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

सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

FACILITATOR GUIDE
FOR
HIV & STI COUNSELLORS

APRIL 2024

NATIONAL AIDS CONTROL ORGANISATION
Ministry of Health and Family Welfare
Government of India

सत्यमेव जयते

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अपर सचिव एवं महानिदेशक
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आज़ादी का अमृत महोत्सव

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

I am pleased to introduce the NACP Counsellors Training *Facilitators' Guide* developed under the National AIDS & STD Control Programme (NACP) Phase V. This document serves as a valuable resource for the training facilitators who will be involved in planning, implementing and facilitating the training sessions of the NACP counsellors.

As part of our commitment "to break the silos and build synergy" amongst all programmes divisions, a standardized ToR for all the counsellors working under NACP programs has been developed and shared. The training of counsellors under the NACP is a vital component of our mission to provide standardized and high-quality counselling services. By equipping facilitators with requisite tools and methodologies our aim is to ensure a seamless transmission of knowledge and skill development among counsellors.

The Facilitators' Guide presents a methodical approach to deliver the training sessions consistently. It empowers resource persons and organizers to effectively harness the content of the Handbook for HIV/STI Counsellors, facilitating interactive and stimulating training sessions.

This Facilitators' Guide will help facilitators to promote cross-learning, facilitate the exchange of insights and standardize knowledge augmentation across counsellors hailing from various NACP facilities. This collaborative approach is poised to enhance synergy and optimize resources, ultimately elevating the quality of care extended to individuals afflicted and impacted by HIV.

I encourage all facilitators to adopt this Facilitators' Guide as an invaluable companion resource throughout their training sessions. By doing so, we can collectively work towards our common goal of bridging gaps in the HIV care cascade and ensuring that all individuals receive comprehensive, complete, rightful and quality care.

(MS. V. HEKALI ZHIMOMI)

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Message

In the fifth phase of the **National AIDS & STD Control Program** (NACP - V), NACO aims to enhance efforts by embracing new strategies and expanding the response through optimizing existing interventions. A number of new initiatives and strategies have been adopted to achieve the 95-95-95 goals. The primary focus is to elevate the overall response to meet specific geographic and community needs, as well as emerging programmatic priorities, aiming to eliminate AIDS as a public health threat by 2030. Emphasis is laid on covering hitherto uncovered HIV negative but "at-risk" clients through newly evolved Sampoorna Suraksha Strategy. Best efforts are made in promoting coordinated actions through a unified delivery system, along with functional and measurable referrals and linkages within the HIV control program and other related health and social welfare programs, to ensure effective service provision to both infected and affected individuals.

Counselling, offered across various facilities under the program, stands as a pillar in HIV service delivery. , The training and capacity building of counsellors has been a crucial aspect for the newer approaches and strategies conceived under NACP Phase V. To foster synergy within the program and eliminate barriers, a standardized set of Terms of Reference for all counsellors under NACP was formulated and shared with all State AIDS Control Societies (SACS). Subsequently, the development of a comprehensive training module for all NACP counsellors, encompassing programmatic, attitudinal, and knowledge-based competencies, felt imperative and need of the hour and demonstrate the NACP tenet of "**Break the Silos, Build synergies**."

I am pleased to introduce this NACP Counsellors Training Facilitator Guide, which, in conjunction with the "Handbook for HIV & STI Counsellors," will serve as a valuable resource for training all counsellors working under the NACP. This guide aims to promote uniformity, standardization, and high-quality training by engaging counsellors in participatory and activity-based learning process. Each chapter in this facilitators' guide outlines the objectives, expected outcomes, necessary materials and resources, duration, and recommended delivery process for each session. This structured approach will aid trainers in conducting more standardized quality trainings across all SACS.

I look forward to the trained NACP Counselors contributing towards integrating HIV/STI in health systems.

Shobini

(Dr Shobini Rajan)
27/3/24.

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Acknowledgement

It gives me great pleasure to present before you the "Facilitators' Guide", developed under the NACP V, keeping in view the overarching theme to "Break the Silos and Build The Synergy". I extend my deepest gratitude to Ms. V. Hekali Zhimomi, Additional Secretary & Director General - NACO, for providing the visionary leadership in development of this module. I extend my heartfelt thanks for the time-to-time guidance received from Mr Saurabh Jain, Joint Secretary, NACO. I extend my earnest gratefulness to Dr Anoop Kumar Puri, DDG- NACO, Dr Uday Bhanu Das, DDG NACO, Dr Chinmoyee Das (PHS Gr-I), Dr Bhawani Singh Kushwaha, DD NACO and Dr Bhawna Rao, DD NACO for providing all the technical leads and guidance for development of the module.

I would like to express my sincere thanks to Dr Shobini Rajan, DDG (BSD, STI and Prevention) for her experienced and expertized inputs received in the conceptualization of this training module and efficient leadership in giving this document the required shape. The expertise, experience and the technical support provided by the National Working Group (NWG), comprising of NACO officials from all divisions, technical experts, programme managers from State AIDS Control Societies (SACS), representatives from the development partners and other stakeholders is greatly acknowledged and is referenced at Annexure- 27.

I take this opportunity to express my thanks to Dr. Vibhavari Deshmukh- National Consultant, Dr. Abhishek Royal - Technical Expert, Ms Suman Sehrawat- Consultant, Dr. Vishal Yadav- Consultant, Mr. Chaitanya Bhatt Technical Expert, Dr. Sheikh Mohd. Saleem- Technical Expert, Dr. Payal Sahu- Technical Expert, and the whole BSD Team at NACO for their effective coordination and timely delivery of this Module. I extend my gratitude to the SAATHII team – Mr. S. Hedvees Christopher, Mr. Arpan Bose and Dr. Sai Subhasree Raghavan - for their continuous support in the development and production of the facilitator guide.'

(Dr. S. P. Bhavsar)

अपनी एचआईवी अवस्था जाने, निकटतम सरकारी अस्पताल में अपनी मुफ्त सलाह व जाँच पाएँ
Know your HIV status, go the nearest Goverment Hospital for free Voluntary Counselling and Testing

LIST OF ABBREVATIONS

AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents Living with HIV
ANM	Auxiliary Nurse Midwife
ART	Anti-Retroviral Therapy
ASHA	Accredited Social Health Activists
BB	Brothel Based
BCC	Behavior Change Communication
BP	Bridge Population (Migrant and Trucker)
BSD	Basic Service Division
CABA	Children Affected by HIV and AIDS
CBO	Community Based Organization
CBS	Community Based Screening
CD4	Cluster of Differentiation 4
CLHIV	Children Living with HIV
CN	Condom Negotiation
CoE	Centre of Excellence
CPT	Co-trimoxazole Prophylactic Therapy
CSM	Condom Social Marketing
CSS	Community System Strengthening
DB	Dhaba Based
DDG	Deputy Director General
DISHA	District Integrated Strategy for HIV/AIDS
DR-TB	Drug-Resistant Tuberculosis
DSRC	Designated STI /RTI Center
EBF	Exclusive Breastfeeding
EID	Early Infant Diagnosis
ELISA	Enzyme-linked Immune Sorbent Assay
EQA	External Quality Assurance
ERF	Exclusive Replacement Feeding
EVTHS	Elimination of vertical transmission of HIV and syphilis
FIDU	Female Injecting Drug Users
FSPs	Female Sex Partners
FSW	Female Sex Worker
GBV	Gender-Based Violence
HB	Home Based
HBV	Hepatitis B virus
HCPs	Health Care Providers
HCTS	HIV Counselling and Testing Services
HCV	Hepatitis C virus

HEIs	HIV Exposed Infants
HIV	Human immunodeficiency virus
HRG	High-Risk Group
HWB	Highway based Sex worker
HWC	Health and Wellness Centre
ICTC	Integrated Counselling and Testing Center
IDUs	Injecting Drug Users
IEC	Information Education and Communication
IMAI	Integrated Management of adult Illness
INSTIs	Integrase strand transfer inhibitors
LB	Lodge Based
LDT	Long Distance Truckers
LFU	Lost to Follow Up
LHV	Lady Health Visitor
LWS	Link Worker Scheme
MARPs	Most at-risk populations
MH	Mental Health
MO	Medical Officer
MOS	Mobile Outreach Services
MPW	Multipurpose worker
MSMs	Men Sex with Men's
MTs	Master Trainers
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NB	Network Based
NCD	Non-Communicable Diseases
NDPS	Narcotic Drugs and Psychotropic Substances
NGO	Non-Governmental Organization
NHM	National Health Mission
NNRTIs	Non-nucleoside Reverse Transcriptase Inhibitors
NRTIs	Nucleoside (and nucleotide) Reverse Transcriptase Inhibitors
NSEP	Needs Syringe Exchange Program
NTEP	National Tuberculosis Elimination Programme
NWG	National Working Group
OIs	Opportunity Infections
ORW	Outreach Worker
OSC	One Stop Center
OST	Opioid Substitution Therapy
PCC	Preconception Care
PE	Peer Educator
PEP	Pre-Exposure Prophylaxis
PHN	Public Health Nurse
PIs	Protease Inhibitors
PLHIV	People Living with HIV/AIDS

PPs	Prison Populations
PPT	PowerPoint Presentation
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Injecting Drugs
PWUD	People Who Use Drug
RMNCAH+N	Reproductive, Maternal, New-born, Child, Adolescent Health and Nutrition
RoT	Route of Transmission
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
SACEP	State AIDS Clinical Expert Panel
SACS	Sate AIDS Control Society
SA-ICTC	Stand-Alone Integrated Counselling and Testing Centre
SB	Street Based
SCM	Syndromic Case Management
SEIs	Syphilis-Exposed Infants
SMM	Single Male Migrants
SN	Sexual Network
SOP	Standard Operating Procedure
SSC	Sampoorna Suraksha Counsellor
SSC	Sampoorna Suraksha Counsellor
SSK	Sampoorna Suraksha Kendras
SSLT	Sampoorna Suraksha Lab Technician
SSM	Sampoorna Suraksha Manager
SSORW	Sampoorna Suraksha Outreach
SSS	Sampoorna Suraksha Strategy
STI	Sexually Transmitted Infection
SWP	Standard Workplace Precautions
SWs	Sex Workers
TB	Tuberculosis
TG	Hijra/Transgender
TI	Targeted Intervention
ToR	Terms of Reference
ToT	Training of Trainers
TPHA	Treponema pallidum hemagglutination
TPT	TB Preventive Therapy
U=U	HIV undetectable = untransmittable
UNAIDS	United Nations Programme on HIV/AIDS
UWP	Universal Work Precautions
VDRL	Venereal Disease Research Laboratory Test
VHSND	Village Health, Sanitation and Nutrition Day
VI	Virtual Interventions
VP	Vulnerable Population
WHO	World Health Organization
WLHIV	Women Living with HIV

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STANDARD OPERATING PROCEDURE (SOP) FOR THE FIVE-DAY RESIDENTIAL TRAINING TO THE HIV & STI COUNSELLORS

I. Background and Purpose:

One of the guiding principles of NACP-V (2021-26) is breaking the silos and building synergies. In order to provide quality services to the clients in a holistic manner, the counsellors' ToR has been revised to break the silos and to create synergy in the counselling support provided to the clients visiting various facilities such as ICTCs, TI programmes, ART centres, DSRCs, OST centres, Sampoorna Suraksha Kendras (SSKs), OSCs, and 1097 helpline under the NACP.

Post 2014, various guidelines such as NACP V, National Guidelines for HCTS, 2016, National Guideline for HIV care and Treatment, 2021, National Operational Guidelines for ART Services 2021, Revised guidance document on EVTHS, OST Guidelines, TI revamped strategies, RMNCAH+N Counselling Manual, Sep 2021, etc. have also been revised that are important for the counsellors to understand. As a result, a comprehensive module for training of all NACP counsellors has been developed to align with the common ToR of counsellors and the revised guidelines. The trained counsellors on the present comprehensive training module can be placed in any facility and/or rotated as per the requirement by the respective SACS.

The National Working Group (NWG) had been constituted by NACO with the objectives to review, strengthen, and finalize the draft counsellors induction training module.

II. Operations Management of NACP Counsellors Training

The respective State AIDS Control Societies (SACS) are responsible for the planning, implementation, and supervision of all the training for the NACP Counsellors working in TI, ICTCs, ART centres, DSRCs, OST centres, Sampoorna Suraksha Kendras (SSKs), OSCs, and 1097 helpline under the NACP for their respective states and union territories.

Following are the important aspects of implementation and management of the training for the counsellors;

1. Planning

The NACP counsellors training is a five-day class-room, residential training. Each batch has to be between 25 and 30 participants, preferably. The SACS is required to develop a training calendar and submit it to NACO while considering the total number of NACP counsellors in the state and the number of participants in each batch.

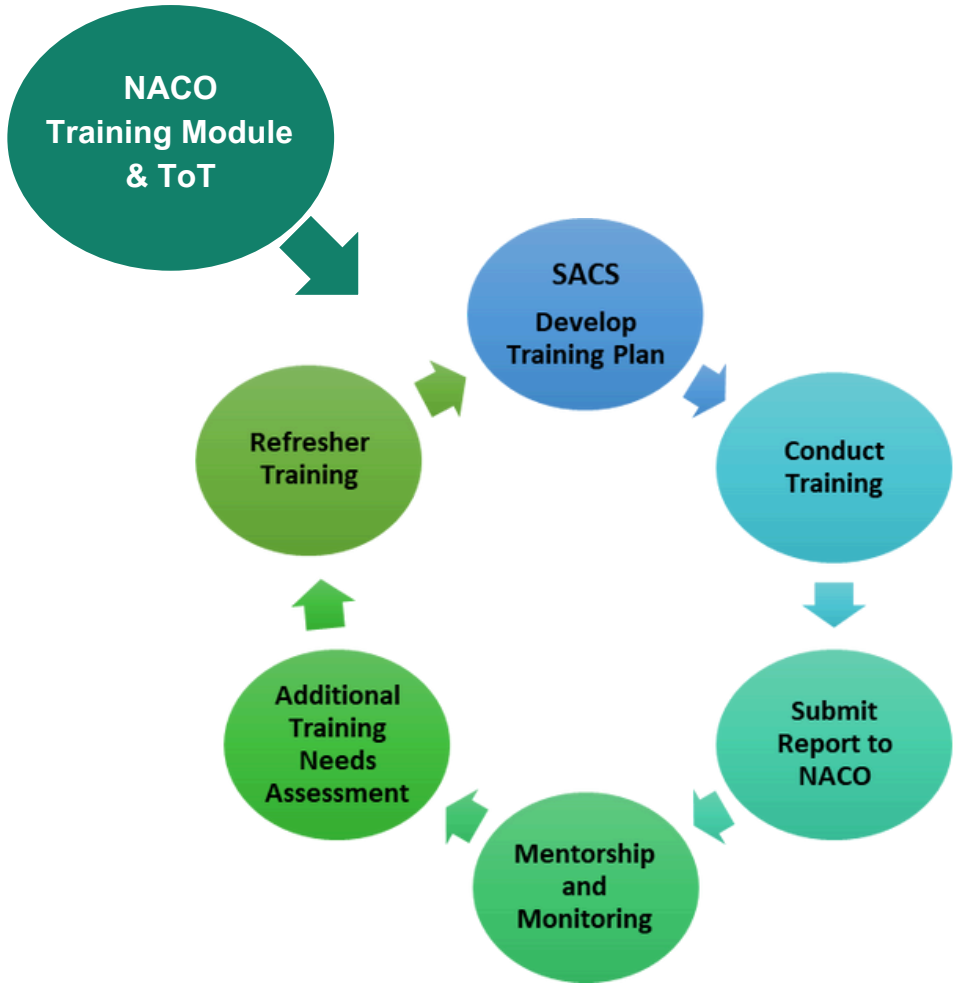
2. Implementation

The SACS can either plan and carry out the trainings on its own or it can engage with external organisations/agencies (NGOs/CBOs, educational institutions, both government and non- government training institutions, etc.) to arrange training logistics and organize the training. The SACS will mobilize the counsellors from various NACP facilities for the training. NACO in coordination with SACS have also identified the Master Trainers and thus SACS can seek the support of master trainers for implementation of training through the resource persons identified by SACS.

3. Supervision

SACS in each state and union territories is expected to appoint a nodal person from the BSD division who is at the Joint Director or Deputy Director level. The nodal person makes sure that the training is completed as scheduled with the highest quality.

NACP Counsellors Training Implementation Plan



III. Training Management of the NACP counsellors training

Training to the NACP counsellors is provided to build the capacity i.e., knowledge and skills to execute their roles and responsibilities more effectively as per the revised ToR towards halting the spread of HIV/AIDS in India.

1. About the training module

The training package developed by NACO includes a facilitator's guide, the handbook for HIV & STI Counsellors', and the PowerPoint presentations. The training module was created in collaboration with subject matter experts, pilot tested in a real-world setting with counsellors, and then finalised. The following topics are primarily covered in the introduction training module:

- ·Introduction and Basics to NACO, NACP, HIV/AIDS, and Newer Initiatives of NACP
- ·Counselling and diagnosis
- ·Treatment and monitoring
- ·Prevention, community engagement, and reporting

There are 24 chapters in the training module, which are equivalent to 24 sessions. Step-by-step instructions for conducting the session are provided in each chapter. Objectives of the session, the expected outcomes, the suggested training methodologies, materials required and duration are charted out right at the beginning of the chapter. The second part of the chapter provides guidance to the facilitator on how the session will have to be facilitated step-by-step. Technical information, a session summary, and annexures are given in the 'Handbook for HIV & STI Counsellors'.

2. Master Trainers

The different SACS has recommended a list of Master Trainers for their respective states. NACO thoroughly reviews these lists before deciding who are to be included, based on their training, experience, and subject-matter competence. The SACS is expected to use them for counsellor training.

3. ToT of Master Trainers:

Four regional five-day ToTs for Master Trainers will be conducted by NACO: those in the north-west, east and north-east, central, and southern regions. Senior master trainers who are subject matter specialists and were involved in the development of training modules and pilot testing will be engaged by NACO to train the master trainers on the training module through ToT.

When the need arises to replace the master trainers, SACS is tasked with identifying and developing the capabilities of additional master trainers. The overall resource pool of the trainers for counsellors training will have to be identified by SACS which will also include the trained master trainers.

4. How to Facilitate the session

In their capacity as a session facilitator, each master trainer will be required to comply with the subsequent guidelines/detailed out process in the “facilitator’s note” in this module:

a. Preparedness

Every master trainer must possess a thorough comprehension of the technical content pertaining to the chapters given to them, as well as the recommended training methodologies, the accompanying PowerPoint presentation, and the handbook for HIV & STI counsellors. Ensure that all necessary materials, including charts, sketch markers, printed case studies, questions and tools etc. are prepared/available in advance of the training. If assistance is needed, seek the assistance of the organizers.

b. Open Session

If this is your first session of the training, extend a warm welcome to the attendees and introduce yourselves. Establish a sense of ease among the participants in your presence. Introduce the topic and the learning objectives of the session.

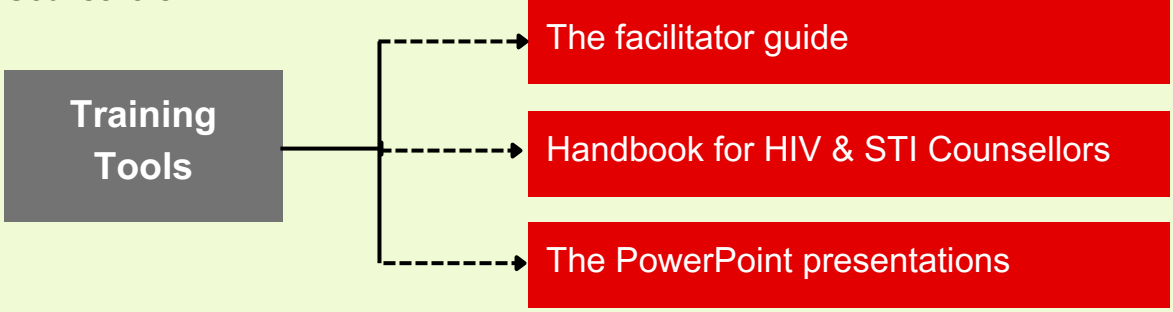
c. Know your Trainees’ exercise

This exercise is performed at the commencement of each session and serves to assist in customizing the training session (in accordance with the session's objectives) to the participants' prior knowledge, interests, learning styles, expectations, interests, and experience pertaining to the subject matter of the session. Conduct the ‘know your trainees’ exercise at the beginning of the session by asking a few questions to the participants.

The sole objective of posing these questions is to ascertain the knowledge and expertise of the participants; therefore, refrain from engaging in discussion or correcting the responses at this juncture. Allow the participants to freely express their thoughts and record their responses on the board. Before concluding the exercise, inform them that answers to all of the questions will be provided during the session.

d. Use of the training tools

There are three training tools are provided i.e. facilitator guide, PowerPoints, and Handbook for HIV & STI Counsellors. For each session, the facilitator is expected to use the facilitator guide, the PPT and the ‘Handbook for HIV & STI Counsellors’.



i. The facilitator guide

The facilitator guide attempts to help the facilitator how s/he will conduct the session step-by- step and the use of training methodologies. It is expected that the facilitator of the session uses the guidelines outlined in the facilitator guide while conducting the session. The additional innovations in training are always welcomed.

ii. Handbook for HIV & STI Counsellors

Technical information, formats, annexures, and key messages for the counsellors are given in the Handbook for HIV & STI Counsellors and these must be imparted to the participants during each session. The facilitator is expected to either be thorough with the content of the handbook or have in hand the printed copy of the handbook or a copy of his/her session during the training.

iii. The PowerPoint presentations

The PowerPoint presentations were developed by taking the content from the handbook for HIV & STI Counsellors. However, the entire module's content is not transmitted to the PPT and therefore, it is recommended that the session facilitator refrain from relying solely on the PPT presentation for the session. The PowerPoint is merely a supplementary instrument for both the instructor and participants.

e. Session summary

a summary PPT slide is included in each session. Even if time is running out, proceed with the session summary, as it assists the participants in synthesizing what they have learned.

f. Use of Annexures

Additional reading materials for the facilitator, formats, quiz questions and answers, tools, etc., are given in annexures after every chapter. It is expected that the facilitators utilize them in a suitable manner throughout the session.

5. Training Batch

To ensure the efficacy of training and facilitate personalized attention, it is recommended that the ideal size of a training batch range from 25 to 30 individuals. The batch will have to be a heterogenous group which comprises of counsellors from at least a minimum of four different facilities such as TI projects, ART centre, HCTS confirmatory site, DSRC, SSKs, etc. The inclusion of counsellors from other institutions/facilities not only promotes knowledge exchange but also dismantles organizational barriers, enabling them to effectively adapt to different facilities as required. The counsellors who have not attended the 12-day counsellor training will have to be called in first for the induction training.

6. Certificate to counsellors

SACS, desirable to distribute certificates, will do so for the counsellors who have successfully completed the full five-day induction training.

IV. Training quality assurance:

SACS' approach towards learning should be on adult learning principles. It should basically focus on

- An understanding of diverse participants from different health facilities with varied experience and skills and their different learning styles
- Design trainings using activities explained in the training modules that increasingly involve active experiential learning and debriefings
- Use of learner-centred instruction, especially self-directed learning, meaning that trainers will need to create better ways and environment to include and generate opportunities for reflection, brain-storm, clarification and guidance
- Capture pre and post learning information and training feedback from the participants during every training, analyse the data and use the data for training improvement
- Conduct feedback sessions with the master trainers based on the pre and post-test and training feedback data analysis

V. Reporting

It is expected that SACS would submit a monthly report about the training of counsellors. NACO will share the reporting format. The individuals designated as the nodal person bears the responsibility of submitting the monthly report.

VI. Mentorship and Supportive Monitoring

After completing the training, SACS and DISHA personnel are required to conduct routine field visits to various health facilities in order to supervise and provide guidance to the counsellors. Field visits provide the SACS and DISHA teams with insight into the skill development of different categories of counsellors who have completed training. In addition to ensuring that the skills are enhanced, the field trips will aid in identifying any knowledge or skill deficiencies that are essential for the execution of their responsibilities.

VII. Training Budget

I.SACS will utilize the training budget year marked for the financial year for the counsellors training. SACS is expected to follow the training financial norms which was shared with SACS on June 1, 2022 via a communication letter regarding pattern of assistance for conducting training with File No T.11025/28/2009-NACP dated 3rd May 2010.

Roles of NACO and SACS

NACO	SACS
• Provides guidance, gives approvals, and supports SACS for the smooth implementation of the NACP counsellors training Develops and shares the NACP counsellors training modules, facilitators guide, handbook and presentations.	• ·Translates the counselling tool in their native language Appoints the nodal person organize and monitor the NACP Counsellors training
• Finalize Master Trainers pool	• ·Develop training calendar and submit to the respective SACS/UT for approval
• Conducts the ToT of Master Trainers at the regional level Develop and share the monthly reporting format	• ·Conducts the NACP counsellors training as per the training calendar
• Makes periodical visits to states to oversee the implementation of cascade training	• ·Monitors the progress of the trainings against the monthly/quarterly/ annual target
	• ·Assesses the skills and knowledge of the MTs and provide necessary guidance
	• ·Collects necessary data during the training, analyse and use to improve the training
	• ·Provide supportive monitoring and mentorship visits to various health facilities

Facilitator's Note

A five-day workshop needs extensive preparation and the facilitator should ensure that the same is done well in advance:

1. Preparation

- Read the NACO Operational Guidelines and training manual completely before the workshop.
- Understand the profile of participants attending the training so that the training can be tailored to suit their requirements for e.g. if it is a group of counsellors from various facilities such as ICTC, ART, STI, SSK, etc., then ensure there is space for all the counsellors to share their experience with others.
- Translate all materials required for the sessions - for pre and post test, quiz, practice of tools, games and exercises as specified.
- Ensure all other arrangements have been made like projector and laptop to screen the PowerPoint presentations and handouts.

2. How to Facilitate

- The facilitators should be familiar with experiential and participatory forms of learning.
- They should have the ability to ask exploratory open-ended questions and should be sensitive towards involving all the participants.
- Respect participants' local knowledge.
- The facilitators should be technically competent to answer various HIV/STI counselling related questions. Adaptations of the various topics may be made in order to suit local needs and priorities.
- There being many hands-on sessions, the facilitators would need to be familiar with all those processes in the field so that they can actually demonstrate as well as guide the participants correctly. It will be important at all stages for participants to be able to correlate their class room teachings with field level learning and vice versa. Facilitator will have to ensure this correlation.

3. Tips for an Effective Training Environment

- Start the sessions with a circular sitting arrangement if possible. Whether you use chairs and tables or the floor depends on availability.
- Change the layout of the training space each day to match the content of the sessions.
- Use energizers/games whenever it is felt that the group is becoming lethargic or bored. These are especially effective at the start of the post lunch session or during 'heavy' technical sessions.
- Go over few key learning points of each day, first thing the next morning in order to refresh the participant's memory and ensure that they comprehend the linkages between sessions. This also maintains a sense of continuity.
- Remember, this is a participatory workshop and your role is to FACILITATE!

4. Don'ts

- Let any one person dominate the discussion.
- Speak more than the participants – let the participants brainstorm and discuss.
- Allow distractions like mobile phones and chatting between participants.
- Make the training a boring experience – intersperse the sessions with energizers.
- Read out from the PowerPoint presentations – prepare yourself well and use the presentation slides as cue cards to elaborate on the relevant points

Proposed Agenda

Duration	Topics	Facilitator	Theme
Day One			
09:30 – 10:00	Welcome and registration		General and Prevention
10:00 – 10:30	Introduction and Objectives & Pre-Test		
10:30 – 11:30	Breaking the Silos – Counselling Needs and ToR of NACP Counsellors		
11:30 – 11:45	*Tea Break*		
11:45 – 12:45	Introduction to the National HIV/AIDS Control Program and National AIDS Control Organization		
12:45 – 01:45	Basic of HIV and AIDS		
01:45 – 02:30	*Lunch Break*		
02:30 – 03:30	Drivers of the HIV epidemic		
03:30 – 04:30	The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017		
04:30 – 04:45	*Tea Break*		
04:45 – 05:45	Introduction to Prevention Programme under NACP V		
Day Two			
09:00 – 09:15	Recap of Day 1		HIV CTS/ STI
10:00 – 10:30	Substance Use in the context of HIV/AIDS		
11:30 – 11:45	*Tea Break*		
11:30 – 01:00	Counselling and Testing for HIV		
01:45 – 02:30	*Lunch Break*		
01:45 – 02:45	Basic Counselling Skills		
02:45 – 04:45	Risk Assessment, Pre and Post test counselling and Index testing		
04:45 – 5:00	*Tea Break*		
05:00 – 06:00	Risk Assessment, Pre and Post test counselling and Index testing (Cont'd…)		
06:00 – 06:45	Condom use		

Day Three			
09:00 – 09:15	Recap of Day 1 & 2		
09:15 – 11:15	Screening and Management of Sexually Transmitted Infections and Reproductive Tract Infections		
11:15 – 11:30	*Tea Break*		
11:30 – 12:30	Post Exposure Prophylaxis, Universal Work Precautions, and Pre-Exposure Prophylaxis (PrEP)		
12:30 – 01:30	Anti Retro Viral Treatment and Management of PLHIV		
01:30 – 02:15	*Lunch Break*		
02:15 – 04:15	Anti Retro Viral Treatment and Management of PLHIV (Cont'd…)		
04:15 – 4:30	*Tea Break*		
04:30 – 06:30	Prevention and Management of Opportunistic Infections & Co-morbidities		
Day Four			
09:00 – 09:15	Recap of Day 1, 2 & 3		
09:15 – 10:15	Nutrition in the Context of HIV and Adherence		
10:15 – 11:15	Elimination of Vertical Transmission of HIV and Syphilis		
11:15 – 11:30	*Tea Break*		
11:30 – 12:30	Elimination of Vertical Transmission of HIV and Syphilis (Cont'd…)		
12:30 – 01:15	Family Planning Methods for PLHIV		
01:15 – 02:00	*Lunch Break*		
02:00 – 03:45	Counselling of Children and Parent/Guardian		
03:45 – 4:00	*Tea Break*		
04:00 – 05:30	Counselling for Adolescents Living with HIV (ALHIV) and Adolescents at Risk		

Day Five			
09:00 – 09:15	Recap of Day 1,2,3 &4		
09:15 – 11:15	Newer Initiatives in NACP-V (SSK, OSC, CSS, Virtual Interventions)		
11:15 – 11:30	*Tea Break*		
11:30 – 12:15	Mobile Outreach Services		
12:15 – 01:00	Linkages and referrals for PLHIV and At-Risk Negative Clients		
01:00 – 01:45	*Lunch Break*		
01:45 – 02:30	Data Safety and Management at Facilities under NACP		
02:30 – 03:15	Open Session, Summing up and Post-Test		
03:15 – 04:00	Valedictory and bid adieu with tea		

FACILITATOR GUIDE

1

60 Mins

Introduction to the National HIV/AIDS Control Programme and National AIDS Control Organization

1.1 Learning objectives

To orient the participants about the:

- HIV epidemic in India and India's response to the epidemic
- National AIDS Control Organization and it's structure
- HIV/AIDS programme implementation structure at the National, State and District level
- National AIDS Control Programme (NACP) – phases I, II, III, IV and V

1.2 Expected outcomes

At the end of the session, the participants will be able to:

- Understand the HIV epidemic in India and India's response to the epidemic
- Understand HIV/AIDS programme implementation structure at the National, State and District level
- Understand the evolution of phases I to V of the NACP

1.3 Suggested Training Method:

MS PowerPoint presentation, 'Know your Trainees' exercise, discussion, quiz

1.4 Materials/Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation (# 1)
- Handbook for HIV & STI Counsellors (Chapter 1)

Facilitation Steps

Step 1: Introduction and Presentation on the HIV Epidemic (PPT slides 1-6)

- Welcome the participants to the session and present session objectives and the HIV epidemic data to create the context for the NACP discussion.

Step 2: Presentation on India's commitment to Ending HIV/AIDS (PPT slides 7-12)

- Present the national core and priority indicators
- Emphasis on the UNAIDS' 95-95-95 goal during the presentation
- Explain HIV/AIDS programme implementation structure

Step 3: 'Know your Trainees' exercise and presentation on India's response to HIV/AIDS (PPT slide 13)

- Ask the trainees on what they understand by the term NACP.
- Use the whiteboard or a chart paper and draw a lifeline and mark the years – example, 1981, 1985, 1992, 2007 and so on.
- Ask the participants about the important achievements and milestones of the NACP in the years marked in the lifeline.
- Encourage the participants to share more information on the lifeline and specific years.
- Facilitate a guided participatory discussion by asking the following questions to the participants one after the other:
- From which year did NACP-V begin?
    a) What is the focus of the programme by 2026?
    b) What is aimed to be achieved by the end of 2026?
    c) What is the 2030 goal?

Step 4: PPT presentation on NACP V (PPT slides 14-20)

- After the initial 'Know your Trainees' exercise, use the MS PowerPoint presentation to clearly explain objectives and the goals of NACP V

Step 5: Summary of the Session:

End the session with the following summary of the session **(PPT slide 21)**

i. India is estimated to have around 24.01 lakh people living with HIV/AIDS (PLHIV). Around 63,000 new HIV infections were estimated in 2021. Almost 92% of total new infections were reported to be among population aged 15 years or older, including around 24.55 thousand among women.

ii. Self-reported route of HIV Transmission (RoT) indicates that the HIV epidemic in India, 2019-20 is still primarily driven through the heterosexual route (84%).

iii. India's response to HIV/AIDS started in 1985 and from 1992, the NACP launched and we are currently in NACP Phase V which started in 2021.

iv. NACP V aims to attain 95-95-95 by 2025.

v. NACP-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26.

