Department of AIDS Control

Operational Guidelines for PLHIV help desk

NATIONAL AIDS CONTROL PROGRAMME

2013

A**cronyms**

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nursing and Midwifery
ART	Anti Retroviral Treatment
ARV	Anti Retroviral
BCC	Behaviour Change Communication
CBO	Community Based organization
CCC	Community Care Centre
CLHA	Children Living with HIV
CSO	Civil Society Organization
DAAC	District AIDS Action Committee
DAPCU	District AIDS Prevention Control Unit
DIC	Drop-in-centre
DLN	District Level Network
DOTS	Directly Observed Treatment Short-course
DPM	District Program Manager
DS	District Supervisor
FSW	Female Sex workers
GFATM	Global Fight against AIDS Tuberculosis and Malaria
GH	General Hospital
GIPA	Greater Involvement of People Living with HIV/AIDS
HBV	Hepatitis B Virus
HIV	Human Immuno Virus
ICDS	Integrated Child Development Schemes
ICTC	Integrated Counseling and Testing Centre
IDU	Injecting Drug Users
IEC	Information Education Communication
IGP	Income Generating Program
LAC	Legal Aid Clinic
LSE	Life Skill Education
M&E	Monitoring & Evaluation
MSM	Males having Sex with Males
NACO	National AIDS Control Organization
NACP III	National AIDS Control Program – Phase III
NGO	Non Governmental Organization
NSEP	Needle Syringe Exchange Program
NYK	Nehru Yuva Kendra
OI	Opportunistic Infection
OST	Oral Substitution Therapy
OVC	Orphan and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PPTCT	Prevention of Parent To Child Transmission
PRI	Panchayati Raj Institution
RNTCP	Revised National TB Control Program
SACS	State AIDS Control Society
SGM	Support Group Meeting
STI /D	Sexually Transmitted Infection/Disease
TB	Tuberculosis
TG	Transgender
TI	Targeted Intervention
TSU	Technical Support Unit
WLHA	Woman/Women Living with HIV/AIDS

Key Definitions:

1. **Adherence:** Ensuring consistent, timely and regular treatment is taken and regular follow up done. This might include having regular checkups (or reminder systems) with the health worker or having a treatment supporter at home
2. **Advocacy:** It is an ongoing process aiming at change of attitudes, actions, policies and laws by influencing people and organizations with power, systems and structures at different levels of betterment of people affected by the issue
3. **Balanced Food:** The food which provides essential nutrients and calories required to maintain good health. It contains well balanced portions of carbohydrates, proteins, fats, vitamins and minerals
4. **CD4 count:** A clinical test to see the extent of damage to one's immune system . The lower the count, the more damaged your immune system is and the more likely you are to develop illnesses
5. **Chronic HIV Care:** Ongoing long term care given to people living with HIV to enable them to keep themselves 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 would lead to collectivisation and empowerment of the community if adequately backed by capacity building.
7. **Cremation:** A burning; especially the act or practice of cremating the dead. Method of disposing of dead bodies by burning. It is the natural method of disposal in those religions (e.g. Hinduism) which regard the body as a dispensable vehicle for an immortal soul (soma sema, 'the body a tomb'), or, as in the case of Buddhism, where the process of reappearance alone continues. But in religions such as Judaism, Christianity, and Islam, where there is belief in resurrection of the body, burial has been preferred as, intuitively, suggesting an easier reconstitution of the parts
8. **Disclosure:** It is 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 counselor
9. **Discordant:** In the case of person living with HIV who has partner or spouse, when either of the couple is sero-positive for HIV virus and the other is negative it is discordant
10. **Discrimination:** Refers to an unfair action against an individual because he/she belongs to a certain stigmatized groups
11. **Disclosure:** To reveal [open] the sero-positive status to other members/partners/ close friends/ family/people living with the immediate environment
12. **Documentation & Reporting:** The process of systematically recording the process and outcome of the project activities with the help of data analysis and interpretations where ever possible and sending them to the apex centres through proper formats and in time
13. **Enabling Environment:** The component of an intervention program that envisages planning and undertaking initiatives aimed at enhancing the supportive attitude of the existing structures in the project area to support the program.
14. **Home visit:** Visit undertaken by an outreach worker with the consent of their clients (PLHIVs & OCVs) to provide support and assistance as and when required at the doorstep.
15. **Linkages:** The program component that explores and establishes functional partnership with different existing management and service delivery outlets of project related program and institutions in the project area.

