

CONVERGENCE OF HIV  
AND  
SEXUAL AND REPRODUCTIVE HEALTH SERVICES  
FOR  
PEOPLE LIVING WITH OR MOST AT RISK OF HIV

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A TOOLKIT FOR BUILDING CAPACITY

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PATH is an international, nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act.

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Designed by : Printocrat Inc.

Printed in India by : Printocrat Inc.

December 2009

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# Acknowledgements

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This capacity-building toolkit was developed for the PATH Convergence Project in India in the course of implementing its interventions. The first phase of the PATH Convergence Project involved formative research to understand the options for and challenges to converging or integrating HIV and sexual and reproductive health services. This phase of the project was funded by the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation, and the UK Department for International Development (DfID). In the current phase, PATH is implementing two demonstration projects to test the feasibility of district-based models of convergence: one in Bihar with support from the David and Lucile Packard Foundation and the other in Andhra Pradesh with support from the William and Flora Hewlett Foundation. We are grateful to all our donors for their support in implementing the PATH Convergence Project.

PATH also thanks the following organizations and persons for their collaboration in developing and testing out the content of this capacity-building toolkit:

- Area Hospital Palakonda, Srikakulam, Andhra Pradesh
- Gramin Evam Nagar Vikas Parishad (GENVP), Patna, Bihar
- Janani, Bihar
- Rajiv Gandhi Institute of Medical Sciences, Srikakulam, Andhra Pradesh
- Sewa Sankalp Evam Vikas Samiti, Muzaffarpur, Bihar
- Sri Krishna Medical College and Hospital, Muzaffarpur, Bihar
- Youth Club of Bejjipuram (YCB), Srikakulam, Andhra Pradesh
- M. Ram Babu, National Key Population Consultant
- Ravimapula Geetha, National Key Population Consultant
- Sangeeta Paul, National Key Population Consultant
- Shikha Das, National Key Population Consultant

# Acronyms

<b>ANM</b>	Auxiliary nurse midwife
<b>ARV</b>	Anti retroviral
<b>ART</b>	Anti retroviral therapy
<b>AZT</b>	Zidovudine
<b>CBO</b>	Community-based organization
<b>CHC</b>	Community health center
<b>DfID</b>	UK Department for International Development
<b>EFV</b>	Efavirenz
<b>FSW</b>	Female sex worker
<b>GENVP</b>	Gramin Evam Nagar Vikas Parishad
<b>HIV</b>	Human immunodeficiency virus
<b>HPV</b>	Human papillomavirus
<b>ICTC</b>	Integrated counseling and testing centre
<b>IDU</b>	Injecting drug user
<b>IPC</b>	Inter-personal communication
<b>MSM</b>	Men who have sex with men
<b>MTP</b>	Medical termination of pregnancy
<b>NACP III</b>	National AIDS Control Programme III
<b>NGO</b>	Non governmental organization
<b>NRHM</b>	National Rural Health Mission
<b>NVP</b>	Nevirapine
<b>ORW</b>	Outreach worker
<b>PHC</b>	Primary health center
<b>PLA</b>	Participatory Learning and Action
<b>PPTCT</b>	Prevention of parent-to-child transmission
<b>RCH II</b>	Reproductive and Child Health Program
<b>RTI</b>	Reproductive tract infection
<b>SRH</b>	Sexual and reproductive health
<b>STI</b>	Sexually transmitted infection
<b>TG</b>	Transgender
<b>YCB</b>	Youth Club of Bejjipuram



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# Introduction

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The 2007 estimates of the Government of India suggest that the national adult HIV prevalence in India is approximately 0.34 percent, amounting to 1.8 to 2.9 million people living with HIV across the country, with women accounting for about 39 percent of all infections. The epidemic in India is concentrated among particular sub-populations, with the prevalence being as high as 7.23 percent among injecting drug users (IDUs), 7.41 percent among men who have sex with men (MSM) and transgenders (TG) and 5.06 percent among female sex workers (FSWs).<sup>1</sup>

National-level surveys and research in India show that contraceptive use is quite low, with less than half of married women in reproductive age groups using any method of contraception at all. Twenty-one percent of all pregnancies that result in live births are therefore unintended,<sup>2</sup> and there are over 6 million abortions performed annually in India.<sup>3</sup>

People most at risk of HIV,—or key populations<sup>4</sup> like sex workers, MSMs, TGs, or IDUs and their sexual partners, as well as those living with HIV, are likely to be of reproductive age and also may have an unmet need for family-planning and abortion services. Most key populations are marginalized and stigma is a significant problem for them, impacting on, among other things, their service access. There are nearly a million HIV-positive women in India, many of whom experience unwanted pregnancies resulting from contraceptive failure or lack of contraceptive use. Although there is increasing recognition of their right to sexual and reproductive health (SRH), women with HIV or from key populations are not always able to access the information and services they need. Stigma, lack of confidentiality, lack of health care provider knowledge, and having their rights subsumed by priorities to prevent peri-natal transmission all act as barriers for people living with HIV and key populations to access SRH services. It is urgent that these barriers are addressed immediately. Family planning protects against unwanted pregnancy, reduces maternal mortality and unsafe abortion, reduces the number of HIV-infected babies, and reduces HIV-related infant deaths. Although these facts are well known, programming and funding in the areas of family planning and HIV remain largely vertical and often fail to include men.

The government of India has recognized the need for increasing access to SRH services for people living with HIV and key populations by converging or integrating SRH and HIV services. Policy on convergence is articulated in the Reproductive and Child Health plans (RCH II), in the current phase of the National AIDS Control Programme launched in 2007 (NACP III) and in the National Rural Health Mission (NRHM).

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1 Technical Brief, HIV Sentinel Surveillance and HIV estimates 2007, NACO

2 International Institute for Population Sciences (IIPS) and ORC Macro. National family health survey (NFHS-2) 1998-99. Demographic and Health Surveys. Mumbai, India, 2000

3 Abortion Assessment Project, CEHAT and HealthWatch Trust, 2004. Available at: <http://www.cehat.org/aap1/keyfindings.htm>

4 In this toolkit, key populations have also been referred to as people most at risk of HIV or most-at-risk populations.

## What is convergence?

At the basic level, HIV-SRH convergence is defined as a very wide range of activities or processes, which are undertaken with an objective to provide a complete package to enable people to access services for HIV and Sexual and reproductive health (SRH) which overlap. It entails mutual referrals and communication activities between these two services, enabling communication on HIV issues and relevant referrals within SRH settings and vice-versa. Second, converging HIV and SRH services means paying attention to dual-purpose interventions such as diagnosis and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), counseling and provision of male and female condoms, and prevention of parent-to-child transmission (PPTCT) services. Third, and more comprehensively, HIV-SRH service convergence means provision of partially integrated services such as adding voluntary counseling and testing to family-planning services, introducing family-planning services in HIV clinics, and providing SRH counseling, HIV counseling and life-skills, and sexuality education in both.

While there is strong policy commitment at the national level to push forward the agenda of convergence, translating the policies into practice still faces a range of challenges. At the programmatic level, there is lack of information about which convergence options result in the best outcomes in different settings and with different populations. Questions relating to health systems, public-private partnerships, and how best to utilize and strengthen existing services—including private-sector health care—in resource-poor settings also remain unanswered. The issue of capacity—that of people living with HIV and key populations—to demand and access integrated services on one hand, and the institutional capacity of health service providers to provide appropriate services to them, also remains a big challenge.

