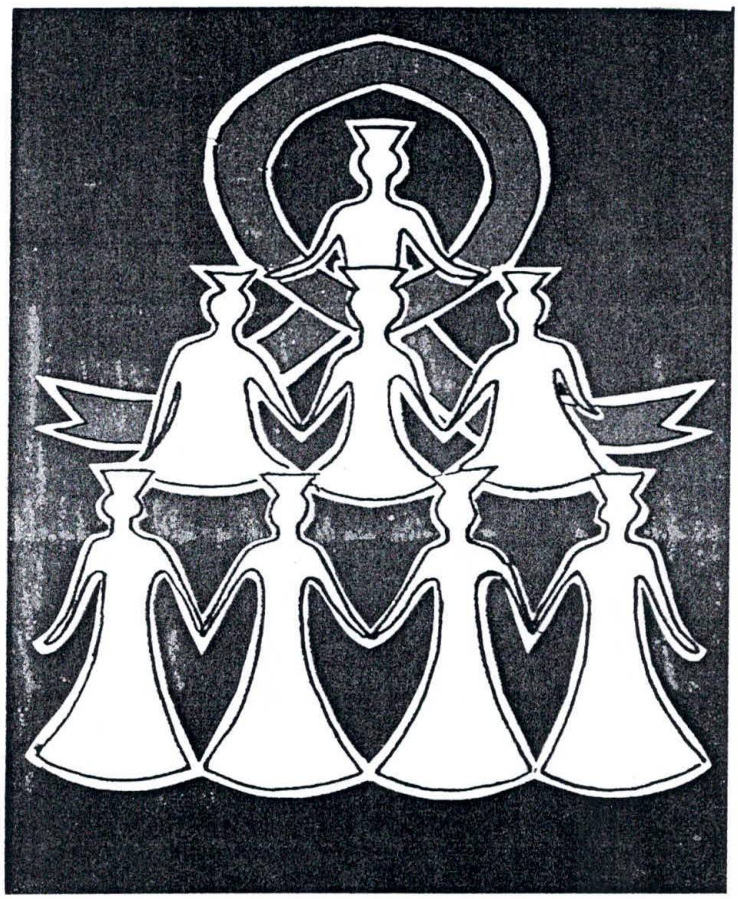
TRAINING ON HIV / AIDS FOR NURSES AT PRIMARY HEALTH CENTERS



FACILITATORS MODULE

2004

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LIST OF CONTENTS

DESIGN OF THE MODULE

This module includes 12 chapters:

Chapter I : Magnitude of HIV / STI
Chapter II : The implications of RTI / STI / STDs
Chapter III : HIV and AIDS – the challenge we face
Chapter IV : Prevention of STD / HIV / AIDS
Chapter V : Universal precautions – in caring for a person with STD / HIV
Chapter VI : Post exposure prophylaxis
Chapter VII : Attitudes about STI / HIV / AIDS
Chapter VIII : Communication and counseling in the context of STI / STD / HIV
Chapter IX : Community based care for people living with HIV / AIDS
Chapter X : Role of nurse in caring for a person with HIV /AIDS
Chapter XI : Referral, services and networking
Chapter XII : Legal and ethical issues

Each chapter contains a number of topics that explore related subject matters.

Purpose of the module

This module is designed to enable nurses working in the Primary Health Center as facilitators to carry out discussions and provide information on STI, HIV and AIDS. The training provided to nurses at this level through this module would equip them with information on the diseases, their prevention, how to be active in the prevention of these diseases and on available services for persons living with STI/HIV/AIDS. They could become the information banks/ resources for the community at large.

Scheduling

This module has been designed for a 3-day training workshop and it is preferable that trainees devote three continuous days to training, as this is a skill-based module.

The sessions are presented in sequential order of the chapters suggesting that session 1 should be covered before session 2. Likewise, the topics within the sessions should follow the suggested sequential order. However, the facilitator can adapt any of the training material depending on the level of training and expertise of the trainees and the availability of time. For example the topic on hand washing would be very familiar and hence this may be omitted or modified. A sample workshop schedule is included for your convenience (See Annexure A).

How to facilitate

The workshop trainers / facilitators should be familiar with experiential and participatory forms of learning. The trainers / facilitators should have the ability to ask exploratory open-ended questions and should be sensitive towards involving all the trainees. The

facilitator should also be technically competent to answer questions related to the training topics.

Some sessions can be sensitive and exploring the topics can be difficult and embarrassing, for example, talking about and demonstrating condoms. Hence it is suggested that this training be facilitated separately for women's group and men's group. That would mean that even facilitators would have to be of the sex as that of the group. However, for any HIV and AIDS work, becoming comfortable about talking about sex and sexual activities is essential. Fortunately, these tasks become more comfortable with practice.

The module also includes some ideas for energizers to provide a break during long sessions (See Annexure B).

Suggested teaching methods

A variety of teaching methods have been suggested for each topic. These include the following participatory techniques:

1. ***Group discussion***
   Discussion is a technique that is central to participatory education. It allows members of a group to openly express their opinions on a subject, and listen to the opinions of others thus learning occurs through interchange among members. Discussion can be conducted with the whole group (large group), but reducing the number of participants in a discussion creates a more informal atmosphere and promotes participation by all. Small groups of 4 to 5 participants are ideal. It is preferable to give the group a guideline so that discussion is focused.

2. ***Work pairs***
   Two participants can explore topics or issues that could be sensitive or of a very personal nature in a secure setting. Pair work is also appropriate for problem solving exercises that encourage intensive input, not consensus agreement. Remember to change pairs often so that the same two people do not always work together.

3. ***Brainstorming***
   Brainstorming involves getting people to list all of the related ideas that they can think while someone records the ideas on paper without editing them. This technique helps participants to generate ideas quickly and fluidly while allowing them freedom to express any /all ideas. The advantage of working in groups is that the thoughts of one person may stimulate new directions of thought in another. When approaching a difficult topic, such as sex, which usually makes people nervous and shy, you may find brainstorming invaluable in loosening up a group. It can also be a lot of fun

4. ***Role play***
   A role – play is a simulation technique and involves a participant imitating or acting out a situation with members of the group. These members assume other roles related to learning objectives. Role-play allows participants to practice situations before they

come across them in real life. It helps in sensitizing the participants to what may happen in a real situation.

5. ***Mini lecture***
   This is brief and well-paced lecture where definitions, facts or other information are presented to participants. The lecture should be presented verbally and should be visually supplemented by teaching aids such as information on flip charts, handouts, chalkboards, power point, transparencies etc. It should not last more than 10 minutes.

6. ***Demonstration***
   In a demonstration, facilitators use examples, experiments, models or actual materials in order to illustrate a principle and show the participants how to carry out a certain activity. Demonstration provides concrete experiences of life-like situations. Demonstration improves practical skills and the ability to communicate with others. For example, using demonstration as a technique can be vital in educating participants how to use condoms.

7. ***Case studies***
   It is a method of simulation, aiming to give experience in the sort of decision-making that the participants will have to do later. They are written based on real life events from existing sources of information such as newspapers, journals etc. Hence it is important to avoid over simplifying the case study since it would dilute the reality of the case. It would help the participants in self analysis if at the end of a case study the facilitator ends like this 'we have considered the case presented to us and come to certain conclusions; now let us consider the case ourselves. How do we solve the problem ourselves'?

Suggested teaching aids
Try to use many different teaching aids when presenting the topic information. Examples include:

Brochures	Chalkboard	Checklists
Flip chart	Films and/or videos	Graphs/diagrams
Games	Handouts	Participants module
Photographs or pictures	Overhead projector/ LCD	Models

How to use the guide
The content in this module is comprehensive and it is preferable to have a minimum of five to six facilitators for each training workshop, so that the facilitators can themselves interchange content or complement each other.

Organization of the chapters
Each chapter is organized under the following headings

- ***Introduction***

- ***General objectives***: What the facilitator hopes to achieve overall at the end of teaching the session.
- ***Specific objectives***: What the facilitator hopes to achieve in behavioral terms at the end of the session
- ***Key concepts***: It highlights what is expected to be achieved at the end of the session
- ***Suggested teaching methods***: What teaching methodology and techniques will be used for the session
- ***Materials / preparation required***: What material are required for the session viz. handouts, marking pens, black board, OHP, chart paper, flip charts etc.
- ***Topic outline***: Lists the individual topics in the session
- ***Total session time***: Gives an overview of approximate time to cover the session
- ***Background material***: Gives the information to help the facilitator to have a successful teaching experience in each chapter. Interspersed between the text content appropriate exercises are placed to facilitate in the achievement of the objectives

How to prepare for every topic

- Read the entire module thoroughly to see how each topic relates to the next topic
- Prepare the materials and resources identified. For e.g. if the module says to use pictures, check whether the pictures are available or make them before the workshop, or if it is recommended to use the black board, see that chalk, duster etc is available, etc.

How to evaluate

It is important to see that the participants give a feed back of the workshop that is conducted. This is needed to assess the strengths and weaknesses of the training sessions. Hence there should be time set aside in the schedule of the workshop. Various aspects of the workshop and of the module it self have been considered in the evaluation tool given in Annexure - B.

How to close the workshop

Close the workshop with a wrap up debriefing, songs, tea, distribution of certificates, and an oral feedback from a representative of the participants.

After the training workshop

Classroom training is the first step. Participants would need to be supported by providing them information in the form a participant's module, contact numbers or addresses of facilitators or of one person who would be responsible for providing follow-up support of the participants.

ACRONYMS

AFB	: Acid fast bacilli
AIDS	: Acquired Immuno Deficiency Syndrome
ANM	: Auxiliary nurse midwife
ART	: Antiretroviral therapy
AZT	: Zidovudine
BMT	: Breast milk transmission
CRC	: Convention of Rights of Children
EC	: Exposure code
ELISA	: Enzyme linked immunosorbent assay
FHAC	: Family health awareness campaign
HAART	: Highly active antiretroviral therapy
HBV	: Hepatitis B virus
HCV	: Hepatitis C virus
HIV	: Human Immuno Deficiency Virus
ICHAP	: India Canada Collaborative HIV /AIDS Project
IDV	: Indanivar
IEC	: Education, information and communication
IUD	: Intrauterine device
IVDU	: Intra venous drug users
KSAPS	: Karnataka State AIDS Prevention Society
LGV	: Lymphoma granuloma venerium
MEC	: Medical education cell
MTCT	: Mother to child transmission
NACO	: National AIDS Control Organization
NGO	: Non government organization
NNRTI	: Non Nucleoside Reverse Transcriptase Inhibitors
NRTI	: Nucleoside Reverse Transcriptase Inhibitors
NVP	: Nevirapine
OI	: Opportunistic infections
OPIM	: Other potentially infectious material
OT	: Operation theater
PEP	: Post exposure prophylaxis
PI	: Protease Inhibitors
PID	: Pelvic inflammatory diseases
PLHA	: People living with HIV /AIDS
PPTCT	: Prevention of parent to child transmission
PMTCT	: Prevention to mother to child transmission
RTI	: Reproductive tract infections
STD	: Sexually transmitted disease
STI	: Sexually transmitted infection
USAIDS	: United States Agency for International Development
VCT	: Voluntary counseling and testing
VCTC	: Voluntary counseling and testing center

WHO : World Health Organization
ZDV : Zidovudine

This module is not entirely an original development. It has borrowed extensively from existing documents and training modules / Manuals. A bibliography is provided. Faculty of St. John's College of Nursing, St. John's National Academy of Health Sciences, has compiled this module. We would like to thank

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Views expressed in the module are those of the authors. Comments from readers or users are encouraged and should be sent to ICHAP.

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INTRODUCTION

An overview of the whole workshop is given to the participants. After this, to help the participants get familiarized with each other, they can be introduced with the help of an icebreaker (an enjoyable activity that will help persons to feel at ease with each other).

General objectives

At the end of the introductory session the participants will be able to get to know each other, the objectives of the workshop, their commitments for the workshop and the schedule and other details concerning the workshop.

Specific objectives

- To welcome the participants to the workshop
- To get to know each other so that they could feel comfortable with each other
- To clarify the objectives of the workshop so that the participants are aware of the scope and purpose of the workshop
- To be aware of the norms to be followed during the three day workshop

Teaching methods

- Ice breakers
- Group activity
- Brain storming

Material / preparation required

- Chits of paper with names of animals / birds
- Black board, chalk, duster
- Chart paper, colour pens
- Transparencies of objectives, OHP and pens

Topic outline

- Welcome of the participants
- Introduction of facilitators and participants
- Clarifying the objectives
- Formulating norms to be observed
- Introducing the MET concept

Total session time

30 minutes

BACKGROUND MATERIAL

Welcome of the participants

- Begin the workshop with a welcome to all the participants
- Welcome any guest or important person who may be available

Introduction of facilitators and participants

Exercise 1.

The purpose of this exercise is to divide the participants into smaller groups so that they can get to know each other

1. The facilitator distributes small chits of paper that have the name of an animal or bird written in it (e.g. dog, cat, donkey, crow, hen, goat).
2. The participants are instructed not to reveal to the neighbor what is written in the chit of paper they have received.
3. Once all the participants have received the chits, the facilitator instructs them to find the group members by making the sound of the animal / bird
4. Once they have identified their group members, the participants are instructed to find out the name of the person on their right and to also describe the person with an adjective preferably starting with the first alphabet of the person's name (e.g. Bharathy – beautiful / beaming). This activity should not take more than 3 minutes
5. Once the above activity is completed each group is called to come forward and each participant is asked to introduce the person whose details they had collected to the rest of the participants. This activity should not take more than 20 minutes

Clarifying the objectives

- Deliver a short speech about the overall objectives of the workshop and the relevance of the workshop to them
- Encourage participants to voice out their expectations of the workshop and to clarify any aspects about the objectives

Formulating norms to be observed

The facilitator needs to tell the participants that in order to make the best of the workshop everyone must agree on some ground norms or ways of preventing any group tensions or conflicts during the three days. Encourage the participants to brainstorm and finally agree upon the norms they would like to observe as a group during the three-day workshop

Exercise 2.

1. The facilitator encourages the participants to remain in the same groups as in Exercise 1
2. Place a chart in the middle of the floor / table of each group
3. Each group is asked to discuss within their groups about ideas that can be formulated into a rule provided all the members in the group agree upon it (e.g. punctuality, being nonjudgmental, making everybody to talk etc.). This should be completed in 5 minutes. This rule is then written on the chart paper, large enough for all the participants to see
4. Then the leader of each group is asked to present the norms that were identified in the group and to fix the chart in the front of the class for all the participants to see.
5. Any clarifications are encouraged by the facilitator, and if needed the rule is reviewed again for clarity
6. One volunteer of the participants is asked to finalize the list of norms on a chart. This is placed on the wall or at the entrance of the class where all the participants can see it clearly. All other chart papers can be removed
7. The participants are then encouraged to follow these rules and are asked to remind each other about the same if someone forgets

Note: This is an optional exercise if time permits. But if done it could help in developing good team effort.

Introducing the MET concept

Introduce the concept of MET (Monitoring Evaluation Team) by saying, this training program is a participatory one and we want you to participate in coordinating it. So we are entrusting the responsibility of the training to you. A team of three participants would need to volunteer to be the Monitor, the Reporter and the Evaluator. This team will take care of the training program and coordinate it.

The responsibilities

The monitor

Is the team leader and the overall coordinator of the program

- Fixes the starting time, tea break, lunch time and the ending time
- Discusses with the participants and facilitators on any extension or change in timings during the training and informs the concerned people
- Ensures that the arrangement are done properly for food, stay, trips, training hall arrangements and so on
- Ensures that the reporter and the evaluator are doing their works properly

This person has an over all control over the program and its proceedings, even the facilitators function only based on his recommendations with regard to these areas.

The reporter

The reporter records the day's proceedings and he/she prepares a summary of it and presents it on the following day morning for the benefit of the participants and the facilitators.

The evaluator

The evaluator gets the feedback from all the participants as to how the day went on. He/she prepares a few heads or questions and discusses with 75% of the participants and gets their feedback on how effective and useful the training was and ask them the positive and negative aspects of the training. The Evaluator presents the report on the following day morning.

Functions

Assembling all the participants and facilitators starts the day. The monitor starts the day with a thought for the day or a song or a prayer, followed by a short presentation of the previous day's proceedings by asking the reporter and the evaluator to present their reports. Then after a concluding note the monitor invites three new participants to take up their positions and all the three previous participants handover their responsibilities to the next team. The duration of the MET is a day.

The MET that takes responsibility on the last day will have to conduct a valedictory function. If the participants feel that the MET has to continue for one more day then the team's duration can be extended for half day or a day with their consent.

Chapter – I

MAGNITUDE OF STI AND HIV / AIDS

Introduction

The greatest challenge today before us is the prevention of HIV / AIDS epidemic in the world. AIDS is a real challenge for the health professionals as there is no effective cure or vaccine against it. But however STI / HIV/AIDS is preventable and the epidemic could be controlled. Consequently the prevalence figures during the last few years have been increasing all over the world without any manifest sign of remission.

General objective

At the end of the session, the participants would be able to understand the significance of STI / HIV / AIDS epidemic, appreciate its importance and apply this information in her / his approach to individuals.

Specific Objectives

At the end of the chapter the participants would be able to:

- Recognize the gravity of HIV/AIDS situation
- Recognize the gravity of STI

Key concepts

- The prevalence of HIV in the country is growing at an alarming rate
- Karnataka state has a rate of around 1% prevalence rate of HIV in the general population
- Burden of STI / STD is higher than HIV

Teaching methods

- Lecture
- Group discussion
- Reflective exercise

Materials /preparation required

- Transparencies of maps of India, Karnataka, world indicating scenario of HIV
- Transparencies of relevant tables
- Black board, chalk, duster; overhead projector

Topic outline

- History and origin of HIV / AIDS
- Magnitude of HIV /AIDS
- Magnitude of STI

Total session time: 30 minutes

BACKGROUND MATERIAL

1. **The facilitator starts the session with the statement which is projected *'HIV /AIDS the biggest challenge of the 21st century?'***
2. **The facilitator asks the participants whether they could agree with the statement and if so why. The activity should not take more than 3 minutes.**

History and origin of HIV / AIDS

Scientists have different theories about the origin of HIV, but none have been proven. The earliest known case of HIV was from a man's blood sample collected in 1959 although it is not known how he became infected. He was from Kinshasha, Democratic Republic of Congo. Genetic analysis of this blood sample suggests that HIV-1 may have stemmed from a single virus in the late 1940s or early 1950s.

The virus has been said to exist in the United States since at least the mid-to late 1970s. Between 1979-1981 rare types of pneumonia, cancer, and other illnesses were being reported by doctors in Los Angeles and New York among a number of gay male patients. These were conditions not usually found in people with healthy immune systems. In 1982 public health officials began to use the term "acquired immunodeficiency syndrome," or AIDS, to describe the occurrences of opportunistic infections, Kaposi's sarcoma, and *Pneumocystis carinii* pneumonia in previously healthy men. Formal tracking (surveillance) of AIDS cases began that year in the United States.

The virus causing AIDS was identified by a team of French scientists lead by Dr. Luc Montanier of Pasteur Institute and American Scientists lead by Dr. Robert C. Gallo of National Cancer Institute in 1983-1984. The virus was at first called by an International Scientific Committee as HTLV-III/LAV (human T-cell lymphotropic virus-type III/lymphadenopathy- associated virus) and only later was named HIV (human immunodeficiency virus) by the same committee. To date two types HIV-1 and HIV-2 are identified.

Historical perspectives

- The HIV may be a mutant or more virulent form of the already existing organism
- Organism was circulating in an isolated group of population which developed resistance
- Organism has been introduced to human from another source like chimpanzees.

The first case of HIV infection in India was diagnosed in commercial sex workers in Chennai, Tamilnadu in 1986. The first patient of full-blown AIDS was reported from Bombay in 1987 that had received blood transfusion in USA for coronary artery bypass graft. The first case that was detected in Karnataka was in Belgaum in 1987.

Magnitude of HIV /AIDS

Global scenario

- World Health report (2004) estimated 34-46 million people living with HIV AIDS
- 3 million people died with HIV /AIDS in 2003 alone (WHO Report 2004)
- About 1/3rd of people currently living with HIV / AIDS are aged 15-24. Over 50% of new infections are occurring in age group 10-24 years.
- Ratio of male: female affected is 1:1 globally
- Of the 31-43 million adults with HIV infection - the global estimate in end-2003 - 25-28.2 million were in Sub-Saharan Africa and more than 9.5 million in Asia. The South-East Asia region is said to be most likely to suffer the greatest from this pandemic – it being the home of over half the world's population
- According to UNAIDS estimates, by December-2003, nearly 34-46 million people including over 2.5 million children - had been infected with HIV since the start of the epidemic.
- More than 95% of people infected during 2002 occurred in developing countries. Among these about 12,000 are in persons aged between 15-49 years of whom almost 50% are women and 50% are aged between 15-24 years

Table 1.1. Total summary of the HIV/AIDS epidemic – Dec. 2003

Particulars	No. of Person living With HIV/AIDS	Persons newly infected with HIV during 2003	AIDS death during 2003
Total	42.0 million	5.0million	3.1 million
Adult	37.0 million	4.2 million	2.5 million
Women	19.2 million	2.0 million	1.2 million
Children < 15 yrs.	2.5 million	0.7 million	0.5million

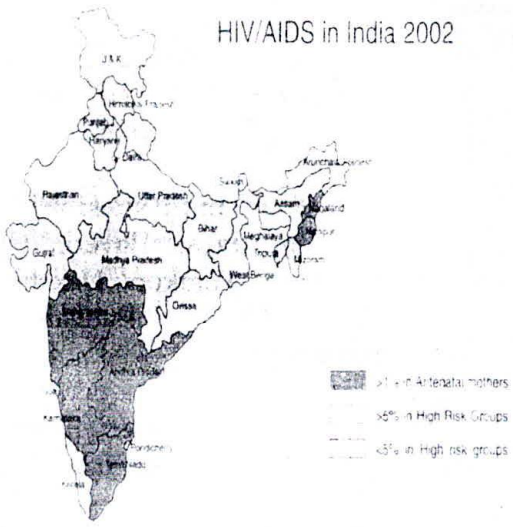
Source: UNAIDS, 2003

Scenario of HIV / AIDS in India

Exercise 1.1

The purpose of this exercise is to help the participants become aware of the scenario of HIV/ AIDS in India

1. The facilitator divides the participants into 5 small groups of 5-8 members each
2. Each group is given the map of India
3. The participants have to discuss in the group and indicate (using asterix signs as given below) in the map the risk status according to the categorization given below of the States in 5 minutes
   - ***Generalized high risk epidemic****
   - ***Concentrated moderate epidemic risk****
   - ***Low risk epidemic****
4. After the exercise the facilitator presents the following information



Group I ***Generalized high risk epidemic*****:** HIV>=1% among ANC	Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur and Nagaland.
Group II ***Concentrated moderate epidemic risk*****:** HIV> 5% among high risk group < 1 % among ANC	Gujarat, Goa, Pondicherry
Group III ***Low risk epidemic:*** HIV<5% among high risk groups < 1 % among ANC	All remaining states

Figure1.1Scenario of HIV in India

The other information to be highlighted is

- There were 51. million Indians reported to be living with HIV / AIDS during 2003, of them 38.5 % were women
- The total AIDS cases in India during 2003 were 55,764, of whom 14,486 were women
- 54% reported AIDS cases were between the age 30-44 years
- The UN population Division projects that India's adult HIV prevalence will be 1.9% in 2019
- UN projects 12.3 million deaths due to AIDS during 2000-2015 and 49.5 million deaths due to AIDS during 2015-2050
- Globally India is second to South Africa in terms of overall number of people living with the disease

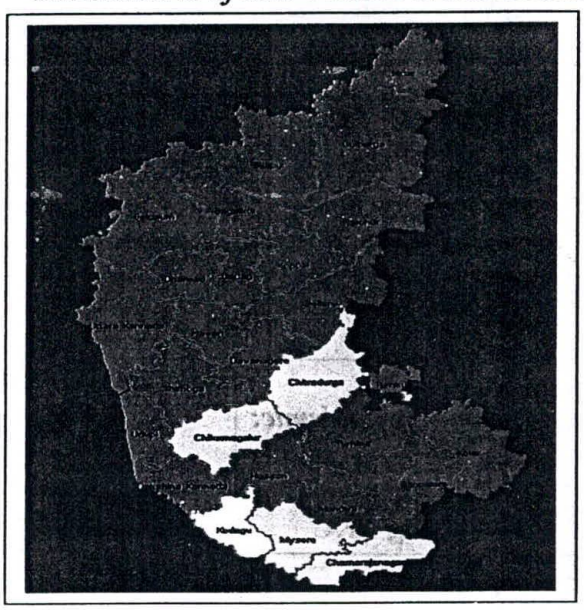
During the last 13 years, the HIV epidemic has spread rapidly in the country. It is also no longer a problem restricted to the high-risk behavior groups such as sex workers and intravenous drug users. In five states namely Tamilnadu, Maharastra, Andra Pradesh, Karnataka and Manipur, the HIV prevalence is 1% of the general population and threatens to further increase in women and children.

Some other important aspects of HIV / AIDS in India are:

- The heterosexual contact is still by far the most prevalent modes of transmission
- IV drug users in North Eastern states are having increasing sero – positivity rate
- Most of the AIDS cases are males (79%)
- Antenatal mothers are also found to be HIV positive (1%)

- HIV is rapidly spreading to rural areas through migrant workers and truck drivers.

The scenario of HIV / AIDS in Karnataka



Prevalence of HIV at District ANC clinic sentinel sites, Karnataka, 2003

<1% in both sites: Bidar, Gulbarga, Uttara Karnataka, Haveri, Chikmangalur, Chitradurga, Tumkur, Dakshina Kannada, Hassan, Kolar, Bangalore, Mysore, Chamarajanagar.

>1 in one site: Dharwad, Gadag, Shimoga, Udupi, Kodagu and Mandya.

Both sites or mean > 1.0%: Bijapur, Bagalkot, Belgaum, Raichur, Koppal, Bellary & Davangere.

Figure 1.2 Prevalence of HIV at district ANC clinical sentinel sites in Karnataka (2003)

- Although there is not enough data for accurate estimation, the HIV disease burden in Karnataka is already high. Mean prevalence is 1.5%. Median prevalence is 1.25%
- Based on the HIV sentinel surveillance data, the prevalence of HIV among those attending STD clinics is approximately 14 % meaning that at least one in six persons with an STD is perhaps already infected with HIV.
- Assuming an adult prevalence of 1.7% and an adult population age 15-49 years of over 30 million, there are more than 5,00,000 persons now living with HIV in Karnataka. However, most of these persons have not yet been diagnosed
- 15,321 persons have tested positive for HIV since 1987. Officially 1,648 AIDS cases and 183 deaths due to AIDS have been reported (Dec. 2002)

Magnitude of STI / STD

Global scenario

- The population at risk of acquiring STI / STD / HIV has increased as a result of demographic sociologic and behavioral changes that have occurred over the past 20 years.
- Women and newborn children have the most significant complication of these diseases. WHO estimates that 340 million new cases of Syphilis, Gonorrhea, Clamydia and Trichomoniasis have occurred through out the world in men and women aged between 15 to 49 years.
- Two thirds of infertility is due to STI / STDs.

Indian scenario

- STDs have been found to occur both in villages and in the cities. They affect both males and females. Every year nearly 40 million new STI / STD cases are reported through out India.
- At any given time, STDS affect 9.7% of people
- 1-5 % maternal deaths are due to ectopic pregnancies due to STI / STDs.
- 35% of postpartum morbidity is due to STI / STDs.
- 50-60% of women in India are known to have RTIs.
- During pregnancy 8 - 23 % of the women screened for VDRL are positive.

Summary

- The prevalence of HIV in the country is growing at an alarming rate
- Our State Karnataka has a rate of around 1% prevalence rate of HIV in the general population
- The prevalence rate in some districts in Karnataka is alarming
- Prevalence of STI / STD is also increasing
- There are no boundaries for STI / STD / HIV in terms of age, religion, caste, sex, or geography

Chapter -II

THE IMPLICATIONS OF RTI / STI / STD

Introduction

A person already having STI / STD has the greater risk of acquiring HIV. The growing evidence available from all over the world undoubtedly indicates that the incidence of HIV infection is higher in conditions of presence of sexually transmitted diseases (STDs). This calls for a discussion on RTI / STI / STD.

General objectives

On completion of this session the participants will understand the reasons why RTI, STI and STD are gaining more importance today, appreciate the focus given to this topic and apply knowledge gained in the daily work activities.

Specific objectives

On completion of this session the participants will:

- Be aware of common symptoms of RTI / STI / STD
- Demonstrate skill in history taking process in symptomatic individual
- Recognize the components of care of STI / STDs
- Participate in syndromic case management of STI / STDs

Key concepts

- All STI / STDs are preventable
- Persons with STI / STDs need to take complete treatment
- STI / STDs can be recognized by careful observation of changes in urethral or vaginal discharge and presence or ulcers in the genitalia

Teaching methods

- Lecture
- Small group discussion
- Reflective exercises

Materials / preparation required

- Black board, chalk, duster
- Transparencies, pictures, flowcharts of syndromic management
- Handouts

Topic outline

- Rationale for knowing about RTI / STI / STD
- Basics of RTI / STI / STD
- Assessment for a person suspected to have RTI / STI / STD
- Components of care for STI / STDs

Total session time: 1 hour

BACKGROUND MATERIAL

Rationale for knowing about RTI / STI / STD

Link between STI / STD and HIV

- HIV infection leading to AIDS is also sexually transmitted in most instances
- It is estimated that a person with STI / STDs is 5-9 times more likely to acquire HIV infection since ulcers and sores and genital discharges caused by STI / STDs in men and women will make it easier for the HIV to enter into the persons body
- Many persons with the HIV infection say that they had episodes of STI / STD in the past
- STI / STD may also be present in some of the HIV infected persons
- Effective treatment of STI / STDs will reduce the risk of HIV transmission
- Measures to reduce HIV transmission will include control of STI / STDs
- Most of the STI / STDs are curable and early detection and treatment of STI / STDs will greatly reduce the sexual transmission of HIV

Hence knowledge of these diseases would facilitate in recognizing them and thus help you to

i. Stress on the need for early treatment of STI / STDs since

- Its magnitude is high and it has a strong association with HIV transmission.
- If STI / STDs are left untreated they can be transmitted from one person to another during sexual intercourse.
- If untreated, STI / STD can cause infertility in both men and women
- Some STI / STDs can be passed from a woman to her baby while it is still in the womb or during birth.
- If untreated STI / STDs can spread into women's reproductive organs and cause pelvic inflammatory diseases (PID) or pain in the abdomen or ectopic pregnancies.
- Some STI / STDs can cause miscarriage, abortion or stillbirths.

ii. Concentrate on the prevention and treatment of STIs / STDs

- People are more likely to change their behavior to prevent a problem, which affects them now, than to prevent an illness, which they have never, seen and which may not appear for another ten years.
- The actions, which prevent STD, will prevent HIV, so people at low risk of STI / STDs are also at low risk of HIV.
- The reduction of STI / STDs will also reduce HIV transmission. This is because HIV is more easily transmitted when a person has sores or discharges.
- The reduction of STI / STDs will prevent a lot of infertility.

Exercise 2.1

The purpose of this exercise is to make the participants aware of the present situation faced by those infected with STI /STD especially women.

1. Ask the groups to listen to the story of 'Mayadevi'

Story of Mayadevi

"I am a village health worker and one day a friend, Mayadevi came to visit me to my house. She looked worried. We had some tea and talked a while and then she told me that she was having a lot of pain when she had sexual intercourse. She also said she had a thick and bad smelling discharge from the vagina. She felt shy and embarrassed to go to the health center regarding this and it was difficult for her to even tell me. Mayadevi got this infection from her husband Raman, who works as a driver and travels out of the district almost every month. She loves her husband and they have one daughter also. She & her husband are hoping to have another child after a year also".

2. Divide the participants into 2-4 groups depending on the number of participants so that the total number of members in each group does not exceed 8 members
3. Ask the groups to discuss the following questions. Take 5 minutes for this
    - *What do you think is the problem? What are the possible factors predisposing to high-risk behavior?*
    - *What are the reasons for Mayadevi or any other person with a similar problem not wanting to seek treatment?*
4. At the end one representative from each group can present the summary of their discussions
5. The facilitator will then discuss points given in the Handout 2.1. Any clarifications could be made in this period

Handout 2.1 (Optional could make out copies and give to the participants if needed)

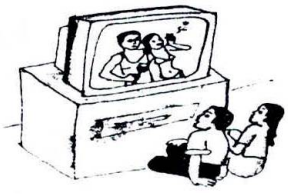
Possible factors predisposing to high-risk behavior

- Travel to far off places where identity of the person may not be known.
- Girls and boys attain maturity and become sexually active at young age
- The trend of both parents being employed and thus away from home may predispose to lack of time for them to counsel their children about sex.
- Lack of knowledge, the desire to experiment, peer pressure may compel youth to experience sexual encounters before marriage
- The easy availability of money to the young
- The easy availability of pornographic films, books and Internet to the young
- Inadequate and improper medicines to treat STI / STDs by untrained personnel

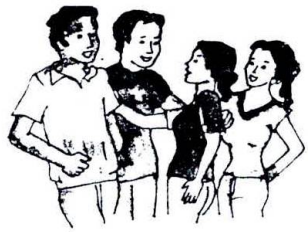
Reasons for persons with STI / STDs failing to seek treatment

- Stigma attached to the disease
- Preference for self medication, to go to unqualified medical practitioners
- Fear that they will be treated with discrimination

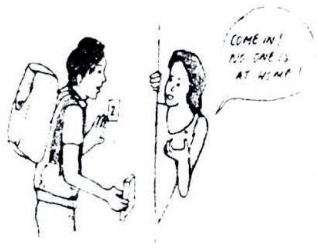
Possible factors predisposing to high risk behavior among youth



Watching phonographic pictures...



Peer pressure...



Both parents being busy / Easy money...

Basics of RTI / STI / STD

Just like STI / STDs, RTIs could also predispose a person to developing STI /STDs and thus HIV /AIDS. Hence a brief review of RTI will be covered, before STI / STDs are discussed.

1. Reproductive Tract Infections

Reproductive Tract Infections (RTI) is an infection of the genital tract. The infection can affect vulva, vagina, cervix, uterus, tubes and ovaries in the women. Infection of the uterus, and the tubes is known as pelvic inflammatory Disease (PID). This infection is usually acquired due to poor personal hygiene; is usually not transmitted from one person to another person unlike that of STI / STD, but could be due to STI, poor sterile techniques during procedures on the reproductive tract by the health personnel .

2. Sexually Transmitted Infections (STI) / Sexually Transmitted Diseases (STD)

These are infections that are commonly acquired by sexual contact but this may not be the only route of transmission in all cases (For example Scabies, and Herpes simplex could be acquired through contact). They are also sometimes called venereal diseases (VD).

RTI/STI is suspected in women whose husband / sexual partner has problem of urethral discharge with burning or ulcers in genitals or with scrotal swelling.

Symptoms of RTI / STI / STD

Exercise 2.2

1. Ask the participants to name any sign and symptom of RTI / STI / STDs for men and for women that they know about (3 minutes)
2. Write these on a large paper for all to see with the heading **women** and **men**.
3. One participant could then be asked to read out Handout 2.1 from their module (Facilitators module Handout 2.2).

Handout 2.2 Common symptoms of RTI / STI / STD in men and women are:

Men	Women
• Ulcers, sores, warts near the penis • Ulcers around the mouth or anus for those who practice oral or anal sex • Discharge from the urethra • Burning sensation while passing urine • Swellings in the groin • Swelling of scrotum in males • Tenderness in inguinal region	• Ulcers, sores, warts near the vagina • Ulcers around the mouth or anus for those who practice oral or anal sex • Discharge from the vagina or specifically cervical discharge in women • May complain burning sensation while passing urine • Swelling in the vagina or a feeling of fullness • Chronic lower abdominal pain • Back ache

List of STDs

Exercise 2.3

1. Ask the participants to name any list of STDs they have heard of before or know
2. Write these on a large paper or the black board for all to see
3. Then the facilitator can ask the participants to read the Handout 2.2 from their module (see Handout 2.3 in Facilitators module)

Handout 2.3 List of common STDs

Major STDs	Other STDS
• Chancroid • Donovanosis (Granuloma inguinale) • Gonorrhea • Lymphogranuloma Venereum • Syphilis	• Candidiasis • Condyloma acciminate (warts) • Hepatitis B • Hepatitis C • Herpes Simplex (Herpes Genitalia) • HIV infection • Pubic Louse • Molluscum Contagiosum • Mycoplasma infection • Scabies • Trichomoniasis • Vaginitis

Who can get STI / STD?

The persons who are more predisposed to STD include those who indulge in unsafe sexual behavior.

Sexual contact may include:

- Vaginal sex (contact between penis and vagina)
- Anal sex (contact between the penis and anus)
- Oral sex (contact between penis/vagina and the mouth or tongue)

Unsafe/ high risk sexual behavior means having

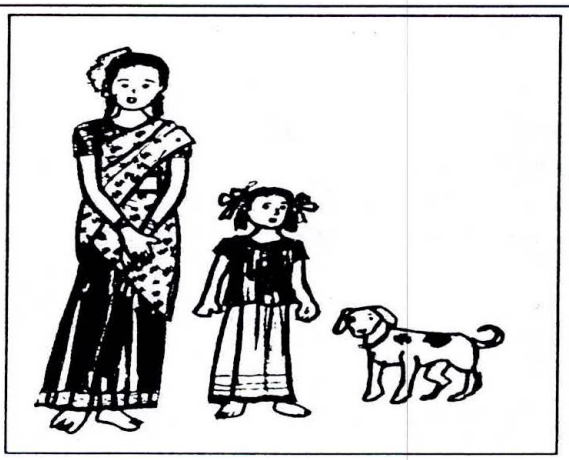
- Sexual intercourse with multiple partners, without using condoms
- Sexual contact with single known infected partner without using condoms (the spouse remains infected as long as he/she is not fully treated)

Anyone and everyone can get STD

STI /STDs are not restricted only to those with so-called high-risk behavior. A person with high-risk behavior may pick up the infection and he/she will spread the STDs to his/her partner, who may not have the same behavior.

Remember that women are more prone to STDS than men. The important reasons being…

- Due to the hidden nature of the reproductive organ of women, the symptoms are revealed much later or not at all and consequently if at all they seek treatment, have they done so at a late stage.
- STD lesions in women are asymptomatic in 50% of the cases
- White discharge is considered natural and women are ignorant that some of the white discharges could be STDs
- Many women may not have the facility to use separate toilets or bathrooms to examine themselves.



Assessment for a person suspected to have RTI / STI / STD/

i. History taking

History taking is important for a number of reasons such as it:

- Helps to establish a rapport between the health care personnel and the concerned person
- Gives early clues to the possible presence of an STD, traumatic lesions, previous treatment and allergies
- Helps to assess the person's risk factors for infection, and duration of infection if present
- Helps to identify sexual partners who may have been exposed to the infection so that measures can be taken to ensure that the partners are also treated

Exercise2.4

The purpose of this exercise is to make the participants aware of how to question a woman presenting with the problem of foul smelling from the vagina

1. Give the following case to the participants

Ms X comes to you with a problem of foul smelling per vaginal discharge associated with lower abdominal pain and back pain for the past 2 weeks.

2. Ask the participants 'what questions will you ask her? Write the responses on the black board
3. Facilitator supplements information and tells the participants to read the Handout 2.3 from their module (Handout 2.4 of the Facilitators module)

Handout 2.4 Questions to be asked in the event of vaginal discharge

If a woman complains of vaginal discharge, ask her the following question

- When did the discharge start?
- Whether the sexual partner has any sore on the genital organ or urethral discharge?
- What is the nature of the discharge, is it
  - Watery /Sticky and clear / Purulent / Curd – like / Yellow / Greenish and frothy / Blood stained or foul smelling / Whether it is scanty or profuse
- Whether the woman is pregnant or has recently delivered?
- Whether the woman is using loop/IUD?
- Whether she has burning while passing urine or itching in the vulva?
- Does she have any pain in the lower abdomen?
- Does she have any ulcer in the genital region?

