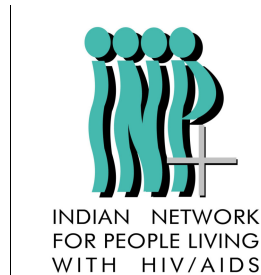


Review of the existing STD/HIV/AIDS training curriculum for doctors in Tamil Nadu

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Manorama Pinagapany, MD; DCH; *DM*¹, Murali Shanmugam, *MSW*²

1. Community Health Education Society (CHES), Chennai, India
2. Indian Network for People living with HIV/AIDS (INP+), Chennai, India

Study Supported by:

Asia Pacific Council of AIDS Service Organizations (APCASO), Malaysia



Contact details of INP+:

Indian Network for People Living with HIV/AIDS (INP+),
New No. 41 (Old No. 42/3),
Kalaimagal Nagar,
Second Main Road,
Ekkaduthangal, Chennai-600097. India
Phone: 91- 44 - 42641580
Web: www.inpplus.net
E-mail: inpplus@eth.net, inp@inpplus.net

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Abbreviations & Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APCASO	Asia Pacific Council of AIDS Service Organizations
ART	Anti Retroviral Treatment
ARV	Anti Retro Virus
CAA	Children Affected by AIDS
CBO	Community Based Organization
CD4	A glycoprotein on the surface of helper T cells that serves as a receptor for HIV
CHES	Community Health Education Society
DME	Directorate of Medical Education
FHI	Family Health International
FSW	Female Sex Worker
HIV	Human Immune Deficiency Virus
ICDS	Integrated Child Development Services
IEC	Information Education and Communication
IGP	Income Generation Program
IMR	Infant Mortality Rate
INP+	Indian Network for People Living with HIV/AIDS (INP+)
IPH	Institute of Public Health
IRDA	The Insurance Regulatory and Development Authority
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NACO	National AIDS Control Organization
NCC	National Cadet Corps
NGO	Non Government Organization
NSS	National Service Scheme
OI	Opportunistic Infection
OVC	Orphan Vulnerable Children
P24	Protein 24 antigen
PCR	Polymer Chain Reaction
PEP	Post Exposure Prophylaxis
PLHA	People Living with HIV / AIDS
PPTCT	Prevention of Parent to Child Transmission
PSG IMSR	PSG Institute of Medical Science & Research
RCH	Reproductive Child Health
RTH	Reproductive Tract Health
SHG	Self Help Group
STD	Sexually Transmitted Diseases
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children Fund
VCCTC	Voluntary Confidential Counseling and Testing Center

Table of Content

No.	Chapter heading	Page number
1	Proposed Plan of Action	6
2	Introduction	7
3	Aims and Objectives	8
4	Gaps in training schedule	9
5	Information on sexual risk assessment and risk reduction with reference to female/male sex workers and IVDUs	14
6	Information on women and pediatric issues	23
7	Information provided from human rights perspective	25
8	Information on ethical considerations	26
9	Gross Gaps	27
10	Recommendations	30
11	Conclusion	32

PROPOSED PLAN OF ACTION

Tool 1 – Desk review

Collection and analysis of existing information from TANSACS, APAC-VHS, CAPACS, I-TECH during desk review:

1. Standard curriculum from WHO or CDC or NACO will be used as a base
2. Necessary permissions, assistance and guidance will be obtained from all the agencies

Tool 2 – Primary data collection

1. Planned to collect information through one of the following ways:

1. Through personal interviews with officers of TANSACS, APAC-VHS, and I-Tech, Chennai
2. CETC institutes and
3. Some of the ace trainers
4. Document Case studies if any
5. Through email contacts for people who are unreachable

A questionnaire has been prepared and pre-tested. Technical support was obtained from the Project Advisory Committee of this project at INP+.

2. Planned to collect information from following groups:

- Representatives from APAC, TANSACS and I -Tech
- Trainers such as Dr. Usman and Dr. Shobana from KMC

Proposed Time Schedule for the Research

No.	Details of activity	Date of completion
1.	Concept note	11 th September 2007
2.	Finalization of the tools of data collection	12 th September 2007
3.	Pre testing of the tool of data collection	14 th September 2007
4.	Commencement of data collection	15 th September 2007
5.	Completion of data collection	25 th September 2007
6.	Data checking, editing and entry into computer	27 th September 2007
7.	Report Writing completion	4 th October 2007
8.	Submission of the draft Report	5 th October 2007
9.	Final report	10 th October 2007
10.	Dissemination of report	15 th October 2007

Review of the existing STD/HIV/AIDS training curriculum for doctors in Tamilnadu

Introduction

The first case of HIV/AIDS in India was reported in 1986. Since then India has become a country with a concentrated HIV epidemic. As the HIV epidemic continues its primary spread throughout developing countries of the world, the quality and effectiveness of interventions designed to reduce transmission are as critical as ever. After more than 15 years of fighting the epidemic, the worldwide track record is mixed: Some countries have documented success in curtailing new infections, while others continue to witness high incidence rates.

Soon after reporting of the first few HIV/AIDS cases in the state of Tamilnadu in 1986, Government recognized the seriousness of the problem and took a series of important measures to tackle the epidemic. Generating awareness about HIV/AIDS prevention services, and care, treatment and support of those infected and affected has always been critical to our efforts to stem the growth and spread of HIV/AIDS. Increasingly, evidence suggests that there is a need to move beyond awareness generation to behaviour change communication. Thus institutional strengthening, capacity building and training of health care professionals at the state and sub-state level are key objectives of the second phase of the National AIDS Control Programme. Training is used as a sustained tool to strengthen the capacity of NACO and the State AIDS Control Societies to respond to the long-term challenges posed by HIV/AIDS. Acquisition of knowledge on HIV and developmental skills help the health care providers in allaying fears and misconceptions regarding infectivity, and set the ground for the medical fraternity to reach out to communities through their services in an enabling environment free from discrimination. Given the broad spectrum of prevention management of HIV (human immunodeficiency virus) disease, HIV-related education is an important curriculum topic for all physicians.

Recent reports from Tamilnadu indicate that there are approximately 52,036 AIDS cases and around 1.65lakhs people living with HIV. In the absence of effective interventions, it is estimated that HIV prevalence could increase to become the leading cause of death in Tamilnadu within the next decade. This has led to calls to expand the role of the health care system to provide sexual and reproductive health services for people. An adequately informed, skilled and motivated health workforce is critical to meeting the needs of people on sexual health, but unless they too are supported, they may become a major systems constraint in scaling-up of services.

Hence Indian Network for People Living with HIV/AIDS (INP+) with support from Asia Pacific Council of AIDS Service Organizations (APCASO) would like to review the existing STD/HIV/AIDS training curriculum for doctors in Tamilnadu, identify gaps on risk reduction information, ethics and human rights, and develop recommendations to key stakeholders such as TN State AIDS Control Society (TANSACS), AIDS Prevention and Control (APAC) Project, CMC-Vellore, and I-TECH, Chennai for bridging the identified gaps.

Aim of this analysis:

Identify gaps in the existing STD/HIV/AIDS training curriculum for doctors in Tamilnadu and develop recommendations in the form of a report to key stakeholders such as TANSACS, APAC, CMC-Vellore, and I-TECH, Chennai for bridging the identified gaps.

Objectives:

- To identify gaps in the existing STD/HIV/AIDS training curriculum for doctors with reference to methodology
- To identify gaps in the existing STD/HIV/AIDS training curriculum for doctors with reference to risk reduction
- To identify gaps in the existing STD/HIV/AIDS training curriculum for doctors with reference to women and children and adolescents issues
- To identify gaps in the existing STD/HIV/AIDS training curriculum for doctors with reference to Human rights perspective
- To identify gaps in the existing STD/HIV/AIDS training curriculum for doctors with reference to ethical issues

Review of the existing STD/HIV/AIDS training programs for doctors:

For this gap analysis the author has selected 5 modules used by different agencies such as APAC-VHS-USAID, TANSACS and I-Tech. The following were considered for this study:

1. STD/HIV/AIDS Allopathic Private Practitioner Training module and its training by APAC¹- VHS – USAID IN Chennai
2. STDs/RTIs and HIV/AIDS resource manual and its training by TANSACS²
3. The training module on continuum of Care for health care providers by TANSACS
4. The I-Tech fellowship training curriculum and its training program by I-Tech- CDC
5. The NACO training module and training for medical officers³

An interview tool was prepared with technical support from INP+. Training supervisors and facilitators were contacted for personal interviews. The author met the following people:

