

**MID TERM EVALUATION OF THE GFATM
ROUND II PROJECT
'SCALING UP PREVENTION OF PARENT TO
CHILD TRANSMISSION OF HIV AND
ANTIRETROVIRAL TREATMENT
INVOLVING PUBLIC PRIVATE SECTOR'**

Final Report

Submitted to
National AIDS Control Organisation
Government of India, New Delhi



Development & Research Services Pvt. Ltd.
A-1/19, Safdarjung Enclave, New Delhi-110029,
Ph: 26161061, 26177413, 51694846, Telefax: 26172045,
e-mail: info@drsindia.org, Website: www.drsindia.org

CONTENTS

	Executive Summary	I - XIII
	Abbreviations	XIV - XVI
Chapter I	Introduction	1
Chapter II	Methodology	3
Chapter III	Evaluation of the Impact of the PPTCT programme	7
	Andhra Pradesh	8
	Tamilnadu	16
	Karnataka	23
	Maharashtra	30
	Manipur	37
	Nagaland	44
	Mumbai	50
	Analysis of State Wise Data	56
Chapter IV	Assessment of Graduated Cost Recovery Scheme	66
Chapter V	Assessment of Project Management by SACS	83
Chapter VI	Assessment of PPTCT Services	102
Chapter VII	Recommendations	134
Annexure I	Success Stories	139
Annexure II	Details of Entries in Line List Register (APSACS)	145

EXECUTIVE SUMMARY

In March 2000, the National AIDS Control Organisation initiated a 2-year Prevention of Parent to Child Transmission of HIV / AIDS (PPTCT) feasibility study aimed at designing an implementation model of PPTCT for the public health sector. The study supported by the Government of India and UNICEF involved 11 major hospitals of the 5 most affected states in India. Besides demonstrating that it was possible to implement PPTCT in the public sector, these studies also found that the programme provided opportunities for HIV prevention counseling and STI diagnosis and treatment for the 98-99% of the women who were unaffected. Based on the results of this study, it was decided to scale up the programme not only for prevention of HIV in women and their children but also to provide treatment, care and support services to HIV-infected women and their families.

NACO has proposed to conduct a mid term evaluation of the project to assess the impact of the PPTCT programme in the six high prevalence states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu and in the city of Mumbai as well as the graduated cost recovery scheme for the delivery of ART through public-private partnership in the three cities of Mumbai, Chennai and Bangalore.

This section outlines the key findings of the evaluation study.

Evaluation of the Impact of PPTCT Programme

Considerable increase, from 2004-05 to 2007-08, in the number of pregnant women attending ANC is noticed in all the states except Maharashtra. In the state of Maharashtra though there was gradual increase in the number of pregnant women attending ANC from 2004-05 to 2006-07, it declined sharply in 2007-08. In general the data indicates increased awareness among pregnant women with respect to attending ANC and getting tested for the HIV status. This is a positive impact of the efforts of mobilization of pregnant women in the PPTCT programme.

The percentage of pregnant women attending pre-test counseling (of those attending ANC) and the percentage of pregnant women accepting HIV test (as percentage of pre-test counseled women) in all the SACS was found to be about or over 90% during 2007-08. During 2007-08, TNSACS recorded 100% achievement with respect to the acceptance of HIV test by pregnant women.

Post-test counseling of pregnant women is also as important as pre-test counseling. However, in the states of Andhra Pradesh, Maharashtra, Manipur and Nagaland the turnout for the post-test counseling seems to be low. It is observed that pregnant women in Manipur and Nagaland rarely turn up at the health centres for any follow up after their first visit. Because of this post-test counseling is offered to those who turn out to be HIV positive. Efforts should be made to ensure that at least those women who accept the HIV test are convinced to attend the post-test counseling also. This helps in not only maintaining the confidentiality of the test results but also counseling the HIV negative women about avoidance of infection.

When it comes to the counseling of husbands of HIV positive women the performance of all the states except Nagaland and Manipur is found to be very impressive. The performance of NSACS in this respect is very poor and in Manipur though a good percentage of husbands of HIV positive women are attending the pre-test counseling, the rate of acceptance of the test is poor.

In NSACS the performance of NGOs and the outreach workers associated with the NGOs seems to be very poor. In fact, the services of the NGOs are discontinued from March 2008 in NSACS. Difficulties in accessibility to habitations because of hilly terrain is another problem observed in Nagaland. In these regions, options like forming local PLHA networks and delegating the responsibility of outreach work to them may work out well. These networks will be directly monitored by the district supervisors / in-charge medical officer of the district and paid by the SACS.

With respect to the important component of NVP administration to mother/baby pairs, a gradual improvement is shown by all the states except Mumbai (Mumbai DACS) and Nagaland. The performance of APSACS and TNSACS is found to be commendable with over 94% of mother baby pairs in Andhra Pradesh and over 91% in Tamilnadu receiving NVP during 2007-08. Next in the order are Maharashtra and Manipur with coverage of 77% and 70% mother baby pairs respectively during the year 2007-08. The performance of Manipur and Mumbai DACS is found to be average in this respect. The performance of Nagaland is very poor with none of the mother/baby pairs receiving NVP during 2005-06 & 2006-07 and only 1 out of the 3 receiving NVP during 2007-08.

The results with respect to follow up of HIV positive pregnant women and their babies are not impressive in any of the states except Tamilnadu where an encouraging trend is observed during the last three years (2005-08). In Tamilnadu a method called line listing of mothers is being implemented as part of web-based system of monitoring. This system seems to be yielding positive results with respect to the follow up of HIV positive mothers.

The data indicates that the number of children brought for follow up at different intervals post-partum is less than the number of mothers turning up at the PPTCT centres. Also the number of babies of HIV positive mothers tested at the age of 18 months is less than the number of babies brought for follow up at that age. This shows that not all the babies brought for follow up at 18 months age are tested for their HIV status. Testing of the babies is also an important factor as the impact of the programme can be correctly assessed only when the HIV status of the babies borne to HIV positive mothers is established.

Overall, it can be concluded that there is a positive impact of the PPTCT programme in 6 out of the 7 SACS surveyed and the performance of APSACS & TNSACS is very impressive.

Assessment of the Graduated Cost Recovery Scheme for Delivery of ART through Public-Private Partnership:

The assessment of graduated cost recovery scheme was carried out in the ART centres run by YRG CARE in Chennai, Freedom Foundation in Bangalore and ARCON in Mumbai.

Assessment of Facilities in the ART Centre: All the three ART Centres have sufficient space for carrying out the day-to-day activities. Patient examination rooms, counseling rooms, waiting area and office space are available in all the three centres as per the norms prescribed by NACO. Basic amenities like drinking water and toilets for patients are provided in all the centres.

All the three centres have full-fledged laboratory facilities for carrying out diagnostic tests for the patients. The laboratories are manned by qualified and experienced lab technicians. They also have pharmacies with qualified pharmacists. All the required drugs are available in the pharmacies in sufficient quantities as on the day of visit.

Staff in the ART Centre: All the three ART centres have the essential staff like Senior Medical Officer, Medical Officer (ART), Counselors, Nursing Staff, Community Care Coordinators, Record Keeper-cum-DEO and other support staff. YRG CARE and ARCON have Microbiologists on their rolls. The centre run by Freedom Foundation in Bangalore does not have a Microbiologist (MD Microbiology). However, a postgraduate in Medical Microbiology trained in the area of HIV / AIDS is heading the laboratory. Functions of the other specialists like Paediatrician, Dermatologist, Obstetrician & Gynaecologist etc., where not available in the centre are outsourced and the specialists visit the centres on specified days of the week.

Records and Registers: All the records and registers like Pre ART Register, Patient ART Record, ART Enrolment Register, Anti-retroviral Drug Dispensing Register, Anti-retroviral Drug Stock Register etc., are available in all the three surveyed centres and are maintained up-to-date.

Referrals and Linkages: All the three surveyed ART centres have facilities for referrals of the patients as per requirement. As and when required, patients on ART are referred to other hospitals for specific treatment. The centres have linkages with NGOs, Community Care Centres, HBOs, PLHA Networks, Rehabilitation Centres, Family Planning Services and MCH Services for care and support.

Assessment of Effectiveness of ART Centres: Assessment of the effectiveness of the ART centres was carried out using the following parameters:

- Number of patients on ART
- Number of patients on ART who are continuing on medication at the end of 12 months
- Number of patients on ART who are alive after 12 months of treatment

The percentage of patients continuing on ART after 12 months for the 3 surveyed centres shows an improvement during the 4th year of the programme.

The data collected from the centres indicates that none of the surveyed ART centres could achieve their set targets with respect to patient enrolment. It is observed that these ART centers, which offer medication on graduated cost recovery basis and charge the patients for treatment, are facing stiff competition from the other ART centers that offer treatment free of cost. When ART is offered free of cost by the Government, schemes like GCR run through NGOs become redundant. NACO may have to think of options for discontinuing such schemes.

Assessment of Project Management by SACS

Effectiveness of Monitoring of PPTCT Programme: Monitoring of the PPTCT programme in all the SACS is done mainly through the review of monthly reports submitted by the PPTCT centres. Regular review meetings are held by the SACS officials with the District Supervisors, NGOs and the in-charge Medical Officers periodically. During these review meetings the performance of the centres with respect to the set of prescribed parameters is assessed and suggestions are offered for better performance. The review meetings are held either in the SACS office or in the district centres during the visit of the concerned officers. Full data pertaining to the review meetings and visits of the officials is available in APSACS and Manipur SACS only. Though meetings with the functionaries are regularly held in the remaining SACS also the information concerning the number of visits and review meetings etc., is not properly recorded. An overview shows that Karnataka SACS & APSACS involved themselves in maximum number of review meetings with SACS officials, NGO organizations and outreach workers. The other societies like Manipur, Nagaland, and to certain extent Mumbai SACS lagged behind in this particular component of the programme.

TNSACS and APSACS have a strong monitoring system in place. TNSACS has a total online monitoring system for monitoring all the programmes implemented by the society including PPTCT programme. A similar system is available in APSACS but it is presently available in only 10 districts where DAPCUs are formed.

Utilisation and Management of Funds: All the SACS were performing well with respect to this component. There was an initial lag in utilisation of funds by KSAPS, Mumbai DACS, Maharashtra SACS and Manipur SACS. But this was made up during the latter years and there was maximum utilisation of funds in all the SACS by 2007-08.

All the SACS have a dedicated finance department headed by an officer of in the cadre of Joint Director / Deputy Director. None of the officers heading the finance departments in SACS are chartered accountants except in TNSACS.

All these officers are on deputation from the finance & accounts / treasury department of the respective governments. Only in Manipur SACS, it is reported, that the head of the finance department is assisted by a full time chartered accountant. All the societies except Manipur SACS have the system of internal audit of their accounts. Likewise, all the societies except Maharashtra SACS have an established external audit system to audit the accounts of the societies. The 100% voucher auditing system adopted by TNSACS is giving good results with respect to the performance of NGOs in proper utilization of funds.

Procurement of Goods and Services under GFATM II: Only TNSACS, MDACS and NSACS have separate procurement departments. However, irrespective of the existence of a separate department, all the SACS have a designated officer in-charge of procurement. The designated officers, except in MDACS, received training for procurement of goods under GFATM. All the SACS follow the guidelines issued by NACO for procurement of goods and services. All the societies have a good forecasting system for procurement of goods and the annual procurement plans are prepared depending on the quantum of utilization of goods by the peripheral centres. All the societies follow a streamlined system of distribution of consumables, diagnostic kits and ART drugs to the PPTCT / ART centers. In APSACS, TNSACS and KSAPS the procurement is done by another government agency constituted for this purpose. The system of distribution by cold chain which is essential for distribution of diagnostic test kits is followed by all the SACS except NSACS.

It is better if the SACS have a materials management department headed by a qualified and experienced professional. The SACS be allowed to purchase their requirements on their own without the intervention of a third party agency as done in APSACS, TNSACS and KSAPS. This would help avoiding delays in the procurements of goods.

Management of Human Resources: None of the surveyed SACS have a separate human resources department headed by a qualified HR professional. However, this function is taken care of by the administrative department in the SACS. Usually the Administrative Officer or Chief

Administrative Officer is in-charge of the human resources management. All the PPTCT centres in the surveyed states are manned by qualified and trained professionals.

The system for payment of salaries to the staff of PPTCT centres is decentralised in TNSACS, Maharashtra SACS, MDACS and Nagaland where the designated district officer is the disbursing officer. There is a quarterly release of funds towards salaries to the designated officer. In the remaining SACS i.e., APSACS, KSAPS and Manipur SACS the disbursement of salaries to the PPTCT centre staff is directly done by the SACS. In Andhra Pradesh the salaries of the staff are directly credited to their bank accounts by the SACS every month. In Manipur SACS there are complaints from the counselors at the PPTCT centres / ICTC centres about irregular disbursement of salaries. In all the surveyed centres in Manipur the staff complained about release of salaries once in two or three months.

Except APSACS and TNSACS, none of the surveyed SACS have the system of obtaining periodical performance appraisal reports from the staff of PPTCT centers.

In all the surveyed SACS the staff in PPTCT centres underwent induction training by NACO / SACS. Annual training plans for all categories of PPTCT staff are formulated and implemented by all the SACS except Manipur SACS and KSAPS. Only MDACS and APSACS have system of obtaining feedback from the staff of PPTCT centres regarding the training programmes conducted for them.

Periodical appraisal of the performance of the PPTCT staff and obtaining their feedback on the training programmes conducted would help the SACS in not only monitoring the performance of their staff but also identifying their training requirements and designing & restructuring of the training plans in the direction of honing skills of the staff for an improved performance. Hence, performance appraisal may be made mandatory.

Steering Committees: Steering Committees are constituted in all the surveyed SACS. Quarterly meetings of the steering committee are regularly being held in only four of the surveyed SACS i.e. KSAPS, MDACS, APSACS and TNSACS. In Maharashtra, Manipur and Nagaland the steering committee meetings are being convened but not exactly at quarterly intervals.

Filling up of Posts Earmarked under GFATM II: APSACS is the only society where all the posts earmarked under GFATM II, PPTCT M&E Officer, PLHA Coordinator and NGO Coordinator are filled on whole time basis. All the surveyed SACS have a whole time PPTCT M & E officer except in Maharashtra SACS and MDACS. Similarly, only MDACS and APSACS have a whole time PLHA coordinator. All the societies have a whole time NGO coordinator except in the State of Karnataka.

Procedure Adopted for Selection of NGOs: All the surveyed SACS follow the guidelines issued by NACO for the selection of NGOs. Conditions like having registration under Societies Act, Indian Trust Act or Charitable Trusts Act , having established presence in the area, having minimum of 3 years experience, having clear financial track record, not having been blacklisted etc., are strictly adhered to while selecting the NGOs.

In all the societies, except in KSAPS where the post is presently vacant, the NGO coordinator is regularly monitoring the performance of NGOs and offering suggestions. However, in the state of Nagaland the performance of the NGOs seems to be dismal.

MNSACS, APSACS, MDACS and TNSACS have properly established system for monitoring the performance of the NGOs. Apart from obtaining the monthly performance reports from the NGOs, these SACS also conduct monthly review meetings with the NGO representatives. Compared to the other surveyed SACS the follow up of HIV positive pregnant women seems to be better in the state of Tamilnadu. This is because of careful monitoring of the outreach activities performed by the outreach workers working under the NGOs.

In TNSACS there is a system of “100% voucher audit” to monitor the financial performance of the NGOs periodically. After introduction of voucher auditing system financial discipline has been established and leakage of funds could be arrested. As a part of this system the NGOs were provided 3-day training for capacity building on book keeping and accountancy. This capacity building programme helped the NGOs in maintaining their accounts properly.

Effectiveness of Data Management System in SACS: Computerised Management Information System (CMIS) is in existence in all the SACS. In TNSACS all the PPTCT / ICT centres are linked online with the server in the SACS facilitating an online data entry by all the peripheral centres. All the centres are provided with computers and internet connection. In Andhra Pradesh also, ten districts where DAPCUs are formed are connected online with the SACS. The data from the districts is fed to the server at SACS from the DAPCUs.

In the remaining societies i.e., MSACS, MNSACS, NSACS, KSAPS and MDACS, the data from the centres is sent to the district coordinator / district manager from where it is sent to SACS in the form of hard copies or through fax or e-mail. After reaching the respective SACS the data is entered into CMIS and submitted to NACO.

With the online data entry system from the centres directly along with validations TNSACS has the best data management system among all the SACS. APSACS can be rated next to TNSACS in implementing the online data entry system. Efforts may be put in the direction of introducing online data entry in the remaining SACS also, which will improve the efficiency of data management.

Assessment of PPTCT Services

Counselors: Most of the counselors recruited in the SACS of Maharashtra, Andhra Pradesh, Tamilnadu, Karnataka and Mumbai DACS are from social sciences background with a master's degree in Social Work. In Manipur most of the counselors are from nursing background and in Nagaland several of them are from Theology background who are into social work. In Andhra Pradesh in some of the centers located at PHC level, have new designated posts called as "Nurse Practitioners" who carry out the functions of counseling, HIV testing, conduct of deliveries, maintenance of records and outreach work, the nurse practitioners replace the work of technician and the counselor and in addition will conduct deliveries also.

All the counselors have undergone induction training and most of them also underwent refresher training. The counseling skills of the counselors have been appraised and all of them are performing well in their assigned duties. However, it can be said that the counselors from Andhra Pradesh and Tamilnadu are a notch above their counterparts from the other states.

Laboratories: All the surveyed PPTCT centers have laboratory facility, either separately or attached to the main hospital, and the laboratories are manned by qualified lab technicians who are also trained by SACS. Basic facilities like workbenches, laboratory stools, glassware, chemicals, needle destroyers, fin pipettes, centrifuge, refrigerators etc. are present in most of the laboratories.

In Manipur and Nagaland none of the laboratories, except in RIMS Imphal, have running water facility. In Nagaland one of the PPTCT centers does not have electricity supply and the refrigerator available in the laboratory was not installed because of lack of electricity supply. The HIV test kits are stored in a steel cupboard in this laboratory at room temperature. 3 centres each in Andhra Pradesh and Karnataka, 2 centres each in Maharashtra and Nagaland and 1 centre in Manipur do not have all 3 types of test kits. All the centres surveyed are following the standard laboratory procedures in performing HIV testing as per NACO guidelines. All the laboratories are maintaining proper record of the tests carried out in the laboratory.

Training Programmes: In all the surveyed states in-charge medical officers in all centers have undergone induction training for PPTCT programme organized by the respective SACS. When asked about the quality of the training imparted to them most of the medical officers informed that the training was effective in all aspects and helped them in successful implementation of the programme.

Monitoring, Information, and Evaluation System for PPCCT Services: All the SACS surveyed have a system for monitoring & evaluation of the PPTCT services. A significant variation is observed in the functioning of the M&E system from state to state. In TNSACS the monitoring system is completely online and web-based. In APSACS also online monitoring system is adopted in 10 districts and is under the process of extension to the other districts. In the remaining SACS the monitoring is done by review of the monthly reports submitted either by hand or fax or email. An efficient and effective M&E system is essential for proper implementation of any programme. While the M&E system in TNSACS is found to be performing extremely well, in APSACS also it is functioning more or less on the same lines. These two states can be taken as model states and their experience and expertise may be shared with other SACS to improve their performance with respect to this very important component.

Assessment of the Effectiveness of NGOs: All the surveyed PPTCT centres except those located in Karnataka and Nagaland have NGOs associated with them for performing the outreach work of mobilizing the pregnant women to attend ANC, follow up of HIV positive pregnant women, follow up of post natal HIV positive women and their babies etc. With respect to mobilization of pregnant women, the performance of the NGOs in Andhra Pradesh, Tamilnadu and Manipur is found to be better. However, none of the NGOs in any of the surveyed states, except in Tamilnadu to some extent, are faring well with respect to follow up of HIV positive mothers and their babies. Employing PLHAs / social workers who work directly under the control of the PPTCT centres may be a better option for outreach work. This might give a better monitoring edge and help in improving the follow up.

Client Satisfaction: A total of 115 clients utilizing the services at various surveyed PPTCT centres were interviewed for the purpose of gathering their feedback on the services provided in the centres. Most of the clients expressed their satisfaction with respect to important parameters like attitude of the counselor, care and support offered in the centre, confidentiality of the information related to the client etc. Some of the clients in Andhra Pradesh expressed their dissatisfaction about the cleanliness of the centres. Very few clients in Karnataka acknowledged the visits of outreach workers to their homes.

ABBREVIATIONS USED IN THE REPORT

ADMHO	Additional District Medical & Health Officer
AIDS	Acquired Immune Deficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ANC	Antenatal Clinic
APMHIDC	Andhra Pradesh Health & Medical Housing & Infrastructure Development Corporation
APSACS	Andhra Pradesh State AIDS Control Society
ARCON	AIDS Research & Control Centre
ART	Anti Retroviral Treatment
ARV drugs	Anti Retroviral Drugs
ATR	Action Taken Report
ATT	Anti Tuberculosis Treatment
BPL patients	Below Poverty Line patients
CD4	Cluster of Differentiation 4
CHC	Community Health Center
CMIS	Computerised Management Information System
CMO	Chief Medical Officer
DAO	District AIDS Officer
DACS	District AIDS Control Society
DAPCU	District AIDS Prevention & Control Unit
DD	Deputy Director
DEO	Data Entry Operator
DIC	District ICTC Coordinator
DLS	Drugs Logistics Society
DPM	District Project Manager
ELISA	Enzyme Linked Immuno Sorbent Assay
EQAS	External Quality Assessment Scheme
FC	Finance Controller
GCR	Graduated Cost Recovery
GFATM	Global Fund for AIDS Tuberculosis & Malaria
GGH	Government General Hospital
GMC	Government Medical College

HAART	Highly Active Anti Retroviral Therapy
Hb	Haemoglobin
HBOs	Home Based Organisations
HIV	Human Immuno Deficiency Virus
HR	Human Resources
ICTC	Integrated Counseling and Testing Center
IEC	Information Education & Communication
JD	Joint Director
KSAPS	Karnataka State AIDS Prevention Society
M&E	Monitoring & Evaluation
M/B pairs	Mother Baby pairs
MCH	Maternal & Child Health
MDACS	Mumbai District AIDS Control Society
MNSACS	Manipur State AIDS Control Society
MoUs	Memorandum of Understanding
MTP	Medical Termination of Pregnancy
NACO	National AIDS Control Organisation
NACP-III	National AIDS Control Project III
NARI	National AIDS Research Institute
NGOs	Non Governmental Organisations
NRHM	National Rural Health Mission
NSACS	Nagaland State AIDS Control Society
NVP	Nevirapine
OIs	Opportunistic Infections
ORW	Outreach Worker
PCP	Pneumocystis Carinii Pneumonia
PEP	Post Exposure Prophylaxis
PHC	Primary Health Center
PLHA	People Living with HIV / AIDS
PPTCT	Prevention of Parent to Child Transmission
RIMS	Regional Institute of Medical Sciences
RPR	Rapid Plasma Reagin
SACS	State AIDS control Societies

SIMU	Strategic Information Management Unit
SOEs	Statement of Expenditure
SOPs	Standard Operating Procedures
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TI	Targeted Interventions
TNSACS	Tamilnadu State AIDS control Society
UCs	Utilisation Certificates
UHC	Urban Health Center
VDRL	Venereal Disease Research Laboratory test

CHAPTER 1

INTRODUCTION

BACKGROUND OF THE PROJECT

In March 2000, the National AIDS Control Organisation initiated a 2-year Prevention of Parent to Child Transmission of HIV / AIDS (PPTCT) feasibility study aimed at designing an implementation model of PPTCT for the public health sector. The study supported by the Government of India and UNICEF involved 11 major hospitals of the 5 most affected states in India. Besides demonstrating that it was possible to implement PPTCT in the public sector, these studies also found that the programme provided opportunities for HIV prevention counseling and STI diagnosis and treatment for the 98-99% of women who were unaffected. Based on the results of this study, it was decided to scale up the programme not only for prevention of HIV in women and their children but also to provide treatment, care and support services to HIV-infected women and their families.

The implementation of the project began in May 2004 with funding from GFATM. The project was started with the following objectives:

1. To scale up prevention and care interventions among women of child bearing age and their families through providing a package of primary prevention, family planning, voluntary counseling and confidential testing, anti-retroviral prophylaxis, and counseling on infant feeding.
2. To implement a comprehensive HIV/AIDS care package, including antiretroviral treatment for HIV-infected mothers, their infants and partners.
3. To enhance access to antiretroviral therapy through public / private partnership.

It was envisaged that objectives 1 and 2 would be implemented by NACO and State AIDS control Societies (SACS). Objective 3 was to be implemented by a consortium of three NGOs, namely, ARCON Mumbai, YRG CARE Chennai, and Freedom Foundation, Bangalore.

With this background, NACO has proposed to conduct a mid term evaluation of the project to assess the impact of the PPTCT programme in the six high prevalence states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu and in the city of Mumbai as well as the graduated cost recovery scheme for the delivery of ART through public-private partnership in the three cities of Mumbai, Chennai and Bangalore.

OBJECTIVES OF EVALUATION:

- To evaluate the impact of the PPTCT programme in preventing the perinatal transmission of HIV amongst pregnant women who accessed the Government health system in the six high prevalence states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu and in the city of Mumbai.
- To assess the effectiveness of the graduated cost recovery scheme for the delivery of ART through a public private partnership between NACO and NGOs in the cities of Mumbai, Chennai and Bangalore.
- To undertake an assessment of the delivery of PPTCT services in the six high prevalence states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu and in the city of Mumbai.
- To assess the project management of the GFATM II PPTCT programme at the State AIDS Control Societies.
- To document important experiences of the programme highlighting the lessons learnt.

CHAPTER 2

METHODOLOGY

Information from both secondary and primary sources was gathered as a part of the evaluation study. Primary data collection was done through field visits to the sampled locations in the 6 states and the city of Mumbai. Secondary data was collected from all the AIDS control societies in the respective states and also from the sampled centres. A combination of quantitative and qualitative methods were adopted for data collection using structured / semi-structured questionnaires.

The following schedules were used for the study:

- 1) Schedule for evaluation of the impact of the PPTCT programme.
- 2) Schedule for assessment of the graduated cost recovery scheme under public-private partnership.
- 3) Schedule for assessment of project management by SACS
- 4) Schedule for assessment of PPTCT services

After prior field testing, the questionnaires and checklists developed for the purpose of data collection were submitted to NACO. After obtaining approval from NACO the questionnaires were canvassed in the field for data collection from the sampled locations.

Field survey was carried out by the field teams constituted for this purpose. The field teams worked under the supervision of a team of experts consisting of national and international experts who have ample experience in matters related to HIV / AIDS.

A week long orientation programme was conducted for the field investigators to impart them with knowledge of project related matters and train them in the canvassing of the questionnaires in the field. The orientation programme included practical training for the field investigators in two PPTCT centers,

one at district level and another at sub-district level, and review of the field experience to clear any doubts they had in data collection.

SAMPLING

Following the Terms of Reference for the study 12 PPTCT centres each in the states of Andhra Pradesh, Karnataka, Maharashtra and Tamilnadu were sampled for this purpose. In the states of Nagaland, Manipur and Mumbai city 6 PPTCT centres each were sampled.

List of PPTCT centres for all the six states (Andhra Pradesh, Tamilnadu, Maharashtra, Karnataka, Manipur & Nagaland) and the City of Mumbai were obtained from the respective SACS.

The PPTCT centres in all the states were segregated district wise. In each district the centres were again segregated into three categories viz., centres present in Medical Colleges, District Hospitals and those present at Sub-district level.

The total number of PPTCT centres in each district was calculated and the districts in each state were sorted out in a descending order of the number of PPTCT centres.

In the states of Andhra Pradesh, Tamilnadu, Karnataka and Maharashtra the districts, after sorting out, were divided into four quartiles. One district from each quartile was selected randomly using a random number generation function. In the states of Andhra Pradesh, Karnataka, Maharashtra and Tamilnadu 4 districts each were sampled for this purpose. In case of Nagaland and Manipur, two districts were selected from each state following the same procedure.

From each of the selected districts of the respective states, three PPTCT centres were sampled. Of these, one is the centre associated with a medical college, the second is one attached to the district head quarters hospital and the third is located in a sub-district centre. The sub-district centre in each district was again selected randomly. Where the number of medical colleges present in a district is more than one, one medical college was selected randomly.

In case a medical college is not present in the sampled district, the nearest medical college, which is already not sampled, is taken.

In the state of Nagaland there are no medical colleges. Hence, apart from the district hospital, two sub-district centres were selected in each district to complement the sample size of 6 centres from this state.

In case of Manipur state, there is only one medical college located in Imphal. Though Imphal district itself was not selected, this medical college is sampled for the purpose of collection of data. In the second district in Manipur i.e. Senapati, one district hospital and two sub-district centres were sampled, as there was no medical college in this district.

The list of sampled locations is detailed in the following table:

Name of the State	Name of the District	PPTCTC in Medical College	PPTCTC in District HQ Hospital	PPTCTC in Sub-district Centre
Andhra Pradesh	East Godavari	GGH - Kakinada (Rangaraya Medical College)	District Hospital Rajahmundry	PHC, Rajanagaram
	Nizamabad	Chalmada Institute of Medical Sciences, Karimnagar	District Hospital Nizamabad	PHC, Navipet
	Warangal	Kakatiya Medical College	District Hospital - Janagaon	CHC, Gudur
	Kurnool	GGH - Kurnool (Kurnool Medical College)	District Hospital Nandyal	CHC, Banaganapalli

Name of the State	Name of the District	PPTCTC in Medical College	PPTCTC in District HQ Hospital	PPTCTC in Sub-district Centre
Karnataka	Gulbarga	Mahadevappa Rampuri Medical College, Gulbarga	Gulbarga District Hospital,	General Hospital Chincholi
	Uttar Kannada (Karwar)	Karnataka Institute of Medical Sciences, Hubli	Karwar, District Hospital,	General Hospital Sirsi
	Mandya	Adichunchanagiri Institute of Medical Sciences, B.G. Nagar, Nagamangala Taluk, Mandya District.	Mandya, District Hospital,	General Hospital K R Pet
	Udupi	Kasaturba Medical college, Manipal	Udupi, District Hospital,	GH Karkala
Maharashtra	Ahmadnagar	Rural Medical College Of Pravara	Civil Hospital PPTCT	RH Pathardi
	Solapur	VMG Medical College	SMC Solapur	PHC Borgaon
	Kolhapur	RCSM, GMC Kolhapur	ICTC Savitribai Phule Hospital Kolhapur	Sub-district Hospital, Kodoli
	Wardha	MGIMS ,Sevagram	CIVIL HOSPITAL PPTCT	RH Selco
Tamilnadu	Erode	IRT Perundurai Medical College & Hospital, Perundurai Sanatorium, Erode – 638 053.	District Govt. Head Quarters Hospital, Erode	T N Palyam PHC
	Thiruvallur	Sri Ramachandra Medical College and Research Institute, Porur, Chennai 600 116.	District Govt. Head Quarters Hospital, Thiruvallur.	Block Primary Health Centre, Beerakuppam, Tiruttani Block, Tiruvallur District.
	Virudhnagar	Theni Medical College Hospital, Theni District – 625 512	District Head Quarters Hospital, Virudhunagar.	Sivakasi Municipality, Sivakasi, Virudhunagar District.
	Kanniyakumari	Kanyakumari Medical College Hospital, Kanyakumari at Nagercoil.	Government Hospital Padmanabhapuram, Kanyakumari	Block Primary Health Centre, Killiyur, Killiyur Block, Kanyakumari District.
Manipur	Senapati	Nil	District Hospital, Senapati	CHC, Kangpokpi PHC, Motbung
	Tamenglong	Regional Institute of Medical Sciences, Imphal	District Hospital Tamenglong	PHC Noney
Nagaland	Wokha	Nil	Wokha Civil Hospital	Chukitong PHC, Wokha Baghty PHC, Wokha
	Phek	Nil	Phek Civil Hospital	Pfutsero CHC, Phek Meluri CHC, Phek
Mumbai DACS		K.J.Somaiya Hospital (Pvt. Hosp)	MGM Hospital	UHC Bandra
			ESIS Hospital (Mulund)	Charkop Maternity Home Prabhadevi Maternity Home

Chapter 3

EVALUATION OF THE IMPACT OF PPTCT PROGRAMME

The evaluation of the Impact of PPTCT programme in all the high prevalence states of Andhra Pradesh, Tamilnadu, Karnataka, Maharashtra, Manipur, Nagaland and the city of Mumbai had been carried out by gathering the secondary data available in the sampled PPTCT centers. In all the states, except in Nagaland, the data corresponding to 4 years of programme implementation i.e. 2004-05, 2005-2006, 2006-07 & 2007-08 was collected. In Nagaland all the centres sampled for the purpose of the study were opened after 2004-05 only. Hence data for 3 years could only be collected from this state.

The following information is presented in this chapter:

- A) Data that is collected from the sampled centres in the respective states.
- B) Consolidated state wise data obtained from the respective SACS

The data collection format used for collection of data from the sampled locations and SACS is similar

3.1 EVALUATION OF IMPACT OF PPTCT PROGRAMME IN ANDHRA PRADESH

Table 3.1.1	2004-05	2005-06	2006-07	2007-08
Number of Pregnant women who registered for ANC in the Health facility	47195	52834	56169	47934
Number of pregnant women who attended the pre-test counseling	42801	46965	52063	42803
Number of pregnant women who accepted HIV test	37882	45625	48879	34439
Number of pregnant women who were found HIV positive	762	866	821	488

Figure 3.1.1

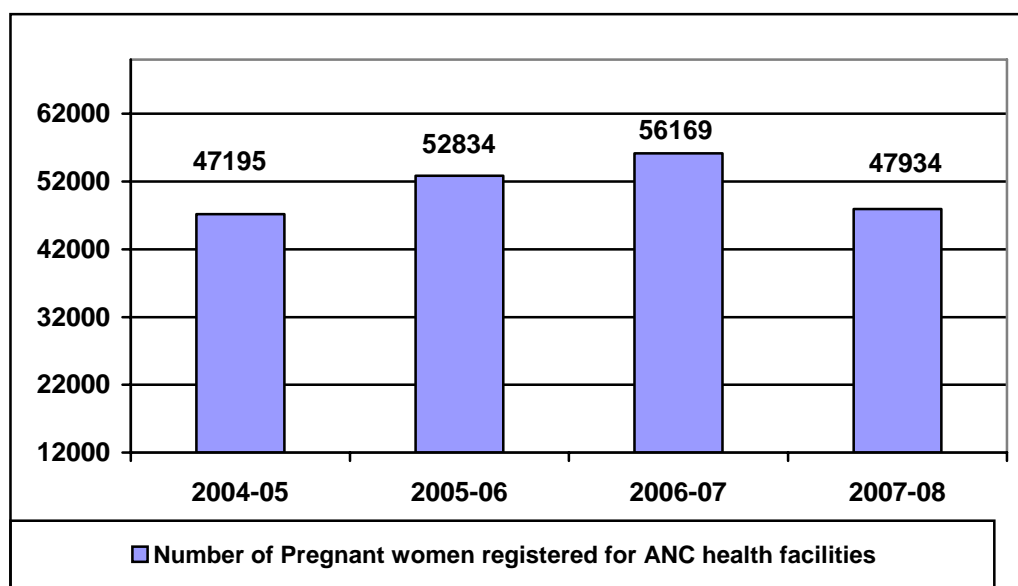
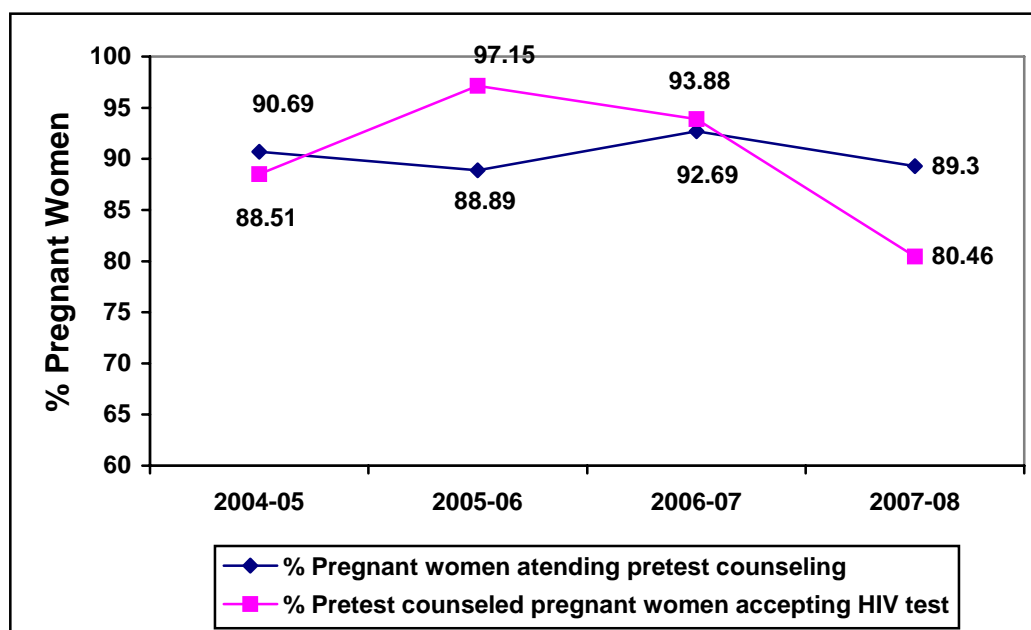


Figure 3.1.2



As indicated by the data (table 3.1.1 & figure 3.1.1) there is an increase in the number of ANC registrations from 2004 – 05 to 2006 – 07. During 2007 – 08 the number dropped by over 14% compared to 2006-07. However, there is no considerable variation in the number of women attending pre-test counseling as percentage of those registered for ANC from 2004-05 to 2006-07. The decline registered during 2007-08 is marginal and in fact the number of women registering for ANC has also dropped during this period. Though the percentage of pretest counseled pregnant women who accepted HIV test increased by 20% from 2004-05 to 2005-06, it started declining in the following years and stood at 80% in 2007-08. The data shows that there is a gradual decrease in the percentage of HIV positive pregnant women from 2.01 in 2004-05 to 1.42 in 2007-08. This may be due to effective counseling with respect to prevention and successful implementation of the programme.

Table 3.1.2	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who attended the pre-test counseling	42801	46965	52063	42803
Number of pregnant women who accepted HIV test	37882	45625	48879	34439
Number of pregnant women who attended the post-test counseling	23037	31498	36459	24619

As per the NACO guidelines all the women who registered for ANC and attended pretest counseling should also be counseled after the test in spite of their being HIV positive or negative. The reason for this is to avoid revealing the identity of HIV positive women and also to counsel the HIV negative women on how to avoid infection and maintain their negative status. The data shows that the number of pregnant women attending post-test counseling is always less than the number of those who attended pre-test counseling. Though the percentage of pregnant women attending post-test counseling increased considerably from 2004-05 to 2006-07, there was a drastic decline in this figure during 2007-08. The number of women attending the post-test counseling is also lower than the number of women who accepted the HIV test. This may be because of the following reasons:

1. Those who accepted the test might not have come back to the centre because of the element of fear or stigma.
2. Long distance between their place of stay and the centre could be the second factor for the drop in post-test counseling figures.

3. Another reason could be that the patients who have undergone test might not have got the test report on the same day and this delay might have resulted in missing the post test counseling.
4. For some of the pregnant women the HIV + ve status was already known and hence they did not show any interest in attending the post-test counseling.
5. This might also reflect on the quality of counseling and indicates the need to improve not only the quality of counseling in the centres but also the facilities provided in the centres.

Table 3.1.3	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found HIV positive	762	866	821	488
Number of husbands of HIV positive women counseled	333	566	640	405
Number of husbands of HIV positive women who accepted HIV test	284	486	549	376
Number of husbands found HIV positive	247	354	416	272

Data presented in table 3.1.3 shows a steep increase, by about 90%, in the number of husbands of HIV positive women attending post-test counseling from 2004-05 to 2007-08. This indicates a paradigm shift in the attitude of HIV positive women's spouses in attending the counseling sessions. This is again an indication of the positive impact of the counseling and generation of awareness among people. Though the percentage of husbands of HIV positive women accepting the test remained same from 2004-05 to 2006-07, it showed an increase during 2007-08. The data also shows a perceptible decline in the percentage of husbands with HIV + ve status from 2004-05 to 2007-08, which once again may be attributed to effective prevention counseling.

