OPERATIONAL GUIDELINES FOR

DISTRICT
HIV/AIDS Prevention Control Unit

NATIONAL AIDS CONTROL ORAGANISATION
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

2008

ACRONYMS

AIDS	*Acquired Immuno Deficiency Syndrome*
ANC	*Ante Natal Clinic*
ANM	*Auxiliary Nurse Midwife*
APAC	*AIDS Prevention Control Project*
ART	*Antiretroviral Therapy*
ARV	*Anti Retro Viral*
ASHA	*Accredited Social Health Activist*
AWC	*Anganwadi Centre*
AWW	*Aaganwadi Worker*
AYUSH	*Ayurved, Yoga, Unani, Siddha & Homeopathy*
BB	*Blood Bank*
BCC	*Behaviour Change Communication*
BP	*Bridge Population*
BSS	*Behavioural Surveillance Survey*
BSU	*Blood Storage Unit*
CBO	*Community Based Organization*
CCC	*Community Care Centres*
CEO	*Chief Executive Officer*
CHC	*Community Health Centres*
CII	*Confederation of Indian Industries*
CM&HO	*Chief Medical & Health Officer*
CMIS	*Computerized Management Information System*
CST	*Care, Support and Treatment*
CSW	*Commercial Sex Worker*
DACO	*District AIDS Control Officer*
DAPCC	*District AIDS Prevention & Control Committee*
DAPCU	*District AIDS Prevention and Control Unit*
DH	*District Hospital*
DHS	*District Health Society*
DIC	*Drop In Centre*
DMU	*District Management Unit*
DPMU	*District program management Unit*
DRDA	*District Rural Development Agency*
EQAS	*External Quality Assessment System*
FMG	*Financial Management Group*
FSW	*Female Sex Worker*
HIV	*Human Immuno-deficiency Virus*
HRG	*High Risk Group*
ICDS	*Integrated Child Development Services*
ICT	*Integrated Counseling & Testing*
ICTC	*Integrated Counseling & Testing Center*

ICWM	*Infection Control and Waste Management*
IDSP	*Integrated Disease Surveillance Programme*
IDU	*Intravenous Drug User*
IEC	*Information, Education and Communication*
IMNCI	*Integrated Management of Neonatal Childhood Illness*
IPHS	*Indian Public Health Standard*
LW	*Link Workers*
M&E	*Monitoring & Evaluation*
MCHN	*Mother Child Health & Nutrition*
MDGs	*Millennium Development Goals*
MSM	*Men having Sex with Men*
MSW	*Male Sex Worker*
NACO	*National AIDS Control Organization*
NACP	*National AIDS Control Programme*
NE	*North East*
NFHS	*National Family Health Survey*
NGO	*Non-Governmental Organization*
NRHM	*National Rural Health Mission*
NSS	*National Service Scheme*
NYKS	*Nehru Yuva Kendra Sangathan*
OI	*Opportunistic Infection*
PD	*Project Director*
PHC	*Primary Health Centre*
PIP	*Programme Implementation Plan*
PLHA	*People Living with HIV / AIDS*
PMSU	*Program Management Support Unit*
PMU	*Project Management Unit*
PPTCT	*Prevention of Parent to Child Transmission*
PR & RD	*Panchayati Raj & Rural Development*
RCH	*Reproductive & Child Health*
RNTCP	*Revised National TB Control Programme*
RRC	*Red Ribbon Club*
RTI	*Reproductive Tract Infection*
SACS	*State AIDS Control Society*
SC	*Sub Centre*
SHG	*Self Help Group*
SMO	*Social Marketing Organization*
STD	*Sexually Transmitted Disease*
STI	*Sexually Transmitted Infection*
TI	*Targeted Intervention*
TOR	*Terms of Reference*
VCT	*Voluntary Counseling & Testing*
VCTC	*Voluntary Counseling & Testing Center*
W&CD	*Women & Child Development*

I. POLICY AND STRATEGIC FRAME WORK FOR THE IMPLEMENTATION OF THE NACP AT THE DISTRICT LEVEL:

A. INTRODUCTION

India is committed to the Millennium Development Goal of halting and reversing the HIV/AIDS epidemic in the country by 2012.The implementation of NACP-I (1992-99) and NACP-II (1999-2006) has resulted in institutionalization of efforts nationwide and there is encouraging evidence regarding its stabilization in some parts of the country. However, it is also true that over the years the virus has travelled from urban to rural areas and from high risk to general populations, affecting the women and the youth disproportionately. Thus the reorientation of Program strategy is a crucial challenge before NACP-III.

NACO recognizes that the magnitude of the response to HIV epidemic in India under NACP-III cannot be managed centrally. During NACP-II, programme management was decentralized to State AIDS Control Societies (SACS). Under NACP-III, programme implementation will be further decentralized to District and Sub District levels. Based on the epidemiological and vulnerability criteria, 611 districts in the country have been divided into four categories viz Category A-163 districts-High prevalence; Category B-59 Districts-concentrated epidemic; CategoryC-278 districts-increased presence of vulnerable population and Category D-111 districts-low/unknown vulnerability (**Annexure-1**). Differential package of services have been planned for each category of districts. Every District will have District AIDS Prevention and Control Unit (DAPCU) to implement AIDS Control and Prevention strategies, synchronized with the public health infrastructure and programmes at that level.

The Government of India launched a flagship programme called the NRHM in 2005 with the objective of expanding access to quality health care to rural populations by undertaking architectural corrections in the institutional mechanism for health care delivery. The crucial strategies under NRHM have been the integration of Family Welfare and National Disease Control Programmes under an umbrella approach for optimization of resources and manpower; strengthening of outreach services by incorporation of village health worker called ASHA; efforts for communitization of services through formation of Health and Sanitation Committees at village, block and district level; registering Rogi Kalyan Samities for improving hospital management; strengthening and upgrading the public health infrastructure to Indian Public Health Standards (IPHS); and consolidation of the District Level Programme Management Unit through the induction of professionals.

The NACP-III aims at integration of NACP interventions in the NRHM framework for optimization of scarce resources and provision of seamless services to the end customer / patients as also for ensuring long term sustainability of interventions. Thus, the institutionalization of DAPCU within the District Health Society, sharing administrative and financial structure of NRHM becomes a crucial programme strategy for NACP-III. The DAPCU will ensure implementation and supervision of ongoing NACP-III activities related to care and treatment, and further facilitate civil society partnership at the district with NGOs, CBOs, Red Ribbon Clubs and PLHAs network, private sector organization and academic institutions working in the area of HIV/AIDS in the district. Simultaneously, it will attempt to create a wider knowledge base in the district for effective prevention, detection, referrals and treatment strategies through convergence with the ongoing interventions of NRHM, RCH, TB Control etc. and build a strong monitoring and evaluation system through the public health infrastructure in the district.

B. STRATEGY FOR DISTRICT PLANNING

NACP-III recognizes the need for a comprehensive package of graded services covering the entire population of the district unlike the focused approach adopted hitherto in the earlier phases of NACP. Four Service Groups have been identified broadly as follows:

- Saturating the coverage of three High Risk Groups (HRG): Sex Workers and their clients. Injecting Drug Users and partners, and Men having Sex with Men
- Expanding the coverage of two Bridge Populations(BP) - truckers and migrant workers
- HIV Prevention among the highly vulnerable populations: women, youth and children
- HIV Prevention among general population: a multi sectoral response through mainstreaming

The following four components of the strategy will be undertaken in all districts, except the 3rd component only on "A&B" districts. (Figure-1).

1) **Formation of Community Based Organizations & Peer led Interventions for saturating coverage of all HRGs in urban areas**: All towns and cities (defined as per Census 2001) will be covered with high-intensity Target Intervention with outreach and service provisions for sex workers (female, male and Hijra populations) and their clients.

2) **NGO led Interventions in rural areas with 5000+population:** NGO led intervention will be planned in large villages on lines of TI approach, with the expectation to cover approximately 10 FSWs or more practicing in these villages.

3) **Mainstreaming Interventions in rural areas with <5000 population:** In these villages, focus will be on creating general awareness about HIV/AIDS and STIs, and also providing referral services for STI treatment, VCT/PPTCT, care and support. Such interventions will be done through the link worker model

4) **Small, scattered villages:** Focus will be on environment building through the government machinery by mainstreaming HIV/AIDS in all departments.