## **Aim of the capacity-building toolkit**

The aim of this capacity-building toolkit is to provide practical guidance for building capacity of various institutions to converge or integrate HIV and SRH services strategically, so that people who are living with HIV or are most at risk of HIV can access the SRH services they need without any barriers. The capacity-building toolkit focuses on (a) building capacity of non governmental organizations (NGOs) and community-based organizations (CBOs) for generating demand for SRH services among people living with and most at risk of HIV; and (b) strengthening the capacity of health service providers to meet the sexual and reproductive health needs of these populations with quality services.

## **Who is this capacity-building toolkit for?**

This capacity-building toolkit has been developed for program managers of NGOs and CBOs working with people living with and most at risk of HIV, health care providers in the public sector at the national, district, and facility levels, as well as those running private-sector programs providing SRH services.

## **Structure of the capacity-building toolkit**

This capacity-building toolkit has four sections. Section A gives a brief description of the PATH Convergence Project, to provide a context within which the interventions described in this toolkit were developed. Section B suggests a range of interventions that could be put in place to build district-level capacities to enable convergence of HIV and SRH services. The next two sections, C and D, describe in more detail two specific interventions that can be used to build capacity for convergence: Section C describes interpersonal communication (IPC) methods for strengthening awareness of people living with and most at risk of HIV about SRH needs and for generating demand for SRH services among them. Section D describes training modules that can be used with health care service providers in public or private sectors to strengthen their capacity to provide quality SRH services to people living with and most at risk of HIV.

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## Section A: The PATH Convergence Project - exploring what works

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### The first phase of the PATH Convergence Project (2006–2007)

During the first phase of the PATH Convergence Project in India, formative research was carried out in four districts in Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh to begin to identify options for and challenges to HIV-SRH service convergence. Findings from the formative research indicated that stigma is the main barrier to accessing services and that HIV positive people and key populations find specialized government HIV services to be less stigmatizing than government RH services provided at district hospitals, community health centers (CHCs), primary health centers (PHCs), etc. Vertical, but non-identified specialized HIV services were liked by HIV positive people and key populations, and there is a demand to add family planning and STI counseling, communications, and services to Anti Retroviral Treatment (ART) and Voluntary Counseling and Testing (VCT) centers. This finding is in line with NACP III strategy for promoting Integrated Counseling and Testing Centers (ICTC). In contrast, HIV positive people would like to use mainstream government abortion, delivery, and PPTCT services if stigma can be addressed and if service providers are better trained to respond to the SRH needs of HIV positive people. In addition, although the majority of the demand for convergence from HIV positive people and key populations was within the public sector, the findings showed that they currently procure most SRH services from the private sector. Private health care providers interviewed as part of the study were very interested in convergence but many were cautious about strengthening SRH services for HIV positive people in case they lose revenue from other general population clientele. Public- and private-sector service providers also mentioned the need to create or strengthen demand for SRH services amongst HIV positive people and key populations through communications work at the community level.

In order to strengthen access to SRH services for people living with and most at risk of HIV, demand needs to be generated among them; strategies need to be developed and tested with both the public and private sector to reduce stigma from service providers and from other clients; service providers need to be trained to respond to the specific SRH needs of HIV positive people and key population groups; and VCT and SRH services need to be added in locations which will increase access for HIV positive people and key populations. All of this needs to be accomplished while maintaining existing client loads—truly integrating services for HIV positive people with those services for people who do not have HIV.

### The current phase of the PATH Convergence Project (2007–2010)

Following the formative research, the PATH Convergence Project initiated interventions in two states, Bihar and Andhra Pradesh, in order to test the feasibility of working with government, local NGOs, CBOs, and private health care providers at the district level to strengthen the demand for, and increase the uptake of SRH services by people living with and most at risk of HIV; and to strengthen the capacity of SRH service providers in the public and private sectors to meet this increased demand with quality services. The overall goal of this phase of the PATH Convergence Project is to contribute to a reduction in HIV and unintended pregnancies in India by strengthening and promoting SRH and HIV convergence.

### **The objectives of the current phase of the PATH Convergence Project:**

- To strengthen state- and district-level capacity of government, NGOs, and selected private health care service providers for creating demand, reducing stigma, and meeting the SRH needs of people living with HIV and key populations.
- To provide information to strengthen state- and district-level decision-making and planning and advocate for scaling up HIV-SRH convergence.

### **The main strategies and activities at both project sites include:**

- Identifying and creating partnerships with key players in the government and the private sector.
- Building capacity of NGO/CBO outreach workers to mobilize awareness and demand for SRH services among people living with HIV and key populations.
- Building capacity of health care providers in providing SRH services to these populations.
- Collecting base-line and end-line information at both health care facility and community level.
- Advocating at local and national level for scaling up convergence of HIV and SRH services.

The key difference between the implementation strategies in the two sites is that interventions among the health care service providers are being carried out only in government facilities in Andhra Pradesh, while in Bihar both government and private health care facilities are involved in these interventions.

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## Section B: Basket of interventions for building capacity for convergence at district level

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The capacity-building strategy for the PATH Convergence Project went beyond training: a comprehensive package of capacity-building interventions was designed to complement and reinforce more traditional classroom-based training. The process of developing these interventions was iterative; as the project was being implemented, PATH staff and trained consultants from key populations (National Key Population Consultants), kept revising them with feedback from the field and project partners. Depending on the opportunities present in each site, some of the interventions were implemented more regularly than the others; a few were dropped altogether.

This section describes the entire basket of interventions; the users of this toolkit can select the ones they find most useful in their given contexts. The interventions are not meant to be implemented in the order they are described; a number of them can be, and often have to be implemented simultaneously. An ideal time for implementing each intervention has been suggested; however, once again, the users will have to draw on their judgement to identify the best opportunities for implementing them in their own project cycles.

These capacity-building interventions are meant for a range of stakeholders in a district—public and private health care providers and managers; people living with and most at risk of HIV in the district; and representatives of local NGOs, CBOs, and networks working with them. These interventions will work best when all stakeholders work together as project partners. These capacity-building interventions are unlikely to be as effective if implemented in isolation, as one-off events or training exercises. Support from other key stakeholders from the district, such as representatives of district health administration, government development and social service agencies in the district, other NGOs, and local journalists is also crucial to make these interventions work.

## 1 Six-monthly district-level review meetings

### Who is it for?

- Public and private health care providers and managers.
- Representatives from district-level networks of people living with HIV.
- Representatives of most-at-risk populations from the district.
- Representatives of local NGOs and CBOs.
- Other key stakeholders from the district, such as representatives of district health administration, government development and social service agencies in the district, other NGOs, local journalists, and so on.

### Purpose of the intervention

#### At the start of the project:

1. To bring all stakeholders together on a common platform.
2. To develop a common understanding among them about the ways in which lack of access to SRH services leads to increased health risks for people living with and most at risk of HIV, and how convergence of HIV and SRH services can address this risk.
3. To enable them to collectively identify the SRH service-access barriers for people living with and most at risk of HIV in their district.
4. To build a consensus among them that these service-access barriers are a common problem shared by service providers and people living with and most at risk of HIV; they therefore must be collectively addressed by both groups.
5. To present and discuss the basket of capacity-building interventions offered by the project and to understand how these can help in addressing the barriers identified.
6. To identify the opportunities for implementing the capacity-building interventions, and develop an action plan with targets for the next six months.

#### Subsequently, during the course of the project:

1. To review progress against targets.
2. To document key challenges faced and how these were overcome.
3. To identify persistent bottlenecks in converging HIV and SRH services and develop strategies to address them.
4. To prepare the work plan with targets for the next 6 months.