1. Dr.N.Usman, Dr.Shobana and Dr.Raviraj William for the STD/HIV/AIDS Allopathic Private Practitioner Training module and its training by APAC- VHS – USAID in Chennai
2. Dr.P.K.Rajendran for the TANSAC trainings on STDs/RTIs and HIV/AIDS and on Continuum of Care for health care providers by TANSACS
3. Dr.G.Manoharan for the I-Tech fellowship training curriculum and its training program by I-Tech- CDC and the NACO training module and training for medical officers

¹ APAC – project is administrated by Voluntary Health Services, Chennai with financial assistance from United States Agency for International Development under bilateral agreement with the Government of India

² Tamilnadu State AIDS Control Society, Chennai

³ The Training module for medical officers on HIV care and treatment

Permission from respective project directors was also obtained. Since the spectrum of information varied, the following points were selected for consideration:

1. Gaps in the training schedule
2. Information on sexual risk assessment and risk reduction with reference to female/male sex workers and IVDUs
3. Information on women and pediatric issues
4. Information provided from human rights perspective
5. Information on ethical considerations

Training schedule

The present edition of APAC module is an updated version of the original module with additional topics such as clinical features and management of HIV/AIDS, PEP and PPTCT. This training program has been designed with an aim “to provide quality care for STIs.” APAC has collaborated with five institutions to train the various categories of health care providers. The same module has been used for all the groups of health care providers including the following:

1. Allopathic Private Practitioners
2. Registered Medical Practitioners
3. Pharmacists
4. Auxiliary Nurses
5. Midwives
6. Community health workers

Since this study is restricted to medical doctors, this report is restricted to the Allopathic Private Practitioners only. Three key trainers for this training were interviewed for this study, namely Dr.Shobana, Dr.Raviraj William, who is in-charge of one of the CETC, and Dr.Usman.

According to Dr.Raviraj William,⁴ the aim of this training is that the “selected doctors would provide the back-up service to implementing agencies for their STI and HIV/AIDS care” and according to Dr.Shobhana⁵ it is “to educate doctors on STD/HIV/AIDS manifestation, testing, prevention, and treatment protocols.” The module does not describe the role of NGOs nor the CETC. The module looks more like a pocket reference than a module.

Under the APAC training for doctors, the entire spectrum of disease prevention was dealt with in around six hours. How much the doctors will be able to grasp this delicate difficult and complex subject in just six hours is questionable.

These trainings reached doctors from the urban populations of Tamilnadu and Pondicherry territory. According to Dr.Raviraj William, these trainings are routinely held in hotels as a post-lunch session from 2-5 p.m, and usually were planned during weekends. Since it was difficult to get the doctors during the active listening hours such as the morning or early evening hours, there was no choice than to conduct this session

⁴ Dr.Raviraj Williams has been associated with APAC through his training Institute Christian Council for Rural Development and Research

⁵ Dr.Shobana has been associated with APAC physician training through TNVHA since 1998

during the post-lunch period. It is highly debatable whether this post-lunch hour is a suitable time especially when the doctor is sandwiched between their morning practice and the anxious moments before going to their evening practice. We need to think whether this really helps the doctors or the organizers. As per Dr.Shobana⁶ who has been training doctors over many years, says that this is an inappropriate time to capture one's attention. In contrast Dr.Raviraj contradicts this, saying that this is an appropriate time as evidenced by a 100% attendance on the second day of the training. Dr.Shobana disagrees by saying "rarely did we see the same people on the second day. Some dropped while a few added hearing about this training through their friends."

The second module in - this study is that from I-Tech. I-Tech {with technical support of CDC} conducts training for different groups of Health care providers such as:

- The Fellowship program for doctor
- The NACO trainings for the Medical officers
- The NACO trainings for the specialists

Each of these training have different schedule as given below:

- The Fellowship program for doctor is an intense training at the government hospital for Thoracic medicine Tambaram with linkage to clinical care and this training goes on for almost a full year
- The NACO trainings for the Medical officers is provided for two full weeks
- The NACO trainings for the specialists is for four full days

This concept of different schedule and different curriculum for different groups of health care providers is something ideal. There should be enough time for doctors to understand the curriculum so that it may help them to provide quality care to patients. The medical officers who opt for these trainings agree for a full-day course, unlike those attending the APAC training. These trainings are normally held at Government hospital for Thoracic medicine and at various places in India.

Each curriculum has their own goals and objectives; for example, the NACO curriculum is based on the goals and objectives formulated the NACO. According to Dr.Manoharan⁷ from I-Tech, there was separate curriculum for the doctors, nurses and other health care workers.

The module designed by I-Tech used for the training of junior doctors working in ART centers has a variety of approaches to teach and learn, with the underlying assumption that participants are adult learners who will take considerable responsibility for their own learning. The focus is on active learning and emphasizes the key knowledge and skills needed for Medical Officers caring for individuals living with HIV/AIDS.

TANSAC has 5 different kinds of training for doctors as follows:

1. Training on STD/HIV/RTI for doctors

⁷ Dr.G.Manoharan of I-Tech

2. Training on continuum of Care for HCPs
3. ART training for ART medical officers
4. Training on blood safety for medical officers in blood banks
5. Training on ICTC for doctors associated with testing centers

For this gap analysis, the first two modules in the above list were taken for consideration. While discussing - the training modules on continuum of care for HCPs with the joint director of TANSACS it was understood that there are 2 different kinds of training for doctors working in Government: one for those working under the Director of Medical Education and the other for those working at Primary Health Center. For those under medical education department and working at medical college, the training is just for one full day. It is really amazing how such a voluminous curriculum is covered in a day's time. But in contrast, training for those working at PHC is six days. This has been made so because those at PHC may have left to rural areas long back and may need more information as accessing information may be difficult at their locale. All trainings have been held at TANSACS. These trainings are mostly for doctors in Tamilnadu Medical services, but occasionally doctors from private practice also participate and both the groups cover only allopathic medical practitioners.

Dr.Rajendran⁸, who was met for this research study, explained the continuum of care training. He said that in 2005, 10 master trainers, who are stalwarts in the medical field and specialists of long-standing experience, were identified to conduct this massive Trainer of Trainers for doctors. These trainees who were trained by the master trainers continued the process of training of all doctors working under their respective departments from either medical college departments or from PHC. These trainings were made compulsory for all doctors in government services especially those who have completed their MBBS.

Trainers:

Trainers for all trainings are selected based on aptitude and the list included senior members of Medical Profession who are specialists in the subject, willing to practice participatory techniques. The training institutes have their own data base of resource persons for the all trainings.

Trainees

According to Dr.Shobana, the APAC training were meant for general practitioners but in practice it had a mixed group of private practitioners, gynecologist, surgeons, pediatricians, ENT, Ortho specialists, etc; However the forward text in the module talks about training general practitioners and the introduction chapter do describe the training of health care providers in general. The same module is used to train an entire spectrum of health care providers. This decision needs to be debated. Doctors should be the focus of this training since they provide direct medical care. Every training would cover 20-40 doctors and one-sixth were women candidates, according to Dr.Shobana while Dr.Ravi Raj William says it is about 33%.

TANSAC had aimed to train all government doctors and was successful in doing so but at times had doctors from private sector also. 30 to 40% of the trainees were women. So far 4900 doctors have been trained through both these trainings in smaller batches of 25 to 30 in each. Attendance has been 100% since it is mainly for government doctors.

⁸ Joint Director TANSACS

According to Dr.Rajendran 30 to 40% of the trainees are women. Both the trainings used the same module as base. Each curriculum has its own goals and objectives.

The I-Tech trainings were aimed and conducted for a specific group of fellows undergoing fellowship training or for doctors in ART centers. This training also gave good opportunity to women candidates.

Module design should be tailored to a specific group of people. Government doctors and private doctors have different systems of case follow up, referrals, diagnosis and management.

Follow up of training

Under the APAC training there is a pre- and post-evaluation. There are written evaluations plus there also are rapid questions. NGOs who identify the medical practitioners will also visit them every month and collect data on STD/HIV/AIDS. "Once a year APAC sends mock patients to understand the knowledge and attitude of doctors," says Dr. Shobhana. She also adds that nearly 75% of the trained doctors are also followed. For the same training, Dr.Raviraj William adds, the trainer meets the trained doctors once in six months, plus they also have annual Alumni meetings. But even with all that, he adds, the follow up was only 63%. The teams had a lot of difficulties - like meeting the busy doctor and finding time to talk to him or her leisurely.

According to Dr.Rajendran, since regular follow up was not feasible, TANSAC has hired ACNielsen (A private research firm in Chennai) at a cost of 7lakhs to evaluate the impact of the program. The report is yet to be released. This is a one- time follow up. It was decided to evaluate 400 TANSACS-trained doctors using the sampling technique. TANSAC officers also visited the trained doctors on and off, especially during their regular field visits.