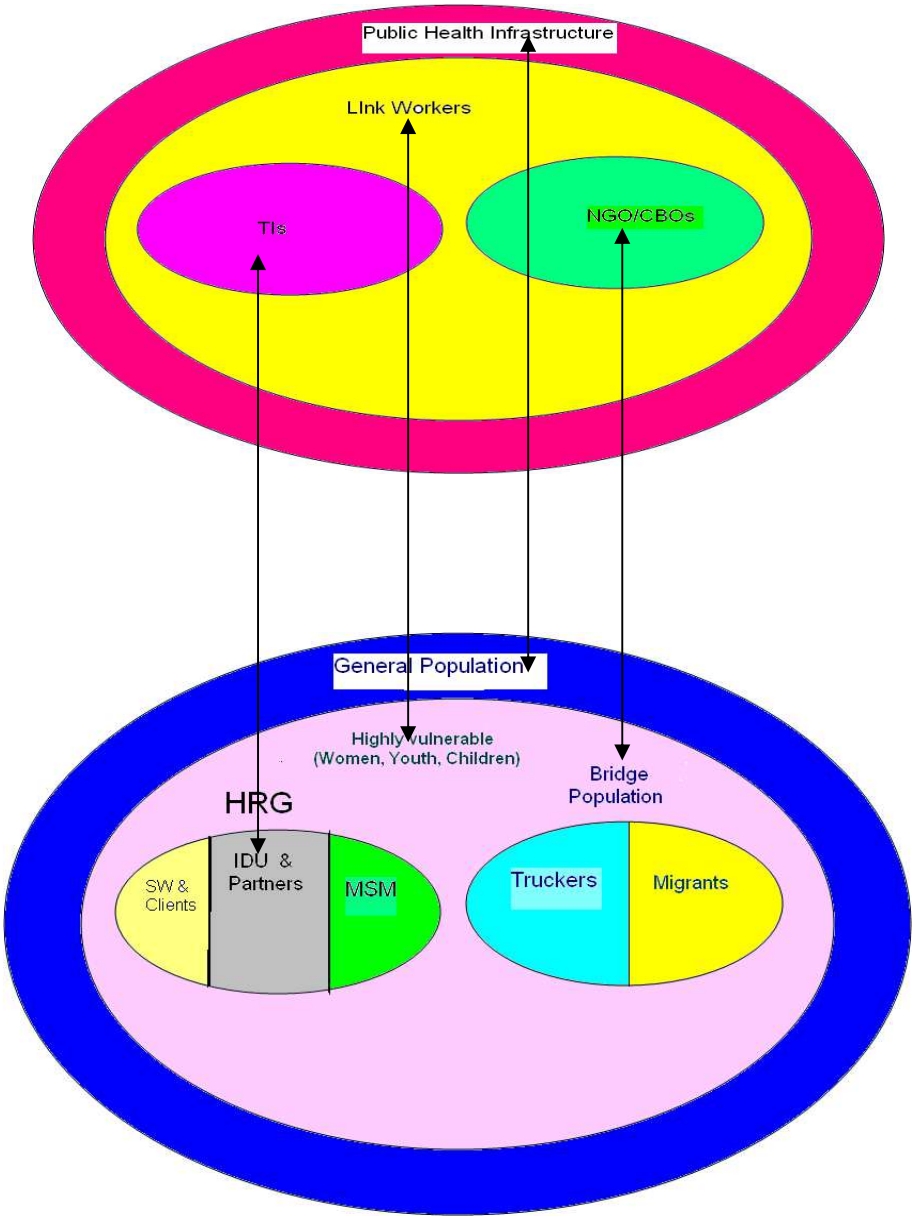

Figure 1- Population mapping for targeting service provision

C. ACCESS TO PACKAGE OF SERVICES AT DISTRICT LEVEL

The District Hospital will provide the full complement of preventive, supportive and curative services. It will provide the whole spectrum of HIV related 'core and integrated services': psycho-social counseling and support, ART, OI management as out-and-in-patient, positive prevention services, TB, STI, specialized pediatric HIV care and treatment, palliative care and pain management as well as referral for specialist needs such as surgery, ENT and ophthalmology etc. Linkages of NGOs/CBOs with the District Hospital will help provide the additional components of continuum of care and support with outreach, peer support services and home-based care. Additional testing facility for PPTCT services will be provided in the district hospital in the antenatal clinics. Community linkages will also provide means to follow-up with children born to HIV-positive women, support at the community level and outreach. Ensure access to safe blood will be a major area of work in collaboration with NRHM.

The Package of services to be made available in Districts as per its categorisation under NACP III (Table 1 and at Figure 2)

Table-1: Differential Service Package based on Epidemiological Profile of the District

Districts (High Prevalence)	**Low Prevalence**	
Category A & B	**Category C**	**Category D**
All HIV related services will be made available under one roof. This will include ICT, PPTCT, STD,OI and ART with necessary linkages. CHC will provide: ICT,PPTCT, STD and OI with necessary linkages to prevention and care treatment services. PHC will be responsible for ICTC services, STD control, OI and condom promotion. Mobile ICTC to service hard to reach areas.	As in Category A& B Districts. – ART provision clinic will be added only for large districts and if not available within 6 hours travel by road. ICTC will be established in CHCs where the case load for testing is high (average more than 15/day including PPTCT). Where case load is less existing staff will be trained to provide counseling services. Drugs and supplies will be adjusted as per reduced case load in category 'C' districts PLHA related services – community care centers to be established only if there is a minimum of 50 PLHA identified in the district.	ART Services limited to medical colleges if available. CHC will provide STD, OI management and ICTC services. Services limited to syndromic management of STD, IEC, condom promotion and access to safe blood through Blood storage centres in FRUs.

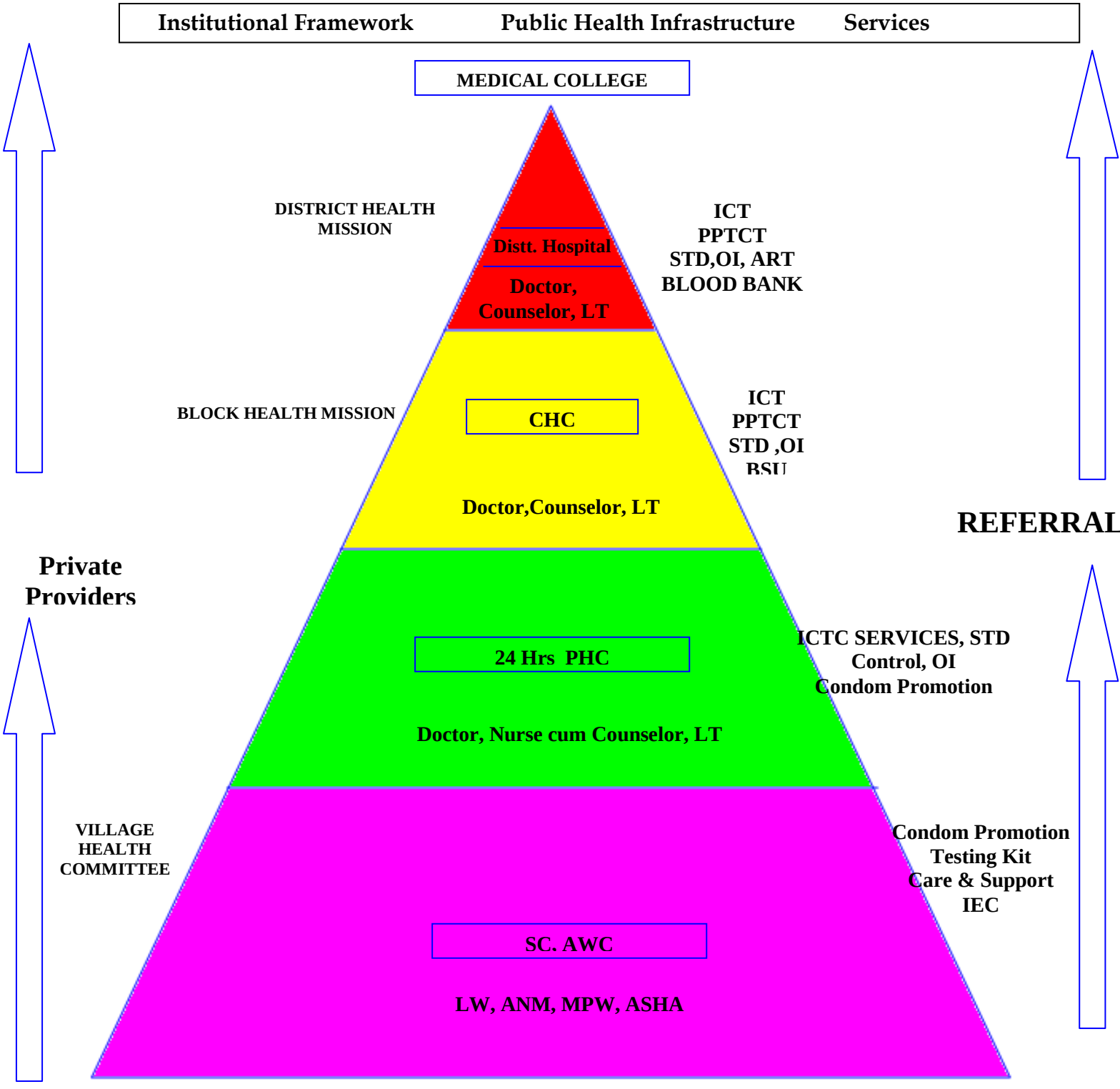

Figure 2- Service availability at district Level for NACP activities

II. INSTITUTIONAL FRAMEWORK FOR THE IMPLEMENTATION OF NACP ACTIVITIES

A. PROGRAM STRUCTURE – INTEGERATION WITH THE NRHM

(1) DISTRICT HEALTH SOCIETY (DHS)

Under the NRHM framework different Societies of national programmes such as Reproductive and Child Health Programme, Malaria, TB, Leprosy, National Blindness Control Programme have been merged into a common State Health Society chaired by the Chief Minister of the State. Similarly, at the district level all programme societies have been merged into the District Health Society (DHS). Funds from Government of India come to the State Health Society in a funnel mode and are passed on to the District Health Societies. The Governing Body of the DHS is chaired by the Chairman of the Zila Parishad / District Collector. The Executive Body is chaired by the District Collector (subject to State specific variations). The CMHO is the Member -Secretary of the District Health Society. Different programmes operate through programme specific committees constituted at State and District level and also maintain separate bank accounts at each level. Funds coming to the Health Society are transferred to the Bank accounts of the Programme Committee after requisite approvals at appropriate stage. This system ensures both convergence as well as independence in achieving programme goals through specific interventions.

District Officials for related Departments supporting the Health, Family Welfare & Sanitation activities in the district are represented in the DHS and issues of program implementation and convergence are discussed at the monthly meeting under the guidance of the District Collector.

It is envisaged to merge the proposed District HIV/AIDS Control Unit into the DHS. In order to ensure sustaining the current momentum and continued focus, the State may direct that separate meetings of the DHS be convened dedicated primarily to monitor the implementation of the NACP activities.

(2) DISTRICT HIV/AIDS PREVENTION CONTROL COMMITTEE (DAPCC)

Analogous to the presence of district program committees for all National programs under the NRHM framework, the DAPCC will be constituted for effective ownership, implementation, supervision and mainstreaming of the NACP activities at the district level. The Committee will oversee the planning and monitoring of the physical and financial activities planned in the District HIV/AIDS Action Plan. It will ensure appropriate management of the funds

coming to DAPCU for project activities. The committee ideally should not have more than 20 members. The suggested membership of this committee is given below. Subject to the broad structure, States have feasibility to add further persons as special invitees

i. Chief medical & Health Officer(CMHO) - Chairman
ii. Medical Superintendent, District Hospital
iii. District HIV/AIDS Control Officer - Member Secretary
iv. District Programme Manager (HIV / AIDS)
v. District Programme Manager (NRHM)
vi. District level officers for TB and RCH
vii. District IEC officer
viii. M&E officer
ix. Medical Officers in rotations - In-charge of one ICTC centre in the district, ART and CCC (3 in all)
x. One representative each of TIs, CCCs and PLHA networks (3)
xi.
xii. Representatives of related Departments identified by DAPCU for convergence, viz. Women & Child, Panchayati Raj, Labour, Mines, Tribal, Industry, Tourism, Urban Local Bodies etc.(5)

(3) DISTRICT AIDS CONTROL OFFICER (DACO)

A Nodal Officer for AIDS Prevention and Control Programme at district level may be appointed from among the available Additional District Medical Officer/ Dy. CMHO (Health), or the district officer for Leprosy as In-charge of NACP activities in the district, as per the State Government notification. The District HIV/AIDS Programme Control Unit (DAPCU) headed by a District Manager will be assisted by the DAPCU programme officer taken on contract to discharge the duties, similar to the role of District Programme Management Unit (DPMU) for NRHM activities.

The District AIDS Control Officer will be the nodal person for all HIV/AIDS activities in the district. S/he would be central to framing and implementing the district level strategy for prevention and control of HIV / AIDS in the district. S/He would assist the District Administration to put up a unified action plan for stabilizing and reversing the HIV/AIDS epidemic in the district by building convergence within the HFW sector and also with the different stakeholders present in the district. S/He would ensure the continuity of the supply chain, service delivery and implementation of directions of SACS.

