



COMMUNITY BASED CARE AND SUPPORT PROGRAMME 2000-2010

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MAMTA
Health Institute for Mother and Child

Acknowledgement

We sincerely thank Ms. Morli Pandya for taking in this tedious task of evaluating a ten year process in such a concise and analytical manner and portraying them in this document.

We also thank all the NGO partners, MAMTA CBCS programme team and the beneficiaries for their involvement and contribution in to the programme.

I hope this document helps everyone for better understanding of the issues and community based care & support for children

With Thanks,



Dr. Sunil Mehra

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Foreword Note

The Delhi State AIDS Control Society (DSACS) is an autonomous body of Delhi Govt. It became functional from 1st November, 1998 and a nodal agency which is responsible for implementing the National AIDS Control Program in Delhi, funded by Govt. of India.



DSACS extends heartiest congratulation to MAMTA – Health Institute for Mother & Child and their Partner Organizations for 10 years of long successful intervention for the lives of People Living with HIV and AIDS especially among women and children through Community Based Care and Support Program supported by Abbott Fund, USA. We have realized that, it was the first project in Union Territory of Delhi, which had comprehensive package for children living and affected by AIDS. Really the project had contributed a lot at community as well as service delivery level by strengthening the capacities of service providers, reducing stigma and discrimination, increasing access for prevention, treatment, care and support services and building community leadership and ownership for the sustainable outcomes.

We appreciate such a long term, consistent intervention, where change is visible. The project complemented the efforts of Government especially DSACS to prevent and control HIV transmission and to strengthen state capacity to respond to long-term challenge posed by the epidemic.

With Best Wishes!

A handwritten signature in blue ink, appearing to read 'Dr. AK Gupta', written over a blue horizontal line.

Dr. AK Gupta

Assistant Project Director

Delhi State AIDS Control Society

Foreword Note

I am very happy to introduce an impact document of Community Based Care and Support programme in Delhi. The report entails 10 year long collaborative processes to bring progressive change in infected and affected lives of children. The purpose to put across the document was to bring forth the way the programme emerged and has later impacted the overall scenario, at community and at systems level. At the onset our sincere thanks to Abbott Fund for its continued support to this effort.



This intervention was planned in two high and in one low prevalence states i.e Delhi. MAMTA was the lead organisation for this state. When started in 2000, community based interventions for HIV were few & far. Using participatory approaches and community ownership helped in overcoming the stigma & discrimination for HIV.

As the strategy unfolds, we started bringing up the number of infected and affected over a period of time. This was not without the technical capacity being built not just of implementing partners but also of MAMTA.

It would have been futile if we had only focused on community and not brought services closer to them. A concerted effort was put in to integrate our work from community to system (health, education, nutrition and others). Gradually the programme brought in the positive groups and all the positive pregnant mothers. This expanded the scope of work for its target beneficiaries.

Let me emphasize, the programme evolved in line with the national programme as it moved from NACP II to NACP III. Giving us an opportunity to put our learning in NACP III and Global Fund Round 6. My sincere gratitude to International HIV/AIDS Alliance for its facilitatory and capacity building role in the initial phase of the programme.

In the end as you read this report you will find that we could make a significant impact not only in survival but also in quality of life of children who are affected & infected and the positive groups. The credit sincerely goes to all implementing partners and the dedicated staff of MAMTA who worked in it over ten years. I just hope that DSACS continues to take this effort forward to the other districts and strengthen work in ongoing districts.

I convey my sincere thanks to all DSACS staff, especially Dr. AK Gupta for their relentless support throughout.

I hope you enjoy reading and referring the document...



Dr. Sunil Mehra

Executive Director

MAMTA Health Institute for Mother & Child

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Executive Summary

The document captures a decade long journey of Community Based Care & Support (CBCS) programme through evaluation objectives that were set out for the closing year of implementation in context to gather learning, experiences and key outcomes of the 10 year programme.

The Community Based Care & Support Programme (CBCS) with the support from Abbott Fund USA, was facilitated and technically supported by MAMTA for its six implementing NGO partners. The programme was implemented in 5 B & C Category districts of the national capital i.e. North, North-west, North-east, East & Central Delhi.¹ The programme covered over 1.6 million populations to reach out to children living with and affected by HIV & AIDS along with children who are orphans and vulnerable. The project aimed to mitigate the impact of HIV/AIDS on People Living with HIV/AIDS especially women and children; capacitate the community and service delivery system for quality and equitable access for prevention, care and treatment services in Union Territory of Delhi, India.

With its child centric approach, the programme focused on developing and strengthening community based linkages and networking mechanism with existing services to enable and to enhance children to take appropriate decisions and responsible actions. The overall approach of the programme was concentrated on the needs of the children in context to their families, community as a whole and in reference to the available health and welfare services.

The programme strategies were evolved and envisaged from several processes of programme management cycle which were reviewed and if felt required then, renewed periodically. The consultations and participation of all key stakeholders were essential vehicles used by the programme implementation for the expected outcomes. The programme was entrusted through, Identification of community Inducers, Formation and strengthening of Support Groups, , Sensitisation & Capacity building of service providers , Provision of direct Support for Nutrition, Education, Medical, Income Generation, specific Travel, Emergency.

The evaluation was kept participatory in nature thus could assess the relativity, relevance and the representativeness of the context through interaction on the personal experiences of all the stakeholders involved demonstrating the outcomes.

The CBCS programme has reached out to 3322 registered children who are CLHA, CAA or OVC from which 125 are Children who are living with HIV. According to UNAIDS India Country Progress Report, total of 63,889 children living with HIV are registered, as on January 2010. The data indicates that the 0.19% of the CLHIV have been benefited from the CBCS programme.² As on December 2008, total of 18501 HIV positives were registered in 9 ARTCs across the Delhi city out of which 92.8% were adult compare to 7.2% (i.e. 1332 in numbers) children with HIV. Considering the stated scenario, total of 9.38% CLHIV are covered through the CBCS programme.³ According to Delhi State AIDS Control Society, 5476 PLHIVs were alive and on ART by

¹ Prioritisation Of Districts For Programme Implementation NACO
<http://www.nacoonline.org/upload/NACO%20PDF/District%20Categorisation%20for%20Priority%20Attention.pdf>

² http://data.unaids.org/pub/Report/2010/india_2010_country_progress_report_en.pdf

³ <http://www.scribd.com/Epidemiology-of-HIV-Infection-by-Dr-AK-Gupta-Additional-Project-Director-Delhi-State-AIDS-Control-Society/d/13047007-presentation-Dr.-AK-Gupta-APD-DSACS>

May 2010,⁴ keeping this data in to the account, the CBCS programme could identify 622 PLHAs i.e 11.36% of the city. The programme strategies were successful in linking 247 beneficiaries which is almost 40% from the total PLHIV beneficiaries to the ARTCs, 71% & 29% were linked to opportunistic infection services and for prophylactic treatment services respectively. Out of total 622 PLHIV, 13% of PLHIV are trained Positive Speakers and from them 61% are women positive speakers. With the child centric programme design, the CBCS programme has developed 23% positive CLHIV speakers from which 55% are girls CLHIV speakers. The programme with its strategy to reach out to the children through the mothers has registered 4671 pregnant women during the whole period out of which 0.36% were identified HIV positive expecting mothers. 0.25% pregnant women were linked to ARTC. 3514 & 96 beneficiaries were provided support for nutrition & for emergency respectively through linkages. The inference indicates that the nutritional support was the most required support to the beneficiaries than to address any emergencies. The programme has involved 898 community inducers, 1300 public and private service providers after training and engaging them for various programme effects. The partner NGOs could form 155 Support Groups of children and adults.

The CBCS programme was successful in identifying priority needs of the children beneficiaries and effective approaches to address those needs in a more systematic and sustainable ways. The basic life needs in terms of psychosocial, health, education and financial were understood and addressal of them was interwoven in the programme design through component of networking, advocacy, capacity building, GIPA and through approach of community mobilisation. Subsequently, the capacity of institutions was strengthen not only for HIV related issues but for overall human health and support/services required for healthy human life.

However, the programme has gone through various challenges which were faced and converted in to renewed learnings. These constructive learnings were made part of the planning cycle. The programme could establish its wider reach in term of - the geographical locations, the range of beneficiaries covered, the levels of stakeholders involved, the thematic attributes that were considered, the partnerships optimised - and through the continuity in efforts, it is seen that obstacles were progressively resolved.

