

ICTC TEAM TRAINING

TRAINER'S GUIDE

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National AIDS Control Organisation

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Foreword

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

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

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


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

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

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List of abbreviations

AEB	Accidental Exposure to Blood
AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Treatment
ARV	Antiretroviral
BCC	Behaviour Change Communication
BCG	Bacillus Calmette Guerin
CBO	Community-Based Organisation
CCC	Community Care Centre
CDC	Centers for Disease Control
CHC	Community Health Centre
CMV	Cytomegalovirus infections
CPT	Cotrimoxazole Preventive Treatment
CST	Care, Support and Treatment
CSW	Commercial Sex Worker
DAPCU	District AIDS Prevention and Control Unit
DBS	Dried Blood Spot
DHO	District Health Officer
DMC	Designated Microscopy Centre
DOTS	Directly Observed Treatment - Short course
DPT	Diphtheria, Pertussis, Tetanus
EID	Early Infant Diagnosis
ELISA	Enzyme-Linked Immunosorbent Assay
EQAS	External Quality Assessment Scheme
FBO	Faith-Based Organisation
FOGSI	Federation of Obstetricians and Gynaecologists Societies of India
FSW	Female Sex Worker
HBV	Hepatitis B Virus
HCP	Health Care Personnel
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus

HPV	Human Papilloma Virus
IAP	Indian Association of Paediatricians
I/C	In-Charge
ICT	Integrated Counselling and Testing
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting/ Intravenous Drug User
IEC	Information, Education and Communication
IMA	Indian Medical Association
LT	Laboratory Technician
MAC	Mycobacterium Avium Complex
MCH	Maternal and Child Health Services
MO	Medical Officer
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NACO	National AIDS Control Organisation
NACP III	National AIDS Control Programme Phase III
NGO	Non-Governmental Organisation
NRHM	National Rural Health Mission
NVP	Nevirapine
OI	Opportunistic Infection
OPD	Out-Patients Department
OPV	Oral Polio Vaccine
PCP	Pneumocystis Carinii Pneumonia
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Centre
PID	Patient Identification Digit
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnership
PPTCT	Prevention of Parent-to-Child Transmission
RMP	Registered Medical Practitioner
RNTCP	Revised National Tuberculosis Control Programme
RRC	Red Ribbon Club
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SOP	Standard Operating Procedure

SRL	State Reference Laboratory
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targetted Intervention
UNAIDS	Joint United Nations Programme on HIV/AIDS
USP	Universal Safety Precaution
VCT	Voluntary Counselling and Testing
VCTC	Voluntary Counselling and Testing Centre
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organisation
ZDV	Zidovudine

Introduction to the Training Module

Introduction to the Training Module

Who does this training module address?

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

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

What is the purpose of this training module?

Each ICTC team member is likely to have already undergone induction training to their work, and a refresher training every year.

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

If trainees mention that some information in their handbook is very basic, you could help them to understand that:

- ✓ At this ICTC team training programme, they would benefit from identifying what daily procedure and materials apply to their work
- ✓ They will be encouraged to share their particular experiences with the group where time is available
- ✓ Advanced information related to their particular work function may be available in the manual they received at their induction training or on the NACO website.

If you, as the trainer, find that your group of trainees includes members who have not yet undergone the orientation programme:

- ✓ encourage them to keep reading their training materials
- ✓ ask questions
- ✓ remind them that their colleagues are likely to be very good resources.

In this context, it is also important to remind them that as individuals with different professional backgrounds, they have much to learn from each other. This is an opportunity to get to know other members of the team – a task that is sometimes difficult given the quantum of work in some ICTCs.

Basic Structure of the Training Programme

This training module covers 3 days.

Day 1

- ✓ Introduction to the workshop
- ✓ ICTC Referrals and Linkages in the light of the NACP III
- ✓ Basic Information about Counselling

Day 2

- ✓ Basic Information about HIV Testing
- ✓ ICTCs and the National TB Programme
- ✓ Stigma and Discrimination, Universal Safety Precautions and Post-Exposure Prophylaxis

Day 3

- ✓ ICTCs and PPTCT Services
- ✓ Enhancing the work of the ICTC Team Including Documentation

A detailed break-up of the training schedule is given in the table on the next page.

The Trainer's Guide contains information about how to conduct each session. The slides for each session is prepared for your convenience.

Each session has a write-up in the Trainee's Handbook. But some sessions require you to make print-outs of some training material in advance.

Programme Schedule

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

Operational Guidelines for Integrated Counselling and Testing Centres

You should also keep handy a copy of NACO's Operational Guidelines for Integrated Counselling and Testing Centres. A great deal of the training material in this guide is based on the structure proposed in the Operational Guidelines. If you cannot get a print version, you can access the online version on the NACO website

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

Notes for the Trainer

Notes for the Trainer

Purpose:

Training health workers is an important means of enabling them to perform their work-related tasks more effectively. The objective of the workshop, therefore, is to help trainees identify good practices and reinforce these as well as to identify poor practices and correct them.

Training helps trainees to

- ✓ acquire new information pertaining to their professional activities
- ✓ explore their attitudes relevant to that situation, and understand the need for change, if it exists
- ✓ develop new skills
- ✓ reinforce those behaviours that are effective in their work
- ✓ improve their confidence and pride in their skills

This team training workshop focuses on personnel who are already working in the ICTCs. They would have attended induction training pertaining to their particular professional tasks.

For an effective training outcome:

- ✓ Encourage trainees to participate actively
- ✓ Use experiential learning techniques
- ✓ Recognize that trainees bring to the workshop a wealth of information, and that this training only adds to, or builds on, to this existing knowledge

Trainers are strongly recommended to be enthusiastic and lively in conducting the different exercises mentioned in the manual.

Experiential Learning Techniques vs Conventional Learning

- ✓ Using experiential learning techniques means that learners are actively and directly involved in a learning event. This event leads to a process of reflection where they reflect on the experience and draw conclusions from it.
- ✓ This contrasts sharply with conventional learning where learners are passively exposed to the experience of other people through such modalities as lectures or readings – that is without the possibility of participating and commenting on these experiences, or the possibility of making them part of their own make-up.
- ✓ Activities that involve participants as active learners not only provide inputs to the trainees but also enrich the sharing through the contributions of trainees' own particular experiences and problem-solving.
- ✓ It is important to permit trainees to share their experiences because the training workshop will include a range of people with different years of experience, as well as people from different professional backgrounds.
- ✓ To foster the ICTC team component, the training module provides opportunities for cross-team sharing (that is across different ICTCs) as well as for cross-professional sharing (that is medical officers, counselling personnel, testing personnel).

Training using experiential techniques is relevant to the trainees' work, and uses a variety of methods and materials. People tend to learn more when they are doing than when they are listening passively.

This section explains some of these methods which involve more than the sense of hearing.

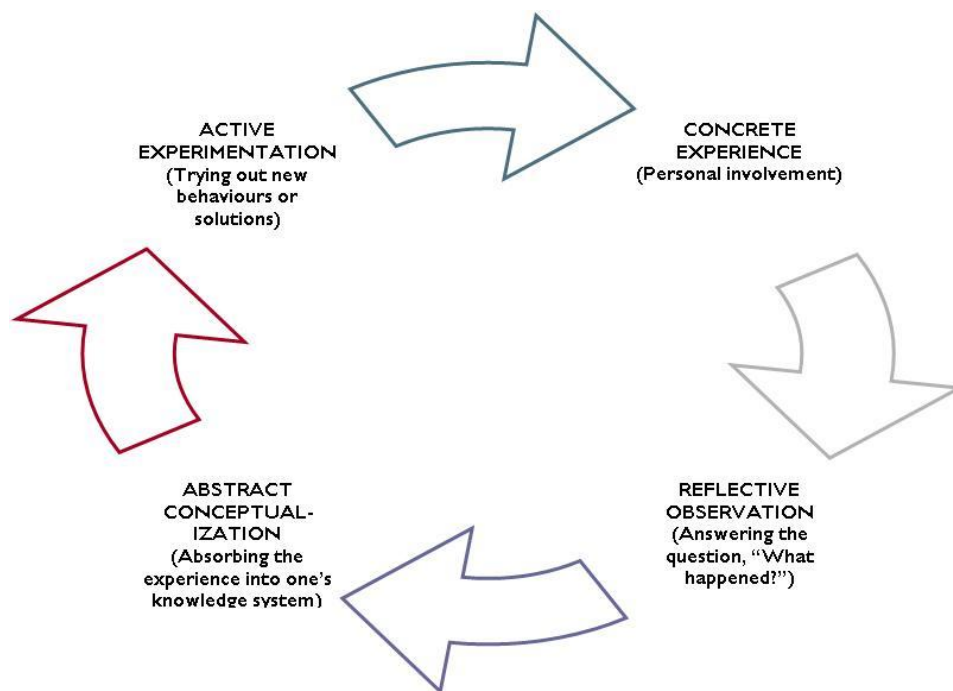
This percent of learning....	Occurs through this sense
80%	Sight
10%	Hearing
5%	Touch
5%	Smell/ Taste

This training workshop follows the experiential model of David Kolb. He suggested a cycle of activities composed of four elements.

- ✓ After being involved in a concrete experience (1),
- ✓ the trainee has an opportunity to reflect (2) on it.
- ✓ This in turn should lead the trainee to abstract some principles and concepts (3) from the experience,
- ✓ and finally to test these generalizations and abstractions by actively experimenting (4).

The active experimentation or testing out of behaviour, it is hoped, will provide a new set of concrete experiences that will cause the learner to think about the issues some more. We hope that trainees will be inspired by the exercises to reflect on these key questions: What happened here? Why is this significant for me/ my work? What can I do as a result of this insight?

Your role, as the trainer, will be to encourage the trainees to move from the concrete experience through the reflection to the process of abstracting principles and ideas. For this, it is important to read and prepare each exercise carefully.



In some instances, sessions begin with a lecturette covering key points that the ICTC team must know (e.g., the integration between TB and HIV programmes). The role-plays or case discussions would follow the lecturette. Built into the role-plays are discussion points to help the trainees to process the role-play and make linkages with the lecturette points.

It is helpful for trainers to develop good relationships with trainees during the program because this will make communication easier and create a warm workshop climate. Some ways to do this are to learn participants' names, recognise their strengths and weaknesses, and spend some informal time with them. A good trainer is able to relate to many types of people, and involve them in the programme.

Group dynamics

Group dynamics refers to how people interact with each other in groups. All training workshops have people with different levels of experience and ability. In the ICTC workshop, the trainer is faced with an additional factor- people from different professional backgrounds who traditionally hold different social statuses (e.g., nurse is subordinate to the doctor). These differences are challenging for the trainer who must find a way to get everyone to take part. Acknowledging each profession's respective contributions to the group would lighten up the atmosphere. One way of doing this in the ICTC workshop is to ask for reactions from different participants such as counselling personnel and testing personnel, as well as the doctors.

Instruction for new team members:

While this training is intended for ICTC team members who have already received induction training, there might be some staff who have been recently hired. These individuals who have not received induction training require special encouragement to participate as much as they can. As a trainer, you can also refer them to the training manuals relevant to their work which are available on the NACO website. It may not be possible to meet all their informational needs during this workshop. However, you can help them see how certain topics do not require prior technical knowledge (e.g., learning about the different forms).

Establishing a Learning Agreement

A learning agreement focuses on the training needs of the workshop participants. It is important to facilitate this process because it conveys to the trainees that learning is a two-way, interactive process.

- ✓ Ask participants what they hope to learn from this workshop
- ✓ Assist trainees to get a quick snap-shot of learning needs
- ✓ Emphasize learning new skills, attitudes and knowledge
- ✓ Display on a flip-chart the learning agreement.

Ask participants what they can do to maximise their own learning from this workshop and record their responses. Also referred to as **Ground rules**, these would range from

- ✓ reaching on time
- ✓ listening attentively
- ✓ reading materials given to them
- ✓ listening to divergent viewpoints respectfully, given that HIV/AIDS is a stigmatising disease.

Other questions for trainees to consider are:

- ✓ What might stop you from achieving what you want from this workshop?
- ✓ How will you know when you have learned what you want to learn?

Some common ground rules:

- ***respect opinions***
- ***only one person to talk at a time***
- ***stick to the subject***
- ***no shouting***
- ***everyone to contribute***
- ***no interruptions from cell phones***
- ***punctuality***

A learning agreement is incomplete without a commitment from trainees to participate fully. This is also the point where you as the trainer can make explicit own goals, and explain how the various workshop sessions relate to these goals. The workshop schedule can also be related to the NACP III. As the trainer, you can also use the findings from the Pre-test questionnaire to identify common knowledge gaps and point these out to the group without naming any particular individual. The session on the Refresher Quiz on AIDS is another self-diagnostic tool for the trainees.

REMEMBER:

Participants often come with many needs and expectations.

- ✓ You are a trainer and solving all the problems faced by different staff in their working environment is not one of the objectives of this workshop.
- ✓ For example, trainees may report they don't get salary in time, or there is too much workload for counselling personnel; While acknowledging their problems, you could explain why this workshop may not solve their problem and clarify the scope and limits of the workshop
 - The trainer may be someone hired to train staff in a particular state and may have no real voice in funding and allocation decisions. However, the trainer may be able to pass on trainees concerns in a brief feedback report to the commissioning authority such as the State AIDS Society, or the trainer could make time for trainees to prepare such a report themselves
 - The Operational Guidelines for the ICTCs indicate who is in-charge of various functions. The trainer can help the trainees to identify the proper official, note his/ her name down in their list of Common Contacts (See the session on ICTC Ecomapping) and encourage them to contact this person through the proper channels
 - The trainer clarifies limits of his/her powers and abilities to change the ground-level reality.

Some Experiential Techniques Used in this Training Programme

Brainstorming

This technique permits a group to generate a range of useful ideas and opinions on a subject or problem by withholding criticism, judgment and evaluation. It is a useful tool to encourage quiet or low-status group members to contribute, and may generate good ideas for problem-solving.

If you are using this technique it is important that you emphasize the following rules:

- ✓ No comment, criticism, judgment or evaluation while brainstorming
- ✓ Brainstorming focuses on quantity not quality
- ✓ Even completely wild or unfeasible ideas are accepted while brainstorming
- ✓ There is no personal ownership of ideas. So trainees may build on ideas contributed by others
- ✓ All ideas will be briefly noted on a flipchart or blackboard without comment.

When it is clear that the group has stopped generating ideas, you as the trainer can facilitate a discussion about the most promising possibilities.

In this workshop, trainees are asked to brainstorm how they can build up referrals between the ICTC and other health facilities/ community services in the “ICTC Referrals and Linkages” session, (Page 44).



Case Studies

Case studies comprise real (or invented but realistic) incidents. These are described to trainees orally or in writing during this workshop. Trainees are then asked to use their knowledge and skills to suggest solutions, alternatives, or consequences. The discussion to analyse the situation could be in small groups which report back to the main group later. It is important when using case studies to allow the ideas to emerge from the groups. While you as the trainer are interested in shaping certain attitudes, you can gently question certain assumptions implicit in the presentations.

In this workshop, trainees discuss case studies in the “ICTC Referrals and Linkages” session, Page 49 (Do I need HIV Testing case profiles) as well as the “Understanding and Managing Stigma and Discrimination” session, Page 140.



Role Plays

While trainees generate verbal solutions to case studies, they act out their solutions in role-plays. Role-plays can also be used to practise new skills.

This workshop involves role plays in the session titled “Why do patients need counselling?” (related to Provider-initiated Testing, Page 74). Trainees have



to apply the information from the lecturette. They also have a chance to voice their reactions to the role play.

Story Telling

Story-telling is an ancient tradition. The oral tradition passes on many epic stories with morals for good living. They can be used effectively in a training situation. Ribes (1990) states that stories or parables are not “gap-fillers” or “time-killers” to entertain the audience. They are intended to trigger off a discussion, to provoke the trainees to look back on their own experience to when they might have encountered a similar attitude or behaved in a like manner themselves.

Care should be taken in introducing this activity.

- ✓ The trainer should ask the trainees to listen attentively.
- ✓ The story is either read out or narrated by a good story teller.
- ✓ When different voices are involved, the trainer can request audience members to take these different roles.

The story should be followed immediately by discussion. It is a good idea to give questions related to the story. Even shy and diffident trainees can relate to a story and share their opinion because this does not involve technical knowledge.

Write down the key points on the board or the overhead transparency. Allow the views of the participants to emerge, rather than feeding the answers to the trainees.

The final question relates to the “moral of the story.” Again this has more impact if voiced by the trainees themselves instead of the trainer stating it.

In this workshop, the session titled “The Tree and the Branches, Page 154 is an example of this training technique.



Breaking up into groups

Participatory learning activities usually involve working in small groups where participants all have a chance to voice their views. In this training programme, some activities require participants to work in groups consisting of their own ICTC team members, or groups

consisting of people performing the same function as themselves (e.g., lab technicians, nurses, etc.). But some activities call for breaking the whole group into smaller ones.

This can be done in creative ways:

- ✓ You can ask trainees to group themselves according to the season they prefer, or the toothpaste brand they use.
- ✓ Trainees who are seated in particular places can be mixed up through simple statements such as, “The wind came and blew all people wearing watches, all people wearing earrings, all people in blue, all the men, etc.” After this the trainer can ask trainees to form groups with people sitting around them in their new spots.
- ✓ Trainees can also line themselves up in series such as their birthdays, or their height or where they were born (that is from East to West) and then be divided into groups of the desired number.

Question Box

The question box is a good technique to elicit instant feedback from participants about areas where they are still confused or where they have doubts. You should display the box on the first day and announce that you will place it within the training hall so that trainees can drop those questions they may feel have not been answered during the course of a session, or which they may feel too intimidated to ask because of the presence of their peers.

At the end of each day, before dispersing, open the box in the presence of the participants and along with your team of resource persons, answer the notes placed there.

Remember that your trainees are also a resource. So a good idea might be to say something like, “One of our friends has the following doubt. Is there anyone here who knows the answer?” Only after it is clear that no one within the group has a satisfactory answer should you turn to the team of resource persons.

Participants might use this opportunity to give feedback about something that is bothering them about the training programme. If you receive such feedback through the question box, try to address it as best you can.

Note:

Please note that we have tried to verbalise the dialogue for you. This will assist you in giving instructions to trainees as well as explain the role plays and other training mediums.

References

- ✓ Bourner, T., Martin, V., & Race, P. (1993). *Workshops that work: 100 ideas to make your training events more effective*. London, UK: McGraw-Hill Book Company.
- ✓ Healthlink Worldwide and Disability Dialogue (2003). Exploring the training process. Accessed from <http://www.healthlink.org.uk> on July 27, 2009.
- ✓ Ribes, P. (1990). *Parables and fables for modern man*. Bombay, India: St. Paul's Publications
- ✓ Wade, P.A. (1995) *Producing high-impact learning tools*. Irvine, CA: Kogan Page.

Trainer's Checklist

Two months before training

Training Site	YES	NO
Have I selected a suitable training site with sufficient space to accommodate the trainees?		
Does this training site allow me to rearrange chairs for group work?		
Are there enough electrical points for equipment such as a slide projector, and do I need to darken the room with curtains?		
Have I reserved the training site?		
Does the training site also provide food or do I have to make other arrangements?		
Invitations		
Have I sent out invitations or circulars to the officials who will depute the trainees? OR Have I sent the invitations or circulars to the ICTC staff who will attend the workshop?		
Have I identified my resource people? Have I spoken to them informally, and then followed up with a letter of invitation?		
Do my invitation letters and circulars contain the dates, times and directions related to the workshop? Are trainees and invitees able to call me up for clarification?		
Training Materials		
Do I have the trainer's guide and any other training material required?		
Do I have enough copies of the trainees' handbook for distribution or do I have to order them?		
Do I have a copy of the Operational Guidelines?		

Two weeks before training

Training Site	YES	NO
Have I reserved sufficient chairs?		
Have I reserved the training equipment such as microphone, projectors and projection screen?		
Have I tested the electrical equipment? Do I know who to contact if there is a failure? Besides me, can anyone else troubleshoot with the equipment?		
Have I ordered the food for all the workshop meals? Does my headcount for the catering include trainees, trainers, invitees and assistants?		
Do I need to prepare a workshop banner?		
Have I prepared little posters to guide people to the workshop site?		
Invitations		
Have I received confirmation from trainees or their supervisors? Do I need to make follow-up phone calls in case there is no confirmation?		
Have I reconfirmed with my resource people? Do they know how to reach the training site? Have I informed them about the workshop theme?		
Am I planning to click photographs?		
Training Materials		
Are the workshop handouts such as Pre-Workshop Questionnaire ready?		
Have I made enough copies of the session materials such as the Case Profiles and Role Play Situations?		
Have I purchased the stationery for the trainees?		
Have I purchased materials for the training exercises such as markers, chart paper, sticking tape, name tags, OHP sheets?		

The morning of the workshop

Training Site	YES	NO
Is the training site clean and welcoming?		
Is all the equipment in place?		
Is the furniture arranged?		
Are the little posters to guide people to the workshop site and to the toilets displayed at visible locations?		
Is the workshop banner in place?		
Is there water or tea for guests to drink when they arrive?		
Are the meal arrangements set?		
Training Materials		
Are the workshop handouts for the first day ready?		
Is there a sign-in/ registration sheet? Do trainees receive their workshop materials on arrival?		

Day 1

Pre-Workshop Questionnaire

Pre Workshop Questionnaire

Session Overview

- ✓ Pre-workshop questionnaire (15 minutes)
- ✓ Compilation of key concerns (outside workshop schedule)

Session Objectives

- ✓ To identify the training needs of the ICTC trainees at the beginning of the workshop.
- ✓ To obtain a baseline of HIV/AIDS knowledge of trainees at the beginning of the workshop.

Time Allowed

15 minutes

Materials

- ✓ Pre-workshop Questionnaires

Method

Preparation

- 1) Before the session, you, as the trainer, will make enough copies of the Pre-workshop Questionnaires and keep them ready in an envelope.

Pre-Workshop Questionnaire

Page 18

- 2) You, as the trainer, will distribute the questionnaires with the following instructions:
“Please fill this form completely and return it to me. Please do not discuss the answers with other people around you. You have about 10 minutes for this. Write as much as you know and don’t worry about not knowing the answers. This is just to give us an idea about the level of the group to conduct a good training workshop. Do not worry, if you don’t know some of these items. They will be covered during the workshop.”
- 3) Collect the forms as trainees finish them and thank them for completing it.
- 4) While the other sessions take place, you or an assistant should go through the questionnaires and score them with the point system given below.
- 5) Also, you should compile a list of key concerns of the trainees that comes from their answer to question on challenging situation at ICTC. You may display this list on a chart paper and refer to it during the workshop during the relevant sessions.

Pre-Workshop Questionnaire

NAME: _____

1. Your position in the ICTC: Medical Officer/ Counsellor/ Lab Technician/ Outreach Worker/ Nurse/ others (specify)_____
2. Address of your ICTC:_____
3. How long you have been working in the ICTC? _____
4. Tell us about one challenging situation that you have faced in the ICTC.

INSTRUCTION: Circle the right answer for the questions below.

5. When HIV spreads in the general population and HIV prevalence is consistently over 1% in pregnant women, this is described as a
 - a. Low-level epidemic
 - b. Concentrated epidemic
 - c. Generalized epidemic
6. HIV has 2 subtypes. The MORE COMMON SUBTYPE in India is
 - a. HIV-2
 - b. HIV-1
 - c. HIV-3
7. Opportunistic infections are so called because
 - a. They do not infect HIV negative persons
 - b. They take advantage of the immune system that is weakened by the HIV
 - c. They infect HIV positive individuals at home
8. Which of the following is a common opportunistic infection in India
 - a. Tuberculosis
 - b. Avian flu
 - c. Worm infections

9. You can DEFINITELY confirm that a person is infected with HIV using an ELISA test
- a. In the first week after infection
 - d. After the window period
 - e. Any time after HIV virus enters blood
10. Say TRUE or FALSE
- a. Rapid antibody tests for HIV are conducted using blood from a finger prick
 - b. AIDS and HIV are one and the same
 - c. Persons with low CD4 have low viral load
11. Antiretroviral treatment is started
- a. To cure HIV/AIDS
 - b. When CD4 is below 300
 - c. If person is tested positive for HIV virus
12. The regimen used by NACO to prevent transmission of HIV from a pregnant HIV-positive woman to her unborn child (that is PPTCT) is:
- a. Single dose of Nevirapine to the baby on the third day
 - b. Single dose of Nevirapine to the mother at the time of labour and on the third day after delivery
 - c. Single dose of Nevirapine to the mother at the time of delivery and a single dose of Nevirapine to the infant immediately after birth
13. Provider Initiated Testing means
- a. The Health Care Provider (that is doctors and nurses) get tested for HIV every month
 - b. The Health Care Provider (that is doctors and nurses) refer for testing those patients who show symptoms of HIV/AIDS or who have conditions that might encourage HIV infection (like STIs)
 - c. The Health Care Provider tests all the patients for HIV

Scoring of the Pre-Workshop Questionnaire

1-4 : no scoring, only information gathering.

5.) (c) Generalised epidemic. The National AIDS Control Programme III terms those districts which have such a generalized epidemic as Category A Districts or High Prevalence districts. There are 163 such districts in India as per 2006 behavioural surveillance survey.

6.) (b) HIV-1. The two subtypes of HIV are HIV-1 and HIV-2. The most common subtype in India is HIV-1. HIV-1 has a faster course than HIV-2 in general. But there are many other factors which affect the course of the illness.

7.) (b) They are the common illnesses but when the immune system of the HIV positive person gets weakened by the virus, the person contracts these illnesses easily.

8.) (a) Tuberculosis is the most common opportunistic infection in HIV disease, the most common cause of morbidity and the leading cause of death in PLWHA. PLWHA have a 50 to 60 percent lifetime risk of developing TB as compared to HIV negative persons whose life time risk is 10 percent.

9.) (b) Seroconversion which is the development of antibodies takes place 1 to 6 weeks after infection. ELISA is an antibody test which will only show a true picture after this period. The average time taken for people to develop detectable antibodies is 25 days. In extreme cases, it can take upto 6 months. The Window Period is the time when the person has been infected but antibodies have not developed. The person can still transmit HIV.

10.) (a-True) Currently HIV testing in India is performed on serum/ whole blood (finger prick) and plasma.

10.) (b-False) HIV is the virus which causes AIDS. AIDS is the advanced stage of infection. They are not the same.

10.) (c-False) When CD4 is low, viral load will be high. High CD4 and low viral load is the sign of healthy individual.

11.) (b) ART assists in increasing the CD4 (helper cells) and thus decrease the amount of virus in the body. This assists the person in fighting infections. It is not a cure for AIDS.

12. (c)

13.) (b) Provider-initiated testing involves recommending testing to those patients who need it because they show signs and symptoms of HIV/AIDS, or because they may have conditions like STIs which provide a good environment for HIV transmission. Though providers may refer them for testing, patients always have the right to refuse to be tested, that is they can

‘opt out.’ Health Care Providers should not refer all patients for HIV testing. Such routine or universal precaution violates human rights and is also against national health policy.

References

- ✓ Joint United Nations Programme on HIV/AIDS (2008). Fast facts about HIV. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ Joint United Nations Programme on HIV/AIDS (2008). Fast facts about HIV prevention. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ Joint United Nations Programme on HIV/AIDS (n.d.). Fast facts about HIV testing and counselling. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ Joint United Nations Programme on HIV/AIDS (2008). Fast facts about HIV treatment. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ National AIDS Control Organisation (2007). *Guidelines for HIV testing*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- ✓ National AIDS Control Organisation (n.d.). FAQs. Accessed from http://www.nacoonline.org/Quick_Links/FAQs/ on August 12, 2009.

Day 1

Introduction Game

Introduction Game

Session Overview

- ✓ Personal introduction by each trainee (20 minutes)
- ✓ Team-wise introductions (30 minutes)
- ✓ Brief overview of the programme (10 minutes)

Session Objectives

- ✓ To enable trainees to become acquainted with each other.
- ✓ To provide a brief overview of the workshop activities and structure.

Time Allowed

1 hour

Method

Preparation

- 1) You and your team of trainers and training assistants have to prepare for the second stage of this session, Team-wise Introductions. Just as you will ask each ICTC team to develop an introduction of the team, your team (trainer's team) will also have to produce a team identity and present to the group. For this you may have to meet before and practise. Your team may unleash its creativity with a song and dance routine to inspire the trainees. But make sure that this is something that all your trainers feel comfortable doing

Personal Introduction by Each Trainee

- 2) You, as the trainer, will begin the session with these words of welcome: "Welcome to the ICTC Team Training Workshop. We will be spending three days together as a group. We will be learning new things and will perform many group activities. So it would be nice to get to know each other beyond just our names. I invite you to take turns introducing yourself to the group. Tell us your name, which ICTC you represent, what is your designation (Nurse, LT, MO, Counsellor), and one thing you find interesting in your work in the ICTC."
- 3) As trainees may be shy, you, as the trainer, should start the introduction by talking about yourself personally, and in brief. For example, you may say, "I am Dr. Kiran. I am the ICTC trainer from XYZ. While I don't have an interesting story about the ICTC, one interesting thing about the training programme is how hard the ICTC teams work to provide services to People Living with HIV/AIDS."
- 4) After all the trainees have introduced themselves, also invite other members of your training team to introduce themselves.

Team-wise Introductions

- 5) "Now that we know each other's names, let us introduce ourselves as a team. Here each ICTC team will get together and discuss what they would like to call themselves. The name should say something about your work or about yourself as a group. It could describe the type of work you do, or the people to whom you provide service. But the name should be something that is self-explanatory. You will have five minutes to discuss this with your team members. When you tell us your team name, please also tell us why you have decided to choose that name."

