India's voice against AIDS

National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India
www.naco.gov.in

# Shaping Our Lives

## Learning to Live Safe and Healthy, free from HIV/Syphilis & other STIs

A Booklet on

**Women and HIV/AIDS**

**for**

**Auxiliary Nurse Midwives (ANMs)**

**Accredited Social Health Activists (ASHAs)**

**Anganwadi Workers (AWWs) and**

**Members of Self-help Groups (SHGs)**





VERSION – 2

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Ministry of Women and Child Development
(Government of India)

सत्यमेव जयते
Ministry of Rural Development
(Government of India)

UNIFEM

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Empowered lives. Resilient nations.

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This booklet was prepared through a consultation process with the Training Division of NHM, HIV and AIDS Unit of UNIFEM, UNDP and Technical Divisions of NACO.

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Ministry of Health & Family Welfare
Government of India

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राष्ट्रीय एड्स नियंत्रण संगठन
Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation

# Foreword

Government of India is committed to eliminating parent-to-child transmission (e-PTCT) of Syphilis by 2017 and new HIV infections in children by 2020. To achieve this goal, Ministry of Health & Family Welfare & Family Welfare , Government of India has taken a policy decision for universal screening and testing of pregnant women for HIV and Syphilis as a part of the essential ante-natal package.

This booklet "Shaping our Lives" developed by the IEC division of NACO along with the Ministry of Women & Child Development and the Ministry of Rural Development, Government of India in 2010 brought about tremendous awareness on HIV/AIDS among front-line health workers: Auxiliary Nurse Midwives (ANMs), Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs) and the Self-Help Groups (SHGs).

The booklet previously translated into the regional languages by the states was used as a Training aid for ANMs, ASHAs, AWWs and SHGs for understanding issues related to HIV/AIDS. This helped in dispelling myths and misconceptions about the disease and in reducing stigma & discrimination against People living with HIV/AIDS (PLHIV). Social acceptance facilitated them to avail many of the social protection schemes provided by the Government.

This revised booklet (Version-2) has been technically updated by WHO based on the current guidelines of the Prevention of Parent-To-Child-Transmission Programme (PPTCT) of HIV and Syphilis. I am sure that this will serve as a ready-reckoner for all the front-line workers especially the ANMs who will be actively engaged henceforth in screening of all pregnant women for HIV and Syphilis and referring them for treatment and continuum of care services when infected. This will give a big boost to improve the PPTCT outcomes and achieve the goal of elimination of Parent–to-child Transmission (e-PTCT) of HIV and Syphilis.

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Government of India
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi - 110011

# Message

Government of India is committed to eliminating parent-to-child- transmission (e-PTCT) of Syphilis by 2017 and HIV by 2020. I am happy to share that to achieve this goal, the Ministry of Health & Family Welfare Government of India has taken a policy decision for universal screening/testing of all ante-natal cases for HIV and Syphilis as part of essential ante-natal care package. The PPTCT progamme has been integrated with the Reproductive, Maternal, Newborn, Child Health plus Adolescent Programme (RMNCH+A) for achieving the above goal of e-PTCT of HIV and Syphilis.

The handbook "**Shaping our Lives**", which has been developed by the IEC division of NACO in collaboration with the Ministry of Women & Child Development and the Ministry of Rural Development, United National Development Fund for Women and UNDP has been revised by WHO on the latest PPTCT technical guidelines (option B+) and on the Reproductive, Maternal, Newborn Child Health plus Adolescent (RMNCH+A) Programme guidelines. This will serve as a comprehensive training aide and ready-reckoner for Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activist (ASHAs), who will now play a pivotal role in ensuring universal screening for HIV and Syphilis in the first trimester and linking them to the PPTCT continuum of care services. The language being simple with pictorial descriptions on HIV/AIDS and other STIs is a learner-friendly manual. I am sure this book will address the purpose for which it has been intended for –ensuring confidentiality of people living with HIV/AIDS (PLHIV), for dispelling myths and misconceptions of HIV/AIDS and reducing stigma and discrimination against them.

I am confident this manual will help in developing synergies between ANMs and ASHAs with the counsellors of Integrated Counseling & Testing Centers (ICTCs) & Anti-Retroviral Therapy (ART) Centers thereby De-verticalising the National AIDS Control Programme for impacting Maternal, Newborn & Child mortality rates and achieving the goal of eliminating Parent-to-child Transmission of HIV and Syphilis.

(C.K. Mishra)
AS & MD (NHM)

# Purpose of the booklet

The booklet has been designed to facilitate the work of ANMs, ASHAs, AWWs and SHGs members who are working as front-line workers in the area of reproductive health, nutrition, empowerment and poverty alleviation programmes.

Though the booklet takes inspiration from various existing IEC materials, yet it provides a new insight into how HIV and AIDS impact women and their conditions. Consultations with different programme managers and civil society groups have helped in transforming the technical know-how into a simple step-by-step guide. The use of easy to understand language, interspersed with illustrations, enhances acceptability of messages and their use among women in villages.

This booklet will facilitate front-line workers in working with women, not just in the context of HIV and AIDS but exploring inter-linked issues of rights, economic barriers and poverty conditions. This booklet can also be used to work with other development groups in villages to empower women in transforming barriers into opportunities.

***For additional copies of this booklet, please contact:***

IEC Division
NACO
www.nacoonline.org/NACO

# A Word with You

*My Dear Friend,*

As I sit down to write to you, I realise that we think alike on so many important matters, such as health, empowerment of women and girls and the wellbeing of all. Indeed, these shared beliefs, strengthen our friendship. This time, I want to share some of the issues related to HIV and AIDS which may have an impact on our work with various groups of women and young girls in the village.

If we all work together, we ***can*** prevent the spread of HIV/AIDS and STIs and make our villages and communities healthy, productive and safe. You will ask me, 'How?' Well, by just following some simple, yet important steps:

- Share information with women about how to prevent HIV infection and STIs (including Syphilis).
- If women and men want to get tested for HIV, tell them about the services available at integrated counselling and testing centres (ICTCs) in community health centres (CHCs) sub district and district hospitals. Some of the PHCs are also FICTCs (Facility Integrated ICTCs).
- If a family in the village has a person living with HIV and AIDS (PLHIV), motivate the family for his/her treatment at the ART Centre located in the government hospital.
- Counsel the family about the special diet and importance of nutrition for the PLHIV.
- You can take the lead to work with community leaders in providing care and support to people who are living with HIV and AIDS to facilitate them and get their social entitlements.
- You, along with the elders in the village, must also inform young people, migrating for work to other places, about preventive and safe behaviour.

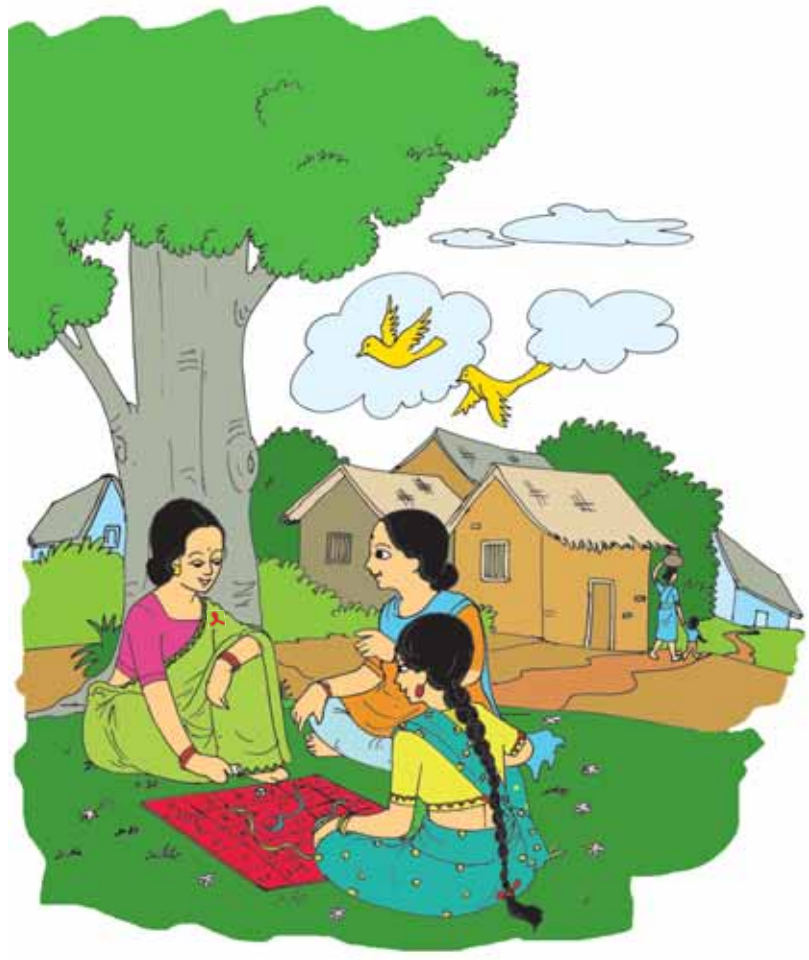
I have compiled a small booklet containing as much useful information as I could find on this crucial subject. If you feel there is something important we can together add to this booklet, please write to me. It would help us in the fight against HIV and AIDS.

## How to use this booklet

This booklet will not only tell you more about HIV and AIDS, but also help you to provide correct information to women and their families. As you know, there are many myths about HIV and AIDS! Myths and misconceptions seriously come in the way of our attempts to reduce stigma & discrimination against PLHIV. We must always strive to provide correct information. You will find that I have been able to put in important information in this booklet to help us in our work as self-help group members, as ANMs, ASHAs, or AWWs in removing stigma and discrimination associated with HIV and AIDS. This booklet is a tool to work with the community.

## Use of additional material

In our society, women are often the most vulnerable because they lack power, both socially and economically. You will ask 'What does that have to do with HIV and AIDS?'. Everything! This booklet helps to assess how women can become a potential target of HIV and AIDS. This is one more reason why women should understand and exercise their rights. I have included stories in the form of conversations between friends in the booklet. The stories are useful for organising role plays among women. I end this letter with a heartfelt request that all of us must work together on the mission of driving away stigma and discrimination against and PLHIV from our villages and towns to ensure an empowered, safe and healthy life for all including our PLHIV brethren.

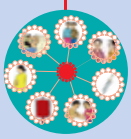


Wishing you all the best always,

*Your Friend*,

NHM/NACO/Ministry of Health/Women & Child Development, GoI

# Contents




Section I

**Learning about HIV and AIDS and Our Role** 1



Section II

**Counselling and Testing, Treatment and Child Care** 13



Section III

**Gender Dimensions of HIV and AIDS** 27



Section IV

**Fighting Stigma and Discrimination** 41



Section V

**Good Nutrition Is Important for Well-Being of all Pregnant Women Especially when HIV Positive** 51



Section VI

**Fighting Myths and Misconceptions about HIV/AIDS** 59

Section VII

Annexure 1: **New indicators included in HMIS for elimination of parent-to-child-transmission (E-PTCT) of HIV and Syphilis** 67

Annexure 2: **Standard Operating Procedures for HIV testing using POC screening test** 80

Annexure 3: **Standard Operating Procedure for Syphilis testing using POC screening test** 81

Annexure 4: **Mainstreaming & Social Protection Schemes for PLHIV** 83


# Glossary

| | | |
|---|---|---|
| AFHC | - | Adolescent Friendly Health Clinic |
| AIDS | - | Acquired Immunodeficiency Syndrome |
| ANC | - | Antenatal Care |
| ANM | - | Auxiliary Nurse Midwife |
| ART | - | Antiretroviral Treatment |
| ARV | - | Antiretroviral Drug |
| ASHA | - | Accredited Social Health Activist |
| AWW | - | Anganwadi Worker |
| CABA | - | Children Affected by AIDS |
| CHC | - | Community Health Centre |
| CSC | - | Care Support Centres |
| DAPCU | - | District AIDS Prevention & Control Unit |
| DIC | - | Drop-in-Centre |
| DLN | - | District Level Network of Positive People |
| EID | - | Early Infant Diagnosis |
| FSW | - | Female Sex Worker |
| HIV | - | Human Immunodeficiency Virus |
| ICTC | - | Integrated Counselling and Testing Centre |
| IDU | - | Injecting Drug User |
| JSY | - | Janani Suraksha Yojana |
| MARPS | - | Most at Risk Populations |
| MSM | - | Men who have Sex with Men |
| NGO | - | Non-governmental Organisation |
| NHM | - | National Health Mission |
| NVP | - | Nevirapine |
| OI | - | Opportunistic Infection |
| OVC | - | Orphans & Vulnerable Children |
| PHC | - | Primary Health Centre |
| PLHIV | - | People Living with HIV and AIDS |
| PPTCT | - | Prevention of Parent-to-Child Transmission |
| PWID | - | People Who Inject Drugs |
| SHG | - | Self-help Group |
| STD | - | Sexually Transmitted Disease |
| STI | - | Sexually Transmitted Infection |
| VHND | - | Village Health & Nutrition Day |
| VHSC | - | Village Health & Sanitation Committee |
| WLHA | - | Women Living with HIV and AIDS |

Section I

# Learning about HIV and AIDS and Our Role



# Learning about HIV and AIDS and Our Role

Today, I will share with you how and why HIV and AIDS has become one of the major health threats affecting young men and women.

As an Anganwadi Worker (AWW), ASHA, ANM and member of a self help group, it is our role, indeed our duty, to give women and their family members critical information about:

HIV prevention

its treatment

ART Medicines

correct & consistent use of condom

How to practice and negotiate safe sexual behaviour

Did you know why the two words - HIV and AIDS are written together? HIV, if left untreated, leads to AIDS. AIDS is the condition when the body becomes weak and prone to Opportunistic Infections (OIs) eg. TB, Candidiasis, Pneumocystis jiroveci Pneumonia (PCP), Herpes etc.

Unclear? Well read on.

You will find answers to many questions that are most commonly asked.

## Let us learn in a simple way what HIV is.

HIV is the short form of three separate words.

**H** **Human.** A person like you or me who belong to our family, neighbours and friends.

**I** **Immunodeficiency.** This long word means a reduced capacity of the body to fight against infections.

**V** **Virus.** Virus is a disease-causing micro-organism. In this case we refer to the virus as HIV.

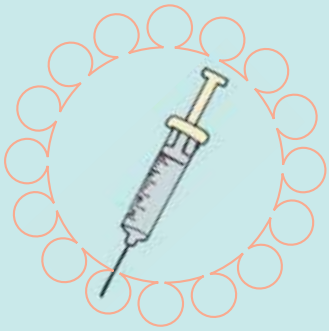
## How do people get infected with HIV?

HIV spreads through four main routes:

### 1. By having unprotected sex

You can avoid HIV by:

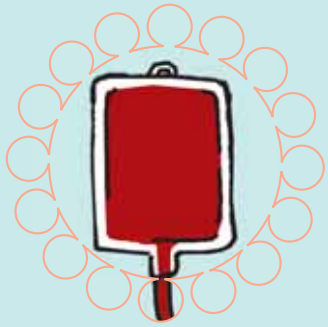
- Abstaining from casual sex. Be faithful to your partner always.
- Use condoms during sex. They are easily available in government health facilities, chemist shops and general stores. Check the expiry date and use correctly and consistently.
- Don't take the risk of getting infected for life for a few moments of unprotected pleasure.



### 2. By receiving HIV infected blood or blood products

You can avoid HIV by:

- Always ensuring you take blood from a licensed blood bank if you or any family member is in need of blood.
- Check with the blood bank to ensure that the blood has been screened for HIV. Ensure your blood bag carries the sticker of mandatory testing for transfusion transmitted infections, including HIV.



### 3. By using unsterilised needles, syringes or lancets

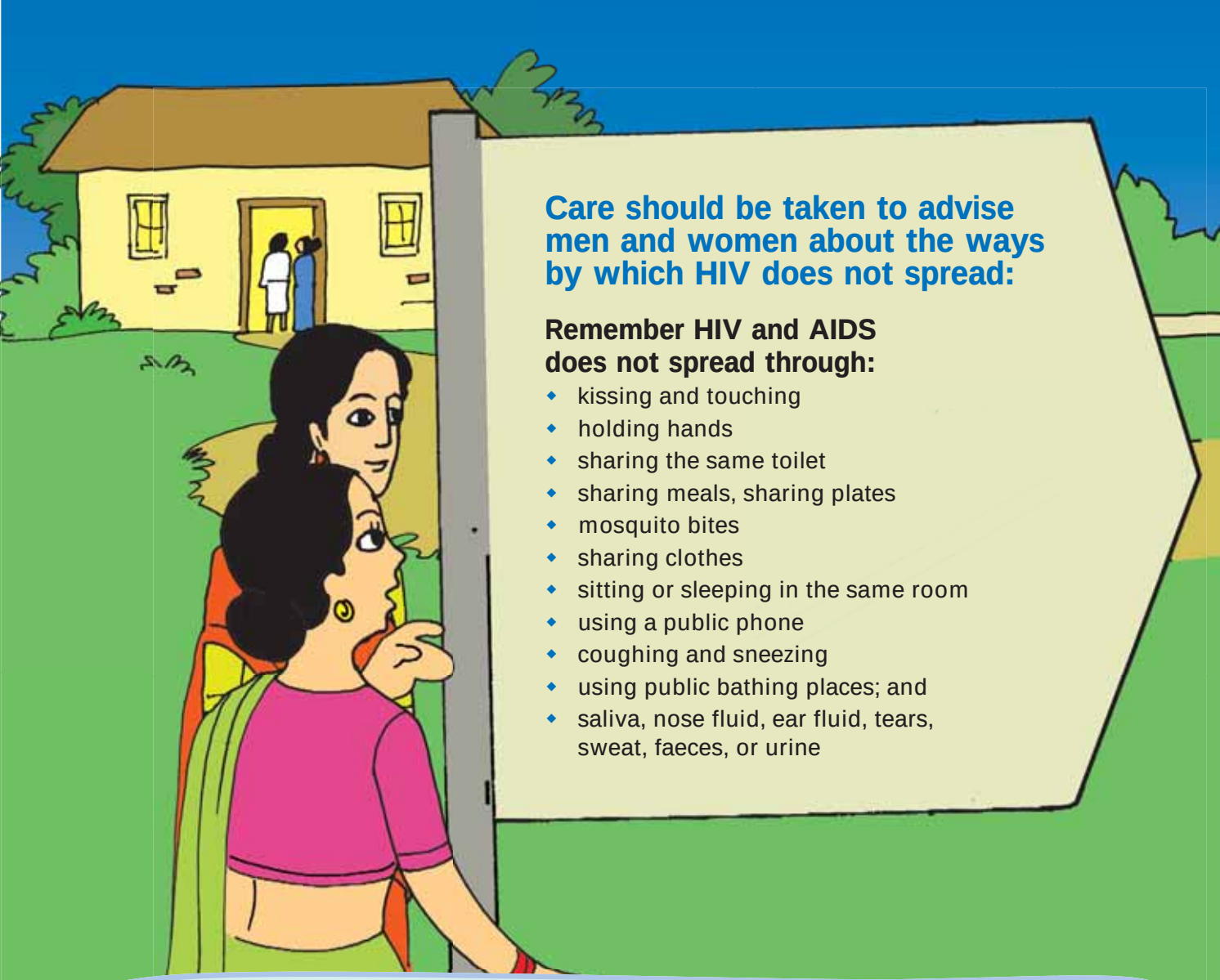
You can avoid HIV by:

- Always insisting on using disposable syringes when blood tests are being done during treatment.
- Avoiding injecting drugs, and not sharing needles and syringes.
- Being responsible. Ensuring needles and syringes are destroyed after use and putting in dedicated colour-coded waste management bins for plastics and sharps.

