Study on Situation Assessment of Availability of PPTCT Services in Nagaur District of Rajasthan

By

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Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2014-2016

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Priyanka Sharma** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Piramal Swasthya Management and Research Institute, Jaipur from February 16' to April 16'.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.
I wish him all success in all his future endeavors.

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Certificate of completion of dissertation

This gives me immense pleasure to certify that Dr. Priyanka Sharma, student of MBA Hospital and Health management at the IIHMR University, Jaipur has successfully completed her dissertation titled " Situation assessment of availability of PPTCT services at government hospitals in Nagaur district of Rajasthan". The dissertation was carried out by me in my work capacity as District Officer representing Piramal Swasthya Management and Research Institute(PSMRI).

Dr. Priyanka Sharma is committed, sincere and a diligent person with sharp analytical skills. I wish her all the success in her future endeavors.

Mr. Dhruv Kulshrestha

Project Co-ordinator

Ahana Project (Improving Access to Public Sector PPTCT Services in India- part of multi state program on increasing PPTCT uptake in EAG states of India)

Date of letter issued – 02/05/2016

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Situation assessment of availability of PPTCT services in Nagaur district of Rajasthan** and submitted by Dr. Priyanka Sharma Enrollment No. **0195** under the supervision of **Professor Dr. Anoop Khanna** for award of MBA Hospital and Health Management of the Institute carried out during the period from **2th February 2016** to **30th April 2016** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Dr. Priyanka Sharma

Priyanka Sharma

Signature

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ACKNOWLEDGEMENT

It gives me immense pleasure to remember the moments when my teachers, seniors and batch mates were extending their support and guidance to me. I feel highly fortunate to express my deep sense of gratitude to all of them at this moment.

At the outset I feel great pleasure to express my sincere regards to Dr. Anoop Khanna, Professor, IIHMR University for his incessant moral boosting, inspiring encouragement, patients and ever readiness to help. It is my privilege to work under his dynamic supervision.

I am sincerely thankful to Mr.Pankaj Mathur and Dhruv Kulshrestha (Project co ordinator) Piramal Swasthya Management and Research Institute, my external guide who lent me a caring and supporting hand throughout my dissertation period.

It gives me immense pleasure to express gratitude and thanks to my family and friends, which constantly fostered me for my efforts during this learning period and made me free from all the responsibilities.

I am thankful to the faculty at IIHMR University, Jaipur for providing me the invaluable learning experience.

Last but not least I would like to thank god for all that I achieve every day by his grace.

Priyanka Sharma

PREFACE

Dissertation is an integral part of the MBA curriculum. As a part of course; students of the second year are required to undergo summer training at an organization to get in depth exposure of the organization and understanding of the health care delivery system.

The major objective of the dissertation programs are to better understand the existing health delivery system, observe the implementation of various National Health Programs at National/State/District levels, understand various functions of health systems by interactions with key stakeholders, policy makers program managers, academicians and researchers and work on the project/task assigned by summer training organizations.

During our training period we had an opportunity to work for Piramal Swasthya Management and Research Institute, Jaipur (Rajasthan) in their ongoing project AHANA.

List of Abbreviations

S. No.	Abbreviation	Full Form
1	**AIDS**	Acquired Immune Deficiency Syndrome
2	**ANC**	Ante Natal Care
3	**ANM**	Auxiliary Nurse Midwife
4	**ART**	Antiretroviral therapy
5	**DBS**	Dried blood spot
6	**DIL**	Direct in labour
7	**EBF**	Exclusive breast feeding
8	**EID**	Early infant diagnosis
9	**CPT**	Cotrimoxazole prophylactic therapy
10	**PPTCT**	Prevention-of parent –to-child –transmission of HIV
11	**NVP**	Nevirapine
12	**LHV**	Lady Health Visitor
13	**MO**	Medical Officer
14	**NACO**	National AIDS control organisation
15	**NRHM**	National rural health mission
16	**NGO**	Non Government Organization
17	**WBFPT**	Whole blood finger prick test
18	**FICTC**	Facility integrated counselling and testing centre
19	**OIs**	Opportunistic infections
20	**PHC**	Primary Health Centre
21	**ICTC**	Integrated counselling and testing centre
22	**RPR**	Rapid Plasma Reagin
23	**RTI**	Reproductive Tract Infections
24	**VCT**	Voluntary counselling and testing
25	**STI**	Sexual Tract Infections
26	**UN**	United Nations
27	**UNICEF**	United Nations Children's Fund
28	**VDRL**	Venereal Disease Research Laboratory

Dissertation

Background:

There are an estimated 2.1 million (2011) People Living with HIV (PLHIV) in India, with National adult HIV prevalence of 0.27% (2011). Of these, women constitute 39% of all PLHIV while children less than 15 years of age constitute 7% of all infections.

As on March 2013, 0.1 million HIV positive children had been registered under the antiretroviral therapy (ART) programme and 38,579 are receiving free ART. There has been a significant scale-up of HIV counselling & testing, Prevention of Parent-to-Child Transmission (PPTCT) and ART services across the country over last five years. Between 2004 and 2013, the number of pregnant women tested annually under the Prevention of Parent-To-Child –Transmission (PPTCT) programme increased from 0.8 million to 8.83 million and reach of the services has expanded to the rural areas to a large extent.

Concurrently, there has also been a significant decentralisation and scale-up of the ART services; with 7.34 Lakhs PLHIV receiving free ART across the country through 409 ART centres and 860 Link-ART centres (LAC).

Mother-to-child-transmission of HIV is a major route of HIV infection in children. However, out of an estimated 27 million pregnancies in a year, only about 52.7% attend health services for skilled care during child birth in India. Of those who availed health services, 8.83 million ANCs received HIV counselling and testing (March 2013) out of which 12,551 pregnant women were detected to be HIV positive. To enhance this coverage, a joint directive from the National AIDS Control Programme (NACP) and the National Rural Health Mission (NRHM) regarding convergence of the two programme components was issued in July 2010, explicitly stating that universal HIV screening should be included as an integral component of routine ANC check-up. The objective was to ensure that pregnant women who are diagnosed with HIV would be linked to HIV services for their own health as well as to ensure: p**revention of HIV transmission to newborn babies under the PPTCT programme.**

In the absence of any intervention, a substantial proportion of children born to women living with HIV, acquire HIV infection from their mothers either during pregnancy, labour/delivery or during breastfeeding. *Without any intervention*, the risk of transmission of HIV from infected pregnant women to her children is estimated to be around 20-45%. Use of ART and sd NVP/Sy NVP to mother-baby pairs has shown to be quite effective in reducing this transmission a s l o w a s 10 per cent. Use of single dose Nevirapine (sd-NVP) at the onset of labour signifiantly reduces pre-partum HIV transmission. However, it is less effective than other available ARV prophylaxis and it does not cover the risk of HIV transmission during the antenatal or breastfeeding periods. Further, it also adds to the risk of acquiring drug resistance to nevirapine (NVP) as well as cross resistance to Efavirenz (NNRTIs).

1. Providing lifelong ART to all the pregnant and breastfeeding women living with HIV regardless of CD4 count or clinical stage OR
2. Providing ART (ARV drugs) for pregnant and breastfeeding women with HIV during the mother to-child transmission risk period and then continuing life-long ART for those women eligible for treatment for their own health.

Government of India is committed to work towards achievement of the global target of "elimination of new HIV infections among children" by 2015.

