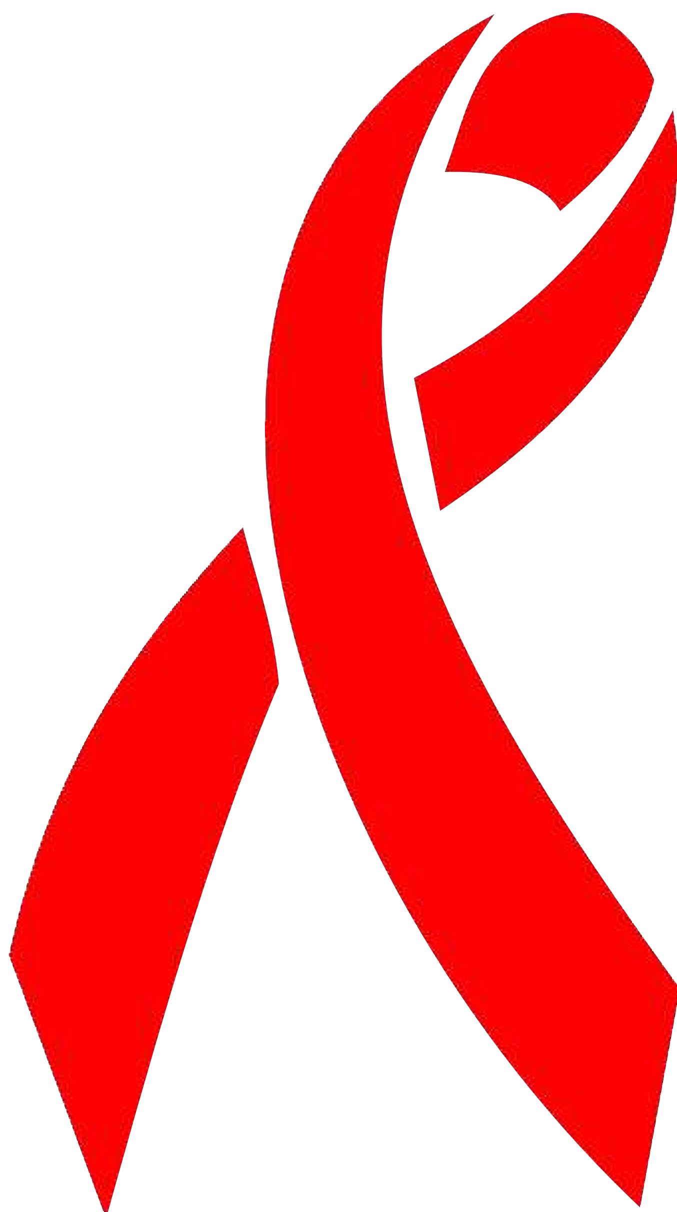
National Technical Support Unit (NTSU)

Priority Districts Visit Report– Round II

January to June 2011



National AIDS Control Organisation
Department of AIDS Control
Ministry of Health and Family Welfare
Government of India

December 2011

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

NACO acknowledges effort of all field level functionaries, clinic in-charge, counselor of designated clinic, DACO, DPM and other DAPCU staff; TI Programme managers, ORWs, peer educators, preferred providers of the TI NGO for contributing towards generating and transmitting data from the field. We also acknowledge contribution of state focal persons at SACS/TSU (DD/AD STI, JD TI, TL TSU, PO STI, PO TI, M&E officer and all other staff) in collecting, compiling, analyzing and transferring data to us. Our thanks to all Project Directors of SACS in ensuring timely reporting of data from field and SACS.

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Introduction

In May 2010, DG NACO instructed that districts should be identified for priority attention based on HSS data and data triangulation. The criteria for selection of such districts was

- ANC prevalence >= 3% in 3 out of 6 years OR
- ANC prevalence 1 % to 3 % in 5 out of 6 years OR
- HRG prevalence >= 15% in 3 out of 6 years OR
- HRG prevalence 5 % to 15% in 4 out of 6 years

Accordingly 67 districts were identified as priority districts in 14 states. The NTSU visited the priority districts between June and December 2010 with a view to strengthen the quality of program implementation. A report on the visit was submitted to NACO

Subsequently, DG NACO approved the second round of visits (hereafter referred to as Round II) to be conducted between January 2011 and June 2011.

Strategy for Round II

The strategy for the Round II was agreed as below

Scope of Round II (geographic)

In order to ensure that the POs/TSU/SACS have transplanted the learning of the NTSU visits in the remaining facilities of the 67 districts, the round II visits would be made to the other facilities (not visited in round I) in these 67districts. The NTSU team would observe the POs/TSU/SACS officials carry out the capacity building exercises at the facilities. The round II visits would be carried out between January 2011 and June 2011

Mentoring and Capacity Building

POs- Round II would ensure that all POs of the state are covered during the visit to districts. In case there are more than one priority districts in the state, the POs would be asked to participate in groups. However, if only one priority district is to be covered in the state, all the POs would be required to be present for the district visit.

DAPCU - Visits would be co-ordinated to ensure that one representative from DAPCU would also be present for the visit. Skills of the DAPCU such as analytical, strategy and program management would be built to facilitate the development of "District Action Plan" by DAPCU.

SACS/TSU – NTSU would participate in the periodic review of the POs/TSU/SACS. Based on field observations, thematic (need based) 1/2 day capacity building workshops would be organised in the state.

NACO - NACO TI and STI division officers would also be present during round II visits.

System strengthening - Based on field visit observations, specific input would be provided to strengthen the supply chain systems in the state for STI drug kits, condoms and Needles/ Syringes.

Reporting - The visiting officers would ensure that all the reports are compiled by the end of the visit day. Efforts would be made as far as possible to prepare reports online. At the end of each month all the facilities in the priority districts would submit the report.

The report would be generated by the respective facility incharge (e.g TI Project manager) and would be sent through TSU/SACS to NACO.

Feedback

Facility - The visiting team from NACO would write down their program feedback in the facility register which would spell out concise action points.

Further on receipt of data from the visited facilities every month, each facility would get feedback on the data submitted i.e

- Query on performance (expected vs. actual)
- Clarifications on data submitted (for discordant/ambiguous data)
- Query/Justification on changes made to previously submitted data (if any)

District – Subsequent to the visits, feedback would be given to DAPCU and the District Collector for follow up and corrective action.

SACS/TSU – Subsequent to the visits, feedback would be given to PD SACS on field observations. Further specific feedback would be provided to other divisions such as STI, IEC, CST, Basic Services & Procurement.

NACO **–** Subsequent to observations made at visited facilities in the districts and consequent interactions with the SACS, feedback would be given to respective divisions at NACO for troubleshooting and providing directives to SACS.

Achievements

- **Districts covered –** 34 districts out of the 67 priority districts in 13 states have been visited by NTSU between January 2011 and June 2011. The only state that was not visited was Nagaland.
- **Facilities visited**
    - 66 TI visits were made and staffs were trained on TI components. TIs in all 34 districts were visited. Of these 31 were visits to FSW TIs, 9 to MSM TIs, 13 to IDU TIs, 12 to Core Composite TIs, and 1 to Migrant TI.
    - 38 DSRC (Designated STI/RTI Clinics) have been visited and staff including doctor, nurse and counsellor have been trained.
    - Clinics in all visited TIs (either static or preferred providers) were seen, and clinic staff have been trained on treatment protocol, STI reporting and clinic management.
    - ICTCs linked to all visited TIs have been visited and referral systems strengthened.
- **Data analysis –** During round I, NTSU developed a 13 indicator format which captured TI performance data that was not available in CMIS. This data helped the team to understand TI performance more rigourously. The team analysed this data and provided feedback to the SACS/TSU for program improvement.

In order to strengthen the response to the epidemic in the priority districts, it was felt that DAPCUs in these districts should be strengthened. It should be noted here that 60 out of the 67 districts have DAPCUs. Thus, in addition to the NTSU visit, DAPCU National Resource Team (DNRT) was also directed to conduct visits to priority districts. As this was decided in April 2011, the DNRT visits to priority districts extended beyond Round II.

