Drop-In Centres (DIC)





Review Study by

FXB India Suraksha

Supported by

NACO
&
UNDP

INDEX

ACRONYM/ABBREVIATION

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
AP	Andhra Pradesh
CBO	Community Based Organisation
CCC	Community Care Centre
CHAN	Chandigarh
CLHIV	Children Living with HIV
CSR	Corporate Social Responsibility
DAPCU	District AIDS Prevention Control Unit
DEL	Delhi
DIC	Drop in Centre
DLN	District Level Network
DOT	Direct Observation Therapy
FGD	Focus Group Discussion
FSW	Female Sex Worker
GH	Government Hospital
GIPA	Greater Involvement of People Living with HIV/AIDS
GUJ	Gujarat
HIV	Human Immune deficiency Virus
ICTC	Integrated Counselling and Testing Centre
IDI	In Depth Interview
IEC	Information Education and Communication
JD	Job Description
KAR	Karnataka
KER	Kerala
KII	Key Informants Interviews
LFU	Lost to Follow Ups
MAHA	Maharashtra
MANI	Manipur
MIZO	Mizoram
MSM	Men having Sex with Men
MP	Madhya Pradesh

MSC	Most Significant Changes
MO	Medical Officer
NA	Not Available
NACO	National AIDS Control Organisation
NGO	Non Government Organization
NAGA	Nagaland
OI	Opportunistic Infection
ORW	Outreach worker
ORI	Orissa
PC	Project Coordinator
PD	Project Director
PDS	Public Distribution System
PUN	Punjab
PLHIV	People Living with HIV
PPTCT	Prevention of Parents to Child Transmission
SACS	State AIDS Control Society
SLN	State Level Network
SWOT	Strength Weakness Opportunities and Threat
TB	Tuberculosis
TN	Tamil Nadu
TG	Trans Gender
UNDP	United Nations Development Program
UP	Uttar Pradesh
WB	West Bengal

EXECUTIVE SUMMARY

Drop in Centres (DICs) are crucial service facilities for the People Living with Human Immune Deficiency Virus (PLHIV) under the National AIDS Control Program (NACP). Under NACP III, the structure and function of the DICs have been improvised to provide quality services to the PLHIV. DICs are the first referral points for ensuring PLHIV are able to receive information, access services and are also managed by them. DIC services are based on addressing immediate needs for care, support, treatment & protection for the PLHIV and also provide counselling, referral and follow up services required for a life with dignity. In June 2010 FXB India Suraksha was commissioned by United Nations Development Program (UNDP) on behalf of National AIDS Control Organization (NACO) to carry out evaluation of 77 DICs in 17 states of the country. The aim was to augment the information about DIC operations and the gaps if any to later develop the recommendations and strengthen the same.

Preliminary findings suggest DIC as key to bring about change in the stigma and discrimination situation. DICs offer a platform to PLHIV for self expression and empowerment. Courage to own the situation and asserting for rights is experienced by many PLHIVs registered with DIC due to regular participation in support group meeting. Lack of - operational guidelines, strategic planning, uniform monitoring and reporting system, provision of legal aid in-house, adequate services for Children Living with HIV (CLHIV) and adequate budgetary provisions- are the current challenges faced by DIC program across the country.

Recommendations to improve DIC functioning are both technical and financial. Technically developing operational guidelines will shape DIC functioning and financially revisiting budget will enhance the performance at all levels of operations. It will be useful if an operational guideline includes details for - infrastructure, target and activities, reporting formats, output and outcome indicators, staff training and appraisal, Job Description (JD) for staff, recreation space, consent forms, the ways to meet the needs of children and women and other marginalised groups like TG (Trans Gender), MSM (Men having Sex with Men), FSW (Female Sex Worker), and budget allocation for each activity.

There is a need to work with the healthcare providers like Integrated Counselling and Testing Centre (ICTC), Anti Retroviral Therapy (ART) Centre, Prevention of Parent to Child Transmission (PPTCT) Centre and Community Care Centre (CCC) to strengthen coordination, and especially enhance mutual understanding of the HIV as any other clinical conditions so that they may become advocates of positive living. Community mobilization is needed to raise awareness and dispel myths and protect rights of the PLHIV so that they can meet with the challenges in the life after HIV infection.

CHAPTER 1

OVERVIEW AND METHODOLOGY

1.1 Overview

The Eleventh Five Year Plan of the Government of India lays specific emphasis on the process of inclusion as the foundation for development in India. Stress is on to involve and integrate the most marginalized and weakest sections of population, the most voiceless groups, within development. In this context, the NACP has set out to ensure, through different strategies, that PLHIV and other affected groups are included as partners in the various stages of the program implementation. NACP-III has evolved mechanisms to address human rights and ethical issues concerning HIV/AIDS. Particular focus is on "The fundamental rights of PLHIV and their active involvement as important partners in prevention, care, support and treatment initiatives" and "Creation of an enabling environment wherein those infected and affected by HIV can lead a life of dignity". This is the cornerstone of all interventions. DICs have been motivated by GIPA principles to strengthen the treatment, care, support and rights access for PLHIV in the country.

Drop-in-Centre (DIC) emerged as an effective means to promote enabling environment for PLHIVs, to strengthen linkages between PLHIVs and service providers and to protect and promote their rights. DIC functions by addressing immediate needs for care, support, treatment, counselling & protection for the PLHIV. DICs offer opportunities for HIV infected persons to meet, share and seek solutions for their problems, avail services and support and get directions for their lives. Services are offered more in a peer lead informal manner.

DICs are run by Networks of People living with HIV (District level or state level) and work with the following objectives -

1. To promote positive living among PLHIV and improve the quality of life of the infected.
2. To build the capacity and skills of PLHIV to cope with the infection
3. To create an enabling environment for the PLHIV
4. To link PLHIVs with the existing health services, NGOs, CBOs and other welfare and development programmes.
5. To protect and promote the rights of the infected.

NACO supports 208 DICs in the country. It is an effort at national level to make DIC strategy more effective to meet PLHIV needs in the area of legal, social and financial spheres by increased participation of providers and beneficiary. In order to do this NACO recommends conducting a participatory review of the functioning of those DICs, supported for last two consecutive years in order to make recommendations for addressing gaps and redesigning strategies. The mainstreaming cell, IEC division in NACO guided the entire review process by providing technical expertise. NACO played major role in finalizing the research tools, ensuring the participatory nature of review, facilitating coordination to inform the respective

State AIDS Control Society (SACS) about the review process, intervened the technical emergencies in Goa and Manipur, providing inputs for the preparation of reports, and the process of fund disbursement.

FXB India Suraksha has developed the DIC Performance Assessment Tool in consultation with NACO and UNDP. The objective of the assessment was -

a) To determine the status of DIC functioning using Performance assessment tool

b) To categorise the DICs based on the performance score

c) To develop a response plan for strengthening the DIC program.

DICs were scored along the evaluation themes and ranked as "very good", "good" and "needs attention" using a simple scoring system (More about it anon). A detailed ranking of the DICs based on the Performance Assessment is presented in the report.

1.2 Key Objectives

The objective of this review was

- To review the programmatic and financial progress/ achievements of each of the DICs against set targets and objectives,
- To discuss with significant service providers in HIV/AIDS area (ART, ICTC staff, health care providers in the district involved in treatment of Opportunistic Infections(OIs), or Paediatrics ART and key officials at the District AIDS Prevention Control Unit (DAPCU) and State AIDS Control Society(SACS) regarding the functioning of the DICs and their contribution to the overall HIV/AIDS prevention and care in the districts,
- To assess the impact of the DICs in lives of PLHIV and with specific emphasis on access to care and support for women and children and other marginalised groups of PLHIV like Female Sex Worker (FSW), Men having Sex with Men (MSM) , Trans Gender(TG)
- To assess mechanism for providing legal aid to PLHIVs through DICs and discuss strategies being followed for livelihoods provision for PLHIVs
- To identify strengths and gaps in DIC project implementation and make recommendations with respect to continuation of the existing DICs depending on assessed need

Output/Deliverables

- Current status of DIC's functioning in terms of efficacy, efficiency and effectiveness
- Comment on the relevance and reach of DICs
- Suggest strategies for enhancing the chances of sustainability
- Recommendations for operational guidelines to strengthen the implementation of DICs; and
- Recommendations for the continuation of individual DICs, with focus on identification of gaps and capacity building needs

1.3 Methodology

a) Evaluation themes - The most important conditions of services and roles that the DICs are expected to play in the community have been taken as the themes of operation on which the DICs have been evaluated and tested for their efficiency and impact on the PLHIV community. These themes were:

- Services and its impact – includes methods of service delivery like outreach, home visits and Advocacy for reduced Stigma and Discrimination

- Governance and Systems in DIC - includes Documentations ,Infrastructure in addition to the conventional parameters

- Support from SACS

b) Sampling Design FXB Suraksha conducted DIC review study in 17 states (Maharashtra, Gujarat, West Bengal, Orissa, Nagaland, Mizoram, Manipur, Delhi, Punjab, Chandigarh, Madhya Pradesh, Uttar Pradesh, Goa, Kerala, Andhra Pradesh, Tamilnadu, and Karnataka).

- Inclusion criteria - DICs operational for last two years were selected for the review. Karnataka state DICs though operational since a year was included to get the representation about the state.
- Exclusion criteria - DICs which were running for less than two years were excluded. The defaulted lists of DICs were in the states of Maharashtra-5 (Mumbai-4 and Jalgaon -1), Gujarat- (Ahmadabad) - 2, and Nagaland – (Teunsang) -4. The DICs were either closed or were not meeting the criteria for the study.

c) Developing the tools- Focus Group Discussion (FGD), Key Informant Interview (KII), In Depth Interview (IDI) and Semi Structured Questionnaire were developed in consultation with FXB India Suraksha Study review team and submitted to UNDP. Inputs given by both were incorporated and field testing of the tool was carried out at DIC in Delhi. UNDP inputs on tools were more about capturing the information on functioning of the DIC through Semi structured Questionnaire and those from DIC review team were about capturing specific information from in- depth- interview. While developing semi structure Questionnaire an attempt was made to use mixture of Qualitative and Quantitative methods to capture diverse view point on DIC functioning. Triangulation was done for methods as well as data. Data triangulation was done for all the parameters of services and Governance by beneficiaries and providers interveiw. **Annexure 1 (Research Tools and Guides)**

Qualitative tools FGD, KII and IDI and Semi Structured Quantitative Questionnaire were administered in 77 DICs in 17 states to gather information about DIC functioning

- Key informant interview with SACS officials , DIC Project Coordinator(PC) and Chief Functionary (DLN) to obtain information on targets/achievements and major contribution of DIC towards district level HIV/AIDS prevention and care activities.
- Key Informant Interview with DAPCU nodal officer, ICTC/PPTCT counsellor, ART counsellor to gather information on the functioning of the DICs and their contribution to the overall HIV/AIDS prevention and care in the districts. The discussion also explored ways of strengthening the linkages of the DICs with the existing service providers at the district
- FGDs with different groups of PLHIVs (Women, MSM, and TG) to understand the impact of DIC on improving quality of life of PLHIVs and satisfaction derived from the services received.
- Most Significant Change (MSC) - MSC techniques with individual PLHIV to bring out the changes brought about by DICs using In-depth-Interview.
- Discussion with CCCs, especially around the role of DICs for following up on Lost to Follow Ups (LFUs)

d) Sample Size

Table 1: Tool type and sample size

No States	Tools	Number	Male Group/ Male	Female Group/ Female	Mixed Group(Male,Female,MSM,TG)
17	FGD	100	13	17	70
	IDI	298	134	163	
	Semi Structured Questionnaire	77			
	KII	148			

Table 2: KII – Profile

No States	No of DICs	ART/ICTC/ PPTCT Counsellor	DAPCU Officers	MO,APD, PD,IEC directors	GIPA coordinator	Others	Total
17	77	90	26	25	2	5	148

- **IDI –** Total of 298 IDI in 17 states with 134 Male and 163 Female PLHIV and one Female affected by HIV AIDS were interviewed. The affected individual interviewed is not included in Table 1.

- **Semi structured Questionnaire -** one questionnaire per DIC was administered and DIC staff facilitated the information flow through discussion and one to one meeting. Total of 77 Semi structured Questionnaire were administered.

e) Training and orientation of team: DIC review team was trained with the objective to orient them about the study, make them familiar with tools and facilitate region wise Action planning development. Orientation training was carried out on 10th June 2010. A session by UNDP representative about overall DIC review study completed the training need. A region specific action plan was developed with timeline to match the UNDP reporting requirement.

f) Pilot testing of the tools: was carried out in one of the DICs in Delhi. Relevant consent process was completed prior to tool testing**.** Changes were made in the tools based on the findings of the testing in consultation with UNDP.

g) Data collection and analysis: State wise Research team comprising of, Research Officer and Field Investigator was formed. Region Specific Team Leaders guided the state team. **Annexure -2 (DIC list with teams).** Data collection per DIC was stretched over two days. Morning half of both the days were kept for collecting DIC related information and second half's were utilized for FGD, KII and IDI by the team. KII, FGD and IDI were conducted as per the guide developed for the study.

Data Analysis: Raw data from Semi structured Questionnaire was transported to excel sheet template for analysis using SPSS 10. Data verification and cleaning were done as per the standard protocol. FGDs were recorded and transcripts were prepared which were translated in English and uploaded to Atlas TI version 5.0 for further analysis as per the action plan. The states of Manipur and Karnataka were delayed in data collection and FGD transcripts were analyzed manually. FGD analysis was done as per the Krueger's framework analysis[1]. KII analysis was done using Strength Weakness Opportunity Threat (SWOT) technique used by Business Management School and IDIs were analyzed using case study approach. Recordings for IDIs and KIIs were questionnaire and note based. Review process followed the action plan prepared in consultation with NACO UNDP. **Annexure 3 (Action Plan)**

[1] Krueger RA (1994) Focus Groups – A practical guide for Applied Research SAGE Publication

h) DIC Performance Assessment Tool: - Performance for 77 DICs were scored using the Performance Assessment Tool developed by FXB India Suraksha in consultation with NACO. The Performance assessment tool has four service components of DIC functioning namely – Service, Governance, Documentation and Infrastructure - which are scored. . Each of these components have been rated on a scale of 1 to 3, in an ascending order where 1 refers to minimum condition of service functioning, 2 the moderate functioning of service component an 3 the optimum.

Weighted ranking method was applied to the four service parameters evaluated. Budget guidelines and Beneficiary vote were the basis for the weight assigned to each parameter. Accordingly 70% weight was given to the service component;15% to the Governance;10% to Documentation and 5% to Infrastructure.

Each Service component weight is multiplied with the scale of functioning viz.3,2 or 1 as graded by the evaluation team and a final score is calculated. A maximum score of 300 calculated as 70 x 3 + 15x3 + 10x3 + 5x3 = 300 referred as outstanding level of performance of DIC, score between 200 and 299 is referred as Good , score between 100-199 is referred as Average functioning DIC and scores less than 100 is referred as needing attention. When a particular DIC under study meets the conditions for services it is given the relevant score. Following table shows the details of scoring for each parameter of functioning:

Table 3 DIC Performance Assessment Scale

Scale of Service Functioning	
Optimum - 3	
Moderate - 2	
Minimum -1	
DIC Performance	
Outstanding DIC if Score is 300	
DIC working is good if score is 200-299	
DIC working is average if score is 100-199	
DIC needs attention if score is below 100	
Scoring System	
Services Provided	
Home visits, Outreach, Community sensitization, Counseling, LFU tracking, Referral and Linkages to more than 60 % of the registered PLHIV in last two years (minimum one service but good if more than one service)	3
Home visits, Outreach, Community sensitization, Counseling, Referral and Linkages to more than 40% of the registered PLHIV in last two years(minimum one service but good if more than one service)	2
Home visits, Outreach, Community sensitization, Counseling, LFU tracking, Referral and Linkages to less than 25% of the registered PLHIV in last two years	1

Governance	
Regular EC meetings- 1 each quarter and minutes prepared, Books of accounts updated, One staff one post- Board memo not staff ,	3
Accounts -Cashbooks updated but EC meeting irregular ,Board member as DIC staff	2
Accounts -Cashbooks not updated, Board member as DIC staff, no records about EC meeting	1
Documentation	
Registers -Drop-in, Services provided, Referral, LFU and Outreach, Reports - Monthly or Quarterly on regular basis for last two years, Success stories and Written consent maintained.	3
Registers -Drop-in, Services provided, Referral, LFU and Outreach, Reports - Monthly or Quarterly on regular basis for last one year	2
Only few registers maintained and Monthly report submitted.	1
Infrastructure	
Separate room for counseling, Adequate lighting, basic amenities- chair table almirah,fan,clean water, toilet facility, facility for group meeting, IECs	3
Partition for counseling, and basic amenities like meeting room, IEC materials,	2
No privacy , no basic amenities	1

While developing the tool the inputs from field research team were taken and the Performance assessment was carried out by the field research team under the guidance of team leaders from the respective region. The detailed tool is available as **Annexure –4. (DIC Performance Assessment Tool)**

CHAPTER 2

INDIVIDUAL DIC UPDATE

Chapter 2 of this report contains an update about individual Drop in Centre, organised region wise namely East, West, South and North. East region had 25 DICs in five states namely West Bengal, Orissa, Manipur, Mizoram and Nagaland. West regions had 20 DICs in three states viz. Gujarat, Goa and Maharashtra. South region had 25 DICs in four states viz. Andhra Pradesh, Karnataka, Kerala and Tamil Nadu. North region had 7 DICs in five states viz. Chandigarh, Delhi, Madhya Pradesh, Punjab and Uttar Pradesh. DIC information in Orissa and West Bengal is clubbed under east region and those in UP,MP,CHANDIGARH,PANJAB and DELHI are clubbed under North region to facilitate reading.

Information on each DIC is organized into five tables.

- Table 1 mentions about the District and number of PLHIV registered and reached by a DIC through Home visits till the evaluation period. Table 1 is incomplete in many ways. This is due to the lack of district specific information with SACS in many states. Home visits count is not head count always some have counted service count and some have headcount as the reporting unit. Many DICs lacked clarity about service count and head count leading to number of services provided being reported as number of PLHIV reached. Thus to highlight the need for reporting guidelines the parameter of "PLHIV reached" has been selected. In this section symbol "?" refers to the lack of clarity for the parameter "PLHIV reached" at a particular DIC level. DICs marked "?", in the states of Andhra Pradesh, Goa, Gujarat, Maharashtra, Nagaland, Tamil Nadu and West Bengal reported the gap in the understanding of the parameter "PLHIV reached".
- Table 2 summarizes the issues pertaining to women (PLHIV) and children (CLHIV) registered by the DIC. Data triangulated both from Provider's and Beneficiaries point of view. Tool Source – Semi Quantitative Questionnaire, FGD and IDI
- Table 3 summarizes the Gaps in the Governance in individual DIC. Triangulated by KII with SACS officials
- Table 4 presents the recommendations made by SACS officials and community of the respective districts. Tool Source – KII, IDI,FGD
- Table 5 summarizes the training needs of individual DIC. Each DIC staff has received induction training but the demand is for refresher's training on regular basis in the areas of counselling, MIS formats, Program and Finance Management, Communication and Documentation skills. (Tool Source – Semi Quantitative Questionnaire for DIC staff)

2.1 North Region

Table 1: PLHIV Registration and reach /DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Delhi	West Delhi	51818	0.25	692	300	**43**
02	Delhi	Central Delhi			258	258	**100**
03	Chandigarh	Chandigarh	NA	0.1	502	240	**48**
04	Punjab	Amritsar	16972	0.3	260	260	**100**
05	Uttar Pradesh	Allahabad	NA	0.48	806	163	**20**
06	Madhya Pradesh	Rewa	NA	1.72	332	162	**49**
07	Madhya Pradesh	Dewas			165	165	**100**

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues – Children
West Delhi	Discrimination by Family, Lack of income sources, Increased financial burden, Children future	Lack of nutritional and education support, orphan hood, lack of support and protection for children
Central Delhi	Lack of income, Discrimination at health facility, fear of children future	malnutrition, ART adherence, Discrimination in neighbours
Chandigarh	Discrimination by family, Property Issues, lack of Income source	School admission, Nutrition and Orphan Care
Amritsar	Social stigma, financial crisis, property issues	Study loss due to tension lack of nutrition and care.
Allahabad	Discrimination by in-laws, Property issues, financial crises, Future of children.	Discrimination in Schools, Poor Nutrition, Orphan hood, Future after parents death
Rewa	Discrimination at health facility, denial of property, Financial crises	Lack of knowledge about ART in care takers, nutrition problem and care for orphans
Dewas	Domestic violence, and Community discrimination	Lack of - ART on time, education support and nutrition support.

Table 3: Gaps in Governance

Districts	Gaps identified
West Delhi (Shadipur)	Needs to develop linkages with other Government services for women.
Central Delhi (Patel Nagar)	Lack of network with Hospital ART Centre, ICTC.
Chandigarh	Documentation need to be maintained properly.
Amritsar	Staff Capacity building & strengthening.
Allahabad	Documentation was not maintained properly, only one year data was available.
Rewa	Staff Capacity Building required in documentation
Dewas	All staff positions were not filled, two counsellor posts were vacant

Table 4: Recommendations (Compiled from FGD and IDI with Community/ KII with SACS officials)

District	SACS Officials	Community
West Delhi	DIC should focus more on networking with the Hospital.	Income generation support to poor PLHIV
Central Delhi	staff capacity building, increase outreach staff, Proper guideline for DIC	Nutrition support and Income generation support to poor PLHIV
Chandigarh	Capacity Building of staff, increase fund, increase outreach team	Increase the outreach staff, Organize and conduct more awareness camps, Counselling before approach to government services
Amritsar	Strengthening linkages with various scheme, Staff capacity building	Income Generation Support to PLHIV, Education and nutrition support to the CLHIV
Allahabad	Linkages with various Government health schemes should be strengthen more, Increase in staff salaries, Staff capacity building	Increase the outreach staff, Vocational trainings to PLHIVs, Facility to avail Widow pensions, Education and Nutritional support to OVCs.
Rewa	Timely release of funds, Increase outreach staff, staff training and capacity building.	Education & Nutritional support to the Children.
Dewas	Increase fund, capacity building of staff, reimbursement of travel cost for the patient visiting ART centre	Income Generation support to poor PLHIV, Nutritional support to all PLHIV.

2.2 South Region

ANDHRA PRADESH (AP)

Table 1: PLHIV Registration and reach /DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Krishna	Vijayawada	>40000	0.9	4406	664	15.07
02	Guntur	Guntur	52475	5	1227	395	32.19
03	West Godavari	Eluru	30000	1.9	2320	2410	?
04	East Godavari	Rajahmundry	20362	2.8	1762	968	54.93
05	Prakasam	Ongole	31114	0.5	2078	1326	63.81
06	Ananthpur	Ananthpur	14781	0.88	1545	1520	98.38
07	Nalgonda	Nalgonda	4772	0.8	1417	2011	141.9
08	Warangal	Warangal	10536	0.5	3311	793	23.95

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues – Children
Prakasam	Denial of Property rights, Discrimina-tion by Family, economic support	School admission and property denial
Anantpur	Access to water denied , cremation disallowed sometimes, social exclusion,	Lack of friends, school admissions, orphan hood, malnutrition, ART adherence, Discrimination by neighbours
Guntur	Family problem, Access to care and support	School admission, Nutrition and Orphan Care
Nalagonda	Social stigma, loss of employment, financial crisis, denial of property rights	ART adherence, study loss due to tension lack of nutrition and care for double orphans,
Krishna	Loss of employment ,denial of property rights, discrimination by in-laws,	Lack of knowledge about medicines and adherence, lack of care for orphans, loss of study due to illness
Warangal	Fear of Loss of employment ,denial of property rights, discrimination by in-laws, financial burden due to loss of spouse	Lack of ART medicine on time, transportation cost affecting ART adherence, lack of paediatric counselling, lack of knowledge in care taker about HIV
East Godavari	Domestic violence, Divorce and Community discrimination	Lack of - ART on time, education support and nutrition support.
West Godavari	Discrimination at health facility, denial of property, divorce and family problem	Lack of knowledge about ART in care takers, nutrition problem and care for orphans

Table 3: Gaps in Governance

District	Gap Identified
Krishna	DIC PC of DIC is also President of DLN (CHES) & Treasurer of INP+.
Nalgonda	DIC PC is also Vice president of DLN (NYPS).
Warangal	PC of DIC is also Treasurer and Ex President of DLN (KMPPS).
Anantapur	PC of DIC is also Vice President of DLN
Prakasam	PC of DLN is also Member of Gov Body of DLN. Counsellor in DIC is also Vice President of DLN. ORW (Out Reach Worker) in DIC is also Secretary in DLN.
East Godavari	PC of DIC is also Executive Member of Coastal Network of Positive People (CNP+)
West Godavari	Counsellor in DIC is also Executive Member of Association of Positive People for Living Excellence (APPLE)
Guntur	Staff Salary delayed due to delayed receipt of funds

Table 4: Recommendations (Compiled from FGD and IDI with Community/ KII with SACS officials)

District	SACS officials	Community
Prakasam	DIC monitoring under DAPCU, Operational guidelines for DIC	Educational and Nutritional support for Children, Vocational training for women
Anantpur	Improve referral services to DIC, staff capacity building, increase outreach staff	Orphan care, Training in Livelihood options, Nutrition for Children , more outreach staff,CD4 machine at DIC,Training in marketing,
Guntur	Additional DICs for the districts Staff capacity building ,PLHIV SHG formation, DIC monitoring and handholding	Increase the outreach staff, Organize and conduct more awareness camps, Provide doctor and medicines, Initiate IGP and facilitate loans,Counseling before approach to government services
Nalagonda	PLHIV to be part of village health committee, improved Community awareness, Sensitization of health sector, Linkage strengthening	Increase the outreach staff, Pensions to PLHIVs those are on ART,IGP and loan facilities for self sufficiency, Vocational trainings to PLHIVs,Facility to avail Widow pensions, Regular medical check-up for children, Education and Nutritional support to OVCs
Krishna	Improve PLHIV reach, Increase number of DICs, Timely release of funds, Operational guidelines for DIC	Enhance quality of DIC services, Provide doctor
Warangal	CMIS in telugu, increase PLHIV reach , strengthen linkages, staff capacity building	Regular medical check up, Medical and Nutritional support, Loan facilities, Vocational trainings ,Awareness programs Increase DIC staff
East Godavari	PLHIV recruitment based on education, timely release of funds, Travel charge to be paid to PLHIV to attend Support group meeting, Operational guidelines for DIC	Arrange for Doctors in DIC,OI medicine, give travel money to PLHIV for support group meeting, Referral Counselling
West Godavari	Timely release of funds, Increase outreach staff, short shelter for PLHIV for ART workup, staff training and adequate counselling space	Training and support on income generation, Support for conducting periodic meetings, Support to start short stay homes, Support to fight legal cases

KARNATAKA

Table 1: PLHIV Registration and reach /DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Bangalore Urban	Wilson Garden, Bangalore	17067	0.43	1382	743	**53.76**
02	Koppal	Koppal	6782	0.49	1965	1000	**50.89**
03	Mandya	Mandya	4297	0.30	1096	935	**46.61**
04	Udupi	Udupi	6799	0.46	840	558	**66.43**

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues – Children
Bangalore Urban	Discrimination at workplace. Difficulty faced during inheritance of Property	Insufficient financial and nutritional support to CLHIVs and orphaned affected children.
Koppal	Problem getting leave for treatment. Forced into isolation by family.	Problem in school admission and malnutrition in CLHIV
Mandya	Mental trauma due to rejection by family, loss of job.	Attendance problem due to ill health in family, apathy/fear among relatives towards orphaned CLHIVs.
Udupi	Refusal to allow continuation to employment, Problem in inheritance to husband's property.	Problem in getting school admission and discrimination in school.

Table 3: Gaps in Governance

District	Gap
Banglore,Mandya,Udupi, Koppal	Fund Delay leading to staff turn over
	Lack of procurement Policy

Table 4: Recommendations (Compiled from FGD and IDI with Community /KII with SACS officials)

District	SACS Officials	Community
Bangalore Urban	Recruitment of more qualified staff, provide better training and infrastructure at DIC. Stronger advocacy.	Monthly pension for those PLHIVs who are unable to work. OI treatment facility provided at DIC. Help in getting house/site to PLHIVs from Government.
Koppal	Better team effort, strong monitoring and need based advocacy. More training.	Ambulance needed to reach out & follow up for ART treatment to those who are in faraway places. Providing Hostel facility for CLHIVs & non-CLHIVs in Koppal itself.
Mandya	Project focus and activities to match the PLHIV needs. Capacity building for tapping facilities on behalf of PLHIVs.	Stay and entertainment facility like beds, TV. Carom board etc., required in DIC. More DICs opened in Mandya. Better CCC referral centres.
Udupi	Timely release of funds. Avoid programmatic restrictions on activities conceived necessary for PLHIVs	Provide vehicle facility to reach out to far off patients. Strengthen relationships with all other agencies.

KERALA

Table 1: PLHIV Registration and reach /DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Ernakulum	Kochi	206	0.38	337	144	**42.72**
02	Calicut	Calicut	2677	0.38	308	90	**29.22**

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues – Children
Ernakulum	Taking care of children, discrimination from family, caring of infected spouse, financial difficulties, no platform to open up women's issues, difficulty to get a job	School related issues, decreased interest in studies, single parenting, double orphan status, anxiety on higher education, poor knowledge on HIV/AIDS, increased stress due to HIV
Calicut	Getting property of husband, taking care of children, disclosing HIV status, psychological harassment, discrimination at hospital (gynaecology), disclosing HIV status to children,	School admission, decreased interest in studies, violation of right to education, poor knowledge on HIV/AIDS, lack of nutrition, psychological discrimination, financial difficulty for education.