16. **Monitoring & Evaluation:** Process that together helps us to assess the progress we are making towards our aims and objectives. It enables 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. **Needle exchange program:** An intervention method under the category of harm reduction, being used in Targeted Intervention Project among IDUs. Fresh needles and syringes are given when used ones are returned. This is to ensure that there is no needle syringe sharing happens during injections.
18. **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)
19. **Palliative Care:** Care given to improve the quality of life of patients who have a serious or life-threatening disease. Treatment to relieve, rather than cure, symptoms caused by terminal illness. Palliative care can help people live more comfortably.
20. **Positive Living:** Acceptance of ones HIV status in a positive way and making plans to ensure a healthy lifestyle that would ensure a quality life. A self confident person, living has a role model and motivating others to lead a healthy and positive live as part of positive living.
21. **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.
22. **Referrals:** Ensuring that project beneficiaries are sent to the appropriate service delivery outlets like 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 ensuring the required service
23. **Safer Sex:** Any sexual practice that does not let the partner's semen, vaginal fluids, or blood get into someone one'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
24. **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
25. **Stakeholders:** Individuals and groups who are directly or indirectly getting benefited or affected by any program activities.
26. **Stigma:** A powerful force of social control and is often used to isolate and control individuals with certain characteristics that some consider socially undesirable
27. **Support Group Meeting:** It is a gathering of homogenous group, experience sharing, develop the skills and capacity of individual
28. **Viral Load:** The number of HIV virus present in a human body in the context of HIV infection that is being measured through scientific methods.
29. **Welfare / Development Scheme:** The schemes announced by central and state governments and other donor agencies from time to time like housing, employment, education, financial assistance etc that would be of benefit to the PLHIVs.

I. Introduction

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

To achieve the goal the strategy will be:

1. To scale up access to anti-retroviral and opportunistic infections prophylaxis & treatment for children, adolescents and adults, free of stigma and discrimination
2. To strengthen linkages between ART, ICTC, PPTCT, RNTCP, STI, CCC, CCSC and TI.
3. To strengthen capacity of existing health system for effective delivery of care, support and treatment related services.
4. To integrate and mainstream care, support and treatment related services within the health system, other department/ministries and private sector.
5. To strengthen systems for quality assurance, monitoring and evaluation of CST services

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

The introduction of Antiretroviral Therapy (ART) in 2004 has 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. Under NACP III, adequate number of CCCs were established to cover high prevalent and highly vulnerable districts over the period 2007-12.

Challenges in Care &Support under NACPIII

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

i. Unmet care and support needs

Though the access to clinical services has improved significantly in NACP III, not all infected individuals receive comprehensive and holistic care and support especially that addresses psychosocial needs. There are limited strategies that are operational to mitigate impact for PLHIV, children and their families. Additionally, the coverage of key populations, 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 issues, the linkages and referrals between various service components such as DIC/DLN, ART, ICTC and TI are inadequate.

ii. **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

iii. **Lack of M&E systems to measure care & support**

The current M&E system captures information on clinical services. However, it does not capture indicators by HRG or residential status (urban vs. rural). Additionally, there are no indicators that capture type and quality of services. As noted by the Commission on AIDS in Asia, the lack of systematic efforts in the area of care and support "the bulk of the economic and social costs of AIDS being borne by members of the general public, particularly women and children."

iv. **Sub optimal use of Human resources:**

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

As we move forward to the next stage of the response, it is critical that care and support is positioned firmly at the centre of our response, reflecting not only the role of care and support in supporting prevention and treatment but also crucial recognition of its importance in its own right

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

Under NACP IV **350 Care & Support Centers (CSCs) will be established and linked** to high-burden ART centres and Link ART Centers in 31 states.

These CSCs will serve as a **comprehensive unit** for **treatment support**, **positive living** and strengthening the **enabling environment** for PLHIV. These community-based care and support centres will be part of the national response to meet the needs of PLHIV especially those from high risk groups and women and children living with and affected by HIV. CSCs will be run by civil society partners (SSR) including District Level Networks (DLN) and NGOs. These partners will be selected primarily on the basis of their track record of working successfully with local PLHIV community and few other assessment criteria that.

These guidelines focus on the objectives, criteria for selection, required infrastructure, human resources, monitoring tools and financial guidelines for CSCs. They will provide directions for setting up new CSCs and guide the existing ones on effective implementation of the programme.