A decade ago, when such efforts were initiated, children with their HIV positivity were not priority focus of the programme domain yet resources were pulled and invested. The recommendations read in terms of need as - of district estimates of CLHIV/CAA, to increase in volume of resource required, to mainstream CLHIV/CAA centric policies/schemes, of converging HIV & MCH at programme & services level, of maximising the support for nutrition, of strengthening the positive speaking and there by HIV positives and the positive networks. Besides, the human resource that was developed with required capacities and the mechanisms that were established for deliverables should be considered for future or further investments.

⁴ Delhi Scenario, Delhi State AIDS Control Society http://www.delhi.gov.in/wps/wcm/connect/doiit_dsacs/DSACS/Home/HIV+-+AIDS+Scenario/HIV+or+AIDS+Scenario+in+Delhi Last Updated : 21 May,2010IV

Introduction

NACO estimates that 57,000 children are infected at birth in India each year, while there are no reliable estimates of 'affected' children in the country and is yet to finalise the estimates of Children infected with HIV as mentioned in UNAIDS India Country Report 2010.⁵

Back then, two decades ago, throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as 'low-risk', such as housewives.⁶

In 1999, the second phase of the National AIDS Control Programme (NACP II) came into effect with the stated aim of reducing the spread of HIV through promoting behaviour change.⁷ Till then, the approach to tackle the HIV epidemic was mainly prevention based. While this approach emphasizes the need for prevention, it significantly overlooked the social stigma and discrimination attached to the infection, and the needs of people living with HIV and AIDS.⁸

An environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced, those infected with and affected by HIV/AIDS live a life of dignity without discrimination, and the personal and societal impact of HIV infection is alleviated

UNAIDS 'Rights Based Approach'

With highly diverse epidemic in India, protection of another generation of young people from premature illness and death was a responsibility of the highest order. Caring for those orphans that the epidemic had left behind compounded this task.⁹

Children orphaned by AIDS are at greater risk of poor health, education and protection than children who have lost parents for other reasons. They are also more likely to be malnourished, sick, or subject to child labour, abuse and neglect, or sexual exploitation—all of which increase their vulnerability to HIV infection. Such children frequently suffer from stigma and discrimination and may be denied access to basic services such as education and shelter as well as opportunities for play.¹⁰

In India, according to the Human Rights Watch (2004), there were 1.2 million children under age fifteen orphaned by AIDS.¹¹ It was evident by then that holistic approaches were needed for HIV/AIDS prevention and impact alleviation, taking into account all the areas in which the epidemic has a possibly detrimental impact on fulfilling children's different needs. Henceforth, it is important to adopt a rights-based approach.

⁵ http://data.unaids.org/pub/Report/2010/india_2010_country_progress_report_en.pdf

⁶ Baria F. et al., India Today (15th March 1997), 'AIDS - striking home'

⁷ india.gov.in, 'Spotlight: National Portal of India National AIDS Control Programme',

⁸ CBCS programme Update Vol.1 Dec 2001

⁹ http://www.aegis.com/files/unaids/WADJune2000_epidemic_report.pdf

¹⁰ The Millennium Development Goal Report 2010 <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf#page=28>

¹¹ The Impact of HIV/AIDS on Children and Young People UNESCO http://www2.unescobkk.org/elib/publications/073/Impact_of_HIV.pdf

This means that children – HIV-positive or negative, from AIDS affected households or not – have certain basic rights that governments in most countries of the world have promised to uphold or fulfill in numerous declarations, treaties and commitments.¹²

With MAMTA's commitment to Reproductive & Child Health, Sexual Health and Rights, it was felt appropriate to work on Care & support of youth, children and others living with or affected by HIV and AIDS.

Therefore, when initiatives were taken up to meet the current and anticipated increase in demand for HIV-related services, MAMTA as the lead organisation in to partnership with India HIV and AIDS Alliance, in association with eight partner NGOs initiated Community Based Care and Support Programme (CBCS) in March 2000 with support from Abbott Fund USA.¹³ In Delhi being the low prevalence state.

There was an emerging concern for an alternative model that incorporates the issues surrounding prevention and simultaneously takes care for reducing stigma and discrimination in the society for increasing access to care and services.

*Dr. Sunil Mehra Executive Director MAMTA
CBCS programme Update Vol. 1 Dec 2001*

The programme was simultaneously being implemented in another two priority states i.e. Andhra Pradesh and Tamil Nadu by other agencies.

The programme is **aimed** to mitigate the impact of HIV/ & AIDS on People Living with HIV & AIDS especially women and children; capacitate the community and service delivery system for quality and equitable access for prevention, care and treatment services in Union Territory of Delhi, India.

From 2008 onwards, Abbott Fund USA started providing direct support to MAMTA and thereafter, the restructured CBCS Program has been carried out with 6 partnered NGOs in 5 B & C Category districts of North, North-west, North-east, East & Central Delhi.¹⁴ The main focus of the programme is on Children Living with HIV (CLHIV) and Children Affected by AIDS (CAA).

As programme proceeds towards the exit phase this **participatory evaluation** was conducted with the prime **objectives** as,



- ♦ To conduct participatory evaluation of the care & support programme for the period of 2000 to 2010; and consequently.
- ♦ To gather learning, experiences and key outcomes of the 10 year programme.

¹² The Impact of HIV/AIDS on Children and Young People UNESCO http://www2.unescobkk.org/elib/publications/073/Impact_of_HIV.pdf

¹³ CBCS programme Update Vol.1 Dec 2001

¹⁴ Prioritisation of Districts For Programme Implementation NACO <http://www.nacoonline.org/upload/NACO%20PDF/District%20Categorisation%20for%20Priority%20Attention.pdf>

As not many community based care and support programmes for children have been implemented and documented in the country context, the evaluation will recommend adaptability of the strategies and successful processes of the programme in other settings.

The Concept behind the CBCS programme is not to continue to provide services to the communities forever. Its objective is to enable and help the communities to become independent with the available resources and to link them with the available services

CBCS Programme Update Vol. 6 December 2006

As mentioned previously, the estimation of CLHA/CAA for the country was available only in 2002 that too with the absence of the city specific estimation till 2006,¹⁵ the evaluation was designed to capture the progression of the programme implementation, the key challenges that were faced, whether the progression in approach continued to remain relevant to the needs and priorities of target groups with the focus on sustenance of the results.

The review of the existing linkages and referral approach indicated the need of building community based points to develop linkages with service providers as well as the community's capacity to access the services

CBCS Programme Update Vol. 7 December 2007

The evaluation methodology was developed to utilize all the possible range of resources and sources available for and of the programme in consultation with partner NGOs and their CBCS teams.

The design approach for evaluation was at two levels. One level was to do a desk review of all the documents prepared and disseminated in last 10 years, including project reports, newsletters, programme review meeting reports and others. Also good look was given to the changing state focus on children and HIV in last 10 years. At the other level participatory tools were used to interview different stakeholders for their views on different aspects of the programme.

The role of PNGOs during Participatory Evaluation is very crucial, since they are directly implementing project, are very familiar with the communities and moreover the evaluation can not be participatory until and unless the participation of community and service providers ensured

Consultation Report for CBCS Participatory Evaluation August 2010

¹⁵ Table -A2: Percent Distribution of HIV Infections in 2006 by Age Group

Delhi: 3.73 Percent Distribution in age group <15 and Number in lakh 0.30

Technical Report India HIV Estimates 2006 NACO, National Institute of Medical Statistics

<http://www.nacoonline.org/upload/NACO%20PDF/District%20Categorisation%20for%20Priority%20Attention.pdf>

The Evaluated Intervention

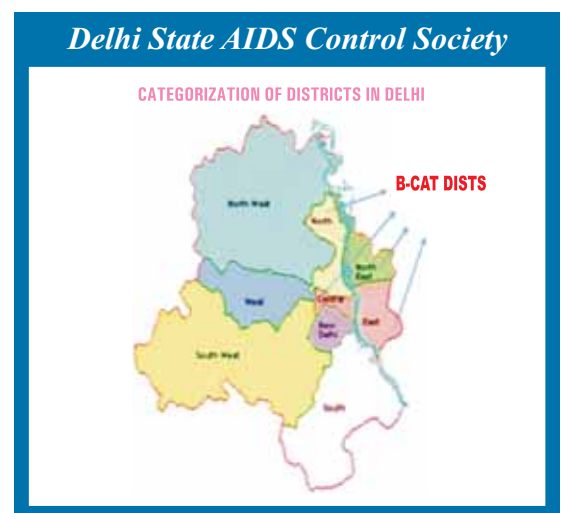
This program is being implemented with 6 partner NGOs, covering over 1.6 million populations from 5 districts of Delhi, in order to mitigate the impact on the lives of PLHA especially the children infected and affected by HIV/AIDS.

