

Options and Challenges for Converging HIV and Sexual and Reproductive Health Services in India

Findings from an Assessment in Andhra Pradesh, Bihar,
Maharashtra, and Uttar Pradesh

June 2007

 **PATH**
A catalyst for global health

PATH is an international, nonprofit organisation 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 27 offices in 18 countries. The India country office is based in New Delhi, with project offices in Lucknow, Mumbai, Hyderabad, and Imphal, as well as partnership operations in Assam, West Bengal, Bihar, Tamil Nadu, and Karnataka.

This assessment was carried out by PATH with financial support from the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation in India, and from the Department for International Development (United Kingdom). The views in this report do not necessarily reflect the views of these organizations.

Copyright © 2007, Program for Appropriate Technology in Health (PATH). All rights reserved. The material in this document may be freely used for educational or noncommercial purposes, provided that the material is accompanied by an acknowledgement line.

For more information, please contact:
Dr. Amitrajit Saha
Associate Director, Sexual and Reproductive Health, India
PATH
Tel: 91-11-26530080 to 88
Fax: 91-11-26530089
Email: asaha@path.org
www.path.org

Cover photo: Siri Wood

Acknowledgments

This assessment was carried out by PATH with financial support from the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation in India, and from the Department for International Development (United Kingdom). The assessment team was comprised of Amitrajit Saha, Tilly Sellers, Madhavi Panda, Raj Kumar Bidla, and Irfan Khan of PATH. Jeff O'Malley, PATH's Country Director for India Program, provided guidance to the project, Patricia Coffey provided technical support from Seattle and Smriti Acharya, Samuel Varaprasad, Swati Pongrulekar, Omega Jyotsna and Indira Rani from PATH provided assistance at state level.

First, we would like to thank senior government officials from the departments (and bureaus) of health and family welfare, the state health societies, and the state AIDS control societies of Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh:

Andhra Pradesh

C. B. S. Venkata Ramna (former Commissioner, Family Welfare, Government of Andhra Pradesh); G. Ashok Kumar Pillai (Project Director, Andhra Pradesh State AIDS Control Society); Dr. P. Venkateswara Rao (Director, Family Welfare, Government of Andhra Pradesh).

Bihar

Deepak Kumar (Principal Secretary/Commissioner, Department of Health and Family Welfare, Government of Bihar); A. N. Singh (former Project Director, Bihar State AIDS Control Society); Jayant Kaushal (Regional Director—Bihar and Jharkhand, Department of Health and Family Welfare, Government of India).

Lucknow

Dr. K. K. Singh (Chief Medical Officer of Health); Dr. C. B. M. Tripathi (Director, Maternal and Child Health, Government of Uttar Pradesh); Dr. Rajiv Chowdhary (Assistant Director, Uttar Pradesh State AIDS Control Society); Dr. Neelam Singh (Vatsalya); Sehba Hussain (Better Education Through Innovation); Kaushik Das (Naz Foundation International); Bharat Bhushan (People's Action for National Integration); Qasim Mehndi (Bharosa Trust).

Patna

Dr. Geetanjali Kumari (former Assistant Project Director, Bihar State AIDS Control Society, now Regional Coordinator, East, National AIDS Control Organisation); Sanjay Kumar Sinha (Assistant Director – Condom promotion, Bihar State AIDS Control Society); Dr. C. B. Singh (Civil Surgeon cum Chief Medical Officer of Health); S.Pankaj (Organisation for Socio-Economic and Rural Development); Ram Kishore Prasad Singh and Anju

Maharashtra

Anna Dani (Principal Secretary, Family Welfare, Government of Maharashtra); Dr. P. P. Doke (Director General, Health Services, Government of Maharashtra); Dr. Chitale (Joint Director, Reproductive and Child Health, Government of Maharashtra).

Uttar Pradesh

Dr. Shakeel Nayara (Joint Director, Reproductive and Child Health, Government of Uttar Pradesh); Dr. S. P. Goel (Project Director, Uttar Pradesh State AIDS Control Society); Dr. Aradhana Johri (former World Health Organization advisor on polio, now Joint Secretary, Ministry of Health and Family Welfare, Government of India).

(Gramin Evam Nagar Vikas Parishad); Pawan Kumar; Pinky; Manju; (Suryodaya Sarvagirn Vikas Parishad); Christopher Bachman (YMCA, Bihar); Rajneesh Singh (President, The Bihar Network For People Living With HIV/AIDS).