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

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

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

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

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

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

f. Attainment of elimination of vertical transmission of syphilis

2

45 Mins

Basics of HIV and AIDS

2.1 Session objectives

To train the participants to learn:

- What the human immunodeficiency virus (HIV) is
- About the modes of transmission of HIV
- About the difference between HIV and AIDS
- About the progress of HIV infection

2.2 Expected outcomes

At the end of the session, the participants will be able to:

- Explain what HIV is and the difference between HIV and AIDS
- Explain how HIV is transmitted
- Explain the progress of HIV infection to a client

2.3 Methodology:

MS PowerPoint presentation, 'Know your Trainees' exercise, discussion and group activities

2.4 Material needed:

- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation **#HIV2**
- Handbook for HIV & STI Counsellors **(Chapter 2)**

Facilitation Steps

Step 1: Introduction (PPT slides 1-2)

- Welcome the participants to the session and present the session objectives.
- Next, mention the following:

a) *In the previous session (introduction to the National HIV/AIDS Program and National AIDS Control Organization), we had talked about the HIV epidemic and India's response to the epidemic.*

b) *While discharging your duties as a counsellor, you must ask questions to understand the client and answer the queries and concerns of your client. During this process of gathering and giving information, you need to have clear facts about HIV/AIDS. In this session, we will understand the basics of HIV and AIDS, and the information you will be expected to give to your clients.*

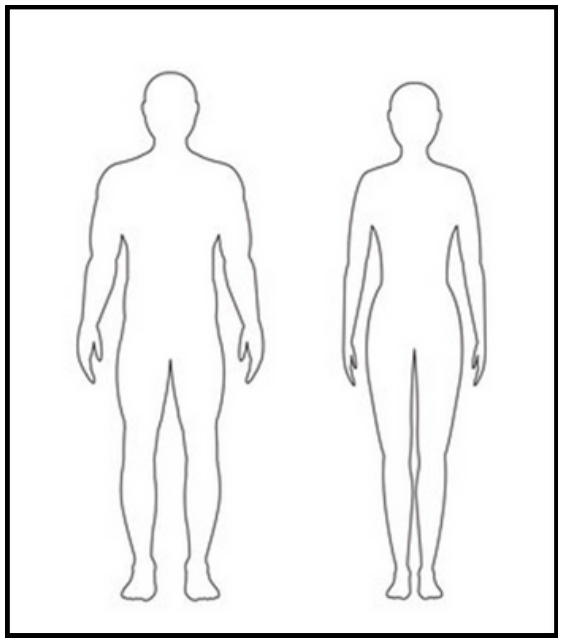
Step 2: 'Know your Trainees' exercise and group exercise (PPT slides 3-8)

- Write the words 'HIV' and 'AIDS' on two sides of the whiteboard or chart paper. Facilitate a guided participatory discussion by asking the following questions to the participants one after the other:

  a) What do you mean by these two words?
  b) Is there any difference between them? If yes, what is it?

- Use the PowerPoint slides to illustrate HIV/AIDS after the 'Know your Trainees' exercise.

- Divide the participants into two groups and give a chart paper to each group. Ask one group to draw the outline of a male person and another group to draw the outline of a female person as shown below. **(PPT slide 9)**



- Mention that the outline is to be treated as a naked body and ask the participants to fill in the details of the various organs.

- Ask the participants to list the different fluids present in the human body and note all the responses on the chart paper.

- Ask the participants to list sexual acts between men and their partners (male or female). Brainstorm, and arrive at a list of sexual acts with a high potential for HIV transmission.

- Use the concept of viral load and port of entry to explain how the fluids can enter from one human body to another. Explain in which fluids the viral load/concentration is likely to be high, leading to higher chances of transmission.

- Use the PowerPoint slides to illustrate risk and prevention of HIV transmission after the group exercise. **(PPT slides 10-12)**

Step 3: PPT Presentation on the stages of disease progression (PPT slide 13)

- Following this, begin with explaining the stages of disease progression and its impact on the human body. Remember to explain the following terms:

  a) *Primary HIV infection*
  b) *Clinically asymptomatic stage*
  c) *Symptomatic HIV infection and AIDS*

- Explain each of the above terms to emphasize that HIV causes a condition. Ensure that participants use terms like 'AIDS patient' carefully and preferably not at all.

- Again, ask the participants to repeat the major modes of HIV transmission. Emphasize and reiterate the transmission 'through unprotected sex with an infected person'.

Step 4: Myths and Misconceptions (PPT slides 14-17)

- Discuss on the myths and misconceptions around HIV/AIDS/STI. Encourage the counsellors to openly share the myths talked among the counsellors and clarify them.

- In the process, you must address the most common myths and misconceptions regarding the transmission of HIV.

- Divide the participants into two groups and give a chart paper to each group. Ask one group to draw the outline of a male person and another group to draw the outline of a female person as shown below. **(PPT slide 9)**

Step 5: Summary of the session:

Conclude the session with the summary given in the PowerPoint **(PPT slides 18-19)**

i HIV infects and destroys cells of your immune system, making it hard to fight off other diseases. When HIV has severely weakened your immune system, it can lead to acquired immunodeficiency syndrome (AIDS).

---

ii. HIV can affect anyone.

---

iii. HIV infection is largely silent except when opportunistic infections/AIDS sets in.

---

iv. People infected with HIV can also lead a positive and productive life by adopting a healthy lifestyle and by taking anti-retroviral medicines.

---

v. Women are more vulnerable to HIV because of biological and social factors.

---

vi. Strong association between the occurrence of HIV infection and the presence of certain STIs

3

60 Mins

Drivers of the HIV Epidemic

3.1 Learning objectives

To train the participants to understand:

- The drivers of the HIV epidemic in India (Sexual behaviour, Substance use, Changing places of solicitation/ networking through virtual platform, stigma and discrimination)
- Understand the role of gender and sexuality related norms and violence as a social driver of the HIV epidemic
- Gender as a social construct – linkage between gender and vulnerability to HIV
- How migration and mobility contribute in increasing the chances of HIV infection

3.2 Expected outcomes

At the end of the session, the participants will be able to explain:

- Various drivers contributing to the spread of HIV epidemic in India.
- Ways to scale up identification of the vulnerable populations and reduce their risk of HIV infection by addressing the drivers contributing to the risk and enhanced vulnerability.
- Provide improved quality and community-friendly services to vulnerable populations by addressing the factors that impede their health seeking behaviours

3.3 Suggested Training Method:

MS PowerPoint presentation, 'Know your Trainees' exercise, group work, games, case studies

3.4 Materials/Preparation Required:

- Case studies
- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation (# 3)
- Handbook for HIV & STI Counsellors (Chapter 3)

Facilitation Steps

Step 1: Introduction and Know Your Trainees Exercise (PPT slides 1-4)

- ·Welcome the participants and introduce the session objectives. Conduct a Know Your Trainees exercise and list the various - drivers/factors that enhance HIV vulnerabilities. The following questions can be asked:

a) Who are the High-Risk groups or vulnerable populations? Guide the participants to speak about high-risk groups like SWs, IDUs, Hijral Transgender persons, MSMs, Female Injecting Drug Users (FIDUs), Female Sex Partners (FSPs), migrants, and spouse and partners of High-risk Populations.

b) Do the at-risk populations face GBV? Probe the types of GBV faced by the at-risk populations.

c) Are there any push factors that make these populations vulnerable to HIV? Encourage a discussion around factors like migration, stigma and discrimination, customers of SWs, and local goons.

d) Refer to annexure 1 Chapter 3 for more information

Step 2: PPT presentation (PPT slides 5-23)

- Complete the presentations on various drivers of HIV epidemic
- Walk the participants through each of the case studies one at a time using the presentation slides. Discuss the questions associated with each case study – ensure active engagement of the participants. Case studies are included in an annexure.

Step 3: Case Studies discussions

Case Study 1: (PPT slide 24)
Shamina is standing near a movie theatre, waiting for her friends. A group of boys, who are also waiting nearby, cat-call her and pass remarks on her clothes and make-up. They ask her if she wants to join them.

1. Is there an issue here?
2. Do you see GBV in this scenario?

Points for sum up: The boys' behaviour is an act of sexual harassment, even if the boys were just doing it for 'fun'. This is also a form of sexual violence. Even though they might not have harmed the girl physically, their remarks could have hurt and humiliated the girl; since she was alone, she might have been frightened as well.

Case Study 2: (PPT slide 25)
Rani, a transgender, visited a service delivery point for HIV testing as encouraged by a Peer Educator from one of the TI NGOs, where she was kept waiting for long hours. When she wanted to use the washroom, the hospital staff and other patients did not let her use the female washroom, nor was she comfortable using the men's washroom. After some time, she left the hospital without taking the health services.

1. Is there an issue here?
2. Do you see gender-based violence (GBV) in this scenario?
3. How will this increase Rani's vulnerability to HIV?

Points for sum up: For a person with gender dysphoria, choosing between which of the restrooms to be used is always a million-dollar question. It is necessary that any public institution should consider all, irrespective of their gender and sexuality. Lack of gender-neutral restrooms and a hostile environment can lead to traumatizing experiences with the healthcare system as a whole, which can ultimately prevent access to health care in the future and make oneself and others vulnerable to HIV.

Case Study 3: ***(PPT slide 26)***

A male client visits an FSW and wants to have sex without a condom. He pays her more money than she asked. After paying the money, he demands sex without a condom. The FSW does not agree and returns the amount but the client tries to have sex with her forcefully and she is physically hurt.

1. Is there an issue here?
2. Do you see GBV in this scenario?
3. How will this increase the FSW's vulnerability to HIV?
4. How do you think that we can address the issue?

Points for sum up: This typical case of gender-based violence against a woman by a man. Sex work is a work where one's health is at stake. There is already a vulnerability to acquire infection as well as be a carrier of the infection. For the sole reason of sex work being stigmatised and frowned upon by the society, some chooses exploiting their livelihood by paying extra money, on their valuable life as a bid. There is increased risk of acquiring HIV infection when a person has multiple sexual partners and inconsistent use of physical protection.

Case Study 4: ***(PPT slide 27)***

Ritesh is a 25 years old gay person. His family came to know about this and forced him to get married. He had to marry a girl. He left his village to earn money for his family however he continues to have sexual relationships with men besides his marital relationship. He visits his hometown once in six months and also as per the need. He has a circle of queer friends in his adopted home and lives a happy life.

1. Is there an issue here?
2. Do you see GBV in this scenario?
3. How will this increase Ritesh's and his wife's vulnerability to HIV?

Points for sum up: Family members of Ritesh did not recognise his gender expression or gender identity; instead, they assumed he was a man and pressured him into being married, which is an act of gender-based abuse. He is forced to migrate as a result of GBV and poverty, increasing his risk of contracting HIV. The Indian Supreme court has decriminalized consensual relationships between consenting adults in 2018 irrespective of their gender identity and sexual orientation by rephrasing section 377. Although law protects the people from engaging in consensual sexual activity and adultery, the society still stigmatizes these kinds of homo-sexual practices which will end up in people indulging in unsafe sexual behaviors, not having an access to safe healthcare and/ or even be the carrier of the infection without having the knowledge of getting infected. In addition to putting himself at risk for HIV, Ritesh also runs the risk of infecting his wife when he engages in sexual activity with his married partner.

Step 4: Summary of the Session:

End the session with the summary of the session. **(PPT slide 28-29)**

i. Drivers of the HIV epidemic are sexual behaviour, substance use, Sharing of injecting equipment, Solicitation/Networking for sexual work through virtual platform, gender-based violence, stigma and discrimination.

ii. HIV prevalence among high-risk groups and bridge population remains very high.

iii. The self-reported route of HIV Transmission (RoT) indicates that the HIV epidemic in India, 2019-20 is still primarily driven through the heterosexual route (84%)

iv. It is generally agreed upon that safer sex, harm reduction practices and consensual sex can help men and women reduce their risk of contracting HIV.

v. Women are just as important as men in socializing boys and girls into their gender roles. Girls, boys, and women are expected to play distinct roles in society, yet men and women are valued differently.

vi. Gender and gender-based violence make an individual susceptible to HIV infection, their capacity to receive HIV care, support, or treatment, and their capacity to cope when infected or impacted. These all have all been significantly influenced by a number of gender-related norms and attitudes.

4

60 Mins

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

4.1 Learning Objectives

To train the participants to learn about:

- The HIV and AIDS (Prevention and Control) Act, 2017 (henceforth HIV and AIDS Act)
- The grievance redressal mechanisms envisaged under the Act

4.2 Expected outcomes

At the end of the session, the participants will be able to:

- Understand the importance of the HIV and AIDS Act in streamlining HIV interventions
- Enumerate the provisions under the Act
- Discuss the grievance redressal mechanisms and support a client in writing a complaint for redressal under the Act

4.3 Suggested Training Methods:

Know Your Trainees exercise, discussion, meditation with music, positive speaking, case studies, sharing by the state Ombudsman or SACS representative on the implementation of the Act, MS PowerPoint presentation

4.4 Materials/Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation **(# 4)**
- Handbook for HIV & STI Counsellors **(Chapter 4)**
- A positive speaker

Facilitation Steps

Step 1: Reflection session and PPT presentation (PPT slides 1-4)

- Begin the session with a short reflection session. Ask the participants to close their eyes and relax, with soothing music playing in the background. During the reflection, ask the participants to imagine how they would feel if they were deprived of their basic human rights (examples to be given). Ask them to particularly make a note of their feelings. The reflection will create a situation where the participants can empathize and connect more with the issue at hand.
- Next, talk about the NACP from the perspective of a client-centric approach, mention the NACP-V goals and explain how these include human rights as an important component.

Step 2: Sharing from a positive speaker (PPT slide 5)

- Introduce a positive speaker who will share their life journey with the participants. Ask the speaker to talk about their life challenges and how the Act helped in mitigating the challenges.
- Encourage the trainees to ask questions around the need and use of the HIV/AIDS Act, 2017.

Step 3: 'Know your Trainees' exercise and PPT presentation (PPT slides 6-13)

- Next, ask the participants the following questions:

  a) What comes to mind when you hear the word 'law'?
  b) Can you name some Acts or laws that you have heard of?
  c) If you are given the responsibility to secure the rights of PLHIV, which rights and laws will help them improve the quality of life?

- Summarize the responses to the questions and explain the genesis of the HIV and AIDS Act using the MS PowerPoint presentation. Discuss the important provisions of the Act.
- Highlight the points clearly and ask the participants to share their experiences of challenging situations when they felt the need of the HIV and AIDS Act for protecting the rights of PLHIV.

Step 4: Introduction and 'Know your Trainees' exercise

- ·Decide which section of the Act you want to play and play the links:

https://www.youtube.com/watch?v=gWYbw0Bj0rs&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=1

https://www.youtube.com/watch?v=GWBTnCCv5Vw&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=2

https://www.youtube.com/watch?v=eoBo8kX9S0g&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=8

https://www.youtube.com/watch?v=S2Z5uA-dnFc&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=7

https://www.youtube.com/watch?v=-VpFL1qa2NY&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=11

https://www.youtube.com/watch?v=gWYbw0Bj0rs&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=1

Step 5: Group Work on case scenarios (PPT slides 19-22)

- After playing the video/s, divide the participants into three groups and give each group a case scenario to discuss and present to the larger group. Allot 15 minutes for the discussion and three minutes each for the larger group sharing.

Case scenario – 1

A 25-year-old woman was brought to a community health centre with labour pain. The medical officer (MO) examined her and checked all her medical records and came to know that she was HIV positive. The MO informed her relatives that she needed to be shifted to a higher-level health centre like a district hospital for the delivery due to complications. But the MO did not explain the complications to the relatives.

- What could be the possible reasons for the referral?
- Do you think that any of the reasons may be a violation of the HIV and AIDS Act? If yes, which sections of the Act?
- What is the remedy suggested in the Act?
- What are the remedial steps you suggest?

Summary Points: The complainant thinks that it is a denial of healthcare services, it is an act of discrimination mentioned in the section 3 of the Act. The complainant can submit a complaint against the healthcare provider to the Ombudsman who, upon receiving a complaint inquire into the violations of the provisions of this Act.

Case scenario – 2

A young boy of seven years was living with his mother. His father died of AIDS two years ago and life was very difficult for the mother and son. Being at home was not ideal because they were being harassed by his father's brothers and other family members who wanted them to leave the house. They wanted to leave the place but they did not have any place to go.

- In this case scenario, is there any violation of the HIV and AIDS Act? If yes, which sections are relevant?
- What is the remedy suggested in the Act?
- What are the remedial steps you suggest?

Summary Points: The act of harassment from the family members to push them out of home is against the section 29 of the act. Right to residence assures every protected person shall have the right to reside in the shared household, the right not to be excluded from the shared household or any part of it and the right to enjoy and use the facilities of such shared household in a non-discriminatory manner.

Case scenario – 3

A man was working as an electrician in a government office. He was hardworking and dedicated. Due to a health condition, he took leave from work. Unfortunately, his blood test confirmed that he had HIV. A few days later he got back to work. The management came to know of his HIV status and terminated him from the job.

- In this case scenario, is there any violation of the HIV and AIDS Act? If yes, against which sections of the Act?
- What is the remedy suggested in the Act?
- What are the remedial steps you suggest?

Summary Points: It is a violation against one of the three principles mentioned in the HIV and AIDS Act, 2017 is non-discrimination against people infected with and affected by HIV and AIDS and against the HIV and AIDS Policy for Establishments, 2022. As per the policy, a person should not be discriminated in the establishments on the basis of HIV status. Discrimination here includes the denial of, or termination from, employment and also unfair treatment at establishment. The employer may also provide a reasonable accommodation to the PLHIV if need be. Reasonable accommodation means minor adjustments to a job or work that enables a HIV positive person who is otherwise qualified to enjoy equal benefits or to perform the essential functions of the job or work.

Step 6: Sharing session by Ombudsman or SACS representative (PPT slides 23-24)

- Invite the Ombudsperson or the SACS representative to speak about the grievance redressal mechanisms under the Act.

Step 7: Conclusion:

Conclude the session by reinforcing the points given at the end of the chapter **(PPT slides 25-26)**

- This Act is called the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 commonly referred to as the HIV and AIDS Act, 2017.

- This Act came into force with a purpose to control the spread of HIV and to mitigate discrimination against PLHIV in work and social, medical and financial settings and was notified by the Government of India on April 21, 2017.

- This law criminalizes discrimination against PLHIV. Some of the salient features of the Act are:

  o Prohibition of discrimination – it lists the various grounds on which discrimination against PLHIV is prohibited such as:
    - » employment
    - » educational establishments
    - » healthcare services
    - » residing or renting a property
    - » standing for public or private office
    - » provision of insurance

  o The requirement for HIV testing as a prerequisite for obtaining employment or accessing health care is prohibited

  o Provides an environment for enhancing access to healthcare services by ensuring informed consent and confidentiality for HIV-related testing, treatment and clinical research.

  o Informed consent not required for conducting HIV tests in certain cases – for court-mandated medical examination, medical research, epidemiological or surveillance purpose (in an unlinked anonymous manner), and screening in any licensed blood bank.

  o No person shall be compelled to disclose their HIV status – except by an order of a court or with the informed consent of that person.

  o Every HIV-infected or affected person, including those below the age of 18, will have the right to live in a shared household and enjoy household facilities in a non-discriminatory manner.

  o Provision for appointment of an Ombudsman by state governments to address grievances related to violation of the Act and penal action in case of non-compliance.

5

60 Mins

Introduction to Prevention Programmes under NACP

5.1 Learning Objectives

To train the participants to:

- Understand HIV prevention programmes being implemented under NACP with reference to Targeted Intervention (TI) projects, Link Worker Scheme, Opioid Substitution Therapy (OST), and Communication activities
- Familiarize themselves with the high-risk groups and bridge populations
- Learn about TI revamped activities to cover subgroup of populations
- Gain knowledge on various communication activities focusing on prevention aspects
- Understand the importance of counselling in the HIV prevention programmes

5.2 Expected outcomes

At the end of the session, the participants will be able to:

- Explain NACP's prevention programmes and various activities
- Explain what the high-risk groups and bridge populations are
- Explain the revamped TI strategies and programmes for other subgroups
- Understand prevention focused activities and how to use NACO's free AIDS help line-1097
- Talk about the importance of counselling in HIV prevention programmes

5.3 Suggested Training Method:

MS PowerPoint presentation, 'Know your Trainees' exercise and group work

5.4 Materials/Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation **(# 5)**
- Handbook for HIV & STI Counsellors **(Chapter 5)**

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise (PPT slides 1-3)

- Welcome the participants and outline the session objectives and expected outcomes.
- Conduct a 'Know your Trainees' exercise session on key aspects related to the session.

Step 2: Group discussion (PPT slides 4-6)

- Next, conduct a group discussion. Divide the participants into six groups and assign the topics as given below:

Group 1: Sex Workers

- Who are Sex Workers (SWs)?
- What increases the risk of HIV infection in SWs?
- What are the strategies to reduce the risk?

Group 2: Injecting Drug Users

- Who are Injecting Drug Users?
- What increases the risk of HIV infection in IDUS?
- What are the strategies to reduce the risk?

Group 3: Hijra/Transgender Women

- Who are Hijra/ transgender women?
- What increases the risk of HIV infection among Hijra/transgender women?
- What are the strategies to reduce the risk?

Group 4: Men Who have Sex with Men

- Who are Injecting Drug Users?
- What increases the risk of HIV infection in IDUS?
- What are the strategies to reduce the risk?

Group 5: Bridge Populations

- Who are the bridge Populations?
- What increases the risk of HIV infection among bridge populations?
- What are the strategies to reduce the risk?

Group 6: Prison populations (incarcerated)

- Who are the prison Populations?
- What increases the risk of HIV among prison populations?
- What are the strategies to reduce the risk?

- Allocate 10 minutes for the group discussion and eight minutes for each presentation

Step 3: PPT presentation on key TI components and revamped strategies (PPT slides 7-25)

- After the group discussion, explain the focus of the session – the high-risk groups and bridge populations – with a specific focus on who they are and their vulnerabilities to HIV.
- Continue to explain the six key components of Targeted intervention (TI) projects under NACP and the revamped TI strategies.
- Explain the LWS, Opioid Substitution Therapy (OST) and the National Toll-Free AIDS Helpline-1097
- Summarize the step 3 by explaining the importance of counselling in HIV prevention programmes under the NACP.

Step 4: Summary of the Session:

Clarifying questions about the TI programmes and summarise the session **(PPT slides 26-27)**

- TI is a flagship programme of NACO.

- The high-risk groups covered by the TI are FSW, MSM, IDUS and Transgender/Hijras and the trucker and migrants.

- An adult woman who relies on consensual sexual relations as her primary source of income is referred to as an FSW. The vulnerability factor like lack of knowledge and poor risk perception, misinformation regarding HIV and STIs and their spread, exposure to violence from the clients, forced sex without condom use and involvement in high-risk behaviour by having unprotected sex.

- There are TG/Hijra and MSM populations with high rates of partner change and multiple sexual partners, and individuals who frequently engage in anal sex with several partners are especially at risk since anal sex is more likely to transmit HIV than other forms of sexual activity.

- IDUs are yet another HRG for whom TIs are essential. HIV can spread quickly within networks of IDUS who share injecting equipment because it is extremely contagious through sharing used needles and other injecting equipment/paraphernalia.

- Stigma and discrimination in social and healthcare settings, refusal from HCPs to treat persons engaging in sex work or same-sex behaviours, Stigmatized, marginalized, criminalized by society, and Concerns about the breach of confidentiality were a few common issues in all the HRGs.

- The key components of TI are Behaviour Change Communication, Clinical services, Referral & linkage, Provision for commodities, Enabling environment and Community mobilization.

- LWS is implemented to cover HRGs and other vulnerable rural populations.

- On the occasion of World AIDS Day on 01st December 2014, the National Toll-Free AIDS Helpline-1097 was launched and provides support in counselling, referral, feedback or grievances redressal and any general information related to HIV/AIDS in 16 Indian languages.

6

120 Mins

Substance Use in the Context of HIV/AIDS

6.1 Session objectives

To train the participants to learn about:

- Different terminologies and concepts used in the context of substance use
- Risks and vulnerabilities associated with injecting drug use
- Harms arising from injecting drug use and strategies for management
- Harm Reduction package of services under National AIDS Control Program
- Counselling for people who inject drugs/people who use drugs

6.2 Expected outcomes

At the end of the session, the participants will be able to:

- Explain the different terminologies used in the context of substance use
- Explain the various risks and vulnerabilities associated with injecting drug use
- Discuss the various harms arising from injecting drug use and strategies for management i.e., Harm reduction, demand reduction and supply reduction
- Discuss Harm reduction package of services under the National AIDS Control Programme such as Needle Syringe Exchange, Opioid Substitution Therapy, HIV testing, STI testing and treatment, condom promotion, overdose prevention, referrals and linkages
- Discuss the counselling for people who inject drugs/people who use drugs

6.3 Suggested Training Method:

MS PowerPoint presentation, open discussion, case scenario and quiz

6.4 Material needed:

- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation **(# 6)**
- Handbook for HIV & STI Counsellors **(Chapter 6)**

Facilitation Steps

Step 1: Welcome the participants. Introduce the session and its objectives. To recapitulate any previous knowledge on Substance use, injecting drug use, Targeted Intervention and High-Risk Groups, basics of HIV/AIDS etc. start the session by asking the following questions: **(PPT slides 1-3)**

a) What do you understand by the acronyms 'IDU', PWID', FIDU and PWUD?
b) Who are the populations considered as IDU/PWID and FIDU under NACP?
c) What are the various types of drugs being abused in the country?
d) What are the risks and vulnerabilities associated with injecting drug use behaviour?
e) Why are they considered High Risk Groups (HRGs) in the context of HIV/AIDS under NACP?
f) What are the different approaches and services available for addressing the risk and vulnerabilities?

Step 2: Conduct 'Know your Trainees' exercises at appropriate times to understand the participants' knowledge and experiences and to involve them actively in the session.

Step 3: Use the MS PowerPoint presentation to explain the acronym IDU/PWID/FIDU/ PWUDs and the following points covered in the chapter: **(PPT slides 4-23)**

a) Understanding the different terminologies and concepts in the context of substance use
b) Various risks and vulnerabilities associated with injecting drug use
c) Various harms arising from injecting drug use and strategies for management i.e. Harm reduction, demand reduction and supply reduction
d) Harm reduction services under the National AIDS Control Programme such as Needle Syringe Exchange, Opioid Substitution Therapy, HIV testing, STI testing and treatment, condom promotion, overdose prevention, referrals and linkages etc.
e) Counselling for people who inject drugs and/or people who use drugs

- **Play the following video on harm reduction for drug users during breaks or lunch time:**

1. https://www.youtube.com/watch?v=6hzQxwEXK8&list=PLeJXNnyNlRhM49eSWdUf0mSzMY45IGUtb&index=27

2. https://youtu.be/KZLQIecPjsk

Step 4: Demonstrations
As part of overdose management, conduct a demo session to build the skills of the participants to support PWID during overdose. Include a demo on the recovery position for overdose. **(PPT slides 24-28)**

- Demonstrate the method to clean needle and syringes
- Conduct activities for the participants to understand the dangerous sites for injecting **(Refer to Annexure 2: Chapter 6)**
- Demonstrate overdose recovery **(Refer to Annexure 3: Chapter 6)**

Step 5: Role Play

Invite two volunteers. One person plays the role of a client and the other the role of a counsellor. The role play situation is given below: (PPT slides 29-30)

Mohit, a 28-year-old PWID, says during the counselling session that he is a heroin injecting drug user and has lost his job and his wife left him due to financial difficulties. But he is unable to hold a job because of his daily drug habit of injecting 3 times a day. The counsellor has to counsel Mohit before he is referred to OST centre located near his home using the harm reduction principles.

Summary of the session: (PPT slides 31-33)

- NACO defines PWID as persons who have used any psychoactive substance through the injecting route for non-medical purposes at least once in the last three months.

- In India, a vast majority of PWID use opioids and opioid derivatives from the poppy plant as their primary drug of choice. These opioids include heroin, smack or brown sugar as well as pharmaceutical opioids such as pentazocine and dextropropoxyphene

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- PWIDs are considered a High-Risk Group under the National AIDS Program having the highest HIV prevalence as a consequence of injecting drug use

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- PWID are highly prone to sharing of used or infected needles syringes and other injecting paraphernalia such as cookers, water, swabs etc.

- Sharing of infected needles syringes lead to the transmission of blood-borne viruses such as HIV and hepatitis B and C as well as a number of clinical complications including abscesses, blocked veins

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- PWID/PWUDs require a comprehensive package of services to address the various harms of HIV, HBV, HCV, Sexually Transmitted Infections, Tuberculosis, Mental health and other issues such as poor nutrition, homelessness, prosecution by law enforcement agents. These issues need to be addressed holistically.

- Approaches for addressing drug use consists of supply reduction, demand reduction, and harm reduction.

- Harm reduction refers to policies and programmes that aim to reduce the harms (physical, legal, social, financial and psychological harms) arising from drug use/injecting drug use without necessarily stopping the drug use per se. eg. HIV prevention and treatment programmes.

- The main harm reduction components are needle syringe exchange and opioid substitution therapy

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- Needle Syringe Exchange Program is provided for injecting drug users to ensure that every injecting act is covered by a new/sterile needle-syringe and to stop any further transmission of HIV or other Blood Born Viruses by reducing sharing of used infected needle syringes

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- OST is the administration of an opioid agonist medication for treating opioid dependency and under medical supervision. A patient on OST is able to overcome his/her injecting habit and lead a stable life with gainful employment.

- PWIDs must be counselled to practice safer injecting, safer sex practices and to go for regular HIV, TB testing along-with their spouses/partners

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- Risk factors for opioid overdose include periods of abstinence, change in the purity of the drug, and mixing different types of drugs together. The first thing to do in the case of overdose management is to clear the airways place the victim on recovery position and call the ambulance. Naloxone is to be administered immediately in cases of opioid overdose.

- Section 64A of NDPS ACT 1985 provides immunity from prosecution if an addict volunteers for drug dependence treatment at government recognized centre

7

75 Mins

Counselling and Testing for HIV

7.1 Learning Objectives

To train the participants to learn about:

- HIV counselling and testing services
- Testing strategies for HIV and interpretation of results
- Importance of confidentiality, consent, counselling and window period
- Facility, Mobile and Community based HIV counselling and testing services
- Process flow for HIV testing at the HIV counselling and testing services (HCTS)
- HCTS confirmatory site, HCTS screening site, CBS linkages for confirmation and ART registration and monitoring
- External Quality Assurance (EQA)

7.2 Expected outcomes

At the end of the session participants will be able to:

- Discuss and define the importance of HIV counselling and testing under the national program
- Discuss and define the HIV testing strategies under different scenarios and testing algorithm
- Three different testing principles under the program. Recommendations of the TRG for alternatively using the three testing principles for confirmation.
- In exigency condition the use of alternative testing principles if one or more of the testing kit of different principle is in short supply under the program.
- Understand the various results of HIV testing
- Understand the process flow for HIV testing at HCTS, at stand-alone confirmatory sites, at facility integrated and community-based screening sites so as to guide clients
- Understand the different modalities of Facility, mobile and community-based HIV counselling and testing services
- Establish and strengthen linkages for confirmation, ART registration and monitoring
- Understand the importance and role of participation for External Quality Assurance

7.3 Suggested Training Methods:

MS PowerPoint presentation, Know Your Trainees exercise, case discussions, group work, model demonstration, and poster preparation

7.4 Materials/Preparation required:

- Colour chart papers
- Markers (whiteboard and permanent)
- Double-sided tape
- HIV testing kits (with sample results)
- MS PowerPoint presentation (#7)
- Handbook for HIV & STI Counsellors (Chapter 7)

Facilitation Steps

Step 1: Introduction and Case Discussion (PPT slides 1-5)

- Welcome the participants and open the session with two stories about two truck drivers. One of the stories is about Mr. Vinod, who developed a variety of symptoms and went to a doctor. Even after receiving repeated advice from the doctor, the truck driver did not go for HIV test attributing the unhealthy food to his poor health. The other story is about Mr. Babu, realizing his risk behaviours after attending a BCC activity of an NGO, he decides to visit the nearest government hospital ICTC center for a HIV test.
- Ask the participants which of the two truck drivers had acted correctly. Is it necessary to know one's HIV status? What risks exist if one does not find out in time?
- After receiving the participants' responses, explain why it is important to know one's HIV status. List the following benefits of knowing the HIV status on the whiteboard and elaborate each of the points:

  a) Knowing the HIV Status earlier, starting the treatment earlier if found positive
  b) Linkage to the preventive services to the HRGs and at-risk negatives
  c) Importance and ways and means of staying HIV-free
  d) Looking after loved ones
  e) Stopping transmission to partner/spouse/children

- Conduct a 'Know your Trainees' exercise session by asking the participants the following questions:

  a) What is meant by HIV diagnosis?
  b) What is an antibody and HIV antibody?
  c) What are the types of HIV antibody tests? What are the different HIV testing principles used under the program
  d) What strategies are used in our testing laboratories?
  e) What are the various types of testing results and its importance

- What strategy is used for testing adults and children older than 18 months for HIV?
- What are risk assessment tools and revised client flow?

Step 2: PPT presentation: (PPT slides 6-16)

- Highlight and elaborate on the following topics using the MS PowerPoint presentation:

  a) HIV Counselling and Testing Services (HCTS) with specific focus on five Cs for HIV testing
  b) Strategies for HIV testing
  c) Algorithm for the three testing strategies

- Next, discuss the tests for children below 18 months of age

Step 3: PPT presentation (PPT slides 17-20)

·From the presentation, discuss the slides on:

- Again, speak about the five Cs for HIV testing
- Facility-based, Mobile and Community based HCTS
- External Quality Assurance System (EQA)

Step 4: Concluding the session: (PPT slides 21-22)

- Sum up the session with the summary points given in the learning content section

- Knowing their HIV status enables people to make informed decisions about their future.

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

- It is important to know that a person in the window period remains infective and can transmit the infection to others.

- It is recommended that HIV testing should be done using highly sensitive and specific rapid tests in HCTS, which provide reliable and accurate results.

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

- Counsellors have a greater role to support especially the community-based HCTS

- Important to follow the EQAS

8

60 Mins

Basic Counselling Skills

8.1 Learning objectives

To train the participants to:

- Review the definition of counselling and its principles, qualities of counsellors, and the elements of effective counselling
- Learn major counselling skills
- Apply counselling skills in the context of HRGs, PLHIV and CLHIV

8.2 Expected outcomes

At the end of the session, the participants will be able to:

- Define counselling and understand the components of effective counselling
- Learn and apply counselling skills in the context of HRGs, PLHIV and CLHIV
- Learn how to use counselling to reduce the lost to follow-up (LFU) cases among PLHIV (including CLHIV and HRG members who are HIV positive)
- Learn how to use counselling to increase the scope of BCC

8.3 Suggested Training Method:

'Know your Trainees' exercise, discussion, group activity, role plays/mock sessions, MS PowerPoint presentation

8.4 Materials/ Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- Case studies - print outs
- MS PowerPoint presentation **(# 8)**
- Handbook for HIV & STI Counsellors **(Chapter 8)**

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise (PPT slides 1-3)

- Welcome the participants to the session and introduce the session topic and objectives.
- Ask a few of the participants that after having learned the objectives of the session, what are your expectations from the session?
- Conduct a 'Know your Trainees' exercise by asking the participants to describe counselling in a few words.