Table 3: Gaps in Governance

District	Gaps Identified
Ernakulum	Purchase register not available, no procurement policy, no systematic documentation, no cash expenditure limit, lack of infrastructure facility like computer, printer, internet etc.
Calicut	Purchase register not available, stock register not available, no procurement policy, utilization certificate not available, no systematic documentation, no idea about cash expenditure limit, no computer, printer, internet etc.

Table 4: Recommendations (Compiled from FGD and IDI with Community/ KII with SACS officials)

District	SACS officials	Community
Ernakulum	Bring DIC staff and positive network to a professional level by capacitating them, Start DIC in all districts without restricting to 'A' and 'B' category states, National GIPA coordinator is needed at NACO level, Provide training in managing IDUs, Give importance to state level networks. They may be given the assignment for training DIC and DLN. May conduct meeting of specific groups like women, men etc. This will help in giving more focus to specific groups and specific needs of the groups, May give 10% of the total budget allocation for the basic infrastructure and office maintenance of district level network, State wise flexibility is needed in implementing DIC program in relation to NACO policy and within NACO framework, Change the staff structure. NACO policy is needed to bring professional support at the DIC level, Increase the staff strength. Provide two wheelers to all staff to reach all ICTC on time. State AIDS Control Society should give more funds to DICs. DIC should increase advocacy/ networking to provide more services to PLHIVs and CLHIVs	Increased medical support, Second line ART support for all the needy, Education session for children on ART, Mobilizing more support for the education of children, Income generation support for more people, need more money for medical support, support for more people with second line ART, classes for children on ART, especially for teenage children. They are not aware of the pros and cons of this disease and its impact in life, More support should be given for the education of children.
Calicut	Training needed on problem solving. Help needed for selecting the right leaders. Get the support of sincere core of the PLHAs. Intermediary needed for solving the problem. Need more sincerity from the staff. Increase the activities of the DIC. Need commitment from DIC staff like people working in other offices serving the PLHIVs. Get the support of professional staff. Monitoring system needed. DIC is not to be meant for giving jobs, should be meant for giving goodness to PLHIVs, Conduct more training for capacity building of DIC staff KSACS should intervene to solve group problems/ non cooperation among staff. Appoint professionally qualified people to help DIC staff.	Provide nutrition kits in time, Increase the self employment training. develop team spirit, DIC staff should be role models for other people, make available the financial support from "Panchayats" and other agencies, give the necessary support to the terminally ill people, training for IGP and financial support for starting IGP, bystander support during hospitalization.

TAMIL NADU

Table 1: PLHIV Registration and reach /DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Chennai	Ayanavaram	NA	0.50	852	501	58.8
02	Cuddalore	Cuddalore	NA	0.25	2136	1301	60.9
03	Erode	Erode	NA	0.38	910	1406	?
04	Chennai	Guindy	NA	0.50	336	324	96.4
05	Karur	Karur	NA	0.38	929	1858	?
06	Madurai	Madurai	NA	0.00	2880	2282	79.2
07	Chennai	Periyar Nagar	NA	0.50	467	86	18.4
08	Salem	Salem	NA	2.25	744	3198	?
09	Theni	Theni	NA	1.25	2983	4820	?
10	Trichy	Trichy	NA	0.83	956	1268	?
11	Villupuram	Villupuram	NA	0.38	760	3758	?

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues – Children
Ayanavaram Chennai	Stigma and discrimination of family members ; no short stay home for medical emergencies	Difficult to obtain school admission; discrimination by teachers and students; no hostel for infected & orphaned
Cuddalore	Discrimination of medical professionals; delay in getting vitamins	Difficult to get school admissions at times
Erode	Social exclusion; lack of medical services	Discrimination by neighbours if status is known to them
Guindy, Chennai	Delayed response of medical professionals of other specialities	Lack of nutritional support; less health services; lack of counselling and knowledge of HIV
Karur	Social stigma; loss of employment; financial crisis; denial of property rights	Diminished academic performance; lack of care for the infected and the affected
Madurai	Forced to leave the village; denial of property rights ; not allowed to use the cremation ground	Dismissal from school; social isolation; not addressing emotional issues;
Periyar Nagar, Chennai	Fear of Loss of employment; discrimination by in-laws; financial burden due to loss of spouse	Lack of ART medicine on time; lack of paediatric counselling; lack of knowledge among caretakers
Salem	Domestic violence, Divorce and Community discrimination	Lack of knowledge about ART among caretakers; less educational support to children
Theni	Social exclusion even for fetching drinking water from common pumps; denial of property rights; divorce	Lack of care for orphans; less educational support services
Trichy	Lack of mental health support services; denial of job offers	Mental health issues; non-adherence; fear of future
Villupuram	Psychosocial issues; deserted by family	Deprived of education and psychosocial support

Table 3: Gaps in Governance

District	Gap
All the districts	Fund Delay leading to staff turn over
	Staff Capacity Building
	Lack of monitoring and handholding by SACS

Table 4: Recommendations (Compiled from FGD and IDI with Community /KII with SACS officials)

District	SACS officials	Community
Ayanavaram Chennai	Improve the reach of PLHA; increase number of DICs; timely release of funds; uniformed operational guidelines for DIC	Marital coordination for PLHIV's children; Skill development classes like tailoring, basket making; life enhancing interventions for CLHIV and affected; Educational and Nutritional support to PLHIV and their Children
Cuddalore	Enable referral services to DIC; professional counselling to improve adherence; staff capacity building; increase outreach staff	Hostel facilities or home for the infected and affected families and children; TACDCO loan should be provided to all without caste discrimination; medical services can be provided at DIC for general health needs; more staff in DIC; additional DICs; CD4 machine at DIC
Erode	Additional DICs for the districts; Staff capacity building; SHG formation; DIC monitoring and handholding; training for documentation; job insecurity of staff should be addressed	Educational support to the infected/affected children; Skill training programs; More projects so DIC; IGP; SHG promotional activities; more number of ORWs; Scholarship for the CLHIV; Hostel for the orphan CLHIV; widower pension; compulsory referral services
Guindy, Chennai	PLHIV to be a part of service planning and implementation; improved Community awareness, Sensitization of health professionals and the sector; strengthening networks	Home for orphan children (affected/ infected) without bias; ration card through DIC; ID cards; IGP for both men and women; SHG should also be formed for men; Legal assistance at DIC for legal issues; Provisional support for BPL
Karur	Address self stigma and discrimination; intensive interventions to address mental health issues; more ORWs; adequate funds; advanced and intensive training to DIC staff about all aspects; DIC to be the part of ART Centre	Alternative medicine for CLHIV; pension for positive men; creating more jobs at DIC; amalgamating community care centre with DIC; more professional counselling services; placing DICs closer to ART, ICTC and PPTCT centres; more outreach workers; more Financial support to DIC; more support to the education of children of PLHIV; welfare board for PLHA
Madurai	More trainings to DIC staff; more funds; more referrals from ART centres; counsellor training; special schemes for PLHIV; improved referrals from Govt. hospitals; timely auditing from SACS; timely release of funds	Separate hostel for the children and house for the PLHIV; Pulses and cereals along with the provisions; IGP from the DIC; Capacity building for the Staff for the better communication; financial assistance for more support group meetings; Widow pension; Protection and legal aid services at DIC; Dispensary should be made available in the DIC
Periyar Nagar, Chennai	Uniform norms for all DICs; improved communication; adequate budget allocation; appropriate & timely training;	Self employment and livelihood support; own building for DIC; loan for men and women; treatment should be given at

District	SACS officials	Community
	nutrition packet distribution; more training to staff in all quality of life domains; correct addresses of PLHIV from hospitals	DIC; visit of physician and nurse to DIC; better and more intensive counselling services; educational support for children; paediatric counsellor; ambulance services; nutritional food supply at DIC; treatment for the side effects of ART
Salem	Training to health officials to get rid of stigma and discrimination; adequate number of meetings with the SACS officials; sensitizing PLHIV regarding family roles and responsibilities; sufficient fund allocation; awareness to IAS and IPS officers regarding HIV/AIDS; appointing a doctor and a nurse in the DIC; intensive psychological counselling; providing nutritious food	Employment services for the PLHIV; educational support and Nutritional mix; monthly stipend to the PLHIV; a doctor, a nurse and a counsellor available continuously; An exclusive welfare board for PLHA; Arranging loans; Training (Entrepreneurship); educational support to CLHIV; more emotional and behavioural interventions; more budget to DIC.
Theni	TANSACS should provide necessary fund; more peer educators and volunteers; more awareness programmes; more effective modes of IEC; necessary policy change; hybrid with other esteemed organizations.	A clinic consisting of a doctor, a nurse and a counsellor which is maintained by the DIC; permanent building for the DIC; medical facilities should be available within the DIC premises; nutritional and health mix powder; multivitamin tablet given at DIC; more professional psychosocial interventions
Trichy	Stable and steady income to DIC staff; more intensive and social support to PLHIV; livelihood support; continue educating the people; intensive & professional counselling training; creating more supportive/enabling environment; more training to handle stigma & discrimination	Skill based training for livelihood; funds to start a small scale industry; advocacy – widow & widower pensions; housing support; financial support; job placement through employment exchange in places like ration shops and Anganwadi centres; increased educational support to children; more intensive psychosocial support services
Villupuram	Provide nutritional food products to PLHIV through DIC; more DICs in a district; additional projects can be implemented through DIC; More awareness programs; intensive counselling services; and more family and peer interventions.	More Advocacy – Widow Pension, Housing schemes; Training to para medical staff through DIC; need for more professional - effective and intensive counselling services; legal aids; livelihood supports; medical services for general health.

2.3 East Region

MIZORAM

Table 1: PLHIV Registration and reach /DIC

S.N	District	Location	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Aizwal	South	1900	1.75	469	574	**55**
02	Aizwal	North			227	NA	
03	Aizwal	Bawngkawn			352	225	**69.2**
04	Aizwal	New Hope soc			158	NA	
05	Chandmari	Hope Care	500	.75	286	163	**57**
06	Kolasib	New world	300	.5	176	103	**59**

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues – Children
Aizawl-4DICs*	Separate DIC for the women, financial crisis, Income generation and skill building	Nutrition supplement, Substitute breast-milk, School fees, dumping of orphans in orphanages.
Champhai	Transportation cost for higher health facility, Not fully aware of PPTCT and safe delivery, Poverty.	Many are not breastfed and Infant feeding formula not afforded. Dumping of orphans in orphanages. Lack of knowledge on ART and other HIV Services
Kolasib	Transportation and stay expenditure problem for higher health facility, Some Positive women frightened to disclose their status to their husband though they got it from the husband, Poverty.	Nutrition supplement, Substitute breast-milk, School fees, dumping of orphans in orphanages. Lack of knowledge on ART and other HIV Services

Table 3: Gaps in Governance

District	Gaps Identified
Aizawl -4 DICs	Limited service offered by DIC, limited outreach activities, Irregularity in documentation, No systematic and proper monitoring and reporting system.
Champhai	Limited staff capacity, No systematic documents of activities, No systematic and proper monitoring and reporting system.
Kolasib	Limited staff capacity, documentation is inconsistent, No systematic and proper monitoring and reporting system.

Table 4: Recommendations (Compiled from FGD and IDI with Community/ KII with SACS officials)

District	SACS Officials	Community
Aizawl – 4 DICs	Staff Capacity building, Proper and regular monitoring system for referrals, networking and linkages. Develop proper guide lines for DIC. Relocation of DIC location for wider coverage, Upgrade DIC for Short stay facility. Supply of medicines to DIC for Opportunistic infections. Formation of SHGs and IGA for PLHIV	Proper implementation guidelines, monitoring and reporting system from SACS, Regular flow of funds, Increase service by adding the component like IGA, Nutrition etc. in DIC
Champhai	More training for staff to build up their capacities. Linkage with ICDS, social welfare Dept etc,	Regular flow of funds, scaling up of DIC to give more service to PLHIV. More funds for transportation in referral.
Kolasib	Increase Availability, more Coordination with other departments and services i.e. NGOs, ICTC,ART,CCC	Regular flow of funds, Nutrition for Children , more staff, more component like IGA etc.

Aizwal district has four DICs and compiled data for the district is presented in Table 2, 3, & 4

MANIPUR

Table 1: PLHIV Registration and reach /DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Imphal East	Yaiskul Hiruhanba Leikai - 795001, Manipur – India	8485	0.75	691	325	47
02	Imphal West	Thangmeiband Hijam Diwan Leikai - 795001, Manipur – India	4794	0.33	547	171	31
03	Thoubal	Thoubal bazaar Maning Keithel - 795138, Manipur – India	734	0.0	620	196	32
04	Ukhrul	Wino Bazar, Greenland, Manipur-India	1521	2.1	361	184	50

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues - Children
Imphal East	Discrimination by families (parental and in laws), lack of economic and social support.	Lack of HIV and AIDS care and support including counselling, nutrition, education, recreation, leading to school drop outs and social disintegration especially among AIDS orphans and vulnerable children.
Imphal West	No separate support system even at the level of the DIC hindering privacy and representations.	Lack of friends, school admissions, orphan hood, malnutrition. As innocent victims they often suffer from denial, low self esteem, loneliness and self hatred.
Thoubal	Tendency of hiding their status in the rural areas, stigma discrimination and often fails to access to care and support. Denial of property rights.	Lack of HIV and AIDS care and support including counselling, nutrition and education. As innocent victims they often suffer from denial, low self esteem, loneliness and self hatred.
Ukhrul	Social stigma, no separate support system even at the DIC hindering privacy and representations. Institutional delivery is below 20% when the ANC prevalence rate in the state is 1.3%.	Lack of recreation, nutrition, discrimination by neighbours and leading to school drop outs.

Table 3: Gaps in Governance

District	Gap identified
All Manipur	Funding is irregular and delayed. Monitoring and evaluation of PLHIV DICs had not taken place.
Imphal East	DIC is established in Imphal West (Yaiskul Hiruhanba Leikai) not in Imphal East as it should be. Cash expenditure limit is not specified.
Imphal West	Cash expenditure limit is not specified. Staff shortage due to the expiry of 1 counsellor. Record of outreach and follow up not updated.
Thoubal	Bank is operated in the name of Manipur Network of Positive People, not in the name of the DIC. Cash expenditure limit is not specified. Record of outreach and follow up not updated.
Ukhrul	Purchase register and procurement policy not available. Cash expenditure limit is not specified. Record of outreach and follow up not updated.

Table 4: Recommendations (Compiled from FGD and IDI with Community/ KII with SACS officials)

District	SACS officials	Community
Imphal East	The funding partners should monitor and review the functioning of the DIC regularly. DIC can strengthen PLHIV networks and take part in policy and planning meetings in HIV and AIDS policy. The ART centres, ICTC have various limitations of their own. The DIC also should be incorporated with minimum standard service of medical care and testing at its level.	The Imphal East DIC should be located at Imphal East. Clients from Imphal East feel inconvenient to travel to Imphal West to get the service. Livelihood, nutrition support for PLHIVs and CLHIVs. Regular OI medicines and group meetings for PLHIVs.
Imphal West	The DIC to prepare/procure IEC materials in simple local language for the PLHIV and community. Organisers to work on greater advocacy linkage with school, NGOs, hospital etc.	The DIC should be located and shifted to a locality nearer to the main road so that it is more accessible. Recreational items, increase referral and networking provisions for children for education and nutrition. Livelihood support for PLHIVs. There should be some female staff.
Ukhrul	Distinct operational guideline for DIC. Regular follow up and monitoring from the funding agency. Local based NGOs and CBOs or DLNS be entrusted and encouraged to run the DICs or community care centres.	Baseline investigation cost to initiate ARVT, provision for regular health check up and medicine support, the space of the DIC be increased or there be a separate DIC for women, DIC and facilities for recreation for children. Lack of community care centre in the district is a major issue.
Thoubal	Induct trained staff, a doctor/nurse. More decentralisation at the level of the DIC and ART centre. PLHIV themselves can play an influential role in pursuing the authorities to implement the plans in time. Need for more coordination and networking among district level Networks.	Need for a doctor and nurse, livelihood support for PLHIVs, a separate DIC for women, DIC, venue of DIC in the market place is inconvenient for drop in. Medical Officer in the ART centre Thoubal is lying vacant for more than a year.

WEST BENGAL & ORISSA

Table 1: PLHIV Registration and reach/DIC

S. N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
1	Sparsha – Kolkata	Rabindrapally	NA	NA	464	88	19
2	Sangoboddha –Darjeeling Plains	Sastrutnagar near NBMCH	NA	0.67	699	699	100
3	MNP+ - Malda	Jhaljalia Road station	NA	NA	199	205	?
4	Sparsha – Purba Medinipur	Basudebpur	NA	NA	364	410	?
5	JSP+ - Jalpaiguri	West Kerani Para	NA	NA	684	265	39
6	UDSP+ - Uttar Dinajpur	Ismail Chowk	NA	NA	318	185	58
7	BSP+ - Burdwan	Rasikpur Road	NA	0.75	383	118	31
8	KNP+ - Kolkata	Shivnarayandas Lane	NA	NA	648	162	25
9	KNP+ - Khurda , Orissa	Behind Barmunda Bus stand	NA	NA	275	120	44

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues - Children
Sparsha –Kolkata	Denial of medical care at hospitals.	Discrimination and isolation within the extended family.
Sangoboddha – Darjeeling Plains	Blamed for spouses HIV status, driven out of in laws home after husband's death.	Admission in schools denied no one to care for orphan CLHIVs.
MNP+ - Malda	Resistance from in-laws, lack of support of male members in case of widows.	Malnutrition and lack of proper diet.
Sparsha – Purba Medinipur	Social isolation and prohibited to socialise with others. Rejection from inheriting family assets, property.	Denies school admission, immunisation. Not allowed to play or sit with other children in the community.
JSP+ - Jalpaiguri	Spousal conflict, discrimination within family and torture by neighbour.	School drop outs, no shelter home for CLHIV.
UDSP+ - Uttar Dinajpur	In-laws make female responsible for PLHIV status. Denial of right to property	Neglect by family members due to PLHIV status, non availability of paediatric ART.
BSP+ - Burdwan	Separated from joint family, no one to take responsibility of treatment costs. Driven out if in-laws home.	Education hampered due to frequent travel for ART, CD4, OI treatment etc.
KNP+ - Kolkata	Dependent on others, rejection from employment opportunity.	School admission denied, neglect by parents.
KNP+ - Khurda , Orissa	Family doesn't support treatment of PLHIV women.	Denied admission to school and private tuition. No orphanage for CLHIV.

Table 3: Gaps in Governance

District	Gaps Identified
All WB	Irregular funding from SACS, staff shortage, proper and systematic documentation of activities.
Sparsha –Kolkata	Executive committee meeting minutes not available. Cash book, purchase register, procurement policy, stock register etc not available.
Sangoboddha – Darjeeling Plains	Cash expenditure limit is Rs 5000 (beyond permissible limit of Rs 2000)
MNP+ - Malda	Cash Book not updated purchase register and procurement policy not available, cash expenditure limit is Rs 4999.
Sparsha – Purba Medinipur	Only 1 Executive committee meeting minutes available, Audited financial report & procurement policy missing.
JSP+ - Jalpaiguri	Utilization certificate missing.
UDSP+ - Uttar Dinajpur	Staff salary paid in cash, Purchase register & procurement policy missing.
BSP+ - Burdwan	Cash expenditure limit is Rs 5000
KNP+ - Kolkata	Cash expenditure limit is Rs 5000
KNP+ - Khurda, Orissa	Purchase register missing, Communication gap with OSACS

Table 4: Recommendations (Compiled from FGD and IDI with Community/KII with SACS officials)

District	SACS officials	Community
Sparsha – Kolkata	More involvement of SACS in DIC program	Scale up education support for children.
Sangoboddha – Darjeeling Plains	DIC & CCC should resolve issues and strengthen co-ordination.	Same service for HIV+ & HIV- children of PLHIVs. More frequent home visits.
MNP+ - Malda	Co-operation between CCC and DIC staff, issues must not be taken to SACS.	Opening DIC & ART centre at block level, making available medicines for CLHIV at Malda.
Sparsha – Purba Medinipur	Increase man power for follow-up and counselling. Co-ordinate activities with CCC.	Provision of blood supply and linkage for Thalasemia affected children of PLHAs.
JSP+ - Jalpaiguri	Introduce feasible Livelihood options; develop good networking with police and local clubs.	BPL card and widow pension for PLHAs, Mobile medical unit for PLHAs in far flung forest area.
UDSP+ - Uttar Dinajpur	Advocate PLHIV issues actively to get recognition at administrative level. Programme for OVC care & support.	DIC at block level, Integrity and transparency of PLHIV members of DIC
BSP+ - Burdwan	Day care centre for children of PLHIV, Co-ordination meeting between DIC and ART,ICTC,PPTCT,CCC etc.	Take initiative for IGP, More sensitization of Hospital staff to treat PLHA with dignity.
KNP+ - Kolkata	Local fund mobilisation to help PLHIVs	Provision for nutrition and health support for HIV- child of PLHIV.
KNP+ - Khurda , Orissa	Local fund collection, Advocacy with influential persons and health care staffs.	Regular health camp, ambulance facility, logistic support for coming to DIC.

NAGALAND

Table 1: PLHIV Registration and reach/DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Kohima	TCP Gate, N.H -39	1735	1.2	192	250	?
02	Dimapur	Bank Colony	3410	1.8	698	274	39.2
03	Wokha	N.S.T Colony	1150	0.4	108	110	?
04	Zunheboto	South Point,N.S.T. Road	1675	0.5	274	425	?
05	Teunsang-1	Near Teunsang Town Baptist Church	6141	2.4	216	1874	?
06	Teunsang-2	Near Khiamnuingan Baptist Church Teunsang.	6141	2.4	236	2372	?

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues - Children
Kohima	Chased out from family residence, Discrimination in hospital for treatment.	Discrimination in school by teachers and peers.
Dimapur	Denial of Property rights, Discrimination by Family, economic support	Ill treatment by family members.
Wokha	Family discrimination	Discrimination by society
Zunheboto	Discrimination and Financial problem,	Discrimination in School, Community isolation.
Teunsang-1	Not accepted by family members, Giving all blame on women for spreading HIV/AIDS	Discrimination by family, No support for education.
Teunsang-2	Societal and Workplace discrimination.	Discrimination by neighbours.

Table 3: Gaps in Governance

District	Gaps
Kohima	Lack of Staff training, effective monitoring, problem of timely receipt of fund, Cash amount expenditure limits Rs 3000.
Dimapur	Cash amount expenditure limit Rs 4000.
Wokha	Salary delayed, Cash amount expenditure limit Rs 2000.
Zunheboto	Cash amount expenditure limit Rs 4000, problem in timely receipt of fund.
Teunsang-1	Salary delayed, Cash amount expenditure limit Rs 2000.
Teunsang-2	Salary sometimes delayed, Fund allotment, Cash amount expenditure limit Rs2000.

Table 4: Recommendations (Compiled from FGD and IDI with Community / KII with SACS officials)

District	SACS Officials	Community
Kohima	DIC monitoring under NSACS, Networking, Commitment and teamwork	Require more educational and nutritional support for clients, require constant review.
Dimapur	Sincerity, Teamwork, Health and ART follow up.	Require Orphanage home, more recreational and activity based programmes for the clients, nutritional and educational support and more DIC staff required.
Wokha	Commitment, Sincerity.	Organize and conduct more awareness programmes to eradicate stigma and discrimination, strengthen DIC Staff.
Zunheboto	Coordination.	To effectively deal with Stigma and discrimination, improve communication and transportation .for more outreach.
Teunsang-1	Commitment, Coordination.	Improve communication, provide more fund for effective outreach, eradicate stigma and discrimination, and require educational and nutritional support.
Teunsang-2	Coordination	Increase DIC staff, more contact with PLHIV, and support for educational and nutritional supplement, improve transportation for more outreach and networking.

2.4 West Region

GUJARAT

Table 1: PLHIV Registration and reach /DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Surat - 1	Nr. sahara gate	NA	0.25	1050	2955?	**?**
02	Surat- 2	Nr.Bombay market	NA	0.25	1015	317	**31.2**
03	Surat - 3	New Civil Hospital	NA	0.25	946	407	**43.0**
04	Ahemadabad-1	Abad-Network	NA	0.25	425	1059?	**?**
05	Ahemadabad-2	Adhar-Asarva	NA	0.25	2786	5032	**?**
06	Ahemadabad-3	Adhar-Bapunagar	NA	0.25	747	2655	**?**
07	Rajkot	RDNP+ Dhebar road	NA	0.25	1378	1273	**92.3**
08	Vadodara	AP+ Alkapuri	NA	0.25	630	337	**53.4**

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues - Children
Ahmadabad- 3 DICs	Denial of Property rights Discrimination by Family, economic support	School admission and property denial
Surat- 3 DICs	Access to water denied ,cremation disallowed sometimes, social exclusion,	Lack of friends, school admissions, orphan hood, malnutrition, ART adherence, Discrimination by neighbours,
Rajkot	Family problem, Access to care and support	School admission, Nutrition and Orphan Care
Vadodara	Social stigma, loss of employment, financial crisis, denial of property rights	ART adherence, study loss due to tension lack of nutrition and care for double orphans,

Table 3: Gaps in Governance

Districts	Gaps
Surat- 3 DICs	Delay of fund receipt and staff turnover, NO procurement guidelines, lack of monitoring by SACS. ,Lack of operational guidelines
Vadodara	Delay of fund receipt and staff turnover, No procurement guidelines, lack of operational guidelines

Table 4: Recommendations (Compiled from FGD and IDI with Community / KII with SACS officials)

District	SACS officials	Community
Ahmadabad-3 DICs	Network with Corporate for support, strategic planning to share outreach work with CCC to trace LFU, Education based recruitment of PLHIV in DIC	Basic needs like travel money to attend the support group meeting, IGA for women, Paediatric counselling.
Surat-3 DICs	Staff capacity building, Separate DIC for migrants	More home visits ,awareness for reduced stigma and discrimination, more funds for children support., DIC must know language of migrants as counselling for migrants not done due to language problem
Rajkot	More number of outreach staff, more fund for travel	More staff to reach more people by home visits, Information to reach village level.
Vadodara	Operational guidelines, staff capacity building, strategic location of DIC	Livelihood option training, Educational support for children, more funds to travel to attend support group meeting

Ahmadabad and Surat districts has three DICs each and compiled data for the district is presented in Table 2, 3, & 4

MAHARASHTRA

Table 1: PLHIV Registration and reach/DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	Nanded	Nanded		1.54	640	469	73.2
02	Hingoli	Hingoli		0.16	691	257	37.1
03	Yavatmal	Yavatmal		0.25	1418	357	25.17
04	Chandrapur	Chandrapur		0.85	864	819	94.7
05	Pune	Pune		0.3	3461	272	7.8
06	Mumbai	Kurla		0.3	659	687	?
07	Mumbai	Andheri		0.3	539	2982	?
08	Ahmadnagar	Ahmadnagar		0.01	1055	334	31.65
09	Beed	Beed		NA	861	899	?
10	Raigad	Raigad		NA	593	1540	?