### 4. From an HIV infected mother to her baby

You can avoid infecting your baby with HIV by:

- Knowing your HIV status. As soon as the pregnancy test comes positive; get tested for HIV during the first visit, preferably as soon as you know you are pregnant. Visit the nearest public health facility for free HIV testing.
- Take timely medication at the closest ART Centre to prevent transmission of HIV from mother to child as advised by your doctor.



## Care should be taken to advise men and women about the ways by which HIV does not spread:

**Remember HIV and AIDS does not spread through:**

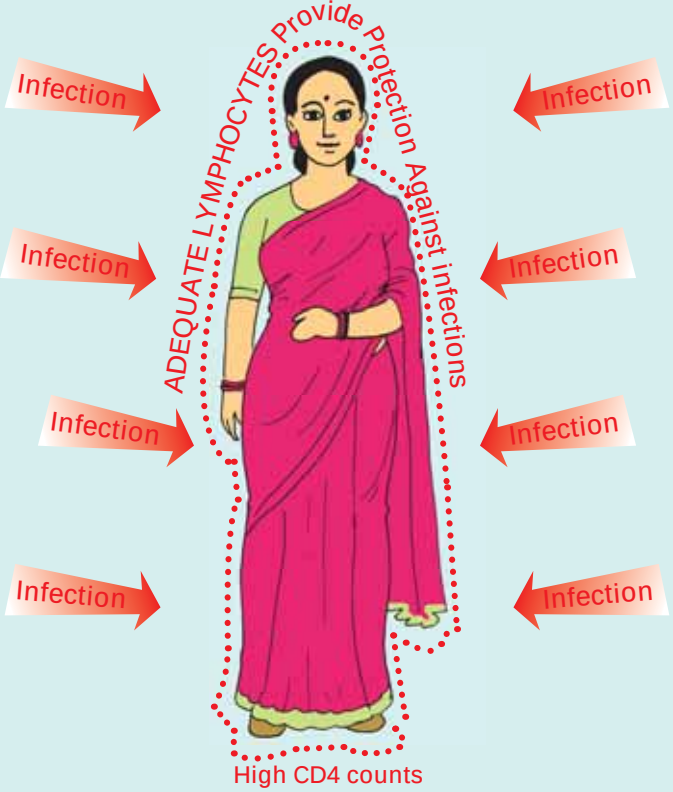
- kissing and touching
- holding hands
- sharing the same toilet
- sharing meals, sharing plates
- mosquito bites
- sharing clothes
- sitting or sleeping in the same room
- using a public phone
- coughing and sneezing
- using public bathing places; and
- saliva, nose fluid, ear fluid, tears, sweat, faeces, or urine

## What happens when a person gets HIV?

Our body has a set of white blood cells known as lymphocytes whose adequacy will be known by CD4 count. These cells protect us from various infections and provide us with natural immunity. When HIV enters our body, it destroys these CD4 cells making us more susceptible to infections.

## When does HIV become AIDS?

AIDS is the short form for **Acquired Immunodeficiency Syndrome.** AIDS is the last stage of the infection when the body loses its strength to fight infections. In other words, the person is in a condition which impairs his/her immune system. As a result, the person becomes prone to all kinds of infections.



## What happens once HIV replicates and spreads?

There are various stages of how the infection progresses. These are:

### Initial stage

HIV spreads throughout the body, within weeks of entry. Many may not have any external symptoms or face any ill health. Some persons may, however, show the following signs and symptoms:

- Fever
- Headache , body ache
- Cough
- Skin rash
- Night sweats
- Swelling of lymph nodes. The flu-like symptoms last for 1 to 2 weeks.

These symptoms should be taken seriously if the person is known to or suspected to have high risk behaviour or exposes to high risk situations. In such a situation the person should be referred to an Integrated Counselling and Testing Centre (ICTC) which is located in most Government hospitals.

### Window period

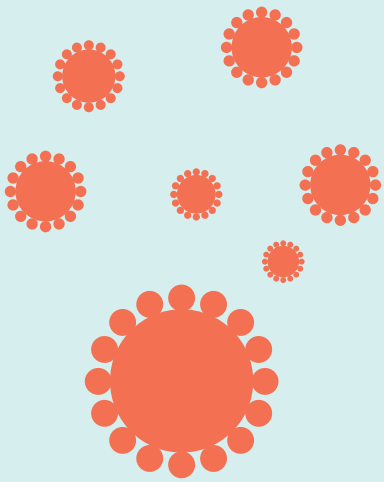
It takes between 6 weeks to 6 months (average 3 months) for HIV test (antibodies) to become positive after infection. During this time, even if the antibody test is negative, infected persons can still spread the infection to others. During this period the person may not test positive. Therefore, the test should be repeated after three months.

**DURING WINDOW PERIOD**


In your role as a friend and as a counsellor, you can provide women in your community most appropriate information and motivation on important preventive actions.

## No symptoms stage

HIV spreads fast, in deep tissues. There it may remain dormant for many months or years. This is the stage of 'clinical latency', which can last from 3 months to 17 years, depending on the immune status of individual patients. During this time though the person may look healthy, he is infected with HIV.



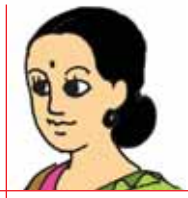
## Symptoms stage

Our body loses the capacity to fight the virus at this stage. The destruction of the CD4 lymphocytes by the virus in our body disables the immune system gradually. The person suffers from obvious signs of the infection. Various Opportunistic Infections (OIs), such as tuberculosis, candidiasis (thrush), herpes, Pneumocystis jiroveci Pneumonia (PCP) and others occur and the person becomes weak and ill. Later, the following symptoms may worsen the condition:

- Long spells of fever, and significant weight loss
- Frequent diarrhoea, fatigue and loss of appetite
- Dry cough or shortness of breath and swollen lymph glands
- Curdy white spots in the mouth and on the tongue (oral thrush).

Counsel women so that they can persuade their husband or partner to visit the nearest ICTC for testing.

With your help women can learn about how to prevent STIs.

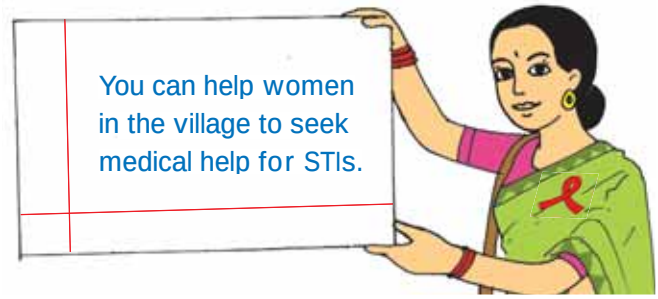


## Learning about Sexually Transmitted Infections (STIs)

Let us learn how sexually transmitted infections play a role in transmitting HIV from one person to another. I would like to share with you what I learnt on this subject.

- Men and women with STIs have a ten-fold risk of contracting HIV than those who do not have STIs.
- STIs are generally caused by bacterial or viral infections. Some can cause ulcers, open wounds or sores in the genital areas.
- The ulcers, warts, etc. that form as a result of STIs, facilitate easy entry of HIV into the body.
- STIs are mainly transmitted through sexual contact.
- STIs can also be passed on, during pregnancy from an infected mother to her unborn child.

You can help women in the village to seek medical help for STIs.



## How does a person know if he or she has STI?

If a person has the following symptoms he/she may have STI:

- Discharge from the private parts
- Blisters, sores or lumps around the private parts, genitals or anus
- Swollen glands in the groin
- Increased frequency of urination or pain, irritation and itching, while urinating

**Seeking early treatment is very important**.

## Where can you send people with STI for treatment?

Treatment is available for STI in Primary Health Centres (PHCs), Community Health Centres (CHCs), district hospitals and by trained private doctors.

## What else can you do to help?

Motivate persons with STIs to take the following steps:

1. With the support of ANMs and ASHAs, seek medical help for investigation and treatment.

## Use of condom

2. Condoms offers protection from: (i) HIV (ii) sexually transmitted infections (STIs) and (iii) unwanted pregnancies. Using a fresh condom during every act of sexual intercourse is the only way to ensure protection and prevention of infections. Even if both husband/wife/partners are HIV positive, the male should use a condom to prevent transfer of high HIV viral infection/load from one to another.

Male condoms are available free of cost at all sub-centres, PHCs, CHCs and district hospitals.

### Male condom use

Proper use of male condom

- It is advisable to decide on the use of a condom with your partner beforehand as you may forget in the heat of the moment.
- Always check the expiry date or manufacturing date on the condom pack to ensure that it has not expired. Also make sure that the manufacturing date is not more than 4 years old.
- Press the condom pack with your fingers to make sure it is intact.
- To open the pack and identify the appropriate point to tear the pack, push the condom downward and carefully tear the pack with your fingers. Make sure your fingernails do not damage the condom. DO NOT use sharp objects such as scissors or a razor as they may cut the condom.
- To put on the condom, the penis must be erect (hard).
- Ensure that the part to be unrolled is on the outside. Press and hold the tip of the condom with your thumb and forefinger to keep out the air.
- Place the tip of the condom on the head of the penis and using your other hand, unroll the condom all the way to the base of the penis.
- Use only water-based lubricants; oil-based lubricants such as Vaseline, Crisco, hand lotion or massage oil cause the condom to break.
- Keep the condom on, during intercourse. After ejaculation, while the penis is still in erection, pull out of your partner, holding the condom at the base of the penis to avoid it spilling semen.
- Wrap the condom in paper and throw it away as soon as possible where it is out of reach. DO NOT flush condoms down the toilet.
- NEVER reuse the condom.

As a community friend you can counsel young girls and boys and married couples to practice safe behaviour

## Remind women about personal hygiene as well

Keeping ourselves clean and taking care of our personal hygiene is a very effective way of being free from illness and staying healthy. Many women have yellowish or white discharge which if not treated on time, can lead to ulceration of the vaginal area.

You can explain to the menstruating girls about the importance of sanitary pads and clean clothes:

1. Sanitary cloth should be kept clean and dry.
2. If re-using the cloth, wash it with proper soap and if possible, dry it in the sun.

If pads are available, ensure:

- Proper use of clean and sterile pads
- No re-use of pads
- Proper disposal of pads

## How can men be responsible in practising safe behaviour?

- By being faithful and responsible towards the spouse or partner.
- By always using a condom in multi-partner sexual relations.
- By seeking immediate medical help for treatment of STIs.
- **Sexual violence or coercion in sex may lead to higher risk of HIV infection.**

## Men have an important role to play in ensuring women are not at risk of HIV

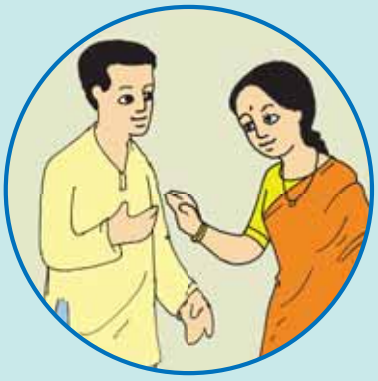
A RESPONSIBLE MAN is one who

DOES NOT abuse, beat, indulgences in violent behaviour or discriminates against women and girls

EDUCATES his son to take early responsibilities towards his mother and sister and share equally in household work. Respects girls/women always

Respects his wife and appreciates all that she's doing for the happiness and well-being of the family

EDUCATES his daughter and ensures her access to opportunities equally



SHARES household and financial decision-making with her

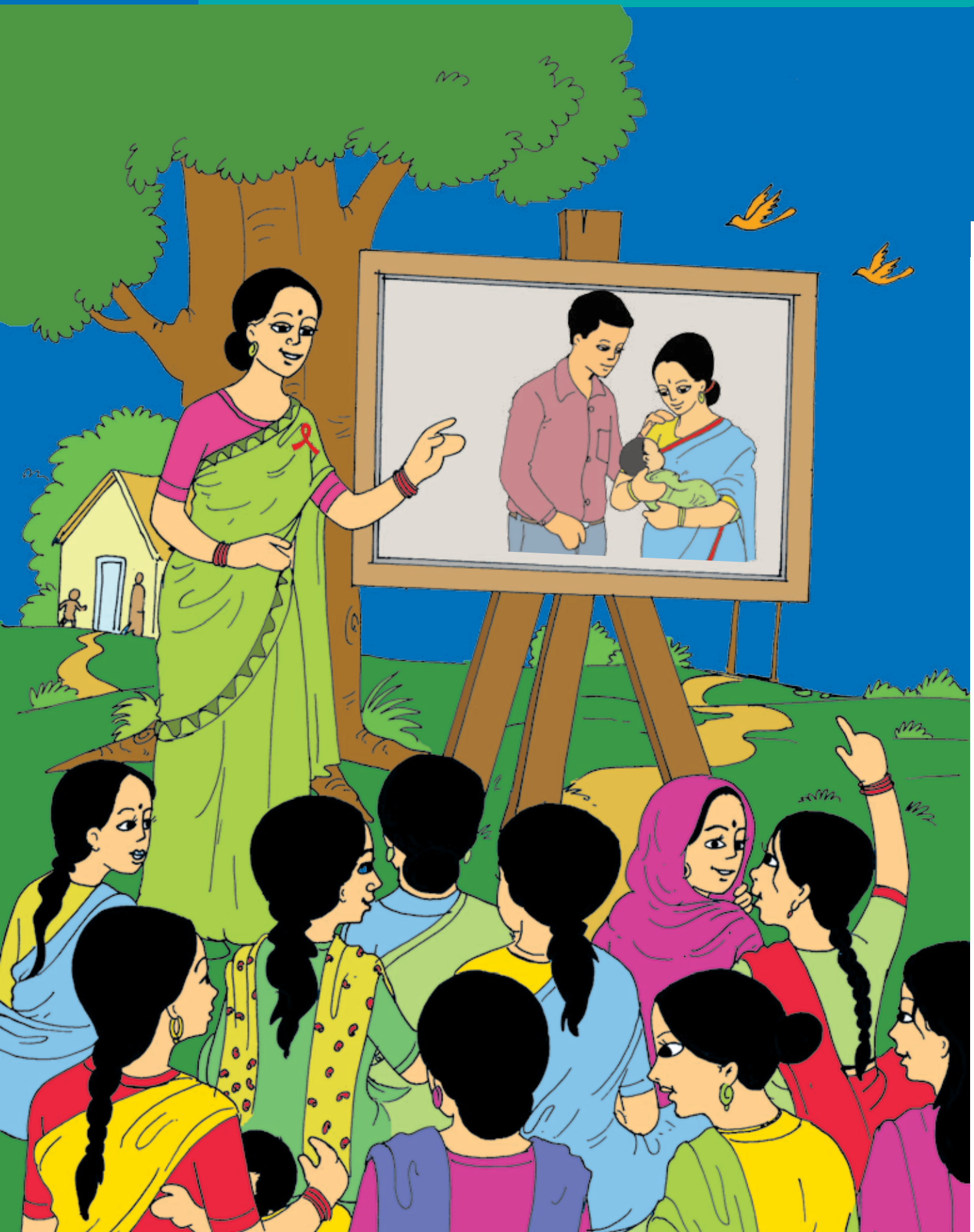
Men in the community can be motivated to play more proactive social roles. Such messages should reach men through panchayats, or through one-to-one talks.

## What did we learn in this section?

- Modes of transmission of HIV
- Symptoms and stages of HIV and AIDS
- STI and its treatment
- Prevention of HIV and AIDS
- Men's role and responsibility in protection and prevention of HIV

Section II

# Counselling and Testing, Treatment and Child Care



# Counselling and Testing, Treatment and Child Care


Indeed, it is really simple to get a HIV test done. A blood test for HIV at the nearest ICTC located in the community health centre or district hospital can confirm if a person has HIV infection or not. But do remember to tell the person wanting to be tested about the **"window period"**. In fact, because there are so many important issues to consider about HIV, the counsellors in the ICTC provide pre-test and post-test counseling to all persons being tested for HIV. The identity of the person getting tested is kept confidential. Now you may well ask:

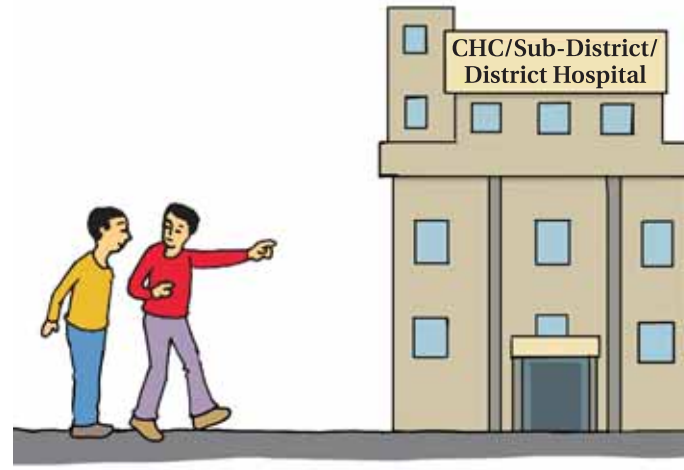
## What is a HIV test?