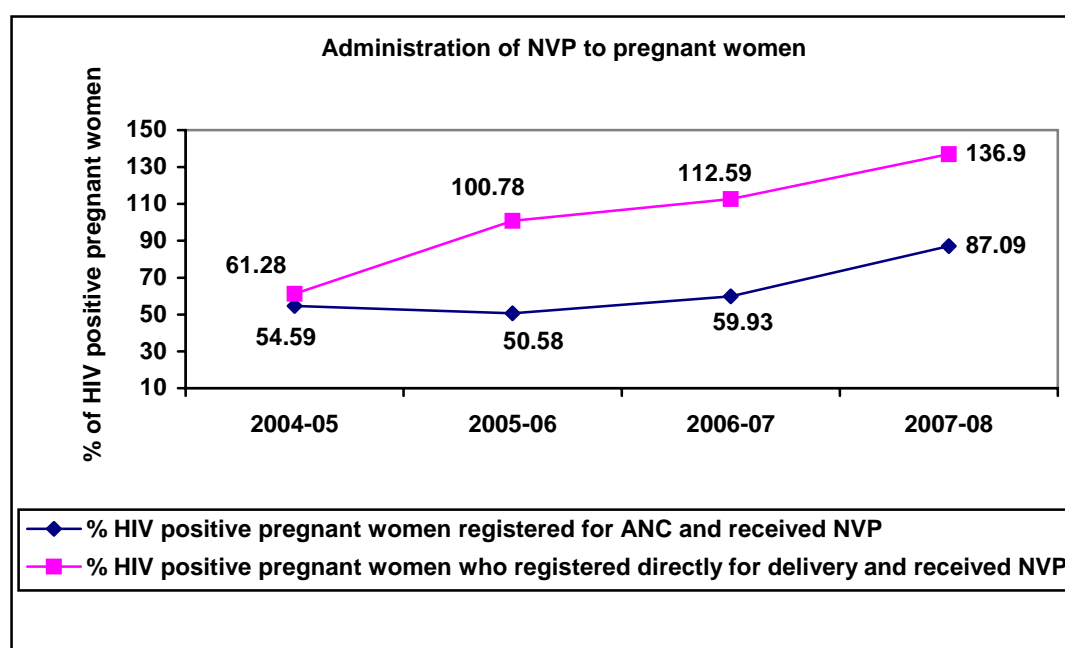
Table 3.1.4	2004-05	2005-06	2006-07	2007-08
Number of women registered directly for delivery without ANC registration in the health facility	6725	7614	7123	3669
Number of pregnant women counseled and accepted HIV test from above	6414	4702	4724	3326
Number of pregnant women found positive	235	128	135	84

Table 3.1.4 shows the impact of counseling and HIV testing among the pregnant women who attended the health center directly for delivery. The following inferences are drawn from the presented data:

Though there is an increase in the number of women coming directly for delivery without ANC registration from 2004-05 to 2005-06, it started declining in the following years with a drastic drop in 2007-08. There is a perceptible decrease in the number of HIV positive women among those coming directly for delivery, from 3.66% in 2004-05 to 2.53% in 2007-08. This can be a positive impact of counseling for avoidance of HIV infection. The decline in the number of cases registered directly for delivery (without attending ANC) may be because of the increase in the number of antenatal care facilities.

Table 3.1.5	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found HIV positive	762	866	821	488
Number of HIV positive pregnant women registered for ANC and received NVP	416	438	492	425
Pregnant women who registered directly for delivery and found positive	235	128	135	84
Number of HIV positive pregnant women who registered directly for delivery and received NVP	144	129	152	115

Figure 3.1.3



When a comparison is made between the number ANC registered HIV positive women and the number of ANC registered positive women who received NVP (table 3.1.5 & Figure 3.1.3), the latter figure is always lower than the former indicating that not all the HIV positive pregnant women were given NVP. One reason for this may be that the deliveries for these women are not conducted in the centre where they were registered for ANC, as there is a custom of pregnant women going to their mothers' places for delivery. The other reason may be that some of them might have opted for MTP. However, the data indicates that while the percentage of women receiving NVP in this category is between 50–60% during 2004–07, it considerably increased to 87% during 2007-08. This may be attributed to efficient implementation of the project during 2007-08.

On the other hand when a comparison is made between the number of HIV positive pregnant women who registered directly for delivery and the number of HIV positive pregnant women who registered directly for delivery and received NVP, the latter figure is higher than the former during 2004-05, 2006-07 & 2007-08. The reason for this can be that several of the un-booked cases whose HIV status is established as positive elsewhere come for deliveries as referral cases to centres like district hospitals and general hospitals. In those centres these pregnant women, who directly came for delivery, are administered NVP during labour. The fact of administration of NVP to these women is recorded but these are not registered as cases that are coming for direct delivery in the referral hospital to avoid duplication of figures.

Table 3.1.6	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	997	994	956	572
Total number of deliveries of HIV positive women	582	543	608	568
Total number of live births to HIV positive mothers	545	519	588	546
Total number of mother / baby pairs received NVP	438	512	579	540

Figure 3.1.4

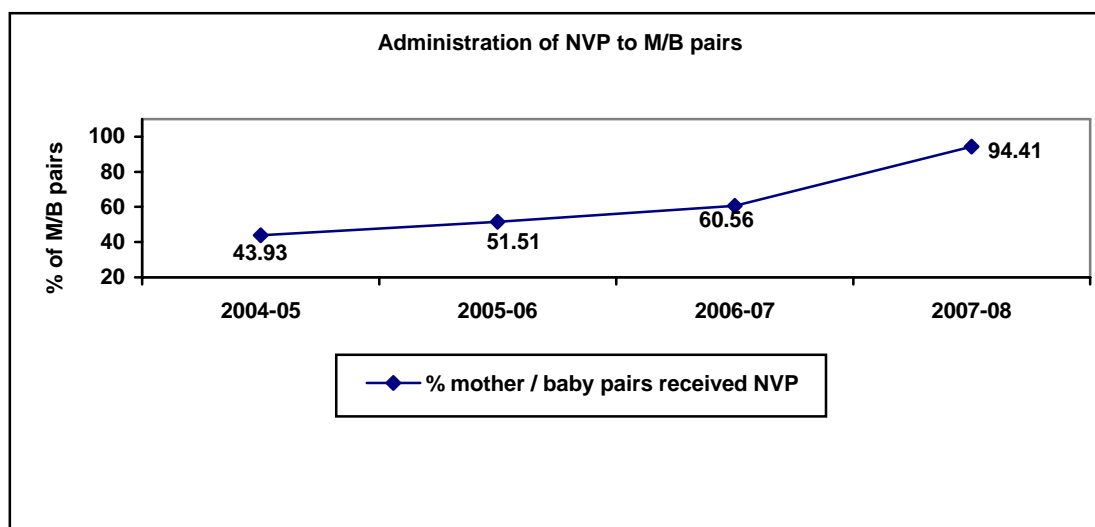


Table 3.1.6 & figure 3.1.4 present the data pertaining to total number of pregnant women who were found positive vis-à-vis the total number of mother / baby pairs received NVP. While 44% of the Mother Baby pairs received NVP during 2004-05, the figure increased to 51.51 and 60.56 percent respectively during the next two years. During 2007-08 it increased considerably to about 95%. This may be because of increased awareness among the health staff with respect to administration of NVP and also meticulous and successful implementation of the programme. However, it should be ensured that there are no cases of missed administration of the drug and all the Mother Baby pairs are given NVP as per the protocol.

Table 3.1.7	2004-05	2005-06	2006-07	2007-08
Total number of deliveries of HIV positive women	582	543	608	568
Number of HIV positive women coming for follow up (post partum) at,				
3 months	81	97	204	193
6 Months	72	146	197	223
12 Months	23	66	150	122
18 Months	13	43	101	99
Total number of live births to HIV positive mothers	545	519	588	546
Number of babies of HIV positive women – brought for follow up at,				
3 months	81	131	269	211
6 Months	65	126	150	164
12 Months	27	43	122	123
18 Months	21	46	70	68

Table 3.1.8	2004-05	2005-06	2006-07	2007-08
Total number of live births to HIV positive mothers	545	519	588	546
Number of babies tested at 12 months	4	5	2	1
Number of babies found HIV positive at 12 months	3	0	0	0
Number of babies tested at 18 months	8	32	70	58
Number of babies found HIV positive at 18 months	0	3	14	14

Tables 3.1.7 & 3.1.8 present the data pertaining to follow up of HIV positive mothers and children born to them. The data clearly indicates that there is a large gap between the number of deliveries to HIV positive mothers and the number of mothers & babies coming for follow up at 3 months, 6 months, 8 months and 12 months post-partum. The number of mothers attending the follow up sessions is considerably low and there is no correlation between the number of mothers attending the follow up sessions and the number of children brought for follow up. For example while 223 mothers attended the follow up at 6 months post-partum in 2007-08, only 160 babies were brought for follow up. Likewise, 204 mothers attended the follow up at 3 months post-partum in 2006-07, and the number of babies brought for follow up is 269. It is possible that when the mother is not attending the follow up, some other elder member in the family may bring the child for follow up.

The number of babies brought for testing at the age of 18 months is also very low compared to the number of live births. As evident from the data all the babies brought for follow up at the age of 18 months are not tested for their HIV status. This reflects the poor performance with respect to follow up of HIV positive mothers and their babies.

Table 3.1.9	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	997	994	956	572
Number of HIV positive pregnant women referred to ART centres	0	40	262	349

The above table shows the referral status of HIV positive pregnant women to ART centers either before or after delivery. While the year 2004-05 recorded no referrals, 4.02%, 27.40% and 61.01% women were referred to ART centres for treatment during 2005-06, 2006-07 and 2007-08 respectively. This indicates a clear understanding of the programme among the people involved and also coordination between PPTCT & ART

centers. This shows improved availability of ART, which prolongs the life tenure of HIV positive patients.

Table 3.1.10

District	2004-05		2005-06		2006-07		2007-08	
	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries
East Godavari	116561	80493	94778	83179	95529	89762	94173	88875
Nizamabad	56044	37909	55245	39372	56080	49351	57026	51755
Warangal	77295	36238	77166	47806	78335	46218	80105	55282
Kurnool	84019	31777	89624	45863	91302	48157	95068	56800

Table 3.1.10 portrays the data pertaining to the number of expected pregnancies vis-à-vis the number of institutional deliveries in all the four districts surveyed in Andhra Pradesh. In all the districts there is a considerable increase in the number of institutional deliveries which indicates the awareness generated among pregnant women and their families in opting for institutional deliveries.

3.2 EVALUATION OF IMPACT OF PPTCT PROGRAMME IN TAMILNADU

Table 3.2.1	2004-05	2005-06	2006-07	2007-08
Number of Pregnant women who registered for ANC in the Health facility	15621	69798	61094	46099
Number of pregnant women who attended the pre-test counseling	14208	68502	60429	44844
Number of pregnant women who accepted HIV test	14075	64644	59806	44844
Number of ANC registered pregnant women who were found positive	83	264	171	125

Figure 3.2.1

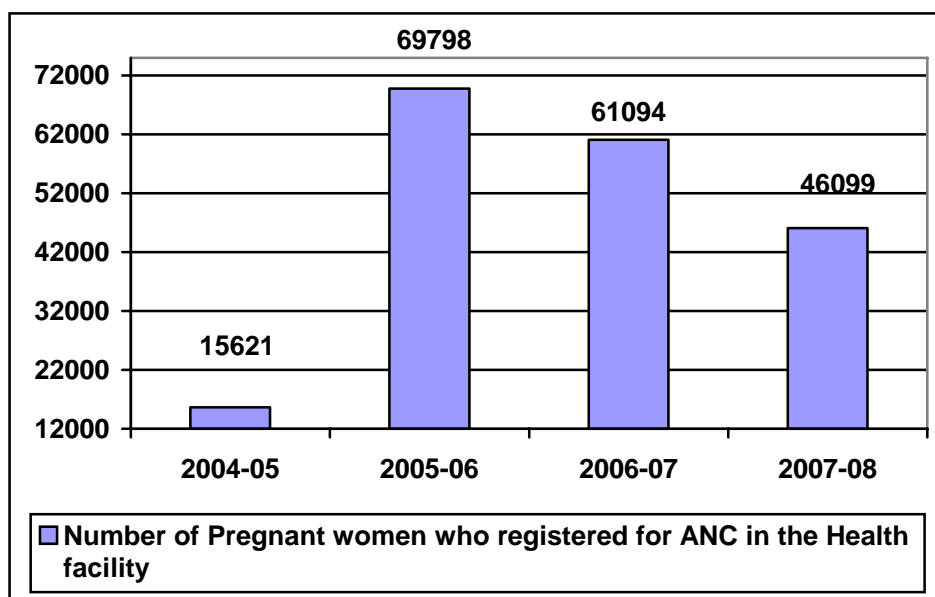
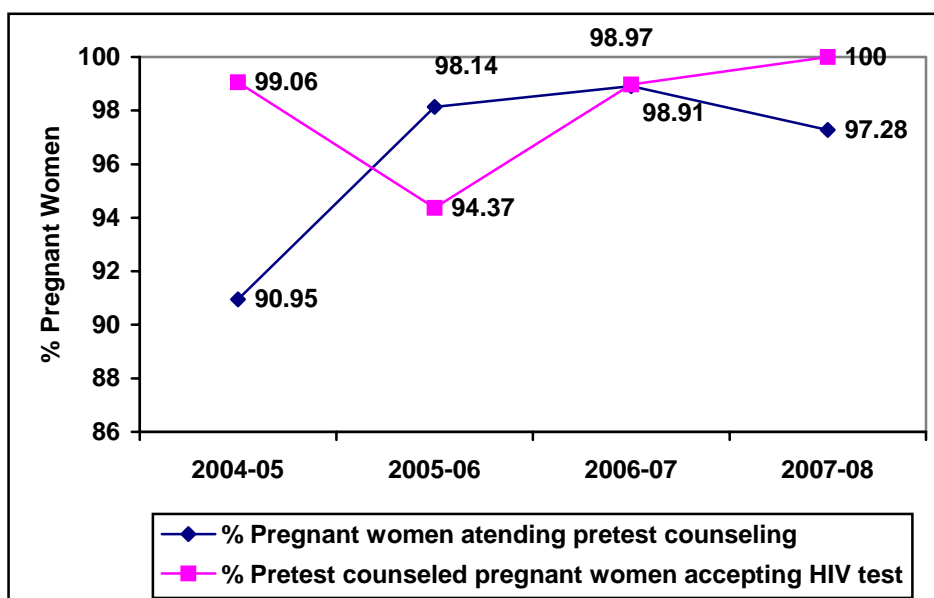


Figure 3.2.2



The data presented in table 3.2.1 & fig. 3.2.1 shows tremendous increase (almost by 200%) in the number of ANC registrations in health facilities from 2004-05 to 2007-08. Most of the pregnant women registering for ANC in Tamilnadu are attending the pre-test counseling and accepting the HIV test. While 90.95% ANC registered pregnant women attended pre-test counseling in 2004-05, the corresponding figures for 2005-06, 2006-07 and 2007-08 are 98.14%, 98.91% and 97.28%. The drop in the uptake of pregnant women for pretest counseling from 98.91% to 97.28% is only marginal. Likewise there is a 100% achievement with respect to the acceptance for HIV test after pre-test counseling. The percentage of HIV positive pregnant women among ANC registrations came down to 0.59 in 2004-05 to 0.28 in 2007-08. The figures speak of the successful implementation of the programme in the state.

Table 3.2.2	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who attended the pre-test counseling	14208	68502	60429	44844
Number of pregnant women who accepted HIV test	14075	64644	59806	44844
Number of pregnant women who attended the post-test counseling	13958	58813	57237	44290

The number of women attending post-test counseling, as percentage of those attending pre-test counseling, was 98.24% (2004-05), 85.86% (2007-08), 94.72% (2006-07) and 98.76 (2007-08) for the four years. As per NACO guidelines all the women who attended pre-test counseling should also be counseled after the test. The available data indicates that this objective is more or less fulfilled in Tamilnadu.

Table 3.2.3	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive.	83	264	171	125
Number of husbands of HIV positive women counseled	78	226	134	97
Number of husbands of HIV positive women who accepted HIV test	74	216	108	95
Number of husbands found HIV positive	53	184	107	78

The percentage of husbands of HIV positive women attending the counseling sessions was 93.98 during 2004-05. A gradual decrease was noted in this figure during the following years to 85.61% in 2005-06, 78.36% in 2006-07 and 77.60% in 2007-08. The percentage of husbands of HIV positive women accepting the test was 94.87% in 2004-

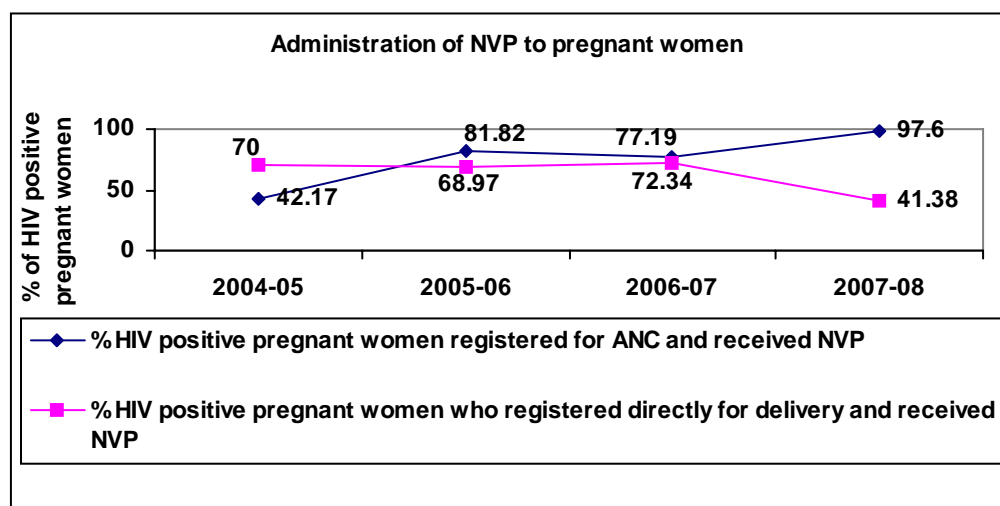
05, 95.58% in 2005-06, 80.60% in 2006-07 and 97.94% in 2007-08. The data reflects the positive impact of counseling on the husbands of HIV positive women and the degree of awareness generated among them.

Table 3.2.4	2004-05	2005-06	2006-07	2007-08
Number of women registered directly for delivery without ANC registration in the health facility	1358	9965	4574	2210
Number of pregnant women counseled and accepted for HIV test from above	1358	7070	4492	2210
Number of pregnant women found positive	10	58	47	29

The data presented in the above table (table 3.2.4) indicates that the acceptance for HIV test among pregnant women attending the health facility for direct delivery is 100% or near 100% during 2004-05, 2006-07 and 2007-08. However, a drop in this percentage was registered during 2005-06. The percentage of HIV positive women among those coming for direct delivery was 0.74%, 0.82%, 1.05% and 1.31% during 2004-05, 2005-06, 2006-07 and 2007-08 respectively.

Table 3.2.5	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	83	264	171	125
Number of HIV positive pregnant women registered for ANC and received NVP	35	216	132	122
Pregnant women who registered directly for delivery and found positive	10	58	47	29
Number of HIV positive pregnant women who registered directly for delivery and received NVP	7	40	34	12

Figure 3.2.3



The percentage of HIV positive pregnant women registered for ANC and given NVP was found to be 42.17% in 2004-05, 81.82% in 2005-06, 77.19% in 2006-07 and 97.60% in the year 2007-08. The progress with respect to administration of NVP among ANC registered HIV positive pregnant women is found to be highly encouraging. In contrast, the percentage of HIV positive pregnant women who registered directly for delivery and received NVP had fallen from 70% in 2004-05 to 41.38% in 2007-08. This seems to be an issue, which requires attention.

Table 3.2.6	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	93	322	218	154
Total number of deliveries of HIV positive women	39	247	160	140
Total number of live births to HIV positive mothers	39	245	160	140
Total number of mother / baby pairs received NVP	39	167	153	140

Figure 3.2.4

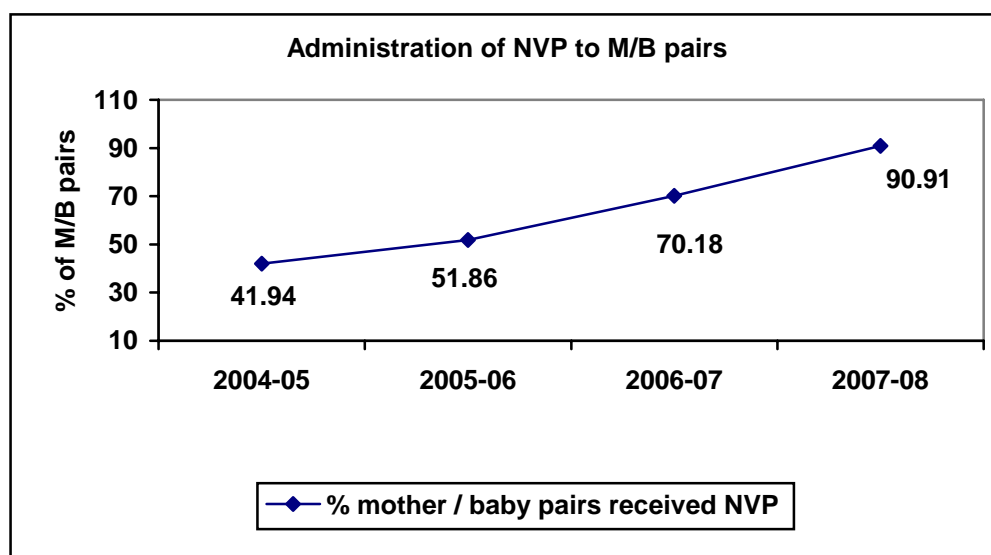


Table 3.2.6 & fig.3.2.4 presents the data pertaining to NVP administration to mother baby pairs. The figures indicate a gradual increase in the coverage of M/B pairs with NVP. Achievement of 91% coverage during 2007-08 reflects the successful implementation of the programme in the state.

Table 3.2.7	2004-05	2005-06	2006-07	2007-08
Total number of deliveries of HIV positive women	39	247	160	140
Number of HIV positive women coming for follow up (post partum) at, 3 months	12	2	0	2
6 Months	14	63	154	186
12 Months	5	134	132	217
18 Months	4	236	169	113
Total number of live births to HIV positive mothers	39	245	160	140
Number of babies of HIV positive women – brought for follow up at, 3 months	10	40	152	116
6 Months	9	27	154	182
12 Months	3	72	132	213
18 Months	7	145	169	109

Table 3.2.8	2004-05	2005-06	2006-07	2007-08
Total number of live births to HIV positive mothers	39	245	160	140
Number of babies tested at 12 months	1	2	0	0
Number of babies found HIV positive at 12 months	0	0	0	0
Number of babies tested at 18 months	7	30	19	40
Number of babies found HIV positive at 18 months	0	1	0	2

Tables 3.2.7 & 3.2.8 present the data pertaining to follow up of HIV positive mothers and babies born to them. During 2004-05 the number of HIV positive mothers coming for follow up is very low. However, during the remaining three years, i.e., 2005-06, 2006-07, 2007-08 the turnout seems to have improved indicating a positive impact of the follow up. The data also indicates that the number of children borne to HIV positive mothers brought for follow up different periods post-partum is lower than the number of live births. Some times there is a mismatch between the number of deliveries and the number of mothers attending the follow up. Similar is the case with the number of children brought for follow up, especially at the age of 12 months and 18 months post-partum. For example the total number of HIV positive deliveries is shown as 160 during 2006-07 but, 169 mothers attended the follow up at 18 months post-partum. Likewise, during 2007-08 the data indicates that 140 HIV positive deliveries took place whereas 186 and 217 mothers attended the follow up at 6 months and 12 months post-partum respectively. The reason for this discrepancy may be that women who underwent

delivery at one health centre are attending follow up sessions in some other health centre. The data available at Theni Medical College PPTCT centre and District Head Quarters Hospital, Virudhnagar corroborates this opinion. There is also a possibility of women who underwent delivery and children borne to HIV positive women during a given year coming for follow up during the following year, especially at the ages of 12 and 18 months post-partum. In spite of these reasons, there is a need to improve the performance with respect to follow up of HIV positive mothers and children borne to them.

The other important observation from this data is that there is a large gap between the number of babies brought for follow up and the number of babies tested at 18 months age. While 145, 169 and 109 babies were brought for follow up at 18 months age during 2005-06, 2006-07 and 2007-08, the data shows that 30, 19 and 40 babies only were tested during these three years respectively. It is essential to address such discrepancies in testing. Otherwise the impact of the programme cannot be accurately measured.

Table 3.2.9	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	93	322	218	154
Number of HIV positive pregnant women referred to ART centres	22	101	125	116

The above table shows the referral status of HIV positive pregnant women to ARV centers. While the year 2004-05 recorded 23.65% referrals, 31.36%, 57.33% and 75.32% women were referred to ART centres for treatment during 2005-06, 2006-07 and 2007-08 respectively. The performance with respect to referrals of pregnant women to ART centers is encouraging in the state of Tamilnadu.

District	2005-06		2006-07		2007-08	
	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries
Erode	47242	41425	43234	38549	43651	39355
Thiruvallur	60954	53039	58709	51728	60063	53908
Virudhnagar	35817	31918	35705	31775	35516	31995
Kanniyakumari	26985	24170	26569	23933	27328	24665

Table 3.2.10 portrays the data pertaining to the number of expected pregnancies vis-à-vis the number of institutional deliveries in all the four districts surveyed in the state of Tamil Nadu. Data for the year 2004 – 05 is not available in this state. Hence, data for the remaining three years only is presented here. The number of institutional deliveries in Tamil Nadu is considerably high in all the four districts (between 87% and 90%) during 2005-06. A further increase in the number of institutional deliveries, though marginal, is observed in the following years in all the surveyed districts.

3.3 EVALUATION OF IMPACT OF PPTCT PROGRAMME IN KARNATAKA

Table 3.3.1	2004-05	2005-06	2006-07	2007-08
Number of Pregnant women who registered for ANC in the Health facility	13602	18222	20065	21372
Number of pregnant women who attended the pre-test counseling	11248	14718	16976	18335
Number of pregnant women who accepted HIV test	11147	14385	16592	17735
Number of ANC registered pregnant women who were found positive	197	213	224	190

Figure 3.3.1

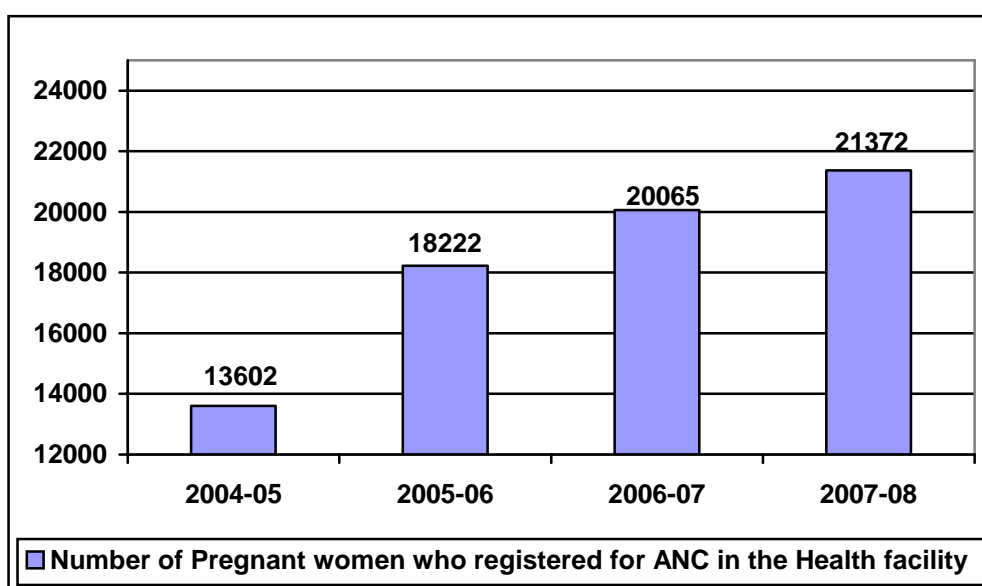
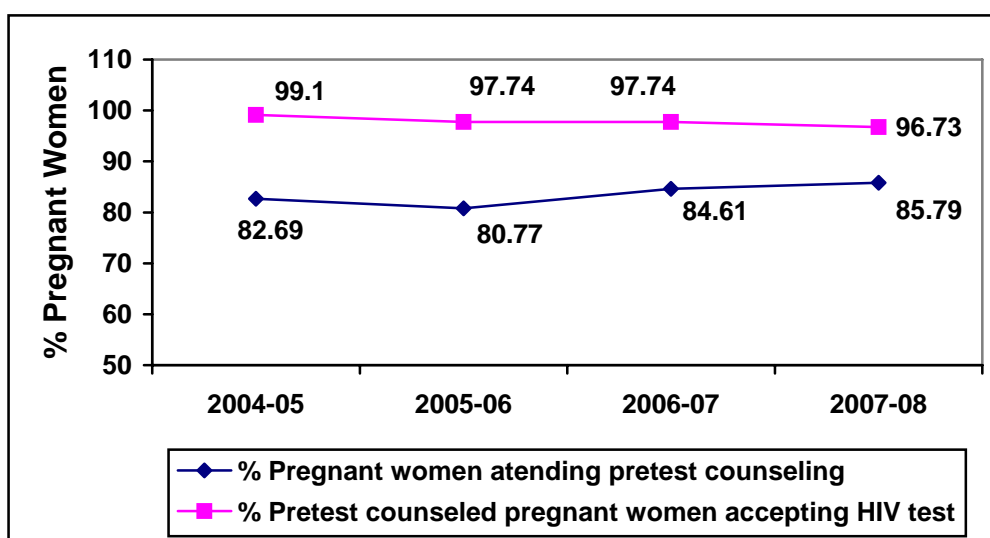


Figure 3.3.2



Data from table 3.3.1 and figure 3.3.1 shows a 57% increase in the number of ANC registrations from 2004-05 to 2007-08. This speaks of the efforts put for mobilization of pregnant women to attend ANC by generating awareness among them about the benefits of attending ANC. The number of pregnant women attending pre-test counseling as percentage of ANC registrations remained more or less constant ranging between 81% and 86% from 2004-05 to 2007-08. The percentage of pregnant women who accepted HIV test registered a marginal decrease from 99 in 2004-05 to 97 in 2007-08. The percentage of ANC registered women who were found HIV positive went down from 1.77 in 2004-05 to 1.07 in 2007-08. On the whole, the results portray a good performance of the surveyed PPTCT centres with satisfactory implementation of the programme.

Table 3.3.2	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who attended the pre-test counseling	11248	14718	16976	18335
Number of pregnant women who accepted HIV test	11147	14385	16592	17735
Number of pregnant women who attended the post-test counseling	9851	13068	15531	16958

Table 3.3.2 shows that there is an increase in the number of pregnant women who attended post test counseling from 2004-05 to 2007-08. The increase in percentage terms from 2004-05 to 2005-06 was found to be a significant 32.66%. While the number of women who attended post-test counseling as percentage of those who attended pre-test counseling was 87.58 in 2004-05, it rose to 88.79% in 2005-06 and then to 91.49% in 2006-07 and further to 92.49% in 2007-08. These figures speak of the commendable performance of the programme and the positive impact of counseling.

Table 3.3.3	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	197	213	224	190
Number of husbands of HIV positive women counseled	107	117	150	124
Number of husbands of HIV positive women who accepted HIV test	106	112	149	121
Number of husbands found HIV positive	87	88	131	110

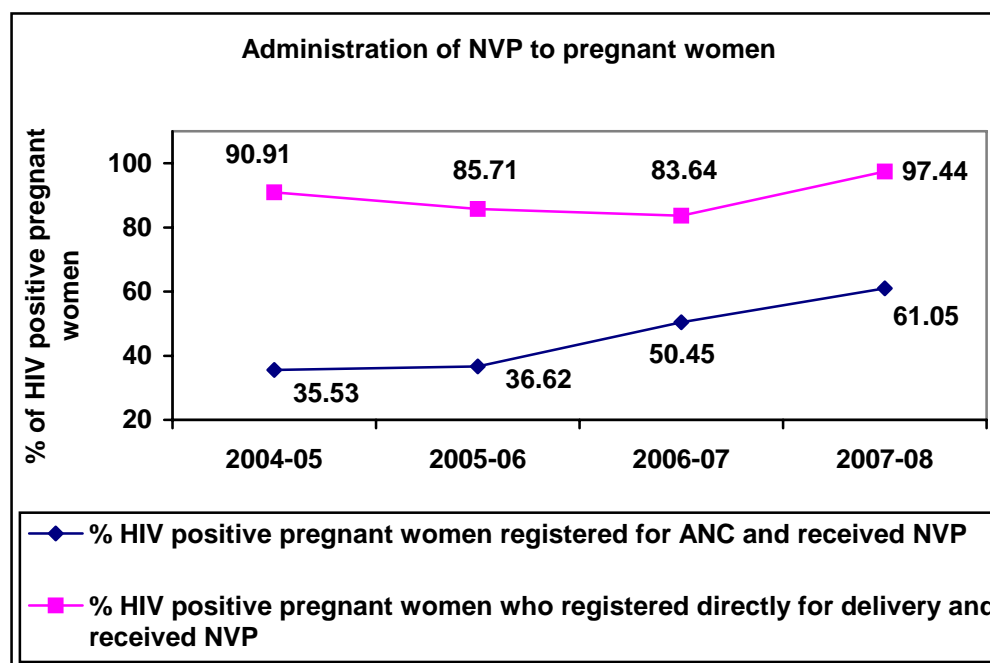
The percentage of husbands of HIV positive women attending the counseling sessions was around 55 during 2004-05 & 2005-06. It increased to 67% during 2006-07 but marginally decreased to 65% during 2007-08. However, the data shows that after attending the counseling session, most of the husbands of HIV positive women are accepting the test. Though it reflects the positive impact of counseling on the husbands, further efforts should be put in the direction of generation of awareness among the husbands of HIV positive women to make them understand the need for attending the counseling and accepting the test.

Table 3.3.4	2004-05	2005-06	2006-07	2007-08
Number of women registered directly for delivery without ANC registration in the health facility	3506	1432	3907	4002
Number of pregnant women counseled and accepted HIV test from above	2874	875	3255	3616
Number of Pregnant women found positive	33	14	55	39

The number of pregnant women coming directly for delivery to the health facility increased by 14.15% from 2004-05 to 2007-08. This is a good indication of awareness generated among pregnant women to opt for institutional deliveries. The number of women in this category being counseled and accepting the HIV test also increased from 81.97% in 2004-05 to 90.35% in 2007-08.

Table 3.3.5	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	197	213	224	190
Number of HIV positive pregnant women registered for ANC and received NVP	70	78	113	116
Pregnant women who registered directly for delivery and found positive	33	14	55	39
Number of HIV positive pregnant women who registered directly for delivery and received NVP	30	12	46	38

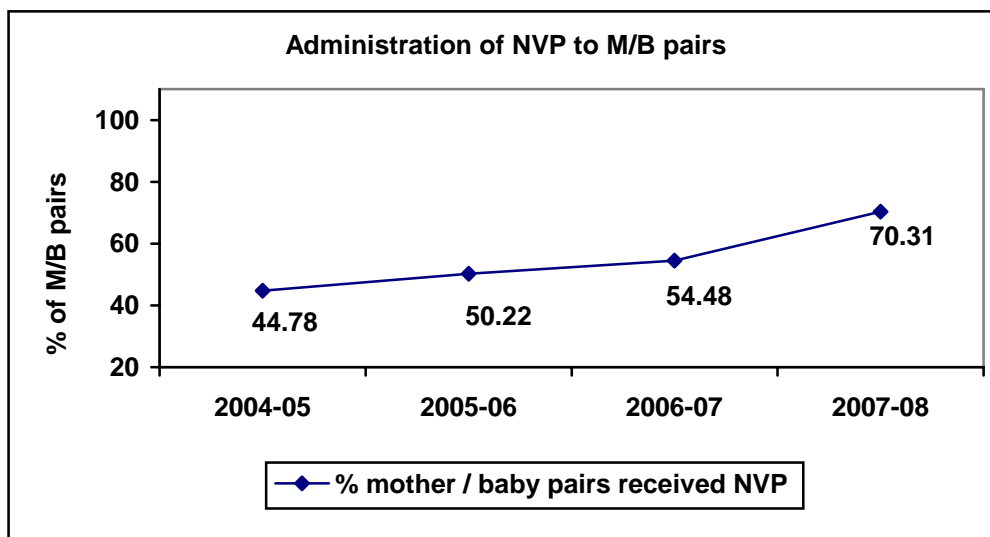
Figure 3.3.3



Only 35.53% pregnant women among ANC registered HIV positive cases received NVP during 2004-05 and this number rose to 61% in 2007-08 (Table 3.3.5 & fig.3.3.3). In contrast, 90.91% pregnant women among those who came for direct delivery were given NVP and the corresponding figure for 2007-08 was 97.44%. Though the results pertaining to administration of NVP among women coming for direct delivery are very encouraging, further efforts are required to improve the performance in the category of women registering for ANC.

Table 3.3.6	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	230	227	279	229
Total number of deliveries of HIV positive women	114	126	168	173
Total number of live births to HIV positive mothers	113	126	152	161
Total number of mother / baby pairs received NVP	103	114	152	161

Figure 3.3.4



The data shows a considerable improvement, from year to year, in the administration of NVP to mother baby pairs in Karnataka. About 45% mother baby pairs were given NVP during 2004-05 and it rose to 50% in 2005-06. In the year 2006-07 the administration of NVP to M/B pairs increased by about 5% compared to the previous year and during 2007-08 it registered a figure of 70%. However, efforts are required to increase the coverage further.

	2004-05	2005-06	2006-07	2007-08
Total number of deliveries of HIV positive women	114	126	168	173
Number of HIV positive women coming for follow up (post partum) at,				
3 Months	15	22	32	22
6 Months	11	19	34	15
12 Months	19	29	9	31
18 Months	7	29	23	28
Total number of live births to HIV positive mothers	113	126	152	161
Number of babies of HIV positive women – brought for follow up at,				
3 months	13	25	28	28
6 Months	12	23	26	28
12 Months	23	19	11	17
18 Months	5	25	25	18

Table 3.3.8	2004-05	2005-06	2006-07	2007-08
Total number of live births to HIV positive mothers	106	126	152	161
Number of babies tested at 12 months	10	12	0	0
Number of babies found HIV positive at 12 months	0	1	0	0
Number of babies tested at 18 months	1	24	25	16
Number of babies found HIV positive at 18 months	0	0	1	1

Tables 3.3.7 & 3.3.8 present the data pertaining to follow up of HIV positive mothers and babies born to them. The data clearly indicates that there is a large gap between the number of deliveries to HIV positive mothers and the number of mothers & babies coming for follow up at 3 months, 6 months, 8 months and 12 months post-partum. The number of mothers attending the follow up sessions is considerably low and there is no correlation between the number of mothers attending the follow up sessions and the number of children brought for follow up.

The number of babies brought for testing at the age of 18 months is also very low compared to the number of live births. Not all the babies who were brought for follow up at the age of 18 months were tested. This reflects poor performance with respect to follow up of HIV positive mothers and babies borne to them in the PPTCT programme.

Table 3.3.9	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	230	227	279	229
Number of HIV positive pregnant women referred to ART centres	30	57	116	141

The above table shows the referral status of HIV positive pregnant women to ART centers. While the year 2004-05 recorded 13.04% referrals, 25.11%, 41.57% and 61.57% women were referred to ART centres for treatment during 2005-06, 2006-07 and 2007-08 respectively. The increase in the number of referrals, year after year, indicates a clear understanding of the programme among the people involved and also coordination between PPTCT & ART centers. This shows improved availability of ART which prolongs the life of HIV positive patients.

