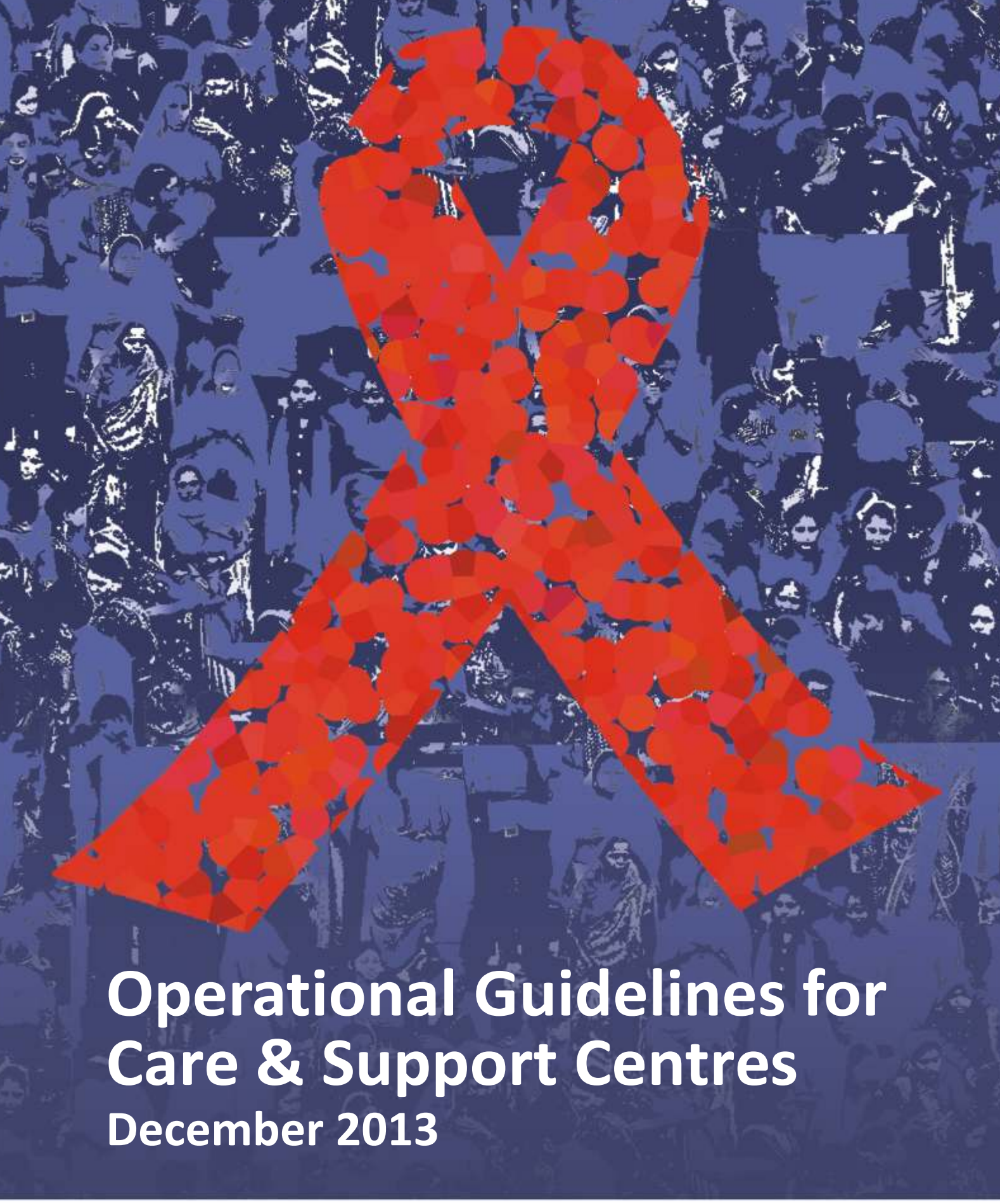

Operational Guidelines for Care & Support Centres

December 2013

National AIDS Control Organisation
India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

सत्यमेव जयते

Operational Guidelines for Care & Support Centres

Department Of AIDS Control
(National AIDS Control Organisation)
Ministry of Health and Family Welfare
Government of India
6th Floor, Chandralok Building, 36 Janapath,
New Delhi - 110001

December 2013

सत्यमेव जयते

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Ministry of Health & Family Welfare
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FOREWORD

The Department of AIDS Control envisions an India where every person living with HIV has access to quality care and is treated with respect. The Care and Support Centres set up throughout the country are a robust endeavour to help the PLHIV lead a life of dignity. Effective prevention, care and support for HIV/AIDS is possible in an environment where human rights are respected and people living with of affected by HIV can live life without stigma and discrimination. In order to make this happen, this scheme seeks to plug the gaps in the care and support scheme that was formerly implemented under NACP III.

The free Anti Retroviral Therapy (ART) initiative in India was launched on 1st April, 2004. It is considered one of the most effective interventions available today to efficiently control the replication of HIV virus in human bodies. The Care and Support Centres would be complementing the National ART programme. Care and support will be provided through institutional as well as community based counselling services, outreach activities and linkages with other service providers to ensure that no PLHIV is left out of the care continuum. With the clear mandate of creating an enabling environment, the Centres will work with stakeholders to ensure stigma free holistic services for all PLHIV.

I hope these guidelines will be useful to the care providers, programme managers, and all stakeholders in providing excellent care to the people living with HIV/AIDS.

01 December, 2013

(LOV VERMA)

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अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ
Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing

सत्यमेव जयते

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We hope these guidelines go a long way in implementing the Care and Support Centres in the country.

01 December, 2013

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Glossary

ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWW	Aanganwadi Worker
BPL	Below Poverty Line
CAB	Community Advisory Board
CBO	Community Based Organization
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CST	Care, Support and Treatment
CSC	Care and Support Centre
CLHIV	Child Living with HIV
CSO	Civil Society Organization
CST	Care, Support and Treatment
DAC	Department of AIDS Control
DALSA	District Legal Services Authority
DAPCU	District AIDS Prevention & Control Unit
DIC	Drop-in Center
DLN	District Level Network
DHO	District Health Officer
DRT	Discrimination Response Team
DRS	Discrimination Response System
DOTS	Direct Observed Treatment Short course
DQA	Data Quality Audit
FSW	Female Sex Worker
HRGs	High Risk Groups
JAT	Joint Appraisal Team
JD	Joint Director
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug Users
IEC	Information Education Communication
LFU	Lost to Follow Up
LSE	Life Skill Education
LWS	Link Worker Scheme

NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NRLM	National Rural Livelihood Mission
MNERGA	Mahatma Gandhi National Rural Employment Guarantee Act
MSM	Men who have Sex with Men
MTH	MSM/Transgender/Hijra
OBC	Other Backward Classes
OI	Opportunistic Infections
ORW	Outreach Worker
OVC	Orphan and Vulnerable Children
PAC	Project Advisory Committee
PC	Project Coordinators
PD	Project Director
PEP	Post Exposure Prophylaxis
PLHIV	People living with HIV
PHC	Primary Health Centre
PPTCT	Prevention of Parent to Child Transmission of HIV
PR	Principal Recipient
PWID	People Who Inject Drugs
RFP	Request for Proposal
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infections
SACS	State AIDS Control Society
SC	Scheduled Caste
SLN	State Level Network
ST	Scheduled Tribe
STI	Sexually Transmitted Infections
SOC	State Oversight Committee
SOE	Statement of Expenditure
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SSR	Sub-Sub-Recipient
ST	Scheduled Tribe
TB	Tuberculosis
TG	Transgender
TI	Targeted Interventions
TOT	Training of Trainers
UC	Utilization Certificate

Key Definitions

1. **Adherence:** "Extent to which a person's behaviour – the taking of medication and the following of a healthy lifestyle including a healthy diet and other activities – corresponds with the agreed recommendations of the health care providers." (WHO, 2003).

2. **Advocacy:** Advocacy is a method and process of influencing decision-makers and public perceptions about an issue of concern and facilitating collective action to achieve social change and a favourable policy environment to address the concerns.

3. **Balanced Diet:** A balanced diet consists of adequate amounts of all the necessary nutrients required for healthy growth and activity. It includes fats, carbohydrates, proteins, and vitamins.

4. **CD4 Count:** CD4 cells are a type of white blood cells that fight infection. Another name for them is T-helper cells. The CD4 count measures the number of CD4 cells in the blood sample. The CD4 count helps to understand how strong one's immune system is, indicates the stage of HIV disease, guides treatment, and predicts how the disease may progress. Keeping the CD4 count high can reduce complications of HIV disease and extend life.

5. **Chronic HIV Care:** Ongoing long term care given to people living with HIV to enable them to be healthy and enjoy quality life through available scientific methods with the help of professionals.

6. **Community Mobilisation:** A process through which individuals, groups or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs either on their own initiative or stimulated by others. This leads to collectivization and empowerment of the community if adequately backed by capacity building.

7. **Concordant Couple:** In the case of HIV infected individuals who are married, when both the couple is seropositive, they are referred to as a concordant couple.

8. **Disclosure:** The act of informing another person or persons of the HIV-positive status of an individual. Disclosure may be done by the clients themselves or with the help of another person such as a counsellor.

9. **Discordant Couple:** In the case of HIV infected individuals who are married, when either of the couple is seropositive for HIV virus and the other is negative, they are referred to as a discordant couple.

10. **Discrimination:** Refers to an unfair action against an individual because he/she belongs to a certain stigmatized group.

11. **Documentation & Reporting:** The procedure of systematically recording processes and outcomes of project activities with the help of data analysis and interpretations wherever possible and sending them to the apex centres through proper formats and on time.

12. **Enabling Environment:** As part of programme intervention, advocacy is undertaken with key stakeholders to ensure there is support for the programme and communities are able to access services.

13. **Home Visit:** Visit undertaken by an outreach worker with the consent of their clients to provide support and assistance at their doorstep as and when required

14. **Linkages:** The programme component that explores and establishes functional partnership with different existing management and service delivery outlets of project related programmes and institutions in the project area.

15. **Linked In:** Successful application facilitated by CSC for any social benefit scheme or social entitlement.

16. **Monitoring & Evaluation:** Processes that help us to assess the progress we are making towards our aims and objectives. They enable us to answer important questions such as:

    a. How well are we doing?

    b. How far are we from meeting the aims?

    c. Are we doing the right thing?

    d. What difference are we making?

    e. What do we need to change about what / how we are doing it?

17. **Opportunistic Infections (OIs):** These are infections that occur in a person because they have a damaged immune system (their body has a reduced ability to fight infections due to the presence of HIV).

18. **Palliative Care:** Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. (WHO)

19. **Positive Living:** Acceptance of one's HIV status in a positive way, leading a healthy lifestyle that ensures a quality life and motivating others to lead a healthy and positive life as part of positive living.

20. **Prophylaxis:** The usage of a drug or vaccination specifically aimed at ensuring effective prevention of an infection even when there is a chance for the person to get exposed to the causative agent.

21. **Referrals:** Ensuring that project beneficiaries are sent to the appropriate service delivery outlets such as ART centre, STI clinics, RNTCP centres etc. when they are in need of various services. Mutual referrals can happen when the referred beneficiary is sent back to the original setting after accessing the required service.

22. **Safer Sex:** Any sexual practice that does not let the partner's semen, vaginal fluids or blood get into someone's body. Safer sex often involves the use of male or female condoms as barriers between the possibly infectious fluids and mucous membrane or open cuts.

23. **Self-stigma:** Refers to feelings of hatred, shame and blame towards oneself. Individuals may believe that they may be judged by others and may refuse to disclose their HIV status for fear of possible negative reactions from family and friends.

24. **Stakeholders:** Individuals and groups who are directly or indirectly benefiting from or affected by any programme activities.

25. **Stigma:** A powerful force of social control which is often used to isolate and control individuals with certain characteristics that some consider socially undesirable.

26. **Viral Load:** The amount of HIV virus present in a human body in the context of HIV infection that is being measured through scientific methods.

27. **Social Welfare/Protection Schemes:** The schemes announced by central and state governments and other donor agencies from time-to-time such as housing, employment, education, financial assistance, etc. that would be beneficial to the PLHIV.

Introduction

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1. Introduction

Care, Support & Treatment (CST) is an integral component of the National AIDS Control Programme (NACP). Under the National AIDS Control Programme Phase - II, 122 Community Care Centres (CCCs) were set up to provide treatment for minor opportunistic infections (OIs), side effects of anti-retroviral therapy (ART) and to provide psychosocial support through sustained counselling. CCCs were intended to function as a bridge between hospital and home-based care. Hence, CCCs were envisaged as stand-alone short-stay homes for people living with HIV (PLHIV). These were not linked to other activities of the programme.

The introduction of ART in 2004 brought about a change in the role to be played by the CCCs. The CCCs transformed from a stand-alone short-stay home to playing a critical role in enabling PLHIV to access ART as well as providing monitoring, follow-up, counselling support to those who are initiated on ART, positive prevention, drug adherence, nutrition counselling, etc.

1.1 Challenges in Care and Support under NACP III[1]

NACP IV working group on care and support had identified the following gaps in care and support services provided under NACP III:

1. Unmet care and support needs

   Although the access to clinical services has improved significantly in NACP III, not all infected individuals receive comprehensive and holistic care and support, especially where psychosocial needs are concerned. There are limited strategies to mitigate the impact for PLHIV, children and their families. Additionally, the coverage of PLHIV from high risk groups (HRGs) and PLHIV living in rural areas and hard to reach areas with care and support services is inadequate. Though there are many service delivery points for different components in NACP III, the linkages and referrals among various service components such as Drop-in-centre (DIC)/District level network (DLN), ART, ICTC, and TI are inadequate.

2. Inadequate utilization of existing schemes and structures

   Though the utilization of services has been improving year-on-year, the proportion of HIV infected women accessing services continues to be a challenge due to stigma. The health care workers' sensitivity is low. There is a lack of clarity of the roles of link and outreach workers. It is also not clear as to who they are accountable to. Their outreach services are offered in a vertical manner requiring strengthening of co-ordination. Mechanisms for referral are weak and inadequate.

3. Lack of monitoring and evaluation (M&E) systems to measure care and support

   The current M&E system captures information on clinical services. However, it does not capture indicators of care and support or services provided to HRG. Additionally, there are no indicators that capture type and quality of services.

4. Sub optimal use of human resources

   Currently for activities involving community mobilization and coverage of PLHIV, the same PLHIV is reached by multiple ORWs from different components such as TI NGOs, CCC and DIC, resulting in sub-optimal utilisation of scarce resources.

[1]Adapted from report of NACP IV working group on Care, Support and Treatment for PLHIV

1.2 Care, Support and Treatment under NACP IV

The overall goal of CST component under NACP IV is to provide universal access to comprehensive, equitable, stigma-free, quality care, support and treatment services to all PLHIV using an integrated approach.

Based on the recommendation of NACP IV working group on care and support, the strategy of implementation of the care and support is being completely revamped to ensure cost effectiveness and sustainability. In line with the priorities of NACP IV, medical services are being completely integrated into the existing health system and simultaneously efforts are being made to strengthen capacity of the existing health system for effective delivery of care, support and treatment related services.

Under NACP IV, Care & Support Centers (CSCs) will be established and linked to all ART centres across the country. The CSCs will serve as a comprehensive unit for treatment support for retention, adherence, positive living, referral, linkages to need-based services, and strengthening an enabling environment for PLHIV. This will be part of the national response to meet the needs of PLHIV, especially those from the high risk groups, and women and children infected and affected by HIV. CSCs will be run by civil society partners including District Level Networks (DLN) and non-government organizations (NGOs). These partners have been selected primarily on the basis of their track record of working successfully with the local PLHIV community. The guideline focuses on the objectives, criteria for selection, required infrastructure, human resources, MIS tools, and financial guidelines for CSCs. This will also provide directions for setting up new CSCs and guide the existing ones on effective implementation of the programme.

1.3 Brief introduction to Care & Support Centres

Care and Support Centre is a national initiative to provide expanded and holistic care and support services for PLHIV. It symbolises a ray of hope in the lives of PLHIV. CSC expands access to essential services, supports treatment adherence, reduces stigma and discrimination, and improves the quality of life of PLHIV across India.

Goal: The overall goal of CSC is to improve the survival and quality of life of PLHIV.

Specific objectives of the programme include the following

- **Early linkages of PLHIV to care, support and treatment services:** The CSC will support PLHIV in early linkage to care, support and treatment services.
- **Improved treatment adherence and education for PLHIV:** Adherence education and support can help PLHIV sustain and manage their treatment regimes.
- **Expanded positive prevention activities:** Early testing and diagnosis will be encouraged through appropriate counselling and peer support. All who are tested will be supported to engage their sexual partners, family members and children toward testing.
- **Improved social protection and wellbeing of PLHIV:** The CSC will facilitate linkage to the existing social welfare and protection schemes under different line departments, corporate sector, public sector undertakings, faith based organisations, and civil society organizations.
- **Strengthened community systems and reduced stigma and discrimination:** To ensure a robust system that supports the program goal and ensures reduced stigma and a discrimination free access to quality services.

To meet the above objectives, 350 CSCs will be established and each CSC will undertake a series of activities such as providing counseling, treatment education, and linking the clients to various health and non-health services. These activities will be measured through specific indicators which are described in the chapter on supervision, monitoring and evaluation.

Infrastructure and Human Resources of CSC

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2. Infrastructure and Human Resources of CSC

The Care & Support Centre is the focal point of all activities under the project where all care and support services for PLHIV are provided under one umbrella. The centre will not only provide a safe space to PLHIV but will also serve as a link between the community and other allied services required for PLHIV. Thus CSC should be suitably located for PLHIV to access the service and have adequate space and facilities to provide envisaged services to the community. The following are the essential features of the CSC structure to ensure the best operational systems.

2.1 Location and Access to CSC

CSC shall be located at a central place that is easily accessible to PLHIV and well connected with different modes of transportation available in the district. Every CSC will be connected to at least one ART centre (in many cases it will be more than one) in the area. The distance between the ART centre and CSC should be around 2.5 to 3 kms.[2] In case a CSC covers more than one ART centre, it should be located closer to the ART centre with higher client load, and preferably located in the district headquarter for better coordination with all the stakeholders. At the same time, this CSC will work in coordination with other ART centres.

2.2 Infrastructure Required at CSC

CSC Building and Space

CSC is to be set up in a leased-out space or in rented space. However, the CSC must be housed in a permanent concrete/pucca building and have enough space to enable various operations and obligations of support to PLHIV. The availability of open areas for the community members to rest and relax will be an added advantage. Good ventilation, clean and safe drinking water and clean toilets with water storage facility are essential requirements. The following internal provisions are essential to set up a CSC.

Reception: This is to be located at the front entrance. Reception and waiting room should have an ideal space of 50 to 100 sq. feet area with enough provisions for people to wait. There shall be a reception counter/table and chairs for the people to sit. There shall be provision for displaying welcome board, visitors' registers, take away IEC materials, leaflets/pamphlets, suggestion box, first aid box, and information on programme related services available in the locality. The area should make the client feel welcome and give a positive feeling.

Project office area: This area may be devoted as the work station for the staff, keeping the assets, documents, forms and records, and conducting group meetings, review meetings, etc. The office area ideally should be of 200 – 300 sq. feet area with adequate furniture like almirah/cupboards for documents, chairs, tables, etc.

Space for relaxation: This area is devoted for PLHIV to rest and for conducting infotainment activities. There should be enough space for people to rest and to conduct meetings such as SGM, staff meetings, etc. Recreational facilities like TV/DVD/CDs, indoor games like carom, chess and other games materials for children, and/or collection of books/magazines should be kept here. There should

[2] In rare case if it is more than that, a special permission from PR is needed routed through SOC of the state.

be the provision of 2-3 mattresses for the PLHIV to relax. Condom box should be placed from where the PLHIV can access free condoms. A referral directory with the details of referral centres, facilities available, contact details, etc. should be displayed in the centre. A visitors' register is to be maintained for all clients visiting the CSC. All the activities conducted at the centre are to be documented in a register (CSC Register). These activities are to be reported in the quarterly narrative report.

Rest and relaxation service to clients will be provided only during day time and overnight stay should not be allowed in CSC.

Counselling room/space: Every CSC will have a separate space for counselling with complete audio-visual privacy and provision for storing confidential records. The area should be large enough to conduct family counselling (2-4 people). Condom demonstration kit, IEC materials and posters on nutrition, positive living and PEP, referral directory with details of services available, referral forms, and job aids like flip books on ART adherence should be available in the counselling room.

2.3 Information to be Displayed at CSC

- Confidentiality statement
- Do's and don'ts chart
- Client's rights and responsibilities
- Take away IEC materials, leaflets/pamphlets
- Staff designation and contact details
- List of Link ART Centers attached to the relevant ART center
- Details of Social Benefit Schemes
- Details of CSC functionaries
- Emergency contacts
- Details of Discrimination Response Team (DRT) members
- Referral Directory providing information on programme related services available in the locality
- A separate display of all services of CSC, including days and timings for important support group meetings should also be ensured

The information displayed should ideally be in the local language and in pictorial form as much as possible.

2.4 Furniture Provisions for CSC

The CSC shall have essential furniture as required for its optimal and adequate functioning and should be decided by the population size for which the CSC is set up. The following essential criteria may be followed in a CSC related to furniture.

- Small sized and less space occupying furniture.
- Comfortable chairs with armrests for PLHIV. Having light weight chairs would be convenient as they could be moved as desired for small group meetings/discussions.
- Computer table.
- A weighing machine and height measuring chart on wall.
- Sturdy steel cupboards which can be locked.
- Clean drinking water and glasses.

2.5 Human Resource at CSC

The day-to-day functioning of the CSC shall be supported by a team comprising of project coordinator, counsellor, peer counsellor, and outreach workers. The staff members must have compassion for community, multitasking skills and strong emotional intelligence. To enhance community participation and ownership, it is necessary for CSC to recruit at least 50% of their staff from the PLHIV community. Peer counsellor must be from the community and as far as possible, ORWs also should be selected from the PLHIV community. It would be preferable to identify at least one ORW from the community represented by HRGs in order to better understand the special needs of these population groups.

2.6 Staff Selection Process

SSR should publish the vacancy details in their office, CSC, SR Office, DLN office, ART centre, DAPCU office, local TI NGOs, and other civil society organizations. A committee should be formed to screen the applications and document the process, and date of interview should be intimated to the candidates well in advance to ensure their participation.

Suggested interview panel for the selection

The interview panel should consist of one member each from the following to make the recruitment process transparent.

1. Representative from Sub-Recipient Organisation
2. DAPCU Representative and/or Medical Officer- ART centre /Deputy CMHO or any other government Medical Officer/ ART Counsellor
3. SSR Organization Representative

The SSR shall issue a contractual service agreement to the selected candidate, in accordance with SSR contract with the SR, which could be further renewed on the basis of satisfactory performance.

Staff positions for CSC[3]

Name of the position	Essential qualification and experience	Sanctioned number of positions	Reporting to	Reported by
Project Coordinator	Post graduate with two years relevant experience or graduate with more than three years of experience.	One	Institutional Head	Counsellor, Peer Counsellor, Outreach Worker, and Accountant
Counsellor	Graduate in Psychology/ Sociology/Social Work/Human Development (PG In any of these subjects is desirable) Two years relevant experience	One	Project Coordinator	Peer Counsellor
MIS Assistant **(CSC category A and B)**	Graduate with relevant experience	One (for CSC with target > 5000)	Project Coordinator	None

[3] The criteria for selection will be relaxed for members from PLHIV or key population group from master degree to the level of degree, from degree to plus two, and from plus two to matriculation. However, the final decision lies with the interview panel in this regard however no concession should be given beyond the limit

Peer Counsellor	12th passed with relevant experience and essentially from PLHIV community	One	Project Coordinator	None
Outreach Worker (ORW)	8th Std passed. Basic understanding on NACP and willing to work among PLHIV groups with reasonable writing and speaking skills and preferably from the community of people infected or affected by HIV/AIDS	2-12	Project Coordinator	None
Accountant	B.Com with experience of working with Tally	One	Project Coordinator	None
Support Staff	1-2 years' relevant experience	One	Project Coordinator	None

The CSC will be open for at least eight hours per day for six days a week. All contractual employees are entitled to 30 days accrued/earned leave (i.e. 2½ days per month) & 10 days sick leave.

2.7 Terms of Reference (TOR) for Staff at CSC

Name of the staff	Key responsibilities
Project Director	• PD in CSC is an honorary official of the SSR • PD has to make minimum one visit in a month to review the programme activities • Responsible for overall management including finance management of CSC • Provides supervisory support to CSC staff • Represent CSC in important meetings with stakeholders • Supports CSC team in undertaking local level advocacy • He/she is the supporting link between organization and CSC team
Project Coordinator	**Key Functions:** The Project coordinator will be responsible for implementation of the programme, documentation of programme activities and timely preparation of reports at respective SSRs. The PC will work in close collaboration with the programme team and Sub Recipient (SR). **Specific roles and responsibilities of PC** • Develop and facilitate implementation of weekly and monthly work plan for CSC 1. Support all staff to develop their weekly/monthly plan based on programme priorities and monthly targets. 2. Ensure that the peer counselor and ORWs carry materials that are important for the smooth conducting of programme activities, both within the CSC and during the field visits; for example, daily diaries and communication/advocacy materials for distribution/demonstration. 3. Ensure availability of materials (condoms and communication materials wherever necessary) for distribution. 4. Undertake random field visits with/without ORWs/PE Counselor to observe programme activities in the field and to provide handholding support. • Provide the CSC registration number to all clients registered in CSC/field by ORW. • Undertake regular monitoring of programme activities by doing the following 1. Oversee all the M&E activities in the project. Ensure that all the data collected are entered in respective tools on a daily basis and verify all the records on weekly basis to ensure quality of the data.

	2. Ensure timely data entry in CMIS and SIMS. 3. Generate monthly and quarterly reports as per protocol. 4. Ensure LFU/MIS cases tracking details are shared with ARTC on a regular basis. 5. Ensure timely submission of quarterly report to SR/DAPCU/ARTC. 6. Provide monthly update on target versus achievement to PD of the organization and CSC staff. 7. Arrange weekly and monthly meetings to identify lacunae in the project and lead the efforts to address them. • Lead advocacy, networking and linkages related activities of CSC. • Establish linkages with local service providers, especially with ART centre, ICTC, PPTCT, DOT, STI clinics, TI, LWS and other service providers 1. Lead/facilitate all advocacy efforts at the CSC (SSR) level, including conducting meetings and focus group discussions in the field. 2. Participation in DAPCU and ART Coordination meeting and sharing CSC activities and priorities. 3. Plan for quarterly advocacy events in collaboration with Advocacy Officer of SR. 4. Mobilize resources from other sources for the benefit of PLHIV. • Provide administrative and capacity building support for the following 1. Liaise with the accountant to monitor the financial transactions and expenditure pattern in accordance with approved budget. 2. Support the accountant in developing financial forecast. 3. Verify and approve the vouchers. 4. Facilitate visits from SR, PR, SACS, DAC, donors, etc. 5. Identify the capacity building needs of CSC staff and arrange in-house training in coordination with PO of SR.
Counsellor	**Key Functions:** The Counsellor is the key person responsible for providing overall psychosocial counselling support to PLHIV including children and their families who frequent the CSCs. The counsellor will work closely with ORWs and Peer Counsellor and equip them with skills on developing support groups, providing counselling support on selected thematic areas. **Specific roles and responsibilities of Counsellor** • Provision of advance level counselling on selected themes to PLHIV beneficiaries and their families in the project. 1. Understand the sub-group-specific special needs in counselling (e.g., PLHIV from HRGs, CLHIV) and provide advanced psychosocial and family counselling on emotional and spiritual well-being of PLHIV. 2. To provide treatment education and adherence counselling at the CSC with PLHIV clients/caregivers who visit CSC. 3. Counselling on positive prevention, including discordant couple counselling. 4. Counselling on reproductive health and child bearing. 5. Drug/alcohol and substance abuse counselling. 6. Give basic information on legal rights and if required refer them to District Legal Service Authority (DALSA). 7. Nutrition/dietary counselling and conduct nutrition assessment. 8. Information sharing (related to HIV disease, quality of life, etc.). 9. Counselling of children and adolescents infected and affected by HIV by assisting in varied activities such as life skills training, talent promotion, recreational activities, child protection issues, formation of children support groups, youth clubs, sports activities, and family support groups.

	• To ensure that PLHIV, wherever necessary, are linked to other services/service providers both within the CSC and outside (as part of linkages established by the CSC), and linkage with social entitlements is facilitated. • Facilitating the process of capacity building of peer counsellors. • Help the ORW/peer counsellor in organising and facilitating support group meetings (SGM). • Assist/develop the communication activities of CSC • Assist with the development of content/strategy for sensitisation meetings with different stakeholders as part of the advocacy initiatives. • Undertake field visits along with peer counsellor and ORW to meet with members of PLHIV community and their families. • Ensure compliance with the ethical norms in counselling as established by the project and in line with the NACP guidelines. • Facilitate the following 1. Monitoring the weekly work plan of ORWs. 2. Coordination in creating linkages/networking, especially with ART centre. 3. Helping Project Coordinator in creating appropriate strategies for advocacy environment. 4. Maintenance of counselling and referral registers. 5. Recording feedback from the community in matters relating to counselling. 6. Assist Project coordinator in building an effective field team.
Peer Counsellor	**Key Functions:** Key link between the CSC and the field in all matters relating to counselling. S/he will also play an important role of linking beneficiary PLHIV to the project, linking the CSC with the PLHIV networks and also in the advocacy activities in the project. **Specific roles and responsibilities of Peer Counsellor** • Conduct sensitization meeting with village panchayats and key stakeholders on issues of care and support and prioritize PLHIV and affected families for availing social entitlements and schemes. • Advocacy with local stakeholders. • Liaise with local positive networks (wherever CSCs are managed by NGO). • Encourage and counsel partners/spouses and children for early testing and accompany and refer family members and partners for ICTC and other health referrals as needed. • Lay counseling on treatment adherence. • Formation and strengthening of support groups of adults and children in the respective field areas with the help of Counsellor and PC. • Support outreach by providing first stop counselling services in the field for PLHIV and families on treatment education for people who are on ART and not on ART. • Provide basic psycho-social support to PLHIV who are on ART and their family members and motivate them to come to CSC for advance counselling. • Motivate the PLHIV to address the issue of self-stigma. • Undertake following activities 1. Assist the ORW in providing referral services to other service providers, home visit and follow-up visits for PLHIV on ART. 2. Attend the training programs organized by the DLN/NGO (SSR). 3. Maintain records/registers and submit monthly reports to the DLN/NGO. • Play lead role or assist (ORW and other CSC staff) in project activities that require the presence of community members (e.g., advocacy initiatives).

