Availability and Accessibility of Care, Support &Treatment Services Available For People Living With HIV/AIDs in Hyderabad

A dissertation submitted in partial fulfillment of the requirements

for the award of

Postgraduate Diploma in Hospital and Health Management

By

Dr. Niharika Mohapatra

Roll No.PG/09/027

International Institute of Health Management Research

New Delhi

April,2011

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Under the guidance of

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New Delhi

April, 2011

Certificate of Dissertation Completion

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Dr. Niharika Mohapatra has successfully completed her 3 months internship in our organization from January 6, 2011 to April 6, 2011. During this internship she has worked on Mother NGO scheme under Regional Resource Center project under the guidance of me and my team at HLFPPT, Hyderabad, Andhra Pradesh.

She proves her efficiency through her sincerity. She is hard working .

We wish her good luck for her future assignments.

Ms.Sunita Arora
Senior Program Manager
HLFPPT

Certificate of Approval

The following dissertation titled "**Availability and accessibility of Care, Support and Treatment service available for PLHA in Hyderabad** " is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
_____	_____
_____	_____
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Certificate from Dissertation Advisory Committee

This is to certify that Dr. Niharika Mohapatra , a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled "**Availability and Accessibility of Care, Support and Treatment Service available for PLHA in Hyderabad**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**. This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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ABSTRACT

AVAILABILITY AND ACCESSIBILITY of CARE,SUPPORT &TREATMENT SERVICES AVAILABLE FOR PLWHA IN HYDERABAD

By

Dr. Niharika Mohapatra

Background:- The overall goals of NACP-III is to halt and reverse the epidemic in India over the next five years by integrating programmes for ***prevention, care and support and treatment***. Care, support and treatment (CST)services are Diagnosis of HIV,ARV treatment, Opportunistic Infections diagnosis and treatment, Psychological support, Nutritional support, Travel and vocational support.

Andhra Pradesh ranks second among the five high HIV prevalence states i.e. AP, Karnataka, Maharashtra, Manipur and Tamilnadu as per NFHS-III. Only Manipur has a higher HIV prevalence rate than Andhra Pradesh. Prevalence rate of HIV in Hyderabad was 2.00 % in 2005 -06 and now it is 1.13% as per district wise HIV prevalence in ANC report (2002-2008). In spite of the downward trend, there is no room for complacency as the State has high population of high risk group (HRG) . Saturated coverage of HRGs, scaling up of preventive services, community led structural intervention, linkage of positive HRGs with ART services will contribute good bang in bringing down the prevalence rate. Another important factor is the widespread distribution of condoms. As prevention is better than cure, the A.P. State AIDS Control Society (APSACS) has primary focus is to prevent HIV transmission among the HRGs. Hyderabad is one of famous business hub and hi-tech city. Andhra Pradesh has highly floating population for business and higher studies.

Apart from creating awareness on HIV/AIDS and modes of transmission, it is imperative to equip all the departments concerned to have the complete information on the availability of various services in Hyderabad(AP) with high prevalence rate of HIV/AIDS. The major drive for access of quality care, treatment will be possible by spreading awareness about the available services.

Objective:- To appraise the availability and delivery of quality care and treatment services for people living with HIV/AIDS through a three-tier structure of NACO at Hyderabad

Scope: Scaling up of care support and treatment is the main component of NACP-III. Optimal use of available resources with proficient strategy we can increase the lifespan of PLHA more than 15 years by providing quality health services (care support and treatment).

Methodology:- The study analysis is based on qualitative data. Both Primary and secondary data has been collected for this study. The secondary data source is Government reports like NACO and APSAC report, Publications of NGO reports and articles. The secondary data will be base for the qualitative analysis. The primary data source is randomly selected ART centre, ICTC, PPTCT from the list of DSAC, Hyderabad which is purposive. As it is a qualitative study, in-depth interview was conducted by the structured open ended questionnaires with different stake holders such as PLHA community and healthcare service providers.

Conclusion: - As we have seen in findings, it is not only matter of availability and accessibility of CST services for PLHA but also there should be good link, communication mechanism with community, family members and NGOs as well as support to PLHA and their family members. Because lack of that care, support may shape the HIV care related trajectories worse for PLHA.

There is need to establish better monitoring and support mechanisms for drug adherence at ART centers. Because PLHA from some community are migrant and they have no identity. Some are hiding population due to social discrimination. They have no specific corresponding address. There should be some better tracking/follow up system like unique identity card or swipe card .Referral linkages among NGO - TI, STD clinics need to improve with ICTC and in turn with ART centers. Without adequate patient preparation and support we may compromise in the success of care, support and treatment service program. Yet the systems for treatment adherence and monitoring are still not in place. We should have special focus on tracking or follow up and management of psycho-social issues of PLHA.

Lastly, the programme needs to look beyond HIV and AIDS, to make its prevention efforts more successful as well as to reduce the impact on the affected.

ACKNOWLEDGEMENTS

It is immensely gratifying to finally come-up with my dissertation report..Since joining on January ,it has been a wonderful journey and an enlightening experience at Hindustan Latex Family Planning Promotion Trust (HLFPPT). I take this opportunity with much pleasure to thank all the people who have helped me through the course of my journey towards producing this thesis. I express my gratitude to all participants in this study for sharing their experiences and insights with me. In spite of my routine work as project officer, RRC, Hyderabad, I had support from colleague at HLFPPT to complete my dissertation in time. I sincerely thank my Organisation Mentor Ms.Sunita Arora and Ms.Preeti B.Upadhaya Programme Manager, HLFPPT for their guidance, help and motivation. I would like to express my gratitude to the other members of HLFPPT for guidance in my project work specially to.

I would like to express my gratitude to Dr. Shubhra Phillips, Head-Technical Service Division, and HLFPPT for involving and encouraging me in a Study of ***Acceptability of Extra Lubricated Condoms among MSM*** which is a study of Govt. for social marketing.

My special thanks and gratitude to Dr. G. Sreedhar, DPM, Hyderabad for giving permission for this study.

I am also thankful to my mentor Dr. S.K.Patel, Asst. Professor, IIHMR for his kind consideration, motivation and guidance in my project and throughout my course at IIHMR. This study is a good team effort with my friends and colleagues. A special thanks to K.Balakrishna and Marry Augustine, HLFPPT for their assistance in coordinating data collection during the study. I would also like to thank IIHMR Dean Dr. Rajesh Bhalla and faculty Dr. Ash Pachauri and Dr.Sumant Swain sir for their immense support and encouragement.

Finally this is all possible due to grace of Almighty Lord Jagannath.

Dr.Niharika Mohapatra
PGDHHM,2009-2011
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ACRONYMS

AIDS	Acquired Immune -Deficiency Syndrome
ANC	Antenatal Clinics
ART	Anti retroviral Therapy
CCC	Community Care Center
COE	Center of Excellence
CST	Care Support and Treatment
FSW	Female Sex Worker
HRG	High Risk Group
HIV	Human Immune-Deficiency Virus
HLFPPT	Hindustan Latex Family Planning Promotion Trust
IDU	Injecting Drug User
ICTC	Integrated Counseling Testing Centers
LAC	Link ART Center
LFU	Lost to Follow Up
MS M	Men who have Sex with Men
NACP	National AIDS Control Programme
NACO	National AIDS Control Organization
NFHS	National Family Health Survey
NGO	Non –Governmental Organization
OI	Opportunistic Infection
PLHA	People living with HIV and AIDS
PPTCT	Prevention of Parent to Child Transmission
RCH	Reproductive and Child health
SACS	State AIDS Control Society
STD	Sexually Transmitted Disease
TI	Targeted Intervention
TG	Trans Gender

HINDUSTHAN LATEX FAMILY PLANNING PROMOTION TRUST

1.1 PROFILE

Hindustan Latex Family Planning Promotion Trust was established and promoted by Hindustan Latex Limited (HLL, a Public Sector Undertaking) since 1992. HLFPPT has grown as a social enterprise with more than five hundred employees.

Hindustan Latex Family Planning Promotion Trust (HLFPPT) has been supporting implementation of Reproductive Child Health (RCH) and HIV prevention and care programs across eleven states in India. HLFPPT has established partnership with the Ministry of Health and Family Welfare (MOHFW), state governments of Andhra Pradesh, Bihar, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, North Eastern States, Orissa, Rajasthan, Uttaranchal and Uttar Pradesh for implementing intensive programmes that reach millions of women and families. Besides, HLFPPT programmes are supported by Department for International Development (DfID), European Commission (EC), United States Agency for International Development (USAID), OXFAM, Norway India Partnership Initiative (NIPI) and Bill and Melinda Gates Foundation (BMGF) among others.

MISSION

Offer innovative and affordable health solutions, globally, that empower communities address their health challenges and vulnerabilities.

VISION

Touching Lives with Quality Care, Compassion and effective services.

BELIEFS

- **G –** Good governance
- **R** – Respect
- **E** – Excellence
- **A** – Accountability
- **T** – Trust & Transparency

1.2 DIVISIONS

There are six divisions in HLFPPT to run all health programs.

1. ***Social Marketing and Franchising division***:-

   This is a well established Social Marketing and Franchising Division with strength of more than four hundred professional staff across eleven states of the country. We are focused on leveraging the private sector and establishing efficient public-private partnerships, focusing on maximum benefits for people at the 'Bottom of the Pyramid'.

2. ***HIV/AIDS: Prevention, treatment and care***

   The specialized HIV-AIDS division has the strength of approximately, 80 highly dedicated and professionally qualified staff in Andhra Pradesh, Madhya Pradesh, Rajasthan, Uttar Pradesh and Chhattisgarh.

3. ***Technical services division***

   The Technical Services Division (TSD) consists of a dynamic team of doctors, paramedics, public health professionals, social workers, management executives and researchers, who have lent technical expertise to organizations like OXFAM, Norway India Partnership Initiatives (NIPI), ECTA, SCOVA and DFID among others. We are widely recognized for consultations and services in quality management and technical assistance to programs in RCH, MCH, and HIV-AIDS.

4. ***Finance Division***

   HLFPPT has a robust team of Financial Management Experts and Chartered Accountants as an integral part of all programs. We believe in building a strong monitoring and Financial Control System ensuring transparency and accountability to all our stakeholders.

5. ***Human Resource and Administration division***

   The HR and Administration Division are fundamental to all our operations. All our policies and systems are ensured to be people-centric and build enabling environments to assure a highly result oriented workforce.

6. ***Knowledge Management Division***

   To achieve the Millennium Development Goals (MDG), **Knowledge Management Division (KMD)** at HLFPPT aims to strengthen health infra-structure and human

resources. KMD facilitates the process of organizational learning as a forum for resource support and intends to strengthen the programme interventions on HIV/AIDS, RCH and Public Health, through training and capacity building, information sharing, analysis, research and documentation. KMD is conducting Training Need Assessment among organizations of varied background to plan for customized training programmes covering diverse needs of the organizations working in the health and development sector. Please find enclosed the **Performa on "Training and Capacity Building Needs"**, which will enable HLFPPT to understand the training and technical requirements of your organization. Knowledge management division is being strategised with the sole aim of converting the learning accrued over a decade of HLFPPT's work, towards continuous and sustained development of its own internal human capital and also to make an effective influence on the policy making process undertaken by governments and policy makers.

1.3 ACTIVITIES

- **Reproductive and child health** : *Preserving lives with quality care*
- **HIV/AIDS care treatment and support** : *Protecting lives with pioneering solutions*
- **Public Health Consulting** : *Nurturing lives with compassion forever*

A. Reproductive and Child Health

In a growing economy like India the need to accelerate efforts for the improvement of Reproductive and Child Health statistics has been the foremost agenda of Millennium Development Goals (MDG) 4 & 5. In an effort to strengthen work that impacts the national RCH indicators, HLFPPT has initiated various Family Planning, Maternal and Child Health and Newborn Care Programs which are working hand-in-hand with national policies like National Population Policy, Reproductive and Child Health Program, National Rural Health Mission, and the Tenth and Eleventh Five Year Plans.

