CONVERGENCE BETWEEN THE NATIONAL AIDS CONTROL PROGRAMME (NACP) AND THE DEPARTMENT OF HEALTH AND FAMILY WELFARE (DOHFW)

1. INTRODUCTION

1.1 The HIV/AIDS epidemic in India is complex, with intense focal epidemics among sub groups (IDUs, Sex workers, Truckers, Men who have sex with Men) in some states, situations where prevalence is over 1% in the general population, and low prevalence in some others states. In states like Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra, Manipur, and Nagaland, prevalence among antenatal women (based on sentinel surveillance data (2003) located in ANC clinics), considered representative of the general population, is around 1.25%. Annexure 1 provides state wise HIV prevalence levels from 455 sentinel surveillance sites, for the year 2003. NACO has classified states as high prevalent, medium prevalent, highly vulnerable and vulnerable states (Annexure 2). The index of vulnerability is based on extent of migration, size of population, and poor health infrastructure. Among highly vulnerable states are: Bihar, Rajasthan, MP, UP, Uttaranchal, Chhatisgarh, Jharkhand, Orissa, and Assam. This includes all the EAG states of the DHFW.

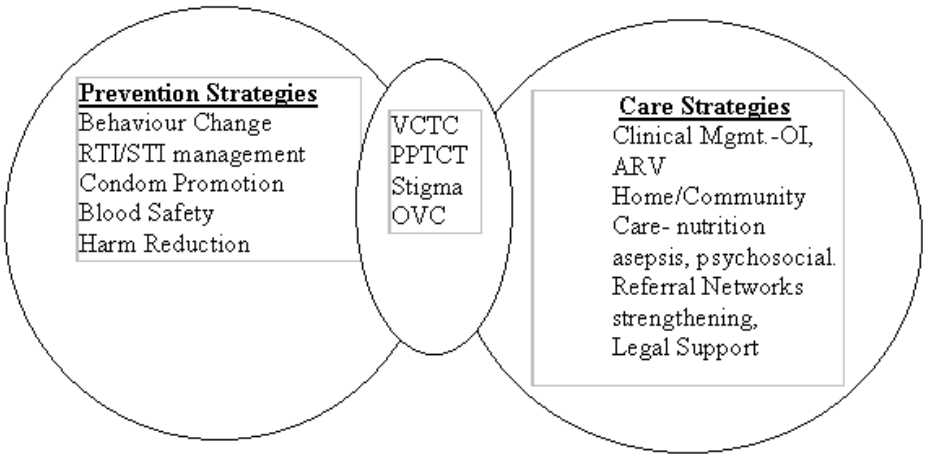
1.2 There is a pressing need to scale up prevention strategies based on factors of risk, vulnerability, and impact, expand delivery of interventions and ensure that populations at risk and vulnerable groups are reached. India is at a stage in the epidemic where all sexually active individuals must be offered information and services on preventive interventions. Sexually active youth, particularly girls are at high risk given the paucity of needs specific information and services. HIV/AIDS infection prevalence is increasingly acquiring gender connotations. Sentinel surveillance data also show that women account for more than half of all infections in rural areas (nearly 60%) and about two fifths of all infections in urban areas. Sentinel surveillance sites are located mainly in either Antenatal clinics or in STD clinics. Given the evidence that most STD clinic attendees are men, it can be assumed that most women who are positive are also pregnant, a rather ominous portent for risk of transmission to newborns, and a substantial justification to expand the number of sites offering PPTCT.

1.3 **Convergence between the National AIDS Control Programme (NACP)** with over a decade of experience and technical competence in HIV/AIDS prevention and care interventions and the **Health and Family Welfare programmes (HFW)** with its infrastructure, human resources and capacity reach to every village and community is critical to ensure scaling up and effective service delivery.

1.4 Behavior Change, prevention/management of RTI/STI and condom promotion are the cornerstones of HIV/AIDS prevention. All three areas have a significant degree of overlap with interventions in the Reproductive and Child Health programme, since target groups and services fall in the same arena. Other areas of prevention linked to

HIV/AIDS interventions and which have implications for services in the HFW are Voluntary Counseling and Testing, (VCTC), Prevention of Parent to Child Transmission (PPTCT), and ensuring safety of blood and blood products. Comprehensive HIV/AIDS Programmes include components of both prevention and care. VCTC and PPTCT are two areas of overlap between prevention and care strategies. Areas of cross cutting importance that need to be addressed in prevention and care strategies include: gender, private sector involvement, and reduction of stigma and discrimination among health care providers and communities.

(Figure1)



2. CONVERGENT TECHNICAL STRATEGIES AND PROGRAMMATIC INTERVENTIONS OF NACO AND HFW

2.1 The National AIDS Control Organization (NACO) is the implementing agency for the NACP. At the state level, State AIDS Control Societies (SACS) implement HIV/AIDS interventions. Currently NACO and the SACS support about 900 NGOs for targeted interventions aimed at reaching the so-called high-risk groups. (those with high numbers of sexual encounters increasing possibility of transmission, such as Sex Workers, Truckers, Men who have sex with Men, Intravenous Drug Users, Adolescents, Migrant men and women,). They also support behaviour change communication aimed at the general population through variety of mechanisms. The reach of the NACP to men and in urban areas is significant.