District	2004-05		2005-06		2006-07		2007-08	
	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries
Gulbarga	65437	20532	51287	15826	64027	22409	67634	25933
Uttar Kannada (Karwar)	19269	16005	16819	14207	20442	17375	19814	17604
Mandya	18393	14190	18853	16235	23045	19844	24182	22963
Udupi	22369	13591	11529	11083	13964	13423	13774	13531

Table 3.3.10 portrays the data pertaining to the number of expected pregnancies vis-à-vis the number of institutional deliveries in all the four districts surveyed in Karnataka. In Gulbarga district the number of institutional deliveries is considerably low. From about 31% (of the expected number of pregnancies) in the year 2004-05 the number of institutional deliveries increased to about 39% in 2007-08. However, in the remaining three districts there is a considerable increase in the number of institutional deliveries from 2004-05 to 2006-07.

3.4 EVALUATION OF IMPACT OF PPTCT PROGRAMME IN MAHARASHTRA

Table 3.4.1	2004-05	2005-06	2006-07	2007-08
Number of Pregnant women who registered for ANC in the Health facility	23890	27600	32071	19776
Number of pregnant women who attended the pre-test counseling	22339	26806	30826	17228
Number of pregnant women who accepted HIV test	18392	22657	25192	14492
Number of ANC registered pregnant women who were found positive	234	232	268	94

Figure 3.4.1

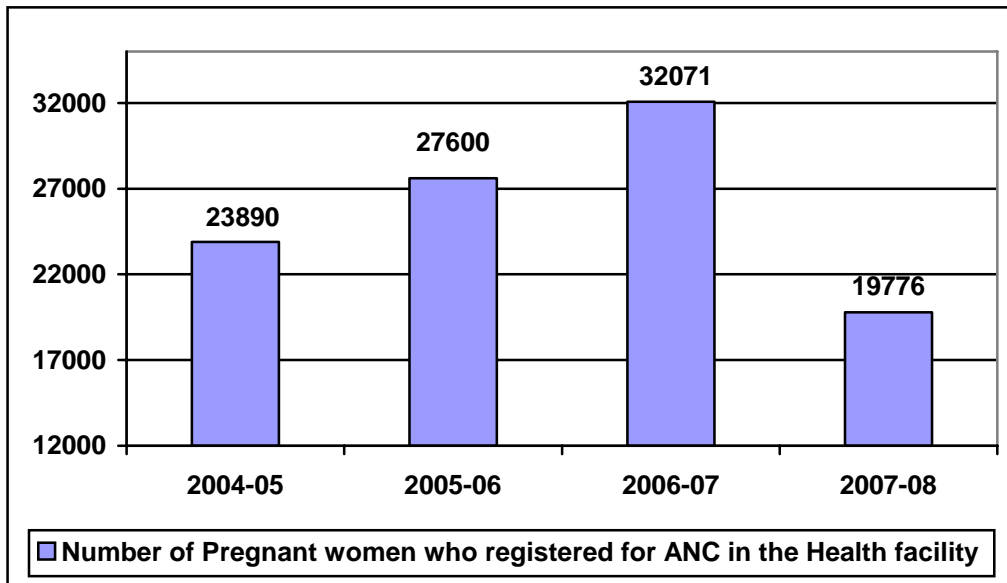
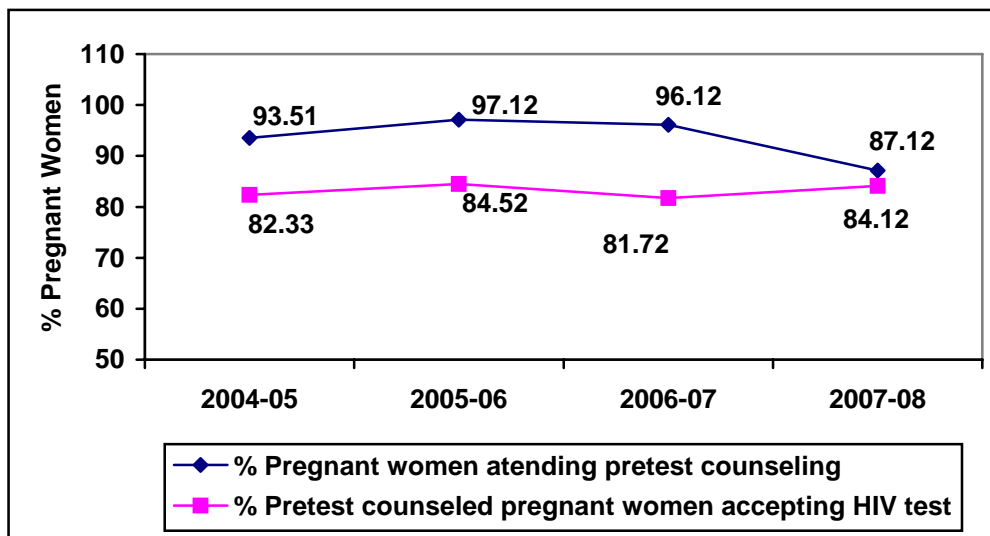


Figure 3.4.2



The data presented in table 3.4.1 & figure 3.4.1 shows a consistent increase in the ANC registrations from 2004-05 to 2005-06 & 2005-06 to 2006-07. However, an abrupt and steep decline in ANC registrations was recorded during 2007-08. Similar trend is shown with respect to the number of women attending pre-test counseling as percentage of ANC registered pregnant women. It went up from 93.51% in 2004-05 to 97.12% in 2005-06 and started declining thereafter to record a figure of 87.12% in 2007-08. In Maharashtra, it is observed that in some of the surveyed PPTCT centres no full time counselors are available. Counselors from the nearby centres are sent on deputation to these centres. This might have resulted in drop in the efficiency of services because of increased work load in these particular centres. However, the number of pregnant women accepting HIV test after counseling remained more or less constant through the four years of the project implementation. Probably more focused efforts are required for generation of awareness among pregnant women and mobilizing them to attend ANC.

Table 3.4.2	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who attended the pre-test counseling	22339	26806	30826	17228
Number of pregnant women who accepted HIV test	18392	22657	25192	14492
Number of pregnant women who attended the post-test counseling	9343	11656	13675	8096

Table 3.4.2 shows a marginal increase in the number of women attending post-test counseling, as percentage of those attending pre-test counseling, from 41.82% (2004-05) to 46.99% (2007-08). As per NACO guidelines all the women who attended pre-test counseling should also be counseled after the test. This objective is not fulfilled with only less than 50% of the women who attended pre-test counseling going for post-test counseling. As already indicated, this reflects the poor quality counseling services to pregnant women.

Table 3.4.3	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	234	232	268	94
Number of husbands of HIV positive women counseled	151	142	153	61
Number of husbands of HIV positive women who accepted HIV test	127	124	121	58
Number of husbands found HIV positive	117	104	105	55

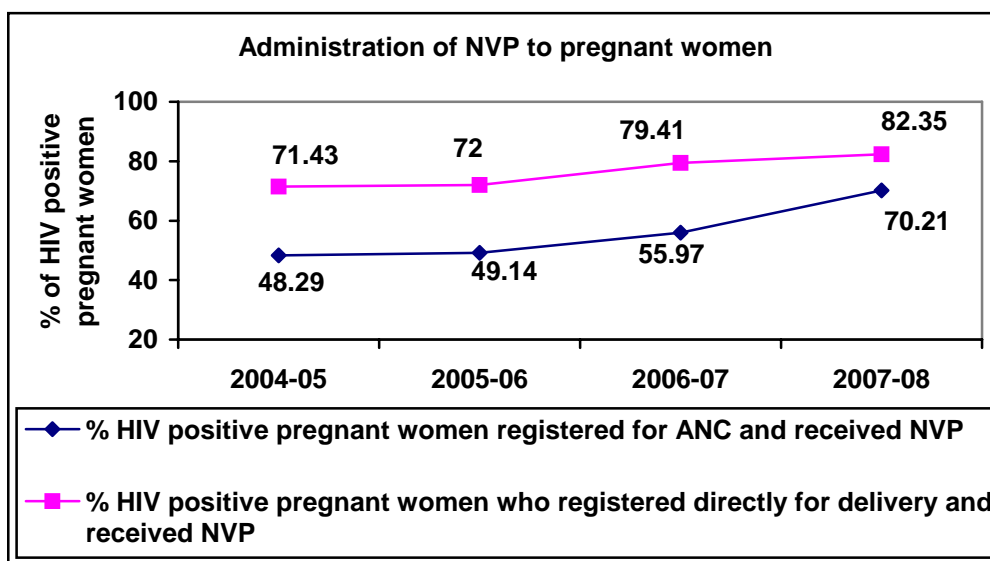
The percentage of husbands of HIV positive women attending the counseling sessions was 65% during 2004-05 which dropped in the years 2005-06 & 2006-07 to 61% & 57% respectively. An increase in the figure to 65% was noted during 2007-08. The number of husbands accepting HIV test was 84.11% in 2004-05, 87.32% in 2005-06, 79.08% in 2006-07 and 95.08% in 2007-08. Though it reflects the positive impact of counseling on the husbands, further efforts should be put in the direction of generation of awareness among the husbands of HIV positive women to make them understand the need for attending the counseling and accepting the test.

Table 3.4.4	2004-05	2005-06	2006-07	2007-08
Number of women registered directly for delivery without ANC registration in the health facility	8139	8301	7586	2122
Number of pregnant women counseled and accepted for HIV test from above	1675	1597	1148	502
Number of Pregnant women found positive	42	25	34	17

The number of pregnant women coming direct for delivery to the health facility increased marginally from 2004-05 to 2005-06. Thereafter it started declining registering the lowest figure in 2007-08. The number of pregnant women counseled and accepted HIV test among those coming direct for delivery is found to be low and inconsistent. The figures for different years are 20.58% (2004-05), 19.24% (2005-06), 15.13% (2006-07) and 23.66% (2007-08). This may be because of either poor performance with respect to counseling and convincing the pregnant women for accepting the test or lack of feasibility for conducting the counseling in case the women are already in labour.

Table 3.4.5	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	234	232	268	94
Number of HIV positive pregnant women registered for ANC and received NVP	113	114	150	66
Pregnant women who registered directly for delivery and found positive	42	25	34	17
Number of HIV positive pregnant women who registered directly for delivery and received NVP	30	18	27	14

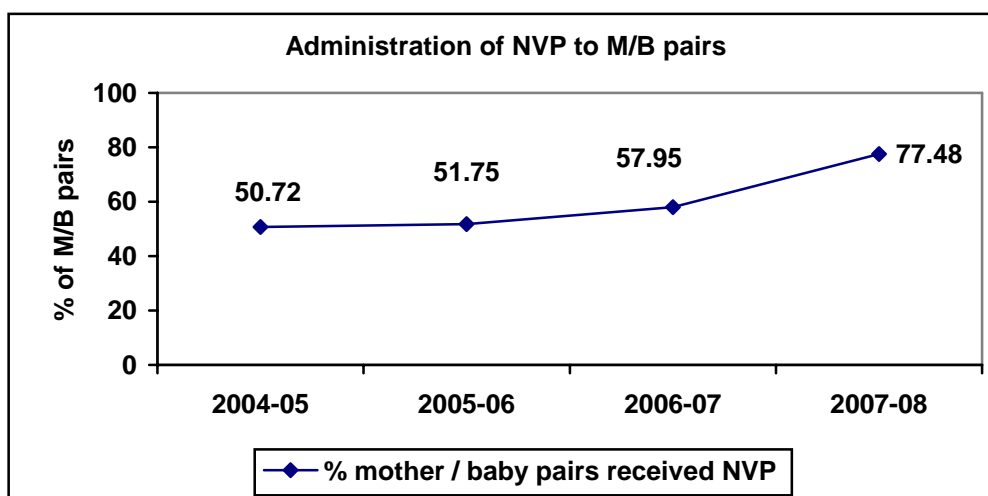
Figure 3.4.3



The data shows a gradual increase in the percentage of HIV positive pregnant women, both ANC registered and registered for direct delivery, receiving NVP from 2004-05 to 2007-08. During 2007-08 70.21% ANC registered HIV positive women and 82.35% of direct registered women received NVP. This indicates a good performance with respect to administration of NVP among HIV positive pregnant women.

	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	276	257	302	111
Total number of deliveries of HIV positive women	170	155	197	98
Total number of live births to HIV positive mothers	159	150	190	92
Total number of mother / baby pairs received NVP	140	133	175	86

Figure 3.4.4



The data shows a steady increase in the coverage of mother and baby pairs with respect to NVP administration from 2004-05 to 2007-08. While 50.72% mother baby pairs received NVP during 2004-05 this rose to about 77% during the year 2007-08. Though the figures indicate a good performance with respect to administration of NVP efforts are required to increase the coverage further.

Table 3.4.7	2004-05	2005-06	2006-07	2007-08
Total number of deliveries of HIV positive women	170	155	197	98
Number of HIV positive women coming for follow up (post partum) at,				
3 Months,	43	38	49	33
6 Months	44	46	48	37
12 Months	19	35	31	32
18 Months	8	25	43	14
Total number of live births to HIV positive mothers	159	150	190	92
Number of babies of HIV positive women – brought for follow up at,				
3 months	38	35	47	31
6 Months	42	44	45	34
12 Months	38	32	30	30
18 Months	8	25	55	15

Table 3.4.8	2004-05	2005-06	2006-07	2007-08
Total number of live births to HIV positive mothers	159	150	190	92
Number of babies tested at 12 months	0	0	0	0
Number of babies found HIV positive at 12 months	0	0	0	0
Number of babies tested at 18 months	6	25	55	15
Number of babies found HIV positive at 18 months	1	3	8	0

Tables 3.4.7 & 3.4.8 present the data pertaining to follow up of HIV positive mothers and babies born to them. The data clearly indicates that there is a large gap between the number of deliveries to HIV positive mothers and the number of mothers & babies coming for follow up at 3 months, 6 months, 8 months and 12 months post-partum. The number of mothers attending the follow up sessions is considerably low and there is no correlation between the number of mothers attending the follow up sessions and the number of children brought for follow up.

The number of babies brought for testing at the age of 18 months is also very low compared to the number of live births. Mere 3.77% of the babies borne to HIV positive mothers were tested during 2004-05. This figure increased to 16.67% in 2005-06 and to 28.95 in 2006-07. However, it dropped drastically to 16.30% during 2007-08. This reflects poor performance with respect to the component of follow up in the PPTCT programme. However, the available results indicate a decrease in the incidence of HIV positivity from 16.67% in 2004-05 to 0% in 2007-08.

Table 3.4.9	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	276	257	302	111
Number of HIV positive pregnant women referred to ART centres	50	45	158	88

The above table shows the referral status of HIV positive pregnant women to ART centers. While the year 2004-05 recorded 18.11% referrals, 17.50%, 52.31% and 79.27% women were referred to ART centres for treatment during 2005-06, 2006-07 and 2007-08 respectively. There is a significant increase in the referrals made during 2007-08. The increase in the number of referrals, year after year, indicates a clear understanding of the programme among the people involved and also coordination between PPTCT & ART centers. This shows improved availability of ART, which prolongs the life of HIV positive patients.

Table 3.4.10					
District	Total Expected No. of Pregnancies	2004-05	2005-06	2006-07	2007-08
		No. of Institutional Deliveries	No. of Institutional Deliveries	No. of Institutional Deliveries	No. of Institutional Deliveries
Ahmadnagar	84449	51695	57954	56152	67876
Solapur	80455	32561	37547	37740	41881
Kolhapur	73634	58339	56830	57647	68313
Wardha	20848	15876	16842	14624	17109

Table 3.4.10 portrays the data pertaining to the number of expected pregnancies vis-à-vis the number of institutional deliveries in all the four districts surveyed in Maharashtra. Solapur district is found to be lagging behind in the number of institutional deliveries in spite of a 12% increase from 2004-05 to 2007-08. The remaining three districts registered a considerable increase in the number of institutional deliveries. While over 80% of the pregnant women opted for institutional deliveries in the districts of Ahmadnagar and Wardha, about 93% women underwent deliveries in hospitals in Kolhapur district. This speaks of a significant achievement in mobilizing pregnant women towards institutional deliveries in the surveyed districts.

3.5 EVALUATION OF IMPACT OF PPTCT PROGRAMME IN MANIPUR

Table 3.5.1	2004-05	2005-06	2006-07	2007-08
Number of Pregnant women who registered for ANC in the Health facility	13928	14287	14549	18449
Number of pregnant women who attended the pre-test counseling	3388	8542	12668	16614
Number of pregnant women who accepted HIV test	949	3592	12131	16315
Number of ANC registered pregnant women who were found positive	23	50	113	104

Figure 3.5.1

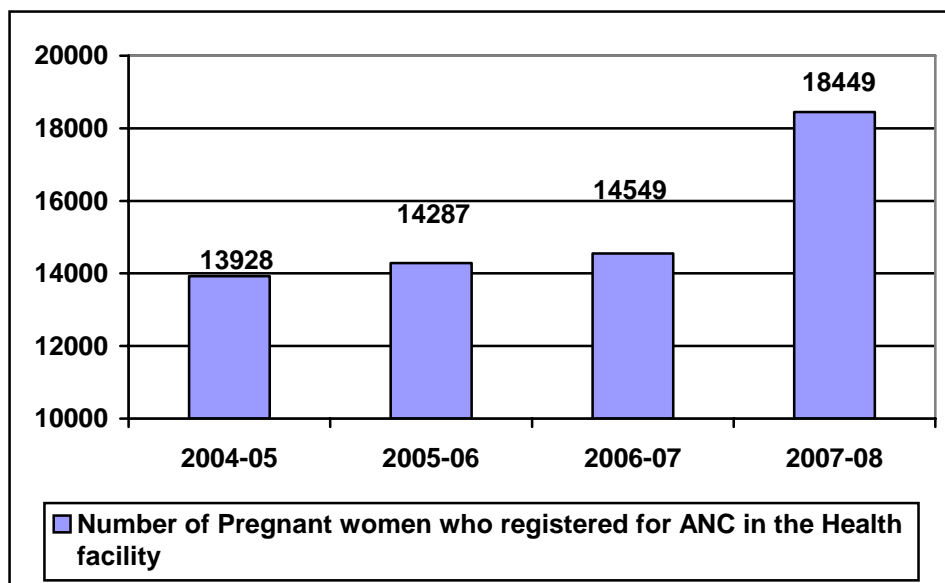


Figure 3.5.2

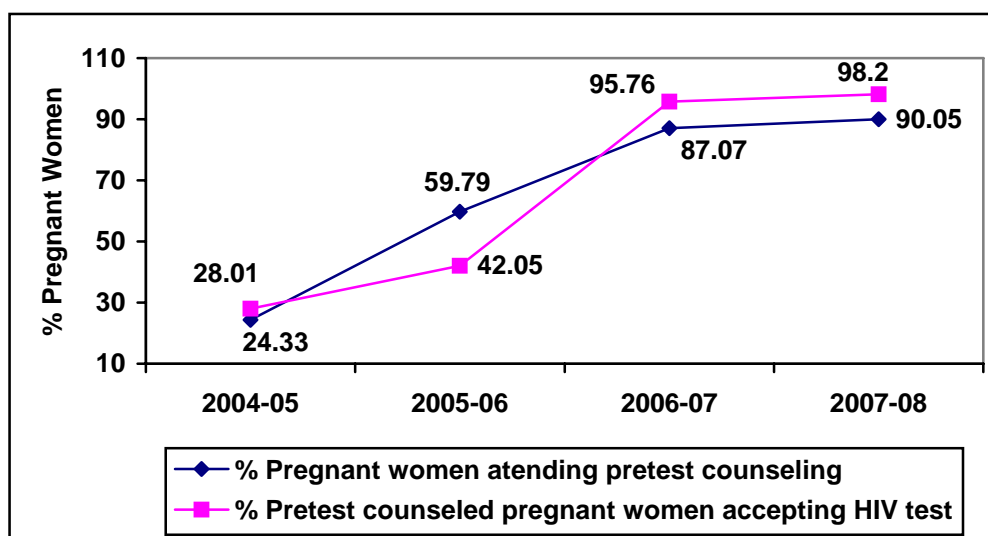


Table 3.5.1 & figure 3.5.1 shows that there has been a marginal rise, from 2004-05 to 2006-07, in the number of pregnant women registered for ANC. The increase from 2006-07 to 2007-08 was found to be considerable at 27% taking the net rise of ANC registrations from 2006-07 to 2007-08 to over 32%. The number of pregnant women who attended pre-test counseling as percentage of ANC registered pregnant women was 24.33% in 2004-05. This figure increased to 59.79% in 2005-06, then to 87.07% during 2006-07 and it further increased to 90.05% in 2007-08. The number of pregnant women who accepted HIV test as percentage of the pre-test counseled women also displayed a similar trend. It registered a figure of 28.01% in 2004-05, which gradually rose to 98.20% in 2007-08. This is an indication of the awareness levels generated among pregnant women regarding attending ANC and getting tested to know their HIV status.

Table 3.5.2	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who attended the pre-test counseling	3388	8542	12668	17014
Number of pregnant women who accepted HIV test	949	3592	12131	16315
Number of pregnant women who attended the post-test counseling	246	275	489	737

Table 3.5.2 shows that only a meager number of women attending pre-test counseling turned up for post-test counseling. It was found to be 7.26%, 3.22%, 3.86% and 4.33% respectively, during the four years starting from 2004-05. In Manipur state pregnant women have to travel in the hilly terrain, where no proper conveyance is available, to attend the ANC. They visit the health centre only once and thereafter they rarely come to the centre for the second time whether it is for post-test counseling or for further follow up. Deliveries are also mostly home deliveries. This seems to be the main reason for the low turnout for post-test counseling.

Table 3.5.3	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	23	50	113	104
Number of husbands of HIV positive women counseled	17	35	59	81
Number of husbands of HIV positive women who accepted HIV test	8	18	25	35
Number of husbands found HIV positive	7	14	24	27

The percentage of husbands of HIV positive women attending the counseling sessions was 73.91 during 2004-05, which marginally decreased during 2005-06 to 70.00% (table 3.5.3). A considerable drop was noted in this percentage to 52.21% in 2006-07. However, it once again rose to 77.88% in 2007-08. The number of husbands accepting HIV test was found to be considerably lower in comparison to the number of those who attended the counseling. The corresponding figures for the four years are 47.06%, 51.43%, 42.37% and 43.21%. This indicates the lack of awareness among and unwilling attitude of husbands of the HIV positive women to accept the test. Ways are to be explored to motivate the husbands of HIV positive women to undergo testing without fail.

Table 3.5.4	2004-05	2005-06	2006-07	2007-08
Number of women registered directly for delivery without ANC registration in a health facility	3210	3867	4599	3279
Number of pregnant women counseled and accepted for HIV test from above	3	47	1060	1354
Number of Pregnant women found positive	0	4	9	13

The performance with respect to motivation of pregnant women who are coming to the health centers directly for delivery to accept the HIV test was very poor during 2004-05 and 2005-06 with only 0.09% and 1.22% of the women in this category accepting the test. However, during the later years of 2006-07 & 2007-08 there was increase in the number of pregnant women, among those registering for direct delivery, with 23.05% and 41.29% women accepting to undergo the HIV screening test. In this aspect also the performance is found to be not up to the mark, in spite of the improvement during 2007-08.

Table 3.5.5	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	23	50	113	104
Number of HIV positive pregnant women registered for ANC and received NVP	13	19	48	40
Pregnant women who registered directly for delivery and found positive	0	4	9	13
Number of HIV positive pregnant women who registered directly for delivery and received NVP	0	3	8	10

Figure 3.5.3

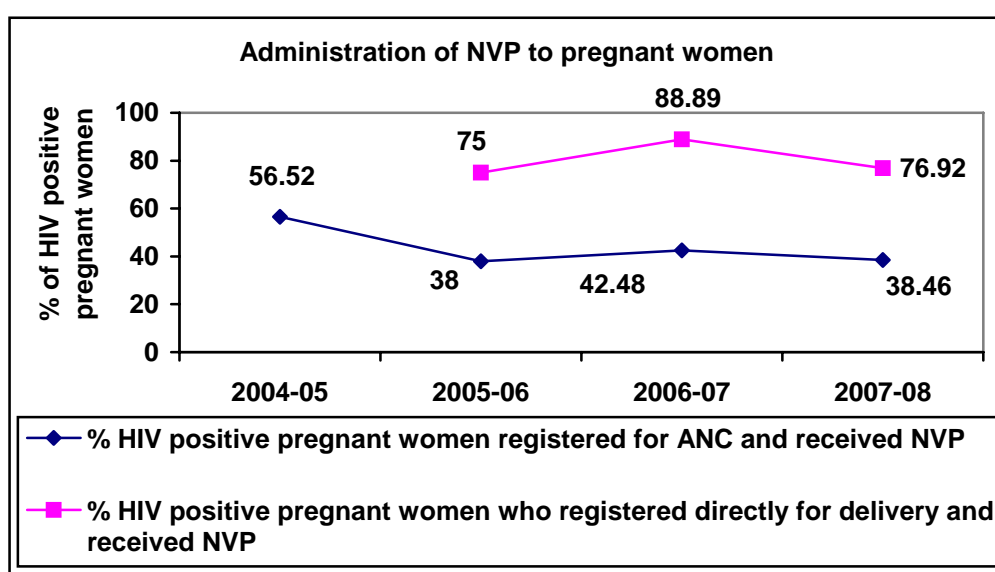
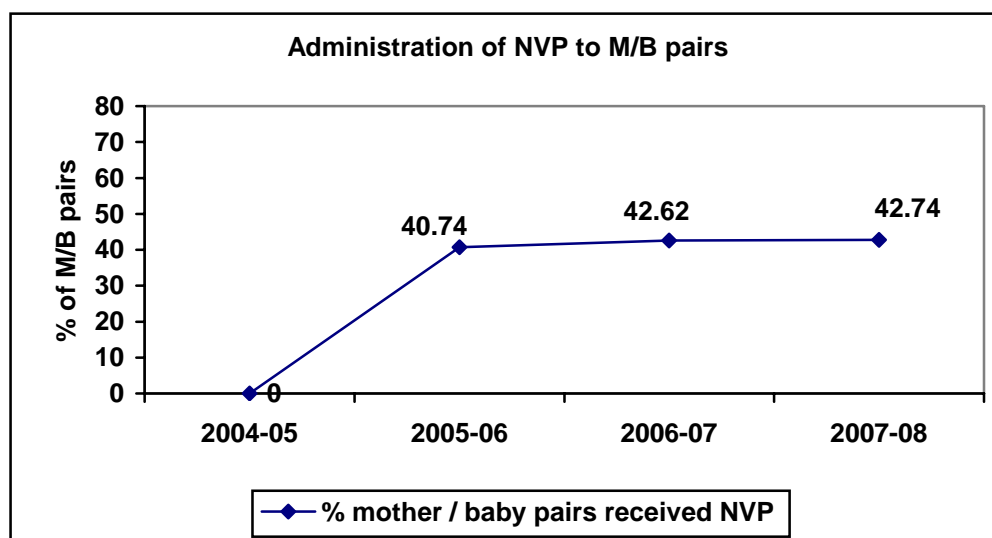


Table 3.5.5 presents the data pertaining to NVP administration to HIV positive pregnant women, both ANC registered and coming for direct delivery. The performance is found to be poor and inconsistent with 56.52% ANC registered HIV positive pregnant women receiving NVP in 2004-05, 38.00% in 2005-06, 42.48% in 2006-07 and 38.46% of them in 2007-08. There were no cases of HIV positive pregnant women directly registering for delivery. The coverage was found to be good during the following three years with 75.00% of the women receiving NVP during 2005-06, 88.89% in 2006-07 and 76.92% in 2007-08.

Table 3.5.6	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	23	54	122	117
Total number of deliveries of HIV positive women	13	22	55	57
Total number of live births to HIV positive mothers	13	22	52	56
Total number of mother / baby pairs received NVP	0	22	52	50

Figure 3.5.4



Data pertaining to administration of NVP to mother/baby pairs, which is presented in table 3.5.6, shows that there was no coverage of M/B pairs with NVP in 2004-05. During 2005-06 the coverage was found to be about 41% and in 2006-07 & 2007-08 around 43% M/B pairs received NVP. The performance with respect to administration of NVP to M/B pairs is found to be poor.

Table 3.5.7	2004-05	2005-06	2006-07	2007-08
Total number of deliveries of HIV positive women	13	22	55	57
Number of HIV positive women coming for follow up (post partum) at, 3 Months,	0	1	1	2
6 Months	0	0	12	129
12 Months	0	0	7	3
18 Months	0	0	1	0
Total number of live births to HIV positive mothers	13	22	52	56
Number of babies of HIV positive women – brought for follow up at, 3 months	0	1	6	2
6 Months	0	0	4	6
12 Months	0	0	1	0
18 Months	0	0	2	3

Table 3.5.8	2004-05	2005-06	2006-07	2007-08
Total number of live births to HIV positive mothers	0	0	51	56
Number of babies tested at 12 months	0	0	0	0
Number of babies found HIV positive at 12 months	0	0	0	0
Number of babies tested at 18 months	0	0	2	3
Number of babies found HIV positive at 18 months	0	0	0	1

Tables 3.5.7 & 3.5.8 present the data pertaining to follow up of HIV positive mothers and babies born to them. The data clearly indicates that the follow up of HIV positive mothers and babies is very poor. The number of mothers attending the follow up sessions is considerably lower in comparison to the number of deliveries took place. Likewise the number of babies brought for follow up is also very low. While none of the babies borne during 2004-05 & 2005-06 were tested, 2 out of 51 and 3 out of 56 cases of recorded live births were tested during 2006-07 & 2007-08. Once again this indicates the poor implementation of the programme by MNSACS with respect to follow up of mother/baby pairs.

Table 3.5.9	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found positive	23	54	122	117
Number of HIV positive pregnant women referred to ART centres	0	4	49	107

The above table (table 3.5.9) shows the referral status of HIV positive pregnant women to ART centers. While the year 2004-05 recorded 0% referrals, 7.40%, 40.16% and 91.45% women were referred to ART centres for treatment during 2005-06, 2006-07 and 2007-08 respectively. There is a significant increase in the referrals from one year to the other. The increase in the number of referrals, year after year, indicates a good coordination between PPTCT & ART centers. This shows improved availability of ART, which prolongs the life of HIV positive patients.

Table 3.5.10								
District	2004-05		2005-06		2006-07		2007-08	
	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries
Senapati	-	-	-	-	-	-	3130	977
Tamenglong	-	-	-	-	-	-	2230	832

In Manipur no data pertaining to institutional deliveries could be made available for the years 2004-05, 2005-06 and 2006-07. About 31% and 37% pregnant women opted for institutional deliveries during 2007-08 in the districts of Senapati and Tamenglong respectively. The system of home deliveries is more prevalent in the north-eastern states of India and as such very few pregnant women turn up for institutional deliveries. This is one of the bottlenecks in the implementation of the programme in the state of Manipur.

3.6 EVALUATION OF IMPACT OF PPTCT PROGRAMME IN NAGALAND

Table 3.6.1	2004-05	2005-06	2006-07	2007-08
Number of Pregnant women who registered for ANC in the Health facility	-	527	1271	1664
Number of pregnant women who attended the pre-test counseling	-	513	1270	1640
Number of pregnant women who accepted HIV test	-	503	1030	1588
Number of ANC registered pregnant women who were found positive	-	6	5	5

Figure 3.6.1

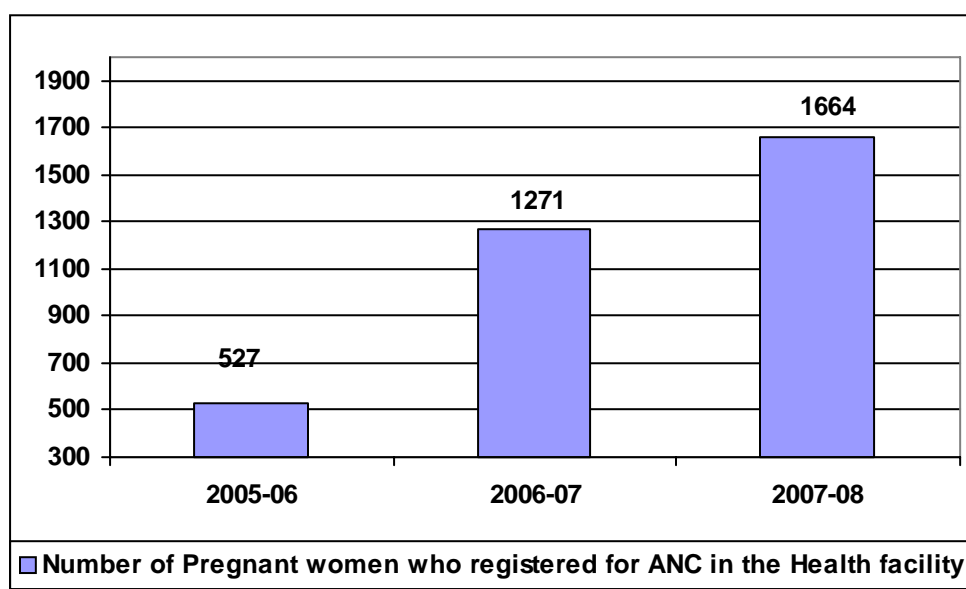
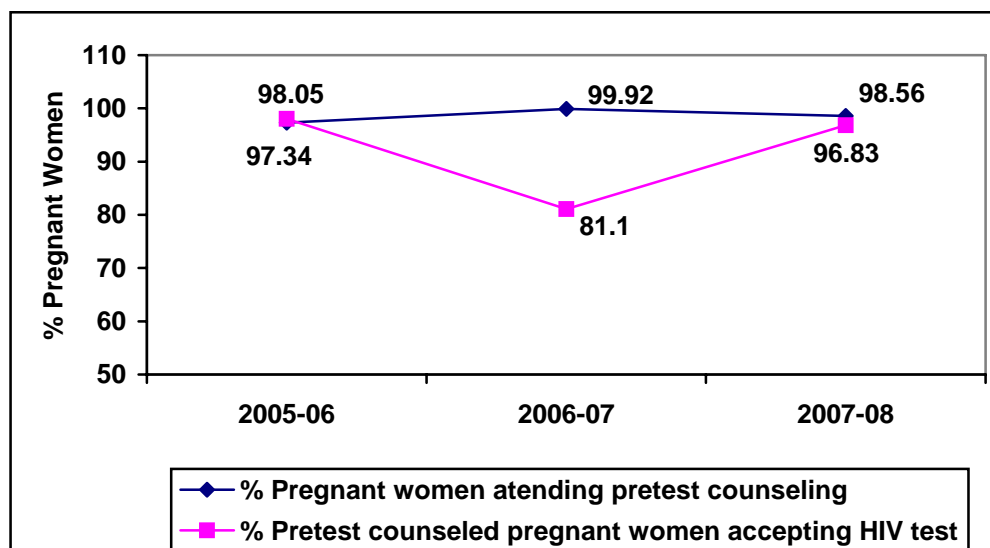


Figure 3.6.2



The data in table 3.6.1 shows a significant increase in the number of ANC registrations from 2005-06 to 2006-07 and from 2006-07 to 2007-08. While 97.34% of the ANC registered pregnant women attended pre-test counseling in 2005-06, the corresponding figures for the years 2006-07 and 2007-08 are 99.92% & 98.56%. Most of the pregnant women who attended pre-test counseling have accepted the HIV test. In 2005-06, 98.05% pre-test counseled women accepted HIV test and in 2006-07 there was a decline in the number of women accepting HIV test to 81.10%. However, the figure once again increased during 2007-08 to 96.83%. These figures indicate an increased acceptance for counseling and testing among pregnant women who are attending ANC and good performance with respect to mobilization of pregnant women to attend ANC.

The available data shows that the percentage of HIV positive pregnant women among those who accepted the HIV test is 1.19% in 2005-06, 0.49% in 2006-07 and 0.31% in 2007-08.

Table 3.6.2	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who attended the pre-test counseling	-	513	1270	1640
Number of pregnant women who accepted HIV test	-	503	1030	1588
Number of pregnant women who attended the post-test counseling	-	6	5	5

It can be inferred from the data presented in table 3 that a negligible number of women who attended pre-test counseling had turned up for post-test counseling. Probably post-test counseling was done only for those women who were found positive.

Table 3.6.3	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	-	6	5	5
Number of husbands of HIV positive women counseled	-	1	0	4
Number of husbands of HIV positive women who accepted HIV test	-	0	0	4
Number of husbands found HIV positive	-	0	0	2

In 2005-06, husband of only one of the HIV positive pregnant women had attended the counseling session and he did not give his acceptance for the test. In 2006-07 husbands of none of the HIV positive pregnant women had turned up for counseling nor did they accept the test. However, during 2007-08, 5 pregnant women had been found to be positive and husbands of 4 of them had attended the counseling and also accepted the HIV test. Two of them turned out to be positive. The data indicates a poor performance with respect counseling and testing of HIV positive women's spouses during the years 2005-06 & 2006-07 with a considerable betterment during 2007-08.

Table 3.6.4	2004-05	2005-06	2006-07	2007-08
Number of women registered directly for delivery without ANC registration in a health facility	-	66	130	265
Number of pregnant women counseled and accepted for HIV test from above	-	0	42	167
Number of Pregnant women found positive	-	0	0	2

During 2005-06, none of the women who came directly for delivery had been counseled nor tested for HIV status. In 2006-07, 32% of the pregnant women in this category had been counseled and tested but none of them were positive. In the year 2007-08, 63% of the pregnant women, who came for delivery directly, had attended the counseling and accepted the HIV test showing a considerable increase from the year before. Once again it reflects a poor performance during the first two years with significant improvement during the third year.

Table 3.6.5	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	-	6	5	5
Number of HIV positive pregnant women registered for ANC and received NVP	-	0	0	0
Pregnant women who registered directly for delivery and found positive	-	0	0	2
Number of HIV positive pregnant women who registered directly for delivery and received NVP	-	0	0	1

Table 3.6.5 presents the data pertaining to NVP administration to HIV positive pregnant women. A total of 16 pregnant women who attended ANC were found to be positive from 2005-08. The available data shows that none of them were given NVP. Of the two positive pregnant women who came for direct delivery, only one was given NVP.

Table 3.6.6	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found HIV positive	-	6	5	7
Total number of deliveries of HIV positive women	-	0	0	3
Total number of live birth to HIV positive mothers	-	0	0	3
Total number of mother / baby pairs received NVP	-	0	0	1

The data in table 3.6.6 shows the coverage of M/B pairs with NVP. As can be perceived from the above data no M/B pairs received NVP during 2005-06 & 2006-07. In 2007-08 there were 7 registered HIV +ve cases among pregnant women but only one M/B pair received NVP. The figures with respect to NVP administration to mother / baby pairs speak of a very poor performance in the State of Nagaland.

Table 3.6.7	2004-05	2005-06	2006-07	2007-08
Total number of deliveries of HIV positive women	-	0	0	3
Number of HIV positive women coming for follow up (post partum) at, 3 months	-	0	0	2
6 Months	-	0	0	0
12 Months	-	0	0	0
18 Months	-	0	0	0
Total number of live births to HIV positive mothers	-	0	0	3
Number of babies of HIV positive women – brought for follow up at, 3 months	-	0	0	2
6 Months	-	0	0	0
12 Months	-	0	0	0
18 Months	-	0	0	0

Table 3.6.8	2004-05	2005-06	2006-07	2007-08
Total number of live births to HIV positive mothers	-	0	0	3
Number of babies tested at 12 months	-	0	0	0
Number of babies found HIV positive at 12 months	-	0	0	0
Number of babies tested at 18 months	-	0	0	0
Number of babies found HIV positive at 18 months	-	0	0	0

The available data pertaining to follow up of HIV positive mothers and babies borne to them, presented in tables 3.6.7 & 3.6.8 is indicative of the poor implementation of the programme in Nagaland with respect to follow up and testing of HIV +ve mothers and babies borne to them.

Table 3.6.9	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who were found HIV positive	-	6	5	7
Number of HIV positive pregnant women referred to ART centres	-	0	0	3

The above table (table 3.6.9) shows the referral status of HIV positive pregnant women to ART centers. There were 3 referrals out of the 7 HIV positive pregnant women during the year 2007-08. During the discussions with the concerned functionaries in the sampled PPTCT centres it is learnt that the women who were referred to ART centres rarely follow the instructions and visit the centres for getting tested and taking ART. The network for follow up for convincing the women on the importance of ART is very poor. The role played by the NGOs in this aspect is also not satisfactory.