(4) DISTRICT HIV/AIDS PREVENTION AND CONTROL UNIT

IV.4. (i) NACP –III institutionalizes the District program implementation framework for HIV/AIDS prevention and control through the introduction of the DAPCU. Based on the expected scope of activities, the structure of DAPCU in the four categories of Districts A, B, C, and D will be as follows (Table 2 and Figure 3):

Table-2: District Level Staffing Structure (Category-wise)

Staff	Categories of Districts			
	A	B	C	D
District Programme Manager (HIV/AIDS)	1	1	1	1
Assistant-cum-accountant	2	2	1	1
M&E Assistant	1	1	1	-
Support Staff	1	1	1	1
Supervisors for the ICTC Programme	1	1	-	-

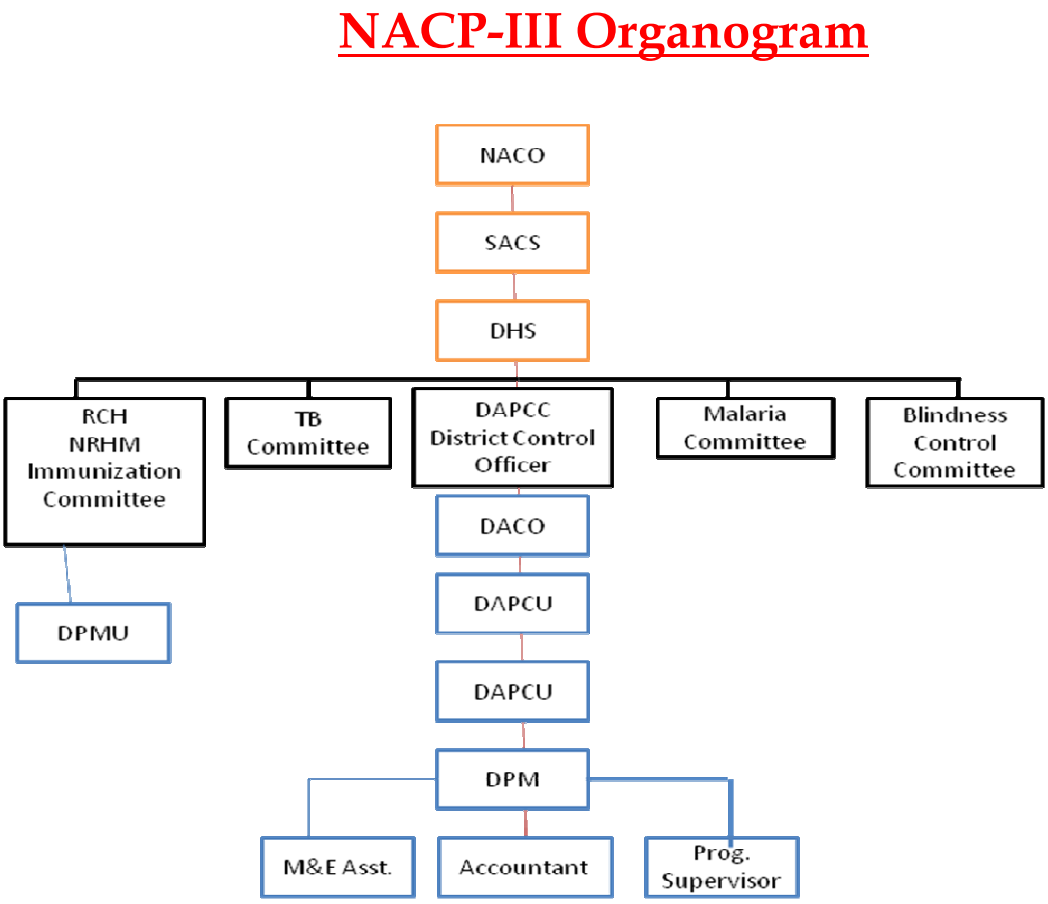

Figure 3: NACP-III Organogram

B. THE ROLE OF DAPCU IS THREEFOLD:

- implementation of NACP strategies;
- convergence with NRHM activities; and
- convergence with the other related Departments in the District.

The detailed programme activities to be implemented as per operational guidelines is detailed as below at Table 3.

Table 3

A thematic listing of functions for distinct activities is given below

S.No	Thematic Component	Roles and functions of DAPCU
I.	**Delivery of Services**	
1	Targeted interventions	Facilitate access to AIDS prevention and treatment services, general health services and other entitlements including package of services for HRG Create a supportive environment for TIs to function
2	Package of Services	Monitor the delivery of services Manage the integration of services with the general health system and other non health interventions
3	Assured Safe Blood and Blood Products	Develop a district wise information and transportation schedule to provide blood and blood components to Blood Storage Centres Systematize voluntary blood donation and schedule as well as monitor activities of VBD camps Deal with infrastructure issues of new blood banks
4	Condom Promotion	Monitor availability of condoms at service provision point
5	Convergence with RCH, TB and other MOHFW	Work with concerned programme officers to effectively integrate their functions
6	Improved access to treatment for ART and opportunistic infections and continuum	Monitor the management of OIs and ART.
7	Providing care support and	Monitor children born to sero positive mothers for early signs of the need for ART

	treatment for children infected and affected with HIV/AIDS	Monitor and investigate any instance of denial of rights to HIV infected and affected children Advocate with district authorities and organisations to protect the rights of children
8	Management of ART drug adherence	Follow up patients through home based counseling for ART Drug adherence
II. **Monitoring and Revising awareness & impact mitigation**		
9	Women, Children and young adults	Working with district level departments for prevention, treatment and impact mitigation on women, children and adolescents
10	Migrants, Trafficked Persons & Populations in Cross-border areas	Provide pre departure guidance to migrants and provide linkages to organizations in destination areas and link up with existing health services for STI management and Condom promotion
11	HIV/AIDS Response in the world of Work	Facilitate access to treatment and prevention services for referrals from interventions
12	Communication and Social Mobilization	Conduct district level IEC campaign Use local channels for demand generation Work with PRI institutions and local CSOs for social mobilization for HIV prevention and management
13	Mainstreaming with Public and Private Sector	Technical support to district level organisations to integrate HIV in their functions Provide linkages to HIV services in to district departments and organization
14	Civil Society Partnership forum at District levels	Support the formation and functioning of district civil society partners forum
15	Strengthening community care and support programs	Establish referral linkages to service providers Monitor functioning of approved centres
III. **Management**		
16	Linking care, support and treatment with prevention	Monitor integration
17	Impact mitigation	Set up linkages with district level organisations and departments for support to PLHA and their families

		Facilitate access of PLHAs to social support
18	Surveillance	Oversee collection and forwarding of samples
19	Capacity building	Conduct district level trainings
20	Program management	Engage contractual manpower at DAPCU, LTs, Consultants and Link Workers
21	Financial management	Maintain fund flow for NACP activities , submit UCs and ensure financial propriety
22	MIS	Maintaining the District dashboard and regular reporting to SACS on physical, financial, epidemiological progress

The functions to be implemented are expected to be through the NRHM framework and using the available infrastructure under other departments, civil society organizations and local elected bodies, village level committees, etc, as described in Table 4.

(1) Terms of Reference OF DAPCU STAFF

The staff of DAPCU could be selected on deputation/contract basis as per the guidelines issued by NACO in this regard. The selection will be made by the SACS/DHS as per the State specific policy. The suggested TORs of the DAPCU staff are as follows:

(a) District Programme Manager (HIV / AIDS)

The District AIDS Program Manager's role is to provide techno-managerial, support for training, reporting, monitoring, supervision, implementation and surveillance of NACP and all HIV/AIDS related programs / projects in the assigned District according to policies and guidelines of SACS**.** The DAPM shall supervise the DACO. S/He will be selected by PD SACS but be responsible to CMHO/Nodal Officer at District level and PD SACS at State level in the discharge of his duties. The roles and responsibilities of DAPM are as follows:

i. Planning and implementation of District Action Plans :

- Ensure the preparation and smooth implementation of the District Action Plan for HIV/AIDS Prevention and Control, emphasizing both on the implementation of core NACP strategies and effective mainstreaming with NRHM activities.

- Send regular Reports on physical, financial and epidemiological parameters to SACS.
    - Operationalisation of ICTCs, PPTCTs, Blood Banks, Blood Storage Units
    - Ensure engagement of contractual manpower, including Link Workers, Lab Technicians and Consultants **and maintaining systems for timely payments, training & monitoring**
    - Supply chain management at the district and sub-district level.
    - Facilitate in supplying of testing/delivery kits, condoms, drugs and other consumables from the district to the public health institutions – ICTC, PPTCT, ART, Blood Banks & TI.

ii. Capacity Building:

- Ensure the implementation of training plans
- Ensure district level support to TIs , with emphasis on ensuring access to services including referrals to Public Health Infrastructure, including hospital facilities and manpower.

iii. Advocacy

- Organising Stakeholder Consultations with Govt Departments, SMOs, CBOs, PLHAs, NGOs through the NGO forum to be constituted and
- Undertake effective IEC for the NACP activities

iv. Programme Management

- Institutionalize system of interaction with Distt Program Management Unit for NRHM to work out effective convergence with activities under NRHM, RCH, TB & IEC
- Ensuring need based institutionalization of systems of Fund Flow to Rogi Kalyan Samitis and collection of UCs
- Maintain a Bank account for DAPCU and submit reports on fund flow and annual Audit to SACS
- Oversee the functional status of Blood Banks in the district and their adherence to NACP protocols
- Collecting the information about functional status of each institution on a monthly basis, compilation of data and sending this information to the SACS.
- Supervise the functioning of the HIV service outlets and attend quarterly meeting of Medical officers, monthly meeting of other project staffs and frequent visit to these service outlets.
- Provide feedback and support to the field staff for better performance

(b) M&E Assistant

The role of M&E Assistant is to strengthen the DAPCU and assisting the DAPM by monitoring all the HIV/AIDS related activities in the district and provide timely feedback to the District team for better execution of HIV/AIDS plans. The responsibilities of M&E Assistant are as follows:

- Enter the data and send the completed reports to SACS/NACO and partner NGOs on time
- Ensure that the formats submitted by the field staff are filled completely and are being submitted on time
- Undertake field visits to verify the registers, PHC maps, (content and quality of information) in the centers
- Maintain the district dashboard and update it regularly.
- Update the team members about the district situation in the monthly team meetings

(c) Supervisor

The District Supervisor will assist the DAPM in implementation of the ICTC programme including PPTCT and HIV/TB in accordance the operational guidelines

(d) Assistant cum Accountant

The Accountant will maintain the accounts of the DAPCC. He will prepare the budget for the activities as per the given guidelines by SACS. He ensure fund flow for various activities under the DAAP and proper monitoring and report of fund utilization. He/She will facilitate audit of the DAPCC accounts for submission to the SACS.