Step 2: PPT presentation (PPT slide 4)

- List down their responses on the whiteboard and summarize by explaining the definition of counselling from the MS PowerPoint presentation.

Step 3: Group Activity (PPT slide 5-14)

- Divide the participants into four groups. Give each group 10 minutes to discuss one of the four topics given below:
  a) Principles of counselling
  b) Qualities of counsellors
  c) Skills of counselling
  d) Importance of counselling in the context of HIV/AIDS
- Ask each group to assign a member to record the important discussions on a chart paper.
- The groups are not required to make presentations to the larger group, but when the facilitator discusses their topic, they should be asked to share their points.

Step 4: Summing up the Group Activity

- After the presentation is complete, summarize the activity with the following key points:

  a) Counselling is a process, where a client (individuals, couples, or family members) meet with a counsellor to confidentially discuss problems in their lives.

  b) During the process of counselling, goals will be identified, and to achieve these goals a counsellor is a medium who helps the client explore available options and identify the best suitable option to help themselves in solving their problems.

  c) Counselling is often client-centered; the goal is for the client to make the decision on the best course of action. The goals can change if that is what the counsellor and client see as beneficial.

  d) Counselling is not advice-giving or directing, but it is a process of empowering individuals to take their own decisions in varied fields.

  e) It is vital that HIV counselling should have a dual aim – Prevention of HIV transmission and better management of those who have already acquired HIV through behavior changes and provision of support for those affected directly or indirectly by HIV.

  f) In the context of HIV, there are four basic types of counselling:

    - Pre-test counselling
    - Post-test counselling
    - Follow-up counselling
    - Treatment and adherence counselling (details are covered in chapter 7: Counselling and testing for HIV)

  g) An effective counselling relationship or alliance occurs when acceptance, understanding, and trust develop between a counsellor and a client and it is maintained throughout the counselling process.

Step 5: Role Play (PPT slide 15)

- Carry out the next group work. Divide the participants into four groups and give each group a case scenario to discuss.
- Give them 15 minutes to discuss the case scenario and ask two persons from each group to perform a role play for the larger group.
- You can reduce the number of roleplays if sufficient time is not available.

Case scenario – 1	**Case scenario – 2**
27 years old pregnant woman found to be positive during HIV test and she is now highly afraid to disclose her status to her husband. She has no caregiver as such. She has fear of being disowned by her husband and in-laws. 1) What are the potential real problems? 2) Which of the counselling skills must be used during the counselling? 3) What are the predominant emotions and behaviour of the clients in this case? 4) As a counsellor, what you should not do in this scenario? 5) As a counsellor, what will be the core focus of your counselling?	52 years old WLHIV came along with her 20-year-old son to the centre. Recently her husband expired and his HIV positive status has been revealed to her son. The son is very angry and worried about his own status. 1) What are the potential real problems? 2) Which of the counselling skills must be used during the counselling? 3) What are the predominant emotions and behaviour of the clients in this case? 4) As a counsellor, what you should not do in this scenario? 5) As a counsellor, what will be the core focus of your counselling?

Case scenario – 3	Case scenario – 4
44-year-old trans woman reached the counselling centre for a follow-up visit. She is very upset as her guru expired two weeks back and she is feeling very lonely. She says that she is taking ARV medicines regularly, whereas her viral load test shows a high viral load. 1) What are the potential real problems? 2) Which of the counselling skills must be used during the counselling? 3) What are the predominant emotions and behaviour of the clients in this case? 4) As a counsellor, what you should not do in this scenario? 5) As a counsellor, what will be the core focus of your counselling?	A 38 years old man reaches the counselling centre as he is anxious about his HIV status because his sexual partner has been identified as HIV positive, whereas his own report is negative. He is so close to his partner that sometimes they had unprotected sex. Besides this, he had other causal partners with whom he had sex with condoms. 1) What are the potential real problems? 2) Which of the counselling skills must be used during the counselling? 3) What are the predominant emotions and behaviour of the clients in this case? 4) As a counsellor, what you should not do in this scenario? 5) As a counsellor, what will be the core focus of your counselling?

- After each role play, take the client's feedback whether all their concerns were understood and addressed by the counsellors.
- Take feedback from the larger group about what they liked in the activity, what counselling skills were exhibited during the role plays, and what could have been done better.

Step 6: Summarising the Role play

End the activity by summarizing with the following points:

o A counsellor can be approached by clients in relation to the concerns they have and, in each case, the counsellor's role can be different.

o A client may seek counselling support during emotional turmoil, relationship concerns -family/friends/intimate partners, peer pressure, addiction, self-concept and sexual identity, harassment - physical/psychological/sexual, discrimination, financial crisis, and adjustment issues, to name a few.

o A counsellor irrespective of the situation must be aware of the key issues and concerns a client may encounter.

o The prime concern of the counsellor must be first to handle the immediate concern of the client before referring the client to any other service.

o In each case, the role of the counsellor changes but the counselling skills that have been utilized remain the same. Some skills can be used on a day-to-day basis like active listening, questioning and empathizing, while some can be used from case to case like confrontation skills, paraphrasing, rephrasing, etc.

o Point out that in the first case scenario, the client wants the counsellor's emphatic support on concerns related to disclosing her HIV positive status to her husband. The counsellor should discuss with her the availability of different options to disclose her status. She should be referred to an ART centre and explained the importance of taking care of herself. Multiple counselling skills such as active listening, empathizing, questioning, and paraphrasing have to be used to understand the family situation and the support required by the client to disclose her HIV status.

o In the second case scenario, the counsellor needs to normalize the feeling of the son by using empathizing skills and clearing his misconceptions, if any, and prepare him for an HIV test and its results.

o In the third case scenario, the counsellor needs to provide mental support and use unconditional positive regard and confrontation skills during counselling, so that the client realizes the importance of ARV medicines and adherence to suppress the viral load.

o In the fourth case scenario, the client is in confusion, so the counsellor needs to clear the confusion, myths and misconceptions, and focus on preventive counselling using active listening, questioning, and summarizing skills.

- Discuss the importance of the ambience of the counselling room **(PPT slides 16-17)**

Step 7: Summary of the Session: End the session with the summary of the session **(PPT slides 18-19)**

- Counselling is a confidential dialogue between an individual and a counsellor.

- Counselling is not advice-giving or directing, but it is a process of empowering individuals to take their own decisions in varied fields.

- The prime concern of the counsellor must be first to handle the immediate concern of the client before referring the client to any other service.

- In each case, the role of the counsellor changes but the counselling skills that have been utilized remain the same. Some skills can be used on a day-to-day basis like active listening, questioning and empathizing, while some can be used from case to case like confrontation skills, paraphrasing, rephrasing, etc.

- Counsellors while providing services, at times, become over confident. Counsellors should be cautious about their own ability and extent to which they can solve client's problems especially medical problems.

- Counsellors should always keep in mind that they cannot play a role of a doctor for the client. Their role is to empower the client and not to make them dependent on counsellors. Hence counsellors should be very open to understand their limits and should be able to tell the clients the areas where they cannot help them.

- Counsellor should be knowledgeable about government programs, NGO schemes, and new policies in their local context.

- https://app.steve.ai/video/C987EL3HVLAL7RBV

9

180 Mins

Risk Assessment, Pre and Post-test counselling and Index Testing Services

9.1 Session objectives:

To train the participants to learn about:

- Risk assessment techniques to identify potential risks of HIV and STI transmission
- Potential topics/contents of pre and post-test counselling
- Beneficiaries and strategies for delivering Index Testing Services

9.2 Expected outcomes:

At the end of the session, the participants will be able to:

- Differentiate risk of HIV and STI transmission and refer client to appropriate prevention services
- Effectively counsel the clients to ensure optimal uptake of HIV Services
- Provide Index Testing Services to all index clients so that to identify and test HIV exposed clients/at risk clients

9.3 Methodology:

MS PowerPoint presentation, role play, case studies, mock sessions

9.4 Material needed:

- Case studies
- Mock session assessment formats
- Colour chart papers
- Markers (whiteboard and permanent)
- Risk assessment tools (printed for group work and distributed to the participants)
- MS PowerPoint presentation **(# 9)**
- Handbook for HIV & STI Counsellors **(Chapter 9)**

Facilitation Steps

Step 1: 'Know your Trainees' exercise and presentation on risk assessment (PPT slides 1-9)

- Welcome the participants and introduce the session.
- Conduct a 'Know your Trainees' exercise and ask the participants if they are aware of Risk Assessment to identify At-Risk clients
- Use the MS PowerPoint presentation to explain risk assessment technique and tool

o Distribute the printed risk assessment tool and the interpretation of the risk assessment sheet to each of the participants.

o Take them through the risk assessment tool first and explain to them the method to categorize the at-risk population based on the risks assessed.

Step 2: Pre/post-test, follow-up counselling (PPT slides 10-20)

- Ask all the participants to write down their understanding on the following and pick a couple of participants to share what they have written:

a) Pre-test counselling
b) Post-test counselling
c) Follow-up counselling

Step 3: Role Play (PPT slides 21-22)

- Ask two volunteers to come, one of whom will act as a counsellor and the other as a client.
- Read out the case scenario and ask the two volunteers to perform the role play.
- Request the rest of the participants in the training hall to record both the positive and negative aspects of the role play.
- Following the role play, first ask the client and then the participants for their feedback regarding the improvisation of counseling skills demonstrated during the role plays

Role play 1: Sheela, 22-year-old pregnant woman, was referred to an ICTC centre for a HIV test.

Role Play 2: Sheela comes back to collect her HIV test results. The counsellor will have to disclose her HIV positive result.

Step 4: 'Know your Trainees' exercise and presentation on Index Testing Services (PPT slides 23-32)

- Ask the participants if they have heard about ITS. If yes:

a) What have they heard?
b) Do they know who is an index and who is a contact?

- Write the responses from the participants on the whiteboard or a chart paper.
- Next, use the MS PowerPoint presentation and explain ITS

Step 5: Group Work (PPT slides 33-35)

- Divide the participants into three groups and ask each group to discuss their counselling experience with the provider-assisted referral approach. They should focus on the following four questions:

(i) Which of the three provider-assisted referral approaches have you experienced?
(ii) What were the challenges you faced?

(iii) How did you overcome the challenges?
(iv) What are your recommendations to counsellors?

- Allow 10 minutes for discussion and five minutes to each group for presentation.
- After the groups' presentation, summarize the group work.

Step 6: Summary (PPT slides 36-37)

- Risk assessment is critical component to identify risk and link to preventive services

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- Pre and post-test counselling is essential for all the clients undergoing HIV test.

- The post-test counselling needs to be customized as per need of the client

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- Some clients may need additional follow up counselling and should be provided as per national guidelines

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- Index Testing Services is not a onetime activity and is essential to reach first 95 as well as to reduce new infection by breaking the chain of transmission

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- Index testing services should be offered at various NACP facilities as per the clients' needs

10

60 Mins

Condom Use

10.1 Learning Objectives

To help the participants:

- Understand what a condom is and its usage as a prevention tool
- Understand the basics of the provisioning of free condoms
- Learn condom negotiation techniques
- Learn correct use of male and female condoms through demonstration, including correct ways of disposal

10.2 Expected outcomes

At the end of the session, the participants will be able to:

- Have clear knowledge about condom, and its importance in preventing HIV & STIs and pregnancy
- Understand the basics of the condom programme
- Be adept and comfortable with condom use, and demonstration, for guiding their clients on the correct use of condoms and successful condom negotiation

10.3 Suggested Training Method:

MS PowerPoint presentation, and condom demonstration exercise

10.4 Materials/Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- Male and female condoms
- Penis model
- MS PowerPoint presentation **(# 10)**
- Handbook for HIV & STI Counsellors **(Chapter 10)**

Facilitation Steps

Step 1: Conduct 'Know your Trainees''exercise and PPT presentation (PPT slides 1-11)

- Ask the participants to visit a medical store or pharmacy the day before the session and purchase a packet of condoms.
- Welcome the participants to the session and brainstorm around the HIV risk reduction methods and discuss on the non-penetrative sexual practices as one of the effective methods to reduce the risk for HIV.

- While explaining non-penetrative sex as an effective approach to preventing HIV transmission, the counsellors must also explain the risk for STI transmission through non-penetrative risk.
- Introduce condom use as yet another effective method to reduce risks of acquiring HIV and ask the following questions:

  a) What is a condom?
  b) Do you know some of the condom brands?
  c) How many of you have ever touched a condom?

- As there are many inhibitions and hesitation around speaking about condoms, some of the participants may not respond or feel shy or hesitant in responding.
- However, record the few responses that you get, and if these are correct, mention a word of appreciation for the participants because it is very important to talk about condoms.

Step 2: Experience sharing – buying condom (PPT slide 12)

- Invite a few participants to the stage and ask them to share their experience of buying condoms from the stores the day before.
- After the experience sharing, use the MS PowerPoint presentation for the second part of the session, that is, how condoms help in risk reduction by preventing the transmission of HIV and other STIs, and preventing unwanted pregnancy. Discuss the following:

  a) How correct and consistent use of condoms can help in preventing the transmission of HIV
  b) How the chances of becoming pregnant can be minimized through correct condom usage
  c) How correct and consistent use of condoms can help in preventing the transmission of other STIs
  d) Myths and misconceptions related to condom usage
  e) Availability and accessibility of condoms
  f) Brief explanation on condom social marketing (CSM) – channels of distribution
  g) Things to take care of while using condoms

Step 3: Condom demonstration (PPT slides 13-17)

- Next, conduct the condom demonstration exercise:

  a) Distribute condom packets to all the participants to make them comfortable with handling condoms – they should open the packet and hold the condom in their hands.
  b) Invite two participants for the demonstration exercise (one to hold the penis model and the other person to show the proper way of using the condom). This activity can be repeated with more pairs of participants for better understanding.

c) You can help in the demonstration if the participants do not provide a satisfactory demonstration and explanation.
d) Now, repeat the demonstration but deliberately make a few mistakes – ask the participants to identify the mistakes and write them on the whiteboard – provide a rectified explanation to the participants on proper condom usage.

- Play either of the following YouTube video which demonstrates female condom use

  https://www.youtube.com/watch?v=OBQ4kUA01qI
  https://www.youtube.com/watch?v=8xNBntU01TY

- Mention that the counsellors need to train their clients on both condom use and condom negotiation skills.

Step 4: Condom negotiation skill and role play (PPT slides 18-23)

- Use the presentation to talk about condom negotiation skill.
- Teach the participants how to explain the five steps of condom negotiation to their clients for use in real life situations. If a client does not want to practice unprotected sex, they should follow the five steps as explained below:

  a) Say NO! Use the word. Say it in a firm tone of voice.
  b) Use actions and body language that support the NO message.
  c) Repeat. One may need to say NO more than once.
  d) Suggest an alternative. Offer something that's safer and healthier to do instead, if this is someone you still want a relationship with.
  e) Be sure your words and actions are real for the situation and are likely to work with the sexual partner concerned.

- If time permits, read out the following situation and ask two volunteers to enact the situation using the above five steps to say NO to sex without condoms:

  Radha is an FSW. She has been in sex work for the past two years. She has a client who wants to have sex with her but does not want to use a condom. She has made a promise to herself to never have sex without using a condom, and up until now has always used one each time she and her client have had sex. The entire day Radha did not have a single client and it is important for her to earn for the day.

- An example of a successful condom negotiation conversation for the above situation may be as follows:

Radha: Come on my darling, let's have fun today.
Client: Hmm.
Radha: Do not feel shy, come close to me…
Client: This feels so good. I feel so close to you. Let's have sex.
Radha: This feels good to me too. But maybe we should use a condom?
Client: I don't have one. But it won't hurt if we don't use a condom just one time.
Radha: NO, I want us to use a condom every time we have sex.

Client: It is okay, let's skip it just this once.
Radha: No. It's not okay. I won't have sex without a condom.
Client: Don't you think it would be nice just to see what it feels like without a condom?
Radha: It might be nice, but it's not worth the risk. My body is my investment and I need to take care of it.
Client: I know, but this feeling is so good. I don't want to stop now.
Radha: I know it's hard to stop, but I have a condom with me. Let's use it.
Client: Having sex without a condom will give me a lot of pleasure. I'm sure you'll also enjoy it without a condom. You can use it with the others.
Radha: No, I'm not going to have sex without a condom. It's also important for me to safeguard your health as well.
Client: Alright, I guess you're right. Let's use a condom.

Step 5: Summary (PPT slides 24-25)

- Conclude the session by explaining the key points that the counsellors should focus on when they counsel their clients on condom use.

- Condom is barrier against infections such as HIV/AIDS, gonorrhoea, chlamydia, syphilis, and herpes.

- Regardless of gender, condoms offer protection to both sexual partners.

- Used for a variety of sexual activities, including oral, anal, and vaginal sex.

- Non-penetrative sex is encouraged as one of the efficient ways to lower the risk of HIV transmission.

- Only water-based lubricants are recommended for use with condoms.

- Condoms are easily available at Govt. health centres, family planning clinics, Sampoorna Suraksha Kendras, ICTC, DSRC, One Stop Centres and OST centres, medical stores, ASHAs and ANMs, NGOs, and CBOs working on sexual health.

- Condoms should be kept in a cool, dry place at room temperature and used as per instructions.

- Individual circumstances, cultural values, and societal influences can all influence these barriers in different ways.

- Motivate the clients in risk behaviours to adopt risk reduction techniques and say NO to sex without condom.

11

180 Mins

Screening and Management of Sexually Transmitted Infections and Reproductive Tract Infections

11.1 Learning Objectives

To train the participants to learn about:

·Sexually transmitted infections (STIs) and reproductive tract infections (RTIs)

·Syndromic Case Management of STIs/RTIs

·Counselling for prevention, treatment and management of STIs/RTIs

11.2 Expected outcomes

At the end of the session, the participants will be able to:

·Discuss and define the importance of STI/RTI screening and management

·Explain the syndromic case management of STIs/RTIs

·Develop counselling skills and strategies for STI/RTI prevention and control

11.3 Suggested Training Method:

PPT, Case Discussions, and Counselling mocks sessions

11.4 Materials/Preparation Required

- MS PowerPoint presentation
- Case studies
- Counselling mock sessions assessment format
- Chart papers and markers MS PowerPoint presentation **(# 11)**
- Handbook for HIV & STI Counsellors **(Chapter 11)**

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise (PPT slides 1-2)

- Welcome the participants to the session and introduce the topic i.e., sexually transmitted infections (STIs) and reproductive tract infections (RTI) and present them the objectives and outcome of the session.
- Before moving on to the technical content on the STI and RTI, begin the session by asking all participants what comes to their mind when they hear the words "Sexually Transmitted Infections". Record the points on the board.
- Next, ask the participants to name some of the STIs they know or have heard of. Add the responses to the whiteboard.
- Thank the participants. Explain that in this session we will be dealing with the basic information on STI and RTI.

Step 2: PPT Presentation (PPT slides 3-14)

- Having known the basic knowledge of the participants, move on explain the following content with the support of the PPT slides.
  - o What is STI and RTI?
  - o Epidemiology of STI/RTI
  - o Causative Agents of Common STIs and RTIs
  - o Signs/Symptoms/ Syndromes of STIs/RTIs
  - o Syndromic case management of STIs/RTIs

- First explain the concept of an STI –that it mainly spreads through sexual contact.
  - o Remind them that HIV/ AIDS is also an STI and explain the relationship between STIs and HIV infection

- The importance of assessment of risk behavior and risk reduction counselling should be explained to the participants.
- The facilitator then moves on to explain the Syndromic Case Management (SCM) with the support of PPT

Step 3: Group Activity (PPT slides 15-20)

- After the syndromic case management slides, the facilitator conducts group discussion.

o Divide the participants into six groups and give a case scenario each to groups for discussion

o Give them 15 minutes to discuss in the group and five minutes each for presentation

o After the group presentation, the facilitator clarifies the misunderstandings if any that came up during the group presentation and concludes the group work.

o Ensure the groups discuss the partner notification and management (the last question in the list) during the group work.

Case Scenario – 1

A woman comes to the hospital with a complaint of vaginal discharge with foul odour for the last two weeks.

Questions for discussion:

- Is it STI or RTI?
- What could be the reasons for the symptom?
- How will you proceed with management of this case?
- As part of the syndromic Case Management (SCM) what kit will you suggest for treatment?
- What will be your core focus of counselling for this client?
- What will be your advice on follow-up for this client?
- How will you ensure partner notification and management?

Case Scenario – 2

A man comes to the hospital with the complaint of discharge from his penis.

Questions for discussion:

- Is it STI or RTI?
- What could be the reasons for the symptom?
- How will you proceed with management of this case?
- As part of the Syndromic Case Management (SCM) what kit will you suggest for treatment?
- What will be your core focus of counselling for this client?
- What will be your advice on follow-up for this client?
- How will you ensure partner notification and management?

Case Scenario – 3

A young man comes to the hospital with complaints of discharge from anal opening and difficulty in passing stools.

- Is it STI or RTI?
- What could be the possible causes for these symptoms?
- How will you proceed with assessment and management of this case?
- As part of the Syndromic Case Management (SCM) what kit will you suggest for treatment?
- What will be the plan of counselling? What will be your advice on follow-up for this client?
- How will you ensure partner notification and management?

Case Scenario – 4

A young boy presents with a history of protected sexual encounter 3 months back. He mentions of great distress and fear of acquiring STI during that encounter.

- What will be your line of action for this boy?
- How will you counsel this boy?

Case Scenario – 5

A lady complaint of greenish vaginal discharge. She visited a OBGY doctor and is diagnosed with an RTI. She is afraid to inform her husband for a about the same for management because she believes that he would question her behaviour and their marriage will end.

- What could be the possible reason of this discharge? What would be the line of management?
- As a counsellor, how can you encourage her to tell her spouse about her condition?
- How will you assist her in disclosing her RTI and encourage her spouse to seek treatment?

Case Scenario – 6

An adolescent boy calls 1097 and says of having sores around his penis and he is afraid of the sores.

- What could be the possible reasons for this symptom?
- How will you encourage this client for seeking STI services?
- What are the important points to cover in his counselling?
- How will you ensure partner notification and management?

- After the group work, the facilitator explains the following areas: **(PPT slides 21-25)**
  - Syphilis
  - Coordination among facilities and STI services to Sex Workers, MSM, TG/Hijra, and IDUs
  - Clinical Management of STI/RTI in HRGs

Step 4: Quiz Session (PPT slide 26)

- Post the group work, the facilitator conducts a quiz (given as annexure) to ensure all the participants understood the session.

Step 5: Concluding the Session (PPT slides 27-29)

- Finally, conclude the session by reinforcing the points given at the end of the chapter

- STI and RTI are infections that affect the reproductive tract, but STI are spread through sexual contact, while RTI can also be caused by overgrowth of normal organisms or improper medical procedures.

- STI and RTI can increase the risk of HIV transmission and acquisition, alter the natural history and manifestations of HIV infection, and affect the success of ART treatment.

- STI and RTI can be prevented and treated by safe sex practices, hygiene, screening, diagnosis, counselling, and medication.

- STI/RTI can present with various signs and symptoms, such as genital discharge, ulcers, warts, pain, itching, fever, etc. Some STI/RTI may be asymptomatic and require screening and diagnosis.

- STI/RTI can affect men, women, and transgender persons depending on their anatomy, physiology, and sexual behavior. Adequate history taking is important to understand the symptoms and risk factors of each client.

- Syndromic case management is a public health approach to treat STI/RTI based on the symptoms and signs of the patient.

- Syndromic case management has advantages such as being fast, effective, inexpensive, easy, and standardized

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- Limitations are such as not being useful for asymptomatic patients, over-treating some cases, and increasing antibiotic resistance.

- Syphilis is a bacterial infection that can cause serious complications if not treated early. It has three stages: primary, secondary, and tertiary, each with different signs and symptoms.

- Syphilis can be diagnosed and treated by using serological tests (treponemal or non-treponemal) and penicillin injections. The treatment regimen depends on the stage of infection and the patient's allergy status.

12

60 Mins

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

12.1 Learning Objectives:

To train the participants to learn about:

- Post-exposure prophylaxis (PEP) and universal work precautions (UWP)
- Standard of care for individuals exposed to HIV
- Pre-exposure prophylaxis (PrEP)

12.2 Expected outcomes:

At the end of the session, the participants will be able to:

- Define who are at risk of exposure and routes of exposure
- Discuss and define the importance of PEP and standard safety precautions to be followed to prevent exposure to and transmission of HIV
- Discuss and counsel on the standard of care to be adopted for individuals exposed to HIV
- Discuss the Pre-exposure prophylaxis (PrEP) with clients

12.3 Suggested Training Methods:

MS PowerPoint presentation, group discussion and quiz

12.4 Materials/ Preparation Required:

- Colour chart paper
- Markers (whiteboard and permanent)
- Case studies print-outs
- MS PowerPoint presentation (# 12)
- Handbook for HIV & STI Counsellors (Chapter 12)

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise: (PPT slides 1-3)

- Welcome the participants to the session and present them the learning objectives and outcomes
- Conduct 'Know your Trainees' exercise to understand the participants' knowledge and experience about Post Exposure Prophylaxis by asking a few of the following questions to the participants:
  - How many of you have heard about PEP?
  - What is the full-form of PEP?
  - What is it?
  - Has anyone in this group provided PEP services? If yes, what was the process?

- Put all the answers on the board that come from the participants' queues. While conducting the 'Know your Trainees' exercise, note down the gaps in their understanding which s/he clarifies during the course of session.

Step 2: PPT presentation: (PPT slides 4-17)

- Then, move on to explain the training content with the support of the PPTs available for the session. The PPT will cover the following key areas:
  - o Introduction about PEP
  - o Risk of exposure from different body fluids
  - o Standard of care for individuals exposed to HIV

Step 3: Case presentation in the larger group (PPT slide 18)

Present each of the following five situations one-by-one using the PPT. Instead of asking all the participants to respond to a situation, ask a group of 5-6 participants to give answers to one situation and move on to ask the other 5-6 participants to another situation until all of the situations are discussed.

- o Practices that increase the risk of needle stick injury
- o How to reduce the risks of needle stick injury
- o Standards of care for individuals exposed to HIV
- o Standard workplace precautions
- o Management of the Exposed Person

Step 4: Quiz for the participants: (PPT slides 19-21)

Before closing the topic on PEP, conduct a quiz. The sample questions are given below and you are encouraged to add more questions:

1. Contact with what samples put us to occupational risk of blood-borne pathogens like HCV, HBV, and HIV?
Ans: Blood, body fluids and tissues

2. "PEP can be administered to the sexual assault victims under the National Programme". Is the statement true or false?
Ans: True

3. "Should we recap needles after use before disposing". Is the statement true or false?
Ans: False

4. "Performing activities involving needles and sharps, in a rush increases the likelihood of an accidental exposure". Is the statement true or false?
Ans: True

5. Putting finger in mouth after needle stick injury will help to reduce the blood loss and prevention of infection transmission (True/False)
Ans: False

6. Vaccination for hepatitis B consists of how many doses?
Ans: Consists of 3 doses: baseline, 1 month, and 6 months. Most of the recipients (99 %) seroconvert after completing the full course. There is no vaccine or prophylaxis against hepatitis C.

7. "After a splash of blood or body fluids and for unbroken skin, wash the area immediately with antiseptics." Is the statement true or false?
Ans: False

8.Within how many hours, the first dose of PEP should be administered ideally?
Ans: Within 2 hours (but certainly within the first 72 hours) of exposure and the risk evaluated as soon as possible.

9. For which are the cases, the expert's opinion may be obtained?
Ans:

- **Delay in reporting exposure (> 72 hours)**
- **Unknown source**
- **Known or suspected pregnancy**
- **Breastfeeding issues in the exposed person**
- **Source patient is on ART**
- **Major toxicity of PEP regimen**
- **A person with major psychological problem**

Step 5: Pre-exposure prophylaxis (PrEP) **(PPT slides 22-28)**

- After completing the quiz, briefly explain the PrEP and common PrEP myths

Step 6: Concluding the session:
The facilitator sums up the session with the summary points. **(PPT slides 29-31)**

- Post exposure prophylaxis (PEP) refers to the comprehensive management instituted to minimize the risk of infection following potential occupational exposure to blood-borne pathogens (HIV, HBV, HCV).

- PEP must be initiated within 2 hours (but preferably within the first 72 hours) after a recent possible exposure to HIV.

- Research has shown that PEP has little or no effect in preventing HIV infection if it is started later than 72 hours after HIV exposure.

- Duration of PEP is 28 days, regardless of the PEP regimen.

- Do not recap needles to prevent the risk of needle stick injury.

- Performing activities involving needles and sharps, in a rush increases the likelihood of an accidental exposure.

- All hospital staff members must know whom to report for PEP and where PEP drugs are available in case of occupational exposure.

- Standard Workplace Precaution (SWP) is to be practiced by every person working in the health care system to reduce the risk of transmission of pathogenic agents including HIV.

- Pre-exposure prophylaxis (PrEP) refers to use of anti-retroviral medication, to reduce chances of getting infected, by people at risk of acquiring HIV infection.

- PrEP is for use by HIV negative persons only.

- Refer to the National Technical Guidelines for PrEP for FAQs

13

120 Mins

Anti Retro Viral Treatment and Management of PLHIV

13.1 Learning Objectives:

To train the participants to learn about the:

- Importance of anti-retroviral therapy (ART) for HIV/AIDS
- Core principles and approaches to the treatment of HIV/AIDS
- ART regimens and their common side-effects
- Action points for client support for successful ART initiation and lifelong treatment adherence.
- U=U, Rapid ART initiation, Step up adherence (Enhanced Adherence Counselling) and State AIDS Clinical Expert Panel (SACEP)

13.2 Expected outcomes:

At the end of the session, the participants will be able to:

- Discuss the importance of ART and its advantages
- Develop counselling skills for preparedness, Rapid ART initiation, regimens and side effects, step-up adherence (Enhanced Adherence Counselling) and U=U
- Prepare checklists and action points for counselling clients on monitoring of adherence, CD4, and Viral Load.

13.3 Suggested Training Method:

MS PowerPointpresentation, 'Know your Trainees' exercise, and group work

13.4 Materials/Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation (# 13)
- Handbook for HIV & STI Counsellors (Chapter 13)

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise (PPT slides 1-5)

- Greet the participants, recapitulate the previous session, and remind them that HIV is a chronic manageable disease, although there is no cure for it, there are medicines that can halt the progression of the HIV in the body and people living with HIV can remain healthy.
- Next, conduct a 'Know your Trainees' exercise' on the UNAIDS 95-95-95 targets to END AIDS by 2030 and ask what it stands for (95% of HIV positive people know their status, 95% of those who know their status are put on treatment, and 95% of those who are on treatment have viral load suppression). Record the responses on the whiteboard or a chart paper.

- Record the responses on the flipchart/ board.
- Following this, the facilitator emphasizes to the participants that early initiation of all PLHIV on treatment is essential to achieve all the three 95 of the UNAIDS goal.

Step 2: 'Know your Trainees' exercise and PPT Presentation (PPT slides 6-25)

- Ask the participants about the objectives and functions of ART centre and Link ART centre
- Use the MS PowerPoint presentation and explain the following;

  a) Objectives and functions of ART centre and Link ART centre
  b) ART and benefits of ART

- Ask the participants:

  a) What should be considered prior to ART initiation?
  b) Write down the responses on the whiteboard.

- Continue using the presentation to explain the following:

  a) When to start ART as per the latest NACO guidelines
  b) What are the steps of preparedness counselling
  c) What is rapid ART initiation
  d) CD4 recovery and early anti-retroviral (ARV) toxicities

- Pause the presentation, and ask:

  a) Do you know what treatment failure is?
  b) What types of treatment failures normally occur and what do they mean?

After the discussion, present the slides on the different types of treatment failures, when to suspect the failures, and common factors contributing to the failures.

Step 3: Case Scenario:

Present the three case scenarios one-by-one using the PPT slides (PPT slides 26-28)

Step 4: Treatment Failure (PPT slides 29-38)

- After the case scenario discussion, conduct ''Know your Trainees'' exercise and discuss about treatment failure
- Explain the treatment failure, importance of follow-up and monitoring and step-up adherence counselling using the PPT slides
- Next, present the slides on the differences between 'switch' and 'substitution'

Step 5: Presentation (PPT slides 39-40)

- Present the What is U=U or TasP and SACEP

Step 6: Role play (PPT slide 41)

Group work: Divide the participants in two groups and assign a case situation to each group for role play (Table 1). Each group is to be given 10 minutes to discuss the case situation and reassemble. Two persons (counsellor and client) from each group will have to enact a scene where the counsellor successfully completes ART-related counselling.

Table 1: Group work on ART counselling

Group 1	Group 2
• Group 1: A newly HIV diagnosed person visits the ART center for ART initiation. • ·What is the process to be followed to initiate ART? • ·How is it explained to the client?	• Group 2: A person on ART visits the ART centre after a month of ART initiation with side effects and does not want to continue the ART drugs. • ·How to convince the client to continue the treatment? • How to explain the issue of drug resistance to the client?

- Facilitator, during the first role play, ensure that the seven-point counselling tool for ART preparedness (attached as annexure) are used:
  - o Explain WHAT medicines should be given.
  - o Specify WHEN the medicines should be given/taken. Timing with other drugs (TLD has interactions with antacids, iron, calcium, vitamins, metformin, etc.)
  - o Provide details on HOW the medicines should be given/taken.
  - o Identify WHO will administer the medicines in children and ill patients

Source: Operational guidelines on ART Services

Step 5:

Concluding the Session: Summarize the significant points and ask the participants to refer to the handout for side effects. **(PPT slides 43-44)**

- ART is a treatment for HIV that uses antiretroviral drugs (ARVs) to reduce the viral load and improve the immune system of the infected person.

- ART can increase survival chances and quality of life, reduce the risk of transmission, and prevent opportunistic infections and AIDS-related illnesses.

- There are different classes of ARVs that act on different stages of the HIV life cycle, such as NRTIs, NNRTIs, PIs, INSTIs, and others.

- ART should be started as early as possible and continued for life, following the national guidelines and the advice of the health care provider.

- ART may have some side effects, but they can be managed with proper monitoring and support.

- PLHIV should start ART as soon as possible after diagnosis and adhere to the treatment.

- Before initiating ART, the patient should be prepared, consented, screened for TB and OIs, and prescribed CPT and TPT as needed.

- Early ARV toxicity is the occurrence of adverse effects in the first weeks or months of ART, such as rash, nausea, anaemia, or liver damage. Mortality on ART is higher in the first six months, especially for patients with advanced disease.

- Treatment failure is the loss of effectiveness of ART due to viral resistance, immunological decline, or clinical progression. Treatment failure is the result of poor adherence to ART, which leads to viral resistance and disease progression.

