NATIONAL STRATEGIC PLAN

Multi-Drug ARV for Prevention of Parent to Child Transmission of HIV (PPTCT) under National AIDS Control Programme in India

May, 2013 and Updated December, 2013

Government of India
Ministry of Health & Family Welfare
Department of AIDS Control
Basic Services Division
Chandralok Building, Janpath
New Delhi - 110001

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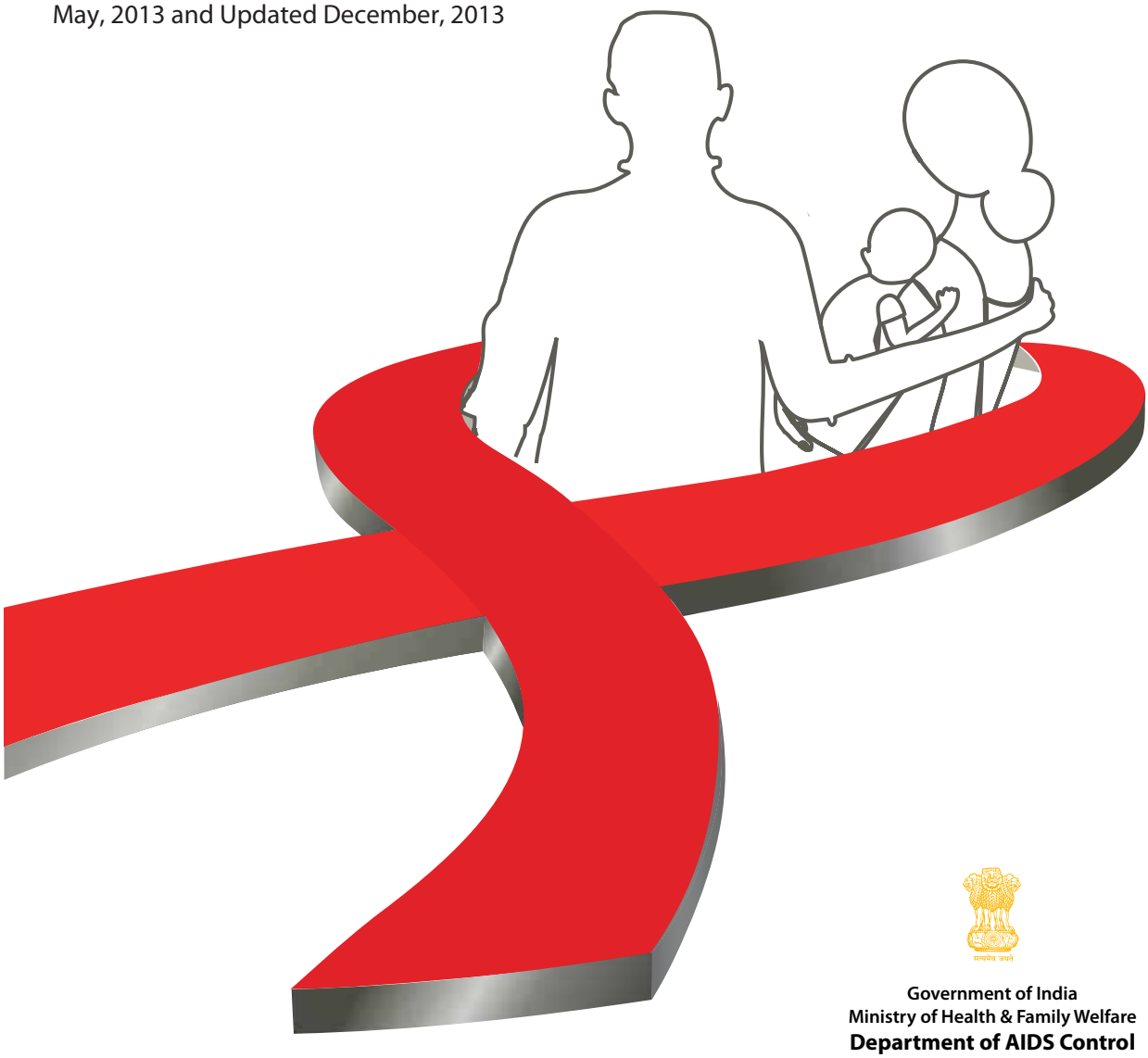

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Foreword

The National AIDS Control Programme (NACP) **launched** Prevention of Parent to Child Transmission (PPTCT) of HIV in the year 2001-02. This provided access to HIV testing services to all pregnant women enrolled for Ante-natal Care (ANC) along with provision of ARV prophylaxis with single dose of Nevirapine (SD-NVP) at the time of delivery; and rapidly **scaled-up** this intervention across India during the NACP-III (2007-12).

In September, 2012, NACP as a **policy** adopted the more efficacious multi drug ARV regimen for PPTCT, based on the recommendations of WHO (2010).

Government of India is **committed** to work towards achievement of the global target of "Elimination of new HIV infection among children" by 2015. **Based on the new Guidelines from WHO (June 2013), Department of AIDS Control (DAC) has decided to initiate lifelong ART (triple drug regimen) for all pregnant and breast feeding women living with HIV, regardless of CD4 count or WHO clinical stage, both for their own health and to prevent vertical HIV transmission and with additional HIV prevention benefits**. This would also help in maximum coverage for those needing treatment for their own health, avoid stopping and starting drugs with repeat pregnancies, provide early protection against mother-to child transmission in future pregnancies, reduce the risk of HIV transmission to HIV sero discordant partners and improve maternal health.

Thus this **"National Strategic Plan for PPTCT (2013)"** has been strategically designed and updated to incorporate global recommendations for nationwide implementation of Multi Drug Regimen for PPTCT, with immediate effect.

It is **crucial** that for efficient PPTCT, all the States /UTs strengthen the **convergence** between NACP and National Reproductive & Child Health (RCH) including STI/RTI, to improve access of HIV awareness, counseling and screening/ testing services **to detect HIV infection amongst pregnant women on their very first contact with health system**. This will promote birth of HIV free children and improve longevity with quality life of people living with HIV infection with supportive environment. It is important that synergies with National Health Mission (NHM) and the General Health Care System are sustained for efficient delivery & management of PPTCT services with well functioning referrals and linkages.

The **meticulous efforts** made by the Basic Services Division with support from all concerned stakeholders and partners are **appreciated** for bringing out this "PPTCT National Strategic Plan,2013", and surely the PPTCT services will rapidly scale up and strive towards **elimination** of mother-to-child transmission of HIV (e-MTCT) in our country.

(Lov Verma)

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Preface

India had an estimated 2.1 million persons living with HIV in 2011. The **HIV prevalence** among adult population in India has **consistently declined** over the last one decade from 0.4% in 2000 to 0.27% in 2011. This decline is due to reduction in the new HIV infections among adults, from 2.7 lakh in 2000 to 1.17 lakh in 2011, a drop of about 57%. Wider access to ART has resulted in 29% reduction in estimated annual deaths due to AIDS related causes between 2007 and 2011. This decline reflects the impact of scaled up HIV prevention interventions under NACP.

Mother to child transmission of HIV is the primary route of transmission for HIV among children. This transmission is known to occur during pregnancy, delivery and breast-feeding period with equal frequency. It is estimated that without any intervention the risk of transmission of HIV from infected mother to her child is between 20 to 45%. Global evidences suggest that although ARV prophylaxis with single dose Nevirapine is useful, it offers only partial protection against the vertical HIV transmission. Therefore more efficacious multiple drug ARV regimens are recommended, to be started early during the pregnancy and continued throughout pregnancy and until cessation of breastfeeding. These regimens have potential to dramatically reduce HIV transmission from mother-to-child to less than 5%.

In India, the **PPTCT** interventions under the NACP **started in 2001- 02** using single dose Nevirapine prophylaxis to HIV (+ve) pregnant women during labor and her new born child immediately after the birth.

The **PPTCT interventions globally**, over the past few years, have **transitioned** from the use of the single dose Nevirapine (administered to HIV positive Ante-natal women and their exposed babies), to the multi-drug Anti Retro Virals (ARVs) to efficiently bring down the rate of transmission of HIV from mother-to-child to the level of less than 5 percent.

With the Department of AIDS Control / GoI adopting "Option B" of the WHO Recommendations (2010), **India has also transitioned from the single dose Nevirapine strategy to that of multi-drug ARV prophylaxis from September 2012**. To begin with, this strategy was executed in the three southern high HIV prevalent states of Andhra Pradesh, Karnataka and Tamil Nadu. **The National Strategic Plan for PPTCT Services using Multi-drug ARVs in India was developed in May / June 2013 for nationwide implementation in a phased manner.**

The new Guidelines **of World Health Organization (June 2013) recommends** that instead of previous terms "Options A, B and B+", **only following option(s) be practiced**, viz;

1. Providing lifelong ART to all the pregnant and breastfeeding women living with HIV regardless of CD4 count or clinical stage,

Or

2. Providing ART (ARV drugs) for pregnant and breastfeeding women with HIV during the mother to child transmission risk period and then continuing lifelong ART for those women eligible for treatment for their own health.

Based on the suggestions from the Technical Resource Groups during December 2013, the **Department of AIDS Control / GoI decided to implement the latest WHO Guide lines (2013)** vide which lifelong ART will be initiated for all pregnant and breastfeeding women with HIV irrespective of CD4 count, in India with immediate effect. **Thus the present updated "National Strategic Plan – Multi-drug ARV for PPTCT under NACP in India (December 2013)" is contained in this document for implementation of PPTCT services in our country.**

(Dr Ashok Kumar)

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7. Dr B B Rewari, WHO National Consultant & NPO/ ART, DAC
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9. Dr Pauline Harvey, Country Director, CDC DGHA, India
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We express our **heartfelt gratitude** to Shri. Lov Verma, Secretary DAC/ GOI & Ms Aradhana Johri former Addl. Secy DAC/ GOI for their continued guidance, encouragement & support towards the development of this National Plan.

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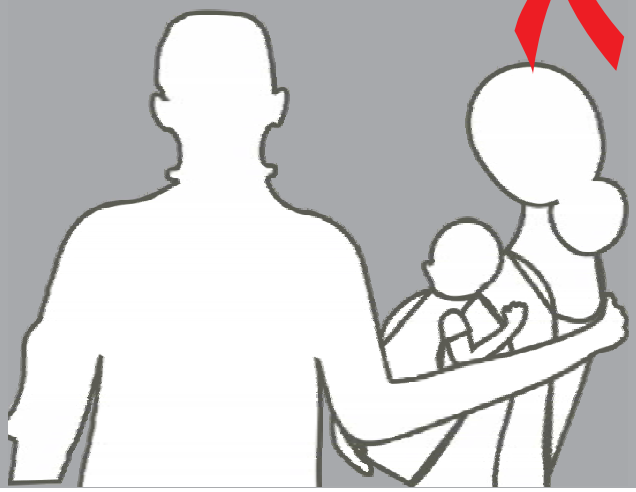

Annexure

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1. Background

India had an estimated 2.1 million persons living with HIV in 2011. HIV prevalence among adult population in India has declined consistently over last one decade from 0.4% in the year 2000 to 0.27% in 2011.This decline is made possible due to reduction in New HIV infections among adults from about 2.7 lakh in the year 2000 to 1.17 lakh in 2011, a drop of about 57%. This decline reflects impact of scaled-up HIV prevention interventions under the National AIDS Control Programme (NACP) during this period. On the contrary, reduction in new HIV infections among children is only about 35% which indicates continued and high level of transmission of HIV from infected mothers to their children.

A total of 1.42 lakh children (0 to14 years) are estimated to be living with HIV in India with about 14 000 new HIV infections annually. Mother-to-child transmission of HIV is the primary route of transmission for HIV among children. This transmission is known to occur during pregnancy, delivery and breast-feeding period. It is estimated that without any intervention the risk of transmission of HIV from infected mother to her child is between 20 to 45%. However, with effective use of Anti-retroviral (ARV) drugs, this risk reduces significantly. Therefore, to reduce the burden of HIV among children, the National AIDS Control Programme (NACP) launched Prevention of Parent to Child (HIV) Transmission (PPTCT) of HIV services in the year 2002. This provided access to HIV testing services to all pregnant women enrolled into Ante Natal Care (ANC) along with provision of ARV prophylaxis with a single dose of Nevirapine (SD-NVP) Tablet at the time of delivery to mother and Syrup NVP to the baby. These services were rapidly scaled-up across India during NACP-III (2007-2012). Although implemented effectively in the high HIV prevalence states, the reach of PPTCT services to all pregnant women in the country remains limited. In line with WHO recommendations, India has successfully launched (September 2012) the multi-drug PPTCT Option -B regimen in the three southern high prevalence States of Andhra Pradesh, Karnataka initially and subsequently in Tamil Nadu.

Globally, evidence suggest that although ARV prophylaxis using SD-NVP is highly effective in reducing risk of transmission from about 45% to less than 10%, the 10% uncovered risk is unacceptably high, considering the fact that paediatric HIV can be eliminated if the currently available drugs are used effectively. The World Health Organization (WHO) therefore recommends the use of multi-drug ARV regimens, for PPTCT. These regimens can reduce transmission to less than 5% if started early in pregnancy and continued throughout period of delivery and breasts feeding.

WHO is moving away from the previous terms “Options A, B and B+”. Instead, the WHO new guidelines (June 2013)[1] recommend two options:

1. Providing lifelong ART to all the pregnant and breast-feeding women living with HIV regardless of CD4 count or clinical stage OR

2. Providing ART (ARV drugs) for pregnant and breast-feeding women with HIV during the mother to child transmission risk period and then continuing lifelong ART for those women eligible for treatment for their own health.

[1]*World Health Organization, Consolidated guidelines on the use of Antiretroviral drugs for treating and preventing HIV infection, Recommendations for a public health approach, June 2013.*

The Government of India in-turn has committed itself to work towards achieving the global target of elimination of new HIV infections among children by 2015. Department of AIDS Control (DAC) has decided to provide lifelong ART for all pregnant and breast feeding women living with HIV, in which all pregnant women living with HIV receive a triple-drug ART regimen (TDF+3TC+ EFV) regardless of CD4 count or clinical stage, both for their own health and to prevent vertical HIV transmission and for additional HIV prevention benefits. These PPTCT services are planned to be scaled-up rapidly across the country, in a phased manner to replace currently available SD-NVP prophylaxis.

In India the Department of AIDS Control has decided:

- All HIV positive pregnant women including those presenting in labour and breast feeding should be initiated on a triple ART irrespective of CD4 count and clinical stage, for preventing Mother-to-Child Transmission risk and should continue
- The duration of NVP to infant be minimum 6 weeks but more if ART to mother was started in late pregnancy, during or after delivery and has not been on adequate period of ART as to be effective to achieve optimal viral suppression (which is at least 24 weeks), then the infant NVP should be increased to 12 weeks. This recommendation on extended NVP duration applies to infants of breast feeding women only and not those on exclusive replacement feeding

Why Lifelong ART for all Pregnant and Breast Feeding Women Living with HIV?

According to WHO **p**roviding an optimized, fixed-dose combination first-line ART regimen of TDF + 3TC+ EFV to all pregnant and breastfeeding women with HIV provides important programmatic and clinical benefits, including the following.

- **Ease of implementation:** The same simplified ART regimen is administered to all pregnant women (regardless of "eligibility" for treatment) and continued during pregnancy and labor and postpartum.
- **Harmonized regimens:** The optimized first-line fixed-dose combination regimen can be harmonized with guidelines for ART in non-pregnant adults.
- **Increased coverage of ART:** This ensures that immune-compromised women who do not have access to CD4 testing receive appropriate ART without delay.
- **Vertical transmission benefit.** Provides coverage with ART to maximize the prevention of infant infections.
- **Maternal health benefit:** Will delay disease progression over the course of treatment.
- **Acceptability:** Reviews conducted for these guidelines generally indicated strong community preference and acceptability for this approach.
- **Sexual prevention benefit:** ART will reduce sexual transmission of HIV to sexual partners

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2. Estimated Burden of HIV in Pregnant Women and Children in India

Burden of HIV in pregnant women and children follow overall HIV epidemic in India. Thus cases are primarily concentrated in state and districts with high underlying HIV prevalence.

Highest burden of HIV among pregnant women is found in the state of Andhra Pradesh followed by Bihar, Maharashtra, Uttar Pradesh etc. Out of the estimated 38,204 HIV infected pregnant women in India 34,465 i.e. 90% are concentrated in only 13 states (Table-1). These include the four high HIV prevalence states in the south (Andhra Pradesh, Karnataka, Tamil Nadu and Maharashtra) and 9 other states across the country (Gujarat, Odisha, Rajasthan, Madhya Pradesh, Chhattisgarh, Bihar, Uttar Pradesh, West Bengal and Jharkhand). Although these states have a low HIV prevalence, they do have pockets of high HIV prevalence or increasing trends in prevalence due to vulnerability factors like outmigration to high prevalence states etc. HIV infection among children show similar distribution, as HIV positive pregnant women estimated are more than 90% cases in these 13 states.

Table 1: Estimated Burden of HIV Infected Pregnant Women Requiring PPTCT Services and Estimated New Infections in Children in India in 2012-13

SN	State	Estimated HIV Infected Pregnant Women Requiring PPTCT Services	Estimated NEW HIV Infections in Children	SN	State	Estimated HIV Infected Pregnant Women Requiring PPTCT Services	Estimated NEW Infections Children
1	Andhra Pradesh	5465	2012	19	Assam	332	132
2	Bihar	4066	1660	20	Uttaranchal	270	113
3	Maharashtra	3796	1382	21	Nagaland	163	56
4	Uttar Pradesh	3350	1409	22	Himachal Pradesh	133	50
5	Gujarat	3045	1106	23	Tripura	109	47
6	Karnataka	2943	962	24	Mizoram	100	32
7	Orissa	2538	1030	25	Jammu & Kashmir	88	39
8	West Bengal	1978	873	26	Meghalaya	57	20
9	Rajasthan	1929	758	27	Goa	55	20
10	Jharkhand	1505	585	28	Chandigarh	32	11
11	Tamil Nadu	1476	410	29	Arunachal Pradesh	23	9
12	Madhya Pradesh	1277	487	30	Pondicherry	14	4
13	Chhattisgarh	1097	466	31	Sikkim	11	4
14	Punjab	601	208	32	Dadar and Nagar Haveli	6	2
15	Kerala	485	189	33	Daman & Diu	5	2
16	Haryana	453	163	34	Andaman & Nicobar Islands	3	1
17	Delhi	441	141	35	Lakshadweep	0	0
18	Manipur	358	139		Total	38204	14522

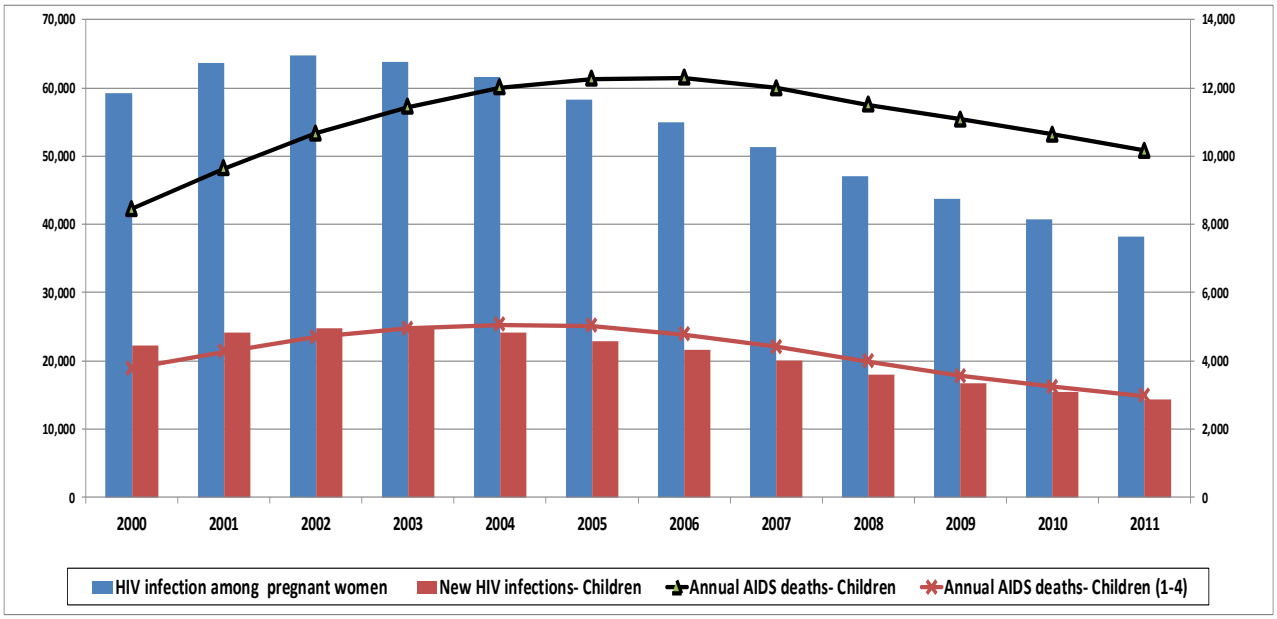
2.1 Trend in Burden of HIV among Pregnant Women and Children is shown in Figure 1

Both HIV infections among pregnant women and children show consistent decline over last one decade. The estimated HIV infections among pregnant women reduced from about 65,000 cases in the year 2002 to 38,202 in 2011 (32% decline) while the number of children between 0-14 years age-group, shows a decline of about 44%.

2.2 Burden of AIDS Related Deaths among Children

The absolute numbers of deaths among children 0 to 14 years also shows a consistent decline, in contrast to more than 10,000 AIDS deaths that continue to occur in India annually. But it can be inferred from the Figure-1 that the proportion of deaths occurring among younger children (1-4 years) out of all childhood deaths have reduced considerably from 45% in the year 2000 to less than 28% in 2012. This is probably due to improvement in access to HIV detection services along with availability of ART services.

Figure 1: Trend of Estimated Number of New HIV Infections among Pregnant Women and Children along with Trend of Estimated AIDS Deaths from 2000-2011, India



Source: NACO HIV estimations 2012

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3. Situational Analysis of PPTCT Services in India

3.1 Detection of HIV Infected Pregnant Women and Children under NACP

A total of 13,443 HIV infected women and 11,639 HIV infected children were detected at the ICTC under NACP in India in 2012-13. It is observed that about 86% of all cases are detected in the 13 states mentioned below (Table-2)

Table 2: Detection of HIV Infected Pregnant Women and Children (0-14 years) at Integrated Counselling and Testing Centres (ICTC) in India (2012-2013)

S.N	State	No. of HIV Infected Pregnant Women Detected	No. of HIV Infected Children-(0-14 Yrs) Detected	S.N	State	No. of HIV Infected Pregnant Women Detected	No. of HIV Infected Children-(0-14 Yrs) Detected
1	Andhra Pradesh	2810	1926	19	Assam	117	78
2	Maharashtra	1545	2255	20	Kerala	63	5
3	Karnataka	2232	1644	21	Jharkhand	76	165
4	Tamil Nadu	749	387	22	Uttaranchal	51	56
5	Gujarat	701	573	23	Chandigarh	42	67
6	West Bengal	478	478	24	Meghalaya	57	14
7	Uttar Pradesh	445	912	25	Pondicherry	16	28
8	Rajasthan	381	479	26	Goa	26	26
9	Delhi	338	371	27	Himachal Pradesh	32	58
10	Bihar	248	613	28	Jammu &Kashmir	76	22
11	Orissa	272	248	29	Tripura	20	10
12	Punjab	275	197	30	Dadar and Nagar Haveli	5	2
13	Madhya Pradesh	1545	346	31	Daman & Diu	5	0
14	Chhattisgarh	159	201	32	Sikkim	6	3
15	Haryana	244	230	33	Arunachal Pradesh	3	3
16	Manipur	151	116	34	Andaman & Nicobar Islands	0	0
17	Nagaland	151	85	35	Lakshadweep	Data not available	
18	Mizoram	124	41	**India Total**		13,443	11,639

3.2 Early Infant Diagnosis (EID)

HIV exposed infants born to infected pregnant women have to undergo DNA-PCR tests using dried blood spot and whole blood specimen. The tests are done at 6 weeks, repeated at 6 months if previous tests were negative and again 12 months if the 6 month tests were negative(the third EID testing should be undertaken after 6 weeks of stopping breast feeds which may not happen exactly at 12 months, but any time after 6 months and before 13 months). Confirmation of HIV status is done using 3 rapid anti-body tests at 18 months at the Integrated Counselling and Testing Centres (ICTCs).Table-3 shows level of EID.

In 2012-13, 8,496 HIV exposed babies underwent Dried Blood Spot (DBS) tests out of which about 8% were found positive under the EID services of NACP. The information regarding referral to ART centres and WBS testing of this cohort is not available at national level. But the information on total Whole Blood Specimen (WBS) tests conducted during same period is available. About 86% of the DBS positive children in 2012-13 were found positive with WBS test too.

Table 3: Status of Early Infant Diagnosis (EID) using Dried Blood Spot and Whole Blood Specimen for DNA/ PCR Tests in India (2011-13)

	Number of DBS Test (A)	Number DBS Positive	Whole Blood Specimen Test (Not Cohort of A)	No. Whole Blood Test Positive
2011-12	3329	607(18%)	513	419 (82%)
2012-13	8496	671(8%)	430	373 (86%)

3.3 Enrolment of Children Living with HIV (CLHIV) into HIV Care

Table-4 shows trend of enrolment of Children Living with HIV/ AIDS (CLHIV) into HIV care with about 15,000 children being enrolled every year. However, cohort information on numbers detected and linked to ART Services during the same period is not available at national level.

Table 4: Trend of Enrolment of Children Living with HIV/AIDS (CLHIV) into HIV Care (Pre-ART Registration) in India (2009-14)

Year	Pre-ART Registration of CLHIV
2009-10	15,940
2010-11	20,328
2011-12	16,241
2012-13	15,123
2013-14 Data source ART/ till December	9666

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4. Goal and Objectives of PPTCT Services in India

Vision: Women and children, alive and free from HIV

Goal: To work towards elimination of paediatric HIV and improve maternal, newborn and child health and survival in the context of HIV infection

Objectives:

1. **To detect more than 80%** HIV infected pregnant women in India
2. To provide **access to comprehensive PPTCT services** to more than 90% of the detected pregnant women
3. To provide **access to early infant diagnosis** to more than 90% HIV exposed infants
4. To ensure **access to anti-retroviral drugs (ARVs) prophylaxis** or Anti-Retroviral Therapy (ART) to 100% HIV exposed infants
5. To ensure **more than 95% compliance with ART** in HIV infected pregnant women and ARV/ART in exposed children

India has a concentrated HIV epidemic and accordingly the diagnostic and treatment services are concentrated in states and districts having high HIV prevalence. These services are far and few in the rest of the country. On the other hand, currently only about 70% of estimated pregnant women in India are enrolled into ante-natal care (ANC) at national level and less than 60% of all deliveries are Institutional deliveries. Out of these less than 30% women have their HIV status known due to sub-optimal access to testing facilities. The objectives of PPTCT services are therefore decided considering both HIV epidemiology and the current level of coverage of key Reproductive and Child Health (RCH) activities like ANC registration and institutional deliveries etc.