(e) Other Contractual Manpower at Sub-District Level

In all "A&B" districts NACP III envisages creation of a new cadre of Link Workers to be introduced for providing HIV/AIDS prevention, control, care and support services in villages with population more than 5000. Approximately 50 link workers may be engaged in a district, of which 20 will be upgraded to the post of Supervisor. The link worker will be assisted by local volunteers for outreach functions. In villages where the link workers and volunteers are not engaged, their services shall be provided by the mainstream health workers viz. ANM, MPW and ASHA. Provision of induction and in-service training to link workers and support for advocacy/IEC material and monthly meetings shall be an important task of DAPCU.

Link Workers will be monitored by 2 superiors in accordance with the operational guidelines. Broadly, it is proposed to implement this component by NGOs':

(f) Staff at ICTCs: It is also envisaged that NACP will provide contractual Lab Technicians and Counselors at every ICTC/PPTCT. Systems for assessment of man power requirement, recruitments, fund flow or payment of honorarium and monitoring will be operationalized by DAPCU. The modality for engagement of contractual manpower either through the DAPCU, NGO or the Hospital Management Society will be decided by the SACS.

III. DISTRICT NACP-NRHM CONVERGENCE STRATEGY

One of the key lessons of NACP-II was that centralized program implementation restricts opportunity for optimum utilization of HIV/AIDS related services (ICTC,PPTCT, STI, ART, CCC etc) and offered inadequate outreach to clients accessing the public health infrastructure for FW,TB and OI. Since the programs were being administered directly by the SACS, ownership amongst doctors, lab technicians and nurses remained low despite orientation on the AIDS program.

NACP-III envisages mainstreaming of HIV/AIDS issues with the general health system upto the village level through grassroot workers like ANM, ASHA, MPW etc. The HIV related issues will be included in the IEC, training curriculum, monitoring and evaluation indicators and reporting formats in the health system; and issues of family planning, nutrition and triple protective role of condoms, referrals etc. in the NACP activities at all levels.

The NRHM focuses on 18 States across the country for special inputs to improve their demographic indicators and service delivery systems. These include the States of Uttar Pradesh, Bihar, Uttaranchal, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Sikkim, Himachal Pradesh, Jammu & Kashmir and the 7 North-Eastern States. The high focus Category A & B Districts under NACP are as per Annexure 1. The District AIDS Action Plan will attempt to optimize the available resources under these two Flagship programmes of Govt. of India in the district.

(a) Village Level Services: Village Health & Sanitation Committee:

The NRHM provides for a Village Health and Sanitation Committee to plan, monitor and supervise the implementation of the multi-sectoral health and sanitation plan at the village level. The Village Health Plan is to be prepared by the ANM, assisted by the ASHA and Anganwari worker, after undertaking a detailed household survey of the village for health related parameters. The planning exercise is expected to be undertaken in consultation with the multifarious stake holders at each level.

Comprehensive HFW and Woman and child care services are being provided through the provision of fixed monthly Mother Child Health and Nutrition (MCHN) day at the Anganwari level under NRHM. It is expected that pregnant and lactating women and Under 5 children will be provided the crucial package of services on these days for antenatal and post-natal care and/or nutritional needs and immunization In addition, ASHA along with the link worker will ensure that their HIV prevention and care needs are met through effective linkage and referral system.

Thus, the convergence of NACP activities at the village level will include the following:

- The Village Health Committee will be oriented about the threat of AIDS and strategies for prevention, treatment and care. The committee will be motivated to provide community support to PLHAs for treatment and support.
- Link Worker will be included as member of Village Health Committee
- The Household survey to be updated annually, could include HIV related parameters.
- The Village Health Plan will mainstream issues of AIDS prevention care & support.
- The untied fund at the Sub Centre could be accessed for AIDS agenda also.
- Under the revised NACP-NRHM coordination framework, the ASHAs would be given two day orientation training on HIV/AIDS.
- Other functionaries like ANM, MPW, Nurse, AWW and Link Workers will be similarly sensitized on joint issues.
- Counselling pregnant women in risk areas to seek PPTCT services, oversee the nutritional support to PLHA mother and her newborn, referral for timely testing of the newborn to assess the HIV status etc will be undertaken at the MCHN Day.
- ANM/ASHA will ensure institutional delivery of the HIV positive mother.
- Mobile Labs could provide testing facility on MCHN Day at the Anganwari .
- These functionaries will be sensitized about the PLHAs and HRG in their jurisdiction and will ensure supply of condoms.
- Simultaneously patients with STI/TB/OI in such high risk zones/group will be motivated to seek referrals for HIV testing and counseling and further management.
- The grassroot functionaries will also ensure follow up with HIV/AIDS cases for ART services and community support.
- ASHA, after orientation, will be able to sensitize villagers/women on RTI/HIV/AIDS, advise them on the use of condoms, and refer the RTI/STI cases to PHCs for treatment after testing and counseling.
- ASHA will promote ANC and institutional deliveries for the joint mandate of NRHM & NACP.
- The IMNCI protocol will include special care for HIV positive infants.

Destigmatisation of the epidemic and reduced insistence on confidentiality is key to the efforts for mainstreaming HIV/AIDS services under NRHM. Sharing of PLHA data would be crucial for improved tracking, service provision & rehabilitation of PLHAs through Public Health infrastructure.

There is scope for mainstreaming efforts at every level. To illustrate, if a pregnant women with TB symptoms visits a District Hospital, she is pricked 4 times for blood test - for PPTCT, TB, ICTC and blood profile! Each Wing in the hospital feels accountable only for its component and not for the holistic patient profile.

Tracking of PLHA mothers and administration of nevrapine during delivery can be made a subset of Janani Suraksha Yojana (JSY). Some States have split the JSY package to include monetary payment for 3 ANC check ups. Counselling is being provided before blood testing during ANC to promote PPTCT risk analysis. The incentive of ASHA can also be split to include ANC before institutional delivery.

(b) **Block Level Services**:

The Block Health Mission implements the comprehensive Block Action Plan in its jurisdiction chaired by the Pradhan of the Panchayat Samiti. The Member Secretary of the committee is the Medical Officer/OIC of the CHC/PHC in the Block. There is provision of a Hospital Management Committee at CHC and PHC level under NRHM which will be supported through Untied Funds annually. Further, NRHM seeks to upgrade all SubCentres, PHCs and CHCs to the Indian Standard of Public Health (IPHS). The possibilities of NACP-NRHM convergence at this level will include the following:

- The District Plan will map out the need for equipping the PHC/CHC to provide PPTCT/ICTC services based on the vulnerability pattern of the district. It has been decided that in A&B category districts, all 24 hour PHCs/CHC will built in capacity to provide ICTC services, to improve accessibility.
- DAPCU will orient the existing Lab Technician and LHV/Nurses on AIDS to provide need based referral, testing and counseling.
- The provision for equipments for testing like centrifuge, refrigerator and infantometer at all identified PHCs would be made under NRHM. HIV/AIDS testing kits will be provided by SACS.
- The accommodation and confidentiality for counseling services would be provided by NRHM.
- DAPCU will ensure establishment of cross referrals for follow up of HIV positives so that their future ART needs can be taken care in addition to management of HIV TB co-infection.
- IEC on STI/RTI/HIV/AIDS will be intensified and posters be pasted at AWCs, SCs, PHCs and CHCs.
- List of referral hospitals/rehabilitation Centre/NGO etc. will be made available at all PHCs/CHCs and referral protocols established , for confirmatory testing, counseling and follow up of suspected cases detected at the PPTCT.
- The monthly review meeting at CHC level will be attended by the PHC in-charges, representatives of TIs, BSUs, Supervisors, and counselors of ICTCs

Joint strategy will be formulated based on the feedback received at these meetings which will enable improved supervision and monitoring of the program, and also address integration issues with NRHM and other Departments in the jurisdiction of the CHC.

(c) DISTRICT LEVEL

District level convergence with NRHM and other Departments shall be worked out in the DHS. The meetings of the DAPCC will specifically focus on the opportunities for mainstreaming activities with those of TB, STI, FW, NRHM and with other departments.

Under NRHM, the District Health Action Plan reflects an overview of epidemiological status of the District and comprises the following five parts:-

a. Reproductive and Child Heath Programme
b. Immunization
c. NRHM Additionalities
d. National Disease Control Programme
e. Inter-sectoral convergence, including AYUSH
f. The District AIDS Action Plan will become the sixth component of the Comprehensive Framework, drawing strength from the convergences with the different components of the plan. The Specific areas of convergence have been elaborated upon in Part B of this Document.

IV. INTERSECTORAL CONVERGENCE FOR NACP

NACP-III envisages expansion in outreach and effectiveness of the prevention and support strategies through wider convergence with different Departments functioning at the District level. HIV/AIDS is to be seen not only as a medical issue but a manifestation of the socio-economic profile of the district. While response to the epidemic is the responsibility of the Medical & Health Department, effective strategies for Prevention and Support are possible only through the creation of a wider support system under the leadership of the District Collector. The Table-4 below, attempts an indicative menu of suggested activities that can be incorporated in the District AIDS Action Plan. The Nodal Officers of these Departments will be inducted as members of the District Health Society, and participate in all monthly meetings. Some crucial Departments can also be inducted as member of the District AIDS Prevention and Control Committee (DAPCC), which will meet at more frequent intervals to plan and implement the activities approved in the District Action Plan.

Table-4 – Suggested list of activities

Department	Convergence Issues	Nodal Officer
Women and Child Department	➢ Anganwari worker to counsel pregnant women for PPTCT ➢ SHGs to support PLHA ➢ Integrate HIV into all training programs ➢ Establish Red Ribbon Clubs among adolescent girls ➢ Train Anganwadi workers to detect and report HIV related discrimination in villages	Deputy Director, ICDS
Panchayati Raj	➢ Training to departmental functionaries and elected representatives for sensitization and community ownership, participatory planning, care and support ➢ Advocacy ➢ Issue instructions to Panchayats to protect infected persons and affected households from discrimination and protect the inheritance of widows and orphans ➢ Issue guidelines to Panchayats to discuss HIV related issues relevant to the village in Gram Sabhas and other meetings ➢ Request Panchayats with their own budget to allocate resources to supplement HIV prevention and control programme	CEO Zila Parishad
Rural	➢ Integrate HIV into all training programs	

Department	Convergence Issues	Nodal Officer
Development	➢ SHGs to work with Red Ribbon Clubs to support efforts for prevention, treatment & support to women ➢ Integrated IEC efforts	PD DRDA
Youth Affairs & Sports	➢ Promote Voluntary blood donation ➢ Undertake condom promotion ➢ Conduct special campaigns/ programmes by the NSS on safe reproductive health and HIV for rural youth ➢ Train all NSS Programme Officers and NYK coordinators ➢ Undertake social marketing of condoms through Youth Clubs, Youth Development Centres. ➢ Reorient Youth Development Centres at university/ college level youth centres to provide Young People Friendly Information Services.	District Sports Officer
SC/ST Welfare	➢ Preparation of ST component plan especially for TADA/MADA Blocks in the District ➢ Provide technical support to ITDASs to analyse the vulnerability & risk perception for HIV/AIDS ➢ Train traditional healers and unqualified doctors with influence in the community on management of STIs and referrals to ICTC centres.	District Social Welfare Officer
Tourism	➢ Increased surveillance in tourist spots for HRGs ➢ Condom promotion ➢ IEC	District Tourism Officer
Labour/Mines/ Fisheries /Industry	➢ Condom Promotion ➢ IEC ➢ Provide the package of services including prevention and treatment services in all major ESI hospitals ➢ Advocate with and facilitate trade unions to manage provision of services to migrant labour and workers in the informal sector and to lead on reducing stigma of infected workers and their families ➢ Integrate HIV prevention in all training programmes undertaken in labour department	District Industry Officer, CII/FICCI District Coordinator