Based on the new guidelines from WHO (June 2013),Department of AIDS Control has decided to provide life-long ART (triple drug regimen) for all pregnant and breast feeding women living with HIV, in which all pregnant women living with HIV receive a triple drug ART regimen regardless of CD4 count or WHO clinical stage, both for their own health and to prevent vertical HIV transmission from mother-to-child. This would also help in maximising coverage for those needing treatment for keeping them alive and for their own health, avoiding stopping and starting drugs with repeat pregnancies, provide early protection against mother-to-child transmission in future pregnancies and avoiding drug resistance.

These recommendations have the potential to reduce the risk of mother-to-child-transmission to less than 5 per cent in breastfeeding populations.

The Goals of the PPTCT Programme

In line with WHO standards for a comprehensive strategy, the National PPTCT programme recognises the four elements integral to preventing HIV transmission among women and children. These are:

Prong 1: Primary prevention of HIV, especially among women of child bearing age.
Prong 2: Preventing unintended pregnancies among women living with HIV.
Prong 3: Prevent HIV transmission from pregnant women infected with HIV to their child.
Prong 4: Provide care, support and treatment to women living with HIV, her children and family in women in child bearing age.

The National PPTCT programme adopts a public health approach to provide these services to pregnant women and their children. This approach seeks to ensure equitable access to high-quality PPTCT services at the grass-root level while taking into account what is feasible on a large-scale within available health infrastructure, human and financial resources.

The essential package of services under the PPTCT programme

The PPTCT services provide access to all pregnant women for HIV diagnostic, prevention, care and treatment services. As such, the key goal is to ensure the integrated PPTCT services delivery with existing Reproductive & Child Health (RCH) programme.

- Routine offer of HIV counselling (Group/Individual counselling) and testing to all pregnant women attending antenatal care, with 'opt out' option.

- Ensure involvement of spouse & other family members and move from an "ANC Centric" to a "family centric" approach.

- Promote institutional deliveries of all HIV infected pregnant women (ANMs/ASHAs, Community workers to accompany to institutions; reduction of stigma and discrimination amongst health care providers through capacity building).

- Provision of care for associated conditions (STI/RTI, TB & other opportunistic infections (OIs).

- Provide appropriate ART or ARV prophylactic regimen to the HIV infected pregnant women based on the medical assessment, CD4 Count and WHO clinical Staging.

- Provide nutrition counselling and psychosocial support for HIV infected pregnant women (Linkages with ANM, ASHAs, Community outreach workers, DLNs to advise them on the right foods to take and to go to Anganwadi Centres for nutritional support and to the district level network of Positive People for peer counselling and psycho-social support).

- Provide counselling and support for initiation of exclusive breastfeeds within an hour of delivery as the preferred Option and continue for 6 months. After 6 months, complementary feeding should be given along with breastfeed. Only a small number of babies born to HIV infected mothers who have serious illness or have died and a few reluctant mothers (who at their own risk despite of counselling) not to breastfed but adopt exclusive replacement feeding.

- Provide antiretroviral prophylaxis to infants from birth up to minimum 6 weeks. Integrate follow-up of HIV-exposed infants into routine healthcare services including immunisation.

- Ensure initiation of Co-trimoxazole Prophylactic Therapy (CPT) and Early Infant Diagnosis (EID) using HIV-DNA PCR at 6 weeks of age onwards as per the EID guidelines.

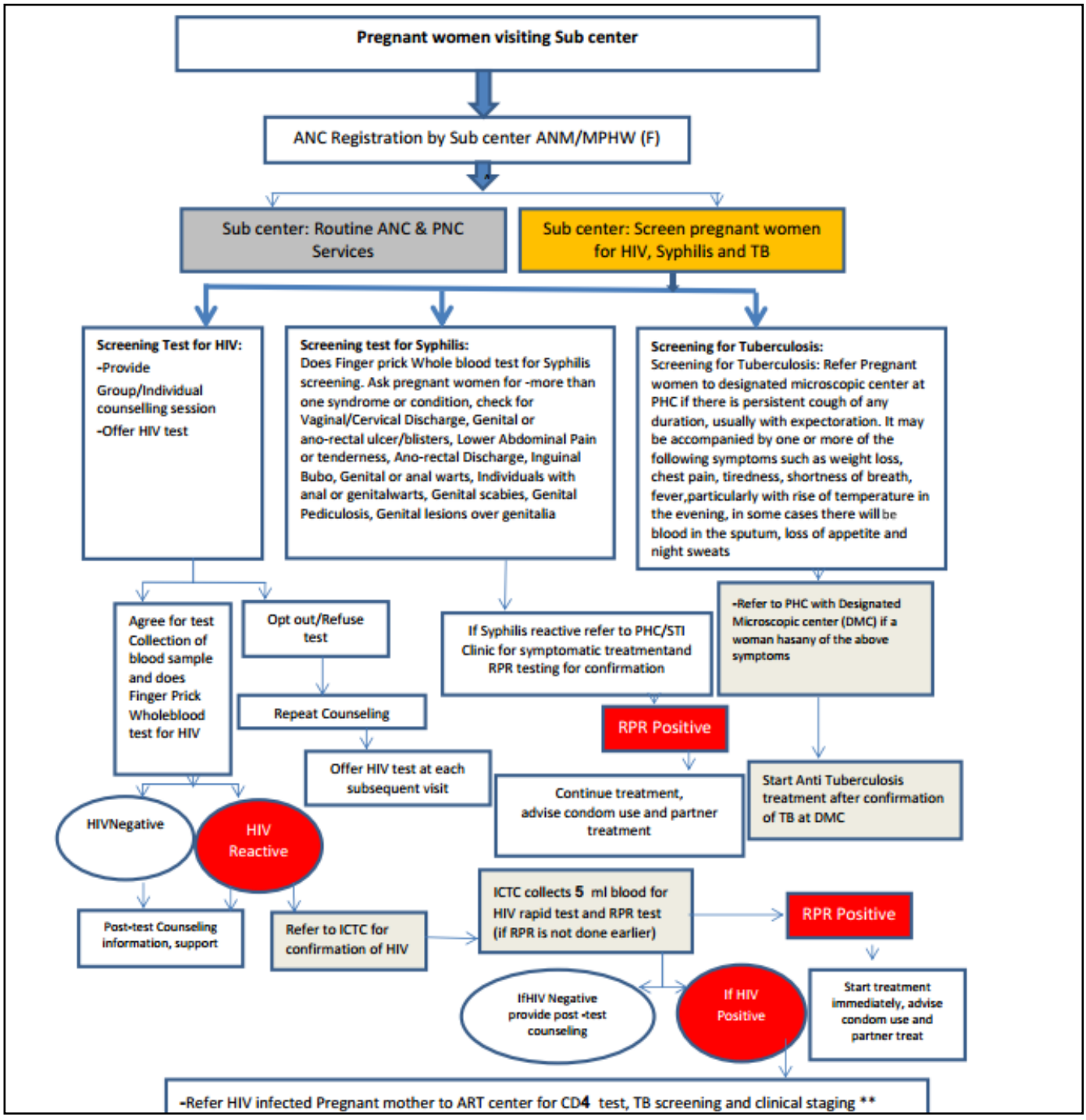
- Strengthen follow up and outreach through ANMs, ASHA and District level networks and other outreach workers to support HIV infected pregnant women and their family.

Existing facilities

➢

Under the National AIDS Control Programme, various HIV related services are provided through public and private health providers depending on the programme need and the availability of health infrastructure, human resource and their expertise.