	• Generate demand for welfare programs/schemes and facilitate identification of beneficiaries. • Building skills of PLHIV community in understanding the importance of positive prevention. • Attend review meetings and prepare and present daily reports to CSC counsellor. • Attend all trainings, workshops and seminars conducted by the SR/SSR.
ORW	**Key Functions:** ORW will lead the field activities of the CSC. They will identify and facilitate registration of PLHIV including those with special needs (children, HRGs) at the CSC. In conjunction with peer counsellors, they will support the PLHIV to access health and non-health services through regular follow up. **Specific roles and responsibilities of ORW** • Identification of new PLHIV and registering them for CSC. • Conduct field visits and participate in the following awareness generation activities 1. Conduct home visits for the registered PLHIV and affected families to provide treatment education, education on OIs, nutrition, healthy lifestyles and positive living, and psychosocial support. Support of peer counsellor can be taken for addressing specific issues during home visits. 2. Track LFUs (ART and pre-ART) and report back on the status. Based on the list of LFU and MIS cases received from the ART centre, plan home visits for the defaulters, and motivate them to resume their treatment. Where feasible, accompany them to the services. For untraced defaulters, report the status to PC with evidence. 3. Liaise with and conduct regular visits to respective ART centres assigned by the coordinator. • Provide information on home based care to PLHIV and their family members. • Develop weekly and monthly work plans, including details of activities such as home visits, LFU follow-up, advocacy events, visit to health facilities, meetings in CSC, and participation in support group meetings. • Document outreach activities and other works undertaken in prescribed MIS tools and submit to PC once in a week. • Undertake advocacy by doing the following a. Organizing community events with the help of peer counsellors and DLN (e.g., health camps, fairs, festivals). b. Organizing and participating in advocacy activities, including rapport building with other stakeholders both within government and in the community. c. Liaise with Anganwadi worker (AWW) and ASHA for referral of eligible children and pregnant women to access supplementary nutrition. d. Liaise with community leaders, local clubs and other social organizations to enhance their involvement in the program. • Facilitate filling of forms for social entitlements and schemes and hand them over to the PC.
Accountant	**Key Functions:** Key focal person at the SSR level for all financial matters in SSR. He/she will work closely with PC and the Finance Officer in SR to ensure smooth conduct of financial matters. **Specific roles and responsibilities of Accountant** • Disbursement of salary. • Work closely with PC and other staff of CSC. • Liaise with finance staff at SR. • Preparation of appointment letters for new staff in consultation with PC.

	• Maintaining indent file, requisition slip, order file, quotation file, challan, cash book, ledger book, voucher file, rent and service charges file, office operating cost file, communication (telephone/T.A.), bank transactions, recording daily flow chart. • To maintain inventory and stock registers. • Maintain attendance register and leave record. • Bank reconciliation. • Representing the organization at meetings, conferences and workshops. • Preparation of financial reports such as CMIS and SOE.
MIS Assistant **(CSC with more than 5,000 target)**	**Key Functions:** The MIS Assistant will be responsible for documentation including maintenance of MIS tools, CMIS and timely preparation of monthly and quarterly reports at CSC level. The MIS Assistant will work in close collaboration with the CSC team and Sub Recipient (SR). **Specific roles and responsibilities of MIS Officer** • Maintenance of MIS and M&E activities in CSC on regular basis. • Providing assistance to CSC staff on data updation in MIS forms and enter data in CMIS on a daily basis. • Periodic cross verification of data collected by CSC staff at the field level. • Cross check the data of monthly ART registrations received from ART centre to calculate monthly registration targets and LFU/MIS cases with coordination of other CSC Staff. • Help project coordinator to prepare the Monthly Progress Report (MPR) and Quarterly Progress Report (QPR). • Updation of SIMS MPR on a monthly basis. • Provide the data and information to SR as and when required. • To do basic analysis of data and provide programmatic feedback to project coordinators. • To help team from SR/PR during OSDV/DQA visit. • To ensure timeliness, completeness and correctness of CSC reporting.

Services Provided by CSC

03

3.1 Registration Criteria 28

3.2 Services of CSC 30

3. Services Provided by CSC

This chapter describes the criteria for registration in a CSC and explains the services that are provided through the centre.

Registration

PLHIV will be registered at CSC for receiving care and support services. A unique identification number (UID) will be assigned to each registered individual. However, this can be done only after one of the following services has been provided to the client.

3.1 Registration Criteria

Criteria for registration of clients in CSC

	Service provided	Conditions for registration	Means of verification	Responsible team member
1	Counselling in CSC	Client is provided any one type of counselling	Counselling register	Counsellor or peer-counsellor
2	Support group meeting in CSC	Client has participated in the SGM conducted in CSC	SGM register	Counsellor, peer-counsellor, ORW, PC
3	LFU track back to ART	If the client is LFU and CSC staff track them and bring them back to treatment	ART-CSC tracker sheet	ORW, peer-counsellor
4	MIS case follow up	If the client is MIS case and CSC staff track them and bring them back to treatment	ART-CSC tracker sheet	ORW, peer-counsellor
5	Pre-ART Registration	If the client is not registered for Pre-ART and CSC staff refers them for registration and Pre-ART registration has been done	Referral Reporting Register, Outreach Register & Referral slip (Part-C)	Counsellor, peer-counsellor, ORW, PC
6	CD4 follow up	If the follow-up CD4 test of the client is due and client is referred for testing and CD4 test is completed	ART- CSC Tracker	Counsellor, peer-counsellor, ORW, PC
7	Link to TI	If a HRG PLHIV is not linked with TI and successfully linked with TI to get all services from TI	Referral Register, Outreach Register & Referral slip (Part-C)	Counsellor, peer-counsellor, ORW, PC
8	Testing of partner/ spouse, children and family member	If a partner/spouse, children and family members have not been tested for HIV, are referred for testing and testing done	Referral Register, Outreach Register & Referral slip (Part-C)	Counsellor, peer-counsellor, ORW
9	Hospital /clinical referrals (OI management, side effects, general ailment, TB, STI treatment)	If a client is referred to OI treatment or any other general ailments in any health facility and receives treatment	Referral Register, Outreach Register & Referral slip (Part-C)	Counsellor, peer-counsellor, ORW, PC

10	Support for Legal Aid	If a client requires legal aid and CSC staff facilitate successful application for legal aid	Referral Register, Outreach Register & Referral slip (Part-C)	Counsellor, peer-counsellor, ORW, PC
11	Social protection	If a client requires any social protection schemes and CSC staff facilitate successful application	Referral slip Copy of the application submitted with receipt note	Counsellor, peer-counsellor, ORW, PC
12	Social entitlements	If a client requires any social protection schemes and CSC staff facilitate successful application	Referral slip Copy of the application submitted with receipt note	Counsellor, peer-counsellor, ORW, PC

3.1.1 Registration cannot be done in the following situations

- If a client received an information session from CSC staff
- If the client only visits CSC for rest and relaxation
- If the client is provided condoms in the field
- If the client received counseling services in the field
- If the client is contacted either in ARTC and ICTC and given information on CSC services
- Registration cannot be done in mass social entitlement events or camps

At CSC, counsellor or peer counsellor will facilitate the registration whereas in the field, ORW also can do this along with counsellor and peer counsellor. They will collect the required information in Client Registration Form (CRF) and submit the filled format along with documentary evidence of the service provided to project coordinator. After the verification of information in CRF and evidence document, project coordinator will generate UID for the client.

3.1.2 Documents required for registration at the CSC

1. Copy of HIV test report
2. Copy of ART Green Card (*applicable for all positive clients who are already registered at ART*)
3. Documentary evidence of the service provided

UID number is an eleven digit number with first six digits representing the state, district and CSC code and last five digits representing the registration number of individuals starting with 00001in each CSC. This number will facilitate tracking of the individual over the entire period of the project. For the individuals on ART, this number must be written on their ART books as well to ensure better coordination with ART centers. Moreover, in case the PLHIV migrates to another district or state, duplication of registration in the CSC programme will be avoided.

The clients will also be assigned a family ID number.When a client enrols in CSC, he/she will be provided a family ID and the same number will be given to all other members of the family later on. Each ORW will cover a fixed geographical area. First two digits of Family ID have the ORW number, followed by three-digit serial number starting with 001. This number will help in tracking the services provided to PLHIV's family members who are HIV negative or their status is unknown. The PC will be providing the family ID number.

The registration details from all CRF will be recorded in an enrolment register (Annexure II.b) by the project coordinator or MIS Assistant. This line listing will be updated on a weekly basis and will help weekly outreach planning by the ORW.

3.2 Services of CSC

The services of CSC are counselling, outreach, linkages & referrals, advocacy & communication, support group meeting and creating an enabling environment.

Services	Activities	Infrastructure resources and supplies required	Expected output
Counselling services	• One-to-one counselling • Group/couple/family counselling • Specialised counselling for children and pregnant women • Counselling for HRGs • Outdoor counselling (through outreach)	• Facilities for individual and group counselling • Audio-visual equipment, DVD, etc. • Information, education and communication (IEC) materials (flipcharts on nutrition, ART, etc) • Demonstration models, condoms (male and female) for demonstration and distribution	Clients get support and information on: • Psycho-social support • Treatment literacy for drug adherence • Nutrition • Sexual and reproductive health issues (contraception, condom demonstration and promotion, unmet need for counselling on conception, medical termination of pregnancy, family planning for HIV positive couples, etc.) • Positive living and positive prevention • Home based care
Outreach services	• Follow up of PLHIV for ART adherence • Follow up of PLHIV for retention in care: — Pre-ART LFU — Tested positive but CD4 not done — Pre-ART clients who are eligible but not started ART — On ART MIS cases — On ART LFU cases • Follow up repeat CD4 tests • Reinforcement of key counselling messages as per client's need • Disseminate information on signs and symptoms of OIs	• Micro planning • Vulnerability index • Social map and geographical map • IEC materials • Referral slips and referral directory	• LFU and MIS clients are linked back to ARTCs • Early linkage to OI services • Every registered PLHIV is contacted periodically (once in a quarter)

Services	Activities	Infrastructure resources and supplies required	Expected output
Training on home based care services	• Educating care giver (family member) on taking care of minor ailments at home, health and hygiene maintenance to delay opportunistic infections, identifying signs and symptoms of OIs that need medical treatment, etc. • Counselling family members on preventive measures, and how to cope with emotions while dealing with family member/s who are living with HIV	• IEC materials for education	• Clients and family members educated on preventive measures • Clients take self- care, care givers provide basic home care to clients leading to reduction in OI episodes • Care givers of the clients practicing precautions to prevent HIV infection • Clients and family members are educated to overcome self- perceived stigma
Referral and linkage services	• Referral for treatment and health needs • Linkages and referrals for social welfare schemes and entitlements • Linkages and referrals for non-health needs • Accompanied referral from and to ARTC and other facilities • Coordination with referral centres	• List of facilities, services and schemes • Referral directory and referral slips	• Successful linkages (defined as clients getting the benefits) with service delivery points for medical and non-medical needs of PLHIV
Life skill education and vocational training	• Counselling on livelihood options, with special emphasis on women and youths • Life skills training • Vocational training through linkages with vocational training institutes in collaboration with departments such as Women and Child Development, Social Justice and Empowerment and other corporate sectors		• Clients motivated to be financially productive • Clients undergone vocational training and linked with schemes providing livelihood options

Services	Activities	Infrastructure resources and supplies required	Expected output
Advocacy and communication	• Regular sensitization meeting of all stakeholders • Media advocacy • Quarterly advocacy meetings • Regular meeting of DRT	• Advocacy meeting(one meeting per quarter) • Workshops • DRT	• Larger issues pertaining to PLHIV community are addressed through advocacy • Discrimination and other issues of PLHIV are addressed
Support group meeting	• Formation of support groups based on thematic areas • Regular SGM • Documentation of SGM	• Space for meeting register • Minimum number of participants (10 to 15)	• Platform for PLHIV to share their concerns and problems and learn from each other • Capacity building of PLHIV through SGM

Counselling Services

A trained counsellor will provide one-to-one counselling and family/couple counselling to the PLHIV on different thematic areas. The counselling details are to be recorded in the counselling register and updated on daily basis. Counselling at CSC is the provision of professional assistance and guidance in resolving personal or psychological problems by the following

- Helping PLHIV tell their stories.
- Giving PLHIV correct and appropriate information on HIV/AIDS and related issues.
- Helping PLHIV make informed decisions.
- Helping PLHIV identify and build upon their strengths.
- Helping PLHIV develop positive attitudes towards life.

Types of counselling

1. **Individual counselling:** The trained Counsellor at the CSC will provide one-on-one counselling to clients on thematic areas addressing need-based personal issues. All newly registered clients should be given at least one individual counselling based on need. The trained peer counselor will be providing one-on-one follow up counselling as per the needs of the clients, either at CSC or during field visits.

2. **Couple counselling:** Couple counselling is majorly undertaken to support the client in disclosure, coping with stress and also to motivate other partner for early testing. Couple counselling is to be provided on priority basis to discordant couples with an aim of ensuring prevention of HIV transmission from the infected partner to the uninfected partner. Uninfected partner of the discordant couples should be counselled to go for HIV testing once in six months. Concordant couples (both partners are living with HIV) will be counselled on positive prevention, positive living, coping with stress and emotion, and any other issues identified as per their needs.

3. **Paediatric counselling:** The trained counselor, using child friendly counseling techniques, will counsel children living with HIV on issues related to HIV status disclosure, ART adherence, personal hygiene, eating healthy and hygienic food, coping with emotion, etc.

4. **Adolescent counselling:** The trained counselor will provide counseling services to adolescents living with HIV on issues related to HIV status disclosure, ART adherence, personal hygiene, eating healthy and hygienic food, positive living, coping with emotion, dealing with peer pressure, etc. The adolescents who are affected as the children of parents living with HIV and siblings of children living with HIV will also be counseled on HIV prevention measures, coping with emotion and stress, dealing with parents/siblings living with HIV, significance of HIV testing, etc. Although affected adolescents will be provided counseling and other educational services at CSC or during field visit, they will not be registered at CSC separately. However, if they are the family member of any of the client registered at CSC, they will be registered as family member of the client.
5. **Peer counselling:** Peer counsellor is the person living with HIV who has been trained to provide psycho-social support counselling services to his/her peer members who are living with HIV. As a follow up of counselling service provided by the professional counselor, the peer counselor as a role model will provide counselling to clients on ART adherence, positive living, positive prevention and any other pertaining issues. Peer counselling service can be provided at CSC during home visits and any other places during field visits as per the convenience of the clients.
6. **Family counselling:** The trained professional counselor/peer counselor will provide counselling services to the parents, sisters, brothers, or any other person identified by the clients as care providers on issues related to dealing with the PLHIV, HIV preventive measures, home based care, etc.

Thematic areas of counselling

1) ART adherence
2) OI management
3) Nutrition
4) Psychosocial counselling
5) Maternal health and early infant diagnosis
6) HIV prevention
7) Home based care
8) Sexual and reproductive health
9) Adolescent counselling
10) Counselling for discordant couples
11) Safe sex education
12) Family planning
13) Counselling on disclosure
14) Others as per needs of the clients

Outreach Services

Refer to Chapter 4 for details.

Training on Home-based Care Services

Training on home-based care services will be imparted to PLHIV and their care givers in the family on basic infection control practices at home, cleanliness and sanitation of home environment, and also to take nursing care of small ailments and minor infections at home. Education and training on home-based care will also be aimed at enabling clients and care givers to identify signs and symptoms of infections or any health complaints requiring immediate medical attention. Clients will be provided with information about the nearest available health care facilities and importance of good health seeking behaviour.

The education and training on home based care will be incorporated into the regular support group meeting, and basic nursing care will be provided by peer counsellor and ORWs during their home visit.

Life Skill Education and Vocational Training

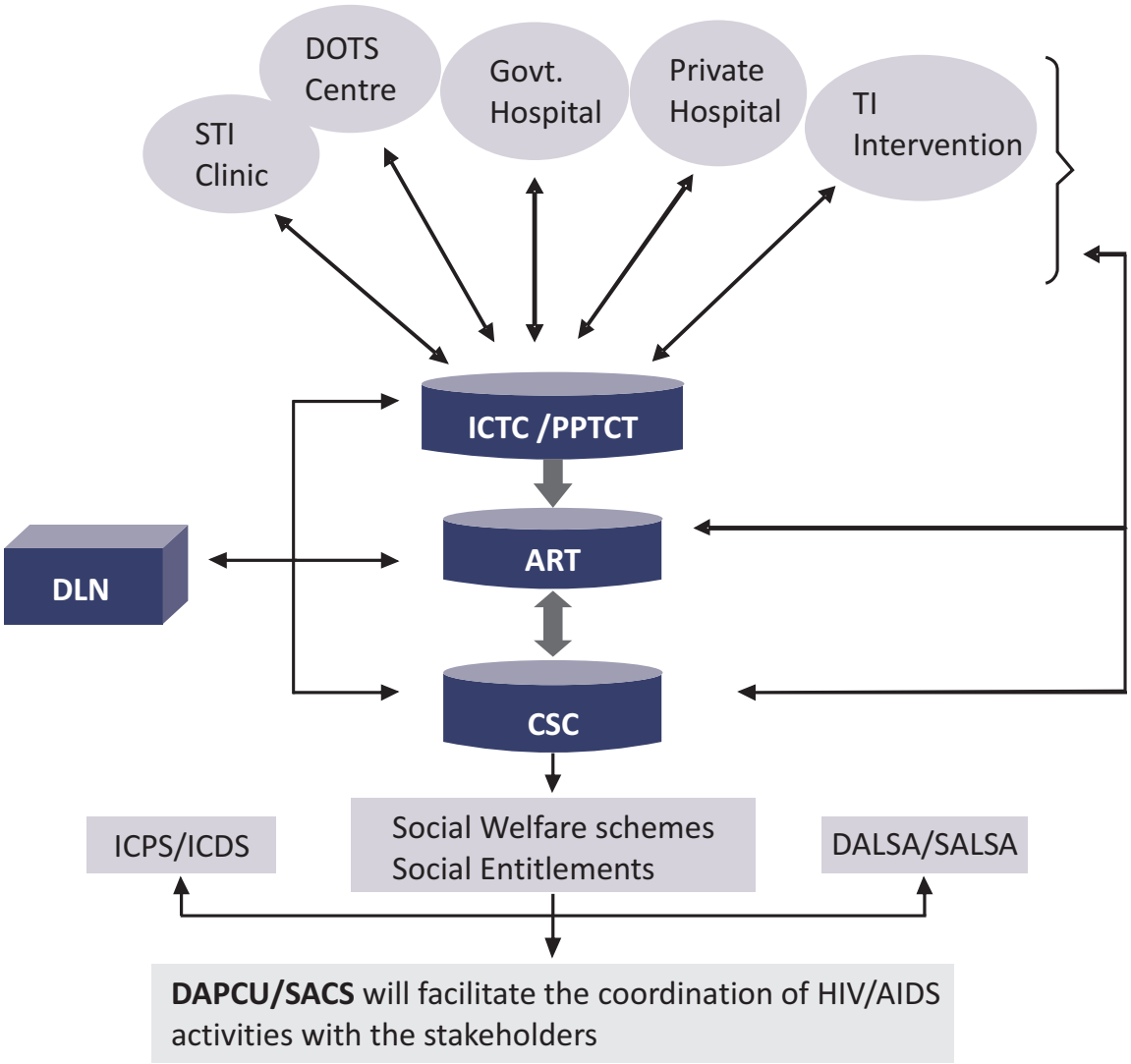
One of the important services of CSC will be providing life skill education and vocational training to clients with special emphasis on women and youths. Theoretical aspects of life skills will be incorporated into the on-going educational and training components and the vocational training will be provided through linkages with vocational training institutes under government departments as well as corporate sectors. The trained clients will also be linked to social protection schemes having livelihood options.

Referral and Linkage Services

CSC will act as referral hub from where the health and non-health needs of PLHIV will be addressed through referral to appropriate facilities. The programme will assess the needs of PLHIV under broad categories (psycho-social, legal, vocational, and so on) and identify the required resources in the region/district for addressing these needs, ensuring optimal use of resources is available.

CSC will establish linkages with other service delivery outlets in the district which will address some of the needs that cannot be addressed at the CSCs.

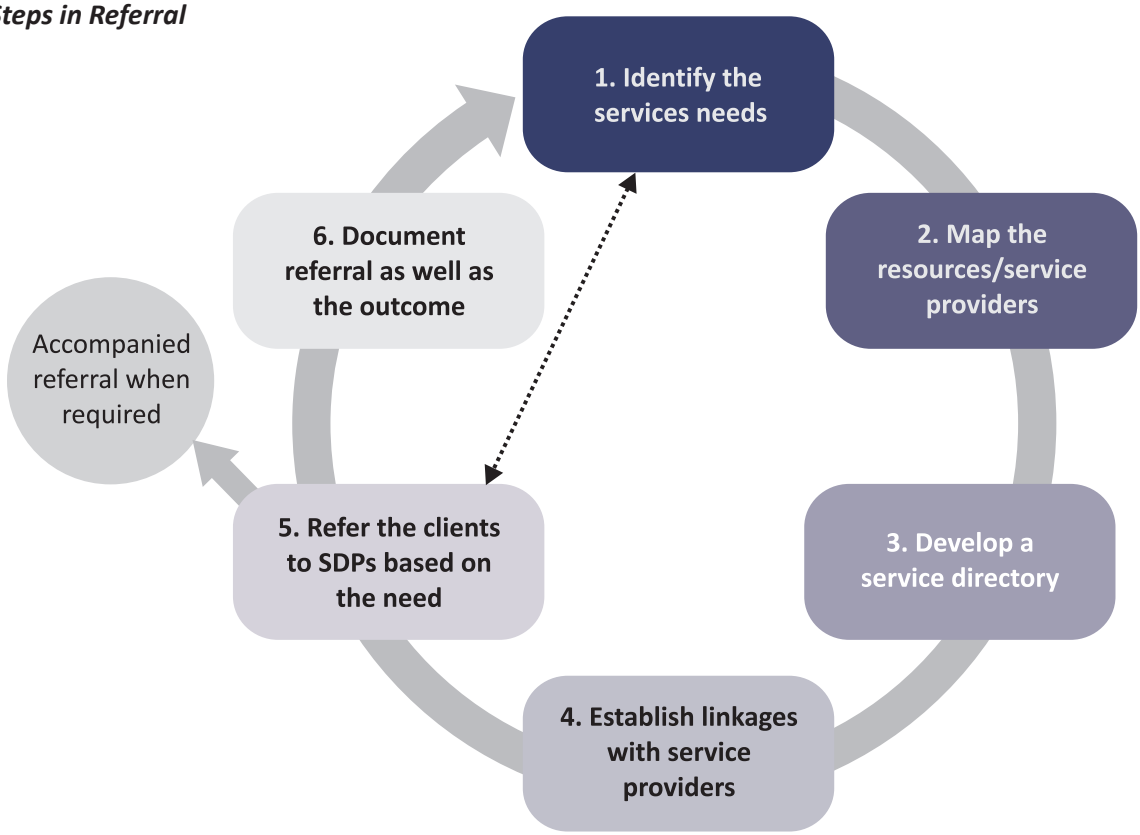
Referral and Linkage System



CSC Referral Matrix

	Referral centre	Purpose of referral		Referral centre	Purpose of referral
Health Needs	ART centre	• For ART initiation • CD4 tests • Management of ART side effects • Follow up	Non-Health Needs	Govt. dept.	• Social entitlements • Social benefit schemes
	ICTC and PPTCT	• HIV testing of spouse, partner and family members		Legal aid	• Free legal aid to needy PLHIV • Legal literacy
	Govt. & Pvt. hospitals	• Early identification • Follow-up of illnesses • OI treatment • General health issues • ANC • Child care • Access to co-trimoxazole prophylaxis		IGP	• Income generation programme for needy PLHIV • Vocational training
	STI clinics	• For STI treatment		FBO	• To mobilize nutritional support • For meeting non-HIV needs of PLHIV • Spiritual counselling
	DOTS center	• For TB diagnosis and treatment		CSR	• For IGP • Nutritional support
	OST centre	• For the provision of OST to IDUs		VHSC	Travel support to avail ART medicine
	Specialized counselling centre	• For advanced counselling			

Steps in Referral



Emergency/Referral Support

PLHIV community members will need medical services for many reasons including treatment of opportunistic infections, ART and also palliative care during terminally ill stage. Since CSC do not have any treatment provision, all cases have to be referred to other referral centres. The CSC can provide emergency financial support to the needy PLHIV in following situations:

- Transport to hospital for management of a sudden emergency (e.g., sudden collapse, onset of labor pains)
- Emergency care during hospitalization

SSR can set up a three member committee (project coordinator, one member of the board, one community volunteer) who can decide on the eligibility of PLHIV for this support on a case-to-case basis.

Advocacy

Refer to the Chapter 5 for details.

Support Group Meetings (SGM)

The PC and/or the trained counsellor of the CSC will organize support group meetings (SGM) to help develop support mechanisms for the PLHIV. These meetings will provide the members a platform to share their problems and concerns about confidentiality and learn from each other on how to cope. The support groups will also help strengthen their knowledge on HIV related issues and develop a community voice to advocate for better policies. The SGM will be mainly organized at the CSC and will be conducted by the trained PC or the counsellor. The trained PC will also be organizing and conducting the SGM during field visits as per the need of the PLHIV groups. However, the PC in consultation with the peer counsellor will plan the SGM to be carried out in the month.

SGM Modalities

Categories
- Children SGM
- MSM SGM
- Transgender & Hijra SGM
- IDU SGM
- FSW SGM
- Discordant couple SGM
- Single or widow women SGM
- Male SGM
- Pregnant women SGM

Key features

Theme based discussion

Provides emotional and social support

Facilitates the community to promote experiential sharing and learning

Well planned and documented

Venue

Mainly at CSC, Community friendly place in the field.

DIC/hotspots of TI

Size of the group:

10-15 members should participate in each SGM

Efforts to be made to ensure 70% participants remain regular

Dos

Conduct maximum SGM in CSC only

Donts

No monetory benefit is given to participants for attending the meeting

Frequency
- Based on category of CSC, 15 to 25 SGM in a month
- PC will decide the number of meeting, venue and type of SGM

Suggested Strategies

- Every member of the support group is encouraged to bring their ART Green Card for the meeting to understand the clinical profile.
- It is also suggested to take the details of weight, CD4 count, and treatment details of participants.
- Everyone will sign the meeting attendance sheet.
- The minutes of each meeting must be recorded in the meeting register (Annexure II.e).

Thematic areas for support group meetings can include the following

1. **Basic Health & Hygiene**
   a. Personal hygiene
   b. Regular health check up
   c. Importance of yoga and meditation
   d. Positive living
   e. Sexual and reproductive health
2. **Basic HIV Information**
   a. Modes of HIV transmission
   b. HIV life cycle and living with HIV
   c. Disclosure issues
3. **Diet and Nutrition**
   a. Balanced diet
   b. Nutritional demo
   c. Kitchen garden promotion
   d. Timely intake of food
4. **Home-based Care**
   a. First aid care
   b. Basic information to care givers
   c. Palliative care
5. **OI Management and Co-infection**
   a. Types of OIs and their symptoms
   b. Treatment for OIs
   c. Follow up
6. **Treatment Adherence**
   a. Antiretroviral therapy, Tuberculosis & STI
   b. CD4 count
   c. Treatment schedule
   d. Viral load
7. **Treatment Education**
   a. First line and second line ART
   b. Side effects of ART
   c. HBC/Hep B co-infection
8. **Positive Prevention**
   a. Safe sex
   b. Positive prevention and condom promotion
   c. Discordant couples
9. **Social Events & Livelihoods**
   a. Government schemes
   b. Facilitation of local donor support
   c. Income Generation Programmes
   d. NRLM, MNREGA, etc

Enabling Environment

The CSC will always try to achieve an outstanding level of best practice in creating and sustaining a positive and effective social environment. At the community level, partnerships with critical stakeholders will be created and strengthened for an enabling environment. Partnerships will be established with district level service delivery facilities and governance systems and discrimination response team of the CSC to eliminate stigma and provide discrimination free services. Specific activities for this shall include:

- Community sensitisation meetings and developing community ownership.
- Coordination meetings at community level with Panchayats, anganwadi workers, ASHA, teachers and village health committees.

Activities at village and district level during special events such as World AIDS Day, Women's Day, Children's Day and other related events such as health and nutrition day.

Popularising CSC services among PLHIV

- Celebration of national/international days in CSC and organizing competitions among PLHIV.
- Use of audio-video material for infotainment of the community members.
- Celebrating festivals in the CSC.
- Ensuring conducive atmosphere for all PLHIV to walk-in, relax and share their feelings with fellow community members.
- Organizing hobby classes (e.g., painting, music, drama, etc.) through patrnerships with external agencies.
- A meeting with community champions or volunteers at district/taluk /cluster level at least once in a quarter.
- Create a cadre of volunteers comprising of PLHIV from different segments of population.
- Developing job directory to help needy PLHIV.
- Developing information centre on various schemes at CSC.
- Organising periodic health camps on specialized services (e.g. eye check-up) with the help of local donors.
- Organsing life skill education programmes for adolescents with the help of other NGOs and supporters.

Outreach

04

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4. Outreach

Outreach activity is the backbone for the care and support services provision to PLHIV and their families. The goal of conducting outreach activity is to connect PLHIV with care and support services that would improve their knowledge level, service uptake and ultimately result in improved adherence and better quality of life. Reaching out to PLHIV and their families in their own homes and communities acts as a catalyst in bridging the gap between the community and service providers. Outreach to the PLHIV is important because prevailing stigma and discrimination often prevent them from accessing available services and they are often not even aware of the available services. The main reasons for LFU/MIS cases is either limited information on treatment adherence or socio-economic problems such as poverty, poor accessibility, etc. Effective outreach will bridge these gaps by providing comprehensive information to enhance the knowledge, skills and also linking PLHIV to services which help them in accessing the required support services beyond medical services. This will lead to reduced LFU/MIS cases and improve the retention in treatment. Outreach worker and peer counsellor will spearhead the outreach activity in the programme. They will coordinate with the rest of the CSC staff to ensure that PLHIV derive the greatest benefits from the programme. The Project Coordinator will have the overall responsibility to support, guide, supervise, monitor and evaluate the outreach activities conducted by ORWs and Peer Counsellors.