2.2 In the public sector, NACO and the SACS support RTI/STI management, VCTC, PPTCT, Blood Safety, and several other interventions. However the reach of these interventions through the health system is primarily through teaching hospitals and medical colleges, district hospitals and in the case of the six high prevalence states, taluk hospitals as well. The SACS in the high prevalence states (most of which are the ones with better health infrastructure and moderate to high care seeking) are also active in implementing HIV/AIDS interventions.

2.3 The Department of Health and Family Welfare at National and State levels (with state specific variations) supports a range of services for improving primary (including reproductive) health care at community, primary, secondary and tertiary levels. Community based interventions are primarily provided by the Auxiliary Nurse Midwife located at the sub center. The coverage of the sub centre is about 5000 (3000 in tribal areas) and covers about the area of three to four gram panchayats. Service delivery is through the sub center on fixed days, supplemented by outreach visits to the coverage area. At the village level, the Anganwadi Worker (AWW) and/or the Traditional Birth Attendant (TBA) often assist the ANM. With the advent of the National Rural Health Mission it is expected that the ANM will soon be supported by a female community health volunteer (ASHA), and assisted by the AWW and TBA. Thus the potential reach of the system will be to every community and habitation. In addition to the public sector health system, the DHFW supports NGOs (through the Mother NGO scheme) to implement a range of RH interventions (Safe motherhood, family planning, adolescent health, RTI/STI management, child health, and male involvement) in areas underserved or not served by the public sector system. While the DHFW through its flagship RCH project does include enhancing male responsibility as a key intervention, the emphasis is on women and children. Urban health is a component of the RCH 2 programme.

2.4 The following areas of convergence have been identified[1[1]] for scaling up HIV/AIDS prevention responses: RTI/STI management, Condom Promotion, Voluntary Counseling and Testing, Prevention of Parent to Child Transmission, Behaviour Change Communication, Blood Safety, Training, and Management Information Systems. In addition *male involvement* and ensuring convergence of NACP and DHFW through *strengthening urban health infrastructure and reach* are two additional strategies, which are common to the major areas identified above.

2.5 This paper provides a broad framework for action to address the major convergence areas. The effectiveness of convergence of key interventions is dependent on several factors, but critical is the operationalization of convergence within *well functioning health systems and programme management structures at all levels*. RCH II has been designed to address reproductive and child health interventions through a framework of health sector reforms at various levels. It is opportune that NACO and DHFW *jointly look for ways to improve reach, enhance access and coverage, provide quality services, address synergistic intervention elements, and prioritize interventions based*

[1[1]] NACO and the DFW jointly constituted a six member Task Force in late December, 2004 to identify areas of convergence and develop an operational plan by January 31, 2005.

on prevalence, infrastructure, current programme efficacy, and resources. It must be emphasized that this framework is proposed at the National level and state level consultations with key stakeholders are necessary to operationalize the plan in the context of state realities.

2.6 Section 3 provides substantive details on each convergence area, with a brief technical background for each area, highlights current interventions of NACO and DHFW, identifies points of convergence in order to reach groups and communities that are at risk and vulnerable, and defines broad areas for operationalizing these strategies. Section 4 includes operationalization of convergence and details institutional mechanisms to facilitate convergence. Section 4 is supplemented by a matrix, which summarizes key convergence areas, primary responsibility, and convergence aspects. Section 5 briefly discusses next steps.

3. OPPORTUNITIES AND ISSUES FOR CONVERGENCE

3.1 *RTI/STI prevention and management*

3.1.1 *Background:* RTI/STI has a severe impact on the reproductive health of individuals as well as significantly enhances the risk of transmitting or acquiring HIV/AIDS. Women are biologically more vulnerable to acquiring RTI/STI and consequences of STI in women are more serious (ectopic pregnancy, pelvic inflammatory disease, still births). Unequal gender relations resulting in sexual coercion is more pronounced among women, and women often have limited access to care. There is evidence that RTI/STI care is more often sought in the private sector than in the public sector and in several places from untrained practitioners as well as chemists. There is little published comparable and reliable data on RTI/STI in the country. Efforts at programme planning have been based on micro studies conducted with different methodologies, using varying criteria and for clinical and laboratory diagnosis.

3.1.2 *DHFW strategies:* The National STD control programme has been in place since 1946. However, it was only in the RCH 1 programme, that RTI/STI management was included on a national scale. Many donor-funded programmes in states have also supported RTI/STI services through state health and family welfare programmes. While there are no formal evaluations to assess the performance effectiveness of these efforts, anecdotal evidence suggests that several lacuna hampered these efforts and they remained largely out of the reach of women and men in need of services. Current policy guidelines stipulate that only medical officers are allowed to prescribe RTI/STI drugs, thus limiting the reach of effective RTI/STI services.

