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HIV-SRH Convergence

A periodic policy and practice update of work undertaken by PATH on the convergence of HIV services and sexual and reproductive health (SRH) services in India.

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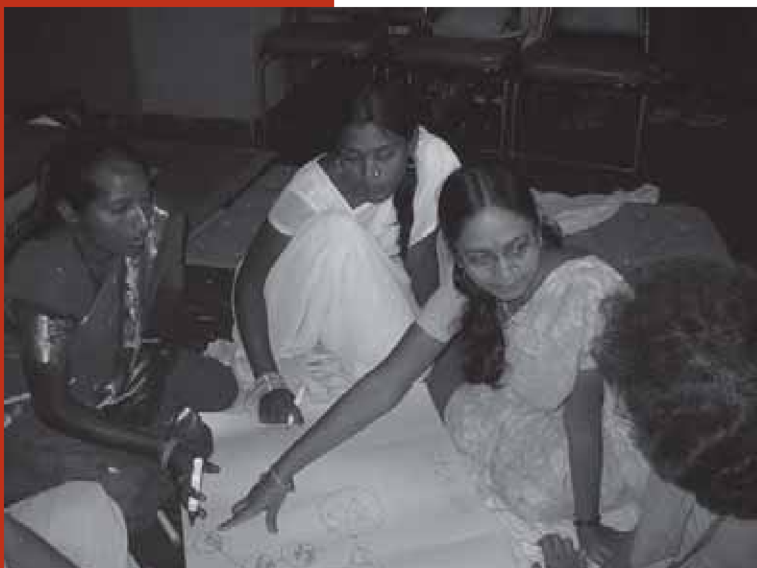
What is convergence?

In India, the terms "integration," "mainstreaming," and "convergence" are often used synonymously and interchangeably by the National Health Policy, the National Rural Health Mission (NRHM), and the National AIDS Control Programme (NACP-III). The word convergence is beginning to be widely used in the context of HIV and sexual reproductive health (SRH) services by both the National AIDS Control Organisation (NACO) and the Ministry of Health and Family Welfare (MOHFW). But what does convergence mean? At a basic level, HIV-SRH convergence entails *mutual referrals and communication* activities between these two services, enabling communication on HIV issues and relevant referrals within SRH settings and vice-versa. Second, converging HIV and SRH services means paying attention to *dual-purpose* interventions such as diagnosis and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), counselling and provision of male and female condoms, preventing parent-to-child transmission (PPTCT) services, and HPV vaccination. Third, and more comprehensively, HIV-SRH service convergence means provision of *partially integrated* services such as adding voluntary counselling and testing to family planning services, introducing family planning services in HIV clinics – and providing SRH counselling, HIV counselling and life-skills, and sexuality education in both. An example of partially integrated services in the Indian context is the proposed setting up of integrated counselling and testing centres (ICTCs) in the NACP-III programme.



PATH

Policy environment for convergence of HIV and SRH in India

Evolution of reproductive and child health and HIV/AIDS programmes

Reproductive and child health programmes

Family planning and family welfare programme: According to Article 47 of the Indian Constitution, health is a state responsibility. While the central government initiates and finances health programmes, it is the responsibility of the state governments to implement them.

The first attempt to plan for an integrated health system was made in 1946, with the constitution of the Bhore Committee by the Government of India. In 1951, India was the first country in the world to launch a national family planning programme. In 1977, maternal and child health (MCH) became an integral part of the family planning programme and came to be known as the family welfare programme. The basis of this change was the understanding that a decrease in the birth rate would bring about a related reduction in the rate of infant and child mortality.

RCH-I programme (1998-2003): In 1997-1998 the Government launched the Reproductive and Child Health (RCH) programme by integrating the Child Survival and Safe Motherhood (CSSM) programme with other RCH services. The altered programme incorporated an additional component for the management of RTIs and STIs. It aimed to improve the health status of women and children by fulfilling the unmet need for family welfare services in the country.

The RCH programme introduced a new system of service delivery through decentralized planning and an extended menu of services delivered under the family planning programme.

RCH–II programme (2005-2010): The RCH-II programme was launched in April 2005 after wide consultation as a long-term programme, oriented towards achieving ambitious, but realistic health outcomes, and improveming the couple protection rate (CPR) and total fertility rate (TFR). While designing state-specific programme implementation plans (PIPs), states take into account their different requirements, levels of performance, and capacity. The programme also conceives that this differential approach will be extended to the district level depending upon the performance of each district. RCH-II is also envisioned to bring in the key elements of sector management and reform and systems strengthening. Partnerships will be built with panchayati raj institutions (PRIs), urban local bodies (ULBs), the private sector, the NACP-III and the Integrated Child Development Services (ICDS) programmes during RCH-II.