Vaginal discharge in women may be

- **Physiological**
- **Due to infections that occur due to**
  - **Unsafe sexual practices**
  - **Invasive procedures in the reproductive tract**
  - **Unsterile procedures during labor**
  - **Unsafe methods followed for termination of pregnancy**

Vaginal discharge is a common complaint in women:

- **Physiological** during ovulation or during pregnancy. The discharge is
  - Mucoid
  - Not blood strained or foul smelling
  - Not associated with itching of the vulva
- **Candidial infection (Thrush)** Occurs commonly during pregnancy. A woman would present with the following:
  - Curd like white patches on the vaginal mucosa
  - Thick, curd white discharge
  - Itching at the vulva
- **Trichomonal vaginitis (parasitic infestation)** Is transmitted during sexual intercourse or by contact with contaminated articles. It is characterized by
  - Greenish yellow, frothy, foul smelling discharge
  - Itching and redness of the genital area
- **Gonorrhea:** In women it is characterized
  - By purulent discharge from the cervix
  - Or may pass unnoticed
  - If untreated, it may result in infertility in women.
- **Puerperal sepsis:** Is an infection of the genital tract, occurring after delivery or after an abortion. It presents as
  - High fever
  - Headache
  - Low abdominal pain
  - Foul smelling, purulent vaginal discharge
- **Following IUD insertion:** This discharge
  - Is profuse
  - Is watery
  - Usually subsides after the first menstrual period following insertion
- **Cancer cervix:** Occurs more commonly in older women.
  - In the early stage it is characterized by watery discharge
  - Later it becomes blood stained and fouls smelling
  - They could present with irregular vaginal bleeding

Components of care for STI / STDs

i. Early treatment through syndromic case management

Rationale for syndromic case management

- Facilitates early diagnosis and treatment of STI / STD
- Prevents complications
- Renders a person with STI / STD non-infective to his/her partner quickly
- Provides simple and easy flow charts (see at the end of the chapter)
- Enhances cost effectiveness

ii. Treatment compliance

Non-compliance with treatment of STI / STD not only prevents cure but also leads to a lot of complications like drug resistance. It may be more difficult to treat such drug-resistant cases. If there is no compliance to treatment incomplete treatment will only lead to disappearance of symptoms but not 'cure', thus leading to severe complications.

iii. Follow –up

- Follow-up of patients being treated for STI / STDs is essential to assess the extent of cure, and to be on the look out for any possible treatment failure, or complication of STI / STDs.
- Referral to centers with STI / STD specialists (see Annexure C for details of centers) will be needed for treatment failure, suspected drug resistance and complications of STI / STD.

iv. Partner treatment

Treating the partner is important because:

- The treated person may again get the disease from the partner not yet detected, who may sometimes be symptomless.
- A person who takes treatment for STI / STD may not abstain from sex

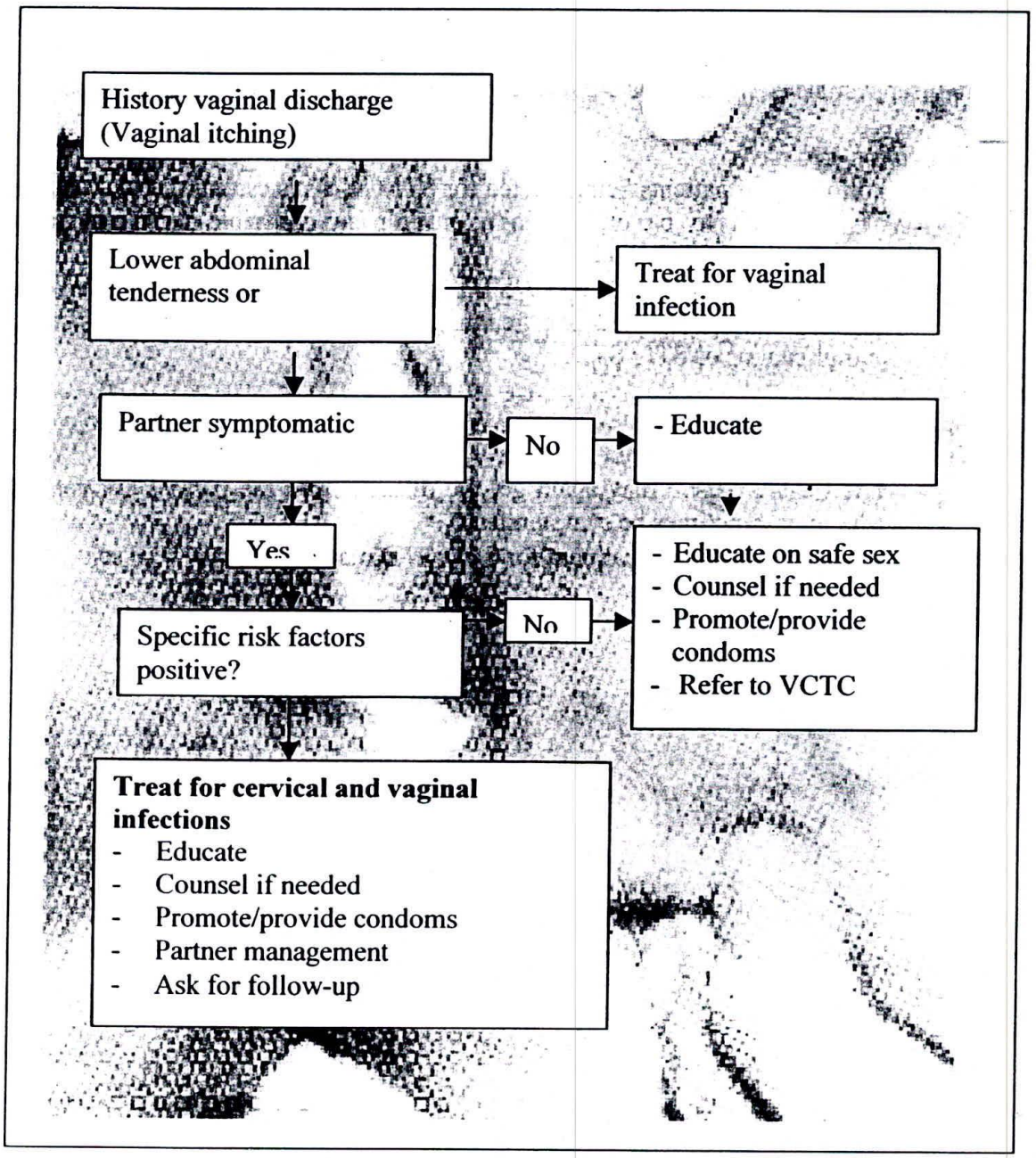
Advice partners to get treated...

v. Condom promotion

- Persons suffering from STI / STDs should be educated about the usefulness of condom in preventing further spread of these infections/diseases (See Chapter IV for details).

FLOW CHARTS OF SYNDROMIC CASE MANAGEMENT

VAGINAL DISCHARGE



Discharge from the vagina

Treatment for Gonorrhoea and Chlamydia (Mucopus from cervix- cervicitis)

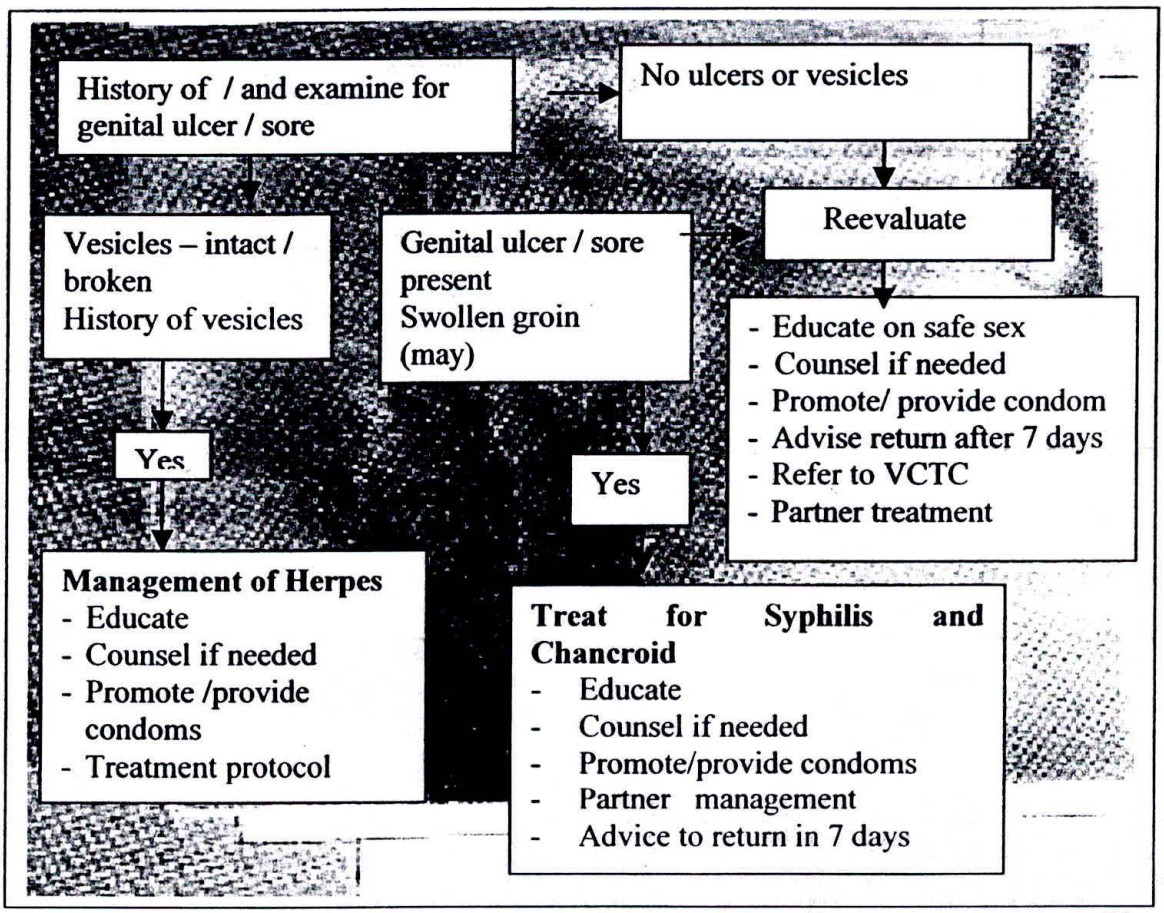
- Azithromycin 2 G single dose OR
- Azithromycin 1 G + Cefixime 400 mg single dose. OR
- Azithromycin 1 G + Inj. Ceftriaxone 250 mg IM single dose

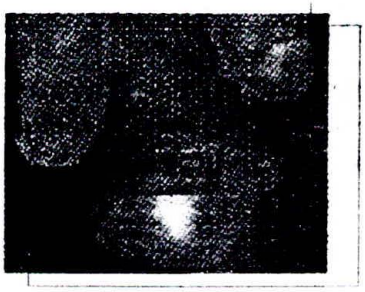
Treatment for Trichomoniasis (Profuse discharge- Vaginitis)

- Tinidazole or Metronidazole 2G stat + Fluconazole 150 mg stat

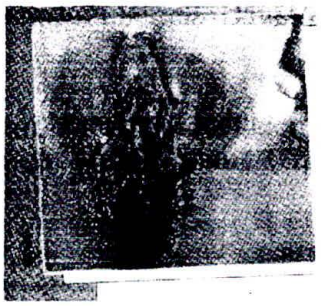
Complications: Sterility, tubal pregnancy, pelvic inflammatory disease (PID) may result if prompt treatment is not given.

GENITAL ULCERS / SORES





Ulcer in the penis



Ulcer in the female genitalia

Treatment for Herpes Genitalis

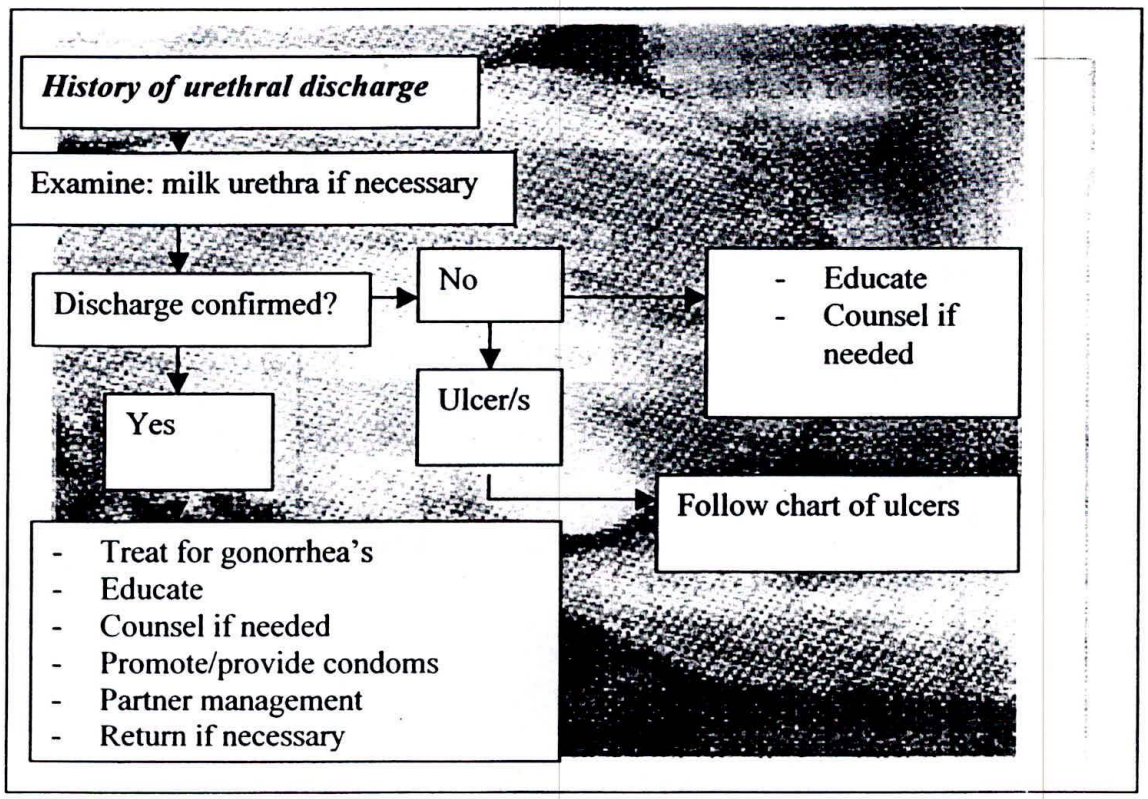
- Genital hygiene
- Acyclovir 400 mg orally 3 times daily for 5-10 days.

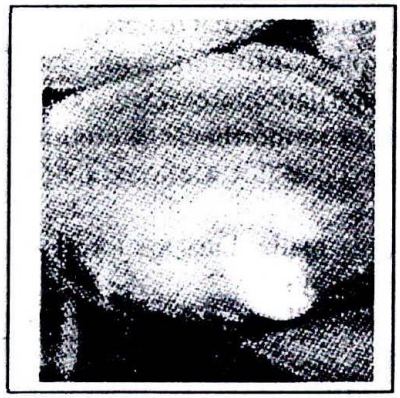
Treatment for Syphilis and Chancroid

- Inj. Benzathine Penicillin G 24 Lakhs IM in 2 equally divided doses + Inj. Ceftrioxone250 mg single dose IM OR
- Azitromycin 1 G single dose orally under supervision OR
- Ciprofloxacin 500 mg 2 times a day
- For persons sensitive to penicillin Doxycyclin 100 mg orally 2 times daily for 15 days
- During pregnancy: Erythromycin stearate 500 mg orally 4 times daily 15 days.

Complications: Cardiovascular and nervous symptoms may result if prompt treatment is not given.

URETHRAL DISCHARGE





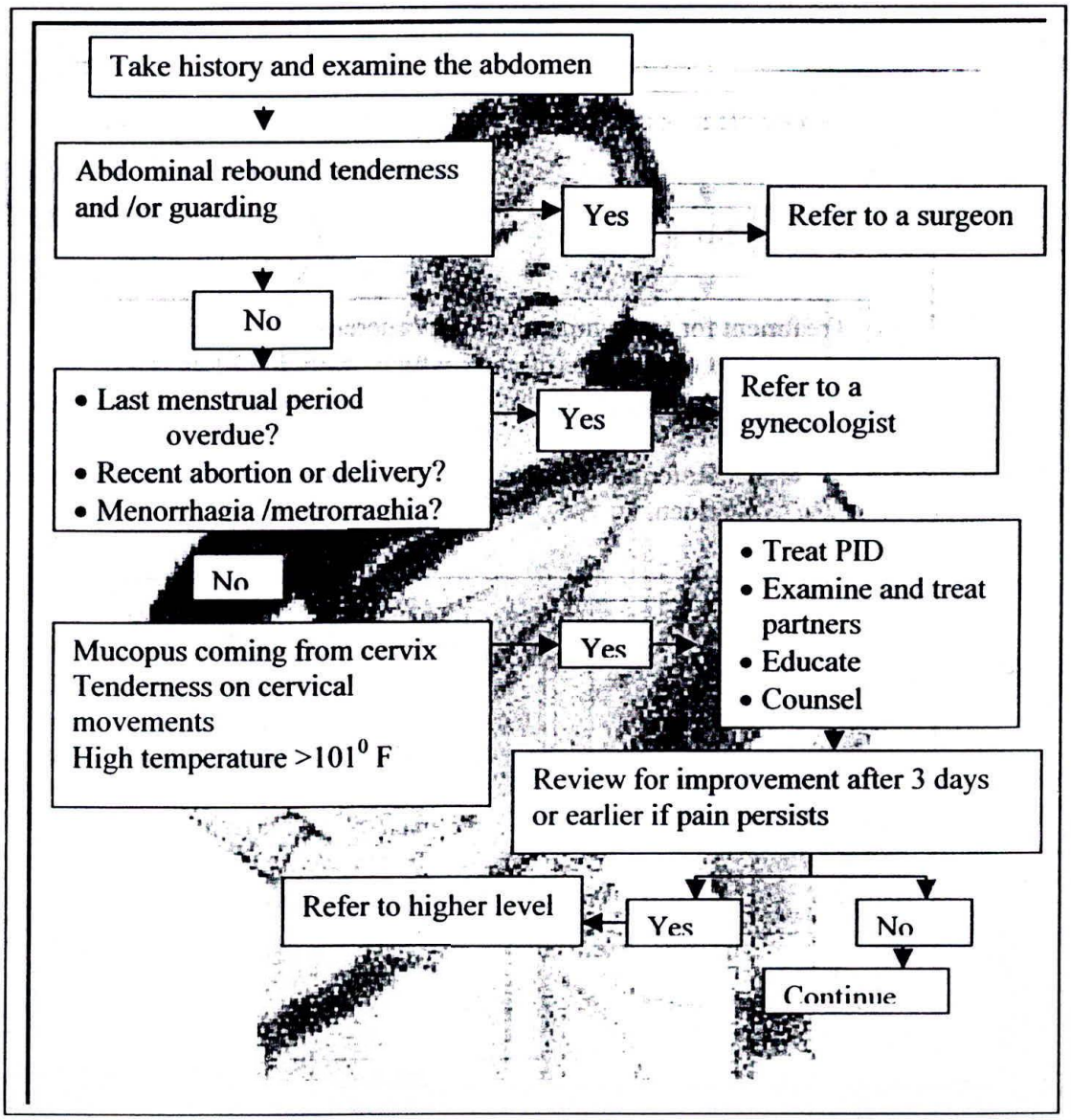
Urethral discharge

Treatment for Gonorrhoea and Chlamydial Infections:

- Azithromicin 2 G single dose OR
- Azithromicin 1 G single dose + Cefaxime 400 mg single dose OR
- Azithromicin 1 G single dose + Inj Ceftriaxone 250 mg IM single dose

Complication: Stricture of urethra may result if prompt and complete treatment is not given

LOWER ABDOMINAL PAIN



- Treat Gonorrhoea and Chlamydia infection (PID) as given for vaginal discharge
- Treat anaerobic infection with metronidazole 400 mg. Twice daily for two weeks
- Treatment for gonorrhoea: Cefixime 400 mg orally single dose OR Ceftriaxone 250 mg IM single dose
- Treament for Chlamydia: Doxycycline 100 mg 2 times daily for 14 days
- Woman must be well enough to take food and lots of liquids
- Refer if needed to VCTC
- Remove IUD, if present

INGUINAL BUBO (SWELLING)

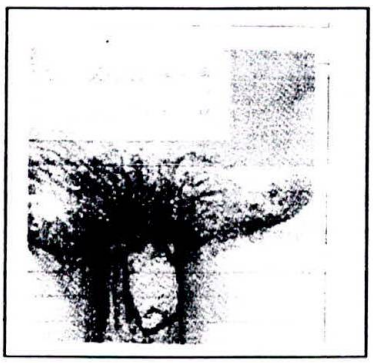
Take relevant history and examine

Genital ulcer –present? → Yes → Use genital ulcer – flow chart

No

Treatment for Lymphogranuloma Venereum (LGV)

- Doxycyline 100 mg orally twice daily for 14 days
- Alternative regimen: Erythromycin stearate 500mg orally for 14 days
- Refer to the doctor for aspiration every 2nd or 3rd day if fluctuant



- Educate on safe sex
- Counsel
- Advise to complete treatment
- Advise to return and refer to higher facility if does not respond to treatment
- Provide condoms and promote usage
- Refer to VCTC
- Treat partner

Chapter – III

HIV /AIDS – THE CHALLENGE WE FACE

Introduction

Persons infected with HIV may not show any signs of the disease immediately but could present with features any time later, perhaps as late as when they reach the stage of AIDS defining illness (or major opportunistic infection). A nurse thus would need to have a thorough knowledge about the virus causing HIV, modes of transmission, clinical manifestations and progression of the disease.

General objectives

At the end of this chapter, the participants will be able to understand the various aspects of HIV / AIDS, appreciate this knowledge and apply the information in their daily nursing practice

Specific objectives

At the end of this chapter the participants will

- Describe the meaning of HIV / AIDS
- List the modes of transmission of STI / STD / HIV
- Discuss the clinical spectrum of HIV/AIDS
- Be able to recognize the progression of HIV to AIDS in persons
- Describe the management of persons with HIV infection

Key concepts

- HIV is transmitted through the specific routes
- A person with HIV infection has a decreased capacity to fight organisms which normally reside in the human body
- The rate at which HIV infection progresses to AIDS could be increased with anti retro viral therapy and practice of safe behaviors

Teaching methods

- Lecture
- Group discussion
- Role play
- Reflective exercise

Materials/preparation required

- Chart paper and colour pens
- Black board, chalk, duster
- Transparencies of figures, tables, important content, OHP
- Plain A-4 size paper for group discussions
- Handouts copies
- Case study handouts for all participants

Topic outline

- Basics of HIV and AIDS
- Modes of transmission of STI / STD / HIV
- Clinical spectrum of HIV/AIDS
- Opportunistic infections
- Progression from HIV to AIDS
- Management of HIV

Total session time

1 hour

BACKGROUND MATERIAL

Basics of HIV and AIDS

Exercise 3.1

1. Ask the group to sit back and close their eyes, and then ask them to remember all what they heard about AIDS.
2. Ask them what is their understanding about the HIV / AIDS. Record responses on a larger paper/ black board for all to see (take only 2-3 minutes)
3. After which the facilitator explains the following content

Meaning of HIV and AIDS

HIV stands for Human Immunodeficiency Virus. It is called so because

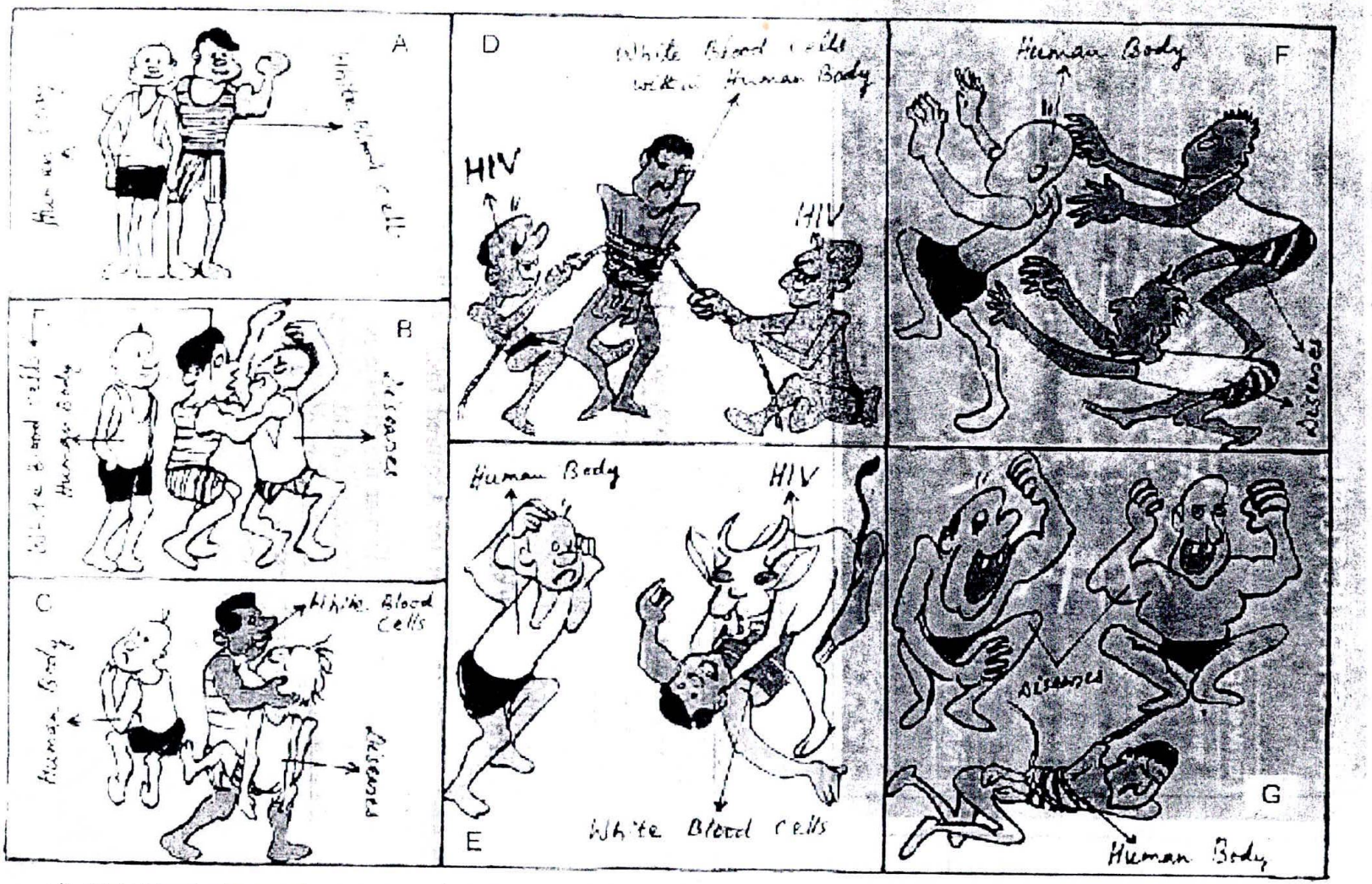
Human: Because HIV is found only in humans and can live only in human beings or on human cells.

Immunodeficiency Means that the capacity of the immune systems to respond and fight against infections is lost (see Figure I). The immune system is the system in our body that helps us fight against common infections. The HIV slowly destroys the body's defense system. It kills an important kind of blood cell, the CD4 T lymphocytes (T cells). Without these important defenses, person with AIDS cannot fight off germs and cancers. The HIV infected person therefore gets a number of common infections and disease.

Virus: Because it is a virus. HIV is a retrovirus. A retrovirus is a type of virus that is able to convert RNA into DNA (see Figure II for the structure of HIV).

- Single stranded RNA Virus
- Envelope protein has affinity for CD4 molecule on host cell membrane
- Mutates rapidly
- Killed by heat
- Two types of virus: Type I and II
- Both types are prevalent in India. Type I is more frequently reported
- HIV Type I is more virulent than Type II

HIV Type II is generally milder, slower to progress and poorly transmitted vertically (mother to child)



(A) White blood cells guard our body against diseases. (B) They fight germs that attack our body. (C) Serious illnesses make us sick during fight against germs, but finally white blood cells win. (D) If HIV enters our body, it will destroy white blood cells. (E) After white blood cells are attacked, our body loses all types of protection. (F) Without white blood cells diseases can attack our body. (G) Once HIV has weakened us any disease can take over our body.

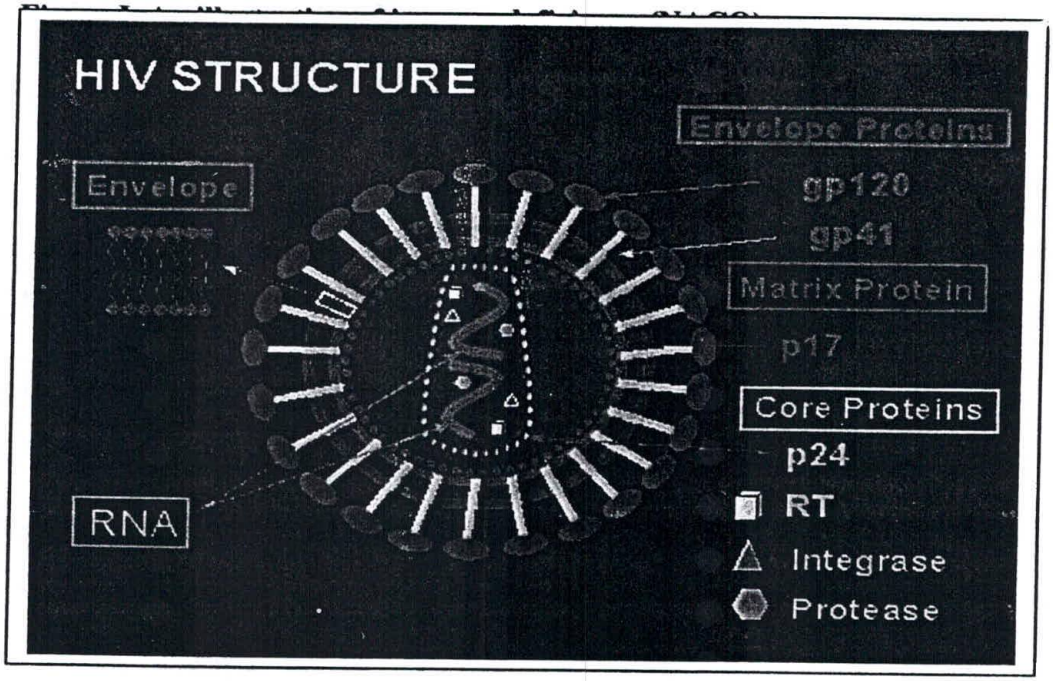


Figure 3.1 Structure of the human immunodeficiency virus.

HIV replication in the cell (see Figure 3.2)

- HIV infects predominantly t helper (CD4) Lymphocytes
- Virus gets attached to the CD4 receptor of CD4 T lymphocyte
- The reverse transcriptase uses viral RNA and synthesizes DNA (Double stranded proviral DNA)
- Viral DNA gets attached to the cell DNA (viral DNA takes control and hijacks the lymphocytes)
- ProRNA (New virus) is formed with the help of protease enzyme

AIDS is the short form for **A**cquired **I**mmune **D**eficiency **S**yndrome. It is called so because

Acquired: This means that the disease is 'got' and not 'caught'. HIV cannot be caught from the air like common old or cough. It spreads only by few specific routes.

Syndrome: means a collection of signs and symptoms. AIDS is a disease that presents with different kinds of signs and symptoms. The diseases that are caused because of the immunodeficiency are referred to as opportunistic infections (OI). When people with HIV get these infections or when their CD4 T cell levels become very low they have AIDS.

Incubation period

Following are some of the significant features regarding incubation period of HIV infection:

- It ranges from few months to many years
- HIV positive person can develop AIDS within 10 years usually. Median incubation period 5-8 years in adults while in infants and children 2-5 years

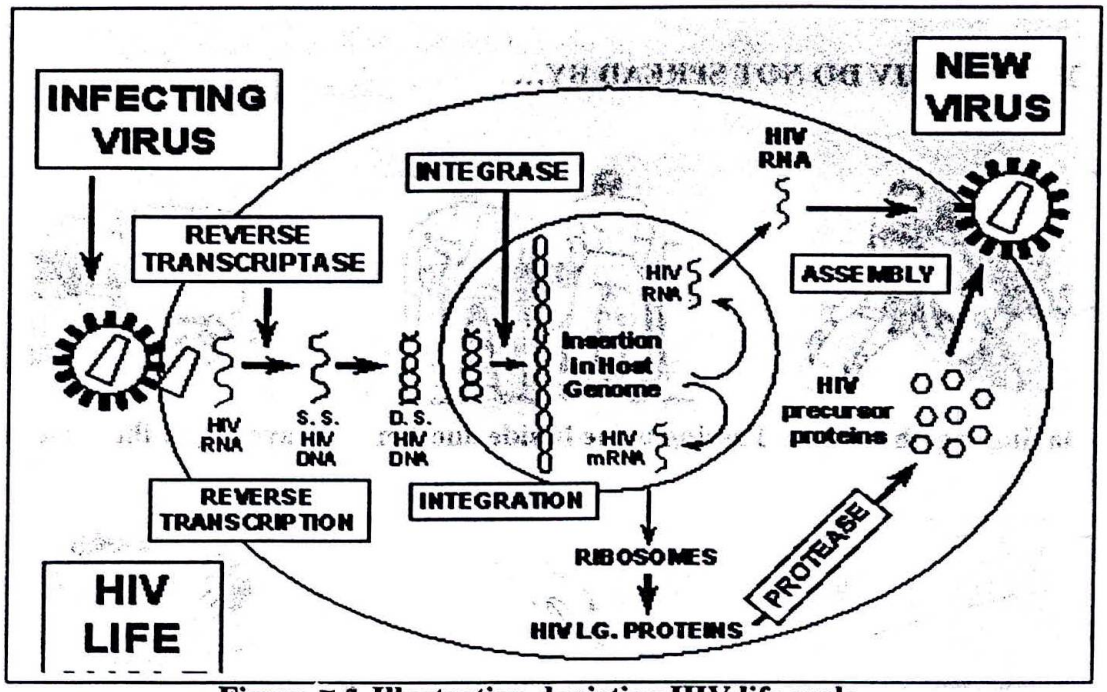


Figure 3.2 Illustration depicting HIV life cycle

Modes of transmission of STI / STD / HIV

Exercise 3.2

The purpose of this exercise is to make the participants not only aware of modes of transmission but to become comfortable to talk about the modes of transmission

1. Distribute one flash card to each participant. Ask them to look at the card and make sure that they have understood the meaning of the picture. If in doubt tell them to look behind the picture for the meaning of the picture

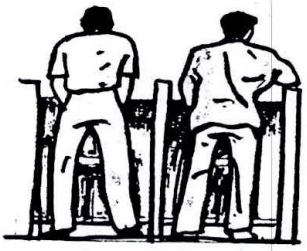
Flash card illustrations include

Anal sex / Blood transfusion / Bathing in the same pond/lake / Breast-feeding / Coughing / Giving birth / Drinking from the same cup or glass / Holding hands / Hugging / Kissing / Mosquito biting a person / Oral Sex / Per vaginal examination / Playing with others / Sharing clothes, combs etc. / Sharing needles or syringes Swimming in the same pool / Using same toilets / Using condoms / Vaginal intercourse

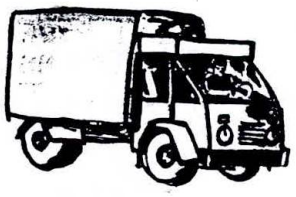
2. Then ask them to decide whether or not STI /STD / HIV could be transmitted or not transmitted through the route depicted in the picture.
3. Divide the black board equally and have the words written as: ***" STI /STD/HIV could spread through this" / "STI/ STD / HIV could not spread".*** Place two chairs under each heading
4. Call out for each participant with the card one by one and ask each of them to place the given card in the chair under the proper heading after showing the card to all participants and telling them aloud what she / he thinks the picture depicts. Ask them to confirm with the rest of the participants whether or not their answer is right.
5. If there is a controversy among the participants about the answer ask the said participant to place the card on the floor in between both chairs.
6. Then have the participants read the Handout 3.1 as well as see the pictures given in the book and to correct mistakes that are written in the board
7. Clarify any picture that participants have doubts about (those pictures which are placed on the floor)

STI / STD / HIV DO NOT SPREAD BY...

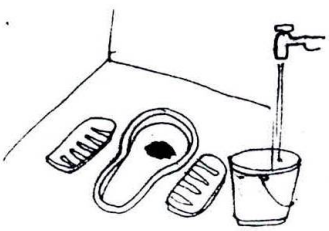
Playing together



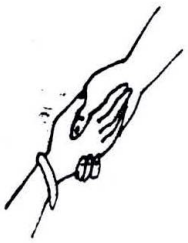
Passing urine beside another



Traveling in the same vehicle



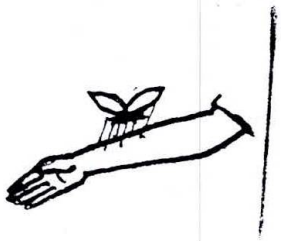
Sharing the same toilet



Holding hands

Hugging and kissing.

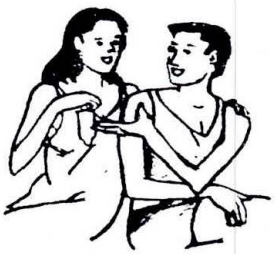
Coughing



Mosquito bite

Bathing in the same pond

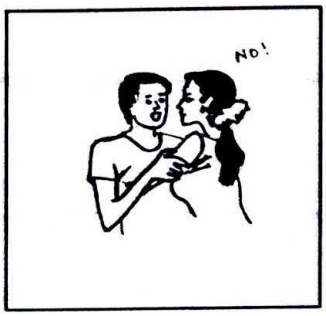
Sharing the same glass



Using a condom

Talking to each other

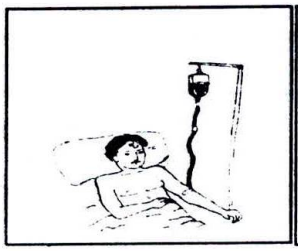
STI / STD / HIV SPREAD BY.....



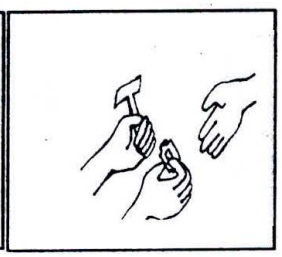
Unprotected sex...

Multiple sex partners...

From an infected mother ...

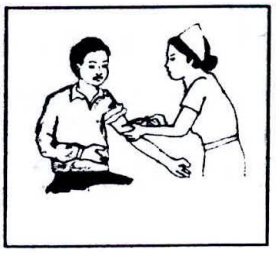


Infected blood



Sharing shaving blades

Sharing needles



Occupational exposure

Handout 3.1. Modes of transmission of STI / STD / HIV infection

1. **Sexual route:**
   From infected person to his or her sexual partner (anal, oral or vaginal sex)
   - man to woman
   - woman to man
   - man to man
   - rarely woman to woman

2. **Intravenous route:**
   - By sharing needles and syringes when injecting drugs
   - By blood transfusion which may be from an infected donor

3. **Occupational exposure**

4. **Traditional customs and practices**
   - Through **scarification with unsterilised needles or blades** as part of traditional customs or circumcision
   - Sharing blades for shaving

5. **From parent to child transmission**
   - From infected mother to child during pregnancy, delivery or breast feeding

Exercise3.3

The purpose of this exercise is to help participants recall from experience what the signs and symptoms of a person with HIV could be.

1. **Divide the participants into smaller groups of 4-6members each.**
2. **The participants in each group would have to discuss about the clinical picture of people infected with HIV either from the experience of taking care of the patient or from prior knowledge for 5 minutes**
3. **They must be instructed to compile the information and present to the whole group**
4. **The facilitator could then present the following information on how an adult and a child present with HIV and then could ask the participants to read Handout 3.2 in their module.**

Clinical spectrum of HIV/AIDS

An adult person infected with HIV could present with

- Positive test for HIV infection
- Any one of the following five criteria
  - Weight loss ≥10 per cent of body weight or cachexia (not known to be due to a condition other than HIV infection) and/or chronic diarrheas for more than one month (intermittent or constant) and/or prolonged fever for more than one month (intermittent or constant)
  - Tuberculosis: disseminated, miliary or extra-pulmonary
  - Kaposi's sarcomas
  - Neurologic impairment preventing independent daily activities, not known to be due to a condition unrelated to HIV infection (e.g. trauma).
  - Candidiasis of the esophagus (diagnosable with dysphagia and oral candidiasis)

Clinical presentation of children with HIV

Pediatric AIDS is suspected in an infant or child presenting with at least two major signs and two minor signs in the absence of known causes of immunosupression.

Major signs

- Weight loss abnormally slow growth (failure to thrive)
- Chronic diarrhea for more than one month
- Prolonged fever for more than one month

Minor signs

- Generalized lymphadenopathy
- Orpharyngeal candidiasis
- Repeated common infections (Otitis, pharyngitis, ARI and so on)
- Persistent cough for more than one month
- Generalized dermatitis
- Confirmed maternal HIV infection

Handout 3.2 Systemic manifestations when a person has HIV infection

SYSTEMS	MANIFESTATIONS
• GASTROINTESTINAL	- Diarrhea - Dysphagia - Perianal discomfort
• RESPIRATORY	- Cough - Cyanosis - Dyspnoea - Pleural effusion - Tachypnea
• NEUROLOGICAL	- Head ache - Personality changes - Lethargy - Dementia - Ataxia - Convulsions - Meningitis - Neuropathy - Visual impairment

Opportunistic infections

There are many microorganisms that commonly inhabit the body without causing any illness, but when the immune system is depressed, they can cause serious problems like oral candidiasis. These are called opportunistic infection. Pneumocystis Carinii found in lungs can cause pneumonia in immunodeficiency. The tubercle bacilli are reactivated when the immune system is depressed causing pulmonary tuberculosis in AIDS.

Exercise 3.4

The purpose of this exercise is to help participants gain confidence about their ability to identify the problems a person with HIV could present with and their ability to do a thorough assessment through history collection

1. Make one copy of the case study to distribute to each group. Divide the participants into 4 smaller groups. And give them some blank paper to write their responses
2. Each group is given one case study and they are instructed to discuss in 5 minutes the possible causes for the persons described in the case study to be presenting with the specified features
3. The group must also present to the rest of the participants what additional history they would collect from the person in the concerned case study
4. After the groups present the facilitator could supplement any information that was missed out. Following this the facilitator could present the symptoms of opportunistic infections in persons with AIDS and the list of opportunistic infections

Case Studies for Exercise 3.4

Case study I

- A woman has had progressive weight loss for six months. She is weak and needs rest when she walks to the PHC. She has a poor appetite and had diarrhea for the past four months. She comes from a village where there is a history of frequent episodes of gastroenteritis. She has had no fever, no enlargement of lymph nodes, nor any history of cough but is seen to have white patches in her tongue.

Case study II

- A woman comes to the PHC with a history of cough for the past two months, shortness of breath on walking, fever in the evenings for the last two months. She has a good appetite but is always tired. She has a history of several sexual partners for the past four years.

Case study III

- A man has a dry cough, is breathless on walking and feels tired by the afternoon. He presents to the PHC with a history of weight loss of 4 kilograms in the last month and notices that his memory has reduced considerably. You also notice that his speech is also slow and when you ask him he tells you that he has noticed a change in the way he speaks as well. He gave a history of having sex with both men and women.

Case study IV

- A woman brings her two-year-old child to the PHC because he is lethargic and weak. She also gives a history of poor appetite in the child, diarrhea and fever for the past one month. She says that he has been treated several times for hemophilia in a near by hospital and is worried that something else is wrong with the child.

Possible answers to case studies in Exercise 3.4

Case study I

- The woman may be having a intestinal parasites
- Do a thorough physical examination to rule out other possible causes
- Collect relevant history including spouse / partners history in the light of association of the symptoms to a HIV infection
- Treat for intestinal parasites and if her condition remains the same or worsens suspicion of HIV infection becomes stronger
- Refer for counseling and blood test to a VCTC

Case study II

- The woman could have tuberculosis
- Ask for a chest X-ray and sputum for AFB to be done
- History is suggestive of her likelihood for HIV infection
- Refer for further investigations

Case study III

- All signs and symptoms of the man are more or less suggestive of HIV infection
- He may also have a tuberculosis, hence rule this out as well
- Refer for further investigations to confirm the diagnosis

Case study IV

- Get a detailed history from the mother to rule out the possibility of recurrent enteritis
- Get a detailed history of possible risk factors in the child as well in the mother which could point to the possibility of HIV infection
- Refer the child for further investigations if the history collected is suggestive of a possible HIV infection

Symptoms of opportunistic infections common in persons with AIDS

- Coughing and shortness of breath
- Seizures and lack of coordination
- Difficult or painful swallowing
- Mental symptoms such as confusion and forgetfulness
- Severe and persistent diarrhea
- Fever
- Vision loss
- Nausea, abdominal cramps and vomiting
- Weight loss and extreme fatigue
- Coma

Opportunistic Infections related to HIV Infections

- Pneumonia caused by
  - Mycobacterium tuberculosis
  - Pneumocystis carinii
  - Cytomegalovirus
  - Atypical Mycobacterium
  - Lymphoid interstitial pneumonitis
- Oral and /or esophageal candidiasis
- Kaposis sarcoma
- Recurrent bacterial and viral infections
- Herpes zoster infections
- Generalized lymphadenopathy
- Herpes simplex infections
- Neurological impairment
- Wasting disease
- Gastro intestinal infections
- Neurological infections
- Lymphoma
- Cytomegalo virus infection

NB: The above is only a selected list of opportunistic conditions

Progression of HIV to AIDS

Factors influencing progression of AIDS include

- Type and subtype of HIV
- General health
- Access to good nutrition
- Access to medicines to treat opportunistic infections
- Access to medicines which help to control the spread of HIV in the body

Frequently asked question by people affected with HIV .....