Services to Pregnant Women during Antenatal Period



The PPTCT services are provided through the Integrated Counselling and Testing Centres (ICTCs) which are of the following types:

1. **Stand Alone ICTCs**: These are HIV counselling and testing facilities supported by NACPT in the form of staff (Counsellor & Lab Tech) and necessary logistic support. These centres perform confirmatory tests for HIV. Typically these centres are located at Medical Colleges, District Hospitals, Taluk Hospitals and Community Health Centres.

Available ICTC in Nagaur District

Nagaur	DISTRICT HOSPITAL (G)
Nagaur	Govet. Hospital Kuchaman City
Nagaur	GOVT. BANGAR HOSPITAL
Nagaur	GOVT. HOSPITAL (P)

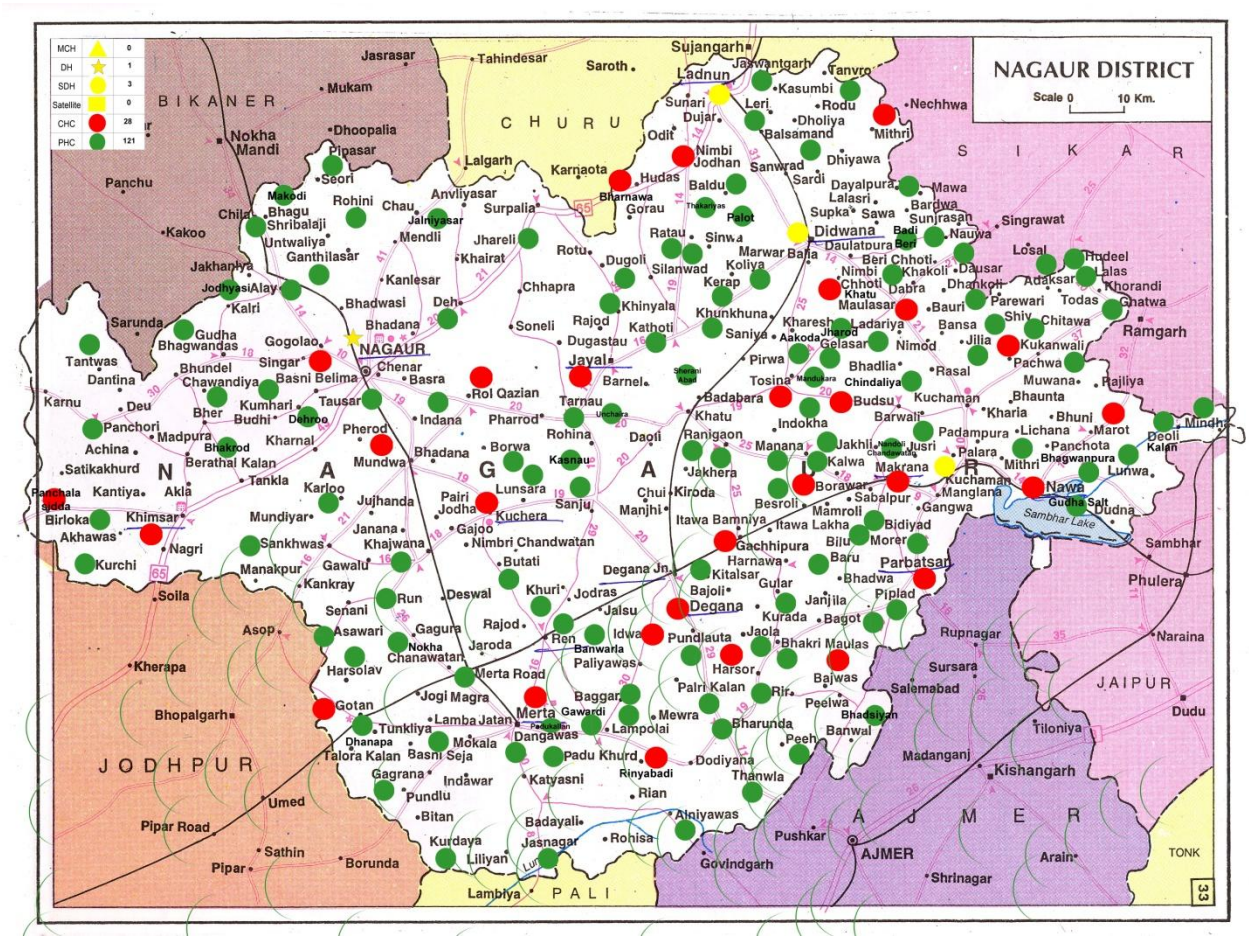
2. **Facility Integrated ICTCs (FICTCs)**: These are facilities where the staff – (Staff Nurses and Lab Technicians) from existing health facilities are trained in counselling and testing, and service delivery is ensured with provision of HIV testing kits from the NACP. These centres perform only screening test for HIV using Rapid HIV test kits and any client found positive on screening is referred to stand-alone ICTC for confirmation. Typically these centres are located at PHCs. The private/NGO facilities also function under this model.

Available FICTC in Nagaur

Nagaur	Jayal	FICTC, CHC, Jayal
Nagaur	Ladnu	FICTC, CHC, Nimbijodha
Nagaur	Makrana	FICTC, CHC, Makrana
Nagaur	Mundwa	FICTC,CHC,Kuchera
Nagaur	Mundwa	FICTC,CHC,Mundwa
Nagaur	Mundwa	FICTC,CHC,Khinwasar
Nagaur	Parbatsar	FICTC, CHC, Parbatsar

3. **Screening Centres**: These are health facilities where the Auxillary Nurse Midwives (Now called Jr.Health Assistant (F)) from existing health facilities are trained in counselling and screening for HIV through whole blood finger prick test. These centres perform only screening test for HIV through whole blood finger prick test (WBFPT) and any client found positive through this screening is referred to Stand-Alone ICTCs for confirmation. Typically, these centres are located at PHCs and Sub Centres.

Map of health facilities in Nagaur District



ART centre in Nagaur

- Nagaur district hospital

Link ART center

- Kuchaman hospital
- Deedwana hospital

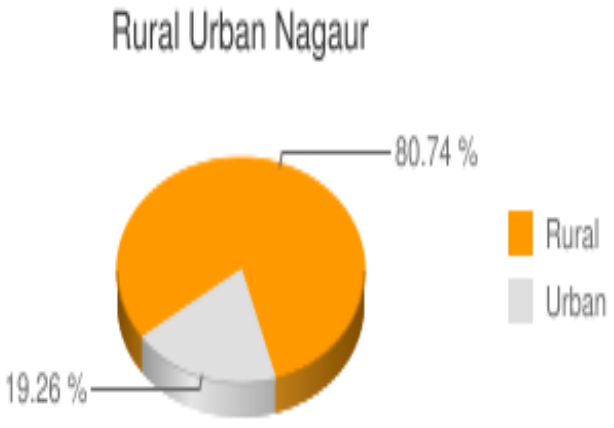
Nagaur District

Census 2011 data

- An official Census 2011 detail of Nagaur, a district of Rajasthan has been released by Directorate of Census Operations in Rajasthan. Enumeration of key persons was also done by census officials in Nagaur.
- In 2011, Nagaur had population of 3,307,743 of which male and female were 1,696,325 and 1,611,418 respectively.
- In 2001 census, Nagaur had a population of 2,775,058 of which males were 1,424,967 and remaining 1,350,091 were females.