4.1 Outreach Strategy

a. Allocation of ORWs

- Outreach workers are allotted to CSC on the basis of the number of PLHIV to be covered in a year, as given below:

CSC coverage in a year	No. of ORWs working with CSC
0-1500	2-4
1501-5500	4-6
5501-8000	6-8
8001-10000	8-10
10001-12000	10-12
>12000	12

Note: When the coverage of the CSC is enhanced in the subsequent year, number of ORWs will also be increased proportionately with approval from SR and PR.

b. Consideration for difficult terrain and scattered population

- In difficult terrain such as hilly districts where communication and transportation is inadequate, the number of outreach workers can be increased. The proposal should be first discussed in the state oversight committee and, if recommended, the SR will take approval from PR and DAC.
- PR in consultation with DAC will provide conditional approval.

c. Minimum standards to be maintained

- The CSC will take outreach consent from clients at the time of registration by getting the client to sign the Outreach Consent Form for Home Visit (Annexure III), and by making him/her understand the importance of outreach.
- An ORW will ideally spend a minimum of 20 days in the field per month. One day in every week will be spent in the CSC for documentation, review and planning. For CSC in difficult terrains, ORW should spend one day in the CSC once in 15 days.
- Each ORW is expected to undertake 4-5 home visits per day. Families here are defined as all individuals staying under one roof, sharing the same kitchen (may or may not be related by blood relations).

d. Activities to be carried out during outreach

- The first priority is tracking LFU/MIS cases for pre-ART and on-ART clients and linking them back to the ART centers.
- Follow up of pre-ART clients who are eligible but not initiated on ART and whose pre-ART baseline CD4 not done.
- Follow up of pre-ART and on-ART clients for CD4 testing on regular basis (once in 6 months).
- Identifying new clients for providing services is another prime activity under outreach. ORW will identify PLHIV who are not yet registered with ARTC or CSC and link them to services after providing information.
- Meeting important stakeholders in the villages to mobilise their support for the cause of PLHIV is another prime activity in outreach. ORW should also attend VHND, VHSC meetings, panchayat meetings, and meet PRI members and local leaders regularly to appraise them about CSC services.
- Organising support group meetings in the field.
- The ORWs will identify community champions at village level who will support outreach activities in the village and also address stigma at the community level.

For greater impact, the outreach staff of CSC should, at all times, work in close coordination with outreach workers from projects that share common interests with CSC. This could include Community Care Coordinator under ARTC; District Level Network (DLN) members; ORWs under PPTCT programme; link workers; and counsellors at ICTC and Link ART Centres (LAC). To support the ORW in their follow-up activity of the registered CSC members, the services to be provided to PLHIV are documented in Checklist for ORW (Annexure IV).

4.2 Key Steps Involved in Outreach Planning

Geographical division and allocation to ORWs

The Project Coordinator, in consultation with the entire CSC team, will divide their operational area among the outreach workers for carrying out the outreach activities effectively. It will be on the basis of the following considerations

- ORW's familiarity with the area
- Language familiarity
- Rapport with the key stakeholders in the area

Outreach mapping

As CSC is linked to ART centres, mapping of geographical distribution of PLHIV is a significant exercise. In many of the ART centres, there may be clients registered from the same district where the ART centre is located as well as from other districts and states. Hence, for developing outreach plans, it is important to map the geographical distribution of PLHIV registered in the ART with which the CSC is linked.

The Project Coordinator will guide the ORWs to map the PLHIV distribution and their locations within the geographical area allocated to the ORWs.

a. Mapping of PLHIV within the geographical areas covered by the CSC

- Take a map of the districts covered by the CSC, and demarcate the districts into blocks/ villages.
- Map the number of PLHIV (male, female and children) in each of the block/village as per the data received from the ART centre.
- Map the distance to these areas from the CSC and identify transportation facilities available.

b. Mapping of PLHIV outside the CSC coverage areas

- List out the number of clients from other districts/states.
- Communicate the information to SR who will further coordinate with the CSC functioning in the client's district. In case the clients are from other states, SR will communicate it to PR, who will further communicate it to the concerned SR.
- Border district and border state coordination meeting can be conducted along with SRs and concerned CSCs in order to further coordinate with the CSC functioning in the client's district. It can be planned to share the list of LFU/MIS clients who are registered in one CSC and residing in another CSC area. Inter district sharing of information/line list can be done during SR- SSR state level meeting.

c. Inter-district LFU tracking mechanism

In many places, ART centres were set up in the district headquarters or other prominent towns and centres are gradually being established in the peripheries as well. Clients registered in these ART centres are getting transfered out to newly established ART centres which are closer to their residence. At the same time, there are clients who do not wish to get transferred out to ART centres in their own district. Moreover, there are many other districts where not even one ART centre is established. All these conditions lead to inter-district LFU/MIS cases with the ART centres. Tracking these clients and bringing them back to the treatment is a vital task and all concerned agencies have to work in close coordination for the effective tracking of such cases.

Suggested activities for each stakeholder are decribed below.

ART Centre	• Generate the list of inter-disctrict LFU/MIS cases • Share MIS cases with CSC every Saturday and LFU cases by 5th of every month
CSC	• Share the list of inter-district LFU with the CSC in the concerned district and request them to follow-u. • If the PLHA is in a very hard to reach area, the ORW responsible for the area can coordinate with other outreach services (outreach workers from other NACP schemes) available in the area to track the PLHIV. • If other support is not available in the district , allot an ORW for follow-up. • Develop and train community volunteers in hard-to-reach area who can help in following-up LFU/MIS cases. • Share the LFU/MIS tracked details with the ART centre. • Share the status with SR and seek support in coordination with all stakeholders.
SR	• Coordinate inter-district CSC LFU tracking by CSC. • Share the inter-district LFU/MIS cases with concerned CSC and keep regular follow-up on tracking. • Develop network and linkages with other programmes of SACS for for utilizing their outreach workforce for LFU tracking. • Facilitate data sharing with other partners of SACS for LFU tracking. • Provide regular feedback on LFU tracking and seek support from SACS in addressing coordination issues arising, if any. • Facilitate effective coordination and acknowledge the good practices in quarterly coordination meeting with CSCs state level.
SACS	• Support SR in inter-discrict coordination for LFU tracking. • Keep regular track of LFU cases and take corrective steps to intensity the follow-up by all the partners in the state.

4.3 Interstate LFU Tracking

There are clients accessing ART from centres in the neighbouring states. Moreover, clients may get registered in one ART centre and migrate to other places later on due to various reasons. Tracking these interstate LFU is also an important task in the programme. Since CSCs are functioning in almost every state, data sharing with partners becomes a vital task in the process. Monitoring and evaluation officers at SR and PR will facilitate the process of interstate data sharing. Suggested methods for interstate LFU data sharing and follow-up are given below

Name of the activity	ART Centre	CSC	SR	SACS	PR	DAC
Developing the list of LFU/MIS cases and sharing with SACS by 5th of every month	✓					
Collating inter-state LFU/MIS cases and sharing with SR/PR				✓		
Obtaining the list of inter-state LFU/MIS cases from SACS by 8th of every month			✓			
Sharing the list of inter-state LFU/MIS cases with PR by 10th of every month			✓			
Sharing the list of inter-state LFU/MIS cases with concerned SR by 12th of every month					✓	
Sharing the list of LFU/MIS cases from other states with concerned CSCs by 12th of every month			✓			
Tracking the LFU/MIS cases list as per the list received		✓				
Reporting back the status of LFU/MIS cases from other states to SR on the last day of the month		✓				
Collating the tracked back information of LFU/MIS cases from other states from all CSCs			✓			
Sharing the details of LFU/MIS cases from other states who are tracked with PR			✓			
Sharing the details of LFU/MIS cases from other states tracked with concerned SR and SACS					✓	
Sharing the details of LFU/MIS cases from other states tracked with concerned SSR and ART centre			✓			
Developing monthly status of LFU/MIS cases tracked from other states and sharing with DAC					✓	
Facilitating conference calls between source and destination states SR for understanding the tracking process and developments by 20th of every month					✓	
Identifying the most common source and destination states and developing strategies for effective LFU/MIS case tracking					✓	✓

4.4 Micro Planning of Outreach

Each ORW will develop a micro plan for outreach activities to be carried out in the geographical areas allocated to them. In order to ensure that the most vulnerable clients are contacted on priority basis through outreach, prioritization of clients' needs to be done. Steps involved in prioritization of clients are given below

- Project Coordinator will prepare a list of clients who need services on a priority basis and hand over it to the concerned ORW for follow-up.

- Project Coordinator and ORW will prepare a fresh list every month based on the most recent data available.

Prioritization Format

Priority Groups	Intensive follow-up (frequency of visit: 15 days to one month)	Less-intensive follow-up (frequency of visit: 2-3 months)	Follow-up once in six months
On-ART (MIS /LFU cases, CD4 follow-up)	1. Refer back to ART Centre 2. Report back to ART Centre on status of tracking Intensive follow-up till client is linked back to the ART Centre and linked with CSC and support group	Follow-up with treatment education and linking the client to support group and CSC	Once the client is regular to ART Centre, Support Group Meetings and availing CSC services, follow-up once in six months for routine health check-up
Pre -ART (eligible but not initiated On-ART,Baseline CD4 or follow up CD4 not done, LFU)	1. Refer back to ART Centre 2. Report back to ART Centre on status of tracking 3. Intensive follow-up till client is linked back to the ART Centre and linked with CSC and Support Group	Follow-up with treatment education and linking the client to support group and CSC	Once the client is regular to ART Centre, Support Group Meetings and availing CSC services, follow-up once in six months for routine health check-up
HIV/TB co-infection	1. Treatment education, referral to regular health check-up		Follow-up once in six months once the client is cured of TB and regular to ART
PLHIV from HRG group	1. Treatment education 2. Linking them with ART Centre 3. Positive prevention and living positively Intensive follow-up till client is registered with CSC and regularly participating in Support Group Meetings	1. Forming a support group of HRG PLHIV based on typology 2. Referral to regular health check-up 3. Addressing group specific issues	
Pregnant WLHIV	1. Linking the client to PPTCT programme and ASHA 2. Promote institutional delivery 3. Follow-up with baby till 18 months 4. Link the client with CSC and support group	1. Follow-up the mother and baby till 18 months 2. Link them to social benefit schemes 3. Make them regular to support group meeting	If the client is regular to post-delivery check-ups, adherence rate is high and regular to SGM, follow-up once in six months for checking health status
CLHIV	1. Link CLHIV to ARTC and CSC for care and support services 2. Home visit to train care givers 3. Link children to education, nutrition support and social benefit schemes 4. Link children with children group meeting at CSC 5. Follow up for OI/side effect management/ Home based care	1. Linking children to vocational courses and training 2. Networking with other agencies to provide psychosocial support and to address child/ adolescent issues	

Single WLHIV	1. Link client to ARTC and CSC 2. Link the client to SG 3. Link the client to social benefit schemes 4. Follow up for OI/side effect management / Home based care	1. Link the client to vocational courses 2. Link with social welfare schemes and entitlements	Once the client is regular to ART, SGM and availing CSC services, follow-up once in six months for routine health check-up
Discordant couple	1. Encourage partner testing on a regular interval 2. Information on positive prevention 3. Condom promotion 4. Linking couples to CSC and support groups 5. Follow up for routine HIV testing of negative partner 6. Refer to counselling services on positive prevention	1. Routine health check-up 2. Testing of partner	Once the couples are regular to ART, SGM and availing CSC services, follow-up once in six months for routine health check-up
Support required to PLHIV who face stigma and discrimination	1. Address the case in 24 hours and link the client to DRT 2. Link them to other support agencies 3. CSC team to address the stigma cases with stakeholders taking support from other agencies	1. Follow-up with DRT	
PLHIV to whom legal support is required	1. Linking the client to support agencies such as DALSA and legal clinics 2. Refer the case to DRT		

4.5 Social Mapping of Services Available for PLHIV

The purpose of the social map is to help ORWs identify key stakeholders and existing facilities in their respective geographical areas. For example, ARTC, ICTC, STI Clinic, DHO, TI, LWS, other facilities, District Legal Aid Cell, village panchayats, etc. The ORWs will include these identified facilities and stakeholders while developing the micro plan for outreach activity. Thus, social map will help ORWs plan for the necessary coordination with the identified service providers and also to provide referral and linkage services to the clients. Project Coordinator will guide the ORWs in developing the social map.

CSC team also motivates these stakeholders to generate interest on CSC programme activities, establish contact with community, and identify the potential source of support among these people.

Develop visit plan

ORWs will develop his/her visit plan in consultation with project coordinator every month. ORW will further develop detailed weekly plan in line with the monthly plan. The weekly plan should have

details such as number of prioritized clients, specific location of meeting clients and stakeholders, purpose of the visit, specific activities to be carried out, etc.

Conduct outreach

ORW will undertake outreach visits as per the plan, disseminate outreach messages and record the same in outreach register.

Evaluate the plan periodically

CSC team should revisit the plan periodically based on the new data they have, changed circumstances, and priorities of clients as well as the programme.

Revise the plan

After evaluation of plan, develop the new plan based on the priorities and the planning cycle will continue.

Outcomes of outreach

- LFU/MIS cases tracked and brought back to ART centre
- Retention of clients in HIV care
- Timely initiation of ART for the eligible pre-ART clients
- All pre-ART and on-ART clients are reported to ART center for CD4 test on regular basis
- Early linkage of PLHIV to ART and other related services
- Improved treatment education and adherence
- PLHIV are linked to various service delivery points for meeting health and non-health needs
- Knowledge and skills of PLHIV enhanced in care and support
- Through home visits, the following purposes will be served
  - Family members in a PLHIV household are motivated to get tested
  - Treatment education/adherence is given to family members and care givers
  - Nutritional information will be given to family members and care givers
  - Education to family members on positive prevention

Advocacy

05

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5. Advocacy

Advocacy is a method and a process of influencing decision-makers and public perceptions about an issue of concern, and mobilizing community action to achieve social change and a favourable policy environment to address the concern.

5.1 Stakeholders for Advocacy

Individuals or institutions that have a direct or indirect link with HIV programme, especially care and support services, are stakeholders for the programme. While carrying out advocacy activities, various stakeholders at district, state and national levels may be mobilized for their involvement.

The following table highlights just an indicative lists of stakeholders at village, block, district, state and national level. CSC team may identify other relevant stakeholders and add to the list

Local/District level stakeholders	PLHIV forums/community groups
	Affected family members
	DAPCU
	District hospitals/PHC
	DLNs
	Service providers (health, social benefits, legal aid)
State level stakeholders	SACS/State Health Authority
	Media
	State level network
National level stakeholders	Department of AIDS Control
	Ministry of Women and Child Development
	Ministry of Social Justice and Empowerment
	Ministry of Law

5.2 Steps in Advocacy

Advocacy is a continuous process that has to be done systematically. The steps involved in the advocacy process are discussed below

Steps in advocacy	How to do/process	What to do/activities under CSC
Identify advocacy issues, goals, and objectives	Advocacy issues may be related to PLHIV communities' access to health care facilities, social protection schemes, legal aid services, and addressing stigma and discrimination. For the identified advocacy issues, it is a must to gather evidences and relevant data. This will help in ensuring evidence based advocacy. The data should be presented in such a way that it supports the actions required by the decision maker. For the identified advocacy issue, it is important to formulate the goals and objectives (what are the desired changes/results to be accomplished?).	Community consultations to identify and prioritize the advocacy issues. Feedback from outreach, counseling and support group meetings to identify the burning issues of the community for advocacy.

Steps in advocacy	How to do/process	What to do/activities under CSC
	For example: Advocacy issue identified; PLHIV unable to initiate ART on time due to non-affordability of health investigation which is mandatory before ART initiation. Goal: Timely initiation of ART for improved quality of life. Objectives: To ensure availability of health investigation for PLHIV.	Analysis of discrimination response team report /relevant data to identify the common issues for advocacy.
Determine target audience	Identification of target audience to whom advocacy is to be carried out; for example, for the above mentioned, target audience is:- - Medical Superintendent of the concerned hospital - CMO - Health Commissioner of the state Target audiences are the individuals who can take decision about bringing the desired change.	Based on the advocacy issue as well as expected outcome of advocacy efforts, the CSC will identify primary and secondary audience for advocacy.
Develop advocacy messages	Advocacy messages need to be tailored to specific target audiences. It is important to reflect and decide Who are you trying to reach? What do you want to achieve with the message? What do you want the recipient of the message to do as a result?	CSC team can take support from CAB members and advocacy officer from SR in developing their advocacy messages. Messages should be supported by evidence and should give concrete information about the advocacy issue.
Build support	Stakeholders who can support the community in advocacy issues need to be identified. Some of them can be the community leaders, CSO, NGO, professional associates, activists, donors, media and govt. departments	Based on the advocacy issue, approach the pre-identified organizations for support for the advocacy cause in the district. Some of the important stakeholders who can be approached are DAPCU, DALSA, SR, community leaders,etc.
Choose communication channels	Select right methods and mediums for reaching target audiences. Some of them can be • Face to face meetings • Briefing leaflets • Public rallies • Fact sheets • Policy forums • Policy briefs • Posters or flyers in public places • Petitions • Public debate • Press releases • Press conferences	It is always preferable to have one on one sensitisation meetings with different stakeholders and gatekeepers who the programme considers as having the greatest influence on the uptake of services by PLHIV. CSC should participate in monthly meetings with concerned representatives from DAPCU and DHO office and also in State Grievance Redressal Committee (SGRC) as a platform to share concerns and seek reassurance and solutions. Other mediums can be used based on the gravity of the advocacy issue.

Steps in advocacy	How to do/process	What to do/activities under CSC
Implement activities	The implementation plan should consider tasks/ issue and target audience who are responsible for timeframes, expected outcomes and resources needed.	PC will participate in regular meetings with DAPCU and other district level meetings. DRT will address the cases as and when reported. CSC will develop the quarterly advocacy plan and a progress report will be shared with SR and SACS
Monitor progress and outcomes along the way; Evaluate progress, outcomes & impact	Determine how you will do the following • Monitor your activities at the outset • Evaluate or measure the impact of your work • How will you know the situation has changed • Process and impact measures (e.g., has the network worked well vs. has the networks' work had an effect) Some of the important indicators to assess the advocacy work are the following: Increase in support from various sources in terms of support, resource mobilization, changes in policies, increased service uptake and decrease in violence, stigma and discrimination.	Advocacy Officer in SR will help SSR to understand the outcome of advocacy efforts and help them in evaluating their activities. Community Advisory Board (CAB) will review the advocacy efforts once in a quarter and provide inputs to CSC team.

5.2.1 Characteristics of good advocacy messages

- Simple
- Concise
- Tone/language consistent with message (serious, humorous)
- Use of appropriate language
- Credible messenger (spokesperson)

5.3 Role of CSC Staff in Advocacy

Name of the staff	Advocacy roles
Project Coordinator	• Collation of information received from other staffs and community members and developing the same as an advocacy message • Coordinating with different stakeholders including CAB, SR, DAPCU, district administration and media on advocacy issues • Developing purposive linkages with other stakeholders for the benefit of the community • Supporting other staff members and the DRT in documentation of cases • Developing case studies and issue briefs for advocacy • Maintaining the data base of beneficiaries of various schemes and potential beneficiaries • Identify positive speakers as resource persons

Counsellor	• Documentation of stigma and discrimination shared by the clients during counselling session and sharing with DRT and Project Coordinator • Constant advocacy with health care providers in the district to provide services to PLHIV in stigma-free environment
Peer Counsellor	• Documentation of stigma and discrimination cases reported during outreach activities with the support of other CSC staff • Facilitation of DRT and leading the activities of discrimination response team • Home visits to those PLHIV who are facing the problems with their families and local people to address the issues • Regular meeting with various departments to advocate social benefit schemes for PLHIV and also accompanying the potential PLHIV to these departments

Mechanisms under CSC to support advocacy initiatives in the district

Information Centre

Every CSC will have an information centre. This information centre will have the details of various social benefit schemes for PLHIV, application procedures for such schemes, documents required to apply for such schemes, and also the contact details of department officers. Any PLHIV member walking in to the CSC will get information about all the schemes available. They can also avail of application forms from the information centre. CSC staff, mainly PC and Peer Counsellor, will facilitate the filling up of applications and also educate them on how to get the supporting documents required.

5.4 Discrimination Response System

Addressing discrimination is a key aspect of reducing vulnerability as well as fostering quality of life. In order to address discrimination, every CSC will have community led Discrimination Response System (DRS) through DLNs and partner NGOs. The purpose of DRS is to establish an effective and sustainable mechanism to address cases of discrimination faced by PLHIV. Under this system, a Discrimination Response Team (DRT) will be set up.

Structure of DRT

DRT will consist of community volunteers, outreach worker and peer counsellor, and legal resource person familiar with the legal issues surrounding harassment of PLHIV. The team will be supported by the PC and the Project Director of the CSC.

The team may have 7 – 15 members depending on need (i.e., frequency of incidents, size of area to be covered). There should be representation from each cluster and also a member from FSW/MTH community/IDU each.

Selection criteria

- Committed community members who are willing to be 'on call' 24 hours a day and to respond immediately whenever a discrimination incident occurs.
- The DRT members should preferably be literate.
- At least one member should have excellent communication skills – especially verbal skills.
- At least one member should have basic writing skills.
- At least one member should acquire basic computer skills.

It is important that the DRT members are trained on advocacy and networking skills as well as documentation and reporting.

Roles and responsibilities

- DRT shall provide moral/psychological support to PLHIV individuals who have faced discrimination.
- DRT will establish emergency linkages to health/shelter and/or other emergency needs.
- DRT shall inform appropriate district or government authorities about the incidents of discrimination faced by PLHIV individuals.
- The DRT should meet regularly once a month besides any emergency meeting. The meetings should be well documented.
- The team will have to maintain a log of the incidents of stigma and discrimination happening in the area. These are to be recorded in the CRF and reported quarterly in advocacy reporting tool.
- Networking, alliance-building, and sensitization work with local stakeholders through regular meetings and education as appropriate. This includes creating awareness among PLHIV on their rights.
- Establish linkages with DALSA, DAPCU, District Administration, etc. as well as with lawyers and health care providers who are community friendly.
- Close alliances with other civil society organizations, activists and local media contacts who can advocate on behalf of the community when necessary.
- Reflections on discrimination cases managed to improve and build internal capacities.

Response to discrimination incident

- When a community member informs on one's behalf or on behalf of another member who gets harassed, the member of the DRT responding to the information is to get in touch with the affected person by phone or in person to confirm the issue. S/he also will contact other team members to apprise them of the situation. It is important to provide immediate moral support and give the message that the person is not alone in this situation and the person has support from the programme.
- External stakeholders (lawyers, other NGOs, district administration officers, healthcare providers, etc.) to be involved to resolve the issues.
- Inform issues related to stigma and discrimination to the following
  - Police Department
  - DAPCU
  - Block/District level administrative officers
  - Gram pradhan
  - Media

Reporting mechanism for DRT: Documenting any incidence of stigma and discrimination happening in any setup is very important as these documents will be directing the advocacy initiatives. The documented cases will be good advocacy tools. The incidents will be recorded in DRT register (Annexure II.g) and reported in Advocacy Report Format (Annexure V) every quarter.

5.5 Social Entitlement Events

One of the vital tasks for CSCs under programme is to link PLHIV community with these social benefit schemes. In order to operationalize the same, a PLHIV community interface with officers from Social benefit schemes will be organized for mass application, awareness generation and linkage. CSCs will organise one such meeting every quarter along with various officers as per need. All the needy PLHIV will be informed well in advance about the event and will also be asked to bring required documents to avail of the services. Officers from the department will be sensitized on PLHIV issues and motivated to attend these events to provide information about the schemes to PLHIV as well as to facilitate mass applications. These events can be a good community mobilization strategy.

5.6 Advocacy Meetings

Each CSC has to arrange an advocacy meeting once in a quarter. This meeting will be used as an opportunity to sensitize various stakeholders on PLHIV issues. The meeting can happen in any place which is convenient to all the stakeholders. In the advocacy meeting, community needs will be put forward to the stakeholders to mobilize their support. Based on local needs, CSC can organize thematic advocacy meeting in each quarter.

The sensitization and advocacy meetings are to be recorded in the meeting register (Annexure II.e) and reported quarterly to the SR in Advocacy Report format (Annexure V).

Role of CSC in Improving Access to Services for Children Affected by AIDS (CABA)

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6. Role of CSC in Improving Access to Services for Children Affected by AIDS (CABA)

6.1 Services for CABA

As per National AIDS Control Programme, children affected by AIDS (CABA), refer a child (below 18 years of age) who

- Has any one or both parents or immediate care provider/s living with HIV
- Has lost one or both parents/guardian/immediate care provider or siblings to AIDS
- Is living with HIV

The needs of the children living with HIV and AIDS are unique, dynamic and differ a lot from adults. Hence along with addressing the medical needs, other needs of children should also be addressed to reduce the mortality and morbidity among children. Although medical care for children is available free of cost at the ART centres, other needs such as education, nutrition, psychosocial support, shelter, and family care still remain a challenge.

The potential impact of HIV on children could include

- Decline in health status
- Depression and anxiety
- Stigma (in family, socialization, schooling)
- Caring for sick and diseased parents
- Increased demands for household work and labour
- Drop-out from school due to disease, poverty or to supplement family income
- Migration
- Homelessness
- Loss of property inheritance

As a response to the above mentioned concerns related to children affected by AIDS, Care and Support Centres will be ensuring a child friendly environment and atmosphere to make CSC conducive for CABA to access services at the CSC. CSC will also facilitate linkages with different government departments, corporate sectors and FBO wherever feasible to meet the specific needs of CABA for their overall health improvement, education and other services. CSC may also mobilize additional resources to provide basic requirements of CABA at the CSC such as nutritional supplements, educational items like books, drawing materials, toys, blocks for learning, etc.

6.2 Special Provision for Children under CSC

The resting/relaxing place can be made child-friendly. One of the walls of the room/hall can be painted with images of cartoons, nutritional pyramid, and fruits and vegetable pictures. This room should also have indoor play materials for children who are visiting the centre along with their parents or care providers. Indoor play materials can consist of toys (both for girls and boys), stuffed toys, etc. Materials highlighting spread of HIV/AIDS and associated illnesses may be better avoided among the display materials in this space of the CSC as this can further cause stigma against children.

The key strategies of catering to children and adolescents needs through CSC are as follows:

1. Provision of child-friendly counselling services

- In order to make the children comfortable, counselling room will be made child friendly by decoration, using counselling techniques such as storytelling and/or by using other visual aids.
- Counselling services will address children specific issues such as dealing with HIV status, hygienic behaviours, healthy lifestyles, playing safely, dealing with stigma and discrimination by friends, etc.
- Parent/guardian of the CABA will also be provided with counselling, addressing their concerns in terms of handling difficult circumstances with CABA. They also will be counselled on protecting CABA from sexual/physical harassment at home, school and community.

2. Need-based home visit for CABA

- Line list of CABA generated from enrolment register will be considered on priority basis for the outreach plan; reaching out to CABA for follow ups will be given special focus.
- Those CABA who are not coming to CSC will be prioritized for home visit by CSC team to ensure need-based services are being provided through referral and linkages to appropriate service centres.
- Identification of new CABA will be one of the priority tasks for the outreach workers and peer counsellors during field visit for referral to ICTC and ART.

3. Support group for children

As CSC will be facilitating formation of different types of support groups in order to provide a safe and comfortable space for various specific groups, a separate group for CABA will also be formed. Support group meetings for CABA will be facilitated wherever feasible. The support groups will contribute to creating awareness and motivating PLHIV to access health services.

4. **Support group for adolescent boys and girls**

In order to encourage adolescent boys and girls to promote a positive environment for a healthy lifestyle, “Buddy Groups” will be organized and facilitated wherever possible. For example, buddy groups are groups for boys and girls of similar age, education, socio-economic status, or similar living circumstances (such as Living with HIV and on ART, children of FSWs, adolescent sex workers, IDU, etc). Such buddy groups will help members to be comfortable discussing issues related to safe and healthy lifestyle, treatment adherence such as ART, DOT, STI, etc. They will also promote abstinence from unwanted sexual practices/relationship, ability to deal with negative peer pressure, etc. Through these buddy groups, age appropriate and group specific information will be provided from time to time. These buddy groups will also provide a very safe space for the members to share their concerns/issues which may be very personal and confidential and thus enhance a valuable learning opportunity and also help create an effective care and support system amongst the group members.Wherever feasible, at least once in a month, CSC should organise buddy group meetings for those CABA registered at the CSC.

5. **Referral and linkages**

a. **For access to health care provision:**

- **Pre-ART registration at ART centres:** On priority basis, CSC team will give special efforts to identify any children newly diagnosed and will be ensured successful linkages to ART centre for Pre-ART registration. Accompanied referral will be provided whenever necessary.

- **Management of OIs and other general health care provisions:** Special emphasis will be given through counselling, home visits and community outreach activities to identify children living with HIV with signs and symptoms of opportunistic infections and or any other health care needs. Children will be supported for OI prophylaxis and treatment adherence through regular visits, use of mobile phone technology, and other innovative methods such as"buddies' follow-up", which would basically mean two or more families/children who need a service will be clubbed to ensure support. Wherever possible, CSC team will coordinate with PPTCT NGOs, Link Workers, AWWs, ASHAs, ANMs, etc. to ensure coverage of CABA in remote areas and link them up with the necessary service delivery units (adolescent STI clinics, DOTs and any other general hospitals for regular health check-ups and treatment).

b. **For access to supplementary nutrition:** The CSCs will ensure that children affected by AIDS are linked to sources of supplementary nutrition such as the mid-day meals under Integrated Child Development Scheme (ICDS). Along with this parents/care givers of children will be educated through regular support group meetings, counselling of parents on balanced diet and low cost nutrition from locally available resources. CSC will give special emphasis to mobilize any form of support, be it in kind, cash, and volunteers to educate children and their parents on nutrition.

c. **For access to education:** As a part of CSC's sensitization and advocacy initiatives, the following measures will be undertaken

- Children below 14 years will be helped to access primary education from Sarva Sikhsha Abhiyan through referral and coordination with the education system.

- The families of CABA who are in need of support to get the basic citizenship documents necessary to ensure access to education will be supported by CSC team. The necessary documentation will be facilitated in coordination with local authorities like the talati-taluka officials. The CSC team will especially work with district education officer and share information on children dropped out of school for appropriate directions.

d. **For access to social schemes and entitlements:** Widow and orphan-headed families need special support to protect children vulnerable to exploitation. In extreme cases it might be necessary to provide alternative care for some children. This will be done by informing families on available child protection services, schemes and structures, e.g., DCPS and CWC. Establishing and strengthening coordination mechanisms with DCPS and CWC to refer children and develop protection plans according to the best interest of the children are among the priorities of CSC. The CSC team will also support families with necessary documentation and guidance support to access welfare schemes such as

- Getting ration cards, Below Poverty Line (BPL) and Antyodaya Anna Yojana (AAY) cards. Where eligible, CLHIV on ART will be ensured access to special schemes such as fortified nutrition from ART centres.

- Coordinating with the SC and ST Corporation to access loans for families who fall in the list of beneficiaries.

- Linking families to income generation schemes available at village level, such as National Rural Employment Guarantee Scheme (NREGS). The CSC team will identify families that are in need of this support and work with Panchayats to give priority to these families to access NREGS.

e. For access to legal services: The CSC team will coordinate with existing state and district level legal aids cell/unit in order to provide the necessary legal support to CABA. Common situations needing legal aid could be denial of property rights, sexual abuse and most importantly children being terminated from schools. Coordination mechanisms will be established with District Child Protection Scheme and Child Welfare Committees to refer children for support and assistance. Using the platform of support group meetings, members will be educated on legal rights and other related issues by mobilizing resource persons from district level legal units/cells.