Does this mean that I have AIDS even though I feel quite healthy?

The most appropriate response would be

No, it does not mean that you have AIDS right now. The Human Immuno Deficiency Virus (HIV) kills cell that defend our body against diseases. Gradually the body finds it difficult to fight germs, which do not normally affect people with good immune systems. Only then a person develops AIDS.

Then ask the participants a question to determine if they know the difference between HIV and AIDS

'What is the difference between HIV and AIDS?

Stage I: Acute primary infection (seroconversion)

- Usually asymptomatic
- Incubation period (2-6 weeks up to 36 weeks)
- Acute viral syndrome experienced by 50 % of persons
- Symptoms may be mild and disappear. This self limiting condition is called seroconversion illness
- Within 6-12 weeks after infection it is possible to detect HIV antibodies I the blood
- Common signs and symptoms include
  - Fever / rash / joint pain / swollen lymph node enlargement / diarrhea / sore throat
- Few may develop (10-20%)
  - Headache / Meningo-encephalitis / Peripheral neuropathies / Myelopathy / Bells palsy / Guillain Barre syndrome / Oropharyngeal candidiasis

Stage II: Early asymptomatic disease (CD_4 count > 500/mm^3)

- Longest period (5-7 years) when the person is asymptomatic
- Virus continues to replicate leading to progressive damage to the immune and nervous system
- Common signs and symptoms
  - seborrhoeic dermatitis / pruritis / cellulites / Herpes zoster infection / Persistent generalized lymphadenopathy (PGL) / Lab reports show leucopoenia and thrombocytopenia

Stage III: Intermediate HIV infection (CD_4 count 200- 500/ mm^3)

- Early symptoms of the illness
- Signs and symptoms (called AIDS related complex –ARC)
  - Oral thrush / diarrhea / weight loss / low grade intermittent fever, night sweats / skin rashes / loss of energy / fungal infection (Tinea infection) / herpes zoster infection / oropharyngeal or vaginal candidiasis / mycobacterium tuberculosis

Stage IV: Late stage HIV disease (CD_4 count 50- 200/ mm^3)

- Signs and symptoms are related to aids defining opportunistic infection or malignancy
- Common opportunistic infections include
  - Pneumocystis Carinii pnuemonia / cerebral toxoplasmosis / diarrheal disorders / pulmonary or disseminated tuberculosis / severe oropharyngeal candidiasis / cryptococcal meningitis
- Opportunistic cancers include
  - Kaposis sarcoma / undifferentiated B-cell lymphomas

Stage V: Advanced HIV disease (CD_4 count < 50/ mm^3)

- Even with therapy the persons in this stage have a likelihood of dying in 2 years
- Other manifestations in this period include

- Neurological effects that present as motor abnormalities, cognitive impairment, and behavior changes / significant weight loss / wasting of muscles / various types of malabsorption / HIV wasting syndrome

Management of HIV infection

i. History

ii. Physical assessment

iii. Laboratory investigations

- HIV test (See chapter IX)
- Immune functions: CD4, CD8 cell counts, CD4/CD8 ratio
- Plasma viral loads (where-ever possible)
- Full blood counts, liver and renal functions tests
- Mantoux test
- X-ray chest
- Co-infections: Tests for Syphilis, Gonorrhea, Hepatitis A, B & C, Toxoplasma, E-B virus, Pap smear for women

Various hematological, renal, cardiac, endocrinal, reproductive and other manifestations have also been reported and must be kept in mind.

iv. Medical management

The nurse dealing with HIV/AIDS affected individuals need to be aware of the medical management of HIV/AIDS. Antiretroviral drugs suppress the viral replication by inhibiting either reverse transcriptase or protease. The other aspect of therapy includes prompt treatment of opportunistic infections.

Aims of therapy

- Prolonging life and improved quality of life.
- Reduction of viral replication as much as possible for as long as possible to halt disease progression and to prevent and reduce resistant variants
- To achieve immune reconstitution and thus to prevent opportunistic infections and malignancies
- To achieve reduction in HIV transmission

Anti retro viral drugs All the currently licensed anti-retroviral drugs, namely AZT, ZDV, Stavudine, etc.

- Have effects that last only for a limited duration
- Are very expensive
- Have severe adverse reactions

In addition the virus tends to develop resistance rather quickly if the person is not compliant with medication or takes single-drug therapy. The emphasis is now on giving a combination of drugs including newer drugs called protease inhibitors; but this makes treatment even more expensive. These drugs if however are taken optimally could result

in undetectable viral loads, increase in CD4 counts, clinical improvement and decrease in mortality. No one regimen has shown superiority over others. Therefore the choice of the initial regimen is based on tolerability, potential for adverse drug reactions, drug interactions and cost.

WHO's present policy does not recommend antiviral drugs but instead advocates strengthening of clinical management for HIV- associated opportunistic infections such as tuberculosis and diarrhea. Better care programs have been shown to prolong survival and improve the quality of life of people living with HIV/AIDS.

When to start?

Guidelines for when to start anti-retroviral treatment may vary with country to country and depend on a lot of factors. In India presently according to NACO the guidelines that are followed are as shown below:

- Positive HIV test
- CD 4 count < 200
- Total lymphocyte cell count < 1200
- History of chronic diarrhea > 1 month
- Any other major sign

Regimens

The most commonly recommended treatment regimen in India as per NACO includes:

- Start Nevirapine 200 mg. twice a day for 14 days. It is important that the person is hospitalized during this period in order to monitor and manage effectively any side effects of the drug. The person must have been counseled adequately on the need for adherence to the regimen for life since this could reduce resistance
- Then if the person tolerates the medication on the 15th day onwards this regimen is followed (2 NRTI + 1 NNRTI):

Combination drug (Trade name- Virolans) *Single drug given twice in a day*	**Dosage according to body weight**	
	< 60 Kilograms	**> 60 Kilograms**
• Nevirapine (NNRTI) • Lamivudine (NRTI) • Stavudine (NRTI)	• 200 mg. • 150 mg. • 30 mg.	• 200 mg. • 150 mg. • 40 mg.

Other important points if this regimen is followed includes

- Counseling the person on the need for adherence to the drug
- On the 15th day PLHA will be given tablets for 30 days, but will be asked to return on the 28th day. He / She should show the drug strip indicating the number of tablets taken plus additional two drugs remaining for the next two days.
- Following which the person is again given drugs for the next 30 days.

- CD-4 count should be checked after 3 months of starting therapy. Good response is indicated by an increase in CD-4 count.
- All PLHAs must be necessarily treated with Tab. Albendazole

- Zidovudine is also available as a combination drug (see below) twice a day after administration of nevirapine alone for 14 days. But it is not given to persons with a hemoglobin level of less than 6 Gms, since it causes severe anemia. Hence if the PLHA has anemia this is usually contraindicated
  - Nevirapine 200 mg.
  - Lamivudine 150 mg.
  - Zidovudine 300 mg.

Caution

- Avoid mono therapy or dual therapy **(EXCEPT for PMTCT AND PEP)**
- Adherence to therapy for life is important and needs to be emphasized to the PLHA
- Watch for resistance for drugs
- Treat side effects of the drugs promptly. Common side effects include: nausea, vomiting, skin rashes, myalgia, diarrhea and headache. Persons may normally succumb to the side effects
- Keep in mind ART is expensive and needs to be given life long. It is not the cure but only prolongs life
- Hence sometimes better to treat OIs than to recommend ARTs since this is a good means to prolong the life of the person

Chapter -IV

PREVENTION OF STD / HIV / AIDS

Introduction

Emphasis is placed on the **ABC** approach to AIDS prevention. **A** – ***Abstinence*** translates to efforts to delay sexual initiation among young people; **B** - ***Be faithful*** focuses on remaining faithful after marriage; and **C** - ***Condom use*** promotes safer sex practices and condom use among people who are sexually active. The ABC approach is widely accepted as a model to approach adolescents and young adults where HIV infection has been spreading most rapidly, as the approach is not only flexible but also comprehensive. In this module the approach used is referred to as the SCAAB-P way to mean

- Safe sex
- Condom promotion
- Avoid substance abuse
- Adapt traditional customs safely
- Blood management and handling of body fluids done safely
- Prevention of mother to child transmission

Brief descriptions of these methods are given in this chapter to help the nurse become more competent in educating the public on these issues.

General objective

At the end of this session the participants will be able to understand the prevention of HIV transmission and will use this knowledge in educating persons and the community on preventive aspects.

Specific objectives

- Be sensitized to the methods of preventing of HIV transmission
- Identify areas of health education for the public on prevention of HIV transmission
- Participate in awareness programs on safe sex, substance use, blood transfusion and traditional customs to sensitize the public on prevention of HIV transmission

Key concepts

- HIV could be prevented by adopting safe sex
- There is a link between substance use and HIV transmission
- Safe blood transfusion is needed
- Traditional practices could be made more safer

Teaching methods

- Lecture
- Small and large group discussion
- Reflective exercises
- Role play
- Case study

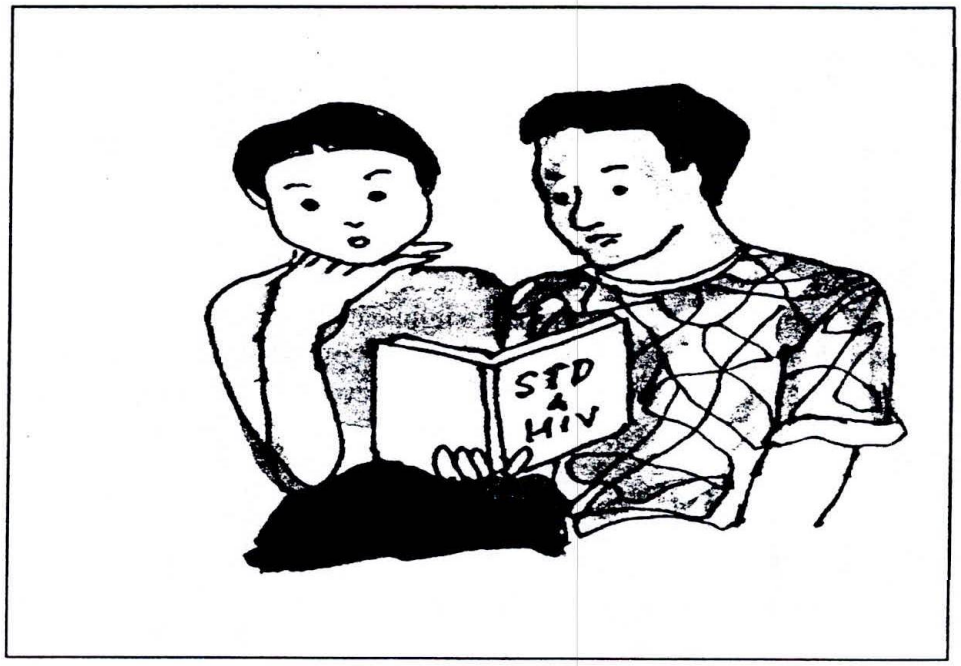
Material /preparation required

- Black board, chalk, duster
- Chart paper, colour pens
- Transparencies of figures or pictures and OHP
- Handout copies

Topic outline

- Safe sex
- Condom promotion
- Avoid substance abuse
- Adapt traditional customs safely
- Blood management and handling of body fluids done safely
- Prevent transmission of infection from parent to child

Total session time: 3 hours



BACKGROUND INFORMATION

Prevention of STI / STD/ HIV – SCAAB-P

Exercise 4.1

The purpose of this exercise is to help the facilitator gain an insight as to what the participants already know about prevention of HIV. The facilitator, when covering the contents of this chapter could also use it subsequently.

1. The facilitator divides the participants into two groups
2. Asks the participants of group I and group II to enact the respective situations

Group I

- ***The nurse visiting the community found people are afraid of drinking water from a well situated near the house of a person who died of AIDS. She plans for a health education to the people in that locality regarding the ways of transmission and prevention of AIDS.***

Group II

- ***As a nurse you have to talk to a group of college going youths regarding how to prevent HIV infection***

3. One of the participants from the first group could enact the role of a nurse and 4 other participants would enact as the local people in the first situation while for the second situation one of the participants from the second group could enact the role of a nurse and 4 other participants would enact as youths
4. Each group is given 5 minutes to prepare themselves and 5 minutes to perform. Any five participants could volunteer from each of the group to enact the two situations
5. The rest of participants are instructed to observe carefully the interaction between the nurse and the local people or the nurse and the youth and also to make note of the points they learnt from the exercise.
6. Following the role play the facilitator discusses on prevention of HIV infection under these headings:
    - Safe sex
    - Condom promotion
    - Avoiding substance abuse
    - Adapting traditional customs safely
    - Blood management and handling of body fluids done safely
    - Prevention of mother to child transmission

1. Safe sex

- Avoid premarital sex
- Practice monogamy (having only one partner or being faithful to your partner)
- Practice abstinence if possible
- Use condoms during sex with partners
- If you know that you are uninfected and are already sexually active, have sex only with a mutually faithful partner who is also known to be uninfected
- Engage in non – penetrating sex if infected (such as hugging, kissing, petting etc. In simple terms not having sexual intercourse)
- Avoid sex when intoxicated or under the influence of drugs

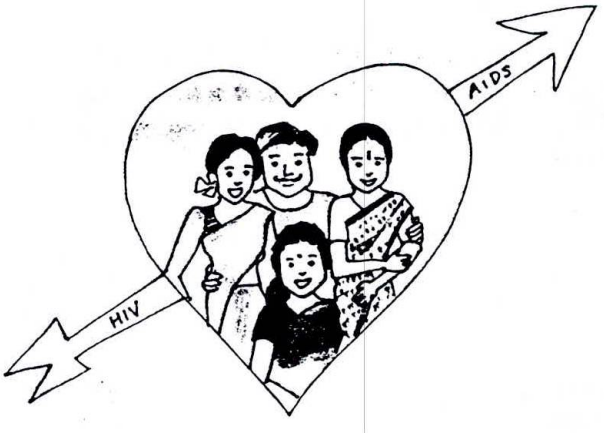


Figure 4.1. Practicing safe sex.... monogamy

Remember that...

- The most common way people get HIV is by **having sex with an infected** person. In India, more than 85% of reported HIV cases have got the infection through the sexual route
- **Safe sex** means that no vaginal fluid, semen, or blood enters the partner's body

2. Condom promotion

Condom promotion is perhaps the most significant preventive measure for STI / STD / HIV/AIDS. Behavioral change in a person who is at a high risk of acquiring STI/HIV/AIDS towards practice of safer sex is the basic prevention strategy, the other strategies being abstaining from sex and sex between mutually faithful partners.

Role of nurse in condom promotion

- To motivate persons to accept and adopt preventive behavior
- To promote the use of condoms as a part of treatment
- Demonstrating condom use to the patient

What is a condom?

Condom is a rubber sheath (latex) and is used on an erect penis. The semen after ejaculation is collected at the tip of the condom and prevents the exchange of semen and vaginal fluids during a vaginal/oral/anal intercourse.

Use of condoms

- Prevent unwanted pregnancies and
- Protect from diseases such as STI /STD and thus HIV infection

Remember...

- Condoms must be used consistently and correctly to provide maximum protection
- Condom users have product options (can choose from a variety of condoms)
- Education about condom efficacy does not promote sexual activity
- Prevention is cost-effective

Efficiency of condoms

Numerous studies among sexually active people have demonstrated that a properly used latex condom provides a high degree of protection against a variety of STI /STD, including HIV infection. The degree of protection that proper use of latex condoms provides against HIV transmission is most evident from studies of couples in which one member is infected with HIV and the other is not.

Nirodh is of good quality even though the packet does not look attractive

When should one use condoms?

- When spouse is pregnant
- When partners feel that one of them would have an RTI / STI / STD infection
- When one partner has other sexual partners
- When having casual sexual intercourse
- When partner is hired

Exercise 4.2

1. The facilitator calls for one or two volunteers to demonstrate correct condom usage on the model of the penis
2. After that the facilitator will demonstrate the steps of correct condom usage as given below
3. Following this the participants can be divided into small groups of 5-6 members and each member is asked to demonstrate the correct usage of condom or if there are sufficient models available the participants could be divided into pairs and then asked to demonstrate the same. They must be supervised by facilitators
4. The activity must not take more than 20 minutes.
5. Highlight to participants about how could one ascertain the expiry date if the person is illiterate or when in the dark. Participants could be asked to practice the same when they are free during the training program

Correct condom usage (see Figure II)

- Check the expiry date for condoms
  - Emphasize that if sex is taking place in the dark or if the person is illiterate then it is important to check for the movement of the condom within the packet. If it moves freely it indicates that it is within the expiry date and safe to use. ***Condoms that appear to be stiff within the pack or not moving freely may be beyond the expiry date.***
- Open the pack carefully without damaging the condom
  - Emphasize that if sex is taking place in the dark or if the person is illiterate then it is important to push the condom to one side and tear the packet from the side that is empty to avoid damage of the condom
- Wear the condom only after penis becomes fully erect
- Press the tip of the condom (to expel any air, since if air is trapped at the tip it would be most likely that the condom could tear during ejaculation) and fix it on the erect penis
- Hold the tip of the condom and slowly unroll it to full length so that the penis is completely covered
- Ensure that the condom is in position before commencement of sexual intercourse
- After ejaculation hold the bottom of the condom while withdrawing the penis after the act.
- Slip out the condom carefully without spilling the semen and tie a knot at the open end to avoid spilling of the semen
- Dispose the condom into a garbage bin.

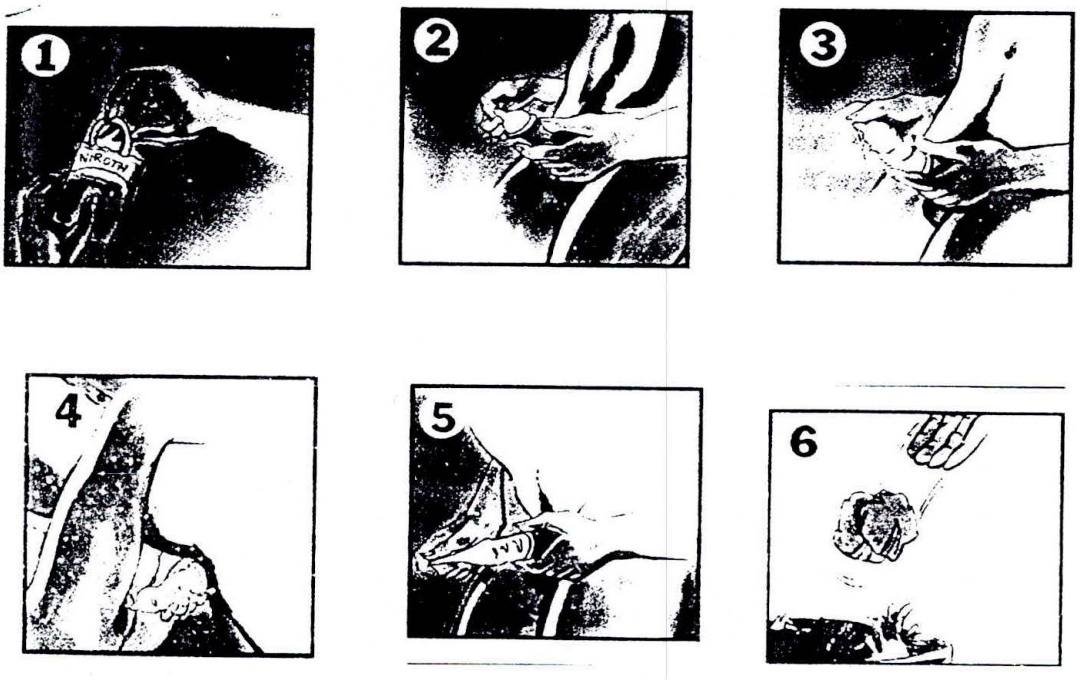


Figure 4.2: Proper usage of the condom (diagram)

Female condoms

The Department of Family Welfare had launched the country's first women controlled contraceptive that also offers protection against sexually transmitted infections and HIV / AIDS. Presently the cost of the condom is Rs. 45/- but it is likely to come down with subsequent increase in use. Hindusthan Latex will distribute it. The brand name of the female condom is Femidome.

Other characteristics of the condom are

- It is made of polyurethane
- It is soft, thin, odorless and strong
- It is 17 cms. Long with flexible rings
- It can be worn up to 8 hours before sex and need not be removed immediately after sexual act
- It must be used only once and then discarded

Using a female condom (See Figure III)

1. **Open end (Outer Ring)**: The open end covers the area around the opening of the vagina. The inner ring is used for insertion, and to help hold the sheath in place.

2. **How to hold the sheath:** a. Hold inner ring between thumb and middle finger. Put index finger on pouch between other two fingers, (or) b. Just squeeze.

3. **How to insert the condom**: Squeeze the inner ring. Insert the sheath as far as it will go. It's in the right place when you can't feel it. Don't worry--it can't go too far, and IT WON'T HURT!

4. **Make sure placement is correct**: Make sure the sheath is not twisted. The outer ring should be outside the vagina.

5. **Removal**: Remove before standing up. Squeeze and twist the outer ring. Pull out gently. Dispose in the dustbin, not in toilet.

Remove and insert a new female condom if:

- ***The female condom*** rips or tears during insertion or use
- The outer ring is pushed inside
- The penis enters outside the pouch
- ***The female condom*** bunches inside the vagina
- You have sex again

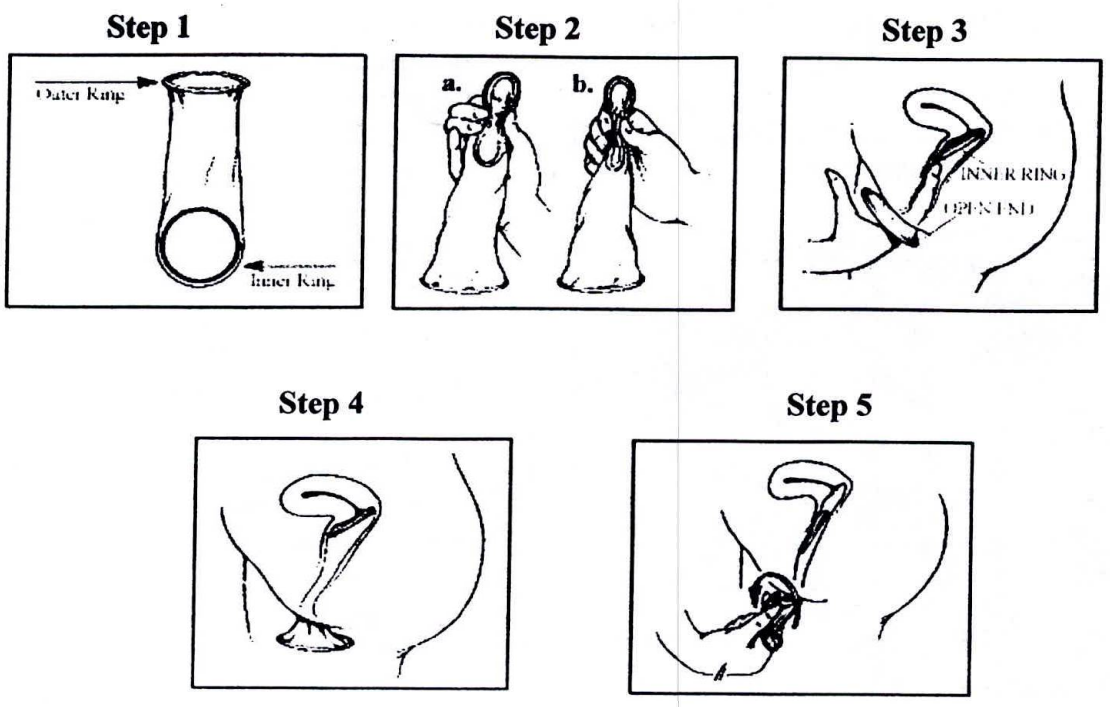


Figure 4.3: Steps to be kept in mind when using the female condom

Use more lubricant if:

- The penis does not move freely in and out
- The outer ring is pushed inside
- You feel ***the female condom*** when it is in place
- The ***female condom*** comes out of the vagina when in use
- There is noise during sex

Why don't people use condom?

Exercise 4.3

1. The facilitator conducts a brain storming session by asking the participants to respond to the question 'Why don't people use condoms?'
2. One volunteer from the participants is asked to write the responses on one half of the black board
3. Then the participants are asked to give ways by which they feel these problems can be overcome
4. Another volunteer is asked to write these responses on the black board
5. The facilitator first mentions any points that have not been mentioned and then draws the attention of the participants to Handout 4.1

People may not use condoms because

- Sometimes they may not be available or accessible
- They may have fear of being looked upon as persons indulging in high risk behavior

- Lack of knowledge on correct use of condoms
- Myths and misconceptions

Handout 4.1 Myths / misconceptions about use of condoms

Myths / Misconceptions	Reason	How to overcome
Using condom during sex is irritating	- Inadequate foreplay leads to lack of lubrication in the vaginal passage - This could also happen with an old condom	- Adequate foreplay before penetration - To use a quality condom within its expiry date
Condom will tear during intercourse	- Condom may burst if the air is not expelled from the tip of the condom - This may also happen when the condom in use is an old one after its expiry date.	- Hold the tip of the condom before rolling it over the erect penis to expel the air in it. - Ask the patient to check the expiry date, packing condition. Address the wrong belief and demonstrate condom use.
Condom is sticky and oily	- Sexual intercourse also is sticky due to the semen and vaginal fluids. - Presence of lubricant	- Educate how lubrication helps to avoid genital trauma and also makes it pleasurable.
Condom reduces sexual pleasure	- Lack of practice of using condom - It has to be used at a very sensitive moment	- Educate and demonstrate (it is simple and easy to use) - Educate to introduce condom at the right time. - Sexual pleasure is not just limited to penetrative pleasure and therefore condom use cannot reduce other types of sexual pleasure.
Women do not like condom	- It is an excuse by men	- Women would like it because it would make them feel that the man cares enough to protect them from diseases and also because it enhances duration of penetrative sex
Erection goes before using condom	- Ignorance in using condom	- Educate with practical tips - Demonstrate how to use these tips effectively

Frequently asked questions about condoms

Are Indian condoms inferior?

India is one among the leading condom manufacturing countries. Indian manufactured condoms are at par with International quality. Indian condoms are exported to nearly 150 countries including USA.

Who are the condom manufacturers in India? Which are the popular brands?

The major Indian condom manufacturers are Hindustan Latex Limited, TTK LIG, JK Ansell, etc. Hindustan Latex manufactures Moods, Moods Supreme and Ustad, while TTK-LIG's famous brands are Kohinoor, Durex and Fiesta. JK Ansell manufactures Kama Sutra, Midnight Cowboy and Sajan.

Do Indian condoms go through quality tests?

Condom passes vigorous testing for burst volume, lubrication quantity & packaging to ensure quality. Condoms manufactured by different companies are procured by Government and distributed free of cost under the brand name Nirodh. These free distributed condoms are on par in quality with other commercially sold condoms.

How many condoms are there in a pack?

Condom is available as packs ranging from 3-6, 10-15 and even as many 20 pieces; now single piece condom packets are also available.

Where are commercial condoms are available?

Condoms are available in all medical shops, grocery shops, provision shops and even petty shops as well as petrol bunks. They are also available in every PHC, dispensaries, government hospitals, and NGO working for the control of STI / STD / HIV.

Where are free condoms are available?

Condoms are freely distributed by all Government hospitals, Primary Health Centers (PHCs), dispensaries and NGOs working for STI/ STD / HIV control.

What is the price of the condom?

Varieties of priced condoms are available in the market & their prices vary accordingly. It ranges from approximately Rs.0.40 to Rs.6/- per piece.

3. Avoiding substance abuse

The patterns of substance use in any society can have an influence on HIV transmission because of

- Practices connected with the administration of the substance
- Effect the substance can have on perception, judgment and behavior of the person
- The risk of the person indulging in unsafe sexual behavior due to the altered perception and judgment

Exercise 4.4 (Optional)

The purpose of this exercise is to help participants recognize what routes of substance administration could be most risky for STD / HIV transmission

1. The facilitator will write down the following methods of substance administration on six large pieces of paper
    - Ingestion / Sucking or chewing / Inhalation / Sniffing / Intravenous injection / Other modes of ingestion
2. The facilitator will stick the six sheets of paper on the wall, some distance apart.
3. Then a substance name is called out (E.g. tobacco) from the list of substances given below and one of the participants will be asked to write the name of the substance under any of the headings to indicate the way in which the substance could be taken by people. Alternatively the following substances could be written, one on each chit of paper. Participants could be randomly given one chit and then asked to come forward and write the name of the substance under the appropriate route/s of administration
    - Tobacco / Ganja / Marijuana / Opium / Pethidine / Morphine / Phenobarbital / Cannabis / Brown sugar / Caffeine / Cocaine / Heroin
4. The facilitator must be able to draw the attention of the participants to the methods of substance abuse that is most risky for HIV transmission. (See note given below)

Note:

- **Intravenous drug abuse is highly associated with HIV transmission**
- **All other routes viz. intramuscular, intradermal and subcutaneous could also aid in transmission of HIV infection**
- **All other routes viz. ingestion, sucking, chewing, sniffing, inhalation could be safe with regard to HIV transmission but remember it could alter the perception, judgment and behavior of the person which may predispose to unsafe sexual practices**

4. Adapt traditional customs safely

Some traditional customs are now risky because of HIV, for example customs, which involve having non – regular sexual partners. Any custom, which involves sharing cutting instruments, is also risky.

Risky customs include

- Wife- sharing and wife inheritance that has a become dangerous for the spread of HIV
- Circumcision with unsterilised knives or blades
- Scarification with unsterilised knives or blades or needles
- Devadasi
- Skin piercing practices when many people share an instrument, without sterilization between uses.

Remember that....

You cannot know who has HIV. HIV is found both in villages and town. So it is much safer to modify dangerous practices in order to make customs safe

Exercise 4.5 (Optional)

The purpose of this exercise is to sensitize the participants that it may be difficult to tell people to give up traditional practices but that traditional practices could be done safely so as to avoid transmission of STD/ HIV

1. The facilitator asks the participants for volunteers to role-play considering the following points.

You have to approach a traditional practitioner who is known in the community to use skin piercing methods that are not safe

- How would you let the person know that you respect him /her?
- How would you present the problem to the practitioner?
- How would you describe the harmful effects of the practices?
- How would you arrive at solutions for the above problem?

2. Summarize the role play at the end with the following points

- **When you cannot avoid skin-piercing instruments such as blades, needles and syringes insist on having sterilized instruments**
- **Do not share razor blades, because they might come into contact with blood from an infected person from cuts on the skin**
- **Do not share needles that have been used for intravenous injection, either for therapeutic purposes or as part of drug abuse**

i. Blood transfusion

- Avoid the need for blood transfusion (seek proper medical treatment for malabsorption, hookworm, and during pregnancy to prevent anemia)
- When blood transfusion cannot be avoided, insist on having blood, which has been tested for HIV. It is safer when relatives donate blood than professional donors.

Ensure the safety of blood and blood product

- A well organized blood transfusion service (BTS) is a necessary part of any safe and effective use of blood and blood products
- Safety considerations must be built into every stage of the blood collection process: testing, storing, distribution and transfusion
- Emphasize volunteer non remunerated blood donors
- Defer donors who report risk behaviors until screened
- Effective blood testing strategies
- Appropriate use of blood and blood components. Use only when necessary.
- Training of staff handling blood and blood products

Contact with potentially infective body fluids

- Universal precautions (See Chapter V) to be followed while taking care of any person in the community / patient in the hospital setting

6. Prevention of mother to child transmission (MTCT)

More than 70% of pediatric HIV occurs due to parent to child transmission of HIV. When a mother is infected transmission to the child could occur mainly through the placental route in the antenatal period or, during the process of labor or during the delivery of the baby and in the postnatal period through breastfeeding. However this risk of transmission can be significantly reduced by antiretroviral (ARV) chemoprophylaxis. This section is dealt with in detail in order to enable the nurse to provide appropriate health education to potential mothers.

Table 4.1. Risk of MTCT

Time of transmission	Percentage of perinatal transmission	Manifests
Antenatal period	30-40%	- Early fetal loss - In early infancy
Intrapartum period	60-80%	- Between 1-5 years
Post partum period	12-14%	- Between 1-5 years

This section will be dealing with methods of prevention of MTCT through primary prevention, and secondary prevention strategies. Secondary prevention strategies target women who have been diagnosed to have HIV infection while primary prevention strategies target women who have not yet acquired the infection.

On whom should a nurse focus to prevent HIV infection among the childbearing age in women?

Exercise 4.6

1. The facilitator conducts a brainstorming session with the participants for 3 minutes
2. The participants are asked a question

On whom should a nurse focus to prevent HIV infection among the childbearing age in women?

3. One participant is asked to come forward and write down all the responses given to the question on the black board
4. Then the participants are also asked to give reasons why they had given the previous responses. This is also written in the black board for all to see
5. The Handout 4.2 is then given to the participants to read and comment on

Handout 4.2: Which women must a nurse focus on to prevent STD /HIV infection in them?

A nurse must focus on **all women** because

- Women are more susceptible to STDs since they are
  - Biologically more susceptible to infection if exposed to HIV and others STDs
  - Often socially, economically as well as sexually subordinate to men. Hence the chance of their exposure to practices, which are risky such as, forced sex, unprotected sex could raise their risk for acquiring the infection
- Women under 20 years are increasingly presenting with HIV infection in our State despite the fact that most of them are house wives

This means that our programs should be targeted towards:

- ***Commercial sex workers***: However to focus only on them would be useful in controlling the infection in the early phases of the epidemic
- ***Teenagers:*** since high rates of teenage pregnancy and STDs indicate the extent of unprotected sexual activity among them
- ***Women in stable relationships but who are exposed to the infection*** due to their partners' behavior or changing patterns of sexual relationships
- ***Pregnant and lactating women***: The risk of the infant acquiring HIV from the mother is said to be higher especially when she acquired the infection either during pregnancy or lactation

Strategies for prevention of HIV Infection from mother to child

Exercise 4.7

The whole session of PMTCT is dealt in such a manner the participants learn from experience and then information is reinforced in them when they read the handouts

1. The facilitator divides the participants into 6 smaller groups. Each group is given one situation. ***Make sure that participants are asked not to refer their modules***. Distribute to each group only their topic for discussion written on an A4 size paper. Do not write the Handout number in this paper.

Group I: How to reduce the risk for women to get infected with HIV (***Handout 4.3/ Handout 4.4)***

Group II: Steps to reduce the risk of MTCT of HIV during pregnancy and delivery ***(Handout 4.5)***

Group III: Steps to reduce breast milk transmission of HIV ***(Handout 4.6)***

Group IV: Helping a HIV positive mother on how to feed her infant ***(Handout 4.7)***

Group V: Helping a HIV positive mother reduce infant's vulnerability to infection ***(Handout 4.8)***

Group VI: Helping a mother whose status is not known on how to protect her baby from acquiring the infection ***(Handout 4.9)***

2. Each group will have a leader. The group must discuss what the role of the nurse must be and how could he / she fulfills the said role.
3. Each group will be given 5 minutes to discuss and one member of the group must volunteer to write down points discussed
4. Then any one member of Group I must be called up after 5 minutes to read out to all participants what they discussed in their respective groups. The corresponding Handout for that particular group must then be read aloud to all the participants following this. Any clarification could be made by the resource person
5. The facilitator must be able to give any other pertinent information before the next group comes forward to present their points of discussion
6. Similarly all other groups must come forward and present their discussion after which the respective handout is read aloud to all participants.

Strategies for primary prevention of HIV Infection from mother to child

This means reducing the risk of a woman from acquiring STD / HIV infection even before she becomes pregnant

Handout 4.3 Primary prevention – ways in which the infection can be avoided and cannot be spread

Aspects of prevention
1. Information, Education and Communication (IEC) • Give sex education in the school to pre-adolescent girls (10-12 years) • Give information on STD / HIV and the ways of preventing these diseases to all adolescent girls • Inform girls about risk behaviors • Teach problem solving skills to girls • Help adolescent girls to develop skills in decision making, resisting negative influence, protecting themselves from eve teasing, rape, and sexual harassment, building and maintaining healthy and satisfying relationships • Help adolescents girls need to learn about sexual and reproductive health, safe sex, different forms of sexual behavior and the consequences of sexual behavior • Teach teachers of preadolescent girls about how to give sex education • Encourage the use of posters with important messages so that the adolescent and preadolescent girls can learn
2. Increasing access of family planning for women at risk to prevent unintended pregnancy • Deliver family planning services more extensively in AIDS affected areas • Discuss family planning and sexual health issues with women • Emphasize on barrier methods • Address the dual protection (i.e. to use one or more contraceptives to protect from the HIV infection and to prevent pregnancy simultaneously) appropriately (see Handout 4.3).
3. Expanding access to HIV counseling and testing • Develop link with VCTCs, PMTCTs • Identify infected women in the antenatal period and refer • Reduce the risk in seronegative women by education and motivation so that they could modify their behavior • Provide sero positive women with the services of a VCTC

Handout 4.4. Contraceptives and their role in prevention of infection

Contraceptive methods	Bacterial RTI /STI/STD	Viral RTI /STI/STD
Condoms	Protective	Protective
Spermicidal	Moderately protective against cervical gonorrhea	No evidence of protection in vivo
Diaphragms	Protection against cervical infection. Associated with vaginal anaerobic overgrowth	Protective against cervical neoplasia
Hormonal	Associated with increased cervical chlamydia. Protective against symptomatic PID, but not unrecognized endometritis	Not protective
IUD	Associated with PID in the first month after insertion	Not protective
Fertility awareness	Not protective	Not protective

The dual method is not recommended for all women. The following steps are recommended as a guideline for you to help women:

- Be aware of the STD/HIV prevalence rates for a geographical area. This will help you know what is risk women are likely to face
- Consider those women who think of themselves or their partners in the high risk category as good candidate for dual method
- Know that the male condom alone, if used in the correct manner will be sufficient enough to protect against infection and unintended pregnancy
- Encourage the women whose husband or partner refuse to use the condom, to use the female condom or diaphragm along with a spermicidal

Inform women regardless of her status that if the contraceptive she is using presently does not protect her against STD /HIV, and she is concerned about her partners' behavior and thus her risk status, she should immediately start using additional protection.

Strategies for secondary prevention of HIV Infection from mother to child

This means reducing the risk of HIV transmission from a HIV positive mother to the child. For this it is important to first know what factors increase the risk for MTCT.

Risk factors for MTCT of HIV during pregnancy and delivery

The risk of MTCT is multifactorial, and is influenced by maternal, obstetrical, child, and viral factors:

Table 4.2. Risk factors during pregnancy and delivery for MTCT

Maternal factors

- Stage of maternal HIV disease
- Maternal nutritional status
- Disruption of placental barrier integrity by chorioamnionitis
- STD during pregnancy
- Substance abuse
- Vitamin deficiency

Obstetrical factors

- Vaginal delivery over cesarean section
- Preterm delivery
- Breast feeding
- Rupture of membranes
- First born among twin pregnancy

Factors related to the child

- Genetic characteristics of the fetus has been suspected to increase risk for transmission

Viral factors

- MTCT rates of HIV-1 is higher than that of HIV-2

Handout 4.5

1. Reducing risk of MTCT of HIV during pregnancy and delivery

This section attempts to give a brief overview of various preventive options available to reduce the risk of MTCT.

Reducing risk of MTCT of HIV during pregnancy

***a.* Vitamin supplementation**

- Administration of multivitamin supplementation has shown a significant reduction in the risk for low birth weight babies, severe prematurity, or small for date babies. These babies have higher risks of mortality especially if they acquire HIV infection perinatally
- Administration of Vitamin A during pregnancy may be helpful in reducing the risk of MTCT

***b.* Avoid invasive procedures on the uterus such as amnioscopy, fetal scalp electrodes, amniocentesis etc.**

c.Antiretroviral therapy:

Anti retroviral therapy is recommended to reduce the maternal viral load and to inhibit the replication of the virus in the newborn. Various regimens have been recommended based on the cost and logistical obstacles. What we follow in our country is:

- Avoid ART in the first trimester of pregnancy due to know teratogenic effects
- Advise monotherpy such as Zidovudine 300 mg. twice a day for the full course of pregnancy from the second trimester

Reducing risk of MTCT of HIV during delivery

***a.* Antiretroviral therapy:**

What we follow in our country includes

- Nevirapine (NVP) 200 mg administered as a single dose to the mother at the onset of labor.

It is said to reduce the risk of transmission from 35 % to 12 %.

***b.* Prevention of premature rupture of membranes**

***c.* Mode of delivery**

- Elective cesarean section protects more than vaginal delivery
- With constraints of resources (equipment, experienced personnel to perform a cesarean section as well as the cost), then hospital / home vaginal deliveries must be conducted by the health personnel with extreme caution to avoid the spread of infection to the baby. Avoid episiotomy for such mothers as far as possible
- The episiotomy needs to be sutured as fast as possible to reduce the chance of bleeding and thus the risk of occupational exposure

***d.* Vaginal disinfections**

- Vaginal disinfection with chlorhexidine solution (0.25%) is a low cost method and also helps to reduce neonatal morbidity

***e.* Care of the baby soon after birth**

- Suction any secretions from the oral cavity first and then from the nose to prevent the baby from swallowing any secretions
- Do not milk the umbilical cord
- Cut the cord as soon as pulsations are not felt
- Wipe the baby's body thoroughly with a warm clean towel to remove any blood stained secretions
- Administer single dose (2mg /kg) of Syrup Nevirapine to the child within 72 hours after birth

Follow-up care of the mother and the infant

Any intervention to reduce MTCT should include good postpartum and infant care. Continued counseling about

- The infant and young child feeding
- Prevention of HIV transmission to sexual partners
- Access to and provision of family planning
- Emotional support for the mother and the family
- Follow-up of the baby to check for HIV infection
- If HIV positive the woman needs to be warned about early medical management. They need to be motivated to seek help as early as possible since they are more prone for infections in the post partum period.