Provision of comprehensive PPTCT services requires strategic approach like strengthening current interventions, scale-up of services in areas with high disease burden, supervision and monitoring and multi-stake holder engagement. Following the set of interventions are envisaged to achieve the objectives of PPTCT services in Indian:

4.1 Key Steps for Achievement of Objectives:

(1) **To detect more than 80% HIV infected pregnant women in India**

a. Enhance HIV testing facilities –Stand-alone-ICTCs, Facility integrated -ICTCs

b. Establish facilities for HIV screening at the time of ANC registration at sub-centre level

c. HIV screening at all facilities conducting deliveries (>5 deliveries/ month)

d. Common ANC and ICTC registration at medical colleges, district and sub-district hospitals

e. Mechanism to capture information on HIV testing of women accessing services in private sector

(2) **To provide access to comprehensive PPTCT services to more than 90% of the detected pregnant women**

a. Mechanism to ensure 100% linkage to ART facilities

b. Priority assessment at ART centres for prompt initiation of ART e.g. fast tracking for CD4 testing, investigation etc.

c. Provision of ART from a location convenient to women

d. Mechanism to ensure safe hospital delivery for all HIV infected women

(3) **To provide access to early infant diagnosis to more than 90% HIV exposed infants**

a. Mapping of EID facilities and establishing mechanisms for linkage to them to all ART Centres

b. Ensure prompt collection and dispatch of DBS specimens

c. Mechanism for follow-up with testing laboratories to ensure prompt results. (Minimise the turn around time of test results)

d. Prompt referral of DBS positive babies for testing using whole blood specimens to the ART centre

e. Priority assessment at ART centre for WBS testing

f. Ensure confirmation of HIV status of babies at 18 months irrespective of previous DBS and WBS status

(4) **To ensure access to anti-retroviral drug (ARV) prophylaxis or Anti-Retroviral Therapy (ART) to 100% HIV exposed infants**

a. Mechanisms to ensure 100% linkage of HIV infected children to ART centres

b. Ensure priority assessment at ART centres including fast tracking for CD4 testing, investigations etc.

(5) **To ensure more than 90% compliance with ART in HIV infected pregnant women and ARV/ ART in exposed children**

a. Provision of ART from a facility convenient to women

b. Drug adherence counselling at every visit to ART facility

c. Mechanism for prompt detection of missed visit for ARV collection and retrieval actions

d. Ensure patient home visit by outreach worker/ health workers at prescribed frequency before and after labour and delivery

e. Integrate follow-up visits of HIV-exposed infants with other visits like immunisation etc.

f. Provision of travel support and other enablers to ensure regularity for drug collection and follow-up visits

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5. Programme Interventions and ARV Regimen in the New PPTCT Services

The National PPTCT programme recognizes the four elements integral to preventing HIV transmission from mother-to-child which include: (I) Primary prevention of HIV, especially among women of child bearing age (ii) Preventing unintended pregnancies among women living with HIV (iii) Prevent HIV transmission from pregnant women infected with HIV to their child and (iv) Provide care, support and treatment to women living with HIV, her children and family.

5.1 The Essential Package of PPTCT Services in India Includes:

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

1. Routine offer of HIV counselling and testing to all pregnant women enrolled into antenatal care (ANC) with 'opt out' option
2. Ensure involvement of spouse & other family members and move from an "ANC Centric" to a "Family Centric" approach.
3. Provision of life long ART (TDF+3TC+ EFV) to all Pregnant and breast feeding HIV infected women regardless of CD4 count and Clinical stage
4. Promote institutional deliveries of all HIV infected pregnant women
5. Provision of care for associated conditions (STI/ RTI, TB & other Opportunistic Infections -OIs).
6. Provide nutrition counselling and psychosocial support for HIV-infected pregnant women
7. Provide counselling and support for initiation of exclusive breastfeeds within an hour of delivery as the preferred Option and continue for 6 months.
8. Provide ARV prophylaxis to infants from birth up to minimum 6 months
9. Integrate follow-up of HIV-exposed infants into routine healthcare services including immunisation
10. Ensure initiation of Co-trimoxazole Prophylactic Therapy (CPT) and Early Infant Diagnosis (EID) using HIV-DNA PCR at 6 weeks of age onwards as per the EID guidelines.
11. Strengthen community follow- up and outreach through local community networks to support HIV-positive pregnant women and their families

The figure-2 and figure-2.1 details the overall PPTCT cascade including the drug regimen to be used under PPTCT. It includes the services for HIV exposed infants also along with guidance pertaining to breast feeding status. Details of PPTCT regimens, follow-up schedules, baseline evaluation, investigations, side-effects etc., is covered in great detail in the PPTCT technical guidelines which is placed at **Annex-9.**

Figure 2: Overall Summary of PPTCT Programme Interventions in India: Pregnant Women Presenting during Antenatal Period

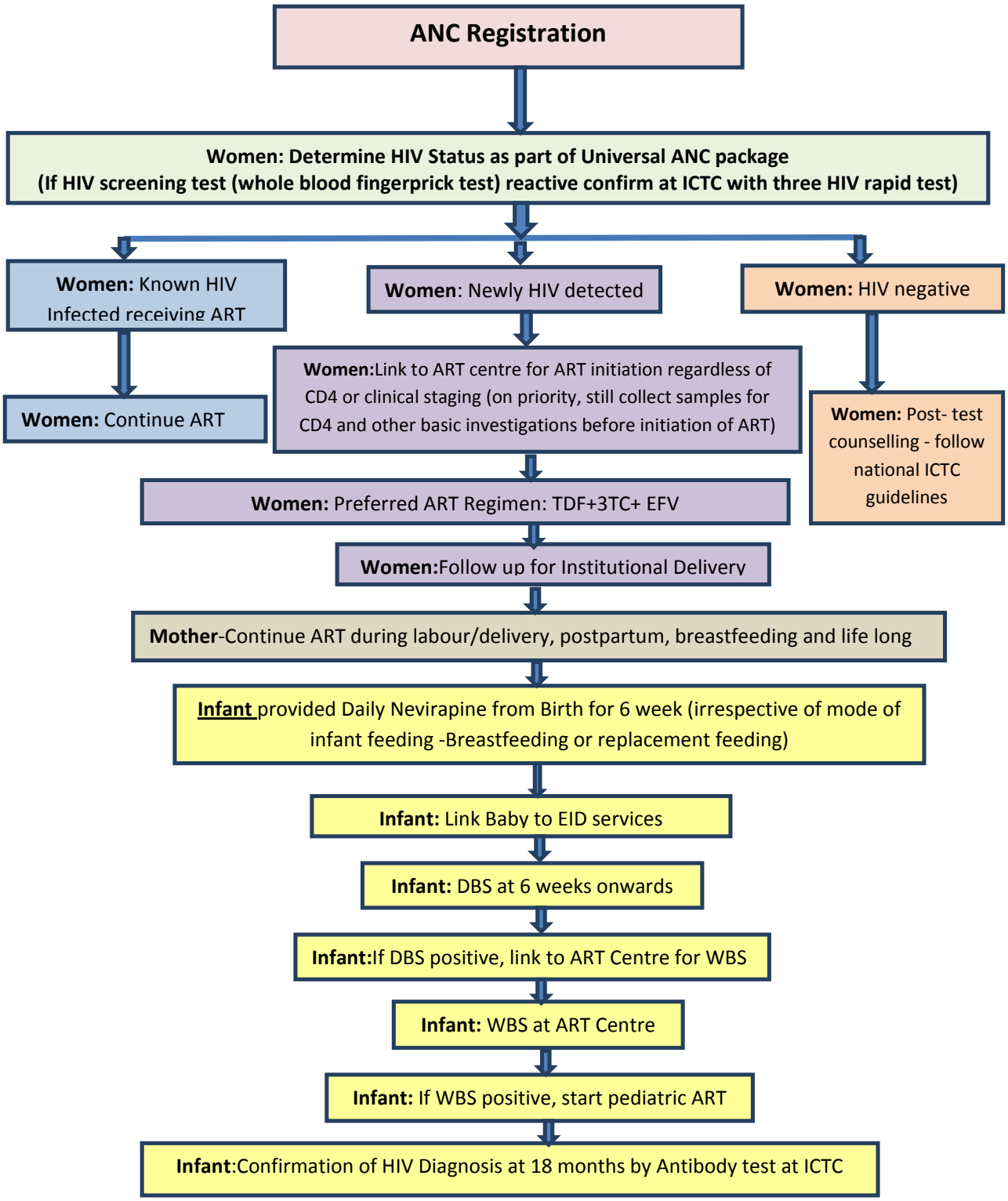
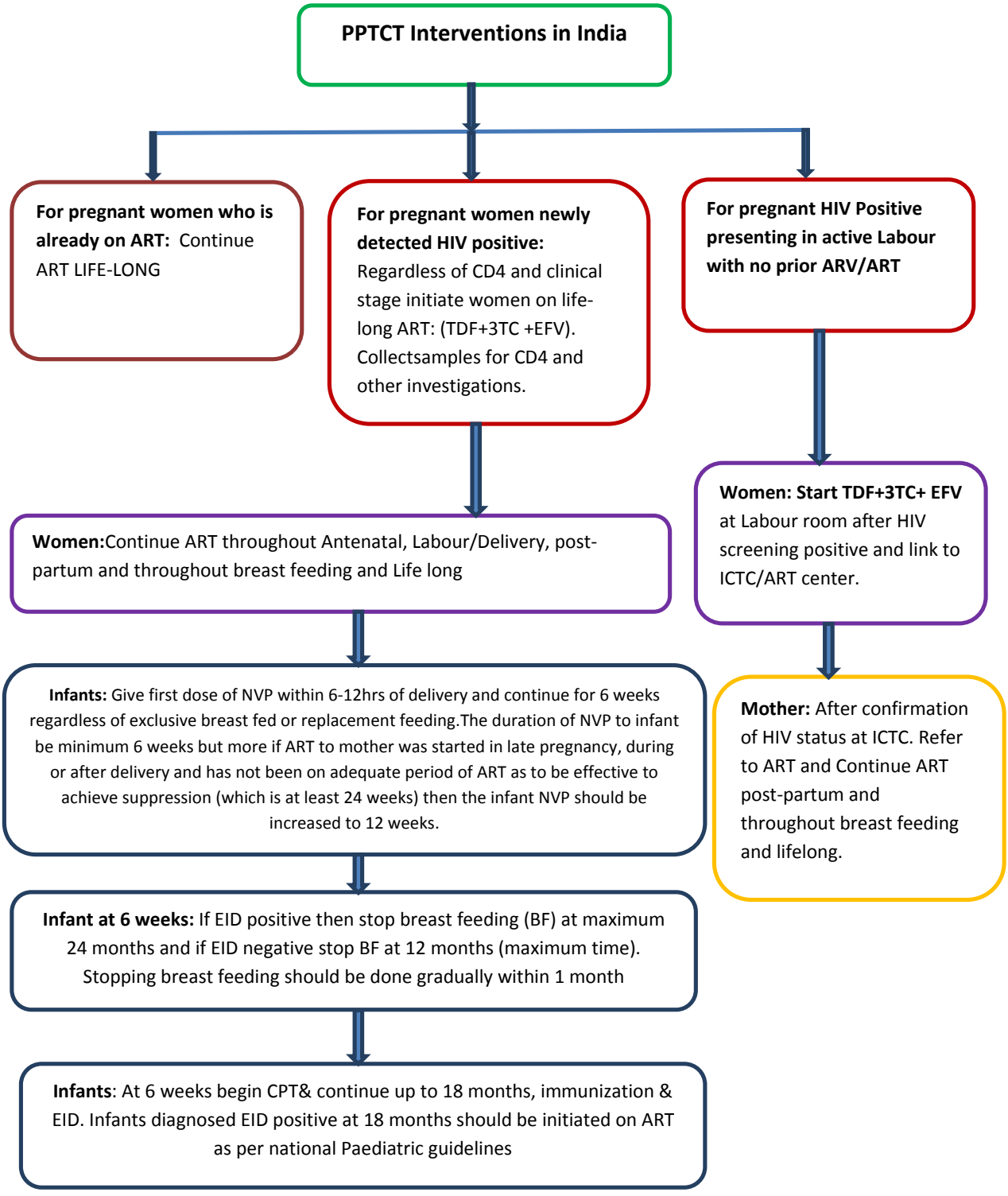


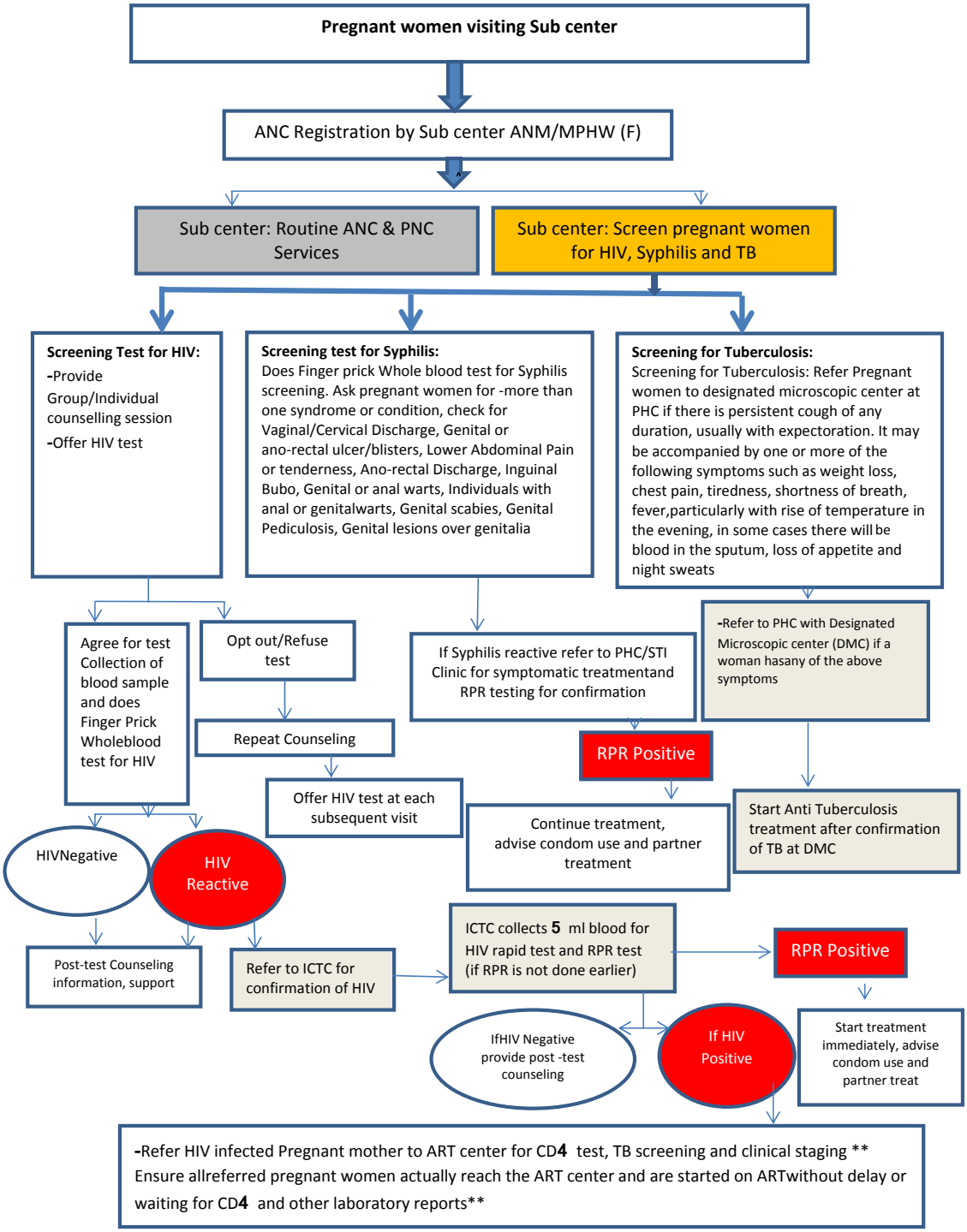
Figure 2.1: PPTCT Programme Interventions in India (Women Already on ART, Women Newly Detected HIV and Women Presenting Directly-in-Labour)



5.2 Flow of HIV Infected Pregnant Women Detected during Ante-natal Care and PPTCT Services

Figure-3 summarizes the flow of pregnant women presenting in antenatal care and PPTCT services.

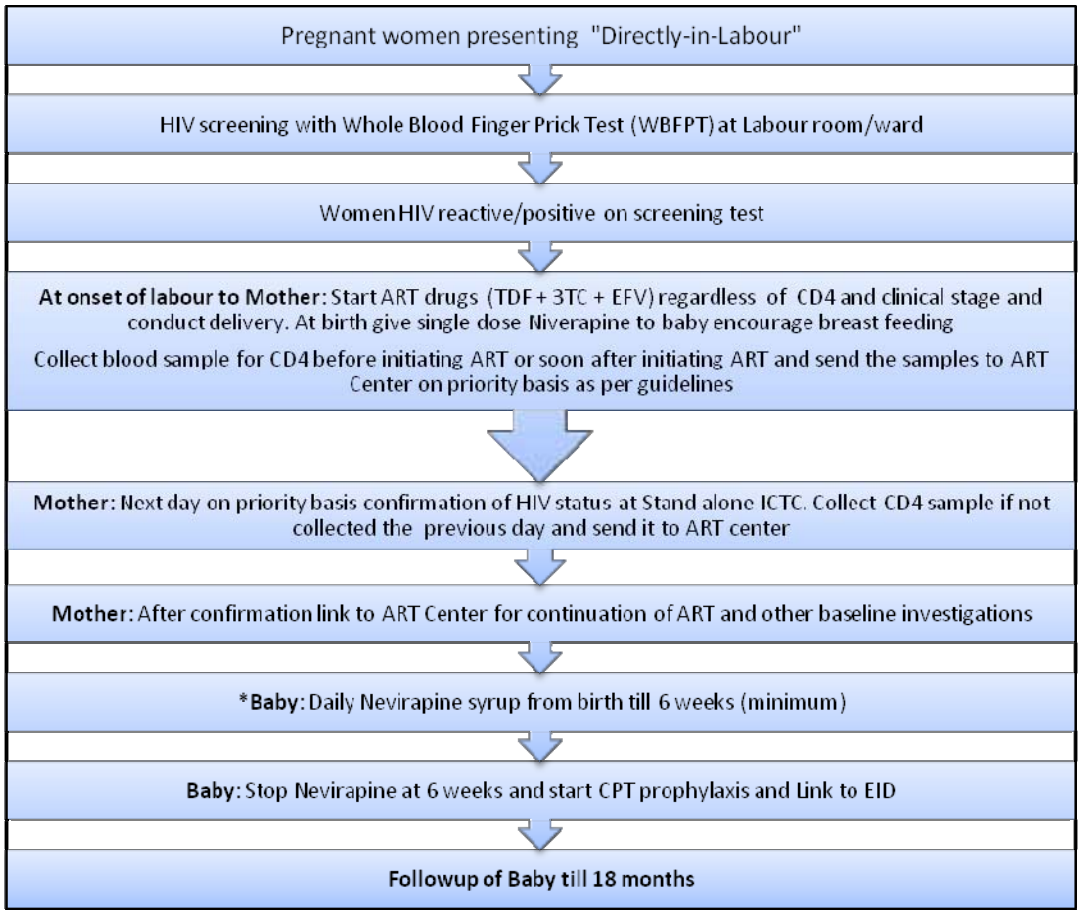
Figure 3: Services to Pregnant Women during Antenatal Period



5.3 PPTCT Interventions for Women Screened HIV Positive Directly-in-labour

The figure-4 schematically shows interventions to pregnant women screened HIV positive directly during labour and shows flow of patients to access these services

Figure 4: PPTCT Summary of Interventions in Pregnant Women Presenting Directly in Labour



- *Several weeks or months are required for maternal ART to achieve virological suppression and a breastfeeding infant may not be protected against postnatal transmission during that period, or when a breastfeeding mother initiates ART very late in pregnancy (such as if mother is on ART for less than 24 weeks/6 months) during labour or postpartum, increasing the duration of infant NVP prophylaxis to 12 weeks can be considered.
- *Infant prophylaxis is also important when a breastfeeding mother interrupts ART during breastfeeding, as this places her infant at increased risk of postnatal transmission. In such situation, providing daily infant NVP during the period of maternal ART interruption should be considered, and this could be stopped six weeks after maternal ART is restarted (or one week after breastfeeding ends, whichever comes first).

6

6. Strategy for Scale-up of New PPTCT Services

6.1 Guiding Principles

1. Focus effective implementation of services in priority states and districts
2. Implementation of services in 100% districts in phase-1 states
3. Among phase 2 and phase 3 states:
   a. Implementation of services in 100% districts in Maharashtra and Goa
   b. In remaining states ensure access to ART (TDF+3TC+EFV) to 100% HIV infected pregnant women detected across the state
   c. Scale-up HIV testing services in high burden districts were selected using following criterion:
      i. All A and B category districts as per NACO re-categorization (2013) –Category A1, A2, A3, B1, B2 – ANC prevalence >0.5%
      ii. Districts detecting more than 5 HIV infected pregnant women in 2012-13
   d. All CHC in selected districts to have a stand- alone ICTC (SA-ICTC)
   e. All "high" delivery points below CHC level to have facility integrated ICTCs
   f. All sub-centres in the selected districts to have HIV and Syphilis screening facility using whole blood finger prick test (WBFPT) including TB screening.
   g. All "high" delivery points under NRHM to have PPTCT services (testing, ARV, outreach support)
   h. Measures to strengthen **collaboration with the** RCH programme to facilitate **early HIV testing** (early second trimester)
   i. Measures to ensure coverage of all hospital deliveries reported under **Reproductive and Child Health Programme** (RCH) in the states with HIV screening services
   j. Mechanism for provision of access to EID services to ICTC in the selected district
   k. Establishment of effective referral linkages between the delivery points and SA-ICTCs, ART centres and EID centres
   l. Strengthening **supervision and monitoring** to consolidate implementation of programme activities
   m. Establish **monitoring structures** at state, district and facility level, by identifying/ nominating person responsible for PPTCT at all levels
   n. Measure to systematically **involve the private sector nursing homes** with strategy for "Notification" of HIV infected pregnant women. This is aimed at provision of more efficacious multi drug ART under the programme to all. Implementation of Clinical Establishment Bill Act 2010.

4. In phase 4 and 5 PPTCT services will be implemented in selected districts based on disease burden similar to phase-2 &3.

6.2 Prioritization of States for Implementation of PPTCT Services

As seen in Table-1 immediate nationwide coverage coverage with focus all HIV infected pregnant women in India about 90% are concentrated in only 13 states including Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra, Gujarat, Odisha, Rajasthan, Madhya Pradesh, Chhattisgarh, Bihar, Uttar Pradesh, West Bengal and Jharkhand. It is therefore planned to scale-up PPTCT services in these states on a priority, even though nationwide coverage has also been planned. Even in these states the services will be scaled-up in selected districts to ensure optimal coverage for epidemiologic impact. Table-5 outlines the plan for scale-up of PPTCT services in 5 phases along with state and districts to be covered and likely coverage anticipated with effective implementation of services. Considering current levels of detection, about 98% of the same occurred in the state and districts prioritized for scale-up of PPTCT services.

Table 5: Plan for Scale-up of National PPTCT Programme in India

Phase	States to be Covered	Estimated Number of HIV Infected Pregnant Women Requiring PPTCT Services	Proportion of the Estimated Load Phase-wise	Priority Districts	Current Detection in Priority State and Districts Out of Total (2011-12)	Time-line
Phase 1	Andhra Pradesh, Karnataka, Tamil Nadu and Puducherry	9898	25.90%	89/ 89	7235 (47%)	Aug-13
Phase 2	Maharashtra + Mumbai + Goa +D&D; Gujarat +DNH; Odisha, Rajasthan; Madhya Pradesh	12651	33.10%	124/ 186	4590 (30%)	Jan-14
Phase 3	Bihar, Chhattisgarh Uttar Pradesh, West Bengal, Jharkhand	11996	31.40%	95/ 183	1580(10%)	Apr-14
Phase 4	Punjab, Kerala +Lakshadweep; Haryana, Chandigarh, Delhi, Manipur, Mizoram, Nagaland, Assam, Uttaranchal, Himachal Pradesh, Tripura	3477	9.10%	94/ 156	1605 (10%)	Sep-14
Phase 5	J & K, Meghalaya, Arunachal Pradesh, Sikkim, A&N Islands	182	0.50%	03/ 57	61(0.4%)	Dec-14
Total		38204	100%	405/ 671	15071/ 15362 (98%)	

6.3 Prioritization of Districts for Scale-up of HIV Testing Services

Using the criterion mentioned above, districts are selected for scale-up of HIV testing facilities, provision of PPTCT services at delivery points etc. The number of districts chosen is shown in table-6 and list of all the districts is placed at **Annexure-1.** Complete national coverage of PPTCT services will mean implementation in 405 out of 671 districts.

Table 6: State Wise and in Phase Wise Number of Districts Prioritized for Scale-up of HIV Testing Services in India

Phase	State	Total Number of Districts	No. of Districts Prioritized	Percentage
Phase 1	Andhra Pradesh	23	23	100%
	Karnataka	30	30	100%
	Tamil Nadu +Puducherry	36	36	100%
Total		89	89	100%
Phase 2	Maharashtra + Mumbai+ Goa + Daman & Diu	37	37	100%
	Gujarat + Dadar and Nagar Haveli	36	24	67%
	Madhya Pradesh	50	20	40%
	Odisha	30	23	77%
	Rajasthan	33	20	61%
Total		186	124	67%
Phase 3	Chhattisgarh	27	12	44%
	Bihar	38	19	50%
	Jharkhand	24	7	29%
	Uttar Pradesh	75	41	55%
	West Bengal	19	16	84%
Total		183	95	52%
Phase 4	Assam	27	10	37%
	Delhi	9	9	100%
	Haryana	21	15	71%
	Himachal Pradesh	12	2	17%
	Kerala+Lakshdweep	15	10	67%
	Manipur	9	9	100%
	Mizoram	8	7	88%
	Nagaland	11	9	82%
	Punjab and Chandigarh	23	18	78%
	Tripura	8	1	13%
	Uttarakhand	13	4	31%
Total		156	94	60%
Phase 5	Jammu & Kashmir	22	1	5%
	Arunachal Pradesh	17	0	0%
	Meghalaya	11	2	18%
	Sikkim	4	0	0%
	Andaman & Nicobar Islands	3	0	0%
Total		57	3	5%
Total districts selected in India		671	405	60%

6.4 Activity Plan for Districts Other than Priority Districts

Training and sensitization of all the following staff on PPTCT new guidelines-"Lifelong ART for all pregnant and breastfeeding women with HIV regardless of CD4 for women's health and prevention of parent -to -child transmission of HIV guidelines".