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues –Women	Issues – Children
Nanded	Loneliness, Social withdrawal, Discrimination by family & at job, at hospital, Restriction from meeting their children	stigma and discrimination at neighbourhood and school, School admission denial
Hingoli	Family & social discrimination, economic problem ,loneliness, employment issues	Loneliness, school discrimination
Yavatmal	Family, legal & Property issues, social discrimination	No issues
Chandrapur	Family & social discrimination	Not specified
Pune	Social & family stigma, loss of employment, financial crisis, denial of property rights	Rehabilitation of OVC, ART adherence, school discrimination
Mumbai-Kurla	Loss of employment ,denial of property rights, discrimination by in-laws, Denial for possession of children or meeting children, livelihood & IGA issue for widows	Treatment, Nutritional & educational issue due to economic problem; Rehabilitation as relatives not ready to take care, loneliness
Mumbai-Andheri	domestic violence , property and legal rights , sexual harassment and abuse , treatment access issues , lack of family support	treatment and adherence, abuse, stigma and discrimination and violence, lack of good nutrition, hygiene, impact on education
Ahmadnagar	property & right issue, mental harassment, economical problem	educational , economical support & treatment problems, Lack of family support
Beed	Family & social Discrimination ,Employment issues	Care & support, educational issues
Raigad	domestic violence , property and legal rights , sexual harassment and abuse , treatment access issues , lack of family support	treatment and adherence, abuse, stigma and discrimination and violence, lack of good nutrition, hygiene, impact on education

Table 3: Gaps in Governance

District	Gaps Identified
Nanded	Irregular funding from SACS, No EC meeting record, manual updating of record [not updated], no procurement policy & purchase register
Hingoli	Executive committee meeting minutes record not available. Purchase register, procurement policy, stock register etc not available. manual updating of record [not updated],
Yavatmal	Cash expenditure limit is Rs 10000 (beyond permissible limit of Rs 1000), Irregular funding from SACS, manual updating of record [not updated], no procurement policy & purchase register
Chandrapur	Cash Book not updated purchase register and procurement policy not available, cash expenditure limit is Rs 5000. Nonpayment of staff, No EC meeting, irregular fund from SACs, As per Ashwini Nikam of MSACS & Review report Inspite of knowledge about mismanagement at DIC only verbal communication to refund balance fund of staff payment, , No audit report available, Immediate made bills n voucher; Even SACS review report found unavailability of bills n voucher
Pune	Executive committee meeting minutes available, Audited financial report & only procurement policy missing. Purchase & stock register available
Mumbai-Kurla	Cash expenditure limit is Rs 5000., No procurement register or policy, finance report not updated
Mumbai-Andheri	Staff salary paid in cash n cherub, , no audit report seen, only current yr bills voucher shown, Purchase register & procurement policy missing.
Ahmadnagar	Cash expenditure limit is Rs 5000.
Beed	Cash expenditure limit is Rs 1000.
Raigad	Purchase register not available,

Table 4: Recommendations (Compiled from FGD and IDI with Community/KII with SACS officials)

District	SACS Officials	Community
Nanded	Training and capacity building of the staff. Proper linkages & coordination with referral system; Good dedicated team.;.; DIC monitoring under SACs, Operational guidelines for DIC	Easy accessibility of DIC ; SHG promotional activities; Matrimonial and IGA support or widows ; Matrimonial and IGA support or widows ; Educational and Nutritional support for Children, Vocational training for women
Hingoli	Support and guidance from MSACS and NACO to make the proper policy guideline strategies, and regular M & E. ; Capacity building of Staff; Coordination with DIC/ART and CCC to cover vast geographical area.; Additional budget for the children programs	Educational & Nutritional support for Children, more outreach staff, Adequate transportation charges to the participants of the Support Group Meeting; Matrimonial and IGA support or widows
Yavatmal	Capacity building of staff. Linkages and coordination with ART and CCC. 3. proper communication with NACO and MSACS ; Revise the budget of DIC .Linkage and coordination with CCC,ART and DIC ;	Increase the outreach staff, Educational & medical treatment facility for children, Shelter facility at DIC.; IGA activities
Chandrapur	Capacity building of staff. , strengthening of linkages and coordination with ART and CCC.; Regular monitoring, guidance and support from MSACS.	**Dissolve and reconstitute to the Executive Committee with the immediate effect.**
Pune	Coordination with Go/NGO,ART,CCC and ICTC; Timely execution of Funds; Improve PLHIV reach, Operational guidelines for DIC	Increase number of DICs, Community level awareness program to reduce the stigma and discrimination. Increase in Human resource and budget. Enhance quality of DIC services,
Mumbai-Kurla	increase PLHIV reach , strengthen linkages, staff capacity building	Regular medical check up, Medical and Nutritional support, Loan facilities, Vocational trainings ,Awareness programs Job placement; Human Resource Increment [esp. ORW]; Need fulfilment at DIC instead of referral service like nutritional & educational support to children; Better coordination among DIC staff; proper linkages with referral system so that their nee d really get fulfilled from their; Improvement in DIC infrastructure with regard to children

District	SACS Officials	Community
Mumbai-Andheri	Training and capacity building of the staff; Salary increment of the staff; Well network and linkages with govt schemes	Arrange for Doctors in DIC,OI medicine, give travel money to PLHIV for support group meeting, IGA activities
Ahmadnagar	Training and capacity building of DIC Coordination with DIC/ART and CCC through regular meeting. Easy accessibility of DIC; Timely release of funds, Increase outreach staff,	Provision of Services considering CLHIV like educational, nutritional etc; Transportation facility to and fro to DIC; knowledge about various GO's schemes, Swyam Rojgar Yojna; IGA- job placement; Organising events nearby or collaboration with ART/ACTC centre for effective services; DIC availability at taluka level or at least their service should reach at taluka level by appointing ORW for each taluka
Beed	Linkages and coordination with Art and ICTC. Availability of NACO guidelines, training of the staff, coordination with the ART.	Provision of Services considering CLHIV like educational, nutritional etc; Transportation facility to n fro to DIC ; Income Generation Activity -Job placement/vocational training & also providing financial help in small scale business [Laghu Udyog like Papad making, Tailoring, Masala making] which female PLHIV could do at home.
Raigad	Coordination with ART centre and other referral system, Training of the staff, linkages through internet services. Coordination with ART centre and other referral system, monitoring and evaluation by MSACS. Training of the staff.	Arrange for Doctors in DIC,OI medicine, IGA activities Educational, nutritional support to children

GOA

Table 1: PLHIV Registration and Reach/DIC

S.N	State	District	Estimates	ANC Prevalence (%)	Registration (last two years)	PLHIV Reached (last two years)	PLHIV reached (%)
01	North Goa	Panjim	NA	0.18	956	2143	?
02	South Goa	Vasco	NA	0.18	773	360	40

Table 2: Issues faced by Women (PLHIV) and Children (CLHIV)

District	Issues -Women	Issues - Children
North	Sigma and discrimination, sexual harassment at work and community, lack of information, financial problems, emotional imbalance, legal problems, medical problems, prejudice and isolation, reproductive health problems.	Orphans, Lack of facilities for orphan HIV/AIDS children, lack of paediatric care, no specialist for treating HIV positive children, minimum services from DIC due to lack of resources, No care home, No orphanage for affected and infected children, children need syrups instead of tablets as ART medicines, schooling and rehabilitation support, nutrition, financial support ,
South	Family discrimination, Harassment at work place, rental house owner harassment, Social discrimination, Unemployment, property rights.	Discrimination at school, Social discrimination, lack of OI medicines, Lack of Educational support, No care home for children, discrimination in the family.

Table 3: Gaps in Governance

Districts	Gaps
North Goa	Funds delay, staff capacity and turnover, lack of Operational guidelines
South Goa	Funds delay, staff capacity and turnover, lack of Operational guidelines, lack of monitoring

Table 4: Recommendations (Compiled from FGD and IDI with Community/KII with SACS officials)

District	SACS Officials	Community
North	Defaulters necessary, good linkage between medical departments, shared confidentiality between ART, ICTC etc, standard checklist on documentation, visits to related departments to know linkages and have the knowledge of functioning, co-ordination between departments, regular meeting and monitoring, guidelines on networking. CCC needed.	Dayanand social security scheme (DSSS) should be provided without many formalities, Ambulance or van in case of emergency, resting place at DIC, Direct Observation Therapy (DOT) monitoring, separate medical facilities for children, Improvement in PPTC facilities like through DIC nutrition supplements for infants as they get infected through breast feeding, Visiting doctor at the DIC, general physician at the ART centre, CCC in North Goa.
South	Sensitising Programmes on behaviour and attitude change to be conducted for staff and higher level stake holders and community, allocation of 60% of funds for the programme, vocational training, income generation schemes and activities, form self help groups, work towards a healthy future, professional counsellors, strengthen networking with related government departments, monitoring of DIC by GSACS. DIC should be in the primacies of the district hospital. Care home, rest room at ART centre for distant patients, ambulance for HIV positive, marriage bureau, children club, sustaining livelihood.	More information on different schemes available for PLHIV, Help to get the DSSS 1,000 scheme without HIV status certificate, Need funds for reimbursement of medical bills, Bus fare should include some concession, Doctor should be appointed in DIC, Monetary help to buy medicine, Educational support for children

Table 5 presents the expressed training needs of staff in 74 DICs. Maharashtra DIC staff in Ahmednagar, Beed and Mumbai did not express any training needs

Table 5: Training Needs DIC wise

STATE	DIC	TRAINING NEEDS
Andhra Pradesh	ANP +- Ananthpur	Advocacy
		Community Mobilisation
		Counselling
		Rights of children
	APP + West Godavari	Government schemes for PLHIV
		Home based care
		Leadership
		Personality Development
		Preventive Care
		Stigma and Discrimination
	CHES + - Krishana	Accounting
		Advocacy
		Counselling
		Life Skill Training
		Positive Speaking
		Reporting and documentation
	CNP + East Godavari	Advocacy
		Legal Rights
	KMPPSS- Warangal	Advocacy
		ART
		Computerized accounts-Tally
		Home based care
		Legal Rights
		MIS
		Reporting and documentation
	NYPS-Nalgonda	Advocacy
		Child Counselling
		Legal Rights
		Management
		MIS
		Outreaching
		Reporting and documentation
	Positive People Network –Prakasam	Accounting
		IEC Development
		Income Generation

STATE	DIC	TRAINING NEEDS
	SHIP + Guntur	MIS
		Reporting and documentation
Chandigarh	CNP + Chandigarh	Counselling
		Outreaching
		Reporting and documentation
Delhi	PWN + Shadipur	Accounting
		Capacity and skill development
		Counselling
		GIPA
		HIV and TB
	Jagriti Network – Uttamnagar	Accounting
		Counselling
		Outreaching
Goa	Positive life India- North	Advocacy
		Communication
		Reporting and documentation
	Zindagi Goa - South	Advocacy & Child Counselling
Gujarat	Abad Network Ahmadabad	CBO Development
		Counselling
		General Orientation about DIC
		Leadership
		SHG
	Adhar Asarva Ahmadabad	Communication
		Leadership
	Adhar Bapunagar Ahmadabad	Advocacy
		Reporting and Documentation
		STD/HIV/AIDS
		Writing Project Proposal
	RDNP + Rajkot	GENDER
		Reporting and documentation
	Sahara Gate Surat	Capacity and skill development
		Communication
		Computer operation
		Counselling
		Reporting and documentation
	Bombay Market Surat	Capacity and skill development
		Computer operation
		Counselling
		Outreaching
	New Civil Hospital Surat	Capacity and skill development

STATE	DIC	TRAINING NEEDS
		Communication
		Computer operation
		Counselling
	AP + Vadodara	Child Counselling
		Communication
		Writing Project Proposal
Karnataka	Adharsha Jeevana AJPP + Mandya	Counselliing
		Documentation and record keeping
		Orientation on project for PC and Counsellor
	Jeevana Sangha network of positive people Udupi	Counselling
		Documentation and record keeping
		Legal Rights
	KNP + Bangalore	Advocacy
		Communication
		Counselling
		Documentation and reporting (incl MIS)
		Outreaching
		Skill training
	Navajothi NNP+ Koppal	Advocacy
		Counselliing
		Documentation and record keeping
		PSB training
		STI (package training)
Kerala	Prathyasa (Calicut)	Accounting
		Counselling
		Management
		Reporting and documentation
	Prathyasa (Ernakulam)	Computer operation
		Counselling
		Reporting and documentation
Madhya Pradesh	MPNP + Dewas	Advocacy
		BCC
		Counselling
		Reporting and documentation
		Resource Mobilisation
		STD/HIV/AIDS
	MPNP + Rewa	Accounting
		Advocacy
		Counselling

STATE	DIC	TRAINING NEEDS
		Reporting and documentation
Maharashtra	Adhar Raigadh	Counselling
		General Orientation about DIC
		Management
		MIS
		Outreaching
		Reporting and documentation
		Social Worker Training
	NMP+ Pune	Program Management
		Counseling
	Network of Hingoli By people living with HIV / AIDS	Accounting
		Reporting and documentation
		STD/HIV/AIDS
	Network of Nanded District By people living with HIV / AIDS	ANM Training
		Counselling
		Leadership
		stress management
	NMP+ Mumbai	Capacity and skill development
		Counselling
		Management
	NYP+, Yavatmal	Capacity and skill development
		Counselling
		Knowledge on Panchayat Raj Institution
		Management
		Reporting and documentation
	SHIVAR Chandrapur	Counselling
		Human Rights
		Reporting and documentation
		STD/HIV/AIDS
	Maha- Beed, Ahmadnagar and Mumba (Andheri) DICs	Not any Expressed needs
Manipur	PLHIV Ukhrul DIC	Reporting and documentation
	PLHIV Imphal East DIC	Training on food and nutrition, ART counseling
	PLHIV Imphal West DIC	Counselling
	PLHIV Thoubal DIC	Training on integrated of adolescent a
Mizoram	Aizawl North PLHIV . PNM Bawngkaw	Accounting
		BCC
		Counselling

STATE	DIC	TRAINING NEEDS
		Documentation
	Hope Care(MPLAS) Chandmari	Accounting
		Counselling
		Documentation
		Management
		TOT
	MPLAS DIC Bawngkawn	Accounting
		Counselling
		Documentation
		Management
		TOT
	New Hope Society PLHIV DIC	Accounting
		BCC
		Documentation
		Skill training
	New World PLHIV DIC. Kolasib	Accounting
		BCC
		Documentation
	PNM Aizawl South	Accounting
		BCC
		Capacity and skill development
		Counselling
Nagaland	IDCCS Wockha	Home based care
	Ke-lomei Teunsang	Counselling
		Life Skill Training
		Preventive Care
	Mt Gerizim Teunsang	Counselling
	NEDHIV Oasis Dimapur	Exposure Visit
	NNP+ Kohima	Accounting
		Counselling
		MIS
	ZNP+ Zuhenboto	Counselling
		Public Speaking
Orissa	KNP+ Khurda	Counselling
		Management
		Reporting and documentation
Punjab	Amritsar DIC	Counselling
		General Orientation about DIC
		Reporting and documentation

STATE	DIC	TRAINING NEEDS
Tamil Nadu	PWN + Chennai	Program management
		Public Speaking
		Information about ART and treatment
		1st and 2nd line ART information
	Cuddalore District HIV positive Society	Counselling Techniques
		Reporting and Documentation
		MIS
	Erode District Positive Network	Documentation Training for ORW
	TNP+ Villupuram	Documentation Training
		Project implementation of activities training
		training in counselling aspects
		Training -Computer Skills
		Accountant training
	Karur network for positive people	Areas for staff training suggested by staff (use one row for each training need)
		Training for documentation, Intensive counselling, Best- Practice sharing and
		Training , Positive prevention, Peer education training.
	Madurai network of positive people society	Basic information of HIV
		nutrition and hygienic information
		soft skill training
	SOUTH INDIA POSITIVE NETWORK (SIP+) Chennai	Documentation training, training on accounts,
		advocacy training and training on Intensive counselling
	Salem district network of positive people (SNP+)	refresher training
		Positive prevention training for ORW
		Reporting and documentation for ORW
	People living with and affected by HIV/AIDS trust Theni	Fresher training
		Treatment Adherence
		Current status of HIV
		Chilren Adherence
		HIV and TB co-infection training

STATE	DIC	TRAINING NEEDS
	NETWORK FOR POSITIVE PEOPLE IN TRICHY (NPT+)	Government schemes for PLHIV
		Documentation
		Psychological counselling
		Positive speaker
		Treatment literacy
		Advocacy
	TNP+ Chennai	Training about usage of ART and its importance
		Training in documentation
		Reporting and documentation
Uttar Pradesh	UPNP + Allahabad	Accounting
		Counselling
		Livelihood
		MIS
West Bengal	BSP+ Burdwan	Counselling
		Organisational Development
		Reporting and documentation
	JSP+ Jalpaiguri	Counselling
		Leadership
		Reporting and documentation
	KNP+ Kolkatta	ART
		Communication
		Counselling
		Reporting and documentation
	MNP+ Malda	Counselling
		Organisational Development
		STD/HIV/AIDS
	Sangaboddha Darjeeling Plains	ART
		Communication
		HIV and TB
		MIS
	Sparsha (Kolkata)	Accounting
		ART
		Communication
		Counselling
		Reporting and documentation
		Social Marketing of Condoms
		STD/HIV/AIDS
	Sparsha (Purba Medinipur)	Accounting

STATE	DIC	TRAINING NEEDS
		ART
		Communication
		HIV and TB
		Reporting and documentation
	UDSP+ Dinajpur	Accounting
		Communication
		Counselling
		Reporting and documentation

CHAPTER 3

RESULTS AND DISCUSSIONS

Chapter 3 of this report presents detailed quantitative and qualitative analysis outcome for each state. Reasons for the gaps are discussed and solutions offered by the community and SACS are narrated. Data generated using tools like FGD, KII and IDI were analyzed and make qualitative section of the report whereas outcome from semi structured tool analysis forms the quantitative section of the report. Contributions made by the DIC are summarized at the end of the report.

3.1 Qualitative Analysis findings

Qualitative Section of the report summarizes findings under each evaluation theme described in the earlier section and offers recommendations emerged during FGDs, IDIs and KIIs with SACS officials for NACO-UNDP to strengthen the DIC program. It also presents the Most Significant Change (MSC) brought about in PLHIV's life after service uptake from DIC.

3.1.1 Services

a) Services and its impact

In terms of Services, the recurring themes that emerged after FGD analysis were the Best and the weak services, duration of service uptake and services needed to improve DIC functioning. While all the services were appreciated, the educational aid for children were rated the best. Out of 77 DICs reviewed the DIC in West Delhi was able to provide Education aid and Nutritional Support to 10% of the registered children through private donors once in last two years. DIC budget does not have provision for any kind of services for children. Psychological support and counselling was appreciated across the DICs by all the PLHIV. PLHIV who were attending DIC ranged from those who are member of the DIC from the inception of DLN as well as DIC to the latest entrants about 3- 5 months. Table 1 shows the types of services and percentages of DICs offering them. Table 2 presents the data about the earliest and latest entrants to DIC, Best and the weak services. Counselling, Get Together, Home Visits and ART referrals are the services offered by all the DICs reviewed. While referral service is offered by 60-90% of the DICs reviewed.

Table 1: Types of Services offered by percent (%) DICs reviewed –FGD Analysis

Services	DIC provider (%)
Peer Counselling, Get Together, Referral to ART Centre, Home Visits	100
Referral to STD,TB,PPTCT,OI escorts, Matrimonial Coordination, ICTC	80-97
Referral to Paediatric ART, TI, Other NGO, Social Welfare Schemes,	60-79

Triangulated with the Service Provider's Perspective –Refer section 3.2.a Table 1

Table 2: DIC entrants, Best and Weak Services –FGD Analysis

	Range of Response	Average/Most response
Visiting DIC since	4 months – 14 years	2- 3 years
Best Service	Psychological Support, Marriage Bureau, Positive Living, Enabling space trough events, Information about HIV AIDS, Referral and Linkages	Psychological Support and acceptance.
Weak Services	Nutrition Support for children, Double orphan care and Income generation support	Income Generation support.

Source Tool – FGD

Peer Counselling was perceived as the best service by both the community and KII SACS officials interviewed in the study. Community perceived it as the process that helps them integrate HIV infection without fear, boosts their moral, helps them explore positivity amidst all adversity. SACS Officials stressed that catharsis of feelings is best achieved by peer counselling.

> "The Counselling by DIC Counsellor is motivational and the one by ART,ICTC ,CCC or PPTCT is informational and thus complement each other."
>
> KII - ART/CCC/PPTCT/ICTC Counsellors

Peer Counseling given at DIC changed the life -*"We had love marriage and having three children, I was admitted in the hospital when my CD4 count was completely low, I wanted to die along with my 3 daughters, fortunately I enrolled in DIC and started attending meetings. Counseling helped me to lead normal and better life. I wanted to inform others about DIC service".*

Nutrition Support for children - *"The nutrition that I got for my child is very valuable for me, as I do not breast feed my child. The cost of milk is very expensive, and I could not meet it from my income and this makes life very difficult, but for the help I got from this DIC. I and my child are still alive, sometimes I even forget that I am HIV positive"* Most of the DICs do not have provision for the nutrition support and community across the states urged to make it available in the coming years. Networking efforts does not address the uneven demand supply ratio.

DIC staff interviews about DIC reach suggest that outreach budget is limited and coverage area is vast which limits the PLHIV reach in the district. KII shared about coordination gap between CCC and DIC staff resulting in travel resources being used by both CCC and DIC to track the same lost to follow up case.

Services not reached - PLHIV also shared about the experiences when DIC Services could not reach and they suffered

- *"My husband expired and no one was touching his body, I had no money for funeral but DIC could not reach in time to support me "*
- *"When my daughter born nobody even my sisters from my family didn't touch my daughter and also not allowed me to go to kitchen. I was working as nurse in hospital and lost employment due to termination of job. DIC could not help me retain my job"*
- *"In 2004 I came to know that I have been infected by HIV and I was pregnant by 7 months. We consulted a private doctor at Perundorai & we were asked to go to the Government Hospital (GH). They refused to treat me at GH stating that facilities for such patients are not available there. Within a week my condition appeared critical but they didn't treat me and I delivered my baby who is also infected, what I feel is if I DIC was there I could have saved my baby from infection by providing me the right information at the right time.". (Source Tool – FGD)*

Service not reached - Double orphan (Source Tool –IDI)

Shubham, a ten year old boy is withdrawn and speaks only when spoken to. It is holiday time and his school is closed for Diwali. While all the other children in the area run around happily meeting friends, and bursting crackers, clad in tatters, walking bare feet, Shubham roams aimlessly all day around the area where he lives, as he has no friends and is not welcome at home. When he gets tired, he curls up and goes to sleep under a tree, or in the nearby temple. The loneliness and despair he feels are reflected in his eyes. He misses his mother who he lost to AIDS related illness in 2007. His father has deserted him and Shubham refuses to speak about him. Shubham was detected HIV positive after his mother died. He goes to a government school, while his sister's children attend a convent school. His sister says that her husband has severe objections to Shubham staying with them and will not hear of giving him the same facilities he gives to his own children. He has been given place to sleep outside the house, and Shubham does not eat at home. He eats his morning meal at school and waits at the local temple till someone gives him his evening meal.

Shubham's life in school is no better. His teachers know of his condition and make him sit separately and have forbidden the other children from playing with him or speaking to him. He is given his meals separately and constantly berated for his condition. "Everybody beats me," he says, "at school and at home."

Ill treatment, lack of adequate nutrition and hopelessness is taking its toll on Shubham's health. He is not yet on ART, but he is severely malnourished, weighs only about 20 kgs and complains that his body aches all the time. He also coughs continuously, indicating he is in need of immediate medical treatment. He says, "I feel unwell all the time. My body aches, my neck hurts, and I am too tired to play or do anything. If I lie down inside the house, I am beaten and chased outside. So I go to the temple and sleep there. Even if I want to play I have no one to play with as my cousins beat me and no other child wants to play with me." In a rare burst of emotion he says, "I hate everybody around me except my sister. No one likes me. I have no one in the world. I don't want to stay at home. Send me away to a hostel where nobody will beat me."

Shubham is in urgent need of medical treatment. There has been no effort on the part of his family to find out whether he needs ART medication, or whether he is suffering from any opportunistic infection. His flushed face and tired walk indicates all is not well. Who will ensure he can access his right to health? What can the state do to ensure that he gets timely help and he does not become just another HIV statistic?

Impact of DIC in PLHIV's life – While progressing with FGD analysis, it was observed that DIC services impacted the life of PLHIV by two strategies. These were enabling environment and information hub. Community expressed that DIC plays a very significant role in their life by dissociating from self stigma and barriers self imposed by PLHIV.

DIC as an Enabling Environment - DIC creates a platform for self expression and elevates self esteem by offering enabling space. Courage and Confidence to live positively was considered to be the gift of DIC by most of the PLHIV. *"I made suicide attempts several times due to fear of HIV/AIDS, my husband died with AIDS. Now I am living with two children with courage and hope after receipt of DIC services".* The support group meetings and Get together were considered as enabler by all the PLHIV in the FGD . Support group meeting was termed as the life line - *"I would have died if not for this DIC, even though we do not have much activities here, Just meeting other people who are so care free give me the will to survive".* Get-togethers and events at DIC created the feelings of family in PLHIV. The events celebrated by DICs were Navaratri, Durga pooja, Onam, Kite Flying, Diwali, Christmas, Id ul Zuha , Holi, Picnics, Birthdays, Women's Day, Children's Day, New Year Welcome, and PLHIV Get together. *" I feel I have a family when I attend the Durga Pooja" , " I can never forget when my children were given gifts during Diwali and Christmas festival at DIC" "We had great fun in the Picnics " "Women's Day celebration made me feel proud to be the woman", "We celebrated Holi by playing with colours at the DIC with all". "Our children were given food packets on Id ul zuha"*

DIC as an Information Hub - When DIC was not there many PLHIVs shared that they had Suicidal thoughts; No hope to live; low awareness about HIV and its treatment; they were longing for kind words; they feared disclosure; there was no psychological support; fear of future; fear of society; fear of disclosing the status to the family masked their existence. *"There was almost no information regarding HIV/AIDS. I didn't have any knowledge about HIV. Doctors asked my grandmother not to touch me and she was very scared. Never got any psychological support from anywhere. I was suffering a lot. I wanted to draw end line in my life before coming to the DIC. My life was dark - filled with the clouds of tears." "Before the existence of DIC, we had the fear of Stigma and discrimination and also feared that HIV did not have any proper medication and treatment. We were also helpless with our children's education getting spoiled. We never knew where to approach, whom to approach, what is it, how to get services etc. In short we didn't have proper awareness and education about HIV and its treatment"*

Source Tool - FGD

Most Significant Change - The study also captured the impact of DIC in PLHIV life through Most Significant Change Technique using IDI tool. IDI not only surfaced the success story but brought to the light the gap about strategies to address the needs of double orphans in the National Program. IDI interviews were analyzed and case stories were prepared.

Total 298 In-depth-interviews were conducted to capture the significant change in the life of PLHIV after intervention**.** Most of the IDIs reported psychological support, peer acceptance and enabling space created by support group meetings brought about transformation of attitude towards self. Self confidence and self esteem were elevated. A major credit for significant change though was given to national response. While strategies like ART, CCC and OI managements were appreciated the gaps in intervention were the major highlights of all the IDIs. IDIs stressed upon the need for Paediatric Counselling, Status disclosure and Substance abuse counselling, Need for the care of double orphans, ART for children, and second line ART.

1) Abo is from a village from Imphal East. He is 43yrs old. While he was studying in college, he happened to intermingle with a few friends with whom he was injecting drugs together. In those days the whole sections of the society were treating the drug users as criminals. They were threatened, chased after, harassed and severely beaten up. They went underground. He even started injecting with ink droppers and used needle. Sharing was compulsive and rampant. Mr. Abo got rehabilitated for his drug taking behaviour with the support from his family and one of the NGOs. His family thought that he could be better rehabilitated with marriage. He got married. After 3 years of marriage a son was born to them. Happiness was all around. But it was not for long. The child started developing all kinds of health conditions and died. With the advice from the NGO both Mr. Abo and his wife were referred to the ICTC in Jawaharlal Nehru hospital, Imphal. Both were found to be HIV positive. Mr. Abo started blaming himself for his past actions. He lost all his dreams in life. The Manipur Network of Positive People (MNP+) enrolled them in their DIC. This gave them a new hope an energy to live all again. DIC Imphal East is run by MNP+. The DIC has been helping the husband and wife with counselling, treatment support and testing possibly through referrals. Both of them are now on ARVT and are doing well. In the year 2006 the DIC referred the couple to the PPTCT in JN hospital. They have a 3 years old daughter. She is free from HIV. Everyone in Mr. Abo' family has started to smile again.

2) Sheeba "My marriage was on 8th November 1996. My husband had several infections by mid of 1998. Hospital authorities in Calicut conducted an HIV test while treating him for TB. He died on October 1998 without completing treatment for TB. My husband's HIV status was known to my neighbourhood through a nurse from the private hospital where my husband was treated. So nobody came to my house during his death. A health inspector from the nearby PHC came to my house and applied bleaching powder on the dead body. But my husband's family was very supportive. After the death of my husband, I was thinking of committing suicide. My family members took me back home (from husband's home).

Somebody from IMA Ashrays counselling centre visited me knowing my status. I also visited the centre along with my brother.

By that time state level net work of positive people was formed. I started attending the meeting conducted by them. In 2001 CPK+ called for applications to the post of accountant. But nobody was willing to join. I joined there as an accountant as I was commerce graduate. In March 2010, I started facing problems from my family. This was regarding my share in the family property. My mother decided to give me a share saying that nobody would be there for my child after my death. My elder brother was against this. He started ridiculing me about my HIV status saying that "if I were having disease like you, I might have committed suicide. There is no point in living like this as a burden to others.". But I did not reply. But my mother consoled me. I could face all these due to the support I am getting from DIC. I am strong enough to face any challenges. Now I am able to find a means for living through CPK+. There is no need for me to commit suicide. I will live by facing all these challenges. DIC is with me.

3) Poornima - Mrs. Poornima was working in a Muslim Education Society as Head Mistress. Once she took long leave to treat her multiple Opportunistic Infections. When she returned to work the school authority denied her the job. She failed to convince the authority of the school. All this was due to her HIV status only. She found her status after visiting our DIC and testing her blood. She got counselled in the DIC to take the help of Legal Support Cell. She is now fighting the school authority in court of law. She is now out of her psychological depression and leading a healthy positive life. She has been enrolled as member of Jeevana Sangharsha in Udupi.

Source Tool -IDI

FGDs and IDIs generated a large number of issues pertaining to women and children which were quantified in terms of percentage (%) of Participants Response (PR) and are mentioned in Table 3. It is very interesting to learn that outcome from quantitative and qualitative data matched in terms of both the types of issues and percentage respondent sharing them. This was in part due to the mixture of Quantitative and Qualitative method use and in part to the level of articulation of issues by PLHIVs in the districts.

Table 3: Issues of women (PLHIV) and Children (CLHIV) –FGD/IDI – Analysis

Issues – Women	**% PR**	**Issues –Children**	**% PR**
Access to Care and Treatment	4	Access to Care and Treatment	6
Community Discrimination	17		
Family issues -Abandonment by family	8	Denial of Property Rights double orphans	4
Family issues-Substance abuse problem of spouse affecting life	10	Discrimination -Family	27
Denial of property rights	44	Discrimination at School	46
Domestic Violence	13	Educational problem – attendance problem	21
Denial of Child bearing and rearing rights	4	Early loss of parents – single or double orphans	15
Divorce and marital disharmony	19	Lack of Services for orphans	4
Livelihood Options	40	Lack of effective Paediatric counselling	100
Positive Living	13	Lack of Knowledge about ART adherence	12
Stigma and discrimination health sector	13	Livelihood option –double orphans	10
Sexual Exploitation after spouse death	6	Lack of Nutrition Support	37
Workplace discrimination	31	Treatment Adherence	12

FGD and IDI data were triangulated with Semistructured Quantitative Questionnaire.. Data is not repeated and only children's data is presented in Chapter 3 figure 16.

