit of healthcare services, starting with testing at the ICTC.

In this context, it is also important to recognise bridge populations - people who are vulnerable to HIV infection because of their intimate interactions with people in the HRGs. These include sexual partners of sex workers, both male and female. Two groups with particularly high vulnerability are migrant workers and truckers and other workers in the transportation industry. These are very mobile populations who might be infected as well as pass on the infection because they are likely to have multiple sexual partners.

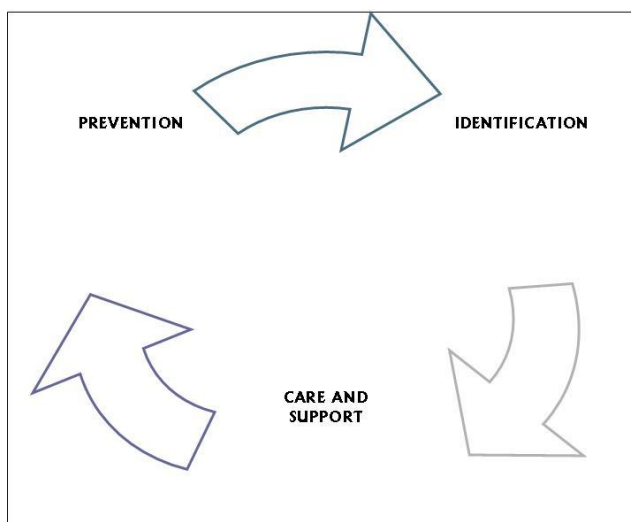
Interventions for the general population focus on raising their awareness of HIV. Among the general population, women, youth and adolescents are seen as most vulnerable

Providing greater care, support and treatment to PLWHAs

NACP III also provides care, support and treatment services to people living with HIV through a variety of facilities which are discussed in this section. When the disease is at an initial stage, disease management is **prophylactic** – namely to prevent Opportunistic Infections (OIs). This is also termed as **secondary prevention**. At a later stage, disease management involves treating the opportunistic infections.

The continuum between prevention and care

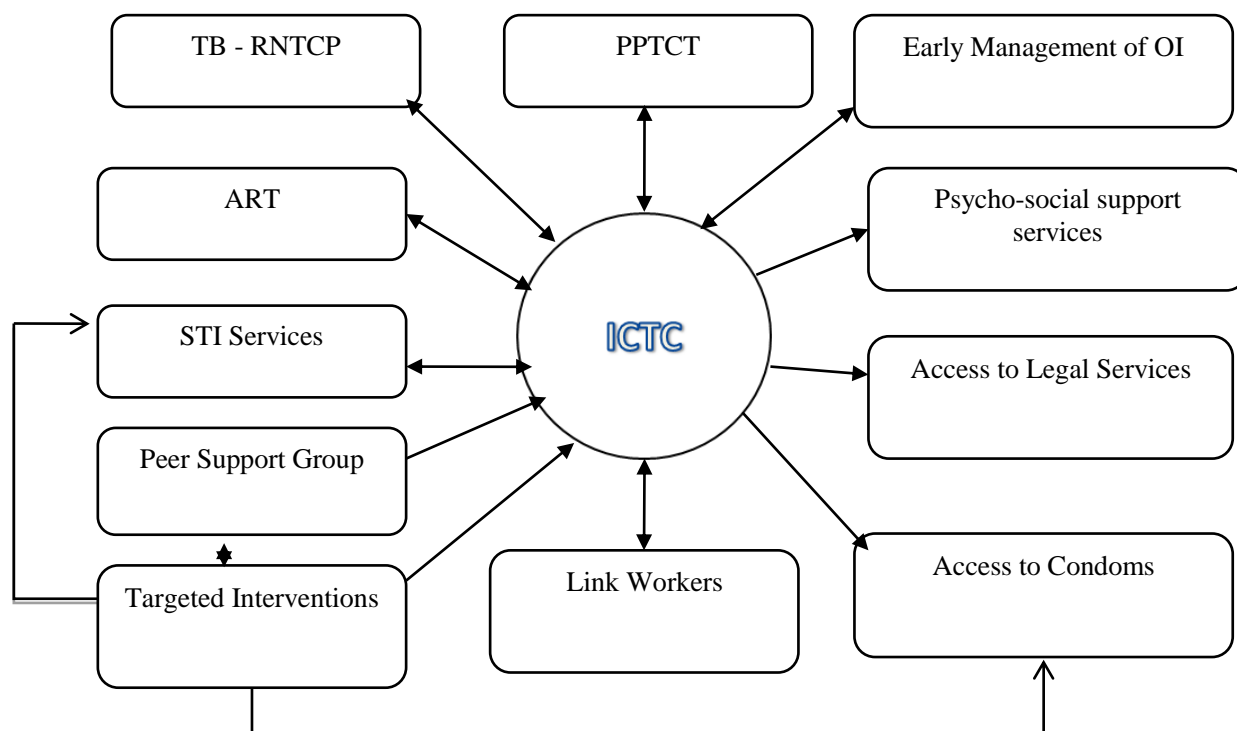
There is a continuum between prevention and care services (MacNeil & Anderson, 1998). Prevention activities help in reducing the number of people infected and in turn reduce the need for future care. Care and support activities, on the other hand, make HIV/AIDS visible in the general public and thus help to make it a “normal,” treatable and common experience. This way general population will become more aware of the disease and individuals become more likely to engage in protective and preventive behaviour as well as to seek testing.



For instance, knowing that a care service is available that provides affordable anti-retroviral treatment (ART) without judging the individual for their lifestyle and past deeds will make it more comfortable for a PLWHA to go to such a centre. Connecting up to such services means that PLWHAs are more likely to receive the treatment they need as well as to get information on how to reduce the chances of opportunistic infections. If they act on this information then others around them will also be safer.

Even though ICTCs are the entry-point for clients into the health system, they form part of a range of services, and must maintain good linkages with these other facilities and refer clients to these services as necessary.

The following figure points out the linkages between ICTCs and the other centres.



Targeted Intervention Projects

The most effective means of controlling the spread of HIV in India is through the implementation of Targeted Interventions (TIs) amongst people most vulnerable to HIV, such as female sex workers (FSWs), Men who have Sex with Men (MSM) & Transgenders (TGs) and Injecting Drug Users (IDUs). In addition the bridge populations of Truckers and Migrants also require focussed interventions.

NACP III has placed a high priority on full coverage of FSWs, MSM/TGs, IDUs, Truckers and Migrants with prevention and access to care services. The recent estimates state that more than 90% of HIV transmission in India accounts for unprotected sexual intercourse or sharing of injecting equipment between an infected and uninfected individual.

The Targeted Intervention projects are aimed at effective behaviour change among the people with high risk behaviours and their clients through behaviour change communication and safe sex and safe injecting interventions. Apart from prevention of HIV infection, TIs facilitate prevention and treatment of Sexually Transmitted Diseases as they increase the risk of HIV infection, and link the HIV infected to care, support and treatment services.

The major component of Targeted Intervention projects are

- Management of STI
- Behavioral Change Communication (Out reach, peer education, IEC etc)
- Referral and Linkages (STI, ICTCs, near by health services etc.)
- Condom promotion (Distribution of condom through non-traditional outlets, during out reach, Social marketing etc.)
- Enabling environment (addressing different vulnerabilities of HRGs such as violence, poverty, social discrimination etc)
- Community mobilization (CBOs, formation of different committees)
- Needle and Syringe Exchange Programme (for IDUs)

NACO recommends that all the HRGs covered by the targeted intervention projects to be tested for HIV at least twice in a year. The operational guideline for ICTC suggests that the counselors in ICTCs will undertake out reach work in order to increase the client coverage of ICTCs from the most vulnerable people to HIV. This may be seen as an opportunity for building better relationships with TI projects and increase the coverage of people who are at risk of HIV.

ART Centres

ART centers provide People Living with HIV/ AIDS (PLWHAs) a set of services including treatment and care. **All clients diagnosed with HIV should be referred to the nearest ART centre for assessment for ART and treatment.** When referred, the client must be informed about the services available at the ART Center and about the importance of adhering to the treatment.

Services available at ART centers include:

- Identifying eligible PLWHAs who require ART through laboratory services (HIV testing, CD4 Count and other investigations).
- Free ARV drugs to eligible persons with HIV/AIDS.
- Counselling services before and during treatment to ensure drug adherence.
- Education on nutritional requirements, hygiene and other preventive measures.
- Referral services for specialised services or admission.
- Condoms distribution.

Link ART Centres

Distance between home and the ART Centre is one factor affecting adherence of patients to ART. Link ART Centres minimise travel time for the patients on ART. They function as authorised drug distribution centers and are linked to a Nodal ART centre within accessible distance. Link ART centres function at some existing ICTCs and CCCs where the existing staff members undertake the responsibility of managing these.

Services available at Link ART Centers include:

- ART drug distribution
- Monitoring patients on ART for OIs, side effects, adherence and weight
- Referral services to ART centres for treatment of OIs, side effects of drugs, ANC care, etc.
- Psychological support
- Adherence counselling
- Health education on prevention of infections

Community Care Centre (CCC)

A Community Care Centre (CCC) is a facility for accessible, affordable and sustainable counselling, support and treatment of PLWHAs. The CCC is attached to an ART centre and act as a bridge between PLWHAs and the ART centre. It has a maximum capacity of 30 beds and provides services to PLWHAs such as

- In-patient care for 5 days for PLWHAs
- Out-patient facility for OIs and other illnesses related to HIV/AIDS
- Counselling for adherence

- Referral services to ICTC, PPTCT, Pediatric HIV services, ART Centre, medical facilities, DOTS centre and other required services
- Home based care
- Condom distribution

STI/RTI clinics

Treating Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) is an important HIV prevention strategy. All ICTC clients who have symptoms or signs of any STI or RTIs need to be referred to designated STI/RTI clinics or identified STI service providers under private sector for diagnostics and treatment services for STI/RTI. Additionally, all patients attending an STI/RTI clinic must be referred to ICTC for HIV testing.

Designated STI clinics under government sector are found at

- All Government Medical Colleges
- All District Hospitals
- Some Sub-district Hospitals in large volume districts.

STI clinics function within the skin and VD department of the facility or separately. All TI projects run STI clinics as part of the project. RTI clinics function within the gynaecology departments. Usually women with symptoms like vaginal discharge, are sent to the RTI clinics.

Services at STI/RTI clinics include:

- Syndromic management of STIs, which is diagnosis-based treatment depending on the symptoms present
- Laboratory tests like VDRL
- STI counselling
- Provision of medication
- Partner counselling and treatment
- Patient follow-up
- Syphilis screening services for all pregnant women at the RTI clinics

STI treatment services including medicines are also available with some identified STI service providers in the private sector.

TB clinics/Designated Microscopic Centers

Preventing and treating tuberculosis (TB) is another important HIV prevention strategy. For this purpose, all clients at of the ICTC should be screened for the presence of symptoms of TB irrespective of their HIV status. Clients who have symptoms or signs of TB should be referred to the nearest facility providing TB diagnostic and treatment services such as the DOTS centre, Designated Microscopic Centre, District TB Centre, etc.

Service available at TB Clinics include

- Diagnostic services such as sputum examination for pulmonary TB, chest x-ray if required or other investigations for extra pulmonary TB
- Treatment services such as DOTS and DOTS Plus
- Follow-up till the completion of TB treatment
- Linkages with ICTC, ART Centers and CCCs

Drop-In Centres (DIC)

Drop-In Centres have a very important role in ensuring continuity of care for PLWHA and their quality of life. These centres are run by Networks of PLWHA at the district or state level with support from NACO. They offer opportunities for HIV infected persons to come together, share and seek solutions to their problems, avail services and support and get directions for their lives. Services are offered in a peer-led, informal manner.

Depending on the availability of resources and requirements of PLWHAs, DICs can support the quality of life of PLWHA through:

- Peer support to cope with the infection and consequences
- Treatment education and adherence support
- Psychosocial support

- Legal support
- Nutrition and livelihood support
- Linkages to employment generation programmes, social welfare programmes, health care services etc
- Advocating for the protection of rights of PPLWHA
- Help in addressing stigma and discrimination
- Facilitate vocational or occupational rehabilitation
- Care and help in education of children affected by or infected with HIV

It is also to be noted that clients presenting symptoms of TB or STIs need to be referred and linked to the respective treatment services.

Focus on Children

It is estimated that 50,000 children below 15 years are infected by HIV every year. Recognising this, NACP–III seeks to strengthen preventive services as well as ensure early diagnosis and treatment of children infected with HIV. Prevention of Parent to Child Transmission (PPTCT) focuses on prevention of the transmission of the infection to children. The care and support element involves developing comprehensive guidelines on paediatric HIV care for each level of the health system and special training for counselling HIV positive children.

What ICTCs can do to Increase their Client Coverage

While the ICTC is the first stop of a person seeking HIV care few people who need such services are actually likely to see themselves at risk, or in need of services. It has been estimated that only one in three infected persons is aware of his/her sero-status, which indicates that there is a vast unmet need for testing services.

In order to ensure that ICTCs are fully utilised by the people, it is important to build up referrals of clients from other health units within the public health system as well as organisations which are working with people and groups vulnerable to HIV.

In addition to clients who walk in to the centre on their own volition, the ICTC should, build up referrals of, and reach more effectively to:

1. Patients at a health service who have symptoms which could be due to HIV infection (e.g., pneumonia, tuberculosis, persistent diarrhoea).
2. Patients at a health service who have conditions that develop due to the same vulnerabilities as HIV (e.g., STI/ RTI).
3. Pregnant women who come to ANCs or who come to health centres to deliver their babies.

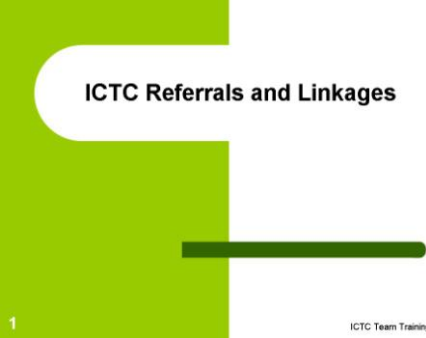
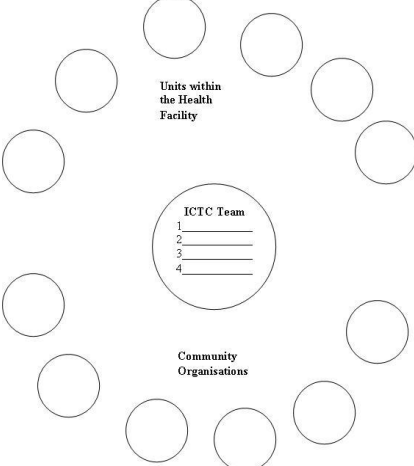
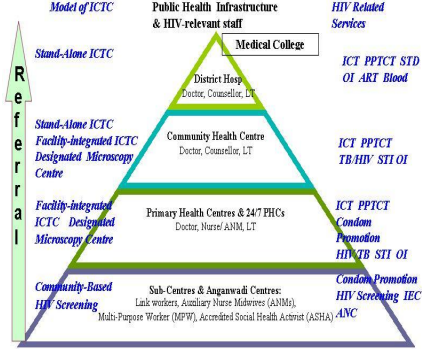
It is not the mandate of the ICTC to test everybody in the general population. Populations who are more vulnerable to HIV or who practise high risk behaviour are in need of ICTC services.

This handbook includes NACO's Healthcare Provider Tool which is a handy guide for HCP who can make such referrals to the ICTC. It contains information about signs and symptoms that should alert a provider to the need for HIV testing and the kind of information they should give to the patients. It can be used as a tool to educate providers who could refer patients.

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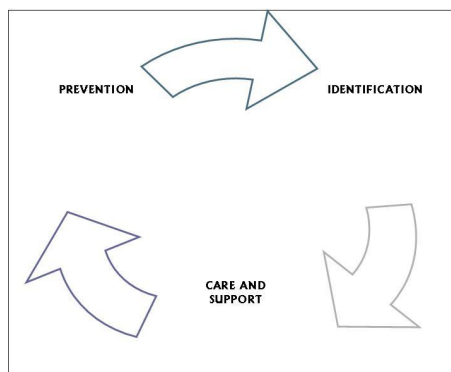
SLIDES

<h3>ICTC Referrals and Linkages</h3>  <p>1</p> <p>ICTC Team Training</p>	 <p>Units within the Health Facility</p> <p>ICTC Team</p> <p>1 2 3 4</p> <p>Community Organisations</p>
<h3>Discussion Questions</h3> <ul style="list-style-type: none"> • What kind of patients does your ICTC generally serve? • Do you know how far they come from and how they travel? • From which hospital units do your ICTC clients usually come from? • From which community organizations do your ICTC clients mostly come? • To which hospital units do you refer your clients? • To which community organizations do you refer your clients? • The ICTC may refer patients to other units. But how would you know if they are reaching there? 	<h3>Main Functions of an ICTC</h3> <ul style="list-style-type: none"> • Early detection of HIV. • Provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioural change and reducing vulnerability. • Linking people with other HIV prevention, care and treatment services.
<h3>Types of ICTCs</h3> <ul style="list-style-type: none"> • Stand-alone ICTCs • Facility-integrated ICTCs 	 <p><i>Model of ICTC</i></p> <p>Public Health Infrastructure & HIV-relevant staff</p> <p>Stand-Alone ICTC</p> <p>Medical College</p> <p>District Hosp</p> <p>Doctor, Counsellor, LT</p> <p>Facility-integrated ICTC</p> <p>Community Health Centre</p> <p>Doctor, Counsellor, LT</p> <p>Facility-integrated ICTC Designated Microscopy Centre</p> <p>Primary Health Centres & 24/7 PHCs</p> <p>Doctor, Nurse/ANM, LT</p> <p>Community-Based HIV Screening</p> <p>Sub-Centres & Anganwadi Centres:</p> <p>Link workers, Auxiliary Nurse Midwives (ANMs), Multi-Purpose Worker (MPW), Accredited Social Health Activist (ASHA)</p> <p>HIV Related Services</p> <p>ICT PPTCT STD OI ART Blood</p> <p>ICT PPTCT TB/HIV STI OI</p> <p>ICT PPTCT Condon Promotion HIV TB STI OI</p> <p>Candm Promotion HIV Screening IEC ANC</p>

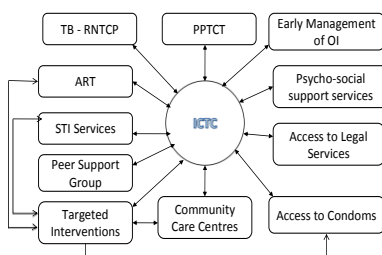
Overall goal of the NACP III is to halt and reverse the epidemic in India over five years:

- Prevention of new infections in high risk groups and general population.
- Providing greater care, support and treatment to larger numbers of PLWHA.
- Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.
- Strengthening the nationwide Strategic Information Management System.

Continuum between Care and Prevention



ICTC and its Linkages



ART Centres

All clients diagnosed with HIV should be referred to the nearest ART centre for assessment for ART and treatment.

Services available at ART centers include:

- Identifying eligible PLWHAs who require ART.
- Free ARV drugs to eligible persons with HIV/AIDS.
- Counselling for adherence.
- Education on nutritional requirements, hygiene & other measures.
- Referral services for specialised services or admission.
- Condom Distribution

Link ART Centres

Services available at Link ART Centers include:

- ART drug distribution and treatment
- Monitoring patients on ART for OIs, side effects, adherence and weight
- Referral services to ART centres for treatment of OIs, side effects of drugs, ANC care, etc.
- Psychological support
- Adherence counselling
- Health education on prevention of infections

Community Care Centres

A CCC provides services to PLWHAs such as

- In-patient care for 5 days for PLWHAs
- Out-patient facility for OIs and other illnesses related to HIV/AIDS
- Counselling for adherence
- Referral services to ICTC, PPTCT, Paediatric HIV services, ART Centre, medical facilities, DOTS centre and other required services
- Home based care
- Condom distribution

<p>Targeted Intervention Projects</p> <p>The major component of Targeted Intervention projects are</p> <ul style="list-style-type: none"> ❖ Management of STI ❖ Behavioral Change Communication (Out reach, peer education, IEC etc) ❖ Referral and Linkages (STI, ICTCs, near by health services etc.) ❖ Condom promotion (Distribution of condom through non-traditional outlets, during out reach, Social marketing etc.) 	<p>Targeted Intervention Projects (contd..)</p> <ul style="list-style-type: none"> ❖ Enabling environment (addressing different vulnerabilities of HRGs such as violence, poverty, social discrimination etc) ❖ Community mobilization (CBOs, formation of different committees) ❖ Needle and Syringe Exchange Programme (for IDUs)
<p>Drop-In Centres</p> <p>Drop-In Centres are run by Networks of PLWHA and provide these service:</p> <ul style="list-style-type: none"> • Peer support to cope with the infection and consequences • Treatment education and adherence support • Psychosocial support • Legal support • Nutrition and livelihood support • Linkages to social welfare programmes, health care services etc • Advocating for the protection of rights of PLWHA • Help in addressing stigma and discrimination • Facilitate vocational or occupational rehabilitation • Care and help in education of for children living with HIV/AIDS 	<p>STI/RTI Clinics</p> <ul style="list-style-type: none"> • Patients coming to STI/RTI clinics must be referred to ICTC for HIV testing • All ICTC clients with signs of any STI/RTI must be referred to designated STI/RTI clinics for diagnostics and treatment services. <p>Services at STI/RTI clinics include:</p> <ul style="list-style-type: none"> • Syndromic management of STIs • Laboratory tests like VDRL • STI counselling • Provision of medication • Partner counselling and treatment • Patient follow up • Syphilis screening services for all pregnant women at the RTI clinics
<p>Discussion Questions</p> <ul style="list-style-type: none"> • At present, with which health facilities and organisations does our ICTC not have STRONG linkages? • What can the ICTC team members do to build strong linkages? 	<p>Discussion Questions</p> <ul style="list-style-type: none"> • Who are the people who should be coming to our centre for HIV counselling and testing? • How can we increase our patient load?

<p>HIV spreads through four principal modes:</p> <ul style="list-style-type: none"> ➤ through unprotected sex between a man and a woman or between two men (when one partner is infected); ➤ through transfusion of blood that is infected ➤ through using infected syringes and needles; ➤ from an infected mother to her child during pregnancy, child birth or breastfeeding. <ul style="list-style-type: none"> • If a person is exposed to HIV through any of these routes, they should get tested. 	<p>Who Needs Testing</p> <ul style="list-style-type: none"> • Clients who walk in to the centre on their own <p>ICTC should also build up referrals of:</p> <ul style="list-style-type: none"> • Patients with symptoms which could be due to HIV infection. • Patients with conditions that develop due to the same vulnerabilities as HIV. • Pregnant women who come to ANCs or who come to health centres to deliver their babies. • People belonging to high risk groups like sex workers, injecting drug users and men having sex with men and bridge populations like high risk migrant workers, truckers and partners of sex workers/MSM/TGs . • Patients diagnosed with TB <p>It is not the mandate of the ICTC to test everybody in the general population. Populations who are more vulnerable to HIV or who practise high risk behaviour are in need of ICTC services.</p>
<p>Health care Provider Tool</p> <p>See Page 121 to 122</p>	<p>Exercise: Do I Need HIV Testing</p> <ul style="list-style-type: none"> • Does the person in the case need HIV testing? • Explain why. • Is there anyone else in that situation who also needs testing (e.g., a sexual partner)?

A Brief Refresher on HIV/AIDS

A Brief Refresher on HIV/AIDS

What is HIV?

HIV stands for

Human: refers to the fact that the virus only affects human beings (it is species-specific).

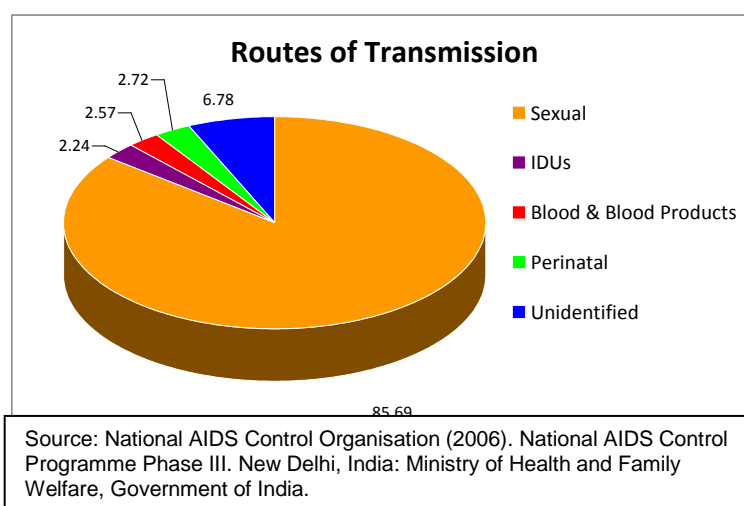
Immunodeficiency: refers to the weakening of the immune system – the system that defends the body against illnesses.

Virus: refers to the micro-organism that causes the immune system to weaken. This virus belongs to the family of retroviruses – an uncommon type of virus.

Modes of Transmission

HIV/AIDS spreads through four ways only

1. Sexual Route: This includes anal, vaginal or oral sex between a man and a woman, or anal and oral sex between a man and a man where one partner is infected with HIV.
2. Parental/ Vertical Route: This means the virus passes from an infected mother to her child before delivery, during delivery, and through breast milk (however, given the non-availability of safe drinking water to prepare bottle feeds, it is still safer in India for the child to be breast-fed exclusively for 6 months. Transfer of virus through exclusive breastfeeding is less compared with mixed feeding- both breastfeeding and bottle feeding at the same time).
3. Blood Route: This refers to HIV transmission through infected blood and blood products (There is a government policy that all blood and blood products should be tested)
4. Or through sharing needles and syringes with an infected person. This route also includes tattooing, ear piercing and acupuncture which involve needles.



The most common route of transmission is through sexual contact.

HIV cannot be passed on through any of the following:

- Coughing or sneezing
- Insect bites
- Touching or hugging
- Drinking water or preparing or eating food
- Kissing
- Shaking hands
- Working along side an HIV-infected person
- Sharing cups, glasses, plates or other utensils.

Symptoms of HIV at different stages of Infection:

Early Symptoms: One to four weeks

Early Symptoms include swelling of the lymph nodes, headache, fever, loss of appetite, sweating and sore throat. Often this can be mistaken for flue or another viral infection. Sometimes, an

infected person may develop skin rashes on the chest, abdomen and/or back. This period is called the window period and HIV test will not give a positive result despite the person having HIV infection. In some people, the window period may be as long as 3 months.

Seroconversion: Second stage

Symptoms of HIV in this second stage usually occur anytime after four weeks of having contracted the infection. Seroconversion is the point at which antibodies to HIV can be detected in a blood test. At this stage, an infected person's body has produced enough antibodies specific for the HIV virus: white blood cells called B lymphocytes. However, people will lead a fairly healthy life where no symptoms are present. It may take five years or more before a person develops any physical signs. It is the person's large amount of CD4 cells (helper cells which support immune system, by helping to fight viruses) that determines this. Immune system trying to battle the HIV infection eventually weakens and makes the person more susceptible to opportunistic infections. The actual length of this asymptomatic period differs from one person to another. For instance, the asymptomatic period is shorter for children. Other factors that affect this are general health, nutritional condition of the patient and the type of virus (sub-type HIV 1 which is more common in India has a quicker progression than the sub-type HIV 2).

Last Stage: AIDS and Opportunistic Infections

AIDS is the most advanced stage of HIV infection. The infected person becomes susceptible to (opportunistic) infections frequently.

AIDS stands for

Acquired: Refers to how a person gets infected with HIV, that is acquired as different from inherited or genetic.

Immune Deficiency: The terms *Immune* and *Deficiency* refer to the systemic effect of HIV on the body's capacity to fight illness.

Syndrome: Refers to the group of symptoms or illnesses that together indicate a person is infected with HIV and has reached an advanced stage of the illness.

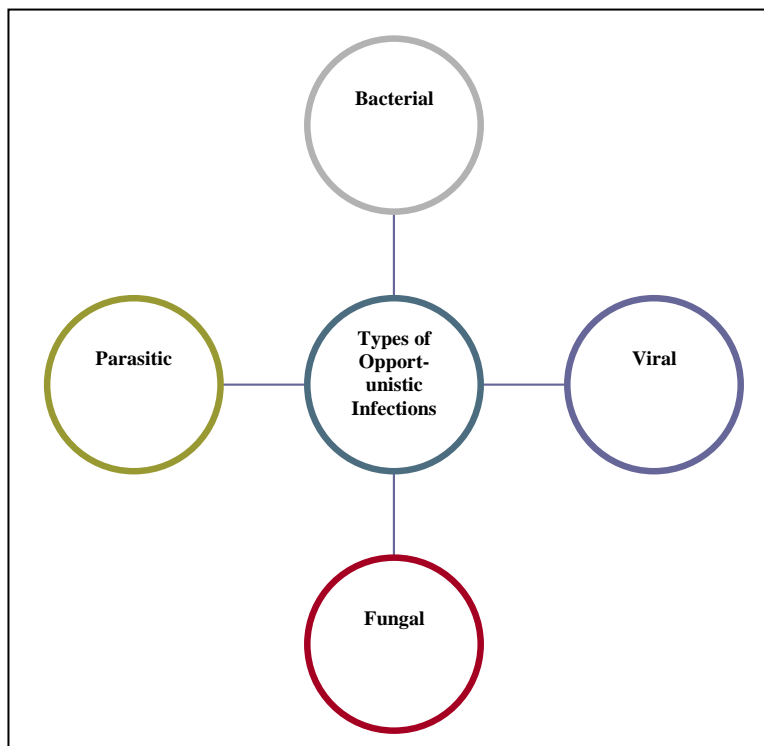
It is particularly difficult for HIV-infected individuals to fight off HIV infection for the following reasons:

1. HIV affects the body's defence system itself
2. HIV replicates in large numbers which overwhelms the body's defence system
3. HIV can mutate (change) itself

The infections in an HIV-positive person are termed as opportunistic infection because in a non-infected person they are unlikely to cause illness. Early symptoms/illnesses occur usually when a person has a CD4 count of 300 or below, but can happen at even higher CD4 counts. Some of the infections can be life threatening in a person with AIDS. A person whose CD4 count is below 200 is said to be having AIDS.

Opportunistic Infections

Opportunistic infections can be either caused by bacteria like tuberculosis (TB), respiratory infections and pneumonia; virus like Herpes and flu; parasites like diarrhoea and pneumonia or it can be fungal like skin infections and thrush. The infections that an HIV positive person will get may not be caused by micro organism causing infection in a sero negative person. For example, pneumonia in sero-positive person is seen to be caused by bacteria, virus and parasites. In India, for example parasite Isoporiasis causes diarrhoea in 40 percent of PLWHA with an average of 3 episodes/year. TB is one of the commonest opportunistic infection. Opportunistic Infections in Children Living with HIV/AIDS may look slightly different from the clinical picture in adults. For instance, some common ailments in younger aged patients include dermatitis, bacterial meningitis, anaemia, varicella disseminated (complicated chicken pox), herpes simplex virus, bronchitis and oesophagitis



HIV Testing

Most tests to detect HIV like the ELISA are based on detecting antibodies against HIV. So they will fail to correctly recognise people who are in the window period when antibodies are yet to be developed. In this period, an infected individual's test will be negative though s/he may be infected. This is called a false-negative.

Thus, at the ICTC, risk assessment is important process to find out the last possible time when a person might have been exposed to HIV infection. If it appears to be likely that they may be in the window period, then they should be counselled to repeat the test later.

NACO Policy endorses the use of rapid tests in the ICTC. Here, in principle, a patient will be able to give a blood sample for testing in the morning and leave with the test result (and the accompanying counselling and referral) the same day. NACO also endorses the 3-test algorithm which is discussed in the section on HIV Testing.

The advantages of the rapid screening test as compared with the traditional ELISA method are:

1. The result is ready on the same day, so a client who comes in for testing does not have to make more than one visit to the ICTC.
2. Providers need not waste their time tracking down test results days after the test was done.
3. Rapid tests are cost-effective because they do not need special laboratory equipment and can be conducted in the clinic setting.
4. There is less potential for specimen getting mixed up and the consequent loss and wastage of time.

Risk Assessment

Risk assessment is a key aspect of HIV/AIDS Counselling. Here counselling personnel ask various questions about the client's behaviour in order to assess whether he/ she is at risk of HIV infection. Questions cover the client's sexual practices, drug use behaviours, occupational practices and whether they have received a transfusion of blood or blood products (other rarer instances of exposure involve receiving organ transplants or artificial insemination.)

Clients often raise questions about various possibilities for how HIV may have entered their system. A common story circulating on the internet and the newspapers is about being pricked by a blood-filled syringe in a cinema hall that bears a message that it is filled with HIV. Some stories are more believable than others.

One way to explain the process of HIV transmission was described by E.M. Armstrong (See Dixon, 1993). According to Armstrong, "We can envisage transmission in terms of a 'chain' which must not be broken in any place if infection is to occur." For the virus to be passed on to another person, three conditions must be present:

- There must be an adequate quantity of the virus present to cause the infection. This description fits blood, semen and cerebrospinal fluid which have high concentrations of virus.
- The virus must be of a suitable quality to cause infection, that is undamaged by heat, bleach, or chemicals (such as acid)
- There must be a suitable route for the virus to reach the particular cells for which it has an affinity – namely the CD4 cells and the macrophages which are found in tissues lining the vagina and the foreskin. This is through sex, blood transfusions and from a pregnant mother to her unborn child.