Description	2011	2001
Actual Population	3,307,743	2,775,058
Male	1,696,325	1,424,967
Female	1,611,418	1,350,091
Population Growth	19.20%	26.65%
Area Sq. Km	17,718	17,718
Density/km2	187	157
Proportion to Rajasthan Population	4.83%	4.91%
Sex Ratio (Per 1000)	950	947
Child Sex Ratio (0-6 Age)	897	915
Average Literacy	62.80	57.28

Male Literacy	77.17	74.10
Female Literacy	47.82	39.67
Total Child Population (0-6 Age)	507,176	526,511
Male Population (0-6 Age)	267,391	274,933
Female Population (0-6 Age)	239,785	251,578
Literates	1,758,624	1,287,921
Male Literates	1,102,750	852,126
Female Literates	655,874	435,795
Child Proportion (0-6 Age)	15.33%	18.97%
Boys Proportion (0-6 Age)	15.76%	19.29%
Girls Proportion (0-6 Age)	14.88%	18.63%



Research Question:

1. What is the availability of PPTCT services (Screening and treatment) in Nagaur of Rajasthan?

Objectives of the study

- To study the availability and utilization of PPTCT services in Nagaur district.
- To conduct a situational analysis in terms of logistic and training of staff for PPTCT services in Nagaur district.
- To identify the gaps and problems in delivery of PPTCT services and suggest solution for them.

Research Methodology

Study type- Descriptive study, cross sectional
Study Duration- 3 months
Study Area- CHCs
District- Nagaur

Selection criteria- Less HIV screening among pregnant women

Study Respondents- Medical officer, ANMs, LHVs, Lab technicians, PPTCT counsellor

Sample Size -
Sampling technique - } all 28 CHCs covered

Data collection:

Observation: By health facility visit regarding availability of kit for HIV screening, training of lab technician for doing this testing and availability of Lab at these CHCs.

Records and RCH register: data about HIV screening is collected by meeting ANM and lab technician and done verification by data entry in their register.

Data collection tool: situation need assessment checklist and other format to collect HIV screening

Data Analysis: The collected data was analyzed and accordingly required tables and graphs were generated and interpreted.

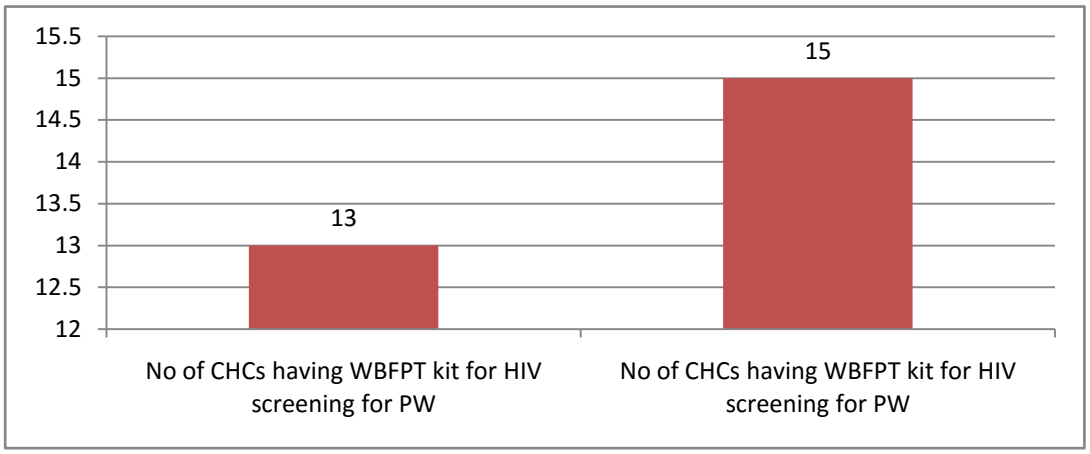
Work Plan:

S No.	Tasks	Timeline	Duration
1)	Document study	15th March 16 to 21st 16	7 days
2)	Development of study design and tools	22nd March 16 to 2nd April 16	12 days
3)	Field testing of tools	3rd April 16 to 8th April 16	6 days
4)	data collection	Feb to april	3 months
5)	Data entry	23rd April 16 to 27th April 16	5 days
6)	Data analysis	28th April 16 to 3rd May 16	6 days
7)	Finalization of Data And Report writing	4th May 16 to11th May 16	8 days

Results

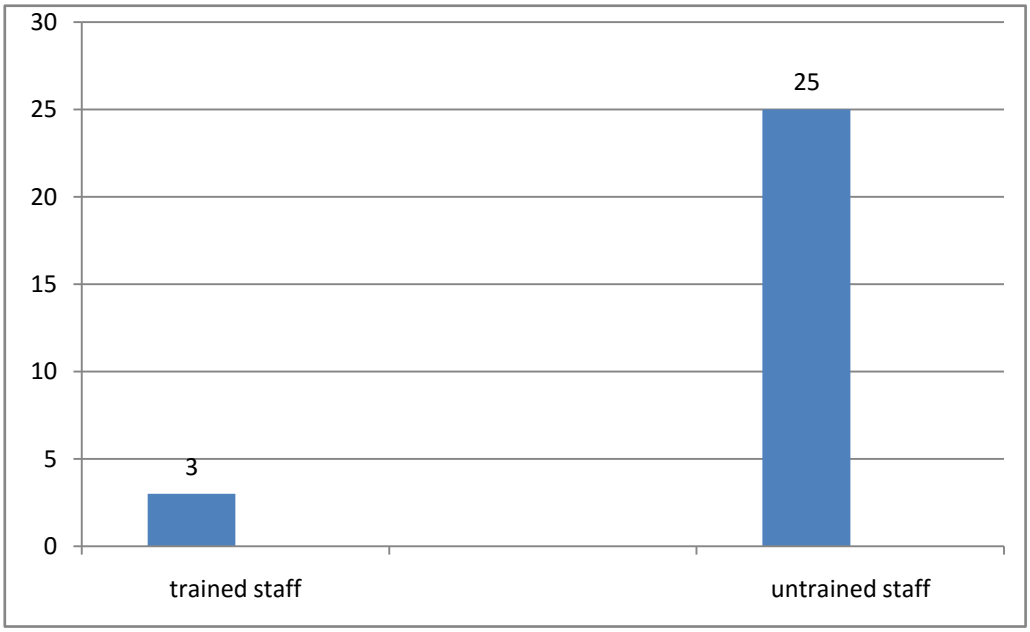
WBFPT Kit Availability at CHCs

The analysis from all CHCs has revealed that only 13 CHCs are having WBFPT HIV screening kit that is less than 50% CHCs are having HIV screening kit which is very surprising when we are focusing that all Pregnant women should be screened for HIV so we can achieve ZERO infection in children.