Srikakulam

Dr. M. V. Ramanna Rao (Joint Director, Andhra Pradesh State AIDS Control Society); Dr. Jaganmohan Rao (former District Medical and Health Officer); Kanaka Durga (District Project Officer, Integrated Child Development Service); Dr. P. Tirupathi Rao (District Tuberculosis Control Officer); Dr. B. Rama Rao (Project Officer); Dr. G. Kondala Rao (Field Publicity Officer); S. Raveendar (Resource Education Society); M. Prasad Rao (Youth Club of Bejjipuram); Sarojini; Ramanna Amma; Padma.

Nashik

Dr. A. B. Chitale (former Joint Director, Maharashtra State AIDS Control Society, now Joint Director, Reproductive and Child Health); Dr. P. D. Gandal (Assistant District Health Officer); Dr. P.H. Aher (District TB officer); Kshirsagar Arvind (Manas Vyasankmukti Kendra); Kailash More (Lokvikas Samajik Sanstha); Prakash Yende (President, Positive People of Amannagar); Dr. C. R. Namapurkar (Project Manager, Manas Vyasankmukti Kendra); Kavita Shivdas Shikhare (Krupa Prasad Care and Support Centre) (now deceased); Neelesh Sonawane (Krupa Prasad Care and Support Centre).

The assessment team would like to acknowledge the contributions of staff from Research Pacific International: James Washington, Archana Sinha, Tilak Arora, Priya Panwar, and Shruti Singh.

Our thanks also go to the community investigators: G. Sarojini; B. Sarojini; Ramalaxmi; Indira; G. Srinu; G. Raju; Prashant; Gautam (National Key Population Consultant [NKPC]); Priya Murthy (NKPC); Anita; Sanjita; Meena Devi; Kailash Bhagat (now deceased); Mahua; Asha Bhatia; Moin (NKPC); Munnisa (NKPC); Sangeeta (NKPC); Gayatri (now deceased); Bhoju Singh; Jyoti Pawar; Manisha; Madhuri; Kshama; Savita; Sunita (NKPC); Tanaji (NKPC); Ranno; Manju Pandey; Neelam Rawat; Kavita Rawat; Gopal Gour; Indira; Laxmi; Srinu (NKPC); Vijay (NKPC); Prashant; Vijay; and Suresh.

We would like to acknowledge the administrative support received throughout the assessment from Srinivasan Venkatraman and Aditi Joshi of PATH. Finally, we would like to express our gratitude to all those who participated in the assessment and shared their time and thoughts to help us understand the issues.

Acronyms

AIDS	Acquired immune deficiency syndrome	NGO	Nongovernmental organisation
ANC	Antenatal care	NRHM	National Rural Health Mission
ANM	Auxiliary nurse midwife	PATH	Program for Appropriate Technology in Health
ART	Antiretroviral therapy	PHC	Primary health centre
BCC	Behaviour change communication	PMTCT	Prevention of mother-to-child transmission
CBO	Community-based organisation	PPTCT	Prevention of parent-to-child transmission
CHC	Community health centre	RCH	Reproductive and child health
DOTS	Directly observed (tuberculosis) treatment short course	RCHP	Reproductive and Child Health Programme
HIV	Human immunodeficiency virus	RMP	Registered medical practitioner
HSPC	Human Subjects Protection Committee	RTI	Reproductive tract infection
ICDS	Integrated Child Development Service	SACS	State AIDS control society/societies
ICTC	Integrated counselling and testing centre	SRH	Sexual and reproductive health
IEC	Information, education, and communication	STD	Sexually transmitted disease
LAG	Local advisory group	STI	Sexually transmitted infection
LTFQP	Less than fully qualified practitioner	TB	Tuberculosis
MCH	Maternal and child health	VCT	Voluntary counselling and testing
NACO	National AIDS Control Organisation	WHO	World Health Organization
NACP	National AIDS Control Programme		