1. **All NACP staff** including, DAPCU officer, District ICTC supervisor, ICTC counsellors, ART centre medical officers, ART centre counsellors and staff nurses to be trained
2. All Medical officers in-charge of ICTC/ PPTCT, District HIV/ AIDS **Nodal Officers** and district **RCH officers** to be trained especially on importance of **HIV testing**:
    a. Ensure 100% testing coverage or ANCs registered at health centres having co-located HIV testing facility
    b. Ensure provision of Whole Blood finger prick test at all "High delivery points" to cover pregnant women presenting "directly in labour"
3. **Multi-drug ART PPTCT regimen**:
    a. Ensure prompt evaluation at the ART centre/ LAC of 100% of the detected pregnant women within districts and initiate ART for pregnant women regardless of CD4 and clinical stage
    b. Ensure access to 100% pregnant women detected "directly-in-labour" to lifelong ART and the exposed baby to ARV for PPTCT of HIV
    c. The drugs to be stocked at the nearest stand-alone ICTCs and mechanism to transfer them to other health centres where delivery of infected pregnant woman is conducted to be established
4. **EID services**: ensure availability of at least one EID facility in the district (district headquarters ICTC)
5. Development of **state specific plans for referral-linkages** within and outside districts. Following are the key linkages:
    a. Institutional delivery for detected HIV infected pregnant women
    b. Confirmation of HIV status for "direct-in-labour cases"/ pregnant women screened HIV positive at F-ICTCs
    c. Enrolment into HIV care –ART registration and initiation of ART
    d. CD4-testing and other investigations
    e. Early Infant Diagnosis for Babies
6. **Supervision and monitoring**:
    a. District level ICTC medical officers and counsellors to be part of all PPTCT review meetings at state level
    b. The in-charge medical officer at the LACs or MOs ARTs (if available) to be to be part of all PPTCT review meetings at the state level
    c. DAPCU medical officers from neighbouring districts to undertake supervisory visits at least one per month

7

7. Anticipated Challenges for Nation Wide-scale-up of PPTCT Services

7.1 HIV Testing Coverage in Ante-Natal Cases (ANCs) and Direct-in-labour Cases

Table-7 shows the status of HIV testing coverage against the estimated pregnancies and pregnant women registered into ANC (NRHM for the year 2011). Following issues are noted:

1. The reported number of ANC registrations are more than estimated pregnancies in 13/35 states and UTs.
2. Out of total ANC registrations only 24% pregnant women know their HIV status. The highest coverage is in Phase-1 states (50%) and least in phase 5 states.

At national level, the gap in detection of HIV infected pregnant women is about 67% (Table 8) while the gap is 41% in phase 1 states and it is as high as 88% in phase 3 states. Enhancing coverage in these states hold the key to PPTCT scale-up

7.2 Provision of Single dose Nevirapine

It is also seen in table-7 that, 91% of HIV infected women delivered during the period were covered with SD-Nevirapine in India. This is not a cohort information and proportions are calculated assuming same number of positive pregnant women detection during the period. Mother-baby-pair coverage in phase 1 states is close to 100%, 85% in phase 2 and 70% in Phase 3. Hence, as scale-up moves into phase -3 and further the biggest challenge is to enhance coverage of HIV testing among pregnant women and also to ensure coverage with SD-Nevirapine in these states.

Table 7: HIV Testing among Ante-Natal and Direct-in-labour Cases and Single dose Nevirapine Coverage in India (April 2012 to March 2013)

	States	Estimated no. of Pregnancy	Total Pregnant Women Registered for ANC	Total HIV Tested	Proportion HIV Tested among ANC Registered	HIV Infected Pregnant Women Detected	Total Mother-Baby Pairs Receiving SD-Nevirapine	Percentage of M-B Pair Coverage
Phase 1	Karnataka	1291080	1590880	1044706	66%	2232	1768	**79%**
	Tamil Nadu +Puducherry	1284571	1169902	873654	75%	765	1042	**136%**
	Andhra Pradesh	1667064	1780005	1141437	64%	2810	2895	**103%**
Total Phase 1		**4242715**	**4540787**	**3059797**	67%	**5807**	**5705**	**98%**
Phase 2	Maharashtra, Mumbai,Goa	2134902	2326014	1273599	55%	1962	2164	**110%**
	Gujarat+Dadra and Nagar Haveli + Daman & Dui	1463055	1401430	665532	47%	706	624	**88%**
	Madhya Pradesh	2180105	1944683	491043	25%	319	223	**70%**
	Odisha	945913	884312	274995	31%	272	189	**69%**
	Rajasthan	2015399	1852251	386007	21%	381	346	**91%**
Total Phase 2		**8739374**	**8408690**	**3091176**	37%	**3640**	**3546**	**97%**
Phase 3	Chhattisgarh	710784	706518	77479	11%	159	92	**58%**
	Bihar	3208601	2511093	187450	7%	248	205	**83%**
	Jharkhand	917450	735974	92059	13%	76	40	**53%**
	Uttar Pradesh	6212971	4959016	493925	10%	445	351	**79%**
	West Bengal	1688106	1953096	479576	25%	478	309	**65%**
Total Phase 3		**12737912**	**10865697**	**1330489**	12%	**1406**	**997**	**71%**
Phase 4	Assam	795440	809378	234370	29%	117	89	**76%**
	Delhi	328028	842729	206388	24%	338	301	**89%**
	Haryana	621911	601919	189580	31%	244	115	**47%**
	Himachal Pradesh	127463	139468	55347	40%	32	7	**22%**
	Kerala	544565	530203	137565	26%	63	81	**129%**
	Manipur	44610	92231	48713	53%	151	193	**128%**
	Mizoram	20522	24049	20271	84%	124	135	**109%**
	Nagaland	36602	41030	19608	48%	151	135	**89%**
	Punjab, Chandigarh	523978	521791	250472	48%	317	246	**78%**
	Tripura	60168	76645	23701	31%	20	14	**70%**
	Uttarakhand	214779	224194	68823	31%	51	15	**29%**
Total Phase 4		**3318064**	**3903637**	**1254838**	32%	**1608**	**1331**	**83%**
Phase 5	J & K	252610	460795	53890	12%	24	5	**21%**
	Arunachal Pradesh	31178	26290	9482	36%	3	0	**0%**
	Meghalaya	79880	119796	17257	14%	57	26	**46%**
	Sikkim	11899	10070	8495	84%	6	1	**17%**
	Andaman & Nicobar Islands	6520	6085	6430	106%	0	NA	**NA**
Total Phase 5		**382086**	**623036**	**95554**	**15%**	**90**	**32**	**36%**
Total in all states		**29420153**	**28341847**	**8831854**	31%	**12551**	**11611**	**93%**

Table 8: "Detection" of HIV Infected Pregnant Women against Estimated Cases in India, 2012-13

Phase	State	Estimated HIV Infected Pregnant Women	Programme Detection in 2012-13	(%) Detection against Estimate
Phase 1	Karnataka	2943	2232	76%
	Tamil Nadu+PD	1490	765	51%
	Andhra Pradesh	5465	2810	51%
Total		9898	5807	59%
Phase 2	Maharashtra + Mumbai+ Goa + D&D	3856	1962	51%
	Gujarat + DNH	3051	706	23%
	Madhya Pradesh	1277	319	25%
	Odisha	2538	272	11%
	Rajasthan	1929	381	20%
Total		12651	3640	29%
Phase 3	Bihar	4066	248	6%
	Chhattisgarh	1097	159	14%
	Jharkhand	1505	76	5%
	Uttar Pradesh	3350	445	13%
	West Bengal	1978	478	24%
Total		11996	1406	12%
Phase 4	Assam	332	117	35%
	Delhi	441	338	77%
	Haryana	453	244	54%
	Himachal Pradesh	133	32	24%
	Kerala+Lakshdweep	485	63	13%
	Manipur	358	151	42%
	Mizoram	100	124	124%
	Nagaland	163	151	93%
	Punjab and Chandigarh	633	317	50%
	Tripura	109	20	18%
	Uttarakhand	270	51	19%
Total		3477	1608	46%
Phase 5	J & K	88	24	27%
	Arunachal Pradesh	23	3	13%
	Meghalaya	57	57	100%
	Sikkim	11	6	55%
	A & N Islands	3	0	0%
Total		182	90	49%
Total in India		38204	12551	33%

7.3 Access to HIV Testing Facilities

Phase 1 and 2 states together have about 80% of existing HIV testing facilities in the country. But the phase 3 states have only 8% facilities. This is the biggest challenge in PPTCT scale-up in India.

Table 9: Availability of HIV Testing Facilities in India, 2013

Phase	State	Stand Alone ICTC (+ Mobile ICTC)	F-ICTC	PPP-ICTC	Total ICTC	Percentage out of Total Facilities
Phase 1	Karnataka	444	854	138	1436	39%
	Tamil Nadu +Puducherry	405	935	105	1445	
	Andhra Pradesh	406	1494	236	2136	
Total		1255	3283	479	5017	
Phase 2	Maharashtra+Mumbai + Goa + D&D	675	1394	492	2561	40%
	Gujarat + DNH	313	881	184	1378	
	Madhya Pradesh	143	446	19	608	
	Odisha	185	42	7	234	
	Rajasthan	182	150	11	343	
Total		1498	2913	713	5124	
Phase 3	Chhattisgarh	104	86	0	190	8%
	Bihar	208	0	5	213	
	Jharkhand	67	21	2	90	
	Uttar Pradesh	217	32	47	296	
	West Bengal	256	12	4	272	
Total		852	151	58	1061	
Phase 4	Assam	83	78	15	176	12%
	Delhi	95	50	0	145	
	Haryana	88	43	6	137	
	Himachal Pradesh	47	19	2	68	
	Kerala	164	90	37	291	
	Manipur	60	25	7	92	
	Mizoram	36	24	5	65	
	Nagaland	70	34	1	105	
	Punjab and Chandigarh	85	153	3	241	
	Tripura	18	25	1	44	
	Uttarakhand	48	129	10	187	
Total		794	670	87	1551	
Phase 5	J & K	35	0	0	35	1%
	Arunachal Pradesh	36	13	0	49	
	Meghalaya	12	5	4	21	
	Sikkim	13	6	0	19	
	A & N Islands	13	7	0	20	
Total		109	31	4	144	
Total India		4508	7048	1341	12897	100%

7.4 Access to ART Services

Similar to testing facilities, ART services too are concentrated in phase 1 and 2 states (75%), with only 12% facilities in phase-3 states.

Table 10: Availability of ART Facilities in India, 2013

Phase	State	ART Centres	Link ART-Plus Centres	Link ART Centres	Total ART Facilities	Percentage of Total Facilities
Phase 1	Karnataka	55	54	184	293	46%
	Tamil Nadu +Puducherry	45	6	98	149	
	Andhra Pradesh	51	59	99	209	
Total		**151**	**119**	**381**	**651**	
Phase 2	Maharashtra + Mumbai+ Goa + D&D	60	26	120	206	29%
	Gujarat + DNH	25	5	49	79	
	Madhya Pradesh	10	2	32	44	
	Odisha	9	4	19	32	
	Rajasthan	11	9	31	51	
Total		**115**	**46**	**251**	**412**	
Phase 3	Bihar	13		27	40	12%
	Chhattisgarh	5		2	7	
	Jharkhand	6		17	23	
	Uttar Pradesh	22	1	35	58	
	West Bengal	10		26	36	
Total		**56**	**1**	**107**	**164**	
Phase 4	Assam	3	2	11	16	12%
	Delhi	9		0	9	
	Haryana	1	5	15	21	
	Himachal Pradesh	3		8	11	
	Kerala	8	1	13	22	
	Manipur	9	3	11	23	
	Mizoram	3		5	8	
	Nagaland	6	1	8	15	
	Punjab and Chandigarh	8	5	6	19	
	Tripura	1		2	3	
	Uttarakhand	2		13	15	
Total		**53**	**17**	**92**	**162**	
Phase 5	J & K	2		3	5	1%
	Arunachal Pradesh	1		2	3	
	Meghalaya	1		3	4	
	Sikkim	1		0	1	
	A & N Islands	0		1	1	
Total		**5**	**0**	**9**	**14**	
Total in all districts		**380**	**183**	**840**	**1403**	100%

7.5 Access to EID Services

Majority of EID services are concentrated in phase 1 and 2 states (80%), with only 20% facilities in remaining states.

Table 11: Availability of EID Centres in India, 2013

Phase	State	Number of EID facilities	Proportion of all EID Centres Phase wise
Phase 1	Karnataka	219	49%
	Tamil Nadu +Puducherry	120	
	Andhra Pradesh	233	
Total		**572**	
Phase 2	Maharashtra + Mumbai+ Goa + D&D	245	31%
	Gujarat + DNH	58	
	Madhya Pradesh	12	
	Odisha	20	
	Rajasthan	24	
Total		**359**	
Phase 3	Bihar	15	9%
	Chhattisgarh	9	
	Jharkhand	8	
	Uttar Pradesh	40	
	West Bengal	31	
Total		**103**	
Phase 4	Assam	6	10%
	Delhi	27	
	Haryana	13	
	Himachal Pradesh	0	
	Kerala	9	
	Manipur	17	
	Mizoram	9	
	Nagaland	11	
	Punjab and Chandigarh	21	
	Tripura	0	
	Uttarakhand	3	
Total		**116**	
Phase 5	J & K	1	1%
	Arunachal Pradesh	1	
	Meghalaya	2	
	Sikkim	1	
	A & N Islands	1	
Total		**6**	
Total in all districts		**1156**	100%

7.6 Level of Saturation of Health Facilities with HIV Testing Services

While 100% medical colleges and district hospitals have a HIV testing facility across the country, about 86% sub-district hospitals have the same. But lower down in the health system the levels of saturation differ in different phases. Overall, only 56% CHCs and 29% PHCs in the country have HIV testing facilities. The saturation of CHCs with HIV testing facility is close to 100% in Phase 1, about 75% in phase 2 and less than 40% in phase 3, 4, and 5 states. Similarly while 62% PHCs in phase 1 states have testing facilities, it is only 33% in phase 2 states and only 2% in phase 3 states (Table-12).

Table 12: Saturation of Health Facilities with HIV Testing Services in India (2013)

Phase	State	Medical College				District Hospital				Sub-district Hospital			
		Medical College	Stand Alone + Mobile ICTC)	F-ICTC	% Medical Colleges with Facility	District Hospital	Stand Alone ICTC + Mobile	F-ICTC	(%) District Hospital with Facility	Number of SDH	Stand Alone ICTC	F-ICTC	(%) SDH with Testing Facilities
Phase 1	Karnataka	48	56	0	117%	27	52	0	193%	146	163	0	112%
	Tamil Nadu, Puduchery	44	40	0	91%	36	37	0	103%	232	186	0	80%
	Andhra Pradesh	40	39	2	103%	23	23	0	100%	99	99	0	100%
Total		**132**	**135**	**2**	104%	**86**	**112**	**0**	130%	**477**	**448**	**0**	94%
Phase 2	Maharashtra + Mumbai+ Goa + D&D	67	59	1	90%	48	56	0	117%	132	125	0	95%
	Gujarat + DNH	22	24	2	118%	28	25	0	89%	32	32	0	100%
	MP	6	11	0	183%	50	50	0	100%	56	37	19	100%
	Odisha	6	6	1	117%	32	61	0	191%	28	24	4	100%
	Rajasthan	10	17	1	180%	34	54	0	159%	18	15	0	83%
Total		**111**	**117**	**5**	110%	**192**	**246**	**0**	128%	**266**	**233**	**23**	96%
Phase 3	Bihar	8	15	0	188%	39	72	0	185%	55	12	0	22%
	Chhattisgarh	6	6	0	100%	24	24	0	100%	15	15	0	100%
	Jharkhand	3	6	0	200%	22	21	0	95%	16	16	0	100%
	Uttar Pradesh	16	19	0	119%	153	146	0	95%	2	0	0	0%
	West Bengal	12	23	0	192%	65	30	0	46%	77	69	0	90%
Total		**45**	**69**	**0**	153%	**303**	**293**	**0**	97%	**165**	**112**	**0**	68%
Phase 4	Assam	5	10	0	200%	20	37	1	190%	6	0	3	50%
	Delhi	6	10	0	167%	15	15	0	100%	18	21	0	117%
	Haryana	7	5	0	71%	21	21	0	100%	6	6	2	133%
	Himachal Pradesh	2	3	0	150%	12	12	0	100%	72	23	0	32%
	Kerala+L'dweep	11	11	0	100%	45	30	3	73%	80	45	5	63%
	Manipur	2	4	0	200%	7	14	0	200%	0	0	0	0%
	Mizoram	0	0	0	0%	8	9	0	0%	2	2	0	0%
	Nagaland	0	0	0	0%	11	15	0	0%	0	0	0	0%
	Punjab & Ch'garh	11	13	0	118%	23	24	0	104%	38	38	0	100%
	Tripura	1	1	0	100%	3	3	0	100%	11	11	0	100%
	Uttarakhand	3	3	0	100%	18	17	0	94%	20	12	4	80%
Total		**48**	**60**	**0**	125%	**183**	**197**	**4**	110%	**253**	**158**	**14**	68%
Phase 5	J&K	4	7	0	175%	22	22	0	100%	0	0	0	0%
	Arunachal	0	0	0	0%	16	21	0	0%	0	0	0	0%
	Meghalaya	1	1	0	100%	8	7	0	88%	0	0	0	0%
	Sikkim	2	4	0	200%	4	8	0	200%	0	0	0	0%
	A & N Islands	0	0	0	0%	0	3	0	0%	0	6	6	0%
Total		**7**	**12**	**0**	171%	**50**	**61**	**0**	122%	**0**	**6**	**6**	#DIV/ 0!
Total India		**343**	**393**	**7**	**117%**	**814**	**909**	4	112%	1161	957	43	86%

Table 12 (Saturation of Health Facilities Contd.)...

...Table 12 (Saturation of Health Facilities Contd.)

Phase	State	Community Health Centre (CHC)				Mobile ICTC				Primary Health Centres			
		Total CHC	Stand Alone ICTC	F-ICTC	% CHC with Facilities	Mobile ICTC	Stand Alone Facility	F-ICTC	% Mobile van with Facilities	Total PHC	Stand Alone ICTC	F-ICTC	% PHC with Testing Facility
Phase 1	Karnataka	180	169	0	94%	0	12	25	0%	2310	66	825	39%
	Tamil Nadu, Puducherry	304	296	0	97%	17	17	0	100%	1210	108	608	59%
	Andhra Pradesh	245	218	27	100%	26	0	0	0%	1710	0	1624	95%
Total		729	**683**	**27**	97%	**43**	**29**	**25**	126%	**5230**	**174**	**3057**	62%
Phase 2	Maharashtra + Mumbai+ Goa + D&D	372	360	0	97%	9	8	0	89%	1811	0	1233	68%
	Gujarat + DNH	263	205	57	100%	3	3	0	100%	1205	4	820	68%
	MP	333	41	292	100%	90	0	0	0%	1155	0	134	12%
	Odisha	367	88	37	34%	0	1	0	0%	1228	0	0	0%
	Rajasthan	376	93	93	49%	0	0	0	0%	1516	0	65	4%
Total		**1711**	**787**	**479**	74%	**102**	**12**	**0**	12%	**6915**	**4**	**2252**	33%
Phase 3	Bihar	70	10	0	14%	1	1	0	100%	534	89	0	17%
	Chhattisgarh	56	56	0	100%	3	3	0	100%	0	0	0	0!
	Jharkhand	173	19	106	72%	3	3	0	100%	313	0	0	0%
	Uttar Pradesh	515	47	21	13%	0	0	0	0%	3690	0	0	0%
	West Bengal	348	114	10	36%	4	4	0	100%	909	6	0	1%
Total		**1162**	**246**	**137**	33%	**11**	**11**	**0**	100%	**5446**	**95**	**0**	2%
Phase 4	Assam	149	36	26	42%	2	2	0	100%	714	0	40	6%
	Delhi	860	27	52	9%	3	3	0	100%	0	0	0	0
	Haryana	95	56	39	100%	0	0	0	0%	440	0	4	1%
	Himachal Pradesh	64	8	0	13%	2	2	0	100%	95	0	19	20%
	Kerala+L'dweep	230	53	82	59%	4	4	0	100%	660	0	95	14%
	Manipur	16	16	0	100%	6	6	0	100%	72	12	18	42%
	Mizoram	8	8	0	0%	0	9	0	0%	57	5	26	0%
	Nagaland	21	21	0	0%	0	10	0	0%	126	24	45	0%
	Punjab &Cha'garh	123	9	109	96%	22	1	20	95%	214	0	19	9%
	Tripura	11	3	9	109%	0	0	0	0%	96	0	34	35%
	Uttarakhand	55	13	37	91%	1	1	0	100%	254	0	38	15%
Total		**1632**	**250**	**354**	37%	**40**	**38**	**20**	145%	**2728**	**41**	**338**	14%
Phase 5	J&K	68	6	0	9%	0	0	0	0%	0	0	0	0
	Arunachal	50	10	0	0%	1	1	0	0%	119	0	11	0%
	Meghalaya	28	2	3	18%	2	2	0	100%	103	0	2	2%
	Sikkim	2	0	2	100%	1	1	0	100%	24	0	14	58%
	A & N Islands	0	4	0	0%	0	0	0	0%	0	0	0	0%
Total		**148**	**22**	**5**	18%	**4**	**4**	**0**	100%	**246**	**0**	**27**	11%
Total India		5382	1988	1002	56%	200	94	45	70%	20565	314	5674	29%

7.7 Lack of Availability of Cohort Information on EID and Linkage of HIV Infected Children to ART

At National level 70% of the detected positive pregnant women are enrolled at ART centres have undergone CD4 testing and out of those eligible 88% have been initiated on ART. But this information is obtained from two separate sources and is not the cohort information.

Table 13: Compilation of PPTCT Line-list Information in India, 2012-13

Phase	State	Pregnant Women Tested 2012-13	Pregnant Women Detected (A)	Pregnant Women who Underwent CD4 test	Percentage	Positive Pregnant Women with CD4 <350	Number Initiated on ART	Percentage	Remarks
Phase 1	Karnataka	1044706	1786	1605	90%	519	565	109%	Outlier
	Tamil Nadu +Puducherry	873654	1016	971	96%	661	313	47%	
	Andhra Pradesh	1141437	2798	2588	92%	737	710	96%	
Total		**3059797**	**5600**	**5164**	**92%**	**1917**	**1588**	**83%**	
Phase 2	Maharashtra + Mumbai+ Goa + D&D	1277017	1892	390	21%	160	106	66%	Needs to be updated
	Gujarat + DNH	662114	691	611	88%	252	224	89%	
	Madhya Pradesh	491043	323	176	54%	47	53	113%	Outlier
	Odisha	274995	246	158	64%	62	56	90%	
	Rajasthan	386007	383	0	0%	0	00	0%	Incomplete data
Total		**3091176**	**3535**	**1335**	**38%**	**521**	**439**	**84%**	
Phase 3	Bihar	187450	284	186	65%	49	44	90%	
	Chhattisgarh	77479	190	70	37%	34	29	85%	
	Jharkhand	92059	58	50	86%	12	51	425%	Outlier
	Uttar Pradesh	493925							Data Not Rep
	West Bengal	479576	475	375	79%	134	106	79%	
Total		**1130489**	**1007**	**681**	**68%**	**229**	**230**	**100%**	
Phase 4	Assam	234370	117	78	67%	36	98	272%	Outlier
	Delhi	206388	338	300	89%	115	102	89%	
	Haryana	189580	224	115	47%	13	25	192%	Outlier
	Himachal Pradesh	55347	0						Data Not Rep
	Kerala+L'dweep	137565	63	61	97%	21	19	90%	
	Manipur	48713	151	113	75%	66	64	97%	
	Mizoram	20271	151	53	35%	24	16	67%	
	Nagaland	19608	124	102	82%	32	29	91%	
	Punjab and Chandigarh	250472	42	24	57%	16	16	100%	
	Tripura	23701	20						Incomplete
	Uttarakhand	48823	51	**28**	55%	**28**	**28**	100%	
Total		**1254838**	**1301**	**874**	**67%**	**351**	**397**	**113%**	
Phase 5	J & K	53890							Data Not Rep
	Arunachal Pradesh	9482	3	0	0%	0	0		
	Meghalaya	17257	57	28	49%	16	9	56%	
	Sikkim	8495							Data Not Rep
	A & N Islands	6430							Data Not Rep
Total		95554	60	28	47%	16	9	**56%**	
Total in all districts		8631854	11503	8082	70.2%	3034	2663	87.7%	

8

8. Supervision, Monitoring and Evaluation

8.1 Standard Operating Procedures (SOPs) for Supervisory Visits

Intensive supervision is critical for scale-up and consolidation of PPTCT implementation at the States and districts. The SOPs for these visits from national and state level are as mentioned below:

(1) **Identification of states/ districts** for field visits based on performance against the targets set in Annual Action Plan 2013-14

a. **Sources of data for assessment**: CMIS data from ICTC/ PPTCT line-list reports

b. **Key Indicators for selection of state**:

i. Low coverage of HIV testing for ANC/ large proportion of HIV infected women detected directly- in- labour

ii. Low levels of linkage to ART

iii. Low level of DBS testing

(2) **Preparation for visit:**

a. Targets set in Annual Action Plan (2013-14) pertaining PPTCT activities

b. PPTCT performance status pertaining–State level/ District wise

c. Communication to SACS/ district health officer/ DAPCU officer regarding

d. Communication to SACS/ DAPCU officer to set meeting with State/ district Officials for debriefing

(3) **Key officers to accompany during field visit:**

a. JD BSD/ PPTCT consultant

b. JD CST/ Regional coordinator

c. DAPCU Officer/ DPM

d. State RCH officer/ District RCH officer

(4) **Activities during field visit:**

a. In-depth review of performance against physical indicators, process indicators quality indicators

b. Review of data management & data analysis done by the state/ district

c. Mentoring of state/ district officials on data analysis to facilitate functioning

d. Assessment to be done as per supervisory check-lists

e. Visit to at least 4-ICTCs, one each at district, sub-district, block and PHC levels and the concerned ART centres/ Link ART centres

f. Debriefing of PD SACS/ MD-NRHM and District collectors/ District Health & Family Welfare Officer at the end of the visit

(5) **Activities Post field visit:**

a. Preparation & submission of report within one week to competent authority

b. Share report with RCH/ NRHM counterparts

c. Feedback to state/ district including recommended action, time lines & persons responsible within two days of approval of the tour report by NACO/ SACS

d. Monthly follow -up with the states for follow-up actions based on recommendations

8.2 Supervisory Checklist:

Checklists to be used by officers visiting from national level to states, State level to districts and facility level are included in **Annexure 3.**

8.3 Monitoring Mechanisms:

The following paragraphs describe a framework for monitoring implementation of PPTCT services at different levels. Establishment of these mechanisms will facilitate effective implementation of programme interventions.