Given below are the details of the visits by the DAPCU National Resource Team between April and June 2011

Table 1.1

State	District	Month	ICTC	TI	DSRC	Blood Bank	ART	Link ART Centre	CCC	LWS
Karnataka	Bagalkot	Apr-11	1	2	1		1			1
Karnataka	Belgaum	Apr-11	1	1	1	1	1			
Karnataka	Dharwad	Jun-11	1	2	1		1			
Maharashtra	Sangli	Jun-11	1	1			1		1	
Maharashtra	Satara	Jun-11	1	1	1	1	1			
Nagaland	Kohima	Jun-11				1				
Nagaland	Tuensang	Jun-11	1		1		1			
Tamil Nadu	Namakkal	Jun-11	1	2	1		1	1	1	
Tamil Nadu	Salem	May-11	1	1	1	1	1	1	1	1
Tamil Nadu	Trichy	Jun-11	1	1	1	1	1		1	
Tamil Nadu	Villupuram	May-11	1	1	1	1	1	1	1	
West Bengal	East Medinipur	May-11	1	1	1					
West Bengal	Kolkatta	Jun-11	1		1					
Total Facilities Visited => 62			**12**	**13**	**11**	**6**	**10**	**3**	**5**	**2**

In addition to building the capacities of the DAPCU teams and facilities in the above 13 districts, the DNRT also called upon the District Collector/Deputy Commissioner wherever possible. Accordingly the DNRT met with District Collector/Deputy Commissioner (DC) in Belgaum, Satara, Namakkal, Salem, Trichy and Villupuram between April and June 2011.

During the meeting with the DCs, the DNRT apprised them on the NACP III and its initiatives in the district. They sought the support of the DCs in conducting District AIDS Prevention and Control Committee (DAPCC) meetings and in integration of the NACP program with other departments and schemes in the districts.

- On site demonstration and training has been provided by the NTSU to the following:

Table 1.2

Personnel	No. Trained
JD/DD/AD TI (SACS)	7
DD/AD STI (SACS)	23
TL TI (TSU)	4
PO TI (TSU)	44
PO Clinic (TSU)	12
M&E personnel (SACS/TSU and Partners)	17
TI NGO PM	66
DSRC Doctor	106
DSRC Counsellor	88
Preferred Provider	244
DAPCU staff	53
Total	664

The above table lists only key staff and does not include other staff (e.g TI ORWs, PEs, Counsellor, Accountant etc)

- NTSU team facilitated TI review in the following states

Table 1.3

State	Review conducted in (Month)	State	Review conducted in (Month)
Andhra Pradesh	March 2011	Orissa	January 2011
Delhi	April 2011	Tamil Nadu	January 2011
Karnataka	February 2011 and April 2011	Uttar Pradesh	March 2011
Maharashtra	January 2011	West Bengal	June 2011
Gujarat	January 2011		

The table above. list the TI review conducted between January and June 2011, in states which have priority districts only. Reviews conducted in other states have not been shown above

At the end of the review, detailed action points to improve program performance for facilities, SACS and TSU are formulated.

Major observations

TI programme

- Most SACS/TSU now have good examples of TI implementation in the state. However, only few SACS/TSU have initiated development of TI learning sites.
- Social Marketing outlets are not present in all TIs. Co-ordination between TSU and SMO is needed to improve this.
- Validation of HRGs is needed. Some SACS/TSU have initiated this activity.
- Clinic access has improved significantly. Currently it averages 67% and many states are doing 70 to 80 % in a quarter.
- While syphilis screening has improved it has not reached 100%. Currently it averages at 48% (6 months) in priority districts.
- HIV testing has improved but has not reached 100%. Currently it averages 47% (6 months) in priority districts.
- Needle/Syringe distribution averages at 90% in the priority districts. Part of the gap is due to limited provision in budget by SACS which does not provide for 100% demand.
- Condom distribution has improved and averages at 100% of demand.
- Linkages with ART have improved and TIs are now reporting of old cases (previously detected HIV positive but not linked) being registered.

STI programme

- All TIs are providing package of STI services to HRGs as per NACO guidelines.
- All TIs have identified and trained the preferred providers for STI service delivery.
- STI service uptake at the DSRCs has improved. The average clinic load is about 8-10 patients per day.
- STI service uptake in TI has also improved; about 5-6 HRG access STI services per day.
- Average STI service utilization of STI services in previous year was 2-3 per day.
- 80% of DSRCs have good infrastructure (examination facility, audio visual privacy, space for counselling etc).
- All the DSRC have counsellors. About 78% of the STI attendees have received counselling services from counsellor at DSRC.

- More than 90% DSRCs and TIs are reporting in NACO STI CMIS format.
- Functional linkages between Gynae/Obs department has improved and about 65% of the clinics have shown linkages.
- STI drug kits were not provided to Gynaecology OPDs at 22 DSRCs visited.
- Functional linkages between DSRCs and ICTC have been established. 40% of all DSRC attendees are being referred and tested at ICTC for HIV.
- 60% of all DSRC attendees are tested for syphilis which should now be scaled up to 100%.
- Branding of “Suraksha” clinics has been done at 42 DSRCs which has improved the visibility of the STI services.

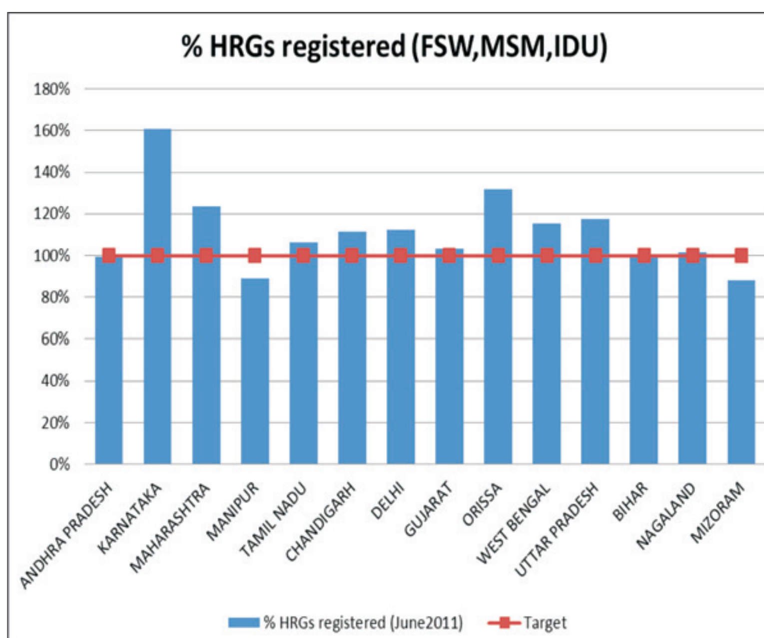
Monitoring and Evaluation system

- TIs now have better clarity on use of revised TI data collection tools.
- Reporting in TI CMIS has been consistent. 91% of all TIs are consistently reporting in CMIS.
- In TIs working with less than 800 HRGs and hence not having full time M&E officers, TI accountants and PMs are completing data entry and report submission.
- Monthly TI data is being analysed at all SACS/TSU. Continuous inputs are being given and it is expected that SACS/TSU now take the analysis to a more mature level. It is also encouraging to note that many TIs are now analysing their monthly performance data.
- TIs need periodic refresher trainings to ensure uniformity in understanding and especially considering the significant turnover in TI staff.
- POs are using TI performance tool to analyse the progress of their TIs.
- Most SACS/TSU are conducting quarterly review of all TIs (PO review) under the leadership of SACS. In some states, review is conducted monthly.
- Priority districts identified by NACO are now receiving special attention by SACS/TSU. The indicators developed to monitor the priority districts are being used for other districts also. Some TSUs are analysing ICTC/PPTCT data to monitor trends of HIV sero – reactivity among districts.
- Some TSUs have come up with innovative M&E training methods (Tamil Nadu developed a software that guides learners through a self-learning tool).

Trends of TI performance among Core Group TIs

The first round of visits was conducted between June and December 2010. Round II was initiated in January 2011 and hence data starting January 2011 is presented in this report. Only data of TIs visited by the NTSU between January and June 2011 in the priority districts has been taken into consideration.