1) Family Planning
2) Maternal and Child Health Programs
3) Nishchay
4) Sankalp

1) **Family Planning :-**

❖ **Rural social marketing program**

HLFPPT undertook its premier Family Planning Program of Uttar Pradesh with the SIFPSA supported 'Sukhi Sansar' Project which is involved in the Social Marketing of Deluxe Nirodh Condoms, and Mala-D Oral Contraceptive Pills in Rural Uttar Pradesh. Over the past eleven years the Rural Social Marketing Program has developed a Direct Distribution System of condoms in over 25,000 villages in the 'C' and 'D' categories in the State which has resulted in a substantial increase in the sale of condoms. The success of this project encouraged us to undertake the following projects in Uttar Pradesh.

❖ **Community Based Social Marketing Program**

HLFPPT has been immensely successful in creating awareness about the importance of Family Planning. The Community Based Social Marketing Program undertaken in Bihar, Jharkhand & Orissa - boasts of the following achievements.

Table-1

States	Districts Covered	No. of Villages	Tarang Partners	Condoms Marketed	OCPs Marketed	Village re-presentation	Rural population
Bihar Since 2001	Patna, Vaishali, Saran, Samastipur	4200	2125	11 milli	952,640 Lac Jharkhand Since 2001	70%	80%
Jharkhand Since 2001	Ranchi, Hazaribagh, Gumla and Lohardhaga	3143	2000	10 million	958,000 Lac	65%	85%

Orissa since 2001	Khurdah, Nayagarh, Ganjam and Phulbani (Kandhamaal)	2125	900	6.4 million	445,000 Lac	56%	75%

Our organization has been implementing the Social Marketing Program supported by NACO in four Indian states. The chart below explains the rate of success achieved through this program.

Table-2

States	**Bihar**	**Jharkhand**	**Orissa**
Number of districts covered	11	11	3
Number of villages covered	6000	5000	1200
Number of outlets	8000	6000	1500
Condoms marketed	5.8 million	5.5 million	5.6 million
Oral Contraceptives marketed	1.5Lac	1.2Lac	0.8Lac
Stockists	28	22	7
Retailers	6400	8000	600
Helped by	2 Area Managers, 25 Field Sales Officers and 12 promotion staff	3 Area Managers, 22 Field Sales Officers and 15 promotion staff	2 Area Managers, 3 Field Sales Officers and 6 promotion staff

❖ **Network based social marketing program,Andhra Pradesh**

HLFPPT commenced operations in Andhra Pradesh in 1999 with the implementation of the State Management Agency (SMA) for APSACS. And in 2000, HLFPPT started the Andhra Pradesh Social Marketing Program (APSMP) with funding from the Government of India. This Program worked on the Social Marketing of Contraceptives in order to increase awareness of Family Planning. This was followed up with a second phase of APSMP which ran from 2004 to 2007 and worked exclusively in over 10,000 villages.

The Trust has created and nurtured a network of RMPs in the State known as 'Tarang Network' whose members are called 'Tarang Partners'. Internal research has confirmed that the RMP is the first source of information, counseling and treatment for all ailments in the village, this being especially true where access to an MBBS qualified doctor is rare. Thus, the RMP acts as a very strong influence of people's behavior when it comes to health and health care in villages.

2) Maternal and Child Health Programs :-

❖ **Marigold Health Network (social franchising)**

Merry gold Health Network aims at creating access to low cost good quality Maternal and Child Health (MCH) services by networking with Private health service providers as franchisees. The project has a hub and spoke design with Level 1 franchisees (Merry gold) established at district levels as the hub connected to level 2 and level 3. Level 2 comprises of fractional franchisees (Merry silver) established at subdivision and block level. Level 3 (MerryAYUSH) comprises of providers like ANMs, ASHA and AYUSH and acts as first point of contact with the community as also referral support to Merry silver and Merry Gold hospitals. Emphasis is on affordable pricing, quality assurance, customer servicing and efficient service delivery through standardized operating protocols. IT enabled Hospital Management Information System (HMIS) is also being established. A team of public health and clinical professionals facilitates capacity building and quality assurance. Integrated Health Insurance policy for coverage of risk during maternity has been introduced, a branded pharmacy and chain of diagnostic facilities is also being strategized. State government has

accredited Merrygold hospitals for Janani Suraksha Yojana and Sowbhagyavati Scheme to provide free of cost RCH services and emergency obstetric care.

- **Kanpur Voucher Scheme**

HLFPPT is the implementing partner for this USAID project which provides free health care vouchers to people living Below the Poverty Line (BPL) in urban slums which can be exchanged for free Maternal and Child Health Services in accredited private facilities/hospitals.

- **Sehat ki Sawari (**Mobile Health Vans, Uttaranchal)

Mobile Health Clinics were introduced as an easily accessible health care tool in the absence of primary health care delivery services. The aim was to provide remote and under-served communities with quality Reproductive and Child Health services.

The Mobile Health Clinic Project initiated by the Government of Uttaranchal was piloted in Chamoli District in 2004. Following the success of this endeavor the UAHFS (Uttaranchal Health and Family Welfare Society) decided to undertake a similar Project in Tehri Garwal District in 2005. The health van and the MHC team follow well planned routes that take them to stations of a Fixed Service Delivery Point for a day and then move to the next Delivery Point in the evening. The MHC operates in two cycles.

- Day 1-12: Cycle 1
- Day 16-27: Cycle 2

The MHC follows a 'fixed date' approach for its operation irrespective of the day including Sunday.

3) Nishchay-(Home based Pregnancy Test Card)

Nishchay home based pregnancy test cards were introduced through ASHA workers in all states and union territories of the country by HLFPPT with funding support from National Rural Health Mission (NRHM). Family Planning (FP) and Maternal and Child Health (MCH) programmes, for decades have been struggling with primarily three issues, low percentage of women going for Ante Natal Care (ANC) in first trimester due to late detection of pregnancy, contraceptive provisioning not started after ruling out pregnancy, very high

number of unsafe abortions due to late detection of pregnancy. This nationwide program was hence rolled out to address them and make this home based pregnancy testing technology available to rural women free of cost with appropriate information. Various state/district level NGOs and CBOs are an integral part of the programme for provisioning of training and monitoring support. Raising community awareness is the key approach of the program. Important activities include capacity building of ASHAs through resource persons with field and NGO experience, brand and logo visibility using mass media campaign, community outreach activities using mid -media campaign, and integrating the card into the monitoring system of NRHM/RCH-II. Project Nischay is thus, not an end but a means towards safe motherhood and healthy families.

HIV/AIDS care treatment and support

The rise in the HIV-AIDS epidemic and its overlapping nature with issues related to sexuality and reproductive health have led the organization to initiate efforts to combat this critical health challenge. As a result HLFPPT partnered with the Bill and Melinda Gates Foundation (BMGF), National Aids Control Organization (NACO), Department For International Development (DFID), USAID and various other State AIDS Control Societies in implementing a gamut of community based HIV/AIDS interventions, that aim to reach out to the most vulnerable and high risk population in four states in India.

- **TECHNICAL SUPPORT UNIT**

The Technical Support Unit provides techno-managerial assistance throughout the project management cycle to NGOs and prisons across the State of Andhra Pradesh and Madhya Pradesh for Prevention of HIV through Targeted Interventions. The major groups covered under this Unit are sex workers, MSM, street children, migrants, truckers and workplace interventions. The Project follows the Targeted Intervention strategy of the National AIDS Control Program under the Third Phase.TSU also facilitates and supports Regional Resource Center(RRC) of two states AP,HP for Mother NGO scheme (MNGO).

- **Regional Resource Center**

HLFPPT (RRC-AP) implementing **MNGO scheme** from the year 2004-05, making a difference to the communities in RCH by working with NGOs and CFW to increase access to RCH services .RRC-AP functioned as a management & support agency and addressing the issues with state for effective utilization of services from service providers, HLFPPT with its effective internal resources through its TSD . MNGO scheme is a program content towards strengthening GO-NGO partnership and service in un-served and underserved areas for vulnerable populations. HLFPPT is identified as RRC for Reproductive and Child Health in Andhra Pradesh and Himachal Pradesh by GoI for implementation of MNGO scheme.

Key Service Areas

- ✓ Maternal And Child Health (MCH)
- ✓ Adolescent Reproductive and Sexual Health (ARSH)
- ✓ Family Planning (FP)
- ✓ Prevention and Management of RTI/STI

- **SWAGATI**

HLFPPT has been implementing the 'Swagati' Program for HIV prevention among the most vulnerable populations in nine coastal districts of Andhra Pradesh with support from the Bill and Melinda Gates Foundation (BMGF). This program covers 30,000 sex workers and 10,000 MSM (Men who have Sex with Men) population in the State. This program has set up 85 STI clinics for providing quality Sexually Transmitted Infection (STI) treatment to the vulnerable population and has developed a network of 200 Civil Society Organizations.

- **MAHARASHTRA CONDOM SOCIAL MARKETING PROGRAM**

Maharashtra is a high burden state of India that reports over one fifth of the total HIV cases in the country (Behavior surveillance Survey, 2006). HLFPPT is implementing Maharashtra Condom Social Marketing Project (MCSMP) with support from USAID as a generic condom promotion campaign in high risk areas of 22 districts of Maharashtra.

The program is being implemented with the aim of significantly halting and reversing HIV/AIDS infections by ensuring, 100% condom usage in all unprotected sex acts. In year the 2007-08 approximately 21,000 Non-Traditional Outlets (NTO) have been mapped for targeted distribution. We have trained 7500 NTO personnel, of which around 5000 NTOs have started stocking condoms, which is an encouraging development.

These initiatives have created the desired impact which shows on the condom market in the state which has hit the growth trajectory as seen in the ORG Retail Audit Report of the last two years. This program is scheduled to continue up to 2011. HLFPPT has a dedicated team of 25 Field Officers, five supervisors and five managers for efficiently implementing the targeted intervention program in Maharashtra.

- **FEMALE CONDOM**

Starting in September 2006 with funding support from DFID, HLFPPT implemented female condom (FC) social marketing study in Andhra Pradesh. FC was socially marketed at a price of 5 Rupees to the target population, Female Sex Workers (FSWs). FC was introduced with the support of three key partners in the state - Andhra Pradesh State AIDS Control Society (APSACS), the Bill and Melinda Gates Foundation (BMGF) and the Alliance. In December 2007 a final impact assessment was conducted. As an outcome of this pre-programming assessment study, NACO has decided to scale up the FC program in India in four states amongst Targeted Intervention NGOs working with FSWs with an additional procurement of 1.5 million Female Condoms. NACO has placed an indent on HLL, which has recently set up a factory to manufacture female condoms, making India the only country in the world to manufacture female condoms and market it too in the country.

- **COMMUNITY CARE CENTERS**

Community Care Centers have been designed and established to reduce HIV related morbidity and mortality in adults and children and reduce the impact of HIV on children and women headed households. These centers are a bridge between the community and the hospital providing comprehensive care to PLHA with special emphasis on nutrition and drug

adherence. With support from PACT (Promoting Access to Care and Treatment) initiative of Global Fund Round VI, HLFPPT is committed to establish 24 such centers in Madhya Pradesh, Uttar Pradesh and Rajasthan through Population Foundation of India (PFI).

- **WORKPLACE INTERVENTION: Andhra Pradesh, Orissa**

  HLFPPT has initiated a consultation process with the Government of Andhra Pradesh and the industries on workplace intervention in the state. A baseline survey was conducted among 12 industries/workplaces belonging to processing, manufacturing, hospitality, and transportation and service industries in both the public and private sectors. We conducted a workshop at Hyderabad to share the survey findings and facilitate preparation of operation module for workplace intervention in industries according to size, shape and scale of the industries.