When infected with HIV, our body produces antibodies specific to HIV. The HIV test (Rapid or ELISA) detects these antibodies in the blood.

**Process of Testing for HIV**

## Where can HIV test be done?

HIV testing facilities are available free of cost at the Integrated Counselling and Testing Centre (ICTC) located at the district, sub-district hospitals and community health centres.



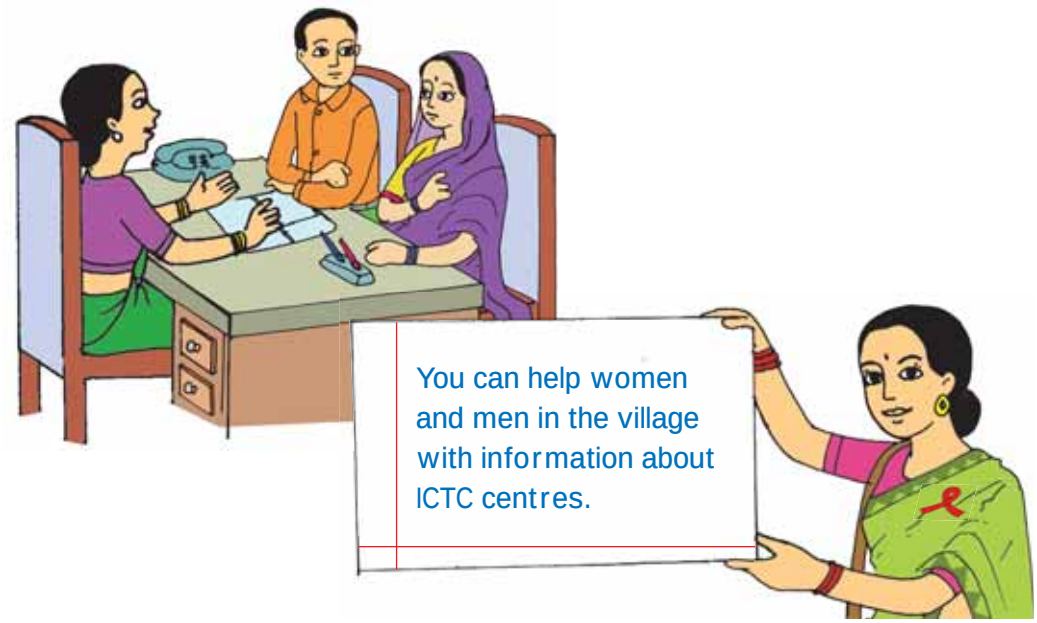

It usually takes about three months from the date of exposure for HIV antibodies to appear in the blood. This period is called the **"window period"**. If the HIV antibody test is taken during the window period, it may give a negative result because the blood test is looking for antibodies that have not yet developed. However, the person may already be HIV infected.

## What is pre- and post-test counselling?

The counsellor helps the person to understand the importance of taking the blood test to know his/her status, the importance of taking treatment if HIV positive, planning for children and the use of condoms to protect the partner from the virus.

**Help women and their family to get tested for HIV** at the nearest ICTC. The list of centres in your district is with the Medical Officer at the PHC, and also with the District Medical Officer.

Anybody can get HIV, but HIV test should be taken by those who may have been exposed to high risk situation or behaviour at some point in the life.



## Let us see how you can help people living with HIV and AIDS (PLHIV)

1 Ensure that the woman and her partner or spouse agree to go to the nearest ICTC and get tested.

2 Help them in getting their results from the counsellor at the centre.


3 Encourage all those diagnosed as HIV positive to get themselves registered at Antiretroviral Treatment (ART) centres and advise them to get the CD4 test done at the earliest so that they can get free ART (if required).

4 Ensure that People Living with HIV and AIDS (PLHIV) are regularly taking Antiretroviral Treatment as advised by the doctor.


5 Ensure they visit the ART centre regularly every month and earlier if they experience any symptoms

6 Ensure that PLHIV are taking the diet as advised by the counsellor

Provide moral and psycho-social support to PLHIV and keep them motivated with a positive attitude to life. Don't let anyone stigmatise and discriminate against them.

## How do I help them?

### If the result is negative

- If one or both partners have a high-risk behaviour and test negative for HIV, they should be advised to repeat the test after **three months**.
- Counsel them to avoid any high-risk behaviour during the **"window period"** even if the test is negative.
- Counsel about using condoms consistently and correctly

### Provide information about:

- Avoiding unwanted pregnancies, coercive sexual behaviour of the partner
- Sharing and caring for each other
- Delivery and breastfeeding practices
- Using condoms
- Staying healthy

### If the result is positive

- Advise the HIV positive person to register at an ART centre and get the CD4 count test done and every six months thereafter.
- Develop their social support though family, friends and peer group.
- Ensure they follow-up regularly at the ART Centre
- In case of pregnant women, ensure they are tested for HIV and Syphilis and they deliver at the hospital, and receive life-long ART if HIV positive and for Syphilis cases, at least one dose of injection benzathine penicillin to be given to her and her spouse/partner immediately. RPR testing to be done for pregnant women and recorded on MCP card.
- Discuss issues related to diet, nutrition, exercise and risk reduction.

**Chances of leading a normal life**

**If the right kind of treatment and care is taken at the earliest, people infected with HIV can lead a normal life. Provide regular information and appropriate counselling about diet and developing a positive attitude.**

## HIV and TB

This is also the right time for you to give information about one of the most common Opportunistic Infections (OIs) amongst PLHIV called tuberculosis

(TB). More than half of the PLHIV develop TB as their body's immunity weakens. Common signs and symptoms of TB are:

- Cough of any duration
- Fever
- Weight loss within one year
- Night sweats
- Any enlarged/swollen lymph nodes in the body
- Loss of appetite etc.

**Your role**

Along with medicines, a positive attitude to life helps the person and the family to overcome the trauma of having this infection. You can be a source of support and guidance for HIV infected couples and women in making informed decisions about treatment and care.

If any of these symptoms is reported, you should refer the person to the nearest TB diagnostic centre, DMC (Designated Microscopy Centre) which is located at all medical colleges, district hospitals, CHCs and most PHCs under the Revised National Tuberculosis Control Programme (RNTCP). Presently newer Rapid diagnostic tools available in the programme, can provide results in 2 hrs.

TB can easily be treated with medicines taken regularly for six to eight months. Get in touch with the doctor for more information about this programme and treatment which is available for TB patients. TB treatment is started **first** and after 15 days ART is started. Both TB and ART medicines can be taken together. TB and ART treatment is started irrespective of CD4 count. Adherence to Anti TB treatment is most important for cure from TB Disease. Many patients with HIV - TB co-infection do not take regularly their TB treatment and ART treatment together. Due to this, many deaths amongst HIV - TB co-infection occur.

For other infections like diarrhoea, oral thrush, fever etc. go to the nearest PHC/CSC for treatment.

## People infected with HIV must remember the following:

- **Must not donate blood, semen or organs**
- **Must inform the sexual partner and always use condoms**
- **Must consult the doctor at the nearest medical centre**
- **Must plan pregnancy carefully, and seek advice of the doctor at the ICTC**
- **Must seek early treatment at PHC or CHC if suffering from any other infection**

# Living with HIV and AIDS

## Motivate people living with HIV and AIDS to take care of themselves by:

- Eating healthy and nutritious food

- Exercising regularly

- Stopping alcohol and tobacco use

- Getting regular health check-ups

- Taking medicine as prescribed by the doctor for prevention of Opportunistic Infections (OIs) and treatment if any

- ANMs, ASHAs, AWWs and SHGs can play an important role by disseminating prevention messages to the community in general and women in particular. During the women's group meetings, they should talk about the services available in ICTCs and ART centres. They should also talk about the services available for HIV and Syphilis positive women and how they can avoid passing on the infection to their child if they are pregnant or planning pregnancy in the future.

## Antiretroviral Treatment (ART)

ART is a combination of three drugs given to an HIV positive person having CD4 count below 350 cells. Shortly, NACO will be putting all PLHIV on ART with CD4 counts below 500. These medicines need to be taken regularly for the rest of the HIV positive person's life. Discontinuation/irregular intake of medicines can make the treatment ineffective after some time. HIV/AIDS has no cure but with proper treatment, the person infected with HIV can live a long and productive life.

In HIV positive pregnant women and those with HIV-TB, irrespective of WHO clinical staging or CD4 count they should start on life-long ART. Single pill containing all three medicines taken once a day (at bedtime) are available now.

## Initiating ART: Patient Education:

- **It is not curative, but prolongs life with good health**
- **Treatment is lifelong, given free in all Government ART Centres**
- **High level of adherence is critical for ensuring long & healthy life**
- **May have short and long term adverse events**
- **Safe sex is still essential**
- **Do not share ART medicines with family members and friends**

ART must be started only when the person living with HIV is ready to take it life-long.

**Sometimes ART medicines may have some side-effects. This does not mean that the person should stop taking the medicine. Counsel the person to continue taking the medicine as they will come down soon.**

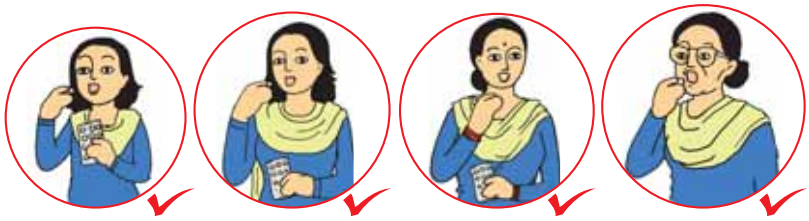
### Let us learn more about it:

Nausea, diarrhoea and tiredness may appear after a person starts taking ART. However, these do not last long, and decrease over a period on their own. This is because the body gets used to the drugs, which allows treatment to continue without problems. In case the side-effects persist, counsel the person to consult the doctor.

### Common side effects of ART:

- **Anaemia (tiredness, weakness, fatigue, breathlessness)**
- **Jaundice (yellows eyes, yellow urine)**
- **Skin rash**
- **Changes in mood and concentration**

The decision to change treatment due to side-effects should always be taken only on advice from the doctor.



ART drug is to be taken regularly life-long

## What is a CD4 count test?

CD4 test is a blood test which reflects the capability of the body to fight infections (immune status). Higher the CD4 count, better is the capability of the body to fight infections. This test is done, free of cost, at the ART centres, located in the medical colleges and district hospitals. If CD4 count goes down below the level of 350, a doctor may prescribe ART after thorough investigations. Soon, NACO will start PLHIV with CD4 counts less than 500 on life-long ART.


- PLHIV must be counselled about undertaking regular 'CD4' tests once every six months.
- Advise women and their spouses about their roles as caregivers/caretakers of the family in making sure that treatment is being taken by both.
- Finally, do counsel the family to provide care and support for the infected person. A good diet is very important in fighting infections.

A separate section is here to help you with information related to healthy and balanced diet to strengthen the immune system of the body.


## What is 'Prevention of Parent-to-Child-Transmission' (PPTCT) programme?

The HIV virus can pass on to the child from a HIV positive pregnant mother. 'How? you may ask. HIV positive woman can pass the virus to her child during pregnancy, delivery or breastfeeding. However, in a majority of cases child can be protected from getting the infection by timely interventions.

PPTCT programme aims at preventing the transmission of HIV infection from an HIV positive pregnant woman to her child. PPTCT programme helps HIV positive couples or mothers to ensure that the child is born free from infection by taking certain precautions/medications and life-long ART. Ensure that this should be continued during pregnancy, labour, delivery and breast feeding of the infant and thereafter, life-long (Option B+).


**ART** reduces the HIV concentration in maternal fluid, tissues and breast milk. This provides protection from risk for the infant if given to the mother during pregnancy, delivery and post-delivery and hence HIV testing done early in pregnancy and if positive, starting on life-long ART as soon as possible is very important. Now, three medicines in one pill is given as soon as the pregnant woman/mother is detected to be HIV positive even if detected in the first trimester. This should be taken every day at bedtime.


For new born baby for 6 weeks usually (or 12 weeks if mother was put on ART after 6 months of pregnancy/or later)

## Infant Feeding and HIV

As HIV can be transmitted to the infant through breast milk, there is often a dilemma in the choice of feeding to be recommended for babies of HIV positive mothers. However breast feeding should be advised as first preference. Exclusive breast feeding (EBF) is advised for first 6 months. It is crucial that the breastfeeding must be initiated within the first hour of child birth.


If parents or the mother is HIV positive we can test the baby's HIV status (EID) from six weeks of age onwards; again at 6 months of age and finally 6 weeks after breast feeds are stopped. Early infant diagnosis is being done at identified ICTCs & soon may be available in all ICTCs.

Exclusive replacement feeding (ERF) during first months is recommended only in inevitable situations after ensuring that replacement feeding is AFASS where mother is unable to breast feed due to a terminal illness or is not alive. First preference in all HIV positive mothers should be exclusive breast feeds during the first six months. At six months introduction of weaning foods and complementary feeds with continuation of breast feeds for at least one year (if baby is HIV negative) and upto two years if HIV positive and put on paediatric ART.

## AFASS criteria

- **Acceptable**
- **Feasible: the feeding option must be easily available**
- **Affordable**
- **Sustainable: the mother should be able to provide it for as long as the child needs it**
- **Safe (hygienic)**

It should be explained to the mother about the increased chances of HIV transmission if **"mixed feeding"** is done during the first 6 months. If replacement feeding is being done, hygienic ways of preparation and feeding by cup and spoon has to be advised. **IT MUST BE EMPHASISED THAT FEEDING BOTTLES MUST NOT BE USED**.

Please refer to the section on nutrition for more information on feeding options for children and babies born to HIV positive mothers.


The HIV status of the child can be known after 6 weeks of birth through early infant diagnosis (EID) tests done at ICTCs. All children born to HIV positive mothers (HIV exposed infants) must be followed-up regularly at the ICTCs and ART centres.

If the baby is tested positive using EID tests she/he should be started on paediatric ART, at the ART Centre as soon as possible. Such a child requires a nutritious diet which should be provided in consultation with the counsellor at the ART Centre or at the Care and Support Centre (CSC) in your district.

A child may be subjected to social and other negative consequences of this disease from birth itself. Children, therefore, need support from their family and the community regarding their HIV status and that of their parents.

# Steps in PPTCT Programme and your role


1 Visit a pregnant woman and motivate her to go to the nearby ICTC for a check-up and motivate her to take the HIV test which is free.

2 If found HIV positive, provide her with accurate information about location of ART Centre and inform her about the importance of being started on life-long ART as soon as possible. Give her continuous support. If positive, husband should also be motivated to be tested for HIV and if positive refer him to ART Centre. Please test her remaining children born before this pregnancy, also for HIV.

3 During the pregnancy ensure that regular ante-natal check-ups are given.


4 Poor maternal nutritional status also affects the child's immunity and increases the risk of HIV infection. Both parents must be explained about foods, fruits and vegetables that make up a nutritious meal for the mother and the unborn child.

5 The mother-to-be should be advised to have the delivery in the hospital and "Birth-Planning" has to be done by the ANM/MO. The husband should be motivated to accompany the wife for institutional delivery. ANM/ASHA to take her to the CHC/district hospital. After delivery counsel her & ensure a PPIUCD is inserted before discharge from hospital to prevent a unwanted pregnancy in the future.

6 Children are given Sy. Nevirapine for first six weeks. If mother has not received ART for at least 24 weeks (6 months) during pregnancy then give Sy. NVP to the baby for 12 weeks instead of for just 6 weeks which is given for most babies whose mothers are started early on ART.

7 Demonstrate safe feeding practices to the mother and other women in the house, who assist the mother with child care. Exclusive breastfeeding by the mother for first six months is recommended as the best and preferred option. Top feeding is an option only if she cannot breast feed for some extreme reason, if she can afford it and it is sustainable and acceptable. Breastfeeding should not be mixed with top feeds during the first six months.

## Care & Support Centres (CSCs)

Find out about Care & Support Centres (CSCs) in your district which serve as an important link with the ART Centre. CSCs are run by NGOs and linked to the nearest ART centres. You can get the list of these CSCs at the ICTC in your block.

### What do CSCs do?


These centres provide the following information and extend support and help to PLHIV:

- Motivation and counselling for ART initiation & continuation life-long
- ART drug adherence
- Information related to nutritious food
- Treatment for Opportunistic Infections (OIs)
- Information about contact persons for accessing government support services and their social entitlements either directly or connect them to the District Level Networks (DLNs) of positive people living in the community

**These centres can provide the right information and linkages to PLHIV to other service providers. Motivate PLHIV in your community to seek the help of CSCs/DLNs when they visit the ICTC or ART Centre.**

## What did we learn in this section?

**About testing**

- What is pre- and post-test counselling?
- Institutional safe delivery for maximum benefits, and to become a part of women's health care programmes.
- How can you help once the result comes out?
- What is the CD4 count test?
- What is Parent-to-Child Transmission (PPTCT) and how can it be prevented?
- What is your role in the PPTCT programme?
- What is the difference in treatment for infants, children and adults?
- What is the role of Care and Support Centres?

**More about ART therapy**

- ART is not required for all HIV positive persons
- ART, if discontinued, may lead to body resistance to the HIV virus. If re-started it may not show any improvement and different medicines may have to be taken
- ART treatment is free in all ART Centres
- Start treatment only after medical advice

Section III

# Gender Dimensions of HIV and AIDS

# Gender Dimensions of HIV and AIDS

## Why is HIV and AIDS a gender issue?

HIV and AIDS affect men and women differently in terms of biological, social, cultural and economic factors. Roles and responsibilities of women and men are changing today. An increasing number of women are learning new skills and taking up new tasks at home, at the farm and outside within the community. Not only that, women are getting educated and being elected to panchayats, are forming self-help and micro credit groups.