Table of contents

Acknowledgments	3
Acronyms	4
Executive summary	7
Summary of findings from participatory mapping	8
Summary of findings from interviews with service providers	8
Summary of findings from interviews with policymakers	9
Conclusions	10
Introduction	13
What is convergence	13
Directions of convergence	13
Benefits of convergence	14
Challenges of convergence.....	14
Populations of interest for convergence	15
Convergence needs in India	16
Government services and convergence policy in India	16
Assessment of HIV-SRH convergence in four states	19
Assessment objectives and questions	19
Assessment methods	19
Selection of assessment sites	20
Forming local advisory groups	20
Selection and training of the assessment team	20
Developing and pre-testing data collection instruments	21
Selection of assessment participants and data collection	21
Findings from participatory mapping	25
Managing sexual and reproductive health	25
HIV and SRH service and information needs	26
Barriers to service use	27
Demand for convergence	28
Findings from interviews with service providers	32
General attitudes toward convergence	33
Benefits of convergence	33
Challenges in implementing convergence.....	34
Training needs.....	37
Policy and partnerships	39
Findings from interviews with policymakers and influencers	41
Policy and partnerships	41
Funding and cost implications	42
Provider skills	42
Conclusions	43
Limitations of the assessment.....	43
Implications for implementing and scaling up HIV-SRH service convergence.....	44
Implications for strengthening capacity for convergence.....	45
Implications for translating policy into practice	46
Further research	46
Annexes	48
Annex 1. Sexual and reproductive health services provided in the public sector in India	48
Annex 2. Current policy regarding integration of HIV and SRH services in India.....	49
Annex 3. Resource materials developed by PATH for the convergence project	50
Annex 4. Background information on assessment districts	51
Annex 5. Terms of reference for local advisory groups.....	57
Annex 6. Participatory mapping guidelines	59
Annex 7. Guidelines for semi-structured interviews with service providers and policymakers	61
Annex 8. Consent form.....	63
Annex 9. Suggested convergence options	66
References	69



Community investigators learn how to conduct participatory mapping. PATH—Hyderabad, India, June 2006.

Executive Summary

This report is primarily for state- and district-level policymakers and service providers working in the government and in nongovernmental organisations (NGOs) in India. The report aims to share findings from an assessment carried out by PATH to explore how access to critical services for populations at risk of HIV and unintended pregnancy can be strengthened by converging HIV and sexual and reproductive health (SRH) services under the National Rural Health Mission (NRHM) and the National Aids Control Programme (NACP). The report provides information on the demand and opportunities for and the challenges of implementing HIV and SRH convergence in four states—Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh.

Global evidence shows that populations at risk of HIV and unintended pregnancies, such as young men and women, people who sell sex, and people with HIV, are not able to access the HIV and SRH services they need. Young women and sex workers, for example, have difficulty accessing family planning services, which are geared toward the needs of married women. Services for family planning, maternal and child health (MCH), sexually transmitted infection (STI), HIV, and abortion are provided separately and often target different populations. Consequently, there are several missed opportunities for providing a better response to HIV and SRH. “Convergence” of HIV and SRH services refers to a very wide range of activities or processes, which are undertaken with the broad objective of capturing these “missed opportunities” by adding on services or paying attention to the overlap areas in HIV and SRH.

The Government of India has recognised the need for converging or linking HIV and SRH services in the Reproductive and Child Health Programme (RCH II), the National AIDS Control Programme launched in 2007 (NACP III), and in the NRHM. Whilst the policy environment is favourable, the voice of the client, or demand for different convergence options, is significantly lacking, and state governments lack the evidence necessary to make informed decisions about what options will work best in different settings. In recognition of this need, PATH worked with state governments, NGOs, and local communities in Bihar, Andhra Pradesh, Maharashtra, and Uttar Pradesh to identify the options for and challenges of HIV-SRH convergence.

An assessment was conducted in one district in each state in order to generate an understanding of the demand for HIV-SRH convergence and of the potential challenges of responding to this demand. The assessment was carried out with HIV and SRH service providers

and policymakers and with people at risk of HIV and unintended pregnancy (female sex workers, sexually active young men and women, and people with HIV). Background information and secondary data on the assessment districts were collected first. This was followed by participatory mapping and analysis of potential convergence options with 1,545 sex workers, young people, and people living with HIV. Semi-structured interviews were then conducted with 159 service providers and 60 policymakers to assess the opportunities for and challenges of implementing the convergence options suggested during mapping activities. The preliminary findings and key convergence options that emerged from the assessment were verified with state and district stakeholders through a series of meetings to prioritise convergence options that could potentially be taken forward. Local advisory groups in each state were convened to support the assessment process. Key questions for the participatory mapping part of the assessment included:

- *What SRH-related illnesses do groups at risk suffer from?*
- *How do they manage these conditions?*
- *What are the barriers to accessing HIV and SRH services?*
- *What specific convergence options in each area would increase access to HIV and/or SR services?*

During the semi-structured interviews, respondents were asked about their general reactions to converging HIV and SRH services, what they felt would be the feasibility of responding to the demand to implement specific convergence options in their facilities, what would be the training needs and policy and cost implications, what partners would be needed, what would be the benefits and barriers, and who would be influential in making convergence happen.