Department	Convergence Issues	Nodal Officer
	➢ Promote AIDS prevention with industry under CSR	
Police & Jail	➢ Support in identification of HRGs ➢ Orientation for HIV threat perception and sympathetic dealing with HRGs & HIV patients including to affected and migrant women ➢ Condom Promotion among jail inmates	Superintendant of Police
Education	➢ Emphasis on Adolescent Health Education for Life Skills ➢ Include HIV awareness in Adult Education Programme. ➢ Emphasis on retention of HIV affected children in schools	District Education Officer
Transport (including Bus stands & railway stations)	➢ IEC at Bus Stand/Railway Station ➢ Provision of Condom Vending Machines ➢ Focus on routes used for migration & upscale IEC on those routes, in buses & trains ➢ Train all personnel on HIV	District Transport Officer
Revenue	➢ Integrate HIV training in all Departmental training	ADM
Municipal Corporation & Urban Local Body	➢ Mapping of HRGs ➢ Awareness and Support for service provision through NGOs and TIs ➢ Provision of Condom Vending machines ➢ Advocacy and support for AIDS program and PLHAs	Municipal Commisioner
Civil Supplies	➢ Antyodaya cards for PLHAs	District Supply Officer

V. FUND FLOW TO DAPCU

After the introduction of NRHM, the District Health Society has the following system of fund transfer:

There is a single bank account for (A) RCH, (B) Additionalties under NRHM, and (C) Immunization. Individual bank accounts are being maintained by all the National Disease Control Programs, based on the exigency of their programs. All bank accounts are being managed by the Financial Management Group (FMG) of the District Program Management Support Unit (PMSU) which supports all NRHM activities under the wider NRHM umbrella framework. The FMG maintains ledgers for all program bank accounts, issues cheques, collects UCs, and assists audit of the DHS accounts. The funds for District Action Plans will be transferred to the FMG to

be in turn released to the District Health Society and DAPCU. Till this arrangement is finalized, funds will be sanctioned by SACS for the implementation of the District AIDS Control and Prevention Action Plan by transferring to the District Health Society, in the Bank Account of the District AIDS Prevention and Control Committee (DAPCC). The Bank account of DAPCC will be operated by the DAPM and DACO.

The Funds to be released to the DAPCU will be for the following activities:-

a) Funds for operational expenses and salaries of DAPCU
b) Payments for Counselors and Lab. Technicians at ICTC/ PPTCT
c) Funds for Training and IEC activities
d) Operational expenses for transportation of Blood to Blood Storage centres, voluntary blood donation camps etc,
e) Funds for other interventions e.g. CCC, DIC, TIs and STI clinic.
f) Monitoring and evaluation of various interventions from time to time.
g) Salaries and other expenditures for ART centres
h) Any other

Besides, supplies will be received in kind for condoms, drug/testing kits, consumables at ICTCs, PPTCTs, Blood Storage Unit, ART Centres etc. These will be indented by the SACS after counseling DAPCU and passed on to assigned health facilities for which proper maintenance of registers and records shall be ensured.

The Financial delegation of powers will be as per guidelines issued from NACO under the scheme.

VI GUIDELINES FOR THE PREPARATION OF DISTRICT HIV/AIDS ACTION PLAN

The key to the the effective decentralization of implementation of HIV/AIDS control programme is the District Action Plan, based on which financial and other resources will be provided. The District HIV/AIDS Action Plan will be a component of the District Health Plan prepared under the NRHM. The plan will contain list of interventions to be taken up based on evidence and available data and prepared containing the following information and activity components : -

1. VISION :

To evolve and implement a multipronged sustainable strategy to enable the district to achieve the NACP-III goal of halting and reversing the HIV/AIDs epidemic by 2012 through effective management of Core NACP interventions and expanding the outreach services through mainstreaming with activities of NRHM and cognate Departments.

2. GOAL :

Formulation and implementation of a comprehensive inter-sectoral Action Plan to reduce the incidence of new HIV cases to zero through effective strategies for prevention; and provision for identification, treatment, care and destigmatised community support for PLHAs to improve their quality of life.

3. STRATEGY :

Expansion of the network of HIV/AIDS services from the NACP-II pattern of selective NGO/CBO led provision of care, treatment and support, to universalisation of services through mainstreaming with the public health infrastructure for ensuring continuum of care. The new approach emphasises on decentralisation of services, mainstreaming, inter sectoral convergence and community ownership and support for HIV/AIDS prevention and control efforts. It seeks a unified strategy under the leadership of the District Collector for effectiveness, optimisation of resources and unity of efforts. From the district, the program will filter down to every village and Anganwadi level, with a cadre of customised service providers called Link Workers. The DAPCU will ensure professional management of the program through regular monitoring & supervision.

4. DISTRICT PROFILE

(i) General indicators

Indicator	District	State
Geographical Area (in Sq. Km)		
Revenue Sub Divisions		
No. of Tehsils		
No. of Panchayat Samiti		
No. of Municipalities/ULB		
No. of Gram .Panchayats		
Total Number of villages		
No. of inhabitated villages <5000 No. of inhabitated villages <5000		
No. of villages of difficult to reach		
No. of towns		

(ii) Demographic Indicators

Population Index (2001)	District	State
Total Population		
Female population		
Male population		
Rural Population		
Urban Population		
Child Population (0-6 years)		
% of child population (0-6 years)		
Density of population		
Decadal growth rate (1991-2001)		
Male Female ratio		
Ratio of children male female (0-6 years)		
Literacy Rate		
Male Literacy Rate		
Female Literacy Rate		
SC %		
ST %		

Source :

(iii) 1.3 Health Facilities at a glance, Block wise

Health Institute	Blockwise			District Total
	X	Y	Z	
District Hospital				
Referral Hospital				
Community Health Centre				
ICTC				
Blood Banks (Public, Private)				
Blood Storage Units				
Primary Health Centre				
PPTCT				
Sub centre				

(iv) Profile related to PPTCT & STI status in the District

Index (2006-07)	Name of Block					Distt. Total
Pregnant Women						
Partial ANC %						
Full ANC %						
Women referred for MTP						
Total Delivery						
Institutional Delivery						
Total deliveries at home						
Number & % of women benefited under Janani Surksha Yojana						
STI/RTI cases reported						

(v) Identified Facilities

Block Name	ICTC	PPTCT	Blood Bank	Blood Storage Unit	STD	ART	TI	DIC	Care Centre	Sentinel Sites

(vi) **Trends In Coverage of HRG**

S. No.	HRG	Size	Covered	% Coverage
1	**FSW**			
2	**MSM**			
3	**IDU**			
4	**Truckers**			
5				

(vii) Sentinel Data Profile

Sites	Year	Year	**Year**	**Year**
HSS data				
STD Clinic				
ANC Clinic				
TI Project CSW				
CMIS data				
Blood Bank				
PPTCT				
ICTC				

(viii) PLHA data for the District

Name of ICTC	**No. of PLHAs**			
	On ART	**New**	**Died**	**Lost to Follow-up**

(ix) Trends in Referrals and Identification of PLHA

Referrals from	**TI**		**PPTCT /PHC**		**Private Clinic**		**BSU**	**STI**	**TB**	**OI**
	Tested	**+ve**	**Tested**	**+ve**	**Tested**	**+ve**				

(x) HIV – TB activities

Index	Name of block	District training
Estimated TB infected person		
Estimated no. of co-infection		

No. referred from ICTC to TB microscopy		
No. referred from TB microscopy centre to ICTC		
NO. tested and found positive (%)		
No. on DOTS programme (%)		

(xi) Overview of District AIDS Profile

Study of epidemiological status of the district with respect to NACP activities would be conducted by examining HIV positivity among HRG, STD patients and attendees coming to Antenatal clinic attendees and ICTC, route of transmission of AIDS cases, distribution of HIV positive cases within the district and in adjacent districts, trends in HIV prevalence, ANC, STD and FSW

Based on the available data (including data from NFHS-III and HSS), the HIV/AIDS situation in the District would then be analysed in the following format:-

- Population of the District
- Size of various HRG populations
- Size of HRG population covered under TI.
- Total Number of people tested for HIV in ICTC.
- Number of women tested and diagnosed positive in ICTC
- HIV Sero Positivity rate (among tested): %
- Total number of STI cases expected:
- Total STI treated
- Percentage of people who report that in the last 12 months they had STI: %
- Total condom distributed:
- Total blood units donated :
- Total Nos. & members of the Red Ribbon Clubs:
- Total PLHA CD4 count:
- Total PLHA registered for ART (pre ART):
- Total PLHA on ART:
- Total (HIV patients in TB+ TB patients diagnosed HIV) :
- Overall ANC prevalence % (HSS-2006) :
- Total Positive deliveries :
- Total reported deaths :

(xii) PLANNING PROCESS

a) INSTITUTIONAL. FRAMEWORK

This section would unfold the institutional framework for NACP activities in the District and would include information about the following:

- Merger of District AIDS Control Society with the District Health Society
- Structure of Governing Council and Executive Body of the Society
- Composition and ToRs of the District AIDS Control & Prevention Committee(DAPCC)
- Functions of DAPCU with workplan
- Linkages with the Block Rural Health Mission & Village Health & Sanitation Committees

b) CONSULTATIVE PROCESS

In the first year, the consultative process for framing the District Action Plan may be limited to the members of the DAPCC. However, from next year, with the sub district structures in place and with the consolidation of the broader institutional framework, the AIDS Action Plan may be based on the inputs received from the Village & Block level consultations. This will need an extensive plan for orienting the members of the Health Mission at these levels and organizing structured staggered meetings for obtaining their inputs.

(xiii) GOAL SETTING

The Goals of the District will be guided by the overarching goals identified by SACS for the XIth FYP and the current year and the goals of NACP III.

(xiv) MAPPING OF DISTRICT HIV/AIDS PROFILE

A detailed pictorial map of the District would be attempted depicting the high risk sites for high risk groups, migrant workers, sex workers etc., and the functional status of ICTCs, PPTCTs, Blood Storage Units. This district mapping will give a clear idea of the presence of affected and high risk population groups, the network of TIs and other care givers and the need and opportunity for further upscalling of services either through link workers or through mainstream healthcare infrastructure including existing outreach health care workers such as ASHA, ANM, MPW etc. Such analysis may also reflect the need for identification and upgradation of existing PHCs to PPTCTs and CHCs to ICTCs.