- 6) “As an example, our team of trainers will introduce themselves to you. We are the Wonder Trainers of Bhopal. (We are the Super six Teachers of Chennai; We are the HIV Superbusters.) We chose this name because ...”
- 7) After doing your team introduction, give the teams five minutes to decide the name.
- 8) Invite each team to announce or perform their team name and to explain it. After each team announces their team name, show your appreciation by clapping and inviting all the other trainees to clap for them.
- 9) End this activity with a brief comment: “Thank-you for sharing your team names with us. Just as you work in the ICTC as a team to carry out the task of working with people needing testing and HIV referral services, so also you had to work together to select a team name and then present it. Through this workshop you will have a chance to examine different aspects of the work that your team is required to do. Some of these you are already doing, and in many cases, doing well. But there may be areas which are new or require review. Through this workshop you will have a chance to learn about them and work on them.”

Brief Overview of the Programme

- 10) Give a brief overview of the workshop: “Before we proceed to our first session, let me just tell you briefly what you can expect from this workshop.”
 - a. “On the first day, we will look at some issues related to who comes to the ICTC and what kind of services they can expect from there. We will also briefly examine the national policy related to ICTCs.”
 - b. “On the second day, we will begin with group presentations. I am giving you this advance notice so that you can start thinking about the presentations. The presentations will be made separately by testing personnel, counselling personnel and by MOs. So please start thinking about what you think you would like the group to know about your work as testing personnel, counselling personnel or MO. More details will be given tomorrow. Tomorrow, we will also discuss HIV testing, the role of ICTCs in relation to the national TB programme, and we will look at stigma, discrimination, universal precautions, and post-exposure prophylaxis.”
 - c. “On the last day, in the morning, we will cover a lot of important information about PPTCT, that is Prevention of Parent to Child Transmission, and in the

afternoon, we will talk about documentation, reporting, working together as a team, etc. Some groups will make their presentations on Day 3.”

- d. “All through the workshop, we will talk about the various registers and forms ICTC staff must maintain because this is an important aspect of being able to account for the good work the ICTCs do.”
- e. “Many of you have already attended Induction workshops. For instance, counselling personnel would have attended a 12-day induction. So you may think that some of the information is very simple and basic. Please remember, this workshop is not trying to teach you how to be a good counsellor, or how to conduct laboratory testing. Instead, this training programme is geared towards the day-to-day procedures you are expected to follow as ICTC staff. These have been mentioned in the Operational Guidelines for ICTCs. They include what documentation and registers you have to maintain.”
- f. “This workshop has a mix of counselling personnel, testing personnel and doctors. So what may seem like very simple and basic information about counselling to counselling personnel may be complex for those who are not doing counselling. In the same way, what testing personnel find easy, may be difficult for non- testing personnel. We are trying to stick to a middle level of difficulty.”
- g. “There may be a few people who have not been fortunate to attend an induction so far. This workshop will give you some idea of what you should be doing. But you should also refer to the induction materials related to your work. You can find this on the NACO website. Please ask your colleagues to guide you. Many of them have undergone induction training and are familiar with these materials. They are good resources for you. You are also welcome to ask questions during the workshop.”
- h. “Also, as we talk about how the ICTC should work, you may find that you are already doing something. In this case, please use the sessions as a revision, and share your experience with the group if time permits. Some information may be new and you may have to pay more attention. For example, you may be aware of how to do the testing or the counselling for general patients, but the same for pregnant women may be new for you. So we request your co-operation.”

11) At this point, go over the Ground Rules for the workshop. Refer to the Notes to the Trainer for this. (Page 5)

Day 1

ICTC: Roles, Referrals and Linkages

ICTC: Roles, Referrals and Linkages

Session Overview

- ✓ Filling the ICTC Ecomap as a the team (25 minutes)
- ✓ Large group discussion of ICTC Ecomaps (20 minutes)
- ✓ Lecture using slides (30 minutes)
- ✓ Small group discussion of Do I need HIV Testing? Case Profiles (15 minutes)
- ✓ Large group discussion of Do I need HIV Testing? Case Profiles (30minutes)

Session Objectives

- ✓ To demonstrate the counselling and testing needs of various population groups.
- ✓ To discuss the role of the ICTC as a service provider of HIV testing services.
- ✓ To examine from where ICTC clients come and organisations or services referring clients to ICTC
- ✓ To examine how the ICTC serves as a referral and linkage organization to other services.
- ✓ To explore how to increase and strengthen such linkages with other services.

Time Allowed

2 hours

Materials

- ✓ ICTC Ecomap from Handbook
- ✓ Poster papers (one for each ICTC team)
- ✓ Coloured markers (two for each ICTC team)
- ✓ Common Contacts pages in the Trainee's Handbook
- ✓ Slides related to the session
- ✓ Case profiles titled Do I need HIV testing?

Suggestion to the Trainer:

If your training venue has space, you can encourage the ICTC teams to display their Ecomap posters on the walls. Provide them with cello tape or thumb tacks for this. If space is limited, then you can rotate the team posters, displaying a few each day and changing them every morning. This will give the trainees a greater sense of participation and ownership in the workshop.



Method

Preparation

- 1) Before the session, make enough copies of the Case profiles titled ‘Do I need HIV testing?’ so that there is one case profile for each trainee. Cut up the slips and keep them ready in an envelope.



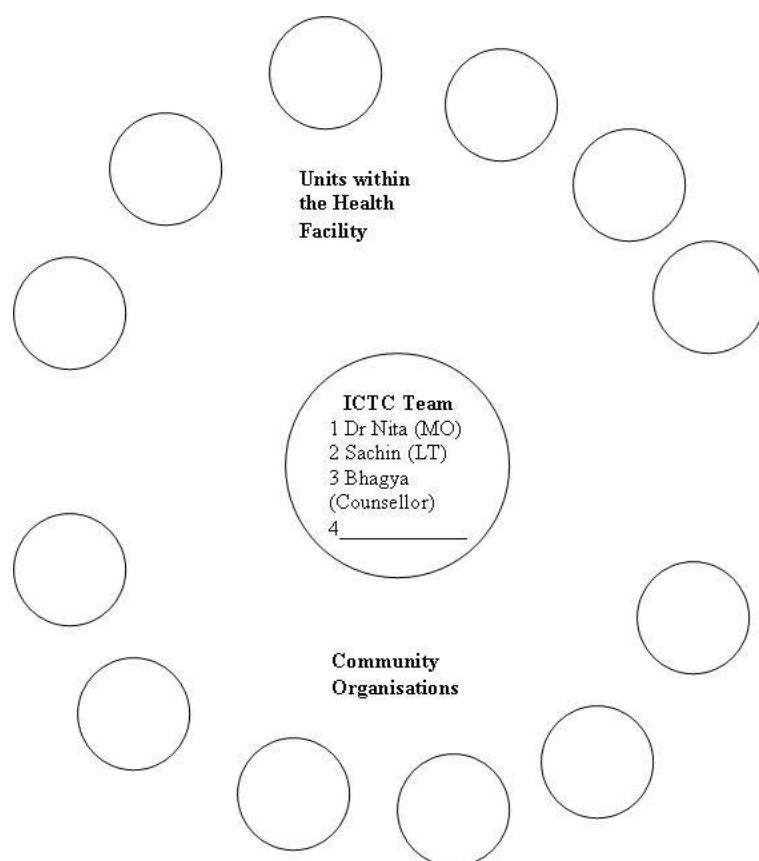
Filling the ICTC Ecomap as a Team

- 2) You as the trainer will ask the trainees to sit together with other members of their ICTC. Give each team one poster sheet and two markers.
- 3) Introduce the session with the following brief background of the ICTC.
 - a. “Integrated Counselling and Testing Centres are the entry point for people wanting to know if they are infected with HIV/AIDS. The people who come for testing have many profiles. There are women who are married and have probably been infected by their husbands. There are their children whose HIV status is unknown. There are men who have sex with other men. There are men who have sex with sex workers. There are the women who do sex work. The ICTC has to deal with all of these individuals.”
 - b. “Clients come to the ICTC in two ways. Some come to the ICTC because they have heard about AIDS somewhere and are worried that they may have it. Others are sent or referred by doctors or nurses or NGOs. In this exercise, we will look at where they come from.”
 - c. “Clients are also referred from the ICTC to other services. In this exercise we will also look at where we send the ICTC clients.”
- 4) “Please turn to the ICTC Ecomap in your handbook. This is a visual tool that permits a person to see how they interact with key services and elements in their environment. The organisational ecomap is a systems application created by Armand Lauffer to allow organizations to examine their community connections. We will use it to see how our different ICTCs operate and link up with other services.”
 - a. What you see in your handbook is the basic empty map. Each ICTC team is going to create the ecomap of their particular centre on the poster papers

Page 46 in Trainer's Guide; Page 115 in Handbook

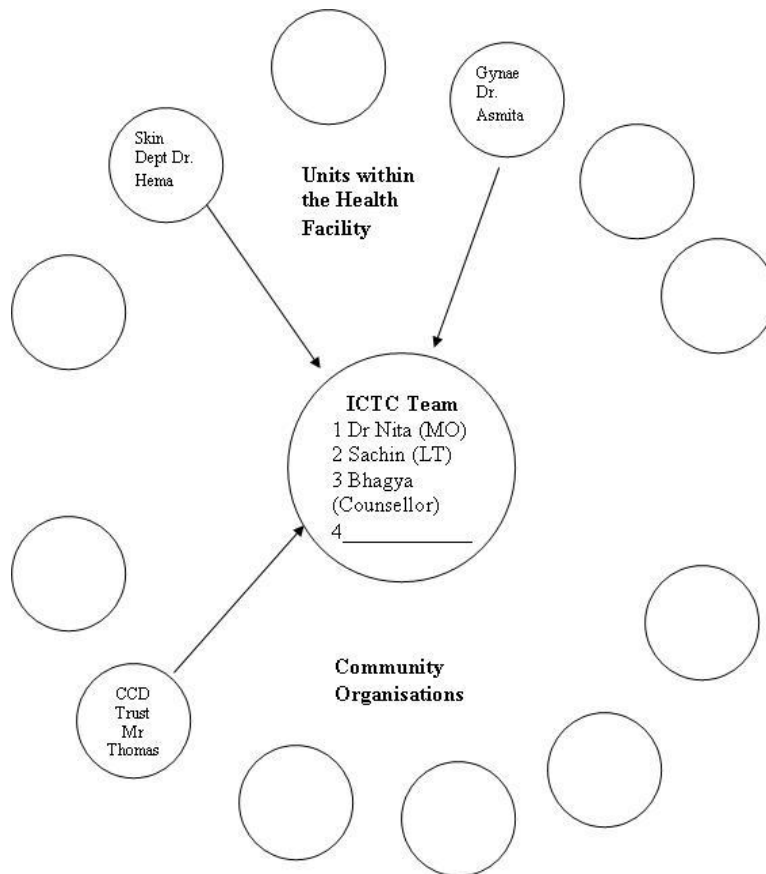
- b. “First, look at the big circle in the centre which represents your ICTC team. Fill in the names of all the members.”

Give the trainees some time to complete this first task. They might decide to sit on the floor with the poster so that they all have space. Ask them if they are ready to move to the next step.

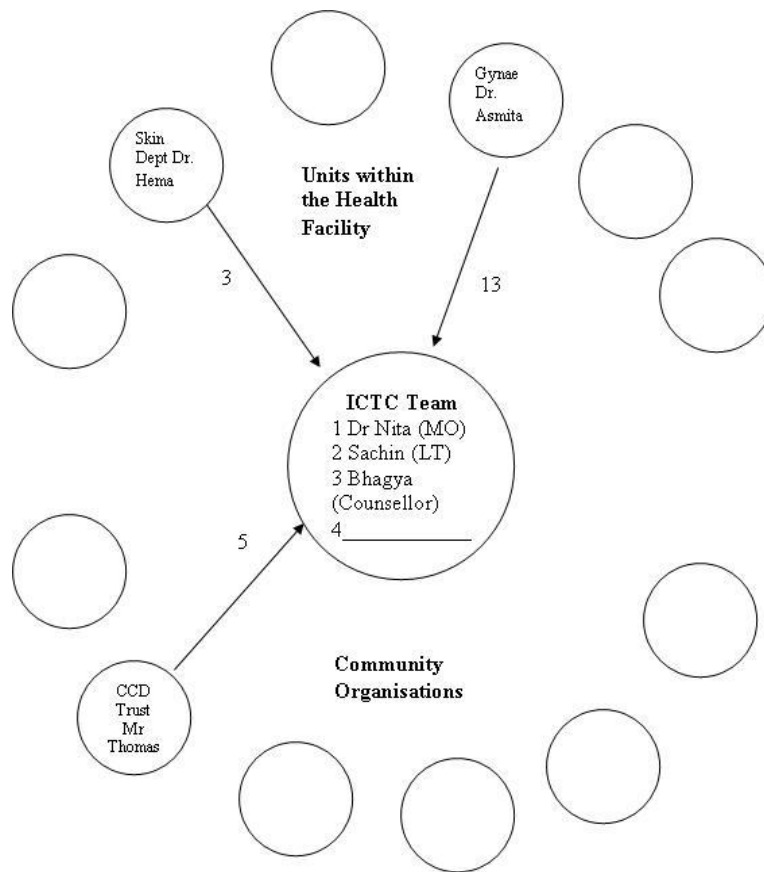


- c. “Next, look at the upper circles. These are units or departments within your hospital or health centre. For instance, your ICTC might get clients referred by the Skin department. Show this by writing the word Skin department in one of the upper circles. Your ICTC might also be seeing in-referral patients from the Gynaecology unit. So use another circle to show the Gynae department.”
- d. “As you fill in details of the hospital units that send patients for testing to your ICTC, also mention the name of the person who is referring patients from that unit. You may have more than one doctor or social worker referring from some department.”

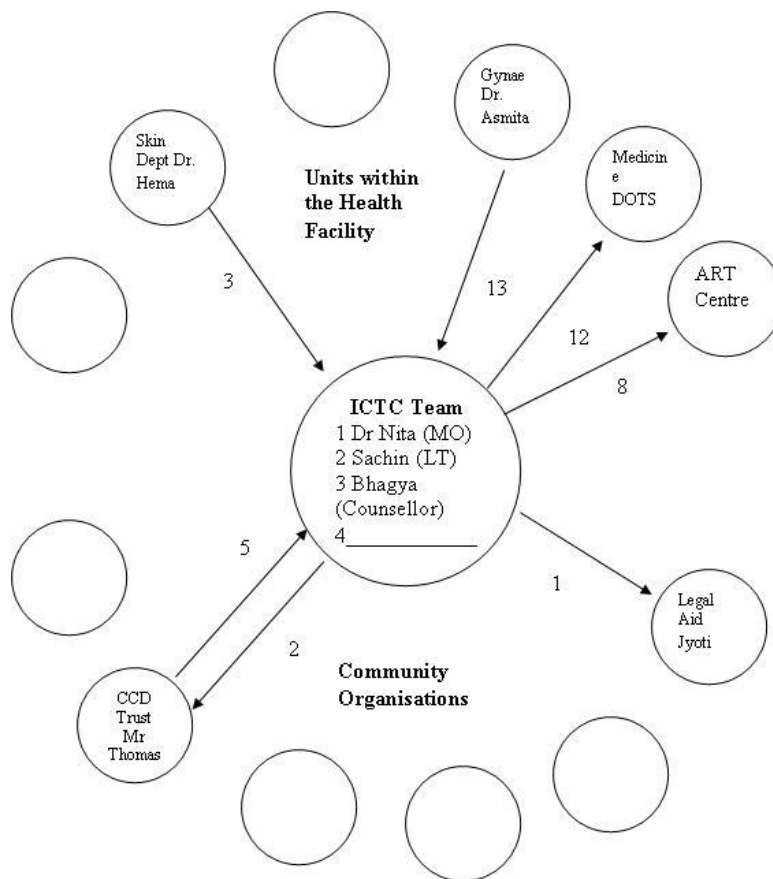
Give the teams time to fill in the upper circles. Ask them which units are referring clients for testing.



- e. “Now that you have all the hospital units mapped out, draw an arrow from each smaller circle to the larger ICTC circle to show the direction in which patients are travelling, that is from the other departments to your centre.”
- f. “If you know how many patients came from each unit last month or last week, write that number on the arrow.”
- g. “Now let us look at the lower circles. The lower circles represent organisations in the community that send patients for testing. For instance, there may be a local, private maternity hospital or a non-governmental organisation (NGO) working with truckers. Highlight also other targeted interventions. Just as you did with the upper circles, write the names of the different organizations in the different circles. For each organization write the name of the organisation and the name of the contact person within that organisation. Draw an arrow to show that patients travel from the NGO to the ICTC.



- h. “The last step is for you to draw where patients go from the ICTC that is the out-referrals. Just as other organizations or departments refer clients to the ICTC, the ICTC also refers clients to other services. For instance, you may send someone for tuberculosis treatment to a microscopy centre, or someone else to the ART centre. Just as you used the upper circles to show hospital departments which refer patients to you, use the upper circles to show the hospital or health centre departments where you send patients. Write the name of the unit and the name of the contact person. Draw the arrow going from the ICTC to the upper circle.”
- i. “In the same way, your ICTC may also refer clients to community services or organizations. Show these out-referrals with arrows to the lower circles.”
- j. “At the end you have a visual which shows from where patients come to the ICTC, and also where they go.”



Large Group Discussion of the ICTC Ecomap

- 5) For the group discussion phase, first ask two different ICTC teams to come forward with their poster and explain the in-referrals and the out-referrals. Ask them simple questions like how many clients are referred from outside the health centre, and how many from within, and how many patients they serve within the day.
- 6) Next, select different ICTC teams to answer the questions below. Ask at least 2 different teams to answer one question, and encourage the quieter ones to talk. Encourage the team to hold up the ICTC ecomap when answering:
 - a. In general what kind of patients does your ICTC serve?
 - b. Do you know how far they come from and how they travel?
 - c. From which hospital units do your ICTC clients usually come?
 - d. From which community organizations do your ICTC clients mostly come?
 - e. To which hospital units do you refer your clients?
 - f. To which community organizations do you refer your clients?

- g. The ICTC may refer patients to other units. But how would you know if they are reaching there?

Lecture using Slides

Page 37

Page 47 in Trainer's Guide; Page 116 in Handbook

- 7) Explain the key points using the slides.
- 8) “Please turn to the Common Contacts page in your handbooks. This is a place where you can note the contact details and addresses of key people with whom you interact professionally for the purpose of referrals and linkages. Such people could be within your health centre or could be at NGOs and community organisations. We encourage all ICTC staff to use this section in the handbook.”
- 9) Give the trainees some time to fill this section in their handbook. This is only to introduce them to this activity. Instruct them to update this list periodically.

Small Group Discussion of ‘Do I need HIV Testing?’ Case Profiles

- 10) Ask the trainees to form groups of 5 members. Distribute a ‘Do I Need HIV Testing?’ case profile slip to each trainee. Each group will have more than one case profile to discuss. Ask the trainees to answer 3 questions in relation to the case profile:
- Does the person need HIV testing?
 - Explain why.
 - Does anyone else in that situation also need to be referred for testing (e.g., a sexual partner)?

Page 49 in Trainer's Guide; Page 127 in Handbook

Large Group Discussion of ‘Do I need HIV Testing?’ Case Profiles

- 11) Gather everyone together into the main group.
- 12) Ask each group to report one case only. Other groups may add to the sharing or challenge their conclusions. Let the large group discussion continue till all the case profiles have been discussed. But make sure that there is order in the presentation. If the group is too noisy, or if more than one person is speaking, remind them about the ground rules.


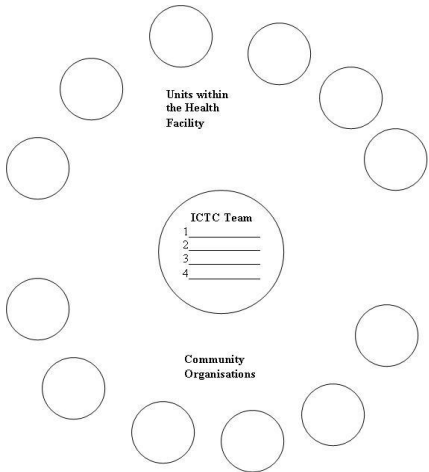
At the end of this session, there is a sample discussion of a few cases to guide you.

Page 52

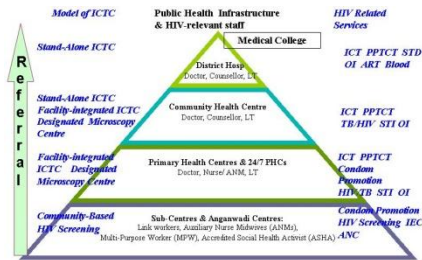
References

- ✓ Lauffer, A. (1982). *Assessment tools for practitioners, managers, and trainers*. Beverly Hills, CA: Sage Publications.
- ✓ MacNeil, J.M., & Anderson, S. (1998). Beyond the dichotomy: Linking HIV prevention with care. *AIDS*, 12 (suppl 2), S19-S26
- ✓ National AIDS Control Organisation (2006). *National AIDS Control Programme Phase III*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- ✓ National AIDS Control Organisation (2007). *Operational guidelines for Integrated Counselling and Testing Centres*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- ✓ Data supplied by the National AIDS Control Organisation.

Slides

SLIDES	COMMENTARY
	<p>Title Slide</p>
	<p>ICTC Ecomap Exercise</p>
<p>Discussion Questions</p> <ul style="list-style-type: none"> ➤ What kind of patients does your ICTC generally serve? ➤ Do you know how far they come from and how they travel? ➤ From which hospital units do your ICTC clients usually come? ➤ From which community organizations do your ICTC clients mostly come? ➤ To which hospital units do you refer your clients? ➤ To which community organizations do you refer your clients? ➤ The ICTC may refer patients to other units. But how would you know if they are reaching there? 	

<p>Main Functions of an ICTC</p> <ul style="list-style-type: none"> ➤ Early detection of HIV. ➤ Provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioural change and reducing vulnerability. ➤ Linking people with other HIV prevention, care and treatment services. 	<p>Unless an individual who is infected with HIV is aware of his/her status, they</p> <ul style="list-style-type: none"> ➤ Could unknowingly transmit the virus to others. ➤ Will not receive timely treatment. <p>The infected person can detect the presence of HIV through a simple blood test. An Integrated Counselling and Testing centre is such a service where a person is counselled and tested for HIV, on his/ her own free will or as advised by a medical provider. Its main functions are:</p> <ul style="list-style-type: none"> ➤ Early detection of HIV. ➤ Provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioural change and reducing vulnerability. ➤ Linking people with other HIV prevention, care and treatment services.
<p>Types of ICTCs</p> <ul style="list-style-type: none"> ➤ Stand-alone ICTCs ➤ Facility-integrated ICTCs 	<p>At present, there are two models of ICTCs operating in the country:</p> <p>Stand alone ICTCs: These are centres with a full-time counselling personnel and testing personnel who undertake HIV counselling and testing. They are found in medical colleges, district hospitals and 30-bedded CHCs throughout the country.</p> <p>Facility-integrated ICTC: which do not have full-time staff and provides HIV counselling and testing as a service along with other services in the facility. Existing staff such as the auxiliary nurse midwife (ANM), staff nurse or health visitor undertake HIV counselling and testing. Such ICTCs are usually established in facilities that do not have a very large client load and where it would be uneconomical to establish a stand-alone ICTC. Typically, such facilities are established in India in integration with the National Rural Health Mission (NRHM) in 24-hour Primary Health Centres (PHC).</p> <p>Less visible are mobile ICTCs which provide services to high-risk or vulnerable populations. These individuals are less likely to access ICTCs which are geographically fixed due to impediments such as distance and timing. Mobile ICTCs carry health services nearer to such groups.</p> <ul style="list-style-type: none"> ➤ Ask trainees from stand-alone ICTCs to raise their hands. ➤ Ask trainees from facility-integrated ICTCs to raise their hands. ➤ Ask trainees from mobile ICTCs to raise their hands.



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

- Ask trainees from District Hospitals to raise their hands.
- Ask trainees from Community Health Centres to raise their hands.
- Ask trainees from PHCs, NGOs or others to raise their hands.

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

Prevention of new infections in high risk groups and general population.

Providing greater care, support and treatment to larger numbers of PLWHA.

Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.

Strengthening the nationwide Strategic Information Management System.

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

Prevention of new infections in high risk groups (HRGs) and general population through:

Saturation of coverage of high risk groups with targeted interventions.

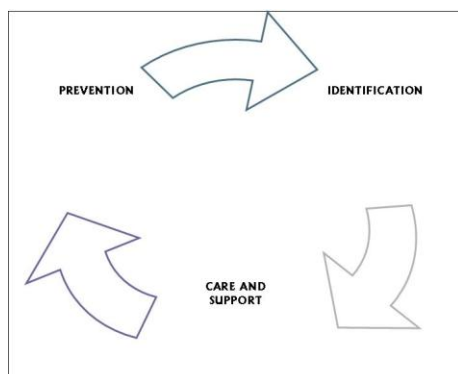
Scaled up interventions in the general population.

Providing greater care, support and treatment to larger numbers of PLWHA.

Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.

Strengthening the nationwide Strategic Information Management System.

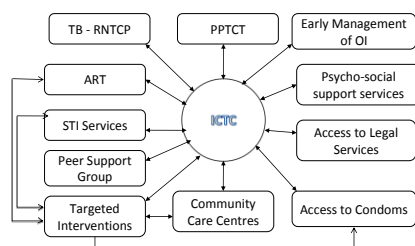
Continuum between Care and Prevention



This slide shows the relation between prevention and care activities. There is a connection or a continuum between them. Prevention activities reduce the number of people infected and in turn reduce the need for future care. At the same time, knowing that there are care and support activities, make HIV/AIDS visible in the community. For instance, if a PLWHA knows that there are care services available such as an ART centre that provides affordable services they will go to such a centre. Here they may receive the treatment they need as well as information on how to reduce the chances of opportunistic infections. If they act on this information then other people around them are safer.

Even though ICTCs are the entry-point for clients into the health system, they form part of a range of services, and must maintain good linkages with these other facilities and refer clients to these services as necessary. That is ICTCs fall into the category of prevention and identification. But personnel in the ICTC must also be aware of how their services flow into the care activities at other facilities.

ICTC and its Linkages



While you have each drawn your own ICTC ecomap, you may want to also look at the linkages that the NACP III is trying to strengthen between the ICTCs and the other service components. We will talk about these service linkages during the course of the workshop. Basically, the ICTC serves as a gateway or an entry-point to many other services.

The patient

may not know that such services are available,

or may not know how to use them,

or may not think that he/ she is eligible to use them.

The ICTC, therefore, must make suitable referrals to the services needed by the patient.

<p>Targeted Intervention Projects</p> <p>The major component of Targeted Intervention projects are</p> <p>Management of STI</p> <p>Behavioral Change Communication (Out reach, peer education, IEC etc)</p> <p>Referral and Linkages (STI, ICTCs, near by health services etc.)</p> <p>Condom promotion (Distribution of condom through non-traditional outlets, during out reach, Social marketing etc.)</p> <p>Enabling environment (addressing different vulnerabilities of HRGs such as violence, poverty, social discrimination etc)</p> <p>Community mobilization (CBOs, formation of different committees)</p> <p>Needle and Syringe Exchange Programme (for IDUs)</p>	<p>The Targeted Intervention projects are aimed at effective behaviour change among the people with high risk behaviours and their clients through behaviour change communication and safe sex and safe injecting interventions. Apart from prevention of HIV infection, TIs facilitate prevention and treatment of Sexually Transmitted Diseases as they increase the risk of HIV infection, and link the HIV infected to care, support and treatment services.</p>
<p>ART Centres</p> <p>All clients diagnosed with HIV should be referred to the nearest ART centre for assessment for ART and treatment.</p> <p>Services available at ART centers include:</p> <p>Identifying eligible PLWHAs who require ART.</p> <p>Free ARV drugs to eligible persons with HIV/AIDS.</p> <p>Counselling for adherence.</p> <p>Education on nutritional requirements, hygiene & other measures.</p> <p>Referral services for specialised services or admission.</p> <p>Condoms distribution.</p>	<p>Let us discuss some of the facilities to which we should be referring ICTC clients, starting with ART Centres</p> <p>ART centers provide People Living with HIV/AIDS (PLWHAs) a set of services including treatment and care. All clients diagnosed with HIV should be referred to the nearest ART centre for assessment for ART and treatment. When referred, the client must be informed about the services available at the ART Center and about the importance of adhering to the ARV treatment.</p> <p>Services available at ART centers include:</p> <ul style="list-style-type: none"> • Identifying eligible PLWHAs who require ART through laboratory services (HIV testing, CD4 Count and other investigations). • Free ARV drugs to eligible persons with HIV/AIDS. • Counselling services before and during treatment to ensure drug adherence. • Education on nutritional requirements, hygiene and other preventive measures. • Referral services for specialised services or admission. • Condoms distribution.