Summary of findings from participatory mapping

Findings from the participatory mapping showed that STIs are widespread amongst all groups, indicating that people who are HIV-positive, sex workers, and sexually active youth are groups that could benefit from increased access to HIV and SRH services. Sex workers had the most difficulties relating to pregnancy and childbirth and also the least access to government SRH services at district hospitals, community health centres, and primary health centres (PHCs) and sub-centres. Findings also showed that men (in general) rarely use government services for management of STIs and that sexually active young men and women need information and access to services at PHCs and sub-centres for HIV prevention, particularly condom use and STI management. Young men and women know the least about existing HIV and SRH services, and young people in higher-prevalence states mentioned the need for access to HIV testing more than those in lower-prevalence states. **Stigma experienced at mainstream government SRH services was the main barrier to access for sex workers, positive people, and young men.** Sex workers and positive people also require more privacy and better confidentiality at these services.

The majority (60 percent) of suggestions for convergence involved government services, and more government convergence options were suggested in lower-prevalence states. Positive people saw government HIV services, such as antiretroviral therapy (ART) and voluntary counselling and testing (VCT) centres, as less stigmatising than government SRH services. As a result, positive people and sex workers did not suggest full integration of HIV and SRH services but had very specific suggestions for what should be converged and where. **Positive people would like to see family planning and STI services added to vertical government services, such as ART and VCT centres,** and they also said that signage identifying HIV services should be removed. **Sex workers and positive people in all four districts would like to use mainstream government services for surgical abortion, MCH, and prevention of parent-to-child transmission (PPTCT)—but only if staff attitudes and social stigma are addressed.** Positive people suggested that HIV workers could train government SRH workers in how best to work with people with HIV and other marginalized groups.

Summary of findings from interviews with service providers

Service providers' awareness and understanding of convergence "policy" was mixed, and there was some confusion between "guidelines/protocols" and "policies." Most providers, particularly frontline workers, were not aware of the concept of HIV and SRH convergence, and many assumed that convergence automatically meant full integration and "one-stop shops." Once they understood, managers and frontline workers in all sectors were generally receptive to the notion of convergence.

Service providers felt that HIV-SRH service convergence would increase access to much-needed services for groups at risk, strengthen the quality of service provision to them, and help reduce stigma and discrimination. Negative staff attitude was mentioned as a major challenge to convergence by the majority of government SRH providers. In contrast, government HIV service providers did not see staff attitudes as a challenge to providing SRH services to positive people within HIV settings. Overcoming service providers' fear of contracting HIV through their work by providing training and equipment for universal precautions was seen as key to addressing negative staff attitudes.

As well as seeing the benefits of HIV-SRH service convergence, there were some concerns. Service providers worried that women in the general population would boycott antenatal care (ANC) services, and/or the quality of services would be compromised by increasing access to sex workers and positive people. Some private providers thought they would lose business by being overly identified with HIV and sex workers. Frontline workers raised concerns about the fact that auxiliary nurse midwives, health volunteers, and Anganwadi workers are already involved in a number of programmes and explained how any additional programme would mean an increased workload. Also noted was a need to work with the populations at risk of HIV and unintended pregnancy, to generate demand so that clients would know what services were available and utilise them. Service providers felt that some convergence options, like communications and referrals, could be initiated at a minimum additional cost but that other options would need additional funds. Private-sector service providers were concerned about whether or not populations at risk would be able to afford converged services at their facilities and felt the government should provide them with some support to compensate for loss of revenue.

Training needs identified for service providers included stigma reduction; counselling; universal precautions; strategies for working with populations at risk; HIV prevention, care, and treatment; and referrals. Although the need for service provider training in gender and sexuality and expanded contraceptive options was mentioned during the mapping activities, this training need was not mentioned during the interviews with service providers. In contrast to SRH providers, whose main concern was improving staff attitudes and behaviour toward people at risk, HIV service providers expressed the

need to improve their SRH skills to be able to provide a wider range of services to their clients.