(xv) INSTITUTION- WISE NEED ANALYSIS FOR NACP ADDITIONALITIES

(i) Man Power

Name of ICTC/PPTCT	Addl. Manpower in place			BSU Operationalisation	TI/NGO linkage
	Counsellor	LT	LW		

(ii)Supplies

Name of ICTC/PPTCT	Supply of Kits			
	Drugs	Kits	Condoms	Consumables

(xvi) INSTITUTIONAL STRENGTHENING FOR CORE ACTIVITIES

TIs

Objective	To support and mainstream TIs for effectiveness and sustainability
Situational Analysis	• Number of TIs operational in the district • Physical area and HRG covered • Targets and ToRs • Budget sanctioned • Understanding the strengths and areas for support
Strategies	Mainstreaming with Public Health delivery system for supplies, service, delivery and follow up
Action Plan	- Including TI representatives in DAPCU and DHS - Institutionalizing formal system of monthly interaction with OIC of ICTC/PPTCT in TI jurisdiction - supply of condoms, IEC material to TIs from SACS to be routed through DAPCU - MIS report from TI to SACS to be copied to DAPCU - Public Health Outreach Workers in TI jurisdiction to assist in TI activities, so that TI exit does not cause vacuum for service delivery.

ART/Treatment

Objective	To make ART services available to all eligible PLHAs in the district
Situational Analysis	- Number of PLHAs in the district by age profile, institution (ICTC / PPTCT) - spatial distribution of PLHAs - Number of PLHAs : HIV+, Pre-ART & ART - Availability of ART centre & Link ART Centre within the district or at Medical College - Functional Status of ART centres - Operational issues in accessing ART drugs by PLHAs - Linkages with ICTC, TI, CCC, etc - Existence of Drop-in and Community Care Centres
Strategies	- Increase and strengthen ART Centre in the district - Promote Counselling for ART compliance - Mop up all eligible adult and child PLHAs - Monitoring ART adherence - Ensure supply of ART drugs
Action Plan	- Expansion of ART services to District Hospital - HOD Medicine will be in-charge of administration of ART Program - Link up ART Centres with CD4 testing facility and the ICTC/CCC and care and support centres - Update registration and tracking of PLHAs on ART - Mopping up eligible PLHAs through LWs, NGOs, outreach workers & PLHA network - Depending on the transparencies of the program, health staff & outreach workers can be oriented for PLHA tracking - Train staff of DH/ICTC facilities for empathetic effective & timely response to PLHAs - Sample collection for CD4 count from district level if there is no ART centre in district.

ICTC

Objective	- To provide counselling and service for HIV testing - To prevent HIV Transmission by PLHAs - To promote Positive living in PLHAs
Situational Analysis	- No. of ICTCs functional in the district hospital/CHC/PHC level - Vacancies at ICTCs and training need for ICTC staff and outreach workers - Linkages with TIs, if any - Trend of PLHA identification from HRG and

	through referrals from RNTCP, PPTCT, STI clinics, private nursing homes, TIs - Outreach worker for AIDS at the ICTC - Need for upgradation of ICTC services in the district if any - Quality upgradation status
Strategies	- Scale up ICTC services to expand access, encourage safe sex practices and to ensure prevention and positive living - Promote ICTC in private sector
Action Plan	- Make available ICTC services in 24 hour PHCs - Introduce mobile ICTC in hard to reach tribal areas - Train and position counsellors in new ICTCs - Organize periodic training and retraining for ICTC staff - Generate demand for ICTC by IEC. - Identify private provider with high STI client load to provide ICTC services - Establish linkage of ICTCs with TB, PPTCT, STI, ART, Care and support (with mainstreaming departments) - Regular facilitative technical supervision to be done by ICTC district coordinator.

BLOOD SAFETY

Objective	To reduce transmission of HIV infection through blood safety, and to ensure timely availability of safe blood and blood products to patients and health institutions, especially in remote and rural areas, by enhancing the annual collection of safe blood in the district.
Situational Analysis	• Total number of public and private Blood Banks/Blood Storage Units in the district. • Identification of inputs required for strengthening Blood Banks and BSUs viz. man power, equipments, consumables etc. • Trends of requirement and supply of blood and blood products in the district. • Predicting blood requirement for the coming year based on trends • HIV cases being reported at sentinel sites of blood banks in the district • The size of IDU population in the district • HIV prevalence among blood donors
Strategies	• To strengthen the infrastructural requirements in blood banks/ blood storage units operational in the

	district through inputs from SACS and NRHM • Promote blood donation to maintain optimum level of blood supply as per the needs of the district. • Licensing of all blood banks in the district and strengthening the safety protocols in both public and private blood banks • To ensure quality compliance • Capacity building of doctors and paramedics for blood safety • Institutionalizing the supervisory system at the district level through District AIDS Control Officer for public and private blood banks/blood storage units for blood supply, data sharing and quality compliances • Promoting blood safety practices in the district
Action Plan	• Geographical mapping of blood banks and blood storage units to streamline collection, supply and storage of blood in the district • Appointing District Aids Control Officer as the Nodal Officer for blood safety in the district. This officer will ensure convergence between the interventions of Public Health, SACS and NRHM for this activity at district level • Conduct training plan for blood bank medical officer and staff in accordance with the NRHM and NACP protocols • Ensuring supply of equipments and consumables through NRHM and NACP • Emphasis on quality assurance through constitution of external assurance team from Medical College • Involve NGOs and PLHA networks for HIV risk reduction services, specially among HRG population groups • Promoting IEC and advocacy for blood donation and blood safety

SUPPLIES AND LOGISTICS

Objective	Ensuring uninterrupted, regular supply of goods and consumables under NACP and NRHM to support the AIDS prevention, treatment, care & support activities in the district
Situational	- Estimation of requirement of different components, facility wise. The list would include testing kits, safe

Analysis	delivery kits, condoms, ART drugs, components for Infection Control and Waste Management, IEC material, training modules etc. - Social Marketing Organisations functional in the district - The modality for logistic management & supplies and gaps therein - Quality Control Checks
Strategies	- optimum utilization of resources through convergence with NRHM and Public Health Department - Overcoming bottlenecks to obviate delays and stock outs - Inventory Control and Quality Checks
Action Plan	- Designating District ICTC Coordinator as supply officer for NACP activities - Timely collection of requirement from DH, ICTC, PPTCT, BBs, BSUs, TIs, ART Centre, Drop-in Centre, CCC, Nodal Link Workers - Compilation of requirement and consultation with CM&HO to enable convergence with other programmes - Systematic inventory control - Using NRHM logistic system for supply within district - Liaison with SACS for receiving goods/supplies timely - In case of stock out, replenishment to be arranged from parallel health interventions wherever possible

(xvii) HUMAN RESOURCE PLANNING

Operationalisation of DAPCU

This component has been dealt at length in preceding pages. The District planning would be undertaken accordingly.

- Posts envisaged, with TORs (option of mainstreaming existing personnel in health care system examined)
- Budget Requirement
- Time Line

Engagement of LTs, Counsellors

- Total manpower requirement identified

- Budget Required
- Time Line

Link Workers

Situational analysis to define the

- geographical area
- HRG population profile
- Number of LWs proposed

Strategy for operationalisation

- Engagement of LTs, Counsellors and LW proposed through DAPCU , Hospital Management Society or NGO
- Budget requirement
- Time Line

(xviii) TRAINING PLAN

The high risk perception of HIV/AIDS epidemic, together with the need for mass awareness for prevention and control implies equipping service providers with necessary skills and large scale orientation of health workers, policy makers, private providers, employees of cognate Departments, NGOs, SHG members & PRI members. The Training Plan for capacity building at District level should be carefully drawn out to enable time bound coverage of the entire training load. Some trainings would be funded by SACS , others could be mainstreamed into the training modules planned by different Departments for their personnel. The Corporate/ Private Sector and professional Bodies like IMA & FOGSI could be motivated to self finance orientations for their members. An indicative training Plan of the District could include the following stakeholders:

A. Public representatives, NGOs and Private/Corporate stakeholders

1. District heads of SHG organizations
2. Heads of urban local bodies
3. Zila Panchayat Presidents
4. Block Panchayat Presidents
5. Gram Panchayat Presidents
6. Office bearers of civil society partners forum at state, district and national level
7. Office bearers of PLHA networks at district, state and national level
8. Nehru Yuvak Kendra regional and district Coordinator

9. Trade and industry associations
10. Professional Medical Associations

B. Service Delivery Personnel whose capacities are to be built

1. Counsellors
2. Lab Technicians
3. Medical Officers in charge of ICTCs
4. Obstetric & Gynecological, Pediatric Medical Officers
5. RNTCP Medical Officers
6. Medical Officers in ART clinics
7. Nurses
8. Pharmacists
9. Record Keepers
10. Lab Technicians
11. PHC and CHC Medical Officers
12. Medical Officers in government hospitals
13. Private practitioners
14. Para Medical staff
15. Medical Officer in charge of blood bank
16. Blood Bank Technicians
17. Technical Assistants in Component Separation Units
18. Managers of community care centres
19. Outreach volunteers for treatment adherence
20. Orientation of Labour Welfare Officers on interventions in the place of work
21. Orientation of Programme Managers of NGOs on migrant support
22. STI specialists
23. Lab Technicians in district and medical college hospitals
24. Programme Managers of social management organizations

C. Other Functionaries

1. District, Block and Village level officers/ functionaries of key Departments identified for Convergence
2. ANM, MPW, ASHA
3. Anganwari workers
4. Police personnel & Jail staff
5. Teachers in Colleges & schools

The training action plan would be finalised as per Table below:

Category of personnel whose capacities are to be built	Implementing Agency	No. of Persons	No. of Sessions	Costing	Time Line Q1 Q2 Q3 Q4

(xix) CONVERGENCE WITH NRHM

Institutional Arrangements for Communitisation of AIDS Program

Objective	To create a district structure for planning, implementation and supervision of the NACP activities for greater ownership and effective outreach of the strategies and also ensure sustainability of efforts through mainstreaming with public health infrastructure. Converging the NACP activities with the District Health Administration would result in optimisation of resources and efforts.
Situational Analysis	Under NACP II, the implementation of activities for HIV AIDS was mostly through TIs and NGOs. The Nodal Officer for District level activities was either the District Collector or the CM&HO or the Superintendant of the District Hospital as per the State specific models. NACP III explores the opportunity for convergence of activities with the institutional framework of NRHM at the district level.
Strategies & Action Plan	• Placing the AIDS Control Programme under the over all umbrella of District Health Society under the NRHM framework while retaining the autonomy of operations through the structure of the District AIDS Prevention & Control Committee. • Upgrading the technical capacity at District level through creation of a District Aids Programme Control Unit manned by professionals either on deputation, or engaged through contracts • Creation of a cadre of Link Workers in the District to focus on identified High Risk Groups in the district • Mainstreaming programme activities through the existing cadre of health workers viz. ANM, MPW and ASHAs • Strengthening the delivery of services by integration

	with the CHCs / PHCs & SCs. • Including the agenda of AIDS prevention control, care, treatment and support in the Village Health Plan, Block Health Plan and District Health Plan which would be implemented by the Village Health and Sanitation Committee, Block Rural Health Mission and District Health Mission at respective levels. • Expansion in counseling, advocacy and testing services at village level through the MCHN Days