DIC in West Delhi and Chennai cater specifically to women and children. The issues raised by the beneficiary revealed that the primary issues of women is services for children- single and double orphans, denial of property rights, lack of financial resources, and lack of social protection. The PLHIV reach is not significantly more or less in comparison to the DICs that cater to all the PLHIV.

In terms of strengthening of DIC functions the beneficiaries revealed the importance of following services - (Source Tool –FGD,IDI)

- Paediatric ART Counselling skills are imparted to the DIC staff so that they can provide Counselling to the children on ART.
- Basic Counselling for legal rights of a PLHIV provided by DIC staff
- Family Counselling to enhance awareness of HIV AIDS in the community
- Educational aid for all the children –infected, affected, orphans
- Availability of Medical Doctor in the DIC.(PNM Aizawl North has visiting doctor to DIC)
- Trainings for Livelihood options
- Allocating more budget for outreach , emergency visits and escorts to the hospital to increase the reach
- Care and Support for HIV orphans – Children without parents and HIV infection suffers the most. It is very useful to have one CCC per state be dedicated to HIV orphans

b) **Role and Impact of outreach by DIC staff**

FGD analysis further revealed the role of outreach by DIC staff in mitigating some of the social evils like stigma discrimination. The DIC staff structure across the country has Project coordinator, Male and Female Counsellor, Outreach /Field worker and a part time accountant. Most of the DICs have PLHIV in the position of Counsellor and Outreach worker. This practice of having PLHIV as DIC staff has both strength and weakness. The social change in the stigma and discrimination is brought about by the GIPA (Greater Involvement of People Living with AIDS) practices.(want to shift this para to page 77) Some of examples of the outreach activity by DIC staff bringing about change in the stigma and discrimination situation at the community, interpersonal and family level are -

"My neighbours stopped washing the passage I walked after DIC staff intervened and made them aware."

"My in-laws deserted me after HIV detection. DIC staff came in and resolved the situation and I was included in the family"

"After detection of HIV, my in-laws made us vacate the house we were staying and pushed us in the Stable with cows and buffalos. I lived in Stable for two years and then once I met DIC outreach worker and narrated the story. He solved the issue by making my in-laws understand the situation"

Group Discussions(GD) with DIC staff revealed the factors that weaken the outreach effectiveness. The same were triangulated by KII with SACS official and narrated further. First is the distance travelled by PLHIV and second the coverage area under each DIC. Distance travelled by PLHIV hampers the DIC service uptake due to the travel cost. Second, the vast geographical coverage makes the outreach staffs reach less numbers of PLHIV and other important stakeholder in the catchment area. PLHIV to Outreach worker ratio is third important determinant that inversely correlates with outreach outcome. Andhra Pradesh state 8 DICs were reviewed. AP reports total of 18065 enrolments but the percentage regularly outreached is as low as 13.5 % as against Nagaland 6 DICs reviewed reports 278 enrolment and 86% outreach.

Lack of operational guidelines makes the outreach reporting inconsistent. Number of PLHIV counselled on field, number reached through advocacy, non registered number of PLHIV reached but not reported, makes the data inconsistent across the DIC pausing challenges to analysis process. Goa and Gujarat reaches with outreach to many but does not register them unless a drop in is met twice. Some DICs register every drop in and others do not which in turn affects the data utility. However, in absence of proper guidelines the service uptake number and the number registered shows poor relation. Availability of guidelines across the DICs will make the data quality useful for quantitative analysis.

Lost to follow up cases tracking is an important budget linked area that suffers due to operational criteria. While CCC has the operational guidelines of outreach within the 30km radius, the CCC staff and DIC staff often outreach the same LFU irrespective of distance. Resources are limited and outreach duplication leads to waste of the same. Making operational guidelines will address many of the outreach issue

In terms of improving the role of outreach by DIC staff, the FGD,IDI,GD and KII analysis arrived at the following ideas to improve the DIC functioning

- Monthly Support Group Meeting – Support Group meeting is perceived as very vital to empowerment and overcoming fear of stigma. However, due to the budget constraint the meetings are not taking place regularly. It may even be helpful to have taluka level support groups formed to take care of travel expenses.
- Improving accessibility of DIC in terms of distance- one of the barrier to the service uptake is distance to DIC
- Giving Health/Travel Card for all PLHIV for travel at concessional rate so that increased participation in the support group meetings and ART adherence could occur.
- Creating Health (Tatkal)Helpline for emergency outreach of PLHIV in crisis – Many PLHIV suggested that in the AIDS stage the escorts needed are more frequents and if an emergency (Tatkal) Helpline number is allotted it can prove useful

c) Advocacy for Reduced Stigma and Discrimination

Stigma is the mental perception of the discriminating behaviour and Discrimination is the behavioural expression of stigma. While Stigma is always an intra psychic phenomenon, Discrimination is always expressed from an external agency towards the individual infected or affected by HIV and AIDS **or** self imposed by PLHIV

FGD analysis and IDI analysis revealed recurring theme about beginning of stigma and discrimination at self and extending to family, workplace, society, and health systems. Not disclosing the HIV status to spouse and family were the examples of self stigma shared by respondents. Recurring forms of stigma and Discrimination across the 17 states were abandoned by family, thrown out of the job, discriminated by neighbour and friends. FGD and IDI analysis further revealed the levels of advocacy efforts made by DIC to face discriminating situation in community, family, with spouse, police, and friends.

FGD analysislead to the identification of DIC support to PLHIV in the stigma and discrimination situation at various levels viz. Community, Social, Family and Systems-health and police.

Community Advocacy - *" Whenever I walked through the lobby of the houses to reach main road , the neighbours would immediately wash the gangway with disinfectants*." I shared this with DIC staff and outreach team intervened and discriminating behaviour ended.

Advocacy in Social Discrimination" - "My friends stopped talking to me and made me alone no one would talk to me and even if I would approach them they will turn their back, not receive my phone calls and give excuses that network is a problem **".** This continued for months until landed in DIC

Discrimination by Spouse **-***"My wife filed a case against me under 498 sections though there was no incidence of violence or harassment by me" Peer* counsellor met my spouse and counselled her and we are united again. *"My husband divorced me when I was detected HIV reactive at ANC. He has married someone else. I live with my baby and work through SHG group***"** DIC came to my rescue helped me become SHG member. I am selling fish and making my living through SHG loan.

Advocacy with System **-** *" Even police gets influenced by neighbour and beat us up. They forced me to close my grocery shop. Police treats us as untouchables. Police even asks us for bribe, if we need to undertake any activity in our house as simple as building a toilet, we are asked for a bribe. They just want to trouble us after they have come to know of our status"* . DIC staff came with me and stood by my side and sensitized police station about HV AIDS. *"I am Police and could not carry out my usual duty due to HIV infection, my service naturally suffer. I was even in the point of suspension and could not get my salary for*

months". DIC staff came with me and approached my superiors and sensitized them about HIV AIDS. My duty was changed and I was given lighter posts so that health does not deteriorate.

Advocacy for property rights – *"My husband died of HIV AIDS and in-laws abandoned me. My brother did not want to give me share from my father's property and DIC linked me to legal aid and I got my share in the property after a court trial for two years."*

Advocacy with Family -*"My husband died because of HIV and AIDS. Everyone in the family (in laws) and community blamed me for the cause. The community told that it was she who spreads the virus to her husband and children. But the fact was that my husband was an intravenous drug user who used to shared needles and syringes while injecting"* DIC staff came to my help. They sensitized my in- laws and other relatives about HIV AIDS and changed the discrimination scene in my life.

Advocacy for personal problem - *"I was cheated by the car agent while selling my car". The agent said to me that no one would wish to buy this car as I am HIV infected and so the agent wanted for a much cheaper price. I sought the help of the DIC and he got the best market price then available."*

Advocacy in the health Sector - "*I was neglected while admitted in the hospital. Meals and Medicines were given to other patients on time but to me both were missed too frequently. I contacted DIC staff, they came and talked to the hospital authority and situation was changed."*

Beneficiary perspective is triangulated with provider's perspective.(Refer Figure 9 &10)

Source Tool –FGD/IDI

Table 4 Presents summary of range of responses in Stigma and Discrimination in various areas of PLHIV's life with its intensity as analysed by FGD. The last column represents the community priority of an issue to be addressed.

Table 4: Summary of responses - Stigma and Discrimination – FGD Analysis

Sector	Range	Strong	Mild	To address
Health	Non verbal and verbal abuse, negligence,	Negligence	Verbal abuse	Negligence
Family	Verbal abuse and disowning, denial of property,	Denial of property	Disowning	Property rights
Community	non inclusion, lack of status disclosure, emotional violence, police harassment	Lack of status disclosure for the fear of discrimination	-	Community perception
Workplace	Exclusion, denial of promotion, thrown out of the job, emotional violence	Loss of job, emotional violence	Denial of promotion	Workplace problem
Policy makers	Second line ART non availability and lack of planning for Livelihood options and paediatric needs.	Lack of planning for children's need	Lack of planning for livelihood options	Children's need to be met, livelihood options to be generated.

In terms of reducing stigma and discrimination, beneficiaries suggested following measure to improve the DIC function.

- Creating awareness in the community about Rights of PLHIV
- Sensitization of health professional about HIV AIDS.
- Advocacy for Second line ART medicine
- Advocacy for HIV Orphan Care
- Advocacy for PLHIV inclusion in BPL category across the country
- Sensitization of non health sector about HIV AIDS –Corporate, Civil Services etc.

Source Tool – FGD/IDI

3.1.2

Governance and Systems

To understand the local governance at DIC level, questions pertaining to the Finance system, Governing Board functions, and Procurement Systems were included in the semi structured questionnaire in this study. The answers were generated by discussion with DIC staffs in group and individually with Project Coordinator

Systems - It was observed that Goa and Uttar Pradesh reported computerized accounting system which was updated regularly. Nagaland and West Bengal do have manual accounting system but is not updated. Chandrapur district of Maharashtra state board members do not meet, cash books were made a day prior to the review and photocopies were available for showcase. 79% of the DICs reviewed paid the staff salary by cheque except Nagaland where 66% of the DICs reviewed payments were made in cash. Cash expenditure limit for Nagaland was sometimes Rs.4000 but all other DICs reviewed set Rs.2573 as cash expenditure amount. Audit reports and financial statements were available with 88% of the DICs reviewed. Barring Punjab all the DICs reviewed reported quarterly meetings of Executive Committee. However minutes of the meetings were lacking in quality though quorum was met. In DIC Sparsha at Kolkatta, Executive committee meeting minutes were not available. Cash book, purchase register, procurement policy, stock register etc were not available for verification although the DIC is managed by NGO.

KIIs SACS officials suggested that money associated with HIV AIDS work causes a lot of interest of conflicts among PLHIV groups and this perpetuates internal stigma and discrimination at management level in the DLN as well as DIC. DIC staffs who are not HIV reactive endorsed the same.

> *Internal conflict within DLN leading to stigma and discrimination within PLHIV groups need attention -*
>
> *KII -GIPA co-coordinator*

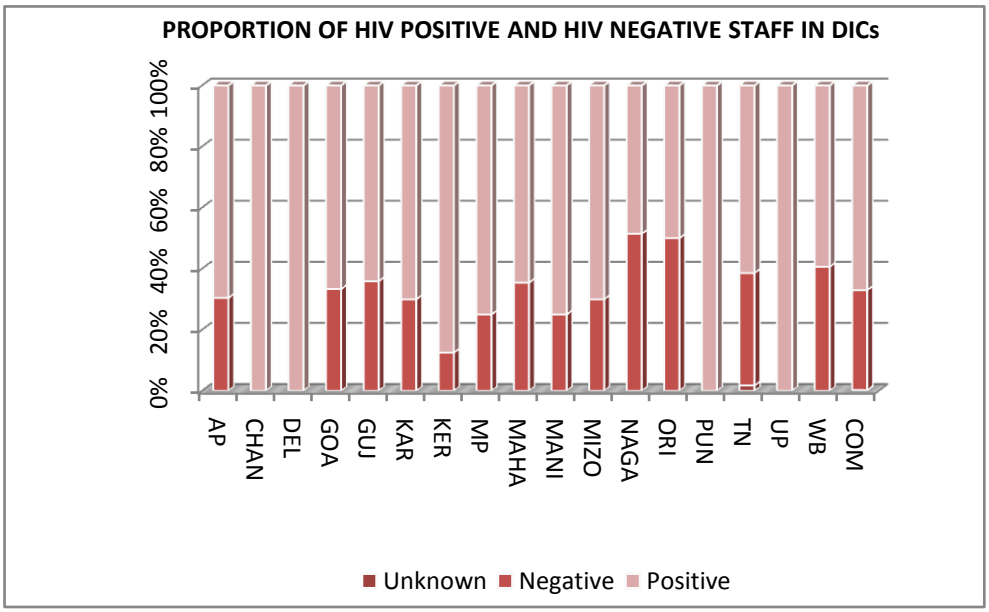
In Maharashtra Chandrapur District DLN secretary runs the DIC program and he works for Police Department. DIC staff turnover is high, PLHIV beneficiary are fatigued and frustrated without any services. During FGD they expressed their disgust over the situation and requested the review team to take some emergency action to change the situation. DIC has received an ambulance for outreach from a local donor but it used by the DLN secretary for personal use. Maharashtra SACS review report also captured some of the financial issues. The grant was continued with advice to improve the system.

Procurement - All the DICs maintained purchase, stock and asset registers but these were not updated in WB, Delhi and Chandrapur Maharashtra. 42 % of the DICs maintained procurement policy which needs updating while 55 % of the DICs do not have procurement policy. It may be useful to have procurement policy guidelines developed for strengthening DIC function.

Infrastructure – All the 52 DICs reviewed so far have Basic amenities like Almirah, Chair, Table, Fan, Adequate privacy and ventilation except four DICs. Amritsar and Vadodara DIC does not have Almirah, Mumbai DIC lacks in adequate ventilation, Surat DIC lacks in chairs. 50% of the DICs reviewed so far have computer, printer and net connection while 35% use cyber café for reporting. 12 % did not have information about reporting system. 81% of the DICs subscribe to the local news paper while only 33% (WB, AP, GUJ, MAHA, and DEL) have TV in DIC.

Staffing

Figure 1: States Comparison - Staff HIV status



67% of the DIC staff is PLHIV (People Living with HIV AIDS). Job profile of the reactive staff is Accountant – 4%, Program Manager and Accountant - 15%, Counsellor – 32%, and Outreach worker – 32%. Qualification of PC and Accountant was Graduate and above while that of Field staff was 8th standard to 12th Standard. Figure 1 shows the state wise comparison of PLHIV and non PLHIV staff.

> DIC staff positions for PLHIV should be based on Education and work experience of PLHIV in addition to GIPA criteria. To avoid conflict of interest DLN office bearers to be not DIC staff.
>
> KII - SACS officials

The 33% non PLHIV staff shared the stark reality about GIPA practices. Many a times working with PLHIV, if a non reactive staff does not share his belongings like mobile, Pen or food item in the same plate, Water bottle etc it is perceived as discriminating instead of health and hygiene reason. It was shared by non-reactive staff that occasionally PLHIV staff remains on duty despite sputum positivity. The PLHIV empowerment occasionally fails in giving non PLHIV staff the space due to them. Reverse discrimination though not substantial was reported to be one of the reasons for staff attrition. DIC management neglects the issue given its weak intensity.

3.1.3

Support by SACS

DIC review study conducted 148 Key Informant Interview (KII) in 77 DICs of 17 States. The KIIs were interviewed to discuss the strength and weakness in DIC functioning. They were requested to make recommendation to improve the functioning of DIC. SWOT analysis was performed on the data collected through KII tool. Most of the KIIs interviewed were Counsellors either in CCC, ART,PPTCT or ICTC centre under the study shared - Peer Counselling as the most effective in handling self stigma and enabling space created by DIC Counsellor for PLHIV – as the greatest strength of DIC. Most of the KIIs (ICTC and ART counsellors) find DIC very complementary to their functioning. There seemed a two way referral system active and Peer counselling was considered very useful by ICTC and ART counsellors both in HIV post testing and ART adherence. However the KIIs accepted that the capacity building of the DIC staff is mandatory to improve the quality of the information given by Peer Counsellor as most of the ART counsellors are not able to provide one to one counselling to PLHIV on ART

All the KIIs interviewed across the country informed the review team about lack of involvement of SACS officials in the programs at DIC; no operational guideline available to run the DIC program; limited budget and underdeveloped MIS as the major weakness of the DIC program. Monitoring and Evaluation budget is reflected in the approved budget but the grant received by DIC has M&E budget deducted from it. Barring DIC in Nalagonda district of Andhra Pradesh, no monitoring visits and technical support is provided to any DIC by SACS on regular basis. In some of the states trainings are conducted for staff by respective SACS but no further mentoring is provided. SACS officials when interviewed accepted that technical inputs given to the DICs are minimal across the states. Operational guidelines are not available with all the states. State AIDS cells officials have not been able to integrate

DIC component in the total HIV AIDS response by the state. They all agreed that DIC review study by NACO UNDP has brought the focus to the important role SACS needs to play in revitalizing the DIC strategy in HIV AIDS prevention.

KIIs interviewed (ART Centre MO, Nodal Officer or DAPCU) shared that - “CCC is well integrated in the health system but DICs are not considered as part of the Government response at grass root level”. This has impacted the grass root functioning of both. CCC and DIC staff both spent time and resources in tracking LFU resulting into poor output and efficiency for both. CCC and DIC staffs wait for coordination strategy and operational guidelines to mention it. Joint Directors and Associate Project Directors of Gujarat and Manipur SACS suggested that monthly outreach planning for CCC and DIC should be done jointly and DICs must be monitored by DAPCU till operational guidelines are developed

All the SACS officials’ interview as Key Informant in the DIC review study explained in detail the Strength (S), Weakness (W), Opportunity (O) and Threats (T) to effective DIC functioning and offered recommendations which are summarized in Table 5. Recommendations by counsellors were technical and those from senior officials were of planning and policy level in nature.

Parameters like Governance and Support from SACS were triangulated. Statistics shared by DIC were verified by the respective SACS and the findings about the support provided by SACS was endorsed by both the DIC staff and SACS officials.

Source Tool - KII,GD and Semi structured Quantitative Questionnaire

Table 5: SWOT Analysis - DIC functioning as per SACS Officials- KII outcome

Strength	Weakness	Opportunity	Threats/Challenges
Platform for leadership development	Lack of PLHIV leadership and direction	Linkages with Link Workers, ANM, Anganwadi,	Fear of status disclosure in PLHIV
Resource Mobilizer	Lack of outreach staff	Social Welfare department schemes	Conflict within PLHIV groups (MAHA,MANI)
Psychological Support	PLHIV to ORW ratio not decided	Linkages with PDS system	Lack of operational guidelines
Enabling Space by Peer Counselling	Geographical coverage too vast	GIPA positions at SACS	Inadequate Budget allocation
Temporary shelter	Lack of coordination with CCC for tracking LFU	Corporate Social Responsibility (CSR) projects	Lack of Strategic planning at SACS for DIC
Information Hub	Lack of qualified staff		Lack of regular trainings and technical input from SACS
	Staff turnover		

Recommendations made by KIIs –SACS officials - under study

- **Operational Guidelines**
- **Monitoring and technical support**
- **Staff Capacity Building**
- **Strategic Planning**
- **Increased outreach strength**
- **Allocation of more budget**
- **Conflict resolution within PLHIV groups**

3.2 Quantitative Analysis

Following section of the report presents the findings from Quantitative Analysis using SPSS. Semi-structured Quantitative Questionnaire tool was used to collect data which was then transferred to master template excel sheet prepared for analysis using software SPSS- 10

a) Overall summary of services being provide by the DIC (Period April 08 - March 10)

Table 6: States Comparison - Services Provided by DIC

STATES	AP	DEL	KER	MP	MAHA	MANI	MIZO	NAGA	ORI	TN	UP	WB
NUMBER OF DICs	8	2	2	2	10	4	6	6	1	11	1	8
Counselling Per And Family	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Get Together	100 %	100 %	100 %	100 %	90%	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Home Visits	100 %	50%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Outreach	100 %	100 %	100 %	100 %	90%	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Referral Linkage ART	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	91%	100 %	100 %
Advocacy	100 %	100 %	100 %	50%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Referral Linkage ICTC	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	91%	100 %	75%
Escort To Hospital	100 %	100 %	100 %	100 %	80%	100 %	100 %	83%	100 %	100 %	0%	100 %
Community Awareness And Education	100 %	100 %	100 %	50%	100 %	25%	67%	83%	100 %	100 %	0%	100 %
Referral Linkage PPTCT	100 %	100 %	100 %	100 %	90%	75%	100 %	100 %	100 %	64%	100 %	75%
Referral Linkage TB	100 %	100 %	100 %	100 %	80%	100 %	100 %	100 %	100 %	55%	100 %	88%
Support Group	63%	100 %	100 %	100 %	90%	50%	100 %	100 %	100 %	100 %	100 %	100 %

STATES	AP	DEL	KER	MP	MAHA	MANI	MIZO	NAGA	ORI	TN	UP	WB
NUMBER OF DICs	8	2	2	2	10	4	6	6	1	11	1	8
Meeting												
Referral Linkage health	100 %	100 %	100 %	100 %	90%	75%	100 %	100 %	100 %	100 %	0%	38%
Referral Linkage STD	100 %	100 %	100 %	100 %	70%	75%	100 %	100 %	100 %	55%	100 %	75%
Referral Linkage Nutrition	100 %	50%	100 %	100 %	80%	25%	100 %	100 %	0%	100 %	0%	25%
Matrimonial Coordination	75%	100 %	50%	0%	60%	0%	67%	83%	100 %	100 %	100 %	100 %
Referral Linkage Ped ART	88%	100 %	100 %	100 %	80%	100 %	100 %	0%	0%	64%	0%	50%
Referral Linkage livelihood	88%	50%	100 %	50%	70%	0%	100 %	100 %	0%	91%	0%	13%
Referral Linkage Transport	88%	100 %	50%	50%	70%	25%	100 %	100 %	0%	91%	0%	13%
Referral Linkage TI	38%	100 %	100 %	0%	70%	75%	100 %	83%	0%	45%	0%	13%
Skill Development Training	88%	0%	100 %	50%	30%	0%	0%	67%	100 %	82%	100 %	75%
Referral Linkage PDS	50%	100 %	100 %	0%	60%	0%	17%	83%	0%	45%	0%	0%
IGA Support	0	50%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nutritional Support	0	50%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Referral Linkage CCC	0	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	13%

Counselling, Get Together, Outreach and ART referrals are the services provided by 100% DICs reviewed. Linkages with Public Distribution Systems are strongest (100%) in Gujarat, Delhi and Punjab.

DICs in Gujarat, Punjab, Nagaland, Goa, Chandigarh and Karnataka reached with all the services except IGA, Nutrition and CCC linkages and hence not captured in Table 9. Surprisingly referrals from DICs to CCC were reported only by West Bengal and only 13 %

of the DICs in West Bengal refer cases to CCC. No other states DICs reported cases to CCC. Income Generation support and Nutrition support is provided by DIC in Delhi. Coordination between CCC and DIC will enhance the quality care at grass root level. DICs reviewed in the states Chandigarh and Punjab provide maximum services followed by Goa, Karnataka and Nagaland who rank second in the number of services provided. Triangulated with beneficiary perspective – 3.1.1 **Table 1. Annexure 5 (Summary of Services by 17 states).**

b) Enrolment of PLHIVs VS reach (Period April 08- March 10)

Figure 2: States Comparison - PLHIV registered

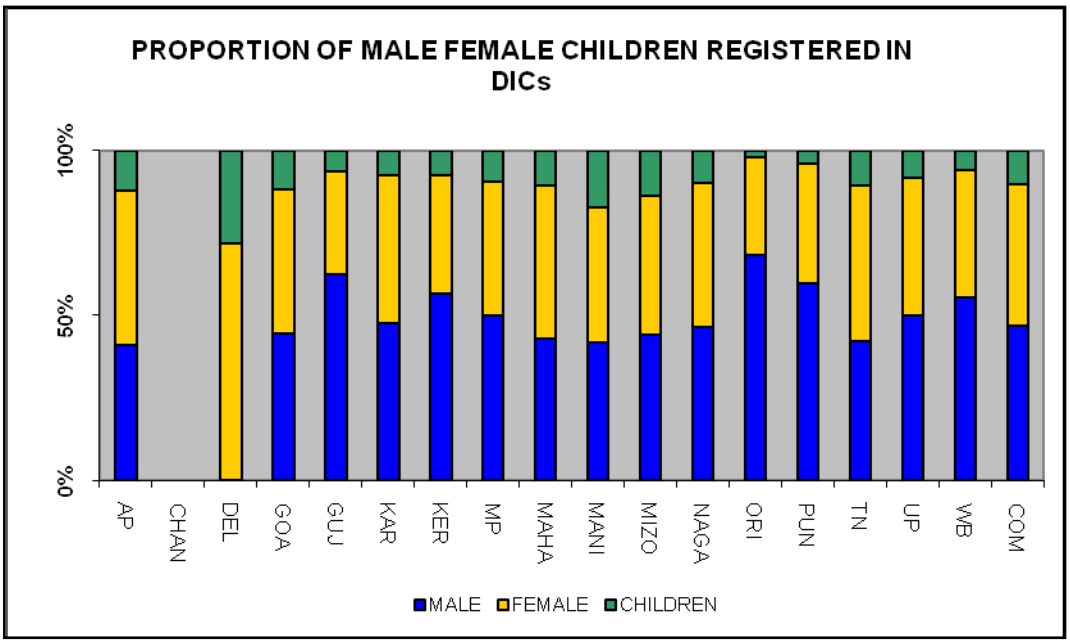
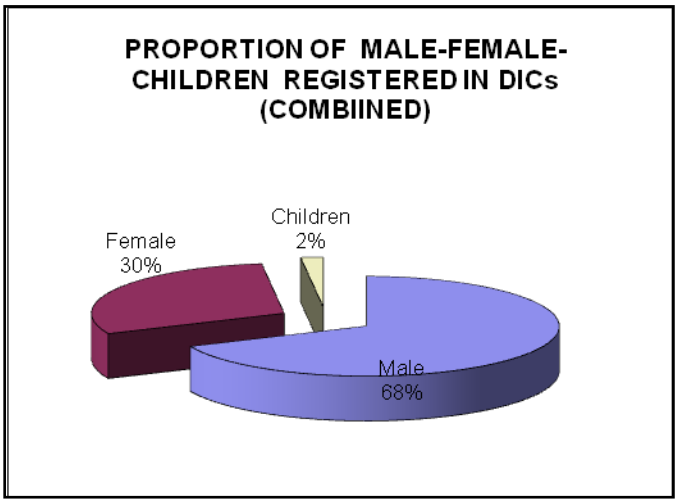


Figure 2 shows the percentage distribution of Registered PLHIV by gender.

DICs in Delhi although caters to male PLHIV do not register them as their mandate is for women and children. Andhra Pradesh and Goa shows almost equal percentages of male and female PLHIV but in almost all other DICs the registered population is dominated by male. The findings in this figure are corroborated by IDIs interviewed in the study. All the women (N=163) IDIs endorsed the gender differences in the DIC Service uptake. The reason given was lack of priority for women's health in the family and society at large. Some DICs have guidelines to register a PLHIV after three visits and many register after one visit. The variation in registration criteria also leads to gender imbalance as women are not able to make more visits due to family responsibilities**. Annexure 6 (State wise enrolment)**

Figure 3: Percentage Distirbution of PLHIV – Male, Female, Children



DIC registration across the country has 68% male, 30% female and 2% children. Major reasons for low registration of women and children in DIC are domestic responsibility, travel cost to reach DIC, fear of status disclosure, lack of services for children.