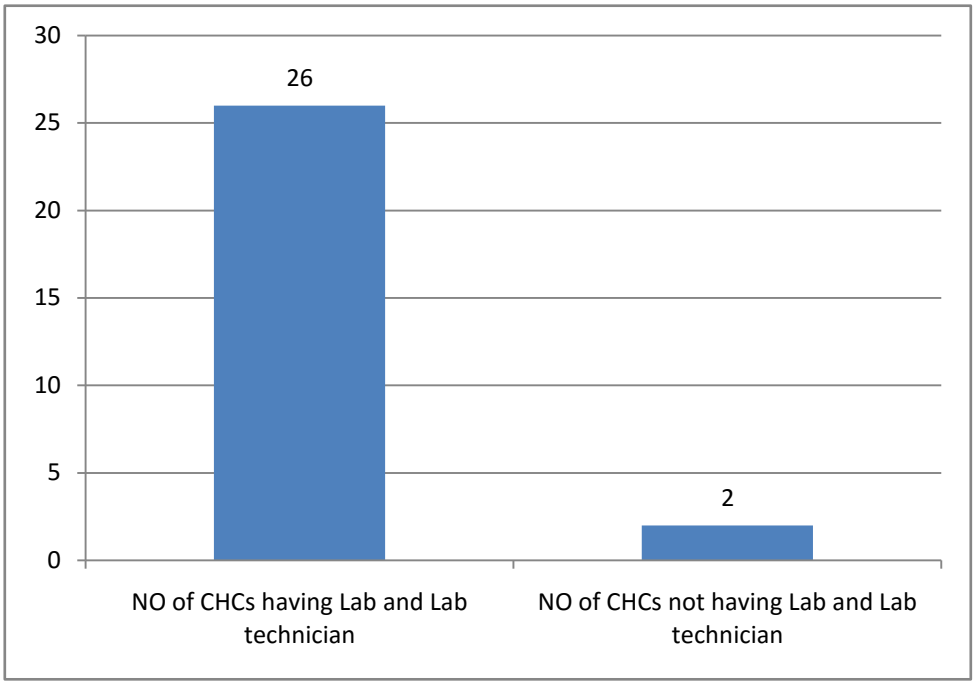


Availability of trained staff

The analysis about training of Laboratory technician about WBFPT(whole blood finger prick test) HIV testing procedure ,only 10% lab technician are trained for this HIV screening kit.
This is the situation of CHCs, so what we can expect from our PHCs and Sub centre.



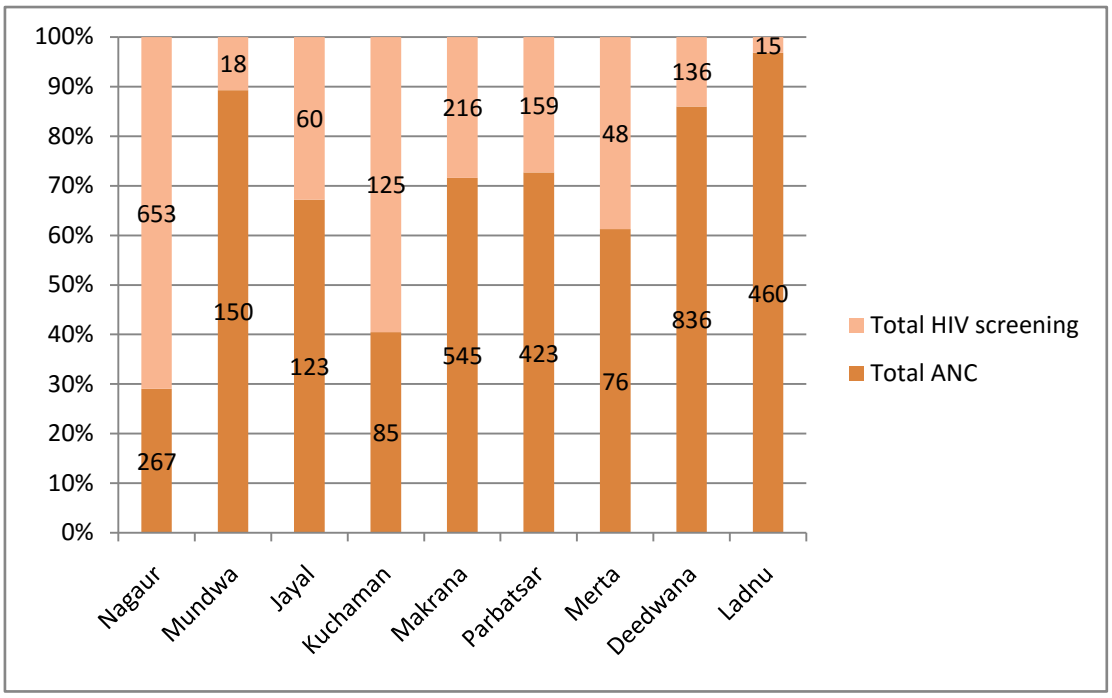
Availability of labs & lab technician



The above analysis is telling about the availability of laboratory facility ,which is good but still two CHCs are not having laboratory facility which is alarming ,so work on availability of infrastructure is mandatory and should be the prior concern.

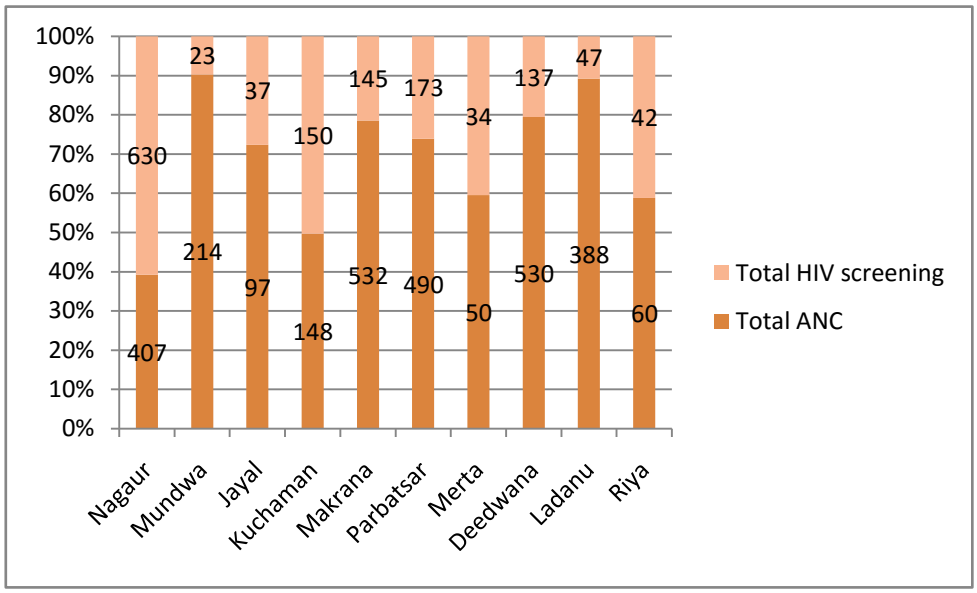
Data collected for HIV screening in Nagaur district

(January 2016)



In month of January the **situation of** HIV screening is very low as compared to ANC registered on different CHC in Nagaur District.