3.1.3 *NACP strategies*: RTI/STI management has been attempted through several approaches:

a. NGOs working with High Risk Groups on targeted interventions are provided with support for medical personnel, clinics, and Drugs for RTI/STI. In some instances NGOs collaborate with the public health system or private providers to provide STI diagnostic and treatment services.
b. Annual Family Health Awareness Campaigns are held across the country. These are two week campaigns which are period of heightened activity at the district level and below when the machinery of the HFW system is expected to conducts house to house and group education, media and advocacy events and promote care seeking for RTI/STI. Patients are referred to PHC and above, where RTI/STI are treated using the syndromic approach. Annexure 3 provides details of the achievements of FHAC from 1999 to 2003. Coverage increased from 100 districts to 572 districts.
c. NACO has provided support to establishing STD clinics at hospitals upto and including district hospitals. By the end of fiscal 2004, NACO had supported 735 STD clinics in all medical colleges and in most district hospitals. Each STD clinic includes a qualified STD specialist and laboratory support for diagnosis and treatment of STI. NACO also ensures a continuous supply of STI drugs. (Annexure 4 provides details of number of STD clinics in each state)
d. NACO supported training of a range of HFW providers (MO, ANM, LHV, Laboratory technicians) in areas such as RTI/STI, universal precautions, nature and content of HIV/AIDS programming, stigma and discrimination. Annexure 5 provides details of personnel trained.

3.1.4 Core Convergence Recommendations for RTI/STI:

From the above data it is clear that NACP interventions in the public sector system reach only the district hospitals and are not programmed to be gender sensitive. Although Medical officers have been trained in syndromic diagnosis, they are located in primary health centers and above. Current utilization of PHCs is low. Thus the benefit of the knowledge and skills of the medical officers does not reach communities in many parts of the country. The FHAC could do a good job of spreading awareness but services are still provided at the district level, reducing reach. DFW interventions are also primarily through medical officers. Grass roots workers such as the ANM in most areas are not empowered to provide information and services for RTI/STI. There is little by way of health education at the community level on RTI/STI, which highlights issues of risk and vulnerability, male responsibility, and the use of condoms for dual protection. This varies from state to state and in high prevalence states, awareness levels are high, but access to services remains low. One of the challenges that needs to be taken into account while converging the programme into the DHFW programme is that the reach to important core and bridge groups such as: “sex workers, men who have sex with men, men in the general population, and youth. RCH II does include interventions to address youth, enhance male responsibility, and health in urban areas and care must be taken to ensure that convergence mechanisms address the inclusion of such groups.

a. Public Sector interventions from district to peripheral level for RTI/STI to be implemented through DHFW, in line with the RCH II design document. RTI/STI

prevention, management of the client, partner notification, treatment, and follow-up are the key components of an RTI/STI programme. Comprehensive RT/STI treatment will be provided at CHC and 24 hour PHC (clinical and etiologic) and first line drugs at the PHCs.

b. RTI/STI control among High Risk Groups through NGOs with funding support for RTI/STI diagnosis and treatment, to continue through NACO and SACS, but reporting also to HFW.
c. It is expected that ASHA will be provided with enough information/supplies to support health education, prevention advice and treatment facilitation (through referral) at the village level. Presently the closest possible site for services by trained personnel is the sub center level. The ANM/Male MPW will be the frontline service providers for RTI/STI management, MO/SN/LHV at the PHC level, and MO/Ob-Gyn. at the CHC/FRU level. It is expected that over time, with strengthened Primary Health Care, laboratory based management of RTI/STI will be the norm rather than the syndromic approach. At the CHC level, basic screening tests for RTI/STI will be made available. At the district level, RTI/STI will be managed by STD specialists supported by or linked through referral to high quality laboratory services supporting the full complement of laboratory tests for RTI/STI.
d. At the community health centers and district hospitals, RTI/STI management has to be included in protocols in Ob/Gyn and Medicine departments. Medical and paramedical professionals to be oriented to risk identification and referral to VCTC.
e. NGOs under HFW to include RTI/STI in their package of interventions, with referral or services as appropriate.
f. Private providers (reached through Indian Medial Association (IMA) and Federation of Obstetrics and Gynaecology-FOGSI) to be part of RTI/STI management strategy for training and to ensure appropriate reporting and notification, particularly in the case of sexually transmitted infections and drug resistance surveillance. This will also need to be implemented through DHFW.

3.1 *Voluntary Counseling and Testing Centers (VCTC)*

3.2.1 *Background:* Voluntary Counseling and Testing is now acknowledged as an efficacious and pivotal strategy for prevention and care for HIV/AIDS. Counseling is an important skill and is a necessary part of interventions for several areas within Family Welfare, family planning, safe motherhood, RTI/STI, and in dealing with youth. It is also more cost effective to integrate VCT into sexual and reproductive health services, rather than support them as freestanding sites. Counseling requires specialized skills and attitudes, space to assure confidentiality, laboratory services for testing, adequate reporting systems.