As per Dr.Manoharan, almost 100% of 10,000 doctors trained have been followed up. According to Dr.Manoharan, "I-Tech has different follow up system for each of the training category; for example, the fellows are followed up by focus group discussions and individual contacts periodically. The NACO trainees are followed up periodically using the check list." He also adds that the follow up varies depending upon the program: every six months in the case of fellowship program and every three months in the case of NACO trainings. The NACO training for doctors has an excellent system of evaluation. There are pre- and post-test questionnaire, which measure the transfer of knowledge, plus there is daily feedback session.

Training curriculum

It was indeed a Himalayan task to review these 5 modules and compare them as each of the modules had different curriculum. However the key areas were taken for consideration and special interest was given to areas of our aims and objectives.

None of the modules had a facilitator guide. Reviewing the modules, one is not sure to what extent issues are discussed. For example, the Training module on continuum of care covers a lot of information in one day but the PHC training allows six days.

The APAC training module included chapters on Epidemiology, Problems in management of STI, Condoms, Testing centers and Counseling, PPTCT, Social and

ethical issues. It focuses more on prevention aspects with little emphasis on HIV Care. This module is more like a pocket reference material. The training had no participatory exercises or case study discussions nor did the training include field visits to STI clinic or HIV care centers. These visits would be valuable and also would reduce the boredom of sitting in a hall. Senior trainers did discuss their experience and provide case studies for discussion, says Dr.Usman⁹.

The TANSAC continuum of care module includes chapters on Epidemiology, Continuum of care, ICTC, Blood safety, STD, ART and OI, HIV &TB, Community home based care, Targeted interventions, Workplace and Universal precautions, Legal and ethical issues, and Monitoring system. This is an extensive resource for people working in HIV care with little emphasis on prevention. Even here the training was more of a lecture with no field visit. But the training curriculum of both the NACO and Fellowship has been designed as participatory hands-on discussions at the bedside, with case study discussions and case presentation at the clinical setting. Senior trainers did discuss their experience and provide case studies for discussion.

The Continuum of Care training for doctors is expected to make the participants understand the concept of continuum of care and formation of ICTC, to understand HIV/AIDS and also the intervention programs for prevention, care and support, to understand hospital care, community based care and linkages, to learn issues related to stigma and discrimination, legal and ethical issues, to understand the quality of counseling and testing services and the importance of scaling up services. The STD/RTI/HIV manual aims to inform physicians about the guidelines and protocols to be followed for effectively treating STIs/RTIs and HIV/AIDS.

The STD/RTI/HIV training module for doctors has chapters on Epidemiology of STD and HIV/AIDS, STDs, RTIs, Syndromic management of STDs, HIV/AIDS, Public health prevention and Sex and sex education. In the annexure there are STD management guidelines, reporting formats, etc. This module by TANSACS to train doctors on STD/HIV/RTI is again only a resource manual. This informs the physician about the guidelines and protocols to be followed for effectively treating STIs/RTIs and HIV/AIDS. Early diagnosis and effective treatment for STD/RTI is clearly the need of the hour. Keeping this in mind, this training program has been initiated. Since this is not in a training module form, one can only use this information as a resource material. It would also mean that it is not necessary that all information mentioned in this resource manual be used in a training program. Hence there is an urgent need to adapt this resource manual as a training module or one need to think if this can be kept as a resource manual itself and can be used as a supplementary reading material for trainings.

The Module followed by I-Tech is more clinically oriented with topics such as infection control, management of newly diagnosed patient, transmission and prevention of infection, basic science and pathogenesis, symptoms and system evaluation, acute infection, OIs, STD, ART, PPTCT, AIDS vaccine research, care and support, laboratory components, and diagnosis of HIV and OIs. In this module there is very little information on HIV prevention aspects or speaking on sexuality issues.

⁹ Dr.Usman is the retired professor of STD department Government General hospital Chennai and an ace trainer

The NACO training for doctors includes Universal Precautions and Biomedical Waste Management , Epidemiology of HIV , HIV Prevention, Infection Care and NACP III, Psychosocial Aspects and Counseling, testing Related to HIV , Natural History of HIV and Clinical Staging of HIV Infection, Clinical Pharmacology of ARV drugs , Impact of HAART, ART and its adherence Issues , Post-Exposure Prophylaxis, OIs, monitoring & Evaluation and Operational Guidelines , HIV and TB , PPTCT , Lab diagnosis, Children and HIV, pediatric ART, Palliative Care and Nutrition, Stigma, Discrimination, Legal and Ethical Issues in HIV/ AIDS Care .

Information on Sexual risk assessment and risk reduction

a. Information provided in the epidemiology chapter

In fact all modules have epidemiology as their first chapter. Normally information on disease progression, who can get it, how it is transmitted, how to avoid it, and statistical data are discussed in this chapter, which faithfully, most of them have done. But in **addition** there have been some **additional** points in each.

Under the epidemiology chapter, statistical data are outdated in all the modules. Since we don't update the modules every year, there could have been some additional update note to refer to changing trends with reference to NACO and other sources. It would also have been complete if the module had a note with the web addresses where one can look for more details regarding the changing trends. The estimates of HIV in all the modules are with reference to the global and Indian scenario. More thrust should have been given to Tamilnadu state statistics such as the number of HIV infected, men versus women ratio, children, different age groups , information on several studies undertaken with reference to sexually transmitted diseases, Reproductive infection in India and Tamilnadu, the community STD in Tamilnadu¹⁰, or the behaviour surveillance survey¹¹ could have been discussed here as these physicians will be able to understand the magnitude of the disease plus also understand their role in diagnosis and effective management as part of the disease prevention.

Most of these modules have been developed recently [after 2004]. It is surprising to note that still certain groups of people {commercial sex worker, trucker, cleaners, traveling men, construction workers, rickshaw pullers and hostel-based students} have been mentioned as more prone for HIV in the APAC module. This should have been avoided considering the stigma that is associated with the disease. Instead a phrase such as "those practicing high-risk behaviour or unsafe sex with unknown partners" could have been used. We have rich experience on the outcome of initiatives stereotyping certain groups as being responsible for spreading HIV. It has taken almost a decade to start overcoming this and we are yet to eradicate it altogether. Therefore such stigmatizing words need to be removed immediately.

While talking about HIV transmission, most of the information is inadequate. In the continuum of care and STD/RTI/HIV modules, transmission through the standard route has just been mentioned. In the NACO module, there has been special mention of four main factors which increase the risk of becoming infected through an act of unprotected sexual intercourse. These factors are: the likelihood that the sex partner is infected, the

¹⁰ Source APAC-VHS-USAID 1998

¹¹ Source APAC-VHS-USAID

type of sex act, the amount of virus present in the blood or sexual secretions (semen, vaginal or cervical secretions) of the infected partner, and the presence of other sexually-transmitted infections and/or genital lesions in either partner. This information is very important because it makes one understand why all unsafe sex has not brought the infection or why only few get infected even though many may practice unsafe sex. Even in the APAC module the same has been mentioned about the host factors, but it lacks clarity. Information on which route is more dangerous, why the sexual route is common even though the transmission rate is only less than 1%, why women are more prone than men, why anal sex is more dangerous, when HIV can spread through the oral route could be explained. Looking at the time constraint this valid information is brushed aside, saying doctors should know all this.

While discussing the prevention of HIV transmission, the APAC and the STD/RTI/HIV modules mention only the means by which HIV is transmitted. We need to spend more time discussing the sexual life and behaviour of a person. Only if a medical practitioner is able to know why someone choose this risky behaviour, only then can they compassionately treat as person with a STD or HIV. They should be exposed to the lifestyles of a sex worker or transgender or an intravenous drug user. The physician must learn why a sex worker values money more than her health in her profession, or what are the environmental causes leading to IVDU or what has led to homosexual behaviour (this implies homosexuality is “caused”). They must understand that probing questions on sexual behaviour alone is not going to make doctors understand the entire spectrum of the disease. Many times doctors, without understanding how difficult it is to change these behaviours, start preaching and expecting their patients to change at once, or they verbally abuse them and blame them for HIV. Sometime during their training doctors must meet these kinds of people and have an open discussion on their lifestyle, how they got into such risky behaviour, and why they are unable to overcome these behaviours inspite of knowing the outcome. They also should hear their clients' and their families' demands.