NACO's HIV Counselling Training Module (2006) describes the following as the four principles of HIV transmission (page 89):

- **EXIT:** The virus should have an exit point where it can leave the body of the infected individual.
- **SURVIVE:** The virus should be in an environment where it can survive.
- **ENTER:** The virus should have a point of entry to the bloodstream of another person.
- **SUFFICIENT:** The amount of virus should be enough to cause infection.

Measuring the Progress of HIV Infection

There are two measures of the progression of HIV disease:

1. **Viral load** refers to the amount of HIV in the blood. It is measured by the HIV ribonucleic polymerase chain reaction (PCR) and is an independent predictor of the progression of the HIV infection in the individual. Viral load is very high just after primary infection. It is also very high during the final stage, namely AIDS. A high viral load means the person has a greater capacity to transmit infection to others through the four routes of transmission. The PCR test is used to judge the effect of ART.

A result below 10,000 is considered low and a result over 100,000 is considered high. If the viral load is high, the health care provider may consider switching the patient to another drug therapy. Viral load test results are best used if result trends are studied and compared over time. If the viral load is observed to increase over time, then the drug treatment may need to be changed. If the viral load goes down over time, one could conclude that the ARV treatment is working. At present, the meaning of a test result between 10,000 and 100,000 is not clear. That is why trends in viral load tests are of much greater value.

2. **CD4 count** refers to the number of CD4 cells in the blood of the sero-positive person. These are the cells that are attacked by HIV. So a low amount in a Person Living with HIV/AIDS (PLWHA) means that their immune system is being affected by the virus and their disease is progressing (that is, their health is becoming worse). The normal count in

a healthy adult is between 600 and 1200 cells per cubic millimetre blood. A low count is one below 200 cells per cubic millimetre blood.

Thus a low CD4 count and high viral load is a sign of poor health. Low viral load and high CD4 is a sign of relatively good health.

Once an ICTC client tests positive, he/ she should be referred to treatment services at the ART as well as tuberculosis detection to rule it out as an OI. Through the ART centre, the patient can access tests that measure the viral load and the CD4 count.

Antiretroviral Treatment

Drugs which disrupt the action of the HIV are called anti-retrovirals (ARV). These come in different formulations and are designed to act during different stages of the viral life-cycle.

Early prophylaxis (preventive treatment) and treatment of OIs can delay the onset of AIDS. Antiretroviral treatment (ART) can also help delay the breakdown of the immune system by attacking the virus directly. This, however, has a limited effect in curbing the levels of virus in the body.

Some other commonly used terms are **HIV-infected** and **HIV-positive**. HIV-infected refers to a person infected with the virus while HIV-positive means an infected person who has undergone a diagnostic test and whose test result detects the infection. In this handbook, the term **sero-positive** has also been used to mean HIV-positive, and **sero-status** refers to knowing whether one is infected or not. You may also hear the term PLWHA which means **People Living with HIV/AIDS**. This is a term to constantly remind us that we are dealing with human beings who have feelings and whose lives are disturbed by the virus.

Interrupting the Progress of HIV Infection

At present the treatment for HIV can only dramatically SLOW down the spread of HIV in the body IF taken properly and ALMOST halt its progression. It cannot cure the infection (make the person completely free of the virus). People on such anti-retroviral treatment need to take the drugs consistently and continuously.

Such treatment consists of a combination of medicines that when taken together make it difficult for the virus to adapt and damage the immune system. It is important to take such antiretroviral treatment (ART)

- Everyday
- At the right time
- In the right way

Missing a dose can increase the possibility of the virus becoming resistant.

Some of the medicines produce side effects like nausea and vomiting or headaches. These side effects become less troublesome when patients adjust to taking the medicine. Some specific medicines cause more serious side effects such as redistribution of the body fats.

There are several classes of drugs:

- Nucleoside Reverse Transcriptase Inhibitors
These inhibit reverse transcriptase – a substance needed by HIV to duplicate its genetic material.
- Non-Nucleoside Reverse Transcriptase Inhibitors
These drugs also inhibit reverse transcriptase.
- Protease Inhibitors
These drugs block protease – a substance that helps HIV to multiply.
- Other drugs
Other drugs are available that interfere with other aspects of the HIV life cycle.

Often the first combination of drugs taken by the patient fails as HIV begins to adapt to the medicines. When this happens, the patient's viral load will go up and CD4 count will go down. To keep the person healthy, a new combination of drugs must be prescribed. These are termed as first-line and second-line antiretroviral drugs.

It is important to note that ART does not prevent HIV from spreading to sexual partners of a PLWHA, or to children through the vertical route, or through blood or organ donations.

Along with the medical treatment PLWHAs need constant psycho-social support from family, community and HCP.

Other Kinds of Care

Besides ART, PLWHAs can also remain healthy by preventing the onset of OIs. This can be done through prophylactic treatment such as cotrimoxazole. This can also be achieved through early identification and treatment of OIs. There is a programmatic integration of services for TB and STIs with those available for HIV/AIDS.

HIV Vaccines

As of date the research related to vaccines has not been very promising. Prevention through behaviour change is the best hope.

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Why do Patients Need Counselling

Why do Patients Need Counselling

The aim of the current workshop is not to train staff in how to do counselling. For this there is specific induction training in counselling. However, this section of the handbook is trying to clarify why HIV/AIDS counselling is a necessity, and not a frivolous luxury.

What does counselling do?

Counselling is a helping process where one person, explicitly and purposefully gives his/ her time, attention and skills to assist a client to explore their situation, identify and act upon solutions within the limitations of their given environment (World Health Organisation, 1993).

The ICTC Operational Guidelines defines it as a “confidential dialogue between a client and a counsellor aimed at providing information on HIV/AIDS and bringing about behaviour change in the client. It is also aimed at enabling the client to take a decision regarding HIV testing and to understand the implications of the test results (p. 15).”

Confidentiality is an important element in the process because this is a right of the client. Ensuring confidentiality and assuring the patient of this will make it more likely that the patient will honestly discuss their intimate behavioural concerns. While counselling is often done in a formal setting by a designated counselling personnel, in public, the client’s first contact may be with a nurse or a peer educator.

HIV/AIDS Counselling has two different focus points:

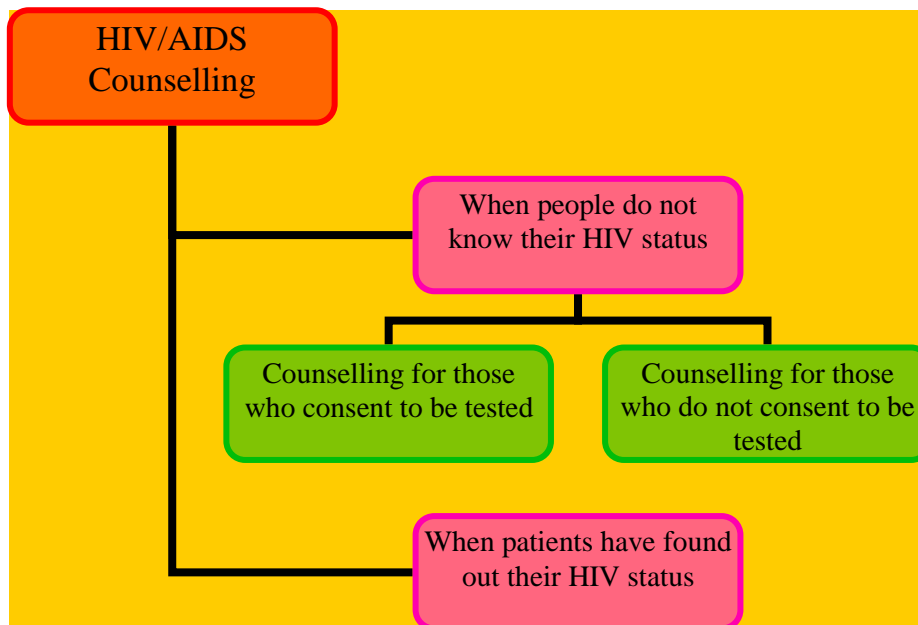
- For people who may be infected but who do not know their status, the HIV counselling personnel helps them to process the reasons why it may be a good idea to get tested.
- For those who know they are infected, the counselling personnel is a source of psychosocial support.

HIV Counselling in the ICTC

In the context of the ICTC, the purpose of HIV counselling is to help patients or clients who are referred for testing or those who come voluntarily for testing to understand why and how testing might help them, and to support them through the decision-making required to get tested or not.

- For patients who opt out of testing, counselling covers the implications of such opting-out and will help them adopt safe behaviours to prevent any future infection to them and others. When patients consent to being tested, counselling guides them through the events in the testing process and will later help them absorb the results of the HIV test.
- For a negative test result, counselling points include behavioural change related to reducing future risk of infection (that is “What should you do to remain negative?”), and to minimise any risky behaviour that might result from the relief of getting a negative test outcome.
- Sometimes, counselling personnel find out through a risk assessment of the client’s behaviour that there was a possible HIV exposure in the last 6 weeks before testing (e.g., a sexual act with a sex worker or an MSM partner or sharing of needles). This means that person could be in the window period where a rapid anti-body based test would show a false negative – absence of antibodies when the person is actually infected. Counselling here would also include scheduling another HIV antibody test.

In case of a positive test result, counselling offers support in absorbing the bad news. Ten to fifteen years ago, knowledge of being HIV infected was almost certainly a death sentence. However, scientific improvements have made it possible for People Living with HIV/AIDS to live longer and much healthier lives than their counterparts in the earlier phase of the AIDS pandemic. A counselling personnel can offer hope at this point and direct the person to resources such as ART centres.



The advantages of knowing your sero-status

There are many advantages to knowing one's HIV status:

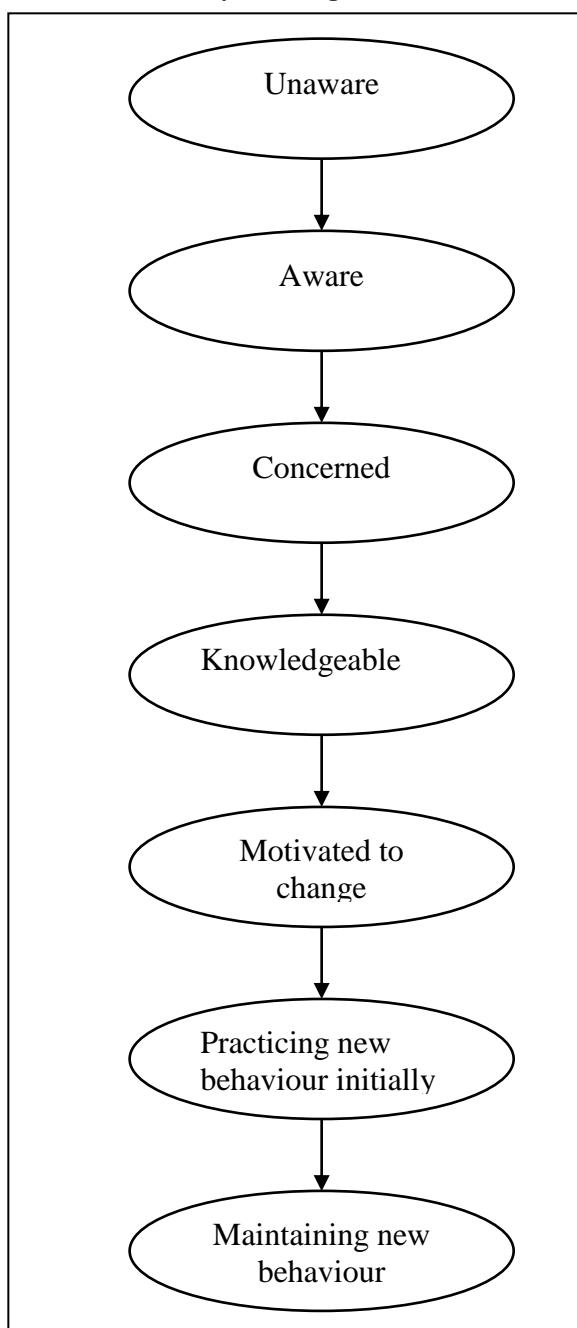
1. A person who knows his/her status early has the advantage of being referred for appropriate medical treatment early. This includes
 - a. prophylaxis (preventive treatment) against opportunistic infections (e.g., cotrimoxazole),
 - b. early detection of opportunistic infections (e.g., TB),
 - c. curative treatment for opportunistic infections or antiretroviral treatment to slow down the effect of HIV itself.
2. He/ she can take precautions to protect their sexual partners, or in the case of pregnant women, their unborn child (i.e., PPTCT).
3. Finally, a Person who is Living with HIV/AIDS can also take precautions about being re-infected with another strain of HIV.

People have the right to know their HIV status so that they can protect themselves and others. It has been seen that this knowledge often pushes people to change their risky behaviours in the direction of safer ones. Clients can choose to share the knowledge of their diagnosis with others and obtain social support, though the act of disclosure has often been seen to cause stigma and discrimination, even within families.

HIV counselling makes good sense for all concerned.

Understanding Behaviour Change

Underlying HIV counselling is the theoretical premise of stages of change: The individual is viewed as moving through a series of steps. Sometimes, progress is backwards or negative. But the movement may be along a continuum of being unaware initially about the problem, to



becoming aware to begin with and then concerned. Concern may propel the person to seek knowledge which might in turn motivate him/ her to change. The person may also skip steps along this continuum.

Counselling can help the person move from one step to another in a more orderly fashion. While information-giving is part of the process, moving from being aware to wanting to change behaviour is influenced by more than just information. For instance, we may disbelieve the information, or we may accept the information but not believe that we are capable of change, or we may not think that we need to change. In addition to information, counselling must also include social support which can build the individual's confidence to try new behaviours, and must try to address specific barriers in the person's situation.

Trying to change behaviour is not easy. Human habits and actions are influenced by personal beliefs and social norms. These must be considered in counselling. Further, there might be many reasons why a particular behaviour persists. In the area of sexuality, some behaviours persist because they are pleasurable. Some persist because the individual does not know of alternatives. Also, it is difficult to change behaviour when appropriate resources are missing. For instance, advising a sex worker to use a different female condom with each new client is useless if it is not available locally.

The HIV Counselling Training Modules for VCT, PPTCT and ART Counsellors (NACO, 2006) describe 3 models of behaviour change:

1. **Risk Elimination Model:** The example here is the "Just Say No to Drugs" campaign. Such an approach emphasizes total abstinence from an undesirable behaviour.
2. **Risk Reduction Model:** This model recognises the difficulties inherent in trying to totally suppress a behaviour. It encourages people to engage in a safer version of the behaviour rather than trying to eliminate it completely (e.g., using condoms during sexual encounters).
3. **Harm Reduction Model:** This model acknowledges how difficult it is for some people to change their behaviour, and that risk is an unavoidable part of life. But the counselling personnel works to reduce the harm that might accompany the risky behaviour. An example of this is needle exchange programmes.

The ICTC is the gateway to services for People with HIV. In simple terms, it is important to ensure that people move geographically from the ICTC to other health facilities where they can get appropriate treatment. Simply handing a test result paper will not help the person cope with

the diagnosis, leave alone understand and explore actions and services that can keep them healthy.

The **Transtheoretical Model** of Prochaska, DiClemente and Norcross (1992) is one theory of behaviour change. It has been tested with other issues besides AIDS such as smoking cessation and mammogram screening. It lists the following stages:

- **Precontemplation** where the individual does not recognise nor wish to deal with the problem. They can be helped to move to the next stage through consciousness-raising or through environmental re-evaluation about how the problem affects their life.
- **Contemplation** where he/she recognizes the problem and thinks seriously about changing it.
- **Preparation for Action** where the individual intends to change the behaviour within the next month. He/ she makes a commitment to change.
- **Action** where the individual has been engaging in the behaviour for less than 6 months. The processes that help to consolidate these behaviours are the overt and covert rewards, social support, and avoidance of cues for the old behaviour.
- **Maintenance** where the individual has been able to sustain this change consistently for more than 6 months.

The ICTC set-up as per the Operational Guidelines makes provision for individual and group counselling. Group sessions are more appropriate in settings where general information about HIV/AIDS and the testing process must be delivered in a busy health centre with a high patient load. For instance, this is recommended when ANC women are referred for HIV testing, and all of them are expected to be given the same general information about HIV/AIDS before an individual assessment is undertaken. But effective behaviour change is more likely to emerge when counselling personnel spend some one-on-one time to understand the intimate concerns of the patient, and the barriers that might hold them back from effective behaviour change. Also outreach work provides an opportunity to check on the well-being of clients and support them in their ongoing behaviour change efforts. In this context counselling personnel should plan the time set aside for out reach work on Saturday afternoons to reach populations with messages and aid in preventing risky behaviours. There are many NGOs reaching key at risk populations with targeted interventions. Counselling personnel should work with the different NGOs to increase client coverage. NGOs play a key role in reaching patients to ICTC for testing or referrals for HIV testing.

A term that is often heard among HIV/AIDS practitioners is **Behaviour Change Communication** (BCC). These are informational messages that try to give people greater insight into their personal situations and motivate them to experiment with new, healthy actions so that they can improve the quality of their life. These messages are based on sociocultural and behavioural research about what is most effective in relation to altering attitudes and actions. They replicate with the general public what counselling personnel do at the individual level. However, they do not replace individualised counselling.

Provider-Initiated Testing

Though the number of counselling facilities for HIV/AIDS has increased over the years, the average number of people tested at ICTCs is low – 3 to 4 per day. Poor utilization of services means that only about 55 to 60% of infected people in India actually know their sero-status. Those who do not know their status remain out of the ambit of health care services. So there is a need to scale up HIV testing and facilitate the entry of more people into the continuum of care services.

Provider Initiated Testing means that HIV counselling and testing are recommended by health care providers to people who come to them for other

health concerns when they display signs and symptoms suggestive of HIV infection or other co-infections.

WHO recommendations for provider initiated testing are as given below.

ALL EPIDEMIC SETTINGS: HIV testing and counselling should be recommended in all health facilities to:

- HIV-exposed children or children born to HIV-positive women.
- Children with suboptimal growth or malnutrition or malnourished children, in generalized epidemics, who are not responding to appropriate nutritional therapy.
- Men seeking circumcision as an HIV prevention intervention.

GENERALIZED EPIDEMIC SETTINGS

In the case of phased implementation of provider-initiated HIV testing and counselling, an approximate order of priority, depending on local conditions, may be as follows:

- Medical inpatient and out patient facilities, including TB clinics
- Antenatal, childbirth, and postpartum health services
- STI services
- Services for most-at-risk populations
- Services for children under 10 years of age
- Services for adolescents
- Surgical services
- Reproductive health services, including family planning

CONCENTRATED AND LOW-LEVEL EPIDEMIC SETTINGS

Implementation of provider-initiated HIV testing and counselling should additionally be considered in:

- STI services
- Services for most-at-risk populations
- Antenatal, childbirth, and postpartum health services
- TB services

In India provider initiated testing services are provided only to:

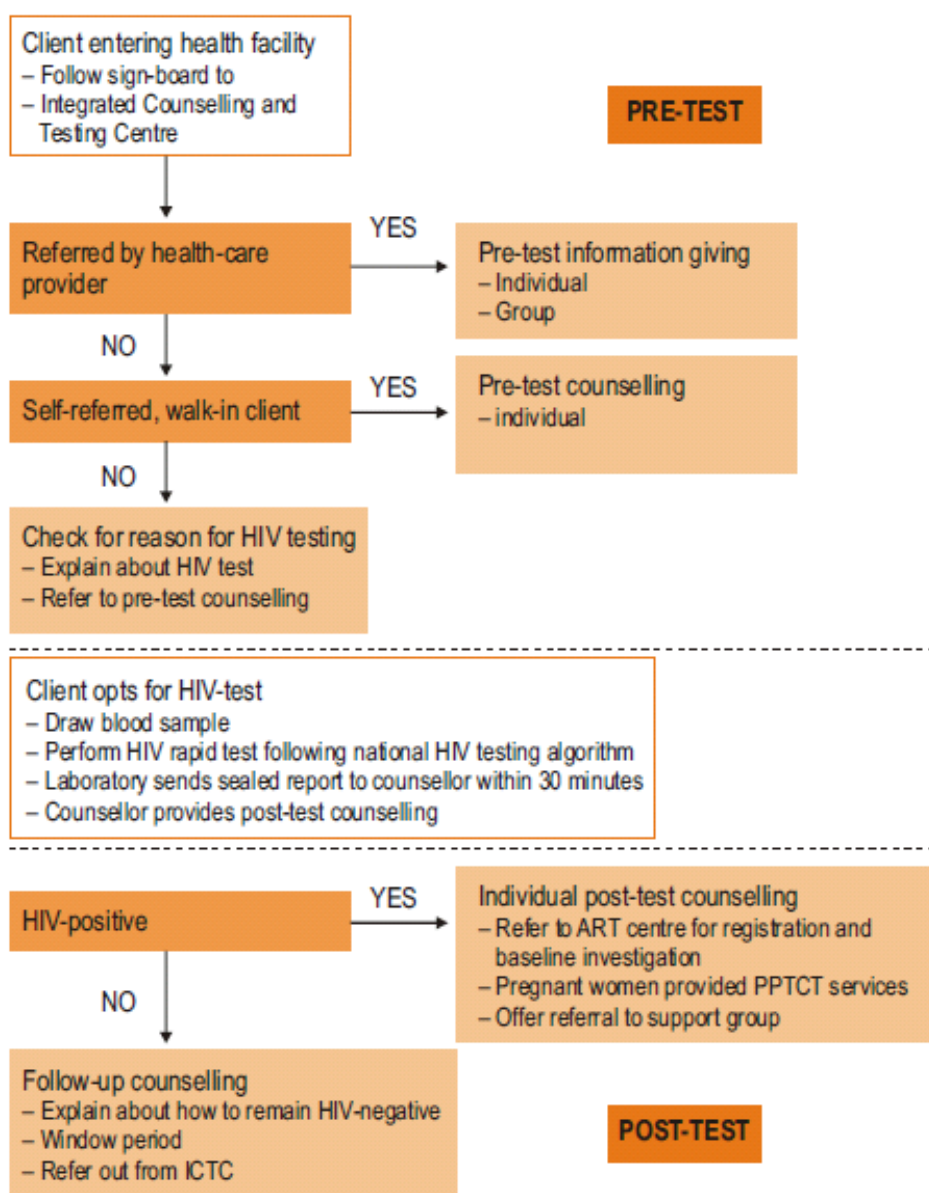
- **Patients who present themselves to a health facility with symptoms suggestive of HIV infection like TB, pneumonia or persistent diarrhea**
- **Patients with conditions that could be associated with HIV such as STI/RTI**
- **Pregnant women who register at ANCs. This also include pregnant women who directly come in labour without any ANC.**

From the different services mentioned above, providers will identify clients for testing and will refer them to ICTC for testing.

- Clients are **referred** by health care providers to the ICTC.
- At the ICTC, they are given **basic information** on HIV, they are educated about HIV testing and are informed about the clinical and prevention advantages of being tested.
- The counselling personnel then makes a **routine offer of HIV testing**: The counselling personnel asks the client: “Do you wish to be tested for HIV or not?”
- The client has a **right to accept or to refuse testing** and “opt out.”
- If the client agrees, he/ she is **tested** for HIV.
- Testing is followed by **post-test counselling**.

Client flow in an ICTC

The suggested client flow in an ICTC is shown below:



It is difficult for health care providers to accept that patients may say, “No” to being tested. But the principle of Informed Consent remains inviolate. Even though health care providers may refer individuals for testing, the patient has to agree to being tested. The ICTC Operational Guidelines require counselling personnel to ask each client, “Do you wish to test for HIV or not?” The patient’s wishes must be respected even if they refuse to be tested. Clients are also informed that saying “No” will not affect their use of other health services. But these individuals also need to receive relevant information related to reducing risk of HIV infection to self and others. For instance, STI patients who refuse to be tested, or who “opt out” will benefit from information about safer sex options. Pregnant women should be told about nutrition, hygiene, and how an institutional delivery will reduce the risk of HIV transmission from mother to child.

Provider-initiated testing is especially important in those areas where there is a high prevalence of HIV infection. This would refer in particular to the Category A districts in India which have high HIV prevalence, and the Category B districts which have a concentrated epidemic.

A common question is how does provider initiated testing and counselling differ from testing all patients in a health facility?

1. The latter refers to the stigmatizing and discriminatory practice of universal HIV testing for screening purposes in hospitals (for instance, asking all pre-surgery patients to be tested for HIV). There is a difference between such testing and Provider-initiated testing. The priority of Provider-initiated testing is to ensure that people who are most at risk have a chance to find out their sero-status. Universal testing for screening is done for the convenience of physicians who may falsely believe that they can protect themselves and their staff by taking special precautions with HIV-positive patients or even denying services to HIV-positive patients. HCP may become more relaxed with HIV-negative patients not realizing that the person may be in the window period.
2. Such universal testing for the purposes of screening violates the principle of informed consent because such testing does not respect the patient's right to "opt-out" from the testing process. Often it is unaccompanied by counselling and informed consent. Also, it will overwhelm the testing facilities and might mean that people who are actually infected experience a delay in knowing they are HIV infected and then in seeking treatment. Apart from this is the legal and ethical issue of subjecting people to unnecessary medical procedures. In contrast, Provider-initiated testing involves a routine offer to test with the option to say no to being tested. Testing is not mandatory.
3. Mandatory testing for the purposes of screening will involve testing ALL patients. The mandate of the ICTC is NOT to test all people in the population. Provider-initiated testing and counselling involves a routine offer of counselling to people who are more vulnerable to HIV or who practise risk behaviour.

Informed Consent for HIV Testing

- The client agrees to HIV testing through giving his/her informed consent.
- Informed consent is a deliberate and autonomous permission given by a client to a health-care provider to proceed with the proposed HIV test procedure. This permission is based on adequate understanding of the advantages, risks, potential consequences and implications of an HIV test result, which could be both positive and negative.
- This permission is entirely the choice of the client and can never be implied or presumed.

(From ICTC Operational Guidelines)

STIs as a case of Provider-Initiated Testing

Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI) are a co-factor for HIV. Some STIs and RTIs cause the development of open ulcers can facilitate transfer of HIV infection to and from the patient. Once a person is infected with STI, his/ her chances of acquiring and transmitting HIV go up 5 to 10 times.

Studies by the Indian Council of Medical Research (ICMR) show that 6% of the male and 12% of the female patients in Outpatient Departments (OPD) at government facilities seek treatment due to STI/RTI symptoms. Asymptomatic infection is more common in women, especially during pregnancy. Often women fail to recognise and properly label symptoms associated with STIs. Therefore, it is necessary to ask directly about symptoms such as lower abdominal pain, abnormal discharge from the vagina/ penis, and ulcers on the sexual organs.

Most of the people infected with STI belong to populations at risk. With their mobility and their large number of sexual partners, they can easily transfer STIs to other people. So from a public health point of view it is important to treat STIs as part of an effective HIV management strategy. This also benefits the individual patient because treating STIs can reduce the person's chances of getting HIV by 40%.

Under NACP-III, NACO supports 886 STI/RTI clinics. These clinics are strengthened to provide good quality STI/RTI services, including the services of counselling personnel. By year 2009, 621 counselling personnel were providing counselling to patients. Since studies indicate that people in the HRGs prefer to use the services of private providers, the programme also includes links with treatment facilities in the private sector.

WHY YOU MUST TREAT STI/RTI

- A person with STI/RTI has 5-10 times more chance of giving or receiving HIV.
- Most of the STI/RTI are curable.
- It is indirectly the best way of dealing with HIV because when you control STI/RTI, you bring down HIV by 40%.

The key principles of STI management are:

- Correct diagnosis
- Effective treatment
- Education on risk reduction and prevention
- Promotion and provision of condoms
- Partner notification and treatment

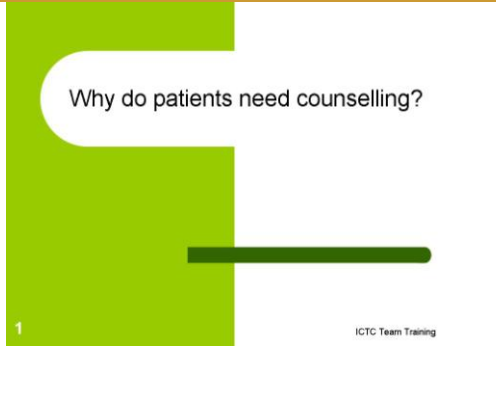
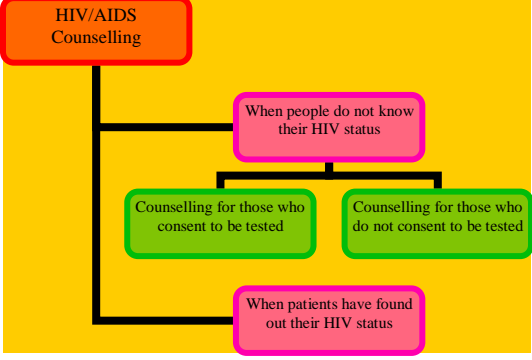
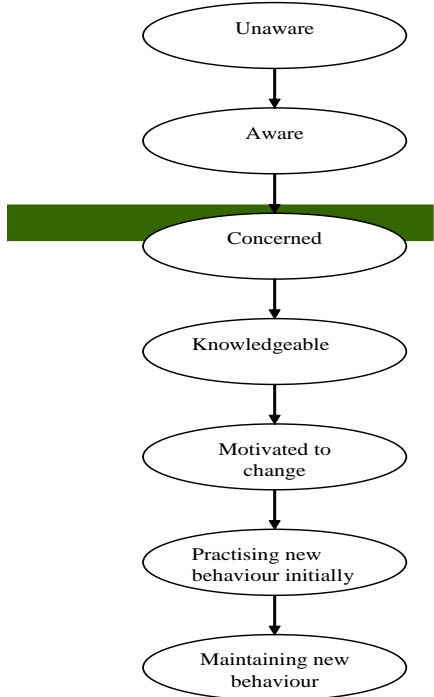
In later sections, we will also discuss tuberculosis and women receiving antenatal care as instances of provider-initiated testing.

***Provider Initiated Testing is neither mandatory nor compulsory.
NACO does not support mandatory or compulsory testing of individuals on public health grounds.***

References

1. Family Health International (2002). *Behavior Change Communication (BCC) for HIV/AIDS: A strategic framework*. Arlington, VA: Family Health International.
2. Joint United Nations Programme on HIV/AIDS (1999). *Sexual behavioural change for HIV: Where have theories taken us?* Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS.
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7. World Health Organisation (1993) *An orientation to HIV/AIDS counselling: A Guide for Trainers*. New Delhi: World Health Organisation.
8. World Health Organisation & UNAIDS (2007). *Guidance on Provider-initiated HIV testing and counselling in health facilities*. Geneva, Switzerland: World Health Organisation.

SLIDES

 <p>Why do patients need counselling?</p> <p>1</p> <p>ICTC Team Training</p>	<p>Questions</p> <ol style="list-style-type: none"> In general, how easy was it to help the person to consider the behaviour change? What problems were discussed and what solutions were offered in each group? What solutions or suggestions were most successful in your group? Why were they successful? What solutions or suggestions were not successful? Why were they not successful? What kind of objections did the person raise? What counter-arguments did the group offer? How does this relate to HIV/AIDS counselling in the ICTC?
<p>Counselling</p> <ul style="list-style-type: none"> A confidential dialogue between a client and a counselling personnel aimed at providing information on HIV/AIDS and bringing about behaviour change in the client. Also aimed at enabling the client to take a decision regarding HIV testing and to understand the implications of the test results 	 <pre> graph TD A[When people do not know their HIV status] --> B[Counselling for those who consent to be tested] A --> C[Counselling for those who do not consent to be tested] B --> D[When patients have found out their HIV status] C --> D </pre>
<p>Advantages of knowing your sero-status</p> <ul style="list-style-type: none"> Early referral for appropriate medical treatment: prophylaxis, early detection, curative treatment, antiretroviral treatment. Precautions to protect others. Prevention against re-infection with HIV. 	 <pre> graph TD A([Unaware]) --> B([Aware]) B --> C([Concerned]) C --> D([Knowledgeable]) D --> E([Motivated to change]) E --> F([Practising new behaviour initially]) F --> G([Maintaining new behaviour]) </pre> <p>ICTC Team Training</p>

<p>Three Models of Behaviour Change</p> <ul style="list-style-type: none"> • Risk Elimination Model • Risk Reduction Model • Harm Reduction Model <p>(The HIV Counselling Training Modules for VCT, PPTCT and ART Counsellors, NACO, 2006)</p>	<p>Provider Initiated Testing</p> <ul style="list-style-type: none"> • Knowing one's sero-status is the first step to getting HIV services. • Only 1 in 3 infected people knows their sero-status. • Need to increase the number of people visiting ICTC. <p>Provider Initiated Testing: HIV Counselling and Testing are recommended by health care providers to people who come to them for other health concerns when they display signs and symptoms suggestive of HIV infection or other co-infections.</p>
<p>CONCENTRATED AND LOW-LEVEL EPIDEMIC SETTINGS STI services</p> <ul style="list-style-type: none"> • Services for most-at-risk populations • Antenatal, childbirth, and postpartum health services • TB services 	<p>Provider Initiated Testing in India</p> <ul style="list-style-type: none"> • Patients who present themselves to a health facility with symptoms suggestive of HIV infection like TB, pneumonia or persistent diarrhoea • Patients with conditions that could be associated with HIV such as STI/RTI • Pregnant women who register at ANCs. This also include pregnant women who directly come in labour without any ANC.
<p>Provider Initiated Testing: Steps</p> <ul style="list-style-type: none"> • Clients are referred by health care providers to the ICTC. • At the ICTC, they are given basic information on HIV, they are educated about HIV testing, and are informed about the clinical and prevention advantages of being tested. • Counselling personnel then makes a routine offer of HIV testing: The counselling personnel asks the client: "Do you wish to be test for HIV or not?" • The client has a right to accept or to refuse testing and "opt out." • If the client agrees, he/ she is tested for HIV. • Testing is followed by post-test counselling. 	<p>Informed Consent</p> <ul style="list-style-type: none"> • The client agrees to HIV testing through giving his/ her informed consent. • Informed consent is a deliberate and autonomous permission given by a client to a health-care provider to proceed with the proposed HIV test procedure. • This permission is entirely the choice of the client and can never be implied or presumed. <p>(From ICTC Operational Guidelines)</p>

<p>The next 4 slides consist of the records maintained by the counselling personnel</p>	
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HIV testing at the ICTC

HIV testing at the ICTC

The aim of the current workshop is not to train staff in how to conduct HIV testing. However, this section of the handbook deals with key aspects of HIV testing in the ICTCs.

