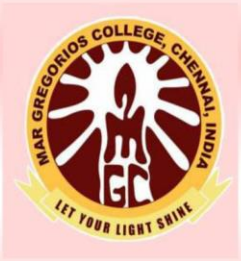
MAR GREGORIOS COLLEGE OF ARTS & SCIENCE

Block No.8, College Road, Mogappair West, Chennai – 37

Affiliated to the University of Madras
Approved by the Government of Tamil Nadu
An ISO 9001:2015 Certified Institution



PG DEPARTMENT OF SOCIAL WORK

SUBJECT NAME: WORKING WITH PEOPLE LIVING WITH HIV/AIDS

SUBJECT CODE: HBWEX

SEMESTER: II

PREPARED BY: PROF. D. KAVITHA RANI D

ELECTIVE –I- 2. Working with People living with HIV / AIDS

Total Teaching Hours: 45

Objectives

- To help students get a better understanding of HIV / AIDS in India
- To enable students in developing skills to work with people living with HIV
- To encourage students in understanding the ethical and human rights issues

Unit 1

Introduction to Sexually Transmitted Diseases. Epidemiology of HIV / AIDS Global situation; HIV / AIDS in India; Approach to patients with suspected HIV infection. Pre-test and Post-test Counseling. Target groups – sex workers, MSM, Truck drivers, IDU (Intra venous drug abuses) Street children.

Unit 2

Assessment, Intervention; Psychological and social factors: Other diseases -Tuberculosis, Skin diseases, Cancer, Herpes, STD, Liver disorders, steroids; physical examination; emphasis on gender sensitivity; Transgender issues; laboratory investigations, risk factors and contacts.

Unit 3

Social Work approach to a patient living with HIV infection: Systemic approach – trust, confidence and confidentiality. Initial assessment, history taking and Intervention. Behaviour change communication : Life Skills.

Unit 4

Awareness Raising and Preventative Programmes. Demythologising HIV / AIDS. – Sex education – peer influence / pressure – Adolescent behaviour – Sex, Alcohol and Drugs interplay – Use of condoms, prevention and control of STDs, HIV / AIDS – Healthy Sexuality and reproductive behaviour and relationship gender equity. HIV infection and pregnancy.Needle and condom distribution.

Unit 5

Social, ethical and legal issues: National AIDS Control Programmes (NACP), role of NGOs – networking, skills to manage HIV / AIDS and STDs. Social Support systems; Family Counseling – partners and children, strategies, community health programmes, conducting and managing awareness programmes, Role of Social Workers, Support groups.

ELECTIVE –I- 2. Working with People living with HIV / AIDS(HBWEX)

Objectives

• To help students get a better understanding of HIV / AIDS in India
• To enable students in developing skills to work with people living with HIV
• To encourage students in understanding the ethical and human rights issues

Unit 1

Introduction to Sexually Transmitted Diseases. Epidemiology of HIV / AIDS Global situation; HIV / AIDS in India; Approach to patients with suspected HIV infection. Pre-test and Post-test Counseling. Target groups – sex workers, MSM, Truck drivers, IDU (Intra venous drug abuses) Street children

INTRODUCTION TO SEXUALLY TRANSMITTED DISEASES

The term sexually transmitted disease (STD) is used to refer to a condition passed from one person to another through sexual contact. A person can contract an STD by having unprotected vaginal, anal, or oral sex with someone who has the STD.An STD may also be called a sexually transmitted infection (STI) or venereal disease (VD).

That doesn't mean sex is the only way STDs are transmitted. Depending on the specific STD, infections may also be transmitted through sharing needles and breastfeeding.

Symptoms of STDs in men

It's possible to contract an STD without developing symptoms. But some STDs cause obvious symptoms. In men, common symptoms include:

- pain or discomfort during sex or urination
- sores, bumps, or rashes on or around the penis, testicles, anus, buttocks, thighs, or mouth
- unusual discharge or bleeding from the penis
- painful or swollen testicles

Symptoms of STDs in women

In many cases, STDs don't cause noticeable symptoms. When they do, common STD symptoms in women include:

- pain or discomfort during sex or urination
- sores, bumps, or rashes on or around the vagina, anus, buttocks, thighs, or mouth
- unusual discharge or bleeding from the vagina
- itchiness in or around the vagina

The specific symptoms can vary from one STD to another. Here's more about the symptoms of STDs in women.

Types of STDs

Many different types of infections can be transmitted sexually. The most common STDs are described below.

- Chlamydia
- HPV (human papillomavirus)
- Syphilis
- HIV
- Gonorrhea
- Pubic lice (‘crabs’
- Trichomoniasis
- Herpes

Other STDs

Other, less common STDs include:

- chancroid
- lymphogranuloma venereum
- granuloma inguinale
- molluscum contagiosum
- scabies

Epidemiology of HIV/AIDS in Global situation

HIV continues to be a major global public health issue, having claimed almost 33 million lives so far. However, with increasing access to effective HIV prevention, diagnosis, treatment and care, including for opportunistic infections, HIV infection has become a manageable chronic health condition, enabling people living with HIV to lead long and healthy lives.

There were an estimated 38.0 million people living with HIV at the end of 2019.

As a result of concerted international efforts to respond to HIV, coverage of services has been steadily increasing. In 2019, 68% of adults and 53% of children living with HIV globally were receiving lifelong antiretroviral therapy (ART).

A great majority (85%) of pregnant and breastfeeding women living with HIV also received ART, which not only protects their health, but also ensures prevention of HIV transmission to their newborns.

At the end of 2019, an estimated 81% of people living with HIV knew their status. 67% were receiving antiretroviral therapy (ART) and 59% had achieved suppression of the HIV virus with no risk of infecting others; about 30 million adolescent boys and men in East and Southern Africa had received VMMC services.

By June 2020, 26 million people were accessing antiretroviral therapy, marking a 2.4% increase from an estimate of 25.4 million at the end of 2019. By comparison, treatment coverage increased by an estimated 4.8% between January and June of 2019.

The number of new people starting treatment is far below expectation due to the reduction in HIV-testing and treatment initiation and ARV disruptions that occurred during the COVID-19 pandemic. By end 2020, testing and treatment rates showed steady but variable recovery.

Nevertheless, between 2000 and 2019, new HIV infections fell by 39% and HIV-related deaths fell by 51%, with 15.3 million lives saved due to ART. This achievement was the result of great efforts by national HIV programmes supported by civil society and international development partners.

But success has been variable by region, country and population; However, not everyone is able to access HIV testing, treatment and care. Notably, the 2018 Super-Fast-Track targets for reducing new paediatric HIV infections to 40 000 was not achieved. Geven prior to the COVID-19 pandemic, reduction of new infections and deaths had plateaued; global 90/90/90 targets for 2020 are at risk of beingwill be missed unless rapid action is taken.

Due to gaps in HIV services, 690 000 people died from HIV-related causes in 2019 and 1.7 million people were newly infected.

To reach the new proposed global 95/95/95 targets, we will need to redouble our efforts to avoid the worst-case scenario a half million excess deaths in Sub Saharan Africa, increasing HIV infections due to HIV service disruptions during COVID-19, and the slowing public health response to HIV.

Interventions will need to focus on the populations left-behind: Key population groups and their sexual partners accounted for over 62% of all new HIV infections globally among the age group 15-49 years in 2019. In eastern European and central Asia, Asia and the Pacific, western and central Europe, and north America, and the Middle East and north Africa, these groups accounted for over 95% of new HIV infections in each of these regions.

WHO defines key populations as people in populations who are at increased HIV risk in all countries and regions. Key populations include: men who have sex with men; people who inject drugs; people in prisons and other closed settings; sex workers and their clients; and transgender people.

Increased HIV vulnerability is often associated with legal and social factors, which increases exposure to risk situations and creates barriers to accessing effective, quality and affordable HIV prevention, testing and treatment services. Prioritising key populations in the HIV response with appropriate interventions would have the biggest impact on the epidemic and reduce new infections.

In addition, given their life circumstances, a range of other populations may be particularly vulnerable, and at increased risk of HIV infection, such as adolescent girls and young women in southern and eastern Africa and indigenous peoples in some communities.

HIV can be diagnosed through rapid diagnostic tests that can provide same-day results. HIV self-tests are increasingly available and provide an effective and acceptable alternative way to increase access to people who are not reached for HIV testing through facility-based services. Rapid test and self-tests have greatly facilitated diagnosis and linkage with treatment and care.

There is no cure for HIV infection. However, effective prevention interventions are available: preventing mother-to-child-transmission, male and female condom use, harm reduction interventions, pre-exposure prophylaxis, post exposure prophylaxis, voluntary medical male circumcision (VMMC) and antiretroviral drugs (ARVs) which can control the virus and help prevent onward transmission to other people.

The human immunodeficiency virus (HIV) targets the immune system and weakens people's defense against many infections and some types of cancer. As the virus destroys and impairs the function of immune cells, infected individuals gradually become immunodeficient. Immune function is typically measured by CD4 cell count.

Signs and symptoms

The symptoms of HIV vary depending on the stage of infection. Though people living with HIV tend to be most infectious in the first few months after being infected, many are unaware of their status until the later stages. In the first few weeks after initial infection people may experience no symptoms or an influenza-like illness including fever, headache, rash or sore throat.

As the infection progressively weakens the immune system, they can develop other signs and symptoms, such as swollen lymph nodes, weight loss, fever, diarrhoea and cough. Without treatment, they could also develop severe illnesses such as tuberculosis (TB), cryptococcal meningitis, severe bacterial infections, and cancers such as lymphomas and Kaposi's sarcoma.

Transmission

HIV can be transmitted via the exchange of a variety of body fluids from infected people, such as blood, breast milk, semen and vaginal secretions. HIV can also be transmitted from a mother to her child during pregnancy and delivery. Individuals cannot become infected through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing personal objects, food or water.

It is important to note that people with HIV who are taking ART and are virally suppressed do not transmit HIV to their sexual partners. Early access to ART and support to remain on treatment is therefore critical not only to improve the health of people with HIV but also to prevent HIV transmission.

Risk factors

Behaviours and conditions that put individuals at greater risk of contracting HIV include:

- having unprotected anal or vaginal sex;
- having another sexually transmitted infection (STI) such as syphilis, herpes, chlamydia, gonorrhoea and bacterial vaginosis;
- sharing contaminated needles, syringes and other injecting equipment and drug solutions when injecting drugs;
- receiving unsafe injections, blood transfusions and tissue transplantation, and medical procedures that involve unsterile cutting or piercing; and
- experiencing accidental needle stick injuries, including among health workers

Diagnosis

HIV can be diagnosed through rapid diagnostic tests that provide same-day results. This greatly facilitates early diagnosis and linkage with treatment and care. People can also use HIV self-tests to test themselves. However, no single test can provide a full HIV diagnosis; confirmatory testing is required, conducted by a qualified and trained health or community worker at a community center or clinic. HIV infection can be detected with great accuracy using WHO prequalified tests within a nationally approved testing strategy.

Most widely-used HIV diagnostic tests detect antibodies produced by the person as part of their immune response to fight HIV. In most cases, people develop antibodies to HIV within 28 days of infection. During this time, people experience the so-called “window” period. when HIV antibodies haven’t been produced in high enough levels to be detected by standard tests and when they may have had no signs of HIV infection, but also when they may transmit HIV to others. After infection, an individual may transmit HIV transmission to a sexual or drug-sharing partner or for pregnant women to their infant during pregnancy or the breastfeeding period.

Following a positive diagnosis, people should be retested before they are enrolled in treatment and care to rule out any potential testing or reporting error. Notably, once a person diagnosed with HIV and has started treatment they should not be retested.

While testing for adolescents and adults has been made simple and efficient, this is not the case for babies born to HIV-positive mothers. For children less than 18 months of age, serological testing is not sufficient to identify HIV infection – virological testing must be provided as early as birth or at 6 weeks of age). New technologies are now becoming available to perform this test at the point of care and enable same-day results, which will accelerate appropriate linkage with treatment and care.

All HIV testing services must follow the WHO-recommended principles known as the "5 Cs":

- informed Consent
- Confidentiality
- Counselling
- Correct test results
- Connection (linkage to care, treatment and other services).

KEY POINTS

- The 5 Cs are essential for all HTS: consent, confidentiality, counselling, correct test results and connection to HIV prevention, treatment and care.
- HTS should be prioritized for and promoted to those who are at high risk and have not been tested recently.
- Verbal consent is usually adequate, but all individuals should have a private opportunity to refuse testing. Mandatory testing is never warranted.
- HTS must ensure that all tests' results and client information are confidential. Although disclosure to sexual partners, supportive family members and health workers is often beneficial, this must be done only by or with the consent of the person being tested.
- Retesting for individuals thought to be in the window period is needed only for those who report specific recent risk.
- It is the ethical and professional responsibility of the person providing HIV test results to adhere to international and national guidelines to ensure correct test results.
- People who test HIV-negative will usually need only brief health information about their HIV status report, how to prevent acquisition of HIV in the future and where and how to link to HIV prevention services, as appropriate. People with significant ongoing risk may need more active support and linkage to HIV prevention services. Everyone who is diagnosed HIV-positive should receive post-test counselling, including couples where one or both are diagnosed HIV-positive.
- People whose test results are not yet confirmed or whose HIV status is reported as inconclusive need follow-up services to ensure that they receive an HIV diagnosis.
- Key populations need tailored approaches and messages.
- Connection to prevention, treatment and care is an essential component of HTS.

Define Sex workers

- **Prostitution** is the business or practice of engaging in sexual activity in exchange for payment. Prostitution is sometimes described as **sexual services**, **commercial sex** or, colloquially, **hooking**. A person who works in this field is called a **prostitute** and is a type of sex worker.

Sex workers

- In 2017, an estimated 1.6% of female sex workers in India were living with HIV, although this figure varies between states. For example, prevalence among female sex workers is estimated at 7.4% in Maharashtra and 6.3% in Andhra Pradesh.
- Although sex work is not illegal in India, associated activities such as running a brothel are. This means that police are often hostile towards sex workers at best and that authorities justify routine brothel raids. Stigma and discrimination against sex workers restrict their access to healthcare. A 2011 study in Andhra Pradesh indicated a significant association between police abuse and increased risk of HIV transmission and inconsistent condom use.
- Sex workers are one of the high-risk groups targeted by India's National AIDS Control Organization (NACO) who programme successful peer-to-peer HIV interventions (when individuals from key affected populations provide services to their peers or link them to services within healthcare settings). In 2015, NACO reported reaching 77.4% of sex workers with HIV prevention activities.11
- In 2017, around 67% of HIV positive sex workers were aware of their status and 91% of sex workers (HIV positive and negative) reported using condoms.12

Sex worker communities in India

- Since 1992, SANGRAM has worked to unite sex workers and provide access to HIV treatment, prevention and education across six districts in Maharashtra and the border areas of north Karnataka. These are all places in which the rate of HIV infection is significantly higher than other areas of the country.
- The organization has achieved notable successes within these diverse communities. Peer educators deliver hundreds of thousands of condoms to women each month, and they report that in some areas 100% of sex workers have attended voluntary HIV testing.13
- Male sex workers are particularly vulnerable to HIV. A study of men who have sex with men (sometimes referred to as MSM) who attended STI clinics at Mumbai and Hyderabad, found that 70% of them engaged in sex work. Of those who engaged in sex work, HIV prevalence was found to be 43.6%, compared to 18.1% among all men who have sex with men attending the clinics.14

Men who have sex with men (MSM)

- Around 2.7% of men who have sex with men in India are living with HIV, of whom around 65% are aware of their status.
- HIV prevalence varies between areas. For example, around 10% of men who have sex with men in Andhra Pradesh and 5% in Maharashtra are estimated to be living with HIV.
- A 2015 study of men who have sex with men, conducted across 12 Indian cities, found 7% tested positive for HIV. Just under a third (30%) of those who reported having anal or oral sex with a man in the past 12 months were married to a women and engaging in heterosexual sex.17 The study also found evidence of emerging epidemics among men who have sex with men in urban areas not previously recognised as having high HIV burdens.
- In September 2018, India's Supreme Court decriminalised homosexuality between consenting adults. The ruling overturned Section 377, a British pre-colonial era law that banned 'carnal intercourse against the order of nature' and carried a maximum jail sentence of 10 years. To date this law meant

that HIV services were out of reach for men who have sex with men. The decision overturned a ruling made by the Supreme Court in 2013 that reinstated Section 377, having previously suspended it in 2009.

People who inject drugs (PWID)

- In 2016, 1.7 million people in India were estimated to inject drugs.
- HIV prevalence among this group is high, with injecting drug use the major route of HIV transmission in India's north-eastern states. In 2017, 6.3% of people who inject drugs were thought to be living with HIV, of whom half (50%) were aware of their status.
- Prevalence varies between locations, standing at 12.1% in Manipur, 10% in Mizoram, and 3.2% in Nagaland.
- A 2018 study analyzed unsafe injecting and sexual risk behaviors among around 20,000 Indian men who inject drugs. Results suggest that beginning drug use at age 25 or above, engagement in drug use for longer, injecting three times or more per day, sharing needles and syringes, and self-reported sexually transmitted diseases were all linked to an increased likelihood of HIV infection.
- HIV prevention efforts in the northeast of the country have been effective in reducing the number of new infections. However, there is evidence that the number of people who inject drugs is growing. In addition, evidence of higher HIV prevalence among sub-populations of people who inject drugs is also emerging. For instance, a 2015 study found prevalence to be more than three times higher among women who inject drugs than men.

Hijras/transgender people

- HIV prevalence among transgender people in India was estimated to be 3.1% in 2017, the second highest prevalence among all key populations in the country. Around 68% of HIV positive transgender people are aware of their status.
- In India, being a hijra (also known as 'aravani', 'aruvani' or 'jagappa' in other areas) is an identity associated with being a transgender woman, intersex or a eunuch. However, not all transgender women in India belong to a hijra community. The traditional background of hijras is linked to high-risk behaviours such as alcohol and substance abuse, and low literacy rates.
- In April 2014, the Indian Supreme Court recognized transgender people as a distinct gender. Since then, health and welfare programmes to meet this group's specific needs have been set up. Evidence of improved access to HIV services is emerging, with NACO reporting 240,000 hijras reached with HIV prevention and treatment services in 2015, compared to 180,000 the previous year.
- In 2017, NACO reported around 45% of transgender people and hijras were receiving targeted interventions.

Migrant workers

- Research worldwide has linked migration to increases in HIV transmission. There are an estimated 7.2 million migrant workers in India, of whom 0.2% are living with HIV.
- NACO categorises groups of migrants as 'bridge populations', as they form links between urban and rural areas, and between groups that are at high- and low-risk of HIV transmission. HIV testing among these groups remains low, standing at 11.32% in 2016.
- Despite being an important driver of the HIV epidemic in India, data on migrant sexual behaviour is limited. In 2014, UNAIDS reported that 75% of women testing positive in India have a husband who is a migrant labourer.[fn]NACO (2017) Annual Report 2016-17 [pdf] A 2017 study found HIV

prevalence among the wives of migrant workers in rural northern India was higher than among women in the general population at 0.59%. Only 15.5% of those questioned had heard of HIV.

- A 2011 study on migrants and HIV by UNDP, NACO and the Population Council also found higher levels of HIV among migrants than the general population in certain areas. For example, in northern Bihar migrant men were eight times more likely to be living with HIV than non-migrant men. It also found male and female migrants to be engaged in high levels of extra-marital sex and low condom use.

Truck drivers

- A number of studies have reported high vulnerability of truckers to HIV transmission in India. NACO estimated that 0.2% of truck drivers were living with HIV in 2017/18. NACO also categorizes truck drivers as a bridge population because they often have unprotected sex with high-risk groups such as female sex workers as well as their regular sexual partners, which increases the risk of transmitting HIV into the general population.
- A 2015 study found 49% of truckers in central India reported paying for sex, of whom 21.5% had a sexually transmitted infection. HIV testing among truck drivers remains low, standing at 21.74% in 2016.