It would be ideal if there were detailed group discussions on host factors and risky situations including discussions on sexual behaviours, sex being everybody's right, challenges in changing sexual behavior, etc. From our experience we know that many doctors have the wrong notion of behaviour change. They normally think this means changing from multiple partner to abstinence and never think of condom use as an alternative. The session must capture a person's feelings while discussing their sexual behaviour. This is still more stigmatizing for a women who feels irked when questioned about sexual behaviour and when morality is linked with a STD, to bring the emotional feeling of a women with STD who is treated with suspicion of high risk behaviour could have been well brought here by asking the participants to do a role play and later asking them to explain how they felt being a sex worker and also how they felt when people spoke ill about her even though she had not done anything of that sort.

The group must be made to understand that many times women don't even know that they have a STI and that the husband the source. In the APAC module the discussion about susceptibility to HIV infection is general and refers only to anatomical, biological and serological. Efforts to explain the same would explain how women are more susceptible to the infection than men. They would understand how a woman is powerless with regards to condom usage or is unable to negotiate condom, or the woman is more prone to spouse abuse. As we are educating the medical doctors I think we need to explain more about the uterine walls, the position of the women during sex

and also the mucosa of the uterine wall, etc. Thus this would have explained how women are more prone.

When Dr.P.K.Rajendran, State epidemiologist of TANSACS, was asked about this, he said, “general information regarding sexual risk assessment among specific groups like those practicing high risk behaviour was discussed but not in details”¹² and he suggested probably a counselor would deal with this. Dr. Shobana also commented, “yes we do discuss about homosexual behaviour, condom use, people practicing high risk behaviour, sex practices and in particular about child sexual abuse.”¹³ She also adds that once or twice PLHA members, female sex workers, MSM and IVDU have provided talks in between the sessions. But these are not in the curriculum and are determined by the experience of the trainers. Dr.Raviraj William also agrees with them by saying, “Discussed, but superficially. More time could have been allocated”¹⁴ to this topic.

Dr.G.Manoharan claims a definite positive answer to this. In the I-Tech curriculum they go further and discuss about mobile, roaming vulnerable HIV positive persons.¹⁵

An individual’s decision to have safer sex is supported by an environment in which this is the norm. Young people’s decisions about when to start having sex and whether to use condoms are affected by family and community norms and peer pressure. An individual sex worker’s decision to have safer sex is supported if the brothel or area has a 100% condom use policy. It is jeopardized if the owner and the clients do not support the behaviour. Police harassment and arrest of people who carry condoms are environmental factors that have a direct impact on the person’s ability to sustain safer sex.¹⁶

This is a complex area. For people to avoid HIV infection they need the knowledge, the means and the power to remain safe. Many factors affect people’s power in this area. Women who do not have the power to discuss sex and HIV risk with their husbands or sexual partners may not be able to avoid HIV infection. Female and male sex workers who do not have adequate food and shelter for themselves and their families may not be able to refuse a client who wants to pay for unsafe sex. People using alcohol and other drugs may find it difficult to make sound decisions about safer sex. Marginalized women working illegally as sex workers may be more prone to sexual assault. The discussion on transmission has covered the sexual route. Discussion of other routes, especially needle sharing, has not gained importance.

In the APAC module in the epidemiology chapter there is a message about the low risk with needle stick injuries and it looks as if the whole issue has been dismissed. It is not enough if we alleviate the fear in the minds of young doctors, but we need to provide information about what to do when there is an accidental poke. Time again we have been seeing people get infected with needle stick injuries. Also I think we need to talk more about the risk a medical practitioner faces with reference to needle pricks instead

¹² Personal interview for this study

¹³ Personal interview for this study

¹⁴ Personal interview for this study

¹⁵ I-Tech HIV Fellowship curriculum

¹⁶ In the WHO National AIDS program management Submodule 6.1: Minimizing sexual transmission of HIV and other STIs 2007

of saying the incidence is low. They must realize at the end of the session that they are probably exposed to HIV without their knowledge. They must learn to follow the universal precautions and start using all barriers so as to protect themselves. This may raise an issue that they may refuse to treat HIV infected people. As trainers I think it is our responsibility to make them understand that if they fail to treat HIV infected people then they lose their practices because it is difficult to get each patients HIV status. Similarly one never thinks of how a patient who is knowledgeable feels when he comes to a doctor. He may think "does this doctor use universal precaution or is this doctor free from HIV?" We need to understand the plight of our patients instead of discriminating against them because they are HIV positive. Even the STD/RTI/HIV and AIDS module and Continuum of Care module fails to keep doctors informed on this.

In the Continuum of Care module, there has been inclusion of HIV testing with discussions on National testing policy, informed consent, confidentiality, and violation of human rights by conducting mandatory testing. Plus there is information on the district-wise mapping details of different target population in Tamilnadu, which would help the physicians understand the magnitude of the problem. Also in the Continuum of Care module there has been information on the major determinants of the HIV/AIDS epidemic which needs appreciation. When pains have been taken to provide these modules with reference materials, it is difficult to understand why there is no information on testing centers, OI clinics, ART centers or mention of informed consent and how to motivate a client to walk in to a testing center voluntarily. Also there has been no discussion on the rights of a person, his or her rights to health, to treatment, to decide about testing. Nowhere has it been mentioned that a patient has a right to express him/herself.

Similarly HIV impact has been discussed at the population and family level but not at the individual level. Only this will make the doctor understand the issue in a more empathetic way and address stigma reduction.

Last but not the least, one needs to discuss on HIV staging and the different classification based on WHO standards or CDC. Physicians must be trained to stage the disease because only then they will learn when to start ART.

b. Information provided on Sexually transmitted diseases

The next most common chapter is management of STD. APAC handles this as Problems in management of STI. There is mention of problems with reference to a patient's perspective. This is really good and it would have been even better if there were instructions in a box to doctors as follows:

- Be empathetic
- Good Client /Dr. relationship
- Be considerate
- Don't force them to talk about their sexual life.
- Don't look down on them
- They don't need our sympathy
- Don't exploit them
- Treat them as any patient
- Maintain confidentiality
- Don't over charge

- Speak in simple language
- Be practical in approach
- Syndrome based management is better
- Make them understand the risk
- Use the service of counselors –NGO
- Assure to keep promise –Partner
- Greet them with a smile

In the TANSAC STD/RTI/HIV training there is a special session on **STD clinical examination**. This is a very innovative thought. Though it cover issues related to men and women separately, it does not cover the ethical aspects in clinical care such as taking patients permission for examination, women attendee while examining a lady patient, etc. This manual is also quite unique because under **every STD disease** discussion there is, not only plenty of specific information regarding the disease, but also a note on counseling aspects, partner treatment, infection among children, different presentations in women, men and children, advice on follow-up, and prevention aspects such as hepatitis B vaccines.

In the same module, under the RTI section, care has been taken to talk about the reproductive defense mechanisms in particular about the women. There has been discussion on variations in efficiency of these defense mechanisms. The link between RTI/STD and fertility in women has also been discussed. One also needs to welcome the efforts taken by the authors to include chapters on referral system and a specific chapter on STD clinical setting. Care has been taken to keep doctors informed about the coordination between the STD department and the other allied departments such as laboratory services, testing centers, PPTCT and NGOs. Mentioning the personnel involved and their roles is also something much different from other manuals.

In the APAC trainings, there have been attempts to explain the challenges in diagnosis and management of STI in women. This is valuable but could have been explained better by separating the challenges in diagnosis and management from the outcomes of these issues if not well managed. Thus at the end of the session, the health care provider would understand his or her duty in effectively managing the STI which could otherwise lead to many other medical problems such as cancer, infertility, miscarriage, stillbirths, increase in fetal deaths, infant and child mortality and morbidity. They should also understand the word “manage” is not just treatment but ranges from prevention to cure.

All training could have also provided some STI photo folders or flash cards which the doctors would take with them and use it to explain to the patients in a take away kit.

Also to make the understanding much more clear, basics of anatomy and physiology with reference to the reproductive system could have been included.

When we talk about management skills we also need to talk about handling patients with dignity and more so the women patient and one need to stress here that a female nurse or the patient attendee should be along when the female patient is subjected to medical examination.