Fig 2.1: Registration of HRGs

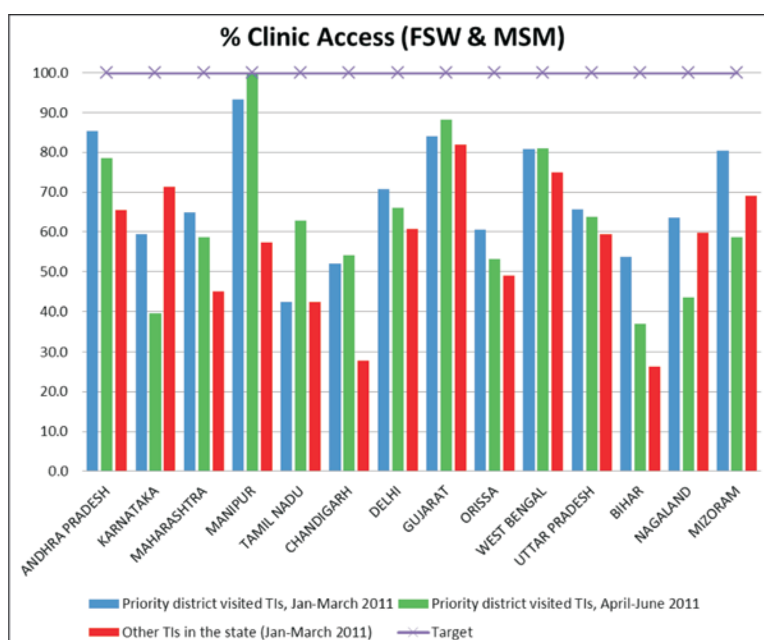


It is expected that 100% of core group HRGs (FSW, MSM and IDU) are registered by TIs and provided services.

- The above graph compares the numbers of HRGs registered by TIs in relation to the target given to them in their contract.
- Among the core group TIs (FSW, MSM, IDU and Core Composite {CC}), Manipur (89%) Mizoram (88%), are close to achieving their targets. Other 12 states have registered 100% or more. Districts that have seen significant correction (reduction) in numbers are Churachandpur (Manipur) and Kolasib (Mizoram).

- During Round I visit, The Core group TIs were directed to identify newer HRGs available in their respective areas and not limit the registration to the target given. Thus, 9 states of Karnataka, Maharashtra, Tamil Nadu, Delhi, Gujarat, Orissa, West Bengal, Uttar Pradesh and Chandigarh have registered beyond their respective TI contracted targets.
- HRGs that are inaccessible for 6 months are being "dropped out" periodically.
- The TIs have been trained to ensure that "most at risk HRGs" are being covered by TI services on priority.

Fig 2.2: Clinic access by HRGs

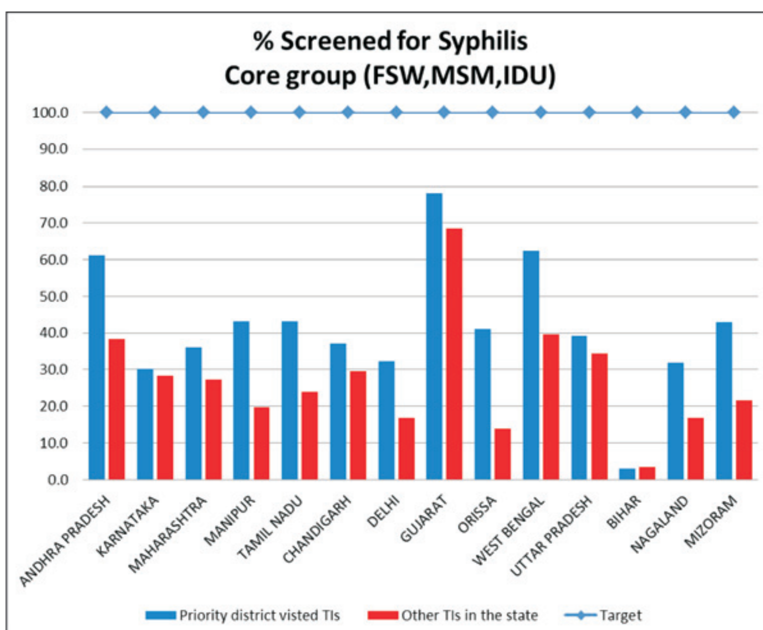


- It is expected that 100% HRGs access clinic services in a quarter and hence the target line.
- The graph above is indicative of the clinic access w.r.t the number of HRGs (FSW and MSM) registered and not in reference to the TI contract target. Further the HRG registration figure has been taken as the 'average cumulative HRGs registered' for the respective quarter. This is done to compare the clinic access with the number of HRGs available in that period.

- It is seen that TIs are yet to achieve 100% clinic access in quarter. Among states that have significant FSW population coverage, Andhra Pradesh, Gujarat and West Bengal have averaged 80% clinic access per quarter in priority districts. All the states (priority districts) average 50% or more clinic access in the quarter.
- The red bars indicate the performance of the TIs in all the districts of the respective states (as reported in TI CMIS). An attempt has been made to compare the performance of the 'TIs visited in the priority districts' with the remaining TIs of the respective state. In 12 of the 14 states taken into consideration TIs visited in priority districts (Blue bar) have performed better that the rest of the TIs in the state (Red bar) for the same period (Jan to Mar 2011).

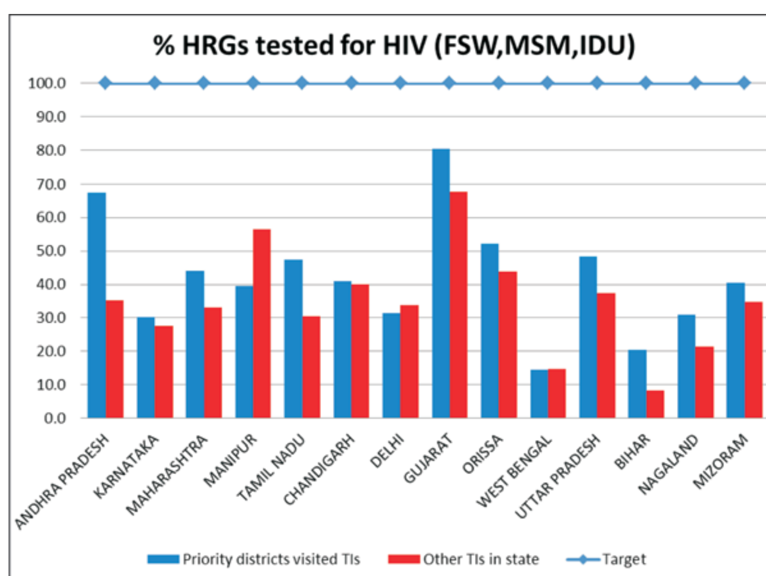
The above graph does not include data from IDU TIs as they do not attempt 100% clinic access in a quarter

Fig 2.3: HRGs screened for syphilis



- It is expected that 100% HRGs are screened for syphilis once every 6 months and hence the target line.
- The graph above is indicative of the HRGs screened for syphilis w.r.t the number of HRGs registered and not in reference to the TI target.
- The graph above is indicative for % of the HRGs (FSW, MSM and IDU) screened for syphilis from January 2011 to June 2011 among those registered. Further the HRG registration figure has been taken as the 'average cumulative HRGs registered' for 6 months of January to June 2011. This is done to compare the syphilis screening with the number of HRGs available in that period.
- It is seen that TIs are yet to achieve 100% syphilis screening in 6 months. Among states that have significant core group numbers, Gujarat has achieved around 80% syphilis screening while Andhra Pradesh and West Bengal have achieved 60% syphilis screening during 6 months in priority districts. All the other states (priority districts) are below 50% syphilis screening during 6 months in priority districts
- In 13 of the 14 states taken into consideration, TIs visited in priority districts (Blue bar) have performed better that the rest of the TIs in the state (Red bar). Here again, TI CMIS data has been utilised for 'rest of the state' performance. The performance is at par in Bihar

Fig 2.4 : HRGs tested for HIV



- It is expected that 100% HRGs access ICTC for HIV testing once every 6 months and hence the target line.
- The graph above is indicative of the HRGs tested for HIV w.r.t the number of HRGs registered and not in reference to the TI target.
- The graph above is indicative for % of the HRGs (FSW, MSM and IDU) tested for HIV from January 2011 to June 2011 among those registered. Further the HRG registration figure has been taken as the 'average cumulative HRGs registered' for 6 months of January to June 2011. This is done to compare the HIV testing with the number of HRGs available in that period.
- It is seen that TIs are yet to achieve 100% HIV testing in 6 months. Among states that have significant core group numbers, Gujarat has achieved 80% HIV testing while Andhra Pradesh has achieved 60% and Orissa 52% HIV testing during 6 months in priority districts. All the other states (priority districts) are below 50% HIV testing during 6 months in priority districts
- In 11 of the 14 states taken into consideration, TIs visited in priority districts (Blue bar) have performed better that the rest of the TIs in the state (Red bar). Here also, TI CMIS data has been utilised for 'rest of the state' performance. In Manipur and Delhi, rest of the TIs in the state have performed better than the TIs visited in priority districts. The performance is at par in West Bengal.