3.2.2 *DHFW strategies:* While counseling is an important element of several reproductive health services, counselors are not part of the health provider cadre. ANM, LHV and other providers have been trained in basic motivation,

interpersonal skills, but these are not dealt with in any depth, nor are they geared toward attitudinal change. It has thus far formed part of an integrated training package. In some states donors have supported separate training to improve counseling and motivation skills of ANM and LHV (UNFPA through IPD projects, USAID in SIFPSA), but only in selected districts.

3.2.3 *NACP strategies:* NACO and the SACS have established 650 VCTCs across the country with about half of them located in high and medium prevalence states. They are primarily located in medical colleges and district hospitals. Annexure 6 provides state wise details of numbers of VCTC. Each VCT includes one male and one female counselor, and one laboratory technician. NACO and SACS supply testing kits for these VCTCs. In the medical colleges, the VCTC are located within the microbiology departments (with counselors reporting to the HOD, Microbiology) and in charge of the Pathologist in a district hospital. Currently the view of the State AIDS Control Societies is that VCTC utilization is low, particularly in the low prevalence states.

3.2.4 *Core Convergence Recommendations for VCTC*

a. The NACP will manage the VCTC in collaboration with the key staff of the facility in which the VCTC is located. Youth information centers to be established with the VCTC to increase access of young people to information and referral for services for a range of reproductive and sexual health issues.
b. NACP will support the staff of VCTC and supplies required with DHFW will provide the physical infrastructure.
c. It is proposed that the district VCTC function as a satellite center to coordinate, support and supervise operations of the VCTC's located in the CHC and 24 hour PHC. This internal coordination is important for several reasons- to maintain quality of services at all sites, to ensure uninterrupted supplies, link with PPTCT at district and CHC levels, and to enable referral linkages of clients that test positive to appropriate centers.
d. VCTC' s will not function as sites for counseling of HIVAIDS alone. Counselors in VCTC, particularly at secondary and primary health care levels should be able to counsel for family planning, RTI/STI prevention, safe delivery, and male responsibility. A cadre of counselors could be established who would serve the RH needs of women and men, including HIV/AIDS, and the RH information and service for young people. It is hoped that this measure will increase utilization of VCTC.
e. Expand the number of VCTC sites. The expansion should be informed by a rapid assessment of VCTCs in low and high prevalence areas, and identify systems issues, human resource training gaps, and logistics. **The expansion is proposed in a phased manner, and will be governed by the following: prevalence, physical infrastructure, human resources, and community use of facilities.** Fortunately the high prevalence states also have better infrastructure and increased utilization (higher rates of antenatal coverage, institutional deliveries, and overall increased care seeking behaviour). As a

long-term plan, (by 2012) it is expected that all PHCs will have VCTC facilities that will cover a range of services beyond just HIV/AIDS counseling. The expansion process is proposed as follows:

Phase 1: (2005-2008) In the high prevalence states, district hospitals, all CHCs and all 24 hour PHCs will have Voluntary Counseling and Testing Centers, staffed by a full complement of male and female counselors; separate space and laboratory back up. In the low prevalence centers, VCTC could be located at the district level and at all CHCs. In high prevalence districts within low prevalence states, the choice of whether 24 hour PHCs could offer VCTC could be left to the state.

Phase 2: (2008-2010) All PHCs in high prevalence states and 24 hour PHCs in other states will have VCTC.

Phase 3: (by 2012): PHCs, all CHCs and district hospitals, will offer VCTC services.

Expansion will be based on review of past experience, utilization and need.

f. Basics of Counseling for all cadres of staff (sub center to CHC) to be included in training package, so that at the very minimum all staff have the skills to enable clients to understand risk perception, motivate them to seek services, and finally be able to facilitate informed referral.

g. Involvement of private providers and private laboratories, through IMA, FOGSI, and pathologists Association, where testing takes place to ensure that their clients also are counseled and their data is reported at district and state levels.

h. NGOs under HFW programme and NGOs working with High Risk Groups to include information on VCTC functions and sites so that they can carry the message to the community, and increase utilization as appropriate.

3.3 *Prevention of Parent to Child Transmission (PPTCT)*

3.3.1 *Background:* Core PPTCT interventions need action in the community, and depending on the package of services offered, at the levels of the sub center, Primary Health Center and at the Community Health Center. PPTCT interventions for HIV positive women relate to a range of services provided in the HFW system: antenatal, delivery, and postpartum care, abortion services, VCTC, Management of STIs in pregnancy, Antiretroviral therapy based on current policies- (currently Nevirapine), Family planning counseling and easy access to services, Expansion of well baby clinics, high quality education and information provision on nutrition, breastfeeding, RTI/STI, and HIV/AIDS, male involvement in MCH care, and linkages to community based care and support programs for HIV/AIDS.

3.3.2 *DHFW Strategies:* DHFW per se does not implement PPTCT interventions. Currently PPTCT interventions are being provided in selected locations through the health facilities of HFW. However, training, supplies and logistics, and drugs are primarily supplied through NACO.