These have not been mentioned and doctors forget to remember their good old clinical practice ethics.

a. Psychosocial Support:

The next chapter to be considered is providing psychosocial support. While training physicians it is important to make them understand the need for psychosocial support as this disease is a chronic lifelong disease with no cure but can be prevented through one's behavior change. The impact of stigma and discrimination is enormous, weakness in prevention strategies in many countries has been the failure to target intensive prevention efforts to people who have been diagnosed with HIV and hence people with HIV need lifelong counseling support. This support can be initiated as a pretest counseling and can then move forward as a risk reduction counseling with provision of information on positive prevention including disclosure, informed consent, partner notification, secondary prevention to maintain well-being of people with HIV, sex positive efforts and delay disease progression, promotion of preventive behaviour among PLHA (Safer sex and safer injecting drug use behaviour among PLHA), post test counseling, counseling for positive living, nutritional, economical and ART counseling with stress on adherence to stay much longer without ART and then on first line averting drug resistance. This intense follow-up counseling is very difficult for a physician and hence may need the support of trained counselors or nurses trained in counseling skills. Often doctors are judgmental about the behavior of their clients and may start advising them on what is right or wrong or on moral behavior or morality. In doing so they fail to understand under what circumstances such high risk behaviours happen. This leads to a lot of confusion in the mind of the client who may switch to a quack who provides the best soul healing. This is not only against the medical ethics, it is inhumane. Such an approach will never contain such a disease which has no cure, is lifelong, and has high morbidity and mortality. We have seen that just by changing the attitude of doctors, patient flow to various care settings have improved.

According to Dr.P.K.Rajendran, "the session on counseling has been liked by most doctors who come for TANSACs training who felt as a new exposure"¹⁷ since the subject was new to them, as they had earlier practiced only judgmental attitudes. In the TANSAC STD/RTI/HIV training module counseling has been dealt with extensively. Here there is information on risk assessment and risk reduction. It discusses the competent caring counseling technique "GATHER – which stands for greet, ask, tell, help, explain and return."¹⁸ But there has been no mention of who should provide the support, when and where it should be provided, why peer counseling is effective, why people need counseling, etc.

In the continuum of care module there is a separate chapter on Integrated counseling and testing centers. Here they have vividly described the various groups and categories of HIV transmission, the role of counselors at ICTC, counseling goals, risk reduction, peer support, basic guidelines for counseling pre and post test counseling, counseling on positive result, continued counseling, supportive counseling, and counseling to care givers. This shows the need for continued counseling. Also it speaks well about the "opt in" concept for counseling and its linkage to ICTC. Counseling skills are critical for those serving people with HIV, but skills vary widely in depth and quality across settings. For example, the boundary between choice and coercion in provider-initiated HIV testing to

¹⁷ Personal interview with State Epidemiologist

¹⁸ STD/RTI/HIV and AIDS resource manual for doctors

women attending antenatal care may be blurred. As regards the way in which HIV testing should be offered, the proposed policy that pregnant women must routinely be offered an HIV test through either an “opt-in” or “opt-out” model is in fact still contested^{19 20 21}. The opt-in model offers all women the option of choosing whether to be tested while the opt-out model informs women that they will be tested for HIV unless they specifically state that they wish to opt out. The provider’s role is critical in explaining these options and in respecting people’s decision, especially in the case of less educated, poor or young women and men. However, the problem of the opt-out model is that it can be used to impose testing without informing women that they have the right to refuse^{22 23}. A Canadian study reported that despite policy to use the opt-out model with women in one centre, not all women seemed to know that they could opt out or even that they were being tested for HIV²⁴.

In the NACO module for physicians, there has been discussion on VCTC as the entry point for HIV-infected persons at a secondary or tertiary care level, as they are available only at most district headquarters as of today. If a person is found to be HIV-positive at the VCTC, the person is subsequently referred to appropriate areas to facilitate care. Once the person’s care issues are sorted out and a long term plan is made, the PLHA is referred to a lower level- to primary care, home care for further follow up. They can be subsequently referred back if they develop new problems that require special intervention (e.g., need for starting ART). There is interaction with NGOs, CBOs and other support groups to facilitate the process. The PLHA network can offer assistance in the form of peer support. This ensures that good quality care can be accessed by all PLHA. So here the emphasis is more with reference to care and support than in the STD chapters.

I-Tech module also deals with this. The best training could have brought some real case studies and the physicians should be allowed to talk of this. Many things are written but when it comes to action it is not happening. Once while training a group of counselor’s a role play was given. The counselor was asked to counsel a PLHA pregnant lady who has come with her discordant partner. When the dialogue rolled on the counselor started to talk to the spouse about the lady’s status without consent and the counselors who acted as the husband and wife were quick enough to find the mistake and started to fight with the counselor on breaking the confidentiality. Dr.Shobana said that such case studies were discussed some times and pitfalls were highlighted. In order to better serve the patients, physicians must understand basic principles and skills involved in

¹⁹ Asia-Pacific Network of People Living with HIV/AIDS. AIDS Discrimination in Asia, 2004. At: www.gnpplus.net/regions/human_rights_initiative.doc

²⁰ International Community of Women Living with HIV/AIDS. HIV positive women and human rights. ICW Vision Paper 4. London7 ICW, 2004.

²¹ Medrek M, Eckman AK, Yaremenko O, et al. Problems HIV-positive women face accessing reproductive health care in Ukraine. Abstract TuPeE5404, Bangkok: XV International Conference on AIDS, 2004.

²² Lindsey E. HIV-infected women and their families: psychosocial support and related issues. A literature review. Geneva7 WHO, 2003.

²³ Health and Development Network. Why we should oppose a return by stealth to the days of mandatory HIV testing. Newsletter. Bangkok: XV International Conference on AIDS 2004

²⁴ Margolese SL. HIV testing and pregnancy: protecting access to informed consent through community action in Canada. Poster abstract ThPeE7981. Bangkok: XV International Conference on AIDS, 2004.

counseling patients. The Specialist has an important role in counseling patients. People take the words of their doctors very seriously. Doctors should have effective communication skills not only to deliver basic medical information to patients but also to provide psychosocial support.

b. Condoms :

Generally in all the modules basic information on condoms has been provided but this will not sensitize the doctor enough. Still many senior lady doctors refuse to talk about condoms as if it is a prohibited word. To ease the situation while discussing about condoms and to bring down the difficulty which doctors feel while discussing about condoms there would have been some participatory less stigmatizing exercises such as the follows: run on

1. Naming the condoms – a participatory exercise
2. Discussion on condoms could have brought what myths a doctor has in his mind?
3. Condom demo which would make a doctor feel comfortable with condoms
4. Discussions on cultural barriers in talking about condoms
5. Different models and varieties could be shown as a demo or an exhibition and a doctor can go around and learn about them
6. Different situation on difficulties faced by a client in using a condom could have been done as a role play
7. More discussion on female condom and the right of the client to use condoms

All the above said points would have added value to this training session on condom promotion and would have emphasized the need for doctors to prescribe condoms. The session would have ended with distribution of penile models and condoms in attractive reusable condom kits.

Now coming back to the specific modules, the module prepared by APAC while discussing about when one should use condom, information on dual role of condom has been missed which may stigmatize the whole topic itself. Pains have been taken to address many of the frequently asked questions and why people fail to use condom, but the most important myth about condom use, that it does not give pleasure, should have been discussed in more depth. There could have been a demo comparing condom and surgical gloves to prove that one is able to feel the touch and hence this is a myth. In India doctors are considered like GOD and people will just listen to what doctors say. If a doctor needs to prescribe condoms then he must also know the myths associated with condom use.

While acknowledging the efforts taken in preparing the continuum of care module and including information on male and female condom and mentioning the dual use, under the learning objective it is said “whenever one indulges in sexual act, outside the marital territory the usage of condom is the most significant preventive measure for STIs/HIV”. This also has been stressed in the APAC module which is really not acceptable. Do we mean that condoms are meant only for this? Does this mean that a husband and his wife should not use a condom? This does not mean that a discordant couple need not use condoms. One must be very careful when such critical statements are made and it is the author’s responsibility to explain what he means by this. Otherwise it would disseminate the wrong meaning.

In the STD/RTI/HIV module condoms are mentioned along with other safer sex practices. I am a little worried whether this could bring down the importance of condom in prevention of disease and pregnancy. The other topics that have been missed are the role of condoms in STD prevention and the role of sex education in RTI prevention. As already said, still many senior lady doctors refuse to talk about condoms as if it is a prohibited word. There could be some participatory sessions of condom demos and discussions on cultural barriers, dual role of condom, the economic importance of condom in disease prevention. There can't be a manual on STD and RTI without the information on condoms. As said already these points can add value to the condom promotion and would have emphasized the need for doctors to prescribe condoms. The session would have ended with distribution of penile models and condoms in an attractive reusable condom kits.

c. Discussion on HIV testing

In the 5th session of APAC module, issues of testing, counseling, VCCTC and tests for STD have been discussed. One gross gap in all the modules and trainings is that there is no mention on number or location of testing centers or OI clinics or ART centers. This information can also include the names of PRAM – abbreviation needed doctors and their contact details, names of CBO or NGOS who could be associated or PLHA networks at various places, community care centers, etc. This will motivate the doctor to refer patients for their various needs instead of thinking that ART or medical management alone is not enough for providing care and support to the families affected by HIV/AIDS and at the end of the day the physician must also learn to cross refer families for various services to provide a comprehensive care. Run on

In the STD/RTI/HIV module and training, the battery of tests have been mentioned but there is no clarity as to when and why you do a test, which test should be done in which period, what tests are available or who should opt for HIV testing. This is a resource module and should not miss such details.