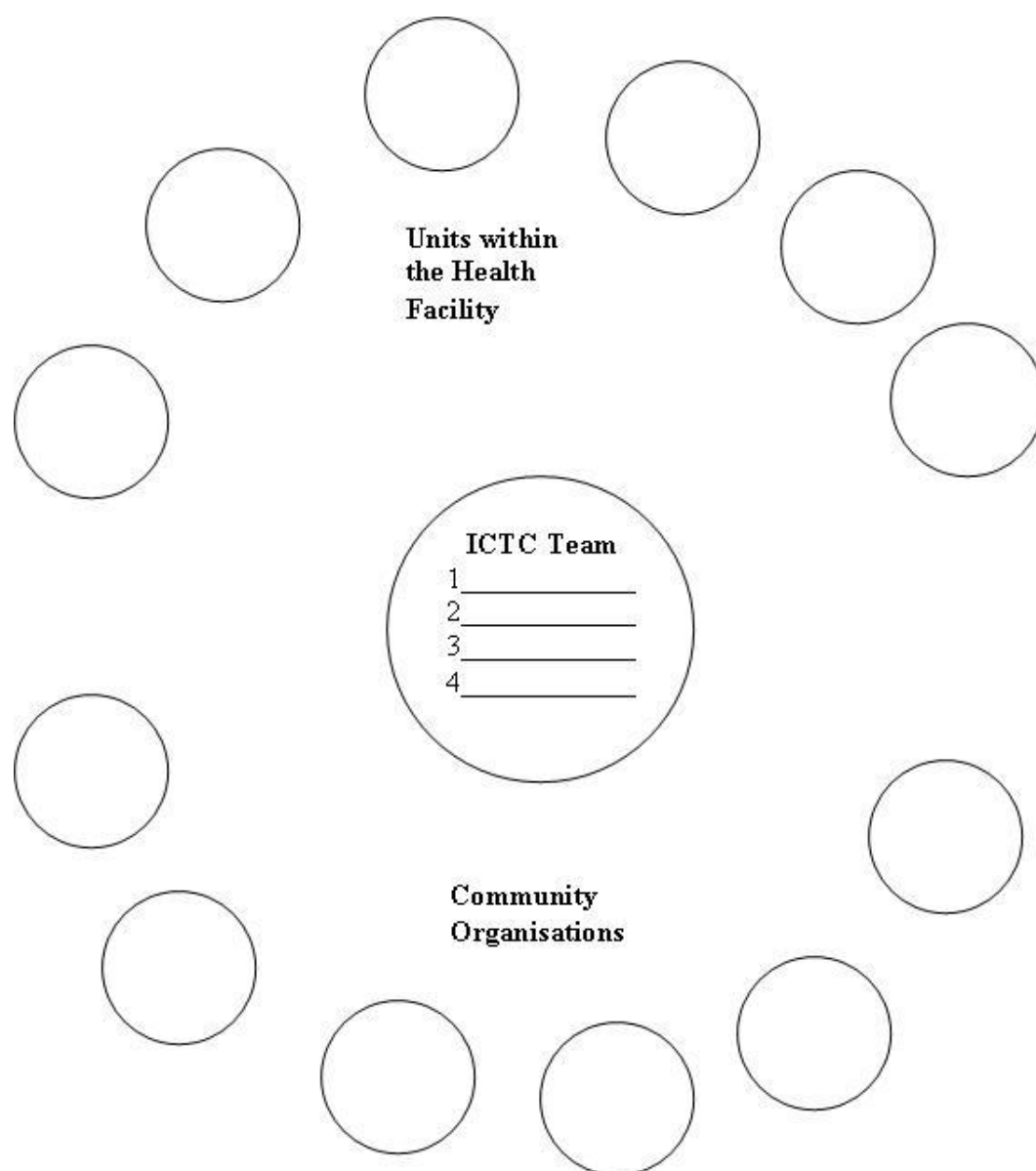
<p>Link ART Centres</p> <p>Services available at Link ART Centers include:</p> <p>ART drug distribution and treatment</p> <p>Monitoring patients on ART for OIs, side effects, adherence and weight</p> <p>Referral services to ART centres for treatment of OIs, side effects of drugs, ANC care, etc.</p> <p>Psychological support</p> <p>Adherence counselling</p> <p>Health education on prevention of infections</p>	<p>Link ART Centres</p> <p>Distance between home and the ART Centre is one factor affecting adherence of patients to ART. Link ART Centres minimise travel time for the patients on ART. They function as authorised drug distribution centers and are linked to a Nodal ART centre within accessible distance. Link ART centres function at some existing ICTCs and CCCs where the existing staff members undertake the responsibilities of Link ART Centers.</p> <p>Services available at Link ART Centers include:</p> <p>ART drug distribution and treatment</p> <p>Monitoring patients on ART for OIs, side effects, adherence and weight</p> <p>Referral services to ART centres for treatment of OIs, side effects of drugs, ANC care, etc.</p> <p>Psychological support</p> <p>Adherence counselling</p> <p>Health education on prevention of infections</p> <p>Ask the trainees if any of their ICTCs have a Link ART Centre. Ask them to <i>briefly</i> share their experiences.</p>
<p>Community Care Centres</p> <p>A CCC provides services to PLWHAs such as</p> <p>In-patient care for 5 days for PLWHAs</p> <p>Out-patient facility for OIs and other illnesses related to HIV/AIDS</p> <p>Counselling for adherence</p> <p>Referral services to ICTC, PPTCT, Paediatric HIV services, ART Centre, medical facilities, DOTS centre and other required services</p> <p>Home based care</p> <p>Condom distribution</p>	<p>A Community Care Centre (CCC) is a community-based facility for accessible, affordable and sustainable counselling, support and treatment of PLWHAs. The CCC is attached to an ART centre to act as a bridge between PLWHAs and the ART centre. It has a maximum capacity of 30 beds and provides services to PLWHAs such as</p> <p>In-patient care for 5 days for PLWHAs</p> <p>Out-patient facility for OIs and other illnesses related to HIV/AIDS</p> <p>Counselling for adherence</p> <p>Referral services to ICTC, PPTCT, Paediatric HIV services, ART Centre, medical facilities, DOTS centre and other required services</p> <p>Home based care</p> <p>Condom distribution</p>

<p>Drop-In Centres</p> <p>Drop In Centres are run by Networks of PLWHA and provide these service:</p> <ul style="list-style-type: none"> • Peer support to cope with the infection and consequences • Treatment education and adherence support • Psychosocial support • Legal support • Nutrition and livelihood support • Linkages to social welfare programmes, health care services etc • Advocating for the protection of rights of PLWHA • Help in addressing stigma and discrimination • Facilitate vocational or occupational rehabilitation • Care and help in education of children living with HIV/AIDS 	<p>Drop In Centres (DICs) have a very important role in ensuring continuity of care for PLWHA and their quality of life. These centres are run by Networks of PLWHA at the district or state level with support from NACO. They offer opportunities for HIV infected persons to come together, share and seek solutions for their problems, avail services and support and get directions for their lives. Services are offered in a peer-led, informal manner.</p> <p>Depending on the availability of resources and requirements of PLWHAs, DICs can support the quality of life of PLHIV through:</p> <ul style="list-style-type: none"> • Peer support to cope with the infection and consequences • Treatment education and adherence support • Psychosocial support • Legal support • Nutrition and livelihood support • Linkages to employment generation programmes, social welfare programmes, health care services etc • Advocating for the protection of rights of PLWHA • Help in addressing stigma and discrimination • Facilitate vocational or occupational rehabilitation • Care and help in education of children affected by or infected with HIV/AIDS
<p>STI/RTI Clinics</p> <p>Patients coming to STI/RTI clinics must be referred to ICTC for HIV testing</p> <p>All ICTC clients with signs of any STI/RTI must be referred to designated STI/RTI clinics for diagnostics and treatment services.</p> <p>Services at STI/RTI clinics include:</p> <ul style="list-style-type: none"> • Syndromic management of STIs • Laboratory tests like VDRL • STI counselling • Provision of medication • Partner counselling and treatment • Patient follow up • Syphilis screening services for all pregnant women at the RTI clinics 	<p>Treating Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) is an important HIV prevention strategy. All patients attending STI/RTI clinics must be referred for HIV testing. Additionally, all ICTC clients who have symptoms or signs of any STI or RTIs need to be referred to designated STI/RTI clinics or identified STI service providers under private sector for diagnostics and treatment services for STI/RTI. Designated STI clinics under government sector are found at</p> <p>All Government Medical Colleges All District Hospitals Some Sub District Hospitals in large volume districts.</p> <p>These are the services at STI/RTI clinics</p> <p>We will discuss the TB clinics in detail in another session.</p>

<p>Discussion Questions</p> <p>At present, with which health facilities and organisations does our ICTC not have STRONG linkages?</p> <p>What can the ICTC team members do to build strong linkages?</p>	<p>Let us reflect on our individual ICTCs. Take a few seconds to think about these two questions:</p> <p>At present, with which health facilities and organisations does our ICTC not have STRONG linkages?</p> <p>What can the ICTC team members do to build strong linkages?</p> <p>Ask a few trainees to give answers. Encourage trainees to think about what each team member can do in this regard. For instance, even testing personnel can alert counselling personnel if they notice a client is showing signs of TB and STI, and needs a referral.</p>
<p>Discussion Questions</p> <p>Who are the people who should be coming to our centre for HIV counselling and testing?</p> <p>How can we increase our patient load?</p>	<p>Encourage trainees to brainstorm on these questions.</p>
<p>HIV spreads through four principal modes:</p> <p>through unprotected sex between a man and a woman or between two men (when one partner is infected);</p> <p>through transfusion of blood that is infected</p> <p>through using infected syringes and needles;</p> <p>from an infected mother to her child during pregnancy, childbirth or breast feeding.</p> <p>If a person is exposed to HIV through any of these routes, they should get tested.</p>	<p>Who should be tested? We know that HIV spreads through four principal modes: through unprotected sex between a man and a woman or between two men (when one partner is infected); through transfusion of blood that is infected; through using infected syringes and needles; and finally from an infected mother to her child during pregnancy, childbirth or breast feeding. If a person has been exposed to the virus through any of these routes, they should get tested.</p>
<p>Who Needs HIV Testing</p> <p>Clients who walk in to the centre on their own</p> <p>ICTC should also build up referrals of:</p> <p>Patients with symptoms which could be due to HIV infection.</p> <p>Patients with conditions that develop due to the same vulnerabilities as HIV.</p> <p>Pregnant women who come to ANCs or who come to health centres to deliver their babies.</p>	<p>In addition to clients who walk in to the centre on their own volition, the ICTC should, build up referrals of, and reach more effectively to:</p> <p>Patients at a health service who have symptoms which could be due to HIV infection (e.g., pneumonia, tuberculosis, persistent diarrhoea).</p> <p>Patients at a health service who have conditions that develop due to the same vulnerabilities as HIV (e.g., STI/ RTI).</p> <p>Pregnant women who come to ANCs or who come to health centres to deliver their babies.</p> <p>Patients attending outpatient or inpatient services who are belonging to high risk groups</p>

<p>People belonging to high risk groups like sex workers, injecting drug users and men having sex with men and bridge populations like high risk migrant workers, truckers and partners of sex workers/MSM/TGs .</p> <p>Patients diagnosed with TB</p> <p>It is not the mandate of the ICTC to test everybody in the general population. Populations who are more vulnerable to HIV or who practise high risk behaviour are in need of ICTC services.</p>	<p>(e.g. MSM, IDUs, sex workers, truck drivers, eunuchs etc.)</p> <p>Patients presenting with TB symptoms or diagnosed with TB</p> <p>It is not the mandate of the ICTC to test everybody in the general population. Populations who are more vulnerable to HIV or who practise high risk behaviour are in need of ICTC services.</p>
<p>Health care Provider Tool</p> <p>See Page 54-55</p>	<p>This slide shows you a NACO information card for health care providers. It shows you the type of symptoms that should alert providers to suspect HIV infection, and refer a patient to the ICTC. When educating providers, you can use this card to explain which conditions could indicate HIV infection. At the bottom, of the page you will see the populations at risk of HIV infection who need to be referred for testing.</p>
<p>Health care Provider Tool</p> <p>See Page 54-55</p>	<p>This is the second part of the information card. It contains information which the Providers need to know, such as information about testing and about confidentiality. You can use this card to educate your colleagues in departments related to STIs, TB and Maternity Services to send the patients for counselling and testing. You should also be thinking at this point about putting the names of key people in these departments to your list of Common Contacts. This is a place where you can mention the contact details of people you are in touch with for referring clients and who refer clients to you.</p>
<p>Exercise: Do I Need HIV Testing</p>	<p>Does the person in the case need HIV testing?</p> <p>Explain why.</p> <p>Is there anyone else in that situation who also needs testing (e.g., a sexual partner)?</p>

ICTC Ecomap



Common Contacts

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

- ✓ places from where clients get referred,
- ✓ or places where you refer clients
- ✓ NGOs involved in targeted interventions
- ✓ medical officers at ART centres, etc
- ✓ important SACS officials such as the person supplying testing kits and other items
- ✓ or the medical expert who evaluates staff who might need PEP following an incident of exposure.

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

All the best!

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

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

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

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

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

Do I Need Testing

Case Profiles

The profile slips must be cut up by the trainer before the session. Please make enough copies so that each trainee has one slip.



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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

✂-----

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

Do I need HIV testing?

Sample Discussion of Case Profiles

For trainer's guidance only. Not intended for verbatim use.

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

Discussion: Viswanathan is a truck driver who moves from one place to another. He has more than one sexual partner – his wife and sex workers. It is possible that he could be infected through sexual transmission either with HIV or with sexually transmitted infections (STI). If he has an STI with an open sore or ulcer, he is even more vulnerable to HIV infection. Through counselling and testing at an ICTC he might be able to think about his risky behaviour and adopt some safer sex practices like using a condom. If he is infected with HIV, then at the ICTC he can learn about ways to prevent opportunistic infections as well as learn about other services available to people with HIV such as tuberculosis treatment, prophylaxis and antiretroviral treatment. If he is infected, it is also an opportunity to encourage his wife to get tested.

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

Discussion: Umar's father is HIV-positive. We do not know when he was infected. But there is a possibility that he might have infected Umar's mother. If such infection took place before or during her pregnancy Umar could also be infected. Antibody testing using a rapid test will reveal if Umar has been infected. Through counselling, a detailed history of the pregnancy and birth can be developed. Helping the family to know Umar's sero-status as well as that of his mother will help them to develop healthier and safer feeding habits and accessing health care .

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

Discussion: Janet has apparently not yet been sexually active with her friend. However, they have developed some physical intimacy and may engage in sex later. If counselling and history taking shows that Janet has not had any sexual exposure of any kind, nor has she been at risk of HIV exposure through other modes of infection, then she need not undergo the HIV test. However, she should leave the ICTC with a clear understanding of what she needs to do in order to remain uninfected: namely delay sexual initiation if she has not already started, limit herself to one partner who should also be sexually faithful to her, use non-penetrative sex options, and finally use a protective device like a male or female condom during sex. She may have come for testing because of misconceptions about HIV transmission or lack of proper understanding about sex. So she needs education and counselling on these topics too.



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



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

Ask/Assess

Presenting complaints:

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

History

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

Look during clinical examination

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

Actions

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

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

Key points: Advise and Refer for HIV testing

1. Establish trust with the patient :

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

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

3. Provide Key Information on HIV

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

HIV can be transmitted through:

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

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

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

4. Provide Information on HIV Testing

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

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

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

5. Explain procedures to safeguard confidentiality

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

6. Confirm willingness to be referred to ICTC

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

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

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

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

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

Day 1

The Wheels on the Bus Go Round and Round

The Wheels on the Bus Go Round and Round

Session Overview

- ✓ Planning by the teams (5 minutes)
- ✓ Presentations by the teams (20 minutes)
- ✓ Discussion of group processes (10 minutes)
- ✓ Making a vegetable sandwich (25 minutes)

Session Objectives

- ✓ To facilitate an awareness of how the group makes decisions.
- ✓ To demonstrate how communication affects human activities.

Time Allowed

1 hour

Materials

- ✓ Materials to make a vegetable sandwich: Loaf of bread, butter, tomatoes, boiled potatoes, cucumbers, knife, *chaat* powder/ salt and pepper, plate



Note to the Trainer: Please select food items that are appropriate to your state. For instance, some groups of people do not eat food items that grow below the ground. So they may not want to use potatoes. Alternatively, you can also substitute the vegetable sandwich with making *sev puri*.

Method

Preparation

- 1) You, as the trainer, will obtain and keep ready the items required for making the vegetable sandwich or whatever variation you are planning to use. Some items can be purchased in the market. Some need light cooking (e.g., boiling potatoes). These are for the second part of this session.



Planning by the Teams

- 2) You, as the trainer, will provide the following instructions: “This is a group activity involving each ICTC team. You will have 5 minutes to plan this activity. Each ICTC team has to select a machine and then mime out the actions of that machine using their bodies. For instance, your team may decide to mime out a mixer-grinder. One team member will act as the blades of the mixer-grinder and turn around. Another will act as the vegetables being mixed or blended. Another person will act as the cook putting the materials in the machine. Your actions should be clear enough for other people to guess what you are demonstrating. Your 5 minutes start now.”
- 3) Give the groups 5 minutes to plan their demonstrations.

Presentations by the Teams

- 4) Invite each team to demonstrate their machine and invite other groups to guess the correct answer.
 - a. Ask the teams to repeat their performance till someone guesses correctly.
 - b. Encourage the teams who are shy by saying that everyone is required to participate and this really does not need acting skills.
 - c. This is an activity which makes some people conscious, especially trainees who are older. Another factor that may make people conscious is performing in front of professional colleagues who are of higher or lower status.
 - d. Draw positive attention to the efforts of a trainee who makes particular effort to demonstrate the activity (e.g., someone who may roll on the floor, or who may dance vigorously). Show appreciation by clapping hands.

Discussion of Group Processes

- 5) After all the presentations, ask the trainees the following questions:
 - a. Was it easy or difficult to act out the machine in front of others? Explain why.
 - b. How easy or difficult was it to decide what machine to act out? Explain why.
 - c. Did everyone take part in the decision?
 - d. Why were some people quiet in the group?
 - e. What made it easier for people to participate?
 - f. What made it more difficult for people to participate?
 - g. Finally, would the machine have worked if even one person had backed out?
- 6) Note the answers from the trainees on the blackboard or an overhead transparency.
- 7) Use the answers to bring out the following points about group decisions:
 - a. Sometimes it is difficult in teams for everyone to take part because people are naturally shy.
 - b. Sometimes, teams have members with different social status. People who are more educated may dominate people with lesser education. Also, people who are more articulate may speak more.
 - c. There is value to encouraging everyone to take part in the group decisions.
 - d. This is only possible through an attitude of respect towards everyone.
 - e. Every one has a role of some kind in a team.
 - f. Will Rogers once said, "Everybody is ignorant, only on different subjects." People who we have known for a long time may surprise us with some previously hidden talent. We will not learn what other people have to offer unless we develop an attitude of listening carefully to other people.
 - g. Negative behaviours like interrupting, accusing, blaming, calling people names, frowning, and threatening keep people from participating fully and openly in a social situation.

- h. The SOLER technique is a good way to show active listening. This is a technique that some counselling personnel use in counselling situations. But it is also useful for general communication. Other techniques of showing active listening are using sounds like Umhmm, repeating what the person is saying, and nodding.

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

Making a Vegetable Sandwich

- 8) For this activity, ask for a couple of volunteers who know how to make a vegetable sandwich and ask them to leave the room.
- 9) Announce to the rest of the room that these volunteers are going to help you to make the sandwich. But ask the group for silence during the demonstration. That is, they should not laugh or pass comments.
- 10) Call the first volunteer in and ask them to take a good look at the materials. Then ask them to turn their back to the audience as well as to you. Then, ask them to give instructions to make the sandwich.
- 11) You will demonstrate WITHOUT asking for any directions or clarifications.
- a. Follow the directions LITERALLY. For instance, if the volunteer says, "Take the bread and put it on the plate," place the ENTIRE loaf of bread on the plate without opening the packet. If the volunteer says, "Put the butter on the bread," place the butter PACKET on the bread."

- b. When the volunteer is finished with the instructions, ask him/ her to turn around and see the final product.
- c. Shake hands with the volunteer and say thank-you for being a sport and ask them to return to their seat.

12) Rearrange the materials.

13) Call in the second volunteer and repeat the procedure. THIS TIME ask for clarifications and directions.

14) Discuss the two demonstrations with the group with the following questions.

- a. Tell me what happened here.
- b. What kind of communication was used?
- c. What instructions were given?
- d. Which instructions were more useful?
- e. What kind of communication was more successful?

15) Explain the following points from the demonstration.

- a. It is easy to assume that what we have said has been followed by the other person.
- b. In any communication, be it written, verbal or non-verbal, there are 2 sides – the person who has a message to communicate (the sender) and the person for whom the message is intended (the receiver).
- c. The sender must never assume that the message was understood. Instead, she/ he must check back what was followed by the receiver. In the ICTC situation, we can see many instances where clients misunderstand what, according to the staff, are simple instructions. The same kind of misunderstanding can affect even the interactions within a team.
- d. The receiver also must seek clarifications about instructions and messages from the sender. Within a team situation, both sides carry the responsibility of clear communication.

- e. When discussing work-related matters, it is important to use clear and simple language. Technical or medical terms are constantly used within teams. But the same language is not easily understood by non-technical people.
- 16) Ask a couple of people to share instances of miscommunication at work situations. Ask other people to comment on how the misunderstandings could have been avoided. Please note this is not a forum to solve ongoing work issues within any one centre. If someone has such an issue, mention that perhaps this situation could be discussed at lunch time when there is more time to consider the various aspects of the situation.

References

- ✓ Hunter-Geboy, C. (1995). *Life Planning Education: A youth development program*. Washington, DC: Advocates for Youth.

Day 1

Why do Patients Need Counselling?

Why do Patients Need Counselling?

Session Overview

- ✓ Starter exercise (20 minutes)
- ✓ Large group discussion of starter exercise (15 minutes)
- ✓ Lecture using slides (25 minutes)
- ✓ Role plays on Provider-Initiated Testing (1 hour)

Session Objectives

- ✓ To examine why counselling is needed in the HIV testing process.
- ✓ To explain how counselling assists in behaviour change related to HIV/AIDS.
- ✓ To discuss basic documentation related to ICTC Counselling.

Time Allowed

2 hours

Materials

- ✓ Slides related to the session
- ✓ Handout
- ✓ Roleplay scenarios for Provider-Initiated Testing
- ✓ Forms related to ICTC Counselling.
- ✓ NACO's Healthcare Provider's Tool

Method

Starter Exercise

- 1) You, as the trainer, will begin this exercise by asking for volunteers: “I need some volunteers to help me with a special task in the next activity. Volunteers should be people who have tried to change some personal habit or behaviour. For instance, you may have found out you were diabetic and needed to change your food habits to take in less sugar. Or you might have been asked by the doctor to lose weight. Or you might have wanted to stop smoking.”
- 2) When at least 5 to 7 people have volunteered, take them aside and give them instructions in private.
 - a. First, ask each one to state briefly what behaviour they tried to change.
 - b. Then, give the following instructions: “Each of you will be sitting individually in a group of 5 or 6 people. They will try to help you to change your behaviour by giving you information or helpful suggestions. Your job is to reject all the suggestions and information using whatever reason or strategy you think fits best.”
 - c. “For instance, if someone tells you that smoking kills people, you might say that there are lots of people who are smoking and walking around, or you might say that you will not die immediately. You might say that you have heard that if you stop smoking you will put on weight, or you might lose your friends who also smoke. Another reason could be that doing that activity feels good or satisfying. “
 - d. “You could also point out barriers. For instance, if you have to eat less fatty food, then you could say that you are not able to cook less fatty food because family members will not change along with you.”
 - e. “Use any reason that sounds logical to reject the ideas presented to you. But don’t tell the group that I advised you to reject their suggestions.”
 - f. “We will role-play for about 7-10 minutes.”
- 3) Ask the rest of the trainees to form groups of 5 or 6 people.
- 4) Explain the next stage to the groups: “Now that you are seated in groups, here is what you have to do. Each group will be joined by a trainee who is trying to change a

particular behaviour. They require your suggestions. Please try to help them in this task. However, please maintain some order in the group so that only one person is speaking at a time within the group. Let one person make a suggestion, and then allow some time for discussion before moving onto the next suggestion.”

- 5) Call the volunteers back and assign each one to a group. Let the role-playing continue for about 7 to 10 minutes. Walk around the group and listen in on the discussion without interrupting or suggestions of your own. Note some of the interactions you observe in the group for the later discussion. You could also ask 1-2 trainees to act as observers.

Large Group Discussion of the Starter Exercise

- 6) When you feel the interaction has gone on for a sufficiently long enough time, gather everyone into the larger group. Allow all groups to participate equally so that all groups will feel involved and not get bored. Guide the discussion using the following questions:
 - a. In general, how easy was it to help the person to consider the behaviour change?
 - b. What problems were discussed and what solutions were offered in each group?
 - c. What solutions or suggestions were most successful in your group? Why were they successful?
 - d. What solutions or suggestions were not successful? Why were they not successful?
 - e. What kind of objections did the person raise? What counter-arguments did the group offer?
 - f. How does this relate to HIV/AIDS counselling in the ICTC?

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Lecture using Slides

- 7) Now you will link up the activity with HIV/AIDS counselling in relation to behaviour change and risk reduction using the slides.

Role Plays on Provider Initiated Testing

- 8) End up this session with the 3 role plays related to Provider-Initiated Testing: “Let us now see how we can use our information about Provider-Initiated Testing. We will role-play 3 scenarios for which we need 6 volunteers.”
- 9) When the 6 people come forward to role-play, hand them their scenarios and let them role-play in the order.
- 10) After each role play, give time for the audience to suggest additional strategies to be more effective.
- 11) You can invite volunteers to come forward and role-play these alternative suggestions if there is time. Encourage them to use the information from the slides to explain the benefits of knowing one’s sero-status, the types of people who need counselling and testing and how to manage informed consent.
- 12) Each role-play and the discussion may take about 15 to 20 minutes.

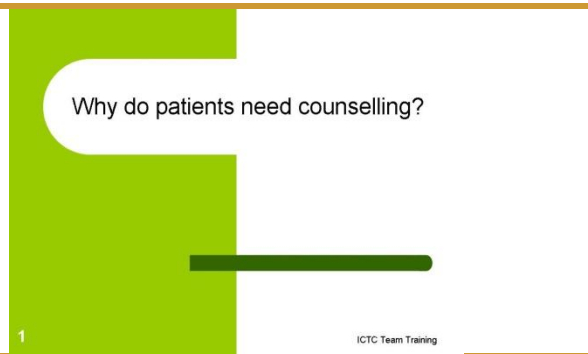
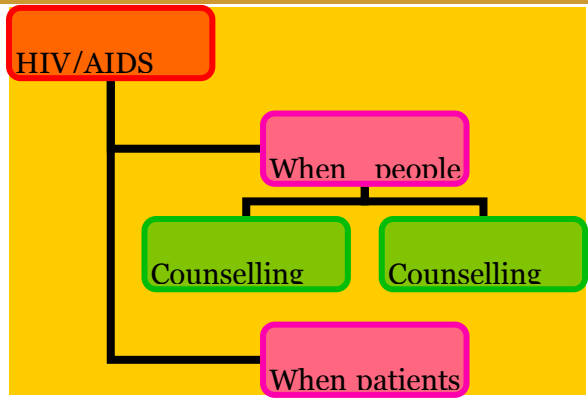
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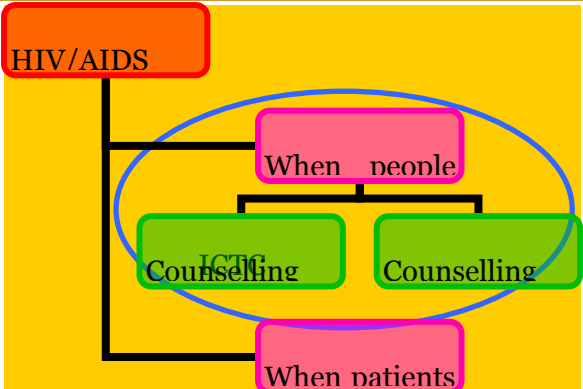
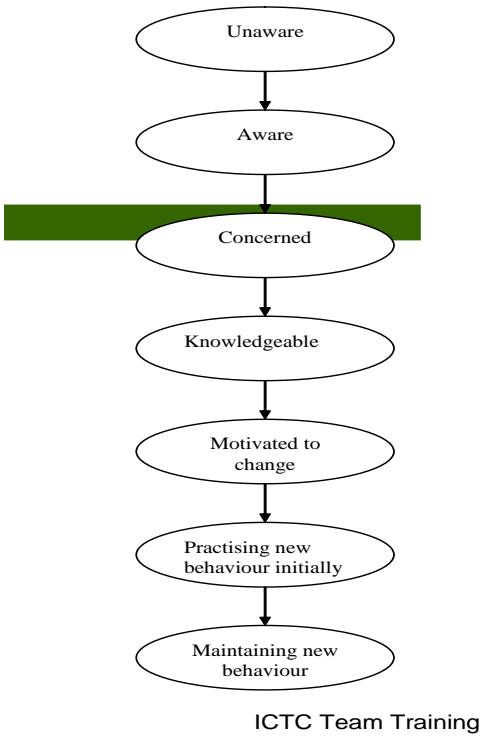
References

- ✓ Family Health International (2002). *Behavior Change Communication (BCC) for HIV/AIDS: A strategic framework*. Arlington, VA: Family Health International.
- ✓ Joint United Nations Programme on HIV/AIDS (1999). *Sexual behavioural change for HIV: Where have theories taken us?* Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS.
- ✓ National AIDS Control Organisation (2006). *HIV counselling training modules for VCT, PPTCT and ART counsellors*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- ✓ National AIDS Control Organisation (2007). *Operational guidelines for Integrated Counselling and Testing Centres*. New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- ✓ World Health Organisation (1993) *An orientation to HIV/AIDS counselling: A guide for trainers*. New Delhi: World Health Organisation.

- ✓ World Health Organisation & UNAIDS (2007). *Guidance on Provider-initiated HIV testing and counselling in health facilities*. Geneva, Switzerland: World Health Organisation.