The RCH-II is designed to set out broad strategic directions, define a core minimum service package, and estimate national resource requirement. Within this broad evidence-based strategic direction, and after assessing their own priorities, states have prepared five-year plans linked to clear outcomes. While RCH-II necessarily includes supply side strategies, these will be complemented by an integrated and robust strategy to stimulate demand for services.

The National Population Policy 2000 and National Health Policy 2002: India's long-term strategy for health-sector development was articulated in the 1983 National Health Policy (NHP). NHP-1983 gave high priorities to the control of (1) infectious diseases and (2) preventable causes of maternal and child mortality. However, investments did not always reflect these priorities.

A performance review by the Department of Health, Government of India, led to the formulation of NHP-2002. NHP-2002 envisaged the gradual convergence of all health programmes under a single field administration but stated that vertical programmes on RCH, TB (tuberculosis), malaria, HIV/AIDS control, as

well as the Universal Immunization Programme (UIP), were to continue until respective disease prevalence comes down to moderate levels.

The National Rural Health Mission (NRHM 2005-2012): GOI launched the NRHM in 2005 with the objective of making necessary corrections in the basic health care delivery system. NRHM uses a synergistic approach in relating health to other determinants of good health, such as nutrition, sanitation, hygiene, and safe drinking water. It seeks to ensure expanded outreach, linkages with local governance institutions, and inter-sectoral convergence with drinking water, sanitation, hygiene, and nutrition.

The National AIDS Control Programme

GOI initiated a series of measures to control HIV infection soon after the first AIDS case was reported in 1986. In the same year, a high-powered National AIDS Committee was constituted and the National AIDS Control Programme (NACP) was launched in 1987. The objective of the project was to slow the spread of the HIV epidemic and to reduce related morbidity and mortality. In the initial years, the programme focused on (1) awareness generation through mass communication, (2) blood screening, and (3) surveillance activities.

In 1992, the Government formulated a multi-sectoral strategy for AIDS prevention and control in India. This was implemented through the National AIDS Control Organisation (NACO) at the national level and state AIDS cells at the state and union territory (UT) levels. The policy envisaged effective containment of HIV in the general population in order to achieve zero levels of new infections by 2007.

NACP-II (1999–2006): The second phase of the NACO initiative aimed at shifting the focus from generating awareness to changing behaviours through interventions, targeted particularly at groups who were at high risk of HIV infection. Project activities included peer counselling, condom promotion, and STI treatment. Activities were locally modified and delivered largely through nongovernmental organisations (NGOs) and community-based organisations (CBOs).

NACP-III (2006–2011): The third phase of the NACO initiative is currently in its final stages of planning. The goal of NACP-III is to halt and reverse the epidemic in India over the next five years by integrating programmes for prevention and care, support and treatment. To achieve this goal, NACP-III will pursue four main objectives: (1) preventing new infections in high-risk groups and the general population through saturation of coverage of groups at high risk of infection and through scaled-up interventions in the general population; (2) increasing the proportion of people living with HIV/AIDS who receive care, support, and treatment; (3) strengthening the infrastructure, systems, and human resources in prevention and treatment programmes at the district, state, and national levels; and (4) strengthening a nation-wide strategic information management system.

The management of the response to HIV/AIDS is by the respective state governments through the State AIDS Control Societies (SACS) supported by a Technical Advisory Committee (TAC). State-level policy on implementation of the HIV/AIDS programme is decided by an empowered committee under the chair of either the chief secretary of the state or an additional chief secretary.

National recommendations for HIV-SRH convergence policy and practice

The spread of the HIV epidemic and high prevalence of unintended pregnancies in India has led to recognition of the significant role for convergence of HIV and SRH services to provide an effective response. A policy framework for the convergence of HIV and SRH services in India is being put in place.

An NACP-HFW convergence committee has been set up at the Department of Health and Family Welfare (DOHFW, GOI) to oversee the convergence between NACP and the DOHFW programmes. It is chaired by the Secretary (H&FW) and co-chaired by the Project Director of NACO. In addition, two joint working groups (JWGs) are envisaged: (1) one on the convergence of RTI/STI, VCTC (voluntary counselling and testing centres) and PPTCT into DOHFW

infrastructure/services; and (2) the other on training and management information systems (MIS), which will comprise technical and programme managers from NACO and DHFW. It is expected that the NACP-HFW convergence committee, which meets quarterly, will obtain reports from the JWGs, which are expected to not only provide feedback, but also serve as a problem-solving mechanism.