Delhi is national capital territory having 17.2 million populations spread over nine districts. The Delhi State AIDS Control Society (DSACS) is an autonomous body of Delhi Government and a nodal agency which is responsible for implementing the National AIDS Control Programme components. It is estimated that 51,818 People Living with HIV(2007) with 0.25% prevalence rate. According to available data from DSACS that 15,970 HIV Positive People are registered at ART and 5476 AIDS Cases on ART. DSACS through 66 ICTC/PPTCT (Integrated Counseling & Testing Center / Prevention of Parent to Child Transmission), 9 ART and 9 CCC (Community Care Center) has been engaged to realize the NACP-III goal to halt and reverse the epidemic in India over the next five years.¹⁶

The evaluated programme has close collaboration and coordination with DSACS and Municipal Corporation of Delhi (MCD) as DSACS designs, implements and coordinates all the HIV and AIDS control and prevention program in Delhi, the MCD is the largest provider of health care and support in the National Capital Territory.

This program endeavours aim to work under and enhance the framework of the Government of India's National AIDS Control Program (NACP) which has identified the importance of building capacities for the provisions of low cost community based care for People living with HIV and AIDS and creating supportive environment.

The program provides direct support to children and also links them to relevant care, support and treatment services. The program has committed towards prevention of HIV infection among children, works with/through People living with HIV, women in reproductive age group and their spouses to promote quality family life and also works with vulnerable children living on the street and in slums.



“The CBCS programme has helped me understand children's needs, the issues that they handle at such a young age and through which I can provide them support. I knew about HIV and AIDS but never in this way”

A respondent from Service Providers

¹⁶ Delhi State AIDS Control Society Last Updated : 21 May,2010 http://www.delhi.gov.in/wps/wcm/connect/doi_dsacs/DSACS/Home/HIV+-+AIDS+Scenario/HIV+or+AIDS+Scenario+in+DelhiH

History and Description of Programme Implementation

Under the lead partnership of MAMTA, the project was designed based on, the Rapid Situation Analysis (RSA), Strategic planning workshop, Participatory Community Assessment (April – May 2001), Project design workshop (June 2001) in consultation with NGO partners in Delhi.

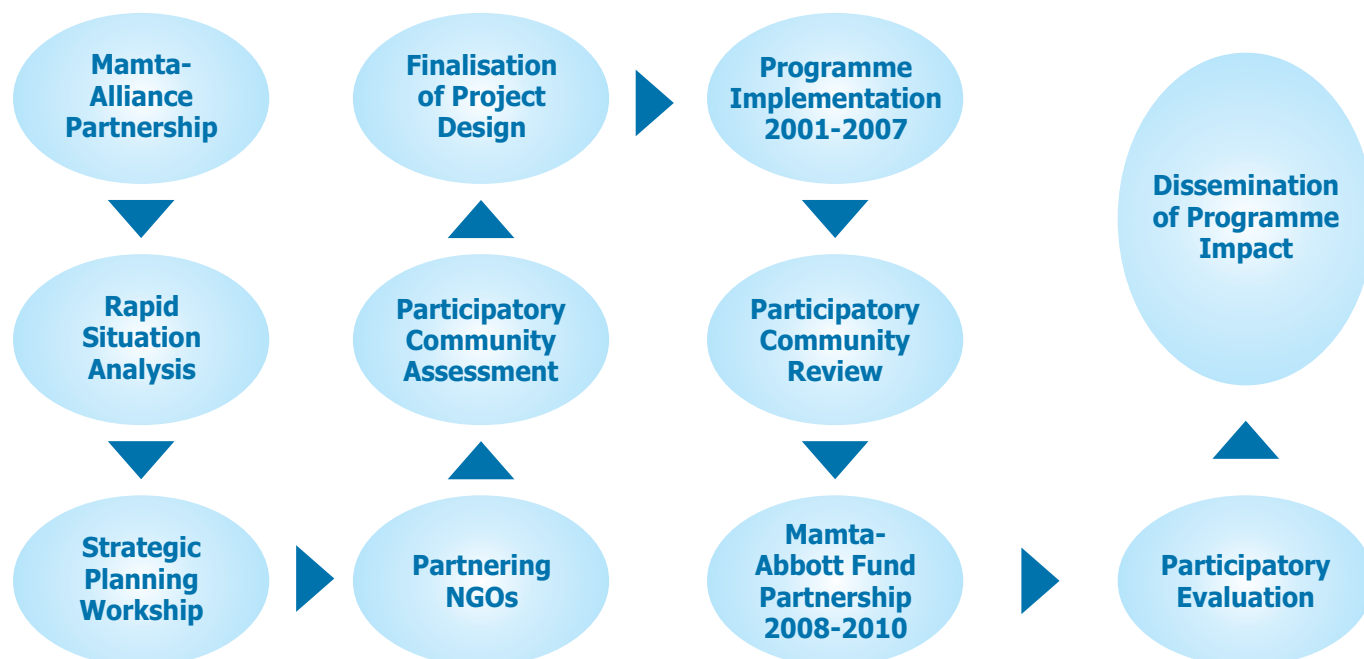


Figure 1: Steps undertaken for CBCS Programme Implementation

The salient findings of RSA were that extent of epidemic was difficult to gauge, as there was lack of epidemiological data, reported cases were less than estimated and not much is known about prevalence rate and number of positive cases. Lack of resources, community resistance and poor linkages were certain shortcomings those were brought out.¹⁷

With an aim to develop the programme strategies and for contextual clarity on Delhi scenario, consultation was held with organisations working on HIV/AIDS and with Government functionaries.¹⁸ This was followed by identification of NGOs and technical resource group to carry community based support program across the Delhi. The thrust was to include and strengthen institutions working with children affected and infected with HIV and AIDS and Key Population. The criteria for their selection was developed during the strategic planning workshop based on which Implementing NGOS were selected. These NGOs were trained to undertake Participatory Community Assessments (PCA) through capacity building workshop; which was organized in March 2001. The PCAs were planned and completed in the nine sites / communities from 3 District of Delhi with the help of the Partner NGOs.¹⁹

The PCAs brought the situation related to HIV and AIDS care and support and needs in the nine areas of study. This PCA was completed in April-May 2001. Workshop to share the findings of the PCA was organised on

¹⁷ Rapid situation analysis study Report CBCS programme October-November 2000

¹⁸ Strategic Planning Workshop Report CBCS programme December 2000

¹⁹ Participatory Community Assessment Report April – May 2001

30th May 2001. This was followed by a Project Design Workshop in June, and based on the findings of the PCA the Community Based Care & Support Program design was developed.

With the lack of visible presence of and willingness for disclosure of HIV positivity, it was difficult for the implementers to outreach even adult positives. The reach to the PLHA was still confined to the close positive networks and preferred service providers who were known 'AIDS specialists'. The health system and the health seekers, both, were still not habituated to provide and access multiple service outlets or well acquainted with the HIV related services.

The programme implementation initiated with identification of Peer Educators from different geographical locations to build rapport and sensitise the community. This had later contributed in accessing PLHAs and families affected by AIDS (FAA).

To identify and reach out to the target communities in **initial years**, below mentioned strategic actions were taken up.

Empowering communities on stigma and discrimination against HIV and AIDS: Regular community sensitization and motivation was the key feature in all PNGOs programs which resulted in increased general awareness and better understanding on HIV and AIDS issues. It was basically aimed at giving factual information and knowledge to community in general and PLHIV/FAAs in particular. The implementers had embedded safe sexual practices in the workshops content for Peer Educators. It also needed efforts to increase men's involvement in the Program.

“Our community based care and support programme tailors the messages as per the needs of target groups and is strongly based on active and effective linkages with general health services and HIV testing services. Linkages with different services and organisations are helping us to reach out to difficult groups.”

*Response by an Implementing partner
CBCS programme Update Vol.2 Dec 2002*

Dissemination of IEC/ BCC material in the community: All Implementing PNGOs were made concentrated efforts to use issue based IEC/ BCC material in the community meetings and workshops to increase its efficacy. Various audio visual and print mediums were used such as film shows, street play to attract the community attention.

Promotion of safe sex practices and condom use: Intensive efforts were made by Implementing PNGOs to launch a massive campaign to promote safe sexual practices and use of condom by reaching out to various groups i.e. truckers, transgender, PLHIV/ FAAs. More outreach centers besides 'Drop in' centers were promoted in the community.

Early diagnosis and treatment of STIs: Community sensitization and counselling for early diagnosis and treatment for STIs were initiated at community level in respective PNGOs. Crucial link between STI and HIV and AIDS was focused in the awareness programs for optimum utilization of clinics within community.