Condom promotion

Objective	Condom promotion for dual safety.
Situational Analysis	- % population using condoms - mapping hotspots, condom outlets and identification of gaps in availability & supply - SMOs working in the district under RCH & NACP - Availability of Condom Vending Machines & their operational issues - Awareness level for condom usage for dual protection - supply of condoms in TIs
Strategies	- Promoting safety practices for PLHA - IEC to promote dual protection message - Collaborative condom promotion and supply strategy under NRHM & NACP. - Promotion of condom usage among PLHAs - Ensure free and regular condom supply to HRGs - Promotion of social marketing in rural segments & through LWs - Capacity building of LWs & Health staff and outreach workers for demonstrating correct and consistent use of condom
Action Plan	- Ensure availability of condoms at hotspots, STI, Clinic and drop-in centres - Increase in sites for Condom Vending Machines - Enhanced IEC - Training module/orientation for ANM, MPW, ASHA, LW to cover this aspect - Special orientation of PLHAs - Appropriate logistic planning to ensure uninterrupted supply of condoms at all levels

Mother Health

Objective	To promote identification of HIV positive pregnant women to enable timely care and support for prevention of positive deliveries in the district.
Situational Analysis	• Number of pregnant women in the district • Percentage of institutional deliveries • Percentage of pregnant women seeking antenatal care • PPTCT trends in the district • Number & spatial mapping of PPTCTs in the district • Number of positive deliveries reported in the district
Strategies	• Upscale advocacy and counselling to motivate pregnant women to avail timely PPTCT services • Promote transparency in the programme to enable tracking of PLHA pregnant women for timely services • Availability of trained practitioners to handle PPTCT deliveries • Support mechanism for PLHA pregnant women. • Maintaining supply chain of safe delivery kits and Nevirapine drugs for PPTCT cases
Action Plan	• Counselling for PPTCT services at MCHN Day • Promoting institutional deliveries through Janani Surksha Yojana • Training of doctors, ANMs and other service providers to administer Nevirapine to Mother –Baby pair. • Tracking and support to PLHA pregnant women through ASHA/Link Worker/ANM/ AIDs Outreach Worker • Referral Protocol for PPTCT and HIV/AIDS (Line list being used for monitoring such referrals at Annexure -3) • Identifying doctors/hospitals ready to handle PPTCT cases and offering information to Positive pregnant women through Red Ribbon Clubs or Helpline • Ensuring supply of safe delivery kits from SACS and disbursal to ICTCs / PPTCTs /

	outreach worker / pregnant women for timely availability • Mobile ICTCs can be operationalised in hard to access areas for counseling and testing services at MCHN Day • Liaisoning with private nursing homes and hospitals to ensure observance of PPTCTs services and sharing of data with DAPCU • PPTCT cards can be introduced for inter district referral system to enhance the Nevirapine coverage for the mother/baby pair • The District ICTCT Coordinator will over see the functioning of PPTCT services in ICTCs and PPTCTs as also in private institutions • DAPCU can propose upgradation of new PHCs for PPTCT services as per the situational analysis of the district. PHCs close to national highways or where at least 10 deliveries are conducted per month, outpatient attendance of more than 700 per month and hard to access areas such as tribal areas, hotspots and tourist centres can be considered in such categories. • Provision of Obstetric/Gynecological doctors at ICTCs/PPTCTs to be ensured through convergence with NRHM.

Infant and Paediatric Care

Objective	Timely Identification of HIV +ve newborn and vision of support, care & treatment
Situational Analysis	- Numbers and % of the deliveries in the district (trend for 5 years) - Number of newborn with HIV - Deaths reported - Support mechanism for the children
Action Plan	- Testing of the newborn of PLHA mother 6 weeks after delivery - ART support for the newborn - Nutrition support tie up from the Anganwari - Including PLHA newborn care under IMNCI trainings
Strategies	Training and monitoring of LWs, ANMs & ASHAs for PLHA mother tracking - strengthening PPTCT services in Public

	Private hospitals for timely tracking & follow up - Convergence with NRHM (RCH) under IMNCI - Convergence with ICDS for nutritional support to PLHA mother & newborn

STI/STD

Objective	Reduction of STI/STD burden in the district & identification & prevention of HIV/AIDS cases through cross referrals.
Situational Analysis	1. Profile of Total No. of STI cases being reported & cured in last 3-5 years 2. Institutions (DH,CHC,PHC) where STI care & treatment is available 3. Bottlenecks in provision of STI services • Ability of ANMs & ASHAs to counsel, treat & refer STI patients from villages to Health Institutions • Availability of trained provider at PHC/CHC • Availability of drugs • Regular follow up by ANM/ASHA • Referral observed for what % of cases
Strategies	1. Promote health seeking behaviour among STI/STD cases and their partners 2. Expand access to quality STD treatment 3. Convergence with RCH /NRHM for STD clinics & treatment program 4. Capacity Building of outreach workers to strengthen service delivery for STI cases.
Action Plan	1. Stress on STI services & possible link with HIV/AIDS prevalence in ASHA, MPW, ANM Training module 2. Promoting discussion on this issue on MCHN day and in SHG meetings 3. Preparing IEC material for ASHA/ANM [inclusion of this topic in flip chart] for counselling 4. Improving the skills of ANM, MPW ASHA on this component 5. Ensuring availability of STI drugs at SC, PHC & CHC 6. Availability of trained manpower in Public Health institutions to be ensured through

	manpower rationalization and/or contractual engagement under NRHM. 7. Introducing referral mechanism for STI cases to ICTCs 8. Capacity building of all Ob/Gyn doctors in partnership with FOGSI and IMA
Budget	Financial implications, if any, to be worked out

Blood Safety

Objective	To ensure access to safe and quality blood in FRU as BSC in the district.
Situational Analysis	1. Assessment of demand and supply of safe Blood. 2. Status of Voluntary Blood Donation 3. Existing mechanism of supply of Blood to FRU.
Strategies	1. Regular supply of Blood to Blood Bank 2. Augmantation of VBD through structured VBD programme with the help of Red Cross and other partners. 3. Fixed supply schedule for supply of Blood to BSC.
Action Plan	1. Compliance to standards to ensure quality 2. Regular organization of VBD camps in the district. 3. Participation of Red cross, NYK, NSS and colleges for VBD. 4. Fixed plan with pre-determined date and time to replenish blood supply in BSC.

IEC & Advocacy for Behavioral Change

Objective	To raise awareness levels to promote health seeking behaviour & encourage practices for prevention from AIDS, as also to increase social acceptability and support for PLHAs
Situational Analysis	The awareness level for HIV/AIDS as per NFHS-III be examined and inferences made - Low Health seeking behavior for ICTC testing & ART treatment - Awareness and motivation of health providers on HIV/AIDS service delivery to be strengthened - Stigma related problems of PLHAs

	- Community support for programme low
Strategies	1. IEC strategy for HRGs, Bridge Populations, Adolescents, Women, general community 2. IEC strategy for Doctors, paramedics 3. Strategy for Policy makers & stakeholders from other Departments 4. Dual protection messaging
Action Plan	1. Display of IEC material prepared by NACO/SACS/NGOs at public places including major Govt. offices, health institutions, transport nodes, tourist spots etc. 2. Mainstreaming AIDS messages in IEC material of other Departments 3. Promoting NGOs, TIs, FOGSI, etc. to generate some IEC material for AIDS
	For Adolescents 4. Incorporation of AIDS awareness in School Health Program 5. Promoting Red Ribbon Clubs in Schools, Colleges & NSS/NYK 6. Organising Blood donation campaigns 7. Promoting Adolescent Education in formal & non formal education programs
	For Women 8. Discussion in SHG meetings & MCHN Day for awareness on safe sex, community, nutritional and economic support for PLHAs 9. Promotion of PPTCT services and safeguards for newborn
	HRG, PLHA Groups 10. Prevention messages for safe sex in location of HRGs (CSW,MSM, IDU, truckers, transgender, migrants, slum populations, hotels etc.
	Providers 11. Compaign for doctors & other service providers
	General Public 12. Promotion of message for public acceptability for PLHAs 13. Promote voluntary testing 14. Brand ambassadors 15. Promoting transparency & openness for AIDS affected
Activities	IEC through print, TV, radio, melas, meeting etc.

Budget	To be costed as per norms

Other opportunities for Convergence with NRHM

Other opportunities for Convergence with NRHM	- Adolescent Health & School Program - Referral protocol between DOTS and ICTCs - Surveillance mechanism sharing under Integrated Disease Surveillance Program

(xx) INTERSECTORAL CONVERGENCE

The Intersectoral Convergence Plan for the District will be prepared as per detailed guideline given in the previous section, in consultation with the nodal officers in cognate Departments. These officers shall be co-opted in the DAPCC and DHS for regular monitoring and mid course correction of the Plan, if required.

(xxi) PUBLIC PRIVATE PARTNERSHIPS

Objective	To utilize and promote the involvement and support NGOs, corporate sector, professional associations, CBOs and PLHA networks in the AIDS prevention and control program
Situational Analysis	- No. of NGOs working in the District for TIs, Drop-in-Centres. CCC and NGO projects. - Details of each intervention, including mapping PLHA networks and Red Ribbon Clubs.
Strategies	• Promoting PPP for AIDS program by liasoning with leaders of Industry, Trade and Medical Associations • Increasing public support for the program • Encouraging and supporting PLHA networks • Using NGOs for home based care, nutrition needs & OI referrals
Action Plan	- Promoting AIDS NGO Forum in the District - Giving representation to this Forum in DHS/ DAPCC - Train positive networks in home based care, nutrition needs and peer counseling on positive living - Organising events for PLHAs - Supporting NGOs in service delivery - Providing publicity to PPP models operating in the district

	- Promoting Corporate/ Industry led innovations for AIDS program

(xxii) TRIBAL SUB-PLAN

Objective	To tailor strategies for prevention and control suited to special needs of Tribal Areas (MADA/TADA Blocks)
Situational Analysis	- Number of MADA/TADA Blocks in the district - Map hotspots and vulnerable groups - Map healthcare facilities and providers
Strategies	- convergence with Tribal Area Development Plan for funds, functionaries and services - Specific interventions suited to needs of the tribal population - Promotion of NGO for service delivery - Local specific IEC in the ethnic language
Action Plan	1. Strengthening Public Health Institutions by addressing vacancies 2. Selection of local people for Link Worker/AIDS outreach worker 3. Sensitize/train ITDA staff and partner NGOs/CBOs 4. Mainstream AIDS prevention, care, support and treatment activities in health activities of ITDA projects 5. Implement local specific HIV/AIDS awareness campaigns especially for community leaders 6. Expand prevention, treatment and care services through hospitals, girls complexes and residential schools in Tribal Areas 7. Build capacities of healthcare providers including traditional leaders 8. Support mobile dispensaries 9. Regular health check ups and condom supply at village level 10. Reimburse travel cost to ICTC and ART facility 11. Establish referral services for STI, OI and ART