II. Brief introduction to Vihaan

Vihaan which means 'Dawn's First Light' in Sanskrit works towards scaling up care, support &treatment (CST) Services for PLHIV. *The overall goal of the Vihaan program is 'To improve the survival and quality of life of People Living with HIV (PLHIV)'*. Beginning 1st April 2013 and lasting until 31 March 2016, Vihaan will complement NACP IV plans to put in place a quality C&S system that will complement HIV prevention and treatment programmes already in place.

"The overall goal of *Vihaan* is to improve the survival and quality of life of PLHIV"

a. Vihaan objectives

Specific objectives that the programme will support include:

- **Early linkages of PLHIV to Care ,Support and treatment services**: The CSC will support PLHIV newly enrolled into the program and have come for periodic check-up, i.e., the pre-ART registration group
- **Improved treatment adherence and education for PLHIV**: Adherence education and support can help PLHIV sustain and manage their treatment regimes. It is essential that all three elements of successful treatment are supported: the client; the provider; and the process.
- **Expanded positive prevention activities: To e**ncourage early testing. Improved positive prevention will contribute to the national efforts to prevent HIV transmission and reduce overall burden of disease. Illustrative activities include
- **Improved social protection and wellbeing of PLHIV:** Social and economic well-being is an important component of care and support.
- **Strengthened community systems and reduced stigma and discrimination:** To ensure a robust system that supports the program goal.

b. Vihaan key characteristics

CSC will be central to all the activities of Vihaan (see later for more details on the structure/selection /activities /services of CSCs). Vihaan will *ensure access to care & support services through 350 Care and Support Centers (CSCs) in 31 states*. These comprehensive community-based care and support centres will be part of the national response to meet the needs of PLHIV especially those from high risk groups and women and children living with and affected by HIV. Over the life of the programme, these CSCs will be developed and linked to high-burden ART centres in 31 states, in accordance with the NACP IV CSC guidelines developed under NACO's leadership. Key functions of CSCs are as follows:

- Link between health care service delivery & community
- Provide information on care & support
- C&SCs will provide access to health referrals, Education, & linkage to social welfare schemes
- Safe space for all PLHIV (including women, children, adolescents, FSWs, MSM, transgenders, hijras and IDUs)
- Function as social support and service delivery facility, set for complementing the priority services of PLHIV community.

- Provide platforms for children to voice their aspirations and concerns.
- Plan activities which are sector specific through a participatory planning process.
- Plan activities for special group like women, children, MSMs and Transgender groups in a way such that each group are getting full freedom and opportunity for expression and privacy.

- Plan outreach activities in coordination with ART centres so that MISSED and LFU cases are linked backed to the programme

- There shall be definite outputs and outcomes planned for the C&SC and those shall be measured with simple and clear indicators.

III. Introduction of Help Desks

The most challenging aspect in the national response to HIV is to ensure quality care & support to all persons living with HIV and help prevent infection, stigma & discrimination there by enriching the overall quality of life. Creating an enabling environment is very essential to ensure that PLHIV can access care, support, dignity, protection and treatment services. To mobilize community support to enhance the access to services, Care and Support Centers (CSCs) will play a crucial role in selected 350 districts over a period of next three years.

Earlier in NACP III, SSACS SACS was supporting Drop-In-Centers (DICs), wherein PLHIV networks across the country have developed DICs and institutionalized their functions of providing vital services to their members.. The services in DICs includes providing safer space to PLHIV to emotionally and socially support themselves, reinforcing the vital need to have committed responsibility from CBOs to develop positive attitudes in the community towards individuals and families living with HIV/AIDS. In spite of the continuous efforts, stigma and discrimination against PLHIV remains an issue in the society. Most PLHIV hesitate to disclose their HIV status due to fear of isolation and discrimination. DICs can play an important role in helping members cope with the stress of disclosure, isolation and discrimination and also address the issue with service providers, CSOs, families and community through sustainable integrated approaches and on the over all improve and increase the quality of life of the PLHIV.
Most of these DICs will continue to provide services as CSCs. However, in 68 districts where ART client load is low, the continuum of services to PLHIV community is planned through 'Help Desk'.