Table 3.6.10								
District	2004-05		2005-06		2006-07		2007-08	
	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries	Expected No. of Pregnancies	No. of Institutional Deliveries
Phek	49	0	314	1	568	123	640	128
Wokha	17	0	370	12	1434	259	1174	231

In the state of Nagaland, where the system of home deliveries is more prevalent, the number of institutional deliveries is considerably less in both the districts surveyed. While no institutional deliveries were registered during 2004-05, around 20% of the pregnant women opted for deliveries in hospitals during the year 2007-08.

3.7 EVALUATION OF IMPACT OF PPTCT PROGRAMME IN MUMBAI DACS

Table 3.7.1	2004-05	2005-06	2006-07	2007-08
Number of Pregnant women who registered for ANC in the Health facility	3376	5377	7406	5885
Number of pregnant women who attended the pre-test counseling	3355	5297	7193	5613
Number of pregnant women who accepted HIV test	3304	5143	6874	5351
Number of ANC registered pregnant women who were found positive	32	36	41	22

Figure 3.7.1

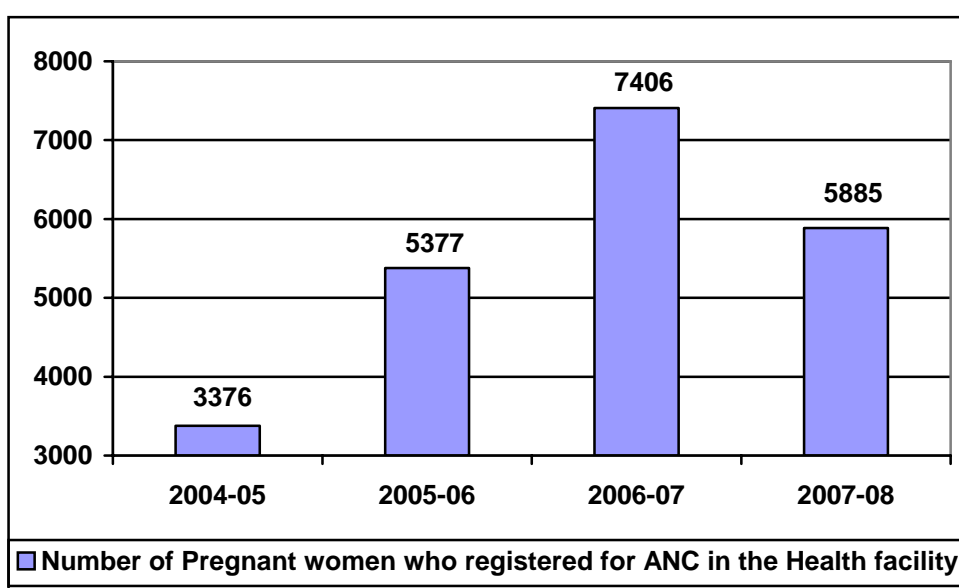
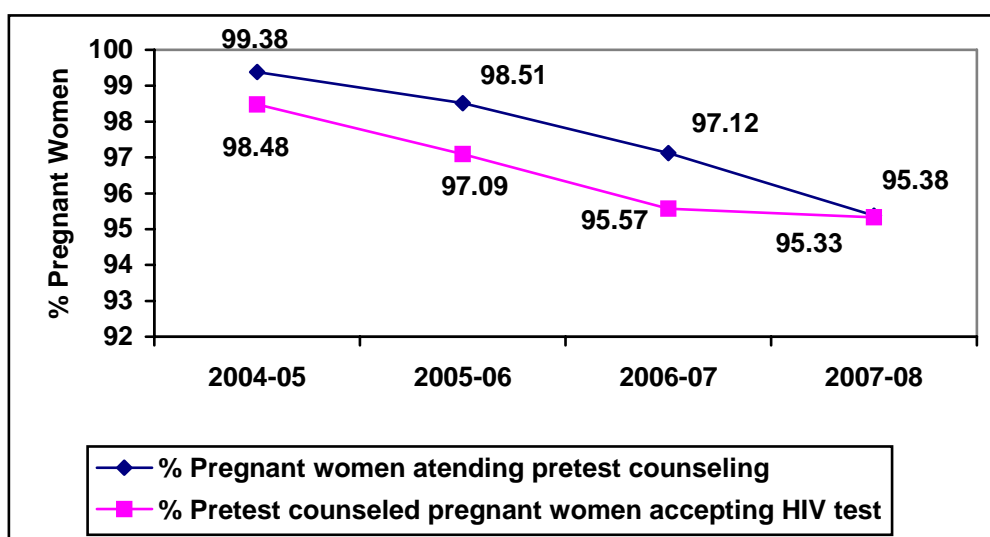


Figure 3.7.2



The data in table 3.7.1 indicates a rise in the ANC registrations from 2004-05 to 2005-06 by 59% and this figure increased further during 2006-07 by about 38%. A decline in the ANC registrations by 21% was recorded during 2007-08. However, a net increase in ANC registrations by 74% is observed from the beginning of the programme (2004-05) to 2007-08. Almost 100% of the women registering for ANC had attended the pretest counseling during 2004-05. This percentage started declining marginally, year after year and during 2007-08 the percentage of women attending pre-test counseling was 95.38. A similar trend is observed with respect to the number of pre-test counseled pregnant women who accepted HIV test. While 98% of the pregnant women who attended the pre-test counseling accepted for the test, it declined marginally to 95% during 2007-08. In spite of the gradual and marginal decline, these figures speak of the positive impact of mobilization of pregnant women to attend ANC and accepting HIV test.

Table 3.7.2	2004-05	2005-06	2006-07	2007-08
Number of pregnant women who attended the pre-test counseling	3355	5297	7193	5613
Number of pregnant women who accepted HIV test	3304	5143	6874	5351
Number of pregnant women who attended the post-test counseling	2540	3922	5836	4657

Table 3.7.2 shows a perceptible increase in the number of women attending post-test counseling, as percentage of those attending pre-test counseling, from 75.71% (2004-05) to 82.94% (2007-08). As per NACO guidelines all the women who attended pre-test counseling should also be counseled after the test. Though the results are encouraging further efforts are required to fulfill this objective, which is also intended to generate awareness among HIV negative women for avoidance of infection.

Table 3.7.3	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	32	36	41	22
Number of husbands of HIV positive women counseled	19	28	33	15
Number of husbands of HIV positive women who accepted HIV test	15	23	28	14
Number of husbands found HIV positive	10	19	26	12

The percentage of husbands of HIV positive women attending the counseling sessions was 59.38 during 2004-05, which increased during 2005-06 & 2006-07 to 77.78%, & 80.49% respectively. However, during 2007-08 this figure registered a decline to 68.18%. The number of husbands accepting HIV test was 78.95% in 2004-05, 82.14% in 2005-06, 84.85% in 2006-07 and 93.33% in 2007-08. Though the number of husbands accepting HIV test increased year after year reflecting a positive impact of the counseling, the decline in the number of husbands attending the pretest counseling is a cause of concern.

Table 3.7.4	2004-05	2005-06	2006-07	2007-08
Number of women registered directly for delivery without ANC registration in the health facility	371	420	420	135
Number of pregnant women counseled and accepted for HIV test from above	363	420	404	87
Number of Pregnant women found positive	4	2	4	1

The results pertaining to the acceptance of HIV test among pregnant women who registered directly for delivery (table 3.7.4) are very encouraging during the first three years of the programme with more than 96% of the women counseled and accepting the HIV test. However, this number declined during 2007-08 to 64.44%, which requires attention.

Table 3.7.5	2004-05	2005-06	2006-07	2007-08
Number of ANC registered pregnant women who were found positive	32	36	41	22
Number of HIV positive pregnant women registered for ANC and received NVP	11	17	12	8
Pregnant women who registered directly for delivery and found positive	4	2	4	1
Number of HIV positive pregnant women who registered directly for delivery and received NVP	3	1	1	1

Figure 3.7.3

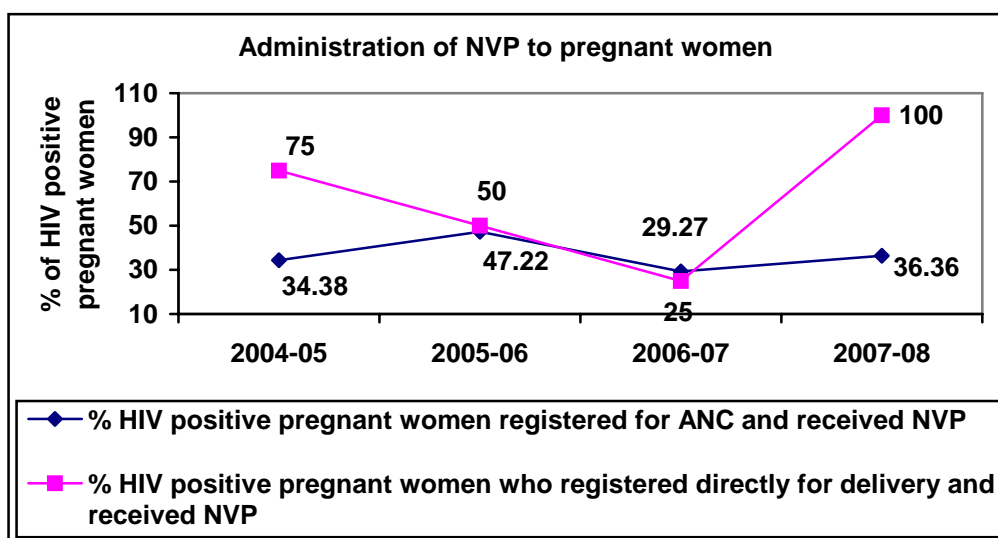
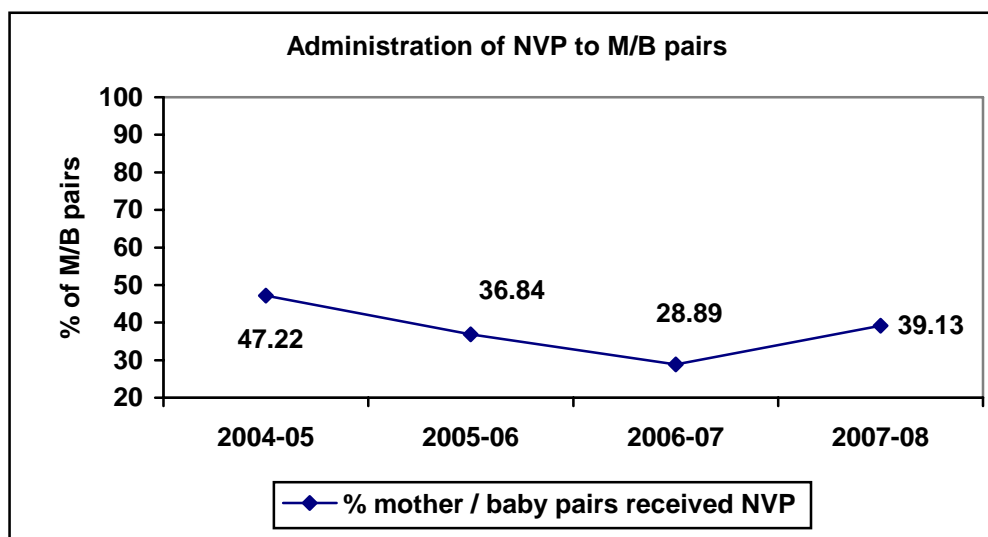


Table 3.7.5 & figure 3.7.3 present the data pertaining to NVP administration to HIV positive pregnant women, both ANC registered and coming for direct delivery. The figures are reflective of the poor performance with 34.38% (2004-05), 47.22% (2005-06), 29.27% (2006-07) and 36.36% (2007-08) women being administered NVP among ANC registered pregnant women. In the category of women coming for direct delivery also all the cases were not covered (except in 2007-08) in spite of the very low number of HIV positive women in this category. These results indicate the poor performance with respect to administration of NVP among HIV positive pregnant women.

Table 3.7.6	2004-05	2005-06	2006-07	2007-08
Number of ANC tested pregnant women who were found positive	36	38	45	23
Total number of deliveries of HIV positive women	17	17	22	16
Total number of live births to HIV positive mothers	17	15	15	13
Total number of mother / baby pairs received NVP	17	14	13	9

Figure 3.7.4



When it comes to the administration of NVP to mother/baby pairs, there was 47% coverage during 2004-05, which started declining in the following years to about 37% in 2005-06 and further down to 29% in 2006-07. However, it improved by about 10% during 2007-08 and stood at 39%. This data warrants more focused efforts with respect to administration of NVP to mother/baby pairs, which is the most important component of the PPTCT programme.

Table 3.7.7	2004-05	2005-06	2006-07	2007-08
Total number of deliveries of HIV positive women	17	17	22	16
Number of HIV positive women coming for follow up (post partum) at,				
3 months	3	1	3	1
6 Months	1	2	15	4
12 Months	0	0	4	2
18 Months	0	1	7	3
Total number of live birth to HIV positive mothers	17	15	15	13
Number of babies of HIV positive women – brought for follow up at,				
3 months	3	1	3	0
6 Months	1	2	8	2
12 Months	0	0	4	2
18 Months	0	1	7	4

Table 3.7.8	2004-05	2005-06	2006-07	2007-08
Total number of live births to HIV positive mothers	17	15	15	13
Number of babies tested at 12 months	0	0	0	0
Number of babies found HIV positive at 12 months	0	0	0	0
Number of babies tested at 18 months	0	1	5	1
Number of babies found HIV positive at 18 months	0	0	1	0

Tables 3.7.7 & 3.7.8 present the data pertaining to follow up of HIV positive mothers and babies born to them. The data clearly indicates that there is a large gap between the number of deliveries to HIV positive mothers and the number of mothers & babies coming for follow up at 3 months, 6 months, 12 months and 18 months post-partum. The number of mothers attending the follow up sessions is considerably low. The available data for 2006-07 shows that while 7 babies were brought for follow up only 5 were tested. This one again indicates the poor implementation of the programme by MDACS with respect to follow up of mother/baby pairs.

Table 3.7.9	2004-05	2005-06	2006-07	2007-08
Number of ANC tested pregnant women who were found positive	36	38	45	23
Number of HIV positive pregnant women referred to ART centres	0	3	15	12

The above table (table 3.7.9) shows the referral status of HIV positive pregnant women to ART centers. While the year 2004-05 recorded 0% referrals, 7.89%, 33.33% and 52.17% women were referred to ART centres for treatment during 2005-06, 2006-07 and 2007-08 respectively. There is a significant increase in the referrals made during 2007-08 compared to 2005-06. The increase in the number of referrals, year after year, indicates a clear understanding of the programme among the people involved and also coordination between PPTCT & ART centers.

The available data with respect to institutional deliveries indicates that there is a considerable increase in the number of institutional deliveries in Mumbai District from 22932 in 2004-05 to 82437 in 2007-08.

3.8 ANALYSIS OF THE STATE WISE DATA

Data pertaining to the entire state obtained from the respective SACS is presented in the following tables:

Andhra Pradesh

Table 3.8.1	2004-05	2005-06	2006-07	2007-08
Expected number of pregnancies	---	---	---	1690539
Number of Pregnant women who registered for ANC	239266	231581	479611	526620
Number of pregnant women who were found HIV positive	3227	3794	5812	5223
Total number of deliveries of HIV positive women		2213	3274	3204
Total number of live births to HIV positive mothers	2068	1983	3087	3024
Total number of mother / baby pairs received NVP	2007	1957	3044	2853
Number of HIV positive women coming for follow up (post partum) at,				
3 months	---	---	2604	3100
6 Months	---	314	1373	1560
12 Months	---	148	740	916
18 Months	---	86	---	---
Number of babies of HIV positive women – brought for follow up at,				
3 months	---	4	1092	1314
6 Months	---	234	1789	1736
12 Months	---	114	975	1211
18 Months	---	61	528	650
Number of babies tested at 18 months	---	58	494	571
Number of babies found positive at 18 months	---	9	72	90

- There is a steady increase in the number of pregnant women attending ANC in government hospitals / health care centres during the four years. There is 120% net increase in ANC registrations from 2004-05 to 2007-08. The results indicate a good performance with respect to mobilization of pregnant women to attend ANC. The data reveals that out of the 1690539 expected number of pregnancies, 526620 (31.15%) pregnant women were covered under PPTCT programme.
- During 2007-08 31.15% of the pregnant women (as percentage of expected pregnancies) had attended ANC. This indicates requirement of focused efforts for mobilization of more pregnant women to attend ANC.
- Though the percentage of HIV positive pregnant women (as percentage of ANC registered pregnant women) increased marginally from 1.35% in 2004-05 to 1.64% in 2005-06, it started declining thereafter and stood at 0.99% in 2007-08.
- During 2004 – 05, 62.19% of the mother baby pairs received NVP. There was a decline in this figure during 2005-06 to 51.58%. in the following years there was a marginal increase in the number of mother baby pairs received NVP which stood at 54.62% in 2007-08.

- Data pertaining to follow up of HIV positive women (post partum) and their babies reflects a very poor performance. This aspect of the programme in this state needs strengthening.

Tamil Nadu

Table 3.8.2	2004-05	2005-06	2006-07	2007-08
Expected number of pregnancies	---	---	---	1173233
Number of Pregnant women who registered for ANC	---	416864	620602	867962
Number of pregnant women who were found HIV positive	---	1567	2117	2144
Total number of deliveries of HIV positive women	---	996	1526	1780
Total number of live births to HIV positive mothers	---	941	1339	1751
Total number of mother / baby pairs received NVP	---	914	1303	1605
Number of HIV positive women coming for follow up (post partum) at,	---			
3 months		203	1245	739
6 Months	---	225	959	753
12 Months	---	168	791	569
18 Months	---	92	791	569
Number of babies of HIV positive women – brought for follow up at,	---			
3 months		292	1035	430
6 Months	---	326	1245	739
12 Months	---	310	959	753
18 Months	---	92	791	569
Number of babies tested at 18 months	---	85	10	4
Number of babies found positive at 18 months	---	8	3	0

- As percentage of expected number of pregnancies in the state, 74.0% pregnant women had attended ANC in Tamil Nadu during 2007-08 thus being covered under the PPTCT programme. The number of ANC registrations showed an increasing trend from 2005-06 to 2007-08 indicating successful mobilization of pregnant women for ANC in the state.
- Over 58% mother / baby pairs (as percentage of HIV +ve pregnant women) received NVP during 2005-06. This figure increased to 61.54% during 2006-07 and to 74.86% during the year 2007-08 indicating a considerable increase in NVP coverage to M/B pairs.
- The follow up of HIV positive mothers and their babies is poor during 2005-06. Considerable improvement is seen in this aspect during the latter two years.

Karnataka

Table 3.8.3	2004-05	2005-06	2006-07	2007-08
Expected number of pregnancies	---	---	---	1255295
Number of Pregnant women who registered for ANC	---	28092	113560	217166
Number of pregnant women who were found HIV positive	---	248	1212	2081
Total number of deliveries of HIV positive women	---	71	395	575
Total number of live births to HIV positive mothers	---	45	273	471
Total number of mother / baby pairs received NVP	---	229	641	817
Number of HIV positive women coming for follow up (post partum) at,	---	---	31	28
3 months	---	---	1	5
6 Months	---	---	9	4
12 Months	---	---		
18 Months	---	---		
Number of babies of HIV positive women – brought for follow up at,	---	---	859	6
3 months	---	---	17	5
6 Months	---	---	15	2
12 Months	---	---	18	4
18 Months	---	---	17	3
Number of babies tested at 18 months	---	---	12	5
Number of babies found positive at 18 months	---	---		

- Data for 2004-05 is not available in KSAPS and data for the year 2005-06 is partly available.
- There is almost an 8-fold increase in the number of women attending ANC from 2005-06 to 2007-08. However, it is to be noted that only 17.30% cases of the expected number of pregnancies attended ANC during 2007-08. It is reflective of a poor performance with respect to coverage of pregnant women under PPTCT programme.
- A declining trend in the administration of NVP to M/B pairs during the years was observed. It was found that 92.34% M/B pairs were covered during 2005-06 and the coverage drastically declined to 52.89% in 2006-07 and further to 39.26% in 2007-08.
- The data retrieved from the MIS of KSAPS seems to be inconsistent and several mismatches are observed. No valid interpretations could be drawn from this data.

Maharashtra

Table 3.8.4	2004-05	2005-06	2006-07	2007-08
Expected number of pregnancies	---	---	---	2147149
Number of Pregnant women who registered for ANC	---	---	410729	610043
Number of pregnant women who were found HIV positive	---	---	3008	3196
Total number of deliveries of HIV positive women	---	---	1419	1958
Total number of live births to HIV positive mothers	---	---	1030	1824
Total number of mother / baby pairs received NVP	---	---	1035	1709
Number of HIV positive women coming for follow up (post partum) at,	---	---		
3 months	---	---	1130	453
6 Months	---	---	674	957
12 Months	---	---	243	592
18 Months	---	---		0
Number of babies of HIV positive women – brought for follow up at,	---	---		
3 months	---	---	397	239
6 Months	---	---	307	431
12 Months	---	---	194	601
18 Months	---	---	118	401
Number of babies tested at 18 months	---	---	619	361
Number of babies found positive at 18 months	---	---	11	54

- Data was available for the years 2006-07 & 2007-08 only.
- The number of pregnant women attending ANC increased by about 30% from 2006-07 to 2007-08. However, the percentage of ANC registrations (as percentage of expected pregnancies in the state) is 28.41 and indicates a poor coverage of pregnant women under PPTCT programme.
- The data shows that the focus on the follow up of HIV positive mothers and their babies is not adequate. The number of women turning up for follow up is very low.
- While 34.41% mother / baby pairs were given NVP during the year 2006-07, the coverage increased considerably to 53.47 during the year 2007-08. There is a mismatch in the data related to the figures of total number of live births to HIV positive mothers and the number of M/B pairs given NVP during 2006-07.
- During 2006-07 while 118 babies were brought for follow up at the age of 18 months the available data indicates that 619 babies were tested. This indicates a clear mismatch between the number of babies brought for follow up and those tested probably due to improper recording of data. During 2007-08 401 babies were brought for follow up at the age of 18 months but only 361 of them were tested for their HIV status. This is a matter which requires attention as it is important to know the HIV status of the babies borne to the HIV +ve mothers to evaluate the effectiveness of NVP administration.

Manipur

Table 3.8.5	2004-05	2005-06	2006-07	2007-08
Expected number of pregnancies	---	---	---	38236
Number of Pregnant women who registered for ANC	20163	21410	27498	36005
Number of pregnant women who were found HIV positive	123	174	306	330
Total number of deliveries of HIV positive women	33	44	147	190
Total number of live births to HIV positive mothers	33	42	145	187
Total number of mother / baby pairs received NVP	---	---	---	---
Number of HIV positive women coming for follow up (post partum) at,	---	---	---	---
3 months	---	---	---	---
6 Months	---	---	---	---
12 Months	---	---	---	---
18 Months	---	---	---	---
Number of babies of HIV positive women – brought for follow up at,	---	---	29	39
3 months	---	---	29	39
6 Months	---	---	11	29
12 Months	---	---	6	16
18 Months	---	---	6	22
Number of babies tested at 18 months	---	---	8	31
Number of babies found positive at 18 months	---	---	2	5

- Data shows a gradual increase in the ANC registrations from 2004-05 to 2007-08.
- 94.17% cases of the expected number of pregnancies in the state attended ANC during 2007-08. This is a commendable performance with respect to mobilization of pregnant women to attend ANC and shows an excellent coverage of pregnant women under PPTCT programme.
- Though there was an increase in the percentage of HIV positive pregnant women from 2004-05 to 2006-07, it started showing a declining trend in 2007-08.
- Data related to administration of NVP to mother / baby pairs and post partum follow up of HIV positive mothers was not available.
- Data pertaining to the follow up of babies borne to HIV positive mothers is available only for the years 2006-07 & 2007-08. Follow up of babies seems to be poor. While 4.13% (as percentage of live births to HIV positive mothers) were brought for follow up at 18 months post partum during 2006-07, the corresponding figure for 2007-08 was 11.76%
- While the number of babies brought for follow up at the age of 18 months during 2006-07 & 2007-08 was 6 and 22 respectively, the corresponding number of babies tested during these two years was recorded as 8 and 31. This may be because of improper recording of data.

Nagaland

Table 3.8.6	2004-05	2005-06	2006-07	2007-08
Expected number of pregnancies	---	---	---	41105
Number of Pregnant women who registered for ANC	1289	7357	11574	20119
Number of pregnant women who were found HIV positive	11	100	145	806
Total number of deliveries of HIV positive women	2	47	42	28
Total number of live births to HIV positive mothers	2	38	25	22
Total number of mother / baby pairs received NVP	19	24	39	50
Number of HIV positive women coming for follow up (post partum) at,	---	---	---	---
3 months	---	---	---	---
6 Months	---	---	50	25
12 Months	---	---	43	42
18 Months	---	---	60	15
Number of babies of HIV positive women – brought for follow up at,	---	---	---	---
3 months	---	---	23	4
6 Months	---	---	30	17
12 Months	---	---	42	22
18 Months	---	---	22	16
Number of babies tested at 18 months	---	---	11	1
Number of babies found positive at 18 months	---	---	4	---

- There is consistent and considerable increase in the number of pregnant women attending ANC. The percentage of pregnant women (as percentage of expected number of pregnancies in the state) attending ANC in 2007-08 is 48.94. This indicates an average performance with respect to coverage of pregnant women under PPTCT programme. However, the increase in the number of ANC registration year after year is an indication of the attention paid to mobilization of the pregnant women to attend ANC.
- The reported number of HIV positive pregnant women during 2007-08 seems to be very high. The percentage of positive pregnant women which was between 1 to 1.5 from 2004 – 07 suddenly rose to 4% during 2007-08. This can be a clear indication of error in the reported data.
- There seems to be an error in the data pertaining to the number of live births to HIV positive mothers. Except in the year 2005-06, this number is always less than the number of M/B pairs receiving NVP. NVP was given to 24% and 27% M/B pairs during 2005-06 2006-07 respectively. Improper monitoring / tracking of HIV positive pregnant women and the prevalent system of home deliveries are observed to be the reasons for this poor performance. During 2007-08 the coverage was very low with only 6.2% M/B pairs receiving NVP. This may be due to the probable wrong reporting of the number of HIV positive pregnant women during this year.

- The number of babies brought for follow up at the age of 18 months is 22 and 16 during 2006-07 and 2007-08 respectively. However, only 11 babies were tested during 2006-07 and only 1 was tested during 2007-08.

Mumbai

Table 3.8.7	2004-05	2005-06	2006-07	2007-08
Expected number of pregnancies	---	---	---	---
Number of Pregnant women who registered for ANC	66492	89139	125602	128005
Number of pregnant women who were found HIV positive	929	994	1210	1070
Total number of deliveries of HIV positive women	382	564	638	689
Total number of live births to HIV positive mothers	429	548	622	666
Total number of mother / baby pairs received NVP	346	466	506	575
Number of HIV positive women coming for follow up (post partum) at,				
3 months	34	---	---	---
6 Months	35	2	389	598
12 Months	25	2	185	336
18 Months	32	---	115	224
Number of babies of HIV positive women – brought for follow up at,				
3 months	47	---	85	182
6 Months	41	---	240	255
12 Months	36	---	164	299
18 Months	59	---	121	206
Number of babies tested at 18 months	---	---	88	139
Number of babies found positive at 18 months	---	---	15	6

- Consistent increase in the number of ANC registrations is observed from 2004-05 to 2007-08. In percentage terms the net increase from 2004-05 to 2007-08 is 107.41. This is indicative of a good performance with respect to mobilization of pregnant women to attend ANC.
- 37.24%, 46.88%, 41.81% and 53.73% mother / baby pairs were given NVP during the years 2004-05, 2005-06, 06-07 and 07-08 respectively. The data indicates a considerable improvement in the performance from 2004-05 to 2007-08 in spite of a drop during 2006-07. In 2004-05 a mismatch is noticed between the number of deliveries of HIV positive women and the number of live births with the latter being more in number than the former. This is told to have happened because of faulty recording of the number of HIV positive deliveries.
- The follow up with respect to HIV positive mothers and the babies borne to them is not up to the mark.

- While 121 and 206 babies were brought for follow up at the age of 18 months during 2006-07 and 2007-08 respectively, only 15 and 6 of them were tested.

3.9 OBSERVATIONS ON THE DATA AVAILABILITY AT THE STATE LEVEL

NVP Administration

State level data was retrieved from the MIS of SACS in all the surveyed states. Complete data pertaining to the indicated parameters for all the four years (2004-05 to 2006-07) could not be furnished by any of the SACS. The data obtained from APSACS, TANSACS and Mumbai DACS is found to be consistent to a large extent. In the remaining SACS the availability of data is not satisfactory, mainly because of poor data management. In case of KSAPS the data was found to be largely inconsistent and no inferences could be drawn from the available data. In Maharashtra the data was available for only two years. In Maharashtra, Karnataka and Nagaland the major inconsistency found was that the number of mother baby pairs receiving NVP was found to be higher than the number of HIV positive deliveries / live births to HIV positive women. This indicates improper recording of deliveries to HIV positive pregnant women. In case of Manipur no data with respect to the administration of NVP to mother baby pairs was available for any of the four years.

During the survey, data from the sampled locations was gathered by the field investigators by going through the records maintained at the centre level (medical college / district hospital / sub-district centre). The data availability at most of the surveyed centres, except in Manipur and Nagaland was found to be satisfactory to a large extent. This data is supposed to be consolidated by the respective SACS to obtain the state level data. However, poor quality of state level data is reflective of gaps in data transmission from lower to higher levels and poor data management at the state level.

In the present survey three locations were sampled from each of the selected districts in the respective states. They are

- 1) PPTCTC attached to a medical college
- 2) PPTCTC in the district head quarters hospital and
- 3) PPTCTC in one of the sub-district centres which is randomly sampled

In any district there will be one district hospital and usually one medical college while the number of sub-district centres like PHCs and CHCs is more. In most of the surveyed districts the PPTCTCs attached to district hospital and the medical college were found to be performing well. When this data is consolidated for evaluation of the impact of PPTCT programme the result mostly influenced by the performance of the district hospital and the medical college irrespective of the performance of the single sub-district centre sampled for the purpose of the survey. However, for obtaining the state level data, the SACS will consolidate data obtained from all the sub-district centres from the state. The possibility of poor performance by several sub-district centres cannot be ruled out and this might bring down the average performance at the state level.

Reasons for High or Low Coverage of Pregnant Women across the Surveyed States

When the coverage of pregnant women under the PPTCT programme is compared across the surveyed states, in Tamil Nadu and Manipur the coverage seems to be good while in the other states the coverage is either average or poor.

The following reasons may be attributed for this variation:

- In the states of Andhra Pradesh, Karnataka and Maharashtra where health care facilities in private sector are considered to be better, there is a possibility of more number of pregnant women, especially from middle class and above in the society, opting for health care in private nursing homes. In the existing system not all the ANC registrations in private sector are accounted for so that the recorded number of ANC registrations is lower than the actual number. The system should be geared up to gather full information of ANC registrations in private sector also by roping in the private nursing homes into the programme. This seems to be effectively being done in case of Tamil Nadu where the coverage is found to be 74%.
- Under utilization or ineffective utilization of the outreach workers in the mobilization of pregnant women to PPTCT centres can be one of the reasons for low coverage. On the contrary efficient functioning of the outreach workers might have resulted in more number of pregnant women attending ANC in PPTCT centres.

- In states like Karnataka, the poor data management might have resulted in ineffective transmission of data from the lower level to the apex level resulting in faulty figures with respect to ANC registration.

- Lack of private sector health care facilities (probably in states like Manipur) might have resulted in maximum number of pregnant women showing up at Government health facilities.

Chapter 4

ASSESSMENT OF THE GRADUATED COST RECOVERY SCHEME FOR DELIVERY OF ART THROUGH PUBLIC PRIVATE PARTNERSHIP

Under this component the following three ART Centres run by NGOs in three cities were covered:

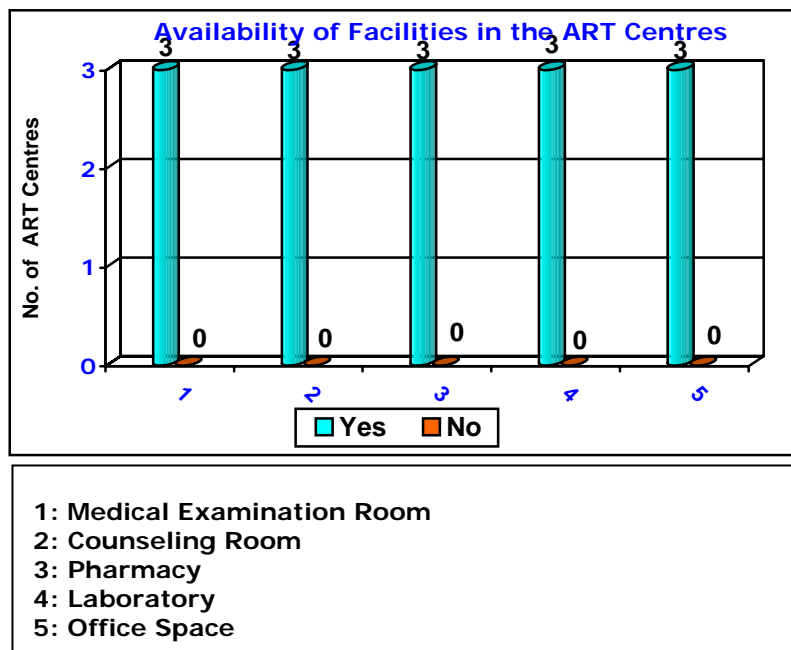
- 1) ART Centre run by AIDS Research & Control Centre (ARCON), Mumbai.
- 2) ART Centre run by YRG CARE in Chennai
- 3) ART Centre run by Freedom Foundation in Bangalore

Availability of facilities like laboratory, counseling rooms, patient examination rooms is assessed in all the three centres. An assessment of the effectiveness of the ART Centres in delivering the ART is carried out. Client satisfaction with respect to the services offered by the centre to the patients is also assessed.

ASSESSMENT OF FACILITIES IN THE ART CENTRE

All the three ART Centres have sufficient space for carrying out the day-to-day activities. Patient examination rooms, counseling rooms, waiting area and

Figure 4.1



office space are available in all the three centres as per the norms prescribed by NACO. All the centres are computerised. The centres have adequate ventilation and are well lit. All of them have electricity supply. The centres experience power cuts on and off. However, only two of them, YRG CARE – Chennai and ARCON – Mumbai are equipped with a back up generator facility and the third one, the centre run by Freedom Foundation in Bangalore, lacks this facility. All of them have basic amenities like drinking water, toilet etc.

The centres are equipped with adequate number of tables, chairs and stools. All of them have patient examination tables with curtains as per NACO guidelines. There are office shelves and secure cupboards for safe and confidential keeping of the patient records.

All the three centres have basic medical equipment like BP Apparatus, Stethoscopes, Weighing Balance etc. They are also equipped with counseling aids like posters, flip-charts, penis models for condom usage demonstration, audio visual equipment for showing films related to HIV / AIDS and leaflets and take-home material for patients for IEC and generation of awareness.

Staff in the ART Centre

Table 4.1

The following table gives the availability of different categories of staff in the surveyed ART Centres:

Staff	Number of Staff Available		
	YRG CARE	Freedom Foundation	ARCON
Senior Medical Officer	2	1	2
Microbiologist	1	0	1
Paediatrician	1	*	0
Obstetrician & Gynaecologist	1	*	0
Dermatologist	0	*	1
Medical Officer (ART)	6	2	1
Counselor	3	3	4
Pharmacist	1	1	1
Data Manager	1	#	#
Lab Technician	3	4	3
Nursing Staff	3	1	0
Community Care Coordinator	2	1	0
Record Keeper cum DEO	1	1	1
Cleaning & Other Support Staff	4	2	3

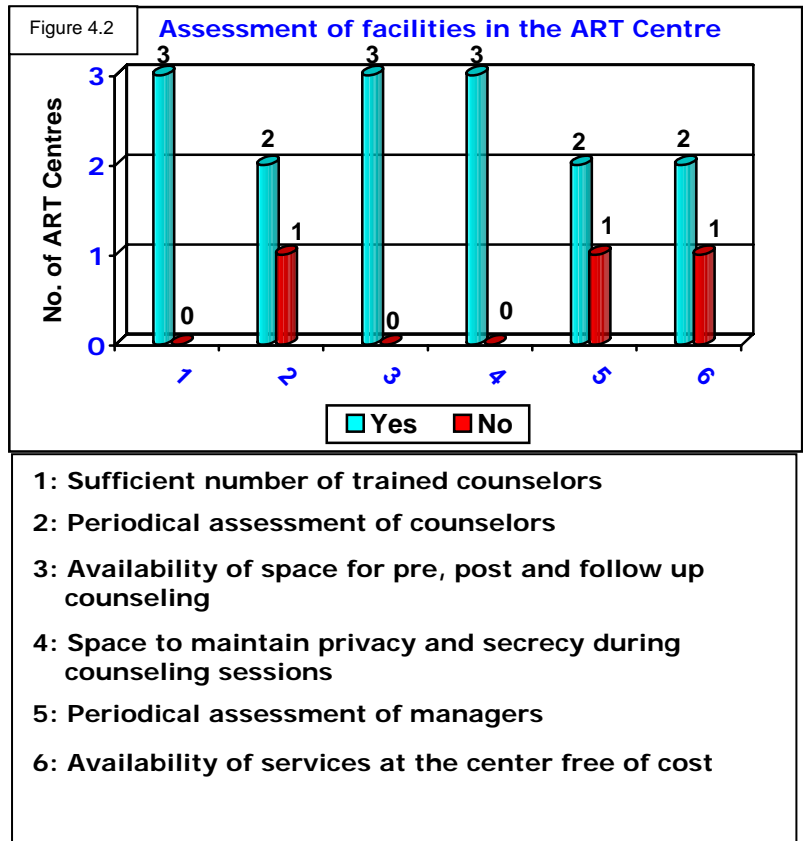
* These positions are outsourced and the specialists visit the centre on specified days.

The function is carried out by the DEO

As per the NACO Operational Guidelines for ART Centres (March 2007) all ART centres should have a microbiologist, paediatrician, gynaecologist and a dermatologist (venereologist). None of the three centres surveyed have all the medical staff as per the NACO guidelines. While dermatologist is not available in YRG CARE, there is no microbiologist in the ART centre run by Freedom Foundation. ARCON in Mumbai has neither a paediatrician nor a gynaecologist. ARCON also does not have any nursing staff and community coordinators. In the centre run by Freedom Foundation, Bangalore, the positions of paediatrician, dermatologist and gynaecologist are outsourced and these medical experts visit the centre on specified days of the week to offer consultancy to the patients.

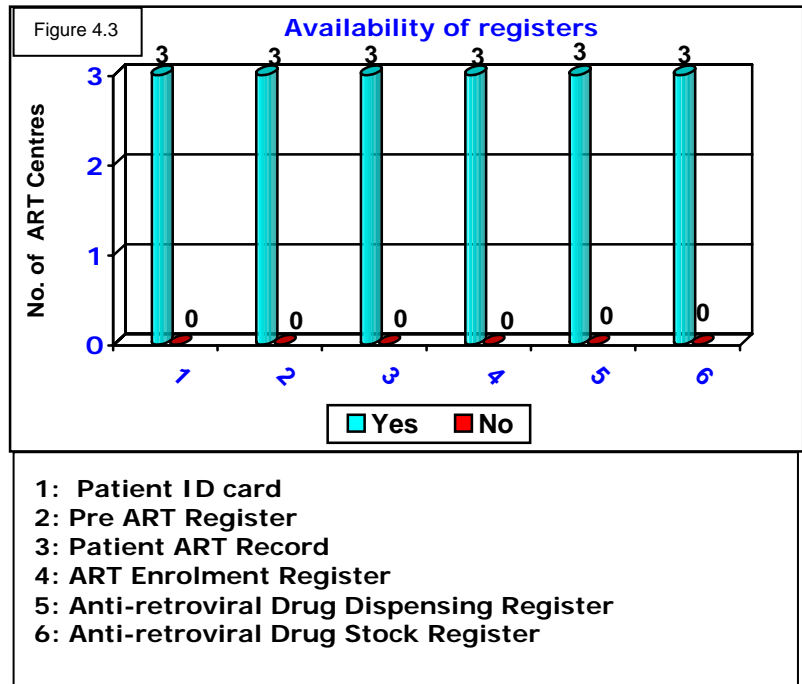
The centres have sufficient number of qualified and trained counselors. Except in the centre run by ARCON, Mumbai, there is an established system for periodical assessment of the competence and skills of the counselors and for giving guidance and suggestions for improvement wherever

required. These centres have minimum prescribed space for pre and post test counseling and also maintaining privacy and secrecy of the clients during counseling sessions.