In the Continuum of Care module there has been good coverage on purpose and principles of HIV testing, informed consent, confidentiality, the different test, group discussions on the same, advantages of collection of result the same day and comparison between Eliza and Rapid.

The NACO module goes further and discusses issues with reference to Quality assurance (QA) and Quality Control (QC) procedures, which are very important in lab testing protocols to avoid erroneous test results.

Also there could have been a role-play of a situation between the client and doctor when the doctor is referring him for testing center. This would have helped the participants to learn how to motivate a client to walk in to a testing center voluntarily. This should also be followed by asking the same client when he returns after a test to ask for his experience to understand if the center has been handling the patient well and also the physician will be able to understand the emotional aspects of reaching to a testing center run on. Once I had the experience of walking to a petty shop and asking for a condom. Only then was I able to understand how difficult it is for a woman to reach a shop and ask for a condom. Several people looked at me, as if wondering why I needed a condom, and the shop keeper, a young boy, was very shy about providing me a pack.

Information on women and pediatric issues

Most modules did speak about women issues in a very superficial way. Most of the key trainers interviewed agreed that there were two areas that were considered while talking about women issues, one was on STD prevention and the other was on PPTCT program. Each are ends of different spectrum of disease and a physiological conditions.

We have learnt from experience that women who have never been engaged in HIV education have poor knowledge about STD/HIV/AIDS prevention and care, while those who have attended some community group meetings or had an opportunity to hear about this disease try their best to avoid such infection. This is best evident from the recent report by Hindu, which stated that “the consistently high levels of women’s participation in HIV counseling and testing programs remain a striking feature of the campaign against HIV/AIDS in Tamil Nadu. Women outnumbered men who reported at the 760 Integrated Counseling and Testing Centers (ICTC) established by the Tamil Nadu State AIDS Control Society (TANSACS), according to data released by it for the period between January and September this year.

About 2.65 lakh women turned up for the voluntary counseling and testing services as opposed to the 2.54 lakh men who opted for the important assessment. This is besides the over six lakh mothers who participated in the Prevention of Parent to Child Transmission Program.”²⁵

Even though women take responsibility, it is equally important to make the men become more responsible and responsive in this male dominant society. The physicians are the right people to motivate men to observe safe sex practices. Much of prevention needs to be dealt with from within this group. Because the doctor’s clinic is usually the first place where couples learn about their HIV status. This issue becomes very important when the couple is discordant.

For women, health is last in their day-to-day priority list. She tries to seek household remedies for all minor illness before visiting a health care provider and it is usual that she seeks medical treatment only when the illness becomes worse. She also consults her neighbours or good friends or grannies at home, who provide her a huge quantum of information, some of which is true while much is myth. For example, the common symptom of white discharge is treated as “HEAT” and women resort to many trials from washing their genitals with soda, lime or alcohol, to sitting on a hot rock or self medication, to buying over-the-counter drugs. Such issues have been missed from all the modules. Similarly the difference between a cervicitis and a vaginitis needs to be explained while speaking about per vaginal examination. It is also important to emphasis that women, especially sex workers, may refuse a speculum examination for fear of the instrumentation. Such women need to be counseled for the same prior to the examination and should be convinced for such a examination. For completion sake the physicians must also be told about having a female nurse while examining a female patient. These are a few key areas which, when practiced, develop good trust between the physician and the client.

²⁵ Date:01/12/2007 URL:

[25.http://www.thehindu.com/2007/12/01/stories/20071201421421100_](http://www.thehindu.com/2007/12/01/stories/20071201421421100_)

Looking at women and HIV with reference to risk reduction there has been discussion about female sex workers but the authors of all modules have failed to project the entire women population. This has been missed even in the Continuum of Care module. A lot of issues have not been touched on, such as how the woman struggles to tell her family about her STD or HIV status, what kind of discrimination she faces when she tells, what the impact of testing a woman before a couple is, how society reacts to a woman who has been tested, what difficulty a woman has coming to an STD clinic or a testing center, the right a woman has to either abort or continue her pregnancy, what rights she has to get a healthy HIV negative baby, what her feelings and fears are regarding breast feeding, whether she practices safe feeding techniques, what role the nurse plays in such support services in a clinical set up, is she provided with information on family planning/contraceptive options, whether there has been discussion on sexual health as a whole remain unclear in almost all modules. Most trainings cover information that can be obtained through adult learning but these practical or critical aspects need to be given more importance in the curriculum. The physician must learn that women are more prone to HIV and that the infection has a devastating effect on the life of a woman, who often loses the support of her husband's family and her own. She struggles for her children until she dies.

Even speaking to a woman about her sexual life is difficult for a male clinician. Women may have so many doubts which she cannot clear with a male clinician. There is a need for female physicians who can handle these issues. In practice women doctors are said to be more fault-finding than a male doctor. A woman is refrained from speaking about her sexuality issues. Many women refuse to be examined by a male doctor. According to Dr. Raviraj²⁶ a lady doctor deals with the training chapter "STD and woman." What is important is not that a lady doctor handles the session but that the medical examination be done by lady doctors who can empathize with women issues.

In the APAC module women and STI has been dealt as a separate chapter. Many key points have been identified such as the asymptomatic disease in women, why women are more prone, the complications being more in women, late treatment of symptoms in women, the presence of infection in antenatal period posing threat to the child in the womb, the incidence of cancer etc. This speaks to the seriousness of the illness in women. It would be more complete if attention were paid to including STD clinical examination in women, subjecting women for HIV test, and disclosure to spouse when the wife alone tests positive.

The STD/RTI/HIV and AIDS module covers special mention about gonococcal infection and mucopurulent cervicitis in women. Also while discussing about Reproductive tract infections, special care has been taken to explain the defense mechanisms of reproductive tract and variations in defense mechanisms. There is a separate chapter on HIV and pregnancy. Most of the information shared is from the point of medical aspects but not on the social aspects of a woman's life.

None of the trainings cover women sexuality issues or the myths and misconceptions associated with this disease. It is appreciable to note that the APAC training covers desensitization of the group in usage of sexual words like masturbation, vaginal, anal sex etc; but does this training sensitize a male clinician to ask the female patient whether she wants to be examined by a lady doctor, is a big question.

²⁶ Personal interview for this study

The training module used to train doctors on STD/RTI/HIV and AIDS, speaks about women issues with reference to a clinical examination. What would have been ideal is that both key points and clinical examination should have been clubbed together to make the physicians understand the issue in a better way.

Reducing sexual transmission of HIV and other STIs is not a simple matter of increasing the knowledge and awareness of individuals at risk. There are complex issues of power, poverty, economics and marginalization that need to be dealt with if safer sexual behaviours are to be adopted and sustained. For women to avoid HIV infection they need the knowledge, the means and the power to remain safe. Many factors affect women's power in this area such as women who do not have the power to discuss sex and HIV risk with their husbands or sexual partners may not be able to avoid HIV infection or Female sex workers who are in need of money to provide food for their children may not be able to refuse a client who wants to pay for unsafe sex or female sex workers using alcohol and other drugs may find it difficult to make sound decisions about safer sex or a marginalized women working illegally as sex workers may be more prone to sexual assault. An individual sex worker's decision to have safer sex is supported if the brothel or area has a 100% condom use policy. It is jeopardized if the owner and the clients do not support the behaviour. Police harassment and arrest of people who carry condoms are environmental factors that have a direct impact on the person's ability to sustain safer sex.²⁷

Thus information on women and STD/ HIV needs to gain more importance in disease prevention as they have no access to information; they have poor health seeking behaviour, and can be easily affected when compared to men.

While talking about risk of transmission under PPTCT there should have been inclusions on fetal factors also such as fetal blood sampling, amniocentesis, etc. One of the most successful programs in Tamilnadu is the PPTCT program and it has been successful because the medical experts and their team, including the counselor, have started to speak about involving Husbands, Infant feeding, Safe breast feeding, Abrupt weaning, the role of ART and getting HIV infection during postnatal period and breast feeding. But all these important points have been missed and while talking about vertical transmission we have started to use the acronym PPTCT and PMTCT has been dropped because it stigmatized women. The fact that most women get infection from their spouse needs to be emphasized.