- **HIV/AIDS PREVENTION AND CARE PROGRAM FOR RURAL AND TRIBAL YOUTH IN INDIA**

This Program is aimed at providing appropriate information about HIV/AIDS prevention and care among the rural and tribal youth in India. This program has facilitated the exchange of information and services regarding reproductive and sexual health and HIV/AIDS to 250,000 – 300,000 schools in 4 districts of Orissa and 2 districts of Rajasthan by November 2007.

This Program is a consortium-based approach for implementation where various partners like OXFAM, HLFPPT, IIHMR and CRHC play a vital role. The component of research has been handled by IIHMR. OXFAM plays the role of lead partner, CRHC functions as a coordinating agency for implementation partners while HLFPPT has a role of conducting CBNA of partners, formulating a communication strategy that will help involve youngsters in an effective way.

Public Health Consulting

Over the years HLFPPT has lent its expertise to organizations like OXFAM, Norway India Partnership Initiatives (NIPI), ECTA, SCOVA and DFID

among others. It is recognized across the country for services in consultation, quality management and technical assistance to programs in RCH, MCH, HIV-AIDS and other Health Systems

1.4 My Role

The Project officer will be responsible for developing linkage between Government Officials and NGOs operational in respective state. The position will also act as link between various stakeholders outside the project and connect them with project goals, objectives and activities. My responsibilities:

- Planning, implementing and monitoring of RCH strategies and activities, especially for NGOs operational in the State.
- Organizing monthly meeting with the key stakeholders.
- Prepare minutes of the meeting and share with all the members and ensure its compliance and adherence
- Developing training schedule/calendar by collating the training needs.
- Coordinating state level activities, organise workshop
- Providing periodic supportive supervision to the NGOs.
- Ensuring flow of funds to the respective NGOs as per the budget projections and agreed installments.

I had made contacts with Government officials in Andhra Pradesh. When I had gone to meet the Principal Secretary, Ministry of Health and Family Welfare of AP, Mr.P.V. Ramesh (IAS) Garu , I was surprised to see such a higher and busy official face to face. The way he expressed his interest in supporting me for the RRC program was very overwhelming. He also told that “when a girl from Orissa has come all the way to help our AP, I’m here to give you all the support needed from this office”. This statement enriched me and I took it as a challenge and as requested by the Principal Secretary of AP, we as a team from AP had developed a proposal to submit the same to him according to his requirement. The same is drafted and put forward to the senior officials of HLFPPT for screening and finalizing. I had put in more than 80% of my efforts in developing the proposal on RCH service for un-served and underserved areas of districts in AP under MNGO scheme.

In spite of language barrier I had got a good support from the HLFPPT staff and the Government officials, MSM community etc.

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I had also participated in a study by the NACO for social marketing of extra lubricated condom. I had put my effort in data processing of study on “Acceptability of extra lubricated condom among MSM community”.

Due to good relationship Dr.G.Sreedhar, DPM had permitted me to conduct my study and helped me in assessing the data of APSAC in Hyderabad the capital city of AP, which is also called as the “City of Pearls”. It’s a wonderful experience to work in HLFPPT with so many projects flowing in and appreciate our CEO madam Vashanthi Krishnan for taking HLFPPT to such great heights. Each time I visited with HLFPPT card to any of the government offices, I was given all the respect and appreciation for this organization. I really feel proud to be called as an HLFPPTian. My sincere thanks to this organization for helping me to complete this dissertation successfully and on time.

Chapter-1

2.1 INTRODUCTION

India is one of the largest and most populated countries in the world, with over one billion inhabitants. Of this number, it's estimated that around 2.4 million people are currently living with HIV. In a country where poverty, illiteracy and poor health are rife, the spread of HIV presents a daunting challenge.

India's first cases of HIV were diagnosed among sex workers in Chennai, Tamil Nadu in 1986 due to contact with foreign visitors had played a role in initial infections among sex workers.

In 2009 (NACO report) it was estimated that 2.4 million people were living with HIV in India, which equates to a prevalence of 0.3%. High prevalence rate of HIV/AIDS are in states like Andhra Pradesh, Tamilnadu, Karnataka, Maharashtra, Goa, Manipur, Mizoram, Nagaland, Punjab.

Under **NACP–II**, focus was given on low-cost care, support and treatment of common opportunistic infections (OI). Apart from further improving the availability, accessibility and affordability of ART treatment to the poor, NACP-III plans to strengthen family and community care through psycho-social support to the individuals, more particularly to the marginalised women and children affected by the epidemic, improve compliance of the prescribed ART regimen, and address stigma and discrimination associated with the epidemic.

The **National AIDS Control Programme Phase III** (2007-2012) is being launched with the objective to halt and reverse the spread of the HIV/AIDS epidemic in India.NACP-III has evolved mechanisms to address human rights and ethics issues concerning HIV/AIDS. Particular focus is on the fundamental rights of PLHA and their active involvement as important partners in prevention, care, support and treatment initiatives. Respect for the rights of people living with HIV/AIDS (PLHA), as it contributes most positively to prevention and control efforts. The overall goals of NACP-III is to halt and reverse the epidemic in India over the next five years by integrating programmes for ***prevention, care and support and treatment***. Care, support and treatment services are Diagnosis of HIV,ARV treatment, Opportunistic Infections diagnosis and treatment, Psychological support, Nutritional support, Travel and vocational support.

Table-3

SCALE UP PLAN OF NACP – III (Based on spectrum projections)

Year	2006	2007	2008	2009	2010	2011
Total no of AIDS cases estimated	508200	501800	493000	486000	478000	473500
Target for ART in the public sector not including 40,000 children	31234	100000	125000	150000	184000	300000
Proportion of AIDS patients covered with ART	6.1%	20%	25%	31%	38.5%	63%

Source: Strategy and Implementation Plan, National AIDS Control Programme, Phase-III (2006-2011), November 30, 2006

To achieve this objective, 350 Community Care Centres were established based on the epidemiological profile and PLHA load of the districts, and linked to the nearest ART centre. The centres will provide counselling for drug adherence, nutritional needs, treatment support, referral and outreach for follow up, social support and legal services. State AIDS Prevention and Control Societies will ensure access of high risk groups to community care centres through linkages between TIs and the centres.

Respect for the rights of people living with HIV/AIDS (PLHA), as it contributes most positively to prevention and control efforts. NACP-III has evolved mechanisms to address human rights and ethics issues concerning HIV/AIDS. Particular focus is on the fundamental

rights of PLHA and their active involvement as important partners in prevention, care, support and treatment initiatives.

An analysis of Annual Sentinel Surveillance data (2003-2005) shows that female sex workers (FSWs), men-who- have-sex-with-men (MSM) and injecting drug users (IDUs) have disproportionately higher incidence of HIV infection.

NACP- III will be implemented through a four pronged strategy

1. Preventing new infections in high risk groups and general population through:
    - Saturation of coverage of high risk groups with targeted interventions (TIs)
    - Scaled up interventions in the general population
2. Providing greater care, support and treatment to larger number of PLHA.
3. Strengthening the infrastructure, systems and human resources for scaling-up prevention, care, support and treatment programmes at the district, state and national level.
4. Strengthening the nationwide Strategic Information Management System.

Epidemic in General Population

Through MSM and sex worker-client interactions the infection spreads to general population. As a majority of men with MSM behaviour are married and a majority of sex worker clients are migrant labours and truck drivers, they pose the risk of infecting their spouses and unborn children.

Targeted Interventions for Prevention, Care and Treatment

For the overall reduction in the epidemic, targeted interventions (TIs) are aimed to effect behaviour change through awareness raising among the high risk groups and clients of sex workers or bridge populations. These interventions are aimed to saturate three high risk groups with information on prevention; address clients of sex workers with safe sex interventions, and build awareness among the spouses of truckers and migrant workers, women aged 15 to 49 and children affected by HIV or vulnerable population groups.

Apart from prevention of HIV infection, TIs facilitate prevention and treatment of sexually transmitted diseases as that increase the risk of HIV infection, and are linked to care, support and treatment services for HIV infected.

2.2 REVIEW OF LITERATURE

The care ,support and treatment of PLHA is an important component of National AIDS Control Programme, Phase-III (NACP-III) and aims to provide comprehensive management to PLHIV with respect to prevention and treatment of OI, ART, psychosocial support, home based care, positive prevention and impact mitigation.

The current HIV/AIDS scenario in India is quite grim with an estimated 2.4 million people living with HIV/AIDS (PLHA) in 2008, just behind South Africa and Nigeria. The anti-retroviral drugs (ARVs) remain the main stay of global HIV/AIDS treatment. Over 30 ARVs (single and FDCs) available under six categories viz., NRTIs (nucleoside reverse transcriptase inhibitors), NNRTIs (non-nucleoside reverse transcriptase inhibitors), Protease inhibitors, the new Fusion inhibitors, Entry inhibitors-CCR5 co-receptor antagonists and HIV integrate strand transfer inhibitors. The major originator companies for these ARVs are: Abbott, Boehringer Ingelheim (BI), Bristol-Myers Squibb (BMS), Gilead, GlaxoSmithKline (GSK), Merck, Pfizer, Roche, and Tibotec. Beginning with zidovidine in 1987, all the drugs are available in the developed countries. In India, about 30 ARVs are available as generics manufactured by Aurobindo, Hyderabad, Andhra Pradesh; Cipla Limited, Goa; Emcure Pharmaceuticals, Pune, Maharashtra; Hetero Drugs, Hyderabad, Andhra Pradesh; Macleods Pharmaceuticals, Daman; Matrix Laboratories, Nashik, Maharashtra; Ranbaxy, Sirmour, Himachal Pradesh; and Strides Arcolab, Bangalore, Karnataka. The National AIDS Control Organization (NACO) set up in 1992 by the Govt. of India provides free ARVs to HIV positive patients in India since 2004. The drugs available in India include both single drugs and FDCs covering both first line and second line ARVs. Other concerns include heat stable, other better formulations and second line ARVs for adults and more drugs and formulations for pediatric groups that are still to be widely available in India and other developing countries[1].

Indian manufacturers of generic antiretroviral (ARV) medicines facilitated the rapid scale up of HIV/AIDS treatment in developing countries though provision of low-priced, quality-assured medicines.[2]

The free ART services were introduced on 1st April ,2004 in eight Govt. Hospitals located in six high prevalence states. Since then the services have been scaled up to 285 centres

providing ART to more than 3,68,703 patients across the country .In order to facilitate the delivery of ART services nearer to the beneficiaries, concept of link ART Centre (LAC) was conceived and presently 520 LAC have been established.

