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RESEARCH ARTICLE

STUDY OF INTEGRATED COUNSELLING AND TESTING SERVICE IN SIVAKASI PUBLIC HEALTH CENTRE

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ABSTRACT

The December 2001 report of United Nations Commission on Macroeconomics and Health makes explicit connection between development (macroeconomics) and health. Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) pandemic have emerged as a serious public health problem all over the world. While addressing the problem of HIV/AIDS among the economically productive and sexually active sections of population, specific emphasis needs to be given not only to high risk groups like commercial sex workers and injecting drug users, but also to general population like students, youth, migrant workers in urban and rural areas, women and children. Such target group needs to be given adequate care and proper counselling to bring them into mainstream population and present study is a moderate attempt towards this direction. The present study was undertaken in Sivakasi Government Public Hospital in Virudhunagar district with secondary data. The study is confined to Integrated Couselling and Testing Centre (ICTC) Services, covering a period from 2006 to March 2011. ICTC service centre has been functioning under the control of (Tamil Nadu State Aids Control Society) TNSACS. Of total screening cases for HIV/AIDS of 21014 cases and infected with HIV/AIDS were 338 cases from 2006 to 2011. Prevention strategies must continue to be given primary focus through awareness campaigns and conuselling facilities with local languages, which leads to behavioral change. Specific partners or migrant workers need specially packaged awareness progammes on the risk and vulnerability to HIV/AIDS.

INTRODUCTION

HIV/AIDS pandemic have emerged as a serious public health problem all over the world, ever since the first AIDS case was diagnosed in 1981. Once a person gets infected with the virus, it is there for a life time. There is no permanent cure for the disease, as there is no effective vaccine has also been developed. So for 95 percent of all HIV/AIDS infected people are living in developing countries. Infections with HIV are being increasingly reported from South-East Asia (Chin, 1991) and half of the new infections are among the young adults aged less than 25 years. Promising developments have been seen in recent years in global efforts to address the AIDS epidemic, including increased access to effective treatment and prevention programmes. However, the number of people living with HIV continues to grow as does the number of deaths due to AIDS (Park, 2007). Globally there were an estimated 38.6 million people living with HIV/AIDS at the end of 2005. Of these, about 8.3 million were people living in Asia and more than two-thirds of them were in India (UNAIDS, 2006). It is estimated that in 2007, there were 2.4 million (1.8-3.2 million) people living with HIV/AIDS in India with an estimated adult HIV prevalence of 0.34 percent (0.25 percent- 0.43 percent).

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Disturbingly out of the estimated number of people living with HIV/AIDS, 39 percent were females and 3.5 percent were children (Park, 2009). The first HIV infected case in India was detected in Tamil Nadu in 1986 and the first AIDS was reported in the same year from Mumbai. The highest prevalence is in Manipur and Nagaland is the second highest. Of the estimated number, 22 percent in Andhra Pradesh., 20 percent in Maharashtra, 11 percent in Karnataka, 7 percent in Tamil Nadu and the remaining states constitute 40 percent. The 2006 estimates indicate that the epidemic has stabilized in Tamil Nadu and other southern states but increased in the northern and eastern regions. Four of India's largest cities (Chennai, Delhi, Mumbai and Chandigarh) have a significant population living with HIV/AIDS, especially among Injecting Drug Users (IDUs) (NACO, 2007). In the recent years it has spread from urban to rural areas and from individuals practicing risk behaviour to the general population. Studies indicate that more and more women attending ante-natal clinics is testing HIV-positive thereby increasing the risk of perinatal transmission. The majorities (85 percent) of India's HIV infections are due to unprotected heterosexual intercourse and sex work drives transmission in southern and western states (UNAIDS, 2006). A significant proportion of new infections occurs in women who are married and who have been infected by husbands who (either currently or in the past) frequented sex workers.