## Process

- The meetings must be led by trained facilitators, who have skills in engaging all participants to work toward a common purpose, irrespective of their different interests and institutional locations.
- Prepare structured session plans for the meetings, using participatory methods. Make sure the sessions are planned in a way so that all the objectives of the meetings are met.
- Experience shows that it is very effective for community consultants (trained facilitators from networks of people living with HIV and representatives from most-at-risk populations) to moderate these meetings. Later on in the project, other stakeholders can take turns hosting these meetings, and can also volunteer to moderate them along with community consultants.
- Document the proceedings of the meetings and share them with all participants for collectively monitoring progress of the work plan generated at each meeting.

## 2 Capacity analysis of health care facilities and NGOs/CBOs/networks

### Who is it for?

- Staff and managers of health care facilities.
- NGOs, CBOs, and networks working with people living with and most at risk of HIV.

### Purpose of the intervention

1. To enable NGOs, CBOs, and networks working with people living with and most at risk of HIV to self-analyze their capacity to facilitate interpersonal communication (IPC) sessions among the community members for creating awareness about SRH needs, and generating demand for SRH services among them and identifying further capacity-building needs.
2. To enable staff and managers of health care facilities to self-analyze their capacity to provide SRH services for people living with and most at risk of HIV and identify areas for further capacity-strengthening.

### Process

- At different stages of the project, facilitate structured discussions with members, managers and staff of NGOs, CBOs and networks of people living with and most at risk of HIV and health care facilities to help them analyze their institutional capacity, identify their capacity-building needs, plan technical support interventions, and monitor and evaluate the impact of capacity-building.
- Develop a list of capacity standards,—qualitative indicators based on best practices of implementing IPC for generating SRH demand, against which NGOs, CBOs, and networks can assess their existing capacities. Similarly, develop capacity standards for health care facilities who are participating in the project based on best practices of SRH service provision to people living with and most at risk of HIV.
- To get the most out of the self-analysis process, members, managers, and staff of all organizations must be committed to honest and critical reflection. To foster this, a safe environment for discussion needs to be created: the analysis should take place at a time convenient to all participants; the facilitator should reassure the participants that they can be openly critical without fear of negative consequences.
- While discussing each capacity standard, start with an open-ended question, followed by more detailed questions. Ask members, managers and staff of NGOs, CBOs, networks, or health facilities to give their institution a score based on the listed indicators. At the end of the discussion, ask what can be done to plan improvements in any weak areas and help them identify resources that will be needed.

### 3 Training in interpersonal communication for generating demand for SRH services

#### Who is it for?

- Positive networks.
- NGOs, CBOs working with most-at-risk populations.

#### Purpose of the intervention

To strengthen the capacity of frontline workers of NGOs, CBOs, and positive networks to raise awareness about SRH issues among people living with HIV and those most at risk of HIV, and to strengthen the demand for SRH services among them.

#### Process

- PATH developed five IPC methods for SRH demand generation based on Participatory Learning and Action (PLA) approaches which can be used for this purpose. Similar methods can also be developed based on problem-solving PLA approaches.
- Community consultants who have experience in training and mentoring frontline HIV workers can be trained as Master Trainers for this intervention. They can then train trainers from NGOs, CBOs, and positive networks.
- Community consultants can then hand-hold and mentor these trainers once they train peer educators and outreach workers from their organizations in facilitating IPC for SRH demand generation.
- Community consultants can also provide supportive supervision to peer educators and ORWs when they facilitate IPC sessions with people living with and most at risk of HIV.

*The SRH IPC methods developed for the PATH Convergence Project are described in Section C.*

## 4 Face-to-face interactions

### Who is it for?

- Staff and managers of health care facilities.
- People living with HIV.
- Members of most-at-risk populations.

### Purpose of the intervention

1. To understand from each others' perspectives why people living with and most at risk of HIV find it difficult to access SRH services at a given health care facility and the constraints the service providers work under.
2. To assess and deal with prejudices and to find common ground.

### Process

- This intervention has to be implemented at each health care facility participating in the project, ideally with at least one such event taking place every month.
- At these meetings, trained community consultants facilitate face-to-face dialogue between the service providers and people living with and most at risk of HIV. The idea is to discuss concrete examples of service-access barriers and then jointly identify realistic and locally appropriate ways of addressing them. During this process, it is expected that the service providers get to know the community better and come to empathize with their real problems in accessing services at their health care facility. The community members also get to understand better how the health care facility works, what services are offered there at what time and at what cost—and can therefore become better-equipped to utilize the services offered. The process needs skilled facilitation to start with, before the service providers and the community members come to trust each other, so that the dialogue focuses on problem-solving and is not reduced to apportioning blame.
- The meetings can take place at the health care facility. Local HIV positive people's networks and CBOs/NGOs working with most-at-risk populations can support the intervention by hosting these events jointly with the health care facilities and sometimes taking the service providers to the field to meet community members.

## 5 Training of health care providers on SRH services for people living with and most at risk of HIV

### Who is it for?

- Staff and managers of health care facilities.

### Purpose of the intervention

To strengthen the capacity of SRH service providers to give appropriate and stigma-free services to people living with and most at risk of HIV.

### Process

- Wherever possible, embed training sessions into ongoing training programs or staff meetings of the health care facilities, so that staff and managers of the health care facilities do not have to find extra time to attend these training sessions.
- Community consultants using participatory, problem-solving training methods are once again best-suited to facilitate the training sessions, as they can bring the perspective of the clients into the training. Wherever possible, include in the training team health care providers with skills in and experience of working closely with people living with and most at risk of HIV, so that they can share examples of good practice from their real-life clinical experience.
- It is also important to identify potential 'champions' from among the staff and managers of the health care facility. They can then be motivated to provide ongoing training and supportive supervision to staff.
- Use pre- and post-training evaluation by administering questionnaires to assess knowledge and attitudes of trainees.

*The training modules developed for this intervention for the PATH Convergence Project are described in Section D. A sample evaluation questionnaire for pre- and post-training evaluation is attached as an annexure.*

## 6 Community representatives as a resource for the health care facility

### Who is it for?

- Staff and managers of health care facilities.
- People living with HIV.
- Members of most-at-risk populations.

### Purpose of the intervention

To make available insights and experiences of community members working with people living with and most at risk of HIV to the staff and management of health care facilities.

### Process

- Encourage community representatives to be part of management committees/boards of the health care facilities.
- Work with the local HIV positive networks and CBOs of most-at-risk populations to identify community members who are interested in and capable of fulfilling this role.
- At the same time, explain to the managers of the health care facilities that they will gain from including community representatives in their management committees, as they can provide an insight into what expectations community members have from the facility.
- If necessary, advocate with the district health authority to persuade the health care facility management to include community members in their management committees. Inclusion of patient representatives in governance of health care facilities is increasingly being accepted as a good practice for realizing accountability and transparency.

## **7 Advocacy to address resource/supply/system/training bottlenecks**

### **Who it is for?**

- Public and private health care providers and managers.
- Representatives from district-level networks of people living with HIV.
- Representatives of most-at-risk populations from the district.
- Representatives of local NGOs and CBOs.
- Other key stakeholders from the district, such as representatives of district health administration, government development and social service agencies in the district, other NGOs, local journalists, and so on.

### **Purpose of the intervention**

To address resource/supply/system/training bottlenecks or failures which directly impact access to SRH services for people living with and most at risk of HIV.