Figure 4: States Comparison – Distance travelled vs. PLHIV Outreached

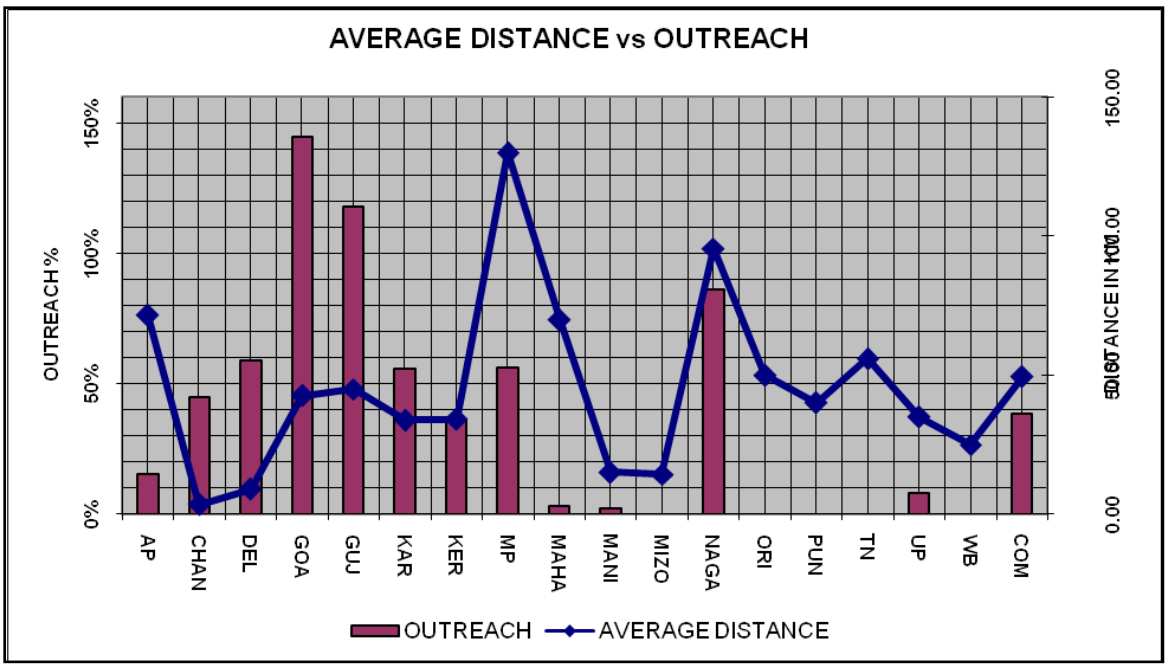


Figure 4 suggests that the parameter percentage regularly outreached and average distance travelled by PLHIV to reach DIC inversely correlates. As the distance increases the outreach efficiency decreases. However, the strength of correlation is weak (-0.05). This is due to the inconsistent documentation and record keeping practices at DIC as evident from Table8. However the in-depth interview with PLHIV and discussions held with staff revealed the cost

of travel to be the major constraint in DIC service uptake by PLHIV as well as outreach by Staff.

An attempt was made to look at the district Data for the relation between distance travelled and number outreached. In Chennai (Table 7) when distance travelled by PLHIV was 25 km the number reached by outreach was 250 per month as against 120 km in Cuddalore reaching only 120 PLHIV through outreach. However when we tried to average the data for the state we could not see the significant difference due to the differing practices of reporting and record keeping.

Table 7: Districts Comparison – Distance travelled vs. PLHIV reached

State	District Name	No registered in DIC	Total no of PLHIV in the District	HIV Prevalence rate	No regularly outreached/ contacted by DIC	Average distance travelled by the PLHIV	No of Villages/blocks/wards covered through outreach
Tamil Nadu	Chennai-PWN	852	NA	7%	250/month	25	4 zones/35 Areas
Tamil Nadu	Cuddalore	2136	NA	2%	120/month	120	7 Taluks

In the state of Tamil Nadu it was observed that DIC operated by Positive Women's Network reached more numbers of PLHIV on regular basis (250 per month) as compared to other DICs when the distance travelled for outreach was about 25-30 km. DIC in West Delhi caters to women and children and outreaches 300 PLHIV every month however the distance travelled to outreach was only 8-10 km. It may be useful if DIC operational guidelines defines the Geographical area to maximise reach.

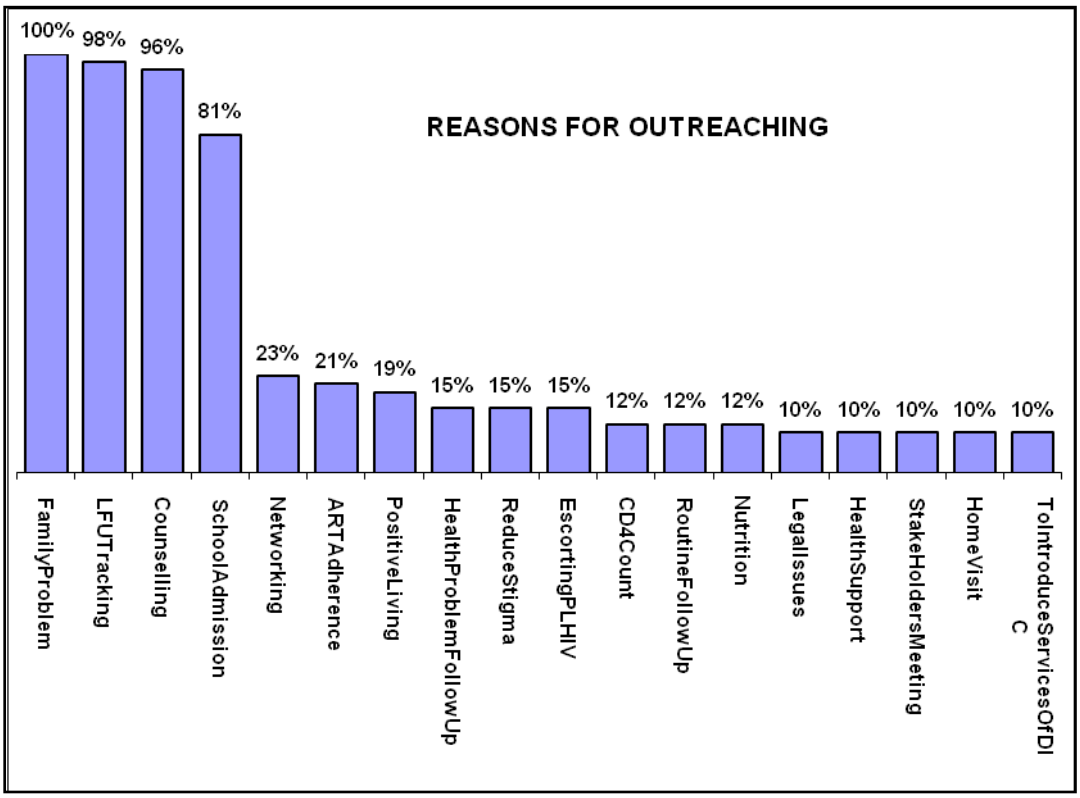
Table 8: States Comparison - PLHIV Registered vs. Reached

State	No of DICs	Total PLHIV registered	Total PLHIV reached regularly
AP	8	18066	2447
Delhi	2	950	558
Goa	2	1731	2503
Gujarat	8	8977	4155
Kerala	2	645	234
Madhya Pradesh	2	497	260
Maharashtra	10	10718	177
Manipur	4	2219	Data NA
Mizoram	6	1408	Data NA
Nagaland	6	1668	1439
Orissa	1	276	Data NA
Punjab &Chandigarh	2	762	240
UP	1	778	63
WB	8	2743	Data NA
TN	11	17571	2813
Karnataka	4	5283	3493

In AP and Gujarat 4 DICs, and Maharashtra 5 DICs did not have data for the parameter PLHIV reached , Goa, Tamil Nadu, West Bengal, lacked clarity about the definition of total PLHIV reached and used service count and head count interchangeably. Manipur, Mizoram, Orissa and some DICs in WB did not know the difference between PLHIV reached regularly and could not extract the data from the records. MP, UP, Punjab and Chandigarh DICs shared the results only for the first quarter (Jan-Mar 10) of the current year. DICs in Delhi and Kerala demonstrated fair understanding of PLHIV reached regularly. No mechanisms for service tracking or PLHIV tracking were in place at any of the DICs reviewed. The qualitative questions about reporting registers in DICs generated a very positive picture about documentation. However, when registers were physically verified the information was absent, incomplete, ambiguous or inconsistent in terms of number of individuals reached. Absolute inconsistency in record keeping, lack of standard reporting guidelines and reporting formats across the DICs cloud the projection of quantitative performance in this evaluation but has created a huge scope to showcase qualitative aspects of DIC functions**. Annexure 7** shows the mean values for PLHIV registered and reached in each state

c) Linkages with other Service Provider

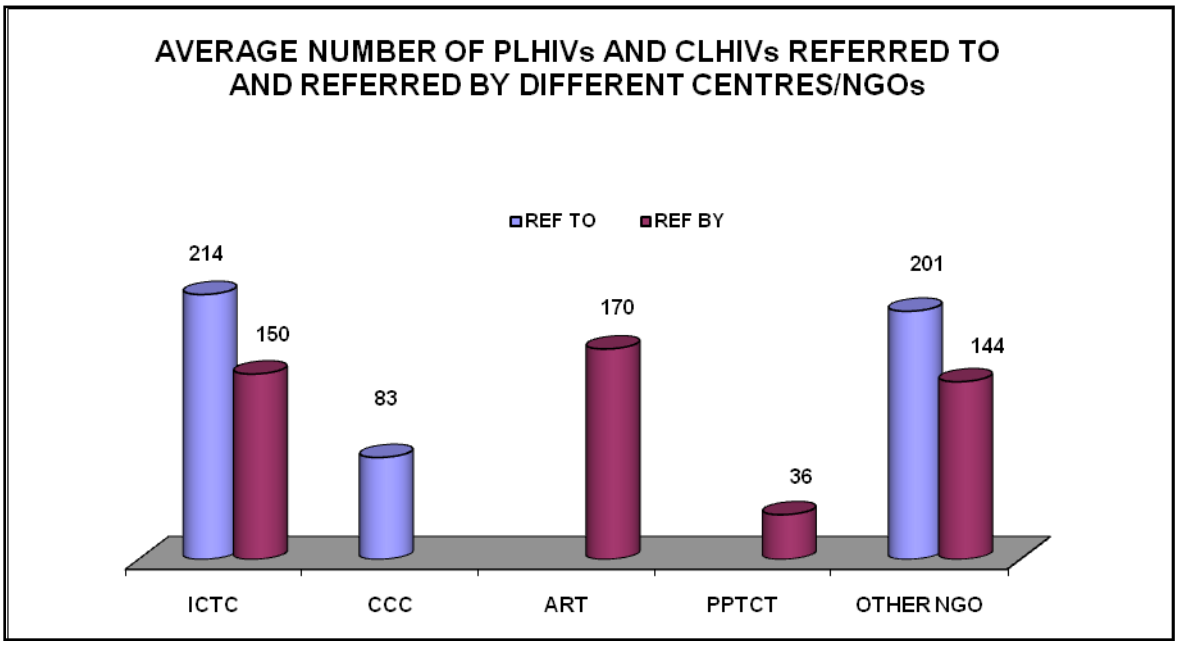
Figure 5: Reasons for Outreach



The 23% of the DICs shared about the efforts made by them to develop linkages with other Service Providers who are not Government agency. These Service providers are largely other NGOs who help PLHIV with Nutrition, Education material like books, raincoats, school uniform. 80-100 % of the DICs staff spend majority of their time in supporting PLHIV with counselling for various issues in their life, family and legal problem, School admission issues of CLHIV and LFU tracking. Reduce stigma and discrimination is major focus of the DIC work. Referrals for Livelihood Schemes are reported by majority of the states except Uttar Pradesh, and Orissa. However the follow up is very poor and output is not measurable in terms of sustainability of PLHIV. The reason for weak networking efforts are both budget and time constraint.

d) Referral services - Referrals from the DIC and referrals to DIC from other service providers - comparison

Figure 6: Referral Services



The study had built in the tools, the mechanism to unveil the aspects of referral system. The same sets of questions were asked to the KII and DIC staff about their views on the referral system at DIC. Semi structured Questionnaire captures the gaps in the referral system very well. As evident from Figure 6 DICs have two way referral systems with ICTC, and other NGOs. The numeric refers to the number of PLHIV referred to or referred by any centre during the evaluation period. The weakest of all the linkage is CCC and strongest with the other NGOs. DICs are not the first point of contact for ART and PPTCT and there is weak evidence for referral to ART centre by DIC. KIIs not only confirmed these findings but reasoned it and made suggestions to improve the same.

Table 9: States Comparison - Referral Services

STATE	Referred BY ICTC	Ref by PPTCT	Ref BY ART	Ref by Other NGO	Ref to CCC	Ref to ICTC	Ref to other NGO
	Total	Total	Total	Total	Total	Total	Total
AP	377	139	607	624	186	360	646
CHAN	172	7	14	33	37	17	27
DEL	NA.	NA.	100	16	193	75	60
GOA	113	20	82	85	220	314	143
GUJ	131	11	144	114	40	136	229
KAR	686	25	472	161	82	250	214
KER	40	10	72	42	19	5	128
MP	121	NA.	3	.NA	17	9	7
MAHA	77	13	132	55	72	207	131
MANI	8	1	13	14	14	108	128
MIZO	9	4	0	12	13	28	0
NAGA	51	15	21	21	49	756	51
ORI	182	10	15	12	140	97	37
PUN	8	NA.	230	NA.	.NA	8	14
TN	39	39	116	134	98	230	220
UP	42	1	128	NA.	16	145	.NA
WB	148	20	52	16	98	74	120
COMB	150	36	**170**	144	**83**	**214**	201

Table 9 summarizes the number of PLHIV referred in the evaluation period. An attempt was made to look for trend if any over last two years in terms of improvement or deterioration in referral system but due to the inconsistent data comparison was not possible. Probing discussions with staff revealed that some recorded the services and not the number of PLHIV although the reporting is under number of PLHIV section. Some states lacked the information which hampered detailed analysis.

e) Pre and On ART numbers at DIC as against LFU

Figure 7 present the state wise data about percentage on ART. X-axis present the state bars and Y axis shows percentage. Each bar is colour coded to fit the percentage information about Male (blue), Female (Yellow) and Children (Green).

Figure 7: States Comparisons - PLHIV on ART

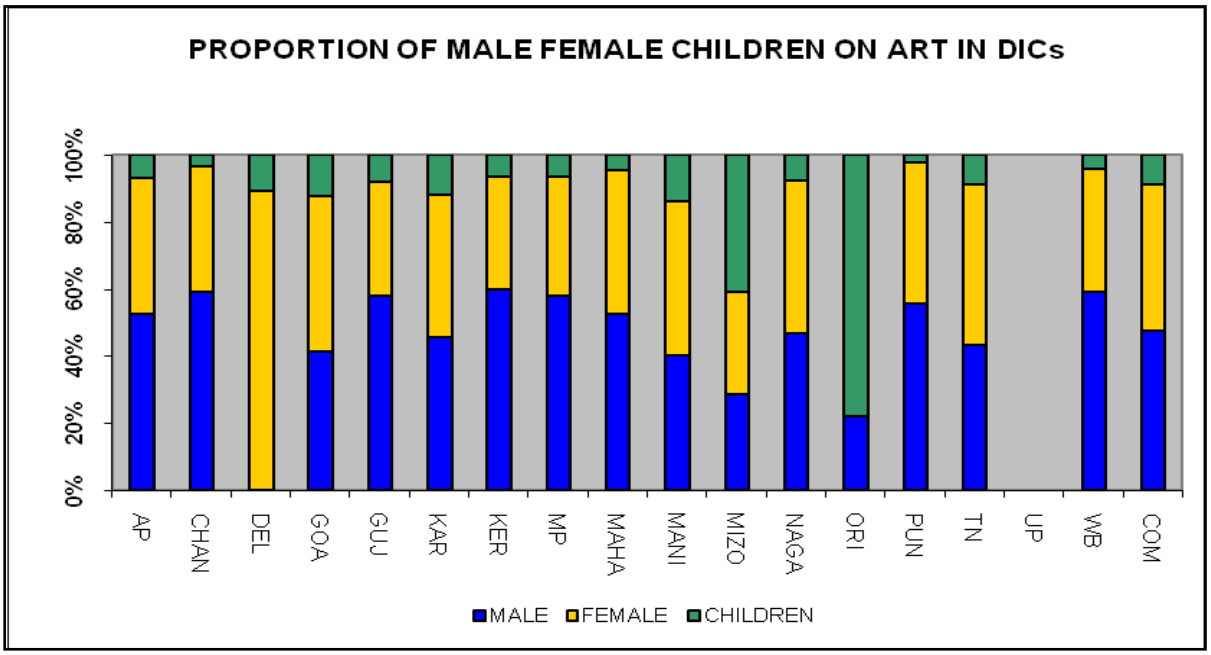


Figure 7 reflects the gender differences with respect to On ART uptake. The reason for gender differences in ART uptake could also be negligence towards women's health in the family. Many women IDIs shared that they would rather have the ART medicines for their children. Demand for Paediatric ART is very high and women IDI pleaded the investigator team to make recommendations to NACO for making it available at the earliest. (**Annexure 8 State Comparison- ART enrolment)**

Figure 8. Number of PLHIV on ART and Alive. (Source –NACO –Oct 2010)

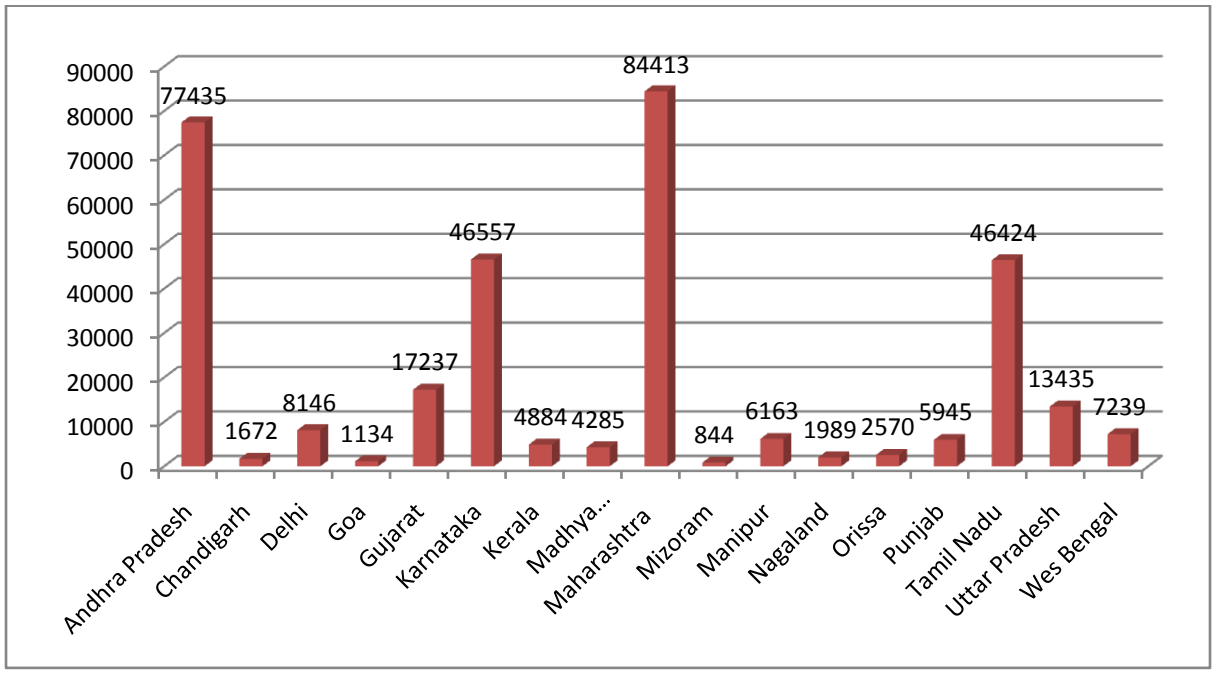


Figure 9. Number of PLHIV on ART and Lost to Follow up – Source –NACO –Oct.2010

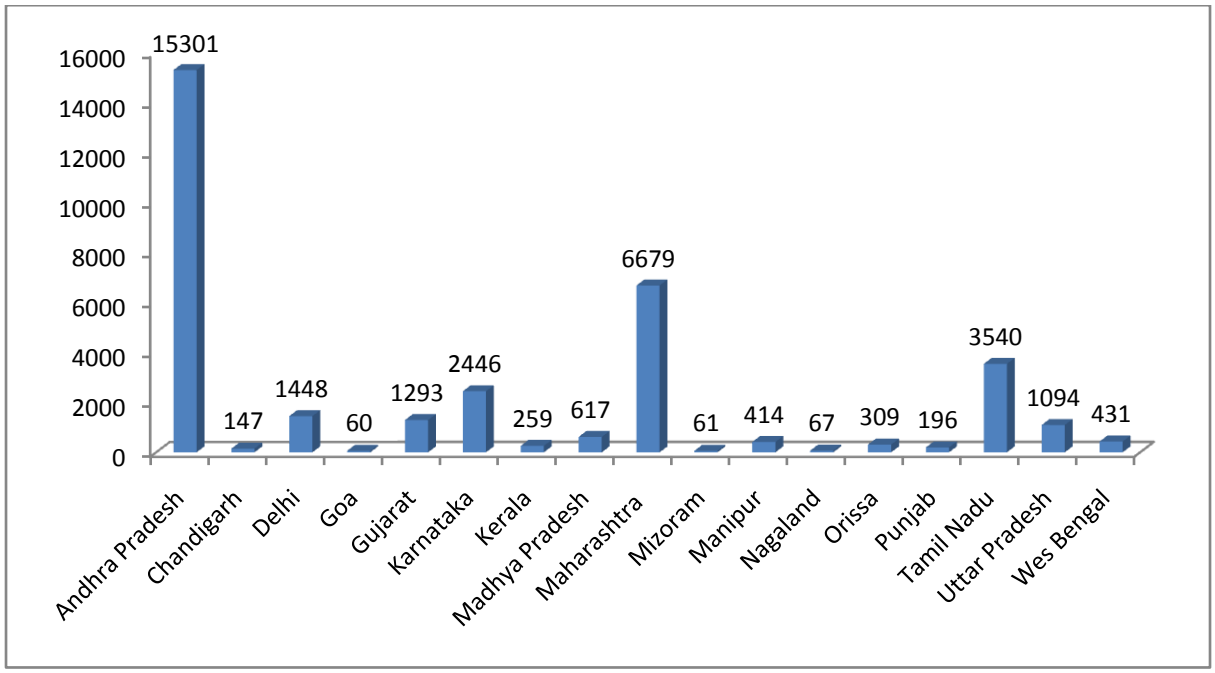


Figure 10: State Comparison- Number of PLHIV on ART tracked by DIC from the LFU list given by ART centre

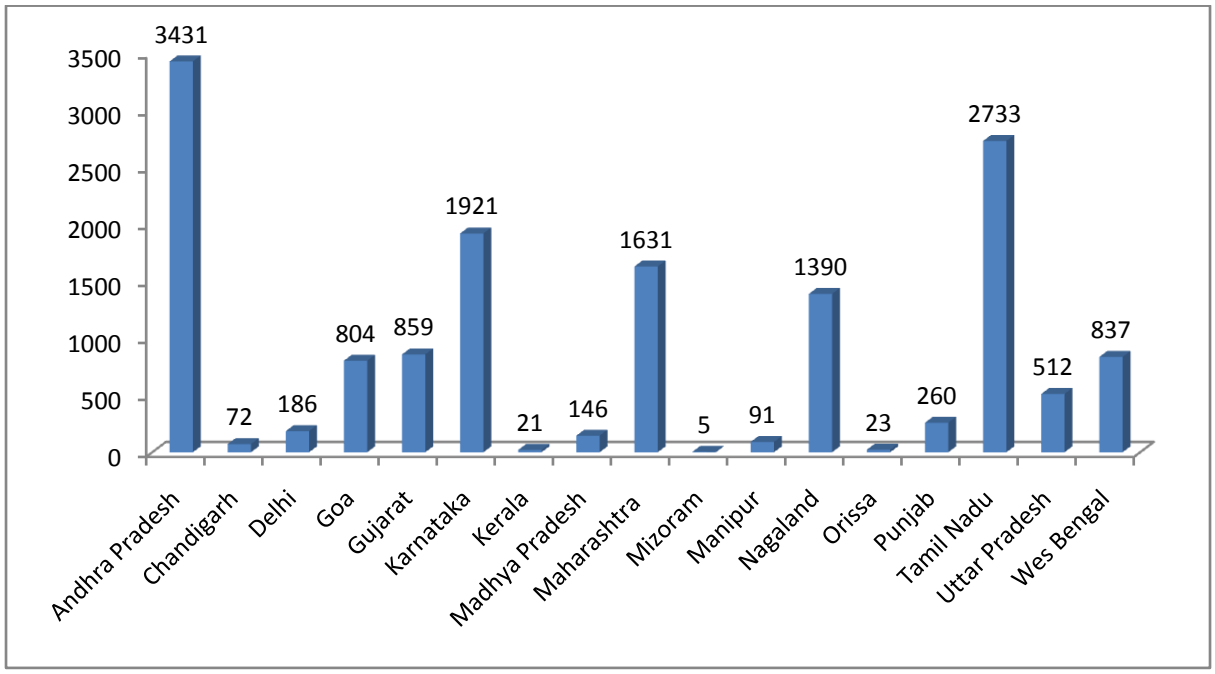


Figure 11: States Comparison - Lost to Follow Up on – ART not traced due to wrong address.

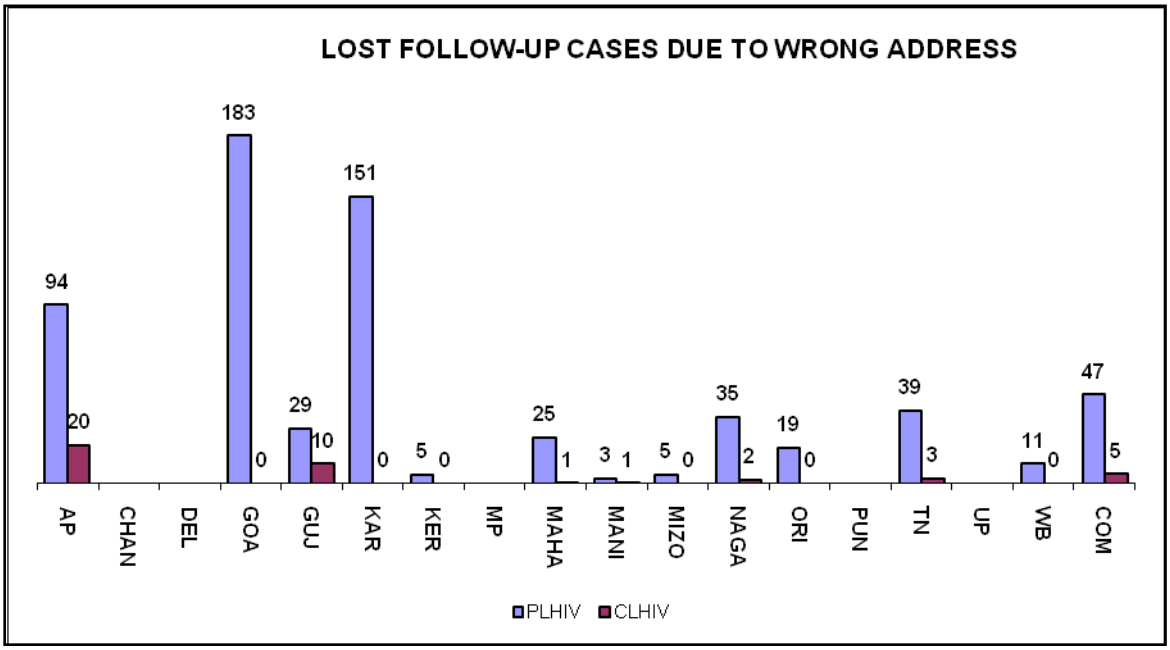
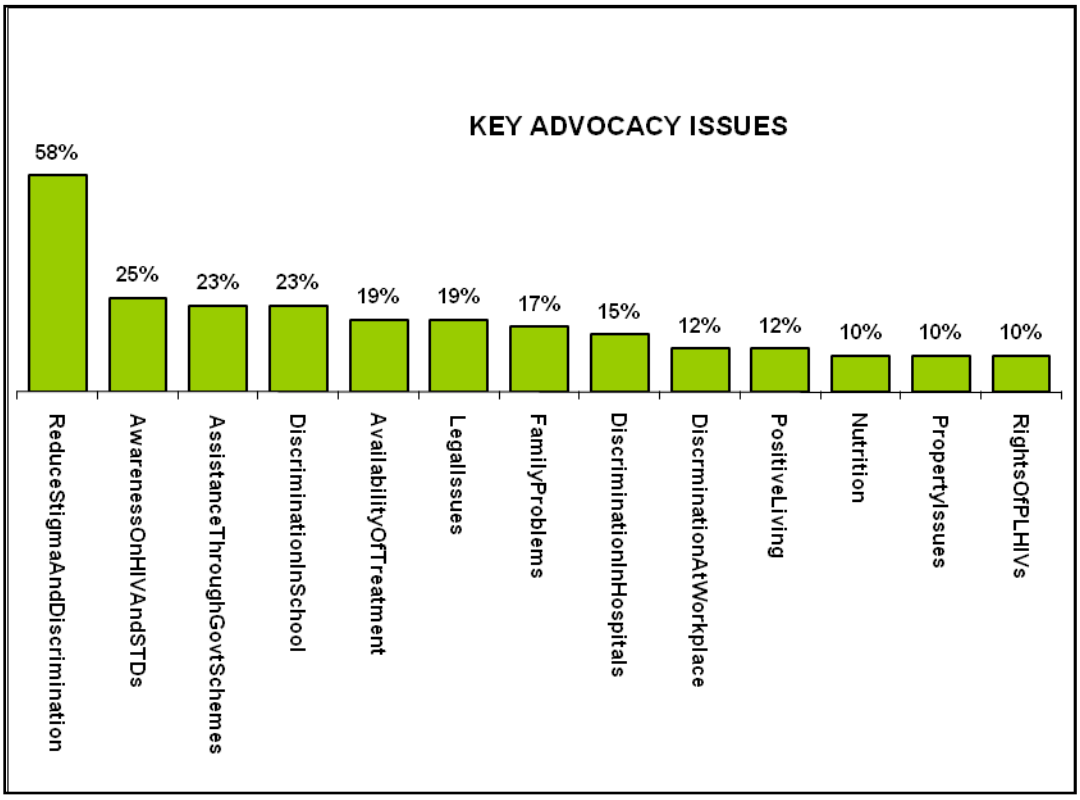


Figure 11. reveals the number of PLHIV on ART lost to follow up due to wrong addresses given by PLHIV on ART. A limited children outreached is due to non availability of children as school and outreach time being same and less number of children on ART. The stigma and discrimination following the status disclosure was considered as the major reason for the LFU. Overlapping of LFU tracking with CCC leading to less time for Networking needs careful attention for future strategic planning.