The HIV Antibody Test

The only way for an HIV infected person to find out their sero-status is by undergoing an HIV test. The most common way of diagnosing HIV infection is by detecting whether the blood of the patient being that is being tested contains antibodies to HIV.

The infected individual's immune (defence) system produces these antibodies as it tries to resist the virus. Antibodies to HIV are usually produced from 6 to 12 weeks after the infection is contracted (in some rare cases, it may even take up to 6 months for antibodies to develop). The period immediately after infection when there are no antibodies is called the **window period**.

A positive result on an HIV antibody test means that the individual's blood contains HIV antibodies. In an adult human being we infer this to mean that the person has the virus. In the case of a new born, born to a woman who is infected with HIV, a positive result on an HIV antibody test up to the age of 18 months could merely mean the presence of antibodies received from the mother.

Additionally, if an infected person is tested immediately after being infected, they may still be in the window period. Here the antibody test will fail to detect antibodies, but this test result is a "false negative" because the person is actually infected and can pass on the infection to others. In this situation, it is important to ask the person to get retested. The time of the retest should be approximately 3 months from the last time of possible exposure to HIV - that is the last time they had unsafe sex or used an infected needle.

Both these situations show that it is important to interpret the results of the test result in the light of the person's life situation and behaviour.

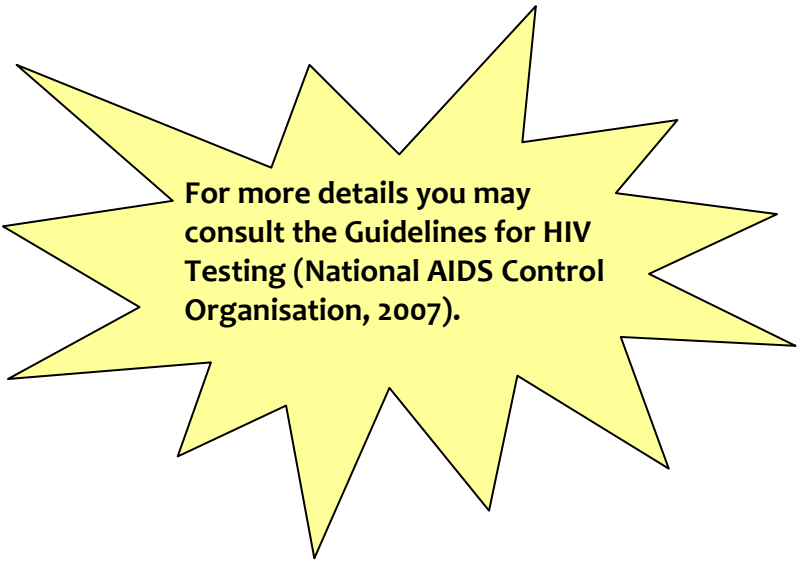
Commonly used HIV tests

Rapid tests

Currently, rapid tests are commonly used to detect the presence of HIV antibodies. These tests do not need special equipment. They are user-friendly and so do not require the presence of highly trained staff. There are four types: agglutination assays, comb/dot blot assays, flowthrough membrane assays and lateral flow membrane assays. In most tests, a positive result is indicated by the appearance of a clearly visible dot or line.

NACO recommends that ICTCs use rapid HIV tests so that the client who comes to the ICTC for services can receive their results within 30 minutes of the test.

Rapid HIV test kits should be stored at a temperature of 4 to 8 degrees Celsius. They should be transported from the SACS in a thermos flask with ice packs to maintain the cold chain.



For more details you may consult the Guidelines for HIV Testing (National AIDS Control Organisation, 2007).

ELISA

ELISA or enzyme-linked immunosorbent assay was the earliest method to detect antibodies. This is an efficient test for testing large numbers of samples per day, as in large blood banks or for surveillance studies. It is easy to perform but it requires careful adherence to procedures. Any deviation in incubation times and/ or temperature and pipetted volume can dramatically change test results. So it requires skilled technical staff. It also requires equipment maintenance and a steady power supply and, therefore, may be less suitable for smaller or more isolated clinics or laboratories.

Western Blot

This is also a test that detects antibodies but it is more expensive. So it is used more as a confirmatory test.

Tests to detect the virus itself

These tests look for the presence of HIV itself, not the antibodies. Though these are more expensive, it is important to mention them. These include the Polymerase Chain Reaction (PCR).

The PCR can be performed using 2 sample collection methods: the dried blood spot (DBS) and whole blood (WB). For the DBS, blood is collected on a filter paper and sent to the ICTC laboratory for testing. For WB procedure, the blood is collected in a vial or vacutainer and sent within hours to a laboratory. The DNA PCR whole blood test is available only at the ART centres. This is another important referral linkage that the ICTC should establish.

There are three main objectives for HIV tests:

- **Screening** of donated blood to reduce transmission of the virus through transfusions;
- **Epidemiological surveillance** of HIV prevalence or trends over time in a given population, through unlinked testing of serum (anonymous testing for statistical purposes only)
- **Diagnosis** of infection in individuals. This is the function of the ICTC.

One instance when it makes clinical sense to use the PCR test is to check for infection in babies born to women infected with HIV/AIDS. Since maternal antibodies that are circulating in child's blood will only disappear by about 18 months of age, the direct test is necessary to detect the presence of the virus in their system. The protocols for this test are described in the section on Prevention of Parent to Child Transmission.

What makes a test result trustworthy?

In order to trust a diagnostic test, we would like to make sure that its results are accurate and consistent.

Sensitivity

We would like the HIV test to be able to produce as few false negatives as possible – that is we want a test which can detect even tiny amounts of antibodies. This means the test should have a high degree of sensitivity.

Specificity

We also want the test to avoid labelling someone as infected with HIV when they are not. This means the test should have a high degree of specificity. It should differentiate well between people who are negative and those who are positive.

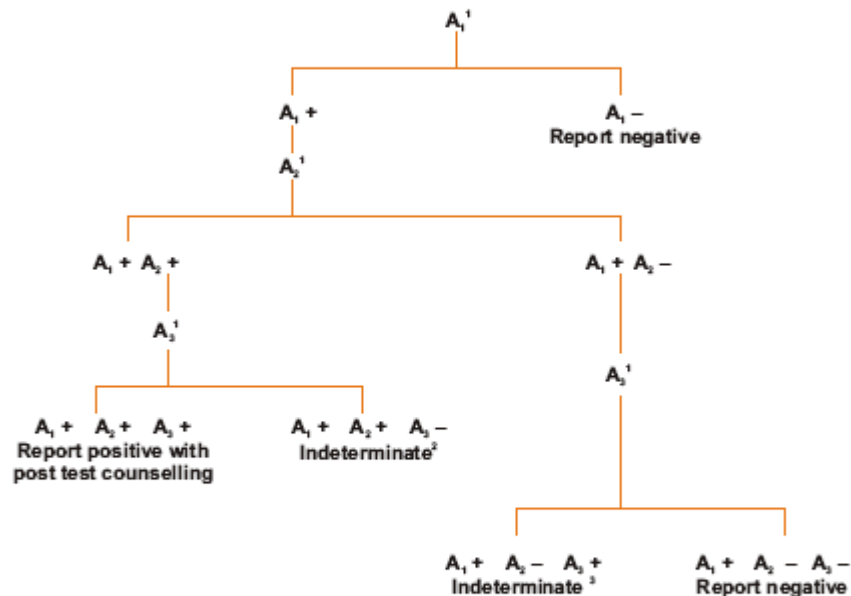
NACO standards for the rapid tests in the ICTC are those which detect more than 99.5% of patients infected with HIV and which give a false positive result in less than 2% of patients.

The three-test algorithm

Sometimes rapid tests may label a patient as HIV-infected when they are not – that means that they are not specific enough. A positive test result causes a lot of tension for the individual who undergoes that test. It is therefore important to confirm the positive test result. For this reason, the Operational Guidelines for ICTCs recommend a three-test algorithm.

A client who is referred for testing has a blood sample drawn once. If he/ she tests negative on one rapid test, he/ she is declared as HIV-negative. But for a client who tests positive on the first kit, the same blood sample is tested a total of three times using other kits with different antigens before the person is declared to be HIV-positive or HIV-infected. A positive test result is only declared when all three tests pick up the presence of antibodies. If two kits show a positive result but the third is negative, the result is declared as indeterminate.

For the purpose of diagnosis three rapid HIV test kits based on different antigens/principles are to be used. Blood samples are processed for HIV. The test result may be positive, negative or indeterminate to HIV as described below:



¹ Assays A₁, A₂, A₃ represent 3 different assays.

² Testing should be repeated on a second sample taken after 14–28 days. In case the serological results continue to be indeterminate, then the sample is to be subjected to a Western blot/PCR if facilities are available or refer to the National Reference Laboratory for further testing.

Some patients have trouble accepting a positive test result. It is important to explain to them that their blood has been tested with 3 different test kits.

For an indeterminate test result, counselling should include the recommendation to get tested again after 14 to 28 days. If the sample continues to produce an indeterminate result, the sample should be subjected to a Western Blot or a PCR test where such facilities are available, or sent to a National Reference Laboratory for further testing.

It is important to follow this testing algorithm carefully because we want to avoid causing unnecessary distress to a patient.

Emergency Testing

The ICTC Operational Guidelines mention emergency testing for women in labour whose sero-status is unknown. In such cases, the labour room nurses, resident doctors, or medical officers will provide her basic information on HIV/AIDS and about HIV testing. They also inform her that if she is infected with HIV, ARV prophylaxis can be administered to her new born infant to limit the chance of passing on the

virus. If she consents to be tested, a single HIV test will be conducted. This test result will be used to determine her HIV status, and further if ARV prophylaxis needs to be administered. The next working day, a repeat sample will be collected and tested to confirm her HIV status.

Estimating baseline CD4 count in HIV positive pregnant women

Pregnant female clients who are infected may need to start ART. This can only be determined through a baseline CD4 count. For this purpose, whole blood samples of all pregnant women who test positive for HIV are sent to the nearest ART centre which has a CD4 testing facility. The whole blood is drawn on a fixed day in the week in consultation with this ART centre. The whole blood is drawn into an EDTA vacuum tube and transported by a messenger in a cold box to the ART centre *within* 24 hours of drawing the sample. The same messenger will carry back the results of the CD4 count.

Quality assurance

In order to maintain the highest standards of quality in ICTCs, the following measures are instituted. Each ICTC will take part in an external quality assessment scheme (EQAS). Each one will be assigned to a State Reference Laboratory (SRL).

In the first week of every quarter (that is January, April, July and October) , the Laboratory Technician will send to the SRL 20% of all positive samples as well as 5% of all negative samples collected in the previous quarter. The other part of the EQAS consists of “coded” samples that the SRL will send to the ICTC for testing twice a year.


The testing personnel can ensure high quality in the testing service through:

- Use of test kits that have not expired
- Adherence to standard operating procedures (SOPs)
- Correct interpretation of results
- Availability of laboratory internal quality control
- Regular calibration, monitoring and maintenance of equipment
- Proper, regular documentation

References

- 1) Joint United Nations Programme on HIV/AIDS (n.d.). *Fast facts about HIV testing and counselling*. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- 2) National AIDS Control Organisation (2007). *Guidelines for HIV testing*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- 3) National AIDS Control Organisation (2007). *Operational guidelines for Integrated Counselling and Testing Centres*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.

SLIDES

 <p>HIV testing at the ICTC</p> <p>1</p> <p>ICTC Team Training</p>	<p>The HIV Antibody Test</p> <ul style="list-style-type: none"> • An HIV infected person can find out their sero-status through an HIV test. • Most common tests detect antibodies to HIV.
<p>Window Period</p> <ul style="list-style-type: none"> • HIV Antibodies usually develop 4 to 12 weeks after infection (Sometimes even 3 months after infection). • Window period: the period immediately after infection when there are no antibodies. 	<p>Meaning of HIV antibody test result</p> <ul style="list-style-type: none"> • A positive antibody test result • Individual's blood contains HIV antibodies • Therefore, the person has HIV.
<p>False negative test result</p> <ul style="list-style-type: none"> • Testing during the window period will always produce a negative result • But person is infected • Therefore the result is false negative 	<p>Infant's positive test result</p> <ul style="list-style-type: none"> • Testing a newly born child to a woman who is infected with HIV will always cause a positive result • But these could be antibodies from the mother which have passed to the child • Therefore infant needs additional testing
<p>Commonly used HIV tests</p> <ul style="list-style-type: none"> • Rapid tests • Western Blot • Tests to detect the virus itself : PCR <p>NACO recommends the use of rapid tests so that the client can receive the result within 30 minutes.</p>	<p>Diagram of Three-Test Algorithm</p>
<p>The next 3 slides consist of the records maintained by the testing personnel</p>	

Integration between ICTCs and TB services

Integration between ICTCs and TB services

Understanding why TB is a problem in the context of HIV

As per the NACO sentinel surveillance report of 2007, the prevalence of HIV infection is estimated to be 0.34 % of the population which translates to 2.31 million people living with HIV/AIDS in India. Tuberculosis (TB) continues to be a public health challenge in India and is estimated that 1.9 million new cases of TB occur in India annually. Tuberculosis is the most common and serious opportunistic infection among PLWHAs in India. It is also the most common cause of death amongst the HIV infected patients in India.

When a PLWHA contracts TB they are likely to live shorter lives. Tuberculosis speeds up the movement of the person from HIV infection to AIDS. There is seen to be six-to- seven fold increase in the HIV viral load among tuberculosis patients.

A person who is infected with HIV is vulnerable to TB infection because his/ her CD4 cells reduce in number as does the ability to combat HIV. The individual's immune system is less able to fight the growth and spread of the TB bacilli. The individual may suffer from extra-pulmonary TB disease as well as pulmonary TB. A PLWHA has a 50 to 60% lifetime risk of developing TB as compared to a person who is uninfected and whose lifetime risk is 10%.

HIV-TB Integration as a way of limiting harm to the PLWHA

PLWHAs are vulnerable to opportunistic infections. After detecting the patient's sero-status, it is important to limit harm that can be caused to their health. This can be done through preventing opportunistic infections and suitable treatment of OIs once infected.

TB is the most dangerous infection for a PLWHA. However, if caught in time, there are effective treatments. Directly Observed Treatment-short course (DOTS) is a treatment strategy that can increase the lifespan of PLWHAs and improve their quality of life. Here a health worker watches the patient swallow the drugs according to the schedule. This is done to ensure that patients take the medicine properly. They can also monitor other problems such as the need for injections and any side-effects that may occur.

Treatment for TB is slightly longer than for small complaints. So it is easy for a patient to forget to take the medicine regularly. Also, they may not remember side-effects if they see a health professional after a long period of time. Thus, from the programme perspective, DOTS is associated with better patient outcomes and better adherence. It can also prevent the emergence of more severe forms of tuberculosis such as Multi-Drug Resistance Tuberculosis (MDR-TB).

In general, TB treatment for PLWHAs is the same as for non-infected patients. The only difference is that thiacetazone, a drug for treating TB could cause severe reactions in PLWHAs and is therefore not prescribed.

While it is useful for PLWHAs to know their TB status, it is also important for tuberculosis patients to learn their HIV status. The benefits of this are that if they are detected as HIV-positive, they can have access to cotrimoxazole prophylaxis (CPT) and ART. Besides this, they can also protect their sexual partners through safer sex, and encourage them to check their HIV status as well as TB status. Counselling such patients should cover testing of sexual partners as well.

TB Treatment Issues

Cotrimoxazole prophylaxis is daily medicine taken to reduce the risk of serious opportunistic infections in HIV-infected persons. It is provided free of charge to PLWHAs at DOT centres by the pharmacist or the DOTS provider.

ART refers to antiretroviral medicines which attack the HIV directly, and try to reduce its levels in the body. TB patients who test positive for HIV can register themselves at an ART centre. The benefits of this registration are that they can get free CD4 testing to determine the level of infection in their system. When required, they can also get ART.

A patient who has been experiencing prolonged cough for 2 weeks or more should be referred for TB testing.

Anti-TB treatment is generally the same for HIV-infected and HIV-free TB patients, with the exception being that the drug thiacetazone which causes severe cutaneous reactions among HIV--positive patients and could be fatal, is not prescribed for them. Patients who complete treatment show the same response to short-course treatment whether they are HIV positive or not. Self-administration of treatment is dangerous. Directly Observed Treatment--short course (DOTS), therefore, becomes even more important for HIV-infected TB patients.

HIV-TB Integration as a case of Provider-Initiated Testing

Earlier, we learned about Provider Initiated Counselling and Testing where patients whose clinical profile indicates that they are at risk of HIV infection are referred by health professionals to the ICTC. Given the close links between HIV and TB, government policy since February 2008 is to routinely offer voluntary counselling and testing to all TB patients to “know their HIV status.” Thus HIV-TB programmatic integration can also be seen as an example of provider-initiated testing.

All TB patients must receive a routine offer to test for HIV so that they may learn their HIV status and take the necessary preventive measures where needed. If they decide to “opt out” then the HCP provider must be sensitive to their wishes.

Here, it is important to work with the TB centres closest to your ICTC to increase the referrals from there. It is important to explain to staff at these centres why TB patients should “know their status.” It is important for you to make sure that these centres have sufficient numbers of Integrated Counseling and Testing Centre referral form (please see the sample copy in this module) and that the service providers here know how to direct patients properly to your centre. It would be a good idea to fill in the names and contact numbers of key staff at these centres in your list of Common Contacts.

Just as you have to explain to the TB centre staff, you may also find yourself explaining to patients why they need to know their status. TB patients may have reservations about getting tested for HIV. They may have gone for TB testing and treatment because of difficulties such as coughing. However, they may not experience symptoms related to HIV because HIV signs and symptoms manifest after a while. Further, they may not associate their own behaviour with the risks normally associated with HIV infection. All of these issues must be explored within the counselling set-up.

The Training Manual on Intensified TB/HIV Package for ICTC counsellors (2008) suggests the following guidelines for different objections raised by patients:

- 1) If the patients refuse HIV testing on the grounds that their previous HIV tests were negative
 - a) Ask them why they have had HIV tests in the past, when they had these, and try to obtain a record of the test result.
 - b) Explain the need for a test result that is current and issued by the ICTC.
 - c) Review the benefits of HIV testing on treatment of TB and on the patients' own health in the longer term.
- 2) If the patients refuse HIV testing on the condition that they cannot accept the fact if their HIV test results are positive
 - a) Review their basic knowledge of HIV transmission.

- b) Assure them that “knowing their HIV” status can be life-saving as proper treatment can be provided.
 - c) Use a media (sic.) that portrays well-known persons who are infected with HIV or other TB patients with HIV co-infection who accepted HIV testing, and still have a good quality life despite the HIV infection.
 - d) Explain that the patient can get counselling and HIV testing whenever the patient is ready to be tested.
- 3) If the patients refuse HIV testing on the grounds that they did not have HIV-risk behaviours in the past
 - a) Review their basic knowledge of HIV transmission.
 - b) Explain the need for current test results and information for valid diagnosis (studies have shown that [sic.] some clients who initially declined HIV testing because of self-perceived low-risk may be HIV-positive. Therefore, HIV testing with blood is the only reliable way to determine whether or not one has HIV.)
- 4) If the patients refuse HIV testing on the condition that they are old
 - a) Explain that studies have shown older people too have been found to be HIV infected, even though TB patients older than 50 years infected with HIV account for only 1%.
 - b) The belief that older persons do not have risks related to HIV infection is not correct.
 - c) Explain to them that, in some people, HIV infection may stay asymptomatic for up to ten years. Individuals who have not had high-risk behaviour recently may have been infected with HIV many years ago.

Again we repeat that though patients may be referred to the ICTC, they have the right to “opt-out”, that is refuse to be tested. This may happen despite the best efforts of the counselling personnel to explain the need for testing. If patients opt out, then they should be given similar counselling as any other client who refuses to be tested –they should leave only after knowing how to protect themselves and others from harm by using safer sex techniques, by not sharing syringes, etc. If patients do get tested, then regular procedures for pre- and post-test counselling are to be followed.

The box titled **Inform about TB: provide initial information on TB** contains the key messages about HIV that must be given to patients. Counselling personnel can use this as a checklist to ensure that they mention all the points during counselling.

Inform about TB – provide initial information on TB:

Ask the patient questions such as:	Then give the relevant messages on TB:
<p>What do you understand tuberculosis to be?</p> <p>What do you think may have caused your illness?</p>	<p>What is TB? Tuberculosis or TB, is an illness caused by germs that are breathed into the lungs. TB germs can settle anywhere in the body, but we most often hear about TB in the lungs. When the lungs are damaged by TB, the person coughs up sputum (mucus from lungs) and cannot breathe easily. Without correct treatment, a person can die from TB</p>
<p>Have you ever known anyone with TB? What happened to that person?</p> <p>Do you know that TB can be completely cured?</p>	<p>TB can be cured: TB can be cured with the correct drug treatment. The patient must take all of the recommended drugs for the entire treatment time in order to be cured.</p> <p>Drugs for treatment of TB are provided free of cost. Treatment can be done without interrupting normal life and work</p>
<p>How do you think TB spreads?</p>	<p>How TB spreads: TB spreads when an infected person coughs or sneezes, spraying TB germs into the air. Others may breathe in these germs and become infected.</p> <p>It is easy to pass germs to family members when many people live closely together. Anyone can get TB. However, not everyone who is infected with TB will become sick.</p>
<p>How can you avoid spreading TB?</p>	<p>How to prevent TB from spreading?</p> <ul style="list-style-type: none"> ▪ Take regular treatment to become cured ▪ Cover mouth and nose when coughing or sneezing ▪ Open windows and doors to allow fresh air through the house, use a fan
<p>How many people live with you? What ages?</p> <p>Does anyone else in your household have cough? Who has cough?</p> <p>Who else should be examined or tested for TB?</p>	<p>All children aged under 6 years living in the household should be examined for TB symptoms. This is especially important because children under 6 years are at risk of severe forms of TB. Young children may need preventive medicines and need to be examined by the doctor.</p> <p>Other household members should be screened and tested for TB if they have cough.</p>
<p>Can you explain why it is important that somebody else observes you taking your pill?</p>	<p>A health worker must watch you swallow all the drugs according to schedule. This will ensure that you take the correct drugs regularly for the required time. If injections are needed, they will be given properly. By seeing you regularly, the health worker will notice if you have side effects or other problems.</p> <p>If you do not take all of the drugs, you will continue to spread TB to others in your family or community, and the TB will not be cured. It is dangerous to stop or interrupt treatment, because then the disease may become incurable. With directly observed treatment (DOTS), the health worker will know if you miss a dose and will quickly investigate the problem.</p> <p>If you must travel, or if you plan to move, tell the health worker so that arrangements can be made to continue treatment without interruption</p>
<p>How long should you take the drugs for?</p> <p>How frequent and where are your visits?</p>	<p>Explain to specific patient:</p> <ul style="list-style-type: none"> - duration of treatment - frequency of visits for taking treatment - where to go for treatment
<p>What should you expect when taking the drugs? What should you do next</p>	<p>Urine may turn orange/red as a result of the drug (rifampicin). This is not harmful. If you feel nausea from the drugs, bring a bit of food to eat when taking the next dose.</p> <p>Treatment should not interfere with normal life and work</p> <p>Make sure that the patient knows exactly where and when to go for the next treatment.</p> <p>Remind patient to bring family and other close contacts for TB tested as needed.</p>
<p>Ask checking questions and review. Make sure s/he understands key points and reinforce. Give more information as needed.</p>	

Documentation for HIV-TB Integration

With regard to documentation, the counselling personnel must record the referral from the RNTCP in column 4 of the ICTC Register for General clients (this we have already seen in the section on counselling). In addition, the counselling personnel also has to note the information in the ICTC HIV-TB Collaborative Activity Register. A copy of this register is available in this module for your reference. Details will be noted against the Patient Identification Digit– the PID.

Also, the counselling personnel or the medical officer must make a note of the test result on the Integrated Counseling and Testing Centre referral form. The patient is encouraged to take this form back to the TB centre and to share the result with their care provider. This is to ensure that the DOTS provider can tailor the treatment according to situation of the patient. During counselling, the counselling personnel informs that the test result will be communicated directly to the DOTS provider (in person or by phone). However, if the patient objects to such direct communication of their test result, this objection should be honoured by the counselling personnel.

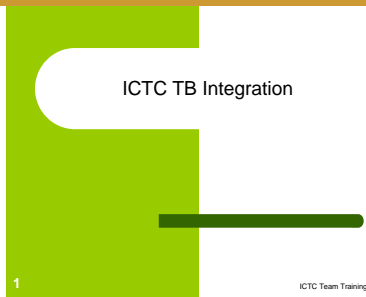
When the ICTC refers the patient for TB testing, the counselling personnel has to note this information in the ICTC HIV-TB Collaborative Activity Register using the Patient Identification Digit – the PID. It is desirable that patients inform the ICTC the results of their TB test. If patients do report this information, it should be noted in the register.

At the end of the month, the data from the register is extracted into the Line-list of Persons referred from the ICTC to the RNTCP. This line list is then shared with the STS who provide information regarding the TB diagnosis and TB treatment of the patients who were referred by the ICTC during the month. The STS then returns the completed line list to the ICTC counselling personnel at the end of the month.

References

- 1) Central TB Division (n.d.). *Improving Interpersonal Communication Skills in RNTCP Training: Key Concepts and Sample Role Plays*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- 2) National AIDS Control Organisation (n.d.). *FAQs*. Accessed from http://www.nacoonline.org/Quick_Links/FAQs/ on August 12, 2009.
- 3) National AIDS Control Organisation (n.d.). *Ten point counselling tool on TB*. Accessed from <https://www.nacoonline.org> on August 12, 2009.
- 4) National AIDS Control Organisation (2006). *HIV counselling training Modules for VCT, PPTCT and ART Counsellors*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- 5) National AIDS Control Organisation (2006). *National AIDS Control Programme Phase III*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- 6) National AIDS Control Organisation (2007). *Operational guidelines for Integrated Counselling and Testing Centres*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- 7) World Health Organisation & UNAIDS (2007). *Guidance on Provider-initiated HIV testing and counselling in health facilities*. Geneva, Switzerland: World Health Organisation.
- 8) Data provided by NACO.

SLIDES

 <p>ICTC TB Integration</p> <p>1</p> <p>ICTC Team Training</p>	<p>Why should ICTCs worry about TB ?</p> <ul style="list-style-type: none"> • One of the most common OI in HIV positive persons • PLWHA have 50 to 60% lifetime risk of TB compared to uninfected person's 10% lifetime risk • PLWHA co-infected with TB live a shorter life because TB hastens progress of HIV by increasing viral replication/multiplication
<p>National Policy on TB and HIV</p> <ul style="list-style-type: none"> • All the clients at the ICTC should be screened for symptoms and signs of TB • Every TB patient should be encouraged to "know their HIV status" 	<p>How does knowing TB status help PLWHAs</p> <ul style="list-style-type: none"> • Start TB treatment early and prevent wide spread infection • Reduce morbidity and mortality from TB • Start treatment under DOTS, complete the full course and prevent relapse of infection or emergence of resistant TB • Diagnosing TB infection and starting treatment early can prevent spread of infection among family members
<p>ICTC Counselling personnel should ask all HIV positive patients about history of cough, sputum and fever.</p> <p>All PLWHA experiencing prolonged cough for 2 weeks or more should be referred for TB testing</p>	
<p>What is DOTS?</p> <ul style="list-style-type: none"> • Directly Observed Treatment - short course is provided by the national TB programme • Health worker watches the patient swallow TB medications according to the treatment schedule. • Decreases risk of drug-resistance resulting from erratic or incomplete treatment. 	<p>Benefits of DOTS</p> <ul style="list-style-type: none"> • Ensures patients take medicine correctly and that patients complete their full anti TB course. • Provides close monitoring of side effects, the need for injections, drug interactions with other medications and treatment failure. • Decreases chances of treatment failure and relapse
<p>How does knowing HIV status help TB patients</p> <p>TB Patients with HIV can access:</p> <ul style="list-style-type: none"> • Care and support services • Co-trimoxazole prophylaxis (CPT) • Treatment for OIs • Antiretroviral therapy (ART) • Prevention counselling and services • Social support services (PLWHA networks) 	<p>HIV-TB Integration as a case of Provider-Initiated Testing</p> <ul style="list-style-type: none"> • Provider initiated testing is a strategy designed to increase HIV testing among at risk populations • As HIV-TB co-infection is common: • --counsel and make a routine offer to test all TB patients for HIV • --all HIV positive patients with symptoms suggestive of TB to be evaluated for TB infection.

<p>HIV infected TB patients should be counselled to get their sexual partners tested for HIV and TB.</p>	<p>Remember: Though TB patients may be referred to the ICTC, they have the right to “opt-out” of being tested!</p>
<p>How can we strengthen linkages between TB and HIV</p> <ul style="list-style-type: none"> • ICTC centres and Designated Microscopy centres (DMC) or DOTS should be in the same premises • All ICTC and RNTCP staff should be trained in HIV-TB • All ICTCs should have a directory of state wide DMC/DOTS centres 	<p>How can we strengthen linkages between TB and HIV (contd)</p> <ul style="list-style-type: none"> • All RNTCP units should have a directory of state wide ICTCs • ICTC and RNTCP staff should follow-up referral cases • Monthly review meetings at RNTCP units should be attended by ICTC staff • Referral forms for HIV testing/ICTC should be available at TB units
<p>What is TB?</p> <ul style="list-style-type: none"> ➤ Tuberculosis or TB, is an illness caused by germs that are breathed into the lungs. ➤ TB germs can settle anywhere in the body, but we most often hear about TB in the lungs. When the lungs are damaged by TB, the person coughs up sputum (mucus from lungs) and cannot breathe easily. ➤ Without correct treatment, a person can die from TB 	<p>TB can be cured: with the correct drug treatment.</p> <ul style="list-style-type: none"> ❖ The patient must take all of the recommended drugs for the entire treatment time in order to be cured. ❖ Drugs for treatment of TB are provided free of cost. ❖ Treatment can be done without interrupting normal life and work
<p>TB spreads:</p> <ul style="list-style-type: none"> ❖ when an infected person coughs or sneezes, spraying TB germs into the air. Others may breathe in these germs and become infected. ❖ Anyone can get TB. However, not everyone who is infected with TB will become sick 	<p>How to prevent TB from spreading?</p> <ul style="list-style-type: none"> ▪ Take regular treatment to become cured ▪ Cover mouth and nose when coughing or sneezing ▪ Open windows and doors to allow fresh air through the house, use a fan
<p>Why test children?</p> <ul style="list-style-type: none"> ▪ All children aged under 6 years living in the household should be examined for TB symptoms. ▪ important because children under 6 years are at risk of severe forms of TB. ▪ Young children may need preventive medicines and need to be examined by the doctor. 	<p>Why the health worker must observe you swallow pill?</p> <ul style="list-style-type: none"> ▪ ensure that you take the correct drugs regularly for the required time. ▪ If injections are needed, they will be given properly. ▪ By seeing you regularly, the health worker will notice if you have side effects or other problems. ▪ If you do not take all of the drugs, you will continue to spread TB to others in your family or community

	<ul style="list-style-type: none"> interrupted treatment may make disease to become incurable. With directly observed treatment (DOTS), the health worker will know if you miss a dose and will quickly investigate the problem. <p>If you must travel, or if you plan to move, tell the health worker so that arrangements can be made to continue treatment without interruption</p>
<p>Explain to the specific patient:</p> <ul style="list-style-type: none"> duration of treatment frequency of visits for taking treatment where to go for treatment 	<p>Changes with Drugs:</p> <ol style="list-style-type: none"> Urine may turn orange/red as a result of the drug (rifampicin). This is not harmful. If you feel nausea from the drugs, bring a bit of food to eat when taking the next dose. <ul style="list-style-type: none"> Treatment should not interfere with normal life and work Make sure that the patient knows exactly where and when to go for the next treatment. Remind patient to bring family and other close contacts for TB tested as needed
<p>Health Care Provider Tool See Page 121-122</p>	<p>ICTC Referral form</p>
<p>The next 5 slides consist of the records maintained by the counselling personnel related to ICTC-TB integration.</p>	<p>Documentation for HIV-TB Integration</p> <ul style="list-style-type: none"> Column 4 and 17 of the ICTC Register for General clients The ICTC HIV-TB Collaborative Activity Register. (Use the PID) Integrated Counseling and Testing Centre referral form. <p>End of the month</p> <ul style="list-style-type: none"> Line-list of Persons referred from the ICTC to the RNTCP

Understanding and Managing Stigma and Discrimination

Understanding and Managing Stigma and Discrimination

Defining Stigma and Discrimination

HIV/AIDS is viewed as a disease that affects “others,” that is people who are different from us, people whose lifestyles are often seen as “perverted” and “sinful.” Hence it is easy for it to go hand in hand with discrimination, stigma, and denial.