6. Strengthening system for sustainable care and support to CABA

a. Empowering families of CABA: At least once a month, support meeting should be held for parents/guardians of CABA to address issues/concerns related to dealing with CABA. If necessary parenting skills to handle critical behaviours of CABA should be imparted by mobilizing locally available expertise. As CSC does not have night shelter/stay facility, CSC team will empower relatives/guardians of CABA for foster care. In emergency or crisis situations where short stay/night stay is required, CSC will link them to the existing shelter home for children in general and or with the orphanage/care homes for children living with HIV supported by the state government.

b. Strengthening community system to reduce HIV/AIDS related stigma and discrimination, especially towards CABA

- As a part of the sensitization and advocacy activities to be conducted by CSC team, advocacy should be conducted particularly focusing on local service delivery and governance systems such as ASHAs, Anganwadi workers, teachers, village health committees and panchayats addressing CABA issues.
- At district level, CSC team should establish partnership with District Child Protection Society, Child Welfare Committees, and positive networks to support the affected families.
- CSC team should participate in the coordination meetings at community with panchayats, AWW, ASHA, teachers, and village health committees organized by the concerned department.
- Integrate messages related to CABA into the ongoing/existing activities under RHC program, rural youth development program at village and district level. Special events such as World AIDS Day and Children's Day observations can also include such messages.
- Coordination mechanisms with DAPCUs (along with CSCs) and DCPS will be ensured.
- Along with SR team at the state level, coordination and linkages with SACS, NRHM, WCD, and Department of Education will bring issues of children and families to the notice of respective line departments.

Role of CSC in Improving Access to Services for High Risk Groups (HRGs)

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7. Role of CSC in Improving Access to Services for High Risk Groups (HRGs)

National AIDS Control Programme through its Targeted Interventions amongst high risks groups such as IDU, MSM, FSW, transgender, truckers and migrants emphasises reaching out to these most at risk population. The aim of the Targeted Intervention is to ensure early detection of HIV infection and linking up with care, support and treatment programmes to enhance the quality of life of PLHIV.

The existing Targeted Intervention program focuses on prevention of HIV infection, early detection of HIV, and early linkages of identified positive HRGs to ART centres. However there are various other care and support needs for PLHIV HRGs. Some of them are ongoing counseling on positive prevention, positive living, and livelihood options and linkages to social protection schemes. CSC will give special focus to address these unmet needs through suitable strategies pertaining to HRG issues and concerns.

7.1 Care and Support Needs of HRGs

HRG populations, by the virtue of their living circumstances and the behaviour associated, are different from other people and have different needs. Hence CSC must ensure special provisions for them to create a friendly and conducive environment to access the services provided at CSC.

Special Provision for PLHIV High Risk Groups under CSC

1. **Counselling services**
   - As a part of induction training, CSC counsellors will be sensitised towards HRGs issues and concerns. They will be trained to provide counselling services addressing specific concerns of HRGs.
   - CSC counsellors will prioritise need-based counselling services for HRG both at CSC and during home visits.
2. **Outreach activities to ensure reach to HRG:** CSC team, while developing outreach plan, will give priority to the following
   - Reach out to all HRGs registered at CSC
   - Identify new HRGs through peer counsellors during outreach
   - Collaborate with TI and LWS NGOs to scale up reach to HRGs in remote areas
3. **Support group meeting for HRGs:** The CSC team will/shall identify peer positive speakers amongst different groups of HRGs (IDU, MSM, TG, hijra, FSW, truckers and migrants) and encourage them to educate members of the group on HRGs specific care and support issues and concerns such as disclosure of HIV status to spouses, positive prevention, ART adherence, addressing stigma and discrimination, etc. Some of the group specific issues and concerns to be addressed through the support group meeting are as follows

   a. **Female sex workers (FSWs)**
      - Negotiation for safer sex with clients of sex workers
      - Dealing with children of sex workers
      - Overcoming self-perceived stigma and discrimination
      - Dealing with substance abuse and harassment

- Response to crisis such as police raid, sexual harassment, etc.
- Reproductive and sexual health issues and concerns

b. Men who have sex with men, transgender and hijras (MTH)

- Sexual identity issues and concerns
- Overcoming self-perceived stigma and discrimination
- Dealing with substance abuse and harassment
- Response to crisis such as police raid, sexual harassment, etc.

c. Injecting drug users (IDUs)

- Care for IDUs and their spouses and children
- Safer injecting and sexual practices
- Counselling on safe sex
- Co-infection with HIV and Hepatitis C and/or STI
- Counselling support for those who want to remarry
- Assistance to widows in legal issues that commonly affect the lives of widows, including referrals to District Legal Aid Clinic

4. Linkages and referrals for services

a. **Linkage with TI NGOs and OST centres:** PLHIV who are IDUs and those who are in need of OST services will be referred to TI NGOs for the needle syringe exchange program and IDU specific counselling services. If any of the IDU PLHIV is in need of OST, they will be referred to the OST centres for the services. Additionally, all newly contacted HRGs during field visits, community outreach or by any source of referral to CSC will also be referred to TI NGO and OST centres.

b. **Referral of partners and spouses of HIV positive HRGs to ICTC:** CSC counsellor and peer counsellor will identify spouses and partners of positive HRG and motivate them to go to ICTC for HIV testing. Special emphasis will be given to discordant couples by ensuring referral of non-infected partner to ICTC once in six months. Counsellor will provide counselling on positive prevention to these discordant couples.

c. **Social protection schemes and entitlements:** The needs of PLHIV coming to CSC may be varied, including health, social, economic, emotional, and legal needs. As CSC does not have provision to provide all these wide range of care and support needs of the HRGs, CSC will meet these needs through effective referral and linkages with different departments providing the services.

7.2 HRG Service Matrix under CSC

What	Why	How	When	Who
Developing linkage with TI NGO	• For cross referral • Data sharing • Positive prevention among HRG • Linking positive HRGs to care and support	Regular meeting with TI team	Every month	Project Coordinator
Registration of positive HRGs with CSC	• To provide care and support services	• Obtaining the line list from TI • Provide any one service under CSC to positive HRGs and register them with CSC	Ongoing activity	Peer Counsellor/ ORW

What	Why	How	When	Who
Participation in group meeting/FGD conducted by TI	• In TI FGDs, group meeting, CSC staff will get an opportunity to interact with all HRGs • To educate HRGs on benefits of early testing and also CST services	• Participation in group meeting at TI DIC, hotspots and STI clinics	Ongoing activity	Peer Counselor/ ORW
Referral of HRGs to TI	• To provide prevention services	If ORW/Peer Counsellor reached HRG who is not reached by TI, refer such HRGs to TI	Ongoing activity	Peer Counselor/ ORW
Follow-up of pre-ART	• Retention in care	Outreach with the support of TI staff	Regular	Peer Counselor/ ORW
Referral to care and support centres, especially ART services	• Proportion of positive HRGs registered in ARTC is less when compared togeneral population	Regular follow-up with positive HRGs who are LFU/MIS ART or who are not yet registered with ARTC with the support of outreach staff from TI	Ongoing activity	Peer Counselor/ ORW
Formation of HRG specific support groups and regular meeting of support groups	• Issues pertaining to HRGs are different than general population • HRG specific issues, particularly care and support matters, to be discussed in SGM without any taboo	Separate SG for FSW, MSM, IDU, hijra, transgender to be formed wherever feasible Meeting can be held either in TI DIC, CSC office or in hotspot preferred by group members, Positive speakers and CSC staff will facilitate the meeting	Ongoing activity	Peer Counselor/ ORW
Focussed counselling	• Needs are different for different clientele	• Through home visits • While CSC visit of the client	Need based	Counsellor/ Peer counsellor/ ORW
Mobilization of support for positive HRG and their children	• High vulnerability to physical and psychosocial risks	Link with available services	Need based	PC/ Counsellor/ Peer counsellor/ ORW

Supervision and Monitoring of CSC

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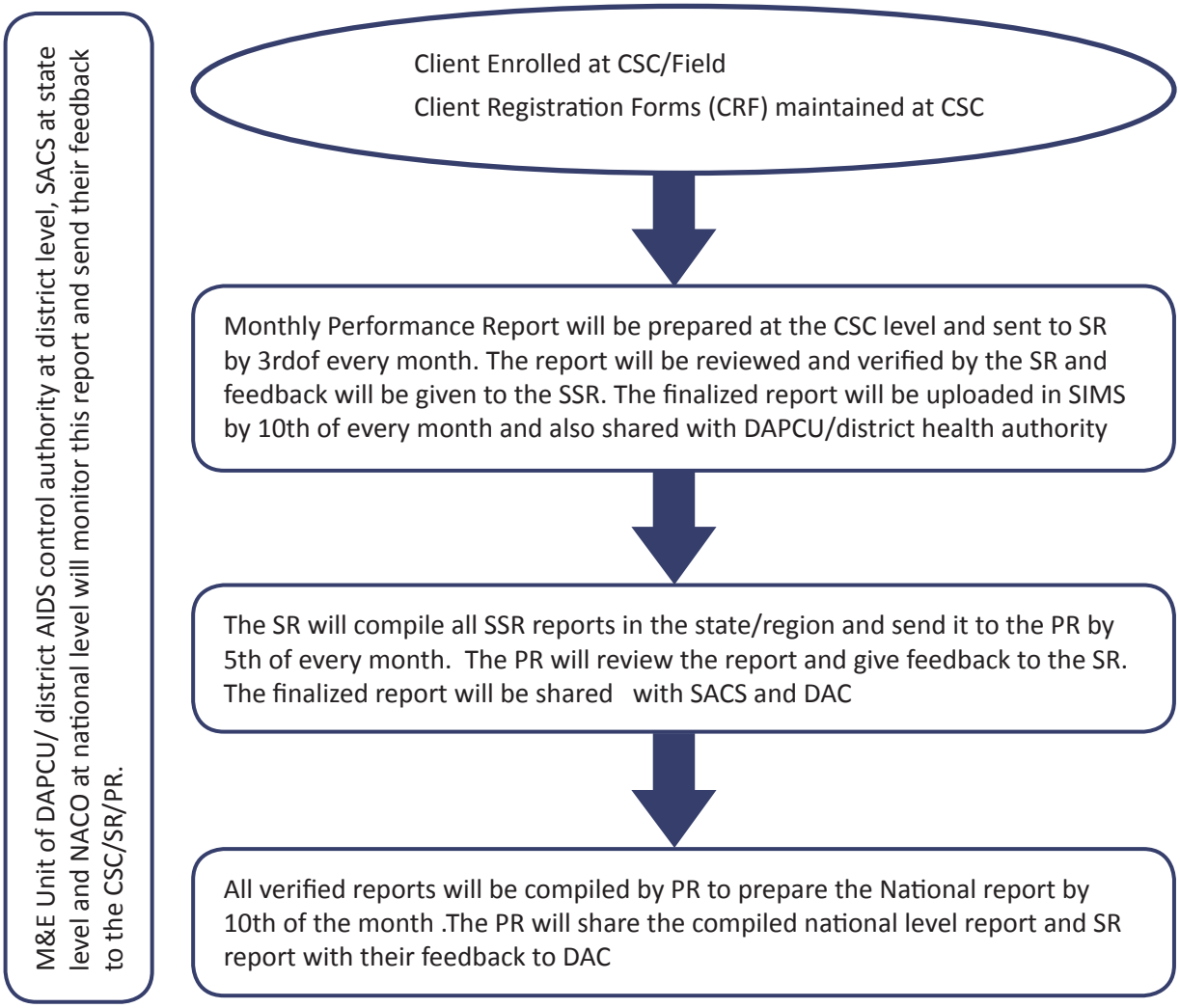
8. Supervision and Monitoring of CSC

Project Director (PD) has overall management responsibility of the performance of every CSC while Project Coordinator is responsible for day-to-day management of the project and achievement of targets, ensuring effective planning and implementation of the activities and monitoring/evaluation of the programme. PD will take a lead role in advocacy and linkage building with important stakeholders. PD should meet with the team at least once a month to get progress updates of the project and take necessary steps to achieve the overall results.

The programme has a rigorous monitoring and evaluation framework and as part of that, CMIS application software will be put in place to collect, store and utilise the information at all the three different levels of programme implementation. Through a standardized MIS system, data will be collected at CSC level on a regular basis. The Monthly Performance Report (MPR) of CSC will be integrated with SIMS. The report will also be submitted to SACS and DAPCU every month.

Data Flow of CSC



8.1 Monitoring Framework

a. Routine data collection, analysis and reporting

Routine data collection will be done through client-based information generation system supported by simple reporting tools (Annexure II.a to II.i). There will be a computerized management information system developed to store the data use and for automated submission of report. The reporting mechanism ensures smooth generation of customized report in DAC reporting template for submission to national reporting system (SIMS). Additionally, programme data analysis will be done at different levels of programme management at regular intervals to give feedback to the partners towards effective programme management and implementation. PR will also provide adequate capacity building support to SR partners so that the staff at the SR level are technically capacitated to analyze and use the data for the programme decision making.

b. Reporting through SIMS

Performance report will be submitted by the CSC every month. Requisite training on SIMS application will be provided to the CSC staff. CSC will submit MPR to the SR. At SR level this report will be cross checked, corrected and reports of all CSCs will be collated. Monthly Performance Report (MPR) is generated at the CSC level and submitted to online SIMS after verification and correction of report is completed by SR (Annexure VI).

c. MIS framework at the CSC level

There will be a client-based reporting system developed through which data entry will be done by staff members using a simple reporting tool to eliminate duplication of data entry and to simplify the reporting and documentation processes.

8.2 Reporting Architecture

The reporting architecture for routine data collection will be as follows

	Name of the reporting tool	Purpose	Person responsible
1	CRF/enrolment register	Total enrolment	Project Coordinator
2	Counselling register	Counselling	Counsellor/Peer Counsellor
3	Referral register (out referral, social welfare schemes linkages, social entitlement register)	Out referral, social welfare linkage and social entitlement	Counsellor/Peer Counsellor/ Project Coordinator/ORW
4	Outreach register	Outreach visit	Outreach worker
5	Meeting register	Support group meeting / advocacy/coordination meeting register	Project Coordinator
6	Discrimination response register	Incidents of discrimination/ violence	Peer Counsellor/Project Coordinator
7	HR & training register (applicable for SR level only)	Admin and training done at SR level	Project Coordinator

Regular training (induction and refresher) of SRs and SSRs staff on M&E systems and management will be done to build their capacity for effective understanding of MIS and submit quality reports in a timely manner. The regular monitoring will be done through a core performance framework and other programme indicators.

8.3 Indicators for Monitoring Programme Activities

8.3.1 Core indicators

	Indicator	Target
1 1 a) 1 b)	Proportions of PLHIV registered in HIV care from ART Centre are registered in the CSC. Proportion of PLHIV in Pre ART care from ART Centre and also registered in the CSC Proportion of PLHIV registered in ART Centre and ON ART are registered in the CSC	The CSCs are expected to give care and support services to all PLHIV registered in HIV care at ART centres. CSC will register at least 50 per cent of PLHIV registered in HIV care (pre ART as well as ON ART) by the end of the first year of scheme and increase gradually thereafter. By the end of 2nd year they will register 70% and by the end of the 3rd year the CSC should register at least 80% of Pre ART and ON ART PLHIV (Denominator: total number of PLHIV (Pre /ON ART) registered in HIV care at ART centre, Numerator: out of total registered in ART centre,number of (Pre/ON ART) PLHIV registered in CSC
2	Proportion of registered PLHIV receiving at least one peer counselling service in the quarter.	It is expected that all PLHIV registered at CSCs receive peer counselling services. Every quarter at least 80 per cent of clients registered in CSC will receive at least one peer counselling service. (Denominator: number of patients registered at CSC in the quarter. Numerator: out of PLHIV registered in the quarter those who received peer counselling service within the quarter)
3	Proportion of registered PLHIV receiving at least one counselling session on thematic areas	It is expected that all PLHIV registered at CSCs receive regular counselling services. Every quarter at least 60 per cent of clients registered in CSC will receive at least one counselling service on thematic areas. (Denominator: number of patients registered at CSC in the quarter. Numerator: out of PLHIV registered in the quarter those who received thematic counselling service within the quarter)
4	Proportion of PLHIV who have at least one family member or sexual partner referred for HIV testing and received test result.	Of the total registered PLHIV in the CSC, there would be many PLHIV whose family member/s or sexual partners need to be referred to ICTCs. It is mandated that CSC will refer and receive testing result of at least 90 percent of them. (Denominator: of the registered PLHIV number of patients whose family member or sexual partner need to be referred to ICTC. Numerator: number of PLHIV whose family member or sexual partner referred to ICTC and received testing result)
5	Proportion of PLHIV registered in CSC linked to social welfare scheme/s.	At least 80 percent of the PLHIV registered in CSC will be linked to needful social welfare scheme/s. (Denominator: PLHIV registered in CSC. Numerator: out of them number of PLHIV linked to social welfare scheme/s)
6	Proportion of PLHIV lost to follow up/MIS brought back to treatment.	Treatment retention and adherence are the most crucial activities in the care and support programme. CSC should aim to track back at least 90 per cent of all alive LFU/MIScases atART centre through outreach. (Denominator: number of LFU/MIS cases reported by ART centre. Numerator: out of them number of LFU/MIS cases tracked back by CSC)

8.3.2 Additional indicators to be used for monitoring programme performance

- Number and proportion of registered PLHIV receiving at least one counselling session on thematic areas
- Number of one-on-one counselling sessions conducted
- Number of PLHIV attended one on one counselling
- Number of families counselled
- Number of couples counselled
- Number of PLHIV registered during the month contacted through outreach
- Number of registered PLHIV contacted through outreach for follow up services
- Number of on-ART LFU cases list provided by the ARTC
- Number of on-ART LFU cases contacted through outreach
- Number of on-ART LFU cases reported back to ART centre
- Number of on ART MIS cases provided by the ART centre
- Number of on ART MIS cases contacted through outreach
- Number of on ART MIS cases reported back to ART centre
- Number of PLHIV whose Pre-ART baseline CD4 not done shared by ART Centre
- Number of PLHIV in Pre-ART followed up for baseline CD4 testing
- Number of PLHIV in Pre-ART reported back for baseline CD4 testing
- Number of PLHIV in Pre-ART eligible, but not initiated on ART, shared by ART centre
- Number of PLHIV in Pre-ART eligible, but not initiated on ART, followed up for ART initiation
- Number of PLHIV in Pre-ART eligible, but not initiated, linked back to ART centre for ART initiation
- Number of PLHIV in Pre-ART whose CD4 testing is due shared by ART centre
- Number of PLHIV in Pre-ART whose CD4 testing is due followed up
- Number of PLHIV in Pre-ART whose CD4 testing is due is linked back to ART centre for CD4 testing
- Number of Pre-ART LFU cases provided by the ART centre
- Number of Pre-ART LFU contacted through outreach
- Number of Pre-ART LFU reported back to ART centre
- Number of newly identified discordant couple tested for HIV
- Number of discordant couples followed up for HIV re-test
- Number of discordant couples receiving services from the CSC
- Number of discordant couples remaining discordant from last one year in the program
- Number of new clients referred to CSC (in-referral)
- Number of clients referred from CSC (out-referral)

- Number of support group meetings conducted
- Number of persons that attended support group meetings
- Number of ART coordination meetings attended by the CSC
- Number of DAPCU coordination meetings attended by the CSC
- Number of coordination meetings with PLHIV networks
- Number of coordination meetings with district administration andother departments
- Number of coordination meetings attended by the CSC with District Health Society
- Number of discrimination cases reported at the CSC
- Number of advocacy meetings organised by the CSC
- Number of CABA registered at CSC
- Number of CABA that received counselling services
- Number of outreach services done for CABA
- Number of CABA that received referral services
- Number of support group meetings conducted with CABA
- Number of CABA that attended support group meeting
- Number of single women/widow registered at CSC
- Number of single women/widow that received counselling services
- Number of outreach services done for single women/widow
- Number of single women/widow that received referral services
- Number of support group meetings conducted with single women/widow
- Number of single women/widow that attended support group meetings
- Number of HRG registered at CSC
- Number of HRG that received counselling services
- Number of outreach services done for HRG
- Number of HRG that received referral services
- Number of support group meetings conducted with HRG
- Number of HRG that attended support group meetings
- Number of PR, SR, SSR and the service providers trained on programme, monitoring and evaluation, and finance management on different thematic areas

8.4 Reporting Mechanism

All above indicators will be reported through the following:

1. **Monthly Performance Report (MPR)** will be generated every month at the CSC level and submitted from SSR to SR and DAPCU, and from SR to PR, SACS and DAC (Annexure VI).

2. **Quarterly Progress Report (QPR)** will be generated at the SR level and submitted to PR and DAC every quarter on a Qualitative Reporting Template (Annexure VII).

8.5 Provision of Technical Assistance to CSC

Technical assistance will be provided to the CSC through different levels. SR will be responsible to mentor/provide support to the CSC, enabling them to effectively implement the approved CSC activities. PR will provide need-based support to the SRs to enable them provide support to the CSCs. DAC and SACS will also provide support from time to time. Areas of support will be encompassing programmatic performance, financial utilization and data quality.

To ensure quality of the supervisory visit, the visiting officials will use a standardized CSC visit checklist (CSC Visit Report format - Annexure IX). The visit report will be analysed and shared with CSC, SR, and PR from time to time and the action taken reports will be included in the QPR.

Supportive supervisory visits by SR team

On a regular basis, SR team will analyse the MPR submitted by CSCs in order to identify the gap areas. On the basis of the observations made in the areas of programmatic performance, financial utilization and data quality, SR team will develop the supportive supervisory visit plan to the CSCs.

- All CSCs should be visited at least once a month by one of the SR staff or in a team comprising of PO, Finance and M&E.
- Poor performing CSCs should be given more attention for providing intensive technical support.
- CSCs having administrative hindrance should be identified and immediately visited to address the identified administrative issues by involving the concerned PD or board member of the CSC implementing agency.
- For data validation and reconciliation, M&E officer will discuss with the CSC team, verify data in all registers, cross check with activity reports using the M&E Checklist (Annexure VIII).
- For supervision of overall performance, the PM/PO will interact with CSC staffs to review the progress, recognize good practices, identify gaps, assess knowledge and skills, and provide feedback to the team.
- In case it is required, SR team will organize a small orientation to CSC staff on the identified knowledge gap areas.
- SR team with CSC representative will visit important stakeholders such as ART centre, DAPCU and other district level officers to strengthen coordination system and team spirit.
- PM/PO/Advocacy Officer, during their visit to the CSC, should plan to interact with community members to understand their perspective on CSC services.
- CSC visit report should be completed within five days after the completion of the visit. The report is to be shared with CSC for the necessary measures to be taken up. SR should also incorporate the findings/observations into their plan to mentor the CSC team.
- The Programme Manager in SR team will review all visit reports and consolidate the visit findings to share with SACS and PR.

Supportive supervisory visit by PR

- PR team will analyse the reports (MPR and QPR) submitted by SRs on regular basis; accordingly supervisory visit plan will be developed.
- PR should ensure visit to all SRs at least once in a quarter.
- In the PR team's visit plan, visit to CSC and ART centres should be included.
- PR team should meet key stakeholders such as SACS, DAPCU, and PLHIV networks wherever and whenever possible.
- PR visiting official should use the checklist and report within 5-7 days to SR, SACS and DAC.

Supportive supervisory visit by DAPCU/SACS/DAC

- As and when necessary, officials from DAPCU/SACS/DAC will also be visiting the CSC and SR from time to time.
- Visit report will be shared with PR, SR, and CSC for necessary measures to be taken up at CSC, SR and PR level.

Data quality audit

PR and SR M&E team will be responsible for carrying out the onsite data verification visits (OSDV) at regular intervals to keep track of the data generated and reported under the programme. A randomly selected set of CSCs and SRs would be audited every quarter using the auditing methodology. Regular monitoring visit will be undertaken both from PR/SR/SACS and DAC level to provide quality feedback on the programme performance.

Data quality auditing methodology

To ensure quality of data in terms of accuracy, completeness and timely submission, PR and SR team will adopt the following methodology

- SR team, during their field visit, will verify all reports and documents using the standardized M&E checklist mentioned above and necessary corrective measures to be taken up by SR and CSC team.
- At the PR level, all M&E checklist report will be analysed and corrective feedback will be given to SR. PR team during the visit to the SR will cross-check/verify the reconciliations. PR will use this data collected through M&E checklist and use it for understanding programmatic variances and for further planning of the programmes.

Structure for supportive supervision visit

Visit done by	Purpose of the visit	Outcome of the visit
SR and PR	i. To understand and generate a summary of the organization's performance. ii. To verify the organization's achievements declared in the reports on the basis of reviewing project's primary documentation as well as by means of direct observation. iii. To track follow-up on remedial actions taken in accordance with recommendations provided to the organization, to which the visit was made.	I. Provide feedback to the implementing SSR on its overall performance and attainment of the set targets. II. Suggest corrective measures to be taken, if necessary, by the SSR in order to improve service provision. III. Assist managerial decision making within the PR regarding a particular grant/organization. IV. Enable follow-up on the implementation of remedial actions by the SSRs in relation to recommendations provided during the monitoring visit. V. Assist the SSR in improving its monitoring and reporting practices in order to provide accurate and up-to-date data.

8.6 Data Sharing Mechanism with ART Centre, DAPCU and SACS

There will be a data sharing mechanism in place between ART centres and the CSCs. Project Coordinator of CSC will coordinate with Medical Officer/Counsellor of ART centre every Saturday for data sharing. CSC will collect following data from the ART centre

- Pre-ART baseline CD4 not done
- Pre-ART eligible but not initiated on ART

- Pre-ART CD4 due
- Pre-ART LFU
- On ART MIS
- On ART LFU

CSC will collect the details of on-ART MIS and pre-ART baseline CD4 not done cases on every Saturday and submit the follow-up details on subsequent Saturday. CSC will submit the details of other follow-up (on-ART LFU, pre-ART LFU, pre-ART not initiated, not eligible for ART and not visited during last six months for CD4 testing, follow up baseline CD4 not done) to ART centre on a monthly basis. ART and CSC will have monthly coordination meeting on a fixed date preferably on the fifth of every month. The coordination meeting between ART centre and CSC will have the following agenda points

- CSC to submit the status report of follow-up with line list
- To share the details of clients who have migrated, opted out, died with documentary evidence
- ART centre will share the monthly ART registration data (pre-ART and on-ART) with the CSC which will be the basis for fixing the monthly target for SSR for all the core indicators, capturing activities in CSC.
- ART centre will share the MIS and LFU cases
- In the DAPCU districts, DAPCUs (in non-DAPCU districts nodal officer HIV/ SMO ART centre/MO ART centre) will facilitate data sharing mechanisms. Similar data sharing mechanism will be in place between SR and SACS at state level and DAC and PR at the national level.

Data sharing mechanism

Name of the agency	Type of report/data to be shared	Shared with	Purpose	Frequency
ART Centre	Monthly ART and pre-ART registration numbers	CSC	To understand the target and to develop outreach plan	5th of every month
ART Centre	On-ART MIS cases	CSC	For follow-up	Every Saturday
ART Centre	• Pre-ART baseline CD4 not done • Pre-ART eligible but not initiated on ART • Pre-ART CD4 due • Pre-ART LFU • On-ART MIS • On-ART LFU	CSC	For follow-up	5th of every month
CSC	On ART MIS case follow-up details	ART centre	Follow-up details submitted back to ART	Every Saturday
CSC	LFU follow-up details	ART centre	Follow-up details submitted back to ART	Once in a month
CSC	Field visit plans	ART centre	Action plan submitted to ART centre for their information	Once in a week
CSC	Monthly report	ART centre, DAPCU SR	Monthly progress report	10th of every month
CSC	Quarterly report	ART centre DAPCU SR	Quarterly progress report	10th of the first month of every quarter

Name of the agency	Type of report/data to be shared	Shared with	Purpose	Frequency
SACS	ART Centre Registration data	SR	For target calculation and data triangulation	10th of every month
SR	Monthly report	SACS PR DAC	To share the monthly progress report	10th of every month
SR	Summary of field visits by PO	SACS PR DAC	To understand the major observation during supportive supervision visit to CSC	10th of every month
DAC	ART centre registration data	PR	For target calculation	Once in a quarter
PR	SR wise consolidated monthly report	DAC	To share the monthly report	10th of every month
PR	SR wise consolidated quarterly report	DAC	To share the quarterly report	15th of every quarter

To capture data for registered clients who have died and reported during outreach, ORW will collect adequate proof (e.g. copy of the death certificate/signed certification from a relative of the client/ head or elder of the village) of the client from the field and submit to CSC as a supporting document. The copy of the same will be shared with ART centre for data updation. To keep a track on migration, UID of CSC will be mentioned in the ART Green Card of the client with CSC stamp to avoid duplication of registration under the same programme and to keep a track on migration.

Capacity Building

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9. Capacity Building

Capacity building will be an important component to strengthen the quality and access of services through CSC. Staffs at different levels including SR and SSR will be capacitated through series of trainings and supportive supervision initiatives. Trainings will be imparted to functionaries on organizational development and systems which includes programme management, monitoring and evaluation, and grant management. Functionaries will also receive trainings on thematic areas, including sexual and reproductive health (SRH), treatment adherence, positive prevention, and psychosocial support.

9.1 Trainings Planned in the Program

1. **Orientation workshop**

    a. **SR team induction training:** PR will organize and conduct induction training for the SR team (Project Director, Project Manager, M&S Officer, Project Officer, Finance Officer, and Advocacy Officer) on programme management, M&E and financial management.

    b. **SSR team induction training:** SR with the support from PR wherever needed will organize and conduct four days induction training of the SSR team (Project Coordinator, Counsellor, ORWs, Peer Counsellor, and Accountant). This training will cover all imperative aspects of CSC program, such as outreach planning, advocacy, lost to follow-up, M&E indicators, budget, etc.

2. **Training of trainers:** A pool of master trainers will be developed to strengthen the capacity of SRs and SSRs teams. While using a cascade approach wherein master trainers will be used to impart trainings and transfer skills at different levels. Focus will also be on developing an understanding on concepts pertaining to psychosocial care, positive prevention, sexual reproductive health, and treatment adherence. Moreover, soft skills of trainers will also be enhanced through clarity on training skills, various training methods, and adult learning methods.