- U=U or TND is an undetectable viral load in PLHIV, which needs to be achieved and maintained to prevents sexual transmission of HIV and reduces stigma and discrimination.

- Patients with suspected ARV treatment failure, severe adverse effects and complicated clinical cases are referred for review by a panel of experts called SACEP.

14

90 Mins

Prevention and Management of Opportunistic Infections & Co-morbidities

14.1 Learning Objectives:

To train the participants to learn about:

- Understanding of impact of dual diseases and strategies for reducing impact of dual (TB and HIV) disease burden
- Treatment adherence support system
- Infection Control and fast-tracking of TB symptomatic patients
- Establishing referral and Linkage to NTEP facilities for DR-TB
- TB preventive treatment among PLHIV
- Understand what Hepatitis B and C are
- Understand the close association between Hepatitis B, C and HIV
- Learn the counselling skills involved with Hepatitis B and C
- Prevention and management of opportunistic infections and comorbidities

14.2 Expected outcomes:

At the end of the session participants will be able to:

- ·Discuss and define the importance of prevention, diagnosis, treatment and management of HIV-TB co-infection
- Enumerate the strategies for reducing the impact of TB in PLHIV
- Develop counselling skills through the practice of checklists for detecting, testing and treatment management and prevention of TB, other opportunistic infections, and non-communicable diseases among PLHIV clients
- Explain ther clients for the presence of the risk factors of Hepatitis B and C
- Develop counselling skills through practice of screening for depression and deciding key supportive counselling services for PLHIV with depression
- Create a supportive environment to encourage diagnosis, treatment and effective cure

14.3 Suggested Training Method:

PPT Presentation, Quiz, Group activities, and ‘Know your Trainees’ exercise

14.4 Materials/Preparation Required:

- Case studies
- Mock sessions assessment formats
- Chart papers and Markers
- PPT Presentation, **(# 14)**
- Handbook for HIV & STI Counsellors **(Chapter 14)**
- TB Champion to be invited

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise: (PPT slides 1-2)

- Welcome all the participants and start the session with a few basic questions around opportunistic Infections (OIs) and Comorbidities.

Step 2: PPT presentation: (PPT slides 3-11)

- Present them the table of OIs and Comorbidities by using the PPT
- Move to ask again a few basic questions around TB. Reward the participants who give correct answers to the questions with a chocolate. Refer the question box below for the questions (the facilitator can also frame his/her own questions).

Question box

1. What is full form of TB?
2. What is the name of micro-organism that causes TB?
3. How does TB spread from one person to another person?
4. Do all the people who are infected with M. tuberculosis develop the TB disease?

- After having created an interest in the topic, start capturing the interest of participants on session, the facilitator conducts the training session with the support of the PPT for which the content is taken from the learning content from the chapter.
- After explaining the treatment adherence support system, the facilitator conducts a role play on the following case scenario.

Step 3: Role play: (PPT slide 12)

- Ask two trainees to volunteer to play a counsellor and a client. Read aloud the case scenario. Let the role play unfold. Ask the audience for suggestions after the role play. If there is a second volunteer, let them try playing the counsellor. At the end of the role play, use the Role Play Key to make sure that trainees know what are the points to be addressed in the counselling. Remember to tell trainees that counselling is NOT only information-giving. It includes assessment and support as well.

Roleplay

A Case Scenario:

Poonam, 28 years old woman living with HIV, is married and living with in-laws, husband and kids in the village. Her health was good till a month ago and she used to do all the household works. She is having cough for the last 10 -15 days. She thinks it may be because of the dust and it will go away on its own. During her routine visit the hospital, the doctor here has asked her to undergo some tests for TB.

Summing up the role play: Facilitator sums up with the following points:

o Poonam needs to be counselled for TB and OI.

o She should be assessed for the risk of TB by asking questions such as whether anyone in her home has been diagnosed with TB or has had a persistent cough for more than two weeks.

o The counsellor will also have to explain TB and then conduct 4 S.

o Duration of cough symptom for presumptive TB in general population is for 2 weeks whereas in case of PLHIV any duration of cough has to be referred.

Step 4: PPT presentation: (PPT slides 13-30)

·After the roleplays, the facilitator moves on explain the rest of the PPT slides.

Step 5: Concluding the TB session

·To end the TB session, a TB Champion can be invited to the training and ask her or him to share their treatment experience and the support required from the counsellors.

Step 6: 'Know your Trainee' exercise and PPT presentation on Hep B and C (PPT slides 31-35)

·Conduct a 'know your trainee' exercise for a few minutes by asking a few questions around Hepatitis B and C:

a) What have you heard about Hepatitis B and C?
b) How are Hepatitis B and C spread?
c) Is there a vaccine for Hepatitis B and C?
d) Can Hepatitis B and C be cured?

- Elucidate the basics of Hepatitis B and C using the MS PowerPoint presentation.
- Explain the close association of Hepatitis B and C with HIV.

Step 7: Group Activity (PPT slide 36-39)

- ·Before discussing the role of counsellors, conduct a discussion through the activity called Value Clarification for the statement: "There is no effective treatment for Hepatitis C."

  a) Paste the pre-arranged cards written as True on one side of the room, False on another side of the room, and Do Not Know in the middle of the room.
  b) Ask the participants to move to the side or zone where they think they should be regarding the given statement.
  c) Ask the participants in each zone to give reasons for their choice.
  d) Create a debate between the participants till the given answers are clarified and understood by all.
  e) Ask open-ended questions to conclude that Hepatitis C is a curable disease with a treatment of 12 weeks (84 days), extendable to 168 days in severely complicated cases.

- You can also take up other statements in relation to the session objectives and repeat the activity.

a) Paste the pre-arranged cards written as True on one side of the room, False on

Step 8: PPT presentation: (PPT slides 40-46)

- After the conclusion of the Hep B and C session, discuss the opportunistic infections (IOs), non-communicable diseases (NCDs), and mental health problems among PLHIV with the support of PowerPoint presentation.

Step 9: Group Activity (PPT slides 47-49)

- Conduct the following practice exercise among the participants on screening for depression and deciding key supportive counselling services for PLHIV with depression
  - o Divide the participants in pair and give each pair the patient health questionnaire and the score card
  - o One of the pairs plays the role of a patient and the other a counsellor
  - o By the use of the questionnaire, the counsellor screens the client for depression; scores the depression by using the score card; and comes up with the action plan/recommendations for the client to overcome the depression.

Step 10: Conclusion (PPT slides 49-51)

- Do not forget to appreciate the participants for their active participation.
- Conclude the session by reiterating the summary points from the session.

- Opportunistic Infections are common in PLHIV due to immunosuppression.

- Management of OIs is based on syndromic evaluation and treating the cause.

- Vaccinations, Preventive therapy and Good Personal hygiene will help prevent OIs.

- HIV and TB are two diseases that have a synergistic impact on each other, increasing the risk of morbidity and mortality for co-infected patients.

- To reduce the dual burden of HIV and TB, four strategies are recommended: intensified case finding, TB preventive therapy, infection control, and ART for all PLHIV.

- India has launched a national programme to eliminate HCV by 2030 and reduce the burden of other types of viral hepatitis.

- The programme provides free diagnostics and drugs for HCV and HBV at government health facilities.

- Testing for hepatitis B and C requires screening tests (anti-HCV and HBsAg) and molecular tests (HCV RNA and HBV DNA) to confirm the diagnosis and decide the treatment.

- Pre and post-test counselling and screening for HBV and HCV at the ICTCs involve educating the clients about the nature, transmission, symptoms, consequences, prevention, and treatment of viral hepatitis.

- Non-communicable diseases are chronic diseases that do not spread from person to person and affect various organ systems.

- They are influenced by risk factors such as unhealthy diet, lack of exercise, smoking, and alcohol.

- People living with HIV (PLHIV) are more prone to non-communicable diseases due to immune activation, medication side effects, coinfections, and aging.

- They need health promotion, screening, diagnosis, management, and follow-up to prevent and treat non-communicable diseases.

15

60 Mins

Nutrition in context of HIV and Adherence

15.1 Learning Objectives:

To train the participants to learn:

- About nutrition in the context of HIV and AIDS
- About healthy eating and its importance
- How malnutrition affects the quality of life for PLHIV
- The strategies for correct nutritional practices for PLHIV and CLHIV

15.2 Expected outcomes

At the end of the session, the participants will be able to:

- Discuss nutrition in the context of HIV and AIDS
- Counsel PLHIV for taking the appropriate nutrition
- Develop skills for growth monitoring along with a medical officer in the case of CLHIV and how to use weight-related data for dosing purposes

15.3 Suggested Training Method:

'Know your Trainees' exercise, game, group activities, counselling mock sessions, MS PowerPoint presentation

15.4 Materials/ Preparation Required:

- Paper chits for game on food components
- Colour chart papers
- Markers (whiteboard and permanent), sketch pens
- Sheets of A4 size paper
- MS PowerPoint presentation **(# 15)**
- Handbook for HIV & STI Counsellors **(Chapter 15)**

Facilitation Steps

Step 1: Home Work - Sampurna Poshan contest:

On the previous day of the session, give an assignment to the participants either to enlist low-cost locally available healthy food recipes on a sheet of paper (at least five) or bring at least five varieties of actual food or images of food, which may be suggested to PLHIV during counselling.

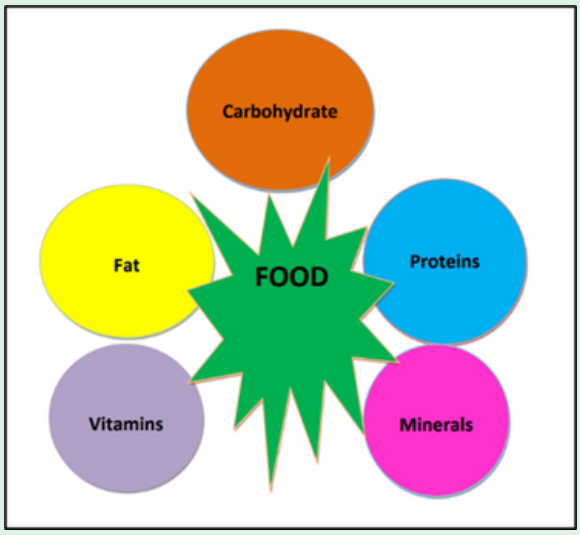
Step 2: Introduction and 'Know your Trainees' exercise: (PPT slides 1-3)

- Greet the participants and ask about their experience of breakfast – what they had, what they liked the most, and why. Then ask which food they feel is healthy for the body and why.

- Food is required to make our body strong, to provide energy to work, play, study, to do daily activities, to maintain all body functions, to grow, to gain height, to fight illness and remain healthy, to become healthy adults.

Step 3: Group Activity (PPT slide 4)

- Conduct a game to talk about the components of food as shown in the adjoining figure:



a) Cut the food slips (available in the fancy stores sold to school children to do project works) for the game and keep these ready before the session.

b) Divide the participants into three teams.

c) Distribute a minimum of 10-15 food slips for each group (images of food, fruits, vegetables, fish, meat, etc. which are energy-giving/body building/protective foods) and ask them to place their food slips on the appropriate chart.

d) Display three charts stating 'energy giving foods', 'bodybuilding foods' and 'protective foods', and paste these on a wall/whiteboard

Step 4: Summing up the Group Activity

- Correct any misplaced food slips and conclude by explaining the nutritional value of the various food items as mentioned below:

- Energy-giving foods – carbohydrates and fats provide energy to our body. Carbohydrate-rich foods are rice, wheat, potato, sugar, honey, bajra, jowar etc. Fat-rich foods are oil, ghee, butter and nuts.
- Proteins are the building blocks of our body. Muscles and other organs are mainly made up of proteins. Protein-rich foods are pulses, peas, beans, soyabeans, milk, egg, fish and meat.
- Minerals are needed for bones, teeth, healing of wounds, fighting infections, converting food into energy, and body repair. Important minerals required by our body are:
    - o Calcium – for strong bones and teeth. Calcium-rich foods are milk, pulses, cauliflower, turnip, mustard seeds, cumin seeds, and curry leaves.
    - o Iron – for healthy blood. Iron-rich foods are Bengal gram, spinach, mint, mustard leaves, turmeric, dry coconut, and amaranth (Rajgira/Chaulai)
    - o Iodine – for brain development, body growth, maturation, bone growth. Iodine-rich foods are iodized salt, fresh fish, fish oils, potato and milk.

-Vitamins are important for normal body function, resistance to infection, wound healing, energy production, healthy skin. Vitamins are A, B, C, D, E and K. Vitamin-rich foods are vegetables, yellow fruits, citrus fruits, milk and egg. Vitamin C is found in carrot, guava, lemon, tomato, green chilies, amla and drumstick.

Step 5: PPT Presentation (PPT slides 5-10)

- Next, explain how nutrition is important in the context of HIV and AIDS. Use the MS PowerPoint presentation to talk about the principles and benefits of healthy eating, and the tips to manage the side effects of medicines with food, food handling, and hygiene.

Step 6: PPT presentation (PPT slide 11)

- Present the following questions on the screen and ask the participants to answer the questions one by one. After each question, present the important points.

  a) If an HIV-positive person does not take adequate nutrition, what will be the impact?
  b) What are the strategies and approaches to meet nutritional requirements of PLHIV?
  c) What are the foods required for healthy living and foods that should be avoided?
  d) What are the key discussion points during the nutrition counselling?

Step 7: PPT presentation (PPT slides 12-23)

- After the groups present their findings, sum up the following key messages using the presentation:

  o How lack of proper nutrition for PLHIV weakens their immune system, which results in repeated opportunistic infections that can hasten the disease progression from HIV to AIDS.
  o Repeated infections further increase the nutritional needs, leading to poor nutritional status, and so the cycle continues.

- Explain the content and skills of nutrition counselling.
- Use the presentation to elaborate and discuss household management of acute malnutrition.
- Explain the interaction of medication and nutrition.
- Elucidate that counselling on dietary intake simply refers to the question of what to eat. The counsellor should help the client to understand the need to have a diet which is diverse enough to provide them the necessary nutrients.

Step 8: Group Activity (PPT slide 24)

- Now ask the participants to get ready for a drawing exercise. Distribute the paper and sketch pens and ask the participants to draw a 'healthy plate' – they will need to draw a plate with the important food items. They should brainstorm about the locally available foods and prepare the drawing. At the end, all sheets should be displayed for experience sharing.

Step 9: Concluding the session: (PPT slides 25-27)

- Sampurna Poshan contest: Ask the participants to share their homework and discuss the various recipes and their nutritional value. The participants presenting the best recipes may be given a small prize

- Nutrition assessment and counselling are important components of the ART preparedness and follow-up for PLHIV, especially children, to understand their dietary habits, nutritional status, and needs, and to link them with nutritional supplementation schemes.

- HIV and nutrition have a complex interaction that affects the immune system, delay the response to ART, disease progression, and the vulnerability to opportunistic infections. HIV increases the energy and nutrient needs of the body, while also interfering with food intake and nutrient absorption.

- PLHIV need to consume a variety of foods from each of the main groups daily to meet their increased nutrient requirements and maintain good nutritional status and regain the lost weight.

- Good nutrition may help them fight illness, survive infections, and improve their quality of life.

- Counselling for weight loss involves informing the client about the causes and consequences of weight loss due to HIV, and suggesting ways to increase the quantity and quality of food intake to regain the lost weight.

- Counselling on food safety involves educating the client about the importance of preventing food contamination and food-borne illness, and recommending practices to maintain clean surroundings, utensils, hands, and food.

- Ensure that the malnourished children and adults are referred to the paediatricians, internist, and dietician.

16

120 Mins

Elimination of Vertical Transmission of HIV and Syphilis

16.1 Learning Objectives:

To train the participants to:

- Instil a comprehensive understanding of the critical significance of dual elimination of vertical transmission of HIV and syphilis (EVTHS)
- Provide in-depth knowledge for preventing, managing, and treating HIV, syphilis, and Hepatitis B during pregnancy and for exposed infants.

16.2 Expected outcomes:

At the end of the session, the participants will be able to:

- Define vertical transmission and explain the risk associated with the vertical transmission of HIV and syphilis.
- Enumerate and explain the approaches to the management of safe pregnancy for women living with HIV.
- Discuss and define the management of maternal syphilis.
- Discuss infant prophylaxis and treatment

16.3 Suggested Training Method:

PowerPoint presentation, 'Know your Trainees' exercises and group work

16.4 Materials/Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- Double-sided tape
- PowerPoint presentation **(#16)**
- Handbook for HIV & STI Counsellors **(Chapter 16)**

Facilitation Steps

Step 1: Introduction and 'Know your Trainee' exercise (PPT slides 1-5)

- Welcome the participants and introduce the national EVTHS programme using data from the MS PowerPoint presentation and followed by the four prongs of the EVTHS interventions.
- Next, inform the participants that the session will be divided into three parts – elimination of vertical transmission of: (a) HIV, (b) Syphilis, and (c) Hepatitis B.
- Mention that we will begin with HIV and conduct a 'Know your Trainees' exercise by asking the participants about the routes of HIV vertical transmission. Write the responses on the whiteboard. Some of the questions are:

a) When is HIV transmitted from mother to child?
b) What is the percentage of HIV transmission risk in each of the routes?
c) How can the chances of HIV transmission be reduced?

Step 2: PPT Presentation (PPT slides 6-11)

- After the 'Know your Trainees' exercise, explain the following with the support of the MS PowerPoint presentation:

a) Risk of HIV transmission from mother to child without and with ARV interventions
b) India's commitment to the dual elimination of HIV and Syphilis
c) Newer four prongs of EVTHS under NACP-V
d) Primary prevention
e) Introduction to the essential package of EVTHS services

Step 3: Group Activity (PPT slide 12)

- Carry out the activity called Knowledge Corner to explain the essential package of EVTHS services:

a) Split the participants into three groups, and assign each group a corner in the training hall where they can gather and work together.
b) Distribute a set of chart papers, markers, double-sided tape, etc. to each group.
c) Give each group information on one of the three essential packages of EVTHS services (that is, interventions throughout pregnancy, interventions during labour and delivery, and care of infants exposed to HIV) and ask them to create a poster on the package given to them.
d) After the groups have completed the poster work, ask them to display the posters in their respective corners.
e) Barring one member in each group who stays back to explain their poster, the other members move as a group to the other two groups to learn from their posters. The person who stays back in each group explains the group's poster and answers the questions posed by the members of the other groups.
f) The facilitator also helps with information that remains unexplained by referring to additional reading materials.

Step 4: PPT Presentation (PPT slides 13-34)

- After the group work, explain the Management of HIV Exposed Infants (HEIs), Early Infant Diagnosis (EID), National Infant Feeding Guidelines using the MS PowerPoint presentation.
- Present the PPT in an engaging and didactic manner by interspersing it with thought-provoking questions throughout the presentation.
- Next, move on to the second part – the elimination of vertical transmission of syphilis.
- Use the MS PowerPoint presentation to explain in detail the following:

a) Syphilis in pregnancy
b) Screening, diagnosis and management of syphilis in pregnancy
c) Screening and management of syphilis-exposed infants (SEIs)

- Following the syphilis section, inform the participants that they will learn in short about vertical transmission of Hep B in this session and it will be discussed in detail in the OIs, Co-infections and other medical conditions (Hep B/C, NCD, mental health, and TB) session. Explain screening, treatment, and vaccination for Hep B using the PowerPoint presentation.

Step 5: Conclusion: (PPT slides 35-36)

- Discuss the specific counselling messages of the chapter
- Conclude the session by reinforcing the points given at the end of the chapter

- Vertical transmission is the transmission of HIV, syphilis, Hep B of a child by the mother during pregnancy, delivery, or breastfeeding.

- India has programmatically moved towards achieving the global 95:95:95 targets by 2025 through four-pronged approach.

- To eliminate vertical transmission of HIV and Syphilis, various interventions are needed, such as primary prevention of HIV, testing and counselling, ART, safe delivery, optimal infant feeding, and postnatal prophylaxis.

- Rapid initiation of ART within seven days of HIV diagnosis to reduce viral load and prevent transmission.

- Viral load monitoring in pregnancy is the measurement of the amount of HIV in the blood of pregnant women to assess their response to ART and the risk of transmitting HIV to their infants.

- Initiate ARV prophylaxis within 72 hours of birth for all HEIs, based on their risk stratification according to the viral load of the mother.

- ARV prophylaxis should be available in all healthcare centres conducting deliveries of HIV patients.

- The interventions include offering HIV screening and ART to women presenting in labour, preferring vaginal delivery over caesarean section, initiating breastfeeding or replacement feeding, providing ARV prophylaxis and CPT to the infants, and following up and treating the mother and the child.

- The National Infant Feeding Guidelines recommend exclusive breastfeeding for six months, unless exclusive replacement feeding is feasible, affordable, acceptable, sustainable, and safe.

- According to NACO protocol the EID test needs to be done at 60 days, 6 months, 12 months and 18 months of the age of HEI. Discordance among the EID results and Rapid tests at 18 months or beyond is a situation where the HIV status of the child is unclear and requires additional testing and referral to SACEP or Centre of Excellence (CoE)

- Primary prevention, family planning, birth planning, and preconception care are services and counselling provided to women of reproductive age and their partners to prevent HIV and syphilis transmission and improve maternal and child health.

- Elimination of vertical transmission of HIV, Syphilis and Hep B are focused upon, leading to triple elimination.

17

45 Mins

Family Planning Methods for PLHIV

17.1 Learning Objectives:

To train the participants to:

- Gain an enhanced understanding of the need for family planning for PLHIV
- Learn about family planning methods and approaches in the context of HIV and AIDS

17.2 Expected outcomes:

At the end of the session, the participants will be able to:

- Discuss and define the importance of family planning for PLHIV
- Enumerate and explain the methods of family planning
- Develop counselling skills for family planning

17.3 Suggested Training Method:

MS PowerPoint presentation and case discussion

17.4 Materials/Preparation Required

- MS PowerPoint presentation (# 17)
- Case scenarios print outs
- Handbook for HIV & STI Counsellors (Chapter 17)

Facilitation Steps

Step 1: Introduction and know your trainee (PPT slides 1-2)

- Welcome the participants and introduce the session topic, objectives and expected outcomes with the support of the PPT
- Conduct a 'Know your Trainees' exercise by asking the following questions:
  a) What is family planning?
  b) What is the purpose of family planning?
  c) What is the spectrum of contraceptive options offered through India's National Family Planning Programme?
- Following the 'Know your Trainees' exercise, deliver a PPT to provide a comprehensive overview of family planning.

Step 2: PPT Presentation (PPT slides 2-13)

- After providing a general overview of family planning, transition to discussing the family planning methods available within India's public health system.
- Present the ppt through a didactic approach by incorporating a series of probing questions related to the family planning methods being presented.

- Introduce family planning services tailored to People Living with HIV (PLHIV), along with preconception care (PCC) and counselling for birth planning specific to PLHIV.

Step 3: Case scenario discussion (PPT slides 14-18)

- Next, present the following case scenarios from the presentation and encourage discussions:

Case scenario 1: An HIV discordant couple insists that they do not want to use condoms because they have not been infected so far.

Notes for the participants:

a) Some discordant couples may emphasize their lack of infection thus far or attribute it to divine protection. It's crucial to clarify that the negative partner's status up to this point does not guarantee continued protection from HIV.

b) The counsellor must clearly explain to the clients about proper adherence to ART and its efficiency in preventing horizontal transmission. The concept of U=U (HIV undetectable = untransmittable) needs to be explained along with its risks and exceptions.

c) It should be made clear that U=U does not denote complete exception of disease transmission. Repeated unprotected sexual exposures increase the risk of transmission.

d) Couples should be counselled about the dual benefits of condom usage: prevention of HIV transmission and protection against other sexually transmitted infections (STIs). Utilize Information, Education, and Communication (IEC) materials to reinforce the causes and consequences of common STIs.

e) The couple should also be counselled that condom usage helps to prevent unplanned pregnancies.

f) In the ABC of HIV prevention, the B (be mutually faithful to partner) and C (consistent and correct use of condom) must be reiterated for both partners.

g) The counsellor should enquire about the practice of non-penetrative sex by the couple, and insist on the importance of using condoms even during

Case scenario 2: A concordant couple says that they are tired of having sex using condoms.

Notes for the participants: When couples start to feel fatigued from the constant need for vigilance, providing support becomes even more important. Appreciate the couple for using condoms consistently to date. Also, appreciate their efforts to inform the counsellor about their thought/decision to stop using condoms henceforth.

a) Encourage them to express their affection using non-penetrative sex.

b) Inform the clients about why condoms should be used despite both being infected. Explain about how condom usage will prevent cross-infections with different strains of HIV.

c) Emphasize that high viral load and low immune status of one partner can worsen the levels of the other partner.

d) Reiterate that condoms not only help in preventing HIV transmission but also help to prevent transmission of other STIs. IEC materials should be used to reiterate the causes and effects of a few common STIs.

e) Remind the couple that condom usage also helps to prevent unplanned pregnancies.

Case scenario 3: What family planning method would be suitable for a woman who is asymptomatic for HIV, currently on ART, and wishes to avoid unintended pregnancies?

Notes for the participants:

a) As a counsellor, you can present a range of contraceptive options to an asymptomatic HIV-positive woman on ART, including combined hormonal contraceptives, progestogen-only pills/injectables, implants, and IUDs as any of these contraceptive methods will be safe to use. However, it is important to emphasize that the selection of the most suitable contraceptive method should be determined by a doctor, so it's essential to refer the woman to a doctor for the proper prescription.

b) However, the counsellor must reiterate that these methods are only temporary contraceptive methods, they do not protect the person against STI/HIV transmission.

c) Also, inform the negligible possibilities of contraceptive failures and emphasize on the correct and consistent use of condoms despite the use of other contraceptive methods (dual protection).

d) If the number of living children of the women is greater than one, then a permanent sterilization method can be recommended. If the woman does not want permanent sterilization, adequate information on healthy timing and spacing of pregnancy (HTSP) must be emphasized.

Step 4: PPT presentation on sero-discordant counselling (PPT slides 19-23)

- Engage in discussions regarding counselling sero-discordant couples for family planning and the process of integrating family planning into HIV counselling.

Step 5: Conclusion: (PPT slides 24-25)

- Discuss the counselling messages during family planning counselling
- Conclude the session by reinforcing the points given at the end of the chapter

- Family planning is the process of deciding the number, timing, and spacing of children, which affects the health and well-being of women and their families.

- During the family planning counselling, focus on the family planning methods that are available under the public health system of India.

- Family planning for PLHIV involves preventing unintended pregnancy, optimizing maternal health, improving pregnancy outcomes, and preventing HIV transmission to the partner or the child.

- Specific family planning needs of PLHIV include respecting their reproductive rights.

- Integrating family planning into HIV counselling involves asking clients about their fertility intentions, contraceptive methods, and HIV prevention concerns, and providing them with information and support on their choices.

- Counsellor's responsibilities include affirming the right of WLHIV and couples to make informed decisions, providing preconception care, discussing dual protection and disclosure, and following up on contraceptive use.

- Counselling sero-discordant couples for family planning involves providing information and support on the factors, methods, and risks of conceiving and preventing HIV transmission.

- Sero-discordant couples should also consider screening and treatment for STIs, viral load control, male circumcision, and ART prophylaxis to prevent vertical transmission.

- Refer to the gynaecologists for the right choice of family planning methods for the PLHIV

18

90 Mins

Counselling of Children and Parent/Guardian

18.1 Learning Objectives:

To train the participants to learn about:

- Child centered counselling
- Disclosure of HIV status to children and parents/guardians
- Key counselling points while counselling parents/guardians living with HIV
- Child abuse and counselling
- Child and parents/guardians counselling skills

18.2 Expected outcomes:

By the end of the session, the participants will be able to:

- Understand what child centered counselling is
- Understand the process of disclosing the HIV status of a child to the child and the parents/guardians
- Demonstrate skills in counselling children and parents/guardians

18.3 Suggested Training Methods:

MS PowerPoint presentation, case studies, group work, 'Know your Trainees' exercise

18.5 Materials/Preparation Required:

- MS PowerPoint presentation **(# 18)**
- Case studies print-outs
- Colour chart papers
- Markers (whiteboard and permanent)
- Handbook for HIV & STI Counsellors **(Chapter 18)**

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise: (PPT slides 1-3)

- Welcome the participants to the session, introduce the topic, and present the session objectives and expected outcomes.
- Conduct a 'Know your Trainees' exercise by asking the following questions (indicative list):

  a) How many of you have counselled children below the age of 10 years in the last three months?

  b) If you can recall, narrate your counselling experience (ask this question only to those who said yes to the first question)

  c) What is your understanding of child centered counselling?

- These questions will help you understand the group's experience and understanding of child centered counselling, which will help to steer the session.

Step 2: PPT Presentation (PPT slides 4-8)

- After the 'Know your Trainees' exercise, explain the following key points on child centered counselling with the support of the presentation:
  a) Challenges faced while counselling CLHIV
  b) Child-friendly ART centre
  c) Child-centric counselling

Step 3: Group Activity (PPT slides 9-11)

- After the PPT presentation, move onto discussing the disclosure of HIV status to children and their parents/guardians.
- Give a short introduction on disclosure of HIV status to children and parents/guardians and divide the participants into two groups for a debate (time 10 minutes):
  a) Debate topic: HIV positive status must be informed to the children who are below the age of 10 years.
  b) Give each group five minutes to prepare and five more minutes to present their arguments.
  c) One group argues against the statement and another group argues for the topic.
- After the debate, let the participants know that we will arrange the following questions in a sequence that will guide us in comprehending disclosure one step at a time. Explain that we will address these questions in the specified order. It's essential for participants to grasp that disclosure takes time and can't be completed in a single session. It's also important for them to recognize the main components of both partial disclosure and full disclosure.
  a) What is disclosure?
  b) Why should disclosure be done?
  c) When to start disclosure?
  d) Who is the right person to disclose to the child?
  e) To whom should the HIV status of a child be disclosed?
  f) How much information should we give the child during disclosure?
  g) How to disclose the HIV positive status of a child?
  h) What to do when the parents/guardians do not allow disclosure to the child?
  i) Parents/guardians say that they will disclose to the child later when the child gets older. What do you say?

Step 4: Counselling the parent/guardian and child (PPT slides 12-13)

Present the PPT and discuss on Counselling the parent/guardian and child: Treatment preparedness, adherence and follow-up counselling.

Step 5: Role Play (PPT slides 14-17)

·Following the presentation, divide the participants into three groups and give each group a case scenario to discuss and perform a role play. During the group discussion, make sure that they apply what they learnt during the presentation on child centered counselling and that it reflects in the role plays.

a) **Group I**: Tejas is six years old and comes with his mother to the ART centre but does not talk. He seems to be very sad but does not talk about it as it seems difficult for the child to put his thoughts into words.

b) **Group II**: Satish, a five-year-old boy lives with his grandmother in a village. The grandmother is very old and finds it difficult to take care of the house and the boy. But she does not admit this at the session with the counsellor at the ART centre. The boy does not seem to be clean and is always tired.

c) **Group III**: Rani is eight years old and her mother says that she gives a lot of trouble while taking her ARV medicines.

Step 6: PPT presentation (PPT slides 18-22)

- After the discussion, discuss about child abuse with the support of the PPT.
- After the discussion on disclosure, present Protection of Children from Sexual Offences Act, 2012.

Step 7: Concluding the session: Wind up the session with the summary of the session. **(PPT slides 23-24)**

- The estimated children living with HIV (CLHIV) in India are 69,808. Of these, about 90% have been infected through mother-to-child transmission during pregnancy, childbirth or through breastfeeding. The other 10% have acquired the infection through blood transfusion with HIV-contaminated blood, injections with contaminated needles, sexual contact /sexual abuse.

- Challenges Faced while Counselling CLHIV can be overcome by providing emotional support to both the child client and his/her caregivers. Counselling messages should be tailored as per child's age, developmental status, ability to understand HIV disease and treatment and his/her social circumstances.

- Counselling messages should be adapted to changing needs as the child grows older and progresses through various stages of child development. It is essential to identify the primary caregiver and a back-up secondary caregiver if the primary caregiver is not available.

- Disclosure of HIV status to a child is a continuous and progressive process. It is important that the disclosure be done by the caregiver, the role of the counsellor is to support this process. If the caregiver really cannot do it, then he counsellor can help to do it in the presence of the caregiver.

- Three types of disclosure: Initiating disclosure (Age 4 to 6 years) is done when the child is curious about the illness, Partial disclosure (Age 7 to 11 years) is done when the child is aware that the medicines are being taken for some chronic illness and Full disclosure (Age 12 and above) is done when the child can understand and cope up.

19

90 Mins

Counselling for Adolescents Living with HIV (ALHIV) and Adolescents at Risk

19.1 Learning Objectives

To train the participants to:

- Gain a detailed understanding on two distinct populations i.e., vertically infected adolescents and horizontally infected adolescents and challenges faced
- Understand key areas of counselling for adolescents living with HIV (ALHIV)
- Demonstrate skills required for working with adolescents during counselling

19.2 Expected Outcomes

At the end of the session, the participants will be able to:

- Explain what adolescent-friendly counselling services are
- Talk about how to address adolescent-specific challenges and issues

19.3 Suggested Training Methods:

MS PowerPoint presentation, discussion, demonstration, know your Trainees exercise

19.4 Materials/Preparation Required:

- Colour chart papers
- Markers (whiteboard and permanent)
- Case studies
- MS PowerPoint presentation **(#19)**
- Handbook for HIV & STI Counsellors **(Chapter 19)**

Facilitation Steps

Step 1: Introduction and 'Know your Trainees' exercise **(PPT slides 1-3)**

·Welcome the participants and introduce the topic, session objectives and expected outcomes with the help of the PPT

- Conduct a 'Know your Trainees' exercise by asking
  a) Who is an adolescent?
  b) How many of you believe that adolescents are vulnerable to HIV?
  c) How many of you have provided counselling to adolescents?
  d) What was your experience like when counselling adolescents?
- Summarize the exercise by noting that as counsellors, the participants may have interacted with adolescents as their clients. Often, counsellors report difficulties in working with adolescents, such as dealing with their emotions, conducting risk assessment counselling, taking consent from parents/guardians on behalf of an adolescent, disclosure of results.
- Assure the participants that the session will provide them with adequate information and skills to counsel adolescents.