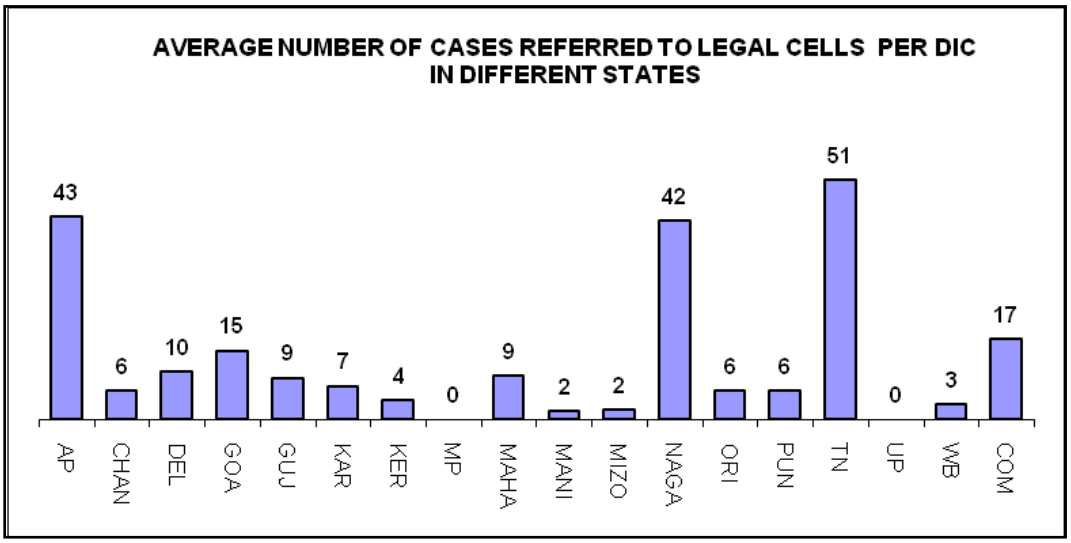
f) Advocacy and mainstreaming effort with stakeholders like government departments, private sector, civil society for ensuring access to welfare and rehabilitation schemes for PLHIVs and their families - During FGD and IDI issues pertaining to the women and children were enumerated. Stigma and Discrimination was the major challenge PLHIV face even after 24 years of HIV presence in the country and aggressive efforts are indicated. Figure 9 shows the advocacy issues handled by DICs and figure represents percentage of DICs handling a particular issue across the country.

Figure 12: Advocacy Issues



The issues are many but the staff and budget provisions are not enough to allow networking enough to address them. However, provision for reduced stigma and discrimination is integral to national HIV AIDS response and TI, CCC and programs from many other funding agencies work towards resolving it. It is envisaged that collective efforts will surely bring about the zero tolerance for stigma and discrimination at all levels.

Figure 13: States Comparison - Legal Cell referrals



To understand the role of DICs in PLHIV's life a record of legal cell referral was investigated. It reveals significantly low numbers especially with the High prevalence states like Maharashtra. DIC staff shared that fear of stigma is very high and a large number of people are not ready to disclose the status even to their family. Secondly, the demanding legal proceedings in terms of travel cost also demotivates the PLHIV who are most of the time living on the support system of family. Thirdly lack of knowledge about human rights does not allow PLHIV to assert for one self. Fourthly, lack of proper recording mechanism masks the magnitude of legal issues presented by PLHIV.

g) Provision of care and support for women and children through networking.

Figure 14: States Comparison - PLHIV (Male/Female/Children) – Pre ART registration with DIC

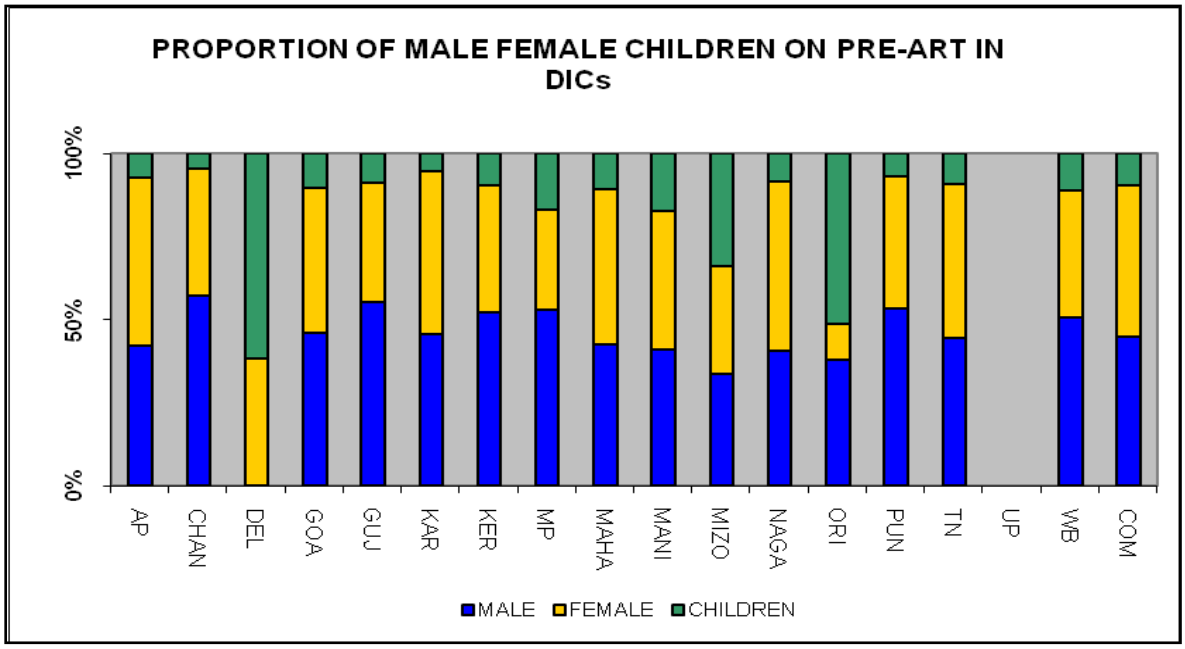


Figure 14 represents the distribution of total Pre ART registration with DIC. Women and children numbers across the states are increasing but the provision for services are limited. Cost of ART from private supplier is high and positive living is the only strategy DIC uses to support PLHIV so that CD4 count is sustained and need for ART is delayed. State of Uttar Pradesh did not have data about ART status of PLHIV but has 42 CLHIV –male and 21 CLHIV –female on ART registered with DIC.

States like Delhi, Goa, Karnataka, Madhya Pradesh and Uttar Pradesh lack the data about number of children at District level so comparison about proportion of children reached could not be ascertained. One DIC at Chandigarh reported maximum number of CLHIV registered (172) and tested for HIV when compared to Andhra Pradesh (647) where ten DICs were reviewed. The field team reported lack of validation of data from different registers maintained by the DIC in Chandigarh. The quality of data pause a major challenge while reporting numbers. Lack of reporting guidelines is a major cause for poor quality data. (**Annexure 9 State Comparison - Pre ART registration**)

Figure 15: States Comparison – Percentage CLHIV registered by Gender

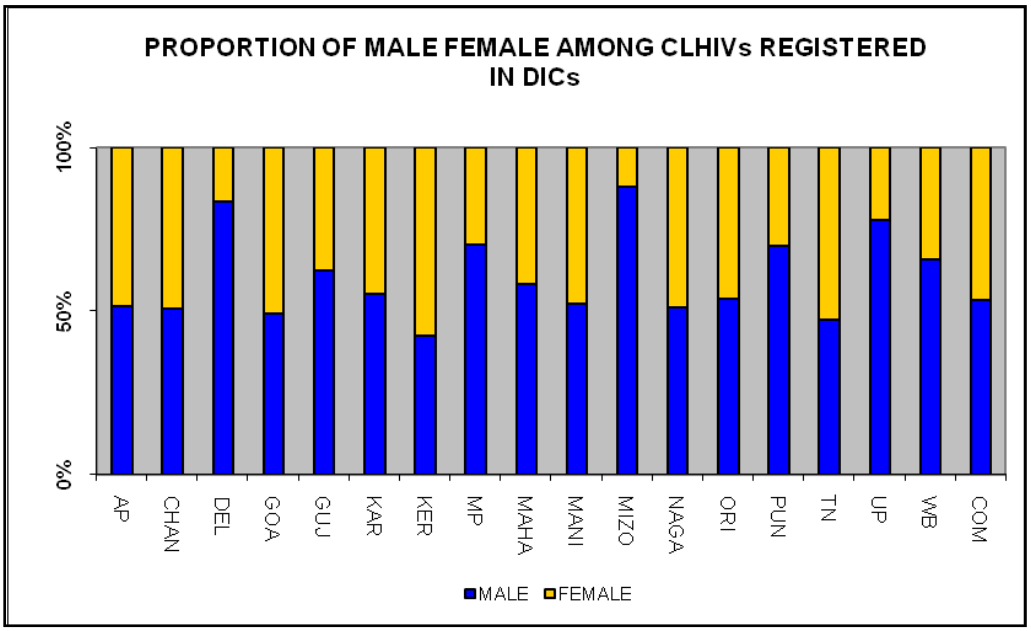
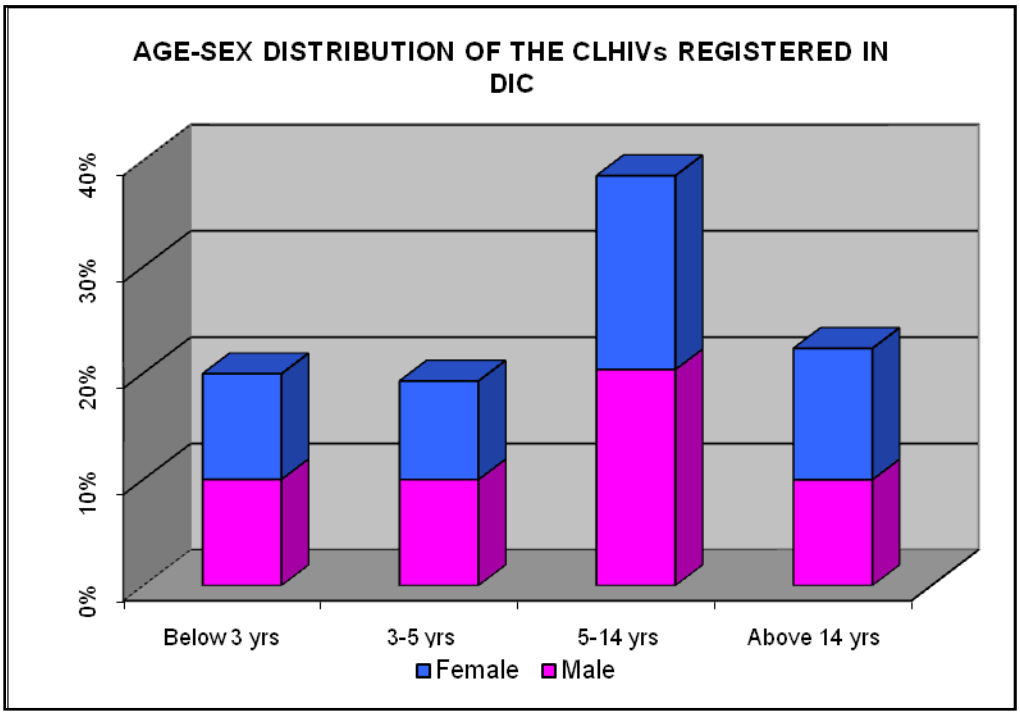


Table 10: States Comparison - CLHIV registered in DIC

Number of Children registered in DIC					
State	**Mean**		**Percentage**		
	Male	**Female**	**Male**	**Female**	**Total**
AP	332	315	51%	49%	100%
CHAN	87	85	51%	49%	100%
DEL	60	12	83%	17%	100%
GOA	62	64	49%	51%	100%
GUJ	53	32	62%	38%	100%
KAR	54	44	55%	45%	100%
KER	10	14	43%	57%	100%
MP	17	7	70%	30%	100%
MAHA	79	56	58%	42%	100%
MANI	43	39	52%	48%	100%
MIZO	88	12	88%	12%	100%
NAGA	30	28	51%	49%	100%
ORI	7	6	54%	46%	100%
PUN	7	3	70%	30%	100%
TN	**104**	**116**	47%	53%	100%
UP	49	14	78%	22%	100%
WB	34	18	66%	34%	100%
COM	**91**	**79**	**53%**	**47%**	**100%**

Andhra Pradesh reported maximum number of CLHIV registration and Punjab and Orissa were the least registrant states for CLHIV. Maharashtra, Tamil Nadu has very low numbers of CLHIV registered. This is in part due to the lack of services available for children.

Figure 16: Demographic Profile - CLHIV registered in DIC



Maximum children registered are in the age group 5-14. In the earlier age group both the status of the child is not detected and after detection the lack of services delays the registration of CLHIV with DIC.

Figure 17: States Comparison – CLHIV HIV testing done

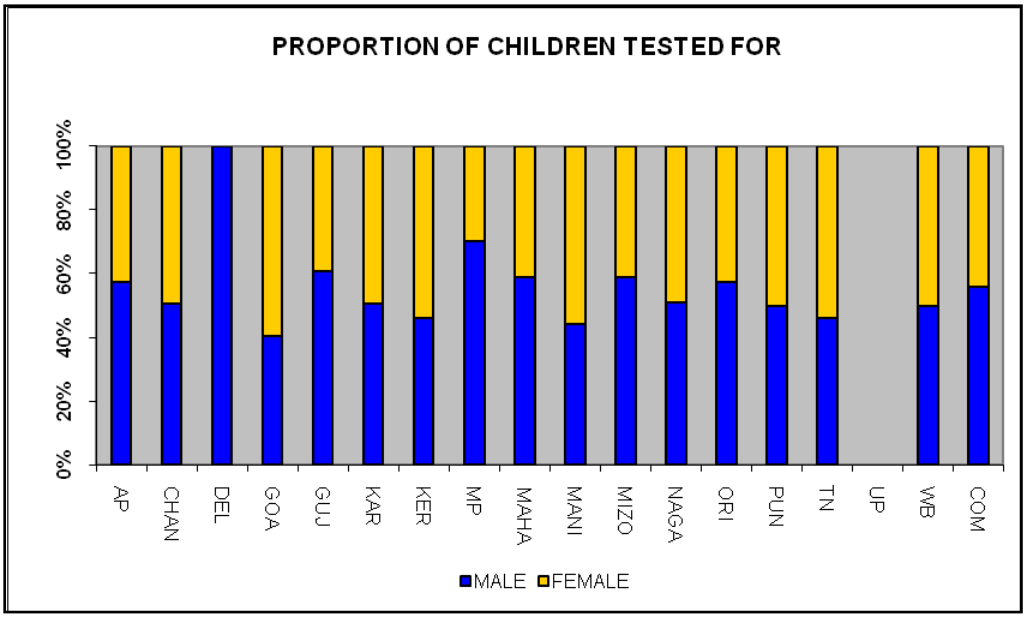


Table 11: States Comparison - CLHIV tested

Number of Children Tested for HIV					
State	Mean		Percentage		
	Male	Female	Male	Female	Total
AP	735	542	58%	42%	100%
CHAN	87	85	51%	49%	100%
DEL	7	.0	100%		100%
GOA	90	132	40%	60%	100%
GUJ	467	300	61%	39%	100%
KAR	69	67	51%	49%	100%
KER	20	24	46%	54%	100%
MP	17	7	70%	30%	100%
MAHA	83	58	59%	41%	100%
MANI	29	36	44%	56%	100%
MIZO	10	7	59%	41%	100%
NAGA	21	20	51%	49%	100%
ORI	31	23	57%	43%	100%
PUN	7	7	50%	50%	100%
TN	**79**	**91**	46%	54%	100%
UP	0	.0			
WB	17	17	50%	50%	100%
COM	**181**	**142**	**56%**	**44%**	**100%**

Figure 18: CLHIV – Pre and On ART proportion

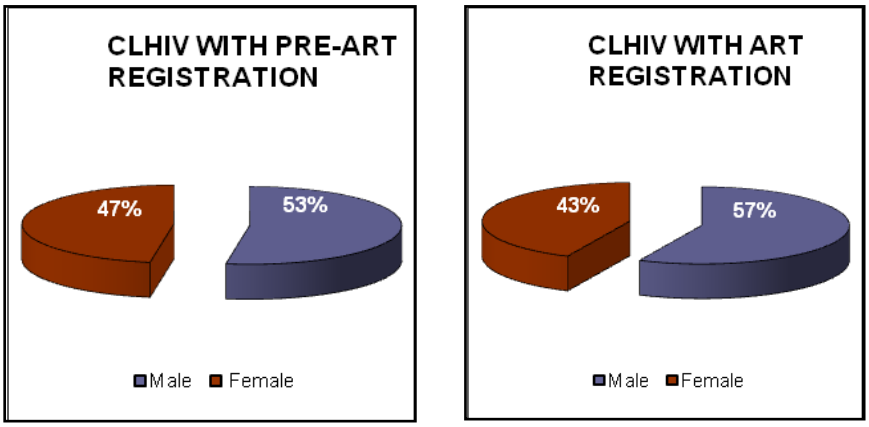
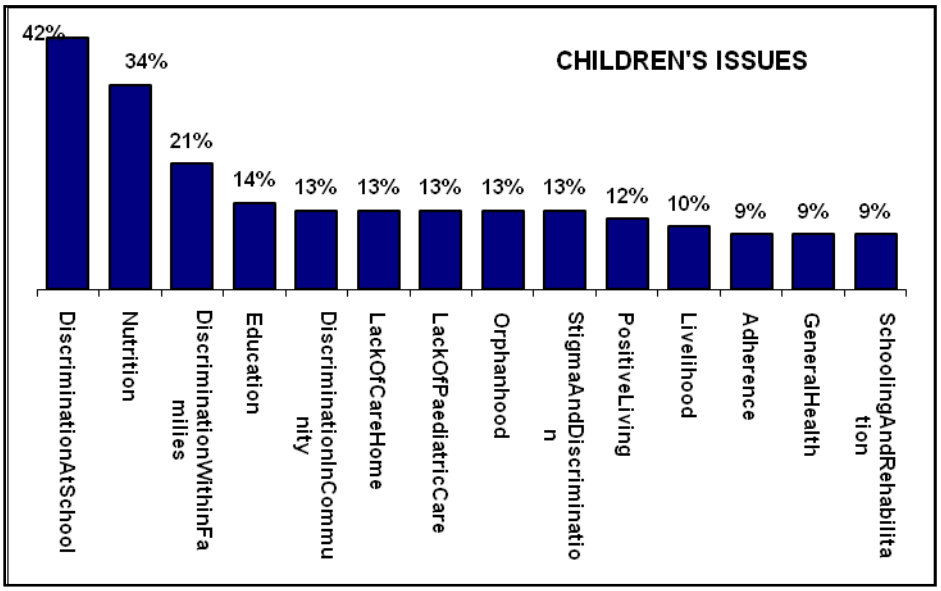


Table 12: States Comparison - CLHIV pre and on ART

State	Number of Pre ART registration		Number –ART registration		Number of Pre ART registration		Number –ART registration	
	Mean				Percentage			
	Male	Female	Male	Female	Male	Female	Male	Female
AP	587	523	308	249	53%	47%	55%	45%
GOA	24	31	12	17	44%	56%	41%	59%
GUJ	28	16	27	13	63%	37%	68%	32%
KAR	28	20	15	14	58%	42%	51%	49%
KER	4	8	6	6	35%	65%	48%	52%
MP	12	4	10	2	75%	25%	83%	17%
MAHA	35	29	52	36	55%	45%	59%	41%
MANI	16	9	15	13	66%	34%	54%	46%
MIZO	28	49	37	53	36%	64%	41%	59%
NAGA	6	12	1	1	34%	66%	48%	52%
ORI	45	13	13	.	78%	22%	100%	
PUN	7	6	4	2	54%	46%	67%	33%
TN	**38**	**36**	**42**	**35**	51%	49%	55%	45%
UP	.	.	42	21			67%	33%
WB	17	13	5	4	57%	43%	57%	43%
COM	**103**	**93**	**64**	**49**	**53%**	**47%**	**57%**	**43%**

Figure 16,17,18 and Table 10, 11, 12 reveal the Gender Difference in the DIC registration, HIV testing, Pre ART and On ART service uptake. The gender discrimination seems to begin after the age of 3. The reason could be due to the better immunity of female child in comparison to male child or increased need of the male child or increased attention to the health of the male child. During IDI analysis the recurring theme that emerged was preference of a mother for the treatment of her child and husband over self. Further probing also reflected the social and religious conditioning of women about husband as head of the family and earning member to be more important than one's own self. DICs in the states of Delhi and Chandigarh did not have ART related records. DIC in UP did not have data about pre ART registration.

Figure 19: Children's Issue



Children's issue that emerged after FGD and IDI analysis were more or less similar to the one captured by semi structured tool during discussion with DIC staff. Also, a lot of DIC staff being PLHIV the similarity seemed logical. However, none of the DIC staff were FGD or IDI participants but community empowerment by DIC staff through support group and Get Together were visible in FGD and IDI analysis.

Figure 20: CLHIV – Parents status

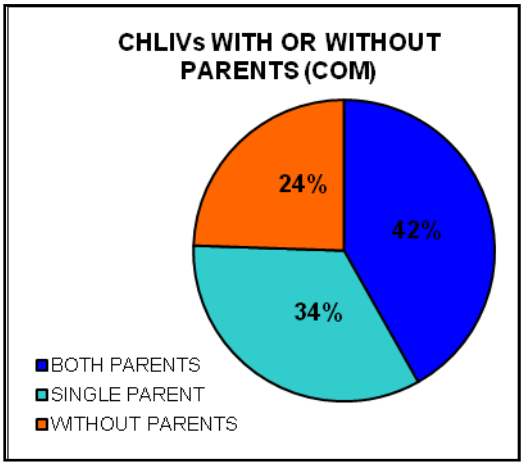


Figure 20 shows the DIC record of CLHIV status. 24% of the children registered with DIC are double orphans, and 34 % are single orphans. However, DIC budget for emergency support is so little that it can hardly meet the needs of any child. Linkages with Anganwadi and other NGOs are the only support system for double orphans in the project.

h) **Counselling services** - counselling session and individuals counselled number confusion, records related untidiness, space available for counselling, follow – up to counselling through outreach activities, types of issues handled.

Figure 21: Counselling Sessions

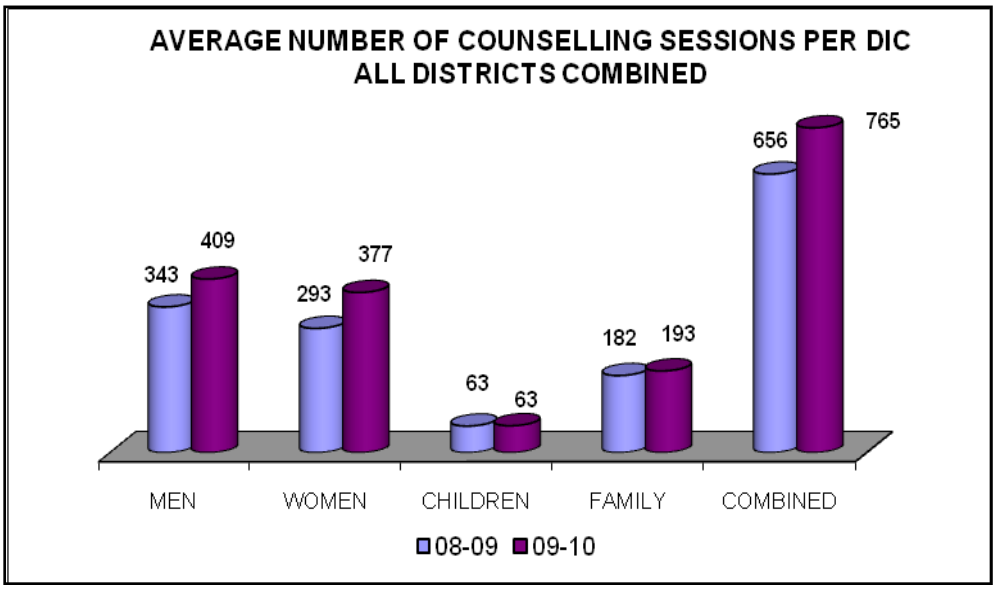
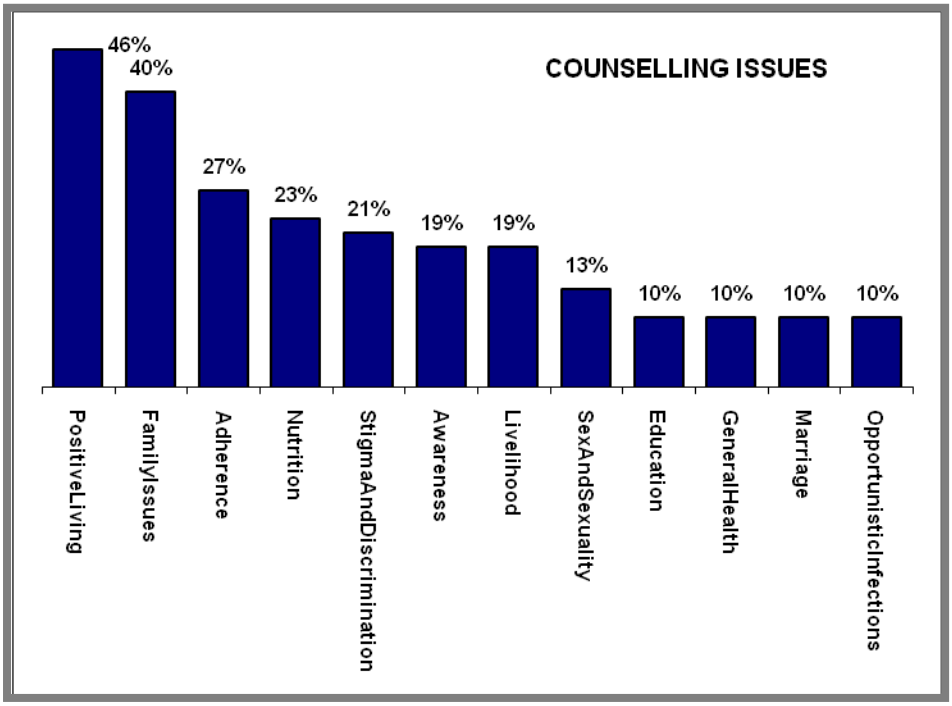


Figure 21 represents average number of counselling sessions per DIC for the study period. Numbers of counselling sessions for women are more than that for men. Children counselling sessions are practically very low though the need is very high expressed in IDI and FGD. The major gap in this figure is the lack of understanding in the counsellors about Number of individuals counselled and number of sessions of counselling. This causes inconsistent reporting. Many DICs could not provide a consistent data about quantitative aspects of counselling. Peer counsellor and education, lack of technical expertise, lack of reporting mechanism were reported as technical gaps in counselling reporting.

There was a good understanding about the issues in the counselling and types of issues of counselling offered across the country are depicted in Figure 19. Also, investigator suggests that it may be worthwhile developing a counselling module on positive living highlighting coping mechanisms adopted by community. However this evaluation does not provide scope for deeper exploration on the same.

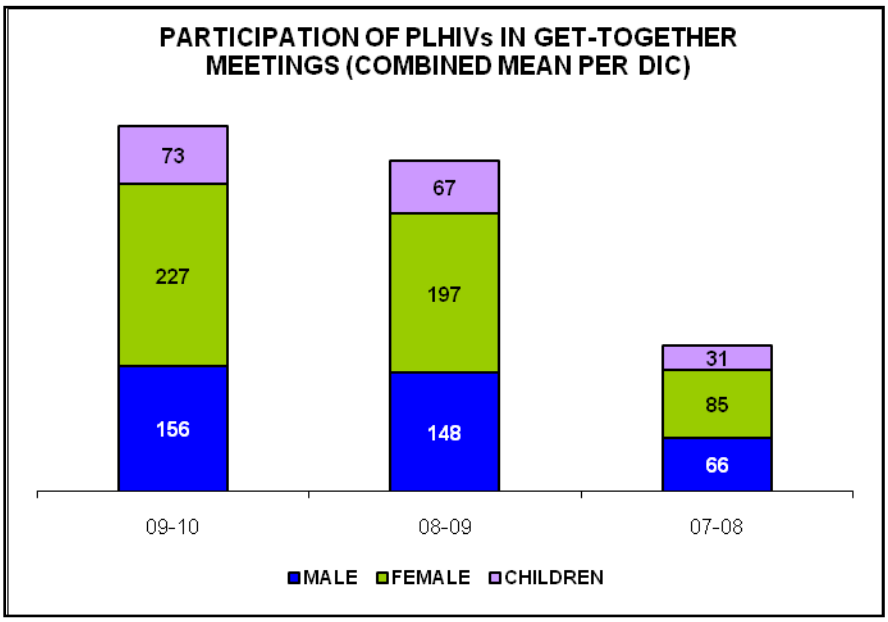
Figure 22: Issues in Counselling



It was interesting that positive living was viewed as separate from all other counselling issues and it mainly focused on listening, empathising and motivating the client in the face of adversity. Livelihood counselling was mainly sharing contact details of other NGOs who could facilitate support. Sex and Sexuality counselling mainly restricted to safe sex counselling but in some of the positive network managed DICs in Maharashtra, the sex and sexuality counselling expanded to explain PLHIV about non penetrative sexual intercourse as pleasuring method without having to exchange viral load of the partner/spouse. Matrimonial coordination is arranged by many DICs in North, South and Western region of the country. DIC staff shared that PLHIVs express greater need for partner /spouse as many of the men and women lost partner in young age of less than twenty five. DICs staff also shared that PLHIV men prefer to have a PLHIV partner/spouse without child and PLHIV women prefer to have spouse who accepts the child.

i) Meetings/get together at the DICs- number of meetings or people.