### **Process**

- Monitor existing reporting and feedback systems within the health care facility so that problems and bottlenecks can be immediately spotted and addressed on an ongoing basis at the facility level.
- Raise issues that can be directly dealt with by the project partners at the 6-monthly review meetings and plan and monitor follow-up action.
- Identify those responsible for administrative decisions at health care facilities and those who can influence them, and establish informal mechanisms for keeping them informed about bottlenecks.
- Refer failures and bottlenecks that cannot be addressed by the project partners to the relevant district and state authorities.
- Identify 'champions' who can effectively advocate with the relevant district and state authorities to address the bottlenecks.

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## Section C: Interpersonal communication methods for generating demand for SRH services

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This section describes five dialogue-based interpersonal communication (IPC) methods for raising awareness about SRH needs and strengthening demand for SRH services among people living with and most at risk of HIV.

Based on Participatory Learning and Action (PLA) approaches, these IPC methods are designed to translate messages into practice. Through face-to-face interaction, dialogue, and critical reflection, these methods can help people living with and most at risk of HIV to recognize their SRH needs; identify and analyze barriers to their access to SRH services; and plan ways to address these barriers and utilize necessary services. These methods do not require any literacy and are based on visual, participatory methods that include mapping, ranking, storytelling, diagramming, and visual representations of different kinds.

Peer educators or outreach workers of an NGO, CBO, or network, who are already working with people living with and most at risk of HIV, can be trained to facilitate these methods. They can then facilitate these methods among small groups of people they work with during their regular outreach. For each session, they can identify an appropriate IPC method to use, depending on the time the group can give for the session, the amount of space available, and the level of privacy.

It is good to start the IPC session with an ice-breaker exercise to settle the group. The facilitator then introduces the objectives and the various steps of the method. He or she facilitates the group to use the method and ensures that the participants go through the process of identifying barriers, analyzing these barriers, and finding practical solutions. Solutions to problems are then organized into things the group itself can act on; and solutions that need support from others (organizations, community, etc). The group makes a plan of action they consider feasible (who does what, when). After the session is complete, the facilitator follows up on agreed action points and, when they next meet, shares the results.

## Method 1: *Aao baat karain* (Come, let us talk!)

### Purpose of the Method

To enable participants to identify their own SRH needs.

### Requirements for facilitation

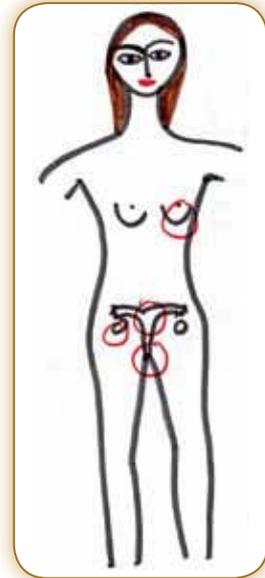
Good knowledge of SRH, including HIV/STI.

### Material required

Chart papers and colored markers, or chalk for drawing on the ground.

### Process

1. Settle the participants with an ice-breaker. Divide them into small groups if necessary.
2. Explain the purpose of the method to the participants.
3. Ask for a volunteer in each group to lie on the ground and have someone trace the outline of her body on the ground or on the chart paper.
4. Ask the participants to treat the outline as a body of a woman or a man (depending on whose SRH needs the participants want to discuss in the session) and to draw in the details.
5. Now ask the participants to draw the sexual and reproductive organs and discuss:
  - What SRH problems or events have you ever experienced (or heard of) and where in the body? Correct any misconceptions.
  - What do you (or other people) do to address these problems, or what do you do when these events occur?
  - Are there better ways of addressing these problems or dealing with these events?
6. Finish the session by asking the group to reflect on what they had shared and learned during the session that would be useful for them. Let the participants keep their drawings if they want to.





**Technical note for facilitator: Possible SRH events, emergencies and symptoms that can be referred to while facilitating Methods 1 and 2**

**Possible SRH events**

- Pregnancy
- Delivery
- Miscarriage
- Menstrual disturbances
- Abortion
- Abortion complications (incomplete abortion, bleeding, infection, post-abortion fever)
- STI
- Seeking HIV counseling and/or testing
- Sexual inadequacy (in men)
- Premature ejaculation
- Seeking family-planning counseling
- SRH emergencies

**Common SRH Emergencies**

- Severe bleeding
- Bleeding in pregnancy (anytime)
- Bleeding during delivery
- Bleeding after delivery
- Fever during pregnancy
- Fever after delivery
- High blood pressure in pregnancy
- Convulsions during pregnancy, during and after delivery
- Abnormal delivery: hand prolapse, cord prolapse, breech, shoulder delivery
- Retained placenta/delay in 3rd stage of labor

**Contraception**

- Condoms (male and female)
- Oral pills
- IUD (Copper-T)
- Female sterilization
- Male sterilization

**STI symptoms**

- Genital ulcers (in both men and women)
- Genital discharge (in both men and women)
- Warts and growths (in both men and women)
- Painful urination (in both men and women)
- Painful sex (in women)

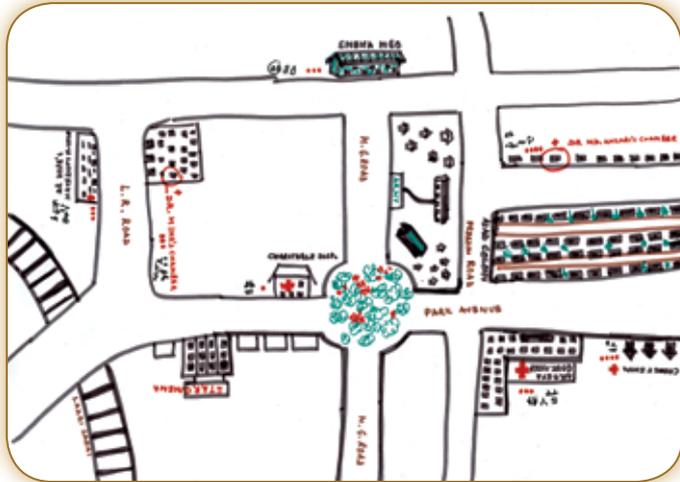
### Method 3: *Seva Chitra* (SRH Services Map)

#### Purpose of the method

To help participants map, assess, and learn how to access formal and informal SRH services available to people living with and most at risk of HIV in the project site.

#### Requirements for facilitation

Knowledge of types of formal and informal SRH services important for people living with and most at risk of HIV.



#### Material required

Chart paper and colored markers, or chalk for drawing on the ground.

#### Process

1. Settle the participants with an ice-breaker. Divide them into small groups if necessary.
2. Explain the purpose of the method to the participants.
3. Ask the participants to draw a map of the site, including a few main landmarks.
4. Ask the participants to include in the map any place or person that they could go to for SRH services.
5. Ask the participants to write or draw against each place or person:
  - What service each of them provides?
  - How each service addresses the participants' SRH needs?
6. Ask the participants to identify factors that make a particular service attractive to them (e.g., distance, cost, behavior of service providers, confidentiality, effectiveness of services provided, availability and timing, and so on).
7. Now ask the participants to rank the services marked as important in terms of how accessible they are (high, medium, low) for them.
8. Ask the participants to discuss the services ranked with 'low' and 'medium' accessibility. What could be done to make these services more accessible to them?