In spite of these changes, inequalities between men and women continue to exist. Most women still have no say or role in major household and community decisions. The prevailing conditions in our communities make it more difficult for women to avoid risks and deal with them. Some of the social, cultural and economic factors which make women vulnerable and at risk of HIV infection are:

### Early age at marriage

- Early marriage and adolescent pregnancies force the girls to play the roles of adults without enjoying their childhood. From an early age, they have to take care of younger children and household chores.
- Child marriage and early marriage mean that the girls are biologically, socially and mentally not prepared for sexual relationships.
- Older men, who seek younger girls as sexual partners, put them at greater risk of infection. Older men are likely to have more casual and unsafe sex with young women.

### Violence

- Incidence of violence, rape and abuse of women and girls subject them to abusive relationships and makes them vulnerable to sexually transmitted infections, including HIV.
- Women are not able to negotiate condom use with men which makes them more vulnerable to HIV. If they insist on condom use, they often face violent behaviour from their partner/s.

- Having sex with multiple partners, without negotiating condom use, exposes women to violence, economic deprivation and risk of sexually transmitted infections.
- If such a situation arises she can be given post-exposure prophylaxis (PEP) drugs to prevent HIV as soon as possible. (Available in ICTCs, ART centres & in casualty, labour-rooms; OTs)

### Health risks

- Women are at risk if they are in relationships with partners who use drugs through needle exchange or are alcoholics.
- A person, who has an untreated STI, is on an average, 6–10 times more likely to pass on or acquire HIV during sex.

## Migration, trafficking and women

In our society many families have someone travelling outside the home for work. This is called migration. However, when young girls, women and children are sent outside and money is exchanged for this transaction, it is called trafficking.

Majority of those trafficked into sex work are adolescent girls in the age group of 12-18 years. These young girls and children are forced to live in exploitative and dangerous situations, where they are vulnerable to physical and sexual abuse.

All these young people, and girls in particular, are extremely vulnerable to HIV infections due to their powerlessness (including lack of decision-making power). Poverty, illiteracy and discrimination make the girls and women more vulnerable to HIV.

## Why are women more vulnerable even if they are married?

As stated earlier:

- Often women are not in a position to insist on condom use by their husbands/clients.
- During sexual intercourse female genitalia are more vulnerable to injuries, especially when sex is forced or when she is young.

- Most women do not get treatment because they are financially dependent on the husband. This also restricts women from accessing information and preventive services and care if tested positive for STIs or HIV.
- Women with HIV and AIDS are blamed and rejected by the family. The family and the community often deny them treatment, care and basic human rights.
- Women still bear the major responsibility of caring for the sick at home, including men living with HIV and AIDS, even while they themselves may be infected!!

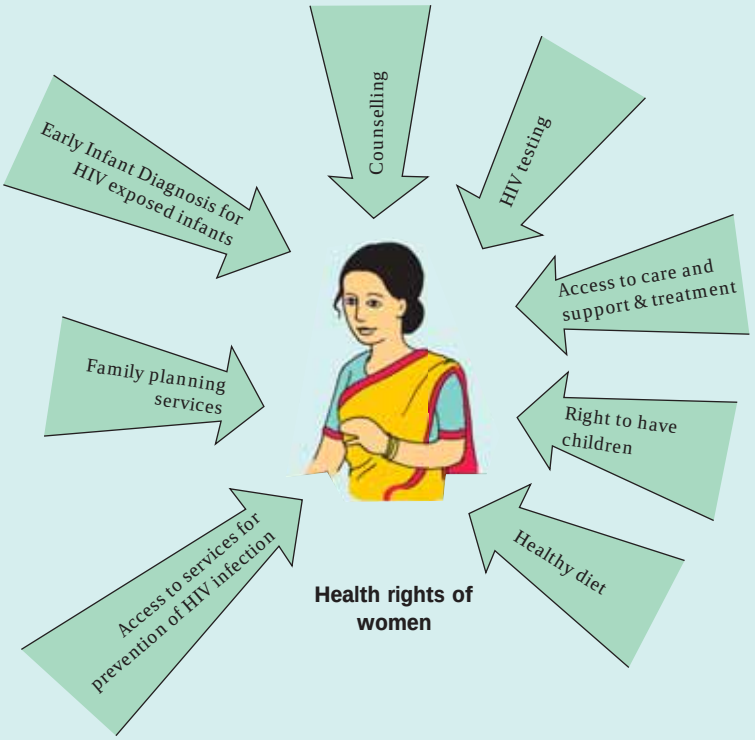
For women to be able to carry out their different roles in community development, we have to safeguard the rights of women and girls. Working with communities, we can bring about change.

## Rights of women who are HIV positive

### What about the rights of women who are HIV positive?

1. **Right to Equal Opportunity**
Government of India encourages equal wages for both men and women. However, in some cases women may not get an equal wage for their labour at the work place. The government provides livelihood through various schemes. You can create economic opportunities for these women and their families by working with the village panchayat and officials, working at the block level, to provide them opportunities for financial relief through different schemes – Social Protection Schemes.

2. **The Right to Health** Women can be protected from HIV and AIDS by providing them adequate information and access to health services. This will enable them to ensure condom-use, plan their families, avoid unwanted pregnancies and prevent and seek STI treatment. You should be aware of the various services available, and make appropriate referrals. It is important to ensure that there is no stigma or discrimination towards those seeking health care.



3. **Right to Residence, Property and Inheritance** Women have equal right of claim in marital residence and can stake a claim in property inheritance. Self-help group members, NGOs, PLHIV networks can work with panchayat members and help women and children infected and affected by HIV to get their share in family assets and resources.

4. Free legal services are being provided at ART Centres

## Can women living with HIV and AIDS have children?

Yes, women with HIV can have children. As mentioned earlier in this booklet, if precautions are taken as advised, they can protect their children from HIV.

### Janani Suraksha Yojna (JSY)

JSY is a scheme of the government under the National Health Mission (NHM) for providing pregnant women assistance in accessing ante-natal care during pregnancy and provision for institutional deliveries. ANMs and ASHAs should help women in their sub-centre area and in their village by giving information and assisting them in availing these services (contact the nearest PHC in your area for more information on the same).

## Partner counselling

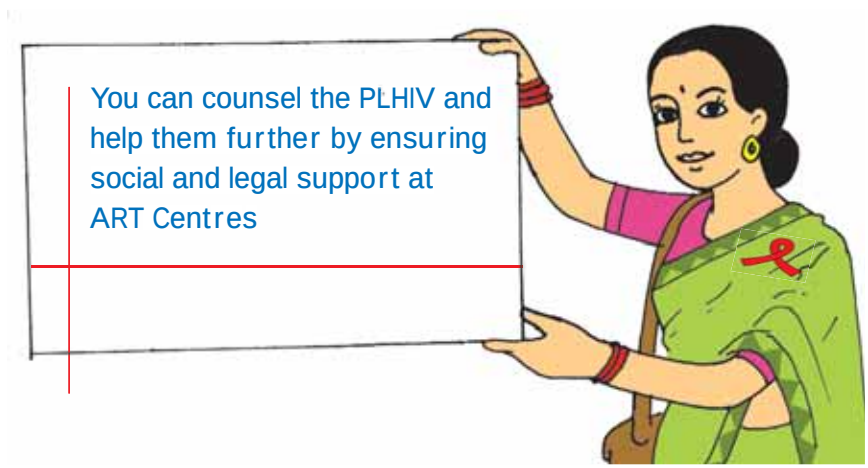

The wife or partner of a person with HIV and AIDS, deserves to know the truth. But sometimes you might find an infected person who has refused to tell his wife or partner about his/her status. In such a case, it is our duty to make strong efforts to encourage, persuade and support them to speak up about their HIV status.

You can guide men and women in making sensible decisions and adhering to a balanced life-style which would allow them to lead a better quality of life with their family.

## What if our best efforts fail and a person living with HIV still refuses to tell his wife or partner?

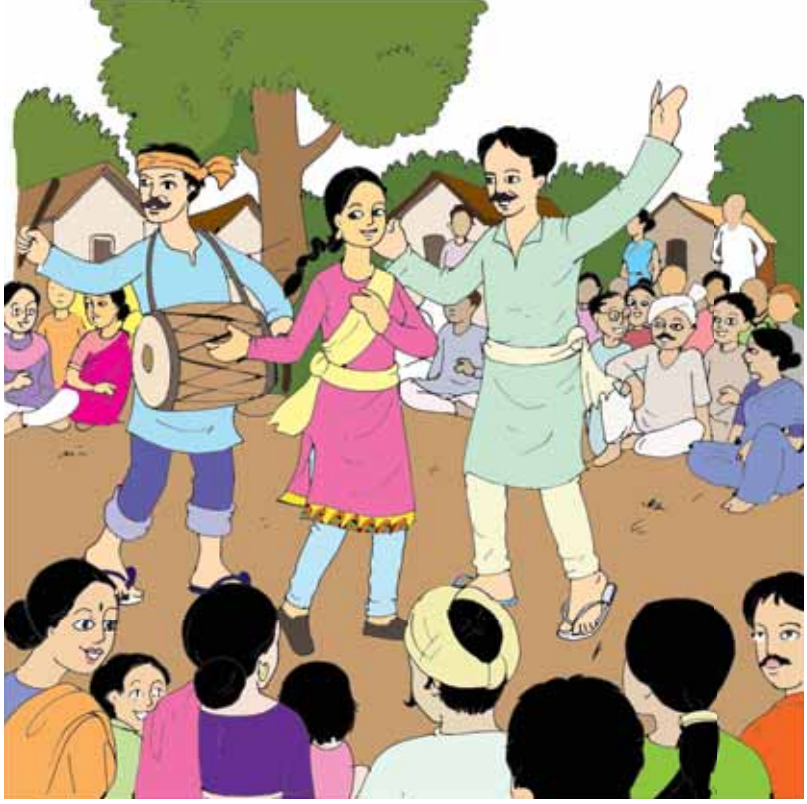
In such a case the following steps are advised:

1. Bring up the issue with the infected person in a confidential manner. Motivate him/her to disclose the status to the spouse/partner. You may not succeed in the first attempt.
2. Continue repeated efforts to persuade the person living with HIV.
3. Tell him/her that the partner has to know the truth since it can help them both lead a better qualitative life.
4. Ensure that he/she tells the partner the truth.
5. Ensure social and legal support for the person living with HIV to protect him/her from any physical abuse, discrimination and stigma by taking help from District Network of HIV positive people; District HIV/AIDS Nodal officer and staff at ART Centres.



## Stories and role plays

To sensitise women on various gender dimensions of HIV, you can use short stories as presented below.



### Pushpa's Story

Pushpa is 30 years old. She and her husband Maganlal are migrant construction labourers. They have four children – two daughters and two sons. Unfortunately, two months after they moved into the city for work, Maganlal died in an accident on the construction site. Pushpa, now pregnant, is faced with the double burden of caring for her children, sending money back home for her aging in-laws, and working.

The mother and four children live in the open on the construction site. She needs to feed the newborn baby, which the contractor feels is a waste of time. Taking advantage of her situation, he abuses her and pays her low daily wages. One night, the contractor rapes her and threatens to harm her children and to fire her if she talks to anyone about this. This occurs again and again. One day, he brings more men with him. She is forced into sex work because of the conditions of deprivation and exploitation leaving her with few choices. Her health weakens day by day because of the laborious work, domestic responsibilities and the sex work at night. Her sleep hours are reduced.

One day, she runs into Kamala, a childhood friend of hers from her native village. Kamala is married to Ram Prakash, a factory worker. Kamala works in a non-governmental organisation (NGO) as a peon and has two children. Pushpa confides in her and Kamala takes her to the NGO. At the NGO, a new world opens up for Pushpa. She joins a self-help group for women where she becomes aware of the importance of education, health and savings. Initially, she is unable to take out time to attend the group's activities. She learns to access the local government hospital and undergoes

a medical check-up for her failing health. Here, she tests HIV positive. The group is very supportive and she finds that there are others in the group who are HIV positive. She learns how to access treatment and to look after herself. She also moves out of forced sex work and starts a small tea-stall with the help of a loan from the NGO. After school, her children also help her. She is now a confident, independent woman living with HIV, bringing up four children and helping other women living with HIV, face their lives bravely.

## Some of the issues addressed in this story that can be discussed:

- Why are women subjected to violence?
- Sexual harassment at the workplace.
- Importance of access to health care for women.
- Importance of community support.
- Importance of timely interventions with support of NGOs and government.

Ask the opinions of all the members of the group and motivate them to take an active part in any of the issues discussed above. This way you add more strength and hands to your work with the community.

The following two stories have been put in a role play format. You can motivate the members of a women's group to deliberate on the factors which make them vulnerable and how the community can be organised in changing such regressive norms.

## Nazneen's Nikah

### *Scene 1: Get-together of young girls at Nazneen's nikah*

**Rani:** 'You are looking lovely, Nazneen, in this bridal wear.'

**Kamla:** 'I remember my wedding day. I was feeling so nervous.'

**Nazneen:** 'I am also very nervous. Abdul has been working in the city for a long time and I don't know what his expectations are from me.'

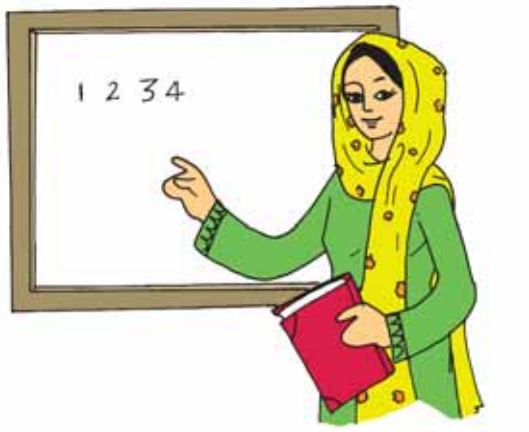
**Grandma:** 'You young girls know much more than we did in our times. I remember, I was so scared on my first night when my husband walked inside the room.'

**Feroza:** 'No, grandma, don't worry. Thanks to the life-skills education programmes and HIV prevention classes that we attended, we are quite well aware and informed.'

**Kamla:** 'You girls are more confident than we could ever dream of being. I could never say "No" to my husband whenever he demanded sex even when I did not want it. I used to feel so shy and always thought that he would take decisions related to our sexual activities.'

**Salima:** 'Like Nazneen's husband-to-be, my husband too works in the city. He is a truck driver. He comes home only once in four months. I cannot refuse him since he is here only for a few days. I have to fulfil my duties as a wife too.'

**Rani:** 'But Salima, you already have five children and you are pregnant. Don't you think you should not have more children?'




**Salima:** 'What can I do? My mother-in-law does not want to even hear of me undergoing tubectomy.'

**Feroza:** 'But Salima, at least you can tell your husband to wear a condom.'

**Salima:** 'He's always drinking at night. Most nights, he hits me.'

**Kamla:** 'My husband too used to do the same. When my mother came to know that Ramu's father used to beat me up every night, she was furious. She then lamented the fact that she had not educated me and that I was dependent on Ramu's father. That was when I decided to join the adult education classes.'

**Rani:** 'Isn't that great? Today, you are actually teaching in that non-formal school in the village.'

**Feroza:** 'Yes, even the Anganwadi worker depends on you for everything. Well, Nazneen, don't fear. Be brave and ask your husband to wear a condom in case you have any doubts that he has HIV!' *(Everyone laughs).*

Aunty enters: Come out everyone, the ceremony has begun.

## *Scene 2: Nazneen and her husband Abdul*

**Abdul:** 'Nazneen, why are you feeling so shy? Don't be scared, I'm your husband not your teacher!'

**Nazneen:** (Shakes her head)

**Abdul:** 'Look, I'm a sensible and educated man and I consider you my friend and equal. I want us to take all our decisions together.'

**Nazneen:** 'Really! In that case, I think that you must wear a condom. I know all about HIV and AIDS from those classes that I attended.'

**Abdul:** 'HIV! Yes. A friend of mine too told me about it. Yes, Nazneen, I care about you a lot and don't want to cause you any sorrow. Let me go and get the condom my friend gave me when I was leaving for the village! It's in my bag.'

**Nazneen:** 'Yes, and tomorrow, we shall go and get tested for HIV.'

## What we learn from Pushpa's and Nazneen's stories:

1. The social and cultural factors that put both women and men at risk of HIV infection.

2. The importance of sensitising and informing men about their roles as husbands, fathers and members of a responsible community.
3. Interventions at the family and community levels that can help women and girls to access information, skills and services.

## Sita's story

### *Scene 1: Sita's home*

**Ramkali:** 'Namaste, Sita, I heard that you will not be coming to work after this week? You have also not been coming to work regularly.'

**Sita:** 'Namaste, Ramkali, yes, you have heard right. My husband is seriously ill. He has been diagnosed with HIV. My aged in-laws cannot take care of him. I really have no other option.'

**Manju:** 'This is really sad. There is no other breadwinner in your family. How will you take care of the expenses? If the others in your village come to know, you will be condemned by them!'

**Salma:** 'Yes, remember what happened to Urmila and her family? Nobody would talk to them and ultimately, they had to leave the village and live in the city.'

**Ramkali:** 'Why don't you ask your parents and brothers for help? Your father has a lot of land. If only you could own some land and irrigate it and cultivate food!'

**Sita:** 'No, Ramkali, that's impossible although I wish that could happen. Oh! to have my own piece of land!'

**Salma:** 'I have an idea! Why don't you approach the Sarpanch? She's a woman, she will understand your situation.'

**Manju:** 'Yes, she really supported Urmila all the way and in fact, it was she who got her a job in the city.'

**Salma:** 'Yes, come, let's go and approach her. Given that your husband and you consent to it?'

**Manju:** 'I have talked to my husband. Yes, we feel this is the best option for us now.'

## *Scene 2: A panchayat baithak to discuss Sita's case*

**Sarpanch:** 'We are here to discuss how we can all help Sita. I have invited the employer of her factory, Chhagan Lalji, and the Anganwadi behenji also for their advice and cooperation.'**Chhagan Lal:** 'I assure you, Sita and Sarpanchji, that we will do our best to support you in your time of difficulty. No long working hours from today for you. After all, you have the double burden of looking after your family.'