1) **National PPTCT-NRHM coordination committee**

a. **Members:** Programme manager in Department of AIDS Control, counterpart in National Rural Health Mission (NRHM) and Maternal and Child Health programme, Programme officers in DAC, WHO, UNICEF and other partners has been constituted in October 2013.

b. **Mandate**:

i. Establish co-ordination mechanisms between NACP and NRHM at state and district levels

ii. Policy decision

1. To facilitate HIV testing coverage among pregnant women early during pregnancy

2. To ensure 100% HIV testing coverage for ANC attending health facilities in public sector

3. To ensure implementation of common ANC-PPTCT package of services

4. Incorporation of PPTCT activities in the Mother and child tracking system (MCTS)
5. Facilitate involvement of general health system staff including PHC supervisors and Sub-centre ANMs in home visits to the HIV infected mothers, prompt retrieval action etc.
6. To facilitate establishment of Facility integrated ICTCs and screening facilities up to sub-centre level in priority districts
7. To facilitate management of supply of HIV test KITS in cold -chain

iii. Establish mechanism for sharing of data between NACP and NRHM

iv. Provision of enablers for access to stand-alone ICTCs for confirmation and to ART centres for enrolment and drug collection visits

v. Monitoring and Evaluation

vi. Development of normative tools –guidelines, training curriculum/ modules etc.

vii. Review of procurement and supply chain management of HIV test kits and ARV drugs

c. **Frequency of Meetings**: quarterly

2) **National PPTCT technical Resource Group (TRG)** – experts in the field of PPTCT, MCH, Public Health, Programme etc. provide technical inputs for programme. This groups mandate is to:

a. Review of progress in programme implementation

b. Review of Evidence generated globally and nationally for inputs into national programme

c. **Frequency of Meetings:** quarterly

3) **Joint NACP-NRHM State PPTCT programme implementation committee**: to be constituted at state level consisting of programme managers from the SACS, NRHM, particularly state RCH officers, partners etc. This committee is to be mandated with the following:

a. District and facility level co-ordination between NACP and General health staff

b. Draw training plans and ensure timely execution of the same

c. Ensure uninterrupted supply of logistics including test kits, drugs, safe delivery kits, registers and formats

d. Plan for joint supervisory visits

e. Joint monitoring, using technology to track linkages of all pregnant women to testing and treatment services along with safe delivery

f. Overall this committee will provide supportive supervision and issue guidelines for ensuring linkage between ARTS, ICTC through ANMs. ASHAs & ORWs etc.

Frequency of Meetings: quarterly

4) **Ensure Joint NACP-NRHM District PPTCT implementation committees** are established. Members to include HIV nodal officers of district/ DAPCU officers, District RCH Officers, SMOs of ART centres etc. This committee is jointly responsible for

   a. District level planning and implementation of services,

   b. Ensure involvement of general health staff in programme activities including, HIV screening, referral to ICTCs, ensuring hospital deliveries, referral to ART centres, follow-up of cases etc.

   c. Collaboration with NGOs and other partners.

   Frequency of Meetings: monthly meetings

5) **Case Management Teams** comprising of ICTC counsellors (of the facility where pregnant woman is tested positive or place of delivery or place of migration), ORWs of concerned ICTCs and Medical Officers of nearest ART centres to jointly supervise progress in provision of PPTCT services on a case- to -case basis. This team will together ensure:

   a. Linkages to ART centres

   b. Prompt evaluation and initiation of ART on priority

   c. Linkage to the patient to nearest facility for drug collection

   d. Ensure preparation for safe hospital delivery

   e. Provision of Sy NVP prophylaxis for babies for 6 weeks

   f. Linkage of babies to EID sites both DBS testing at selected ICTCs and Whole blood Specimen (WBS) testing at ART Centres

   g. Regular collection and compliance with consumption of ART for mother and ARV for baby

   h. Update all events in PPTCT line-lists maintained at all facilities and the district level

8.4 Responsibility for Supervision and Monitoring

State Level:

1. JD/ AD/ DD BSD
2. JD CST/ consultant CST/ AD nursing
3. PPTCT consultant
4. Regional co-ordinator CST
5. State RCH Officer

District Level:

1. DAPCU officer
2. Non-DAPCU district: ART SMO/ MO or In-charge of headquarters ICTC or District RCH Officer/ Deputy CMHO.

8.4 Roles and Responsibilities of Programme Managers and Staff in PPTCT Programme

PPTCT program is to be implemented through the ICTC and ART centres and also needs to be an integrated response with general health systems. Following table details terms of reference of staff at different levels regarding their roles and responsibilities in the implementation of the PPTCT programme:

Table 14: Roles and Responsibilities of Programme Managers and Staff in PPTCT Programme

S.N.	Designation of Official/ Staff	Role in PPTCT Implementation
1	Project Director State AIDS Control Society (SACS)	1. Facilitate development of state micro-plan for implementation of PPTCT programme 2. Facilitate establishment of **Joint State PPTCT programme implementation committee** 3. Facilitate regular meetings of the implementation committee for programme review and policy decisions 4. Advocacy with Secretary Health and MD-NRHM to ensure ownership of PPTCT programme by Director, Health & Family Welfare services, state RCH officer 5. Facilitate formation of the Joint District PPTCT implementation committee and Case Management Teams in all districts of the state 6. Facilitate measures to ensure ownership of the programme at district level by District Health Officer, CMHO, Civil Surgeon, district RCH officer etc. 7. Advocacy with Secretary, Medical Education Department to ensure adherence to National programme guidelines so as to minimize linkage loss in medical college hospitals 8. Facilitate joint review meetings of NACP-NRHM and Medical Education programme managers at regular intervals 9. Facilitate involvement of professional organizations like FOGSI, IAP, IMA etc. to ensure systematic involvement of the private sector 10. Overall leadership of programme with regular monitoring of progress
2	Nodal Officer for PPTCT in the SACS	1. Ensure close co-ordination between the Basic Services Division and Care, Support & Treatment Division at state and district level 2. Establish close liaison with State RCH officers and other key stakeholders in NRHM 3. Establish close liaison with state level office bearers of professional organizations like FOGSI, IAP, IMA etc. for systematic involvement of private nursing homes 4. Facilitate formation of the Joint District PPTCT implementation committee and Case Management Team in all districts of the state 5. Ensure regular meetings of Joint District PPTCT implementation committee through supportive supervision and monitoring 6. Establish mechanism for monitoring progress in linkage of HIV infected pregnant women to services under PPTCT programme e.g. use of google doc. for tracking and monitoring at state level 7. Establish Stand-alone ICTCs at all CHC level health facilities 8. Ensure availability of HIV screening facilities at all high delivery points below CHC in the form of F-ICTCs and sub-centre level screening using WBFPT 9. Ensure availability of PPTCT services at all high delivery points 10. Ensure mechanisms for quick linkage of screened HIV positive pregnant women to SA-ICTCs for confirmation, to ART Centres for baseline tests and ART initiation and EID services for HIV exposed babies 11. Monitoring of compliance of infected pregnant women with PPTCT guidelines through regular follow-up visits of NACP outreach workers and other health system resources

S.N.	Designation of Official/ Staff	Role in PPTCT Implementation
3	State RCH Officer	1. Facilitate ownership of the PPTCT programme by the District health Officers (CMHO, Civil surgeon) 2. Facilitate ownership of PPTCT activities by PHC medical officers and the field staff 3. Facilitate provision of support for confirmation of HIV status of pregnant women, travel to ART centres for enrolment and drug collection, along with facilities for institutional deliveries 4. Facilitate establishment of HIV screening facilities at all high delivery points in the form of F-ICTCs and sub-centre level HIV and Syphilis screening using WBFPT, TB and Nutritional screening. 5. Ensure availability of PPTCT services at all high delivery points 6. Facilitate regular meeting of the Joint District PPTCT implementation committee 7. Facilitate involvement of PHC medical officers and concerned ANMs and other health system functionaries with the **Case Management Team** 8. Ensure involvement of medical officers at PHCs and ANMs in monitoring linkage to ICTCs, ART centres and compliance of HIV infected pregnant women to PPTCT regimens
4	District HIV programme Manager – DAPCU/ DNO	1. Ensure formation of the Joint District PPTCT implementation committee and Case Management Team in all districts of the state 2. Ensure regular meetings of Joint District PPTCT implementation committees 3. Establish Stand-alone ICTCs at all CHC level health facilities 4. Ensure availability of HIV screening facilities at all high delivery points below CHC in the form of F-ICTCs and sub-centre level HIV and Syphilis screening using WBFPT, TB and Nutritional screening 5. Ensure availability of PPTCT services at all high delivery points 6. Ensure mechanisms for quick linkage of screened positive HIV positive pregnant women to SA-ICTCs for confirmation, to ART Centres for baseline tests and initiation of ART and EID services for HIV exposed babies 7. Monitoring of compliance of infected pregnant women with PPTCT guidelines through regular follow-up visits of through ANMS/ ASHAs and ORWs (NACP outreach workers) 8. Training load assessment 9. Establish close liaison with District Health and Family Welfare Officer (CMHO/ Dy. CMHO/ RCH officer) 10. Overall planning and implementation of programme at district level 11. Ensure up to date recording at all facilities and timely reporting to state level 12. Supervisory visits to ART centres, ICTCs and other HIV screening centres 13. Close liaison with professional doctors associations like FOGSI, IAP, and IMA etc. to facilitate involvement of private nursing homes and Private Practitioners 14. Advocacy, Communication and social mobilization activities for effective implementation of PPTCT services
5	District RCH Officer	1. Advocacy with District Health & Family Welfare Officers (DH & FWOs, CMHOs, Civil surgeons) for ownership of PPTCT programme 2. Ensure ownership of PPTCT activities by PHC medical officers and the field staff 3. Ensure provision of support for confirmation of HIV status of pregnant women, travel to ART centres for enrolment and drug collection along with facilities for institutional deliveries 4. Facilitate establishment of HIV screening facilities at all high delivery points in the form of F-ICTCs and sub-centre level HIV and Syphilis screening using WBFPT, TB and Nutritional screening 5. Ensure availability of PPTCT services at all high delivery points 6. Ensure regular meeting of Joint District PPTCT implementation committees 7. Ensure involvement of PHC medical officer, concerned ANM and other health system functionaries in **Case Management Team so as to ensure** linkage to screened positive pregnant women to ICTCs for confirmation, to ART centre for enrolment and to monitor compliance with PPTCT programme guidelines

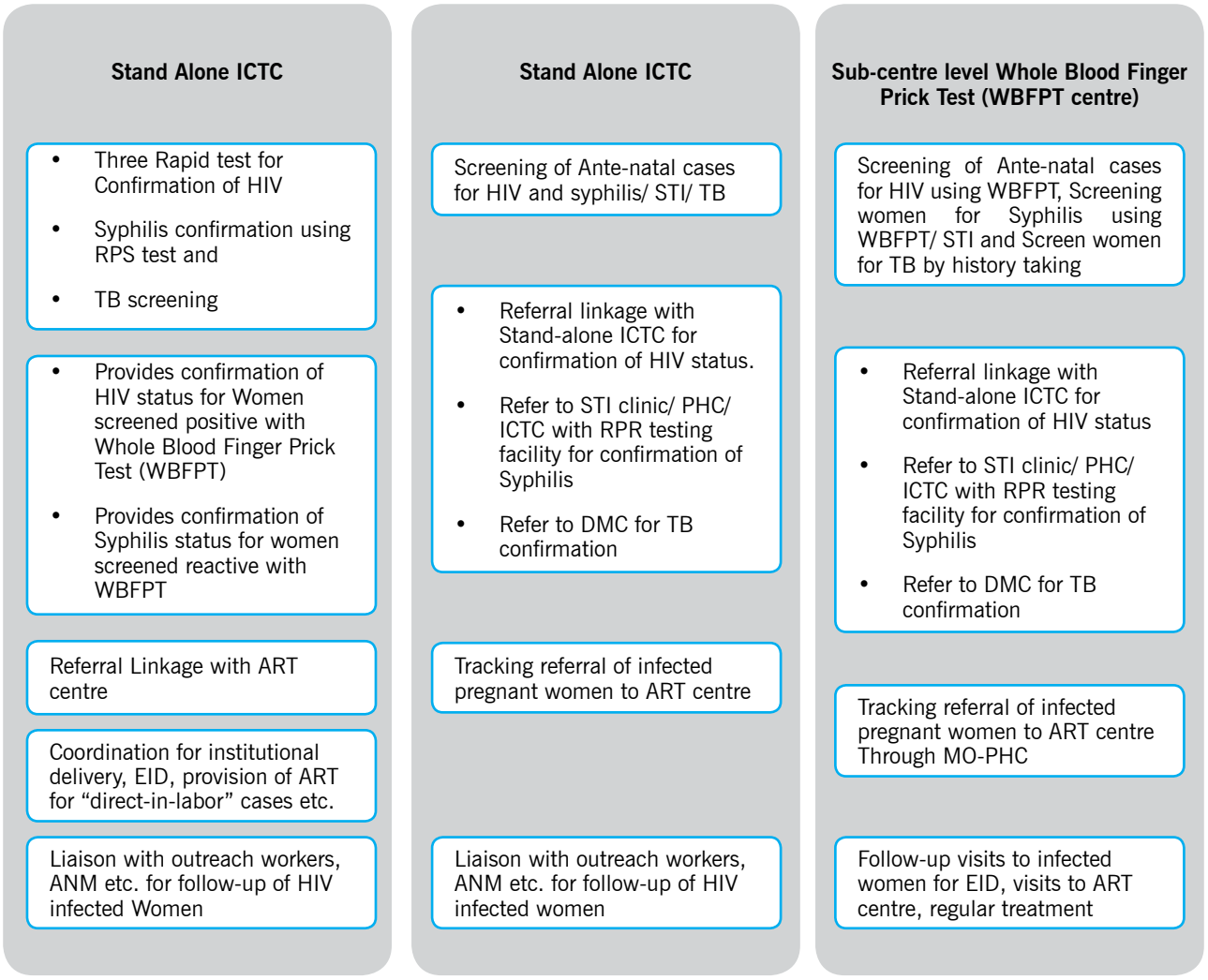
S.N.	Designation of Official/ Staff	Role in PPTCT Implementation
6	Monitoring and evaluation assistant at DAPCU/ ICTC counsellor at the district headquarter	1. Maintenance of consolidated PPTCT line-lists 2. Updating PPTCT line-lists with all events, compilation, analysis and interpretation etc. 3. Timely reporting of PPTCT line-lists to SACS
7	District ICTC supervisor	1. Supervisory visit ART centres, ICTCs and other HIV screening centres 2. Supportive supervision of ICTC 3. Facilitate co-ordination between ICTC/ ART centre staff with general health staff (RCH/ NRHM) 4. Ensure preparedness for conducting HIV positive deliveries at delivery points 5. Ensure linkages of HIV exposed babies to Early Infant diagnosis Programme 6. Ensure follow-up visits to HIV infected pregnant women by health staff/ outreach workers 7. Facilitate reporting of all key events to district M & E Assistant for updating line-lists
8	In-charge medical officer at ICTC	1. Measures to ensure 100% screening of all pregnant women enrolled into Ante-Natal Care within General Health Systems 2. Measure to ensure HIV, Syphilis, TB and Nutritional screening early in pregnancy. 3. Ensure uninterrupted availability of HIV test-kits, drugs, referral forms and registers 4. Ensure prompt referrals and linkage of HIV infected pregnant women to ART centres 5. Ensure safe institutional deliveries 6. Ensure provision of ARV: Sy NVP for 6 weeks for all babies irrespective of choice of feeding 7. Ensure linkage of the baby to EID services 8. Clinical assessment and care of patients while on ART 9. Monitoring adherence to ART 10. Ensure home visits to the HIV infected pregnant women at prescribed frequency 11. Ensure timely follow-up visits of infected pregnant women to ART centres
9	Counsellor stand-alone ICTC/ F-ICTC	1. Provision of preventive health education to all Ante-natal care women 2. Ensure coverage of all registered ANCs in the area of jurisdiction with HIV testing. Ensure HIV and Syphilis screening TB and Nutritional screening. 3. Provision of psychosocial support to all infected women 4. Ensure prompt referral of HIV infected ANCs to ART centres 5. Coordination with ART Centres/ LAC Plus/ LAC for confirmation of linkages and follow -up 6. Track evaluation at ART centres, initiation of ART and referral back for care 7. Maintaining record of referral, its outcomes, planned place for delivery, planned follow- up dates, persons responsible for follow-up etc. 8. Ensure hospital deliveries 9. Ensure provision of ARV to baby as prescribed 10. Ensure provision of ART to all direct-in-labour cases 11. Maintain up-to-date recording of all events and communication of the same to district M&E assistant 12. Ensure linkages of HIV exposed infants to EID Programme
10	Nurse	1. Nurses at F-ICTCs –all activities mentioned for counsellors 2. Administration of ART (TDF+3TC+EFV) to mother presenting directly-in-labour and initiation of Sy Nevirapine for 6 weeks to all HIV exposed babies

S.N.	Designation of Official/ Staff	Role in PPTCT Implementation
11.	ANM	1. Screening test for HIV, Syphilis using WBFPT for all ANCs registered in pregnancy including TB and Nutritional screening. 2. Ensure confirmation of HIV status in SA ICTCs among screened HIV positive ANCs 3. Establishing linkages of infected pregnant women to ART Centres 4. Facilitate their institutional deliveries 5. Follow-up with the mother after delivery to monitor compliance in ART consumption 6. Facilitate linkages of HIV exposed babies to EID Programme 7. Provide reminders to mother on ART regarding visits to ART centre, CD4 testing, etc.
12	ICTC Lab technician	1. Conduct HIV testing as per guidelines and provide feedback to referring PHC MO regarding status with concurrence of patient. Conduct of RPR testing for Syphilis confirmation. 2. Liaison with F-ICTC and Sub-centre screening facility staff for early information on screened positive women and track their arrival for confirmation. Collection and dispatch of blood specimens for CD4 testing and base-line tests 3. Collection and dispatch of blood specimens for CD4 testing & base-line tests 4. Maintaining stock of WBFPT for F-ICTCs and Sub-centre screening facilities 5. Ensure uninterrupted supply of test kits to Screening facility in the jurisdiction with cold- chain maintenance 6. Records maintenance and timely reporting to district and state level
13	Outreach worker (IL &IL&FS/ Link-workers, CSC outreach worker, etc.)	1. Mobilize pregnant women screened positive for HIV and or Syphilis with WBFPT to visit ICTC for confirmation 2. Facilitate Linkage of HIV infected pregnant female to ART centre 3. Facilitate institutional delivery 4. Facilitate visit of the infected female to ICTC for EID 5. Facilitate regular follow-up visits to ART centre for ART, CD4 testing etc. 6. Home visit to monitor compliance with ART medication 7. Liaison with AWW, ASHA,ANM for follow-up with the infected female
14	Medical Officer of facility conducting positive delivery	1. Ensure safe delivery practices, availability of safe delivery KIT 2. Ensure continuation of ART during labour and delivery 3. Provide ART (TDF+3TC+EFV) for direct –in- labour HIV positive pregnant women and Sy Nevirapine to HIV exposed babies 4. Ensure confirmation of HIV status of direct-in labour cases at the earliest 5. Counsel the infected pregnant women regarding importance of visiting ART centres and receiving ART and doing their base-line tests 6. Counsel infected pregnant women regarding importance of EID and saving their lives
15	ART centre SMO/ MO	1. Prompt evaluation of HIV infected pregnant women at ART centres 2. Prompt initiation of life-long ART (TDF+3TC+EFV) to every HIV infected pregnant woman regardless of CD4 levels 3. Ensure feedback to referring ICTC regarding receipt of case at ART centre, outcome of evaluation and prescribed drug regimen for the patients 4. Ensure Constitution of **Case Management Team** comprising ICTC counsellor, concerned ANM, ASHA & concerned out-reach worker 5. Draw plan for follow-up visits including linkages to LAC in consultation with the HIV infected pregnant women for assessment and drug collection 6. Ensure uninterrupted supply of drugs and logistics to LAC-Plus, LACs 7. Ensure provision of information on all events to the district M&E assistant for updating in PPTCT line-lists

S.N.	Designation of Official/ Staff	Role in PPTCT Implementation
16	ART centre counsellor/ staff nurse	1. Prioritization of HIV infected pregnant women for ART preparedness and adherence counselling 2. Counselling on important components of PPTCT programme like role of ART, duration, safe hospital delivery, EID, breastfeeding etc. 3. Up-to- date record keeping and documentation of follow -up and ensure tracking of missed cases 4. Liaison with referring ICTC counsellor, outreach workers to track compliance and adherence to schedule of follow-up visit to ART centre 5. Liaison with referring ICTC counsellor for WBS) testing (whole blood specimen) of DBS positive babies

8.6 HIV Screening/ Testing Facilities in PPTCT Programme

Figure 5: PPTCT Services to Pregnant Women in India



8.7 Monitoring Indicators

Table 15: Process, Outcome and Impact Indicators

		Numerator	Denominator	Norm
Process Indicators				
1	HIV testing coverage for ANCs	Number PW HIV tested	Total ANC registration	80%
2	Linkage of HIV positive pregnant women to ART	Total Number enrolled in HIV care	Total positive pregnant women detected	90%
3	CD4 testing coverage	Total CD4 done among those enrolled	Total Number enrolled in HIV care	95%
4	ART initiation for HIV positive pregnant women	Number initiated on ART for her own health	Total Number eligible for ART	95%
5	Women: Regularity on ART	Total number on ART at 6 months/ 12 months	Total number initiated on ART during the month	95%
6	Baby: Regularity on ARV Prophylaxis and its completion	Total number on ARV prophylaxis completed for full 6 weeks	Total number of babies initiated on ARV prophylaxis	90%
7	Baby: EID coverage at 6 weeks	Total number tested with dried blood spot (DBS) tests between 6 weeks -6 months	Total Number of live births among positive pregnant women prior to 6 months	80%
8	Linkage of baby to ART centre for whole blood specimen (WBS) testing	Total number of babies tested using whole blood test amongst those DBS positive	Total number of DBS positive babies	90%
Outcome Indicators				
1	Number of babies found HIV infected by whole blood specimen test	Number found positive on whole blood specimen tests	Total number of WBS tests done	<5%
2	Number of HIV positive babies confirmed at 18 months with anti-body test	Number confirmed positive using anti-body based HIV test at 18 months	Total number of live births in HIV infected mother during the past 18 months	<5%
Impact Indicator				
1	Rate of transmission of HIV	Total number of babies found HIV infected born to them at 18 months	Total Number of HIV infected pregnant women detected during the period (18 months prior)	<5%

8.8 Evaluation of Implementing States

Following activities are envisaged for evaluation of implementation of PPTCT services

(1) **Visit** to the implementing state from NACO BSD every month for the first six months of implementation. Programme partners at national level may also be involved in these supervisory visits

(2) **A review** meeting of all implementing states to be done at national level every two months for the initial 6 months of implementation (3 meetings). These review meetings are expected to facilitate cross-learning between the states. Nodal Officer PPTCT services at SACS and the state RCH officer to be invited for participation in these meetings

(3) **State level review** meeting of district nodal officer for PPTCT services along with district RCH officers to be conducted every two months for initial 6 months of implementation (3 meetings), and then quarterly.

(4) **Centrally driven evaluation** of implementation of PPTCT services in each state after completion of six months of implementation. These evaluations to be undertaken every 6 months.

(5) **SACS driven evaluation** of implementation of PPTCT services in two districts per month. These evaluations are to be started after establishment of the services in the districts i.e. after three months implementation of services.

(6) **Monthly review meeting district level:** District nodal officer to convene PPTCT review meeting every month with participation of District RCH officer, medical officer from ART centre, DAPCU officer/ DPM, District ICTC supervisor and all stand-alone ICTC counsellors. Alternatively PPTCT agenda should be incorporated into monthly meeting of ICTC counsellors and district level review meetings of medical officers.