The MOHFW, GOI, recommends that similar mechanisms are also set up at the state level, in order to have coordinated state and central-level reviews, monitoring, and information flows. At the district level, NACO is considering the appointment of a convergence facilitator, reporting to the District Medical Officer of health and the SACS, who would ensure coordinated inputs between programmes implemented by NACO/SACS, programmes managed by NGOs, and interventions managed/funded by the DOHFW. Additionally, the district health committee would include a sub-group to review NGO functioning and HIV/AIDS and H&FW convergence in the major service areas such as management of RTI/STI, VCTC, PPTCT, etc.

RTI/STI prevention and management

Under the NACP, RTI/STI management includes support (medical personnel, clinics and drugs) to NGOs working with groups at high risk of HIV infection. NACO also has supported the establishment of STI clinics at district hospitals and other hospitals up to the block level. The five key components of the RTI/STI programme as envisioned under the NACP-III are: (1) RTI/STI prevention, (2) client management, (3) partner notification, (4) treatment, and (5) follow-up. NACP-III also envisions comprehensive RTI/STI treatment to be available at the CHC and PHC levels.

The proposed structure for delivering RTI/STI treatment is as follows:

At the frontline (grassroots) level, the auxiliary nurse-midwife (ANM) or the male multi-purpose worker would be the service provider for RTI/STI management. At the primary health centre (PHC) level, the medical officer, senior nurse or the lady health volunteer would be the service provider.

At the community health centre (CHC)/first referral unit (FRU) level, the medical officer for obstetrics and gynaecology would be the service provider. Basic screening tests for STIs/RTIs would be available at the CHC/FRU level with STI specialists having laboratory support for management of STI/RTI at the district hospital level.

Voluntary counselling and testing centres

NACP-III has envisaged setting up ICTCs, which would provide antenatal care (ANC) services, HIV testing/counselling, PPTCT, antiretroviral therapy (ART), family planning and STI treatment. Staff present at these ICTCs would include a counsellor, a lab technician, a community nurse, and a medical officer.

It is proposed that what is currently the district VCTC would function as a satellite centre to supervise the operations of VCTCs located at the CHC and PHC to maintain and assure quality of services, ensure uninterrupted supplies, link with PPTCT centres, and ensure appropriate referrals of clients who test positive. To increase young people's access to SRH information and referral services, these centres would function as youth information centres. By 2012, all PHCs, CHCs, and district hospitals would aim to offer VCTC services.

Prevention of parent-to-child transmission

PPTCT services for HIV-positive women under the existing system include: (1) Family planning counselling, (2) ANC, PNC, delivery and abortion services, (3) VCTC, (4) STI management, (5) ART, (6) information, education and communication (IEC) on nutrition, breastfeeding, RTI/STI, and HIV/AIDS, (7) male involvement in MCH care, and (8) linkages with community-based care and support programmes for HIV/AIDS.

It is now proposed that PPTCT, being a function of the obstetrics department, would be implemented within the proposed RCH-II framework because this framework focuses on improving the quality of and access to institutional deliveries. At the tertiary care level, the PPTCT staff would continue to report to the head of obstetrics/gynaecology. At the district

level, the PPTCT would be the focal point for the coordination of quality, supplies, reporting, and referral. NACP would fund the PPTCT counsellor/ laboratory technician as well as meet the cost of necessary supplies.

Condom promotion

The male condom is currently the most widely available method for protection against HIV and STIs. NACO and SACS supply condoms to STI clinics, VCTCs, and obstetrics/gynaecology clinics. Condoms are also made available at outlets situated near state highways and in areas where trucker-intervention projects are underway. It is now proposed that condom programming for NACP and the DOHFW could be managed under a single entity and that there should be joint development of a strategy on condom procurement and distribution.

Sources

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2. Policy Document on AIDS. Available at www.naco.nic.in. Accessed on November 20, 2006.
3. Toward a stronger multi-sectoral response to combat the spread of HIV/AIDS. A study commissioned by UNDP, New Delhi for Design team, NACO (Phase-III), New Delhi.