The major scope of a Help Desk is to function as a facility for PLHIV from where information, basic services and guidance for social, economic, legal, health and family issues etc are available. Help Desks will also provide a space like DIC where PLHIVs are supported and motivated to improve their health and life expectancy. Help Desks, like CSCs will be confined to the non-medical needs of PLHIV, but the social, psychological and referral support provided to the PLHIV are none the less significant. The following are specific areas of scope as envisaged in the NACP perspective:

- Semi – institutionalized system having activism and advocacy in balanced way in functioning to ensure essential services, basic rights and health needs of PLHIV.
- Exploring and accessing support from all segments of civil society to ensure non-denial of fundamental human rights as per the constitution of India to PLHIVs
- Functioning with competence to address legal and GIPA related issues of PLHIVs.
- Help Desk could undertake resource mobilisation, community mobilisation, establishing linkages and influencing policy decisions in a way it leads to the welfare and benefit to PLHIVs.

- Grass root level initiatives by Help Desks shall result in getting greater acceptance and opportunity for PLHIVs in own family and community.

a. **The Objective of Help Desk**

HDs are expected to function with the following objectives-

1. To mobilize and enroll all PLHIVs through community friendly strategies assuring confidentiality and protecting rights.
2. To provide specific information to PLHIVs and their family members on important issues and services like HIV, prevention of HIV, counseling, nutrition, PLHIV rights, livelihood, education, etc and various government schemes related to food, skill training, health, social protection, etc
3. To reduce stigma and discrimination of various forms against PLHIVs.
4. To establish effective functional linkages with existing health care provisions in government and private settings like ICTC, ART centres, RNTCP Clinics, STI Clinics, PPTCT and OI treatment services aimed at helping PLHIVs to access needed health care services at the earliest needed time.
5. To make the presence felt in the district as a government partnership community centered establishment advocating for policy revisions; care, support & treatment and human rights protection aimed at improving the quality of life of the PLHIV community.
6. To plan and provide PLHIV friendly and innovative support services like stress counseling, relaxation therapy, yoga, etc to support their physical and emotional needs.
7. To facilitate the process for sustainability of district level networks through resource mobilisation, organizational development strategies and partnership building with various government & non-government resource agencies.

b. **Beneficiaries of Help Desk**

The direct beneficiaries / target group to access services would be all PLHIVs in the target areas. The affected family members who share the impact of HIV infection like the children, spouse, close relatives, intimate friends etc may also be encouraged to access services as required. The activities and services of the Help desk would be structured in such a way that the priority issues of the marginalised sector of the PLHIV groups will be addressed. Other CBOs, NGOs, governments, CSO bodies, individuals could also approach and be indirectly benefited from help desk. Institution, agencies or individuals who wish to support PLHIV groups and the care givers to PLHIVs can also support the Help Desks. HDs most importantly can benefit the children living with or affected by HIV who are without parental care or vulnerable to abuse, lack of treatment, care support and from marginalized section of population such as MSM, TG, Hijras, PWID and women in sex work. The emotional support service, guidance for positive living and health issues and nutritional support services would be of great benefit to such communities.

c. The Structure of Help Desk

The structure of HD will be similar to that of the DIC in accordance with the vision, mission, scope and objectives. It needs to be structured in an ideal way to deliver optimum services to PLHIV and support NACP in achieving its goal. The following are the essential feature of the HD structure to ensure best operational systems.

d. **Infrastructure Provisions for HD**

Since the current Help Desks are the DICs run for long time, the infrastructure etc will continue to remain the same. *Good ventilation, clean & safe drinking water and clean toilets are essential criteria.* The following internal provisions are essential to set up a DIC:

Project office area: - This area may be devoted as the work station for the project staff, keeping the project assets, documents and records and conducting group meetings, review meetings, etc.

Resting / Relaxing / Entertainment space: - This is the heart of the HD and shall be well ventilated with adequate light. The area may be separated from reception and other provisions in the HD offering services with confidentiality. Ideally this place could have provisions like TV, recreation materials like Caroms, Chess etc IEC display of positive and motivating messages etc. There shall be chairs, beds, sofa and other furniture that will be used by the beneficiaries to rest relax and have entertainment.

Counseling space: - This is the place of the HD from where essential services like counseling are delivered. The place will be a room with provisions to keep closed and have confident interactions and will have complete audiovisual privacy.