(7) Review of "case management teams" is to be an important agenda for the monthly meeting

8.9 Tools for Data Collection for Supervision and Monitoring

8.9.1 PPTCT Line-List (ICTC-ART)

Table 16: PPTCT Beneficiary Line-List (ICTC-ART)

Name of the State:	Updated for the Month
	Year:
District:	Name of MO I/ c ICTC:
	Contact No. of MO:
Name of ICTC:	e-mail id:
(where generated)	**Name of SMO/ MO of ART Centre:**
	Contact No. of SMO/ MO
Name of ART:	e-mail.id:
(with whom shared)	**Name of DAPCUO/ Nodal Officer I/ c of HIV Programme:**
	Designation of I/ c Officer
	Contact No.:
	e-mail.id:
	Pertains to ICTC
	Pertains to ART centre

PPTCT Checklist

Sl. No.	Name of the HIV infected Pregnant Female	Age (in Years)	Husband's name and Current Address	Father's name and Parental Address	Date of HIV Test (Confirmatory test)	PID Number	Name of the ICTC where tested	Type of Client ANC/ Direct-in Labour/ Post-delivery	Gestational Age (Weeks)
1	2	3	4	5	6	7	8	9	**10**

Expected Date of Delivery (EDD)	Expected Place of Delivery	Date of Actual Delivery	Actual Place of Delivery (refer to guidance)	Outcome of Pregnancy (Live Birth/ Still Birth/ MTP/ Abortion)	Status of Mother after delivery up to 6 weeks (Alive/ Dead)	**17.** Infant feeding practice			
						6 weeks	6 months	12 months	18 months
						1. Exclusive Breast Feeding (BF) 2. Exclusive Replacement feeding (ERF) 3. Mixed feeding*	1. Continued BF+ Complimentary, 2. Continued ERF + semi solids, 3. Mixed feed between 6 W to 6 M	1. Continued BF 2. BF stopped date (DD/ MM/ YY)	1. Continued BF 2. Stopped BF
11	12	13	14	15	16	17a	17b	17c	17d

New Case/ Already Registered at ART	Date of ART Registration + ART No.	Date of CD4 testing with Baseline Count	WHO Clinical Stage		Whether diagnosed as having TB (Yes/ No)	If "Yes", date of starting ATT (dd/ mm/ yy)	Date of Completing ATT (dd/ mm/ yy)	ART Registration no.	Date of initiating ART		Reason for Stopping ART
18	19	20	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**26**	**29**

Date of starting NVP Syp at birth DD/ MM/ YY	Date of completing 6 weeks of NVP Syp	If stopped before 6 weeks, reason	Date of initiation of CPT in baby	At 6 weeks, Family Planning method adopted (Cu-T/ OCP/ Tubectomy (in case of C-sections and 2nd child/ >2 living children already in addition to use of condoms)	Name of Infant	ICTC ID of infant	Unique DNA infant code	**38.** DNA PCR: DBS tests		
								6 weeks (positive or negative)	6 months (positive or negative)	6 weeks after stopping of breastfeeds
30	31	32	33	34	35	36	37	38a	**38b**	**38c**

39. DNA PCR: WBS tests			HIV +ve infant			
WB specimen collection date	Result (Positive/ Negative)	Result of 2nd WBS (in case of DBS & 1st WBS discordance) Pos/ Neg	If infant is negative with 2nd WBS, Date of Referral back to ICTC	Pre-ART registration Date and Number	Baseline CD4 count	Date of Initiation of ART
39a	**39b**	**39c**	**39d**	**40**	**41**	**42**

Date & result of Antibody Tests at 18 months – Pos/ Neg	Date of stopping CPT	**45.** Outcome ART		**46.** Outcome ART/ ARV prophylaxis		**47.** Whether immunization completed		Remarks***
		Mother		**Baby**				
		Alive & On Treatment	ARTdiscontinuation** Date and reason (code below)	Alive & On Treatment	ART/ ARV discontinuation** Date and reason	Primary including measles and Vitamin A (Y/ N)	First booster dose at 18 months (Y/ N)	
43	44	45a	45b	46a	46b	47a	47b	48

* 1. After one week of stopping breastfeeding, 2. Death of baby, 3. Death of mother, 4. Parent/ Guardian decision, 5. Medical Reason,
**A – Maternal death, B – Stopped on Medical advice, C – Transfer out, D – Lost to follow up. E – opted out of the programme
***Relevant information to be captured, e.g.: 1. Client's current location with date, 2. Information on authorized attendant to whom ART can be dispensed (from 6 months of pregnancy up to 2 months post-delivery), 3. Any other important information on related to client or her baby

8.9.2 Mechanism for Maintenance of PPTCT Line-list

Table 17: Shared Responsibility for Completion of PPTCT Line-list

	Activities	Time line	Responsibilities
Monitoring, Data Compilation and Validation	a) Initiation & Maintenance of **PPTCT Line list** at ICTC	Event basis	ICTC counsellor
	b) Sharing of line- lists with concerned ART centre/ s by email on event basis/ weekly	Monthly	ICTC Counsellor
	c) Obtaining feedback of triplicate referral form	Event basis	
	d) **Compilation** of line lists at the ICTC level by Counsellor at 15 days and at the end of the month	Every 15 days	ICTC Counsellor/ ART Counsellor
	e) Sharing completed/ compiled line list with full details to DAPCU/ SACS BSD	Every 15 days	ICTC Counsellor/ DPM/ DIS/ District Nodal Officer for HIV/ AIDS
	Activities	**Time line**	**Responsibilities**
Monitoring, Data Compilation and Validation	f) **Monthly meeting** between ICTC and concerned ART centre and other stakeholder/ NRHM at district/ regional level to be conducted in 1st week of every month for verifying data	Monthly	ICTC Counsellor/ DPM/ DIS/ District Nodal Officer for HIV/ AIDS
	g) After the monthly meeting, DAPCU to **analyse/ validate** and share completed line list with SACS BSD every month by 10th	Monthly	DAPCU, Dist ICTC Sup, MO-ART, In Non DAPCU dist – responsibility of validation will be of DNO with the help of HQ ICTC Counsellor
	h) BSD at SACS to share analysed/ verified/ completed line list with CST. **PPTCT cohort report** preparation from Line-list and submitted to NACO by 15th of every month	Monthly	SACS BSD, CST/ PD/ APD SACS
	i) **Review** at SACS level, identification of priority districts/ sites and specific action plan	Quarterly basis	PD SACS), APD (SACS), JD (BSD), Consultant PPTCT, DD/ AD (BSD/ CST),JD (M&E), RC (CST)
Counsellor of ICTC where PW is detected is responsible for follow-up and retention in care during pregnancy, delivery of both the mother and baby with support from MO-PHC, concerned PHC supervisors, ANMs/ ASHAs and outreach workers			

8.9.3 Referral and Feedback form for HIV Infected Pregnant Women

A. To be filled by ICTC counsellor

Date of referral: ____/ ____/ ____ Referring ICTC:_____

Name of ART centre e where referred: _____

Client's age: _____ PID number: _____

Any relevant information or records to be mentioned (e.g., past CD4 if any etc.,):

_____

Signature of MO

Details of Contact person at ICTC with telephone and e-mail: _____

B. Feedback from ART centre (To be filled by the receiving ART centre counsellor or staff nurse and sent to the transferring ART centre by e-mail)

_____ (Name of Patient with PID number), referred by you on date___/ ___/ ___ has reported and is registered with us on___/ ___/ ___ She is eligible/ not eligible for ART. Please discuss the follow-up plans on phone on _____/ _____/ _____ We will be referring the patient back on___/ ___/ ___

Name and Signature of SMO/ MO *Phone no with e mail of SMO/ MO*

Follow- up actions for case management after discussion with ART centre (to be filled and records maintained at ICTCs). {*Important items for planning– when will patient be referred back, who will follow -up with her, PPTCT interventions plans, visit to ART centre, breast feeding decision etc.*}

8.9.4 PPTCT Service Delivery Matrix-HIV Infected Pregnant Women

Table 18: PPTCT Service Delivery Matrix-HIV Infected Pregnant Women

Activities	Screening for HIV	Confirmation of Status	Initial Assessment and ARV Initiation	Follow-up Visit	Labour and Delivery	Post-natal Follow-up
Level of facility	Sub-centre, PHC, F-ICTC	Stand-alone ICTC	Nearest ART centre	ART centre, LAC-Plus centre, LAC	1. Patient's choice 2. Preferably institutional	Stand-alone ICTC
Procedure	Whole Blood Finger Prick Test (WBFPT) for HIV and Syphilis	• Three sequential rapid HIV Antibody tests and • RPR confirmation for Syphilis and • Draw blood for CD4 count, Other baseline investigations and send to ART centre	• Start ART regardless of CD4 and Clinical Stage of HIV • Draw blood for CD4 count, Other baseline investigations if not done at ICTC before initiation of ART • Clinical staging	1. Dispensing ART 2. Assessment of compliance 3. Clinical and laboratory assessment 4. Provision of additional month ARV near EDD	1. Continue ART for mother 2. Initiate and dispense Nevirapine for baby for 6 weeks	EBF, EID, CPT initiation, Immunization for Child and Continue ART for mother post natal period and life long
Direct Responsibility	ANM/ staff nurse/ F-ICTC counsellors/ LT	Stand Alone ICTC counsellor/ LT	ART centre Medical Officer	1. ART centre MO/ SMO, MO-IC LAC-Plus and LAC. 2. ICTC counsellor for compliance of ARV	MO of the institution/ labour room nurse	MO IC and counsellor of SA ICTC
Responsibility for co-ordination	DAPCU/ nodal Officer/ District RCH Officer/ Mo-PHC	Concerned ANM, Supervisor at PHC, MPI/ C	Stand-alone ICTC counsellor, District ICTC supervisor (DIS), DAPCU, ART centre MO	Stand-alone ICTC counsellor	DAPCU/ HIV nodal Officer/ District RCH Officer/ Stand-alone ICTC counsellor	DAPCU/ District ICTC supervisor

Table 18.1

HIV Infection Detected "Directly-in-Labour"					
Activities	**Screening for HIV**	**Confirmation**	**Provision of ART**	**Linkage to ART**	**Post Natal Follow-up**
Level of facility	Labour room	Nearest stand-alone ICTC the next day	• Provision of ART during labour as soon as screened positive regardless of CD4 and Clinical stage • Collection of blood sample for CD4 and other basic investigations before starting ART and send to ART on priority basis	1. Through SA-ICTC. 2. Blood sample to be transported for CD4 testing	Nearest Stand-alone ICTC
Procedure	1. Screening with WBFPT 2. Referral for confirmation	1. Confirmation of HIV status at the earliest	1. Administration of ART	Initiate ART based on clinical staging and CD4 count	EID, CPT initiation
Direct Responsibility	Labour room nurse/ ICTC LT	SA ICTC counsellor/ LT	MO of the institution/ Labour room nurse	ART centre MO/ SMO	MO ICTC and counsellor of SA ICTC
Responsibility for co-ordination	Stand-alone ICTC counsellor	Stand-alone ICTC counsellor	DAPCU/ HIV nodal Officer/ District RCH Officer/ MO-PHC	Stand-alone ICTC counsellor, District ICTC supervisor, DAPCU, ART centre medical officer	DAPCU/ HIV nodal Officer/ District RCH Officer/ MO-PHC

9

9. Strategy for retention in care: Outreach activities

Mechanism for Retention in Care

1. Formation of case management team (CMT)
2. Mechanism for co-ordination between the members of CMT
3. Mechanism for patient home visit once a month initially, biweekly in 8th & 9th month of pregnancy and weekly in 10th month of pregnancy and during post-partum period

The functioning of case management team is discussed earlier. Following paragraphs discuss the mechanism for outreach activities

9.1 Need of Outreach Activities in PPTCT Services

Outreach for confirmation of HIV testing among those screened positive at F-ICTCs/ Sub-centres

1. Outreach for ensuring linkage of HIV infected pregnant women to ART
2. Outreach to ensure compliance with medication and follow-up visit to ART centres
3. Linkage of HIV exposed babies for DNA/ PCR testing with Dried Blood Spot (DBS), Whole blood specimen (WBS) and confirmation with antibody tests at 18 months
4. Linkage of HIV infected child to ART
5. Compliance of HIV infected child on ART
6. Scheduled home visit for HIV infected pregnant women as recommended in PPTCT programme

9.2 Human Resources Options Available for Outreach

1. Outreach sessions of ICTC counsellors
2. ART centre Care coordinator through outreach worker under the Care and Support centres
3. Outreach workers supported under the GFATM RCC Round-2 through the IL&FS
4. Engagement of general health system staff (Karnataka experience)
5. Coordination of above activities by District ICTC Supervisor and District Programme manager

9.3 Levels of Outreach Activities

ICTC Counsellors

SACS and DAPCU should establish mechanisms to inform the ICTC counsellor about pregnant woman screened HIV positive with first rapid test. Counsellor in turn should ensure confirmation of result, provision of adequate counselling and linkage to ART, DNA/ PCR testing of exposed babies along with provision of ART/ ARV etc. Any gap in this continuum of care is to be addressed through outreach

session, to be undertaken by ICTC counsellors every Saturday afternoon. In these sessions counsellor should prioritize following group of clients for outreach:

1. Pregnant women screened "positive" for HIV but pending confirmation of HIV status at stand-alone ICTCs
2. HIV infected pregnant women who are "not linked" to ART
3. HIV exposed babies whose specimen collection for DNA/ PCR test using DBS or WBS is pending from ICTC or ART centre respectively
4. HIV infected babies not initiated on ART

ART centre Care coordinator (CC) and outreach worker under the Care and Support centres (CSC): All patients enrolled into HIV care at ART centres are tracked by the ART centre staff. A patient due for visit at ART centres is generated for those on ART and CD4 testing. The care co-ordinator or ART centre staff nurse is usually entrusted with the responsibility to track the attendance/ CD4 testing according to due lists. Following is the desired mechanism for tracking:

1. CC/ staff nurse identifies the patients who failed to present at ART centres on the due date and 2-3 subsequent days as patients are likely to have drugs until this time
2. If the patient does not report to ART centre, CC contacts her/ him over telephone and if she/ he is traced and agrees to report back immediately the activity is closed
3. If patient does not report back even after 2-3 phone calls, the information is passed on to the CSC for retrieval action
4. The CSC entrusts the responsibility on ANMs/ ASHAs/ outreach workers who have to pay a home visit and motivate the patient back on care
5. If the patient could not be retrieved after this, support from the district level network is sought if available
6. The information may also be passed back to the ICTC counsellor for contact during outreach session

9.4 Outreach Worker of IL& FS

IL&FS ETS is a private company that received grant under Global Fund RCC-2 to support NACP in outreach activity especially for HIV infected pregnant women. It has employed outreach Workers (ORW) in most states in the country except Karnataka (where integration with the RCH Programme health functionaries: ANMs/ ASHAs have been successful), numbers being directly proportional to number of Positive pregnant women found in an area. The ORWs, work in close liaison with ICTC counsellors and facilitate monitoring, tracking and following-up of HIV positive pregnant women. Once the ICTC

counsellor informs them about detection of a HIV infected pregnant woman the ORW follows the infected pregnant woman throughout the pregnancy, delivery and post-partum period. She/ he undertake following activities:

1. Home visit at a prescribed interval during pregnancy, delivery and post-partum period
2. Ensure linkage to ART centre for registration, CD4 testing and initiation of ART/ ARV
3. Compliance with drug collection and follow-up visits to ART centres
4. Institutional delivery
5. Linkage of HIV exposed baby to DNA/ PCR testing at 6 weeks, 6 months and 6 weeks after breast feeds have been stopped (anytime after 6 months and before 13 months)
6. Linkage of HIV exposed baby to ART centre

9.5 Close Coordination with of ILFS Outreach Workers

1. Quarterly meeting of NACP staff and IL&FS through the steering committee at national and state level
2. Monthly meeting of IL& FS NGO staff and NACP programme managers and staff at district level
3. Monthly meeting of NACP staff, ORWs and NGO staff at sub-district/ block level to review performance and share data

9.6 Involvement of General Health System Staff (Karnataka Experience)

As a policy the Government of Karnataka has engaged general health system staff for provision of HIV detection, treatment and care and support services. Accordingly, health functionaries like ANMs and ASHAs are entrusted with all outreach activities in their area of work.

The NACP staff work in close coordination with the general health system staff. While ICTC counsellors work in close coordination with ANMs ASHAs, DAPCU manager and ICTC supervisors ensure coordination at district level and Taluk levels, including review of PHC -wise performance along with other health programmes.

The health workers implement the complete range of activities as follows:

1. ANM/ ASHA facilitate HIV testing of pregnant women registered for ANC
2. If detected HIV infected linkage to ART and institutional deliveries
3. Ensure regular follow-up visit of patient to ART centre for drug collection etc.,
4. Early Infant diagnosis
5. Linkage of HIV exposed/ infected babies to ART centre

10

10. Steps in Roll-out of PPTCT Services in a State

10.1 Assessment Visit

It is planned to visit each state where new PPTCT services are to be implemented. This visit is to be undertaken by a team visit comprising of officers from National level (NACO, WHO, UNICEF etc.), SACS and officers from implementing states. This team will assess following aspects and provide recommendations to the state:

a) SWOT analysis (Strength, Weakness, Opportunity and Threats) for PPTCT services in the state

b) Re-evaluate identified districts for specific interventions for scale-up of testing services by NACO

c) Mapping of available service delivery facilities and human resources at state and district level

d) Analysis of performance of the state pertaining to existing programme of single dose Nevirapine (if new multi-drug regimen has not yet been rolled-out already)

e) Evaluation of reporting mechanisms for existing programme

f) Evaluation of supply and logistics management for existing programme

g) The team will undertake meeting with all stakeholders including Secretary Health, Project Director SACS, MD NRHM, Director Health & Family Welfare Services, State RCH Officer, SACS BSD & CST programme Managers, State IL& FS programme manager etc.

h) Field visits to at least 2 districts including all levels of health facilities and interaction with all stakeholders

i) Identification of gaps and recommendations for complete base-line preparation along with timelines and persons responsible

j) Debriefing with all stakeholders including Principal Secretary Health, PD-SACS, MD-NRHM and others state officers so as to provide momentum and enhance ownership.

k) SACS to submit an action taken report (within 4 weeks of assessment visit)

10.2 Pre-appraisal Visit for Launch of PPTCT Services

a) A team comprising of programme managers from national and state level along with representatives from implementing state who will undertake pre-appraisal visit to a state preparing for implementation of new PPTCT services. The aim of this visit is to evaluate the micro-plan for implementation developed by state

b) This team will provide technical inputs into the micro-plan based on their experience of implementation. It will ensure that following activities are clearly reflected in the state micro-plan:

i) Identification of **nodal person** for PPTCT activities at state and districts district level

ii) **Training plan**:

1) National level **training of trainers (ToT)**-identification of trainers for medical and Para-medical staff from within the state

2) Assessment of **training load**, number of batches, schedule for training, time-line, resource person etc.

3) Conduct of state level **training for the Key programme staff** like DAPCU officer, District RCH officer, ART centre medical officers, ICTC counsellors, ART centre staff nurse and counsellors etc.

4) **Training of general health staff** like Medical Officers ICTCs and -F-ICTCs, the PHC supervisors, ANMs/ ASHAs etc.

5) Sensitization of personnel involved in outreach activities for HIV infected pregnant women including the IL&FS, LWS, CSC, ART Centre and ASHA etc.

iii) **Plan for management of supplies and logistics**

1) Forecasting requirement,

2) Mechanism for receipt of supplies from national level,

3) Storage and supply to ART centres along with Link-ART centres

4) Mode of transport of stocks

5) Maintenance of record and reporting on stock position

iv) **Plan for supervision, monitoring and reporting**

1) Establishment of **coordination mechanism** between NACP and NRHM at National, State and District level

2) Schedules for co-ordination meetings at all levels

3) Directive to ART centre and DAPCU/ DNO for establishment of "patient management unit" for compliance of patient with the ARV regimens

4) Plan of Review meetings -frequency and level

5) Plan for Joint field visit between NACP and NRHM officers

6) Plan for internal evaluation to assess quality of programme implementation at district level

v) The team will facilitate a **consultation with all stakeholders** for finalization of micro-plan. This micro-plan is to be presented by Project Director of SACS to highest authorities in the state i.e. Principal Secretary Health & Family Welfare, MD-NRHM, Director of Health and Family Welfare Services etc. The finalized micro-plan is to be submitted to NACO for approval.

vi) The appraisal team will also provide recommendations to state team to expedite preparatory activities along with timelines and person responsible.

10.3. Execution of Activities Enlisted in Micro-plan

a. Measures to enhance HIV testing facilities: Directives from state level authorities for establishment of F-ICTCs and sub-centre level HIV screening facility

b. Request to NACO for Prioritization of Trainees from the state of F-ICTCs and WBFPT

c. SACS team to ensure organization of "Training of Trainers".

d. This above mentioned ToT is to be utilized for finalization of training plan for all state and district level trainings

e. SACS to extend all support for time-bound completion of preparatory activities including

   i) Issue of directives to all selected District Health & Family Welfare Officers from MD-NRHM/ Director Health to facilitate implementation of programme

   ii) Provision of funds and logistics for field trainings

   iii) Mobilization of resource persons

   iv) Supply of drugs and other logistics like whole blood finger prick test kits, registers, referral formats etc. to the districts

f. The national and state level programme managers will participate in selected trainings for monitoring of quality of training. At least two district level training programmes are to be covered. Programme managers from implementing states will also participate in these activities

10.4 Report on Completion of Preparation

The Project Director, SACS is to submit a **completion report** on preparatory activities to NACO in a time-bound manner. The DAC will then issue approval for implementation of new PPTCT services based on following criterion:

i) Training of more than 90% ART and ICTC centre staff

ii) Training of more than 80% of the health system staff –Medical officers/ labour room nurse, ANMs etc.

iii) Sensitisation of more than 90% DAPCU/ DNO

iv) Availability of drugs sufficient to last for at least 6 months

v) Availability of formats for recording and reporting

vi) Availability of functional internet facility in >90% of ART/ ICTC facilities

vii) Issuance of a directive from Principal Secretary, Health of the state to all districts and all concerned to facilitate implementation of new PPTCT services

On fulfilment of above criterion, Secretary DAC will issue approval letter to Principal Secretary Health of the state for implementation of PPTCT services and need for his ongoing support.

The SACS is to launch the services formally on a large scale to ensure coverage of the event in media so as to generate awareness. Inclusion of public representatives is desirable.

A template for preparatory activities is placed at **Annexure-2**

10.5. Strengthening Linkage between Service Delivery Points

1. Testing linkages:
    - Incorporation of HIV testing in the ANC package
    - Common registration for ANC and HIV testing
    - Co-location of HIV testing facilities with the OBGY OPD to minimize drop outs
    - ANC Whole Blood Finger Prick Test kits (WBFPT) for HIV and Syphilis for ANC mothers in all settings
2. Linkage to ART centres for enrolment:
    - Use of line-lists
    - Mechanism to update the line-lists event-wise
    - Mechanism to collate information between ICTC and ART centre real time use of customised software (IL& FS), google.doc (e.g., Andhra Pradesh)
    - Collation of line-lists at state level
    - Linkage to EID centre for HIV exposed infants
    - Expansion of EID facilities to stand -alone ICTC in all selected districts
    - Updating of information on DBS reports etc. into the line-lists on a real time basis
3. Linkage to DBS positive children to ART centre for WBS tests
4. Linkage of HIV infected children to ART

10.6. Training Plan

10.6.1: Training Guidelines

Table 19 provides guidance on different types of training, level, participants and resource persons

Table 19: Training Guideline for Scale-up of PPTCT Services

SN	Type of Training	Participants	Level of Training	Batch size	Duration	Resource Person
1	**Training of Trainers (ToT)**	1. SACS- In-charge Basic Services Division 2. SACS-in-charge of CST Division 3. PPTCT consultant 4. Regional Co-ordinator CST 5. State RCH Officer 6. Selected Medical college Faculty OBGY department(3)Selected 7. Senior Medical Officer at ART centres (4 in number) 8. State Institute of Health & FW;Maternal Health/ Child Health Faculty 9. Selected DAPCU officers (4), 10. Selected DPM (4) 11. President FOGSI/ IAP/ IMA	State levels	20	4 days	1. Nodal Officer from NACO 2. WHO 3. UNICEF 4. CDC 5. Programme managers from implementing states 6. Consultants/ medical college faculty from implementing states
2	**Training of Doctors and District programme managers**	1. ART centre SMO 2. ART centre MO 3. DAPCU Officer 4. District Programme manager 5. District RCH Officer 6. Regional/ District Training Institute Principal/ HEO/ DNO	State levels	20	3 days	1. Trainers trained in ToT 2. One facilitator every 5 participants 3. Facilitators to be mix of state programme managers, medical college faculties and ART centre SMO 4. Observer from national level
3	**Training of key programme staff**	1. District ICTC supervisors 2. Stand-alone ICTC Counsellors 3. ART centre counsellors 4. ART centre staff nurse 5. Principals of Schools of Nursing 6. Principals ANM Training Centre 7. Principals LHV Training centre 8. District Nursing Officers 9. DHEOs/ Dy HEOs	State levels	20	2 days	1. Trainers trained in ToT 2. One facilitator every 5 participants 3. Facilitator-mix of state and District programme manager, medical college faculty and ART centre SMO 4. One observer from national level
4	**Training of medical officers**	1. Block medical officer (Taluk health officer) 2. MO-IC of stand-alone ICTC 3. MO-IC of F-ICTC	Regional/ District level	20	2 days	1. Trainers trained in ToT or state level training 2. One facilitator every 5 participants 3. Facilitators to include DAPCU officer, ART SMO, DPM, Medical college faculty 4. A observer from state level trained in ToT
5	**Sensitization of Medical officers**	All medical officers other than in-charge ICTCs and F-ICTCs	District level	25-30	Half day	1. DAPCU officer 2. ART centre SMO 3. Observer from state level trained in ToT
5	**Training of paramedical staff**	1. Staff nurse at F-ICTC 2. Staff nurse at labour rooms/ delivery points 3. Block health Education Officers	District level	20	1 day	1. DAPCU officer 2. MO-I/ c stand-alone ICTC 3. DPM/ District ICTC supervisor 4. One observer from district level trained at state level
6	**Sensitization of health workers**	1. PHC supervisors -health assistant male/ female 2. ANMs/ ASHAs/ dlnS	District	25-30	Half day	1. MO-IC stand-alone ICTC 2. DPM/ District ICTC supervisor 3. One observer from district level trained at state level
7	**Sensitization of Outreach workers**	Outreach workers from IL&FS, CSC, Link workers scheme and ART centre)ANMs/ ASHAs/ DLNs	District	25-30	Half day	1. DPM 2. District ICTC supervisor/ HQ ICTC counsellor

10.6.2 Prioritization of Staff Training for District Level Staff

The trainings may follow a cascade with State level ToT followed by district level ToT and then field staff training. The priority training is as follows:

1. State level ToT
2. State level training of key programme staff
3. District level training of Labour room nurses
4. Regional/ District level training Medical officers in-charge at ICTCs
5. Sensitization of PHC MOs ANMs/ ASHAs etc.