Promotion of referrals for VCT: Encouraging community member to avail VCT services (currently known as ICTC) was one of the key activities of all PNGOs. The community based leadership was promoted to increase the referral and linkages to VCTC. All the PNGOs were able to establish liaison with local Government Hospital which resulted increase number of VCT.

Capacity building of key members: The capacity of the PLHIV/ FAAs, Peer Educators, local health service providers were developed through different capacity building workshops and trainings for safe sexual practices, home based care, STIs and VCT, etc. There was a conscious effort to evolve participation of key community members in reducing stigma and discrimination, encouraging members for early testing of STIs and accessing VCT services.

Networking and Linkage building: Series of training workshops were conducted with the nursing orderlies of government hospital and also organized sensitization meetings in the hospital and in the vicinity. The core groups were formed of nurses and other staff members of government hospitals to form a base so that partner NGOs can refer PLHIV to receive ART.

These strategies evolved through consultations and by collective measures to address project processes. Few of the strategies described in following paragraphs were added and implemented for stipulated time periods which then were revisited and modified.

The issue of advocacy on PMTCT and access to services was incorporated in the strategic focus from **the year 2002** as a result of participatory community review. This was made possible only because by then, PPTCT programme was scaled up in the country with Nevirapine as the regimen of choice.²⁰

The significant point of programme from **year 2003** was the direct involvement of children and was of more children focused. More and more vulnerable/affected children were targeted and services were expanded for CAAs in shelter homes and for care & support. In 2002, an estimated 4 million children lived on the street²¹ and approximately 9 per cent of all children²² under the age of 18 had lost one or both parents. It was estimated that 170,000 children below the age of 15 years are infected with HIV & AIDS in India and 57,000 children infected every year through mother to child transmission.^{23 24}



From 2004 onward the purpose to Increase community action for and access to prevention, care and impact mitigation efforts were taken up in direction for improved coverage of effective community focused AIDS efforts with strengthened leadership and capacity of civil society to respond to AIDS by Improved institutional, organizational and policy environment for community AIDS responses. It moved towards mainstreaming child rights issues and addressing concerns of children as they being the most vulnerable group in the given settings. It also made concerted efforts to facilitate common platforms for children who are

²⁰ Strategy and Implementation Plan NACO 2006
<http://www.nacoonline.org/upload/Publication/Strategy%20and%20Implementation%20Plan%20%20NACO%20Programme%20Phase%20I%20III%20.pdf>

²¹ Silent Cries and Hidden Tears, Veena Johari, 2002, Lawyers Collective

²² Children on the Brink 2004: A joint report of new orphan estimates and a framework for action. UNAIDS, UNICEF, USAID. 2004:
www.unicef.org/publications/index_22212.html

²³ Mother R Emerging initiatives to decrease the HIV vulnerability of marginalized children in India: The example of children of sex workers and street children Sexual Health Exchange 2005-1 http://www.kit.nl/frameset.asp?ils/exchange_content/html/2005-1_emerging_initiatives_.asp&fmr=1&

²⁴ Strategy and Implementation Plan NACO 2006
<http://www.nacoonline.org/upload/Publication/Strategy%20and%20Implementation%20Plan%20%20NACO%20Programme%20Phase%20I%20III%20.pdf>

affected and infected with HIV and other children who are most vulnerable i.e., street and working children, children of commercial sex workers and IDUs.

In later years of the decade, the programme had evolved to much defined themes and approaches to address the emerging needs and to achieve programme impact. That was also partially resulted due to the strategic shifts of and packaging of services offered through National AIDS Control Programme. The broad strategies of the project can be outlined as,

- ◆ Identification of CLHIV, CAA(including OVC) and linking them with a wide range of services
- ◆ Identification of community Inducers to create a continuous and sustainable source of information and education within the community. Where majority of the CIs are from Frontline Public System Functionaries viz. Anganwadi Workers, ANMs, Private Medical Practitioners, Medical Store Keepers, Local Vendors, Community leaders & PLHIVs
- ◆ Formation and strengthening of Support Groups to strengthen sustainable collective action by community and to develop an enabling environment for people living with HIV; at family, community and service delivery level
- ◆ Provision of direct Support for Nutrition, Education, Medical, Income Generation, specific Travel, Emergency to improve the quality of life of the target group and to mitigate the immediate needs of children living with and affected by HIV & AIDS
- ◆ Sensitisation & Capacity Building of health care providers In order to develop sustained linkages for prevention, treatment, care & support services between community (especially children living with & affected by HIV & AIDS) and service providers (public & private)
- ◆ Establishing referral & linkages to maximise access to continuum of care for target group.



The programme had inbuilt component of capacity building through various trainings, workshops, exposure visits, review & replanning, cross sharing & learning on periodic bases to build the capacities of the teams. The focus remained on building knowledge and skills such as documentation skills, Aspects of Programme management, MIS & information management etc. The thematic issues such as strengthening GIPA, Continuum of Care, Community Mobilisation, Advocacy & Networking, Stigma & discrimination, Home & community based care & support, life skill education, prevention of parent to child transmission, to name with were interwoven in such forums.

“I am thankful to the entire CBCS team for changing my life from Male Sex Worker to an Outreach Worker”

Response of a PNGO staff

Partnership with NGOs for programme Implementation

The CBCS programme, since the beginning, was conceptualized to be implemented through collaborations be they of lead organisations with technical & managerial roles or of partner NGOs with project execution roles. The NGOs which had connectivity with state health systems and directly with community/ies, had maximum participation in developmental initiatives on the bases of evidences and had visibility within the community were partnered. During the course of the programme period the partnerships were reviewed and updated.

Child Survival India

Child Survival India (CSI), based in New Delhi is a community development agency established in 1991. It currently operates in Northern India States of Delhi, Haryana, Punjab, Chandigarh & UP. Integrated approach to development with a prime focus on health, education and gender is the basic theme of all its programs. Working on the mission of helping people help themselves, a major aim of the organization has been to mobilize the community into self help groups like Support groups for HIV positive individuals, Mahila panchayats for women facing domestic violence and Swasthya samooths for women in the reproductive age group. CSI addresses the entire continuum of the HIV/AIDS problem.

Salaam Baalak Trust

Salaam Baalak Trust (SBT) grew out of Nukkad – a street-based intervention program that worked with street children. Established in the year 1988 after the success of Mira Nair's film Salaam Bombay, Delhi-based Salaam Baalak Trust is proud to be among the first of the NGOs who realized the dire conditions of these underprivileged street children. SBT with its support to more than 60,000 children, is dedicated to the care and protection of neglected street children, regardless of caste, color, creed or religion. It offers a comprehensive package of services with a range of programmatic activities like; health, education, life skill, mental health, theatre, sports, games, vocational training, HIV/AIDS care and through 1098 – emergency help line.



Asha Deep Foundation

Asha Deep Foundation (ADF) carrying out development activities since last 25 years in the slums of Delhi and Uttar Pradesh. ADF is executing the development activities in the urban slums, resettlement colonies and rural to reach out maximum number of community people who are socially, economically, politically and culturally disadvantaged. Since its inception, the emphasis was given on the holistic development of the community people. The foundation has strong belief on all section of the society to be covered to experience a visible change. The foundation also runs different social change and Community transformation projects for marginalized people. In Asha Deep Foundation many trained & well experienced professional working with motto of holistic development of the marginalized communities, the foundation also sharing working experience of community development with national & international organizations.

“After I got registered, looking at the positive attitude of other HIV positive people towards life, had changed my entire negative outlook and helped me to overcome from fears and anxieties about my HIV status. The financial assistance I received for opening a tea stall helped me to become economically independent”

Response of a CBCS beneficiary

Bhartiya Association for Rural Development

Bhartiya Association for Rural Development (BARD) is a registered in year 1993 as a non profit organization. It has been continuously working in North East of National capital territory Delhi and Uttar Pradesh on issues of women empowerment, sexual and reproductive health and HIV and AIDS with specific focus on High Risk Groups, Women and Children.

ANCHAL Charitable Trust

ANCHAL Charitable Trust [ACT] is an independent, professionally managed institution extending effective development facilities in the field of education and health for the economically depressed segments in India. ACT was established in 1993 with the coming together of like-minded professionals from different areas of activity, bound together by a common goal - the 'Rights of the Child'. ACT covers two strategic programme areas - Health and Education ensuring better standards in the delivery system and an improved capability to deliver quality work standards today to meet the stringent demands of tomorrow. The focus of ACT activity is on women and children especially, the needs of the girl child and children in difficult circumstances from the under privileged, underserved sections of society.