2. Reducing the risk of MTCT through breast feeding

I. Handout 4.6: Helping a HIV positive mother to reduce chance of breast milk transmission (BMT)

a. Ensure good nutrition during pregnancy and the postnatal period

All women need to be counseled and educated to

- Take a nutritious and well balanced diet during this period
- Supplement diet with iron, folic acid, zinc and other nutrients
- Use high doses of vitamin A following delivery

b. Instruct on good breast-feeding technique

i. Preparation of breasts in the antenatal period

The women should be advised to

- Examine her breasts for any defects such as bifid nipple, flat nipple etc.
- Prepare the nipples for suckling by massaging them well with oil everyday and then drawing them out gently.

ii. Adopting proper methods while breast feeding

Mothers must be advised on

- Proper positioning of the herself and baby (See Table 3; see relationship of poor position, latching on BMT in Figure IV)
- To use a mild soap

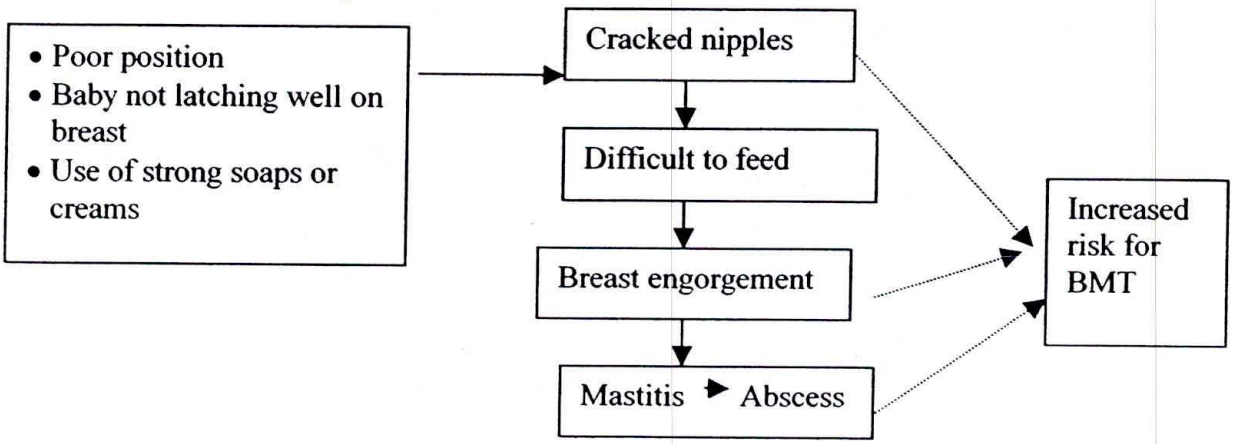


Figure 4.4: Relationship of improper methods of breast-feeding technique with BMT

Table 4.3. Correct positioning and attachment

If the baby is:	Show mother
Not positioned correctly: • Baby's tummy is not flat against mother's 	**Correct positioning** • Baby is facing mother and is close to her. • Baby's tummy is flat against mother's tummy. 
Not properly attached to the breast: • Baby looks like sucking a straw • Baby's mouth does not cover areola 	**Correct Attachment** • Baby's chin is touching the breast. • Baby's mouth covers all the areola (dark skin around the nipple). • Baby's lower lip is curled outward 

II. <u>Handout 4.7</u>: Helping a HIV positive mother decide how to feed her infant

- Explain the benefits of breastfeeding
- Confirm by asking mother if she knows her HIV status
- Explain the risks of breastfeeding for **HIV positive** women
- Explain the options HIV positive mother have for infant feeding (see Table 4)
- Explain about the concept of a wet nurse (someone known to the family who is not HIV positive, who is willing to breast-feed the baby. **Remember breast milk is the best milk for a baby)**

Table 4.4 Options for breast feeding in HIV positive mother

If an HIV positive mother	Counsel her to:	Rationale
WANTS to breastfeed AND IS ABLE AND WILLING to use animal milk or commercial infant formula	• Feed colostrum • Put the baby on the breast within 30 minutes of birth • Breastfeed exclusively for **3 months or less** • Practice abstinence **or** consistent use of condoms during sex • Avoid giving water or other foods with breast milk • Avoid the use of pacifiers • Breastfeed regularly • Stop breast milk abruptly at 3 months or earlier if possible • Feed **only** animal milk or commercial infant formula from 3 months (or earlier) to 6 months • Feed animal milk or commercial infant formula **and** give complementary foods (ragi / rice etc.) from 6 to 24 months.	• Protects the baby • Aids in successful breast feeding • Protects the baby • Protect herself from sexually transmitted diseases • It increases the risk of passing HIV to the infant • Reduces the number of times the baby would suckle on the breast and therefore decrease the amount of milk production • Increases milk production by suckling • Longer the duration of breast feeding greater is the risk for transmission • Mixed feeding (breast milk and artificial feeding increases risk of transmission • Builds the nutritional status of the baby • Reduces risk of transmission
CHOOSES NOT to breastfeed AND IS ABLE AND WILLING to use commercial infant formula or animal milk	• Use commercial infant formula or animal milk from birth to 6 months • Use infant formula or animal milk **and** give complementary foods from 6 to 24 months • Take all precautions to maintain hygiene during feeding	• Safest for a baby not to be breast fed • Meets the basic caloric requirements of the baby • Protects the baby from gastrointestinal infection

WANTS to breastfeed AND IS NOT ABLE OR WILLING to use animal milk or commercial infant formula	• Breastfeed exclusively for only **6 months** or less (**no** other food or drink, except prescribed medications) • Stop breastfeeding abruptly at 6 months • Avoid feeds such as fruit juices, acidic milk like curds, sugar water, skimmed milk or even sweetened condensed milk before six months of age • Give **only** complementary foods from 6 to 24 months • Practice abstinence **or** consistent use of condoms during sex	• Mixed feeding increases risk of transmission • Longer the duration of breast feeding greater is the risk for transmission • Since the infants gut is not yet ready to digest these foods readily and they are likely to cause allergies • Meets the basic caloric requirements of the baby • Protect herself from sexually transmitted diseases

Inform HIV positive woman and those who are unaware of their HIV status to avoid feeding if they have cracked nipples, mastitis or breast abscess.

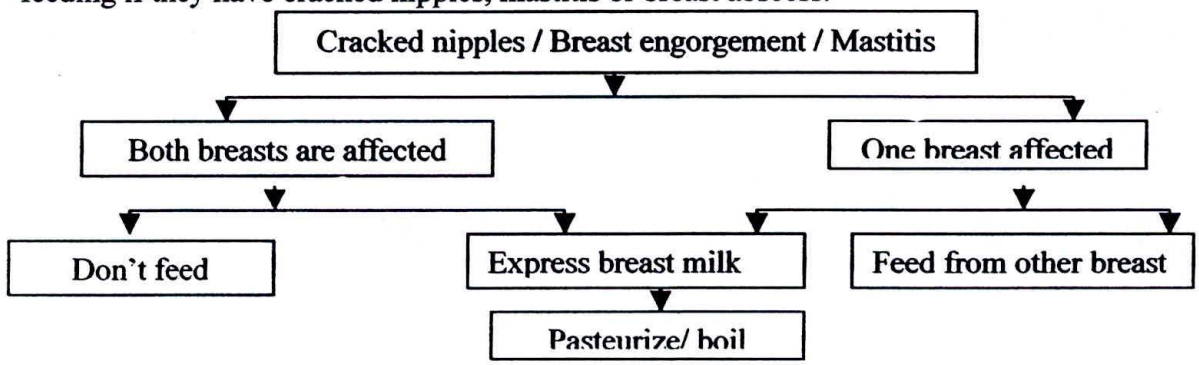


Figure 4.5. Algorithm to follow for cracked nipples, breast engorgement, mastitis

Handout 4.8. Helping a HIV positive mother reduce infant's vulnerability to infection

i. Help mother to learn when to stop breast milk: (See Table 4.5)

Table 4.5 Options for breast-feeding in a HIV Positive mother

If an HIV positive mother is:	Tell her to:
Willing and able to use animal milk or commercial infant formula	Stop breast milk abruptly when infant is 3 months or less.
Not willing or able to use animal milk or commercial infant formula	Stop breast milk abruptly when infant is 6 months or less.

ii Explain how stop breast milk abruptly (See Table 4.6)

Table 4.6. Steps to be taken by the HIV positive mother to stop breast feeding abruptly

When the mother decides to stop breast milk as in Table 4.5, tell her to express breast milk (EBM) and give to baby using cup / paladai / spoon especially during the day
Encourage the mother to continue to breastfeed during the night
Increase the number of breast milk feeds from the cup, while decreasing the number of breastfeeding gradually over a period of 2 weeks.
Ensure the mother knows how to prepare animal milk or commercial milk
Stop breast-feeding abruptly. Tell the mother to ensure that there is a reliable supply of replacement feeding (animal milk or commercial infant formula) before stopping breast milk
Explain how much milk to feed the baby (See Table 4.7)

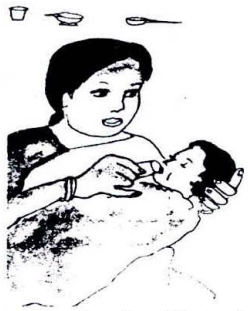


Table 4.7. Guidelines for the amount of milk to be given to the baby

If baby's weight is:	Or the baby is:	Then tell the mother to:
3Kg	1 month old	• Use 450 ml of milk per day • Give about 60 ml of milk per feed • Feed the baby at least 8 times per day
4 Kg	2 months old	• Use 600 ml of milk per day • Give about 90 ml of milk per feed • Feed the baby at least 7 times per day
5Kgs	3-4 months	• Use 750 ml of milk per day • Give about 120 ml of milk per feed • Feed the baby at least 6 times per day
6 Kg	5-6 months	• Use 900 ml of milk per day • Give about 150 ml of milk per feed • Feed the baby at least 6 times per day

Note:

1. ***The amounts above are only a guide as some babies are better feeders than others.***
2. ***An adequately fed baby will gain weight and pass urine 7 to 8 times in a 24- hour period.***

IV. <u>Handout 4.9</u>: Helping a mother with unknown HIV status decide how to protect her baby from acquiring the infection

1. Ask her what she knows about mother to child transmission of HIV
2. Ask her if she wants to know her HIV status
3. If she says yes, refer her to the nearest voluntary counseling and testing (VCT) center.
4. Explain that HIV can be transmitted to a child of an HIV positive mother through breastfeeding.
5. Reinforce the benefits of breastfeeding. If the mother is HIV negative or her status unknown, counsel her to
   - Breastfeed exclusively for 6 months.
   - Continue breastfeeding and give complementary foods from 6 - 24 months.
   - Protect herself from getting HIV during the time she is breastfeeding through:
     -Abstinence or
     -Consistent use of condoms during sex.
   - Explain the risks of artificial feeding
6. Explain the risks of breastfeeding for HIV positive women but also
   - Explain that exclusive breastfeeding means giving the baby breast milk only without any other foods, drinks or water (except prescribed medications).
   - Explain that mixed feeding (giving breast milk plus other foods or drinks) for infants born to HIV positive women increases the risk of transmission of HIV.
   - Encourage her to eat more food while breastfeeding.

<u>Watch out for...THE SPILL-OVER EFFECT</u>

The effect of giving information about the risk of HIV transmission through breast milk on infant feeding practices of HIV negative mothers or on those who do not know their HIV status. Advise them on the benefits of breast- feeding.

<u>Summary of PMTCT</u>

<u>i Primary prevention strategies</u>

This includes reducing the risk for women to get infected with HIV by

- Information, Education and Communication (IEC)
- Increasing access of family planning for women at risk to prevent unintended pregnancy
- Expanding access to HIV counseling and testing

<u>ii.Secondary prevention strategies</u>

This includes

- Reducing risk of MTCT of HIV during pregnancy and delivery
- Reducing the risk of MTCT through breast feeding
  - Helping a HIV positive mother to reduce chance of breast milk transmission (BMT)
  - Helping a HIV positive mother decide how to feed her infant
  - Helping a HIV positive mother reduce infant's vulnerability to infection
  - Helping a mother with unknown HIV status decide how to protect her baby from acquiring the infection

Chapter – V

UNIVERSAL PRECAUTIONS – IN CARING FOR A PERSON WITH STD/ HIV

Introduction

HIV may be transmitted in the health care setting from either patient to patient, from patient to health care worker or from health care worker to a patient. Infection control measures are those standards recommended by the health authority and are adopted by the health personnel, which help to prevent or minimize occurrence of infection among themselves or their patients. Adequate infection control measures like universal precautions, waste management and post exposure prophylaxis need to be practiced at all times to ensure safety of both patients and staff.

General Objective: **On completion of this section, the participants will understand the** general safety practices and precautions to be taken while caring for clients, apply this knowledge while at work, for the prevention of blood borne pathogens.

Specific Objectives

By the end of the training program the participants will:

- Recall the principles of universal precautions.
- Use universal precautions within the available facilities while caring for patients or while handling potentially infections materials
- Demonstrate how to disinfect materials used for caring for patients or persons
- Segregate infected materials appropriately in the health care setting

Key concepts

- Universal precautions is necessary to prevent transmission of infection through potentially infected body fluids
- Contact with body fluids make one at risk for acquiring blood borne infections
- All persons in the health care scenario i.e. both health care personnel and patients are at risk of acquiring infection
- Universal precautions can be easily put into practice if one is sensitized to its importance

Teaching methods

- Lecture
- Discussion both small and large
- Reflective exercises
- Demonstration

Materials /preparation required

- Transparencies with figures, OHP
- Black board, chalk, duster
- Copies of handouts
- Charts for writing and colour pens

Topic outline

- What are Universal Precautions?
- Body fluids and universal precautions
- Principles of universal precautions
    - Using protective devices
    - Protecting oneself
    - Preventing accidents
- Precautions in the event of handling potentially infective material

Total session time

1 hour

BACKGROUND MATERIAL

The risk of transmission of blood borne viruses is as follows:

- HIV - percutaneous exposure : 0.05 – 0.4%
- HIV - mucocutaneous exposure : 0.006 - 0.05%
- Hepatitis B virus (HBV) - percutaneous exposure : 9 – 30%
- Hepatitis C virus (HCV) - percutaneous exposure : 3 – 10%

Hence in order to prevent this risk we need to follow universal precautions

What are universal precautions?

Universal precautions are a set of guidelines designed to protect the health care worker from exposure to blood borne pathogens like HIV or Hepatitis B and C.

- They are based on the assumption that body fluids are potentially infectious regardless of whether it is from any patient or a health care worker
- They are procedure based and not person based.

The practice of universal precautions including proper sharp disposal (needles/ampoules etc) has reduced the risk of transmission from 50% to 20%.

Cardinal rules of universal precautions

- **All patients / persons** as potentially infectious
- Never consider the diagnosis or presumed infection status
- **All blood, body fluids and tissue** are contaminated
- **All unsterile needles and sharps** are considered contaminated
- Identify **a risk** before starting **any procedure**
- The **type of barrier protection** used should be appropriate

Body fluids and universal precautions

Exercise 5.1

The purpose of this exercise is to help participants become aware of what they presently know about when they must or must not apply universal precautions

1. Write on the various body fluids as given below on small chits of paper (one on each chit of paper)

   Blood / Semen / Vaginal secretions / Any visible bloody body fluid / Amniotic fluid / Breast milk / / CSF / Pericardial fluid / Peritoneal fluid / Pleural fluid / Pus / Synovial fluid / Feces / Nasal secretions / Saliva / Sputum / Sweat / Tears / Urine / Vomitus

2. Distribute one chit of paper to each participant. Ask the participant to identify whether they would apply **universal precautions** or **not apply universal precautions** to the said body fluid in 1 minute.
3. Call out one participant at a time and ask them to state whether they would apply **universal precautions** or **not apply universal precautions** to the said body fluid and the facilitator could list these on the board or a big chart paper
4. Following this the attention of the participants is drawn towards Handout 5.1

Table 5.1 Body fluids to which you would need to or need not apply universal precautions

Universal Precautions needed	Universal Precautions not needed
Infectious body fluids or secretions • Blood • Semen • Vaginal secretions • Any visible bloody body fluid **Any potentially infectious body fluid or secretion** • Amniotic fluid • Breast milk • CSF • Pericardial fluid • Peritoneal fluid • Pleural fluid • Pus • Synovial fluid	**Non infectious body fluid or secretion** • Feces • Nasal secretions • Saliva • Sputum • Sweat • Tears • Urine • Vomitus ***(Unless they contain visible blood)***

Components of universal precautions

1. Using protective devices
The protective devices used include

i. Gloves: Nurses need to be judicious while using gloves. Since **Gloves are not 100% safe** double gloving that affords greater protection is recommended where exposure risk is very high.

Remember...

There are two types of gloves available in the hospital:

* Examination gloves: These are clean but not sterile – to be used for all procedures not requiring sterile technique e.g. used for sponge bath

* Sterile gloves: These are used for all procedures where sterile technique is mandatory

Do's while using gloves

- Thick rubber gloves to be worn while cleaning instruments and handling soiled linen
- Remove gloves before leaving the patients bedside
- Change gloves between patients and procedures

Don'ts while using gloves

- Don't use gloves with holes or tears
- Do not wash hands with gloves on
- Do not reuse disposable gloves

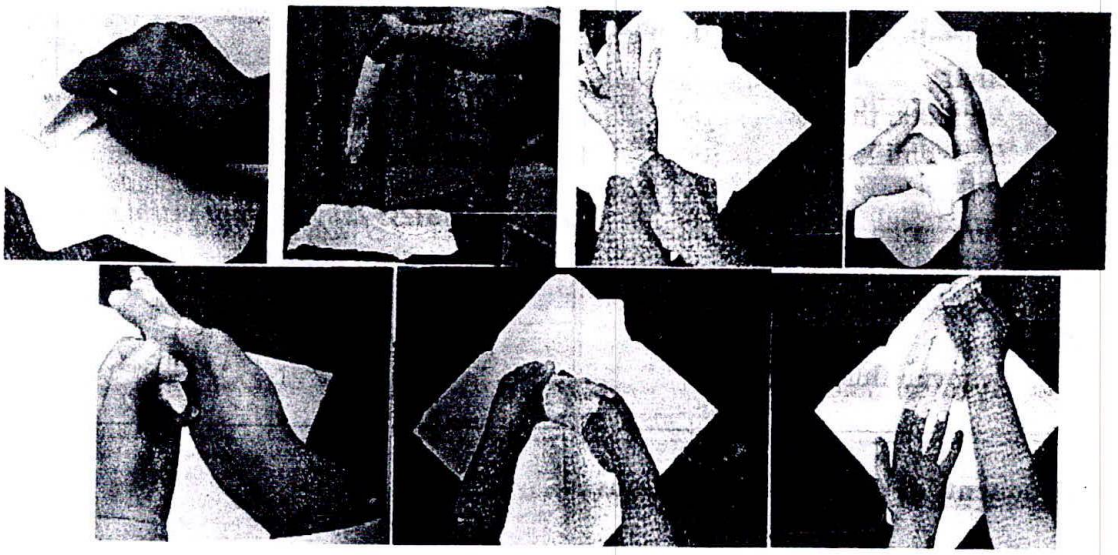


Figure 5.1: Procedure for putting on and removing gloves

ii. Masks

- Use complete face mask for all procedures that are likely to contaminate eyes, nose or mouth by droplets of blood and body fluids
- Cover the mouth and nose
- Change masks for every procedure or immediately if they become contaminated

iii. Eyewear

- Choose the type that helps to cover the eyes both in front and on the sides
- See that they do not restrict your vision and you are comfortable
- See that it fits well on the face and is directly in contact with the skin
- If eyewear is not available you could improvise one by making use of the face shield that is attached to a helmet. The advantage of this is it could be easily cleansed.

iv. Protective clothing

It is important to remember that all protective clothing and equipment must be properly discarded / stored before leaving the work area.

v. Gowns:

- Wear a plastic apron under the gown.
- Use impervious (does not allow liquid to soak through) full – sleeved gowns for procedures where hands are thrust deep into the viscera, and much blood loss is anticipated

vi. Shoes:

- Use impervious shoes covering the dorsum (top surface) of the feet completely in the operation theatre (OR) and in the labor room.
- If this is not available then you could use plastic packets or bags and put a rubber band to hold it in place

Use of the protective devices depends on the type of risk of transmission associated with each procedure

Exercise 5.2

The purpose of this exercise is to help participants become aware of what they presently know about when they must use the appropriate protective device. It could be a period when any misconceptions could be clarified by the facilitator

1. **Write the various procedures as given below done by a nurse, one procedure each on a card**

   Bed making / Endotracheal intubation / Conduct of delivery / Uncontrolled bleeding / Back care / Insertion and removal of IV needles / During surgery / Per-vaginal examinations / Sponge bath / Dressing of large open wounds / Minor wound dressing / Handling blood spills / Mouth care / Handling lab specimens/ Suctioning / Catheter care / Perineal care / Injections / Expressing breast milk / Handling dead bodies / Lumbar puncture

2. **Mark on three separate tables 'low risk', 'medium risk' and ' high risk' (this could be done on the black board or a flannel graph or even by using three boxes which are labeled in this manner)**
3. **Ask the participants to come up one by one, give them a card and ask them to place a given card under the categories of low, medium or high risk after having identified the risk of the procedure**
4. **Following this the attention of the participants is drawn towards Handout 5.2**

Handout 5.1. Type of risk associated with procedure

Type of exposure	Examples	Protection Required
Low Risk	Bed making, back care, sponge bath, mouth care, minor wound dressing, catheter care, perineal care, injections, expressing breast milk, handling dead bodies, lumbar puncture (LP),	Gloves helpful, but not essential. In the case of LP, use gloves and mask.
Medium Risk	Insertion and removal of IV needles, per-vaginal examinations, dressing of large open wounds, handling blood spills, handling lab specimens, suctioning, endotracheal intubation (ET)	Use of gloves and waterproof aprons may be necessary. Gloves, apron, goggles, mask are needed for ET.
High Risk	Conduct of delivery, uncontrolled bleeding, during surgery	Gloves, waterproof aprons masks and protective eyewear is necessary

2. Protecting oneself

When in risk of exposure to potentially infectious or infectious body fluids

- Apply good basic hygienic practices with regular handwashing
- Wear gloves
- Avoid direct patient care till you cover breaks in your skin with a waterproof dressing and sterilized gloves
- Take care when you handle instruments

i.Hand washing

- It is the single most important method
- Use running water and soap
- Remember to wash hands before as well as after any procedure
- Wash for 20 seconds
- Never scrub your hands with a brush when there is a break or cut in the skin

The steps of the procedure are given in Figure 5.2.

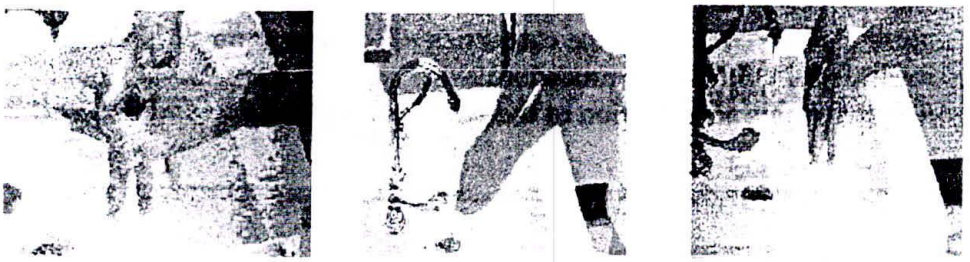


Figure 5.2. Steps of hand washing procedure

3. Preventing accidents

Accidents can be prevented by the following measures

- Always use puncture resistant containers
- Disinfect used syringes

- Segregate wastes at the source itself
- Use appropriate technique of disinfecting for each item before disposal
- Incinerate disposable items wherever and whenever possible
- Avoid overfilling of containers
- Avoid putting hands into the waste containers
- Protect fingers from injury by using forceps and needle holders when suturing is being done
- Keep disposal containers with disposable items close to the work spot

Care of used needles and syringes

- Never bend / break disposable needle
- Do not recap needles. If so do it in the manner given below by using the single hand technique
  - Place the needle cap on the table
  - Hold the hub of the needle with the right hand and push it into the cap
  - Then lift the needle with the cap above the table
  - Fix the needle to the cap with the left hand
- Keep needles/ sharps in puncture resistant disposal containers like a tin with a lid, a thick plastic bottle or box.
- Use all needles and syringes only once followed by proper disinfection and sterilization techniques
- Use disposable syringe and needle only once and then discard as mentioned previously

4. Proper use of disinfecting techniques and sterilization

HIV is a weak virus that is easily destroyed by heat and drying. Disinfectants should not be used for cleaning needles and syringes because they are not reliable enough. They can be used for cleaning surface such as table tops & spill blood

How to prepare a bleach solution (if not already available)

Bleach: water = 1: 9

- Prepare just before use
- Soak for at least 30 min.
- Soak heavily contaminated objects overnight
- Do not soak metal objects e.g. needles scissors, forceps, scalpels
- Cover the container

Points to keep in mind for disinfection

- Clean instruments thoroughly before disinfecting
- Rinse bleach or chloramine off metal instruments with H_2O as soon as sterilization is complete or they will corrode
- Sterilize soiled or blood stained laundry, plastic sheets or gloves by boiling or soaking in disinfectant.

Labor boards, examination table, OT tables, floor and work surfaces should be cleaned with 10% sodium hypochlorite solution. Table spreads should be changed at the end of each procedure.

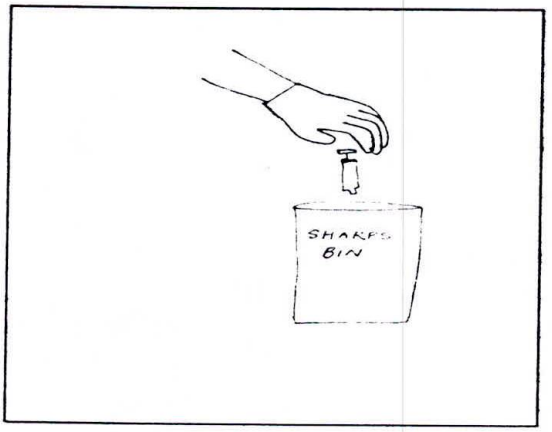
There are four ways to sterilize instruments and kill HIV and other viruses and bacteria. These methods are listed below

1. Boil in water for 20 minutes after through cleaning of instruments
2. Sterilize with steam under pressure for least 20 minutes:1 atmosphere (101 kpa, 15 lb/m^2) above atmospheric pressure, 121^0C (250^0 F) in an autoclave, pressure cooker or steam sterilizer.
3. Sterilize with dry heat in an electric oven for 2 hours at $170^0C(340^0F)$
4. Soak in one of the following disinfectants for 30 minutes.
    a) Chlorine releasing compounds (e.g. bleach 0.5% to 1% which is freshly prepared)
    b) 2% Glutaraldehyde / gluteral
    c) 70% ethyl & isopropyl alcohol / spirit
    d) Others
        - Polyvidone Iodine (2.5%)
        - Formaldehyde / Formalin (4%)
        - H_2O_2 (6%)

Low level disinfectants e.g. Dettol and Lysol do not kill HIV

5. Disposal of wastes

All of us as health personnel are at risk of contact with potentially infected body fluids during our day-to-day routines. Hence we must be doubly cautious of the way we dispose wastes either in the hospital setting or even in the home setting.



Exercise 5.3

The purpose of this exercise is to help participants become aware of what they presently know about and how they must use the appropriate colour code in segregating wastes.

1. **Write the various waste materials that one may come across in the hospital setting as given below, one each on a card**

   Blood / used IV needles / soaked sponges during surgery / gloves used for per-vaginal examinations / soaked dressing of large open wounds / Minor wound dressing / suction catheter / indwelling urinary catheter / used disposable needles / Expressed breast milk / urine / stool / tissue biopsy specimens / sanitary napkins / scalpel blade / food / vomitus / sputum / paper / glass syringe which is broken / disposable syringe

2. **Place on the table five separate boxes colored 'black', ' 'red', 'yellow', 'blue', and 'steel /metal /grey color' (this could be done on the black board or a flannel graph by writing the color as given above)**
3. **Ask the participants to come up one by one, give them a card and ask them to place a given card in the respective colored boxes namely boxes colored 'black', ' 'red', 'yellow', 'blue', and 'steel /metal /grey color' after having identified the categorization of the particular waste**
4. **Following this the attention of the participants is drawn towards Handout 5.3 /** 5.4

In the hospital setting definite color codes are given depending under what category the waste material would come under as given in Handout 5.3. Handout 5.4 gives details of ways wastes can be disposed in the hospital or in the home setting.

Handout 5.2. Colour coding for segregation of wastes

Colour	Type of waste	Examples - type of waste
Black	General waste	Office waste / Dry non infectious waste
Red	Infectious plastic	Syringe / Cannula / Catheter
Yellow	Infectious waste	Pathological specimens / Anatomical waste
Blue	Glass waste	Whole and broken glass
Steel / metal	Sharps	Needles / Blades / Scalpels

Handout 5.3. Method of disposal of specific wastes

Wastes	Examples	Method of disposal
Liquid	• Blood • Urine • Stool	• Flush into the sanitary sewer or pit latrine
Solid	• Soaked dressing • Sanitary pads / napkins • Placenta • Tissue biopsy specimens	• Burn or carefully bury • Incinerate if possible • Avoid placing these materials in open dumps to which animals and children have access • Avoid burying where there is a possibility of it being dug up or where it might contaminate water sources
Sharp instruments	• Needles • Scalpel • Blades	• Dispose into puncture proof containers • Disinfected with chemicals or autoclave or incinerate before disposal

Precautions in the event of handling potentially infective material

Exercise 5.4

The purpose of this exercise is to help participants become aware of what they presently know about how they must dispose wastes in the hospital or in the home setting.

1. Divide the participants into 4 groups. Each group is asked to select a leader
2. Give each group one topic to discuss for 15 minutes

Group I: As you were starting an IV line for a patient, blood spilled on the floor

Group II: You have a patient coming to you for dressing

Group III: A patient with pneumonia needs IV antibiotics. You start an IV line for the patient. In the process, a bloodstain is found on the bed sheet after the procedure

Group IV: A 45 year old person who was in the health center had died

3. Have the group decide what action is to be taken
4. After the discussion the leader of each group is asked to come forward and report the summary of the discussion to the entire class
5. Following this the attention of the participants is drawn towards the respective part of Handout 5.5. Any clarifications could be done by the facilitator at this point
6. The next three groups would also be asked to present their discussion in a similar manner
7. The facilitator could also discuss respective sections of the Handout 5.5 that have not been presented

Handout 5.4:

i. Steps to be taken if there is a blood / body fluid spill

You must be aware that blood or body spill can occur both in the hospital as well as in the home setting of a person who is HIV positive. There are definite protocols that you have to follow in order to protect yourself.

In Hospital	At Home
• Wear gloves • Place cloth / cotton over the spill • Flood with freshly prepared sodium hypochlorite solution (0.5-1%) • Wipe thoroughly • Discard cloth in to appropriate waste container • Wipe surface with disinfectant solution • Incinerate wastes • Remove gloves and wash hands	• Cover your hand with a plastic bag / wear rubber (latex) gloves – available in medical stores. • Pour some freshly prepared bleaching powder solution on the blood. • Mop up the blood • Burn or bury the cloth used or wash it as described above • Wash hands with soap solution and water.

ii. Steps to be taken in handling of vomitus, suction fluid, other secretions and excretions

- Pour down drain connected to sewer
- Disinfect bedpans, urinals, suction jars etc., with 1% household bleach for 30 minutes or by any other methods of disinfections.
- Wash the articles with soap and water
- Re-use articles after proper disinfection and cleaning

iii. Steps to be taken in dressing an open wound

In Hospital	At Home
• Cover hands with rubber or latex gloves • Clean the cut or wound with antiseptic solution • Apply medicines • Cover it with a pad and apply plaster • Burn or bury the blood soaked bandages, cotton, gauge, and plastic bag/gloves • Soak reusable gloves in freshly prepared bleaching powder solution for 30 minutes. • Wash hands with soap and water	• Make sure you do not touch the blood directly. • Cover hands with a thick plastic bag or a towel or wear rubber (latex) gloves, before touching the bleeding part. Clean the cut or wound with solution and water • Apply medicine and cover with plaster • Burn or bury the blood soaked bandage, cotton, gauze and plastic bag/ gloves • Reusable gloves are handled in the same manner as in the hospital • Wash hands with soap and water

iv. Steps to be taken in handling laundry and linen

In Hospital	At Home
• Handle with gloved hands • Prepare bleach solution a bucket • Place all the contaminated into the solution • Soak for 30 minutes and then send to laundry	• Handle with gloved hands • Put clothes in the bucket of water with bleaching powder • Cover the bucket with a lid • Soak the clothes for 30 minutes • Burn clothes that are grossly soaked with blood

v. Steps to be taken if the person infected with HIV dies

- Treat the body with respect
- Remove all ornaments if needed and place in a separate package. Then hand over to the relatives. Instruct them to disinfect the ornaments or if possible disinfect before handing them over
- Place the body in the position preferred by the family members. In order to keep the normal features, close the eyes immediately as in sleep, straighten the body and keep the arms straight by the sides, close the mouth, replace any dentures if needed
- Use gloves while giving the ceremonial bath
- Pack all orifices (nasal, ears, mouth, anus) with non absorbent cotton wool
- Advise cremation
- Advise those who want to bury the body to wrap it in a large heavy-duty plastic bag. And to sprinkle bleaching powder below and above it.

Chapter-VI

POST EXPOSURE PROPHYLAXIS

Introduction

Nurses / ANMs while caring for patients / persons who are HIV positive, are at risk of developing the infection.

All health care workers by nature of their work put themselves at risk for acquiring the infection. Though the risk of acquiring HIV infection while taking care of a person infected with HIV or a patient (called ***occupational exposure)*** is low, in the health care setting, improvement of hospital infection control practices and adoption of standard safety precautions can further reduce the risk. If occupational exposure has occurred post exposure prophylaxis (PEP) can make a difference through appropriate treatment and immediate care, leading to reduced risk of acquiring infection.

General objective

On completion of this session, the participants will be able to understand the general precautions to be taken against accidental exposure to infective and potentially infective body fluids in the health care setting

Specific objectives

By the end of the session the participants will:

- Be sensitized to the meaning of Post Exposure Prophylaxis.
- Be aware of steps to be taken during an accidental exposure.
- Identify the situations where PEP should be used

Key concepts

- Post exposure prophylaxis is only relevant for accidental exposure of health personnel in the health care setting
- Post exposure prophylaxis will reduce the risk of acquiring infection after an accidental exposure
- The only way of preventing accidental exposure is by adopting safe work practices or universal precautions

Teaching methods

- Case discussion
- Lecture
- Reflective Exercise

Materials / preparation required

- Transparencies with important points or figures, OHP
- Black board, chalk, duster
- Chart paper and colour pens
- Handouts

Topic outline

- Meaning of occupational exposure and PEP
- Indications for PEP
- Components of PEP
  - Crisis management
  - Immediate care
  - Recording
  - Risk assessment
  - Testing and counseling
  - PEP medication
  - Follow up care
- Frequently asked questions with regard to PEP

Total session time

1 hour

BACKGROUND MATERIAL

Meaning of occupational exposure and PEP

Occupational exposure: is an exposure that may place any health care personnel at risk for infection.

***Post Exposure Prophylaxis*:** PEP means taking precautionary measures and antiviral medications as soon as possible after exposure to HIV, so that the exposure will not result in HIV infection.

***How can occupational exposure to infections such as HIV and HBV prevented*?**
Following safety guidelines known as Universal Precautions may prevent occupational exposure.

Indications for PEP

PEP reduces the rate of HIV infection from workplace exposures by 79%. This does not mean that it provides 100% protection against the infection. PEP is to be practiced in the following situations, which are considered as a serious exposure:

- Exposure to a large amount of blood
- Blood coming in contact with cuts or open sores on the skin
- All Needle stick injuries
- Exposure to blood from someone who has a high viral load (a large amount of virus in the blood)

Components of PEP

Exercise 6.1
The purpose of this exercise is to help participants become aware of what they presently know about how they must act in the event of an accidental occupational exposure to HIV infection

Case Study 6.1
A needle pricks Ms. Kavitha (28 years old) who is working as a staff nurse in the medical ICU accidentally while collecting blood from a patient diagnosed to have tuberculosis.

The facilitator must be able to draw the attention of the participants to these questions as and when the content is to be covered

- Would Ms Kavitha have cause to be worried?
- What should Ms. Kavitha do immediately after the accidental exposure?
- To whom and when should Ms Kavitha report about the incident?
- How high is the risk for infection in Ms. Kavitha?
- Since the patient's HIV status is not known, should we wait for ELISA HIV result of the patient before beginning PEP?
- How soon after exposure should PEP be initiated?
- For how long should Ms. Kavitha take the treatment?

1. Crisis Management

- It can be a frightening experience for any person and in this situation for Mrs. Kavitha, the staff nurse
- Persons are likely to be anxious especially when there is a high degree of suspicion that the index person is HIV positive or has been diagnosed so.
- Some may present with extreme anxiety, which needs direct confrontation. Reassurance without dismissing the feelings of the concerned person is vital.
- The person may underestimate their risk status and hence the person in charge of such situations should also take measures to inform people of the need for reporting and need for appropriate measures.

2. Immediate care

i. For Needle pricks, cuts:

- Encourage bleeding by squeezing
- Wash for 10 minutes with soap and water or antiseptic.
- Cover with waterproof dressing e.g. Band-Aid. Don't attend to patients until the wound is covered
- Pricked finger should not be put into mouth reflexively

ii. For splash to nose / mouth

- Flush with water

iii. For splash to eyes

- Rinse thoroughly with plenty of running water or irrigate copiously by running a pint of normal saline over 10 minutes, with the eye being held open by another person.

3. Recording and reporting

- It is important that Mrs. Kavitha goes by herself to the person in charge of such situations in the hospital (medical officer/ authorities / infection control officer) regardless of the patient HIV status
- If she does not go she is reminded to seek the help of the person in charge of such situations.
- Complete the "Needle stick or occupational exposure register."

The register would provide information regarding the type of injury, the category of the staff, the time, the place and the circumstances of the injury. Information from the register could be used to assess risks and trends. This database should help reduce the possibility of injury in the future. An example of how such a register is to be maintained is given.

Sharps / needle stick injury report

DETAILS	PATIENT	HEALTH PERSONNEL
NAME		
Hospital No.		
Designation		
Age		
Sex		
HIV Status (Known/Unknown)		
HBV Status		
Other		

INCIDENT DETAILS
Time: .....**Location:** .....
Describe the mode of injury:
.....
Sharp / Needle – with visible blood on the instrument: YES / NO
Reported to:.....**Time of the report:** .....
ACTION TAKEN (for administration purpose only):

FOLLOW UP (including serological investigations):

4. Risk Assessment

A person is considered to be at a greater risk if any of the following factors are present

- Large bore Needle - No. 22 gauge and above was instrumental for the prick
- Peripheral blood was collected
- Visible blood was found on the tip of the needle
- Deep muscle injury occurred with the needle stick injury
- Patient or person is HIV positive or HIV status is not yet clear

Table 6.1. Categorization of occupational exposure and type of PEP regimen

Small volume	• Few drops of blood / body fluids / other potentially infectious materials (OPIM) • Short duration	**Basic Regimen**
Less severe	• Solid needle (no bore in it) • Superficial scratch	
Large volume	• Several drops of blood / body fluids / OPIM • Long duration (several minutes or more)	**Advanced Regimen**
More severe	• Large bore hollow needle • Deep puncture • Visible blood or needle used in persons artery /vein	

5. Testing and counseling

i. ***Test the patient / person (on whom the procedure was being done) for HIV antibodies:*** **It is advised that the nurse / ANM who sustains the injury collects 2-5 ml** of blood from the index patient (for HIV, HbsAg and HCV testing) and takes it to the Medical officer / infection control officer, while going for risk assessment.

ii. ***Test the nurse / ANM for HIV antibodies after obtaining informed consent***: **The** blood samples are sent to Virology lab for screening for HIV antibodies. The duty doctor would need to check the results within 45 minutes. The confirmatory test must be done later. If the Nurse / ANM refuses HIV testing, this must be recorded in her medical record.

iii. ***Pre-test and posttest counseling:*** **All health care personnel must be counseled by a** trained professional or in the case if such a person is not available then by the chief medical officer / concerned authorities responsible to manage such situations / or the infection control officer. Counseling must be performed irrespective of the status of the index case and as appropriate. HIV testing must be carried out on three ERS test kits or antigen preparations (Elisa / Rapid / simple) as a base line assessment for legal purposes to rule out positive HIV status at the time of injury. Advice must be given to refrain from donating – blood, semen or organs/ tissue and to practice safe sex. Further counseling would be required in the case of a pregnant nurse.

6. PEP medication

When should PEP be initiated?

Do not delay PEP while awaiting index person or source patient's laboratory results. The PEP decision is based on the clinical risk assessment. And no time should be lost since the best result occurs if PEP is started immediately. Moreover, the concerned health care personnel in this case Mrs. Kavitha can stop PEP if the result is negative.

Mrs. Kavitha knows that prevention is possible if PEP is initiated. PEP must be started as soon as possible preferably within 1-24 hours and is best if started within 1-2 hours. Initiating treatment after 72 hrs of exposure is not recommended.

What are the investigations that have to be done before starting PEP?

The other investigations that have to be done before starting chemoprophylaxis testing includes

- Hemoglobin / Platelet count / Reticulocyte count / WBC – Total and differential counts / Renal function tests / Liver function tests / Random blood sugar

Do not delay starting chemoprophylaxis for the sake of these investigations. This should be done to obtain baseline values and at follow-up every two weeks.

Frequentiy asked questions with regard to PEP

1. Should the only concern of the health care personnel after stick injury be only HIV or is she at risk to infections from other organisms?

Yes, one is at a risk to Hepatitis B (HBV) and Hepatitis C(HCV) . The risk to HBV and HCV is greater when compared to HIV.

2. If the nurse begins the drug regimen and develops fever and feels sick. Does she have the acute symptoms of HIV infection or is it related to her drugs?

Symptoms of acute HIV or hepatitis resemble those of an adverse drug reaction (fever, rash, abnormal liver function tests) so the nurse / ANM needs to consult the doctor immediately.

3. If the Nurse / ANM begins PEP what are the possible reasons why she may discontinue the regimen?

One may discontinue the regimen for reasons such as

- Source is HIV negative
- Side effects are not manageable
- One's own choice
- Lab results are negative

4. You want to do a blood test to determine the index person's HIV status. He /she may refuse. What will you do?

- Counsel the index person on the need for being tested

5. Is there a PEP program in the Government?

Yes! PEP is now available in all district hospitals in Karnataka. Any accidental exposure needs to be reported to the medical officer. Though the risk for Nurse / ANM acquiring HIV is very low, the absence of a vaccine or effective curative treatment makes the Nurse / ANM apprehensive. So it is very necessary to have a comprehensive program in place to deal with anticipated accidental exposure.

6.What is the protocol followed in private hospitals?

When a staff gets accidentally injured it is immediately reported to the ward in charge and the infection control officer and the treatment is started. This is also been informed to the nursing superintendent and the needle stick register is entered. The same procedure of PEP is followed even in private hospitals. The hospital administrator has to sanction the prescription for issue of these drugs from the pharmacy, especially in situations when the exposure is found to be genuinely accidental. But this is subject to institutional policy.