HIV testing and counselling (HTC) in India

- In 2017, 79% of people living with HIV in India were aware of their status. HIV positive women are significantly more likely to be diagnosed, compared to HIV positive men (87% vs. 68%). This is due to the number of women testing for HIV through preventing mother to child transmission (PMTCT) services.
- In 1997, there were just 67 HIV testing and counselling (HTC) sites in India. By 2017, around 23,400 facilities were offering HIV testing and counselling. Between April 2016 and April 2017, 18.6 million general users accessed these services, surpassing India's annual testing target of 14 million.
- Testing is offered in a variety of settings including standalone clinics, health facilities and through public/private partnerships. Mobile testing units also offer community-based testing, aimed at improving early diagnosis, reaching first-time testers and people who seldom use clinical services. Community-based testing is particularly important, as the stigma of HIV and the criminalization of populations at high risk of HIV discourages many people from attending clinics and health facilities.
- HIV self-testing is not publicly available. However, after the World Health Organization (WHO) recommended HIV self-testing in 2016, India's Ministry of Health indicated it would investigate the feasibility of self-testing kits, initially among high-risk populations.

HIV prevention programmes in India

- In 2017, 88,000 people in India were newly infected with HIV. The majority were men, who accounted for 50,000 new infections. There were 34,000 new infections among women and around 3,700 among children (aged 0-14 years). NACO is the body responsible for formulating policy and implementing programmes for the prevention and control of the HIV epidemic in India.
- The most recent programme, NACP-IV (2012-2017, extended to 2018), aims to reduce annual new HIV infections by 50% through the provision of comprehensive HIV treatment, education, care and support for the general population and build on targeted interventions for key affected groups and those at high risk of HIV transmission.

- A key component of the NACP-IV is the prevention of new HIV infections by reaching 80% of key affected populations with targeted interventions. Targeted interventions are implemented on the premise that prevention of HIV transmission among key affected populations will also lower HIV transmission among the general population. For example, targeting interventions towards female sex workers and their male clients will help reduce the risk of clients transmitting HIV to their regular sexual partners.

IDUStreetchildren

Alcohol Alcohol is a depressant which inhibits or decreases some aspects of central nervous system activity (ie., activity of the brain, spinal cord, and some major nerves). Substances containing alcohol include the following: wine, beer, spirits, home-brew, some medicinal tonics and syrups (e.g. cough syrups), some toiletries and industrial products. Nicotine

Nicotine is a stimulant; that is any substance which activates, enhances or increases central nervous system activity. Nicotine is found in the following substances: cigarettes, cigars, pipe tobacco, chewed tobacco, snuff, nicotine gum, spray, skin patches. Most cigarettes have about 1-2 milligrams of nicotine. Lesson 1 - Types of psychoactive substances

Psychoactive substances street children may use. The types of psychoactive substances street children use can be many and varied and it may be difficult to determine what substances they are using. Substances which are sold on the market can be identified by their generic name. This is the standard name used throughout the world. However, some substances are marketed under various names known as trade names and others have ‘street names’. For example, diazepan is the generic name while valium is a trade name.

Diacetlymorphine is a generic name for heroin and ‘brown sugar’ or ‘smack’ are some of the names it is called by on the streets. It is important for the street educator to know the general categories of substances and the effects that substances can have on a street child. The following examples of substances in their general categories may not be the ones used in your country, they are merely illustrative.

Working With Street Children 3 Opioids Substances in this group may act as analgesics (they relieve physical pain) and depressants. They may be synthetic or made from opium poppies (opiates). The following substances are examples of opioids: opiates: codeine (such as in some cough mixtures), heroin, morphine, opium synthetic opioids: buprenorphine hydrochloride

(Temgesic), methadone (Physeptone), pethidine. Hallucinogens Hallucinogenic substances can alter a person's mood, the way the person perceives his or her surroundings and the way the person experiences his or her own body. There are many different types of hallucinogens, some of which are chemically produced and others which are naturally occurring. LSD (Lysergic Acid Diethylamide): in its pure state LSD is a white, odourless powder. It is usually mixed with a lot of other ingredients. It is often put into capsules, liquids, tablets, and as small spots on absorbent paper. mescaline: made from the pulp of the peyote cactus. psilocybin mushrooms:

Psilocybin is the hallucinogen found in some mushrooms. It is usually made available as dried mushrooms. PCP (phencyclidine): this substance was used as an animal tranquilliser. Cannabis The cannabis plant grows in many parts of the world. Preparations containing different concentrations of cannabis are consumed. marijuana: the leaves and flowers of the marijuana or hemp plant. hashish (oil and resin): these forms of cannabis are made from the resin of the flowering heads of the plant tablets containing THC (Tetrahydrocannabinol, the main active ingredient in cannabis) Hypnosedatives

Unit 2

UNIT -II

Assessment, Intervention; Psychological and social factors: Other diseases Tuberculosis, Skin diseases, Cancer, Herpes, STD, Liver disorders, steroids; physical examination; emphasis on gender sensitivity; Transgender issues; laboratory investigations, risk factors and contacts

TUBERCLOSIS:

Tuberculosis -- or TB, as it's commonly called -- is a contagious infection that usually attacks your lungs. It can spread to other parts of your body, like your brain and spine. A type of bacteria called *Mycobacterium tuberculosis* causes it.

Tuberculosis

Key facts

- A total of 1.4 million people died from TB in 2019 (including 208 000 people with HIV). Worldwide, TB is one of the top 10 causes of death and the leading cause from a single infectious agent (above HIV/AIDS).
- In 2019, an estimated 10 million people fell ill with tuberculosis (TB) worldwide. 5.6 million men, 3.2 million women and 1.2 million children. TB is present in all countries and age groups. But TB is curable and preventable.
- In 2019, 1.2 million children fell ill with TB globally. Child and adolescent TB is often overlooked by health providers and can be difficult to diagnose and treat.
- In 2019, the 30 high TB burden countries accounted for 87% of new TB cases. Eight countries account for two thirds of the total, with India leading the count, followed by Indonesia, China, the Philippines, Pakistan, Nigeria, Bangladesh and South Africa.
- Multidrug-resistant TB (MDR-TB) remains a public health crisis and a health security threat. A global total of 206 030 people with multidrug- or rifampicin-resistant TB (MDR/RR-TB) were detected and notified in 2019, a 10% increase from 186 883 in 2018.
- Globally, TB incidence is falling at about 2% per year and between 2015 and 2019 the cumulative reduction was 9%. This was less than half way to the End TB Strategy milestone of 20% reduction between 2015 and 2020.
- An estimated 60 million lives were saved through TB diagnosis and treatment between 2000 and 2019.
- Ending the TB epidemic by 2030 is among the health targets of the United Nations Sustainable Development Goals (SDGs).

Tuberculosis (TB) is caused by bacteria (Mycobacterium tuberculosis) that most often affect the lungs. Tuberculosis is curable and preventable. TB is spread from person to person through the air. When people with lung TB cough, sneeze or spit, they propel the TB germs into the air. A person needs to inhale only a few of these germs to become infected.

About one-quarter of the world's population has a TB infection, which means people have been infected by TB bacteria but are not (yet) ill with the disease and cannot transmit it.

People infected with TB bacteria have a 5–15% lifetime risk of falling ill with TB. Those with compromised immune systems, such as people living with HIV, malnutrition or diabetes, or people who use tobacco, have a higher risk of falling ill.

When a person develops active TB disease, the symptoms (such as cough, fever, night sweats, or weight loss) may be mild for many months. This can lead to delays in seeking care, and results in transmission of

the bacteria to others. People with active TB can infect 5–15 other people through close contact over the course of a year. Without proper treatment, 45% of HIV-negative people with TB on average and nearly all HIV-positive people with TB will die.

Who is most at risk?

Tuberculosis mostly affects adults in their most productive years. However, all age groups are at risk. Over 95% of cases and deaths are in developing countries.

People who are infected with HIV are 18 times more likely to develop active TB (see TB and HIV section below). The risk of active TB is also greater in persons suffering from other conditions that impair the immune system. People with undernutrition are 3 times more at risk. Globally in 2019, there were 2.2 million new TB cases in 2018 that were attributable to undernutrition.

Alcohol use disorder and tobacco smoking increase the risk of TB disease by a factor of 3.3 and 1.6, respectively. In 2019, 0.72 million new TB cases worldwide were attributable to alcohol use disorder and 0.70 million were attributable to smoking.

Global impact of TB

TB occurs in every part of the world. In 2019, the largest number of new TB cases occurred in the WHO South-East Asian region, with 44% of new cases, followed by the WHO African region, with 25% of new cases and the WHO Western Pacific with 18%.

In 2019, 87% of new TB cases occurred in the 30 high TB burden countries. Eight countries accounted for two thirds of the new TB cases: India, Indonesia, China, Philippines, Pakistan, Nigeria, Bangladesh and South Africa.

Symptoms and diagnosis

Common symptoms of active lung TB are

- cough with sputum and blood at times,
- chest pains,
- weakness,
- weight loss,
- fever and
- night sweats.

WHO recommends the use of rapid molecular diagnostic tests as the initial diagnostic test in all persons with signs and symptoms of TB as they have high diagnostic accuracy and will lead to major improvements in the early detection of TB and drug-resistant TB. Rapid tests recommended by WHO are the Xpert MTB/RIF, Xpert Ultra and Truenat assays.

Diagnosing multidrug-resistant and other resistant forms of TB (see Multidrug-resistant TB section below) as well as HIV-associated TB can be complex and expensive.

Tuberculosis is particularly difficult to diagnose in children.

Treatment

TB is a treatable and curable disease. Active, drug-susceptible TB disease is treated with a standard 6-month course of 4 antimicrobial drugs that are provided with information and support to the patient by a health worker or trained volunteer. Without such support, treatment adherence is more difficult.

INTERVENTION

Doctors will prescribe several special medications that you must take for six to nine months.

- Standard therapy for active TB consists of a six-month regimen:
- two months with Rifater (isoniazid, rifampin, and pyrazinamide);
- four months of isoniazid and rifampin (Rifamate, Rimactane);
- and ethambutol (Myambutol) or streptomycin added until your drug sensitivity is known (from the results of bacterial cultures).

SPECIFIC INTERVENTIONS

- Chemotherapy
- Prophylactic treatment-Antibiotics
- Vaccination
- Preventive chemotherapy

Since 2000, an estimated 63 million lives were saved through TB diagnosis and treatment.

TB and HIV

People living with HIV are 18 (15-21) times more likely to develop active TB disease than people without HIV.

HIV and TB form a lethal combination, each speeding the other's progress. In 2019, about 208 000 people died of HIV-associated TB. The percentage of notified TB patients who had a documented HIV test result in 2019 was 69%, up from 64% in 2018. In the WHO African Region, where the burden of HIV-associated TB is highest, 86% of TB patients had a documented HIV test result. Overall in 2019, 88% of TB patients known to be living with HIV were on ART.

WHO recommends a 12-component approach of collaborative TB-HIV activities, including actions for prevention and treatment of infection and disease, to reduce deaths.

Multidrug-resistant TB

Anti-TB medicines have been used for decades and strains that are resistant to one or more of the medicines have been documented in every country surveyed. Drug resistance emerges when anti-TB medicines are used inappropriately, through incorrect prescription by health care providers, poor quality drugs, and patients stopping treatment prematurely.

Multidrug-resistant tuberculosis (MDR-TB) is a form of TB caused by bacteria that do not respond to isoniazid and rifampicin, the 2 most effective first-line anti-TB drugs. MDR-TB is treatable and curable by using second-line drugs. However, second-line treatment options are limited and require extensive chemotherapy (up to 2 years of treatment) with medicines that are expensive and toxic.

In some cases, more severe drug resistance can develop. TB caused by bacteria that do not respond to the most effective second-line anti-TB drugs can leave patients without any further treatment options.

In 2019, MDR-TB remains a public health crisis and a health security threat. **A global total of 206 030 people with multidrug- or rifampicin-resistant TB (MDR/RR-TB) were detected and notified in 2019, a 10% increase from 186 883 in 2018.** About half of the global burden of MDR-TB is in 3 countries – India, China and the Russian Federation.

Worldwide, only 57% of MDR-TB patients are currently successfully treated. In 2020, WHO recommended a new shorter (9-11 months) and fully-oral regimen for patients with MDB-TB. This research has shown that

patients find it easier to complete the regimen, compared with the longer regimens that last up to 20 months. Resistance to fluoroquinolones should be excluded prior to the initiation of treatment with this regimen.

In accordance with WHO guidelines, detection of MDR/RR-TB requires bacteriological confirmation of TB and testing for drug resistance using rapid molecular tests, culture methods or sequencing technologies. Treatment requires a course of second-line drugs for at least 9 months and up to 20 months, supported by counselling and monitoring for adverse events. WHO recommends expanded access to all-oral regimens.

By the end of 2019, 89 countries started using shorter MDR-TB regimens and 109 had imported or started using bedaquiline, in an effort to improve the effectiveness of MDR-TB treatment.

TuberculosisTypes

A TB infection doesn't mean you'll get sick. There are two forms of the disease:

Latent TB. You have the germs in your body, but your immune system stops them from spreading. That means you don't have any symptoms and you're not contagious. But the infection is still alive in your body and can one day become active. If you're at high risk for re-activation -- for instance, you have HIV, your primary infection was in the past 2 years, your chest X-ray is abnormal, or your immune system is compromised --- your doctor will treat you with antibiotics to lower the risk for developing active TB.

Active TB. This means the germs multiply and can make you sick. You can spread the disease to others. Ninety percent of adult cases of active TB are from the reactivation of a latent TB infection.

ASSESMENT:

- doctor will use a stethoscope to listen to the lungs and check for swelling in the lymph nodes.
- They will also ask about symptoms and medical history as well as assessing the individual's risk of exposure to TB.
- The most common diagnostic test for TB is a skin test where a small injection of PPD tuberculin, an extract of the TB bacterium, is made just below the inside forearm.
- The injection site should be checked after 2-3 days, and, if a hard, red bump has swollen up to a specific size, then it is likely that TB is present.
- Unfortunately, the skin test is not 100 percent accurate and has been known to give incorrect positive and negative readings.
- However, there are other tests that are available to diagnose TB. Blood tests, chest X-rays, and sputum tests can all be used to test for the presence of TB bacteria and may be used alongside a skin test.

SKINDISEASE

Skin disease, any of the diseases or disorders that affect the human skin. They have a wide range of causes. Visible alterations in the texture of the skin, such as rashes and hives, can be indicative of serious disease

ASSESMENT

The most common skin tests include:

Patch testing: Patch tests are used to help diagnose skin allergies. Identified allergens (substances that a person may be allergic to) are applied to the skin on the back with adhesive patches and left for a period of time. The skin is then examined for any reaction.

Skin biopsy : Skin biopsies are performed to diagnose skin cancer or benign skin disorders. During a skin biopsy, skin is removed (after a local anesthetic is applied) and is taken to a laboratory for analysis. Skin may be removed with a scalpel, Gillette blue blade, or a cylindrical punch biopsy tool. Stitches may be used to close the wound.

Culture: A culture is a test that is done to identify the microorganism (bacteria, fungus, or virus) that is causing an infection. Skin (surface scrapings, biopsies, contents of pus bumps and blisters), hair, or nails may be cultured to detect bacteria, fungi, or viruses.

INTERVENTION

Many skin disorders are treatable. Common treatment methods for skin conditions include:

- antihistamines
- medicated creams and ointments
- antibiotics
- vitamin or steroid injections
- laser therapy
- targeted prescription medications

CANCER

Cancer is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow uncontrollably, go beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs. The latter process is called metastasizing and is a major cause of death from cancer. A neoplasm and malignant tumour are other common names for cancer.

Cancer is the second leading cause of death globally, accounting for an estimated 9.6 million deaths, or one in six deaths, in 2018. Lung, prostate, colorectal, stomach and liver cancer are the most common types of cancer in men, while breast, colorectal, lung, cervical and thyroid cancer are the most common among women.

The cancer burden continues to grow globally, exerting tremendous physical, emotional and financial strain on individuals, families, communities and health systems. Many health systems in low- and middle-income countries are least prepared to manage this burden, and large numbers of cancer patients globally do not have access to timely quality diagnosis and treatment. In countries where health systems are strong, survival rates of many types of cancers are improving thanks to accessible early detection, quality treatment and survivorship care.

KEY FACTS

- Approximately 70% of deaths from cancer occur in low- and middle-income countries.
- Cancer is the second leading cause of death globally, and is responsible for about 10 million deaths per year. Globally, about 1 in 6 deaths is due to cancer. (1)
- Around one-third of deaths from cancer are due to tobacco use, high body mass index, alcohol use, low fruit and vegetable intake, and lack of physical activity.
- Tobacco use is the most important risk factor for cancer and is responsible for approximately 25% of cancer deaths (2).
- Cancer-causing infections, such as hepatitis and human papillomavirus (HPV), are responsible for approximately 30% of cancer cases in low- and lower-middle-income countries (3).

- Late-stage presentation and lack of access to diagnosis and treatment are common, particularly in low- and middle-income countries. Comprehensive treatment is reportedly available in more than 90% of high-income countries but less than 15% of low-income countries. (4)
- The economic impact of cancer is significant and increasing. The total annual economic cost of cancer in 2010 was estimated at US$ 1.16 trillion (5).
- Only 1 in 3 countries reported high quality cancer incidence data in 2019 (6).

Cancer is a generic term for a large group of diseases that can affect any part of the body. Other terms used are malignant tumors and neoplasms. **One defining feature of cancer is the rapid creation of abnormal cells that grow beyond their usual boundaries, and which can then invade adjoining parts of the body and spread to other organs, the latter process is referred to as metastasizing. Metastases are a major cause of death from cancer.**

The problem

Cancer is a leading cause of death worldwide, accounting for an estimated 9.6 million deaths in 2018. The most common cancers are:

- Lung (2.09 million cases)
- Breast (2.09 million cases)
- Colorectal (1.80 million cases)
- Prostate (1.28 million cases)
- Skin cancer (non-melanoma) (1.04 million cases)
- Stomach (1.03 million cases)

The most common causes of cancer death are cancers of:

- Lung (1.76 million deaths)
- Colorectal (862 000 deaths)
- Stomach (783 000 deaths)
- Liver (782 000 deaths)
- Breast (627 000 deaths)

What causes cancer?

Cancer arises from the transformation of normal cells into tumour cells in a multistage process that generally progresses from a pre-cancerous lesion to a malignant tumour. These changes are the result of the interaction between a person's genetic factors and 3 categories of external agents, including:

- physical carcinogens, such as ultraviolet and ionizing radiation;
- chemical carcinogens, such as asbestos, components of tobacco smoke, aflatoxin (a food contaminant), and arsenic (a drinking water contaminant); and
- biological carcinogens, such as infections from certain viruses, bacteria, or parasites.

WHO, through its cancer research agency, International Agency for Research on Cancer (IARC), maintains a classification of cancer-causing agents?

Ageing is another fundamental factor for the development of cancer. The incidence of cancer rises dramatically with age, most likely due to a build-up of risks for specific cancers that increase with age. The

overall risk accumulation is combined with the tendency for cellular repair mechanisms to be less effective as a person grows older.

Risk factors for cancers

Tobacco use, alcohol use, unhealthy diet, and physical inactivity are major cancer risk factors worldwide and are also the 4 shared risk factors for other noncommunicable diseases.

Some chronic infections are risk factors for cancer and have major relevance in low- and middle-income countries. Approximately 15% of cancers diagnosed in 2012 were attributed to carcinogenic infections, including Helicobacter pylori, Human papillomavirus (HPV), Hepatitis B virus, Hepatitis C virus, and Epstein-Barr virus[3].

Hepatitis B and C virus and some types of HPV increase the risk for liver and cervical cancer, respectively. Infection with HIV substantially increases the risk of cancers such as cervical cancer.

Reducing the Cancer Burden

Between 30–50% of cancers can currently be prevented by avoiding risk factors and implementing existing evidence-based prevention strategies. The cancer burden can also be reduced through early detection of cancer and management of patients who develop cancer. Many cancers have a high chance of cure if diagnosed early and treated adequately.

Modify and avoid risk factors

Modifying or avoiding key risk factors can significantly reduce the burden of cancer. These risk factors include:

- tobacco use including cigarettes and smokeless tobacco
- being overweight or obese
- unhealthy diet with low fruit and vegetable intake
- lack of physical activity
- alcohol use
- sexually transmitted HPV-infection
- infection by hepatitis or other carcinogenic infections
- ionizing and ultraviolet radiation
- urban air pollution
- indoor smoke from household use of solid fuels.
- Tobacco use is the single most important risk factor for cancer and is responsible for approximately 22% of cancer-related deaths globally[2].

