सत्यमेव जयते

NATIONAL HIV COUNSELLING AND TESTING SERVICES (HCTS) GUIDELINES

Government of India
National AIDS Control Organization
Basic Services Division
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36, Janpath, New Delhi

DECEMBER 2016

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स्वास्थ्य एवं परिवार कल्याण मंत्री
भारत सरकार
Minister of Health & Family Welfare
Government of India

जगत प्रकाश नड्डा
Jagat Prakash Nadda

MESSAGE

The HIV prevalence among the adult population in India has substantially declined from 0.4% in the year 2000 to 0.26% in the year 2015, with also a reduction of 66% in new HIV infection among adults. This clearly reflects the impact of various interventions under the National AIDS Control Programme (NACP), reiterating India's success story on HIV/AIDS control.

India is a signatory with full commitment towards the global vision to end AIDS as a public health threat by 2030.

Scaling up of HIV counselling and testing services, while ensuring privacy and confidentiality, has been an integral component of NACP and remains the gateway to HIV prevention, treatment, care and other support services.

The National AIDS Control Organization (NACO) has meticulously updated and brought out these "National HIV Counselling and Testing Services Guidelines, 2016" incorporating newer strategies to maximize access to HIV counselling and testing services across the country, then linking individuals to necessary care, support and treatment services.

I am confident that all States and Union Territories will ensure efficient implementation of these National Guidelines in public and private sectors for expeditious achievement of desired goals.

(J P Nadda)

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Government of India
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Ministry of Health & Family Welfare

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सचिव
Bhanu Pratap Sharma
Secretary

MESSAGE

The National AIDS Control Programme Phase IV (2012-17) aims to accelerate the process of reversal and further strengthen the epidemic response in India, while consolidating the gains made during the earlier three phases of the Programme from 1992 to 2012.

National HIV Estimates 2015 confirm that the epidemic in India has shown an appreciable declining trend in HIV prevalence, new HIV infections and AIDS-related deaths. With an estimated 2.12 million People Living with HIV (PLHIV), new HIV infections have dropped from 1.27 lakhs in the year 2007 to 87,000 in the year 2015, and AIDS related deaths have also reduced from 1.5 Lakhs to 67,600 during the same period.

In accordance with the global vision to end AIDS as public health threat by 2030, India has moved ahead towards achieving the global 90:90:90 target by 2020.

Scaling up of HIV Counselling and Testing Services (HCTS) is a crucial step towards achieving the first 90, wherein, it is desired that 90% of the estimated PLHIV in the country are aware of their HIV. Achieving this is vital for the success of the subsequent 90:90 related to anti-retroviral treatment and viral suppression.

Government of India is thus committed to further expand access to quality-assured HIV Counselling and Testing Services, while involving the healthcare delivery system under the National Health Mission and in close collaboration with other concerned ministries and the private sector, using innovative strategies to reach priority populations and hard to reach areas in the country.

The National AIDS Control Organization has diligently updated and developed the "National HIV Counselling and Testing Services Guidelines, 2016". Since these guidelines clearly outline a well-defined public health approach to strengthen and expand HCTS for spearheading the country's response to HIV/AIDS, these will be immensely useful for all its users.

(B P Sharma)

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FOREWORD

In India, HIV Counselling and Testing Services started in the year 1997 and since then have been scaled up at different healthcare settings. Currently, there are more than 19,800 centers, including 5,385 Stand-Alone ICTCs, 11,780 Facility-ICTCs and 2,581 PPP-ICTCs across the country. This scale up was guided by the "Operational Guidelines for Integrated Counselling and Testing Centres 2007", where the Programme was able to detect 67% of the estimated 2.12 million PLHIVs in the country by 2015.

Additionally, in continued collaboration with the National RCH Programme, an estimated 29 million pregnancies need to be annually screened for HIV and Syphilis so as to meet the goal for elimination of Mother to Child Transmission.

Considering the experiences of the past, the current goal of 90% of estimated PLHIV knowing their HIV status and WHO (2015) Consolidated Guidelines on HIV Testing Services, NACO/GoI has envisaged evidence-based innovative modalities for scaling up quality-assured HIV testing services in India.

A National Consultative process involving all concerned experts, development partners, community representatives, technical resource group, academia and research institutes, program managers / implementers and NGOs was adopted for updating the existing 2007 guidelines into a comprehensive "National HIV Counselling and Testing Services Guidelines 2016".

These updated National guidelines will surely help and facilitate in efficient - planning, implementation, guidance, supervision, monitoring and review, management, and in maintaining high quality HIV Testing Services in both public and private sectors throughout the country.

(N S Kang)

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

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MESSAGE

HIV Counselling and Testing Services (HCTS) have been rapidly scaled up by National AIDS Control Organization throughout the country both in Public and Private Sector Institutions. There is an 88% increase in number of HIV testing centers from 2011-12 (10,515 centers) to 2015-16 (19,800 centers). To enhance access to HIV Counselling and Testing Services with, Integrated Counselling and Testing Centers have been decentralized to the district, Sub-district and block levels through Stand-alone Integrated Counselling and Testing Centres (ICTCs), Public Private Partnership ICTCs, Facility-integrated ICTCs, public and private for HIV screening, and mobile ICTCs.

ICTCs are now established at all levels starting from medical colleges, districts/civil hospitals and sub district hospitals. In many states HIV testing services are also made available in Community Health Centres, Rural and Urban Centres, Clinics, Maternity Homes, Private Nursing Homes, Corporate Hospitals, Public and Private Industries etc.

Achieving the 90:90:90 goals may not be realistic without universalization of HIV testing services in all the public health care institutions in the country and NACO is striving to reaching this goal through implementation of new National HCTS guidelines. The new HCTS guidelines give us an opportunity to move forward to explore new mechanisms and effective strategies to involve both public and private sector institutions.

I strongly encourage the health care providers at all levels to create demand for HCTS services, translate the new guidelines into action, while applying the principles of existing five C's of HCTS-consent, confidentiality, counselling, correct test results and connection care and treatment under all circumstances, while maintaining high quality of services.

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PREFACE

The world is embarking on the Fast-track strategy to end the AIDS epidemic by 2030. India is committed to achieving the global 90:90:90 target by 2020 viz. 90% of people living with HIV would know their HIV status, 90% of people who know their HIV status will receive treatment and 90% of people on treatment would have suppressed viral load to minimize HIV transmission. Thus, further rapid scale up of the HIV Testing. Prevention and Treatment services is warranted in India.

The National AIDS Control Programme, hitherto, has been following the 'Operational Guidelines for Integrated Counselling and Testing Centres (ICTCs) 2007". But still nearly one-third of the estimated PLHIV do not know their status.

This necessitated appropriate updating of the existing guidelines of 2007. Therefore, NACO embarked on a participatory process beginning with a National Consultation on HIV Testing Services in India, involving different stakeholders including state programme managers, community representatives and RCH programme, followed by in-depth deliberations by (a) the group of experts and development partners and (b) NACO's Technical Resource Group on ICTC comprising of technical experts, development partners and community representatives. Simultaneously, NACO/GoI constituted a Writing Group including technical experts from research and academic institutions, development partners and NACO officials. This group meticulously developed the "National HIV Counselling and Testing Services Guidelines, 2016", taking into consideration the recommendations of WHO (2015). National Consultations and Technical Resource Group, along with the inputs from concerned officials of all the State AIDS Control Societies (SACS) as well as the public through the NACO website.

The valuable support from MoHFW/GoI, different Divisions of NACO, all development partners, research & academic institutions and SACS towards the development and bringing out of these National HCTS Guidelines is highly appreciated.

I am sure that these National Guidelines will facilitate smooth scale up, efficient implementation and uptake of HIV Counselling and Testing Services through concerted and determined efforts at all levels in India.

(Dr K S Sachdeva)

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2. The valuable support from MoHFW/GoI, all divisions of NACO, development partners, research & academic institutions and State AIDS Control Societies towards the development of these National Guidelines, is highly appreciated.

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List of Abbreviations

AAY	: Antyodaya Anna Yojana
ACH	: Air Changes per Hour
ACSM	: Advocacy, Communication and Social Mobilization
AIC	: Airborne Infection Control
AIDS	: Acquired Immune Deficiency Syndrome
AI, A2, A3	: Assays 1,2,3
ANC	: Antenatal Care
ANM	: Auxiliary Nurse Midwife
ART	: Anti-retroviral Therapy
ART Centre	: Anti-retroviral Therapy Centre
ART Plus	: Anti-retroviral Therapy Plus Centre
ARV	: Anti-retroviral Drugs
ASHA	: Accredited Social Health Activists
AWW	: Anganwadi Worker
AYUSH	: Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BCC	: Behaviour Change Communication
BPL	: Below Poverty Line
CB NAAT	: Cartridge-Based Nucleic Acid Amplification Test
CBS	: Community Based Screening
CBO	: Community Based Organization
CDC	: Centres for Disease Control and Prevention
CHC	: Community Health Centre
CLIA	: Chemiluminescence Immunoassay
CMO	: Chief Medical Officer
CSC	: Care & Support Centre
CSO	: Civil Society Organization
DACO	: District AIDS Control Officer
DAPCU	: District AIDS Control and Prevention Unit
DBS	: Dried Blood Spot
DCC	: District Coordination Committees
DH	: District Hospital
DHO	: District Health Officer
DIS	: District ICTC Supervisor
DMC	: Designated Microscopy Center
DMLT	: Diploma in Medical Laboratory Technology
DNA	: Deoxyribonucleic Acid

DPM	: District Programme Manager
DR TB	: Drug Resistant TB
DSRC	: Designated STI/RTI Clinic
ECL	: Electrochemiluminescence Immunoassay
ECS	: Elimination of Congenital Syphilis
EIA	: Enzyme Immunoassay
EID	: Early Infant Diagnosis
ELISA	: Enzyme Linked Immunosorbent Assay
ELM	: Employee-Led Model
eMTCT	: Elimination of Mother-To-Child Transmission
EQA	: External Quality Assessment
EQAS	: External Quality Assessment Scheme
FBO	: Faith-Based Organization
FEFO	: First Expired First Out
F-ICTC	: Facility-Integrated Counselling and Testing Centres
FSW	: Female Sex Worker
GoI	: Government of India
GRADE	: Grading of Recommendations, Assessment, Development and Evaluation
HBV	: Hepatitis B Virus
HCV	: Hepatitis C Virus
HIV	: Human Immunodeficiency Virus
HRB	: High Risk Behaviour
HRG	: High Risk Group
HCTS	: HIV Counselling and Testing Services
I/C	: In-Charge
IATA	: International Air Transport Association
IAY	: Indira Aawas Yojana
IC	: Infection Control
ICDS	: Integrated Child Development Services
ICF	: Intensified Case Finding
ICTC	: Integrated Counselling and Testing Centre
IDU	: Injecting Drug User
IEC	: Information, Education and Communication
IGNWPS	: Indira Gandhi National Widow Pension Scheme
IMA	: Indian Medical Association
IPC	: Interpersonal Communication
IPD	: In-Patient Department
IPT	: Isoniazid Preventive Therapy
IQC	: Internal Quality Control

I-TECH	: International Training & Educational Centre for Health
ITS	: Individual Tracking Sheet
IVD	: In Vitro Diagnostic Medical Device
JSY	: Janani Suraksha Yojana
LAC	: Link ART Centre
LAC +	: Link ART Plus Centre
LHV	: Lady Health Visitor
LPA	: Line Probe Assay
LT	: Laboratory Technician
LWS	: Link Workers Scheme
MA/MSc	: Master of Arts/Master of Science
MARPs	: Most At Risk Populations
MGNREGS	: Mahatma Gandhi National Rural Employment Guarantee Scheme
MMR	: Maternal Mortality Rate
MMU	: Mobile Medical Unit
MO	: Medical Officer
MoHFW	: Ministry of Health and Family Welfare
MOU	: Memorandum of Understanding
MPW	: Multipurpose Worker
MSM	: Men Who Have Sex with Men
MTB	: Mycobacterium Tuberculosis
NACO	: National AIDS Control Organization
NACP	: National AIDS Control Programme
NASBA	: Nucleic Acid Sequence-Based Amplification
NAT	: Nucleic Acid Testing
NFBS	: National Family Benefit Scheme
NGO	: Non-Governmental Organization
NHM	: National Health Mission
NRL	: National Reference Laboratory
NTWG	: National Technical Working Group
OI	: Opportunistic Infection
OPD	: Out-Patient Department
ORW	: Outreach Worker
OST	: Opioid Substitution Therapy
PALS	: PLHIV ART Linkage System
PAN	: Permanent Account Number
PCR	: Polymerase Chain Reaction
PD	: Project Director
PE	: Peer Educator

PEP : Post-Exposure Prophylaxis
PEPFAR : United States President's Emergency Plan For AIDS Relief
PHC : Primary Health Centre
PHN : Public Health Nurse
PICO : Population/Intervention/Comparison/Outcome
PID : Person Identification Digit
PITC : Provider-Initiated Testing and Counselling
PLHIV : People Living with HIV/AIDS
PMTCT : Prevention of Mother-To-Child Transmission
PPP-ICTC : Public Private Partner ICTC
POC : Point of Care
PPTCT : Prevention of Parent-To-Child Transmission
PrEP : Pre-Exposure Prophylaxis
PSUs : Public Sector Units
PTI : Pre-Test Information
PW : Pregnant Women
QA : Quality Assurance
QC : Quality Control
QI : Quality Improvement
QMS : Quality Management System
RCH : Reproductive Child Health
RDT : Rapid Diagnostic Test
Rif : Rifampicin
RKS : Rogi Kalyan Samiti
RKSK : Rashtriya Kishore Swasthiya Karyakram
RNA : Ribonucleic Acid
RNTCP : Revised National Tuberculosis Control Programme
RPR : Rapid Plasma Reagin
RSBY : Rashtriya Swasthya Bima Yojana
RU : Reporting Units
SACS : State AIDS Control Society
SA-ICTC : Stand-Alone Integrated Counselling and Testing Centre
SCC : State Coordination Committee
SGSY : Swarnajayanti Gram Swarozgar Yojna
SHG : Self Help Group
SIMS : Strategic Information Management System
SOP : Standard Operating Procedure
SRL : State Reference Laboratory
STI/RTI : Sexually Transmitted Infection / Reproductive Tract Infection

SWG	: State Technical Working Group
TB	: Tuberculosis
TI	: Targeted Intervention
TNA	: Total Nucleic Acid
TG	: Transgender
TTI	: Temperature Track Indicator / Trans Track Indicator
TV	: Television
UAT	: Unlinked Anonymous Testing
UID	: Unique Identification Number
UN	: United Nations
UNAIDS	: Joint United Nations Programme on HIV/AIDS
UNICEF	: United Nations Children's Fund
UNDP	: United Nations Development Programme
USAID	: United States Agency for International Development
USP	: Universal Safety Precautions
UWP	: Universal Work Precaution
VCT	: Voluntary Counselling and Testing
VDRL	: Venereal Diseases Research Laboratory Test
VMMC	: Voluntary Medical Male Circumcision
WB	: Western Blot
WBFPT	: Whole Blood Finger Prick Test
WHO	: World Health Organization
WLHIV	: Women living with HIV

1

Executive Summary

Background:

The prevalence of HIV among the adult population has continued a steady decline at the national level from an estimated peak of 0.4% in 2000 down to 0.26% in 2015. The total number of people living with HIV (PLHIV) in India is estimated at 21.17 lakhs in 2015 compared with 22.26 lakhs in 2007. Children below 15 years of age account for 6.54% while women account for 40.5% of the total estimated HIV positives.

India has successfully achieved the sixth Millennium Development Goal of halting and reversing the HIV epidemic. Between 2000 and 2015, the number of new HIV infections dropped from 2.51 lakhs to 86,000, a reduction of 66% against the global average of 35%. Children below 15 years of age accounted for 12% of the total number of new infections while the remaining new infections were among adults.

Since 2007, the annual number of AIDS-related deaths has declined by 54%. This decline is consistent in conformity with the rapid expansion of access to services providing antiretroviral therapy (ART) in India. It is estimated that the scale up of free ART in India since 2004 has cumulatively saved around 4.5 lakh lives until 2014.

During 2014-15, the National AIDS Control Programme (NACP) in collaboration with the National Reproductive and Child Health Programme has included screening for HIV and syphilis in the essential package of ante-natal care services for all pregnant women. This will enable India to eliminate both HIV and syphilis in the new born.

So far, NACP has been following the 2007 Operational Guidelines for Integrated Counselling and Testing Centres. In 2015, the World Health Organization (WHO) released the 'Consolidated guidelines on HIV testing services, 2015'. India being a signatory to the global 90:90:90 targets, felt the need to update the existing operational guidelines for rapid scale up of HCTS to reach the first 90.

Early testing and diagnosis, on a voluntary basis, is the gateway to HIV prevention, treatment, care and other support services. The challenge is to increase access to and uptake of HIV testing among priority populations. This warrants different innovative strategic approaches suitable for implementation across different states and union territories of India.

HCTS continues to envisage the provision of comprehensive services in an integrated manner, and not limited to HIV testing. HCTS comprises of (i) counselling (pre-test counselling, informed consent and post-test counselling); (ii) testing and prompt delivery of test results with embedded quality assurance;(iii) ensuring audio-visual privacy and confidentiality; and (iv) linkages to appropriate HIV prevention, care, support and treatment services. India meticulously follows the "5 Cs (Consent, Confidentiality, Counselling, Correct test results and Connection)", as articulated in the WHO 'Consolidated Guidelines on HIV Testing Services, 2015', since the introduction of voluntary counselling and testing services for HIV.

The present 'National HIV Counselling and Testing Services Guidelines 2016' provides extensive details on the different strategic approaches with implementation plan to scale up the reach and coverage of services to priority populations.

Summary of Key Changes:

NACO has made significant advances in terms of how HIV counselling and testing services will be offered across the country. The major changes from the 2007 Operational Guidelines for Integrated Counselling and Testing Centres are highlighted below:

1. All HCTS facilities have been divided into two groups:
    - Screening Facility (F-ICTC, PPP-ICTC, TI-ICTC, OPD, IPD, Emergency wards etc.), and
    - Confirmatory Facility (SA-ICTC)
2. Community-based HIV screening approaches have been included in the present National HIV Counselling and Testing Services Guidelines, 2016 to improve access to HIV testing.
3. Three different Public Private Partnership models have been introduced to increase HIV testing and improve data sharing practices in the private sector.
4. Counselling remains one of the key pillars of HIV services. NACO endeavours to standardize pre-test and post-test counselling at both the screening and confirmatory facilities and detailed notes for the same have been included in these guidelines. However, the post-test counselling and the follow-up counselling sessions shall now be customized to the patient being tested - such as pregnant women, adolescents, HRG etc.
5. To promote early detection of co-infections, all individuals accessing ICTCs will now be verbally screened for TB, STI/RTI and other co-infections by the counsellor.
6. Standard operating procedures for all counsellors at screening and confirmatory facilities have been created to enable them to carry out these additional responsibilities with ease. Additionally, standard operating procedures have been included for all ICTC personnel conducting HIV tests at the HCTS facility.
7. New sections on (a) HIV-TB collaborative activities, (b) linkages, (c) supply chain management, (d) IEC activities, (e) information management system and (f) testing for syphilis at the HCTS testing facility, have also been added.

Keeping these changes in mind, updated information on trainings has also been outlined in these guidelines. The major changes in the training section include a section on HIV-TB, information management systems, and supportive supervision system.

2

HIV Counselling and Testing Service Delivery Strategies

An individual's knowledge of his/her HIV status is crucial to the success of the national programme. PLHIV who do not know their HIV status need to be diagnosed as early as possible after acquiring HIV infection. However, through the existing approaches, only about two-thirds of the estimated PLHIV have been diagnosed. Thus, to reach the remaining PLHIV, it is important to have cost-effective HCTS delivery approaches.

NACO is augmenting efforts to scale up HCTS for priority populations with a special focus on reaching the unreached. A strategic mix of HCTS has been planned to facilitate early diagnosis of HIV amongst priority populations. The aim is to maximize efficiency and cost-effectiveness while ensuring equity.

Every effort needs to be made to ensure timely and prompt linkage of those found HIV-positive to treatment, care and support services. Likewise, all those individuals found non-reactive for HIV should be appropriately counselled, referred and linked for follow-up HIV testing, while ensuring privacy and confidentiality.

2.1 Priority populations for HCTS

The focus should be on the following priority populations:

1. **Infants and children**

   A child may acquire HIV from the HIV infected mother-in-utero (during pregnancy), peripartum (during delivery), postpartum (through breastfeeding) or via parenteral exposure through infected needles and syringes. Early diagnosis of HIV infection in infants/children is very important to plan their care, support and treatment, and to reduce morbidity and mortality.

   All newborn babies of HIV-positive mothers and infants/children with signs or symptoms suggestive of HIV infection should be tested for HIV.

2. **Adolescents (age group 10–19 years)**

   Adolescents are vulnerable to HIV due to physical and emotional transition, and potentially heightened risk-taking behaviour. The NACP, in collaboration with the '*Rashtriya Kishore Swasthya Karyakram (RKSK)*', focuses on early diagnosis of HIV and appropriate referral linkages to address high-risk behaviour, reproductive, sexual, STI/RTI and HIV-related issues among adolescents. If the adolescent is below 18 years of age, informed consent of the parent/guardian needs to be obtained for HIV testing.

3. **Pregnant and breastfeeding women**

   Mother-to-child transmission of HIV during pregnancy, delivery or breastfeeding is the primary cause of HIV infection among children. It is estimated that without any intervention, the risk of transmission of HIV from infected mother to her child is between 20% and 45%. With appropriate interventions, this risk of HIV transmission can be reduced to less than 5% in breastfed children.

The Government of India is committed to eliminating HIV and syphilis amongst newborns through universal screening of pregnant women for HIV and syphilis as an essential component of the ANC service package. To achieve this objective, on-going PPTCT services are being implemented in close collaboration with the

Reproductive and Child Health (RCH) Programme of the National Health Mission (NHM). Even pregnant women coming direct-in-labour and breastfeeding women need to be tested for HIV and syphilis, if not tested during pregnancy.

For further details, please refer to -

- "Updated National PPTCT Guidelines, December 2013"
- "National Strategic Plan on PPTCT, December 2013"

4. Occupational exposure

Health-care workers exposed to infected material, with a possible risk of acquiring HIV, need to be referred to HCTS before initiating any Post Exposure Prophylaxis (PEP) and, after completion of the PEP course, for follow-up HIV testing.

5. Emergency settings (casualty)

Patients who present with signs and symptoms suggestive of HIV/AIDS in emergency health-care setting need to be offered HCTS in the same emergency health-care setting.

6. Patients with Kala-azar (Visceral Leishmaniasis)

In India, Kala-azar is reported to be endemic in 54 districts spread across Bihar, Jharkhand, Uttar Pradesh and West Bengal. It is one of the opportunistic infections (OIs) seen among PLHIV. Morbidity and mortality is high in HIV and Kala-azar co-infected patients. Hence, the NACP and the National Vector-Borne Disease Control Programme have recommended that HCTS should be offered to all Kala-azar patients and persons suspected to have Kala-azar.

7. Tuberculosis patients including presumptive TB cases

Since TB is the most common OI and the leading cause of mortality in PLHIV, all TB patients and presumptive TB cases need to be tested for HIV. Partners of known HIV-positive TB patients should also be offered HCTS with mutual disclosure. Likewise, all individuals availing HCTS should be verbally screened for TB and all eligible symptomatic persons should be promptly referred to TB diagnostic facilities under the Revised National Tuberculosis Control Programme (RNTCP).

8. STI / RTI attendees and patients

In India, HIV transmission is mostly through the sexual route. An unprotected sexual encounter with a casual sexual partner may put the individual at risk of acquiring STIs including HIV. As patients with STI / RTI are at higher risk of acquiring HIV infection, all STI / RTI attendees should be offered HCTS.

9. Sexual partners / spouses of PLHIV (couples)

The chance of transmission of HIV from the index PLHIV to their sexual partner is the highest. Hence, efforts should be made to test all sexual partners for HIV with counselling support for mutual disclosure.

10. High-risk groups (HRGs)

HRGs comprising core groups such as FSWs, MSM, IDUs, TS/TG and bridge populations such as migrants and truckers have a higher risk of acquiring HIV infection due to multiple casual sexual partners and risky sexual practices. Thus, for early diagnosis and prevention of HIV, HCTS should be routinely offered to all HRGs.

11. Prison inmates

Voluntary HIV testing should be an integral part of the health-care package for prison inmates.

12. Persons who have undergone sexual assault

HCTS should be offered to all individuals who have faced sexual assault. Such individuals should also be counselled for follow-up testing and care should be taken to avoid any form of stigmatization.

2.2 Flow of individuals for accessing HCTS

Individuals can access HCTS in two ways:

1. **"Self- initiated":** Individuals who self-perceive their risk and need for HIV testing and thus voluntarily approach for HCTS.
2. **"Provider-initiated":** Individuals referred by a health-care provider for HIV testing.

In case of provider-initiated HCTS, the individual must receive pre-test counselling about HIV testing to make an informed choice, with an option to "opt-out". The process of informed consent and information related to testing should be documented in the counselling register. Health-care providers should offer HCTS in a confidential manner, without stigma or discrimination. HIV screening test may be done in the outpatient department (OPD)/ inpatient department (IPD)/ emergency settings or at a general laboratory. If the individual is found reactive for HIV at screening, such individuals should be referred to a SA-ICTC with a Linkage form ***(Annexure B1)*** for confirmation of the HIV diagnosis. All individuals found HIV positive at SA-ICTC should be promptly linked to an ART centre.

NACP also recommends the establishment of provider-initiated HIV screening at all designated STI / RTI clinics (DSRCs) and designated microscopy centres (DMCs) under the RNTCP.

Box 2.1: Provider-initiated HCTS may be offered to the following priority populations:

a) All pregnant women

b) Babies born to HIV-positive women

c) Untested children of women living with HIV (WLHIV)

d) Children presenting with suboptimal growth or severe acute malnutrition, delay in developmental milestones, oral thrush, severe pneumonia and sepsis

e) Patients who present with signs and symptoms suggestive of HIV/AIDS in any health-care setting including emergency

f) Individuals who have faced sexual assault

g) Before initiating PEP and as a follow-up testing

h) Patients with TB or presumptive TB, Kala-azar, hepatitis B or C, or STI/RTI

i) STI/RTI clinic attendees

j) Sexual partners/spouses of PLHIV

k) Any other situation where the health-care provider feels HIV testing is essential

2.3 Roles and responsibilities of HCTS personnel

Key personnel involved in HCTS:

1. NACO official
2. SACS official
3. District ICTC Supervisor
4. HCTS facilities (Screening and Confirmatory Facility)

The key responsibilities of each of these personnel are detailed in the following section.

2.3.1 NACO Personnel

Strategy formulation

- Based on need and situation analysis, supervise the formulation, implementation and achievements of National & State/UT annual physical and financial plan for HCTS services
- Facilitate the development and implementation of strategies/protocols/standards etc. laid down by NACO
- Facilitate the meetings of related Technical Resource Groups/committees etc.

Supervision

- Supervise the implementation of HCTS activities in all States/UTs
- Handhold SACS in the implementation of HCTS technical and operational guidelines for ensuring efficient functioning of HCTS activities
- Supervise the related HR needs assessment and training plan for capacity building of staff, ensuring the effective implementation of training modules
- Ensure information system management
- Monitor, supervise and ensure Supply Chain Management (SCM) for all related diagnostics, pharmaceuticals and other logistics across the country

- Supervise, guide and mentor the efficient functioning of concerned subordinate offices and functionaries
- Undertake field visits to the relevant health facilities including teaching, training and research institutes, up to peripheral levels in all States/UTs

Coordinate with other Government functionaries

- Liaison with National Health Mission (NHM), various development partners, public and private sector institutions, NGOs, professional bodies etc.
- Co-ordinate with SACS, TSUs, DAPCUs etc.
- Provide technical support to NACP for related operational research
- Assist in preparing draft material for replies to Parliament Questions/RTIs/ Court cases/ Parliamentary committees etc.
- Facilitate related ACSM activities
- Ensure quality and management standards in all programmatic activities

Others

All other work related to execution of listed activities and any other relevant work as and when assigned

2.3.2 SACS Personnel

Supervision of HCTS facilities

- Monitor and supervise the implementation of ICTC/PPTCT/HIV-TB programme in the State & timely report the progress to NACO
- Plan and supervise the implementation of scale-up plan for HCTS facilities to the level of CHCs, 24 × 7 PHCs and Private Sector health institutions
- Undertake field visits to HCTS facilities in the State, especially to poorly performing centres
- Organize quarterly review meetings of District ICTC Supervisor and all Counsellors of HCTS facilities

Training and Capacity Building of HCTS facilities

- Supervise the selection and training of counsellors and LTs for HCTS facilities
- Supervise the selection, training and posting of district coordinators for HCTS facilities in A and B category districts
- Monitor the quality of training/capacity building being imparted in institutions of excellence identified by NACO for training of counsellors and LTs from the state

Planning and forecasting

- Prepare the State annual physical and financial plan for HCTS facilities
- Make annual forecast of rapid test kits and consumables and prophylactic Nevirapine required for HCTS facilities

- Ensure 100% timely reporting in SIMS for all HCTS facilities and data quality monitoring for consistency, correctness and completeness
- Supply chain monitoring of HIV rapid test kits and other consumables required for HCTS facilities including service delivery point-wise monitoring for variances and reporting to NACO on monthly basis

Coordination with other Government Departments

- Liaise with senior officials of the National Health Mission (NHM) and conduct coordination meetings regularly at State level
- Liaise with the State TB officer and conduct meetings of the State HIV-TB coordination committee every quarter
- Coordinate with other divisions of SACS like CST, TI, STI & RNTCP
- Assist the Project Director in preparing replies to Legislature/Parliament Questions, reports to various Departments of the State Government including the Department of Health and Family Welfare on issues pertaining to ICTC/PPTCT/HIV-TB

2.3.3 District Personnel

The main function of District ICTC Supervisor is to coordinate and monitor HIV testing services in the district according to NACO/SACS policies and guidelines. S/he is responsible for planning and implementation of the HIV programme, extensive monitoring of the programme activities implementation by the service delivery facilities, capacity building of the peripheral units' staff and coordination with key players involved in the HIV programme implementation in the district. In districts which do not have a DAPCU, a senior ICTC counsellor may be nominated as District ICTC Supervisor.

Responsibilities of the District ICTC Supervisor are as given below:

- **Programme Planning:** Assume the responsibility of planning HIV activities by the HIV/AIDS facilities based on the epidemiological profile, location and performance of the facility following the NACP and SACS priorities for developing more realistic plans. The planning will be done under the guidance of the DPM in collaboration with other DAPCU members
- **Programme Implementation:** Support DACO and DPM in facilitating effective implementation of the approved plan based on SACS operational and implementation guidelines for different components of the programme for achieving the desired outcomes
- **Monitoring and Reporting:** Be responsible for monitoring the programme activities through different forums to gauge the programme directions, use and encourage the facility staff to make informed decisions for sound implementation, and ensure reporting of quality data and information through the preparation of periodic reports for submission to SACS/NACO
- **Capacity Building:** Assess the capacity building needs of facility-level staff and in consultation with the DACO/DPM, address the gaps locally or centrally as per SACS directives to enhance their performance for better programme outcomes

- **Coordination:** Support the DACO for coordinating with the district administration, related line departments and non-governmental partners working in the sector to enhance the convergence to bring better synergy and promote NACP activities in the district
- In addition to the above, the position will carry out additional responsibilities as assigned by the DACO or DPM to address the programme needs and priorities

The key responsibilities of personnel at HCTS facilities are outlined in the sections below.

2.4 HCTS delivery approaches

HCTS are delivered in two ways – (a) Facility-based services and (b) Community-based services

2.4.1 Facility-based HCTS

Facility-based HCTS (screening or confirmation) are offered to individuals accessing health-care facilities functioning as per the OPD timings of the institution where the HCTS facility is located. However, SACS should ensure that at least HIV screening test services are available after normal work hours.

All the concerned functionaries need to ensure privacy, confidentiality and safe custody of the personal information and test results of the individual. The package of services at different HCTS facilities is summarized in Table 2.1.

Table 2.1: Service package at different HCTS facilities

S.No.	Types of HCTS facility	Institution where HCTS facility can be established	Package of HIV testing services as per the National HCTS Guidelines, 2016
1	HCTS Confirmatory facility	- Government healthcare facilities under Central, State and corporation administration of the level of medical college, general hospital, district hospital, sub-district hospital and community health centre (CHC) - Health facilities under public sector undertakings - Private medical colleges - Public-private partnership facilities - Mobile SA-ICTC - Targeted intervention (TI-based SA-ICTC)	- Pre-test counselling and informed consent - HIV testing and sharing of test result - Post-test counselling & disclosure - Early infant diagnosis (EID) - Testing of sexual partner/spouse - Screening for STI/RTI, TB and other co-infections - Linkages to care and treatment and other health services - Linkage to social welfare schemes - Outreach activity - Follow-up testing and counselling - Follow up of discordant couple - Act as a nodal point for coordination, supportive supervision, capacity building and supply chain management of all F-ICTCs

S.No.	Types of HCTS facility	Institution where HCTS facility can be established	Package of HIV testing services as per the National HCTS Guidelines, 2016
2	HCTS Screening facility	- F-ICTC - Government Health Facility (PHC/CHC/SDH) - OPD/IPD/Emergency ward - Mobile F-ICTC - Public-private partnership facility - Health facilities under corporations and public sector undertakings - Private medical colleges - TI-based - Designated microscopy centre (DMC) - Designated STI/RTI Clinics (DSRC)	- Pre-test counselling and informed consent - HIV screening - Screening for STI/RTI, TB and other co-infections - Post-test counselling - Linkages to SA-ICTC for confirmation of diagnosis and care and treatment - Linkage to other health services

2.4.1.1 Stand-Alone ICTC (SA-ICTC)

1. Physical infrastructure

The SA-ICTC facility should be located at an easily accessible place with proper signages to direct and guide people to the location. The SA-ICTC facility should consist of at least two rooms, one for counselling and the other for testing.

i. Counselling room

The counselling room should be at least 15'X15' in size (225 sq. ft.) with ventilation standards of 6–12 air changes per hour (ACH) to reduce the risk of air-borne infection to the staff and individuals accessing HCTS. The room should ensure audio-visual privacy. This room should be furnished with a desk and chair for the counsellor, another 10–15 chairs for group counselling sessions, a lockable filing cabinet for keeping records, and a desktop computer with a computer table along with UPS and printer. The SA-ICTC should have functional internet connectivity. It should be equipped with the following communication and educational aids:

- TV and DVD player in a lockable stand
- Wall-hanging posters and information materials for display
- Flip charts, and penis model for demonstration of condom use
- Leaflets/pamphlets as take-home material

ii. Blood collection and testing room

The blood collection and testing room should have an area of at least 10'x10' in size (100 sq. ft.), furnished with a desk, a chair and a workstation, and should preferably be co-located with a counselling room. The testing room should also have a comfortable seating arrangement for

the individual accessing HCTS. The laboratory should be equipped with one refrigerator with voltage stabilizer, thermometer, centrifuge, needle destroyer, micropipette and colour-coded waste disposal bins with disposable polybags, as per the NACO HIV Testing Guidelines 2015.

The availability of the following laboratory consumables should be ensured for collection and testing of blood:

- Sterile needles and syringes/vacutainers
- Disposable gloves
- Vials and tubes for collection and storage of blood
- Cotton swabs
- Cleaning material such as spirit/antiseptic lotion/distilled water
- Bleach/hypochlorite solution
- Micro tips for use in micropipettes

Box 2.2: Infection control and protection of staff

The staff working in the blood collection room and laboratory should adopt the universal work precautions. A detailed description of the universal precautions is provided in the National HIV Testing Guidelines 2015. In case of accidental exposure of any staff member to HIV infection, PEP must be administered within the stipulated time frame. The protocol for administration of PEP is available on NACO website.

Air-borne infection control (AIC): To prevent the transmission of TB and other air-borne infections, an HCTS facility should carry out the following activities:

- Ensure cross-ventilation at the waiting hall, hallway, counsellor room and testing room
- Educate and counsel on cough hygiene for persons with cough
- Fast-track persons with cough to appropriate service delivery points, including TB diagnosis

2. **Major responsibilities of staff at SA-ICTC**

The details of deployment, training, orientation, major roles/responsibilities and activities of the different staff at SA-ICTC are highlighted in Table 2.2.

1. Medical Officer, In-charge of SA-ICTC

Criteria and mechanism of deployment: The administrative head of the institution where the SA-ICTC is located will nominate a medical officer as officer in-charge of the SA-ICTC.

Essential orientation /training requirement: Three days by the State AIDS Control Society (SACS)

Table 2.2: SA-ICTC staff roles and responsibilities

Major roles and responsibilities	Major activities to execute roles and responsibilities
Maintain attendance register	▪ Ensure punctuality and facilitate timely payment of salaries to the SA-ICTC staff
Sensitization	▪ Ensure that all staff at institution where SA-ICTC/linked F-ICTCs is located are sensitized on NACP including HCTS
Conduct capacity building of staff	▪ Ensure induction and periodic refresher training of staff at SA-ICTC and linked F-ICTCs
Ensure supply chain and logistics management of kits and all other HCTS-related commodities at the SA-ICTC and linked F-ICTCs. The log and inventory management should be as per the NACO Guidelines	▪ Forecast requirement of kits and commodities for SA-ICTC & linked F-ICTCs basis estimated requirement per month ▪ Monitor and ensure supplies of kits and all HCTS related commodities from SACS and their proper utilization, ensuring that the kits do not expire ▪ First expiry first out (FEFO) principle must be followed ▪ Ensure availability of stocks of rapid diagnostic test (RDT) kits and consumables at all times by timely indenting and coordinating with district HIV/AIDS nodal office and SACS ▪ Ensure availability of condoms at SA-ICTC & linked F-ICTCs including condom demonstration models ▪ Ensure that requisite space, equipment & information, education & communication (IEC) materials for efficient functioning of SA-ICTC/ linked F-ICTCs are made available
Monitoring and supportive supervision of staff at the SA-ICTC and linked F-ICTCs, to ensure quality of service	▪ Ensure that medical officer's validated and signed laboratory reports are provided on the **same day** to individuals tested for HIV ▪ In the absence of medical officer In-charge, any other doctor in the health facility is authorized to sign the test report after duly verifying the records ▪ Ensure that HIV testing is as per National HIV Testing Protocol ▪ Facilitate maintenance of equipment at SA-ICTC ▪ Conduct monthly in-depth review of all activities of SA-ICTC and ensure timely & appropriate corrective actions ▪ Review and validate daily maintenance of all records and registers at SA-ICTC, as per the National HCTS guidelines ▪ Review the monthly report of the SA-ICTC for completeness and correctness, before the report is uploaded in SIMS by the 5th of every month. Also ensure that quarterly report shared by SA-ICTC is complete and correct. ▪ Recording and data entry needs to be done daily and periodically reviewed for quality. Ensure accuracy of data generated by SA-ICTC staff by cross-checking with the registers maintained in the SA-ICTC ▪ Facilitate the supportive supervision of staff of linked F-ICTCs through the SA-ICTC counsellor and laboratory technician to ensure quality of service

Major roles and responsibilities	Major activities to execute roles and responsibilities
Demand generation for HCTS: plan and implement activities to mobilize priority populations for HCTS	▪ Appropriately engage community and opinion leaders ▪ Coordinate with NGOs conducting targeted interventions to strengthen linkages ▪ Liaise with professional bodies such as the Indian Medical Association (IMA), Federation of Obstetric and Gynaecological Societies of India (FOGSI), Indian Association of Paediatrics (IAP), etc. to strengthen linkages with private health-care institutions ▪ Engage organizations and community-based structures such as truck owners' associations, labour unions, NSS, youth clubs, self-help groups, not-for-profit organizations, etc. to increase HCTS uptake
Quality assurance (QA) in all HCTS components at the SA-ICTC and linked F-ICTCs	▪ Adhere to NACO's quality assurance guidelines and standard operating procedures (SOPs), as detailed in the guidelines

2. Counsellor

Criteria and mechanism of deployment: One counsellor appointed on a contractual basis. In the SA-ICTC where counselling is required to be done for more than 500 individuals in a month, an additional counsellor may be appointed, based on the review by a committee comprising the project director (PD) of the concerned SACS as chairman, and two experts from the fields of counselling and testing as members. The counsellor reports to the medical officer in-charge of the SA-ICTC.

Essential orientation/training requirement: Counsellor should be a graduate degree holder in Psychology/Social Work/Sociology/ Anthropology/Human Development OR diploma in Nursing with minimum 3 years of experience in HIV/AIDS. In case of those recruited from community of people infected with or affected by HIV/AIDS, graduates from any field or diploma in Nursing may be considered if they have minimum 1 year of experience in HIV/AIDS. It is desirable that counsellor holds post-graduate degree in Psychology (MA/MSc) or Social Work. As per contract, counsellor needs to undergo the integrated induction and refresher training as per NACO Guidelines.

Major roles and responsibilities	Major activities to execute roles and responsibilities
Deliver the counselling package as detailed in Chapter 3 on Counselling in these HCTS guidelines	▪ Ensure that each individual tested for HIV is given pre-test counselling, post-test counselling & follow-up counselling, ensuring audio-visual privacy and confidentiality ▪ Provide psychosocial support to individuals for accepting HIV test results ▪ With the consent of PLHIV, counsel and prepare the family for acceptance and support the PLHIV ▪ Home visit to PLHIV with prior consent, is one of the outreach activities. The visit is to be planned based on need, such as loss of linkage, or non-compliance to the prescribed services
IEC	▪ Well-designed and communicative signages should be displayed at strategic points, guiding individuals for easy access to the HCTS facility ▪ Posters, flip books, penis model for condom demonstration, public educational material, short videos and films must be efficiently utilized in the SA-ICTC ▪ Posters on standardized dashboard indicators should be displayed (***Annexure C7***)

Major roles and responsibilities	Major activities to execute roles and responsibilities
Priority populations	▪ As detailed above
Referral and linkage	▪ Please refer to **Chapter 6** on Linkage in these guidelines
Supply chain and logistics management	▪ Report to the medical officer/in-charge of the SA-ICTC on the stock situation of registers, condoms and IEC materials in the SA-ICTC and place an indent accordingly
Maintenance of records and reports, including data analysis	▪ Maintain counselling records and registers, and prepare monthly report for upload in SIMS by 5th of every month. Also, prepare quarterly SIMS report. ▪ Update details of HIV-positive individuals on a weekly basis in PLHIV ART Linkage System (PALS) ▪ Prepare a monthly/quarterly /annual data analysis and display the updates ▪ Facilitate and monitor linkages and referrals to and from the ICTC
Supportive supervision	▪ Conduct supportive supervision of the staff of linked F-ICTCs, to ensure quality of services

3. Lab Technician

Criteria and mechanism of deployment: One LT appointed on a contractual basis, with less than 10,000 annual test load. For every additional 5,000 annual tests, one additional LT, subject to the maximum of three LTs, may be appointed on a contractual basis. The LT will report to the medical officer in-charge of the SA-ICTC.

Essential orientation/training requirement: The LT should hold at minimum a Diploma in Medical Laboratory Technology (DMLT) from state government-approved institution. However, the services of the existing LTs who do not hold DMLT may continue if they have done Certificate Course in Medical Laboratory Technology and have over 5 years of experience working in ICTC. As per contract, LT needs to undergo the 5-days induction and 3-days refresher training as per the NACO guidelines.