Stigma involves setting aside certain persons or groups from the normal social order because they are viewed as having some negative characteristic. Separating them from general society means a lowered social status for them. UNAIDS defines HIV-related stigma as a ‘process of devaluation’ of people either living with or associated with HIV and AIDS.

Discrimination is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. It is the result of the social separation or devaluation. It is sometimes referred to as enacted stigma. It is important to note that even if a person feels stigma towards another, she/ he can decide not to act in a way that is unfair or discriminatory.

Stigma can be thought of as attitudes and thoughts. Discrimination is the behaviour based on stigmatizing attitudes and thoughts

Stigma and discrimination violate human rights. This includes health-related discrimination. They arise from 3 factors:

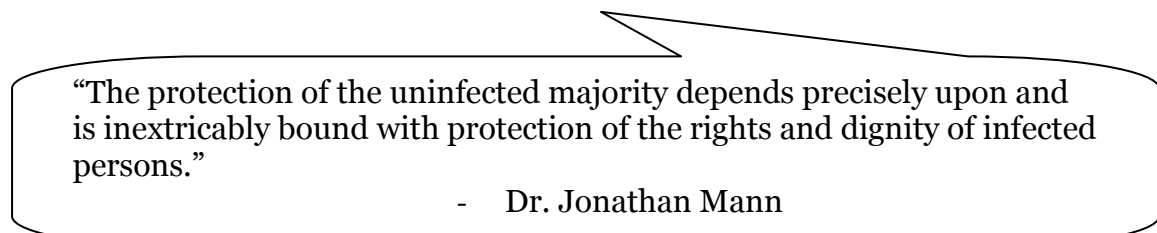
- Lack of awareness of how stigma affects People Living with HIV/AIDS
- Fear of human beings of being infected from ordinary contact with people already infected with HIV
- Associating people with HIV with behaviours that are immoral

Examples of Stigma and Discrimination

When we think of discrimination, we might identify instances where people were denied medical services, or where they were denied a job. But discrimination is of different types and can happen in many situations. It consists of both specific actions against PLWHAs as well as omissions. Examples of specific discriminatory actions would be firing someone from a job because they test positive for HIV during a routine workplace health check-up, or using plastic sheeting to wrap the corpse of only PLWHAs. Examples of specific discriminatory omissions would be delays in treating a person with HIV infection or changing a planned surgery when the person tests positive for HIV infection. Some of these actions are open while others are more hidden.

In India, a study by UNAIDS (2001) found the several types of open and hidden discrimination (See Table).

Many PLWHAs point out that health care settings are a major source of discrimination and stigma. However, such practices are also seen in families and NGOs. For instance, some NGO staff assume that all HIV-positive women clients work in the sex trade or they may maintain a casual attitude towards the rights of PLWHAs (e.g., photographing them without consent and brushing aside their objections).



“The protection of the uninfected majority depends precisely upon and is inextricably bound with protection of the rights and dignity of infected persons.”

- Dr. Jonathan Mann

	OPEN DISCRIMINATION	HIDDEN DISCRIMINATION
Hospitals	<ul style="list-style-type: none"> • Refusal to provide treatment for HIV/AIDS-related illness • Refusal to admit for hospital care/treatment • Refusal to operate or assist in clinical procedures • Restricted access to facilities like toilets and common eating and drinking utensils • Physical isolation in the ward (e.g. separate arrangements for a bed outside the ward in a gallery or corridor) • Stopping ongoing treatment • Early discharge from hospital • Mandatory testing for HIV before surgery and during pregnancy • Restrictions on movement around the ward or room • Unnecessary use of protective gear (gowns, masks, etc.) by health care staff • Refusal to lift or touch the dead body of an HIV-positive person • Use of plastic sheeting to wrap the dead body • Reluctance to provide transport for the body 	<ul style="list-style-type: none"> • Delays in treatment; slow service (e.g. made to wait in queues, asked to come again) • Excuses or explanations given for non-admission (but admission not directly refused) • Shunting patient between wards/doctors/hospitals • Keeping patient under observation without any treatment plan • Postponed treatment or operations • Unnecessarily repeated HIV tests • Conditional treatment (e.g. only on the condition that the patient will come for follow up or join a drug trial programme).
Home and Community	<ul style="list-style-type: none"> • Severed relationships, desertion, separation • Denial of share of property or access to finance • Blocked access to spouse, children, or other relatives • Physical isolation at home (e.g. separate sleeping arrangements) • Blocked entry to common areas or facilities (toilet, etc.) • Blocked entry to common places like village or a neighbourhood area • Denial of death rituals • Labelling and name-calling 	<ul style="list-style-type: none"> • Disparaging remarks about the HIV-positive family member (e.g. “he is paying for past sins”) • “Guilt tripping” for burdening the family economy and for lowering family prestige
Workplace	<ul style="list-style-type: none"> • Removal from job • Forced resignation • Withdrawal of health/insurance benefits • Poor access to shared facilities • Social distance • Labelling and name calling 	

Some forms of discrimination are very difficult to detect. For instance, health care workers may refer all their HIV-positive patients to a particular hospital that has a good reputation for caring for PLWHAs. This is designated as the “AIDS hospital”, but such referrals may really be dumping the patient. The referring hospital would have the facilities with which to care for an HIV patient, but may be sending him/her away to avoid dealing with an HIV infected person rather than as a decision of what is in the best medical interests of the patient.

Some reasons put forward by medical professionals to avoid treating PLWHAs are:

- It is very risky to the care provider to provide treatment
- It is very expensive to provide safety precautions or there is a lack of proper equipment
- They have a low opinion of HIV patients
- They have no experience or are not sure of how to treat
- The treatment is not economical for the patients
- Other staff will oppose the treatment or they are not trained

Some care providers do agree to provide service under the following conditions:

- They give tablets for symptomatic conditions, but avoid any physical contact with the patient
- They limit themselves to those procedures which do not involve blood.
- They do not admit a patient with very poor health

ICTC staff may observe that some physicians send patients for repeated testing (this is different from NACO’s 3-test policy which is used to clarify what an initial indeterminate test result actually means). Even if testing is free or subsidized, there are other costs incurred by the patient such as unnecessary travel time and money, and time taken off from work. Further, this is a waste of public funds.

Also, Provider-Initiated Testing should not be used as an opportunity to routinely test all patients (e.g., prior to surgery.) It is meant to ensure that people who might be infected are actively referred for counselling related to HIV testing, and are given the opportunity to “opt-out” if they are not willing to be tested.

ICTC staff may also observe another way of discriminating which involves disclosing test results to non-treating staff as well as to family members and friends before telling the patient. Often women are not informed about their status. One exception is disclosure to children: The test result is shared with the parent/ guardian.

While many hospitals are aware that they should not overtly label PLWHAs by placing placards on their doors or beds, a more hidden form of discrimination is to identify them with alternative terms such as “barrier nursing” or “immuno-compromised,” or by placing special symbols on their chart. All of these serve to announce to staff that a certain individual is HIV infected.

Effects of Stigma and Discrimination

AIDS-related stigma is almost as big a burden to a PLWHA as being infected itself. The possibility of facing discrimination may cause People Living with HIV/AIDS to

- avoid preventive HIV services
- reduce or delay disclosure of their status
- reduce adherence to the medication regime
- not to use condoms in all sexual encounters
- postpone or reject treatment and care

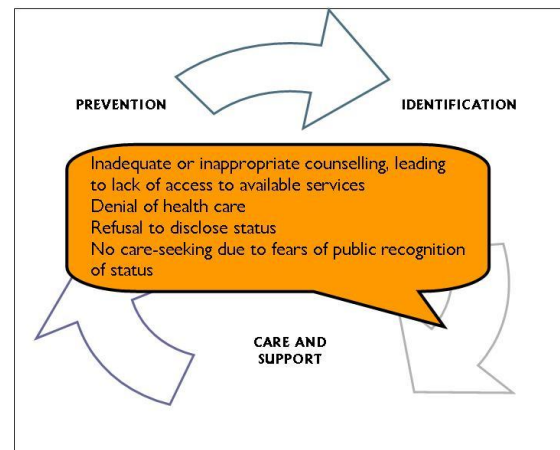
ICTCs are the gateway to other HIV services. If patients who are infected with the virus find it difficult to enter the ICTC, or experience discriminatory behaviours, they may not return to pick up their test results, or they may not move to the other AIDS services such as ART centres.



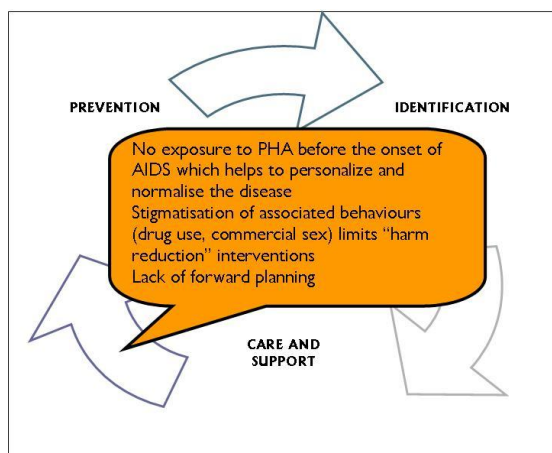
This is seen in a framework proposed by Busza (1999). She in turn used the continuum developed by MacNeil and Anderson (1998) between prevention and care which was explained in an earlier section in this handbook. Busza pointed out the poisonous effect of stigma and discrimination at all stages of the cycle. For instance, when there is a stigma associated with the illness, people whose behaviour places them at risk may try to relieve their worry by pointing to “other” groups with the stigmatised and despised behaviour instead of examining their own risky activities. They may put off undergoing the HIV test. Since testing and counselling generally precede the decision to take self-protective and other-protective behaviours such as using a condom in all sexual encounters, these delays in testing put the individual (and their sexual

partners) at greater risk. Once identified as being HIV-infected, people may put off seeking early treatment (e.g., cotrimoxazole prophylaxis, TB diagnosis) because they worry about facing stigma in the health set-up. Seeking treatment at later stages of illness places more financial and care burden on the family and the individual.

Since HIV is common in groups that are already stigmatised for their behaviours such as drug-taking, commercial sex, or male-to-male sex, the HIV-related stigma and blame is an additional burden. Some PLWHAs experience shame in relation to being infected with HIV. This shame is a manifestation of stigma that



some writers call ‘internalized’ stigma. Feeling ashamed of oneself may also prevent people living with HIV from seeking treatment, care and support and exercising other rights, such as working, attending school, etc. Such shame can have a powerful psychological influence on their self-concept and how they adjust to their status, making them vulnerable to blame, depression and self-imposed isolation



Also, the link between behaviour and infection often gets passed on to people who are infected through other routes of transmission. In this context, society tends to classify PLWHAs as “innocent” or “guilty.”

Some considerations when disclosing to children

While failure to disclose HIV test results directly to a client is ethically wrong, there is one exception: children. Informing infected children about their diagnosis or telling them about the diagnosis of a loved one is a delicate matter. When asked what holds them back, caregivers usually mention the following:

- Fears regarding depressing the child or worrying them excessively.
- Child's difficulty in maintaining a secret
- Fears that other people will find out and discriminate against them.
- Parent's own guilt about being the source of infection
- Parent's denial and/or difficulty in accepting their own illness.

Children have a right to know something this important. However, informing them can be spread out given various factors such as:

- Their age and maturity,
- Their ability to cope with the knowledge of such a life-changing infection
- The complexity of family dynamics
- The clinical context: the exact diagnosis and prognosis of the disease.
- Their circumstances (e.g., discrimination in schools, communities, and families remains a serious problem)

Such disclosure should include continued counselling and psycho-social support. Disclosure may be undertaken by a counsellor or by a parent (or other care provider) in consultation with a counsellor. It may be partial or complete depending on the age and level of functioning of the child. In partial disclosure, the counsellor or care provider describes what is happening to the body and what treatments will help to resolve this, rather than naming the virus or illness. In complete disclosure, the counsellor or care provider will openly discuss HIV, and other related issues.

Combating Stigma and Discrimination

As already pointed out, stigma and discrimination arise from 3 factors:

- Lack of awareness of how stigma affects People Living with HIV/AIDS
- Fear of human beings of being infected from ordinary contact with people who are already infected with HIV
- Associating people with HIV with behaviours that are immoral

Consistent with this finding, a study by the Population Council and SHARAN (Mahendra et al., 2006) with hospital staff also found that staff prejudice and discrimination against patients infected with HIV was related to misconceptions about HIV transmission. They found that these discriminatory attitudes and practices reduced after staff education was carried out. This staff education involved general information about HIV/AIDS as well as specific information related to infection control and post-exposure prophylaxis.

If ICTC staff face situations where other colleagues in a health centre practise discrimination, then the first thing they could do is to educate them about how HIV spreads and does not spread. They can also discuss the basics of bio-safety precautions and post-exposure prophylaxis. This handbook contains sections related to each of these topics.

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Universal Safety Precautions

The personal risk of infection in a health setting concerns all health care personnel (HCP). While counselling personnel interacts directly with clients, it is other HCP who are at the risk of infection when their work responsibilities put them in contact with blood or other body fluids of an infected person.

Occupational Exposure

In a health institution such as a hospital or an ICTC, a staff member who handles body fluids such as blood could be exposed to HIV. Such an Accidental Exposure to Blood (AEB) falls under the broad category of occupational exposure. Occupational exposure involves exposure to potential blood-borne infections such as HIV, Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) that may occur in health care settings while performing the responsibilities related to one's job.

The table below which is extracted from NACO's (2007) Guidelines for Testing shows which HCP may be at risk during each stage of the procedure of drawing blood as well as the manner in which they may be exposed to risk.

Laboratory Procedure	HCP at risk	Source/ Modes of Transmission
Collection of blood/ body fluids	Laboratory technician/ Nursing staff	Needle-stick injury, Broken specimen container, Blood contamination of hand with skin lesion/ breach.
Transfer of specimen	Laboratory technician and transport worker	Contaminated exterior of the container/ requisition slip
Processing of specimen	Laboratory personnel	Puncture of skin or contamination of skin/ mucous membrane from <ul style="list-style-type: none">- Contaminated work surface- Spill/ splash of specimen- Broken specimen container- Faulty techniques
Cleaning/ washing	Support staff	Puncture/ contamination of skin from <ul style="list-style-type: none">- Contaminated glassware- Sharps- Contaminated work surface
Disposal of waste	Laboratory personnel support staff	Contact with infectious waste, specially sharps
Transport of specimen to distant laboratory	Transport/ Postal staff	Broken/ leaking container

Thus the ICTC team members who might be at risk of such occupational exposure include testing personnel who conduct the blood tests, medical officers and nurses when they come in contact with body fluids of a Person Living with HIV/AIDS. Casual contact such as talking with a PLWHA or shaking their hands cannot transmit the infection.

There is as yet no vaccine or cure for HIV/AIDS. Treatment to control the activity of the virus while available, is expensive, complicated and is lifelong. So, prevention is of the highest importance.

It is quite likely that all HCP fear being infected through accidental exposure to blood or AEB. This has led some individuals to protect themselves by avoiding any physical contact with PLWHAs, or by trying to ascertain the sero-status of every person walking in for health services. Not only do these measures discriminate against the rights of the patients; they also fail to guarantee the safety of the HCP practicing these measures.

For instance, testing every patient may build a false sense of complacency and confidence that one can identify PLWHAs and take special precautions against being infected in relation to only these individuals. Such an irrational fear fails to account for the fact that some people might be in the window period when they are actually infectious but fail to register on an antibody test.

The only real antidote or solution is to practise Universal Safety Precautions (USP). These were originally developed by the United States Centres for Disease Control and Prevention (CDC) in 1985 largely as a response to the emergence of HIV/AIDS. This is a workplace parallel to risk reduction measures for individuals. It aims to ensure a safe and healthy working environment in hospitals and other health facilities.

Practising Universal Safety Precautions means applying blood and body-fluid precautions universally to all persons regardless of their presumed infectious status. That is, all HCP must take standard precautions whenever they work with blood and body-fluids because there is a possibility of being infected.

Universal Safety Precautions in the ICTC

Compared to the risk of being infected with HBV or HCV at the workplace, the average risk of acquiring HIV infection from different types of occupational exposure is low. The important routes of occupational exposure are needle stick exposure (0.3% risk for HIV, 9–30% for HBV and 1–10% for HCV) and mucous membrane exposure (0.09% for HIV).

The ICTC Operational

Guidelines state that, “Staff working in the blood collection room and laboratory should observe the following precautions while handling blood and blood products. These include:

- Using gloves when handling blood samples
- Using disposable needles and syringes for drawing blood
- Practising routine hand-washing before and after any contact with blood samples
- Disposing of sharp instruments safely as per procedure, e.g., discard disposable syringes in a puncture-resistant container after disinfection with bleach solution. In areas where such work is undertaken a source of clean water should be maintained.”

With regard to disinfection and sterilisation, the testing personnel is required to adhere to disinfection and sterilisation standards. All reusable supplies and laboratory equipment should be disinfected by sterilization or with soap and bleach solution.

Further, kits are made available in all ICTCs which will enable medical staff such as doctors, nurses and attenders, etc. to perform a safe delivery of HIV-positive pregnant female patients. These kits include:

- Plastic disposable gowns
- Disposable goggles to protect the eyes
- Face mask
- Disposable shoe covers
- Two pairs of long gloves

Waste management guidelines in the ICTC Operational Guidelines address hospital waste such as medical waste, clinical waste, pathological waste, infectious waste, non-hazardous waste, biodegradable kitchen waste and non-biodegradable waste. These, it is advised, should be managed through the use of colour-coded containers. Other instructions are given for disposal of items such as gloves, syringes, etc.

The aim of this training programme is not to give detailed instructions about Universal Safety Precautions or Waste Management. More information can be obtained, if needed, from NACO's (2007) Guidelines for Testing. The important take-home point is that Universal Safety Precautions should be carried out systematically and consistently with ALL patients within the ICTC setting.

Documentation

The Laboratory Technician must maintain in the Stock Register details of supplies related to USP such as disposable gloves, and safe delivery kits. From these one can extract information such as the Opening stock, Receipts, Utilisation and Closing balance.

References

- 1) National AIDS Control Organisation (2007). Guidelines for HIV testing New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- 2) National AIDS Control Organisation (2007). *Operational guidelines for Integrated Counselling and Testing Centres*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.

Post-Exposure Prophylaxis

One major reason why people behave in a discriminatory manner towards PLWHAs is that they fear getting the HIV infection themselves. Some people wrongly worry that they can get affected by just being in the same room as a PLWHA or by using items that he/ she has used (such as a towel or a plate).

HIV/AIDS spreads through four routes only:

1. Unprotected sex with an infected person
2. Transfusion of HIV infested blood
3. Use of infected needles and syringes
4. From an infected mother to her child during pregnancy, childbirth or breastfeeding

Health Care Personnel (HCP) could be infected with blood-borne infections through

- percutaneous injuries such as needle-stick injuries or cuts with a sharp instrument
- contact with the mucous membranes of the eye or mouth of an infected person
- contact with non-intact skin (particularly when the exposed skin is chapped, abraded, or afflicted with dermatitis)
- contact with blood or other potentially infectious body fluids such as semen, vaginal secretions, cerebrospinal fluid, synovial, pleural, peritoneal, pericardial fluid and amniotic fluid.

The section on Universal Safety Precautions provided information about how HCP must treat all these potentially infective materials safely in order to avoid getting infected. However, sometimes accidents do happen. This is termed as an Accidental Exposure to Blood (AEB).

When a HCP is exposed to the blood or other contaminated body fluids of someone infected with HIV, the actual risk of infection depends on several factors such as:

- Type of needle (hollow bore versus solid)
- Device visibly contaminated with patient's blood
- Depth of injury
- The amount of blood involved in the exposure
- The amount of virus (viral load) in the patient's blood at the time of exposure.
- Whether Post-Exposure Prophylaxis was taken within the recommended period (within 2 hours; upto 72 hours)

Post exposure prophylaxis

Post exposure prophylaxis (PEP) is a strategy to combat occupational exposure to HIV. According to the National AIDS Control Organisation, it refers to “comprehensive medical management to minimise the risk of infection among Health Care Personnel (HCP) following potential exposure to blood-borne pathogens (HIV, HBV, HCV). This includes counselling, risk assessment, relevant laboratory investigations based on informed consent of the source and exposed person, first aid and depending on the risk assessment, the provision of short term (four weeks) of antiretroviral drugs, with follow up and support.”

It is recommended that ICTC staff note in their list of Common Contacts the name of the designated person in their district who is trained to conduct the rapid assessment and begin administering PEP. Detailed information such as telephone contact numbers should be updated. The same information should be displayed on a small display area for the staff or on a blackboard for immediate consultation in case of an emergency.

NACO Policy on Post exposure prophylaxis

Here are the steps in NACO's policy on PEP in case of an AEB.

Step 1: First-aid in management of exposure

For skin

- 1) If the skin is broken after a needle-stick or sharp instrument
 - a) Immediately wash the wound and surrounding skin with water and soap, and rinse. Do not scrub.
 - b) Do not use antiseptics or skin washes (bleach, chlorine, alcohol, betadine).
- 2) After a splash of blood or body fluids on unbroken skin:
 - a) Wash the area immediately
 - b) Do not use antiseptics

For the eye

- 1) Irrigate exposed eye immediately with water or normal saline. Sit in a chair, tilt head back and ask a colleague to gently pour water or normal saline over the eye.
- 2) If wearing contact lens, 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 lens and clean them in the normal manner. This will make them safe to wear again
- 3) Do not use soap or disinfectant on the eye.

For the mouth

- 1) Spit fluid out immediately
- 2) Rinse the mouth thoroughly, using water or saline and spit again. Repeat this process several times
- 3) Do not use soap or disinfectant in the mouth
- 4) Consult the designated physician of the institution for management of the exposure immediately.

Step 2: Establish eligibility for PEP

The HIV sero-conversion rate of 0.3% after an AEB (for percutaneous exposure) is an average rate. The risk of infection transmission is proportional to the amount of HIV transmitted, which depends on the nature of exposure and the status of the source patient. A baseline rapid HIV-testing of exposed and source person must be done for PEP. However, initiation of PEP should not be delayed while waiting for the results of HIV-testing of the source of exposure. Informed consent should be obtained before testing of the source as per national HIV testing guidelines.

First PEP dose within 72 hours

A designated person/trained doctor must assess the risk of HIV and HBV transmission following an AEB. This evaluation must be quick so as to start treatment without any delay, ideally within two hours but certainly within 72 hours; PEP is not effective when given more than 72 hours after exposure. The first dose of PEP should be administered within the first 72 hours of exposure. If the risk is insignificant, PEP could be discontinued, if already commenced.

Assessing risk of transmission

Exposure is defined under three categories based on the amount of blood/fluid involved and the entry port. These categories are intended to help in assessing the severity of the exposure but may not cover all possibilities (please see the table below).

DON'TS

- Do not panic
- Do not put the pricked finger in the mouth
- Do not squeeze the wound to bleed it
- Do not use bleach, chlorine, alcohol, betadine, iodine or any antiseptic or detergent

Categories of Exposure	
Category	Definition and example
Mild exposure	Mucous membrane/non-intact skin with small volumes E.g.: a superficial wound (erosion of the epidermis) with a plain or low calibre needle, or contact with the eyes or mucous membranes, subcutaneous injections following small-bore needles.
Moderate exposure	Mucous membrane/non intact skin with large volumes Percutaneous superficial exposure with solid needle E.g. : a cut or needle stick injury penetrating gloves
Severe exposure	Percutaneous with large volume E.g.: an accident with a high calibre needle (>18 G) visibly contaminated with blood; A deep wound (haemorrhagic wound and/ or very painful) Transmission of a significant volume of blood An accident with material that has previously been used intravenously or intra-arterially.

The wearing of gloves during any of these accidents constitutes a protective factor.

Note: In case of an AEB with material such as discarded sharps/needles, contaminated for over 48 hours, the risk of infection is negligible for HIV, but still remains significant for HBV. HBV survives longer than HIV outside the body.

Assess exposed individual

The exposed individual should have confidential counselling and assessment by an experienced physician. Exposed individuals who are known or discovered to be HIV- positive should not receive PEP. They should be offered counselling and information on prevention of transmission and referred to clinical and laboratory assessment to determine eligibility for antiretroviral therapy (ART). Besides the medical assessment, counselling [the] exposed HCP is essential to allay fear and start PEP.

Step 3: Counselling for PEP

Exposed persons (clients) should receive appropriate information about what PEP is about and the risk and benefits of PEP in order to provide informed consent for taking PEP. It should be clear that PEP is not mandatory.

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. Some clients may require further specialised psychological support.

Document exposure

Documentation of exposure is essential. Special leave from work should be considered initially for a period of two weeks. Subsequently, it can be extended based on the assessment of the exposed person's mental state, side- effects and requirements.

Practical application in the clinical settings

- For prophylactic treatment, the exposed person must sign [the] consent form.
- Informed consent also means that if the exposed person has been advised PEP, but refuses to start it, this needs to be recorded. This document should be kept by the designated officer for PEP.
- An information sheet covering the PEP and the biological follow-up after any AEB must be given to the person under treatment. However, this sheet cannot replace verbal explanations.

Step 4: Prescribe PEP

Deciding on PEP regimen

There are two types of regimens:

- Basic regimen: 2-drug combination
- Expanded regimen: 3-drug combination

The decision to initiate the type of regimen depends on the type of exposure and HIV serostatus of the source person.

In the case of a high risk exposure from a source patient who has been exposed to or is taking antiretroviral medications, consult an expert to choose the PEP regimen, as the risk of drug resistance is high. Refer/consult [an] expert physician. Start [the] 2-drug regimen first.

HIV-PEP Evaluation

Exposure	Status of Source		
	HIV+ and Asymptomatic	HIV+ and Clinically symptomatic	HIV status unknown
Mild	Consider 2-drug PEP	Start 2-drug PEP	Usually no PEP or consider 2-drug PEP
Moderate	Start 2-drug PEP	Start 3-drug PEP	Usually no PEP or consider 2-drug PEP
Severe	Start 3-drug PEP	Start 3- drug PEP	Usually no PEP or consider 2-drug PEP

Seek expert opinion in case of

- Delay in reporting exposure (> 72 hours).
- Unknown source
- Known or suspected pregnancy, but initiate PEP
- Breastfeeding mothers, but initiate PEP
- Source patient is on ART
- Major toxicity of PEP regimen.⁸³

Dosage of Drugs for PEP

Medication	2-drug regimen	3-drug regimen
Zidovudine (AZT)	300 mg twice a day	300 mg twice a day
Stavudine (d4T)	30 mg twice a day	30 mg twice a day
Lamivudine (3TC)	150 mg twice a day	150 mg twice a day
Protease Inhibitors		1st choice Lopinavir/ritonavir (LPV/r) 400/100 mg twice a day or 800/200 mg once daily with meals
		2nd choice Nelfinavir (NLF) 1250 mg twice a day or 750 mg three times a day with empty stomach
		3rd choice Indinavir (IND) 800 mg every 8 hours and drink 8–10 glasses (1.5 litres) of water daily

Note: If protease inhibitor is not available and the 3rd drug is indicated, one can consider using Efavirenz (EFV 600 mg once daily).

Monitoring should be instituted for side effects of this drug eg CNS toxicity such as nightmares, insomnia etc.

* Fixed Dose Combination (FDC) are preferred, if available. Ritonavir requires refrigeration.

Step 5: HIV chemoprophylaxis

Because post-exposure prophylaxis (PEP) has its greatest effect if begun within two hours of exposure, it is essential to act immediately. The prophylaxis needs to be continued for four weeks. Exposure must be immediately reported to [the] designated authority and therapy administered. Never delay start of therapy due to debate over regimen. Begin with basic two-drug regimen, and once expert advice is obtained, change as required.

Selection of PEP regimen when the source patient is on ART

The physician should consider the comparative risk represented by the exposure taking in view [the] exposure source's history of and response to antiretroviral therapy based on [the] clinical response, CD4 cell counts, viral load measurements (if available), and current disease stage (WHO clinical staging and history). If the source person's virus is known or suspected to be resistant to one or more drugs considered for the PEP regimen, [the] exposed person needs to be given alternate PEP drug regimen, and referred for expert opinion.

Changes in the PEP regimen can be made after PEP has been started. Re-evaluation of the exposed person should be considered within 72 hours post-exposure, especially as additional information about the exposure or source person becomes available.

ARV drugs during pregnancy

Data regarding the potential effects of antiretroviral drugs on the developing foetus or neonate are limited. There is a clear contraindication for Efavirenz (first 3 months of pregnancy) and Indinavir (pre natal).

PEP regimens to be prescribed by Health Centres

	Preferred	Alternative
2-drug regimen (basic PEP regimen)	Zidovudine (AZT) + Lamivudine (3TC)	Stavudine (d4T) + Lamivudine (3TC)
3-drug regimen (consult expert opinion for starting 3 drug eg LPV/r, NLF or IND regimen)		
Not recommended	ddI + d4T combination NNRTI such as Nevirapine should not be used in PEP	

More information on alternative schedules is available in the latest update USPHS guidelines issued 30 September 2005. (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm>)

For a female HCP considering PEP, a pregnancy test is recommended in case of a doubt. Pregnant HCP are recommended to begin the basic 2-drug regimen, and if a third drug is needed, Nelfinavir is the drug of choice.

Side-effects and adherence to PEP

Studies have indicated more side effects, most commonly nausea and fatigue, among HCP taking PEP than PLWHAs taking ART. These side-effects occur mainly at the beginning of the treatment and include nausea, diarrhoea, muscular pain and headache. The person taking the treatment should be informed that these may occur and should be dissuaded from stopping the treatment as most side-effects are mild and transient, though possibly uncomfortable. Anaemia and/or leucopenia and/or thrombocytopenia may occur during the month of treatment.

Adherence information and psychological support are essential. More than 95% adherence is important in order to maximise the efficacy of the medication in PEP. Side effects can be reduced through medications. A complete blood count and liver function tests (transaminases) may be performed at the beginning of treatment (as baseline) and after 4 weeks.

Step 6: Follow-up of an exposed person

Whether or not post-exposure prophylaxis is started, a follow up is needed to monitor for possible infections and to provide psychological support.

Clinical follow-up

In the weeks following an AEB, the exposed person must be monitored for the eventual appearance of signs indicating an HIV sero-conversion: acute fever, generalized lymphadenopathy, cutaneous eruption, pharyngitis, non-specific flu symptoms and ulcers of the mouth or genital area. These symptoms appear in 50%-70% of individuals with an HIV primary (acute) infection and almost always within 3 to 6 weeks after exposure. When a primary (acute) infection is suspected, referral to an ART centre or for expert opinion should be arranged rapidly.

An exposed person should be advised to use precautions (e.g., avoid blood or tissue donations, breastfeeding, unprotected sexual relations or pregnancy) to prevent secondary transmission, especially during the first 6–12 weeks following exposure. Condom use is essential.

Drug adherence and side effect counselling should be provided and reinforced at every follow-up visit. Psychological support and mental health counselling is often required.

Laboratory follow-up

Exposed persons should have post-PEP HIV tests. HIV-test at 3 months and again at 6 months is recommended. If the test at 6 months is negative, no further testing is recommended.

(Refer Antiretroviral Therapy Guidelines for HIV-infected Adults and Adolescents including Post-exposure Prophylaxis, May 2007, NACO, Ministry of Health and Family Welfare, Government of India for details on exposure prevention and essential information to be provided to exposed person.)

References

1. National AIDS Control Organisation (nd). NACO policy on PEP. Accessed from http://www.nacoonline.org/National_AIDS_Control_Program/PEP_full/ on August 6, 2009.

SLIDES

Understanding Stigma and Discrimination

1

ICTC Team Training

We often view AIDS as something that can affect other people, people who are different from us, people who lead perverted or sinful lives.

From here it is a short step to blaming People with AIDS for their own condition.