Information provided from Human Rights perspective

From the point of human rights perspective there was a lot of debate and media reports on mandatory testing, and people with HIV being called AIDS patients. But today the PLHA networks have come in to play with such a force that one dares to go for mandatory testing. It took us almost two decades to move forward towards this routinization of HIV testing may actually lead to reducing stigma associated with this disease. With reference to testing clinicians must understand the need to request for a HIV test, the meaning of informed consent and confidentiality, the patients' rights to refuse a test meaning the willingness to treat the patient without a HIV test report, privacy issues in a testing center, handling the reports of a patient etc; "the concept of

²⁷ Publications_NAP_ module 6.1 Minimising sexual transmission of HIV and other STIs

volunteerism must remain at the heart of all testing strategies not only to be consistent with human rights principles, but also to ensure their public health benefit²⁸. But none of these important issues have been dealt considered in any of these trainings and it is very important to keep physician informed to motivate a client to walk in to a testing center voluntarily. Also there has been no discussion on the rights of a person, his or her rights to health, information, to treatment, to decide about testing and no where it has been mentioned that a patient has a right to express. Even in the STD/RTI/HIV module and the continuum of care module where HIV testing has been handled in a larger sense.

There should have been brainstorming session on the impact of forced testing, case studies of discriminations at hospital setting could have been discussed, there could be group discussion on the rights of a person, his or her rights to health, to treatment, to decide about testing and no where it has been mentioned that a patient has a right to express. There would have been a question in the pre and post-test about “ can the HIV status of a man be informed to his bride before marriage if the clinician comes to know his status or what is the role of the clinician when he knows that his HIV positive patient is going to marry”. Even in the STD/RTI/HIV module and the continuum of care module where HIV testing is discussed there are no such information. If these are going to be used as reference manual then they should be giving information on how to get these from web.

HIV/AIDS has been having devastating impact on the families affected by AIDS. Such families have been ostracized and many such families have faced different kinds of discrimination. Most of these stemmed from the hospital setting when a doctor refused treatment based on the HIV status. One is not sure whether at the end of this training the medical practitioners were aware of their responsibility in treating PLHA. In the APAC module the word commercial sex workers has been used. Long back this word has been dropped from use respecting the feeling of a sex worker and their rights, and instead we can use the terminology of female sex work or women in prostitution or women in sex work could be used.

Information on ethical considerations

A separate chapter on social and ethical issues needs appreciation in almost all modules. The continuum of care modules has dealt this extensively talking about ABC, domestic violence, discrimination against women, gender issues, disclosure, reproductive rights etc;

In the training for doctors on STD/RTI/HIV and AIDS by TANSACS specific issues have been dealt such as obligation to treat a person with HIV, mandatory testing, informed consent, confidentiality issues, notification of partners etc; but most of these issues have been left as open ended questions to the participants to discuss and find the most appropriate method. They have gone one step ahead speaking about euthanasia whether it is ethical and moral.

²⁸ Legal and thical issues chapter in the Continuum of Care module by TANSACS.

The APAC module also deals in depth with testing, but there has been no mention about testing in private labs, which have no counseling back up. Again here we also need to discuss or do a role play on how stigma affects a person emotions.

All the training focused on testing and care by health care providers. But there has been a large gap of limiting ethical issues only to testing. The duty of medical practitioner in curtailing the disease, the physician duty not only to treat a person living with HIV/AIDS but his responsibility in reducing mother to child transmission, his responsibility to adhere to universal precautions and follow strict guidelines in waste management, litigations with reference to malpractices, the health care providers role in dealing with infertility and providing artificial insemination, his role as a blood bank officer or as medical officer at a testing center, his role in preventing public health problems all need to be emphasized. Doctors should have been provided various legal cases that have been given verdict to learn more from the past.

It was a felt need that an introductory refreshing sessions on RTH of men and women [anatomy and physiology] will be helpful for practitioners who have been away from teaching sides for many years or have no time for referring.

Gross Gaps

Gaps in training schedule

- Time constraint in delivering messages
- Time varied from 6 hours to one year
- Quality of information shared was superficial and horizontal
- The same module was used to train all groups of health care providers
- Huge number of people trained but no structured systematic follow-up system
- No participatory approaches, group discussions, brain storming sessions
- No field visit
- Case discussion, clinical ward rounds or group work and role plays
- No facilitator guide
- Pre and post evaluation not done systematically

Gaps in Sexual risk assessment and risk reduction information

- Statistical data, Tamilnadu data, data on men, women and children are not updated
- Stigmatizing word are used to explain people who practice high risk behaviour
- Critical information on which route is more dangerous, why the sexual route is common, why women are more prone then men, why anal sex is more dangerous are missing
- Information on host factors with reference to HIV transmission, sexual behaviours, sex being everybody's right, challenges in changing sexual behavior missing, homosexual behaviour, condom use, people practicing high risk behaviour, Marginalized women working illegally as sex workers being more prone, sex practices and in particular about child sexual abuse, women being powerless and susceptible to HIV infection is missing

- Information on the importance of promoting preventive behaviour – safer sex and safer injecting drug use behaviour among PLHA is missing
- Information on the life style of people practicing high risk behaviour missing
- Use of alcohol and linkage to risky behaviour is missing
- Discussion of other routes, especially needle sharing, has not gained importance.
- Crucial information about what to do when there is an accidental poke is missing
- There is no information on testing centers, OI clinics, ART centers or mention of informed consent and how to motivate a client to walk in to a testing center voluntarily.
- Also there has been no discussion on the rights of a person, his or her rights to health, to treatment, to decide about testing. Nowhere has it been mentioned that a patient has a right to express him/herself.
- Similarly HIV impact has been discussed at the population and family level but not at the individual level.
- Physicians must be trained to stage the disease because only then they will learn when to start ART.
- The ethical aspects in clinical care such as taking patients permission for examination, women attendee while examining a lady patient, etc.
- Information on STD varies in all modules. Consistency is not there
- STD leading to cancer, infertility, miscarriage, stillbirths, increase in fetal deaths, infant and child mortality and morbidity not mentioned clearly.
- Counseling needs have not been well brought out. The relationship between counseling and behaviour change has also not been brought out. The role of counseling from pre and post test counseling, to risk reduction counseling, counseling for positive living, nutritional, economical and ART counseling including adherence have not been dealt.
- Importance of peer counseling has not been missed
- Information on HIV transmission, the role of counselors at ICTC, counseling goals, risk reduction, peer support, basic guidelines for counseling pre and post test counseling, counseling on positive result, continued counseling, supportive counseling, and counseling to care givers have all been missed.
- Non discriminating approach to condom is missing
- Myths about condom use not highlighted
- Condom demo as part of training not done
- Dual role of condom not mentioned
- Information on other contraceptive options not mentioned
- The other topics that have been missed are the role of condoms in STD prevention and the role of sex education in RTI prevention, cultural barriers, dual role of condom, the economic importance of condom in disease prevention and the need for doctor to prescribe condom is also missing
- There is no mention on number or location of testing centers or OI clinics or ART centers, PRAM doctors and their contact details, names of CBO or NGOS who could be associated or PLHA networks at various places, community care centers, etc.
- Inadequate information on choice of HIV test- which test for whom and when

Information on women and pediatric issues

- Information on women's knowledge about HIV and AIDS, how to make men more responsible, dealing with concordant and discordant couples have been missed.
- Information on household remedies sorted by woman, difference between a cervicitis and a vaginitis, the need to counsel women before speculum examination have missed
- The author has failed to project the entire woman community instead has projected only the sex workers community alone.
- A lot of issues have not been touched on, such as how the woman struggles to tell her family about her STD or HIV status, what kind of discrimination she faces when she tells, what the impact of testing a women before a couple is, how society reacts to a women who has been tested, what difficulty a women has coming to an STD clinic or a testing center, the right a women has to either abort or continue her pregnancy, what rights she has to get a healthy HIV negative baby, what her feelings and fears are regarding breast feeding, whether she practices safe feeding techniques, what role the nurse plays in such support services in a clinical set up.
- Practical or critical aspects have been given importance
- Difficulty a male clinician will face discussing with a woman about her sexual life or difficulties a women may have discussing the same with a male clinician has not been mentioned.
- Many key points such as asymptomatic disease in women, why women are more prone, the complications being more in women, late treatment of symptoms in women, the presence of infection in antenatal period posing threat to the child in the womb, the incidence of cancer, referring a woman for testing etc have not been highlighted
- Most of the information shared is from the point of medical aspects but not on the social aspects of a woman's life.
- None of the trainings cover women sexuality issues or the myths and misconceptions associated with this disease.
 - While talking about risk of transmission inclusions on fetal factors also such as fetal blood sampling, amniocentesis, have been missed.
 - Information on husband friendly antenatal clinics, Infant feeding, Safe breast feeding, abrupt weaning, the role of ART and getting HIV infection during postnatal period and breast feeding have been missed