Service providers in both the public and private sectors felt that NGOs would play an important role in convergence—in demand generation, mobilisation, awareness-building, advocacy, outreach to vulnerable populations, and provision of support and training. A range of other partnerships was seen as important for implementing and promoting convergence.

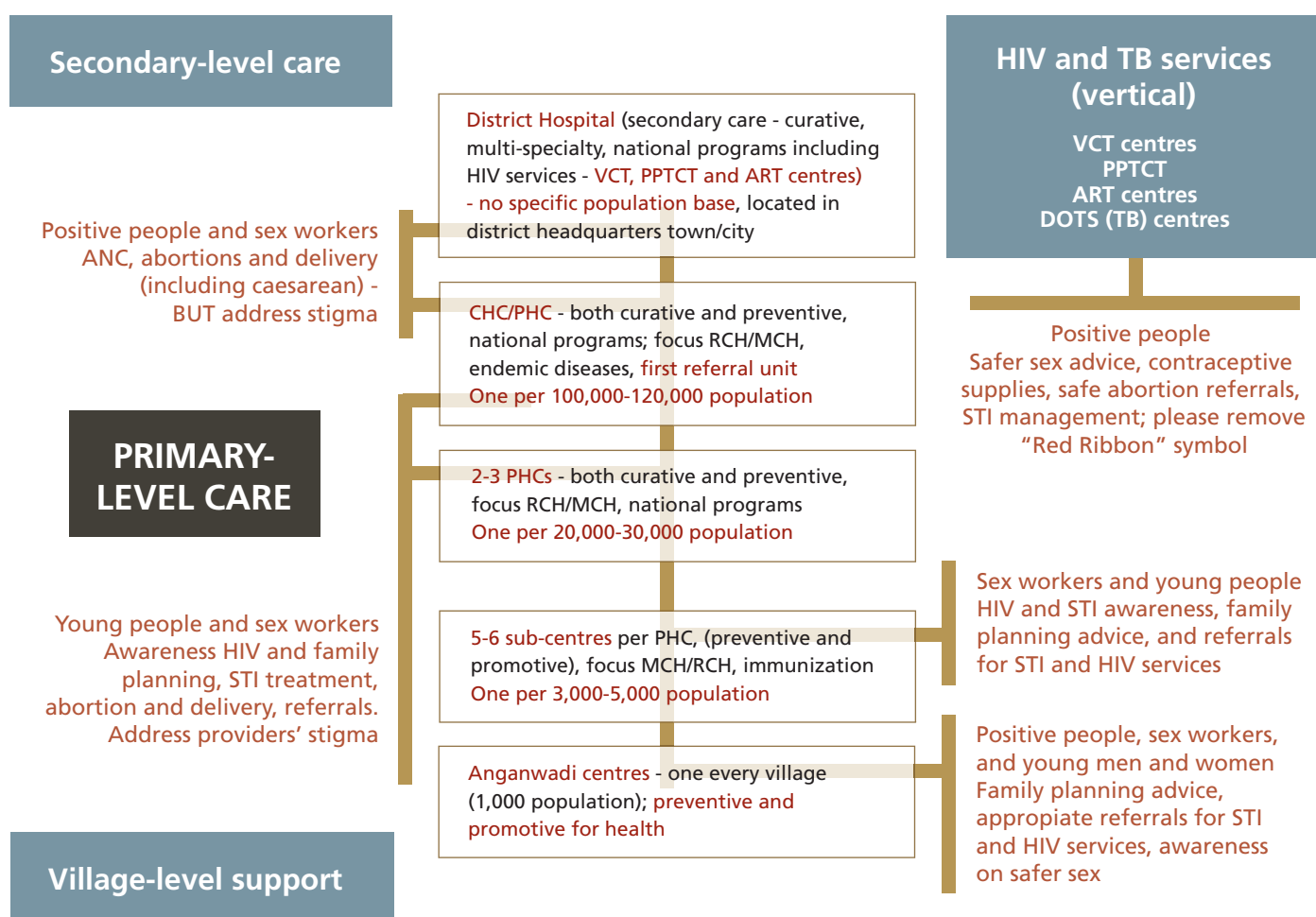
Summary of findings from interviews with policymakers

Policymakers/people of influence that were interviewed across the four assessment states were the most aware of any group about what convergence was and of the national- and state-level policies on HIV-SRH convergence. Eighty percent of policymakers across the four states felt that converging HIV and SRH services would have a positive impact on the reduction of HIV and unintended pregnancy, and 92 percent of policymakers felt that it was possible to implement convergence of government HIV and SRH services immediately. Eighty percent of policymakers interviewed said it was necessary to have NGOs as partners—particularly to support community mobilisation efforts and assist in provider trainings, as well as to provide other technical assistance. Policymakers also emphasized the importance of strategic partnerships and suggested a range of partners to implement and take forward the convergence agenda.