Pursue Prevention Strategies

To prevent cancer, people may:

- increase avoidance of the risk factors listed above;
- vaccinate against HPV and hepatitis B virus;
- control occupational hazards;
- reduce exposure to ultraviolet radiation;
- reduce exposure to ionizing radiation (occupational or medical diagnostic imaging).
- Vaccination against these HPV and hepatitis B viruses could prevent 1 million cancer cases each year.

Early Detection

Cancer mortality can be reduced if cases are detected and treated early. There are 2 components of early detection:

Early Diagnosis

When identified early, cancer is more likely to respond to effective treatment and can result in a greater probability of surviving, less morbidity, and less expensive treatment. Significant improvements can be made in the lives of cancer patients by detecting cancer early and avoiding delays in care.

Early diagnosis consists of 3 steps that must be integrated and provided in a timely manner:

- awareness and accessing care
- clinical evaluation, diagnosis and staging
- access to treatment.

Early diagnosis is relevant in all settings and the majority of cancers. In absence of early diagnosis, patients are diagnosed at late stages when curative treatment may no longer be an option. Programmes can be designed to reduce delays in, and barriers to, care, allowing patients to access treatment in a timely manner.

Screening

Screening aims to identify individuals with abnormalities suggestive of a specific cancer or pre-cancer who have not developed any symptoms and refer them promptly for diagnosis and treatment.

Screening programmes can be effective for select cancer types when appropriate tests are used, implemented effectively, linked to other steps in the screening process and when quality is assured. In general, a screening programme is a far more complex public health intervention compared to early diagnosis.

ASSESMENT

- **Physical exam.** Your doctor may feel areas of your body for lumps that may indicate a tumor. During a physical exam, he or she may look for abnormalities, such as changes in skin color or enlargement of an organ, that may indicate the presence of cancer.
- **Laboratory tests.** Laboratory tests, such as urine and blood tests, may help your doctor identify abnormalities that can be caused by cancer. For instance, in people with leukemia, a common blood test called complete blood count may reveal an unusual number or type of white blood cells.
- **Imaging tests.** Imaging tests allow your doctor to examine your bones and internal organs in a noninvasive way. Imaging tests used in diagnosing cancer may include a computerized tomography (CT) scan, bone scan, magnetic resonance imaging (MRI), positron emission tomography (PET) scan, ultrasound and X-ray, among others.
- **Biopsy.** During a biopsy, your doctor collects a sample of cells for testing in the laboratory. There are several ways of collecting a sample. Which biopsy procedure is right for you depends on your type of cancer and its location? In most cases, a biopsy is the only way to definitively diagnose cancer.
- In the laboratory, doctors look at cell samples under the microscope. Normal cells look uniform, with similar sizes and orderly organization. Cancer cells look less orderly, with varying sizes and without apparent organization.

Examples of screening methods are:

- visual inspection with acetic acid (VIA) for cervical cancer in low-income settings;
- HPV testing for cervical cancer;

- PAP cytology test for cervical cancer in middle- and high-income settings; and
- mammography screening for breast cancer in settings with strong or relatively strong health systems.

Methods of TREATMENT

A correct cancer diagnosis is essential for adequate and effective treatment because every cancer type requires a specific treatment regimen that encompasses one or more modalities such as surgery, radiotherapy, and chemotherapy. Determining the goals of treatment and palliative care is an important first step, and health services should be integrated and people-centred. The primary goal is generally to cure cancer or to considerably prolong life. Improving the patient's quality of life is also an important goal. This can be achieved by supportive or palliative care and psychosocial support.

Potential for cure among early detectable cancers

Some of the most common cancer types, such as breast cancer, cervical cancer, oral cancer, and colorectal cancer have high cure rates when detected early and treated according to best practices.

Potential for cure of some other cancers

Some cancer types, even when cancerous cells have traveled to other areas of the body, such as testicular seminoma and leukaemias and lymphomas in children, can have high cure rates if appropriate treatment is provided.

Palliative care

Palliative care is treatment to relieve, rather than cure, symptoms caused by cancer and improve the quality of life of patients and their families. Palliative care can help people live more comfortably. It is an urgent humanitarian need for people worldwide with cancer and other chronic fatal diseases and particularly needed in places with a high proportion of patients in advanced stages of cancer where there is little chance of cure.

Relief from physical, psychosocial, and spiritual problems can be achieved in over 90% of advanced cancer patients through palliative care.

Palliative care strategies

Effective public health strategies, comprising of community- and home-based care are essential to provide pain relief and palliative care for patients and their families in low-resource settings.

Improved access to oral morphine is mandatory for the treatment of moderate to severe cancer pain, suffered by over 80% of cancer patients in terminal phase.

In the most basic terms, cancer refers to cells that grow out-of-control and invade other tissues. Cells become cancerous due to the accumulation of defects, or mutations, in their DNA. Certain:

- inherited genetic defects (for example, BRCA1 and BRCA2 mutations),
- infections,
- environmental factors (for example, air pollution), and
- poor lifestyle choices -- such as smoking and heavy alcohol use -- can also damage DNA and lead to cancer.

INTERVENTION

Adjuvant treatment. The goal of adjuvant therapy is to kill any cancer cells that may remain after primary treatment in order to reduce the chance that the cancer will recur.

Palliative treatment. Palliative treatments may help relieve side effects of treatment or signs and symptoms caused by cancer itself. Surgery, radiation, chemotherapy and hormone therapy can all be used to relieve signs and symptoms.

Surgery. The goal of surgery is to remove the cancer or as much of the cancer as possible.

Chemotherapy. Chemotherapy uses drugs to kill cancer cells.

Radiation therapy. Radiation therapy uses high-powered energy beams, such as X-rays, to kill cancer cells. Radiation treatment can come from a machine outside your body (external beam radiation), or it can be placed inside your body (brachytherapy).

Bone marrow transplant. Bone marrow transplant is also known as a stem cell transplant. Your bone marrow is the material inside your bones that makes blood cells. A bone marrow transplant can use your own cells or cells from a donor.

Immunotherapy. Immunotherapy, also known as biological therapy, uses your body's immune system to fight cancer.

Hormone therapy. Some types of cancer are fueled by your body's hormones. Examples include breast cancer and prostate cancer. Removing those hormones from the body or blocking their effects may cause the cancer cells to stop growing.

Targeted drug therapy. Targeted drug treatment focuses on specific abnormalities within cancer cells that allow them to survive.

Clinical trials. Clinical trials are studies to investigate new ways of treating cancer. Thousands of cancer clinical trials are underway.

Psychological Intervention

DABDA

Denial Anger Bargaining Depression Acceptance

Social Intervention

- Belongingness
- Social awareness

HERPES

The herpes simplex virus, also known as HSV, is an infection that causes herpes. Herpes can appear in various parts of the body, most commonly on the genitals or mouth. There are two types of the herpes simplex virus:

- HSV-1: primarily causes oral herpes, and is generally responsible for cold sores and fever blisters around the mouth and on the face.

- HSV-2: primarily causes genital herpes, and is generally responsible for genital herpes outbreaks.

What causes herpes simplex?

The herpes simplex virus is a contagious virus that can be transmitted from person to person through direct contact. Children will often contract HSV-1 from early contact with an adult who has an infection. They then carry the virus with them for the rest of their lives.

HSV-1

HSV-1 can be contracted from general interactions such as:

- eating from the same utensils
- sharing lip balm
- kissing

The virus spreads more quickly during an outbreak. An estimated 67 percent Trusted Source of people ages 49 or younger are seropositive for HSV-1, though they may never experience an outbreak. It's also possible to get genital herpes from HSV-1 if someone who performed oral sex had cold sores during that time.

HSV-2

HSV-2 is contracted through forms of sexual contact with a person who has HSV-2. An estimated 20 percent of sexually active adults in the United States have an infection with HSV-2, according to the American Academy of Dermatology (AAD). HSV-2 infections are spread through contact with a herpes sore. In contrast, most people get HSV-1 from a person with an infection who is asymptomatic, or does not have sores.

Who is at risk of developing herpes simplex infections?

Anyone can contract HSV, regardless of age. Your risk is based almost entirely on exposure to the infection.

In cases of sexually transmitted HSV, people are more at risk when they have sex not protected by condoms or other barrier methods.

Other risk factors for HSV-2 include:

- having multiple sex partners
- having sex at a younger age
- being female
- having another sexually transmitted infection (STI)
- having a weakened immune system
- If a pregnant woman is having an outbreak of genital herpes at the time of childbirth, it can expose the baby to both types of HSV, and may put them at risk for serious complications.

Recognizing the signs of herpes simplex

It's important to understand that someone may not have visible sores or symptoms and still have an infection. They may also transmit the virus to others. Some of the symptoms associated with this virus include:

- blistering sores (in the mouth or on the genitals)
- pain during urination (genital herpes)
- itching

You may also experience symptoms that are similar to the flu. These symptoms can include:

- fever
- swollen lymph nodes

- headaches
- tiredness
- lack of appetite

HSV can also spread to the eyes, causing a condition called herpes keratitis. This can cause symptoms such as eye pain, discharge, and a gritty feeling in the eye.

How is herpes simplex diagnosed?

This type of virus is generally diagnosed with a physical exam. Your doctor may check your body for sores and ask you about some of your symptoms.Doctor may also request HSV testing. This is known as a herpes culture. It will confirm the diagnosis if you have sores on your genitals. During this test, your doctor will take a swab sample of fluid from the sore and then send it to a laboratory for testing.

Blood tests for antibodies to HSV-1 and HSV-2 can also help diagnose these infections. This is especially helpful when there are no sores present.Alternatively, at-home testing for Herpes Simplex is available. You can buy a test kit online from

How is herpes simplex treated?

There is currently no cure for this virus. Treatment focuses on getting rid of sores and limiting outbreaks.It's possible that your sores will go away without treatment. However, your doctor may determine you need one or more of the following medications:

- acyclovir
- famciclovir
- valacyclovir

These medications can help people with an infection reduce the risk of transmitting the virus to others. The medications also help to lower the intensity and frequency of outbreaks.

These medications may come in oral (pill) form, or may be applied as a cream. For severe outbreaks, these medications may also be administered by injection.

What is the long-term outlook for herpes simplex?

People who contract HSV will have the virus for the rest of their lives. Even if it does not manifest symptoms, the virus will continue to live in nerve cells.

Some people may experience regular outbreaks. Others will only experience one outbreak after they contract the virus, and then the virus may become dormant. Even if a virus is dormant, certain stimuli can trigger an outbreak. These include:

- stress
- menstrual periods
- fever or illness
- sun exposure or sunburn

It's believed that outbreaks may become less intense over time because the body starts creating antibodies. If a generally healthy person is contracting the virus, there are usually no complications.

Preventing the spread of herpes simplex infections

- Although there is no cure for herpes, you can take measures to avoid contracting the virus, or to prevent transmitting HSV to another person.
- If you're experiencing an outbreak of HSV-1, consider taking a few preventive steps:
- Try to avoid direct physical contact with other people.
- Don't share any items that can pass the virus around, such as cups, towels, silverware, clothing, makeup, or lip balm.
- Don't participate in oral sex, kissing, or any other type of sexual activity during an outbreak.
- Wash your hands thoroughly and apply medication with cotton swabs to reduce contact with sores.
- People with HSV-2 should avoid any type of sexual activity with other people during an outbreak. If the person is not experiencing symptoms but has been diagnosed with the virus, a condom should be used during intercourse. But even when using a condom, the virus can still be passed to a partner from uncovered skin.
- Women who are pregnant and have an infection may have to take medication to prevent the virus from infecting their unborn babies.

PSYCHOLOGICAL & SOCIAL INTERVENTIONS

- stress
- menstrual periods
- fever or illness
- sun exposure or sunburn
- unprotected Sex

STD

An infection transmitted through sexual contact, caused by bacteria, viruses or parasites.

Assesment

- Blood tests. Blood tests can confirm the diagnosis of HIV or later stages of syphilis.
- Urine samples.
- Fluid samples. If you have open genital sores, your doctor may test fluid and samples from the sores to diagnose the type of infection

Interventions

Antibiotics. Antibiotics, often in a single dose, can cure many sexually transmitted bacterial and parasitic infections, including gonorrhea, syphilis, chlamydia and trichomoniasis. ...

Antiviral drugs.

Special Interventions

1) Drug licensure and uptake of immunization against STD

(2) validation of male circumcision as a potent prevention tool against acquisition of HIV and some other sexually transmitted infections (STIs)

(3) encouragement about the use of antiretroviral agents as preexposure to reduce risk of HIV and herpes simplex virus acquisition

(4) enhanced emphasis on expedited partner management and rescreening for persons infected

(5) recognition that behavioral interventions will be needed to address a new trend of sexually transmitted hepatitis C among men who have sex with men

Liver Disease/ Disorders

There are many kinds of liver diseases:

- Diseases caused by viruses, such as hepatitis A, hepatitis B, and hepatitis C.
- Diseases caused by drugs, poisons, or too much alcohol. Examples include fatty liver disease and cirrhosis.
- Liver cancer.
- Inherited diseases, such as hemochromatosis and Wilson disease

ASSESMNET

- Blood tests. A group of blood tests called liver function tests can be used to diagnose liver disease. Other blood tests can be done to look for specific liver problems or genetic conditions.
- Imaging tests. An ultrasound, CT scan and MRI can show liver damage.
- Tissue analysis. Removing a tissue sample (biopsy) from your liver may help diagnose liver disease and look for signs of liver damage. A liver biopsy is most often done using a long needle inserted through the skin to extract a tissue sample. It is then analyzed in a laboratory.

INTERVENTION

liver problems can be treated with lifestyle modifications, such as stopping alcohol use or losing weight, typically as part of a medical program that includes careful monitoring of liver function. Other liver problems may be treated with medications or may require surgery.

GENDERSENSITISATION:

Sex indicates biological characteristics of man and woman.

Gender indicates the characteristics, positions and roles of man and woman in all social relationships

Difference Between Gender and Sex

SEX- Biologically determined • Universal for all human beings • Unchanging • Inborn (by Birth)

GENDER - Constructed by society • Multi-faceted differs within and between cultures • Dynamic, changes over time • Acquired

what is GENDER SENSITIZATION?

- Modification of behaviour
- To behave in a manner which is sensitive to gender justice
- Changing behaviour and instilling empathy
- Helps people in examining their personal attitudes
- Against sexual harassment at workplace

Aim of Gendersensitzation

The aim of GS is to make people aware of the power relationship between men and women in the society and to understand the importance of affording men and women equal opportunities and treatment.

The Indian Society still have traditional minds like

- Male superior to female
- School dropouts
- Female eating the leftovers of the food of a male
- Serving the food first to the male in the family during dining
- Boys should't cry.
- Men don't cook food
- You should wear certain types of clothes to be safe.
- Women should take care of their families only
- Boys shouldn't mingle with girls.
- Married women should have children early.
- Men should look after the Finances and Women should take care of Home.

Gender stereotypes are the beliefs that people have about the characteristics of males and females. The content of stereotypes varies over cultures and over time. These expectations are often related to the roles that the sexes fulfill in the culture.

Gender inequality acknowledges that men and women are not equal and that gender affects an individual's living experience. These differences arise from distinctions in biology, psychology, and cultural norms. Some of these distinctions are empirically grounded while others appear to be socially constructed

This can be achieved by conducting various sensitization campaigns, workshop, program etc. sensitization in the domain of "humanities and social Sciences, is seen as "the awareness informed disposition or propensity to behave in a manner which is sensitive to gender justice and equality issues.

Constitutional Provisions

The Constitution of India contains various provisions, which provide for equal rights and opportunities for both men and women.

The salient features are:-

Article 14 guarantees that the State shall not deny equality before the law and equal protection of the laws;

Article 14 guarantees that the State shall not deny equality

Article 15 prohibits discrimination against any citizen on the ground of sex

Article 16 empowers the State to make positive discrimi-nation in favour of women and children

Article 17rovides for Equality of Opportunity in matters of public employment.

Article 23 prohibits trafficking in human beings and forced labour

Article 39 (a) and (d) enjoins the State to provide equal means of livelihood and equal pay for equal work

TRANSGENDER

"Transgender" is an umbrella term that describes people whose gender identity or expression does not match the sex they were assigned at birth. For example, a transgender person may identify as a woman despite having been born with male genitalia.

Transgender issues

Discrimination in Public Accommodations- Public accommodations are places accessible to the public, such as retail stores, restaurants, parks, hotels, libraries, movie theatres, and banks.

Discrimination in Employment- Transgender people experience pervasive discrimination at work. Between 13% and 47% of transgender workers report being unfairly denied a job,10 and 78% report being harassed, mistreated, or discriminated against at work.

Discrimination in Education -Schools, colleges are difficult places for transgender students as they regularly face discrimination, bullying, and harassment in elementary, secondary, and postsecondary institutions. In one survey, 40% of gender nonconfirming youth a reported being frequently harassed by their peers and 37% reported frequent verbal harassment and name calling.31 In another survey, 33% of all students reported frequently hearing anti-transgender slurs.32 The same study found that levels of physical and verbal harassment were very high among surveyed students (see Figure 5 on the next page). This harassment, bullying, and discrimination have a cumulative negative effect on education and achievement for transgender people:

Family Rejection

Trans people face discriminatory policies about health care coverage and discrimination from health care professionals.

- Fear of using public bathrooms is particularly prominent among trans people
- Sexual Abuse
- Filling out forms
- Social security issues
- Lack of welfare schemes
- Harassment
- Lack of asses to health insurance schemes
- Advocacy groups and health care professions can help them

Unit 3

SOCIAL WORK APPROACH TO A PATIENT LIVING WITH HIV INFECTION

TRUST

Patients have to either choose to trust their health care providers or to not seek care. Many medical encounters are episodic in nature and the need for trust is short lived. The patient will quickly know if the trust was warranted by whether or not the presenting complaint was successfully treated. Chronic diseases in general and HIV infection in particular are different. These conditions require lifelong treatment, and HIV is so complex that care is only provided by a relative handful of practitioners. Ongoing trust is essential to successful treatment. As a result, the concept of trust has received attention in both the HIV literature and the general health care literature.

The US Department of Health and Human Services (DHHS) Panel on Antiretroviral Guidelines Patients have to either choose to trust their health care providers or to not seek care. Many medical encounters are episodic in nature and the need for trust is short lived. The patient will quickly know if the trust was warranted by whether or not the presenting complaint was successfully treated. Chronic diseases in general and HIV infection in particular are different. These conditions require lifelong treatment, and HIV is so complex that care is only provided by a relative handful of practitioners. Ongoing trust is essential to successful treatment. As a result, the concept of trust has received attention in both the HIV literature and the general health care literature. The US Department of Health and Human Services (DHHS) Panel on Antiretroviral Guidelines

WHAT IS TRUST IN HEALTH CARE

Trust in physicians has been defined as the expectation of the patient that physicians (as well as nurses and ancillary personnel) act in a manner that keeps the patient's best interest as a priority.

The trusting patient is placed in a position of being hurt by the actions or inactions of another. The patient grants discretionary powers to doctors, clinicians, and health care institutions for the purpose of restoring health, including the saving of one's life.

Trust in the patient–physician interaction has also been described as a series of expectations. Patients expect that their health care provider will be competent and compassionate, will keep personal information private, and will act in a manner that is consistent with the patient's best interest.

Trust can take varied forms: (1) expectant trust is the mind-set the patient brings to the first encounter; (2) experiential trust develops from knowledge of the trusted over time; and (3) identification-based trust is formed on the basis of shared values

Trust and HIV Health Care Most of the studies on trust in medical settings concern general health care populations, with few studies of patient trust focusing on patients living with HIV/AIDS. This is perhaps surprising, given the extraordinary need of patients living with HIV/ AIDS to closely follow their physicians' directions. Poor adherence to care can have severe consequences for both the patient and the community, including disease progression and the spread of drug-resistant virus. Whetten and colleagues noted the lack of peer-reviewed literature on trust and HIV care and conducted a study that assessed the level of trust that.
We can all suffer from low self-esteem or experience self-confidence problems at times in our lives, but if you're living with HIV, you're more likely to struggle with these.

How can my HIV diagnosis affect my mental health?

If you've experienced low self-esteem, anxiety or depression before your HIV diagnosis, receiving your diagnosis may have made your symptoms worse. Even if you've enjoyed good mental health, an HIV diagnosis can still cause shock and trauma, and often requires some adjustment.

Worries about your future, health, body image and telling people that you're HIV positive are all common. Feeling ashamed or guilty about your HIV status can stop you from taking an active role in society, isolating you and preventing you from living a full and enjoyable life.