Chapter-VII

ATTITUDES REGARDING STI / HIV / AIDS

Introduction

Nurses are members of the society and are influenced by prevailing cultural, social and religious attitudes. This can affect their attitudes towards those they care for and lead to conflicts. Becoming aware of our own values and beliefs may help us to see how these could affect our work with the community.

Exercise 7.1

A list of statements is given below. Ask the members to go through each statement and put a tick (√) mark in the column provided and write briefly why they think so in the reason column. Give them 3 minutes to do so.

	Agree	Disagree	Reason
1. The purpose of having sex is to show love for some one			
2. If a person gets a sexually transmitted disease it is his / her own fault			
3. People with AIDS should be isolated from the rest of the community.			
4. Women who talk about sexuality are of low moral character			
5. Any sexual behavior between two consenting individuals is O.K			
6. Laws should be passed against the practice of commercial sex			

After the participants complete the exercise ***pick up one or two statements and ask any one participant what they feel about it. Check if there are any contradictions and allow the contradictions.***

Then point out that ***nearly everyone has strong feelings and opinions about certain issues.*** But sometimes beliefs can change after listening to different perspectives.

Nurses must have open minds and not judge what others believe.

General Objectives

On completion of this topic, the participants should be able to identify the psychosocial factor that affect people with HIV infection and be aware of the nurses role in relation to social attitudes, values and beliefs and their effect on the individual.

Specific Objectives:

On completion of this session the participants will

- Be sensitized to attitude towards sexuality.
- Discuss the social and cultural attitudes and beliefs that affect individuals infected with HIV/ AIDS & STD and their care.
- Describe the socio cultural constraints that a nurse and counters while educating or communicating to people regarding STD / HIV/ AIDS.

Key concepts

- Sexual feelings are normal and real and no one should be embarrassed for having them
- Persons with HIV are stigmatized and discriminated
- The human rights of all individuals including persons with HIV should be respected
- Nurses and persons with HIV face sociocultural constraints which have to be identified and dealt with

Teaching methods

- Large and small group discussion
- Case presentation
- Reflective exercises

Material /preparation required

- Transparencies of important points, OHP
- Black board
- Handouts of exercises, other handouts

Topic outline

- Attitudes towards sexuality
- Illustrate ways in which some diseases are stigmatized
- Discuss the social and cultural attitudes and beliefs that affect individuals infected with HIV/ AIDS & STD and their care
- Sensitive controversial issues

Total session time

45 minutes

BACKGROUND MATERIAL

Meanings

Values: **Those aspects of culture that are held within high regard by the group and are** felt to be desirable and worthy of acceptance and practice.

Belief: **Principles having a shared meaning among members of the group and held** by the group to be true. E.g. Belief in the existence of evil spirit.

Attitude: **A pattern of mental views established on the basis of all one's prior** experiences

Sexuality: **Is how one describes him /herself as a person, how one feels about being a** man or a woman or the third sex (intersex / transgender / hijra) and how one relates to members of either sex

Attitudes towards sexuality

Exercise 7.2

1. The facilitator gives the participants a handout on 'talking about sex' that has 17 items.
2. The participants are read the following instructions.

'For each of the topics below please mark how you would feel about discussing the topic in general or with a particular group or person. You can choose to mark that you are "uncomfortable", "comfortable", or "undecided". You have 5 minutes for the activity'.

3. The facilitator must reinforce to the participants that there are no right or wrong answers, and that everyone has a right to their own opinions.
4. After the participants have completed the handout the following questions may be discussed under the guidance of the facilitator

- ***Which topics were you most uncomfortable discussing?***
- ***Which group of people were you most uncomfortable talking to?***
- ***Did you find any items offensive?***
- ***What concerns do you have with respect to talking / teaching about sex?***

Then tell the participants this exercise is to sensitize you about your own attitudes. But when we talk to people we must go with an open mind only then we communicate with them successfully.

How would I feel talking	uncomfortable	comfortable	undecided
1. About homosexuality with adults?			
2. About homosexuality with adolescents?			
3. About incest (act of sexual intercourse between close relatives E.g. Between sister and brother)?			
4. With unmarried pregnant girls?			
5. About sex in the workplace?			
6. With someone who has AIDS?			
7. About specific sexual behavior?			
8. With my daughter about sex?			
9. With my son about sex?			
10. How to properly use a condom with adults?			
11. How to properly use a condom with adolescents?			
12. With your partner about sexual matters?			
13. About masturbation?			
14. About sex and religion?			
15. About specific male and female anatomy?			
16. About sex in a mixed company (both men and women)?			
17. With doctors about sexually related issues (STDS and contraceptives)?			

Negative attitudes towards sexuality

- It is dirty to discuss about sex.
- Too much knowledge is dangerous – can lead to sexual experimentation.
- Too embarrassing a subject to talk about.

Positive attitudes towards sexuality

- Sexuality is a natural and healthy part of living.
- All persons are sexual.
- Sexuality includes – physical, ethical, social, spiritual, psychological and emotional aspects.
- Individuals express their sexuality in various ways.
- It is the families that provide children the first education about sexuality.
- Sexual relationship should never be coercive / exploitative.
- All sexual decisions have effects and consequences.
- All persons have the right and obligations to make responsible sexual choices.
- Young people develop their values about sexuality as a part of becoming adults.
- Premature involvement in sexual behavior poses risks.

- Young people who are involved in sexual relationship need access to information about health care.

Illustrate ways in which some diseases are stigmatized

Exercise 7.3

Purpose of this exercise is to sensitize the group with regards to the effects of misconceptions and attitudes of the community on the infected person.

1. **Get a person who has been diagnosed as HIV/AIDS positive and has come to terms with it to discuss his/ her experience in relation to the societies response to his diagnosis, treatment, management (attitudes and beliefs)**

2. **This could also be done in the form of a video or audio recording.**

Discuss the social and cultural attitudes and beliefs that affect individuals infected with HIV/ AIDS & STD and their care

Stigma: It is a mark of shame or disgrace

Discrimination: It is to treat a person, an idea or a thing as different (worse or better)

The most common reasons for the prevailing beliefs and attitudes regarding HIV/AIDS or STI/RTI are

- Lack of knowledge
- Fear of contacting the disease
- Fear of society (fear to show affection and acceptance of an infected person)

Education and awareness building among the general public about the causes, signs and symptoms, spread, treatment and prevention of RTI/STD and HIV/AIDS could help in removing these misconceptions. These misconceptions are major determinants in decisions made by persons who are affected with the infection.

Exercise 7.4

The purpose of this exercise is to sensitize participant about possibility of STIGMA because of RTI/STD/HIV/AIDS.

1. **Have two charts ready. On one chart write rejected and on the other accepted. Stick these charts on two opposite corners of the room.**
2. **Make chits of paper; write one each of the following examples on each chit. Ask for 13 volunteers and then pin one chit on the front of a participant.**

- **Woman who is faithful to her husband but has developed HIV**
- **Woman who has multiple partners presenting with STD**
- **Woman who comes from a poor background presenting with HIV**
- **Woman coming from a rich background presenting with HIV**
- **A devadasi presenting with STD**
- **Woman who is forced to have sex with many in the same family (wife sharing) presenting with STD**
- **Man who has several partners presenting with STD**
- **Man who has only one partner and is an influential person in the community presenting with STD**
- Man who has several partners and who comes from a rich family that is well known in the community presenting with HIV
- A young girl (13-18 years) who presents with features of STD
- A young boy who presents with features of HIV
- A young boy who present with features of HIV, known to be of good character, but having a history of taking blood transfusions
- A man (20 years) known to have behaviors such as drug abuse presenting with STD

3. Then ask all the participants to stand up and mix with each other
4. The facilitator asks the participants

Who in your mind are most likely to be rejected (thrown out) by their community or looked down upon or are treated as outcasts?

5. As when the rest of the participants see a volunteer participant with a chit of paper pinned in front of them ask them to decide whether or not the person will be accepted or rejected by the community. That means those that feel the person will be rejected or accepted must ask the respective volunteer towards the chart, which is either written, **rejected or accepted**

Certain prevailing beliefs and attitudes (Misconceptions)

Reflective exercise 7.5 (optional)

1. **The facilitator divides the participants into 4 smaller groups of 5-8 members**
2. **The participants are asked to discuss in 5 minutes the various misconceptions they feel are prevailing in their community regarding HIV/ AIDS and STI/ RTI**
3. **The group leaders could then come forward and present the points discussed in their respective groups**
4. **The facilitator then tells the participants various beliefs/misconceptions relating to RTI/STD/HIV/AIDS are given in Hand out 7.1 which they could read later and discuss when time permits during tea/lunch break or after the days session**

Handout 7.1 Certain prevailing beliefs and attitudes (Misconceptions)

Beliefs / Misconceptions	Facts
Causes of RTI /STD • Dirt, contaminated water and air • Eating hot and cold food together • Evil eye • Heredity • Mixture of many men's sperms in one woman's vagina • Needles and unsterile syringes • Single contact will not cause STD • Tubectomy & contraceptive devises • Consumption of tea, chilies & hot food	**Causes of RTI / STD** • Specific causative organisms • Indulgence in unsafe sex behavior i.e. multiple partners • Young ones born to STD infected mother • Infected blood transfusions
Causes of HIV / AIDS • Casual contact • Multiple sexual encounters • Punishment from god • People with low morals get infected • Western disease that you get only if you sleep with a foreigner. • Homosexuals and drug users	**Causes of HIV /AIDS** • Causative organisms - virus (HIV) • Unprotected sexual intercourse with an infected person • Sharing needles, blades, syringes of an HIV infected person • Blood of an HIV infected individual transfused to another • Infected women may pass it on to their child during birth.

Signs & symptoms of RTI / STD & HIV / AIDS • Look weak and thin • Feeling hot • Black or dark face • Wants to stay in a lonely place • Pimples on the face and tongue • Healthy looking person cannot harbor HIV • All white discharges in females are normal.	**Signs & symptoms of RTI / STD & HIV / AIDS** **STD / RTI** • May be asymptomatic in females • Excessive discharge • Ulcer in the genitalia • Chronic pain in lower abdomen • **Child born with eye infection leading to permanent blindness.** **HIV/AIDS:** ***Major*** - Greater than 10% weight loss - Fever longer than one month - Chronic diarrhea ***Minor*** : - Persistent cough (> one month) - General itchy dermatitis /Herpes - Oropharyngeal candidiasis - Generalized lymph- adenopathy
Spread of RTI / STD • Blood transfusion • Bodily warmth of an infected person • Clothing / underwear/dirty linen • Evil eye • Kissing • Needles and unsterile syringes • One passes urine immediately in the same place where an infected person just passed urine • Shaking hands / sharing food • Warm seat **Spread of HIV/ AIDS** • Bathing in dirty water • Mosquito bites / insect bites • Sharing the same cup, plate and spoon • Sharing food of an infected person • Shaking hands and hugging an infected person • Sitting next to an infected person • Using the public swimming pool/pond • Using the same toilet seat Wearing the infected persons clothes	**Spread of RTI / STD** • Through sexual intercourse • From infected mother to child **Spread of HIV/ AIDS** • Spread through infected persons, blood, semen, vaginal secretions, and any secretions mixed with blood • It is also spread through breast milk CSF, synovial, pleural, peritoneal and amniotic fluid and pass

Treatment of RTI / STD / /HIV /AIDS • Apply lemon to genitals after sex • Cured with out treatment • Having sex with virgin • Drinking lime juice • Being treated for STD is enough • Taking antibiotics before sex • Washing private parts with dettol • Treatment can be stopped as soon as symptoms subside • Sex with a pig / virgins • Take bath 4-5 times per day With exorcism	**Treatment of RTI / STD** • Medical management **Treatment of HIV / AIDS** • No cure but care and prevention is possible
Attitude toward HIV / AIDS positive person • Extent of sympathy depends on how the person gets the infection. • People who die of AIDS deserve it. • It is dangerous to have people with HIV/ AIDS in the community. • A child who is HIV positive should not be given admission into a school in order to protect other children. • A person who is HIV positive should be removed from the workplace to protect other workers.	• Accept the individual as he /she is • They are eligible for basic human rights (Refer the annexure)

Exercise 7.6

The purpose of this exercise is to sensitize participants about constraints they might face in dealing with PLHAs

1. The participants remain in the same group as in exercise 7.5
2. The facilitator distributes two colour cards viz. yellow and blue to each group. All groups are asked to use the cards in the following order in 5 minutes
   a. List down the constraints that nurse's face while working with persons with HIV/AIDS in yellow colour cards
   b. List down the constraints that person with HIV /AIDS may face in blue colour cards
3. The group leaders could then come forward and present the points discussed in their respective groups
4. The facilitator then supplements any information, which did not come out from the group presentation following which the facilitator gives information on some sensitive controversial issues

Sensitive controversial issues

In the Indian context we have the following psychosocial constraints:

1.Traditional customs and practices

i. ***Wife sharing practices***

In some of the parts of India it is normal for the brother – in – law of the widow (brother of the husband) to marry her in order to retain the property within the family.

ii. ***Skin piercing rituals***

It is a normal Indian practice to pierce the ears and noses of women and occasionally men. The instruments used are usually not sterile and the same needle may be used for many. Tattoos are another form of skin piercing practices that is a cultural practice, which again involves the use of needles shared by many.

iii. ***Traditional healers and remedies:*** This may give people false hope of healing and thus hinder adequate health seeking behavior, which to some extent can prolong life.

iv. ***Devadasies:*** They are girls who are groomed from the time they attain menarche to live in temples. They are temple dancers and are used as sex professionals.

2.False information

A typical example is in relation to adolescents. Wet dreams are a normal occurrence as a part of growing up leading to masturbation. But the elders often tell the adolescents that this makes them weak. In order to overcome this problem they are encouraged to indulge in sexual activity that may not be safe or typically due to their developmental age they may indulge in unsafe sex practices.

3. Decision makers of the family

In a joint family, which is a norm in the Indian scenario, the decision maker in the family happens to be the father or mother-in-law. In such situations it is typically seen that the younger members of the family are encouraged to keep their problems within the family. This prevailing practice may prevent persons especially women, from discussing the issues related to STD/RTI with the health personnel and seeking help.

Chapter-VIII

COMMUNICATION AND COUNSELING IN CONTEXT OF STI / STD / HIV

Introduction

HIV has no territorial boundaries. It is found in urban and rural areas. By and large it may not be feasible to know who is infected and who is not. It is therefore safer to modify dangerous practices and prevent the spread of HIV.

Nurses can play on important role in informing and counseling the people with whom they come in contact including their patients about HIV, and its prevention. This being a sensitive issue calls for tremendous skills in communication.

Exercise 8.1

1. Ask for 4 -5 volunteers to go out of the room. They must not be able to hear what the facilitator will tell rest of the participants.

The message that is read out is...

Mrs. Yamuna, wife of Mr. Yellappa came to the PHC at Maddur and met Dr. Dasappa. She complained of feeling of weakness, fever, loss of appetite and sleep for the past 8 days. Says her husband is a lorry driver and comes home only once a week. Over the past few months she finds him withdrawn and dull. She asks the doctor if she can bring him along during the next visit. The doctor gives her two tablets to be taken in the mornings for five days and asks her to take an injection daily from Mrs. Dayamma for the same five days.

2. One volunteer is called back into the classroom and the same above message is read to him / her in front of the rest, only once.
3. The first volunteer must listen carefully and repeat the message to the second volunteer
4. The second volunteer then should repeat the message to the third volunteer who is called in to the class room, the third to the fourth and the fourth to the last volunteer.
5. The 5th volunteer is then asked to repeat the message to the group.

There will be a change in the meaning of the message. Once this happens the facilitator must make the group aware of how communication if not properly done can lead to distorted and untrue messages.

General objectives

On completion of this session the participants will be able to understand the basic theories and practice of communication as it is related to people with STD / RTI and HIV/ AIDS and feel confident to use the skills with adequate guidelines and support.

Specific objectives

On completion of this session the participants will:

- Identify their personal strengths and weaknesses in communication
- Be sensitized to the points for effective communication and phases of communication
- Be aware of barriers to effective communication
- Identify various aspects of behavior change communication
- Develop appropriate communication and counseling skills for individuals in need of HIV testing services

Key concepts

- The nurse needs to have self awareness regarding her / his communication skills
- Communication follows a series of well organized steps in order to be effective
- Effective communication techniques enhance communication
- Barriers of communication need to be identified and overcome
- Counseling is part of the caring process of persons at risk for HIV or with HIV
- Nurses could help in the counseling of persons at risk for HIV or with HIV in settings where trained counselors are not available
- Nurses can learn the various aspects of counseling of persons at risk for HIV or with HIV through practice

Teaching methods

- Small and large group discussion
- Reflective exercise
- Role play
- Lecture

Materials/ preparation required

- Black board, chalk, duster
- OHP, transparencies of important points
- Copies of handouts, checklists

Topic outline

- How do I rate as a communicator?
- Points to remember about communication
- Tips on communicating sensitive issues
- Barriers to communication
- Skills in counseling
- Characteristics of a good counselor
- Pretest counseling
- Post test counseling

Total session time

3 hours

BACKGROUND MATERIAL

How do I rate as a communicator?

Exercise 8.2

1. **Ask the participants to give their meaning of the word communication**
2. **Write the responses on the board**
3. **Supplement this with the following definition**

'Communication is a process by which information ideas and feelings are exchanged between individuals'

It is important that each one of us is able to introspect and discover what are our own personal strengths and weaknesses in relation to communication. This is necessary since we have to build our skills in communication, as it is one of the strongest ways to facilitate behavior change. The next exercise will provide you with a means to discover your own strengths and weaknesses in relation to communication.

Exercise 8.3

This exercise would help participants evaluate themselves in relation to how well they could communicate

1. Ask the participants to read the rating scale given soon after Exercise 8.3 of the module
2. Read the instructions to the group to rate themselves against each item by placing a check (√) in the column that best suits them.
3. Instruct them to fill in the columns as soon as they read the statement /item and not to delve for too long on the item since then they are likely to rate themselves differently. Also affirm to them there are no right and wrong answers.
4. Ask each participant to complete the Performa in 2 minutes
5. Give them a feed back after they complete the exercise

Evaluation – The more the number of " can do very well" the better the communication

Performa -How do I rate as a communicator?

Instructions:

A list of statements is given. Please read each statement and then **rate yourself** according to the following criteria **'can do very well', 'can do ' and 'unable to do'. Place a check** (√) against the respective column for the item. Complete all the 20 items.

Please remember there is **no 'right ' or 'wrong'** response. This is only an exercise which would help you understand your self better and would help you identify the areas in communication which you would have to improve on. Try and be as honest as possible with your response.

Do not take too much time with each item. Just check (√) the item as soon as you have rated yourself for the item. We will not be asking you how you have scored in this exercise. It is just an exercise for self-awareness.

	Can do very well	**Can do**	**Unable to do**
I can recognize my own feeling			
I can recognize another feelings			
I can express my own feeling			
I can accept my own worth and feel happy with myself			
I can accept my own limitations / weakness with myself			
I can recognize and express my negative feelings			
I can accept positive feedback without feeling shy			
I can accept negative feedback without feeling bad			
I can read others non-verbal communication well			
I can show sympathy or identify with other feelings			
I can express my goals and intensions clearly			
I can deal effectively with misused messages (words say one thing and actions another)			
I remain calm in high stress situations			
I can give positive feedback to others so they feel good and reassured			
I can give negative feedback in a helpful way			
I can express my feelings nonverbally			
I can accept others as they are			
I can describe another's behavior without passing judgments			
I can accept other peoples opinion even though they are not my own			
I am open to new values, attitudes and experience			

Tips on communicating sensitive issues

1. ***Create an environment that is supportive.*** This includes:
   - Considering the timing of the discussion
   - Selecting a place that provides privacy and less distraction
   - Acknowledging the feelings of the person and reminding them that they are not the only ones who face such problems.
   - Beginning with less intimidating / less sensitive issues

2. Keep in mind the message: (Refer back to Exercise 8.1)

Distorted message occurs if	*Solution for avoiding it*
It is too long	Keep sentences short
Too many names / unfamiliar words	Use simple understandable words / language
It is not repeated	Repeat important points
It is not important to the listener	Make it appropriate for the listener
If the listener is nervous	Make the listener comfortable

3. Use audio visual aids since it makes communication clearer

Remember – " What I hear, I forget.
What I see, I remember.
What I do, I know."

4.Remain non judgmental and relaxed

5.Do not be afraid to ask but be aware of how to ask for information

*6.**Keep the following points (see Handout 8.2) in mind for effective communication / counseling***

Handout 8.1. Points to keep in mind for effective communication / counseling

Message

- Keep sentences short and simple
- Make the listener comfortable
- Use a language known to the listener
- Do not use too many names and unfamiliar words
- Discuss one point at a time
- Focus on the listeners needs and interests.
- Talk slowly
- Ask for a feedback
- Repeat important points
- Summarize main points

Listening / Non verbal communication

- Respect the person/s.
- Maintain eye to eye contact
- Smile when necessary
- Lean toward the person
- Nod head occasionally
- Say "yes" "hmm" and "OK"
- Do not hesitate to touch the person when needed

Tone

- Use a tone of voice that encourages communication
- Utilize praise and encouragement more

Questioning technique

- Use open ended questions
- State questions clearly
- Use the language understood by the person
- Start with 'how', 'when', 'why' or 'what'
- Ask only one question at a time
- Waits for answers rather than speaking immediately
- Repeats questions when not understood

Brainstorm (3 minutes)

What do you think are the barriers to communication?

1. List the points on the black board?
2. Ask one participant to read Handout 8.2 and clarify any doubts if any?

Handout 8.2

Barriers to communication

Personal Barriers	Remedies
Attitudes Differences in attitudes	- Allow differences in attitudes and respect their viewpoints even if you do not agree
Belief Differences in beliefs between individuals	- Encourage helpful beliefs - Accept neutral beliefs - Discourage through education / awareness those beliefs that are harmful. E.g. People with AIDS should be isolated
Misunderstanding	- Identify and clear doubts
Language	- Speak / communicate in the language familiar to the listener
Not listening	- Be a keen listener (see checklist –2) - Draw the individual back to the topic of discussion
Cultural differences E.g., wearing of footwear inside the house	- Be aware and respect the culture of the target group
Lack of identification of the need of the community E.g. There is a prevalence of cholera in the village but the nurse addresses the issue of TB	- Always communicate with consideration of the felt need of the person to whom you are talking
Interruptions	- Redirect the communication back to the topic
Personal values and morals E.g. The nurse may strongly oppose idea that commercial sex workers are also considered as professionals.	- Although all values and morals of the person may not be acceptable respect his / her right to their values / morals
Prejudice (pre judgment) E.g. That all professional sex workers are anti social elements.	- Show acceptance of the individual but not the value / moral - Always communicate with an open mind - Avoid being judgmental

Personal barriers to communication.....

Being embarassed...

Having no solution...

Being unsure of self...

Being in a hurry...

Being unable to establish a rapport...

Community Barriers	Remedies
Denial – of the existence of the problem E.g. "AIDS is not a problem in our village."	- IEC activities - Networking with influential people
Fear and stigma E.g. "The more we talk about AIDS the more frightened we get therefore it is better not to talk about it".	- Prevent it by showing positive attitude - Educate the public about HIV/AIDS
Illiteracy	- Make them aware of the problem
Embarrassment / discomfort To talk about the issue evidenced by trying to change the topic	- Build rapport and help them feel comfortable
Helplessness E.g. "I can't do anything about it."	- Make them aware of their role in controlling and preventing the spread of the disease. E.g. Through behavior control and education

We need to learn to communicate effectively, as nurses we are responsible for

- Educating individuals, family and community.
- Facilitating change in high-risk behavior.

Hence a brief discussion of behavior change communication will follow.

Behavior change communication

Meaning

Behavior: **Is any or all of a persons total activity, especially that which is externally** observable.

Behavior change communication: **Is communication by which information, ideas and** feelings are exchanged between individuals for the purpose of bringing about a change in some of the concerned persons activities.

Goals of behavioral change communication

- Facilitate a positive attitude
- Aid in motivating the concerned person
- Identify obstacles in behavior change
- Recognize resources required for behavior change
- Assist and support individuals during the process of behavior change

Area in which behavior change would be required

- Self-care behaviors such meetings one's personal hygiene needs
- Personal habits such as intake of alcohol, drug abuse, late night parties etc. that may predispose the person to taking part in risky sexual behaviors
- Sexual behaviors
- Family life especially in terms of making plans for the future

Obstacles to behavior change

- Personal attitude such as denial and feeling of powerlessness (meaning that the person feels that she / he cannot make the change)
- Socio–cultural factors like financers, peer group pressure, attitudes and beliefs
- Lack of knowledge and experience in the field
- Lack of resources

Factors influencing behavior changes	Methods to overcome obstacles
Information: If persons are given correct and appropriate information they may become sensitized to the need for change in their life styles or behaviors. Becoming aware of the need to change by receiving information is one of the strongest motivations for a person to want to change.	***Knowledge:*** Increase the knowledge, through IEC activities • Regarding spread of STD / RTI and HIV / AIDS • Its presentation • Signs and symptoms • Available resources for the treatment of any of these infections • Appropriate use of resources • Risk reduction practices
Motivation: Several factors could aid in motivating individuals to want to change their behaviors. It is however important to remember that change and motivation is strongest when it comes from within the person. This usually happens when an individual is faced with a personal crisis or is in the cross roads of his or her life, during which time the person is internally driven to try a difficult change.	***Attitudes and beliefs:*** Promote among the listeners the following attitudes and beliefs: • I am in control of my life and health and can change behavior. • I deserve good health • The sacrifices required to change is worth it • What the health personnel is telling me is true • Anyone can get STD / HIV • There is no cure for HIV • Condoms are for everyone to use ***Skills:*** Enhance the following skills • Increased ability to communicate with their partner • Improve their ability to discuss and try new sexual practices with one partner • Acquiring and using condoms properly • Planning in advance for sexual activity
Support: Support can be available from any number of sources (self, peers, family, community and significant others viz. religious, teachers, etc). It is important that focus of all support persons must be in risk reduction strategies. Other sources of emotional support when change becomes difficult must be tapped so that the person at risk for infection is motivated enough to practice safe behaviors.	***Support to promote*** Risk reduction practices includes the following: • The partner's willingness to change • Use of readily available and affordable condoms • Encourage practice of safe sexual activities

Components of counseling in the context of STI / STD / HIV

Role play guidelines

1. The facilitator along with one or two other co-facilitators role plays a situation

Mrs. Srimathi is presenting with a history of excessive vaginal discharge. She approaches the nurse in the PHC for help

2. The participants are taken through a scene of assessment, pretest counseling and if time permits, post test counseling, follow –up and support
3. The participants are then asked to review the Handouts 8.1, 8.2 and 8.3.
4. The facilitator then reviews components of pretest counseling. All the participants are also asked to review Handouts 8.4 - 8.5

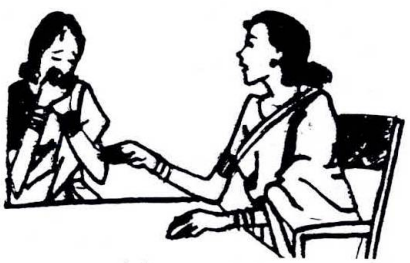
DON'T'S DURING COUNSELING....

Be judgmental

Be embarrassed

Advise

DO'S DURING A COUNSELING SESSION



Show concern with your posture / same sex preferable

Be supportive

Handout 8.3 Phases of communication / counseling

Pre-orientation phase

- Obtaining available information of the person
- Self examination (comes to terms with own feelings about HIV/AIDS)

Orientation phase

- Develops a rapport
- Builds trust
- Assures confidentiality (keep in secret the information received)
- Gathers assessment information
  (High risk behavior, time of the last risk behavior or contact, specific life situations such as marriage, pregnancy and migration)
- Identifies strengths and weaknesses of the person (e.g. coping skills, family support etc.)
- Assesses the knowledge of the person regarding HIV

Working phase (in relation to the case given)

- Gives information
  - The test details
  - Purposes
  - Window period
  - Interpretation of the test
  - Implications of the test
  - Who should know the test result
- Clarifies any misconceptions and doubts
- Orients regarding facilities available for testing and management
- Obtains consent for HIV testing
- Assesses the person's capacity to cope with the results
- Educates regarding HIV
- Identifies problems and helps to find solutions
- Helps the person in making decisions
- Makes attempts to overcome resistant behavior if present

Termination phase

- Summarizes / reinforces the information given
- Assures the person of the availability of any staff to meet her needs (letting go)

Proper testing and counseling for HIV infection involves several activities and skills that you would have to develop.

1. Pretest Counseling

Aims of pretest counseling

- Preventing transmission
- Providing the opportunity to prepare the person emotionally for accepting a positive result.
- Helping to become aware of the strengths and weaknesses of the person.

Steps in pretest counseling

i. Identify need for being tested

It is important that you are able to identify who should be tested. Highlights of persons who must be encouraged to take the test are listed in Handout 8.4.

Many experts today feel that **ALL** individuals should be encouraged to be tested, irrespective of their risk status. Figure I can be used as a simple guide to know who should be counseled to seek HIV testing.

Handout 8.4. Persons who need to be tested

- **H**omosexual or bisexual men
- **I**ntra venous drug users (IVDUs)
- **T**ransfusion of blood
- **D**onors - blood, sperm or organ
- **I**nfants born to HIV infected or high risk mothers
- Sexually transmitted diseases (STDs)
- **C**oncerned - Any person worried about the possibility of having HIV disease
- **H**epatitis B, Hepatitis C (non A / B Hepatitis)
- AIDS –like illness or illness consistent with AIDS
- **M**ultiple sexual partners –sex for money, pleasure or drugs
- **P**artners of homosexuals, bisexuals, IVDUs or of any HIV positive individual
- **O**rgan recipients
- **T**uberculosis infected persons

ii. Appraise the persons risk status

In order to identify the risk status, you must be able to obtain reliable, personal history of person's concerned.

You do not need to go in to details but it is necessary for you to ascertain whether or not a risk behavior was present or not in the individual. A list of some questions that you can ask to the person is given in Handout 8.5.

Handout 8.5: List of questions that may be asked to a person to assess their risk status

- **Do you have sex with more than one person?**
- **Do you have sex with men or women or both?**
- **Do you have oral, anal or vaginal sex without using a condom?**
- **Do you have sex with someone with known or suspected history of**
  - **Multiple sex partners?**
  - **Bisexuality?**
  - **Intravenous drug use?**
  - **Taking other drugs?**
  - **Receiving blood transfusion?**
- Have you ever had
  - **Genital ulcers?**
  - **Warts?**
  - **STDs such as syphilis, gonorrhea, crabs, scabies, herpes, hepatitis B?**
- **Have you ever injected any drugs intravenously and if so, do you share needles?**

iii. Provide needed information during pretest counseling

Information that has to be provided during pretest counseling includes

- The purpose of HIV testing
- The limitation of HIV testing
- Consequences of testing result
- Methods of prevention
- Importance of early medical intervention, since it is likely to decrease the sense of hopelessness that goes hand in hand with the diagnosis of HIV
- Causes, spread, treatment and prognosis of HIV and AIDS with the main aim to correct any misconception the person may have
- Anonymous testing in the event of persons who may refuse to consent for HIV testing.

iv. Inform about the required tests and interpret the results

- In VCTs cost of testing is only Rs. 10/-
- A rapid test for detecting antibody to HIV is a screening test that produces very quick results, usually in 5 to 30 minutes. In comparison, results from the commonly used HIV antibody-screening test, the EIA (enzyme immunoassay), are not available for 1-2 weeks.
- The availability of rapid HIV tests may differ from one place to another. The rapid HIV test is considered to be just as accurate as the EIA.

- **Both the rapid test and the EIA look for the presence of antibodies to HIV. As is true for all screening tests (including the EIA), a reactive rapid HIV test result must be confirmed before a diagnosis of infection can be given.**

Do not to tell the person the result until three tests are positive or reactive on the same blood sample.

Remember

1. **Confirmed diagnosis: Three positive tests on the same sample of blood is needed to confirm the diagnosis of HIV**
2. **For known exposure: Advice them to repeat tests within 3-6 months if the first test is non-reactive since they may be in the window period**
3. **Symptoms related HIV: Advice the need for retesting serially on the same sample of blood till three consecutive positive test is obtained**

2. Post test counseling: Posttest counseling could be done following HIV testing and once the results are known definitely.

Aim of post-test counseling is to:

- Support the HIV positive person
- Prevent HIV transmission to a HIV negative person

Posttest counseling should be considered separately for two categories of people

- Persons who are HIV negative or have indeterminate tests
- Persons who are HIV positive

Exercise 8.4

The purpose of this exercise is to give participants the chance to role play different situations of pre test counseling.

1. **Divide the participants into 6 groups**
2. **Ask participants to role play the following situations while the rest of the participant observes**

Counsel a person

- ***Whose test is negative with high risk behavior (see Handout 8.6)***
- ***Whose test is positive (see Handout 8.7)***
- ***Whose spouse needs to be informed about the partners HIV status (see Handout 8.7)***
- ***Regarding follow-up (see Handout 8.9 in Facilitators module and Handout 8.8 in Participants module)***
- ***Regarding reducing risk for oneself(see Handout 8.10 in Facilitators module and Handout 8.9 in Participants module)***
- ***Regarding preparation for death (see Handout 8.11 in Facilitators module and Handout 8.10 in Participants module)***

3. It is preferable that all participants and each group be given the opportunity to role play all situations and then given the chance to read out handouts 8.6-8.11 provided time permits. Alternatively if time does not permit, ask each group to come forward and present a role-play on the given topic. After the role play the rest

Handout 8.6: Persons who are HIV negative (no clinical signs but has risk factors) and those with indeterminate results (no clinical signs but have risk factors)

HIV negative

a. Counsel face to face as soon as the results are obtained
b. Check whether the person is ready to hear the result, if not suggest a later date and ask them to bring a support person if needed
c. Emphasize on the need for change in life styles in relation to sexual relationships, habits such as drinking, smoking etc. since this could increase their risk for participating in unsafe sex

Indeterminate results

a. Counsel face to face as soon as the results are obtained
b. Check whether the person is ready to hear the result, if not suggest a later date and ask them to bring a support person if needed
c. Counsel on need for additional testing, clinical follow-up, and change in subsequent high-risk behaviors if they have repeated indeterminate result but have a history of exposure
d. Confirm the need for subsequent testing to those persons who have a non-reactive result but have been recently exposed to any of the risk factors
e. Do not tell the person with the indeterminate test that they have the infection
f. Advice them on the need to avoid donating blood, semen, breast milk or organs.

Handout 8.7. Person who is positive - Points to be kept in mind when revealing HIV status to the person or to the infected person's spouse/partner

a. Counsel face to face as soon as the results are obtained
b. Check whether the person is ready to hear the result, if not suggest a later date and ask them to bring a support person if needed
c. Reveal the HIV status sensitively.
   - Keep in mind that there are no standard instructions for this
   - Follow the person's lead. For example even before revealing the diagnosis you may start by asking ' Have you been thinking a lot about your tests results? Would you like to know it? The person's response to these questions would reveal how prepared for the diagnosis
   - Give result simply, clearly and humanely
   - Allow time for result to sink
   - Be positive in approach. Reinforce that presently the person is healthy but is likely to develop problems in the future
   - Give information according to the needs of the person.
d. Deal with immediate reactions (see **Handout 8.8**)
e. Remind them on the need for more counseling sessions.
f. It is encouraging to tell the person 'you may have HIV infection but there are a number of ways in which you can live healthily' or 'I have suggestions for you which you can use to live healthily despite knowing that you have HIV'

Handout 8.8:Immediate reactions of persons when they are revealed the diagnosis of HIV

Denial / Shock – Phrases that they are likely to come out with 'ME?' or they might just be silent having a blank expression.

Anger – it may be directed to themselves for their previous behavior or it would be directed towards the people who most likely infected the person, or even to God for not sparing the person. Typical phrases are' why me? Others do it all the time and yet I have got the disease!

Revenge or spite – due to excess anger the person likely says ' I got the disease because of one act, now why I should only suffer, let the others also get the disease from me!'

Bargaining- sometimes they bargain with God for a better deal. Common phrases being mentioned during this period are ' if I am given a chance I will live a better life' etc.

Loneliness, despair and depression- manifested in the later stages of reactions to any bad news and are aggravated by the way significant others are likely to react to the affected person. Depression could lead to suicide.

Fear – Common reasons of fear are of pain, losing a job, others getting to know that the person is HIV is positive, leaving children, death, or even of spreading the disease. Fears are worsened because of media and literature, which refer to the disease as a fatal disease or a bad disease.

Acceptance and hope – If the person is given continued support and reassurance they are likely to accept their HIV status and learn to live with the infection

Handout 8.9

Speak the truth gently in discussing follow-up care and support

- ☐ need for ongoing counseling
- ☐ counseling the partner and the family
- ☐ personal, family, social implications
- ☐ social support
- ☐ legal advice
- ☐ referral for screening and treatment of STDs
- ☐ family planning counseling
- ☐ special services to pregnant women
- ☐ medical reference
- ☐ treatment plan and future plans

Handout 8.10: Develop personalized risk reduction plan

Discuss issues such as

- **Practicing safe sex**
- **Enhancing self esteem**
- **Avoiding alcohol, drugs and smoking**
- **Changing lifestyles to avoid transmission**
- **Those related to transmission such as to**
  - **Avoid donating blood, semen, breast milk, organs**
  - **Avoid sharing needles**
  - **Always use sterile needles and syringes for drug use**
  - **Take care of blood stained clothes especially those after**
  - **Use separate tooth brushes razors, blades etc.**

Identify options and resources for future

Issues that may need to be discussed depend on the individual person's need. It is also necessary to communicate to the individuals the availability of counseling whenever needed. Points that need to be discussed include

- **Initiation of appropriate early treatment**
- **Reinforcement of the concept of hope**
- **Need for health information**
  - ***HIV disease process- cause, spread, treatment options, prognosis***
  - ***Associated opportunistic infection***
  - ***Prevention of transmission through sexual contact, breast milk, placental, during delivery, intravenous route***
  - ***Availability of methods to prevent transmission to others and in the case of HIV positive mother methods of prevention to the fetus or the baby***
  - ***Need for complete health or medical evaluation***
  - ***Availability of support services and community based organizations***
  - ***Referrals to rehabilitation and community agencies for additional support***

Handout 8.11: Preparing a person for death

- Assess the persons knowledge of what he/she has been told about the condition
- Assess the person's support systems (Family, friends, any other form of support)
- Find out what resources the person has to cope with the situation of impending death
- Encourage the person to express his /her feelings or fears or needs or concerns
- Support the person while he / she reacts
- Enquire whether the person requires any specific help or person to be with him / her
- Check whether the person wants to make plans for the family
- Check whether the person wants to see any religious person
- Enquire about what the person wishes for his / her last rites
- Make appropriate measures to see that the person is comfortable
- Above all be with the person

Chapter - IX

COMMUNITY BASED CARE FOR PEOPLE LIVING WITH HIV / AIDS (PLHA)

Introduction

Persons with HIV infection/AIDS do not require isolation but the virus needs to be isolated. Hence focus is shifting on care for people with HIV in the community itself with the hospital being reserved only for acute episodic illnesses.

Comprehensive care concept encompasses medical treatment, nursing care, counseling and other social as well as psychological support for persons with HIV/AIDS, their families and dependents. Community based care requires effective linkages between hospitals, health centers, communities and home which can be initiated by nurses. By involving communities, the quality of life for people living with HIV/AIDS can be substantially improved.

General objectives

The participants will be able to understand the meaning of community based care and develop skill in providing need based care in the community for people living with HIV and AIDS.

Specific objectives

On completion of this session, the participants will:

- Demonstrate an awareness of care and support
- Recognize the types of care and its benefits
- Implement the components of community-based care
- Participate as link for providing community based care

Key concepts

- Community based care is necessary for PLHA
- Nurses could play a vital role as links for providing community based care
- Hospitals could be best used to meet the acute needs of PLHAs
- Community based organizations, support groups, NGOs and homes could be used to meet the day to day needs of PLHAs

Learning methods

- Lecture
- Discussion both small and large group
- Case study
- Exercises

Materials /preparation required

- Transparencies with figures and important points, OHP
- Black board, chalk, duster
- Chart paper, pens
- Handouts

Topic outline

- Meaning of key terms
- The present scenario of care and support
- The purpose of care and support for PLHAs
- Components of community based care
- Types of care
- Frequently asked questions while caring for PLHAs

Total session time

45 minutes

BACKGROUND MATERIAL

Meaning of key terms

Exercise 9.1

1. **The facilitator conducts a brainstorming session on the meaning of 'care' and 'support'**
2. **Participants are requested to express anything that comes in their mind about the two words**
3. **The facilitator then summarizes the points that come forth**

Caring

Caring means 'concern for the well being of another. It means helping persons to recover from illness so that they can live as normal a life as possible

Caring process

- Knowing
- Being with
- Doing for
- Enabling
- Maintaining belief

Caring may mean...

- **Being there to help them get a meal together**
- **Feeding them**
- **Helping them get dressed**
- **Sitting with them, being quiet/talking**
- **Helping them get to the bathroom**

Continuum of care

- Entry
- Counseling and information
- Management
- Home based care and family counseling
- Palliative care in the hospital or home
- Care and support of the family after death

Support

Support means the assistance given to the person by another in all ways. Support is important to maintain a positive attitude and includes support from family, friends, lovers and partners.

The present scenario of care and support

Present situation	Our dire need and vision
• Many states in India do not have adequate care center • Majority of money is spent on prevention rather than care • Essential life saving drugs is not available. • Death rate increasing • Rejection from the community	• Education of the community to facilitate in community based care • Home and community care • Medicines for all OI including ART • Support groups to help PLHAs lead a normal life

The purpose of care and support for PLHAs

- Improving the quality of life
- Developing cost effective, sustainable approaches
- Increasing life expectancy
- Reducing the stigma
- Providing diagnosis and treatment for common diseases
- Preventing the spread of the infection
- Improving counseling care and support services
- Providing palliative treatment and supportive rehabilitation
- Enhancing awareness on legal and human rights
- Initiating livelihood program
- Developing support agencies and other financiers of AIDS program as a powerful tool for expanding the response to the epidemic
- The final goal of all care and support intervention is to help PLHAs live positively

Exercise 9.2

1. The facilitator divides the participants in to four small groups
2. Each group is asked to discuss what they mean by living positively in 5 minutes
3. A representative of each of these small groups would then come and present this to the rest of the participants
4. The facilitator then could then request one volunteer from among the participants to read aloud Handout 9.1

Handout 9.1: Living positively with HIV /AIDS

Living positively with HIV/AIDS means...