10.6.3 Training Load–NACP and Related Staff

10.6.4 Training Load for Health System Staff

Table 20: Training Load of NACP Staff for Implementation of PPTCT Services

Phase	State	Total Number of Districts	Key NACP Facilities							Out Reach Workers (IL&FS)	No. of Persons to be Trained		
			Number of HIV Testing Facilities				ART Centres	Centre of excellence (CoE)	Paediatric CoE				
			Stand-Alone ICTCs	F-ICTCs	PPP ICTCs	Total					Medical Officers	Para-Medical Staff	Total Staff to be Trained
Phase 1	Karnataka	30	444	854	138	1436	55	1	1		1612	1612	3224
	Tamil Nadu +Puducherry	36	405	935	105	1445	50	1	1	397	1626	2023	3649
	Andhra Pradesh	23	406	1494	236	2136	51	1	1	611	2290	2901	5191
Total Phase 1		**89**	**1255**	**3283**	**479**	**5017**	**156**	**3**	**3**	**1008**	**5528**	**6536**	**12064**
Phase 2	Maharashtra + Goa + D&D	37	675	1394	492	2561	64	1	1	763	2775	3538	6313
	Gujarat + DNH	36	313	881	184	1378	25	1	0	134	1511	1645	3156
	Madhya Pradesh	50	143	446	19	608	10			30	731	761	1492
	Odisha	30	185	42	7	234	9			50	315	365	680
	Rajasthan	33	182	150	11	343	11			25	434	459	893
Total Phase 2		**186**	**1498**	**2913**	**713**	**5124**	**119**	**2**	**1**	**1002**	**5766**	**6768**	**12534**
Phase 3	Chhattisgarh	27	104	86	0	190	5			26	257	283	540
	Bihar	38	208	0	5	213	13			73	318	391	709
	Jharkhand	24	67	21	2	90	6			20	153	173	326
	Uttar Pradesh	75	217	32	47	296	22	1		65	495	560	1055
	West Bengal	19	256	12	4	272	10	1	1	49	336	385	721
Total Phase 3		**183**	**852**	**151**	**58**	**1061**	**56**	**2**	**1**	**233**	**1559**	**1792**	**3351**

Phase	State	Total Number of Districts	Key NACP Facilities							Out Reach Workers (IL&FS)	No. of Persons to be Trained		
			Number of HIV Testing Facilities				ART Centres	Centre of excellence (CoE)	Paediatric CoE				
			Stand-Alone ICTCs	F-ICTCs	PPP ICTCs	Total					Medical Officers	Para-Medical Staff	Total Staff to be Trained
Phase 4	Assam	27	83	78	15	176	3			19	239	258	497
	Delhi	9	95	50	0	145	9	1	1	15	187	202	389
	Haryana	21	88	43	6	137	1				184	184	368
	Himachal Pradesh	12	47	19	2	68	3			6	101	107	208
	Kerala	15	165	91	37	293	8	0	0	17	343	365	708
	Manipur	9	60	25	7	92	9	1	1	104	134	238	372
	Mizoram	8	36	24	5	65	3			33	90	123	213
	Nagaland	11	70	34	1	105	6			48	142	190	332
	Punjab and Chandigarh	23	85	153	3	241	8	1	0	31	311	342	653
	Tripura	8	18	25	1	44	1			4	65	69	134
	Uttarakhand	13	48	129	10	187	2			11	220	231	451
Total Phase 4		**156**	**795**	**671**	**87**	**1553**	**53**	**3**	**2**	**288**	**2016**	**2309**	**4325**
Phase 5	J & K	22	35	0	0	35	2				86	86	172
	Arunachal Pradesh	17	36	13	0	49	2				90	90	180
	Meghalaya	11	12	5	4	21	1				48	48	96
	Sikkim	4	13	6	0	19	1				32	32	64
	A & N Islands	3	13	7	0	20	0				29	29	58
Total Phase 5		**57**	**109**	**31**	**4**	**144**	**6**	**0**	**0**	**0**	**285**	**285**	**570**
Total in all states		**671**	**4509**	**7049**	**1341**	**12899**	**390**	**10**	**7**	**2531**	**15154**	**17690**	**32844**

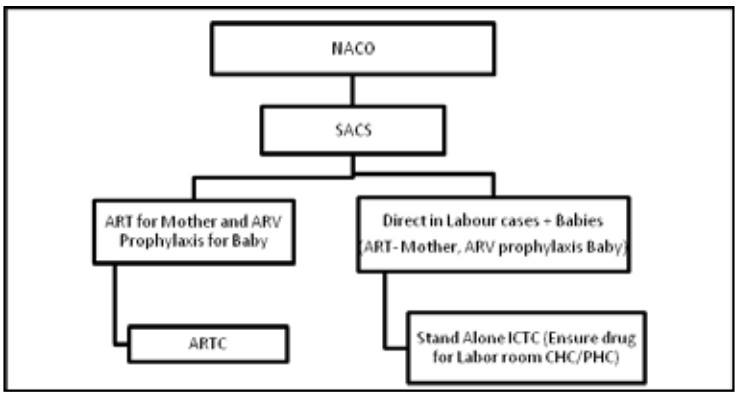
Considerations in computation of training load:
A. Medical Officers: 1. One doctor per stand-alone ICTC, F-ICTC, PPP ICTC 2. Two doctors per ART centre, 3. Two from CoE, 4. One from pCoE 5. Two district level officers 6. Plus additional three need base + BSD
B. Para-Medical Staff: 1. One Staff per Stand-alone ICTC, F-ICTC, PPP ICTC 2. Two people per ART centre, 3. Two from CoE, 4. One from pCOE 5. Two district level officers, 6. All ORWs from IL&FS and additional 7. Plus additional three need based
C. These are the recommended minimum no. of participants to be trained, depending upon high delivery sites, need -based decisions can be taken at state level
D. *Plan for refresher trainings in implementing states

Table 21: Training Load for Staff Nurse at Delivery Points

Phase	State	Approximate No. of Facilities for Delivery in Selected Districts				Number of Staff Nurses to be Trained		
		Total Districts Selected for Scale-up	District Hospital	Sub-Divisional Hospital	CHC	District Hospital	SDH	CHC
Phase 1	Karnataka	30	31	146	180	372	876	540
	Tamil Nadu +Puducherry	36	36	230	389	432	1380	1167
	Andhra Pradesh	23	17	58	281	204	348	843
Total Phase 1		**89**	**84**	**434**	**850**	**1008**	**2604**	**2550**
Phase 2	Maharashtra + Mumbai+ Goa+D&D	37	2	81	368	24	486	1104
	Gujarat + DNH	24	22	28	310	264	168	930
	Madhya Pradesh	20	20	35	131	240	210	393
	Odisha	23	25	25	300	300	150	900
	Rajasthan	20	22	12	269	264	72	807
Total Phase 2		**124**	**91**	**181**	**1378**	**1092**	**1086**	**4134**
Phase 3	Bihar	19	17	19	43	204	114	129
	Chhattisgarh	12	11	15	74	132	90	222
	Jharkhand	7	5	1	63	60	6	189
	Uttar Pradesh	41	99	0	317	1188	0	951
	West Bengal	16	0	0	301	0	0	903
Total Phase 3		**95**	**132**	**35**	**798**	**1584**	**210**	**2394**
Phase 4	Assam	10	9	6	42	108	36	126
	Delhi	9	31	15	0	372	90	0
	Haryana	15	15	18	84	180	108	252
	Himachal Pradesh	2	2	8	19	24	48	57
	Kerala+L'dweep	10	11	60	0	132	360	0
	Manipur	9	7	1	16	84	6	48
	Mizoram	7	7	2	9	84	12	27
	Nagaland	9	9	0	19	108	0	57
	Punjab and Chandigarh	18	18	32	122	216	192	366
	Tripura	1	0	0	2	0	0	6
	Uttarakhand	4	7	9	0	84	54	0
Total Phase 4		**94**	**116**	**151**	**313**	**1392**	**906**	**939**
Phase 5	J & K	1	1	0	8	12	0	24
	Arunachal Pradesh					0	0	0
	Meghalaya	2	5	0	11	60	0	33
	Sikkim					0	0	0
	A & N Islands							
Total Phase 5		**3**	**6**	**0**	**19**	**72**	**0**	**57**
Total in all selected districts		**405**	**429**	**801**	**3358**	**5148**	**4806**	**10074**
Consideration: 12 nurses at district hospital, 6 at SDH and 3 at CHC								

10.7. Supply Chain Management Structure

Figure 6: Supply Chain Management Structure



10.8 Drugs and Logistics Stocking Guidelines

Table 22: Drugs and Logistics Stocking Guidelines

S.N.	Item	Storage	Calculation of Requirement	Supply Chain
1	TDF+3TC+EFV	Cool dry place	1. If number of Direct-in-labour women screened HIV positive is less then number of SA-ICTC's requirement is calculated as per actual number of facilities, other-wise as per number of Direct-in-labour cases detected 2. 10% buffer added	SACS to DAPCU to ICTC
2	TDF+3TC+EFV	Cool dry place	1. All HIV positive pregnant women need ART for own health. Calculation done for 365 days requirement considering 1 tablet per day 2. Stocks to be provided to ART centres for initiation	SACS to ART centre to LAC
3	Nevirapine Syrup	Cool dry place	1. Syrup Nevirapine required for 6 weeks per HIV exposed baby. It is assumed that each baby will require 3 bottles of 25 ml each. 2. Requirement calculated considering all live births to HIV infected pregnant women 3. Supply to be done similar to ARV for direct-in labour cases	SACS to DAPCU to ICTC
4	Whole blood finger prick test (HIV and Syphilis)	Cold Chain	1. Requirement based on average number of monthly direct-in labour cases per facility 2. Supplies to be linked with other ICTC HIV test kits	SACS to DAPCU to ICTC

10.9 Guidelines for ARV Drug Management

District Level

1) Forecasting should be done per facility

2) Supplies for 3 months to be done to each facility

3) Stocks should be monitored for consumption vs programme data and variance analysis to be done on a monthly basis
4) Reporting for Stock status at ART centre level and at ICTC level for relevant commodities should be done by the 15th of every month and the same should be monitored on a monthly basis by DAPCU/ SACS (existing formats in CMIS/ SIMS should be used for reporting)
5) Buffer stock for one quarter should be maintained at all levels
6) Relocation within district should be done to ensure that no drugs expire and no stock-outs occur in any facility
7) Replenishment of stock for each facility should be based on
    a. Last stock supplied
    b. Stock consumed during the period
    c. Closing balance for each commodity
    d. Requirement for next 3 months
8) Storage principles for each commodity of drugs should be followed as prescribed in ART guidelines **(Annexure-8)**

State Level

1) Forecasting should be done per district/ ART centre level after compilation of the facility wise information from each district
2) Supplies for 3 months to be done to each district/ ART centre level
3) Stocks should be monitored for consumption vs programme data and variance analysis to be done on a monthly basis for each district ART centre level
4) Analysis of stock positions at State level for drugs & report to NACO
5) Feedback to DAPCU/ ART centers on analysis of stock positions/ non reporting facilities/ variances in consumption vs programme performance
6) Buffer stock for one quarter should be maintained at all levels
7) Relocation between districts should be done to ensure that no drugs expire and no stock outs occur in any district
8) Replenishment of stock for each facility should be based on
    a. Last stock supplied
    b. Stock consumed during the period
    c. Closing balance for each commodity
    d. Requirement for next 3 months
9) Storage principles for each commodity of drugs should be followed as prescribed in ART guidelines

Annexure 1: List of Districts for PPTCT Interventions

	State	District
1	**Andhra Pradesh**	Adilabad
2		Anantapur
3		Chittoor
4		Cuddapah
5		East Godavari
6		Guntur
7		Hyderabad
8		Karimnagar
9		Khammam
10		Krishna
11		Kurnool
12		Mahbubnagar
13		Medak
14		Nalgonda
15		Nellore
16		Nizamabad
17		Prakasam
18		Rangareddy
19		Srikakulam
20		Visakhapatnam
21		Vizianagaram
22		Warangal
23		West Godavari
24	**Goa**	North Goa
25		South Goa
26	**Karnataka**	Bagalkot
27	**Karnataka**	Bangalore
28	**Karnataka**	Bangalore Rural
29	**Karnataka**	Belgaum
30	**Karnataka**	Bellary
31	**Karnataka**	Bidar
32	**Karnataka**	Bijapur
33	**Karnataka**	Chamrajnagar
34	**Karnataka**	Chikballapur
35	**Karnataka**	Chikmagalur
36	**Karnataka**	Chitradurga

	State	District
37	**Karnataka**	Dakshina Kannada
38	**Karnataka**	Davangere
39	**Karnataka**	Dharwad
40	**Karnataka**	Gadag
41	**Karnataka**	Gulbarga
42	**Karnataka**	Hassan
43	**Karnataka**	Haveri
44	**Karnataka**	Kodagu
45	**Karnataka**	Kolar
46	**Karnataka**	Koppal
47	**Karnataka**	Mandya
48	**Karnataka**	Mysore
49	**Karnataka**	Raichur
50	**Karnataka**	Ramnagaram
51	**Karnataka**	Shimoga
52	**Karnataka**	Tumkur
53	**Karnataka**	Udupi
54	**Karnataka**	Uttara Kannada
55	**Karnataka**	Yadgir
56	**Maharashtra**	Ahmadnagar
57	**Maharashtra**	Akola
58	**Maharashtra**	Amravati
59	**Maharashtra**	Aurangabad
60	**Maharashtra**	Bhandara
61	**Maharashtra**	Bid
62	**Maharashtra**	Buldana
63	**Maharashtra**	Chandrapur
64	**Maharashtra**	Dhule
65	**Maharashtra**	Gadchiroli
66	**Maharashtra**	Gondiya
67	**Maharashtra**	Hingoli
68	**Maharashtra**	Jalgaon
69	**Maharashtra**	Jalna
70	**Maharashtra**	Kolhapur
71	**Maharashtra**	Latur
72	**Maharashtra**	Mumbai
73	**Maharashtra**	Mumbai (Suburban) *
74	**Maharashtra**	Nagpur

	State	District
75	**Maharashtra**	Nanded
76	**Maharashtra**	Nandurbar
77	**Maharashtra**	Nashik
78	**Maharashtra**	Osmanabad
79	**Maharashtra**	Parbhani
80	**Maharashtra**	Pune
81	**Maharashtra**	Raigarh
82	**Maharashtra**	Ratnagiri
83	**Maharashtra**	Sangli
84	**Maharashtra**	Satara
85	**Maharashtra**	Sindhudurg
86	**Maharashtra**	Solapur
87	**Maharashtra**	Thane
88	**Maharashtra**	Wardha
89	**Maharashtra**	Washim
90	**Maharashtra**	Yavatmal
91	**Pondicherry**	Karaikal
92	**Pondicherry**	Mahe
93	**Pondicherry**	Pondicherry
94	**Pondicherry**	Yanam
95	**Tamil Nadu**	Ariyalur
96	**Tamil Nadu**	Chennai
97	**Tamil Nadu**	Coimbatore
98	**Tamil Nadu**	Cuddalore
99	**Tamil Nadu**	Dharmapuri
100	**Tamil Nadu**	Dindigul
101	**Tamil Nadu**	Erode
102	**Tamil Nadu**	Kancheepuram
103	**Tamil Nadu**	Kanniyakumari
104	**Tamil Nadu**	Karur
105	**Tamil Nadu**	Krishnagiri
106	**Tamil Nadu**	Madurai
107	**Tamil Nadu**	Nagapattinam
108	**Tamil Nadu**	Namakkal
109	**Tamil Nadu**	Perambalur
110	**Tamil Nadu**	Pudukkottai
111	**Tamil Nadu**	Ramanathapuram
112	**Tamil Nadu**	Salem

	State	District
113	**Tamil Nadu**	Sivaganga
114	**Tamil Nadu**	Thanjavur
115	**Tamil Nadu**	The Nilgiris
116	**Tamil Nadu**	Theni
117	**Tamil Nadu**	Thiruvallur
118	**Tamil Nadu**	Thiruvarur
119	**Tamil Nadu**	Thoothukkudi
120	**Tamil Nadu**	Tiruchirappalli
121	**Tamil Nadu**	Tirunelveli
122	**Tamil Nadu**	Tiruppur
123	**Tamil Nadu**	Tiruvannamalai
124	**Tamil Nadu**	Vellore
125	**Tamil Nadu**	Viluppuram
126	**Tamil Nadu**	Virudhunagar
127	**Assam**	Bongaigaon
128	**Assam**	Cachar
129	**Assam**	Goalpara
130	**Assam**	Jorhat
131	**Assam**	Kamrup
132	**Assam**	Kamrup (Rural)
133	**Assam**	Karimganj
134	**Assam**	Kokrajhar
135	**Assam**	Nagaon
136	**Assam**	Sonitpur
137	**Bihar**	Patna
138	**Bihar**	Banka
139	**Bihar**	Darbhanga
140	**Bihar**	Sitamarhi
141	**Bihar**	Araria
142	**Bihar**	Bhagalpur
143	**Bihar**	Bhojpur
144	**Bihar**	Gaya
145	**Bihar**	Gopalganj
146	**Bihar**	Katihar
147	**Bihar**	Kishanganj
148	**Bihar**	Lakhisarai
149	**Bihar**	Madhubani
150	**Bihar**	Muzaffarpur

	State	District
151	**Bihar**	Purba Champaran
152	**Bihar**	Purnia
153	**Bihar**	Saran
154	**Bihar**	Sitamarhi
155	**Bihar**	Siwan
156	**Bihar**	Vaishali
157	**Chandigarh**	Chandigarh
158	**Chhattisgarh**	Bilaspur
159	**Chhattisgarh**	Dhamtari
160	**Chhattisgarh**	Durg
161	**Chhattisgarh**	Mahasamund
162	**Chhattisgarh**	Raipur
163	**Chhattisgarh**	Rajnandgaon
164	**Chhattisgarh**	Raipur
165	**Chhattisgarh**	Jangir-Champa
166	**Chhattisgarh**	Korba
167	**Chhattisgarh**	Koriya
168	**Chhattisgarh**	Raigarh_CT
169	**Chhattisgarh**	Bastar
170	**Chhattisgarh**	Surguja
171	**Dadra & Nagar Haveli**	Dadra & Nagar Haveli
172	**Delhi**	North_DE
173	**Delhi**	Central
174	**Delhi**	South West
175	**Delhi**	East
176	**Delhi**	NEW DELHI
177	**Delhi**	NORTH EAST
178	**Delhi**	North West
179	**Delhi**	South
180	**Delhi**	WEST
181	**Gujarat**	Sabarkantha
182	**Gujarat**	Surat
183	**Gujarat**	Amreli
184	**Gujarat**	Dahod
185	**Gujarat**	Gandhinagar
186	**Gujarat**	Mehsana
187	**Gujarat**	Navsari
188	**Gujarat**	Rajkot

	State	District
189	**Gujarat**	Bharuch
190	**Gujarat**	Panchmahal
191	**Gujarat**	Tapi
192	**Gujarat**	Ahmedabad
193	**Gujarat**	Anand
194	**Gujarat**	Banaskantha
195	**Gujarat**	Bhavnagar
196	**Gujarat**	Jamnagar
197	**Gujarat**	Junagadh
198	**Gujarat**	Kachchh
199	**Gujarat**	Kheda
200	**Gujarat**	Patan
201	**Gujarat**	Surendranagar
202	**Gujarat**	Vadodara
203	**Gujarat**	Valsad
204	**Haryana**	Jind
205	**Haryana**	Ambala
206	**Haryana**	Gurgaon
207	**Haryana**	Rewari
208	**Haryana**	Rohtak
209	**Haryana**	Sirsa
210	**Haryana**	Sonipat
211	**Haryana**	Bhiwani
212	**Haryana**	Hisar
213	**Haryana**	Jhajjar
214	**Haryana**	Kaithal
215	**Haryana**	Karnal
216	**Haryana**	Kurukshetra
217	**Haryana**	Palwal
218	**Haryana**	Panipat
219	**HimachalPradesh**	Hamirpur
220	**HimachalPradesh**	Kangra
221	**Jammu & Kashmir**	Jammu
222	**Jharkhand**	Godda
223	**Jharkhand**	Koderma
224	**Jharkhand**	Purbi Singhbhum
225	**Jharkhand**	Ranchi
226	**Jharkhand**	Dhanbad

	State	District
227	**Jharkhand**	Giridih
228	**Jharkhand**	Hazaribagh
229	**Kerala**	Alappuzha
230	**Kerala**	Thiruvananthapuram
231	**Kerala**	Thrissur
232	**Kerala**	Kasaragod
233	**Kerala**	Malappuram
234	**Kerala**	Palakkad
235	**Kerala**	Kannur
236	**Kerala**	Kollam
237	**Kerala**	Kottayam
238	**Kerala**	Kozhikode
239	**Madhya Pradesh**	Balaghat
240	**Madhya Pradesh**	Gwalior
241	**Madhya Pradesh**	Hoshangabad
242	**Madhya Pradesh**	Ujjain
243	**Madhya Pradesh**	Indore
244	**Madhya Pradesh**	Mandsaur
245	**Madhya Pradesh**	Sehore
246	**Madhya Pradesh**	Seoni
247	**Madhya Pradesh**	Burhanpur
248	**Madhya Pradesh**	Khargone
249	**Madhya Pradesh**	Mandla
250	**Madhya Pradesh**	Betul
251	**Madhya Pradesh**	Bhopal
252	**Madhya Pradesh**	Chhindwara
253	**Madhya Pradesh**	Dewas
254	**Madhya Pradesh**	East Nimar
255	**Madhya Pradesh**	Jabalpur
256	**Madhya Pradesh**	Neemuch
257	**Madhya Pradesh**	Ratlam
258	**Madhya Pradesh**	Rewa
259	**Meghalaya**	Jaintia Hills
260	**Meghalaya**	East Khasi Hills
261	**Manipur**	Bishnupur
262	**Manipur**	Chandel
263	**Manipur**	Churachandpur
264	**Manipur**	Imphal East

	State	District
265	**Manipur**	Imphal West
266	**Manipur**	Senapati
267	**Manipur**	Tamenglong
268	**Manipur**	Thoubal
269	**Manipur**	Ukhrul
270	**Mizoram**	Aizawl
271	**Mizoram**	Champhai
272	**Mizoram**	Serchhip
273	**Mizoram**	Lawngtlai
274	**Mizoram**	Lunglei
275	**Mizoram**	Mamit
276	**Mizoram**	Kolasib
277	**Nagaland**	Mon
278	**Nagaland**	Dimapur
279	**Nagaland**	Kiphire
280	**Nagaland**	Kohima
281	**Nagaland**	Mokokchung
282	**Nagaland**	Peren
283	**Nagaland**	Phek
284	**Nagaland**	Tuensang
285	**Nagaland**	WOKHA
286	**Odisha**	Anugul
287	**Odisha**	Bargarh
288	**Odisha**	Balangir
289	**Odisha**	Balasore
290	**Odisha**	Deogarh
291	**Odisha**	Jajapur
292	**Odisha**	Jharsuguda
293	**Odisha**	Kandhamal
294	**Odisha**	Nabarangapur
295	**Odisha**	Nuapada
296	**Odisha**	Sonapur
297	**Odisha**	Sundargarh
298	**Odisha**	Cuttack
299	**Odisha**	Ganjam
300	**Odisha**	Baleshwar
301	**Odisha**	Dhenkanal
302	**Odisha**	Gajapati

	State	District
303	**Odisha**	Kendrapara
304	**Odisha**	Kendujhar
305	**Odisha**	Bhadrak
306	**Odisha**	Khordha
307	**Odisha**	Koraput
308	**Odisha**	Mayurbhanj
309	**Odisha**	Sambalpur
310	**Punjab**	Jalandhar
311	**Punjab**	Ludhiana
312	**Punjab**	Faridkot
313	**Punjab**	Kapurthala
314	**Punjab**	Rupnagar
315	**Punjab**	Sangrur
316	**Punjab**	Amritsar
317	**Punjab**	Bathinda
318	**Punjab**	Fatehgarh Sahib
319	**Punjab**	Firozpur
320	**Punjab**	Gurdaspur
321	**Punjab**	Hoshiarpur
322	**Punjab**	Mansa
323	**Punjab**	Moga
324	**Punjab**	Mohali
325	**Punjab**	Patiala
326	**Punjab**	Tarn Taran
327	**Rajasthan**	Barmer
328	**Rajasthan**	Jalor
329	**Rajasthan**	Jodhpur
330	**Rajasthan**	Bhilwara
331	**Rajasthan**	Chittaurgarh
332	**Rajasthan**	Dhaulpur
333	**Rajasthan**	Rajsamand
334	**Rajasthan**	Ajmer
335	**Rajasthan**	Bikaner
336	**Rajasthan**	Ganganagar
337	**Rajasthan**	Nagaur
338	**Rajasthan**	Sikar
339	**Rajasthan**	Alwar
340	**Rajasthan**	Banswara

	State	District
341	**Rajasthan**	Dungarpur
342	**Rajasthan**	Jaipur
343	**Rajasthan**	Kota
344	**Rajasthan**	Pali
345	**Rajasthan**	Tonk
346	**Rajasthan**	Udaipur
347	**Tripura**	West Tripura
348	**Uttar Pradesh**	Agra
349	**Uttar Pradesh**	Azamgarh
350	**Uttar Pradesh**	Ballia
351	**Uttar Pradesh**	Banda
352	**Uttar Pradesh**	Deoria
353	**Uttar Pradesh**	Etawah
354	**Uttar Pradesh**	Firozabad
355	**Uttar Pradesh**	Hardoi
356	**Uttar Pradesh**	Jaunpur
357	**Uttar Pradesh**	Jhansi
358	**Uttar Pradesh**	Kanpur Nagar
359	**Uttar Pradesh**	Kaushambi
360	**Uttar Pradesh**	Mau
361	**Uttar Pradesh**	Meerut
362	**Uttar Pradesh**	Mirzapur
363	**Uttar Pradesh**	Pratapgarh
364	**Uttar Pradesh**	Rae Bareli
365	**Uttar Pradesh**	Saharanpur
366	**Uttar Pradesh**	Aligarh
367	**Uttar Pradesh**	Allahabad
368	**Uttar Pradesh**	Baghpat
369	**Uttar Pradesh**	Bahraich
370	**Uttar Pradesh**	Basti
371	**Uttar Pradesh**	Bijnor
372	**Uttar Pradesh**	Chandauli
373	**Uttar Pradesh**	Chitrakoot
374	**Uttar Pradesh**	Etah
375	**Uttar Pradesh**	Faizabad
376	**Uttar Pradesh**	Gautam Buddha Nagar
377	**Uttar Pradesh**	Ghaziabad
378	**Uttar Pradesh**	Ghazipur

	State	District
379	**Uttar Pradesh**	Gorakhpur
380	**Uttar Pradesh**	Kaushambi
381	**Uttar Pradesh**	Kushinagar
382	**Uttar Pradesh**	Lalitpur
383	**Uttar Pradesh**	Lucknow
384	**Uttar Pradesh**	Maharajganj
385	**Uttar Pradesh**	Mathura
386	**Uttar Pradesh**	Mirzapur
387	**Uttar Pradesh**	Muzaffarnagar
388	**Uttar Pradesh**	Sant Kabir Nagar
389	**Uttar Pradesh**	Unnao
390	**Uttar Pradesh**	Varanasi
391	**Uttarakhand**	Dehradun
392	**Uttarakhand**	Hardwar
393	**Uttarakhand**	Udham Singh Nagar
394	**Uttarakhand**	Pauri Garhwal
395	**West Bengal**	Darjeeling
396	**West Bengal**	Maldah
397	**West Bengal**	Medinipur (West)
398	**West Bengal**	Murshidabad
399	**West Bengal**	Nadia
400	**West Bengal**	Bankura
401	**West Bengal**	Barddhaman
402	**West Bengal**	Haora
403	**West Bengal**	Hugli
404	**West Bengal**	Jalpaiguri
405	**West Bengal**	Koch Bihar
406	**West Bengal**	Kolkata
407	**West Bengal**	Medinipur
408	**West Bengal**	North Twenty Four Parganas
409	**West Bengal**	South Twenty Four Parganas
410	**West Bengal**	Uttar Dinajpur

Annexure 2: List of Activities to be Facilitated from National Level for Rollout of PPTCT Services

National Level			
Sr. No.	**Activity**	**Person Responsible**	**Timeline**
1	**Assessment visit** from national level to the state		
1.1	Preparation of tool for state assessment		
1.2	Finalization of tool		
1.3	Sharing of tool with state to prepare in advance		
1.4	Constitution of National Team for visit to state		
1.5	Finalization of tour plan and sharing with state		
1.6	Visit to state for assessment		
1.7	Feedback to state for action required		
1.8	Follow up on progress of actions recommended		
2	**National Level ToT**		
2.1	Training Modules are translated and tailored for state need		
2.2	ToT dates finalization		
2.3	Confirmation of National level resource persons required		
2.4	Ensure funds availability for training		
2.5	Identification of state level participants in coordination with SACS - ensure regional representations of state level master trainers		
2.6	Ensure finalization of venue in coordination with SACS		
2.7	Ensure confirmation of trainees in coordination with SACS		
2.8	Share with SACS list of pre requisites for conduction of training like venue arrangements, audio visuals, training materials, participant hand-out copies, certificates, requirement for opening ceremony/ valedictory, TA/ DA arrangements, accommodation, food, etc		
2.9	Coordination for National Level resource persons travel approvals, accommodation, time schedules, etc.		
2.1	Conduction of ToT		
2.1	Finalization of state level cascade trainings during the last day of the ToT		
2.1	Preparation of Training Report		
3	**Supply Chain Management of Drugs**		
3.1	Forecasting requirement of drugs for the state in coordination with SACS		
3.2	Preparation of indent for drugs		
3.3	Finalization and approval of Indent at NACO		
3.4	Procurement of drugs by NACO		