The delivery of care and treatment services for people living with HI/AIDS is provided through a three-tier structure .The various levels where HIV care and treatment is provided are ART centre, Link ART centre and Centres of Excellence. ART centres are linked with Community care centres for a comprehensive package of services. There is a close linkage with Revised National TB Control Programme (RNTCP).[3]

THREE TIER STRUCTURE FOR HIV TREATMENT

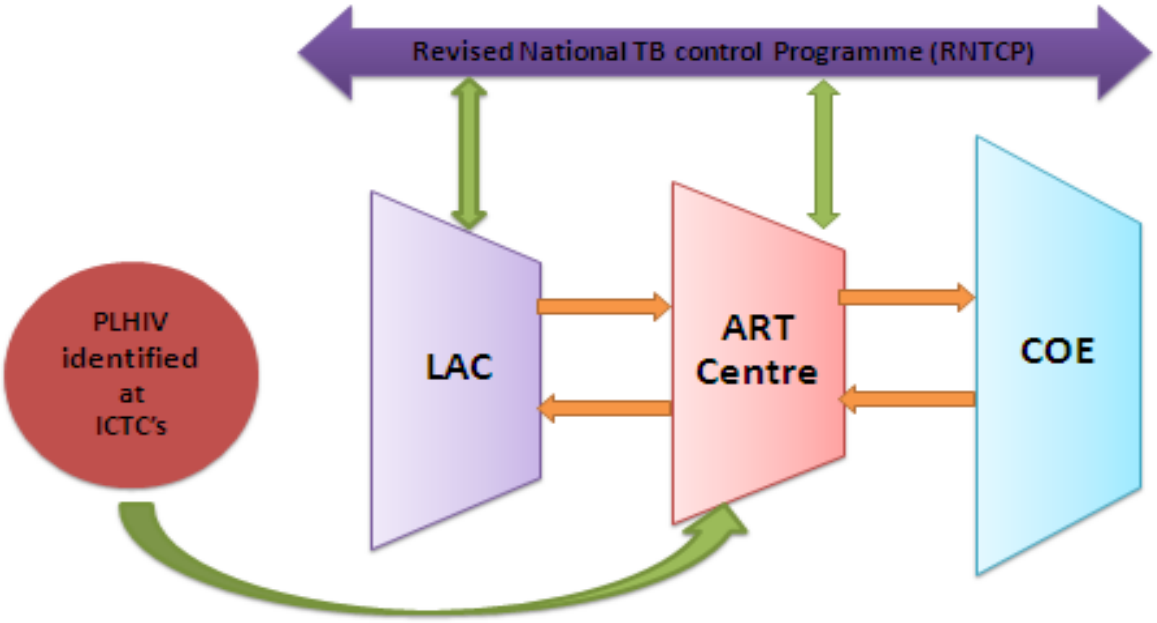

Figure 1

Antiretroviral therapy scale-up needs to continue to grow exponentially to meet the need for universal access and keep pace with or exceed the new HIV infections. This calls for strategies that will have the greatest impact on the reduction of opportunistic infections, toxicities, and early mortality after antiretroviral therapy initiation as well improve

adherence, clinical, immunological, and virologic responses, patient retention in antiretroviral therapy programs, and overall quality of life of people living with HIV/AIDS. Expanding antiretroviral therapy to all those eligible requires evidence-based decisions about how, when, and where expansion should occur. Key strategies to optimize HIV treatment outcomes include,

i) Scaling up HIV testing to identify all in need of HIV treatment,
ii) Strengthening the links between HIV diagnosis and comprehensive HIV/AIDS care,
iii) Timely initiation of antiretroviral therapy,
iv) Optimal diagnosis and treatment of opportunistic infections and comorbidities,
v) Investing in laboratory tests to support clinical monitoring of patients on antiretroviral therapy
vi) Maximizing adherence to antiretroviral medication and retention of patients in HIV/AIDS care,
vii) Improving the health infrastructure, and increasing the human resources to handle the growing numbers of people in need of HIV treatment.[4]

A significant challenge to the success of achieving universal access to HIV prevention, treatment, care and support by 2010 is HIV-AIDS stigma and discrimination. Studies to investigate the cultural context of stigma, health seeking behavior and the role both perceived and community stigma play in HIV prevention. Results and findings of the study suggest that reducing stigma does increase the individual as well as community acceptance of people living with HIV-AIDS (PLWHAs) .[5]

Major barriers included fear of adverse consequences of disclosure of HIV status due to stigma and discrimination associated with HIV and sex work, lack of family support, negative experiences with health care providers, lack of adequate counseling services at government centers and by outreach workers employed by nongovernmental organizations (NGOs), perceived biased treatment of FSWs who are not referred by NGOs, lack of adequate knowledge about ART, and fatalism. Barriers can be addressed by: creating effective measures to reduce stigma associated with HIV/AIDS and sex work at the familial, societal, and health care system levels; incorporating information about ART into targeted

interventions among FSWs; training counselors at government hospitals and NGO outreach workers on treatment issues; improving infrastructure and staffing levels at government centers to allow adequate time and privacy for counseling; and implementing government mass media campaigns on ART availability. Finally, it is crucial that NACO begin monitoring ART coverage of FSWs and other marginalized populations to ensure equitable ART access .India's National AIDS Control Organization (NACO) provides free first-line antiretroviral treatment (ART) at government centers for people living with HIV. To assist in developing policies and programs to ensure equity in ART access, we explored barriers to ART access among female sex workers (FSWs) living with HIV in Chennai.[6]

Highly active antiretroviral treatment (HAART) usage in India is escalating. With the government of India launching the free HAART rollout as part of the "3 by 5" initiative, many people living with HIV/AIDS (PLHA) have been able to gain access to HAART medications. Currently, the national HAART centers are located in a few district hospitals (in the high- and medium-prevalence states) and have very stringent criteria for enrolling PLHA. Patients who do not fit these criteria or patients who are too ill to undergo the prolonged wait at the government hospitals avail themselves of nongovernment organization (NGO) services in order to take HAART medications. In addition, the government program has not yet started providing second-line HAART (protease inhibitors). Hence, even with the free HAART rollout, NGOs with the expertise to provide HAART continue to look for funding opportunities and other innovative ways of making HAART available to PLHA. Currently, no study from Indian NGOs has compared the direct and indirect costs of solely managing opportunistic infections (OIs) vs HAART.[7]

Control of sexually transmitted infections (STIs) is an important part of the effort to reduce the risk of HIV/AIDS. STI clinics in the government hospitals in India provide services predominantly to the poor.

India has one of the highest number of persons living with HIV in the world . The presence of sexually transmitted infections other than HIV (referred to as STIs in this paper) increases substantially the risk of acquiring/transmitting HIV, and therefore, the control of STIs can be an important part of the effort to control emerging HIV epidemics . The state of Andhra Pradesh with 80 million population has one of the highest estimated burden of HIV among

the Indian states based on antenatal sentinel surveillance, and also one of the highest HIV prevalence (16–30%) among public sector STI clinic attendees included in the sentinel surveillance during 1998–2004.[8]

In the Andhra Pradesh state of India, analysis of 14 public sector STI clinics revealed that the average cost of diagnosing and treating each STI was INR 729.5 (US$ 15.88), and this cost ranged many-fold between the 14 clinics. Fixed costs of the STI clinics made up the predominant proportion, with personnel costs exceeding three-fourths of the total cost. According to conclusion of study there is un-utilised capacity in the public sector STI clinics that provide services predominantly to the poor. Efforts to facilitate utilisation of this capacity would be useful, as this would enable more poor patients with STIs to be served at minimal additional cost, and would also reduce the cost per STI treated leading to more efficient use of public resources. Comprehensive and dynamic analysis of the efficiency of HIV prevention services using standardised methods is necessary to make optimal use of the increasing resources that are becoming available for this purpose in India and other parts of the developing world.[9]

The inequity between rich and poor countries in terms of access to HIV treatment has rightly given rise to widespread moral indignation, and a few outstanding leaders have been consistent and courageous in their personal and public stances. Building on these lessons, the World Health Organization (WHO) has advocated a public health approach for treating people with HIV and AIDS in resource-limited settings. This approach proposes the use of standard first-line treatment regimens based on a simple five-drug formulary, with a more complex — and so far, much more expensive — set of second-line options. The steps in decision making for patients (the mnemonic is “the four S's”: when to start, substitute for toxicity, switch for failure, or stop and move to end-of-life care) have been standardized, and intensive-training packages for health and community workers have been developed and implemented in many countries.[10]

Depression has been shown to be an independent predictor of poor adherence in other studies. Usually depression is also common among HIV infected persons. Early identification and management of severe depression and interventions to provide adherence support would be required to maintain high levels of adherence.[11]

"Some people were afraid of breach of confidentiality and gave false addresses,"says Dr. Somasekhar Reddy of APSACS. "Some of them would default and when we sent outreach workers to trace them, we would learn that they had given false addresses."[12]

High HIV prevalence, risky behavior and concomitant marriage in MSM population suggest the need for focused prevention interventions. The relatively higher CD4 counts in this population detected through this community based screening program suggest that risky men were reached early in their disease, and such efforts should be scaled up and supported by governmental AIDS control organizations.[13]

A study showed that the use of condoms is very low in MSM population. Extra lubricated condom is being produced for MSM (men who have sex with men). The Hindustan Latex Family Planning Promotion Trust in association with the National Aids Control Organisation (NACO) is manufacturing the condom to check the HIV AIDS infection in the MSM community.[14]

LIMITATIONS

- Major barriers included fear of adverse consequences of disclosure of HIV status due to stigma and discrimination associated with HIV and sex work, lack of family support. Due to this reason they hide the facts. This is the main limitation of study.
- The other high prevalence districts could not be studied because of time constraint.
- Compliance of PLHA respondent is a limitation for this study as HIV/AIDS is very sensitive issue. It needs gradual rapport-building with that population .It was difficult during this study in limited time.

2.3 RATIONALE OF THE STUDY

Maharashtra and Andhra Pradesh have an estimated 0.5 million PLHIV each (NACO, 2008b). In January 2006, there were five ART centers in Maharashtra and three in Andhra Pradesh. Based on the HIV Sentinel Surveillance with more than 1% HIV prevalence among antenatal clinics (ANC) attendees (NACO, 2007), ART delivery was initiated in December 2004 in *Maharashtra* and January 2005 in *Andhra Pradesh.*

Up-scaling of HIV prevention, care, support and treatment services with the spirit of providing universal access for quality care -->is one out of eight guiding principles of NACP-III. By strengthening local responses, NACP–III seeks high levels of drug adherence (>95 percent) and compliance of the prescribed ART regimen. This approach to care, support and treatment also creates awareness about the prevention of HIV infection and, thus, is a very significant part of NACP–III in achieving NACO's mission of containing and reversing HIV/AIDS incidence in India.

According to NACO report on Sentinel surveillance (2007) the HIV prevalence in AP at antenatal clinics was 1% in 2007. This figure is smaller than the reported 1.26% in 2006, but remains the highest out of all states.HIV prevalence at STD clinics was very high at 17% in 2007. Among high-risk groups, HIV prevalence was highest among men who have sex with men (MSM) (17%), followed by female sex workers (9.7%) and IDUs (3.7%). Initially A.P was the epicenter of the HIV epidemic accounting for almost 21 per cent of the country's estimated burden of PLHA and the most significant factor, drives HIV transmission here is mostly unprotected sex.

Prevalence rate of HIV in Hyderabad was 2.00 % in 2005 -06 and now it is 1.13% as per district wise HIV prevalence in ANC report (2002-2008).In spite of the downward trend, there is no room for complacency as the State has high population of high risk group (HRG) in terms of female sex workers (FSWs), MSMs (men having sex with men) and the bridge populations - truckers and migrants. Saturated coverage of HRGs, scaling up of preventive services, community led structural intervention, linkage of positive HRGs with ART services will contribute good bang in bringing down the prevalence rate. Another important factor is the widespread distribution of condoms . As prevention is better than cure, the A.P. State

AIDS Control Society (APSACS) has primary focus is to prevent HIV transmission among the HRGs.

Andhra Pradesh in the southeast of the country has a total population of around 76 million, of whom 6 million live in or around the city of Hyderabad .Hyderabad is one of famous business hub and hi-tech city in Andhra Pradesh and it has highly floating population for business and higher studies.

Apart from creating awareness on HIV and AIDS, modes of transmission, it is imperative to equip all the departments working to contain the spread of HIV and AIDS with the complete information on the availability of various services in the state of Andhra Pradesh and that to Hyderabad with high prevalence rate of HIV/AIDS. The major drive for access of quality care, treatment can be possible by awareness about available service.

As per my knowledge no major study has been done on Care, Support and Treatment Services for PLHA. As Hyderabad is hub of mobile population and HRG groups, there is possibility of more prevalence rate which may be barrier in achievement of Goals of NACP-III providing services.

2.4 OBJECTIVE

General:

To appraise the availability and delivery of quality care and treatment services for people living with HIV/AIDS through a three-tier structure like Link ART centre (LAC), ART centre, Centre of Excellence (COE) of NACO at Hyderabad.

The specific objective is to draw overall function and role of all functionaries at different level to achieve the goals of NACP-III i.e.to halt and reverse the epidemic in India over the next five years by integrating programmes for prevention, care and support and treatment.