Stigma and lack of understanding around HIV can be demoralising, and media stories can be both positive and negative. This can lead to a constant reminder that you're now 'different' in some way.

What are the long-term consequences of low confidence?

- When you're low on self-confidence, you can feel trapped and unable to progress with your life. Your energy decreases and your mood are affected.
- Perhaps you feel that your life isn't worth investing in or that you simply don't have the ability, money or looks to achieve what you think others have managed to do.
- Social media can add enormous pressures, especially for younger people, who may also be experiencing cyberbullying.
- Self-confidence can also impact upon your relationships with others and you may not feel confident enough to discuss your HIV status with anyone. It's really useful to think carefully about disclosure and decide who will be most supportive and at what time.
- Difficult feelings are perfectly normal, but if you can find a way to overcome them and improve your self-esteem, you'll be happier.
- You're also likely to be healthier as you take control of your life and what you want out of it.

How to make them more confident?

- If they lack in confidence will prevent you from talking about your HIV status with your loved ones, it could be useful to explore ways to better adapt to your situation.
- Talking and socializing with your friends and family can be a good way to boost your confidence.
- If you're on your own or don't have close family or friends, seeing a registered counsellor or psychotherapist can really help to make sense of what has happened in your past and to make some decisions about the present.
- Taking some time to look at all of the things achieved and the problems you have overcome is a good starting point to give yourself a lift.
- They could also try making contact with support groups for HIV positive people. These can be a good place to talk in safe surroundings with like-minded people. Workshops that aim to give you skills to boost your confidence and self-esteem could also be useful.

How to improve your self-esteem

1. **Think about when you did something new for the first time**

Learning something new often goes together with feelings of nervousness, lack of self-belief and high levels of stress – but these feelings are all normal, and are a crucial part of the learning process.

The next time you feel under-confident, try to remember the last time you did something new: when you started a new job, joined a class or built up the courage to go to the gym for the first time. Remembering this

will remind you that it's perfectly normal to feel stress or think you're less than capable when learning something new.

2. **Do something you've been procrastinating about**

Phone or write to a friend, clean the house, tidy up the garden, mend your bike, organise your bills, make a tasty and healthy meal – do anything that involves you making a decision, committing to it and then completing the task.

The sense of accomplishment they will feel is a building block to greater self-confidence and esteem.

3. Make them to do something good at

Swimming, running, hiking, dancing, cooking, gardening, climbing, painting, writing... If possible, it should be something that holds your attention and requires enough focus to get you into that state of 'flow', or relaxed concentration, where you forget about everything else. You'll feel more competent and capable afterwards.

Seriously consider doing something like this at least once a week. People who experience 'flow' regularly seem to be happier and healthier and find it easier to focus on a task.

4. Do something for others

Low self-esteem is often accompanied by too much negative focus on the self. Doing something that absorbs you and holds your attention can quickly make you feel better.

Helping others is a great way of shifting your focus into a more positive direction. Consider volunteering with us – we'd be happy to have you!

5. **Learn to relax**

Some people do this by exercising, others by involving themselves in something else that occupies their thoughts, like reading or watching television.

Being able to relax whenever you want is a fantastic life skill. Learning to practise mindfulness meditation or a physically-based relaxation technique such as gentle yoga can be incredibly useful.

The life of the person who finds they are infected with the immunodeficiency virus is transformed after the diagnosis. And, given the stigma of the disease, confidentiality is the way to ensure privacy when facing this condition. Through an integrative review of the literature, this study aimed to identify how confidentiality has been addressed in the care of people with HIV/AIDS. Nineteen national and international scientific publications, published between 2010 and 2015, were selected in open access databases. Studies have pointed out that stigma, prejudice and discrimination permeate the lives of HIV-positive people, who are constantly living in fear of being discovered. In addition, it has been found that discrimination is present even among health professionals and that breaking confidentiality usually leads the patient to abandon treatment. Therefore, preserving the privacy and confidentiality of the person with HIV/AIDS is the duty of professionals and represents a challenge in the information age

In the 21st century, in the face of so many technological advances that allow us to intervene in the various peculiarities of human beings, in a world where the impossible is becoming extinct and the interpretation of social norms is becoming more flexible, distinguishing what is good from bad and setting ethical limits on people's actions is increasingly complex[1] . In the area of health, scientific development expands the set of information that enable care to be given to users of the services. Amongst this information, there are those of a confidential nature that, although they are the exclusive property of the patient, must be provided to professionals in order to make care effective. In this context, new technologies further increase the risk of misuse of such information[2,3]. Ethics are fundamental not only for good social interaction, but also for the practice of professionals, especially those who deal directly with human beings[4] . Among all the conditions that health professionals have to deal with in their daily practice, confidentiality is one of the most relevant from an ethical point of view, since it guarantees the privacy of technical and personal information. Maintaining professional confidentiality is one of the moral precepts in health[5] . Confidentiality should motivate professionals to develop appropriate conduct, avoiding embarrassment to users[6] . Privacy, therefore, would be a form of "individual protection"[7] . The emergence of acquired immunodeficiency syndrome (AIDS) and its rapid spread has shaken the world, testing our ability to deal with a previously unknown disease. Given the unknown and the mortality rates caused by the disease, the diagnosis of the human immunodeficiency virus (HIV) became a landmark in the lives of those infected[9] , since it also implied social discrimination. Consequently, in order to protect themselves against intolerance and aggression, people living with HIV/AIDS (PLWHA) often choose not to expose their health status[10]. Because it is a communicable disease, AIDS leads the person to suffer some public interest implications, with the possibility of breaking the secrecy of their serology[11]. In the face of such conflicting situations involving PLWHA, how can physicians maintain ethical behavior? Under what circumstances should professional secrecy be preserved, and what may or may not be said without characterizing breach of confidentiality? Under what circumstances should confidentiality be violated? What are the limits of the duty to preserve confidentiality? Are Rosenthal and Scheffer right to say that there will be no ethics as long as prejudice prevails

Confidentiality

As a legal term, *confidentiality* refers to a duty of an individual to refrain from sharing confidential information with others, except with the express consent of the other party. There are rules and regulations which place restrictions on the circumstances in which a professional, such as a doctor or attorney, may divulge information about a client or patient, and other situations may be deemed confidential by the use of a contract. To explore this concept, consider the following confidentiality definition.

1. Something told in confidence, or in secret
2. The state of knowledge being held in confidence
3. The state of trusting another individual with private affairs or secrets

What is Confidentiality

Confidentiality is the keeping of another person or entity's information private. Certain professionals are required by law to keep information shared by a client or patient private, without disclosing the information, even to law enforcement, except under certain specific circumstances. The principle of confidentiality is most commonly expected in the medical field, and the legal field.

Other businesses have a right to expect employees or other business associates to maintain confidentiality. This type of discretion is not automatically assumed, but requires an express agreement between the parties that such information will be kept secret, usually in the form of a signed confidentiality agreement.

Responsibility to Keep Client Information Confidential

Confidentiality means that information shared within a relationship will not be shared outside that relationship. The expectation is that what a client tells a social worker, the social worker will not reveal to others. The purpose of client confidentiality is to encourage clients to share information that may be embarrassing, or even self-incriminating. Through the sharing of such information, the social worker can help the client address an issue, concern, or problem the client may be experiencing. The social worker's obligation to keep client information confidential is supported through state and federal law, but most often is discussed in reference to the NASW Code of Ethics.

In the NASW Code of Ethics (NASW, 2008), Standard 1.07 outlines that social workers "should respect client's right to privacy" (1.07[a]) by protecting "confidentiality of all information obtained in the course of professional service, except for compelling professional reasons" (1.07[b]). So, is the legal requirement to report suspected child maltreatment a "compelling professional reason" to break client confidentiality? And the simple answer is "yes."

Although a social worker's primary commitment is to his or her client, the Code outlines that social workers have a responsibility to the larger society as well. In Standard 1.01, the Code acknowledges there are times when the social worker's responsibility to society at large, or a specific legal obligation of the social worker, may supersede loyalty to a client. The example of child abuse reporting is specifically highlighted in this standard.

So, the legal requirement of all social workers to report suspected child maltreatment trumps the responsibility to keep client confidences quiet. The NASW Code and related laws all find this to be so.

The Importance of Informed Consent

Balancing the ethical responsibility to protect client confidentiality and the legal obligation to protect children from harm is difficult, even for social workers with decades of experience! So, how do you actually do this? First things first, you start at the beginning of the relationship with your client by incorporating a discussion of the limits to client confidentiality with your client through informed consent.

Informed consent is the process through which social workers discuss with clients the nature of the social worker/client relationship. Through informed consent, the social worker and client outline what the client can expect from the professional relationship, as well as what the social worker expects from the client's participation.

Informed consent often includes a discussion of basic protocols, such as how to make or cancel appointments, or the best way to contact the social worker. The process should also involve outlining what work will be done with and for the client, and what expectations there are for client involvement. Integral to the informed consent process is a discussion of client confidentiality.

Using simple language, appropriate to the developmental and language needs of the client, the social worker needs to explain to the client that he or she will generally keep information private, but that there are specific instances when the social worker is required to break client confidentiality. It is at this point that the social worker should highlight that if he or she suspects child maltreatment based on information received from the client, the social worker must break client confidentiality to make a report of the suspicion to child protective services.

It is important to clarify with the client that this means that the social worker may have to report suspected child abuse or neglect based on what the client says, even if the client is neither the victim nor the perpetrator. In other words, the social worker may (depending on the state where he or she resides*) have to make a report involving people he or she has never met.

In some agencies or practice settings, informed consent involves the client signing a form that acknowledges receipt of certain information. Although a written tool is a good idea, it is important that there be additional methods for ensuring informed consent.

In all cases, with or without written informed consent tools, the social worker and client should discuss, face-to-face, expectations for confidentiality and when confidentiality will be breached. The social worker should use language the client can understand. So, the social worker can say that he or she will keep information "private" or "between the two of us." But it is very important that the social worker make it clear that there may be times when the "private" information will be shared with others. Basic language can be used, such as, "I will have to share this private information if I think that you are going to hurt yourself, or hurt someone else, or if I think someone may be hurting you or someone else."

As with other forms of communication with clients, it is important to ensure that the client understands what you outline through informed consent. With child clients, or clients with impaired cognitive ability, you can start by asking them if they understand, but it is best to follow up. You can ask a question like, "If a boy told me that his mother was hurting him, would I keep that private?" And then explain who you would report to and why, highlighting that child protective services would then help protect that person from being hurt again.

It is possible that by explaining to your client the limits of confidentiality, the client may choose not to disclose information that would warrant you to make a report to child protective services. It is important to remember that it is the client's right to choose what information to share with you. That is part of the client's right to "self-determination" (NASW Code, Standard 1.02).

State and federal laws prohibit the disclosure of a person's HIV status, except in limited instances. Maintaining the privacy of a person's HIV status is important because discrimination against people living with HIV is still pervasive. People will only get tested and treated for HIV if they know their test results and treatment records will be kept private.

Social work approach to aPerson living withHiv infection

- Initial Assessment
- History Taking and
- Intervention

Initial assessment of HIV

The initial assessment of the patient with HIVdisease requires clinical staging, identification of HIV-relatedand nonrelated illness, discussion of specific psychosocialissues, initiation of the process of patient education, andinitiation of a sustained partnership between patient andclinician.The clinical content of the assessment depends onknowledgeable history-taking, focused physical examination,and specific laboratory tests.

The medical history and physical exam are done right aftera person has been diagnosed with HIV infection (a positiveELISA test and detection of HIV RNA or DNA). Athorough physical exam will provide information about yourpresent state of health.

Types of tests of HIV

There are threetypes of HIVdiagnostic tests: nucleic acidtests (NAT), antigen/antibody tests,and antibody tests.

- NATs look for the actual virus inthe blood. ...

- Antigen/antibody tests look for bothHIV antibodies and antigens. ...
- Antibody tests look for antibodies toHIV in your blood or oral fluid.

Medical history

1. Do you have an increased risk for developing HIV? You have anincreased risk of developing HIV if you:

- Are a man who has sex with men.
- Have more than one sex partner
- Inject drugs or steroids, especially if you share needles, syringes
- Have high-risk partner(s) (a man or woman who has multiple separtners or injects drugs, or a man who has sex with men).
- Have recently had a sexually transmitted infection

2. Have you ever had symptoms such as fever, weight loss, shortness

of breath, or diarrhea?

3. Have you ever had tuberculosis , fungal or yeast infections, liver

infection (hepatitis), cold sores (oral herpes), or any other sexually

transmitted diseases?

4. Are you a caregiver, such as a partner or parent, of a person who

is HIV-positive and has hemophilia?

Physical Examination

The doctor will do a complete physical exam to find out the present state of health. This

may include the following exams:

- **Temperature**. Fevers are common in people who have HIV, even when no othersymptoms are present. Fever can sometimes be a sign of a certain kind of infecction orcancer
- **Weight**.. A loss of 10% or more of your body weight may be a result of wastingsyndrome, which is one of the signs of AIDS, the last and most severe stage of HIVinfection.
- **Eyes**.Cytomegalovirus (CMV) retinitis is a common complication of AIDS. It occurs morefrequently in people who have a CD4+cell count of less than 100 cells per microliter(mcL). Symptoms include seeing floaters, blurred vision, or loss of vision. Some doctorsrecommend ophthalmologist visits every 3 to 6 months
- **Mouth**. Oral yeast infections and other mouth sores are very common in people who areHIV-infected. You should have a dental exam at least twice a year.
- **Lymphnodes**. A biopsy may be considered if lymph nodes are getting larger
- **Abdomen**. The abdominal exam may show an enlarged liver (hepatomegaly) orenlarged spleen (splenomegaly). These conditions can be caused by new infections ormay indicate cancer.
- **Skin**. Skin problems are common for people with HIV infection.
- **Gynecologic**. Women who are HIV-infected have more cervical cell abnormalities thanwomen who do not have HIV. These cell changes can be detected with a pap test.

Result of the Tests

The medical history and physical exam may provide the following results.

Normal

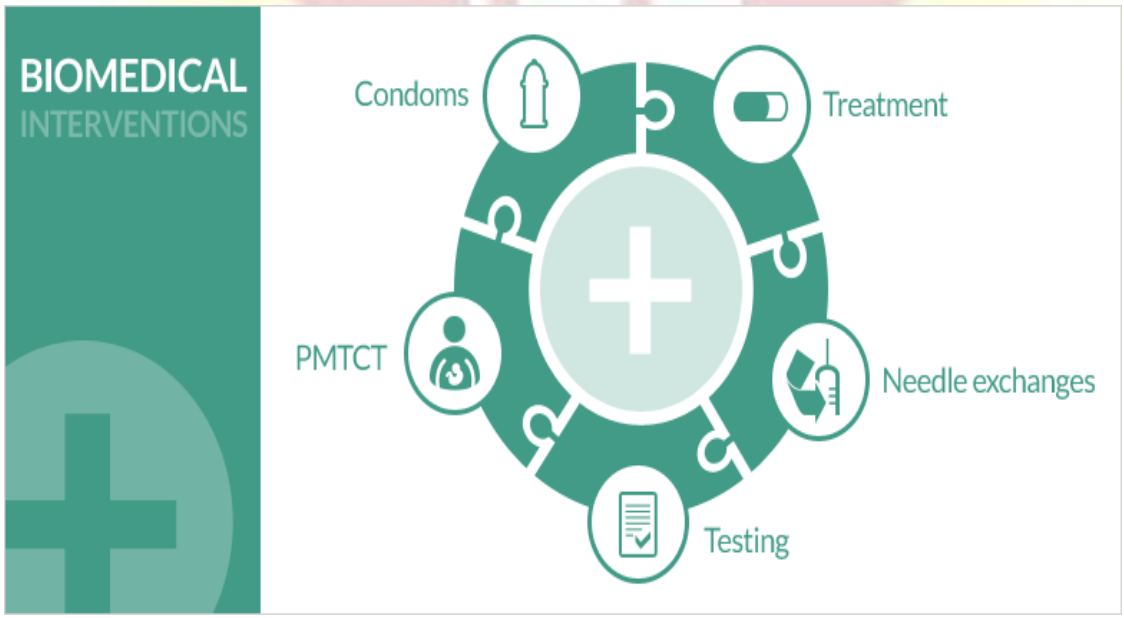
- No abnormalities are found. Then decide how often to schedule follow-upexams.
- The frequency of follow-up exams depends on symptoms of illness andinitial viral load and CD4+ cell count measurements.
- Follow-up exams may be done as often as every 3 to 6 months, possiblymore often, especially right after the start of medicine treatment.
- If in absence of symptoms but a high CD4+ cell count and a low viral load,the doctor will probably recommend the follow-up exams at least every 6months or sooner if symptoms of illness develop.

Abnormal

Signs of illness are found. Follow-up and treatment will depend on thespecific problem.

INTERVENTIONS

- HIV prevention programs are interventions that aim to haltthe transmission of HIV.
- HIV prevention programs usually focus on preventing thetransmission of HIV through a complementary combinationof behavioral, biomedical and structural strategies.
- Despite the progress made by prevention programs acrossthe globe, the decline in new HIV infections among adultshas slowed in the past decade, which indicates the need forincreased funding and scale up of services.
- For maximum impact, HIV prevention programs need to betargeted at high prevalence regions or 'hot spots',and alsomeet the needs of high-risk groups.



Effective HIV prevention programmes require a combination of behavioural, biomedical and structural interventions

CONCLUSION

- Living with any serious illness can impact onemotional health. People with HIV are morelikely to experience mental health problems.
- Healthcare professional may suggestmedication, including antidepressant drugs,or talking therapies, such as counselling orcognitive behaviour therapy (CBT).
- Talk to family and friends

Unit 4

Awareness Raising and Preventative Programmes.Demythologising HIV / AIDS. – Sex education – peer influence / pressure – Adolescent behaviour – Sex, Alcohol and Drugs interplay – Use of condoms, prevention and control of STDs, HIV / AIDS – Healthy Sexuality and reproductive behaviour and relationship gender equity. HIV infection and pregnancy.Needle and condom distribution.

Introduction

MEANING OF DEMYTHOLOGIZE.

- To eliminate all mythical elements from so as to arrive at an essential meaning.
- Demythologization as a hermeneutic approach to religious texts seeks to separate cosmological and historic claims from philosophical, ethical and theological teachings. Rudolf Bultmann introduced the term demythologization in this context, but the concept has earlier precedents.

7 MYTHS ABOUT HIV/AIDS

Many myths are still around about HIV and AIDS. Get the real story here -- it can help you enjoy a full, healthy life.

Myth 1: Treating HIV will require me to take dozens of pills every day.

Fact: Years ago, people with HIV needed to take a lot of pills. Now, most people starting on HIV treatment only take 1 to 4 pills daily. You may be able to take medicines that combine 2 or 3 drugs in a single pill.

Myth 2: I can wait to start taking medicine for my HIV.

Fact: You probably need to start taking HIV meds right away. Your doctor will talk to you about taking these drugs, whichj are called “antiretroviral treatment.” They limit the level of HIV virus in your body. This helps protect your immune system and lowers the chance that you’ll pass the virus to others.

Myth 3: Because I have HIV, I’m going to develop AIDS.

Fact: It’s possible that you’ll develop AIDS, the disease that HIV causes. But it’s also possible you won’t. If you begin taking HIV drugs promptly, they can help protect you from advancing to AIDS. In fact, it is possible that you will never dvelp AIDS and will achieve a near normal life span if you continue to take the drugs correctly.

Myth 4: If I’m on medication, I can’t spread HIV through sex.

Fact: Even if you are taking medication, you still have a risk of passing the virus to a sex partner, so use protection. If you take your HIV drugs properly, over time the level of virus in your blood may fall so low that your doctor will call it “undetectable.” At that point, experts believe that as long as you continue to take your medication there is little to no risk of transmission. However, remember that using condoms, in addition to protecting your partner, will also protect you from getting other strains of HIV and other sexually transmitted infections.

Myth 5: I should avoid exercise since I have HIV.

Fact: Exercise is a good way to protect your health when you have HIV. It can:

- Prevent fatigue
- Improve your appetite

- Lower your stress
- Maintain your muscles
- Protect your bones

Aim for 30 to 45 minutes of exercise a day. Get both aerobic and strength-training exercise.

Myth 6: I'm not going to live long enough to need to worry about other diseases.