Major roles and responsibilities	Major activities to execute roles and responsibilities
Testing for HIV (as detailed in Chapter 4 on HIV testing in these guidelines)	▪ Ensure that the laboratory premises and workstation are maintained as per the infection control protocols (Refer to the National HIV Testing Guidelines 2015) ▪ Ensure maintenance of all laboratory equipment including cold chain of test kits ▪ Conduct testing for HIV as per NACO testing protocols following SOPs ▪ Follow internal and external quality assurance procedures ▪ Collect dried blood spot (DBS) specimens for EID Following SOPs as per NACO protocols ▪ Follow universal safety precautions and strictly adhere to biomedical waste management guidelines ▪ Document separately results of HIV test and DBS collection result in their respective lab registers, on a daily basis
Supply chain and logistics manage-ment	▪ Report to the medical officer in-charge SA-ICTC on stock situation of HIV test kits and related commodities, registers in SA-ICTC and place indent accordingly to ensure all-time availability of all these items

Major roles and responsibilities	Major activities to execute roles and responsibilities
Maintenance of reports and records and submission of reports as per the norms.	▪ Ensure that the lab report duly signed by the medical officer is recorded in the Lab register. Share this signed Lab report with the counsellor, on the **same day** ▪ Update laboratory, EID card,and stock register daily ▪ Submit weekly stock report to district HIV/AIDS nodal officer through the in-charge medical officer ▪ Complete the laboratory section information in monthly SIMS report format for timely uploading of monthly report in SIMS by counsellor. Also, complete the relevant sections in SIMS quarterly report. ▪ Ensure timely submission of EID reports (***Annexure D3***)
Supportive supervision	▪ Conduct supportive supervision of the staff of linked F-ICTCs, to ensure quality of services (Refer to **Chapter 7** on Capacity building and supportive supervision)

2.4.1.2 Facility-integrated counselling and testing centres (F-ICTC)

To increase the access of at-risk populations to HCTS in a cost-effective manner, NACO in addition to establishing SA-ICTC at the CHC and higher levels, has evolved a strategy with the RCH programme for integrating HIV screening at all primary health centres (PHCs) and delivery points across India. They are labelled as facility integrated counselling and testing centres (F-ICTCs) and should be appropriately linked to the nearest SA-ICTC. HIV screening at all F-ICTCs will be implemented through their existing staff with due sensitization, orientation, guidance, monitoring and supervision by the linked SA-ICTC.

This mechanism of taking HCTS closer to the people may increase the uptake of services while reducing transportation costs and waiting times. Further, integrating HCTS into the general health system will ensure sustainability, cost-effectiveness and facilitate the mainstreaming of HCTS. This will also ensure achievement of the national objectives of eliminating HIV and syphilis among newborns.

Proper signages should direct and guide people to reach the site and functionary for HIV screening. To ensure audio-visual privacy and confidentiality during HIV screening and counselling, the health facility should earmark a suitable room with good cross-ventilation to prevent air-borne infection.

The facility should use whole blood finger-prick test kits for HIV screening. Need-based quantities of these test kits should be supplied on a regular basis by the district HIV/AIDS nodal officer through the linked SA-ICTC. In case of unavailability of whole blood finger prick test kits, the facility should inform the linked SA-ICTC immediately and they should either (a) advise the individual to visit the nearest HCTS facility or(b) test the individual using the serum/ plasma Rapid Diagnostic Test (RDT) HIV test kit (if available).

These test kits need to be stored between 2°C to 8 °C in the refrigerator available at the health facility. The temperature track indicator (TTI) should be monitored regularly for any change in colour, by the staff in-charge of HIV screening. Kits that show a change in colour in the TTI should not be used and promptly replaced through the linked SA-ICTC. The generated bio-waste should be disposed of as per the infection control guidelines.

HCTS related major roles and responsibilities of F-ICTC staff are summarized in Table 2.3

Table 2.3: F-ICTC staff roles and responsibilities

Staff of health facility functioning as F-ICTC	Major roles and responsibilities in the context of HIV screening	Major activities to execute roles and responsibilities
Medical officer in-charge	HIV and syphilis screening of all pregnant women within the jurisdiction of health facility	▪ Ensure that all pregnant women are screened for HIV and syphilis ▪ Refer all those pregnant women found reactive for HIV screening to linked SA-ICTC for HIV diagnosis and further necessary action ▪ Treat all those pregnant women found to be positive for syphilis as well as their partners ▪ Ensure institutional delivery; facilitate newborn HIV/syphilis testing and treatment as applicable
	HIV and syphilis screening of individuals with high-risk behaviour attending the health facility	▪ Ensure that all individuals with high-risk behaviour are screened for HIV and syphilis ▪ Ensure that all TB patients or suspects, STI clinic attendees and HRGs availing services at this facility are screened for HIV and syphilis ▪ Refer all those individuals found reactive on HIV screening to the linked SA-ICTC for HIV diagnosis and further necessary action ▪ Ensure that every HIV screening laboratory report is signed and provide the same to individuals found non-reactive for HIV screening on the same day ▪ Treat all those found positive for syphilis as well as their partners ▪ Counsel and educate on safer sexual behaviour for individuals found negative for syphilis
	Capacity building	▪ Ensure that all the staff at the health facility where the F-ICTC is located are sensitized on all aspects of the NACP, including HIV screening
	Supply, logistics and cold chain management of kits at F-ICTCs. The log and inventory management should be as per the NACO Guidelines.	▪ Forecast and share with the linked SA-ICTC about the number of whole blood finger-prick (WBFP) test kits required for the F-ICTC based on the estimated requirement per month ▪ Monitor and ensure the supplies of these test kits from the linked SA-ICTC and their proper utilization, ensuring that the cold chain (2–8 °C) is maintained at all times and kits do not expire. The principle of first expiry first out (FEFO) should be followed ▪ Ensure the availability of stock of WBFP test kits by timely indent and close coordination with the linked SA-ICTC ▪ Ensure the demonstration, distribution and availability of condoms at the F-ICTC ▪ Ensure that requisite space and IEC materials for efficient functioning of the F-ICTC are made available

Staff of health facility functioning as F-ICTC	Major roles and responsibilities in the context of HIV screening	Major activities to execute roles and responsibilities
	Monitoring and supportive supervision of staff at F-ICTCs, to ensure quality of service	▪ Ensure that individuals found reactive for HIV are promptly linked to the SA-ICTC for confirmation of HIV diagnosis and further necessary action ▪ Ensure that HIV screening is as per the national HIV testing guidelines ▪ Regularly review HCTS during monthly meetings of the health facility staff and ensure timely and appropriate corrective action ▪ Review and validate the daily maintenance of all prescribed HCTS related records and registers at the F-ICTC ▪ Review the monthly report of the F-ICTC for completeness and correctness, before the report is uploaded in the SIMS by the 5th of every month. Ensure that recording and data entry is done daily and periodically review for quality. Ensure the accuracy of the data generated by the F-ICTC staff by cross-checking with the registers maintained in the F-ICTC ▪ Coordinate with the linked SA-ICTC to address issues that arise while delivering HCTS
	Demand generation for HTS: plan and implement activities to mobilize priority populations to increase coverage of HCTS by engaging accredited social health activists (ASHAs), PLHIV community and high-risk community	▪ Appropriately engage community and opinion leaders ▪ Coordinate with targeted intervention NGOs for strengthening referral linkages ▪ Liaise with private health-care providers in the jurisdiction of the health facility to strengthen referral linkages ▪ Engage organizations and community-based structures such as truck owner associations, labour unions, NSS, Youth Clubs, self-help groups, not–for-profit organizations, etc. to enhance access to and uptake of HCTS
	Internal quality assurance (QA) in F-ICTCs	▪ Adhere to NACO's internal QA guidelines and SOPs (as described in **Chapter 3** and **Chapter 4** of these guidelines)
Any paramedical staff designated for HIV screening (PHN/ LHV/ANM/MPW-male/pharmacist) in the health facility Note: If the facility has an LT, HIV screening tests should be preferably carried out by them.	Deliver the HCTS package (as detailed in **Chapter 3** and **Chapter 4** on Counselling and HIV testing, respectively, in these guidelines)	▪ Ensure that each individual screened for HIV is given pre-test counselling with documented informed consent, perform HIV screening test using the whole blood finger-prick test and given post-test counselling. ▪ Ensure audio-visual privacy and confidentiality ▪ If found reactive on HIV screening, link the individual to the linked SA-ICTC for confirmation of HIV diagnosis and further necessary action, using Linkage Form ▪ If found non-reactive on HIV screening, the laboratory report duly signed by the medical officer should be given to the individual during post-test counselling, on the same day as the screening
	IEC	▪ Posters, flip books, penis model for condom demonstration, public education materials, short videos and films should be efficiently used in the F-ICTC ▪ Posters on standardized dashboard indicators be displayed (***Annexure C6***)

Staff of health facility functioning as F-ICTC	Major roles and responsibilities in the context of HIV screening	Major activities to execute roles and responsibilities
	Supply chain and logistics management	▪ Report to the medical officer on stock situation of test kits, registers, condoms and IEC materials in the F-ICTC and place an indent accordingly
	Records and report maintenance, including data analysis	▪ Maintain HCTS related records and registers, and prepare a monthly report to be uploaded in SIMS by 5th of every month. Prepare quarterly SIMS report as well.
	Cold chain maintenance	▪ Daily monitor the time temperature Indicator (TTI) of the HIV testing kits stored as per the required temperature. If any colour change is noted in the TTI, promptly report to the medical officer for immediate necessary action.

Testing Individuals at OPD/IPD/Emergency/Casualty wards or General Labs:

It should be noted that each of the in-patient department (IPD)/out-patient department (OPD) etc. should function as an individual F-ICTCs within an institute where an individual can be screened for HIV, and will follow the SOPs for an F-ICTC. Proper pre-test counselling and informed consent should be taken from individuals who are being tested at these facilities. If an individual tests reactive on the screening test, then the individual should be linked to a Stand-Alone ICTC for confirmatory testing. (refer to **Chapter 4** for more details)

Testing Pregnant Women:

Auxiliary nurse midwives (ANMs) along with accredited social health activists (ASHAs) should identify all the pregnant women in hard-to-reach areas and ensure that they undergo HIV screening. The identified paramedical staff for HIV and syphilis screening at the F-ICTC should coordinate with the concerned sub-centre ANMs as well as ASHAs and make a monthly plan (dates, venues, estimated number of pregnant women) for conducting HIV and syphilis screening as an outreach activity, in confidential settings. The kits should be carried in a carrier that maintains cold chain. Unused kits should be promptly returned to the F-ICTC while maintaining cold chain. The HIV screening conducted at Sub centers or during VHND should be documented in the SIMS F-ICTC monthly report of the linked PHC. All the health facilities must try to conduct delivery of HIV positive pregnant women registered at their facility. DAPCU and SACS must ensure that safe delivery kits and ARV prophylaxis are made available at these facilities.

In case any HIV positive pregnant woman arrives at a facility for delivery, the facility must use HIV Positive Pregnant Women Delivery Register ***(Annexure A11)*** to capture all the necessary information about the pregnant woman and the outcome of her pregnancy.

The HIV screening conducted in Labour ward for direct in labour cases (un booked cases) should be reported in the monthly F-ICTC SIMS report ***(Annexure C 2)***

The sexual partners/spouses of pregnant women who are found reactive for HIV/syphilis or both should also be screened for HIV and syphilis. Additionally, partners/spouses of pregnant women who are found non-reactive for HIV/syphilis but fall under any high risk group category must be screened for HIV and syphilis. Sexual partner/spouse notification is a sensitive issue and requires utmost care and confidentiality.

All individuals found HIV reactive with a whole blood finger-prick (WBFP) test should be promptly linked to the SA-ICTC for confirmation of HIV diagnosis and further necessary action.

All individuals found to be syphilis reactive with the WBFP test (POC) should be promptly treated at the same health facility, as per the prescribed national guidelines.

2.4.1.3 Unique PID (Person Identification Digit) Code

Unique PID number for SA-ICTC

Every individual will be allocated a 23 digit unique code, to be allocated on the following basis:

Digits	Meaning
First 2 digits	Type of Individual [PW/GI]
Second 6 digits	Reporting Unit [SAICTC]
Third 2 digits	State Code
Fourth 3 digits	District Code
Fifth 3 digits	ICTC Centre Number
Sixth 2 digits	Year
Last 5 digits	Individual Serial Number

Example:

23 digit Unique PID number expressed as **PW SAICTC AP APR 001 15 00001** can be translated as described below:

- First 2 digits reflect type of individual which is Pregnant woman in this case
- Second 6 digits reflect that the reporting unit is SAICTC and the same code will apply to all SAICTC
- Next 2 digits reflect state code which is AP i.e. Andhra Pradesh
- Next 3 digits reflect district code which is APR i.e. Anantapur
- Next 3 digits reflect ICTC number which is 001
- Next 2 digits stand for the year which in this case is 15 reflecting year of 2015
- Last 5 digits are unique to the ICTC individual

Unique PID number for F-ICTC

Every individual will be allocated a 23 digit unique code, to be allocated on the following basis:

Digits	Meaning
First 2 digits	Type of Individual [PW/GI]
Second 5 digits	Reporting Unit [FICTC]
Third 2 digits	State Code
Fourth 3 digits	District Code
Fifth 4 digits	ICTC Centre Number
Sixth 2 digits	Year
Last 5 digits	Individual Serial Number

Example:

23 digit Unique PID number expressed as **GI FICTC AP APR 0001 15 00001** can be translated as described below:

- First 2 digits reflect type of individual which is General Individual in this case
- Second 6 digits reflect that the reporting unit is FICTC and the same code will apply to all FICTC
- Next 2 digits reflect state code which is AP i.e. Andhra Pradesh
- Next 3 digits reflect district code which is APR i.e. Anantapur
- Next 4 digits reflect ICTC number which is 0001
- Next 2 digits stand for the year which in this case is 15 reflecting year of 2015
- Last 5 digits are unique to the ICTC individual

Flow of activities at HCTS facility

Figure 2.1: Process flow for HCTS screening facility

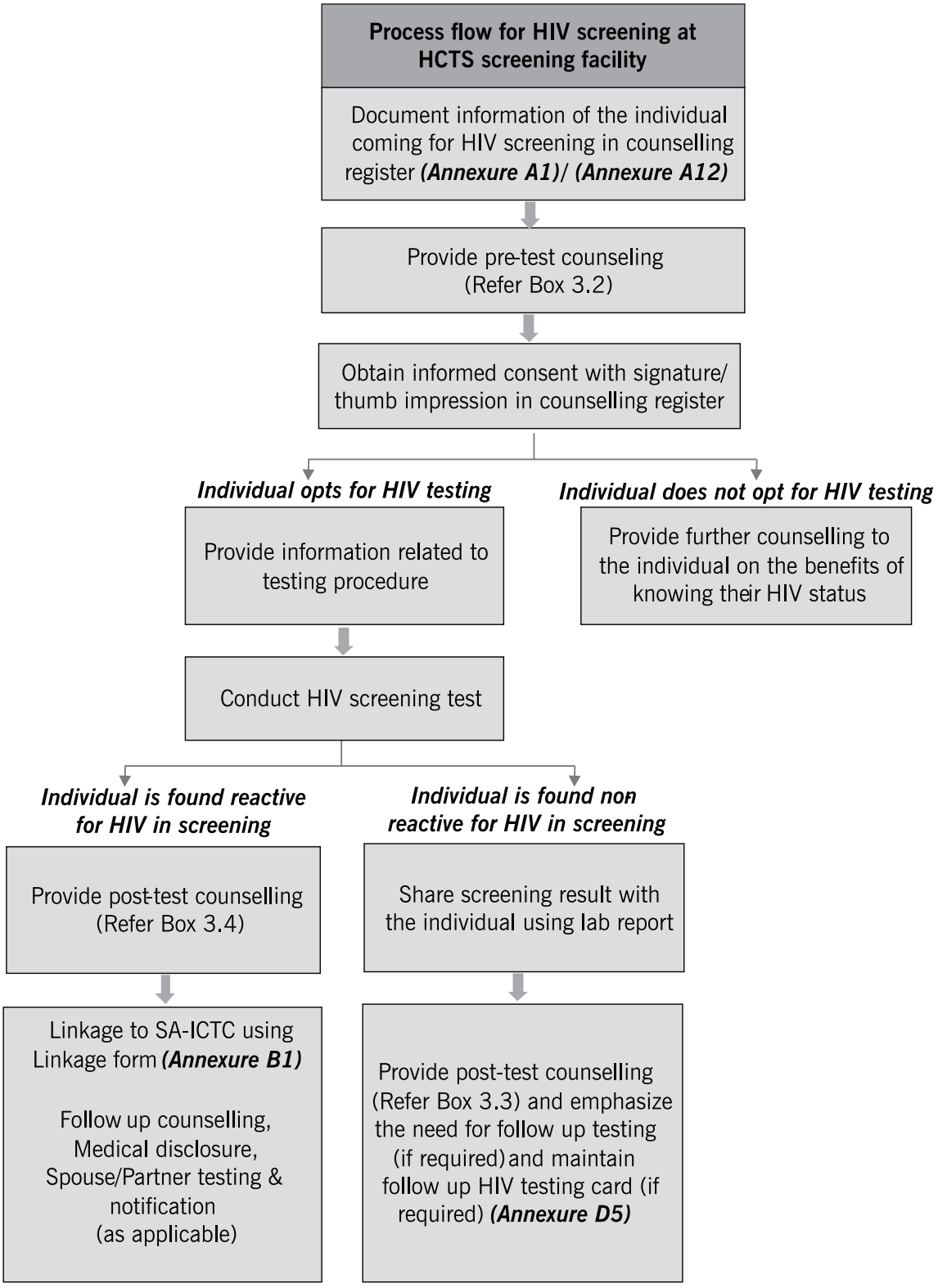
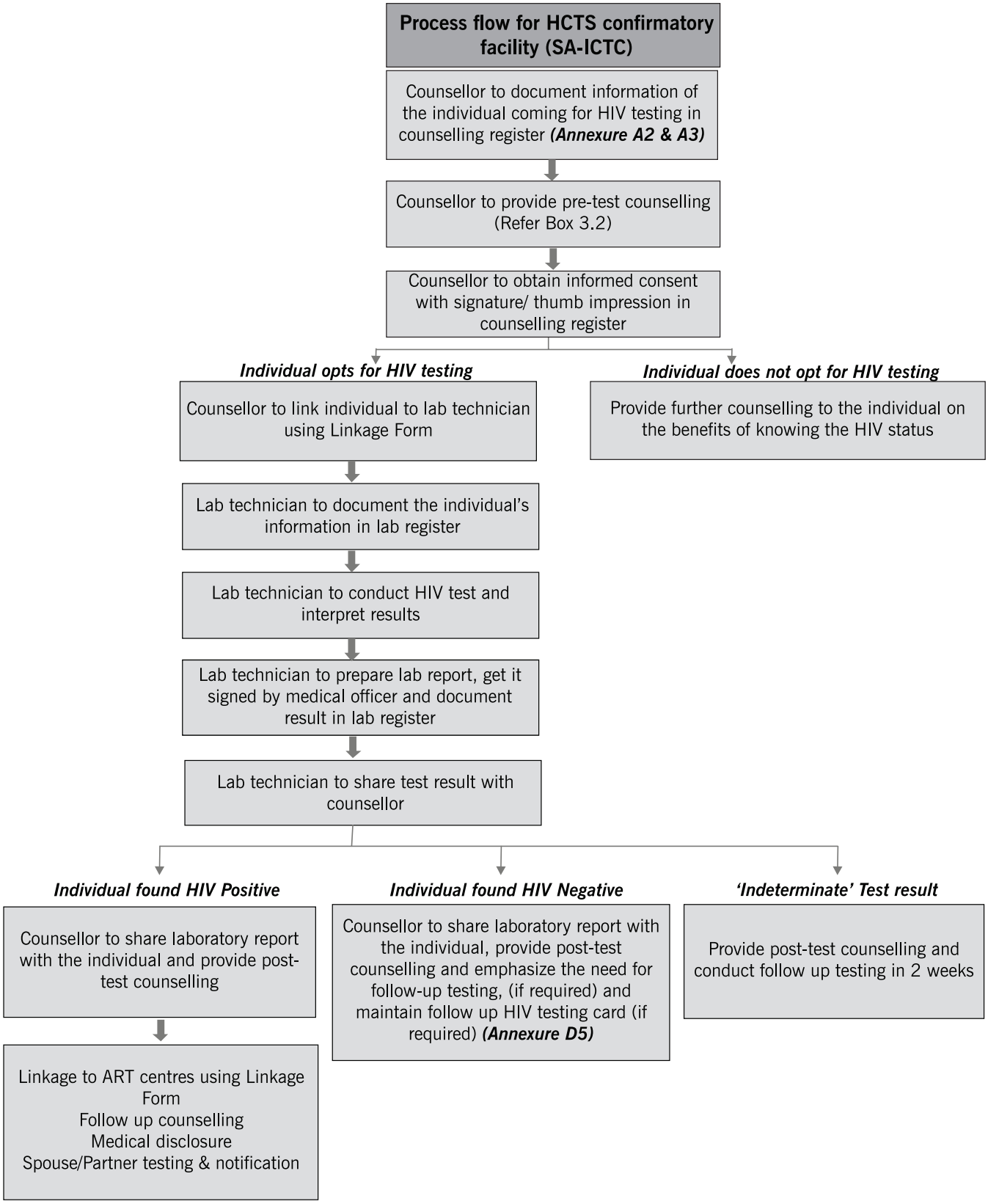


Figure 2.2: Process flow for HCTS Confirmatory Facility (SA-ICTC)



Note:

- All efforts must be made by the counsellors at the HCTS facilities to explore the details of the previous HIV testing and availability of the PID number. If the PID number of the previous test is available, then that PID number should be used for all subsequent tests. If the individual has been tested previously but the PID number is unavailable, then provide a new PID number to the individual and record as "No" in the column labelled "Previous PID available?" in the counselling registers.
- In case of unavailability of whole blood finger prick test kits, HCTS screening facility should inform the linked SA-ICTC immediately and they should either (a) advise the individual to visit the nearest HCTS facility or (b) test the individual using the serum plasma Rapid Diagnostic Test (RDT) HIV test kit (if available).
- In case of unavailability of kits at the SA-ICTC, the facility should inform District/SACS immediately. Please follow the below procedure in case of rare situations such as:
    - When the facility has only 2 types of test kits available and the individual is symptomatic for AIDS defining illness, then Strategy II (B) explained in **Chapter 4** of this guideline should be used for HIV diagnosis
    - When the facility has only 1 type of test kit available and if the result of this test kit is reactive then the individual should be linked to other SA-ICTC immediately or the sample may be transported to the nearest SA-ICTC for confirmation of HIV diagnosis, or the sample may be stored following standard guidelines till the test kits are made available.
    - In such cases, the linked screening centres should be informed and referral should be directed to other SA-ICTC.
- In case of unavailability of the lab technician at the SA-ICTC, the following steps should be undertaken:
    - The facility should inform District/ SACS immediately
    - If an individual arrives for HIV testing, lab technician from other programs might be utilized to conduct his/her HIV testing. Else, sample of the individual must be sent to the nearest facility for conducting the test
- HCTS facilities are advised to create rubber stamps – one with the Name and Address of the facility and another with the fixed digits of the UID code (14 digits Code of ICTC – to reduce documentation time in the forms. Please refer to ***(Annexure E3)***.

2.4.1.5 Public Private Partnership ICTC (PPP- ICTC)

India is a large country with a vast and divergent public sector complemented by an equally large private sector. Delivering equitable health care in such diverse conditions requires meaningful partnership with the private sector. The private health sector in India is large and heterogeneous, and includes for-profit providers of varying capacity, NGOs and even unqualified providers.

NACP has established partnerships with bona-fide registered entities, which include NGOs, community-based organizations, federation of Self-Help Groups (SHGs), registered medical practitioners (allopathic/ AYUSH), hospitals, nursing homes, clinics, health professional bodies and organizations.

The three primary models for establishing a 'Facility-ICTC' in the private sector under a Public Private Partnership (PPP-ICTC) are detailed below. Refer ***(Annexure E1)*** for MoUs for the three models of PPP-ICTC.

Table 2.4: Types of PPP-ICTC Models

Type of PPP-ICTC Model	Role of NACO/SACS
Model A: Market-Led Model	▪ Provide training to medical/para-medical staff on National Guidelines and protocols ▪ On-going technical support on ICTC/PPTCT/HIV-TB/ART/STI through regular technical visits by SACS/DAPCU supervisors ▪ Demand creation through linkages with local NGOs, community-based organizations etc. ▪ Linkages for confirmatory HIV testing with SA-ICTC for individuals screened positive by HIV test kits,and further with ART centre for those tested positive ▪ **No support for commodities**
Model B: Market Sharing Model	▪ Provide training to medical/para-medical staff on National Guidelines and protocols ▪ On-going technical support on ICTC/PPTCT/HIV-TB/ART/STI through regular technical visits by SACS/DAPCU supervisors ▪ Demand creation through linkages with local NGOs, community-based organizationsetc. ▪ Linkages for confirmatory HIV testing with SA-ICTC for individuals screened positive by Whole Blood Finger Prick Test (WBFT) kits,and further with ART centre for those tested positive ▪ **Support of commodities such as HIV diagnostic test kits, PPTCT drugs, counselling tools, IEC as per requirement**
Model C: Data Sharing Model	▪ Provide sensitization to medical/para-medical staff on National Guidelines ▪ Provide reporting formats and details of reporting systems ▪ Combined reporting of all various small private health units (combined into one report per district) as District (name of the district) PPP ICTC centres ▪ Linkages for confirmatory HIV testing with SA-ICTC for individuals screened positive by HIV test kits & further with ART centre for those tested positive ▪ **No training to medical/ para-medical staff** ▪ **No support on commodities**

2.4.2 Community-based HIV screening approaches

Community-based screening (CBS) is an important approach for improving early diagnosis, reaching first-time testers and people who seldom use clinical services, including men and adolescents in high-prevalence settings and HRG populations. To improve HCTS access and coverage, community-based HIV screening is carried out through various approaches such as:

(i) Mobile HCTS

(ii) Screening by ancillary health-care providers (ANC)

(iii) Screening for HIV by targeted intervention (TI-ICTC)

(iv) HCTS for prison inmates

(v) HCTS at the workplace

2.4.2.1 Mobile HCTS

There are two types of mobile HCTS, the details of which are highlighted in Table 2.4.

Table 2.5: Types of mobile HCTS and their description

Description	Type I: Mobile SA-ICTC for HIV confirmatory test	Type II: Mobile F-ICTC for HIV screening test
Structure	A mobile SA-ICTC is a vehicle (van, boat, etc.) with facilities to conduct HIV testing and counselling services, and regular medical and ANC check-up. The mobile SA-ICTC should function as per the prescribed norms and standards of the SA-ICTC.	As per the MoHFW/GoI decision, the existing mobile medical units (MMU) serving hard-to-reach areas under the NHM should be leveraged as mobile F-ICTCs, as per the prescribed norms, for conducting HIV screening services (pre-test counselling, informed consent, HIV screening test and post-test counselling) in addition to routine activities.
Criteria	Hard-to-reach areas where the SA-ICTC is not accessible At least five km away from the nearest fixed SA- ICTC Location of Mobile SA-ICTC should be accessible and acceptable to pregnant women and HRG communities	While following the monthly route plan of NHM MMUs, the focus should be on hard-to-reach areas where HCTS is not available. This is to be done in close coordination with the respective District AIDS Prevention and Control Unit (DAPCU)/district HIV nodal officer.
Functions	Mobilize pregnant women and vulnerable populations in the community through networking with community volunteers, field-level government health functionaries, Self Help Groups (SHGs), NGOs/Community-Based Organizations and HRGs and PLHIV community networks. All HCTS functions should be as per the prescribed standards for an SA-ICTC.	Mobilize pregnant women and vulnerable populations in the community through networking with community volunteers, field-level government health functionaries, self-help groups, NGOs/Community-Based Organizations and HRGs and PLHIV community networks. All HCTS functions should be as per the prescribed standards for an F-ICTC.

Description	Type I: Mobile SA-ICTC for HIV confirmatory test	Type II: Mobile F-ICTC for HIV screening test
Package of HCTS	HCTS as described under the SA-ICTC section Referral and linkage as detailed in the **Chapter 6** on Linkages in these Guidelines	HIV screening package as described for the F-ICTC, in addition to other routine activities of MMUs HIV-reactive individuals should be linked to the nearest SA-ICTC for confirmation of HIV infection and further necessary action. See other linkage as detailed in the **Chapter 6** on Linkages in these Guidelines.
Staffing	The respective DAPCU/district HIV nodal officer; Counsellor; Laboratory technician; Driver (to also support the team in the organization of clinic functions); Cleaner. This team may be supported by health volunteers such as ASHA or any community volunteer.	As per the prescribed norms of existing MMUs under the NHM
Reporting and information management	Mobile SA-ICTC ▪ Should report to DAPCU/district HIV nodal officer ▪ Will maintain all records/registers as per the SA-ICTC norms ▪ Will report in SIMS in the standard SA-ICTC format on a monthly basis(***Annexure C1***)and on quarterly basis (***Annexure C9***)	Mobile F-ICTC ▪ Will share a copy of the report to linked DAPCU/district HIV nodal officer ▪ Will maintain all records/registers as per the F-ICTC norms ▪ Will report in the standard F-ICTC format (***Annexure C2***) on a monthly basis through the officer in-charge of MMU to DAPCU/ district HIV nodal officer
Logistics	Based on the estimated footfalls, the mobile ICTC in-charge will ensure supplies and logistics as per the norms of the SA-ICTC.	Based on the estimated footfalls, the officer in-charge of the MMU will ensure supplies and logistics as per the norms of the F-ICTC, in coordination with DAPCU/district HIV nodal officer.

2.4.2.2 HIV testing through trained ancillary health-care providers

To enhance the outreach and coverage of priority populations, the following nursing and paramedical functionaries have been identified to be trained to conduct HIV screening:

- Public health nurse (PHN)
- Lady health visitor (LHV)
- Auxiliary nurse midwife (ANM)
- Counsellor
- Pharmacist
- Multipurpose worker (MPW)-male
- Peer educator (PE)
- Outreach worker (ORW)
- Other trained ancillary health cadre

2.4.2.3 Screening for HIV by targeted intervention

The NGO-led targeted intervention (TI) programme is an effective strategy to provide HIV prevention and care services to high-risk populations. The services provided by TI include behaviour change communication, access to STI services, provision of commodities to ensure safe practices (condoms, opioid substitution therapy (OST) drugs, and needles and syringes), linkages to HIV testing, care and treatment services, and creating an enabling environment.

The TI programme is faced with challenges of increasing the coverage of HIV testing, including care and treatment services among HRGs. Hence, to increase the HIV testing coverage among HRGs, screening for HIV by targeted intervention should be implemented to ensure that HCTS is easily available and accessible to high-risk (core and bridge) groups, and priority populations.

The TI programme should ensure 100% coverage of HRGs for HIV screening, while prioritizing newly registered groups, groups of young people, groups that get repeated STI, abscess, etc. or are not using condoms or clean needle/syringes regularly; regular partners, babus, etc., or groups that have never been screened/tested.

HIV screening facilities should be selected before the planned day of screening. High-risk groups should be identified and facilities (or alternative facilities) should be selected to suit the convenience of the groups. At all screening facilities, audio-visual privacy should be ensured and informed consent documented.

The following process needs to be followed in implementing screening for HIV by targeted intervention.

1. **Micro-planning**
    - The TI NGO/Community-Based Organizations should develop a detailed monthly micro-plan, which includes identification of screening site/s, estimated number of individuals to be screened, date, time, mobilization activity, and referral site for confirmatory testing and a responsible person for linkages.
    - The site-wise list of HRGs and bridge populations who need to undergo HIV screening on priority needs to be generated from the individual tracking sheet (ITS) before the day of the HIV screening, and should be discussed with the respective peer educator (PE) and ORW. A project manager needs to oversee the complete list.
2. **Community mobilization**
    - ORWs and PEs should mobilize the potential individuals based on the lists generated.
    - At the field level, HRGs: ORWs and PEs will individually contact the eligible high-risk populations and ensure that they reach the HIV screening site on the planned day.
    - At the field level, bridge group (migrants): ORW and peer leaders (PLs) will conduct interpersonal communication (IPC) sessions (1 group) in the field with registered high-risk migrants, 4–5 days before the planned HIV screening day. On the day of HIV screening, they should conduct

the mid-media event, IPC sessions and health games at the site to mobilize individuals for the HIV screening.

- At the field level, bridge group (truckers): ORWs and PEs will conduct IPC sessions (1 group) and mid-media event at the site to mobilize individuals for HIV screening. The ORWs and PEs will also contact stakeholders such as brokers and transporters for referring the truckers for HIV screening.

3. Human resources and roles

The HIV screening process will be managed by a project manager along with counsellor/ANM with the assistance of ORWs and PEs/PLs.

Roles and responsibilities of the ANM/counsellor/ORW and PE at the TI will be the same as described in Table 2.3. ORWs and PEs will also mobilize the community and assist in logistics during testing.

4. Logistics and transport:

The screening for HIV by targeted intervention will require the following consumables and other materials:

- **HIV testing kits:** TIs will place an indent and collect their weekly supply from the nearest SA-ICTC/DAPCU/SACS. The WBFP HIV test kit also contains a lancet and alcohol swab.
- **Consumables:** TIs will procure consumables such as hand gloves, colour-coded disposable bags for bio-waste, puncture-proof containers for used sharps, bleaching powder/hypochlorite solution.
- **Fixed assets:** TIs will have to procure the following items through the TI budget: one refrigerator, two thermometers (dial thermometer), timer, two dustbins, icepacks and aprons for ANMs.
- **Registers and forms (in paper and preferably electronic):** The TI will maintain the counselling register, stock register, laboratory reports, linkage slips and SIMS monthly report. Refer ***Annexure C8*** for SIMS monthly reporting format for TI.
- The TI will transport all the consumables and other materials to the screening site in advance through local transport to ensure that everything is ready at least half an hour before the scheduled starting time.

5. Biomedical waste management plan

The TI team will ensure that the required protocols are being followed for maintaining universal safety precautions during HIV screening.

6. Cold chain management

- Cold chain will be strictly maintained throughout the supply chain (2–8°C). The TI will collect the test kits in icepack-lined carriers from the nearest SA-ICTC/DAPCU on a weekly basis; the test kits will be stored in a refrigerator at the TI office; in case of load shedding for more than four hours, the TI will shift the kits to the nearest SA-ICTC/DAPCU to maintain the cold chain.

- On the day of HIV screening, the test kits will be collected and transported to the site in a carrier ensuring cold chain maintenance. Before use, the TTI in each kit will be checked for any colour change. If any colour change is noted, the kit will be handed over to the nearest SA-ICTC, which will follow the necessary laboratory protocol. A temperature log should be maintained for the refrigerator and also at the testing site.
- Testing kits will be taken out from the cold chain-maintained carrier for use as per the number of individuals waiting at the testing site. The timing will depend on the number of individuals to be tested. Care should be taken to maintain the required temperature in the carrier to transport the unused kits back to the TI.

7. Activities to be ensured for a successful screening for HIV by targeted intervention:

- The TI should identify HRGs that are due and overdue for HIV testing and these targeted groups should be made aware of the day, date, timing and venue for HTS
- More than 90% of the targeted individuals should attend the event
- HIV screening should be conducted while ensuring audio-visual privacy and confidentiality
- The TI should adhere to the date, venue and timings communicated to the HRGs for HIV screening
- Pre-test counselling and post-test counselling should be done as per **Chapter 3** of these guidelines
- The project manager should validate the number of targeted HRGs that availed the screening services, the number of WBFP test kits consumed, and the number of individuals found reactive against the documented data in the records/registers maintained by the counsellor/ANM
- An individual found reactive for HIV with the screening test should be referred to the SA-ICTC for confirmation of HIV diagnosis and further necessary action
- Biomedical waste should be collected, disinfected and disposed of as per the NACO testing guidelines, 2015
- Maintenance of the cold chain for test kits should be ensured and the stock register updated on a regular basis

8. Monitoring, supervision and reporting

The project manager of a TI shall be completely responsible for this activity. The Programme Officer (Technical Support Unit) will visit at least one screening site of the TIs monitored by them once in a quarter. The linked SA-ICTC LT will visit at least one TI screening site per month, and observe and document the screening procedure conducted by the ANM/counsellor in a predefined checklist (***Annexure E4***)

Reporting will be done using the following data reporting tools:

- Data input registers/forms/reports
  a) Counselling register – filled by the counsellor/ANM ***(Annexure A12)***
  b) Stock register–filled up by the counsellor/ANM ***(Annexure A5)***

c) Laboratory report form– to be filled and signed by the doctor for both non-reactive as well as reactive reports (***Annexure C3)***

d) Linkage form for individuals found to be reactive to the SA-ICTC for confirmation of HIV diagnosis (***Annexure B1***)

e) Temperature log book format (***Annexure A7***)

f) Indent format for HCTS commodities ***(Annexure B2***)

g) SIMS monthly report format (***Annexure C8***)

h) Follow up HIV Testing Card (***Annexure D5***)

For details, please refer to the following:

- **Chapter 3** on counselling for pre-test counselling, informed consent, confidentiality, post-test counselling
- **Chapter 4** on HIV testing and Quality Management Systems for HIV screening

2.4.2.4 HCTS for prison inmates

HIV screening/confirmation should be included as an integral component of the health-care service package being offered to the inmates of prisons in India. A plan for HCTS in prisons needs to be developed in all States to scale up HIV testing among prison inmates. SACS should facilitate appropriate training on HCTS to the existing health staff in prisons.

The HCTS facility should ensure audio-visual privacy and confidentiality. The prison health system should follow the same National HCTS guidelines as detailed earlier for an SA-ICTC/F-ICTC, including the maintenance of records and reports. Proper linkages to care, support and treatment services should be ensured for those who are found positive for HIV. The following steps may be taken to improve testing and linkage to treatment of individuals in the prison setting:

A. Improving testing coverage:
   a. Prison staff can be sensitized and trained on conducting HIV tests
   b. SACS/DAPCU can arrange regular HIV testing camps in prisons by deputing a counsellor and lab technician on specific days at a given prison

B. Linkage to treatment:
   a. Prison doctor/medical staff can be trained on ART initiation and the prison hospital can be made a Linked ART centre (LAC) for dispensing medications to the prisoners
   b. SACS/DAPCU in association with relevant authorities can arrange for transportation of the HIV positive inmate to the ART centre with appropriate security for initiation on treatment and getting regular monitoring tests

Relevant information about the inmate's discharge from the prison must be provided to the concerned ICTC and ART centre so that the HIV positive individual can be followed up at regular intervals and linked to an ART centre close to his/her place of residence.

2.2.4.5 HCTS at the workplace

HIV screening should be included as an integral component of the health-care service package being offered to employees of both the organized and unorganized sectors in India. A plan for HCTS scaling up in workplace settings should be developed by all SACS, in consultation with the concerned sectors. SACS should facilitate appropriate training on HCTS to the health staff associated with providing health services to employees at the respective workplaces.

HCTS facility should ensure audio-visual privacy and confidentiality. The workplace health system should follow the same National HCTS guidelines as detailed above for an F-ICTC, including the maintenance of records and reports. Proper linkages to the linked SA-ICTC should be ensured for all those who are reactive for HIV on screening.

NACO also offers HIV-related services at workplaces through an employer-led model, the details of which may be accessed at the NACO website www.naco.gov.in.

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

For further details, please refer to

- **"Updated National PPTCT Guidelines, December 2013"**
- **"National Strategic Plan on PPTCT, December 2013"**
- **"National Guidelines for HIV Testing, 2015"**

3

Counselling for HIV Testing

Counselling is a confidential dialogue between an individual and a counsellor. It aims to provide information on HIV/AIDS and bring about behaviour change in the individual. It also enables the individual to take a decision regarding HIV testing and to understand the implications of the test results.

Counselling includes the assessment of an individual's risk of acquisition and transmission of HIV, facilitation of preventive behaviour, and coping mechanisms in case an individual is found to be HIV positive. More importantly, counselling is intended to address the physical, social, psychological and spiritual needs of the individual availing HCTS.

Counselling is an integral part of HIV screening as well as confirmatory facilities under HCTS. It ensures audio-visual privacy and confidentiality of information shared by the individual, including HIV test results. All records and registers should be securely stored.

Box 3.1: Following should be ensured during counselling

a) Audio-visual privacy and confidentiality

b) Counsel each individual separately– do not take a history when another person is present unless consent has been sought and given

c) The individual is comfortable and at ease

d) Do not allow your personal values or beliefs to influence the history-taking procedure

e) Employ communication skills in:

   i. listening

   ii. questioning

   iii. non-verbal skills or body language

f) Use clear and simple language

g) Use models or drawings if needed

h) Use neutral language– no colloquial, offensive or technical terms

3.1 Pre-test counselling

Pre-test counselling is provided to the individual before HIV testing using posters, flip charts, brochures and short video clips so as to prepare him/her for the HIV test and to address myths and misconceptions regarding HIV/AIDS.

This can be done in two ways – (a) one-on-one counselling and (b) group counselling. One-on-one counselling should be done for all individuals accessing HCTS services. Group counselling can be done when the counsellor is addressing a group such as pregnant women at ANC clinics.

Box 3.2: Contents of pre-test counselling

a) Provide information on HIV and AIDS: what is HIV, what is AIDS, window period, route of transmission, prevention message, care, support and treatment services

b) Explain the benefits of HIV testing

c) Assure the individual that the test result and any information shared will be kept confidential

d) Explain that the individual has the right to opt out of HIV testing and this will not affect their access to any other health-related services

e) Obtain informed consent and document it in the relevant register (refer to 3.2)

f) Carry out a risk assessment of the individual

g) Provide information on genital, menstrual and sexual hygiene

h) Demonstrate the use of a condom using a model

i) Provide information on spouse/sexual partner testing

j) Conduct symptomatic screening for STI/RTI: Genital discharge/genital ulceration/swelling or growth in the genital area; itching in the pubic area; burning sensation while passing urine; lower abdominal pain; menstrual irregularities; poor obstetric history

k) Conduct verbal screening (4 Symptom Screening) for tuberculosis (TB), use 10 point Counselling Tool for TB. **(Annexure E5)**

l) Extend the opportunity to the individual to ask and clarify doubts

The information may be delivered in a local language and tailored to the specific audience.

Ensure that:

a) The individual found reactive for HIV on screening is promptly linked to SA-ICTC for confirmation of HIV diagnosis

b) For individuals found reactive for HIV on screening, the following pre-test counselling points are emphasized at HCTS confirmatory facilities (SA-ICTC):

- Explain the test result of screening test and emphasize the need for confirmatory test to correctly assess the HIV status
- Explain the process followed at the SA-ICTC for test confirmation

In addition to the details given in Box 3.2, explain to all pregnant/breastfeeding women regarding –

- Potential risk of transmitting HIV to the infant
- Benefits of early HIV diagnosis and treatment for mother and infant
- Infant-feeding practices

3.2 Informed consent

Informed consent remains one of the essential 5Cs and should always be obtained individually and in private. Even if pre-test counselling is provided in a group setting, each individual should give informed consent for testing with an opt-out option.

3.2.1 Consent for individuals below the age of 18 years

In case of individuals below 18 years of age, informed consent has to be obtained from their parents/guardians/care-taking institutions or non-governmental organization (NGO). If there is no parent/guardian, then the local legal authorities may grant permission for testing. In case there is a difference of opinion on consent for testing between the parents/guardians and the individual below 18 years of age, the counsellor may further counsel the individual/parent/guardian to prepare for testing. In case such individuals are unwilling to involve parents/guardians in their HIV testing process, they should be counselled again.

3.2.2 Consent for non-ambulatory individuals

In some situations, within the public health-care facility, there may be a non-ambulatory in-patient who requires HIV testing and is not in a position to visit the HIV testing site. The blood sample of such a patient should be sent to the nearest HCTS facility and the health-care provider should sign the register in lieu of the patient, after obtaining verbal informed consent.

3.2.3 Consent for patients in coma

In case of individuals in a coma, informed consent has to be obtained from their family/parents/guardians/care-taking institution, or non-governmental organization (NGO). If there is no parent/guardian, then the local legal authorities may grant permission for testing. The relevant person/organization providing consent will also be responsible for signing the counselling register.

In certain circumstances where HIV testing is warranted, the decision to test lies with the concerned medical health-care provider.

3.3 Post-test counselling

All efforts must be made to provide same day test results and post-test counselling to all those accessing HIV services at the HCTS facilities.

Post-test counselling helps the individual to understand and cope with the HIV test result. Individual post-test counselling must be conducted irrespective of whether the result is HIV non-reactive (screening facility), HIV-negative, HIV-Indeterminate or HIV-positive (confirmatory facility).