Specific

- To explore the knowledge of availability of care, and support and Treatment facility for PLH A in Hyderabad.
- To assess the equal accessibility to quality health services by PLHA in Hyderabad.
- To identify the gap among people accessing services by age, gender and community (FSW, MSM) in Hyderabad.

OUTCOME

Scaling up of care support and treatment is the main component of NACP-III. Optimal use of available resources with proficient strategy we can increase the lifespan of PLHA more than 15 years by providing quality health services (care support and treatment).

Chapter-2

2.5 METHODOLOGY

The study analysis is based on qualitative data. Both Primary and secondary data has been collected for this study. The secondary data source is Government reports like NACO, APSAC report and Publications of NGO reports and articles. The secondary data will be base for the qualitative analysis. The primary data source is randomly selected ART centre, ICTC, PPTCT from the list of DSAC, Hyderabad ***(Annexure-2).*** The selection of these centers is also purposive or convenient through snowballing. For qualitative analysis semi-structured and open ended questionnaire (***Annexure-1***) was prepared. Questionnaire was prepared which include access to ART, public sector response, health systems interface, social stigma in context of ART delivery etc. As it is a qualitative study, in-depth interview was conducted with different stake holders like community leaders (FSW, MSM), healthcare providers (Doctors, Counselor) of selected service provider centre for HIV/AIDS.

Total fifteen PLHIV of FSW and MSM Targeted Intervention center had participated in this study. KIIs were conducted in English and interviews with PLHIV were in Telugu. Then Telugu was translated to English. Data collection and analysis was done. The qualitative data was compared with secondary quantitative data i.e. scaling up of care support and treatment services. After analysis documentation was done.

Chapter-3

2.6 Results and Findings

After conducting In Depth interview of the concerned doctors, counselor of ART center and ICTC center to explore the CST available for PLHA and analyzing their recommendations on the flaws of the scheme. Following are the findings:

- People accessing care, support and treatment services are mostly young population i.e.15-40 years..

- Patient / People Identification (PID) is provided by ICTC centre after testing and confirmation of +ve cases. Pre-ART registration number is given to PLHA coming for CD4 count first time. On ART registration number to PLHA who will take ART medicine.

- Care, Support and Treatment services: -- CD4 count, Liver function test,(LFT) and Hemoglobin tests are compulsory at Pre-ART, Counseling. Demonstration and distribution of condom for safe sex. Preparedness for ART and OI.

- Some required surgeries are not provided to PLHA as it is not free of cost.
- On ART services are mostly from MSM community.
- PLHA from adjacent districts are accessing service from Hyderabad as ART centre of Hyderabad is nearer.
- APSAC is telecasting the live show and discussion with doctor to generate awareness **in DD-1 (Samtagiri) channel** on Tuesday and Saturday.
- Sometimes there is lack of IEC material for counseling.
- In some Art centers there is no provision of video clipping.
- Counseling is provided in three sessions:
    - **1st Session:** Family background ,risk assessment, Rapo-build up ,Initial HIV information.

- **2nd Session:** Asked about first session, Clarification of doubts, Awareness about safe and healthy sexual relation, Assurance for psychological condition like phobia.
- **3rd Session:** Explanation of investigations,CD4 count, Counseling for future plans, Suggestions for nutrition and exercise and healthy routine life, Ongoing counseling for family problems.

- Problems or barrier to service :--

  - ✓ Most of them face ***problems to earn livelihood*** for their family or some lost their job.

  - ✓ Due to social and family discrimination they are bound **to live a secret life** without any identification.
  - ✓ Sometimes this is ***difficult to track or follow up*** as they hide their identity and correspondences
  - ✓ It is difficult for PLHA to access/ avail service regularly due to ***transport cost***.
  - ✓ It is difficult at the part of field executive to follow up PLHA regularly by phone calls.
  - ✓ Lack of nutritional food to maintain the immunity of PLHA. There is no locally available nutritional chart for counselor.
  - ✓ There is no proper counseling for exercise and nutrition.
  - ✓ But Counseling for healthy life through exercise and proper locally available and easily affordable nutritious food is not adequate. There should be separate service for nutrition and meditation, yoga (exercise) with CST programme.
  - ✓ Adherence to ART is difficult due to lack of health seeking behavior, social discrimination.

Doctors suggested Iron Folic Acid, B-complex, Calcium, Zudovin (for Hemoglobin) should be provided to PLHA on ART.

Following are the findings after in depth interview of TI Project director and PLHA.

- Awakening Programme—***Melukolupu*** **once** in a year.
- Gathering of PLHAs at TI once in a week to discuss their issues.
- Once in a month PLHA of BPL category getting food supplements from TI.
- Registered PLHA of MSM community, TI contributes some money monthly to provide food to PLHA of BPL category.
- 10 to 12 voluntarily walk in daily to TI drop in centre.
- Counselor of TI counsel 5-6 people daily.
- Activities conducted by TI are Prophylaxis, Referral, Nutrition, Motivational counseling and referral for regular CD4 ,Hb and LFT.
- As per vast geographic area the ART centers cater in Hyderabad with well facility as per Annexure -3
- Problems:--

    - ✓ Gender Inequality→ Reservation, Family Mind set, Society and doctors mind set.
    - ✓ Inadequate staff and staff with insufficient salary
    - ✓ Less funding of APSAC.
    - ✓ HRG reluctant to express emotions.
    - ✓ Lack of proper nutrition
    - ✓ Funds from APSAC not sufficient to manage the expenditure of establishment.
    - ✓ Sometimes PLHA face problems due non-availability of testing kits and machinery.
    - ✓ Number of PLHA on ART is increasing which causes long waiting time.
    - ✓ Salary of TI staff is not sufficient to provide the services.

Suggestions for problem:-

- ✓ The PLHA should be provided nutritious food with 200 rupees pension.
- ✓ Legal support should be provided.
- ✓ Training on reveal of privacy
- ✓ There should be good communication and contacts with PLHA for proper tracking.
- ✓ Salary or any honorarium for motivation should be provided to staff to execute best services.
- ✓ Understanding of emotions during counseling.
- ✓ Govt. should provide nutrition to PLHA with low immunity and CD4 count.
- ✓ Provision of single men home.

After collecting Data from all stake holders during in depth interview, overall it was found that dropouts exist and other consequences also persist. This may be due to different reasons like social stigma, poverty, no assistance/support from society and family. There is no such system to follow –up to track these registered cases.

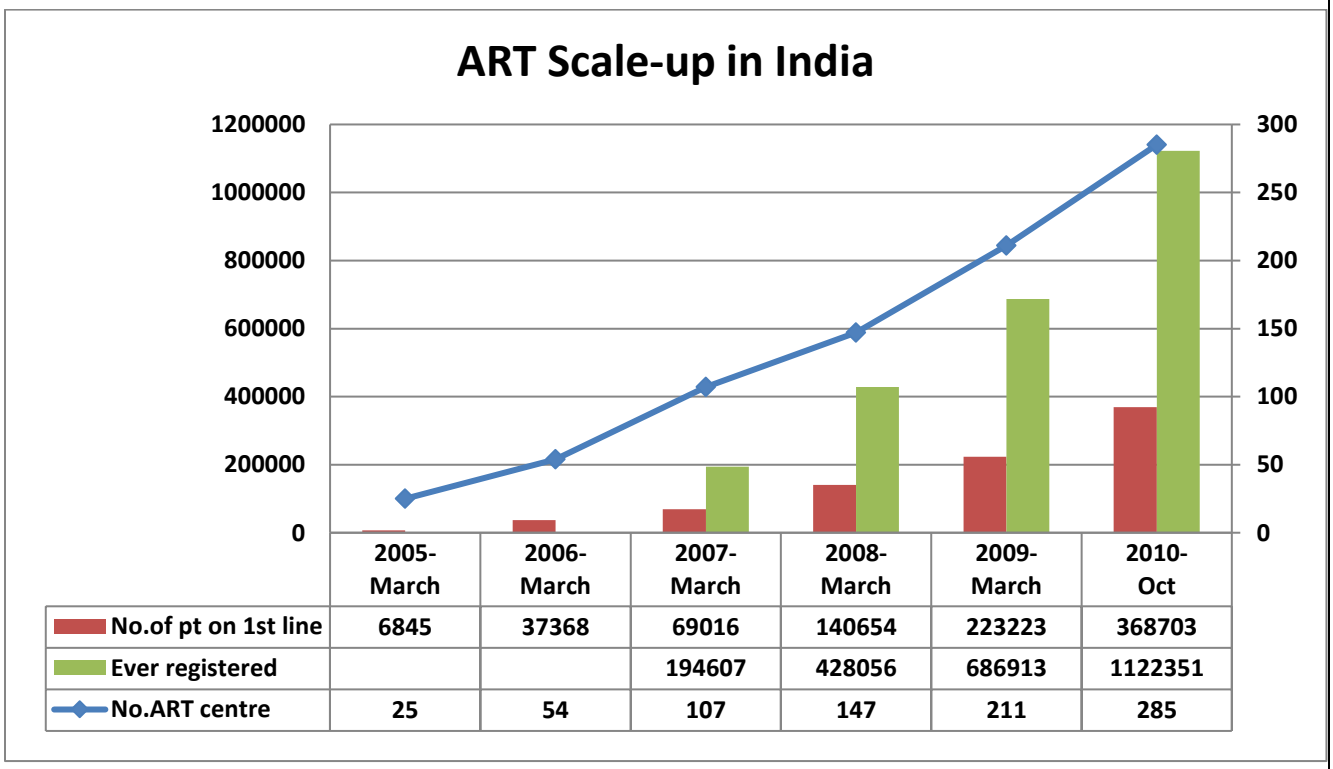

Figure 2

Scaling up Access to Pediatric ART :Bringing treatment to children,2004-2010(NACO)