3.3.3 *NACP strategies:* Currently NACO is providing PPTCT services in 273 units across the country of which 234 are located in high prevalence states. Annexure 7 provides details of PPTCT in the country presently. They are primarily located at the medical colleges of high and low prevalence states and at district hospitals only in the high prevalence states. They are located in the Ob/Gyn department. A counselor, mostly female and one laboratory technician staff each PPTCT. Staff of PPTCT sites (PPTCT team- Ob/Gyn, Microbiologist, Paediatrican, Staff nurse, and one health educator) are trained for five days. Counselors of PPTCT are trained for a ten-day period. Sensitization training of other staff in the facility where the PPTCT site is located is also conducted.

3.3.4 Core Convergence Recommendations for PPTCT

a. The management of PPTCT sites should continue to be with the NACP, since all clients of the PPTCT will need to be followed up for care and support. At the institution level, the PPTCT staff will continue to report to the Head of Ob/Gyn. PPTCT at the district level will function as the hub or satellite center to coordinate quality, supplies, reporting and facilitation of referral.
b. NACP will fund the counselor and laboratory technician in the PTCT and the supplies required for the PPTCT programme. The PPTCT will be located in the Ob/Gyn department of the CHC and will function through existing staff.
c. PPTCT sites should be expanded in a phased manner. Since PPTCT is a function of the obstetric department, and since RCH II is focusing on improving/strengthening access and quality of institutional deliveries, PPTCT can be implemented within the framework proposed for RCH II.

   Phase 1 (2005-2008): All district hospitals and CHCs to offer PPTCT, regardless of prevalence.
   Phase 2 (2008-2010) In high prevalence states, 24 hour PHCs, should also offer PPTCT.
   Phase 3(by 2012 years): 24 hour PHCs in all states to offer PPTCT services, based on prevalence, utilization, and need.

d. At the community level, ASHA/ANM will be trained through health education and motivation among women and men for risk perception, risk identification, facilitation in accessing VCTC, and thus identifying positive women in need of PPTCT. Para medical and medial providers at the PHC level will also be trained in similar areas to facilitate referral to PPTCT and enable follow up.
e. Positive women will be followed up through pregnancy by ANM/ASHA and encouraged to opt for institutional delivery in district or CHC/FRU.
f. PPTCT programmes should establish linkages with the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) component of RCH II, to address issues of infant feeding, nutrition, and infections.
g. All providers would need sensitization on issues of stigma and discrimination, so that positive women do not fear institutional deliveries. PPTCT teams should be

specially trained in areas of infection prevention, and stigma and discrimination attitudes, as well as the specific technical aspects of PPTCT

h. Institutions to be strengthened to adopt universal precaution measures and waste management. Delivery kits to be made freely available under the PPTCT programme.
i. Orientation and sensitization of private providers (through IMA, FOGSI, Indian Health Care federation, Hospital forums and associations) and involvement of private hospitals in VCTC and PPTCT as appropriate.
j. NGOs supported by DHW and NGOs working with high-risk groups to be provided with information on location of PPTCT sites and encouraged to facilitate referral and follow up.

3.4 Behavior Change Communication

3.4.1 *Background:* Changing individual and community behaviour is critical to HIV prevention In order to impact the epidemic it is necessary to target behaviour change interventions at the individual level to increase knowledge, enhance risk perception, and develop safe sex skills. These are primarily through interpersonal communication and small group discussions and peer education. Such efforts at the individual level need to be reinforced by community level interventions to increase understanding of a supportive environment to reduce risk and vulnerability, and influence societal norms. Messages that are targeted to sexually active individuals include: postponing age of sexual activity, using condoms correctly and consistently, decreasing number of sexual partners, increasing STI and TB treatment seeking and prevention behaviors.

3.4.2 *DHFW strategies:* HFW has not integrated HIV/AIDS messages in BCC material till date. However, in the past few months, efforts are on to integrate HIV/AIDS prevention messages in some initiatives of the HFW department- wall calendar and diary for 2005 of the MOHFW includes HIV/AIDS messages. Adolescent health education and life skills programmes have included HIV/AIDS content quite substantially, especially in the adolescent friendly health clinics, piloted by MOHFW.

3.4.3 *NACP strategies:* At the National level, NACO frames guidelines for IEC activities countrywide and undertakes multimedia campaigns along with political and media advocacy. NGOs working with high-risk groups for targeted interventions develop their own BCC strategies. SACS in each state have mass media campaigns and other activities for general population- varied across states and school AIDS Education programmes.

3.4.4 *Core Convergence Recommendations for BCC*

- Create a mechanism to ensure that the leadership for developing BCC strategies and programmes for DHFW and NACP is vested with one authority.

- Joint (NACO, DFW) behaviour change communication strategy to be developed based on commonality of target groups, and tailored for reach of general as well as high-risk populations. This needs to take place at state level as well between State AIDS Control Societies and State IEC bureaus.

3.5 Condom promotion

3.5.1 Background: Currently the male condom is the most widely available effective protection method against HIV and other STI. Condom distribution can be through free or social marketing channels. They could be through community based distribution systems, depot holders, health facilities, pharmacies, and village stores. For any scaled up prevention response it is important to improve access and availability of condoms to all communities (rural and urban) and groups.