Most states reported intermittent availability of HIV test kits during the period as the single most factor adversely affecting the testing of HRGs.

Table 1.4 – HIV positivity and PLHIVs linked to ART (among HRGs)

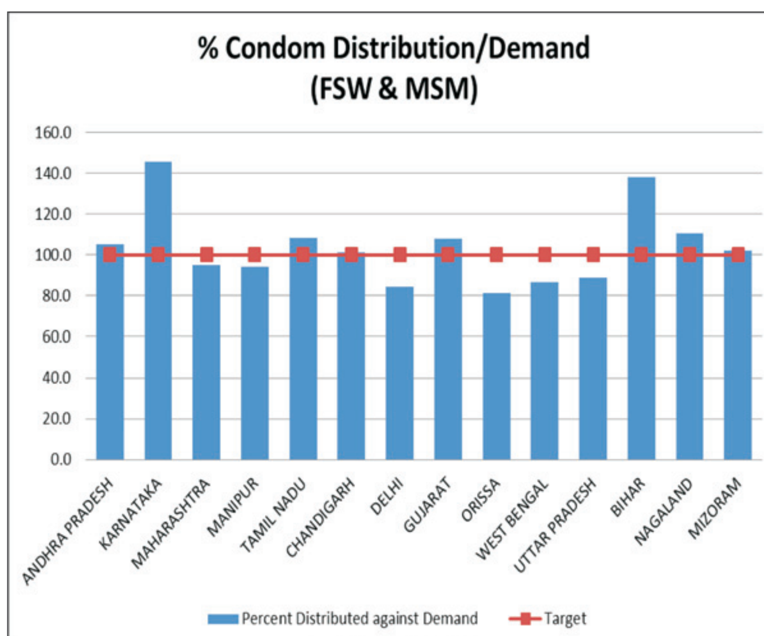
State	Tested at ICTC (FSW,MSM, IDU)	Found HIV positive	% detected HIV Positive	Linked to ART
Andhra Pradesh	33,368	132	0.4	116
Karnataka	13,436	242	1.8	93
Maharashtra	11,833	262	2.2	373
Manipur	1,407	34	2.4	26
Tamil Nadu	7,429	32	0.4	23
Chandigarh	2,046	6	0.3	4
Delhi	2,826	39	1.4	13
Gujarat	17,569	78	0.4	59

State	Tested at ICTC (FSW,MSM, IDU)	Found HIV positive	% detected HIV Positive	Linked to ART
Orissa	1,556	7	0.4	10
West Bengal	2,958	60	2.0	68
Uttar Pradesh	2,342	9	0.4	4
Bihar	120	6	5.0	0
Nagaland	1,081	25	2.3	31
Mizoram	1,056	30	2.8	60
Total	**99,027**	**962**	**1.0**	**880**

- The above table provides HIV positivity among HRGs (FSW,MSM and IDU) tested between January to June 2011 in priority districts. Bihar (Katihar) has shown 5% but total number of HRGs tested is less (120). 5 states (Maharashtra, Manipur, West Bengal, Nagaland and Mizoram) showed 2% or more sero-reactivity. *It should be noted here that TIs attempt to refer only 'known HIV sero-negatives' to ICTC. Known positives (HRGs detected HIV positive in tests prior to January 2011) are not included in this table.*
- The table also provides data of the PLHIVs (HRGs) linked to ART. As the HRGs are difficult to reach populations, TIs play a crucial role in ensuring the linkage.
- It is expected that all the HRGs detected HIV positive are linked to ART centres. Out of the 962 HRGs found positive, 880 were reported as registered with ART centres.
- The states reporting excess PLHIVs linked for ART is due to HRGs detected HIV positive in the past but not registered with ART which were subsequently linked. This was seen in Maharashtra, Orissa, West Bengal, Nagaland and Mizoram.
- Significant gap in linking PLHIVs to ART was seen in Karnataka, Delhi and Gujarat. During the field visits, NTSU team members reiterated the importance of ensuring that PLHIVs detected be linked to ART centres. *Some gap is attributed also to 'unknown cases' where HRGs have registered with ART but not shared the same with TI. However, TIs attempt to refer all detected PLHIVs (HRGs) to ART centre.*

- Additionally
  - TIs are now trained to ascertain that the linkage match beyond numbers.
  - { numbers represented above should link to the same individuals (those who have reported as being tested positive and those registered with ART centres) }
  - Capacities to carry out "Positive Prevention" in TIs are being built to ensure that the Positive HRGs are accessing TI services.

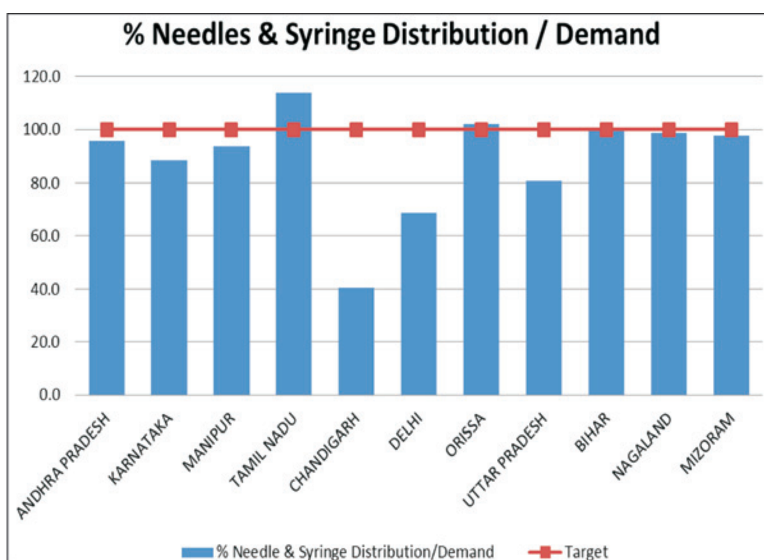
Fig 2.5: Condom distributed to HRGs



- The above graph indicates the % of condoms distributed directly by TI staff and PEs to HRGs in comparison to the respective demand of the HRGs. Data from TIs for FSWs and MSMs has been taken into account. This was done by computing the average condom distribution / average condom demand for the months of January to June 2011
- It is expected that 100% of condom demand for core group HRGs is met through direct outreach. As seen in the graph above, 9 states have distributed 100% and more compared to their demand through direct outreach. This is encouraging considering that the data has been taken for the registered HRGs (for the same period) and not the contract target wherein the number of HRGs have exceeded the target. It has also been seen that when HRGs are dropped out, condom demand has been corrected.

- After consistent mentoring, all states now factor actual condom demand as stated by each HRG based on number of sex acts instead of estimates that were earlier used to calculate demand.
- *This performance indicator was not compared with condom distribution in other TIs in the states for which TI CMIS data is used. As CMIS does not factor in actual demand (based on sex acts) the two data sets were not comparable.*

Fig 2.6: Needles/Syringes distributed to IDUs



- The above graph indicates the % of N/S distributed directly by TI staff and PEs to IDUs in comparison to the respective demand of the IDUs. Data from TIs covering IDUs has been taken into account. This was done by computing the average Needles & Syringes distribution / average Needles & Syringes demand for the months of January to June 2011.
- It is expected that 100% of N/S demand for IDUs is met through direct outreach. As seen in the graph above, 3 states have distributed 100% and more compared to their demand through direct outreach. *However, numbers of IDUs reached by two of these states (Bihar and Tamil Nadu) is less.* 4 states have shown 90% and more distribution compared to their demand. Of these, 3 states (Manipur, Nagaland and Mizoram) manage significant number of IDU population. Hence this is encouraging.