Transmission among IDUs is also one of the major causes for the spread of HIV/AIDS in the country. Even though the cases are more prevalent in the north-eastern States, incidence of HIV through IDUs is evident from many parts of the country, especially in the urban areas. It not only costs huge sums of money in terms of controlling the opportunistic infections such as Tuberculosis (TB), Pneumonia and cryptococcal meningitis, but seriously affects individuals in their prime productive years causing serious economic loss to them and their families. As of December 2010, 384726 people living with HIV are on antiretroviral therapy in India and more than 47,955 of them are in Tamil Nadu (NACO, 2012), India's seventh most populous state. The state has been investing sizeable large resources for health sector (Reddy and Selvaraju, 1994). While addressing the problem of HIV/AIDS among the economically productive and sexually active sections of population, specific emphasis needs to be given not only to high risk groups like commercial sex workers and IDUs, but also to general population like students, youth, migrant workers in urban and rural areas, women and children. In India with a large population and population density, low literacy levels and consequent low levels of awareness, HIV/AIDS is one of the most challenging public health problems ever faced by the country. With a high prevalence of TB infection in India the problem of HIV/TB co-infection also poses a major challenge. Nearly 60 percent of the AIDS cases are reported to be opportunistic TB infection cases. Treatment of TB among the HIV-infected persons is a new challenge to the National TB Control Programme which has now adopted Directly Observed Treatment Shortcoure (DOTS) strategy for control of TB infection. Some of the drugs which are recommended for TB treatment pose complications in cases of HIV-infected persons and had to be withdrawn in areas of high HIV prevalence.

HIV/AIDS is not merely a public health challenge; it is also a political and social challenge. Behaviour change will not occur without a significant change in the social and political environment. Unequal gender and power relations, taboos in frank and open communication about sexual health and stigma and discrimination are particularly significant obstacles to an effective response. The economic impact of AIDS epidemic can't be underestimated. The largest economic cost of a death due to HIV/AIDS is usually lost income as those who die from AIDS are generally younger and in their most productive years. Because of faster economic development in certain regions of the country in the last few decades, there has been significant migration of population from rural to urban areas, both inter-State and intra-State. Migration of rural population in search of employment has also led to increase in the number of slums with poor public health infrastructure in urban and semi urban areas. Migration is mostly single with the workers living alone in sub standard living conditions. The separation from families for long periods also results in high risk behavior among these migrant workers. These workers, after they get infected with HIV, do also infect their unsuspecting spouses when they go home for vacation. Against these, it is important to offer efficient counselling as preventive measure in the health care centres and in four such centres is functioning in public state owned hospitals (Rajendran and Ramachandran, 2013). The problem therefore has to be addressed both at the place of origin and the place of migration. The present study has been taken up Integrated Couselling and Testing Centre (ICTC) services in public hospital with two fold objectives as to study the performance of ICTC services in Sivakasi government hospital and to understand the cost of laboratory investigation and counselling services.

Methodological Framework

The present study was undertaken in Sivakasi Public Hospital in Virudhunagar district with secondary data. Sivakasi, known for fire cracker and printing industry for which migrant workers live in large number. The study is confined to ICTC services, covering a period from 2006 to March 2011. There are nine public hospitals in Virudhunagar district, namely Virudhunagar, Aruppukottai, Tiruchuli, Kariapatti, Rajapalayam, Watrap, Srivilliputtur, Sattur and Sivakasi and for the present study; Sivakasi government hospital alone was selected. On an average 806 patients are coming every day. Tamil Nadu State Aids Control Society (TNSAC) was registered on 11.05.1994 under the Tamil Nadu Societies Registration Act 1975. The TNCACS is implementing various programmes (appendix–1) effectively with an aim of "Getting to Zero - No new infection, No HIV/AIDS related death, No HIV/AIDS related Stigma and Discrimination"[1]. ICTC is nothing but it is merging programme of prevention parents' transfusion to child and voluntary counseling and testing centre. Age for testing of HIV/AIDS was above 15 year. It is possible for self testing for those who are above 15 year old. The parents' permission is needed for testing HIV/AIDS for those were below 15 year old. The qualification of counselor was master of social work, sociology or psychology.