Health workers and HIV-SRH convergence

In terms of putting policy into practice, health workers are at important junctures for either reproducing or challenging stigma. Training in both technical and human rights issues is a priority for increasing their potential to address stigma and delivering services effectively. There is growing evidence that involving health workers in the planning of sexual health interventions improves their ability to discuss sexual health issues, for example, and that bottom-up approaches focusing on areas where health workers feel they can make improvements are effective (de Koning et al. 2005). Training may need to be intensive; a project in Egypt to integrate sexual health counselling into family planning sessions found that their less-intensive training sessions left providers still too embarrassed to discuss sexual issues sufficiently (Abdel-Tawab et al. 2000). Good training can resolve many issues; for example, the POLICY project in Uganda found that their training helped overcome resistance by health workers who saw integration as increasing their work burdens (Druce et al. 2006). Training may need to be generalised at all levels of the health system – the Haiti Partners in Health project involves both clinical and non-clinical staff in addressing non-medical impediments to HIV care in PHC settings (Druce et al. 2006). A Population Council project to reduce discrimination in hospitals in Delhi also involved all levels of health workers in the hospitals – not only doctors – in developing a "people-with-HIV-friendly checklist" to act as a gold standard of non-discriminatory care in a self-assessment process (Mahendra et al. 2006). Training also needs to be properly balanced for the various integration combinations being promoted, for example, Rutenberg and Baek (2004) report that in PMTCT/family planning combination initiatives, family planning often only constitutes a small component of training, with the assumption that workers are already trained in family planning, although this is often not the case.

It is important to be realistic about the limits of the role of health workers as pioneers in sexual and human rights advocacy. Several reports point out that it is often health workers' fear of infection which fuels health worker discriminatory attitudes to HIV-positive people, including a reluctance to treat them. Although this fear is often exaggerated – given that the risk of HIV transmission from patient to health care worker is relatively small and can therefore be partly addressed through information and training – the reality of situations in which providers have to work without adequate supplies of gloves, gowns, masks, adequate needle disposal systems, and post-exposure prophylaxis (PEP), or even soap and water for washing hands, needs to be taken into account. Convergence initiatives may need to work in ways supportive of efforts to improve adherence to universal precautions in health facilities, as part of a strategy to tackle stigma.

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4. Mahendra VS, Gilborn L, George B, et al. *Reducing AIDS-related stigma and discrimination in Indian hospitals.* Horizons Final Report. Population Council: New Delhi; 2006. Available at: www.popcouncil.org/pdfs/horizons/inplhafriendly.pdf.
5. Rutenberg N, Baek C. *Review of Field Experiences: Integration of Family Planning and PMTCT Services*. Population Council; 2004.

SRH needs and aspirations of HIV-positive people

This article was drawn from abstracts presented at the XVI International AIDS Conference, Toronto, Canada

Background

In 2005, there were approximately 38.3 million adults worldwide living with HIV. Over the last five years, approximately, the global HIV prevalence rate has shown signs of stabilising. Even so, the actual numbers of those infected continue to rise (UNAIDS 2006).

Given that women comprise nearly half of the total number of adults worldwide living with HIV, the provision of SRH services – including family planning services – to people with HIV is seen as critical to prevention efforts. With unprotected sex being the primary mode of HIV transmission (75–80% of all cases) and breastfeeding accounting for another 10 percent of all cases, the significance of this is further underlined. Here, support for the integration of HIV and SRH services and programmes is also gaining ground. Any effective intervention, however, would also need to consider and engage with the SRH needs and aspirations of HIV-positive people.

Three important aspects related to these needs and aspirations emerged from the Toronto AIDS Summit: 1) that the central role of family planning is to support the reproductive choices of HIV-positive people through appropriate counselling, so family planning is significant to HIV-positive people in planning and not preventing a family; 2) that women of reproductive age are key clients for SRH services. However, supporting the SRH needs and aspirations of HIV-positive men is equally important for their well-being and to the rights of HIV-positive people in general; and 3) that the "pursuit of pleasure" is a vital sexual need of HIV-positive people.[1]

A selectionof key findings reported at the Toronto conference includes the following:

- **Paiva**'s [2] study among HIV-positive people attending two specialised AIDS care centres in Sao Paolo (Brazil) found that HIV-positive men have a greater desire to have children (50.1%) as compared to women (19.2%). Despite this significant difference in parenting aspirations, health care services are oriented towards women. Pavia concludes that two key challenges to the organisation of services are: 1) HIV-positive persons' access to objective information on reproductive options; and 2) male involvement in reproductive health care.
- **Sarna**[3] explained that despite no evidence linking HAART with an increase in risky sexual behaviour, a significant risk of HIV transmission and/or re-infection remains. This is especially true of sexual relations between regular partners, which are characterised by inconsistent condom use and low HIV disclosure rates. A better understanding of the latter two issues is needed to design prevention programmes for HIV-positive people.
- Among a sample of French patients on HAART, **Bouhnik** [4] reports sexual dysfunction as a frequent side-effect of the patients' negative experiences with HIV and/or treatment. She recommends psychological support for HIV-positive people in dealing with such experiences and in countering sexual dysfunction.
- **Sukati** [5] explored HIV-positive Swazi women's perceptions on child-bearing. She found that Swazi culture, in general, discourages their involvement with reproductive decision-making. Although her cohort expressed anxieties about child-bearing, they often had children to satisfy in-laws, avoid desertion by their husband, or express their "feminity." Sukati points out that these Swazi women expect greater sensitivity and emotional support from health care workers.
- **Weinberg**'s pilot study[6] aimed to assess the counselling needs and fertility intentions of HIV-positive men. She found that an overwhelming majority of her sample of HIV-positive men (87%) – irrespective of whether or not they wanted to have children – had not

been able to discuss family planning issues with their health care providers. The study also showed that HIV-positive people had a limited understanding of vertical transmission of HIV to the child. Weinberg recommends that clinicians should address fertility issues, risk behaviours, and HIV education more frequently with their patients, since the latter may not feel comfortable initiating this dialogue with their health care providers.

- More than 90 percent of pregnant women, especially those in resource-limited settings, do not get the PPTCT services they need. With this admission, the session on PPTCT proceeded with discussions on its scale-up and individual country experiences. Besides expansion of services, key recommendations for meeting HIV-positive people's need for PPTCT included linking PPTCT with HIV care/treatment programs, for example HAART (**Abrams**[7]), reach/follow-up on rural populations, and those who deliver at home and training health care providers (**Singh**[8]) .
- **Odhiambo's**[9] presentation sums up some of the issues identified above. It offers a comprehensive account of the fertility desires and SRH needs of HIV-positive people. In general, across all HIV-positive people these include

1. Satisfactory sexual and reproductive life in a supportive and non-discriminatory environment.
2. Need to access information, services, and support to express SRH needs and desires, freedom of choice in fertility and contraception choices, safe pregnancy, and delivery.
3. Security to ensure availability and access to SRH commodities for HIV-positive people, including dual-protection methods.
4. Need for safe and protected sex.
5. Need for contraception and information on safe contraceptives for HIV-positive people.
6. Relevant information for adolescents living with HIV on safer sex practices and appropriate contraceptives (if sexually active), life skills, and SRHR education.
7. Policies that promote and protect SRHR for HIV-positive people and the right to decide freely and responsibly on matters of SRH and needs. Specifically, for HIV-positive women these include:

a. Family planning and safe motherhood services.

b. Female-controlled barrier and protection methods.

c. Comprehensive education on sexuality RH counselling.

d. Screening for human papillomma virus (HPV) and cervical cancer, genital warts, and rectal cancers.

e. Information on the effect of hormonal contraceptives on ART and vice-versa.

Full presentations and detailed descriptions of the sessions can be obtained from the sources listed below.

Sources

a. Joint United Nations Programme on HIV/AIDS (UNAIDS). *Report on the Global AIDS Epidemic*. Geneva: UNAIDS; 2006.

b. XVI International Conference on AIDS, Toronto, Canada, 2006. Available at www.aids2006.org. Accessed December 15-25, 2006. See presentations listed below:

Presentations

1. Satellite (MOSA16): Where is the Pleasure in Safer Sex?

Oral Abstract Session (TUAD01): Sexual and Reproductive Health and Rights of People living with HIV.

2. Paiva V (TUAD0105). Reproductive desires of men and women living with HIV in Brazil: a challenge for healthcare.

3. Sarna A (TUAD0102). Sexual risk behaviour in regular partner relationships is still a concern among PLHA receiving HAART: experiences from Mombasa, Kenya.

4. Bouhnik A (TUAD0103). Sexual dysfunction in HIV-infected patients in France – results of a large representative sample of outpatients attending French hospitals (ANRS-EN12-VESPA).

5. Sukati NA (TUAD0104). Perceptions of HIV-positive Swazi women on childbearing.

Symposium (THSY03): Prevention of Mother-to-Child Transmission: Translating Evidence into Action.

6. Weinberg A (TUAD010). Assessing the fertility intentions and behaviors of HIV-positive men utilizing an urban clinic in Brooklyn, New York.

7. Abrams E (THSY0301). Current scientific evidence and programmatic experiences in PMTCT: Scenarios for achieving the global goal of eliminating HIV/AIDS in children.