SAHARA

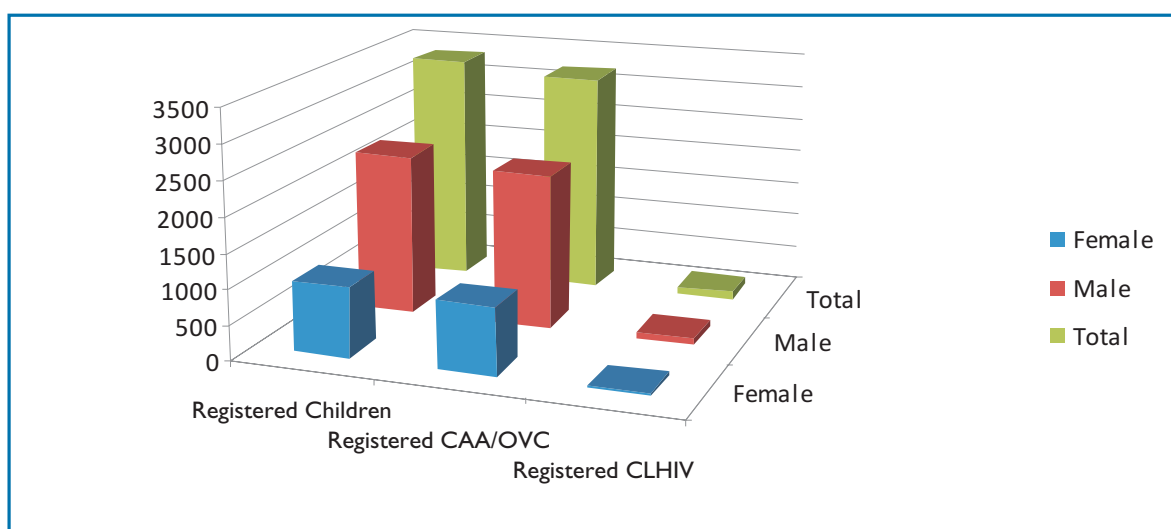
Sahara is an organization that has worked on substance use and HIV/AIDS prevention, awareness and care for the past 33 years, addressing the needs of men, women, transgender and children through a variety of projects. The organisation has projects in Delhi, Manipur, Nagaland, Hyderabad, Pune and Mumbai with a sophisticated matrix of activities and services that meet its clients' needs. The majority of Sahara's staff are former clients who have risen through the organization to now play a role in changing the lives of others, just as they were once helped. This peer-based structure has provided a unique approach to problem solving, based on personal experience, empathy and self-discipline. Sahara provides training and awareness on drug abuse and HIV/AIDS to other organizations including the local police.

The Evaluation Findings

The evaluation was, intended to and thus, designed to capture the relativity, relevance and the representativeness of the context through the personal experiences of all the stakeholders involved demonstrating the outcomes. The evaluation is hence seeking findings in terms of the needs and priorities of registered target groups, challenges faced while addressing them, implementation results and the mechanism set up for sustenance in the future.

The findings, mainly, are captured pertaining to the programme as well the evaluation objectives such as coverage of various beneficiaries and their sub categories, linkages with HIV related services, range of support provided to the beneficiaries, identification and capacity building of service providers, etc. The source for these graphical presentations is the compilation of the different data reported by the PNGOs and verified during the evaluation exercise.

Graph 1 : CBCS Children



Source: CBCS Coverage Data

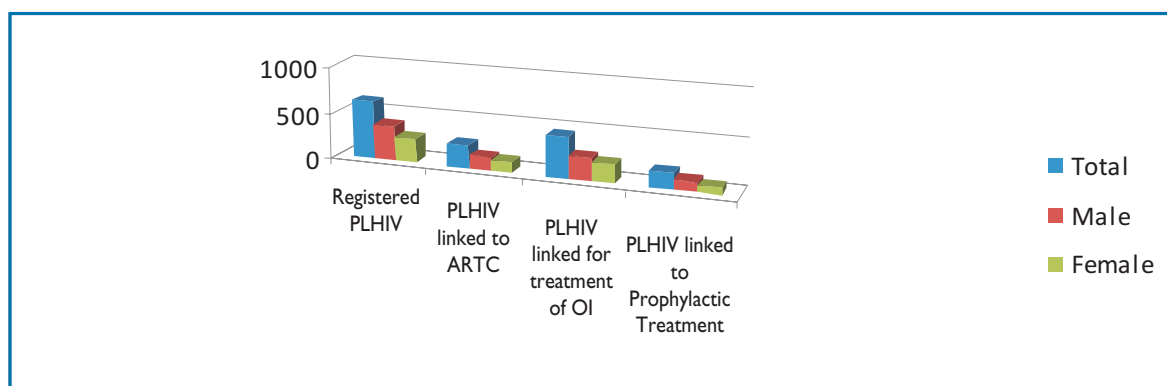
According to UNAIDS India Country Progress Report, total of 63,889 children living with HIV are registered, as on January 2010. The CBCS programme has reached out to 125 Children who are living with HIV out of registered 3322 children who are CLHA, CAA or OVC. The data indicates that the 0.19% of the CLHIV have been benefitted from the CBCS programme.²⁵

As on December 2008, total of 18501 HIV positives were registered in 9 ARTCs across the Delhi city out of which 92.8% were adult compare to 7.2% (i.e. 1332 in numbers) children with HIV. Considering the stated scenario, total of 9.38% CLHIV are covered through the CBCS programme.²⁶

²⁵ http://data.unaids.org/pub/Report/2010/india_2010_country_progress_report_en.pdf

²⁶ <http://www.scribd.com/Epidemiology-of-HIV-Infection-by-Dr-AK-Gupta-Additional-Project-Director-Delhi-State-AIDS-Control-Society/d/13047007-presentation-Dr.-AK-Gupta-APD-DSACS>

Graph 2 : CBCS PLHIV beneficiaries

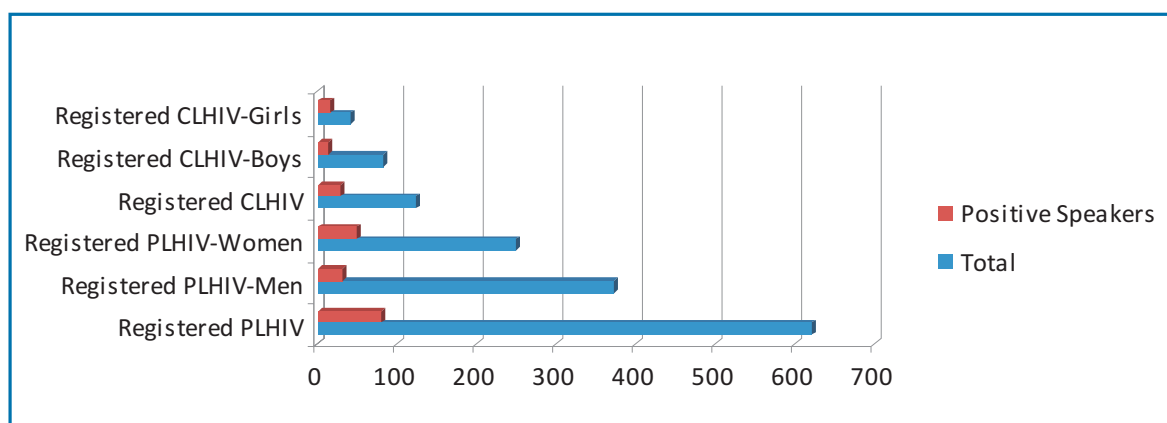


Source: CBCS Coverage Data

According to Delhi State AIDS Control Society, 5476 PLHIVs were alive and on ART by May 2010,²⁷ keeping this data in to the account, the CBCS programme could identify 622 PLHAs i.e 11.36% of the city.

The programme strategies were successful in linking 247 beneficiaries which is almost 40% from the total PLHIV beneficiaries to the ARTCs, 71% & 29% were linked to opportunistic infection services and for prophylactic treatment services respectively.