Information provided from Human Rights perspective

- Information on when to subject a person for HIV testing , the meaning of voluntary testing informed consent and confidentiality, the patients' rights to refuse a test meaning the willingness to treat the patient without a HIV test report, privacy issues in a testing center, handling the reports of a patient have not been mentioned.
- There has been no mention about the impact of forced testing, case studies of discriminations at hospital setting, rights of a person, his or her rights to health, to treatment, to decide about testing has not been mentioned.
- One is not sure whether at the end of this training the medical practitioners were aware of their responsibility in treating PLHA.
- Stigmatizing words have been used

Information on ethical considerations

- Information on dealing with ABC, domestic violence, discrimination against women, gender issues, disclosure, reproductive rights have not been said in all trainings.
- Information on obligation to treat a person with HIV, mandatory testing, informed consent, confidentiality issues, notification of partners etc; but most of these issues have been left as open ended questions to the participants to discuss and find the most appropriate method.
- No mention about testing in private labs, which have no counseling back up.
- There has been a large gap of limiting ethical issues only to testing. The duty of medical practitioner in curtailing the disease, the physician duty not only to treat a person living with HIV/AIDS but his responsibility in reducing mother to child transmission, his responsibility to adhere to universal precautions and follow strict guidelines in waste management, litigations with reference to malpractices, the health care providers role in dealing with infertility and providing artificial insemination, his role as a blood bank officer or as medical officer at a testing center, his role in preventing public health problems all need to be emphasized.

Recommendations

- It was a felt need that an **introductory refreshing session on RTH** of men and women [anatomy and physiology] will be helpful for practitioners who have been away from teaching sides for many years or have no time for referring.
- **The module format** – To use standard formats such as the learning objective for each session, materials needed, Time allotted and the content.
- **Facilitator Guide** - There must be a separate facilitator guide specifying details such as who are the beneficiaries, training schedule, number of days, ground rules etc;
- **Training session** - The training sessions should have participatory exercises, or case study discussions or field visits to STI clinic or HIV care centers, which would add more value to the training. Role plays, Group discussions, brainstorming sessions.
- **Adequate time to** be provided for learning. Time constraint and variations to be sorted out. It may need minimum of three full days to learn about STD alone.
- **Separate modules** to be designed and used for different groups of health care providers.
- There must be **regular structured systematic follow up system**, with CME, workshops etc; **Pre and post evaluation to be done**
Provide web address to get more details on changing trends, ICTC, OI, ART centers, or contact details of locally available PRAM doctors, names of CBO or NGOS who could be associated or PLHA networks, community care centers could be added. **Statistical data, Tamilnadu data**, data on men, women and children to be updated through a news letter
- **Stigmatizing words** to be dropped
- Include discussion on all **routes of HIV transmission and behaviours**. Critical information on which route is more dangerous, why the sexual route is common, why women are more prone than men, why anal sex is more dangerous, information on host factors with reference to HIV transmission, sexual

- behaviours, sex being everybody's right, challenges in changing sexual behavior, homosexual behaviour, condom use, people practicing high risk behaviour, Marginalized women working illegally as sex workers being more prone, sex practices and in particular about child sexual abuse, women being powerless and susceptible to HIV infection to be added
- Representatives from female and male sex workers, PLHA, IVDU must provide **information on their life style**
 - Crucial information about what to do when there is an **accidental poke** to be mentioned
 - **HIV impact** needs to be discussed at the population, family and individual level.
 - Physicians must be trained to **stage the disease**
 - Since most of the modules **specify STD/HIV and AIDS prevention education** for allopathic medical practitioner, information on STD should not very much. However additional reading material can be attached to each module which could speak volumes in training the doctors.
 - The **impact of untreated STD** leading to various complications such as cancer, infertility, miscarriage, stillbirths, increase in fetal deaths, infant and child mortality and morbidity need to be added.
 - The **importance of Counseling** through a trained empathetic counselor and the relationship between counseling and behaviour change, the role of counseling from pre and post test counseling, the role of counselors at ICTC, counseling goals, risk reduction, peer support, basic guidelines for counseling, counseling on positive result, continued counseling, supportive counseling, and counseling to care giver, counseling for positive living, nutritional, economical and ART counseling including adherence need to be added.
 - Importance of **peer counseling** has not been missed
 - Regarding **condom education** a non discriminating approach, its dual role, myths associated with condom use and a demo highlighting how to use a condom should be included. The other topics such as the role of condoms in STD prevention and the role of sex education in RTI prevention, cultural barriers, the economic importance of condom in disease prevention and the need for doctor to prescribe condom need to be included
 - Adequate **information testing** such as choice of HIV tests, different tests, information on informed consent and how to motivate a client to walk in to a testing center voluntarily to be added
 - Regarding **women issues** information on social aspects of her life such as her knowledge about HIV and AIDS, how men role in disease prevention, dealing with concordant and discordant couples, information on household remedies sorted by woman, difference between a cervicitis and a vaginitis, counseling women before speculum examination, her struggles on disclosure STD or HIV status, discrimination faced by her, problems in testing her before her husband, discrimination faced by PLHA women, difficulty faced by a women accessing STD services, her right to either abort or continue her pregnancy, to get a healthy HIV negative baby, her feelings and fears are regarding breast feeding, issues of practicing safe feeding techniques, difficulty in discussing about her sexual life with a male clinician needs to be included.
 - Many key points such as asymptomatic disease in women, why women are more prone, the complications being more in women, late treatment of symptoms in women, the presence of infection in antenatal period posing threat to the child

- in the womb, the incidence of cancer, referring a woman for testing etc needs to be highlighted.
- While talking about risk of **vertical transmission** inclusions on fetal factors also such as fetal blood sampling, amniocentesis and information on husband friendly antenatal clinics, Infant feeding, Safe breast feeding, abrupt weaning, the role of ART and getting HIV infection during postnatal period and breast feeding need to be included. A separate chapter on Woman and HIV can bring in all those points.
 - Information on when to subject a person for HIV testing , the meaning of voluntary testing informed consent and confidentiality, the patients' rights to refuse a test meaning the willingness to treat the patient without a HIV test report, privacy issues in a testing center, handling the reports of a patient, impact of forced testing, case studies of discriminations at hospital setting, rights of a person, his or her rights to health, to treatment, to decide about testing needs to be mentioned.
 - This training should result in medical practitioners who are more **responsible to treat PLHA**.
 - The **ethical aspects** in clinical care such as taking patients permission for examination, women attendee while examining a lady patient, information on dealing with ABC, domestic violence, discrimination against women, gender issues, disclosure, reproductive rights, obligation to treat a person with HIV, mandatory testing, informed consent, confidentiality issues, notification of partners etc need to be included and done in a more participatory way;
 - **Scaling up testing services in private labs**, with counseling needs to be informed
 - The **duty of medical practitioner** in curtailing the disease, the physician duty not only to treat a person living with HIV/AIDS but his responsibility in reducing mother to child transmission, his responsibility to adhere to universal precautions and follow strict guidelines in waste management, litigations with reference to malpractices, the health care providers role in dealing with infertility and providing artificial insemination, his role as a blood bank officer or as medical officer at a testing center, his role in preventing public health problems all need to be emphasized.
 - **Provide kits to doctors** - containing STD photo folder, condom outlets, address of STD, ICTC, PPTCT, ART centers, few packs of condoms, penile model, address of local NGO for counseling support and list of resource people and their addresses for further contacts and clarifications.

Conclusion :

India's population surpassed 1 billion in 2001; 67% live in rural areas and 33% in urban areas. In areas that are more severely affected, the epidemic has started to challenge recent development achievements and to raise fundamental issues of human rights concerning people living with HIV/AIDS. The HIV/AIDS epidemic in India is heterogeneous; it seems to be following the type 4 pattern, where the epidemic shifts from the most vulnerable populations (such as sex workers, injecting drug users and men who have sex with men) to bridge populations (clients of sex workers, people with sexually transmitted infection and partners of drug users) and then to the general population. The shift usually occurs when the prevalence in the first group exceeds 5%, with a two- to three-year time lag between shifts from one group to another. The spread of HIV is as diverse as the societal patterns between India's different regions, states and metropolitan areas. A total of 111 districts in 18 states are currently considered high

prevalence districts. The transmission route is predominantly heterosexual (more than 85%), except in the northeastern states, where injecting drug use is the main route of HIV transmission. What the country needs to do is to act now and make sure that good treatment is available to all who require the same. India has the drugs and the manpower all it needs is to train the different group of health care providers including the caregivers.