It has been seen that when IDUs are dropped out, N/S demand has been corrected. *Chandigarh has shown the least N/S distribution vs. demand. During the visit to Chandigarh, NTSU members learnt that TIs are not allowed to procure N/S beyond the cost of INR 1,50,000/- in a financial year due to stipulations of procurement guidelines. However, there was some misinterpretation of the guidelines and this matter was brought to the notice of NACO for rectification and has been addressed.*

- After consistent mentoring, all states now factor actual N/S demand as stated by each IDU based on number of injecting acts. *However, most SACS do not provide budget to procure for 100% N/S. During the visits to the states, NTSU conveyed to POs to assess actual demand and put it up for consideration by SACS to provide N/S budget for 100% demand.*

- *This performance indicator was not compared with N/S distribution in other TIs in the states for which TI CMIS data is used. As CMIS does not factor in actual demand (based on injecting acts) the two data sets were not comparable.*

No IDU TIs were visited in Maharashtra, Gujarat and West Bengal and hence these states do not feature in the above graph.

Major Observations in each district visited

Table 1.5

<table>
<tr><th colspan="2">Delhi</th></tr>
<tr><td colspan="2">• SACS and TSU should identify learning sites for each PO in addition to learning sites for STRC.
• TI wise Hotspot list needs to be shared with Condom TSG for SMO outlets.
• TSU POs should share their visit plans with Condom TSG so that joint visits can be made.
• STRC should make training plan in close consultation with TSU.
• Re-validation of HRGs across all TIs should be conducted.
• State (2 priority districts) has reported low numbers of HIV testing (14% in 1st quarter*) . Syphilis testing is also low (12% in 1st quarter).
• TI - ART linkage needs strengthening. Out of the 43 detected positive in the two priority districts during 1st quarter, only 17 were linked to ART.</td></tr>
<tr><td>Delhi North</td><td>Linkages with Govt. STI facilities need to be strengthened so that service delivery is not limited to TI clinic and PPP</td></tr>
</table>

<table>
<tr><td rowspan="4">Delhi
North East</td><td>BPS FSW has reported low syphilis screening (7% in 1st quarter)</td></tr>
<tr><td>JYM has reported low syphilis screening (1% in 1st quarter)</td></tr>
<tr><td>SACS and TSU M&E to organise a two day orientation for all the 3 DAPCU staff on the TI monitoring indicators.</td></tr>
<tr><td>Risk Prioritization, vulnerability of HRGs, condom demand calculation and community master register to be updated every quarter at each TI</td></tr>
<tr><td colspan="2" align="center">Karnataka</td></tr>
<tr><td colspan="2">
All TIs to be transitioned in 2012 should be visited by TSU and KSAPS to ensure that alignment to NACO guidelines is completed prior to transition.
SACS and TSU need to identify TI learning sites across all partners for replication of best practices.
NRHM convergence is being done and most of the 24*7 PHCs are involved in provision of PPTCT services. The health system machinery like (ASHAs, ANMs, etc) was being utilised effectively for follow up to ensure HIV testing of ANC mother, positive ANC mothers for institutional delivery, NVP coverage.
All the PHC medical officers have been trained in Syndromic Case Management. Colour coded STI drug kits have been supplied from NRHM to its facilities.
SACS needs to review innovative IEC/BCC material prepared by KHPT, Ashodaya Samiti, Swati Mahila Sangha and consider adaptation.
Re-validation of HRGs across all TIs should be conducted.
</td></tr>
<tr><td rowspan="5">Bangalore</td><td>Condom demand analysis should be done based on number of sexual encounters (previous week's recall method) for each HRG.</td></tr>
<tr><td>Gaps observed in understanding of TI/STI CMIS monthly reporting formats.</td></tr>
<tr><td>Understanding among STRC staff, TSU personnel and TI staff needs to be uniform.</td></tr>
<tr><td>Maintain the individual HRG tracking sheet for RMC, Syphilis screening and HIV testing.</td></tr>
<tr><td>SPAD TI PM found ineffective in TI quality implementation The TI DIC and Clinic is not operational according to HRG availability.</td></tr>
</table>

Dharwad	The MSM TI intervention is good and SACS/TSU can utilise TI for exposure visit from other MSM TIs so that best practices can be replicated.
	MSM TI HRGs are in process of forming a CBO but there is division among the community members w.r.t affiliation. SACS/TSU should get involved and address the issues for smoother transition.
	SACS/TSU should address needs of innovative IEC material expressed by MSM population.
Koppal	DAPCU should facilitate the distribution of coverage areas between LWS and TI to prevent overlapping in coverage.
	MSM TI needs to ensure that no HRGs are left out in service delivery. In absence of PE, ORW should take over outreach responsibility.
Gulbarga	Outreach depends on micro-credit program. But only 1063/3666 HRGs are covered under micro credit. SACS/TSU needs to restructure outreach.
	Individual tracking for clinic access and condom distribution is weak. Needs strengthening.
	Use of outreach formats by PEs is weak and needs to be strengthened.
Bagalkot	TI - ART linkage needs to be strengthened. FSW TI detected 60 HIV positives in 1st quarter but only 5 were linked to ART.
	Condom demand needs to be corrected. In FSW TI, Condom distribution does not match demand i.e 3.9 lakh condoms were distributed vs. demand of 1.4 lakh condoms for the same period. Similar mismatch seen in MSM TI also.
Orissa	
Khurda	Lepra (IDU TI) in Bhubaneswar. -Needle/Syringe return was not being recorded based on actual but as reported by PEs. This did not give correct assessment of TI performance. - In some PEs, the clinic due/overdue date was only tracked in 1st week and was missing for subsequent weeks. - Gloves used for picking up used Needles/Syringes to be changed to thick electrician gloves instead of currently used thin surgical gloves. - No contract with bio-medical waste agency. TI recommended to complete the contracting formalities at the earliest. - BCC message to be developed to correct the practice of recapping the used needles/syringe.

<table>
<tr><td>Ganjam</td><td>Janasadhana both FSW and MSM TIs showed low clinic access 24% and 17% respectively in 1st quarter. the same TIs showed high rate of STI treated (66% and 36% of clinic attendees respectively) in the same quarter.</td></tr>
<tr><td></td><td>Aruna FSW and MSM TIs showed high rate of STI treated (27% and 30% of clinic attendees respectively) in 1st quarter. None of the HRGs were screened for syphilis in 3 months for both the FSW and MSM TI.</td></tr>
<tr><td colspan="2" align="center">West Bengal</td></tr>
<tr><td colspan="2">• Team Leader TSU needs to be recruited and team issues need to be addressed.
• Many TIs had near expiry STI drugs. SACS/TSU needs to address this.
• PD SACS may conduct Monthly review of TIs.
• Refresher training needed on TI/STI CMIS and data collection tools for common understanding.
• Re-validation of HRGs across all TIs should be conducted.</td></tr>
<tr><td>Kolkata</td><td>Gynaecologists of NRS Medical College and Victoria Women and Child Hospital need to be trained on SCM and linked with for TI program.</td></tr>
<tr><td></td><td>STI drug kits at the DSRC need to be replaced.</td></tr>
<tr><td></td><td>DMSC Ship program needs to reviewed thoroughly for HRG registration, clinic uptake, ICTC testing and condom demand vs. distribution analysis. The peers are of old age and may not be effective with the young sex workers.</td></tr>
<tr><td></td><td>Reports of TSU POs indicating that TIs have inflated HRG numbers needs to be looked into by SACS.</td></tr>
<tr><td>Barddhaman</td><td>Form B is filled by ORWs instead of PEs.</td></tr>
<tr><td></td><td>Risk Prioritization, vulnerability of HRGs, condom demand calculation and community master register to be updated every quarter at each TI.</td></tr>
<tr><td></td><td>Condom demand needs to be redone (Current method is not based on last week's recall and hence outdated).</td></tr>
<tr><td></td><td>TI staff need re-orientation on Form B as understanding is weak.</td></tr>
<tr><td></td><td>Vivekananda Education Society -Mecheda showed high STI treated figures (28% of clinic attendees) in 1st quarter. This needs to be looked into DMSC GBIP Zone -4-DMSC Kanthi/Contai showed high STI treated figures (31% of clinic attendees) in 1st quarter. This needs to be looked into. HIV testing is also low (7% in 1st quarter).</td></tr>
<tr><td></td><td>BBDNKS had not tested single HRG for HIV in 1st quarter. This needs to be looked into.</td></tr>
</table>