3.5.2 DHFW Strategies: In the family welfare programme, male condoms are promoted as a method of contraception. In order to improve the use of condoms as a contraceptive, several initiatives at social marketing and distribution through government and NGOs are being undertaken. Thus DFW is the repository of substantial experience in promoting condom use as well as condom procumbent and distribution. However the use of condoms as a method of dual protection has not been promoted so far. About 25% of the overall condoms procured are distributed as free supplies with 75% being programmed though social marketing agencies. Of these 25 %, over three quarters are channeled to NACO for distribution to HRG through NGOs.

3.5.3 NACO strategies: Currently NACO procures and supplies condoms to the NGOs working with HRG. Primarily NACO and the SACS obtain their supplies through the DHFW. NGOs also directly access social marketing agencies. NACO and SACS ensure hat there is adequate supply of condoms in STD clinics, VCTC, and Ob/Gyn clinics. SM condoms are made available at outlets situated near state highways and in areas where TI projects are underway. NGOs are encouraged to use a mix of free and SM approaches.

3.5.4 Core Convergence Recommendations for Condom promotion

- Create a mechanism to ensure that condom programming for NACP and DHFW is managed within a single entity to provide leadership and direction. This integration will greatly facilitate streamlining the condom promotion strategy between the FW and HIV/AIDS programmes.
- Joint development of a strategy on condom procurement and distribution to meet the needs of sexually active women and men as a contraceptive method, as a method of dual protection and to meet the needs of high-risk groups.
- Condom supplies for NGO s involved in TI to be through NACO and SACS.
- HFW to promote condoms as dual protection method through improved distribution channels.
- Pilots to promote female condom use among general population as well sex workers both as a contraceptive and barrier method.

3.6 Safety of blood and blood products

3.6.1 Background: In addition to ensuring blood safety, other strategies to reduce transmission include: reducing the need for transfusions, educating and motivating low risk individuals to donate blood.

3.6.2 DHFW strategy: Currently blood banks are located at state and at district levels. Stringent guidelines for blood banks are in place. In the RCH II programme, DHFW has planned blood storage centers at FRU level. However the procurement of blood will be primarily from the blood banks certified by NACO, so quality control appears to be taken care of.

3.6.3 NACP Strategy: NACO has been involved in developing a blood safety policy and guidelines for blood banks. Annexures 8 and 9 provide state wise details of blood banks supported and strengthened by NACO respectively.

3.6.4 <u>Core Convergence Recommendations fro Blood Safety</u>

It is recommended that this policy be continued so that stringent quality controls are maintained at the district levels, and high quality blood is available at secondary levels of care.

3.7 Training

3.7.1 DHFW strategies: In RCH 1, Medical Officers, Staff Nurses, Lady Health Visitors and ANMs were trained for periods of between 4 to 6 hours (depending on job profiles) in the area of HIV/AIDS and RTI/STI. In RCH II, four core committees are currently reviewing the content of training for each level of provider.

3.7.2 NACP strategies: NACO, SACS (and partner agencies- NGOs) have developed modules for training in a range of areas- prevention, universal precautions care and support, PPTCT for all providers. These have been implemented separately from the HFW trainings.

3.7.3 <u>Core Convergence Recommendations for training</u>

- NACP to designate an officer to coordinate with the groups responsible for ongoing module development for RCH II and ensure that HIV/AIDS training inputs cover all areas of concern adequately.
- Joint finalization of areas of training with respect to content, duration, mix of knowledge and skills, for all cadres of health and community workers.
- NACO and DHFW to jointly develop a specific plan to train staff of PPTCT and VCTC to ensure that these functions include other HFW elements as well.
- Finalized modules to be shared with private sector and NGO partners supported by HFW and NACP.

3.8 Management Information Systems

3.8.1 *DHFW strategies:* As part of the RCH II programme a Management Information System is being designed. An Integrated Disease Surveillance Project is also underway. Both these systems will essentially capture data on an ongoing basis at all levels for programme implementation and ongoing monitoring. Small and large scale surveys such as the NFHS and District level HH surveys are also conducted periodically.

3.8.2 *NACP strategies:* The nationwide sentinel surveillance system captures data on an annual basis from about 455 sites across the country. In addition, VCTC, blood banks and PPTC serve as a reporting base. Programme supported NGOs also report on STI treated, condoms distributed and coverage of high-risk groups.

3.8.3 Core Convergence Recommendations for Management Information Systems

- Joint working group to review data needs, assess ongoing sources, and finalize requirements to fit into RCH II MIS, so that all facilities report service performance on RTI/STI, VCTC and PPTCT as part of routine reporting, while maintaining confidentiality.
- State and national level surveys (NFHS III, DLHS) designed to provide information on KAP related to RTI/STI/HIV/AIDS
- Research and prevalence studies to assess nature of STIs to develop suitable management protocols and assess antibiotic resistance patterns. Need to explore linkages with integrated disease surveillance programme.
- Mechanisms to ensure periodic reporting on STI/HIV/AIDS by private providers
- Include NGO reports as part of district level reporting.