9. Ask the group to debate which steps are critical and who has to initiate and follow up on those steps.
10. Ask the group to draw up an action plan with a timeline based on the discussion, indicating people responsible for each action.
11. Finish the session by asking the group to reflect on what they shared and learned during the session that will be useful for them, noting down what actions need to take place now.

**Note for the NGO/CBO/network:** *Keep the chart papers to track changes in ranking of SRH services and analyze if such changes indicate that these services are becoming more accessible to people living with and most at risk of HIV, why such changes are taking place, and what more can be done to strengthen these services.*

## Method 4: *Do kahaniyan* (A tale of two people)

### Purpose of the method

To enable participants to identify barriers to accessing SRH services and work out ways of addressing those barriers.

### Requirements for facilitation

Good knowledge of SRH services and understanding about the lives and realities of people living with and most at risk of HIV.



### Material required

Chart papers and colored markers, or chalk for drawing on the ground.

### Process

1. Settle the participants with an ice-breaker. Divide them into small groups if necessary.
2. Explain the purpose of the method to the participants.
3. Ask the group to draw two different pictures of 'someone like themselves.' One of the characters they draw represents someone who has faced difficulties in accessing SRH services. The other character represents someone who has accessed SRH services successfully. Now ask them to fill in details about the two imaginary persons in the drawings. Help them to build up a story around the drawings:
  - What are the names of the imaginary persons?
  - Where do they live?
  - What are their lives like?
  - Why did they find it hard or easy to access SRH services?
4. When the two stories are complete, ask the group to think of things that would help the person in the first drawing become more like the person in the second drawing. After some discussion, ask them to settle on one (or more, depending on the time available) change that would help the person in the first drawing access SRH services more easily. It does not necessarily have to be a change that the person in the drawing would make herself; it is more likely to be a change that other people have to make.

5. Now ask the group to make a series of brief drawings outlining the steps necessary for the change to happen and debate which of those steps are critical and who has to initiate and follow up on those steps.
6. Ask the group to draw up an action plan with a timeline based on the discussion, indicating people responsible for each action.
7. Finish the session by asking the group to reflect on what they shared and learned during the session that would be useful for them, noting down what actions need to take place now.

## Method 5: *Jab main gayi aspataal....* (When I went to the hospital....)

### Purpose of the method

To enable participants to identify barriers to accessing SRH services and work out ways of addressing those barriers.

### Requirements for facilitation

Good knowledge of how SRH care facilities work and understanding about the lives and realities of people living with and most at risk of HIV.



### Material required

Chart papers and colored markers, or chalk for drawing on the ground.

### Process

1. Settle the participants with an ice-breaker. Divide them into small groups if necessary.
2. Explain the purpose of the method to the participants.
3. Ask the group to draw a map representing their journey to a SRH service point (including different destinations within the service point), indicating who they interact with at every point of their journey.
4. Ask the participants to analyze who or what either helped them in accessing services or made it difficult.
5. After some discussion, ask the participants what changes (both in terms of physical infrastructure and also people and their skills and values) need to take place for making SRH services more accessible for them.
6. Now ask the group to make a series of brief drawings outlining the steps necessary for the change to happen and debate which steps are critical and who has to initiate and follow up on those steps.
7. Ask the group to draw up an action plan with a timeline based on the discussion, indicating people responsible for each action.
8. Finish the session by asking the group to reflect on what they shared and learned during the session that would be useful for them and noting down what actions need to take place now.

**Note:** While facilitating the last three methods, encourage participants to discuss and analyze formal SRH services, both public and private.

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## Section D: Training modules for health care service providers

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The formative research conducted under the PATH Convergence Project had consulted health care service providers in the project sites to identify what their capacity needs were for providing quality SRH services to people living with and most at risk of HIV. The service providers had said that fear of casual infection while treating people living with and most at risk of HIV often made them uncertain about how to provide services. In addition, they articulated the need for getting to know these communities better, and the need to understand their cultures and the circumstances in which they live better; this, they felt, would help them better appreciate the service needs of people living with and most at risk of HIV. The service providers also expressed the need to strengthen their own knowledge about any special SRH needs that these communities may have.

The training modules for health care service providers described in this section were developed for the PATH Convergence Project, based on these capacity-building needs identified. It is suggested that the users of this toolkit identify the specific capacity-building needs of the health care providers they are working with to decide which modules to use. Alternatively, they can also develop their own modules based on the examples described in this section.

The modules are short, so that they can be easily slotted into ongoing training programs or regular meetings of managers and staff of health care facilities. The modules are designed to refresh the technical knowledge of managers and staff of health care facilities and, more importantly, to encourage them to critically reflect on what barriers may exist in their own health care facility for people living with and most at risk of HIV, and how best to address them.

### **Purpose of the modules**

To strengthen the capacity of SRH service providers to offer appropriate and stigma-free services to people living with HIV and those most at risk of HIV by strengthening their:

1. Understanding of and familiarity with people living with and most at risk of HIV.
2. Understanding of stigma and discrimination experienced by people living with and most at risk of HIV.
3. Capacity to practice universal precautions, in the same manner, with all patients at all times.
4. Knowledge of and skills in meeting SRH needs of people living with and most at risk of HIV.

## Module 1: Understanding people living with and most at risk of HIV and their experiences of stigma and discrimination

### Objectives of the module

1. To strengthen participants' understanding of people living with and most at risk of HIV and the contexts within which they are exposed to HIV risk.
2. To enable participants to explore and understand how stigma and discrimination operate.
3. To enable participants to identify stigmatizing behaviors by health care service providers to people living with and most at risk of HIV, analyze why such behaviors take place, identify ways of addressing these behaviors, and plan follow-up actions.

### Ice-breaker – What do we have in common?

The facilitator calls out characteristics of people in the group, such as 'has sister/s.' All those who have sisters should quickly move to one corner of the room. As the facilitator calls out more characteristics, people with the characteristics move to another part of the room, leaving earlier groups they may have joined.

#### Characteristics (examples)

- |                          |                         |
|--------------------------|-------------------------|
| 1. Has sister/s          | 6. Can understand Hindi |
| 2. Likes cricket         | 7. Is kind              |
| 3. Was born in a village | 8. Can sing             |
| 4. Can climb trees       | 9. Loves to eat fish    |
| 5. Is wearing black      | 10. Has pierced ear/s   |

### Session 1: Understanding risks

1. Divide participants into three groups and ask the first group to draw a picture of a sex worker; the second group to draw a picture of a woman who comes to their health facility for services; and the third group to draw a picture of a woman in their household.
2. Ask each group to imagine that the person they have drawn is either HIV-positive or is at risk of HIV and discuss.
  - Why were/are they at risk of HIV?
  - How do you feel about the person?
  - What help or support could you give to the person?
3. After groups have briefly presented their discussions in plenary, summarize the main points.
4. Ask participants to 'buzz' in pairs and look back at any risk (can be about anything, for example, riding a motorcycle without a helmet, smoking) they may have taken in life and share it with their partner. Ask them to discuss:
  - What factors made them take the risk, their feelings at the time of taking the risk, and the outcomes of taking the risk (positive and negative)?
  - What the implications of their attitudes are towards risk, in relation to the characters they discussed and their vulnerability to HIV?

- Ask them now to go back to their drawings and reflect for a couple of minutes on whether or not they would change anything on that list of reasons for risk taking. It is only for introspection and not for sharing.
5. Sum up the session noting that most people take risks for a number of reasons, under various circumstances. As service providers, we should focus on minimizing the adverse outcomes of risks taken by our clients, rather than judging whether they are right or wrong.