Slides

SLIDES	COMMENTARY
 <p>Why do patients need counselling?</p> <p>1</p> <p>ICTC Team Training</p>	<p>Title Slide</p>
<p>Questions</p> <ul style="list-style-type: none"> • In general, how easy was it to help the person to consider the behaviour change? • What problems were discussed and what solutions were offered in each group? • What solutions or suggestions were most successful in your group? Why were they successful? • What solutions or suggestions were not successful? Why were they not successful? • What kind of objections did the person raise? What counter-arguments did the group offer? • How does this relate to HIV/AIDS counselling in the ICTC? 	<p>Questions related to the exercise</p>
<p>Counselling</p> <p>A confidential dialogue between a client and a counselling personnel aimed at providing information on HIV/AIDS and bringing about behaviour change in the client.</p> <p>Also aimed at enabling the client to take a decision regarding HIV testing and to understand the implications of the test results</p>	<p>Let us see how this exercise links up to HIV. What you did in the activity just now was a kind of advice-giving or suggestion for behaviour change. We see some of this in counselling for HIV/AIDS also. Given that HIV/AIDS is caused by particular behaviours, the counselling personnel and the patient or the client will sit together and confidentially discuss these behaviours, whether they expose the client to risk of HIV, and whether the client needs to get tested. The choice is always in the hands of the patient or the client</p>
 <pre> graph TD A[HIV/AIDS] --> B[When people] A --> C[When patients] B --> D[Counselling] C --> E[Counselling] </pre>	<p>The aim of this session is not to teach counselling. But ICTC staff must know what counselling broadly covers. Clients need support at all stages of HIV infection. Initially, they need support before they know whether they are infected. Later they need support and help when they get tested and know their status. However not all people are ready to be tested initially. Some need more time than others to adjust to the idea that they may be at risk. So the initial counselling is for people who consent to be tested and for those who refuse their consent. After the HIV test, there is post-test counselling related to accepting the test result. Later on counselling focuses on how to remain positive and healthy, how to avoid OIs, how to manage ART, etc.</p>

	<p>In the ICTC, counselling is related to the decision whether to get tested and the acceptance of test result. But a helpful experience here will encourage a PLWHA to seek other services like ART.</p>
<p>Advantages of knowing your sero-status</p> <ul style="list-style-type: none"> • Early referral for appropriate medical treatment: prophylaxis, early detection, curative treatment, antiretroviral treatment. • Precautions to protect others. • Prevention against re-infection with HIV. 	<p>People have a right to know if they are infected with HIV, that is their sero-status. There are many advantages to a patient to find out if they are HIV-positive.</p> <p>If you know your status early you can get medical treatment early such as prophylaxis or preventive treatment against opportunistic infections (e.g., cotrimoxazole), you can detect opportunistic infections like TB early and treat them or you can start antiretroviral treatment. You can try to protect other people from being infected. The PPTCT programme is one example of this. Other examples are protecting spouses and sexual partners. You can also take precautions against getting re-infected with another strain of HIV.”</p>
 <p>ICTC Team Training</p>	<p>Underlying HIV counselling is the theory of stages of change. Behaviour change has various stages. The individual moves through these stages. Sometimes, movement is backwards or negative. But the person is initially unaware about the problem, for example being at risk of HIV infection. In order to get tested and adopt safer behaviours they have to become aware and concerned. Concern may push the person to seek knowledge and may motivate him/ her to change (e.g., use a condom or get tested for HIV or take their ART medication consistently). In counselling, the counselling personnel helps the patient to move along this continuum in an orderly fashion. Can you relate these stages to the exercise you just did? Were some people more aware than others? Did you find differences in knowledge about the problem? Counselling has to take this into consideration.</p>

See Page 75 for an enlarged picture

<p>Three Models of Behaviour Change</p> <ul style="list-style-type: none"> • Risk Elimination Model • Risk Reduction Model • Harm Reduction Model <p>(The HIV Counselling Training Modules for VCT, PPTCT and ART Counsellors, NACO, 2006)</p>	<p>It is not easy to change behaviour. Human habits and actions are influenced by personal beliefs and social norms. Also, in the area of sexuality, some behaviours persist because they are pleasurable. When discussing safer sex, it is sometimes easier for a person to substitute a more harmful behaviour with a more benign (harmless) activity rather than try to eliminate the behaviour completely. This is called risk reduction. There are other models of behaviour change such as risk elimination which is totally avoiding the behaviour and harm reduction where the counselling personnel works to reduce the harm that might accompany the risky behaviour. An example of this would be needle exchange programmes for intravenous drug users.</p>
<p>Provider Initiated Testing Knowing one's sero-status is the first step to getting HIV services. Only 1 in 3 infected people knows their sero-status. Need to increase the number of people visiting ICTC.</p> <p>Provider Initiated Testing: HIV Counselling and Testing are recommended by health care providers to people who come to them for other health concerns when they display signs and symptoms suggestive of HIV infection or other co-infections.</p>	<p>Even though it is a good idea to know if one is infected with HIV or not, very few people who are infected actually make the connection between their risky behaviour and exposure to HIV. So it is necessary to increase the number of people who get tested. The next slides relate to Provider-Initiated Testing. This is one way of encouraging more people to get tested.</p> <p>As the name suggests, in Provider-Initiated Testing, it is health care providers (HCPs) who identify which of their patients are at risk of HIV infection, and then refer them to the ICTC. HCP identify people who have signs and symptoms, or infections suggestive of HIV, and they recommend that they go for HIV testing.</p>
<p>Concentrated And Low-Level Epidemic Settings STI services Services for most-at-risk populations Antenatal, childbirth, and postpartum health services TB services</p>	<p>To recap, in Provider-Initiated Testing, it is health care providers who identify which of their patients are at risk of HIV infection, and then refer them to the ICTC. They identify people who have signs and symptoms, or infections suggestive of HIV, and they recommend that they go for HIV testing.</p> <p>Specific groups that are the focus of Provider-Initiated Testing are are patients who show signs of what could be HIV infection (such as pneumonia, tuberculosis and persistent diarrhoea), patients who have STIs (because these arise from the same behaviours that transmit HIV) and all pregnant women (because we would like to reduce HIV transmission to children).</p>
<p>Provider Initiated Testing in India Patients who present themselves to a health facility with symptoms suggestive of HIV infection like TB, pneumonia or persistent diarrhoea Patients with conditions that could be associated with HIV such as STI/RTI Pregnant women who register at ANCs. This also include pregnant women who directly come in labour without any ANC.</p>	<p>These services are covered under PIT in India. Let explain this in detail in the next slide Both in high and low prevalent states, PIT is offered to: Patients who present themselves to a health facility with symptoms suggestive of HIV infection like TB, pneumonia or persistent diarrhoea; Patients with conditions that could be associated with HIV such as STI/RTI; Pregnant women who register at ANCs. This also include pregnant women who directly come in labour without any ANC.</p>

<p>Provider Initiated Testing: Steps Clients are referred by health care providers to the ICTC. At the ICTC, they are given basic information on HIV, they are educated about HIV testing, and are informed about the clinical and prevention advantages of being tested. Counselling personnel then makes a routine offer of HIV testing: The counselling personnel asks the client: “Do you wish to be test for HIV or not?” The client has a right to accept or to refuse testing and “opt out.” If the client agrees, he/ she is tested for HIV. Testing is followed by post-test counselling.</p>	<p>These are the steps in the process: Such clients are referred by health care providers to the ICTC. At the ICTC, they are given basic information on HIV, they are educated about HIV testing, and are informed about the clinical and prevention advantages of being tested. The counselling personnel then makes a routine offer of HIV testing: The counselling personnel asks the client: “Do you wish to be test for HIV or not?” The client has a right to accept or to refuse testing and “opt out.” If the client agrees, he/ she is tested for HIV. Testing is followed by post-test counselling.</p>
<p>Informed Consent The client agrees to HIV testing through giving his/ her informed consent. Informed consent is a deliberate and autonomous permission given by a client to a health-care provider to proceed with the proposed HIV test procedure. This permission is based on adequate understanding of the advantages, risks, potential consequences and implications of an HIV test result, which could be both positive and negative. This permission is entirely the choice of the client and can never be implied or presumed. (From ICTC Operational Guidelines)</p>	<p>Let us review informed consent for testing: The client agrees to HIV testing through giving his/ her informed consent. Informed consent is a deliberate and autonomous permission given by a client to a health-care provider to proceed with the proposed HIV test procedure. This permission is based on adequate understanding of the advantages, risks, potential consequences and implications of an HIV test result, which could be both positive and negative. This permission is entirely the choice of the client and can never be implied or presumed. (From ICTC Operational Guidelines)</p>
<p>The next 4 slides consist of the records maintained by the counselling personnel</p> <p>Please see Pages 76 to 79</p>	<p>These last slides relate to the forms to be filled when a client comes to the ICTC. The first is the PID register. The purpose of this register is to have records for identifying the client visiting the ICTC. This is the first register where client details would be recorded when the client visits the ICTC. Each client is registered as per a number called the Patient Identification digit (PID). This is a unique number assigned to each individual and helps identify the client and the centre where the client is tested. It records the contact details of the client so that follow-up is possible. This record is confidential and needs to be kept safely. The PID number of a particular client assigned in this register continues in the other registers. It is important to note the client’s contact details as completely as possible (e.g., with a house number and a street name) because outreach workers can then effectively reach out to these people in the community for follow-up. You will notice that the PID register is separate for ANC women but has the same information. We will discuss this more in the session on PPTCT. Please fill in the PID register as soon as the patient meets you the first time so that all other records and forms can carry the PID number. Remember the PID number is also going to be used by the patient in other services such as the ART centre. We would like to avoid patients returning to the ICTC and taking up more time just because the ART centre says they do not have a proper PID.</p>

<p>The next 4 slides consist of the records maintained by the counselling personnel</p> <p>Please see Pages 76 to 79</p>	<p>The next three slides are the ICTC register for general clients – that is every one except pregnant women. This register is maintained by the counselling personnel and its purpose is to collect in a single record all information relating to a client. Each client is registered here only with his/her PID which you will have already assigned in the previous form. You see, therefore, the need to be updated with these records. A brief history of the client is maintained in this register. In Column 4, you will see that you have to mention where the patients have been referred from. Again, this should remind you of the ICTC Mapping exercise where you mapped out the referral organizations.</p>
<p>The next 4 slides consist of the records maintained by the counselling personnel</p> <p>Please see Pages 76 to 79</p>	<p>On this form the counselling personnel will also have to note what kind of risk behaviour the client revealed. Sometimes they may have more than one type.</p>
<p>The next 4 slides consist of the records maintained by the counselling personnel</p> <p>Please see Pages 76 to 79</p>	<p>Column 17 has details about where you referred the person such as a targetted intervention for MSMs, or the TB programme or the ART centre. Again it is important to mention before we end this slide presentation that the need to be up-to-date with maintaining records. Throughout the ICTC training, we will be seeing different forms. This one is for general patients. You will see different forms for ANC patients. On the third day of the programme, you will see how each of these forms ties up to the monthly reports to the DAPCU or the SACS.</p> <p>From this register, the following information is extracted for the monthly report:</p> <ul style="list-style-type: none"> • Clients who receive HIV pre-test counselling • Clients who receive HIV post-test counselling • Total number of clients undergoing HIV testing • Male and female distribution of clients • Age-wise distribution of clients • Follow-up counselling • Partner counselling, testing • Advice on family planning and condom use demonstration • Positivity status of clients and • partner (if tested) • Referral linkages (in and out)

Role play scenarios for Provider-Initiated Testing

Role Play Scenario 1

You are the medical officer in an ICTC at a district hospital. You have to explain Provider-initiated testing to someone in the STI unit because you want them to refer patients for HIV testing.

✂-----

Role Play Scenario 1

You are an STI officer at a district hospital. The medical officer of the ICTC is trying to explain Provider-initiated testing to you. But you have never heard about it and have a lot of questions.

✂-----

Role Play Scenario 2

You are from the surgery department and have heard about Provider-initiated testing. You think this is a good way to know your patients' HIV status. So you ask the lab technician how to send patients for screening.

✂-----

Role Play Scenario 2

You are a lab technician at the ICTC. A surgeon has heard about Provider-initiated testing and wants to send all the patients for routine screening. You know this is a misuse of the testing process and have to explain this to the surgeon. But you are also aware that you are only a lab technician.

✂-----

Role Play Scenario 3

You are a counselling personnel. You have to explain to a patient referred from the STI unit why the doctor sent them to the ICTC.

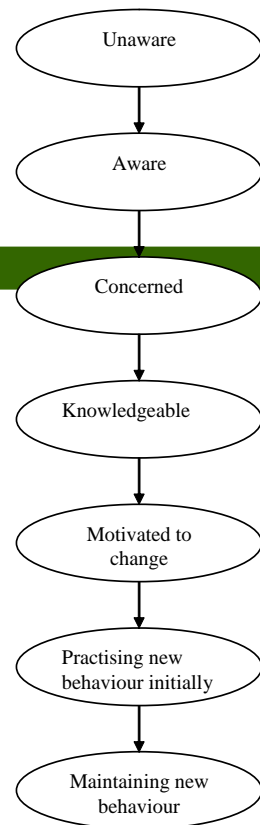
✂-----

Role Play Scenario 3

You had gone to the STI unit because you had intense burning sensation while urinating. From there the doctor sent you to the ICTC where they want to draw blood. You are confused.



Understanding Behaviour Change



ICTC Team Training

[illegible]

Annexure III.b

ICTC Register for General Clients (excluding Pregnant Women)

ICTC Code:

ICTC Name:

District:

State:

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

Continued...



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

Continued...



Annexure III.b**ICTC Register for General Clients (excluding Pregnant Women) (contd.)**

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

Continued...

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

Continued...



Day 2

Self-Assessment Quiz

Self-Assessment Quiz

Session Overview

- ✓ Self-assessment quiz (10 minutes)
- ✓ Checking answers (10 minutes)

Session Objectives

- ✓ To provide an opportunity for the trainees to check their personal knowledge about HIV/AIDS.

Time Allowed

20 minutes

Materials

- ✓ Self Assessment Quiz in trainee's handbook 'How Well Do I Know HIV/AIDS?'
- ✓ Copies of the Answer Key

Method

Preparation

- 1) Before the session, make enough copies of the Answer Key so that there is one Answer Key for each trainee (See Page 90).



Conducting the Quiz

- 2) You, as the trainer, will introduce the session: “During this workshop, you will hear some new information and some information that you may have heard in other training programmes. Each of you is already working in the field of HIV/AIDS. You already have a rich store of knowledge. But the field is changing constantly. As scientists work to find better prevention methods and more effective treatments, the information base keeps changing. What you learned in your orientation programmes may already be out-of-date.”

“At this point, each of you will have a chance to see how up-to-date your personal knowledge is about the topic. Please turn to the Self-Assessment Quiz titled How Well Do I Know HIV/AIDS and answer the questions on your own. You can check your answers after you have finished it.”

“It is natural to feel a little worried. Please relax. I will not collect your answers. So please be as honest as possible when doing it. The quiz is not easy. It may contain items you are not sure about. I hope that you will use the quiz as a chance to see where you may have to read more. As someone has said, ‘Mistakes show us what needs improving. Without mistakes, how would we know what we had to work on?’ So I invite you to discover what you need to work on to be a better MO, or a better counselling personnel, or a better testing personnel.”

Page 84 in Trainer’s Guide; Page 124 in Handbook

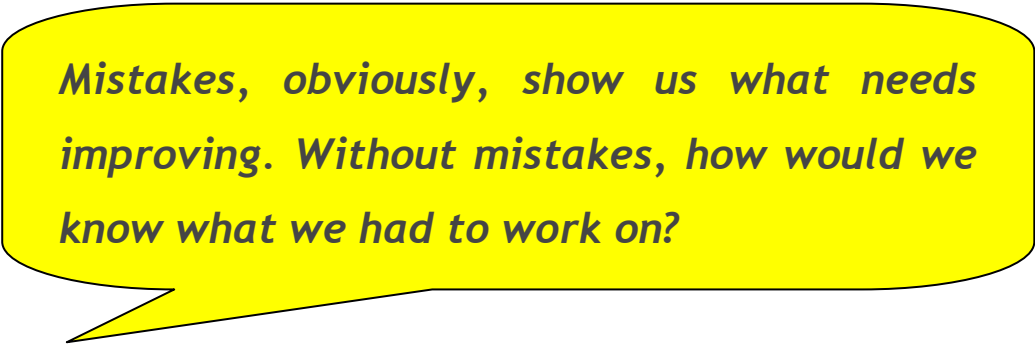
- 3) Announce the page number of the Quiz and allow the trainees 10 minutes to answer the quiz on their own. Do not watch the trainees while they are working as this may make them comfortable. Answer any questions that may come up.
- 4) When people finish the quiz, hand over the answer key. But do not collect the quizzes from the participants. Also, tell the participants, that they can visit the websites of NACO and UNAIDS for up-to-date information. A brief participatory discussion of answers can put trainees at ease if they found the quiz tough.

How Well Do I Know HIV/AIDS:

Self-Assessment Quiz on HIV/AIDS

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

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



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

The source materials for the quiz are

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

QUIZ: How Well Do I Know HIV/AIDS?

INSTRUCTION: Circle the right answer.

1. We all know that HIV affects CD4 cells which are part of the body's immune system. But they also affect the
 - a. Sebaceous (sweat) gland cells
 - b. Organ of Corti
 - c. CD Six cells
 - d. Macrophages
2. HIV is a
 - a. Adenovirus
 - b. Retrovirus
 - c. Trojan
3. It is particularly difficult for HIV-infected individuals to fight off HIV infection for ALL of the following reasons EXCEPT
 - a. HIV affects the body's defence system itself
 - b. HIV replicates in large numbers which overwhelms the body's defense system
 - c. HIV can mutate (change) itself
 - d. HIV is difficult to identify through a blood test
4. As part of the National Blood Policy, under the Drugs and Cosmetics Act, blood that is donated is tested for all of the following EXCEPT
 - a. HIV
 - b. Hepatitis
 - c. Muscular dystrophy
 - d. Malaria
 - e. Syphilis
5. A test to detect HIV is said to have high sensitivity when
 - a. It identifies all false negatives correctly
 - b. It can detect even minute amounts of antibodies

6. All of the following are possible signs of HIV infection EXCEPT
- a. Dry cough
 - b. Red, brown, pink or purplish blotches on or under the skin or inside the mouth, nose, or eyelids
 - c. Salty sweat
 - d. Rapid Weight loss
 - e. Swollen lymph glands in the armpits, groin, or neck
 - f. Memory loss or depression
7. HIV is NOT found in
- a. Sweat
 - b. Cerebrospinal fluid
 - c. Synovial fluid
 - d. Amniotic fluid
8. HIV has been around since at least
- a. 1927
 - b. 1959
 - c. 1982
 - d. 1993
9. Giving babies breast milk together with other liquids like water, herbal mixtures, or juice, or other foods like animal milk, formula milk, or soft porridge is called
- a. Mixed feeding
 - b. Exclusive breastfeeding
 - c. Replacement feeding

10. Which of the following are NOT part of Universal Precautions
- a. Carefully disposing items that could cause cuts or puncture wounds, including needles, hypodermic needles and scalpels
 - b. Wearing gloves during counselling
 - c. Hand-washing with soap and water before and after all surgical procedures
 - d. Safely disposing waste contaminated with blood or body fluids
 - e. Disinfecting instruments and other contaminated equipment
 - f. Properly handling bedding stained with blood, diarrhoea or other body fluids
11. Post exposure prophylaxis ideally should start
- a. Within 2 hours of the occupational exposure
 - b. Within 48 hours of the occupational exposure
 - c. Within 72 hours of the occupational exposure
 - d. Within 2 days of the occupational exposure
12. During surgery on a known HIV-infected patient, blood of the patient unexpectedly spurted into eye of the surgeon, Dr. X. Of the following first aid actions taken by the staff all of the following were correct EXCEPT
- a. Dr. X sat in a chair with head tilted back and asked a colleague to gently pour water or normal saline over the eye.
 - b. Dr. X sat in a chair with head tilted back and asked a colleague to gently pour water and disinfectant over the eye.
 - c. Dr. X was wearing contact lens and left them in place while irrigating.
 - d. Once the eye was cleaned, Dr. X removed the contact lens and cleaned them in the normal manner.
 - e. Document the incident

13. All of the following drugs are part of the two-drug Post-Exposure Prophylaxis regimen EXCEPT
- a. Lamivudine
 - b. Stavudine
 - c. Indinavir
 - d. Zidovudine
14. It is helpful for a person living with HIV/AIDS to know
- a. That their viral load is below 10,000
 - b. That their viral load is between 10,000 and 100,000
 - c. That their viral load is above 100,000
 - d. The trends in their viral load – whether it is increasing or decreasing
15. All of the following are advantages of ICTCs as listed by NACO EXCEPT
- a. Getting a free midday meal
 - b. Earlier access to care and treatment
 - c. Emotional support
 - d. Motivating to initiate or maintain safer sexual practices and behaviour change
 - e. Safer blood donation
 - f. Motivating HIV infected person to involve spouse/partner for future spread and care
16. Antiretroviral treatment CAN
- a. Cure HIV/AIDS
 - b. Increase the CD4 cells and decrease the amount of virus in the body
 - c. Prevent the spread of HIV

17. Which is TRUE?

- a. 5 out of every 100 Indians are infected with Mycobacterium tuberculosis
- b. 20 out of every 100 Indians are infected with Mycobacterium tuberculosis
- c. 40 out of every 100 Indians are infected with Mycobacterium tuberculosis
- d. 50 out of every 100 Indians are infected with Mycobacterium tuberculosis

18. Someone who is HIV-infected has a

- a. 10% lifetime risk of developing tuberculosis
- b. 20 to 30% lifetime risk of developing tuberculosis
- c. 50 to 60% lifetime risk of developing tuberculosis
- d. 85% lifetime risk of developing tuberculosis

19. Which is TRUE?

- a. Early detection and treatment of HIV infection in TB patients can reduce the number of deaths of such patients.
- b. Detection of HIV infection in a TB patient and subsequent treatment will not help the patient at all.

20. Which is TRUE?

- a. PLWHAs have to pay Rs 400 per month for cotrimoxazole preventive treatment (CPT).
- b. PLWHAs have to pay Rs 175 per month for cotrimoxazole preventive treatment (CPT).
- c. PLWHAs can get cotrimoxazole preventive treatment (CPT) free of charge.

21. The BEST way to detect tuberculosis infection is:

- a. Sputum test (Checking the saliva)
- b. Chest X-ray

22. The regimen used by NACO to prevent transmission of HIV from a pregnant HIV-positive woman to her unborn child (that is PPTCT) is:

- a. Single dose of Nevirapine to the baby on the third day
- b. Single dose of Nevirapine to the mother at the time of labour and on the third day after delivery
- c. Single dose of Nevirapine to the mother at the time of delivery and a single dose of Nevirapine to the infant immediately after birth

Answer Key: How Well Do I Know HIV/AIDS Quiz

1. (d) We are all familiar with CD4-Cells. Macrophages are another type of cell in the immune system that are affected by HIV. They are present within the lining of the vagina and foreskin.
2. (b)
3. (d)
4. (c) Donated blood is safe.
5. (b) An HIV test should be both sensitive and specific. A sensitive test detects even small amounts of antibodies. A test high in specificity will identify all false negatives correctly. ELISA is both highly specific and sensitive. Details of various kits are mentioned in the NACO guidelines on HIV testing.
6. (c) However, none of these signs are conclusive for HIV infection. A person can only know their sero-status for sure if they get tested.
7. (a) Cerebrospinal fluid (which surrounds the brain and the spinal cord), Synovial fluid (which surrounds the joints) and Amniotic fluid (which surrounds the foetus) all contain the virus in addition to the familiar body fluids such as blood, semen, vaginal fluid and breast milk. Health care personnel are at risk of infection from all these. Sweat does not transmit HIV.
8. (b) Though AIDS was first recognized as an illness in 1982, the virus HIV has been isolated in a blood sample of a patient collected and stored in 1959. It is assumed that the virus has been around even before that in the 1940s.
9. (a) Exclusive breastfeeding means only breast-feeding the child (Medicines and other oral drops can be administered to the child who is exclusively breast-fed). Mixed feeding combines breast milk and formula feeds. Replacement feeding means giving babies only formula and is only recommended when it is AFASS - acceptable, feasible, affordable, sustainable and safe. NACO policy recommends exclusive breastfeeding since for most women in the country, this is the safer option.
10. (b) There is no exchange of body fluids in counselling.
11. (a)
12. (b)
13. (c)

14. (d) Viral load tests measure how much of the HIV virus is in the bloodstream. A result below 10,000 is considered a low result. A result over 100,000 is considered a high result. The primary use of these tests is to help determine how well a certain antiviral drug is working. If the viral load is high, your physician may consider switching you to another drug therapy. The viral load tests are best used if trends in results are compared over time. If the viral load increases over time, then the drug treatment may need to be changed. If the viral load goes down over time, antiviral treatment may be working for you. Other tests (like CD4 cell counts) are also important indicators as to how well antiviral therapy is working. It is presently not known what a test result between 10,000 and 100,000 means. That's why trends in viral load tests are of much greater value.
15. (a)
16. (b)
17. (c) Large numbers of people have latent TB infection which can become activated. HIV infection is one risk factor that can increase risk of activating the disease. Hence TB is such a serious opportunistic infection.
18. (c) This is high compared to 10% lifetime risk in a person who is not infected with HIV.
19. (a) In fact detecting and treating TB infection in PLWHAs not only helps infected people but it can also reduce the likelihood that other people they come in contact with will be protected from TB. One untreated sputum-positive (one way of detecting TB) can infect 10 to 15 other individuals per year.
20. (c) PLWHAs with TB infection can get cotrimoxazole preventive treatment (CPT) free of charge at the DOT centres. This is a daily medicine which reduces the risk of serious opportunistic infections
21. (a) Though patients often insist on chest X-rays, these are difficult to interpret and may sometimes be wrong. The more efficient method is to obtain 3 sputum samples: one spot sample when patient first shows up, one early morning sample and a second spot sample when the patient returns to turn in the early morning sample.
22. (c)

References

- ✓ Joint United Nations Programme on HIV/AIDS (2008). Fast Facts about HIV. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ Joint United Nations Programme on HIV/AIDS (2008). Fast Facts about HIV Prevention. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ Joint United Nations Programme on HIV/AIDS (n.d.). Fast Facts about HIV Testing and Counselling. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ Joint United Nations Programme on HIV/AIDS (2008). Fast Facts about HIV Treatment. Accessed from <http://www.unaids.org/en/knowledgecentre/resources/fastfacts/> on August 12, 2009.
- ✓ National AIDS Control Organisation (2007). *Guidelines for HIV Testing* New Delhi, India: Ministry of Health and Family Welfare, Government of India.
- ✓ National AIDS Control Organisation (n.d.). FAQs. Accessed from http://www.nacoonline.org/Quick_Links/FAQs/ on August 12, 2009.

Day 2

Planning for Group Presentation
Here's What we do in the ICTC

Planning for Group Presentation

Here's What we do in the ICTC

Session Overview

This session is actually a set of mini-sessions divided across the three-day workshop.

- ✓ Group planning of presentations (30 minutes)
- ✓ Group presentations at scheduled times in the workshop (15 minutes each)

Session Objectives

- ✓ To provide an opportunity for ICTC team members to learn from each others' experiences.

Time Allowed

30 minutes for planning

15 minutes for each presentation

Materials

- ✓ Copies of the Instruction Sheet for the Group Presentation
- ✓ Overhead Transparency sheets
- ✓ Markers

Method

Preparation

- 1) You, as the trainer, will make 5 to 6 copies of the Instruction Sheet for the Group Presentation before the session.

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Group Planning of Presentations

- 2) Divide the trainees into groups according to their profession: “For this session, I want the testing personnel to sit together, the nurses to sit together, the medical officers to sit together, etc.” You can ask the counselling personnel to break up into 2 smaller groups based on whether they offer PPTCT services in their ICTC or not: “Some ICTCs offer PPTCT services and some do not. The counselling personnel doing PPTCT work can form one group, and the other counselling personnel can form a second group.”
- 3) Ask the trainees to plan a brief 10 minute presentation using the following points: “You have a total time of 30 minutes to do 2 things in your group. First, you will briefly share what each of you are doing in your ICTCs. The second thing you have to do is to make a brief presentation to the other groups of what you do. The groups will be
 - a. testing personnel
 - b. counselling personnel doing PPTCT
 - c. counselling personnel not doing PPTCT
 - d. medical officers.”



Note to the Trainer:

Nurses might be playing one of two roles or both in their respective ICTC: Labour room nurse attending to pregnant women, and/or doing counselling. Offer them the option to join the group of counsellors doing PPTCT or not doing PPTCT.

“Each group presentation will only be for 10 minutes and will cover the following points:

- In the ICTC, the main tasks we do are
- When a patient or PLWHA comes to us, we
- The forms and documentation we look after are
- One common mistake people make about our work is

4) For the actual presentations, you will have to show each group when they are presenting as per the programme schedule. These presentations are arranged so that after each group discusses their work, there is a session or exercise related to that activity or function. So it is not suggested to change the timing of these sessions.



5) Also, explain to the groups, that their presentation should be very brief and should contain the most important points about their work. Reassure them that you are not interested in any one ICTC or any one person. Instead, it is a presentation to colleagues to inform them about their general activities, and to correct any misperceptions. If trainees want to use overhead transparencies in their presentation, please give them the supplies. But do not make it mandatory for each group to do so. This might only make the trainees more conscious of their performance in public.