3.9 Male involvement: The case to promote male participation in improving reproductive and sexual health for women has been articulated in several documents and is being implemented through several community-based initiatives. However, the reach of programmes of the DHFW to men is low. NACP on the other hand, (given that men are the predominant target group in the general population) has significant experience in approaches to reach men, through condom promotion, STI clinics, and mass media. In RCH II, it is proposed to provide gender sensitization training for all providers. Specific BCC interventions will implemented to increase demand for male contraceptive methods, male RH services, and to heighten awareness about men's responsibility in support of women's sexual and reproductive health.

Core Convergence Recommendations to improve male involvement

- Ensure that NACP and DHFW training include male responsibility as a key area
- BCC strategies for both NACP and DHFW to address the area of male responsibility and shared action for improved women's RH as a major issue-

includes partner notification, drug compliance, safe sexual practices and condom promotion.

3.10 Strengthening urban health services to improve convergence: Urban health particularly among the poor presents a special challenge to the DHFW. While overall health indicators in rural areas may be better than in rural areas, they mask significant disparities. The reach of the poor to good health care is limited, and they are often served by the private sector, poorly regulated and offering care of questionable quality. Given the increase of slum populations, migrants, and street children, and that these groups are identified as high risk groups for HIV/AIDS, it is essential that their access to the services such as RTI/STI, VCTC, PPTCT, condom promotion and BCC interventions be improved.

The NACP supports several targeted interventions in urban areas, primarily through NGOs, and targeted at marginalized, high-risk groups, and not often general population based. NACP also support STI clinics, VCTC and PPTCT in large medical colleges/teaching hospitals. However primary and secondary health care facilities in urban areas are not as clearly structured or organized as in rural areas. RCH II proposes a two-tier facility – an urban health center for a population of 50,000- to address primary health care needs of the population, particularly the vulnerable, and a second tier (mix of private and public sector) to serve as referral sites.

Core convergence Recommendations to improve reach of urban health

- Strengthening urban health infrastructure, including training of urban providers will have benefits for urban RCH and NACP.
- Involvement of urban private sector practitioners in training programmes, through involvement of IMA and FOGSI. .
- Referral information on sites where RTI/STI, VCTC, and PPTCT are available to be widely disseminated to both general and high risk populations through NGOs, private sector, and IEC efforts.
- UHC and Referral sites to offer a range of RCH services without discrimination and in an equitable manner to general populations and populations at risk.

4. OPERATIONALIZATION OF CONVERGENCE

4.1 Of the key areas identified for convergence, RTI/STI management for the general population could be integrated within the DHFW. VCTCs and PPTC still need to be managed by NACO and the SACS to retain focus and ensure referral linkages to care and support. In the area of blood safety, it is recommended that NACO continue to ensure safe blood supplies at district levels, and that blood storage units at secondary levels of care procure supplies from the district. In the areas of behaviour change and condom procurement/distribution, it is recommended that the leadership for the

programmes be entrusted to one entity to ensure overall guidance of both areas for Health, Family Welfare and the National AIDS Control Programme. Male involvement needs to be woven into all components. Strategies to improve services in rural areas must be replicated/adapted for urban areas. Joint working groups are recommended at national and state level to ensure that the training plans and monitoring and reporting systems of the DHFW and NACO (and corresponding groups at the state levels) are well coordinated, reflect shared concerns and are synchronized at the delivery levels.

4.2 *Recommended Institutional Mechanisms*

4.2.1 At the National level a *NACP-HFW convergence committee* is to be set up at DHFW to provide policy inputs and oversight to the convergence between NACP and DHFW. The Convergence Committee will be chaired by Secy, HFW and co-chaired by Project Director NACO.

4.2.2 At the National level, two joint working groups are visualized comprised of technical and programme mangers from NACO and DHFW. They include:

1. Joint working group on convergence of RTI/STI, VCTC and PPTCT into DHFW infrastructure and services. (NACO/DDG/MH)
2. Joint working Group on Training and MIS. (NACO/DC Training, and CD, Statistics)

Broadly the roles of the JWG are to review quarterly performance from each state and jointly review and prepare a report on performance coverage and quality. Reporting formats would be developed in conjunction with existing formats or those proposed for larger programmes so that programme managers at state and district levels are not burdened. It is expected that the NACP-HFW Convergence Committee, which meets every quarter, will obtain reports from each of the National JWG, provide feedback and serve as a problem solving mechanism.

4.2.3 It is recommended that at the state level, a similar mechanism be set up, so that the state and central level review and monitoring, and information needs and flow are co-ordinated.

4.2.4 At the district level, NACO is considering the appointment of a convergence facilitator who could ensure coordinated inputs between those programmes directly implemented by NACO/SACS, between various NGO managed programmes, and finally between those interventions that depend upon the DHFW resources for effective operationalization. In addition this individual would follow up on the training plan for the district as well as the MIS to ensure that there is convergence. This individual would report to the SACS and to the CMO at the district level. At the district level, the District Health Mission (where all other programmes of HFW are integrated), will include a

sub- group to review HIV/AIDS and HFW convergence in the major service areas (RTI/STI, VCTC, PPTCT) and NGO functioning.