Records and Registers

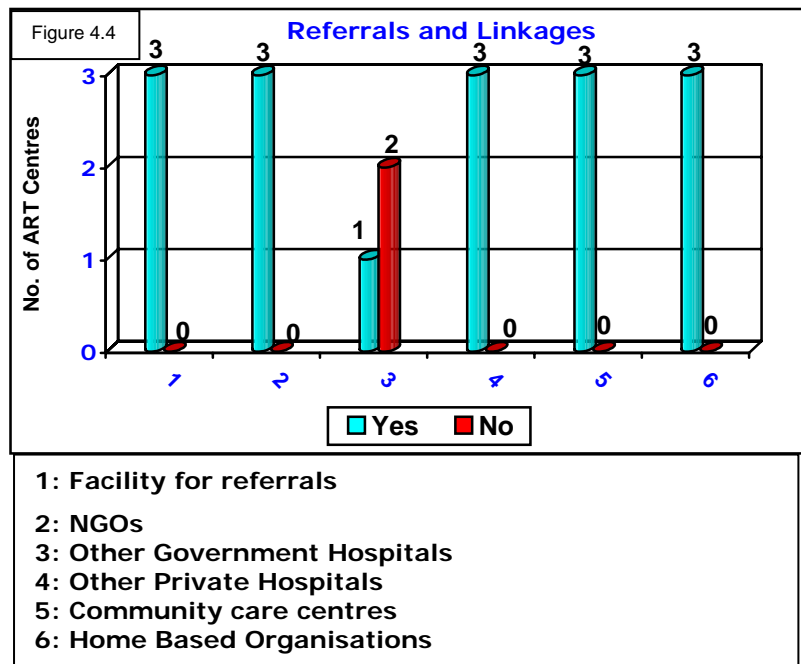
All the centres maintain records and registers up to date as per the guidelines given by NACO. All of them issue patient ID cards, maintain Pre-ART Registers, Patient ART Records, ART Enrolment Registers, Anti-retroviral Drug Dispensing Registers and Drug Stock Registers.



In none of the three centres the treatment available is totally free of cost. ARCON, Mumbai and YRG CARE, Chennai follow Graduated Cost Recovery Scheme as prescribed by NACO, wherein BPL patients (about 20% of the total enrolled) receive treatment free of cost, patients belonging to low income groups (about 20%) receive treatment on payment of 25% of the MRP of drugs, patients belonging to middle income groups (about 40%) receive treatment on payment of 50% of the MRP and the ones belonging to higher income groups (about 20%) receive treatment on full payment basis. In the centre run by Freedom Foundation, Bangalore, this system is not followed. Though they offer free of cost treatment to patients belonging to BPL categories, they charge patients belonging to all the other three groups uniformly. The former two centres stated that presently they are able to follow the graduated cost recovery scheme successfully.

Referrals and Linkages

All the surveyed centres have facilities for referral of the patients as per requirement. As and when required, patients on the ART are referred to other hospitals for specific treatment. The centres have linkages with NGOs, Community Care Centres, HBOs, PLHA Networks, Rehabilitation Centres,



Family Planning Services and MCH Services for care and support.

Freedom Foundation has linkages with 25 NGOs and YRG CARE with 317 NGOs.

The following are some of the NGOs associated with ART Centres and their areas of activity:

Freedom Foundation, Bangalore

Table 4.2

Name of the NGO	Major Area of Activity
World Vision	Community care and Community education
ACCEPT *	Community care and support
Snehadaan*	Community care and support
Sthree	Women empowerment

* These NGOs are empanelled with KSAPS

ARCON, Mumbai

Table 4.3

Name of the NGO	Major Area of Activity
PRAYAS	Referrals and follow up
PSI	Referrals and follow up
UDAAN	Referrals and follow up
Yuva Pratistan	Referrals and follow up

YRG CARE, Chennai

Table 4.4

Name of the NGO	Major Area of Activity
PWDS	Community care and support
YWCA	Community care and support
RWDC	Community care and support
ISM	Community care and support
Navajeevan	Community care and support
Scope Trust	Community care and support
CARDS	Community care and support

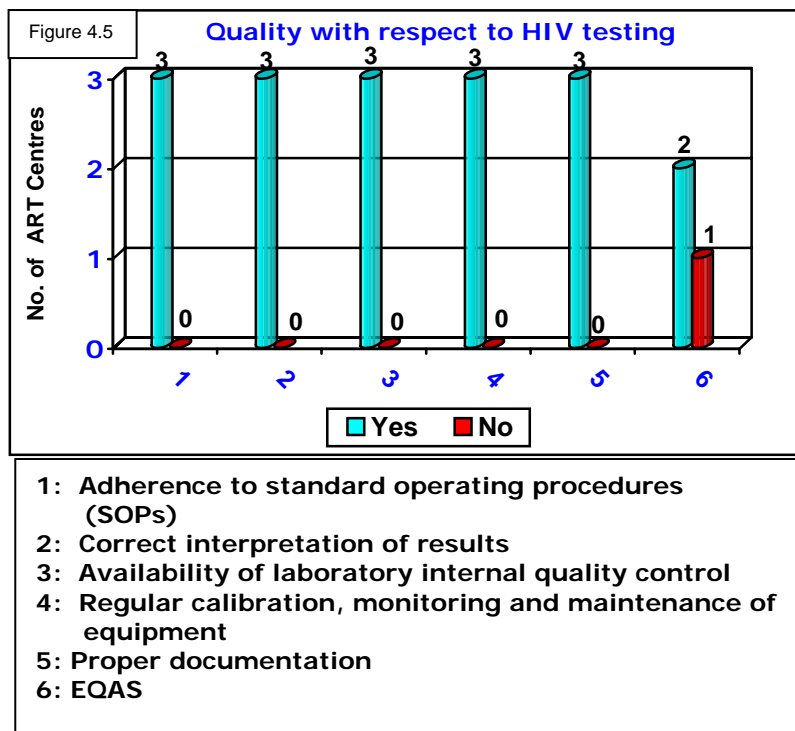
Laboratory

The laboratories in all the three surveyed ART Centres are well equipped and manned by qualified and trained lab technicians who are well versed in HIV / AIDS related laboratory procedures.

All the laboratories have the basic facilities like refrigerators, centrifuges, variable micropipettes, needle

destroyers, colour coded waste disposal bins, adequate number of work benches and stools, binocular microscopes, required chemicals & glassware etc.

All the three centres have facilities for carrying out CD4 counts. Facilities for carrying out tests like ELISA, VDRL, RPR, analysis of serum alanine, creatinine and blood urea nitrogen are available in all the three centres.



Laboratories in all the three centres adhere to Standard Operating Procedures (SOPs), procedures for correct interpretation of results, carry out regular calibration, monitoring and maintenance of equipment and follow proper documentation procedures. All the three labs follow procedures for internal quality control but except ARCON the remaining two centres also participate in External Quality Assessment Scheme (EQAS).

Freedom Foundation has linkages with the following Laboratories for EQAS

CD 4	NARI
Biochemistry	CMC, Vellore
Microbiology	Indian Association of Medical Microbiologists
Haematology	AIIMS

Pharmacy

All the three surveyed centres have patient load of more than 500 per month and have a pharmacy manned by a qualified and trained pharmacist. The centres procure ARV drugs and drugs for OIs from the suppliers directly. The usual periodicity of procurement of drugs is once in a month but need based forecasting and procurement is also done. They maintain adequate stocks of the drugs and the stock registers are maintained up to date. All centres generate computerised stock reports.

The stock position of ARV drugs as on the day of visit is summarised in Table 4.5:

Table 4.5

Name of the ARV Combination	YRG CARE	Freedom Foundation	ARCON
	No. of Tablets Available		
Stavudine 30 mg plus Lamivudine 150 mg	6059	5804	390
Stavudine 40 mg plus Lamivudine 150mg	Not in use	Not in use	500
Zidovudine 300mg plus Lamivudine 150mg	2772	7927	310
Stavudine 30 mg plus Lamivudine 150 mg plus Nevirapine 200 mg	3144	12014	4650
Stavudine 40 mg plus Lamivudine 150mg plus Nevirapine 200 mg	Not in use	Not in use	2940
Zidovudine 300 mg plus Lamivudine 150 mg plus Nevirapine 200 mg	8662	1434	2670
Tablet Nevirapine 200 mg	579	2506	80
Tablet Effaviranz 600 mg	5328	4841	90

ASSESSMENT OF EFFECTIVENESS OF ART CENTRES

Assessment of the effectiveness of the ART centre was carried out using the following parameters:

- Number of patients on ART
- Number of patients on ART who are continuing on medication at the end of 12 months
- Number of patients on ART who are alive after 12 months of treatment

The data is summarised in the following tables:

YRG CARE, Chennai

Table 4.6

	2004-05		2005-06		2006-07		2007-08		Total
	Ad.	Ch.	Ad.	Ch.	Ad.	Ch.	Ad.	Ch.	
Number of patients on ART	502	0	546	0	980	40	233	9	2310
Patients continuing on ART after 12 months	455	0	516	0	957	40	233	9	2210
Patients discontinued ART during 12 months	46	0	30	0	19	0	0	0	95
Number of patients on ART alive after 12 months	455	0	516	0	957	40	233	9	2210
Number of patients expired during 12 months	1	0	0	0	4	0	0	0	5
% of patients on ART and alive after 12 months	99.78	---	100	---	99.58	100	100	100	99.77

Freedom Foundation, Bangalore

Table 4.7

	2004-05		2005-06		2006-07		2007-08		Total
	Ad.	Ch.	Ad.	Ch.	Ad.	Ch.	Ad.	Ch.	
Number of patients on ART	54	0	85	32	589	22	649	17	1448
Patients continuing on ART after 12 months	54	0	70	32	525	22	586	17	1306
Patients discontinued ART during 12 months	0	0	3	0	30	0	34	0	67
Number of patients on ART alive after 12 months	54	0	70	32	525	22	586	17	1306
Number of patients expired during 12 months	0	0	12	0	34	0	29	0	75
% of patients on ART and alive after 12 months	100	---	85.36	100	93.91	100	95.28	100	94.57

ARCON, Mumbai**Table 4.8**

	2004-05		2005-06		2006-07		2007-08		Total
	Ad.	Ch	Ad.	Ch	Ad.	Ch.	Ad.	Ch	
Number of patients on ART	128	0	131	0	1506	0	419	2	2186
Patients continuing on ART after 12 months	74	0	96	0	1337	0	352	2	1861
Patients discontinued ART during 12 months	50	0	32	0	131	0	50	0	263
Number of patients on ART alive after 12 months	74	0	96	0	1337	0	352	2	1861
Number of patients expired during 12 months	4	0	3	0	38	0	17	0	62
% of patients on ART and alive after 12 months	94.87	---	96.97	---	97.23	---	95.39	---	96.77

The targets set for mobilization of patients for ART vis-à-vis their achievements are summarized in the following table:

Table 4.9

	YRG CARE	Freedom Foundation	ARCON
Target*	3000	1500	3000
Achievement	2310	1448	2186
% Achievement	77	96.53	72.86

* These figures are obtained from NACO

The percentage of patients continuing on ART after 12 months for the 3 surveyed centres is summarized in Table 4.10:

Table 4.10

Name of the ART Centre	Year wise % of patients continuing on ART after 12 months			
	2005	2006	2007	2008
YRG CARE, Chennai	91%	94%	98%	100%
Freedom Foundation, Bangalore	94%	85%	91%	94%
ARCON, Mumbai	60%	75%	84%	86%

*In ARCON, Mumbai ART was started from July 05. Hence the figures for 2005 are only for 6 months

The data presented in the above tables indicate that none of the surveyed ART centres could achieve their set targets with respect to the patient enrolment. Of those patients started on ART, about 5% in Freedom Foundation & YRG CARE and about 12% in ARCON discontinued the treatment. However, over 95% of the patients put on ART in all the three surveyed centres were reported to be alive.

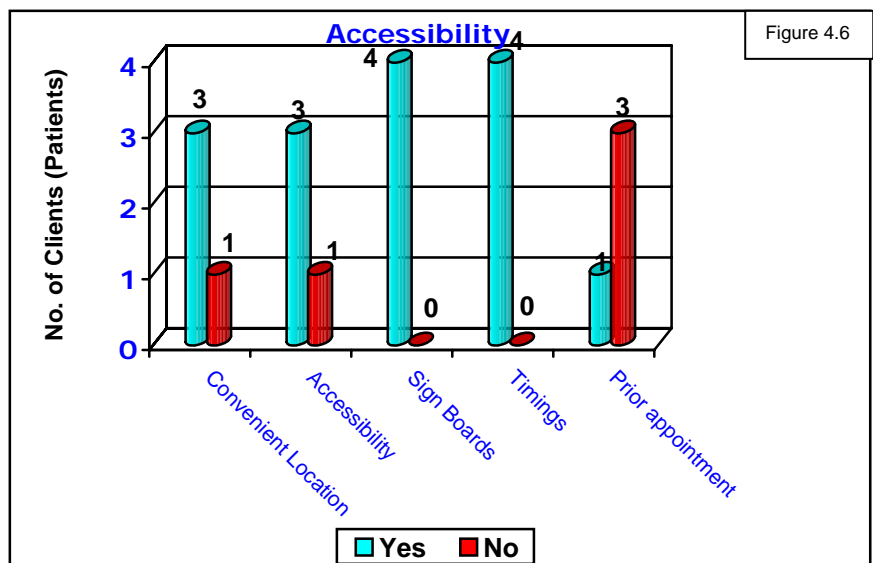
It is observed that these ART centers, which offer medication on graduated cost recovery basis and charge the patients for treatment, are facing stiff competition from the other ART centers, which are offering treatment free of cost. In Bangalore, it is said that the PLHAs buy directly from the pharmaceutical distributors so that they can get the drugs at a price lower than the maximum retail price. Hence, the persons who are included in the 100% payment slot of GCR will not opt to go for medication under this scheme and instead obtain their medicines from the pharma distributors directly. This can be another form of competition being faced by organizations like Freedom Foundation. In fact when the Government is offering ART free of cost, schemes like Graduated Cost Recovery which charge patients for the treatment become redundant and NACO may have to think of options for discontinuing such schemes and winding up the centres.

ASSESSMENT OF PATIENT SATISFACTION

YRG CARE, Chennai

Client satisfaction was gathered from four patients in the ART Centre run by YRG CARE, Chennai.

Of these four, three patients were referred to this centre by Private / Govt. hospitals. One patient came here on her own after inquiring about the centre.



When asked about the accessibility, three of them told that the centre was easily accessible and conveniently located. All of them said that there were sign boards to for guiding the patients in reaching the centre and the timings of the centre were very convenient. Only one of them had to take prior appointment for meeting the counselor and the remaining three could talk to the counselor without any prior appointment. After reaching the ART centre, they need not wait for

long to see the counselor nor to receive the test results. All the interviewed patients expressed their satisfaction regarding the facilities and amenities provided in the centre. However the level of satisfaction varied with

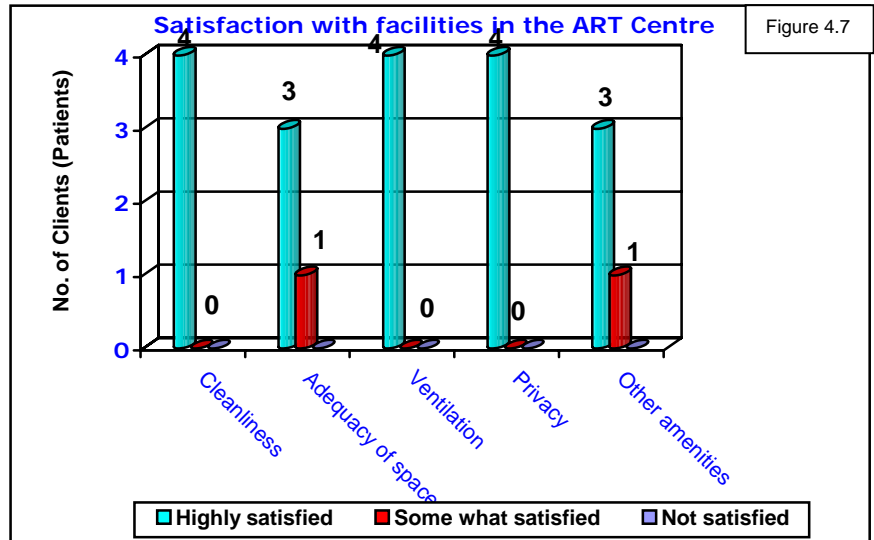


Figure 4.7

respect to adequacy of space and other amenities provided in the centre. While three of the patients are highly satisfied with these parameters. One patient said that he was only some what satisfied.

The patients expressed their utmost satisfaction with respect to the attitude of the counselors and psychosocial support provided by the counselors. The confidentiality of the information and the treatment offered in the center is good.

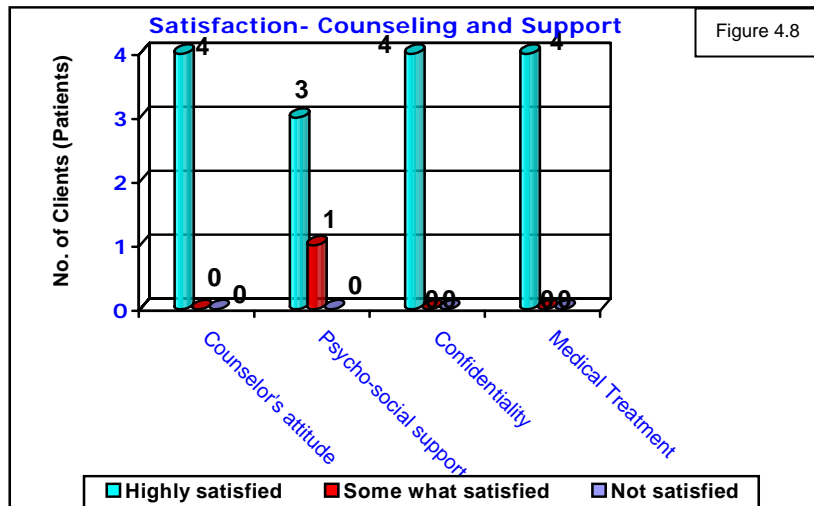


Figure 4.8

Though the centre has linkages with local PLHA networks, NGOs, Care and Support Services, Home based Organisations and other government and private hospitals, none the four respondent patients were referred to any of these services.

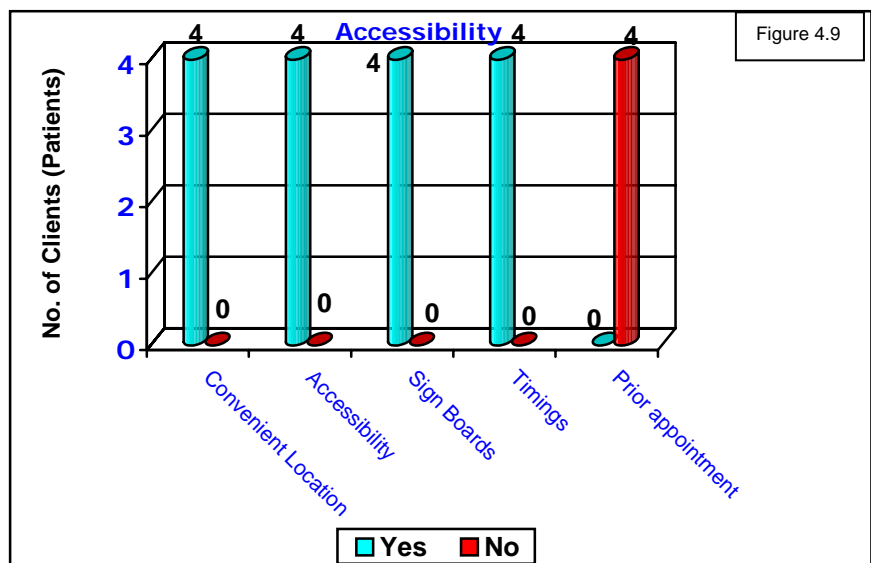
All the patients expressed overall satisfaction regarding the services offered by the centre, and the friendly attitude of the counselors. Though none of them recommended this centre’s service to any other HIV positive person, they said that they would like to recommend it to others who are in need of these services. It is also observed that people from far flung areas are also visiting this centre for treatment because of the quality of services rendered by this centre.

This centre which is offering ART on Graduated Cost Recovery basis has a system of assessing the economic condition of the patients every year and shifting them to an appropriate slot depending on their capability to pay for the treatment.

Freedom Foundation, Bangalore

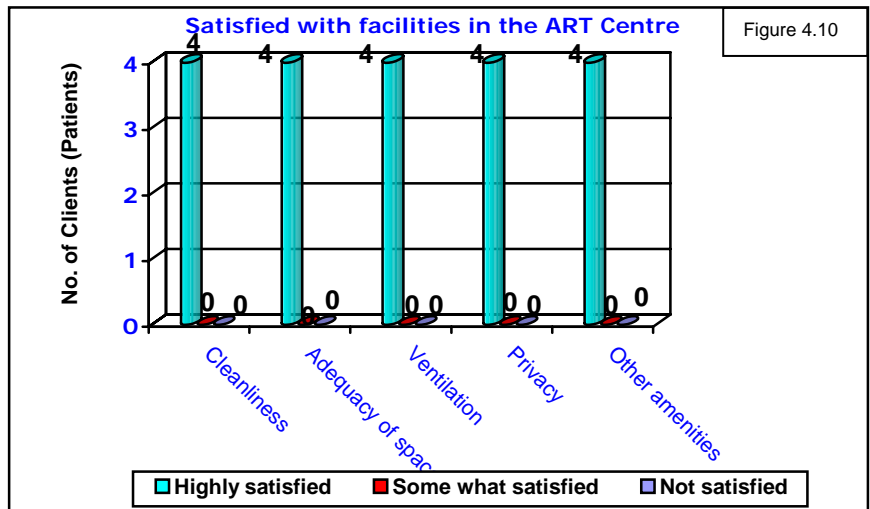
Client satisfaction was gathered from four patients in the ART Centre run by Freedom Foundation, Bangalore. Of these four, three patients were referred to this centre by Private / Govt. hospitals and one patient was referred by PPTCT centre.

When asked about the accessibility, all of them told that the centre was easily accessible and conveniently located. All of them said that proper sign boards were displayed for reaching the centre easily and the

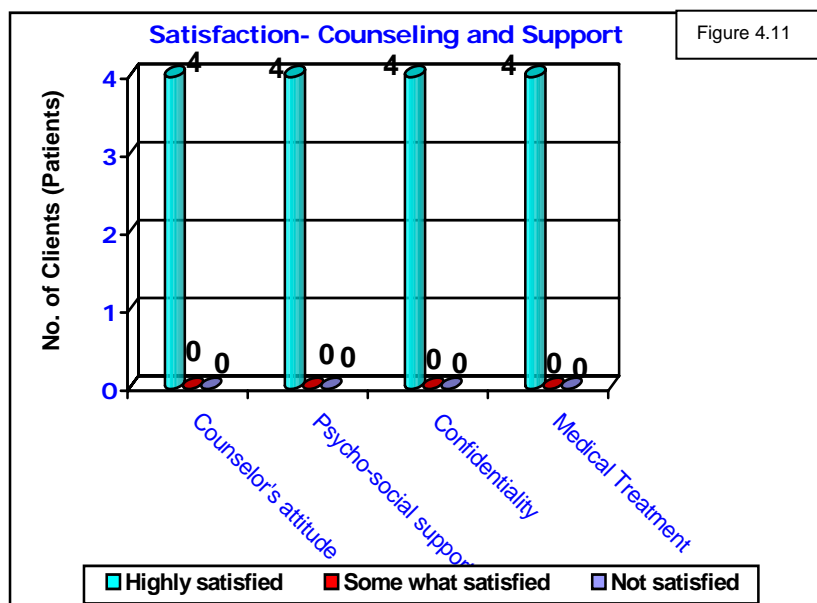


timings of the centre were very convenient. None of them took any prior appointment for meeting the counselor in the centre. After reaching the ART centre, they need not wait for long to see the counselor nor to receive the test results. Usually the test results are handed over to the patients within 24 hours.

All the interviewed patients expressed high level of satisfaction regarding the cleanliness in the centre, adequacy of space, ventilation in the centre and privacy during counseling sessions. They were also satisfied with the provision of other amenities like drinking water and toilets in the centre.



The patients expressed their utmost satisfaction with respect to the attitude of the counselors and psychosocial support provided by the counselors. The confidentiality of the information and the treatment offered in the center is good.



The services offered by NGOs were availed of by three of the interviewed patients. While one of them was highly satisfied with the NGO services they received, the remaining two said that they were somewhat satisfied with the NGOs.

One of the patients suffered from cryptococcal meningitis and was referred to care and support centre. The patient expressed his satisfaction about the services offered by the centre.

The patient who was referred by PPTCT centre for ART came to this ART centre during the 7th month of pregnancy with a CD4 count of <200. She was put on ART and after full term pregnancy gave birth to a normal child who was tested negative after 18 months post-partum. She was referred to community care centres and PLHA Networks.

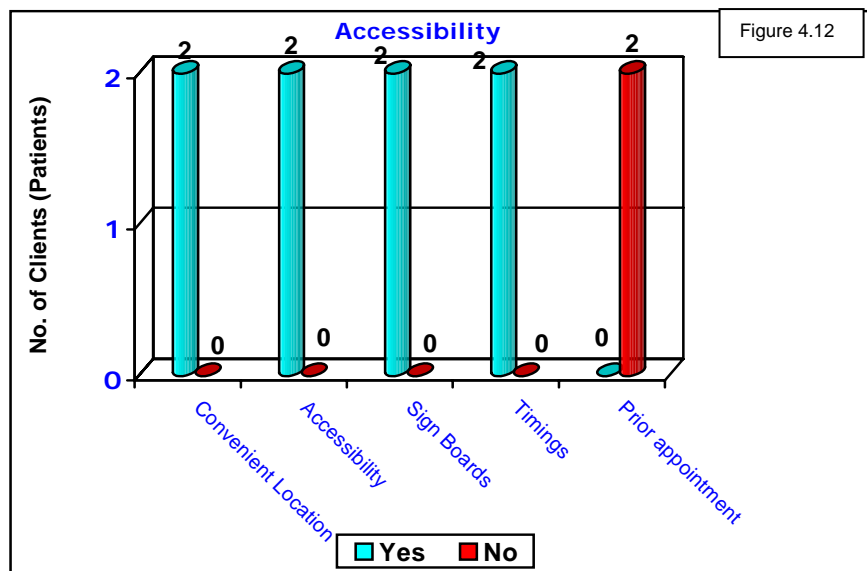
All the patients expressed overall satisfaction regarding the services offered by the centre, and the friendly attitude of the counselors.

ARCON, Mumbai

Only two patients could be interviewed in this centre. Both these patients were referred to this centre by Private hospitals.

The patients stated that they had to come to the centre from far away places which requires more

than 12 hours journey. However, they said that there was no problem with accessibility of the centre after reaching Mumbai. Both of them said that proper sign boards were displayed for reaching the centre easily and the timings of the centre were also convenient. Neither of them took any prior



appointment for meeting the counselor in the centre. After reaching the ART centre, they did not wait for long to see the counselor nor to receive the test results. One of the patients had to wait for only 10 minutes for seeing the counselor during the first session. The other patient said that he had to wait for 30 minutes. Usually the test results are handed over to the patients within 24 hours.

Both the interviewed patients expressed high level of satisfaction regarding the cleanliness in the centre, adequacy of space, ventilation in the centre and privacy during counseling sessions. They were

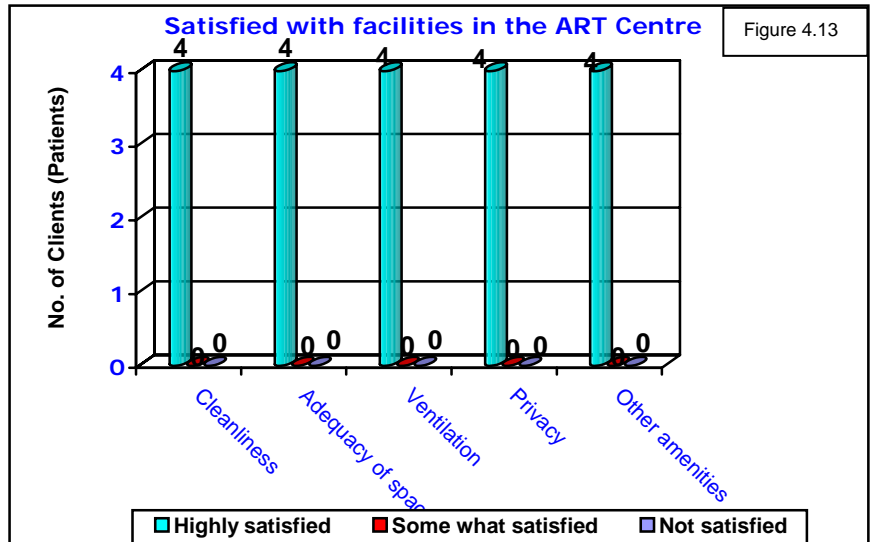


Figure 4.13

also satisfied with the provision of other amenities like drinking water and toilets in the centre.

The patients expressed their utmost satisfaction with respect to the attitude of the counselors, psychosocial support provided by the counselors. The confidentiality of the information and the treatment offered in the center is good.

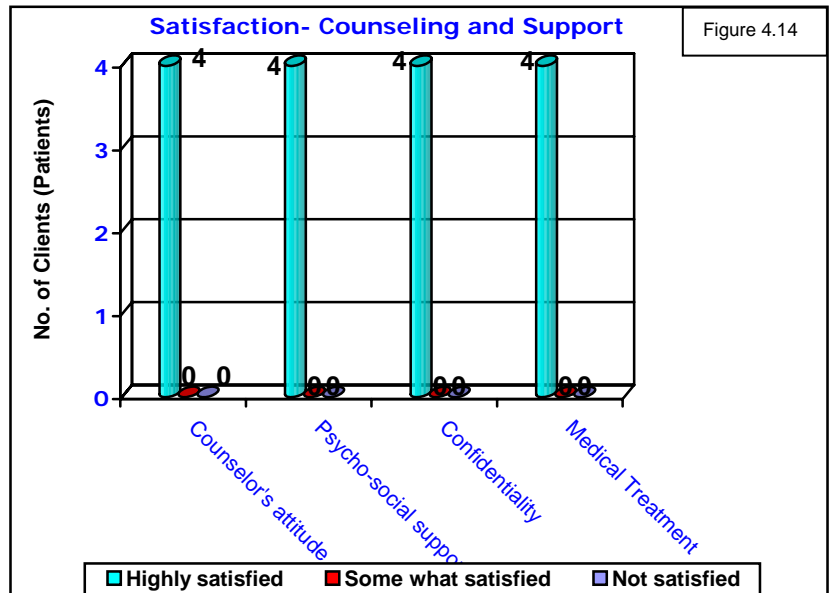


Figure 4.14

Neither of them availed the services offered by NGOs. Both the patients expressed overall satisfaction regarding the services offered by the centre,

and the friendly attitude of the counselors. One of them recommended the services of this centre to another 7 patients.

ART Training programmes

Assessment of trainings imparted by the ART centers to Government and private sector providers on ART has been carried out. The persons in-charge of the surveyed ART centers have informed that they were not getting any budget for conducting training programmes. However, these ART centers are conducting certain training programmes on ART to NGOs and medical officers / practitioners on their own cost.

The Freedom Foundation, Bangalore imparted one month training to post graduate students (M.Sc. microbiology) and doctors from private institutions. Nine members participated in these training programmes during the year 2006-07 and five members during 2007-08. The topics covered were basics of HIV, HIV testing procedures, opportunistic infections, HAART as per NACO module.

YRG CARE, Chennai conducted training courses for nurses, counselors, outreach workers, health workers from 25 community care centers. This center offers fellowship (3 months) training for doctors. The center conducts three month course in aptitude element for general physicians. This center also offers nine months overseas fellowship for doctors. GFATM training programme for counselors, field health workers is also conducted by this center. The well-equipped laboratory in this center manned by experts offers training courses for laboratory technicians in various components like bio-chemistry, micro-biology and clinical pathology. These courses are either orientation or refresher type.

ARCON, Mumbai

This center has conducted the following training programmes :

1. 62 persons in Government sector, 403 persons in private sectors from different categories have been trained in HIV and ART, HIV counseling, lab testing and monitoring.
2. They also provided training in HIV and ART for 204 General Practitioners and Medical officers.
3. 135 counselors have been trained in matters related to HIV counseling and basic clinical aspects of HIV / AIDS.
4. About 84 Pathologists and Micro Biologists were given training in laboratory testing and monitoring.

CHAPTER 5

ASSESSMENT OF PROJECT MANAGEMENT BY STATE AIDS CONTROL SOCIETIES

As part of the Mid-term Evaluation of GFATM Round II Project “Scaling up Prevention of Parent to Child Transmission of HIV and Anti-retroviral Treatment Involving Public Private Partnership”, an assessment of the project management by the State AIDS Control Societies in all the 6 high prevalence states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, Tamilnadu and the city of Mumbai was carried out.

The broad parameters used for the assessment are:

- Effectiveness of monitoring of PPTCT programme
- Utilization & management of funds
- Procurement of goods & services
- Management of human resources of PPTCT centres
- Formation and functional status of steering committees
- Filling up of posts earmarked under GRATM Round II
- Involvement of NGOs
- Effectiveness of data management system
- Other general information pertaining to PPTCT activities

The observations in respect of the above parameters are presented below:

- The number of meetings conducted by SACS officials with ICTC managers, Counselors, Outreach workers, PPTCT medical officers and number of site visits made by SACS officials have been assessed.
- As per the available data collected from the field, though there are certain variations in implementation among the surveyed State AIDS control Societies, most of the societies have adhered to the guidelines issued by NACO. The SACS officials are monitoring the PPTCT programme by conducting periodical review meetings at the State and District level with the concerned officials for assessing the progress in the programme. During the field visits, the officials are also reviewing all the records related to the programme and guiding the staff at the PPTCT centres whenever any discrepancy is found.

I. Effectiveness of Monitoring of PPTCT Programme

Table No. 5.1

Name of ACS	No. of Review Meetings with PPTCTC Managers				No. of Review Meetings with Councillors			
	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08
Karnataka SAPS	---	---	2	4	---	---	2	---
Maharashtra SACS	---	---	---	1	---	---	---	1
Manipur SACS	3	3	3	3	12	12	12	12
Mumbai DACS	---	---	---	2	8	12	12	12
Nagaland SACS	---	---	---	---	12	12	12	12
TamilNadu SACS	---	---	3	12	12	12	12	12
AP SACS	2	2	1	2	2	2	2	2

* --- : Data Not Available

Data pertaining to review meetings is presented in tables 5.1. and 5.2. Most of the SACS conduct review meetings with the functionaries but not at regular intervals. In fact, it is observed, during the discussions with the respective SACS officials, that the functioning of the PPTCT centres is being reviewed by the SACS officials whenever they go for field visits. But this is resulting in some of the centres being reviewed several times in a year and the other centres fewer number of times. Records of the review meetings held with functionaries of the peripheral centres are not maintained with the SACS. Except in APSACS the review meetings with counselors / PPTCT Centre managers are mostly held at the district level along with the respective district officers concerned with implementation of PPTCT / ICTC programme. With respect to conduct of review meetings, the performance of APSACS, TNSACS and Manipur SACS seems to be better. Some of the societies have not furnished the data necessary for evaluation, as the data was not recorded properly.

Table No. 5.2

Name of ACS	No. of Review Meetings with JD/DDS of SACS				No. of Review Meetings with NGO Organizations			
	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08
Karnataka SACS	---	---	---	---	---	1	2	2
Maharashtra SACS	---	---	---	2	---	---	---	3
Manipur SACS	---	---	8	3	---	---	3	2
Mumbai DACS	---	4	4	4	---	---	2	4
Nagaland SACS	---	---	---	---	---	---	4	4
TamilNadu SACS	12	12	12	12	---	---	12	12
APSACS	12	12	12	12	2	2	2	2

* ---: Data Not Available

During the discussions, officials from all the SACS stated that internal review meetings were conducted with the Joint Directors / Deputy Directors regularly to review the progress of the implementation of the PPTCT programme. In TNSACS and APSACS these meetings are conducted at least once in a month. In Mumbai DACS these review meetings are conducted at quarterly intervals. In Manipur SACS 8 such meetings were conducted in 2006-07 and 3 meetings in 2007-08. In the remaining SACS, though it was stated that review meetings are conducted, data pertaining to the number of meetings held in a year is not available.

Review Meetings with NGO Organisations / ORWs: The available data indicates that review meetings with NGO organizations are held regularly in APSACS and TNSACS. In TNSACS monthly meetings were held with NGOs during the years 2006-07 & 2007-08. In APSACS these meetings are usually held at district level on a regular basis. However, at least two meetings in a year are also held at SACS level to review the performance of NGOs. In the remaining SACS meetings with NGOs are held but no regular periodicity is observed. Outreach workers also participate in the meetings held with NGO organizations especially those held at district level.

Site Visits by the SACS Officials: Data pertaining to the exact number of site visits made by the SACS officials each year is not available in any of the surveyed SACS. In TNSACS, Manipur SACS, KSAPS and Maharashtra SACS this information for the year 2007-08 could be gathered from

examination of the available records. The feedback from the field visits by the study teams reveals that the deputy directors and M&E officers concerned with the implementation of the programme in all the SACS, except NSACS, visit the PPTCT centres regularly and review meetings are conducted with the staff of PPTCT centres. In Nagaland site visits by the officials seem to be very irregular.

The available data and feedback from the field gives an overall impression that the performance of TNSACS, APSACS and MDACS with respect to review meetings with functionaries and site visits by the concerned officials is commendable.