**Note for facilitator: Clarify misconceptions about sex workers and people living with HIV. Taking risks (or having to take risks) is likely to come out as one of the main reasons why people get infected/are at the risk of getting infected with HIV. It is also likely that participants will feel some people cannot avoid taking risks because of their circumstances, and therefore they should be sympathized with, while others are just irresponsible or habitual risk-takers and therefore should be condemned. If this happens, flag it and then introduce the next step.**

## Session 2: Understanding our values and attitudes

1. Ask everyone to stand at one end of the room and read out a statement from the center of the room.
2. If participants agree with the statement, they move to the right side of the facilitator; if they disagree with it, they move to the left; if they are not sure, they remain with the facilitator.
3. Ask the 'agree' and 'disagree' groups to give reasons to convince the 'unsure' group and others as well to join their groups.

### Statements (examples)

1. Separate hospitals and clinics should be set up to treat HIV positive people and sex workers.
2. There is no point in treating a sex worker for STIs since she will come back with the infection again.
3. Sex workers do not need family-planning services as they already use condoms to prevent HIV infection which also prevents pregnancy.
4. One can look at a person and identify that s/he is HIV-positive.
5. The law says that all clients coming to a health facility or hospital **must** be tested for HIV.
6. People who are infected with HIV should not be treated in the same place as other patients in order to protect other patients from infection.
7. Health care providers have a right to know the HIV status of all patients.
8. Women with HIV should not conceive.
9. The need for consent is exaggerated. HIV tests should be handled like any other blood test.

## Session 3: Understanding stigma and discrimination

1. Divide participants into small groups.
2. Ask the groups to draw two different pictures of SRH service providers. One of the characters they draw represents someone who has difficulties in providing SRH services to people living with and most at risk of HIV. The other character represents someone who provides quality services to these groups without stigmatizing them. Now ask the participants details about the two imaginary persons in the drawings. Help

them to build up a story around the drawings by asking them:

- What are the names of the imaginary persons?
  - Where do they live and work?
  - What are their working conditions like?
  - What are their values and attitudes toward patient care?
  - Why do they find it hard or easy to provide SRH services to people living with and most at risk of HIV?
3. When the two stories are complete, ask the participants to think of things that would help the person in the first drawing become more like the person in the second drawing. After some discussion, ask them to settle on one (or more, depending on the time available) change that would really help the person in the first drawing to better provide SRH services to people living with and most at risk of HIV.
  4. Now ask the participants to make a series of brief drawings outlining the steps necessary for the change to happen and debate which steps are critical and who has to initiate and follow up on those steps.
  5. Ask the group to draw up an action plan with a timeline based on the discussion, indicating people responsible for each action.
  6. Finish the session by asking the participants to reflect on what they shared and learned during the session that would be useful for them and noting down what actions need to take place now.

### **An alternative exercise**

1. Divide the participants into six groups, each representing one of the following people: women living with HIV; men living with HIV; female sex worker; men who have sex with men; transgender; women who use injecting drugs.
2. Ask the participants what SRH services the group they represent might need.
3. Ask each group to then think of the different kinds of stigmatizing behaviors the people their group represents may experience; ask each group to write down each type of stigma on small cards. Use as many cards as types of stigma identified.
4. Ask the participants to divide the cards on the basis of the place where that 'stigma' gets played out (home, work, hospital, school, market, neighborhood, etc).
5. Select "health care facilities" as a category and ask participants to analyze why people living with and most at risk of HIV may experience stigma there, and how it could be reduced.
6. Ask participants to draw up an action plan (with timeline and assigned responsibilities) for reducing such stigma at their own health care facility. (If improving practice of universal precautions or strengthening knowledge of and skills in meeting SRH needs of people living with HIV and those most at risk of HIV come up in the action plan, say that these will be addressed in the subsequent modules).

## Module 2: Practicing universal precaution

### Objectives of the module

1. To help participants explore their own prejudices and enable them to understand how fear of infection can exacerbate stigma and discrimination.
2. To strengthen participants' knowledge of universal precaution protocol for their health facility.
3. To enable participants to identify the barriers to always practicing universal precaution and plan ways of addressing those barriers.

### Session 1: Assessing our knowledge, understanding our fears

1. Divide participants into two groups.
2. Use the following statements to facilitate a quiz competition between the two groups. Each group has to say whether a statement is true or false and give reasons for their answers.

#### Statements for the quiz

1. Healthcare provider safety can be maintained by always following principles of universal precaution.
2. Sweat is a body fluid that requires as strict universal precautions as pleural fluid.
3. HIV can be transmitted by tears.
4. We need to cap used injection needles before disposing of them.
5. Universal precaution includes regular hand washing.
6. Universal precaution advises that all surgical instruments are decontaminated immediately following a procedure.
7. It is advisable to clean used surgical instruments before decontaminating them.
8. Segregating waste is not important: appropriate disposal is key.
9. Waste disposal staff should always wear strong utility gloves and protective clothing.
10. High-level disinfection (HLD) is better than sterilizing surgical instruments.

3. Correct misconceptions and lead an interactive discussion on universal precautions.
4. Conclude by drawing the following learning points:
  - The practice of universal precautions for infection control enables health care workers to handle all patients in a similar manner.
  - If universal precautions are being practiced, no additional, different, or extreme procedures should be needed when handling patients with HIV or other infectious diseases, in particular, blood-borne pathogens.
  - However, research indicates that health care workers often practice "universal" precautions only with patients they knew were HIV-positive or suspected to be infected. This amounts to stigmatizing people living with and most at risk of HIV.

- Research also indicates that in the absence of always practicing universal precaution with all patients, health care providers sometimes refuse services to people whom they know are HIV-positive or suspect to be infected. This is a violation of patient rights.

### Technical note for the facilitator<sup>1</sup>

- Universal precautions are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other blood-borne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other blood-borne pathogens.
- The basic guideline recommends wearing gloves when collecting or handling blood and body fluids contaminated with blood, and wearing face shields when there is danger of blood splashing on mucous membranes and when disposing of all needles and sharp objects in puncture-resistant containers.
- Universal precautions should be practiced in any environment where workers are exposed to bodily fluids, such as blood, semen, vaginal secretions, synovial fluid, cerebrospinal fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid.
- Bodily fluids that do not require such precautions include feces, nasal secretions, sputum, sweat, tears, urine, vomitus, and saliva (except in the dental setting, where saliva is likely to be contaminated with blood).

The basic elements<sup>2</sup> of universal precautions include:

- Hand washing thoroughly with soap and running water, before carrying out the procedure; immediately if gloves are torn and hand is contaminated with blood or other body fluids; soon after the procedure, with gloves on and again after removing the gloves.
- Barrier precautions: using protective gloves, mask, waterproof aprons, and gowns.
- Strict asepsis during the operative procedure and cleaning the operative site.
- Practice the “no touch technique” which is: any instrument or part of an instrument which is to be inserted in the body must not touch any non-sterile object / surface prior to insertion.
- Decontamination and cleaning of all instruments immediately after each use.
- Sterilization / high-level disinfection of instruments with meticulous attention.
- Appropriate waste disposal.