Presentations

6) During each presentation, repeat that the presentation is a brief one for 10 minutes only. You can enforce this, by asking someone to be a time keeper and to inform the group when their allotted time of 10 minutes is over. Allow the other participants a chance to ask a few questions. But, it is important to conclude the session within the allotted time.

Note to the Trainer:

We have used the light-bulb sign to remind you of the presentations which should precede particular sessions. Please look out for them ahead in the book.



Here's What We Do in the ICTC

Instruction Sheet for the Group Presentation

You have 30 minutes to do 2 activities:

The first activity is to share IN BRIEF with your colleagues what you do at your ICTC. As you are most likely doing the same thing, this should not take too long. But there might be differences based on the type of ICTC.

The second activity is to plan a brief presentation of what you do at the ICTC. You will make this presentation to the other groups at specific times in the workshop schedule. The trainer will give you more details. The total time of this presentation is 10 minutes for each group. So please keep it BRIEF. To guide you, here are some points

- **In the ICTC, the main tasks we do are**
- **When a patient or PLWHA comes to us, we**
- **The forms and documentation we look after are**
- **One common mistake people make about our work is**

Day 2

HIV Testing at the ICTC



Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Testing Personnel**.

HIV Testing at the ICTC

Session Overview

- ✓ Lecture using slides (20 minutes)

Session Objectives

- ✓ To explore key issues related to HIV testing.
- ✓ To describe the three-test algorithm used at the ICTC.
- ✓ To discuss ICTC documentation related to HIV testing.

Time Allowed

20 minutes

Materials

- ✓ Slides related to the session



Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Testing Personnel**.

Method

Lecture using slides

- 1) You, as the trainer, will present the material using the relevant overhead transparencies or slides.
- 2) Finally, ask trainees to turn to the Handbook pages which contain the forms related to testing. Explain these using the slides.

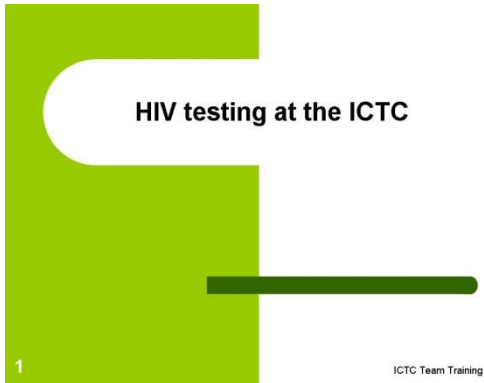
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Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Testing Personnel**.

Slides

SLIDES	COMMENTARY
	Title Slide
<p>The HIV Antibody Test</p> <p>An HIV infected person can find out their sero-status through an HIV test.</p> <p>Most common tests detect antibodies to HIV.</p>	<p>The only way for an HIV infected person to find out their sero-status is through undergoing an HIV test. The most common way is to detect whether their blood contains antibodies to HIV.</p>
<p>Window Period</p> <p>HIV Antibodies usually develop 4 to 12 weeks after infection</p> <p>(Sometimes even 3 months after infection).</p> <p>Window period: the period immediately after infection when there are no antibodies.</p>	<p>Antibodies to HIV are produced from 3 to 12 weeks after the moment of infection. The period immediately after infection when there are no antibodies is called the window period.</p>
<p>Meaning of HIV antibody test result</p> <p>A positive antibody test result</p> <p>Individual's blood contains HIV antibodies</p> <p>Therefore, the person has HIV.</p>	<p>A positive result on an HIV antibody test means that the individual's blood contains the presence of HIV antibodies. So we conclude the person has the virus.</p>

<p>False negative test result</p> <p>Testing during the window period will always produce a negative result</p> <p>But person is infected</p> <p>Therefore result is false negative</p>	<p>Testing someone during the window period will not detect antibodies but since the person is infected, this negative result is a false negative.</p>
<p>Infant's positive test result</p> <p>Testing a newly born child to a woman who is infected with HIV will always cause a positive result</p> <p>But these could be antibodies from the mother which have passed to the child</p> <p>Therefore infant needs additional testing</p>	<p>Antibody testing in a new-born child may pick up antibodies that have been passed on from the mother if she is infected. So we cannot accept the positive antibody test result in a new-born infant. We need to use other tests in this situation.</p>
<p>Commonly used HIV tests</p> <p>Rapid tests</p> <p>Western Blot</p> <p>Tests to detect the virus itself : PCR</p> <p>NACO recommends the use of rapid tests so that the client can receive the result within 30 minutes.</p>	<p>In the ICTCs, rapid tests are used to detect HIV antibodies. They do not need special equipment and are user-friendly. ELISA or enzyme-linked immunosorbent assay is an efficient test for testing large numbers of samples per day, as in large blood banks or for surveillance studies. But it is not recommended for ICTCs because it requires skilled technical staff, equipment maintenance and a steady power supply and, therefore, may be less suitable for smaller or more isolated clinics or laboratories. The Western Blot is also an antibody test. But it is more expensive. So it is used less frequently. It is used especially in the case of an indeterminate or unclear test result from a rapid test. Finally, there are tests to detect the virus itself such as the Polymerase Chain Reaction or the PCR. The PCR is used to check for infection in babies born to women infected with HIV/AIDS. Since maternal antibodies that are circulating in the blood of new-born infants only disappear by about 18 months of age, the direct test is necessary to detect the presence of the virus in their system.</p>

<p>Diagram of Three-Test Algorithm</p> <p>See Page 108</p>	<p>NACO recommends a three-test algorithm. A client has a blood sample drawn once. If he/ she tests negative on one rapid test, he/ she is declared as HIV-negative. But when a client tests positive on the first kit, the same blood sample is tested a total of three times using other kits with different antigens before the person is declared to be HIV-positive or HIV-infected. A positive test result is only declared when all three tests pick up the presence of antibodies. If two kits show a positive result but the third is negative, the result is declared as indeterminate. Some patients have trouble accepting a positive test result. It is important to explain to them that their blood has been tested with 3 different test kits. For an indeterminate test result, counsel the person to get tested again after 14 to 28 days. If the sample continues to produce an indeterminate result, use a Western Blot or a PCR test or send it to a National Reference Laboratory for further testing. It is important to follow this testing algorithm carefully because we want to avoid causing unnecessary distress to a patient.</p>
<p>The next 3 slides consist of the records maintained by the testing personnel</p> <p>See Pages 105 to 107</p>	<p>Ask trainees to turn to the Handbook pages which contain the forms related to testing. These are maintained by the testing personnel. The client is identified by a Patient Identification Digit (PID) which should have been assigned by the counselling personnel. The Laboratory Register contains details of the number of tests that have been run on a sample and the final result.</p>
<p>The next 3 slides consist of the records maintained by the testing personnel</p> <p>See Pages 105 to 107</p>	<p>Point to Column 10 which shows the samples that are sent for quality checking to the State Reference Laboratory. This includes 20% of all positive sample and 5% of all negative samples in the first week of every quarter (that is January, April, July and October).</p> <p>From the Laboratory Register, the following information can be extracted for the monthly report: HIV status of clients (positive, negative, indeterminate); Kit utilisation ;External quality assurance</p>

<p>The next 3 slides consist of the records maintained by the testing personnel</p> <p>See Pages 105 to 107</p>	<p>The stock register provides information on the stock of critical test kits, drugs, and other essential consumables. The information that can be extracted from this register is:</p> <p>Opening stock</p> <p>Receipts</p> <p>Utilisation</p> <p>Closing balance</p> <p>Note that each kit is separately recorded.</p>
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Annexure III.f

Laboratory Register for ICTC

Continued...





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Annexure III.f

Quality control no.	Confirmation result received from lab	Signature
Sent to SRL/NRL		
10	11	12

.....

58 Operational Guidelines for Integrated Counselling and Testing Centres

Name of Test/Drug/Consumable* : _____

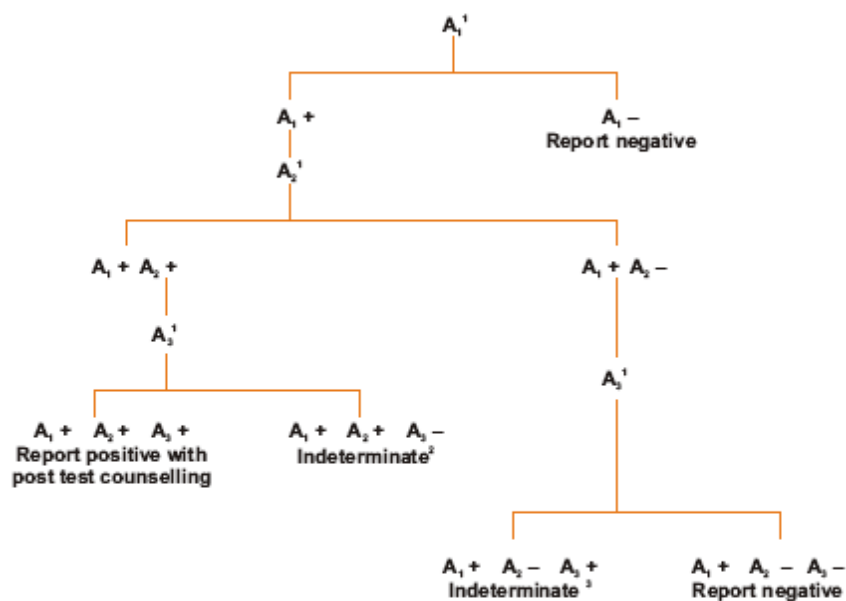
[illegible]

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



THE THREE TEST ALGORITHM

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



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

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

Day 2

Integration between ICTCs and TB Services



Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Counselling personnel doing General ICTC Counselling (that is non-PPTCT work)**.

Integration between ICTCs and TB Services

Session Overview

- ✓ Lecture using slides (30 minutes)
- ✓ Small group discussion of Case Scenarios (30 minutes)
- ✓ Large group discussion of Case Scenarios (1 hour)

Session Objectives

- ✓ To demonstrate the need for strong linkages between the ICTC and the Revised National Tuberculosis Control Programme (RNTCP).
- ✓ To explore issues related to referrals from the ICTC to TB services.
- ✓ To list the key messages about HIV for TB patients who come to the ICTC.
- ✓ To list the key messages about TB for HIV patients.
- ✓ To explain the documentation related to ICTC TB integration.

Time Allowed

1 hour 45 minutes

Materials

- ✓ Slides related to the session
- ✓ Case Scenarios for ICTC-TB Integration
- ✓ Forms related to ICTC Counselling.
- ✓ NACO's Healthcare Provider's Tool

Method

Preparation

- 1) Before the session, you, as the trainer, will make copies of the Case Scenarios for ICTC-TB Integration and keep them ready in an envelope.

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Note to the Trainer:

This session follows immediately after the ‘Here’s what we do in the ICTC’ presentation by the **Counselling personnel doing General ICTC Counselling (that is non-PPTCT work)**.

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Lecture using slides

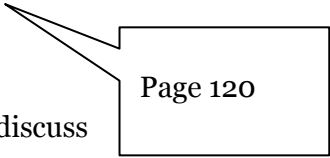
- 2) Introduce the session using the relevant slides.
- 3) When discussing the Nine Point Counselling Tool on TB integration, ask trainees to turn to the relevant page in the handbook. Display the next five slides slowly as trainees read the information in the box.
- 4) Ask them what they think about the recommendations for confidentiality.
- 5) Encourage trainees to debate the pros and cons of informing the DOTS provider about the HIV status when the patient has asked not to reveal the test result: e.g., loss of trust in ICTC, may discontinue DOTS, may face stigma, may not go to ART centre because of worry of lack of confidentiality there.
- 6) Ask trainees what they will do if a patient referred from the DOTS centre absolutely refuses to do a rapid HIV test, and the DOTS centre staff are upset because the ICTC honoured the wishes of the patient (that is they allowed the patient to “opt out.”).

Small Group Discussion of Case Scenarios

- 7) Ask the trainees to sit with other members of their ICTC team.

- 8) Hand each team a Case Scenario and ask them to discuss the possible solutions.

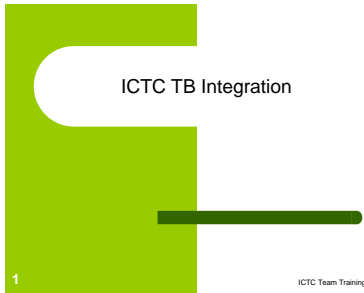
Large Group Discussion of Case Scenarios



Page 120

- 9) Gather the trainees together into the larger group and discuss the case scenarios. Emphasise: Provider-Initiated Testing, right to opt out, knowing the benefits of one's TB status and one's sero-status. Discuss strategies that ICTCs can use to generate more referrals. Encourage them to use the Nine-Point Counselling Tool and the Health Care Provider's Tool to select appropriate information for educating patients and other Health Care Personnel.

Slides

SLIDES	COMMENTARY
	<p>Title Slide</p>
<p>Why should ICTCs worry about TB ?</p> <p>One of the most common OI in HIV positive persons</p> <p>PLWHA have a 50 to 60% lifetime risk of TB; uninfected person's lifetime risk is 10%</p> <p>PLWHA co-infected with TB live a shorter life because TB hastens progress of HIV by increasing viral replication/multiplication</p>	<p>This session is related to the link between the national TB and HIV programmes. TB is a serious problem for PLWHAs. It is one of the most common opportunistic infections. A PLWHA has a higher chance of getting infected with TB than a non-HIV-infected person. His/ her CD4 cells are less in number because of HIV. Once co-infected with TB the PLWHA may live a shorter life than a non-HIV-infected person.</p>
<p>National Policy on TB and HIV</p> <p>All the clients at the ICTC should be screened for symptoms and signs of TB</p> <p>Every TB patient should be encouraged to “know their HIV status”</p>	<p>National Policy wants to increase the number of PLWHAs who get tested for tuberculosis infection. This is done with a sputum exam. On the other hand, the national policy also wants to encourage each and every TB patient to undergo an HIV test and ‘know their sero-status.’ For this purpose, HCP are encouraged to make a routine offer to TB patients to get tested for HIV and refer them to the ICTC.</p>
<p>How does knowing TB status help PLWHAs</p> <p>Start TB treatment early and prevent spread of infection</p> <p>Reduce morbidity and mortality from TB</p> <p>Start DOTS, complete full course and prevent relapse of infection or emergence of resistant TB</p> <p>Diagnosing TB infection and starting treatment early can prevent spread of infection among family members</p>	<p>If a PLWHA finds out they are co-infected with HIV, they can start DOTS. By getting treated, they also prevent harm to their family members. It is important to counsel any ICTC patient with a continuing cough for 2 weeks or more to get tested for TB. It is important to explain to them the benefits of getting tested for TB and then getting treated.</p>

<p>ICTC Counselling personnel should ask all HIV positive patients about history of cough, sputum and fever. All PLWHA experiencing prolonged cough for 2 weeks or more should be referred for TB testing</p>	
<p>What is DOTS?</p> <p>Directly Observed Treatment - short course is provided by the national TB programme</p> <p>Health worker watches the patient swallow TB medications according to the treatment schedule.</p> <p>Decreases risk of drug-resistance resulting from erratic or incomplete treatment.</p>	<p>DOTS is a method to ensure that the patient takes medications regularly and correctly and completes his/her treatment. Patients are asked to take their anti-TB medicines in the presence of the health worker. DOTS also decreases the risk of drug-resistance resulting from erratic or incomplete treatment.</p>
<p>Benefits of DOTS</p> <p>Ensures patients take medicine correctly and that patients complete their full anti TB course.</p> <p>Provides close monitoring of side effects, the need for injections, drug interactions with other medications and treatment failure.</p> <p>Decreases the chances of treatment failure and relapse</p>	<p>Describe the advantages of DOTS which are listed on the slide.</p>
<p>How does knowing HIV status help TB patients</p> <p>TB Patients with HIV can access:</p> <ul style="list-style-type: none"> Care and support services Co-trimoxazole prophylaxis (CPT) Treatment for OIs Antiretroviral therapy (ART) Prevention counselling and services Social support services (PLWHA networks) 	<p>Similarly, a TB patient who knows his/ her HIV status can register at an ART centre and check their CD4 count. They can receive free ART. They can receive co-trimoxazole prophylaxis to protect them against other opportunistic infections. Besides this, they can also protect their sexual partners through safer sex, and get them to check their HIV status as well.</p>

<p>Partner Testing</p> <p>HIV infected TB patients should be counselled to get their sexual partners tested for HIV and TB.</p>	<p>It is important to urge all TB patients who test positive for HIV to get their sexual partners tested for HIV as well.</p>
<p>HIV-TB Integration as a case of Provider-Initiated Testing</p> <p>Provider initiated testing is a strategy designed to increase HIV testing among at risk populations</p> <p>As HIV-TB co-infection is common:</p> <ul style="list-style-type: none"> - counsel offer to test all TB patients for HIV. - all HIV positive patients with symptoms suggestive of TB to be evaluated for TB infection. 	<p>As we have seen, HIV-TB referrals are one type of Provider-Initiated Testing. The same strategies that we discussed in that session will apply here: namely talking to the DOTS providers to increase the referrals, making sure they have the referral forms and knowing where to send patients for HIV testing. As HIV-TB co-infection is common, it is important for HCP to counsel and make a routine offer to test all TB patients for HIV. Similarly, it is important for all HIV positive patients with symptoms suggestive of TB to be evaluated for TB infection.</p>
<p>Remember:</p> <p>Though TB patients may be referred to the ICTC, they have the right to “opt-out” of being tested!</p>	<p>Again, we repeat, though providers may refer their patients for testing to the ICTC, patients can always “opt out” of testing, that is they can refuse to be tested.</p>
<p>How can we strengthen linkages between TB and HIV</p> <p>ICTC centres and Designated Microscopy centres (DMC) or DOTS should be in the same premises</p> <p>All ICTC and RNTCP staff should be trained in HIV-TB</p> <p>All ICTCs should have a directory of state wide DMC/DOTS centres</p> <p>All RNTCP units should have a directory of state wide ICTCs</p> <p style="text-align: right;">contd..</p>	

<p>How can we strengthen linkages between TB and HIV(contd..)</p> <p>ICTC and RNTCP staff should follow-up referral cases</p> <p>Monthly review meetings at RNTCP units should be attended by ICTC staff</p> <p>Referral forms for HIV testing/ICTC should be available at TB units</p>	
<p>Some key counselling points for HIV TB integration</p>	<p>Ask trainees to turn to the page in the handbook with Inform about TB – provide initial information on TB:</p> <p>. Display the next 8 slides slowly as trainees read the information in the box.</p>
<p>What is TB?</p> <p>Tuberculosis or TB, is an illness caused by germs that are breathed into the lungs.</p> <p>TB germs can settle anywhere in the body, but we most often hear about TB in the lungs. When the lungs are damaged by TB, the person coughs up sputum (mucus from lungs) and cannot breathe easily.</p> <p>Without correct treatment, a person can die from TB</p>	<p>Ask trainees about their understanding and what they would ask the patient. Questions to patient are not shown in the slides.</p>
<p>TB can be cured: with the correct drug treatment.</p> <p>The patient must take all of the recommended drugs for the entire treatment time in order to be cured.</p> <p>Drugs for treatment of TB are provided free of cost.</p> <p>Treatment can be done without interrupting normal life and work</p>	

<p>TB spreads:</p> <p>when an infected person coughs or sneezes, spraying TB germs into the air. Others may breathe in these germs and become infected.</p> <p>Anyone can get TB. However, not everyone who is infected with TB will become sick</p>	
<p>How to prevent TB from spreading?</p> <p>Take regular treatment to become cured</p> <p>Cover mouth and nose when coughing or sneezing</p> <p>Open windows and doors to allow fresh air through the house, use a fan</p>	
<p>Why test children?</p> <p>All children aged under 6 years living in the household should be examined for TB symptoms.</p> <p>important because children under 6 years are at risk of severe forms of TB.</p> <p>Young children may need preventive medicines and need to be examined by the doctor.</p>	
<p>Why the health worker must observe you swallow pill?</p> <p>ensure that you take the correct drugs regularly for the required time.</p> <p>If injections are needed, they will be given properly.</p> <p>By seeing you regularly, the health worker will notice if you have side effects or other problems.</p> <p>If you do not take all of the drugs, you will continue to spread TB to others in your family or community</p> <p>Interrupted treatment may make disease to become incurable.</p> <p>With directly observed treatment (DOTS), the health worker will know if you miss a dose and will quickly investigate the problem.</p> <p>If you must travel, or if you plan to move, tell the health worker so that arrangements can be made to continue treatment without interruption</p>	<p>Point out the need for proper contact details so that follow-up by outreach workers is more efficient. Remind them that at the ICTC, they should maintain this in a confidential manner in the PID register while all other records should only identify the patient by the PID number.</p> <p>Ask them what they think about the recommendations for confidentiality. Encourage trainees to debate the pros and cons of informing the DOTS provider about the HIV status when the patient has asked not to reveal the test result: e.g., loss of trust in ICTC, may discontinue DOTS, may face stigma, may not go to ART centre because of worry of lack of confidentiality there.</p>

<p>Explain to the specific patient:</p> <p>duration of treatment</p> <p>frequency of visits for taking treatment</p> <p>where to go for treatment</p>	
<p>Changes with Drugs:</p> <p>Urine may turn orange/red as a result of the drug (rifampicin). This is not harmful.</p> <p>If you feel nausea from the drugs, bring a bit of food to eat when taking the next dose.</p> <p>Treatment should not interfere with normal life and work</p> <p>Make sure that the patient knows exactly where and when to go for the next treatment.</p> <p>Remind patient to bring family and other close contacts TB tested as needed</p>	
<p>ICTC Referral form</p> <p>See Page 121</p>	<p>Display the last slides related to the relevant documentation and ask trainees to turn to the forms in their handbooks. Discuss each one.</p>
<p>The next 5 slides consist of the records maintained by the counselling personnel related to ICTC-TB integration.</p> <p>See Pages 122 to 126</p>	<p>In the ICTC Register for General Clients which the trainees have already seen, point out Column 4 where they have to mention the source of the referral where they will circle the TB centre in case of patients referred from there.</p> <p>Point out Column 17 where they have to mention the TB centre when they are referring an ICTC patient with a persistent cough.</p>

<p>The next 5 slides consist of the records maintained by the counselling personnel related to ICTC-TB integration.</p> <p>See Pages 122 to 126</p>	<p>In addition to the ICTC general register, the ICTC also has to maintain an HIV-TB Collaborative Activity Register. This contains details such as</p> <p>Number of HIV-positive clients referred to the RNTCP</p> <p>Number of clients referred from the RNTCP</p> <p>Number of HIV-positive clients put on DOTS</p> <p>Number of the referrals to and from the TB programme.</p> <p>Here as well the patient is identified only by the PID.</p>
<p>The next 5 slides consist of the records maintained by the counselling personnel related to ICTC-TB integration.</p> <p>See Pages 122 to 126</p>	<p>At the end of the month, the data from the ICTC Collaborative Activity register is extracted into the Line-list of Persons referred from the ICTC to the RNTCP. This line list is then shared with the STS who provide information regarding the TB diagnosis and TB treatment of the patients who were referred by the ICTC during the month. The STS then returns the completed line list to the ICTC counselling personnel at the end of the month.</p>
<p>HIV-TB Integration as a case of Provider-Initiated Testing</p> <p>Column 4 and 17 of the ICTC Register for General clients</p> <p>The ICTC HIV-TB Collaborative Activity Register. (Use the PID)</p> <p>Integrated Counseling and Testing Centre referral form.</p> <p>End of the month</p> <p>Line-list of Persons referred from the ICTC to the RNTCP</p>	

Case Scenarios for ICTC-TB Integration

The Case Scenario slips must be cut up by the trainer before the session.



Case Scenario 1

The Testing personnel at a CHC notices that the client who came for testing was coughing badly. The client's test result is positive. What should the testing personnel do?

✂-----

Case Scenario 2

The medical officer of the ICTC at the district hospital wants to explain to the medical officer in-charge of the DOTS centre at the hospital; the need to refer all TB patients to the ICTC for testing. But the DOTS medical officer is not convinced. He/ she has not heard of this “new” HIV-TB policy. What should the MO do?

✂-----

Case Scenario 3

The ICTC counselling personnel at a CHC gets a client for testing. The client's test result is positive. What should the counselling personnel do?

✂-----

Case Scenario 4

The nurse in an ICTC at the PHC meets a patient referred by the nearest DOTS centre for HIV testing. The patient does not want to be tested for HIV. What should the nurse do?

Annex.

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

Annexure III.b**ICTC Register for General Clients (excluding Pregnant Women)**

ICTC Code:

ICTC Name:

District:

State:

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

Continued...



Annexure III.b**ICTC Register for General Clients (excluding Pregnant Women) (contd.)**

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

Continued...

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

Continued...



Annexure III.e

ICTC HIV–TB Collaborative Activity Register[illegible]

Continued...



Annexure III.e

ICTC HIV-TB Collaborative Activity Register (contd.)

[illegible]

Line-list of Persons Referred from ICTC to RNTCP

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

TO BE COMPLETED BY ICTC COUNSELLOR				TO BE COMPLETED BY the STS									
1	2	3	4	5	6	7	8	9	10	11	12	13	
Sr.N o.	PHD NO.	Complete Name & Complete Address	Age	Sex	Date of referral to RNTCP	Name of facility by which referred	Is patient diagnosed as TB – Yes or No	If diagnosed as TB, specify whether patient is sputum positive TB, sputum negative TB or Extrapulmonary TB	Is patient initiated on DOTS	Date of Starting Treatment	TB No.	Remarks	
Sign of Counsellor Date of completion:				Sign of MO-ICTC				Name of the TU: Signature of STS Date of Completion:					Signature of DTC/CTO/MO-TU

Day 2

Picture-Perfect Team

Picture-Perfect Team

Session Overview

- ✓ Team relay (35 minutes)
- ✓ Picture exercise (25 minutes)

Session Objectives

- ✓ To highlight how groups need to work in unison to become a team.

Time Allowed

1 hour

Materials

- ✓ Medium-size, flat bowl (one for each team)
- ✓ Water mugs (one for each team)
- ✓ A sack of cheap grain like rice, wheat or millet (Optional: A drum of water)
- ✓ Whistle for the trainer
- ✓ An outdoor location
- ✓ Slides

Method

Preparation

- 1) Before the session, you, as the trainer, will need to gather all the materials for the water game. **Make sure that each team has a bowl and a water mug.**
- 2) **Set up the outdoor location for the game.** There should be clear space for groups of trainees to run/ walk across. Set up the sack of grain at the starting line. Set up a line of water mugs at the finishing line.
- 3) Select an assistant trainer to help you with the game.
- 4) Arrange for someone to clean up the mess created by the exercise.



Note to the Trainer:

This Team Relay is actually a variation of a Water Relay Race. You can substitute the sack of grain with water for the original race. Using water will be more messy and should be played outside only. The dynamics of this original exercise cause the adult trainees to want to protect themselves from getting wet. It equalises the difference between the trainees even more instantaneously than using the dry grain.

Team Relay

- 5) Ask the trainees to gather at the outdoor location.
- 6) At the outdoor location ask the various ICTC teams to stand with each other.
- 7) Introduce the game as follows: “This is a relay game to see which ICTC team is the fastest.”
 - a. “Each ICTC team will be given a bowl which they will use to fill the mug at the finishing line.”

- b. "The team has to fill the bowl at the starting point from the sack (Point to the starting point) and empty it into the water mug at the finishing line (Point to the finishing line)."
 - c. **"To carry the bowl across to the finishing line, TWO members of the team must walk or run supporting the bowl from below with only THREE fingers."**
 - d. "The bowl should be above the shoulder level of the two people."
 - e. "Holding the edge of the bowl is not permitted."
 - f. "EVERY member of the team must take a turn in this relay."
 - g. "The team finishes when the mug is filled."
 - h. "The race starts when I blow the whistle."
 - i. "MY decision is final."
- 8) Start the game by blowing the whistle. Correct those teams who are holding the bowls, rather than supporting it from below. If some teams continuously disobey the rules, send them back to the finishing line. Watch for trainees who do not take a turn in the relay.
- 9) Stop the game when about 3 teams finish the task.
- 10) Ask the trainees to return to the training hall.

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Picture Exercise

- 11) When trainees have gathered together in the training hall, show them the slide related to the Picture-perfect team. Ask them to think about the relay game in which they just took part and then to select the picture that best reflected how their group performed.
- 12) Ask a few trainees to narrate which picture they selected and why. Encourage different people to narrate experiences but maintain order. Make sure that more dominant speakers make time for others. You could say, "Thank-you for sharing that but let's hear from someone else."

Some possible answers:


- “I chose the langar picture because here there is no hierarchy. It does not matter if it was a man or a woman, older person or younger person.”
- “I think the snake boat race is closest because we were racing against time.”
- “The picture of the inside wheels of the clock represent our group effort best because we had to move together to function properly.”
- “In my view, the tug-of-war picture is the best image because it was a difficult task.”

13) Ask trainees about pictures that they did not select and why. Point out that even these pictures convey impressions of teams.

- “Sometimes we do not realize that there is a team effort involved. For instance, the man on the moon would not reach there unless there was a good team supporting him from earth. Yet we do not see the team. We see the man on the moon.”
- “Let’s look at the picture of the jet planes in formation. Each plane is part of the overall team of planes. But within each plane is a set of people running that plane who have different functions just as our various ICTC centres and ART centres, or our different units in the health centre or hospital.”
- “In the picture of the tug-of-war, we see the effort and hard work of the team players. But they are also helped by the support and cheering of the audience watching them.”
- “The Gokulashtami/Janmashtami picture represents the players who form the human pyramid on the day of the festival. What we must also realize that if they manage this difficult and dangerous feat, it is because many teams practise before the festival. Here the person who finally breaks the pot is sometimes the youngest and the lightest of the team. Heavy-weights and egos have no place here.”
- “The picture of the people with their laptops shows people sitting with their backs to each other. There is no eye-contact. This often represents how we function in health centres where we are not constantly sitting with each other. So to achieve good team-work, good channels of communication are needed.”