Figure 5.1

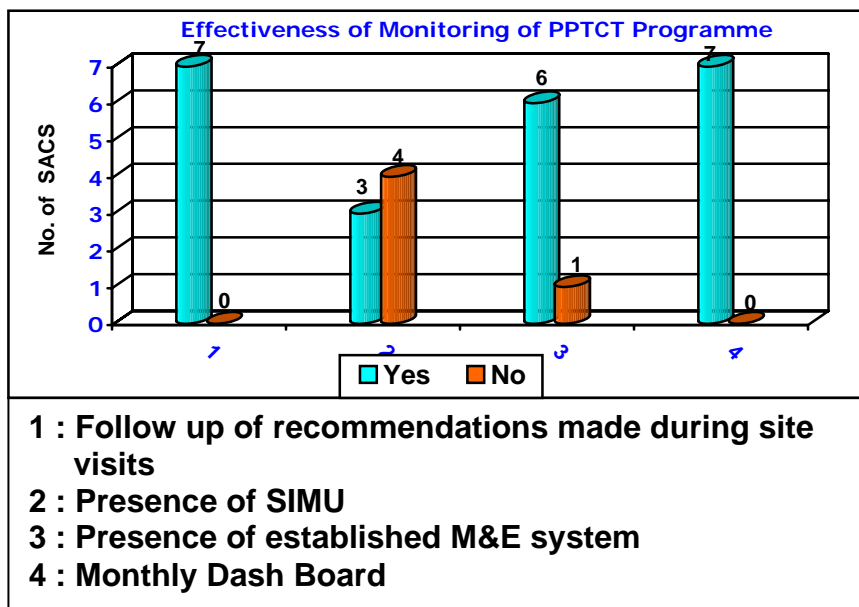


Figure 5.1 shows data concerning the effectiveness of monitoring of PPTCT programme by different SACS. A Strategic Information Management Unit (SIMU) is established in KSAPS, MDACS and TNSACS. M&E System headed by a designated officer of the rank of Deputy Director / Joint Director is there in all the surveyed SACS. An M&E officer is appointed in all the SACS to assist the DD / JD. In TNSACS there is an online connectivity for data entry from peripheral units to the SACS. In Andhra Pradesh also online connectivity for data entry and management is established in 10 districts where DAPCUs are functioning. The remaining AIDS Control Societies lack a strong M&E

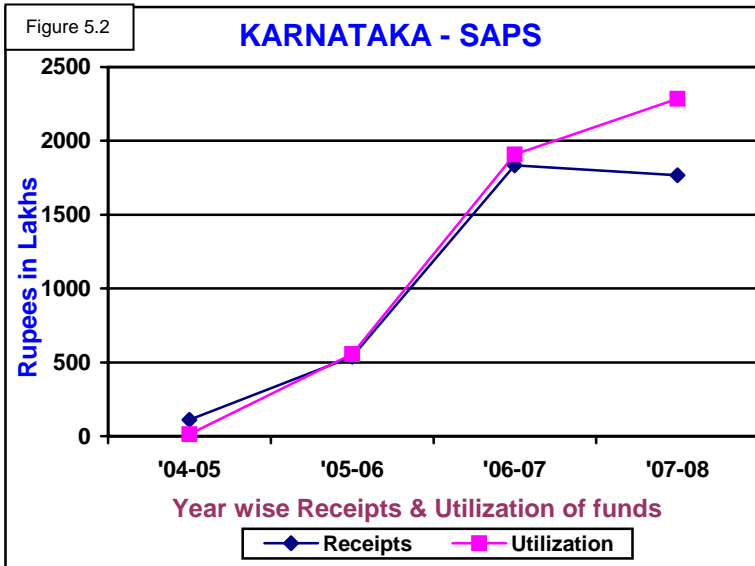
system and the monitoring is limited to submission of monthly reports by the peripheral units to the SACS. Actual monitoring of the programme depending on the performance and functioning of the peripheral units is not done in these societies. In Manipur and Nagaland the system is further weakened by the fact that accessibility to several of the peripheral centres is difficult and the concerned officers rarely visit these centres. Monthly dash board is submitted regularly by all the SACS

II. Utilization and Management of Funds:

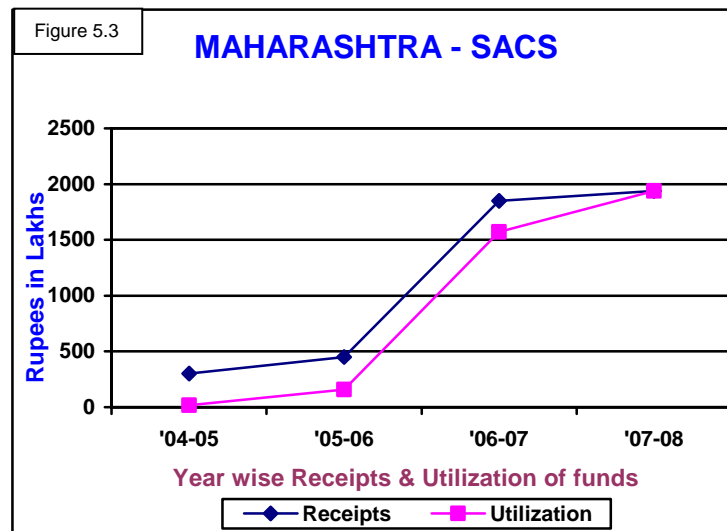
In all the surveyed SACS there is a Dedicated finance & Accounts Department headed by an experienced officer who is on deputation from the treasury department or other departments of the state government dealing with finance & accounts. Though the designations of these officers varied from state to state (Finance Controller / Joint Director / Deputy Director) they are all appointed as full time officers. Only in Manipur SACS, it is reported, that the head of the finance department is assisted by a full time chartered accountant. In TNSACS the Finance & Accounts department is headed by a chartered accountant who is on deputation from the treasury department of the state government. However, the appointment of a full time chartered accountant in TNSACS is under process. In the remaining SACS the function of auditing of the SOEs and UCs by chartered Accountants is outsourced.

When the data pertaining to release of funds by NACO and utilization by SACS is examined, there is a gross under utilization of funds by KSAPS, Maharashtra SACS and MDACS during the first year of implementation of the project. From the second year onwards the fund utilization increased in all the societies except Maharashtra SACS which was still lagging behind. The cumulative receipts and utilization for 4 financial years (2004-05, 05-06, 06-07 and 07-08) show an optimum utilization of the released funds by all the SACS. In fact, KSAPS is showing a utilization of 12% in excess of the receipts.

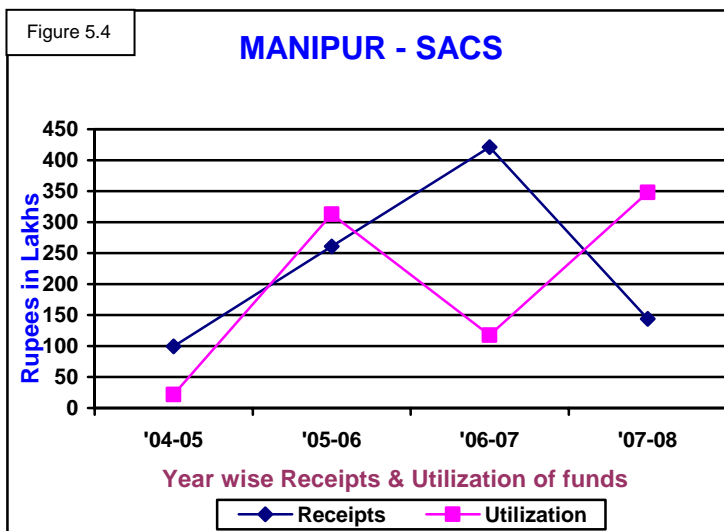
Year wise Receipts & Utilization of funds for four financial years



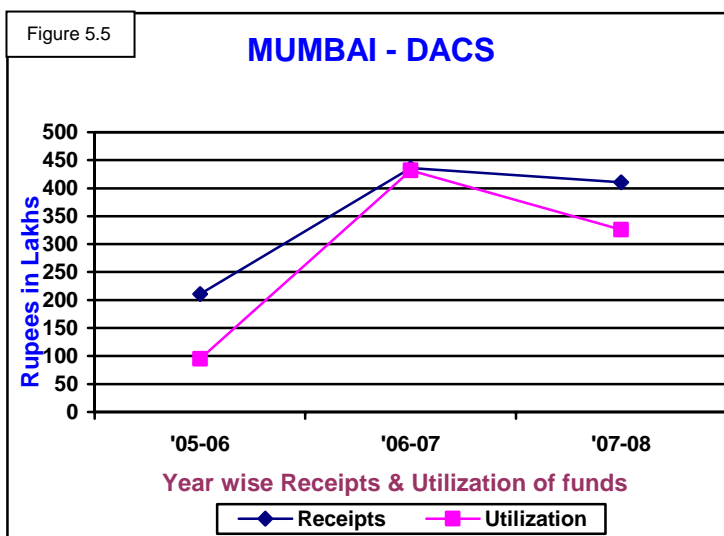
KARNATAKA - SAPS				
	2004-05	2005-06	2006-07	2007-08
Receipts (Rs.in Lakhs)	111.36	538.08	1832.9	1767.52
Utilization (Rs.in Lakhs)	13.77	555.41	1907.19	2284.13



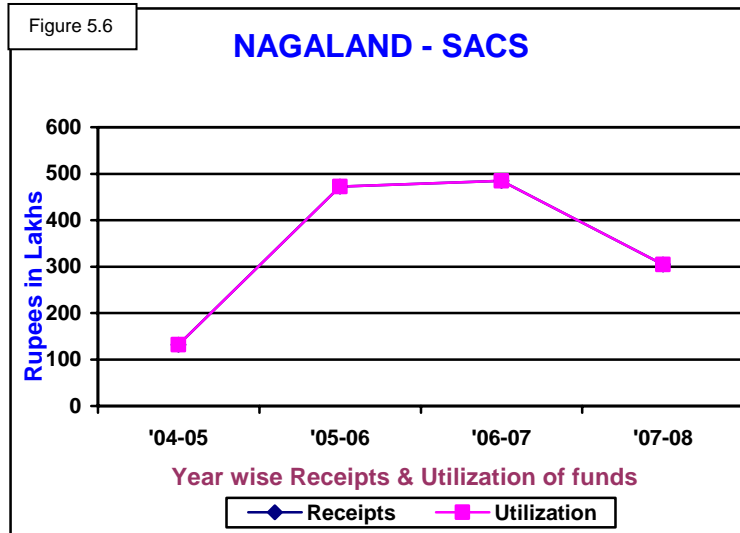
MAHARASHTRA - SACS				
	2004-05	2005-06	2006-07	2007-08
Receipts (Rs.in Lakhs)	302.06	450	1849.36	1939.34
Utilization (Rs.in Lakhs)	17.83	156.34	1571.46	1939.02



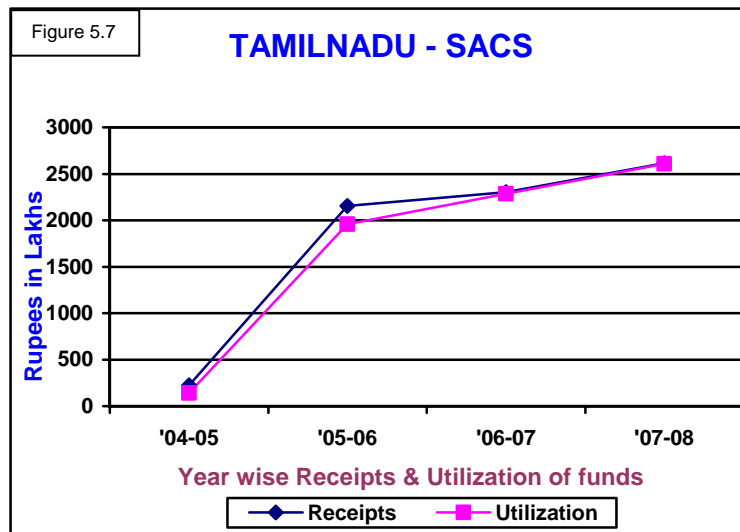
MANIPUR- SACS				
	2004-05	2005-06	2006-07	2007-08
Receipts (Rs.in Lakhs)	99.60000	260.90485	421.00000	143.96000
Utilization (Rs.in Lakhs)	21.56399	312.86902	117.51417	347.95050



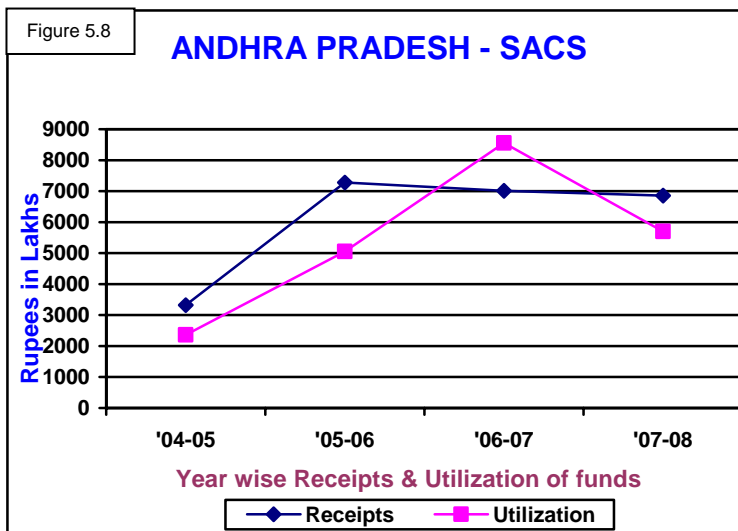
MUMBAI - DACS				
	2004-05	2005-06	2006-07	2007-08
Receipts (Rs.in Lakhs)	-	210.76	435.57	410.77
Utilization (Rs.in Lakhs)	-	95.16	431.59	325.95



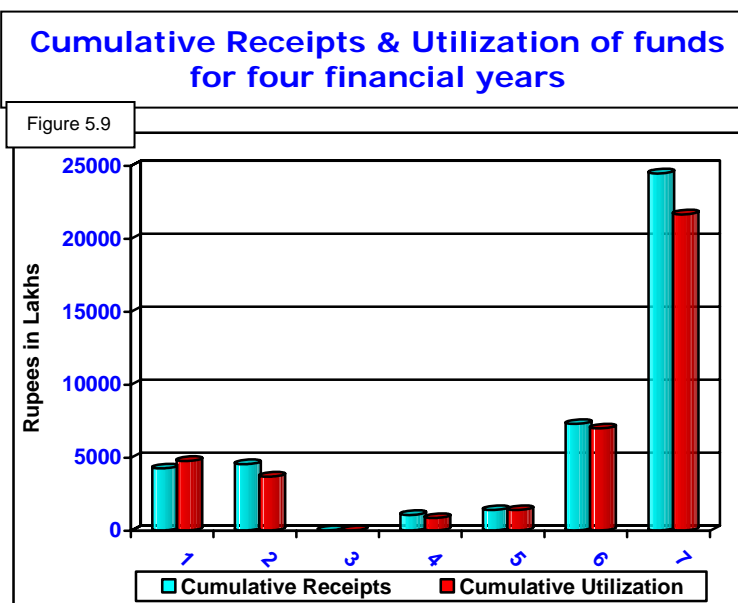
NAGALAND - SACS				
	2004-05	2005-06	2006-07	2007-08
Receipts (Rs.in Lakhs)	132.15	472.1	484.71	304.46
Utilization (Rs.in Lakhs)	132.15	472.1	484.71	304.46



TAMILNADU - SACS				
	2004-05	2005-06	2006-07	2007-08
Receipts (Rs.in Lakhs)	221.94	2155.42	2302.04	2615.92
Utilization (Rs.in Lakhs)	142.03	1958.35	2284.27	2608.42



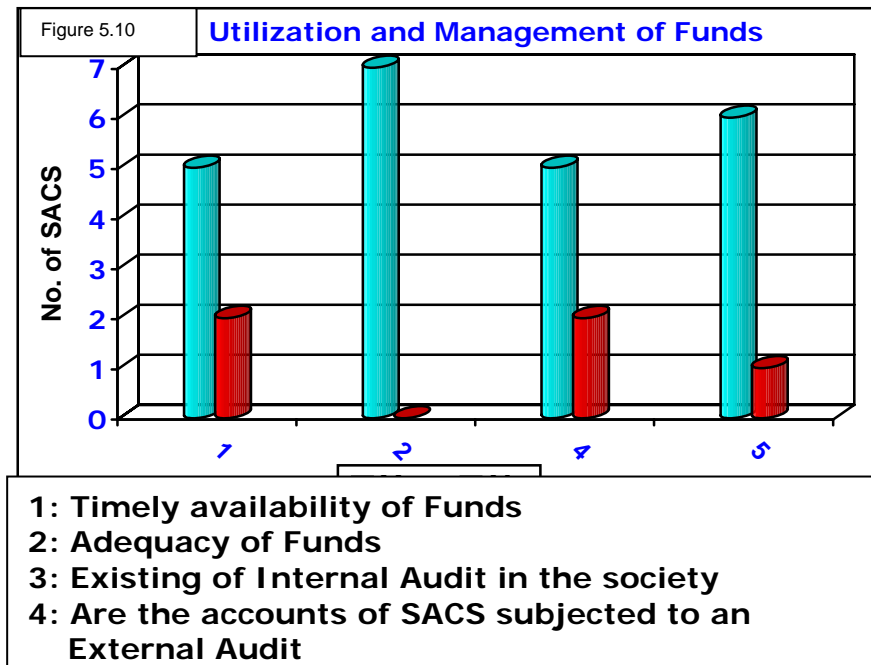
ANDHRA PRADESH - SACS				
	2004-05	2005-06	2006-07	2007-08
Receipts (Rs.in Lakhs)	3323.17	7281.34	7007.75	6858.4
Utilization (Rs.in Lakhs)	2358.01	5050.04	8556.63	5699.47



Cumulative Receipts & Utilization of Funds for Four Financial Years (Rs. Lakhs)			
		Receipts	Utilisation
1	Karnataka – SAPS	4249.86	4760.5
2	Maharashtra – SACS	4540.76	3684.65
3	Manipur – SACS	925.4649	799.8977
4	Mumbai – DACS	1057.1	852.7
5	Nagaland – SACS	1393.42	1393.42
6	TamilNadu – SACS	7295.32	6993.07
7	Andhra Pradesh - SACS	24470.66	21664.15

Table No.5.3

Name of SACS	Q6. Funds received by SACS (Rupees in Lakhs)				Q7. Funds utilization by SACS (Rupees in Lakhs)			
	2004-05	2005-06	2006-07	2007-08	2004-05	2005-06	2006-07	2007-08
Karnataka - SACS	111.36	538.08	1832.90	1767.52	13.77	555.41	1907.19	2284.13
Maharashtra - SACS	302.06	450.00	1849.36	1939.34	17.83	156.34	1571.46	1939.02
Manipur - SACS	99.60000	260.90485	421.00000	143.96000	21.56399	312.86902	117.51417	347.95050
Mumbai – DACS	---	210.76	435.57	410.77	---	95.16	431.59	325.95
Nagaland - SACS	132.15	472.10	484.71	304.46	132.15	472.10	484.71	304.46
TamilNadu - SACS	221.94	2155.42	2302.04	2615.92	142.03	1958.35	2284.27	2608.42
Andhra Pradesh - SACS	3323.17	7281.34	7007.75	6858.40	2358.01	5050.04	8556.63	5699.47



With respect to timely receipt of funds from NACO, Manipur SACS and NSACS have reported delay in release of funds for them. The remaining SACS said that the release of funds for them was on time. The fund allocation for all the 7 surveyed AIDS Control Societies was reported to be adequate for various programmes being carried out by the respective societies. All the societies except Manipur SACS have the system of internal audit of their accounts. Likewise, all the societies except Maharashtra SACS have an established external audit system to audit the accounts of the societies.

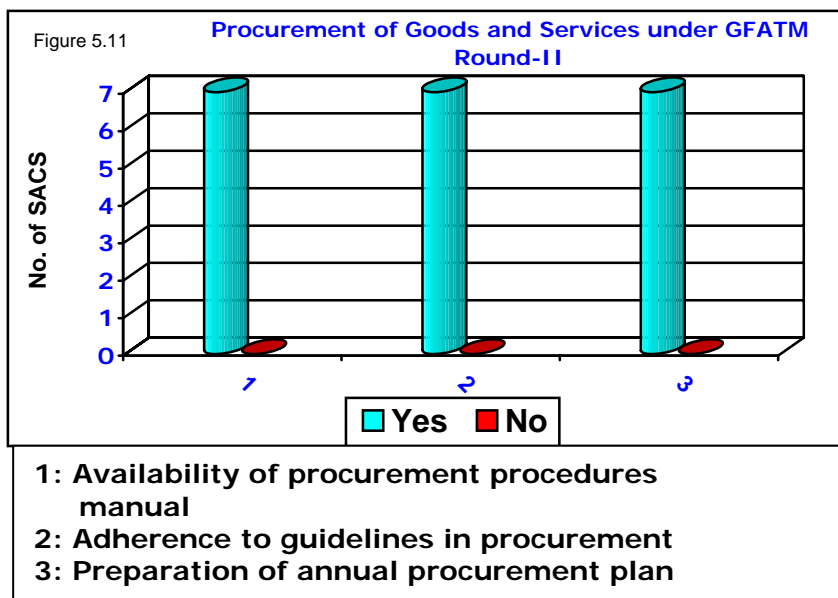
All the surveyed SACS have been regularly submitting SOEs to NACO. Four of the seven societies, APSACS, KSAPS, TNSACS and NSACS, obtain SOEs

from the PPTCTs / ICTCs and NGOs. Further fund release is affected only after checking the utilization certificates / SOEs submitted by the peripheral centres / NGOs. Like this, a sort of performance based fund utilization is done in these SACS. TNSACS is adopting a system called “Voucher Auditing” for auditing the accounts of NGOs. Voucher auditing is conducted by a panel of auditors appointed by TNSACS. It is carried out twice a year for NGO projects under TI, CCC and GFATM. All the vouchers generated by the NGOs are checked and utilization certificates are issued by the auditors. Subsequent fund release to the NGOs is based on the UCs given by the auditors. Voucher auditing of NGOs has helped in streamlining and ensuring compliance with the budget line items by NGOs. After introduction of voucher auditing system financial discipline has been established and leakage of funds could be arrested. As a part of this system the NGOs were provided 3-day training for capacity building on book keeping and accountancy. This capacity building programme helped the NGOs in maintaining their accounts properly.

Though voucher auditing is not done for PPTCTCs and ICTCs, TNSACS conducts monthly meetings at district level with the accounts officials of the offices of Joint Director (Health Services), Deputy Director (Health Services) and Deans of the hospitals. The accounts of the peripheral centres are available with these district offices and reconciliation of accounts is done after checking the advance registers which are maintained by both TNSACS and the districts. Periodically officers from TNSACS are also deputed to collect the UCs. By taking these initiatives TNSACS is able to strengthen the UC collection system from the peripheral centres.

III. Procurement of Goods and Services under GFATM Round-II:

Four societies namely, Karnataka, Manipur, Mumbai and Andhra Pradesh do not have a separate department in their office. All the societies except Manipur have a designated person to conduct all procurement activities. The persons in-charge of procurement are trained in all the societies except Mumbai DACS where an untrained person is manning for procurement department.



TNSACS, MDACS and NSACS have separate procurement departments. However, all of them have a designated officer in-charge of procurement. The designated officers, except in MDACS, received training for procurement of goods under GFATM. All the SACS follow the guidelines issued by NACO for procurement of goods and services. All the societies have a good forecasting system for procurement of goods and the annual procurement plans are prepared depending on the quantum of utilization of goods by the peripheral centres. In respect of procurement of goods and services, Maharashtra SACS, TNSACS and APSACS have reported to be following open tender system while KSAPS, Manipur SACS, NSACS and MDACS are following limited tender system. In the very rare instance of emergency procurement, national shopping procedures or procurement by direct contract are resorted to. The pre-testing of goods by an accredited testing laboratory is an important prerequisite for bulk purchases. In this respect all the societies are religiously observing the procedure of pre-testing of goods.

There are certain items, which are supplied by NACO to the SACS. Usually SACS need not purchase these goods on their own. However, in case of delay in the supply from NACO coupled with an urgent requirement of these goods, SACS have reported purchase of these goods on their own with prior permission from NACO. The expenses incurred on purchase of these goods are met from the funds released by NACO.

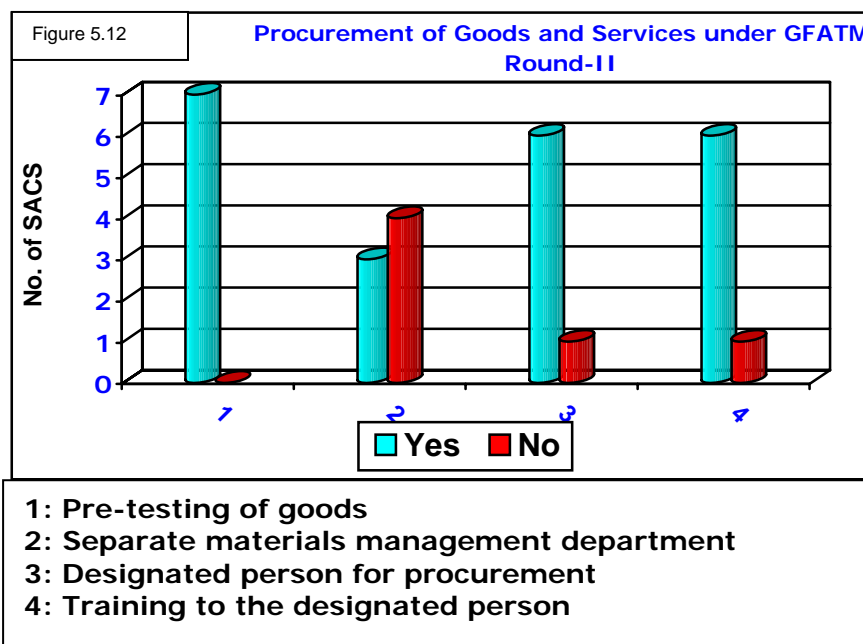
All the societies follow a streamlined system of distribution of consumables, diagnostic kits and ART drugs to the PPTCT / ART centers. In some of the SACS the procurement is done by another government agency constituted for this purpose. Tamilnadu Medical Supplies Corporation in Tamilnadu, Drugs Logistics Society (DLS) in Karnataka and APMHIDC in Andhra Pradesh are the agencies, which deal with procurement of goods on behalf of SACS. In Karnataka the goods procured by DLS are directly supplied to the peripheral centres without the intervention of KSAPS. KSAPS plays the role of placing an indent against the requirements of the peripheral centres. However, diagnostic kits for HIV testing are procured by DLS and are stored in the walk-in-cooler (cold storage) in KSAPS from where the peripheral centres draw their requirements on monthly basis. It is reported that this third party procurement of goods is some times resulting in delayed supplies. Instances of delayed supplies by DLS are specifically reported during the discussions with officials in KSAPS. Except in KSAPS where there is a system of supplying goods directly to the peripheral centres, all the other surveyed SACS maintain adequate quantity of stocks. Periodical stock verification at the peripheral centres is carried out by all the SACS except Manipur SACS and NSACS. All the societies obtain monthly stock reports from the PPTCT centres.

All the surveyed SACS except NSACS maintain a cold chain system for the distribution of HIV diagnostic test kits from SACS to the PPTCT centres. All the SACS have the facility of cold storage for diagnostic kits. Either refrigerated vans or insulated containers with dry ice are used for the transport of the kits. It is observed that frequent power cuts are experienced by many centres in the states of Andhra Pradesh and Maharashtra. However, back up generator facility is available in all the surveyed centres. In Nagaland SACS a proper cold chain system is not maintained. In none of the PPTCT centres, including those located in district head quarters hospitals, a back up generator facility is available to meet the contingency of power failures. In Wokha civil hospital, Nagaland the kits were left out side in the laboratory exposing them to ambient temperature which was around 22° C at the time of the visit to the hospital by the consultant's team. The PPTCT centre located in

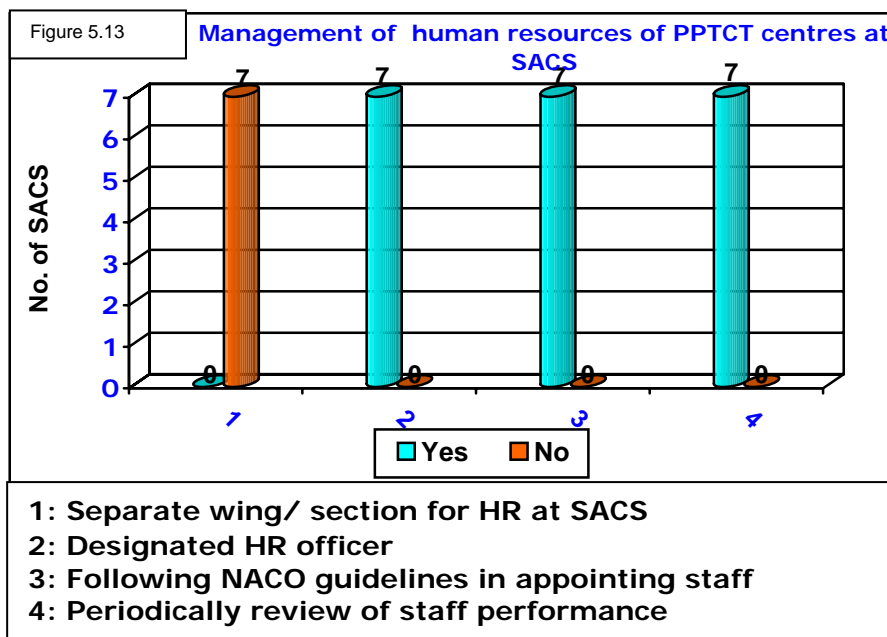
Chukitong, in the same district does not have power supply and the kits are stored in a steel cupboard at room temperature.

Except in Nagaland SACS all the surveyed societies have a system for checking the use of date-expired diagnostic kits and drugs by the PPTCT centres. In Nagaland three out of the six PPTCT centres surveyed have expired diagnostic kits / nevirapine tablets.

The pre-testing of goods by an accredited testing laboratory is an important prerequisite for purchased items. In this respect all the societies are religiously observing the procedure of pre-testing of goods.



IV. Management of human resources of PPTCT centres at SACS



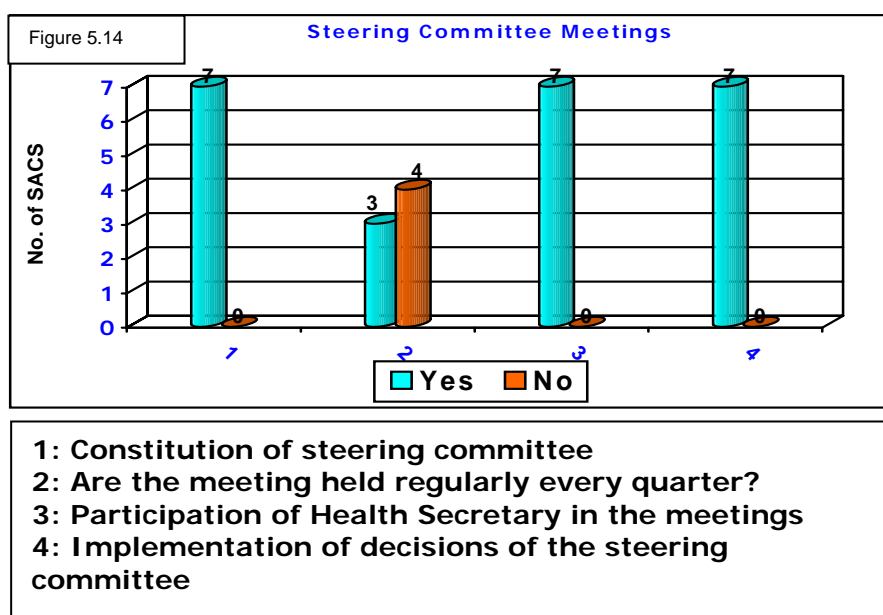
None of the surveyed SACS have a separate human resources department headed by a qualified HR professional. However, this function is taken care of by the administrative department in the SACS. Usually the Administrative Officer or Chief Administrative Officer is in-charge of the human resources management. In Manipur SACS the HR functions are under the control of the Project Director himself.

All PPTCT centres in the surveyed states are manned by qualified and trained professionals. The PPTCT centre in-charge is a medical officer. Similarly all the counselors (wherever available) in the PPTCT centres are qualified, mostly from social sciences background and at some places from nursing background, and trained. In Nagaland out of the 6 centres visited by the study team, three centres have counselors with Theology (church) background. They are into social service and are trained by the SACS before taking up the position as counselor. In Andhra Pradesh some of the centers located at PHC level, have new designated posts called 'Nurse Practitioners' who carry out the functions of counseling, HIV testing, conduct of deliveries, maintenance of records and outreach work, the nurse practitioners replace the work of technician and the counselor and in addition will conduct deliveries also. Except in Karnataka and Nagaland, all the SACS have NGOs associated with the PPTCT centres for taking up different activities like care and support, outreach, follow up etc.

The system for payment of salaries to the staff of PPTCT centres is decentralised in TNSACS, Maharashtra SACS, MDACS and Nagaland where the designated district officer is the disbursing officer. There is a quarterly release of funds towards salaries to the designated officer. In the remaining SACS i.e., APSACS, KSAPS and Manipur SACS the disbursement of salaries to the PPTCT centre staff is directly done by the SACS. In Andhra Pradesh the salaries of the staff are directly credited to their bank accounts by the SACS every month. In Manipur SACS there are reports from the counselors at the PPTCT centres / ICTC centres about irregular disbursement of salaries. In all the surveyed centres of the state the staff complained about release of salaries once in two or three months.

Except in Tamilnadu and Andhra Pradesh, none of the surveyed SACS have the system of obtaining periodical performance appraisal reports from the staff of PPTCT centers. KSAPS is planning to conduct an examination for their PPTCT / ICTC staff for evaluating their performance and their knowledge of issues related to HIV / AIDS and counseling for the first time during the four years. During discussions with the KSAPS officials it is revealed that the performance report would be shared with NACO. In all the surveyed SACS the staff in PPTCT centres underwent induction training by NACO / SACS. All the SACS except Manipur SACS and KSAPS have formulated annual training plans for all categories of PPTCT staff and implementing the training plan. Only MDACS and APSACS have system of obtaining feedback from the staff of PPTCT centres regarding the training programmes conducted for them. These two SACS assess the quality of training imparted to their staff based on the feedback and make improvements in the content of training.

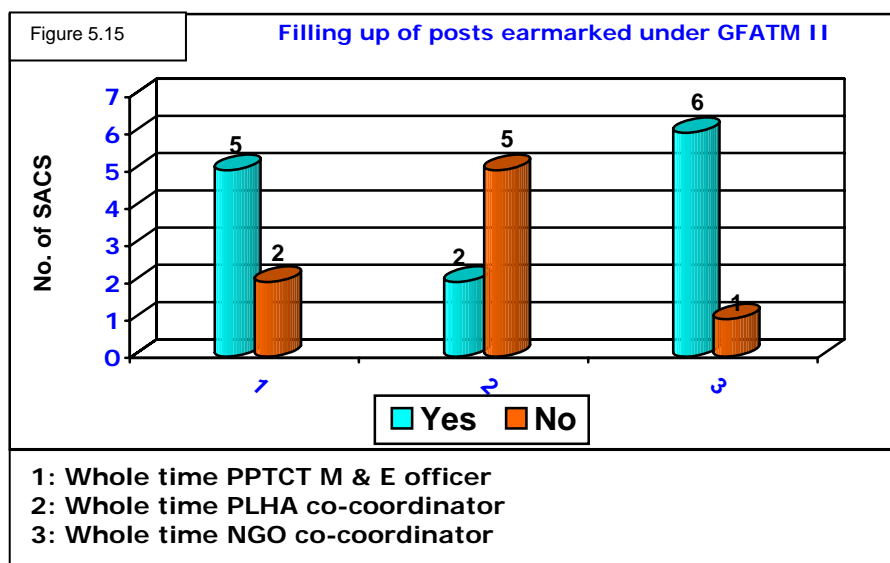
V. Steering Committee Meetings



Steering Committees, which ensure proper implementation and progress of different programmes of the society including PPTCT programme are constituted in all the surveyed SACS. In four of the surveyed SACS i.e. KSAPS, MDACS, APSACS and TNSACS quarterly meetings of the steering committee are regularly being held. In Maharashtra, Manipur and Nagaland the steering committee meetings are being convened but not exactly at

quarterly intervals. The Health Secretaries of the respective state governments are participating in the steering committee meetings in all the societies whenever meetings are convened. It is reported that the decisions taken in the steering committee meetings are implemented without fail in all the SACS.

VI. Filling up of posts earmarked under GFATM II



APSACS is the only society where all the posts earmarked under GFATM II, PPTCT M&E Officer, PLHA Coordinator and NGO Coordinator, are filled on whole time basis. All the surveyed SACS have a whole time PPTCT M & E officer except in Maharashtra SACS and MDACS. Both the SACS are making efforts to appoint a suitable candidate for the above post and the process is in progress. Similarly, only MDACS and APSACS have a whole time PLHA coordinator. All the societies, except KSAPS have a whole time NGO coordinator. In Karnataka the efforts are underway to appoint a candidate in this position. Presently the TI coordinator is acting as NGO coordinator in additional charge.

VII. Procedure adopted for selection of NGO doing outreach for PPTCT services

All the surveyed SACS follow the guidelines issued by NACO for the selection of NGOs. Conditions like having registration under Societies Act, Indian Trust Act or Charitable Trusts Act , having established presence in the area, having minimum of 3 years experience, having clear financial track record, not having been blacklisted etc., are strictly adhered to while selecting the NGOs.

In all the societies, except in KSAPS where the post is presently vacant, the NGO coordinator is regularly monitoring the performance of NGOs and offering suggestions. However, in the state of Nagaland the performance of the NGOs seems to be dismal. The follow up by NGOs in respect of HIV positive pregnant women and mother baby pairs is very poor as reflected by the data pertaining to impact of PPTCT programme and services. MNSACS, APSACS, MDACS and TNSACS have a properly established system for monitoring the performance of the NGOs. Apart from obtaining the monthly performance reports from the NGOs, these SACS also conduct monthly review meetings with the NGO representatives. Site visits are carried out by the NGO coordinator and concerned officials of SACS to monitor the performance of the NGOs and offer suggestions wherever required. In Tamilnadu the M&E section is also involved in monitoring the performance of the NGOs and a monthly ATR is obtained from the NGOs in response to the recommendations or suggestions extended from SACS. In TNSACS there is a system of “voucher audit” to monitor the financial performance of the NGOs periodically.

VIII. Effectiveness Data Management Systems at the SACS

Computerised Management Information System (CMIS) is established in all the SACS. In TNSACS all the PPTCT / ICT centres are linked online with the server in the SACS facilitating an online data entry by all the peripheral centres. All the centres are provided with computers and internet connection. In Andhra Pradesh also ten districts (East Godavari, West Godavari, Guntur, Kadapa, Karimnagar, Khammam, Krishna, Nellore, Nizamabad and Prakasam) where DAPCUs are formed are connected online with the SACS.

The data from the districts is fed to the server at SACS from the DAPCUs. However, unlike in TNSACS, all the PPTCT centres in the districts do not have direct online connectivity to APSACS. In the remaining societies i.e., MSACS, MNSACS, NSACS, KSAPS and MDACS, the data from the centres is sent to the district coordinator / district manager from where it is sent to SACS in the form of hard copies or through fax or e-mail. After reaching the respective SACS the data is entered into CMIS and submitted to NACO. In TNSACS, MDACS and APSACS there is a system of validation to check the correctness of the data fed from the peripheral centres before submitting it to NACO. There is a timely collection of data from the PPTCT centres in APSACS, Maharashtra SACS, MDACS and KSAPS. Both in MNSACS and NSACS it is observed that the data from the centres does not reach SACS on time. Hilly terrain and the location of the centres in areas with difficult accessibility for communication and transport are found to be the major reasons for delayed transfer of data from the centres to SACS.

CHAPTER 6

ASSESSMENT OF THE PPTCT SERVICES

Assessment of the PPTCT services as part of the study included the following:

- I. Appraisal of the functioning of the counselors
- II. Assessment of the functioning of the laboratory testing system
- III. Qualitative assessment of the training and orientation programmes for the medical and para-medical staff
- IV. System study of the monitoring, information and evaluation system for PPTCT services
- V. Assessment of the effectiveness of NGOs
- VI. Assessment of the system of follow up of HIV positive mothers and their children given NVP
- VII. Assessment of the client (patient) satisfaction with regard to the services provided

I. Appraisal of the Functioning of the Counselors:

Appraisal of the functioning of the counselors including their counseling skills with reference to the prescribed guidelines imparted during their training is assessed.

Most of the counselors recruited in the SACS of Maharashtra, Andhra Pradesh, Tamilnadu, Karnataka and Mumbai DACS are from social sciences background with a master's degree in Social Work. In Manipur most of the counselors are from nursing background and in Nagaland several of them are from Theology background who are into social work. In Andhra Pradesh some of the centers located at PHC level, have new designated posts called 'Nurse Practitioners' who carry out the functions of counseling, HIV testing, conduct of deliveries, maintenance of records and outreach work, the nurse practitioners replace the work of technician and the counselor and in addition will conduct deliveries also. The background details of the counselors are given in Table No. 6.1

Table 6.1

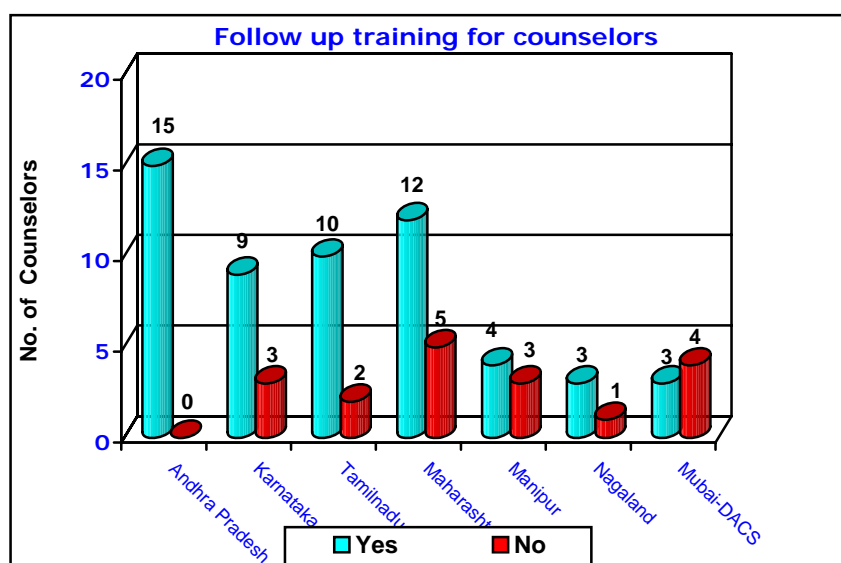
Name of the State	Number of counselors	Background of the counselor			
		Nurse	Social Worker	PLHA	Other
Andhra Pradesh	15	2 *	13		
Karnataka	12		11	1	
Maharashtra	17		17		
Manipur	7	3	4		
Mumbai	7		7		
Nagaland	4		1		3
TamilNadu	12	1	11		

* In AP the counselors with nursing background are nurse practitioners.