- **Spending time with family and friends**
- **Planning for the future of loved ones**
- **Maintaining spiritual health**
- **Having hope**
- **Managing self care**
- **Eating a balanced diet**
- **Keeping busy**
- **Remaining productive**
- **Maintaining a balance between activity and rest**
- **Avoiding the use of alcohol and tobacco**
- **Seeking medical help whenever an illness arises**
- **Going for individual and for group counseling**
- **Learning about transmission and management of HIV infection.**

Components of community based care

The components within the continuum of care can be summarized as follows

Medical services
For details refer to Chapter-II

Nursing care: Nursing care can be given at the

- Hospital
- Day care centers
- The homes of persons with HIV/AIDS preferably by family members after appropriate training and with supervision by nursing staff
- Outreach programs
- Community based health
- Social welfare programs

Focus of nursing care must be towards

- Modifying behaviors to reduce risk of HIV transmission (see Chapter VIII)
- Educating persons with HIV/AIDS and their family members about prevention (see Chapter IV)
- Counseling (see Chapter VIII)

Focus of nursing care.....counseling

Social support

- Starts in the hospital by health care personnel at all levels and/or social workers
- Needs to be followed up through the community based care program in collaboration with social welfare institutions and NGOs.

Social support of PLHAs could help....

Types of care

Types of care for PLHAs may include care in the hospital, clinic, home based care, day care centers, and respite care.

Exercise 9.3.

This learning activity gives the participants the opportunities to consider the relative advantages and disadvantages of people being cared for in a variety of settings (E.g.) in hospital, in out person clinics and in the home.

1. The facilitator divides the participants into 3 groups of 5-6 members each
2. Ask them to discuss the advantages as well as disadvantages of care given in different settings 10 minutes
3. One representative from the group will come forward and present points discussed to all the participants

i. Home based care

Objectives

To visit people with HIV infection in their homes in order to

- Assess their physical, psychological, social and spiritual needs
- Provide for these needs where possible
- Carry out contact testing
- Carry out counseling and education with the families and communities
- Provide personal support, and promote sustained behavior change through community support
- Counseling of the concerned person regarding treatment and prevention of transmission
- Assess the educational input of AIDS management on people with HIV/AIDS and their families

Who provides home based care?

The health team members can be a clinical officer, 2-3 nurses, social workers, health educators and project manager. There must be strong links between medical professionals, paramedics, social workers, volunteers, families and communities. The home care teams use a medical kit that contains a range of basic treatment to improve the clinical status and personal comfort of the PLHA

Steps involved in home based care

Exercise 9.4: Role Play

1. **The facilitator requests for volunteers to enact a scene where a nurse is providing home based care for a person with HIV infection.**
2. **Review with the participants once the role play is over what are the Do's and Don'ts to be kept in mind during home visits**

Do's during home visits	Don'ts during home visits
• Customary greeting • Respect confidentiality of the person • Review of how the illness has developed since the last visit • Physical examination • Enquire about any new probelms, care and supplies of medicine • Provide hygiene advice to the PLHA and their families. • Spiritual support (if needed or requested) • Demonstrate any procedure to other members in the family • Involve other members in active care • Give date for next visit	• Go without prior notice to the person • Dress inappropriately • Show facial expressions such as disgust, surprise, non-approval etc. • Give blind referrals • Be in a hurry • Go without a plan of care

Handout 9.2. Advantages and disadvantages of some settings of care for PLHAs

Advantages	Disadvantages
Hospital • Ideal for investigation • Ideal for treatment of acute conditions (e.g.) acute respiratory infections, severe diarrhea, encephalitis etc	• Costly or sometimes not affordable • May increase chance of stigmatization especially if isolation of persons is a policy • May not be appropriate • May not be available • May be rejected by the person • May be too far away
Outpatient clinic • More person friendly than hospitals • Cheaper for hospital and person • Can continue one's social and personal activities • More acceptable to persons because their needs are assessed • More possible to preserve confidentiality	• May not be able to treat acute conditions
Home-based • Holistic care possible and more personal • Person may feel more accepted • Less expensive • Facilitates availability of hospital beds for care of other persons • Reduces stigma • Helps in tracing contacts • Enables the ill to be as active and productive as the disease allows • Preferred option if they know they cannot be cured in hospital • Reduced pressure on hospital • Family support is strengthened for the person and his /her dependents after death • Preventive education takes place within the immediate and extended family and outwards into the wider community • Avoids dependability on hospitals • Is more sustainable • Relatives may be able to carry out their duties more easily	• May cause emotional drain in persons • Person affected must feel confident of the possibility of care at home • Availability of a support system to provide care e.g. Family, partner, friends, community people • Shortage of care providers • Lack of home nursing resources • Person may not have a home • Places continuous demand on other family members • Other members of the family may also be sick or fall sick • Break in confidentiality

Contents of Home Care kit

Medications

- **Bicarbonate of soda, 500 mg.**
- **Ferrous sulphate**
- **Loperamide**
- **Multivitamin tablets**
- **Oral rehydration salts**
- **Nystatin suspension 25 ml**
- **Paracetamol tablets 500 mg.**

External medications

- **Benzyl benzoate – 30 ml.**
- **Calamine lotion 500 ml.**
- **Gentian violet 15 ml. Vials**
- **Hydrogen peroxide – 30 ml. Vials**
- **Household bleach**
- **Iodine solutions 10% 30 ml. Vials**
- **Menthol balm**
- **Potassium permanganate 10 mg. Sachets**

Miscellaneous

- **Bandages, Cloth pieces, Coconut oil, Condoms, Cotton wool, Gloves, Matches, Micro pore tape, Plasters, Plastic bags, Soap powder, Safety pins, Talcum powder, Scissors, Elastic bands**

Community care

Community based groups; NGO and associations of people living with HIV have become key partners in the fight against the epidemic. Women's club, youth, religious groups as well as local political and social organizations can also be mobilized to assist. Community organization should organize

- Educational sessions on how HIV infection is spread
- How HIV is not spread
- How to help support individuals/families affected with HIV infections/AIDS by arranging for:
    - Financial assistance
    - Food
    - Spiritual care
    - Medical care
    - Ambulance/transport for medical care
    - Care and support of children affected with HIV infection/AIDS as well as healthy children and orphans.

Hospice care

Hospices

- Cater to the needs of the terminally and acutely ill
- Are very good environment for pain management and palliative care
- Are good respite options for PLHAs and their carers
- Provides for convalescent care with the aim to return the person to their home

Hospices may vary with their policies as well as their health and support services. Hospices may be public health services, which will be free, or private, for which you will have to pay. Even public hospices may have to charge for some services, which are not provided directly by them.

Respite care

Respite care means someone else cares for the people that are cared for. It could be for a few hours, a few days or longer. It could be regular or something that just happens when needed.

There are 3 main ways respite care is usually provided.

- In-home respite care
- Day centers
- Residential respite care. Most people end up using a combination of all 3.

<u>In-home respite care:</u>

- Someone (family, friends, or a volunteering caring service) comes into the home of the person and looks after the person
- The person who requires care goes and stays with relatives or friends for a while

It's often the easiest to organize. It can be the least threatening and the least disruptive. It can feel intrusive, at least at the start, but most people get used to it.

<u>Day centers</u>

Day centres are places that someone who is mostly at home can go to on a daily basis for socializing, recreating, and to give their carer some respite.

Most day centres offer a mix of passive and active recreation, books and television on the one hand or games and may be some less energetic sports. Many will also offer a meal at mid-day on some of the days they are open. They may offer art and craft classes, outings, or fitness and relaxation programs. Some have services like hairdressing. Day centers are generally free, but may charge a small amount of money for some of the activities or meals.

Frequently asked questions while caring for PLHAs

What can I do to safeguard others from HIV?

- Adopt safer sex practices
- Do not donate blood or organs, such as eyes, kidneys
- Do not share needles and syringes

Can I get married and have children?

Most appropriate response: Yes, you can get married. The choice is yours. It is better to tell your partner that you have HIV before the marriage. You will need your partner's support and care if you get sick. If your partner has been deceived, he or she will be hurt and resentful, especially if he or she has also become infected. There are other ways like adoption.

To have children you will have to practice unprotected sex, i.e. not use a condom. You may want to discuss this with your partner as he or she may become infected. The chances that your baby will be HIV infected is high. To protect your partner and prevent pregnancy you will have to adopt safer sex practices, especially use condoms regularly and correctly.

Pregnancy in a HIV positive woman can hasten the onset of AIDS, as her body's resistance to disease is lowered. Even if her baby does not have HIV when it is born, there is some chance that it may get infected with HIV through breast milk. So, even if both partners have HIV, use condoms to prevent

- Pregnancy
- STDs
- Infection with another strain of HIV

Can I live with my family and take up responsibilities?

Home is the best place for a person with HIV because:

- You are not exposed to infections
- You have the support, love and comfort of your family
- You can carry out your daily activities
- You can relax in a loving, stress free atmosphere.

There is no danger to other members as HIV is only transmitted through direct contact with blood, semen and vaginal secretions; you will not expose others to infection by:

- Playing with children
- Cooking food for family members
- Sharing food, plates and other utensils
- Sharing the toilet
- Touching and kissing others
- Working with others

Caution them by saying 'You should not share your...':

- Toothbrush
- Razors/shaving blade
- Menstrual pads/clothes that are reused after washing

What can my family do to help me?

Like everybody, you also need your family's love, understanding, support and help. You may feel that the society has turned against you. Your family can give support and bring you out of your lonely feelings. Your family can help you by:

- Including you in family activities
- Showing affection, touching, hugging, kissing
- Encouraging you to eat well and maintain good health
- Recognizing that you may have poor memory, concentration or little interest as a result of HIV infection.
- Tolerating changes in behavior and mood
- Seeking your doctor's advice and assistance
- Keeping you in good humor
- Discussing their fears and anxieties.

Is it safe for family and friends to look after someone with HIV?

Yes, it is safe if you follow precautions like wearing gloves/plastic bags and disinfecting with bleach solution.

The need for broad educational programs is equally urgent. The AIDS crisis has shown the difficulty of modifying attitudes towards sex. Even more difficult to change is actual sexual behavior. Religious teachings and social norms with regard to sex provides one picture or reality, while the AIDS crisis has revealed quite another. Hidden homosexuality, marital unfaithfulness, and premarital sex have surfaced as causes of HIV infection. Because of the association of AIDS with such behavior, people infected with the disease are understandably reluctant to admit to being ill. Those infected through contaminated blood transfusions and blood products may also be afraid to admit their illness, for fear of how they will be viewed by others secrecy and dishonesty act to increase the burden of the illness.

Chapter X

ROLE OF NURSE IN CARING FOR A PERSON WITH HIV /AIDS

Introduction

Persons with HIV /AIDS have similar health problems as any other sick person. The nursing care becomes different only when the nurse considers the precautions she / he would have to take while caring for PLHAs.

This chapter gives a brief overview of the care needs of PLHAs in a simplified manner that could help nurses in their functions.

General objectives

At the end of this chapter, the participants will be able to understand the various aspects of care of PLHAs, appreciate this knowledge and apply the information in their daily nursing practice

Specific objectives

At the end of this chapter the participants will

- Recognize the common problems in PLHAs
- Plan appropriate care for person with HIV /AIDS both in the home setting and hospital setting
- Be aware of the treatment protocols of various problems related to HIV /AIDS
- Be aware of teaching topics for PLHAs

Key concepts

- PLHAs have specific health problems
- Nurses can take care of these persons both in the hospital and home setting
- Nurses need to be aware of teaching needs of PLHAs

Teaching methods

- Small and large group discussion
- Reflective exercises
- Brainstorming

Materials /preparation required

- Black board, chalk, duster
- Handouts
- Transparencies of important points, OHP

Topic outline

- Common health care problems of persons with PLHAs
- Nurses role in the management of various health care problems in PLHAs
- Treatment protocols for home based care of PLHAs

- **Teaching needs of PLHAs**
- **Nursing care of persons with HIV and AIDS with focus on community based care**

Total session time
45 minutes

BACKGROUND MATERIAL

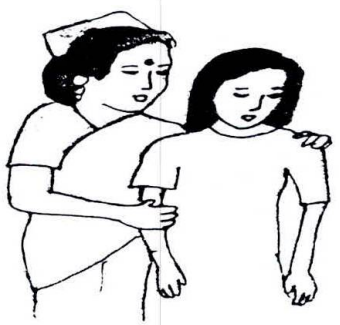
Common health care problems in PLHAs

Exercise 10.1

This activity is intended to familiarize participants with the broad range of potential health care problems commonly seen in symptomatic HIV infection so that they could develop increased skills in appropriate nursing interventions.

The format of a large group discussion is used so that students can contribute and discuss possible interventions. This will enable the facilitator to draw upon the considerable expertise which already exists within the group, and to reinforce the point that the participants current competencies, practice skills and knowledge are sufficient to enable them to assess, plan, implement and evaluate meaningful nursing care for people with symptomatic HIV infection.

1. The facilitator asks the participants to come forward and write on a board in front of the class the list the health care problems of a person with HIV /AIDS
2. As each problem is listed, ask the participants to describe:
    - The assessment and observations relevant to that specific health care problem
    - Appropriate interventions that might be planned for a person with that particular health care problem
3. The participants responses should be written on the board as they are made
4. The facilitator could then supply and list additional relevant information if it is not forthcoming from the group as given in Table 1.



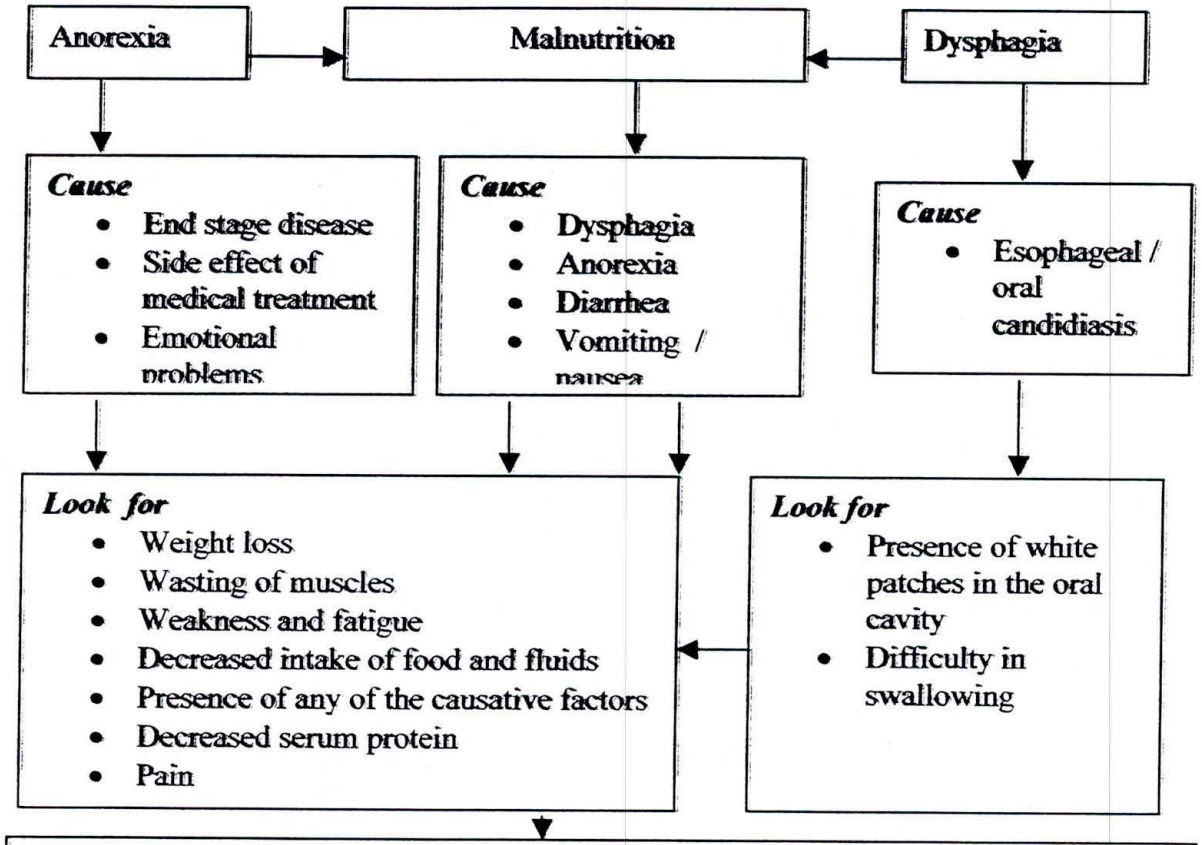
A nurse must be able to identify the health problems of PLHAs

Table 10.1. Common health care problems in symptomatic HIV infection

Problem	Possible cause
Anorexia	Commonly seen in end-stage disease, sometimes complicated by nausea and vomiting may be a side-effect of some drugs used in medical treatment
Dependence	May be caused by chronic disease progression, weakness and neurological impairment (physical / cognitive)
Diarrhea	Often chronic and severe, it can make the person house-bound or confined to bed. It may cause significant weight loss and may be life threatening because of dehydration and electrolyte imbalance
Dysphagia	Frequently caused by oesophageal candidiasis
Dyspnea	Chest infections, anemia
Malnutrition	May be due to dysphagia, anorexia, or malabsorption or inadequate intake of nutrients (esp. protein). Severe weight loss often seen in end-stage disease
Neurological Impairment	This may have physical and cognitive aspects. Physical: Lack of fine motor coordination, peripheral neuropathy, ataxia, dysphasia, visual impairment and blindness, loss of hearing, paralysis
Edema	May be due to lymph node enlargement as a result of Kaposis sarcoma
Pyrexia	Continuous or intermittent, often low grade, rising during periods of acute infection and sometimes associated with night sweats
Skin lesions	May be caused by a variety of skin problems (e.g.) candidiasis, Kaposis sarcoma, Herpes simplex/zoster, etc. lesions often involve mucous membranes
Visual problems	Frequently seen in retinitis caused by cytomegalovirus (CMV) or may be neurological in origin

Nurses' role in the management of various health care problems of PLHAs

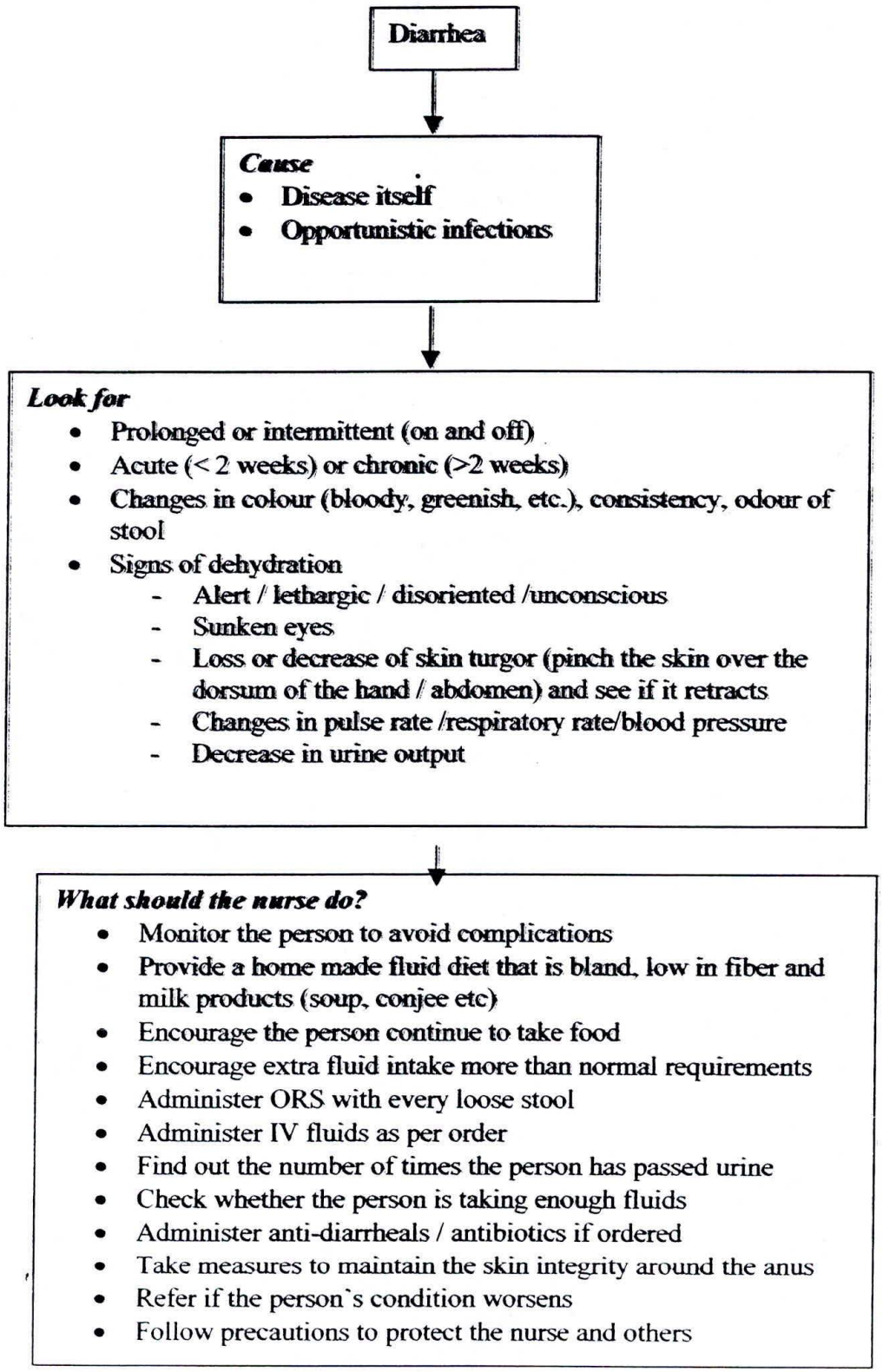
NURSES' ROLE IN MANAGEMENT OF ANOREXIA /MALNUTRITION /DYSPHAGIA



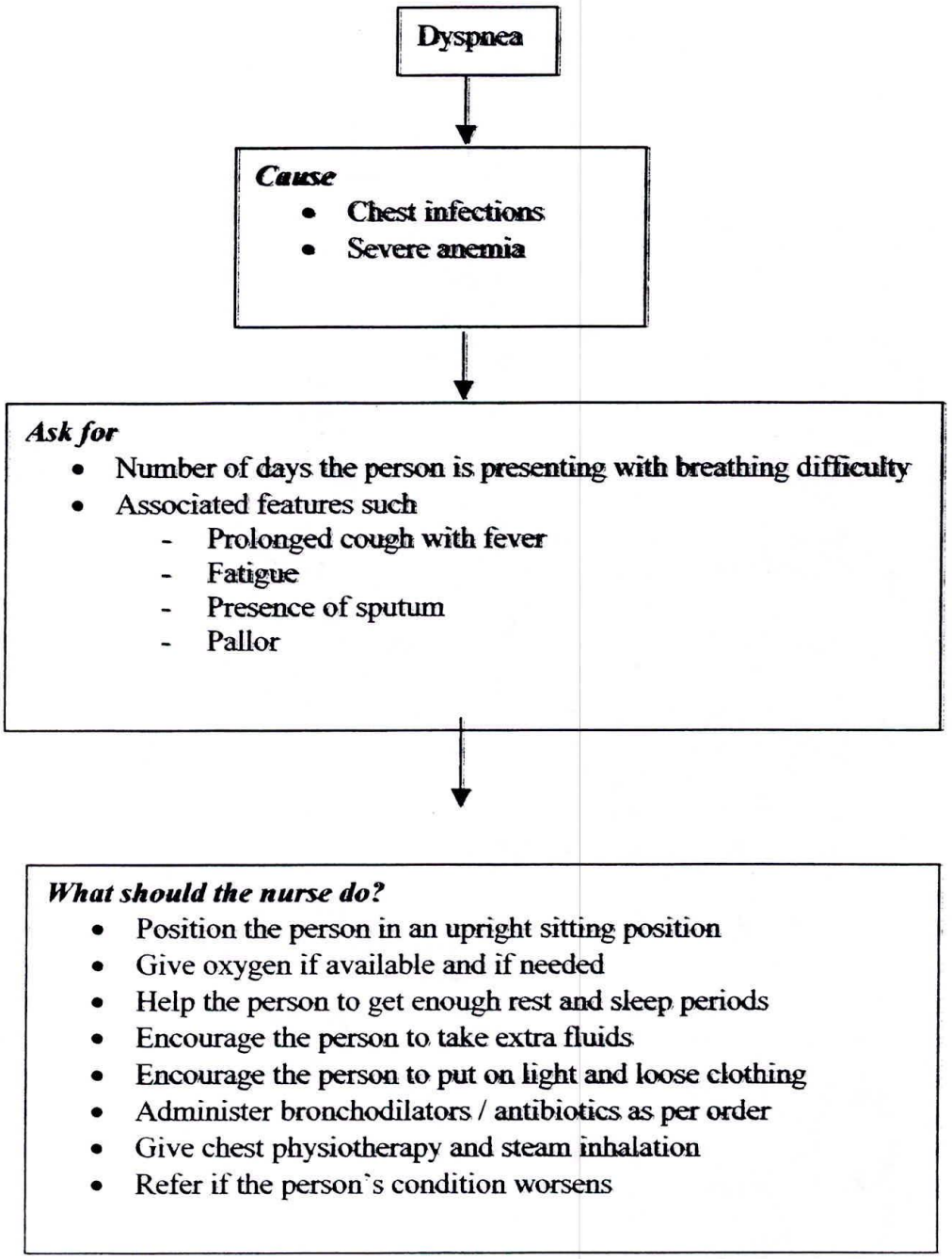
What should the nurse do?

- Give fluids orally 1500-2000 mL per day
- Plan a diet according to the preferences of the person
- Encourage the person to take food preferred according to taste
- Provide dietary supplements like Folic acid, Vitamins, and Iron etc.
- Encourage or assist the person to maintain good oral hygiene
- Administer anti-emetics, analgesics as per doctors orders
- Avoid painful procedure just before meals
- Administer IV fluids and electrolytes if prescribed
- Provide soft bland diet in small and frequent amounts in the case of dysphagia
- Take measures to treat the cause as prescribed (Oral candid /nystatin for candidiasis)
- Advice not to take alcohol or other irritants
- Advice the use of a soft tooth brush, pain relieving topical agents (xylocane gel) and good oral hygiene if there are ulcers in the mouth (brush teeth twice a day) and to rinse mouth well with water.

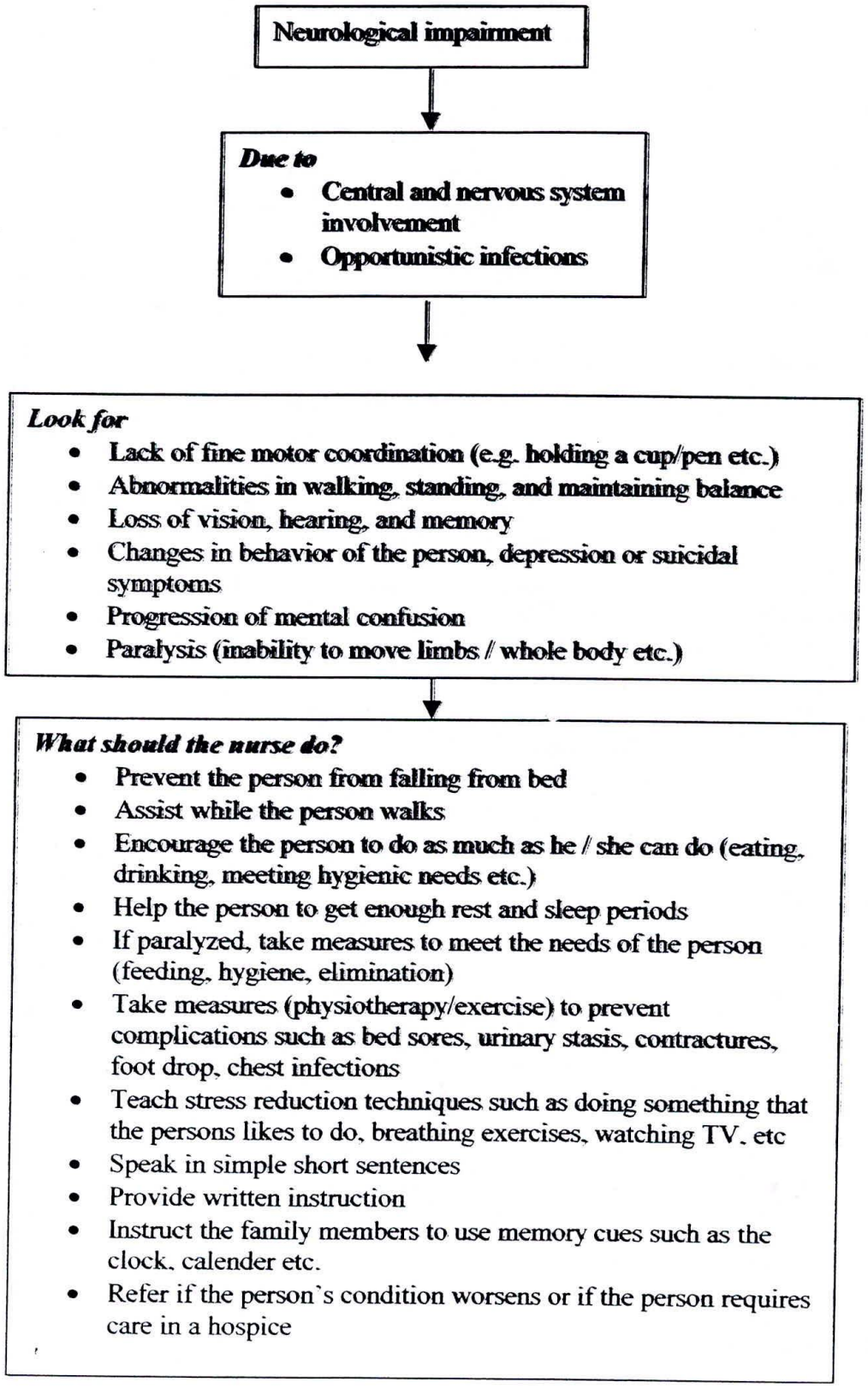
NURSES' ROLE IN MANAGEMENT OF DIARRHEA



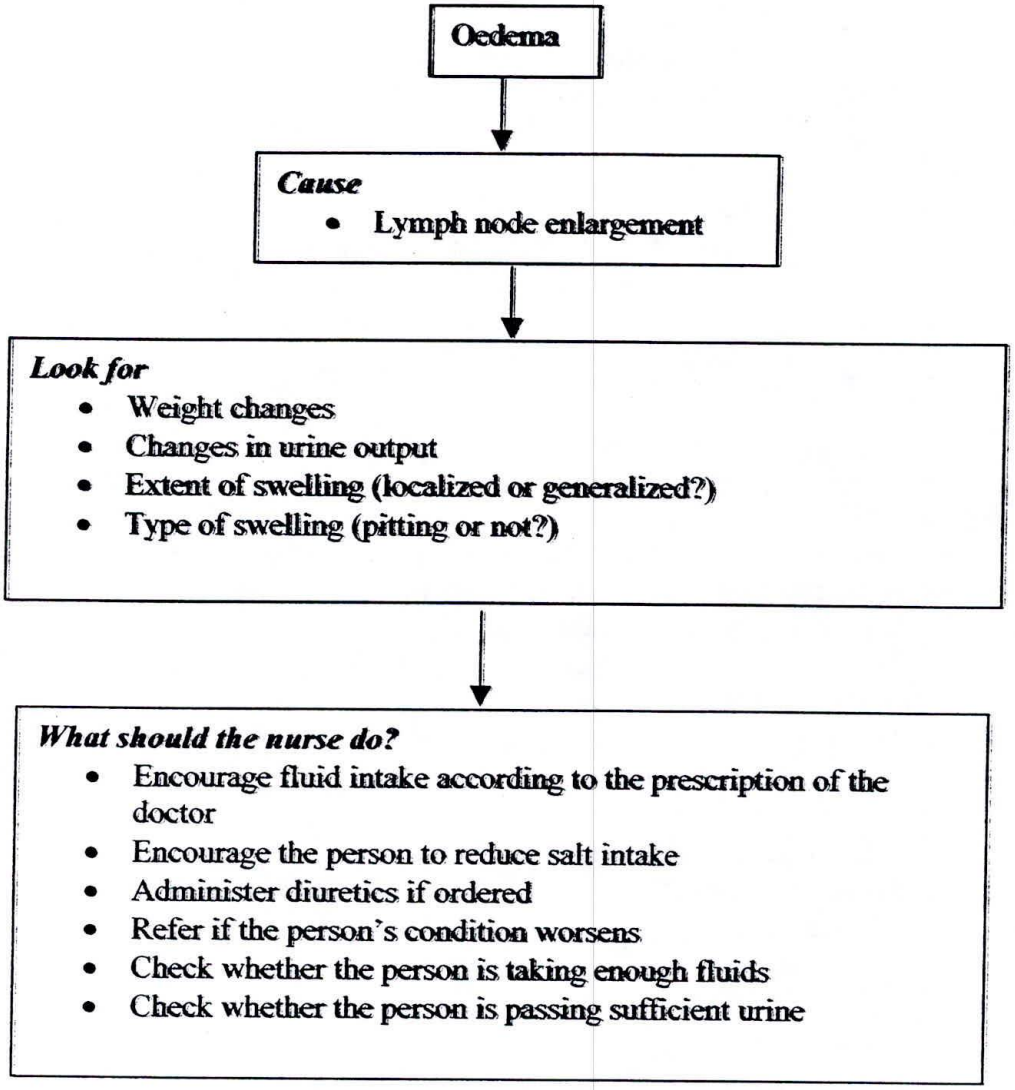
NURSES' ROLE IN MANAGEMENT OF DYSPNEA



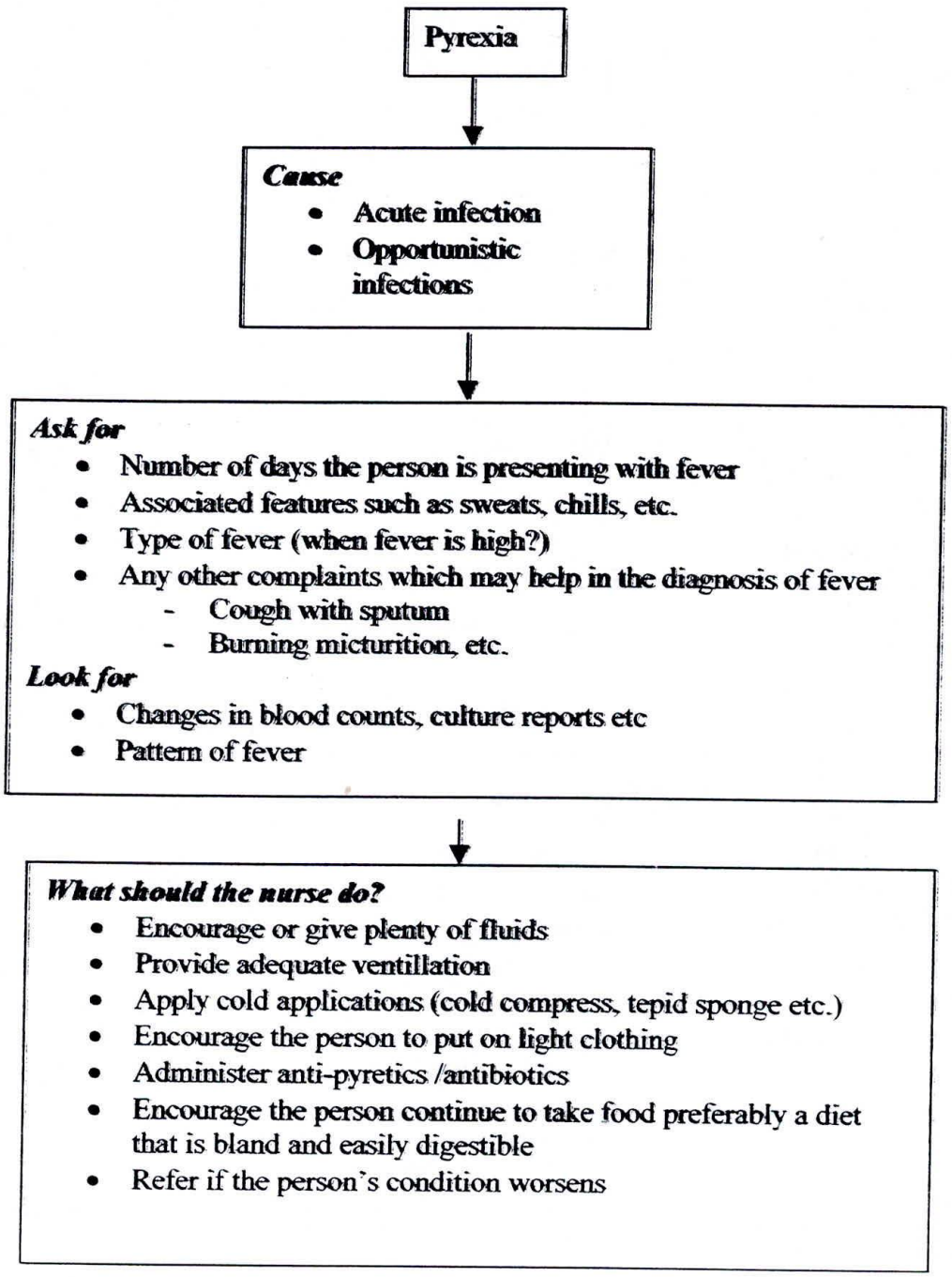
NURSES' ROLE IN MANAGEMENT OF NEUROLOGICAL IMPAIRMENT / PHYSICAL DEPENDENCE



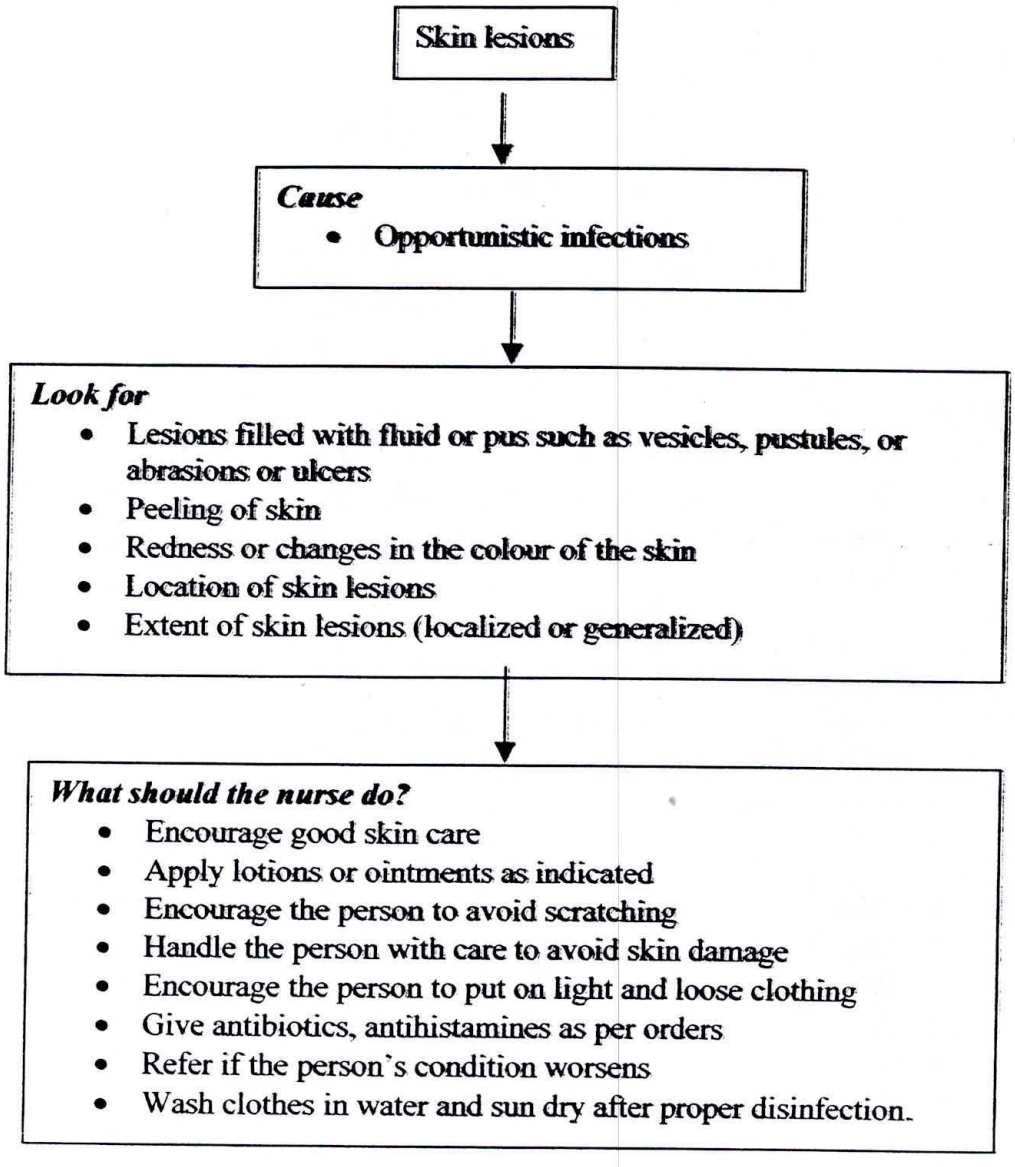
NURSES' ROLE IN MANAGEMENT OF OEDEMA



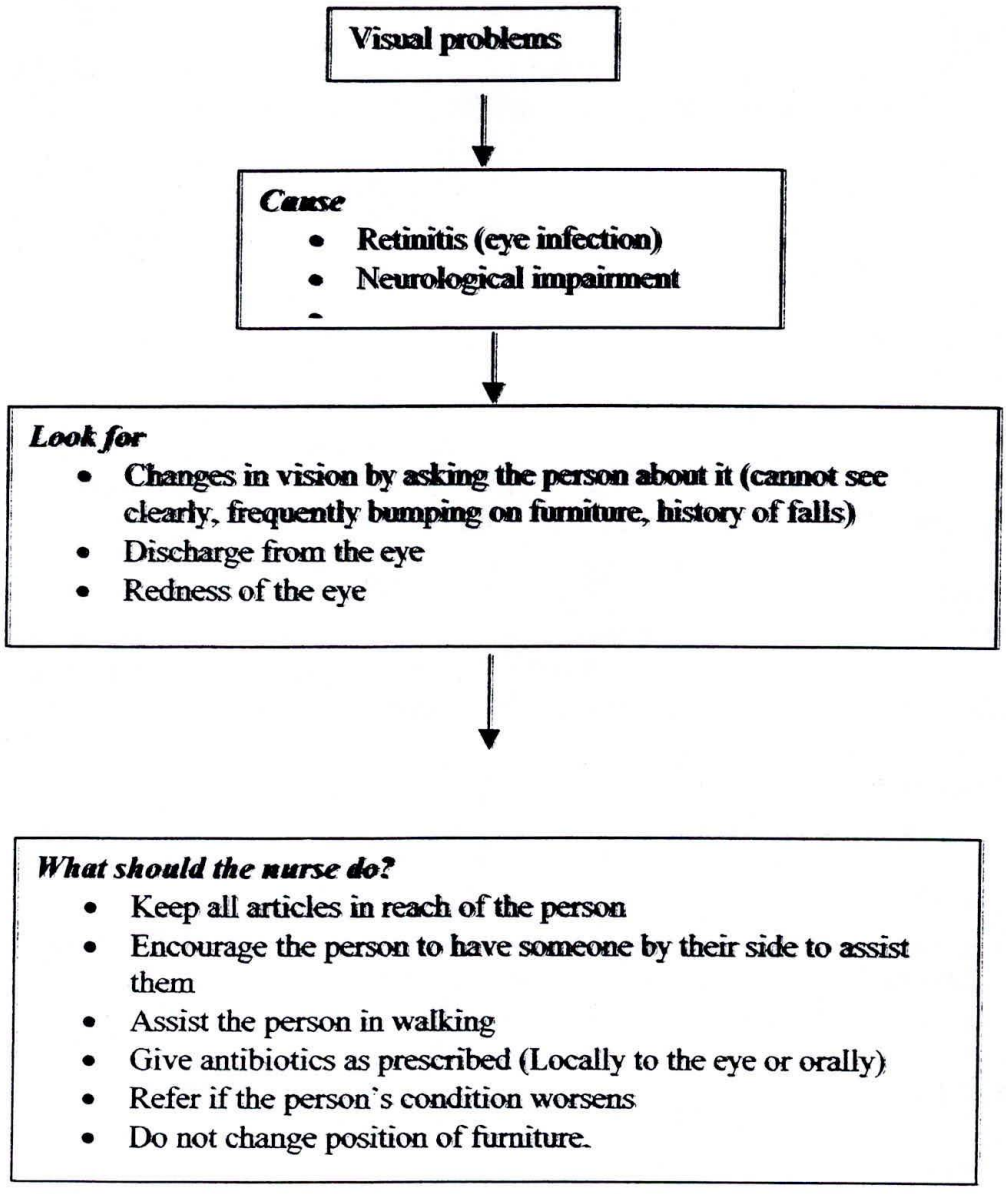
NURSES' ROLE IN MANAGEMENT OF PYREXIA



NURSES' ROLE IN MANAGEMENT OF SKIN LESIONS



NURSES' ROLE IN MANAGEMENT OF VISUAL PROBLEMS



Treatment protocols for home based care

Respiratory system

The most common respiratory symptoms are cough, chest pain, weight loss and hemoptysis. The most frequently used antibiotics in both hospital and home-based care are:

- Cotrimoxazole
- Penicillin V
- Erythromycin
- Tetracycline

1. Treated as pneumonia with antibiotics
2. Pain relief with acetyl salicylic acid/paracetamol if indicated.
3. Severe cases/suspicion of PTB are brought back to hospital for further investigations.
4. Persons who are coughing are encouraged to cough up sputum into a cup/cloth, which can be emptied or washed regularly and allowed to dry in the sun.