Step 2: PPT presentation (PPT slides 4-16)

- Share information on the following with the help of the presentation slides:

  a) Basic information about adolescents
  b) Characteristics and challenges of two distinct populations i.e., vertically infected adolescents and horizontally infected adolescents
  c) Counselling needs and key areas of counselling for ALHIV
  d) Do's and don'ts of communication with adolescents
  e) Steps involved in the integrated management of adult illness (IMAI) approach to chronic HIV care with ART
  f) Strategies for Disclosing HIV Status to ALHIV

Step 3: Role play (PPT slides 17-23)

- Share information on the following with the help of the presentation slides:

  a) Divide the participants into four groups; four groups will discuss a question each for 10 minutes and each group will present their points to the larger group; the fourth group discusses a case scenario for 10 minutes and two persons from the group will perform a role play.
  b) Make sure that the information from the presentation is applied and discussed during the group discussions and presentations.

Group	Question/case scenario
Group – 1	What are the risks factors and what are the vulnerability factors that make adolescents susceptible to HIV?
Group – 2	How will you involve adolescents in counselling and what are the effective communication techniques you will use?
Group – 3	When do you involve parents in adolescent counselling and why?
Group – 4	Discuss and demonstrate adolescent counselling.

Step 4: Concluding the session (PPT slides 24-26)

- After the group activity, discuss referrals and linkages services for adolescents and other issues faced by them.
- Conclude the session with key messages of the session.

- According to WHO, Adolescents are individuals in the age group of 10–19 years and are in transition period from being children to adults.

- Counselling adolescents is neither like counselling children nor like counselling adults.

- Normalization can be used to reassure clients that feelings such as guilt and anger are common or normal reactions.

- Normalize feelings of shyness, anxiety, and embarrassment. Explain that it is common or normal to feel this way.

- Depending on the mode of acquisition of HIV, ALHIV may be classified into two distinct populations: Vertically infected adolescents and horizontally infected adolescents.

- Vertically Infected Adolescents likely to be in advanced HIV stage, have opportunistic infections (OIs), higher mortality rate and experienced multiple HIV related losses, whereas Horizontally Infected Adolescents are in earlier stage in HIV, less chances for OIs, Lower mortality rate and likely to lack familial, social and clinical support system.

- Common challenges faced by both vertically and horizontally infected adolescents are poor family and social support, non-acceptance of their HIV status, increased mental stress & risk of acquiring deviant and aggressive behaviour, stigma at school and workplace, Higher chance of hindered education and a greater risk of unwanted pregnancy.

- Mental Health Problems & HIV: There is a two-way relationship between HIV infection and mental health problems. ALHIV are more prone to develop mental health problems due to social stressors, lack of support structures and medications implication. Adolescents with mental health problems are more prone to acquire HIV, due to chances of engage in risky behaviours like unprotected sex and substance abuse.

- ALHIV demands counselling on Care and Treatment, Sex and HIV and Life skills and 5 As (Assess, Advise, Agree, Assist, Arrange) are called as integrated management of adult illness approach (IMAI) to manage chronic HIV care with ART in ALHIV.

- Key principles of communicating with adolescents are understand their interests, address their concerns, constructively respond to their feelings and help the adolescents with adherence to ART.

- Refer to them for additional supports required

- Ensure follow-ups

20

135 Mins

Newer Initiatives in NACP-V (SSK, OSC, CSS, Virtual Interventions)

20.1 Session objectives

To train the participants to learn about:

- Sampoorna Suraksha Strategy, key elements, target population, comprehensive service package and implementation plan through Sampoorna Suraksha Kendras (SSKs)
- One Stop Centres (OSC) under Global Fund Grant 2021-24 and various services provided to Transgender (T/G) Persons, Persons Who Inject Drugs (PWID), and Bridge Population (BP) typologies from OSC
- Objectives and implementing modalities of the Community System Strengthening (CSS) framework and community-led monitoring
- Understanding the need for interventions for the difficult to reach high risk groups and vulnerable population operating through Virtual Platforms

20.2 Expected outcomes

At the end of the session, the participants will be able to:

- Understand the relevance and importance of SSS and the functions of the SSKs
- Understand the client flow at SSKs and the service delivery packages and processes
- Understand the concept of OSC and comprehensive and tailor-made integrated service delivery provided through OSC
- Define the planning and implementation of CSS and conceptualize CLM
- Understand the various virtual intervention projects in India

20.3 Duration:

75 minutes (SSK) + 30 minutes (OSC) + 30 minutes (CSS) = 2 hrs 15 mins

20.4 Methodology:

Group discussions, ‘Know your Trainees’ exercise, Quiz and MS PowerPoint presentation

20.5 Material needed:

- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation (# 20)
- Handbook for HIV & STI Counsellors (Chapter 20)

Facilitation Steps

Sampoorna Suraksha Strategy (SSS)

Step 1: Open Session (PPT slides 1-3)

- Welcome the participants to the session and introduce yourselves if this is your first session of the training.
- Introduce the topic and the learning objectives of the session.
- Knowing your trainees will help you tailor your training (within the session's objectives) to their expectations, interests, learning styles, prior knowledge and experience on the topic of your session. Conduct the 'know your trainees' exercise at the beginning of the session by asking the participants the following questions:

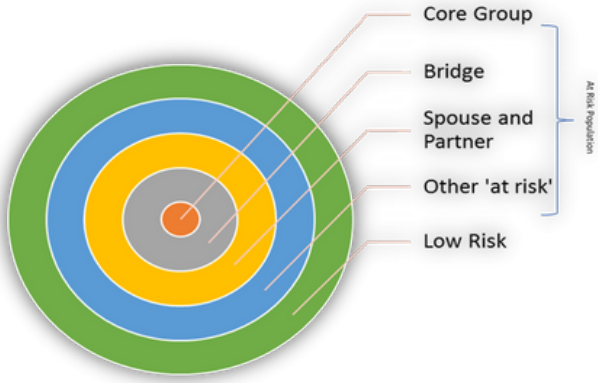
Note: The purpose of asking these questions is only to understand your trainees' knowledge and experience and thus do not get into discussion mode or correct the answers at this point of time. Let the flow of thoughts shared by the participants and note the response on the board. Towards the end of the exercise, tell them that the session will provide answers to all the questions.

1. Have you heard of SSS & SSK?
2. How SSS will contribute to prevent HIV infection?
3. Who does SSS cater to?
4. What is Sampoorna Suraksha readiness?
5. After having heard about the objectives of the session, what are your expectations from the session?

- Put the responses on the board/ flipchart and close the 'know your trainees' exercise and move on with the flow of the session.

Step 2: Demo session (PPT slides 4-7)

- After the 'know your trainees' exercise, draw a smaller circle and question what the circle signifies in the context of HIV/AIDS.
- And draw four more circles as given below and ask the responses from the participants what they think would be the population in each circle. Now explain the uncovered population falling under each group which will be covered through SSK. (A detail explanation will be given in the presentation).



- Following the responses, introduce and explain the concept of SSK utilizing the PPT presentation.
- At the end of the presentation, conduct group work or Quiz with the participants to determine whether they understood the SSK concept.

Step 3: PPT Presentation (PPT slides 8-21)

- Use the PPT presentation to explain the SSS/SSK to the participants

Step 4: Group Work (PPT slides 22-24)

- Divide the participants into three groups and assign them a topic each for the group discussion or Quiz contest.
  - o Group 1 – What are the benefits of establishing the SSKs and what services does the SSK provide?
  - o Group 2 – What are the roles and responsibilities of counsellors in the SSK?
  - o Group 3 – How SSS is helpful in addressing 95-95-95 and reaching out to the at-risk HIV negative clients?
- Allow 10 minutes for group discussion and give 3 minutes each for the group presentation.

OR

Step 4: Quiz

- Questions for Quiz towards the end but before the summary of the SSS session: (Answers are given in the annexure)
  1) How many SSKs are currently established under the programme?
  2) Name the facilities where SSKs are established (ICTC/ DSRC)
  3) What is the staffing pattern of SSKs?
  4) What is the roles and responsibilities of counsellors in the SSK?
  5) What are the 7 Risk assessment questions to be asked at SSK by the counsellor?
  6) What is the target population of SSKs?
  7) Give 3 benefits of establishing SSKs
  8) What you mean by comprehensive service package?
  9) Name 4 direct services and 4 indirect services given by SSKs
  10) What commodities can be given directly through SSKs?
  11) What is the client flow where DSRCs are re-modelled as SSK?
  12) What all activities are to be done through outreach?
  13) How many visits suggested for SSK Client for follow up? Tell the period also.
  14) What is the graduation criteria of at risk negative clients?
  15) Can the no. of client visits and duration of visits be changed? And by whom?
  16) How SSS is helpful in addressing 95-95-95 and reaching out to the at-risk HIV negative clients?

Step 5: Summarize the SSK session (PPT slide 25)

- At the end of the presentation/ Quiz result, facilitator summarizes the discussion points and ends the session.
- In case time is a constraint or a choice may be given to the group, the group work may be converted to Quiz session in 3 groups. 5 questions to each group and 16th question for tie up or as additional question for all 3 groups. Winning group members may be given some prize.

One Stop Centre (OSC)

Step 1: 'Know your Trainees' exercise (PPT slides 26-27)

- Present the objectives and outcome of the session and begin with a 'know your trainees' exercise on what they understand an OSC to be.
- Record their responses on the whiteboard/chart papers

Step 2: PPT Presentation (PPT slides 28-35)

- Use the PPT presentation to explain the following;
  a) Introduction to OSC
  b) Rationale and concept of OSCs
  c) Comprehensive Service Delivery Package
  d) Commodities
  e) OSC Service Delivery Model
  f) OSC Coverage

Step 5: Summarize the OSC session (PPT slide 36)

- Summarize the key points and conclude the discussion

Community Systems Strengthening (CSS)

Step 1: 'Know your Trainees' exercise (PPT slides 37-38)

- Present the objectives and outcome of the session and begin with a 'know your trainees' exercise on what they understand by asking a few simple questions on the expression 'community engagement' since most counsellors are likely to be familiar with it.
- Write the expression 'community engagement' on the whiteboard. Facilitate a participatory discussion by asking the following questions to the participants:
  - Who does the word community refer to in the context of the HIV/AIDS programme?
  - In what ways are the community members engaged in the HIV/AIDS programme?
  - What are the benefits of community engagement?
  - Any other questions…

- The facilitator summarizes the 'know your trainees' exercise by highlighting the following points:

  o The term 'communities' here refers to people who are living with HIV, People who inject drugs (PWID), Female Sex Workers (FSWs), Men who have Sex with Men (MSM), Transgender (TG) and Hijra, Young KP and People living with HIV.
  o The NACP recognizes the need of community engagement for the elimination of HIV/AIDS and related stigma and discrimination and to improve health care services.
  o The HIV prevention program is being implemented through Peer Educators (PE) specifically identified from the communities where non-governmental organization's function. These PEs from the community impart knowledge and skills to the community members at the grass root level on the HIV prevention initiatives of NACO.
  o Empowered members of the communities are members in the below-given community committees (that need to be functional) of the TI project:

    - Clinic/Health/STI committee;
    - Crisis committee;
    - DIC cum Ethical committee;
    - Condom committee;
    - Program Management and Finance committee

  o For more than two decades, apart from HIV prevention programmes, Community-based Organisations (CBOs) and Networks are also engaged in advocacy, reducing stigma and discrimination, enhancing treatment literacy, and ensuring greater involvement of communities in the decision-making process.

- After summarizing the community engagement, the facilitator writes the expression 'community system strengthening' on the whiteboard and tells that it is nothing but the community engagement that NACO has been doing for decades is currently being implemented in a more systematic manner under the banner of community system strengthening

Step 2: PPT presentation on the components of the CSS (PPT slides 39-44)

- The facilitator moves on to explain the key components of the CSS with the support of the MS PowerPoint presentation.

Step 3: Summarise the CSS session (PPT slide 45)

·Conclude the session by asking the participants a few random questions from the content covered during the session.
·Summarize the session with the summary points given in the PPT

Virtual Intervention (VI)

Step 1: 'Know your Trainees' exercise (PPT slides 46-47)

- Present the objectives and outcome of the session and begin with a 'know your trainees' exercise on what they understand by asking a few simple questions on the expression virtual or web- based platforms.
- Write the expression 'Virtual Population' on the whiteboard. Facilitate a participatory discussion by asking the following questions to the participants:
  - o What are the various virtual platforms that they have heard off?
  - o Are there persons on those virtual or web-based platforms who are at "high-risk" of acquiring HIV/STI?
  - o Why are they at high risk of acquiring HIV/STI?

- The facilitator summarizes the 'know your trainees' exercise by highlighting the following points:
  - o The virtual population includes all individuals using various social media and web-based platforms and dating applications for engaging in sexual and other activities known to increase risk of acquisition and transmission of HIV and STIs.
  - o 'Virtual Intervention' emphasize upon generating demand on HIV comprehensive services and strengthen linkages specifically for the higher at-risk population that pre-dominantly use virtual platforms for information, socialising, soliciting and other networking purpose.
  - o Aim of the intervention is to reach out to the key and vulnerable populations through Virtual Platforms including identification of their social and sexual networks through Virtual platform outreach and refer them to HIV prevention programs.

Step 2: PPT presentation on Virtual interventions (PPT slides 45-50)

- The facilitator moves on to explain the key components of Virtual Intervention with the support of the MS PowerPoint presentation.

Step 3: Summarise the VI session (PPT slides 51-52)

- Conclude the session by asking the participants a few random questions from the content covered during the session.
- Summarize the session with the summary points given in the PPT

• Summary Points for Sampoorna Suraksha Strategy (SSS)
• The Sampoorna Suraksha Strategy (SSS) intends to reach populations "At Risk" for HIV and STIs that are not connected to TI and LWS services and are potentially at risk of contracting the diseases.
• SSS is an approach designed to reach out to persons who do not self-identify as HRGs but are at risk
• The objective of SSK is to identify an individual who is at risk HIV negative and maintain their HIV and STI-negative status

- The SSS is being implemented through ICTCs and DSRCs, which are being remodeled into Sampoorna Suraksha Kendra's (SSKs).
- The SSKs will provide a full-service package under one roof, addressing the beneficiaries' total health needs.
- The risk assessment can also be used to determine whether or not the client is at risk. Furthermore, at-risk clients might be classified as low, moderate, or high risk.
- Coverage as per Phase I & II there are 150 SSKs in 150 Districts across 20 States, as of 2021 to 2024.
- Summary Points for One Stop Centre (OSC)
- One Stop Centers (OSCs) provides comprehensive HIV prevention-care cascade services in areas with low-level and concentrated HIV infections.
- OSCs provides prevention and care services to high-risk populations.
- OSCs promotes screening, referral, and linkage for HIV and other essential health services.
- Overall, there are 74 One-Stop-Centres (OSCs) operating throughout 64 districts in 25 Indian states.
- Summary Points for Community Systems Strengthening (CSS)
- Objectives of CSS is to identify and build the capacity of the communities, organizations, and networks
- Promotes meaningful involvement of communities in planning and implementation at the national and sub- national level.
- Community Resource Group (CRG) is to identify, understand, resolve, and address the community's concerns in each state.
- Community Champions are the local resource pool for their own community as well as for the National Programme to address the needs and issues
- Community led monitoring (CLM) mechanism is to gather, analyze and use information to improve access, quality and the impact of services.
- Summary points for Virtual Intervention
- Reaching out to high-risk groups operating on virtual/web-based platforms
- Defining the population operating on virtual/web-based platforms
- Expanded outreach strategy to reach out to the unreached population through digital technology
- The need to size estimation of the unreached high-risk population on virtual platforms
- Communication strategies tailored to this unreached population utilizing digital technology

21

45 Mins

Mobile Outreach Services

21.1 Learning objectives

To train the participants to understand:

- NACP services of last mile at risk /vulnerable / unreached population in underserved areas to minimise the gap of 95-95-95
- Intended Beneficiaries/Priority population for mobile outreach services
- Type of services to be provided through mobile outreach services
- Day to day operationalization of mobile outreach services

21.2 Expected outcomes

At the end of the session, the participants will be able to explain:

- Beneficiaries/Priority population for mobile outreach services
- Type of services provided through mobile outreach services
- Day to day operationalization of mobile outreach services
- Mobile outreach services contribution to reaching the last mile at risk /vulnerable / unreached population in underserved areas to minimise the gap of 95-95-95

21.3 Suggested Training Method:

MS PowerPoint presentation, 'Know your Trainees' exercise, group work, games, case studies

21.4 Materials/Preparation Required:

- Case studies print-outs
- Colour chart papers
- Markers (whiteboard and permanent)
- MS PowerPoint presentation **(# 21)**
- Handbook for HIV & STI Counsellors **(Chapter 21)**

Facilitation Steps

Step 1: Welcome note and 'Know your Trainees' exercise

- Welcome the participants and present the session objectives and expected outcomes.
- Conduct a 'Know your Trainees' exercise with the following questions:
  - In which of the NACP facilities, do you all work?
  - Had you ever been part of the mobile outreach activities?
  - Would a few of you please describe how you planned the mobile outreach activity and your overall experience?

Step 2: PPT presentation on the following areas (PPT slides 2-12)

- Beneficiaries/Priority population for mobile outreach services
- Type of services provided through mobile outreach services
- Day to day operationalization of mobile outreach services
- Mobile outreach services contribution to minimise the gap of 95-95-95

Step 3: Summary of the Session: End the session with the summary of the session (PPT slides 13-14)

- Objective is to increase access to basic NACP services of last mile at risk /vulnerable / unreached population in underserved areas to minimise the gap of 95-95-95

- Beneficiaries/Priority population are the HRGs/at-risk population/ prison & OCS in the vulnerable area who are at risk for HIV/STI/ Hep B/Hep C

- Type of services to be provided:
  - Comprehensive Prevention and treatment Services
  - Differential HIV Screening/Testing
  - HIV and STI treatment services

- SACS may select the districts for mobile outreach based on:
  - Districts with high prevalence, and new infections rate
  - Vast geographies and hilly terrain and limited public transportations
  - Where HIV screening at HWC/other NHM facilities not initiated/limited
  - Places suggested by at-risk clients/PLHIV and stakeholders
  - Semi-rural or rural locations where TIs services are not available

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- The DISHA unit will be responsible for operationalization of Mobile Outreach Services, supervision and monitoring of these units.

- Counsellor posted at the Mobile Outreach Van shall be responsible to ensure referral and follow ups of the clients.

22

30 Mins

Linkages and Referrals for PLHIVs & At-Risk Negative Clients

22.1 Learning Objectives:

To train the participants to learn:

- HIV/AIDS/STI related health services to which counsellors make programmatic linkages for the comprehensive health services to the clients
- The importance of social welfare and social protection for people living with HIV (PLHIV) and their families, including children affected by HIV and AIDS (CABA), and most-at-risk populations (MARPs)
- The role of counsellors in linking their clients including at-risk HIV negative clients to health and social welfare & protection programmes and schemes

22.2 Expected outcomes:

In this session, the participants will learn:

- The benefits of health systems for clients as well as for the effective implementation of the national programme.
- How to map the social welfare & protection services and their providers
- The need for networking with the PLHIV networks and other agencies who can facilitate linkages to social welfare & protection
- How to assess the needs of at-risk negative clients, PLHIV, CABA, their families, and MARPs, and provide relevant information on social protection

22.3 Suggested Training Method:

MS PowerPoint presentation, group activities. 'Know your Trainees' exercise

22.4 Materials/Preparation Required:

- Worksheet attached in Annexure 1
- MS PowerPoint presentation (# 22)
- Handbook for HIV & STI Counsellors (Chapter 22)

Facilitation Steps

Step1: Introduction and 'Know your Trainees' exercise (PPT slides 1-3)

- Split the participants into groups and assign them homework on the evening prior to the session. Ask them to complete the worksheet for mapping the services provided in the annexure 1 and to fill the sheet before coming for the next day sessions. The groups will have to map the social welfare & protection services/ programmes available in their districts and states, and the departments/ agencies that provide those services. Additionally, they will have to provide the local PLHIV network's point of contact and/or any NGOs/CBOs that can help with linkages to the services.

- Welcome the participants and present the session objectives and expected outcomes.
- Conduct a 'know your trainees' exercise with the following questions:
  - Districts with high prevalence, and new infections rate
  - Vast geographies and hilly terrain and limited public transportations
  - Where HIV screening at HWC/other NHM facilities not initiated/limited
  - Places suggested by at-risk clients/PLHIV and stakeholders
  - Semi-rural or rural locations where TIs services are not available

Step 2: PPT presentation (PPT slides 4-14)

- Move on to make a short presentation as an introduction to the topic of social welfare and protection.
- After the presentation, invite the groups to present their homework one by one (if the group presentations take more time, the facilitator can reduce the number of presentations. Help the participants by providing clarifications, if needed.

Step 3: Role play

- Next, invite two pairs of participants for role plays
  - The first pair will perform the role of a counsellor and the other that of a HIV positive client. The role play will focus on how open-ended questions can be asked to the client on social welfare and protection. The lead question can be: "What government documents you, your spouse/partner and children have?" Based on the response, ask specific questions related to the requirements of the client.
  - The second pair will perform of a counsellor and an at-risk HIV negative client. The counsellor explores the support required including to remain negative.
- Or, based on the diagram attached, conduct a quiz on referrals and linkages to health and psychosocial support.

Step 4: Concluding the session (PPT slides 15)

- Conclude the session by reminding the participants that they should have knowledge about where to refer their clients for availing other health services, social welfare and social protection schemes in their district/state. They should prepare a list of all the relevant schemes along with the details of each scheme, do service mapping including the point of contact details. They should also know how to process of referral and linking the clients to the requisite departments offering the schemes, develop referral mechanism and reporting.

- Referrals and linkages health services are the connections between different health facilities that offer various services for PLHIV and their families, such as care and support, STI treatment, TB prevention and treatment, maternal and child health, and positive people's network.

- These services aim to provide comprehensive and holistic care for PLHIV and their partners, At Risk Negative including prevention, diagnosis, treatment, counselling, support, and legal aid.

- Counsellors should be aware of the services available at each facility and guide clients appropriately to access them.

- Counsellors should also coordinate with other service providers and follow up on the referrals and linkages.

- PLHIV and their families face poverty, stigma, and exclusion due to HIV and need social protection to cope and live with dignity.

- Social protection for HIV includes policies, schemes, and legislations that help mitigate the impact of HIV and reduce vulnerability.

- The Indian government offers various welfare schemes for the poor and deprived, including PLHIV, CABA, MARPs, and tribals, to support their livelihood and rights.

- The schemes are implemented by different ministries and departments at the central and state levels, such as rural development, social justice, tribal affairs, agriculture, etc.

- The schemes provide direct benefits such as food, education, health care, disability assistance, skill development, etc.

- Counsellors are expected to develop a booklet/ resource directory that has central and state-specific schemes being implemented in their districts which can help PLHIV and at-risk negative clients to access them.

23

30 Mins

Breaking Silos – Counselling Needs and the ToR of the NACP Counsellors

23.1 Learning objectives

To orient the participants on:X

- Counselling needs
- Breaking the silos in the context of NACP-V
- Revised ToR for counsellors in NACP-V

23.2 Expected outcomes

At the end of the session, the participants will be able to:

- Gain an understanding of the range of counselling needs in the context of the NACP
- Learn about the synergies between the different components of the NACP and other national health programmes
- Learn about the terms and conditions for working as a counsellor in the NACP

23.4 Suggested Training Method:

'Know your Trainee' exercise and MS PowerPoint presentation

23.5 Materials/Preparation Required:

- Markers (whiteboard)
- MS PowerPoint presentation (#23)
- Handbook for HIV & STI Counsellors (Chapter 23)

Facilitation Steps

Step 1: Introduction and 'Know your Trainee' exercise (PPT slides 1-3)

- Welcome the participants and present the session objectives and expected outcomes.
- Conduct a 'Know your Trainee' exercise by asking the participants what the need for counselling is in general and specific to HIV testing.

Step 2: PPT presentation on the need for Counselling (PPT slides 4)

·Discuss the need for breaking the silos and building synergies to promote coordinated actions.

Step 3: PPT presentation on the Revised ToR (PPT slides 5-14)

- Move on to providing the context to the revised ToR for counsellors in the NACP by explaining the need for breaking silos and building synergies which is one of the guiding principles of NACP-V.
- Since the Sampoorna Suraksha Strategy (SSS) is the first step towards breaking the silos and building synergies, counsellors are expected to have at least the basic information on SSS.

- Explain the counsellor's role – the NACP anticipates that all counsellors will be equipped with the same ToR and perform their duties in facilities wherever their services are needed.

Step 4: Summary of the Session:

- Clarifying questions about the new ToR and handing over copies of the ToR to all the participants.
- End the session with the summary of the session

- One of the principle strategies adopted under NACP V is "Breaking the Silos and build the synergy"

- Keeping this in line, a common ToR for all the NACP counsellors have been prepared for all the programmes and facilities

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- The inter-dependency of NACP related services makes is crucial and essential for a counsellor to understand and be knowledgeable about those services to be able to refer the clients for appropriate services.

- Counselling services help in achieving the objectives of NACP, 95:95:95 goal, universal access to quality STI/RTI services to vulnerable/at-risk populations and attaining the elimination of vertical transmission of syphilis.

- Counselling is a two-way process where both counsellor and client play an active role to empower the client to take their own decisions.

- ·Counselling can be beneficial for people of all ages and backgrounds expecting to manage their struggle with anxiety, depression, trauma, abuse, grief or loss and dealing with problems and conflicts.

- Both pre-test and post-test counselling are important for the better understanding and implications of the result.

- Counsellors adopt the principle of empowering clients to take their own decisions by facilitating the exploration of available options and identifying the best suitable solution in their unique framework.

- Respect, acceptance, non-judgemental attitude, and empathy are the essential counselling skills.

- Counselling and follow-up services for 'at-risk' non-reactive/negative clients, provided with information and materials, will help them remain HIV-negative.

24

30 Mins

Data Safety and Management at Facilities under NACP

24.1 Session objectives

To train the participants to learn about:

- Definition of 'HIV-related information' and 'Protected person' under HIV and AIDS (Prevention and Control) Act, 2017
- To understand the composition and role and responsibility of Data Management Committee at NACP Facilities
- To understand the different data protection measures at NACP Facilities
- Data sharing and monitoring of shared data at NACP Facilities
- To understand the dos and don'ts related to NACP Data Management
- Role of counsellor in NACP Data Management

24.2 Expected outcomes

At the end of the session, the participants will be able to:

- Understand data protection measures at facility level and dos and don't for NACP data management and sharing.
- Understand role of counsellor in overall data management at NACP facilities

24.4 Methodology:

MS PowerPoint presentation, conducting 'Know your Trainees' exercise sessions based on real-life scenarios

24.5 Material required

- MS PowerPoint presentation **(#24)**
- Handbook for HIV & STI Counsellors **(Chapter 24)**

Facilitation Steps

Note: The facilitator is expected to have clear knowledge on the basic definitions under HIV and AIDS (P&C) Act, 2017, SOPs of NACP Data Management and NACP Data Sharing of NACO and role of counsellor in overall data management at NACP facilities.

Step 1: Welcome note and 'Know your Trainees' exercise: (PPT slides 1-4)

- Welcome the participants and present the session objectives and expected outcomes.
- Conduct a 'Know your Trainees' exercise with the following questions:
  - In which of the NACP facilities, do you all work?
  - What are the records with type (electronic and physical records) do you maintain in your facility?
  - Data flow at the centres e.g., from one facility to your facility and from your facility to other facility with purpose

- Mechanism of data/record sharing procedures followed at your centre
- Importance of confidentiality of data
- Different type of storage of data at the facility
- List of other organisations working closely with your centres and their data requirement for day-to-day activities how you will facilitate smooth data flow and restricting unauthorised data sharing

Step 2: PPT presentation (PPT slides 5-14)

- Discuss the session with the help of PPT presentation

Step 3: Activity of Confidentiality and Trust (PPT slides 15)

- Before summarizing the session, conduct the game of Confidentiality and Trust
  - The facilitator requests participants to sit in a circle and informs them that this is a game of trust
  - S/he asks the participants to think of a secret that they do not want anyone to know about and write it in a piece of paper, fold the paper and keep it with themselves
  - Now, the facilitator asks the participants to pass the paper to the person on the left
  - The facilitator asks the participants to share what they feel when their secret is on someone else's hands
  - The facilitator then asks the papers to be returned to the concerned person
  - S/he then generates a discussion around the following:
    - What does the game tell us about confidentiality?
    - What kinds of things might people share that we must keep confidential?
    - What are the likely consequences of breach of confidentiality?

Step 4: Summary of the Session: End the session with the summary of the session (PPT slides 16)

- The HIV and AIDS Act, 2017 directs every facility keeping records of HIV infected and affected population is protected and confidentiality is maintained.

- DMC should be formed at each facility and which is responsible to ensure data security.

- Consistently monitor data access and security, and in case of any concerns or data breach, proactively report them to the Data Management Committee or the Head of the Institution.

- Client records are intended to ensure continuity and quality of service delivery

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- Reporting reflects the overall service provided and helps to make decisions.

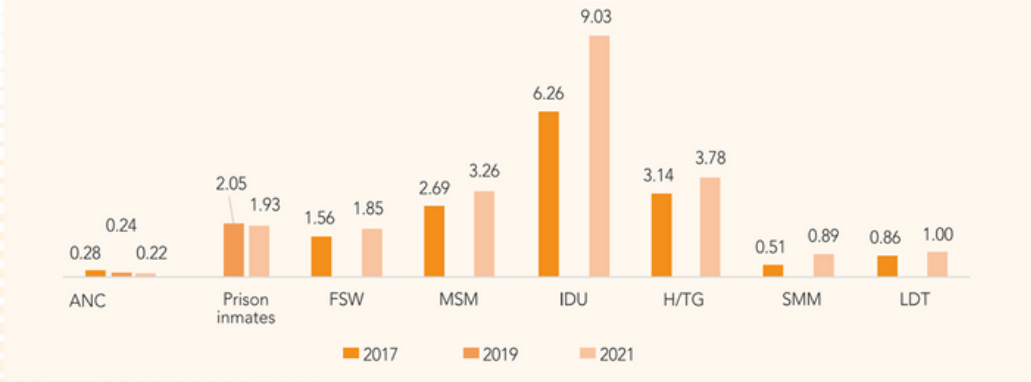
ANNEXURES

Annexure 1: Chapter 3

3.1 HIV epidemic by High-risk groups

In 2021, the 17th round of HSS was implemented across eight population groups comprising pregnant women, FSWs, Hijra/Transgenders (H/TG), MSM, IDU, Prisoners, single male migrants (SMM), and long-distance truckers (LDT). HIV prevalence among high-risk groups and bridge population remains very high. HIV prevalence (in %) by population group in last three rounds is given below:

Figure 3.1: HIV Prevalence (%) by different population groups



(Reference: Sankalak 2021, fourth Edition)

Figure 3.1: HIV Prevalence (%) by different population groups

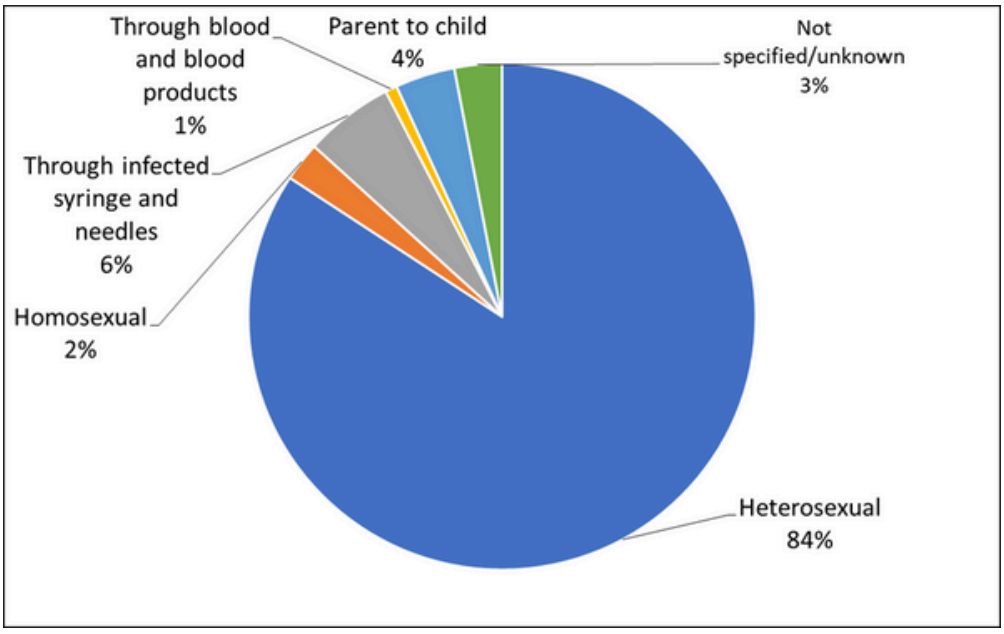
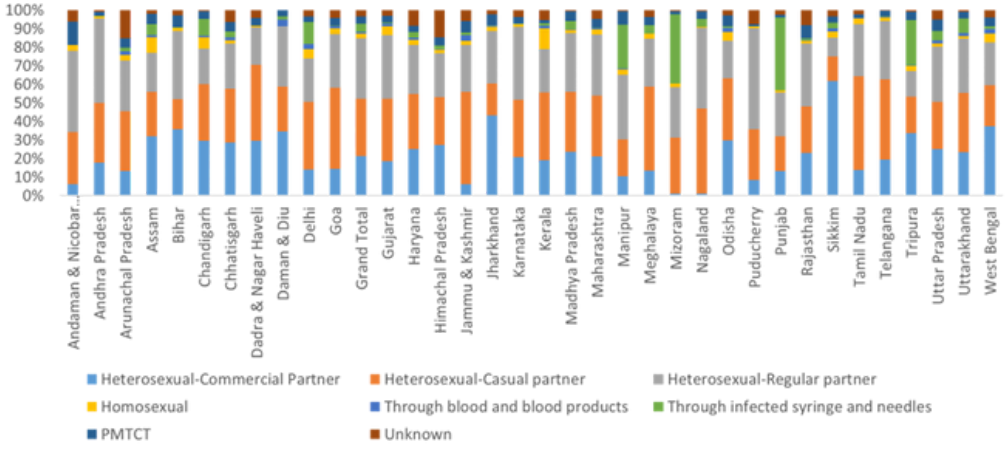


Figure 3.1: HIV Prevalence (%) by different population groups

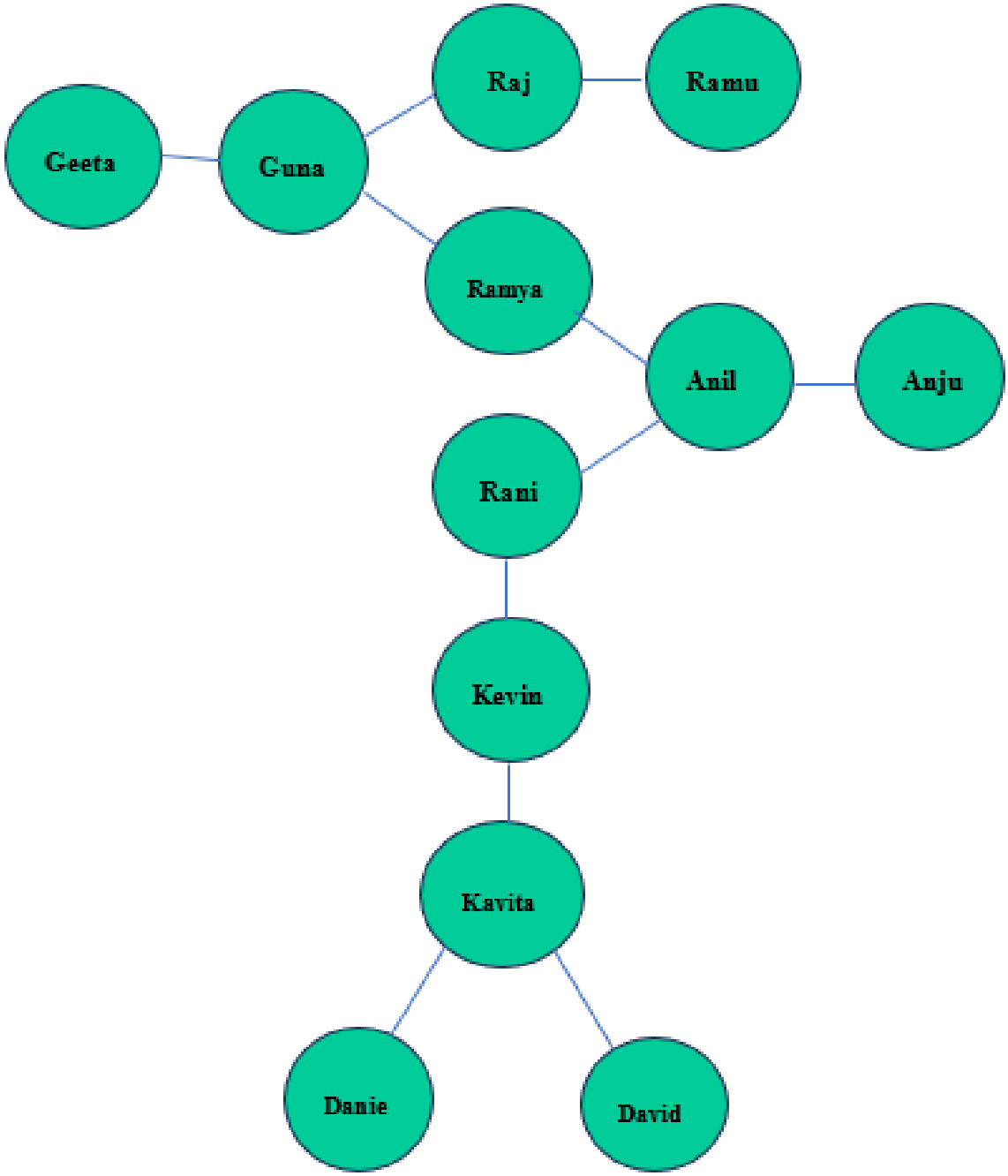


3.2 Multiple Partners

Multiple sexual partnerships are a major driver of the HIV epidemic.
Multiple partnerships can be **concurrent** or **sequential**. A concurrent partnership occurs when someone initiates a new sexual relationship before a previous sexual relationship has ended, so the relationships overlap in time. In contrast, a sequential sexual relationship occurs when a person completely stops having sex with one partner before starting sex with another. But both the practices pose the risk of contracting HIV and STIs.
In **concurrent sexual practices**, even when people have a few sex partners – for example, only two – new HIV infections might still be transmitted broadly and rapidly. If a person becomes infected with HIV by his or her first sex partner, then he or she may pass it on quickly to a second partner. And that partner in turn may pass it on quickly to his or her second partner and so on. As a result, concurrent relationships increase the number of people who are connected in what is called a “sexual network.” The term “sexual network” can refer to anyone connected through a sexual relationship, past or present: every partner you have had, and all of their past and present partners, are connected in one sexual network.