1 Adapted from guidelines on Universal Precaution of CDC, Centre for Occupational Health and Safety

2 Adapted from Indian National Public Health Standards

## Session 2: Addressing barriers to always practicing Universal Precaution

1. Divide the participants into small groups.
2. Ask each group to give an example of when Universal Precaution is not being practiced in a SRH health care facility.
3. Ask the participants to draw a picture of this example in the center of the flipchart inside a circle.
4. Ask 'why is it so?' and ask them to draw and/or write the reasons for not practicing Universal Precaution in balloons.
5. Keep asking 'why is it so?' and add more reasons in connecting balloons until they can think of no more.
6. Ask the participants what the diagram says about:
  - What are the most important barriers to practicing Universal Precaution?
  - What are the ways they already try to address these barriers?
  - What are the most difficult barriers and what would help them overcome these barriers?
7. Ask the group to reflect in plenary what barriers exist in their own health care facility to practicing Universal Precaution and what practical actions need to be taken to address these barriers. Ask the group to draw up an action plan with a timeline based on the discussion, indicating people responsible for each action.

## Module 3: SRH needs of people living with and most at risk of HIV

### Objective of the module

To enable participants to identify and understand the SRH needs of people living with HIV and those most at risk of HIV through discussing:

- The right of people living with HIV and those most at risk of HIV to bear children.
- The right of people living with HIV and those most at risk of HIV to safe contraceptive choices.
- Becoming pregnant—considerations for the woman with HIV.
- Prevention of mother-to-child transmission of HIV.
- HIV and breastfeeding.
- Importance of patient confidentiality.

### Session 1: Making reproductive choices

1. Divide the participants into three groups.
2. Give each group one of the following scenarios and ask them to role-play what advice they will provide as health care practitioners in each scenario.

- Scenario 1  
Sunaina, a female sex worker, has two small children and does not want to have any more children right now. She has had unwanted pregnancies before and has opted for abortion. She does not want to go through the process of abortion again and visits your health care facility to consult the doctor on what her best options are for preventing conception now.
- Scenario 2  
Rashmi, in her fourth month of pregnancy, discovers that she is HIV-infected. She has no idea what to do next. She has heard that HIV can be transmitted from the mother to her unborn child. She is scared. She visits the government hospital.
- Scenario 3  
Rex and Susan are a sero-discordant couple. They have lost their only son recently in an accident and want to have another baby. They have come to your health care facility for advice.

3. As each group finishes their role-play, ask rest of the participants whether they agree or disagree with the advice provided, and why.
4. Correct misconceptions and reiterate that people living with or most at risk of HIV have the right to decide whether they want to have children or not; they have the right to information about the risks involved to them and the baby; and the right to services that reduce their health risks and their baby's risk of HIV infection.

5. Conclude the session by summarizing the correct SRH advice regarding:
- Becoming pregnant—what an HIV-positive woman and those most at risk of HIV need to know about risks to the baby; risks to the mother; risks to the sexual partner; care and support required in pregnancy and childbirth; preventing parent-to-child transmission of HIV; and breastfeeding.
  - Contraception—what are the safe options for HIV-positive men and women and those most at risk of HIV?

### Technical note for the facilitator

#### Becoming pregnant—what an HIV-positive woman needs to know

##### Risks to the baby:

- If the mother is HIV-positive, the baby has a 30% chance of HIV infection during pregnancy/childbirth/breastfeeding. Most babies do NOT get infected, and treatment lowers risk. (Two-thirds of infections occur during labor.)
- If the mother is HIV-positive, there is a greater chance of stillbirth, premature birth, or low birth weight.

##### Risks to the mother:

- Increased risk of childbirth complications: fever and anemia.
- Pregnancy does not speed up the course of HIV infections, but is not a good idea if the woman has advanced disease; CD4 count  $<200/\text{mm}^3$ ; on TB treatment, or waiting to start ART.

##### Risks to partner:

Woman negative; partner positive → risk of HIV infection for woman while getting pregnant; unprotected intercourse during *fertile period*.

- Woman positive; partner negative → man can avoid risk by going for artificial insemination.
- Both partners positive → unprotected sex only during fertile period.

#### Care and support required

- HIV infection can occur during pregnancy, childbirth, and breastfeeding.
- 3 in 10 babies get infected without care; with appropriate and 'special' care, the risk of HIV-infected babies drops to 1 in 10.
- This 'special' care includes anti retroviral (ARV) prophylaxis for the mother during pregnancy and labor; and to the baby after birth; ARV for the mother if she needs it for her own health; exclusive breastfeeding or replacement feeding options that are acceptable, feasible, affordable, sustainable, and safe.
- HIV viral tests (polymerase chain reaction tests) can be used at any time starting at 6 weeks of age to identify HIV infection in the baby.

HIV-antibodies test also can be used; but an HIV-positive result by these tests before 9-12 months means that the baby was *exposed* to the virus and has not necessarily contracted HIV.

### Mother-to-child transmission of HIV and its prevention

- Pregnancy is a special situation which provides a unique opportunity for the prevention of vertical transmission of HIV using various interventions. The risk of transmission of HIV from an infected mother is 14–32% if the child is not breastfed, and 25–48% if the child is breastfed.
- More than two-thirds of such transmission occurs during labor, when the baby is exposed to maternal genital fluids, and a significant proportion occurs through breastfeeding.
- The goals of management of HIV in pregnancy are dual: managing the mother's HIV status and prevention of mother-to-child transmission.
- The indications for ART and drug selection in pregnancy are similar to those in non-pregnant women. However, in the selection of a drug regimen, the following points should be remembered:
  - AZT should be included as one of the components of the regimen unless there are absolute contraindications for using it.
  - EFV should be avoided in the first trimester of pregnancy (because of the risk of teratogenicity).
  - When NVP is substituted for EFV in a mother with good response (i.e., CD4 count is  $>250/\text{mm}^3$ ), close monitoring of liver function is required for the next 12 weeks.

### Session 2: Confidentiality

1. Divide the participants into two groups.
2. Moderate a debate between the two groups.
3. One group *agrees* confidentiality is important for clients, discusses three reasons why, and shares in plenary.
4. The second group *disagrees* and discusses three reasons why, and shares in plenary.
5. Each group then gives two counterarguments.
6. Conclude the session by drawing key lessons.

## Selected bibliography and further reading

A list of resources accessed and referred to develop the capacity-building toolkit is given below:

1. Nyblade L, MacQuarrie K. Can we measure HIV/AIDS-related stigma and discrimination? Current knowledge about quantifying stigma in developing countries. International Center for Research in Women; 2006 (Policy Project).
2. Contraception for Women and Couples with HIV. Slide show and notes. Family Health International, 2005.
3. Guiding Principles for Managing Medical Waste. One-page handout. PATH; 2005.
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5. Infection Prevention: A reference booklet for health care providers. EngenderHealth, New York; 2001.
6. Bachman G, Stuart L, Schietinger H. Integrating HIV prevention in the care setting: health managers' guide. Family Health International (FHI); 2007.
7. Key Steps in Sharps Waste Disposal. One-page poster. PATH (no date).
8. Planning for Safe Syringe Disposal: Making Medical Injections Safer (Version 2). PATH; 2004.
9. Post-exposure Prophylaxis. World Health Organization (no date).
10. Bachman G, Stuart L. PREVENTION FOR POSITIVES: A COURSE MODULE FOR HEALTH CARE PROFESSIONALS (FACILITATORS' GUIDE). Family Health International (FHI); 2007.
11. Prevention of health care-associated HIV infection. 4-page handout. Department of Essential Technologies, World Health Organization, Geneva (no date).
12. Segregation of Medical Waste—Four Categories. One-page poster. MMIS, JSI, PATH (no date).
13. Kidd R, Clay S. Understanding and challenging HIV stigma: Toolkit for Action (Trainers' Guide). CHANGE Project, Washington DC; 2003.
14. WORKING REPORT—MEASURING HIV STIGMA: RESULTS OF A FIELD TEST IN TANZANIA. Tanzania Stigma-Indicators Field Test Group on behalf of Social & Scientific Systems, Inc., under The Synergy Project. USAID; 2005.
15. Reproductive Choices and Family Planning for People Living with HIV - Counseling Tool. World Health Organization (WHO); 2006.
16. ANTIRETROVIRAL DRUGS FOR TREATING PREGNANT WOMEN AND PREVENTING HIV IN INFANTS: TOWARDS UNIVERSAL ACCESS: Recommendations for a public health approach. World Health Organization (WHO); 2006.