- “The picture of the people climbing the abacus, then the calculator and finally the computer shows how the team can progress to greater challenges.”
- 14) Finally, ask the trainees to think about how their ICTC works and to identify a picture that describes how they function. Ask a few people to give their answers (taking care to select people who have been silent in the previous part of the session).

Slides

SLIDES	COMMENTARY
	<p>Title Slide</p>
	<p>The pictures include (from top left to right):</p> <ul style="list-style-type: none"> The langar or communal Sikh kitchen Man on the moon Indian cricket team in a huddle The inside gears of a watch Janmashtami human pyramid People at work on laptops Joined hands Tug of war People putting together a jigsaw puzzle Jet plane formation Bees in a honeycomb People climbing abacus, calculator and computer Snake boat race in Kerala

Day 2

Understanding and Managing Stigma

Understanding and Managing Stigma

Session Overview

- ✓ People Search Exercise (20 minutes)
- ✓ Large group discussion (20 minutes)
- ✓ Discussion of Discrimination Case Note (25 minutes)
- ✓ Lecture using slides (35 minutes)

Session Objectives

- ✓ To highlight the effects of stigma and discrimination.
- ✓ To expose various manifestations of stigma and discrimination related to HIV/AIDS.
- ✓ To analyse reasons for stigma and discrimination.
- ✓ To discuss Universal Safety Precautions and Post Exposure Prophylaxis as strategies to reduce fear that may lead to stigma and discrimination.

Time Allowed

1 hour 40 minutes

Materials

- ✓ People Search
- ✓ Discrimination Case Notes
- ✓ Slides related to the session
- ✓ ICTC Stock Register Form

Method

People Search Exercise

- 1) You, as the trainer, will introduce the session: “Before we carry on with the afternoon session, let us play a small game. This will help us to move around a little after lunch, and we can learn something more about the other trainees. Please turn to the page with the People Search in your handbooks. This contains some descriptions of people. Please speak to the other trainees and see if they fit any of these descriptions. Remember you cannot write down your own name on your list, and you cannot write anyone else’s name twice.”
- 2) Allow the trainees to interact with each other for 10 minutes to fill the list.

Page 139 in Trainer’s Guide; Page 129 in Handbook

Large Group Discussion

- 3) After the trainees complete their list, call out two or three categories in general and ask people to name the person they have listed on their sheet: “Okay! Let’s see who had the experience of riding a horse,” or “Who has visited Agra on their honeymoon?” or “Has anyone represented their district or state for a sport?” Let trainees shout out the names for these descriptions.
- 4) Now, turn to the descriptions of illness by asking: “Could you find anyone who had jaundice?” Let the trainees answer. Then ask: “What about the family member with tuberculosis and the person who has undergone an HIV test?” At this point, trainees are likely to be silent. You might find a female trainee who had to undergo HIV testing as part of antenatal care, or you might get a trainee who had an HIV test before a planned surgery.

Note to the Trainer:

There is a small possibility that there is an HIV positive individual among the staff. Take extra care to ensure this person does not feel unhappy with extra attention.



5) With care and sensitivity, discuss the situation related to HIV testing with the following questions:

- “Why is it easier to ask people about jaundice in comparison to HIV testing?”
- Even if there are people who may have been tested for HIV in this room, what might hold them back from sharing this information in this group?
- Is there a difference in revealing this information to a family doctor?
- Do you think that among the group of trainees, there might be people who should get tested for HIV but don’t go for a test? If there are such people, what might stop them from getting their sero-status checked?”

Some possible responses from trainees to the questions might be:

- “HIV status is a private matter.”
- “It might be difficult for people to share something like this because other people will point a finger and start gossiping about them.”
- “People don’t feel comfortable talking about their own health.”
- “People may shun us because they might worry that we will pass on the infection.”
- “We are middle-class people and we don’t do risk behaviours.”

Discussion of Discrimination Case Note

- 6) Give the trainees 5 minutes to read the Discrimination Case Notes in their handbook and to answer the questions written there.
- 7) Then ask the trainees for their responses, and write these reactions on the flipchart or the blackboard.

Some possible responses might be:


- “The medical staff may feel scared of being infected themselves. They may want to use specific protective gear.”
- “The patient may feel really rejected.”

Page 140 in Trainer’s
Guide; Page 130 in
Handbook

- “Other patients may want to run away because the doctors are also scared.”
- 8) Ask trainees for helpful suggestions for each of the 3 groups: medical staff, the patient who was labelled, and other patients. Be gentle with trainees who suggest further discriminatory or stigmatising behaviour. Point out that labelling one patient as HIV-positive may not help because a staff member could get infected with HIV from another unlabelled patient. Point out that testing everybody will not detect people who are in the window period. Point out that only by treating people fairly and justly can we get them to disclose their sero-status honestly. Also, the only way to protect oneself is to practise universal precautions in all circumstances. Explain that you will discuss Universal Safety Precautions in the training workshop.

Lecture using slides

- 9) End this session using the slides to explain the concepts related to Stigma and Discrimination, Universal Safety Precautions and Post-Exposure Prophylaxis.



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Activity: People Search

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

Someone who is wearing the colour red

Someone who is wearing sandals

Someone who travelled to the training programme by bus

Someone who plays a musical instrument

Someone who has represented their district or state in any sport

Someone who was born in February

Someone who has watched a film shooting

Someone who went to Agra for their honeymoon

Someone who cannot swim

Someone who has 3 brothers or 3 sisters

Someone who has ridden a horse (even in a baraat)

Someone who has suffered from jaundice

Someone whose family member has received tuberculosis treatment

Someone who has been tested for HIV.

Discrimination Case Notes

Hospital puts sticker to mark patient as HIV+

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

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

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

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

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

The hospital owned up but said it was a policy.

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

*Names of the doctor and the hospital have been deleted.

Note to Trainees:

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

Questions for discussion

Why do the hospital staff want to know if a person is infected or not?

Does putting the label really help us to know all the people who are HIV-infected?


Can you imagine the feelings of the medical staff?

Can you imagine the feelings of the patient who is wearing the label?

Can you imagine the feelings of the other patients?

What would you recommend to help the medical staff, the patient with the label and the other patients?

Slides

SLIDES	COMMENTARY
	Title Slide
<p>We often view AIDS as something that can affect other people, people who are different from us, people who lead perverted or sinful lives.</p> <p>From here it is a short step to blaming People with AIDS for their own condition.</p>	<p>One of the major problems related to HIV/AIDS is stigma and discrimination. This is related to the fact that HIV/AIDS was first observed among groups whose behaviours we traditionally stigmatise or look down on such as gay people. From treating people as different from us, it is easy to blame them for their own behaviour, and to justify when we treat them in unfair ways.</p>
<p>Stigma</p> <p>Setting aside certain persons or groups from the normal social order because they have some negative characteristic</p> <p>We devalue them</p> <p>We do this because we believe they are very different from us</p>	<p>Stigma related to HIV/AIDS means setting PLWHAs apart from our communities because of this negative characteristic that is because they have AIDS. We also associate PLWHAs with indiscriminate sex and irresponsible or immoral behaviour. We believe they are different from us.</p>
<p>Discrimination</p> <p>The unfair and unjust treatment of an individual based on his or her real or perceived HIV status.</p> <p>When we stigmatise, it is easier to treat them differently.</p> <p>If a person feels stigma towards another, she /he can decide not to be unfair or discriminatory.</p>	<p>Discrimination or treating PLWHAs unfairly or differently is the next step. Once we set people aside, it is easy to treat them differently. It is important to note that even if a person feels stigma towards another, she /he can decide to not act in a way that is unfair or discriminatory.</p> <p>A simple way of remembering these concepts is Stigma is our attitude, our mental thought pattern, and discrimination is our behaviour.</p>

Open Discrimination

Refusal to provide treatment for HIV/AIDS-related illness

Refusal to admit for hospital care/treatment

Refusal to operate or assist in clinical procedures

Restricted access to facilities like toilets and common eating and drinking utensils

Physical isolation in the ward (e.g. separate arrangements for a bed outside the ward in a gallery or corridor)

Stopping ongoing treatment

Early discharge from hospital

Mandatory testing for HIV before surgery and during pregnancy

Restrictions on movement around the ward or room

Unnecessary use of protective gear (gowns, masks, etc.) by health care staff

Refusal to lift or touch the dead body of an HIV-positive person

Use of plastic sheeting to wrap the dead body

Reluctance to provide transport for the body

Here are some examples of stigma and discrimination in the hospital. When we think of discrimination, we think of people being fired from a job. But discrimination is of two types. Some are specific discriminatory actions like firing someone because they test positive for HIV on a routine workplace health check-up. Some are omissions such as delay in treating a person with HIV infection or changing a planned surgery when the person tests positive for HIV infection. Besides the things mentioned on this table and next table, have you heard of any other?

Hidden Discrimination

Delays in treatment; slow service (e.g. made to wait in queues, asked to come again)

Excuses or explanations given for non-admission (but admission not directly refused)

Shunting patient between wards/doctors/hospitals

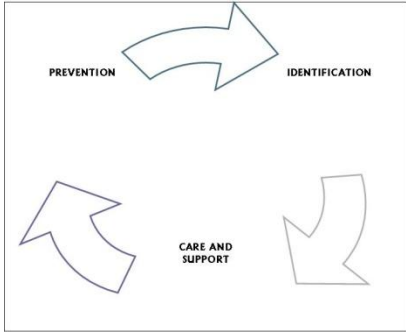
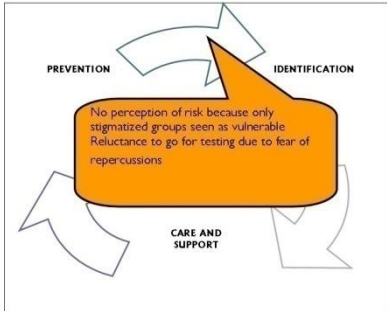

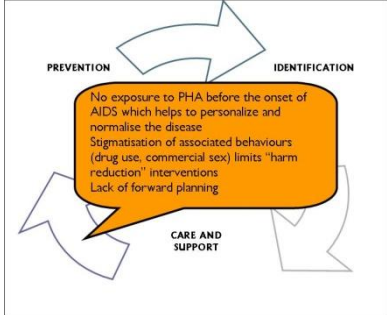
Keeping patient under observation without any treatment plan

Postponed treatment or operations

Unnecessarily repeated HIV tests

Conditional treatment (e.g. only on the condition that the patient will come for follow up or join a drug trial programme).

<p>Informed Consent for HIV Testing</p> <p>The client agrees to HIV testing through giving his/her informed consent.</p> <p>Informed consent is a deliberate and autonomous permission given by a client to a health-care provider to proceed with the proposed HIV test procedure.</p> <p>This permission is based on adequate understanding of the advantages, risks, potential consequences</p> <p>This permission is entirely the choice of the client and can never be implied or presumed.</p> <p>(From ICTC Operational Guidelines)</p>	<p>One place where Health Care Personnel at the ICTC might display discriminatory behaviour is in the matter of obtaining informed consent. Here are the conditions for informed consent as noted in the Operational Guidelines.</p> <p>Allow trainees time to read the slide.</p> <p>Stress that it is important to make sure that clients at the ICTC understand what the test is about and the testing process, before obtaining consent – that is Consent or saying Yes is informed or fully explained and understood.</p>
<p>Discussion Question</p> <p>If mandatory testing for HIV before surgery and during pregnancy that is described here a discriminatory practice, then what about provider-initiated testing and counselling?</p>	<p>Allow time for trainees to give the answer.</p> <p>1) Mandatory or universal testing for screening purposes is stigmatizing and discriminatory practice of universal HIV testing. For instance, we may ask all pre-surgery patients to be tested for HIV not so much to provide clinical services to the patient but to take extra protective actions such as double gloving or to deny services. There is a difference between such testing and Provider-initiated testing. The priority of Provider-initiated testing is to ensure that people who are most at risk have a chance to find out their sero-status. Universal testing for screening is done for the convenience of physicians who may falsely believe that they can protect themselves and their staff by taking special precautions with HIV-positive patients, or even denying services to HIV-positive patients. HCP may become more relaxed with HIV-negative patients not realizing that the person may be in the window period.</p> <p>2) Such universal testing for the purposes of screening violates the principle of informed consent because such testing does not respect the patient's right to "opt-out" from the testing process. Often it is unaccompanied by counselling and informed consent. Also, it will overwhelm the testing facilities and might mean that people who are actually infected experience a delay in knowing they are HIV infected, and in then seeking treatment. Apart from this is the legal and ethical issue of subjecting people to unnecessary medical procedures. In contrast, Provider-initiated testing involves a routine offer to test, and offers the option to say no to being tested. It is not mandatory.</p> <p>3) Mandatory testing for the purposes of screening will involve testing all patients. The mandate of the ICTC is NOT to test all people in the population. Provider-initiated testing and counselling involves a routine offer of counselling to people who are more vulnerable to HIV or who practise risk behaviour. NACO does not promote nor approve mandatory or compulsory testing of HIV.</p>

	<p>We have seen this slide before. It shows that there is a relation between prevention and care activities. There is a connection or a continuum between them. Prevention activities reduce the number of people infected and in turn reduce the need for future care. On the other hand, knowing that there are care and support activities, make HIV/AIDS visible in the community. Communities become more aware of the disease and individuals become more likely to take protective and preventive behaviour, as well as to go for testing.</p>
	<p>But when there is stigma and discrimination, this affects this continuum. For instance, when there is a stigma associated with the illness, people who engaged in risk behaviour try to avoid their personal worry by pointing to “other” groups instead of examining their own risky activities. They may delay going for an HIV test and this will lead to a delay in protective behaviours such as using a condom in all sexual encounters. These delays put the individual (and their sexual partners) at greater risk.</p>
	<p>If PLWHAs are worried about stigma and discrimination, they may also delay seeking early treatment (e.g., cotrimoxazole prophylaxis, TB diagnosis) because they worry about facing stigma in the health set-up. Seeking treatment at later stages of illness places more financial and care burden on the family and the individual. It also makes treating OIs more difficult.</p>
	<p>If there is stigma and discrimination, then the community might not engage in prevention activities. The ICTC is often the first encounter site for PLWHAs with the health system. It is our attitudes here that will convince them whether to take preventive measures, whether to get tested or not, and whether to get treated or not.</p>

<p>Why do we stigmatise and discriminate?</p> <p>Lack of awareness of how stigma affects People Living with HIV/AIDS</p> <p>Fear of human beings of being infected from ordinary contact with people already infected with HIV</p> <p>Associating people with HIV with behaviours that are immoral</p>	<p>As some of you have pointed out, some reasons why discrimination and stigma occur is because people are naturally afraid of getting HIV infection themselves. They don't know how badly stigma affects the stigmatised person. Also they may have many misconceptions.</p>
<p>Universal Safety Precautions</p> <p>Risk reduction measures at the workplace.</p> <p>Practising Universal Safety Precautions means applying blood and body-fluid precautions universally to all persons regardless of their presumed infectious status.</p>	<p>Staff in hospitals may wrongly believe that by labelling the PLWHA they will be able to take special precautions against getting infected themselves. But this is not going to be an effective solution because among the patients in the wards and out-patient departments, there might be people who are in the window period - that is people who were recently infected but who have not developed antibodies yet. The only way to be sure that we are keeping ourselves safe from infection is to practise the same biosafety measures with ALL clients. This is called Universal Safety Precautions. We will not be talking about this in detail in this workshop. But we recommend that you consult your workshop materials for more information.</p>
<p>Universal Safety Precautions</p> <p>Staff working in the blood collection room and laboratory should observe the following precautions:</p> <p>Using gloves when handling blood samples</p> <p>Using disposable needles and syringes for drawing blood</p> <p>Practising routine hand-washing before and after any contact with blood samples</p> <p>Disposing of sharp instruments safely as per procedure</p>	<p>The ICTC Operational Guidelines require the following precautions in the blood collection room and the laboratory – 2 places where a Health Care Personnel may be exposed to HIV-infected blood: gloves, using disposable syringes, hand-washing and safe disposal of sharps, e.g., discard disposable syringes in a puncture-resistant container after disinfection with bleach solution.</p>

<p>Universal Safety Precautions</p> <p>Disinfection and sterilisation</p> <p>Kits for safe delivery of HIV-positive pregnant female patients</p> <p>Waste management</p>	<p>The ICTC Operational Guidelines also give some information about disinfection and sterilisation of instruments, and of waste management. Each ICTC should also receive a supply of kits for safe delivery of HIV-positive pregnant women.</p>
<p>This slide contains an image of the Stock Register which is maintained by the testing personnel</p> <p>See Page 149</p>	<p>Records of the supplies for Universal Safety Precautions such as gloves and pregnancy kits should also be maintained in the Stock register by the testing personnel.</p>
<p>Post Exposure Prophylaxis</p> <p>Comprehensive medical management to minimise the risk of infection among HCP following potential exposure to blood-borne pathogens (HIV, HBV, HCV).</p> <p>Includes counselling, risk assessment, relevant laboratory investigations, first aid and provision of antiretroviral drugs.</p>	<p>Sometimes despite the best of efforts, health care personnel get exposed to infection in the course of their duty. While there is no vaccine against AIDS, there is a possibility of reducing the likelihood of being infected after exposure. This is called Post-Exposure Prophylaxis. Basically it consists of taking anti-retroviral drugs in a specific combination within 2 hours of exposure. The upper limit is 72 hours.</p>
<p>NACO Policy on Post Exposure Prophylaxis</p> <p>Step 1: First aid in management of exposure</p> <p>For skin</p> <p>For the eye</p> <p>For the mouth</p> <p>Step 2: Establish eligibility for PEP</p> <p>First PEP dose within 72 hours</p> <p>Assessing risk of transmission</p> <p>Assess exposed individual</p> <p>Laboratory follow-up</p>	<p>These are the steps in the NACO Policy on PEP. It includes first aid, counselling and laboratory investigations. It is important to note who is in charge of Post-Exposure Prophylaxis in your centre. Do you know who it is? If you do, please note their name in your list of Common Contacts in your handbook. If you do not know, you should find out. You can also display this information on your ICTC noticeboard so that it is easy to locate.</p>

<p>NACO Policy on Post Exposure Prophylaxis (contd..)</p> <p>Step 3: Counselling for PEP</p> <p>Psychological support</p> <p>Document exposure</p> <p>Step 4: Prescribe PEP</p> <p>Step 5: HIV chemoprophylaxis</p> <p>Step 6: Follow-up of an exposed person</p> <p>Clinical follow-up</p>	
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Name of Test/Drug/Consumable* : _____

[illegible]

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



Day 2

The Tree and the Branches

The Tree and the Branches

Session Overview

- ✓ Story-time (5 minutes)
- ✓ Large group discussion (15 minutes)

Session Objectives

- ✓ To highlight how a team is incomplete without its individual members.

Time Allowed

20 minutes

Materials

- ✓ Story of “The Trees and the Branches”

Method

Story-time

- 1) You, as the trainer, will ask the participants to listen silently, and without comment as the story is read out.
- 2) You can read the story to the trainees yourself, or you could ask another individual with a natural aptitude for dramatisation to read it out. Another option would be for the team of trainers to speak as the different voices.

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Large Group Discussion

- 3) Pause for a minute to allow the story to sink in.
- 4) Ask the trainees the following questions and allow a few of them to give the answers.
 - a. What is relation between the branches and the entire tree?
 - b. Why were the branches in the story feeling so sad and angry?
 - c. Can the branches live independently?
 - d. When the tree says, WE are the tree, what could s/he mean?
 - e. Applying this to the ICTC setting, do we sometimes complain about our contribution and pain in comparison to others? Give examples.

Possible answers:

- When ICTC members grumble that other units have better or newer equipment.
 - When one team member feels another team member has a more comfortable job/ workspace.
- f. In the ICTC setting, who would be the people who pluck the flowers and go away?

Possible answers:

- It might represent patients who come and go when they are referred in and out.

- It might represent staff who join for a while and then leave because they get other opportunities.
- g. In the ICTC setting, do we sometimes complain about orchids robbing us of our sap (our inner strength)? Who might the orchids represent? How do we manage these orchids draining our inner resources?

Possible answers:

- These could be patients because they rely on us.
 - These could be other team members who do not always pull their strength.
 - It is inevitable that we should feel some level of burnout from our work with HIV/AIDS. But it is important to develop a sense of perspective about our contributions to the larger cause of HIV/AIDS, to develop alternative pleasurable activities that keep us refreshed and energized, to take planned vacations to recharge our strength.
- h. “WE are the tree.” What could this mean in the ICTC set up?

Note to the Trainer:

This session works best when energy levels of the group are low such as at the end of a busy day. The points emerging from the discussion can be carried away by the trainees to be reflected on in their personal time.



The Tree and the Branches

There was a magnificent tree. It was sturdy, graceful and shady. Its branches loaded with fruits, leaves and freshness were gently swinging in the cool early morning breeze.

On one unhappy day, the branches began complaining to the tree. One of them said: I am not prepared to remain forever a mere branch! I want to be a tree like you with roots and trunk! I want to stand on my own feet and be independent!”

The tree replied: “You are part of the tree as all other branches. You and your lovely leaves give us vibrant beauty and life. All of us make the tree!”

Another branch complained: “Why should I have so many leaves and hardly any fruits? I want to have as many fruits as the branch next to me! It’s not fair that I should be treated differently.”

Very gently the tree said: “What does it matter if leaves and fruits are not evenly distributed among the branches? All that belongs to all belongs to each! Were it not for your leaves there wouldn’t so many fruits on the other branches! Don’t forget “We all are one single tree!”

Still another branch rejoined: “I am fed up of having so many flowers! Insects come to me for nectar and pollen and give me no peace. People passing by injure me to take my flowers away! It’s not fair. Why should I suffer more than the other branches?”

The tree responded: “My dear, beauty goes with suffering. You are the most beautiful branch. Suffering is the price. Your flowers are our flowers. Your sufferings are ours, as our leaves and fruits are yours too! Remember we all make one tree!”

At last, some other branch complained: “Why should these orchids grow on me? Why do they rob me of my sap (inner liquid) and drain my strength? Why should I only of all the branches bear this pain and loss? I do not want to belong to the tree!”

With great patience and kindness the tree remarked: “The precious orchids cannot live without us! They need our support and service. They give to our tree an incomparable beauty and teach us, all the branches can show compassion and love to our brothers and sisters in need! It’s WE, not YOU, not HE or SHE alone and not I. It’s WE all together. WE ARE THE TREE!”

(Reproduced from Ribes, P. (1990). *Parables and fables for modern man*. Bombay, India: St. Paul’s Publications)

Day 3

Prevention of Parent to Child Transmission of HIV



Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Counselling personnel doing PPTCT work.**

Prevention of Parent to Child Transmission of HIV

Session Overview

- ✓ Starter Quiz (10 minutes)
- ✓ Lecture on PPTCT using slides (45 minutes)
- ✓ Exercise based on service needs of pregnant women (1 hour 30 minutes)
- ✓ Lecture on documentation related to PPTCT using slides (20 minutes)

Session Objectives

- ✓ To describe how the PPTCT programme works to reduce HIV prevalence.
- ✓ To discuss the key elements of the PPTCT strategy.
- ✓ To explore the benefits of integrating the PPTCT programme and routine MCH services.
- ✓ To explain the documentation related to the PPTCT programme.

Time Allowed

2 hours 45 minutes

Materials

- ✓ Slides related to the session
- ✓ PPTCT Case Profiles



Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Counselling personnel doing PPTCT work.**

Method

Starter Quiz

- 1) You, as the trainer, will begin this session with a starter quiz using the slides: "This session focuses on the PPTCT programme. But before we review our knowledge, let's see how much we actually know through a short quiz." Flash the slides related to the quiz slowly, and allow trainees to call out answers. Provide the correct answer after they have had a chance to guess.

Lecture using slides

- 2) Next, continue the session using the slides about PPTCT.

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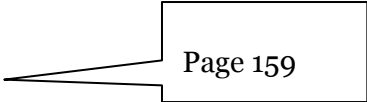
Exercise

- 3) Divide the trainees into small groups of 5 members each.
- 4) Ask the trainees to turn to their handbooks where the PPTCT case profiles are located and introduce the exercise as follows: "Please turn to the PPTCT case profiles in your handbooks. In your small groups, please take 15 minutes to discuss all the cases using the following questions:
 - a. What are the testing needs of the female client?
 - b. What issues should counselling cover on the first visit?

Page 174 in Trainer's Guide; Page 132 in Handbook

- c. What issues should counselling cover on the second visit?
 - d. Are there community organizations or support services where you could refer the client?
- 5) After 15 minutes, gather the small groups together and have each group share their discussion. Make sure that each group has a chance to report their discussion on at least one question. Keep the discussion moving briskly, and refer to points covered on the slide such as the need to conduct a complete ANC check including checking for STIs, the need to involve the partner of the woman and the specific HIV testing regimen for the new-born child.

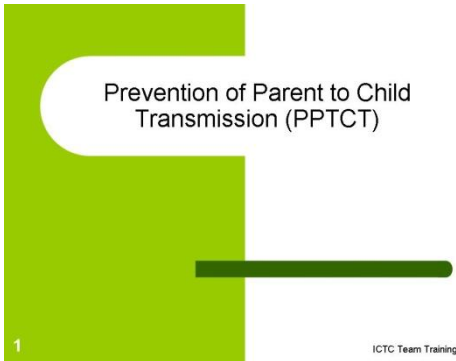
Lecture using slides



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- 6) After the exercise, end the session with the slides to explain the various registers and reports that have to be maintained at the ICTC.

Slides

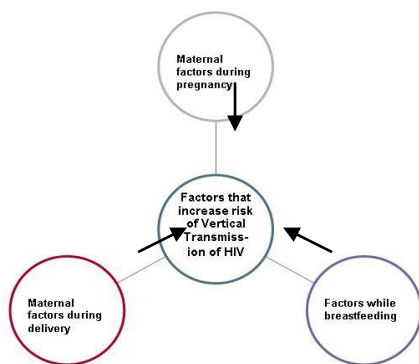
SLIDES	COMMENTARY
	Title Slide
<p>Exclusive breastfeeding is defined by WHO as giving an infant only breastmilk. The ONLY other things also allowed are</p> <ul style="list-style-type: none"> • Chocolates • Drops or syrups containing vitamins, mineral supplements, or medicines • Masoor Dal water • Baby Milk Powder available in tins in the market 	Answer: Drops or syrups containing vitamins, mineral supplements, or medicines
<p>When the mother chooses replacement feeds (instead of breastfeeding), all these are good reasons to choose cup feeding over bottle feeding EXCEPT for</p> <ul style="list-style-type: none"> • Cups are safer because they are easier to clean with soap and water than bottles. • Cups are less likely than bottles to be carried around for a long time, giving bacteria a chance to increase. • Cups come in different designs and colours which can be used to stimulate mental growth in the child. • Cup feeding requires the person feeding the child to hold the child and this increases physical and social contact. 	Answer: Cups come in different designs and colours which can be used to stimulate mental growth in the child.

<p>All the following are reasons why a woman infected with HIV/AIDS may choose to breastfeed her newborn child instead of giving a breastmilk substitute. The ONLY EXCEPTION is</p> <ul style="list-style-type: none"> • To reduce her expenses because replacement feeding is expensive. • To avoid accidentally disclosing her HIV status to others. • To avoid stigma. • To delay accepting her HIV status • To bond with her child physically and socially. • To improve her child's future job prospects. 	<p>Answer: To improve her child's future job prospects.</p>
<p>Name the two tests that can detect HIV infection in an infant:</p> <ul style="list-style-type: none"> • An HIV antibody test (ELISA or a rapid test) conducted at 3 months after birth • An HIV antibody test (ELISA or a rapid test) conducted at 18 months after birth • An HIV antigen test like the PCR test 6 weeks after birth • A urine test 	<p>Answer: An HIV antibody test (ELISA or a rapid test) conducted at 18 months after birth. An HIV antigen test like the PCR test 6 weeks after birth</p>
<p>Maternal factors that may increase the risk of HIV transmission during pregnancy include all of the following EXCEPT</p> <ul style="list-style-type: none"> • New HIV infection during pregnancy • Starting a new job during pregnancy • Advanced HIV disease or AIDS in the mother • High maternal viral load • Viral, bacterial, and parasitic infection of the placenta (especially malaria) • Maternal malnutrition (indirect cause) • STIs 	<p>Answer: Starting a new job during pregnancy</p>

If 100 HIV-positive women give birth to 100 infants, then in the absence of interventions:

- 5 – 10 of the infants will be infected during pregnancy
- 10 - 20 will be infected during labour and delivery
- 20 – 30 will be infected during breastfeeding
- The total number of children thus infected will be 25 to 40.

The total number of children infected through the parental route without any type of intervention is 25 to 40. The PPTCT programme aims to reduce this number.



Here are some of the factors that increase the risk of HIV transmission. They include viral, maternal, obstetrical, foetal and infant-related factors. The most important risk factor is the viral load in the mother's system (the amount of virus). The risk is greatest when the viral load is high, and this occurs just after infection has occurred, and also when the HIV disease is at an advanced stage.

Next three slides spell out the factors in each circle

Factors that increase HIV transmission from the parent to the child

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

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

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

New HIV infection

Advanced HIV disease or AIDS in the mother

High maternal viral load

Prolonged rupture of membranes (more than 4 hours)

Acute chorioamnionitis (infection of the membranes surrounding the baby – the chorion and the amniotic sac)

Invasive child birth procedures that increase contact with mother's infected blood (e.g., episiotomy, foetal scalp monitoring).