When asked about the motivation behind their taking up the counselor's profession most of the counselors in all the states except Karnataka had stated that they were self motivated. Most of the counselors working in Karnataka state said that they were proposed by their senior colleagues for selection as counselors.

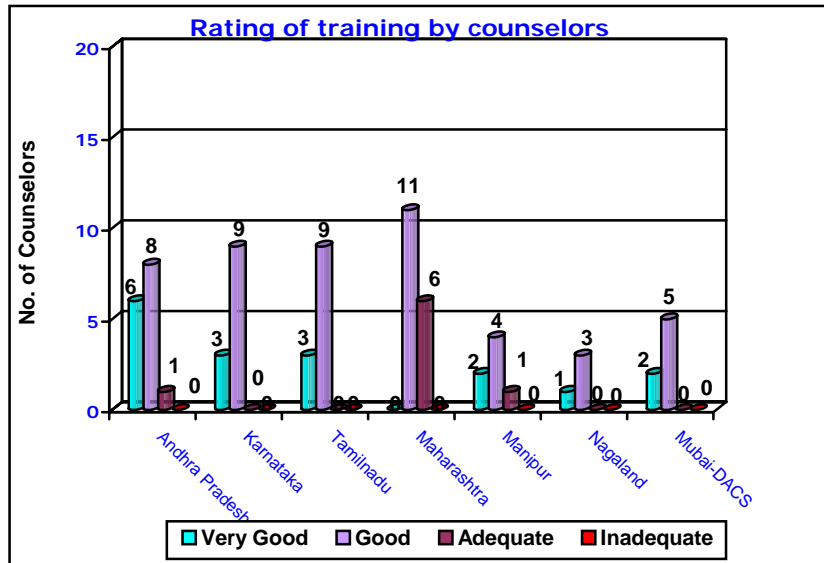
All the counselors across the seven surveyed SACS had undergone induction training conducted by SACS before they took up their job. Apart from the induction training several of the counselors also underwent a refresher training / follow up training. The details of the number of counselors who underwent follow up training are given in the figure 6.1.

Figure 6.1



Counselors rating of the training imparted to them is portrayed in the figure 6.2.

Figure 6.2



All the 74 counselors interviewed across the 7 SACS expressed positive opinion about the training imparted to them. Out of these 74 counselors 17 rated their training as very good, 49 rated it as good and 8 of them rated it as adequate.

The following figures detail the workload of the counselors in different states. Figure 6.3

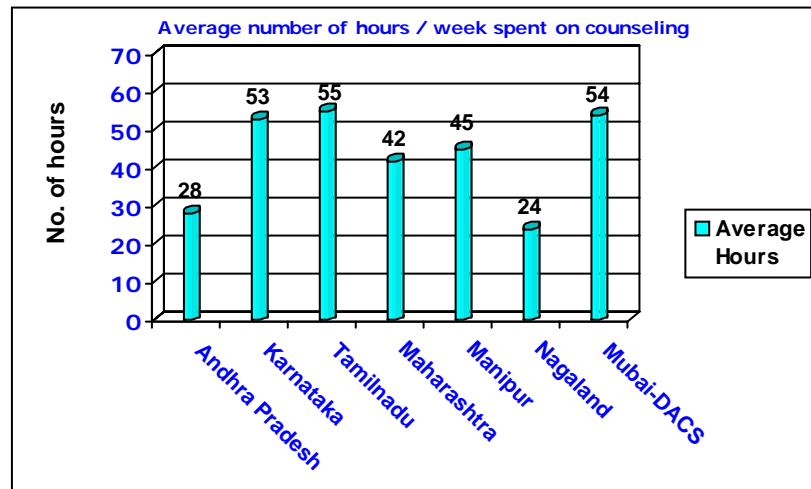
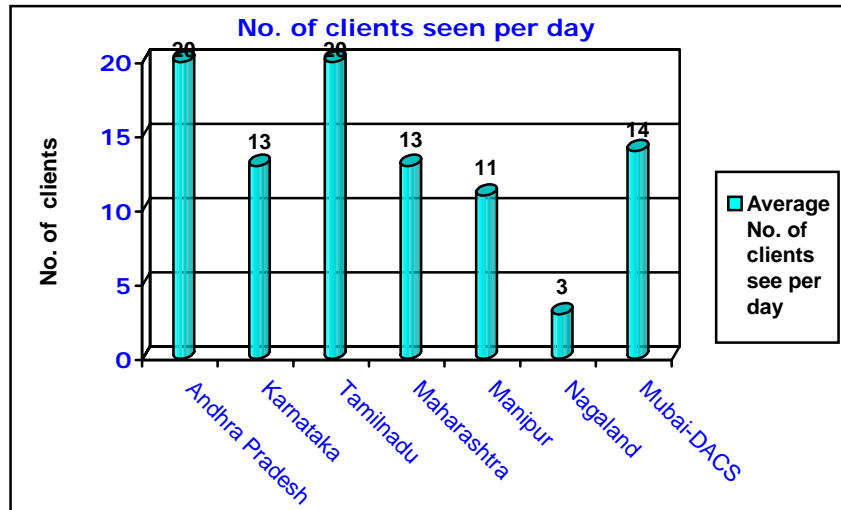


Figure 6.3 shows the average time (in hours) spent by counselors in counseling activities in a week. In Karnataka, Tamilnadu, Maharashtra, Manipur and Mumbai DACS the time spent on counseling activities by the counselors ranges from 40-

50 hours per week. In Andhra Pradesh, Nagaland it ranges between 24-28 hours per week.

Figure 6.4



The average number of clients handled per day by each counselor is the maximum of 20 in Tamilnadu and Andhra Pradesh. Next in the order are Mumbai with 14 and Karnataka and Maharashtra with 13 each. The lowest number of clients handled per day is in Nagaland.

In the states of Andhra Pradesh, Tamilnadu and Karnataka majority of the counselors interviewed are members of counselor support groups. In Maharashtra only 5 out of the 12 counselors were members of counselor support groups. In Mumbai, Manipur and Nagaland most of the counselors did not join any support group or no support groups for counselors were existing.

An attempt has been made to gather the feelings of the counselors regarding the work they are doing. 10 out of 15 counselors in Andhra Pradesh, 8 out of 17 in Maharashtra, 7 out of 12 in Karnataka and Tamilnadu felt that once in a while they get emotionally drained by their work.

More than half of the counselors in the states of Andhra Pradesh, Karnataka, Tamilnadu and Maharashtra occasionally felt that their work was stressful. However, most of them feel that their work is very much rewarding and they learn

something new in their work almost everyday. All the counselors interviewed have confidence in their work and they have a feeling that they can help their clients during the hour of need. Most of the counselors in all the states have expressed they are valued by their clients and also by other staff by supervisors during execution of their respective duties.

Opinion of the concerned medical officers in the surveyed centers regarding the functioning of the counselors working under them is also gathered. The medical officers were asked to give their unbiased opinion about the functioning of the counselors with regard to the following parameters:

- A. Providing counseling to the clients in a friendly atmosphere
- B. Maintaining confidentiality in respect of the HIV status of the client.
- C. Extensive use of IEC materials like posters, flip charts, condom demonstration models etc.
- D. Provision of psycho-social support to the clients.
- E. Sensitization of the family members of HIV positive clients.
- F. Conducting field visits.
- G. Maintenance of effective coordination with RCH, TB and ART programmes.
- H. Maintenance of records and registers and preparation of monthly reports to be sent to SACS.

All the medical officers interviewed gave a positive feedback about the counselors working under them.

Apart from the above two, direct observation of the counseling skills of the counselors was also done using schedules with the following broad parameters:

- 1. Interpersonal relationship
- 2. Information gathering
- 3. Information giving
- 4. Handling special circumstances

It is to be noted that there are limitations for execution of these observation schedules because of non-availability of counselors in some of the visited PPTCT centers, non-availability of clients on the day of the visit, objections from the HIV positive patients to the presence of a third person other than the counselor and patient etc. Scores are awarded to the counselors on a 3-point scale where 3 stands for the best and 1 stands for the least. The results of the observation schedules are summarized below:

1. **Interpersonal relationship:** Interpersonal relationship includes greeting the clients, introducing self, engaging the client in active conversation, active listening and being supportive. In this aspect counselors from all the states fared well. While 10 of the 15 counselors in Andhra Pradesh scored 3 points in this aspect, the remaining 5 counselors scored 2 points. In Maharashtra 14 out of the 17 scored 3 points and the remaining 3 scored 2 points. In Karnataka while 5 of them scored 3 points, the remaining 7 scored 2 points. In Tamilnadu 5 of them scored 3 points, 6 of them scored 2 points and the remaining 1 counselor scored only 1 point. In Mumbai all the 7 scored 3 points. In Manipur and Nagaland half of the counselors whose sessions were observed had scored 3 points and the remaining half scored 2 points. With respect to the parameter of the interpersonal relationship it is observed that the counselors were very good in engaging the clients in conversation, active listening and being supportive. Though most of the counselors greeted their clients before starting the counseling session very few of them introduced themselves to the clients.
2. **Information gathering:** Information gathering includes use of appropriate balance of open and closed questions, using silence to allow for self-expression, seeking clarification about information, avoiding premature conclusions, probing appropriately and summarizing the main issues. It is observed that the counselors in Andhra Pradesh, Karnataka, Maharashtra, Mumbai and Tamilnadu were skilled in using an appropriate balance of open and closed questions. In Andhra Pradesh 11 counselors scored 3

points in this aspect and 4 of them scored 2 points. In Karnataka 5 of them scored 3 points and the remaining 7 scored 2 points. In Maharashtra 6 counselors scored 3 points, 8 scored 2 points and the remaining 3 scored 1 point. In Tamilnadu 9 counselors scored 3 points and 3 scored 2 points. In Mumbai also most of them scored 3 points. However, in Manipur and Nagaland the counselors require to improve their skills. Skills of the interviewed counselors regarding the other aspects of this parameter were found to be good.

3. **Information giving:** Information giving includes giving information in clear and simple terms, giving clients time to absorb information and to respond, having update knowledge about HIV, reiterating the important information, checking for understanding / misunderstanding and summarizing the main issues. With respect to this parameter all the counselors in the surveyed centers scored very well. Extensive use of posters, flip charts, condom demonstration models etc. was observed while sharing the information with the clients. Most of the counselors in all the states have up to date knowledge of HIV related matters, which is adequate to handle the counseling sessions. The counselors are well versed in summarizing the important issues of the information shared before closing the counseling session.
4. **Handling special circumstances:** Handling special circumstances includes accommodating language difficulty, talking about sensitive issues plainly, prioritization of issues to cope with limited time, using silence to deal with difficult emotions, being innovative in overcoming constraints and managing clients distress. All the counselors were recruited locally and were fluent in the local language. Hence, there was no problem with language in communicating with the clients. With respect to talking about sensitive issues with the clients all the counselors scored well. The sociology / social work background of the counselors and the quality of the

training imparted to them might have helped them in acquiring high degree of skills with respect to this aspect. No situations were observed where the counselors faced any constraints during their counseling sessions nor the time was a limiting factor during the conduct of these sessions.

The aspect of using silence for allowing self-expression & dealing with difficult emotions, managing the clients' distress etc. find their place more in counseling the HIV positive patients than in pre-test counseling sessions. During the study rarely there was an opportunity for observing the post-test counseling sessions with HIV positive clients because of the limitations already mentioned. Hence, no conclusions could be drawn with respect to these aspects.

II. Assessment of the functioning of the laboratory testing system

As part of the assessment of the PPTCT services the functioning of the laboratory system in all the surveyed PPTCT centers is also assessed. All the surveyed PPTCT centers have laboratory facility and the laboratories are manned by qualified lab technicians who are also trained by SACS.

All the centres in the states of Karnataka, Tamilnadu, Mumbai DACS, Manipur and Nagaland have separate laboratory facility for HIV testing. In Andhra Pradesh 3 centers out of the surveyed 12 and one center of the surveyed 12 in Maharashtra do not have separate HIV testing laboratory. The tests in these centers are performed in the laboratory attached to the hospital. 43 out of the 66 laboratories have the prescribed space of 10' x 10'. The remaining centers do not have this prescribed area earmarked for laboratories. 50 out of the 66 laboratories surveyed have a separate area earmarked for blood collection and testing. In the remaining 16 laboratories blood collection is carried out in one corner of the laboratory.

Basic facilities like workbenches, laboratory stools, glassware, chemicals, needle destroyers, fin pipettes, centrifuge, refrigerators etc. are present in most of the laboratories. However, 3 centers in Maharashtra, 2 centers each in the states of Andhra Pradesh and Karnataka do not have refrigerators. Likewise, needle destroyer which is an essential equipment in HIV testing laboratory, is not available in 2 centers each in Andhra Pradesh and Nagaland and 1 center each in Maharashtra, Mumbai and Tamilnadu. Centrifuges are not available in 2 centers each in the states of Tamilnadu and Andhra Pradesh and 1 center each in the states of Karanataka and Maharashtra. None of the surveyed laboratories has facilities for carrying out ELISA.

In Manipur and Nagaland none of the laboratories, except RIMS Imphal, have running water facility. In Nagaland one of the PPTCT centers does not have electricity supply and the refrigerator available in the laboratory was not installed because of lack of electricity supply. The HIV test kits in this laboratory were stored in a steel cupboard at room temperature.

Availability of all 3 types of HIV test kits is essential in any HIV testing laboratory. The purpose of establishing an HIV testing laboratory does not serve without supply of all 3 types of HIV kits. However, 3 centres each in Andhra Pradesh and Karnataka , 2 centres each in Maharastra and Nagaland and 1 centre in Manipur do not have all 3 types of test kits.

Another important issue is regular and adequate supply of HIV test kits by respective SACS for proper functioning of the Laboratory. But 6 centres out of 12 in AP, 7 out of 12 in Karnataka, 9 out of 12 centers in Maharastra, 1 out of 4 in Nagaland have expressed that the supply of HIV test kits by SACS is inadequate and irregular during the last year (2007-08).

Supply of HIV test kits to the centres by maintaining cold chain is an important issue. Lack of cold chain management leads to loss of potency of the reagents/antigens and leads to false results. But 3 centres in Karnataka and 2

centers in Nagaland reported that cold chain is not maintained during supply of test kits by SACS to these centers.

In 5 of the 12 centers in Karnataka inadequate supply of disposables including latex gloves, disposable syringes and pipette tips is reported.

All the centres surveyed are following standard laboratory procedures in performing HIV testing as per NACO guidelines.

All the laboratories are maintaining proper record of the tests carried out in the laboratory.

External Quality Assessment Scheme (EQAS) is an important aspect to monitor the functional status and credibility of the laboratory. 52 out of the 66 surveyed laboratories participate in EQAS and the remaining laboratories do not have this facility.

Post Exposure Prophylaxis (PEP) is an important protocol followed to prevent accidental HIV infection to those working in laboratories. Availability of PEP drugs in the laboratories is essential to achieve this. However, it is observed that 2 centers in Karnataka, 8 centers in Maharashtra, 3 in Manipur, 1 in Mumbai and 4 in Nagaland do not have PEP drugs in their stores.

Except for these short falls all the laboratories surveyed are functioning well.

III. Qualitative assessment of the training and orientation programmes for the medical and para-medical staff

In all states incharge medical officers in the surveyed centers have undergone induction training for PPTCT programme organized by the respective SACS. There was use of audio visual equipment and IEC material as done in any of the training programmes. When asked about the quality of the training imparted to them most of the medical officers informed that the training was effective in all aspects and helped them in successful implementation of the programme.

Given below are the details of training programmes conducted for the medical officers in certain centers of Andhra Pradesh:

In Chalmada Institute of Medical Sciences Bommakal, Karimnagar Doctors have been trained for 2 days covering the following sessions. HIV epidemiology, roots of transmission and prevention of HIV, HIV testing, opportunistic infections, PPTCT programme.

In the District HQ Hospital Rajahmundry the Medical officer in-charge has undergone a three day training programme on HIV- TB coordination.

Area hospital, Jangaon- The doctors have undergone 4 to 10 days training on HIV AIDS, PPTCT & HIV-TB coordination. They have also undergone refresher training for updation of the information regarding HIV / AIDS, HIV – TB and STDs. But they expressed that the information is not clear. Staff nurses have undergone training on HIV/ AIDS, PEP treatment.

IV. System study of the monitoring, information and evaluation system for PPTCT services

All the SACS surveyed have a system for monitoring & evaluation of the PPTCT services. A significant variation is observed in the functioning of the M&E system from state to state. The system adopted in each of the 7 surveyed societies is briefly described here.

KSAPS:

Monitoring and evaluation of the PPTCT programme in KSAPS is mainly through obtaining monthly performance reports from the centres. There is a district M&E unit which is responsible for compiling the data from all the centres. The district data will be forwarded to the state M&E unit.

There will be monthly joint visits by the M&E Officer in the SACS and the concerned programme officer. Review meetings are held with the Zonal

Coordinators, District Supervisors and the District Nodal Officer (District TB Officer is the designated nodal officer).

At the district-level, the data on indicators will be analyzed by Taluka, and will be used to identify gaps in coverage by different program components across different Talukas. The analysis will be shared among all the key players in the district on a monthly basis.

Co-ordination Committee meetings are held at the state & district levels in each quarter for HIV-TB co-ordination and NRHM convergence. State level technical working group meeting will be conducted on a monthly basis. Regular Supervisory visits will be undertaken by the staff appointed at the state level (HIV-TB Consultant, District supervisor, concerned officer at the SACS). Monitoring & evaluation and review of all the field staff would be done at the State level on half yearly basis. There will be a monthly review of the district supervisors at regional level and quarterly at SACS. The performance of the Counselors will also be reviewed on a quarterly basis.

There will be regular supervisory visits conducted by the supervisors appointed in each district by SACS. They will look into the functioning of PPTCT/ICTC and ensure that the quality of standard in these centres is maintained.

The constitution of DAPCUs is under progress. Once the DAPCUs are in place, they play a major role in supervising the overall implementation of all the programmes at district level.

TANSACS:

In most of the centres in the state of Tamilnadu, the PPTCT program is being implemented as a component in ICTCs.

The monitoring of the program has the following components

- a) Monthly reports through a Web based reporting system
- b) Line listing of all positive mothers

- c) Structured and fixed day review of district level managers and NGOs

Web Based System of Monitoring: In an effort to ensure that all data and information are monitored simultaneously and regularly, TANSACS has implemented a decentralized system of data entry to be done at the centres itself and a web based system of reporting and monitoring has been put in place.

All the centres are connected to SACS through Internet. It is reported that Tamilnadu is the state in which a decentralized online system of reporting and monitoring has been put in place for the first time in the country.

The features of the system are

- Timely data collection is ensured as the data is entered as soon as it is collected from each of the centres.
- Easy to use and comprehensive data entry and reporting interfaces are developed for this purpose.
- Validation mechanisms built in the system at the form-level and data-level ensures the availability of valid data in the system
- Cohesive and well-managed authentication and authorization mechanism implemented in the system prevents unauthorized persons from hacking the resources of the system.
- Wide variety of reports are available in the system which enable speedy and accurate decision making process

Line Listing of Positive Mothers:

Line listing is a name based reporting from the Integrated Counseling and Testing / PPTCT Centers. The main objective of the line listing is to improve the administration of Nevirapine to both HIV positive mothers and babies born to them and to improve follow up of the mother and children.

The line listing system for tracking of HIV positive mothers and their babies is being implemented in Tamil Nadu from 2007 onwards. The following details are being collected in this system:

- a. Information about the mother
- b. Spouse particulars
- c. Pregnancy particulars i.e LMP, EDD etc
- d. Particulars of tests underwent
- e. Delivery details
- f. Particulars about administration of NVP
- g. Referral to ART Center, if any
- h. Follow up and information about testing of babies

Implementation of line listing

The implementation of line list system involves a perfect coordination between the NGOs and the ICTCs. Once a pregnant woman is identified as HIV positive, willingness of the woman for home visits will be obtained by the counselor. A separate book containing the particulars of the woman will be opened. This book has been standardized and printed by the TANSACS and supplied to all the ICTCs / PPTCTCs

These books will be handed over to the concerned NGO / Outreach Workers (ORW) during the monthly meetings conducted by the District Program Manager (DPM). The outreach worker and Project Coordinator of the NGO will fill up the follow up details in the book assigned to the woman. When the woman is lost to follow up or the follow up period is complete the book will be handed over to the District program manager and they will return the book to the respective ICTCs / PPTCTCs

Every month DPM will send the updated data electronically to SACS office for state level compilation.

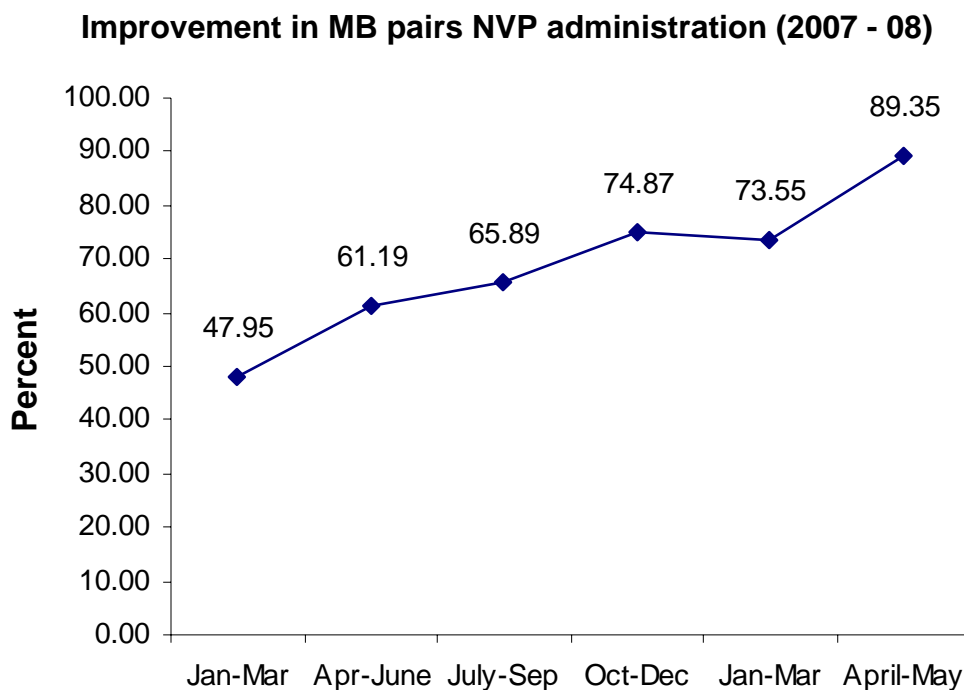
At each level of data exchange, strict confidentiality measures have been ensured by the DPM and SACS officials.

Monitoring of line listing process

A structured monitoring process is in place to monitor the line listing process.

- ❖ First day of every month the DPM conducts meeting with all the ICTC counselors in the district. In this meeting the DPM collects the book and reviews the previous month's data on nevirapine administration.
- ❖ Third day of every month DPM conducts meeting with all the outreach workers in the district. In this meeting the outreach activities relating to follow up of the mothers are reviewed.
- ❖ Updated line lists are sent to SACS before 7th of every month and they are compiled. The data from the line list is correlated with the regular MIS data. When any discrepancy is found, the respective DPM will be asked to explain and correct the data
- ❖ Tenth day of every month the SACS officers review the line lists in a meeting with DPMS and NGO representative.

Nevirapine administration to mother baby pairs could be improved after introduction of the line listing process. Every mother is counted and the service delivery is ensured. The improvement in the NVP administration after the introduction of line listing system is shown in the following graph:



Monthly Meetings:

TANSACS follows structured fixed day meeting for the review of the programs. For PPTCT program the schedule as follows

- Every 1st of the month District program manager conducts a meeting with the ICTC Counselors
- Every 3rd of the month District program Manager conducts meeting with NGOs
- Every 10th of the month TANSACS reviews the District Program Managers and the NGOS

In these reviews the following core indicators will be discussed

- Testing particulars
- Delivery and nevirapine administration
- Baby follow-up
- ART referral
- Validation of line list with CMIS data

This systems adopted in TNSACS helps in the delivery of the monitoring data to SACS on time every month, ensures every mothers is being tracked and also reduces the duplication of mothers who have tested more than once in different centers.

APSACS:

There are 469 centres providing PPTCT services in the state of Andhra Pradesh. Monitoring of these centres is done through various modes.

- Through an established monthly reporting system
- Field-based monitoring of the centres by
 - ADMHOs & District ICTC Coordinator in all the districts
 - DPMs in the 10 high burden districts (East Godavari, West Godavari, Krishna, Guntur, Nellore, Prakasam, Kadapa, Nizamabad, Karinmagar & Khammam)

- APSACS officials
- Implementing partners
- Review meetings:
 - Of the Counselors at the district level at quarterly intervals
 - Review process for monitoring the performance of Lab Technicians at district level is being initiated by the State Reference Laboratories
 - Of the District ICTC Coordinators every month at State level
 - ADMHOs meeting every quarter
 - Of implementation partners every month
 - With SACS Program Officers / Consultants by NACO quarterly.

In all the PPTCT centres a monthly reporting system has been put in place as per the guidelines of NACO. All the Team leaders (Medical Officers in Charge of PPTCT), Counselors, Laboratory Technicians have been trained in the maintenance of input registers and the reporting formats during induction & refresher trainings. As per the guidelines of NACO under NACP-III all the new registers and the reporting system has been put in place and required trainings, printing and supply of registers to the centres has been completed. All the PPTCTCs are reporting to APSACS in the newly implemented formats since Feb 2008.

The Counselors & Lab Technicians prepare their monthly format every month. At the end of the reporting month, review meetings are conducted by ADMHOs at the district level, where the performance of the counselors is reviewed and the monthly formats are checked for their completeness and in terms of quality.

Districts with DPM Teams (10 Districts): All the monthly formats are compiled and the trained M&E Officers in the 10 high burden districts enter the data at the district level in the web-based ICTC MIS, which is linked to NACO-CMIS.

District without the DPM Teams (13 districts): All the monthly formats are compiled and sent to SACS and the data entry is completed at the state level in the web-ICTC MIS. From this MIS, the data is imported to NACO-CMIS.

Innovation in PPTCT Program: In APSACS also the system of Line-listing was introduced in the PPTCT program to track all the positive ANC women from the time of diagnosis of HIV +ve status till the baby is 18 months old so as to efficiently follow up each of such women and also to help the program officers in evaluating the effectiveness of the intervention in a more scientific manner.

The Positive ANC Line list system in Andhra Pradesh was started in June 2007 with an aim of efficient tracking of the HIV positive ANC cases.

All the ANC cases coming to the ICTC / PPTCTC will be recorded either in the OP register or the counseling register. After registration, the ANCs will go to the OBG / ANC clinic and get checked up by the doctor. From there all ANC cases will be referred to the PPTCT counselor. The counselor must enter the details of the cases in the PID Register first and subsequently they must do a “Group Counseling” for all the ANC cases. All the cases, unless opted out, will be referred to the lab technician. Once the testing is carried out, the lab technician must write the report and get it signed by the Medical Officer in-charge for the ICTC / PPTCT.

Details of all the HIV positive ANC cases are recorded in the “Positive ANC Line-list Register”, while handing over the test report during the post-test counseling. Details of the entries made in the Positive ANC Line-list Register are given in Annexure II of this report.

In “Positive ANC Line-list Register”, each column is meant for filling details of a single complete case from the time an ANC woman is found positive till her baby becomes 18 months old and tested for HIV.

The information about the Positive ANCs, which includes the expected place of delivery of the pregnant woman as recorded in the line list register, will be provided to the ORWs in the Positive ANC Line-list Format on a monthly basis, depending on their area of functioning, if the woman is staying and going to deliver within the same NGO area. If the ANC case is going to deliver in a different location (outside the jurisdiction of the PPTCT & NGO), but within the same district, the details of the woman are handed over to the concerned ICTC / PPTCT counselor in the monthly meeting for further follow up. If the ANC case is going to deliver in a different district, the line-list details are handed over to the DIC and the information will be passed on to the DIC of the district where the woman is expected to deliver. In case the woman is expected to deliver in a different state, the details will be handed over to the DIC clearly mentioning the name of the state where she is going to deliver.

Data Management: Once the data entry is complete, all the data related to PPTCT is exported to CMIS, which has in-built analysis module.

With the help of validations, it is checked for completeness of reporting and completeness of data. In case of in-correct data or missing data the concerned District ICTC Coordinators or the respective Counselors / Lab Technicians are contacted for clarification and if any corrections are required, a fresh report is again submitted to SACS from the concerned ICTC (PPTCT) incorporating the necessary changes. The District ICTC Coordinator is requested to follow up such centres producing erroneous reports frequently to minimize data mismatch.

After completion of the data entry, a summary report is prepared and submitted for feedback and necessary action to

- Project Director
- Component Officers
- District Officials
- Implementing Partners

Maharashtra SACS:

There are 604 ICTCs scattered all over the state of Maharashtra excluding Mumbai. The state is divided into 7 regions and each region is headed by a Deputy Director. At district level Civil Surgeon is the administrative head who is responsible for monitoring the performance of PPTCT centres in the district. Monthly monitoring reports are obtained from all the centres and the civil surgeons take review of ICTCs at monthly meetings conducted at district level on 3rd, 4th and 5th of every month. At state level review meeting is held at Maharashtra SACS on 8th of every month. This meeting is attended by the civil surgeons and during this meeting a detailed review of ICTCs / PPTCTCs is taken with respect to their performance.

Mumbai DACS:

There is a PPTCT Programme Supervisor at DACS level designated to look after the monitoring and smooth functioning of the centers.

The PPTCT centers are visited by the supervisor on a regular basis. During the visit the data available in the center is checked and verified thoroughly. Registers are checked to see whether the patient information is appropriately filled. Stock of Nevirapine and other consumables is verified.

Counseling sessions are observed. Proper use of flipcharts and other material during group counseling is ensured.

During every visit PPTCT checklist are filled by the supervisor to ensure appropriate monitoring of the center at the time of visit. Counselors & technicians are asked to incorporate the changes recommended by the supervisor if errors are found in the data or if the records are not completely filled. All the observations by the supervisor are written in visit book of the center. To ensure whether the recommended changes are made or not as per the directions, the visit book is checked on the next visit.

The visit reports are shared with the superiors and accordingly the centers are given written instructions, if found defaulting. Monthly visit reports of the supervisor are submitted to MDACS.

Every month the PPTCT monthly data is checked for any errors and is tallied with the CMIS submitted by the center.

PPTCT patients are tracked case by case for delivery according to their respective due dates. This ensures the follow up of the patients for institutional deliveries.

Manipur SACS and Nagaland SACS:

In both Manipur and Nagaland State AIDS Control Societies the M & E system runs by obtaining monthly reports in the prescribed formats from the PPTCT centers. Meetings are conducted at district level by the CMO / DAO along with the district supervisors and counselors to review the performance of the PPTCT centers and to ensure the correctness of data furnished by the centers. At the SACS level there is a deputy director assisted by an M & E officer who conducts meetings with the district supervisors and the CMOs / DAOs. However, it is observed that none of these meetings are conducted at regular intervals. There is a need to strengthen the M & E system in these states.

V. Assessment of the effectiveness of NGOs

All the surveyed PPTCT centres except those located in Karnataka and Nagaland have NGOs associated with them for performing the outreach work of mobilizing the pregnant women to attend ANC, follow up of HIV positive pregnant women and administration of prophylactic dosage of NVP and follow up of post natal HIV positive women and their babies.

Table 6.2 presents the data pertaining to number of pregnant women mobilized by the NGO to attend the ANC and counseling session

Table 6.2:

	2004-05	2005-06	2006-07	2007-08
Andhra Pradesh	70	13260	35610	42861
Karnataka	-	4763	4240	5159
Maharashtra	-	-	7151	29275
Manipur	-	2044	3210	1643
Mumbai	-	-	16	624
Nagaland	-	429	386	74
Tamilnadu	145	9700	32105	35519

Table 6.3 presents number of HIV positive mothers covered for follow up by the NGOs in different states

Table 6.3:

	2004-05	2005-06	2006-07	2007-08
Andhra Pradesh	9	106	960	960
Karnataka	-	228	313	295
Maharashtra	-	12	31	313
Manipur	-	29	66	53
Mumbai	-	-	3	403
Nagaland	-	-	-	-
Tamilnadu	-	70	263	269

In the states of Andhra Pradesh, Maharashtra, Tamilnadu and the city of Mumbai the performance of NGOs is found to be improving with respect to the mobilization of pregnant women to ANC. In all the SACS where their services are availed, the NGOs have linkages with institutions like anganwadis, spiritual societies and persons like school teachers and opinion leaders in villages. With the help of these groups they are able to penetrate into the society for mobilization of pregnant women. However, it is to be noted that the number of women mobilized by NGOs in these states as percentage of the total ANC registrations in the respective states is very low. In the remaining states surveyed, i.e. Manipur, Nagaland and Karnataka, the role of NGOs in mobilization of pregnant women to ANC is negligible.

The role played by NGOs in keeping track of the HIV positive pregnant women and administration of prophylactic dose of NVP to them also seems to be grossly

inadequate as portrayed by the data pertaining to the NVP administration to mother baby pairs. However, in the states of Tamilnadu and Andhra Pradesh steps taken in the direction of proper monitoring in the form of line listing and online data entry are yielding better results and the performance is found to be good during 2007-08. In Nagaland and Manipur the system for monitoring the functioning of NGOs is very weak. Hilly terrain in the states makes accessibility to habitations difficult and the follow up work is severely hampered.

None of the NGOs in any of the surveyed states, except in Tamilnadu to some extent, are faring well with respect to follow up of HIV positive mothers and their babies. The fact that very few babies borne to HIV positive mothers are brought for follow up and tested at the age of 18 months to establish their HIV status speaks of the inadequate functioning of the NGOs with respect to this important aspect of the programme. Employing PLHAs / social workers who work directly under the control of the PPTCT centres may be a better option for outreach work. This might give a better monitoring edge and help in improving the follow up.

In Karnataka it is reported that the MoUs with NGOs expired by 31st March 2008 and fresh MoUs are to be signed between the SACS and the NGOs for extending their tenure. In Nagaland the services of the NGOs for PPTCT are discontinued with effect from 31st March 2008.

VI. The assessment of the system of follow up of HIV positive mother and children given NVP

The performance with respect to the follow up of HIV positive mothers and their babies is found to be poor in all the states, except Tamilnadu, with some degree of variation. However, in the state of Tamilnadu during the last three years of the programme the performance concerning the follow up of positive pregnant women and their babies improved considerably.

The number of babies tested at the age of 18 months is found to be less than that brought for follow up. This shows that testing of all the babies brought for follow up at the age of 18 is also not ensured. The details pertaining to follow up of HIV positive mothers and their babies is presented in Chapter I of the report.

VII. Assessment of the client (patient) satisfaction with regard to the services provided in the PPTCT Centres

This component deals with the client satisfaction with respect to the accessibility of the center, referrals, cleanliness and other conditions of the center, counselor services provided, treatment received in the centre, care and support and overall satisfaction about the PPTCT services.

A total number of 115 clients were interviewed from the states of Andhra Pradesh, Karnataka, Maharashtra, Tamilnadu, Maniur, Nagaland and the city of Mumbai. Table 6.4 gives the details of the clients covered for client satisfaction interviews.

Table 6.4:

State	HIV positive pregnant women	HIV negative pregnant women	Husbands of +ve pregnant women	HIV +ve pregnant women received NVP	Total
Andhra Pradesh	9	8	6	9	32
Karnataka	6	9	7	11	33
Maharashtra	7	6	6	9	28
Manipur	1	1	0	0	2
Mumbai	0	1	2	2	5
Nagaland	1	0	0	0	1
Tamilnadu	6	4	3	1	14

Awareness about the PPTCT center

Figure 6.5

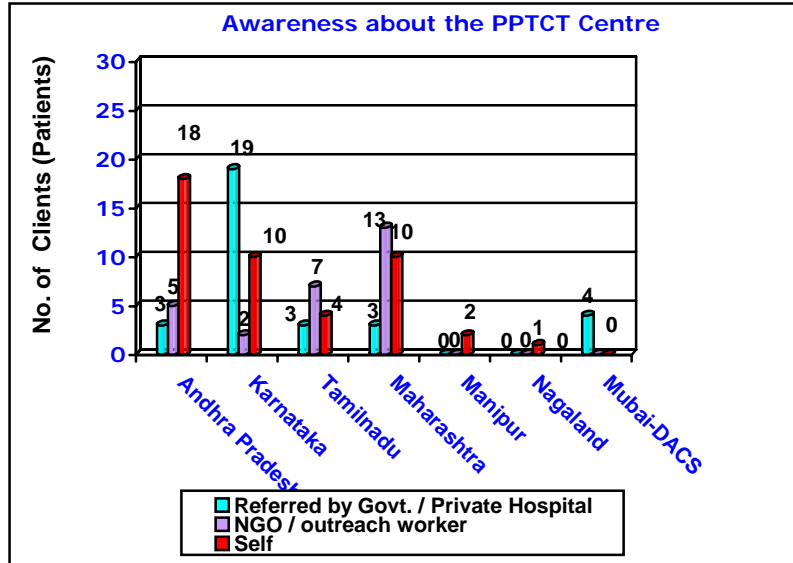
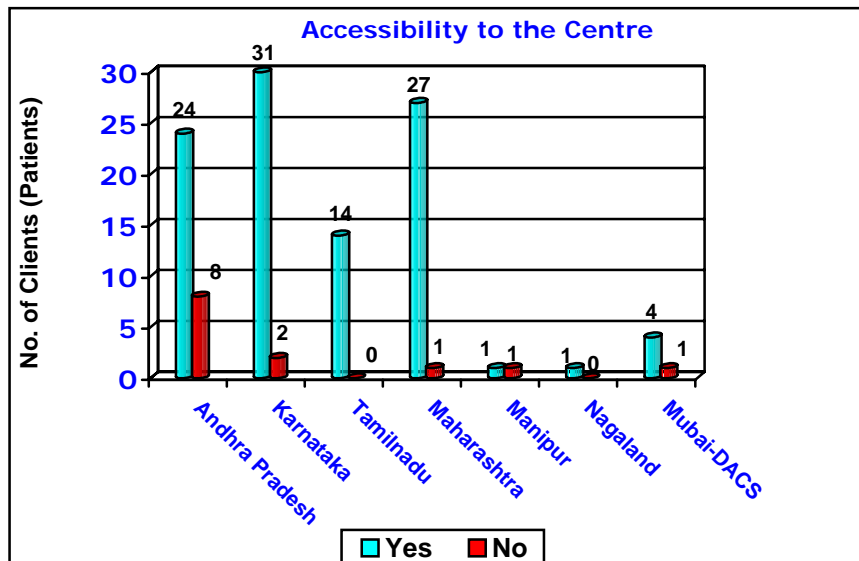


Figure 6.5 shows, the status of referral of clients to the PPTCT center. In States of Andhra Pradesh and Maharashtra most of the clients came to the PPTCT centres on their own. Whereas in Karnataka and Mumbai DACS most of the clients were referred to the PPTCT centres by either Government or Private Hospitals. In the states of Tamilnadu and Maharashtra several of the clients accessed the center through NGOs.