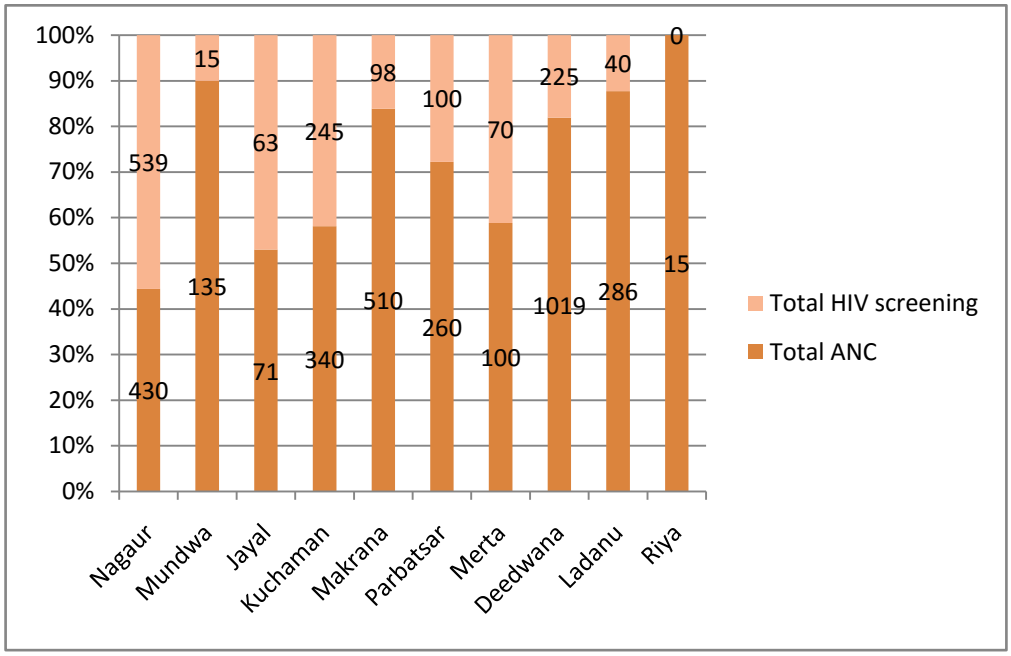
February



During project intervention it is visible that HIV screening is increased a bit in Nagaur district, the intervention were community mobilization meetings to create awareness in peripheral health staff about importance of HIV screening of pregnant women.

Advocacy is done at Block and CHC level to motivate and to give priority to this HIV screening to prevent transmission in children.

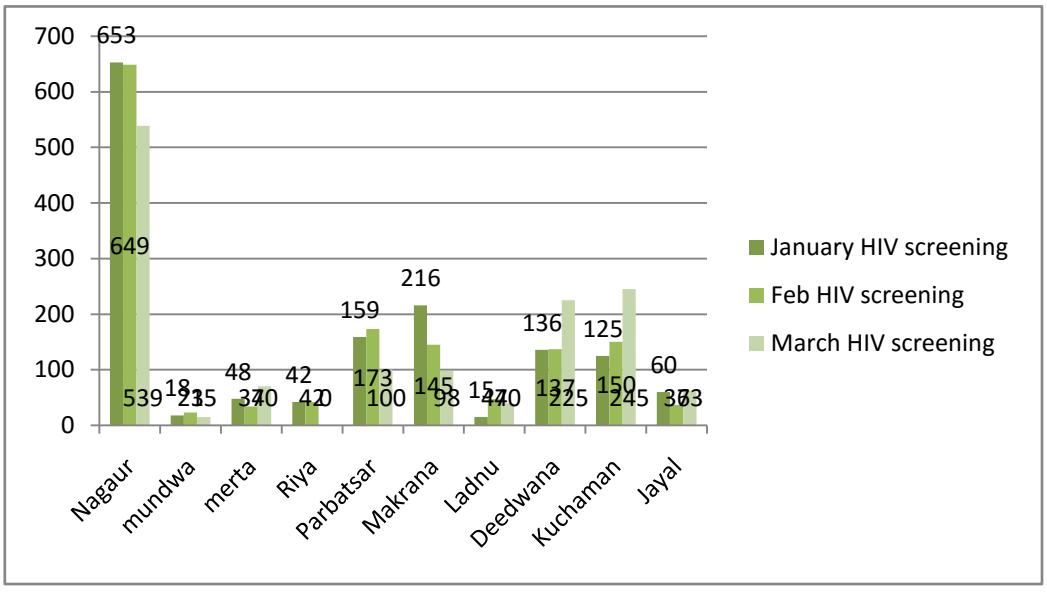
March



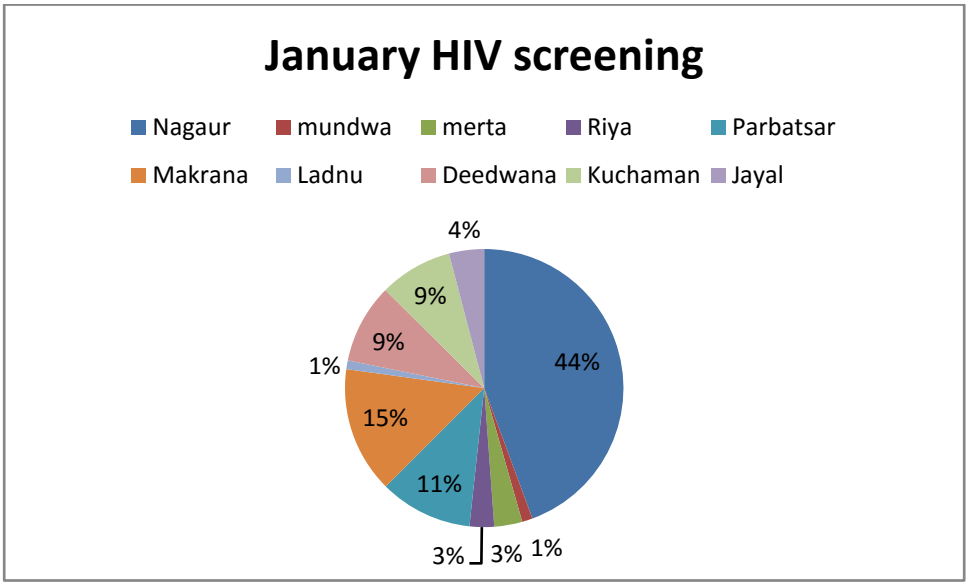
In month of March the HIV screening of pregnant women was less, tried to find out the reason for that

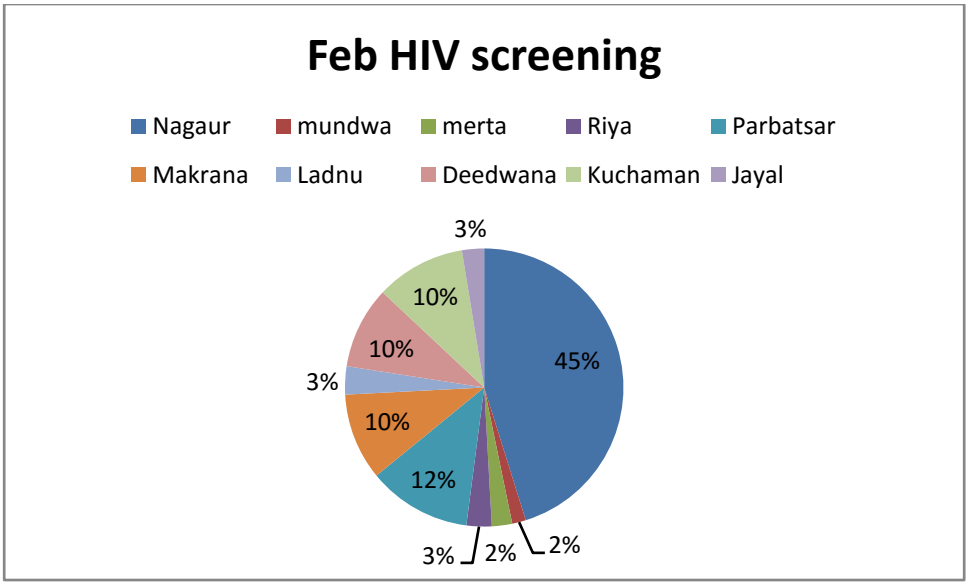
- At some CHCs the kit supply was less as compared to demand.
- Lots of holiday in this month(lab technician)