DISCUSSION

Here the issues are dealt with in four sections such first section describes the screening of male, female and spouse for HIV and AIDS, second section points out the screening of Ante Natal Care (ANC), third section reports the screening of Transgender and last one discuses the cost for testing and counseling per patient. It is noted that of total screened population (13008) 25 percent constitutes males. But from the total positive cases (307) males a account for 57 percent. The public come for medical checkup in the general hospital and doctors motivated them morning time to screen for HIV/AIDS. Between 2006 and 2011 2.4 percent of the cases (307) were detected as positive as could be observed from the table 1. The table 1 shows that the total number of male screening for HIV/AIDS was increasing with minor fluctuation from 243 cases in 2006 to 722 cases in 2011. However, positively tested cases share a declining trend except in 2007. At the same time the total HIV positive male cases were 57 percent. It can be understand that the total screening of female was 31 percent but HIV positive cases was 32 percent. The total number of spouse (those who were coming with spouses) screening was 5777 cases and 11 percent have HIV positive. The total number of screening such as male, female and spouse were 13008 cases

[1]A multipronged approach is used to ensure that all sectors of population are covered by access to services and necessary information is provided to prevent HIV infection.

from 2006 to 2011. Among them, the spouse screening was more than others as the husbands were coming with their wife for ANC checkup. Because of this is first step for prevent from transmission of HIV through mother to child and husband to wife through sexual transmission. The total numbers of HIV positive cases were 307 from 2006 to 2011. It is observed that only males have more number of HIV positive from 2006 to 2011 as compared with other cases. The doctors' motive and advice male and female patients for HIV/AIDS because of their body poor health condition, who are coming general out patients.

Table 1. Screening for HIV and AIDS in Sivakasi Government Hospital

Year	Male	Male +ve	Female	Female +ve	Spouse	Spouse +ve	Total	
							screened	+ve
2006	243	29	435	17	864	4	1542	50
2007	589	47	374	14	1405	5	2368	66
2008	405	30	624	20	1053	6	2082	56
2009	428	24	1101	22	652	8	2181	54
2010	825	18	892	12	717	3	2434	33
2011	722	25	593	13	1086	10	2401	48
Total	3212	173	4019	98	5777	36	13008	307
	(25)	(57)	(31)	(32)	(44)	(11)	(100)	(100)

Source: Annual Reports of ICTC Government Hospital Sivakasi from 2006 to 2011.
Note: Figures in parentheses are percentages.

ANC attendees are considered as the surrogate group for general population in the age group of 15-49 years. The total numbers of ANC screening were 7950 cases from 2006 to 2011 as is given in table 2. Eight ANC women had HIV positive among the total screening 1295 cases in 2006. In 2008, the total numbers of ANC HIV positive cases were two and it was same in 2009. There were three ANC had HIV positive in 2011. There were no HIV positive cases in 2010.

Table 2. Screening of ANC for HIV and AIDS in Sivakasi Public Hospital

Year	ANC	ANC +ve
2006	1295	8
2007	1748	7
2008	1303	2
2009	951	2
2010	1128	0
2011	1525	3
Total	7950 (100)	22 (0.28)

Source: Annual Reports of ICTC Government Hospital Sivakasi from 2006 to 2011.
Note: Figures in parentheses are percentages.

The epidemic is not progressing at an alarming rate, and in fact, the HIV infection prevalence rates are lowering in the ANC population. All the same, the infection has invaded all the spheres of the society, urban-rural, various categories of educational status and different occupational strata. Transgenders (TG) are normally proved to HIV/AIDS. But due to social taboos and conservative thinking they do not come forward to screening. In fact no TG patients came to treatment upto 2009. Notably of 52 TG patients 9 were reported as HIV/AIDS cases (table 3). This gives an alarm that TGs are subjected to inflict HIV/AIDS. In India, one study reported a high HIV prevalence of 42.1 percent among TG in Mumbai from a 2007 sentinel surveillance survey conducted by the government (NACO, 2007a). Another study conducted among the TG population in five districts of Tamil Nadu (2005–2007) reported an aggregate HIV prevalence of 12 percent (ICMR and FHI, 2008). In Indonesia, HIV prevalence ranged from 14 percent to 34 percent among TG (Bandung 14 percent; Surabaya 25 percent; Jakarta 34 percent) in 2007 (RIMH, 2008). Available data indicate that the levels of HIV prevalence are overall considerably higher among TG than among Men who have Sex with Men (MSM), and highlight the need to conduct separate HIV prevalence studies among TG populations in India. Tamil Nadu is the first State that has taken efforts to provide services for transgender.