9.2 Training Schedule of Various CSC Staff

Type of Training	Project Coordinator	Counsellor	Peer counsellor	ORW	MIS Assistant	Accountant	No. of Days
Orientation training	√	√	√			√	2
Induction training (Programme management, financial management and M&E)	√	√	√	√	√	√	4
Refresher training on programme management	√				√	√	2
Functionary specific trainings (Project Coordinators and outreach workers)	√			√			6

9.2.1 Functionary specific trainings

Functionary specific thematic trainings will be organised, focusing on strengthening individual roles and skills of SSR level functionaries. These trainings will focus on the job specific skills required by the functionaries working at SSR level. These trainings will be tailored considering the aspects of program management, counselling, outreach planning, etc. and thematic areas such as positive prevention, sexual reproductive health, treatment adherence, and psychosocial support. Details of functionary specific trainings are mentioned below:

a. **PD & board members:** Project director and board members of the organisation implementing CSC will be capacitated explicitly on programme management leadership and governance, organizational development, resource mobilization, and financial management, along with orientation on care and support background and management structure. This will strengthen the board of an SSR and enhance their vision for sustainability.

b. **Project coordinators:** Project Coordinators needs to be well capacitated on programme management; however, it is very important for them to understand finance management also, as budget and program go hand in hand. MIS tools and documentation will also be covered, as they need to have hands on reporting system in the program too. Along with this, brief sessions on treatment adherence, positive prevention and sexual reproductive health will also be included in the training to strengthen their skills on technical areas in the program.

c. **Counsellors:** Counsellors' training will be planned in coordination with a technical agency so that they develop an in–depth understanding of key concepts relevant to care and support program, along with developing core counselling skills. It will be an intensive training through which counsellors will be capacitated on effective counselling strategies, intervention planning (in context of care and support), psychosocial support, treatment adherence, positive prevention, and sexual reproductive health.

d. **Peer counsellors:** A brief counselling training package will be planned for peer counsellors to capacitate them in addressing counselling needs of the community on field. They will also be given a brief overview of counselling skills and thematic areas such as psychosocial support, treatment adherence, positive prevention, and sexual reproductive health.

e. **Outreach workers:** Outreach workers will be capacitated in outreach planning, on use of various tools, and prioritisation for outreach to efficiently manage varied groups. Further, to strengthen the reporting system, they will also be trained on MIS record keeping tools and data interpretation. They will also be capaciitated on thematic areas such as treatment adherence, positive prevention, and sexual reproductive health.

f. **Finance officer:** Finance Officer will be capacitated on finance management, along with M&E tools and documentation so that they have a perspective of linking budget with outcomes of the program. They will be capacitated onsite during the technical visits, which will be conducted by SR team.

g. **M&E officers:** M&E Officers will be trained on MIS tools and documentation in detail, along with practical usability of the CMIS, software and reporting system.

I. **Field-level handholding:** As a follow up to class room trainings, field level handholding will be done during the technical visits to be conducted by PR and SR team. On site handholding support will be provided to SR and SSR functionaries. To facilitate the understanding at field level, training aids and job aids will be developed along with the modules to be used as a reference document. It will include:

a. **On-site training:** Thematic trainings will be organised at SSR level, focused on strengthening the knowledge and skills of functionaries, as a follow-up to class room trainings. It will be a part of technical visits to be conducted by SR teams.

b. In-house training: Learning from functionary specific trainings will percolate to entire SSR team during the in-house trainings. These trainings will be organised regularly by the SSR teams; post class room trainings will also be organised.

II. **Capacity building of SLN and DLN:** With the objective of ensuring a robust system of community owned and led care and support mechanism in the country beyond the project period, SLN and DLN representatives will be capacitated to enhance their leadership and negotiation skills, which will aid them in future. They will be given an orientation on thematic aspects of treatment, care and support to strengthen their programme management skills. It will include areas like leadership and governance, organizational development and resource mobilization, and financial management.

III. **Addressing needs of special groups (including HRGs):** Capacity building initiatives will focus on highlighting wellbeing of PLHIV, including underserved populations who face difficulty in accessing treatment, including women, children and HRGs such as FSW, MTH and IDUs. Considering the objective of strengthened community systems and reduced stigma and discrimination; the proposed capacity building initiatives will focus on highlighting issues of MARPS and will facilitate in providing them with better access to care and support services.

IV. **Refresher trainings:** SR and SSR teams will also be refreshed on programme management, finance management and MIS tools and documentation, along with leadership and governance, organizational development, resource mobilization, and financial management. A situation assessment will be done to identify the needs of functionaries working at SR and SSR level and accordingly these trainings will be planned in coordination with a team of experts, including doctors and psychologists (master trainers), trained per state by a technical agency. It will also focus on clarifying the basic issues covered in the areas of SRH, positive prevention, psychosocial and treatment adherence. Based on the learning from implementation, refresher trainings will be tailored.

Governance and Role of Stakeholders

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10. Governance and Role of Stakeholders

10.1 CSC Governance

Good governance is a prerequisite for effective implementation of CSC programme that requires the involvement of various stakeholders at different levels. In order to ensure that CSC is community-friendly and working in synergy with all the stakeholders, a systematic governance system needs to be in place. The governance system adopted for the programme from national level to local level is discussed below.

CSC Governance Structure

10.1.1 National Coordination Committee (NCC)

At national level, PR works closely with the Department of AIDS Control (DAC) for smooth functioning of the programme. To review the progress of programme periodically to ensure that the programme is aligned with national priorities and to suggest better implementation strategies, a 'National Coordination Committee' is formed at the national level.

Key functions of NCC

- To provide technical and programmatic inputs for better quality services through the CSCs
- To help align CSC implementation strategies with the goals and objectives of NACP IV
- To facilitate co-ordination and linkages with health and other line departments (especially for directives and orders from different ministries/departments)
- To facilitate synergies among stakeholders at the state level and provide technical inputs to State Oversight Committees
- Support to the PR in carrying out national level advocacy

Profile of members of NCC

Membership will be informed by organizational affiliation and will include representation from the following

1. DDG (CST), DAC (Chairperson)
2. NPO (ART), DAC
3. Programme Officer (C&S) andofficers of other divisions of DAC
4. PR
5. SACS and SR representatives on rotation basis

Terms of reference

NCC will be an expert committee to review and evaluate the implementation of the CSC and provide inputs as and when needed. The key responsibilities of PAC will be the following Review programme implementation on a regular basis.

- Review linkages and synergies between programme constituents and suggest modifications as and when required.
- Review the project progress once every quarter and provide advisory inputs to strengthen the quality and efficiency of implementation and strengthening CSCs all over India.
- Ensuring proper data sharing between ART and CSCs.

Functioning

NCC is expected to meet quarterly. DAC will chair the meetings and the PR will manage the logistics.

State Oversight Committee (SOC)

SOC undertakes state level review of implementation of CSC programme in the state and providesnecessary guidance to the programme based on the local context. It is a platform at the state level to share challenges or difficulties arising in implementation of CSC programme and to seek support from SACS.

Key functions

1. To review implementation of the programme and provide necessary support to the SR and SSRs
2. The SOC will ensure that there is co-ordination and regular meetings between CSCs and ART centres
3. To address the issues of co-ordination with health and other line departments and facilitate active referrals and linkages to health and social entitlements
4. To provide inputs in addressing the issues of stigma and discrimination at various levels
5. To encourage sharing of best practices
6. Support to the PR in carrying out state/district level advocacy
7. The SOC will support SR in major troubleshooting activities as and when required

Member profile

1. Project Director of the SACS or a senior officer nominated by the PD (chairperson)
2. Joint Director (CST) /officer in-charge of CST
3. Regional coordinator for the state
4. GIPA Coordinator, SACS
5. Consultant, Mainstreaming, SACS
6. SR PD will be the member secretary and will provide secretarial support to the SOC chair
7. Five SSRs will be SOC members on a bi-annual rotational basis (in case of less than five, all SSRs)
8. Any other development partner/s as decided by the members of the SOC

Activities

- The SOC will meet quarterly, more often if needed. Out of four meetings in a year, at least one will be attended by a PR/DAC representative.
- The SOC will meet at the SACS premises as far as possible
- Decision making will be guided by a majority vote, and it is suggested that minority objections be discussed and mitigated.
- The SR will be responsible for meeting facilitation, preparing agenda for the meeting, material preparation, and SOC meeting documents (including minutes and decision pieces, sharing the same within three days of the meeting).
- In times of emergencies, three nominated members of the SOC need to be available for consultation at short notice.
- Any travel or administration expenditure will be borne by SR. Minutes of the meeting will be shared with PR and DAC within one week of conducting the SOC.

Quorum

SOC meetings should ensure presence of not less than two-third of the members, in addition to the mandatory attendance of at least one representative each from SACS and SR organization.

10.1.2 Community Advisory Board (CAB)

Community Advisory Board will serve as the voice of the community and ensure linkages and synergy between CSC and the communities with whom they work. This is an effort to ensure that the programme is attuned to real community needs, remains sensitive to issues as they arise, and provides a mechanism to facilitate exchange and promote corrective action as required.

CAB membership criteria

The CAB is constituted at regional/state level with one CAB per SR. Each SR will have three CAB members and at least one member from any of the HRGs. For the selection of CAB members, the SR will invite the nominations from all SSR partners. Based on the TOR of CAB, SSRs will nominate members from PLHIV community who are the direct beneficiaries of the programme. If there are more than three nominations, in the coordination meeting with all SSR, SR will invite all the candidates. Each applicant is given an opportunity to share about themselves and why they want to become CAB members. If three members are not unanimously selected, the SR needs to organize an

election. A representative of SACS or any other external member needs to be invited as an observer to ensure transparency in the election of CAB members.

The CAB members should not be on the board of any of the SSR organization and should not be employed in the programme. It is advisable that at least two-third of CAB members change every year.

Frequency of meeting: Quarterly/need-based

CAB Roles and responsibilities

- Ensure CSC maintains highest degree of accountability to the PLHIV community
- Ensure needs of all groups of PLHIV communities are being met by the programme
- Guide and ensure action on priority issues of the community, including providing assistance in conflict mediation
- Support SR in implementing the programme efficiently
- Identify opportunities for CSC to expand activities especially in terms of community engagement and resource mobilization
- Redress grievances against CSC implementation

10.2 Role of Stakeholders

Department of AIDS Control (DAC)

- Regular communication to SACS in ensuring the local level support to SR for implementing CSC and regular data sharing between ARTC and CSC
- To provide technical and programmatic inputs to PR from time to time
- To support PR in scaling up of CSC
- To support PR in organizing National Coordination Committee meeting regularly
- Supervise and monitor the performance of CSCs on regular basis

State AIDS Control Society (SACS)

The JD/officer in-charge of CST in SACS is 'Nodal Officer' to coordinate with the SR in the state. The main roles of Nodal Officer are as follows:

- Nodal Officer also has to support SR in organising periodic 'State Oversight Committee' (SOC) meeting and facilitate approval of minutes by PD SACS.
- Supervision and monitoring of CSC in the State (each centre may be visited at least once in three months).
- Facilitate coordination between CSC and ART centre for data sharing.
- Collate, compile and forward any pertinent issues/information relating to CSC to DAC and PR.
- Participate in state level trainings organized for SR/SSR staffs for quality assurance and monitoring.
- Organise and participate in reviews and assessment of CSCs as and when required.
- To provide support to SRs in trouble-shooting or crisis management.
- To support advocacy initiatives of SRs with other line departments.
- To provide copies of all guidelines, other documents and IEC materials related to various components of NACP.

District AIDS Prevention Control Unit (DAPCU)

- Facilitate data sharing by ART centres to CSC team.
- Ensure participation of CSC in the monthly ART coordination meeting and in the District AIDS Prevention Coordination Committee organized by DAPCU.
- Regular supportive supervision visits to the CSCs.
- Facilitate coordination of CSC team with other outreach workers in the districts such as PPTCT ORWs, LWS staff, TI staff, etc. for tracking of LFU and MIS cases and bringing back to ART centres.

Principal Recipient (PR)

- Responsible for overall coordination with DAC, SACS, SRs, SSRs, and other key stakeholders involved in the CSC implementation.
- Provide training to SR and SSRs teams.
- Provide technical support to SRs to enable them to provide support to SSRs and ensure adherence to financial and programmatic guidelines.
- Supervise and monitor the performance of CSCs on quarterly basis.
- Ensure timely fund release to SRs and to SSRs.
- Facilitate effective coordination between SRs and SACS.
- Report to DAC from time-to-time about the progress in programme implementation.

Sub-Recipients (SRs)

- Provide technical support to SSRs towards effective functioning of CSCs.
- Timely release of funds to SSRs.
- Support SSRs to develop quarterly and monthly work plan.
- Supervise and monitor performance of CSC on monthly basis.
- Support SSRs towards accomplishment of programmatic goal.
- Coordinate closely with SACS and DAPCUs to ensure smooth data and information sharing between ART centres and CSC team.
- Timely sharing the reports with SACS and PR.
- Providing day-to-day management support to CSC and in handling conflict situations.

Sub-Sub-Recipients (SSRs)

- Implement CSC smoothly and effectively.
- Ensure accomplishment of programmatic targets and financial utilization as per the approved annual plan for CSC.
- Work in close coordination with ART centres, DAPCU and district level stakeholders.
- Sharing Monthly reporting to ART centre, DAPCU and SR.
- Attend monthly ART coordination meeting organized by ART centre.
- Attend meeting organized by DAPCU at the district level.
- Carry out actively intensified tracking of LFU and MIS cases and reporting back to ART centre.
- Mobilize need based additional resources to scale up support services for clients registered at CSCs.
- Carry out effective advocacy for successful linkages of clients for social entitlements and schemes available in the district.

10.3 Coordination Mechanism - CSC and ART Centres

CSC will work as an extended arm of ART Centre in providing holistic care and support for PLHIV. Regular data sharing between ARTC and CSC through active involvement of DAPCU is the core essence of the programme. DAC/SACS will facilitate data sharing between ART centre and CSC. A coordination plan between ARTC and CSC is given below.

Name of the activity or responsible officer	Role of ART Centre	Role of CSC
Coordinating Officer	SMO/MO of ART centre supported by Counsellor with overall guidance of Nodal Officer	Program Coordinator supported by Counsellor
Coordination meeting	Participation in coordination meeting	Participation in coordination meeting
Registration of PLHIV	• Registration	• Taking details of PLHIV registered in ART centre and registering them in CSC as per registration norms for providing services in CSC • Sharing the information of PLHIV who directly enrolled with CSC and not registered with ARTC with ARTC for ART services
Follow-up of MIS and loss to follow-up cases	• To provide the list of MIS cases on weekly basis to CSC • To provide the list of LFU cases on monthly basis to CSC • Providing any other support as and when required by CSCs in follow-up of cases	• Obtaining the list of MIS and LFU cases from ART centre and developing ORW wise follow-up plan • Motivating PLHIV who are MIS or LFU to receive their treatment and bringing them back to treatment • In case of death cases or wrong addresses, reporting back to ARTC with supporting documents • Sharing the status of MIS cases on weekly basis and LFU cases on monthly basis
Support group meeting		• Sharing the CSC monthly activity calendar with ART centre in advance for their information and participation in activities such as SGM
Advocacy	• Supporting CSC in district level advocacy issues,especially with health settings • Coordinating with other departments in the hospital or other hospitals in ensuring treatment needs of PLHIV are met	• Bringing to the notice of Nodal Officer on district level advocacy issues or stigma in health care settings • Seeking support of ARTC in addressing stigma and advocacy plan
Linkage and coordination	• Invite CSC for meetings and local events • Let CSC staff meet new PLHIV and follow up old at ART center	• CSC monthly report to be shared with ARTC on monthly basis • Deployment of ORW at ARTC for follow-up on rotation basis

10.3.1 Monthly ART Centre-CSC coordination meeting

The CSC is expected to coordinate with the ART Centre for regular monthly ART-CSC coordination meeting. CSC in coordination with ART centre can facilitate the participation of CSC and ART Centre staff, counsellors of all ICTCs, district ICTC supervisor, President/ representative of DLN.

This meeting will have the following agenda:

- Referral of newly detected HIV positive cases to ARTC
- Cross referrals between ARTC and CSC
- Cross referrals between facilities of RNTCP and NACP
- MIS or LFU action: progress made on MIS cases and LFU tracking
- Any other locally relevant issues

The supervision will be through review of monthly reports and the mentoring/supervisory visits as by DAPCU/SACS/implementing agency.

10.3.2 CSC and District AIDS Prevention & Control Unit (DAPCU)

CSC will work closely with DAPCU at district level and report the programme activities to DAPCUs. The main elements of coordination with DAPCU are discussed below.

- Project Coordinator will participate in DAPCU Coordination meetings at district level and provide reports on CSC activities to DAPCU.
- DAPCU can also be part of monthly coordination meeting between CSC and ART centre.
- All data related to Pre-ART and LFU should be shared by ART center to CSC through DAPCU and DPO will be responsible for distribution of list to various partners and further verify the authenticity of the follow up of PLHIV back to ART center.
- CSC will develop monthly activity calendar and share with DACPU in advance.
- CSC will invite DAPCU to be part of support group meetings as and when required.
- DAPCU will support CSC in district level advocacy and also in addressing stigma and discrimination cases.
- DAPCU may conduct supportive supervision visit to CSC once in a month.
- DACPU will involve CSC in district level activities especially DHS meeting, media orientation and sensitization meetings for different stakeholders.
- CSC will report all coordination issues and advocacy issues primarily to DAPCU.
- DAPCU will assist CSC in crisis management.

10.3.3 CSC and DLN

In case, the CSC is being run by an NGO and not the DLN, NGOs must find ways to engage the DLN in the program. At the minimum, the NGO must ensure the following

- A coordination meeting is organized with the board members of DLN once every quarter.
- Minimum of three SGMs are organized by the DLN every month.

Some other suggestions in this regard are

- To give preference to DLN experienced members for staff recruitment.
- To ensure SLN/DLN representation in staff recruitment process.
- To involve SLN/DLN members in committees and advisory groups.
- To ensure their representation in coordination meeting, advocacy meeting, SGM, SOC, etc.
- To provide space for the DLN office in CSC premises wherever it is possible.

Establishment and Closure of CSC

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11. Establishment and Closure of CSC

11.1 Establishing CSC

Under NACP IV, DAC envisages that all ART centres in the country should have at least one CSC attached to it. All ARTCs in the country will be attached to one or the other CSCs through the scheme and number of CSC in a district will be based on the pre-ART registration. During the first phase, 225 CSCs will be established by the PR through an external agency in consultation with DAC and SACS. For the subsequent scale up, if the number of SSRs to be selected is more than 10, PR will undertake the selection process through an external agency. If the number of CSCs to be selected is less than 10, respective SR will undertake the selection process in close coordination with the PR and respective SACS. The selection of district for establishing CSC will be done through a consultative process involving DAC/SACS and the PR and SR. For selection of any SSR, uniform selection process will be adopted. Preference will be given to NGO/DLN of proven success in the field of HIV/AIDS, especially in the area of care and support.

11.2 Eligibility Criteria for NGO/CBO Setting Up CSC

- The agency should be a non-profit organisation and legally registered under
  - The Societies Registration Act of 1860 or an equivalent Act of a State; or
  - The Charitable and Religious Act of 1920; or
  - Indian Trusts Act of 1882 or an equivalent Act of a State; or
  - Section 25 C Company ACT
- It should have a clearly defined organisational structure.
- It should have established administrative and management systems.
- It should have sound financial track record with an established financial management system (three years audit reports and audited accounts required in case of NGOs and one year report for CBOs).
- It should have a minimum of three years' experience in managing public health programmes or allied programmes in health.
- Experience in the field of HIV/AIDS, especially in the area of care and support, will be an added benefit.
- The organisation should have been working for minimum three years in case of NGOs and one year in case of CBOs in the same district and have a good track record in providing services.
- Readiness to make available adequate infrastructure deemed necessary to carry out all the activities planned in CSC.

11.3 Selection Process of NGO/CBO for Setting Up CSC

a. Promotion of Request For Proposal (RFP)

If across the country more than 10 SSRs need to be recruited, PR will initiate the selection process through an external organization and if it is less than 10, each SR will initiate the process of recruitment for their state/region.

The process of selection would be transparent, through an advertisement in the local newspapers with maximum circulation in the region and in the websites of PR, SR and SACS. A short RFP will be floated for a two-week period. Information on the RFP will be widely promoted during community consultations and stakeholders will be encouraged to disseminate the RFP widely.

b. Community consultations

Before starting any new CSC, SR has to conduct a community consultation in that area. These consultations should have representation from State Level Networks (SLN), District Level Networks (DLN), officers from SACS, and leaders from PLHIV community, representatives from any other organizations which are providing care and support services and PR. In the community consultation meeting, the goals and objectives of CSC model and strategies, management, and CSC activities should be highlighted. Suggestions from the community will be asked on how to popularise the services among the community in the local area, what are their expectations from the CSC services, what are the unmet needs of the community, etc. This consultation meeting will support the programme in designing specific programme activities under new CSC in the district. Besides this, the selection process and RFP details for new CSC will be shared in the meeting and eligible organizations, including community based organizations, are encouraged to apply for new CSC.

c. **Review of proposals**

Role of external agency:

- In case of more than 10 CSCs selection across the country, external agencies hired by PR will shortlist the eligible applicants.
- Wherever feasible, external agency will take representatives from SACS and SR for site assessments.
- External agency will undertake site assessment of the shortlisted applicants using approved tools.
- After the site assessment, final list of shortlisted applications will be submitted to PR.
- PR will vet the final selection list with National Coordination committee and concerned State oversight committee.
- PR will communicate to successful applicants regarding the selection.
- SR will work with selected SSR for establishment of CSC and to coordinate with district level stakeholders.

Whenever the selection of CSCs is less than 10, SR will form a Joint Appraisal Team (JAT) to facilitate a transparent and quality selection process. JAT will consist of three members:

- Representative from PR/ DAC
- Representative from SR
- External expert/SACS representative/DAPCU representative

Role of JAT

- JAT will review applications received within the stipulated time (two weeks from the release of advertisement). Based on the information provided by the organization, the JAT will scrutinize applications and enclosed documents and shortlist eligible organizations for field appraisal.
- To conduct site visits to assess the capacity and credentials of the shortlisted applicants.
- The JAT will use the prescribed field appraisal format for assessing the proposed CSC. The summary of the findings and the recommendations of the JAT during the visits will be sent to PR, SACS and a copy to the head of CST division in DAC.

d. Final selection and contract signing

- On the basis of the recommendation of JAT, PR will complete the final selection process.
- PR will send communication to the selected agencies with copy to DAC, SACS and SR.
- PR will communicate to SR to complete the contract signing with the selected agency within one week after the receipt of communication from PR.

11.4 Closure of CSC

All the CSCs will be assessed through an established protocol and prescribed format on a yearly basis. Based on the assessment, contract will be renewed with CSC for a duration ranging between six months to one year. Contract with poorly performing CSC will be terminated in consultation with SACS and PR will intimate the status to DAC.

In addition, the contract can also be terminated under the following circumstances

- **Non-performance/financial irregularities:** SR will intimate details of CSCs who are consistently non-performing and/or having financial irregularities confirmed during audit/ internal reviews/ independent assessment to respective SACS and PR. Based on the intimation, a joint review committee consisting of officers from SACS, SR and PR (team should include one finance person) will visit the CSC for fact-finding. The review team findings will be discussed with Project Director of SACS and based on the seriousness of the issue, review committee can propose the termination of contract. After vetting this information with SACS, SR will communicate the decision to PR and PR in consultation with DAC takes the final decision. In case of closure, a one month notice will be given to CSC.
- **Mutual closure:** A CSC may decide to terminate the contract if it is unable to continue the services. This would be done in consultation with SR and SACS by giving one month notice and same has to be intimated to PR and DAC by SR.
- **Programme closure:** In the event of funding support coming to a close, PR and SR would inform the CSC to discontinue services by giving one month notice.

In all cases of termination of the contract, letter of closure will be issued by SR and all assets/items will be the property of the respective SACS. All assets/items and stocks would be transferred to the CSC selected in place of the terminated CSC (if applicable/selected), who will ensure that these are utilised under the scheme.

Closure plan:

In the event of closure on the above grounds, the following process should be followed

- Letter from SR to the CSC informing the decision to terminate the contract and information will also be sent to SACS, PR, DAC, SACS, DAPCU, ARTC, LAC, and DLN.

- Programme and financial audit, verification of assets and takeover process.
- Handing over of all programme and financial records.
- List of enrolled PLHIV at the CSC to be given to the ARTC informing them of their transfer to the adjoining CSC for accessing services.
- Closure report by the contracting agency.

In case of closure of an existing CSC, a communication from SR will be sent to PR and SACS, informing the status which PR will process further.

Closure process:

1. **Furniture fixture and equipment:** List of furniture fixture and equipments is to be obtained from the CSC asset register, which should contain name of the item, brand, product ID, vendor name, bill number, cost of the item, condition of the item, etc. Verify that the items purchased are matching with the cost utilised and as shown in the Statement of Expenditure (SOE). Furniture fixture and equipment list and the respective bills need to be countersigned by the CSC. Copy of the bills should be taken for record. Documents of Annual Maintenance Contract (AMC) and warranty cards should be taken.

2. **Human resources:** Verify the HR position of the CSC and the payments made to the staff up to the end of contract. Verify salary register and travel reimbursements with details of cheque. Letter issued to the staff of CSC regarding end of contract and their acceptance letter and acceptance of full and final settlement by the staff.

3. **Records and reports:** Update the records up to the closure date. Takeover all the registers (including MIS) and client files/records. Updated CMIS soft copy in a CD and in the computer. Takeover printed formats, files, stationery materials after verification with the stock register.

4. **Financial records:** Verify the SOE, cash book, ledger and utilisation shown in the SOE. The accounts of the CSC shall be got audited till the closure date of the CSC. Excess utilisation, if any, to be verified and a statement prepared, showing the expenditure agreed and disallowed, to be signed by both the parties. Bank reconciliation, balance amount in the bank, etc. to be verified and unspent balance and advances lying unadjusted to be returned to the SR. A certificate from the CSC to be collected on the SSR‘s letter head stating that any liability pending to be cleared would be taken care by the SSR.

5. **Rental and other agreement:** Rental agreement of the present premises to be cross checked and electricity bill, water bill, etc. to be paid up to the date of operation.

Handover note, detailing all the above processes and liabilities of both the organisations, should be prepared and signed by both the organizations.

Financial Management

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12. Financial Management

12.1 Financial Management

The project account shall be maintained on cash system of accounting. The release of grant-in-aid to the SSR will be based on the approved plan, budget, contract period and terms. All issues related to finance need to be solved by SR and PR.

The first instalment will be considered for release on signing of the contract. Release of subsequent instalments will be considered on receipt of progress report, statement of expenditure (SOE; Annexure X) and Utilisation Certificate (UC; Annexure XI).

12.1.1 Bank account

The CSC should open a separate bank account in any scheduled bank. The account should be opened in the name of the CSC, which shall be operated jointly by at least two office bearers authorised for the purpose by the management committee of the SSR. This account will be exclusively used for the implementation of the scheme of CSC. Interest earned from banks on the Grant in Aid released to the CSC will be treated as an income of the project and shall be utilized for the project with prior approval. Project mandates that the SSR deposit funds in interest bearing savings accounts/ arrangements with their banks. All payments, other than petty payments up to Rs. 2000, should be made by way of crossed cheques only. All salary payments shall be made by way of account payee cheque only. The SSR can withdraw interest money not exceeding Rs 5000 at time to meet the petty expenses. Bank reconciliation should be carried out on a monthly basis as part of the monthly closing of accounts (latest by the 10th of the following month).

12.1.2 Books of accounts

The accounts of SSR shall be maintained on cash basis using double entry book keeping principles. Standard books of accounts shall be maintained as per details given below

- Cash Book
- Ledger
- Journal
- Register of temporary advances
- Bank Pass Book
- Cheque Register
- Bill Register
- Establishment (salary of staff) Register
- Stock Register of non-consumable and consumable articles
- Fixed Assets Register

Any other books of accounts which may be considered necessary for the day to day functioning

The books of accounts and supporting documents would be made available for inspection to SR/PR/ SACS, if required.

12.1.3 Vouchers

The CSC would be required to prepare separate vouchers for cash and bank transactions undertaken during project period. These vouchers should be serially numbered, supported with proper bills and documents, and duly approved by the authorised person (preferably Board member of the SSR) of the CSC before recording in the Cash Book. All bills and vouchers should be properly defaced by stamping as 'Funded by GFATM for CSC Project'. For any rectification of entries, the CSC should do the same by passing a journal entry instead of changing the cash/bank vouchers. It should be noted that the SSR cannot pass any provisional entry at the end of the financial year or at the end of the project period.

12.1.4 Advances

In event there is a delay in release of grants to the SSR, an advance may be taken from the parent organization (NGO/CBO) with due approval from the SR. These advances should be accounted for in the bank account separately opened for the CSC project. On receipt of the grants, the advances should be refunded to the NGO/CBO immediately. The advances given by the CSC to staff members or vendors shall not be booked as expenditures. The expenditures would be booked on receipt of appropriate vouchers approved by the competent authority.

12.1.5 Fixed assets

Every CSC is required to maintain a Fixed Asset Register. Assets acquired by the CSC are treated as fixed assets, but no depreciation is provided on these assets. All fixed assets should be serially numbered in accordance with the group/nomenclature of the item and should be entered in the Fixed Assets Register indicating the following details

- Name and description of the item
- Date of receipt
- Supplier's name
- Cost of item
- Guarantee period, if any, and its details
- Assets identification number
- Location
- Remarks with regard to disposal/write-off, etc

12.1.6 Submission of report

The SOE should be submitted as per the heads and sub-heads indicated in the approved budget on a quarterly basis to SR as per the standard format (Annexure X). At the end of the financial year, the UC should also be submitted to the SR as per the standard format (Annexure XI). The SSR should ensure that the quarterly/annual SOE so submitted matches with the books of accounts. It should be noted that no alteration would be allowed after the submission of the reports. The amount allocated for one purpose as per the sanctioned budget should not be used for other purposes without specific permission of the PR/SR even if there are savings. Re-appropriation between the sub-heads (except capital items and human resources) up to 10 present can be done by CSC from savings under other sub-heads only with the prior approval of the SR, provided it is within the overall budget. Funds shall not be diverted or re-appropriated to meet any expenditure which has not been approved or contemplated in the sanctioned budget.

12.1.7 Audited statement of accounts and utilization certificate

The following reports should be submitted pertaining to the project at the close of each financial year by the 31st of May or closing of the scheme/contract, whichever is earlier:

- Balance sheet with the list of assets
- Income and expenditure account

- Receipt and payment account
- Trial balance
- Audit report in the prescribed format
- Utilisation Certificate in the prescribed format

Delay in submission of the above documents would result in delay in the release of future Grant in Aid. The unspent cash/bank/advances balance at the end of the financial year shall be carried forward to the next financial year. The unspent cash/bank balance (after adjustment of all advances) at the end of the contract period and audit shall be refunded to the SR.