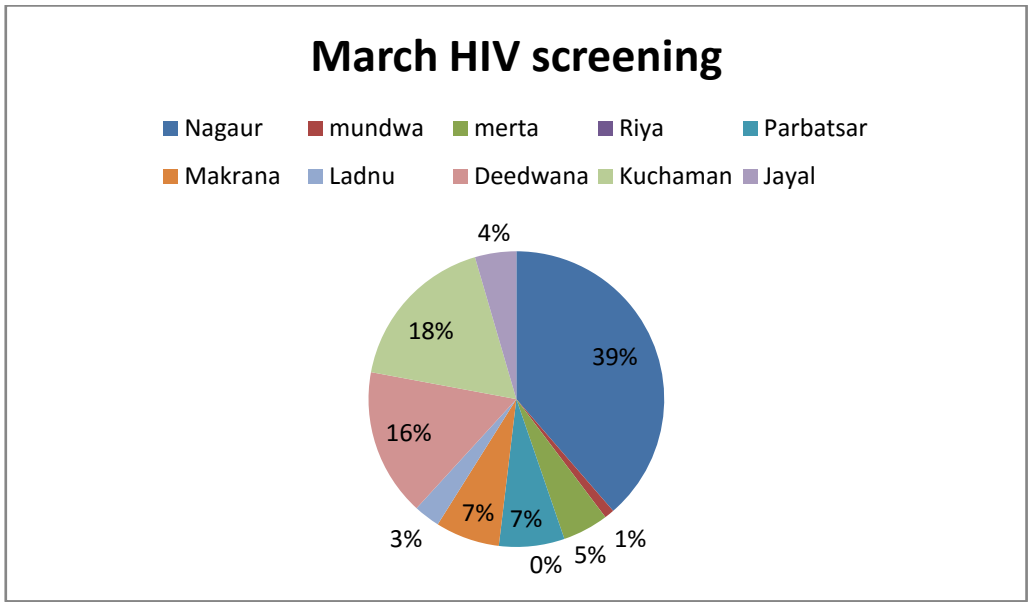
Month wise HIV screening analysis of pregnant women at different blocks



Contribution of different blocks for HIV screening of pregnant women







The three months thorough analysis of all blocks HIV screening, this conclusion can be given that only those blocks are performing the HIV screening of pregnant women who are having ICTC facility otherwise all other center are under performing.

Reasons/ challenges

- Non or interrupted supply of HIV screening kit at all center
- The untrained staff is not having enough knowledge about HIV screening
- Beneficiaries are less aware about facilities that should be available on these center(less demand generation)
- Improper documentation
- Less referral of HIV reactive pregnant women

No counseling after screening in case of reactive Pregnant women(Lab technician is not having time because he is the only person collecting prescription, taking sample, applying test and reporting and delivering the report to the beneficiaries).

Observation and suggestion

Human resource

A) **Quantity**: - when we are discussing about availability of health facility , community health centre is at higher level in hierarchy of health facility available at District level. If these centre are not having adequate number of manpower, the output of all activity organised at these centre will be compromised in terms of quality and quantity both.

Inadequacy of manpower will increase the work load of higher centre (District hospital) unnecessarily. The all other available resources at these centre will be under utilized and the resources at higher centre will be scarce and over utilized due high referral from lower centres.

In field visit of different CHCs, some are not having lab technician which in turn is decreasing the no. of testing at these centres of pregnant women.

Suggestion

These centres should have adequate no. of lab technician so the testing of all beneficiaries can be done timely with accuracy. We should keep some alternative solution for non availability of lab technician and other staff. At each CHC at least one lab technician should be available with one nursing staff, so in absence of lab technician that person can take sample and the visit of those beneficiaries will not go in vein. Because each visit to these centre are resource consuming in terms of time and money.

B) **Quality**:- quality means the knowledge and skills that the responsible person should have for some designated work. Without skills the person will not be competent for this job. For improvement in skills we need to conduct training in timely manner so we can use the manpower effectively and efficiently.
During data collection from CHCs about training of Lab technician for WBFPT HIV (screening) testing, it is very surprising that mostly all laboratory technician are untrained for this HIV screening procedure.

Suggestion

The only solution is that we should do the timely training of the staff so they can perform with full confidence. Without training the staff is not competent and also not taking the responsibility of their work. According to the schedule this WBFPT training should be completed till now including the medical officer, laboratory technician and ANM at PHC level, but we are not able to provide training to the CHCs staff,
So prompt and timely training should be done.

C) **Behaviour change communication:-** it is observed that with availability of all essentials at CHCs (WBFPT kits, training, Availability of staff) , the HIV screening of pregnant women is very low because the provider is not understanding the importance /gravity of this HIV testing, they do not know the benefit of timely screening of Pregnant women for HIV, not aware that timely screening of pregnant women for HIV and in case of reactive proper follow up can prevent the transmission of this infection in baby (PPTCT services).
Still at the higher level in district mostly all health providers are not taking the HIV screening of pregnant women as a compulsory component of Ante natal care.
Because the providers are not having the proper knowledge of PPTCT services they are not motivating the beneficiaries for utilizing them.

Suggestion

Proper orientation of all cadre health staff about PPTCT services should be done on a priority basis so at least the provider can put a choice in front of beneficiaries. By this we can aware and motivate them and can achieve the target of Zero infection in children.

D) **Infrastructure: - A**vailability of infrastructure (laboratory) is a very crucial component to provide health services (Diagnostics) . During visit to CHCs like Chhoti Khatu (Deedwana) and Bharnawa (ladnu) i came to know that these CHCs are not having the facility of Laboratory ,so testing at these centres is not possible. All patients including pregnant women are referred to private centre that is ultimately increasing the out of pocket expenditure of a family.

In case of pregnant women there mobilization to district hospital for testing will create a lot of physical and mental stress and ultimately proper testing and follow up will be difficult.

If it is the situation of some CHCs, so what we can expect from our PHCs.

Suggestion

Availability of laboratory should be ensured as soon as possible so the beneficiaries can avail services.

E) Logistic and supply (availability of kit)

The availability of HIV testing kit (WBFPT screening for HIV) is very less in terms of quantity when compared with beneficiaries .The purchase and distribution channel are not functioning properly. After generation of indent form of requirement there is no supply of kit at CHCs. So we are having laboratory, lab technician and other trained staff but we are not able to do screening or cannot do screening of pregnant women for HIV.

So in some CHCs the staffs is willing to do HIV testing of Pregnant women but due to non availability of screening kit it is not possible.

This non availability of kit is increasing the risk of transmission of HIV infection in baby through mother.

According to the norms the kit should be supplied till PHCs level so HIV screening can be done at the nearby place to the beneficiaries by available ANM/Lab technician but till now the system is not capable of supplying the kit up to CHCs on regular basis.

Suggestion

The supply chain should be maintained properly and more important that at the beginning of the year the pregnant women are estimated for whole year so monthly requirement is already known to us so that much of supply should be provided on time.

F) **Reporting and documentation: - W**hole duration of training we have to face the problem of improper and incomplete reporting. ANM/LHV are not filling the RCH register properly and filling the information regarding HIV/Syphilis testing (leaving the column blank),if testing done not mentioning the date of screening and not writing the result of screening.

In community mobilization meeting in Makrana, i came to know that they are not aware that HIV/Syphilis screening is also a component of ANC services. This is the problem in whole district without screening how we can know the status of pregnant women , how there referral to ICTC center will be done, how they will be linked to ART and how we can prevent infection in delivered babies.