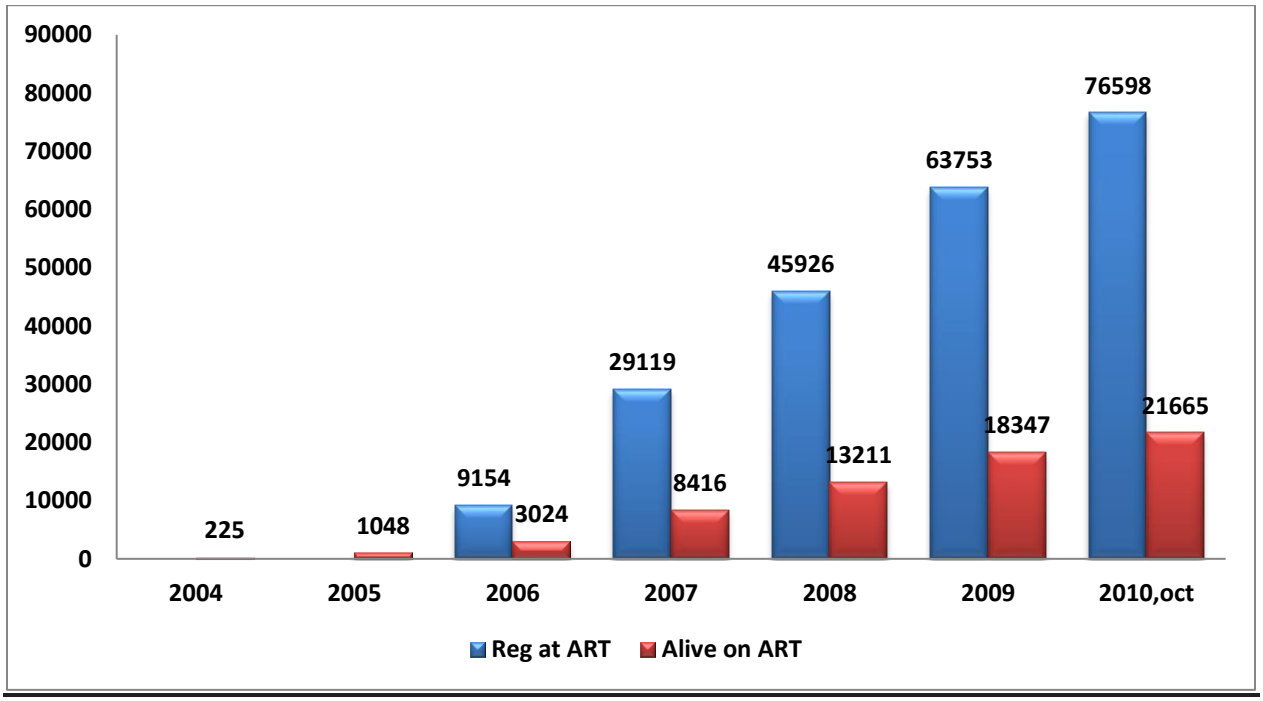

Figure 3

National Pediatric AIDS initiative was in 2006

ART SERVICE in ANDHRA PRADESH

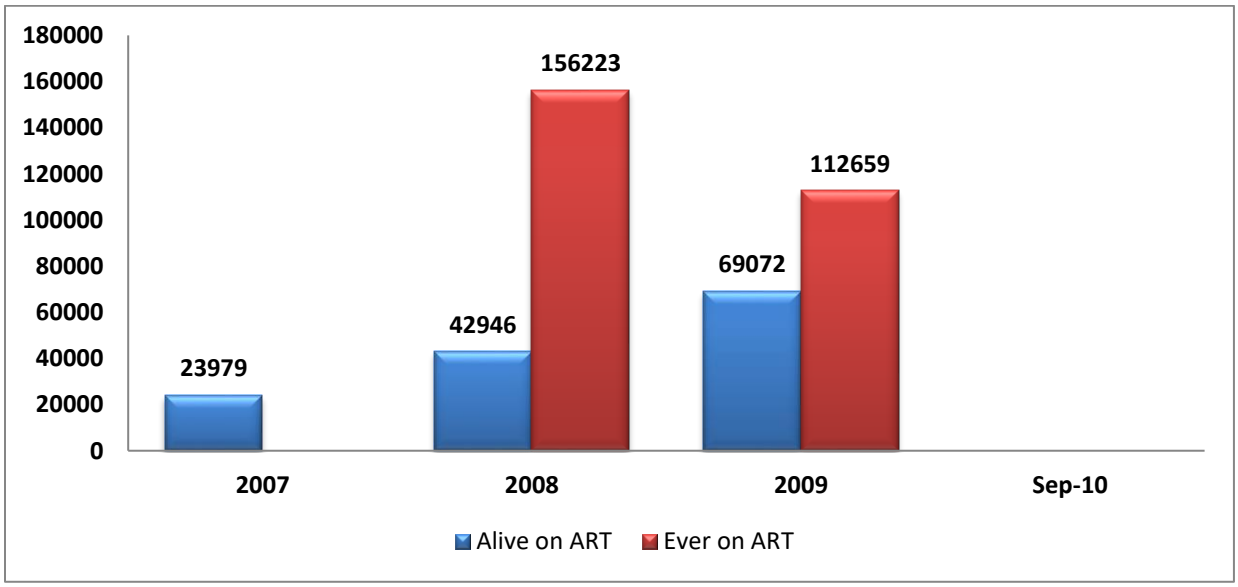

Figure 4

ART SERVICE in HYDERABAD

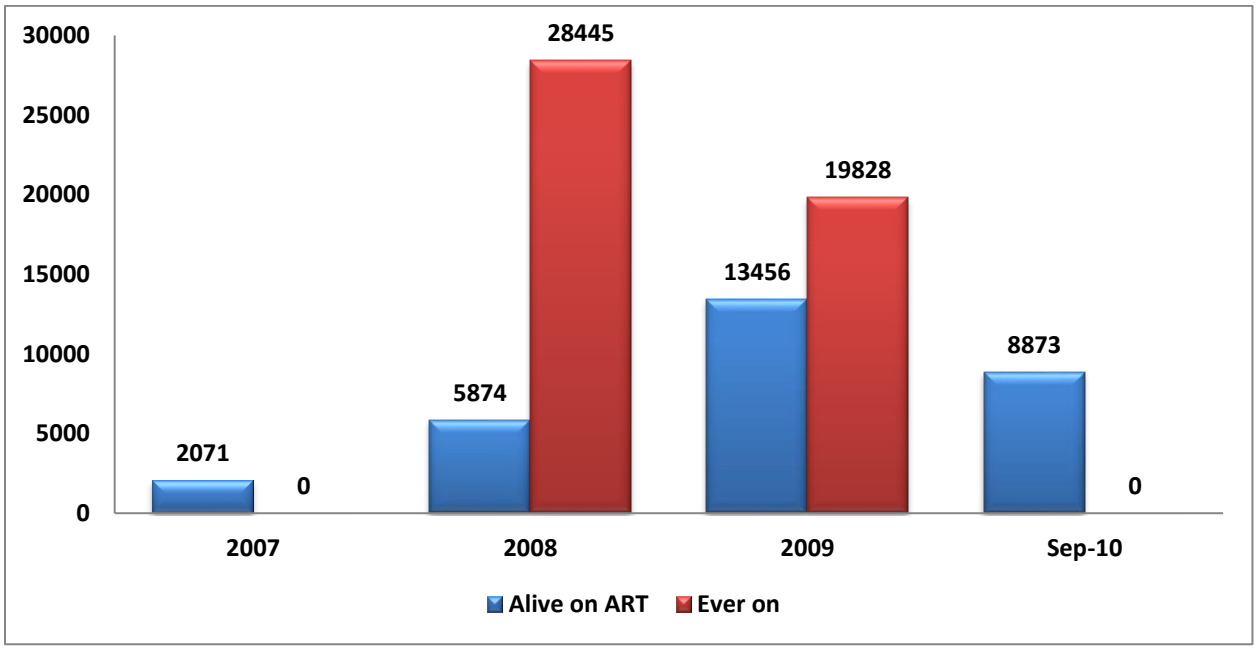

Figure 5

We can deduce from figure 4, 5 that *Alive on ART* cases is increasing overall in Andhra Pradesh but it is decreasing in Hyderabad .Because CST service was scaled up in state vigorously during NACP-III.

We can also infer that *Ever on registered* ART cases are decreasing gradually both in Andhra Pradesh and Hyderabad. Ever on registered cases are increasing due to different causes like death, Lost to follow up(LFU),migration etc.

During the comparison of the above reports, it is learnt that the level of strategy / policy to scale up our CST service is good. However, if we can adapt some new initiative as per recommendations, it would give more accuracy for future impact in terms of longer and healthy life of PLHA. Ultimately we can obtain the real objectives of NACP-III.

The objective of the study has been covered in findings as follows:

Objective-1:

People has knowledge about availability of CST services as follows:

- ✓ Provision of Mobile IEC and ICTC van .

- ✓ APSAC is telecasting the live show and discussion with doctor to generate awareness **in DD-1 (Samtagiri) channel** on Tuesday and Saturday.
- ✓ Awakening Programme—***Melukolupu*** **once** in a year conducted by TIs.
- ✓ Street shows/play is performed regularly by PLHA.

Objective-2

- ✓ Treatment and prevention measures for Opportunistic infections(OI) like skin infection, respiratory problem, anemia and treatments for TB are available.
- ✓ Sometimes there is shortage of IEC material in counseling and testing kit.
- ✓ PLHA can not afford for their normal food. So it is difficult for them to arrange nutritious food.

Objective -3

- ✓ Some PLHA and hiding community due to social and family discrimination don't avail the CST service.
- ✓ The general population and community people has one waiting hall where they face disgust look.

Chapter-4

2.7 DISCUSSION

The care, support and treatment needs of HIV positive people vary with the stage of the infection. The HIV infected person remains asymptomatic for the initial few years; it manifests by six to eight years. As immunity falls over time the person becomes susceptible to various opportunistic infections (OIs). At this stage, medical treatment and psycho-social support is needed. Access to prompt diagnosis and treatment of Ois ensures that PLHAs live longer and have a better quality of life.

All the diagnostic as well as therapeutic services related to ART are provided free of cost to PLHIV, any person who has a confirmed HIV. Integrated Counseling and Testing Centers (ICTCs) are the backbone of preventive services. So is the referral of positives from ICTCs to ART centers. So far 140 PLHIVs have availed the second line of treatment at the Centre of Excellence at Gandhi Medical College. To further promote the ART 43 utilization, the APSACS has proposed to provide free bus passes to persons visiting these centers.

Care:

- Hard Physical work should be prohibited (not to work as labor). Because CD4 count will decrease.
- Support and care from family members/friends.

Support:

- For Positive life.
- Financial support –Rs.200 per month to HIV positive people. It has to be increased .
- Family support.
- They should get some livelihood and facility like Rajeev Avas.
- Support and information from linkage worker/ NGO or Govt.worker.
- Support group people for mutual sharing of information to gain their health.
- Advocacy on stigma and discrimination on human rights.

Treatment:

- ART is initiated depending upon the stage of infection. PLHA with less than 200 CD4 (while blood cells/ mm^3) require treatment irrespective of the clinical stage. For PLHA with 200-350 CD4, ART is offered to symptomatic patients. Among those with CD4 of more than 350, treatment is deferred for asymptomatic persons. Adherence to ART regimen is therefore very vital in this treatment. Any irregularity in following the prescribed regimen can lead to resistance to HIV drugs, and therefore can weaken or negate its effect.

- Treatment and prevention measures for Opportunistic infections(OI) like skin infection, respiratory problem, anemia.
- Treatment of TB patients with DOTS.
- Bactrim DS (Mini ART) is given to PLWHA to control kidney stones.
- Treatment for Sexually Transmitted Infections (STI) like gonorrhea, herpes, syphilis.
- Treatment for liver disorders, vomiting, and motions.

NUTRITION

Any immune impairment as a result of HIV/AIDS can contribute to malnutrition. Malnutrition leads to immune impairment which worsens the condition of HIV as with weak immune power body can not fight against co-infections, particularly without access to ARVs and prophylactic medications. Improvement in nutritional status can help strengthen the immune system, thereby reducing the incidence of infections, preventing loss of weight and lean body mass, and delaying disease progression. So that HIV has less chance to develop in a person who is well nourished.

Nutritional care and support also helps people living with HIV to manage HIV related complications, promotes good responses to medical treatment and effective for those HIV+ve people who have not yet progressed to the stage requiring ARV treatment.