12.2 Financial Assistance to CSC

Activities	Unit Cost (In Rs)	Category A (In Rs)	Category B (In Rs)	Category C (In Rs)	Remarks
Infrastructure for Office Set up	54,800	54,800	54,800	54,800	Computers, software, printer, UPS, chairs, tables, almirah, weight machine, data card, etc. These are one-time cost
Infrastructure & Equipment-Recreation room	20,000	20,000	20,000	20,000	One time infrastructure and equipment cost for setting up recreation unit at CSC. Amount inclusive of one table, five chairs, and one almirah, one TV with DVD, mattress and it is uniform cost for all three categories.
Counselling cabin partition	5,000	5,000	5,000	5,000	One time cost for all categories
Sub Total		**79,800**	**79,800**	**79,800**	
Human Resource					
Project Coordinator		132,000	120,000	108,000	*CSCs targets > 12,000 @ Rs. 11,000 per month (Category A),* *CSCs targets between 5,001-12,000 @ Rs. 10000 per month (Category B)* *CSCs targets <=5,000 @ Rs. 9,000 per month (Category C)* *This is a full time position.*
Accountant		78,000	72,000	66,000	*CSCs targets > 12,000 @ Rs. 6,500 per month (Category A),* *CSCs targets between 5,001-12,000 @ Rs. 6000 per month (Category B)* *CSCs target <=5,000 @ Rs. 5,500 per month (Category C)* *This is a full time position.*
Counsellor		108,000	96,000	84,000	*CSCs targets > 12,000 @ Rs. 9,000 per month (Category A),* *CSCs targets between 5,001-12,000 @ Rs. 8000 per month (Category B)* *CSCs target <=5,000 @ Rs. 7,000 per month (Category C)* *This is a full time position.*

Activities	Unit Cost (In Rs)	Category A (In Rs)	Category B (In Rs)	Category C (In Rs)	Remarks
Outreach Worker		780,000	576,000	264,000	*CSCs targets > 12,000 @ Rs. 6,500 per month per ORW (Category A),* *CSCs targets between 5,001-12,000 @ Rs. 6,000 per month per ORW (Category B)* *CSCs targets <=5,000 @ Rs. 5,500 per month per ORW (Category C)* *This is a full time position.*
MIS Assistant		78,000	72,000		*CSCs targets > 12,000 @ Rs. 6,500 per month (Category A),* *CSCs targets between 5,001-12,000 @ Rs. 6,000 per month (Category B)* *This is a full time position.* *Note: MIS Assistance position will not be applicable where targets <5,000 (Category C)*
Peer Counsellor		78,000	72,000	66,000	*CSCs targets > 12,000 @ Rs. 6,500 per month (Category A),* *CSCs targets between 5,001-12,000 @ Rs. 6,000 per month (Category B)* *CSCs target <=5,000 @ Rs. 5,500 per month (Category C)* *This is a full time position.*
Support Staff		48,000	36,000	24,000	*CSCs targets > 12,000 @ Rs. 4,000 per month (Category A),* *CSCs targets between 5,001-12,000 @ Rs. 3,000 per month (Category B)* *CSCs targets <=5,000 @ Rs. 2,000 per month (Category C)* *This is a full time position.*
Project Oversight cost		72,000	66,000	60,000	***Provision of Project Oversight Cost*** *Target >12,000 - Rs. 6,000 per month (Category A)* *Target 5,001-12,000 - Rs. 5,500 per month (Category B)* *Target <=5,000 - Rs. 5,000 per month (Category C)*
Sub Total		**1,296,000**	**1,038,000**	**672,000**	
Operational Cost					
Office Running Expenses		42,000	42,000	42,000	Water @ Rs. 500/pm, Electricity @ Rs 1,000/ pm, stationery @ Rs.1,000/ pm, photocopy @ Rs. 500/pm, Office cleaning @ Rs 500/pm. This is uniform cost for all three categories.
Communications		30,000	30,000	30,000	Telephone, mobile expenses (including tele-follow up with PLHIV), internet, courier.

Activities	Unit Cost (In Rs)	Category A (In Rs)	Category B (In Rs)	Category C (In Rs)	Remarks
Books, periodicals and audio visuals		6,000	6,000	6,000	Amount will be used for purchasing books, magazines, renting of audio visuals
Office Space Rentals		144,000	108,000	96,000	CSCs target >12,000 @ Rs. 12,000 per month (Category A), CSCs target 5,001-12,000 @ Rs. 9,000 per month (Category B) CSCs target <=5,000 @ Rs. 8,000 per month (Category C) The office space will also be used for meetings, training and counselling.
Emergencies/ Referral Services		72,000	48,000	24,000	***Provision of emergency/referral services:*** *Target >12,000 - Rs. 6,000 (Category A)* *Target 5,001-12,000 –* *Rs. 4,000 (Category B)* *Target <=5,000 - Rs. 2,000 (Category C)*
Office Maintenance/ Repairs/ purchase of materials etc.	500 × 12	6,000	6,000	6,000	To be used for purchasing files for clients, to meet the cost of any broken furniture and small repairs of infrastructure, etc. The budgeted amount is @ 500/- per month only. This is uniform cost for all three categories.
Travel Cost		115,200	96,000	57,600	Provision of Travel Cost: Project Coordinator - Rs. 500/month Counsellor- Rs. 300/month Peer Counsellor - Rs. 600/month ORW - Rs. 800/month per ORW Other staff - Rs. 200/month For Category A (target >12,000): Monthly travel Cost is Rs. 9,600/- For Category B (target 5,001-12,000) : Monthly travel Cost is Rs. 8,000/- For Category C (target <=5,000): Monthly travel Cost is Rs. 4,800/-
Sub Total		**415,200**	**336,000**	**261,600**	
Activities					
Advocacy Meetings		10,000	10,000	10,000	Quarterly advocacy and Liasoning meeting with line departments, academia, media, PRIs, PLHIV, and other potential stakeholders towards creating an enabling environment at district level and to enhance them in uptake of services. Rs. 2,500/per quarter

Activities	Unit Cost (In Rs)	Category A (In Rs)	Category B (In Rs)	Category C (In Rs)	Remarks
CSC staff monthly review and planning meeting		8,400	7,200	6,000	***Provision for Monthly Review Meeting:*** *Targets >12,000 - Rs. 700/month (Category A)* *Targets between* *5,001-12,000 - Rs. 600/month (Category B)* *Targets <=5,000 - Rs. 500/month (Category C)* *A daylong meeting at CSC to reviewing the outreach plans and monthly performance and plans for next month.*
Support Group Meeting		150,000	108,000	72,000	**Provision for Support Group Meeting:** Targets >12,000 - Rs. 500/month for 25 SGM (Category A) Targets 5,001-12,000 - Rs. 450/month for 20 SGM (Category B) Targets <=5,000 - Rs. 400/month for 15 SGM (Category C) SGM are conducted at CSCs ART centre and in the field based on the need. Budget for SGM to be utilized for meeting, travel expenses and for providing tea and snacks for PLHIV who are attending these meetings. Process of conducting SGM and thematic areas to be discussed in the meetings are given in SOP.
Discrimination Response System (DRS)		12,000	11,000	10,000	Expenditure incurred for DRS team. Travel and other incidental expenditure will be covered under this head.
Social Entitlement Events		2,000	1,500	1,000	**Provision for Social Entitlement Events:** Targets >12,000 - Rs. 2,000/yearly (Category A) Targets 5,001-12,000 - Rs. 1500/yearly (Category B) Targets <=5,000 - Rs. 1,000/yearly (category C) PLHIV community interface with officers from Social benefit schemes for mass application, awareness generation and linkage. CSCs will organise one such meeting in a quarter along with various officers as per need.

Activities	Unit Cost (In Rs)	Category A (In Rs)	Category B (In Rs)	Category C (In Rs)	Remarks
IEC Material		5,000	4,000	3,000	**Provision for IEC Material:** Targets >12,000 - Rs. 5,000/year (Category A) Targets 5,001-12,000 - Rs. 4,000/year (Category B) Targets <=5,000 - Rs. 3,000/year (Category C) Development of IEC material such as flipcharts, advocacy material, learning material, leaflets, headbands, bangles, etc. to give visibility to the programme.
In-house Training		3,000	2,500	2,000	**Provision for In-house Training:** Targets >12,000 - Rs. 3,000/year (Category A) Targets 5,001-12,000 - Rs. 2,500/year (Category B) Targets <= - Rs. 2,000/year (Category C) Project Coordinator/institutional head will organize in house trainings to newly joined staff as per the need. Budget should be utilised providing referral materials other training aids and refreshment expenditure.
Sub Total		**190,400**	**144,200**	**104,000**	
Grand Total		**1,981,400**	**1,598,000**	**1,117,400**	

12.3 Procurement Plan

12.3.1 General procedures

- For all purchases of capital good, and goods purchased in bulk such as stationary and other supplies, minimum three quotations should be obtained
- Proper justification should be given in case the bidder with the lowest quotes is not selected. Quotations should be attached with the relevant vouchers while submitting the same for checking.

12.3.2 Procurement of capital/fixed assets

- Any non-consumable item such as equipment, furniture, computers, printers, etc. needed to start program operations and major capital expenditures as outlined in the plans and budgets are called fixed assets.
- Incidental charges which are incurred to get the asset to the place where it is situated and to get the asset into operating condition must be accounted for in the operational costs and not added to the cost of the asset.

- An inventory of the capital assets should be maintained and updated from time to time in the fixed assets register. The fixed assets register should be signed by the competent authority after it is updated. An inventory of assets funded by PR/SR should be maintained separately and this should from part of the overall organisational asset list.
- All assets must be given an asset identification number and such number must be painted on the asset. This number should also be mentioned in the fixed assets register.
- Physical verification of assets should be undertaken (preferably by an office bearer or someone of adequate authority) at least once a year. All additions, deletions, modifications etc. should be recorded and signed.
- Assets which have become worn out or unserviceable should be written off from the list as well as the financial accounts with proper authorisations from the head of office and the SACS/ implementing agency.
- No asset bought under the programme can be disposed of, changed or modified without the express permission of SR/PR.
- Access to the stock room shall be controlled and restricted to authorised persons only.

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Annexure I: Referral Slip

Office copy

Referral slip

Part - A

Slip serial number.....

Name and address of the CSC/Helpdesk

Name of CSC/Helpdesk staff

Referred to (full address of the facility)	
Date of referral	D D M M Y Y Y Y
Name of the client/ spouse/partner	
Vihaan client ID (11 digit)	
Family ID	O R W —
Purpose of referral	

Comments

Referred by

CSC/Helpdesk name & seal

(Name and signature of the staff)

Facility centre copy

Referral slip

Part - B

Slip serial number.....

Name and address of the CSC/Helpdesk

Name of CSC/Helpdesk staff

Referred to (full address of the facility)	
Date of referral	D D M M Y Y Y Y
Name of the client/ spouse/partner	
Vihaan client ID (11 digit)	
Family ID	O R W —
Purpose of referral	

Comments

Referred by

(Note: Kindly send back the acknowledgement copy through CSC/Helpdesk staff)

CSC/Helpdesk name & seal

(Name and signature of the staff)

Acknowledgement copy

Referral slip

Part - C

Slip Serial number.....

Name and address of the CSC/Helpdesk

Name of CSC/Helpdesk staff

Date of service availed	D D M M Y Y Y Y
Date of referral	D D M M Y Y Y Y
Name of the client/ spouse/partner	
Vihaan client ID (11 digit)	
Family ID	O R W —
Purpose of referral	

To be filled by facility centre

Date of service availed

Comments

Facility centre name & seal

To be filled by the CSC/Helpdesk staff

Date of receiving back referral slip D D M M Y Y Y Y

(Signature of the staff)

Annexure II.a: Client Registration Form (CRF)

Client Registration Form (CRF)

Section A - Basic Profile

A.1 Registration date D D M M Y Y Y Y

A.2 Full name.....

A.3 Date of birth D D M M Y Y Y Y If not known, age in completed years ☐☐

A.4 Gender 1. Male 2. Female 3. Transgender ☐

A.5 Client ID (given by CSC/Helpdesk - 11 Digits) ☐☐☐☐☐☐☐☐☐☐☐

A.6 Present address (if child, write parent/caregivers address)

Ward/House/Plot/Door number.....Ward/Street/Colony/Apartment/House name.....

.....

Landmark.....

Village/City.....Taluka/Mandal.....

District.....State.....

Pincode ☐☐☐☐☐☐ Contact phone number (preferably landline).....

A.7 Alternative contact person (if child, caregiver) A. Name and address.....

.....

.....B. Contact phone number.....

A.8 Occupation ☐☐

1. Agricultural labour	6. Petty business/Large business/Small shop/Self-employed	10. Local transport work (auto/ taxi-driving, handcraft/ rickshaw pulling)	13. Unemployed
2. Non-agricultural labour	7. Service (Govt./Pvt.)	11. Hotel staff	14. Retired
3. Domestic servant	8. Student	12. Agricultural cultivation/ Landholding	15. Housewife
4. Skilled work	9. Truck driving/Helper		16. Sex work
5. Semi-skilled work			17. Not applicable (children below 5 yrs.)
			18. Other (specify).....

A.9 Currently going to school? (applicable only for children of school going age) 1. Yes 2. No ☐

A.10 Education ☐

1. Illiterate	5. College and above
2. Primary (1-5)	6. Non-formal education
3. Secondary (6-10)	7. Not applicable (children below 5 yrs.)
4. Higher secondary (11-12)	

A.11 Marital status ☐

1. Single	5. Live-in relationship
2. Married	6. Not applicable (if child)
3. Widow/ Widower	
4. Divorced/ Separated	

Section B - Family History

B.1 Family ID O R W ☐☐-☐☐☐☐

B.2 Details of family members

B.2a. Family members	B.2b. Age (in completed years)	B.2c. Gender 1. Male 2. Female 3. Transgender	B.2d. Living status 1. Alive 2. Dead	B.2e. HIV status 1. Positive 2. Negative 3. Not tested 4. Don't know	B.2f. If positive Latest CD4 count/% (CD4% only for children)	B.2g. ART status 1. Pre ART 2. On ART 3. New PLHIV	B.2h. Pre ART Reg./ On ART Reg./ ICTC PID No.
1. Father							
2. Mother							
3. Spouse							
4. Partner							
5. Child 1							
6. Child 2							
7. Child 3							
8. Child 4							
9. Child 5							
Details of non-traditional family members, if any (refer guideline in page 6)							
10. Member 1							
11. Member 2							
12. Member 3							

B.3 Total family members (excluding client) | **B.4 Average monthly family income in Rs**.....

B.5 Number of family members dependent on the client | **B.6 Number of PLHIV members in the family**

B.7 Whether the client belongs to the BPL family? 1. Yes 2. No

B.8 If the client belongs to the BPL family, ever received any economic assistance? 1. Yes 2. No

B.9 Orphan status (applicable only for children) 1. Single orphan 2. Double orphan 3. Not an orphan

B.10 Total non-traditional family members (excluding client)

B.11 Number of non-traditional family members who are PLHIV

B.12 Number of family members (traditional and non-traditional) **eligible for ICTC referral**

Section C - Testing and Treatment Information

C.1 Have you disclosed your HIV status to spouse/partner/family members? 1. Yes 2. No

C.2 Date of HIV detection (D D M M Y Y Y Y)

C.3 ART status
1. Pre ART
2. On ART

C.4 Source of ART
1. ART centre
2. Private hospitals/Clinic
3. NGO sector
4. Others
If NGO/Private sector/RMP/Others,(specify)
.....
.....

C.5 Date of Pre ART registration (D D M M Y Y Y Y)

C.6 If on ART, date of ART initiation (D D M M Y Y Y Y)

C.7
Pre ART registration number.....
ART registration number (if applicable)
.....
Client smart card ID (if available)
ICTC PID number (if available)
.....

C.8 Latest three CD4 counts

C.8a. Date of CD4 testing	C.8b. CD4 count/% (% only for children)
1. D D M M Y Y Y Y	
2. D D M M Y Y Y Y	
3. D D M M Y Y Y Y	

C.9 If on ART, ART regimen type
1. First line 2. Alternative first line 3. Second line

C.10 Follow-up notes.....
.....
.....

C.11 Tuberculosis details

C.11a. Past history of TB 1. Yes 2. No 3. Don't know

C.11b. Completed treatment 1. Yes 2. No

C.11c. Presently on Anti Tuberculosis Treatment (ATT)?
1. Yes 2. No

C.11d. If on ATT, kindly specify the treatment
1. DOTS 2. Non DOTS 3. Others (specify).....

C.11e. If not on ATT does the client have any of the symptoms?
a. Cough b. Weight loss c. Enlarged lymphatic nodes
d. Continuous fever and or sweating at night

C.11f. Family history of TB
1. Yes 2. No

C.12 Client weight in Kg.

C.13 Client height in Cms. (if child)

C.14 Mid upper arm circumference (MuAC) in Cms. (applicable only for children below 5 years, if available)

Section D - Referral and Linkages Details

D.1 Have you ever been linked with any welfare scheme? 1. Yes 2. No

D.2 Please select the welfare scheme linked to

1. Income generation activity (including microfinance)	1a) Swarnajayanti Gram Swarozgar Yojana (SGSY)	1b) Mahatma Gandhi National Rural Employment Yojana	1c) Others income generation activity
2. Educational support	2a) Sarva Siksha Abhiyan (SSA)	2b) Indira Gandhi Matritva Sahyog Yojana (IGMSY)	2c) Other educational support
3. Nutritional schemes	3a) Antyodaya Anna Yojana (AAY)	3b) Integrated Child Development Scheme (ICDS)	3c) Other nutritional schemes
4. Pension schemes	4a) Indira Gandhi National Widow Pension Scheme (IGNWPS)	4b) Sanjay Gandhi Pension Yojana (SGPY)	4c) Other pension schemes
5. Health related schemes	5a) Janani Suraksha Yojana (JSY)	5b) Rashtriya Swasthya Bima Yojana (RSBY)	5c) Other health related schemes
6. Legal support	6a) District Legal Service Authority (DALSA)	6b) Other legal support	10. Others (specify)
7. Child-specific schemes	7a) Integrated Child Protection Scheme (ICPS)	7b) Other child-specific schemes	.....
8. Adolescent-specific schemes	9. Women-specific schemes	.....	.....

D.3 Have you received any of the below mentioned social entitlement?

	Yes	No	Remarks		Yes	No	Remarks
1. Ration card				9. Marriage certificate			
2. Voter card				10. Income certificate			
3. Aadhaar card				11. Disability certificate			
4. Passport				12. Bank account			
5. PAN card				13. Post office account			
6. Caste certificate				14. Others (specify) (including local entitlements)			
7. Birth certificate				.....			
8. Death certificate of husband for widow or parents for orphan				.....			
				.....			

D.4 Is the client willing to be referred to Social Welfare Schemes? 1. Yes 2. No ☐

D.4a. If Yes, please specify details.....

Section E - Registration Details

E.1 Registration done at 1. CSC/Helpdesk 2. Field/Home ☐

E.2 Referred from ☐☐

1. ART centre	5. DOTS centre	8. STI clinic	11. FSW TI	15. Transgender/Hijra TI
2. Link ART centre	6. NGO/CBO/PLHIV network/DLN	9. Other healthcare facilities.....	12. IDUs TI	16. Core composite TI
3. ICTC			13. Truckers TI	17. Walk in/Self
4. PPTCT	7. Government hospital	10. MSM TI	14. Migrants TI	18. Others (specify).....

E.3 If registered, mechanism of registration (only first service to be recorded) ☐☐

1. Counselling in CSC	5. Pre-ART registration	9. Hospital/clinical referrals (OI management, side effects, general ailment, TB and STI treatment)
2. Support group meeting in CSC/Helpdesk	6. CD4 follow-up	10. Support for legal aid
3. LFU tracked back to ART centre	7. Link to TI	11. Social protection
4. Missed case follow-up	8. Testing of partner/spouse, children and family member	12. Social entitlement

Section F - Stigma and Discrimination

F.1 Have you ever faced any discrimination? 1. Yes 2. No ☐

F.2 If yes, from whom ?

1. Health facilities ☐	3. Local goondas ☐	5. Workplace ☐	7. Social gathering ☐
2. Family members ☐	4. Police & law enforcement ☐	6. Education institution ☐	8. Service delivery points ☐

9. Others (specify).....

F.3 Has discrimination faced by you ever reported in media? 1. Yes 2. No ☐

F.4 Detail of discrimination faced.....

.....

Section G - Risk Profile (Voluntary Disclosure)

G.1 Possible Risk Factors for HIV ☐☐

1. Heterosexual (sex with opposite sex)	5. Mother to child	9. Migrant
2. MSM (sex with same sex)	6. Probable unsafe injection	10. Trucker
3. Injection drug user (IDU)	7. Unknown/Do not know	11. Not disclosed
4. Blood transfusion	8. Commercial sex worker	12. Others (specify).....

G.2 If the client is IDU, is the client on Opioid Substitution Therapy (OST)? 1. Yes 2. No 3. Not applicable ☐

G.2a. If yes, please specify the type of OST 1. Methadone 2. Buprenorphine ☐

G.3 Alcohol and Tobacco use

G.3a. Habit of alcohol use 1. Daily 2. Once in a week 3. Social 4. Never 5. Not applicable ☐

G.3b. Habit of tobacco use (smoking and chewing) 1. Daily 2. Once in a week 3. Social 4. Never 5. Not applicable ☐

G.4 If client is a pregnant woman, has she been linked to PPTCT? 1. Yes 2. No ☐

G.5 Infant feeding (applicable only for infant child) ☐

1. Breastfed (stop:.....month of age) 2. Replacement 3. Mixed

Section H - Client Update Profile Sheet (for Follow-up Clients)

H.1 Date of visit/Follow-up (D D M M Y Y Y Y)	H.2 Place of contact with the client 1. CSC/Helpdesk 2. Outreach (Field/Home)	H.3 ART status update 1.Pre ART 2.On ART	H.4 CD4 count/% update (CD4 % only for children)	H.5 ART regimen update 1. First line 2. Alternative first line 3. Second line	H.6 Weight update in Kg.	H.7 Height update in Cms. (only for children)	H.8 MuAC update for children in Cms. (if available)	H.9 Linkages with Social Welfare Schemes (refer codes below)	H.10 Status of social entitlements (refer codes below)	H.11 Client faced any discrimination from (refer codes below)	H.12 Presently on ATT (Anti Tuberculosis Treatment)? 1. Yes 2. No
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											
D D M M Y Y Y Y											

Coding

H.9 Linkages with Social Welfare Schemes

1. Income generation activity
1a. Swarnajayanti Gram Swarozgar Yojana (SGSY)
1b. Mahatma Gandhi National Rural Employment Yojana (MGNREY)
1c. Other income generation activity
2. Education support
2a. Sarva Siksha Abhiyan (SSA)
2b. Indira Gandhi Matritva Sahyog Yojana (IGMSY)
2c. Other education support
3. Nutritional schemes
3a. Antyodaya Anna Yojana (AAY)
3b. Integrated Child Development Scheme (ICDS)
3c. Other nutritional schemes
4. Pension schemes
4a. Indira Gandhi National Widow Pension Scheme (IGNWPS)
4b. Sanjay Gandhi Pension Yojna (SGPY)
4c. Other pension schemes
5. Health related schemes
5a. Janani Suraksha Yojana (JSY)
5b. Rashtriya Swasthya Bima Yojana (RSBY)
5c. Other health related schemes
6. Legal support
6a. District Legal Service Authority (DALSA)
6b. Other legal support
7. Schemes related with children
7a. Integrated Child Protection Scheme (ICPS)
7b. Other children schemes
8. Adolescent schemes
9. Women specific schemes
10. CLHIV provided education & nutritional assistance
11. CLHIV linked to care homes
12. Others

H.10 Status of Social Entitlements

1. Ration card
2. Voter card
3. Adhaar card
4. Passport
5. PAN card
6. Caste certificate
7. Birth certificate
8. Death certificate of husband or parents for widow or orphans
9. Marriage certificate
10. Income certificate
11. Disablity certificate
12. Bank account
13. Post office account

H.11 Client faced any discrimination from

1. Health facilities
2. Family members
3. Local goondas
4. Police & law enforcement authorities
5. Work place
6. Educational institution
7. Social gathering
8. Service delivery point
9. Others

Section I - For Office Use Only

I.1 Checked on D D M M Y Y Y Y | **I.2 CRF data entered in CMIS on** D D M M Y Y Y Y

I.3 Name and designation of the staff.....

I.4 Comments of the staff.....

I.5 Project Coordinator name.....

Signature **Stamp of CSC/Helpdesk**

Section J - Services Planning Sheet (refer to code on page 6)

J.1 Date of follow-up visit	J.2 Purpose of follow-up (refer code)	J.3 Service needed (Need identified) (refer code)	J.4 Service provided by CSC (refer code)	J.5 Remarks
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
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D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				
D D M M Y Y Y Y				

List of supporting documents required	**Provided** (Yes/No)
A) Copy of HIV test report	
B) Copy of address proof (Aadhaar ID/Voter ID/Ration card/Rent agreement)	
C) Copy of ART green card/ART book (Applicable for all PLHIV who are already registered at ART)	

CRF - Guideline

Section-A Basic Profile: Client ID: Last five digits are to be assigned only by CSC-PC (Project Coordinator)
Section-B Family History: If more than 5 children are there in the family, the total children should be included in the total family members; Non-traditional Family members includes the members of Transgender/Hijra/MSM community living together under the same roof.
Family ID: Family ID will be given to the entire family members who stay together in one family. For example: ORW01-0001 (ORW number + family ID)
Section-G Testing: ICTC PID No.: Voluntary Disclosure: If the client is willing to disclose risk factor for HIV
Section-J Testing: For follow-up clients

Section J - Service Planning Sheet: Coding

Coding for J.2

J.2 Purpose of follow-up

1. Counselling
2. Support group meeting
3. LFU tracked back to ART
4. Missed case follow up
5. Pre-ART registration
6. CD4 follow up
7. Link to TI
8. Testing of partner/spouse, children and family member
9. Hospital/clinical referrals (OI management, side effects, general ailment, TB, STI treatment)
10. Support for legal aid
11. Social protection
12. Social entitlements
13. Others (specify in remarks)

Coding for J.3 & J.4

C-C. Counsellor

C-C-1 ART adherence
C-C-2 OI management
C-C-3 Nutrition
C-C-4 Pshyco-social
C-C-5 Maternal health and early infant diagnosis
C-C-6 HIV prevention
C-C-7 Health and hygiene
C-C-8 Sexual and reproductive health
C-C-9 Adolescence
C-C-10 Discordant couple
C-C-11 Safe sex education
C-C-12 Family planning
C-C-13 Disclosure
C-C-14 Others (specify in remarks)

P-C. Peer Counsellor

P-C-1 ART adherence
P-C-2 OI management
P-C-3 Nutrition
P-C-4 Pshycosocial
P-C-5 Maternal health and early infant diagnosis
P-C-6 HIV prevention
P-C-7 Health and hygiene
P-C-8 Sexual and reproductive health
P-C-9 Adolescence
P-C-10 Discordant couple
P-C-11 Safe sex education
P-C-12 Family planning
P-C-13 Disclosure
P-C-14 Others (specify in remarks)

R-H. Health/Non Health Related Referrals

R-H-1 ART centre
R-H-2 Link ART centre
R-H-3 PPTCT centre
R-H-4 DOTS centre
R-H-5 NGO/CBO/PLHIV network
R-H-6 Govt. hospital
R-H-7 STI clinic
R-H-8 Other healthcare facilities
R-H-9 MSM TI
R-H-10 FSW TI
R-H-11 IDUs TI
R-H-12 Truckers TI
R-H-13 Migrant TI
R-H-14 TG/Hijra TI
R-H-15 Core composite TI
R-H-16 Legal services
R-H-17 Family member/partner referred to ICTC
R-H-18 Newly identified discordant couple tested for HIV
R-H-19 Discordant couple followed up for HIV re-test
R-H-20 Others (specify in remarks)

R-E. Social Entitlement Schemes

R-E-1 Ration card
R-E-2 Voter card
R-E-3 Aadhaar card
R-E-4 Passport
R-E-5 PAN card
R-E-6 Caste certificate
R-E-7 Birth certificate
R-H-8 Death certificate of husband for widow or parents for orphans
R-E-9 Marriage certificate
R-E-10 Income certificate
R-E-11 Disablity certificate
R-E-12 Bank account
R-E-13 Post-office account

S-G. Support Group Meeting

S-G-1 Basics of HIV
S-G-2 Basic health and hygiene
S-G-3 Diet and nutrition
S-G-4 Home based care
S-G-5 OI management and co-infection
S-G-6 Treatment education/ adherence
S-G-7 Social entitlements and livelihood
S-G-8 Positive prevention/ positive living
S-G-9 Yoga and meditation
S-G-10 Side effects of ART and its management
S-G-11 Sexual reproductive health and rights and PPTCT
S-G-12 Legal rights and referrals to legal aid
S-G-13 Marriage, addiction and psychosocial counselling
S-G-14 Family support counselling
S-G-15 Mainstreaming and linkages
S-G-16 Gender sensitisation and women empowerment
S-G-17 CSR linkages with exposure visits to corporate houses including use of positive speaking
S-G-18 Safe sex education to all age groups except children including condom education
S-G-19 Legal issues
S-G-20 Disclosure issues-children/spouse
S-G-21 Stigma and discrimination and GIPA
S-G-22 Peer leaders/positive speaking

R-W. Social Welfare Schemes

R-W-1 Income generation activity
R-W-1a Swarnajayanti Gram Swarozgar Yojana (SGSY)
R-W-1b Mahatma Gandhi National Rural Employment Yojana (MGNREY)
R-W-1c Other income generation activity
R-W-2 Education support
R-W-2a Sarva Siksha Abhiyan (SSA)
R-W-2b Indira Gandhi Matritva Sahyog Yojana
R-W-2c Other education support scheme
R-W-3 Nutritional schemes
R-W-3a Antyodaya Anna Yojana (AAY)
R-W-3b Integrated Child Development Scheme (ICDS)
R-W-3c Other nutritional schemes
R-W-4 Pension schemes
R-W-4a Indira Gandhi National Widow Pension
R-W-4b Sanjay Gandhi Pension Yojana (SGPY)
R-W-4c Other pension schemes
R-W-5 Health related schemes
R-W-5a Janani Suraksha Yojana (JSY)
R-W-5b Rashtriya Swasthya Bima Yojana (RSBY)
R-W-5c Other health related schemes
R-W-6 Legal support
R-W-6a District Legal Service Authority (DALSA)
R-W-6b Other legal support
R-W-7 Child-specific schemes
R-W-7a Integrated Child Protection Scheme
R-W-7b Other child-specific schemes
R-W-8 Adolescent-specific schemes
R-W-9 Women-specific schemes
R-W-10 CLHIV provided education and nutritional assistance
R-W-11 CLHIV linked to care homes
R-W-12 Others (specify in remarks)

O-S. Outreach Services

O-S-1 Address verification
O-S-2 Referral/follow-up for CD4 testing
O-S-3 ART adherence assessment and counselling
O-S-4 Missed/LFU tracking
O-S-5 Refer to medical service
O-S-6 Home-based care
O-S-7 Other (specify in remarks)

Annexure II.b: Enrolment Register

(Enter the codes wherever applicable)

1	2	3	4	5	6	7	8	9	10	11
S. No.	**Date of registration/ follow-up** (DD/MM/YYYY)	**Client name**	**Age**	**Gender** 1. Male 2. Female 3. Transgender 4. Male child (<15 yrs.) 5. Female child (<15 yrs.)	**Client ID given by CSC/Helpdesk** (11 digits)	**Family ID given by CSC/ Helpdesk** (10 digits)	**ART enrolment/ Pre ART enrolment number**	**ART status** 1. Pre ART 2. On ART	**Type of client** 1. New 2. Follow-up	**Follow-up in the same month** 1. Yes 2. No
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										