IV. Principles of Functioning of help desk

- HDs shall function as social support and service delivery facility, set for complementing the priority service needs of the PLHIV community.
- HDs will be referral hubs, setting up linkages with various service providers to fulfill priority service needs of PLHIVs and families, managed and delivered by skilled and experienced PLHIVs.
- HD shall involve children in improving the quality of services at the center and provide platforms for children to voice their concerns and aspirations.
- Simple and easy to measure management principles will be applied in the functioning of HD like timely reports, achievement of targets, regularity of programs, transparency in fund utilization etc.
- HDs shall plan the activities which are sector specific through a participatory planning process.
- Groups like women, children, MSMs and Transgender groups shall plan activities and will be scheduled in a way each the groups are getting full freedom and opportunity for expression and privacy.
- There shall be definite outputs and outcomes planned for the HD and those shall be measured with simple and clear indicators.

V. Function of HDs

The following are the major functions envisaged to be performed:

a) Group Mobilization & Collectivization:

The main focus of the functioning of the HD is to act as the vital link between the health care service delivery system and the community / home settings of PLHIV and the families.

The voluntary process of PLHIVs coming to the HDs could be through a number of mechanisms. The process envisaged in NACP IV is that the IEC campaigns will motivate the people to introspect their risk

behaviors and people will visit ICTCs, where they would be able to access counseling and testing services as recommended. During this testing anyone found positive will be informed about the long term health care services that would be helpful for maintaining the quality of life. They will be referred and motivated to register in ART centres where an individual focused short term and long term planning for health care services including CD4 testing, ART drugs etc in appropriate time is ensured. In this context information on the usefulness of PLHIV networks and HDs and how they can help PLHIV to access the services and essential information in time, are given from ICTCs and ART centres. This would motivate a significant number of the PLHIVs, who are tested to be positive to get themselves registered in HDs and seek membership of PLHIV network/s. The strategy to motivate newly tested PLHIV to come to HD voluntarily is through a process of competent communication by peer counsellor of PC focused on the need and benefit of HDs. The PLHIVs who are registered to the HDs will be provided with a number of capacity strengthening activities to augment the process of fellowship and collectivisation to develop as a peer supporting group with mutual trust and confidence. All the activities happening in the HDs have to be focused to achieve this objective. The following are the major aspects to be practiced regarding mobilisation and collectivisation of PLHIVs:

- The privacy and confidentiality of all the PLHIVs shall be respected in HD at all levels and there shall be no compulsion for disclosure in any situation.
- The details of the PLHIVs registered in ART centre / ICTCs will not be shared with HDs / network as a matter of policy related to confidentiality. Instead the information, benefits and IECs available on the networks and DICs will be shared with the PLHIVs newly detected.

b) **Service delivery and linkages in HD**

One important deliverable of the HDs is ensuring linkage & referral to basic services essential for PLHIV so that a positive health and living are ensured. It is also important that referral linkages with HIV related service and other health related services are monitored in consultation with the various service delivery centers:

1. Two way ongoing linkages for mutual referrals for service have to be maintained by the HDs with DAPCU, ART centres, RNTCP program, ICTCs, TIs etc in the area and STI clinics in health care system.
2. One way in-referrals could be facilitated from ICTCs, Targeted Interventions and PLHIV networks for the PLHIVs to get support and services.
3. One way out-referrals are expected to NGOs / government schemes for the PLHIVs in HDs to get the benefit they are entitled to get from such schemes. The linkages may be effectively managed through periodic reviews and maintenance of updated referral registers

S.N.	Essential Activities	Targets
1	Enrollment	100% of all PLHIV registered at the ART center or at ICTC in the district
2	Communication activities- awareness, treatment services, legal aid services, adherence, etc	At least 1 session every month targeting 20-25 PLHIV
3	Capacity building activities- positive prevention, livelihood, treatment education, etc	2 sessions per month with adult male & female groups of 20-25 each through resource persons
4	Counseling- stress, life style, protection, children, care givers, family, MSM, TG, hijras, PWID, FSW, etc	• All newly registered members of the HD every month • At least 10 registered members of the HD per month
5	Advocacy initiatives	Monthly meetings with ART Centre, DAPCU, ICPS, ICDS, CMOH, ICTC Counselor
6	Public speaking	Monthly once
7	Tracking LFU	100% LFU in nearest ART center

c) **Capacity Building & Empowerment of Members & PLHIV**

The competent functioning of HDs and effectiveness of empowerment of the PLHIV community depends on skill and competence of the staff functioning in the centres and quality of technical inputs provided in various capacity building sessions of the program. Hence capacity building will be one major function of the HDs.