Fact: Today, many people with HIV are living long lives. If you keep the virus under control with HIV medicine, you may live for many decades. In fact, those who adhere to their HIV treatments and maintain a healthy lifestyle can have the same life expectancy as someone who is not infected. But you may have a higher chance of problems including cancer, heart disease, and kidney disease. So follow the usual steps for good health:

- Take your medicines as prescribed
- Eat a healthy diet.
- Exercise.
- Don't smoke.

Some HIV medicines have side effects that can cause diarrhea and nausea. Talk to your doctor about whether your medicines should be taken with or without food, and about any side affects you might have. Don't stop your HIV medicines without talking with your doctor first. Also tell your doctor about any other medicines you're taking and any other health problems you have. HIV drugs can change how your other medicines work. They can also make controlling other health problems, like diabetes, more difficult.

Myth 7: Now that I have HIV, I can't have kids.

Fact: If you're a man with HIV, you may still be able to safely father a child. If you're a woman, you may still be able to safely become pregnant. Doctors can help you take steps to lower -- or remove -- the chance that you'll pass the virus to your partner during conception. If you're pregnant, your doctor will give you certain HIV drugs to protect you and your baby. The baby may also be given medication after birth.

Sex Education

''Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence

Sexual health is defined in terms of well-being, but is challenged by the social, cultural and economic realities faced by women and men with HIV. A sexual rights approach puts women and men with HIV in charge of their sexual health. Accurate, accessible information to make informed choices and safe, pleasurable sexual relationships possible is best delivered through peer education and health professionals trained in empathetic approaches to sensitive issues. Young people with HIV especially need appropriate sex education and support for dealing with sexuality and self-identity with HIV. Women and men with HIV need condoms, appropriate services for sexually transmitted infections, sexual dysfunction and management of cervical and anogenital cancers. Interventions based on positive prevention, that combine protection of personal health with avoiding HIV/STI transmission to partners, are recommended. HIV counselling following a positive test has increased condom use and decreased coercive sex and outside sexual contacts among discordant couples. HIV treatment and care have reduced stigma and increased uptake of HIV testing and disclosure of positive status to partners. High adherence to antiretroviral therapy and safer sexual behaviour must go hand-in-hand. Sexual health services have worked with peer educators and volunteer groups to reach those at higher risk, such as sex workers. Technological advances in diagnosis of STIs,

microbicide development and screening and vaccination for human papillomavirus must be available in developing countries and for those with the highest need globally. A2007 Reproductive Health Matters. All rights reserved.

HIV positive young people are a diverse group, differing in age, gender, sexual orientation, race and ethnicity, educational attainment, economic circumstances and cognitive abilities. They experience differing rates of mental illness, chemical dependency, social isolation and lack of economic opportunity. HIV positive youth are more likely to be female, men who have sex with men, from racial and ethnic minority populations, and from economically deprived groups than their HIV negative counterparts. High-risk sexual behavior is the dominant mode of HIV transmission among youth.

Sexual health and sexuality education for HIV positive adolescents and young people The impact of HIV therapies is particularly noteworthy among HIV-positive youth who have been infected perinatally or through blood products. Significant numbers of youth now treated in adolescent HIV clinics in the USA, for example, have ‘‘graduated’’ into these programmes from paediatric HIV clinics. Such longevity was unthinkable a decade ago, when most HIV positive children died before their tenth birthday. Further, people diagnosed during adolescence now survive well into their 20s, with many maturing into their 30s.6

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence to the highest attainable standard of sexual health, and to access to sexual and reproductive health care services.’’1 *

What is sex education?

To really understand the controversial subject of sex education, we must first know what it encompasses, and how it can actually benefit.

Sex education is a programme which educates and informs young individuals about sex, sexual health, sexuality, and sexual rights in an age-appropriate manner. It increases their awareness about their own body and that of the opposite gender.

Adolescents undergo various physical changes when they hit puberty, and often end up being embarrassed by it. Lack of information and misinformation make them self-conscious about physiological changes such as pubic hair, facial hair, developing body parts, etc. These changes make them prone to insecurities and vulnerable to low self-esteem. AEP quashes these doubts and confusion by preparing young individuals for what is to come.

When there is a supportive and understanding environment for children, they tend not to resort to pornography or random sites on the internet to learn about their own bodies. And most importantly, they learn to respect themselves and each other.

Drug Addiction

Drug addiction, also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substances such as alcohol, marijuana and nicotine also are considered drugs. When you're addicted, you may continue using the drug despite the harm it causes.

Drug addiction can start with experimental use of a recreational drug in social situations, and, for some people, the drug use becomes more frequent. For others, particularly with opioids, drug addiction begins with exposure to prescribed medications, or receiving medications from a friend or relative who has been prescribed the medication.

The risk of addiction and how fast you become addicted varies by drug. Some drugs, such as opioid painkillers, have a higher risk and cause addiction more quickly than others.

As time passes, you may need larger doses of the drug to get high. Soon you may need the drug just to feel good. As your drug use increases, you may find that it's increasingly difficult to go without the drug. Attempts to stop drug use may cause intense cravings and make you feel physically ill (withdrawal symptoms).

Symptoms

Drug addiction symptoms or behaviors include, among others:

- Feeling that you have to use the drug regularly — daily or even several times a day
- Having intense urges for the drug that block out any other thoughts
- Over time, needing more of the drug to get the same effect
- Taking larger amounts of the drug over a longer period of time than you intended
- Making certain that you maintain a supply of the drug
- Spending money on the drug, even though you can't afford it
- Not meeting obligations and work responsibilities, or cutting back on social or recreational activities because of drug use
- Continuing to use the drug, even though you know it's causing problems in your life or causing you physical or psychological harm
- Doing things to get the drug that you normally wouldn't do, such as stealing
- Driving or doing other risky activities when you're under the influence of the drug
- Spending a good deal of time getting the drug, using the drug or recovering from the effects of the drug
- Failing in your attempts to stop using the drug

Experiencing withdrawal symptoms when you attempt to stop taking the drug

Staging an intervention

People struggling with addiction usually deny that their drug use is problematic and are reluctant to seek treatment. An intervention presents a loved one with a structured opportunity to make changes before things get even worse and can motivate someone to seek or accept help.

An intervention should be carefully planned and may be done by family and friends in consultation with a doctor or professional such as a licensed alcohol and drug counselor, or directed by an intervention professional. It involves family and friends and sometimes co-workers, clergy or others who care about the person struggling with addiction.

During the intervention, these people gather together to have a direct, heart-to-heart conversation with the person about the consequences of addiction and ask him or her to accept treatment.

Causes

Like many mental health disorders, several factors may contribute to development of drug addiction. The main factors are:

- **Environment.** Environmental factors, including your family's beliefs and attitudes and exposure to a peer group that encourages drug use, seem to play a role in initial drug use.
- **Genetics.** Once you've started using a drug, the development into addiction may be influenced by inherited (genetic) traits, which may delay or speed up the disease progression.

Changes in the brain

Physical addiction appears to occur when repeated use of a drug changes the way your brain feels pleasure. The addicting drug causes physical changes to some nerve cells (neurons) in your brain. Neurons use chemicals called neurotransmitters to communicate. These changes can remain long after you stop using the drug.

Risk factors

People of any age, sex or economic status can become addicted to a drug. Certain factors can affect the likelihood and speed of developing an addiction:

- **Family history of addiction.** Drug addiction is more common in some families and likely involves genetic predisposition. If you have a blood relative, such as a parent or sibling, with alcohol or drug addiction, you're at greater risk of developing a drug addiction.
- **Mental health disorder.** If you have a mental health disorder such as depression, attention-deficit/hyperactivity disorder (ADHD) or post-traumatic stress disorder, you're more likely to become addicted to drugs. Using drugs can become a way of coping with painful feelings, such as anxiety, depression and loneliness, and can make these problems even worse.

- **Peer pressure.** Peer pressure is a strong factor in starting to use and misuse drugs, particularly for young people.
- **Lack of family involvement.** Difficult family situations or lack of a bond with your parents or siblings may increase the risk of addiction, as can a lack of parental supervision.
- **Early use.** Using drugs at an early age can cause changes in the developing brain and increase the likelihood of progressing to drug addiction.
- **Taking a highly addictive drug.** Some drugs, such as stimulants, cocaine or opioid painkillers, may result in faster development of addiction than other drugs. Smoking or injecting drugs can increase the potential for addiction. Taking drugs considered less addicting — so-called "light drugs" — can start you on a pathway of drug use and addiction.

Complications

Drug use can have significant and damaging short-term and long-term effects. Taking some drugs can be particularly risky, especially if you take high doses or combine them with other drugs or alcohol. Here are some examples.

- Methamphetamine, opiates and cocaine are highly addictive and cause multiple short-term and long-term health consequences, including psychotic behavior, seizures or death due to overdose.
- GHB and flunitrazepam may cause sedation, confusion and memory loss. These so-called "date rape drugs" are known to impair the ability to resist unwanted contact and recollection of the event. At high doses, they can cause seizures, coma and death. The danger increases when these drugs are taken with alcohol.
- Ecstasy or molly (MDMA) can cause dehydration, electrolyte imbalance and complications that can include seizures. Long-term, MDMA can damage the brain.
- One particular danger of club drugs is that the liquid, pill or powder forms of these drugs available on the street often contain unknown substances that can be harmful, including other illegally manufactured or pharmaceutical drugs.
- Due to the toxic nature of inhalants, users may develop brain damage of different levels of severity.

Other life-changing complications

Dependence on drugs can create a number of dangerous and damaging complications, including:

- **Getting a communicable disease.** People who are addicted to a drug are more likely to get an infectious disease, such as HIV, either through unsafe sex or by sharing needles.
- **Other health problems.** Drug addiction can lead to a range of both short-term and long-term mental and physical health problems. These depend on what drug is taken.
- **Accidents.** People who are addicted to drugs are more likely to drive or do other dangerous activities while under the influence.
- **Suicide.** People who are addicted to drugs die by suicide more often than people who aren't addicted.
- **Family problems.** Behavioral changes may cause marital or family conflict and custody issues.
- **Work issues.** Drug use can cause declining performance at work, absenteeism and eventual loss of employment.
- **Problems at school.** Drug use can negatively affect academic performance and motivation to excel in school.
- **Legal issues.** Legal problems are common for drug users and can stem from buying or possessing illegal drugs, stealing to support the drug addiction, driving while under the influence of drugs or alcohol, or disputes over child custody.
- **Financial problems.** Spending money to support drug use takes away money from other needs, could lead to debt, and can lead to illegal or unethical behaviors.

Prevention

The best way to prevent an addiction to a drug is not to take the drug at all. If your doctor prescribes a drug with the potential for addiction, use care when taking the drug and follow the instructions provided by your doctor.Doctors should prescribe these medications at safe doses and amounts and monitor their use so that you're not given too great a dose or for too long a time. If you feel you need to take more than the prescribed dose of a medication, talk to your doctor.

Equality

- Equality has to do with giving everyone the exact same resources, whereas equity involves distributing resources based on the needs of the recipients.
- Equality mean each individual or group of people is given the same resources are opportunities it recognises that each person has different circumstances and unlock it’s their exact resources and opportunities needed to reach and equal outcome

EQUITY vs EQUALITY

Equity as we have seen in was trying to understand and give people what they need to enjoy full healthy lines Equality in contrast aims to ensure that everyone gets the same things in order to enjoy full healthy life

Gender Equity

- Gender equity means that men and women are treated fairly they have equal rights and representation both participate in decision-making and receive the fair share of benefits and cost. women and young girls continue to be disproportionately affected by HIV Around the World.
- Financial disparities and intimate partner violence in relationship of an hinder in its ability to negotiate condom use and protect herself from HIV.
- Gender inequality in education and restricted social economy among women is directed into lower access to sexual health services including HIV testing and treatment.
- Although commitments to reduce their effects of gender inequality have been made by the international community there is a need t
- o significantly scale up efforts as social injustices and violence against women continue to persist across the globe.
- Despite progress in many aspects of global HIV response women particularly adolescent girls and young women continue to be disproportionately affected by HIV women constitute more than half of half of all people living with HIV AIDS related in nurses are the leading cause of death among women of reproductive age globally.
- Gender inequalities include gender based and intimate partner violence excess belt women and girls physiological vulnerability to HIV and block their access to HIV services.
- HIV not only driven by gender inequality but it also in trenches gender inequality leaving them and more vulnerable to its impact.
- The gender inequalities in some regions result in and events Take difference between the way HIV affect men and women .Young women will acquire HIV 5 to 7 years earlier than their male peers this equates to 4500 among new HIV infections among Young women every week in 2015 double the number in young men.
- The power imbalance between genders also means that many Young women not able to make decisions about their own lives.
- In the HIV AIDS epidemic gender defined as the array of societal believes norms customs and practices that define masculine and feminine and attributes and behaviors play an integral role in determining an individual's vulnerability infection his or her ability to access care support or treatment and ability to cope when infected or affected.

Equity and rights

Gender plays an important role in determining a woman's vulnerability to HIV infection and violence and her ability to access treatment, care and support and to cope when infected or affected. The current scope of HIV interventions and policies needs to be expanded to make gender equity a central component in the fight against HIV. All women have the same rights concerning their reproduction and sexuality, but women living with HIV/AIDS require additional care and counselling during their reproductive life. HIV infection accelerates the natural history of some reproductive illnesses, increases the severity of others and adversely affects the ability to become pregnant. Moreover, infection with HIV affects the sexual health and well-being of women

HIV and sexual health

Sexual and reproductive health of women living with HIV /AID S Complex factors affect whether women's expression and experience of sexuality lead to sexual health and well-being or place them at risk of ill-health. Highquality programmes and services that address sexuality positively and promote the sexual health of women living with HIV/AIDS are essential for women living with HIV/AIDS to have responsible, safe and satisfying sexual lives, especially in countries severely affected by HIV.
Violence, including sexual violence against women, is strongly correlated with women's risk of becoming infected with HIV. In addition, violence against a woman can interfere with her ability to access treatment and care, maintain adherence to antiretroviral therapy or feed her infant in the way she would like. Health

services, including those focusing on HIV treatment, care and prevention, provide an important entry point for identifying and responding to women who HIV testing and counselling is the entry point to HIV-related care and support, including antiretroviral therapy. Knowledge of HIV status is essential for tailoring reproductive health care and counselling according to the HIV status of women and to assist women in making decisions on such issues as the number, spacing and timing of pregnancies, use of contraceptive methods and infant-feeding practices. Further, information and counselling are critical components of all sexual and reproductive health services and support women in making these decisions and carrying them out safely and voluntarily.

CONDOM USE

UNAIDS, WHO and UNFPA emphasise that condoms are central to all STI and HIV control strategies.68 The common notion among family planning providers that condoms are only for disease prevention because they are less effective than other contraceptive methods fails to take into account the potential for increasing the number of protected sex acts when their contraceptive potential is also stressed. Due to successful social marketing efforts, condom promotion in Africa has been a success for single women, including for pregnancy prevention, which the main or partial motive of most single women who use condoms even if the risk of HIV/STIs is high.

Male condoms

Male latex condoms are 80–95% effective in preventing HIV and most STIs when used consistently and correctly. They reduce the risk of transmission of human papillomavirus (HPV) and therefore of cervical and ano-genital dysplasia and cancer. They also reduce the risk of transmission of herpes simplex virus-2, although some transmission can still occur through nonpenetrative sex and through skin not covered by a condom. Using a lubricant with male condoms is important for post-menopausal women, who have less natural vaginal lubrication, and for women sex workers and others who are having multiple and/ or rapid intercourse with one or more persons, which can cause discomfort and even pain with condoms alone, because the vagina may not produce adequate natural lubrication.

Lack of stimulation and psychological depression can contribute to vaginal dryness as well. This sometimes leads to condom breakage and an increase in vaginal tearing, thereby increasing the risk of STI/ HIV transmission. Anal sex should always be protected by condoms and a water-based lubricant should always be used to prevent friction, as the anal passage does not have its own natural lubrication like the vagina does, and condom breakage.

Female condom

Female condoms come with lubrication. Female condoms used consistently and correctly are estimated to be 94–97% effective against STIs. While they have not specifically been studied for HIV prevention, effectiveness is assumed to be comparable. Despite limited access and high cost, female condoms are becoming more popular with some women, who are able to negotiate their use with some men.

HIV INFECTIONS

The signs of HIV infection can vary in type and severity from person-to-person, and some people may not have any symptoms for many years.

The stages below describe how HIV infection progresses in the body if it is left untreated. Without antiretroviral treatment for HIV, the virus replicates in the body and causes more and more damage to the immune system.

However, with effective treatment, you can keep the virus under control and stop it from progressing. This is why it's important to start treatment as soon as possible after testing positive.

Stage 1: Acute primary infection

The early symptoms of HIV can feel like having the flu. Around one to four weeks after getting HIV, you may start to experience these flu-like symptoms. These normally don't last long (a week or two). You may only get some of the symptoms and some people don't have any symptoms at all.

Symptoms can include:

- fever (raised temperature)
- rash
- sore throat
- swollen glands
- headache
- upset stomach
- joint aches and pains
- muscle pain.

These symptoms happen because your body is reacting to the HIV virus. Cells that are infected with HIV are circulating throughout your blood system. In response, your immune system tries to attack the virus by producing HIV antibodies – this process is called seroconversion. Timing varies but once you have HIV it can take your body up to a few months to go through the seroconversion process.

Having these symptoms alone does not mean you definitely have HIV. The only way to know if you have HIV is by taking a test. You should always visit your healthcare professional if you're worried about or think you've been at risk of getting HIV, even if you feel well and don't have any symptoms. They can then arrange for you to get tested.

HIV will not always show up in a test at this early stage, and you may need to test again later to confirm your result (find out more about 'window periods'). Your healthcare professional will talk to you about the timing of your test and answer any concerns. It's important not delay speaking to a healthcare worker if you are worried about HIV.

In the early stages of infection, the amount of HIV in your blood is high and you're more likely to pass the virus onto others. Condoms are the best way to protect yourself and your partner when having sex, especially if you think you have been exposed to HIV.

Stage 2: The asymptomatic stage

Once a person has been through the acute primary infection stage and seroconversion process, they can often start to feel better. In fact, HIV may not cause any other symptoms for up to 10 or even 15 years (depending on age, background and general health).

However, the virus will still be active, infecting new cells and making copies of itself. HIV can still be passed on during this stage. If left untreated, over time, HIV infection will cause severe damage to the immune system.

Stage 3: Symptomatic HIV infection

By the third stage of HIV infection a person's immune system is severely damaged. At this point, they're more likely to get serious infections or diseases that the body would otherwise be able to fight off. These infections are known as 'opportunistic infections'.

Symptoms can include:

- weight loss
- chronic diarrhoea
- night sweats
- fever
- persistent cough
- mouth and skin problems
- regular infections
- serious illness or disease.

What is AIDS?

If a person develops certain serious opportunistic infections or diseases – as a result of damage to their immune system from advanced stage 3 HIV infection – they are said to have AIDS.

If you have advanced HIV (with AIDS-defining symptoms), it's important to get the right treatment as soon as possible. With treatment a person can recover from AIDS-related infections and diseases, and bring HIV under control.

The earlier you're diagnosed with HIV and start treatment, the better your health will be. You can avoid getting opportunistic infections and stage 3 HIV, by adhering to antiretroviral treatment and looking after your health.

NEEDLE AND SYRINGE PRACTICES TO PREVENT HIV/AIDS

Needle and syringe programmes (NSPs) are a type of harm reduction initiative that provides clean needles and syringes to people who inject drugs (sometimes referred to as PWID) to reduce transmission of HIV and other blood borne viruses (such as hepatitis B and C). The World Health Organization (WHO) recommends providing 200 sterile needles and syringes per drug injector per year, in order to effectively tackle HIV transmission via this route.1

Many programmes supply other equipment to prepare and consume drugs such as filters, mixing containers and sterile water and also provide ways to dispose used needles safely. The majority of NSPs are run by drug services or pharmacies and operate from a range of fixed, mobile and outreach sites.2

Programmes aim primarily to reduce the transmission of HIV and other blood-borne viruses caused by the sharing of injecting equipment. Many also work to reduce other harms associated with injecting drug use by providing:

- advice on safer injecting practices
- advice on minimising the harm done by drugs
- advice on how to avoid and manage an overdose
- information on the safe handling and disposal of injecting equipment
- referrals to HIV testing and treatment services
- screening for other sexually transmitted diseases (STIs) and tuberculosis (TB)
- help to stop injecting drugs, including access to drug treatment (such as opioid substitution therapy) and encouragement to switch to safer drug taking practices
- links to other HIV prevention interventions such as pre-exposure prophylaxis (PrEP) and free condoms
- referrals to other healthcare services, wider psychosocial support and counselling.3

NSPs substantially and cost effectively reduce the spread of HIV among people who inject drugs and do so without evidence of exacerbating injecting drug use at either the individual or societal level.4

OTHER NOTES

India's Achievemen7ts in Prevention and Control of HIV/AIDS

Over the past decade, India has made significant progress in tackling its HIV epidemic, especially in comparison with other countries in the region. Overall, India's HIV epidemic is slowing down, with a 57% decline in new HIV infections between 2000 and 2011, and a 29% decline in acquired immune deficiency syndrome (AIDS)-related deaths between 2007 and 2011.