8. Singh B (THSY0303). Country experiences: Successful scaling up approaches.

Controversy and common ground (WECC02): Integration of HIV/AIDS and Sexual and Reproductive Health; Finding Common Ground: Risk or Reality?

9. Odhiambo D (WECC0202). Fertility desires and SRH needs of people living with HIV.

A summary of the conference on "Linking Reproductive Health, Family Planning and HIV/AIDS in Africa" held in Addis Ababa, Ethiopia

Introduction

A two-day conference on linking reproductive health, family planning and HIV/AIDS in Africa was held in Addis Ababa from October 9–10, 2006. It was organised jointly by the Department of Community Health, Addis Ababa University, Johns Hopkins Bloomberg School of Public Health, and the Department of Population and Family Health Sciences at the Bill&Melinda Gates Institute for Population and Reproductive Health.

Four hundred and ninety-three participants from 25 countries attended the conference. Break-out sessions covered the following topics: 1) research and evaluation, 2) programs and service delivery, and 3) policy considerations.

The conference themes were:

1. Integration – when and where?
2. Linking family planning services and VCT.
3. Integrating reproductive health and HIV services for youth.
4. Reproductive intentions and HIV.
5. Policy considerations of integrated services.
6. Pregnancy and HIV/AIDS prevention.
7. Impact of integrated services and programmes.

Key issues that emerged from the conference

- Integration of family planning and HIV services requires political commitment at the highest levels of government and needs to be nationally driven. Although policy continues to be a neglected area of enquiry, policy formulation will have to be participative and inclusive to reconcile diverse viewpoints.
- The similarities and differences between the epidemiology of reproductive morbidities and HIV, and between reproductive health-family planning services and HIV services need to be understood in order to introduce appropriate integration strategies.
- There was a need for more longitudinal/prospective studies, and for methodological rigor in research that assesses impact.

Key challenges

The significant barriers to integration at all levels of programme management include a lack of clarity on what to integrate and how, a lack of adequate financial and material resources, providers' bias and client preferences not being addressed, a lack of evidence of impact and an increased staff workload and/or labour turnover.

Steps forward

The conference participants felt that there was a need for conceptual clarity on integration – with respect to epidemiology and patho-physiology of HIV on the one hand, and the epidemiology and physiology of pregnancy and childbirth on the other, as well as clarity on financial, administrative and service provision issues.

There was a need to address issues of demand and community action.

Providers' trainings are needed for enhancing their knowledge of RH and HIV issues.

The research agenda needs to be defined and expanded to include more prospective longitudinal studies, demand-side explorations, costing and scale-up studies as well as the replication of successful action research to inform policy changes.

Conclusion

The conveners concluded that integration was a complex issue and that more evidence is needed for an effective integration of reproductive health, family planning and HIV/AIDS programmes.

(The report was compiled by Dr. Amitrajit Saha who attended the conference as a delegate.)

Strategies to facilitate research on community demand for HIV and SRH convergence

The first part of the PATH Convergence Project aimed to identify and analyse different ways in which HIV services could converge with SRH services. It was designed to generate information both from the demand side (i.e., the community) and from the service side (i.e., service providers and policymakers). For research purposes, key populations accessed in the community included sexually active men and women, men and women with HIV, and female sex workers. To generate information on demand for HIV and SRH convergence, participatory methods were used to work with these key population groups in all the study sites. Two specific strategies were also used to access and facilitate work with these groups in field settings: 1) forming local advisory groups in each of the study districts, and 2) recruiting and training representatives from the key population groups themselves, to conduct participatory research.

Formation of local advisory groups

The project was initiated in each study state (Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh) through conducting a series of state-level meetings. These meetings were attended by state and district-level health and family welfare officials, officials from the respective state AIDS societies, and state and district-level NGOs.

Following the state-level meetings, district-level stakeholders were then contacted and invited to form local advisory groups for the project. The local advisory group in each district comprised district-level health officials, representatives from State AIDS societies, representatives from local NGOs, men and women with HIV, and female sex workers. The remit agreed for the local advisory groups was to reduce risks to the study population, ensure that participation of key population groups in the research was informed, confidential, and truly voluntary, and ensure that the research was conducted in an ethical manner. The PATH Convergence Project shared the research protocol, study methods, method guides, and consent documents with local advisory group members and made changes as the groups recommended. The local advisory groups were also requested to ensure that the research did not violate the rights of the populations accessed and to assist the research investigators in the field in whatever way they could. Local advisory group members met at least three times during the preparatory and data collection phases and provided valuable inputs and support to the research activity.