Graph 3 : CBCS Positive Speakers



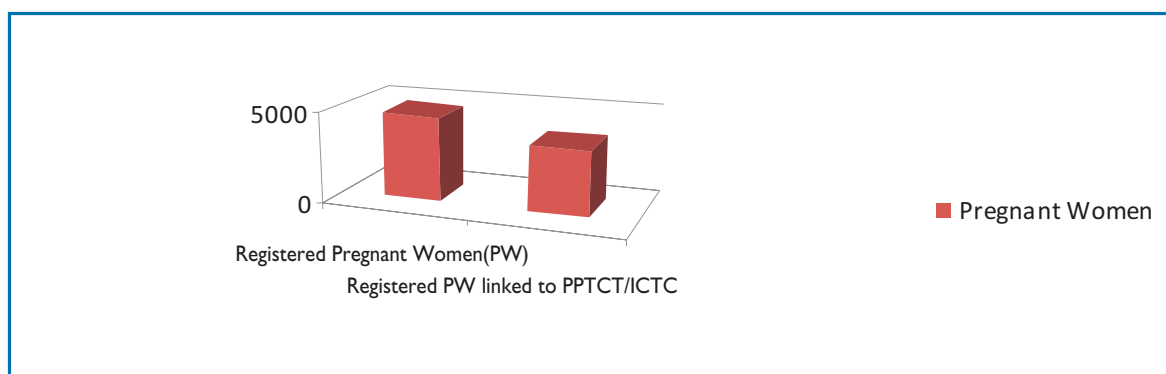
Source: CBCS Coverage Data

Out of total 622 PLHIV, 13% of PLHIV are trained Positive Speakers and from them 61% are women positive speakers.

With the child centric programme design, the CBCS programme has developed 23% positive CLHIV speakers from which 55% are girls CLHIV speakers.

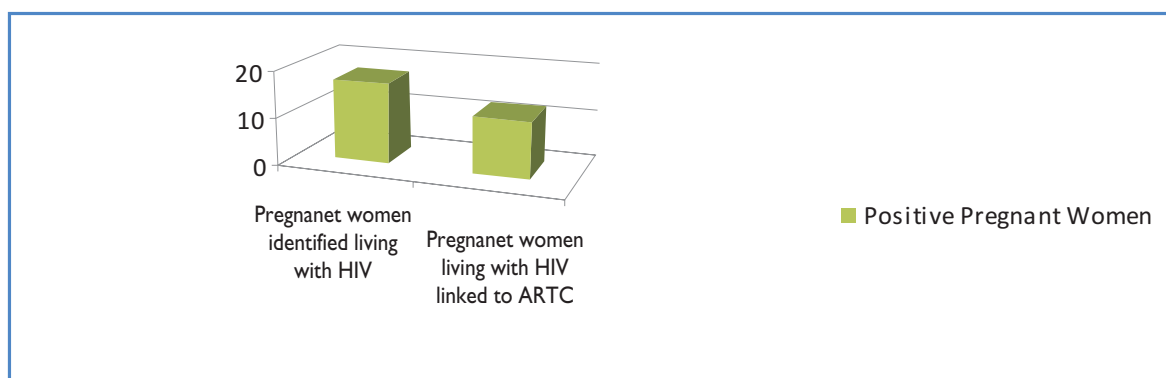
²⁷ Delhi Scenario, Delhi State AIDS Control Society http://www.delhi.gov.in/wps/wcm/connect/doi_t_dsacs/DSACS/Home/HIV+-+AIDS+Scenario/HIV+or+AIDS+Scenario+in+Delhi Last Updated : 21 May,2010IV

Graph 4 : CBCS pregnant women



Source: CBCS Coverage Data

Graph 5 : CBCS pregnant positive women

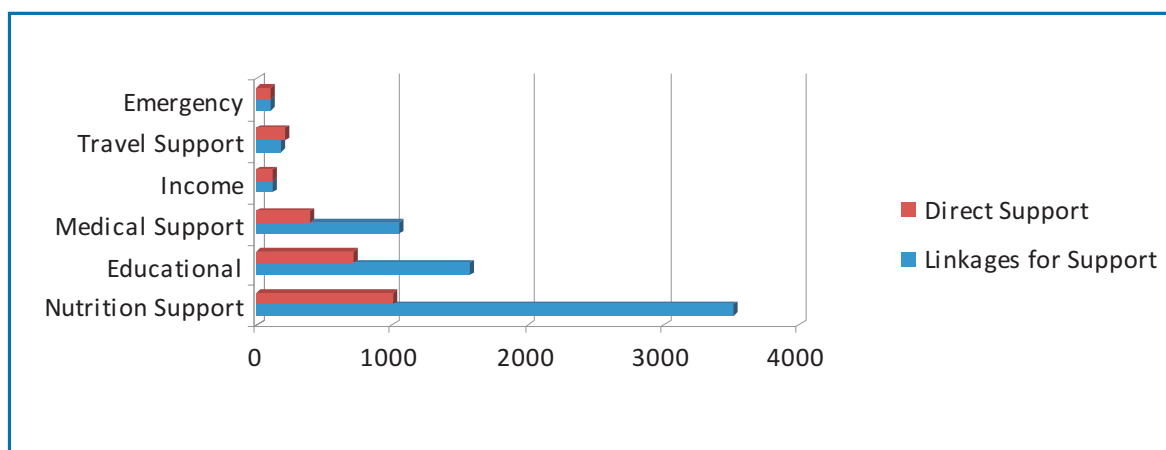


Source: CBCS Coverage Data

The programme with its strategy to reach out to the children through the mothers has registered 4671 pregnant women during the whole period out of which 0.36% were identified HIV positive expecting mothers. 0.25% pregnant women were linked to ARTC.



Graph 6 : CBCS Support



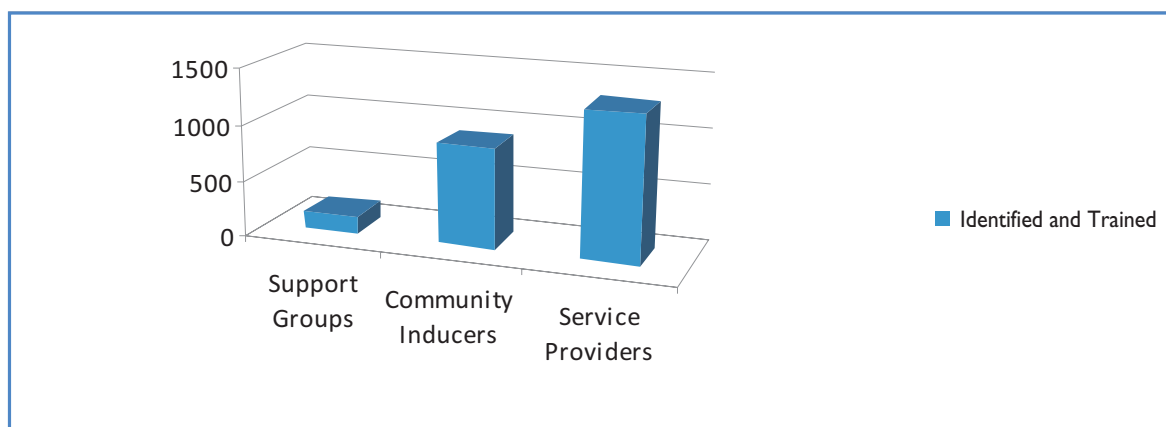
Source: CBCS Coverage Data

It is clear from the graph that the programme has provided support to CLHIV, PLHIV and FAA through linkages more for nutrition, education and medical needs.

It is also evident that direct support was provided from the CBCS programme for Income generation, emergency and travel related to HIV treatment.

The inference also indicates that the nutritional support was the most required support to the beneficiaries than to address any emergencies.

Graph 7 : Capacity building of local resource through CBCS



Source: CBCS Coverage Data

The programme has involved 898 different front line functionaries of health and WCD departments, community leaders, shopkeeper, vendors, etc. 1300 service providers from different health, education and other services after training and engaging them for various programme effects.

The partner NGOs could form 155 Support Groups of children and adults.

The data shows that, with a decade long effort to deal with children centric HIV related issues the programme has liaison with wide range of primary, secondary and tertiary stakeholders.

The Evaluative Conclusions

Considering the period of initiation of the programme implementation in Delhi, the inference shows that the part of programme outcomes are relevant to the current needs of the National AIDS Control Programme as described in Result Framework documents in form of few of Success indicators listed such as Number of Clients tested for HIV, Number of Pregnant Women tested for HIV, Number of HIV+ pregnant women and babies receiving ARV prophylaxis, Number of People Living with HIV&AIDS (PLHA) on ART, Number of new Opportunistic Infections (OIs) treated.²⁸ The programme strategies have contributed largely in working towards achieving these indicators by varied approaches.

It is very well evident that the programme has evolved throughout the period in accordance with the needs of the community and with the systemic change in the available resources. The overall approach funneled from generic prevention approach to more children specific in later years. The child centric approach enabled the programme implementation to focus on the basics needs of the CLHIV and CAA in terms of psychosocial, educational, health related and of monetary needs for day to day survival.