Figure 23: PLHIV Get Together



Total number of participants- male, female and children - increased steadily for last three years. Get together are rated most popular by PLHIV across all the states even by IDIs and requested to increase the number in future. However, the lack of data or incomplete data from the states of Punjab, Uttar Pradesh, Madhya Pradesh and Delhi explains the low numbers in each category.(Table 13) it will help to have uniform reporting system across the country so that the data can become useful for state specific programmatic strategy. DICs in Chandigarh and UP did not have records pertaining to Get Together.

Table 13: States Comparison - Get Together

NUMBER OF PARTCIPANTS GET TOGETHER												
MEAN												
State	GET TOGETHER 09-10				GET TOGETHER 08-09				GET TOGETHER 07-08			
	MALE	FEMALE	CHILDREN	TOTAL	MALE	FEMALE	CHILDREN	TOTAL	MALE	FEMALE	CHILDREN	TOTAL
AP	298	448	140	886	294	420	159	872	62	102	35	199
DEL	.	.	.	.	0	295	92	1,068	.	.	.	.
GOA	248	340	101	688	174	259	63	495	143	228	65	435
GUJ	216	222	112	568	129	131	105	365	118	123	84	325
KAR	41	139	30	209	52	107	39	198	56	116	19	191
KER	398	658	154	1,209	218	435	89	741	204	299	23	526
MP	30	37	11	51	67	84	9	160	.	.	.	.
MAHA	168	202	56	410	154	165	34	340	57	44	18	118
MANI	26	40	2	68	32	35	3	69	38	50	2	89
MIZO	31	28	3	77	37	25	17	91	27	20	2	50
NAGA	23	28	20	64	43	35	5	41	21	30	24	45
ORI	**170**	**105**	**15**	**290**	**110**	**80**	**35**	**225**	**60**	**40**	**23**	**123**
PUN	115	53	.	.	95	37	.	132	.	.	.	.
TN	163	338	87	557	191	274	79	474	29	37	9	34
UP	.	.	.	1,261	.	.	.	.	.	.	.	.
WB	165	225	38	456	212	266	39	548	101	158	54	354
COM	**156**	**227**	**73**	**465**	**148**	**197**	**67**	**421**	**66**	**85**	**31**	**159**

j) Documentation

The best documentation available with DICs is monthly report. However, the practice of monthly reporting is not uniform across the states. Some states have initiated monthly reporting process from the start of the project. Some DICs have started the monthly reporting practices for last six months. Some DICs have quarterly reporting system. In Delhi there are two DICs which were reviewed and one has very weak documentation while the other is average in performance. The best written section of MIS is advocacy related narratives. Due to the uncertain reporting style the number reported in each report did not match when investigating team carried out on field triangulation of records. Example -DIC makes entry of a new PLHIV in three places – DIC enrolment form, Drop-in – Register and Service register if service is provided. However, when physically triangulated the figures could not be validated. This exercise though could not be performed for each set of data due

to time constrain and this could be considered as limitation of the methodology and process. The photo documentation is strength of all the DICs reviewed. However, the written consent is not taken by 43 % if DICs while taking photographs of PLHIV in Get-together or during any events. Trainings report and success story documentation is weak area which needs to be strengthened to create strong evidence base to showcase outcome of National response.

Table 14: States Comparisons -Documentation practices

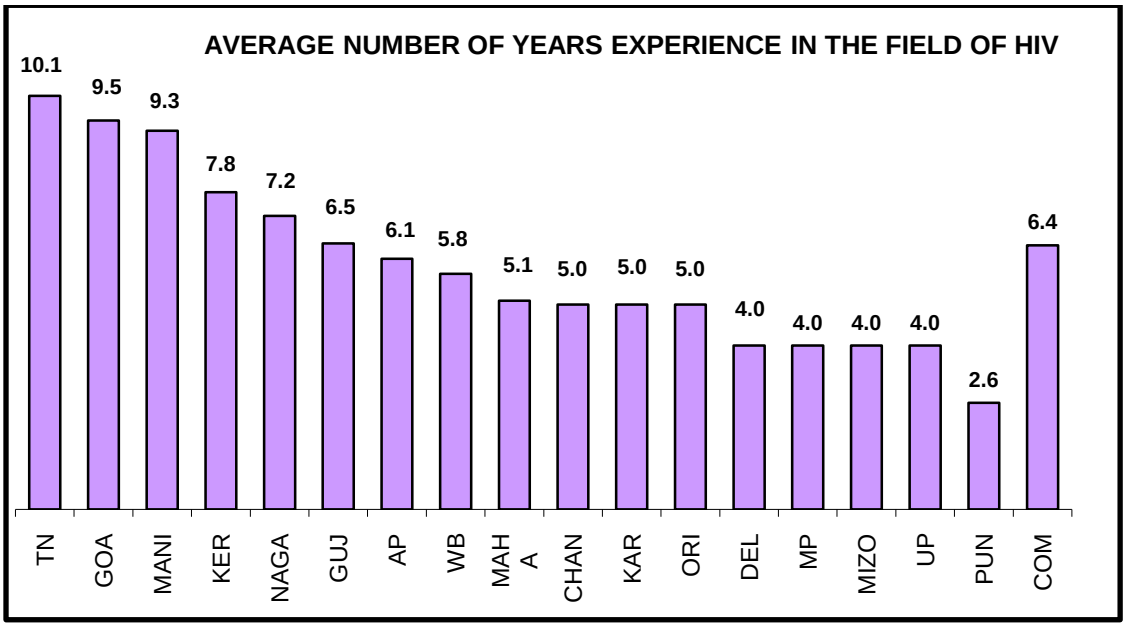
STATE	Documentation Counselling	Documentation Support Group Meeting	Documentation IEC Material Development	Documentation IEC Material Distribution	Documentation advocacy Programme	Documentation Get Together	Documentation Written Consent For Photo	Documentation Monthly Report	Documentation Quarterly Report	Documentation Anual Report	Documentation EC Meeting	Documentation Succes Story	Documentation Positive Prevention Programme	Documentation Training Programme
AP	88%	63%	100 %	100 %	100 %	100 %	25%	88%	63%	75%	88%	88%	63%	25%
CHAN	0%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	0%	0%	100 %	100 %	100 %	0%
DEL	100 %	100 %	50%	50%	100 %	100 %	100 %	100 %	0%	100 %	50%	100 %	50%	0%
GOA	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
GUJ	88%	100 %	100 %	100 %	88%	100 %	100 %	100 %	100 %	100 %	100 %	88%	88%	100 %
KAR	100 %	75%	25%	25%	100 %	100 %	0%	100 %	0%	100 %	100 %	50%	50%	50%
KER	100 %	100 %	50%	50%	100 %	100 %	0%	100 %	0%	50%	50%	50%	100 %	50%
MP	100 %	100 %	100 %	100 %	100 %	100 %	50%	100 %	100 %	100 %	100 %	100 %	100 %	50%
MAHA	900 %	1000 %	700 %	1000 %	900 %	900 %	700 %	1000 %	700 %	900 %	800 %	800 %	600 %	400 %
MANI	75%	50%	50%	100 %	100 %	100 %	0%	100 %	100 %	100 %	75%	50%	0%	0%
MIZO	100 %	50%	100 %	83%	100 %	100 %	0%	83%	0%	33%	50%	0%	100 %	17%
NAGA	83%	83%	100 %	100 %	100 %	100 %	83%	83%	83%	83%	83%	67%	83%	67%
ORI	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	0%

STATE	Documentation Counselling	Documentation Support Group Meeting	Documentation IEC Material Development	Documentation IEC Material Distribution	Documentation advocacy Programme	Documentation Get Together	Documentation Written Consent For Photo	Documentation Monthly Report	Documentation Quarterly Report	Documentation Anual Report	Documentation EC Meeting	Documentation Succes Story	Documentation Positive Prevention Programme	Documentation Training Programme
PUN	100 %	100 %	100 %	100 %	100 %	100 %	0%	100 %	100 %	100 %	0%	0%	100 %	100 %
TN	100 %	100 %	82%	82%	100 %	100 %	27%	91%	64%	100 %	100 %	64%	64%	55%
UP	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	0%	100 %	100 %	100 %	0%	0%
WB	88%	88%	100 %	88%	88%	63%	0%	100 %	100 %	50%	63%	25%	75%	50%
COM	91%	86%	84%	88%	96%	95%	43%	95%	65%	82%	82%	64%	70%	47%

k) Governance - DIC governance was assessed against the markers like years of experience in HIV AIDS, managed by NGO or CBO, Governing Board meetings, Accounting and procurement system, and Support from SACS in terms of funds

- Years of experience in HIV

Figure 24: States Comparison – Years of experience in HIV AIDS area



DICs in Tamil Nadu have maximum number of years in HIV AIDS area while most of the DICs in north region have 3-4 years of experience in HIV AIDS. All high prevalence states like Nagaland, Andhra Pradesh, and Maharashtra have 5-7 year of experience in HIV AIDS.

- DICs run by Network and NGO – 63 DICs reviewed are run by Positive People's Network and 10 DICs in Gujarat -2 , Mizoram -1, Nagaland-3, West Bengal – 2, Maharashtra -1, Delhi – 1 are run by NGO.

Overall performance of NGO run DIC in Delhi is weaker in terms of Documentation and aspects of Governance. In Gujarat NGO run DIC and Network run DICs are equal but level of articulation with respect to documentation is better. Policies are adhered strictly in NGO run DIC.

- Governing Board Meetings – Executive Committee (EC) meetings were held quarterly across all the DICs reviewed except Delhi. However, the minutes of the meetings were not written consistently by all the DICs. Occasionally the quorum was not met. The reason given were EC member being unwell or travelling.

Table 15: States Comparison - Receipt of funds

State	Timely Receipt Of Fund							
	COUNT (No. Of DICs)				PERCENTAGES			
	AT	SD	NT	TOTAL	AT	SD	NT	TOTAL
AP	2		6	8	25.00%		75.00%	100.00%
CHAN			1	1			100.00%	100.00%
DEL			2	2			100.00%	100.00%
GOA			2	2			100.00%	100.00%
GUJ	3		5	8	37.50%		62.50%	100.00%
KAR	1		3	4	25.00%		75.00%	100.00%
KER	2			2	100.00%		0.00%	100.00%
MP			2	2			100.00%	100.00%
MAHA	2		8	10	20.00%		80.00%	100.00%
MANI			4	4			100.00%	100.00%
MIZO			6	6			100.00%	100.00%
NAGA		3	3	6		50.00%	50.00%	100.00%
ORI	1			1	100.00%		0.00%	100.00%
PUN	1			1	100.00%		0.00%	100.00%
TN	5		6	11	45.45%		54.55%	100.00%
UP			1	1			100.00%	100.00%
WB			8	8			100.00%	100.00%
COM	**17**	**3**	**57**	**77**	**22.08%**	**3.90%**	**74.03%**	**100.00%**

AT=Always on Time; SD=Sometime Delayed; NT=Never on Time

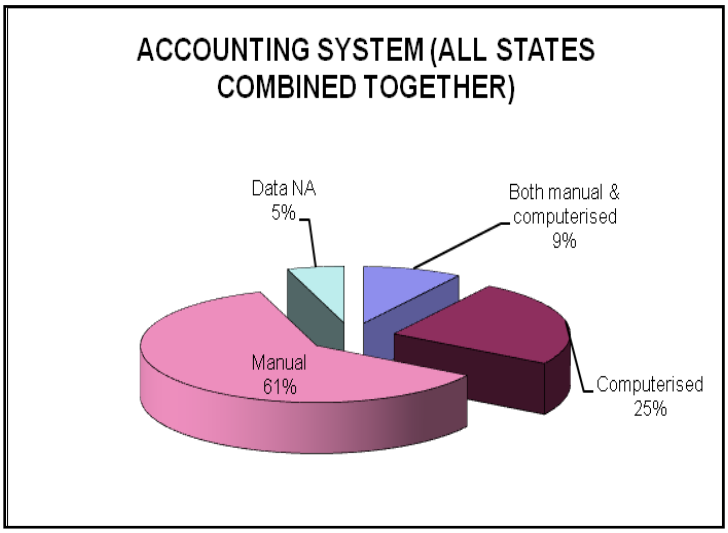
74 % of the states reported delay in the receipt of the funds. DICs in Kerala, Punjab and Orissa reported 100% timeliness of fund receipts. Submission of utilization certificates, financial statements and Audit reports were submitted by 92 % of the DICs reviewed. Table 15 summarises the impact of delay in the fund receipt.

Table 16: States Comparison - Impact of Fund Delay

	AP	DEL	GOA	GUJ	KAR	MP	MAHA	MANI	MIZO	NAGA	TN	WB	COM
NUMBER OF DICs	**8**	**2**	**2**	**8**	**4**	**2**	**10**	**4**	**6**	**6**	**11**	**8**	**77**
Loan	13 %			25 %	25 %		20 %	25 %	100 %	50 %	27 %	38 %	29 %
Project Activities Suspended	13 %		50 %	25 %	100 %	100 %		75 %	100 %				25 %
Salaries Are Not Timely Paid	63 %	50 %	100 %				60 %	25 %			18 %	25 %	25 %
Service For PHLIV Stops									100 %			38 %	12 %
Fund Transfer From Other Projects							30 %					38 %	8%
Loan From Network Organisation				13 %	50 %		10 %				9%		6%
Staff Pay For Expense							10 %	50 %					4%
Affects Whole Organisation										33 %			3%
Emergency Service Suspended				25 %									3%
Outreach Stopped		50 %										13 %	3%
Support Group Meetings Stopped				25 %									3%
Contribution Of Members												13 %	1%
Loan From Church										17 %			1%
Non Availability Of OI And STD Drugs			50 %										1%
Nutrition Support Stopped												13 %	1%

Table 16 summarises the impact of delayed fund disbursement by SACS on the DIC program across the states. DIC staff shared that the maximum impact is on the staff salary and it leads to staff turnover as not many can withstand the interest on the loans taken for day to day living. The most important outreach service is also affected due to delayed disbursement. This also affected the overall scoring of DICs who could not get higher scores due to irregular outreach services. DICs are not always very near to the other support services like ICTC,ART,PPTCT or CCC and travel cost ,lack of salary on time limits the operations despite the will and commitment of the staff.

Figure 25: Accounting System

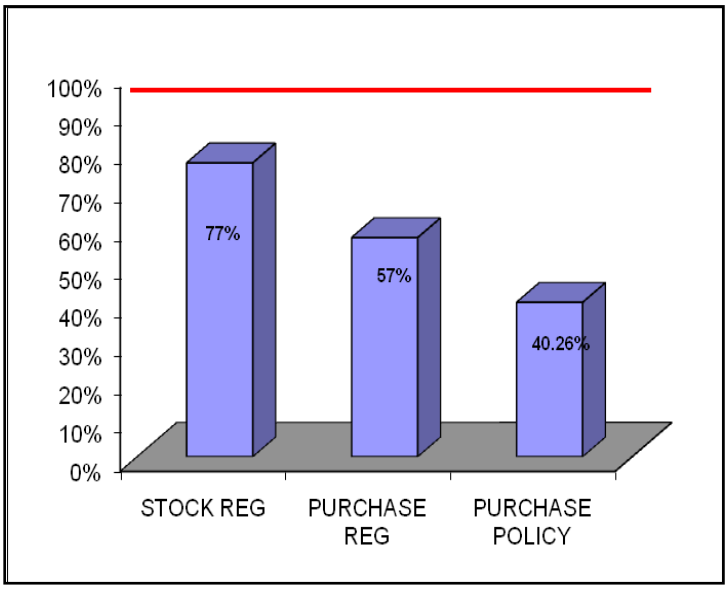


61% of the DICs maintained manual accounting system and 25 % has computerised accounting system in place. 9% have both manual and computerised system while 5% DIC do not have sound data (example - Chandrapur, Kolkata –Sparsha,). 81% of the DICs reported updated books of accounts and 13% do not update books of accounts. 6% update the books irregularly.

Table 17: Procurement system

STOCK REG	77%
PURCHASE REG	57%
PURCHASE POLICY	40%

Figure 26: Procurement System



Procurement Policy is available with 40%, Purchase register is maintained by 57%, and Stock Registers are maintained by 77% of the DICs reviewed. Andhra Pradesh DICs mentioned that they use Procurement Policy prepared by INP plus.

Section 3.1 and 3.2 of the report can be summarized to learn about major Contribution made by DIC in care, support, treatment and prevention of HIV-

- DIC holds a major stake in the community mobilization and empowerment
- DICs (majority) Affiliation to positive people's network has strengthened the GIPA practices.
- DICs are model for GIPA practices in HIV AIDS response
- ART adherence counselling at DIC is complementing the efforts of ART centre
- Psychological support and enabling space provided by DIC is incomparable
- Photo documentation practices at many DICs are excellent
- Networking with other NGO with respect to Nutrition support is very good.
- Emergency support provided by DIC is very transparent
- Escort Service to the hospital for PLHIV is very significant.
- On the field facilitation by outreach staff in particular at ART centre is remarkable.

CHAPTER 4

KEY FINDINGS AND RECOMMENDATIONS

4.1 Key Findings

Based on the analysis of qualitative and quantitative information collected the key findings of this study are summarised below.

4.1.1 Summary

a) Impact of DIC - As an enabling environment, DIC holds a major stake in the community mobilization process and empowerment through strategies of Support Group Meeting, GIPA Practices and information dissemination hub. DIC plays crucial role in reduced stigma and discrimination at community level.

b) Best and the Weak Services – While the Educational Services for children were rated best when received, Psychological Support and Counselling were the services appreciated by all the PLHIVs across all the DICs reviewed. Lack of vital Nutritional support was rated the weakest of all the Services.

c) Types of Services provided - Counselling, Outreach and Escorts in emergencies, Get Together is provided by all the 77 DICs. Referral Services to CCC and Public Distribution System for Nutrition are weakly covered by all the DICs.

d) DIC outreach – the location of DIC is important in service access from DIC and Outreach by DIC. Data suggest that as the distance travelled by PLHIV and the service uptake are inversely correlated. Also, the outreach efficiency weakens with the increase in operational area and high PLHIV to Outreach worker ratio.

e) Legal Services – Across the DICs the legal service uptake is very weak. The community perspective about it was the cost of travel incurred, time consuming legal proceedings and lack of knowledge about legal rights was limiting the legal service uptake.

f) Governance and DIC function - DLNs'/NGOs' number of years of experience of working in HIV AIDS area and extent of facilitation of program by SACS were the major determinants of DIC's overall functioning. Lack of monitoring and handholding/guidance role of SACs in routine functioning of DIC limits the growth and development of DIC program. There has been no difference in the functioning of DIC based on NGO or Positive network management. Both have PLHIV as outreach staff which is significant to community mobilization and empowerment. Utilization certificates, financial statements and Audit reports were submitted in time by 92% of the DICs reviewed. **74% of the DICs reported**

delay in the receipt of the funds. Maximum impact of the delayed funds is related to staff salary and staff turnover. Accounting systems at the DICs reviewed are in place. 61% of the DICs maintained manual accounting system and 25 % has computerised accounting system in place. 9% have both manual and computerised system while 5% DIC do not have appropriate data required for physical verification (example - Chandrapur, Kolkata–Sparsha,). 81% of the DICs reported updated books of accounts and 13% do not update books of accounts. 6% update the books irregularly.

g) DIC reaches out to more men than women and children in terms of registration as well as service uptake. Across the country 68% of the DIC registrants are male, 30% female and 2% children. The negligence towards women and children's concern has emerged as major learning from the study. Table 1 summarizes the issues of children and women emerged from FGD analysis and expressed as Percentages (%) of Participants Response (PR).

Table 1: Issues of PLHIV – Women and Children

Issues –Women	% PR	Issues –Children	% PR
Access to Care and Treatment	4	Access to Care and Treatment	6
Community Discrimination	17		
Family issues -Abandonment by family	8	Denial of Property Rights double orphans	4
Family issues-Substance abuse problem of spouse affecting life	10	Discrimination -Family	27
Denial of property rights	44	Discrimination at School	46
Domestic Violence	13	Educational problem – attendance problem	21
Denial of Child bearing and rearing rights	4	Early loss of parents – single or double orphans	15
Divorce and marital disharmony	19	Lack of Services for orphans	4
Livelihood Options	40	Lack of effective Paediatric counselling	100
Positive Living	13	Lack of Knowledge about ART adherence	12
Stigma and discrimination in health sector	13	Livelihood option –double orphans	10
Sexual Exploitation after spouse death	6	Lack of Nutrition Support	37
Workplace discrimination	31	Treatment Adherence	12

4.1.2 Strengths of the Study

Tools

- Findings from qualitative and quantitative analysis matched although the tools used and source of information were different. This was due to the triangulation research methods used for data collection. Example – Services offered by DIC and issues faced by the PLHIV community –findings from qualitative and quantitative analysis corroborates.
- Tools used- (FGD, IDI, KII and Semi structured Questionnaire) captured the diverse but relevant information about DIC functions. The tools worked equally well in all the states conforming its robustness.

Review process

- Community participating in the review shared that FGD and IDIs were very empowering and enabling like support group meetings and facilitators were very non judgemental about the experiences of PLHIV.
- FGD,KII, IDI , Performance Assessment analysis and report writing were a very capacitating experience for FXB Suraksha research team
- FGD participants were over recruited by 10-20 % keeping in mind the drop out.
- Characteristics of the FGD groups were matched in terms of socio economic background and age and familiarity with each other to ensure active participation
- Active participation and cooperation from SACS officials helped develop recommendations

4.1.3 Limitations of the study

- 70% of the FGD groups were heterogeneous. However the care was taken while recruiting PLHIV for FGD, such that more than 50% participants were the beneficiaries of the DIC at least for one year.
- Qualitative Data analysis for Karnataka and Manipur were done manually using a regional language transcript as data collection was delayed.
- Audio recorder failed in two districts of Maharashtra and Gujarat so the recordings were based on field notes. However, the notes were efficiently taken to overcome the data loss.

4.2 DIC Performance Assessment

Outcome was tabulated DIC wise and subjected to Performance Assessment Tool as described in the methodology. Table 4 summarises the individual DIC ranking. No DICs qualified as “very good”. The reason being the parameter of referral services not getting the desired points in the tool used for Performance assessment. Also Governance documentation issue made few DICs score less on assessment and outreach services limited the others. The important reason however was the lack of adequate funds to cover the given geographical area. Individual DIC Scores are available as **Annexure -10 (Individual DIC Scores)**

Table 2: DIC Ranking Summary

Outstanding		**Good**		**Average**	
State	**Number of DIC**	**State**	**Number of DICs**	**State**	**Number of DICs/District**
Gujrat	1 (Rajkot)	AP	8	Kerala	Calicut -1
		Chandigarh	1	Maharashtra	Chandrapur-1
Tamilnadu	1(Salem)	Delhi	2	Mizoram	Aizwal district-1
		Gujrat	7		Kolasib-1
		Goa	2		
		Karnataka	4		
		Kerala	1		
		Maharashtra	9		
		Madhya Pradesh-	2		
		Manipur	4		
		Mizoram	2		
		Nagaland	6		
		Punjab	1		
		Uttar Pradesh-	1		
		Tamil Nadu	10		
		Orissa	1		
		West Bengal	8		
Total	2		71		4

4 DICS in Kerala, Maharashtra, Mizoram need attention and support so that they can perform to their full capacity and provide the services to the needy PLHIVs. All the DICs

reviewed suggest that the contract can be continued with increased support from SACS and NACO.

4.3 Key Recommendation

To enhance DIC function the study offers recommendations in the important area of DIC operations viz. DIC Services, Governance and Support from SACS/NACO

a) DIC Services

- Micro outreach Planning to enhance outreach efficiency. (Increased Outreach strength- human and financial; fixed outreach worker to PLHIV ratio - target of 1: 75 per month; and fixed radius of operational area per outreach worker to enhance outreach efficiency)
- Taluka Level Support Network formation to increase the access to information for women adolescents and strengthen local support system of PLHIV, particularly in high prevalent districts
- Legal Awareness training within DIC to enhance PLHIV's understanding about their Rights.
- Better planning of programs to address the issues of women and children
- Review of condom supply and demand generation

b) Governance

- Staff hiring policy for DIC – PLHIV to be hired based on motivation, skills, education and experience of work.
- Procurement policy for DIC
- Infrastructure support to improve documentation and communication – Desktop ,Printer, Internet
- Honorarium and capacity building for Governing body of CBO/DLN to build their leadership to strengthen the network activity.

c) Support from SACS/NACO

- Making Operational Guidelines available for DIC
- Regular Capacity building training as per the expressed training needs of the DIC staff
- Increased overall budget for DIC towards travel, office rent, infrastructure, documentation support and outreach activities
- Monitoring and hand holding by SACS.

4.4 Response Plan

FXB Suraksha has developed a response plan in consultation with community and State AIDS Society for better coordination and improved DIC functioning. Table 3 summarises the burning issues in the community and recommended action with timelines. It is envisaged that the response plan will help NACO and UNDP to bring the focus for the improved DIC operations.

Table 3: Response Plan

Concerns	Recommended Action	Timeline	Responsible Agency
DIC resource Planning	Outreach planning of CCC and DIC to avoid duplication of resource utilization for the same purpose of LFU tracking	3 months	NACO and SACS
	Increased outreach strength – human and financial	3 months	NACO and SACS
Access to care, support and treatment for children and women	Advocacy for second line ART for children	6 months	GIPA staff at NACO and SACS
	Strong linkages with Public distribution system in HIV AIDS response	3 months	NACO with relevant ministry
	Services specifically for Double Orphans	3 months	NACO and SACS with Ministry of women and child welfare
Livelihood option for PLHIV	Market needs and PLHIV needs to match and develop a business plan at district level with the help of Corporate	6 months	NACO and CSR wing of the corporate.

As per the key objectives the study has reviewed the programmatic and financial progress of each of the DIC. Important learning from the same is incorporated to make recommendations. Study also looked at the SACS officials (ART, PPTCT, ICTC, DAPCU, Directors and PDs) as very important stakeholders in the DIC functioning. Their suggestions are included in the recommendations made to improve DIC operations. DIC operations were scored using Performance Assessment Tool to make the assessment more meaningful and objective. Study Strongly recommends the continuation of all the DICs with increased attention and support to those DICs scored poor. All the DICs reviewed are required by PLHIVs in the districts and need to grow stronger to serve the PLHIV community.

LIST OF TABLES /ANNEXURE/FIGURES

Annexure 1: Research Tools (After Pilot Testing)

FOCUS GROUP DISCUSSION (FGD)

Names of the PLHIV Participants

District and Location of DIC

Name of the Investigator:

Tool Type – FGD

Date -

Time of the session

DIC contact person

Complete Address:

Phone

Questions with Probes

a) Participant Introduction

b) Since how many months, years they are visiting DICs and how often?(Look for the earliest and latest entrants)

c) What type of services – (referral- IGP, OI, Legal, ICDS, ART,ICTC, RNTCP,STD, DLN, CCC, Social Welfare department, Panchayat, CMOH,TI, Counselling-psychological, legal problems, ART adherence , Information about HIV AIDS, legal issues, Nutrition, IGP, relaxation, forming support group, Home Care visit), they have received so far.?

d) Which service they find the best and which one the weakest?

e) Have they attended any event in the DIC – name the one's they have attended – (example Durga Pooja, Diwali, New Year party, Women's day, Birthday party or any other?)

f) How do they feel about role of DIC in their life? How does DIC impact their life? (Psychological , economic , family or protection of their life)

g) Does anyone in the group recollect any incidence of stigma and discrimination with respect to community, Family- property issues or psychological discrimination, cremation related, workplace or school and support received from DIC to change the situation? Describe in detail. (With one self or another PLHIV's life known to them).

h) Do they see change in the stigma situation in the community in last two years? Give examples of the changed situation?

i) Does anyone recollect any incidence in their life or have witnessed in some other PLHIV's life when support could not reach or delayed in time and eventuality could not be avoided? (Example- crematorium did not allow cremation; relatives did not come to the hospital to own the PLHIV, DIC could not arrange admissions in the hospital, address negligence towards PLHIV in health institution, arrange protection from violence in family/community, take an ailing patient to ART centre or hospital etc. (challenges for our study)

j) What do they suggest to improve the functioning of DIC in future or they feel DIC is not useful in PLHIV's life?

Key Informant Interview (KII)

Name of the person Interviewed-

Designation – ICTC/PPTCT/ART counsellor, CCC staff, DAPCU Nodal Officer, MO at ART/PPTCT centre/ SACS officials /other

District

State

Mobile

Name of the Investigator

Tool Type – KII

Date -

Time of the session

DIC contact person

Address

Phone

Name of the state

Themes to cover during interview

- What do you think about DIC under study in your district in terms of information and support to PLHIV?

- What are the strengths of the DIC? Example - coordination with networking agency, follow up of cases

- What are the challenges in the DIC functioning?

- Tell me more about that.

- How does this affect PLHIV lives?

- What are the options suggested by you to overcome the challenges?