VI. **Capacity Building of the HD staff**

The capacity building of the HD staff aims to ensure program deliverables of earlier DICs is refined to suit the needs of the NACP. All the capacity building for the HD staff shall be undertaken by competent resource team after a proper capacity gap assessment done through a structured scientific process. The SRs of Vihaan in partnership with SACS will provide capacity building related to thematic topics. SRs will further organise training for SSR functionaries (including staff of HDs i.e. Peer Counsellor and Project Coordinator). The frame of the capacity building package shall have the following thematic areas:

Orientation training for HD staff	Induction/orientation training on programme management, MIS and financial management
Trainings on thematic Areas:	
Training of staff (peer counselor and ORW) on SRH	A thematic training will be organised on the basic issues covered in the area of sexual reproductive health, such as menstrual health, growing up, sexual health and rights, STIs, etc.
Training of HD staff (Peer counselor, PC, and ORW) on Positive Prevention	A thematic training will include the basic issues covered in the area of positive prevention, such as issues of discordant couple, safe pregnancy and delivery, secondary infections, medicine resistance and need for healthy living styles like good nutrition, hygiene, etc.
Training of HD staff on Treatment Adherence	A thematic training will be organised at SR level (for SSRsR's) for strengthening the basic issues covered in the area of adherence and discipline. Topics like prophylaxis, diagnostic and treatment adherence will be taken up, ways of supporting adherence, peer support, reasons for resistance to drugs, treatment levels etc will be included in the training.
Training of HD functionaries (DLN functionaries)	A training on organization development, leadership and resource mobilization will be organized for the DLN president and one board member.

The orientation training will be provided by the SR staff who would have been trained already by the PR. The thematic training will be provided through an external agency who will train a set of Master trainers who will then roll out the thematic trainings at SSR level. These trainers will be doctors and psychologists selected from each SR (depending on state load). Main focus of this TOT will be on making the participants develop an understanding on concepts pertaining to positive prevention, SRH and treatment adherence. Moreover, soft skills of trainers will also be capacitated by giving them clarity on trainer's skills, various training methods, adult learning methods etc.

In addition to the above trainings, the capacity building will also be done through:

- Ongoing technical support to SSR's by SRs
- Development of operational guidelines and manuals
- Monitoring SSR's through supportive supervisory visit

VII. Services at the Help Desks

The capacity building of the PLHIV community who are regular drop in population in the HD is as important as the capacity building of the staff of the HD. The process of capacity building for the PLHIV community attending the center would have a structured pattern as follows. Once the new PLHIV is registered in the HD a detailed profiling shall be done. This shall include an assessment of knowledge, attitudes and practices as well as the needs of individual PLHIVs. Consolidating the profiling and need gap assessment report, individual action plan for each individual will be prepared and services provided accordingly.

- ***Identifying lost to follow up***:- In coordination with the ART center, the ORW of the Help Desk will track the LFU cases. Peer counsellor will be used if the person or family is found difficult. The team will be expected to bring the LFU cases back to treatment.

- ***Information, counseling and condom distribution:*** The peer counselors and outreach workers will not only provide information on issues and services that enable the PLHIVs to improve the quality of their life, (eg safer sex practices and positive prevention, healthy lifestyle, ART and OI services, ART adherence, legal aid etc), but will also build their skills on safer sex through condom demonstration and condom provision**.**

- ***Health Education:*** Health Care needs will be addressed through continuous health education and skill building process to help the PLHIV adopt healthy life styles and seek medical help when required. Referrals to appropriate healthcare facilities will be made for management of specific illnesses.

- ***Linkages and Referral for Service provision:*** HDs will ensure linkage & referral to basic services essential for PLHIV so that a positive health and living are ensured. These will include referral to health related services (ART center, STI clinics, RNTCP program, healthcare facilities for management of OIs or other health issues) as well as non –health related services (NGOs/government schemes for PLHIV, legal aid cell, linkage with targeted intervention and PLHIV network). It is important that the linkages are effectively managed through periodic reviews in consultation with various service delivery centers and maintenance of updated referral registers.

- ***Positive living and positive speaking***:- Positive living and positive speaking are the skills to be acquired by the PLHIV community for them and present these themes to the general public. Being, the skills that simultaneously help them in their personal life as well as to impress the skills of PLHIV before the general community, this would be an important and consistent skill building input provided to PLHIV community from the HD.