Figure 3.4 illustrates a sexual network. Anil has three sex partners, but two of those partners, Ramya and Rani, have additional partners. Beyond Ramya and Rani, several other individuals also have concurrent partnerships. When many people are engaged in concurrent partnerships, the sexual network expands much further. If Anju were HIV positive, the virus could enter the network and quickly spread from one person to the next, ultimately infecting all 12 people. However, if Anil were having sex with only Anju, the virus would be contained within the couple.

Figure 3.4 Sexual Network



In contrast, when people engage in sequential partnerships, HIV transmission occurs differently. For example, if someone has only two sequential sex partners during an extended period of time, he or she might be infected by a second partner; however, he or she is no longer having sex with the first partner, and therefore can no longer infect that first partner. As a result, having sequential partners instead of concurrent partners can markedly reduce HIV transmission. Still, having more than one partner, regardless of the pattern, increases one's risk of acquiring HIV.

The details regarding transmission of HIV/STI in the context of Substance/drug use is mentioned in a separate chapter 6: Substance Use in the context of HIV/AIDS.

3.3 Changing Pattern of Networking/ Solicitation - HRGs or Other at-risk population operating through Virtual platform.

With the advent of mobile and newer communication technologies, the patterns of sex work have also changed and evolved. Mobile phones act as a tool for networking and soliciting.

- The NACO study in 2019 in Andhra Pradesh, Delhi, Kerala, Maharashtra, Manipur, Punjab, Tamil Nadu, and West Bengal by TISS found that significant numbers of SWs (20.9%) are now exclusively doing internet-based solicitation by using various social media apps including WhatsApp, Facebook, sex escort sites, etc; 21% of SWs practice traditional form (street-based, brothel-based, lodge-based, dhaba-based, home-based and highway-based sex workers); 14.3% follow non-technology-based solicitation. WhatsApp is also used to communicate with and share pictures with clients.
- The IHAT study in the year 2014-15 in Delhi found that 70% network-based SWs are below the age of 22 years. Of these, 65% are unmarried, earning members of their family. 80% are literate and accustomed to the use of smart phones and apps.
- Similarly, the MSM population are also using virtual platforms for solicitation and they are all the more becoming unreachable by the traditional peer led approach, as they are congregating less at physical hotspots/locations to meet sexual partners.
- The findings indicate that significant number of MSMs are operating exclusively in the virtual space and therefore the estimates from the physical hotspots are likely to under estimate the MSMs in the state.
- The change in the sex work pattern from geographical to virtual networks leads to many program level implications in TI.
- Less visibility of SWs and MSM in hotspot has become a challenge in the traditional hotspot-focused peer-led outreach model.
- More and more young SWs and MSM are operating through mobile phones and since they become most difficult group to reach through TI program, they are likely to get infected with HIV by far quicker.

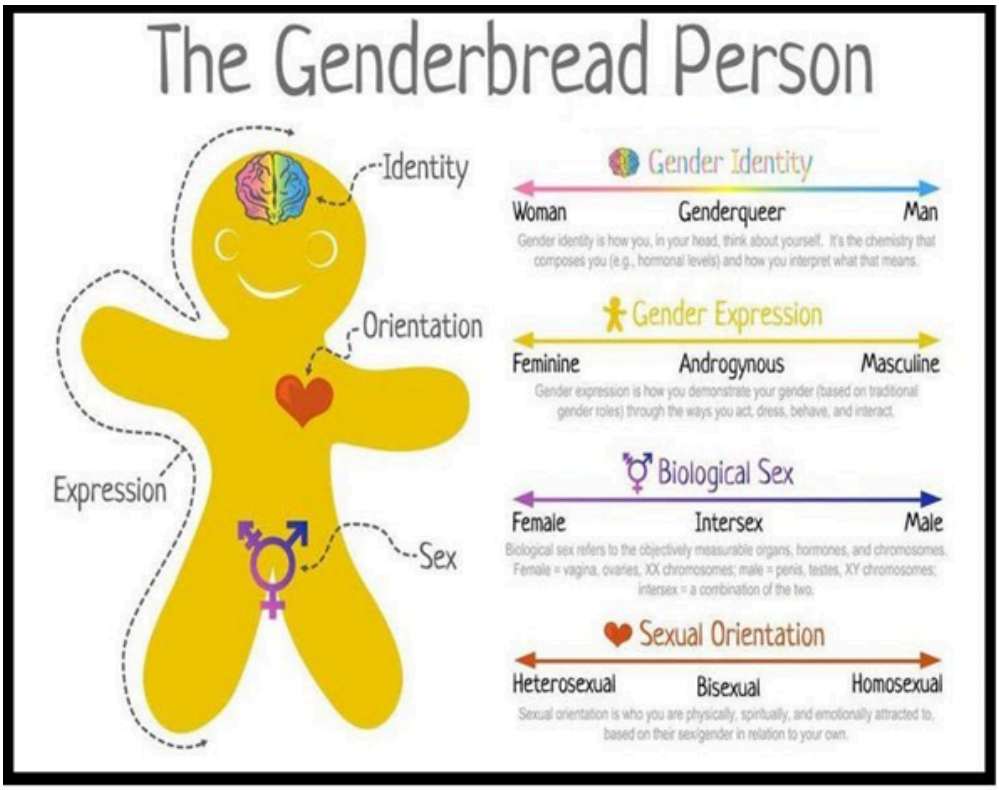
3.4 Sexual Orientation: Sexual orientation is about who you're attracted to and who you feel drawn to romantically, emotionally, and sexually.

Types of sexual orientation:

- **Heterosexual:** An individual who is sexually attracted to people of sex other than their own and/or who identifies as being heterosexual.
- **Homosexual:** An individual who is sexually attracted to people of the same sex as their own, and/or who identifies as being homosexual
- **Lesbian:** A woman who is sexually attracted to other women and/or identifies as a lesbian.
- **Gay:** A man who is sexually attracted to other men and/or identifies as gay. This term can also be used to describe any person (man or woman) who experiences sexual attraction to people of the same gender.
- **Asexual:** An individual who is not sexually attracted to other individuals.

- **Bisexual:** identity corresponding to significant (not necessarily equal) attraction to more than one gender.
- **Pansexual:** Similar to bisexual, sometimes used to denote identity corresponding to attraction INDEPENDENT of gender

Sexuality: Sexuality is not about who the person has sex with, or how often he/she have it. Sexuality is about someone's sexual feelings, thoughts, attractions and behaviors towards other people. Sexuality is diverse and personal, and it is an important part of someone's personality. Discovering own sexuality can be a very liberating, exciting and positive experience. However,

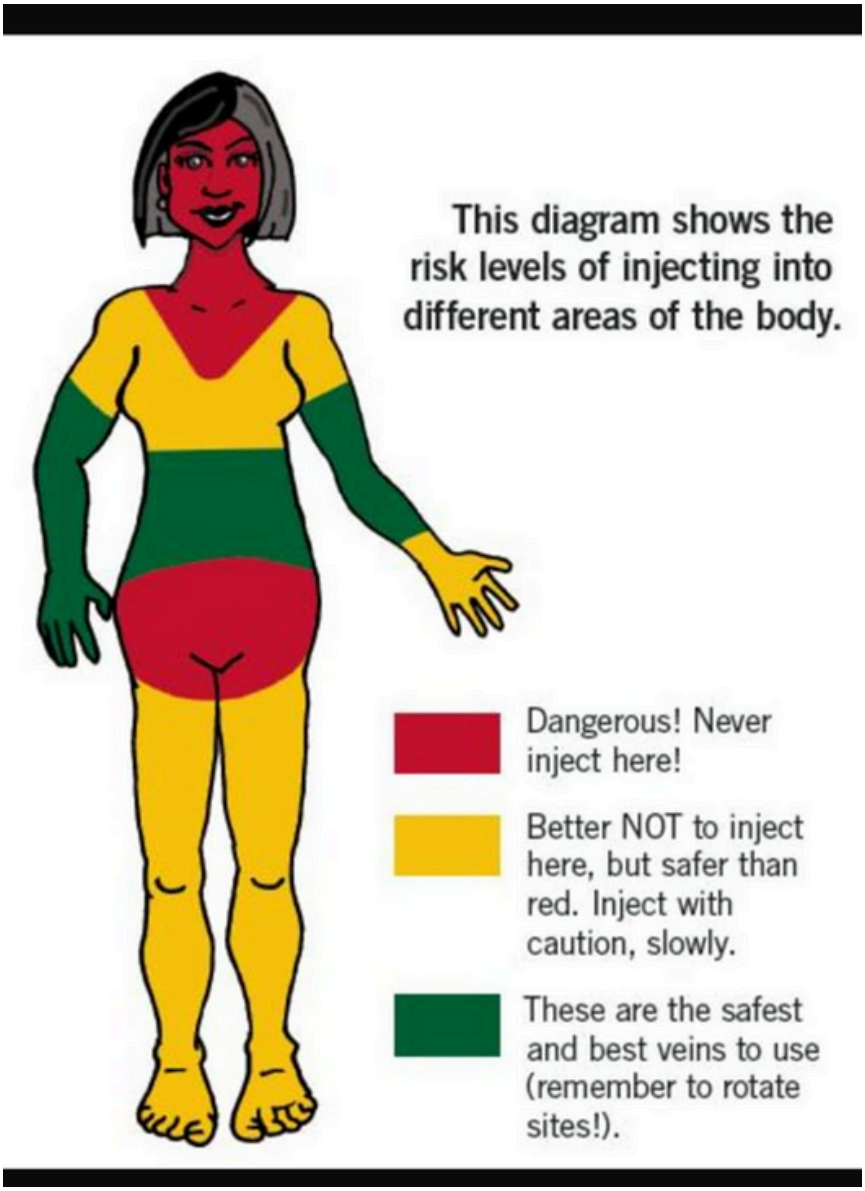


Human sexuality = Sexual behavor + Sexual identity + Sexual orientation.

Annexure 2: Chapter 6

a. **Dangerous sites for injecting**

- Groin veins
- Neck veins
- Veins on the face
- Veins of the hand and legs
- Breast veins
- Penile veins



b. Differentiating an artery from vein

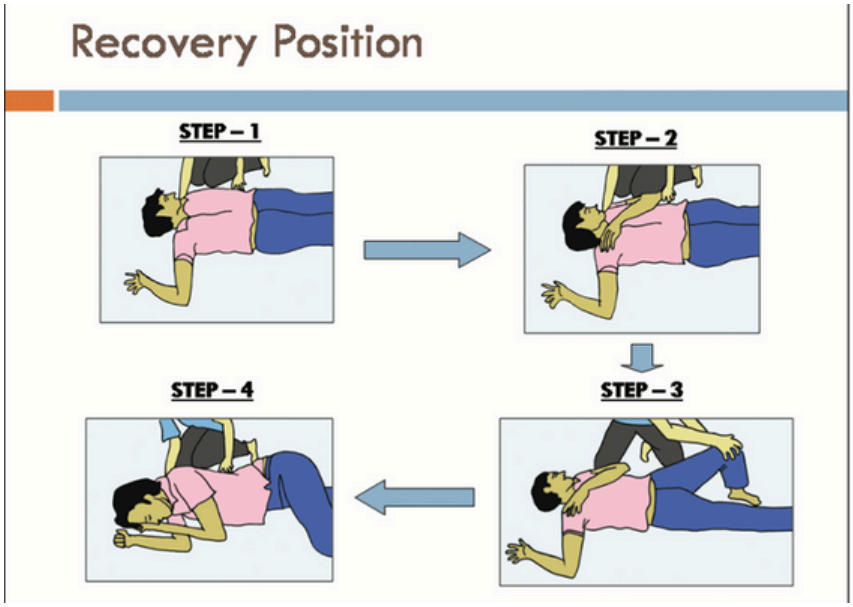
c. Vein care techniques

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

Annexure 3: Chapter 6

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

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



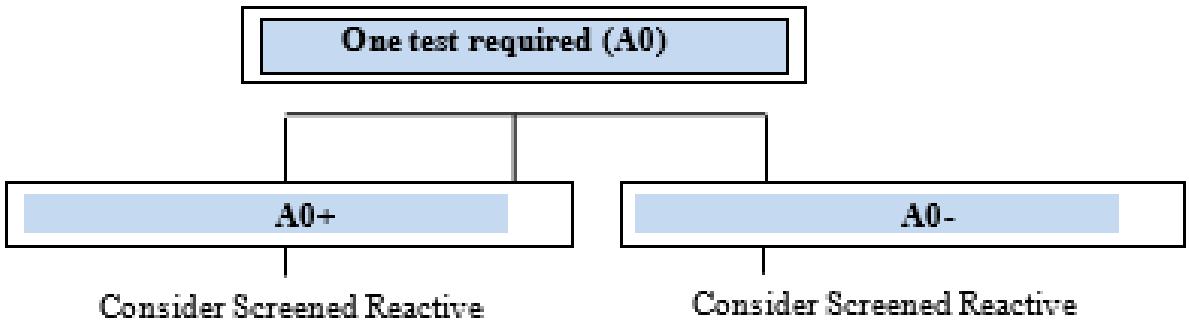
Explain to the participants that the following points need to be kept in mind during overdose management:

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

Annexure 2: : Chapter 7: Strategies for HIV testing

Strategy I

Single test (enzyme-linked immune sorbent assay [ELISA] or rapid) is recommended for screening of donated blood in blood banks. If found reactive for HIV, the donated blood should not be used for transfusion or transplantation, and after informed consent, the donor should be promptly referred for confirmation of the HIV diagnosis at the nearest HCTS confirmatory site for further confirmation and linkage to the cascade of treatment and care services.

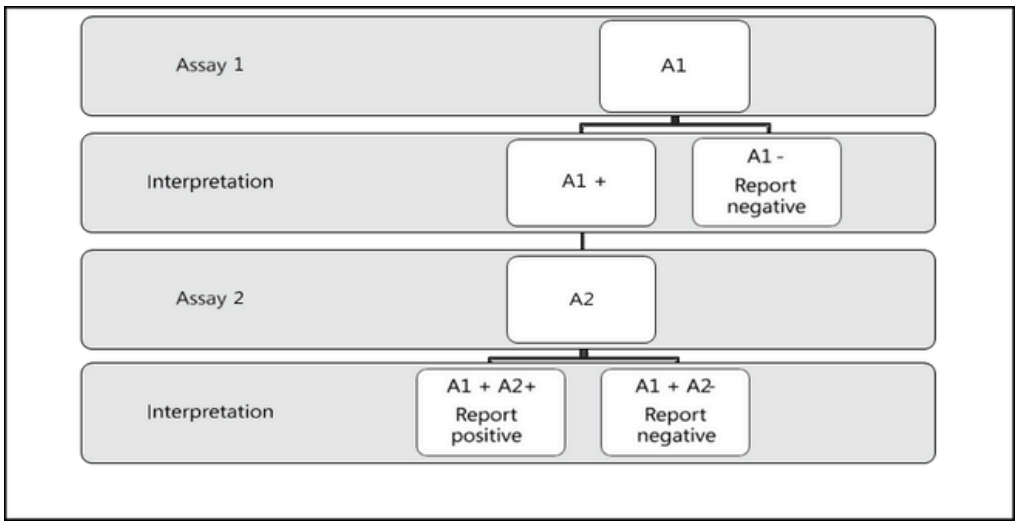


Strategy II(A)

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

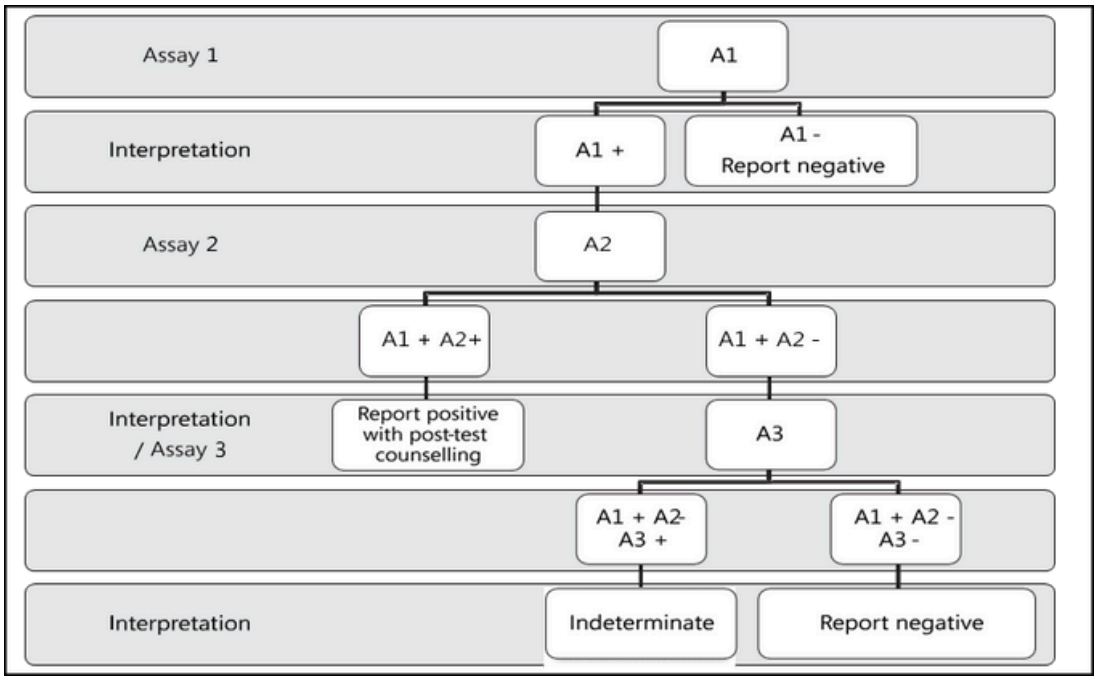
Strategy II(A)

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



Strategy II (B)

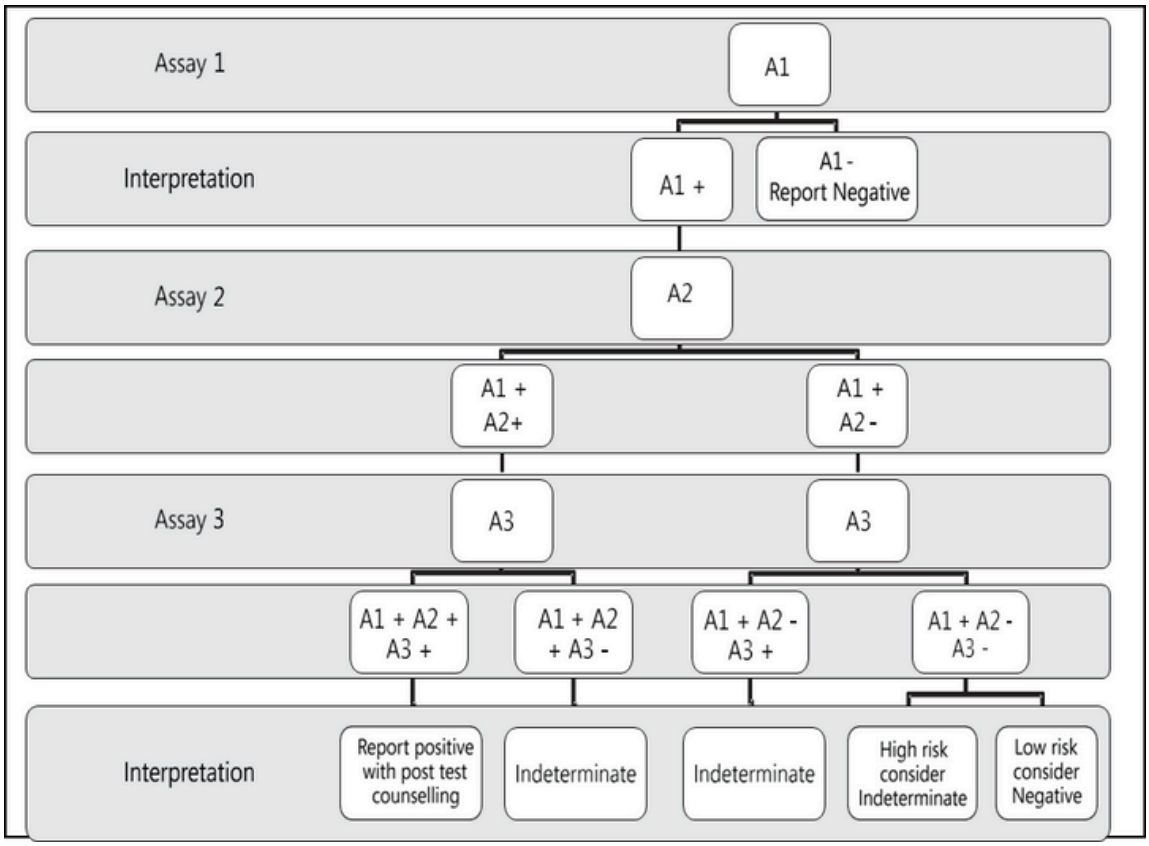
A patient who is clinically symptomatic and suspected to have an AIDS indicator condition/disease should be tested at HCTS confirmatory site twice using kits with either different antigens or principles. The patient is declared HIV-negative if the first test is non- reactive and as HIV-positive when both tests show reactive results. When there is discordance between the first two tests (first reactive and the second non-reactive), a third test is to be done. When the third test is also negative it is reported as negative. When the third test is reactive, it is to be reported as indeterminate and the individual is retested after 14 –28 days.



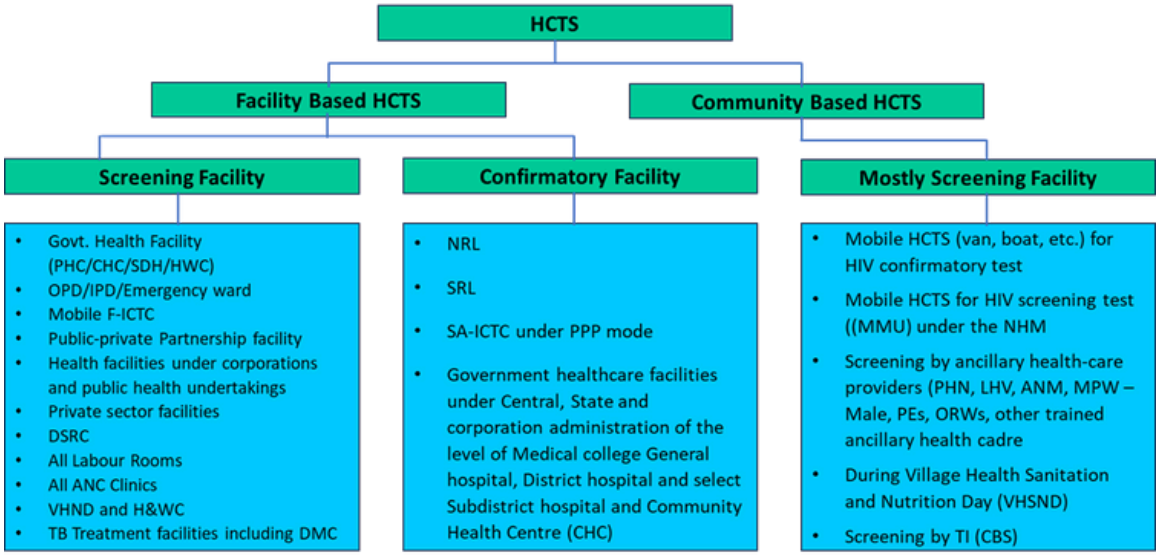
Strategy III

Screening is done at F-ICTC/CBS/VHSND using a single rapid test kit. If the test is found non-reactive, the individual is to be considered HIV-negative and needs to be followed up if the patient is high risk. If the test result is found reactive, the individual should be promptly referred for confirmation of the diagnosis at the linked HCTS confirmatory site and further cascade of services.

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



Annexure 5: Chapter 7: HIV counselling and testing services under NACP



Facility-based HCTS: Facility-based HCTS (screening or confirmation) are offered to individuals accessing health-care facilities functioning of the institution where the HCTS facility is located.

Community-based HCTS: Community-based screening (CBS) is an important approach for improving early diagnosis, reaching first time testers and people who seldom use clinical services, including men and adolescents in high-prevalence settings and HRG populations. To improve HCTS access and coverage, community-based HIV screening is carried out through various approaches such as:

Mobile HCTS: There are two types of mobile HCTS:

- **Mobile HCTS for HIV confirmatory test:** A mobile HCTS confirmatory site is a vehicle (van, boat, etc.) with facilities to conduct HIV testing and counselling services, and regular medical and ANC check-up. The mobile HCTS confirmatory site should function as per the prescribed norms and standards of the HCTS confirmatory site. All HCTS functions should be as per the prescribed standards for and HCTS confirmatory site.

- **Mobile HCTS for HIV screening test:** As per the MoHFW/GoI decision, the existing mobile medical units (MMU) serving hard-to reach areas under the NHM should be leveraged as mobile F-ICTCs, as per the prescribed norms, for conducting HIV screening services (pre-test counselling, informed consent, HIV screening test and post-test counselling) in addition to routine activities. All HCTS functions should be as per the prescribed standards for an F-ICTC.xMain functions of this mobile HCTS confirmatory site are to Mobilize pregnant women and vulnerable populations in the community through networking with community volunteers, field level government health functionaries, self-help groups, NGOs/Community-Based Organizations and HRGs and PLHIV community networks. The mobile ICTC can also be leveraged for the promotion of IEC for HIV/AIDS, condom and other commodity distribution, dispensation of ARV in remote areas and OST dispensation to the peripheral areas. The mobile ICTC can be combined with the general heath camp to provide the range of services to the people who are residing in far flung areas.

Screening by ancillary health-care providers:

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

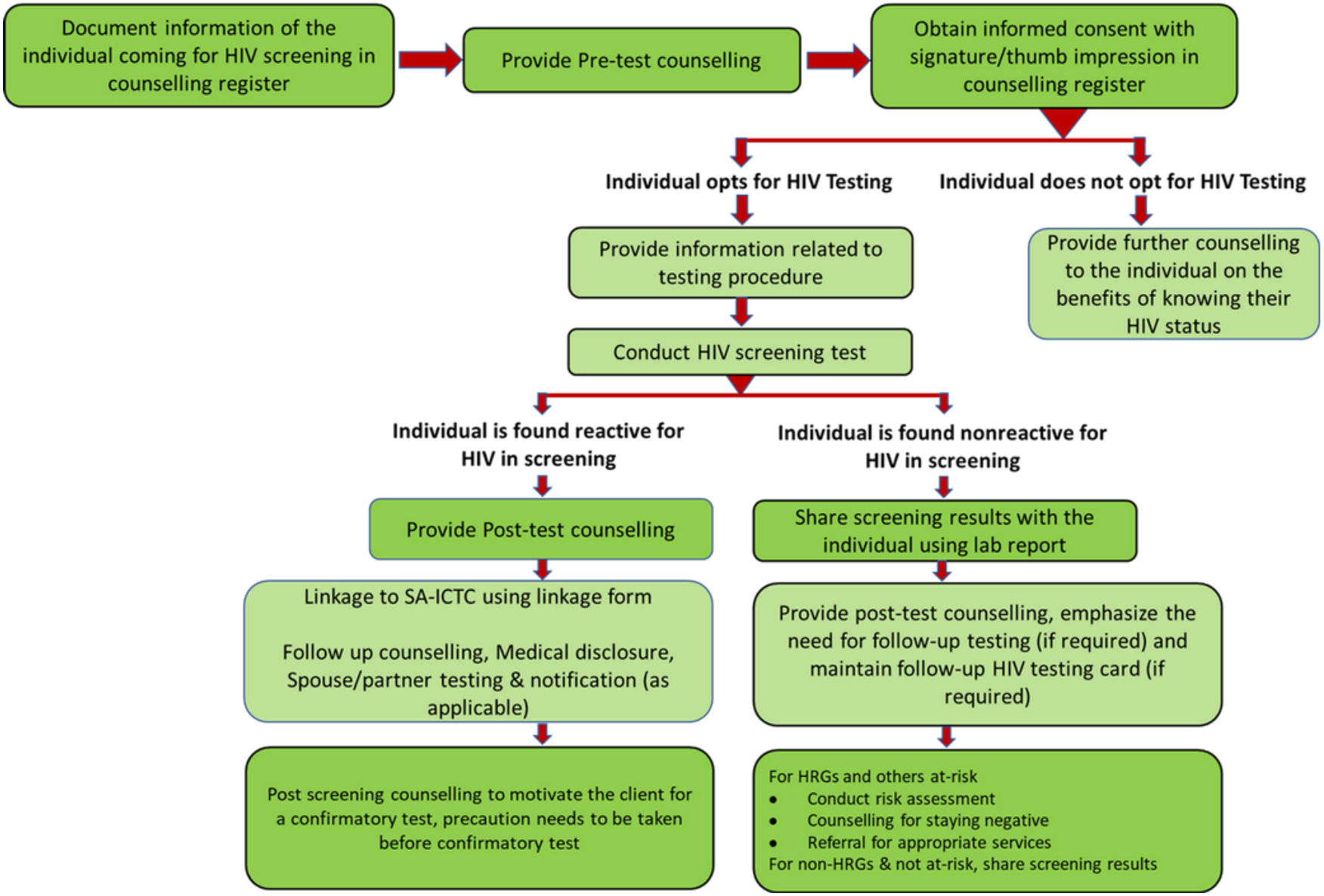
- Public health nurse (PHN)
- Lady health visitor (LHV)
- Auxiliary nurse midwife (ANM)
- Counsellor
- Pharmacist
- Multipurpose worker (MPW)-male
- Peer educator (PE)
- Outreach worker (ORW)
- Other trained ancillary health cadre

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

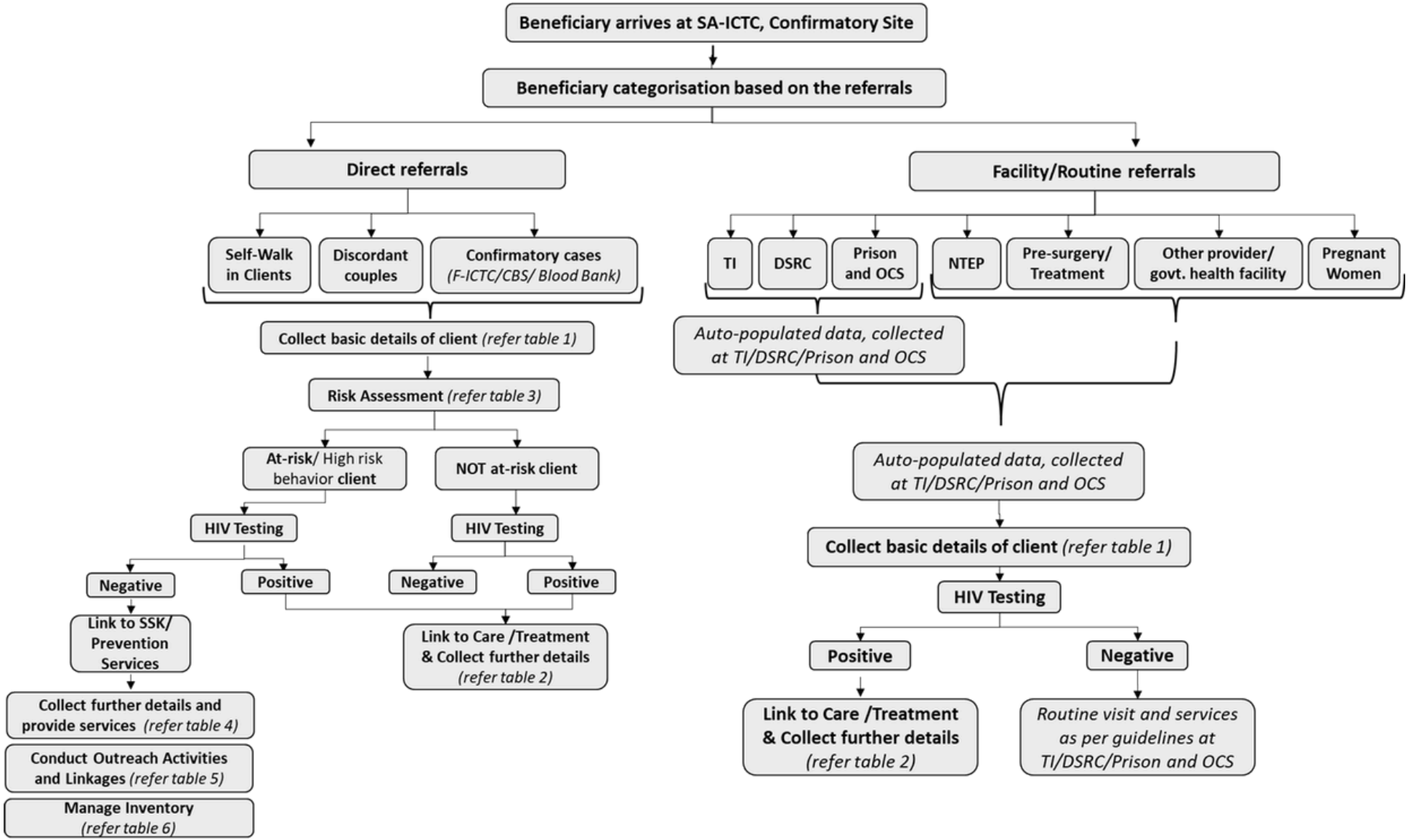
Annexure 6: Chapter 7
Flow of Activities at HCTS Facility: The following two flow charts explain the flow of clients at HCTS screening and the confirmatory facilities.