Accessibility to the Centre

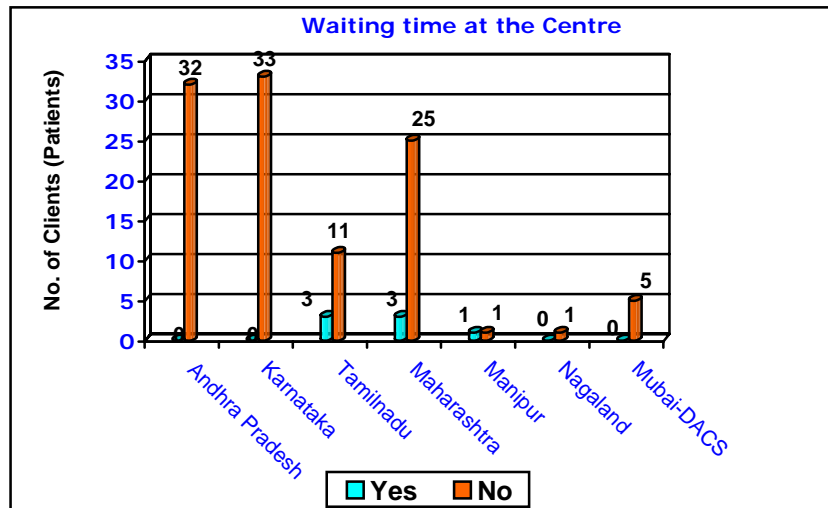
Figure 6.6



Most of the clients in all the states find it easy to locate and arrive at the centre. However, about 25% of the clients in Andhra Pradesh, 9% in Karnataka, 3% in Maharashtra find it difficult to access the centre.

Waiting time at the Centre

Figure 6.7

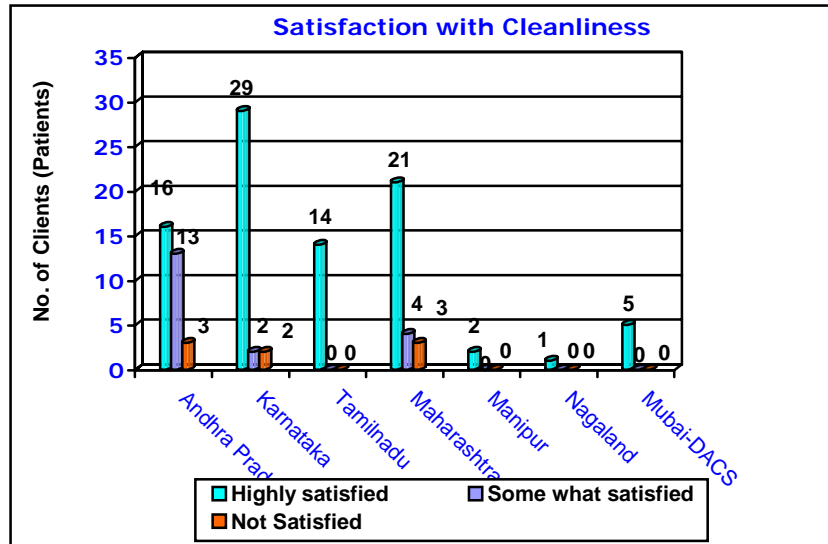


When asked about the time they spent in waiting before meeting the counselor, except for a few clients in the states of Tamilnadu and Maharashtra, all the clients told that they had not waited for a long time for meeting the counselor nor they required any prior appointment to meet the counselor. For most of the patients the test results are delivered within 24 hours. This is an indication of easy and speedy accessibility to the counseling services.

Client Satisfaction with amenities in the centres

Cleanliness

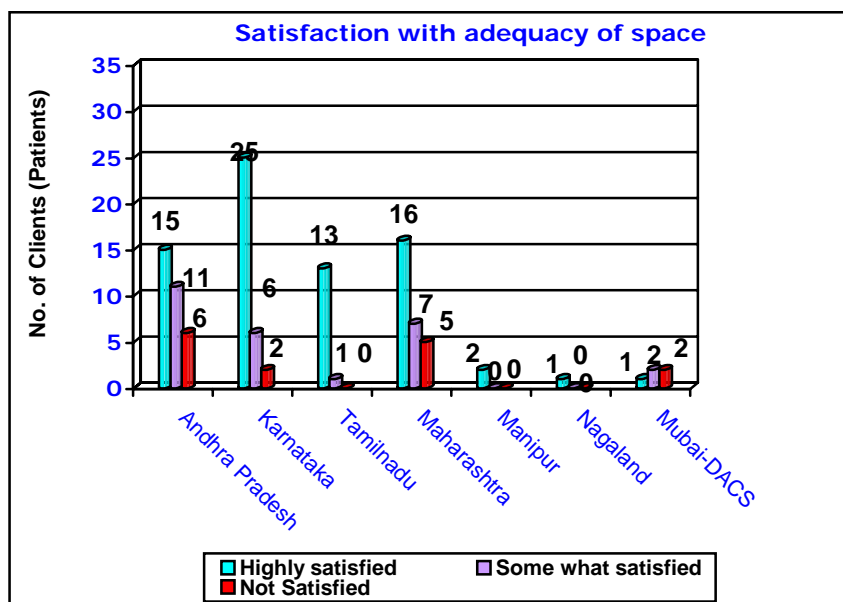
Figure 6.8



In the surveyed centres, a majority of the patients were highly satisfied with the cleanliness in the centre. In Andhra Pradesh, several clients were not very much satisfied with the cleanliness maintained in the centres. It is to be noted that in a small number of clients in Andhra Pradesh, Karnataka and Maharashtra expressed their dissatisfaction.

Adequacy of space

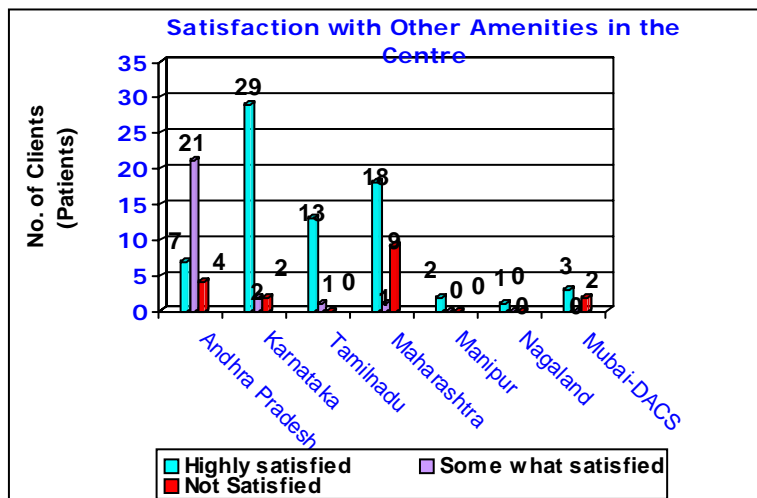
Figure 6.9



The response with respect to satisfaction with the adequacy of space was mixed. Though majority of the clients expressed their satisfaction, there was also a negative response from several of the patients. Similarly, the response with respect to privacy in the centre also evoked a mixed response with a majority of the clients expressing their satisfaction and some of them saying that they were not satisfied with the privacy available in the centres.

Other amenities

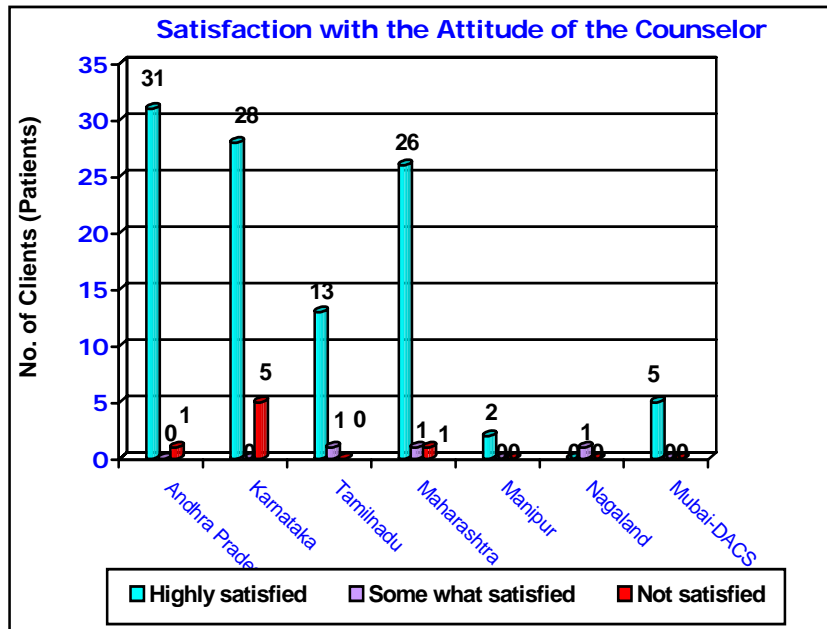
Figure 6.10



The satisfaction levels with respect to other amenities like provision of drinking water and toilets in the PPTCT centres in Andhra Pradesh seem to be of low level, if not negative. In Maharashtra several of the patients were not satisfied with these amenities available in the centres. However, in the remaining states most of the clients expressed their satisfaction.

Client Satisfaction with the Attitude of the Counselor

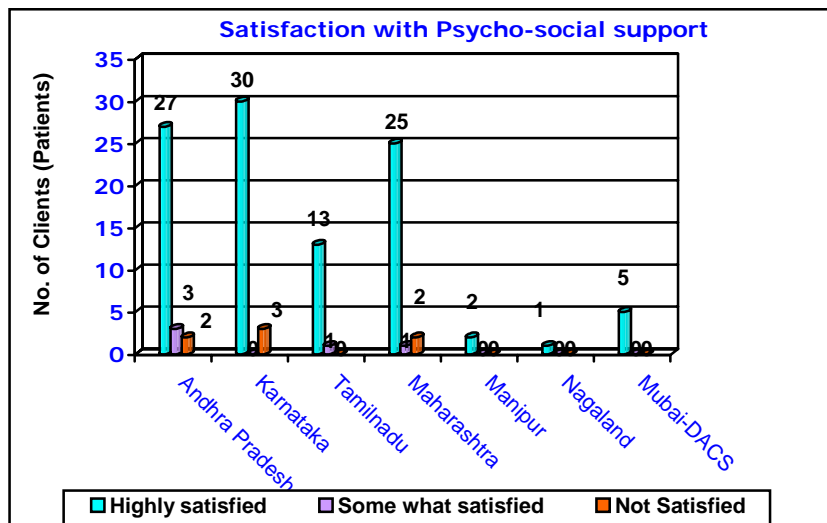
Figure 6.11



The satisfaction levels with respect to the attitude of the counselors in the PPTCT centres in all the centres were found to be very high. However, in Karnataka 5 out of the 33 clients interviewed expressed their dissatisfaction in this aspect. Counseling is a very important component of the PPTCT programme and the data is reflective of the efficient working of the counselors in most of the centres surveyed.

Satisfaction with the Psycho-social Support

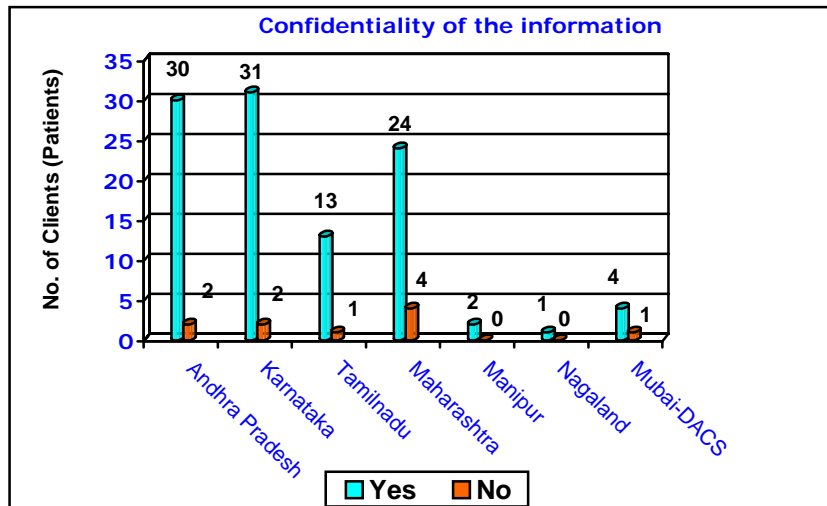
Figure 6.12



Similar to the attitude of the counselors, the satisfaction levels with respect to the psychosocial support provided by the counselors and other staff of the PPTCT centres are found to be very high among the clients.

Confidentiality of the information

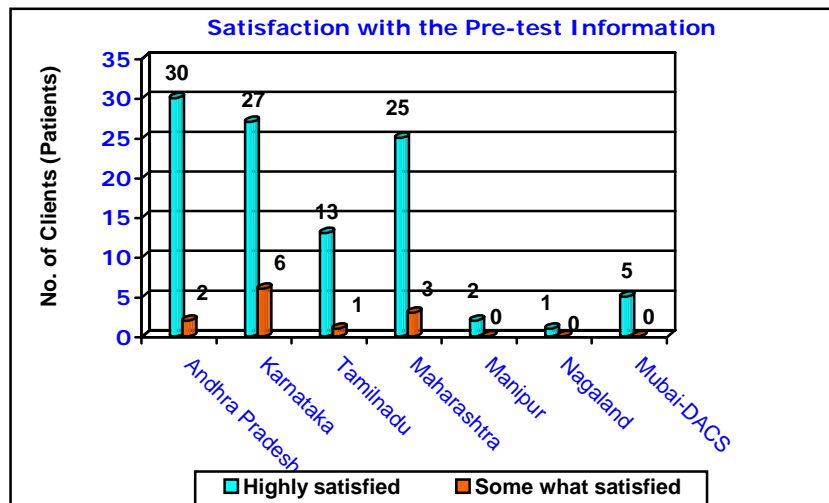
Figure 6.13



The above graph reflects the element of confidentiality maintained by the counselors in keeping the data pertaining to the clients in the respective PPTCT centers. Most of the clients, across the centres surveyed, expressed their utmost confidence in the counselors in the PPTCT centers.

Satisfaction with the Pre-test Counseling

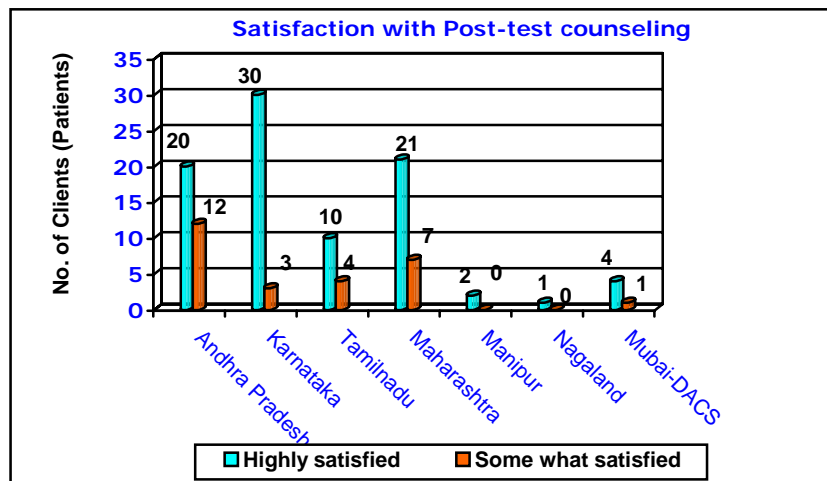
Figure 6.14



The response evoked from the clients with respect to pre-test counseling is positive in spite of the varying degree in the level of satisfaction. It can be observed that most of the clients had expressed their utmost satisfaction with this important component of the programme. While the satisfaction levels of some of the clients were found to be low, there was no negative response from any of the respondents.

Satisfaction with the Post-test Counseling

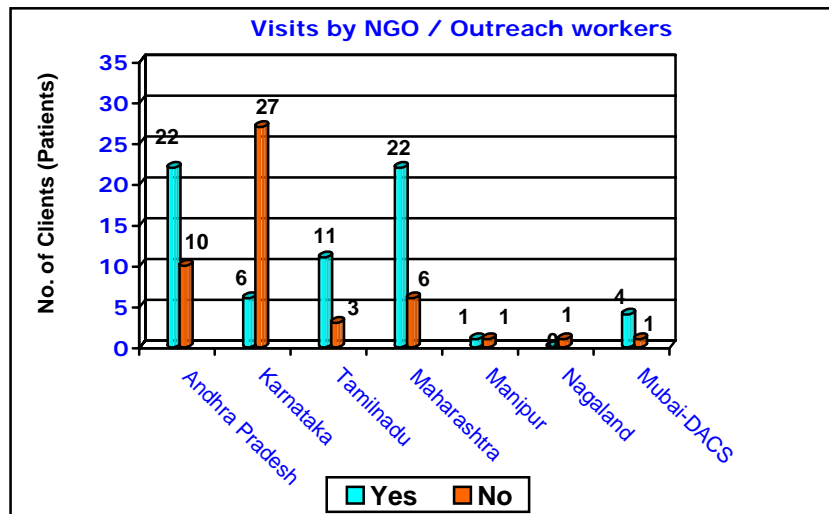
Figure 6.15



The response with respect to post-test counseling evoked a more or less similar response as that of pre-test counseling. Though none of the clients gave a negative response, 12 out of the 32 clients in Andhra Pradesh expressed a low level of satisfaction with respect to post-test counseling.

Visits of NGO / Outreach Workers

Figure 6.16



In the states of Andhra Pradesh, Tamilnadu, Maharashtra and the city of Mumbai most of the people said that the NGOs / outreach workers visited their homes. In the state of Karnataka 27 out of the 33 clients said that no outreach worker ever visited their homes. There was a similar response from 10 out of 32 clients in Andhra Pradesh. In Nagaland the lonely patient who was interviewed for client satisfaction also responded negatively.

Only 35 of the 115 patients who responded to the questionnaire were referred to ART centres for treatment. All of them expressed their satisfaction with the services offered in the ART centres.

When asked about the overall opinion about the services offered by the respective PPTCT centres, all the clients responded positively.

CHAPTER 7

RECOMMENDATIONS

With respect to the important parameter of administration of NVP to mother baby pairs, the performance of states like Andhra Pradesh and Tamil Nadu is commendable. Pertinent measures should be initiated by the other states for the improvement of performance in this regard. Lack of proper monitoring and tracking of pregnant mothers and more number of home deliveries than institutional deliveries in the north-eastern states (12.5% as revealed during the discussions with the NSACS officials) were found to be the major reasons for poor performance. Methods like line-listing of pregnant women followed in the states of Tamil Nadu and Andhra Pradesh resulted in an improved performance with respect to administration of NVP. This can be implemented in the other states also and the results can be compared.

Institutional deliveries in the states of Tamil Nadu and Andhra Pradesh were found to be over 90% and 80%, respectively, during the year 2007-08. This gives a better scope for NVP administration for mother baby pairs without fail. The line-listing system adopted by these states might have helped them in proper tracking of the pregnant mothers and taking appropriate steps for ensuring their deliveries in hospitals. In states like Manipur and Nagaland where the system of home deliveries is prevalent, the services of mobile units can be utilized to ensure delivery of pregnant women under the supervision of trained health care professionals and administration of NVP without fail. Strengthening of the health centers for the institutional deliveries, partnerships with the private institutions, intensified awareness campaigns etc., would also help in effective implementation of the programme.

In the states of Andhra Pradesh, Tamilnadu, Karnataka and Maharashtra there are several nursing homes/maternity homes catering to the needs of people from different walks of society. Several pregnant women visit these centres for undergoing deliveries and there is always a possibility of these deliveries being left unreported. There is a need to generate awareness among private medical practitioners and integrate private nursing homes with

the PPTCT programme which widens the scope for proper monitoring and tracking of the HIV positive pregnant women and thus aids in the successful implementation of the programme. In Tamilnadu steps are being initiated in this direction.

It is found that not all the babies, borne to HIV positive mothers, who were brought for follow up at the age of 18 months are tested for their HIV status. This is observed in the states of Andhra Pradesh and Tamil Nadu also. This could not be explained even by the concerned officials. However, in Andhra Pradesh it is reported, that these babies are taken to ICTC centres for testing and because of lack of coordination between ICTC and PPTCT centres these cases are not reported. Proper coordination between these centres might help solving the problem. Though NVP administration is of paramount importance in the PPTCT programme, it is also important to know the HIV status of the borne babies to determine the success of the programme. Hence, testing of the babies at the age of 18 months is also to be carried out without fail.

Though there is a considerable increase in the number of women attending pretest counseling, not all the women registering for ANC are attending pretest counseling or accepting the HIV test. In most of the centres the pretest counseling is group counseling with a one way communication from the counselor to the pregnant women. Possibility of making HIV testing routine as part of ANC services may be considered. This will ensure testing of every pregnant woman attending ANC.

Post test counseling is also as important as pre test counseling. It seems that there is lack of focus in the states of Andhra Pradesh, Maharashtra on this important component. In Andhra Pradesh about 38% of the patients interviewed for client satisfaction survey have expressed low level of satisfaction with respect to post test counseling. There is a need to bring down the work load on the counselors and improve facilities in the counseling centres.

Coming to the monitoring of the PPTCT programme, a strong system is found to be in place in the state of Tamil Nadu followed by Andhra Pradesh. In the remaining states, especially Karnataka and Nagaland, it requires lot of strengthening. Engaging outreach workers from NGO organisations for this aspect of the programme is advisable but there should be a proper mechanism to motivate and mobilize the ORWs by way of review meetings and performance evaluation. Offering incentives for better performance may be productive. In states like Nagaland and Manipur accessibility is a problem for the NGOs and the coordinating staff associated with the programme implementation. Hence, aspects like accessibility and rough terrain should be given due consideration while evolving a suitable monitoring mechanism.

The data management at state level in several of the surveyed SACS is found to be in a poor state. Much of the important data is either not fed into the MIS or highly inconsistent. Utilisation of services like WAN may be beneficial in maintaining a proper database. The data management should be under the supervision of qualified and experienced professionals to ensure quality and consistency.

The system of Voucher Auditing followed by TANSACS is said to be yielding good results with respect to the monitoring of expenses by the NGOs. Inculcation of financial discipline, adherence to budget line items and arrest in the leakages is ensured by this system. This also may be taken as one of the models for financial monitoring by SACS.

In some of the states like Maharashtra, the counselors are over burdened. Instance of one counselor being in-charge of two or more centres are noticed. This might result in inefficient delivery of the assigned duties. It also to be ensured that the remuneration to the counselors and other staff associated with the programme is paid on time. Increased client load, time constraint, lack of support from the local authorities, no privacy or enough space to conduct counseling sessions in the hospitals are observed to be some of the challenges faced by the counselors.

The system adopted for follow up of HIV positive mothers and their babies seems to be not effective. Even in states like Tamil Nadu and Andhra Pradesh where there is an effective mechanism to track the pregnant mothers to ensure administration of NVP to mother baby pairs, the number of babies brought for follow up is far lower than the number of live births to HIV positive mothers. The tracking mechanism should be extended beyond NVP administration to ensure that the babies are brought for follow up to ensure testing to establish their HIV status. Proper mobilization of the ORWs in this direction is also essential.

There is a system of “Nurse Practitioners” being adopted in the state of Andhra Pradesh. Nurse practitioners are those persons who play the role of a nurse, a counselor and also an outreach worker. This can be taken up in other states also on an experimental basis and later extended depending on the effectiveness. This might help in optimal utilization of resources for the effective implementation of the programme.

Linkage of the programme with other health related programmes implemented either by the state Governments or Central Government also may be useful. An example is linkage of PPTCT programme with “Yashasvini”, a health care insurance scheme for rural people initiated by the Government of Karnataka. An annual premium of Rs. 30 per person is charged in this scheme and health care is provided in identified Government and private hospitals. PPTCT programme is linked with this and deliveries of HIV positive women are tied to Yashasvini scheme. The doctors and other health professionals who take up positive deliveries receive additional payments. In states like Andhra Pradesh where schemes like Rajiv Arogyasri are being implemented, this type of linkages may be helpful. In Tamil Nadu also, as revealed during discussions with SACS officials, such linkages are being proposed.

With respect to the assessment of graduated cost recovery scheme for delivery of ART through public private partnership, none of the three assessed organisations, YRG CARE, ARCON and Freedom Foundation, could meet the target of number of patients on ART. However, the performance of Freedom

Foundation is found to be better with over 96% achievement. The next is YRG CARE with 77% followed by ARCON with 73% achievement respectively. Here it is to be noted that though Freedom Foundation achieved 96%, the system of 0%, 25%, 50% and 100% cost recovery from the patients is not followed by this organization. These centres are facing a stiff competition from the other Government run centres as treatment from the latter is free of cost irrespective of the social and economic status of the patient. Under these circumstances the future sustainability of these centres may turn out to be difficult. NACO may take appropriate measures either to wind up these centres or offer free treatment from these centres also.

ANNEXURE – I

SUCCESS STORIES

Veena a young primi gravida who attended the counseling session at Government Maternity Hospital, Warangal was found to be HIV positive. He was in her 5th month of pregnancy. Her husband died in a road accident. He was also HIV positive. Under these grave and shattering circumstances, she had no motive or will to live her life. She was counseled by the concerned medical officer. After attending the counseling session, she started developing a positive attitude towards life with a hope of seeing her baby fully healthy. She and her new born baby were given the necessary treatment to prevent transmission of HIV from mother to child. Her son who is three years old now is HIV negative and healthy. She was also put on ART which led to improved CD4 count and she is leading a normal life presently. There are many patients like this who lost all hope on life but regained confidence because of the counseling offered in the PPTCT centres and living to see the dawn of a new era thanks to the programme of Prevention of Parent to Child Transmission of HIV.

Well Baby Show by APSACS for Dissemination of Information

Andhra Pradesh State AIDS Control Society had organized a well baby show on 21st August, 2008. A total of 36 HIV positive mothers along with their HIV negative babies attended the show. All these mother baby pairs received NVP. The aim of the show was to educate the parents about the benefits of PPTCT Programme. The objectives of the show are:

- To educate the parents about proper health, immunization and nutrition habits for their children and strengthening mothers forum
- To motivate the mothers for mothers forums and sensitize new ANCs cases

- To inform the mothers to encourage other positive women for institutional deliveries and NVP administration and bring zero positivity among new born infants
- To promote infant feeding and family planning among the positive mothers

Radio Talk Show-TNSACS

A Radio programme on HIV/AIDS has been launched by TANSACS from 22nd April to be broadcast on every Tuesday for the next 26 weeks. This programme is broadcast simultaneously from eight All India Radio Stations located in Chennai, Trichy, Coimbatore, Karaikkal, Kodaikanal, Nagercoil, Pondicherry and Tirunelveli. The programme is being broadcast on all Tuesdays between 1.00 pm and 1.30 pm with a rebroadcast on every Friday between 8.00 p.m and 8.30 pm. Though the programme would cover all aspects of HIV/AIDS, the focus would be on prevention of Parent to Child Transmission. The programme would cover various aspects of HIV/AIDS like myths and misconceptions, importance on prevention, Anti-retro Viral Therapy, HIV testing, Blood Safety, Rehabilitation Programmes etc.

Each half an hour programme has been further subdivided into 3 slots consisting of

1. A news feature of 3 to 4 minutes,
2. Followed by a 15 minute live phone in program with an invited studio guest.
3. And about 9 minutes of individual programming by the local stations.

It is planned to cover one topic every week. The AIR professionals who are hosting the talk show are trained by Internews Network in coordination with TNSACS. The objective of the training was to give the right information about HIV/AIDS to the radio professionals in particular about the PPTCT programme thereby enabling them to produce a total of 24 original news features about the various topics.

The trainees were selected jointly by All India Radio and Internews Network based on the journalists' experience, interest and attitude towards health/social issues. A custom made curriculum was designed and training was imparted for 5 days. The training period included field visits to the ICTCs, ART centres and interaction with the community members. By the end of the 5 day training programme each of the Radio Professionals had produced a news feature and edited and completed the same. It was also ensured that, the trainees followed the basic principles of journalistic ethics and had editorial independence for the creation of their news features.

Another one day meeting was held in the month of March 2008 to summarise the programme and finalise the schedule of the programme including the date of launch etc. The meeting was organised by TNSACS, in which the Deputy Director General AIR (South Zone) with the Station Directors had participated. All the 27 trainees participated in this meeting and certificates were awarded to them.

Before the launch of the programme, TNSACS also selected appropriate studio guests for each of the 8 news stations for all the 26 weeks and communicated to the AIR so that the information given to the public by the studio guests will be correct.

Success Stories from ART Centres

Mr. R, 24 years, Male was referred to YRG CARE in December 2004. He was a worker in a welding shop in Tirupattur. He was finding it difficult to withstand the physical strain. His CD4 count was 43 and Hb 9.4 at the time of registration at the centre. He also had abdominal TB. He had multiple blood units transfused. He was put on ATT and two months later he was enrolled for ARV on tier 1 of GCR (0% cost to be borne by the patient) with a CD4 count of 189. Today he is free of all opportunistic infections and has a CD4 count of 675 and Hb of 12.5gm. Mr. R is back to the welding shop and earns enough to support himself and his mother. He has promised when he earns more he would move to Tier 2 (50%).

Mrs K, 19 years, a widow with a baby girl came to YRG CARE in 1997. Her late husband was working in a Government of India concern, which refused to offer a job to Mrs. K on compassionate grounds as she was HIV positive. Her baby girl died at the age of 7 years. She could not afford to undergo a CD4 count testing and YRG CARE laboratory had not started doing CD4 tests at that time. She developed Tuberculosis in 2000 and was treated. Her CD4 was 320 after completion of ATT. She developed diarrhea and skin lesions. In January 2005 her CD4 count dropped to 104 and she was put on 1st line Antiretroviral Therapy. She could not afford the treatment and was waiting for the GFATM project to roll out. She was enrolled in Tier 2 (50%) and there was no looking back. Her CD4 went up to 750 in 2007. Her desire was to get married and hence YRG CARE matrimonial service arranged her marriage with a HIV positive person from Delhi in 2005. Later he got transferred to Chennai and now he is enrolled in Tier 3. Today she is a proud mother of a HIV negative baby boy.

Mrs. K.S. a HIV positive woman was 18 years old when she came to YRG CARE in 2002. Her husband Mr. T, a farmer, was also HIV positive. Her CD4 count was 14 and fortunately GFATM project was available and hence she was put on Tier 3 (75%) of GCR. Her CD4 count soon went up and in a year it was 203, and today her CD4 count is 487. Meanwhile, she desired to have a baby and at full term had a caesarian section in 2007 and now has a baby boy. Her husband Mr. T's CD4 count dropped to 29 and he was also put on ART in GCR Tier 2 (50%) as his wife was already paying 75%. Both of them are very regular and 95% adherent and the husband's CD4 count is 483 today.

Mr. S, a 29 year old business man, came to YRG CARE in September 2004 with Cryptococcal Meningitis and PCP. His CD4 count was 11 and Hb was 7.9 at the time of registration in the centre. He was very critical when he came to YRG CARE and subsequently was admitted to the in-patient care facility. He was transfused several units of blood and treated for opportunistic infections. Since

he could afford to buy medicines he was enrolled in GCR Tier IV (100% payment option). Today his CD4 count is 459 and Hb is 13.6. Presently he is a successful business man and also looking for a suitable bride from YRG CARE matrimonial service.

The Treatment Buddy

Freedom Foundation has a support group for PLHA on HAART. This is an adherence support group where the members meet every 2 months. The attendance to the meetings is voluntary and generally about 30-40 PLHA attend the meetings. They talk about various issues that affect their treatment such as family support, finances, etc. They also talk about methods they follow to ensure adherence (eg: alarm on the mobile phone). During this meeting, medical experts are also called to discuss various health issues.

Another method adopted is called the “Treatment Buddy”. One PLHA chooses another as his / her buddy. With most people having mobile phones, they keep in touch with each other and also motivate each other to adhere to treatment. Currently there are 10 such pairs who have been going strong for over a year. In case one buddy de-defaults, the other buddy usually advises him/ her on the importance of adherence. If the defaulting continues, he/she also reports the matter to the ART center. The counselors at the HAART center also can get in touch with the ‘buddy’ when a PLHA has not come for follow-up, in-order to enquire about the person. The PLHA feel good to have a treatment buddy who understands and empathizes with him/her.

PLHA Paying for HAART

Mr. KRM is a farmer from Doddabalapura Taluk in Karnataka. When he came to Freedom Foundation / GFATM-2 unit in 2006, he was extremely ill and had been unable to work for more than a year. His CD4 count was 89. He was unable to attend to his routine activities due to the wasting and fatigue that had set in. With a lot of difficulty, he was able to pay only Rs. 200 pm towards his medication. He received support from the centre till he got back on his feet. Within three months,

he started working as a driver and was also coming for regular medical check ups. He not only pays towards his treatment but has also started saving money for a rainy day. His current CD4 count is 552 (in April 2008).

PLHA Gets Free HAART under Freedom Foundation/ GFATM-2 Project

The importance of this program is evident through the story that has been recorded. Ms. UM is about 35 years old, widowed and has a 5 year old daughter who is also HIV positive. She was referred to Freedom Foundation ART centre in Bangalore from another NGO. She had completed her TB treatment and had been referred to the government HAART program since her CD-4 count was very low. After attending the counseling sessions at the government HAART unit, she was disqualified after the interview at the government hospital. The reason stated was that she was unable to understand simple instructions and would most probably default treatment. To add to that, her hearing was also failing and her health was deteriorating. Anorexia had set in and she was bed ridden. Her sister was very upset with the treatment meted out at the government hospital and hence brought her to Freedom Foundation ART centre as a last resort. The mother and child were admitted to the hospital. It took sometime to counsel Ms. UM and finally teach her how to take her medication. At first the medicines were dispensed by the nurses. The next step was to make her take out the medicines on her own in front of the nurses and then swallow them. Finally her sister was also brought in and the treatment was explained to her so that she would supervise Ms. UM at home. She went home and slowly started taking control of her life. This was about 18 months back. In April 2007, she came to the clinic with her daughter. The first thing she told was that she had started working and had earned Rs. 500. Her current CD-4 count is 583. Her child has also completed TB treatment and is on HAART. Both mother & child are on free HAART from Freedom Foundation under GFATM-2.

ANNEXURE – II**APSACS; Details of Entries in Line-list Register**

Sl. No.	Item	Description
(1)	PID No	: As mentioned in the PID Register
(2)	Age	: As given in the ANC Register
(3)	Parity	: No. of earlier deliveries
(4)	EDD	: Has to be calculated as per the formula (LMP, Last Menstrual Period + 9 months and 7 days) and to be entered
(5)	Month of pregnancy	: Pregnancy mostly continues for 9-10 months, so the month of pregnancy in which HIV was diagnosed is to be entered here.
(6)	Husband / Partner's HIV status	: To be collected and entered in this cell. If not yet tested then he has to be motivated for counseling and testing.
(7)	Expected Place of Delivery	: Name of the village / town / city where she is planning to get delivered, along with address, is to be provided here.
(8)	Follow up of ANC case	: Each ANC has to be followed-up minimum for 3 times during her entire ANC period. Each time during the follow up, she has to be counseled for the following issues <ul style="list-style-type: none"> • Nutrition, Warning symptoms, • Institutional delivery and NVP administration, • Family Planning, Breast Feeding & ART <p>The date of each subsequent visit is to be mentioned in this cell.</p>
9,10,11	Date of ANC referred to ART; CD4; Regd No.	: The first day when the ANC cases get diagnosed as HIV positive, they have to be referred to ART centre for Pre-ART Registration and CD4 Testing. Once the CD4 testing is done, they should be advised to come for further follow up and show the CD4 report to the ICTC (PPTCT) counselor, which need to be updated in these rows of the register.

The information entered in the rows from 1-11 are for the details regarding Antenatal period. Subsequent information is to be filled up for the details regarding pregnancy outcomes.

(12)	Outcome of pregnancy	: If ANC case ends up with MTP / abortion / Still birth / death of baby after delivery, the subsequent follow up in the line-list is not required. If there is a live birth, the baby needs to be followed up till 18 months of age
(13)	Date of MTP / Delivery	: In any case the date of MTP / Delivery has to be mentioned in this cell

- (14) Actual place of delivery : Hospital name and location is to be mentioned, e.g, PHC, Rudrapaka, Laxmi Nursing Home, Palakole, etc
- (15) Type of delivery : Code '1' or '2' has to be entered depending on whether it is a normal vaginal delivery (1) or delivery by caesarian section (2)
- (16) Name of doctor / Staff attended to delivery : Gives us the information about the list of people in any particular area providing delivery services to the HIV positive women.
- (17) Family planning operation done during pregnancy : should be filled-up as 'Y' if it is done and 'N' if it is not
- (18) Sex and weight of the baby : To be recorded like this: 'M / 2.5 kg', 'F / 3 kg' etc
- (19); (20) Administration of Nevirapine to the mother & Baby : Administration of NVP to mother and baby is to be recorded separately. If not administered to either of them or both of them mention the reason for not administering.
- (21) Type of infant feeding given : Is to be recorded as '1' if it is exclusive breast feeding and '2' if it is alternate, i.e. anything else than exclusive breast feeding.
- (22) Advised for revisit at 6 weeks : Every woman after delivery is to be advised to come for follow up (start with 6th week of Post-natal period).
- (23) Reference page No. of follow up Register : The post-natal follow up details are to be maintained in the Post-natal Follow up register.
- (24) HIV Status of child (at 6th week, 6th month and 18th month) : The end point of PPTCT program is to test the baby at 18 months to assess the HIV status. There is a scope to assess the HIV status of the babies even before 18th month, by DNA-PCR Testing at 6th week & 6th month. But till the systems of such testing (DNA-PCR) come into practice, the traditional system of 18th month testing is to be relied upon completely and the test result is to be entered in this cell (24).
-

Process of filling up the Line-list:

The whole set of 24 items has to be filled up / updated in various stages.

- Item No. 1-7** : Can be filled in when the client visits the ICTC / PPTCTC for the first time for testing, provided the HIV status of Spouse / Partner is available.
- Item No. 8** : To be updated every time when the ANC woman comes for follow up. The date only has to be updated and she needs to be counseled for various issues related to pregnancy and HIV.
- Item No. 9-11** : These items are related to ART. So all the positive ANC women need to be referred to ART centre for registration and CD4 testing and in the next follow up visits the counselor must enquire from the client and update the same in the line list. In the 10th item, both the CD4 count of the individual and whether she has been put on ART or not to be mentioned. In Item.11, her pre-ART No. (if not put on ART) or ART No. if put on ART is to be filled.
- Item No. 12 to 22** : These items are regarding events related to delivery / MTP.
- Item No. 23 to 24** : These are related to post-natal follow up and testing status at 6th week, 6th month and finally at 18th month.

When to Fill & Update:

- The ANC cases, which are found to be positive, their information is to be filled up (**Item no.1- 7**) and to be **reported to SACS** along with the monthly reporting format.
- Further follow up visits to be updated in **Item No.8**, depending upon the date of visit, but **NOT** be reported to SACS after updating in the Positive ANC Register.
- Visit to ART Centre and follow up at ART centre (**Item No. 9-11**) to be updated in the subsequent visit of the client to the ICTC. This is also **NOT** to be reported after updating in the Positive ANC Register.
- Information regarding MTP / Delivery, taking place in the ICTCs or Private Hospital / Nursing homes / Home delivery / on the way to Hospital etc. is to be updated (**Item No. 12-22**) as and when it takes place or provided by the ORW. This has to be **reported to SACS** without fail along with the monthly reporting format. But while reporting to SACS at the end of the month, all the information from 1-22 has to be filled up in the linelist format.

- Information about Post-natal Follow up and HIV status after testing is to be updated (**Item No. 23-24**) and to be **reported to SACS**, but while reporting all the information from 1-24 has to be filled up and sent.

Reporting to SACS:

All the counselors must report to SACS in the Positive ANC Line-list format every month in the following situation:

- All the Positive ANC cases diagnosed in the ICTC during that month. (Fill up 1-7 and send)
- All the MTP / Delivery (Including Direct labour cases) / Death of mother or child / NVP administration (Fill up 1-22 and send)
- All the babies tested for HIV at 18 months of age (Fill up 1-24 and send)