3.3.1 Post-test counselling for individuals who have been screened for HIV

3.3.1.1 Post-test counselling for individuals found non-reactive for HIV at screening facility

Box 3.3: Contents for post-test counselling for individuals found non-reactive for HIV on screening

a) An explanation of the test result

b) Risk education counselling, condom demonstration and provision of condoms

c) Emphasis on the importance of knowing the status of sexual partner(s) and information about the availability of partner and couples testing and counselling services

d) Information about the window period and retesting (Retesting is needed only for HIV-non-reactive individuals who report recent or on-going risk of exposure)

e) An opportunity for additional counselling of the individual, clarification on myths and misconceptions

f) Information on genital, menstrual and sexual hygiene

g) Linkages to tuberculosis (TB), sexually transmitted infection (STI), antenatal care (ANC), TI, etc.

3.3.1.2 Post-test counselling for individuals found reactive for HIV at screening facility

Box 3.4: Contents for post-test counselling for individuals found reactive for HIV on screening

a) This is only a screening test for HIV

b) With this result, it is not possible to confirm the HIV status

c) Explain the need for confirmation of HIV diagnosis at an SA-ICTC

d) Explain the process followed at the SA-ICTC for test confirmation

e) Fill the linkage form and provide directions for reaching the nearest SA-ICTC

f) Provide risk education, counselling, condom demonstration and provision of condoms

g) Provide information on genital, menstrual and sexual hygiene

h) Emphasize the importance of knowing the status of the sexual partner(s), and provide information about the availability of partner and couples testing and counselling services

i) Provide an opportunity to the individual for additional counselling, clarification of myths and misconceptions

j) Provide linkages to facility providing TB, STI, ANC services etc. as applicable

3.3.2 Post-test counselling for individuals with confirmed results at SA-ICTC

3.3.2.1 Post-test counselling for individuals found positive for HIV

An HIV-positive diagnosis is a life-changing event. Post-test counselling should always be responsive and tailored to the unique situation of each individual or couple.

Box 3.5: Contents for post-test counselling for individuals found positive for HIV at SA-ICTC

a) Explain the test results and diagnosis

b) Give sufficient time to the individual to consider the results and help him/her cope with emotions arising from the diagnosis of HIV infection

c) Discuss immediate concerns and help the individual to identify who in his/her social network may be able to provide immediate requisite support

d) Provide clear information on free ART (where it is offered, when ART will start, for how long it has to be taken, how many times it has to be taken, who will provide ART, what tests are required for starting ART, side-effects and benefits of ART, available social benefit schemes, importance of adherence to ART, role of nutrition and exercise, need to abstain from smoking, drinking and unprotected sex, how to overcome stigma and discrimination, a brief about opportunistic infections, etc.) and reducing the risk of HIV transmission

e) Ensure linkage with an ART centre while addressing any specific barrier

f) Demonstrate condom use and provide condoms

g) Discuss possible disclosure of the result and the risks and benefits of disclosure, particularly among couples and partners

h) Offer counselling to couples to support mutual disclosure

i) Encourage and offer HIV testing for untested sexual partner(s)/spouse and children (age upto14 years) of HIV-positive women

j) Assess the risk of violence by sexual partner/spouse and discuss existing support systems to help such individuals, particularly women, who are diagnosed HIV-positive

k) Assess the risk of suicide, depression and other mental health consequences of a diagnosis of HIV infection

l) Provide information on genital, menstrual and sexual hygiene

m) Provide additional referrals for prevention, counselling, support and other services as appropriate (e.g. TB diagnosis and treatment, prophylaxis for opportunistic infections, STI screening and treatment, contraception, ANC, opioid substitution therapy [OST], access to sterile needles and syringes, and brief counselling on sexual health)

n) Encourage and provide time for the individual to ask additional questions, clarify myths and misconceptions

3.3.2.2 Post-test counselling for individuals with HIV indeterminate result

Box 3.6: Contents for post-test counselling of individuals with an HIV-indeterminate test result, i.e. where the test results vary between the three tests

a) Explain the test results and diagnosis

b) All individuals with an indeterminate test result should be encouraged to undergo follow-up testing in two weeks to confirm their HIV status. Emphasize the need for and ensure follow-up testing

c) Discuss immediate concerns and help the individual

d) Demonstrate condom use and provide condoms

e) Encourage and offer HIV testing for untested sexual partners, and children of the individual

f) Assess the risk of suicide, depression and other mental health consequences of a diagnosis of HIV infection

g) Provide additional referrals for prevention, counselling, support and other services as appropriate (e.g. TB diagnosis and treatment, prophylaxis for opportunistic infections, STI screening and treatment, contraception, ANC, OST and access to sterile needles and syringes, and brief counselling on sexual and reproductive health)

h) Provide information on the window period, risk reduction and safe sexual behaviour

i) Encourage and provide time for the individual to ask additional questions; clarify myths and misconceptions

3.3.2.3 Post Test Counselling for Individuals found Negative for HIV

Box 3.7: Contents for post-test counselling of an HIV-negative individual confirmed at SA-ICTC

a) An explanation of the test result

b) Risk education counselling, condom demonstration and provision of condoms

c) Emphasis on the importance of knowing the status of sexual partner(s), and information about the availability of partner and couples testing and counselling services

d) Information about the window period and retesting. (Retesting is needed only for HIV-non-reactive individuals who report recent or on-going risk of exposure.) Details of follow up testing must be shared.

e) An opportunity for additional counselling of the individual, clarification on myths and misconceptions

f) Information on genital, menstrual and sexual hygiene

g) Linkages to tuberculosis (TB), sexually transmitted infection (STI), antenatal care (ANC),TI, etc.

3.4 Follow-up counselling and HIV testing

Follow-up counselling is a form of repeat counselling where certain key actions are reinforced with the objective of getting an individual to understand and practice them. Follow-up counselling sessions may be conducted as and when required.

1. Follow up counselling and HIV testing is recommended for the below mentioned individuals as per the timelines provided. The counsellors are recommended to use the Follow-up HIV Testing Card ***(Annexure D5)*** to provide the follow up testing dates to the individuals. For discordant couples, follow- up testing details are provided on the reverse side of the discordant card. In addition to this, a follow up HIV testing card can be issued to an individual for his/her record.

Follow up testing timeline from the baseline HIV testing	Individuals who require follow-up counselling and HIV testing
After 2 weeks	▪ Donors found HIV reactive in the Blood Bank and found non-reactive at SA-ICTC ▪ Individuals found HIV reactive by screening test and found non-reactive at SA-ICTC ▪ Any individual with indeterminate HIV test result at SA-ICTC
After 3 months	▪ Individual on post exposure prophylaxis ▪ Individual faced with sexual assault ▪ Individuals with high risk behaviour (to exclude the possibility of window period) ▪ HIV negative partner of a known HIV positive individual
Every 6 months	▪ HIV negative partner of a known HIV positive individual ▪ Priority population groups: o Child less than 18 months of age born to HIV positive mother (as per EID algorithm) o Individuals with continued high risk behaviour o FSW o MSM o TG o IDU

2. Individuals who need follow-up counselling are as follows:
   - Individuals who have not accepted their HIV-positive report
   - Individuals who have not been linked to care, support & treatment services
   - Individuals in need of services from support structures such as legal, socio-economic welfare, etc.

The contents of follow-up counselling are the same as detailed in this chapter and should be followed as applicable.

3.5 Additional counselling

Additional content for counselling specific priority populations is given in Table 3.8.

S. No.	Priority population	Description	Additional counselling content
1.	Infants and children (outside the PPTCT cohort)	Symptomatic children referred by medical officer	▪ Need to test the mother for HIV ▪ Infant feeding ▪ Nutrition ▪ Immunization
		Orphans and vulnerable children	▪ Nutrition ▪ Immunization ▪ Follow-up testing (if applicable)
		Sexually abused children	▪ Screen for other STIs ▪ Post-exposure prophylaxis (PEP) ▪ Follow-up testing(if applicable)
2	Adolescents	10–19 years' age group	▪ PLHIV adolescents should be counselled on positive prevention, nutrition, adherence to ART, coping peer pressure and adapting safer behaviours ▪ Adolescents should be counselled on the need of pre-marital HIV testing and safe sex practices ▪ Customized tailored risk reduction counselling – boys, girls and trans-sexual/trans-gender (TS/TG) ▪ Linkages with the Rashtriya Kishore Swasthya Karyakram (RKSK)
3	Sero-discordant couple	One from a couple is HIV-positive while the other is HIV-non-reactive	▪ Promote mutual disclosure of HIV status and adoption of prevention measures ▪ When a couple receives their results together, there can be mutual disclosure of HIV status, and the couple can receive appropriate support ▪ During the pre-test counselling session for a couple, the counsellor should not explore sexual and or any other risk behaviour. These aspects are to be explored individually/ separately ▪ Both, testing and post-test counselling can be provided individually, if either partner prefers ▪ Promote safer sexual behaviour
4	Sero-concordant couple	Both partners are HIV-positive	▪ Consistent condom use ▪ Nutrition ▪ ART adherence (if applicable)
5	Prison inmates		▪ Customized risk-reduction counselling ▪ Symptomatic screening for TB and STI ▪ Follow-up HIV counselling and testing (if applicable)

S. No.	Priority population	Description	Additional counselling content
6	Victims of sexual assault		▪ Counselled on the need for baseline HIV, pregnancy testing, and for other STIs ▪ Post-exposure prophylaxis (PEP) for HIV and STI, and counselling for its adherence ▪ Follow-up HIV counselling and testing after 3 months and 6 months (as applicable)
7	Pregnant women	All pregnant women	▪ Explain the need to initiate ART and the importance of adherence ▪ Explain the need for regular ANC check-up and institutional delivery ▪ Explain the need for antiretroviral (ARV) and co-trimoxazole prophylaxis for the child ▪ Explain the importance of exclusive breastfeeding for 6 months ▪ Counsel on adequate maternal nutrition, including iron and folic acid supplementation
8	High-risk group (HRG)/bridge population	Female Sex workers (FSWs) Men who have sex with men (MSM) Injecting drug users (IDUs) TG Migrants/Truckers	▪ On stigma and discrimination related issues ▪ An individual may have more than one type of risk behaviour and counselling should explore and address them ▪ Need for follow-up counselling (if applicable) ▪ Social protection schemes and services from support structures as applicable, e.g crisis response team, legal support, etc., when needed

3.6 Sharing of HIV test results

It is important to maintain utmost confidentiality of personal information shared by individuals accessing HCTS, including his/her HIV test results.

However, in the following circumstances, the HIV test results of an individual may be shared:

3.6.1 Sharing of spouse/sexual partner HIV test and partner notification

In order to protect the health of a partner, the counsellor may share a person's HIV test result with the person's partner, or partners. This may occur with or without the expressed consent of the index partner. An HIV-positive person should be encouraged through counselling and tools such as role-play to share the positive test result with his/her spouse, sexual or needle-sharing partner(s), and bring the spouse or partner for counselling to an integrated counselling and testing centre (ICTC). This process of helping the individual share the test result might take more than one visit. If after repeated visits the counsellor feels that the individual is not ready to share his/her status, and the regular sexual partner of the individual is deemed to be at risk, the partner can be notified of the person's positive status. This communication with the partner should be, without exception, in a face-to-face setting. Wherever possible, the counsellor could contact positive network groups to facilitate the disclosure. The notified partner(s) should be counselled and tested for HIV and other STIs.

3.6.2 Shared confidentiality and medical disclosure

Wherever warranted, in the medical interest of an individual, their HIV status may be shared with other health-care provider(s) involved in the treatment and care of that individual. The purpose of sharing information is to ensure that the individual receives better treatment and care. Confidentiality should be maintained during the process.

In a health-care setting, the staff directly involved in caring for the HIV-positive patient may be informed about the patient's HIV status by the counsellor after seeking the person's consent. This is to protect the right of the individual to confidentiality as well as the right of health-care staff to a safe work environment. The disclosed information must be kept confidential by the attending health-care staff.

3.6.3 Disclosure

The person with HIV has the right to privacy and also the right to exercise informed consent in all decisions about disclosure in respect of his/her status. However, in certain circumstances when disclosure of an individual's HIV status to another person is required by law or ethical considerations, the HIV test results may be shared.

3.7 Standard operating procedures

3.7.1 Standard operating procedure for a counsellor at HCTS screening facility

1	Document information of the individual with unique 23-digit ICTC person identification digit (PID) in the counselling register ***(Annexure A1)*** / ***(Annexure A12)***
2	Provide pre-test counselling to the individual and document the details in the counselling register Contents for pre-test counselling are listed in Box 3.2
3	Take informed consent of individual for HIV testing with signature/ thumb impression in the counselling register
4	If individual **opts for HIV testing,** provide information related to testing procedure If individual **opts out,** provide further counselling to the individual on the benefits of knowing his/her HIV status
5	Conduct HIV screening testing as per applicable procedures listed in **Chapter 4** If the result is invalid, repeat the test
6	Document the results of HIV screening test in the counselling register
7A	For individuals screened reactive, provide post-test counselling Box 3.4 and link them to SA-ICTC using duly filled Linkage Form ***(Annexure B1)***
7B	For individuals **screened non-reactive,** provide post-test counselling as per box 3.3 and share the laboratory report signed by medical officer/officer-in-charge ***(Annexure C3).*** Emphasize the need of follow up testing, if required. Use Follow up HIV testing Card ***(Annexure D5)*** if required.
8	Conduct verbal screening of all individuals accessing HCTS for TB, STI and other co-infections
9	If required, link the individuals to ANC, STI, RNTCP programs, etc as applicable using Linkage Form ***(Annexure B1)***

Records (Registers /Forms/ Reports) to be maintained

The following records and reports must be maintained at HCTS screening facilities:

1. Counselling register ***(Annexure A1)*** / ***(Annexure A12)***
2. Linkage form in triplicate ***(Annexure B1)***
3. Laboratory report for screened non-reactive ***(Annexure C3)***
4. Stock register (***Annexure A5***)
5. Follow up HIV Testing Card ***(Annexure D5)***
6. Temperature Log Book ***(Annexure A7)***
7. Indent for HCTS Commodities ***(Annexure B2)***
8. SIMS reporting format ***(Annexure C2)*** / ***(Annexure C8)***
9. Dashboard Indicators at HCTS Screening Facilities ***(Annexure C6)***

3.7.2 Standard operating procedure for a counsellor at HCTS confirmatory facility (SA-ICTC)

1	Document information of individual with unique 23-digit Patient Identification Digit (PID) in the counselling register ***(Annexure A2)*** for general individual and ***(Annexure A3)*** for pregnant women) If an individual has accessed screening HCTS facilities, then use the same PID number as generated on the first visit at screening facility. Similarly if an individual has accessed confirmatory HCTS facilities, then use the same PID number as generated on the first visit at confirmatory facility. If an individual screened reactive at screening site and referred to confirmatory facility, a new PID number should be generated at confirmatory facility. All efforts should be made to ensure that only one unique PID is issued to an individual at every follow up test at either screening or confirmatory HCTS facility.
2	Provide pre-test counselling to the individual and document the details in the counselling register Refer to Box 3.2 for contents of pre-test counselling
3	Take informed consent of individual for HIV testing with signature/ thumb impression in the counselling register
4	If individual **opts for HIV** testing, provide information related to testing procedure If individual **opts out**, provide further counselling to emphasize the need for follow-up testing
5	Link the individual to SA-ICTC laboratory technician for HIV testing by using referral slip to Lab Technician ***(Annexure E7)***
6	Receive signed laboratory reports from the Lab Technician
7A	For individuals found **HIV positive,** provide lab report, conduct post-test counselling and link the individual to ART centre using Linkage form ***(Annexure B1)***
7B	For individuals found **HIV negative,** provide lab report, conduct post-test counselling and emphasize the need for follow up testing (as applicable)
7C	For individuals with **indeterminate test result,** provide post-test counselling and emphasize the need for follow up testing (as applicable, using the Follow up HIV Testing Card in ***Annexure D5)***
8	Screen all patients accessing HCTS for TB and other co-infections and link to applicable facility using Linkage form ***(Annexure B1)***

Records (Registers /Forms/ Reports) to be maintained

The following records and reports must be maintained at HCTS confirmatory facility (SA-ICTC):

Registers:

1. Counselling register for general individuals ***(Annexure A2***)
2. Counselling register for pregnant women ***(Annexure A3***)
3. HIV–TB line list ***(Annexure A8)***
4. HIV–TB register ***(Annexure A9)***
5. ICTC HIV exposed Infant/Child Register (***Annexure A10***)
6. HIV Positive Pregnant Women Delivery Register ***(Annexure A11)***
7. Outreach Activity Registers ***(Annexure A13)***

Forms:

8. Linkage form in Triplicate ***(Annexure B1)***
9. RNTCP form for referral for Diagnosis ***(Annexure B3)***

Reports:

10. SIMS monthly report ***(Annexure C1)***
11. Laboratory reports ***(Annexure C4)***
12. Dashboard Indicators ***(Annexure C7)***
13. SIMS quarterly report ***(Annexure C9)***

Cards:

14. PLHIV card for General Individuals ***(Annexure D1)***
15. PPTCT Beneficiary card ***(Annexure D2)***
16. EIC card ***(Annexure D3)***
17. Discordant partner card ***(Annexure D4)***
18. Follow up HIV Testing Card ***(Annexure D5)***

Please note that for Discordant couple, follow-up testing details are captured on the back side of the discordant partner card. In addition, Follow-up HIV Testing Card can also be issued to the individual for his/her record.

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

4

HIV Testing and Quality Management Systems for HCTS Facility

HIV infection in any individual beyond 18 months of age can be detected by laboratory test/s that demonstrate(s) either the virus or viral products, or antibodies to the virus in blood/serum/plasma. In children below 18 months of age, due to persistence of maternal antibodies, diagnosis of HIV is made by PCR tests that detect HIV nucleic acid. It is recommended that HIV testing should be done using highly sensitive and specific rapid tests in HCTS, which provide reliable and accurate results within half an hour, as per the prescribed quality standards.

Under the NACP, the most commonly employed rapid tests are based on the principle of enzyme immunoassay, immuno-chromatography (lateral flow), immuno-concentration/dot-blot assays (vertical flow) and particle agglutination. All these different rapid tests should have a sensitivity of ≥99.5% and specificity of ≥98%.

Window period represents the period of time between infection with HIV and the time when HIV antibodies can be detected in the blood (6-12 weeks). A blood test performed during the window period may yield a negative test result for HIV antibodies. These cases may require further testing after 12 weeks.

4.1 HIV testing strategies for Adults and Children (above the age of 18 months)

National HIV testing strategies enable the programme to screen for HIV or confirm the diagnosis of HIV among priority populations at the nearest facility. In view of the low prevalence of HIV in India, it is necessary to use three different principles or antigen-based rapid tests to confirm the diagnosis.

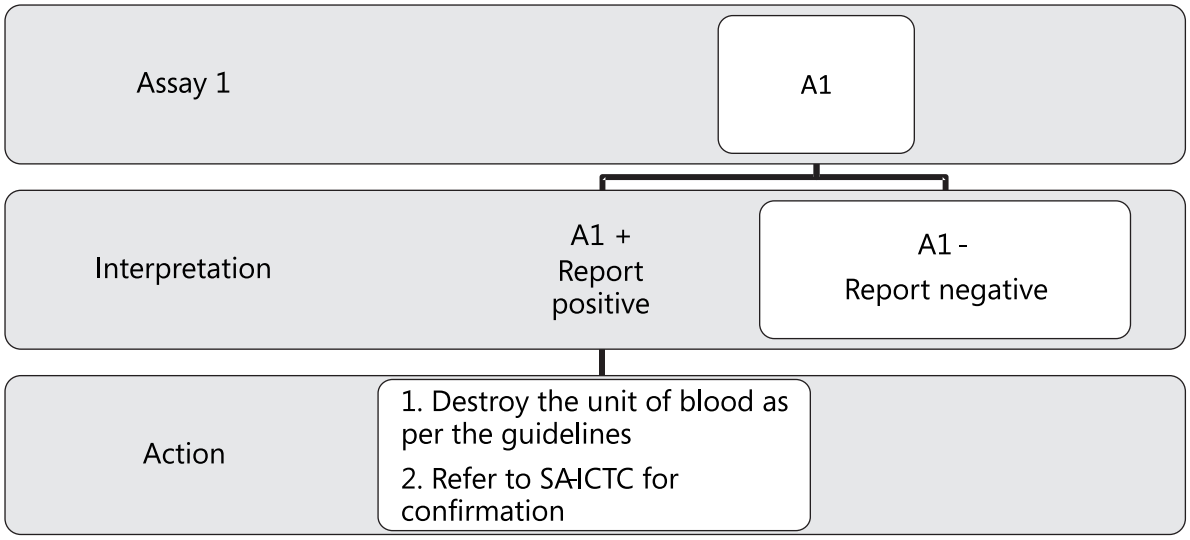
Every individual with an HIV-non-reactive result should be educated about the possibility of a window period, and that a non-reactive result does not always rule out the possibility of HIV infection, if the individual has been recently infected.

The following strategies are to be used for HIV testing in adults and children above the age of 18 months:

4.1.1 Strategy I

Single test (enzyme-linked immune sorbent assay [ELISA] or rapid) is mandatory for screening of donated blood in blood banks. If found reactive for HIV, the donated blood should not be used for transfusion or transplantation, and after informed consent, the donor should be promptly referred to the linked SA-ICTC for confirmation of the HIV diagnosis and further necessary action.

Figure 4.1 Algorithm I (For Blood Banks & HCTS Screening Facilities)

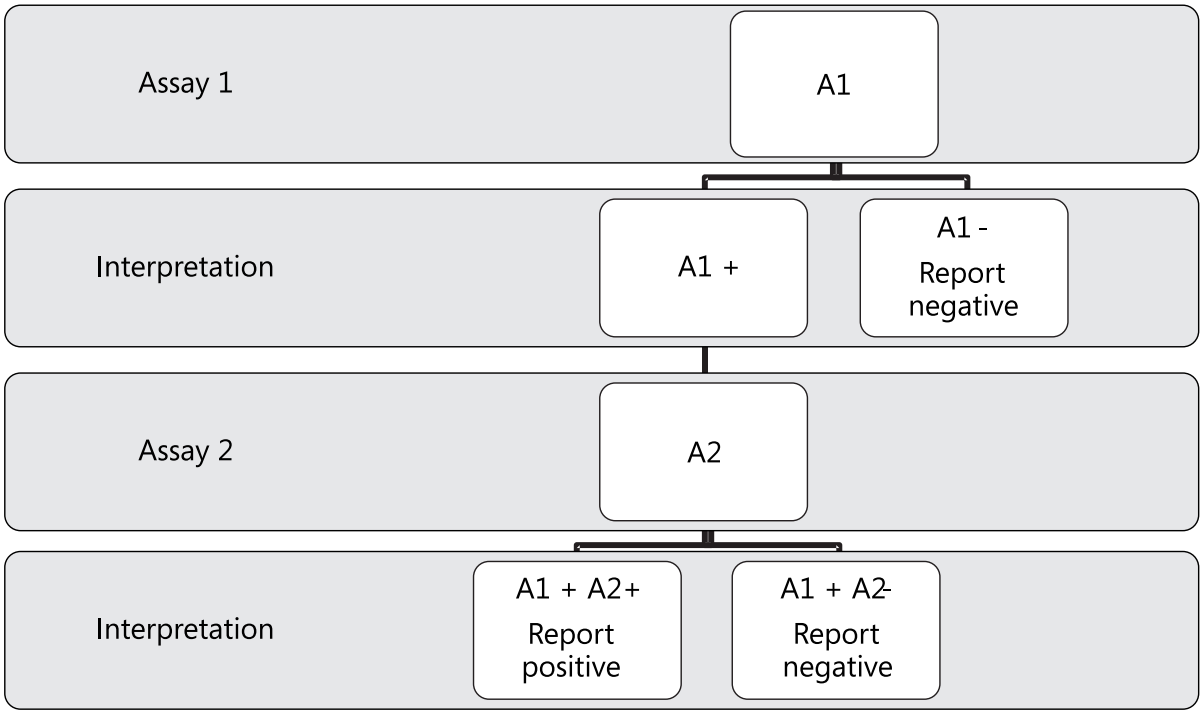


Source: National Guidelines for HIV Testing, 2015

4.1.2 Strategy II (A)

Two rapid tests are mainly used in case of HIV sentinel surveillance where two testing kits are being used.

Figure 4.2: Algorithm II(A) (For surveillance)

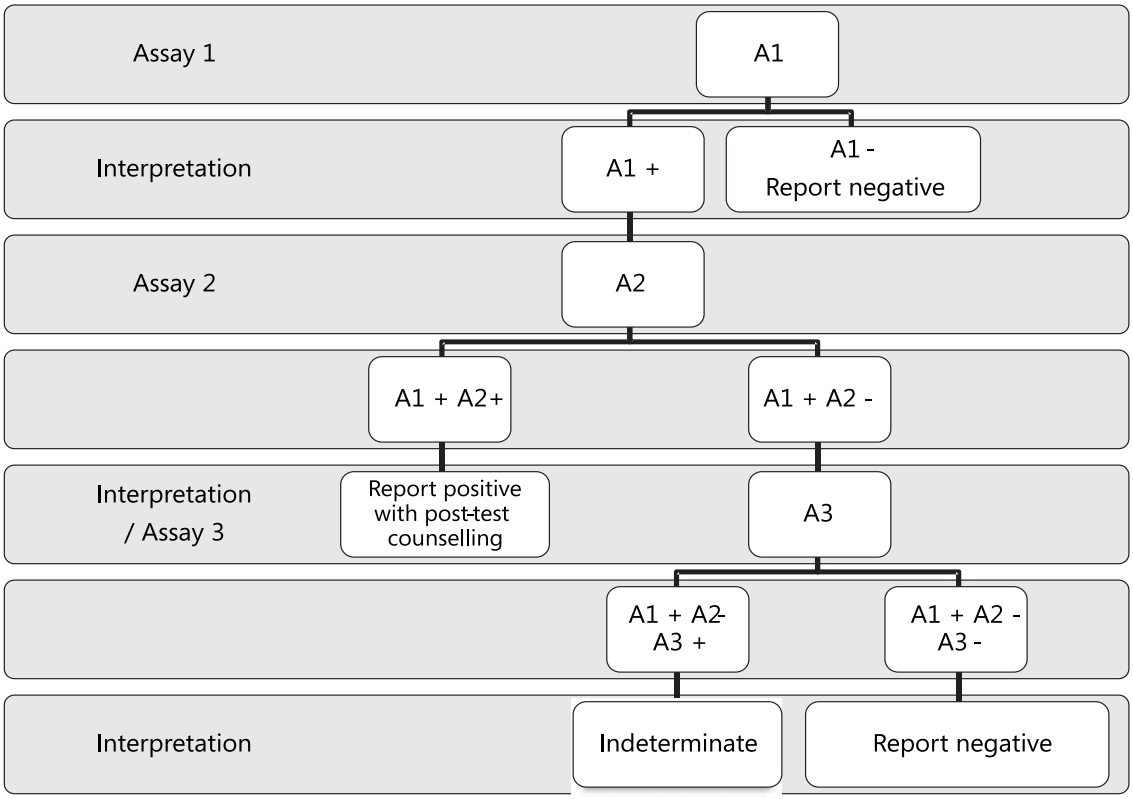


Source: National Guidelines for HIV Testing, 2015

4.1.3 Strategy II (B)

A patient who is clinically symptomatic and suspected to have an AIDS indicator condition/disease is referred to the SA-ICTC for confirmation of the diagnosis. In this case, the same blood sample is tested twice using kits with either different antigens or principles. The patient is declared HIV-negative if the first test is non-reactive and as HIV-positive when both tests show reactive results. When there is discordance between the first two tests (first reactive and the second non-reactive), a third test is done. When the third test is also negative it is reported as negative. When the third test is reactive, it is reported as indeterminate and the individual is retested after 14–28 days.

Figure 4.3: Algorithm II (B)(For diagnosis of clinically symptomatic individual)



Source: National Guidelines for HIV Testing, 2015

4.1.4 Strategy III

4.1.4.1 Screening

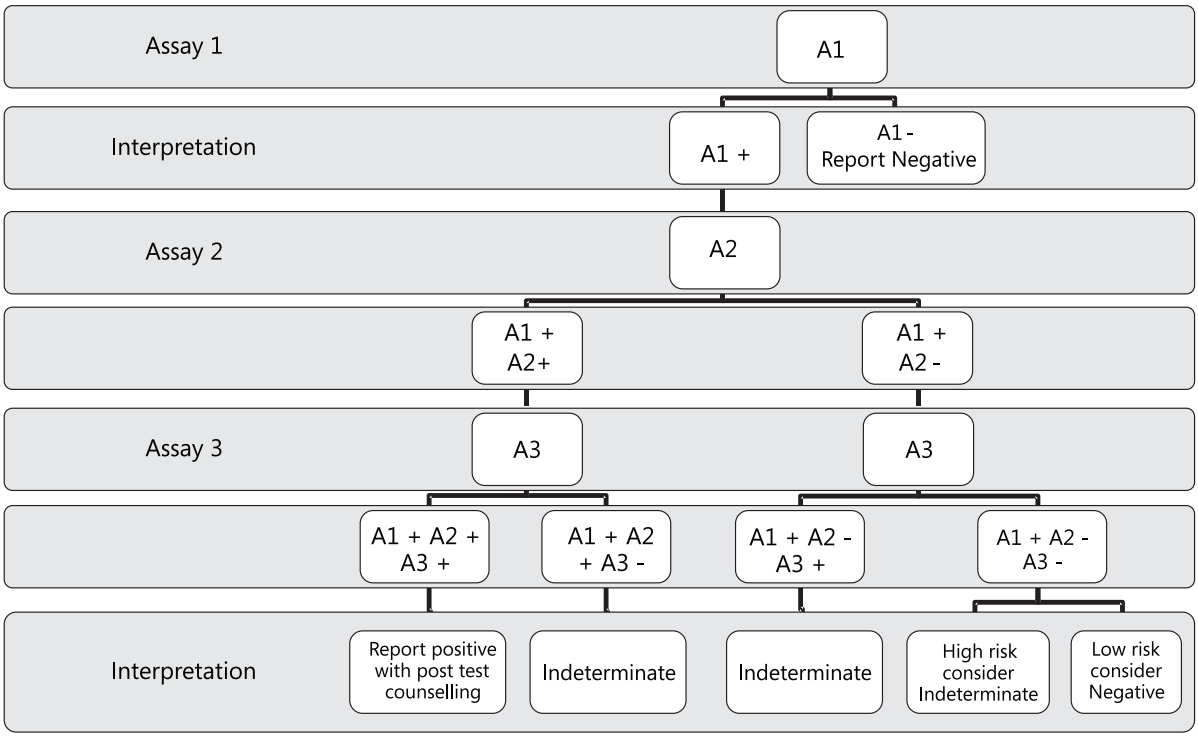
Screening for HIV at an F-ICTC, PPP–ICTC, mobile F-ICTC, community-based screening etc. - using a **single rapid test kit**.

- If the **test is found non-reactive**, the individual is considered HIV-negative and needs to be followed, as per the guidelines.
- If the **test result is found reactive**, the individual should be promptly linked to the SA-ICTC for confirmation of the diagnosis and further necessary action.

4.1.4.2 Confirmation

Confirmation of HIV diagnosis in asymptomatic individuals is done at an SA-ICTC **using three rapid tests of three different antigens or principles**. The individual is considered HIV-negative if the first test is non-reactive and as HIV-positive when all three tests show reactive results, as shown in Figure 4.4.

Figure 4.4: Algorithm III (For diagnosis of clinically asymptomatic patient)



Source: National Guidelines for HIV Testing, 2015

Assays AI, A2, A3 represent three different assays based on different principles or different antigenic compositions. Assay AI should be of high sensitivity and A2 and A3 should be of high specificity. A2 and A3 should also be able to differentiate between HIV 1 and 2 infections. Use strategies II B or III for diagnostic purposes.

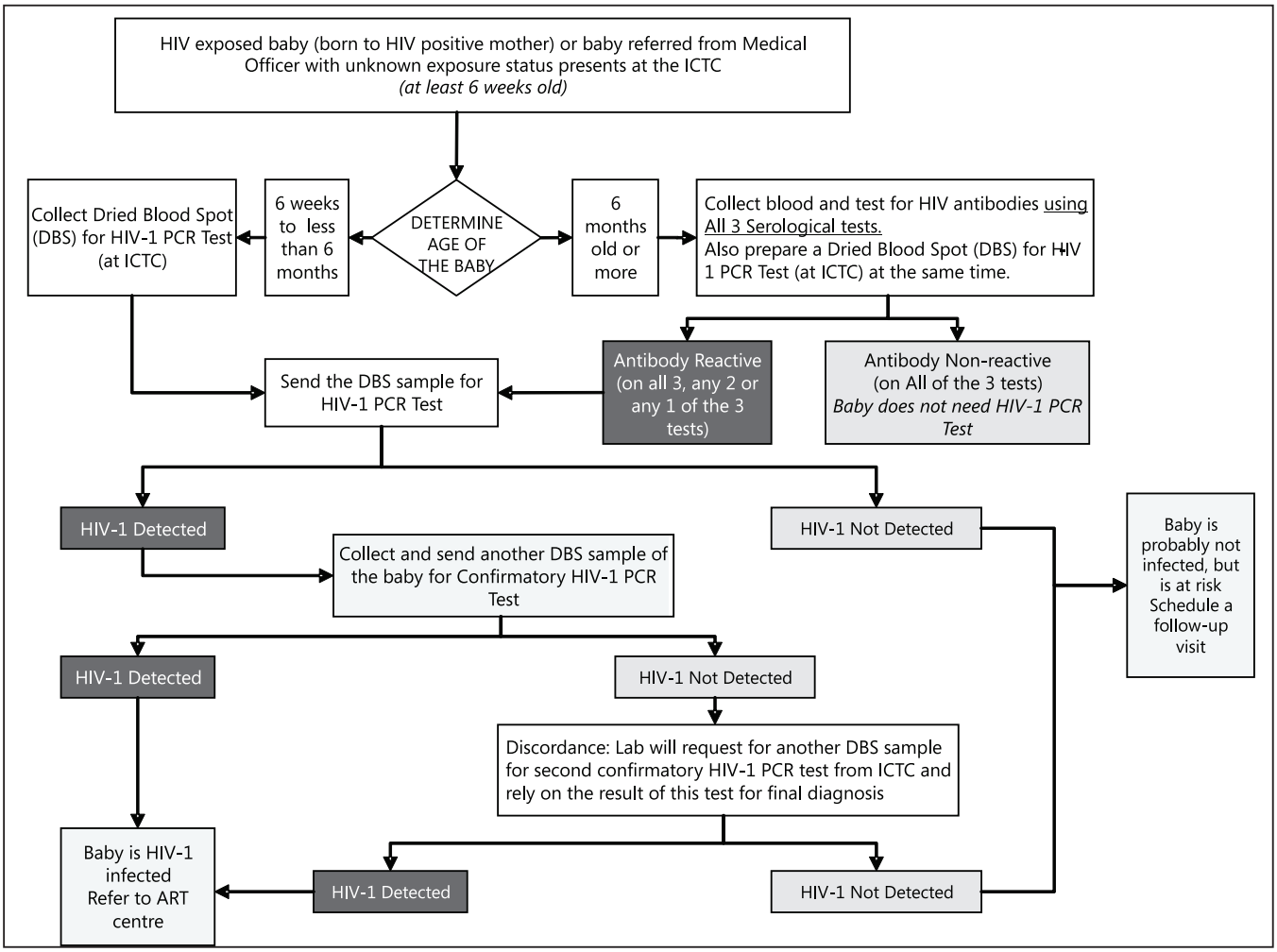
Indeterminate: Testing should be repeated on a second sample taken after 14–28 days. In case the serological results continue to be indeterminate, then the sample should be referred to the linked State Reference Laboratory for further testing.

4.2 Early diagnosis of HIV in children below the age of 18 months

A child may acquire HIV from the HIV infected mother-in-utero(during pregnancy), peripartum (during delivery), postpartum (through breastfeeding) or via parenteral exposure through infected needles and syringes. Early diagnosis is done to determine the HIV status among children below 18 months of age. In children who acquire HIV in-utero and peripartum, disease progression occurs rapidly in the first few months of life, often leading to death. Studies suggest that in the absence of diagnostics, care and treatment, about 35% of HIV-infected children die in the first year of life, 50% by their second birthday, and 60% by their third birthday.

Most children born to HIV-positive mothers will test positive using rapid HIV antibody tests. Maternal antibodies are present in a child's blood for up to 18 months after birth, making it difficult to differentiate maternal from child's antibody by rapid antibody tests. However, HIV antibody tests are useful for identifying potentially uninfected children as early as 6–18 months of age (if they are not breastfed, or if they ceased breastfeeding 6 weeks before testing). Thus, in children below 18 months of age, it is strongly recommended that HIV-1 virological assay be used for testing at 6 weeks of age or at the earliest opportunity thereafter.

Figure 4.5: National Testing Algorithm for HIV-1 exposed infants and children below the age of 18 months



Box 4.6: Presumptive HIV diagnosis for children below the age of 18 months

Any HIV-exposed child who presents with any two of the following symptoms is presumed to be infected with HIV:

- Oral thrush
- Severe pneumonia
- Sepsis

In such cases, while following the laboratory EID algorithm, the clinician may initiate ART immediately

4.3 Single-prick/single-window blood sample collection for testing

An individual may attend a health-care facility for multiple purposes; HIV testing may be one of them and they may require multiple blood tests at the same visit. The person in-charge of the health-care facility should ensure that the blood sample of such an individual is collected in one department of the facility and transported to the relevant testing facilities along with properly filled requisition slips. HIV testing should be undertaken only after pre-test counselling and informed consent, duly documented in the counselling register.

4.4 Non-ambulatory in-patients

In some situations, within the public health-care facility, there may be a non-ambulatory in-patient who requires HIV testing and is not in a position to visit the HIV testing site. The blood sample of such a patient should be sent to the nearest HCTS facility with properly filled requisition slips. The responsibility for the appropriate pre-test counselling and obtaining informed consent will be that of the referring health-care provider. Post-test counselling will be provided by the concerned HCTS functionary in the ward where the patient is admitted.

4.5 Diagnosis of HIV-2

NACO has designated specific laboratories to confirm the diagnosis of HIV-2 as it is important to select appropriate antiretroviral treatment (ART). The SA-ICTC that has diagnosed HIV-1 and/or HIV-2 should refer the PLHIV to the nearest ART centre. The nodal officer at the ART centre will confirm whether an accurate diagnosis of HIV-1, HIV-2 or dual infection has been made through the linked designated HIV-2 reference laboratory. This enables the ART centre to select the appropriate ART regimen. It is to be noted that where the patient is too sick, the ART centre may send the blood sample to the HIV-2 reference laboratory rather than sending the sick patient.

The HIV-2 reference laboratory should promptly share the final report with the concerned SA-ICTC and ART centre, SACS, NACO (Basic Services Division, Care Support and Treatment) and Laboratory Services Divisions).

4.6 Quality assurance of HIV testing

Quality is an absolute requirement of any testing laboratory. A false-positive or false-negative result from an HIV testing laboratory is associated with social, ethical, medical and legal implications, making it extremely important for the HCTS to adopt SOPs to ensure requisite standards of quality in HIV testing and reporting. Training on SOPs, quality control measures (periodic mentoring of HCTS functionaries to ensure adherence to SOPs) and external quality assurance are the various mechanisms used under the NACP to ensure the quality of HIV testing and reporting.

Quality management system (QMS)

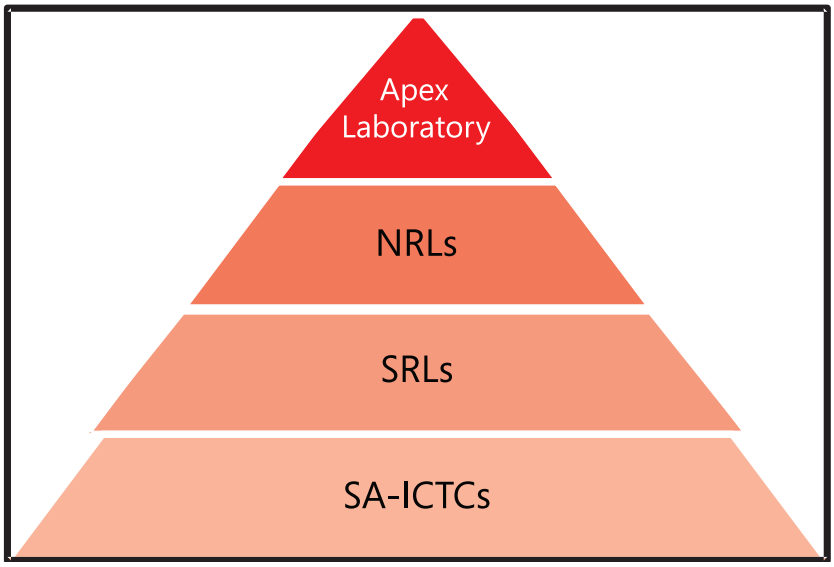
QMS is a management system of coordinated activities to direct and control an organization with regard to quality (ISO 9000). Systemic and process-oriented efforts are essential to meet quality objectives.

A hierarchical network of laboratories has been set up for continued supervision and quality assurance.

The following are important for ensuring reliable and accurate results:

- **"Laboratory Consortium for Kit Quality"**–any HIV test kit used at the HCTS facility for screening and testing under the NACP is validated by the NACO-established laboratory consortium for kit quality. The National AIDS Research Institute (NARI), Pune acts as the secretariat to the laboratory consortium.
- **National external quality assurance system**

Figure 4.7: Hierarchy of supervision and quality assurance of HIV testing



A successful result in an external quality assurance scheme (EQAS) and retesting can be ensured if the following pillars of quality are addressed:

1. **Personnel** – qualified, trained and competent staff for performing HIV testing and correctly interpreting results
2. **Kits and reagents**– use of expired kits must always be avoided. Kits should be stored in a clean, secure place and the cold chain (where indicated) should be maintained.
3. **Sample** – an adequate sample that is not haemolysed is essential for a correct result.
4. **Equipment**–regular calibration, monitoring and maintenance of equipment should be ensured.
5. **Documentation** – proper documentation of samples received and test results. Adherence to SOPs must be ensured.

Each SA-ICTC is linked to an SRL, which is responsible for mentoring and monitoring quality at the SA-ICTC. An SA-ICTC must participate in retesting as well as panel testing/EQAS programme through their SRL.

For retesting, each SA-ICTC should send 20% of all positive samples and 5% of all negative samples received during the first week of the first month in every quarter (January, April, July, October) to the SRL for cross-checking, as per the national EQAS guidelines.

Additionally, once in 6 months, as part of a periodic assessment of quality of testing at the SA-ICTC, a panel of four blinded samples is sent by the linked SRL to the SA-ICTC for testing. The SA-ICTC reports back the panel testing report to the linked SRL. In turn, the SRL provides feedback to the SA-ICTC and plans for retraining of the LT, based on the performance.

4.6.1 Quality control at the SA-ICTC, F-ICTC and other HCTS facilities

All HIV tests need to be performed with strict adherence to protocol, taking into account the national guidelines on Quality Management Systems in HIV testing Laboratories. The quality control procedure for rapid HIV test kits should be adhered as detailed in the above said guidelines. The medical officer in-charge of the SA-ICTC should cross-check every positive result before signing the laboratory report.

4.6.2 Role of SA-ICTC in facilitating HIV screening

Sensitization/orientation, regular supervision and re-training if needed, will be the key mechanisms to ensure the requisite standards of HIV screening. Since SA-ICTC is responsible for the confirmation of the HIV diagnosis for all those individuals found to be HIV reactive at linked screening facilities, it should regularly monitor and supervise the HIV screening activity and handhold the staff at all the linked HIV screening facilities.

4.6.3 Storage of sera for quality assurance

The functionaries at the SA-ICTC should strictly follow the SOPs for both storage and transportation of sera as detailed in the *National HIV testing guidelines*, 2015, NACO.

The sera can be stored at 2–8°C in the refrigerator for only up to a week. For longer storage, specimens need to be kept frozen at–20°C. Repeated freeze–thawing cycles should be avoided.