Involving community participants as researchers

The Convergence Project used participatory methods to generate information about community perceptions on services they needed, services they accessed, barriers they faced while accessing necessary services, and their suggestions for the types of HIV and SRH convergence that would increase access to services for the key populations. To ensure that respondents who volunteered to participate in the group discussions felt comfortable in sharing this information, research investigators conducting the sessions were peers from the communities themselves. Three research teams were recruited in each study district comprising female sex workers, men and women with HIV, and local NGO outreach workers (representing sexually active young men and women). These investigators were recruited at each study district with the help of contacts from the local advisory groups. Investigators then participated in training for six days at a resort outside Hyderabad. The training consisted of team-building exercises, discussion on the PATH Convergence Project, lectures on SRH and HIV services, training in participatory methods, group work, and field practice. On the last day of the training, the district research teams were formed and they interacted with the local advisory group representatives to develop a plan for the fieldwork. The teams began the research within two to three days of training, with technical support and supervision provided by the PATH Convergence team and representatives from the local advisory groups.

Update from the December 2006 state-level meetings on the PATH HIV-SRH Convergence Project

Four state-level meetings with representatives from state governments and NGOs were held in Patna (Bihar), Lucknow (Uttar Pradesh), Hyderabad (Andhra Pradesh) and Mumbai (Maharashtra) in December 2006. The objectives of the meeting were to share the preliminary research findings from the PATH Convergence Project and discuss different convergence options and their relevance to the state. Five convergence options that were generalised during the preliminary analysis of the research data were shared with the participants of the state meetings. These were:

1. **Access to condoms and communication for HIV/STI prevention at village and PHC level.**
2. **STI services at VCT and DOTS (directly observed therapy short-course) centre and at RCH clinics.**
3. **SRH communication, family planning, and abortion.**
4. **Anti-stigma training for RH service providers.**
5. **Strengthening referrals and linkages between HIV and SRH services.**

Bihar state-level meeting: December 11, 2006 (Patna)

Twenty participants attended the meeting, including representatives from the Bihar State AIDS Control Society (BSACS) and the DOHFW, Government of Bihar, and representatives from NGOs who worked with adolescents, married men and women, and people with HIV.

In her opening remarks, Dr. Geetanjali Kumari, Additional Project Director, BSACS, expressed her satisfaction with the Convergence Project. Dr. Kumari spoke about the will of BSACS to implement convergence of HIV and SRH services and highlighted the manner in which it was working closely with the Bihar Network of Positive People (BNP+). She felt that there was a wide recognition of the need for a multi-sectoral approach to ensure the reach of services to those who need them.

During the discussion on convergence options, participants felt that although condoms were available, people do not access them; so creating demand and making condoms accessible right down to the PHC level was important. They also felt that covering the population at village level with communication on STIs and HIV would increase the reach of the programmes to rural communities most in need of such information. Participants also said that DOTS centres, which have a relatively wide reach in Bihar, should be utilised to offer STI services. This would also cater to needs of the large migrant labour population of Bihar who are vulnerable to both TB and STIs. With regard to anti-stigma training of service providers, participants felt that before training, basic universal precautions infrastructure and consumables such as disposable gloves needed to be provided so that health care workers could provide necessary services once they were trained.

The participants identified steps that would be needed to take these convergence options forward and identified some key influencers and people who would need to be involved. The meeting then ended with a brief discussion of next steps in the PATH Convergence Project and a vote of thanks.

Uttar Pradesh state-level meeting: December 13, 2006 (Lucknow)

Twenty-nine participants attended the meeting including representatives from the Uttar Pradesh State AIDS Control Society (UPSACS) and the DOHFW, Government of Uttar Pradesh, and

representatives from local/state and national NGOs working with adolescents, maternal health, and men and women with HIV.

In her opening remarks, Dr. Shakeel Nayara, Joint Director, RCH, Uttar Pradesh DOHFW, stated that implementing the NRHM was a priority for the state, where provision of treatment for RTIs and STIs at the level of FRUs is already being introduced. Dr. Nayara also mentioned the need to integrate other services like provision of abortion, and treatment for opportunistic infections to increase access to larger population groups.

During the discussion on convergence options, participants felt that the role of public-private partnerships, the remit of NRHM, health policy analyses, and referral and linkages at PHC levels were issues that needed to be addressed. They expressed that convergence options selected for piloting in Uttar Pradesh should address issues of feasibility, urgency, cost-effectiveness, and ensure minimal involvement of resources. The need to clarify the concept of convergence within the government and at the community level before initiating convergence of HIV and SRH services was emphasised. The need to substantially address gaps in delivery of health care in the state, including questions on quality of care before introducing convergence was also highlighted — particularly in relation to infrastructure, privacy and confidentiality for patients, stigma, staff expertise, and resource allocation.