Table 3. Screening of Trans Genders for HIV and AIDS in Sivakasi Public Hospital

Year	TG	TG +ve
2006	0	0
2007	0	0
2008	0	0
2009	0	0
2010	52	9
2011	4	0
Total	56 (100)	9 (16.07)

Source: Annual Reports of ICTC Government Hospital Sivakasi from 2006 to 2011. Note: Figures in parentheses are percentages.

A welfare board for this community does not exist anywhere else in the country. 50 per cent of the high risk groups in the State have been linked with government services for care and continued support. The programmes for targeted intervention groups that have been implemented in the State, some with the support of the non-governmental sector, are among the best in the country (Jain, 2012). The Table 3 shows that the total screening of TG was 56 cases. Only nine cases had HIV Positive. Counselling services for suspected cases of HIV infection and for People Living with HIV/AIDS (PLWHAs) should be expanded to increase their reach to those who need them. The Government will extend all necessary help to create necessary infrastructure for establishment of these centres and in training counsellors in large numbers to male these counseling centres. In 2006, the total counseling cost per patient was ` 3.64 and it increased to ` 4.46 in 2007. The counseling cost per patient depends upon number of attending out patients. After that it decreased to ` 2.58 in 2009. TNSACS spends ` 9246160 to laboratory investigation and ` 684000 (free of cost) for counselling to male, female, spouse, ANC and TG from 2006 to 2011. The cost was increasing every year. For instance, TNSACS spends ` 135600 for counseling in 2010 from ` 121200 in 2009. The total counselling cost was ` 684000 from 2006 to 2011. The total testing cost was more than the

Table 4. Total Testing and Counselling Cost in Sivakasi Public Hospital

Year	Total Screening and Counselling	Total HIV / AIDS +ve Cases	Total Testing Cost (in `)	Total Counselling Cost (in ``)	Cost per Testing (in `)	Cost per Couselling (in `)
2006	2837 (13)	58 (17)	1248280 (13)	78000 (11)		3.64
2007	4116 (20)	73 (22)	1811040 (20)	92400 (14)		4.46
2008	3385 (16)	58 (17)	1489400 (16)	106800 (15)		3.17
2009	3132 (15)	56 (17)	1378080 (15)	121200 (18)		2.58
2010	3614 (17)	42 (12)	1590160 (17)	135600 (20)	440	2.66
2011	3930 (19)	51 (15)	1729200 (19)	150000 (22)		2.62
Total	21014 (100)	338 (100)	9246160 (100)	684000 (100)	440	3

Source: Annual Reports of ICTC Government Hospital Sivakasi from 2006 to 2011.
Note: within the parenthesis are percentages and Cost per Testing is estimated value equal to private hospital.

counseling cost. There are three types of test for HIV/AIDS such as camogram, dry diet and dry land. The patients those who don't have diagnosed HIV/AIDS positive, it is better come follow up after three months. It is only for those have high risk such as sexual transaction and blood transfusion. NSACS spends ` 440 for free of cost to screening and testing per patient and ` 3 for counseling per patient from 2006 to 2011. There were two types of follow up such as HIV test reactive and non reactive. It is understood that most of female cases had less HIV/AIDS positive cases and utilized government medical scheme. For example after the implementation of Dr. Muthulakshmi Reddy Maternity Scheme in Tamil Nadu, the enrollments of ANC were increasing every year. At the same time mostly women was treated in this hospital compared with male. This is observed more in the cases of female patients. The counselor gave counseling at the time of pre (before test), post (after testing) and follows up (after getting HIV/AIDS). During the pre test the counselor gave counseling about the HIV/AIDS. During the post test, the counselor gave counseling about result declaration and high risk analysis. During follow up the counselor gave counseling about high risk, positive cases, safe sex, nutrition, partner test and Antiretroviral Treatment (ART) treatment. The cousellor suggested that only awareness can be prevention of HIV/AIDS. Health education leads to empowerment and emancipation of health care consumers resulting in a standardized quality health care system (Rajendran and Ramachandran, 2012). The present examination reveals that the counseling centres have done modestly well regarding the screening of HIV/AIDS patients.