Codes

Column 13: Mechanism of visit (new & follow-up)

1. Counselling in CSC
2. Support group meeting CSC/ Helpdesk
3. LFU tracked back to ART
4. Missed case follow-up
5. Pre-ART registration
6. CD4 follow-up
7. Link to TI/NGOs
8. Testing of partner/spouse, children and family member
9. Hospital /clinical referrals (OI management, side effects, general ailment, TB, STI treatment)
10. Support for Legal Aid
11. Social protection
12. Social entitlements

Column 15: Referred by

1. ART centre
2. Link ART centre
3. ICTC
4. PPTCT
5. DOTS centre
6. NGO/CBO/PLHIV Network/DLN
7. Government hospital
8. STI clinic
9. Other healthcare facilities (specify in remarks)
10. MSM TI
11. FSW TI
12. IDUs TI
13. Truckers TI
14. Migrants TI
15. Transgender/Hijra TI
16. Core composite TI
17. Walk in/Self
18. Others (specify in remarks)

Column 17: Linkages with social welfare schemes

1. Income Generation Activity
1a. Swarnajayanti Gram Swarozgar Yojana (SGSY)
1b. Mahatma Gandhi National Rural Employment Yojana (MGNREY)
1c. Other income generation activity
2. Education Support
2a. Sarva Siksha Abhiyan (SSA)
2b. Indira Gandhi Matritva Sahyog Yojana (IGMSY)
2c. Other education support scheme
3. Nutritional Schemes
3a. Antyodaya Anna Yojana (AAY)
3b. Integrated Child Development Scheme (ICDS)
3c. Other nutritional schemes
4. Pension Schemes
4a. Indira Gandhi National Widow Pension (IGNWP)
4b. Sanjay Gandhi Pension Yojana (SGPY)
4c. Other pension schemes
5. Health Related Schemes
5a. Janani Suraksha Yojana (JSY)
5b. Rashtriya Swasthya Bima Yojana (RSBY)
5c. Other health related schemes
6. Legal Support
6a. District Legal Service Authority (DALSA)
6b. Other legal support
7. Child-specific schemes
7a. Integrated Child Protection Scheme (ICPS)
7b. Other child-specific schemes
8. Adolescent-specific schemes
9. Women-specific schemes
10. CLHIV provided education & nutritional assistance
11. CLHIV linked to care homes
12. Others (mention type in remarks column)

(Enter the codes wherever applicable)

12	13	14	15	16	17	18	19	20	21	22
Registered at 1. CSC/ Helpdesk 2. Outreach (field/ home)	**Mechanism of visit (new & follow-up)** (refer codes below)	**Attending support group meetings** 1. Yes 2. No	**Referred by** (refer codes below)	**Current ART regimen** 1. First line 2. Alternative first line 3. Second line	**Linkages with social welfare scheme** (refer codes below)	**Linkages with social entitlements** (refer codes below)	**Discrimination faced from** (refer codes below)	**Family member eligible for ICTC referral?** 1. Yes 2. No	**The client is willing to be referred to social welfare scheme** 1. Yes 2. No	**Remarks**

Codes

Column 18: Linkages with social entitlements

1. Ration card
2. Voter card
3. Aadhaar card
4. Passport
5. PAN card
6. Caste certificate
7. Birth certificate
8. Death certificate of husband or parents for widow or orphans
9. Marriage certificate
10. Income certificate
11. Disability certificate
12. Bank account
13. Post office account

Column 19: Discrimination faced from

1. Health facilities
2. Family members
3. Local goondas
4. Police & law enforcement
5. Workplace
6. Education institution
7. Social gathering
8. Service delivery points
9. Others (specify in remarks)

To be verified and signed by Project Coordinator

Monthly sheet serial number

Signature

Seal of CSC/Helpdesk

Annexure II.c: Counselling Register

(Enter the codes wherever applicable)

1	2	3	4	5	6	7	8	9
S. No.	**Date of counselling** (DD/MM/YYYY)	**Client name**	**Age**	**Gender** 1. Male 2. Female 3. Transgender 4. Male child (<15 yrs.) 5. Female child (<15 yrs.)	**Client ID given by CSC/Helpdesk** (11 digits)	**Family ID given by CSC/Helpdesk** (10 digits)	**ART status** 1. Pre ART 2. On ART	**Type of client** 1. New 2. Follow-Up
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

Codes

Column 15: Counselled on

1. ART adherence
2. OI management
3. Nutrition
4. Psychosocial
5. Maternal health & early infant diagnosis
6. HIV prevention
7. Health & hygiene
8. Sexual and Reproductive Health (SRH)
9. Adolescence
10. Discordant couple
11. Safe sex education
12. Family planning
13. Disclosure
14. Others (mention the type in the remarks column)

(Enter the codes wherever applicable)

10	11	12	13	14	15	16	17	18
Follow-up in the same month 1. Yes 2. No	**If the client is a follow-up client and receiving counselling** 1. First time 2. Second time/ subsequent times	**Counselling provided to** 1. Client 2. Family 3. Couple	**Counselling provided by** 1. Counsellor 2. Peer counsellor	**Counselling type** 1. One to One 2. Group	**Counselled on** (refer codes below)	**Group counselling session no. during the month**	**No. of condoms distributed**	**Remarks**

To be verified and signed by Project Coordinator

Monthly sheet serial number | | | |

Signature

Seal of CSC/Helpdesk

Annexure II.d: Referral Register

(Enter the codes wherever applicable)

1	2	3	4	5	6	7	8	9	10
S. No.	**Date of referral** (DD/MM/YYYY)	**Client name**	**Age**	**Gender** 1. Male 2. Female 3. Transgender 4. Male child (<15 yrs.) 5. Female Child (<15 yrs.)	**Client ID given by CSC/Helpdesk** (11 digits)	**Family ID given by CSC** (10 digits)	**If family members referred** 1. Spouse 2. Partner 3. Children 4. Parents 5. Others	**ART status** 1. Pre ART 2. On ART 3. Tested positive but not enrolled at ART centre	**Type of client** 1. New 2. Follow-up
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

Codes

Column 15: Health & Non health related out referrals

1. ART centre
2. Link ART centre
3. PPTCT
4. DOTS centre
5. NGO/CBO/PLHIV Network
6. Govt. hospital
7. STI Clinic
8. Other health facilities
9. MSM TI
10. FSW TI
11. IDUs TI
12. Truckers TI
13. Migrants TI
14. Transgender/Hijra TI
15. Core composite TI
16. Legal services
17. Family member/ partner referred to ICTC
18. Newly identified discordant couple tested for HIV
19. Discordant couple followed up for HIV Re test
20. Others (mention the type in the remarks column)

Column 16: Linkages with social welfare schemes

1. Income Generation Activity
1a. Swarnajayanti Gram Swarozgar Yojana (SGSY)
1b. Mahatma Gandhi National Rural Employment Yojana (MGNREY)
1c. Other income generation activity
2. Education Support
2a. Sarva Siksha Abhiyan (SSA)
2b. Indira Gandhi Matritva Sahyog Yojana (IGMSY)
2c. Other education support scheme
3. Nutritional Schemes
3a. Antyodaya Anna Yojana (AAY)
3b. Integrated Child Development Scheme (ICDS)
3c. Other nutritional schemes
4. Pension Schemes
4a. Indira Gandhi National Widow Pension (IGNWP)
4b. Sanjay Gandhi Pension Yojana (SGPY)
4c. Other pension schemes
5. Health Related Schemes
5a. Janani Suraksha Yojana (JSY)
5b. Rashtriya Swasthya Bima Yojana (RSBY)
5c. Other health related schemes
6. Legal Support
6a. District Legal Service Authority (DALSA)
6b. Other legal support
7. Child-specific schemes
7a. Integrated Child Protection Scheme (ICPS)
7b. Other child-specific schemes
8. Adolescent-specific schemes
9. Women-specific schemes
10. CLHIV provided education & nutritional assistance
11. CLHIV linked to care homes
12. Others (mention type in remarks column)

(Enter the codes wherever applicable)

11	12	13	14	15	16	17	18	19	20	21	22
Follow-up in the same month 1. Yes 2. No	**Referral slip no.**	**Clients family member/ sexual partner eligible to be referred to ICTC** 1. Yes 2. No	**The client is willing to be referred to social welfare scheme** 1. Yes 2. No	**Health & Non health related out referrals** (refer codes below)	**Linkages with social welfare schemes** (refer codes below)	**Linkages with social entitlements** (refer codes below)	**Referred for CD4 testing** 1. Yes 2. No	**Result of referral and linkages received** 1. Yes 2. No	**Date of receiving referral slip** (DD/MM/YYYY)	**Result of CD4 count/%** (% only for children)	**Remarks** (for new PLHIV not registered at ART centre but referred by CSC staff kindly mention the ICTC PID No.)

Codes

Column 17: Linkages with social entitlements

1. Ration card
2. Voter card
3. Aadhaar card
4. Passport
5. PAN card
6. Caste certificate
7. Birth certificate
8. Death certificate of husband or parents for widow or orphans
9. Marriage certificate
10. Income certificate
11. Disability certificate
12. Bank account
13. Post office account

To be verified and signed by Project Coordinator

Monthly sheet serial number | | | |

Signature

Seal of CSC/Helpdesk

Annexure II.e: Meeting Register

(Enter the codes wherever applicable)

1	2	3	4	4a	4b	4c
S. No.	**Date of meeting** (DD/MM/YYYY)	**Meeting venue** 1. CSC 2. ART centre 3. Outreach 4. Others (specify)	**Type of meeting** 1. Support group meeting 2. Advocacy meeting 3. Coordination meeting 4. Others (specify)	**Type of support group meeting** (refer codes below)	**Type of advocacy meeting** (refer codes below)	**Type of coordination meeting** (refer codes below)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Codes

Column 4a: Type of support group meetings

1. Basics of HIV/AIDS
2. Basic health and hygiene
3. Diet and nutrition
4. Home-based care
5. OI management and co-infection
6. Treatment education/adherence
7. Social entitlements and livelihood
8. Positive prevention/Positive living
9. Yoga and meditation
10. Side effects of ART and its management
11. Sexual reproductive health and rights and PPTCT
12. Legal rights and referrals to legal aid
13. Marriage, addiction and psychosocial counselling
14. Family support counselling
15. Mainstreaming and linkages
16. Gender sensitization and women empowerment
17. CSR linkages with exposure visits to corporate houses including use of positive speaking
18. Safe sex education to all age groups except children including condom education
19. Legal issues
20. Disclosure issues-children/spouse
21. Stigma and discrimination and GIPA
22. Peer leaders/Positive speaking

Column 4b: Type of advocacy meetings

1. Women & Child Development
2. People representatives
3. Health department
4. Education department
5. Government department concerning social entitlements & social welfare (please specify the department)
6. Advocacy effort made for resource mobilization
7. Media
8. Judiciary
9. Police
10. Others (specify in remarks)

(Enter the codes wherever applicable)

5	6						7
If Advocacy efforts made for resource mobilization is successful, mention the amount of resource mobilized either cash/kind in INR	**Total No of participants attended meeting** (participants attendance and meeting minutes must be maintained separately)						**Remarks**
	Male (A)	Female (B)	Transgender (C)	Male children (<15 yrs.) (D)	Female children (<15 yrs.) (E)	Total (A+B+C+ D+E)	

Codes

Column 4c: Type of coordination meetings

1. ART centre
2. DAPCU/SACS
3. PLHIV networks/DLN
4. District administration & other departments
5. District Health Society (CMO/SMO)
6. Others (specify in remarks)

To be verified and signed by Project Coordinator

Monthly sheet serial number | | | |

Signature

Seal of CSC/Helpdesk

Annexure II.f: Outreach Worker Register

(Enter the codes wherever applicable)

1	2	3	4	5	6	7	8	9	10	11	12
S. No.	**Date of contact** (DD/MM/YYYY)	**Client name**	**Age**	**Gender** 1. Male 2. Female 3. Transgender 4. Male child (<15 yrs.) 5. Female child (<15 yrs.)	**Client ID given by CSC/Helpdesk** (11 digits)	**Family ID given by CSC** (10 digits)	**Pre ART/ ART enrolment No./ICTC PID No.**	**Family member referred** 1. Spouse 2. Partner 3. Children 4. Parents 5. Others (specify in remark)	**ART status** 1. Pre ART 2. On ART 3. New PLHIV (tested positive but not enrolled at ART centre)	**Type of client** 1. Newly registered 2. Follow-up 3. Met at the field to be registered	**Follow-up in the same month** 1. Yes 2. No
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											

Codes

Column 13: Client to be followed-up during Visit

1. ART missed
2. ART lost to follow-up (LFU)
3. Pre ART cases eligible for ART but not coming to ART Centre
4. Pre ART cases not visited ART center in last six months for CD4 testing
5. Pre ART lost to follow-up (LFU)
6. Already registered PLHIV in the CSC
7. Pre ART baseline CD4 not done
8. Others

Column 14: Purpose of visit

1. Address verification
2. Referral/ Follow-up for CD4 testing
3. ART adherence asessment & counselling
4. Missed/LFU tracking
5. Refer to medical service
6. Home-based care
7. Others

Column 16: Outcome of contact

1. Met
2. Incorrect address
3. Out of station
4. Migrated
5. Not available during visit
6. Died
7. Others(Specify)

Column 19: Health & non health related out referrals

1. ART centre
2. Link ART centre
3. PPTCT
4. DOTS centre
5. NGO/CBO/PLHIV Network
6. Govt. hospital
7. STI Clinic
8. Other health facilities
9. MSM TI
10. FSW TI
11. IDUs TI
12. Truckers TI
13. Migrants TI
14. Transgender/Hijra TI
15. Core composite TI
16. Legal services
17. Family member/ partner referred to ICTC
18. Newly identified discordant couple tested for HIV
19. Discordant couple followed up for HIV Re test
20. Others (mention the type in the remarks column)

(Enter the codes wherever applicable)

13	14	15	16	17	18	19	20	21	22	23	24	25	26
Client to be followed up during visit (refer codes below)	**Purpose of visit** (refer codes below)	**Type of Contact** 1. Home 2. Outside home 3. Health facility 4. Telephone	**Outcome of contact** (refer codes below)	**Family member/ sexual partner eligible to be referred to ICTC** 1. Yes 2. No	**The client is willing to be referred to social welfare scheme** 1. Yes 2. No	**Health & Non health related out referrals** (refer codes below)	**Linkages with social welfare schemes** (refer codes below)	**Linkages with social entitlements** (refer codes below)	**Result of referral and linkages received** 1. Yes 2. No	**Result of CD4 count/%** (% only for children)	**Date of receiving referral slip** (DD/MM/YYYY)	**No. of condoms distributed**	**Remarks** (For New PLHIV not registered at ART Centre but referred by CSC staff kindly mention the ICTC PID No.)

Codes

Column 20: Linkages with social welfare schemes

1. Income Generation Activity
1a. Swarnajayanti Gram Swarozgar Yojana (SGSY)
1b. Mahatma Gandhi National Rural Employment Yojana (MGNREY)
1c. Other income generation activity
2. Education Support
2a. Sarva Siksha Abhiyan (SSA)
2b. Indira Gandhi Matritva Sahyog Yojana (IGMSY)
2c. Other education support scheme
3. Nutritional Schemes
3a. Antyodaya Anna Yojana (AAY)
3b. Integrated Child Development Scheme (ICDS)
3c. Other nutritional schemes
4. Pension Schemes
4a. Indira Gandhi National Widow Pension (IGNWP)
4b. Sanjay Gandhi Pension Yojana (SGPY)
4c. Other pension schemes

5. Health Related Schemes
5a. Janani Suraksha Yojana (JSY)
5b. Rashtriya Swasthya Bima Yojana (RSBY)
5c. Other health related schemes
6. Legal Support
6a. District Legal Service Authority (DALSA)
6b. Other legal support
7. Child-specific schemes
7a. Integrated Child Protection Scheme (ICPS)
7b. Other child-specific schemes
8. Adolescent-specific schemes
9. Women-specific schemes
10. CLHIV provided education & nutritional assistance
11. CLHIV linked to care homes
12. Others (mention type in remarks column)

Column 21: Linkages with social entitlements
1. Ration card
2. Voter card
3. Aadhaar card
4. Passport
5. PAN card
6. Caste certificate
7. Birth certificate
8. Death certificate of husband or parents for widow or orphans
9. Marriage certificate
10. Income certificate
11. Disability certificate
12. Bank account
13. Post office account

To be verified and signed by Project Coordinator

Monthly sheet serial number | | | |

Signature

Seal of CSC/Helpdesk

Annexure II.g: Discrimination Response Register

(Enter the codes wherever applicable)

1	2	3	4	5	6
S. No.	**Date** (DD/MM/YYYY)	**Client ID of the registered client reporting discrimination** (11 digit)	**Family ID of the client reporting discrimination** (10 digit)	**Discrimination faced from** (refer codes below)	**DRT responded within 24 hours** 1. Yes 2. No
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Codes

Column 5: Discrimination Faced from

1. Health facilities
2. Family members
3. Local goondas
4. Police & law enforcement
5. Workplace
6. Education institution
7. Social gathering
8. Service delivery point
9. Others (mention the type in the remarks column)

(Enter the codes wherever applicable)

7	8	9
Reasons for not responding within 24 hours	**If responded after 24 hours** 1. Yes 2. No	**If not responded at all** (give reasons)

To be verified and signed by Project Coordinator

Monthly sheet serial number | | | |

Signature

Seal of CSC/Helpdesk

Annexure II.h: SR Training Register

Month : Year:

1	2	3	4	5
S.No.	Date of the Training (DD/MM/YYYY)	Training Organized at Field or Office	New Training /Refresher Training	Theme of Training

6	7	8	9
Conducted by	Duration of Training in Days	Number of Client received training	Remarks

Annexure II.i: ART CSC Tracker Sheet

This format acts as an ART-CSC Tracker, essentially to trace the patients between ART Centre and CSC. It is the responsibility of the ART In-charge to fill up this form.This format will be filled up on a weekly/monthly basis and will be in movement between ART centre and CSC

Name of the State.....Name of the District.....

Name of the CSC .....Name of the ART centre .....

1	2	3	4					5	6	7
S. No.	**ART Center ID**	**Name of Client**	**Address**					**Age**	**Sex**	**Date of Start of ART** (DD/MM/YYYY)
			Father/mother/ Son/ daughter/wife name	Block/ Taluka	District	State	Contact No.			
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

Column 10: Reasons for follow-up

1. Pre-ART baseline CD 4 not done
2. Pre-ART eligible but not initiated on ART
3. Pre ART CD 4 due
4. Pre ART LFU
5. On ART MIS
6. On ART LFU

Column 13: Outcome of Visit

1. Agreed to visit ART
2. Physically Taken to ART Centre
3. Death (with source of information)
4. Taking ART at other ART Centre (Name of the centre)
5. Opted out of programme
6. Incorrect / incomplete address
7. Migrated
8. Others Specify

The columns 1 to 10 are to be filled in by ART Center in-charge and then sent to CSC. CSC project co-ordinator would enter information in columns 11 to 14 post follow up and return the form within a week for MIS / Pre ART base line CD 4 not d one and in a month for others to ART centre. ART Center would then fill-in information in column 15

Date of receipt of form by CSC (DD/MM/YYYY).....

Date of Returning the form at ART (DD/MM/YYYY).....

8	9	10	11	12	13	14	15
Drug Regimen	**Due Date of visit at ART when the patient did not turn up** (DD/MM/YYYY)	**Reasons for follow up** (refer codes below)	**Client ID given at CSC**	**Date of visit by ORW** (DD/MM/YYYY)	**Outcome of Visit** (refer codes below)	**Description**	**Date of visit at ART Centre post follow-up by CSC** (DD/MM/YYYY)

Annexure III: Consent Form for Home Visit

(Consent to be taken for each client enrolled in the program)

Read the consent form to the client and seek his/her consent for conducting home visits.

Client's details

(1) Name of the client: (2) Age: (3) Sex:

My name is (Name of the staff) ..... I work as ..... at .....
As you (Name of the client)..... are enrolled in our centre (Name of the Centre)..... and your client ID is ..... , I would like to have your consent for home visit which will be done by any of our centre staff; at most times home visit will be done by the outreach worker.

It will be a routine home visit by our centre staff for seeking the following information:

- If you are registered as a new client at our centre, our staff can visit your home to verify or obtain information about your accurate address. During the visit, our staff will ask about the complete address (taluk/block/village/street/house No./head of the household) and your contact phone number. Our staff will also request you to provide an emergency contact person's name with his / her address, telephone number and relationship with him/her.
- If you are not coming to the centre for any reason or have missed an appointment or are lost to follow up, our staff will contact you to continue your treatment or services at the centre.
- Through home visits, our staff will provide adherence counselling and help you in identifying side effects if you have just started ART.
- A home visit is also required for family-based counselling in order to promote HIV testing and disclosure support.
- Home visits will also help in identifying and supporting emergency needs, especially home based care.
- Home visits are to reinforce scheduled visits for treatment, participation in regular counselling, and attending support group meetings. If you are missing or not attending, our staff will also refer and link you to treatment centre and support group meeting.
- In case you are taking ART, home visits are important in ensuring optimal adherence. Our staff will discuss on pill counts during home visits and will also ask to report whether you have missed any doses in the last three days, and if so, how many. Staff will provide support to monitor for symptoms of adverse reactions to ART.
- Through home visits, we will make efforts that may enable you to live positively with HIV and minimize negative thoughts.
- During home visits, our staff will listen to your concerns, if any and will attempt to solve issues if possible.
- In order to make our efforts timely, our staff may also visit the places where you usually spend time for work or recreation.
- In your absence, our staff may establish a contact with the immediate contact person that you provided in the client registration/admission form, or your family member or caregivers or friends and leave a message for you.

Whether the client has consented for home visit: Yes No

When a client agrees to home visits ask what day of the week and time is best suited to him/her. Fix schedule for first home visit.

Day of the visit in a week, if any: Time of visit, if any:

Confirm the client's home address and get directions.

Write down the client's address in detail:

- Son of, Daughter of, Wife of, Husband of, Mother of, Father of
- Village name
- Land mark
- Block/Taluk name
- District name and PIN code
- Any more directions or land marks

Signature/Thumb Impression of client _____ Date _____

(For children (Below 14 years), the parent or guardian should also sign)

Signature of parent or guardian _____ Date _____

Note: Attach the filled in form to the Client registration/admission form.

Annexure IV: Checklist for ORWs-Adults

S. No.	Areas	Done/ not done	Date/ month/ year	Supporting documents Yes/No/Not needed	Follow-up/action needed
I	**Health**				
1	HIV test done				
2	Registration at ART centre				
3	Baseline CD4 Testing				
4	ART Initiation				
5	OI Prophylaxis				
6	Referral for OI treatment, management and education				
7	Referral for TB and DOTS				
8	Referral for STI clinic				
9	Adherence to ART/CTX				
10	Education and information on - Treatment education - Education on prophylaxis (adults & children) - on OIs management - Respiratory infections				
II	**Nutrition**				
1	Nutrition education				
2	Low-cost nutritious food demonstration session				
3	Access to Ration card/ Anthyodaya				
4	Linkages to individual donors				
5	Community/resource mobilization for nutrition supplement				
6	AWC for pregnant/lactating mothers				
III	**Psycho-social support**				
1	Counselling				
2	Positive prevention				
3	Peer support via support groups				
4	Referral to positive networks for counselling				
5	SRH education and linkages				
6	Information and capacitating on taking care of children affected by HIV				
IV	**Social protection**				
1	Linkages to at least two Government entitlements				
2	Linkages to at least one Government scheme				
3	Any other additional entitlements or linkages				
4	Resource mobilization				
5	Enrolment in SHG				
6	Linkages to Income Generation Programmes including access to NREGS				
7	Accessing any loan under SC/ST/BC corporations and DRDA				
8	Linkages to health insurance				
9	Emergency support through community mobilization				
10	Referral to WCD/women cell				

S. No.	Areas	Done/ not done	Date/ month/ year	Supporting documents Yes/No/Not needed	Follow-up/action needed
V	**Legal**				
1	Linkages and referral to DLNs				
2	Linkages and referral to positive networks				
3	Linkages and referral to Legal aid cells at the district and state level				
VI	**Any other specific needs of HRGs**				
1	Information and education on Anal STIs, management and care				
2	Information on liver infections, HCV management etc.				
3	Referrals of IDUs to de-addiction centres				

Check list for ORW – Children

S. No.	Areas	Done/ not done	Date/ month/ year	Supporting documents Yes/No/Not needed	Follow-up/action needed
I	**Health**				
1	HIV testing or DNA PCR				
2	Registration at ART centre				
3	CD4 Testing				
4	ART Initiation				
5	CTX Prophylaxis				
5	Immunization				
6	Growth monitoring				
7	OI referrals needed if any				
8	Adherence to ART/CTX				
II	**Nutrition**				
1	Referral to AWC (0-6yrs)				
2	Accessing supplementary nutrition at AWC or double rations				
3	Accessing Mid-day meals(6-14yrs)				
4	Local resource mobilization				
5	Individual donors				
III	**Education**				
1	Referral to ICDS/Formal education/non formal				
2	Linked to individual donors/sponsors				
3	Community/resource mobilization if needed				
IV	**Psychosocial support**				
1	Child specific counselling				
2	Peer support via support groups				
3	Referral to positive networks for counselling				
4	SRH education to adolescents and young children				
V	**Social Protection**				
1	Referral to ICPS				
2	Referral to CWC				
VI	**Legal**				
1	Linkages and referral to DLNs				
2	Linkages and referral to positive networks				
3	Linkages and referral to Legal aid cells at the district and state level				

Annexure V: Advocacy Report

Name of the SR: Reporting Period:

Quarterly Advocacy Report

SR Level

I	Advocacy Workshops and Meetings				
Type of Stakeholders	**Date**	**Number of Stakeholders**	**Number of SSRs participated**	**Purpose of the meeting**	**Brief Description and key outcomes**
Police					
Media					
Judiciary					
Govt Dept concerning social entitlements & social welfare (pls specify the dept.)					
People Representatives					
Any other (Please specify e.g. education dept., WCD, any local resource mobilization activity, etc)					
II	**Sensitisation meeting with health care providers**				
Number of Health Care providers participated	**Date**	**Number of Stakeholders/ Health Departments**	**Whether it was district/state/ regional event**	**Purpose of the meeting**	**Brief Description and key outcomes**

III	Visit to SSR partners by AO					
Name of the SSR	**Date**	**District**	**Purpose of visit**	**Plan of Action**	**List of stakeholders met during the visit**	**Key outcomes of the meeting**

IV	CAB elections/meetings (Frequency - Yearly)				
Name of the state where CAB elections/meeting are held	**Date**	**Total number of CAB members elected/ attended meeting**	**Number of CAB members from Key Populations (KP)**	**Type of KP (MSM/TG/ FSW/IDU)**	**Minutes of the meetings or key outcomes**

V	Planning for the next quarter SR/SSR				
Activity	**SR/SSR**	**Month in which it is planned**	**Whether is it carried forward from the previous quarter**	**If yes, please specify reasons**	**Any particular challenge that you foresee**

SSR Level

VI	Sensitization meetings				
Type of stakeholders	**Date**	**Number of stakeholders**	**Number of the SSRs participated**	**Purpose of the meeting**	**Brief Description**
Police					
Media					
Judiciary					
Govt Dept concerning social entitlements & social welfare (pls specify the dept.)					
People Representatives					
Any other (Please specify e.g. education dept., WCD, any local resource mobilization activity, etc)					

VII	Discrimination Response Team						
Name of the SSR	**Month**	**Details and total number of members**	**Number of cases reported to DRT**	**Number of cases responded by DRT in 24 hours**	**Number of cases responded after 24 hours**	**Reasons for cases responded after 24 hours**	**Number and reasons for cases not responded at all**

Case Studies (not more than 250 words and to include best practices, innovations, discrimination cases, challenges, etc.)