First infant in multiple birth

Factors that may increase the risk of HIV transmission during breastfeeding

New HIV infection

Advanced HIV disease or AIDS in the mother

High maternal viral load

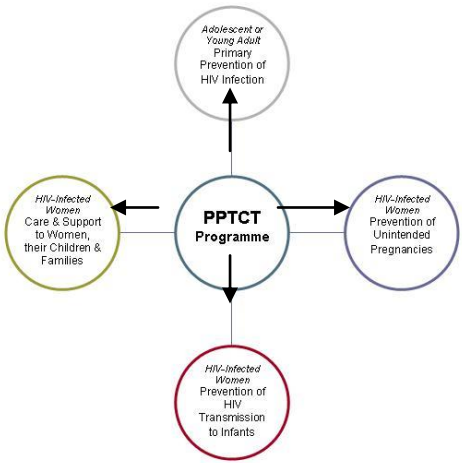
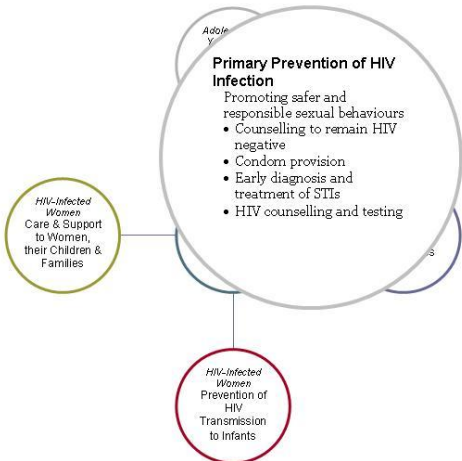
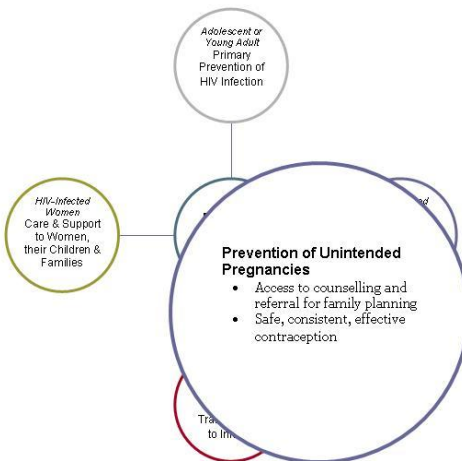
Duration of breastfeeding

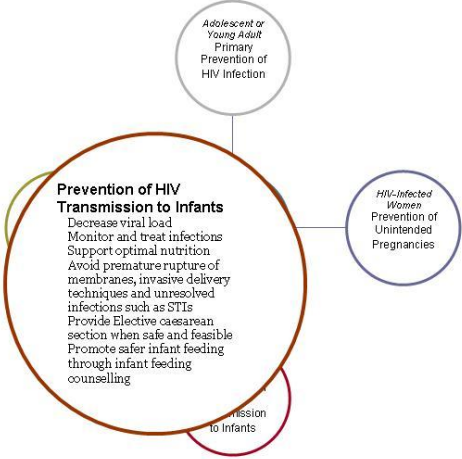
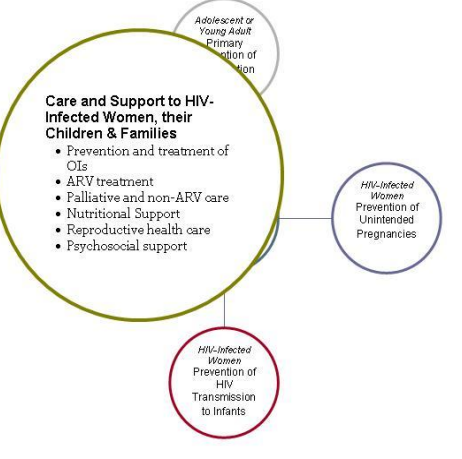
Mixed feeding (breast milk along with replacement feeding i.e. other foods and fluids)

Breast abscesses, nipple fissures (cracked nipples), and mastitis (infection and painful inflammation of the breast tissue)

Malnutrition in the mother

Oral disease in the infant such as candidiasis (thrush) and mouth sores

 <p>The diagram illustrates the PPTCT Programme as a central hub with four main components, each represented by a colored circle connected to a central blue circle labeled 'PPTCT Programme':</p> <ul style="list-style-type: none"> Adolescent or Young Adult Primary Prevention of HIV Infection (Top, light blue circle) HIV-Infected Women Care & Support to Women, their Children & Families (Left, green circle) HIV-Infected Women Prevention of Unintended Pregnancies (Right, purple circle) HIV-Infected Women Prevention of HIV Transmission to Infants (Bottom, red circle) 	<p>NACO mentions that annually, out of an estimated 27 million pregnancies in India, 65,000 occur in HIV + mothers leading to an estimated cohort of 19,500 infected babies. Though India's Prevention of Parent to Child Transmission (PPTCT) strategy using Nevirapine was initiated in 2002, by 2009 approx 17.2% of all pregnant women had received HIV counselling and testing and approx 17 % of all HIV positive of pregnant women received antiretroviral prophylaxis. Thus there is still a huge unmet need and we need to push hard to increase people's access to these services.</p> <p>This slide shows the 4 main prongs of the PPTCT Strategy.</p>
 <p>This diagram focuses on the 'Primary Prevention of HIV Infection' component. It shows a large central circle for this component, with the other three components (Care & Support, Unintended Pregnancies, and Transmission to Infants) shown as smaller circles connected to it. The central circle lists the following strategies:</p> <ul style="list-style-type: none"> Promoting safer and responsible sexual behaviours Counselling to remain HIV negative Condom provision Early diagnosis and treatment of STIs HIV counselling and testing 	<p>HIV infection cannot be passed on to children if their parents are not infected with HIV. So this first prong of PPTCT strategy consists of promoting safer and responsible sexual behaviours in adults. It includes, where appropriate, delaying the onset of sexual activity, practising sexual abstinence, reducing the number of sexual partners and using condoms. The strategies here include condom provision, early diagnosis and treatment of STIs, HIV counselling and testing, and suitable counselling to remain HIV negative for those who are as yet uninfected.</p>
 <p>This diagram focuses on the 'Prevention of Unintended Pregnancies' component. It shows a large central circle for this component, with the other three components (Primary Prevention, Care & Support, and Transmission to Infants) shown as smaller circles connected to it. The central circle lists the following strategies:</p> <ul style="list-style-type: none"> Access to counselling and referral for family planning Safe, consistent, effective contraception 	<p>Prevention of unintended pregnancies is the second prong of the PPTCT strategy. At the ICTC, post-test counselling should cover this information if the client is in a position to absorb it. Inform sero-positive clients that they are capable of transmitting HIV to others including to spouses and, in the case of women, any future children they might bear. Then they should be informed that a counselling personnel can help them to reduce the risk of transmission, and invite them to come back for more information when they are ready. With appropriate support, women who are aware of being sero-positive can plan when to get pregnant, and therefore reduce the possibility of passing on the virus to their future children. The strategies here include high-quality reproductive health counselling and providing effective family planning measures such as effective contraception.</p>

 <p>Prevention of HIV Transmission to Infants Decrease viral load Monitor and treat infections Support optimal nutrition Avoid premature rupture of membranes, invasive delivery techniques and unresolved infections such as STIs Provide Elective caesarean section when safe and feasible Promote safer infant feeding through infant feeding counselling</p> <p>Adolescent or Young Adult Primary Prevention of HIV Infection</p> <p>HIV-Infected Women Prevention of Unintended Pregnancies</p> <p>HIV-Infected Women Prevention of HIV Transmission to Infants</p>	<p>The third prong of PPTCT strategy consists of specific interventions to reduce transmission from a woman living with HIV to her child. This includes HIV counselling and testing, ARV prophylaxis and treatment, safe delivery practices, and safer infant feeding practices.</p>
 <p>Care and Support to HIV-Infected Women, their Children & Families</p> <ul style="list-style-type: none"> • Prevention and treatment of OIs • ARV treatment • Palliative and non-ARV care • Nutritional Support • Reproductive health care • Psychosocial support <p>Adolescent or Young Adult Primary Prevention of HIV Infection</p> <p>HIV-Infected Women Prevention of Unintended Pregnancies</p> <p>HIV-Infected Women Prevention of HIV Transmission to Infants</p>	<p>The service elements of the fourth prong of PPTCT strategy includes prevention and treatment of OIs in women and children living with HIV, ARV treatment, palliative (pain-reducing) and non-ARV care, nutritional support, reproductive health care and psychosocial support.</p>
<p>PPTCT as a Case of Provider-Initiated Testing</p> <p>ICTC provides opportunity to interact with pregnant patients.</p> <p>ICTC team to actively generate referrals from private and public maternity services</p> <p>Educate women about how knowing their HIV status can help</p> <p>Encourage women tested positive to bring their partners for testing and services</p>	<p>At the ICTC, provider can interact with pregnant women and educate them about the advantages of knowing their status. So they must actively generate referrals and build linkages with private and public maternity services. They must explain to these service providers as well the advantages of testing pregnant women. Women must also be counselled about the advantages of knowing their sero-status. If women is tested HIV positive, she should be encouraged to bring her partner for testing and follow-up. If she has come with the partner, explain about the advantages of the test, what should be done to prevent transmission to child and also why it is important he should be tested.</p> <p>However, as always patients referred for testing and counselling have the right to refuse testing, that is they</p>

	<p>can opt out. Service providers should respect this right to opt out. For female clients who refuse to be tested HCP must follow the protocol used for delivering HIV-positive women.</p>
<p>Advantages of PPTCT</p> <p>Mother</p> <p>Decreased chance of HIV transmission to her child</p> <p>Post partum care</p> <p>Infant feeding support</p> <p>Child</p> <p>Decreased chance of being infected with HIV</p> <p>Proper nutritional guidance – breastfeeding vs replacement feeding</p> <p>Prevention & treatment of OI</p> <p>Proper immunization</p> <p>Cotrimoxazole prophylaxis</p> <p>ART when required</p>	<p>These are some of the advantages of the PPTCT programme to mother and child. It basically links them to a range of services.</p>
<p>Routine Antenatal Care</p> <p>Client history</p> <p>Physical exam and vital signs</p> <p>Abdominal exam</p> <p>Lab Tests such as haemoglobin estimation, urine examination</p> <p>Tetanus toxoid immunization</p> <p>Nutritional assessment and counselling</p> <p>STI screening</p> <p>Anti-malarials</p> <p>Counselling on infant feeding</p> <p>Counselling on pregnancy and danger signs</p> <p>Iron-Folic Acid supplementation</p> <p>Effective contraception plan</p>	<p>This is the package of routine antenatal care services. It is a very comprehensive package. In this training programme, we will not discuss all of them in detail. But it is important for ICTC team members to be familiar with them. So we urge you to read your training materials, as well as to look at other NACO materials on PPTCT.</p>

Additional Antenatal care for HIV-infected women HIV-testing Preventing Opportunistic Infection Assessment and Management of HIV-related illnesses Recurrent or Chronic Infection Treatment of STIs Psychosocial and Community Support	<p>Within the essential package of services, there are some aspects that are critical to HIV-infected women.</p>
Antenatal care of HIV-infected women <i>HIV-testing</i> <i>Preventing Opportunistic Infection</i> Assessment and Management of HIV-related illnesses Recurrent or Chronic Infection Treatment of STIs Psychosocial and Community Support	<p>HIV Testing: Determining the woman's sero-status is the first step. Rapid testing makes it possible for her to receive her test results that very day.</p> <p>Preventing Opportunistic Infection: By preventing opportunistic infections like TB, HCP can reduce the rates of illness and death among HIV-infected pregnant women. This can also reduce the risk of adverse pregnancy outcomes such as pre-term labour and childbirth which can increase the chances of transmission of HIV to the infant.</p>
Antenatal care of HIV-infected women HIV-testing Preventing Opportunistic Infection <i>Assessment and Management of HIV-related illnesses</i> <i>Recurrent or Chronic Infection</i> Treatment of STIs Psychosocial and Community Support	<p>Assessment and Management of HIV-related illnesses: Pregnant women who are HIV-positive should be monitored for signs and symptoms of HIV-related illnesses. These can increase the risk of transmission. Where necessary, antiretroviral treatment should be started after the necessary investigations.</p> <p>Recurrent or Chronic Infection: HIV-infected women are susceptible to other infections that also need attention such as STIs, especially syphilis, Urinary tract infections, Respiratory infections, Recurrent diarrhoea, Recurrent vaginal candidiasis</p>
Antenatal care of HIV-infected women HIV-testing Preventing Opportunistic Infection Assessment and Management of HIV-related illnesses Recurrent or Chronic Infection <i>Treatment of STIs</i> <i>Psychosocial and Community Support</i>	<p>Treatment of STIs during pregnancy may reduce the risk of transmitting infection to the infant. Routine syphilis testing of pregnant women is an essential component of good antenatal care. Early diagnosis and treatment of STIs during pregnancy is also important because it may reduce the risk of transmitting infection to the infant. It may be necessary before, during or after pregnancy. Further, at each antenatal visit, it is important to directly ask the pregnant woman about any symptoms that might indicate STIs, such as lower</p>

	<p>abdominal pain, abnormal vaginal discharge or ulcers in the vaginal area. Where feasible, the clinical services should include a genital examination and appropriate laboratory investigations at the first antenatal visit, and at any time she reports an STI complaint. Where laboratory tests are not possible, a syndromic diagnosis should be conducted.</p> <p>Psychosocial and Community Support: Pregnancy is marked with unique stressors. HCP should be sensitive to their concerns and should assess the support they may expect from family and other people in their circle. They should link them up with available resources from where they may derive additional support.</p>
<p>Partner involvement in PPTCT</p> <p>Counselling should include, where possible, the male partner of the pregnant woman in order to acknowledge his role in protecting the child.</p>	<p>Both partners should be made aware of the need to practise safe sex throughout the nine months of the pregnancy, and the period of breastfeeding.</p> <p>Both partners should be tested and counselled about HIV</p> <p>Both partners should be counselling about the services available to them through the PPTCT programme.</p> <p>Further, it is important to encourage male involvement even when they are unaccompanied by the spouses. Where men are coming for testing to ICTC, counselling personnel should probe whether they are married, and if their wives or female partners are pregnant and educate them about PPTCT.</p>
<p>ARV Treatment and Prophylaxis</p> <p>ARV prophylaxis: drugs to prevent primary infection in the infant</p> <p>ARV treatment: drugs to limit the effect of HIV in the woman.</p> <p>Prophylaxis does not provide long-term protection for the infant.</p>	<p>ARV prophylaxis consists of drugs to prevent primary infection in the infant while ARV treatment consists of drugs to limit the effect of HIV in the woman. ARV prophylaxis does not provide long-term protection for the infant. While a pregnant woman diagnosed with HIV who is eligible for ARVs should begin ARV treatment as early as possible, treatment should not begin until after the first trimester. The reason for this is that the foetus is susceptible to the iatrogenic effects of drugs during the first 10 weeks of gestation. However, when the woman is severely ill, the benefits of early treatment outweigh any potential risks to the foetus.</p>

<p>Current NACO recommended regimen for prophylaxis</p> <p>200 mg oral tablet of Nevirapine (NVP) given to the mother at the beginning of labour.</p> <p>Newborn babies should receive 2 mg/ kg NVP in suspension within 72 hours of birth.</p>	<p>Deciding which prophylactic regimen to support at the national level is based on feasibility, efficacy, acceptability, and cost. NACO supports a regimen consisting of a single dose of nevirapine to the pregnant woman at the onset of labour, and a single dose to the infant soon after birth.</p>
<p>Management of Labour & Delivery of Women Infected with HIV</p> <p>ARV Prophylaxis</p> <p>Universal Precautions</p> <p>Minimising Cervical Examinations</p> <p>Avoiding Prolonged Labour</p> <p>Avoiding Prolonged Membrane Rupture and Routine Artificial Rupture of Membranes</p> <p>Avoiding Unnecessary Trauma during Childbirth</p> <p>Minimising the Risk of Postpartum Haemorrhage</p> <p>Safe Transfusions</p>	<p>Out of every 100 babies born to HIV-positive women, 10 to 20 will be infected during labour and delivery. This number can be reduced by limiting foetal exposure to maternal blood and body fluids. To this end, the HCP should minimise cervical examinations, avoid prolonged labour, avoid prolonged membrane rupture, avoid unnecessary trauma during childbirth, and minimise the risk of postpartum haemorrhage. These guidelines also apply to women whose HIV status is unknown such as those who come too late for an HIV test to be conducted, or who opt out from HIV counselling. ICTCs are provided with kits for managing a safe delivery in women with a positive sero-status and those with an unknown status. These kits contain plastic disposable gowns, disposable goggles to protect the eyes, face masks, disposable shoe covers, and two pairs of long gloves.</p>
<p>Infant Feeding: Breast feeding</p> <p>Exclusive breast feeding of the newborn should be advised to all HIV positive mothers for first six months of life unless replacement feeding is Acceptable, Feasible, Affordable, Sustainable, and Safe (AFASS).</p> <p>If the woman opts to exclusively breast feed the baby, it should be stopped at 6 months (early cessation) followed by adequate and timely weaning.</p>	<p>Infant Feeding Choices</p> <p>Counselling for HIV-infected mothers during pregnancy should cover infant-feeding choices to enable them to make an informed decision. After delivery, they should be counselled again.</p> <p>Exclusive breast feeding of the newborn should be advised to all HIV positive mothers for first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable, and safe (“ AFASS”).. If the woman opts to exclusively breast feed the baby, it should be stopped at 6 months (early cessation) followed by adequate and timely weaning.</p>

Infant Feeding: Breast feeding

Breast Milk could transmit HIV infection if mother is infected

Can lower this transmission rate through measures such as ART for mothers, treating breast infections in mother, oral infections in child

Counsel mother to breastfeed exclusively for 6 months and then rapidly wean child within 2 weeks.

There is a possibility of breastmilk being the means for passing on HIV from mother to child. However the possibility of transmission of HIV through breastmilk is lowered if

The mother is healthy.

The mother is on ART, if eligible.

The baby ONLY gets breastmilk for as long as possible.

Breast infections are prevented and treated right away.

Thrush (white spots, yeast) in the baby's mouth is treated right away.

Counselling for infant-feeding provides support to women to select the choice that suits their circumstances. Mothers who decide to breast feed should be alerted that they should not give the infant any other liquids or foods. They should be educated that breastmilk contains all the nutrients needed by the child. Other liquids and foods cause inflammation of the intestines of the child and increase the risk of HIV transmission. The protection conferred by breast milk is reduced when the infant is given water or any other substance during exclusive breast-feeding.

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

Infant feeding: Formula feeding

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

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

Source: WHO, 2006

The terms “ AFASS” are explained below:

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

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

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

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

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

Early Infant Diagnosis

HIV infection follows a more aggressive course among infants and children.

Early HIV diagnosis and treatment for children slows the progress of HIV.

It is mandatory to establish a definite diagnosis at 18 months by HIV antibody.

See table below

HIV infection follows a more aggressive course among infants and children. Once infected, the child faces a high chance of illness and death, unless given timely medical treatment. Early Infant Diagnosis slows the progress of HIV infection. HIV testing of new born babies is not a one-step procedure because they carry antibodies from their mother. In the case of an infant born to an HIV-positive woman, the rapid tests used at the ICTC are not specific enough to differentiate between the mother's and the child's own antibodies. Maternal antibodies take about 18 months to clear from the child's system.

In order to establish if the infant has acquired HIV infection, the DNA of the virus has to be detected in the infant's blood through the PCR test using 2 sample collection methods: Dried Blood Spot (DBS) and Whole Blood (WB). The testing is done according to the age of the child

Some points to note:

The second or third test is applicable only if the child is found positive at the first test,

A child who tests positive on DBS should be confirmed with the DNA PCR WB test.

The WB sample will be collected only in ART centres.

A minimum time period of one month is needed from the date of sample collection for the DNA PCR test results.

It is mandatory to establish a definite diagnosis at 18 months by HIV antibody.

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

Exposed Baby Care

All born to HIV+ woman until established not +VE

Regular growth monitoring and clinical

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

assessment can lead to early detection of HIV infection	disease related morbidity. Regular growth monitoring and clinical assessment can lead to early detection of HIV infection.												
<table border="1"> <tr> <th colspan="2">Cotrimoxazole prophylaxis</th></tr> <tr> <th>Weight (kg)</th><th>Child dispersible tablet (20mg TMP/100mg SMX) Once daily</th></tr> <tr> <td>< 5</td><td>1 tablet</td></tr> <tr> <td>5 – 10</td><td>2 tablets</td></tr> <tr> <td>10 – 15</td><td>3 tablets</td></tr> <tr> <td>15 – 22</td><td>4 tablets</td></tr> </table>	Cotrimoxazole prophylaxis		Weight (kg)	Child dispersible tablet (20mg TMP/100mg SMX) Once daily	< 5	1 tablet	5 – 10	2 tablets	10 – 15	3 tablets	15 – 22	4 tablets	<p>Cotrimoxazole should be given from 6 weeks of life onwards according to the weight of the infant.</p> <p>The tablet can be dispersed in expressed breast milk on a clean table spoon and fed to the infant once a day if the child is still breastfeeding. If the child is not being breastfed, 1-2 table spoons of boiled water is used instead of the breast milk. The mother or caregiver should receive enough cotrimoxazole to last till the next scheduled visit.</p> <p>Cotrimoxazole should be given till the HIV infection has been excluded.</p>
Cotrimoxazole prophylaxis													
Weight (kg)	Child dispersible tablet (20mg TMP/100mg SMX) Once daily												
< 5	1 tablet												
5 – 10	2 tablets												
10 – 15	3 tablets												
15 – 22	4 tablets												
<p>WHO Immunisation Recommendations</p> <table> <tr> <th>Age of infant</th><th>Vaccine</th></tr> <tr> <td>Birth</td><td>BCG, OPV-0</td></tr> <tr> <td>6 weeks</td><td>DPT-1, OPV-1</td></tr> <tr> <td>10 weeks</td><td>DPT-2, OPV-2</td></tr> <tr> <td>14 weeks</td><td>DPT-3, OPV-3</td></tr> <tr> <td>9 months</td><td>Measles</td></tr> </table>	Age of infant	Vaccine	Birth	BCG, OPV-0	6 weeks	DPT-1, OPV-1	10 weeks	DPT-2, OPV-2	14 weeks	DPT-3, OPV-3	9 months	Measles	<p>Other childhood illnesses can be avoided through vaccines and good nutrition. Most routine vaccines are safe for children living with HIV and are strongly recommended along with Vitamin A supplementation. Iron folic supplementation should be given to anaemic children. Immunisation Recommendations from WHO: All HIV-exposed children should be fully immunized according to their age. Because most HIV-infected children do not have severe immune suppression during the first year of life, immunization should occur as early as possible after the recommended age to optimize the immune response.</p>
Age of infant	Vaccine												
Birth	BCG, OPV-0												
6 weeks	DPT-1, OPV-1												
10 weeks	DPT-2, OPV-2												
14 weeks	DPT-3, OPV-3												
9 months	Measles												
<p>EXERCISE</p> <p>What are the testing needs of the female client?</p> <p>What should counselling cover on the first visit?</p> <p>What should counselling cover on the second visit?</p> <p>Are there community organizations or support services where you could refer the client?</p>													

<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>These are the forms that are to be maintained for pregnant women. This is the ICTC register for ANC clients. The purpose of this register is to collect in a single record all information related to an ANC client. It is separate from the general register. Each client is registered as per a number called Patient Identification Digit (PID) which is unique for the ICTC and has a flag indicating an ANC case. This is a unique number assigned to each individual and helps identify the client and the centre where the client is tested and is mentioned in Column 2. The other columns contain a brief history of the client. In Column 4, the counselling personnel must mention whether the patient came at the time of delivery or whether she received antenatal services.</p>
<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>In Column 11, the counselling personnel mentions during which month of pregnancy, the mother registered at the ICTC.</p>
<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>These columns mention the result of testing the partner's status. As already mentioned, it is important to involve the patient's partner.</p>
<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>Some further details to be mentioned are when the pregnant woman was referred to the ART centre for a CD4 test, and the result of that test. Also, noted are how the pregnancy ended, that is columns 27 and 28.</p>
<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>Columns 29 and 30 require information about the new-born. Columns 32 and 33 contain details of the administration of ARV prophylaxis. Column 34 refers to the infant feeding option selected – whether it is exclusive breast-feeding or any other option. Column 36 refers to the follow-up register. As you may have noted, this register contains very different details from the general register maintained for general clients of the ICTC.</p>

<p>Information to be extracted for the monthly report</p> <p>Total number of women who register at the ANC</p> <p>Antenatal women who receive pre-test counselling/ information</p> <p>Antenatal women who receive post-test counselling</p> <p>The sero-status of the ANC client</p> <p>Details of ANC including parity, Expected Date of Delivery, plan of delivery</p> <p>Counselling and testing of women directly coming in labour</p> <p>Spouse or partners counselled, tested and their HIV status</p> <p>Positive women who delivered and received NVP</p> <p>Unregistered ANC women accessing HIV service</p> <p>Referrals to and from TB and details regarding the same</p> <p>Referrals to other care and support services</p> <p>Stock of NVP, kits and condoms</p>	<p>From this register, the following information is extracted for the monthly report:</p>
<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>The ICTC Post-natal follow-up register is essentially mother-baby follow-up. It derives some details from the register for pregnant women. The infant is assigned a number as well.</p>
<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>In the follow-up register, information about the status of babies with PCR testing and administration of treatment including cotrimoxazole is noted.</p>
<p>The next 9 slides consist of the Registers related to PPTCT services</p> <p>See Page 176 to 183</p>	<p>The counselling including feeding practices for babies are recorded in this register. Finally, if the child was referred to the ART centre, these details are also recorded.</p>

PPTCT Case Profiles

Case Profile 1

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

✂-----

Case Profile 2

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

✂-----

Case Profile 3

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

✂-----

Case Profile 4

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

✂-----

Case Profile 5

Jaywantiben is 27 years old. She has 2 children, one aged 6 years and one aged 1 month. She is HIV-positive. At the time of delivery, she was given nevirapine and the baby was given nevirapine before being discharged on the third day. She has come for a follow-up.

Questions for each case profile

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

Annexure III.c

ICTC Register for Pregnant Women*

ICTC Code:

ICTC Name:

District:

State:

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

* To be filled in for all ANC cases.

Continued...



Annexure III.c

ICTC Register for Pregnant Women (contd.)

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

Continued...



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

Continued...



ICTC Register for Pregnant Women (contd.)

[illegible]



Annexure III.d

ICTC Post-natal Follow-Up*

ICTC Code:

ICTC Name:

District:

State:

[illegible]

* To be maintained only for positive cases.



Continued...



Annexure III.d

ICTC Post-natal Follow-Up (contd.)

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



Day 3

Working as an ICTC Team



Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Medical Officers**.

Working as an ICTC Team

Session Overview

- ✓ Starter exercise (25 minutes)
- ✓ Lecture using slides (25 minutes)
- ✓ Exercise related to Documentation (25 minutes)
- ✓ Team Resolutions (60 minutes)

Session Objectives

- ✓ To discuss what working as a team means.
- ✓ To highlight the role of each team member.
- ✓ To link up the work of the individual ICTC with the activities of NACO, SACS and DAPCU.
- ✓ To explain how daily ICTC documentation relates to monthly reports.



Note to the Trainer:

This session follows immediately after the 'Here's what we do in the ICTC' presentation by the **Medical Officers**.

Time Allowed

2 hours 15 minutes

Materials

- ✓ Lengths of string
- ✓ Slides
- ✓ Exercise Sheet: “In Which Register Would You Find Me?”
- ✓ Poster-size papers (one for each team)
- ✓ 5 sets of coloured markers for paper (black, blue, green and red)

Method

Preparation

- 1) Before the session, you, as the trainer, will prepare pieces of string of about 1 foot length. There should be enough so that each trainee has one piece of string.

Starter Exercise

- 2) Ask the trainees to pair up with someone they got to know during the team training programme.
- 3) Distribute the string to each trainee.
- 4) Explain the exercise as follows: “Each of you has a piece of string. Your task is to tie a bow around the wrist of your partner. But for this exercise you cannot use your thumbs. Please fold your thumbs in and use the other 4 fingers only.”



Note to the Trainer:

This session follows immediately after the ‘Here’s what we do in the ICTC’ presentation by the **Medical Officers**.

- 5) After about 10 minutes, ask the trainees to take their seats in the larger group and discuss their experience using the following questions:
 - a. How many of you succeeded in tying the bows on their partner’s wrist?
 - b. How many were unsuccessful, or would have managed if they had a few minutes more?
 - c. What made the task easy or difficult?
 - d. Applying this to the ICTC, is there a lesson we can learn?

Some possible answers to the Question (c) are,

- “The task was difficult/ impossible because the thumb is so crucial to completing any kind of manual activity.”
- “The task was difficult but the partner was supportive and encouraging.”

Link these answers to how critical is the work of each member of the ICTC team. The counselling personnel cannot deliver a test result and do post-test counselling without the test being performed. The testing personnel has no time to counsel a patient who has come for testing, and so counselling personnel’s role is important.

Lecture using slides

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- 6) Next, continue the session using the slides about Working as an ICTC Team.

Exercise related to Documentation

Page 199 in Trainer’s Guide; Page 134 in Handbook

- 7) After discussing the various forms, keep the last slide projected on the screen and ask the trainees to sit with the other members of their ICTC team.
- 8) When they are seated with their team members, ask them to turn to the sheet titled “In Which Register Would You Find Me?” and ask them to work out as a team which registers would be needed for each client described. Give them 7 minutes for the task.
- 9) Discuss the answers in the larger group. Give different teams a chance to present the different cases. But keep the discussion moving swiftly. Use the Answer key to provide the right answers.