4.6.4 Specimen transport for quality assurance

The specimen tube in which serum is to be transported should not have cracks/leaks. Preferably, it should be made of plastic and be screw-capped. The outside of the container should be checked for any visible contamination with blood, which should be disinfected.

Place the tube containing the specimen in a leak-proof container (e.g. a sealed plastic bag with a zip-lock or, alternatively, the bag may be stapled and taped). Pack this container inside a cardboard canister/box containing sufficient material (cotton gauze) to absorb the blood in case the tube breaks or leaks.

Cap the canister/box tightly. Fasten the request slip securely to the outside of this canister. This request slip should have all of the patient's details (i.e. PID, age, sex, risk factors, history of previous testing, etc.) and should accompany the specimen. The request slip should be placed in a plastic zip-lock bag to prevent smudging on account of spillage. For mailing, this canister/box should be placed inside another box containing the mailing label and a biohazard sign.

The specimen should be carefully packaged to protect it from breakage and insulated from extreme temperatures.

Label appropriately and mention the test/s being requested for that sample. The collection site should make use of a unique identification number as sample identity. Names of the patients should be avoided to prevent confusion arising from duplication of names as well as to maintain confidentiality.

Secure the vacutainer cap carefully and seal it further with sticking tape placed so that it covers the lower part of the cap and some part of the tube stem.

During packaging, the tubes containing specimens should be placed in a tube rack and packed inside a cool box (plastic or thermacol) with cool/refrigerated/frozen gel packs (use whichever pack necessary to maintain the sample at the appropriate recommended temperature for the test) placed below and on the sides of the tube rack. Place some cotton or other packaging material between the tubes to ensure that they do not move or rattle while in transit. The cool box required for transportation could be a plastic breadbox or a vaccine carrier. Seal/secure the lid of the cool box.

This cool box should then be placed in a secure transport bag for the purpose of shipping it to the testing facility. The request slips should be placed in a plastic zip-lock bag and fastened securely to the outside of the cool box with a rubber band and sticking tape.

A biohazard label should be pasted on the visible outer surface of the package containing the samples. The package must be marked with arrows indicating the "up" and "down" side of the package.

Samples should be transported to the receiving laboratory by courier or be hand-delivered by a trained delivery person.

The collection site must have prior knowledge of the designated testing days of the laboratory to which the samples are being sent.

Unless prior arrangements have been made with the receiving laboratory, no transportation of samples should be done during weekends, holidays, or non-testing days for the testing laboratory.

4.7 Standard operating procedures for Lab Technicians

4.7.1 Standard operating procedures for Lab Technicians at HCTS Screening Facility

Standard operating procedure for lab technician at screening facility is same as for counsellor detailed in **Chapter 3**, Section 3.7.1 "Standard Operating procedure for Counsellors at HCTS Screening Facility"

Records to be maintained

The following documents have to be maintained at screening centers:

1. Counselling register (***Annexure A1***) / (***Annexure A12***)
2. Linkage form in triplicate (***Annexure B1***)
3. Laboratory report for screened non-reactive (***Annexure C3***)
4. Stock register (***Annexure A5***)
5. Follow up HIV Testing Card ***(Annexure D5)***
6. Temperature Log Book (***Annexure A7***)
7. Indent for HCTS Commodities (***Annexure B2***)
8. SIMS reporting formats for HCTS Screening Facilities (***Annexure C2***) / (***Annexure C8***)
9. Dashboard Indicators at HCTS Screening Facilities (***Annexure C6***)

4.7.2 Standard operating procedures for Lab Technicians at HCTS Confirmatory Facility (SA-ICTC)

1	Document details of the individual in lab register ***(Annexure A4)*** mentioning unique PID number
2	Collect the sample and conduct HIV testing as per the standard operating procedures (refer to National HIV Testing Guidelines 2015)
3	Prepare lab report ***(Annexure C4)***
4	Get the lab report signed by medical officer/officer-in-charge
5	Handover the duly signed lab reports to the counsellor on the same day
6	Document the test results in the lab register
7	Maintain all details of daily testing in the daily worksheet ***(Annexure C5)***

Records to be maintained

The following documents have to be maintained at laboratory of HCTS confirmatory facilities (SA-ICTC):

1. Laboratory register (***Annexure A4***)
2. Temperature Log Book (***Annexure A7***)
3. Stock register at SA-ICTC (***Annexure A6***)
4. Indent form (***Annexure B2*)**
5. Laboratory report (***Annexure C4***)
6. Daily worksheet for laboratory technician (***Annexure C5***)

- For further details on HIV testing, please refer to

  "National Guidelines for HIV Testing, 2015"
- For further details on Quality Management, please refer to

  "National Guidelines for Quality Management Systems in HIV testing laboratories"
- For further details on HIV testing in infants and children below the age of 18 months, please refer to

  "National EID Guidelines, 2016"

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

5

HIV-TB Collaborative Activities

Tuberculosis (TB) is the leading cause of death among PLHIV. Early diagnosis of HIV is critical for reducing the mortality due to the disease. Globally, it has been estimated that less than half of all TB patients with HIV receive an HIV test; hence, HIV testing in TB settings needs to be scaled up. Ministry of Health and Family Welfare, Government of India, through the NACP and RNTCP is implementing well-planned HIV/TB collaborative activities across the country. The current National Framework for HIV/TB Collaborative Activities, November 2013 aims to significantly reduce the morbidity and mortality due to HIV/TB co-infection through prevention, early detection and prompt management of both HIV and TB.

5.1 NACP-RNTCP Coordination Mechanisms and Activities at Various Levels:

It is important to ensure robust and coordinated efforts between these two national programmes at all levels to achieve sustained and successful outcomes. Coordination has been ensured by forming national and state TB/HIV coordination committees; national and state technical working groups; and district coordination committees (DCCs). The in-charge of SA-ICTC should regularly participate in monthly HIV/TB coordination meetings at the district level, which will help to bridge identified implementation gaps and support continuous improvement towards uniform efficient implementation of HIV/TB collaborative activities.

A 'four-pronged strategy' has been envisaged to ensure strong collaboration and coordination between the NACP and RNTCP. It entails prevention, early detection of HIV/TB, prompt treatment and management of TB/HIV cases.

5.1.1 Prevention of TB-HIV

The three I's for prevention of TB/HIV include the following**:**

1. Intensified case finding (ICF)
2. Isoniazid preventive therapy (IPT)
3. Infection control for tuberculosis (IC)

5.1.1.1 Intensified Case Finding (ICF):

Systematic TB screening should be integrated and offered at all HIV testing facilities and to all populations receiving HIV testing, irrespective of their test results. Intensified TB case finding in clinical and outreach settings will facilitate early detection of HIV-associated TB and linkage to treatment.

Presumptive TB cases are those who have cough of two weeks, or more, with or without other symptoms suggestive of TB in adults and adolescents and/or fever and/or cough of recent onset lasting for >2 weeks, recent unexplained loss of weight and history of exposure to an infectious TB patient (smear positive) in children. In people living with HIV, cough of any duration is suggestive of TB.

All people living with HIV should be regularly screened for TB using clinical symptom based algorithm consisting of current cough, fever, weight loss or night sweats (4 symptoms) at the time of initial presentation for HIV care and at every visit to a health facility or contact with a healthcare worker afterwards. Similarly,

children living with HIV who have any of the following symptoms- poor weight gain, fever or current cough or contact history with TB case-may have TB and should be evaluated for TB and other conditions.

Screening of TB through a WHO recommended 'Four symptom screening' is highly sensitive to identify a presumptive TB cases amongst PLHIV. If a patient does not have any of these four symptoms; TB can be confidently ruled-out in 98 out of 100 cases.

Thus all individuals accessing HCTS as well as ART, Link ART, Link ART Plus, Care support centres and Targeted interventions should be screened for TB.

Individuals who have symptoms or signs suggestive of TB, irrespective of their HIV status, should be referred to RNTCP diagnostic and treatment facility. For this purpose, NACP and RNTCP promote the establishment co-located facilities.

5.1.1.2 Isoniazid preventive therapy (IPT) for PLHIV at ART centre /Link ART-Plus and Link ART Centres

IPT is one of the 3Is that are globally recommended for prevention of incident TB among PLHIVs. Isoniazid is the most effective Bactericidal Anti TB drug available currently. While it protects against progression of latent TB infection to active disease i.e. reactivation, it also prevents TB re-infection post the exposure to an open case of TB. This is provided at ART centre/Link ART-plus and LACs.

5.1.1.3 Infection Control for TB:

When patients remain undiagnosed and untreated for tuberculosis, there is risk of transmission of tuberculosis infection at health care facilities. Early diagnosis and prompt treatment of TB will rapidly make TB patients non-infectious and ultimately will break the chain of transmission.

Ensuring appropriate Administrative, Environmental and Personal Protective Measures as recommended in the Airborne Infection Control Guidelines is of utmost importance in reducing the risk of transmission of TB at HIV TB care settings.

5.1.2 Early detection

Early detection of TB and HIV is crucial. The programme identifies the following important strategies to ensure diagnosis of HIV and TB at all service delivery facilities:

1. Provider Initiated Testing and counselling (PITC) for all TB and presumptive TB cases for HIV
2. Rapid diagnostics for detection of TB and DR-TB in PLHIV

5.1.2.1 Provider Initiated HIV Testing and Counselling (PITC) in TB and/or Presumptive TB cases:

PITC includes providing pre-test counselling and obtaining informed consent, with the option to opt out from testing. At all HIV testing facilities, routine HIV screening should be offered to all adult, adolescents and paediatric patients with presumptive and diagnosed TB. Partners of known HIV-positive TB patients should also be offered HCTS with mutual disclosure.

Linkage of presumptive TB cases from HCTS facilities to TB diagnostic facilities should be recorded on a line-list to facilitate exchange of information with the RNTCP, and to track the individuals through the process of TB diagnosis and initiation of directly observed treatment, short-course (DOTS). To streamline this process further, RNTCP functionaries should stay in touch with HCTS functionaries to complete the exchange of information in time and should enter information in the TB/HIV register. In addition, the staff of the above-mentioned NACP facilities and RNTCP should participate in monthly HIV/TB coordination meetings at the district level to validate line-lists and monthly HIV/TB reports, and to promptly resolve operational issues, if any.

5.1.2.2 Early Diagnosis for detection of TB and DR-TB in PLHIV:

Early diagnosis of microbiologically confirmed TB is one of the leading priorities under the programme. The acceptable methods for microbiological diagnosis of TB in the RNTCP include sputum smear microscopy (both conventional and fluorescent), molecular technologies, line probe assay (LPA) or cartridge-based nucleic acid amplification test (CB-NAAT) and culture (on solid or liquid media).

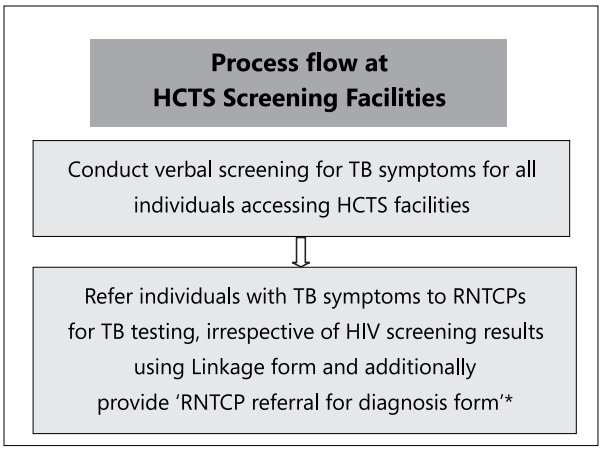
CB-NAAT is a rapid molecular diagnostic technology, which provides results within 2 hours, thus enabling same-day diagnosis and prompt treatment initiation. The use of CB-NAAT has been recommended as the preferential test for early diagnosis of TB and rifampicin resistance among PLHIV.

5.2 Mechanism at ICTCs for identifying and testing individuals with HIV-TB

5.2.1 Process flow at HCTS Screening Facilities for HIV-TB testing

The process for identifying and testing people with HIV-TB co-infection at screening centres is reflected in the figure below:

Figure 5.1: Process flow at HCTS Screening Facilities



**Please ensure to get supplies of 'RNTCP referral for diagnosis form' from RNTCP*

Detailed process flow

1. Document information of the individual as per standard procedure mentioned in **Chapter 3**
2. Conduct verbal screening for TB symptoms for all individuals accessing HCTS facilities

3. Refer individuals who have symptoms or signs suggestive of TB to RNTCP centre using Linkage form (***Annexure B1***).
4. Additionally, provide the individual duly filled RNTCP referral for diagnosis form (***Annexure B3***). This form will ensure that the individual referred can avail services at RNTCP centres swiftly.

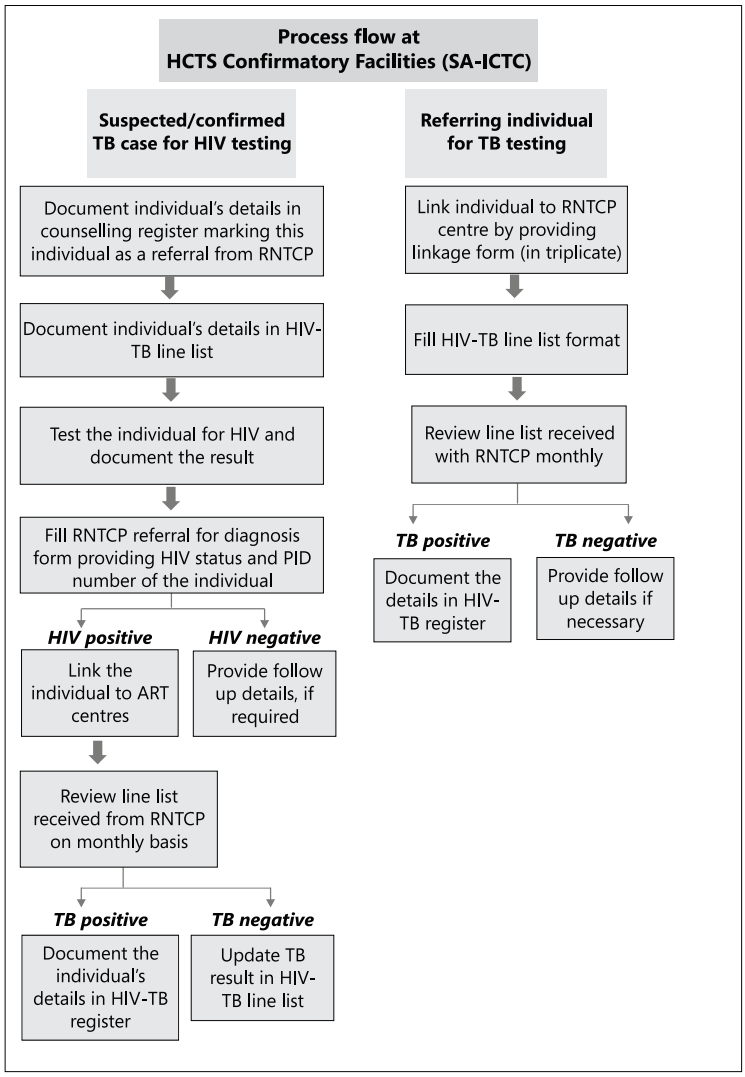
Documents to be maintained at HCTS Screening Facilities for HIV-TB Activities:

1. Linkage form in triplicate (***Annexure B1***)
2. RNTCP referral for diagnosis form (***Annexure B3***)

5.2.2 Process flow at HCTS Confirmatory Facilities (SA-ICTC) for HIV-TB testing

The process for identifying and testing people with HIV-TB co-infection at HCTS Confirmatory Facilities (SA-ICTC) is reflected in the figure below:

Figure 5.2: Process flow at HCTS Confirmatory Facilities (SA-ICTC)



Process flow for all incoming individuals from RNTCP to HCTS Confirmatory Facilities (SA-ICTC)

1. Document the individual details as per standard procedure mentioned in **Chapter 3**
2. Screen the individual for TB by using 'Four Symptom Screening' method
3. For an individual showing symptoms of TB, refer them to nearest RNTCP centre by providing linkage form in triplicate (***Annexure B1***)
4. Document details of the individual in HIV-TB line list (***Annexure A8***)
5. Review HIV-TB line list with RNTCP monthly
6. If the individual is confirmed TB positive, document the details in HIV-TB register (***Annexure A9***). If individual is TB negative, provide follow up details as required.

Process flow for suspected/confirmed TB Individuals who has come for HIV testing

1. Document details of the individual in the counselling register specifying referral from RNTCP ***(Annexure A2)***
2. Fill HIV-TB line with details of the individual ***(Annexure A8)***
3. Conduct HIV testing as per applicable procedure and record the test results
4. Fill RNTCP form with HIV status and PID number of the individual ***(Annexure B3)***
5. If tested HIV positive, link the individual to ART centres using Linkage Form in triplicate ***(Annexure B1)***
6. Review HIV-TB line list with RNTCP monthly and if tested TB positive as well, record their details in HIV-TB register ***(Annexure A9)***
7. If tested HIV negative, provide follow up details as required

Documents to be maintained at HCTS Confirmatory Facilities (SA-ICTC)

1. Counselling register for general individuals ***(Annexure A2)***
2. Counselling register for pregnant women ***(Annexure A3)***
3. HIV-TB Line list ***(Annexure A8)***
4. HIV-TB register ***(Annexure A9)***
5. Linkage Form in triplicate ***(Annexure B1)***
6. RNTCP referral for diagnosis form ***(Annexure B3)***

**Please ensure to get supplies of 'RNTCP referral for diagnosis form' from RNTCP*

It is critical to have strong collaboration of HIV TB activities at all HCTS facilities to diagnose early and significantly reduce morbidity and mortality due to HIV and TB dual infection. Effective prevention strategies, early detection of HIV and TB by using newer methodologies, and prompt management of HIV and TB infections through well-coordinated efforts with National AIDS Control Programme and Revised National TB Control Programme will ensure sustainable long term success with these dual infections.

For more details, please refer to –

"Integrated Module for HIV/TB Collaborative Activities, 2015"

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

6

Linkage of HIV testing to care, support and other prevention services

It is of no value to just test for HIV without linking HIV positive individuals to care and support; and HIV negative individuals, if at continuing high risk, to prevention services.

Thus, it is essential to promptly link all those individuals who know their HIV status to appropriate care, support or other prevention services. Linkage encompasses a spectrum of activities ranging from providing information to a more complex process of ensuring efficient delivery and utilization of all requisite services by the tested individuals based on their needs.

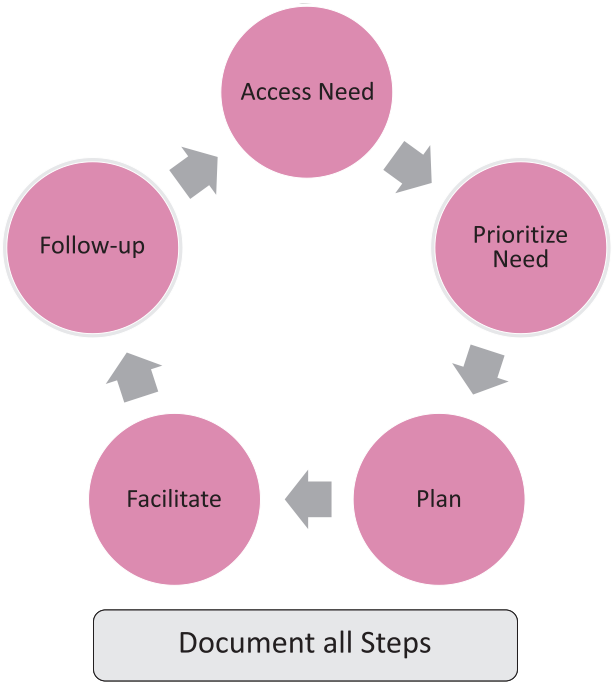
6.1 Process of Linkage:

HIV Testing is the entry point for comprehensive HIV care that aims to provide effective prevention interventions to those at risk and quality life to PLHIV in terms of health, social and emotional wellbeing. Hence, there is a wide spectrum of needs that the PLHIV might have and that can be met through effective linkages to various service providers.

The process of linkage flows through a series of the following steps starting from assessing the need of the individual to facilitation, linkage and documentation:

1. ***Assess Need:*** Identifying the need is the first step and should start immediately along with pre-test counselling and the appropriate facility should be identified where the individual needs to be linked for further services.
2. ***Prioritize Need***: Often there are multiple immediate concerns that need attention which should be prioritized by those affecting the health most, and carry risk if not addressed promptly. Information regarding all required services should be provided to the individual.
3. ***Plan***: Provide complete information regarding the facility where they are referred like address, contact details, focal person, timings etc. and prepare the individual for what to expect when he/she visits the particular facility.
4. ***Facilitate:*** Identify the barrier to linkage and explore the solutions on a case to case basis. Accompanied referral may be offered with help of peers, outreach workers, counsellors or any other health care providers and front-line health care workers for example: ANMs and ASHAs
5. ***Follow Up:*** Follow up with the individual for completion of linkage and receive feedback. If the linkage is incomplete and individual has not reached the facility, try to identify the specific barrier and provide assistance and information wherever required.
6. ***Document:*** It is very important to document every linkage. M & E tools to monitor linkage include Referral slips, Line lists, linkage software, records and reports.

Figure 6.1: PROCESS OF PLANNING A REFERRAL



6.2 Expected linkages at HCTS facilities:

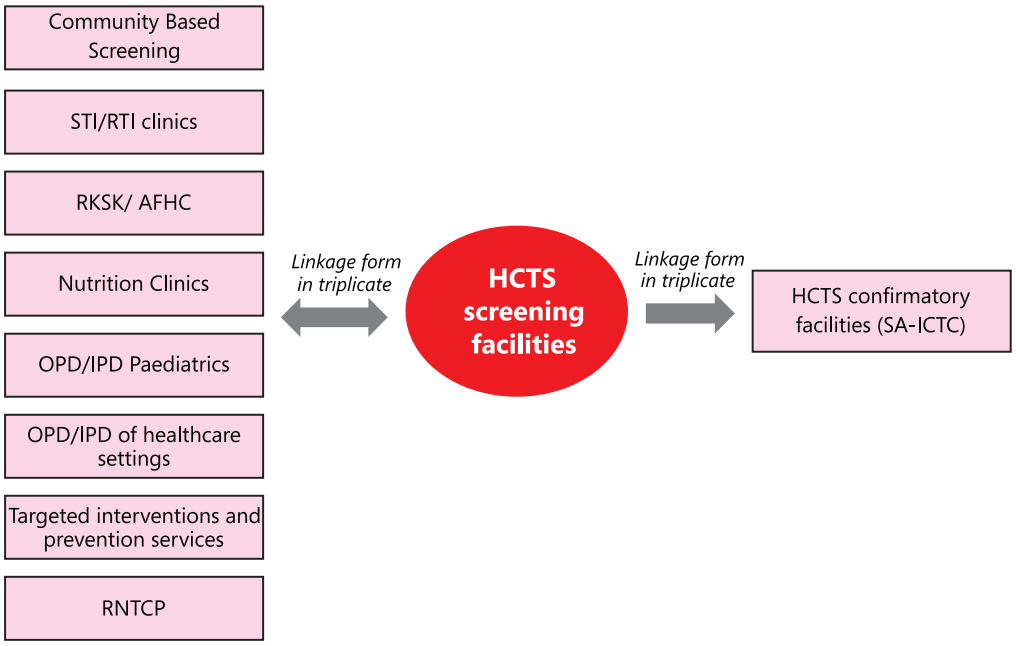
HCTS facilities have multiple linkages with other healthcare facilities to provide better care and support to individuals assessing HCTS. These linkages are established using **seperate** Linkage Form (***Annexure B1***) for each healthcare facility. The linkages could be unidirectional or bi-directional.

6.2.1 Linkages at HCTS Screening Facilities

The key linkages at these facilities include:

1. **Unidirectional linkage** to HCTS Confirmatory Facilities (SA-ICTC) for individuals found to be reactive to HIV at screening
2. **Bidirectional linkage** with other healthcare facilities including but not limited to:
   a. RNTCP: All patients diagnosed with TB and presumptive TB cases
   b. Maternal and Child Health: All pregnant/breastfeeding women
   c. OPD/IPD of Health care settings: All individuals presenting with any signs or symptoms suggestive of HIV or any Opportunistic Infection (OI) or medical condition suggestive of HIV
   d. Nutritional Rehabilitation Clinics
   e. STI/RTI Attendees: All individuals presenting with signs or symptoms of any STI/RTI in STI /RTI Clinic/Obs&Gynae/Dermatology/any other health care setting should be screened for HIV
   f. Targeted Intervention
   g. Adolescent friendly health clinics (RKSK)
   h. Other facilities under NHM

Figure 6.2: Linkages at HCTS screening facilities

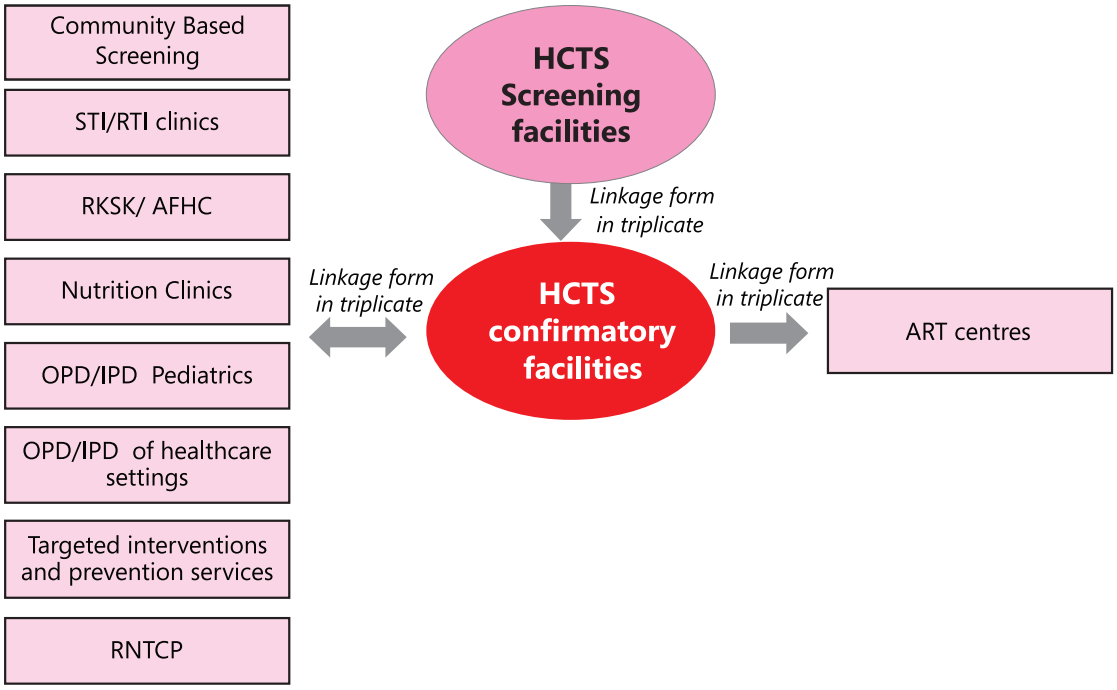


6.2.2 Linkages at HCTS Confirmatory Facilities (SA-ICTC)

The key linkages at these facilities include:

1. Unidirectional linkage to HTCS screening facilities for individuals who are coming to the SA-ICTC for their confirmatory testing
2. **Unidirectional linkage** to ART centres for individuals found to be HIV positive
3. **Bidirectional linkage** with other healthcare facilities including but not limited to:
    a. *RNTCP:* All patients diagnosed with TB and presumptive TB cases
    b. *Maternal and Child Health:* All pregnant/breastfeeding women
    c. *OPD/IPD of Health care settings:* All individuals presenting with any signs or symptoms suggestive of HIV or any opportunistic infection or medical condition suggestive of HIV
    d. *Nutritional Rehabilitation Clinics*
    e. *STI/RTI Attendees:* All individuals presenting with signs or symptoms of any STI/RTI in STI / RTI Clinic/Obs &Gynae/Dermatology/any other health care setting should be screened for HIV
    f. Targeted Intervention
    g. ART Centre: Known HIV positive women who are currently pregnant linked to PPTCT continuum of care services
    h. Adolescent friendly health clinics (RSRK)
    i. Family planning
    j. Substance abuse
    k. Other social support services and schemes
    l. Other facilities under NHM

Figure 6.3: Linkages at HCTS confirmatory facilities



6.2.2.3 Mechanism to ensure linkage from SA-ICTC to ART

During the cascade of HIV services, the linkage from preventive services, diagnosis of HIV and registration to HIV care remain the most critical initial steps. There are several mechanisms under the programme to ensure that there is minimal linkage loss at these steps.

- Regular monthly meeting at District level to share the line list and track referrals of all diagnosed PLHIV from ICTC to ART centre.
- After confirmation of HIV diagnosis at SA-ICTC, efforts should be made to ensure PLHIV enrolment at ART centre/LAC. In case of centres with co-located SA-ICTC and ART centers, accompanied referrals should be promoted.
- The patient should also be guided to take address proof and 2 passport size photos with them while going to ART centres. ART centres must send detailed feedback of PLHIV to centres that have referred them. This will help in tracking patients to understand who are Lost to Follow up to ensure effective actions are taken.

6.3 Roles and responsibilities of HCTS facilities to ensure effective linkage

Table 6.1: Roles and responsibilities of HCTS facilities to ensure linkage

Facility Name	Roles & Responsibilities
SA-ICTC	▪ To coordinate with health settings and other national programs like RNTCP with potential of PITC ▪ Referral of positive individuals to ART centres or LAC plus for availing HIV care ▪ Confirmation of linkages in coordination with ART centers ▪ Documentation of referral and linkages through linkage documents
ART center	▪ Provide feedback to SA-ICTCs from where the individuals have been referred and linked regarding confirmation of enrolment ▪ Refer spouses of HIV positive individuals at ART centres whose status is unknown to SA-ICTC for confirmation ▪ Refer sero-discordant couples to SA-ICTC for regular testing ▪ Refer children of HIV positive women to SA-ICTC whose status is unknown
DAPCU	▪ Arrange coordination meeting of all SA-ICTCs and ART centres in district ▪ Access linkage to and from HCTS facilities on a monthly basis ▪ Encourage PITC facilities for referrals ▪ Compile and manage district level linkage data

6.4 Barriers for Linkages and their addressal

Key barriers to linkage loss that have been identified through scientific studies and programme implementation are as follows:

S.No.	Key barriers for linkages	Ways to address linkage barriers
1	Lack of understanding of importance and requirement of services	Counsellors play an important role in explaining the importance of services such as TB/STI diagnosis, counselling, nutrition etc. While providing the individual with the linkage slip, the counsellor must explain the purpose of referral clearly to the individual. Counsellors must be trained to spread awareness about the importance of sharing this information with the individuals.
2	Lack of confidence on HIV test report	HIV test result might be shocking to some individuals. In such cases, counsellors should provide psychological support and encourage these individuals to accept the result and get registered at the ART centre for treatment initiation. Counsellors should also schedule follow up counselling sessions with the individuals to help them in accepting their HIV status.
3	Distances	Individuals should be referred to a facility which is most convenient to them – either nearest to their residence or workplace. Additionally, counsellors should provide knowledge about the route of transportation and timings of the referral centre to the individual. In case the individual is unable to visit the referred centre, then the counsellor should arrange for transportation of the sample to the referral facility.

S.No.	Key barriers for linkages	Ways to address linkage barriers
4	Fear of discrimination and lack of friendly environment	HCTS facilities must not discriminate against with individuals arriving for HIV testing or are diagnosed as HIV positive. Counsellors must be friendly to the individuals and must provide them with information on HIV to reduce stigma and fear linked tothe disease. HCTS facilities should try to link the individual detected HIV positive to the positive community to promote peer counselling with consent of the individual.
5	Long waiting time	HCTS facilities must create internal systems and streamline procedures to reduce waiting time and ensure that all visitors are well aware of the open timings of the facility. HCTS staff should be trained on relevant SOPs to ensure minimum delay in the processes.
6	Financial constraints	In case of any financial constraints, the HCTS facilities must reach out to the SACS or refer the individual to other well-equipped facility.
7	Lack of care givers	Counsellors must try to reach out to the local NGOs or train the relatives and friends of the individual as care givers in case an individual needs a caregiver.

At SA-ICTC, all possible measures should be taken to identify issues and explore solutions to these barriers on a case-to-case basis. In addition, there are many social benefit schemes and network support that can be offered as solutions.

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

7

Capacity Building and Supportive Supervision of Functionaries under HCTS

Capacity building of human resources is one of the critical in-built components for efficient implementation of a programme at all levels. Capacity building encompasses standardized training-modules, plans, mentoring and monitoring to ensure uniform programme implementation by different cadres across the country. Capacity building of various cadres working under HCTS assumes greater importance as they are the first point of contact for individuals who access these services.

7.1 Training for all HCTS facilities

Table 7.1: Training modules for all HCTS members:

S. No	Training Program	Eligible HCTS staff	Level of conducting training	Training Module	Trainer	Duration
1	Counsellors' Integrated Induction Training	New and untrained Counsellors of FICTC,PPP-ICTC,CBS,PITC, SA-ICTC, ARTC and DSRC/STI	State /UT at Identified Institutions	Integrated Induction Training Module	Master Trainers	Eight days
2	Counsellors' Integrated Refresher Training (Refresher I – after two years of induction training and Refresher II- after two years of Refresher I training)	Counsellors of FICTC, PPP-ICTC, CBS,PITC, SA-ICTC, ARTC and DSRC/STI, those who have already Undergone Induction Training	State /UT at Identified Institutions	Integrated Refresher Training Module	Master Trainers	Refresher I – Three days; Refresher II – Two days
3	HIV/TB Collaborative Training	SA-ICTC Medical Officer* ART Medical Officer * SA-ICTC Counsellor** District ICTC Supervisor** RNTCP – STS / STLS** DR - TB HIV Supervisors**	State/UT/ District	Integrated HIV / TB Training Module	Master Trainers	*Two days for Medical Officers **One day for others
4	Lab Technicians' Induction Training	New and untrained Lab technician at SA - ICTC, F-ICTC & PPP- ICTC	State/UT	Induction Training Module	State Reference Laboratory (SRL)- In charge and Technical Officer	Five days

S. No	Training Program	Eligible HCTS staff	Level of conducting training	Training Module	Trainer	Duration
5	Lab Technicians' Refresher Training After two years of Induction Training	In-service Lab Technicians at SA - ICTC, F-ICTC, & PPP-ICTC	State/UT	Refresher Training Module	SRL - In charge and Technical Officer	Three days
6	F - ICTC Staff' Hands on Sensitization and Orientation	Nurses / LHV / ANM / MPW Male / LT / Pharmacist RNTCP – LT / STS / STLS TI NGO Staff	District / SA - ICTC	Hands on Sensitization and Orientation Module	DAPCU / SA - ICTC Medical Officer, Counsellor and LT	One day
7	District ICTC Supervisors' Training	District ICTC Supervisors	State/District	DAPCU Training Module	Master Trainers	Three days
8	SA – ICTC Staff' Team Training	Medical Officer, Counsellor, Lab Technician from SA -ICTC and Labour Room Staff Nurse of the Health Facility where SA-ICTC is located	State	Team Training Module	Master Trainers	Three days
9	Full Site Sensitization on NACP	Medical, Nursing and Paramedical Staff of the Health Facility where SA-ICTC is located	At respective Health Facility where SA – ICTC is located	Sensitization Module	DAPCU/ District HIV Nodal Officer/ SA-ICTC MO, Counsellor & LT	One day
10	Training on PLHIV - ART Linkage System (PALS)	SA - ICTC Counsellor, ART Data Managerand DAPCU and SACS M&E and Data Managers	State/District/ Facility	Password Protected Software and Web -based User Manual	Master Trainers	One day
11	Training on SIMS	SA-ICTC – Counsellor and Lab Technician F-ICTC/PPP-ICTC/ TI functionary conducting HIV screening tests, DAPCU, District supervisor and SACS officials	State/District/ Facility	SIMS Training module Web -based User Manual	Master Trainers	One day

Note: Pre & post test questionnaire to be conducted during all trainings and training report need to be submitted with in two weeks to NACO.

7.2 Supportive Supervision

HCTS are provided through SA-ICTCs, F-ICTCs, TI NGOs and health sub-centres.

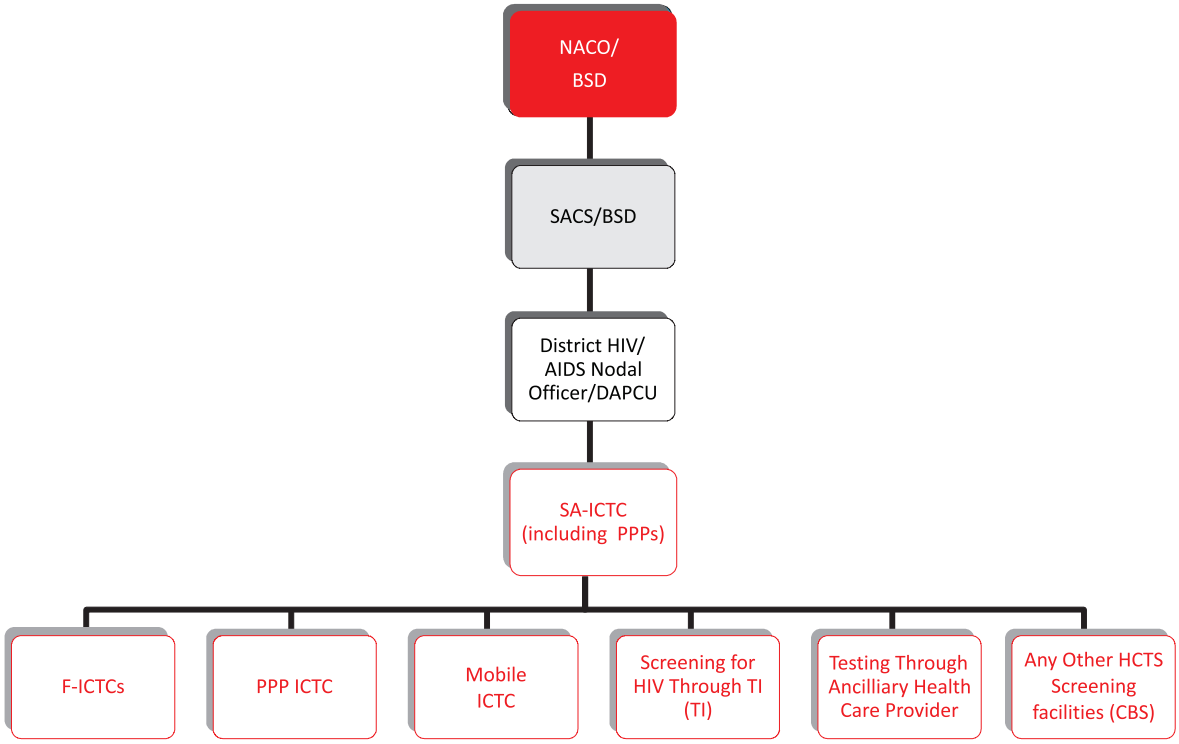
NACO/GoI through its Basic Service Division (BSD) is responsible for the following key activities in respect of HCTS in India:

1. Policy making, strategic planning, direction, guidance and capacity building for implementation, monitoring, review, evaluation and providing feed-back for timely corrective measures in respect of all the components of NACP to all the State AIDS Control Societies (SACS) in the country.
2. Coordinate and collaborate with National Health Mission to ensure efficient and effective HCTS in the country.

Contact details of officer of Basic Services Division at NACO is at (***Annexure E-8***)

In context of HCTS, the supportive supervision levels from national through the peripheral levels are depicted in the flow diagram below

Figure 7.2: Supportive Supervision levels under HCTS



Note: HIV screening at Sub-centre level should report to link PHC for SIMS F-ICTC reporting

Table 7.3: Supportive supervision of HCTS at various levels:

Level of Supportive Supervision	Officials Responsible for Supportive Supervision	Level / Facility / Functionaries to be Supervised	Frequency of Supportive Supervision	Mechanism of Supportive Supervision	Tools for Supportive Supervision
State / UT (SACS)	- Joint Director/ Dy. Dir. /Asst. Dir. - Quality Manager - M&E officer - Consultant PPTCT - Regional Coordinator of Basic Services Division	**All Districts -** - District HIV/ AIDS Nodal Officers - District Programme Officers of DAPCUs - SA-ICTC - Mobile ICTCs - PPP - ICTC - F-ICTC - TI	- At least one district/month be visited up to the peripheral HCTS facility of the district by each of the SACS level BSD officers - Approved tour plan and programme to be shared with all concerned at the State/UT and district to be visited	- Quarterly reviews with district and below level HCTS officers using standardized template. Record details for follow up actions. - In depth review , analysis and timely feedback on reports generated through SIMS and any other prescribed reports - Review through video conference - Regular field visits - Mobilize inputs from other officers in SACS /Directorate of Health Services/ Development partners working in the State/Community/NGOs etc - Review of action taken on earlier feedbacks/directives given - Conduct well planned National and State level reviews /appraisals/ evaluation using well designed formatsand methodology	- SIMS and any other prescribed report - Field Visit check lists for HCTS at different levels & facilities - Registers, records and reports maintained at various level of HCTS - Reviewing various defined HCTS related indicators - Feedback tool
District	- District HIV/AIDS Nodal Officer - District Programme Officer of DAPCU - District ICTC Supervisor - Monitoring and Evaluation Assistant - Programme assistant	- DAPCU staff - SA-ICTC - Mobile ICTC - PPP ICTC - F-ICTCs - TIs	- District level supervisory official to visit every SA-ICTC at least once a month; Visit every HCTS screening centreat least once a quarter - Approved monthly tour plan and program, to be shared with all concerned at district and facilities to be visited	- Monthly reviews with district and below level HCTS facility officers using standardized template; Record details for follow up - In depth review, analysis and timely feedback on reports generated through SIMS or any other prescribed reports - Regular Field Visits - Mobilizing inputs from other officers in District Health Offices/Development partners / Community/ NGOs etc working in district - Review actions taken on earlier feedbacks/directives given - Conduct well planned district level reviews /Appraisals using well-designed formats and methodology	- SIMS and any other prescribed report - Field Visit check lists for HCTS at different facilities - Registers, records and reports maintained at various HCTS facilities - Reviewing various defined HCTS related indicators - Feedback tool
Stand Alone -ICTC	- Medical Officer in-charge - Counselor - Lab technician	- SA-ICTC Staff - F-ICTCs - Mobile ICTCs - PPP ICTCs - TIs - Linked to SA-ICTC	- Every HCTS facility linked to the SA-ICTC should be visited at least once in a quarter, by any of the SA-ICTC staff. - The tour plan and program, duly approved by the competent officer, should be appropriately displayed at SA-ICTC and shared with all concerned facilities to be visited.	- Regular weekly reviews by the MO I/C with the staff of SA-ICTC and appropriately recorded for follow up actions - In depth review, analysis and timely feedback on reports of all the linked HCTS facilities, generated through the SIMS - Regular Field Visits - Mobilizing inputs from Community/ NGOs/Health workers etc in the jurisdiction of all the linked HCTS facilities - Review of the action taken reports on earlier feedbacks/directives given to the linked HCTS facilities	- SIMS and any other prescribed report - Field Visit check lists for HCTS at different facilities - Registers, records and reports maintained at various HCTS facilities - Reviewing various defined HCTS related indicators - Feedback tool

Level of Supportive Supervision	Officials Responsible for Supportive Supervision	Level / Facility / Functionaries to be Supervised	Frequency of Supportive Supervision	Mechanism of Supportive Supervision	Tools for Supportive Supervision
F-ICTC/ TI/ Mobile ICTC/PPP-ICTC	- Medical officer in-charge of health facility where F-ICTC is established	- Identified staff for conducting HCTS at F-ICTC / PPP-ICTC / Mobile ICTC / TI	- On a daily basis	- Regular weekly review with the identified staff responsible for HIV screening and counseling at F-ICTC - Facilitating the correct compilation and timely uploading monthly report in the SIMS - Review of the action taken on earlier feedbacks/directives given to F-ICTC	- SIMS & any other prescribed report - Field Visit to Health Sub centres - Registers, records and reports maintained at F-ICTCs and Health Sub-centers - Reviewing various defined HCTS related indicators - Feedback to the functionaries

7.3 Role of SACS in capability building

1. Each State AIDS Control Society (SACS) is responsible for efficient planning, implementation, coordination, monitoring, reporting and ensuring timely corrective measure in respect of all the above said training programs in the respective State/UT.
2. SACS should ensure an appropriate involvement of the District HIV Nodal Officers, DAPCUs, identified training centres and suitable master trainers as per subject needs.
3. The frequency of conducting the above training programs should be decided by the SACS as per the training needs and Annual Action Plan.
4. The trainings conducted should be reported, on a monthly basis, by all SACS through SIMS.
5. SACS should ensure that supportive supervision is provided at each level for all the defined roles and responsibilities of HCTS functionaries and activities of HCTS facilities to ensure efficient implementation as per the prescribed guidelines and norms.
6. SACS must see that continued supportive supervision is provided to enhance the efficiency and effectiveness of HCTS at all levels of service delivery and for all functionaries so as to maintain desired quality standards.
7. SACS must ensure timely and accurate reporting of HR & Training conducted by filling quarterly HR & Training Format ***(Annexure C10)*** to be uploaded in SIMS.