The participants at the meeting also identified steps that would be needed to take convergence options forward and identified some key influencers and people who would need to be involved in the process. The meeting ended with a brief discussion on next steps in the Convergence Project.

Andhra Pradesh state-level meeting: December 15, 2006 (Hyderabad)

Nineteen participants attended the meeting, including representatives from the DOHFW, the Office of the Commissioner Family Welfare, the Andhra Pradesh State AIDS Control Society (APSACS), and NGOs with experience of working with young men and women, sex workers, and men and women with HIV.

In his opening remarks, Dr. Venkateshwar Rao, Director of Health Services, Andhra Pradesh, emphasised the importance of research and reiterated the importance of taking research and findings closer to the community. He pointed out that networking, synergy, collaboration and partnerships, and integration of different services was being discussed at the highest levels of the Andhra Pradesh government. There was now, he said, a great interest in examining how convergence of HIV and SRH will work and what benefits it would bring users. Mr. Ashok Kumar Pillai, Project Director, APSACS, mentioned that some aspects of convergence have been initiated in recent months through integration with allied departments for HIV prevention activities. In addition, nurse practitioners in high prevalence districts have been trained and at the administrative level, the District Leprosy Officer has recently been re-designated as the District HIV Officer.

During the discussion on convergence options, participants said that a top priority was stigma reduction, since in addition to providers' stigma and discrimination, there was also self-stigma and stigma from within one's community. They also expressed that strengthening communications at the grassroots level was important on certain topics, such as sexuality, gender, adolescent health, early marriage and pregnancy, contraception including condom use, spacing methods, STIs, pregnancy, handling unwanted pregnancies, emergency contraception, safe abortion services, safe delivery, and institutional deliveries. They discussed the role of village sarpanches and village health committees in such communication activities. The participants felt that involvement and participation of males might increase if male accredited social health activist (ASHA) workers are appointed. Participants also suggested that a group of formal and non-formal service providers should be trained to provide referrals, which could be monitored first as a pilot and then scaled up.

At the end of the discussion, participants identified steps that would be needed to take convergence options forward and identified key influencers and people who would need to be

involved in the process. The meeting ended with a brief discussion on next steps in the PATH Convergence Project followed by a vote of thanks.

Maharashtra state-level meeting: December 19, 2006 (Mumbai)

Seventeen participants attended the meeting, including representatives from district-level health officials, the Mumbai District AIDS Control Society (MDACS), and local-, state-, and national-level NGOs. Participants included people with experience in the area of SRH and with population groups such as people with HIV, street children, female sex workers, and migrant labour.

In his opening remarks, Dr. Aher, the District Tuberculosis Officer from Nashik, pointed out that the delivery of MCH/family planning services in Maharashtra was well-developed at the tertiary level. He said that the annual family health awareness campaign has been instrumental in creating awareness on STIs and bringing about a marked decline in STI incidence. Dr. Aher also mentioned that men were participating more actively in the programme and that women were getting STI services at the sub-centre and PHC level.

Participants had concerns about stigma and discrimination affecting key population groups and emphasised that convergence of services should aim at reducing such stigma. They also reiterated the importance of continuing targeted interventions in the current HIV scenario. The participants also felt the need for appropriate policies on convergence and relevant guidelines to assist in implementing converged services.

During the discussion on prioritising convergence options, participants felt that there was a need to develop a state-wide generalised programme to avoid increased workload to providers. They pointed out that issues of universal precaution, blood safety, adequate supplies, and logistics management needed to be addressed concurrent to converging services. They felt that a lack of ownership on HIV issues at the district health level may hinder convergence and suggested having a designated person for HIV activities at the district level. An independent study on the attitudes, knowledge and practice of the service providers, and an appropriate definition of what entails "good quality RCH services" were areas they thought were important to address while initiating convergence of HIV and SRH services.

Participants identified steps that would be needed to take convergence options forward, and key influencers and people who would need to be involved in the process. The meeting ended with a brief discussion on next steps in the Project.

PATH is an international, nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act.

Headquartered in Seattle, Washington, PATH operates 28 offices in 18 countries. The India country office is based in New Delhi, with project offices in Lucknow, Mumbai, Hyderabad, Imphal, Chennai, and Bangalore, as well as partnership operations in Assam and Bihar.

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