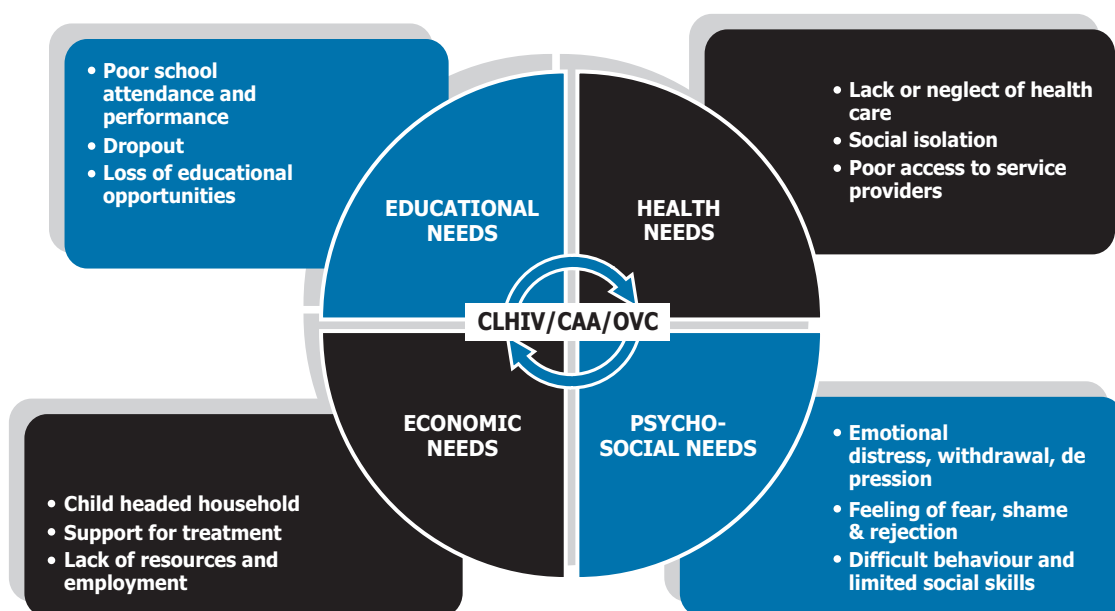


Figure 2: Priority needs of CLHIC/CAA/OVC identified by CBCS Programme

The programme strategies were tailored and updated on periodic bases as with the emerging needs of the beneficiaries and with the available scenario. The needs that were addressed through the programme implementation, which are detailed out in Description of the programme implementation are depicted in above diagram.

²⁸ <http://performance.gov.in/RFD%202010-11/Syndicate%202/AIDS.pdf> Section 4, Pg 11-14
RFD Result frame work document for Department of AIDS Control (2010-2011)

These needs were addressed strategically through various thematic approaches as described below.

“DSACS has comprehensive programme for children living with and affected by HIV & AIDS under which CABA scheme has already been launched in Delhi. OVC Forum has been established. Till January 2011, 779 infected & affected children with HIV have benefited from the scheme.”

Dr. AK Gupta APD DSACS

Community Mobilization:

Community mobilization activities were and are being focused on enhancing the utilization of available safe motherhood, immunization & sexual and reproductive health services and other treatment, care and support services. In addition to, the emphasis was given to condom promotion, counselling voluntary HIV testing, early diagnosis and management of opportunistic infections, sexually transmitted infections and partner notification/treatment. Meetings were conducted with pregnant women in regards to safe motherhood and Prevention of Parent to Child Transmission (PPTCT) of HIV infection. The popular mass media, street plays, group formation and interpersonal communication used as basic tools for community mobilization. Such events were conducted to create awareness and especially in order to mobilize community towards the fighting against stigma and discrimination attached with HIV and AIDS. Community Inducers, different stakeholders, community leaders and involvement of PLHIV played very important role in mobilizing community.

“To become a Positive Speaker, a person goes through the process of coming out from fear and self stigma which helps fighting social stigma associated with the cause and the group”

A Respondent from Positive Speakers

Identification and strengthening capacities of community inducers

One of the important functional prerequisite of running any community intervention programme is to take along different social groups from that community. This becomes even more important while handling a sensitive issue like HIV and AIDS where people are still ignorant about its potential impact, hesitation to aware oneself with. Therefore, it was important to gain their trust before initiating any intervention. Along with other methods CBCS programme initiated to involve active and committed community people in the field level activities.

“It was critical to enable and enhance the access of women and children living with and affected by HIV&AIDS to care, support and treatment services where stigma and discrimination is very much deep rooted at community as well as service delivery level.”

A respondent of the partner NGO

These people named as Community Inducers were taken through the process of structured and systematic capacity building; the most important role of CI's was to create a continuous and sustainable source of information and education within the community and referral and linkages towards prevention, treatment, care and support services. Majority of the CIs are from Frontline Public System Functionaries viz. Anganwadi

Workers, ANMs, and other private Medical Practitioners, Medical Store Keepers, Local Vendors, Community leaders & PLHIV.

Formation and strengthening of support groups

The people especially children living with and affected by HIV and AIDS need special attention in terms of sharing their concerns. Hence the project had envisaged strategy of formation of different support groups viz. children, men and women; which in turn extends psycho-social support to community, reduces stigma and

“I was very young when I met Sir (CBCS staff member), I liked here, they talked to me, they behave with me as they did with others, so I kept coming here and meeting them, then I became part of a group of friends which is called Support Group, we talked about all the problems. Now I am a grown young man and I gather small children who are facing similar problems as I faced.”

A respondent from the Child Support Group

discrimination at personal, family and community level and to further facilitate enabling environment at community and service delivery level. These support groups are also being strengthened as pressure groups through regular meetings, training and workshops to facilitate increased access of much needed services for people living with and affected by HIV and AIDS especially women and children.

Enhancing Greater Involvement of People Living with HIV/AIDS

Through concerted efforts to ensure involvement of adult and children living with HIV the CBCS programme partners have successfully established linkages with Delhi Positive Network (DNP+) and with DSACS. This long term coordination has helped promote positive living, referral linkages, treatment adherence among PLHIV. Many of the beneficiaries have undergone training on Positive Speaking and have been given recognition as trainers.

“Our Lives have been saved through the project”

‘We have now learned to live and face the life which can be different from other children”

“Certain issues we can not discuss at home, but can discuss with Didi (CBCS Staff member) freely”

“I am Happy that I am not ALONE since 3 years of my association”

Voices of CBCS Children Beneficiaries

The Positive speakers share their experiences about life after HIV infection, positive living, sexual & reproductive choices that they have to make, promotion of parent to child transmission, etc. They also address issues related to stigma and discrimination at family, community and service delivery level and the ways to deal with different situations. These initiatives have facilitated to reach out to the hidden populations, building the capacities of PLHIV, enhance their participation and sense of ownership in the programme.

Provision of Direct Support and through Referral & Linkages:

In order to mitigate the immediate need of PLHIV especially children living with and affected by HIV and AIDS; project had provision of need based direct support in line of nutritional, educational, medical, income generation, travel and in case of emergency. This support was being provided on basis of set criteria and participation of community inducers.

“CBCS programme activities are conducted in play way methods thus children enjoy interacting with us and participating in our activities”

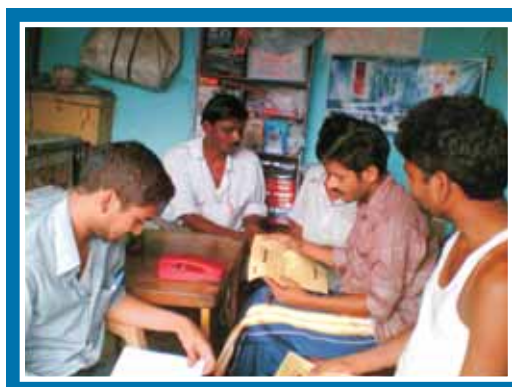
A respondent from Community Inducers

Referral & linkages were one of the important strategies being adopted by the program to sustain the outcome. Secondly it is very much difficult to manage the continuous & rising needs of the community in limited resources, moreover it is prior responsibility of the Government to protect and take care of the welfare of the citizens. Thus project established community based system for referral and linkages towards prevention, treatment, care and support services which increases the utilization of services and facilitates the Government efforts.

Sensitisation and capacity building of service providers

Stigmatisation and discrimination at service delivery level is a major barrier for Key Population, PLHIV, CLHIV, CAA and OVC to access much needed HIV and other support services; secondly it widens the gap between the community and service providers. Therefore in order to bridge the gap between community and services and to facilitate the increase in access of services to them CBCS program executed the strategy to sensitize and build capacity of service providers. To improve quality and delivery of the services; the service providers were being sensitised, trainings and workshops were conducted to further build their capacity with regard to care and support needs of PLHA with a focus on CLHIV and CAA.