   Details of BSD In-charge at SACS are at **(*Annexure E-9*)**

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

8

Supply Chain Management under HCTS

Supply Chain Management (SCM) spans all movement and storage of HCTS related commodities (HIV Test Kits and consumables, Syrup Nevirapine and Zidovudine, DBS Cards and collection kits, registers etc.), from the point of origin to the point of consumption.

8.1 Supply Chain Management under HCTS

To ensure timely availability of HCTS commodities, it is important that effective coordination is maintained at all levels in the supply chain. HCTS facilities should ensure that their demand estimates reach NACO in a timely manner for efficient procurement. While demand estimates flow upward from HCTS facilities to NACO, flow of goods is downward from NACO to the HCTS facilities.

Below are the roles and responsibilities of each of the levels in HCTS supply chain hierarchy:

Figure 8.1: HCTS Supply Chain Management (SCM) at different levels

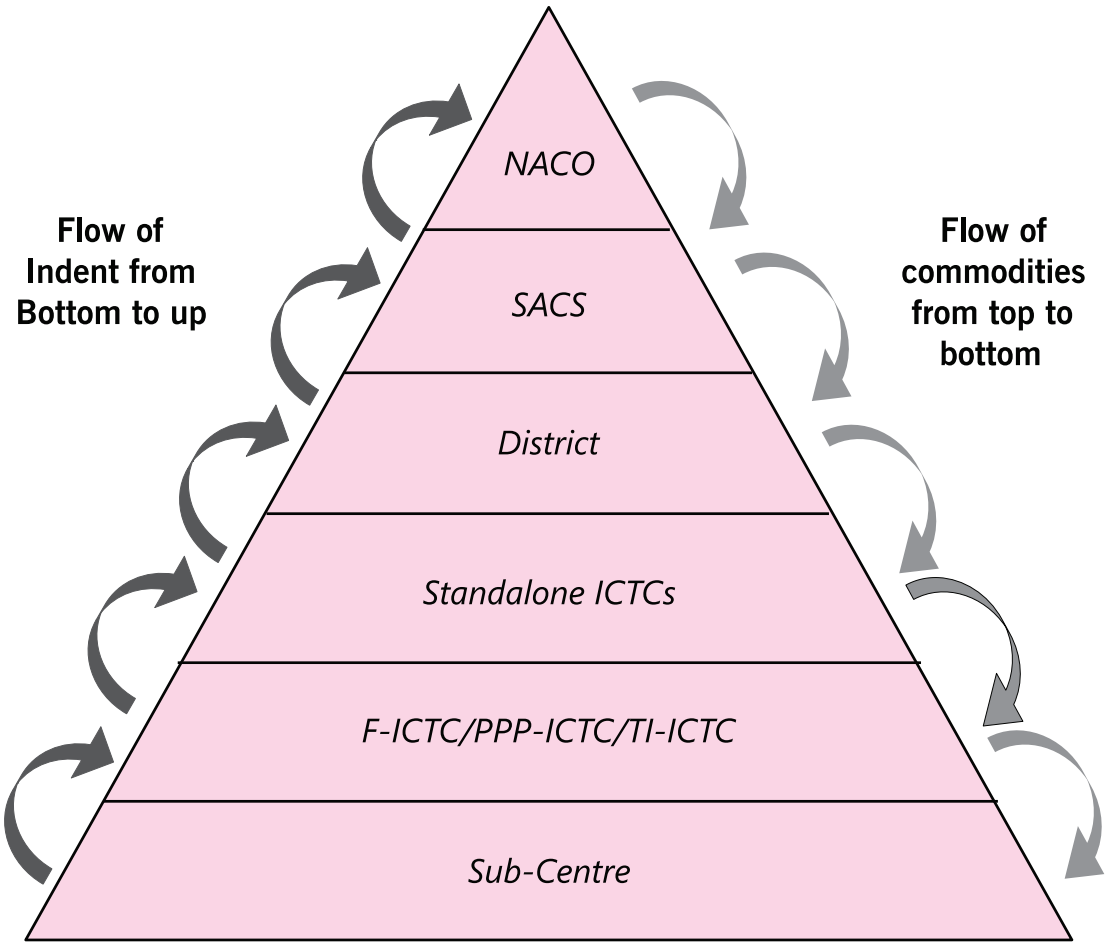


Table 8.1: SCM under HCTS at different levels

S.No.	Level of SCM	SCM responsibility
1.	**NACO**	▪ Forecast the State/UT wise need as per the annual action plan (AAP) and procure HCTS commodities for each to ensure uninterrupted availability of stock in the programme. ▪ Closely monitor the storage, distribution and utilization of commodities from States/UTs through all facilities for taking timely corrective measures.
2.	**SACS**	▪ Forecast the district-wise need and submit the indent to NACO for necessary procurement. ▪ Receive, store, distribute and monitor the utilization of commodities as per the prescribed norms, and ensure similar actions across all the districts. ▪ Ensure all-time availability of stocks at all facilities. ▪ Ensure timely submission of duly completed, signed and stamped consignee receipt certificate (CRC) and consignee acceptance certificate (CAC) to the supplier, procurement agency and NACO. ▪ SACS and the State/UT NHM both should work in close coordination for ensuring an efficient SCM in the State/UT.
3.	**District**	▪ Forecast the facility-wise need and submit the indent to SACS for necessary procurement. ▪ Receive, store, distribute and monitor the utilization of commodities, as per the prescribed norms, and ensure similar actions across all facilities in the district. ▪ Ensure all-time availability of stocks at all facilities. ▪ Whenever supplies are received directly from the supplier,ensure timely submission of duly completed, signed and stamped CRC and CAC by the district to the supplier, procurement agency and NACO. ▪ District HIV and RCH nodal officers should work in close coordination for ensuring an efficient SCM in the district.
4.	**HCTS Confirmatory facility (SA- ICTC)**	▪ Facilitate identification of the need for WBFP HIV test kits and related records/reports at the HCTS screening facilities for HIV and submit the indent to the district for necessary supplies. ▪ Receive, store, distribute and monitor the utilization of commodities, as per the prescribed norms, at the SA-ICTC and ensure similar actions across all linked HCTS screening facilitiesfor HIV. ▪ Ensure all-time availability of stocks at the SA-ICTC and at all linked HCTS screening facilitiesfor HIV. ▪ The SA-ICTC should work in close coordination with the linked HCTS screening facilitiesfor HIV to ensure an efficient SCM.
5.	**HCTS screening facility(FICTC/TI/ PPP-ICTC etc.)**	▪ Identify the need for WBFP HIV test kit and related records/reports at the facility and submit the indent to the linked SA-ICTC for necessary supplies. ▪ Receive, store and monitor the utilization of commodities, as per the prescribed norms, at the facility. ▪ Ensure all-time availability of stocks at the facility in close coordination with the linked SA-ICTC for an efficient SCM.

Note: Always remember and practice -

HIV test kits should be stored at temperature between 2 to 8 °C at all levels

a) Ensure maintenance of cold chain while transporting HIV test kits from the Storage unit to HIV testing facility

b) Use the FEFO (First-Expiry, First-Out) rule: First supplies that are likely to expire are to be taken out/ supplied first

c) Meticulously maintain stock and temperature log records

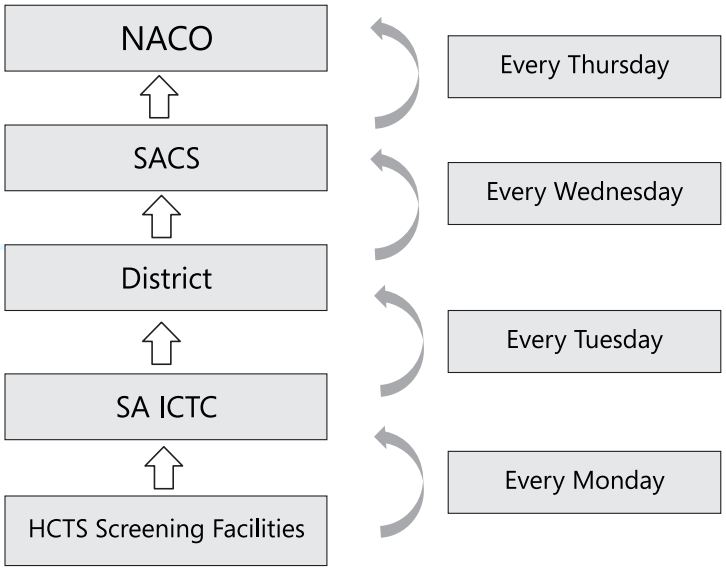
d) Protect from heat, light, moisture/rain, dust, pests and fire

8.2 Reporting, review and prompt follow up action on status of commodities

The reporting structure for all HCTS facilities is reflected in the figure 8.3below:

Every facility (storing and testing) has to submit a weekly status report of commodities in the prescribed format ***(Annexure C11)*** and as per the time lines indicated in the table below:

Figure 8.3 Reporting structure for HCTS facilities for stock status



For example: By Monday (say 7th November 2016), HCTS Screening Facilities will submit stock status for the previous week to SA-ICTC. By Tuesday (8th November 2016), SA-ICTC will submit a consolidated stock status of previous week to District HIV centre. District HIV centre will consolidate details of all SA-ICTC and share details of district level stock to SACS by Wednesday (9th November 2016). SACS will in turn share the consolidated state level details with NACO by Thursday (10th November 2016) of every week.

All HCTS facilities should also update stock status details as present in the SIMS format (***Annexure C1***, ***Annexure C2*** & ***Annexure C8***) by the 5th of every month and ensure timely submission of quarterly reports as given in ***Annexure C9***.

It is necessary to ensure that an appropriate feedback mechanism is established for efficient functioning of all HCTS facilities.

1. NACO must share its feedback with SACS on all the important parameters
2. SACS can further provide feedback to Districts as well as HCTS screening and confirmatory facilities
3. District can also disseminate their feedback to all HCTS screening and confirmatory facilities
4. HCTS confirmatory facilities (SA-ICTC) can provide feedback to HCTS screening facilities

8.3 Common supplies to be maintained at HCTS facilities

Supplies to be maintained at HCTS Screening Facilities

- HIV test kits
- Condoms
- Manuals, reporting forms and registers (as mentioned in Annexure)

Supplies to be maintained at HCTS Confirmatory Facilities (SA-ICTC)

- HIV test kits
- HIV test kits for emergency testing
- EID DBS kits
- Safe Delivery Kits
- Condoms
- Lab consumables (reagents, pipettes, test-tubes)
- Sharp boxes - Cleaning supplies such as bleach - Latex gloves - Auto-disabled syringes
- Medical equipment consumables such as test-tube racks, pipettes, pipette tips, and specimen tubes, gloves, swabs etc
- Disinfectants and cleaning supplies, sharps disposal bins
- Manuals, reporting forms and registers (as mentioned in Annexure)

Please note that 'RNTCP forms' as per (Annexure B3)** will be provided by the RNTCP*

At every HCTS level viz. F-ICTC, SA-ICTC, District/DAPCU and SACS, Person-In-charge should regularly and meticulously monitor and ensure all time availability of adequate stocks of various commodities at each HCTS facility under their supervision. Wherever required the timely re-location of the HCTS commodities, with due approval of the next higher authority, should be undertaken in order to ensure that there is no shortage and critical stock situation at any HCTS facility.

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

9

Advocacy, Communication and Social Mobilization

Information, Education and Communication (IEC) is strategically positioned and integrated with all components of the NACP so as to achieve the goal of 'accelerating reversal and integrating the response'.

9.1 Advocacy

Advocacy is a central pillar of strategic communication. The NACP regularly conducts advocacy with a range of stakeholders including

- Members of Parliament and policy-makers
- Administrative machinery at different levels
- Corporate sector
- Civil society
- Media and with other ministries/departments
- Others

This is done in order to mainstream the prevention of HIV, which helps to reduce stigma and discrimination. An enabling environment presupposes a proactive advocacy strategy.

Advocacy efforts should reach out to the district and panchayat-level leadership.

The advocacy with the National Advisory Council headed by Hon'ble Prime Minister resulted in continuous political will and formation of a parliamentary forum as well as state legislative forum on HIV/AIDS. This facilitated the continuous support and achievements of the NACP in India.

Advocacy should be continuously ensured with the media, opinion leaders, civil societies, industrial organizations, employee welfare associations and unorganized sectors up to the peripheral level. The partnering agencies may pool their advocacy resources and efforts, and liaise with the NACP advocacy efforts.

9.2 IEC activities

IEC activities are important for:

1. Enhancing awareness and knowledge among the general population to promote safer behaviour focusing especially on youth and women;
2. Motivating and sustaining behaviour change across different at-risk vulnerable population sub-groups, bridge and core groups;
3. Generating a demand for quality services;
4. Strengthening the enabling environment by facilitating appropriate changes in societal norms that reinforce positive attitudes, beliefs and practices.

The strategic communication approach in the NACP is reflected in innovation, evidence-based programming and in ensuring synergy between communication and programme priorities.

In view of the concentrated HIV epidemic in India, prevention is the thrust of the programme. The focus is on demand generation for uptake of services by the general population, especially the youth and women; identified populations at risk, including the core populations and bridge populations; and strengthening the enabling environment.

9.2.1 Communication objectives

1. To provide adequate information about the services available and how to access them
2. To strengthen access to services by addressing psychosocial barriers and building a friendly and non-stigmatizing environment
3. To strengthen communication competencies of functionaries under HTS
4. To educate communities on their rights and entitlements to avail quality services
5. To promote health-seeking behaviour and make informed choices

9.2.2 Communication strategies and actions

While NACO is responsible for creating the prototypes of IEC material, it is the responsibility of SACS to refine, replicate and distribute the IEC materials in their respective states, and ensure that it is properly displayed and disseminated at all HCTS facilities.

Information display under NACP

1. Thematic mass-media campaigns to promote services for counselling and testing, PPTCT, STI, HIV–TB and voluntary blood donation will be conducted and supported by outdoor, mid-media and interpersonal communication (IPC) activities. All communication channels to reach the general population should be used.
2. The available display and IPC materials used at service centres, such as information panels, posters, flip charts, booklets, pamphlets, etc. should be reviewed and updated in the local and cultural context and replicated. IPC materials on rights and entitlements of communities to quality services should be developed.
3. Signs and signages should be ensured within the facility premises for easy access to services.
4. Provision of people-friendly services should be prominently displayed in the hospital / service centre.
5. Local branding of services may be considered to build confidence in the facility (appropriate ambience, good posters, etc.).

Linkages to other healthcare facilities

1. Linkages with other services for cross-referral should also be ensured through the communication material.

2. Linkages with hospital redressal systems should be strengthened in case of unsatisfactory services.
3. HIV communication strategies and packages should be integrated with health services of the NHM (RNTCP, Reproductive and Child Health [RCH]) and other departments/ministries.

Training of healthcare workers

1. Capacity building should be done of service providers / counsellors on communication job aids for effective, sensitive and participatory IPC, based on the principles of social inclusion, rights, gender, reducing stigma and discrimination, and addressing psychosocial barriers in accessing services.
2. Special attention should be given to women, children and most-at-risk populations. Male responsibility in sharing the care and support burden at home, and vulnerability factors such as gender violence should be addressed.

Establishing credibility of HCTS services

1. Credibility of services should be enhanced through sharing of testimonials from those who have availed and benefitted from the services, and documenting and disseminating the human interest outcomes in reducing stress, despair and hopelessness.
2. Misleading advertisements by quacks should be countered both through publicizing correct information on quality services and possible police/legal action.

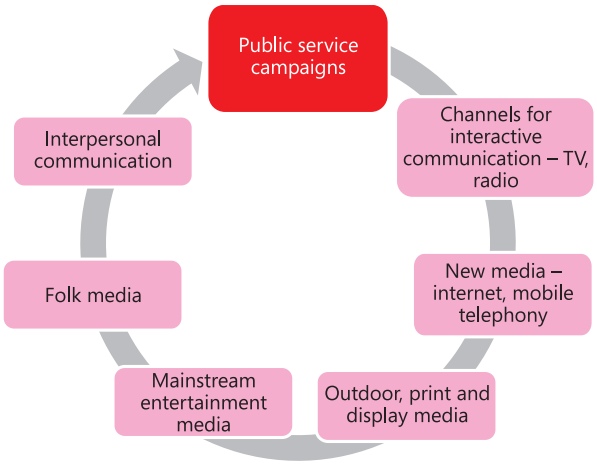
Enhancing performance of HCTS services

1. To set standards, an incentive-based system of awards may be considered.
2. A few model service centres from the communication perspective may be developed in every state/UT for replication.

9.2.3 Communication channels to reach the general population

Addressing the "general population" would require an integrated set of channels, harnessed according to strategic media planning, which would help arrive at the most suitable media mix to reach identified audiences with select campaign themes.

Figure 9.1: Communication channels



9.2.4 Generating demand for services

Uptake of quality services for prevention, testing, treatment, care and support is a key thrust area of the NACP. Appropriate communication actions will be taken to enhance and sustain the demand for services.

9.3 Social welfare and protection schemes for people infected with and affected by HIV

PLHIV face various socio-economic vulnerabilities such as job insecurity, poor access to health-care facilities, low access to nutritional support, education for children, etc. Self and social stigma and discrimination further affect their social support system. Due to the burden of increased illness, they may suffer loss of jobs and income, rising medical expenses, depletion of savings and other resources, food insecurity, psychological stress and social exclusion. Children affected by AIDS tend to be more socially vulnerable since their positive status could lead them to be socially excluded and marginalized, and drive them to poverty and ill-health. Those infected with and affected by HIV and AIDS have needs beyond HIV prevention and treatment services.

Although the primary task of providing care and support to PLHIV is with the health sector, the non-health sector can play an important and meaningful role in reducing the vulnerability to HIV and mitigate the impact of HIV on those infected and affected.

Various stakeholders such as departments and institutions under different ministries, civil society, elected representatives from the local self-government, religious and opinion leaders can play a crucial role in helping PLHIV. PLHIV can be linked to available services, schemes or entitlements that may specifically be developed for them, or to generally available social, legal and economic welfare schemes that might help them to mitigate the impact of HIV and tide over socioeconomic hardships and make them feel more accepted within civil society.

9.3.1 Social protection and welfare measures

All PLHIV accessing services in SA-ICTC, F-ICTCs, PPP-ICTCs, TI-ICTCs, and other HCTS facilities should be made aware of and provided information about the social benefit schemes that are available in their state of residence. The priority population should be prioritized for the provision of these services.

The following are some social protection and welfare schemes currently available for PLHIV:

9.3.1.1 Social protection helpdesk

SACS to follow up the DAPCU-led single window model on social protection for PLHIV, MARPs and children affected by AIDS (CABA) to facilitate one-point access to information on the benefits of various existing government and welfare schemes.

The HIV/AIDS-related facilities in the district (e.g.TI, CBS, State and District network of positive people, ICTC, Suraksha [STI] clinic, ART centre, link ART centre, link workers scheme [LWS], care and support centre [CSC] etc.) are encouraged to establish social protection helpdesks within the existing structure of facilities.

The objective of these helpdesks is to sensitize key populations on HIV-sensitive social protection schemes, generate demand and facilitate access to social entitlements (e.g. voter identity card, Aadhaarcard, ration card, below poverty line [BPL] card, etc.) and HIV social protection schemes (e.g. nutrition, insurance, free transport, livelihood, housing, pension and other financial assistance, etc.).

9.3.1.2 Social entitlement and social protection schemes

Social entitlements basically cover issuance of voter ID cards, permanent account number (PAN) card, identity proof, residence proof, bank account, and BPL / Aadhaar card. These documents are important for enrolment in social welfare schemes and for accessing benefits. Social protection may be ensured broadly in the areas of social, economic and legal protection. It may cover travel support, nutrition support, psychosocial support, financial assistance, insurance, legal aid, housing/shelter, skill building, livelihood, etc. If there is evidence of abuse, PLHIV should be given information and referred to legal services.

9.3.1.3 Sensitive social protection portal

The HIV-sensitive social protection portal is a searchable database on social welfare schemes relevant to MARPs and PLHIV. It serves as a resource for facilitating organizations that work with MARPs and PLHIV communities, as well as for AIDS-affected communities interested in accessing schemes. The portal is a resource for service providers, who can access it on their information technology (IT) system, to provide immediate information related to social welfare and protection in the requisite states. The link for this website is http://socialprotection.in/.

Some common **social protection schemes** offered by the Central and state governments are listed below and counsellors should appropriately guide needy PLHIV during counselling:

1. Integrated Child Development Services (ICDS)
2. Swarnajayanti Gram Swarozgar Yojna (SGSY)
3. Indira Aawas Yojana (IAY)
4. Indira Gandhi National Pension Scheme
5. Mahatama Gandhi National Rural Employment Guarantee Scheme (MGNREGS)
6. Rashtriya Swasthya Bima Yojana (RSBY)
7. Pradhan Mantri Suraksha Bima Yojana
8. Pradhan Mantri Jeevan Jyoti Bima Yojana
9. Pradhan Mantri Jan Dhan Yojana
10. Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG/Sabla)
11. Indira Gandhi National Widow Pension Scheme (IGNWPS)
12. Janani Suraksha Yojana (JSY)

13. Antyodaya Anna Yojana (AAY)
14. National Family Benefit Scheme (NFBS)
15. Travel concession (railways, state transport)
16. Pension schemes
17. Small loans for microcredit programmes

Notes:

- If a social protection helpdesk exists within the facility, PLHIV should be made aware of this.
- PLHIV, MARP, caregivers of CABA should be made aware of social entitlements and social protection schemes.
- Messages on social welfare schemes should be communicated and a regular course of action for demand generation created. PLHIV should be encouraged to enroll in social entitlements and social welfare schemes.
- PLHIV should be linked with the DAPCU of their district and other available facilities in the district (such as TI NGO, ICTC, ART centre, district network of positive people) for further assistance on availing social protection benefits.
- Counsellors should coordinate with the social protection helpdesk and DAPCU for facilitation of awareness and demand-generation activities such as camp and other activities.

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

10

Information Management System

The information management system revolves around the following major guiding principles:

1. To know the socio-demographic details of individuals accessing services;
2. To monitor the services that are being provided to individuals;
3. To evaluate whether the programmatic response is adequate and highlight areas for improvement.

10.1 Information management systems

This section encompasses data recording in registers and reporting from every reporting unit to the district, State/UT and national levels through SIMS, as summarized in Table 10.1.

Table 10.1: HCTS facilities and their corresponding registers, records and reporting formats

S.No.	HCTS facility	Existing registers, records and forms	Electronic reporting formats
1	**HCTS Confirmatory Facilities** (SA-ICTC -public, mobile and PPP models)	**Registers:** 1. Counselling register for general individuals (***Annexure A2***) 2. Counselling register for pregnant women (***Annexure A3***) 3. Laboratory register(***Annexure A4***) 4. Stock register at SA-ICTC (***Annexure A6***) 5. Temperature Log Book (***Annexure A7***) 6. HIV–TB line list (***Annexure A8***) 7. HIV–TB register (***Annexure A9***) 8. ICTC HIV exposed Infant/Child Register (***Annexure A10***) 9. HIV Positive Pregnant Women Delivery Register (***Annexure A11)*** 10. Outreach Activity Registers (***Annexure A13***) 11. Visitor's Register (***Annexure A14***) **Forms:** 1. Linkage form in Triplicate(***Annexure B1***) 2. Indent form (***Annexure B2***) 3. RNTCP form for referral for Diagnosis (***Annexure B3***) **Reports:** 1. SIMS monthly report (***Annexure C1***) 2. Laboratory reports (***Annexure C4***) 3. Daily worksheet for laboratory technician (***Annexure C5***) 4. Dashboard Indicators (***Annexure C7***) 5. SIMS quarterly report (***Annexure C9***) 6. Weekly Stock reporting format ***(Annexure C11)*** **Cards:** 1. PLHIV card for General Individuals (***Annexure D1***) 2. PPTCT Beneficiary card (***Annexure D2***) 3. EIC card (***Annexure D3***) 4. Discordant couple card (***Annexure D4***) 5. Follow up HIV Testing Card (***Annexure D5***)	▪ SA-ICTC monthly and quarterly SIMS format ▪ PLHIV ART linkage system (PALS) HIV positive reporting for general individual & pregnant women ▪ Excel-based reporting- ○ Weekly Stock report

S.No.	HCTS facility	Existing registers, records and forms	Electronic reporting formats
2	**HCTS Screening Facilities** (public, mobile, TI, PPP-ICTC and ancillary health-care provider models)	1. Counselling register (***Annexure A1***) / (***Annexure A12***) 2. Linkage form in triplicate (***Annexure B1***) 3. Laboratory report for screened non-reactive (***Annexure C3***) 4. Stock register (***Annexure A5***) 5. Follow up HIV Testing Card ***(Annexure D5)*** 6. Temperature Log Book (***Annexure A7***) 7. Indent for HCTS Commodities (***Annexure B2***) 8. SIMS reporting formats (***Annexure C2***) / (***Annexure C8***) 9. Dashboard Indicators at HCTS Screening Facilities (***Annexure C6***)	▪ Monthly SIMS format ▪ Stock report

Note:- HCTS facility may store record/registers as per the norms of medical record storage of the institute.

The formats of all the registers, records, forms and reports, including SIMS format, are provided in the Annexure as mentioned above.

10.2 Strategic Information Management System (SIMS)

SIMS is a web-based reporting and data management system that captures monthly aggregated data from reporting units under the NACP across the country. As soon as the data are entered in SIMS they become accessible in real time across all levels of programme implementation. Only the reporting unit can edit/ modify the data, and across the reporting hierarchy the data once entered cannot be modified by any other level, unless reset by a reviewer. This ensures accountability and transparency in reporting.

10.3 HIV case reporting through PALS (PLHIV-ART Linkages System)

PALS (***https://plhiv.naco.gov.in***) is a user friendly web based application with following two modules:

1. PPTCT module - to capture PPTCT programme cascade of services provided to HIV positive pregnant/breastfeeding women and their exposed babies
2. General Individual module - for capturing data related to all the PLHIVs (other than HIV positive pregnant/breastfeeding women) whom we refer as general individuals.

HIV case reporting is done for each individual with a confirmed diagnosis of HIV through PALS System (PLHIV-ART Linkage System). Case reporting of HIV positive individual through PALS is the responsibility of the Counsellor at SA-ICTC in a prescribed format that captures socio-demographic, behavioural variables and linkage to care, support and treatment services details. The SA-ICTC counsellor has to fill the form for each HIV-positive individual detected in their respective SA-ICTC. The format, data definition and guidelines for filling the form are available online at the following link: https://plhiv.naco.gov.in/pdfs/UserManualICTC.pdf/.

10.3.1 PALS- Prevention of Parent to Child Transmission of HIV (PPTCT) Module

PALS- PPTCT module is a web-based system used to register and track HIV-positive pregnant and breast-feeding women and their exposed babies till 18 months. PALS helps us to:

- Track the HIV-positive pregnant and breast feeding women, linkage to ART centre and adherence to ART, outcome of her pregnancy, and following the HIV-exposed baby to ensure that all EID tests are done, results are received and the child is linked to ART, if tested HIV positive.
- Monitor the PPTCT performance at the District, State/UT and National levels on various aspects such as early detection, ART linkage, EID testing, family planning, spouse testing, etc.

Currently, there are two data entry modules in PPTCT module, namely, (a) the SA-ICTC module and (b) the ART module. Data entry in the SA-ICTC module would be done by the SA-ICTC counsellor and for the ART module data entry would be done by the ART data manager. As soon as a pregnant or breast-feeding woman is confirmed to have HIV infection, her demographic and HIV testing details are entered into the SA-ICTC module. When she reaches the ART centre, her record is retrived in the system and a minimal set of details are entered into the ART module in the same system. However, for women who are already under ART care and become pregnant, their details would be entered in the ART module by the SA-ICTC counsellor where the pregnant women are accessing ANC services. This ensure a longitudinal record of the individual's testing and service uptake.

10.3.2 PALS- General Individual Module

PALS- General Individual module is a web-based system used to register and track all HIV-positive individuals (other than PPTCT beneficiaries including pregnant and breastfeeding women who are newly diagnosed as HIV positive and their exposed babies till 18 months). The module is developed to:

1. Track the HIV-positive adults and children, linkage to ART Centre and adherence to ART.
2. Monitor the ICTC performance at the District, State /UT and National levels on various aspects such as HIV detection, ART linkage, family planning, spouse testing etc.

There are two data entry modules in PALS- ICTC module, namely, (a) the SA-ICTC module and (b) the ART module. Data entry in the SA-ICTC module would be done by the SA-ICTC counsellor and for the ART module data entry would be done by the ART data manager. When a General individual is confirmed to have HIV infection, his/her demographic and HIV testing details are entered into the SA-ICTC module. When the beneficiary reaches the ART Centre, a minimal set of details are entered into the ART module in the same system. This ensure a longitudinal record of the individual's testing and service uptake.

For more details on SA-ICTCT and ART modules, please refer to:

"PLHIV ART Linkages System (PALS) https://plhiv.naco.gov.in**"**

Table 10.2: Responsibility and Frequency of Reporting at different HCTS facilities

S.No.	Reporting module	Responsible staff	Frequency/time line for reporting
1.	SIMS/HCTS confirmatory facility	SA-ICTC counselor and LT	By 5th of every month for monthly report Quarterly report end of each quarter
2.	SIMS/HCTS Screening facility	Identified health-care provider in F-ICTC	By 5th of every month
3.	PALS/HCTS confirmatory facility	SA-ICTC counselor	Daily (if not possible for any genuine reason, ensure weekly reporting on every Friday)
4.	PALS/ART	ART data manager	Daily (if not possible for any genuine reason, ensure weekly reporting on every Friday)

SACS has to review and verify the reports for data completeness, consistency and correctness, and should ensure that the report is submitted to NACO by the 15th of every month. Basic Services Division (BSD)/ NACO will provide necessary feedback whenever immediate corrective actions are warranted on the part of SACS.

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

11

Testing for Syphilis

Syphilis is one of the STIs/RTIs caused by *Treponema pallidum*, and is easily preventable, diagnosable and curable. Untreated syphilis may cause multisystem complications. Moreover, in pregnant women, it may lead to miscarriage, premature delivery, low-birth weight and congenital syphilis.

The Government of India (GoI) is a signatory to the global target for elimination of mother-to-child transmission of HIV and syphilis. To achieve this, the Ministry of Health and Family Welfare (MoHFW), GoI has included screening for HIV and syphilis as components in the essential antenatal care services in the public as well as private sectors.

To reach this national goal of elimination, the NACP and RCH programmes under the MoHFW, GoI, are together scaling up screening for HIV and syphilis at all health facilities under the National Health Mission (NHM).

It is not feasible to prevent and control syphilis among pregnant women without strengthening testing and treating of syphilis among the general and bridge populations. All symptomatic and asymptomatic individuals seeking STI/RTI services should be screened and treated for syphilis and HIV. The programme recommends periodic screening of high-risk populations for both HIV and syphilis.

The commonly used serological tests for the diagnosis of syphilis are rapid plasma reagin (RPR) test or venereal diseases research laboratory (VDRL) test, and point-of-care (PoC) test.

The programme recommends using WBFP PoC tests for syphilis and HIV at all health facilities below the district hospital level, and the RPR test for syphilis in facilities at the district level and above. The WBFP PoC test for syphilis and HIV should be used to screen un-booked direct-in-labour pregnant women, at all levels of the health system, to ensure that no pregnant woman remains untested.

RPR testing for syphilis is needed to confirm the diagnosis of congenital syphilis in the newborn and to assess the impact of treatment in the mother, her partner and newborn.

Screening for syphilis is the responsibility of all laboratories in the health-care system, and management of syphilis-positive individuals is the responsibility of medical officers at all health-care facilities/institutions in the country.

All relevant records and reports in this regard should be meticulously maintained at all health facilities. The health facility will also ensure the supply chain and logistics management of test kits and consumables under close supervision of the facility in-charge, and take timely corrective measures as needed.

All pregnant women found reactive for syphilis by any test should be promptly treated for syphilis at the same health facility, and her partner should also be screened and treated with atleast one dose of InjBenzathine Penicillin. Institutional delivery should be ensured for all pregnant women found positive for syphilis, where they have a paediatrician or skilled medical officer to draw blood from the newborn. The newborn of a syphilis-positive mother has to be tested and treated, as detailed in the "Elimination of congenital syphilis" guidelines. Refer ***(Annexure E2)*** for D.O. letter issued by AS& MD (NHM) and AS & DG (NACO) regarding Universal Screening of Pregnant Women for HIV & Syphilis.

For further details, please refer to -
"Strategy and implementation plan for elimination of congenital syphilis (ECS)", jointly issued by NACO and NHM/MoHFW, Government of India, 2015 available at *www.naco.gov.in*

All HCTS facilities should ensure adherence to 5Cs - Consent, Confidentiality, Counselling, Correct test results and Connection

Glossary

AIDS: Acquired Immune Deficiency Syndrome, a condition characterized by a combination of signs and symptoms, caused by Human Immunodeficiency Virus (HIV), which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions as may be specified from time to time

Ancillary health care provider: any person who performs functions related to health-care delivery and has been trained to deliver specific services but has not received a formal professional or paraprofessional certificate/diploma/degree

Concentrated epidemic: HIV has spread rapidly in a defined subpopulation (such as men who have sex with men, sex workers, transgender people, people who use drugs, or people in prison or closed settings) but is not well established in the general population. This type of epidemic suggests that there are active networks of people with high risk behaviours within the subpopulation. The future course of the epidemic is determined by the nature of the links between subpopulations with a high HIV prevalence and the general population. Numerical proxy: HIV prevalence is consistently over 5% in at least one defined subpopulation but is below 1% in pregnant women attending antenatal clinics

Early infant diagnosis (EID): refers totesting of children less than 18 months of age to determine their HIV status, given that HIV can be acquired in utero (during pregnancy), peripartum (during delivery), postpartum (through breastfeeding) or via parenteral exposure

External Quality Assessment (EQA): inter-laboratory comparison to determine if the HIV testing service can provide correct test results and diagnosis

Generalized epidemic: HIV is firmly established in the general population. Although subpopulations at high risk may contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain the epidemic. Numerical proxy: HIV prevalence is consistently over 1% in pregnant women attending antenatal clinics

Global UN 90-90-90 Targets: The global 90-90-90 targets call for 90% of all people with HIV to be diagnosed, 90% of people with HIV diagnosed to receive ART and 90% of those on ART to have suppressed viral load by 2020

Healthcare provider: Any individual whose vocation or profession is directly or indirectly related to the maintenance of the health of another individual and includes any physician, nurse, paramedic, psychologist, counsellor or other individual providing medical, nursing, psychological or other healthcare services including HIV prevention and treatment services

High Risk Group (HRG): Defined groups who, due to specific higher-risk behaviours, are at increased risk for HIV, irrespective of the epidemic type or local context. These guidelines refer to the following groups as key populations: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people

HIV-affected person: An individual who is HIV-positive or whose partner (with whom such individual normally resides) is HIV-positive or has lost a partner (with whom such individual resided) due to AIDS

HIV test: A diagnostic blood test to determine the presence HIV infection

Informed consent: Consent given by any individual or his representative specific to a proposed intervention without any coercion, undue influence, fraud, mistake or misrepresentation and such consent obtained after informing such individual or his representative, as the case may be, such information, as specified in the guidelines, relating to risks and benefits of, and alternatives to, the proposed intervention in such language and in such manner as understood by that individual or his representative, as the case may be

Non-reactive test result: a test result that does not show a reaction indicating the presence of analyte

Quality assurance (QA): a systematic and planned approach to assessing, monitoring and improving the quality of health services on a continuous basis within available resources

Quality control (QC): an assessment of product compliance with stated requirements

Quality Management System: A management system of coordinated activities to direct and control an organization with regard to quality (ISO 9000)

Rapid diagnostic test (RDT): in vitro diagnostic of immune chromatographic or immune filtration format for, in the case of HIV diagnosis, the detection of HIV-1/2 antibodies and / or HIV p24 antigen

Sensitivity: denotes the probability that an HIV assay or a testing algorithm will correctly identify all specimens that contain HIV-1/2 antibodies and/or HIV p24 antigen

Sero-conversion: when an individual produces a quantity of HIV antibodies sufficient to be detectable on a given HIV serological assay

Sero-discordant couple: a couple in which one partner is HIV-positive and one partner is HIV-negative

Specificity: denotes the probability that the assay or a testing algorithm will correctly detect specimens that do not contain HIV-1/2 antibodies and/or HIV-1 p24 antigen

Testing algorithm: Combination and sequence of specific assays used within HIV testing strategies

Testing strategy: generically describes a testing sequence for a specific objective, taking into consideration the presumed HIV prevalence in the population being tested

Universal Precautions: Control measures that prevent exposure to or reduce, the risk of transmission of pathogenic agents (including HIV) and includes education, training, personal protective equipment such as gloves, gowns and masks, hand washing, and employing safe work practices

Pre-Test Counselling: Refers to the basic information provided to the individuals on HIV/AIDS prior to testing which includes information on confidentiality, risk assessment of the individual and procedural details on testing

Post Test Counselling: Refers to the counselling provided to the individual after HIV testing to help him/her understand the meaning of the HIV test result

Follow-up Testing: Refers to HIV testing of individuals who are at risk of acquiring HIV infection at regular time intervals

Follow-up Counselling: Refers to repeat counselling provided to individuals accessing HCTS as per his/her requirements

Self- Initiated testing: Self-initiated/individual initiated testing refers to cases where individuals actively seek HIV testing and counselling at an HCTS facility

Provider-Initiated Testing and Counselling (PITC): PITC refers to HIV testing and counselling recommended by health care providers to people attending health care facilities whose clinical presentation might indicate an underlying HIV infection

Window Period: The window period is the time between potential exposure to HIV infection and the point when the test gives an accurate result. During the window period, a person can be infected with HIV and be infectious but have a negative HIV test. The window period is different for different types of tests

List of Annexures

Annexure A1: Counselling register at HCTS Screening Facilities (FICTC/PPP-ICTC)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sl No.	**Date of Visit**	**PID No.**	**Name**	**Address**	**Contact No.**	**Type of Individual**	**In-referral**	**Age (Completed years)**	**Sex**	**Consent taken for HIV testing (provide Signature/ Thumb Impression)**	**Date of HIV screening**	**Screening Test report**	**Date of Post-test counselling**	**Out-referral**

16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Name of HIV test kit	**Batch no.**	**Expiry date**	**Tested for Syphilis**	**Result of Syphilis test**	**Suspected for TB**	**If yes, referred to RNTCP**	**If Screened reactive** *(Please fill this part after getting Report from SA-ICTC)*			**If positive Pregnant Women / Direct in Labour delivered**				**Remarks**
							Date of HIV Confirmation report	**HIV Status of individual**	**Whether the HIV confirmation report given to Individual**	**Date of Delivery**	**Outcome of pregnancy**	**If Live Birth, whether ARV prophylaxis initiated to the baby**	**If Live Birth, whether the baby linked to SA-ICTC**	

Column No	Specification / Code
2,12,14,18,23,26	DD/MM/YYYY
11,19,21,22,25,28,29	(1) Yes, (2) No
7	(1) ANC, (2) DIL, (3) Breast feeding women, (4) General Individuals
8, 15	(1) OBG/GYN, (2) TI NGO, (3) Link Worker, (4) RNTCP/DMC, (5) STI clinic , (6) Other, (7) SA-ICTC, (8) Self referred (Walk-in)
10	(1) Male, (2) Female, (3) TG
13, 20	(1) Reactive, (2) Non-reactive
24	(1) Positive, (2) Negative, (3) Indeterminate
27	(1) Live Birth-single (2) Live birth-twins (3) MTP/Abortion , (4) Still birth,

Annexure A2: Counselling register for General Individual at HCTS Confirmatory Facilities (SA-ICTC)

1	2	3	4	5	6	7				8	9	10	11	12
Sl. No.	Date of Visit	Whether tested for HIV in SA-ICTC before this visit	If Yes in column (3) then Previous PID No.	If No in column (3) then New PID No.	Name	Address				Contact Number	Aadhaar Number	Type of Individual	If Self-initiated, then source of Information on HIV Testing	Referred by (In-referral)
						House No./ Street	Village/ Block	District	State with pin code					

13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Type of risk behav-iour	Age	Sex	Education	Occupation	Marital Status	Consent taken for HIV testing (provide Signature/ Thumb Impression)	Date of HIV testing	Test Report	Date of post-test Counsel-ling	Pre ART Regis-tration Number	Whether HIV Test result re-ceived within 7 days of testing	Out-referral	Whether Tested for TB	Result of TB test

28	29	30	31	32	33	34	35
Spouse / Sexual partner testing							
Whether HIV Status of Spouse / Sexual partner is known	Date of HIV testing	PID No. of Spouse / Sexual partner	HIV status of Spouse / Sexual Partner	Pre ART Registra-tion Number Of spouse	Couple Counselling provided	If discordant then date of next follow up of Spouse/Sexual Partner	Remarks

Column No.	Specification / Code
2,20,22,29,34	Date (DD/MM/YY)
3,19, 26,28, 33	1-Yes, 2- No
10	(1) Self- Initiated, (2) Provider Initiated
11	(1) TV, (2) News Paper, (3) Radio, (4) Internet, (5) Hoarding, (6) Pamphlet, (7) Bus Panel, (8) Folk Performance, (9) Others (specify)
12, 25	(1) TI NGO / CBO; (2) Non-TI NGOs; (3) OBG / Maternity Homes; (4) RNTCP; (5) Blood Bank; (6) Government Health facilities; (7) ART Centers; (8) STI Clinics; (9) Care Support Centres; (10) Private Health Facility; (11) F-ICTC (Fixed/Mobile); (12) PPP-ICTC (Fixed/Mobile); (13) TI-ICTC (Fixed/Mobile); (14) Others
13	(1) Hetero Sexual: 1 a. Commercial Partner ,1 b. Casual / non- commercial, non- regular partner , 1 c. Regular Partner / spouse, (2) Homosexual / Bi-sexual, (3) Through Blood and Blood products, (4) Through infected Syringe and Needles, (5) Parent to Child (for children), (6) Not specified/unknown.
15	(1)Male, (2)Female, (3) TG
16	(1) Non – literate, (2) Primary School, (3) Secondary School, (4) Higher Secondary, (5) College and above
17	(1) Agriculture Labourer, (2) Non - Agriculture Labourer, (3) Domestic Servant, (4) Housewife, (5)Skilled worker, (6) Semi skilled worker, (7) Petty business / Large business / small shop/self -employed, (8) Service (Govt. Pvt.),(9) Student,(10) Truck Driver / helper, (11) Local transport workers (Auto / Taxi Driver, Handcraft Pullers, Rickshaw Pullers etc., (12) Hotel staff, (13) Agricultural cultivator/ landholder,(14) Unemployed or retired, (15) Others
18	(1) Married, (2) Single, (3) Divorced/Separated, (4) Widowed, (5) Live in relationship
21, 27, 31	(1) Positive, (2) Negative , (3)Not Tested (4)Indeterminate

Note:

1. In case an individual has been tested for HIV in SA-ICTC before the current visit but the previously generated PID number is unavailable, please write 'Yes' in Column 3 and 'Missing PID' in Column 4 and provide a new PID to the individual mentioning it in column 5. All efforts must be made to retrieve the old PID of the individual to avoid this duplication.
2. Please provide Aadhaar card number in column 9, if available. Else keep the column blank.
3. Column no. 11: In-referral from FICTC (11) & PPP-ICTC (12) will be reported only if an individual who is screened reactive at FICTC or PPP-ICTC has been referred to SA_ICTC for confirmation of HIV diagnosis and the PID issued by the FICTC should be used at SAICTC

Annexure A3: Counselling register for Pregnant Women at HCTS Confirmatory Facilities (SA-ICTC)

1	2	3	4	5	6	7				8	9	10	11	12
Sl No.	Date of Visit	Whether tested for HIV before in SA-ICTC this visit?	If Yes to column (3) then Previous PID No.	If No to column (3) then New PID No.	Name	Address				Contact Number	Aadhaar Number	MCTS Number	Referred by (In-referral)	Age (Completed Years)
						House No/ Street	Village/ Block	District	State with pin code					

13	14	15	16	17	18	19	20	21	22	23	24	25
Education	Occupation	Marital Status	Month of pregnancy (Completed Month)	Gravida	Whether Opted for MTP/Abortion	Consent taken for HIV testing (provide Signature/ Thumb Impression)	Date of HIV testing	Test report	Date of Post-test counselling	Pre ART regn. number	Whether a New case or known positive case	Type of Individual ANC/DIL/ BF

26	27	28	29	30	31	32	33	34	35	36	37	38
Whether HIV Test result received within 7 days of testing	Out-referral	Whether tested for Syphilis	Result of Syphilis test	Whether Tested for TB	Result of TB Test	Spouse / Sexual Partner						Remarks
						Whether HIV Status of Spouse / Sexual partner is known	Date of HIV testing	PID No. of Spouse / Sexual partner	HIV status of Spouse / Sexual Partner	Couple Counselling provided	If discordant then date of next follow up of Spouse/Sexual Partner	

Column No.	Specification / Code
2,20, 22,33,37	Date (DD/MM/YY)
3,18,26,28,30, 32, 36	(1) Yes, (2) No
11, 27	(1) TI NGO / CBO; (2) Non-TI NGOs; (3) OBG / Maternity Homes; (4) RNTCP; (5) Blood Bank; (6) Government Health facilities; (7) ART Centers; (8) STI Clinics; (9) Care Support Centres; (10) Private Health Facility; (11) F-ICTC (Fixed/Mobile); (12) PPP-ICTC (Fixed/Mobile); (13) TI-ICTC (Fixed/ Mobile); (14) Others (14) Others
13	(1) Non – literate, (2) Primary School, (3) Secondary School, (4) Higher Secondary, (5) College and above
14	(1) Agriculture Labourer, (2) Non - Agriculture Labourer, (3) Domestic Servant, (4) Housewife, (5)Skilled worker, (6) Semi skilled worker, (7) Petty business / Large business / small shop/self -employed, (8) Service (Govt. Pvt.) ,(9) Student, (10) Truck Driver / helper, (11) Local transport workers (Auto/ Taxi Driver, Handcraft Pullers, Rickshaw Pullers etc., (12) Hotel staff, (13) Agricultural cultivator/ landholder,(14) Unemployed or retired, (15) Others
15	(1) Married, (2) Single, (3) Divorced/Separated, (4) Widowed, (5) Live in relationship
17	State the number of pregnancy. e.g: Primi-1, second pregnancy -2, third pregnancy-3 etc
24	(1) New Case; (2) Known Positive case
25	(1)ANC, (2) DIL,(3) Breast feeding
21, 31, 35	(1) Positive, (2) Negative, (3) Not tested, (4) Indeterminate
29	(1) Reactive ; 2) Non-reactive; 3) Not tested

Note:

1. In case an individual has been tested for HIV in SA-ICTC before the current visit but the previously generated PID number is unavailable, please write 'Yes' in Column 3 and 'Missing PID' in Column 4 and provide a new PID to the individual mentioning it in column 5.(All efforts must be made to retrieve the old PID of the individual to avoid this duplication)
2. Please provide Aadhaar card number in column 9, if available. Else keep the column blank.
3. Col. No. 10, Please note down the MCTS number reported on MCP card (Mother and Child Protection Card)
4. Column no. 11: In-referral from FICTC (11) & PPP-ICTC (12) will be reported only if an individual who is screened reactive at FICTC or PPP-ICTC has been referred to SA_ICTC for confirmation of HIV diagnosis and the PID issued by the FICTC should be used at SAICTC

Annexure A4: Laboratory Register at HCTS Confirmatory Facilities (SA-ICTC)

Sl. No.	Date	PID No.	Name of Referring HCTS facility	Lab. Sample No.	HIV Test Result* (R /NR)			Final Test Result 1-Positive 2-Negative 3-Indeterminant	Type of HIV infection HIV-1 / HIV-2 / HIV-1&2	Control	Quality Control No.	Confirmation result received from Lab. (EQAS result) 1-Concordant 2-Discordant	Signature
					Test 1 Kit Name.....	Test 2 Kit Name.....	Test3 Kit Name.....				Sent to SRL/ NRL		
A	B	C	D	E	F	G	H	I	J	K	L	M	N
					R NR	R NR	R NR						

*Please encircle 'R' if test is reactive, and 'NR' if test is non-reactive in the column.