VII BUDGET

Table -A: Budget for DAPCU

S. No.	Position	Number to be engaged	Salary (Rs.)	Annual Expenditure (Rs.)
1.	District Programme Manager (regular)	1	8000-13500	20000*12= 2,40,000 With periodically increment and other benefits applicable for Govt. employees
2.	M&E Assistant	1	8000 Consolidated	8000*12= 96,000
5.	Accountant	1	8000 Consolidated	8000*12= 96,000
7.	Assistant	1	8000 Consolidated	8000*12= 96,000
	Total			**5, 28,000**

Table B: Fixed Costs (One Time Costs)

a)	Computer, Printer	90,000
	Total	**90,000**

Table - C: Recurring Costs

S. No.	Item	Monthly Expenditure (Rs.)	Annual (Rs.)
1	Operating expenses	5000	5000*12= 60,000
2	Local Travel	1500	1500*12= 18000
	Total		**78,000**

13. M&E : DISTRICT DASHBOARD

The NACP has put into place a rigorous system of monitoring comprising 140 indicators which are to be reported and compiled at District, State and National level on a monthly, quarterly and annual basis. It is suggested that the DAPCU maintain a District Dashboard to monitor the progress of the AIDS Action Plan at its level as follows:

1. District AIDS Society merged into DHS (Y/N)
2. DAPCC constituted (Y/N)
3. DAPCU operationalised (Y/N)

- ***Posts sanctioned*** **-**
- Filled -
- Induction Training held -

4. District Mapping undertaken (Y/N)
5. LW strategy finalized
    - LW sanctioned -
    - In place
    - Trained (induction/in-service) -
6. Lab Technicians
    - sanctioned -
    - In place **-**
7. Counselors
    - sanctioned -
    - In place
8. Delegation of Administrative & financial powers done (Y/N)
9. Fund flow system in place (Y/N)
10. Funds
    - Sanctioned
    - Received
    - Expenditure
11. Supplies

a) Two months stock available for

- ART drugs
- Condoms
- Delivery Kits
- Testing Kits
- IC & WM consumables
- AD syringes

b) Stock out reported:

12. Institutions functional

	ICTC	**PPTCT**	**STD**	**RNTCP**	**Blood Bank**
Sanctioned					
Functional					
Tests/Referral					

13. Blood Banks **Public** **Private**

- Number functioning
- Licensed
- IC & WM measures
- Blood Donation Camp held
- PLHA identified

14. Coverage **Target** **Achievement**

- FSW (Number)
- MSM
- IDU "
- Transgender
- Truckers
- Short stay Migrants
- Adolescents
- Pregnant Women
- +ve delivery
- PLHA (for ART)
- Condom Promotion

15. Cases of discrimination reported

16.

Trainings – category wise	**Target**	**Achievement**
- ASHA		
- ANM		
- Doctors		
- Other Departments		

17. IEC Planned Achievement

18. Tribal Strategy Planned Progress

19. TIs, NGOs, CBOs

- meetings held
- Coverage

20. PLHA Trends

PLHA	ICTC	HRG Category	On ART	Death
Existing				
New				

Schedule of Meetings / submissions proposed at the District Level:

DAPCC meetings : Once a Month

NGO Forum meetings: once in a Quarter

Review by SACS : Once in a Quarter

Stakeholder consultations : Twice a year

Thematic reviews : Once a month (for each component. For ex: TI, ART, ICTC, STI services etc..)

Supervision by SACS/Dev. Partner/NACO: Once a quarter

Annual District plan preparation meetings: Yearly Once

District Plan review meetings: Every Quarter

Submission of dashboards: Quarterly

Submission of audit reports: Quarterly/6 monthly/yearly

CONCLUSION :

Under NRHM, the efforts to ensure the integration of all vertical programmes and strengthening the system of service delivery so that any person visiting a health centre can obtain services in accordance with his/her needs. For achieving this vision of a comprehensive health care system, the providers of care need to be knowledgeable not only of their own particular programme, but more importantly others too, particularly those have co-infections. The relationship with other non-medical aspects such as nutrition, mental well-being, etc. is equally critical.

The Operational Guidelines for the District AIDS Prevention Control Unit is guided by this mandate viz. to ensure the total integration of the HIV/AIDS programme with the health delivery system in all the institutions and facilities ranging from the Health and Sanitation Committee to the district hospitals. Undoubtedly, the role of the District Collectors, the CEOs of '*Zilla Parishads*', the CMOs and other officials engaged in the implementation of the health care programmes will need to be critical in helping make this systemic correction and lay a strong foundation for an environment where not only one person prevented from getting HIV infections but also ensure that all those persons living with HIV infection obtain services in accordance with their needs in a non-discriminatory, non-stigmatizing manner.

Category A and B Districts based on HIV Sentinel Surveillance 2004 - 2006			
Catefory A (158)			Catefory B (38)
ANDHRA PRADESH (23/23)	Kodagu	MIZORAM (2/8)	ASSAM (1/23)
Adilabad	Kolar	Aizawl	Sonitpur
Anantapur	Koppal	Champhai	BIHAR (1/38)
Chittoor	Mandya	NAGALAND (10/11)	Katihar
Cuddapah	Mysore	Dimapur	CHANDIGARH (1/1)
East_Godavari	Raichur	Kohima	Chandigarh
Guntur	Shimoga	Mokokchung	DELHI (4/9)
Hyderabad	Tumkur	Mon	Delhi_Central
Karimnagar	Udupi	Phek	Delhi_East
Khammam	Uttara_Kannada	Tuensang	Delhi_North
Krishna	MADHYA PRADESH (5/48)	Wokha	Delhi_North_East
Kurnool	Balaghat	Kiphera	GOA (1/2)
Mahabubnagar	Dewas	Peren	South_Goa
Medak	Harda	Zunheboto	GUJARAT (4/26)
Nalgonda	Panna	ORISSA (4/30)	Ahmadabad
Nellore	Rewa	Anugul	Bhavnagar
Nizamabad	MAHARASHTRA (32/35)	Bolangir	Rajkot
Prakasam	Ahmadnagar	Bhadrak	Boroda (Varodara)
Rangareddi	Akola	Ganjam	KERALA (2/14)
Srikakulam	Amravati_Rural	PUNJAB (1/17)	Ernakulam
Visakhapatnam	Aurangabad_MH	Ludhiana	Kozhikode
Vizianagaram	Bhandara	RAJASTHAN (1/32)	MADHYA PRADESH (3/48)
Warangal	Beed	Ganganagar	Indore
West_Godavari	Buldana	TAMIL NADU (22/30)	Mandsaur
ARUNACHAL PRADESH (1/16)	Chandrapur	Coimbatore	Bhopal
Lohit	Dhule	Cuddalore	MIZORAM (1/8)
BIHAR (2/38)	Gadchiroli	Dharmapuri	Kolasib
Araria	Hingoli	Erode	ORISSA (3/30)
Lakhisarai	Jalgaon	Kanniyakumari	Baleswar
CHHATTISGARH (1/16)	Jalna	Karur	Khordha
Durg	Kolhapur	Krishnagiri	Koraput
GOA (1/2)	Latur	Madurai	PONDICHERRY (1/4)
North_Goa	Mumbai	Namakkal	Pondicherry
GUJARAT (8/25)	Mumbai (Suburban)	Perambalur	PUNJAB (1/17)
Banas_Kantha	Nagpur_Rural	Pudukkottai	Bhatinda
Dahod	Nanded	Ramanathapuram	RAJASTHAN (8/32)
Mahesana	Nandurbar	Salem	Ajmer
Navsari	Nashik	Sivaganga	Alwar
Surat	Osmanabad	Theni	Barmer
Surendranagar	Parbhani	The_Nilgiris	Jaipur
HARYANA (1/20)	Pune	Thiruvallur	Udaipur
Bhiwani	Raigarh_MH	Tiruchirappalli	Tonk
KARNATAKA (26/27)	Ratnagiri	Tiruvanamalai	TAMIL NADU (6/30)
Bagalkot	Sangli	Toothukudi	Chennai
Bangalore_City	Satara	Vellore	Kancheepuram
Bangalore_Rural	Solapur	Viruddhnagar	Tirunelveli
Belgaum	Thane	UTTAR PRADESH (5/70)	Thanjavur
Bellary	Wardha	Allahabad	Villupuram
Bidar	Yavatmal	Banda	TRIPURA (1/4)
Bijapur	MANIPUR (8/8)	Deoria	North Tripura
Chamarajanagar	Bishnupur	Etawah	WEST BENGAL (4/19)
Chikmagalur	Chandel	Mau	Darjeeling
Dakshina_Kannada	Churachandpur	WEST BENGAL (4/19)	Jalpaiguri
Davanagere	Imphal East	Kolkata	Medinipur_East
Dharwad	Senapati	Purulya	Murshidabad
Gadag	Tamenglong	Bardhaman	
Gulbarga	Thoubal	Uttar_Dinajpur	
Hassan	Ukhrul		
Haveri	Imphal West		

ANN-2

Positive Antenatal Case Line - List Register

Name of the Centre : District :
Reporting Month : Expected Month of Delivery :

S.No.	Details	Sl. No.	Sl. No.	Sl. No.
1	Date of Registration in this Centre			
2	If HIV tested earlier (Give PID No. if Yes)			
3	Name of Centre where HIV was diagnosed earlier			
4	PID No.			
5	EDD			
6	Husband's HIV status (1. Positive 2. Negative 3. Indeterminate 4. Not known)			
7	Expected place of Delivery (with address & other detail including phone/mobile No.)			
8	Link with '7' (if 7 is different from this centre, send details to the place of delivery) Yes/No			
9	Link to Ambulance service			
10	Outcome of pregnancy (1. Live birth 2. Still birth 3. Aborted/MTP/Mis-carriage 4. Others & specify 5. Not known)			
11	Date of delivery			
12	Actual place of delivery (Give details)			
13	Type of delivery (1. Vaginal 2. Cesarian)			
14	Name of the Doctor/Staff attended to delivery			
15	Administration of NVP to Mother (Yes/No) If No, give reason			
16	Administration of NVP to Child (Yes/No) If No, give reason			
17	Child was on breast feeding since birth (Yes/No)			
18	Status of the Child at 6 weeks/6months/18 months (1. Positive 2. Negative 3. Indeterminate 4. Not known)			
19	Family Planning operation/Permanent Sterlization done during delivery (Yes/No)			
20	Remarks			