The trend in annual AIDS deaths has shown a steady decline since the rollout of the free antiretroviral therapy (ART) program in India in 2004. It is estimated that around 1,50,000 lives have been saved due to ART as of 2011. As of March 2014, 7,68,000 people living with HIV (PLWHIV) were on first-line ART at 425 ART centers. Nearly 1,00,000 children living with HIV/AIDS are registered for HIV treatment and care services at these ART centers and 42,015 of these are receiving free ART. Initiation of first-line ART is done on the basis of cluster of differentiation (CD)4 counts. About 254 CD4 counting machines are functional in the country, and over 1.5 million CD4 tests have been performed during 2013-2014.

According to HIV Sentinel Surveillance (HSS) 2012-13, an overall decline in HIV prevalence among antenatal care (ANC) attendees (considered proxy for prevalence in the general population) was noted at the national level. The declining trend for ANC attendees is consistent with India's story of large-scale implementation and high coverage during the National AIDS Control Programme-III (NACP-III). The focus of information, education, and communication (IEC) activities has been on promoting safe behaviors, reducing HIV stigma and discrimination, demanding generation of HIV/AIDS services, and promoting

condom use. A folk media campaign was scaled up in 32 states, which reached out to 15 million people through folk performances during 2013-14.

The Adolescence Education Programme is being implemented in 23 states covering around 49,000 schools. Red Ribbon Clubs (RRCs) are functional in around 14,000 colleges; these include 1,700 new RRCs formed in 2013-14. Of the Millennium Development Goals (MDGs), the sixth target or MDG-6 is to combat HIV/AIDS, malaria, and other diseases. Target 6A is to have halted by 2015 and begun to reverse the spread of HIV/AIDS and Target 6B is to have achieved, by 2010, universal access to treatment for HIV/AIDS for all those who need it. India has made substantial progress in achieving targets related to HIV/AIDS. A major reason for the country's success has been the sustained commitment of the Indian government through National AIDS Control Organisation (NACO) and its NACP. The NACP-III has been particularly effective at targeting high-risk groups such as males having sex with males (MSM), sex workers, and people who inject drugs (PWID), in aiming to stem the wider epidemic.

As rightly mentioned by Claeson and Alexander, there are no real “innovations” in India's approach to HIV prevention planning; rather, there is a strategy of sound policy-making, investment in good data to make informed decisions, analysis of the data to determine the epidemic drivers, and comprehensive plans and budgets for scaling up known interventions directed at those populations with behaviors that are responsible for the most exposure to HIV, without moral undertones. The world has much to learn from India's approach.

Awareness and prevention

India has been working tremendously hard to eradicate HIV/AIDS which poses serious health challenges to a large population living in the country. Efforts are now being made to reduce the number of HIV cases to zero and the nation has already achieved a breakthrough to stop HIV prevalence in the last few years. However, there is a long way to go for an "AIDS Free India" as the country still has about 2.5 million people, aged between 15 and 49, estimated to be living with HIV/AIDS, the third largest in the world.

Based on the HIV Estimation 2012, India has demonstrated an overall reduction of 57% in the annual new HIV infections (among adult population) from 2.74 lakhs in 2000 to 1.16 lakhs in 2011, reflecting the impact of various interventions and scaled-up prevention strategies under the National AIDS Control Programme. The adult HIV prevalence has decreased from 0.41% in 2001 to 0.27% in 2011. Also, the estimated number of people living with HIV has decreased from 24.1 lakh in 2000 to 20.9 lakhs in 2011. Wider access to Anti-Retroviral Therapy (ART) has resulted in 29% reduction in estimated annual deaths due to AIDS related causes between 2007 and 2011. It is estimated that around 1.5 lakhs lives have been saved due to ART till 2011.

India has used extensive and ever increasing sources of HIV related data to plan programmes and monitor the impact of HIV prevention and care interventions.

Latest estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) show that the world continues to close in on the goal of ending the AIDS epidemic by stopping HIV transmission and halting AIDS-related deaths. Remarkable progress has been made over the last decade-yet significant challenges remain.

NACO

The HIV epidemic in India is concentrated among high risk groups (sex workers, men-having-sex-with-men, injecting drug users and clients of sex workers), though there is evidence of the infection spreading to the general population. About one-third of districts in the country have high HIV prevalence.

To contain the infection, NACP-III consolidates efforts in prevention, care, support and treatment of HIV/AIDS. Under the plan all HIV/AIDS linked services are integrated and scaled up to sub-district and community level. However, the services available in any area are based on the prevalence there. This is made necessary as HIV/AIDS in India presents heterogeneous epidemiology with high rate of prevalence, more than one percent in general population in some districts and low prevalence in others.

Core Services at District level

In packaging of services, care is taken for the special needs of the region and availability of complementary healthcare system. In high prevalence districts, the full spectrum of preventive, supportive and curative services are available in medical colleges or district hospitals. These hospitals provide HIV/AIDS prevention services including treatment and cure for sexually transmitted infections, psycho-social counselling and support for people infected or affected by HIV, management of opportunistic infections and anti-retroviral therapy for people living with HIV/AIDS, counselling and testing facility for prevention of parent to child transmission of HIV infection, specialized pediatric HIV care and treatment as well as referral for specialist needs such as surgery, ENT and ophthalmology etc.

CHCs give Basic Services

Community Health Centres and Primary Health Centres are integrated in the programme and facilitate prevention through promotion of condoms, counselling and testing for HIV (ICT Centres), prevention of parent to child transmission (PPTCT), treatment and cure for sexually transmitted diseases and management of opportunistic infections.

CBOs for better Service Outreach

Hospitals providing HIV services are linked to NGOs/CBOs which play a significant role in providing peer support services and home-based care for people living with HIV/AIDS. CBOs also facilitate follow-up with children born to HIV positive women, support at the community level and outreach to services at the district level.

Awareness Raising

HIV infection is entirely preventable through awareness raising. Therefore, awareness raising about its occurrence and spread is very significant in protecting the people from the epidemic. It is for this reason that the National AIDS Control Programme lays maximum emphasis on the widespread reach of information, education and communication on HIV/AIDS prevention. Changing knowledge, attitudes and behaviour as a prevention strategy of HIV/AIDS thus is a key thrust area of the National AIDS Control Programme.

Addressing the Vulnerable

Awareness raising brings behaviour change. Through this route the programme promotes prevention, and aims to reach out to 80 percent of the high risk groups and 95 percent of the young people. In fact, the awareness campaign of NACP has received a big boost with the formation of National Council on AIDS that has mainstreamed HIV prevention activities in various government institutions and programmes.

The programme focuses on saturating an estimated four million high risk groups (commercial sex workers, injecting drug users, men-who-have-sex-with-men), twelve million highly vulnerable populations – migrants and truckers, and a large number of young women and men in the general community, who constitute almost 40 percent of the country's population, with information on various aspects of vulnerability to HIV infection.

PREVENTION STRATEGIES

Targeted Intervention for High Risk Group

India's HIV program has been recognized globally as a very successful public health model with specific interventions for key population of Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgender (TG)/Hijra and Injecting Drug Users (IDUs) known as the Core Group and Migrants and Truckers known as the Bridge Population. Over 3 decades of implementing Targeted Interventions through NGO/CBOs, critical insights into the operational aspects is gained. Consolidating the success gained, a focused HIV intervention has been developed to reduce HIV prevalence among the key population.

The TI program has evolved over 4 Phases of the National AIDS Control Program (NACP) and this has been achieved through national, regional and state level consultations with multiple stake holders including community members and civil society organizations.

Targeted Intervention (TI) Approach

The prevention of HIV infection among the high risk group (HRGs) is the main thrust area for the NACP and the TI program has demonstrated that it is the most effective way of controlling the epidemic among this population. The approach for providing services to this population began by conducting various mapping exercises that helped in arriving at a specific denominator for service provision. The latest mapping was conducted for TGs/Hijra in 2013. One of the primary aims of NACO and the State AIDS Control Society (SACS) is to ensure saturation of this figure through TI service components of Behaviour Change Communication, Condom Distribution for Core Group, Condom Social Marketing for Bridge Population, Outreach Services, Counseling, HIV testing, Linkages/Referrals, STI management, Needle/Syringe Program (for IDUs), Opioid Substitution Therapy (for IDUs), enabling environment for all key population and advocacy to reduce stigma and discrimination.

In order to measure the program efficiency a system of HIV Sentinel Surveillance was introduced and over the years India's efficient response to HIV has resulted in reduction of HIV prevalence among most of the core group with the exception of IDUs and TGs/Hijra. The HIV prevalence among ANC is 0.29% and Female Sex Worker 2.20%, Men who have Sex with Men 4.30%, Injecting Drug Users 9.90%, and Transgender/Hijra population 7.20% (IBBS 2015). The bridge population consisting of Truckers and Migrants had HIV prevalence of 2.59% and 0.99% respectively. (HSS 2012-13 Technical Brief)

Female Sex Workers (FSWs)

The HIV epidemic in India is known to be a concentrated epidemic with FSWs being one of the core risk groups that are affected. FSWs have many sexual partners concurrently. Generally, full time FSWs have at least one client per day. Some FSWs have more clients than others. In addition to the number of clients their nature of work also increases their vulnerability to HIV. The higher risk of FSWs is reflected in a substantially higher prevalence of HIV among them than in the general population.

As per the IBBS conducted in 2014-15, HIV prevalence among FSWs found to be 2.2%, which is eight times more than among pregnant women attending antenatal clinics (0.29%) as per HSS 2014-15. However there has been a steady decline in the HIV prevalence among this population as a result of effective interventions over the years.

Men having Sex with Men (MSM)

Men Having Sex with Men(MSM) are another important group who are highly vulnerable to HIV and are also a strategically important group for focusing HIV prevention programmes. The term 'men who have sex with men' (MSM) is used to denote all men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women or not.

It is important to know that not all MSM have many sexual partners however, there are MSM sub-populations which do have high rates of partner change as well as high number of concurrent sexual partners. These sub-groups of MSM who often engage in anal sex with multiple partners are at particularly high risk. As per the IBBS conducted in 2014-15, HIV prevalence among MSMs found to be 4.30%.

Transgender/Hijra

NACO has initiated exclusive TG/Hijra intervention under NACP IV based on the recommendation from the working groups and needs from communities. A separate costing and operational guideline has been developed for uniformity in scaling up of TG/Hijra intervention in the country based on the mapping.

In order to ensure standardization of program, feedback from stakeholders and communities, the typology wise Technical Resource Groups (TRG) formed and conducted, periodically.

TIs for Bridge Populations

Individuals who have sexual partners in the high risk groups as well as other partners of lower risk(General population) are called a "bridge population", because they form a transmission bridge from the HRGs to the general population. Quite often they are clients or partners of male and female sex workers. Truckers and Migrant workers are named as bridge population through close proximity to high risk groups and are at the risk of contracting HIV.

They are a critical group because of their 'mobility with HIV'. Their living and working conditions, sexually active age and separation from regular partners for extended periods of time predispose them to paid sex or sex with non-regular partners. Further, inadequate access to treatment for sexually transmitted infections aggravates the risk of contracting and transmitting the virus.

TIs to Reduce the Vulnerabilities of Bridge Population

The NACO interventions are aimed at controlling the spread of HIV and STI through increasing awareness about their transmission and prevention. All interventions are aimed at promoting safe sex through use of condoms. They also facilitate easy access to condoms, treatment for STIs, counselling, testing and treatment services.

How are Interventions reached to Truckers?

These interventions involve interaction with the target community about sexually transmitted infections, HIV/AIDS and safe sex. For better recall and understanding information, education and communication materials are used in such community interactions. Peer educational activities are also undertaken for effective outreach of the messages.

So far, all interventions were carried out by NGOs at locations where truck drivers halt for sufficient duration like along highway stretches, business activity areas, check posts or port areas. Under NACP-III, a larger gamut of organisations constituting National Highway Authority of India, social marketing organisations in the promotion of condoms, NGOs and truckers' organisations at state and district level are involved in a concerted effort for better outreach of the interventions. The ultimate aim is to harness the trucking community, associations, brokers and others in driving these interventions.

Interventions aimed at Migrants

The interventions for migrants are focused on 8.64 million temporary, short duration migrants. They are of special significance to the epidemic because of their frequent movement between source and destination areas. Therefore, to provide continuum of services to these migrants and their spouses, interventions are proposed at destination, source and transit areas. As all migrants are not at equal risk of HIV, only the high risk migrants (both male & female) are covered at the destinations through Targeted Interventions run by NGOs. Industrial houses, factory owners, construction companies and other employers engaging these migrants are also being motivated to provide HIV prevention services to these migrants. For reaching to migrants, NGOs identify volunteers among the migrant's community and train them in spreading preventive messages among their fellow workers.

Link Worker Scheme

Rural HIV infection was another challenge area that needed to be addressed. Owing to poor infrastructure, weak health care systems and poor connectivity with most facilities, large number of vulnerable population, HRGs, Bridge Population and PLHIVs needed to be provided services. In order to bridge this gap Link Worker Scheme (LWS) was initiated. For more details please click here for the operational guideline of LWS.

Employer Led Model

Employer Led Model (ELM) is initiated to reach vulnerable informal workers in organized and unorganized sectors. ELM provides broad methodology and implementation strategies for reaching out to vulnerable workforce linked to industries with HIV/AIDS prevention and care programme. The ELM is feasible in industrial sectors which have certain systems and structures such as company management, association, federation, society, contractor and subcontractor mechanisms that can be leveraged for implementation of the model.For more details please click here for the operational guideline of ELM.

Harm Reduction Program

NACO has adopted the harm reduction policy as a strategy for prevention of HIV/AIDS amongst IDUs in 2002 during the second phase of the National AIDS Control Program (NACP II). Counselling, behavior change communication (BCC), Needle Syringe Exchange Program (NSEP), abscess prevention and management, STI treatment, referral and linkages, etc are the service components of the strategy. These services are being provided through the NGOs known as the IDU TI.

In the current NACP IV, the provision of female outreach worker (ORW) was added in all the IDU TIs for reaching out to the spouses of male IDUs. Female Injecting Drug User (FIDU) is also an additional typology being included in NACP IV. The key aspects of the strategy to provide services to FIDUs include:

- Comprehensive package of services including services specifically addressing needs of Female IDUs
- Female friendly service delivery mechanisms
- Gender responsive and need based services
- Community participation in programme planning and implementation
- Evidence driven response- Collection and application of strategic information for program design and improvement in quality implementation

Opioid Substitution Therapy (OST) was integrated as part of the harm reduction service component in 2008. Buprenorphine is the drug for the OST program. India has two models for delivering OST Services:

1. NGO model: NACO has been supporting OST implementation in NGO settings since 2008. In this model, OST services are offered by NGOs already implementing an IDU TI project and offering the package of harm reduction services mentioned above. The medications are dispensed to the clients on a daily basis directly under supervision by a qualified and trained nurse (DOTS). The TI staffs are trained on OST management and are required to follow standard operating procedures drafted to ensure minimum standards of care which include maintenance of records for clinical interactions, dispensing and stock keeping.
2. Collaborative Model: In 2010, NACO has piloted a collaborated model of OST delivery based on partnership between Government hospitals and NGOs implementing IDU TIs. In this model, the OST centre is located in a Government health care setting (medical college hospital, district hospital, sub-divisional hospital, CHC, etc.) and is tasked with clinical assessment, diagnosis, prescription of substitution treatment, follow-up, dispensing of the medications and stock management. Each of these OST centres is linked with nearby IDU TI(s) which facilitate the service uptake by motivating IDU clients in the project area and referring them to the centre for treatment. In addition, the linked IDU TIs also follow-up with clients who drop-out from treatment and conduct regular advocacy with local stakeholders to generate support for the OST programme.

The NGO OST centres are accredited by an external agency (National Accreditation Board of Hospitals and Healthcare Providers) once in 2 years. Only those centres which meet the minimum standards laid down by NACO and are certified by NABH are permitted to dispense medications.

OST distance learning programme for building the capacities of service providers engaged in delivery OST has also been developed. This distance learning program is targeted towards the personnel working in OST centres. The online training programme is a joint endeavour of National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi and Public Health Foundation of India (PHFI), New Delhi under the guidance of NACO.

OST with methadone syrup has been introduced for the first time in the current NACP IV. Regional Institute of Medical Science (RIMS), Imphal is the site identified for the program. NACO plans to scale up the sites gradually in other high burden IDU states. Training module for OST with methadone has been developed in collaboration with NDDTC, AIIMS.

Recognizing that partnerships with law enforcement agencies would be a value addition to the implementation of the harm reduction services, NACO held a National Consultative meeting with key stakeholders including State prison departments in 2014 under the chairmanship of Union Secretary,

MOHFW. Based on the suggestions provided by the subject knowledge experts from the national consultative meeting a National strategy on HIV Prevention and Control in Prison Settings was developed. Additionally, a National Working Committee (NWC) on Prison HIV and Law Enforcement was also constituted to overlook the implementation of the program.

In order to standardise the approach to scaling up coverage among these core groups and bridge populations and maintain a high level of quality, it is important to provide detailed information on various operational issues to TI. Hence, NACO has developed detailed TI operational guidelines and capacity building manuals for each typology

Following are the key concepts about HIV/AIDS and substance abuse disorders that influenced the creation of this TIP:

- Substance abuse increases the risk of contracting HIV. HIV infection is substantially associated with the use of contaminated or used needles to inject heroin. Also, substance abusers may put themselves at risk for HIV infection by engaging in risky sex behaviors in exchange for powder or crack cocaine. However, this fact does not minimize the impact of other substances that may be used (e.g., hallucinogens, inhalants, stimulants, prescription medications).
- Substance abusers are at risk for HIV infection through sexual behaviors. Both men and women may engage in risky sexual behaviors (e.g., unprotected anal, vaginal, or oral sex; sharing of sex toys; handling or consuming body fluids and body waste; sex with infected partners) for the purpose of obtaining substances, while under the influence of substances, or while under coercion.
- Substance abuse treatment serves as HIV prevention. Placing the client in substance abuse treatment along a continuum of care and treatment helps minimize continued risky substance-abusing practices. Reducing a client's involvement in substance-abusing practices reduces the probability of infection.
- HIV/AIDS, substance abuse disorders, and mental disorders interact in a complex fashion. Each acts as a potential catalyst or obstacle in the treatment of the other two--substance abuse can negatively affect adherence to HIV/AIDS treatment regimens; substance abuse disorders and HIV/AIDS are intertwining disorders; HIV/AIDS is changing the shape and face of substance abuse treatment; complex and legal issues arise when treating HIV/AIDS and substance abuse; HIV-infected women with substance abuse disorders have special needs.
- Risk reduction allows for a comprehensive approach to HIV/AIDS prevention. This strategy promotes changing substance-related and sex-related behaviors to reduce clients' risk of contracting or transmitting HIV.

Addiction is a biopsychosocial disorder characterized by repeated use of drugs, or repetitive engagement in a behavior such as gambling, despite harm to self and others. According to the "brain disease model of addiction," while a number of psychosocial factors contribute to the development and maintenance of addiction, a biological process that is induced by repeated exposure to an addictive stimulus is the core pathology that drives the development and maintenance of an addiction. Many scholars who study addiction argue that the brain disease model is incomplete and misleading.