Annexure A5: Stock register at HCTS Screening Facilities

DD/MM/YY (Daily)	Name of Kit	Batch No.	Expiry Date (DD/MM/YY)	Opening Stock	No. of test kits Received in this month	No. of test kits utilized	No. of Expired test kits (re-turn)	Wastage / Damage (if any)	Control	Closing Stock
A	B	C	D	E	F	G	H	I	J	K= (E+ F- G- H- I-J)

Note for Annexure A5:

1. All HCTS facilities which already have a stock register for stock of kits other than HIV should maintain HIV stock details in the same register.

2. This A5 format is only for facilities (such as PPP-ICTC) which may not have their own existing stock register.

3. SACS will not print this register.

Annexure A6: Stock register at HCTS Confirmatory Facilities (SA-ICTC)

Name of the item/particular: .....

DD/MM/YY (Daily)	Batch No.	Expiry Date (DD/MM/YY)	Opening Stock	No. of item Received in this month (from SACS/ DAPCU/NHM/ HCTS/any other	Relocated (Out)	Consumption (including Control used)	Wastage / Damage (if any)	No. of Expired test kits	Closing Stock	Signature
A	B	C	D	E	F	G	H	I	J = (D+E–F–G–H–I)	L

Annexure A7: Temperature log book at HCTS Facilities

National AIDS Control Organization
Daily Temperature Log Sheet
(HIV Counselling & Testing Services Facility)

Name of HCTS Facility (SA-ICTC/F-ICTC/PPP/TI etc): ----------

Address: ----------

Name of the Staff: ----------

Designation: ---------- **Contact No:** ----------

Name of In-charge of HCTS Facility: ----------

Designation: ----------**Contact No:**----------

Month: **Year:**

Day	AM		PM		Remarks
	Time	Temperature (in °C)	Time	Temperature (in °C)	
1					
2					
3					
4					
5					
6					
7					
8					
9					
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11					
12					
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30					
31					

Annexure A8: HIV-TB Line List at HCTS Confirmatory Facilities (SA-ICTC)

Reporting Month: _____							Reporting Year:_____					
Name of the SA-ICTC:_____							Name of the District:_____					
To be completed by HCTS site counsellor							To be completed by the STS					
1	2	3	4	5	6	7	8	9	10	11	12	13
S. No	PID No.	Complete Name & Address	Age	Sex	Date of referral to RNTCP	Name of facility referred to	Is patient diagnosed with TB/ DRTB (Yes/ No)	If diagnosed with TB, specify whether patient is (i) Sputum '+'ve TB, (ii) Sputum '-'ve TB (iii) Extra-pulmonary TB (iv) DR-TB	Whether put on treatment (Anti TB/ DRTB)	Date of Starting Treatment	TB No.	Remarks

Annexure A9: HIV-TB Register at HCTS Confirmatory Facilities (SA-ICTC)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sl. No	PID No.	HIV Status 1-Positive 2-Negetive 3- Indeter-minate	Sus-pected to have TB/ MDRTB	Date of referral to RNTCP for TB/DRTB diagnosis	Result of Investigations				Whether put on treatment (Anti TB/ DRTB)	Referral from RNTCP for HIV testing				
					Sputum positive TB	Sputum Negative TB	Extra pulmo-nary TB	DRTB/Rif Resistant		Registered TB Patient	Drug Resis-tant TB/Rif R patient	TB Sus-pects	Date of Testing for HIV	Tested Positive
			(Y / N)	(DD/MM/YY)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)

Note: In-referral up to col. No. 10

Annexure A10: ICTC HIV exposed Infant/Child register

1	2	3	4	5	6	7	8	9	10	11	12
S.no	Name of Infant*	ICTC PID# of Infant	Unique infant code [15 digit code] (If HIV-1 PCR Test recommended)	Sex 1- Male 2-Female 3-TG	Date of Birth (MM/DD/YYYY)	Mother's name	PID # of Mother	Type of Delivery 1-Normal 2-Caesarean	ARV prophylaxis of the baby administered	Date of Cotrimoxazole Prophylaxis Treatment Initiation (CPT) (MM/DD/YYYY)	Details of Counseling

Visit 1					Visit 2					Visit 3				
Date of visit (DD/MM/YY)	Age of Infant (in Completed Months)	Infant feeding Practices	Type of test 1-DBS 2- Antibody	Result of Test 1-Detected 2-Not Detected	Date of visit (DD/MM/YY)	Age of Infant (in Completed Months)	Infant feeding Practices	Type of test 1-DBS 2- Antibody	Result of Test 1-Detected 2-Not Detected	Date of visit (DD/MM/YY)	Age of Infant (in Completed Months)	Infant feeding Practices	Type of test 1-DBS 2- Antibody	Result of Test 1-Detected 2-Not Detected
13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

28	29	30	31	32	33	34	35
If found Positive with first DBS, Date of Collection of Confirmatory DBS	Result of confirmatory DBS test 1- Detected 2- Not Detected	If discordant, Result of Second Confirmatory DBS 1- Detected 2- Not Detected	Date of 18 month testing (DD/MM/YY)	Confirmatory Antibody Test result at 18 months 1- Positive 2 -Negative	Pre ART Number	ART Regimen Initiated to the baby	Death of the baby 1-Yes, 2- No

Column No.	Specification code
10	**ARV prophylaxis of the baby administered:** A) No prophylaxis; B) 6 weeks NVP syrup; C) 12 weeks NVP syrup; D) 6 weeks AZT syrup; E) 12 weeks AZT syrup ; F) 6 week LPV syrup; G) 12 week LPV syrup
12	**Details of counselling provided: Mark all of the counselling topics covered at today's visit.** A) Infant feeding; B) Cotrimoxazole prophylaxis; C) Immunization; D) Nutrition; E) Psychosocial support; F) HIV testing: G) Seeking medical care: H) Family planning: I) Condom use demonstration; J) Other (specify)
15, 20, 25	**Infant feeding practice in past 6 weeks: A**) Exclusive replacement feeding; B) Exclusive breastfeeding; C) Mixed feeding. (Important note: If either B or C is true AND infant has a NEGATIVE HIV test result (Rapid Tests, screening DBS or confirmatory DBS), then repeat same test six weeks after infant's last breast milk feeding, or if child develops symptoms of HIV infection. Continue cotrimoxazole until infant is definitively negative. Discourage early weaning; only stop breastfeeding if exclusive replacement feeding is AFASS.)
34	**ART Regimen Initiated to the baby:** 1) ZLL; 2) ZLN; 3)Others (specify)
	Rapid test result: Only performed for initially screening infants 6 – 18 months age and report should be delivered at the earliest (maximum on the same day)
	* Please note that the details of the infant and mother (Name, PID etc.) should be same on the white card, register, line list, PPTCT software and any other document ** EIC 3 report to be sent to pptct.reports.naco@gmail.com before the 10th of every month *** Kindly update the infant details on the PPTCT software daily **** Please note that for all the babies who are being tested at age greater than 6 months, if antibody test is positive (i.e. Antibody reactive on one/two/all three tests), then enter result of HIV-1 PCR test report only. If the antibody test is negative (i.e. Non-reactive on all 3 tests), then enter antibody test result.

Annexure A11: HIV Positive Pregnant Women Delivery Register at HCTS Confirmatory facility (SA-ICTC)

1	2	3	4	5	6	7	8	9	10	11	12	13
Sl No.	PID No.	Name	Address (With State & District name)	Contact Number	Place of delivery	Place of HCTS confirmatory facility	Name of ICTC where registered (With State & District name)	Date of HIV Confirmation	Whether Registered at ART center	If Yes in column 10, write Pre ART number	Date of ART initiation	ART regimen initiate to mother

14	15		16	17	18	19	20	21	22	23	24
Details of outcome of pregnancy				Preferred feeding Practice	Gravida	Exposed to Sd. NVP in previous pregnancy	Type of HIV Infection	Duration of mothers ART, during pregnancy (in weeks)	Details of Prophylaxis initiated to baby	Duration of Prophylaxis initiated to baby	Remarks
Date of Delivery	Outcome of Pregnancy	Type of Delivery									

Column No	Specification / Code
6	(1) Same Facility; (2) Other Govt. health facility (which is not an F-ICTC) (3) Pvt. Health Facility (which is not an F-ICTC) (4) Home delivery
7	(1) Tested at the Same Facility, (2) Tested at other Facility
8	If tested in other facility mention the name of facility
9,12, 14	DD/MM/YYYY
10, 19	(1) Yes, (2) No
13	(1) TLE, (2) TLL, (3) ZLN , (4) TLN, (5)ZLE (6) any other (Specify)
15	(1) Live birth (2) Still birth, (3)MTP/Aborted
16	(1) Normal, (2) Caesarean
17	(1) Exclusive Breast Feeding (EBF), (2) Exclusive Replacement Feeding (ERF)
20	(1) HIV-1, (2) HIV-2, (3) HIV 1 & 2
22	(1) NevirapineSyp (2) Zidovudinesyp (3) Lopinavir/r syp,
23	(1) 6-weeks; (2) 12-weeks

Annexure A12: Counselling Register at HCTS Screening Facilities (TI-ICTC)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sl No.	Date of Visit	PID No.	Name	Address	Contact No.	Type of Individual	Referred by (In-referral)	Age (Completed years)	Sex	Consent taken for HIV testing (provide Signature/ Thumb Impression)	Date of HIV screening	Screening Test report	Date of Post-test counselling	Out-referral to

16	17	18	19	20	21	22	23	24	25	26	27
Name of HIV test kit	Batch no.	Expiry date	Tested by whom	Place of testing	Whether Tested for Syphilis	Result of Syphilis test	If Suspected for TB , referred to RNTCP	If Screened reactive *(Please fill this part after getting Report from SA-ICTC)*			Remarks
								Date of HIV Confirmation report	HIV Status of individual	Whether the report given to Individual	

Column No	Specification / Code
2,12,14, 18, 24	DD/MM/YYYY
11,21,23, 26	(1) Yes, (2) No
7	(1) FSW (2) MSM (3) IDU; (4) TS/TG ; (5) Truckers (6) Migrants (7) Sexual Partner/Spouse of HRG individual (8) Other
8, 15	(1) OBG/GYN, (2) TI NGO, (3) Link Worker, (4) RNTCP/DMC, (5) STI clinic , (6) Other (7) SA-ICTC
10	(1) Male, (2) Female, (3) TG/TS
13, 22	(1) Reactive, (2) Non-reactive
19	(1) ORW; (2) Peer Educator; (3) Counsellor; (4) ANM; (5) Doctor/any other health care provider (Testing to be conducted through trained health care provider mentioned above)
20	(1) TI- Facility; (2) Community;

Annexure A13: Out Reach Activity Register for HCTS Confirmatory Facilities (SA-ICTC)

Date of Visit	Place visited	Purpose of Visit	Outcome of visit	Signature of In-charge

Financial Year		Number of Screening facilities linked to this Stand Alone ICTC											
		Government FICTC				Public Private Partnership				PSU		TI ICTC	Others
Month	Number of HIV Screening facilities Linked	PHC	Mobile FICTC	DMC	DSRC	Corporate Hospital	Private Hospital	Private Medical College	Nursing Homes	Public Sector Units	Public Sector Industries	TI ICTC	Others
April													
May													
June													
July													
August													
September													
October													
November													
December													
January													
February													
March													

(Above table to be printed on the first page of the register)

Annexure A14: Visitor's Register

Date of Visit	Name of Visiting official (With Designation & Contact no.)	Organization	Issues /Observation	Action points/ Recommendation	Signature of Visiting official	Signature of In-charge

Annexure B1: Linkage form (in triplicate)

National AIDS Control Organization *Linkage Form (in triplicate) for HCTS facilities*	National AIDS Control Organization *Linkage Form (in triplicate) for HCTS facilities*	National AIDS Control Organization *Linkage Form (in triplicate) for HCTS facilities*
Copy-1 **(to be retained at the facility referring the individual)**	**Copy-2** **(to be carried by the Individual to the referred facility & to be retained at referred facility)**	**Copy-3** **(to be retained by the individual)**
Referred by: SA-ICTC/FICTC/PPP-ICTC/TI/STI/Others____ **Referred to: ART/SA-ICTC/RNTCP/TI/STI/Others____**	**Referred by: SA-ICTC/FICTC/PPP-ICTC/TI/STI/Others__** **Referred to: ART/ SA-ICTC / RNTCP / TI /STI/ Others__**	**Referred by: SA-ICTC/F-ICTC/PPP-ICTC/TI/STI/Others_** **Referred to: ART/ SA-ICTC / RNTCP / TI /STI/ Others___**
Referred by: Name & Address of facility _____ _____	Referred by: Name & Address of facility _____ _____ _____	Referred by: Name & Address of facility _____ _____ _____
To be filled by the facility referring the individual	***To be filled by the facility referring the individual***	***To be filled by the facility referring the individual***
Details of the individual being referred: **PID Number: _____** **Name: _____** **Age: ___ Sex: ___Contact No.: _____** **Category (Tick mark):** **ANC/DIL/PNC/General/Exposed infant/HRG** **Purpose of referral: _____** **Date of referral: _____**	***Details of the individual being referred:*** **PID Number: _____** **Name: _____** **Age: ___ Sex: ___ Contact No.: _____** **Category (Tick mark):** **ANC/DIL/PNC/General/Exposed infant/HRG** **Purpose of referral: _____ ___** **Date of referral: _____**	***Details of the individual being referred:*** **PID Number: _____** **Name: _____** **Age: ___ Sex: ___Contact No: _____** **Category (Tick mark):** **ANC/DIL/PNC/General/Exposed infant/HRG** **Purpose of referral: _____ _____** **Date of referral: _____ _____**
Name and address of the facility referred to: _____ _____ __	***Name and address of the facility referred to:*** _____ _____ _____	***Name and address of the facility referred to:*** _____ _____ _____
Details of the staff referring the individual: **Name :_____** **Designation:_____** **Contact No.:_____** **Signature: _____**	***Details of the staff referring the individual:*** **Name :_____** **Designation:_____** **Contact No.:_____** **Signature: _____**	***Details of the staff referring the individual:*** **Name :_____** **Designation:_____** **Contact No.:_____** **Signature: _____**
To be filled by the facility referring the individual after feedback from referred center	***To be filled by the referred center staff***	
Has the individual reached : ☐ *Yes* ☐ *No* ▪ ***If individual was referred to SA-ICTC, has the individual been tested for HIV? Yes/No*** ▪ ***If individual was referred to ART center, has the individual been registered there? Yes/No*** Remarks: _____ Name of staff documenting this information: _____ _____	Has the individual reached : ☐ *Yes* ☐ *No* ▪ ***If individual was referred to SA-ICTC, has the individual been tested for HIV? Yes/No*** ▪ ***If individual referred to ART center, has the individual been registered there? Yes/No*** Remarks: _____ Name of staff documenting this information: _____	

Annexure B2: Indent form for HCTS commodities

National AIDS Control Organization
HIV Counselling & Testing Service (HCTS) Facility

INDENT FORM FOR SA-ICTC/F-ICTC/PPP-ICTC/TI-ICTC
(to be filled by the staff of HCTS facility)

Address: ----------`

Name of the Staff: ----------

Designation:----------Contact No:----------

Email id: ----------

Name of In-charge HCTS facility: ----------

Designation:---------- Contact No:----------

The following items are required :

S. No.	Details of the item	Status of last supply		Monthly Average consumption	Balance available	Quantity requested	Quantity supplied
		Date	Quantity issued				
1							
2							
3							

Signature of the Staff
(Receiving the consignment)

Name:

Designation:

Date: / /

Signature of the Staff
(Supplying the consignment)

Name:

Designation:

Date: / /

Signature of the BSD In-charge

Name:

Designation:

Contact No.:

Date: / /

Annexure B3: RNTCP Form for Referral for Diagnosis

RNTCP Request Form For Examination Of Biological Specimen For TB
(Required for Diagnosis of TB, Drug Sensitivity Testing and Follow up)

Patient Information			
Patient Name		Age (in yrs)	Gender: ☐ M ☐ F ☐ TG
Patient Mobile No. or other contact no.		Specimen Date of Collection (DD/MM/YY).....	Sputum ☐ Other(specify) ☐
Patient address with landmark		**HIV Status:** ☐ Reactive ☐ Non Reactive ☐ Unknown	
		High Risk Group: ☐ Contact of TB/DRTB Case ☐ Diabetes ☐ Tobacco ☐ Smoker ☐ Prison ☐ Miner ☐ Health –care worker ☐ other (Specify).....	

Name referring facility (PHI/DMC/DR -TB Centre/Laboratory/ Others): Health Establishment ID(NIKSHAY):.....	CDL NIKSHAY ID: ___.___._.C._____ RNTCP TB Reg No._____ Or ☐ Not Applicable
State:_____ District:_____ Tuberculosis Unit (TU):_____	

Reason for Testing:

Drug Sensitive TB	
Diagnosis (NIKSHAY ID_____)	Follow up (Smear and culture)
H/o anti TB Rx for > 1month: ☐ YES ☐ NO	RNTCP TB Reg No._____ NIKSHAY ID:_____
☐ Presumptive TB	Regimen : ☐ New ☐ Previously Treated
☐ Private Referral	Reason: ☐ End IP ☐ End CP
☐ Presumptive NTM	Post Treatment: ☐ 6M ☐ 12M ☐ 18M ☐ 24M

Drug Resistant TB		
Drug Susceptibility Testing(DST)		Follow -Up (Smear and Culture)
☐ Presumptive MDR TB (provide first line DST	☐ New ☐ Previously treated ☐ At diagnosis ☐ Contact of MDR/RR TB ☐ Follow-up SM +ve ☐ Private referral ☐ Discordance resolution	PMDT TB Reg No._____ DR TB NIKSHAY ID:_____ Regimen: ☐ Regimen for H Mono/P oly resistant TB ☐ Regimen for MDR/RR -TB ☐ Regimen for MDR/RR -TB + FQ/SLI resistant ☐ Regimen for XDR -TB ☐ Regimen with Bedaquiline for MDR TB+ FQ/SLI resistan ce ☐ Regimen with Bedaquiline for XDR -TB ☐ Regimen with Bedaquiline for failure of regimen for MDR -TB ±FQ/SLI resistant ☐ Regimen with Bedaquiline for failure of regimen for XDR-TB ☐ Regimen for mixed pattern r esistance **Treatment** ☐ Month ☐ Week:_____
☐ Presumptive H mono/poly (provide first and second line DST)		
☐ Presumptive XDR TB (provide first and second line DST)	☐ MDR/RR TB at Diagnosis ☐ ⩾4 months culture positive ☐ 3month for persistent culture Positive (treatment month__ __ _____) ☐ Culture reversion ☐ Failure of MDR/RR -TB regimen ☐ Recurrent case of second line treatment ☐ Discordan ce resolution	

Test Requested:

☐ Microscopy ☐ CBNAAT ☐ Culture ☐ DST ☐ Line Probe Assay ☐ Gene Sequencing
☐ Other (Please Specify):_____

Requestor Name, Designation and Signature:_____

Contact Number:_____ Email ID:_____

Results: **CDL NIKSH AY ID Generated :**__ -__ __ _-_ - C-__ -_____

Microscopy (☐ ZN ☐ Florescent)							
	Lab Sr. No.	Visual appearance	Result				
			Negative	Scanty	1+	2+	3+
Sample A							
Sample B							

Date tested: _____ Date Reported: _____ Reported by: _____

(Name and Signature)

Note that RNTCP forms are to be provided by RNTCP centres

Annexure C1: SIMS reporting format for HCTS Confirmatory Facilities(SA-ICTC)

	Unique Code		ICTC name			
Monthly Input Formats for Integrated Counseling and Testing Centers (ICTC) [All individuals excluding pregnant women]						
Section B: Progress Made During the Month by the ICTC [All individuals excluding pregnant women]						
i. Details of Individuals visit to ICTC and HIV tests undertaken (excluding pregnant women)						
sl. no	**Indicators**		**Male**	**Female**	**TS/TG**	**Total**
1	Number of individuals received pre-test counseling/information					**0**
2	Number of individuals tested for HIV **(Row is Blocked - Auto Generated from iii.a Age-wise distribution)**		0	0	0	**0**
3	Number of individuals received result within 7 days of HIV Test					**0**
4	Number of individuals receiving post-test counseling and given results					**0**
5	Number of individuals diagnosed HIV positive (after three tests) **(Row is Blocked - Auto Generated from iii.a Age-wise distribution)**		0	0	0	**0**
5.1	(Out of sl no. 5) Number of HIV positive individuals having HIV-II infection					**0**
5.2	(Out of sl no. 5) Number of HIV positive individuals having both HIV-I & II infections					**0**
5.3	(Out of sl no. 5) Number of HIV positive individuals having HIV-I infection **(Row is Blocked - Auto Generated based cells (sl.no 5 -(sl.no.5.1 +5.2))**		0	0	0	**0**
6	Number of HIV +ve individuals registered to ART center, during this month					**0**
7	(Out of sl. No. 5) Number of HIV positive individuals registered in PALS (**only HIV +veGen.Individual)**					**0**
8	Number of individuals with High Risk Behavior received follow-up counseling					**0**
9	Number of Self- initiated Individuals tested for HIV					**0**
9.1	(out of sl. No. 9) Number of 'Self- initiated' individuals diagnosed HIV positive					**0**
10	Number of provider initiated Individuals tested for HIV **(Row is blocked: Auto-generated cells [sl.no 2 - sl.no.9])**		0	0	0	**0**
10.1	(out of sl. No. 10) Number of provider initiated individuals diagnosed HIV positive **Row is blocked: Auto-generated cells [sl.no.5 - sl.no.9.1])**		0	0	0	**0**
11	No. of HIV positive death occurred during this month (Gen. Individuals)					**0**
ii. F-ICTC referral & HIV Confirmation						
	Indicators		**Male**	**Female**	**TS/TG**	**Total**
12	Number of Screened HIV reactive general individuals referred by the F- ICTC tested for Confirmation of HIV diagnosis at SA-ICTC					**0**
12.1	Out of Screened HIV reactive general individuals referred by the F- ICTC above, number Confirmed HIV positive					**0**
12.1	Out of Screened HIV reactive general individuals referred by the F- ICTC above, number Confirmed HIV negative					**0**
iii. Spouse/Sexual partner HIV testing details						
	Indicators		**Male**	**Female**	**TS/TG**	**Total**
13	Number of Sexual partners /Spouse of HIV positive individuals tested					**0**
13.1	(Out of sl.no.13 above) Number of Sexual partners /spouse diagnosed HIV positive (after 3 specified Tests)					**0**
14	Number of Sexual partners /Spouse of HIV negative individuals tested					**0**
14.1	Out of sl. No.14 above) Number of Sexual partners /spouse diagnosed HIV positive (after 3 specified Tests)					0
15	Number of Sexual partners /Spouse of HIV positive individuals who already know their HIV status and did not require HIV testing					0
16	Number of Sexual partners /Spouse of HIV Negative individuals who already know their HIV status and did not require HIV testing					

vi. Composition of individuals undergoing HIV test/diagnosed positive and route of transmission									
iv.a. Age-wise distribution									
Sl.No.	Age categories (in completed months/years)	Total Number of individual tested for HIV				Total Number of individual diagnosed HIV positive			
		Male	Female	TS/TG	Total	Male	Female	TS/TG	Total
1	18 mts -5yrs				0				0
2	6 - 9				0				0
3	10 - 14				0				0
4	15 - 19				0				0
5	20 - 24				0				0
6	25 - 49				0				0
7	≥50				0				0
8	Not specified/unknown				0				0
	Total	0	0	0	0	0	0	0	0
iv.b. Route of transmission reported by HIV positive cases									
Sl.No.	Route of transmission reported by HIV positive cases	Male		Female		TS/TG		Total	
1	**Heterosexual**	0		0		0		0	
1.1	Commercial Partner							0	
1.2	Casual/non-commercial, non-regular partner							0	
1.3	Regular partner/spouse							0	
2	Homosexual							0	
3	Through blood and blood products							0	
4	Through infected syringe and needles							0	
5	Parent to child (for children)							0	
6	Not specified/unknown							0	
	Total	0		0		0		0	

	Unique Code			ICTC Name	

Monthly Input Formats for Integrated Counseling and Testing Centers (ICTC)

Section C: Laboratory Information, Kits & Consumables and Outreach (All individuals including Pregnant women)

i. Laboratory Information for ICTC

	Description	Units
1	Total number of blood specimens tested during this month	
2	Total number of blood specimens found reactive during this month	
2.1	Total number of blood specimens detected HIV- II during this month (Out of sl. No. 2 above)	
2.2	Total number of blood specimens detected both HIV-I & II during this month (Out of sl. No. 2 above)	
2.3	Total number of blood specimens detected HIV-I during this month (Out of sl. No. 2 above) ***Row is Blocked Auto Generated cells (Sl.no 2-(Sl.no2.1+sl.no.2.2)***	0
3	Number of blood specimens found indeterminate (after 3 HIV tests)	

ii. Stock of HIV Test Kits and other Consumables (Section is Blocked for data entry, please enter data ONLINE)

	Consumables	Name of Kit	* Expiry date	Opening Stock	Received	Relocated (In)	Relocated (Out)	Consump-tion	Controls	Wastage/ Damage/ Expired	Closing Stock (Auto Generated Cells)	Average Monthly Consump-tion	Stock suf-ficient for how many months (Auto Gener-ated Cells)
4	HIV test kit 1 (No. of tests)										0		
5	HIV test kit 2 (No. of tests)										0		
6	HIV test kit 3 (No. of tests)										0		
7	Whole Blood Finger Prick Test (No. of tests) POC										0		
8	Syphilis test kit(RPR/ VDRL)										0		
9	DBS Card										0		
10	Nevirapine Syrup										0		
11	Zidovudine syp										0		
12	LopinavirSyp										0		
13	TLE										0		
14	Safe Delivery kit										0		
15	Condom										0		

iii. Out Reach Activity conducted by Counselors during this month

	Type of Activity	Number
1	Number of FICTCs linked to this Stand Alone ICTC	
2	Number of F-ICTCs visited during this month	
3	Number of Capacity building workshop conducted for staff of FICTC and labour ward during this month	
4	Number of Outreach activity conducted (social awareness camps, IEC workshops) during this month	
5	Number of home visits to HIV Positive General individuals during this month	
6	Number of home visits to HIV Positive Pregnant Women/ Breastfeeding women during this month	

ICTC Code		Name of ICTC	

Monthly Input Formats for Integrated Counseling and Testing Centers (ICTC)

Section D: Progress during the month (only for Pregnant & Breast feeding Women)

i. Pregnancy Registration & HIV testing details

S. No	Indicators (Please read Data Definition carefully before entering data in the respective fields)		During ANC	Directly in labor	Breast feeding	Total
			During this month	During this month	During this month	
1	Number of New ANC Registrations as per ANC OPD register					0
2	Number of pregnant/breast feeding women provided pre-test counseling					0
3	Number of pregnant/ breast feeding women tested for HIV					0
4	Total number of pregnant/breast women diagnosed HIV +ve (including Sr. No 1.1)	4.(a) Among those diagnosed HIV +ve, during first trimester				0
		4.(b) Among those diagnosed HIV +ve, during second trimester				
		4.(c) Among those diagnosed HIV +ve, during third trimester				
		4.(d). Among those diagnosed HIV +ve, during Post natal period				
4.1	Already Known HIV +ve women (detected earlier from Same ICTC / Other ICTC) **who is currently pregnant/Breast feeding** & registered for ANC services in this Centre, during this month					0

	Indicators	Number		
4.2	Number of HIV positive Pregnant & breast feeding women registered in PALS Software			
5	Number of pregnant/breast feeding women received HIV test results within 7 days of test			
6	Number of pregnant/breast feeding women received post-test counseling and given test results			
7	Number of HIV +ve Pregnant/breast feeding women registered at ART center during this month			
8	Number of HIV +ve pregnant/breast feeding women initiated on lifelong ART during this month			
9	Number of HIV +ve pregnant/breast feeding women having HIV-II infection			
10	Number of HIV +ve pregnant/breast feeding women having both HIV-I & II infection			
	ii. F-ICTC referral & HIV Confirmation			
11	Number of Screened HIV reactive pregnant women referred by the F- ICTC tested for Confirmation of HIV diagnosis at SA-ICTC			
11.1	Out of Screened HIV reactive pregnant women referred by the F- ICTC above, number Confirmed HIV positive			
11.2	Out of Screened HIV reactive pregnant women referred by the F- ICTC above, number Confirmed HIV negative			
	iii. Pregnant/breast feeding women Tested for Syphilis by SA-ICTC Lab technician			
12	Number of HIV positive Pregnant/breast feeding women tested for syphilis			
12.1	(Out of above) Number Diagnosed with syphilis			
13	Number of HIV negative Pregnant/breast feeding women tested for syphilis			
13.1	(Out of above) Number Diagnosed with syphilis			

iv. Spouse/Sexual partner Testing details			
14	Number of spouses/ partners of HIV positive pregnant women tested		
14.1	Number of spouses/partners of HIV positive pregnant women found HIV positive		
15	Number of spouses/ partners of HIV negative pregnant women tested		
15.1	Number of spouses/partners of HIV negative pregnant women found HIV positive		
16	Number of Sexual partners /Spouse of HIV positive individuals who already know their HIV status and did not require HIV testing		
17	Number of Sexual partners /Spouse of HIV Negative individuals who already know their HIV status and did not require HIV testing		

v. Age-wise distribution						
	Age wise Distribution (incl. DIL and PNC)	**15-19 years**	**20-24 years**	**25-34 years**	**>35 Years**	**Total**
18	Number of pregnant women tested for HIV					0
18.1	Number of pregnant women detected HIV +ve					0

vi. Gravida wise distribution				
	Description	**Primi Gravida**	**Multi- gravida**	**Total**
19	Number of pregnant women tested for HIV			0
19.1	Number of pregnant women detected HIV +ve			0

vii. Delivery & ARV prophylaxis details							
20	Number of HIV positive pregnant women expected to deliver during this month				0		
21	Number of HIV positive pregnant women who underwent MTP/Abortion during the month				0		
			Location→ /Outcome ↓	**In a health facility (Govt./Pvt.)**	**Home delivery**	**Total deliveries**	**Out of HIV +ve deliveries, number of mothers initiated/already initiated on ART**
22	**Total Number of HIV +ve deliveries during this month:**		**20.(a) Live birth**			0	
			20.(b) Still Birth			0	
			Total		0	0	0
23	Number of babies initiated on ARV prophylaxis, during this month (Out of live Birth)					0	

24	**(MB Pairs)-**Number of mothers initiated on lifelong ART and babies initiated on ARV prophylaxis ***(Row is blocked-Auto generated cells)***	0
25	**Only Mother** initiated on lifelong ART (out of total deliveries) but baby not given ARV prophylaxis, during this month ***(Row is blocked-Auto generated cells)***	0
26	**Only baby** initiated on ARV prophylaxis but mother not initiated on ART, during this month ***(Row is blocked-Auto generated cells)***	0
27	Number of babies initiated on **6 weeks** ARV prophylaxis, during this month(Out of live Birth)	
28	Number of babies initiated on **12 weeks** ARV prophylaxis, during this month (Out of live Birth) ***(Row is blocked-Auto generated cells)***	0
29	Number of babies initiated on breast feeding (out of Live births)	
30	Number of babies initiated on replacement feeding (out of Live births) ***(Row is blocked-Auto generated cells)***	0
31	Number of HIV exposed babies who died before 6 weeks EID testing, during this month	

(viii). EID Follow up & 18 month testing details of HIV exposed children				
	A. EID follow up details	First Visit		Follow-up visit
		6 weeks-6 months	6 months -18 months	6 months -18 months
1	Number of children visited the center during this month			
2	Number of children initiated on CPT during this month			
3	Number of children tested for HIV under EID programme (using HIV-1 PCR/ Antibody)			
4	Number of children found Antibody Positive			
5	Number of children tested for HIV using HIV-1 PCR			
6	Number of children who found positive by HIV-1 PCR			
6.1	Number of children who found negative by HIV-1 PCR			
6.2	Number of children who confirmed positive by confirmatory HIV-1 PCR			
6.3	Number of children who found negative (discordant) by confirmatory HIV-1 PCR			
6.3(a)	Number of children who are found negative by second confirmatory HIV-1 PCR			
6.3(b)	Number of children who confirmed positive by second confirmatory HIV-1 PCR			
7	Number of HIV +ve children registered at ART center			
8	Number of children, greater than 6 weeks of age, died during this month			
	B. 18 months testing	Number of child		
9	Number of HIV exposed children beyond 18 months of age, who came for follow up testing			
10	Number of HIV exposed children beyond 18 months of age, tested for HIV antibody test			
11	Number of HIV exposed children beyond 18 months of age, detected HIV +ve			
`12	Number of HIV exposed children beyond 18 months of age, registered at ART Centre			
13	Number of HIV exposed children beyond 18 months of age, who died beyond the age of 18 month			

ICTC Code			ICTC Name				
Monthly Input Formats for Integrated Counseling and Testing Centers (ICTC)							
Section E : HIV-TB Cross referrals (All individuals including Pregnant Women)							
Indicators		**General individual**					**Pregnant Women**	
1	Number of individuals received pre-test counseling/information	**HIV Negative**			**HIV Positive**			**HIV Positive**	**HIV Negative**
	Out Referral to RNTCP	**Male**	**Female**	**TG**	**Male**	**Female**	**TG**		
2	Number of persons suspected to have TB referred to RNTCP Unit								
3	Number of individuals reached to RNTCP DMC out of (2)								
4	Of the referred TB suspects, Number diagnosed as having:								
4.1	(i) Sputum Positive TB								
4.2	(ii) Sputum Negative TB								
4.3	(iii) Extra-Pulmonary TB								
4.4	(iv) Drug Resistant TB/Rif-Resistance								
5	(Out of Sl.no. 4 above) Number receiving Anti- TB/DRTB treatment.								
	In Referral from RNTCP								
6	Number of TB suspects cases referred in for HIV Testing (Presumptive TB Cases)								
7	Number of TB patients referred in for HIV Testing (TB diagnosed cases)								
8	Number of Drug Resistant TB patients referred in for HIV Testing (Rif. Resistant/MDR TB cases)								

Annexure C2: SIMS reporting format for HCTS Screening Facilities (F-ICTC and PPP-ICTC)

	Unique F-ICTC Code			**F-ICTC name**					
MONTHLY REPORTING FORMAT: F-ICTC / PPP-ICTC									
SECTION A. IDENTIFICATION									
1. Name of Centre:					**Type of F-ICTC:**				
Linked SA-ICTC name :					**Linked SA-ICTC Code:**				
2. Address:					**Pin Code:**				
Block/ Mandal/ Taluka:		**District:**			**State:**				
3. Reporting Period:	**From:**_ _/_ _/_ _ _ _ **To:**_ _/_ _/_ _ _		**Month:**		**Year:**				
4. Name of Officer In-charge (F-ICTC):									
5. Contact number:	**Phone:**		**Mobile**						
6. Email Address:									
7. F-ICTC Location:									

1. PROGRESS MADE DURING THE MONTH

Sl. no	**Basic Indicators**	**Pregnant Women**				**General Individual**			
		ANC	**DIL**	**Breast feeding**	**Total**	**Male**	**Female**	**TG**	**Total**
1	Total new ANC individuals registered during the month				**0**				
2	Number of individuals provided pre-test Information				**0**				**0**
3	Number of Individuals screened for HIV by WBFP test				**0**				**0**
4	Number of Individuals provided post-test counseling				**0**				**0**
5	Number of Individuals found HIV reactive after 1st Test, during this month				**0**				**0**
5.1	(out of sl. No. 5)Number confirmed HIV positive at SA-ICTC, during this month				**0**				**0**
5.2	(out of Sl.No. 5) Number Confirmed HIV negative at SA-ICTC, during this month				**0**				**0**
6	Number of Individuals tested for Syphilis (using POC/RPR Test)				**0**				**0**
6.1	(out of sl no. 6)Number of Individuals found reactive for Syphilis				**0**				**0**
6.2	(out of sl no. 6.1)number treated for syphilis in the same facility/ referred facility				**0**				**0**
7	Number of TB suspect individulas refered to RNTCP (out of sl no. 2)				**0**				**0**

2. LINKAGE & REFERRAL				
Sl.No	**Department/ Organisation**	**In Referral**		**Out Referral of Screened reactive individuals to Stand Alone ICTCs for confirmation**
		Tested	Screened reactive in 1st test	
1	OBG / GYN (ANC Clinic)			
2	Targeted Intervention NGOs			
3	Link Worker			
4	RNTCP			
5	STI Clinic			
6	Others			

3. Delivery & ARV prophylaxis details (only for HIV positive Pregnant women deliverd in this institution) fill where applicable					
	Indicator Description (only for DIL)	**Delivery outcome (This month)**			
		Live Birth	**Still Birth**	**Total**	
1	Number of HIV positive Pregnant women Delivered in this facility, During this month			**0**	
2	Number of HIV exposed babies intiated on ARV prophylaxis (Syp NVP/Syp ZDV/Syp LPV)			**0**	
3	(Out of Sl.no.1)no of HIV exposed babies linked to nearest SA ICTC for getting EID services			**0**	

4. STOCK STATUS OF HIV TEST KITS (Number of Tests)											
Sl.no	**Consumables**	**Name of Kit**	**Expiry Date ***	**Opening Stock**	**Received**	**Consumed**	**Control**	**Wastage / Damage/**	**Closing Stock**	**Average Monthly Consumption**	**Stock sufficient for how many months**
1	WBFP Test Kit								0		
2	HIV Rapid Test Kit								0		
3	Syphilis Test Kit (POC)								0		
4	Syp NVP								0		
5	5. Availability of essential STI/RTI drugs (Yes/ No)					**Yes/NO**					

Annexure C3: Laboratory Report at HCTS Screening Facilities

NATIONAL AIDS CONTROL ORGANIZATION
HIV Counselling & Testing Service (HCTS) Facility

Name of HCTS Facility:
(SA-ICTC/F-ICTC/PPP-ICTC/TI-ICTC etc.): ----------

Address: ----------

LABORATORY REPORT FORM FOR HCTS SCREENING FACILITY (CONFIDENTIAL)

PID Number: ----------

Name of Individual: ---------- Age: ----------

Date of HIV screening----------

Result of HIV Antibody test:Non-Reactive

Name of HIV Test Kit---------- Batch No:----------

Date of follow-up testing (if applicable):----------
(Please bring this report during follow-up testing)

Signature of Staff conducting HIV Screening **Signature of Medical Officer**

Note: (1) This report may be signed by the in-charge Medical Officer of the facility or any Medical Officer.

(2) To maintain strict confidentiality, the signed HIV test report must be given only to the individual.