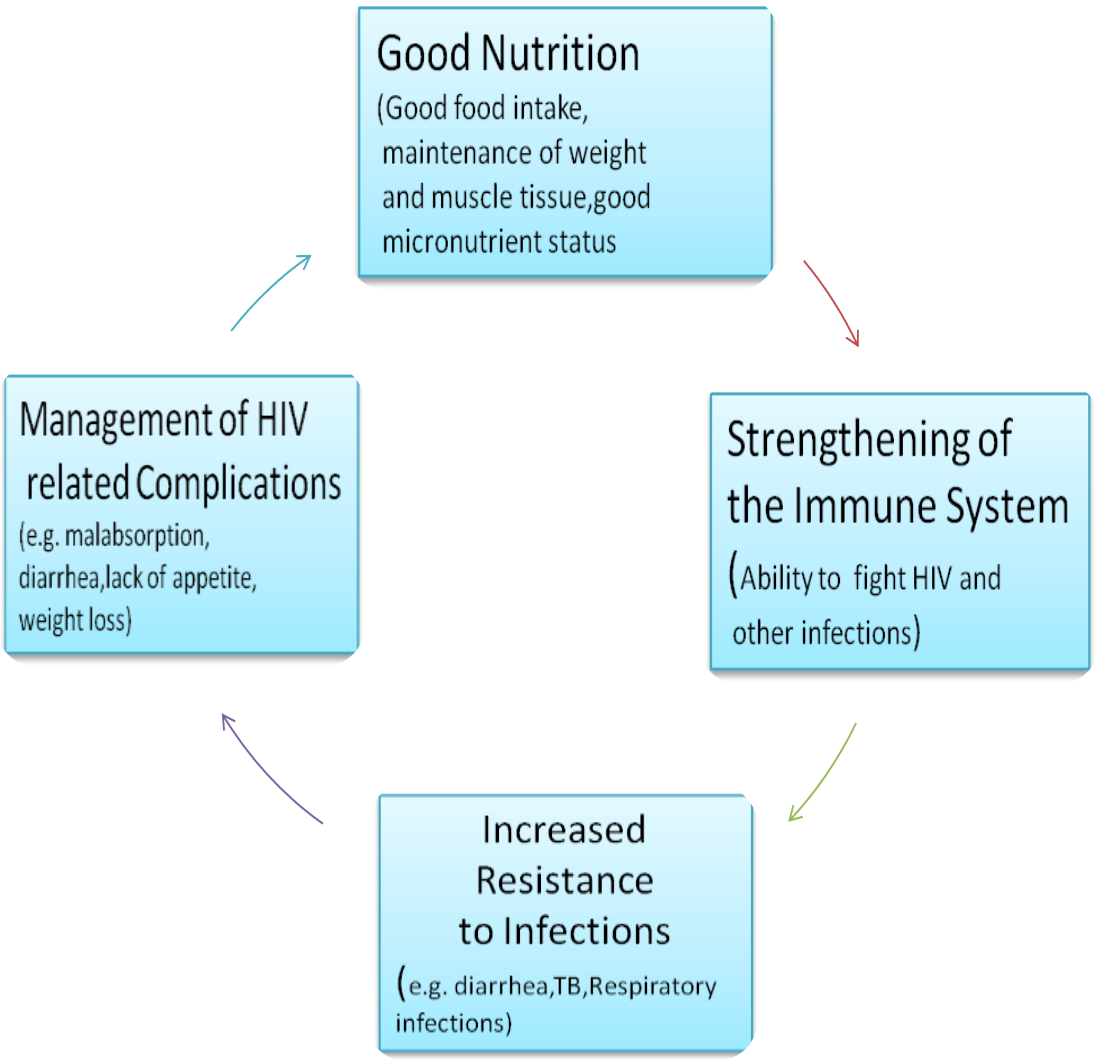

Figure 6

Need for nutrition: There is evidence to suggest that micro-nutrient supplements for Positive People can influence clinical outcomes. Several people expressed the need for nutritional support as part of the ART scheme, as well as care in general. Most PLHA are below the poverty line and unemployed and a very small section is employed. They cannot afford to buy nutritious food. Good nutrition does not mean high-cost nutrition. Nutritional supplements of multi-vitamins and trace elements like zinc, selenium, magnesium, iron, iodine and copper can be obtained through good diets. Some NGOs have developed inexpensive indigenous diets and

also organise sponsorship for those in need. “Ordinary foods like sattu maavu (powdered gram flour) bananas and roasted peanuts are rich in zinc and selenium, “says Snehalata, a nutritionist from Sahara, a Delhi-based NGO specialising in care, treatment and counseling of HIV and AIDS patients. Nutritional counseling and information on nutrition needs to be an integral part of the campaign. Despite the strong need, there are no plans for overall nutritional support in the government’s ART roll-out programme. Recently the government has announced provision of nutritional supplement to take care of 60% of the calorie, protein and micronutrient needs per day of over 3,000 children currently under the ART regime.

Chapter-5

2.8 CONCLUSION

As we have seen in findings, it is not only availability and accessibility of CST services for PLHA but also there should be good link and communication mechanism with community, family members and NGOs as well as support to PLHA and their family members. Because lack of that care, support may shape the HIV care related trajectories worse for PLHA .

There is need to establish better monitoring and support mechanisms for drug adherence at ART centers. Because PLHA from some community are migrant and they have no identity. They are hiding population due to social discrimination. They have no specific corresponding address. There should be some better tracking/follow up system like swipe card or unique identity card. Referral linkages among NGO - TI, STD clinics need to improve with ICTC and in turn with ART centers. Without adequate patient preparation and support we may compromise in the success of care, support and treatment service program. Yet the systems for treatment adherence and monitoring are still not in place. We should have special focus on tracking or follow up and management of psycho-social issues of PLHA.

Lastly, the programme needs to look beyond HIV and AIDS, to make its prevention efforts more successful as well as to reduce the impact or consequences of the affected.

2.9 RECOMMENDATIONS /SUGGESTIONS

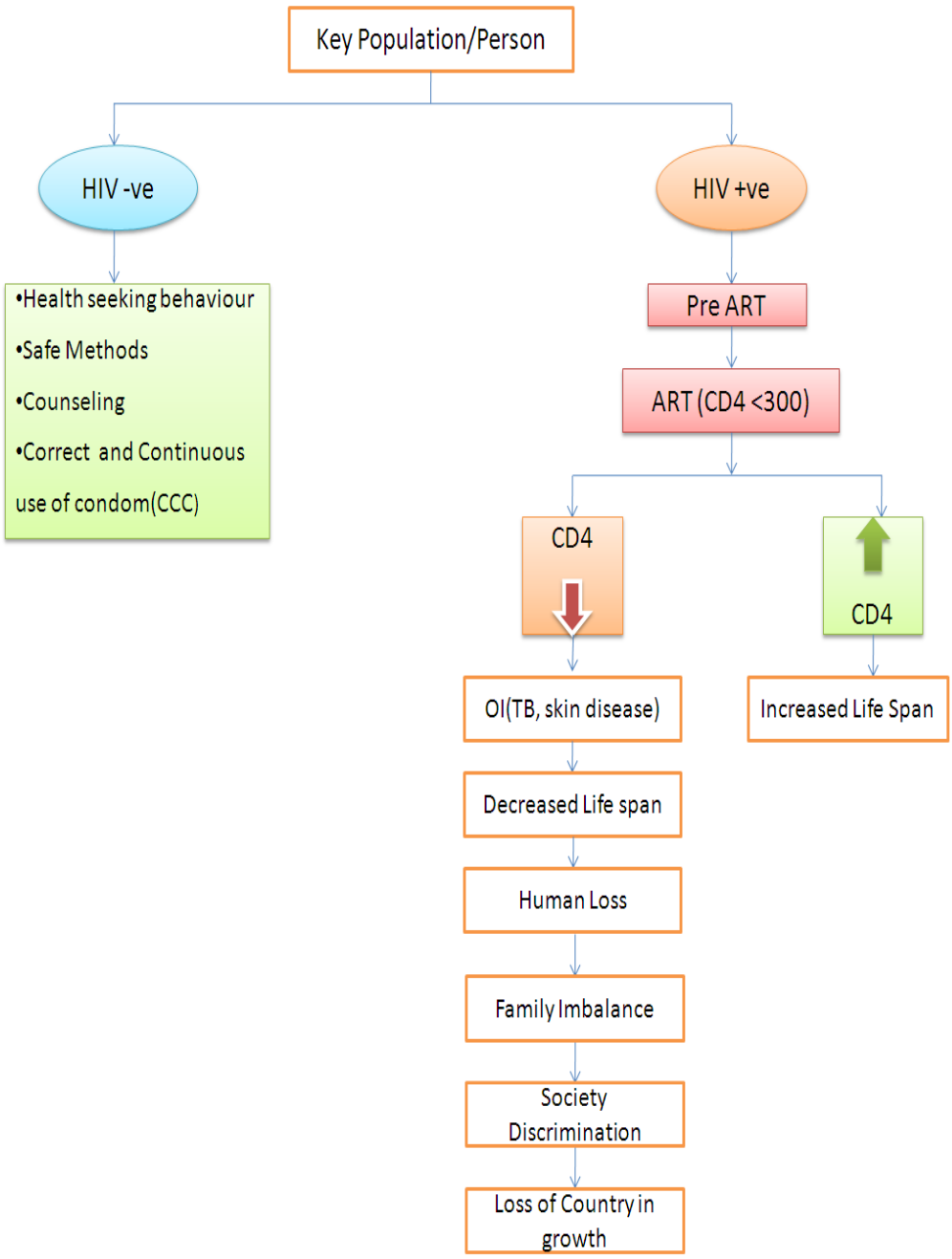

Figure 7

Consequences of people affected by HIV or consequences of decreased CD4 count can be predicted from above flow chart. Ultimately we have to prevent disease and should be

concern for improvement of health of positive community through promotion of sustainable development and intense care, support.

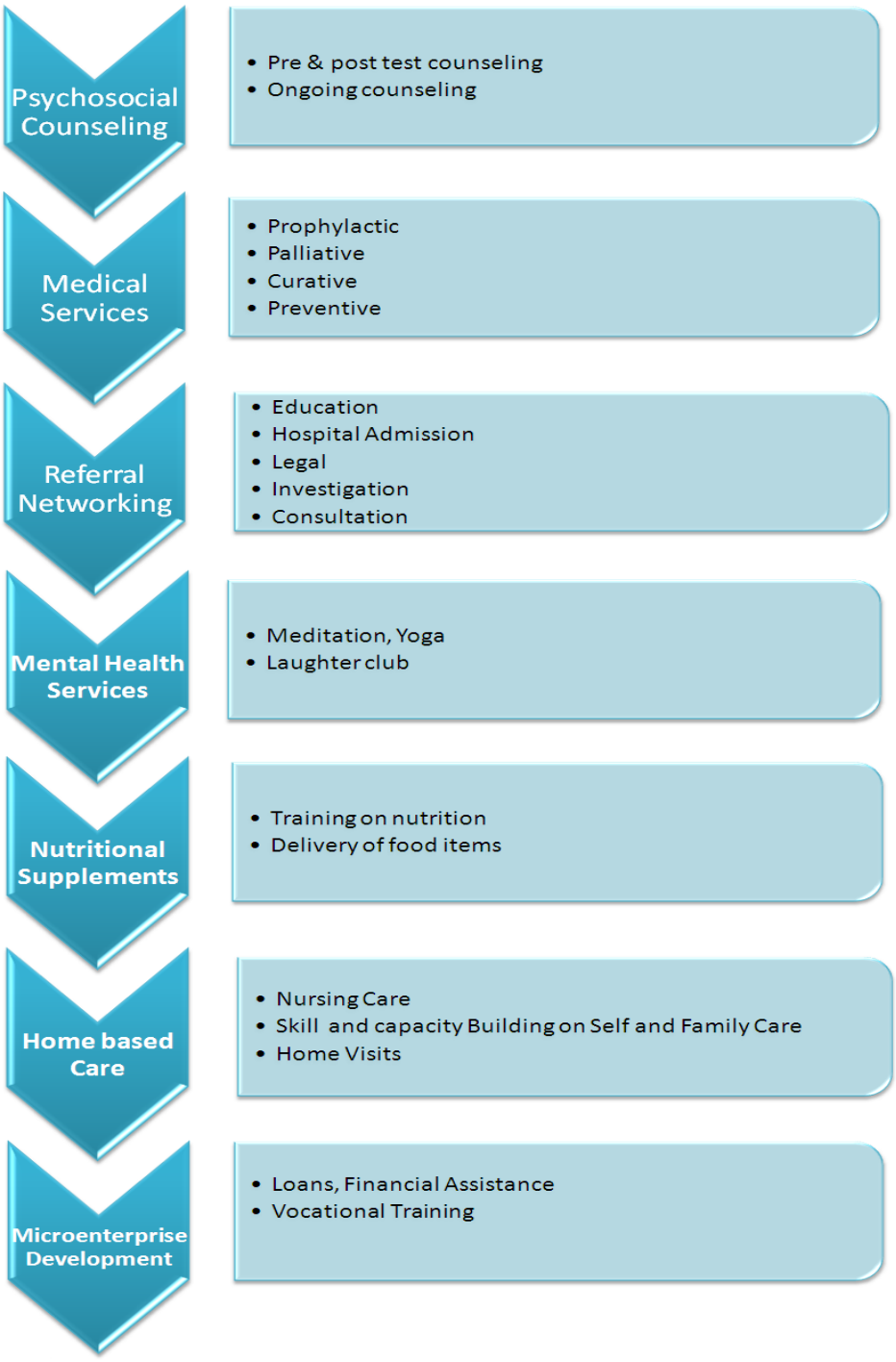

Figure 8

- There should be more importance to raise awareness and sensitization on issues of PLHA.
- Community home based care and support program for people living with HIV/AIDS.
- Income generating opportunities should be provided to PLHA and their family members.
- PLHA should share their experience about sufferings, discrimination stories to other PLHA and at public place. This spirit can enhance a PLHA for positive attitudes towards life.
- Legal rights should be strengthened for PLHA by which human rights can not be violated.
- Policy makers, religious leaders overall civilized society should have soft corners towards the issues of PLHA and their widows, orphan children.
- CBO,TI and Network for people living with HIV should also work for reduction of sufferings of family members and against stigma in society by training, awareness of general population and PLHA .
- Training and advocacy program on self care and home based care.
- Sensitizing education and awareness at school level.