Stigma

Setting aside certain persons or groups from the normal social order because they have some negative characteristic

- We devalue them
- We do this because we believe they are very different from us

Discrimination

The unfair and unjust treatment of an individual based on his or her real or perceived HIV status.

- When we set aside people or stigmatise them, it is easier to treat them differently.
- If a person feels stigma towards another, s/he can decide not to be unfair or discriminatory.

OPEN DISCRIMINATION	HIDDEN DISCRIMINATION
<ul style="list-style-type: none"> • Refusal to provide treatment for HIV/AIDS related illness • Refusal to admit for hospital care/treatment • Refusal to operate or assist in clinical procedures • Restricted access to facilities like toilets and common eating and drinking vessels • Physical isolation in the ward (e.g. separate arrangements for a bed outside the ward in a gallery or corridor) • Stopping ongoing treatment • Early discharge from hospital • Mandatory testing for HIV before surgery and during pregnancy • Restrictions on movement around the ward or room • Unnecessary use of protective gear (gowns, masks, etc.) by health-care staff • Refusal to lift or touch the dead body of an HIV-positive person • Use of plastic sheeting to wrap the dead body • Reluctance to provide transport for the body 	<ul style="list-style-type: none"> • Delays in treatment; slow service (e.g. made to wait in queues, asked to come again) • Excuses or explanations given for non-admission (but admission not directly refused) • Sharing patient between wards/clinics/hospitals • Keeping patient under observation without any treatment plan • Postponed treatment or operations • Unnecessarily repeated HIV tests • Conditional treatment (e.g. only on the condition that the patient will come for follow up or join a drug test programme)

5

ICTC Team Training

See the Table in the Section

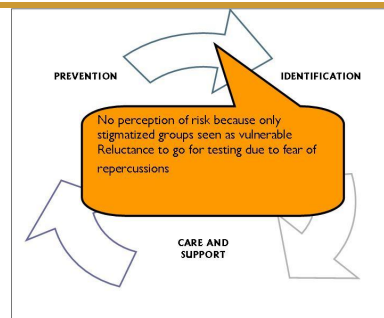
Informed Consent for HIV Testing

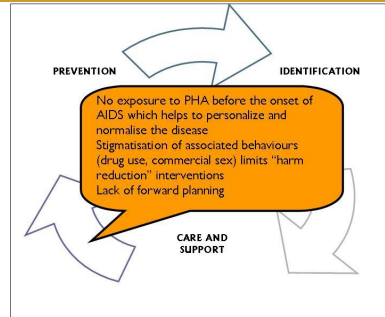
- The client agrees to HIV testing through giving his/her informed consent.
- Informed consent is a deliberate and autonomous permission given by a client to a health-care provider to proceed with the proposed HIV test procedure.
- This permission is based on adequate understanding of the advantages, risks, potential consequences
- This permission is entirely the choice of the client and can never be implied or presumed.

(From ICTC Operational Guidelines)

Discussion Question

If mandatory testing for HIV before surgery and during pregnancy that is described here a discriminatory practice, then what about provider-initiated testing and counselling?





Why do we stigmatise and discriminate?

- Lack of awareness of how stigma affects People Living with HIV/AIDS
- Fear of human beings of being infected from ordinary contact with people already infected with HIV
- Associating people with HIV with behaviours that are immoral

Universal Safety Precautions

- Risk reduction measures at the workplace.
- Practising Universal Safety Precautions means applying blood and body-fluid precautions universally to all persons regardless of their presumed infectious status.

Universal Safety Precautions

Staff working in the blood collection room and laboratory should observe the following precautions:

- Using gloves when handling blood samples
- Using disposable needles and syringes for drawing blood
- Practising routine hand-washing before and after any contact with blood samples
- Disposing of sharp instruments safely as per procedure, e.g., discard disposable syringes in a puncture-resistant container after disinfection with bleach solution

Universal Safety Precautions

- Disinfection and sterilisation
- Kits for safe delivery of HIV-positive pregnant female patients
- Waste management

This slide contains an image of the Stock Register which is maintained by the testing personnel

Post Exposure Prophylaxis

- Comprehensive medical management to minimise the risk of infection among HCP following potential exposure to blood-borne pathogens (HIV, HBV, HCV).
- Includes counselling, risk assessment, relevant laboratory investigations, first aid and provision of antiretroviral drugs.

NACO Policy on PEP

- Step 1: First aid in management of exposure
 - For skin
 - For the eye
 - For the mouth
- Step 2: Establish eligibility for PEP
 - First PEP dose within 72 hours
 - Assessing risk of transmission
 - Assess exposed individual

NACO Policy on PEP(contd..)

- Step 3: Counselling for PEP
 - Psychological support
 - Document exposure
- Step 4: Prescribe PEP
- Step 5: HIV chemoprophylaxis
- Step 6: Follow-up of an exposed person
 - Clinical follow-up
 - Laboratory follow-up

Prevention of Parent to Child Transmission of HIV

Prevention of Parent to Child Transmission of HIV

PPTCT of HIV refers to “a comprehensive, family-centred spectrum of supportive and clinical services provided in conjunction with public health initiatives to prevent the transmission of HIV from a woman to her infant.”

This section deals in detail with issues related to preventing infection through one specific route, the vertical or parental route – from mother to child.

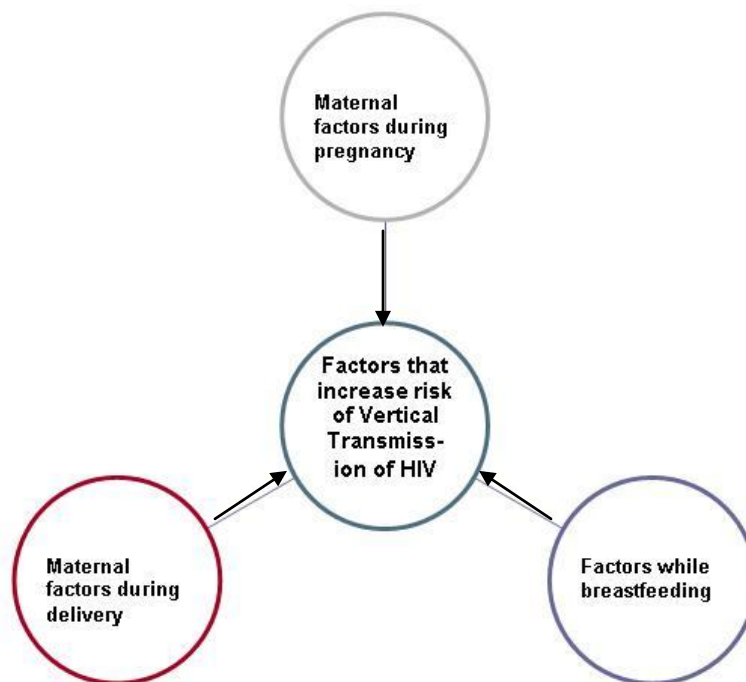
In the absence of intervention; if 100 HIV-positive women give birth to 100 infants, then:

- 5- 10 infants will be infected during pregnancy
- 10 - 20 infants will be infected during labour and delivery
- 20 – 30 infants will be infected during breastfeeding (if breastfed for 18 months)

The total number of children infected through mother without any type of intervention can vary between 25 to 40.

While many countries use the term Mother to Child Transmission, the NACO has chosen to use the term Parent to Child Transmission (PTCT). This term PTCT avoids blaming the mother for passing on HIV to her infant, and recognises the fact that most pregnant women in India are not responsible for getting infected themselves and are often unaware of being infected. This also acknowledges the role and/or responsibility of the father in HIV transmission and taking care of the mother and the child.

The objective of this module is to cover key issues related to PPTCT that ICTC team members must know. However, medical officers and counselling personnel in the ICTC are also urged to read other NACO manuals and publications for more information on the subject. One such source of information is the training manual on Prevention of Parent-to-Child Transmission of HIV (NACO, 2004).



Factors that increase HIV transmission from the parent to the child

Maternal factors that may increase the risk of HIV transmission during pregnancy include

1. New HIV infection during pregnancy
2. Advanced HIV disease or AIDS in the mother
3. High maternal viral load (quantity of HIV in the blood)
4. Viral, bacterial and parasitic infections of the placenta (especially malaria)
5. Maternal malnutrition (indirect cause)
6. STIs

Maternal factors that may increase the risk of HIV transmission during delivery include

1. New HIV infection
2. Advanced HIV disease or AIDS in the mother
3. High maternal viral load
4. Prolonged rupture of membranes (more than 4 hours)
5. Acute chorioamnionitis (infection of the membranes surrounding the baby – the chorion and the amniotic sac)
6. Invasive child birth procedures that increase contact with mother's infected blood (e.g., episiotomy, foetal scalp monitoring).
7. First infant in multiple birth

Factors that may increase the risk of HIV transmission during breastfeeding

1. New HIV infection
2. Advanced HIV disease or AIDS in the mother
3. High maternal viral load
4. Duration of breastfeeding
5. Mixed feeding (breast milk along with replacement feeding i.e. other foods and fluids)
6. Breast abscesses, nipple fissures (cracked nipples), and mastitis (infection and painful inflammation of the breast tissue)
7. Malnutrition in the mother
8. Oral disease in the infant such as candidiasis (thrush) and mouth sores

Thus viral, maternal, obstetrical, foetal and infant-related factors all influence the transmission through the parental route. The most important risk factor is the viral load in the mother's system (the quantity of virus). The risk is the highest when the viral load is high, and this occurs just after infection has occurred, and also when the HIV infection is at an advanced stage.

Preventing Transmission through the Parental Route

Transmission of HIV infection from a parent to the child is one route of infection that can be successfully prevented through the provision of antiretroviral drugs and related services such as counselling. The prevention activities are likely to be more successful if all service elements are carefully and consistently offered to patients who need them.

NACO estimates that out of an estimated 27 million pregnancies in India annually, 65,000 occur in HIV positive mothers leading to an estimated cohort of 19,500 infected babies. India's Prevention of Parent to Child Transmission (PPTCT) programme which uses Nevirapine was initiated in 2002. By 2009, approx 17.2% of all pregnant women had received HIV counselling and testing and approx 17 % of all HIV positive pregnant women received antiretroviral prophylaxis. There is still a huge unmet need and we need to push hard to increase people's access to these services.

ABC approach to responsible sexual behaviour

- A = Abstinence
- B = Be faithful to one HIV-uninfected partner who is also faithful to you
- C = Condom use that is consistent (with all sexual partners) and correct

At the time of preparation of the NACP III, there were a total of 1882 PPTCT centres. This number has risen to over 5,000 in 2009.

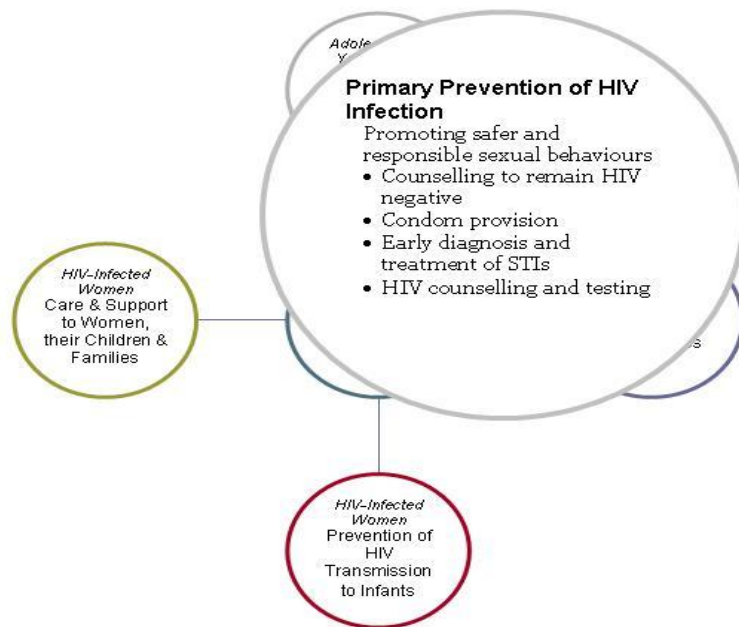
As we have seen earlier, upto 40% of infants born to women infected with HIV are at risk of infection in the absence of any intervention. The PPTCT programme is trying to reduce the number of these likely infected children.

The strategy for PPTCT has 4 prongs:

- Primary prevention of HIV;
- Prevention of unintended pregnancies among HIV-infected women;
- Prevention of HIV transmission from HIV infected pregnant women who are infected to their children;
- Provision of care and support to the HIV-infected women, their infants, and their families.

Each of these is discussed in detail below.

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

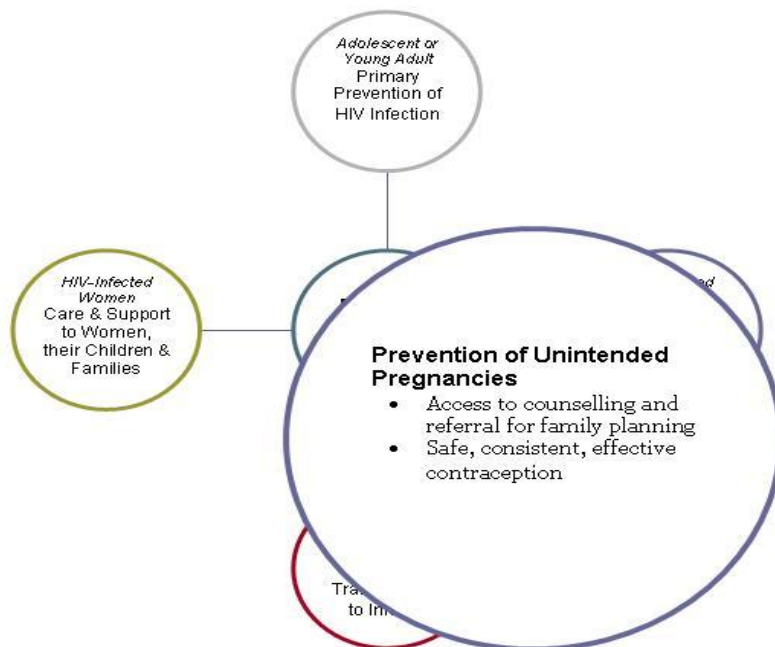


This prong focuses on the parents-to-be. HIV infection cannot be passed on to children if their parents are not infected with HIV. This consists of promoting safer and responsible sexual behaviours which include, where appropriate, delaying the onset of sexual activity, practising sexual abstinence, reducing the number of sexual partners and using condoms. The strategies here include condom provision, early diagnosis and treatment of STIs, HIV counselling and testing, and suitable counselling for the uninfected so that they remain HIV negative.

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

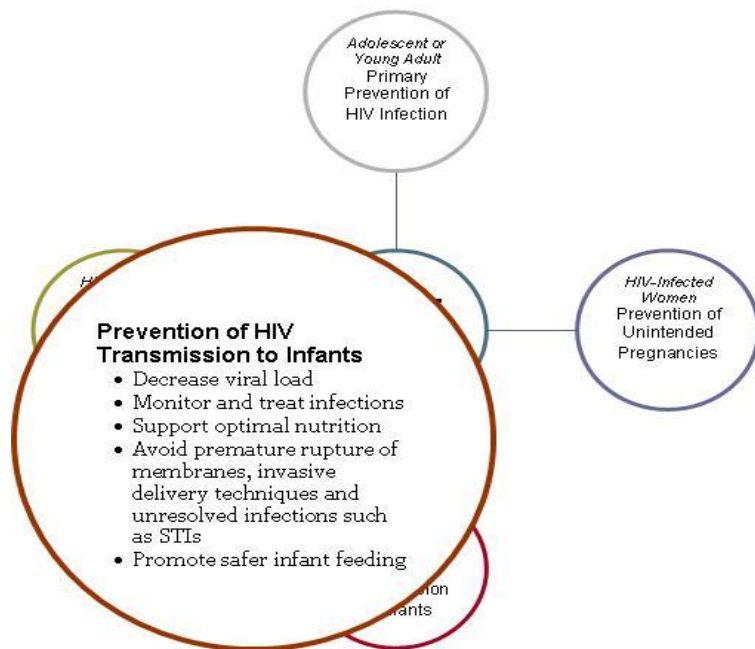
This prong looks at the family planning needs of the HIV infected women. With appropriate support, women who are aware of being sero-positive can plan their pregnancy and therefore reduce the possibility of passing the virus to their future children. They can also take measures to protect their own health.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

At the ICTC, post-test counselling should cover this information if the client is in a position to absorb it, namely inform sero-positive clients that they are capable of transmitting the HIV to others including their spouses and in the case of women, to the children they might bear. They should be informed that a counselling personnel can explain to them how to reduce the risk of transmission and invite them to come back for more information whenever they feel the need.



The third and fourth prongs focus on HIV-infected women, their children, and families

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



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

- Decreasing viral load
- Monitoring and treating infections
- Supporting optimal nutrition
- Avoiding premature rupture of membrane and invasive delivery techniques
- Treating infections such as STIs
- Promoting safer infant feeding

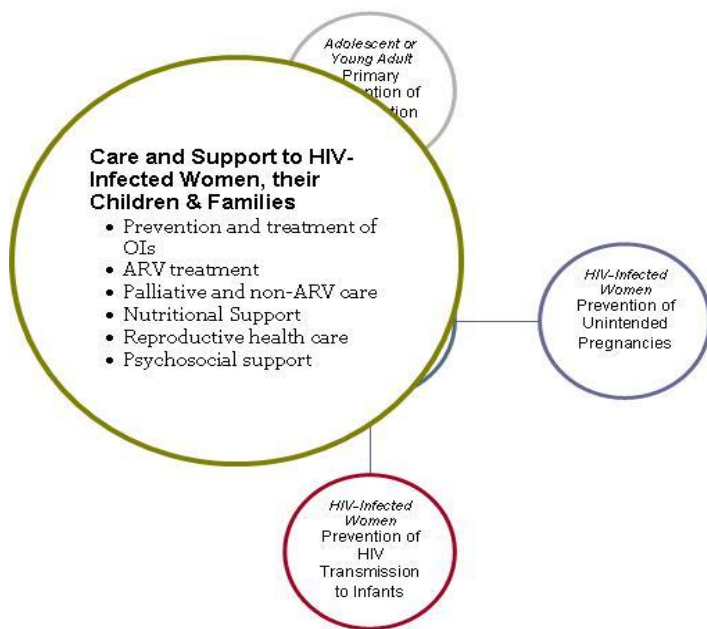
When an ARV drug is given to prevent transmission from the mother to the infant, it is referred to as ARV prophylaxis. This is different from ARV treatment for

the mother which is used to treat her HIV disease.

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

Medical care and social support are necessary to help the woman living with HIV to address and manage her worries about her own health and that of her family. If she is assured of receiving adequate care for herself and her loved ones, she is more likely to undergo HIV testing, and also adhere to the treatment. The service elements here include prevention and treatment of OIs, ARV treatment, palliative (pain-reducing) and non-ARV care, nutritional support, reproductive health care and psychosocial support.

Thus, a comprehensive PPTCT programme provides a continuum of care for the mother and the child. The continuum begins with educating adolescent women about primary prevention of infection and continues through treatment, care and support to HIV-positive women and families. It ensures that women receive



education and services to reduce the risk of mother-to-child-transmission throughout pregnancy, labour and childbirth, and infant feeding. It also provides support for both mother and child, especially during the crucial years of childhood growth and development. This comprehensive approach ultimately provides linkages to existing community services to address the complex needs and issues involved in HIV prevention, treatment and management.

The PPTCT Programme as a Case of Provider-Initiated Testing

Given that scientific advancements have empowered us to reduce the chances of transmission through the parental or vertical route, it is important to make these services available to as many people as possible. However, since many women lack awareness of their personal risk of HIV and the risk to their children, it is necessary to use the antenatal care setting as an occasion to educate them about HIV/AIDS.

Women who access antenatal services at public health facilities should receive a routine offer to test for the HIV infection. That is, the ANC provider should provide them information as to why they need to know their HIV sero-status, and

Mother	Child
❖ Decreased chance of HIV transmission to her child	❖ Decreased chance of being infected with HIV
❖ Post partum care	❖ Proper nutritional guidance
❖ Infant feeding support	❖ Prevention and treatment of OI <ul style="list-style-type: none"> ○ Proper immunization ○ Cotrimoxazole prophylaxis
	❖ ART when required

then refer them to the ICTC. The ICTC personnel should inform them the benefits of testing, and, after conducting the procedures for obtaining informed consent, test them for HIV.

Women who come for ANC, is under provider initiated testing and should be able to leave the ICTC with their test results within a single day. However, the ICTC will have a longer interaction with the HIV positive pregnant women as compared to other HIV-infected clients. Such women are encouraged to involve their partners in the treatment process. They require follow-up for various issues related to a safe pregnancy and delivery.

By encouraging women to know their HIV sero-status, the ICTC can help in reducing parent-to-child transmission. This enrolment into the PPTCT programme opens the door to many key services and advantages.

As with all other instances of provider-initiated testing, the client is always made aware of their right to “opt out” of HIV testing, and this right is respected even if it may appear to a clinician that this decision of the client is illogical.

If woman does not consent for the HIV test, they should be treated as if they are infected with HIV, namely clinical management should proceed as if she were HIV-positive, and the suitable clinical protocols followed.

PPTCT Integration with Maternal and Child Health Services (MCH)

The PPTCT programme must have strong linkages with the MCH services in order to work effectively. MCH services can assist pregnant women through:

- Essential antenatal care
- Family planning services
- ARV prophylaxis
- Safer deliver practices
- Counselling and support for the method the woman uses to feed her new-born child.

Integrating these two services means that women are more likely to continue accessing HIV-related services. It also makes programmatic sense to integrate these two programmes because many elements of PPTCT are similar to those in the MCH programme. These include essential obstetric services, safe abortion, strengthening of first referral units and emergency obstetric care, promotion of institutional deliveries and 24 hours delivery services at PHCs and CHCs and baby-friendly hospitals. The accompanying box contains the essential package of antenatal care services.

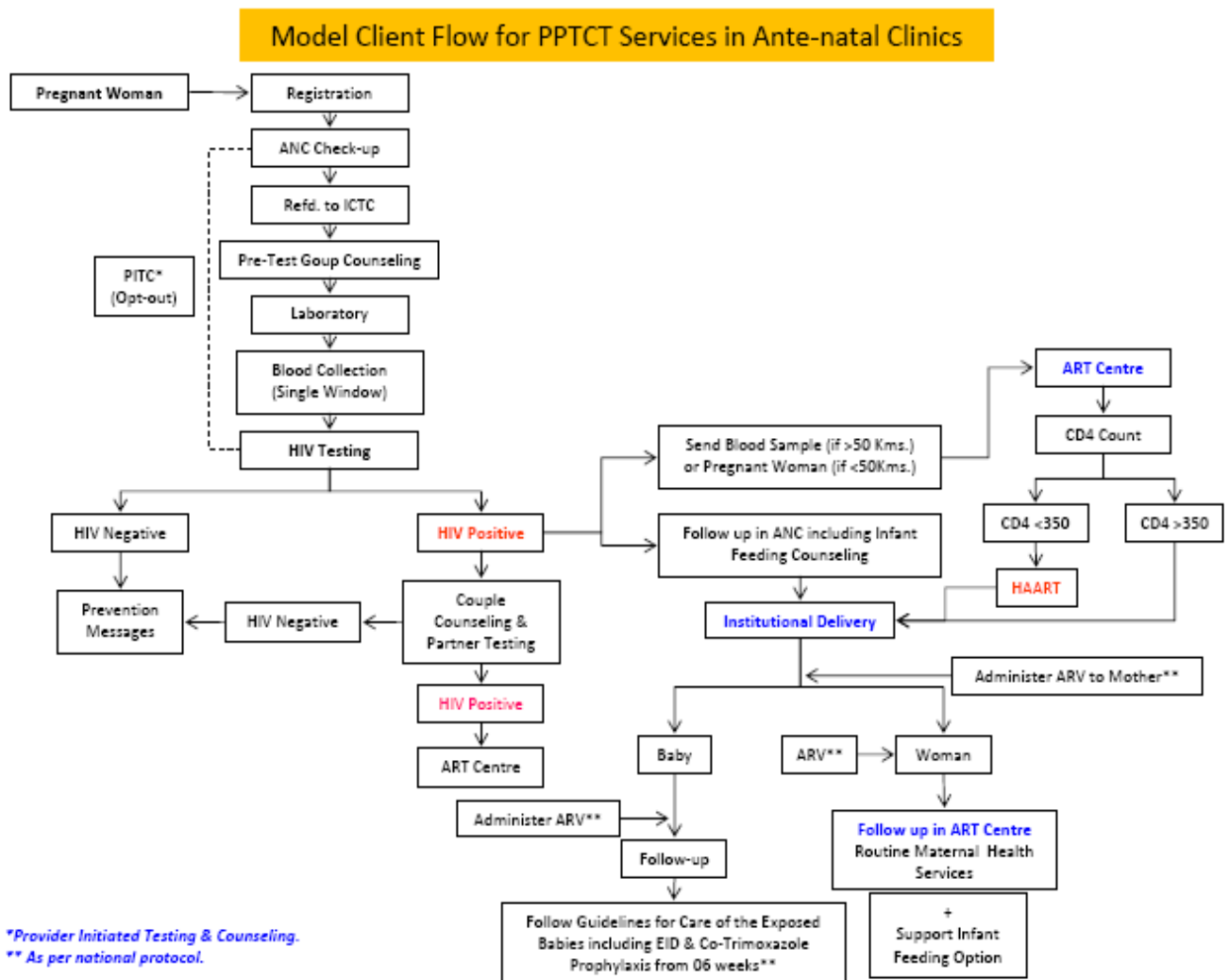
Integration is also likely to increase community acceptance of PPTCT programmes and strengthen maternal care, infant care and family care.

- Maternal care: MCH postpartum care services help protect the mother's health by providing medical and psychosocial supportive care
- Infant care: MCH postnatal care services offer assessment of infant growth and development, nutritional support, immunizations, and early HIV testing.
- If the infant is HIV-positive, additional support services may include ARV treatment
- Family care: MCH services provide social support, testing and counselling for family members; referrals to community-based support programmes; and assistance in dealing with stigma

Routine Antenatal Care

- **Client history:** Include obstetric, medical and sexual information.
- **Physical exam and vital signs:** Include a general physical examination for signs of disease (AIDS, TB, and other infections).
- **Abdominal exam:** Include speculum and bimanual exams, wherever indicated.
- **Lab diagnostics:** Include a complete blood count, urine routine and microscopic examination, rapid HIV testing after informed consent.
- **Tetanus toxoid immunizations**
- **Nutritional assessment and counselling:** Include anaemia testing with iron and folate supplementation and realistic diet adjustments based on local resources.
- **STI screening:** Include risk assessment for STIs which are markers for HIV risk because they are contracted similarly; early and correct diagnosis with syndromic management or lab tests (including syphilis) and prompt treatment and counselling; counselling about STI signs and symptoms; information about safer sex and condom use; and education to avoid transmission or re-infection.
- **Anti-malarials:** Malaria is a major cause of high maternal and infant morbidity and mortality. Identify acute cases and treat aggressively and promptly. Use insecticide on bed nets where possible.
- **Counselling on infant feeding:** Provide counselling related to infant-feeding decisions.
- **Counselling on pregnancy danger signs:** Provide women with information on pregnancy complications such as bleeding, fever, and pre-eclampsia.
- **Partners and family:** Refer women, partners, and families to community-based support organizations as available and appropriate.
- **Effective contraception plan:** Include counselling about permanent and long-term contraception methods; and protection throughout the post-partum and breastfeeding periods.

A comprehensive intervention should envisage male involvement in MCH services that is very low at present in India. Strategies should be adopted to enhance acceptance of antenatal services and make clinics husband-friendly. It is essential to enhance male involvement and provide opportunity to implement various reproductive health-related interventions in a couple-setting.



The figure above has tried to incorporate HIV testing at ICTC as part of provider initiated testing during ANC, corresponding couple counselling and partner testing, referral to ART centre and treatment and institutional delivery and associated measures for HIV infected pregnant women.

Additional Antenatal care for HIV-infected women

Besides the basic ANC package of services, it is necessary to augment the obstetric and medical care for HIV-infected women, in order to reduce HIV-related morbidity and mortality.

1. HIV Testing

Determining a woman's HIV sero-status is the first step. This should be done in a way that respects her privacy and pre-test counselling should cover why it is important to know her HIV status. Rapid testing makes it possible for her to receive her test results that very day.

2. Preventing Opportunistic Infections

By preventing opportunistic infections, health care personnel can reduce the rates of illness and death among HIV-infected pregnant women. They can help also reduce the risk of adverse pregnancy outcomes such as pre-term labour and childbirth which can increase the chances of transmission of HIV to the infant. These opportunistic infections include TB.

3. Assessment and Management of HIV-related Illnesses

Pregnant women who are HIV-positive should be monitored for signs and symptoms of HIV-related illnesses. These can increase the risk of transmitting infection to the child. Where necessary, antiretroviral treatment should be started after the necessary investigations.

4. Recurrent or Chronic Infection

HIV-infected women are susceptible to other infections that also need attention such as

- STIs, especially syphilis
- Urinary tract infections
- Respiratory infections
- Recurrent diarrhoea
- Recurrent vaginal candidiasis

5. Treatment of STIs

Treatment of STIs during pregnancy may reduce the risk of transmitting infection to the infant. Routine syphilis testing of pregnant women is an essential component of good antenatal care, and all antenatal women should be tested for syphilis and treated if infected.

Early diagnosis and treatment of STIs during pregnancy is also important because it may reduce the risk of transmitting infection to the infant. It may be necessary before, during and after pregnancy. Routine testing of pregnant women for syphilis is, therefore, an essential part of good antenatal care. Further, at each antenatal visit, it is important to directly ask the pregnant woman about any symptoms that might indicate the presence of STIs, such as lower abdominal pain, abnormal vaginal discharge or ulcers in the vaginal area. Where feasible, the clinical services should include a genital examination and appropriate laboratory investigations at the first antenatal visit, and at any time she reports an STI complaint. Where laboratory tests are not possible, a syndromic diagnosis should be conducted.

6. Psychosocial and Community Support

Pregnancy is marked with unique stressors. For instance, women have concerns about their health and that of their child. In women infected with HIV these concerns are multiplied. HCP should be sensitive to their concerns and should assess the support they may expect from family and other people in their circle. They should attempt to link them up with available resources from where they may derive additional support.

The accompanying diagram shows how pregnant women should flow through the ICTC. They may present either early in the pregnancy or at the moment of delivery.

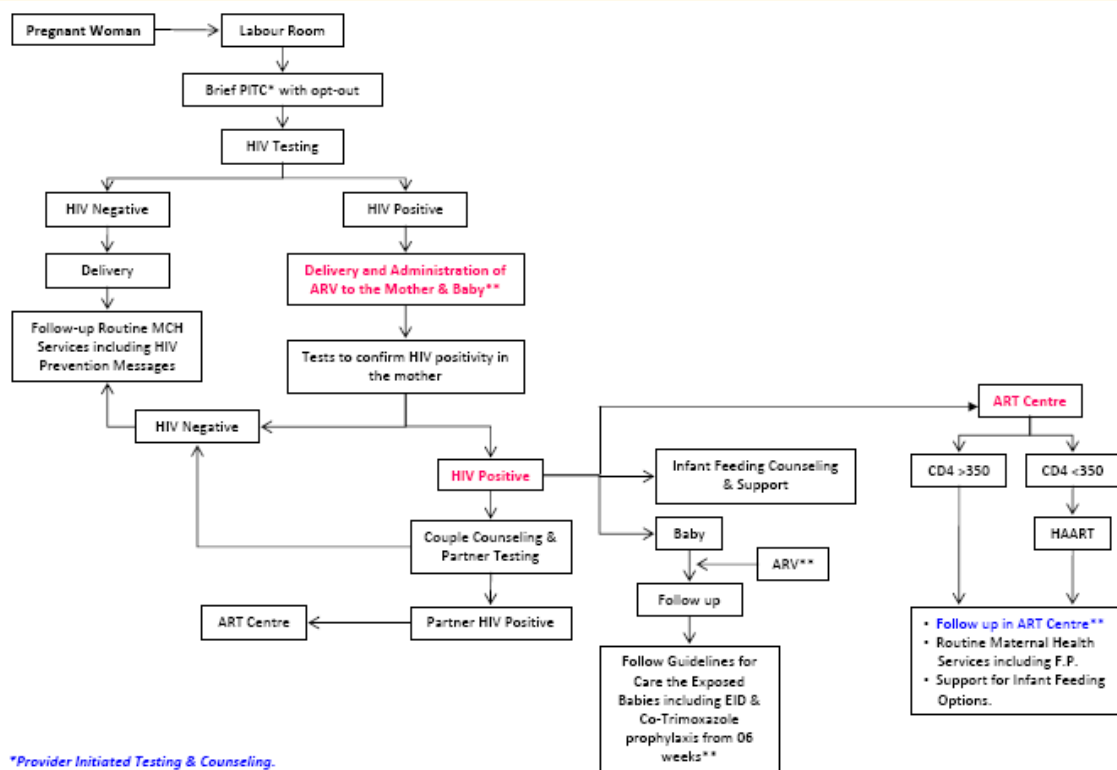
Partner involvement in PPTCT

As the following diagrams demonstrate, counselling should include, where possible, the male partner of the pregnant woman in order to acknowledge his role in protecting the child.