Annexure VI: CSC/Helpdesk - Monthly Progress Report

Name of the SR	Address of the SR	
	No. of SSR	State
Reporting Period	Month	Year
Name of PM/PC	CSC Contact No	E Mail ID

A) Client Registration

Indicator No.	A) Registration during reporting Month	Male	Female	Transgender	Male Children (<15 Yrs.)	Female Children (<15 Yrs.)	Total
A.1	Pre ART						
A.2	On ART						
A.3	Total registration during reporting month						
A1) Cumulative Registration including the reporting Month							
A1.1	Pre ART						
A1.2	On ART						
	Total Cumulative registration including reporting month						

B) Referred From (In Referral)

Indicator No.		Male	Female	Transgender	Male Children (<15 Yrs.)	Female Children (<15 Yrs.)	Total
B.1	1.ART Centre						
B.2	2.Link ART Centre						
B.3	3. ICTC Center						
B.4	4.PPTCT center						
B.5	5.DOTS Centre						
B.6	6.NGO/CBO/PLHIV Network						
B.7	7.Govt. hospital						
B.8	8.STI Clinic						
B.9	9.Other Healthcare Facilities						
B.10	10.MSM TI						
B.11	11.FSW TI						
B.12	12.IDUs TI						
B.13	13.Truckers TI						
B.14	14.Migrants TI						
B.15	15.Transgender/Hijra TI						
B.16	16.Core Composite TI						
B.17	17.Walk In/Self						
B.18	18.Others						
B.19	Grand Total						

C) Registration Details during the Month *(Only first service provided to the client will be recorded)*

Indicator No.	Mechanism of Registration	Male	Female	Transgender	Male Children (<15 Yrs.)	Female Children (<15 Yrs.)	Total
C.1	1. Counselling in CSC/Helpdesk						
C.2	2. Support Group meeting in CSC/Helpdesk						
C.3	3. LFU tracked back to ART						
C.4	4. Missed case follow up						
C.5	5. Pre-ART Registration						
C.6	6. CD4 follow up						
C.7	7. Link to TI						
C.8	8. Testing of partner/spouse, children and family member						
C.9	9. Hospital /clinical referrals (OI management, side effects, general ailment, TB, STI treatment))						
C.10	10. Support for legal Aid						
C.11	11. Social protection						
C.12	12. Social entitlements						
C.13	Grand Total						
Indicator No.	**Place of Registration during the month**	**Male**	**Female**	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
C.14	Total Client Registered at CSC/Helpdesk in the month						
C.15	Total Client Registered at Field/Home						
C.16	Grand Total						

D) Out Referral during the month

Indicator No.	Places to where the PLHIV are referred from CSC during the reporting Month	Male	Female	Transgender	Male Children (<15 Yrs.)	Female Children (<15 Yrs.)	Total
D.1	1.ART Centre						
D.2	2.Link ART Centre						
D.3	3.PPTCT center						
D.4	4.DOTS Centre						
D.5	5.NGO/CBO/PLHIV Network						
D.6	6.Govt. hospital						
D.7	7.STI Clinic						
D.8	8.Other Healthcare Facilities						
D.9	9.MSM TI						
D.10	10.FSW TI						
D.11	11.IDUs TI						
D.12	12.Truckers TI						
D.13	13.Migrants TI						
D.14	14.Transgender/Hijra TI						
D.15	15.Core Composite TI						
D.16	16.Legal Services						
D.17	17.Others						
D.18	Grand Total						

E) Counselling Activity

Indicator No.	Counselling		Clients attended Counselling					
			Male	Female	Transgender	Male Children (<15 Yrs.)	Female Children (<15 Yrs.)	Total
E.1	No of Newly Registered Client given One on One Counselling by CSC Counselor in thematic areas in the reporting Month							
E.2	No of Follow up Client (Registered in programme earlier) given One on One Counselling by CSC Counselor in thematic areas in the reporting Month	Follow up Clients receiving counselling for the first time in the programme						
E.3		Follow up Clients receiving second/ subsequent counselling session in the programme						
E.4	No. of Newly Registered Client given Counselling by Peer Counselor in the reporting Month							
E.5	No. of Follow up Client (Registered in programme earlier) given Counselling by Peer Counselor in the reporting Month	Follow up Clients receiving counselling for the first time in the programme						
E.6		Follow up Clients receiving second/ subsequent counselling session in the programme						
Family Counselling and Couple Counselling								
E.7	**Family/Couple Counselling**		**No of family/couple counselled**					
E7.1	Couple Counselling (Initial)							
E7.2	Family Counselling (Initial)							
E7.3	Couple Counslselling (follow up)							
E7.4	Family Counselling (follow up)							
E1) Cumulative Counseling Data including reporting Month								
E1.1	Cumulative No of registered Client given One on One Counselling by CSC Counselor in thematic areas including the reporting Month (Newly Registered Client+ Follow up Client receiving counseling for the first time in the program)							
E1.2	Cumulative No. of registered Clients Counseled by Peer Counselor including reporting month (Newly Registered Client+ Follow up Client receiving counseling for the first time in the program)							

E2) Different thematic areas of Counselling activity (Theme wise Count)								
Indicator No.			**Male**	**Female**	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
E2.1	Thematic areas of counselling	1.ART Adherence,						
E2.2		2.OI management,						
E2.3		3.Nutrition Counselling						
E2.4		4.Psycho Social						
E2.5		5.Maternal Health & Early Infant Diagnosis						
E2.6		6. HIV Prevention						
E2.7		7.Health & Hygiene Counselling						
E2.8		8.Sexual & Reproductive Health						
E2.9		9.Adolescent Counselling						
E2.10		10.Counselling For Discordant Couples						
E2.11		11.Safe Sex Education						
E2.12		12.Family Planning						
E2.13		13.Counselling on Disclosure						
E2.14		14.Others						
E2.15	**Grand Total**							

F) Support Group Meeting

Indicator No.			**Male**	**Female**	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
F.1	Total No. of Registered Clients Attended Support Group Meeting for the first time during the month							
F.2	Total No. of Follow-up Clients Attended Support Group Meeting During the month (Client attended support group meeting earlier in the program)							
F.3	Total No.of Clients Attended Support Group Meeting During the month							
Indicator No.	**Different Thematic areas for support group meeting**	**No. of Meetings conducted on Each Themes**	**Clients attended Counselling**					
				Female	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
F.4	Basics of HIV,							
F.5	Basic health and Hygiene							
F.6	Diet and nutrition							
F.7	Home Base Care							

F.8	OI management and co-infection							
F.9	Treatment education / adherence							
F.10	Social entitlements and livelihood							
F.11	Positive prevention/ Positive living							
F.12	Yoga and meditation							
F.13	Side effects of ART and its management							
F.14	Sexual Reproductive Health and Rights and PPTCT							
F.15	Legal rights and referrals to legal aid							
F.16	Marriage, addiction and psychosocial counselling							
F.17	Family support counselling							
F.18	Mainstreaming and linkages							
F.19	Gender sensitization and women empowerment							
F.20	CSR linkages with exposure visits to corporate houses including use of positive speaking							
F.21	Safe sex education to all age groups except children including condom education							
F.22	Legal issues							
F.23	Disclosure issues- children / spouse							
F.24	Stigma and Discrimination and GIPA							
F.25	Peer Leaders/Positive Speaking							
F.26	Grand Total							

G) Outreach Activity

Indicator No.	Outreach Contact		Male	Female	Transgender	Male Children (<15 Yrs.)	Female Children (<15 Yrs.)	Total
G.1	No.of PLHIV registered during the month contacted through outreach	Pre ART						
G.2		On ART						
G.3		**Total**						
G.4	No. of already registered PLHIV contacted through outreach	Pre ART						
G.5		On ART						
G.6		**Total**						
G.7	No.of LFU cases provided by the ARTC for the previous month							
G.8	No.of LFU cases contacted through Outreach during the reporting month							
G.9	No.of LFU cases reported as dead through Outreach during the reporting month							
G.10	No.of LFU cases reported back to ART center during the reporting month							

G.11	No.of Missed cases provided by the ARTC in the reporting month							
G.12	No.of Missed cases contacted through Outreach							
G.13	No.of Missed cases reported as dead through Outreach during the reporting month							
G.14	No.of Missed cases reported back to ART center							
G.15	No.of PLHIV in Pre ART to be followed up for CD4 testing shared by ART Centre							
G.16	No.of PLHIV in Pre ART followed up for CD4 testing							
G.17	No.of Deaths Reported in Pre ART followed up for CD4 testing							
G.18	No.of PLHIV in Pre ART reported back for CD 4 testing							
G.19	No.of PLHIV in Pre ART cases to be followed up for ART Initiation shared by ART center							
G.20	No.of PLHIV in Pre ART followed up for ART Initiation							
G.21	No. of Deaths Reported amoung Pre ART cases followed up for initiation of ART							
G.22	No.of PLHIV in Pre ART reported back for ART initiation							
G.23	No of Pre ART LFU cases shared by ART Centre during the Month							
G.24	No of Pre ART LFU cases contacted during the Month							
G.25	No of Deaths Reported among Pre- ART LFU Cases							
G.26	No of Pre ART LFU cases reported back in the ART center during the Month							

I) Linkages

Indicator No.			**Male**	**Female**	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
I 1	**No of PLHIV registered in the CSC linked to Social welfare scheme during the reporting Month**							
Indicator No.			**Type of Linkage with Social Welfare Schemes (Out referral & Outreach)**					
			Male	**Female**	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
I 1.1	**A) Income Generation Activity (including Microfinance)**	Swarnajayanti Gram Swarozgar Yojana (SGSY)						
I 1.2		"Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS)"						
I 1.3		Other Income Generation Activity						

I 1.4	**B) Educational Support**	Sarva Siksha Abhiyan (SSA)						
I 1.5		Indira Gandhi Matritva Sahyog Yojana						
I 1.6		Other Education Support Scheme						
I 1.7	**C) Nutritional Schemes**	Antyodaya Anna Yojana (AAY)						
I 1.8		Integrated Child Development Services Scheme (ICDS)						
I 1.9		Other Nutritional Schemes						
I 1.10	**D) Pension Schemes**	Indira Gandhi National Widow Pension Scheme (IGNWPS)						
I 1.11		Sanjay Gandhi Pension Yojna						
I 1.12		Other Pension Related Schemes						
I 1.13	**E) Health Related Schemes**	Janani Suraksha Yojana (JSY)						
I 1.14		Rashtriya Swasthya Bima Yojana(RSBY)						
I 1.15		Other Health Related Schemes						
I 1.16	**F) Legal Support**	District Legal Service Authority (DALSA)						
I 1.17		Other Legal Support						
I 1.18	**G) Schemes related with Children**	Integrated Child Protection Scheme (ICPS)						
I 1.19		Other Children Schemes						
I 1.20	**H) Adolescent Scheme**							
I 1.21	**I) Women specific schemes**							
I 1.22	**J) CLHIV provided Education & Nutritional assistance**							
I 1.23	**K) CLHIV linked to care homes**							
I 1.24	**L) Others**							
I 1.25	**Total**							
I 1.26	**No of Client Successfully referred to mentioned Social Entitlement during the Month**	1.Ration Card						
I 1.27		2.Voter Card						
I 1.28		3.Aadhaar Card						
I 1.29		4.Passport						
I 1.30		5.PAN Card						
I 1.31		6. Caste Certificate						
I 1.32		7.Birth Certificate						
I 1.33		8.Dealth Certificate of Husband for Widow or Parents for Orphans						

I 1.34		9.Marriage certificate						
I 1.35		10. Income Certificate						
I 1.36		11.Disablity Certificate						
I 1.37		12.Bank Account						
I 1.38		13.Post Office Account						
I 1.39		Total						
I 1.40	**Grand Total**							

J) Testing

Indicator No.		**Spouse**	**Partner**	**Children**	**Parents**	**Others**	**Total**
J.1	**No.of family member/ partner referred to ICTC and received test result**						
Indicator No.		**Male**	**Female**	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
J.2	No of PLHIV registered with CSC whose at least one family member/ sexual partner eligible to be referral to ICTC						
J.3	No of PLHIV registered with CSC whose at least one family member/ sexual partner referred to ICTC and received test result						
J.4	Proportion of PLHIV whose at least one family member or sexual partner referred for HIV testing and received test result						
Indicator No.		**Male**	**Female**	**Transgender**			
J.5	No. of Newly identified Discordant Couple Tested for HIV						
J.6	No. of Discordant Couple followed up for HIV Re test						
J.7	No. of Discordant Couple remaining discordant for the last one year in the program						

K) Incidents of Stigma and Discrimination during month

Indicator No.	**Source of Incidence**	**Male**	**Female**	**Transgender**	**Male Children (<15 Yrs.)**	**Female Children (<15 Yrs.)**	**Total**
K.1	Health Facility						
K.2	Family members						
K.3	Local Gundas						
K.4	Police & Law enforcement						
K.5	Workplace						
K.6	Education Institution						
K.7	Social gathering						
K.8	Media reporting						
K.9	Service delivery points						
K.10	Others						
K.11	**Grand Total**						

L) HR

Indicator No.	Staff	Position Sanctioned	Position Filled	Induction Training Received (Y/N)	Refresher Training Received (Y/N)	Training received during reporting month
L.1	Project Coordinator					
L.2	Counsellor					
L.3	Peer counsellor					
L.4	Outreach Worker					
L.5	Accountant					
L.6	MIS Assistant					
L.7	Any other					

M) Coordination and Supervision

M.1	No.of coordination meeting with ART center		
M.2	No.of coordination meeting with DAPCU/ SACS		
M.3	No of Coordination Meeting took place with PLHIV Networks in last reporting month		
M.4	No of Coordination Meeting with District Administration &Other departments in last reporting month		
M.5	No Coordination Meeting attended by CSC with District Health Society in last reporting month		
M.6	No.of Supervisory visit under taken during the month		
M.7	No.of Supervisory visit under taken during the month	Project Coordinator	
M.8		Project Director	
M.9		DAPCU	
M.10		SR Staff	
M.11		PR Staff	
M.12		SACS/NACO Officials	
M.13		Others	

Annexure VII: Quarterly Report Template

Quarterly Narrative Report

Submitted by: State/Region:

Brief Update on CSC Programme Activities in the State:

1. A brief note on CST programme in the State/Region: (explain CST programme overview in two paragraphs with key information of prevalence rate, number of PLHIV enrolled in ARTC, alive on ART, number of ART, Link ART, LFU rate, death rate etc. and also explain challenges and other qualitative information in bullet points)

2.a. Background of CSC Programme: (explain the Goals and Objective of CSC programme and PR details in a paragraph)

2.b. Brief on SR partner: (write two lines on SR organization and its activities)

2.c. A snapshot of CSC programme activities highlights of the last quarter achievements (two paragraphs and CSC wise achievements in a table)

2.d. Engagement with SACS and DAPCUs (explain the coordination mechanisms in one paragraph)

3. Major programme activities conducted during the last quarter:
   - Events
   - Trainings (PR/SR/SSR level)
   - Media coverage
   - Special initiatives

4. Major Advocacy events/initiatives and networking:
   - Details of inter-departmental meetings conducted and outcome of the meeting
   - Support extended by Advocacy Officer in district level advocacy
   - ART and CSC Coordination meeting and data sharing
   - Coordination mechanisms with stakeholders including TI and district health services

5.a. State Oversight Committee Meeting (brief note on SOC with the details of participation of stakeholders, major issues discussed, action points and follow-up)

5.b. Details of DAPCU Coordination Meeting

District	SSR name	Date of DAPCU meeting	Any points to be brought to attention of PR

6. Social entitlement and welfare schemes for PLHIV:
   - Highlight number of PLHIV benefited with different social entitlement and welfare schemes in the last quarter
   - Challenges in accessing the schemes
   - Resource mobilization by CSCs in the last quarter (both material and non-material)

7. Stigma and discrimination for PLHIV
   - Number of stigma and discrimination cases reported in the last quarter
   - Support extended by SR to CSC to address the stigma and discrimination
   - Support requested from SACS/NACO and PR

8. Community Advisory Board Meeting: (participation details, major issues discussed and action plan)

9.a. Details of Supportive Supervision Visits to SSR: (If more than one visit made, please insert rows to add information)

S.No.	SR Staff	Date of visit	Name of the CSC visited	Purpose of visit	Whether is it a joint visit with SACS? (Yes or No)	Other stakeholders met during the visit
1	Programme Manager					
2	Advocacy Officer					
3	M&E Officer					
4	Programme Officer					
5	Finance Officer					
6	Project Director					
7	Others (PR/NACO/ Special Visits)					

9.b. Major observations during field visits:

- Programme issues
- Advocacy related issues
- Reporting and documentation
- Coordination
- Training needs identified
- Finance

9.c. Support extended by SR to SSR based on visit observations:

9.d. Any issues brought to the notice of SACS/PR based on visit observations:

9.e. Follow-up plan:

10. Best practices/ major achievements:

- CSC
- SR

11. Case studies:

12. Challenges:

13. Action plan for next quarter (can add rows to accommodate more information):

Name of the Activity	Person Responsible	Time			Support required from	Remarks
		Month one	Month two	Month three		
Programme events						
Advocacy Activities						
Training						
SOC						
CAB						
Supportive supervision visits						

Annexure VIII: M&E Checklist and Feedback Form

Name of the SSR: District: State:

Type of SSR : Qtr./Qtrs. Reviewed: Date of Visit:

Name and Designation of Responsible staff participated at CSC: SR Name:

Name and Designation SR staff visited: PR Staff visited with Designation:

Instructions for Scoring: Yes=2,Partly=1 and No =0

Document	Hard Copy (Yes/No)	"Soft Copy (Yes/No)"	"Content Knowledge (Yes/Partly/No)"	Comments
Target Framework (Target Calculation sheets)				
Quick Reference Guide				
Indicator Hand Book				
MIS Tool Kit				
Total Score				

Reporting tool Verification (As per guidelines in quick reference guide)

Reporting tool	"Maintained as per protocols (Yes/Partly/No)"	"Updated (Yes/Partly/No)"	"Reviewed (Yes/Partly/No)"	"Entered in CMIS (Yes/Partly/No)"	Comments
Client Registration form (CRF)					
Enrolment tool					
Counselling tool					
Outreferral tool					
Referral Slip					
Outreach tool					
Meeting Tool					
Discrimination Response Tool					
ART-CSC Tracker sheet					
Total Score					

Files Verification (As per guidelines in quick reference guide)

Records	"Maintained as per guideline (Yes/Partly/No)"	"Updated (Yes/Partly/No)"	"Entered in CMIS (Yes/Partly/No)"	Comments
Quarterly Reports				
Monthly Reports				
M&E Checklists				
Total Score	**Number**			
M&E Tools Log				
Stock in Hand				
Details Stock Requirement (If any)				

Indicators Verification

(Need to verify all the source Reporting tool of the Indicator and report variance even if not matching with one Reporting tool)

Core Indicator No. as per reporting template	Targets calculated as per the target framework (Yes/ No)	Reported	Verified	Variance =(Reported -Verified)	"Compliant (Yes/No)"	Comments with Date for bridging gaps
No of of PLHIVs registered in ART Center and on ART are registered in the CSC						
No of PLHIV in Pre ART phase who get registered at the CSC						
No of registered PLHIVs receiving at least one counselling service in the quarter						
No of registered PLHIVs receiving at least one counselling session on thematic areas						
No of PLHIV who have at least one family member or sexual partner referred for HIV testing and received test result						
No of PLHIV registered in the CSC linked to Govt. social welfare scheme						
Proportion of PLHIV lost to follow up (LFU) brought back to treatment						
No of Advocacy meeting organised						

Additional Indicators (Any of five additional indicators may choose in latest MPR)

Number of new clients referred to CSC (In-referral)					
Number of One one One sessions conducted on Thematic areas:					
Number of Group Counselling sessions conducted on thematic counselling					
Number of Clients referred from CSC (Out-referral)					
Number of Newly identified discordant couple Tested for HIV during the month					
Number of discordant couple followed up for HIV Re test					
Total Number of discordant couple receiving services from the CSC (cumulative number)					
Number of discordant couples remaining discordant from last one year in the program					
Number of clients linked to various Govt. social welfare schemes/social entitlements					
Number of PLHIV registered during the month contacted through outreach (Pre ART, ART& New PLHIV)					
Number of registered PLHIV contacted through outreach for follow up services (Pre ART, ART& New PLHIV)					
Number of LFU cases list provided by the ARTC for the previous month					
Number of LFU cases contacted through Outreach during the reporting month					
Outcome of contact					

Number of LFU cases reported back to ART centre during the reporting month					
Number of Missed cases provided by the ARTC in the reporting month					
Number of Missed cases contacted through Outreach					
Outcome of contact					
Number of Missed cases reported back to ART centre					
Number of PLHIV in Pre ART shared by ART Centre for follow up for CD4 testing					
Number of PLHIV in Pre ART followed up for CD4 testing					
Number of PLHIV in Pre ART reported back for CD 4 testing					
Number of PLHIV in Pre ART cases shared by ART Centre for follow up for ART Initiation					
Number of PLHIV in Pre ART followed up for ART Initiation					
Number Support Group Meeting conducted at CSC level in last reporting month on various thematic areas					
Number of Persons that attended Support Group Meetings					
Number of condoms distributed in last reporting month					
No. of discrimination cases reported at the CSC					
Number of ART coordination Meetings attended by the CSC in last reporting month					
Number of DAPCU Coordination Meetings attended by the CSC in last reporting month					
Number of Coordination Meetings took place with PLHIV Networks in last reporting month					
Number of Coordination Meetings with District Administration & Other departments in last reporting month					
Number of Coordination Meetings attended by the CSC with District Health Society in last reporting month					
Number of Advocacy Meetings organised by the CSC in the last reporting month made by themes					
Number of CLHIV provided Education & Nutritional assistance through local resource mobilization					
Number of PLHIV reported have received any legal aid					
Cumulative Registration in ARTC including the reporting Month					
Proportion of CSC Coverage against ARTC Registration including the reporting period:					
Mechanism of registration					
Place of registration					
at CSC/Help Desk					
at field/home					
Registrations during reporting Month					
Pre-ART					
On ART					
Total Score					

Adherence to Systems/Protocols

Human Resources	Yes/Partly/No	Comments	Infrastructure	Yes/No	Comments
All Staff available			Computer		
All staff Induction Training			Internet		
All Staff Refresher Training			Invertor		
Updation of data in CMIS					
Data Management protocols	**Yes/Partly/No**	**Comments**	**Data safety/Security**	**Yes/No**	**Comments**
Data Flow process are strictly followed (Submission, review, Entry & Storage)			System Password Protected		
Timely Report Submission to SR-Monthly			Authorized access		
Timely Report Submission to SR-Quarterly			Active Antivirus in place		
Reconciliation statement maintained			Taking Data Backup regularly		
Soft Copies (QPRs, emails, Checklists, Imp Docs, presentations & Reporting tool Outputs)					
Total			**Total**		

Technical Support & Supervision

Visit Type	No. of visits	No. of Feedback Reports provided	"Gaps Bridged (Yes/Partly/No)"	BY Whom	Comments
OSDV (On site Data Verification)					
Technical Support Visit					
Data Quality Audits					
Any other Visits					

Over All Scores, Grade & Recommendations

M&E Documents (24)	"Reporting tool (72)"	"Indicators Verification 26)"	"Adherence to Systems/ Protocols (48)"	"Total Score (170)"	"Over All Grade Grade A =>150,Grade B=126-150, Grade C=100-125,Grade D <100"

Strengths of M&E System :

Follow up and recommendation

Issues Identified		"Category of Issue Major Issue/ Minor Issue"	Recommendation	Timeline for incorporating the recommendation
Signature of the Staff visited (SR/PR):				

"We will bridge the gaps before (date)_____ with specific action plan and ensure necessary measures not to repeat again.

Signatures of the responsible Staff :

Bridged the Gaps (Sign & Date) :

Name of the SSR:

Name of the District:

Name of the State:

M&E Checklist and Feedback Form - Guidelines

M&E Documents

Document	Hard Copy	Soft Copy	Content Knowledge	Comments
These are the important guiding documents for the program	Verify the hard copies	Verify the soft copies in designated system	Test the knowledge of the staff through staff interaction	Write any feedback, suggestions, recommendation, best practice, timelines etc.

Reporting Tool Verification

Reporting tool	Maintained as per protocols	Updated	Reviewed	Entered in CMIS	Comments
These are sources for reporting	Physically verify the record and is maintained as per protocols	Physically verify the records are up to date as per the QRG guidelines	Verify the Reporting tool info are reviewed and signed by the designated staff as per guidelines	Verify the Reporting tool info are entered in CMIS and signed by the Designated staff as per guidelines	Write any feedback,suggestions,recommendation,best practice, timelines etc.

Files Verification (As per guidelines in quick reference guide)

Records	"Available (Yes/Partly/No)"	"Updated (Yes/Partly/No)"	"Entered in CMIS (Yes/Partly/No)"	Comments
The records are important submitted to the donor	Physically verify whether the file is available	Verify all the reports/ records are filed as per protocols	Verify the Reporting tool are entered in CMIS and signed by the Designated staff as per guidelines	Write any feedback, suggestions, recommendation, best practice, timelines etc.

Indicators Verification

(Need to verify all the source Reporting tool related to the Indicator)

Indicator No. as per reporting template	Reported	Verified	Variance =(Reported -Verified)	"Compliant (Yes/No)"	Comments with Date for bridging gaps
All the indicators were provided .Choose 2 additional indicators of your choice	Write the final data reported by SSR	Verify data from all the source Reporting tool, triangulate and report the data. Report even one source is not correct	It is the difference between reported and verified. Can also help in reconciliation	Provide Yes in case no variance else No	Write any feedback,suggestions,recommendation,best practice, timelines etc.

Note: (Use reporting guidelines for reference)

Adherence to Systems/Protocols

Human Resources	Guidelines	Infrastructure	Guidelines
All Staff available	Assess the HR staff availability, their training and knowledge about assignments	Computer	Physically verify the designated systems with specified configurations are available or not
Trained/oriented		Internet	
Responsibilities Assigned		Invertor	
Data Management protocols	**Guidelines**	**Data safety/Security**	**Guidelines**
Data Flow process are strictly followed(Submission, review, Entry & Storage)	Analysed and assess the data flow process as per QRG	Password Protected	Verify the system is password protected or not
Timely Report Submission to SR for all Qtrs.	Analyse all the quarterly report submission timelines with date of submission	Authorized access	Verify the designated staff is only using the system or all with interaction
Reconciliation statement maintained	Verify OSDV,DQA and other visits finding statement are available and updated	Antivirus	Verify Antivirus is installed and update
Soft Copies (QPRs,emails,Checklists,Imp Docs,presentations & Register Outputs)	Verify all the soft copies of all the quarters	Data Backup of system	Verify the data backup is taken in CDs,External Hard disk once in a month

Technical Support & Supervision

Visit Type	No of visits	No of Feedback Reports provided	"Gaps Bridged (Yes/Partly/No)"	BY Whom	Comments
OSDV/DQA	Count the no of visits made	Verify the feedback reports	Verify the latest feedback report and status of recommendations	Disaggregate no of visits made PR,SR etc.	Write any feedback,suggestions,recommendation,best practice, timelines etc.

Overall Score and Grade

M&E Documents (30)	Reporting tool(136)	Indicators Verification (32)	"Adherence to Systems/ Protocols "	Total Score	Overall Grade Grade A =>240,Grade B=215-240, Grade C=200-214,Grade D <200
Write the total scores of each sections				Sum all the scores of	

Strengths of M&E System: Write overall comments on the strengths in the M&E system, the best practices etc.

Areas of imporvement: Be specifically write the major areas to be improved as well as explain the importance of them.

Follow up steps and timelines: Detail all the follow-up steps on priority basis with specific timelines

Signature of the Staff visited (SR/PR): All the staff visited from SR,PR must sign after providing the feedback

Signatures of the responsible Staff: All the SSR staff responsible to bridge the gaps must sign

Bridged the Gaps (Sign & Date): SSR Program Manager must sign with date after reviewing the gaps bridged

Annexure IX: CSC Visit Report

(To be filled by the Visiting Officer on every visit to SSR & fill only appropriate columns)

VISIT DETAILS

Name of the SR Visited: Date of visit:

Name of the SSR Visited: State: Region:

Visiting Officer/s:

S.No.	Name	Designation	Organization
1			
2			
3			
PROJECT STAFF MET DURING THE VISIT:			
1			
2			
3			
4			
5			
OBJECTIVES OF THE VISIT:			
1			
2			
3			
4			
5			
FOLLOW-UP ON PREVIOUS VISIT: (for action points, please refer to previous visit reports)			
Last visit date:		**Last visit done by:**	
S.No	**Action points of last visit**	**Action taken by SSR**	
1			
2			
3			
4			
5			

HUMAN RESOURCES:				
Total No. of Staff Sanctioned	Total No. of Staff in place	Total No. of post vacant	Total No. of Staff Trained	Reasons for staff turnover if any reported in last two months
Interactions with Staff: *(Write a brief note on staff knowledge, skills and highlight the training needs if any)*				

ENGAGEMENT WITH ART CENTRE/DAPCU:			
Last Meeting Date:			
S.No	**Major Action Plan given by ART Centre/DAPCU** (refer to meeting minutes for action plan)	**Action taken by SSR**	**Remarks**
1			
2			
3			
4			
5			

PROGRAMMATIC DOCUMENTS VERIFIED:			
Sl. No.	**Name of Register/Tools**	**Updated (Yes/No)**	**Remarks**
1	Client Registration Form (CRF)		
2	Counselling tool		
3	Outreach tool		
4	Out-referral tool		
5	Meeting register		
6	Miscellaneous		

Reports:

S.No	**Report**	**Updated (Yes/No)**	**Programmatic variance recorded (Yes/No)**	Reasons for variances
1	Monthly Progress Report			

INTERACTION WITH STAKEHOLDERS BY VISITING OFFICER/S:			
S.No	**Name of the Stakeholders met**	**Discussion Points**	**Action plan/ follow-up plan**
1			
2			
3			
4			
5			

Interactions with community/beneficiaries:
(write a brief note on interaction with beneficiaries highlighting their feedback on service delivery, suggestions if any etc.)

FINANCIAL PERFORMANCE					
S.No.	**Cost Category**	**Budget**	**Expenditure**	**Variance**	**Reasons for Under/Over Spending**
1	Infrastructure				
2	Human Resources				
3	Overhead				
4	Living Support				
5	Planning and Admin				
	Total				

The above cost category expenses should be support by detail activity wise budget & expenditure sheet.
Cash or fund balance of partners on date of visit:
REPORTING TO DAPCU and SR

1. MPR sent on time (Yes/No) —
2. MFR sent on time (Yes/No) —

Support extended by visiting officer:
(write in brief the support extended by visiting officer/s)

OUTPUT OF THE VISIT *(All action points need to take as priority of project work)*

Sl. No.	Action points	Person responsible	Timeline
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any serious issue to be brought to the notice of SR/PR/SACS/DAC:

NAME OF VISITING OFFICER/S: **NAME OF CSC PROJECT COORDINATOR:**

SIGNATURE: **SIGNATURE:**

DATE:

Annexure X: Expenditure Statement

Name of the CSC:

Period of Reporting:

S.No.	Cost Category	Activities	Budget	Actuals	%	Reasons for variances
1	Human Resource	Project Coordinator				
2	Human Resource	Accountant				
3	Human Resource	Counsellor				
4	Human Resource	Outreach Worker				
5	Human Resource	Community Counsellor				
6	Human Resource	Support staff				
7	Human Resource	Project Oversight Cost				
8	Overheads	Office running expenses				
9	Overheads	Communications				
10	Overheads	Books, Periodicals and Audio Visuals				
11	Overheads	Office Space Rentals				
12	Living Support	Emergencies/Referral Services				
13	Overheads	Office Maintenance/Repairs/ purchase of materials etc.				
14	Planning and Administration	Travel Cost (all staff)				
15	Trainings	Advocacy Meetings				
16	Planning and Administration	CSC staff monthly review and planning meeting				
17	Trainings	Support Group Meeting				
18	Living Support	Discrimination Response System				
19	Living Support	Social Entitlement Events				
20	Communication	IEC Material				
21	Trainings	In-house Training				
		Sub Total for SR	**Rs. 0**	**Rs. 0**		
		GRAND TOTAL	**Rs. 0**	**Rs. 0**		

Table B

Sub Recipient Cash Flow Summary for the Period From to

Name of SR:

Opening Balance as on [Date] (a)		Rs. xx
Add:		
Fund received from PR in last quarter Date [from to] (b)	Rs. xx	
Interest Earned at SR level in last quarter date [from to] (c)	Rs. xx	Rs. xx
Total available fund d=(a+b+c)		Rs. xx
Less:		
Expenses at SR level in the last quarter date [from to] (e)		Rs. xx
Closing Balance as on [Date] f=(d-e)		Rs. xx
Forecast at SR level in the next quarter date [from to] (g)		Rs. xx
Fund Disbursement request at SR level for the next quarter date [from to] h=(g-f)		Rs. xx

Annexure XI: Utilization Certificate

Name of the NGO:

S.No.	Date of Receipt of Funds	Amount (Rs.)

Certified that out of Rs. _____ grants-in-aid sanctioned during the year _____ in favour of _____ (Name of NGO) by the _____ (Name of the implementing agency) as per the details given in the margin and Rs. _____ on account of unspent balance of the previous year, a sum of Rs. _____ has been utilised for the purpose for which it was sanctioned and that the balance of Rs._____ (including advance of Rs. _____) will be refunded/adjusted towards the grants-in-aid payable during the next year_____.

Certified that I have satisfied myself that the conditions on which the grants-in-aid was sanctioned have been duly fulfilled / are being fulfilled and that I have exercised the following checks to see that the money was actually utilised for the purpose for which it was sanctioned.

Kinds of checks exercised

1. SOEs
2. Audited Accounts
3. Project Documents

Auditors Finance Manager Project Director

National AIDS Control Organisation

India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India

www.naco.gov.in