Purbi Mednipur	Since 2010, Digha ICTC is not functional and nearest ICTC is at Kontai (45 kms away).
	TIs had not received funds since April 2010. VES TIs in Macheda and Haldia severely affected.
	Condom demand is met largely by social marketing (60%). SACS/TSU should assess effectiveness.
	SACS/TSU to build capacity of TI on advocacy with police.
Andhra Pradesh	
• **HIV testing at ICTC is low in state for the priority districts (29% in 1st quarter)** • **Several of the TIs have reported HRGs detected positive but not/partially linked to ART** • **Condom distribution is not in relation to condom demand in most of the TIs**	
Hyderabad	Suraksha MSM TI – Registration is 1304 (target is 1000). SACS needs to reviews and revise target.
	Suraksha – HIV testing is low 372/1245 between January to June 2011.
	Suraksha – Syphilis screening started late (March 2011). 315/1245 screened since then.
	IRDS FSW – Major dip in HRG numbers seen in April 2011 (1530 to 980).
	IRDS – Syphilis screening is low (401/1418) between Jan and June 2011.
	IRDS – Condom distribution not as per demand (e.g 72400 distributed vs. demand of 110,233).
Krishna	RIDES FSW showed 13 treated for syphilis in 1st quarter when only 1 detected syphilis sero-reactive. This needs to be examined.
	Guide Composite – Syphilis screening needs to improve. 797/1343 screened between Jan and June 2011.
	Guide Composite – Condom demand needs to be examined. Huge drop in April 2011 (from 143460 to 84820).
Vishakapatnam	DSRC has good infrastructure for STI service delivery.
	Good number of clinic attendees in DSRC but linkages with ICTC is poor (only 20% of STI attendees were referred for HIV testing).
	STI drug kits not provided in Gynae/Obs clinic.
	MSM TI – low STI reported and internal exam (proctoscopy) limited.

Vizianagaram	Chaitanya TI – No clinic access between Jan to March 2011 . Also no individuals screened for syphilis in the same period. This needs to be looked into.
	RES TI – Clinic access data needs to be looked into for Jan to June 2011 (1441/1353 visited clinic). Purpose of repeat visit (if any) needs to be examined. HIV testing is good. Syphilis screening needs to improve 834/1353 for Jan to June 2011.
Guntur	Route/schedule of Mobile ICTC should be planned in consultation with TIs so that remote hotspots are covered.
	Gramasiri has low registration - 1658 / 2190 for FSW and 64 / 384 for MSM. No change from January to March 2011.
Anantapur	CERA 2 TIs – HRG registration saw huge drop in Feb'11(1469 to 1001 and 1820 to 1146). This needs to be examined.
	CERA - HIV testing and syphilis screening is good.
Maharashtra	
Mumbai & Mumbai Suburban	Risk Prioritization, vulnerability of HRGs, condom demand calculation and community master register to be updated every quarter at each TI.
	Aditi Unit 2 – 976 HRGs registered (TI contract 800). SACS may consider revising target. TI ART linkages need to be strengthened. In Unit 2 - Only 2 of 11 detected HIV positive between Jan and March 2011 were linked to ART. HIV testing is good.
	Aditi Unit 2 – Condom distribution is low (especially in Feb'11, Apr'11 and June'11).

Uttar Pradesh	
• **SACS needs a person dedicated to M&E to compile CMIS reports. Currently compilation dependent on TSU** • **N/S demand in IDU TIs needs to be re-examined** • **HIV testing in prirorty districts is low (5% in 1st Quarter)** • **Syphilis screening is also low (13% in 1st Quarter)**	
Allahabad	MSM TI Swarg needs to be trained on advocacy with stakeholders.
	Sawrg – 2 PPPs need training on internal examination.
	Swarg – Several HRGs missed out on PT due to weak individual tracking.
	SACS/TSU need to work out provision for lubes to MSM TI.
Chandigarh	
Chandigarh	PO needed to improve supportive supervision.
	No dropouts reported from TIs for last year. This needs to be examined
	Certain TIs practising 'administration of PT in the field'. SACS should ensure TIs encourage HRGs to access clinic for comprehensive STI checkup.
	Re-validation of HRGs across all TIs should be conducted.

Gujarat	
• **SACS needs to carry out demand generation activities to popularise STI services** • **SACS should ensure that printed IEC are available at the DSRC** • **Doctors from the Gynae/Obs, Skin/VD should be included in the SACS training on SCM**	
Vadodara	Vikas Jyot (FSW TI) in Baroda - Risk and vulnerability factors have not been used to prioritise HRGs for intervention. The clinic due/overdue date was only tracked in 1st week and was missing for subsequent weeks. There was feedback from the community that the January 2011 batch of condoms is unusually salty in taste. This feedback was received from the FSW community who had used the condoms for oral sex. Previously, the FSWs had not experienced any such taste in the condoms provided.
	Jamanabai hospital was not treating STI cases but referring them to SSG Medical college (treatment opportunity lost).
	Regional STI centre's activities need to be reviewed monthly.
	Equipment available at the Regional STI centre need to be made functional.
	Linkages between Gynae/Obs and Skin/VD need to be strengthened
	Lakshya Unit 2 is unable to register HRG population as per target. SACS needs to revise target.
	Lakshya 4 Units – clinic access needs to improve (2389/3948 for Apr to June 2011).
	Lakshya 4 Units – HIV testing needs to improve (2482/3948 for Apr to June 2011).

Surat	Sahyog Mahila Mandal (FSW TI) in Surat - HRGs not prioritized for intervention. Risk and vulnerability factors not filled and hence not taken into consideration. PEs not marking HRGs who are 'due/ overdue' for clinic visit. Doctor does not fill 'reason for visit' – new, old, symptomatic etc. Doctor is not taking sexual history. HRGs do not undergo internal examination. Referral linkage with the ICTC was reasonably good. No Female condom is available. Social marketed condoms of Zaroor and Nirodh Deluxe were available.
	At New Civil Hospital, doctors were not following SCM for treating STI cases.
	Limited co-ordination between Gynae and Obs Department seen in all DSRCs.
	SACS should ensure that regular medical checkup provided to HRGs includes genital examination (speculum and proctoscope), counselling and provision of condoms.
Mahesana	CGVT – Clinic access, syphilis screening and HIV testing is good. Condom demand saw sudden surge in Oct 2010 (from 9007 to 11,258) without any change in HRG numbers. This needs to be examined. Current condom demand is also low (20 per HRG per month).
	Young Citizens - Clinic access, syphilis screening and HIV testing is good.

Rajkot	In 2 MSM TIs – low condom demand, low numbers of STI treated. SACS needs to validate population and also check for overlapping/ duplication.
	Navjeevan Trust – 925 HRGs registered (TI Target 655). SACS needs to validate and revise target.
	Navjeevan – HIV testing needs to improve (374/655 tested between Jan and June 2011). The performance will further decrease if HIV testing is considered against 925 registered.
	Navjeevan – Average condom distribution from Jan to June 2011 is 16,000 but condom demand is shown as 13,000. This needs to be examined.
Tamil Nadu	
• **SACS needs to conduct monthly review of all TIs (PO review) to ensure uniformity in understanding of performance indicators.** • **Across all TIs, condom estimation needs to be corrected and calculated as per actual number of sex acts.** • **SACS/TSU should conduct prescription audit of all TI clinics especially PPPs to ensure that all STIs are diagnosed and correctly treated. Further PPPs should be oriented every quarter on SCM.** • **Terms of reference for post transition support have to be drawn by SACS/TSU.**	
Chennai	Karunalaya FSW TI – HRG registration reduced by 200 in June 2011. This needs to be examined (dropouts or correction etc).
	Karunalaya – clinic access needs to improve (372/1102 from April to June 2011).