**Manju:** 'We women should also join a self-help group in which we can make some savings.'

**Sarpanch:** 'Yes, there are already such SHGs in this village. The bank gives loans to these groups. Sita must join these groups. We will see to it that Sita's husband gets good treatment and that he is not ostracised like Urmila and her family.'

**Anganwadi behenji:** 'Sita, you must also be careful. You are pregnant. You must take precautions. You must get yourself tested for HIV. ANMs are now screening all pregnant women for HIV and Syphilis. Also, you need to know about safe sex.

Not just you, but all men and women should know about these important issues.'

**Sarpanch:** 'Last but not the least, Sita, you and all other women should learn about the importance of educating the girls and boys in our families and community. They should attend the Adolescent Friendly Health Clinics (AFHCs) located in all Government hospitals right from PHCs to the District Hospitals. They need to become independent and aware.' (All the others nod in agreement.)

## What we learn from Sita's story:

1. Working with others in the village to help people living with HIV to overcome stigma and discrimination.

2. Land rights and equal share in property.
3. Mobilising the community and leaders for proactive action in empowering girls.

Dear friends please sit down and discuss the story and add to this list for discussion and taking action in our village.

## What did we learn in this section?

- Why HIV is an issue for women's empowerment.
- Why girls and women are more vulnerable to HIV and how to address this.
- Impact of migration and trafficking on women.
- Why and how even married women are vulnerable.
- Rights of women who are HIV positive
- Interaction with women in villages through role plays and stories.

Section IV

# Fighting Stigma and Discrimination

# Fighting Stigma and Discrimination

## People living with HIV can live a normal life

They and their families need respect, dignity and inclusion in social activities and access to all health care services. Stigma and discrimination attached to HIV add to their suffering. They, as well as their families, need special care and support, including healthy nutrition and a positive outlook towards life.

People living with HIV can lead a healthy and normal life by taking care of themselves. They can do this with regular medication and eating nutritious food. They can also act responsible by using a condom every time they have sex.

They can also help others by spreading awareness about HIV and AIDS prevention and support those who are newly detected positive in accessing social protection schemes and taking treatment regularly.

## Addressing stigma and discrimination issues in your village

In this section we will try to understand how people living with HIV are stigmatised and discriminated against. Also we will learn about the negative impact of HIV related stigma and discrimination. We will also present some practical strategy which will help in gradually reducing the HIV related stigma and discrimination.

Some reasons for HIV related stigma and discrimination:

- Lack of complete information on HIV and myths around HIV which create fear and doubts among people.
- HIV is closely associated with sex which is often viewed as shameful and dirty in our society. This sex-

HIV-shame association leads to HIV positive people being labelled bad. This behaviour should be strongly condemned.

- HIV is more prevalent among sex workers, men who have sex with men (MSM) and injecting drug users (IDUs). These groups are already viewed with hatred and are discriminated against. Therefore, this hatred and stigma gets attached to HIV too.

Stigma and discrimination associated with HIV are damaging in many ways:

- People who are discriminated against, feel humiliated and alienated which has detrimental impact on their health. If the people to be discriminated against are female sex workers, MSMs or IDUs, they face double discrimination and are even more alienated.
- People living with HIV do not access health services because of the stigma and this worsens their health condition.
- Due to the stigma associated with HIV, people do not come forward for testing and often stay in denial about their risk and vulnerability. In this scenario, if they are infected with HIV, they are also likely to infect their partner/spouse.

Therefore, HIV related stigma and discrimination are damaging for people living with HIV. Therefore, it is very important to address HIV related stigma and discrimination through increased awareness on HIV and adopting practical strategies for not only health care providers but also for all people in the community.

## Ways to create awareness

- Dialogue and open discussion in simple, easy to understand language with people. This will allow them to raise their doubts and provide you with an opportunity to clarify myths and misconceptions.
- It is important to remember that this cannot be a one time effort and this process of dialogue and sharing information must be sustained over a long time rather a continuous process. Only then will this wipe out stigma and discrimination.

- Disseminate written information/material to literate people in the village; use VHNDs as opportunities to disseminate information and discourage and condemn ostracisation (social boycott of PLHIV) from participation in important events in the village (town) city and ensure services provision to them in all areas.
- As many people in the villages cannot read, please use local games, folk media and other interactive mediums to disseminate information on HIV.
- Involve village leaders, elders, influencers like panchayat members in the HIV work which will ensure more acceptance of the programme.
- Ensure information is provided to young people in the village.
- If it is possible, invite a person living with HIV, to meet the villagers which will help in reducing their fear and doubts.
- Be an example for your village by having an open and friendly attitude and behaviour with PLHIV which will also have a positive impact on other people in the village.
- If there are female sex workers (FSWs), MSMs or IDUs living in your village, be sensitive and respectful to them.

Most importantly, look at your own behaviour and assess if you have been discriminating against people living with HIV? If yes, then you need to know that FSWs, MSMs, IDUs are also a part of society and entitled to all the rights of a citizen. Their need for information on HIV prevention is very important and hence, it is important to ensure that they have access to all information and services. Even if you do not agree with their behaviour and practices, it is not your job to change their life-style or judge it. It is your responsibility to help them protect themselves from HIV, ensure that they have access to services and that they are not stigmatised and discriminated against.

HIV related stigma and discrimination, impact women more adversely as often the villagers and family members blame them. Experiences show that after the death of her husband from HIV, the widow is forced to leave the home and the village and may not claim her right to the property and inheritance. Children are forced to leave school or are not admitted to schools. All these are examples of discrimination.

If you come across any such incidence of discrimination, immediately bring it to the notice of district HIV/AIDS programme officers/ICTC counsellors, officials and panchayat/VHSC members and take their support. You can even take help from the district level political leaders.

## What is your role?

As an ANM, ASHA, AWW or SHG member or a peer from the District Level Network of HIV positive people, you can do a lot. Here is a list of some of the important actions you can take.

- Strengthen the social support systems available in the community which can help people living with HIV in situations of emergency and crisis.


- Dispel myths and misconceptions about HIV and AIDS because these instill fear and suspicion.

- Work with the panchayat, Village Health & Sanitation Committees (VHSCs) and other leaders to reduce and prevent discrimination towards children whose parents are infected. It will be more helpful if you work with other social networks in the village. Ensure these children are not neglected and denied education but are allowed to lead a normal life.

- Work with other community workers in the village to remove stigma and discrimination against people living with HIV.

- Work with block level officials and village panchayats in getting people living with HIV access facilities made available by the government.


- Help people living with HIV get together in a drop-in-centre. These centres provide an opportunity for people living with HIV to network and access health and other facilities.

## A true story of stigma and discrimination

The following is a true story of a 23-year-old HIV positive woman who became infected through her husband but had to face discrimination from her husband's family as well as from her own parents.

"My mother-in-law has kept everything separate for me — my glass, my plate. They never discriminated like this with their son, and used to eat together with him. For me, it's 'don't do this' or 'don't touch that' and even if I use a bucket to bathe, they yell 'wash it, wash it'. They really harass me. I wish nobody lands up in a situation like mine and I wish nobody does this to anybody. But what can I do? My parents and brother also do not want me back."

More examples of the conditions women face and how to best help them overcome their problems and deal with them are given in with them the "Snakes and Ladders" game and in the above stories.

## Drop-in-centres (DIC)

These centres have been set up by Networks of people living with HIV established in most Districts in the Country, the District Level Networks (DLNs) where people living with HIV or people affected by HIV can drop in to hold meetings, discussions, activities, etc. They can share their experiences, contributions, problems or other issues (pertaining to health, stigma, available resources and services) and together work out ways for solving them. These centres also plan community advocacy and capacity building on issues of HIV and AIDS. These drop-in-centres are/were run with support from grants by the government. For more details, establish contact with the people living with HIV Network in your area. With their support you can also help any family who may be infected or affected by HIV and AIDS in your village.

As an ANM, ASHA, AWW worker or SHG member, or peer living with HIV each of us has a role to play in fighting HIV and AIDS and making our village safe and healthy.

## Let us pledge together

**Let us take a pledge to COMBAT HIV and AIDS together**

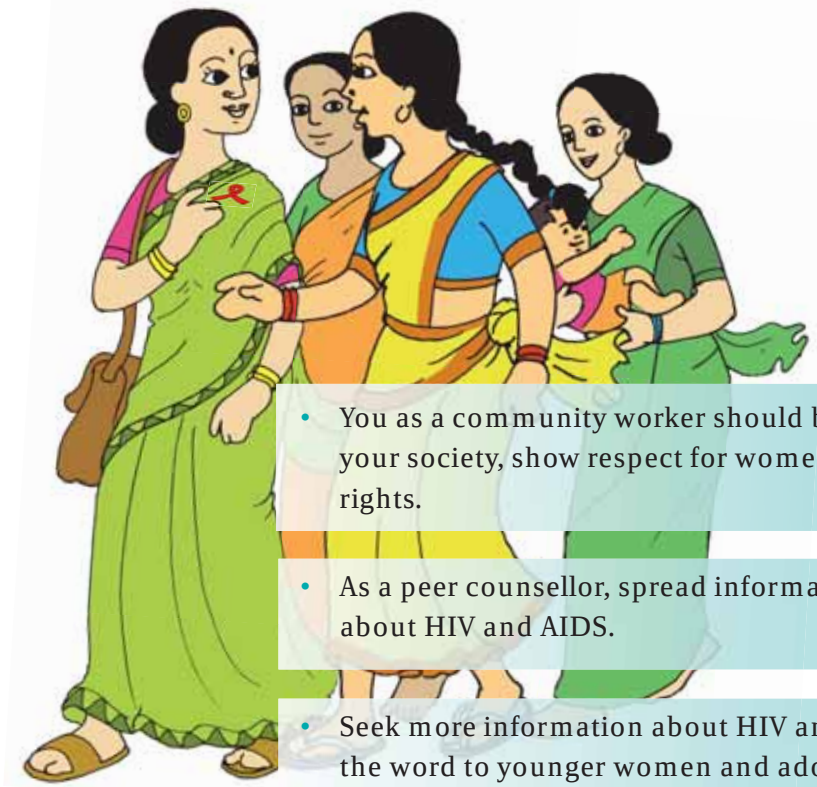
- Say "NO" to any form of violence within the family and in the community.

- Ensure RESPECT towards women.

- ENCOURAGE parents to send their daughters to school and train them in skills which can help them in becoming self-reliant.

- PROTECT the rights of women who are affected or infected with HIV.

If you are a self-help group member, YOU can help to avoid the spread of the epidemic.



- You as a community worker should be a role model for your society, show respect for women and protect their rights.
- As a peer counsellor, spread information and knowledge about HIV and AIDS.
- Seek more information about HIV and AIDS and spread the word to younger women and adolescents and others in your community by asking them to get more information by visiting Adolescent Friendly Health Clinics (AFHCs) located in all PHCs and other public health care institutions.

## What did we learn in this section?

- How to address stigma and discrimination in your village.
- What to do when your best efforts fail and a person living with HIV still refuses to tell his/her spouse or partner.
- How to work with others in the village to protect the rights of women and children infected or affected by HIV and AIDS.
- Pledge together to fight this epidemic and move towards a brighter future.

Section V

# Good Nutrition is Important for Well-Being of all Pregnant Women Especially when HIV Positive

# Good Nutrition is Important for Well-Being of all Pregnant Women Especially when HIV Positive

## Good Nutrition is Important for HIV Positive people

- A nutritious diet is essential not only for growth but also to perform work and protect the body from infections and diseases.
- There is a vicious cycle between HIV and nutrition. When HIV enters a person's body, it weakens the body's defence system against infections. Other infective agents can then get an upper hand in the weakened defence system more easily. To cope with HIV and other infections, the person needs increased amount of nutrients to boost his immune system. Malnutrition occurs if these increased needs are not met.
- Malnutrition contributes to a weakened immune system, which worsens the effects of HIV. This leads to a rapid progression to AIDS.

## A Nutritious Diet

A nutritious diet includes foods from different food groups eg: carbohydrates; proteins; fats & vitamins/minerals in adequate quantities and combinations. It should include the following types of foods as per the availability and choices of people:

- Energy giving foods (carbohydrates and fats) such as whole cereals, starchy vegetables and fruits, sugar and jaggery. Fats and oils need to be consumed in moderation.
- Body building foods (proteins) such as milk and milk products, pulses, meat, fish and eggs.
- Protective foods are rich in minerals and vitamins. They protect the body from infections and strengthen the immune system. Eat fresh green leafy vegetables and locally available seasonal fruits like guava, banana, mango, papaya etc.

Water is essential for body function. Drink plenty of fluids (at least eight glasses a day). Always boil drinking water for 20 minutes and filter it with a clean cloth.

## Nutritional Care of People Living with HIV

### Exercise Regularly

Some benefits of physical activity:

- Improves blood circulation.
- Stimulates appetite.
- Improves mood and mental health.
- Prevents stiffness of joints.
- Maintains muscle tissues and burns fat.
- Increases resistance to disease.

## Diet for Asymptomatic Persons Living with HIV

Even when there are no symptoms, HIV positive persons need to increase their energy intake by 10% or 200 kcals to prevent loss of muscle and wasting. Their diet should be rich in protein, minerals, vitamins and antioxidants.

To achieve this:

- Eat one extra meal a day.
- Increase the amount of whole cereals and millets like wheat, rice, bajra and jowar consumed daily.
- Include at least some milk, pulses and eggs in daily diet.
- Consume good quantity of vegetables and fruits.
- Drink at least eight glasses of water and other fluids like green coconut water (tender coconut), sugarcane and water melon juice etc. Restrict the consumption of tea, coffee or carbonated sweetened drinks etc.

## Diet for Pregnant Women with HIV

- Pregnancy is a vulnerable time because your nutrient needs are increased.
- HIV infection poses an additional burden on the body. Your food intake needs to be increased accordingly. Therefore, you need to consume at least one additional meal and some small snacks in a day.
- You must eat plenty of green leafy vegetables, purple, orange and red coloured vegetables and fruits since they are rich in antioxidant vitamins like beta carotene and minerals like iron.
- Those with Opportunistic Infections (OIs) should further increase their energy intake. After a severe illness or infection, calorie consumption should be greatly increased to promote quicker recovery.

- Do not forget to take the iron folate tablets daily. These supplements are distributed at the Anganwadi Centres and Health Centres. You may also need to take multivitamin supplements of vitamin B, C and E (not vitamin A), if the doctor advises.

## Nutritional Care of Children with HIV

### Infant Feeding Practices

- For HIV positive mothers, only recommended feeding option for the first six months which is exclusive breastfeeding should be given.
- Breast milk supplies all the nutrients and water that the baby needs for the first six months of life. It also protects the baby from infections and allergies. (Exclusive breast feeds - EBF first six months is essential for building immunity in the baby to fight against infections).
- Replacement feeding should only be considered (only if the mother cannot breast feed due to terminal illness) if it is Acceptable, Feasible, Affordable, Sustainable and Safe (AFASS).
- **"Mixed feeding"** should not be adopted as it increases the chances of passing the virus to the baby. (Mixed feeding is when the baby is fed with both breast feeds and alternate feeds during the first six months as this causes bleeding spots in the intestines which become entry points for the virus from breast milk to enter the baby's body.)

### Exclusive Breastfeeding (EBF)

Mother choosing exclusive breastfeeding must ensure:

- Position the baby correctly while feeding. This will help prevent problems like breast swelling, soreness, redness and mastitis.
- Hold the baby close, facing the breast with his/her neck and body straight and supported. The baby is well attached if more areola is visible above the baby's mouth, his/her mouth is wide open, and his/her chin is touching the breast.
- Feed the baby on demand (whenever he/she is hungry).
- Remember to exclusively breastfeed for the first six months. Do not give any other liquids like ghutti, water or other milk. Only, paediatrician prescribed medicines may be given.
- Continue breastfeeding and start complementary feeding at six months & onwards. (Weaning foods to be introduced)
- If the baby is HIV negative when tested at 6 weeks or 6 months please breast feed upto 12 months of age.
- If the baby is tested positive at 6 weeks or 6 months, the child should be referred to Paed. ART Centre for starting Paed. ART. Baby should be given breast feeds for 2 years after ensuring baby is put on Paed. ART.
- Seek health care in case of any problems.

## Exclusive Replacement Feeding (ERF)

If the mother chooses not to breastfeed, she must select a suitable option for replacement feeding:

- Formula feeds are not recommended in India
- Home modified animal milk: Animal milk like cow, buffalo or full cream milk may need to be modified for infants less then six months by removing the fat. Sugar can be added after boiling. As the child grows older, he/she will be able to digest the milk as it is. Avoid bottle-feeding since it can cause infections. Feed with the help of spoons cups or katoris.

Wash hands with soap and water before preparing a replacement feed. All utensils, cups and containers required should also be washed with soap and clean water and sterilised (boiled in water for 20 minutes). The water used should be clean and safe to drink.

## Complementary Feeding

- Continue breastfeeding even after six months. After six months in addition to breast feeds give complementary feeds.
- Introduce semi-solid foods (weaning) in addition to breast milk from six months onwards. Cows milk/dairy milk can also be given.
- Gradually introduce semisolid foods like cereal porridge, khichri, suji kheer, mashed banana with milk, rice with curd and so on.
- The consistency of the food can be thickened as the child grows older. The food may then be soft cooked or cut into small pieces and mashed well after boiling.
- Between 12 to 24 months, the child can eat the same foods as adults except that it should not be spicy or strongly flavoured.

- Take care that the utensils used for preparation of these foods are clean & sterilised and the water is safe to drink.

# Nutritional Guidelines in Specific Situations

## Loss of Appetite

Some suggestions to improve appetite and food intake:

- Do not be rigid about meal times. Eat whenever you feel like it.
- Eat small frequent meals and snacks between meals such as peanuts, biscuits or any kind of fruit. Enrich meals by making meals energy and nutrient dense.

- Include favourite, well-liked foods. Add flavour to foods like a small spoonful of ghee.
- Take care to drink adequate fluids but not immediately before and during meals.
- Eat a variety of foods. Select combinations of different cereals, vegetables and fruits.
- Use different cooking methods.
- Appetisers like rasam, clear tomato soup with no flavouring agents butter milk and jaljeera help to stimulate the appetite.
- Eat food in pleasant surroundings, with family or friends.
- Take light exercise to stimulate the appetite.