Recognizing unhealthy drug use in family members

Sometimes it's difficult to distinguish normal teenage moodiness or angst from signs of drug use. Possible indications that your teenager or other family member is using drugs include:

- **Problems at school or work** — frequently missing school or work, a sudden disinterest in school activities or work, or a drop in grades or work performance
- **Physical health issues** — lack of energy and motivation, weight loss or gain, or red eyes
- **Neglected appearance** — lack of interest in clothing, grooming or looks
- **Changes in behavior** — exaggerated efforts to bar family members from entering his or her room or being secretive about where he or she goes with friends; or drastic changes in behavior and in relationships with family and friends

- **Money issues** — sudden requests for money without a reasonable explanation; or your discovery that money is missing or has been stolen or that items have disappeared from your home, indicating maybe they're being sold to support drug use

Recognizing signs of drug use or intoxication

Signs and symptoms of drug use or intoxication may vary, depending on the type of drug. Below you'll find several examples.

Preventing a relapse

Once you've been addicted to a drug, you're at high risk of falling back into a pattern of addiction. If you do start using the drug, it's likely you'll lose control over its use again — even if you've had treatment and you haven't used the drug for some time.

- **Stick with your treatment plan.** Monitor your cravings. It may seem like you've recovered and you don't need to keep taking steps to stay drug-free. But your chances of staying drug-free will be much higher if you continue seeing your therapist or counselor, going to support group meetings and taking prescribed medication.
- **Avoid high-risk situations.** Don't go back to the neighborhood where you used to get your drugs. And stay away from your old drug crowd.
- **Get help immediately if you use the drug again.** If you start using the drug again, talk to your doctor, your mental health professional or someone else who cavn help you right away

PREVENTION AND CONTROL OF STDS

According to the Centers for Disease Control and Prevention (CDC), the total combined cases of chlamydia, gonorrhea and syphilis reported in 2015 reached a record high. While these conditions are curable with antibiotics, most cases go undiagnosed and untreated. One reason for this may be the recent budget cuts in state and local STD-related health programs. With fewer clinics and programs available, patients have reduced access to STD testing and treatment services.

Unfortunately, patients with untreated STDs have an increased risk of developing chronic pain, infertility and HIV. Ways to Prevent and Control STDs

To lower your risk of contracting an STD, take the following steps:

- Talk openly about STDs. Before beginning a sexual relationship, talk about your sexual health history. This will promote honesty, trust and respect in the relationship.
- Avoid sexual contact with anyone showing symptoms. Beware of genital sores, a rash or discharge. However, some STDs don’t manifest any visible symptoms.
- Get tested regularly. The CDC recommends that most sexually active adults get screened for STDs at least once per year. When beginning a new relationship, request that your partner gets tested before having sex. Pregnant women should also be tested for STDs that may affect the fetus.

- Use barriers such as condoms. Using barriers correctly and consistently during sexual activity will maximize your level of STD protection.
- Practice mutual monogamy if you are sexually active. Only have sex with your committed partner after you've both been tested and cleared for STDs. Sexual activity with multiple partners increases your risk of contracting an STD.
- Avoid alcohol and recreational drug use. These can lower your inhibitions and encourage risky sexual behavior.

- correct and consistent use of the male latex condom is highly effective in reducing STD transmission. Use a condom every time you have anal, vaginal, or oral sex.
- If you have latex allergies, synthetic non-latex condoms can be used. But it is important to note that these condoms have higher breakage rates than latex condoms. Natural membrane condoms are not recommended for STD prevention.

Reduce Number of Sex Partners

Reducing your number of sex partners can decrease your risk for STDs. It is still important that you and your partner get tested, and that you share your test results with one another.

Mutual Monogamy

Mutual monogamy means that you agree to be sexually active with only one person, who has agreed to be sexually active only with you. Being in a long-term mutually monogamous relationship with an uninfected partner is one of the most reliable ways to avoid STDs. But you must both be certain you are not infected with STDs. It is important to have an open and honest conversation with your partner.

Unit 5

Social, ethical and legal issues: National AIDS Control Programmes (NACP), role of NGOs – networking, skills to manage HIV / AIDS and STDs. Social Support systems; Family Counseling – partners and children, strategies, community health programmes, conducting and managing awareness programmes, Role of Social Workers, Support groups.

Introduction about National Aids control organization

NACO envisions an India where every person living with HIV has access to quality care and is treated with dignity. Effective prevention, care and support for HIV/AIDS is possible in an environment where human rights are respected and where those infected or affected by HIV/AIDS live a life without stigma and discrimination.

NACO has taken measures to ensure that people living with HIV have equal access to quality health services. By fostering close collaboration with NGOs, women's self-help groups, faith-based organizations, positive people's networks and communities, NACO hopes to improve access and accountability of the services. It stands committed to building an enabling environment wherein those infected and affected by HIV play a central role in all responses to the epidemic – at state, district and grassroot level.

NACO is thus committed to contain the spread of HIV in India by building an all-encompassing response reaching out to diverse populations. We endeavor to provide people with accurate, complete and consistent information about HIV, promote use of condoms for protection, and emphasizes treatment of sexually transmitted diseases. NACO works to motivate men and women for a responsible sexual behavior.

NACO believes that people need to be aware, motivated, equipped and empowered with knowledge so that they can protect themselves from the impact of HIV. We confront a stark realty – HIV can happen to any of us. Our hope is that anyone can be saved from the infection with appropriate information on prevention. NACO is built on a foundation of care and support, and is committed to consistently fabricate strategic responses for combating HIV/AIDS situation in India.

NACO envisions:

- Building an integrated response by reaching out to diverse populations.
- A National AIDS Control Programme that is firmly rooted in evidence-based planning.
- Achievement of development objective
- Regular dissemination of transparent estimates on the spread and prevalence of HIV/AIDS
- Building an India where every person is safe from HIV/AIDS
- Building partnerships
- An India where every person has accurate knowledge about HIV and contributes towards eradicating stigma and discrimination
- An India where every pregnant woman living with HIV has the choice to bring an HIV free baby into the world
- An India where every person has access to Integrated Counselling & Testing Centres (ICTCs)
- An India where every person living with HIV is treated with dignity and has access to quality care

- An India where every person will eventually live a healthy and safe life, supported by technological advances
- An India where every person who is highly vulnerable to HIV is heard and reached out to

NATIONAL AIDS CONTROL PROGRAMME

India's AIDS Control Programme is globally acclaimed as a success story. The **National AIDS Control Programme (NACP)**, launched in 1992, is being implemented as a comprehensive programme for prevention and control of HIV/AIDS in India. Over time, the focus has shifted from raising awareness to behavior change, from a national response to a more decentralized response and to increasing involvement of NGOs and networks of PLHIV.

In 1992, the Government launched the first National AIDS Control Programme (NACPI) with an IDA Credit of USD84 million and demonstrated its commitment to combat the disease. NACP I was implemented with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country. National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organization (NACO) was set up to implement the project. The first phase focused on awareness generation, setting up surveillance system for monitoring HIV epidemic, measures to ensure access to safe blood and preventive services for high-risk group populations.

In November 1999, the second National AIDS Control Project (NACP II) was launched with World Bank credit support of USD 191 million. The policy and strategic shift was reflected in the two key objectives of NACP II: (i) to reduce the spread of HIV infection in India, and (ii) to increase India's capacity to respond to HIV/AIDS on a long-term basis. Key policy initiatives taken during NACP II included: adoption of National AIDS Prevention and Control Policy (2002); Scale up of Targeted Interventions for High risk groups in high prevalence states; Adoption of National Blood Policy; a strategy for Greater Involvement of People with HIV/AIDS (GIPA); launch of National Adolescent Education Programme (NAEP); introduction of counseling, testing and PPTCT programmes; Launch of National Anti-Retroviral Treatment (ART) programme; formation of anointer-ministerial group for mainstreaming; and setting up of the National Council on AIDS, chaired by the Prime Minister; and setting up of State AIDS Control Societies in all states.

In response to the evolving epidemic, the third phase of the national programme (NACPIII) was launched in July 2007 with the goal of Halting and Reversing the Epidemic by the end of project period. NACP was a scientifically well-evolved programme, grounded on a strong structure of policies, programmes, schemes, operational guidelines, rules and norms. NACP-III aimed at halting and reversing the HIV epidemic in India over its five-year period by scaling up prevention efforts among High-Risk Groups (HRG) and General Population and integrating them with Care, Support & Treatment services. Thus, Prevention and Care, Support & Treatment (CST) form the two key pillars of all the AIDS control efforts in India. Strategic Information Management and Institutional Strengthening activities provide the required technical, managerial and administrative support for implementing the core activities under NACP-III at national, state and district levels.

The capacities of State AIDS Control Societies (SACS) and District AIDS Prevention and Control Units (DAPCUs) have been strengthened. Technical Support Units (TSUs) were established at National and State level to assist in the Programme monitoring and technical areas. A dedicated North-East regional Office has been established for focused attention to the North Eastern states. State Training Resource Centres (STRC)

was set up to help the state level implementation units and functionaries. Strategic Information Management System (SIMS) has been established and nation-wide rollout is under way with about 15,000 reporting units across the country. The next phase of NACP will build on these achievements and it will be ensured that these gains are consolidated and sustained.

KEY STRATEGIES

Strategy 1: Intensifying and consolidating prevention services, with a focus on HRGs and vulnerable population.

Strategy 2: Increasing access and promoting comprehensive care, support and treatment

Strategy 3: Expanding IEC services for (a) general population and (b) high risk groups with a focus on behaviour change and demand generation

Strategy 4: Building capacities at national, state, district and facility levels

Strategy 5: Strengthening Strategic Information Management Systems

STRATEGY 1: INTENSIFYING AND CONSOLIDATING PREVENTION SERVICES

Prevention will continue to be the core strategy of NACP-IV as more than 99% of the people are HIV negative. It will reach out to the widely dispersed population of young women and men with well-designed prevention messages. Accordingly, it is planned to cover 90% of HRGs through Targeted Interventions (TI) implemented by NGO and CBOs. High risk migrants, their spouses, truckers and other vulnerable population will be accessed by collaborating with other departments, voluntary groups, civil society networks, women groups and youth clubs. NACP- IV will add on the existing network of ICTCs in high prevalence states and enhance the coverage in the vulnerable states by establishing new HIV testing facilities up to the CHC and PHC level. This is to ensure that ICTC, PPTCT and HIV-TB services are accessible to the community. More efficacious multi-drug regimen for PPTCT will be scaled up as an effort towards elimination of new infections among children. Condom promotion strategies will be strengthened through free distribution and social marketing channels, non-traditional outlets, female condoms, etc. aided by an effective communication strategy. The programme will continue to link prevention with care, support and treatment. This will promote positive prevention. NACP-IV will focus on strengthening of standardized STI/RTI management to HRG and vulnerable population through designated STI clinics under the programme, NRHM service delivery units and public and private sectors clinics. NACP-IV will also explore the possibilities of streamlining the coordination and management of blood banks and blood transfusion services. Some of the activities under prevention strategy include:

1. Saturating quality HIV prevention services to all HRG groups, based on emerging behaviour patterns and evidence

2. Strengthening needle exchange Programme, drug substitution programme and providing Opioid Substitution Therapy (OST)

3. Reaching out to MSM and Transgender communities

4. Addressing the issues related to coverage and management of rural interventions

5. Providing quality STI/RTI services.

6. Expand the ICTC services and strengthen referral linkages

7. Strengthening positive prevention 8. Strengthening management structure of blood transfusion services

9. Implementing National EQAS for all participating labs at district and above for HIV related diagnostic services.

STRATEGY 2: COMPREHENSIVE CARE, SUPPORT AND TREATMENT

NACP-IV will implement comprehensive HIV care for all those who are in need of such services and facilitate additional support systems for women and children. With a wide network of treatment facilities and collaborative support from PLHIV and civil society groups, it is envisaged that greater adherence and compliance would be possible. Additional Centres of Excellence (CoEs) and upgraded ART Plus Centres will be established to provide highquality treatment and follow-up services, positive prevention and better linkages with health care providers in the periphery. With increasing maturity of the epidemic, it is very likely that there will be greater demand for 2nd line ART, Opportunistic Infections management, etc., and NACP-IV will address these needs. It is proposed that the comprehensive care support and 12 Strategy Document treatment of HIV/AIDS will inter alia include: (i) anti-retroviral treatment (ART), including second line (ii) management of opportunistic infections including TB in PLHIV, (iii) positive preventions and (iv) facilitating social protection and insurance for PLHIV through linkages with concerned Departments/ Ministries. The programme will explore avenues of public-private partnerships. The programme will enhance activities to reduce stigma and discrimination at all levels particularly at health care settings.

Some of the illustrative activities include:

1. Scale up ART Centres, LACs, and COEs ART services.

2. Strengthening follow up of patients on ART and improving quality of counselling services at ART service delivery points.

3. Comprehensive care and support services for PLHIV through linkages.

4. Provide guidelines and training for integrantion in health care settings to NRHM staff

STRATEGY 3: EXPANDING IEC SERVICES FOR (A) GENERAL POPULATION AND (B) HIGH RISK GROUPS WITH A FOCUS ON BEHAVIOUR CHANGE AND DEMAND GENERATION

IEC has been an important component of the NACP. With the expansion of services for counseling and testing, ART, STI treatment and condom promotion, the demand generation campaigns will be the focus of the NACP-IV communication strategy. The IEC will remain an important component of all prevention efforts and will have continued focus on:

1. Increasing awareness among general population in particular women and youth

2. Behaviour change communication strategies for HRG and vulnerable groups

3. Continued focus on demand generation of services

4. Reach out to vulnerable populations in rural settings

5. Extending services to tribal groups and hard-to-reach populations

STRATEGY 4: STRENGTHENING INSTITUTIONAL CAPACITIES

The programme management structures established under NACP will be strengthened further to achieve the NACP-IV objectives. Programme planning and management responsibilities will be enhanced at national, state, district and facility levels to ensure high quality, timely and effective implementation and supervision of field level activities to achieve desired programmatic outcomes. The planning processes and systems will be further strengthened to ensure that the annual action plans are based on evidence, local priorities and in alignment with NACPIV objectives. Sustaining the epidemic response through increased collaboration and convergence, where feasible, with other departments will be given a high priority during NACP- IV. This will involve phased integration of the HIV services with the routine public sector health delivery systems, streamlining the supply chain mechanisms and quality control mechanisms and building capacities of governmental and non-governmental institutions and networks.

Strategy 5: Strategic Information Management System (Sims) Under NACP-IV

it is envisaged to have an overarching Knowledge Management strategy that encompasses the entire gamut of strategic information activities starting with data generation to dissemination and effective use. The strategy will ensure - high quality of data generation systems such as Surveillance, Programme Monitoring and Research; - strengthening systematic analysis, synthesis, development and dissemination of Knowledge products in various forms; - emphasis on Knowledge Translation as an important element of policy making and programme management at all levels; and - establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the programme. The element of Knowledge Translation will be given the highest priority to ensure making the link between Knowledge and action at all levels of the programme. The programme will focus strongly on building capacities of epidemiologists, monitoring & evaluation officers, statisticians as well as programme managers in appropriate and simple methods and tools of analysis and modeling. Institutional linkages will be fostered and strengthened to support programme for its analytical needs, at national and state levels

HISTORY ABOUT NACP IN BRIEF

Objective 1:

Reduce new infections by 50% (2007 Baseline of NACP III)
Objective 2:

Comprehensive care, support and treatment to all persons living with HIV/AIDS
NACP -IV - Planning process

National AIDS Control Programme Phase III (NACP III) was launched in July 2007 with the goal of Halting and Reversing the Epidemic by the end of project period in mid 2012. The National AIDS Control Organization (NACO) has initiated the process to start the next phase of the program. The program will build on the successes of the robust NACP III and ensure completion of the reversal of the epidemic through enhanced prevention linked with care support and treatment.
The NACP III strategy and implementation plan was developed based on the synthesis of evidence with wide range of consultations with government departments, civil society, public and private sector partners, NGOs, PLHA networks. The entire process was a home grown yet world class program that was appreciated by the global community.

Program reviews indicate that most of the targets set for NACP III are likely to be achieved by mid 2012 in terms of scale-up of coverage of HRG, safe blood supply, testing services, scale-up of ART and various interventions with community ownership and following principles such as GIPA. However, consolidating the gains and ensuring quality and coverage will require attention in the next few years.

The process to develop the plan for the next phase of the programme is being initiated. The next phase will continue to be inclusive and focused on marginalised, weaker sections and hard-to-reach population. NACP has explored various approaches towards this. NACP IV will continue to provide care, support and treatment to all eligible population along with focused prevention services for the high-risk groups and vulnerable populations.

The NACP IV planning is adopting the inclusive, participatory and widely consultative approach similar to that of NACP III and is further strengthening on the globally acclaimed and successful planning efforts of NACP III. The process will essentially involve a wide range of consultations with a large number of partners including government departments, development partners, non-governmental organizations, civil society, representatives of people living with HIV, positive networks and experts in various subjects. NACP IV development will use specific mechanisms and follow a structured process.

Mechanisms put in place:

- To give specific inputs into the plan, 15 Working Groups (with 20+ sub-groups), with representation from different stake holders including Government departments, Civil Society, Development Partners and Private Sector (List and schedule).
- Wide consultations across the country with all development partners through workshops and e-consultations.
- A multi stakeholder's apex group to review and endorse the Draft Plan.
- Assessment and studies to provide inputs into the planning process.

The key process and tentative timelines are below:

- Working group meetings, discussions and recommendations and report submission- May-June 2011
- Consultations with PLHAs, civil society, public-sector, private sector and other key stakeholders - May-June 2011 and whenever required
- State level consultations with SACS and other state partners – June 2011
- Special Studies and Assessments – May-June 2011
- E-consultations through which key documents and discussions will be shared – May-June 2011
- Consultation with Development Partners- First week July 2011 (2 Consultations with Development Partners held in January and April 2011)
- Finalising the National Strategic Plan – July-Sept 2011

  Periodic consultations, meetings and reviews will be part of this process over the coming months. The progress updates will be shared on a regular basis to keep all the key stakeholders informed on the development of NACP IV. Very soon an e-consultation process will be launched to facilitate sharing and exchange of ideas and inputs during the plan preparation process. Comments and suggestions would be welcomed through this medium too.

  NACO believes in true partnership with various constituents who contribute to the Programme. This has been the tradition of NACO and it has benefited substantially from this inclusive tradition. Civil Society partners can actively participate and contribute to develop a comprehensive National AIDS Control Programme through:

1. The Working Group members, many of whom are Civil Society leaders (Working group list)
2. National level consultation (12th May, 2011; New Delhi)
3. Participate in the State level consultations
4. Participate in the e-consultations

Other information

The National AIDS Control Programme (NACP), launched in 1992, is being implemented as a comprehensive programme for prevention and control of HIV/ AIDS in India. Over time, the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralized response and to increasing involvement of NGOs and networks of People living with HIV (PLHIV).
The NACP I started in 1992 was implemented with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country.
In November 1999, the second National AIDS Control Project (NACP II) was launched to reduce the spread of HIV infection in India, and (ii) to increase India's capacity to respond to HIV/AIDS on a long-term basis.
NACP III was launched in July 2007 with the goal of Halting and Reversing the Epidemic over its five-year period.
NACP IV, launched in 2012, aims to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well defined integration process over the next five years.

NACP - IV - Objectives

- Reduce new infections by 50% (2007 Baseline of NACP III)
- Provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it.

Key strategies

- Intensifying and consolidating prevention services, with a focus on High-Risk Groups (HRGs) and vulnerable population.
- Increasing access and promoting comprehensive care, support and treatment
- Expanding IEC services for (a) general population and (b) high risk groups with a focus on behavior change and demand generation.
- Building capacities at national, state, district and facility levels
- Strengthening Strategic Information Management System

Key priorities under NACP IV

- Preventing new infections by sustaining the reach of current interventions and effectively addressing emerging epidemics
- Prevention of Parent to Child transmission
- Focusing on IEC strategies for behaviour change in HRG, awareness among general population and demand generation for HIV services
- Providing comprehensive care, support and treatment to eligible PLHIV
- Reducing stigma and discrimination through Greater involvement of PLHA (GIPA)
- De-centralizing rollout of services including technical support
- Ensuring effective use of strategic information at all levels of programme
- Building capacities of NGO and civil society partners especially in states with emerging epidemics
- Integrating HIV services with health systems in a phased manner
- Mainstreaming of HIV/ AIDS activities with all key central/state level Ministries/ departments will be given a high priority and resources of the respective departments will be leveraged. Social protection and insurance mechanisms for PLHIV will be strengthened.