Conclusion

Discrimination against people living with HIV/AIDS denies their rights to access health care, information and other social and economic rights granted by the constitution to its citizen. The protection of human rights is essential to safe guard human dignity in the context of HIV/AIDS. Public health interest does not conflict with human rights. On the contrary, it has been recognised that when human rights are protected, fewer people become infected and those living with HIV/AIDS and their families can better cope with HIV/AIDS. The government recognizes that without the protection of human rights of people, who are vulnerable and afflicted with HIV/AIDS, the response to HIV/AIDS epidemic will remain incomplete. Many eminent scientists are now questioning the assertion that sexual transmission is the sole cause of AIDS, raising the possibility that the presence of the virus merely represents the marker of a body's immune system. These factors include antibiotic abuse, recreational drug abuse and nutritional stress, all of which are major public health problems in India. Evidence both within India and outside, suggests that the damage caused to the immune system is reversible even without drugs. The total screening cases for HIV/AIDS were 21014 cases and infected with HIV/AIDS were 338 cases from 2006 to 2011. There were 19 percent of the female had Counselling about the impact of HIV/AIDS and care. Only one percent of the transgender had counselling. 37 percent of the ANC cases had counselling about preventive from HIV/AIDS through sexually transmission. TNSACS spends ` 9246169 for lab investigation and ` 684000 for counselling to male, female, spouse, ANC and TG from 2006 to 2011. TNSACS spend ` 440 for free of cost to screening and testing per patient and ` 3 for counseling per patient. From the reported cases of patients not infected with HIV, which is a revolving trend. Prevention strategies must continue to be given primary focus through awareness campaigns and counselling facilities, which will lead to behavioral change. With the increase in awareness levels in the community, the demand for voluntary counselling and testing services would rise. Specific groups like students, out of school youth, sexual partners or migrant workers need specially packaged awareness programmes on the risk and vulnerability to HIV/AIDS.

Suggestion

The entireprogramme of prevention and control of HIV/AIDS needs to adopt a more holistic approach looking at AIDS as a developmental problem and not as a mere public health issue. The people aware of its implications and provide them with the necessary tools for protecting themselves. In spite of the strong Information, Education and Communication (IEC) campaign on HIV/AIDS, there is still inadequate understanding of the serious implications of the disease among the legislators, political and social and religious leaders, bureaucracy, media, leaders of trade and industry and professional agencies not to speak of the medical and paramedical personnel engaged in health care delivery system.

In educational institutions AIDS education should be imparted through curricular and extracurricular approach. The programme of AIDS education in schools and the 'Universities Talk AIDS' (UTA) programme should have universal applicability throughout the country in order to mobilise large sections of the student community to bring in awareness among themselves and as peer educators to the rest of the community.

Non-student youth should also be addressed through the large network of youth organizations, sports clubs, National Service Scheme (NSS), Self Help Group (SHG), Youth Red Cross Society and Nehru Yuvak Kendras spread across the Sivakasi in Virudhunagar district. AIDS prevention education should also be integrated into the programmes of workers education and schemes of social development. An efficient referral system would be established starting from testing centres and counseling sites to hospitals or clinics, community-based services and home-based care. PLWHAs would be given adequate information for home care in the form of pamphlets, books and documents to enable them to lead a heal their life and to promote self-help. Doctors are requested to write HIV/AIDS screening to the patients in their note; those are coming above 18 years. They should motivate the patients to co-operate for all investigation and regular treatment. The counselor has to motivate the patients for screening of HIV/AIDS, spend time for health education on life style modification in the out patients registration section. There is an urgent need to look for a cost-effective alternative to antiretroviral drugs in the Indigenous System of Medicine (ISM) like Ayurveda, Unani and Siddha apart from Homoeopathy. Some of the medicines in these systems have the potential of reducing the viral load in the body of the patient thus ensuring a heal their and longer life with the infection. The Government has sponsored research projects in Homoeopathic and Siddha systems of medicines and is receiving encouraging response. It will pursue a policy of sponsoring research in ISM and Homoeopathy for development of drugs which can serve the purpose of anti-retroviral, but at a much lesser cost.

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