# Annexure – 1 Health care provider pre- and post-intervention questionnaire

## Pre- and Post- Intervention Questionnaire for individual health care providers

Date (dd/mm/yy) \_\_\_\_\_

State: \_\_\_\_\_ District: \_\_\_\_\_ Facility: \_\_\_\_\_ Code |\_\_|\_\_|

### Section 1: Please read the questions and statements below and respond as requested.

Q. No.	Question	Response Options	Code	Skip pattern
101	Gender	01 Male 02 Female	__ __	
102	Age in completed years	_____ years	__ __	
103	Education ( <i>please fill in highest level reached</i> ):	01 Cannot read or write 02 Can read and write 03 Primary 04 Secondary 05 Higher Secondary 06 Graduate 07 Professional qualification: basic 08 Professional qualification: advanced 09 Other qualification _____	__ __	
104	Category of staff?	01 Doctor 02 Counselor 03 Nurse 04 ANM 05 Lab technician 06 Ward attendant 07 Janitor/other	__ __	
105	Designation?	_____	__ __	
106	Duration of work (experience in years):	_____ years	__ __	
107	Did you receive any on-the-job training(s)?	01 Yes 02 No	__ __	<b>If “No” skip to 201</b>
108	<b>If ‘YES’ to 107, how long ago did you receive the training? (Write in completed months)</b>	Please write “NA” if “No” to 107 and code as “999” in the next column. _____ months	__ __ __	
109	<b>If ‘YES’ to 107, please mention what training(s):</b>	99 Not Applicable _____	__ __	

**Section 2: Please read the questions/statements below and tick the option(s) you think is (are) correct.**

Q. No.	Question	Response Options		Code
		01- True	02- False	
201	a) Sharing of unsterile needles, syringes, surgical instruments, & instruments for piercing			<input type="checkbox"/>
	b) Mosquito and insect bites			<input type="checkbox"/>
	c) Unprotected sexual intercourse			<input type="checkbox"/>
	d) Transfusion of blood that has not been tested for HIV			<input type="checkbox"/>
	e) (Vertically) HIV-positive mother to her unborn baby			<input type="checkbox"/>
	f) Touch of a HIV-positive person			<input type="checkbox"/>
	g) Sharing of food and clothing			<input type="checkbox"/>
	h) Breast milk			<input type="checkbox"/>
202	Pre-test counseling <b>must</b> be done for everyone advised to have a HIV test			<input type="checkbox"/>
203	One can look at a person and identify that s/he is HIV-positive			<input type="checkbox"/>
204	It is not necessary to have separate BP-instrument, stethoscope, weighing machine, examination table, and waiting spaces for persons who are HIV-positive			<input type="checkbox"/>
205	The law says that all clients coming to a health facility or hospital <b>must</b> be tested for HIV			<input type="checkbox"/>
206	Parent-to-child transmission of HIV can be prevented by giving Nevirapine to the mother before childbirth and to the baby after it is born			<input type="checkbox"/>
207	Universal precautions are to be used <b>only</b> when caring for people with HIV			<input type="checkbox"/>
208	One way of protecting health care providers from being infected with HIV through contact with clients is by following universal precautions regularly and properly			<input type="checkbox"/>

	If gloves are NOT used during the following procedures, what do you think is the risk of HIV infection? Please read the situations (a-j) given below and tick the most appropriate response.	01 There is Risk	02 There is NO Risk	Code
209	a) Delivering a baby			_ _
	b) Taking temperature			_ _
	c) Any surgery			_ _
	d) Changing bed pans			_ _
	e) Wound dressing			_ _
	f) Taking blood sample			_ _
	g) Changing patient's beddings			_ _

**Section 3: Please read the instructions and statements below carefully and respond as directed. Kindly note that there are no 'correct' or 'incorrect' responses for this section.**

301	<b>Would you <u>feel fear</u> if you were doing the following activities? (Please read the statements (from a-f), and tick the response that is closest to what you would <u>feel</u>).</b>	<b>01-YES, feel fear</b>		<b>02-NO, feel no Fear</b>	<b>Code</b>
	a) Dressing the wound of a person with HIV				
	b) Conducting surgery or suturing on a person with HIV				
	c) Removing needle from a syringe after attending a person with HIV				
	d) Taking blood sample from a person with HIV				
	e) Changing soiled (urine/excreta) clothes/bed sheets of a person with HIV				
	f) Handling the dead body of a person with HIV				
302	<b>Please read the following statements (from a-h) carefully and tick the response that is nearest to what you feel is correct.</b>	<b>01 Strongly Agree</b>	<b>98 Don't Know</b>	<b>02 Strongly Disagree</b>	<b>Code</b>
	a) People who are infected with HIV should not be treated in the same place as other patients in order to protect other patients from infection				
	b) I am comfortable performing surgical or invasive procedures on clients whose HIV status is unknown				
	c) I am comfortable providing health care to clients I suspect to be 'at risk' of HIV, like sex workers				
	d) It is required to wear latex gloves whenever performing any task related to examining a patient who may be HIV-positive				
	e) Health care providers have a right to know the HIV status of all patients				
	f) People infected with HIV are generally to blame for becoming infected				
	g) Clients who are sex workers do not deserve the same level and quality of care as other clients				
	h) Providing health care services to persons with HIV is a waste of resources since they will soon die				

<b>Please read the statements below (a-h) carefully and tick the response that is nearest to what you feel.</b>		<b>01 Agree</b>	<b>02 Neutral</b>	<b>03 Disagree</b>	<b>Code</b>
303	a) HIV is punishment for bad behavior				□□□
	b) It is the prostitutes who spread HIV				□□□
	c) Women with HIV should not conceive				□□□
	d) Men with the bad habit of having sex with other men are the ones who spread HIV				□□□
	e) Men having many or multiple sex partners are the ones who spread HIV in our community				□□□
	f) A woman who is HIV-positive is always a prostitute				□□□
	g) I would be ashamed if someone in my family were infected with HIV				□□□
	h) People with HIV should be ashamed of themselves				□□□
<b>In the past 12 months, have you seen or observed the following happen in this health facility because a client was known to have or was suspected of having HIV/AIDS?</b>		<b>01-YES</b>	<b>02-NO</b>	<b>Code</b>	
304	a) Receiving less care/attention than other patients				□□□
	b) Extra precautions being taken in the sterilization of instruments used on HIV-positive patients				□□□
	c) Requiring some clients to be tested for HIV before scheduling surgery				□□□
	d) Using latex gloves for performing non-invasive exams on clients suspected of having HIV				□□□
	e) Testing a client for HIV without his/her consent				□□□
	f) Health care providers gossiping about a client's HIV status				□□□

Signature, Session Facilitator: \_\_\_\_\_, Date: \_\_\_\_\_, Place: \_\_\_\_\_