In this line activities were intensified in the areas where program is already being implemented by increasing the frequency of interaction with the service providers. Project also involved different levels of service delivery in consideration for the execution of program. The state authorities of AIDS Control programme, W&CD, medical officials, in charge of ICTC, ARTC, PPTCT were made part of such activities to address the concern.



“MAMTA has demonstrated state of art leadership through such initiatives under which the work done is actually working towards the cause with lots of collective efforts.”

Dr. AK Gupta APD DSACS

Networking and Advocacy

The strong linkages between the services and PLHIV especially women and children was found critical. It was felt essential to encourage more and more people to voluntarily opt for counselling and HIV testing. The linkages and liaison between community interventions and testing & treatment provisions were always felt short to bridge the gap. In spite of involvement of various organisations in AIDS control programme, the greater involvement of people living with HIV & AIDS at different decision making levels and stages were found limited than the required. The CBCS programme emphasised strongly to advocate for reducing the stigma, strengthening linkages, involving PLHIV to reduce the impact. The programme rigorously worked

towards creating platforms and providing forums to the partnerships and persons for effective networking to bring positive change. To effectively bring change at various levels, numbers of workshops & seminars were being organized, were being participated and the CBCS programme was made visible at different National and International platform.

Capacity building and Institutional Strengthening

These thematic approaches have impacted not only on programme beneficiaries but also on organisations and the individuals involved in various capacities. The decade long input in enhancing the human capacities in terms of Knowledge, attitude and skills have not only effected on their programme specific roles but on the overall professional and on the personal growth as well.

As reported by many team members that they themselves could see changes in their own lives. These changes helped them translate themselves as change agents for the needy communities. Through this approach, they could facilitate children with depressed, demoralised states to more empowered & grown, with different personalities.

“We, as an organisation have grown from, in terms of technical capacities which resulted in attracting other funders and our credentials were raised. This happened only after being recipient of CBCS programme as our work was noticeable.”

Chief of PNGO

This progress is not only limiting to the individuals but also to the organisations that were responsible for the programme delivery during the period. Till then the organisations focused only on prevention aspects of HIV though the addressal for care & support to PLHIV was foreseen by them. This added component of service delivery gave the organisations a comprehensive outlook and progressive opportunity for new and relevant learnings. As a result the newer institutional capacities are apparent, to state a few, to deliver through participatory approaches, to work for reducing stigma associated with by firstly being stigma free and to increase public health systems approach by working towards increasing the access, etc. By addressing the multiple issues in relation to the target community and specifically pertaining to the children, brought integration in approach. That happened in two ways. Rather than seeing the programme needs in isolation, needs of the beneficiaries were brought in the centre and for that all the available resources were tapped, used and incorporated in programme planning. On the other hand, various sectors and the agencies joined hands to collaborate and used the strengths of one another which further strengthened institutional capacities.

Lessons Learned

Delhi being a low HIV prevalence state, making people perceive specific behaviours as health risk and making them access available services for them selves and for their children towards lowering the risk was time taking and of extensive information exchange. However, the programme with a wider reach in term of - the geographical locations, the range of beneficiaries covered, the levels of stakeholders involved, the thematic attributes that were considered, the partnerships optimised - and the continuity in efforts are not possible with out problems, obstacles which were progressively resolved.

However, the following learnings are mirrored through the intervention to meaningfully contribute to the infected and affected young lives.

- ♦ The programme was designed to reach out to the group which was then, NOT focus of the government or of the public systems. Still, with such scenario, the efforts were made to trigger the required supply by bringing existing human resource such as health care functionaries, local leaders and community members in for front for deliverables.
- ♦ Any deliverables linked to the community, are not possible with out continuous community participation, support and involvement of various representations from/with in the community. The project had demonstrated inbuilt mechanism and intensity in/for revisiting and revising the planned processes according to the community needs and demands.
- ♦ Capacity Building sessions conducted during the entire period are evident in actions and seen translated into required skills. The participation of wide range of levels for a long term basis has set a good learning example for future community intervention strategies
- ♦ The project period and the age group that is being targeted – both have confirmed that any vision or concept to be implemented and then to be impacted needs constancy of resources and of target beneficiaries. Thereby, the impact could be seen on human lives.
- ♦ The programme felt logical and also feasible to catch the children who have possibility of acquiring the infection by reaching out to pregnant women on services related to safe mother and child health and simultaneously providing the susceptible family HIV and programme related services for their longer benefits. In this manner, the programme had better understanding of the issues and could provide comprehensive package of need based services to the of sub categories of primary stakeholders.

Providing knowledge about safe health and safe life practices at the early age through various information channels has helped many young beneficiaries to opt for the safer choices and for responsible options be they for oneself or family or friends.

“Child health is just not about ART & follows up. It is about breastfeeding, immunisation, nutrition and various other aspects. This comprehension of child health and development was a great learning for the organisation.”

Dr. Sunil Mehra Executive Director MAMTA

Recommendations

- ◆ It is imperative to get an estimate on periodic bases of children who are infected and also affected by HIV and AIDS. At national level and with some states, the data is available but the district estimates should be systematised.
- ◆ Increase in resource allocation from different sectors will become vital. Without much of estimation through such programme interventions demands are now measured and are evident, but once the estimates are systematised it will need high volume of resources.
- ◆ More and more government programmes should mainstream CLHIV/CAA centric policies and schemes where the conditions are not very service seeker friendly. There are multiple needs identified by the CBCS programme and thus multi layered support mechanisms for nutrition, education, income generation, etc. are required
- ◆ As success rate to reaching out to women, pregnant women and pregnant positive women is high and motivating them to access to the HIV services and testing centres is made demonstrable through this programmes, more efforts should be invested in linking HIV and MCH programmes, integration of respective services which eventually brings better and corresponding outcomes.
- ◆ Availing comprehensive health care services are rights of any citizen and especially in this case of any child irrespective of its HIV status, the system should not only work towards making them available but also bring systemic change according to the demand by making service outlets effective than parallel, multiple outlets with least accessibility and low human resources.
- ◆ The capacity building efforts of this programme were not limiting to the trainings and workshops but also through involving people, giving them recognition & thereby, responsibilities and developing their respective skills. The programme has proved that effective advocacy and continuous dialogues can enhance people's participation in perceived difficult subject and stigmatised issue. The efforts should be carried forward by public and private sectors.
- ◆ As documentary evidences suggest that ensuring proper nutrition is a critical aspect of prevention, since malnutrition increases the risk of death.²⁹ The programme results have emphasised that the nutritional support is the most seek and sought after than any other needs. If that support is continuously made available, the human life that is affected or infected is mainly saved. The funding should be raised and spared to support for nutrition along with the treatment component.
- ◆ The positive networks should advocate with and sensitise the influencers to support needs and life demands of infected and affected children/adolescence. The positive speakers and the efforts to build skills of such a kind should be encouraged to promote acceptance and supportive surrounding to fight against self stigma & social discrimination.

²⁹ <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf#page=28>

Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ART	Anti Retroviral Therapy
ARTC	Anti Retro viral Therapy Centre
BCC	Behaviour Change Communication
CAA	Children Affected by AIDS
CB	Capacity Building
CBCS	Community Based Care & Support Programme
CBO	Community Based Organisation
CCC	Community Care Centre
CI	Community Inducer
CLHIV	Children Living with HIV
CSO	Civil Society Organisation
DNP+	Delhi Network of Positive People
DSACS	Delhi State AIDS Control Society
FAA	Family Affected by AIDS
FGD	Focus Group Discussion
GIPA	Greater Involvement of People with AIDS
HIV	Human Immunodeficiency Virus
ICTC	Integrated Counselling and Testing Centre
IDI	In Depth Interview
IDU	Injecting Drug User
IEC	Information Education Communication
MCD	Municipal Corporation of Delhi
MCH	Mother and Child Health
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non Government Organisation
OI	Opportunistic Infection
OVC	Orphan & Vulnerable Children
PCA	Participatory Community Assessment
PNGO	Partner Non Government Organisation
PLHA	People Living with HIV and AIDS
PPTCT	Prevention from Parent to Child Transmission
PW	Pregnant Woman
RSA	Rapid Situation Analysis
STI	Sexually Transmitted Infection
UNAIDS	The Joint United Nations Programme on HIV & AIDS
USA	United States of America
VCT	Voluntary Counselling & Testing



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