- Both partners should be made aware of the need to practise safe sex throughout the pregnancy, and the period of breastfeeding.
- Both partners should be tested and counselled about HIV
- Both partners should be counselled about the services available to them through the PPTCT programme.

Further, it is important to encourage male involvement even when they are unaccompanied by the spouses and female partners. ICTC personnel should educate men who are referred for testing to bring their wives and female partners for testing as a pre-emptive move against HIV infection. Counselling personnel should probe whether they are married, and if their wives or female partners are pregnant.

Model Client Flow for PPTCT Services for Woman Coming Directly in Labour Room, (Un-booked Case)



Management of Labour and Delivery of Women Infected with HIV

These guidelines also apply to women whose HIV status is unknown such as those who come too late for an HIV test to be conducted, or who opt out from HIV counselling. They should be treated as potentially capable of transmitting HIV.

Out of every 100 babies born to HIV-positive women, 10 to 20 will be infected during labour and delivery. This number can be reduced by limiting foetal exposure to maternal blood and body fluids. There are several strategies to achieve this. Their primary purpose is to reduce the contact of the infant with the blood and other infective secretions of the mother.

ARV Prophylaxis

ARV prophylaxis consists of drugs to prevent primary infection in the infant while ARV treatment consists of drugs to limit the effect of HIV in the woman. ARV prophylaxis does not provide long-term protection to the infant. ARV treatment during pregnancy can improve a woman's health and decrease transmission risk to the infant by reducing the maternal viral load. She should be assessed and referred for treatment where necessary.

Several ARV prophylaxis regimens have demonstrated that they can lower the risk of transmission of HIV through the parental route. These regimens decrease viral replication in the mother and provide protection to the infant by reducing the possibility of viral transmission. In general, the longer regimens are more efficacious than those that are shorter.

Deciding which regimen to support at the national level is based on feasibility, efficacy, acceptability, and cost. **NACO currently supports a regimen consisting of a single dose of Nevirapine (NVP) to the pregnant woman at the onset of labour, and a single dose to the infant soon after birth.**

The following are some of the salient points about Nevirapine (NVP):

- NVP inhibits viral replication.
- NVP is rapidly absorbed and crosses the placenta quickly when given orally.
- NVP can produce a rapid drop in the viral load in the mother.
- NVP has a long half-life which can benefit the infant.
- The normal dose is a 200 mg oral tablet given to the mother at the beginning of labour.
- Newborn babies should receive 2 mg/ kg NVP in suspension within 72 hours of birth, or before discharge, whichever is first.
- NVP is not recommended for concurrent use with rifampicin which is a consideration when TB treatment is indicated.

ARV treatment during pregnancy

Currently, NACO recommends that every HIV positive pregnant women should be subjected to a CD4 count. If the CD4 count is less than 350/cmm, she should be started on HAART without any delay. If the CD4 count is more than 350/cmm, she needs to be administered ARV (currently Nevirapine) when she comes in labour as recommended in figure above. **ARV regimen for PPTCT may change with new recommendations from NACO.**

While an HIV-infected pregnant woman who is eligible for ARVs should begin ARV treatment as early as possible, treatment should not begin until after the first trimester. The reason for this is that the foetus is susceptible to the iatrogenic effects of drugs during the first 10 weeks of gestation. The risks of ARV treatment during the first trimester are not yet known. However, when the woman is severely ill, the benefits of early treatment outweigh any potential risks to the foetus.

Following are the other measures that should be taken while conducting delivery of HIV infected pregnant women.

1. Universal Safety Precautions

Universal Safety Precautions protect clients and healthcare personnel from HIV as well as other blood-borne infections. Appropriate hand and eye-protection should be used, and sharp instruments should be handled with care and safely disposed later. ICTCs are provided with kits for managing a safe delivery in women with a positive sero-status and those with an unknown status. These kits contain plastic disposable gowns, disposable goggles to protect the eyes, face masks, disposable shoe covers, and two pairs of long gloves.

2. Minimising Cervical Examinations:

Cervical examinations must be performed only when absolutely necessary because frequent examination increases the risk of infection.

3. **Avoiding Prolonged Labour:**

Prolonged labour increases exposure of the foetus to maternal blood and infected secretions, thus increasing the risk of transmission to the infant. HCP may consider careful use of Oxytocin to shorten labour when appropriate.

4. **Avoiding Prolonged Membrane Rupture and Routine Artificial Rupture of Membranes:**

The risk of transmission increases with prolonged membrane rupture. HCP can assess the progress of labour and delay the routine rupture of membranes until the cervix is dilated at least 7 cms.

5. **Avoiding Unnecessary Trauma during Childbirth:**

Invasive procedures expose the infant to maternal blood and other infective secretions of the mother and thus increase the risk of infection to the former. Such procedures include invasive foetal monitoring such as scalp sampling and the use of scalp electrodes, episiotomy, and the use of forceps or vacuum extractors. Forceps may shorten labour but also increase trauma.

6. **Minimising the Risk of Postpartum Haemorrhage:**

Postpartum haemorrhage is a common cause of maternal deaths, especially in HIV-infected women who also have pre-existing anaemia.

7. **Safe Transfusions:**

The first recommendation is to minimise the use of blood transfusion. But when necessary, blood that is transfused should have been screened for HIV, syphilis, malaria and hepatitis B and C.

Infant-feeding Choices

Counselling for HIV-infected mothers during pregnancy should cover infant-feeding choices to enable them to make an informed decision. After delivery, they should be counselled again.

Breastfeeding

In general, in case of HIV negative mothers, the UN recommends exclusive breastfeeding for 6 months and continued breastfeeding for up to 2 years or beyond for the health, nutritional and psychosocial benefits it provides to mothers and their infants. Here the mother gives her infant only breastmilk, except for drops or syrups consisting of vitamins, mineral supplements or medicines. The exclusively breastfed child receives no food or drink other than breastmilk – not even water. Breastmilk provides the infant with all required nutrients and immunological factors needed to protect him/ her against common infections.

In the case of HIV positive mothers, there is a possibility of breastmilk being the medium for passing on HIV from mother to child. So, for HIV positive mothers, the UN recommendations vary depending on several factors.

However the possibility of transmission of HIV through breastmilk is lowered if

- The mother is healthy.
- The mother is on ART, if eligible.
- The baby ONLY gets breastmilk for as long as possible.
- Breast infections are prevented and treated right away.
- Thrush (white spots, yeast) in the baby's mouth is treated right away.

Exclusive breast feeding of the newborn should be advised to all HIV positive mothers for first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable, and safe (“ AFASS”)..

The terms “ AFASS” are explained below:

Acceptable: The mother perceives no barrier in choosing a feeding option for cultural or social reasons, or fear of stigma and discrimination.

Feasible: The mother has adequate time, knowledge, skill, and other resources to prepare feedings and to feed her infant, and the support to cope with family, community, and social pressures

Affordable: The mother and family, with available community, and/ or health system support, can pay for the costs of the feeding option's purchase, production, preparation, and use - including all ingredients, fuel, and clean water – without compromising the family's health and nutrition spending.

Sustainable: The mother has access to a continuous and uninterrupted supply of all ingredients and commodities needed to implement the feeding option safely for as long as the infant needs it.

Safe: Replacement foods are correctly and hygienically stored and prepared in nutritionally adequate quantities; infants are fed with clean hands using clean utensils preferably cups.

If the woman opts to exclusively breast feed the baby, it should be stopped at 06 months (early cessation) followed by adequate and timely weaning.

When the child reaches the age of six months or earlier, breast-feeding should be stopped within two weeks while ensuring the comfort level of both mother and infant. At the same time, good quality complementary foods should be introduced, ensuring adequate amounts of energy proteins and micronutrients.

Replacement feeding

Only where exclusive replacement feeding is **AFASS** — acceptable, feasible, affordable, sustainable and safe, avoidance of all breast feeding is recommended.

- The mother who has chosen not to breast-feed must be able to prepare feeds hygienically and should be advised to use cup feeding and not bottle feeding.
- In case replacement feeding is not possible, exclusive breast-feeding for the first six months of life with early cessation is recommended.
- The risks of HIV transmission especially if combined with ART may be less than 0.5%, if exclusive breast-feeding is done.
- If family support is not present, exclusive breast feeding may be difficult and the parent(s) may need consistent psycho-social support.

Conditions needed to safely formula feed

Mothers known to be HIV–infected should only give commercial infant formula milk as a replacement feed to their HIV uninfected infants or infants who are of unknown HIV status, when specific conditions are met (*referred to as AFASS—affordable, feasible, acceptable, sustainable and safe in the 2006 WHO recommendations on HIV and Infant Feeding*).

- a. Safe water and sanitation are assured at the household level and in the community, **and**,
- b. The mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant, **and**,
- c. The mother, or other caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition, **and**,
- d. The mother or caregiver can, in the first six months, exclusively give infant formula milk, **and**,
- e. The family is supportive of this practice, **and**,
- f. The mother or caregiver can access health care that offers comprehensive child health services.

(Strong recommendation, low quality of evidence)

Source: WHO, 2006

Early Infant Diagnosis

HIV infection follows a more aggressive course among infants and children than among adults. Once infected with HIV, the child faces a high chance of illness, morbidity and death, unless given timely medical treatment. Early HIV diagnosis and treatment for children slows the progress of HIV infection and allows infected children to live longer, healthier lives.

HIV testing of new born babies is not a one-step procedure because they carry antibodies from their mother. In the case of an infant born to an HIV-positive woman, the rapid tests used at the ICTC are not specific enough to differentiate between the mother's and the child's own antibodies. Maternal antibodies take about 18 months to clear out of the child's system.

In order to establish if the infant has acquired HIV infection, **the DNA of the virus has to be detected in the infant's blood through the PCR test using two sample collection methods:**

- Dried Blood Spot (DBS)
- Whole Blood (WB).

These are described in the section on HIV testing. The testing is done according to the age of the child.

Some points to note:

1. The second or third test is applicable only if the child is found positive at the first test,
2. A child who tests positive on DBS should be confirmed with the DNA PCR WB test.
3. The WB sample will be collected only in ART centres.
4. A minimum time period of one month is needed from the date of sample collection for the DNA PCR test results.
5. **It is mandatory to establish a definite diagnosis at 18 months by HIV antibody.**

Number of tests	6 weeks – 6 months	6 months – 18 months
First test	DNA-PCR DBS	Rapid test
Second test	DNA-PCR WB	DNA-PCR DBS
		DNA-PCR WB

Exposed Baby Care

All babies born to HIV positive women are called 'Exposed Babies,' until they are no longer breastfed and it has been established that the child is not infected. It is important to identify HIV-infected babies among the exposed babies as soon as possible. HIV-infected children usually grow more slowly than uninfected ones, and have a higher frequency of disease related morbidity. Regular growth monitoring and clinical assessment can lead to early detection of HIV infection.

Once identified as HIV-infected, any illnesses should be diagnosed as quickly as possible, so that these can be provided with appropriate medication and care including ART. The routine use of cotrimoxazole can reduce the risk of some serious infections even before an exposed child has been identified as HIV-infected.

Exposed infants need of cotrimoxazole

Cotrimoxazole in the form of a tablet can treat and prevent infections which exposed infants may otherwise acquire. Cotrimoxazole helps the infant to stay healthy, and should therefore be given every day once a day till HIV infection can be reliably ruled out.

Cotrimoxazole dosage

Cotrimoxazole should be given from 6 weeks of life onwards according to the weight of the infant:

Cotrimoxazole prophylaxis	
Weight (kg)	Child dispersible tablet (20mg TMP/100mg SMX) Once daily
< 5	1 tablet
5 – 10	2 tablets
10 – 15	3 tablets
15 – 22	4 tablets

Cotrimoxazole administration to infants

The tablet can be dispersed in expressed breast milk on a clean table spoon and fed to the infant once a day if the child is still breastfeeding. If the child is not being breastfed, 1-2 table spoons of boiled water is used instead of the breast milk. The mother or caregiver should receive enough cotrimoxazole to last till the next scheduled visit.

Duration of cotrimoxazole administration to infants

Cotrimoxazole should be given till the HIV infection has been excluded. All infants/children who are confirmed HIV-positive should remain on cotrimoxazole prophylaxis till they are five years of age, on ART, and show good clinical and immunologic response.

Other childhood illnesses can be avoided through vaccines and good nutrition. Most routine vaccines are safe for children living with HIV and are strongly recommended along with Vitamin A supplementation. Iron folic supplementation should be given to anaemic children.

WHO Immunisation Recommendations

Age of infant	Vaccine	Key
Birth	BCG, OPV-0	BCG= Bacillus Calmette Guerin, OPV= Oral Polio Vaccine DPT= Diphtheria, Pertussis, Tetanus
6 weeks	DPT-1, OPV-1	
10 weeks	DPT-2, OPV-2	
14 weeks	DPT-3, OPV-3	
9 months	Measles	

Additional immunizations for yellow fever or other diseases, for example, can be included in national recommendations that account for local disease prevalence

An additional, early dose of measles vaccine should be given at age 6 months if the following conditions are met:

- Measles morbidity and mortality before age 9 months represents more than 15% of cases and deaths.
- There is a measles outbreak.
- The infant has a high risk of measles death. This includes infants
 - With documented HIV infection,
 - Living in refugee camps,
 - Admitted to hospitals, or
 - Affected by disasters

Immunisation Recommendations from WHO

All HIV-exposed children should be fully immunized according to their age. Because most HIV-infected children do not have severe immune suppression during the first year of life, immunization should occur as early as possible after the recommended age to optimize the immune response.

BCG and Yellow Fever.

Children with known symptomatic HIV infection should not receive BCG and yellow fever vaccines. However, because most HIV-infected infants are asymptomatic at birth, when BCG immunization occurs, and thus will have unknown HIV status, the birth immunization should be given

Oral Polio Vaccine

If the child has diarrhoea and is scheduled to receive OPV, the dose should be given as scheduled. However, the dose should not be counted in the schedule, and an additional dose of OPV should be given after the diarrhoea has resolved.

Diphtheria, Pertussis, Tetanus

Children who have either recurrent convulsions or active central nervous system disease, or who have had shock or convulsions within 3 days of receiving a DPT vaccination should not receive DPT vaccination. For those children, substitute DT (diphtheria – tetanus) formulation; all other immunizations may be given.

Hepatitis B Vaccine

WHO recommends that the hepatitis B vaccine be included in routine childhood immunization schedules for all children in all countries. Give the hepatitis B vaccine according to any of the following schedules:

- Option 1: Give hepatitis B vaccine at 6, 10, and 14 weeks, to coincide with the DPT schedule. The disadvantage of this option is that it does not protect against perinatal hepatitis B infection.
- Option 2: Give hepatitis B vaccine at birth, 10, and 14 weeks; the last 2 doses coincide with the DPT schedule.
- Give hepatitis B vaccine at birth 6, 10, and 14 weeks; the last three doses coincide with the DPT schedule.

Options 2 and 3 are preferred for India because of the high rate of perinatal hepatitis B transmission.

Haemophilus influenza Type B

Vaccinate at 6, 10, and 14 weeks. In some areas a booster at 12 to 18 months is recommended, if available. This is not a part of universal immunization programme in India.

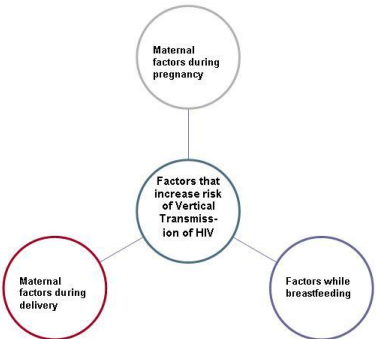
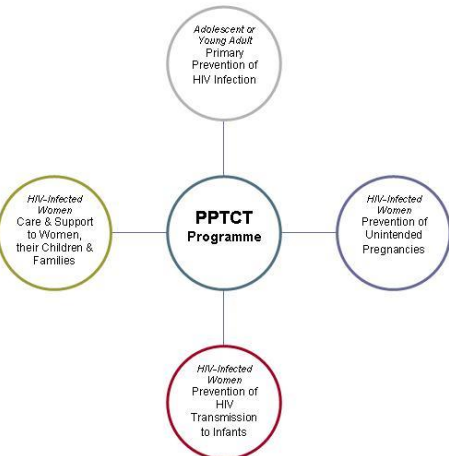
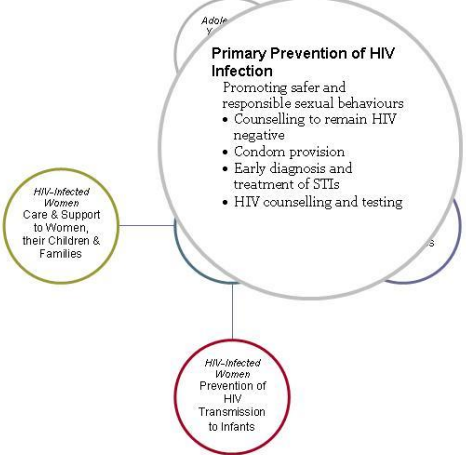
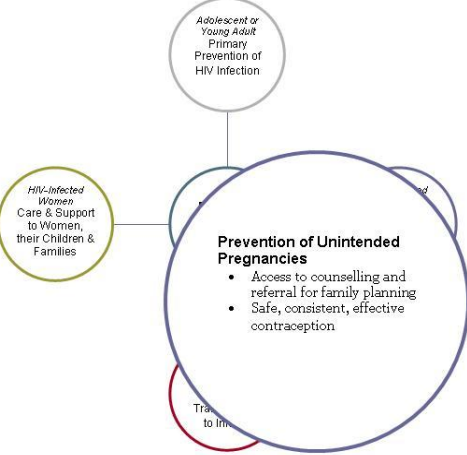
(Source: Revised PPTCT Training Curriculum p. 330-331)

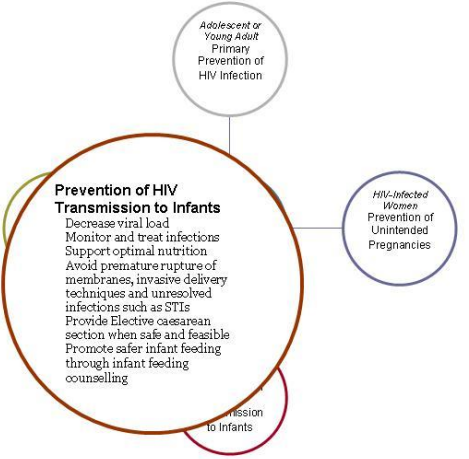
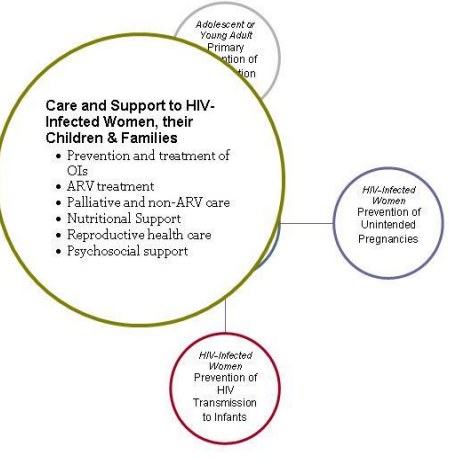
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1. National AIDS Control Organisation (n.d.). FAQs. Accessed from http://www.nacoonline.org/Quick_Links/FAQs/ on August 12, 2009.
2. National AIDS Control Organisation (2006). *National AIDS Control Programme Phase III*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
3. National AIDS Control Organisation (2006). *NACO guidelines for HIV care and treatment in infants and children*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.

4. National AIDS Control Organisation (2007). *Operational guidelines for Integrated Counselling and Testing Centres*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
5. United Nations International Children's Emergency Fund and National AIDS Control Organisation (2004). *Prevention of Parent-to-Child Transmission of HIV (PPTCT)*. New Delhi: United Nations International Children's Emergency Fund and National AIDS Control Organisation.

SLIDES

<div data-bbox="337 371 657 432" data-label="Section-Header"> <h3>Prevention of Parent to Child Transmission (PPTCT)</h3> </div> <div data-bbox="251 636 264 653" data-label="Text"> <p>1</p> </div> <div data-bbox="609 636 703 653" data-label="Text"> <p>ICTC Team Training</p> </div>	<p>If 100 HIV-positive women give birth to 100 infants, then</p> <ul style="list-style-type: none"> • 5 – 10 of the infants will be infected during pregnancy • 10 - 20 will be infected during labour and delivery • 20 – 30 will be infected during breastfeeding <p>The total number of children infected will be 25 to 40.</p>
 <p>Next three slides spell out the factors in each circle</p>	
	

 <p>Prevention of HIV Transmission to Infants</p> <ul style="list-style-type: none"> Decrease viral load Monitor and treat infections Support optimal nutrition Avoid premature rupture of membranes, invasive delivery techniques and unresolved infections such as STIs Provide Elective caesarean section when safe and feasible Promote safer infant feeding through infant feeding counselling <p>Adolescent or Young Adult Primary Prevention of HIV Infection</p> <p>HIV-Infected Women Prevention of Unintended Pregnancies</p> <p>HIV-Infected Women Prevention of HIV Transmission to Infants</p>	 <p>Care and Support to HIV-Infected Women, their Children & Families</p> <ul style="list-style-type: none"> Prevention and treatment of OIs ARV treatment Palliative and non-ARV care Nutritional Support Reproductive health care Psychosocial support <p>Adolescent or Young Adult Primary Prevention of HIV Infection</p> <p>HIV-Infected Women Prevention of Unintended Pregnancies</p> <p>HIV-Infected Women Prevention of HIV Transmission to Infants</p>
<p>PPTCT as a Case of Provider-Initiated Testing</p> <ul style="list-style-type: none"> ICTC provides opportunity to interact with pregnant patients. ICTC team to actively generate referrals from private and public maternity services Educate women about how knowing their HIV status can help Encourage men to bring their female partners for testing and services 	<p>Advantages of PPTCT</p> <p>Mother</p> <ul style="list-style-type: none"> Decreased chance of HIV transmission to her child Postpartum care Infant-feeding support <p>Child</p> <ul style="list-style-type: none"> Decreased chance of being infected with HIV Proper nutritional guidance – breastfeeding vs replacement feeding Prevention & treatment of OI <ul style="list-style-type: none"> Proper immunization Cotrimoxazole prophylaxis ART when required
<p>Routine Antenatal Care</p> <ul style="list-style-type: none"> Client history Physical exam and vital signs Abdominal exam Lab diagnostics Tetanus toxoid immunizations Nutritional assessment and counselling STI screening Anti-malarials Counselling on infant feeding Counselling on pregnancy danger signs Partners and family Effective contraception plan 	<p>Additional Antenatal care of HIV-infected women</p> <ul style="list-style-type: none"> HIV-testing Preventing Opportunistic Infection Assessment and Management of HIV-related illnesses Recurrent or Chronic Infection Treatment of STIs Psychosocial and Community Support

<p>Partner involvement in PPTCT Counselling should include, where possible, the male partner of the pregnant woman in order to acknowledge his role in protecting the child.</p>	<p>ARV Treatment and Prophylaxis ARV prophylaxis: drugs to prevent primary infection in the infant ARV treatment: drugs to limit the effect of HIV in the woman. Prophylaxis does not provide long-term protection for the infant.</p>
<p>NACO recommended regimen for prophylaxis</p> <ul style="list-style-type: none"> • 200 mg oral tablet of Nevirapine given to the mother at the beginning of labour. • Newborn babies should receive 2 mg/ kg NVP in suspension within 72 hours of birth. 	<p>Management of Labour & Delivery of Women Infected with HIV</p> <ul style="list-style-type: none"> • ARV Prophylaxis • Universal Precautions • Minimising Cervical Examinations • Avoiding Prolonged Labour • Avoiding Prolonged Membrane Rupture and Routine Artificial Rupture of Membranes • Avoiding Unnecessary Trauma during Childbirth • Minimising the Risk of Postpartum Haemorrhage • Safe Transfusions
<p>Infant Feeding: Breast feeding</p> <p>Exclusive breast feeding of the newborn should be advised to all HIV positive mothers for first six months of life unless replacement feeding is Acceptable, Feasible, Affordable, Sustainable, and Safe (AFASS).</p> <p>If the woman opts to exclusively breast feed the baby, it should be stopped at 6 months (early cessation) followed by adequate and timely weaning.</p>	<p>Infant Feeding: Breast feeding</p> <ul style="list-style-type: none"> • Breast Milk could transmit HIV infection if mother is infected • Can lower this transmission rate through measures such as ART for mothers, treating breast infections in mother, oral infections in child • Counsel mother to breastfeed exclusively for 6 months and then rapidly wean child within 2 weeks.
<p>Infant Feeding: Formula feeding Mothers known to be HIV-infected should only give commercial infant formula milk as a replacement feed to their HIV uninfected infants or infants who are of unknown HIV status, when specific conditions are met</p> <ol style="list-style-type: none"> a. Safe water and sanitation are assured at the household level and in the community, and, b. The mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant, and, 	<p>Infant Feeding: Formula feeding (contd)</p> <ol style="list-style-type: none"> c. The mother, or other caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition, and, d. The mother or caregiver can, in the first six months, exclusively give infant formula milk, and, e. The family is supportive of this practice, and, f. The mother or caregiver can access health care that offers comprehensive child health services. <p>Source: WHO, 2006</p>

Early Infant Diagnosis

- HIV infection follows a more aggressive course among infants and children.
- Early HIV diagnosis and treatment for children slows the progress of HIV.
- **It is mandatory to establish a definite diagnosis at 18 months by HIV antibody.**

See next table

Exposed Baby Care

- All born to HIV+ woman until established not +VE
- Regular growth monitoring and clinical assessment can lead to early detection of HIV infection

No of tests	6 wks – 6 mths	6 mths – 18 mths
First test	DNA-PCR DBS	Rapid test
Second test	DNA-PCR WB	DNA-PCR DBS
		DNA-PCR WB

Co-Trimoxazole Prophylaxis

Weight **Child dispersible tablet (20mg TMP/100mg SMX) Once daily**

< 5 kgs	1 tablet
5 – 10 kg	2 tablets
10 – 15 kg	3 tablets
15 – 22 kg	4 tablets

WHO Immunisation Recommendations

Age of infant	Vaccine
Birth	BCG, OPV-0
6 weeks	DPT-1, OPV-1
10 weeks	DPT-2, OPV-2
14 weeks	DPT-3, OPV-3
9 months	Measles

EXERCISE

1. What are the testing needs of the female client?
2. What should counselling cover on the first visit?
3. What should counselling cover on the second visit?
4. Are there community organizations or support services where you could refer the client?

The next 9 slides consist of the records maintained by the counselling personnel related to ICTC-TB integration. consist of the Registers related to PPTCT services

Information to be extracted for the monthly report

- Total number of women who register at the ANC
- Antenatal women who receive pre-test counselling/ information
- Antenatal women who receive post-test counselling
- The sero-status of the ANC client
- Details of ANC including parity, Expected Date of Delivery, plan of delivery

Information to be extracted for the monthly report

- Counselling and testing of women directly coming in labour
- Spouse or partners counselled, tested and their HIV status
- Positive women who delivered and received NVP
- Unregistered ANC women accessing HIV service
- Referrals to and from TB and details regarding the same
- Referrals to other care and support services
- Stock of NVP, kits and condoms

Working as an ICTC Team

Working as an ICTC Team

All through this training programme, you have been hearing the word 'team' when it is applied to the Integrated Counselling and Testing Centres. What makes the ICTC a team? A group of people working in an organisation can be called a team "when there is interdependency in how the different team members function, that is the activity or service cannot be undertaken by one individual alone."

The most common examples of teams are found in the different sports. If we apply the explanation above to a cricket team, then we can see that in a team of 11 players, there is a captain who makes on-field decisions, there are players who specialize in batting and those who are good bowlers. When a team is bowling to get their opponents out, only one player can bowl at a time. But the other players support him in their various roles as wicket-keeper and fielders. A weakness in any one area of the field means that the team does not work as effectively as it should.

At the ICTC, counselling personnel, testing personnel and the manager carry out tasks individually that cannot be performed by others. Each of them has educational qualifications and specialised skills that prepare them for their particular jobs, and have undergone induction training related to their particular work in the ICTC. No one individual can undertake the testing, counselling and medical advice all by themselves.

Just as a sports team aims to win the game, the ICTC team is established to carry out the following functions:

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

But as ICTC team members you are also contributing to loftier goals in the NACP III that are mentioned in the adjoining box. To use the sports metaphor again, each individual sports team in a country's Olympic contingent has a chance to increase the country's tally of gold, silver and bronze medals. The work of an individual ICTC team runs alongside the work done by other ICTC teams in a district, the work undertaken by ART centres, and the other health programmes such as the RNTCP. The overall medal tally here is the number of human lives saved or the number of human lives made healthier through the dedicated work of individual staff at the various health facilities.

The flow chart on the next page demonstrates how the ICTC patient interacts with different members of the team – the counselling personnel, and the testing personnel. These individuals provide the counselling and testing services respectively.

The ICTC Manager

The ICTC Manager is like the captain of the team. He/ she is responsible for the overall functioning of the ICTC. For instance, this individual is responsible for hiring staff, liaising with professional bodies such as the local Indian Medical Association (IMA) to increase client referrals, maintaining the attendance register and verifying other ICTC reports before sending them to the SACS or the DAPCU which have been established in Category A and Category B districts.

Counselling Personnel

The Counselling personnel is described by the Operational Guidelines as the bedrock of the ICTC. Her/ his functions include preventive and health education through flip books, providing psychosocial support to clients, and co-ordinating with the RCH, TB and ART programmes. In some ICTCs, counselling personnel might be a person with a nursing diploma.

The overall goal of the NACP III is to halt and reverse the epidemic in India over five years by integrating programmes for prevention, care, support and treatment. This will be achieved through a four-pronged strategy:

- 1. Prevention of new infections in high risk groups and general population through:
 - a. Saturation of coverage of high risk groups with targeted interventions.**
 - b. Scaled up interventions in the general population.****
- 2. Providing greater care, support and treatment to larger numbers of PLWHA.**
- 3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.**
- 4. Strengthening the nationwide Strategic Information Management System.**

Testing Personnel

Testing personnel undertake HIV testing, maintain laboratory equipment, records of HIV test results, rapid HIV testing kits and consumables.

Team Effectiveness

Team effectiveness refers to the degree to which a team accomplishes its purpose. It includes the quality and quantity of services provided. It also includes whether the team is able to remain dynamic and whether it can progress. This will depend to some extent on progress of individual team members. Further, the team must receive adequate management support and adequate resources to function.

The Operational Guidelines provide directions on what is considered good performance for various members of the team. However, a team can also measure its own effectiveness in relation to how near or far it is to its goals and objectives. ICTCs can assess their performance in terms of how many people they are able to provide services to, the follow-up from patients, the referrals from outside organizations, feedback from these organizations about referred clients reaching them, etc.

In order to be effective all teams also need information and skills specific to:

- **Conflict resolution**

Conflict is an inevitable part of human life. It will arise whenever people hold different opinions about how to perform a certain task. This is natural because different people have different life experiences which they bring to a group situation. It is important to recognise that different people's opinions are all probably right under different situations. In the ICTC, it is relatively easy to judge which opinion is more suitable in a certain situation by asking a couple of simple questions: Will this

help the ICTC work better and to serve patients better? Will ICTC clients be healthier or process through the ICTC faster through changing a particular routine?

At the ICTC, it is important to recognise and encourage desirable conflict (that is people expressing different opinions which bring out different facets of a problem situation) while minimizing undesirable team conflict (which causes people to be unable to work together effectively). Conflict should be handled by attacking the ideas and not the people voicing those ideas. Some barriers to good communication or working creatively with different opinions include the use of sarcasm, putting down people, calling names and generally being disrespectful. Even when team members disagree, they can be civil towards each other.

One example of undesirable team conflict may arise over whose responsibility it is to write out monthly reports or to establish linkages with outside organizations. Here clarity of roles at the very beginning will be helpful in avoiding end-of-the-month arguments about records not being completed in a timely manner. It is important for each member of the team to realise that other members of the team are relying on the timely completion of his/ her tasks. For instance, the testing personnel must use the PID which is assigned by the counselling personnel. The counselling personnel can only provide the post-test counselling if the rapid tests were conducted in a timely manner. ICTC managers will be unable to verify the monthly reports and send them in to the SACS or DAPCU by the 3rd of the month if the report has not been prepared earlier. ICTC staff are paid in a timely manner if the manager fulfils his/ her supervisory role in time.

- **Good communication**

Teams that are effective do so with good communication such as speaking openly and positively, listening actively and without judgment, matching verbal and non-verbal behaviour, and creating small communication rituals such as greetings and personal small talk. Conflict resolution needs good within-team communication.

S	Sit facing the person
O	Maintain an Open position. Crossed legs and arms indicate defensiveness or being closed against the other person.
L	Lean forward slightly
E	Maintain Eye contact
R	Relax slightly

It is easy to take communication for granted. Often people say, “But I told you about this before.” The issue is not that the person was not informed. The issue is often that the manner of informing was incomplete. For instance, the message could be incomplete, or the person who receiving the message could be distracted at that moment.