- Civil societies involved to generate community awareness about value of life of PLHA.
- Screening, testing and CST should be under one roof to avoid problems concerned with LFU.
- Travel subsidy should be provided by State Transport Corporation.
- Community care centers should be sufficient to provide temporary stay while initiating on ART.
- Orientation /Training spiritually to PLHA for safe and better future.

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Annexure-1

QUESTIONAIRES

DOCTORS at ART centers

1. Name of ART centre/ICTC /PPTCT centre .
2. Name of Health service Provider(Doctor/Counselor)
3. How many cases (Pre –ART, ART) are registered?
4. How many cases are referred cases and how many are coming by themselves?
5. What are the community or HRGs (FSW, MSM, Truckers, IDUs) accessing optimal health facilities?
6. Whether there is an equal access of care, support service facilities ? or is there any stigmatization for different community and general population accessing service?
7. Are there any distinctions by age and gender accessing services?
8. Whether all facilities/services are available according to NACO guidelines or not?
9. Is there any shortage of drugs or problem in any other services?
10. Are there any problems with linkages?
11. What are the follow-up actions from your side?
12. What is the hurdle you are facing during providing service?

Counsellor at ART centres

1. How many cases are coming for counseling daily?
2. What type of counseling tools are used?(case study, flip chart, self experience, IEC material ,video clipping)
3. What are the main problem in adherence of ART ?
4. What is the main reason of missed and LFU cases?
5. What are the reasons for late registration (Pre-ART, ART)?
6. What type information/perception you are getting from PLWHA regarding stigma/discrimination?
7. Is there any distinctions by age and gender accessing services?

8. How your interaction is going on with PLWHA?
9. What are the gaps/hurdles faced by you to provide service to PLWHAs?
10. What are the problems in linkage (referrals, walk-ins, referral for other testing and treatment)?
11. On behalf of you what services have to increase to strengthen care and support services for PLWHA?

TI Project Director/Community Leaders

1. What are the events or action plan for services as per the NACO guidelines ?
2. How frequently you are conducting awareness campaign and brief about participants?
3. How many PLHAs are registered?
4. How many cases are referred for care, support and treatment?
5. How you are tracking the referral cases? Are there any follow-up actions for PLWHA from TI?
6. How many PLHAs walk-ins DIC daily?
7. How many are getting counseling?
8. How many are pre-ART and how many ART?
9. How many PLHAs with increased CD4 in last one year?
10. What is the status of Stigma and discrimination in society?
11. How much Budget for care, support service?
12. What type of assistance and facility for PLHA?
13. Are you providing condoms to PLHAs? If yes, then what type? Whether under social marketing or what?
14. How linkage is supporting to PLHA?
15. On behalf of your TI how many PLWHA are taking pension(200) by SAC?
16. Whether adequate staff available to manage the PLHA program?
17. What type of legal support is provided?
18. Problems with funding agent?
19. Doctor and Counselor of TI has got any training on PLWHA treatment and services?
20. How many PLWHA are accessing bus passes through your TI?

21. What are all medicines available with your TI for PLWHA?
22. What type of challenges faced by you to provide service?
23. What are your suggestions to equal access to quality health services?

Community Leaders / PLHA

1. You are availing services from which hospital?
2. You are availing what type of service from that hospital?
3. Is there any problem with doctors for care and treatment?
4. Is there any problem with counselors for care and support?
5. Is there any facilities have to increase? Their suggestions.
6. Is there any stigma or discrimination by staff?
7. How is co-ordination with care, support and treatment services?
8. What type of changes you need in care, support centre?
9. Do you know about GIPA?
10. How the person of Greater involvement of people who living with AIDS (GIPA) is interacting with you?
11. Is there any need to appoint one community/ PLWHA at care and support centre for better mobilization of PLWHAs?

Annexure-2(A)

ART and Link –ART centre in Andhra Pradesh

	District name	**ART Centre**
1.	HYDERABAD	Osmania Medical College, Hyderabad
2.	Guntur	Govt. Medical College, Guntur
3.	Visakhapatnam	Govt. MC (King George Hospital), Vizag
4.	Anantapur	GGH, Anantapur
5.	Krishna	GGH, Vijayawada
6.	Cuddapah	RIMS, Kadapa
7.	Chittoor	SVRR GGH, Triupati Chittoor
8.	Prakasam	Government District Hospital, Ongole
9.	Rangareddi	Gandhi Med College, Secundarabad
10.	Warangal	Medical college, Warangal
11.	Karimnagar	Govt. District Hospital, Karimnagar
12.	HYDERABAD	Govt. Gen. Chest hospital, Hyd
13.	Nizamabad	District Head Quarters Hospital, Nizamabad
14.	West Godavari	District Head Quarters Hospital, Eluru
15.	Srikakulam	District Head Quarters Hospital, Srikakulam
16.	Khammam	District Head Quarters Hospital, Khammam
17.	Mahbubnagar	District HQ Hospital, Mehboobnagar
18.	Kurnool	Government General Hospital, Kurnool
19.	Nellore	District Head Quarters Hospital, Nellore
20.	Nalgonda	District HQ Hospital, Nalgonda
21.	Vizianagaram	Government Medical College
22.	Medak	District Headquarter Hospital,Medak
23.	Adilabad	District HQ Hospital, Adilabad
24.	HYDERABAD	Nillofer Hospital (Cerntre of Excellence for children)
25.	East Godavari	Rajahmundry ART Centre

26.	Guntur	Area Hospital, Tenali
27.	Visskhapatnam	ART center Anakapalli
28.	Chittoor	District Hospital Chittoor
29.	HYDERABAD	DH,King Koti, Hyderabad
30.	Krishna	DH, Machilipatnam,Krishna
31.	West Godavari	Tadepalligudem ART center
32.	Khammam	Bhadrachalam ART center
33.	Prakasam	Markapur ART center
34.	Cuddapah	Produtur ART center
35.	Krishna	Tandur ART center
36.	Guntur	Guntur ART center
37.	Guntur	Narasaraopet ART center

Annexure-2(B)

Targeted Interventions in Hyderabad

1.	APSACS (FSW)- CHAITHANYA MAHILA MANDALI
2.	APSACS (FSW)- HYDERABAD LEPROCY CONTROL AND HEALTH SOCIETY (HLCHS)
3.	APSACS (FSW)- HYLEP-TOLICHOWKI (TRANSIT FROM ALLIANCE 09/10)
4.	APSACS (FSW)- IRDS
5.	APSACS (IDU) - DEVELOPMENT ACTION FOR RURAL ENVIRONMENT (DARE)
6.	APSACS (MIGRANTS)- GREEN CROSS SOCIETY (GCS)
7.	APSACS (MIGRANTS)- SIDUR
8.	APSACS (MSM)- DARPAN FOUNDATION
9.	APSACS (MSM)- SURAKSHA SOCIETY
10.	TCIF (TRUCKERS)- BARUKA CHARITABLE TRUST – AUTONAGAR

NACO supported Community Care Centre (CCC) →Sivananda Rehabilitation Home ,Hyderabad

Annexure 2(C)

RESOURCE DIRECTORY OF ICTC/PPTCT/FIICTC

Sl. No.	Name of the Centre	Name of the MO	Name of the Counselor	Name of the Lab Technician
1	Golconda ICTC	Dr. Ramana Babu	D. Dileep Kumar	D. Markandeya
2	Golconda PPTCT	Dr. Ramana Babu	Rukhsana	D. Markandeya
3	Malakpet ICTC	Dr. M.A. Quddus	D. Santhosh Kumar	S. Dasharadham
4	Malakpet PPTCT	Dr. Hareesh Ibrahim	T. Sreelatha	S. Swarnalatha
5	Nampally ICTC	Dr. Jalaja Vironika	M. Dasharadham	K. Shashi
6	Nampally P	Dr. Mahipal Reddy	Sreedevi	K. Shashi
7	Barkas CRPF ICTC	Dr. July Mohanthi	Y. Geethalu	Raju
8	Barkas CHC, ICTC	Dr. Giftson	S. Sreeveni	P. Varalaxmi
9	RTC Hospital ICTC	Dr. Vimala Devi	T. Kiran Kumar	A. Vanaja
10	King Koti DH ICTC	Dr. V. Kishore	Venkat Rajam	T. Ramadevi
11	Fever Hospital ICTC	Dr. K. Taruni	V. Narender	G. Shankar
12	Gandhi ICTC	Dr. P.R. Anuradha	T. Shiva Prasad	K. James
13	Gandhi PPTCT	Dr. Thripura Sundari	N. Balu Naik Mahalaxmi	B.D. Robinson
14	Surajban Bagavati Bai ICTC	Dr. Prathima Deshpande	R. Purnima	J. Venkanna
15	IPM ICTC	Dr. B. Anjaneyulu	Kumara Swamy	A. Narender Reddy
16	Niloufer ICTC	Dr. Sharadha	P. Sujatha	MD. Zakir

			P. Raghavendra	
17	Osmania Medical College ICTC	Dr. Mallikarjun Rao	B. Vidya Sagar T. Indira	M. Naresh K. Mamatha
18	GMH Nayapool PPTCT	Dr. Shailaja	Md. Mahamoduddin Sridevi Vijaya Laxmi Schithra Sujala	Raheem Shek Abdul Malik Anitha Khader (BB)
19	Sultan Bazar PPTCT	Dr. Vijaya Laxmi	S. Swarnamanjari S. Srilatha	R. Chandulal T. Srilatha
20	Amberpet MC ICTC	Dr. Noorjahan	B. Rajamani	K. Soujanya
21	Jangammet MC ICTC	Dr. Vinaya Sheela	N. Sathyasri	A. Surender
22	Lalapet MC ICTC	Dr. Jayashree	T. Snehalatha	P. Ruth Mary
23	Panipura MC ICTC	Dr. A. Vijayakumari	V. Thripura Sundari	R. Sujeeth Gandhi
24	Sriram Magar MC ICTC	Dr. S. Padmaja	V. Bhagyamma	N. Shailaja
25	Andhra Mahila Sabha ICTC	Dr. Rekha, Dr. Madhavi Latha	V. Diamond Ruth	Veeraiah
26	Red Cross, Gaddiannaram ICTC		Srilatha	T. Anitha
27	Esra APAIDSCON ICTC	Vanitha	Vanitha	S. Swapna
28	TB Chest ICTC	Dr. Leelakumari	M. Sridevi	Sd. Khadeeruddin K. Nagasri

Annexure-3

Care, Support and Treatment Center of Govt.Chest Hospital, Hyderabad

Facilities Available at CST Center, Govt. Chest Hospital, Hyderabad