The recommended flow will be helpful in two key ways: first, individuals who are engaging in risky behaviour but are unaware of their status will be screened for "risk assessment," and second, those who are tested negative will be linked to appropriate services to help them to stay negative. In order to ensure this, the counsellor must have enough time to devote to these "at-risk" clients and adhering to the suggested client-flow patterns is highly important.

Process flow for HIV screening at the HCTS Screening facility



Client Flow at HCTS confirmatory facility



Annexure 7: Chapter 10: Condom negotiation

This is a dialogue between two parties who agree to a common logical solution. Just as there are negotiations between father and mother on what to buy for home, negotiations between children on which TV channel to watch, or negotiations in an office between the staff and the HR manager on salary levels, there can be negotiations between an FSW and her clients on using condoms.

For successful negotiation, the following points are essential:

- Communication is the backbone of negotiation. The way you communicate decides the fate of the negotiation.
- It involves identifying non-verbal cues, using the right words, and expressing your thoughts in a compelling and engaging way.
- Often, negotiators are active listeners that help them understand the other party's message.
- Negotiation is not about what you say; it is more about how you say it. Therefore, it is imperative to speak confidently to make the other party believe that your solution is beneficial. Lack of confidence and self-assurance could result in negotiation terms that are more beneficial for the other party.

How to say NO to unsafe sex?

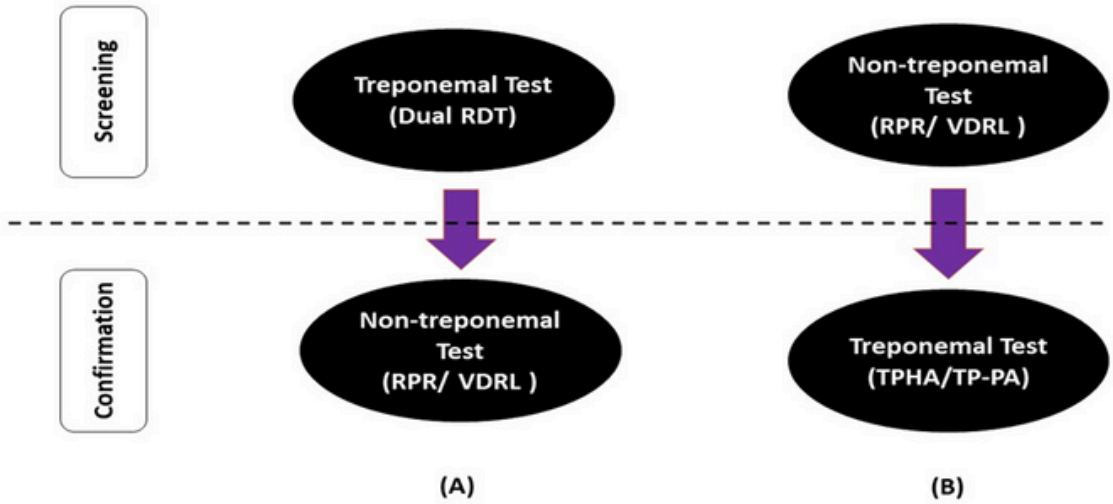
There are five steps during condom use negotiation which will help say NO to sex without condoms in ways that work:

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

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

Annexure 8: Chapter 11: Diagnostic Algorithm for Syphilis

The diagnostic algorithm for syphilis is presented in Figure 1.



Algorithm A: Reverse Algorithm; Algorithm B: Traditional Algorithm

Note:

1. While RPR is the screening test. However, it will act as a confirmatory test when the screening test is Dual RDT kits.
2. The RPR titre value is important for treatment monitoring. The RPR titres should be repeated after 3 months to check whether the treatment was successful.
3. If the titres are stagnant or increasing after 3 months of treatment, the treatment failure may be suspected.

The patients can be treated using Injection benzathine penicillin G or Kit 3 or Kit 4 as per the stage of syphilis.

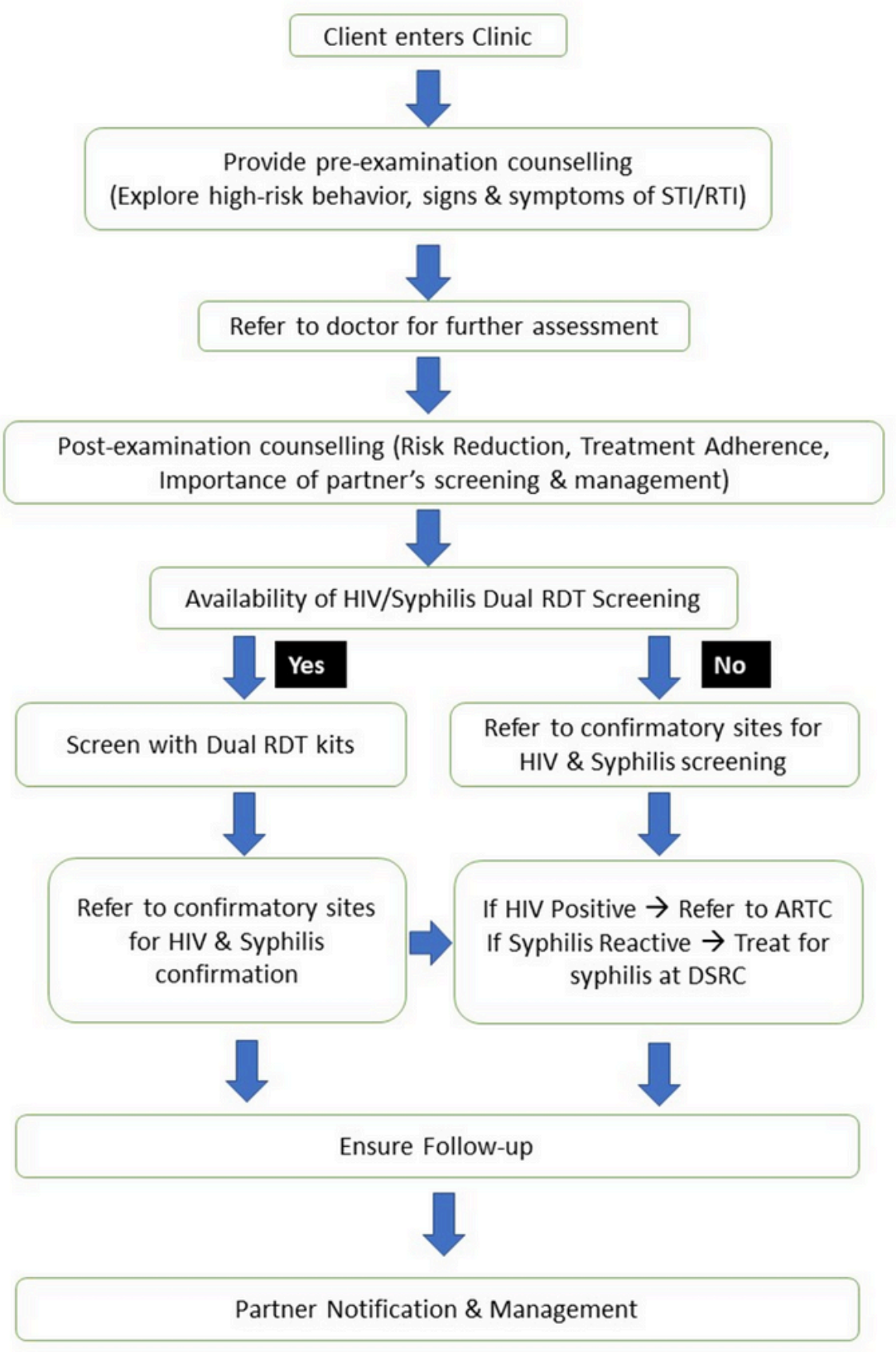
Annexure 9: Chapter 11: STI Treatment and Prevention quiz

- Make the participants seated in four or five groups.
- Distribute set of flags in three colours.
- Ask the groups to raise the appropriate flag (Green for true, red for false, and yellow for confused) against the statement read aloud.
- If the participants are confused or raised wrong flag, the facilitator clarifies.

True	False	Confused
		

1. Non-penetrative sex minimizes the risk for STIs. **(True)**
2. Condoms (both male and female) are the best method available to prevent the transmission of STIs to sexually active people. **(True)**
3. Pre-Exposure Prophylaxis, also known as PrEP, helps prevent transmission of STI **(False)** – It only helps prevent transmission of HIV. Hence consistent use of condoms in sex is essential even if one takes PrEP.
4. Every sexually active person with multiple partners must get screened regularly for Syphilis. **(True)** – NACO recommends that sexually active people at-risk must get themselves screened for Syphilis every six months.
5. NACO provides eight colour coded kits for STI medicines in syndromic case management. **(False)** –There are only seven color-coded groups of medicines. The colour codes are grey, green, white, blue, red, yellow, and black. Please see the photo below.
6. Facilitator can add more questions…

Annexure 10: Chapter 11: Client Flow for Counsellors at DSRC



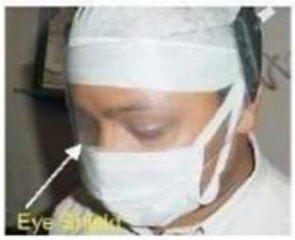
Annexure 11: Chapter 12: Standard Workplace Precautions (SWP) (PPT slides 21-25)

As per the Chapter 1, Section 2-(y) of the HIV/AIDS Act 2017, “Universal Precautions” means control measures that prevent exposure to or reduce, the risk of transmission of pathogenic agents (including HIV) and includes education, training, personal protective equipment such as gloves, gowns and masks, hand washing, and employing safe work practices.

Standard precautions include the following:

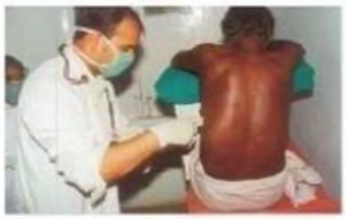
- Handwashing before and after all medical procedures
- Safe handling and immediate safe disposal of sharps: avoiding recapping of needles; using special containers for sharps disposals; using needle cutter/destroyers; using forceps instead of fingers for guiding sutures; using vacutainers where possible for sample collection
- Safe decontamination of instruments
- Use of protective barriers such as gloves, masks, goggles, aprons and boots whenever indicated to prevent direct contact with blood and body fluid. A healthcare personnel who has a cut or abrasion should cover the wound before providing care.
- Safe disposal of contaminated waste

For more information on the guidelines for universal precautions and post exposure prophylaxis with respect to HIV, refer to the Statutory Orders and Notifications Issued by the Ministries of the Government of India (Other than the Ministry of Defence), The Gazette of India, July 9, 2022/ASADHA 18, 1944.



Always use protective gear

Consider all blood samples infectious



Follow universal precautions practices

Safe handling of sharp instruments

Use needle destroyers

“NO” to Recapping of Needle

- Always use protective gear/Consider all blood samples as potentially infectious
- Follow universal precautions Practice/Practice safe handling of sharp instruments/Use needle destroyers

Standard of care for individuals exposed to HIV

Certain work practices increase the risk of needle stick injury such as recapping needles (most important), transferring a body fluid between containers, handling and passing needles or sharps after use, failing to dispose of used needles properly in puncture-resistant sharps containers, and poor healthcare waste management practices.

- "Do Not Recap Needle"
- Performing activities involving needles and sharps, in a rush increases the likelihood of an accidental exposure
- All hospital staff members must know whom to report for PEP and where PEP drugs are available in case of occupational exposure

Annexure 12: Chapter 12: Common PrEP Myths

Myth: You don't need to use condoms on PrEP.

PrEP provides protection from HIV, but it does not protect against other STDs like gonorrhea and chlamydia. Using condoms along with PrEP can help reduce your risk of contracting an STI.

Myth: You can start taking PrEP after you've been exposed.

PrEP is for people who are at risk for HIV. PrEP is not the right choice for people who may have been recently exposed to HIV. If you think you've been exposed in the last 72 hours, talk to your health care provider, an emergency room doctor, or an urgent care provider about post-exposure prophylaxis (PEP) immediately.

Myth: PrEP is only for gay men.

PrEP is recommended if you have an HIV-positive partner, a partner with multiple partners, or a partner whose HIV status is unknown. It is also specifically recommended for those taking drugs intravenously and who are at risk. It can be used for safer conception also..

Myth: You don't need to take PrEP every day.

PrEP is a both a daily prescription and on-demand medication depending on your situation and risk level. Studies have shown on-demand PrEP to be effective for gay and bisexual men having sex without a condom who are not at ongoing risk of HIV, but studies have yet to show the medications on-demand efficacy for heterosexual partners. However, on-demand PrEP should be restricted for MSM who are not at occasional risk, low frequency of sexual encounters and disciplined sexual life. The daily medication is for those with an ongoing risk of contracting HIV. In this situation, PrEP needs to be taken every day as prescribed for it to work effectively. If it's not taken daily, there may not be enough medicine in your bloodstream to block the virus.

To help you remember to take your PrEP pill, you can try our helpful Reminders feature in the Alto app that will let you know when it's time for your next dose. To ensure you don't run out of PrEP, you can also opt into auto refills so that we can reach out to you when you're close to being due for your next delivery.

Annexure 13: Chapter 14: IPT Provision in special Situation

IPT provision in special circumstances, such as for patients who are previously treated for TB, patients with ART, pregnant patients and those with MDR-TB, is summarized in Table below.

Scenario	Action
Patients previously treated for TB (secondary prophylaxis)	All CLHIV/PLHIV, who had successfully completed treatment for TB disease earlier, should receive INH for 6 months.
IPT with ART (secondary prophylaxis)	• Combined use of IPT with ART is recommended for all CLHIV/PLHIV regardless of ▪ degree of immunosuppression ▪ previous treatment for TB ▪ pregnancy. ART should not be delayed while starting or completing a course of IPT.
IPT and pregnancy	• A pregnant woman living with HIV should not be excluded from symptom-based TB screening and receiving IPT. • Isoniazid is safe in pregnancy. Start IPT in all HIV-positive pregnant women regardless of their gestation period. • Advise women to complete IPT if they become pregnant while taking IPT. Assure patient that IPT is safe while breastfeeding.
IPT in children born to microbiologically confirmed TB mothers	• If a baby is born to a microbiologically confirmed TB mother, assess the newborn for active TB. • Non-specific features suggestive of neonatal TB include fever, low birth weight, hepatosplenomegaly, irritability, feeding intolerance • Infants aged <12 months living with HIV who are in contact with a person with TB and who are unlikely to have active TB on an appropriate clinical evaluation or according to national guidelines should receive TB preventive treatment.
IPT and MDR-TB	Contacts of MDR-TB and PLHIV who have completed DR-TB treatment are not eligible for IPT.
Patients develop TB after IPT treatment	• If a patient develops TB symptoms during IPT treatment, evaluate the patient for TB and conduct DST. Based on DST results, the appropriate treatment should be provided. • If the patient is sensitive to all the drugs, then based on history of ATT and duration of IPT decide on the following: ▪ If the patient has not received anti-TB treatment in the past and has taken IPT for less than 1 month, then provide the patient with treatment for new case. ▪ If the patient has received anti-TB treatment in the past OR if the patient has taken IPT for more than 1 month, then provide the patient with retreatment regimen. ▪ If the patient is found to have DR-TB, refer the patient to the DR-TB centre.
Patients develop TB after IPT treatment	Treat the TB episode as new or previously treated case based on previous TB treatment history and Rifampicin resistance pattern (whenever available). **IPT is not to be considered as past history of TB in such cases.**
If a patient had taken IPT for less than 1 month in total and discontinued for any reason (like toxicity or loss to follow-up)	• Conduct adherence counselling, address reasons for discontinuation, conduct ICF and, if asymptomatic, restart INH afresh. • Ensure they have completed a 6-month course.
After taking IPT for more than 1 month: If the patient had discontinued IPT for less than 3 months	• Conduct adherence counselling, conduct ICF and, if asymptomatic, restart INH afresh. • Ensure they complete a 6-month course within a 9-month period.
After taking IPT for more than 1 month: If the patient discontinued for more than 3 months or had discontinued more than once	• Do not re-initiate IPT.

Annexure 14: Chapter 16: Newer four prongs of EVTHS under NACP-V

Prong 1: Primary prevention of HIV and syphilis among women of childbearing age. This can be achieved by providing sexual and reproductive health services and other relevant health services to women at an early age. It is important to engage with the community structures and work collaboratively to increase awareness and improve access to prevention services.

Prong 2: Preventing unintended pregnancies among women living with HIV by offering suitable counselling, guidance, and contraception to women living with HIV, to address their unmet needs for family planning and birth spacing. This will help in improving the health outcomes for these women and their children.

Prong 3: Prevent HIV and syphilis transmission from pregnant women to their children by providing pregnant women with HIV testing and counselling services, as well as access to ARV drugs during pregnancy, delivery, and breastfeeding. Additionally, it is crucial to ensure that screening and management services for syphilis are readily available and accessible to pregnant women.

Prong 4: Providing care, support and treatment to infected pregnant women their partners and HIV exposed infants (HEIs), and management of syphilis exposed infants. This includes ensuring access to ART to manage HIV. Additionally, it is essential to ensure adequate management of syphilis in pregnancy and screening and management of SEIs. Adequate management of infants diagnosed with congenital syphilis is also essential.

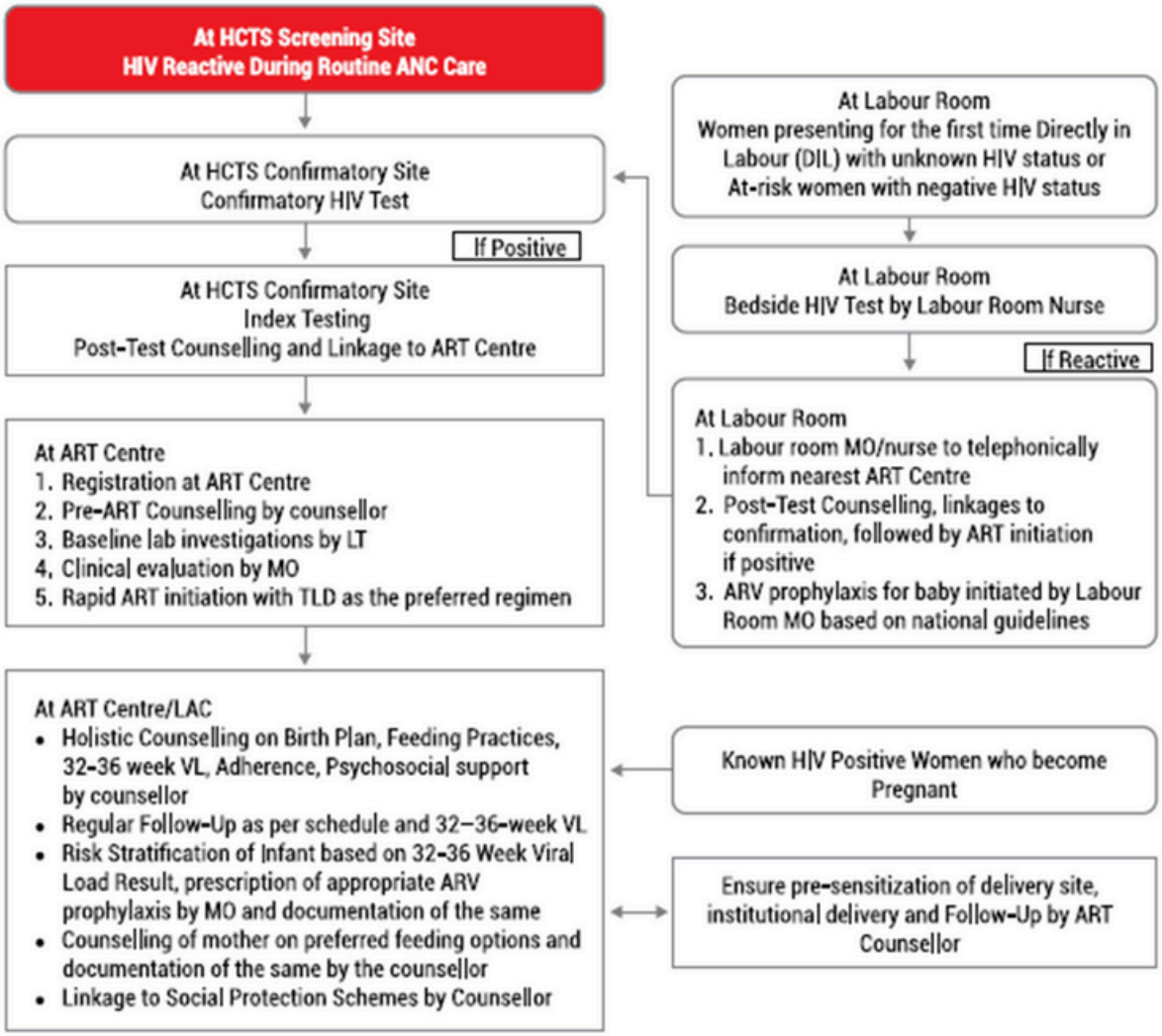
Annexure 15: Chapter 16: Route and risk of HIV transmission to the baby

The most common route of HIV infection among the pediatric age group is from mother to child during pregnancy, during delivery, and during breastfeeding.

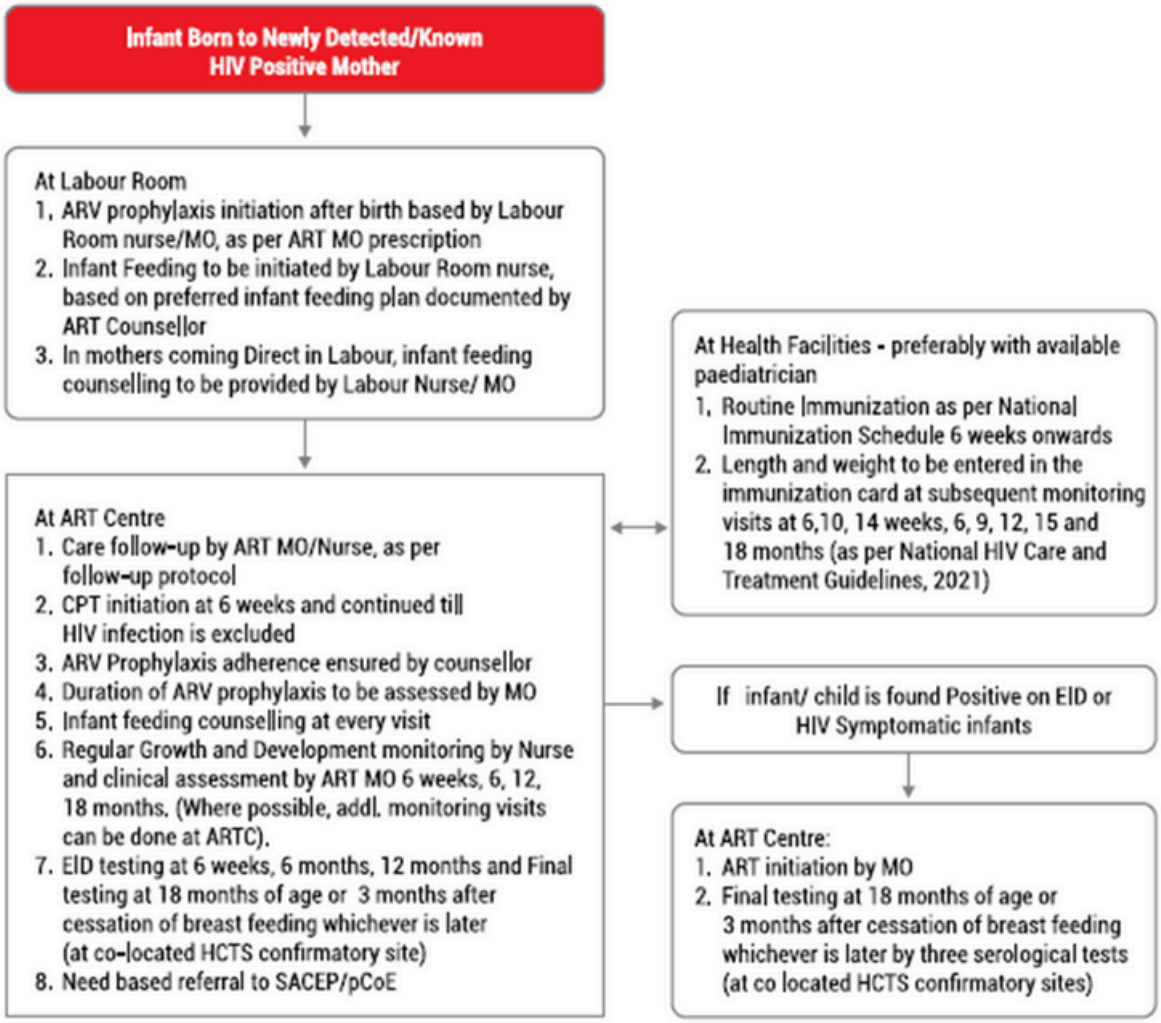
Table 1: Risk of HIV transmission in Pregnancy and Childbirth without any intervention

Stage of Pregnancy	Risk of Transmission
During Pregnancy	5 - 10%
During labor and delivery	10 -15 %
During breastfeeding	5 - 20%

Annexure 16: Chapter 16: Care cascade for HIV positive pregnant women



Annexure 17: Chapter 16: Screening and management of HEIs

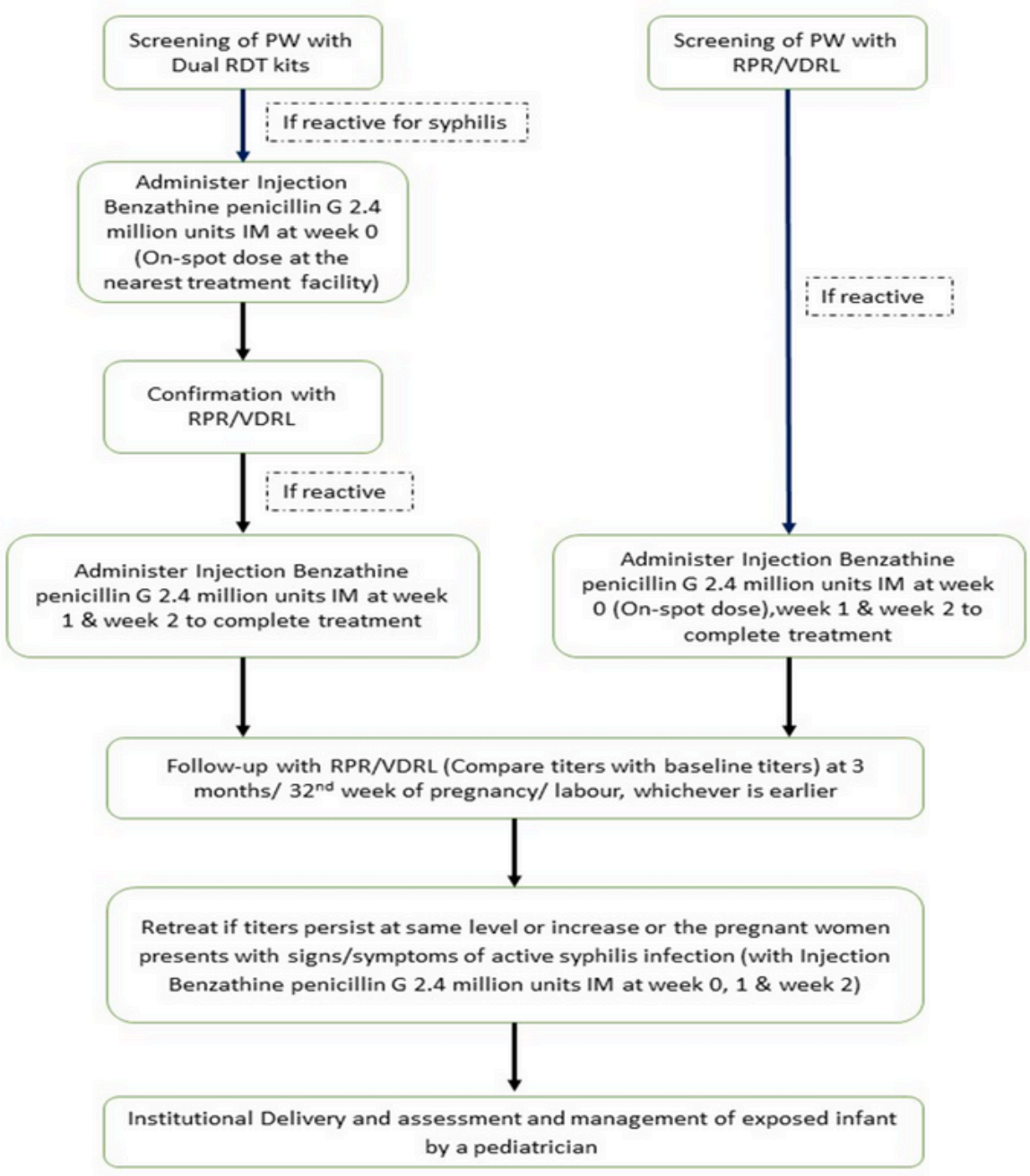


Annexure 18: Chapter 16: Counselling mothers regarding choosing feeding strategy:

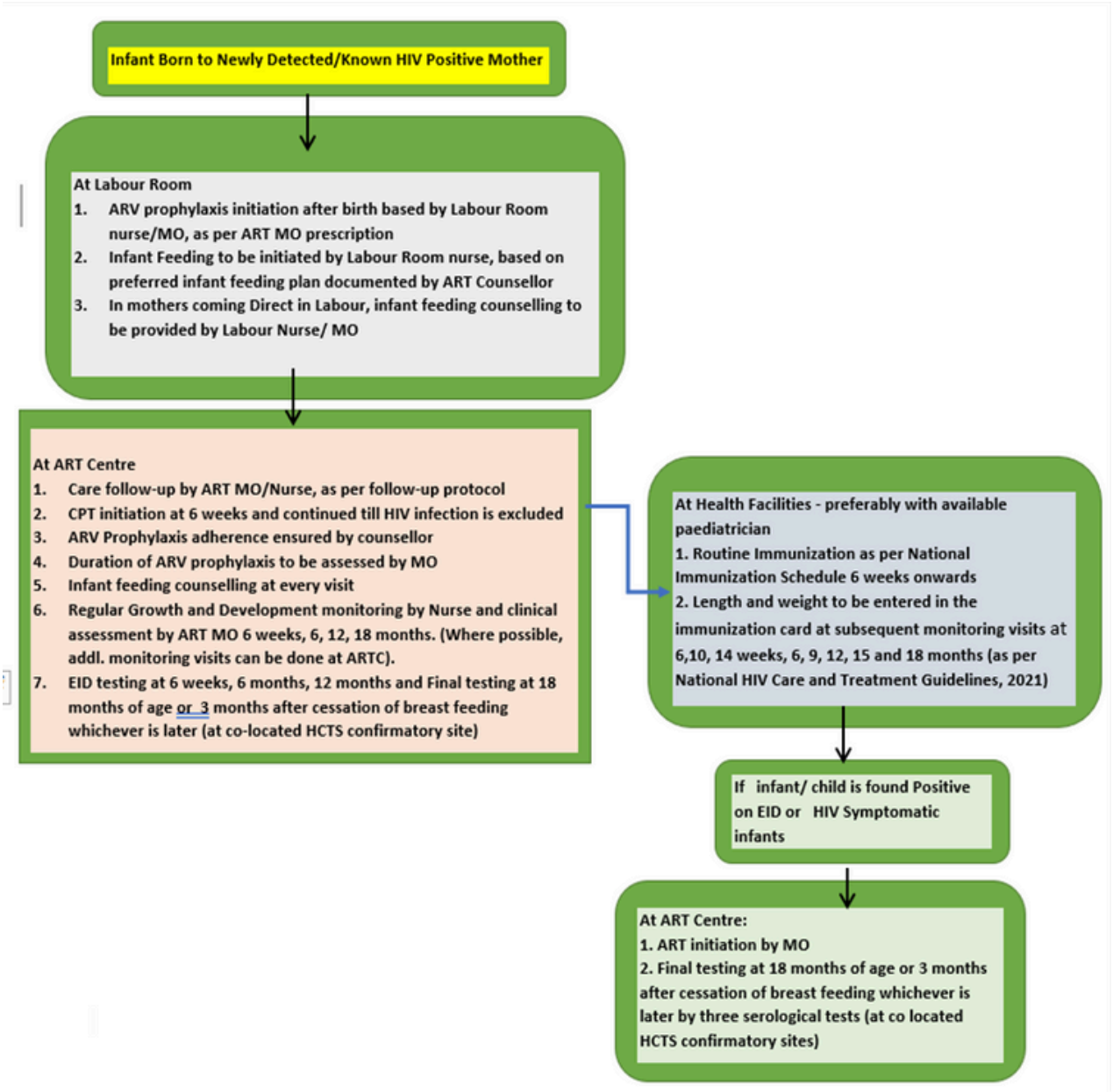
Antenatal counselling for infant feeding is crucial and must be initiated as early as possible. Expectant mothers who test positive for HIV must be informed about the available feeding options, including exclusive breastfeeding (EBF) or Exclusive Replacement Feeding (ERF). The healthcare team and counsellors must educate and guide the parents about the benefits and drawbacks of both options to enable them to make an informed decision. The healthcare providers and counsellors must also undergo adequate training to assist the parents in choosing and implementing their preferred option.