Page 201


Team Resolutions

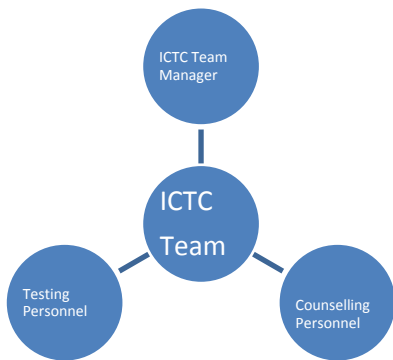
- 10) Finally, tell the trainees the following: “In this training programme, you learned a lot of information. Some of it you already knew. Some of it may have been new. Now it is time to identify as a team what are some of the new things you heard in this training programme, and what you can do about it as a team of people working with People Living with HIV/AIDS.”
- 11) Ask the trainees to return to their ICTC teams and do the following:
 - a. Make a flag representing their ICTC.

- The flag will be drawn using the markers on the poster paper given to each team.
 - The flag could have some symbols depicting what the team is already doing.
 - The flag could also have symbols depicting what the team would like to aspire to.
 - It could have a motto/ slogan written out.
 - The colours could stand for qualities that the team possesses, or wants to possess.
 - This is a chance for the team to be creative.
- b. Identify ONE goal for the next one month, ONE goal for the next three months, and ONE goal for the next six months.
- As mentioned in the slide presentation, each goal should state the time period in which it is to be achieved.
 - It will mention specific tasks or activities to be completed to meet a goal. (e.g., For the goal of improving documentation, the activity will be spending 15 minutes at the end of the day to fill up the stock register or the other records)
 - It will mention who has to do the task.
 - Each team member should be have a chance to aim for at least one goal.
 - A goal could involve actions by more than one team member.
 - A simple format for the goal is as follows: To achieve the goal ... the counselling personnel/ the testing personnel/ the manager will do ... each week/ every 15 days/ in the next one month.
 - If trainees need guidance, ask them what they have not been doing before that they think they need to do. For instance, they might feel the need to build up better referrals with the RNTCP, or they may feel the need to follow up pregnant women in a more systematic manner.

- 12) After 20 minutes, gather the different teams together into the larger group and have each team display their flag and report their team resolutions. After each team has reported their 3 team goals, clap hands to show your appreciation of their resolutions, and encourage other trainees to join you as well.
- 13) After all teams have shared their resolutions, thank them for their participation, and wish them all luck for carrying out these resolutions.

Slides

SLIDES	COMMENTARY
	Title Slide
<p>What is a team</p> <p>A group of people working in an organisation can be called a team “when there is interdependency in how the different team members function, that is the activity or service cannot be undertaken by one individual alone.”</p>	
<p>Why do teams matter</p> <p>As in a game, every team player has a role to play.</p> <p>At the ICTC, no one team member (counselling personnel, testing personnel or ICTC manager) can undertake the testing, counselling and medical advice all by themselves.</p>	<p>If we apply the explanation of team to a cricket team, then we can see that in a team of 11 players, there is a captain who makes on-field decisions, there are players who specialize in batting and those who are good bowlers. When a team is bowling to get their opponents out, only one player can bowl at a time. But the other players support him in their various roles as wicket keeper and fielders. A weakness in any one area of the field means that the team does not work as effectively as they should.</p> <p>At the ICTC, counselling personnel, testing personnel or ICTC manager carry out tasks individually that cannot be performed by others. Each of them has educational qualifications that prepare them for their particular jobs, and have undergone orientation training related to their particular work in the ICTC. No one individual can undertake the testing, counselling and medical advice all by themselves.</p>
<p>Functions of the ICTC</p> <p>Early detection of HIV</p> <p>Provision of basic information on HIV/AIDS for promoting behavioural change & reducing vulnerability</p> <p>Linking people with other HIV prevention, care & treatment services</p>	<p>Just as a sports team aims to win the game, the ICTC team is established to carry out the following functions:</p>

<p>Overall goal of the NACP III is to halt and reverse the epidemic in India over five years:</p> <p>Prevention of new infections in high risk groups and general population.</p> <p>Providing greater care, support and treatment to larger numbers of PLWHA.</p> <p>Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.</p> <p>Strengthening the nationwide Strategic Information Management System.</p>	<p>But as ICTC team members you are also contributing to loftier goals in the NACP III. To use the sports metaphor again, each individual sports team in a country's Olympic contingent has a chance to increase the country's tally of gold, silver and bronze medals. The work of an individual ICTC team runs alongside the work done by other ICTC teams in a district, the work undertaken by ART centres, and the other health programmes such as the RNTCP. The overall medal tally is the number of human lives saved or the number of human lives made healthier through the dedicated work of individual staff at the various health facilities.</p>
	<p>The ICTC team has a Medical Officer who works as the manager, counselling personnel performing counselling, testing personnel who does testing. Some ICTCs have more than one counselling personnel. The exact composition of the ICTC team depends on many factors such as whether the ICTC is situated in a big hospital or a Primary Health centre, whether the district has high HIV prevalence or not.</p>
<p>ICTC Team Manager</p> <p>Administrative</p> <p>Demand Generation</p> <p>Quality Assurance</p> <p>Supply and Logistics</p> <p>Monitoring and supervision</p> <p>Sensitising staff to avoid stigma and discrimination.</p>	<p>The ICTC Manager is like the captain of the team. He/ she is responsible for the overall functioning of the ICTC. For instance, this individual is responsible for hiring staff, liaising with professional bodies such as the local Indian Medical Association (IMA) to increase client referrals, maintaining the attendance register and verifying other ICTC reports before sending them to the SACS or DAPCU.</p>
<p>Counselling Personnel</p> <p>Preventive and health education</p> <p>Psychosocial support</p> <p>Referrals and linkages</p> <p>Supply and logistics</p> <p>Monitoring</p>	<p>The Counselling personnel is described by the Operational Guidelines as the bedrock of the ICTC. Her/ his functions include preventive and health education through flip books, providing psychosocial support to clients, and co-ordinating with the RCH, TB and ART programmes. In some ICTCs, counselling personnel might be a person with a nursing diploma.</p>

<p>Testing Personnel</p> <p>HIV testing</p> <p>Ensuring adequate stock of consumables and testing kits.</p> <p>Maintaining records of HIV test results.</p> <p>Ensuring the maintenance of all equipment.</p> <p>Following internal and external quality assurance procedures.</p> <p>Following universal safety precautions and hospital waste management guidelines.</p>	<p>Testing personnel undertake HIV testing, maintain laboratory equipment, records of HIV test results, rapid HIV testing kits and consumables.</p>
<p>Team Effectiveness</p> <p>Degree to which a team accomplishes its purpose.</p> <p>Includes quality and quantity of services provided.</p> <p>Will depend to some extent on progress of individual team members.</p>	<p>Team effectiveness refers to the degree to which a team accomplishes its purpose. It includes the quality and quantity of services provided. It also includes whether the team is able to remain dynamic and whether it can progress. This will depend to some extent on progress of individual team members.</p>
<p>Conflict resolution</p> <p>Conflict is an inevitable part of human life.</p> <p>Will arise whenever people hold different opinions about how to perform a certain task.</p> <p>At the ICTC, it is important to recognise and encourage desirable conflict while minimizing undesirable team conflict</p> <p>Learn to see a view or opinion dissociated from the person presenting it.</p>	<p>Conflict is an inevitable part of human life. It will arise whenever people hold different opinions about how to perform a certain task. This is natural because different people have different life experiences which they bring to a group situation. It is important to recognise that different people's opinions are all probably right under different situations.</p> <p>In the ICTC, it is relatively easy to judge which opinion is more suitable in a certain situation by asking simple questions: Will this help the ICTC to work better and to serve patients better? Will ICTC clients be healthier or process through the ICTC faster through changing a particular routine?</p> <p>At the ICTC, it is important to recognise and encourage desirable conflict (that is people expressing different opinions which bring out different facets of a problem situation) while minimizing undesirable team conflict (which causes people to be unable to work together effectively).</p> <p>Conflict should be handled by attacking the ideas and not the people voicing those ideas. Differentiate the idea from the person who presents it. Very often we tend to approve ideas presented by a person we like or many sees as an important or clever person, Learning to dissociate idea from person is time consuming effort and should be taken seriously.</p>

<p>Conflict resolution</p> <p>WHAT ARE SOME POSSIBLE AREAS OF CONFLICT IN THE ICTC?</p>	<p>Give some time to the trainees to discuss this question in the larger group. Ask them how they solved such conflicts. One example of undesirable team conflict may arise over whose responsibility it is to write out monthly reports or to establish linkages with outside organizations.</p> <p>Note to trainer: This is not an occasion for problem-solving of any particular ICTC. Rather, it is a time for trainees to understand that conflict is inevitable and should be managed effectively.</p>
<p>Good communication</p> <p>Effective teams cannot manage without good communication</p> <p>Person-to-person communication, enables team members to see each other as human beings with problems</p> <p>Provides a basis to try and see a problem from the other person's perspective.</p>	<p>Teams that are effective cannot manage without good communication such as speaking openly and positively, listening actively and without judgment, matching verbal and non-verbal behaviour, and creating small communication rituals such as greetings and personal small talk. Conflict resolution needs good within-team communication.</p> <p>Person-to-person communication, enables team members to see each other as human beings with individual lives and problems, and provides a basis from which to try and see a problem from the other person's perspective.</p> <p>We have seen this in other sessions.</p>
<p>Goal setting</p> <p>Effective teams agree on goals, work on them and then monitoring team progress towards these goals.</p> <p>Achievable goals include actions and a time limit. The actions are feasible and include mention of who has to do what.</p>	<p>Teams that are effective work by agreeing on goals, working on them and then monitoring team progress towards these goals.</p> <p>Achievable goals include actions and a time limit. The actions are feasible and include mention of who has to do what.</p> <p>In the ICTC, teams can work towards increasing referrals to the centre or on increasing the number of clients tested and counseled. E.g. "Within the next month we will increase our counselling of general public members by (1) having the counselling personnel contact 5 non-governmental organizations, and (2) having the medical officer speak to personnel in the gynaecology department and making a presentation at the local IMA."</p>
<p>Goals should be SMART</p> <p>S Specific – defining what is to be accomplished in terms of specific steps to behavioural change</p> <p>M Measurable – quantifying the objectives by indicating a numerical or percentage change expected</p> <p>A Appropriate – defining intended changes that are acceptable in the local context</p> <p>R Realistic – Avoiding objectives that are beyond the scope of available resources or contrary to relevant experience</p> <p>T Time-bound – identifying the time frame in which changes should be achieved</p>	<p>Goals should be SMART that is Specific, Measurable, Appropriate , Realistic , Time-bound</p>

<p>Planning and task co-ordination</p> <p>Team members perform different sub-tasks.</p> <p>This calls for co-ordination between team members.</p>	<p>Team members perform different sub-tasks that contribute to the larger task. This calls for co-ordination between team members, spelling out of task and role expectations of individual team members (mutual role understanding) and ensuring proper balance of workloads in the team. For instance, there is a provision for 2 counselling personnels in ICTCs where there is an extremely high workload. Here, the tasks must be evenly divided between the two counselling personnel. The ICTC Operational Guidelines also speak of monthly meetings of staff of each ICTC. These are a chance for the ICTC staff to keep each other informed of important matters, and to make decisions. Throughout this training programme, you had a chance to hear from others what kind of work they do, the challenges they face. We hope these presentations gave you an understanding of their work so that you can carry out your own tasks more effectively</p>
<p>Supervision</p> <p>ICTC Manager</p> <p>OR</p> <p>District ICTC Supervisor</p>	<p>The ICTC Manager is responsible for ensuring that staff are properly and regularly trained. He/ she maintains the attendance register and makes sure that staff salaries are paid on time. The Manager is also in charge of ensuring the quality of counselling and testing at the ICTC. He/ she signs the counselling and testing report after verifying the records, and ensures that this report is sent to the SACS by the 3rd of the month. While counselling and testing personnel, fill up the registers, the manager has to check these records for completeness and accuracy. For instance, he/ she must check that the PID is used consistently in all records. He/she must check that addresses are correctly and completely noted (not just the name of the village or town). He/ she performs a supervisory role through monthly meetings at the ICTC and through frequent visits to the ICTC.</p> <p>In districts with high prevalence, some of these functions are undertaken by the District ICTC Supervisor.</p>
<p>Documentation</p> <p>To study the increase or decrease in numbers of people visiting the ICTC</p> <p>To keep track of people who visit the ICTC and provide follow-up where appropriate</p> <p>To understand the change in profile of people visiting the ICTC (increasing number of children, increasing number of MSM) and to prepare for the issues related to these changes</p> <p>To identify groups or communities who are not yet reached (or underserved) if available research shows there is a high prevalence in particular communities but community members are not accessing the testing and counselling</p> <p>To make a case for more staff/ more</p>	<p>It is important to maintain proper records. Besides studying patient flow into the ICTC, we can use this information to carry out proper follow-up with clients, identify which groups we have not yet reached, and understand which advertising medium is effective.</p> <p>When we have a good idea of how people are accessing our services we can develop more effective strategies to help them.</p>

<p>resources more space/ better space if the numbers of patients increase</p> <p>To understand where patients are being referred from, and where they are not, and to then use this information to improve referral patterns</p> <p>To check which advertising medium is most useful in a particular center – radio, TV, posters, referrals from PHCs, referrals from private doctors, etc.</p> <p>To practise transparency and accountability to donors for the funds they are providing</p>																												
<p>Diagram of Data Flow</p> <p>See Page 214</p>	<p>As shown in the diagram from the Operational Guidelines, the registers are maintained by the counselling personnel and testing personnel, and are compiled into monthly reports. It is the responsibility of the ICTC Manager to verify the information and send this monthly report to the DAPCU (if it has been set up) or to the SACS by the 3rd of every month. At the level of the DAPCU or the SACS, the information is checked and then sent on to NACO.</p> <p>The diagram also shows the feedback mechanism by which NACO can review the information in the reports and give suggestions to the SACS. Similar feedback mechanisms exist between the SACS or the DAPCUs to the ICTCs.</p>																											
<table><tr><td>List of registers to be maintained</td><td>Prepare</td><td>Review</td></tr><tr><td>PID Register for General Clients and Pregnant Women</td><td></td><td></td></tr><tr><td>ICTC Register for General Clients (Non ANC Cases)</td><td></td><td></td></tr><tr><td>ICTC Register for ANC Cases</td><td></td><td></td></tr><tr><td>ICTC Post-natal Follow-up Register</td><td></td><td></td></tr><tr><td>ICTC HIV-TB Collaborative Activities Register</td><td></td><td></td></tr><tr><td>Laboratory Register</td><td></td><td></td></tr><tr><td>Stock Register</td><td></td><td></td></tr><tr><td>Monthly Reports</td><td></td><td></td></tr></table>	List of registers to be maintained	Prepare	Review	PID Register for General Clients and Pregnant Women			ICTC Register for General Clients (Non ANC Cases)			ICTC Register for ANC Cases			ICTC Post-natal Follow-up Register			ICTC HIV-TB Collaborative Activities Register			Laboratory Register			Stock Register			Monthly Reports			<p>Over the course of the programme we have seen many registers and forms that ICTC staff members have to maintain. Let us review who is responsible for each form.</p> <p>Allow the trainees to say who is responsible for preparing and for reviewing each form. Then show them the next slide.</p>
List of registers to be maintained	Prepare	Review																										
PID Register for General Clients and Pregnant Women																												
ICTC Register for General Clients (Non ANC Cases)																												
ICTC Register for ANC Cases																												
ICTC Post-natal Follow-up Register																												
ICTC HIV-TB Collaborative Activities Register																												
Laboratory Register																												
Stock Register																												
Monthly Reports																												

List of registers to be maintained	Prepare	Review
PID Register for General Clients and Pregnant Women	CP	Manager
ICTC Register for General Clients (Non ANC Cases)	CP	Manager
ICTC Register for ANC Cases	CP	Manager
ICTC Post-natal Follow-up Register	CP	Manager
ICTC HIV-TB Collaborative Activities Register	CP	Manager
Laboratory Register	TP	Manager
Stock Register	TP	Manager
Monthly Reports	CP	Manager

<p>The next 11 slides consist of the Monthly Reports</p> <p>See Page 203 to 213</p>	<p>Here is the format for the monthly report. As you can see it involves information from all the different registers. The monthly ICTC format comprises information on:</p> <p>The number of clients counselled, tested, HIV status, NVP administration, gender and age-wise distribution.</p> <p>Monthly HIV-TB report on HIV-TB collaborative activities</p> <p>Details of referrals to and from various facilities.</p> <p>Stock of drugs, equipment and consumables</p> <p>Critical staff positions</p>
<p>The next 11 slides consist of the Monthly Reports</p> <p>See Page 203 to 213</p>	<p>The Operational Guidelines for the ICTCs also mention a Monthly Dashboard. The purpose of this is to give a snapshot of the performance of the SACS to NACO. It is sent by each SACS to NACO by the 5th of every month.</p>
<p>The next 11 slides consist of the Monthly Reports</p> <p>See Page 203 to 213</p>	<p>The purpose of this monthly dashboard is to give a snapshot view of the performance of the SACS to NACO. A section of this dashboard covers the performance of the ICTCs. The Monthly dashboard cannot be sent in a complete timely manner to NACO unless individual ICTCs send their monthly reports to the DAPCU or the SACS on time. Thus the SACS can also be seen as a team whose members are the various ICTCs and ART centres. If any single centre does not send in their reports on time, then</p>

	the performance of the SACS as a team is poor. Hence, it is important to be up-to-date in filling the various registers.
<p>The next 11 slides consist of the Monthly Reports</p> <p>See Page 203 to 213</p>	<p>A final note: The training handbook has described in detail various aspects of ICTC functioning such as working with general patients, working with ANC patients, conducting quality testing and quality counselling. However, unless documentation is carried out in a timely and complete manner, the work done by the ICTC staff will remain invisible and uncounted. To continue with the sports team metaphor, it would be like not counting the number of runs or goals scored.</p>
<p>Exercise</p> <p>In Which Register Would You Find Me?</p> <p>See Page 199</p>	<p>Exercise</p> <p>In Which Register Would You Find Me?</p>

In Which Register Would You Find Me?

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

✂-----

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

✂-----

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

✂-----

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

✂-----

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

✂-----

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

✂-----

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

✂-----

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

✂-----

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

Documentation Answer Key

List of Registers at the ICTC	Viswanathan	Umar	Raingam	Bishakha	Dhanesh	Saima	Gurmeet	Madhavi	Azhar
PID Register	X	X	X	X	X	X	X	X	X
ICTC Register for General Clients (Non ANC Cases)	X		X	X	X				X
ICTC Register for ANC Cases		X (Mother)				X	X	X	
ICTC Post-natal Follow-up Register		X				X After delivery if +ve	X After delivery if +ve	X After delivery if +ve	
ICTC HIV-TB Collaborative Activities Register				X					X
Line List of Persons referred from the ICTC to the RNTCP				X Ensure she is on DOTS					X
Laboratory Register	X	X Follow protocol	X	X	X	X	X	X	X
Stock Register									
Monthly Reports									
	Check for TB signs	Will be in PPTCT line list	Check for TB signs		Check for TB signs. Refer to STI	Check for TB signs. Refer to STI	Check for TB signs. Refer to STI	Check for TB signs	

Every ICTC client will have their name and full address mentioned in the PID register. In other registers, they will only be identified by their PID number. No client will be found in the Stock Register and the Monthly Reports. Encourage HCP from the ICTC to enquire about TB signs (prolonged cough for 2 weeks or more) and STI signs (ulcers on genitals, burning sensation while urinating, discharges).

Annexure III.h

Formats for Monthly Reports

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

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

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



Annexure III.h

Monthly Reports (contd.)

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



Annexure III.h

Monthly Reports (contd.)

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

Continued...



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



Annexure III.h

Monthly Reports (contd.)

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

Continued...



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



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

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



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

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Reports from SACS to NACO

Annexure III.j

Annexure III.j

NATIONAL AIDS CONTROL PROGRAMME (PHASE-III)

MONTHLY MONITORING FORMAT-2

Basic Services

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

State: _____ Year: _____

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



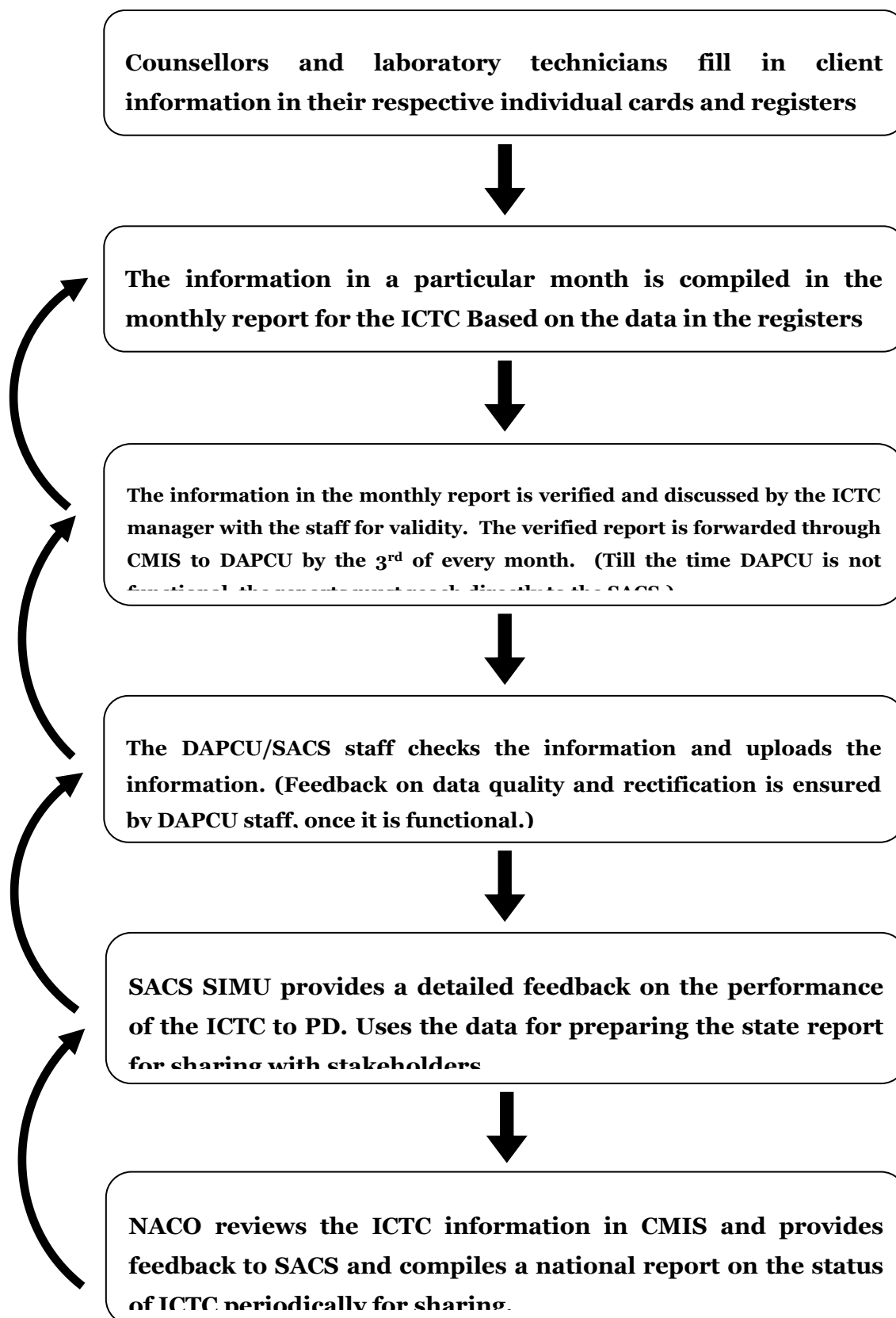
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Data flow

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



Day 3

Post-Workshop Questionnaire

Post Workshop Questionnaire

Session Overview

- ✓ Post-workshop questionnaire (15 minutes)
- ✓ Comparison of HIV/AIDS knowledge of trainees before and after the workshop (outside workshop schedule)

Session Objectives

- ✓ To understand the unmet training needs of the ICTC trainees at the end of the workshop.
- ✓ To compare the rating of HIV/AIDS knowledge of trainees at the end of the workshop with the baseline.

Time Allowed

15 minutes

Materials

- ✓ Post-workshop Questionnaires

Method

Preparation

- 1) Before the session, you, as the trainer, will make enough copies of the Post-workshop Questionnaires and keep them ready in an envelope.

Post-Workshop Questionnaire

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- 2) You, as the trainer, will distribute the questionnaires with the following instructions: “Please fill this form completely and return it to me. Please do not discuss the answers with other people around you. You have about 10 minutes for this.”
- 3) Collect the forms as trainees finish them and thank them for completing it.
- 4) After the workshop, you should go through the questionnaires and score them with the point system given below. By comparing the post-workshop learning with the baseline established from the pre-workshop questionnaire, you will be able to measure immediate learning from the workshop as well as areas where misinformation and doubt persist. You can use this information to strengthen future training workshops you may conduct.

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Post-Workshop Questionnaire

NAME: _____

How would you rate this workshop:

1. Information learned about HIV
(a) Learned a lot (b) Learned some (c) Learned nothing new
2. Information learned about working with People Living with HIV/AIDS
(a) Learned a lot (b) Learned some (c) Learned nothing new
3. Information learned about ICTC work
(a) Learned a lot (b) Learned some (c) Learned nothing new
4. Trainers' overall performance
(a) Very Good (b) Good (c) Average (d) Poor (e) Very Poor

INSTRUCTION: Circle the right answer for the questions below.

5. When HIV spreads in the general population and HIV prevalence is consistently over 1% in pregnant women, this is described as a
 - a. Low-level epidemic
 - b. Concentrated epidemic
 - c. Generalized epidemic
6. HIV has 2 subtypes. The MORE COMMON SUBTYPE in India is
 - a. HIV-2
 - b. HIV-1
 - c. HIV-3
7. Opportunistic infections are so called because
 - a. They do not infect HIV negative persons
 - b. They take advantage of the immune system that is weakened by the HIV
 - c. They infect HIV positive individuals at home

8. Which of the following is a common opportunistic infection in India
- Tuberculosis
 - Avian flu
 - Worm infections
9. You can DEFINITELY confirm that a person is infected with HIV using an ELISA test
- In the first week after infection
 - After the window period
 - Any time after HIV virus enters blood
10. Say TRUE or FALSE
- Rapid antibody tests for HIV are conducted using blood from a finger prick
 - AIDS and HIV are one and the same
 - Persons with low CD4 have low viral load
11. Antiretroviral treatment is started
- To cure HIV/AIDS
 - When CD4 is below 300
 - If person is tested positive for HIV virus
12. The regimen used by NACO to prevent transmission of HIV from a pregnant HIV-positive woman to her unborn child (that is PPTCT) is:
- Single dose of Nevirapine to the baby on the third day
 - Single dose of Nevirapine to the mother at the time of labour and on the third day after delivery
 - Single dose of Nevirapine to the mother at the time of delivery and a single dose of Nevirapine to the infant immediately after birth
13. Provider Initiated Testing means
- The Health Care Provider (that is doctors and nurses) get tested for HIV every month
 - The Health Care Provider (that is doctors and nurses) refer for testing those patients who show symptoms of HIV/AIDS or who have conditions that might encourage HIV infection (like STIs)
 - The Health Care Provider tests all the patients for HIV

Scoring of the Post-Workshop Questionnaire

1-4 : no scoring, only information gathering.

5.) (c) Generalised epidemic. The National AIDS Control Programme III terms those districts which have such a generalized epidemic as Category A Districts or High Prevalence districts. There are 163 such districts in India as per 2006 behavioural surveillance survey.

6.) (b) HIV-1. The two subtypes of HIV are HIV-1 and HIV-2. The most common subtype in India is HIV-1. HIV-1 has a faster course than HIV-2 in general. But there are many other factors which affect the course of the illness.

7.) (b) They are the common illnesses but when the immune system of the HIV positive person gets weakened by the virus, the person contracts these illnesses easily.

8.) (a) Tuberculosis is the most common opportunistic infection in HIV disease, the most common cause of morbidity and the leading cause of death in PLWHA. PLWHA have a 50 to 60 percent lifetime risk of developing TB as compared to HIV negative persons whose life time risk is 10 percent.

9.) (b) Seroconversion which is the development of antibodies takes place 1 to 6 weeks after infection. ELISA is an antibody test which will only show a true picture after this period. The average time taken for people to develop detectable antibodies is 25 days. In extreme cases, it can take upto 6 months. The Window Period is the time when the person has been infected but antibodies have not developed. The person can still transmit HIV.

10.) (a-True) Currently HIV testing in India is performed on serum/ whole blood (finger prick) and plasma.

10.) (b-False) HIV is the virus which causes AIDS. AIDS is the advanced stage of infection. They are not the same.

10.) (c-False) When CD4 is low, viral load will be high. High CD4 and low viral load is the sign of healthy individual.

11.) (b) ART assists in increasing the CD4 (helper cells) and thus decrease the amount of virus in the body. This assists the person in fighting infections. It is not a cure for AIDS.

12. (c)

13.) (b) Provider-initiated testing involves recommending testing to those patients who need it because they show signs and symptoms of HIV/AIDS, or because they may have conditions like STIs which provide a good environment for HIV transmission. Though providers may refer them for testing, patients always have the right to refuse to be tested, that is they can

‘opt out.’ Health Care Providers should not refer all patients for HIV testing. Such routine or universal precaution violates human rights and is also against national health policy.