## Diarrhoea

Ensure adequate fluid intake in diarrhoea:

- Give oral rehydration solution (ORS) (Electral/Peditral). Give plenty of fluids like boiled rice water, cooked dal water, clear soups, strained fruit juices, coconut water, lemon water.
- Remember ORS should be prepared by adding 1 packet of Electral/ Peditral to 1 litre of water & fed frequently. Should not be consumed the next day, but freshly prepared & used the same day.
- Give small frequent feedings of these fluids & sugar.
- Avoid milk initially, as it aggravates the diarrhoea.
- Start soft, bland foods such as soft vegetables and fruits like banana, potatoes and carrots, and porridge from refined cereals such as semolina (Sooji), rice and khichri once condition improves.
- Reduce fat intake. Avoid fried foods & sugar.
- Avoid very spicy and strongly flavoured foods.
- Do not stop eating when having diarrhoea.
- Ensure proper hygiene while preparing these foods.

## Mouth Sores and Oral Thrush

Oral hygiene is very important to prevent mouth sores. Brush your teeth and rinse mouth every morning, night and after every meal.

If you have sores in the mouth:

- Clean mouth with cotton wool and mildly salted water at least twice a day. Rinse mouth with 1 teaspoon of baking soda mixed in a glass of warm boiled water.

- Cut down on sweet foods such as sugar, honey and sweet fruits and drinks.
- Eat soft foods like papaya, banana, khichri, rice and curd. Soften dry foods by dipping in liquids. Avoid foods that need a lot of chewing.
- Don't chew paan, supari and tobacco as they can induce oral infection.
- Avoid acidic, highly salted foods like pickles, curries, vinegar, lemon and oranges.
- Use glycerine to relieve pain.
- Avoid foods and drinks that are too hot or too cold.
- If sores persist for more than seven days, consult a doctor.

### Tuberculosis

- Opportunistic Infections (OIs) like tuberculosis (TB) and pneumonia, increase the body's metabolic rate and therefore, require more food intake.
- Increase intake of energy giving foods like rice, wheat and vegetables. Consume dals, channa, jaggery, chicken, milk or milk products like paneer in meals. Eat small quantities throughout the day to increase overall intake of energy foods.
- TB and its medications may reduce your appetite and therefore, adequate food intake is important.
- Rifampin (Anti-TB drug) (red capsule) should be taken on an empty stomach, 1-2 hours before meals. This may cause your urine to become red in colour. Do not worry
- Alcohol must be avoided.
- Antibiotics used for treatment of pneumonia should be taken with food.

## Nutritional Care When on ART

- Drink at least eight glasses of boiled water daily.
- Do not consume alcohol while on treatment to avoid harm.
- Do not take medicines on an empty stomach.
- Strictly adhere to taking the medicines on time as prescribed by the doctor/counsellor at the ART centre.

Do not miss taking medicines every day.

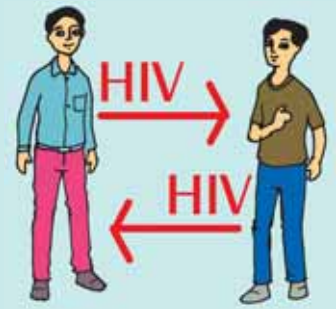
Section VI

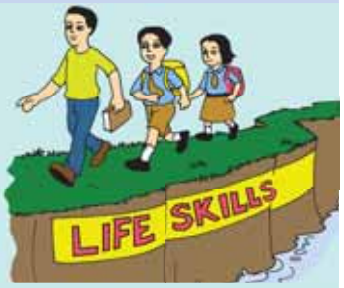
# Fighting Myths & Misconceptions about HIV and AIDS

# Fighting Myths & Misconceptions about HIV and AIDS

## Myths and Misconceptions about HIV and AIDS

| Myths and Misconceptions | Facts |
|---|---|
| HIV can spread through- shaking hands, hugging, making friends, eating, drinking, studying, working, sharing clothes or a house with an HIV positive person. | No. Caring, sharing and friendliness do not spread HIV. They spread happiness and warmth.  |
| A mosquito bite can spread HIV infection. | Mosquito bites do not spread HIV infection. HIV does not reproduce or live in the mosquito's saliva. HIV is a fragile virus that does not live outside the human body for more than a few hours.  |
| Blood donation can lead to HIV infection. | No. Blood donation cannot lead to HIV. The material used for collecting blood are sterile and used only once.<br>Young people should donate blood on a regular basis at licensed blood banks or blood donation camps.  |

| Myths and Misconceptions | Facts |
|---|---|
| It is safe for an HIV positive person to have unprotected sex with another HIV positive person. | False. HIV is of more than one type – HIV 1 and HIV 2 and has different strains. One cannot assume that both partners have exactly the same type of HIV virus. It is possible to get infected with another type/strain of HIV. Moreover, one partner with higher viral loads can transfer infection to the other with lower viral loads. Therefore, it is important for each partner to avoid unprotected sex and use condoms correctly and consistently.   |
| HIV can be cured, but not AIDS. | Neither can be cured. HIV can be suppressed with Antiretroviral Drugs (ARV) but cannot be cured.   |
| The result of HIV test should not be kept confidential so that other people can help the infected person. | The stigma and discrimination associated with HIV/AIDS makes it important to keep the HIV test reports confidential. Only the concerned person who has undergone the test has the right to inform or confide about his/her status to anyone.<br><br>However, in his/her interest and well-being the counsellor shares the details of pregnant women or her spouse/partner/children to ANMs, ASHAs, outreach workers, peer of DLNs to inform about accessing the next set of services in that - "shared - confidentiality" and should take their consent during post test counselling and assure them that it is being shared within health care providers treating her.  |

| Myths and Misconceptions | Facts |
|---|---|
| Caring for people with HIV/AIDS is risky. | False. With adequate precautions we can take care of our loved ones who have been infected with HIV.  |
| Sex education encourages early sexuality. | False. Earlier the adolescents know about life-skills, they become more responsible and they can avoid high risk behaviour to prevent contracting HIV/STIs.   |
| Sex with a virgin and minors can protect/cure a person from STI infections including HIV. | False. Sex with minors or virgins cannot protect a man from STIs including HIV. It is a crime to engage in sex with a minor. It leads to greater risk of injury to the immature sexual organs of the young boys and girls along with psychological/ emotional trauma that the person is left to deal with later in life.   |
| It is not good for women to ask for condoms. It shows that she is unfaithful and also does not trust her partner. | False. When a woman asks for condoms to be used by her spouse/partner, it shows her maturity and concern for herself and her spouse/partner. She has a right to make the decision and negotiate safe sex to protect herself. Female condoms are also available nowadays.  |

Section VII

# Annexures

# Annexure 1: New indicators for E-PTCT

## (1.6; 1.6.1; 1.6.2; 1.6.3) and ANCs tested for HIV (15.3; 15.3.3 a, b, c; 15.3.4 a, b)

### Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| **Part A.** | **REPRODUCTIVE AND CHILD HEALTH** | | | | | | |
| **M1** | **Ante Natal Care Services (ANC)** | | | | | | |
| 1.1 | Total number of pregnant women registered for ANC | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.1.1 | Out of the Total ANC registered, number registered within first trimester *(within 12 weeks)* | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| | New women registered under *Janani Suraksha Yojana (JSY)* | | | | | | |
| | Number of pregnant women received 3 or more ANC check ups | | | | | | |
| 1.1.2 | Number of pregnant women received 4 or more ANC check ups | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2 | **Number of pregnant women given** | | | | | | |
| 1.2.1 | TT1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.2 | TT2 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.3 | TT Booster | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.4 | Number of pregnant women given ANC Corticosteroids in Pre Term Labour | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| | Total number of pregnant women given 100 IFA tablets | | | | | | |
| 1.2.5 | Total number of pregnant women given 180 IFA tablets | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.6 | Number of pregnant women given Calcium tablets | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.7 | Number of pregnant women given one Albendazole tablet during the 2nd trimester | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.3 | **Pregnant women with Hypertension (BP>140/90)** | | | | | | |
| 1.3.1 | New cases detected | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.3.2 | Out of the new cases detected, cases managed at institution | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.3.3 | Number of Eclampsia cases managed during delivery | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.4 | **Pregnant women with Anaemia** | | | | | | |
| 1.4.1 | Number of Haemoglobin(Hb) tests done for Pregnant women | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.4.2 | Number having Hb level<11 (tested cases) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.4.3 | Number having Hb level<7 (tested cases) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.4.4 | Number having severe anaemia (Hb<7) treated | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.5 | **Pregnant women with Gestational Diabetes Mellitus (GDM)** | | | | | | |
| 1.5.1 | Number of pregnant women tested for Blood Sugar | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.5.2 | Number of pregnant women tested positive for Gestational Diabetes Mellitus (GDM ) | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.5.3 | No of pregnant women given insulin out of total tested positive for GDM | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.6 | **Pregnant Women with Syphilis** | | | | | | |
| 1.6.1 | **Point of Care tests conducted for Syphilis** | | | | | | |
| a | Number of pregnant women tested using POC test for Syphilis | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Out of the pregnant women tested-Number found positive | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.6.2 | **VDRL/RPR tests conducted** | | | | | | |
| a. | Out of pregnant women tested positive for Syphilis using POC tests, numbers tested using RPR | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Number of pregnant women tested using RPR as first test | ✓ | ✓ | ✓ | ✓ | X | X |
| c | Number of Pregnant women tested positive using RPR as first test | ✓ | ✓ | ✓ | ✓ | X | X |
| d | Out of the above (1.6.2 c) Number of Pregnant women treated for Syphilis using at least one Injection Benzathine Penicillin (2.4 million. units) | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.6.3 | Number of infants born to Syphilis seropositive mothers who received treatment with atleast 1 dose of Inj Benzathine Penicillin | ✓ | ✓ | ✓ | ✓ | X | X |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| **M2** | **Deliveries** | | | | | | |
| 2.1 | **Deliveries conducted at Home** | | | | | | |
| 2.1.1 | **Number of Home Deliveries** attended by | | | | | | |
| a | SBA (Doctor/Nurse/ANM) | X | X | X | ✓ | ✓ | X |
| b | Non SBA (TBA/Relatives/etc.) | X | X | X | ✓ | ✓ | X |
| 2.1.2 | Number of pregnant women given Tablet Misoprostol during home delivery | X | X | X | X | ✓ | X |
| 2.1.3 | **Number of newborns visited within 24 hours of Home Delivery** | | | | | | |
| 2.1.4 | No.of newborns receiving 7 HBNC visits in case of Home delivery | ✓ | X | X | X | X | X |
| 2.1.4 | **Number of mothers paid *full* JSY incentive for Home deliveries** | | | | | | |
| 2.2 | Number of Institutional Deliveries conducted (Including C-Sections) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 2.2.1 | **Out of total institutional deliveries :** | | | | | | |
| a | Number discharged within 48 hours of delivery | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 2.1.4 | No.of newborns receiving 6 HBNC visits | X | ✓ | ✓ | ✓ | ✓ | X |
| | **Number of Mothers paid full JSY Incentive** | | | | | | |
| | **Number of ASHAs paid full JSY Incentive** | | | | | | |
| | **ANM or AWW (only for HPS States)** | | | | | | |
| **M3** | **Number of Caesarean (C-Section) deliveries** | | | | | | |
| 3.1 | C -Section deliveries performed | ✓ | ✓ | ✓ | ✓ | X | X |
| 3.1.1 | C-sections, performed at night (8 PM- 8 AM) | ✓ | ✓ | ✓ | ✓ | X | X |
| **M4** | **Pregnancy outcome & details of new-born** | | | | | | |
| 4.1 | **Pregnancy Outcome (in number)** | | | | | | |
| 4.1.1 | **Live Birth** | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 4.1.2 | No. of Pre term newborns ( < 37 weeks) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 4.1.3 | Still Birth | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 4.2 | Abortion (spontaneous) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 4.3 | **Medical Termination of Pregnancy (MTP)** | | | | | | |
| 4.3.1 | **Number of MTPs conducted** | | | | | | |
| a | Up to 12 weeks of pregnancy | ✓ | ✓ | ✓ | ✓ | X | X |
| b | More than 12 weeks of pregnancy | ✓ | ✓ | ✓ | ✓ | X | X |
| 4.3.2 | **Post Abortion Complications** | | | | | | |
| a | Identified | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Treated | ✓ | ✓ | ✓ | ✓ | X | X |
| 4.3.3 | No. of women provided with post abortion contraception | ✓ | ✓ | ✓ | ✓ | X | X |
| 4.4 | **Details of Newborn children** | | | | | | |
| 4.4.1 | Number of newborns weighed at birth | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 4.4.2 | Number of newborns having weight less than 2.5 kg | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 4.4.3 | Number of Newborns breast fed within 1 hour *of birth* | ✓ | ✓ | ✓ | ✓ | ✓ | X |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| **M5** | **Complicated Pregnancies** | | | | | | |
| 5.1 | Number of cases of pregnant women with Obstetric Complications attended (APH, PPH, Sepsis, Eclampsia and others) | ✓ | ✓ | ✓ | ✓ | X | X |
| | **Number of Complicated pregnancies treated with**<br>**IV Antibiotics**<br>**IV Antihypertensive/Magsulph injection**<br>**IV Oxytocin** | | | | | | |
| 5.2 | Number of Complicated pregnancies treated with Blood Transfusion | ✓ | ✓ | ✓ | X | X | X |
| **M6** | **Post Natal Care (PNC)** | | | | | | |
| 6.1 | Women receiving post partum checkups within 48 hours of delivery of home delivery | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 6.2 | Women receiving-post partum check up between 48 hours and 14 days | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| | **PNC maternal complications attended** | | | | | | |
| 6.3 | Number of mothers provided full course of 180 IFA tablets | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 6.4 | Number of mothers provided Calcium tablets | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| **M7** | **Reproductive Tract Infections/Sexually transmitted infections (RTI/STI) Cases** | | | | | | |
| 7.1 | **Number of new RTI/STI cases identified** | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | X | X |
| 7.2 | **Number of new RTI/STI for which treatment initiated** | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | X | X |
| | **Number of wet mount tests conducted** | | | | | | |
| **M8** | **Family Planning** | | | | | | |
| **8.1** | **MALE STERLISATION** | | | | | | |
| 8.1.1 | Number of Non Scalpel Vasectomy (NSV) / Conventional Vasectomy conducted | ✓ | ✓ | ✓ | ✓ | X | X |
| **8.2** | **FEMALE STERLISATION** | | | | | | |
| 8.2.1 | Number of Laparoscopic sterilizations conducted | ✓ | ✓ | ✓ | ✓ | X | X |
| 8.2.2 | Number of Mini-lap (other than post-partum) sterilizations conducted | ✓ | ✓ | ✓ | ✓ | X | X |
| 8.2.3 | Out of Total mini lap sterilizations, number conducted within 7 days of delivery (Post Partum sterilizations) | ✓ | ✓ | ✓ | ✓ | X | X |
| **8.3** | **IUCD ( Intra Uterine Contraceptive Device)** | | | | | | |
| 8.3.1 | Number of IUCD Insertions | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.3.2 | Out of the total Number of IUCD Insertions , Post Partum (within 48 hours of delivery) IUCD insertions | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.3.3 | Number of IUCD Removals | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.3.4 | Number of complications following IUCD Insertion | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 8.4 | Number of Oral Pills cycles distributed | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.5 | Number of Condom pieces distributed | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.6 | Number of Centchroman (weekly) pills given | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.7 | Number of Emergency Contraceptive Pills given | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.8 | Number of pregnancy test kits used | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.9 | **Quality in sterilization services** | | | | | | |

# Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| 8.9.1 | **Number of complications** following sterilization | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.9.2 | **Number of failures** following sterilization | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 8.9.3 | **Number of deaths** following sterilization | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| **M9** | **CHILD IMMUNISATION** | | | | | | |
| 9.1 | **Number of Infants 0 to 11 months old who received:** | | | | | | |
| 9.1.1 | Vitamin K (Birth Dose) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.2 | BCG | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.3 | DPT1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.4 | DPT2 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.5 | DPT3 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.6 | Pentavalent 1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.7 | Pentavalent 2 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.8 | Pentavalent 3 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.9 | OPV 0 (Birth Dose) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.10 | OPV1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.11 | OPV2 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.12 | OPV3 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.13 | Hepatitis-B0 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.14 | Hepatitis-B1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.15 | Hepatitis-B2 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.16 | Hepatitis-B3 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.17 | IPV 1 (Inactivated Injectable Polio Vaccine ) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.18 | IPV 2 (Inactivated Injectable Polio Vaccine ) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.19 | Rotavirus 1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.20 | Rotavirus 2 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.1.21 | Rotavirus 3 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.2 | **Number of Children 9-11 months who received:** | | | | | | |
| 9.2.1 | Measles & Rubella (MR)- 1st Dose | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.2.2 | Measles-1$^{st}$ dose | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.2.3 | JE 1st dose | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.2.4 | **Total number of children aged between 9 and 11 months fully immunized (BCG+DPT123/ pentavalent123+OPV123+Measles) during the month** | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.3 | **Children given following vaccination after 12 months** | | | | | | |
| 9.3.1 | Measles & Rubella (MR)- 1st Dose | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.3.2 | Measles-1$^{st}$ dose | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.3.3 | JE 1st dose | ✓ | ✓ | ✓ | ✓ | ✓ | X |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| 9.4 | **Number of Children more than 12 months who received:** | | | | | | |
| 9.4.1 | Measles & Rubella (MR)- 2nd Dose (16-24 months) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.4.2 | Measles 2nd dose (More than 16 months) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.4.3 | DPT 1st Booster | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.4.4 | OPV Booster | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.4.5 | Measles, Mumps, Rubella (MMR) Vaccine | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.4.6 | Number of children more than 16 months of age who received Japanese Encephalitis (JE) vaccine | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.4.7 | **Total number of children aged between 12 and 23 months fully immunised (BCG+DPT123/pentavalent123+OPV123+Measles) during the month** | | | | | | |
| a | **Male** | | | | | | |
| b | **Female** | | | | | | |
| 9.5 | **Number of Children more than 23 months who received:** | | | | | | |
| 9.5.1 | Typhoid | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.5.2 | Children more than 5 years received DPT5 (2nd Booster) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.5.4 | Children more than 10 years received TT10 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.5.4 | Children more than 16 years received TT16 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.6 | **Adverse Event Following Immunisation (AEFI)** | | | | | | |
| a | Abscess | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Death | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| c | Others | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.7 | **Number of Immunisation sessions during the month** | | | | | | |
| a | Planned | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Held | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| c | Number of sessions where ASHAs were present | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| | **Others (Japanese Encephalitis (JE) etc. Please Specify)** | | | | | | |
| 9.8 | **Children received Vitamin A Doses between 9 months and 5 years** | | | | | | |
| a | Dose-1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Dose-5 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| c | Dose-9 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 9.9 | Number of children (6-59 months) provided 8-10 doses (1ml) of IFA syrup (Bi weekly) | X | X | X | ✓ | ✓ | X |
| 9.10 | Total Number of children (12-59 months) provided Albendazole | X | X | X | ✓ | ✓ | X |
| 9.11 | No. of severe underweight children provided Health Checkup (0-5 yrs) | X | X | X | ✓ | ✓ | X |
| **M10** | **Number of cases of Childhood Diseases during the month (0-5 years)** | | | | | | |
| 10.1 | Sepsis | ✓ | ✓ | ✓ | ✓ | X | X |
| 10.2 | Diphtheria | ✓ | ✓ | ✓ | ✓ | X | X |
| 10.3 | Pertussis | ✓ | ✓ | ✓ | ✓ | X | X |
| 10.4 | Tetanus Neonatorum | ✓ | ✓ | ✓ | ✓ | X | X |
| | Tetanus others | ✓ | ✓ | ✓ | ✓ | X | X |
| | Polio | ✓ | ✓ | ✓ | ✓ | X | X |
| 10.5 | Tuberculosis (TB) | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 10.6 | Acute Flaccid Paralysis(AFP) | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 10.7 | Measles | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 10.8 | Malaria | ✓ | ✓ | ✓ | ✓ | ✓ | X |

# Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| | Diarrhoea *with* dehydration | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 10.9 | Diarrhoea | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 10.10 | Diarrhoea treated in IPD | ✓ | ✓ | ✓ | ✓ | X | X |
| 10.11 | Number admitted with Respiratory Infections | ✓ | ✓ | ✓ | ✓ | X | X |
| 10.12 | Severe Acute Malnutrition (SAM) | ✓ | ✓ | ✓ | ✓ | X | X |
| Part B. | **Other Programmes** | | | | | | |
| M11 | **Blindness Control Programme** | | | | | | |
| 11.1 | **Number of Patients operated for cataract** | | | | | | |
| 11.2 | **Number of Intraocular Lens(IOL) implantations** | | | | | | |
| 11.3 | **Number of School children detected with Refractive errors** | | | | | | |
| 11.4 | **Number of children provided with free glasses** | | | | | | |
| 11.5 | **Number of eyes collected** | | | | | | |
| 11.6 | **Number of eyes utilised** | | | | | | |
| **M11** | **NVBDCP** | | | | | | |
| 11.1 | **Malaria** | | | | | | |
| 11.1.1 | **Microscopy Tests** | | | | | | |
| a | Total Blood Smears Examined | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Plasmodium Vivax test positive | ✓ | ✓ | ✓ | ✓ | X | X |
| c | Plasmodium Falciparum test positive | ✓ | ✓ | ✓ | ✓ | X | X |
| 11.1.2 | **Rapid Diagnostic Test (RDT )** | | | | | | X |
| a | Total RDT conducted | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Plasmodium Vivax test positive | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| c | Plamodium Falciparum test positive | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 11.2 | **Kala Azar- Rapid Diagnostic Test (RDT)** | | | | | | X |
| a | Tests Conducted | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Kala Azar Positive Cases | ✓ | ✓ | ✓ | ✓ | X | X |
| c | Post-kala-azar dermal leishmaniasis (PKDL) cases | ✓ | ✓ | ✓ | ✓ | X | X |
| 11.3 | **Dengue** | | | | | | |
| a | RDT Test Positive | ✓ | ✓ | ✓ | ✓ | | X |
| b | Elisa Test Positive | ✓ | X | X | X | X | X |
| 11.4 | **Acute Encephelitis Syndrome/ Japanese Encephalitis (AES/ JE)** | | | | | | X |
| a | Tests Conducted for JE | ✓ | X | X | X | X | X |
| b | Tests Positive for JE | ✓ | X | X | X | X | X |
| **M12** | **Adolscent Health** | | | | | | |
| 12.1 | **Adolescent Friendly Health Clinics (AFHCs)** | | | | | | |
| 12.1.1 | **Number of Adolescents (10-19 years) registered in Adolescent Friendly Health Clinic (AFHC)** | ✓ | ✓ | ✓ | ✓ | X | X |
| a | Girls | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Boys | ✓ | ✓ | ✓ | ✓ | X | X |
| 12.1.2 | **Out of registered adolescents (10-19 years), number received clinical services** | | | | | | |
| a | Girls | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Boys | ✓ | ✓ | ✓ | ✓ | X | X |
| 12.1.3 | **Out of registered adolescents (10-19 years), number received counselling** | | | | | | |
| a | Girls | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Boys | ✓ | ✓ | ✓ | ✓ | X | X |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| **M13** | **DOTS (Directly Observed Treatment, Short-course)** | | | | | | |
| 13.1 | Number of on-going DOTS patients registered | ✓ | ✓ | ✓ | ✓ | X | X |
| 13.2 | Number of DOTS cases completed successfully | ✓ | ✓ | ✓ | ✓ | X | X |
| **Part C.** | **Health Facility Services** | | | | | | |
| **M14** | **Patient Services** | | | | | | |
| 14.1 | **OPD by disease/ health condition** | | | | | | |
| 14.1.1 | Diabetes | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.1.2 | Hypertension | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.1.3 | Stroke (Paralysis) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.1.4 | Acute Heart Diseases | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.1.5 | Mental illness | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.1.6 | Epilepsy | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.1.7 | Ophthalmic Related | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.1.8 | Dental | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.2 | **OPD attendance (All)** | | | | | | |
| 14.2.1 | Allopathic | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.2.2 | Ayush | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 14.3 | **Inpatient** | | | | | | |
| 14.3.1 | **Male Admissions** | | | | | | |
| a | Children<18yrs | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Adults | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.3.2 | **Female Admissions** | | | | | | |
| a | Children<18yrs | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Adults | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.3.3 | Number of LAMA (Left Against Medical Advice) cases | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4 | **Inpatient by disease/ health condition** | | | | | | |
| 14.4.1 | Malaria | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4.2 | Dengue | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4.3 | Typhoid | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4.5 | Asthma, Chronic Ostructive Pulmonary Disease (COPD), Respiratory infections | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4.6 | Tuberculosis | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4.7 | Pyrexia of unknown origin (PUO) | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4.8 | Diarrhea with dehydration | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.4.9 | Hepatitis | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.5 | Total patients registered at Emergency Department | ✓ | ✓ | ✓ | X | X | X |
| 14.6 | **Emergency admissions due to** | | | | | | |
| 14.6.1 | Trauma ( accident, injury, poisoning etc) | ✓ | ✓ | ✓ | X | X | X |
| 14.6.2 | Burn | ✓ | ✓ | ✓ | X | X | X |
| 14.6.3 | Obstetrics complications | ✓ | ✓ | ✓ | X | X | X |
| 14.6.4 | Snake Bite | ✓ | ✓ | ✓ | X | X | X |
| 14.6.5 | Acute Caridiac Emergencies | ✓ | ✓ | ✓ | X | X | X |
| 14.6.7 | CVA ( Cerebovascular Disease) | ✓ | ✓ | ✓ | X | X | X |
| 14.7 | Number of deaths occurring at Emergency Department | ✓ | ✓ | ✓ | X | X | X |

# Monthly HMIS Format

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|---|---|---|---|---|---|---|---|
| 14.8 | **Operations (excluding C-section)** | | | | | | |
| 14.8.1 | Operation major (General and spinal anaesthesia) | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.8.2 | Out of Operation major, Gynecology- Hysterectomy surgeries | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.8.3 | Operation minor (No or local anaesthesia) | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.8.4 | Number of blood units issued | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.8.5 | Number of blood transfusions done | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.9 | **Total Inpatient Deaths (excluding deaths at Emergency department & SNCU)** | | | | | | |
| a | Male | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Female | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.10 | In-Patient Head Count at midnight | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.11 | Total no. of Admission in NBSU ( New Born Stabilisation Unit) | ✓ | ✓ | ✓ | X | X | X |
| 14.12 | **Sick newborn (up to 4 weeks) Admissions** | | | | | | |
| 14.12.1 | Inborn – Male | ✓ | ✓ | ✓ | X | X | X |
| 14.12.2 | Inborn - Female | ✓ | ✓ | ✓ | X | X | X |
| 14.12.3 | Outborn – Male | ✓ | ✓ | ✓ | X | X | X |
| 14.12.4 | Outborn - Female | ✓ | ✓ | ✓ | X | X | X |
| | No.of newborns admitted in SNCU - referred by ASHA | ✓ | ✓ | ✓ | X | X | X |
| 14.13 | Number of deaths occurring at SNCU | ✓ | ✓ | ✓ | X | X | X |
| 14.14 | **Nutritional Rehabilitation Centre (NRC)** | | | | | | |
| 14.14.1 | No. of children admitted in NRC | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.14.2 | No of children discharged with target weight gain from the NRCs | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.15 | Number of RKS meetings held | ✓ | ✓ | ✓ | ✓ | X | X |
| 14.16 | Number of Anganwadi centres/ UPHCs reported to have conducted VHNDs/ UHNDs/ Outreach / Special Outreach | X | X | X | ✓ | ✓ | X |
| | **Number of times ambulance services used for transporting patients** | | | | | | |
| **M15** | **Laboratory Testing** | | | | | | |
| 15.1 | Total Number of Lab Tests done | ✓ | ✓ | ✓ | ✓ | X | X |
| 15.2 | **Hb Tests Conducted** | | | | | | |
| 15.2.1 | Number of Hb tests conducted | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 15.2.2 | Of which Number having Hb < 7 mg | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 15.3 | **HIV tests conducted** | | | | | | |
| 15.3.1 | **Male** | | | | | | |
| a | Number Tested | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Number Positive | ✓ | ✓ | ✓ | ✓ | X | X |
| 15.3.2 | **Female-Non ANC** | | | | | | |
| a | Number Tested | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Number Positive | ✓ | ✓ | ✓ | ✓ | X | X |
| 15.3.3 | **ANCs screened for HIV using POC test or single HIV test :** | | | | | | |
| a | Number of pregnant women/post natal women/Direct -in -labour cases screened for HIV using POC test or any other single test | ✓ | ✓ | ✓ | X | X | X |
| b | Out of the above, number screened positive | ✓ | ✓ | ✓ | X | X | X |
| c | Out of the above number screened positive, number confirmed with HIV infection at ICTC | ✓ | ✓ | ✓ | X | X | X |
| 15.3.4 | **Total Antenatal Cases tested for HIV** | | | | | | |
| a | Numbers Tested for HIV (No.s screened + ICTC tested cases) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Number Positive for HIV (Nos confirmed positive at ICTCs) | ✓ | ✓ | ✓ | ✓ | ✓ | X |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| 15.4 | **Widal tests** | | | | | | |
| a | Number Tested | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Number Positive | ✓ | ✓ | ✓ | ✓ | X | X |
| | **VDRL tests conducted** | | | | | | |
| a | **Male** | | | | | | |
| b | **Female** | | | | | | |
| 15.5 | **Radiology** | | | | | | |
| | X-ray | ✓ | ✓ | ✓ | X | X | X |
| | Ultrasonography (USG) | ✓ | X | X | X | X | X |
| **M16** | **Stock Related Data** | | | | | | |
| 16.1 | Is two month stock of essential drugs available | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 16.2 | Is two month stock of essential vaccines available | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 16.3 | Is two month stock of essential contraceptives available | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| **Part D.** | **Mortality Details** | | | | | | |
| **M17** | **Details of deaths reported during the month with probable causes:** | | | | | | |
| 17.1 | Infant deaths within 24 hrs(1 to 23 Hrs) of birth | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.2 | **Infant Deaths up to 4 weeks (1 to 28 days) due to** | | | | | | |
| 17.2.1 | Sepsis | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.2.2 | Asphyxia | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| | LBW | | | | | | |
| 17.2.3 | Others | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.3 | **Infant Deaths Between 1 month (more than 28 days) and less than 12 months due to** | | | | | | |
| 17.3.1 | Pneumonia | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.3.2 | Diarrhoea | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.3.3 | Fever related | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.3.4 | Measles | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.3.5 | Others | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.4 | **Child Deaths between 1 year and less than 5 years due to** | | | | | | |
| 17.4.1 | Pneumonia | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.4.2 | Diarrhoea | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.4.3 | Fever related | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.4.4 | Measles | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.4.5 | Others | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.5 | **Maternal Deaths (15 to 49 yrs.) due to** | | | | | | |
| 17.5.1 | Bleeding | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.5.2 | High fever | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.5.3 | Abortion | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.5.4 | Obstructed/prolonged labour | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.5.5 | Severe hypertesnion/fits | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.5.6 | Other Causes (including causes not known) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.6 | Total facility based maternal death reviews (FBMDR) done | ✓ | ✓ | ✓ | X | X | X |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| 17.7 | **Other Deaths (except Infant, Child & Maternal Deaths) 5 years and above due to** | | | | | | |
| 17.7.1 | Diarrhoeal diseases | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.2 | Tuberculosis | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.3 | Respiratory diseases including infections (other than TB) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.4 | Other Fever Related | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.5 | HIV/AIDS | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.6 | Heart disease/Hypertension related | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.7 | Cancer | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.8 | Neurological disease including strokes | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.9 | Accidents/Burn cases | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.10 | Suicide | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.11 | Animal bites and stings | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.7.12 | Other Diseases | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| a | Known Acute Disease | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| b | Known Chronic Disease | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| c | Causes not known | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.8 | **Deaths due to Vector Borne Diseases ( all age groups)** | | | | | | |
| 17.8.1 | Malaria- Plasmodium Vivax | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.8.2 | Malaria- Plasmodium Falciparum | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.8.3 | Kala Azar | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.8.4 | Dengue | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.8.5 | Acute Encephelitis Syndrome (AES) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 17.8.6 | Japanese Encephalitis (JE) | ✓ | ✓ | ✓ | ✓ | ✓ | X |

## District HQ Format

| **Part B** | **Inventory details** | | | | | | |
|---|---|---|---|---|---|---|---|
| **H1** | **Vaccines** | | | | | | |
| 1.1 | DPT | X | X | X | X | X | ✓ |
| 1.2 | Pentavalent | X | X | X | X | X | ✓ |
| 1.3 | OPV | X | X | X | X | X | ✓ |
| 1.4 | TT | X | X | X | X | X | ✓ |
| 1.5 | DT | X | X | X | X | X | ✓ |
| 1.6 | BCG | X | X | X | X | X | ✓ |
| 1.7 | Measles | X | X | X | X | X | ✓ |
| 1.8 | JE | X | X | X | X | X | ✓ |
| 1.9 | Hepatitis B | X | X | X | X | X | ✓ |
| 1.10 | Typhoid | X | X | X | X | X | ✓ |
| 1.11 | Vitamin K | X | X | X | X | X | ✓ |
| **H2** | **Family Planning** | | | | | | |
| 2.1 | IUD 380 A | X | X | X | X | X | ✓ |
| 2.2 | IUD 375 A | X | X | X | X | X | ✓ |
| 2.3 | Condoms | X | X | X | X | X | ✓ |
| 2.4 | Oral Contraceptive | X | X | X | X | X | ✓ |
| 2.5 | Emergency Contraceptive Pills | X | X | X | X | X | ✓ |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| 2.6 | Tubal rings | X | X | X | X | X | ✓ |
| | Pregnanct Test Kits | X | X | X | X | X | ✓ |
| **H3** | **Other Items** | | | | | | |
| | **Injection Oxytocin** | | | | | | |
| 3.1 | Gloves | X | X | X | X | X | ✓ |
| 3.2 | MVA Syringes | X | X | X | X | X | ✓ |
| 3.3 | Tab. Fluconazole | X | X | X | X | X | ✓ |
| 3.4 | Blood Transfusion sets | X | X | X | X | X | ✓ |
| 3.5 | Gluteraldehyde 2% | X | X | X | X | X | ✓ |
| 3.6 | IFA tablets ( Adult) | X | X | X | X | X | ✓ |
| 3.7 | IFA - Blue ( Adolescent 10-19 yrs) | X | X | X | X | X | ✓ |
| 3.8 | IFA- Pink ( Junior 6-10 yrs) | X | X | X | X | X | ✓ |
| 3.9 | IFA Syrup (Paediatric) | X | X | X | X | X | ✓ |
| 3.10 | Paediatrics Antibiotics (Amoxycillin and Injectable Gentamicin) | X | X | X | X | X | ✓ |
| 3.11 | Vitamin A solution | X | X | X | X | X | ✓ |
| 3.12 | ORS (New WHO) | X | X | X | X | X | ✓ |
| 3.13 | RTI /STI colour coded syndromic kits ( I to VII) | X | X | X | X | X | ✓ |
| 3.14 | Zinc 20 mg tablet | X | X | X | X | X | ✓ |
| 3.15 | Albendazole 400 mg tablet | X | X | X | X | X | ✓ |
| **H4** | **Syringes** | | | | | | |
| 4.1 | 0.1 ml (AD) | X | X | X | X | X | ✓ |
| 4.2 | 0.5 ml (AD) | X | X | X | X | X | ✓ |
| 4.3 | 5.0 ml (Disposable) | X | X | X | X | X | ✓ |
| **Part B** | **Other Programmes** | | | | | | |
| **H5** | **Rashtriya Bal Swasthaya Karyakram (RBSK)** | | | | | | |
| 5.1 | Number of newborn screened for defects at birth (as per RBSK) | X | X | X | X | X | ✓ |
| 5.2 | Number of children (6 month to 6 years) screened by RBSK mobile health teams at Anganwadi center | X | X | X | X | X | ✓ |
| 5.3 | Number of children (6 years to 18 years) screened by RBSK mobile health teams at Govt and Govt aided schools | X | X | X | X | X | ✓ |
| 5.4 | Number of children identified with selected health conditions ( New Born - 18 years) | | | | | | |
| 5.4.1 | Disease | | | | | | |
| a | Male | X | X | X | X | X | ✓ |
| b | Female | X | X | X | X | X | ✓ |
| 5.4.2 | Deficiency | | | | | | |
| a | Male | X | X | X | X | X | ✓ |
| b | Female | X | X | X | X | X | ✓ |
| 5.4.2 | Developmental delay | | | | | | |
| a | Male | X | X | X | X | X | ✓ |
| b | Female | X | X | X | X | X | ✓ |
| 5.5 | Number of children (affected with selected health conditions) managed by following intervention | | | | | | |
| a | Medical | X | X | X | X | X | ✓ |
| b | Surgical | X | X | X | X | X | ✓ |
| c | Early intervention at DEIC ( District Early Intervention Centre) | X | X | X | X | X | ✓ |

# Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| **H6** | **Adolscent Health** | | | | | | |
| 6.1 | **Coverage under Weekly Iron and Folic Acid (WIFS) Supplementation Programme** | | | | | | |
| 6.1.1 | Number of students (6th -12th class) provided 4-5 IFA tablets in schools | | | | | | |
| a | Girls | X | X | X | X | X | ✓ |
| b | Boys | X | X | X | X | X | ✓ |
| 6.1.2 | Number of students (6th -12th class) provided albendazole in schools | | | | | | |
| a | Girls | X | X | X | X | X | ✓ |
| b | Boys | X | X | X | X | X | ✓ |
| 6.1.3 | Number of out of school adolscent girls (10-19 years) provided 4-5 IFA tablets at Anganwadi Centres | X | X | X | X | X | ✓ |
| 6.1.4 | Number of out of school adolscent girls (10-19 years) provided albendazole at Anganwadi Centres | X | X | X | X | X | ✓ |
| 6.2 | **Coverage under Menstrual Hygiene Scheme** | | | | | | |
| 6.2.1 | Number of sanitary napkin packs distributed free to ASHA | X | X | X | X | X | ✓ |
| 6.2.2 | Number of sanitary napkin packs sold to adolescent girls | X | X | X | X | X | ✓ |
| 6.2.3 | Number of adolescent girls provided sanitary napkins | X | X | X | X | X | ✓ |
| 6.2.4 | Number of adolescent girls attended monthly meeting | X | X | X | X | X | ✓ |
| **H7** | **Coverage under WIFS JUNIOR (Weekly Iron Folic Acid Supplementation Programme for children 6 - 10 years ) - PINK IFA tablet** | | | | | | |
| 7.1 | Number of children (6 - 10 years ) provided 4-5 IFA tablets in schools | X | X | X | X | X | ✓ |
| 7.2 | Number of children (6 - 10 years) provided albendazole in schools | X | X | X | X | X | ✓ |
| 7.3 | Number of out of school children (6-10 years) given 4-5 IFA tablets at Anganwadi Centres | X | X | X | X | X | ✓ |
| 7.4 | Number of out of school children (6-10 years) provided albendazole at Anganwadi Centres | X | X | X | X | X | ✓ |
| **H8** | **Maternal Death Reviews (MDR) Done** | | | | | | |
| 8.1 | Total Maternal Deaths Reviewed (MDR) by CMO | X | X | X | X | X | ✓ |
| 8.2 | Total Maternal Deaths Reviewed (MDR) by DM | X | X | X | X | X | ✓ |
| 8.3 | Total number of maternal deaths reported through Community based Maternal Death Review (CBMDR) | X | X | X | X | X | ✓ |
| **H9** | **JSSK** | | | | | | |
| **9.1** | **Number of Pregnant Women provided** | | | | | | |
| 9.1.1 | Free Medicines | X | X | X | X | X | ✓ |
| 9.1.2 | Free Diet | X | X | X | X | X | ✓ |
| 9.1.3 | Free Diagnostics | X | X | X | X | X | ✓ |
| 9.1.4 | Free Home to facility transport | X | X | X | X | X | ✓ |
| 9.1.5 | Interfacility transfers when needed | X | X | X | X | X | ✓ |
| 9.1.6 | Free Drop Back home | X | X | X | X | X | ✓ |
| **9.2** | **No of sick infants provided** | | | | | | |
| 9.2.1 | Free Medicines | X | X | X | X | X | ✓ |
| 9.2.2 | Free Diagnostics | X | X | X | X | X | ✓ |
| 9.2.3 | Free Home to facility transport | X | X | X | X | X | ✓ |
| 9.2.4 | Interfacility transfers when needed | X | X | X | X | X | ✓ |
| 9.2.5 | Free Drop Back home | X | X | X | X | X | ✓ |

## Monthly HMIS Format

| | | DH | SDH | CHC | PHC | SC | DHQ |
|---|---|---|---|---|---|---|---|
| **Part A.** | **REPRODUCTIVE AND CHILD HEALTH** | | | | | | |
| **M1** | **Ante Natal Care Services (ANC)** | | | | | | |
| 1.1 | Total number of pregnant women registered for ANC | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.1.1 | Out of the Total ANC registered, number registered within first trimester *(within 12 weeks)* | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| | New women registered under *Janani Suraksha Yojana (JSY)* | | | | | | |
| | Number of pregnant women received 3 or more ANC check ups | | | | | | |
| 1.1.2 | Number of pregnant women received 4 or more ANC check ups | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2 | **Number of pregnant women given** | | | | | | |
| 1.2.1 | TT1 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.2 | TT2 | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.3 | TT Booster | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.4 | Number of pregnant women given ANC Corticosteroids in Pre Term Labour | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| | Total number of pregnant women given 100 IFA tablets | | | | | | |
| 1.2.5 | Total number of pregnant women given 180 IFA tablets | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.6 | Number of pregnant women given Calcium tablets | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.2.7 | Number of pregnant women given one Albendazole tablet during the 2nd trimester | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.3 | **Pregnant women with Hypertension (BP>140/90)** | | | | | | |
| 1.3.1 | New cases detected | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.3.2 | Out of the new cases detected, cases managed at institution | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.3.3 | Number of Eclampsia cases managed during delivery | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.4 | **Pregnant women with Anaemia** | | | | | | |
| 1.4.1 | Number of Haemoglobin(Hb) tests done for Pregnant women | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.4.2 | Number having Hb level<11 (tested cases) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.4.3 | Number having Hb level<7 (tested cases) | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| 1.4.4 | Number having severe anaemia (Hb<7) treated | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.5 | **Pregnant women with Gestational Diabetes Mellitus (GDM)** | | | | | | |
| 1.5.1 | Number of pregnant women tested for Blood Sugar | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.5.2 | Number of pregnant women tested positive for Gestational Diabetes Mellitus (GDM ) | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.5.3 | No of pregnant women given insulin out of total tested positive for GDM | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.6 | **Pregnant Women with Syphilis** | | | | | | |
| 1.6.1 | **Point of Care tests conducted for Syphilis** | | | | | | |
| a | Number of pregnant women tested using POC test for Syphilis | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Out of the pregnant women tested-Number found positive | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.6.2 | **VDRL/RPR tests conducted** | | | | | | |
| a. | Out of pregnant women tested positive for Syphilis using POC tests, numbers tested using RPR | ✓ | ✓ | ✓ | ✓ | X | X |
| b | Number of pregnant women tested using RPR as first test | ✓ | ✓ | ✓ | ✓ | X | X |
| c | Number of Pregnant women tested positive using RPR as first test | ✓ | ✓ | ✓ | ✓ | X | X |
| d | Out of the above (1.6.2 c) Number of Pregnant women treated for Syphilis using at least one Injection Benzathine Penicillin (2.4 million. units) | ✓ | ✓ | ✓ | ✓ | X | X |
| 1.6.3 | Number of infants born to Syphilis seropositive mothers who received treatment with atleast 1 dose of Inj Benzathine Penicillin | ✓ | ✓ | ✓ | ✓ | X | X |

# Annexure 2: Standard Operating Procedure for HIV testing using POC Screening Test

## SD Bioline HIV Rapid Test Job Aid

- Check kit before use. Use only items that have not expired or been damaged.
- Bring kits or previously stored specimens to room temperature prior to use.
- Always use universal safety precautions when handling specimens. Keep work area clean and organized.
- This outline does not replace the product insert or your standard operating procedure (SOP).

**Store Kit: 2-8°C**

1. Test kit & supplies


2. Label test device


3. Collect 10µl whole blood twice with capillary pipette provided

4. Add 20µl whole blood into sample well


5. Add 4 drops of assay diluent into sample well

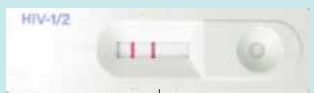

6. Interpret results in 5-20 minutes


7. Result interpretation



Non-Reactive


HIV 1 Reactive




HIV 2 Reactive


HIV 1 & 2 Reactive


Invalid

# Annexure 3: Standard Operating Procedure for Syphilis testing using POC screening Test

National AIDS Control Organisation

## Syphilis Screening using Rapid Point of Care Tests (POC)

### Syphilis testing

Laboratory diagnosis traditionally follows initial screening of serum by a non-treponemal test (VDRL/RPR) confirmed by a specific treponemal test (TPHA/FTA-ABS).

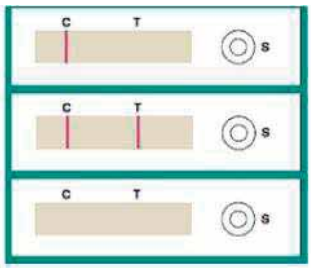
However, operational requirements for RPR/VDRL testing are not available at most primary care sites (available at only 2.9% PHCs and 24% CHCs in India). Delay in obtaining test results through referrals to offsite laboratories can delay or result in missed opportunities for treatment. Very often patients may not return for follow-up particularly if they are asymptomatic.

**Rapid point of care syphilis testing:**

- Developed with an aim to integrate rapid, simple and technologically appropriate syphilis testing at venues with limited resources.
- Six test kits validated by WHO
    - Sensitivity 84.5%, and
    - Specificity 97.7% by serum specimens. (Recommended for further field trials using whole blood).
- Rapid POC kits can be stored at 4 C-30 C for up to a year; the test does not require other equipment, or electricity, and can be performed by a trained para-medic. **Immuno-chroma to graphic strip test performance using whole blood**

Put a drop of blood in the well of the test kit, wait for 8-10 minutes or as recommended by the manufacture of the kit and read the test result as given in figure A2.a.

**Fig : Strip test with interpretation of results**




**Negative:** Only one line below C (control line)

**Positive:** Lines below C (control) and T (test line)

**Indeterminate:** No lines below C or T

*NIRRH. Rapid Assessment Survey, 2005-2006.*

**Suggested guidelines for syphilis screening and treatment using point of care tests:**

- Since it is a specific treponemal test, it cannot distinguish between a new infection and a prior infection which has been successfully treated.

- However, all individuals testing positive at first clinic visit with POC tests should be treated using at least 1 dose of Inj Benzathine Penicillin (2.4 million units) after test dose. (Adverse reactions/Anaphylaxis is very very rare with Inj Benzathine Penicillin. However, every PHC/ CHC where the Inj Benzathine Penicillin is should be administered should keep an anaphylactic tray ready with Inj Adrenaline; Inj Hydrocortisone and Inj Chlorphenaramine (Inj CPM)/diphenhydramine).

- Spouse/partner treatment simultaneously should be done or as soon as possible.

- Soon after treatment with Inj Benzathine Penicillin, the pregnant woman to be referred to the nearest PHC or CHC. All PHC and CHC laboratories need RPR testing (both qualitative and quantitative) equipment, reagents etc for knowing the status of the disease by repeating hers and the newborn baby's tire soon after delivery for prognostic purposes as well as for knowing whether the child is a case of Congenital syphilis. For further radiological and clinical evaluation and treatment of at least 7 days to 10 days with Inj Procaine Penicillin or Crystalline Penicillin.

# Annexure 4: Mainstreaming & Social Protection Schemes for PLHIV

## Mainstreaming and Social Protection Schemes

Mainstreaming is an approach to generate multisectoral response to HIV with the realisation that the non-health sector can play an important and meaningful role in reducing vulnerability to HIV and mitigate impact of HIV on those infected and affected.

Involvement of various stakeholders (like Departments, institutions, civil society, elected representatives- Gram Sabha, religious and opinion leaders etc.) are crucial to spread awareness on HIV and AIDS, strengthen linkages with available services (ICTC, STI Clinic, ART Centre etc.) to those who require and reduce stigma and discrimination against PLHIV.

Benefits of Mainstreaming are summarised below:

- Enhance coverage and reach by spreading information on STI/HIV prevention
- Expansion of HIV related services
- Facilitate for enrolment and access of social protection benefits by PLHIV, CABA and MARPs.

## Why Social Protection?

People Living with HIV (PLHIV) face various vulnerabilities such as job insecurity, livelihood, poor access to health care facilities, low access to nutritional support, education for children etc. Self and social stigma and discrimination diminishes social support system. Further, burden by increased illness, loss of jobs and income, rising medical expenses, depletion of savings and other resources, food insecurity, psychological stress and social exclusion further worsen the socio-economic condition of people infected and affected by HIV.

Children Affected by AIDS (CABA) tend to be more socially vulnerable. Such condition could lead them towards exclusion, marginalisation and poverty. Given these realities, it is recognized that population infected and affected by HIV and AIDS have needs beyond HIV prevention and treatment services. In these circumstances social protection is imperative.

Social Protection may be understood by “Set of policies, schemes and entitlements or legislation which help the HIV infected and affected family and Most at Risk Population (MARPS) to mitigate the impact of HIV; reduce further vulnerability as well as mechanism to lead the life with dignity”.

The social protection is viewed with great importance for reducing vulnerabilities and to mitigate the impact of HIV. The strategy on social and legal protection is to reduce the impact of HIV by ensuring social entitlements and benefits of various welfare schemes to PLHIV and affected families. It reduces the burden on household as well as vulnerabilities of people to infection. The social protection initiatives impact positively in improving the quality of life of PLHIV, CABA & MARPs and its accessibility ensures social, legal and economic rights.

## Social Protection Helpdesk

State AIDS Control Societies are taking initiatives of Single Window model on social protection for PLHIV, MARPs and CABA to facilitate single point access of benefits of various existing government and welfare schemes in order to improve their quality of lives which is led by the DAPCU Officer.

The HIV/AIDS related facilities in the district (for example: Targeted Intervention (TI), Community Based Organization (CBO), State & District Network of Positive People, Integrated Counselling & Testing Centre (ICTC), Suraksha (STI) Clinic, ART Centre, Link ART Centre, Link Workers Scheme (LWS), Care & Support Centre (CSC) etc.) are encouraged to establish Social Protection Helpdesk within the existing structure of facilities. The objective of the helpdesk is to sensitise the key population on HIV sensitive social protection. Generate demand and facilitate access to social entitlements (for example: voter Id card, Aadhaar card, ration card, BPL card etc.) and HIV social protection schemes in the areas of nutrition, insurance, free transport, livelihood, housing, pension and other financial assistance, etc.

## Social Entitlements and Social Protection Schemes

Social entitlements basically would require Voter ID Card, Pan Card, Identity proof, Residence proof, Bank account, BPL/Aadhaar card. These documents are important for enrollment in social welfare schemes and access of benefits.

Social Protection may be ensured broadly in the areas of social, economic and legal protection. It may cover free travel support, nutrition support, financial assistance, insurance, legal aid, housing/shelter, skill building, livelihood etc.

## Who are the first and most affected?

- People living with HIV (PLHIV)
- High risk groups (Female Sex Worker (FSWs), Men who have sex with men (MSMs), Transgender (TGs), Injecting Drug Users (IDUs)

- Orphan and Vulnerable Children (OVC)
- Widows

## How do I contribute in access of social protection schemes by PLHIV?

- Generate awareness among PLHIV, CABA and MARPs about social entitlement and social protection schemes.
- Incorporate messages on social protection in communication and regular course of action for demand generation.
- Facilitate for enrollment of PLHIV in social entitlements and available social welfare schemes
- Coordinate with Social Protection Helpdesk and District AIDS Prevention and Control Unit (DAPCU) for facilitation on awareness and demand generation activities like CAMP and other activities/campaigns.
- Coordinate and link PLHIV with DAPCU and other available facility in the district (like TI NGO, ICTC, ART Centre, District Network of Positive People) for further assistance in social protection benefits.

Some commonly social protection schemes offered by central and state government are as follow:

- Integrated Child Development Services (ICDS)
- Swarnajayanti Gram Swarozgar Yojna (SGSY)
- Indira Aawas Yojana (IAY)
- Indira Gandhi National Pension Scheme
- Mahatama Gandhi National Rural Employment Guarantee Scheme (MGNREGS)
- Rashtriya Swasthya Bima Yojana (RSBY)
- Pradhan Mantri Suraksha Bima Yojana
- Pradhan Mantri Jeevan Jyoti Bima Yojana
- Pradhan Mantri Jan Dhan Yojana
- Janani Surakhsha Yojana (JSY)
- Janani Shishu Suraksha Yojana (JSSY)

- Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG / Sabla)
- Indira Gandhi National Widow Pension Scheme (IGNWPS)
- Antyodaya Anna Yojana (AAY)
- National Family Benefit Scheme (NFBS)
- Travel Concession (Railways, State Transport)
- Pension Schemes (Old Age, ART Pension etc.)
- Small loans for micro credit programme

## What I have learnt:

- Involvement of various stakeholders is important in order to strengthen response to HIV.
- Why social protection is important for PLHIV, CABA and MARPs?
- What are all the social entitlements and social protection schemes for the above?
- What are the common schemes available in order to address social, economic and legal protection?
- How do I contribute in the enrollment of PLHIV for availing the social protection schemes?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