The parents should be engaged in a discussion about infant feeding well before delivery. Although exclusive breastfeeding is the preferred option, the counsellor should inform the family about the risk of HIV transmission associated with breastfeeding and emphasize the importance of ART adherence. The benefits and risks of replacement feeding should also be discussed, and the family's situation should be assessed. Since each mother's circumstances are unique, counselling and the final decision on feeding options must be tailored to their specific needs. The counsellor's crucial role is to support the family in successfully implementing their chosen feeding option.

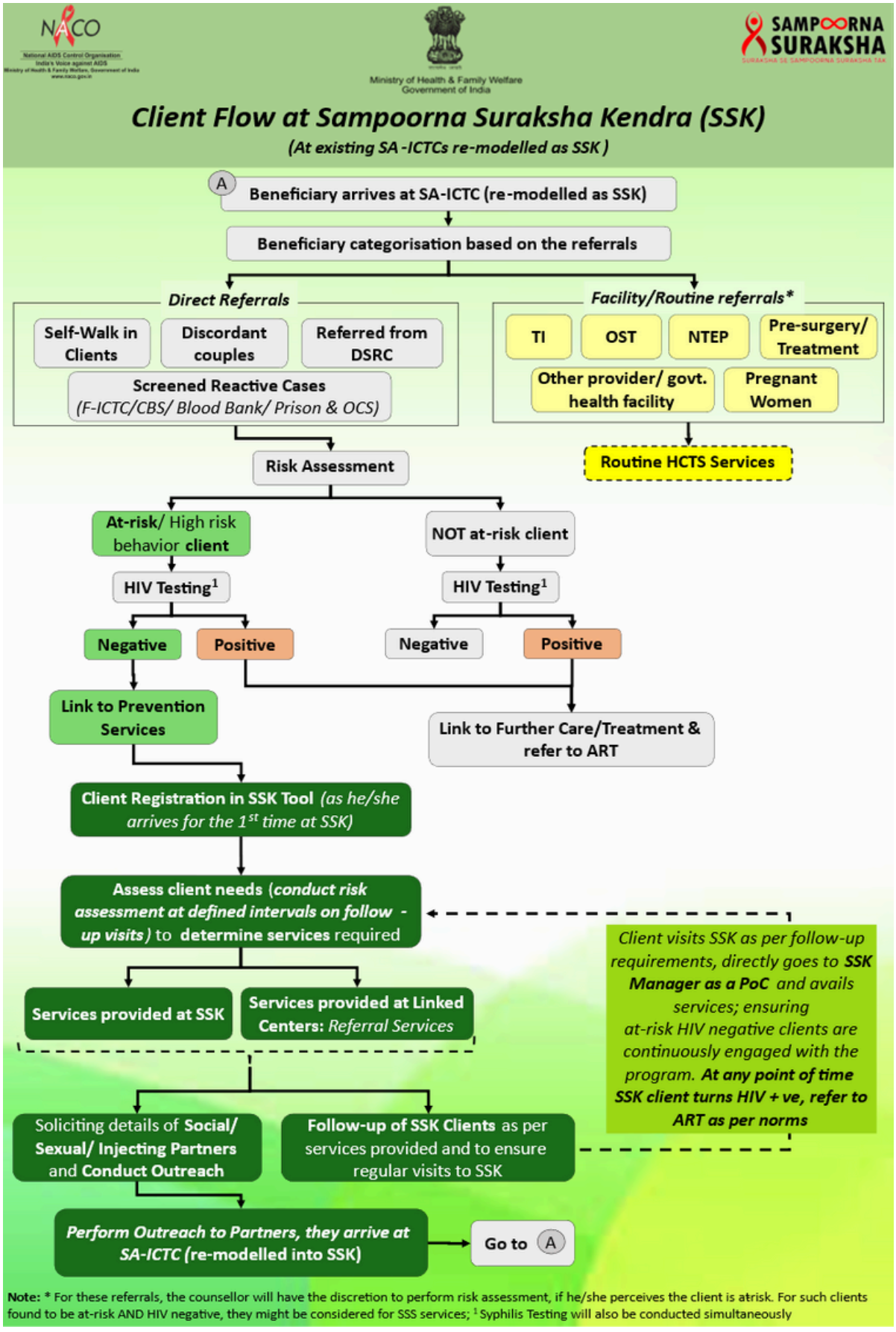
Annexure 19: Chapter 16: Screening and Management of Syphilis in Pregnancy



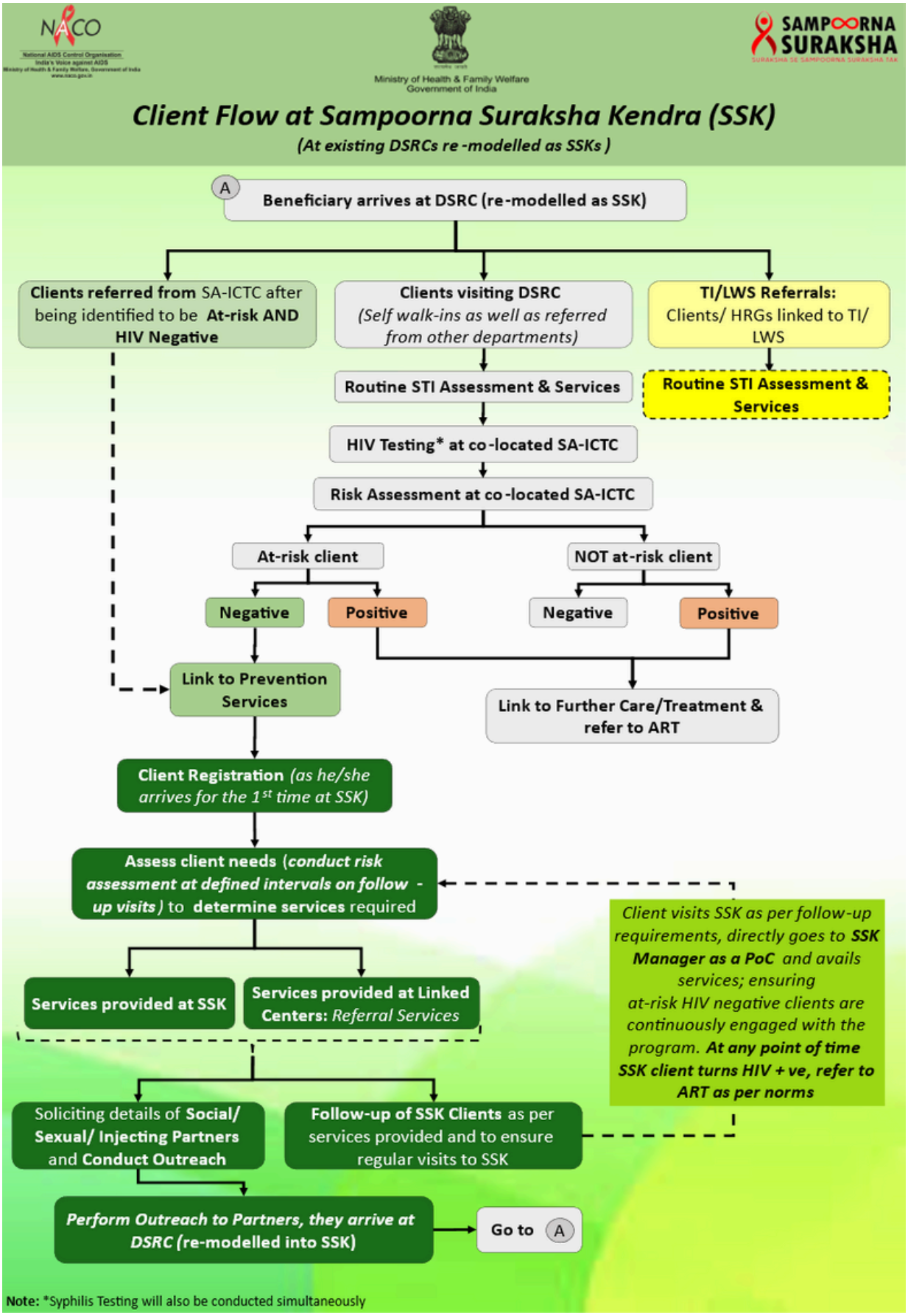
Annexure 20: Chapter 16: Cascade of Care Services for HIV Exposed Infants



Annexure 21: Chapter 20: Client Flow at SSK
(at existing HCTS confirmatory site re-modelled into SSK)



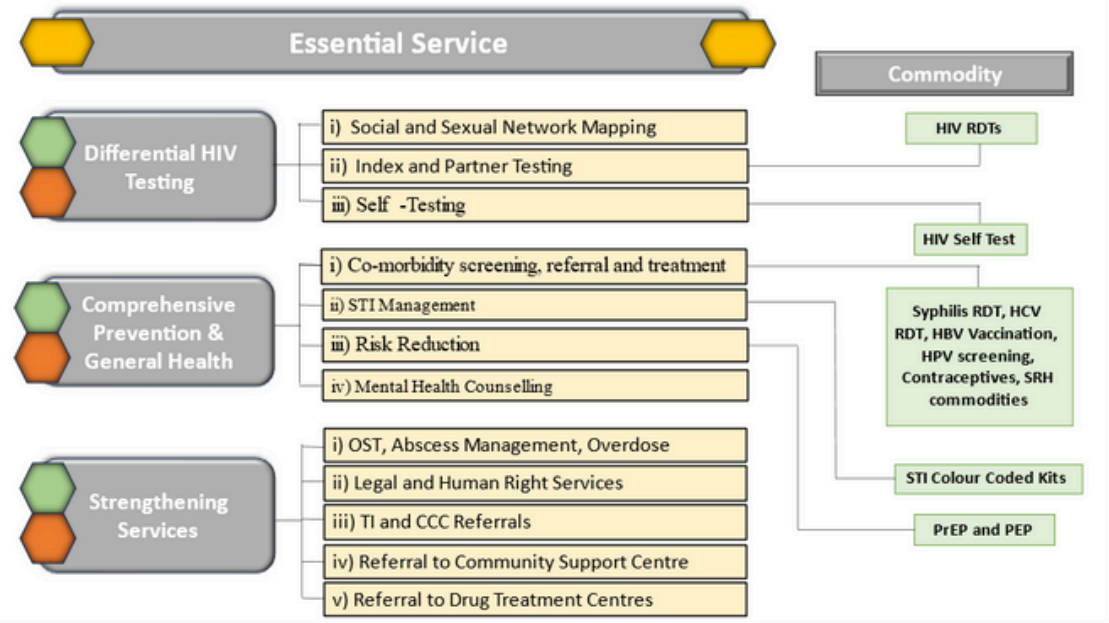
Annexure 22: Chapter 20: Client Flow at SSK
(at existing HCTS confirmatory site re-modelled into SSK)



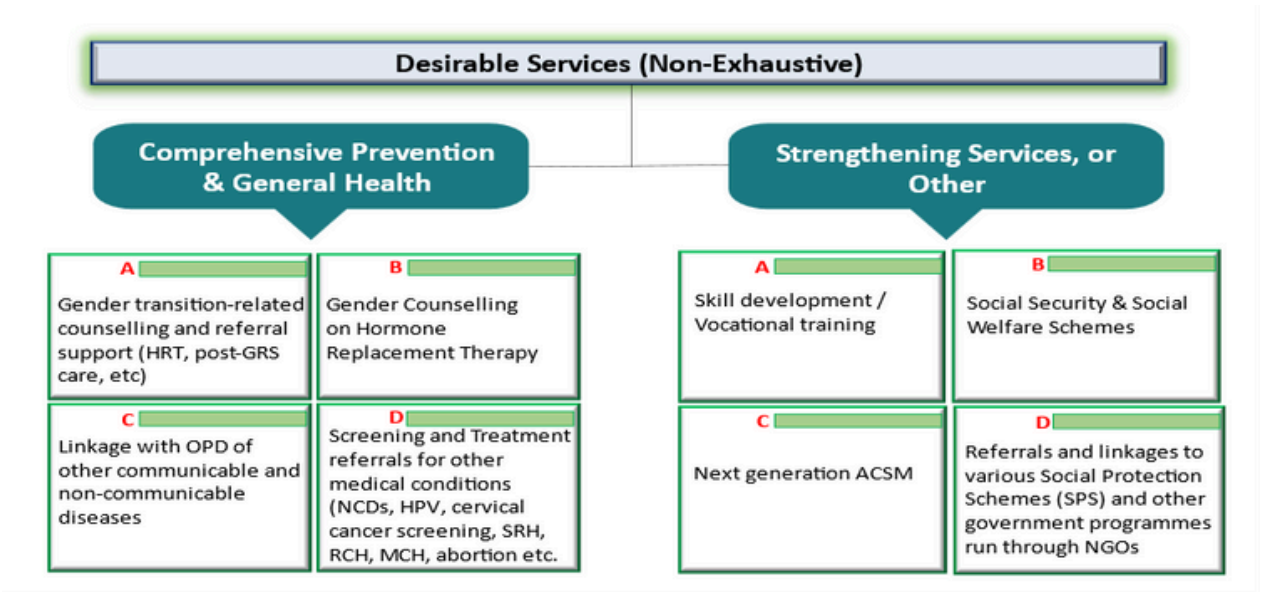
Annexure 23: Chapter 20: Comprehensive Service Package under SSS

Non-exhaustive list of Services and Commodities for Sampoorna Suraksha Service Package

A. Essential Services: These are essential services that are to be provided across all SSKs and their linked centres uniformly.



B. Desirable Services (Non-Exhaustive): These are heterogeneous services tailored to the client-based needs at each SSK. The list of such services has been provided in the SACS implementation plan



Annexure 24: Chapter 20: Commodities to be available at SSK

Kits/ Drugs/ Commodities	Purpose
HIV/Syphilis Dual RDT Kits	For testing at SSK
Needle/ Syringe	For dispensation to relevant clients through ORWs or from SSK
HIV WBFP Kits & HIV Confirmatory Test Kits (A1/A2/A3)	For Screening at field and Confirmatory test
Buprenorphine	For dispensation to client at SSK
STI/RTI Colour Coded Kits	
SRH Commodités (Condoms/ Lubes etc.)	
PEP	
RPR Kits	For Syphilis testing at SSK
Injectable Benzathine Penicillin G	For treatment at SSK through DSRC
HIV Self-Test Kit	Proposed (when approved)
PrEP	Proposed (when approved)
Hepatitis Screening Test-Kits	Proposed (when approved)

Annexure 25: Chapter 20: Answers for the Quiz for Facilitator

1. Have you heard of SSS & SSK?

Ans. SSS- Sampoorna Suraksha Strategy (SSS) is a strategy to reach out to those not self-identifying as HRGs but are at risk, and providing them with a cyclical, need-based and comprehensive package of supportive services that help them stay negative, and stay healthy. It focuses on preventing new infections among at-risk population that is not covered through TI/LWS, with the aim to accelerate achievement of our goal of 80% decline in new infections by 2025-26.

SSK- Sampoorna Suraksha Kendra- The Sampoorna Suraksha Strategy is being implemented through existing NACP facilities i.e., ICTCs or DSRCs functional at the districts which are being re-modelled and branded as Sampoorna Suraksha Kendras. 150 districts were identified as part of the program using pre-determined criteria. The programme has been rolled out in 75 districts in the Phase 1 and an additional 75 districts in Phase 2 during the period of FY 2021-24.

2. How SSS will contribute to prevent HIV infection?

Ans. Through Sampoorna Suraksha Strategy (SSS) we can reach out to the 'at-risk' HIV negative populations through a cyclical and comprehensive package of services as per their needs to keep them HIV-negative, thus boosting the country's progress on prevention of new HIV infections.

3. Who does SSS cater to?

Ans. The population "At Risk" for HIV & STIs is defined as 'any individual who is at risk of acquiring HIV or STI due to risky behaviours of self or partner(s). This includes the core population, the bridge population, their spouses / partners and other populations who are engaging in risky behaviours'

Annexure 26: Answers for the Quiz for Facilitator

1. How many SSKs are currently established under the programme?
Ans. 150
2. Name the facilities where SSKs are established
Ans. HCTS confirmatory site or DSRC
3. What is the staffing pattern of SSKs?
Ans. The staff nomenclature across both the scenarios (i.e., HCTS confirmatory site/ DSRC remodelled into SSK has been provided below)

The staff nomenclature for HCTS confirmatory sites re-modelled into SSK:

- Sampoorna Suraksha Counsellor (SSC) - Existing ICTC Counsellor of the selected facility
- Sampoorna Suraksha Lab Technician (SSLT)- Existing LT of the selected facility (ICTC)
- Sampoorna Suraksha Manager (SSM)- New Hiring
- Sampoorna Suraksha Outreach Worker (SSORW) – One / Two (as per requirement)- New Hiring

The staff nomenclature for DSRCs re-modelled into SSK (co-located HCTS confirmatory site will support the SSK):

- Sampoorna Suraksha Counsellor (SSC) - Existing DSRC Counsellor of the selected facility
- Sampoorna Suraksha Manager (SSM)- New Hiring
- Sampoorna Suraksha Outreach Worker (SSORW) – One / Two (as per requirement)- New Hiring
- Sampoorna Suraksha Support Counsellor - Existing ICTC Counsellor of the co-located ICTC.
- Sampoorna Suraksha Lab Technician (SSLT)- Existing LT of the co-located (ICTC)

4. What is the roles and responsibilities of counsellors in the SSK?
Ans. The R&R has been listed below:

i. Counselling and education of the target audience on prevention measures, testing and treatment of HIV, STIs and related co-infections through one-to-one or group counselling, using suitable medium (Example posters, flip books, flyers, leaflets/brochures, audio-visual materials, tele-counselling, virtual platform etc.)

ii. Undertaking the risk assessment of the target audience and offering of suitable follow-up services as per the risk level of the clients,

iii. Promoting of comprehensive prevention models (Condom, Contraception, Pre-Exposure Prophylaxis, Post-Exposure Prophylaxis etc.), including condom demonstration (using penis model), for prevention of new infections,

iv. Undertake HIV and Syphilis screening services in facility and field settings,

v. Undertake the counselling for people found reactive/positive for HIV, STIs and related co-infections, including but not limited to, anti-retroviral medicines, preparedness counselling, adherence counselling, opportunistic infections management, management of NCD, lifestyle modification, positive prevention, disclosures, index testing, psychosocial support, family counselling, suitable linkage and referrals, including to 1097, social protection schemes, legal aid, rehabilitation and other relevant services etc.

vi. Provide an enabling environment to fight against stigma and discrimination.

vii. Undertake the family planning counselling and follow-up referral and linkages among eligible HIV positive clients,

viii. Undertake the counselling among adolescents and youths for sexual and reproductive health including that for prevention, testing and treatment of HIV, STIs and related co-infections Undertake the counselling and follow-up services for ‘at-risk’ non-reactive/negative clients, including but not limited to, comprehensive prevention models, periodic screening for HIV/STIs and suitable linkage and referrals, including to 1097, as per the national guidelines,

ix. Follow-up for HIV and STIs reactive/positive people through field visit/outreach ensuring uptake of suitable services like confirmatory testing, registration to treatment facilities and adherence counselling,

x. Coordination with various outreach workers/field functionaries/ANM/ASHA Workers/Anganwadi Workers etc. in context of HIV/STI-reactive/positive individuals ensuring uptake of suitable services like confirmatory testing, registration to treatment facilities, adherence counselling etc.

xi. Perform the role of nodal point for Sampoorna Suraksha Strategy as suitable for the given locality,

ixii. Counselling on harm-reduction services for people who injecting drugs (PWIDs) including on the topic of Opioid Substitution Therapy, Viral Load testing and viral suppression.

ixiii. Ensuring the suitable use and maintenance of kits/commodities/ consumables/ equipment's provided under NACP including the cold-chain maintenance of kits/drugs as per the guidelines,

xiv. Undertake the data recording and reporting, including the data entry in IT-enabled platforms, for the services offered as per the system prescribed under the national guidelines.

xv. Carry out the specific activities related to programme monitoring, surveillance and research according to the instructions issued periodically,

xvi. Participation in reviews, trainings and capacity building activities etc. as per the instructions issued periodically.

xvii. Undertaking of any other related activities under NACP as per the instructions issued periodically.

5. What are the 7 Risk assessment questions to be asked at SSK by the counsellor?

Q1: Do you have the habit of using /sharing injecting drugs?
Q2: What kind of sexual partner(s) you have?
Q3: Do you have any sexual relationship beyond your spouse/partner?
Q4: Have you bought sex in the past from a man, woman or TG using money, goods, favours or benefits?
Q5: Have you provided sex in the past in exchange for money, goods, favours or benefits?
Q6: Any STI symptoms in last three months?
Q7. Is your spouse or partner, a PLHIV?

6. What is the target population of SSKs?

Ans.

- o Self-initiated clients at ICTC with risky behaviour
- o Social and sexual networks of self-initiated clients / individuals
- o Youth and adolescents at risk
- o Individuals having casual sexual relation with regular/non-regular partner/s
- o STI/RTI clients visiting DSRC/STI Clinics with STI complaints
- o HIV negative but 'at-risk' clients identified through virtual outreach, NACO Helpline 1097 etc.
- o Regular and Non-Regular Partner/s/Spouse of HRG (FSW, MSM, TG/TS) who are not associated / covered with TIs, LWS & OSC
- o Needle/Syringes sharing Partners (IDU/FIDU) and their sexual Partners (who are not associated with TIs/ LWS/OSC)
- o HIV negative partners of discordant couples

6. What is the target population of SSKs?

Ans.

- o Self-initiated clients at ICTC with risky behaviour
- o Social and sexual networks of self-initiated clients / individuals
- o Youth and adolescents at risk
- o Individuals having casual sexual relation with regular/non-regular partner/s
- o STI/RTI clients visiting DSRC/STI Clinics with STI complaints
- o HIV negative but 'at-risk' clients identified through virtual outreach, NACO Helpline 1097 etc.
- o Regular and Non-Regular Partner/s/Spouse of HRG (FSW, MSM, TG/TS) who are not associated / covered with TIs, LWS & OSC
- o Needle/Syringes sharing Partners (IDU/FIDU) and their sexual Partners (who are not associated with TIs/ LWS/OSC)
- o HIV negative partners of discordant couples

7. Give 3 benefits of establishing SSKs

Ans.

- o Early detection of HIV/STI
- o Destigmatize HIV service-seeking by bringing it under an umbrella of comprehensive services for STI/RTI
- o Identification and enhanced focus on At-Risk negative clients that have not been covered by TI/LWS
- o Provision of comprehensive health and non-health services to cater to the needs of clients and keep them engaged in care
- o HRGs not willing to get associated with TI can seek services

8. What do you mean by comprehensive service package?

Ans.

Comprehensive service package includes the HIV/STI services, other health services and non-health service. These are further divided as follows:

Essential Services- These are essential services that are to be provided across all SSKs and their linked centres uniformly

Additional Services- These are heterogeneous services tailored to the client-based needs at each SSK.

The following types of essential and additional services comprises the Comprehensive SSS package:

- **Differential HIV Testing**- Social and Sexual Network Mapping, Index and Partner Testing, Self-Testing
- **Comprehensive Prevention & General Health**- STI screening, referral and treatment, Co-morbidity screening, referral and treatment, Mental health counselling, Gender transition / hormone replacement counselling, Linkage with OPD of other diseases, Screening and treatment referrals for other medical conditions, Risk reduction
- **Strengthening Existing Services & Non-health Services-** OST & Harm Reduction, Abscess Management, Overdose Management, Legal /HR services. Referrals to TI and CCC, Community centres and Drug treatment centres, Skill development / vocational training, Social security & welfare schemes, Next gen ACSM, Referrals to Social Protection Schemes (SPS) / other government / NGO programs.

9. Name 4 direct services and 4 referral/linkage services given by SSKs

Ans.

Direct Services-

i. HIV Counselling & STI Counselling
ii. HIV Screening & STI Screening
iii. HIV Testing & STI Testing
iv. Follow up services

Referral/Linkages Services- All other services mentioned in above question apart from direct services may be provided through referral/linkages. A SSK may choose to provide any of the referral services at the facility itself directly.

10. What commodities can be dispensed directly through SSKs?

Condoms, Lubes, HIV Self-test kits (on approval from program), PrEP (on approval from program) and PEP. Needle/Syringe and OST drugs may also be dispensed through SSK.

11. What is the client flow where DSRCs are re-modelled as SSK?

12. What activities are to be done through follow-up/outreach?

Ans.

>> Routine follow-up of existing SSK Clients (at-risk and HIV negative) to:

- Ensure continuous communication and engagement
- Ensure timely visits to the SSK, as per guidelines
- To ascertain client's experience and whether the individual was able to receive linkage/referral service

>> Outreach to social/sexual/injecting partners of SSK clients to generate awareness around HIV & STIs, encourage them to access NACP & other services and get linked to SSK

>> Awareness Generation activities to identify new clients and encourage them to get access to NACP & other services through SSKs

13. How many visits suggested for SSK Client for follow up? Tell the period also.

Ans.

At the commencement of operations at SSK, the follow-up visit timelines for clients will be as follows:

- 1st Visit: Client identified as at-risk AND HIV negative, registered in the SSK Data Collection Tool
- For 2nd visit to SSK (or 1st visit after registration): 3 months after 1st visit/ registration or earlier, basis the risk assessed by the counsellor
- For 3rd and every subsequent visit to SSK: 6 months after last visit or earlier, basis the risk assessed by the counsellor

14. What is the graduation criteria of at-risk negative client?

Ans.

In order to ensure that the target population is continuously engaged with the SSK and is prioritised, a graduation criterion has been devised. Upon meeting such criteria, the client can be graduated from the system, or in other words, may not be followed up actively. However, such clients should be provided services/commodities if they voluntarily ask for the same. Additionally, the client may visit the SSK on yearly or half yearly basis as advised by the Counsellor and/or subject to the risk perceived by the client in future. The criteria defined for graduation is:

"If the client has been NOT at-risk AND HIV -ve AND Syphilis -ve in the last 2 years"

This criterion may be revised and refined, basis field experiences, learnings, and data analyses.

15. Can the no. of client visits and duration of visits be changed? And by whom?

Ans

The client may be called earlier than stated timelines, basis the risk assessed by counsellor. Further, the visit can be aligned as per the follow-up prescribed by the doctor for clients attending DSRC for STI/RTI treatment, and/or with timelines for follow-up of other services being received by client (Ex: OST etc.)

These timelines might be revised or defined differently across target populations and risk-categories, basis field experiences and data analyses, as the program progresses.

16. How SSS is helpful in addressing 95-95-95 and reaching out to the at-risk HIV negative clients?

Ans: By motivating the at-risk clients for testing and through the provision of risk reduction commodities.

Annexure 27: Ice Breakers / Energizers / Games

1. Group Statues: Ask the group to move around the room, loosely swinging their arms and gently relaxing their heads and necks. After a short while, shout out a word. The group must form themselves into statues that describe the word. For example, the facilitator shouts “peace”. All the participants have to instantly adopt, without talking, poses that show what ‘peace’ means to them. Repeat the exercise several times.

2. Fruit Salad: Divide the participants into an equal number of three to four fruits, such as oranges and bananas. Ask the participants to then sit on chairs in a circle. One person must stand in the centre of the circle of chairs. Shout out the name of one of the fruits, such as ‘oranges’, and all of the oranges must change places with one another. The person who is standing in the middle tries to take one of their places as they move, leaving another person in the middle without a chair. The new person in the middle shouts another fruit and the game continues. A call of ‘fruit salad’ means that everyone has to change seats.

3. Tide’s In/Tide’s: Out Draw a line representing the seashore and ask participants to stand behind the line. When the facilitator shouts “Tide’s out!” everyone jumps forwards over the line. When the leader shouts “Tide’s in!” everyone jumps backwards over the line. If the facilitator shouts “Tide’s out!” twice in a row, participants who move have to drop out of the game.

4. What Has Changed? Ask the participants to break into pairs. The partners must observe one another and try to memorize the appearance of each other. Then one turns their back while the other makes three changes to his/her appearance; for example, putting their watch on the other wrist, removing their glasses, and rolling up their sleeves. The other player then turns around and has to try to spot the three changes. The players then switch roles.

5. Shopping List: The game begins with the group forming a circle. One person starts by saying “I am going to the market to buy fish.” The next person says, “I am going to the market to buy fish and potatoes.” Each person repeats the list, and then adds an item. The aim is to be able to remember all of the items that all of the people before you have listed.

6. Reflecting on the Day: To help people to reflect on the activities of the day, make a ball out of paper and ask the group to throw the ball to each other in turn. When they have the ball, participants can say one thing they thought about the day.
(Taken from STAYING SAFE A Manual to train Peer Educators in IDU Interventions, 2012, Project HIFAZAT)

Annexure 28: Pre and Post-Test Questionnaire

1. Phase – V of the NACP is implemented between

   a) 2021 – 2026
   b) 2017 – 2021
   c) 2023 – 2028
   d) 2022 – 2026
   e) Do not know

2. The objective of NACP V is to reduce AIDS-related mortality and annual new HIV infections by _____%.

   a) 70%
   b) 100%
   c) 80%
   d) 50%
   e) Do not know

3. The first 95 of UNAIDS's 95-95-95 Fast track goal stands for

   a) People who know their status are receiving ART
   b) People receiving ART to have viral suppression
   c) People living with HIV know their HIV status
   d) Eliminate HIV/AIDS-related stigma and discrimination
   e) Do not know

4. Which of the following benefits is offered by Opioid Substitution Therapy (OST)?

   a) Increases chemical dependence on opioids
   b) Increases drug-related crime rather than sex work, and therefore reduces HIV risks
   c) Help client to reduce harmful use of drug and improve the quality of life.
   d) Do not know

5. Why Waste Disposal Management is important in the NSEP?

   a) Stop others from reusing N/S
   b) Prevention of transmission of infections
   c) Prevention of children accidentally pricking themselves while playing
   d) All the above
   e) Do not know

6. Which following statement is correct about the uses of PrEP?

   a) We can start PrEP after we have been exposed
   b) We don't need to use condoms when on PrEP
   c) PrEP is used by people without HIV who may be exposed to HIV through sex or injection drug use
   d) PrEP can make someone resistant to HIV medication if they become infected with HIV
   e) Do not know

7. In ITS, index refers to

a) HIV-positive client
b) HIV-negative client
c) Sexual partner of HIV-positive client
d) Spouse of HIV-positive client
e) Do not know

8. Sites that conduct index testing and partner services should conduct screening for which one of the following?

a) Intimate partner violence
b) Partner separation
c) Client and partner attitudes
d) Do not know

9. HCV is:

a) Curable with treatment
b) Not curable
c) Manageable
d) Preventable through vaccine
e) Do not know

10. Which are the building blocks of our body?

a) Proteins
b) Carbohydrates
c) Fats
d) Minerals
e) Do not know

11. Which populations are the OSCs intended to serve?

a) Transgender women/Hijras, PWID and bridge populations
b) Only FSWs and bridge populations
c) Only bridge populations
d) Do not know

12. Risk education counselling, condom demonstration and provision of condoms should be given to:

a) Individuals who indulge in sexual activities
b) Individuals who indulge in sexual activities and injecting drugs
c) Individuals found non-reactive for HIV on screening
d) All of the above
e) Do not know

13. Post-test counselling is provided:

a) To the individuals found reactive for HIV on screening
b) To the individuals found non-reactive for HIV on screening
c) To all the individuals who have got HIV tested
d) All of the above
e) Do not know

14. Who is not the target population for SSS?

a) Youth and adolescents who are at risk due to their risky behaviors
b) HIV-negative but not at risk
c) STI/RTI clients visiting DSRC with STI complaints
d) Self-initiated clients at ICTCs and DSRCs with risky behavior
e) Do not know

15. Syphilis is a sexually transmitted infection caused by a:

a) Bacteria
b) Virus
c) Fungus
d) None of the above
e) Do not know

16. Who can be recommended for OST?

a) Clients who are dependent on any type of drugs
b) Clients who are dependent only on opioids
c) Clients who are in relapse
d) Clients who are facing withdrawal symptoms
e) Do not know

17. HIV-2 infected person should not be monitored by viral load testing.

a) True
b) False
c) Do not know

18. When a person has symptoms of HIV despite taking anti-HIV medications, which treatment failure is this?

a) Virologic failure
b) Immunologic failure
c) Clinical failure
d) Do not know

19. Single-drug replacement of individual ARV drugs refers to:

a) Substitution
b) Switch
c) Do not know

20. What is the name of Direct Benefit Transfer (DBT) scheme provides nutritional support for Rs. 500/- every month

a) Nikshay Poshan Yojana
b) Akshaya Poshan
c) Swasthya Yojna
d) Nirogi scheme
e) Do not know

The Key of the correct Answers options for the above Pre & Post Test questions. This is to be used for assessment of the correct answers given by the participants during pre-Training and Post-Training assessment

Question No	Correct Answer Option	Question No	Correct Answer Option
1	a	11	a
2	c	12	d
3	c	13	d
4	c	14	b
5	d	15	b
6	c	16	c
7	a	17	a
8	b	18	c
9	a	19	a
10	c	20	a