Namakkal	NTWVT FSW– HIV testing needs to improve (756/1547 from Jan to June 2011).
	NTWVT FSW – Syphilis screening needs to improve (725/1547 from Jan to June 2011).
	NTWVT MSM – Only 617 registered (Target 700).
	NTWVT MSM - HIV testing needs to improve (256/617 from Jan to June 2011).
	NTWVT MSM – Syphilis screening is poor and needs to improve (129/617 from Jan to June 2011).
Salem	SATWVT FSW 1 – saw a surge in clinic access in May and June 2011 (396 in Apr to 631 in May and 752 in June). This needs to be examined.
	SATWVT FSW 1 and 2 – HIV testing needs to improve (Unit 1 - 808/2040 and Unit 2 – 792/2031) from Jan to June 2011.
	SATWVT FSW 1 and 2 – HIV testing needs to improve (Unit 1 - 761/2040 and Unit 2 – 980/2031) from Jan to June 2011.
	All TIs have shown inconsistent condom demand. This needs to be examined.

<table>
<tr><th colspan="2">Manipur</th></tr>
<tr><td colspan="2">
Needle/Syringe return rate should be calculated from actual collection of used N/S at the DIC and office/clinic on ‘incidental’ basis compared to the N/S distributed.
Due to lack of availability of trained MBBS doctors to serve in TI clinics, Orchid project had trained the ANMs to conduct internal examination. This could be a useful model in other districts where shortage of trained/qualified doctors was felt.
It was recommended that IDU TIs encourage the community to access clinic services (100% every quarter). Clinic visits would provide much needed counseling to IDUs on harm reduction and also give the TI doctor an opportunity to screen for abscesses and STI.
Most IDU Tis are not meeting 100% of the N/S demand of the community due to budget restrictions. It was recommended that SACS look into actual N/S requirement and consider increasing the budget incrementally based on improving N/S return rate.
It was observed that there is a possible overlap in intervention with YARD and SASO addressing the same population in Thoubal. It was recommended that SACS organize a meeting where Orchid presents a list of hotspots where they work which would be compared with the hotspots of SACS supported Tis and areas would be demarcated.
It was recommended that a joint review of POs of NERO and Orchid be organized every month by Manipur SACS. This will bring in uniformity of program priorities.
</td></tr>
<tr><td rowspan="5">Imphal</td><td>MLSS – Though FSW TI has ICTC co-located with DIC, HIV testing is low.</td></tr>
<tr><td>MLSS – All ICTC attendees must also be screened for syphilis. This will help improve syphilis screening.</td></tr>
<tr><td>MLSS –Condom availability was low. SACS/NERO POs need to ensure that there is no stockout.</td></tr>
<tr><td>IDU TIs - Final waste disposal of used/returned N/S is poor across all TIs.</td></tr>
<tr><td>IDU TIs – N/S distribution mechanism is as per guidelines but 100% demand is not met.</td></tr>
</table>

<table>
<tr><td rowspan="2">Churachandpur</td><td>Orchid project in Churachandpur had developed an incinerator with the help of MSF which was very useful for the disposal of used N/S. In absence of incinerators in hospitals in Manipur, the incinerator model could be replicated in all districts.</td></tr>
<tr><td>The Female IDU program has provided adequate rationale for working with spouses of IDUs and also mapping of female sex workers who are also injecting drugs.</td></tr>
<tr><td rowspan="6">Bishnupur</td><td>CARE IDU – has registered 1332 vs. target of 1000. SACS may need to revise target.</td></tr>
<tr><td>Post transition support plan needs to be developed by SACS and Orchid.</td></tr>
<tr><td>CARE IDU TI is showing significant STI treated (64/549 from Apr to June 2011). This needs to be examined.</td></tr>
<tr><td>CARE - HIV testing needs to improve (487/1377 from Jan to June 2011).</td></tr>
<tr><td>CARE – Syphilis screening needs to improve (433/1377 from Jan to June 2011).</td></tr>
<tr><td>CARE – N/S demand needs to be examined. Figures have changed every month from Jan to June 2011.</td></tr>
<tr><td colspan="2" align="center">Mizoram</td></tr>
<tr><td colspan="2">
SACS TI division needs to advocate with young Mizo Association and Church network for effective TI implementation.
It is recommended that monthly review be conducted of TIs (PO review) by NERO and at least once in a quarter by PD SACS.
SMO has to visit TIs and setup non-traditional SM outlets.
PHC doctors need to be trained in SCM.
STI drug kits and condoms are in short supply. SACS needs to intervene.
</td></tr>
<tr><td rowspan="5">Aizawl</td><td>TIs need special attention. District review is recommended.</td></tr>
<tr><td>TIs need capacity building on analysing CMIS data and utilising for program improvement.</td></tr>
<tr><td>District plan that was recently developed needs to be used to monitor program performance.</td></tr>
<tr><td>SACS needs to address the non-performance of 2 FSW TIs.</td></tr>
<tr><td>TIs need SM outlets.</td></tr>
</table>

Kolasib	District needs mobile ICTC. SACS to propose.
	Possible overlap between TI and LWS. SACS needs to facilitate geographical allocation.
	TIs need to provide condoms as per demand (sex acts).
	TI ICTC linkage needs to be strengthened. HIV testing among HRGs is low.
Champai	N/S distribution should be as per demand (injecting acts). SACS needs to rework budget of N/S provision.
	DIC attendance is low. NERO POs need to re-strategize (DIC location, timing, community preference etc).
	Possible overlap between TI and LWS. SACS needs to facilitate geographical allocation.

*1st quarter refers to the period January 2011 to March 2011

Next Steps

The focus of Round II visits to the priority districts was to observe the replication of the quality supportive supervision by SACS/TSU in remaining facilities of the 67 districts (that were not visited by NTSU in Round I). The focus of Round III visit to priority districts will be

- Build capacity of the newly/recently recruited personnel from SACS/TSU on supportive supervision by on-site mentoring and accompanied visits.
- Observe the replication of quality supportive supervision by SACS/TSU in other facility centres of the 67 priority districts (not visited by NTSU in Round I and Round II).
- Besides visiting facilities previously not visited in RI and RII, NTSU would also focus on visiting weak performing and difficult TIs based on feedback from SACS/TSU and analysis of CMIS.
- While visiting TIs in priority districts 2 additional tasks will be undertaken
  - Assess the training provided by the STRC and give feedback to SACS/NACO
  - Meet with the DAPCU to discuss - a) Issues that may have been pointed out by National DAPCU Resource Team, b) Issues of co-ordination between HIV facilities in the district

- The team would assess supervisory human resources available in the state and districts. Subsequently a plan will be developed to build the capacity of these supervisory structures.
- The team will continue to participate in state review of TI and STI program with a special focus on review of each facility in the 67 districts. The objective of participation in the review is to strengthen the program monitoring by SACS/TSU and resolve program gaps observed during field visit. DAPCUs from the priority districts will be invited to attend the reviews to strengthen district level monitoring of the program and improvement of supply chain of essential commodities such as condoms, STI drug kits, HIV test kits etc.
- Performance data of the facility centres in the priority districts will be analysed periodically and specific feedback will be given to SACS/TSU/DAPCU/POs for program improvement.

Round III visits will be conducted between July and December 2011.

Visit Information – List of Facility Centres visited

Table 1.6

Month	State/UT visited	District Visited	Name of Facility visited	Type of Facility
January	Andhra Pradesh	Guntur	Area Hospital, Bapatla	DSRC
January	Andhra Pradesh	Guntur	Gramisiri	Core Composite
January	Andhra Pradesh	Hyderabad	Area Hospital, King Koti	DSRC
January	Andhra Pradesh	Hyderabad	Area Hospital, Nampally	DSRC
January	Andhra Pradesh	Hyderabad	Suraksha	MSM TI
January	Andhra Pradesh	Hyderabad	IRDS	FSW TI
January	Andhra Pradesh	Krishna	District Hospital, Machilipatnam	DSRC
January	Andhra Pradesh	Krishna	Area Hospital, Nuzividu	DSRC