When working with HIV/AIDS, counselling personnel are often urged to check how much their clients have understood about the information provided in the counselling session. The same checking back mechanism is also important at the level of the team. Both the person communicating the information (the sender) and the person for whom the information is intended (the receiver) must clarify the message. The sender must ask if the receiver has questions. The receiver must give feedback about the information in the communication, be it verbal instructions or a written note.

While documents such as the Operational Guidelines spell out who has to fill each particular register, there are many other small routines that ICTC personnel develop to enhance their everyday communication, for instance, maintaining patient flow between the counselling room and the laboratory. This process can be made smooth by talking directly to other team members, expressing problems and concerns using non-blaming language and a non-accusatory tone. It is important to discuss the issue and not the person.

ICTC staff often work together for a long time. It is important not to look down on the small rituals that co-employees often automatically develop such as greeting each other for festivals, or asking after family members. Such person-to-person communication, enables team members to see each other as human beings with individual lives and problems, and provides a basis from which to try and see a problem from the other person's perspective.

Within team meetings and other informal occasions for communication, it is important to use active listening skills such as SOLER, using sounds like "Umhmm," repeating what the person is saying, and nodding.

In addition to personal communication, ICTC team members can also develop a more professional interchange. For instance, there is provision within the ICTC guidelines for on-going training of staff. If counselling personnel or the ICTC manager are deputed for in-service training, it would be a good practise to return to the ICTC and share the main lessons of the training programme with other team members. Things that are of professional interest are latest scientific developments, changes in NACO policy, staffing changes at the State AIDS Control Society or the District AIDS Prevention Unit. These matters affect the functioning of the ICTC directly or indirectly, and are of interest to all members of the team.

- **Goal setting**

Teams that are effective work by agreeing on goals, working on them and then monitoring team progress towards these goals. The overall goal of the ICTC as mentioned in the NACP III has been mentioned earlier in this section. Each individual centre can also work towards creating short-term goals to be achieved over the period of a week, or a month, or a year. For instance, ICTC teams can work towards increasing referrals to the centre over a month or increasing the number of clients tested and counselled over a quarterly period. They can plan to increase patient follow-up, or to decrease the time that clients are kept waiting for their test results, to improve the quality of testing.

Applying the SMART method to goal creation is a simple way of making achievable goals. For instance, to scale up testing and counselling services to the general population the ICTC personnel have to make the services of the ICTC known to the general public as well as to organisations and medical personnel who are in contact with members of the general public. Within this last statement, are three sub-goals.

These can be redefined as short-term goals by restating them in action terms and placing a time limit: "Within the next month we will increase our counselling of general public members by (1) having the counselling personnel contact 5 non-governmental organizations, and (2) having the medical officer speak to personnel in the gynaecology department and making a presentation at the local IMA." Here, the activities of each member of the team are spelled out. Also the action contains a number which makes it easy to verify how close or far the team is from achieving its objective, and there is a time limit. At monthly meetings, the team can assess progress and redefine the goal to match the demands of the situation. The number for the next time period can be increased or decreased based on how difficult it was to achieve the task in that last time period. For instance, on the afternoon when the counselling personnel is supposed to do outreach work, it may be possible to visit only 2 community organizations if the distances are large.

Displaying these goals in a prominent spot in the ICTC space is a good way to remind individual staff of what they are aiming to reach. Further, the team must also identify blocks and barriers that might affect the team's reaching its goals, and discuss ways to manage these blocks and barriers. For instance, in order to increase the practice of Universal Safety Precautions, testing personnel need the proper supplies. But they can only procure sufficient stock if they maintain the stock register properly, and have a good idea of how much is consumed every month.

Goals should be SMART

- S** **Specific – defining what is to be accomplished in terms of specific steps to behavioural change**
- M** **Measurable – quantifying the objectives by indicating a numerical or percentage change expected**
- A** **Appropriate – defining intended changes that are acceptable in the local context**
- R** **Realistic – Avoiding objectives that are beyond the scope of available resources or contrary to relevant experience**
- T** **Time-bound – identifying the time frame in which changes should be achieved**

- **Planning and task co-ordination**

Team members perform different sub-tasks that contribute to the larger task. This calls for co-ordination between team members, spelling out of task and role expectations of individual team members (mutual role understanding) and ensuring proper balance of workloads in the team. For instance, there is a provision for 2 counselling personnel in ICTCs where there is an extremely high workload. Here, the tasks must be evenly divided between the two counselors. The ICTC Operational Guidelines also speak of monthly meetings of staff. These are opportunities for the ICTC staff to keep each other informed of important matters, and to make decisions.

Supervision

The ICTC Manager is a medical officer appointed by the administrative head of the facility which houses the ICTC. He/ she is responsible for ensuring that staff are properly and regularly trained. S/he maintains the attendance register and makes sure that staff salaries are paid on time.

The ICTC Manager is also in charge of ensuring the quality of counselling and testing at the ICTC. S/he signs the counselling and testing report after verifying the records, and ensures that this report is sent to the SACS on time. While counselling and testing personnel fill up the registers, the manager has to check these records for completeness and accuracy. For instance, he/ she must check that the PID is used consistently in all records. He/she must check that addresses are correctly and completely noted (not just the name of the village or town).

S/he performs a supervisory role through monthly meetings at the ICTC and through frequent visits to the ICTC.

In districts with high prevalence, some of these functions are undertaken by the District ICTC Supervisor. This official conducts visits to the ICTCs and conducts a monthly review meeting with all counsellors on the 3rd of the month. The monthly reports of all ICTCs are studied at this review meeting. Here the ranking of ICTCs is done and poorly performing ICTCs are identified for closer supervision. The District ICTC Supervisor reports this information at the monthly meeting at the SACS where all District ICTC Supervisors are present.

Outreach work in the community

Outreach activities are a key aspect of the ICTC functioning. The counselling personnel's job description requires her/ him to set aside one afternoon each week for such outreach work. This consists of two activities:

- **Demand Generation**

The counselling personnel is expected to do outreach work by visiting HIV hot spots.

S/he has to establish and maintain relationships with other community services and organizations such as services for commercial sex workers and migrant workers. This is for the purpose of generating referrals in and referrals out. It is important to state very clearly what kind of services are performed by the ICTC, the kind of people who would benefit from being tested for their HIV status, and the manner in which they would be helped by knowing their sero-status. The counselling personnel should exchange telephone numbers and other contact details. Through this programme, trainees have been encouraged to use the list of Common Contacts to make such notes.

The ICTC Manager also is encouraged to maintain linkages with local chapters of organisations like the Indian Medical Association (IMA), Federation of Obstetricians and Gynaecologists Societies of India (FOGSI) and Indian Association of Paediatricians (IAP) to generate referrals. It is important to inform general practitioners and other medical personnel in the community about the services that are available to people in the community at the ICTC, how the ICTC can link them to a range of other services, and who needs testing. This is important for publicizing the facilities available at the ICTC, and through it at the ART and Comprehensive Care Centres.

Through on-site visits to such organizations, ICTC staff often become aware of the reality of how clients live, the factors that affect their implementation of advice and suggestions provided during the session at the centre. Such awareness can also lead to more realistic assessment of barriers in the client's life that prevent adopting safer habits or adhering to medical and prophylactic treatment.

- **Client follow-up**

Counselling personnels are also encouraged to use the time set aside for follow-up by conducting home visits to long-term clients. For this it is essential to have the full details of the client's address. Activities to undertake are to motivate pregnant women for timely and regular follow-up, and to reach out to new mothers and provide them with proper information on caring for the infant (including early infant diagnosis). Counselling personnel also have this opportunity to work with and educate family members.

ICTC clients should be alerted to the possibility of being visited by personnel from the ICTC, and the actual visit should be undertaken in a manner that respects the privacy and confidentiality of the client. During the outreach visit, the ICTC personnel may have to discreetly identify themselves as associated with the Primary Health Care Centre or the District Hospital, rather than with the ICTC or "AIDS unit" to avoid inadvertent disclosure of sero-status.

Maintaining a good record of clients receiving PPTCT services can help the counselling personnel plan out home visits in a way that maximizes the number of visits while minimising the time taken for travel. As mentioned in the section on stigma and discrimination, this is a good example of how the continuum between prevention, care and support operates. The counselling personnel also has an opportunity to work on stigma and discrimination at the community level.

ICTC counselling personnels can do outreach work more effectively by maintaining good linkages with the auxiliary nurse midwives (ANMs) in their district.

Burnout in the ICTC

In ICTCs with high patient load, the staff are under tremendous pressure. Additionally, working with HIV is a stressful situation. Burnout is one possible consequence. Burnout refers to a progressive loss of idealism, energy, and purpose in personnel as a result of work conditions. Other conditions that may cause burnout are role ambiguity, role conflict, time and staffing, poor work relations, lack of peer support, and increased demand by patients and families.

Recognising Burnout

- Physical symptoms: fatigue, sleeplessness, lack of appetite.
- Psychological symptoms: depression, irritability, grief and guilt.
- Behavioural symptoms: staff conflict and rivalry.

Managing Burnout

Some personal coping tools to cope with burnout are:

- Developing a personal philosophy regarding illness, death and one's role in caring for an ill person.
- Developing self-control, using humour, learning from mistakes and sharing frustrations.
- Maintaining self-esteem
- Lifestyle management such as having activities outside the profession, taking time off, adequate nutrition and sleep, meditation and relaxation.
- Talking to peers during meetings and by forming informal clubs

Documentation

The ICTC maintains a number of registers related to counselling and testing clients, and related to stock of various supplies. It is important to maintain good records for all of the following reasons:

- To study the increase or decrease in numbers of people visiting the ICTC
- To keep track of people who visit the ICTC and provide follow-up where appropriate
- To understand the change in profile of people visiting the ICTC (increasing number of children, increasing number of MSM) and to prepare for the issues related to these changes
- To identify groups or communities who are not yet reached (or underserved) if available research shows there is a high prevalence in particular communities but community members are not accessing the testing and counselling
- To make a case for more staff/more resources more space/better space if the numbers of patients increase
- To understand where patients are being referred from, and where they are not, and to then use this information to improve referral patterns
- To check which advertising medium is most useful in a particular center – radio, TV, posters, referrals from PHCs, referrals from private doctors, etc.
- To practise transparency and accountability to donors for the funds they are providing

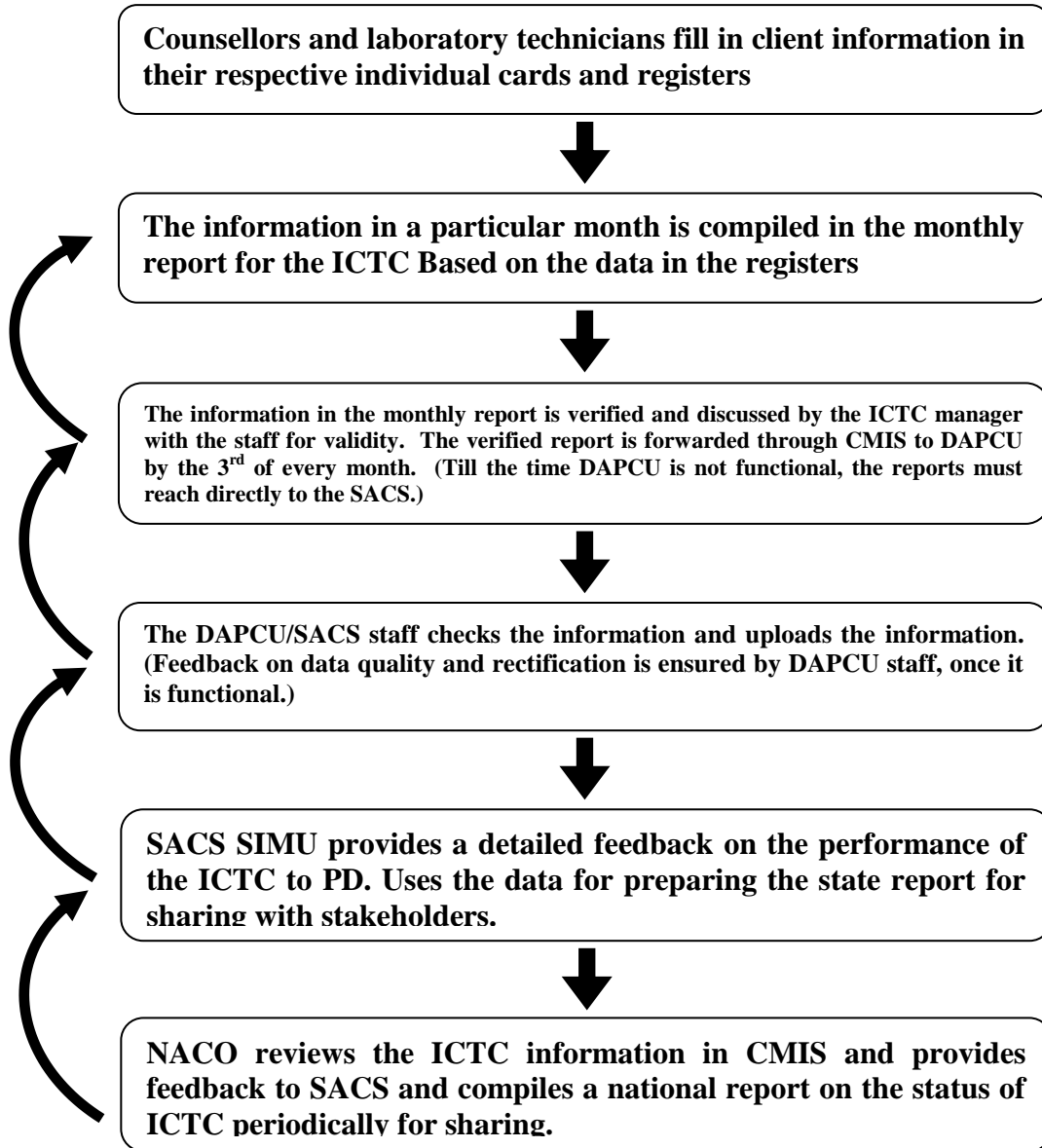
The list of registers and forms to be maintained include:

1. PID Register for General Clients and Pregnant Women
2. ICTC Register for General Clients (Non ANC Cases)
3. ICTC Register for ANC Cases
4. ICTC Exposed Infant Register
5. ICTC HIV-TB Collaborative Activities Register
6. Laboratory Register
7. Stock Register
8. Monthly Reports

The Operational Guidelines for the ICTCs also mention a Monthly Dashboard. The purpose of this is to give a snapshot of the performance of the SACS to NACO. It is sent by each SACS to NACO by the 5th of every month. A section of this dashboard covers the performance of the ICTCs. The Monthly dashboard cannot be sent in a complete timely manner to NACO unless individual ICTCs send their monthly reports to the DAPCU or the SACS on time. Thus the SACS can also be seen as a team whose members are the various ICTCs and ART centres. If any single centre does not send in their reports on time, then the performance of the SACS as a team is poor. Hence, it is important to be up-to-date in filling the various registers.

Data flow

Data flow from the facility to the district level to the national level is depicted in the following diagram:



As shown in the accompanying diagram from the Operational Guidelines, at the ICTC team level, the registers are maintained by the counselling and testing personnel. They bear the responsibility of filling these records in a timely manner and of compiling them into monthly reports. It is the responsibility of the ICTC Manager to verify the information in this monthly report and send it to the DAPCU (if it has been set up) or to the SACS by the 3rd of every month. At the level of the DAPCU or the SACS, the information is checked and then sent on to NACO.

The diagram also shows the feedback mechanism by which NACO can review the information in the reports and give suggestions to the SACS. Similar feedback mechanisms exist between the SACS or the DAPCUs to the ICTCs.

A final note: The training handbook has described in detail various aspects of ICTC functioning such as working with general patients, working with ANC patients, conducting quality testing and quality counselling. However, unless documentation is carried out in a timely and complete manner, the work done by the ICTC staff will remain invisible and uncounted. To continue with the sports team metaphor, it would be like not counting the number of runs or goals scored.

It is easy to dismiss the daily filling of registers as a boring and mundane task, but is something that the health personnel are required to do. It is also easy to see it as relatively unimportant in the light of the more pressing tasks of the day such as drawing blood in a safe manner for the purpose of testing, or speaking with clients to educate them about HIV and assisting them with their life-changing decisions. The task of filling registers and maintaining good and complete data not only records the efforts of the team. Rather, it can sometimes have larger implications.


Surgeon Atul Gawande describes in his book “Better: A Surgeon’s Notes on Performance” how a doctor in a rural hospital following standard reporting procedures alerted the health ministry officials to an outbreak of polio. This incident occurred in 2003 in Karnataka state, and the timely actions of the doctor led the ministry officials to confirm the presence of polio in the district. This led to a state-wide vaccination campaign with 37,000 vaccinators, 4000 health-care supervisors and 2000 vehicles crisscrossing the state over a three-day period to ensure all eligible children received the polio vaccine.

The doctor in the story was not only thorough in fulfilling his work obligations, but he was also timely. Good documentation needs both – completeness and timeliness.

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- 2) Kekki, P. (1990). *Teamwork in Primary Health Care*. Geneva, Switzerland: World Health Organisation.
- 3) National AIDS Control Organisation (2006). *National AIDS Control Programme Phase III*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
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- 5) Piotrow, P.T., Kincaid, D.L., Rimon, J.G. & Rinehart, W. (1997). *Health communication: Lessons from Family Planning and Reproductive Health*. London: Praeger
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SLIDES

 <p>Working as an ICTC Team</p> <p>1</p> <p>ICTC Team Training</p>	<p>What is a team</p> <p>A group of people working in an organisation can be called a team “when there is interdependency in how the different team members function, that is the activity or service cannot be undertaken by one individual alone.”</p>
<p>Why do teams matter</p> <ul style="list-style-type: none"> • As in a game, every team player has a role to play. • At the ICTC, no one team member (counselling personnel, testing personnel or ICTC manager) can undertake the testing, counselling and medical advice all by themselves. 	<p>Functions of the ICTC</p> <ul style="list-style-type: none"> • Early detection of HIV • Provision of basic information on HIV/AIDS for promoting behavioural change and reducing vulnerability • Linking people with other HIV prevention, care and treatment services
<p>Overall goal of the NACP III is to halt and reverse the epidemic in India over five years:</p> <ol style="list-style-type: none"> 1. Prevention of new infections in high-risk groups and the general population. 2. Providing greater care, support and treatment to larger numbers of PLWHA. 3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level. 4. Strengthening the nationwide Strategic Information Management System. 	<p>ICTC Team Manager</p> <ul style="list-style-type: none"> • Administrative • Demand Generation • Quality Assurance • Supply and Logistics • Monitoring and supervision • Sensitising staff to avoid stigma and discrimination.
<p>Counselling Personnel</p> <ul style="list-style-type: none"> • Preventive and health education • Psychosocial support • Referrals and linkages • Supply and logistics • Monitoring 	<p>Testing Personnel</p> <ul style="list-style-type: none"> • HIV-testing • Ensuring adequate stock of consumables and rapid HIV-testing kits. • Maintaining records of HIV test results. • Ensuring the maintenance of all equipment. • Following internal and external quality assurance procedures. • Following universal safety precautions and hospital waste management guidelines.

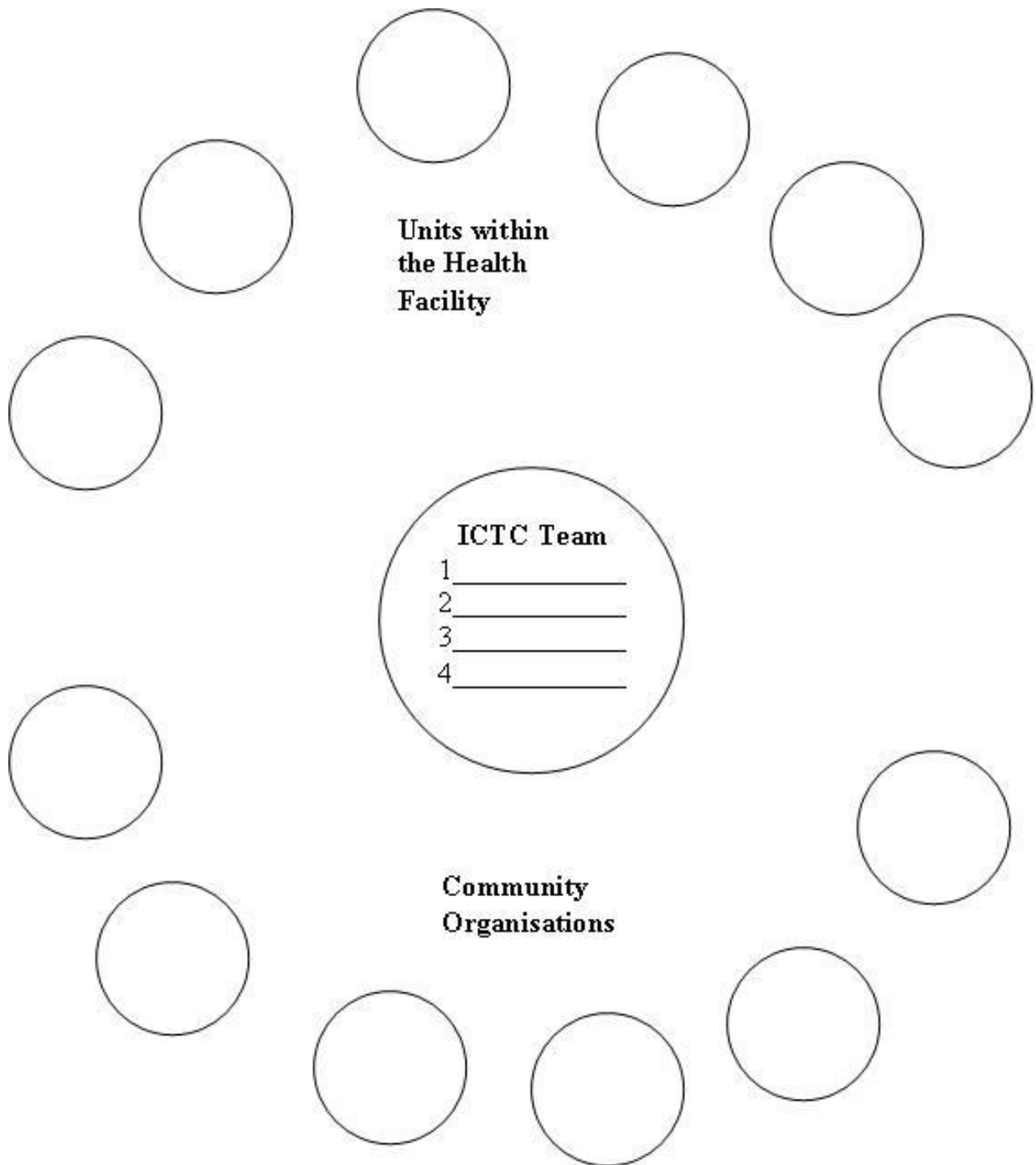
Team Effectiveness <ul style="list-style-type: none"> Degree to which a team accomplishes its purpose. Includes quality and quantity of services provided. Will depend to some extent on progress of individual team members. 	Conflict resolution <ul style="list-style-type: none"> Conflict is an inevitable part of human life. Will arise whenever people hold different opinions about how to perform a certain task. At the ICTC, it is important to recognise and encourage desirable conflict while minimizing undesirable team conflict.
Conflict resolution WHAT ARE SOME POSSIBLE AREAS OF CONFLICT IN THE ICTC?	Good communication <ul style="list-style-type: none"> Effective teams cannot manage without good communication (speaking openly, listening without judgment, creating small communication traditions) Person-to-person communication, enables team members to see each other as human beings with individual lives and problems, and provides a basis from which to try and see a problem from the other person's perspective.
Planning and task co-ordination <ul style="list-style-type: none"> Team members perform different sub-tasks. This calls for co-ordination between team members. 	Goal setting <ul style="list-style-type: none"> Effective teams agree on goals, work on them and then monitoring team progress towards these goals. Achievable goals include actions and a time limit. The actions are feasible and include mention of who has to do what.
Goals should be SMART S Specific – defining what is to be accomplished in terms of specific steps to behavioural change M Measurable – quantifying the objectives by indicating a numerical or percentage change expected A Appropriate – defining intended changes that are acceptable in the local context R Realistic – Avoiding objectives that are beyond the scope of available resources or contrary to relevant experience T Time-bound – identifying the time frame in which changes should be achieved	Supervision <ul style="list-style-type: none"> ICTC Manager OR District ICTC Supervisor
Documentation <ul style="list-style-type: none"> To study the increase or decrease in numbers of people visiting the ICTC To keep track of people who visit the ICTC and provide follow-up 	Diagram of Data Flow

<p>where appropriate</p> <ul style="list-style-type: none"> • To understand the change in profile of people visiting the ICTC and to prepare for the issues related to these changes • To identify people and groups who are not reached. Research has identified these groups as vulnerable to HIV, but they are not accessing the testing and counselling services • To make a case for more staff/more resources/more space/better space if the numbers of patients increase • To understand where patients are being referred from, and where they are not and to then use this information to improve referral • To check which advertising medium is most useful in a particular center – radio, TV, posters, referrals from PHCs, referrals from private doctors, etc. • To practise transparency and accountability to donors for the funds they are providing 																														
<table border="1"> <thead> <tr> <th>List of registers to be maintained</th><th>Prepare</th><th>Review</th></tr> </thead> <tbody> <tr> <td>PID Register for General Clients and Pregnant Women</td><td></td><td></td></tr> <tr> <td>ICTC Register for General Clients (Non ANC Cases)</td><td></td><td></td></tr> <tr> <td>ICTC Register for ANC Cases</td><td></td><td></td></tr> <tr> <td>ICTC Exposed Infant Register</td><td></td><td></td></tr> <tr> <td>ICTC HIV-TB Collaborative Activities Register</td><td></td><td></td></tr> <tr> <td>Laboratory Register</td><td></td><td></td></tr> <tr> <td>Stock Register</td><td></td><td></td></tr> <tr> <td>Monthly Reports</td><td></td><td></td></tr> </tbody> </table>	List of registers to be maintained	Prepare	Review	PID Register for General Clients and Pregnant Women			ICTC Register for General Clients (Non ANC Cases)			ICTC Register for ANC Cases			ICTC Exposed Infant Register			ICTC HIV-TB Collaborative Activities Register			Laboratory Register			Stock Register			Monthly Reports					<p>The next 11 slides consist of monthly records.</p>
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Monthly Reports																														

Training Materials

ICTC Referrals and Linkages

ICTC Ecomap



Common Contacts

This is a space for you to record details of those people and organisations that are most important for your work at the ICTC. These might be

- Places/institutions from where clients get referred, or
- Places/institutions where you refer clients.
- Medical officers at ART centres etc.
- Important SACS officials such as the person who supplies HIV testing kits and other items, or
- The medical expert who evaluates staff who might need PEP following an incident of exposure.

Keep updating this list as you make new contacts and use it when needed in your work.

All the best!

Organisation/ Unit: _____
Name of Person: _____
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Name of Person: _____
Mobile Number: _____
Landline Number: _____
Fax Number: _____
Address: _____



Healthcare Provider Tool: Assess, Suspect & Refer for HIV counseling and testing



Review any patient coming for a medical consultation for any of these: history, symptoms and signs for referral to ICTC

Ask/Assess

Presenting complaints:

- ✦ Prolonged fever for more than 1 month
- ✦ Unexplained fatigue
- ✦ Multiple swellings/lymph gland enlargement
- ✦ Chronic diarrhea more than 1 month
- ✦ Significant weight loss

History

- ✦ Unsafe sexual activity/multiple sexual partners or with sex worker
- ✦ Past/present STIs
- ✦ Sharing of needles and syringes (injecting drug use)
- ✦ High risk occupation (eg commercial sex work, truckers etc)
- ✦ If partner or child is known to be HIV positive or has HIV or HIV-related illness
- ✦ MSM (men having sex with men)
- ✦ Blood transfusions

Look during clinical examination

- Oral thrush or oral hairy leukoplakia
- Herpes zoster or scarring
- Lymphadenopathy swellings in neck and armpit
- Prurigo, skin rashes
- Chronic herpes simplex (genital or oral)
- Signs of injecting drug use: track marks, cellulitis, thrombophlebitis, scarring over veins, multiple abscesses
- Sexually transmitted infections (STI) signs: discharge, ulcers etc
- Gum/mouth ulcers

Actions

1. Treat conditions or refer for treatment
2. Refer to Counseling and Testing (ICTC)

**Routine referral to ICTC : patients who have Sexually Transmitted Infections (STI), Injecting drug users (IDU), high risk occupation (sex worker), Men-who-have sex-with-Men (MSM), Antenatal pregnant women (ANC)
Have heightened suspicion for HIV in TB patients and refer if indicated by other risk factors**

Key points: Advise and Refer for HIV testing

1. Establish trust with the patient :

- Introduce yourself
- Go through the history and presenting complaints
- Explain diagnosis of condition(s)

2. Ensure **privacy and confidentiality** in the consultation room: a one-to one medical consultation in an enclosed space is optimum.

3. Provide Key Information on HIV

HIV is a virus that destroys body's immune system. A person infected with HIV may not feel sick at first, but slowly the body's immune system is weakened. S/he becomes ill and is unable to fight infections. Once a person is infected with HIV, she/he can transmit the virus to others

HIV can be transmitted through:

- Exchange of HIV infected fluid during unprotected sexual intercourse (anal and vaginal)
- HIV-infected blood transfusion
- Injecting drug use
- Sharing instruments for tattoo or skin piercing
- From an infected mother to her child during pregnancy, labour and delivery and breastfeeding

HIV cannot be transmitted through hugging, kissing, eating together or mosquito bites

A special blood test is done at ICTC to find out if the person is infected with HIV

4. Provide Information on HIV Testing

The HIV test will determine whether a person has been infected with the HIV virus. It is a simple blood test that will allow us to make a clearer diagnosis

Before and after the test, counseling will be provided to talk more in-depth about HIV/AIDS

If a person is tested positive, Counselor will provide information about services available to manage the disease. This may include antiretroviral drugs and other medicines to manage the disease. If the test is negative, Counselor will focus on counseling and information on how to remain negative.

5. Explain procedures to safeguard confidentiality

The results of the HIV test will only be known to the patient and the treating medical team. This means that the test results are confidential and it is against testing policy to share results with others without clients permission.

6. Confirm willingness to be referred to ICTC

The treating physician needs to confirm patients willingness to undergo HIV counseling & testing.

Remember: Patient has a right to refuse an HIV test. HIV testing is not mandatory.

7. If patients require additional information, discuss advantages and importance of knowing the HIV status:

- The test will allow health care providers to make a proper diagnosis and ensure effective follow-up & treatment
- If the test is negative, the counseling will focus on information on how to remain negative
- If a person is tested positive, counseling will focus on information to protect themselves from re-infection and their partner from infection
- PLHA will be provided with information regarding treatment and care for managing their disease, including
 - ✦ Cotrimoxazole prophylaxis
 - ✦ Free ART at government ART centers
 - ✦ Treatment for opportunistic infections
 - ✦ Regular follow-up and support
- Positive pregnant women are counseled to access interventions to prevent transmission from mother to infants, and to make decisions about present and future pregnancies
- Counselors are also to discuss the psychological and emotional implications of HIV infection and encourage to disclose the status of infection to those whom patients decide needs to know
- An early diagnosis helps PLHA to cope better with the disease and plan for the future.

If the patient is unsure about or uncomfortable with having an HIV test or declines the test, Treat existing condition and ask for a follow-up.

How Well Do I Know HIV/AIDS?

Self-Assessment Quiz on HIV/AIDS

This is a quiz that you can try out yourself. The trainer will not collect your answers. We invite you to try to answer the questions and then check the answers on the page after the quiz.

The quiz is deliberately set at a slightly difficult and challenging level. So you may get a few questions wrong. We hope this will encourage you to keep reading and learning about HIV/AIDS – a field where scientists are discovering new things constantly. As health care professionals, we cannot rely on information that may be old and out-of-date. As the quotation in the box suggests, you can use your errors on the quiz to identify the areas where you need to read more.

Mistakes, obviously, show us what needs improving. Without mistakes, how would we know what we had to work on?

Peter McWilliams, Life 101

The source materials for the quiz are

- the Frequently Asked Questions at the NACO website (http://www.nacoonline.org/Quick_Links/FAQs/)
- the Fast Facts about HIV at the UNAIDS website (<http://www.unaids.org/en/knowledgecentre/resources/fastfacts/>).
- NACO's 'Guidelines for HIV Testing' which is also available on the NACO website.

How Well Do I Know HIV/AIDS?

INSTRUCTION: Circle the right answer.