5.NEXT STEPS

As pointed out initially, this paper is only a broad framework for actions on convergence. The framework needs to be validated at state level to ensure that there is ownership of the issues between the State AIDS Control Societies and the Departments of Health ad Family Welfare. While RCH II is the focus of convergence since it is due to be launched fairly soon, and there has been significant decentralized planning and design, it is emphasized in this document. However there are several other programmes and partners that also need to be viewed through the lens of convergence to ensure appropriate and effective local responses to HIV/AIDS.

Area of Convergence	**Role and Functions of DHFW**	**Role and Functions of NACP**	**Convergence mechanisms/aspects**
RTI/STI	**-Primary Responsibility-** integrate RTI/STI management at all levels in public sector system -Increase private sector involvement in high quality RT/STI treatment- IMA and FOGSI -Broadly RCH II strategies should be followed-At PHC level, first line drugs to be offered, -District, CHC and FRU to offer comprehensive etiological and lab based treatment. At district level, linkages with STD referral labs to be strengthened.	-Support to HRG-NGOs to continue. Service delivery whether directly through NGOs or referral to public or private sector. -Ensure that all STI service data and special studies are provided to JCWG to enable reporting at the Convergence committee level.	-At National level, NACP and DHFW to set up a JCWG group to monitor access of RTI/STI services for general population and for HRG. Report to HIV/AIDS Convergence Committee. -Training of providers (public, private and NGO) and lab techs within purview of DHFW. -DDG-MH/NACO
VCTC	-Infrastructure (space) to be provided in facilities where VCTC are located. -Support to ensure referral from other departments -Overall supervision by head of facility, in collaboration with Ob/Gyn, STD, Paed, and other depts. -Frontline providers to motivate community at risk for VCTC	**Primary responsibility—** - increase VCTC sites- expansion in phased manner -NACP support for staff and supplies, -Include Youth Friendly Information Centers at CHC and PHC -VCTC to serve other counseling needs. -Cadre/of counselors to staff the sites.	-JCWG to review functioning of VCTC through periodic state reports. Report to HIV/AIDS Convergence Committee -Training of providers of DHFW at all levels to include elements of risk protection, motivation for testing- through DHFW -NGO training

			facilitated by NACP, but modules jointly developed. NACO/DDG-MH
PPTCT	-Overall supervision by head of facility -Located in Ob/Gyn department, managed by HOD -Ensure non discriminatory practices -Ensure universal precautions -At the community level, ANM/ASHA follow up of VCTC clients testing positive for ANC, and motivate for PPTCT -	**Primary Responsibility** to ensure functioning PPTCT -Expand PPTCT sites in a phased manner -NACP to support once counselor and lab. Tech. And supplies for PPTCT.	-JCWG to obtain data on functioning of PPTCT and review performance -Training for all providers to include attitudinal as well technical skills, and universal precautions.-DHFW -Private sector through IMA and FOGSI- DHFW NACO/DDG-MH
BCC	-All messages for HFW to include HIV/AIDS prevention and care and support as appropriate -Ensure that NGO programmes also use message content as defined	-Messages for HIV/AIDS highlight appropriate service provision through public and private health system -Ensure that NGOs highlight service access in addition to prevention messages.	-BCC strategy/division for NACP and DHFW under single management.
Condom Promotion	-Enhance condom use for dual protection -Female condoms to be promoted as a contraceptive/barrier method	-Condom promotion key to prevention -Female condoms to be promoted as a contraceptive/barrier method	Condom procurement and distribution for FW and NACO under single entity.
Training	**Primary Responsibility** for training of all service interventions (except VCTC/PPTCT) to be within DHFW -Support training content and technical support for VCTC and PPTCT training	-Support training in terms of content and technical support -**Primary responsibility** for training VCTC counselors in a range of issues including HIV/AIDS, which include safe motherhood, family planning and childcare. PPTCT staff training also to be conducted by NACO/SACS.	-NACP to coordinate with groups working on RCH II modules to ensure HIV/AIDS content for all workers. -Joint Working Group to be instituted to review and ensure that HIV/AIDS messages and content for training are tailored to each level of provider -Ensure that training modules are shared with NGO partners of DHFW and NACP. -Develop protocols and guidelines for

			key services- -Ensure dissemination of protocols and guidelines to NGOs and private sector.
Reporting	DHFW MIS to capture service data- RTI/STI, VCTC, and PPTCT -MIS to include HIV/AIDS indicators -Support sentinel surveillance data collection	-Ensure that VCTC, PPTCT, and sentinel surveillance data is reflected in district MIS.	-NACP to coordinate with RCH II MIS convener (CD, Statistics to ensure that HIV/AIDS indicators are included in MIS for RCH II. -Joint Working Group to review RCH II MIS and ensure that reporting of RTI/STI, VCTC, and PPTC is also included. -Surveys (NFHS III and DLHS)to include information on HIV/AIDS as well.
Blood Safety	Maintain quality of blood taken from blood banks to blood storage centers at secondary levels of facilities.	-**Primary Responsibility** to assure safety of blood at banks at district level and above	