Gastro-intestinal system

Diarrhea and weight loss are the most common symptoms seen in both hospital and home based setting. Diarrhea responds most commonly to cotrimoxazole or metronidazole

- Rehydration with ORS or home made electrolyte solution
- Antiemetic if excessive vomiting
- Antacid for enteritis.
- Antiobiotic or amoebicide
- Mycostatin suspension or tablets for oral candidiasis
- Pain relief with analgesics if indicated.
- Milk powder or soyabean – based powder 'HEPS' (High Energy Protein Supplement), which can be cooked into a nutritious porridge.
- Persons are brought back to the hospital if this will not benefit them

Central nervous system

- Pain relief with analgesic
- Diazepam given to restless persons.
- Treatment of bacterial meningitis is usually with Chloramphenicol. Restless persons are seen to respond to diazepam or chlorpromazine.

Genitourinary system

- Assessment of progress of STD treatment response
- Specific STDs treated with appropriate antibiotics
- Analgesics if necessary
- If persons condition warrants hospital treatment, person is admitted
- Contact tracing is mostly done in the OPD

Skin

1. *Rash/dermatitis*
   - Skin scraping to rule out fungal infection
   - Anti histamine if itchy
   - Analgesics if indicated
   - Antibiotics if indicated

2. *Herpes Zoster*
   - Unburst pustules – calamine lotion
   - Burst pustules – gentian violet paint
   - Paracetamol/acetyl salicyclic acid or pethidine depending on severity of pain
   - Antibiotics if secondary infection of ulceration

3. *Abscess*
   - If small, incised under local anaesthesia, and treat with antibiotics.
   - If large, send to hospital for incision and drainage under general anesthesia

4. *Kaposis sarcoma*
   - Encourage to continue treatment (if available)

5. *Discharging anal sinus*
   - Zinc oxide and analgesics
   - Surgery for discharging anal sinus is not successful. Healing tends to be poor and prognosis for these persons is poor

Teaching needs of PLHAs and of their families

All family members and PLHAs must be taught to recognize signs and symptoms that are to reported to the health facility immediately

Exercise 10.2

1. The facilitator conducts a brain storming session for 5 minutes
2. The facilitator asks one volunteer among the participants to come forward to write what responses the participants give to the question

What are the signs and symptoms that family or affected person needs to report immediately?

3. The facilitator then tells the participants to read Handout 10.2 on the same topic

Handout 10.1. Signs and symptoms that have to be reported immediately by PLHAs

- Bleeding from the rectum
- Burning, itching or discharge from eyes
- Change in the level of consciousness
- Dehydration
- Flank pain
- Fever which is very high
- Headache with nausea and vomiting
- Onset of weakness
- Oral lesions
- Productive cough.
- Rash
- Seizures
- Severe depression
- Shortness of breath, chest pain
- Yellow discoloration of the skin
- Vision changes
- Vaginal discharge, pain or itching
- Watery diarrhea

Other aspects that have to be taught to PLHAs / family members include

- Good skin care (position changing, emollients, special pads and beds, hydration and nutrition)
- Maintain cleanliness of the environment
- Avoid exposure to persons with infection
- Breathing and coughing exercises especially when confined to bed
- Avoid repeated exposure to HIV by practicing safe sex (use of condoms, abstinence)
- Instruct visitors about hygiene
- Avoid eating raw or under cooked food
- Do not take care of pets
- Handling potentially infected body fluids and waste materials (see details in Chapter V)
- In the event if any family member is exposed to potentially infective body fluids or materials report the matter immediately to health personnel
- Maintain strict aseptic technique when performing invasive procedures e.g. giving an injection
- Avoidance of smoking, alcohol and drugs

Exercise 10.3: Case study of symptomatic HIV infection

1. **The participants are provided with a case presentation that raises the major issues that might need to be dealt with when caring for a person with symptomatic HIV infection.**
2. **The participants are divided into four small groups and each group should be given a copy of the case study.**
3. **Each group is asked to read only one part of the case study, then to assess and identify nursing care needs of the person according to the said situation. They then must answer the questions given in the case study, which follow each section. This should take 5 minutes.**
4. **Group leaders should report back in a plenary class discussion.**

Case study – Part A

Mrs. Gayathri is a 28-year-old woman who lives with her husband and three children in a village in the out skirts of a large city. Her husband is a truck driver who is absent 3-4 days a week. Her mother lives nearby. Mrs. Gayathri has not felt well for the past year and her mother has frequently taken care of the two younger children during the day and the older child after school. Mrs. Gayathri has no appetite, has had diarrhea and has gradually lost weight by10 kg. She thought she had intestinal parasites, a common problem in her village, so six months ago she went to the health clinic where she was treated for parasites. However, since then the diarrhea has become more frequent and the lymph nodes in her neck are swollen and tender, she has fever nearly every evening and wakes up during the night soaked with sweat. This week she has white patches in her mouth and a sore throat. When she swallows, she has a burning feeling in her chest just beneath her ribs. She is dehydrated. You are seeing her at the primary health centre.

Identify the nursing care needs of Mrs. Gayathri

- What additional information do you think you need to ask Mrs. Gayathri in order to decide what action to take?
- What do you suspect is the underlying medical reason for Mrs. Gayathri may different problems?
- What immediate nursing care needs and interventions would you implement for her?
- What nursing support would Mrs. Gayathri required in relation to any potential emotional/social issues she may have to cope with?
- What referrals or further investigations might be appropriate and available?

Case study – Part B

Mrs. Gayathri is admitted to the hospital and rehydrated. A scraping of her tongue reveals oral candidiasis. The doctor thinks that she also has oesophageal candidiasis because of the burning feeling in her chest and her difficulty in swallowing. Nystatin tablets are prescribed and she is also given nystatin suspension for the oral candiasis.

Stool specimens are taken and are negative for parasites, but positive for AFB. Blood studies reveal anemia and the presence of AFB. The doctor asks Mrs. Gayathri for consent to have a blood test for HIV antibodies and explains the reasons why he feels this test is necessary. He also very carefully explains to Mrs. Gayathri what a positive and a negative result might mean. After careful thought, Mrs. Gayathri agrees to have the HIV antibody test. This test is positive for HIV antibodies.

A chest X-ray does not demonstrate pulmonary tuberculosis and the doctor explains that the positive AFB in the stool and blood specimens are probably the result of atypical mycobacterial infection (Mycobacterium avium-intercellular MAI) i.e. MAI and not tuberculosis. He prescribed Ethambutol and streptomycin that may control MAI. The doctor writes this in the chart and asks you to accompany him when he tells Mrs. Gayathri that her diagnosis is AIDS. Mrs. Gayathri is extremely upset and wants her mother contacted immediately.

Identify the nursing care needs of Mrs. Gayathri

- What specific information indicates to the doctor that Mrs. Gayathri has AIDS?
- What should the nurse know about the administration and possible side effects of the medications prescribed by the doctor?
- What aspects would you cover while counseling Mrs. Gayathri with her diagnosis?
- What are her educational needs in relation to her anemia and weight loss and how will you plan to help meet these needs?

Case study – Part C

Mrs. Gayathri has received the medications for two weeks. The candida is no longer a problem and the diarrhea is much better with only one loose stool per day. She has gained 5 kilograms and is feeling much stronger. The doctor is ready to discharge her to her home. She has to continue taking ethambutal and streptomycin and to continue to use the nystatin suspension to keep her oral candidiasis under control. Mrs. Gayathri says she is worried that she will infect her children or that her neighbors will tell her to leave the village.

Identify the nursing care needs of Mrs. Gayathri

- What are the educational needs of Mrs. Gayathri prior to her safe discharge from PHC and how will the nurse meet these needs?
- Mrs. Gayathri is particularly worried about infecting her children and husband and asks the nurse if it is safe to cook for her family and can she still have sexual relations with her husband; how does the nurse respond?
- Is there anything the nurse can do to help Mrs. Gayathri in relation to her fears that her neighbors will reject her and force her to leave the village?

Case study – Part D

Mrs. Gayathri returns home and her condition is stable for two months, although she has started to lose weight again. Then she begins to weaken and to have more severe symptoms. You make a home visit from the clinic. Mrs. Gayathri does not want to return to the hospital because traveling to and from the clinic has been very hard on her husband (who is now also unwell) and her mother. She thinks she will probably die and cries when she thinks about leaving her children and her husband. She wonders what will happen to her children if her husband (who she thinks also has AIDS) dies, as her mother is very old now.

Identify the nursing care needs of Mrs. Gayathri

- What can you teach Mrs. Gayathri's mother and husband to enable them to care for her at home?
- What are you able to do to provide emotional support for Mrs.Gayathri?
- What will you tell her when she asks you to help explain to her husband that she knows she is going to die and wants to die at home?
- What support is available locally to Mrs. Gayathri to die at home?
- How will you help Mrs. Gayathri to cope with her anxiety regarding her children if her husband becomes ill and also dies and Mrs.Gayathri's mother is no longer able to cope?

Different health care needs of PLHA

- ***Health needs***: providing competent health workers, medicines, services, home care and medical supplies.
- ***Emotional needs***: Encouraging a safe and supportive environment in the home and community; decreasing stigma; giving counseling; family support groups.
- ***Spiritual needs***: Encouraging a supportive environment in religious communities, organizing prayer groups, promoting home visits by religious leaders.
- ***Nutritional needs***: teaching about nutritional food and preparation, encouraging safe drinking water, and providing food.
- ***Capacity needs***: Helping PLHAs (People living with HIV/AIDS) and their families and caregivers make their own decisions regarding daily activities
- ***Day to day needs***: Helping with childcare, feeding and tending livestock, going to the market and other household chores.
- ***Financial needs***: Helping families of PLHAs by providing school uniforms or fees, seeds and fertilizers, house rent etc.

Chapter -XI

REFERRAL, SERVICES AND NETWORKING

Introduction

The role of the nurse while dealing with persons infected with RTI / STI / HIV also includes referring the person and his / her partner to a qualified medical practitioner, and stressing on the importance of complete treatment as well as documenting the cases seen and referred.

This section provides information about how the nurse could make a referral, document and network in the context of RTI / STI / HIV.

General objectives

At the end of this chapter the participants will be able to understand the concept of referral, documentation and networking, appreciate this information and be able to apply this in their daily practice in the health care setting

Specific objectives

At the end of this session the participants will

- Be aware of the need for active referrals and networking in the context of HIV/AIDS
- Demonstrate skills in reporting and making referrals
- Be aware of the various VCTCs, PPTCTs, Support centers etc. in Karnataka

Key concepts

- Referral is a good means of supporting persons who require to be treated and followed up
- Nurses could be important links in the care and follow up of persons infected with STI / RTI/ HIV
- Appropriate networking could reduce the load placed on hospitals to care for persons with STI/ RTI/ HIV

Teaching methods

- Discussion
- Group exercises
- Role Play
- Introspection / reflective exercises

Materials /preparation required

- Handouts
- Transparencies, OHP
- Black board, chalk, duster
- Chart paper, pens

Topic outline

- Referral
- VCT
- PPTCT
- Support and care centers
- Reporting and documentation
- Developing effective networks
- Follow-up
- FHAC

Total session time

1 hour

BACKGROUND INFORMATION

Referral

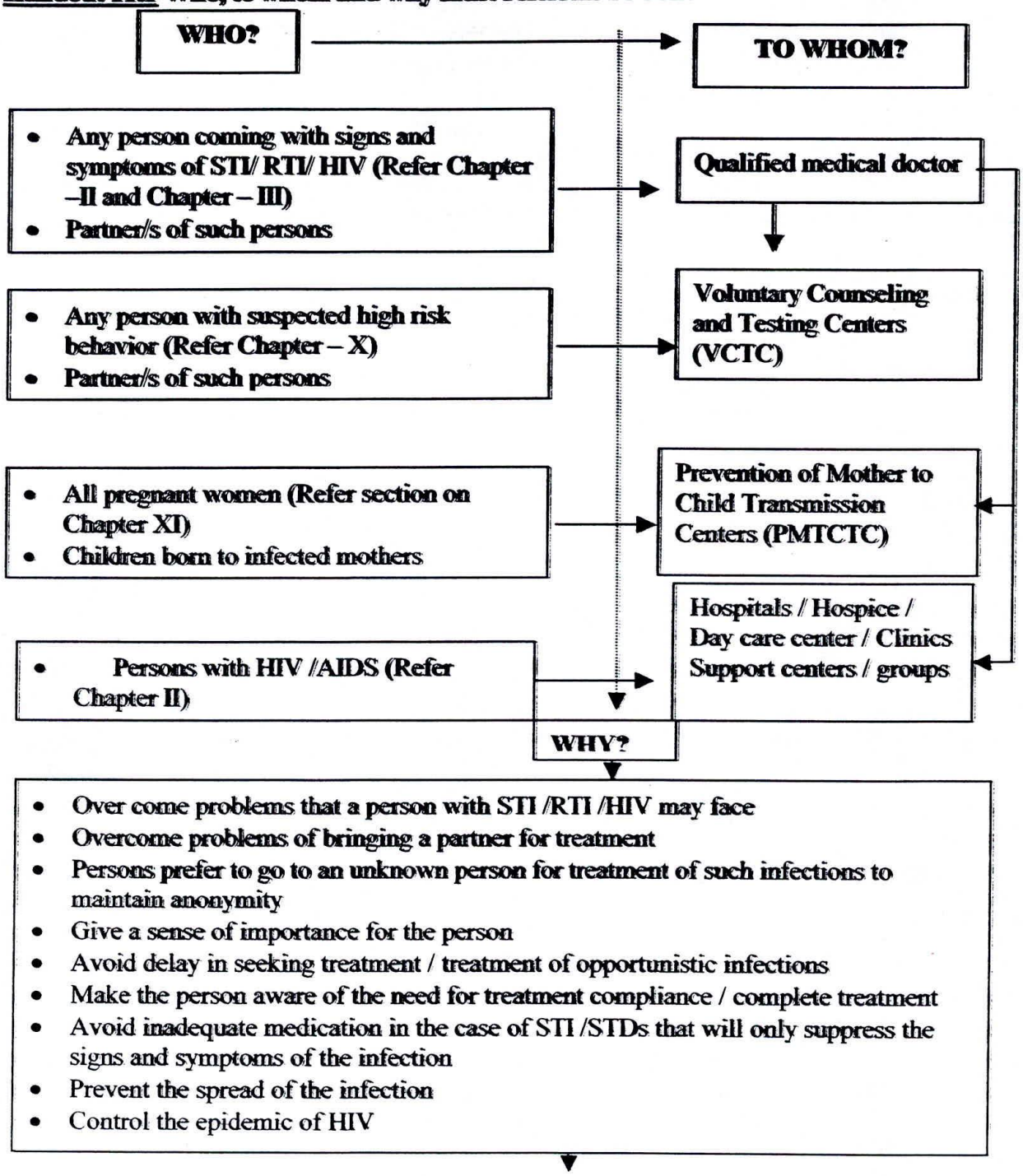
Meaning of referral

It means that if a person approaches you with symptoms of STI / RTI /HIV, you would counsel the person and encourage him / her to go to a qualified doctor for management of his / her problems. This would also mean that you would follow up the person subsequently.

Exercise 11.1

1. **The facilitator asks the participants to mention what type of persons have they referred, to whom and why**
2. **These responses are noted on the black board by one volunteer from the participants**
3. **The participants are asked to read Handout 11.1 that is projected for them or one volunteer is asked to read aloud to the rest of the participants the contents of the handout**
4. **The facilitator would ask the participants if they require any further clarification**
5. **The facilitator could then highlight the precautions to be taken while making a referral**

Handout 11.1 Who, to whom and why must referrals be done



PRECAUTIONS & POINTS WHILE MAKING REFERRAL

Maintain confidentiality, knowledge of referral service, refer to the right person, check absolute need before making the referral, explain to the person about the need for referral, brief the person about distance, cost and how to find the place of referral

Most hospices will take a referral when a person has an AIDS defining illness. People can self-refer or their friends can refer them, but you will usually need to get a doctor to fill in some medical information. Doctors, nurses, social workers and some hospital staff can refer. Some hospices will take referrals from pastoral care workers.

Voluntary counseling and testing (VCT):
Voluntary counseling and testing is the entry point for HIV prevention and care. HIV counseling is defined as ***'the confidential dialogue between the person and the care providers and is aimed at enabling the person to cope with the stress of being diagnosed as HIV positive as well as to make personal decisions related to HIV/AIDS'.*** The benefits of VCT are depicted in Figure I.

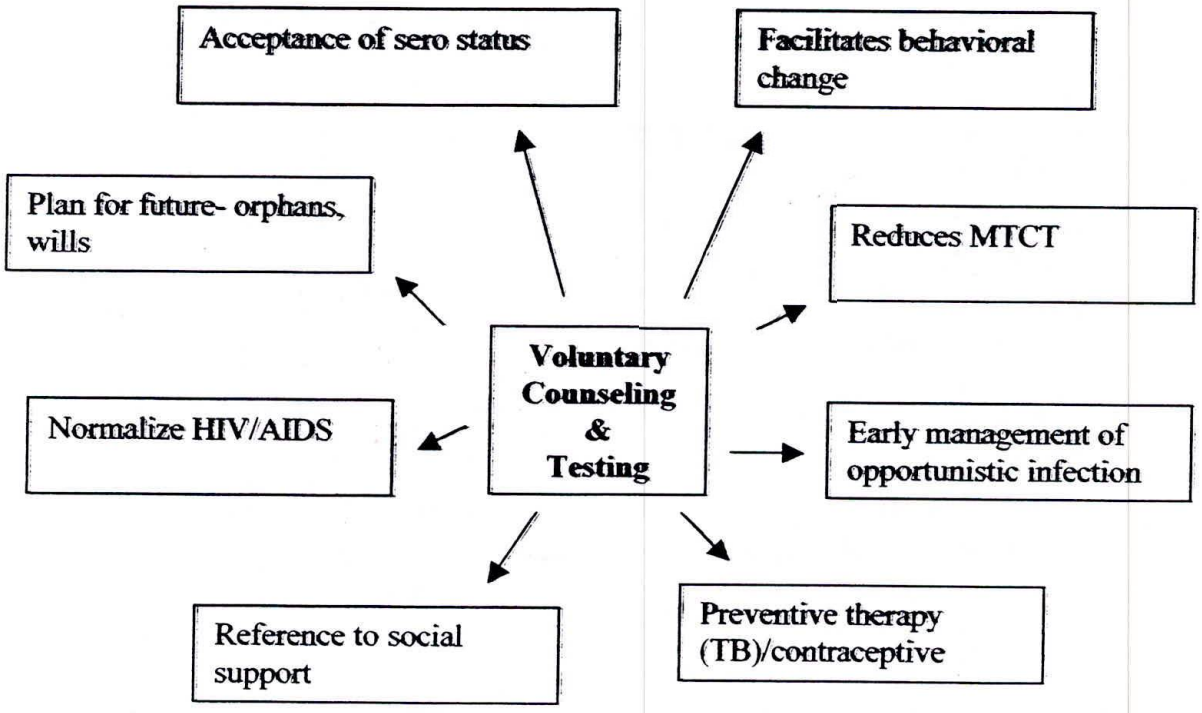


Figure 11.1.Benefits of VCT

Services possible through VCT
- General HIV education in the community could help increase their awareness of the benefits of VCT
- Pretest counseling (See for details in Chapter VIII)
- HIV testing (See for details in Chapter VIII)
- Posttest counseling (See for details in Chapter VIII)
- Future and follow-up counseling and psychological support (See Chapter VIII)

Voluntary counseling testing centers (VCTCs) have been established in 142 microbiology departments of medical colleges and tertiary care hospitals. One VCTC has been established in each district hospital of States with a high prevalence rate of HIV. A list of

the centers operating in Karnataka is given in the Appendix D **(Handout –2)**. National Institute of Mental Health and Neurological Sciences (NIMHANS) in Bangalore is the external quality assessment center for HIV testing.

Barriers to VCT

- ***Stigma*: Many people may hesitate to go o a VCTC for fear that society or the** community, as having HIV or AIDs will shun them. It is important that VCTCs are organized in such a manner so that confidentiality is attained and the community is educated on its benefits.
- ***Gender inequalities*: Women tend to feel more traumatized than men in our setting** simply because of male dominance
- ***Lack of perceived benefit:* Many people are unaware of the benefits of approaching a** VCTC. It may be that someone just requires information on HIV prevention and that he or she does not have any risk behavior or any exposure. It is again necessary that the public is informed about the benefits so that they can utilize the services of VCTCs.

Support could help overcome barriers to VCT

PPTCTs.

Prevention of Parent To Child Transmission Centers (PPTCTs) are usually situated in antenatal clinics of hospitals. All pregnant women need to be counseled about HIV/ AIDS and MTCT. They also need to be told about the advantages of knowing one's own serostatus. (See Appendix E for handout of PPTCT centers in Karnataka) ***Chapter -XI***

Services (see details in Chapter IV)

- Counseling of all mothers
- Voluntary testing for HIV
- Care during prenatal period to prevent transmission to fetus
- Care during intranatal period to prevent spread to the newborn
- Counseling services for follow up care while feeding the baby

Support and care centers

These are centers, which are run by voluntary agencies and provide services such as care; counseling; treatment for opportunistic infections; and palliative care. See Appendix F for Support and care centers in Karnataka

PLHAs will require support .....

One of the ways of controlling the disease from further spread is to carry out direct intervention programs among targeted groups through a comprehensive and integrated approach, which comprises behavior change communication, counseling, providing health care support treatment for STDs

Targeted interventions for behaviour change in Karnataka

Targeted intervention is an important component of the National AIDS Control Program. The basic purpose of the Targeted Intervention program is to reduce the rate of transmission among the most vulnerable and marginalized populations such as sex workers, intravenous drug users, men having sex with men, truckers, migrant laborers and street children. The ultimate aim of targeted intervention programs must be to create an enabling environment that will facilitate behavior change.

All over the world, it has been commonly found that particular groups of people are more vulnerable than others to the HIV/AIDS epidemic. These groups, because of their behavioral attributes, are prone to get the infection more quickly and are likely to cause the spread of the disease in a very short period.

Why is it called target intervention programs?

It is called so because it focuses on specific groups of people. Theses are mostly socially and economically backward, and are easily accessible. Hence conventional government services may not be appropriate for them. NGOs, Community Based /Organizations and other appropriate agencies are recommended since they are able to reach out to these populations more effectively. These groups need information and services in a focused and non-judgmental manner. It is, therefore, important to develop a peer-based approach, which enables and sustains behavior change. An environment that is conducive to empowering them for behavior change must support these interventions.

Karnataka State Aids Prevention Society (KSAPS) has 32- targeted interventions. See Appendix for the details of agencies providing such interventions.

Reporting and documentation

Benefit of maintaining records

- Helps to determine trends in type of people getting the infections
- Helps to determine the whether there is an increase or decrease in the number of people getting infected
- Helps to find the differences in the incidence among areas
- Helps to determine in which area the work has to be more intensive
- Helps to monitor persons
- Helps in follow-up of persons

Exercise 11.2.

The purpose of this exercise is make the participants aware of aspects that have to be documented for a person with STI / STD / HIV

1. **The facilitator divides the participants into four small groups**
2. **The groups are then asked to discuss what information they would document about a person presenting with signs or symptoms of STI / RTI / HIV, why they want to record this information, and how they will maintain confidentiality of the person.**
3. **The groups should come out with a sample format for documentation in 15 minutes**
4. **At the end of this the representative of each of the groups will come and present their information**

Handout 11.2. Sample format for maintaining information on persons with RTI / STI / HIV

1. Case number:
2. Date of registration
3. Age
4. Sex
5. Place of residence
6. Marital status
7. Education
8. Occupation
9. Does occupation involve frequent travel
10. Religion
11. Caste
12. Reported complaints: Ulcer / discharge // inguinal swelling /scrotal swelling / abdominal pain
13. Any treatment taken for current symptoms Yes / no
14. If yes, particulars

    .....

    .....
15. Name of the doctor the person is being referred .....
16. Life style

* Smoking cigarettes/beedi/alcohol	: Never	Sometimes	Regularly
* Chewing tobacco/gutka	: Never	Sometimes	Regularly
* Consumption of alcohol	: Never	Sometimes	Regularly
*Gambling, cards etc.	: Never	Sometimes	Regularly
* Paid sex	: Never	Sometimes	Regularly
* Sex with casual partner	: Never	Sometimes	Regularly
* Use of condoms with spouse	: Never	Sometimes	Regularly
* Use of condoms with casual partner	: Never	Sometimes	Regularly
* Use of condoms with paid sex	: Never	Sometimes	Regularly

17. HIV status: Not tested/Positive/Negative

Handout 11.3. Sample format for Follow-up (to be maintained in continuation of Handout 11.2, on documentation)

1. **Did you meet the doctor after referral** **Yes / No**
2. **If no, why**

---

3. **Did you take full treatment prescribed** **Yes / No**
4. **If no, why**

---

5. **Are your symptoms better** **Yes / No**
6. **Did your partner take treatment** **Yes / No**
7. **If yes, did the partner take full treatment** **Yes /No**
8. **If no, why**

---

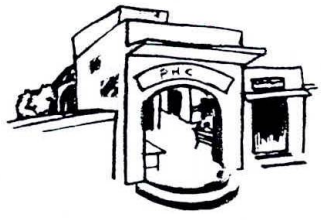
9. **Are your partner's symptoms better?** **Yes / No**
10. **Did you use condoms during the period of infection** **Yes / No**

Once a person who has been detected to be HIV positive has been confirmed to have AIDS, then this should be reported to the State health departments. Specific formats (Report of infectious diseases) are available which have to be filled completely before being notified to the respective departments.

Developing effective networks

Exercise 11.3

1. **The facilitator divides the participants into small groups**
2. **Each group will have to discuss in 5 minutes instances when they have networked (or can network) with persons, NGOs in order to help people they served / or would serve**
3. Then also the groups are asked to discuss the difficulties and challenges they would face in networking
4. The representative of each group is then asked to present their discussion to all the participants
5. One volunteer could then read out Handout 11.4 to the rest of the participants participants



PHC staff need to develop good networks...

Handout 11.4. Networking - Purposes, role of nurse, with whom and skills required

Purposes of networking

- Avoid duplication of services
- Enhance optimum utility of services

Role of a nurse in networking

Be aware of all services and centers providing services in the community, near by localities and in the state

- Develop good rapport with these centers
- Gain skill in making referrals
- Inform the people and the community of these services and centers
- Help persons who require such services to get these services

With whom can a nurse network?

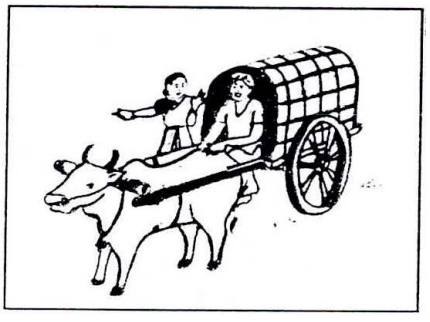
- ***Individual persons***: Anganwadi workers, Counselors, Community workers, Doctors, Influential persons / political persons, Physiotherapists, Religious persons, School teachers, Social workers

- ***Groups***: NGOs, Community based organizations, Support groups / organizations (See appendix F), Village panchayats

- ***Institutions:*** Hospitals- government, private; VCTCs; PMTCTs

What skills must a nurse have to network?

- Be able to recognize the needs of others
- Be able to get along with any one
- Be able to convince
- Commitment to help people in need
- Interpersonal communication
- Speak for the rights of PLHAs (see Annexure)
- Time to take persons to these centers



Effective network means going out of one's way...

Exercise 11.4

1. **The participants are given a case**

A person approaches you in the hospital with features of HIV. The person also expresses difficulties being faced because of the illness. You feel the person can be helped although the PHC where you are working does not have the facility to meet all the needs of the person

2. **Divide the participants into the same groups as in exercise 2**
3. **Ask the group to develop a plan of action so that all the needs of the person are met (see for needs of a person with HIV in Chapter XIII**
4. **Give a chart paper along with pens to each group and ask them to draw the network you would develop for the above case in 10 minutes**
5. **All the representatives would come and exhibit their charts for all to see**
6. **The facilitator then explains that there are no standard ways of networking but that it is important for the nurse to be aware it is possible to get the best for the persons requiring help**

Follow-up

The nurse must take an active role in following up persons who have approached her /him for care. Follow up is essential to ensure quality care for persons with STI/ STD /HIV. It would also ensure complete treatment, partner treatment, and condom use. (See sample format 11.2)

Advantages of follow-up

- Can identify the effect of treatment
- Can ensure compliance to treatment
- To identify the partner/s of the person infected so that treatment of the partner could be initiated
- Can diagnose complications
- Can identify reasons for non compliance
- For ongoing support and counseling
- To facilitate in behavior modification
- To assess cure of the person

Follow-up procedures

- Personal contact with the person during visit to the home of the person
- Contact by mail
- Contact through phone
- Sending messages through community health workers, Community health assistants etc. to the concerned person

Remember at all times to maintain the confidentiality of the person

Family Health Awareness Campaign

As part of the functions of a nurse in prevention of HIV / AIDS a small session on Family Health Awareness Campaign (FHAC) will be taken. This would help you gain insight as to your role in FHAC.

Exercise 11.5: Brain storming session

1. The facilitator invites group responses to the following questions: (Brainstorm for 5 minutes)

- **What is FHAC / When & Where is FHAC conducted / Who conducts FHAC / Why FHAC / Role of Health Workers in FHAC**

2. While the participants are making their comments, the trainer has to make notes of what is being mentioned

3. Feedback of the correct information to the participants must be given according to the questions.

The Family Health Awareness Campaign, which was started in 1999 on a trial basis. It was introduced all over the country by National AIDS Control Organization (NACO) in 2000 in an effort to bring under control the rapidly growing epidemic of HIV, especially in the rural areas and other marginalized populations. It is usually conducted during the months of March and April in Karnataka.

Objectives of FHAC

The overall objective of the campaign is to contain the spread of Reproductive Tract infections including sexually transmitted diseases and HIV/AIDS.

The specific objectives are –

- To raise awareness on RTI/STD and HIV/AIDS in rural areas and other vulnerable groups of the population
- To encourage health seeking behavior in the general population for RTI/STD.
- To make people aware about the services available in the public health system for the management of RTI/STD.
- To facilitate early detection and prompt treatment of RTI/STD by mainstreaming the program.
- To implement a focused IEC strategy for the male population.

Strategy

The strategy includes –

i. Effective intersectoral co-ordination

Steering and mass media co-ordination committees have been established at Central, State and District levels under the Union Health Minister, Chief Secretary and District magistrates respectively with the objective to forge co-ordination amongst public, private and voluntary sector.

ii. Mass awareness and social mobilization

Two rounds of house-to-house contact by health workers are to done prior to the observance of FHAC to inform target group in age range of 15-49 years about reproductive health problems, facilities available for treatment and ways and means to prevent sexually transmitted infections. Sensitization workshops for community opinion leaders, NGOs and representative of panchayats at district and block levels are done to seek their active participation in this campaign. During the week when FAAC is to be conducted camps are conducted in a different subcenters each day. At the camps the various activities includes

- Providing awareness of STI/STD/HIV.
- Doing physical examination and diagnosing of STI/STD.
- Treating those diagnosed with STI/STD.

iii. Capacity building in management of STD

A massive training program is undertaken in all the identified districts. For the training of MOs at each level, booklets on Syndromic management of STD have been supplied. Flip charts are being used for the training of paramedical workers.

iv. Procurement of STD drugs

STD drugs have been supplied to each PHC to treat patients with STD and partners.

v. Holding camps in each village during campaign

Through the campaign separate camps are held for male and female target groups in each village by male and female health workers separately and assisted by community volunteers. The health workers discuss the problems of RTI/STI with the target group in reference to cases, symptoms and complications. They also make persons aware about HIV/AIDS, about the facilities available for treatment of RTI/ STD and referral slips are issued to those who need treatment. Health care workers also keep a record for those who are referred for treatment to permit follow-up visits. A sample record of details required by the health worker is given below.

Name	Address	Age	Sex	Symptoms	Referral	Follow-up

vi. Monitoring and evaluation

- Supervisory visits by central and state level observers- a standardized checklist has been devised for the purpose.
- Concurrent evaluation- state will identify agency for conducting concurrent evaluation.

Chapter XII

LEGAL AND ETHICAL ISSUES RELATED HIV / AIDS

Introduction

Every person has the right to live with dignity, so also a person affected with HIV / AIDS. But there have been instances where PLHAs and or their children were denied schooling, medical care and treatment, employment etc.

This chapter deals with the legal and ethical issues that relate to PLHAs. Awareness of the nurse on these issues could help her take care of such persons more effectively.

General objectives

At the end of this session the participants will be able to understand the legal and ethical issues related to PLHAs, appreciate and apply these concepts in the care of such persons.

Specific objectives

At the end of this session the participants will

- Be sensitized to the legal and ethical issues that relate to person with PHLAs
- Handle situations that may cause dilemma appropriately
- Discuss these issues openly with their colleagues or with other persons in their day to day practice

Key concepts

- HIV positive persons have a right to live with the same dignity as others
- Nurses could play a vital role in handling networking with other groups to meet the legal and ethical issues that relate to persons with HIV /AIDS

Teaching methods

- Case discussions
- Reflective exercises

Materials / preparation required

- Handouts of case studies
- Transparencies of important points

Topic outline

- Issues of overall management of HIV / AIDS
    - Ethical issues
    - Legal issues

Total session time

1 hour

BACKGROUND INFORMATION

All persons have certain rights such as the right to a name; a nationality; a religion; an education; basic amenities such food, water, shelter, clothing; health; to freedom etc. This means that persons with any illness would be entitled to these rights. Appendix H gives some of the rights of persons and rights pertinent to a child who is HIV positive.

Legal issues

- Denial of property rights
- Denial of social security insurance

Exercise 12.1

1. **The participants are asked by the facilitator to respond top the question**

What are the laws relating to a person with HIV / AIDS existing in our country and in other countries?

2. **The facilitator asks for a volunteer to write all the responses on the black board**
3. **The facilitator can ask a volunteer from among the participants to read aloud Handout 12.1 and invite for an open discussion on the same from the participants**
4. **This activity must take only 5 minutes**

Handout 12.1

- **Mandatory testing of blood and blood products for transfusion (drugs and cosmetic rules –1993 Blood safety)**
- **Artificial insemination human act 1995**
- **Right to privacy of a person – article 21 of the constitution of India stress on fundamental right for treatment**
- Testing only
  - For high risk groups with consent
  - For people who volunteer to be tested after pretest counseling
  - For surveillance done anonymously
  - For research purpose it must be unlinked or anonymous but with consent
- Professional misconduct and negligence could lead to legal liability
- A doctor must consider his/ her duty to ensure that any sexual partner of a known HIV positive person is informed of the risk, regardless of the person's own wishes – Supreme court judgment
- Disclosure of the details of treatment must be done only with the permission of the concerned person **except** to the doctor to whom the concerned person may be referred to

Ethical issues

Ethical principles

- Beneficence (do good)
- Nonmaleficence (Above all do no harm)
- Justice (treat everyone fairly, without discrimination, without taking undue advantage of the person)
- Veracity (to be truthful)
- Self determination (to be fully informed so that a rational decision can be made by the person)
- Respect for human dignity
    - Maintain the confidentiality (not to disclose the information received from person to another person)
    - Maintain anonymity (not to be able to link information about one person to the same person)

Exercise 12.2

1. The participants are divided into 5 groups
2. Each group is given one case to discuss the related ethical issues and to determine the actions a nurse would have to take to keep theses ethical issues in mind when taking caring for patients / persons. This should take at least 5 minutes
3. After the discussion one person is asked to come and present the discussion from each group
4. The facilitator must moderate the session using the respective Handouts

Case study 12.1

Mr. X is a clerk working in private institution. He has been presenting with chronic cough, shortness of breath upon walking and fever in the afternoons for the past four weeks. He was diagnosed to have tuberculosis. Detailed history taking revealed that Mr. X had the habit of taking Injection Pethidine every now and then. He had the habit of going to a friend's house where he along with his friend used to share the same needles and syringes for injecting the drug. His friend and he had a close physical relationship. The doctor in the PHC was busy one day and he called the nurse and told the nurse to counsel Mr. X to have the test for HIV. Mr. X refused and informed the nurse that he felt that HIV test was not necessary.

Activity

Discuss the issues involved in the above case

Handout 12.2. Legal and ethical aspects concerning HIV testing (for case study 12.1)

Information to be given to Mr. X

- **Testing of HIV infection involves a simple test but the results have a lot of importance for the person concerned and the community**

Ethical aspects	Solution
• Mandatory testing should not be done	• Counsel the person on the benefits of testing • Counsel the person on the benefits of knowing one's status early i.e. initiation of therapy • Counsel the person on the available options for treatment
• Voluntary testing can be done after informed consent is taken from the person to be tested	• Counsel the person on all aspects of VCT as discussed in Chapter X • Remember that more than one session of counseling may be required
• Pre and post test counseling must be done to ensure that the person being tested has the knowledge of the significance of the test results and options available in case of positive status	• See Chapter X for details on both pre and post test counseling • See Chapter II for details on Therapy • See Chapter XII for options on care

Case study 12.2

Ms. Seetha and Mr. Raghu were engaged for the past three months and had plans to be married in the next six months. Mr. Raghu's parents had recently read in the papers about a couple that were married for just a month. Apparently the girl was found to be HIV positive during her antenatal visit in the first month of her pregnancy, which happened to be just a month after marriage. Mr. Raghu's parents were convinced that this girl might have been positive for HIV even before her marriage. Hence they were determined that Seetha undergoes the HIV test before marriage. They did not want the same situation as they had read in the papers. Finally both families that were in conflict about the issue approached the community health nurse for options.

Activity

Discuss the issues of the above case

Handout 12.3. Legal and ethical issues related to screening (for case study 12.2)

Screening is allowed for

- Safe blood supply
- Antenatal mothers can be counseled and then tested after informed consent is obtained. This is needed to reduce MTCT
- Sero prevalence study: This is unlinked anonymous screening that helps to collect quantitative data to understand whether the epidemic is worsening or under control

Screening for safety purposes is not allowed

- Hence no one can be forced to undergo a HIV test. But individuals who consent to voluntary testing, can be encouraged

Refer laws in relation to HIV testing given earlier in the Chapter

Case study 12.3

A nurse while doing a routine family visit came across a couple that was diagnosed to be HIV positive. The couple was open and discussed their concerns with the nurse. They expressed their wish to have a child of their own.

Activity

What would be the advice the nurse could give in the above issue?

Handout 12.4. Possible advice a nurse could give a couple that is HIV positive (for case study 12.3)

If the husband and wife are both positive

- **All couples by duty of health care personnel must be counseled in order to reduce transmission. Parents can claim damage of wrongful birth if not counseled**
- **It is ideal that they avoid getting children since the chance that the child also be positive does exist**
- **The option of adoption should be made known to them. However the ultimate decision must be that of the couple**
- **Adoption for the couple is legal and will be allowed only if the couple are able to show enough resources as well as support systems in place for the care of the child in the event of them becoming terminally ill**
- The couple needs to be explained about the consequences of having their own child
- They must be explained about the need to practice safe sex i.e. the use of condoms in order to prevent re-infection with HIV

Case study 12.4

Ms. Rani working in a multinational company was diagnosed to be HIV positive. Ms Rani insists that the treating doctors and nurses keep the results confidentially. She did not want even her parents or the company people to know the result. All the members of the company liked Ms Rani and she did not want her image to be spoilt.

Activity

What ethical issues are involved?

Handout 12.5. Ethical issues in case study 12.4

Privacy and confidentiality

- Unwanted disclosure prohibited
- Counsel the concerned person on the need for disclosure
- Inform about the need to disclose HIV status to partner
- Allow disclosure to sexual or needle sharing partner only after the person concerned has given consent for the same
- Identification of HIV status must be prevented on the persons medical record
- Reporting to health authority is allowed
- Reporting to referred doctor is allowed
- , Inform to the concerned person the people who could be revealed the HIV status

Case study 12.5

A tertiary hospital doctor refuses admission of a full-blown AIDS case. The concerned person's relatives insist on the admission to the hospitals. The doctor gave various reasons for not admitting the person. The furious relatives filed a case against the hospital.