- What are the barriers to the alternatives suggested by you?

- Do you think DIC is useful despite all the strengths and challenges?

- Other comments – verify with SACS officials about the utilization of funds and reasons for the disbursement delay if any /

In-depth Interview (IDI)

Name of the Beneficiary Interviewed - code

District - Location

State

Name of the Investigator

Tool Type – IDI

Date -

Time of the session

DIC contact person

Address

Phone

Name of the state

Questions to Lead the Interview

Personal Info about the Person being interviewed

Parameter	Details
Age	Up to 25 years …… 26 to 35 Years…… 36 to 45 Years …… Above 45 years
Sex	Male
	Female
	Transgender
Marital Status	Married
	Single
	Widow
	Widower
Children	Male Female
Spouse	Alive
	Dead
Education	Illiterate
	Primary-(7^{th} class)
	Secondary-(10^{th} Class)
	Higher secondary(up to 12^{th} class)
	Graduate and above
Income source	Unemployed
	NREGA
	Self employed
	Service
Monthly Income	Rs 500-1000
	Up to Rs.1500
	Up to Rs.2000
	Up to Rs.3000
ART status	On
	Pre
	Non

A. Quality of Information received by you at the DIC

1. What do you think of the support you received at DIC? (to capture feelings, thoughts about DIC)

2. Were you treated with respect? Could you explain?

3. Why did you choose to visit DIC?

4. What makes this DIC good for PLHIV to visit?

5. What makes this DIC not so good for PLHIV?

6. How was your life before visit to DIC in terms of information, knowledge and psychological support?

7. What types of Services are offered to children in this DIC/ Are they appropriate and adequate?

B. Knowledge of ICTC/PPTCT/ART services? (Networking of DIC)

8. Do you know about ICTC/ART/PPTCT/ICTC services?

9. Did you learn about HIV/AIDS related services like ICTC, ART, PPTCT, CCC etc from DIC or any other source? Name the source

10. Do you know other people who use DIC facility?

11. Why do people visit DIC?

12. Why do some people do not go to DIC?

13. Do you think it is important for PLHIV to visit DIC? Why or why not?

14. Do HIV positive pregnant women in your area visit DIC? Why or why not?

15. Who did you approach in your town for any problem when DIC was not there (2-3 years back)

C. Gender differences

16. Do you think more women or men go to DIC? Why?

17. Do you think both men and women need to go to DIC? Why or why not?

18. What would make DIC support better for Children? For men? For women?

D. Opinions about own need for DIC?

19. What do you think of DIC in PLHIV's life? Do you have a positive opinion? Negative opinion? Why?

20. Are you working – self employed, Job, or any other?

21. Were you helped by DIC to find livelihood option? If yes narrate the story. If not do you think it would help if DIC can be strengthened to provide IGP related information

22. Did you face any discriminating situation with respect to your rights in the family, workplace or any other place?

23. Did you receive any information or education about legal rights in the DIC for your situation? If yes narrate the story.

24. If no. Do you think DIC can be strengthened to cater the legal information needs of PLHIV?

25. What other services do you expect from the DIC?

26. What services are available for children at DIC? Are they appropriate and adequate? Please give your suggestions.

Semi Structured Questionnaire

Names of the participating staff-

Designations-
District

Name of the Investigator:

Tool Type – Semi Structured Int.

Date:-

Time of the session:-

DIC contact person:-

Address:-

Phone

Name of the state

Program Deliverables

1) Line listing of Target Population (Source – DIC Registers and MIS reports)

a)

	Male	Female	Children
Total number of drop ins registered			
Number dropped in the current month			
No of new members registered in the current month			
Total No of Pre ART in DIC			
Total Number of PLHIV on ART in DIC			
Number of PLHIV not registered with ART			

b) CLHIV status- (Source – DIC/DAPCU/ART centre /ICTC)

	Male	Female
Number of CLHIV in the district		
Number of Children registered in DIC		
Number tested for HIV		
Number not tested for HIV		
Number of CLHIV living with both parents		
Number of CLHIV with Single parents		
Number of CLHIV without parents		
Age groups range Newly born – 3 and below Above 3 – 5 and below Above 5 – 14 and below Above 14		
Number of CLHIV referred for any service		

2) PLHIV Status in the state (Source - SACS or DPACU officials)

District Name	No registered in DIC	Total no of PLHIV in the District	HIV Prevalence rate	No regularly outreached/ contacted by DIC	Average distance travelled by the PLHIV	No of Villages/blocks/ wards covered through outreach

3) Socio economic profile of Target population

Number of Target population	Family economic status		Place of Residence	
	APL	BPL	Rural	Urban
Male				
Female				
Children				

4) Services Provided by DIC

a) Home visits 1) Yes 2) No
b) Outreach 1) Yes 2) No
c) Advocacy 1) Yes 2) No
d) Community Awareness and Education 1) Yes 2) No
e) Counselling – Peer & family 1) Yes 2) No
f) Referral and Linkages –

1) Health, 2) Nutrition, 3)Transport, 4) livelihood, 5) PDS, 6) TI, 7) ART, 8) STD, 9) TB, 10) Ped ART, 11) PPTCT, 12) ICTC etc.

Marked –yes, Not marked -No

g) Skill Development Training 1) Yes 2) No
h) Support Group Meetings 1) Yes 2) No
i) Get Together. 1) Yes 2) No
j) Escort to hospital 1) Yes 2) No
k) Others - e.g.: Matrimonial coordination 1) Yes 2) No

5) Service Uptake – (Source –MIS report /Register –last two years total)

Service Type	No of PLHIV	Number of CLHIV
Home Visits		
Drop –ins		
Referred to ART centre		
Referred to PPTCT centre		
Referred to ICTC centre		
Tested positive		
Tested Negative		
Through Community Awareness programs		
Through Advocacy Programs- Public Hearing		
Referred to CCC		
Distribution of IEC material		
Referred by ART centre to DIC		
Referred by ICTC centre to DIC		
Referred by PPTCT centre to DIC		
No of PLHIV referred to other NGO/CBO/other GO bodies		
No of PLHIV referred by other NGO /CBO to DIC		
LFU- No of PLHIV –wrong address		
LFU No of PLHIV – correct address		

6) Reasons for Outreach

a) Counselling

b) Family problem

c) School admissions

d) Lost to follow up(LFU) tracking

e) ……..

f) ……..

g) ……

7) Barriers to successful outreach work

a) Travel cost

b) Wrong address given

c) Fear of status disclosure

d) Self stigma

e) Resistance from spouse/family

f) …….

g) ……

h) …….

8) Number of PLHIV meetings/gets together held in last two-three years and number of participants

	Male	**Female**	**Children(less than 18 years)**
2009 -2010			
2008 –2009			
2007 – 2008			

9) Number of Advocacy programs conducted (Source MIS report – April 2009-March 2010)

	Year 1 Apr-08-Mar-09	**Year 2 Apr-09 to Mar-10**
Family		
Community		
School		
Panchayat		
Sub centre		
PHC		
Hospital		
Zila Parishad		
Public events		
Others		

10) Types of Issues focussed through Advocacy programs

a) ----------

b) ----------

c) ----------

d) ----------

e) ----------

f) ----------

11) Number of cases referred to legal cells in past two years.

12) Nature of issues faced by HIV positive women (legal, social, workplace)

a) ----------
b) ----------
c) ----------
d) ----------
e) ----------
f) ----------
g) ----------
h) ----------

13) Nature of Issues faced by HIV positive Children

a) ----------
b) ----------
c) ----------
d) ----------
e) ----------
f) ----------
g) ----------

14) Types of issues handled in counselling

a) ----------
b) ----------
c) ----------
d) ----------
e) ----------

15) Number of PLHIV/CLHIV counselled – (Source MIS report)

Type of target population	**Year 1** **Apr-08-Mar-09**	**Year 2** **Apr-09 to Mar-10**
Men		
Women		
Children		
Family		

16) Documentation – (collect copies of some good report)

Activities	**Reporting Register maintained and updated 1 Yes 2-No**
Counselling sessions	
Support Group meeting- Agenda, participant sign, minutes	
IEC material developed	
IEC material distributed	
Advocacy program	
Get together	
Photo documentation-	
Written consent for Photos	
Monthly report	
Quarterly report	
Annual report	
EC meeting report	
Success story records	
Positive prevention programme	
Training programmes	

Governance

1) DIC is run by - 1- CBO, 2- DLN, 3-NGO, 4- other ----------

2) Year and Month established - ----------

3) Number of Years of HIV experience- ----------

4) Types of projects handled

a) ----------

b) ----------

c) ----------

d) ----------

5) Dates of last three Executive committee meetings held

Date of EC meeting	Date of the report /minutes available yes/No	Number of members in EC meeting

Finance

1) Access to Funds

Date of Proposal submission	
Date of Agreement Signed	
Date of Funds received- first	
Second instalment	
Third Instalment	

a. Was it timely received or not? ----------

b. Reasons for irregular fund flow ----------

c. What happened when funds did not reach in time ----------

2) Utilization of Funds

a) Utilization Certificate submitted – 1- copy checked , 2- not available

b) Audit report or financial statements- 1- verified, 2- not available

c) Barriers to fund utilization - SACS as well as CBO/NGO view(Qualitative dimension)

3) Systems

Books of Account- cash book ,ledger etc	**1- Manual, 2-Computerised**
(last entry within last three days, entries made in pen, double entry system of ledger, total balanced etc)	1- Updated 2- not updated
Bank Account opened in the name of DIC	1- Yes, 2- No
Payments – staff	1- Cheque 2- cash
Other- rent, events, GM, Advocacy	1- Cheque 2- cash
Cash amount expenditure limits	Rs.

4) Procurement

a) Purchase register - 1) Available 2) Not available

b) Stock register – 1) Available 2) Not available

c) Procurement Policy – 1) Available 2) Not available

d) Challenges - 1) timely receipt of funds
2) Non availability of free condoms
3)
4)

4) Staffing – current status

Name code	**Designation**	**Education**	**Yrs of experience**	**HIV status**

5) Position Vacant

Position	**Duration of vacancy**	**Reason for vacancy**

6) Salary received in time or delayed? Reasons for delay.

---

7) Staff trainings held

Name	Designation	Training topic	From where

4 Areas for staff training suggested by staff

a) ---

b) ---

c) ---

d) ---

e) ---

5 Infrastructure

a) Meeting room – available - 1) Yes 2) No Privacy – adequate - Yes /No

b) Counselling room- available – 1) Yes 2) No 1) separate or 2) partition Size adequate – 1) –Yes 2) No

c) Asset register – 1) maintained and updated 2) not maintained 3) any other method

d) DIC has -

1) computer 2) Printer 3) net connection 4) uses cyber café for reporting
5) other system 6) Almirah 7) Chair 8)Table 9) Fan 10) Cooler
11) TV 12) News paper 13) Other

e) Lighting - adequate 1) Yes 2) No

f) Ventilation - adequate 1) Yes 2) No

Note – The answers to these questions will be generated in part from FGD, discussion with DIC staff and PC. We will have one set of answers per DIC under study for this questionnaire.

Annexure 2: DIC Review Team

FXB India Suraksha				
Team for Review of DICs funded by NACO-UNDP				
Name of the Team Leader	**Name of the Research Officer (RO)**	**State**	**Location of DIC**	**No. of DICs**
Meenal Mehta	Javed Hasan	Delhi	Delhi West	1
			Shadipur	1
		Chandigarh	Chandigarh	1
		Punjab	Amritsar	1
		M.P.	Dewas	1
			Rewa	1
		U.P.	Allahabad	1
			Sub-Total	**7**
	Pankaj Sinha	Ahmadabad	Ahmadabad	3
			Surat	3
			Rajkot	1
			Baroda	1
			Sub-Total	**8**
Arpan Bose	Snigdha Sen	W.B.	Kolkata	2
			Burdwan	1
			Malda	1
			Darjeeling - plains	1
	Samik Ghosh		Purba Medinipur	1
			Uttar Dinajpur	1
			Jalpaiguri	1
		Orissa	Khurda	1
			Sub-Total	**9**
	Marnungla	Nagaland	Kohima	1
			Dimapur	1
			Wokha	1
			Zunheboto	1
			Teunsang	2
			Sub-Total	**6**
C. Lalsang Zuala	Khoi Dinesh	Manipur	Imphal East	1
			Thoubal	1
			Imphal West	1

FXB India Suraksha				
Team for Review of DICs funded by NACO-UNDP				
Name of the Team Leader	**Name of the Research Officer (RO)**	**State**	**Location of DIC**	**No. of DICs**
			Ookhrul	1
			Sub-Total	**4**
	Christina Lalrindiki	Mizoram	Aizwal	4
			Champai	1
			Kolasib	1
			Sub-Total	**6**
Dr. PSKP Raju	Pragjnanand Busi	Andhra Pradesh	East_Godavari	1
			West Godavari	1
			Warangal	1
			Krishna	1
	Ravindra Kumar	Andhra Pradesh	Guntur	1
			Nalgonda	1
			Prakasam	1
			Anantapur	1
			Sub-Total	**8**
Dr. Surya Prakash	Dr.Rohini	Tamil Nadu	Villupuram	1
			Chennai	3
			Theni	1
			Cuddalore	1
	Alfanso	Tamil Nadu	Trichi	1
			Erode	1
			Salem	1
			Karoor	1
			Madurai	1
			Sub-Total	**11**
	Mitali Das	Karnantaka	Udupi	1
			Banglore	1
			Mandya	1
			Koppal	1
			Sub-Total	**4**
	Mathai V D	Kerala	Ernakulam	1
			Kozhikkode	1
			Sub-Total	**2**
Meenal Mehta	Leela Jaiswal	Mumbai (MC)	Mumbai	2
			Sub-Total	**2**

FXB India Suraksha				
Team for Review of DICs funded by NACO-UNDP				
Name of the Team Leader	**Name of the Research Officer (RO)**	**State**	**Location of DIC**	**No. of DICs**
	Pankaj Baghel	Maharastra	Ahmadnagar	1
			Beed	1
			Chandrapur	1
			Hingoli	1
			Nanded	1
			Pune	1
			Raigarh MAHA	1
			Yavatmal	1
			Sub-Total	**8**
	Godeliva	Goa	North Goa	1
			South Goa	1
			Sub-Total	**2**
			Total (All India)	**77**

Annexure 3: Action Plan

Activities	Jun-10				Jul-10					Aug-10				Sep
	5	12	19	26	3	10	17	24	31	7	14	21	28	15
Contracting														
Review of secondary information														
Preliminary visit to selected DICs for inputs in tools														
Development and finalization of tools and checklists														
Inception Report														
Finalization of Data collection plan														
Training of Research Team														
Pilot testing of the Tools														
Primary data collection														
Data Analysis														
Compilation and analysis of findings														
Draft Report														
Workshop on sharing report to NACO														
Incorporation of feedback & comments from UNDP														
Finalization of report and submission to NACO UNDP														
Submission of Printed report to NACO-UNDP														

Annexure 4: DIC Performance Tool

DIC Performance Assessment Tool	
Parameters	**Score**
Infrastructure (Office premises, Sitting space, furniture, adequate privacy)	
Documentation (Registers are maintained since last two years, data availability)	
Governance (Accounting system, Quarterly EC meetings, Staff positions)	
Services Provided (Home visits, Escorting in Emergency,Counseling, Community sensitization. Referral and Linkages)	
Support to Service Centres (ICTCs, ART Centres, Paediatric ART Centres, etc provided support through outreach and tracking of case drop outs)	
Total	

Scale of Service Functioning	
Optimum - 3	
Moderate - 2	
Minimum -1	
DIC Performance	
Outstanding DIC if Score is 300	
DIC working is good if score is 200-299	
DIC working is average if score is 100-199	
DIC needs attention if score is below 100	
Scoring System	
Infrastructure	
Separate room for counseling, Adequate lighting, basic amenities- chair table almirah,fan,clean water, toilet facility, facility for group meeting, IECs	3
Partition for counseling, and basic amenities like meeting room, IEC materials,	2
No privacy , no basic amenities	1
Documentation	
Registers -Drop-in, Services provided, Referral, LFU and Outreach, Reports - Monthly or Quarterly on regular basis for last two years, Success stories and Written consent maintained.	3
Registers -Drop-in, Services provided, Referral, LFU and Outreach, Reports - Monthly or Quarterly on regular basis for last one year	2
Only few registers maintained and Monthly report submitted.	1
Governance	
Regular EC meetings- 1 each quarter and minutes prepared, Books of accounts updated, One staff one post- Board memo not staff ,	3
Accounts -Cashbooks updated but EC meeting irregular ,Board member as DIC staff	2
Accounts -Cashbooks not updated, Board member as DIC staff, no records about EC	1

meeting

Services Provided	
Home visits, Outreach, Community sensitization, Counseling, LFU tracking, Referral and Linkages to more than 60 % of the registered PLHIV in last two years (minimum one service but good if more than one service)	3
Home visits, Outreach, Community sensitization, Counseling, Referral and Linkages to more than 40% of the registered PLHIV in last two years(minimum one service but good if more than one service)	2
Home visits, Outreach, Community sensitization, Counseling, LFU tracking, Referral and Linkages to less than 25% of the registered PLHIV in last two years	1

Annexure 5: States Comparison - Summary of DIC Services

STATES	AP	CHAN	DEL	GOA	GUJ	KAR	KER	MP	MAHA	MANI	MIZO	NAGA	ORI	PUN	TN	UP	WB
NUMBER OF DICs	**8**	**1**	**2**	**2**	**8**	**4**	**2**	**2**	**1**	**4**	**6**	**6**	**1**	**1**	**11**	**1**	**8**
Counselling Per And Family	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Get Together	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	90 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Home Visits	100 %	100 %	50 %	100 %	100 %	100 %	1	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Outreach	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	90 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Referral Linkage ART	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	91 %	100 %	100 %
Advocacy	100 %	100 %	100 %	100 %	100 %	75 %	100 %	50 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Referral Linkage ICTC	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	91 %	100 %	75 %
Escort To Hospital	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	80 %	100 %	100 %	83 %	100 %	100 %	100 %	0%	100 %
Community Awarenes s And Education	100 %	100 %	100 %	100 %	100 %	100 %	100 %	50 %	100 %	25 %	67 %	83 %	100 %	100 %	100 %	0%	100 %
Referral Linkage PPTCT	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	90 %	75 %	100 %	100 %	100 %	100 %	64 %	100 %	75 %
Referral Linkage TB	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	80 %	100 %	100 %	100 %	100 %	100 %	55 %	100 %	88 %
Support Group Meeting	63 %	100 %	100 %	100 %	88 %	75 %	100 %	100 %	90 %	50 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Referral Linkage health	100 %	100 %	100 %	100 %	88 %	100 %	100 %	100 %	90 %	75 %	100 %	100 %	100 %	100 %	100 %	0%	38 %
Referral	100	100	100	100	100	100	100	100	70	75	100	100	100	100	55	100	75

STATES	AP	CHAN	DEL	GOA	GUJ	KAR	KER	MP	MAHA	MANI	MIZO	NAGA	ORI	PUN	TN	UP	WB
NUMBER OF DICs	**8**	**1**	**2**	**2**	**8**	**4**	**2**	**2**	**1**	**4**	**6**	**6**	**1**	**1**	**11**	**1**	**8**
Linkage STD	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Referral Linkage nutrition	100 %	100 %	50 %	100 %	88 %	100 %	100 %	100 %	80 %	25 %	100 %	100 %	0%	100 %	100 %	0%	25 %
Matrimonial Coordination	75 %	100 %	100 %	100 %	100 %	100 %	50 %	0%	60 %	0%	67 %	83 %	100 %	100 %	100 %	100 %	100 %
Referral Linkage Ped ART	88 %	100 %	100 %	100 %	88 %	100 %	100 %	100 %	80 %	100 %	100 %	0%	0%	100 %	64 %	0%	50 %
Referral Linkage livelihood	88 %	100 %	50 %	100 %	75 %	100 %	100 %	50 %	70 %	0%	100 %	100 %	0%	100 %	91 %	0%	13 %
Referral Linkage transport	88 %	100 %	100 %	100 %	63 %	100 %	50 %	50 %	70 %	25 %	100 %	100 %	0%	100 %	91 %	0%	13 %
Referral Linkage TI	38 %	100 %	100 %	50 %	100 %	100 %	100 %	0%	70 %	75 %	100 %	83 %	0%	100 %	45 %	0%	13 %
Skill Development Training	88 %	100 %	0%	100 %	100 %	50 %	100 %	50 %	30 %	0%	0%	67 %	100 %	100 %	82 %	100 %	75 %
Referral Linkage PDS	50 %	100 %	100 %	100 %	75 %	100 %	100 %	0%	60 %	0%	17 %	83 %	0%	100 %	45 %	0%	0%
IGA Support	0%	0%	50 %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nutritional Support	0%	0%	50 %	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Referral Linkage CCC	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	13 %

Annexure 6: PLHIV Enrolment at DIC state update

STATE	Mean	Median	Minimum	Maximum	Mode	Sum
AP	2,258	1,920	1,227	4,406	1,227	18,066
CHAN	502	502	502	502	502	502
DEL	475	475	258	692	258	950
GOA	866	866	773	958	773	1,731
GUJ	1,718	1,026	514	6,391	514	13,745
KAR	1,321	1,239	840	1,965	840	5,283
KER	323	323	308	337	308	645
MP	249	249	165	332	165	497
MAHA	1,078	776	539	3,461	539	10,781
MANI	555	584	361	691	361	2,219
MIZO	235	196	93	469	93	1,408
NAGA	278	207	106	684	106	1,668
ORI	275	275	275	275	275	275
PUN	260	260	260	260	260	260
TN	1,597	929	336	6,261	336	17,571
UP	778	778	778	778	778	778
WB	362	349	11	699	11	2,892
COM	**1,029**	**691**	**11**	**6,391**	**199**	**79,271**

Annexure 7: PLHIV Registered Vs Reached

STATE	NUMBER OF DICs	Registered In DIC	Total PLHIV In District	% OF PLHIV REGISTERED IN DICs	Regular Outreached By DIC	% OF REGISTERED PLHIVs REGULARLY OUTREACHED BY DICS	Average Distance
AP	8	3175	25505	12%	489	15%	71.50
CHAN	1	537	2141	25%	240	45%	3.50
DEL	2	475	NA.		279	59%	9.00
GOA	2	866	1195	72%	1252	145%	42.50
GUJ	8	1176	11355	10%	1385	118%	45.00
KAR	4	1548	8736	18%	864	56%	33.75
KER	2	323	1442	22%	117	36%	34.00
MP	2	176	122	144%	99	56%	130.00
MAHA	10	1137	5931	19%	35	3%	70.00
MANI	4	555	3884	14%	13	2%	15.00
MIZO	6	1506	2700	55.7%	840.	56%	14.33
NAGA	6	278	1139	24%	240	86%	95.67
ORI	1	276	726	38%	NA		50.00
PUN	1	260	3938	7%	NA		40.00
TN	11	1556	9388	17%	NA		55.91
UP	1	778	806	97%	63	8%	35.00
WB	8	362	.NA		NA		25.00
COM	**77**	**1152**	**8461**	**14%**	**443**	**38%**	**49.40**

Annexure 8: State Comparison – ART Enrolment

Total Number of PLHIV on ART in DIC(Total)						
STATE	**Mean**	**Median**	**Minimum**	**Maximum**	**Mode**	**Sum**
AP	702	568	2	2,285	2	5,617
CHAN	349	349	349	349	349	349
DEL	265	265	250	280	250	530
GOA	233	233	182	283	182	465
GUJ	401	419	268	564	268	3,209
KAR	332	333	149	514	149	1,329
KER	150	150	148	152	148	300
MP	134	134	98	169	98	267
MAHA	288	239	5	659	5	2,884
MANI	228	238	153	285	153	913
MIZO	105	95	31	188	31	525
NAGA	81	45	13	231	13	486
ORI	59	59	59	59	59	59
PUN	129	129	129	129	129	129
TN	875	421	196	4,175	196	9,623
UP	112	112	112	112	112	112
WB	162	126	77	330	77	1,292
COM	**370**	**245**	**2**	**4,175**	**153**	**28,089**

Annexure 9: State Comparison – Pre ART Registration

Total No of Pre ART in DIC (Total)						
STATE	**Mean**	**Median**	**Minimum**	**Maximum**	**Mode**	**Sum**
AP	884	766	21	2,078	21	7,070
CHAN	150	150	150	150	150	150
DEL	255	255	68	442	68	510
GOA	512	512	432	591	432	1,023
GUJ	404	434	140	598	140	2,826
KAR	661	653	181	1,157	181	2,644
KER	137	137	88	185	88	273
MP	89	89	67	110	67	177
MAHA	394	310	10	855	10	3,939
MANI	172	111	74	393	74	688
MIZO	114	68	42	281	42	570
NAGA	145	134	2	337	2	725
ORI	119	119	119	119	119	119
PUN	101	101	101	101	101	101
TN	678	512	87	2,086	87	6,777
UP	186	186	186	186	186	186
WB	239	224	122	398	122	1,673
COM	**409**	**242**	**2**	**2,086**	**21**	**29,451**

Annexure 10: Individual DIC Scores

State	District	Assessment Parameter				
		Infrastructure	**Documentation**	**Governance**	**Services**	**Total Score**
Weight		**5%**	**10%**	**15%**	**70%**	
North						
Chandigarh	Union teritory	**10**	**20**	**30**	**140**	**200**
Delhi	West	**10**	**20**	**30**	**140**	**200**
	Central	**10**	**30**	**30**	**140**	**210**
MP	Dewas	**15**	**30**	**15**	**210**	**270**
	Rewa	**15**	**20**	**45**	**210**	**290**
Punjab	Amritsar	**10**	**20**	**30**	**140**	**200**
UP	Allahabad	**15**	**10**	**45**	**140**	**210**
South						
AP	East Godavari	**15**	**30**	**45**	**140**	**230**
	West Godavari	**15**	**30**	**45**	**140**	**230**
	Warangal	**15**	**30**	**45**	**140**	**230**
	Krishana	**10**	**20**	**30**	**140**	**200**
	Guntur	**10**	**30**	**45**	**140**	**225**
	Nalgonda	**15**	**15**	**30**	**140**	**200**
	Prakasam	**10**	**20**	**30**	**140**	**200**
	Anantapur	**15**	**30**	**30**	**140**	**215**
Karnataka	Banglore	**10**	**20**	**30**	**140**	**200**
	Udupi	**15**	**20**	**30**	**140**	**205**
	Mandya	**10**	**20**	**45**	**210**	**285**
	Koppal	**15**	**20**	**45**	**210**	**290**
Kerala	Ernakulam	**10**	**20**	**30**	**140**	**200**
	Calicut	**10**	**20**	**30**	**70**	**130**
Tamilnadu	Villupuram	**15**	**30**	**45**	**210**	**300**
	Chennai	**15**	**20**	**30**	**210**	**275**
	Chennai	**15**	**30**	**45**	**210**	**300**
	Chennai	**15**	**30**	**30**	**210**	**285**
	Erode	**10**	**20**	**30**	**210**	**270**
	Trichi	**15**	**20**	**45**	**210**	**290**
	Cuddalore	**15**	**30**	**30**	**210**	**285**

State	District	Assessment Parameter				
		Infrastructure	Documentation	Governance	Services	Total Score
Weight		5%	10%	15%	70%	
	Selam	15	30	45	210	300
	Madurai	10	20	30	140	200
	Theni	10	30	30	210	280
East						
Manipur	East Imphal	10	20	45	140	215
	West Imphal	10	20	30	140	200
	Thoubal	10	30	30	210	280
	Ukhrul	10	20	30	140	200
Mizoram	Aizwal-	10	10	50	140	210
	Aizwal-	10	10	30	140	190
	Aizwal-	10	10	50	140	210
	Aizwal-	10	10	50	140	210
	Champai	10	10	30	210	260
	Kolasib	10	10	30	140	190
Nagaland	Kohima	10	20	30	140	200
	Dimapur	15	20	30	140	205
	Wokha	10	10	30	140	190
	Zunheboto	10	10	30	140	190
	Tuensang	10	10	30	140	190
	Tuensang	10	10	30	140	190
West Bengal	Kolkatta	15	30	45	140	230
	Kolkatta	15	20	15	140	190
	Burdwan	15	10	30	140	195
	Darjeeling Plain	15	20	45	140	220
	Maldah	15	20	30	210	275
	Purba Medinipur	15	20	45	210	290
	Uttar Dinajpur	15	30	30	210	285
	Jalpaiguri	15	20	30	140	205
Orissa	Khurda	15	30	30	140	215
West						
Gujrat	Ahamadabad-Bapu nagar-Network	15	20	45	140	220
	Ahamadabad-NGO run in Asarwa	10	30	30	210	280

	Ahamadabad-Bapu nagar-NGO run	10	30	45	210	295
	Surat-Medical College	15	30	30	210	285
	Surat-Bombay market	15	30	30	210	285
	Surat-Civil Hospital	10	30	45	210	295
	Vadodara	10	20	30	140	200
	Rajkot	15	30	75	180	300
Goa	South Goa	15	30	45	140	230
	North Goa	10	30	45	140	225
Maharashtra	Ahmadnagar	15	20	30	140	205
	Beed	15	20	30	140	205
	Chandrapur	10	10	15	70	105
	Hingoli	15	20	30	140	205
	Mumbai-Kurla	15	20	30	140	205
	Mumbai-Andheri	15	20	30	140	205
	Nanded	10	20	30	140	200
	Pune	15	20	30	140	205
	Raigarh	10	20	30	140	200
	Yavatmal	10	20	30	140	200