- 1) We all know that HIV affects CD4 cells which are part of the body's immune system. But they also affect the
 - a) Sebaceous (sweat) gland cells
 - b) Organ of Corti
 - c) CD Six cells
 - d) Macrophages
- 2) HIV is a
 - a) Adenovirus
 - b) Retrovirus
 - c) Trojan
- 3) It is particularly difficult for HIV-infected individuals to fight off HIV infection for ALL of the following reasons EXCEPT
 - a) HIV affects the body's defence system itself
 - b) HIV replicates in large numbers which overwhelms the body's defence system
 - c) HIV can mutate (change) itself
 - d) HIV is difficult to identify through a blood test
- 4) As part of the National Blood Policy, under the Drugs and Cosmetics Act, blood that is donated is tested for all of the following EXCEPT
 - a) HIV
 - b) Hepatitis
 - c) Muscular dystrophy
 - d) Malaria
 - e) Syphilis
- 5) A test to detect HIV is said to have high sensitivity when
 - a) It identifies all false negatives correctly
 - b) It can detect even minute amounts of antibodies
- 6) All of the following are possible signs of HIV infection EXCEPT
 - a) Dry cough
 - b) Red, brown, pink or purplish blotches on or under the skin or inside the mouth, nose, or eyelids
 - c) Salty sweat
 - d) Rapid weight loss
 - e) Swollen lymph glands in the armpits, groin or neck
 - f) Memory loss or depression
- 7) HIV is NOT found in
 - a) Sweat
 - b) Cerebrospinal fluid
 - c) Synovial fluid
 - d) Amniotic fluid
- 8) HIV has been around since at least
 - a) 1927
 - b) 1959
 - c) 1982
 - d) 1993

- 9) Giving babies breast milk together with other liquids like water, herbal mixtures, or juice, or other foods like animal milk, formula milk, or soft porridge is called
 - a) Mixed feeding
 - b) Exclusive breastfeeding
 - c) Replacement feeding
- 10) Which of the following are NOT part of Universal Precautions
 - a) Carefully disposing items that could cause cuts or puncture wounds, including needles, hypodermic needles and scalpels
 - b) Wearing gloves during counselling
 - c) Hand-washing with soap and water before and after all surgical procedures
 - d) Safely disposing waste contaminated with blood or body fluids
 - e) Disinfecting instruments and other contaminated equipment
 - f) Properly handling bedding stained with blood, diarrhoea or other body fluids
- 11) Post- exposure prophylaxis ideally should start
 - a) Within 2 hours of the occupational exposure
 - b) Within 48 hours of the occupational exposure
 - c) Within 72 hours of the occupational exposure
 - d) Within 2 days of the occupational exposure
- 12) During surgery on a known HIV-infected patient, blood of the patient unexpectedly spurted into eye of the surgeon, Dr. X. Of the following first aid actions taken by the staff all of the following were correct EXCEPT
 - a) Dr. X sat in a chair with head tilted back and asked a colleague to gently pour water or normal saline over the eye.
 - b) Dr. X sat in a chair with head tilted back and asked a colleague to gently pour water and disinfectant over the eye.
 - c) Dr. X was wearing contact lens and left them in place while irrigating.
 - d) Once the eye was cleaned, Dr. X removed the contact lens and cleaned them in a normal manner.
 - e) Document the incident
- 13) All of the following drugs are part of the two-drug Post-Exposure Prophylaxis regimen EXCEPT
 - a) Lamivudine
 - b) Stavudine
 - c) Indinavir
 - d) Zidovudine
- 14) It is helpful for a person living with HIV/AIDS to know
 - a) That their viral load is below 10,000
 - b) That their viral load is between 10,000 and 100,000
 - c) That their viral load is above 100,000
 - d) The trends in their viral load – whether it is increasing or decreasing
- 15) All of the following are advantages of ICTCs as listed by NACO EXCEPT
 - a) Getting a free midday meal
 - b) Earlier access to care and treatment
 - c) Emotional support
 - d) Motivation to initiate or maintain safer sexual practices and behaviour change
 - e) Safer blood donation
 - f) Motivating HIV infected person to involve spouse/partner for future spread and care
- 16) Antiretroviral treatment CAN
 - a) Cure HIV/AIDS
 - b) Increase the CD4 cells and decrease the amount of virus in the body
 - c) Prevent the spread of HIV

- 17) Which is TRUE?
- a) 5 out of every 100 Indians are infected with Mycobacterium tuberculosis
 - b) 20 out of every 100 Indians are infected with Mycobacterium tuberculosis
 - c) 40 out of every 100 Indians are infected with Mycobacterium tuberculosis
 - d) 50 out of every 100 Indians are infected with Mycobacterium tuberculosis
- 18) Someone who is HIV-infected has a
- a) 10% lifetime risk of developing tuberculosis
 - b) 20 to 30% lifetime risk of developing tuberculosis
 - c) 50 to 60% lifetime risk of developing tuberculosis
 - d) 85% lifetime risk of developing tuberculosis
- 19) Which is TRUE?
- a) Early detection and treatment of HIV infection in TB patients can reduce the number of deaths of such patients.
 - b) Detection of HIV infection in a TB patient and subsequent treatment will not help the patient at all.
- 20) Which is TRUE?
- a) PLWHAs have to pay Rs 400 per month for cotrimoxazole preventive treatment (CPT).
 - b) PLWHAs have to pay Rs 175 per month for cotrimoxazole preventive treatment (CPT).
 - c) PLWHAs can get cotrimoxazole preventive treatment (CPT) free of charge.
- 21) The BEST way to detect tuberculosis infection is:
- a) Sputum test (Checking the saliva)
 - b) Chest X-ray
- 22) The regimen used by NACO to prevent transmission of HIV from a pregnant HIV-positive woman to her unborn child (that is PPTCT) is:
- a) Single does of Nevirapine to the baby on the third day
 - b) Single does of Nevirapine to the mother at the time of labour and on the third day after delivery
 - c) Single does of Nevirapine to the mother at the time of delivery and a single dose of Nevirapine to the infant immediately after birth

Do I Need Testing

Case Profiles

I am Makarand. I am 23 years old. My family lives in Vada taluka of Thane district. My father is a small farmer. Four years ago he took a loan from the brick manufacturer because the crop was poor. We have to repay this loan. So I work for the brick contractor. I stay in the same district as my family. But it is easier to stay in the small hut on the worksite and visit home occasionally. Work is hard. So I look forward to our once-a-week outing to the nearby village. My companions and I come here for our weekly shopping as well as for some entertainment. I think we will be able to pay off the loan soon. Then I will be free to return to my home where I will get married and help my father in the field.

Do I need HIV testing?

✂-----

I am Shumati. I am 24 years old. I am married and have a 5-year old son and a 3-year old daughter. My husband left our home in Orissa to go to Delhi for work. He used to work as an agricultural labourer. But the salary was not good. His friends told him that he could make more money by digging. So he went there to lay the telephone cables. He has been doing this work for 2 years now. He cannot come home to visit too often. But we are happy when he visits. He has promised me a new saree when he comes the next time.

Do I need HIV testing?

✂-----

I am Viswanathan. I am 32 years old. I drive a truck for my living. Highway No. 7 is familiar territory. I know all the best stops such as Bowenapally and Gananpahad. I am often away from my wife and two-year old child for weeks. Driving on the road is hard work. When we stop for a rest, I look for good food. I like to wash it down with some strong liquor. Sometimes I feel the urge to visit a sex worker.

Do I need HIV testing?

✂-----

I am Umar. I am 2 years old. My father recently went for an HIV test to the ICTC at Ranchi because his doctor asked him to rule it out. He came back crying because the result was positive. Now everybody in the house is very sad. I don't understand what the fuss is about.

Do I need HIV testing?

✂-----

I am Harsha. I am 27 years old. I earn some money through camphor packaging. My husband earns Rs. 3000 a month at a local cinema in Surat. But we still find it difficult to manage household expenses. So I decided to become a sex worker at a local lodge. This helps to bring some extra money. But I don't want my neighbours to find out.

Do I need HIV testing?

✂-----

I am Raingam. I am 22 years old. When I was 17 years old I began taking drugs. To buy the drugs I began to sell items from my home. My family was fed-up with me and put me into jail, hoping that I would improve. I remained there for a few months. It was very bad. Now I am out and I live in a hut with a friend. I do some casual work at the bus-station to earn some money. I use this to buy my drugs. It is the greatest feeling in the world when I inject them into my veins.

Do I need HIV testing?

✂-----

I am Bishakha. I am 35 years old. When I was 13 years old, my father married me to a man who had lent him some money. He used to drink too much, and would beat me often. One day he brought his friend over and tried to force me to have sex with him. But I ran away to my parents. I was then 16 years old. I refused to go back to my husband's house. So a few weeks later my mother took me to a rich family's home to do work. Here she took money from the lady. I did the work for a few months. But when I wanted to go home to visit my family, the house owner told me that she had paid my mother Rs. 8000/- for me which I would have to pay off before I could leave. So I became a sex worker in Kolkatta. Now I have one son who is 9 years old.

Do I need HIV testing?

✂-----

I am Dhanesh. I am 29 years old. I work in a hotel in Agra. Sometimes male guests want to have sex with me. The first time it happened, I was a little worried. But I was happy to get the money. I soon began to enjoy it. I have heard about AIDS and I use a condom. But once a guest told me he prefers to go "bareback." So we did it without a condom. I am single and I don't have any girl friend. My family wants me to marry. I have earned enough money and am ready.

Do I need HIV testing?

✂-----

I am Janet. I am 18 years old. I am in the first year of engineering in Madurai. I have many friends in college. Recently, a boy in my class showed interest in me and we went out for a movie at the cinema. He brought me popcorn. After the interval he held my hand. I allowed him. I like him and I think I will go out again if he asks me.

Do I need HIV testing?

✂-----

I am Chirag. I am 20 years old. I live in Mumbai. I am *kothi* [or *menaka* (Cochin) or *durani* (Kolkotta) or *marulaadi* (Chennai)]. My father works as a clerk in the postal service. I also have 2 older sisters, one of whom is married. From my youth, I have been accused of being feminine and have been pushed around. I have finished my B.Com. Some time back I began having sex with other men. My first experience was with a school friend when we were in Std. IX. Sometimes the sex hurts. Sometimes it feels good. Sometimes when my back passage hurts I take my partner's penis between my thighs. But they are not always agreeable.

Do I need HIV testing?

Activity: People Search

Find people who match the description below. You cannot repeat a person's name. You cannot write your own name on the sheet.

- Someone who is wearing the colour red
- Someone who is wearing sandals
- Someone who travelled to the training programme by bus
- Someone who plays a musical instrument
- Someone who has represented their district or state in any sport
- Someone who was born in February
- Someone who has watched a film shooting
- Someone who went to Agra for their honeymoon
- Someone who cannot swim
- Someone who has 3 brothers or 3 sisters
- Someone who has ridden a horse (even in a baraat)
- Someone who has suffered from jaundice
- Someone whose family member has received tuberculosis treatment
- Someone who has been tested for HIV.

Discrimination Case Notes

Hospital puts sticker to mark patient as HIV+

CNN-IBN: Published on Sat, Jun 20, 2009 at 22:19, Updated on Mon, Jun 22, 2009 at 01:09 in India section

New Delhi: In a case of discrimination, humiliation and insensitive treatment to an HIV positive patient, a woman who tested positive for HIV has been branded in public.

The government hospital singled out the 27-year-old pregnant woman by pasting a sticker on her head declaring her HIV+ status.

"I was in the hospital on Wednesday for a routine check up during my pregnancy when the staff here pasted a sticker with HIV+ written on my forehead. I don't know why they have done this" said the woman.

When she approached a local NGO they came to support her and took up the issue with the hospital.

The hospital owned up but said it was a policy.

"All types of patients come here. The strip has been placed on the forehead of the patient for easy identification. It helps the nurse to identify the special case and it is a policy of the hospital to place a strip on the forehead of the patient. I am willing to apologise in writing on behalf of anyone who has done this but these people are not willing to listen to anything," said Gynaecology Department head at the government hospital [Names of the doctor and the hospital have been deleted].

Note to Trainees:

This type of event could have happened in any place. In fact, research shows that stigma and discrimination like this occurs in many hospitals in India. The government official in the incident described above apologised for the actions of the staff. But let us see what we can learn from this event. The idea is not to blame people in any particular place.

Questions for discussion

1. Why do hospital staff want to know if a person is infected or not?
2. Does putting the label really help us to know all the people who are HIV-infected?
3. Can you imagine the feelings of the medical staff?
4. Can you imagine the feelings of the patient who is wearing the label?
5. Can you imagine the feelings of the other patients?
6. What would you recommend to help the medical staff, the patient with the label and the other patients?

PPTCT Case Profiles

Case Profile 1

Saima is a 32-year-old married woman who is in the fourth month of her third pregnancy. Her other children are 13 years and 9 years respectively. She is visiting the ICTC counselling personnel because she has been referred here by her gynaecologist.

✂-----

Case Profile 2

Gurmeet Kaur is a 24-year-old married woman who is pregnant for the first time. She is accompanied by her mother-in-law. She appears to be in good health except for a burning sensation while urinating. She does not want to get an HIV test done.

✂-----

Case Profile 3

Madhavi arrives at the labour room in her 38th week of pregnancy. She has been having labour pains for 6 to 8 hours. She has not visited the doctor before this, and so does not yet have an ANC card. Birth is likely to happen soon.

✂-----

Case Profile 4

Vanessa is a first-time mother who has just delivered at the district hospital. She arrived at the hospital, which she had not visited previously, just in time to deliver her baby. She had consented for an HIV test. Today is the second day after delivery. Her rapid test result using the three-test algorithm is positive. Neverapine was administered during delivery.

✂-----

Case Profile 5

Jaywantiben is 27 years old. She has 2 children, one aged 6 years and the other aged one month. She is HIV-positive. At the time of delivery, she was given nevirapine and the baby was given nevirapine before being discharged on the third day. She has come for a follow-up.

✂-----

Questions for each case profile

- a) What are the testing needs of the female client?
- b) What should counselling cover on the first visit?
- c) What should counselling cover on the second visit?
- d) Are there organizations or services where you could refer the client?

In Which Register Would You Find Me?

I am Viswanathan. I am 32 years old. I went to the STI clinic for a big open sore on my penis. They sent me to the ICTC where I tested positive for HIV.

I am Umar. I am 2 years old. My mother and father are HIV-positive. I was given NVP soon after birth.

I am Raingam. I am 22 years old. When I was 17 years old I began taking drugs. I was urged by my church pastor to get tested for HIV and went to a local NGO which had an ICTC. I tested positive.

I am Bishakha. I am 35 years old. When I was 13 years old, my father married me to a man who had lent him some money. One day he brought his friend over and tried to force me to have sex with him. But I ran away to my parents. I became a sex worker in Kolkatta. I recently tested positive for HIV. I also have TB.

I am Dhanesh. I am 29 years old. I work in a hotel in Agra. Sometimes male guests want to have sex with me. I went to an ICTC where I tested negative for HIV.

I am Saima. I am 32-years-old. I am in the fourth month of my third pregnancy. My gynaecologist referred me to the ICTC counselling personnel.

I am Gurmeet Kaur. I am 24 years old and this is my first pregnancy. I am in good health except for a burning sensation while urinating. I have been asked to get an HIV test done.

I am Madhavi. I stay in a remote village and I have come to the district hospital in labour I do not have an ANC card.

I am Azhar. I am 27 years old. I have been coughing for a couple of months now and I feel very weak.

List of Registers at the ICTC	Viswanathan	Umar	Raingam	Bishakha	Dhanesh	Saima	Gurmeet	Madhavi	Azhar
PID Register for General Clients and Pregnant Women									
ICTC Register for General Clients (Non ANC Cases)									
ICTC Register for ANC Cases									
ICTC Post-natal Follow-up Register									
ICTC HIV-TB Collaborative Activities Register									
Line List of Persons referred from the ICTC to the RNTCP									
Laboratory Register									
Stock Register									
Monthly Reports									

[illegible]

Annexure III.b

ICTC Register for General Clients (excluding Pregnant Women)

ICTC Code:

ICTC Name:

District:

State:

S. No.	PID No.	Date of visit	Referred by	Mark of identification	Age	Sex	Education	Occupation	Marital status
1	2	3	4	5	6	7	8	9	10
			1. NGO /CBO TI's			1. M	1. Non-literate	1. Daily wage	1. Married
			2. Non-TI NGOs			2. F	2. Primary School	2. Salaried	2. Single
			3. ANC/O and G/PPTCT				3. Secondary School	3. Business	3. Divorce/ Separate
			4. RNTCP				4. College and above	4. Housewife	4. Widowed
			5. Blood Bank					5. Retired	
			6. Government health facilities					6. Student	
			7. ART centre					7. Other	
			8. STI clinics						
			9. Care centres (CCC) and DIC						
			10. Private health facilities						
			11. Others						

Continued...



Date of pre-test counselling done/ information given	Type of risk behaviour	Consented for HIV testing?	Test report	Date when post-test done and test report given	Follow-up due date (for partner counselling)
11	12	13	14	15	16
	1. Heterosexual	1. Yes	1=Positive		
	2. Homosexual	2. No	2=Negative		
	3. History of blood transfusion		3=Not tested		
	4. History of use of infected syringe and needles in health facility		4. Indeterminate		
	5. Parent to child				
	6. Not specified				
	7. Injecting drug user				

Continued...



Annexure III.b

ICTC Register for General Clients (excluding Pregnant Women) (contd.)

Patient referred to	Whether spouse tested (Y/N)	PID No. of spouse/partner	HIV status of spouse (tested at ICTC or elsewhere in last 6 months)	Condom counselling and demonstration (Y/N)	Condom given (Y/N)
17	18	19	20	21	22
1. NGO/CBO TI's	1. Yes		1=Positive		1. Yes
2. Non-TI NGOs	2. No		2=Negative		2. No
3. ANC/O and G/PPTCT			3=Not tested		
4. RNTCP			4=Indeterminate		
5. Government health facilities					
6. ART centre					
7. STI clinics					
8. Care centres (CCC) and DIC					
9. Private health facilities					
10. Others					

Continued...

Confirmation of referral done? (Y/N)	Follow-up I (date)	Subsequent follow-up (dates)
23	24	25
1. Yes		
2. No		

Continued...



Annexure III.c

ICTC Register for Pregnant Women*

ICTC Code:

ICTC Name:

District:

State:

S. No.	PID No.	Date of Visit	Whether an ANC case/direct delivery	Referred by	Mark of identification	Age	Education
1	2	3	4	5	6	7	8
			1. ANC	1. NGO/CBO TI's			1. Non-literate
			2. Delivery	2. Non-TI NGOs			2. Primary School
				3. ANC/O and G/PPTCT			3. Secondary School
				4. RNTCP			4. College and above
				5. Blood Bank			
				6. Government health facilities			
				7. ART centre			
				8. STI clinics			
				9. Care centres (CCC) and DIC			
				10. Private health facilities			
				11. Others			

* To be filled in for all ANC cases.

Continued...



Annexure III.c

ICTC Register for Pregnant Women (contd.)

Marital status	Occupation	Month of pregnancy at the time of registration	Parity	Expected date of delivery (EDD)	Pre-test/ group counselling done	Consented for HIV test
9	10	11	12	13	14	15
1. Married	1. Daily wage				1. Yes	1. Yes
2. Single	2. Salaried				2. No	2. No
3. Divorce/ Separate	3. Business					
4. Widowed	4. Housewife					
	5. Retired					
	6. Student					
	7. Other					

Continued...



HIV test results	Post-test counselling done and received test result	Patient referred to	Partner PID No.	Partner test date	Partner test result	Where is the delivery planned?
16	17	18	19	20	21	22
1=Positive	1. Yes	1. NGO/CBO TI's			1=Positive	1. Same facility
2=Negative	2. No	2. Non-TI NGOs			2=Negative	2. Other govt. nursing home
3=Not tested		3. ANC/O and G			3=Not tested	3. Private nursing home
4. Indeterminate		4. RNTCP			4. Indeterminate	4. Home delivery
		5. Government health facilities				
		6. ART centre				
		7. STI clinics				
		8. Care centres (CCC) and DIC				
		9. Private health facilities				
		10. Others				

Continued...



ICTC Register for Pregnant Women (contd.)[illegible]

State:

S. No.	PID No. of mother	Id for the child	Sex of child	Date of registration of the mother	Date of delivery	Follow-up counselling details
						Follow-up at 6 weeks (date of visit)
1	2	3	4	5	6	7
			1. M			1. Advise/demo of condom use
			2. F			2. Family planning
						3. Infant feeding
						4. HIV testing for baby
						5. Nutrition counselling
						6. Psychosocial support

* To be maintained only for positive cases.



Continued ...



Annexure III.d

ICTC Post-natal Follow-Up (contd.)

Follow-up counselling details					
Current feeding practice	Follow-up at 12 months	Follow-up at 18 months	HIV test at 18 months	Date baby referred to ART centre	ART centre registration number of child
14	15	16	17	18	19
1. BF	1. Mother	1. Mother	1. Positive		
2. Alternative	2. Baby	2. Baby	2. Negative		
	3. Both	3. Both	2. Not tested		



Annexure III.e

ICTC HIV–TB Collaborative Activity Register

Continued...



ICTC HIV–TB Collaborative Activity Register (contd.)[illegible]

Annexure III.f

Laboratory Register for ICTC

Continued...



Annexure III.g

Stock Register for ICTC

Name of Test/Drug/Consumable* :_____

[illegible]

*As per the list :

1. HIV test kit 1 (Number of tests)
2. HIV test kit 2 (Number of tests)
3. HIV test kit 3 (Number of tests)
4. HIV test kit 4 (Number of tests)
5. Disposable gloves
6. Condoms
7. PEP drugs
8. Nevirapine tablets
9. Nevirapine syrup
10. Safe delivery kits



Annexure III.h

Formats for Monthly Reports

ICTC Code
ICTC Centre CMIS Code:
Schedule Code:
Monthly Input Formats for Integrated Counselling and Testing Centres (ICTCs)
Sections A and C common for all ICTC Clients
Section B for all clients excluding Pregnant women
Section D for Pregnant women
Section E for HIV-TB collaboration for all ICTC clients

Section A: Identification
1. Name of ICTC:
2. Address:
City:
Pin code:
District:
State:
3. Reporting period:
Month:
Year:
4. Name of Officer In-charge (ICTC):
5. Contact number (phone):

Summary table : Status for the month			
Indicator	ICTC Clients (excluding Pregnant women)	ICTC Clients - Pregnant women	Total ICTC
1. Total clients registered this month			
2. Number of clients receiving pre-test counselling/ information			
3. Number of clients tested for HIV			
4. Number of clients receiving post-test counselling			
5. Number of clients receiving HIV test results			
6. Total no. of clients testing sero-positive (after 3 specified tests)			
7. Number of mother-baby pairs receiving nevirapine out of those found positive			
8. Number of ICTC clients referred to DOTS centre (TB microscopy centre)			
9. Number of TB clients referred in ICTC from TB microscopy			
10. Total number of HIV-TB co-infection detected in month			



Annexure III.h

Monthly Reports (contd.)

ICTC Code										
ICTC Centre CMIS Code:					Schedule Code:					
Monthly Input Formats for Integrated Counselling and Testing Centres (ICTCs) [All clients excluding pregnant women]										
Section B: Progress Made During the Month by the ICTC [All clients excluding pregnant women]										
(i) Details of client's visit to ICTC and HIV tests undertaken (excluding pregnant women)		Client-initiated			Provider-initiated			Total		
		Male	Female	TS/TG	Male	Female	TS/TG			
1. Number of clients received pre-test counselling/information								0		
2. Number of clients tested for HIV								0		
3. Number of clients receiving post-test counselling								0		
4. Number of clients receiving HIV test results								0		
5. Total number of clients diagnosed sero-positive (after three tests)								0		
6. Number of clients for follow-up counselling								0		
(ii) HIV status of spouse/partner		Total								
1. Number of newly detected discordant couples/partners										
2. Number of couples where husband / male partner is negative and wife /female partner positive										
3. Number of couples where husband / male partner is positive and wife /female negative										
4. Number of newly detected concordant couples (both positive)										
(iii) Composition of clients undergoing HIV test/diagnosed positive and route of transmission										
(iii)(a) Age-wise distribution of HIV-positive cases		Total no. of clients undergoing HIV test				Total no. of clients diagnosed sero-positive				
		Male	Female	TS/TG	Total	Male	Female	TS/TG	Total	
1. <14					0				0	
2. 15-24					0				0	
3. 25-34					0				0	
4. 35-49					0				0	
5. >50					0				0	
6. Not specified/unknown					0				0	
(iii)(b) Route of transmission of HIV-positive cases						Male	Female	TS/TG	Total	
1. Heterosexual									0	
2. Homosexual / Bisexual									0	
3. Through blood and blood products									0	
4. Through infected syringe and needles									0	
5. Parent to child (for children)									0	
6. Not specified/unknown									0	
(iv) Linkages and referrals										
Departments / Agencies	In referral			Out referral - Positive			Out referral - Negative			
	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	
1. NGO / CBO TIs										
2. Non-TI NGOs										
3. OBG/Maternity homes										
4. RNTCP										
5. Blood Bank										
6. Government health facilities										
7. ART centres										
8. STI clinics										
9. Care centres (CCC) and DIC										
10. Private health facilities										
11. Others										



Annexure III.h

Monthly Reports (contd.)

ICTC Code						
ICTC Centre CMIS Code:				Schedule Code:		
Monthly Input Formats for Integrated Counselling and Testing Centres (ICTCs)						
Section C: Laboratory Information, Equipment, Consumables and Staffing (All ICTC Clients including pregnant women)						
(i) Laboratory Information for ICTC						
Description						Units
1. Total number of blood specimens from ICTC tested this month						
1.a) Any other HIV tests undertaken (sentinel surveillance, etc.)						
2. Number of blood specimens found indeterminate (after 3 HIV tests)						
3. Number of positive specimens sent for confirmation						
3.a) Number confirmed positive						
4. Number of negative specimens sent for confirmation						
4.a) Number confirmed negative						
(ii) Infrastructure, Staffing, Equipment, Consumables						
(ii)(a) Stock of HIV Test Kits and other Consumables						
Consumables	Opening Stock	Number received this month	Consumed	Closing Stock	Number requested	Date of placing request
1. HIV test kit 1				0		
2. HIV test kit 2				0		
3. HIV test kit 3				0		
4. HIV test kit 4				0		
5. Disposable gloves				0		
6. Condoms				0		
7. PEP drugs				0		
8. Nevirapine tablets				0		
9. Nevirapine syrup				0		
10. Safe delivery kits				0		
(ii)(b) Status of Equipment at ICTC						
Equipment	Numbers in place	Numbers in working condition	Numbers not in working condition	Complaint for repair registered (Y/N)		
1. Refrigerator			0			
2. Centrifuge			0			
3. Needle destroyer			0			
4. Micropipette			0			
5. Computer			0			
6. Internet connectivity			0			
(ii)(c) Availability of Counselling Aids						
Counselling Aids	Whether available (Y/N)					
1. Separate counselling room						
2. Flip charts						
3. Condom demonstration model						
4. Posters						
5. Other IEC materials (pamphlets, handouts)						
6. TV-DVD						

Continued...



(ii)(d) Staffing details				
Staff type	No. of positions sanctioned	No. of positions filled	No. of positions vacant	No. of staff trained during the month
1. Counsellor			0	
2. Laboratory technician			0	
3. Staff nurse			0	
4. Outreach workers			0	
5. Other staff (specify)			0	



Annexure III.h

Monthly Reports (contd.)

ICTC Code				
ICTC Centre CMIS Code:		Schedule Code:		
Monthly Input Formats for Integrated Counselling and Testing Centres (ICTCs)				
Section D: Progress during the month (only for pregnant women)				
(i) Pregnancy and delivery				
Staff type		During ANC		Directly in labour
		Cumulative at start of month	During this month	Cumulative at start of month
				During this month
1. Number of new registrations				
2. Number of cases receiving pre-test counselling/information out of all ANC registered				
3. Number of cases tested for HIV				
4. Number of cases received HIV test results				
5. Number of cases received post-test counselling				
6. Number of cases diagnosed HIV-positive				
7. Number of HIV-positive cases received HIV test result				
8. Number of spouses/partners of HIV-positive women found HIV-positive				
9. Number of spouses/partners of HIV-negative women found HIV-positive				
10. Total number of deliveries this month				
11. Total number of HIV-positive deliveries this month				
12. Total number of live births to HIV-positive mothers				
13. Total number of mother-baby pairs who received nevirapine				
14. Number of HIV-positive pregnant women receiving nevirapine during the month				
15. Number of babies of HIV-positive receiving Nevirapine during the month				
16. Number of HIV-positive women opting for exclusive breastfeeding				
17. Number of HIV-positive women accepting MTP after counselling				
(ii) Follow up				
Description		This month		
1. Number of HIV-positive women coming for follow up at 6 weeks				
2. Number of babies undergone HIV diagnostic testing (PCR)				
3. Number of babies found positive				
4. Number of mothers counselled for breastfeeding				
5. Number of positive mothers counselled for family planning				
6. Number of HIV-positive women coming for follow-up at 6 months				
7. Number of babies of HIV-positive women undergone HIV diagnostic testing (PCR) at 6 months follow-up				
8. Number of babies found positive at 6 months follow-up				
9. Number of positive women coming for follow-up at 12 months				
10. Number of babies of positive women coming for follow-up at 12 months				
11. Number of positive women coming for follow-up at 18 months				
12. Number of babies of positive women coming for follow-up at 18 months				
13. Number of babies found HIV-positive at 18 months				
14. Number of clients referred for CD4 testing				

Continued...



(iv) Linkages and Referrals for ANC Cases			
Description	In referral	Out referral – Positive	Out referral – Negative
1. NGOs/TIs			
2. Non-TI NGOs			
3. Other OBG/Maternity home			
4. Blood bank			
5. Government health facilities			
6. ART centres			
7. STI clinics			
8. Care centres (CCC) and DIC			
9. Private health facilities			
10. Others			



Annexure III.h**Monthly Reports (contd.)**

ICTC Code		
ICTC Centre CMIS Code:	Schedule Code:	
Monthly Input Formats for Integrated Counselling and Testing Centres (ICTCs)		
Section E for HIV-TB (all clients excluding pregnant women)		
PART-I (For HIV-TB Co-ordination States)		
1. REFERRAL OF SUSPECTED TUBERCULOSIS CASES FROM VCTC TO RNTCP		
Indicators	HIV-positive	HIV-negative
a) No. of persons suspected to have TB referred to RNTCP Unit		
b) Of the referred TB suspects, No. diagnosed as having:		
(i) Sputum positive TB		
(ii) Sputum negative TB		
(iii) Extra-pulmonary TB		
c) Out of above (b), diagnosed TB patients, number receiving DOTS		
2. REFERRAL OF DIAGNOSED TB PATIENTS FROM RNTCP TO VCTC		
a) No. of RNTCP registered TB patients tested for HIV		
b) Out of above (a), no. tested for HIV		
c) Out of above (b), no. detected to be HIV-positive		
PART-II (For all other states)		
3. REFERRAL OF SUSPECTED TUBERCULOSIS CASES FROM VCTC TO RNTCP		
Indicators	HIV-positive	HIV-negative
a) No. of persons suspected to have TB referred to RNTCP unit		
2. REFERRAL OF DIAGNOSED TB PATIENTS FROM RNTCP TO VCTC		
a) No. of RNTCP registered TB patients tested for HIV		
b) Out of above (a), no. tested for HIV		
c) Out of above (b), no. detected to be HIV-positive		



REPORTING MONTH: YEAR NAME OF ICTC: NAME OF DISTRICT:

REPORTING MONTH: YEAR NAME OF ICTC: NAME OF DISTRICT:

Annexure III.j NATIONAL AIDS CONTROL PROGRAMME (PHASE-III)
MONTHLY MONITORING FORMAT-2
Basic Services

(To be prepared and sent by SACS to NACO by mail to cmisdata@gmail.com and signed hard-copy by mail/courier latest by the 5th of every month)

State: _____ Year: _____

S. No.	Indicators		Baseline (as on 31 March of previous year)
1	2		3
1	Number of ICTC established	a. Admn. approval	
		a. Staff appointed	
		a. Staff trained	
		a. All equipments installed	
		a. Consumables available	
		a. Centre fully functional	
2	Number of persons pre-counselled	a. Males	
		b. Females	
3	Number of persons tested for HIV	a. Males	
		b. Females	
4	Number HIV+ among those tested	a. Males	
		b. Females	
5	Number of persons post-counselled	a. Males	
		b. Females	
6	Number of pregnant women counselled		
7	Number of pregnant women tested for HIV		
8	Number of pregnant women found HIV+		
9	Number of mother-baby pairs provided treatment		
10	Number of infant samples sent for PCR testing		
11	Number of HIV+ on DOTS		
12	Number of STI clinics supported	a. Public	
		b. Private	
13	Number of persons treated for STIs	a. Public	Males
			Females
		a. Private	Males
			Females



Reporting Month: _____

Continued...



[illegible]

Annex.

Integrated Counseling and Testing Centre referral form	
Referral to Integrated Counselling and Testing Centre	
<i>Dear Counsellor,</i>	
The patient with the following details is being referred for VCT to your centre:	
Name	_____age/sex
TB Number (if available)	_____
Kindly do the needful and provide me feedback on the same, in a confidential manner.	
Referring Provider	
Name:	Contact Phone #:
Date of referral:	
Name of the PHI:	
Feedback by the Counsellor to referring provider	
<i>(To be filled in duplicate by the counsellor. One copy for patient, the other for referring MO)</i>	
TEST RESULT FROM ICTC	
HIV positive	<input type="checkbox"/>
Indeterminate	<input type="checkbox"/>
HIV negative	<input type="checkbox"/>
Opted out	<input type="checkbox"/>
PID Number	
Date of conducting test	
Additional communication to the referring physician	
Signature of MO ICTC/counsellor	