National Level			
Sr. No.	**Activity**	**Person Responsible**	**Timeline**
3.5	Ensure availability of drugs at SACS well in advance before launch date		
3.6	Monitor SACS to ensure allocation and dispatch of drugs to ART centres/ ICTCs as per forecasted requirement		
3.7	Monthly monitoring of facility level stock positions, consumption of drugs, variances, expiry management		
4	**Finalization of state level micro-plan**		
4.1	Sharing of template for micro- plan with State		
4.2	Visit to State for facilitating preparation of micro-plan		
4.3	Finalization of micro-plan and approval by NACO		
4.4	Issue letters to State Principal Secy, PD SACS and MD NRHM for roll-out		
4.5	Follow -up visit to State for monitoring progress of activities		
5	**Monitoring of Field level trainings in state**		
5.1	Finalize field trainings for state during last day of National ToT		
5.2	Monitor implementation of field level trainings by state		
5.3	Visit to at least 10% trainings for monitoring		
6	**Launch of the MDR for PPTCT ART in State**		
6.1	Pre-launch visit to state for assessing preparedness		
6.2	Preparation of Note for Pre-Launch preparedness of state and approval at NACO on launch date		
6.3	Confirmation of launch date to State		
6.4	Participate in State Launch		
7	**Supervision and Monitoring of implementation**		
7.1	Preparation of checklist for supervisory visit to State		
7.2	Finalization and approval at NACO for checklist		
7.3	Capacity building of National Core Team for PPTCT on checklist and monitoring tools		
7.4	Monthly visit to State - post launch for monitoring		
7.5	Submission of visit reports		
7.6	Quarterly review at National level on progress of implementation		

Annexure 3: Supervisory Checklists

PPTCT Checklist for by NACO Officers-State Level

Name of the state:_____

Name of the supervisor: _____

Situational Analysis: _____

a) Infrastructure:

Levels of Saturation of Service Delivery Points with HIV Testing Facilities

	Name of District	Medical College			District hospital			Sub-district Hospital			CHC			PHC			Sub-centre	
		No.	SA-ICTCs	F-ICTCs	No.	SA-ICTCs	F-ICTCs	No.	SA-ICTCs	F-ICTCs	No.	SA-ICTCs	F-ICTCs	No.	SA-ICTCs	F-ICTCs	No.	HIV screening facility
1																		
2																		
3																		
4																		
Total																		

Note: No =total number of facilities in the district, SA-ICTCs=Stand Alone ICTCs, F-ICTC-Facility integrated ICTCs

Availability of ART Facilities

	Name of District	Number of ART Centres	Link ART-Plus Centres	Link ART Centres	Number of EID Facilities
1					
2					
3					
4					
Total					

b) Reproductive and Child Health (RCH) Services in the State

		ANC Registration					Institutional Deliveries				
	Name of District	Total	At district Hospital	Sub-District Hospital	CHC/ Block Level Hospital	PHC	Total	At District Hospital	Sub-district Hospital	CHC/ Block PHC	PHC
1											
2											
3											
4											
Total											

c) State Level Compiled PPTCT Data

SN	Service Utilization/ Referral Details (Latest Completed Quarter)	Value (Numerator/ Denominator where Applicable)	Observation	Recommendation (Include Person Responsible and Time-line)
1	Estimated number of pregnancies in the state			
2	Total Number "HIV tested" in previous quarter (ANC+Direct-in- labour)			
3	Number detected HIV Positive during **ante-natal care** (ANC)			
4	Number detected HIV positive "**directly-in-labour**"			
5	Total HIV infected pregnant women detected (ANC + direct –in- labour) **(A)**			
6	Total number of HIV infected pregnant women delivered			
7	Number of live births			
8	Number of direct –in- labour cases who received TDF+3TC+EFV			
9	Number of new born who received Syp NVP for 6 weeks			
10	Out (A) Number of HIV infected pregnant women enrolled at ART centres (B)			
11	Out of (B) Number with CD4 count more than 350 (C)			
12	Out of "C" Number initiated on **Multi-drug ART**			
13	Number continuing on ART currently			
14	Out of "B" Number having CD4 count less than 350 (D)			
15	Out of (D)Number initiated on ART			
16	Number of babies who completed 6 weeks after birth in previous quarter			
17	Out of above number in whom DBS specimen is collected and sent for DNA PCR			
18	Number of reports received			
19	Out of above number found positive on DBS			
20	Out of above number, no. of whole Blood specimen was collected for DNA/ PCR			
21	Number of reports received of WBS			
22	Out of above number, no. found positive on Whole Blood Specimen tests			
23	Out of above number, no. of children enrolled at ART centre			
24	Number of children started on ART			
25	Out of all HIV exposed babies detected in the quarter 18 months back, number of babies tested with 3 rapid tests at 18 months			
26	Out of above, no. of children detected positive at 18 months			

D) Convergence with NRHM (NHM)

SN	Activity	Yes/ No/ Number	Remark/ Reason
1	Is state level PPTCT implementation committee formed?		
2	Number (%)of districts where "district PPTCT implementation committee" is formed		
3	Number (%)of district reporting conduct of district PPTCT implementation committee meeting in previous quarter		
4	Is the state government order to incorporate HIV testing in the **routine ANC Package** of services issued?		
5	Is there a state government order to incorporate **common ANC/ PPTCT registration at all hospitals** issued?		
6	Is there a state government order to ensure **co-location of ANC clinic and HIV testing facility** at all hospitals issued?		
7	Is there a mechanism to share data between NACP and NRHM		

E) Supply Chain Management

SN	Activity	Observation	Remark/ Reason
1	Is stock position for drugs and test Kits available at state level facility/ block/ district wise?		
2	What is the tool used for forecasting of drug requirement at state level?		
3	What is distribution system for drugs and KITS?		
4	Frequency of distribution?		
5	Is the storage space available for drugs and KITS adequate?		
6	What are the systems for indenting Kits and drugs?		

F) Supervision and Monitoring

SN	Activity	Observation	Remark/ Reason
1	How is PPTCT line-list data compiled at state level? Is software recommended by NACO used for the same?		
2	How is PPTCT data validated?		
3	Is a feedback provided to district units regularly? If yes –frequency		
4	Number of field visits from SACS –JD BSD/ JD CST/ PPTCT consultant in previous quarter for review of PPTCT activities – review tour reports		
5	Number of review meetings held in last 6 months		

PPTCT Checklist for State Level Officers-District Level Visit

Name of the District:_____

Name of the supervisor:_____

SituationalAnalysis:_____

A) Human Resource:

	Staff	Number of Positions Sanctioned	Number of Positions Filled	Vacant Since (dd/ mm/ yy)
1	District Programme Manager			
2	District ICTC supervisor			
3	ART Centre SMO/ MO			
4	Stand Alone ICTC Counsellor			
5	ART centre counsellors			
6	Stand Alone ICTC Lab Technician			
7	ART centre/ LAC-plus Nurse			
8	Outreach Worker (IL&FS)			

B) Infrastructure:

Levels of Saturation of Service Delivery Points with HIV Testing Facilities

	Name of District	Total Number	Stand-alone ICTC	Facility Integrated-ICTC	HIV Screening Facility (WBFPT)
1	Medical College				
2	District hospital				
3	Sub-district hospital				
4	CHC				
5	PHC				
6	Sub-centre				

Note: No = total number of facilities in the district, SA-ICTC=Stand Alone ICTC, F-ICTC-Facility integrated ICTC

Availability ART Facility

	Name of Block/ Taluk	Number of ART Centre	Link ART-Plus Centre	Link ART Centre	Number of EID Facilities
1					
2					
3					
Total					

C) Reproductive and Child Health (RCH) Services in the District

		Number	Percentage of Total
ANC Registration	At district hospital		
	Sub-district hospital		
	CHC/ Block level hospital		
	PHC		
	Total		
Institutional Deliveries	At district hospital		
	Sub-district hospital		
	CHC/ Block PHC		
	PHC		
	Total		

District Level Compiled PPTCT Data:

SN	Service Utilization/ Referral Details (Latest Completed Quarter)	Value (Numerator/ Denominator)	Observation	Recommendation (Person Responsible and Time-line)
1	Estimated number of pregnancies in the state			
2	Total Number "HIV tested" in previous quarter (ANC+Direct- in- labour)			
3	Number detected HIV Positive during **ante-natal care** (ANC)			
4	Number detected HIV positive "**directly- in -labour**"			
6	Total HIV infected pregnant women detected (ANC + Direct-in-labour) **(A)**			
7	Total number of HIV infected pregnant women delivered			
8	Number of live births to HIV infected Pregnant women			
5	Number of direct -in -labour cases who received TDF+3TC+EVF			
9	Number of newborns who received Syp NVP for 6 weeks			
10	Out (A) Number of HIV infected pregnant women enrolled at ART centres (B)			
11	Out of (B) Number with CD4 count more than 350 (C)			
12	Out of "C" Number initiated on **Multi-drug ART**			
13	Number continuing on ART currently			
14	Out of "B" Number having CD4 count less than 350 (D)			
15	Out of (D)Number initiated on ART			
16	Number of babies who completed 6 weeks after birth in previous quarter			
17	Out of above number in whom DBS specimens collected and sent			
18	Number of reports received of DBS			
20	Out of above number found positive on DBS			
21	Out of above number, no. of Whole Blood specimens collected and sent			
22	Number of reports of WBS tests received			
24	Out of above number, no. found positive for Whole Blood Specimen tests			
25	Out of above number of children tested WBS positive, no. enrolled at ART centre			
26	Number of children started on Paed ART			
27	Out of all HIV exposed babies detected 18 months back, number of babies confirmed with 3 rapid tests at 18 months			

D) Convergence with NRHM (NHM)

SN	Activity	Observation	Remark/ Reason
1	Is District level PPTCT implementation committee formed?		
2	Number (%) of meetings of the "District PPTCT implementation committee" in past six months?		
3	Is HIV testing of pregnant women incorporated in common **ANC Package** of services?		
4	Are HIV testing facilities co-located with ANC clinic at all hospitals?		
5	Is there a PPTCT review in last MO review meeting at district level?		
6	Is there a mechanism to share data between DAPCU/ DNO office and District RCH officer?		

E) Supply Chain Management

SN	Activity	Observation	Remark/ Reason
1	Is stock position for drugs and test Kits available at District level facility and block -wise?		
2	What is the tool used for forecasting of drug requirement at state level?		
3	What is distribution system for drugs and KITS?		
4	Frequency of distribution?		
5	Is the storage space available for drugs and KITS adequate?		
6	What are the systems for indenting Kits and drugs?		

F) Supervision and Monitoring

SN	Activity	Observation	Remark/ Reason
1	How is PPTCT line-list data compiled at district level? Is software recommended by NACO used for the same?		
2	How is PPTCT data validated?		
3	Is a feedback provided to field units regularly? If yes –frequency		
4	Number of field visit from DAPCU office DAPCU officer, DPM, DIS in previous quarter for review of PPTCT activities –review tour reports		
5	Number of review meetings held in last 6 months		

Supervisory Checklist for Assessment of PPTCT Services-Facility Level

Name of Supervisory Officer: _____

Basic Information: _____

Name of Facility:	Date of Visit:
Name of Block/ Mandal:	Name of District & State:
Person Available:	**Type of Facility**:
a) MO-I/ c:	a) Stand-alone ICTC
b) ICTC counsellor:	b) Facility Integrated ICTC
c) Lab-technician:	c) Facility Integrated ICTC under PPP scheme
d) Outreach Worker:	d) Mobile ICTCs
e) Staff Nurse/ ANM	e) Sub-centre with HIV screening facility

Observations

A) Human Resources

Staff	Number of Positions Sanctioned	Number of Positions Filled	Vacant Since (dd/ mm/ yy)
MO In-charge			
Counsellor			
Lab Technician			
Staff Nurse/ ANM			
Outreach Worker (IL&FS)			

B) Training/ Sensitization

Name of the Staff	Designation	Duration of Posting at the Facility	Date of Induction Training	Date of Refresher Training

C) Recording and Reporting

Register	Whether Exists? (Y/ N)	Updated up to (dd/ mm/ yy)	Remarks (Reasons for Backlog if any and Suggested Action)
PID register			
Register for general clients			
Register for Pregnant Women			
Post-natal follow-up register			
PPTCT line-list			
Follow-up due list			
Lab Register			
Stock Register			

Is monthly CMIS report for previous three months sent to SACS before 10th of the month? Yes/ No if No reason_____

Is the entry made in SIMS? Yes/ No if No reason _____

D) Performance:

SN	Service Utilization/ Referral Details (Latest Completed Quarter)	Value (Numerator/ Denominator where Applicable)	Observation	Recommendation (Include Person Responsible and Time-line)
1	Estimated number of pregnancies in the jurisdiction of facility			
2	Total Number "HIV tested" in previous quarter (ANC+Direct-in-labour)	If "%" receiving testing<80%, reasons for the same to be ascertained. Drop out of >20% indicates sub-optimal integration with RCH services		
3	Number detected HIV Positive during **ante-natal care** (ANC)			
4	Number detected HIV positive "**directly in labour**"			
6	Total HIV infected pregnant women detected (ANC+direct-in- labour) **(A)**			
7	Total number of HIV infected pregnant women delivered		If low proportion of institutional deliveries, explore if stigma, discrimination or fear is involved	
8	Number of live births			
5	Number of direct- in -labour cases who received TDF+3TC+ EFV		If all direct- in- labour cases do not receive -explore reasons	
9	Number of newborns who received Syp NVP for 6 weeks			
10	Out (A) Number of HIV infected pregnant women enrolled at ART centres (B)			
11	Out of (B) Number with CD4 count more than 350 (C)			
12	Out of "C" Number initiated on **Multi-drug ART**			
13	Number continuing on ART			
14	Out of "B" Number having CD4 count less than 350 (D)			
15	Out of (D)Number initiated on ART			
16	Number of babies who completed 6 weeks after birth in previous quarter			
17	Out of the above number, in whom DBS specimens are collected and sent for testing			
18	Number of DBS reports received			
20	Out of above number found positive on DBS			
21	Out of above number, no. of Whole Blood Specimens collected for testing			
22	Number of WBS test reports received			
24	Out of above number found positive on Whole Blood test			
25	Out of above, number of children enrolled at ART centre			
26	Number of children started on Paediatric ART			
27	Out of all HIV exposed babies detected in the quarter 18 months back, number of babies confirmed with 3 rapid tests at 18 months			

Linkage and Outreach

SN	Service Utilization/ Referral Details (Previous Quarter)	Mechanism	Observation–is it Working	Remarks
1	Mechanism to ensure linkage to ART-		Confirm information during visit to ART centre If <80% of registered at ART centre, reason for drop-out be ascertained	
2.	Mechanism for retrieval action if 1. Non-linkage to ART 2. No CD4 tested 3. ART for mothers/ ARV for babies- not initiated 4. Missed visit for drug collection		Interact with out-reach workers and patients to judge the robustness of mechanism	
3	Performance of outreach workers (IL&FS)			

E) Physical Verification of Stocks

Name of the Commodity	Opening Stock at the Beginning of Previous Quarter	Closing Stock as per Stock Register	Variance Noted on Physical Verification	Remarks
1. HIV test kit 1				
2. HIV test kit 2				
3. HIV test kit 3				
4. Whole Blood Finger Prick Test				
5. TDF+ 3TC+ EFV tablets				
6. Nevirapine Syrup				
7. Safe Delivery kits				

Stock Out and Expiry

1) Was there stock out of any of the above items: YES/ NO if Yes –Duration of stock out_____Reason _____

2) Are any of the above items near expiry (more than the amount likely to be consumed) items?
YES/ NO, If Yes detail _____

3) Are there any expired items available? YES/ NO, If Yes,
details_____

F) IEC Materials Availability

Name of Material	Type–Flip Chart etc.,	Quantity Available	Whether being Used

Is the material available appropriate for PPTCT services? YES/ NO

Details:_____

Annexure 4: National Level Plan to Facilitate Scale-up of PPTCT Services

	Activities and steps for Maharashtra	Person responsible	Frequency	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Expected Outcome
Development of National Strategic Plan on Roll -out of Multi Drug ART regimen under NACP in India -2013															
1	Preparation of first draft	BSD	NA	3rd week											National Strategic Plan prepared
2	Consultation with programme partners for inputs	BSD		4th week											
3	Finalization of strategy plan	BSD			1st week										
4	Approval of plan by DAC	DDG BSD			1st week										
Co-ordination with NRHM (NHM-National Health Mission)															
1	Meeting of NACP-NRHM Coordination Committee at National level to facilitate following activities and policy decisions	DDG-BSD	Quarterly		2nd week										Joint Meeting done
2	Presentation of PPTCT scale-up plan to the committee		NA												Discussion for policy decision as next steps
3	Policy decision to form NACP-NRHM coordination committee's in all states and UTs	Secretary DAC and MD NRHM	NA												Key decisions taken
4	Decision to Incorporate key PPTCT services into Mother and Child Tracking system		NA												
5	Provision of travel support for - confirmation of HIV status, visit to ART centre for enrolment, drug collection etc. and follow-up visits by HIV infected pregnant woman **under the JSSY scheme**		NA												
6	Steps towards implementation of joint policy decision-on issued by Department of H&FW and DAC in August 2010 for involvement of general health staff in provision of PPTCT services across the country as being implemented by the state of Karnataka		NA												
7	Joint directive to Principal Secretary Health and Family Welfare, of all Phase 2 states to ensure implementation of following activities:		NA		3rd week										Letter issued from DAC and NRHM to all states to disseminate the policy decisions
a	Incorporate HIV testing into **common ANC package** of services		NA												
b	**Co-location** of OBGY OPD and HIV testing facility for 100% coverage		NA												

	Activities and steps for Maharashtra	Person responsible	Frequency	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Expected Outcome
c	**100% HIV testing coverage** for all pregnant women enrolled into Ante-Natal care at all levels		NA												
d	Prompt establishment of **Stand alone ICTC** sanctioned by DAC at all CHC		NA												
e	Ensure establishment of **Facility Integrated ICTC** at all high delivery points		NA												
f	Establishment of HIV **screening facilities at sub-centre** in selected high burden districts		NA												
8	Establish mechanism for sharing of data between NACP and NRHM at least quarterly	DDG BSD /Director RCH	Quarterly		2nd week										
9	Provision of joint feedback to states on status of performance from DAC and NRHM	Nodal Officers in DAC and DHFW	Quarterly												
Preparatory activities for implementation of PPTCT services															
1	Assessment Visit from national level to all phase 2 states	NPO PPTCT/PO-HIV/TB and PO-ICTC			Maharashtra 3rd week	1. Gujarat 3rd week 2. MP 4th week	1. Odisha 1st week 2.Rajasthan 2nd week								Assessment visits completed
2	Finalization of Micro plan in consultation with SACS and partners at national level														Final microplan
3	Presentation of micro plan to Secretary HFW and Director health services of phase 2 states														Directive issued to all District health officers to ensure preparedness and smooth implementation of PPTCT services
4	Identify persons for national level "Training of trainers"														List of potential trainers finalized with concurrence from participants top contribute in trainings
5	Conduct Training of trainers					MH-1st and 2nd week	1. Gujarat 3rd week 2. MP 4th week	1. Odisha 1st week 2.Rajasthan 2nd week							ToT completed
6	Other Training as per training plan	PD-SACS /Nodal Officer for PPTCT				All states									
7	Launch of PPTCT services	NACO /SACS						Maharashtra +Mumbai+Goa +D&D	Gujarat +DNH	Madhya Pradesh	Odisha	Rajasthan			Services formally launched
8	Ensure availability Whole Blood Finger Prick tests and ART enough for supply at all delivery points	NPO PPTCTC /PO ICTC					All states								

	Activities and steps for Maharashtra	Person responsible	Frequency	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Expected Outcome
Monitoring and evaluation															
1	National NACP-NRHM coordination committee meeting	DDG-BSD	Quarterly												100% phase 1 and 2 states conducted meeting
2	Review of progress made by State on implementation of policy directives issued by Secretary HFW and Secretary DAC	DDG-BSD/DDG CST / Director RCH	monthly												Review of progress done
3	Joint review meeting of State RCH officers and JD BSD /JD CST at national level		Biannual												Meeting conducted in coordination with NRHM
4	Monitoring of conduct of State NACP-NRHM PPTCT implementation committee meetings	Nodal Officer PPTCT	Monthly												100% phase 1 and 2 states conducted meeting
5	Centrally driven assessment of implementation of PPTCT services in three initial states	Nodal Officer PPTCT	One time		Last week Karnataka	First week Andhra Pradesh	First week Tamil Nadu								Documentation of experience and learnings for scale-up of PPTCT services
6	Frequent visit to implementing states by officers from NACO BSD /CST during initial implementation	Nodal Officer PPTCT /CST DAC	Monthly visit to each implementing state for first 6 months					MH	MH, GJ	MH, GJ, MP	MH, GJ, MP , Odisha	MH, GJ, MP , Odisha , Rajasthan	MH, GJ, MP , Odisha , Rajasthan		Field visits done as per schedule
7	Joint field visit of nodal officers in BSD /CST /counterparts in NRHM	PD SACS /MD-NRHM	One state per month					Maharashtra +Mumbai+Goa +DD	Gujarat	Madhya Pradesh	Odisha	Rajasthan			Joint field visits done as per schedule
8	Centrally driven internal evaluation of implementing state after 6 months of implementation	JD BSD /JD CST	One state in two months												Planned in April and May 2014 for all Phase 2 states
Strengthen collaboration with IL&FS for outreach services															
1	Meeting of IL&FS steering committee at national level	NPO PPTCT /PO HIV/TB	Quarterly		2nd week after NACP-NRHM meeting										
2	Meeting to review performance		Monthly												
3	Adoption of ANC tracking system with a hand-held device including ICTC and ART centre staff					1st week									

Annexure 5: State Level Micro-plan for Implementation of PPTCT Services

	Name of State -Maharashtra, Mumbai, Goa & Daman & Diu			**Time-line**										
	Activities and steps for Phase 2 states	**Person responsible**	**Frequency**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Expected Outcome**
Preparation for implementation of PPTCT services														
1	Assessment Visit from NACO	NPO PPTCT	NA	2nd week										
2	Finalization of Micro-plan in consultation with all stake holders in the state	PD SACS												
3	Identification of participants for National level "Training of Trainers"	JD BSD /JD CST of three SACS												
4	Decision on dates and venue for ToT	JD BSD /JD CST of three SACS												
Strengthening Co-ordination between SACS and state NRHM (NHM-National health Mission)														
1	Formation of **Joint NACP NRHM state PPTCT implementation committee**	PD-SACS and MD-NRHM	One time	3rd week										
2	Meeting of NACP-NRHM PPTCT implementation committee to take key policy decisions	PD-SACS	Quarterly											
3	Presentation of state PPTCT scale-up plan to the committee	JD BSD /JD CST MSACS												
4	Policy decisions to form **District level PPTCT implementation committee** in all districts and municipal corporations	PD-SACS and MD-NRHM	NA											
5	Decision to implement the joint policy issued by department of HFW and DAC in August of 2010 for involvement of general health staff in provision of PPTCT services-Review of Karnataka experience		NA											
6	Decision on provision of travel support for confirmation of HIV status, visit to ART centre for enrolment and follow-up visit for drug collection, EID etc. under the **JSSY scheme**	MD-NRHM	Ongoing											
7	Joint directive from Principal Health Secretary to all district/corporation health officers to ensure following:	PD-SACS and MD-NRHM	NA	4th week										
a	Incorporate HIV testing into **common ANC package** of services		NA											
b	**Co-location** of OBGYN OPD and HIV testing facility at all health facilities		NA											
c	**100% HIV testing coverage** for all pregnant women enrolled into Ante-Natal care		NA											

	Name of State -Maharashtra, Mumbai, Goa & Daman & Diu			Time-line										
	Activities and steps for Phase 2 states	**Person responsible**	**Frequency**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Expected Outcome**
d	Prompt establishment of **Stand alone ICTCs** sanctioned by DAC at all the CHCs	PD SACS	NA											
e	Ensure establishment of **Facility Integrated ICTCs** at all high delivery points /Municipal corporation dispensaries	PD-SACS and MD-NRHM	NA											
f	Establishment of HIV **screening facilities at sub-centres**		NA											
8	Establish of mechanism for sharing of data between SACS and state RCH programme quarterly	PD-SACS and MD-NRHM	Ongoing											
9	Provision of joint feedback to districts based on performance by SACS and NRHM	State RCH Officer and JD BSD SACS	Quarterly											
Engagement with Medical Colleges														
1	Directive from Secretary Medical Education to ensure **co-location of OBGYN OPDs and ICTCs** in all medical colleges to ensure 100% testing coverage for ANCs	PD SACS			First week									
2	Directive from Secretary Medical Education to all medical colleges to implement the new PPTCT services as per national guidelines	PD SACS												
3	Above directive to also include inclusion of new PPTCT services into the UG, PG nursing and **training curriculum**	Director medical education												
Strengthening Infrastructure for HIV Counselling & testing services														
1	Establishment /relocation of stand alone ICTCs as approved in Annual Action Plans (AAP)	JD BSD												
2	Establishment of F-ICTCs as per targets set in Annual action plan 2013-14 , prioritizing high deliver points for the same	JD BSD /State RCH officer												
3	Training of ANMs at sub-centres level in Whole Blood finger prick testing													
4	Establish Mechanism for storage and transportation of Whole Blood Finger Prick test (WBFPT) from PHCs to sub-centre level													
5	Ensuring HIV screening using WBFPT at sub-centre level													
Ensuring PPTCT services for "direct –in- labour" cases														
1	Training of labour room nurses in HIV testing with WBFPT and new PPTCT regimen	JD BSD /JD CST /DAPCU officer and state RCH officer												

	Name of State -Maharashtra, Mumbai, Goa & Daman & Diu			**Time-line**										
	Activities and steps for Phase 2 states	**Person responsible**	**Frequency**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Expected Outcome**
2	Directive from PD-SACS and MD-NRHM to ensure prompt linkages with stand- alone ICTCs for confirmation of status	JD BSD												
3	Provision of WBFPT to all labour rooms	JD BSD												
4	Provision of ART drugs used in new PPTCT regimen to all delivery points	JD CST/JD BSD												
Ensuring Institutional deliveries for all infected pregnant women														
1	Develop and Disseminate mechanism for advanced information on due date for delivery to ensure preparedness at the facility	State RCH Officer and JD BSD SACS	NA											
2	Availability of safe delivery Kits, PEP drugs etc.	JD BSD /JD CST	NA											
Measures to ensure EARLY HIV testing during Ante-Natal Care														
1	Directive for common ANC and ICTC registration at all hospitals	PD SACS /MD-NRHM	NA											
2	Establish mechanism to ensure 100% testing of ANC clinic attendees and monitor	PD SACS /MD-NRHM	NA											
3	Uninterrupted availability of HIV test kits at ICTCs and F-ICTCs	JD BSD	Ongoing											
4	Incorporation of HIV testing /screening into ANC tracking register of ANMs	MD-NRHM	NA											
5	Develop and implement mechanism to capture information on HIV screening from private providers involved with JSY scheme	State RCH Officer and JD BSD SACS	NA											
Strengthening Linkage to ART														
1	Formation of "**Case management teams**" comprising ICTC counsellor, ART MO, ORW, PHC MO etc. to track linkage of mother and baby to ART centre and other PPTCT services	JD BSD /JD CST /M&EO SACS	Case by case											
2	Training of state M & EO in use of **PID tracking** of clients with the google doc. based system implemented in Andhra Pradesh for monitoring of linkages to ART	PO-ICTC/HIV-TB NACO	NA											
3	Training of DAPCU M& EO in use of **PID tracking system**	JD BSD/DAPCU nodal officer /State MEO	NA											
5	Meeting between ICTC and ART staff at district level for verifying data	PD SACS	Monthly											

	Name of State -Maharashtra, Mumbai, Goa & Daman & Diu			Time-line										
	Activities and steps for Phase 2 states	**Person responsible**	**Frequency**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Expected Outcome**
Outreach services -coordination with IL&FS														
1	Monthly coordination meeting between SACS and IL&FS office bearer and NGO representative	PD SACS/IL&FS state coordinator	Monthly											
2	Directive from PD SACS to establish mechanism of monthly meeting of DAPCU and NGO's employed by IL&FS	PD SACS	NA											
3	Joint directives from PD SACS and state IL&FS coordinator to all staff regarding day-to- day interaction between ICTC/ART counsellors and ORWs	PD SACS/ILFS state coordinator	NA											
4	Sensitization of DPM and DIS in use of information on all relevant events captured by **IL&FS outreach workers in hand held device** for monitoring at district level	JD BSD/DAPCU nodal officer /State M&EO	NA											
5	Directive to utilize ANC tracking information gathered through hand-held device by IL&FS ORW for monitoring and follow-up by ICTC and ART centre staff	JD BSD	NA											
6	Review of performance of NGO and ORW in tandem with ICTC counsellors	JD BSD/JD CST/IL&FS state coordinator	Monthly											
Monitoring and evaluation														
1	Review of progress on directives issued by Secretary Health /MD-NRHM and PDSACS with DH& FWO , Civil Surgeon and MoH of municipal corporation	PD-SACS /MD-NRHM	Quarterly											
2	Joint review meeting of District RCH officers and DAPCU officer at the state level	PD-SACS /MD-NRHM	Quarterly											
3	Review meetings of DAPCU officers at state level	PD-SACS	Monthly											
4	Monitoring of Meetings of district NACP-NRHM PPTCT implementation committee	JD BSD /JD CST	Monthly											
5	Inter-divisional meeting between BSD and CST officers at SACS	JD BSD /JD CST	2nd week of every month											
6	Joint field visits of JD BSD /JD CST along with PPTCT consultant / CST Regional coordinator /Nodal officers from NRHM	PD SACS /MD-NRHM	Two districts per month											
7	Regular field visits of JD-BSD /JD-CST / PPTCT consultant / CST Regional coordinator	PD-SACS	One district per officer											

	Name of State -Maharashtra, Mumbai, Goa & Daman & Diu			Time-line										
	Activities and steps for Phase 2 states	**Person responsible**	**Frequency**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**	**Expected Outcome**
Supply chain and logistics management														
1	Forecasting of drug requirement	PPTCT nodal officer												
2	Ensuring availability of ART drugs at all ART centres	JD CST /PPTCT nodal officer												
3	Ensuring availability of ART drugs for direct- in- labour cases and HIV exposed children at all stand-alone ICTC level	JD CST /PPTCT nodal officer												
4	Supply of referral forms and checklists at all facilities	PPTCT nodal officer												
Information Education and Communication (IEC)														
1	Provision of **information leaflets for use by infected pregnant women** explaining future course of action in HIV positive mother	IEC division in SACS and nodal officer for PPTCT												
2	**Display of PPTCT service cascade** at all relevant facilities -ART centres, ICTCs and facilities conducting ANC clinic													
3	Development of **JOB AIDS** suitable for different levels of health functionaries -Doctors, NACP key staff, Paramedical workers, Outreach workers etc.													