Package of services provided under NACP IV

Prevention Services

- Targeted Interventions for High Risk Groups and Bridge Population (Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgenders/Hijras, Injecting Drug Users (IDU), Truckers & Migrants)
- Needle-Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST) for IDUs
- Prevention Interventions for Migrant population at source, transit and destination
- Link Worker Scheme (LWS) for HRGs and vulnerable population in rural areas
- Prevention & Control of Sexually Transmitted Infections/Reproductive Tract Infections (STI/RTI)
- Blood Safety
- HIV Counseling & Testing Services 8. Prevention of Parent to Child Transmission
- Condom promotion
- Information, Education & Communication (IEC) &Behaviour Change Communication (BCC).
- Social Mobilization, Youth Interventions and Adolescent Education Programme
- Mainstreaming HIV/AIDS response
- Work Place Interventions

Care, Support & Treatment Services

- Laboratory services for CD4 Testing and other investigations
- Free First line & second line Anti-Retroviral Treatment (ART) through ART centres and Link ART Centres (LACs), Centres of Excellence (COE) & ART plus Centres.
- Pediatric ART for children
- Early Infant Diagnosis for HIV exposed infants and children below 18 months
- HIV-TB Coordination (Cross- referral, detection and treatment of co-infections)
- Treatment of Opportunistic Infections
- Drop-in Centres for PLHIV networks

New Initiatives under NACP IV

- Differential strategies for districts based on data triangulation with due weightage to vulnerabilities
- Scale up of programmes to target key vulnerabilities
    - Scale up of Opioid Substitution Therapy (OST) for IDUs
    - Scale up and strengthening of Migrant Interventions at Source, Transit & Destinations including roll out of Migrant Tracking System for effective outreach
    - Establishment and scale up of interventions for Transgenders (TGs) by bringing in community participation and focused strategies to address their vulnerabilities
    - Employer-Led Model for addressing vulnerabilities among migrant labour e. Female Condom Programme
- Scale up of Multi-Drug Regimen for Prevention of Parent to Child Transmission (PPTCT) in keeping with international protocols
- Social protection for marginalized populations through mainstreaming and earmarking budgets for HIV among concerned government departments
- Establishment of Metro Blood Banks and Plasma Fractionation Centre
- Launch of Third Line ART and scale up of first- and second-Line ART
- Demand promotion strategies specially using mid-media, e.g., National Folk Media Campaign & Red Ribbon Express and buses (in convergence with the National Health Mission)

1 Non-Governmental organizations have made significant contribution in the health sector by their innovative approach in the areas of public health, family welfare and in arresting the spread of communicable diseases. It is essential to continue to encourage the involvement of the voluntary sector in HIV/AIDS. The National AIDS Control Programme has recognized the importance of NGOs participation in the Programme for providing community support to people living with HIV/AIDS and their families and for providing the required care and counselling. NGOs

bring with them their experience of community level work in enhancing people's participation by adopting an interpersonal approach with sensitivity and thus benefit the HIV/AIDS programme immensely.

Government commits itself to large-scale involvement and participation of NGOs/CBOs in NACP in the following manner:

i. Involvement of NGOs at the policy making level through regular interaction and adequate representation in national and State level bodies.
ii. Extending their participation to new areas like provision of medical facilities including home-based care, opening of community care centres, etc. apart from the conventional areas of awareness, counselling and targeted interventions among risk groups.
iii. Greater efforts to undertake training and capacity building programmes for the NGOs to empower them to take up these additional responsibilities.
iv. Periodical updating of guidelines issued by NACO for involvement of NGOs to facilitate greater participation of NGOs and for better accountability. Encourage networking among NGOs to avoid duplication of efforts in some of the areas. Efforts will be made to identify nodal NGOs in different States for coordinating the work of all the NGOs working in that State. State Governments also need to address the problem of motivation among Government officials towards involvement of NGOs in the programme.

Control of Sexually Transmitted Diseases (STDs)

The large prevalence of STDs in Indian population is cause for concern as presence of STDs, especially with ulcer or discharge, facilitates transmission of HIV infection. The risk of transmission is 8 to 10 times higher in case of persons with STDs compared with others. As the risk behavior of persons with STDs and HIV is the same, Government attaches top priority to the prevention and control of STDs as a strategy for controlling the spread of HIV/AIDS in the country. The following approach will be adopted by the Government for STDs control: -

i. Management of STDs through syndromic approach (management of sexual transmitted diseases based on specific symptoms and signs and not dependent on laboratory investigations) would be incorporated into the general health service.

SUPPORT SYSTEM

FAMILY SYSTEM BASED COUNSELLING IN HIV/AIDS

AIDS (Acquired Immune Deficiency Syndrome) is caused by multiple sexual contacts, unhygienic blood transfusions and intravenous drug abuse. It is now thought of as a chronic disease whose length is indeterminate and whose course is uncertain. It seems to be an expected diagnosis leading rapidly to death. As the disease is associated with the feelings of isolation and depression in the patients, psychotherapy to the people with this infection and their families is expected to play an important role in the alleviation of psychological symptoms. Family systems therapy leads to intervention of the disease to some extent with the effective counselling of the patient's family.

The counselling goals include reconciliation of the ill person and his/ her family, mobilization of family resources, facilitation of ill person's participation in the on-going life and in the planning for its future. The family therapist explains to the AIDS infected person his/her responsibilities towards her/his spouse before death. He also tells how to cope with the grief after the death of loved one.

The family counselor also makes his/her best efforts to continue communication with the family members after patient's death and suggests medical check-ups of the family members. Moreover, family systems approach in counseling help in understanding common patterns of couple relationships, empowers the family to believe in its own capacities for problem solution and illness management, maps the family illness structure so as to make it healthier and mobilizes extra familial support to the AIDS patients.

The first clinical cases of acquired immunodeficiency syndrome (AIDS) were identified in 1981. The human immunodeficiency virus (HIV), the causative agent of AIDS, was discovered in 1983. It is estimated that almost two million Americans have acquired HIV infection. Although AIDS was initially diagnosed in the United States in a group of gay men, groups recognized as at high risk for infection in this country include a wider sector of the population -- intravenous drug abusers (IVDAs), hemophiliacs and heterosexuals who have sex with patients belonging to high-risk groups.

India has the third highest number of estimated people living with HIV in the world. India has a population of one billion, around half of whom are adults in the sexually active age group. The first AIDS case in India was detected in 1986 and since then HIV infection has been reported in all states and union territories. HIV is increasingly recognized as an illness that affects couples and families, and not just the individual. This is not only because the virus can be passed on from one person to another, but also because for every person infected with HIV, there is a family and community that are also affected.

HIV is a blood-borne virus that can be spread through unprotected sex, sharing drug-injecting equipment and to a child during or shortly after birth from an infected mother. HIV cannot be cured, but can be managed by a combination of medications. However, if left untreated, the condition can progress until the person develops AIDS (acquired immune deficiency syndrome). Immune systems that are compromised are unable to effectively fight infection. People are then susceptible to a range of infections and can die from these.

Family Counseling and HIV/AIDS

As with other chronic illnesses, partners and families often provide most of the physical and emotional care. This places a great strain on them and lead to individual stress and tension between members of the family.
In relationships, the diagnosis of HIV may reveal aspects of a person's behavior that they may have wanted to keep private. This may include infidelity or sexuality (such as male homosexuality) or intravenous drug use. This can result in feelings of guilt, blame and lead to a relationship breakdown.

- The family may also have to face bereavement.
- With HIV, more than one person in a family may be unwell which can add to the burden of care and cause additional emotional and financial problems.
- Stigma and discrimination may mean the diagnosis is kept hidden. This can prevent wider support from extended family or the community.
- A family with an infected child will have to consider when and how to disclose this to them.
- Problems can arise where there are conflicts with people's religious or cultural beliefs about medication.
- Parents may find it difficult to discuss sexual behavior and risk with their young children. This could have prevention implications for the next generation.
- Poor access to information can result in people not taking their medication as prescribed by their physician or not coming to the hospital regularly. People in families may disagree about the best course of treatment.
- The stress of living with HIV causes some people to suffer from mental health problems such as anxiety and depression.

Systemic Therapy Model of Family Counseling

Walker (1992) proposed a systemic family therapy model which emphasized upon the effective counselling. It was suggested that in order to make counselling effective the family therapist should conceptualize the family itself as a living system that provides care and must endure and heal itself after the death of a person with AIDS.

The counselling goals include reconciliation of the ill person and his or her family, mobilization of family and network resources, facilitation of ill person's participation in the life of family of origin or choice and in the planning for its future. Therefore, a systems approach to AIDS views the family as the unit of intervention and entire course of illness as time frame for intervention.

This model for HIV - infected people and their families' stresses on the inherent resources coping skills and problem-solving abilities of families both to manage the illness and to perform non illness related tasks. The family therapist, therefore, acts as a consultant so as to encourage the families to identify and change meaning of illness, define problem areas and effect solutions.

AIDS counselling should be pragmatic and problem focused. The therapist must encourage the family to focus on the tasks of everyday life so as to put illness in its place

A system-oriented counselor not only examines the level of patient and family experience but also attempts to create a holistic approach to intervention that coordinates both medical and psychosocial care for all the family members.

A family counselor working with a family in which a person has AIDS needs to examine his or her own values and biases. Family systems thinking tends to homogenize human relationships as it believes in normative family structure and human behavior. Family therapists need to respect traditions and sexual practices of different cultures that have been most affected by the disease. They should conceptualize family in broad terms. Professional counselors must remember that their own fears about contamination and stigma may distance them from clients thereby encouraging a defensively moralizing stance.

In order to help the client, face the anguish of AIDS, therapists must find what is positive, strong and effective in the client's experience. Counselors, thus, creates a therapeutic bond with the client as well as faces the intensity of emotions engendered by working with AIDS patients and their families. The counselor must help in the removal of social stigmas attached to the person with AIDS.

Principles of Family Systems Counseling

There are a number of principles which family therapists may use to help a patient with AIDS.

(a) Overcoming Resistance to Family Therapy

The family systems model therapist should be sensitive to the issues that AIDS-infected patient brings to therapy and to realize that the patient may be reluctant to involve family members. The therapist must encourage the client to disclose either sexual orientation or HIV infection. The suggestions of couples counseling may also meet with resistance. The patient with AIDS may be terrified that beneath his lover's acceptance and compassion, he may find blame or anger or may find that the lover secretly wishes to protect himself or herself by leaving. Similarly, the lover without AIDS may be reluctant to enter counseling. Drug users may also distance themselves from their families after diagnosis. They may deny their illness, increase their drug use or feel bitter that their family did not succeed in its promise of ultimate rescue. The family in turn feels overwhelming anger and impotence. In couples in which a partner has led at having betrayed his spouse. Counselor, therefore, must be flexible and compassionate towards the fears of the patient and wish for secrecy. In couple therapy, therapist has a duty to protect the partner by informing his denial system of the patient because denial may be his or her best defense against illness itself or a psychological dysfunction.

(b) Counselling as an Ongoing Process

The family counselor should frame counselling as an ongoing process where nature and frequency depend upon the psychosocial demands of the disease. Counselling usually consists of intermittent, brief or intensive

work as the family and patient undergo physical or emotional crisis. By placing the patient with AIDS or family members in support groups problems may be solved thereby alleviating the burden for the therapist.

The family counselling may be conceptualized as following critical phases of course of disease. The first phase of diagnosis of HIV infection creates a crisis of acceptance and adaptation accompanied by intense grief or denial. At diagnosis, the HIV-infected person may experience a variety of emotions of anger, abuse, powerlessness. The therapist must help the client work through complex emotions including fear of rage and abandonment by the partner. Moreover, the client should be helped to find the strategies for keeping the partner safe from further risk of infection as well as to help the client again perceive himself or herself as a person of strength and courage.
The counselor should help clients practice safer sex and help the drug users to prevent blood bone infections. The clinicians should play a role to enhance reduced risk sex thereby helping the couple to discover new and creative avenues for sexual expressions and physical intimacy. The family members should be made alert to the signs of deteriorating health or the onset of infection.
The therapist should ask the dying patient to participate in planning an optimistic future for those he or she will leave as the gradual introduction of a sense of future is healing. After the death of person with AIDS the family enters a period of bereavement and reorganization which may be a complicated process for family. The family therapist should remain in contact with the family as a counselor and encourage it for period checkups.

(c) Empowerment of Family
The counselor should empower the family to believe in its own capacities for problem solution and illness management. The
family should be encouraged to see illness as a deeply personal event.

(d) Mapping Family Illness Structure
The counselor maps the pre and post illness family structure to help the family return to pre-illness stage by carefully taking the history of family development and handling of crises in the past by family members. Pre and post illness functioning is mapped in such areas as school, work, marital satisfaction, parent-child relationships, extended family relationships and drug and alcohol use. Penn (1983) suggests that a very important aspect of understanding the family's pre-illness structure is the mapping of development of family coalitions. The therapist must try to make the structure of family more flexible so that the meaning of illness changes in the direction of alleviating psychological pain.

(e) Identification of Family Resources
The counselor should help the family identify resources both inside and outside of the family. The family or ill person is encouraged to analyze the interconnections among people in the system. The therapist can serve as an organizer and facilitator of meetings attended by representatives of various systems such as schools, health care professionals, child welfare professionals, home makers and volunteers.

(f) Mobilizing Extrafamilial Supports
As AIDS isolates, the therapist should encourage the family to become connected to community support systems to get relief from isolation. In a struggle with emotional issues unique to AIDS including guilt, shame and mutual blame, the families and individuals get alienated from normal social discourse. In order to convert despair into activism, certain political groups must help people develop strategies for living positively with illness.

Specific Techniques and Process of Family Counseling

- Conflict resolution and problem-solving techniques used in sessions can help everyone cope better.
- Emotion regulation skills help to manage negative psychological states like sadness, anger and anxiety. Mindfulness is
- one of the techniques of regulation of emotions.

- Clients can go and see a therapist on their own, with a partner, or together as a family.
- The therapist would make an assessment of the individual, couple or family's needs. Where children are involved, he or
- she will respect the wishes of the parents before including the children in sessions.
- Families coping with serious illness can feel stuck and not know how to move forward. Family therapists can assist in
- helping find ways to challenge this and find new methods of coping. Therapists can provide an open, caring and non-judgmental
- environment to do this.
- Therapy sessions can help the family plan for events that might be difficult to talk about such as illness, hospitalization,
- or telling children about HIV infection.

COMMUNITY HEALTH PROGRAMME

COMMUNITY ROLE IN PREVENTION, CARE AND TREATMENT

It is important to approach HIV as a chronic disease and thereby focus on a patient centered approach, as patients take on their role as the primary manager of their own chronic disease. It is also important to acknowledge the imbalance of power between patients, the community and health workers in order to build good relationships and help strengthen community structures in ways that support long-term patient self-management. HIV care may start at the health centre, but with increasing patient self-management, the vast majority of care takes place in the home and in the community.

Community participation can serve to:

■ raise awareness, disseminate information and reduce stigma through education, acceptance and political buy-in;
■ improve treatment and care outcomes by providing leadership and supportive services;
■ assist in assessing, coordinating and mobilizing resources that complement health centre and hospital services;

■ improve services as HIV care and treatment moves from an acute-care model to a chronic-care framework;

■ support a sustainable patient-centred approach. HIV is a life-long diagnosis and the long-term medical and psychosocial consequences of HIV can be mitigated by sustainable community-based services. For many reasons, the needs of PLHIV cannot be met by the health centre alone:

health centres are oft en under-resourced; the type of support needed by PLHIV is not always health-related;
■ PLHIV may respond better to non-medical people;

■ distance from the health centre to the patient’s home may be great; whereas the patient lives within the community.

Health Centre role in community linkages

Th e health Centre can help to ensure the effective seamless community linkages needed for good chronic care of PLHIV. Key functions of the health Centre include supporting community structures that off er adherence support, patient self-management and psychosocial support. An important mechanism to facilitate the linkages between the community and the health Centre is the establishment of a community advisory board (CAB). The CAB is composed of interested stakeholders from the community as well as members of the health Centre team. Th e role of the CAB and steps to form it are discussed below. It is essential that health centres and CABs establish a plan that links community and home- based care activities with health

centres, and that incorporates all key stakeholders involved in patients' treatment needs. Formalized referral systems should be developed to link health centers and community-based resources to their patients.

■ Interaction between the health Centre and community structures
It is important to formally link with community and home-based care structures that provide additional services to PLHIV and their families in the areas of physical, preventive, psychological/spiritual, and social care. Th ese links were introduced in the Integrationchapter. Use participatory approaches to engage with the community and to fi and mutually acceptable solutions for services and linkages

The Role of Social Workers in HIV/AIDS Prevention and Treatment

Who is Most Affected by HIV/AIDS?

According to the Centers for Disease Control and Prevention (CDC), about 67 percent of people infected are gay or bisexual men, while heterosexual contact accounted for 24 percent of estimated HIV diagnoses, and heterosexual women accounted for 19 percent. Sex workers are at especially high risk, and more than one in five new diagnoses in 2014 were among persons aged 13 to 24 years.

Disadvantaged communities tend to see the highest infection rates, with lack of access to prevention and treatment programs in these communities often results in poorer outcomes. In many cases, HIV/AIDS prevention is prioritized below more urgent problems around unemployment, crime and housing. Furthermore, fear of discrimination often results in people avoiding testing, getting treatment or disclosing their HIV status.

It's also worth noting that the symptoms of AIDS can take 10 years or more to appear. This – and the factors mentioned above – helps to explain the startling fact that one in eight people don't know they're infected.

Reducing New Infections

Tackling HIV effectively requires adopting better community-level approaches. There are many different opportunities open to social workers in helping to integrate HIV prevention and care with social service programs that tackle poverty, crime and other social stressors. The National HIV/AIDS Strategy outlines three key plans to help reduce new infections:

- Educate people about the threat of HIV/AIDS
- Intensify prevention efforts in the most affected communities
- Expand targeted efforts using a combination of evidence-based approaches

With a rise in early and regular HIV testing, the level of HIV infection has declined, with new diagnoses falling by 19 percent from 2005 to 2014 in the U.S. Despite this shift, lack of government resources and access to affordable health care remains a factor, with an estimated 1,218,400 adults and adolescents living with HIV.

HIV/AIDS AWARENESS FACTORS FOR SOCIAL WORKERS

There are other factors that social workers need to consider when trying to stem the rise of new infections. A problem identified by the National HIV/AIDS Strategy is the high rates of male incarceration, which can result in gender imbalance in the local community, and higher chance of infection.

Social workers also need to be aware of the special risks faced by women, as they may be unable to negotiate safer sexual practices due to the risk of violence.

when working with people living with hiv/aids, social workers need to be aware of:

- Local HIV/AIDS support groups and community-based organizations.
- Cultural sensitivity and unconscious biases.
- Drug and alcohol abuse and the role it plays in HIV infection.
- Safer-sex practices and awareness.
- Multidisciplinary teams and the importance of communication between medical professionals, social workers and other team members.

Changing Perceptions and Inspiring Action for the HIV/AIDS Community

There are many roles for social work in HIV/AIDS prevention, particularly around eliminating the misinformation and misunderstandings about the disease.

Social workers involved in HIV/AIDS care are supported by a strong national network of programs, events and information sharing. World AIDS Day serves as the catalyst for various events that help increase awareness and compassion for HIV sufferers, and provides opportunities for social workers to join advocacy efforts.While much has been done to reduce infection rates and improve the lives of those living with HIV/AIDS, the battle is far from won. All people affected by this deadly and debilitating disease deserve compassion and support, and social workers will continue to play a vital role in this regard.

Social workers play an important role in helping people affected by life-threatening illnesses. Invest in your own education and keep up to date with an advanced degree.

A Role of Social Worker In HIV/AIDS

On an individual level social worker provide a broad range of service and supports to those living with the HIV/AIDS. They also provide education to reduce the incidence of HIV through harm reduction and health promotion. Social workers understand that health care is more than medical care

HIV and social work: helping you cope with an HIV diagnosis • Testing positive for the HIV virus generates many feelings. You may experience fear, anger, guilt, surprise, sadness, or relief. There is no right or wrong response to your diagnosis.

Social worker roles with HIV

- Counseling, testing, and referral services
- Partner counseling and referral services
- Prevention for high-risk populations
- Health education and risk reduction activities
- Perinatal transmission prevention
- Public information programs
- Counseling people with HIV infection
- Conducting crisis intervention Providing case management
- Educating the general public and high-risk groups to reduce risk for HIV infection
- Advocating for the needs of HIV/AIDSS Patients