- ***Reduction of stigma & discrimination towards PLHIVs:***- Sigma and discrimination towards PLHIVs is the major issue requiring effective intervention at civil society settings. This task is to be taken by the PLHIV community who are well trained in identifying the existing stigma and its contributing factors and to address it effectively. There shall be regular trainings in centers that enable the PLHIV community members to work in stigma reduction. The understanding of GIPA in the various service and development sector functionaries is minimal. This could be one major task taken up by the PLHIV community leaders. There shall be regular and effective trainings to

the PLHIVs attending HD to enable them to function as "GIPA leaders" to sensitize and motivate on GIPA implementation in various sectors.

- ***Community mobilisation and peer support*:**- Community mobilization and peer support are areas those are important and have lots of ethical concerns. Hence it would be essential to have capacity building programs on the basics of community mobilisation and peer support to develop effective animators from among the community groups

- ***Support group meetings***: Community support groups will be formed of PLHIV registered at HD for sharing positive life experiences of accessing services and providing mutual psychological support. The support groups will contribute to creating awareness and motivating PLHIV to access health services. Regular meetings of support groups and buddy groups will be organized and facilitated by the peer counselor.

VIII. **Services for Special Groups**

Among the groups infected and affected with HIV, some sectors need to be provided special care and specialized services. This has to be addressed by HD to the possible extend. This could also be done through establishing partnerships and linkages with other technical and resource agencies. Depending on the need for such services, the functioning of the HD may be adequately modified. Services for the following special categories may be envisaged.

a) **Orphaned and Vulnerable Children (OVC): -** The services required to OVC include shelter, nutrition, education, health care, protection from abuses etc. Even though, HDs will not have infrastructure and resources to address all the priority needs of the OVC, the HDs shall act as he focal point from which the required services to OVC will be ensured through advocacy and partnership building. Facilities like nutritional program, day care, play school activities that will benefit OVC could be initiated in the premises of HD if it is convenient. There shall be regular advocacy programs aimed at making effective functional partnership with potential agencies which can provide sustainable support for ensuring priority services to OVC.
b) **MSM, hijras and TGs who are PLHIVs: -** Individuals belonging to MTH community have always lot of barriers in accessing various available services. Getting HIV infected would make the situation worse. Most of the hijras and TGs have unsupportive families and extend of stigma that prevail in civil society is also very high. HDs in which PLHIVs belonging to the community are enrolled have to design programs / activities that would benefit the community. This includes group specific sexual health messages and emotional support.
c) **Single women with special needs: -** Many WLHIVs have a number of other social and legal issues like refusing to give the ownership of the property, abuse from some of the male members in the places they live and work etc. This is to be addressed through target group friendly approaches and legal services have to be made available at affordable cost. HDs may also plan and implement women empowerment initiatives.
d) **PWID Groups: -** The issues of IDUs who are infected also have to be addressed with great care and competency. Being the most effective route of transmission, motivating them to have sustainable safe sex practices is very important. Lack of support from families, conflict with the law and order system for providing NSEP, difficulty in follow up during OST etc are other challenges those have to be addressed through the special service packages for IDUs seeking service from the HDs.

IX. **Outputs & outcomes in HD**

The services and provisions in one HD unit shall be planned for average of 200 to 500 PLHIV, who tested positive in the district and those in the relatively initial phase of the infection. Services will be planned for their families as well. HD will be expected to ensure HIV friendly activities and services. The functioning will be based on focused outputs and outcomes those are measurable by SMART indicators.

X. **Reporting indicators:**

S.N.	Activity	Indicators
1	Identifying Lost To Follow up	A)No of LFU Cases brought back to treatment to ART Center
2	Information, counseling and condom distribution	B)No of Registered PLHIV receiving at least one Peer counseling session C)No of Condom distributed in the Quarter/Month
3	Linkages and Referral for Service provision	D)No of Client referred from Helpdesk (Out referral) : 1.ART Centre 2.Link ART Centre 3.ICTC center 4.PPTCT center 5.DOTS Centre 6.NGO/CBO/PLHIV Network 7.STI clinic 8.Govt. hospital 9.OtherHealthcarefacilities 10.TIs (by Type) a) MSM b)FSW c)IDUs d)Truckers e) Migrants f) Transgender/Hijra g)Core Composite 11.Legal Aid Services 12.Others
4	Support Group Meetings	E)No of Support Group Meeting Conducted in any of the following area : 1) ART Adherence , 2) Home Based Care, 3) Nutrition 4)Stigma & discrimination 5)Positive living & Healthy Lifestyle 6)HIV Prevention 7)Side Effects & OI Management 8)Information about Govt schemes 9)Legal Services 10)Treatment Education 11) Self Help Groups 12) Others