Annexure 6: Training Plan-Maharashtra, Mumbai, Goa, Daman & Diu

S. No	Types of training	Level of training /Sensitization	Need	Participants	Number to be trained	Total training load	Batch size	Number of batches	Trainer	Number of Trainers per batch	Duration of training	Person responsible for coordination	Timeline for completion of the activity						
													Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
1	**Training of trainers**	State	1. Training of Key programme staff at state 2. Observer for district level trainings	1.SACS- In charge Basic Services Division 2.SACS-In chare CST Division 3.PPTCT consultant 4.Regional Co-ordinator CST 5.State RCH Officer 6.Faculties from OBGY department from select Medical colleges (3) 7.Selected Senior Medical Officer at ART centres (4 in number) 8.Selected DAPCU officers (4) 9.Selected DPM (4)	MH-20 Mumbai-10 Goa-10	40	20	2	1. Nodal Officer from NACO 2.WHO PPTCT consultant 3.UNICEF national PPTCT consultant **Resource person from implementing state** 1. JD/in charge-BSD JD in charge –CST 2.PPTCT consultant 3.Medical college faculty 4.Regional Coordinator	4 per batch	4 days	JD-BSD MSACS /MDACS/GOA SACS		Batch-1 =1st week Batch 2=2nd Week					
2	**Sensitization of divisional and district level health officers**	State level review meeting under Health Secretary	Advocacy for scale-up of PPTCT services	1.Deputy Director circle 2.District health Officers 3.Civil Surgeon 4.MOH of Municipal corporations	1.Deputy Director circle =8 2.District health Officers=37 3.Civil Surgeon =37 4.MOH of Municipal corporations =22	104		1	Project Director SACS	NA	2 hours	PD SACS		State review meeting					
3	**Joint training of 1. Training of ART centre SMO /MO 2. Training of DAPCU Officers /District RCH Officers**	State	1.Strengthening linkage to ART 2.Prompt care and support after enrollment 3.Effective coordination for follow-up care	1.ART centre SMO 2.ART centre MO 3.DAPCU Officer 4.District Programme manager 5.District RCH Officers	1.ART centre-MH+Mumbai =59*2 Goa=1*2 2.Number of DAPCU = 37*2 3.RCH officers =35	229	20	12	1. Trainers trained in ToT 2.Facilitators to be mix of state programme managers, medical college faculties and ART centre SMO 3.One observer from national level	4 per batch	3 day	JD BSD and JD CST of 3 SACS			6 batches (MSACS 4, MDACS and Goa 1 each)	6 batches (MSACS 4, MDACS and Goa 1 each)			

S. No	Types of training	Level of training /Sensitization	Need	Participants	Number to be trained	Total training load	Batch size	Number of batches	Trainer	Number of Trainers per batch	Duration of training	Person responsible for coordination	Timeline for completion of the activity						
													Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
4	**Training of key programme staff**	Regional level	1. Key programme staff 2. Need of good quality standardized training	1. District ICTC supervisors 2. Stand alone ICTC Counsellors 3. ART centre counsellors 4. ART centre staff nurse	1. DIS= 37 2. ICTC counsellor= 690 3. ART centre Counsellors=150 4. ART centre staff nurse=60	937	30	47	1. Trainers trained in ToT 2. Facilitators to be a mix of state programme managers, District programme manager, medical college faculty and ART centre doctors 3. One observer from national level for one session	One per 10 participants	2 days	JD BSD and JD CST of 3 SACS			2 batches each at divisional level in MH +2 batches each in Mumbai and Goa (Total 20 batches)	2 batches each at divisional level in MH +2 batches each in Mumbai and Goa (Total 20 batches)	One batch per week at all locations =total 11 batches for dropouts and backlog		
5	**Training of medical officers at ICTC**	District level	Prompt linkage to ART centres and follow-up actions	1. Block medical officer (Taluk health officer) 2. MO-IC of stand alone ICTC3. MO-IC of F-ICTC	1. THO -372 =2. MO-ICTC =6903. MO-F-ICTC=1394	2456	30	82	1. Key programme staff (DAPCU officer/District RCH officer/SMO at ART centre) trained at state level 2. Facilitators to include DAPCU officer, ART centre SMO, Medical college faculty 3. A observer from state level trained in ToT	One facilitator every 10 participants	2 days	JD BSD and JD CST of 3 SACS , DAPCU officer and state RCH officer				Two batches per district =74 batches	11 batches to cover backlog at regional level		
6	**Training of Nursing staff**	District level	To streamline PPTCT services at F-ICTC and Labour rooms	1. labour room nurses =12 nurses at district hospital, 6 nurses at SDH and 3 Nurses at CHC 2. 1 nurse at F-ICTC	1. Labour room nurses = 2034 2. F-ICTC nurses=1394	3428	30	115	1. DAPCU officer 2. MO-IC stand alone ICTC 3. District programme managers 4. District ICTC supervisor 5. Stand alone ICTC counsellors	One facilitator every 10 participants	1 Day	DAPCU Officer /District RCH Officer				One batch per district =37 batches	two batches per district =74 batches		
7	**Sensitization of Medical officers**	District level review meeting	To ensure HIV testing of all ANC and prompt linkage for confirmation and care	All medical officers other than in-charge ICTC and F-ICTC	PHC MO=1760 (excluded 1000 F-ICTC)	1760	50	35	1. DAPCU officer 2. ART centre SMO 3. District RCH Officer 4. Observer from state level trained in ToT	One facilitator every 25 participants	Half day during review meeting	DAPCU Officer /District RCH Officer					One batch per district =35 batches		
8	**Sensitization of health workers**	Block level review meeting		1. PHC supervisors i.e. health assistant male /female 2. ANM	ANM=22135	22135	60	370	1. MO-I/c stand alone ICTC 2. DPM 3. District ICTC supervisor 4. HQ stand alone ICTC counsellor	One facilitator every 15 participants		DPM /MO-ICTC / MO-F-ICTC / District ICTC supervisor					One batch per Block=372 batches		
9	**Sensitization of Outreach workers**	Block level		Outreach workers from IL&FS, CSC, and ART centre)	795 (675 ICTC+60 ART+60 CSC)	795	30	27	1. DPM 2. District ICTC supervisor 3. HQ ICTC counsellor	One facilitator every 15 participants		DPM /MO-ICTC / MO-F-ICTC / District ICTC supervisor					One batch per district =37 batches		

Annexure 7 Drug Forecasting

State	District	Number of Positive PW Detected in 2011	Direct-in-labour Cases	No of SA ICTCs in the District	Requirement for Direct-in-labour Cases for Mother (Column D X 1 tab X 7 Days)	Requirement for Mother-ART TDF + 3TC + EFV (Column 'C' X One Tab Daily X 365 Days –F)	Requirement for Baby Syrup Nevirapine for 6 Weeks (Column C X 3 Bottles) (25 ml Bottles) 3 Bottles per Baby)
A	B	C	D	E	F	G	H
Maharashtra	Ahmadnagar	104	10	30	70	37890	312
Maharashtra	Akola	35	4	9	28	12747	105
Maharashtra	Amravati	58	6	16	42	21128	174
Maharashtra	Aurangabad	69	7	21	49	25136	207
Maharashtra	BEED	35	4	17	28	12747	105
Maharashtra	Bhandara	30	3	10	21	10929	90
Maharashtra	Buldana	25	3	17	21	9104	75
Maharashtra	Chandrapur	63	6	15	42	22953	189
Maharashtra	Dhule	44	4	11	28	16032	132
Maharashtra	Gadchiroli	12	1	14	7	4373	36
Maharashtra	Gondiya	49	5	11	35	17850	147
Maharashtra	Hingoli	23	2	6	14	8381	69
Maharashtra	Jalgaon	67	7	24	49	24406	201
Maharashtra	Jalna	21	2	11	14	7651	63
Maharashtra	Kolhapur	78	8	24	56	28414	234
Maharashtra	Latur	46	5	15	35	16755	138
Maharashtra	Nagpur	170	17	21	119	61931	510
Maharashtra	Nanded	70	7	20	49	25501	210
Maharashtra	Nandurbar	23	2	14	14	8381	69
Maharashtra	Nashik	70	7	35	49	25501	210
Maharashtra	Osmanabad	55	6	13	42	20033	165
Maharashtra	Parbhani	74	7	10	49	26961	222
Maharashtra	Pune	282	28	42	196	102734	846
Maharashtra	Raigarh	42	4	15	28	15302	126
Maharashtra	Ratnagiri	33	3	14	21	12024	99
Maharashtra	Sangli	113	11	18	77	41168	339
Maharashtra	Satara	84	8	21	56	30604	252
Maharashtra	Sindhudurg	9	1	12	7	3278	27
Maharashtra	Solapur	120	12	16	84	43716	360
Maharashtra	Thane	212	21	36	147	77233	636
Maharashtra	Wardha	43	4	12	28	15667	129
Maharashtra	Washim	21	2	9	14	7651	63
Maharashtra	Yavatmal	114	11	19	77	41533	342
Mumbai	Mumbai	452	45	98	315	164665	1356
Goa	NORTH GOA	16	2	7	14	5826	48
Goa	South Goa	19	2	7	14	6921	57
Total		2781	278	690	1939	1013126	

Annexure 8: Guidelines for Supply Chain Management (SCM) of ART Drugs (Chapter 10 of ART Guidelines 2012)

NACO introduced a change in the way ARV drugs are distributed to ART Centres starting with the procurement cycle of Financial Year 2011-12. ART distribution will now follow a hub and spoke Wheel model where the suppliers will deliver the entire quantity required by a state to the SACS which will act as the hubs for further distribution of the required quantity of drugs to ART centres. The JD (CST)/ officer in-charge of CST at SACS will be the focal point for SCM at SACS. The staff from Procurement & Supply Chain Management unit at SACS shall be engaged in the logistics & record maintenance.

10.1 Responsibility of DAC

- DAC will be responsible for forecasting the state-wise need, indenting and procuring ARV drugs centrally and make them available to Consignees (SACS)
- Provide indicative annual quantity required by each ART Centre/ CoE/ ART Plus centres to help SACS in further distribution of ART drugs to facilities
- DAC will also facilitate interstate relocation in case of low stocks, near expiry drugs or during natural calamities and conflict situations.

10.2 Responsibility of SACS

- Appointing a nodal person in charge of Supply chain management.
- Ensuring proper receipt and storage of drugs
- Arrange for space for safe storage of drugs at SACS level in the state
- Relocating the drugs to ART Centres as per requirement in two- three instalments in line with the drug supplies
- Maintaining accurate records for all drugs received from suppliers/ other states and distributed to ART Centres
- Monitor and analyse the stock positions at ART Centre for smooth supply chain management
- Ensure continuity and uninterrupted drug supplies at ART centre/ LAC plus/ LAC level
- Prevention of drug expiry by timely relocations within the state and if needed facilitate outside the state relocations with official directives from NACO
- Prevention of Stock outs by need based relocations
- Guard the drugs against misuse/ pilferage/ rodents/ damage etc.,
- Quarterly physical count reconciliation of stocks
- Timely submission of Monthly ART stock report to NACO.

10.3 Responsibility of ART Centres

- Ensuring proper receipt and storage of drugs
- Arranging space for safe storage of drugs
- Maintaining accurate records for all drugs received from SACS/ other ART Centres/ LAC and LAC plus centres and drugs dispensed to patients
- Monitor and analyse the stock positions at ART Centres for smooth supply chain management
- Ensure continuity of drug supplies at ART Centre
- Prevention of drug expiry/ stock outs by timely reporting to SACS
- Guard the drugs against misuse/ pilferage/ rodents/ damage etc.,
- Quarterly physical count reconciliation of stocks
- Timely submission of Monthly ARV stock report to SACS
- Supply of ART drugs to LAC as per requirement

10.4 Guidance to SACS

10.4.1 Regarding Receipt of Drugs

- Cross verify at the time of receiving the drugs that the exact amount is received against the allocated quantity and confirm the same to NACO/ Logistic coordinator/ Supplier/ procurement agency/ Regional Coordinator. Deviation if any should be highlighted for further actions
- Acknowledging the receipt after actual counting of drugs
- Forwarding copies of CRC to Procurement Agent & procurement Division of NACO
- Mention receipt of quantity if received less or in seal broken condition.
- Stacking of drugs should be based on expiry dates FEFO procedures(First Expiry First Out)
- Accurate records for all drugs received from suppliers/ other states
- Refer to the revised guidelines sent from time to time by NACO.

10.4.2 Drug Storage

- Arrange cartons with arrows pointing up and with identification labels, expiry dates and manufacturing dates clearly visible.
- Store drugs and other supplies to facilitate FEFO (First Expiry, First Out) procedures
- Stack cartons at least 10cm (4 in) off the floor, 30cm (1ft) away from the walls and other stacks and no more than 2.5m (8ft) high

- Separate damaged and expired drugs and supplies from usable supplies.
- Remove these damages drugs from inventory immediately and dispose them off using established procedures for disposal of drugs. **SACS will be accountable for expiry of drugs in the state and will have to provide justification for the same**
- Keep fire safety equipment available, accessible and functional.

10.4.3 Distribution of Drugs to ART Centres

- Mechanism for drug transport/ courier needs to be developed
- Drugs are to be distributed to ART centres, based on their requirement in two –three instalments annually
- Minimum three months stock should be available at any given time at the ART centre and Link ART Centre. Immediate action is to be taken if drugs are available for less than THREE months
- Existing stocks at ART centres are to be taken care while making allocation to ART centres
- Accurate records are to be maintained for all drugs distributed to ART Centres
- State Drug stock and drug distribution register should be maintained on daily basis Periodical physical count of stocks should be done
- Stocks should always be dispensed based on First Expiry First Out.
- Nearly 20 % of the received stock is to be kept by SACS as buffer quantity.

10.4.4 Record Keeping

- **State Drug stock and Drug Distribution Register**: This is used by the Store Officer/ to input the inflow and outflow of stock. This is be maintained on daily basis
- **Drug Distribution Register:** This is used by the SACS warehouse to account for the ARV drugs distributed to the various ART Centres or sent to other states on daily basis. Drug stock register must be filled routinely. This is important because:

  a) It provides consumption rate

  b) Avoids stock outs

  c) Avoids expiry

- **Monthly report on ARV stocks** is to be sent to NACO by 4th of every month as per format at ***Annexure 21***
- **Stock Reconciliation:** This is used to determine the discrepancies between the Actual stock and the reported stock. Periodical physical count of stocks should be done and quarterly report to be maintained

- **Goods Received Note:** The Store Officer has to make this note acknowledging receipt of stock from the transportation agency and supplier. This is to certify that the Goods have been received duly inspected in good condition in accordance with the conditions of the contract and amendment if any
- **Final Acceptance Certificate:** The Store Officer has to prepare this note along with the Goods Received Note. The consignee has to prepare four copies of the GRN and FAC – one for the warehouse, and the remaining three for NACO, RITES and the Supplier
- **Pickling List:** This is made by the Store Officer after the stock has been dispatched to the various ART Centres. It keeps account of the stock that has been distributed.

10.4.5 Interstate Relocations

Any additional quantities of Drugs required should be intimated to NACO (artdrugs@gmail.com). NACO will arrange for interstate relocations. Similarly, in case of excess stocks at SACS level, NACO should be informed for any interstate relocation if possible.

10.5 Guidance to ART Centres

10.5.1 Regarding Receipt of Drugs

- Cross verify at the time of receiving the drugs that the exact amount is received against the allocated quantity and confirm the same to SACS/ Regional Coordinator
- Deviation if any should be highlighted for further actions
- Acknowledging the receipt after actual counting of drugs
- Mention receipt of quantity if received less or in seal broken condition
- Accurate records for all drugs received from SACS/ other ART Centres should be maintained
- Refer to the revised guidelines sent from time to time by NACO.

10.5.2 Drug Storage

- Arrange cartons with arrows pointing up and with identification labels, expiry dates and manufacturing dates clearly visible
- Store drugs and other supplies to facilitate FEFO (First-to-expire, First-out) procedures
- Stack cartons at least 10cm (4 in) off the floor, 30cm (1ft) away from the walls and other stacks and no more than 2.5m (8ft) high
- Separate damaged and expired drugs and supplies from usable supplies

Remove them from inventory immediately and dispose them off using established procedures for disposal of drugs. ART Centre will be accountable for expiry of drugs in the centre and will have to provide justification for the same.

10.5.3 Drug Dispensing to Patients

- Drugs are to be dispensed to patients as per the prescription of the SMO/ MO
- Proper instructions should be given to patients while dispensing the medicines
- Accurate records are to be maintained for all drugs dispensed to the patients
- Drug stock and drug distribution register should be maintained on daily basis
- Periodical physical count of stocks should be done
- Drugs should always be dispensed based on First Expiry First Out

10.5.4 Usage of Near Expiry of Drugs

- The drugs being issued to PLHA by ART centre should have at least 45 days left for expiry date from the issue date.
- The SACS should not issue ART drugs having expiry date less than 60 days
- THE DRUGS ARE ISSUED FOR ONE MONTH, so if a drug has expiry in August 2011, it can be used till 31st August 2011 Hence, this can theoretically be issued to patients with one month remaining in expiry i.e. before 31st of July 2011.

The list of Short of Expiry drugs and quantity which cannot be consumed within the time period specified should be intimated to SACS and Regional coordinator at least before 3 months of expiry.

10.5.5 Record Keeping and Reporting

Drug stock Register: This is used by the Store Officer/ to input the inflow and outflow of stock, maintained on daily basis.

Drug Dispensing Register: Monthly report on ARV stocks to be sent to SACS by 2ndof every month as per the format (**Annexure 22).**

- **Stock Reconciliation:** This is used to determine the discrepancies between the Actual stock and the reported stock. Periodical physical count of stocks should be done and quarterly report to be maintained
- Minimum three months stock should be available at any given time at the ART centre and the Link ART Centre. SACS should be immediately informed if any of the ART drug is available for less than THREE months
- Any excess stock beyond the consumption of ART Centre should be reported to SACS for timely relocation.

10.5.6 Transfer of ARV Drugs to Link ART Centres

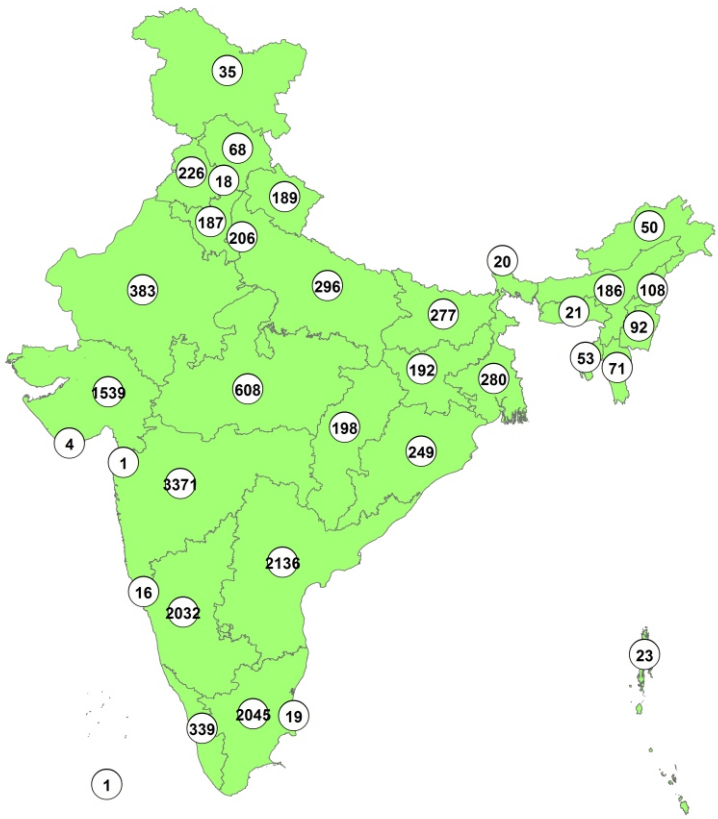
- ARV drugs stock for 3 months, of all PLHIV linked out in last 15 days shall be sent by the Nodal ART Centre, at an interval of 15 days to the LAC through courier/ postal service/ care coordinator or any other staff of nodal ART Centre/ LAC.
- The supply should also include drugs for already linked out patients (due for drug supply) as well as for those linked out in the last 15 days along with a copy of the Nodal ART Centre to LAC referral/ link out form for patients linked out during that period.
- **Drug stock reporting by Nodal ART Centre**: The Nodal ART Centre shall *not* deduct the total quantity of drugs transferred to Link ART Centre in the monthly report sent to NACO. It should only deduct the drugs actually dispensed to the patient at the LAC/ LAC plus during the month as reported in monthly reporting format from LAC/ LAC plus to Nodal Centre.

10.5.7 Procedure for Disposal of Expired Drugs

Empty bottles/ expired drugs should be destroyed to prevent recirculation. These should be destroyed at the centre itself following the procedure adopted for other expired drugs in the hospital. The procedure for disposal for expired drugs is as below: -

1. Forming a committee of two- three persons including Nodal Officer,
2. Listing out the drugs expired along with batch no. and quantity expired (with date of expiry)
3. Separating the tablets from bottle
4. Destroying the tablets in incinerator/ by dissolving in water and then disposing it if the incinerator is not available.
5. Removing the labels from the bottles (may be dipped in water for some time to separate out the labels)
6. The empty bottles to be disposed in the municipal waste,
7. The quantity of expired drugs to be reduced from the balances and reported in the monthly report. Details for the same are to be emailed to SACS and artdrugs@gmail.com.

State / UT wise Number of HIV Counseling and Testing Centers (ICTCs) In India (December, 2013)



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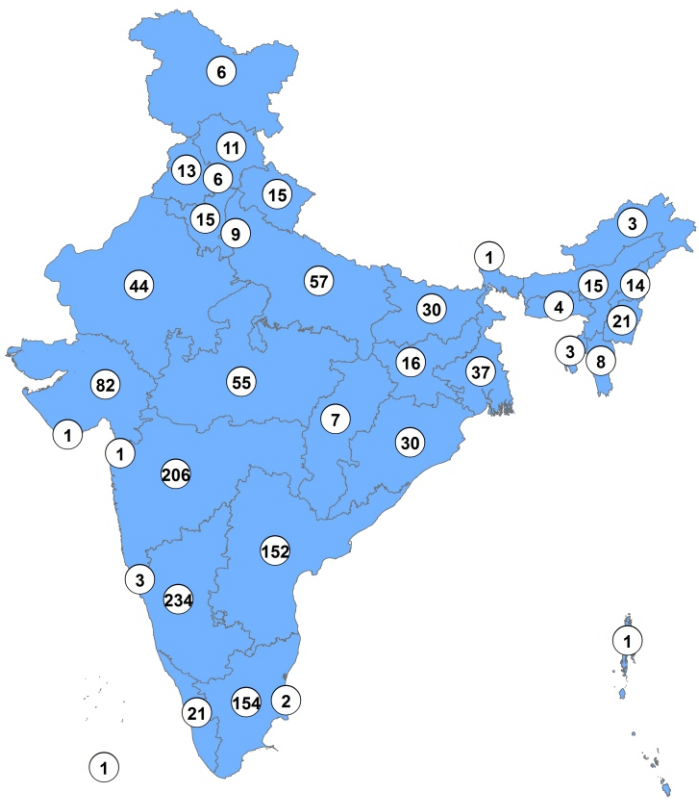
State / UT wise Number of HIV / AIDS Treatment Centers In India (December, 2013)



ART/ LAC
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The HIV Counseling & Testing and Treatment Faclities are being rapidly further scaled up during NACP- IV (2012-17)