Month	State/UT visited	District Visited	Name of Facility visited	Type of Facility
January	Andhra Pradesh	Krishna	GUIDE, Machilipatnam	Core Composite
January	Andhra Pradesh	Krishna	RIDES	FSW TI
January	Bihar	Katihar	District Hospital, Katihar	DSRC
January	Bihar	Katihar	Health Line	IDU TI
January	Bihar	Katihar	Welfare India	FSW TI
January	Gujarat	Vadodara	Vikas Jyot	FSW TI
January	Gujarat	Surat	Sahyog Mahila Mandal	FSW TI
January	Karnataka	Bagalkot	District Hospital	DSRC
January	Karnataka	Bagalkot	Chaitanya Mahila Sangha	FSW TI
January	Karnataka	Bagalkot	Milana	MSM TI
January	Karnataka	Dharwad	KIMS	DSRC
January	Karnataka	Dharwad	District Hospital	DSRC
January	Karnataka	Dharwad	Corporation Hospital 1	DSRC
January	Karnataka	Dharwad	Samraksha	FSW TI
January	Karnataka	Dharwad	Suraksha	MSM TI
January	Karnataka	Dharwad	Corporation Hospital 2	DSRC
January	Maharashtra	Mumbai	Aditi	FSW TI
January	Orissa	Khordha	Lepra Society	IDU TI
January	Orissa	Ganjam	Aruna	Core Composite
February	Andhra Pradesh	Anantapur	Anantapur Area Hospital	DSRC
February	Andhra Pradesh	Anantapur	Government Medical College, Anantapur	DSRC

Month	State/UT visited	District Visited	Name of Facility visited	Type of Facility
February	Andhra Pradesh	Anantapur	CERA-I	FSW TI
February	Andhra Pradesh	Vishakapatnam	King George Hospital and Medical College	DSRC
February	Andhra Pradesh	Vizianagaram	Chaitanya Jyoti Women Welfare Society (CJWSS)	FSW TI
February	Andhra Pradesh	Vizianagaram	District Hospital, Vizianagaram	DSRC
February	Andhra Pradesh	Vizianagaram	Resource Education Society	IDU TI
February	Delhi	North	Shaktivahini, IMDT	FSW TI
February	Delhi	North East	JYM	FSW TI
February	Delhi	North East	BPS	IDU TI
February	Delhi	North	Samarth	FSW TI
February	Delhi	North	Abhivyakti	MSM TI
February	Gujarat	Surat	New Civil Hospital	DSRC
February	Gujarat	Surat	SMIMER	DSRC
February	Gujarat	Surat	Sahyog Mahila Mandal	FSW TI
February	Gujarat	Surat	Lakshya Trust	MSM TI
February	Gujarat	Surat	Lokdristi Charitable Trust	Migrant TI
February	Gujarat	Vadodara	Medical College, Vadodara	DSRC
February	Gujarat	Vadodara	Jamnabai District Hospital	DSRC
February	Gujarat	Vadodara	Lakshya Trust	MSM TI
February	Gujarat	Vadodara	Vikas Jyot Trust	FSW TI
February	Karnataka	Bangalore	Swati Mahila Sangha	FSW TI
February	Manipur	Bishnupur	CARE	IDU TI

Month	State/UT visited	District Visited	Name of Facility visited	Type of Facility
February	Manipur	Churachandpur	SHALOM	IDU TI
February	Manipur	Imphal	UNICAM	IDU TI
February	Manipur	Imphal	MLSS	FSW TI
February	Mizoram	Champhai	CODNERC	IDU TI
February	Mizoram	Champhai	Genreserat Society	IDU TI
February	Mizoram	Champhai	New Horizon	Core Composite
February	Mizoram	Kolasib	AMRO	IDU TI
February	Mizoram	Kolasib	CPD	Core Composite
February	Tamil Nadu	Chennai	MMC	DSRC
February	Tamil Nadu	Chennai	Regional STI Training, Research and Reference Laboratory	DSRC
February	Tamil Nadu	Chennai	Stanley Medical College	DSRC
February	Tamil Nadu	Chennai	SRC Stanley	DSRC
February	Tamil Nadu	Chennai	ECS Hospital of Chennai Corporation	DSRC
February	Tamil Nadu	Chennai	Karunalaya	FSW TI
February	Tamil Nadu	Namakkal	District Hospital, Namakkal	DSRC
February	Tamil Nadu	Namakkal	NTWVT	Core Composite
February	Tamil Nadu	Salem	Govt. Hospital, Sankagiri	DSRC
February	Tamil Nadu	Salem	STWVT	FSW TI
March	Bihar	Katihar	Health line	IDU TI
March	Gujarat	Vadodara	Regional STI Training, Research and Reference Laboratory	DSRC

Month	State/UT visited	District Visited	Name of Facility visited	Type of Facility
March	Gujarat	Vadodara	Govt. Medical College	DSRC
March	Gujarat	Mahesana	District Hospital, Mahesana	DSRC
March	Gujarat	Mahesana	Chuwal Gram Vikas trust, Bechraji	Core Composite
March	Gujarat	Mahesana	Young Citizens of India Charitable Trust	Core Composite
March	Gujarat	Rajkot	PDU Medical College, Rajkot	DSRC
March	Gujarat	Rajkot	Padma Kurub Hospital, Rajkot	DSRC
March	Gujarat	Rajkot	Navjeevan Trust, Shepar	Core Composite
March	Karnataka	Bangalore	SPAD	FSW TI
March	Karnataka	Dharwad	Suraksha	MSM TI
March	Karnataka	Gulbarga	Myrada	FSW TI
March	Karnataka	Koppal	Samrakhsha	Core Composite
April	Bihar	Katihar	Welfare India	FSW TI
April	Chandigarh	Chandigarh	AIWC	IDU TI
May	Tamil Nadu	Chennai	Sahodaran	MSM TI
May	West Bengal	Kolkatta	NRS Medical College Hospital	DSRC
May	West Bengal	Kolkatta	Victoria Women & Child Hospital	DSRC
May	West Bengal	Kolkatta	Regional STI Training, Research and Reference Laboratory	DSRC
May	West Bengal	Kolkatta	SHIP-Abhinash–Sonagachi Project	FSW TI
June	Orissa	Ganjam	City Hospital	DSRC

Month	State/UT visited	District Visited	Name of Facility visited	Type of Facility
June	Orissa	Ganjam	MKCG Medical College	DSRC
June	Orissa	Ganjam	Aruna	Core Composite
June	Orissa	Khordha	Khordha Hospital	DSRC
June	Orissa	Khordha	Bhubaneshwar Municipal Hospital	DSRC
June	Orissa	Khordha	Lepra Society	IDU TI
June	Orissa	Khordha	OPUS	Core Composite
June	Uttar Pradesh	Allahabad	Swarg	MSM TI
June	West Bengal	Barddhaman	Shivshankar Sewa Samiti	FSW TI
June	West Bengal	Barddhaman	DMSC, Aasansol	FSW TI
June	West Bengal	Barddhaman	DISHA, Aasansol	FSW TI
June	West Bengal	Barddhaman	DMSC, Durgapur	FSW TI
June	West Bengal	Purbi Mednipur	VES-Macheda	FSW TI
June	West Bengal	Purbi Mednipur	VES- Haldia	FSW TI
June	West Bengal	Purbi Mednipur	DMSC Kontai	FSW TI
June	West Bengal	Purbi Mednipur	BBDNKS-Digha	FSW TI

Capacity Building – List and category of personnel trained

Table 1.7

Personnel trained

State	JD/DD/ AD TI (SACS)	JD/DD/ AD STI (SACS)	TL Overall / TL TI (TSU)	PO STI TSU	PO TI (TSU)	DSRC Doctors	DSRC Counse-llors	STI PPP	DAPCU	M&E (SACS / TSU / Partners)	TI PM
Andhra Pradesh		2		2	2	18	14	25	12	1	8
Karnataka	1	1	1	2	5	12	10	22	7	2	9
West Bengal		2		2	2	10	9	20	5		9
Maharashtra	1	2		1	7	4	3	16	5	4	1
Mizoram	1	1			4	2	2	8	1		5
Delhi	2	1	1		8	6	4	16	1	2	5
Chandigarh		1		1		3	3	8	1	2	1
Manipur		2			4	6	0	12	2		4
Nagaland		2		1		4	4	10	3		
Tamil Nadu		2	1		3	10	8	18	4	3	4
Gujarat	2	2			2	11	11	15	4	2	10
Orissa		2		1	6	6	6	15	2	1	5
Uttar Pradesh		2	1	2	1	10	10	14	5		1
Bihar		1				4	4	45	1		4
Total	**7**	**23**	**4**	**12**	**44**	**106**	**88**	**244**	**53**	**17**	**66**

National AIDS Control Organisation

India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India

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