XI. **Help Desk Management**

Under the Vihaan project, PR will contract SR and SR will contract SSR or DLNs to implement the Help Desk. President, vice-president, treasurer and general secretary of the DLN will be finally responsible for

the entire project, although day today functioning will be taken care by the Project Coordinator (PC). PC will also take care of reporting, advocacy and management functions. Whereas DLN board members will be expected to play an active role in advocacy and sensitisation activities. HD will report to SR like any other SSR, against above mentioned indicators.

XII. Finance management

There will be a model budgetary guideline and reporting format based on which the HD budgeting will be done. The budget will be part of the contract and will be prepared based on the size of the target population making regular drop in to the center and the programs those are priority needs of the area where center/desk is located. SR shall advance 50% of the total budget amount on signing the contract. This will be followed by quarterly reimbursements against quarterly financial report. The final installment shall be released after the annual audit.

XIII. **Staff positions and responsibilities in Help Desk**

No	Post	Qualification / Experience	Responsibilities	Proposed Pay/ PM
1	Project Coordinator	Pass in plus two or above. More than 3 yrs active working in PLHIV networks / NACP. Candidates with degree may be given relaxation of experience by the selection board if found skilled	Project coordination, periodic monitoring and technical support to the team. Reporting will also be the responsibility of PC. Maintenance of all technical and financial reports up to date and timely sending of all reports in time. Attending all meetings representing the Help Desk. Advocacy, networking, resource mobilisation and partnership initiatives. Will also be responsible for accounts and finance.	Rs.6,000/-
2	Peer Counsellor	Pass in plus two or above. 1 yr experience in HIV/AIDS programs. Candidates with degree may be given relaxation of experience by the selection board if found skilled	Provide counseling of good quality to the PLHIV, community members and their families attending the center. Be in charge of the behavior modification process among the PLHIV. Technical support to ORWs to provide ongoing follow up support to the team	Rs.5,000/-
3	Outreach Worker (One ORW for every 250 PLHIV registered in the district)	8th Std passed. Basic understanding on NACP and willing to work among PLHIV groups and willing for positive speaking.	Regular follow up services to be ensured to the help desk attendees. Doing filed visits and house visits of the PLHIV families as per the approved schedule. Plan and conduct community outreach programs to address stigma and discrimination.	Rs3000/-

XIV. Estimated Budget for Help Desk

BUDGET FOR PLHIV HELP DESK				
Particulars	**Amount**	**Months**	**District with <250 PLHIV**	**District with > 250 PLHIV**
Project coordinator (management and advocacy)	6000	12	72000	72000
Peer counsellor	5000	12	60000	60000
ORW @4000	4000	12	48000	2ORW @4000 96000
Activity cost				
Support group meetings and Advocacy meeting	1500	12	18000	18000
Office supply				
Rent	5000	12	60000	60000
office running expenses (water, electricity, office maintenance)	2000	12	24000	24000
Recreational activity (reading material newspaper etc.)	500	12	6000	6000
Communication	1000	12	12000	12000
stationary and contingencies	500	12	6000	6000
Travel	1800 (500 for PC, 500 for counselo r and 800 for each ORW)	12	21600	31200
Emergency support/ referral services (refer the terminally ill and PLHIV with emergency need to govt facilities)	1000 for <250 PLHIV and 1500 for >250	12	12000	18000
Total			339600	403200

Quarterly Reporting Template (Helpdesk)														
Sl No	**Indicators**	**Q-1**	**Q-2**	**Q-3**	**Q-4**	**Q-5**	**Q-6**	**Q-7**	**Q-8**	**Q-9**	**Q-10**	**Q-11**	**Q-12**	**Total**
1	**No of LFU Cases brought back to treatment to ART Center**													
2	**No of Registered PLHIV receiving at least one Peer counseling session**													
3	**No of Condom distributed in the Month**													
4	**No of Client referred from Helpdesk (Out referral)**													
5	**Support Group Meetings**													