Suggestion

All RCH registers should be maintained and checked by LHV and block resource person for completion of data in register because when these registers will be filled properly then only the data entry operator can provide the real picture of the situation.

Conclusion

After doing a thorough analysis of all CHCs (in term of manpower, HIV screening kit, training and infrastructure) it is revealed that most of the beneficiaries (Pregnant women)are not able to avail the HIV screening at these CHCs due to shortfall of one of the above mentioned components.

It is very alarming when we are trying to achieve zero infection in children, how it will be possible when we are not able to screen the pregnant women for this HIV infection. Less than 50% CHCs are having kit for screening, only 10% manpower is trained for this screening test, and then what should be our expectations.

The whole system should work together to improve the situation and to make India HIV free. The condition is very demanding for achieving the target; that is all pregnant women should be screened for HIV.

References:

1) Revised National PPTCT guidelines 2014 Department of AIDS Control, Ministry of Health &family welfare, Government of India

2) Updated guidelines for Prevention of Parent to child Transmission (PPTCT) of HIV using Multi drug Anti –retroviral Regimen in India ,December 2013

3) Operational guidelines for integrated counselling and testing centres July 2007 NACO, Ministry of Health & family welfare

4) HIV Sentinel Surveillance National Report 2012-13 NACO Department of AIDS Control, Ministry of Health &family welfare, Government of India

5) Screening, Management and Prevention of Parent to child transmission of HIV (Training module 11) NACO

6) Annual report 2013-14 Department of AIDS Control, Ministry of Health &family welfare, Government of India

7) National AIDS Control Organisation (NACO) website. Available at www.nacoonline.org. Accessed January 12, 2008.

8) Park K. Park's Text Book of Preventive and Social Medicine. 19 ed.Prem Nagar, Jabalpur: M/s Banarsidas Bhanot Publishers; 2007.

9) Recent Trends in Mother To Child Transmission of HIV in Pregnancy
Damania Kaizad R_1, Tank Parikshit D_2, Lala Mamatha M_3.

Annexure

Tool for data collection

Outreach Register

Ahana

Basic Profile							
Name of the ORW				Month			
Name of the SR Partner		Name of the State		Name of the district		Name of the Blocks responsible for	1. 2. 3.

Basic Profile of the Outreach activity							
Total Number of Estimated Pregnant women in the district				Total Number of Pregnant Women ANC registered and line listed in ORW-A Register			
Number of HIV positive pregnant women followed up in which trimester	1st	2nd	3rd	[redacted]	No of Infants followed up till the reporting week	0-2 months	2-18 Months

Outreach activities conducted- New cases

Sr. No.	Date	Purpose of Visit														Testing Liaison			Remarks
		Number of PW received WBFPT test and knows test result	Number of PW found HIV reactive as per WBFPT	Number of Pregnant women followed up for WBFPT screening out of ORW-A register	Number of PW received confirmatory test at ICTC and knows test result (without undergoing WBFPT test)	*Total number of pregnant women who know their HIV status (Both confirmatory after WBFPT test and ICTC)*	Total Number of pregnant women HIV-positive	*Number of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission*	*Number of Pregnant women followed up*	Follow up New born			Meetings/ Campaigns organised			ASHA	ANM	AWW	
										Number of Live births	Number of Babies Initiated on CPT Prophylaxis	Number of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Community meeting	Mid media	Advocacy meeting				

Add any remarks:

Tool for line listing of HIV screened pregnant women

Outreach Register- A

Ahana

Name of the ORW											
District			State					Month			
Sr. No.	ANC Registration ID of the PW	Name of PW	Age	Name of the Husband	Address of PW (mention Village Name)	LMP	EDD	Date of HIV screening test #	Screening test result (Reactive/ non reactive)	Date of Receiving Confirmatory Test $	Confirmatory Test Result (Positive/ Negative)

* Please also add the names of the PW received screening while in Directly in Labour and their test result status.

Confirm with Signature of BMO/BPM/ANM and Seal. Ignore this variable if a PW is receiving the ICTC testing without going through WBFPT.

$ Confirm from ICTC register

HIV Positive Pregnant Women Follow up Register (HPPWFR)

Ahana

Name of the ORW			District		State	

Client Sl. No.	Name of the pregnant woman in ANC/ Direct- in labour/ Post-delivery mother	Date of HIV test (Confirmatory test)	New Case/ Already Registered at ART	ART Registration no. Dd/mm/yy	Date of ART initiation dd/mm/yy	Date of Baby Initiated on Prophylaxis	Date of EID test done	Date of TB test done	Follow up with HIV Positive pregnant Woman													Remarks
									Visit-1	Visit-2	Visit-3	Visit-4	Visit-5	Visit-6	Visit-7	Visit-8	Visit-9	Visit-10	Visit-11	Visit-12		

Client and EID Test Card (CETC)											Ahana
Name of the Pregnant Woman											
ANC Registration ID											
ICTC PID No.											
Husband's Name											
Month of Pregnancy in which HIV+ status was known											
ORW visit during pregnancy	Months	1	2	3	4	5	6	7	8		9
Linked to ART	Yes		No		ART ID						
Screened for TB	Yes		No		Confirmed as TB patient		Yes		No		
Place of Delivery	Institutional		Home		Status of Delivery		Live Birth		Still Birth		
Name of the Baby											
Sex of the baby	Girl		Boy		Infant follow up		2		44		60
Infant initiated on Prophylaxis	Yes		No		Date of Initiation of Prophylaxis						
EID test done	Yes		No		EID Test Status		Positive		Negative		
Confirmatory test undergone at 18 months irrespective of previous test and result	Yes		No		Result of the confirmatory test at 18 months		Positive		Negative		
Remarks											

Tool used for situation analysis of all CHCs in Nagaur District

Period : October 2015 to January 2016					Situation Need Assesment							
District	Block	CHC (red colour denote F-ICTCs)	ANC resgistration at the CHC only	HIV Tests at CHC	Date of Visit to CHC	HIV testing kit available on the date of visit (Yes or No)	WBFPT Kit availability on the date of visit (Yes or No)	Syphillis screening kit availability on the date of visit (Yes or No)	Training of staff to do WBFPT test on the date of visit (Yes or No)	Name of LT trained on WBFPT	Name of ANM/GNM/staff nurse trained on WBFPT	Name of MO trained on WBFPT
Nagaur	Deedwana	Chhoti Khatu										
Nagaur		Maulasar										
Nagaur		Tosina										
Nagaur	Degana	Degana										
Nagaur		Harsor										
Nagaur		Idawa										
Nagaur	Jayal	Jayal										
Nagaur		Rol										
Nagaur	Kuchaman City	Kukanwali										
Nagaur		Maroth										
Nagaur		Nawan City										
Nagaur	Ladnu	BHARNAWA										
Nagaur		MEETHRI ladnu										
Nagaur		Nimbijodha										
Nagaur	Makrana	Borawar										
Nagaur		Budsu										
Nagaur		CHC Makrana										
Nagaur		Gachhipura										
Nagaur	Merta	Gothan										
Nagaur		Merta										
Nagaur	Mundwa	Khinwsar										
Nagaur		Kuchera										
Nagaur		Mundwa										
Nagaur		Panchala siddha										
Nagaur	Nagaur	Basni										
Nagaur	Parbatsar	Bajwas										
Nagaur		Parbatsar										
Nagaur	Riyan Bari	Riyan Badi										