Annexure C4: Laboratory Report at HCTS Confirmatory Facilities (SA-ICTC)

NATIONAL AIDS CONTROL ORGANIZATION

Laboratory Test Report form for HCTS Confirmatory facility

Name & Address of the SA-ICTC: _____

_____

Name: Surname _____ Middle name _____First Name_____

Gender: ☐ Male ☐ Female ☐ Transgender **Age:** _____ (years)

PID No.: _____ Lab ID No.: _____

Date & Time of Blood Drawn: _____ (DD/MM/YY) _____ (HH:MM)

Test Details:

- Specimen type used for testing (tick one): Serum / Plasma / Whole Blood
- Date & Time of specimen tested: _____(DD/MM/YY) _____(HH:MM)

Note:

- Column 2 and 3 to be filled only when HIV 1 & 2 antibody discriminatory test(s) used
- No cell has to be left blank; indicate as NA wherever not applicable

Column 1	Column 2	Column 3	Column 4
Name of the HIV kit	**Reactive/Nonreactive (R/NR) for HIV-1 antibodies**	**Reactive/Nonreactive (R/NR) for HIV-2 antibodies**	**Reactive/Nonreactive (R/NR) for HIV antibodies**
Test I:			
Test II:			
Test III:			

Interpretation of the result: Tick (✓) relevant

☐ Specimen is negative for HIV antibodies

☐ Specimen is positive for HIV-1 antibodies

☐ *Specimen is positive for HIV antibodies (HIV-1 and HIV-2; or HIV-2 alone)

☐ Specimen is indeterminate for HIV antibodies. Collect fresh sample in 2 weeks

**Confirmation of HIV 2 sero-status at identified referral laboratory through ART centers*

Name & Signature
Laboratory technician

Name & Signature
Laboratory In-charge

Annexure C5: Daily worksheet for laboratory technician

NATIONAL AIDS CONTROL ORGANISATION									
Daily Work Sheet for SA-ICTC Lab-Technician									
Name of the SACS:						Name of HCTS facility:			
	HIV Test -I (R/NR)						HIV Test -II		HIV Test -III
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Name of the HIV KIT-I :	Name of the HIV KIT-II :	Name of the HIV KIT-III :
Lot / Batch No :	Lot / Batch No :	Lot / Batch No :
Expiry Date :	Expiry Date :	Expiry Date :

Number of Samples Screened :_____ Number of Samples Positive :_____

Number of Samples Indeterminate :_____ Number of Samples Negative :_____

Remarks :

Date : Signature of Laboratory Technician Signature of Medical Officer

Note: Please write 'R' for reactive & 'NR' for non-reactive the 5 digit PID number in the relevent coloumn. Last 5 digit of PID number need to be filled in the cell.

Annexure C6: Dashboard Indicators for HCTS Screening Facility

National AIDS Control Organization													
Dashboard Indicators at Screening facilities (to be displayed at the facility & duly updated for every month)													
Name of Facility	_____											**Financial Year** _____	
Indicator	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
ANC individuals :													
Total new ANC individuals registered during the month													
Number of individuals provided pre-test Information													
Number of Individuals screened for HIV by WBFP test													
Number of Individuals found HIV reactive after 1st Test													
Number of HIV positive Deliveries conducted													
General Individuals:													
Number of individuals provided pre-test Information													
Number of Individuals screened for HIV by WBFP test													
Number of Individuals found HIV reactive after 1st Test													

Annexure C7: Dashboard indicators for HCTS Confirmatory Facility (SA-ICTC)

National AIDS Control Organization													
Dashboard indicators at Confirmatory facilities (to be displayed at the facility & duly updated for every month)													
Name of HCTS Facility	_____							**Financial Year** _____					
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
For all General Individual (excluding pregnant women)													
Number of individuals provided pre-test counselling													
Number of individuals screened for HIV													
Number of individuals confirmed HIV positive													
Number of individuals linked to ART centres													
For pregnant women													
Number of New ANC Registrations as per ANC OPD register													
Number of pregnant/ breast feeding women tested for HIV													
Total number of pregnant/breast women diagnosed HIV +ve													
Number of HIV +ve Pregnant/breast feeding women registered at ART centre													
Number of HIV +ve pregnant/breast feeding women initiated on lifelong ART													
Number of HIV Positive deliveries													
Number of live births to HIV positive mother													
Number of babies initiated on ARV prophylaxis													
Number of children tested for HIV under EID programme													
Number of children who found positive by HIV-1 PCR													
Number of children who confirmed positive by confirmatory HIV-1 PCR													
Number of HIV +ve children registered at ART centre													
Number of infants tested for 18 month HIV antibody test													
Number of infants found HIV positive during 18 month antibody test													
Number of HIV+ infants found during 18 month antibody test registered at the ART center													

Annexure C8: SIMS reporting format for HCTS Screening Facilities (TI-ICTC)

Unique Code:				Name of NGO:		National AIDS Control Organization (NACO),
S.No.	Monthly Reporting Format for Screening of HIV through Targeted Interventions (TI-ICTC)					
1.	State:			District:		
2.	Contract Period: mm/yy)	From:	To:	Reporting Month:		
3.	Type of TI :			No. of hotspots in the project area:		
4.	Name of In-charge:			Phone No:	Mobile	
5.	Email-ID:			Having NGO STI clinic (Y/N):		
6.	Linked SA-ICTC Code:			Linked SA-ICTC name:		

1. PROGRESS MADE DURING THE MONTH

Indicator /Description	Type of Individual HRGs								
	FSW	MSM	IDU	TS/TG	Truckers	Migrants	Sexual partner/ spouse of HRG individual	Others	Total
1.Total number of individuals due for screening during the reporting month									0
2. Number of individual provided pre-test counselling during this month									0
3. Number of individual screened for HIV									0
4. Number of individual provided post-test counselling									0
5. Number of individual HRGs reactive after 1st Test, during this month									0
6. (Out of Sr no. 5), Number of HIV reactive individual confirmed HIV positive (after three test) at SA-ICTC, during this month									0
7. (out of Sr. no. 5), Number of HIV reactive individual confirmed HIV negative at SA-ICTC, during this month									0
8. Number of Individuals tested for Syphilis (using RPR Test)									0
8.1 (out of sl no. 8)Number of Individuals found reactive for Syphilis									0

2. SERVICE PROVIDED BY WHOM & WHERE

	Testing conducted by Location of testing	1. ORW	2. Peer Educator	3. Counsellor	4. ANM	5.Doctor /any other health care provider	Total
Number of HRG Tested	TI-Facility						0
	Community						

3. STOCK STATUS OF HIV TEST KITS (Number of Tests)

Type of Kit	Name of Kit	Expiry Date dd/mm/yyyy	Opening Stock	Received	Consumed	Control	Wastage / Damage/	Closing Stock	Average Monthly Con-sumption	Stock sufficient for how many months
1. WBFP Test Kit								0		
2. HIV Rapid Test Kit								0		
3. Other Test Kit								0		

Annexure C9: Quarterly SIMS reporting format for HCTS Confirmatory Facilities (SA-ICTC)

ICTC Code:		ICTC
Quarterly Input Formats for Integrated Counseling and Testing Centres (ICTC)		
i. EQAS Information		
Sl. No	**Indicator**	**Number**
1	Number of blood samples detected Positive in the first week of the quarter (Jan, April, July, October)	
1.1	Out of above number of sample sent for Quality control to SRL/NRL	
1.1.a	Out of (1.1) number reported concordant	
1.1.b	Out of (1.1) number reported discordant	
2	Number of blood samples detected Negative in the first week of the quarter (Jan, April, July, October)	
2.1	Out of the above number of sample sent for Quality control to SRL/NRL	
2.1.a	Out of (2.1) number reported concordant	
2.1.b	Out of (2.1) number reported discordant	

ii. Social Protection Schemes offered by Government					
Social Protection Schemes		**Number of HIV positives cases availed the social protection schemes this month**			
		Male	**Female**	**TS/TG**	**Total**
1	Integrated Child Development Services (ICDS)				**0**
2	Swarnajayanti Gram SwarozgarYojna(SGSY)				**0**
3	Indira AawasYojana(IAY)				**0**
4	Indira Gandhi National Pension Scheme				**0**
5	Mahatama Gandhi National Rural Employment Guarantee Scheme(MGNREGS)				**0**
6	RashtriyaSwasthyaBimaYojana (RSBY)				**0**
7	Pradhan Mantri Suraksha BimaYojana				**0**
8	Pradhan Mantri Jeevan JyotiBimaYojana				**0**
9	Pradhan Mantri Jan DhanYojana				**0**
10	Janani SurakhshaYojana				**0**
11	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG / Sabla)				**0**
12	Indira Gandhi National Widow Pension Scheme (IGNWPS)				**0**

13	Janani Suraksha Yojana (JSY)				**0**
14	Antyodaya Anna Yojana (AAY)				**0**
15	National Family Benefit Scheme (NFBS)				**0**
16	Travel Concession (Railways, State Transport)				**0**
17	Pension Schemes (Old Age, ART Pension etc.)				**0**
18	Small loans for micro credit programme				**0**
19	Any other _____				
	Total	**0**	**0**	**0**	**0**
iii. Source of information about HIV testing					
Sl. No.	**Source of information about HIV testing**	**Self - Initiated individuals**			
		Male	**Female**	**TS/TG**	**Total**
1	TV				**0**
2	Radio				**0**
3	News paper				**0**
4	internet				**0**
5	hoardings				**0**
6	leaflet/palmlets				**0**
7	buspannel				**0**
8	folk performance				**0**
9	Others				**0**

iv. Details of Occupation for HIV positive individuals			
	Details of Occupation	**Total Number of individual undergone HIV test**	**Total Number of individuals diagnosed HIV positive**
1	Agricultural Laborer		
2	Non-agricultural Laborer		
3	Domestic servant		
4	Housewife		
5	Skilled worker		
6	Semi-skilled worker		
7	Petty business/Large business/ small shop/ self employed		
8	Service (Govt./ Pvt.)		
9	Student		

10	Truck Driver/helper		
11	Local transport workers (Auto/Taxi Driver, Handcart Puller, Rickshaw Puller etc.)		
12	Hotel staff		
13	Agricultural cultivator/landholder		
14	Unemployed or retired		
15	Sex Worker		
16	Others		
	Total	**0**	**0**

v. Linkages and referrals				
	Departments / Agencies	**In referral - Tested**	**In referral - diagnosed as HIV Positive**	**Registered to ART**
1	TI NGO / CBO			
2	Non-TI NGOs			
3	OBG / Maternity Homes			
4	RNTCP			
5	Blood Bank			
6	Govt Health Facility			
7	ART Centre			
8	STI Clinic			
9	Care & Support Centre			
10	Private Health Facility			
11	Others	**0**	**0**	**0**
	Total			

Annexure C10: HR & Training Quarterly Format for SACS

Name of the States/UTs		Period	From	DD/MM/YYYY	To	DD/MM/YYYY
Status on Human Resource & Training						
Quarterly - to be filled by SACS						
Section A Status on Human Resource						

Sub Section i(At Field level)				Sub Section ii (At SACS level)						
Staff Type	**Number of positions sanctioned**	**Number of positions filled**	**Number of positions vacant**	**Staff Type**				**Number of positions sanctioned**	**Number of positions filled**	**Number of positions vacant**
1 ICTC Incharge/ MO			0	1 JD BSD						0
				2 DD ICTC						0
2 ICTC Counselor			0	3 DD PPTCT						0
				4 AD ICTC						0
3 ICTC Laboratory Technician			0	5 AD PPTCT						0
				6 Regional Coordinator BSD						0
4 District ICTC Supervisor			0	7 PPTCT Consultant						0
				8 Divisional Assistant						0

Section B Status on Training

(fill the number of Individual trained during month in each cell)

Training→ / **Staff Type ↓**	**Integrated Induction Training**	**Integrated Refresher I Training**	**Integrated Refresher II Training**	**Induction**	**Refresher**	**HIV-TB Collaborative**	**Hands on Sensitization and Orientation**	**Team Training**	**Full Site Sensitization on NACP**	**PLHIV-ART Linkage System (PALS)**	**Others Trainings (Specify)**
1 a. ICTC Counselor											
1 b. ART Counselor											
1 c. STI Counselor											
2 ICTC Laboratory Technician											
3 ICTC In-charge/MO											
4 District ICTC Supervisor											
5 Staff Nurse/ ANM											
6 Labour Room Nurses											
7 RNTCP STS/ STLS/ LT											
8 Other Staff (Specify)											

Annexure C 11: Weekly Stock reporting format

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organization
Basic Services Division
Format for Submitting the Weekly Stock status of Commodities by the States/UTs

State/UT:			**Reporting Period (Week):**							
Type of Commodities			**HIV Test kit 1**	**HIV Test kit 2**	**HIV Test kit 3**	**WBFP test Kits**	**NVP Syrup**	**ZDV Syrup**	**DBS Cards**	**DBS Consumables**
Name of HIV Test Kit										
Average monthly Consumption										
Stock Availability	**No. of Months**									
	No. of days									
SACS, Regional and District Storing Points (Combined) (Tests)	Opening Stock (to be taken from closing stock of previous Week)									
	Receipts (Stock received during this week from other State / supplier)									
	Stock Transferred	Stock transferred out to other State								
		Stock issued to Facilities								
	Wastage/Damaged									
	Expired									
	Closing stock at the end of this week									
ICTC / F-ICTC / PPTCT Facilities (Tests)	Opening Stock (to be taken from closing stock of previous Week)									
	Receipts (Stock received during this week from SACS)									
	Wastage/Damaged									
	Total Consumption at end of this week									
	Closing stock at the end of this week									
Total	Closing Stock (SACS + Facilities)									
Monthly Status of HIV Testing (to be updated on first week of every month)	No. of General individual tested at the end of last month									
	No. of Pregnant Women tested at the end of last month									
	Total									

SACS must submit this weekly information through Email to bsdcommodity@gmail.com on every Thursday of the week

Annexure D1: PLHIV card at HCTS Confirmatory Facilities (SA-ICTC)

PLHIV Card

(For HIV positive individuals (excluding Pregnant women))

PID No:		**Pre ART No:**	

Demographic details

Name:		Age:	
Sex	☐ Male ☐ Female ☐ Transgender	Mobile number:	
Aadhaar number (UID):		PAN Card No.	
Voter ID No.:		Ration Card No.	
Marital status:	☐ Married ☐ *Divorced* ☐ *Separated* ☐ *Un-married* ☐ *Widowed* ☐ *Live-in relation ship*		
Education:	☐ *Non-Literate* ☐ *Primary School* ☐ *Secondary school* ☐ *College and above*		
Occupation:	☐ *1. Agricultural labourer,* ☐ *2. Non-agricultural labourer,* ☐ *3.Domestic servant,* ☐ *4. Housewife/housemaid,* ☐ *5.Skilled worker,* ☐ *6. Semi-skilled worker,* ☐ *7.Petty business/Large business/small shop/self-employed,* ☐ *8. Service (Govt. / Pvt.),* ☐ *9. Student,* ☐ *10. Truck Driver/helper,* ☐ *11.Local transport workers (Auto/Taxi Driver,* ☐ *12. Handcraft Pullers, Rickshaw Pullers etc.),* ☐ *13.Hotel staff,* ☐ *14. Agricultural cultivator/landholder,* ☐ *15. Unemployed or retired,* ☐ *16. Other*		
Referred by:	☐ *1.a. FSW TI-NGO,* ☐ *1.b. MSM/TG TI-NGO,* ☐ *1.c. IDU TI-NGO,* ☐ *1.d Migrants TI-NGO,* ☐ *1.e. Truckers TI-NGO* ☐ *2. Non-TI NGOs,* ☐ *3. STI Clinics,* ☐ *4. Blood Bank,* ☐ *5. Government Health Facility* ☐ *6. Private Health Facility,* ☐ *7. FICTC Govt.(Fixed/Mobile),* ☐ *8. PPP FICTC (Fixed/Mobile)* ☐ *9. Others*		

HIV testing details

Date of HIV confirmatory test	_ _ /_ _ / _ _ _ _	**Date of post-test counselling**	_ _ /_ _ / _ _ _ _
Type of HIV infection	☐ ***HIV-I*** ☐ ***HIV-II*** ☐ ***Both HIV I & II***		
Route of Transmission of HIV	☐ ***1. a Heterosexual****: Commercial Partner* ☐ ***1.b Heterosexual****: Casual/non-commercial, non-regular partner* ☐ ***1.c Heterosexual:*** *Regular partner/spouse* ☐ ***2.*** *Homosexual / Bisexual* ☐ ***3.*** *Through blood and blood products* ☐ ***4.*** *Through infected syringe and needles* ☐ ***5.*** *Parent to child (for children)* ☐ ***6.*** *Not specified/unknown*		

Referral details of HIV positive individual

Referral State of ART:		Referral District of ART:	
Referral ART center name:		Date of referral to ART center:	_ _ /_ _ / _ _ _ _

TB Testing details

Whether symptomatically screened for TB (based on 4s)	☐ *Yes* ☐ *No*	If yes above, **whether tested for TB?**	☐ *Yes* ☐ *No*
If tested for TB, Result of test	☐ *TB Detected* ☐ *TB not Detected*	Whether started on ATT	☐ *Yes* ☐ *No*

Syphilis Testing details

Whether tested for Syphilis?	☐ *Yes* ☐ *No*	**Result of Syphilis test**	☐ Positive ☐ Negative
If Syphilis Positive, Whether treated for Syphilis?		☐ *Yes* ☐ *No*	

Present Address Details

Name of the Spouse / Partner		Alternate mobile no.	
State		District	
Block / Mandal /Sub-district		Pin code	
Address House/Street No.		Village name	
Nearby land mark if any			

Permanent Address details

Father's Name		Alternate mobile no.	
State		District	
Block / Mandal /Sub-district		Pin code	
Address House/Street No.		Village name	
Nearby land mark if any			

ART referral detail of the individual

Referral State of ART:		Referral District of ART:	
Referral Name of the ART center:		Date of referral to ART center:	_ _ /_ _ / _ _ _ _

ART registration details of Individual (Can be taken form ART centers)

Date of Pre ART registration	_ _ /_ _ / _ _ _ _	Pre ART registration no.	
Date of CD4 test	_ _ /_ _ / _ _ _ _	CD4 Count	
Date on Initiation of ART	_ _ /_ _ / _ _ _ _	On ART Registration no.	
Regimen Initiated	☐ *TLE* ☐ *TLL* ☐ *ZLN* ☐ *TLN* ☐ *ZLE* ☐ *Other (Specify).....*		

Spouse/Partner & Family details			
HIV testing details of Spouse/Partner			
Whether the Spouse / Partner has been tested for HIV?	☐ *Yes* ☐ *No*	Date of HIV Testing:	_ _ /_ _ /_ _ _ _
PID No. of spouse/partner		HIV Status:	☐ Positive ☐ Negative
If Positive, write Pre-ART number of Spouse/Partner:			
Details of HIV testing facility where spouse/partner is tested:			
State:		**District:**	
ICTC center name:			
If spouse/partner is not tested, ***Reason for not testing***	☐ *Not willing* ☐ *Spouse/Partner Died* ☐ *Separated* ☐ *Migrant* ☐ *Tested in private hospital* ☐ *Unmarried ANC*		
****If Spouse/Partner is tested negative, write follow-up HIV testing details of spouse/partner**			
Demographic details of Spouse/Partner			
Name:		**Age:**	
Aadhaar number (UID)		**Mobile number:**	
Education:	☐ *Non-Literate* ☐ *Primary School* ☐ *Secondary school* ☐ *College and above*		
Occupation:	☐ *Agricultural laborer,* ☐ *Non-agricultural laborer,* ☐ *Domestic servant,* ☐ *Housemaid* ☐ *Skilled worker,* ☐ *Semi-skilled worker,* ☐ *Petty business/Large business/small shop/self-employed,* ☐ *Service (Govt. / Pvt.),* ☐ *Student,* ☐ *Truck Driver/helper,* ☐ *Local transport workers (Auto/Taxi Driver,* ☐ *Handcraft Pullers, Rickshaw Pullers etc.),* ☐ *Hotel staff,* ☐ *Agricultural cultivator/landholder,* ☐ *Unemployed or retired,* ☐ *Other*		

Family Planning Measures adopted by couple			
The Family Planning method is being adopted by Female partner	☐ **No FP measure**	***Temporary measure*** ☐ *Female condom* ☐ *PP IUCD* ☐ *Copper T (380-A)* ☐ *Oral Contraceptive Pills (OCPs)* ☐ *Traditional Methods*	***Permanent measure*** ☐ *Tubectomy: Laparoscopic or Tubal ligation*
The Family Planning method is being adopted by male partner	☐ **No FP measure**	***Temporary measure*** ☐ *Male condom*	***Permanent measure*** ☐ *No Scalpel Vasectomy (NSV)*

Social Protection Schemes offered by the Government		
Social Protection Schemes availed:	☐ Integrated Child Development Services (ICDS) ☐ Swarnajayanti Gram SwarozgarYojna(SGSY) ☐ Indira Gandhi National Pension Scheme ☐ Mahatama Gandhi National Rural Employment Guarantee Scheme ☐ RashtriyaSwasthyaBimaYojana (RSBY) ☐ Pradhan Mantri Suraksha BimaYojana ☐ Pradhan Mantri Jeevan JyotiBimaYojana ☐ Indira Gandhi National Widow Pension Scheme (IGNWPS) ☐ Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG / Sabla)	☐ Indira AawasYojana(IAY) ☐ Pradhan Mantri Jan DhanYojana ☐ Janani Suraksha Yojana (JSY) ☐ Antyodaya Anna Yojana (AAY) ☐ National Family Benefit Scheme (NFBS) ☐ Travel Concession (Railways, State Transport) ☐ Pension Schemes (Old Age, ART Pension) ☐ Small loans for micro credit programme ☐ Any other _____

Deaths reported			
Individual death	☐ *Yes* ☐ *No*	Date of death of individual	_ _ /_ _ /_ _ _ _
Spouse/Partner death	☐ *Yes* ☐ *No*	Date of death of spouse/partner	_ _ /_ _ /_ _ _ _
Remarks (if any)			

Annexure D2: PPTCT Beneficiary Card at HCTS Confirmatory Facilities (SA-ICTC)

PPTCT Beneficiary Card

(For HIV positive Pregnant & Breast feeding women)

PID No:			**Pre ART No:**		
Type of HIV Case	☐ *Newly Detected HIV Positive* ☐ *Already Known HIV positive*				
Demographic details of ANC/DIL /PNC mother					
Name:					
Order of pregnancy:		**Age:**		**Mobile number:**	
Aadhaar number (UID)				**Voter ID no.:**	
MCTS ID:				**Ration Card No.**	
Marital status:	☐ Married ☐ *Divorced* ☐ *Separated* ☐ *Un-married* ☐ *Widowed* ☐ *Live-in relation ship*				
Education:	☐ *Non-Literate* ☐ *Primary School* ☐ *Secondary school* ☐ *College and above*				
Occupation:	☐ *Agricultural laborer,* ☐ *Non-agricultural laborer,* ☐ *Domestic servant,* ☐ *Housemaid* ☐ *Skilled worker,* ☐ *Semi-skilled worker,* ☐ *Petty business/Large business/small shop/self-employed,* ☐ *Service (Govt. / Pvt.),* ☐ *Student,* ☐ *Truck Driver/helper,* ☐ *Local transport workers (Auto/Taxi Driver,* ☐ *Handcraft Pullers, Rickshaw Pullers etc.),* ☐ *Hotel staff,* ☐ *Agricultural cultivator/landholder,* ☐ *Unemployed or retired,* ☐ *Other*				
Pregnancy Registration details of ANC/DIL /PNC Woman					
Type of Case	☐ ANC ☐ DIL ☐ PNC			**Date of ANC Registration at ANC clinic:**	_ _ /_ _/ _ _ _ _
Date of first visit to ICTC during current pregnancy	_ _ /_ _/ _ _ _ _			**LMP date:**	_ _ /_ _/ _ _ _ _
Gestational Age (in weeks)				**Expected Date of Delivery (EDD):**	_ _ /_ _/ _ _ _ _
HIV Counselling & testing details					
Date of HIV confirmatory test	_ _ /_ _/ _ _ _ _			**Date of post-test counseling**	_ _ /_ _/ _ _ _ _
Type of HIV infection of Mother	☐ *HIV I* ☐ *Both HIV I & II* ☐ *Only HIV II*				
Route of Transmission of HIV	☐ ***1. a Heterosexual****: Commercial Partner* ☐ ***1.b Heterosexual****: Casual/non-commercial, non-regular partner* ☐ ***1.c Heterosexual:*** *Regular partner/spouse* ☐ ***2.*** *Homosexual / Bisexual* ☐ ***3.*** *Through blood and blood products* ☐ ***4.*** *Through infected syringe and needles* ☐***5.*** *Parent to child (for children)* ☐ ***6.*** *Not specified/unknown*				
If Already Known HIV positive (Details of HIV testing facility where she was tested)					
Whether detected as:	☐ *Pregnant Women* ☐ *General individual*				
State of ICTC			District of ICTC		
ICTC Name					
TB and Syphilis Testing details of ANC/DIL /PNC women					
Whether symptomatically screened for TB (based on 4s)	☐ *Yes* ☐ *No*		**If yes above, whether tested for TB?**	☐ *Yes* ☐ *No*	
If tested for TB, Result of test	☐ *TB Detected* ☐ *TB not Detected*		Whether started on ATT	☐ *Yes* ☐ *No*	
Whether tested for Syphilis?	☐ *Yes* ☐ *No*		**Result of Syphilis test**	☐ Positive ☐ Negative	
If Syphilis positive, whether treated for Syphilis?			☐ *Yes* ☐ *No*		
Present Address of ANC/DIL /PNC Woman					
Name of the Spouse / Partner			Alternate mobile no.		
State			District		
Block / Mandal /Sub-district			Pin code		
Address House/Street No.			Village name		
Nearby land mark if any					
Alternate Address of ANC/DIL /PNC Woman					
Father's Name/Parental Address			Alternate mobile no.		
State			District		
Block / Mandal /Sub-district			Pin code		
Address House/Street No.			Village name		
Nearby land mark if any					

Referral details of HIV positive ANC/DIL /PNC women			
Referral State of ART:		Referral District of ART:	
Referral Name of the ART center:		Date of referral to ART center:	_ _ /_ _ / _ _ _ _

ART registration details of ANC/DIL/PNC (Can be taken form ART centers)			
Date of Pre ART registration	_ _ /_ _ / _ _ _ _	Pre ART registration no.	
Date of CD4 test	_ _ /_ _ / _ _ _ _	CD4 Count	
Date of ART initiation	_ _ /_ _ / _ _ _ _	On ART Registration no.	
Regimen Initiated	☐ *TLE* ☐ *TLL* ☐ *ZLN* ☐ *TLN* ☐ *ZLE* ☐ *Other (Specify).....*		

Spouse/Partner & Family details			
Whether the Spouse / Partner has been tested for HIV?	☐ *Yes* ☐ *No*	Date of HIV Testing:	_ _ /_ _ / _ _ _ _
PID No. of Spouse/partner		**HIV Status**	☐ Positive ☐ Negative
If Positive, write Pre-ART number of Spouse/Partner:			

Details of HIV testing facility where spouse/partner is tested:			
State of ICTC:		**District of ICTC:**	
ICTC center name:			
If spouse/partner is not tested, Reason for not testing	☐ *Not willing* ☐ *Spouse/Partner Died* ☐ *Separated* ☐ *Migrant* ☐ *Tested in private hospital* ☐ *Unmarried ANC*		

****If Spouse/Partner is tested <u>negative,</u>** fill the follow up testing details in the Spouse/Partner discordant card

Demographic details of Spouse/Partner			
Name:		Age	
Aadhaar number (UID)		Mobile number:	
Education:	☐ *Non-Literate* ☐ *Primary School* ☐ *Secondary school* ☐ *College and above*		
Occupation:	☐ *Agricultural laborer,* ☐ *Non-agricultural laborer,* ☐ *Domestic servant,* ☐ *Housemaid* ☐ *Skilled worker,* ☐ *Semi-skilled worker,* ☐ *Petty business/Large business/small shop/self-employed,* ☐ *Service (Govt. / Pvt.),* ☐ *Student,* ☐ *Truck Driver/helper,* ☐ *Local transport workers (Auto/Taxi Driver,* ☐ *Handcraft Pullers, Rickshaw Pullers etc.),* ☐ *Hotel staff,* ☐ *Agricultural cultivator/landholder,* ☐ *Unemployed or retired,* ☐ *Other*		

Children born to this ANC/DIL/PNC women from previous pregnancies	
Number of living children excluding current pregnancy	
Number of living children tested for HIV (Out of above living children)	
Number of living children detected HIV positive pregnancy (Out of above tested for HIV)	
Number of living HIV positive children initiated on ART (Out of above detected HIV positive)	

Delivery details of current pregnancy (Sec. D1)			
Expected Date of Delivery (EDD)	_ _ /_ _ / _ _ _ _	LMP Date:	_ _ /_ _ / _ _ _ _
Outcome of Pregnancy	☐ *Live birth-Single* ☐ *Live birth-Twins,* ☐ *MTP ,* ☐ *Still birth,* ☐ *Abortion*		
Date of Outcome of Pregnancy	_ _ /_ _ / _ _ _ _	**Mode of Delivery**	☐ *Normal* ☐ *Caesarean*
Place where outcome occurred	☐ *Govt. health facility* ☐ *Private health facility* ☐ *Home*		
State		**District**	
Block / Taluk / Mandal		**Pin code**	
Duration of Mother initiated on ART until delivery (in weeks)		Preferred Breast-feeding practice	☐ *EBF* ☐ *ERF*

Family Planning measure adopted		
Family planning method being adopted by mother?	☐ Temporary Measures	☐ *Female Condoms,* ☐ *PPIUCD,* ☐ *Copper T (380-A),* ☐ *Oral contraceptive pills,* ☐ *Traditional method*
	☐ Permanent Measures	*Tubectomy: Laparoscopic or Tubal ligation*
	☐ Not Using FP measures	
Family planning method being adopted by spouse/partner	☐ *Male Condoms* ☐ *No Scalpel Vasectomy (NSV)* ☐ *Not Using FP measures*	

Prophylaxis details of baby			
Weight (in Kgs)		**Gender of Baby**	☐ Male ☐ Female
Expected period of ARV prophylaxis for the baby		**Duration of prophylaxis initiated for baby**	
ARV prophylaxis initiated to baby	☐ Syrup Nevirapine ☐ Syrup Zidovudine ☐ Syrup Lopinavir /ritonavir		
Date of starting prophylaxis in baby	_ _ /_ _ / _ _ _ _	Date of stopping prophylaxis in baby	_ _ /_ _ / _ _ _ _
****If Twins, Prophylaxis details of baby2**			
Weight (in Kgs)		**Gender of Baby**	
Expected period of ARV prophylaxis for the baby		**Duration of prophylaxis initiated for baby**	
ARV prophylaxis initiated to baby	☐ Syrup Nevirapine ☐ Syrup Zidovudine ☐ Syrup Lopinavir /ritonavir		
Date of starting prophylaxis in baby	_ _ /_ _ / _ _ _ _	Date of stopping prophylaxis in baby	_ _ /_ _ / _ _ _ _

EID testing Details of HIV exposed children

** If outcome of pregnancy is Twins, Please maintain separate Case Details form to update the EID details for second baby*

Complete name of the infant:			
ICTC PID of baby:		**DNA PCR Code:**	

Details of Co-trimoxazole Preventive Therapy

Date of initiation of CPT	_ _ /_ _ / _ _ _ _	**Date of Stopping of CPT**	_ _ /_ _ / _ _ _ _	**Duration of CPT initiated (in months)**	

First Follow-up visits of the Baby

Date of Visit	_ _ /_ _ / _ _ _ _	**Age (in months)**		**Weight (in Kgs)**	
Current feeding practices at the time of visit	☐ *EBF* ☐ *ERF* ☐ *Mixed* ☐ *Complementary feeding*				
Type of the test	☐ *HIV-1 PCR test* ☐ *Antibody test*	**No. of DBS Spot collected**		**Date dispatching the DBS sample**	_ _/_ _/_ _ _ _
Result of the test	☐ *Positive* ☐ *Negative*			**Date of obtaining the result**	_ _/_ _/_ _ _ _

****In case, if Antibody test was done and found positive during first visit of baby, write details of DBS sample**

Date of dispatching DBS sample	_ _ /_ _ / _ _ _ _	**No. of DBS Spot collected**	
Result of DBS sample	☐ *Positive* ☐ *Negative*	**Date of obtaining the result**	_ _ /_ _ / _ _ _ _

Second Follow-up visits of the Baby

Date of Visit	_ _ /_ _ / _ _ _ _	**Age (in months)**		**Weight (in Kgs)**	
Current feeding practices at the time of visit	☐ *EBF* ☐ *ERF* ☐ *Mixed* ☐ *Complementary feeding*				
Type of the test	☐ *HIV-1 PCR test* ☐ *Antibody test*	**No. of DBS Spot collected**		**Date dispatching the DBS sample**	_ _/_ _/_ _ _ _
Result of the test	☐ *Positive* ☐ *Negative*			**Date of obtaining the result**	_ _/_ _/_ _ _ _

****In case, if Antibody test was done and found positive during Second visit of baby, write details of DBS sample**

Date of dispatching DBS sample	_ _ /_ _ / _ _ _ _	**No. of DBS Spot collected**	
Result of DBS sample	☐ *Positive* ☐ *Negative*	**Date of obtaining the result**	_ _ /_ _ / _ _ _ _

History of Breast feeding practices

History of breast feeding during the first 6 month	☐ EBF ☐ ERF ☐ Mixed feed	Date of Stopping Breast Feeds	_ _ /_ _ / _ _ _ _
Duration of Breast feeding (in months)		Expected date of Third follow-up	_ _ /_ _ / _ _ _ _

Third Follow-up visits of the Baby

Date of Visit	_ _ /_ _ / _ _ _ _	**Age (in months)**		**Weight (in Kgs)**	
Current feeding practices at the time of visit	☐ *EBF* ☐ *ERF* ☐ *Mixed* ☐ *Complementary feeding*				
Type of the test	☐ *HIV-1 PCR test* ☐ *Antibody test*	**No. of DBS Spot collected**		**Date dispatching the DBS sample**	_ _/_ _/_ _ _ _
Result of the test	☐ *Positive* ☐ *Negative*			**Date of obtaining the result**	_ _/_ _/_ _ _ _

****In case, if Antibody test was done and found positive during third visit of baby, write details of DBS sample**

Date of dispatching DBS sample	_ _ /_ _ / _ _ _ _	**No. of DBS Spot collected**	
Result of DBS sample	☐ *Positive* ☐ *Negative*	**Date of obtaining the result**	_ _ /_ _ / _ _ _ _

Confirmatory HIV-1 PCR Test details **(if baby is found Positive with DBS HIV-1 PCR test during any of the follow up visit above then)**			
Date of dispatching Confirmatory DBS sample	_ _ /_ _ / _ _ _ _	**No. of DBS Spot collected**	
Result of Confirmatory DBS sample	☐ *Positive* ☐ *Negative*	**Date of obtaining the result**	_ _ /_ _ / _ _ _ _
****If the Confirmatory DBS test is Negative (discordant) then Details of Second confirmatory DBS sample**			
Date of dispatching SecondConfirmatory DBS test	_ _ /_ _ / _ _ _ _	**No. of DBS Spot collected**	
Result of Second confirmatory DBS test	☐ *Positive* ☐ *Negative*	**Date of obtaining the result**	_ _ /_ _ / _ _ _ _

**** If Baby, Confirmed positive by two DBS, please enter ART details:**			
Whether baby registered to ART:	☐ *Yes* ☐ *No*		
If yes, Date of Pre ART Registration	_ _ /_ _ / _ _ _ _	**Pre ART registration no. of baby**	
Date of CD4 testing	_ _ /_ _ / _ _ _ _	**CD4 (%) percentage**	
Date of ON ART initiation	_ _ /_ _ / _ _ _ _	**On ART registration no.**	
Regimen Initiated	☐ ZL + LPV/r ☐ AL + LPV/r ☐ Other (Specify)……		

18 month -Confirmatory Antibody Testing			
Date of the 18th month Antibody testing:	_ _ /_ _ / _ _ _ _	Age of child: (in months)	
Result of 18th month Antibody testing:	☐ *Positive* ☐ *Negative*		
If Discordance results found at 18 month age of the baby ***(DNA/PCR was Positive: 18 months Antibody Tests is Negative)***			
Result of Repeat antibody test	☐ *Positive* ☐ *Negative*		
Result of Re-confirmation DBS test (If repeat antibody test above found negative)	☐ *Positive* ☐ *Negative*		
If re-confirmation DBS test above is negative, Please provide details to SACS/NACO, BSD (click here to send the mail) (email-pptctreports.naco@gmail.com)			

Social Protection Schemes offered by the Government		
Social Protection Schemes availed:	☐ Integrated Child Development Services (ICDS) ☐ Swarnajayanti Gram SwarozgarYojna(SGSY) ☐ Indira Gandhi National Pension Scheme ☐ Mahatama Gandhi National Rural Employment Guarantee Scheme ☐ Rashtriya Swasthya Bima Yojana (RSBY) ☐ Pradhan Mantri Suraksha BimaYojana ☐ Pradhan Mantri Jeevan JyotiBimaYojana ☐ Indira Gandhi National Widow Pension ☐ Scheme (IGNWPS) ☐ Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG / Sabla)	☐ Indira AawasYojana(IAY) ☐ Pradhan Mantri Jan DhanYojana ☐ Janani Suraksha Yojana (JSY) ☐ Antyodaya Anna Yojana (AAY) ☐ National Family Benefit Scheme (NFBS) ☐ Travel Concession (Railways, State Transport) ☐ Pension Schemes (Old Age, ART Pension) ☐ Small loans for micro credit programme ☐ Any other _____

Deaths reported			
Whether Baby death occurred?	☐ *Yes* ☐ *No*	Date of death of baby	_ _ /_ _ / _ _ _ _
Whether Mother death occurred?	☐ *Yes* ☐ *No*	Date of death of mother	_ _ /_ _ / _ _ _ _
Whether Spouse/partner death occurred?	☐ *Yes* ☐ *No*	Date of death of Spouse/Partner	_ _ /_ _ / _ _ _ _

Remarks (if any)	

Annexure D3: EIC Card for Infants at HCTS Confirmatory Facility (SA-ICTC)

ICTC HIV- EXPOSED INFANT / CHILD CARD

A. PID No. of mother: _____

B. Mother's name: _____

C. Registration date of mother at ICTC (DD/MM/YY): _ _ / _ _ / _ _

D. Home address:_____

_____

_____ **Phone Number:**_____

E. PID. No. of Infant _____

F. Infant's name: _____

G. Unique Infant code (for HIV-1 PCR test; 15 digit code):_____

H. Sex of infant: ☐ Female ☐ Male

I. Birth date (DD/MM/YY):_ _ / _ _ / _ _

J. Type of delivery : ☐ Full Term Normal Delivery, ☐ Caesarean Section,

☐ Pre Term Delivery (gestational age in Weeks)_____

K. ARV prophylaxis of the baby administered :_____

L. Immunization status: ☐ Child is immunized as scheduled, ☐ Child is not immunized as scheduled

M.List missing/incomplete immunizations_____

	Date of visit (DD/MM/YY)	Current age of infant	Details of counselling provided (use codes)[2]	Infant weight[3](kg)	Infant length[3](cm)	Cotrimoxazole prophylaxis therapy (mark if initiated or renewed)	Infant feeding practice in past 6 weeks(use codes)[4]	Rapid Test	Screening Dried Blood Spot (DBS)	Confirmatory Dried Blood Spot (DBS)		Confirmatory Rapid Test at 18 months	Next scheduled visit (DD/MM/YY)
								Test result	Test result	Date of DBS specimen collection (DD/MM/YY)	Test result	Test result	
	1	2	3	4	5	6	7	8	9	10	11	12	13
Visits conducted while infant is **≥6 weeks**, but **<6 months** age													
Visits conducted while infant is **≥6 months**, but **≤18 months** age													

CODES& NOTES

1. **ARV prophylaxis of the baby administered:** A) No prophylaxis; B) 6 weeks NVP syrup; C) 12 weeks NVP syrup; D) 6 weeks AZT syrup; E) 12 weeks AZT syrup ; F) 6 week LPV syrup; G) 12 week LPV syrup
2. **Details of counseling provided: Mark all of the counseling topics covered at today's visit.** A) Infant feeding; B) HIV testing; C) Cotrimoxazole prophylaxis; D) Immunization; E) Seeking medical care; F) Nutrition;G) Psychosocial support; H) Family planning; I) Condom use demonstration; J) Other (specify)
3. **Infant weight and length: Plot infant's weight and length on the appropriate graph below at each visit.**
4. **Infant feeding practice in past 6 weeks:** A) Exclusive Breastfeeding; B) Breastfeeding and Complimentary feeding; C) Exclusive Replacement Feeding; D) Stopped breastfeeding

Annexure D4: Discordant Partner Card

Discordant Partner Card

(For HIV negative partner of HIV positive individuals)

Discordant Spouse/Partner details							
PID No of HIV Negative Partner/Spouse:							
HIV Positive Partner Details							
PID No of HIV Positive Partner:		Pre ART No of HIV Positive Partner:		Date of HIV Testing:	_ _ /_ _ / _ _ _ _		
Demographic details of Spouse/Partner							
Name:					Age:		
Sex:	☐ *Male* ☐ *Female* ☐ *TS/TG*		If female, then pregnant?	☐ *Yes* ☐ *No*	Number of pregnancies:		
Identification Type:		Identification No:		Mobile No:			
Address:							
Education:	☐ *Non-Literate* ☐ *Primary School* ☐ *Secondary school* ☐ *College and above*						
Occupation:	☐ *Agricultural laborer* ☐ *N on- agricultural laborer* ☐ *Domestic Servant* ☐ *Housewife/housemaid* ☐ *Skilled worker* ☐ *Semi - skilled worker* ☐ *Student* ☐ *Truck Driver/ helper*		☐ *Local transport workers (Auto/Taxi Driver)* ☐ *Service (Govt. / Pvt.)* ☐ *Petty business/ large business/ small shop/ self-employed* ☐ *Handcraft Pullers, Rickshaw Pullers etc.* ☐ *Hotel Staff* ☐ *Unemployed or retired* ☐ *Agricultural cultivator/landholder* ☐ *Others*				
Current Marital Status:	☐ Married ☐ Divorced ☐ Separated ☐ Never married ☐ Widowed ☐ Live-in relationship						
History of Risk Behaviour							
Year of Marriage:		*History of 2nd Marriage*	☐ *Yes* ☐ *No*		*Year of 2nd Marriage:*		
History of sexual behaviour	*Partner detail*	☐ *Single partner*	☐ *Multiple partners*				
	Partner type	☐ *Opposite sex*	☐ *Same sex*	☐ *Bisexual*			
History of sexual/physical abuse	☐ *History of Sexual Abuse* ☐ *History of Physical Abuse* ☐ *No History of sexual/physical abuse*						
History of STI/RTI (during last 6 month)	☐ *Yes* ☐ *No*		Whether single migrant?	☐ *Yes* ☐ *No*			
Aware about Route of HIV transmission	☐ *Yes* ☐ *No*		Aware about prevention in discordant couple settings	☐ *Yes* ☐ *No*			
Whether HIV status known before current testing	☐ *Yes* ☐ *No*		If Yes, then since how many months				
Family Planning Measures adopted by couple							
The Family Planning method is being adopted by Female partner	☐ No FP Measure		*Temporary measure* ☐ *Female condom* ☐ *PP IUCD* ☐ *Copper T (380-A)* ☐ *Oral Contraceptive Pills (OCPs)* ☐ *Traditional Method*		*Permanent measure* ☐ *Tubectomy: Laparoscopic or Tubal ligation*		
The Family Planning method is being adopted by Male partner	☐ No FP Measure		*Temporary measure* ☐ *Male condom*		*Permanent measure* ☐ *No Scalpel Vasectomy (NSV)*		
Methods used for HIV prevention	Condom Use? ☐ *Yes* ☐ *No* Condom Type? ☐ *Male* ☐ *Female* Condom usage frequency? ☐ *Regular* ☐ *Irregular*		*Spouse on ART?* *Adherent?*		☐ *Yes* ☐ *No* ☐ *Yes* ☐ *No*		
Deaths reported							
Discordant partner's death	☐ *Yes* ☐ *No*		Date of death	_ _ /_ _ / _ _ _ _			
HIV positive partner's death	☐ *Yes* ☐ *No*		Date of death	_ _ /_ _ / _ _ _ _			
Remarks (if any)							

Testing Details of Spouse/ Partner		
Date of HIV Test: _ _ /_ _/ _ _ _ _	Baseline HIV Test Result: ☐ Negative	
Follow up testing details		
	Date of Follow-up HIV test	**Result of Follow-up HIV test**
Follow-up HIV test after 3 months		☐ Positive ☐ Negative
Follow-up HIV test after 6 months of last test	_ _ /_ _/ _ _ _ _	☐ Positive ☐ Negative
Follow-up HIV test after 6 months of last test	_ _ /_ _/ _ _ _ _	☐ Positive ☐ Negative
Follow-up HIV test after 6 months of last test	_ _ /_ _/ _ _ _ _	☐ Positive ☐ Negative
Follow-up HIV test after 6 months of last test	_ _ /_ _/ _ _ _ _	☐ Positive ☐ Negative
Follow-up HIV test after 6 months of last test	_ _ /_ _/ _ _ _ _	☐ Positive ☐ Negative
Follow-up HIV test after 6 months of last test	_ _ /_ _/ _ _ _ _	☐ Positive ☐ Negative
If Individual tests positive in follow-up HIV test, fill the details in PLHIV card and link the individual to ART center		

Note that discordant card of HIV negative partner is stapled with the PLHIV card of the positive partner

Annexure D5: Follow up HIV testing Card

Follow Up HIV Testing Card

For Discordant partner and High risk individuals undergoing repeat testing

HCTS Facility Copy

HIV testing details			
PID No:		Date of HIV Testing	- - -/- -/- - - -
Baseline HIV Status:	☐ Negative		
If individual tested negative, write follow-up HIV testing details of the individual in this card			
Follow up testing details			
	Date of Follow-up HIV test	**Result of Follow-up HIV test**	
Follow-up HIV test after 3 months	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
If individual tests positive in follow-up HIV text, fill the details in PLHIV card and link the individual to ART center			

HCTS Facility Stamp

Follow Up HIV Testing Card

For Discordant partner and High risk individuals undergoing repeat testing

Individual's Copy

HIV testing details			
PID No:		Date of HIV Testing	- - -/- -/- - - -
Baseline HIV Status:	☐ Negative		
If individual tested negative, write follow-up HIV testing details of the individual in this card			
Follow up testing details			
	Date of Follow-up HIV test	**Result of Follow-up HIV test**	
Follow-up HIV test after 3 months	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
Follow-up HIV test after 6 months of last test	- - / - - / - - - -	☐ Positive ☐ Negative	
If individual tests positive in follow-up HIV text, fill the details in PLHIV card and link the individual to ART center			

HCTS Facility Stamp

Kindly return for a repeat HIV test on the dates mentioned in this card

Annexure E1: MOU for PPP-ICTC Models

(I) MOU between PPP-ICTC (Market Led Model) and SACS

MEMORANDUM OF UNDERSTANDING FOR SERVICE DELIVERY ON INTEGRATED COUNSELLING AND TESTING CENTRES (ICTCs)

Memorandum of understanding (MOU)between

State AIDS Control Society _____
&
XXYYZZ (Name of Facility and Place)

This Memorandum of Understanding (MoU) is made on _____day of (month and year) by the Project Director (name of State AIDS Control Society and Address) AND

XXYYZZ, a facility having its office at _____ acting through _____, the authorised signatory, hereinafter referred to as "XXYYZZ", which expression shall, unless repugnant to the context, include its successor in business, administrators, liquidators and assigns or legal representatives.