Activity

What are the legal and ethical aspects involved

Handout 12.6. Legal and ethical issues in the event of refusal of treatment by health personnel (for case study 12.5)

- Medical practitioners have the duty to diagnose, treat, counsel
- Litigation in the case of negligence could lead to accountability of the practitioners
- No health personnel can decline to treat or take care of a person because of HIV status
- Health care personnel need to be trained and educated on universal precautions
- Health care personnel need to follow with utmost care universal precautions
- Duty to counsel is important for reducing transmission

Other ethical issues in relation to HIV /AIDS

Exercise 12.3

1. The facilitator conducts a brainstorming session
2. The participants are asked ' Do you think there are any other issues that have ethical concerns when dealing with persons with HIV / AIDS'
3. A volunteer is asked to write the responses on the black board
4. The facilitator finally summarizes the points given and then mentions the points not listed on the black board

The other issues are

- Confidentiality about revealing the test results to spouses, partners, employers etc.
- Exclusion of HIV positive persons from occupations involving high risk practices like health care personnel
- Conducting behavior and intervention research into revealing the identity of the effected person
- Limits and significance of confidentiality
- Obligation to seek informed consent
- To care for those in need
- Testing new drugs

Exercise 12.4

1. **The facilitator presents a case study to the participants**

Mr. Yeshwanth, a construction worker goes to different places for carrying out job contracts, committed suicide along with his wife by consuming rat poison. They lived in a village. Subsequent enquiries revealed the Mr. X, had been diagnosed to be HIV positive and his wife had also got the infection. Unable to cope with the situation they committed suicide.

They had two children one boy, aged 12 years and a girl aged 8 years, both of whom were studying in school situated in the village itself. After the death of their parents both the children were asked not to attend school.

Even close relatives who lived in the same village abandoned the two children. Finally a social worker from a near by village who was working in a NGO took interest in the future of the children and helped them to get admission in an orphanage in the near by town.

When the relatives were approached by the social worker, they revealed that they feared that they would also get the HIV infection

2. The facilitator asks the participants to
    - Identify the issues that are coming out from the case
    - How would you deal with the situation if you come across such a case in your daily practice?

3. The facilitator writes the responses on the black board and supplements information needed

Appendix –A

SAMPLE SCHEDULE FOR WORKSHOP

Particulars	Chapter	Time
Magnitude of HIV / STI	Chapter I	30 minutes
The implications of STI /RTI/STDs	Chapter II	1 hour
HIV and AIDS – the challenge we face	Chapter III	1 hour
Prevention of STI / STD / HIV	Chapter IV	3 hour
Universal precautions – in prevention of STI and HIV	Chapter V	1 hour
Post exposure prophylaxis	Chapter VI	1 hour
Attitudes about STI / HIV / AIDS	Chapter VII	45 minutes
Communication and counseling services in the context of STI / STD / HIV	Chapter VIII	3 hours
Community based care and support	Chapter IX	45 minutes
Role of nurse in caring for a person with HIV /AIDS	Chapter X	45 minutes
Referral, networking and services	Chapter XI	1 hour
Legal and ethical issues	Chapter XII	1 hour

Appendix – B

ENERGIZERS

Energizer 1. In the pond – out of the pond

Description

All the participants are asked to stand in a circle and one volunteer is asked to give instructions to the participants

Process

1. Ask the participants to form a circle
2. Draw a circle in the center and tell the participants that this is a 'pond of water'.
3. The volunteer will call out 'in the pond' or 'out of the pond'. When the volunteer calls out 'in the pond' the participants must be able to get into the circle, which was drawn. Instruct the participants that they can hold each other so that the maximum number of persons could fit in the pond
4. If 'out of the pond' is called out then participants must move out of the circle.
5. Those who do not respond correctly to what is called out and those who cannot fit into the circle have to stand out of the game
6. Change the order of the calling out the two commands so that participants cannot guess what will be called out. You could also keep decreasing the size of the circle by saying the pond is drying up.
7. Continue the process till only one person is left out

Time

5 minutes

Note

This exercise illustrates to people that as a person resources get smaller, the number of persons who can fit in to his / her social life will decrease. It also shows that the maximum number could fit into the pond only if there is cooperation between everyone. If anyone pushes, or if anyone rushes in they are likely not to give others a chance. This could also teach participants the need to support each other, in their activities. The concept of networking could be reinforced here

Energizer 2. Building a tower

Description

The participants are given a set of cards. They have to make a tower in 3 minutes. Then they work in groups to make a tower in the same time limit but before planning

Process

1. Ask for five volunteers who will be observers of the small group activity
2. Then divide the participants in to five smaller groups of five members each
3. Each person is given ten cards that are cut in a particular way (rectangular pieces of cards are cut such that they have three limbs)

4. They are asked to build a tower with their ten cards and before this they must plan in their minds how tall they will make their tower and write it in a piece of paper. They should not discuss with each other and try to avoid looking at what the other person is doing. They should not bend the cards in any way
5. At the end of 3 minutes ask them to stop. And see whether they have achieved their goal
6. Then the five members of each group is asked to discuss in 1 minute how tall a tower they will make with all their cards (25 cards). They will be given 3 minutes to complete the task
7. The observers must see the interaction between the members in the group.

Time 10-15 minutes

Note

This exercise is preferably done after the participants get to know each other, probably, on the second day. It helps to see how when we work as a team we will be able to achieve more than if you work as an individual. The sharing of cards indicates that everyone would have to pool their resources to be able to get the best out come. It is also an exercise that teaches you planning. Do we plan more than we can achieve? Or do we plan less than what we can achieve. It is important that we are realistic in our plans. It is appropriate to do this exercise in the context of community based care.

ENERGIZER 3. DRAW A CAT

Description

The participants are given an activity to perform

Process

1. Ask for ten volunteers from the group. Tell them to step aside.
2. Keep a dupatta or big handkerchief available.
3. Then tell the volunteers to listen to your instructions clearly before proceeding with the activity. Each volunteer would be asked to do the activity separately
4. Narrate a story. 'There once lived a lovely furry black cat in a certain town that everyone loved. One day when it was busy chasing a rat it did not bother to look either side of the road and it ran across the road blindly. At that instant, a car came on the way of the cat. Luckily the cat survived but the tail of the cat got cut.
5. While narrating the story draw a cat on the black board, and then draw its tail fallen off
6. Call for the first volunteer. Tell her / him this ' Take this dupatta, blind fold your self and draw the tail of the cat in 10 seconds'
7. See that you instruct the rest of the participants to remain silent, not to make any comments, but to observe carefully what was happening
8. Call the next volunteer and tell her / him this ' Draw the tail of the cat in 10 seconds'
9. Call the next volunteer and repeat the same command as given to volunteer number 2. Repeat the same till you complete all ten volunteers
10. Then ask the rest of the participants what they observed

Time: 3-5 minutes
Note: This is used to get participants realize how well they listen as well as how preconceived notions could make them do things they were not asked to do. It has been seen that invariably most of the volunteers will do exactly what the first volunteer was told to do although they were not asked to blindfold themselves. It could be used as an energizer for Chapter VIII.

ENERGISER 4.
Description
The participants are given an activity to perform

Process
1. Ask for two volunteers from the group. Tell them to step aside.
2. Tell the rest of the participants to form a circle
3. Ask one of the volunteer to act as a wolf and another as a hen. The wolf is hungry and wants to catch the hen
4. The circle that the rest of the participants form is the boundary and prevents the wolf from entering the safe place of the hen
5. Narrate a story. 'There once lived a lovely black fat hen in a certain town (the circle formed by the participants is the boundary of the town) that everyone loved. One day when it was busy catching a worm it did not bother to look around and went near the boundary. It suddenly was face to face with the prowling hungry wolf that was watching from close by. It immediately ran away but the wolf then started trying to catch it.
6. While narrating the story ask the volunteer who would act like the hen to come inside the circle and the other volunteer to be outside the circle
11. Instruct that the rest of the participants could be asked to try as far as possible to protect the hen from snare of the wolf.
12. Allow the activity to go till 3 minutes elapse. Then ask for another volunteer to act like a wolf. Hence there are two wolves now and only one hen. Both the wolves are hungry. With each minute keep increasing the number of wolves till the hen is caught
13. Then ask the rest of the participants what they learnt from the exercise in relation to the topic HIV /AIDS

Time: 3-5 minutes

Note: This is used to get participants realize about the process of stigma, how the disease HIV could spread despite being careful, how even despite good knowledge and safe practices the infection could be acquired. It could be used as an energizer for Chapter III or VIII.

ENERGISER 5.
Description
The participants are given an activity to perform. It is preferable that this is done as an outdoor activity. Depending on the number of the participants, there could be just one big

group (15 participants) or two groups (if there are 30 participants). If there were two groups then it would be ideal that there are two facilitators to take care of the two groups. It is ideal that the number of participants for this energizer is in multiples of three (9, 12, 15 18, 21 etc). Articles that are required for the activity includes some cloth to blind fold one member of the team, chairs according the number of teams and a ball.

Process

1. Ask the participants to number themselves as 1, 2, 3, 4, and 5. This continues till all the participants are given of a number. If there are 30 participants then see that you ask them to number of till 10. This is because you must have teams of three members each.
2. Tell the participants to form groups according to the numbers they have been given. See how many teams of participants are there. If there are more than five teams then split the number of teams so that there are two groups
3. Suppose there are 10 teams then split the group into two groups, each with five teams
4. Each team must be asked to carry a chair out side.
5. Give the following instructions to the participants once they are taken out
    - This is a race where you would use verbal and nonverbal communication
    - Ask the teams to number themselves as 1, 2, and 3
    - One person (no. 1) in each team will be blind folded by a person from another team. All the blinded folded persons will then stand in a straight line as in a race
    - The chairs will be placed behind each of the blind folded persons in a straight line
    - Another member of each team (no. 2) must sit on the chair
    - The third person (no. 3) in the team must stand facing the person who is sitting on the chair
    - The facilitator will place the ball in a particular place this can be seen only by the person who is standing in front of the chair (no.3). It is either on the ground or held by the hand of the facilitator. This need not be told to the participants but you could change it with the second race
    - Number 3's should then only show actions, to the number 2 of their team to indicate how the person who is blind folded (No.1) must move to reach the ball. The moment No. 2 sees the action then he /she should shout out to Number 1. of their team how to move, i.e must give them directions
    - Rules of the game: No. 1 must be properly blond folded / No. 2 must not turn back but only face No.3 / No. 3 cannot talk but must only show actions to No. 2/ No. 3 and No. 1 can talk to each other but both cannot see each other since one is blind folded and the other is turning in the opposite direction
    - Ask the teams to plan how they are going to try and win the race
    - Set each member of the team in their respective places
6. The whistle will blow and the race can start
7. The winner is the person who gets the ball
8. Then ask the rest of the participants what they learnt from the exercise in relation to the topic HIV /AIDS

Time: 5-10 minutes

Note: This is used to get participants realize about the process of communication. It could be a powerful exercise and an energizer for Chapter III or VIII.

ENERGISER

1. The MET team could decide any other culturally appropriate energizer as and when they feel it is necessary during the training program
2. However the facilitator must try and draw lessons from each energizer used

ENERGISER 6. PLAYING GOD

Description

The participants are given a situation to reflect on. The situation is narrated and the participants are asked to give a response to the questions put forth by the facilitator.

Process

1. Narrate the situation

   ' A wonder drug has been discovered for AIDS. You are the person who has this wonder drug. There are three people who come to you for the drug:

   ii. A child
   iii. A sex worker
   iv. A business man

   Who would you give the drug to?'

2. Tell the participants to respond to the question. As they choose ask them why they chose a particular person. Allow this to go on. Tell participants they could feel free to defend their choice of person
3. As they are more or less sure whom they would give the drug to (it is important since you may see that most of them will choose the child). Then tell them 'I have not completed the story'

   'The child has been diagnosed to have cancer and is said to have only two months to live. Now whom would you choose?

4. Again as they are more or less sure of their choice then tell them ' there is still another part of the story',

   ' The business man is involved in a lot of charity and got HIV as a child through a blood transfusion'

5. The participants will ultimately make their choice
6. Then ask the rest of the participants what they learnt from the exercise

Time: 5-10 minutes

Note: This is used to get participants realize about the likely attitudes one has towards people with HIV/AIDS. It could be a powerful exercise for Chapter VII. Conclude then by telling the participants we do have preconceived notions of people and we easily discriminate among people. It is important that we go with an open mind.

Appendix-C
HANDOUT: LIST OF TARGETED INTERVENTIONS

Sl.No.	Name and address of the NGO	Targeted Intervention	Place of intervention
1	Bhoruka Charitable Trust, BPCL, Lorry parking lot, Devanagundhi, Hoskote Ph: 7945981. e-mail:bctbng@bgl.vsnl.net.in Contact Person: Mr. Govindaraj (Project coordinator); Dr. Surya Prakash (Program Manager)	Truckers	Devanagundhi, Bangalore
2	Bhoruka Charitable Trust, "Ashoka Plaza", No.48, 1st Floor, Gandhi Bazaar Main Road, Bangalore- 560 004. Ph: 6608428. e-mail:bctbng@bgl.vsnl.net.in Contact Person: Dr. Krishna Murthy (Project coordinator); Dr. Surya Prakash (Program Manager)	Healthy Highway Project	NH 4, Bangalore
3	Grama Swaraj Samithi, No.B.318, shetty layout, Ullalu upanagara Bangalore – 560056. Ph: 3289272 Contact Person: Smt. Sudha.S (Programme Coordinator)	Migrant Labourers	Ullalu Upanagara, Bangalore
4	Citizen's Alliance for Rural Development & Training Society, [CARDTS], Samudaya Arogyavahini, D. No: 10-150, D'Souza Villa, Behind Sheethal Apartment, Near Mahakali Temple, Ujjodi, Post Kankanady, Mangalore-575002. e-mail:citizensalliance@yahoo.com Ph: 08242-431215/431947 Contact Person: Mr. Satyendra Prakash(Project coordinator)	Migrant Labourers	Mangalore
5	Citizen's Alliance for Rural Development & Training Society, [CARDTS], Sahachara project, Near S.M.Petrol bunk, Billanakote, NH 4, Nelamangala Taluk, Bangalore Rural. Ph: 080- 7770842 Contact Person: Mr. Ravindra. M. Hegde (Project coordinator)	Truckers	Tumkur
6	Society for People's Action for Development, [SPAD], Flat No.1-13, Orient Manor, 15, Highstreet, Cooke Town, Frazer Town Post, Bangalore-560005. Ph: 5471680 e-mail:spadorg@satyam.net.in Contact Person: Mr. B. Vijay Kumar (Project coordinator)	Commercial Sex Workers	Bangalore
7	Society for People's Action for Development, [SPAD], Flat No.1-13, Orient Manor, 15, Highstreet, Cooke	Healthy	Bangalore

	Town, Frazer Town Post, Bangalore-560005. Ph: 5471680 e-mail:spadorg@satyam.net.in Contact Person: Mr. Augustine. C. Kaunds (Project coordinator/ President)	Highway Project	
8	Bangalore Gniyavara Seva Coota, [BOSCO], # 91, 'B' Street, 6th Cross, Gandhinagar, Bangalore-560009. Ph: 080-2253392/2208471 e-mail:bosco@bgl.vsnl.net.in Contact Person: Fr. Francis (Project coordinator)	Street Children	Bangalore
9	Samuha-Samraksha, Flat. No.4, Sadhashivanagar, Gadag Road, Koppal Ph: 080-3546973/3546965/3546961 Contact Person: V.M.Devi (Project coordinator); Smt. Sangamitra Iyengar (Director)	Truckers	Raichur and Koppal
10	Samuha-Samraksha, # 17/1, Harris Road, Benson Town, Behind ISI, Bangalore-560046. Ph: 080-3546973/3546965/3546961 e-mail:samraksha@vsnl.in Contact Person: Ms. Nagaveni (Project coordinator); Smt. Sangamitra Iyengar (Director)	Commercial Sex Workers	Bangalore
11	Jagruthi, Jyothi Complex, C3, II Floor, # 134/1, Infantry Road, Bangalore-560001. Ph: 91-80-2860346/5266132 e-mail: jagru@vsnl.net Contact Person: Smt. Renu Appachu (Project coordinator/Director)	MSM & Transsexuals	Bangalore
12	Suraksha, # 76, 2nd Stage, Kamalanagar, Bangalore-560079. e-mail:suraksha-harini@yahoo.com Ph: 3223669 Contact Person: Smt. Harini Kakkeri (Project coordinator)	Migrant Labourers	Bangalore
13	Karnataka Integrated Development Services [KIDS], Kalmath Building, Tikare Road, Dharward-580001. Ph: 0836-74087/744196 e-mail:kids_dharward @ hot mail. Com Contact Person: Smt. Pankaja Kalmath (Project coordinator)	Truckers	Dharwad
14	Karnataka Network for PLWH/A, No.113, 1st Floor, 15th Cross, 8th Main, Wilson Garden, Bangalore-560 030. Ph:2120409 ; Fax:2120410 Contact Person : Mr. Elango (Project coordinator)	PLWHA	Bangalore
15	Asha Foundation, No. 58, SBM Colony, 3rd Main, Anandnagar, Bangalore-560024. Ph: 3543333/91-80-3332921	Telephone Counselling	Bangalore

	e-mail:ashaf@satyam.net.in Contact Person: Dr. Glory Alexander (Project coordinator/ Chair person)		
16	Ujwala Rural Development Service Society, [URDSS], Jadar Galli, Shanthi Nagar, Bijapur-586104 Ph: 08352-(R)57136, (o)22972 Contact Person : Smt.Sunanda.V.Tolabandi (Project coordinator)	Commercial Sex Workers	Bijapur
17	Truck Workers Welfare & Charitable Trust, [TWCT], #2, 1st Cross, Chickkanna Garden, Shankarapuram, Bangalore-560018. Ph: 6612126/6678526 Contact Person : Mr. Sathish Joshy (Project co-coordinator); Mr.B.Channa reddy(Managing trustee)	Truckers	Bangalore
18	Bhoruka Charities, No.13, Shanthinagar, Near Amba Bhavani Temple, Gulbarga - 585103 Ph: 08472-453208; 080-2270577/2272271 e-mail: bhoruka_charities@yahoo.com Contact Person: Mr.Devendra Kattimani (Projector co-coordinator); Mr.Krishna Madhav (Director)	Truckers	Gulbarga
19	Belgaum Integrated Rural Development Society, [BIRDS], Naganur, Gokak Taluk, Belgaum District, Karnataka-591319. Ph: 08332-384678/08334-388622; 08332-324435 Contact Person: F.M.Jiralimat (Project co-coordinator)	Truckers	Belgaum
20	Ujwala Vividoddesha Sangha, Veerendra patil colony, Flat No.259, G.D.A. Layout, Sedam Road, Gulbarga – 585106. Ph:08472-465933, Mobile: 94483-33514 Contact Person: Sanganna Ijery (Project coordinator)	Truckers	Gulbarga
21	Sharana Tatva Prasara and Rural Development Seva Samsthe, Aurad, Koutha(B), Bidar. Ph:0848-229003; Mb: 9448011359 Contact Person: Mr.Shiva Kumar (Project co-coordinator)	Truckers 9448410708	Bidar
22	Rural Welfare Trust, Gramadeep, Santibastwad, Belgaum – 590014 Ph:0831-413220/413378/402121; Fax:0831430714 Contact Person: Mr. Sanjeev. R. Kulkarni (Project co-coordinator)	Migrants	Belgaum
23	SWIM- Social Welfare Institute of Mankind, No.3294, MCC, 'B'Block, Davangere – 577004. PH:0819-222294, 223729(Satish), Mb:9844114235 Contact person: B.M.Satish (Project co-coordinator/President)	Telephone counselling	Davangere
24	Baswa Karya Samithi, Kotgyal post Nittur (B), Bhalki taluk, Bidar District Ph: 08482 – 225679/224903; Mb: 9448466567	Migrants	Bidar

	Contact person: Mr.Basavaraj Patil (Project co-coordinator)		
25	Mandya Jilla AIDS Prevention Mahila Sangha, Rudrappa building, 4th Cross, R.P.Road, Subhash Nagar, Opp. Guru Bhavan, Mandya – 571402. Ph: 08232-236083(R)/ 08232-221839(PP) Contact Person: Shanthamma (Project co-ordinator)	Commercial Sex Workers	Mandya
26	Sanjeevini AIDS Jagruthi Mahila Sangha, C/O. B.S. Lokesh, No.52/D, Vinayaka Nagar, 1st cross, Tumkur – 3 Ph: (PP)0816- 2090224/ 08133-266895 (Sharadha (Papamma) Contact Person: Sharadha (Project co-ordinator)	Commercial Sex Workers	Tumkur
27	Vimukthi AIDS Prevention Mahila Sangha, C/O.S.Indirabai, No.16, Ward No.3, Station Road, Bellary – 583101. Ph: 08392-232395(Girijamma) Contact Person: Girijamma (Project co-ordinator)	Commercial Sex Workers	Bellary
28	Shakthi AIDS Prevention Mahila Sangha,Ms. Nulli building, behind ADB Bank(SBI), Gokak Taluk,Belgaum – 591307 Ph: 08332-24435(o), 08332-29178(R) Contact Person: Kasturi Kollur (Project co-ordinator)	Commercial Sex Workers	Belgaum
29	AIDS Jagruthi Mahila Sangha, Flat No.31, Hirendagi building, Opp. Anikethana Hospital, Near ING Vysya Bank, K.K.Colony, Jalnagar, Bijapur - 586101 Contact Person:Yashodha Melinkeri (Project co-orinator)	Commercial Sex Workers	Bijapur
30	Darbari AIDS Prevention Mahila Sangha, C/o. Siddamma Arjun, Railway Employ Calony, H.No.72, Gate No. 83, Afazalapur Road, Gulbarga Contact Person: Mrs.Shamala Kerartigi (Project co-ordinator)	Commercial Sex Workers	Gulbarga
31	Samuha-Samraksha (Raichur/Koppal), # 17/1, Harris Road, Benson Town, Behind ISI, Bangalore-560046. Ph: 080-3546973/3546965/3546961 e-mail:samraksha@vsnl.in Contact Person: V.M. Devi (Project co-ordinator- incharge); Smt. Sangamitra Iyengar Director)	Commercial Sex Workers	Raichur and Koppal
32	Sadhana, Guru Garden, Vasavi nagar, PWD Camp, P.B. No. 19, Sindhanur, Raichur – 584128 Ph: 08535-523699/ 520053; Mb: 9448302953 Contact Person : Sharanappa Barasi (Project co-ordinator/ Secretary)	Migrants	Raichur

Appendix-D

		VCTCs	PPTCTCs	STI/STD
1	Department of Microbiology, Victoria Hospital, Bangalore	✔		✔
2	Department of Neurovirology, NIMHANS, Bangalore	✔		
3	Department of Microbiology, KIMS, Hubli.	✔		
4	Department of Microbiology, VIMS, Bellary.	✔		✔
5	Department of Microbiology, K.M.C. Hospital, Manipal, Udupi Dist.	✔		
6	Department of Microbiology, K.M.C. Hospital, Attavar, Mangalore.	✔		
7	Department of Microbiology, Mysore Medical College, Mysore	✔		
8	District Hospital, Bagalkot	✔	✔	✔
9	District Hospital, Mandhya	✔	✔	
10	District Hospital, Bidar	✔	✔	✔
11	District Hospital, Bijapur	✔	✔	✔
12	District Hospital, Belgaum	✔	✔	✔
13	District Hospital, Chamarajnagar	✔	✔	✔
14	District Hospital, Chitradurga	✔	✔	✔
15	District Hospital, Chikmagalur	✔	✔	✔
16	District Hospital, Davangere	✔		✔
17	District Hospital, Dharwad	✔	✔	✔
18	District Hospital, Gadag	✔	✔	✔
19	District Hospital, Gulbarga	✔	✔	✔
20	District Hospital, Hassan	✔	✔	✔
21	District Hospital, Haveri	✔	✔	
22	District Hospital, Karwar (U.K)	✔	✔	✔
23	District Hospital, Kodagu (Coorg)	✔	✔	
24	District Hospital, Kolar	✔	✔	
25	District Hospital, Koppal	✔	✔	✔
26	District Hospital, Raichur	✔	✔	✔
27	District Hospital, Shimoga	✔		✔

28	District Hospital, Tumkur	✔	✔	✔
29	District Hospital, Udupi	✔	✔	✔
30	Taluka Hospital, Jamkhandi, Bagalkot District	✔		
31	Taluka Hospital, Mudhol, Bagalkot District	✔		
32	JSS Hospital, Mysore	✔		
33	Vivekananda Memorial Hospital, Saragur, H D Kote Tq, Mysore Dist.	✔		
34	Sadhan Clinic, Surathkal, Mangalore	✔		
35	K.C. General Hospital, Bangalore		✔	✔
36	District hospital, Madikeri			✔
37	Vani Vilas Hospital, Bangalore		✔	
38	Kempegowda Institute of Medical Sciences, Bangalore		✔	
39	M .S. Ramaiah Medical College, Bangalore		✔	
40	Dr. B. R. Ambedkar Medical College,Bangalore		✔	
41	Sri Devraj Urs Medical College, Kolar		✔	
42	Sri Siddartha Medical College, Tumkur		✔	
43	Jaya Jagadguru Murugarajendra , Davangere		✔	
44	Karnataka Institute of Medical Science , Hubli		✔	✔
45	Jawaharalal Nehru Medical College, Belgaum		✔	
46	Mahadevappa Rampuri Medical College, Gulbarga		✔	
47	Vijay Nagar Institute of Medical Sciences (VIMS) , Bellary		✔	
48	Al-Ameen Medical College, Bijapur		✔	
49	Sri B M Patil Medical College , Bijapur		✔	
50	Kasturba Medical College (KMC), Mangalore		✔	
51	Father Muller Medical College,Mangalore		✔	
52	K M C (Kasturba Hospital) , Manipal		✔	
53	Government Medical College (K.R.Hpt.), Mysore		✔	
54	Jagadguru Sri Shivarathreswara, Mysore		✔	
55	SNR Hospital, Kolar			✔
56	General Hospital, Ankola			✔

57	General Hospital, Kollegala			✔
58	Bowring & Lady Curzon Hospital, Bangalore			✔
59	District Hospital, Bellary			✔
60	General Hospital, Saudatti, Belgaum District			✔
61	STD Clinic, General Hospital, Hospet, Bellary District			✔
62	General Hospital, Haveri			✔
63	General Hospital, Jayanagar, Bangalore.			✔
64	General Hospital, Shahpur, Dist. Gulbarga.			✔

Appendix-F

LIST OF CARE AND SUPPORT CENTRES

1	Snehasadan, St. Camillus Rotary Rehabilitation Centre, P.O. Kinnikambla, Gurupur, Mangalore-574151. Ph: 0824-2258118/2258119 Contact Person: Fr. Joshy (Project co-ordinator/Director)	Care & Support Mangalore 94481-18119
2	Snehadaan, St. Camillus Home of Charity, Sarjapura Road, Ambedkar Nagar, Carmelaram Post, Bangalore-560035. Ph: 080-8439516-102/080-8439631 Contact Person: Fr. Methew perumpil (Project co-ordinator)	Care and Support Bangalore
3	Freedom Foundation, # 180, Hennur Cross, Bangalore-560043. e-mail: freedom@bgl.vsnl.net.in Ph: 91-805440134/91-80-5449766 Contact Person: Dr. Nirmala (Project co-ordinator) Mr.Ashok.K.Rau (Executive Trustee)	Care and Support Bangalore
4	Freedom Foundation, No.30B, Infantry Road, Opp. T.B.Hospital, Bellary Cantonment, Bellary- 5831102 Ph: 08392-240888/244985 Contact Person: Mrs. Rathi Kapadia (Project co-ordinator) Mr.Ashok.K.Rau (Executive Trustee)	Care and Support Bellary
5	Freedom Foundation, No.3/3A, Survey No.14/1, C-2, Moolur Village, NH 17, Post Uchila- 574117, Udupi District Ph: 0820-2552312 Contact Person: Dr. Krupa (Project co-ordinator) Mr.Ashok.K.Rau (Executive Trustee)	Care and Support Udupi
6	ACCEPT-Aids Care, Counselling, Education and Prevention Training, ***Rehoboth, Agape Street, Horamavu, Agara post, Bangalore – 43.*** Ph No. 080-8465418/56990452 Contact Person: Mr. A.S.Muralidharan (Project Co-ordinator) Sri. Raju.K.Mathew (chairman)	Care and Support Bangalore

7	Moolika Samvrudhi Arogyabhivrudhi Prathishtana® Hariyappa hospital, R.P Road, Sagar Taluk-577401, Shimoga District. Ph.No.08183-326618/321870/328141(R) Contact Person: Dr. K.H. Chandra shekar Rao (Project co-ordinator/Vice President)	Care and Support Sagara, Shimoga
8	Asha Jyothi, Samraksha, No.10, Gundi Road, NH 13, Kustagi - 584121 e-mail:samraksha@vsnl.in Ph: 08536-668214 Contact Person: Ms. Sulekha (Project co-ordinator)	Care and Support Kustagi

Appendix-H

Rights of HIV / AIDS individual

Basic human rights having direct relevance to people living with HIV / AIDS adapted from Kirby 1996 modified in 1992.

- Right to confidentiality and privacy
- Right to employment without discrimination
- Right to gender equity
- Right to development
- Right to highest attainable level of care
- Right to protection against oppressive laws and state policies
- Right to marry and start a family
- Right to receive basic information necessary for their protection, health and life

Rights of a HIV positive child (source: Convention of the Rights of Children)

General principles

- Principles of non discrimination (Article 2)
- The best interest of the child (Article 3)
- The rights to live, survival and development (Article 6)
- Respect the views of the child (Article 12)

Rights

- Right not to be separated from the parents (Article 9)
- Right to privacy (Article 16)
- Right to be protected from violence (Article 19)
- Right to special protection and assistance by the state (Article 20)
- Right to children who are differently abled (Article 23)
- Right to health (Article 24)
- Right to social security (Article 26)
- Right to education and leisure (Article 28 & 31)
- Right to be protected against economic exploitation, narcotic and sexual exploitation (Article 32, 33, 34 and 36)
- Right to be protected from abduction, sale, trafficking, torture, degrading treatment and punishment (Article 35 and 37)
- Right to physical and psychological recovery and social reintegration (Article 39)

Appendix –I

EVALUATION

Aim: To evaluate the overall workshop

Description: The participants are given a chance

- to give a feedback on the overall training workshop
- to give recommendations for improving the workshop

Materials

- Small pieces of paper or index cards
- Three boxes that are clearly labeled 'good points', negative points' and 'suggestions'

Duration

- 20 minutes

Process

- Distribute three index cards to each participant
- Ask the participants not to write their names on the cards, and that it is preferred to have the feedback anonymously
- Ask the participants to write ' three good points' of the workshop on one card; three 'negative points' on another card ; and three 'suggestions' for the workshop to improve in future
- Display the three boxes labeled 'good points', negative points' and 'suggestions'
- Ask the participants to put their cards in the respective boxes
- Tell the participants you will be compiling their feedback and the results will be documented in the workshop report (written within 2 weeks and given to all facilitators and organizers)

Sample format: HIV/AIDS training programme - feedback

Instruction:
Please put tick mark (✔) in the appropriate column. Fill it after each session.

Session I	Excellent	Good	Average	Poor
Information gained Presentation interesting Method of teaching used				
Any comments				

The same format could be used for all sessions

Pre and post test sample questions

A sample of the below questions (20-25) could be used to test the knowledge gained by participants before and after the workshop

Instructions: Please select the single best option for each item. Write your choice in the box provided.

1. The following are the modes of HIV transmission **except**:
   a) From infected person to his or her sexual partner
   b) By sharing needles and syringes when injecting drugs
   c) By sharing bath towels and soaps with an infected person
   d) From infected mother to child during pregnancy, delivery or breast feeding ☐

2. The prevalence rate of HIV infections in Karnataka is:
   a) 0.1% - 0.3%
   b) 1 – 1.7 %
   c) 5 –8%
   d) 10 – 12% ☐

3. Which one of the statements **does not indicate** the link between STI /STD's and HIV
   a) Effective treatment of STI/STD's will reduce the risk of HIV transmission
   b) Measures to reduce HIV transmission will include control of STI/STD's
   c) Both are sexually transmitted in most instances
   d) There is no way to prevent STI's & HIV. ☐

4. Which of the following is a major manifestation of HIV:
   a) Weight loss ≥ 10 percent of body weight
   b) Generalized rashes
   c) Upper respiratory infections for more than 2 weeks
   d) Indigestion for more than one month ☐

5. Which is of the following is **not** an opportunistic infection related to HIV infections.
   a) Mycobacterium tuberculosis
   b) Kaposis sarcoma
   c) Ulcerative colitis
   d) Acquired immuno deficiency syndrome ☐

6. The advanced stage of HIV disease is called:
   a) Opportunistic infections
   b) Symptomatic stage
   c) Seroconversion stage
   d) Acquired immune deficiency syndrome ☐

7. **The antiretroviral drug used in HIV infection:**
   a) Ranitidine
   b) Zidovudine
   c) Cemetidine
   d) Famotidine

8) **The following are sexually transmitted disease except:**
   a) Gonorrhea
   b) Syphilis
   c) Chancroid
   d) Cervical polyps

9) **The probable cause of dysphagia in a person having HIV infection is :**
   a) Esophageal dysmotility
   b) Esophagitis
   c) Esophageal candidiasis
   d) Esophageal stricture

10) **Nurses need to consider all the points while planning diet for HIV persons except:**
   a) Provide soft bland diet in small and frequent amounts
   b) Administer anti-emetics as needed
   c) Provide dietary supplements
   d) Restrict protein in the diet

11) **The body fluid to which universal precautions apply include**
   a) Pus
   b) Saliva
   c) Urine
   d) Stool

12) **The type of risk involved which handling blood spills is:**
   a) Low risk
   b) Medium risk
   c) High risk
   d) No risk

13) **Needles and syringes before the next use should be:**
   a) Disinfected
   b) Sterilized
   c) Cleaned with bleach solution
   d) Boiled

14) **To prepare a bleach solution, the ratio of bleach: water is:**
   a) 1:3
   b) 1:5
   c) 1:9
   d) 1:12

15) The disinfectants effective against HIV
   a) Spirit
   b) Dettol
   c) Lysol
   d) Phenol

16) While segregating wastes the color coding for collecting infection waste is
   a) Red
   b) Blue
   c) Yellow
   d) Green

17) After an accidental needle prick one should immediately:
   a) Report to the concerned person
   b) Pour Hypochlorite solution on to the wound
   c) Put the finger into mouth.
   d) Wash area with soap and water

18) Risk assessment to start PEP is based on:
   a) Location of the injury
   b) Sex of the person
   c) Volume of blood contacted
   d) Age of the person

19) PEP medication should be started:
   a) After obtaining the lab results of the index person
   b) As early as possible
   c) Only when the person wants to start the medication
   d) Within one week after the incident

20) All the following investigations that have to be done before starting PEP **except**
   b) Serum electrolytes
   c) WBC – Total and differential counts
   d) Renal function tests
   e) Liver function tests

21) **The follow up of the person after accidental exposure should be done for:**
   a) 2 months
   b) 4 months
   c) 6 months
   d) 8 months

22) The drugs used in PEP for the basic regimen include:
   a) Lamivudine
   b) Indinavir
   c) Nelfinavir
   d) None of the above

23) A common reason for stigma towards HIV +ve persons is
   a) Lack of openness
   b) Lack of knowledge
   c) Poor interpersonal communication
   d) None of the above

24) One favorable attitude towards sexuality is
   a) Too much knowledge about sexuality is dangerous
   b) It is dirty to talk about sexuality
   c) All humans are sexual beings
   d) It is embarrassing to discuss about sexuality

25) One misconception about the cause of HIV is
   a) Sharing infected needles and blades
   b) Transmission from the mother to the infant
   c) Unprotected sexual intercourse with an infected person
   d) Due to casual contact such as holding hands, hugging etc

26) Nurses need to have the following behavior towards HIV +ve persons
   a) Sympathy towards the person especially considering the way the person got the infection
   b) Acceptance of the person as he or she is
   c) Avoiding contact and interaction with the person
   d) Warning the community against interaction with the person

27) HIV can be treated by
   a) Encouraging exorcism
   b) Having sex with a virgin
   c) Bathing four to five times a day
   d) None of the above

28) **The task involved in the orientation phase of communication includes**
   a) Self examination
   b) Addressing the issue at hand
   c) Building trust
   d) Summarizing information

29) The last phase of interpersonal communication includes
   a) Termination phase
   b) Working phase
   c) Orientation phase
   d) Pre-orientation phase

30) All the below are reasons for distorted messages **except**
   a) Short sentences
   b) Impartial listener
   c) Too many details
   d) Nervous listener

31) Method of handling prejudice include
   a) Showing acceptance
   b) Communicating with an open mind
   c) Not being judgmental
   d) All of the above

32) When beliefs interfere with communication, the principle to avoid it is
   a) Encourage useful beliefs
   b) Accept neutral beliefs
   c) Discourage harmful beliefs
   d) Aggressively confront the belief

33) Areas requiring behavior change in HIV +ve person who is working in an office as a clerk (i) family life (ii) sexual behavior (iii) occupation (iv) personal habits
   a) All of the above
   b) None of the above
   c) Only (i), (ii), (iv)
   d) Only (i), (ii), (iii)

34) The attitude to be promoted for behavior change is
   a) I deserve the illness I got
   b) Sacrifices required of me are not worth it
   c) I am in control of my life
   d) I can not help my self

35) Skills to be promoted for behavior change are
   a) Knowledge of HIV
   b) Ability to communicate with the partner
   c) Knowledge of sexual behavior
   d) Knowledge of resources

36) Aspects to be supported for behavior change include (i) Partners willingness to change (ii) Use of condoms (iii) Building awareness in the community (iv) Developing support groups in the community
   a) All of the above
   b) (i), (ii), (iii)
   c) (i), (iii), (iv)
   d) (ii), (iii), (iv)

37) Pretest counseling is aimed at:
   a) preventing spread of HIV/AIDS
   b) treating persons with HIV/AIDS.
   c) Identifying persons with HIV/AIDS
   d) Managing persons with HIV/AIDS

38) To confirm the diagnosis of HIV ELIZA test must be done:
   a) Three times on the same sample of blood.
   b) Twice on the same sample of blood
   c) Once on different samples of blood
   d) Twice on different samples of blood

39) A person who has been exposed to high risk behavior may not show a positive test because:
   a) The person is still safe from infection
   b) It is the window period
   c) The test is giving a false result
   d) None of the above

40) Post test counseling is needed to (i) reveal test result (ii) support the person (iii) counsel the person on modifying behavior (iv) refer the person
   a) All (i),(ii),(iii) & (iv)
   b) None of the above
   c) Only (i) & (ii)
   d) Only (iii) & (iv)

41) Persons at risk of developing HIV include all except:
   (a) Those involved in unsafe sex
   (b) Those who are mutually faithful to partner
   (c) Those involved in drug abuse
   (d) Those who receive frequent blood transfusions

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42) A nurse must refer persons with high risk for HIV to all except:
a) VCTC
b) PMTCTC
c) Radiographic centre
d) Hospitals

43) A nurse must be able to maintain effective networks with (i) health professionals (ii) support centres, VCTC, PMTCTC (iii) influential person.
a) (i) & (ii)
b) (ii) & (ii)
c) (i) & (iii)
d) (i), (ii) &(iii)

44) Documentation of referrals is necessary since it aids in:
a) Tracing contacts
b) Identifying compliance to treatment
c) Tracing persons with high risk behavior
d) Checking how good referrals were

45) Follow up is needed since it helps in:
a) Checking quality of services to persons referred
b) Identifying persons with high risk behavior
c) Assessing progress of person referred
d) Developing good net works.

46) MTCTCs are centers for HIV testing for:
a) All women who are pregnant
b) All adolescents girls
c) All women at risk for HIV person
d) All married women

47) Women who must be advised to have a HIV test in order to prevent its transmission to the child include those: (i) Who have children >15 years (ii) Who have history of exposure (iii) Want to have children (iv) Who are pregnant
a) (i) (iii) (iv)
b) (ii) (iii) (iv)
c) (iii) (ii) (i)
e) (iv) (ii) (i)

48) Primary prevention of MTCT include:
(a) Educating all adolescents about HIV causes, spread, prevention
(b) Treating women who have been diagnosed to have HIV.
(c) Treating pregnant women who has been tested positive for HIV
(d) Testing all women with history of exposure for HIV.

49)The best advise to give a woman from a low socio economic background who is HIV positive to prevent MTCT is:

a) Not to breast feed
b) To exclusively breast feed for 6 months
c) To breast feed and give top feeds.
d) To breast feed for 3 months and then switch to tin milk

50) Women who is pregnant in her 6th month of gestation and is diagnosed to HIV positive.

a) Can be given ARTs safely
b) Cannot be given ARTs
c) Must be advised to have hospital delivery
d) None of the above

51)If a HIV positive woman opts to breast feed her infant, she must be told: (i) To exclusively breast feed for baby for 3 months (ii) To abruptly stop breast feeding by 3 months (iii) To start feeding expressed breast feed by 2 months using cup/paladai (iv) To mix feeds i.e. (breast milk and other feeds)

a) (i) (ii) (iii)
b) (ii) (iii) (iv)
c) (iii) (iv) (i)
d) (i) (ii) (iv)

52) For PLHAs hospital is an ideal place for:

a) Care
b) Treatment of acute conditions
c) Counseling
d) Health education

53) The content of Home Care kit will include

a) Diazepam
b) Inj. Adrenaline
c) Calcium gluconate
d) Nystatin suspension

54) Hospice care:

a) Provides financial assistance
b) Provides contact testing
c) Caters to the needs of the terminally and acutely ill.
d) Means someone else cares for the people that are cared for

55) HIV infection can be transmitted to other family members through.

a) Sharing the toilet
b) Touching and kissing others
c) Cooking food for family members
d) Sharing razors/shaving blade

56) A HIV infected person:

a) Can get married
b) Cannot get married
c) Can get married provided partner is told about HIV status
d) Can get married, without telling the partner about the HIV status before marriage

KEY

1. c	16. c	31. d	46. a
2. b	17. d	32. a	47. b
3. d	18. c	33. c	48. a
4. a	19. a	34. c	49. b
5. c	20. c	35. b	50. a
6. d	21. c	36. c	51. a
7. d	22. a	37. a	52. b
8. c	23. b	38. a	53. d
9. c	24. c	39. b	54. c
10. d	25. d	40. a	55. d
11. a	26. b	41. b	56. c
12. b	27. d	42. c	
13. b	28. c	43. d	
14. c	29. a	44. b	
15. d	30. a	45. c	

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