I. PURPOSE OF THE COLLABORATIVE PROJECT

The purpose of the Memorandum of Understanding (MoU) is to set up a certified facility integrated counselling and testing centre for HIV counselling and testing in a private sector/not for profit /non-government organisation run health facility through a public private partnership. The aim is to provide access to quality HIV counselling and testing services to individual who access private/not for profit health care system in both urban and rural areas of the country.

II. RESPONSIBILITIES OF THE SACS:

1. To provide training of staff of ICTC (staff of facility) in HIV counselling and testing, PPTCT and universal work precaution in NACO approved centres. If required, more than one training will be provided by the SACS.
2. To supply IEC material required for an ICTC such as flip charts, posters, condom demonstration models, take home materials to XXYYZZ as per requirement.
3. To evaluate the performance of the ICTC periodically as per monitoring and evaluation tools developed by NACO/SACS/DAPCU.
4. To provide Registers and Formats as per "Operational guidelines for Facility Integrated Counselling and Testing Centre" published by NACO, Ministry of Health & Family Welfare, Govt. of India in July, 2007 or any newer version thereof.

III. RESPONSIBILITIES OF XXYYZZ:

1. Designate a Nurse and the Lab technician to be trained by SACS.
2. Designate a Nodal Officer, who would be responsible for all activities of PPP-ICTC.
3. Ensure timely referral of the HIV reactive individual (General as well as ANC) for confirmatory test using the referral slips provided by SACS, if individual so desire.
4. To prepare the Line List for those individuals (General as well as ANC) who found reactive & referred to Stand Alone ICTC.

5. Coordination with ICTC, DAPCU and ART centres about referral of individuals.

6. Report to SACS on the first of every month in naco-sims.gov.in & naco-plhiv.gov.in the number of individual registered and tested and HIV reactive pregnant mothers identified and referred for confirmatory test.

IV. ADRESSES FOR CORRESPONDENCE

In witness thereof, the parties herein have appended their respective signatures the day and the year above stated

Signed For and on behalf of XXYYZZ AABBCC Director / Medical Superintendent XXYYZZ Signature..... Date..... In the presence of Name and Signature ..... Date	Signed For and on behalf of Project Director SACS Signature ..... Date..... In the presence of Name and Signature ..... Date .....

(II) MOU between PPP-ICTC (Market Sharing Model) and SACS

MEMORANDUM OF UNDERSTANDING FOR SERVICE DELIVERY ON INTEGRATED COUNSELING AND TESTING CENTRES (ICTCs)

Memorandum of understanding (MOU)between
State AIDS Control Society _____ &
XXYYZZ (Name of Facility and Place)

This Memorandum of Understanding (MoU) is made on _____ day of _____ 20___ by the Project Director,(hereafter referred to as "SACS"), [name of the Project Director, Designation of Project Director, complete address of SACS]. AND XXYYZZ, a facility having its office at _____ acting through _____, the authorised signatory, hereinafter referred to as "XXYYZZ", which expression shall, unless repugnant to the context, include its successor in business, administrators, liquidators and assigns or legal representatives.

I. PURPOSE OF THE COLLABORATIVE PROJECT

The purpose of the Memorandum of Understanding (MoU) is to set up a certified facility integrated counselling and testing centre for HIV counselling and testing in a private sector/not for profit /non-governmental organisations run health facility through a public private partnership. The aim is to provide access to quality HIV counselling and testing services to individuals who access private/not for profit health care system in both urban and rural areas of the country.

II. RESPONSIBILITIES OF THE SACS

1. To supply rapid HIV diagnostic kits (Only 1st test / 3 different antigens/ principles) in quarterly advance as per annual requirement to XXYYZZ subject to availability of above kits with SACS. While every effort will be made to provide uninterrupted supply of above kits, SACS will not be held responsible for any shortage of above kits due to unforeseen circumstances.
2. To provide training of staff of ICTC (staff of facility) in HIV counselling and testing in NACO approved centres. If required,more than one trainingwill be provided by the SACS.
3. To supply IEC material required for an ICTC such as flip charts, posters, condom demonstration models, take home materials to XXYYZZ as per requirement.
4. To supply condoms required for demonstration and distribution to individuals coming to the ICTC as per requirement.
5. To supply prophylactic ARV drugs for prevention of transmission from HIV positive mother to their new born babies as per national protocol.
6. To evaluate the performance of the ICTC periodically as per monitoring and evaluation tools developed by NACO/SACS/DAPCU.
7. To provide Registers and Formats as per "Operational guidelines for Integrated Counselling and Testing Centre" published by NACO, Ministry of Health & Family Welfare, Govt. of India in July, 2007 or any newer version thereof.

III. RESPONSIBILITIES OF XXYYZZ

1. To provide a room with suitable, sufficient and convenient space to be used for counselling purpose with adequate furniture, lighting and privacy and any other infrastructure required.
2. To provide a laboratory equipped with refrigerator, centrifuge, micropipette, needle cutter, etc for HIV testing & blood sample storing facility.
3. To designate existing staff or appoint new staff for the posts of counsellor and laboratory technician in the ICTC. To also designate an existing Medical Officer as ICTC Manager.

4. To provide consumables such as needles, gloves, syringes, serum storage vials, microtips, etc. of standard quality required for HIV testing to the ICTC.

5. To provide counselling and testing services in the ICTC to any individual who approaches the ICTC without discrimination as per protocol laid out in the guideline text per "Operational guidelines for Integrated Counselling and Testing Centre" published by NACO, Ministry of Health & Family Welfare, Govt. of India in July, 2007 or any newer version thereof. The consultation charge will be used to defray cost for provision of the above services.

6. (For those facilities who opt only 1st test) On identification of a reactive individual through the screening test, to refer the said individual for confirmatory test and follow up services to either a government or PPP-ICTC as per the preference of the individual through appropriate referral mechanism.

7. (For those facilities who opt 3 different antigens/principles) To prepare the Line List for those individuals (General as well as ANC) who found reactive for 3 different antigens/principles.

8. To entirely bear the costs related to staff salary, infrastructure and consumables required for the ICTC.

9. To respect the privacy of individuals and maintain confidentiality. Provide data protection systems to ensure that records of all those who are counselled and tested are not accessible to any unauthorized person.

10. To maintain quality assurance at the service delivery especially in HIV testing services as provided in the guideline text "Operational guidelines for Integrated Counselling and Testing Centre" published by NATIONAL AIDS CONTROL ORGANIZATION, Ministry of Health & Family Welfare, Govt. of India in July, 2007 or any newer version thereof. XXYYZZ will be accountable for any substandard delivery of services.

11. (For those facilities who opt 3 different antigens/principles) To participate in EQAS (External Quality Assessment Scheme) as laid out in the above mentioned guideline text. XXYYZZ will send samples in the first week of every quarter, for cross checking to the SRL (state reference laboratory-state/district ICTC management authority) once every quarter. The laboratory technician designated by XXYYZZ to ensure that these samples are collected in the first week of Jan, Apr, July and Oct & sent to the SRL.

12. To send monthly report to the SACS/DAPCU in naco-sims.gov.in and nacoplhiv.gov.in format by 5th of every month through SIMS and maintain individual records in registers and records supplied by the SACS/DAPCU.

13. To use all the IEC materials, condoms, items required for laboratory use, protective kits for delivery supplied by the SACS/DAPCU at the service delivery purpose by the XXYYZZ.

14. To maintain stock records for the all items and drugs provided by the SACS/DAPCU.

15. To maintain quality bio-medical waste management of disposable items those are used in HIV testing as per their standard protocol or respective State Government norms.

16. To ensure that staff working in the blood collection room and laboratory will observe universal safety precaution (USP).

17. To ensure that ICTC staff are aware of the PEP procedure and display the name and contact information of the PEP focal point/ person as well as the location where the PEP drugs are stored.

18. To follow the national protocol for ARV prophylaxis for prevention of parent to child transmission of HIV (PPTCT).

19. To attend coordination/review meetings conducted by SACS/DAPCU.

20. To ensure that no research or clinical trials are done on the individuals who visit the ICTC or based on data of individuals who visit the ICTCs.

21. To attend review meetings at the district level and SACS level as per the supervisory protocol that is provided in the "Operational guidelines for Integrated Counselling and Testing Centre" published by NATIONAL AIDS CONTROL ORGANIZATION, Ministry of Health & Family Welfare, Govt. of India in July, 2007 or any newer version thereof. To allow access to authorized NATIONAL AIDS CONTROL ORGANIZATION/SACS/DAPCU staffs who visit the ICTC to the premises and records of the ICTC.

22. To permit SACS to periodically test designated counsellor and Lab. Technician for their knowledge, attitude and skills.

23. To follow the testing methodology & algorithm as mentioned in the "Operational guidelines for Integrated Counselling and Testing Centre" published by NATIONAL AIDS CONTROL ORGANIZATION, Ministry of Health & Family Welfare, Govt. of India in July, 2007 or any newer version thereof, in the laboratory by XXYYZZ.

24. To follow various guidelines under National AIDS Control Programme.

25. Test kits supplied by SACS not to be used for routine screening of surgical patients of the facility.

IV. COMMENCEMENT

1. This Memorandum of Understanding shall become effective upon signature by both the parties and certification of the facility site. It shall remain in full force and effect for a period of one year thereafter.

2. Further, the certification of the site of the collaborative testing project as "NATIONAL AIDS CONTROL ORGANIZATION/SACS designated HIV counselling and testing centre" shall run concomitantly with the present Memorandum of Understanding.

V. RENEWAL OF AGREEMENT

1. This Memorandum of Understanding is renewable at the option of /SACS.

2. Three months prior to the expiry of the Memorandum of Understanding due to efflux of time SACS/DAPCU shall intimate XXYYZZ if it intends to renew or not to renew the Memorandum of Understanding.

3. In the event that SACS/DAPCU decides not to renew the Memorandum of Understanding, XXYYZZ shall give notice to the facility regarding the cancellation of its certification. In the event that SACS decide to renew the Memorandum of Understanding, the terms and conditions of this Memorandum of Understanding, as may be amended, will apply de novo.

VI. TERMINATION OF MoU

1. Any party may terminate this Memorandum of Understanding after giving three months' notice to the other party at the address provided in this Memorandum of Understanding for correspondence or the last communicated for the purpose and acknowledges in writing by other party.

2. SACS are authorized to terminate this Memorandum of Understanding (MoU) if any dispute or difference or question arises during the period.

VII. BREACH BY XXYYZZ

In case XXYYZZ is not able to provide services as per Memorandum of Understanding (MoU) or defaults on the provision of this Memorandum of Understanding (MoU) or declines the patient to provide HIV counselling and testing services, it shall be liable for breach of conditions of this MoU.

VIII. ADRESSES FOR CORRESPONDENCE

In witness thereof, the parties herein have appended their respective signatures the day and the year above stated.

Signed For and on behalf of XXYYZZ AABBCC Director / Medical Superintendent XXYYZZ Signature..... Date..... In the presence of Name and Signature ..... Date	Signed For and on behalf of Project Director SACS Signature ..... Date..... In the presence of Name and Signature..... Date .....

(III) MOU between PPP-ICTC (Data Sharing Model) and SACS

MEMORANDUM OF UNDERSTANDING FOR SERVICE DELIVERY ON INTEGRATED COUNSELING AND TESTING CENTRES (ICTCs)

Memorandum of understanding (MOU)between
State AIDS Control Society_____
&
XXYYZZ (Name of Facility and Place)

This Memorandum of Understanding (MoU) is made on _____day of (month and year) by the Project Director (name of State AIDS Control Society and Address) AND

XXYYZZ, a facility having its office at _____ acting through _____, the authorised signatory, hereinafter referred to as "XXYYZZ", which expression shall, unless repugnant to the context, include its successor in business, administrators, liquidators and assigns or legal representatives.

I. PURPOSE OF THE COLLABORATIVE PROJECT

The purpose of the Memorandum of Understanding (MoU) is to set up a certified facility integrated counselling and testing centre for HIV counselling and testing in a private sector/not for profit /non-government organisation run health facility through a public private partnership. The aim is to provide access to quality HIV counselling and testing services to individuals who access private/not for profit health care system in both urban and rural areas of the country.

II. RESPONSIBILITIES OF THE SACS:

1. To provide sensitization of staff of ICTC (staff of facility) in HIV counselling and testing, PPTCT and universal work precaution in NACO approved centres. If required,more than one training will be provided by the SACS.
2. To supply IEC material required for an ICTC such as flip charts, posters, condom demonstration models, take home materials to XXYYZZ as per requirement.
3. To evaluate the performance of the ICTC periodically as per monitoring and evaluation tools developed by NACO/SACS/DAPCU.
4. To provide Registers and Formats as per "Operational guidelines for Facility Integrated Counselling and Testing Centre" published by NACO, Ministry of Health & Family Welfare, Govt. of India in July, 2007 or any newer version thereof.

III. RESPONSIBILITIES OF XXYYZZ:

1. Designate a Nodal Officer, who would be responsible for all activities of PPP-ICTC.
2. Ensure timely referral of the HIV reactive individual (General as well as ANC) for confirmatory test using the referral slips provided by SACS, if individual so desire.
3. To prepare the Line List for those individuals (General as well as ANC) who found reactive & referred to Stand Alone ICTC.
4. Coordination with ICTC, DAPCU and ART centres about referral of individuals.
5. Report to District / SACS on the first of every month in naco-sims.gov.in and naco-plhiv.gov.in the number of individual registered and tested and HIV reactive pregnant mothers identified and referred for confirmatory test.

IV. ADRESSES FOR CORRESPONDENCE

In witness thereof, the parties herein have appended their respective signatures the day and the year above stated.

Signed For and on behalf of XXYYZZ AABBCC Director / Medical Superintendent XXYYZZ Signature..... Date.....	Signed For and on behalf of Project Director SACS Signature ..... Date.....
In the presence of Name and Signature ..... Date	In the presence of Name and Signature..... Date .....

Annexure E2: D.O. letter issued by AS & MD (NHM) and AS & DG (NACO) regarding Universal Screening of Pregnant Women for HIV & Syphilis

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011
M.12015/21/2012-MCH
Dated: 7th March, 2016

Dear Principal Secretary/Secretary,

Subject: Universal screening of pregnant women for HIV and Syphilis

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

Out of the total 28 million annually registered pregnancies, currently only 5 million pregnant women are being tested for Syphilis and around 12 million for HIV. To bridge this huge gap in testing among pregnant women for HIV and Syphilis , an urgent need is felt to strengthen the strategies for scaling-up testing services for HIV and syphilis for their early detection and treatment in them, thereby preventing mother-to-child-transmission of HIV and Syphilis, and moving towards achieving the above mentioned global target.

In this context, Government of India has prepared an action-plan to achieve the goal of e-PTCT of HIV and Syphilis. States are requested to take necessary action and project their budget in their State PIPs (2016-17). Please find details of an action plan for ensuring its smooth implementation in all the states at **Annexure-1**.

(C.K.Mishra)
AS & MD (NHM)
Ministry of Health & Family Welfare

(N.S.Kang)
Additional Secretary (NACO)
Ministry of Health & Family Welfare

To

All Principal Secretaries/Health Secretaries of States/UTs

Copy for information to:-

Mission Directors (NHM) of all States/UTs

एड्स - जानकारी ही बचाव है
Taling about AIDS is taking care of each other
www.mohfw.nic.in

Action-Plan for Universal screening for HIV and Syphilis in Pregnant Women

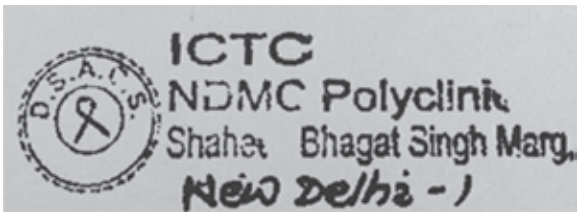
- All pregnant women coming for Ante Natal Care (ANC), will be screened both for HIV and Syphilis by the ANMs at all health care facilities and at sites convened for NHNDs.
  - ✓ Pregnant women, who are screened positive for HIV, should be referred to Stand Alone–ICTCs (SA-ICTCs) for confirmatory testing. Pregnant women who are confirmed HIV positive and their infants will be referred to ART centres at the earliest for initiation of the-long Anti-retroviral therapy (ART).
  - ✓ Like-wise, pregnant women who are tested positive for Syphilis should be referred to the closest PHC/CHC for confirmation using RPR tests (both Qualitative and Quantitaties) and treated with 2-4 million units of Inj. Benzathine penicillin.
  - ✓ Spouses Partners of HIV & Syphilis positive ANCs should be tested and treated on a top priority.
- All Point-of-Care (PoC) test kits for HIV & Syphilis will be centrally procured by NACO and supplied to all the states based on their estimated number of pregnancies.
  - ✓ 15 million PoCs test kits (HIV) will be procured under NACP budget and 10 million PoCs test kits (HIV) will be procured from the NHM budget.
  - ✓ 15 million PoC test kits (Syphilis) will be procured from the NHM budget.
- State NHM and State AIDS Control Societies (SACS) will ensure distribution of PoCs test kits of HIV & Syphilis to the peripheral Institutions - PHCs, SCs, F-ICTCs and to all labour-rooms cold-chain maintenance of them.
- All PoC test kits for HIV & Syphilis and their controls/reagents should be stored in refrigerator at temperatures maintained between 2-8 degrees Centigrade at lowest cold chain point. HIV/Syphilis test kits/their controls/ reagents should not be kept inside IL Rs. During outreach activities, the PoC test kits should be carried in dedicated thermocol boxes placed inside the separate vaccine carrier.
- Priorities and rapidly scale-up of HIV and Syphilis testing sites especially in places with high volume of deliveries taking place i.e. at delivery points. This requires meticulous planning and mapping of existing facilities and linkages to ICTCs and ART centres.
- All the ANMs/Staff Nurses should be trained (half-day) in the HIV and syphilis screening tests techniques, reduction of stigma and discrimination against People Living with HIV (PLHIV) and in maintaining their confidentiality at the PHCs/CHCs during their monthly meetings.
- All Laboratory Technicians working whether contractual under NHM/NACP or regular LTs (General Labs, RNTCP, Malaria) to be trained (half-day training on testing, counselling and referrals). This is to ensure that all LTs are well versed with HIV and Syphilis testing using PoC and confirmatory tests.
- HIV and Syphilis positive pregnant women to be categorised as “High Risk Pregnancies” and birth-planning to be done for all cases, thereby ensuring institutional deliveries and improving the outcomes of mother and child.
- Family planning services especially spacing methods PP IUCDs, need to be promoted among HIV and Syphilis positive women soon after their deliveries in institutions, so that the subsequent pregnancies can be well planned and spaced. To address gender inequalities in adoption of permanent methods for Family Planning. All states should ensure that No Scalpel Vasectomies (NSV) are promoted more rationally despite nil morbidity and mortality rates. This needs development of appropriate IEC/BCC material for enhancing uptake of No scalpel vasectomy (NSV).
- To ensure accurate reporting on numbers of ANCs tested for HIV and Syphilis; numbers detected positive; numbers initiated on treatment; numbers of spouses tested and treated in the monthly HMIS formats (revised during 2015-16) and in RCH registers (MCTS/RCH Portal).
- Encourage and maintain strong coordination mechanisms between State AIDS Control Societies and NHM in all the states for smooth implementation of the strategies for eliminating parent-to-child-transmissions of HIV & Syphilis.
- Joint monthly monitoring teams to review progress and implementation in different states should be planned. This is critical for achieving the goals of e-PTCT of HIV and Syphilis.

Annexure E3: Rubber Stamps Prototype for HCTS facilities

All the HCTS facilities are advised to use rubber stamps to reduce time in filling the (a) Name, Address, Phone and email information and (b) PID number in registers, forms and cards.

Stamp 1: Name, Address, Phone and Email Information

A sample format for a rubber stamp with only Name and Address is provided for ICTC NDMC Polyclinic.



Sample Stamp

SACS Emblem

HIV Counselling and Testing Service (HCTS Facility
Name of HCTS facility:
Unique ID (14 digit)
ADDRESS:
PIN:

Stamp 2

Stamp 2: A rubber stamp for issuing 23 PID to the individual tested at HCTS facility. Initial 14 digits of the 23 digit PID code can be printed through rubber stamp

Sample-1: For HCTS Confirmatory facility (SA-ICTC)

__ __ SAICTC AP APR 001__ __ __ __ __ __ __

Sample-2: For HCTS Screening facility (FICTC/PPP-ICTC/TI-ICTC)

__ __ FICTC AP APR 0001__ __ __ __ __ __ __

Annexure E4: Checklist for HCTS Confirmatory Facilities (SA-ICTC)

ICTC Supervisory Visit Checklist

Checklists for information gathering during field visits *(Please focus on gathering information pertinent to the review period)*

Name of Supervisor: _____ _____ _____ _____ ***Designation:*** _____ _____

Name of Facility:		**Date of Visit:**	__/__/____
Block/ Mandal :		**District:**	
State:		**SIMS RU Code**	
Type of Facility visited:	☐ Stand Alone-ICTC ☐ Mobile ICTC ☐ Facility-ICTC (Sub Center/PHC /CHC/PPP/TI-ICTC)		
	ART Centre/ Link ART Centre		
	Any other facility:_____		
Staff met during visit:	a) MO-IC☐	b) ICTC counsellor ☐	c) Lab-technician ☐
	d) Outreach Worker☐	e) Obs/Gynec Incharge☐	
	f) Staff Nurse /ANM☐	g) Other_ __ ___ __ __	

Human Resource & Training :				
	No. in position	**Induction Training Done**	**Refresher training done and when (mm/yyyy)**	
1. Whether Medical Officer/In-Charge is in place		☐ Yes ☐ No	☐ Yes ☐ No	__/___
2. Counsellor		☐ Yes ☐ No	☐ Yes ☐ No	__/___
3. Lab Technician		☐ Yes ☐ No	☐ Yes ☐ No	__/___
4. Outreach Workers		☐ Yes ☐ No	☐ Yes ☐ No	__/___

Infrastructure & Equipment's			
A. Counselling Room	**Available/ Working**	**No. in place**	**Remark**
1. Separate Counselling room available for ICTC :	☐ Yes ☐ No		
2. Waiting space for the individuals attending the ICTC	☐ Yes ☐ No	☐Adequate ☐ very small	
3. Adequate privacy is maintained during counselling	☐ Yes ☐ No		
4. Computer	☐ Yes ☐ No	☐ Regularly in use ☐ rarely in use☐ defunct	
5. Internet	☐ Yes ☐ No	☐ Regularly in use ☐ rarely in use☐ defunct	
6. Telephone Connectivity	☐ Yes ☐ No	☐ Regularly in use ☐ rarely in use☐ defunct	
7. TV/ DVD	☐ Yes ☐ No	☐ regularly in use ☐ rarely in use☐ defunct	
8. IEC materials displayed :	☐ Yes ☐ No	☐ Adequate ☐ in-adequate	
9. Whether signage & sign board available:	☐ Yes ☐ No		

Recording and Reporting at Counselling room			
Register	**Whether Exists? (Y/N)**	**Updated up to (dd/mm/yy)**	**Remarks (Reasons for backlog if any and suggested action)**
1. Counselling Register for General Individuals	☐ Yes ☐ No		
2. Counselling Register for Pregnant Women	☐ Yes ☐ No		
3. HIV-TB Line list register	☐ Yes ☐ No		
4. HIV-TB Register	☐ Yes ☐ No		
5. Any other register	☐ Yes ☐ No		Look for innovation
1. Is monthly SIMS report for previous three months sent to District before 5th of the month? (hard copy / soft copy in SIMS)	☐ Yes ☐ No	**If No, Reasons:**	
2. Whether reported in SIMS?	☐ Yes ☐ No	**If No, Reasons:**	
3. Is any monthly report pending since last one year?	☐ Yes ☐ No	**No. of monthly report pending:**	
		If No, Reasons:	

B. Laboratory room				
	Available/ Working	**No. in place**	**AMC (Y/N)**	**Remark**
1. Separate room available for Blood sample collection	☐ Yes ☐ No			
2. SOP is displayed at lab	☐ Yes ☐ No			
3. Refrigerator	☐ Yes ☐ No			
4. Whether refrigerator temperature log maintained twice a daily:	☐ Yes ☐ No			

5. Wash Basin available at laboratory	☐ Yes ☐ No			
6. Running water supply available	☐ Yes ☐ No			
7. Color coded Bins for waste disposal:	☐ Yes ☐ No			
8. Whether wastes are collected & disposed as per NACO Guidelines:	☐ Yes ☐ No			
9. Centrifuge	☐ Yes ☐ No			
10. Micro Pipettes	☐ Yes ☐ No			
11. Needle Destroyer	☐ Yes ☐ No			
12. Thermometer	☐ Yes ☐ No			
13. Colour coded Waste Disposal bins	☐ Yes ☐ No			
14. Sample transport box	☐ Yes ☐ No			
Recording and Reporting at LAB				
Register	**Whether Exists?**	**Updated up to (dd/mm/yy)**	**Remarks (Reasons for backlog if any and suggested action)**	
1. Lab Register	☐ Yes ☐ No			
2. Stock Register	☐ Yes ☐ No			
3. Temperature Log book	☐ Yes ☐ No			

Program updates		
A. Visit of ANC Out-patient Division:		
1. Number of days in a week that ANC clinic is functional in the hospital		
2. What is the Average daily ANC clinic attendance		
3. Who conducts the ANC clinic? *Gynecologist/ Doctor/ Nurse/ ANM/ Other: ……)*		
4. Who is the in-charge of ANC OPD/ Clinic		
5. Who is the in Charge of PPTCT center?		
6. If both are different how are the services for ANC/PPTCT coordinated		
B. HIV Counselling and testing:		
General Individual	**Number**	**%**
1. No. of General individuals attended ICTC in Last 3 months		
2. No. tested for HIV (out of above)		
3. No. Opted out for HIV testing		
4. No. found HIV positive (out of tested above)		
5. How many individuals received the HIV rest result within 7 days?		
6. No. registered at ART center (out of above)		
7. No. of HIV positive deaths reported in last three months		
Pregnant women:	**Number**	**%**
1. No. of ANC individuals attended ICTC in last 3 months		
2. No. Tested for HIV (out of above)		
3. No. opted out for HIV testing		
4. No. found HIV positive (out of tested above)		
5. How many individuals received the HIV rest result within 7 days? (out of tested above Sl. No. 2)		
6. No. registered at ART center (out of above)		
7. No. initiated on lifelong ART		
8. No. of Maternal deaths reported in last 3 months		
9. Does ANC essential package include HIV & Syphilis testing at visited centers?	☐ Yes ☐ No	
a. Are these tests done routinely for every pregnant woman? (or only for those prescribed by the doctor)	☐ Yes ☐ No	
b. What is blood collection approach for Syphilis & HIV test?	☐ Single Prick ☐ Multiple prick	
HIV positive Deliveries & ARV prophylaxis	**Number**	**%**
1. No. of MTP/abortion during last 3. months		
2. No. of HIV positive deliveries in last 3 months		
3. No. of still births (out of above)		
4. No. of Live births (out of above)		
5. No. of Babies initiated on ARV prophylaxis (6 weeks/12weeks) (out of above)		
6. No. of Home deliveries (out of above)		

Early infant Diagnosis (EID)		
1. No. of HIV exposed children tested under EID programme (using HIV-1 PCR test/Antibody test) in last 3 months		
2. No. of babies tested using HIV-1 PCR test during first visit		
3. No. of children detected positive in HIV-1 PCR test during last 3 months		
4. No. of children confirmed positive by HIV-1 test in last 3 months		
5. No. of babies initiated on Pediatric ART		
6. No. of Child deaths reported in last 3 months		
ICTC-RNTCP referral (Incl. Pregnant women)		
1. No. of individuals screened TB positive based on 4 symptoms (in last 3 months)		
2. No. tested for TB		
3. No. of TB cases detected		
4. No. of HIV-TB Co-infected cases (in last 3 months)		

Functional linkages between ANC clinic and PPTCT centre	
1. Is there a PPTCT centre functioning in your hospital in same premises as the ANC?	☐ **Yes** ☐ **No**
2. How is it ensured that every pregnant woman attending the ANC clinic for check-up reaches PPTCT centre and gets tested for HIV? *(Tick one or more options below. If any other, describe it in the blank)*	☐ Every pregnant woman is referred to PPTCT centre by doctor in ANC clinic, and the doctor verifies and ensures if HIV test results are available during next visit ☐ PPTCT Counselor sits in/close to ANC clinic and ensures that every pregnant woman comes for HIV counseling after ANC check-up ☐ Every pregnant woman is brought to PPTCT centre from ANC clinic by nurse/ out-reach worker/ hospital attendant (accompanied referral) ☐ Every pregnant woman first comes to the PPTCT centre and goes to ANC clinic for check-up only after registration at PPTCT centre ☐ ANC clinic & PPTCT centre work independently. Pregnant women come to PPTCT centre on their own. No specific procedures are employed. ☐ Any other mechanism:_____
3. How is HIV test results issued?	☐ Written on ANC Card ☐ Separate Report ☐ Both

Physical Verification of stocks

Name of the commodity	Is there Sufficient stock available? (Yes / No)	If Yes, for How many months?	Is storage condition appropriate? (Yes / No)	Remarks
1. HIV test kit 1	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
2. HIV test kit 2	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
3. HIV test kit 3	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
4. Whole Blood Finger Prick Test	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
5. Nevirapine Syrup	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
6. TLE	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
7. Safe Delivery kits	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
8. DBS Kit	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	
9. Syphilis Test kits	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	

2.1 Guidelines:	
1. Do you have any national guidelines/ circulars or orders from SACS or DAC for HIV testing and treatment?	☐ **Yes** ☐ **No**
2. Does the process at the facility differ from in the guidelines?	☐ **Yes** ☐ **No**
If yes, describe in details? _____ _____ _____	
2.2 Opinion on drop outs / cases not treated	
1. If individuals diagnosed with HIV are not registered with ARTc, what are the reasons for drop outs?	☐ Not willing ☐ Death ☐ Migrated ☐ Parent guardian decision ☐ other (Specify)_____
2. What would help to ensure that all individuals who need treatment receive it?	

IEC Material Availability (Look for state / district / facility level innovations):			
Is the IEC material available appropriate for HCTS services?			☐ **Yes** ☐ **No**
Details:_____ _____			
Sr. no	**Name of material**	**Type –Flip Chart etc**	**Whether being used**

2.3 Please note down any comments / remarks / feedback given by the persons from service delivery sites that they think are important to improve the quality of service delivery or any intervention that they have undertaken locally to increase the quality of services as well as the coverage. (This will be the provider perspective plus any suggestions and innovations from their end. Please also ask if they are aware of the new National guidelines, know the process of flow of the pregnant women , any training needs, counselling tools availability, etc… as guiding questions, if needed)

Annexure E5: Integrated 10 Points counselling Tool on TB/Drug Resistant TB

INTEGRATED 10 POINTS COUNSELLING TOOL ON TB/DRUG RESISTANT TB

1. Tuberculosis (TB) is the most common opportunistic Infection in people living with HTC (PLHIV) and leading cause of death in PLHIV.
2. Tuberculosis is an infectious disease caused predominantly by Mycobacterium Tuberculosis. The infection occurs most commonly through droplet nuclei generated by coughing, sneezing etc., inhaled via the respiratory route. TB usually affects the lungs, but may affect other parts of the body as well.
   - **An HIV negative person infected with TB has a 10% life-time risk of developing TB disease.**
   - **HIV increases the risk of progression from TB infection to TB disease and PLHIVs have a 60% lifetime risk of developing TB disease.**
3. Persons having cough of 2 weeks or more, with or without other symptoms, are referred to as pulmonary TB suspect (Presumptive TB case). They should have 2 sputum samples examined at Designated Microscopy Centre (DMC).
4. A person with extra-pulmonary TB may have symptoms related to the organs affected along with symptoms like enlarged cervical lymph modes, Chest pain, Pain and swelling of the joints etc. Extra-pulmonary TB can be confirmed by other investigations.
5. All people living with HIV should be regularly screened for TB using a clinical symptom-based algorithm consisting with any one of the symptoms of Cough of any duration, Fever, Weight loss or Night sweats at the time of initial presentation for HIV care and at every visit to a health facility or contact with a health-care worker afterwards.
6. Diagnosis and treatment services for TB are available free of cost through the Revised National TB Control Programme (RNTCP)
   - 2 sputum smear examinations are necessary for the diagnosis of pulmonary TB. During the course of treatment the progress is monitored by means of follow up sputum examinations.
   - Anti TB drugs are provided in patient-wise drug boxes, which ensure that the full course of treatment is available at the start of treatment. Treatment is provided by "DOT provider" at a place near the patient's home.
   - Cure from TB can only be ensured by taking complete and regular treatment. Without correct and complete treatment, a patient can become very ill or develop Drug resistant TB.
7. PLHIV diagnosed with TB should be linked to ART services at earliest, irrespective of CD4Count. Co-trimoxazole preventive therapy should be provided to all HIV-TB co-infected patients to prevent opportunistic infection.
8. An HIV/TB co-infected patient should be referred to nearest RNTCP certified Culture and Drug sensitivity laboratory facility/CBNAAT facility for diagnosis of Drug resistant TB.
9. The client's information is to be kept confidential and this information is not furnished under any circumstances to any other person except 'Shared confidentiality' with the treating physician and public health system DOT provider for better case management & to get benefit of prophylactic/treatment options available for him.
10. All TB/Drug resistant TB patients should maintain cough hygiene (putting a cloth onnose & mouth while coughing or sneezing) to prevent transmission of TB/DRTB.

Annexure E6: Cover Page & First page of All Registers

Name of the Register

Register No.

National AIDS Control Organization
Ministry of Health and Family Welfare
Government of India

ICTC Code : _____

ICTC Name : _____

State : _____

District : _____

Block : _____

Volume : _____

This is to certify that this register contains_____pages & starts w.e.f.___

Signature of ICTC In-charge

Annexure E7: Referral Slip from ICTC Counsellor to Lab Technician

Referral Slip *(Counsellor to Lab Technician)*	
Name of the Individual:	
Date of Pre test Counselling:	
PID number :	
Consent taken:	☐ Yes ☐ No
Signature of Counsellor	

Annexure E8: Contact details of officials of Basic Services Division at NACO

Sl.No	Name	Designation	Mobile No.	Office No.	E-mail id
1	Dr. K S Sachdeva	DDG(BSD)	9818038890		ks.sachdeva52@nic.in
2	Dr. Asha Hegde	NPO(ICTC)	9711845806	43509 921	ncpptct.naco@gmail.com
3	Dr. Rajesh Deshmukh	PO(HIV/TB)	9873753546	43616 644	pohivtb.naco@gmail.com
4	Dr. Sunny Swarnkar	PO(ICTC)	8860007771	43616 644	po.ictc.naco@gmail.com
5	Mr. Reneej K.B	TO(ICTC)	8010026372	43616 658	reneej.naco@gmail.com
6	Dr. Jyoti Sharma	TO(HIV-TB)	9891424885	43509 903	tohivtbnaco@gmail.com
7	Mr. Mubarak Ali	TO(PPTCT)	9999910622	43509 979	to.pptct.naco1@gmail.com
8	Dr. P. Sujith	TO(M&E)	7838407758	43509 979	to.me.naco1@gmail.com
9	Mr.Tejas Mulik	TA(PPTCT)	9999204579	43509 979	tejas.naco@gmail.com
10	Ms. Meena Arya	PA to DDG (BSD)	9868184722		

Annexure E9: Details of Basic Services Division In-charge at SACS

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1	Andaman & Nicobar Island	Dr. Tripti Banik	I/c, BSD	9531823828	tbanik78@gmail.com
2	Andhra Pradesh	Dr. Ch.A.Padmavathi	I/c, BSD	8008554281	bsdapsacs2015@gmail.com
3	Arunachal Pradesh	Dr. Annong Borang	DD(ICTC)	9436250778	dr.borang@gmail.com
4	Assam	Ms Rashmi Rekha Bhuyan	AD(ICTC)	9435515574	rrbhuyan1972@gmail.com
5	Bihar	Mr. Mithilesh Kumar Pandey	AD(ICTC)	9470836970	ad_ictc@bsacs.in
6	Chandigarh	Mr. Manjeet Singh Gulia	I/c, BSD	9876099199	chandigarhsacs@gmail.com
7	Chattisgarh	Mr. Kshitiz Diwan	AD(M&E)	9425204344	kshitizdiwan@rediffmail.com
8	Dadra and Nagar Haveli	Dr. Anita Mahajan	I/c, BSD	9574262984	dnhsacs@gmail.com
		Ms. Sapna Prasad	I/c, BSD	9904139689	sapnapra@gmail.com
9	Daman & Diu	Mr. Prasad Sant	I/c, BSD	9978930881	pdsant@yahoo.co.in
10	Delhi	Mr. B. C. Joshi	AD(ICTC)	9718513800	Dsacs.ictc@gmail.com
11	Goa	Patsmenia D'Costa /Dr. Marathe	I/c, BSD	0832-2427286	goaaids@gmail.com
12	Gujarat	Dr. Rajendra Gadhavi	JD(BSD)	9825068116	drrgadhavi@yahoo.com
13	Haryana	Dr. Suvir Saxena	I/c, BSD	9888196111	suvirsaxena2002@gmail.com
		Ms. Suman Rathi	AD(ICTC)	8901100811	rathi.suman1979@gmail.com
14	Himachal Pradesh	Dr. Rajesh Thakur	JD(BSD)	9816032406	drrajeshthakur@gmail.com
15	Jammu & Kashmir	Dr. Yash Karsyal	AD(ICTC)	9419642200	Jksacs.bsd@gmail.com
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18	Kerala	Dr Rebecca Thomas	AD(ICTC)	9496020813	adictc@ksacs.in
19	Lakshadweep	Mr.Koya Murthaza	AD(IEC)	9447959601	pdlacs@gmail.com
20	Madhya Pradesh	Mr. Prashant Malaiya	DD(ICTC)	9425863214	pmmpsacs@yahoo.co.in

Sl. No.	State/UT	Name	Designation	Mobile No	E-mail id
21	Maharashtra	Dr. Prakash B. Bhoi	JD(BSD)	9890116583	prakashbhoi7@gmail.com
22	Manipur	Dr. S. Ibungochouba Singh	DD(ICTC)	7085988497	manipursacsbsd@gmail.com
23	Meghalaya	Ms. Mamata Roy Choudhury Rymmai	AD(ICTC)	9774127134	meghalayasacs@gmail.com
24	Mizoram	Dr. Malsawmtluangi Ralte	DD(ICTC)	9436140927	msralte26@gmail.com
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26	Nagaland	Ms. Mhashelenu Nancy	AD(ICTC)	9436006371	mnancykhatso11@gmail.com
27	Orissa	Dr. Gyanabrata Mohanty	JD(BSD)	9437303005	osacsbsd@gmail.com
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28	Pondicherry	Ms. E. Mohana	QM	9092776503	qmlabservicespacs@gmail.com
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30	Rajasthan	Mr. Satveer Lamba	AD(ICTC)	9413505385	satveerlamba@gmail.com
31	Sikkim	Mr. Passang Tamang	AD (M&E)	9614898090	sikkimsacs@gmail.com
32	Tamil Nadu	Ms. R.M. Kalpana	AD (ICTC)	8939073952	adictc.tnsacs@gmail.com
33	Telangana	Mr. D.John Babu	APD, JD(BSD)/Ic	8332835440	apd.telanganasacs@gmail.com
34	Tripura	Mr. Alok Kumar Roy	AD(ICTC)	9436518455	alokkumarroy@yahoo.com
35	Uttar Pradesh	Dr. Preety Pathak	I/c, BSD	9415409772	preetypathak@yahoo.co.in
36	Uttarakhand	Mr. Sunil Kumar Singh	AD(ICTC)	9012240008	suniluasacs@gmail.com
37	West Bengal	Dr. S Soren	DD(ICTC)	8373036521	jdbsd.wbsapcs@gmail.com

Annexure E10: Details of PPTCT Consultant at SACS

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1	Assam	Dr. P D Baruah	9435342620	drpdbaruah@gmail.com,
2	Bihar	Mr. Ajit Sahi	9234600438	pptct.bihar@gmail.com
3	Delhi	Dr. Lopamudra Dutta	8872100134	pptct.dsacs@gmail.com
4	Jharkhand	Ms. Suganthira Sundaraj	9771185073	sugan_tamil@yahoo.co.in
5	Karnataka	Dr. Lalitha Hande	9845092303	lalithahande@gmail.com
6	Madhya Pradesh	Dr. Paras Gupta	9893576216	paras.unicef@gmail.com
7	Odisha	Ms. Trupti Mishra	9437268012	truptimish@yahoo.com
8	Rajasthan	Mr. Ravi Gupta	9460031891	guptabmc@gmail.com
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10	West Bengal	Dr. Suman Ganguly	9339431451	suman.pptct@gmail.com

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