Fifty percent of policymakers interviewed felt that existing funding levels were sufficient to start implementing convergence, but more district-level officials than state-level officials felt that additional funding is needed. Policymakers in Uttar Pradesh spoke of the need for appropriate utilisation of existing funds. Nearly 75 percent of policymakers interviewed mentioned that current service provider skills are not adequate for implementing convergence. Many felt that NGOs would be well-suited to design and roll out convergence training. Policymakers also mentioned ongoing training efforts that could address these needs, including integrated skills-building programmes, which have begun in some states.



Convergence demands of at-risk populations at various levels of health care delivery



Conclusions

Although previous research has shown the need for converging HIV and SRH services, this assessment has begun the process of investigating the demand for convergence amongst populations at risk of HIV and unintended pregnancy in India. It has also explored the attitudes of service providers and policymakers toward responding to this demand and what the challenges might be in implementing convergence. The assessment findings have implications for programme implementation, capacity-strengthening, policy, and the need for further research.

Implications for implementing convergence

Full integration of HIV and SRH services is not required: Most people who participated in the assessment were enthusiastic about the idea of convergence, and many practical suggestions were made. Rather than advocating for full integration of all HIV and SRH services, suggestions for convergence from groups at risk in the community were pragmatic, based on their

own experiences with service utilisation and what would work for them within their own contexts. The assessment showed that HIV providers are attitudinally more ready for convergence and that it may be more feasible initially to initiate convergence of SRH services within existing HIV services.

Stigma in mainstream government health facilities must be reduced: Female sex workers are both key to HIV epidemic dynamics in India and to the response and they suffer more complications with pregnancy and delivery than other women. The assessment showed that their HIV and SRH service needs are not being met adequately by the public sector, largely due to stigma. There is a critical need to enable sex workers to access family planning, safe abortion, pregnancy and delivery services through the government health system and be referred as appropriate for VCT, HIV/STI prevention, care and treatment. Widespread training of health workers in addressing the needs of sex workers needs to be carried out as a

matter of urgency and strategies need to be developed to reduce stigma from staff and other clients at public health facilities.

The SRH needs of positive people must be met:

Similarly, the SRH needs of positive women are not being adequately met by the public sector. Family planning and STI services need to be provided by existing HIV facilities, such as VCT and ART centres. As for sex workers, safe, non-stigmatised abortion and delivery should also be available for positive women from mainstream government providers. Positive men need to be given opportunities to access safer sex information, condoms, and other SRH services at the government HIV facilities with which they are already familiar and comfortable—like VCT, ART, and tuberculosis (TB) directly observed treatment short course (DOTS) centres.

More attention needs to be paid to the HIV prevention needs of sexually active young people: Assessment findings showed that health facilities do not generally provide services or space to address the needs and concerns of young, sexually active men and women. “Young-people-friendly” services need to be provided at mainstream government facilities, and more opportunities to access condoms and HIV prevention information and referrals need to be given to young women at the sub-centre level.

Demand must be generated for convergence:

The assessment highlighted the importance of raising awareness of and demand for services as part of implementing convergence. There was a striking lack of awareness about current services amongst groups at risk, particularly young people. Stigma must be addressed before demand is generated, since sex workers and positive people will need convincing that the situation has changed before they risk exposure and discrimination.

A wide range of stakeholders needs to be engaged:

NGOs should work with the government to deliver anti-stigma and other training to government health workers and work with communities to reduce social stigma and generate demand amongst populations at risk. In addition, government providers and policymakers need to utilise the spaces and opportunities within the NRHM to firm up partnerships to facilitate referrals and increase coverage—particularly with Panchayati Raj institutions, NGOs, and private service providers. Partnerships appear to be important not only to alleviate social stigma and reduce barriers to implementing convergence, but also to leverage financial and political support and share expertise.

Implications for strengthening capacity

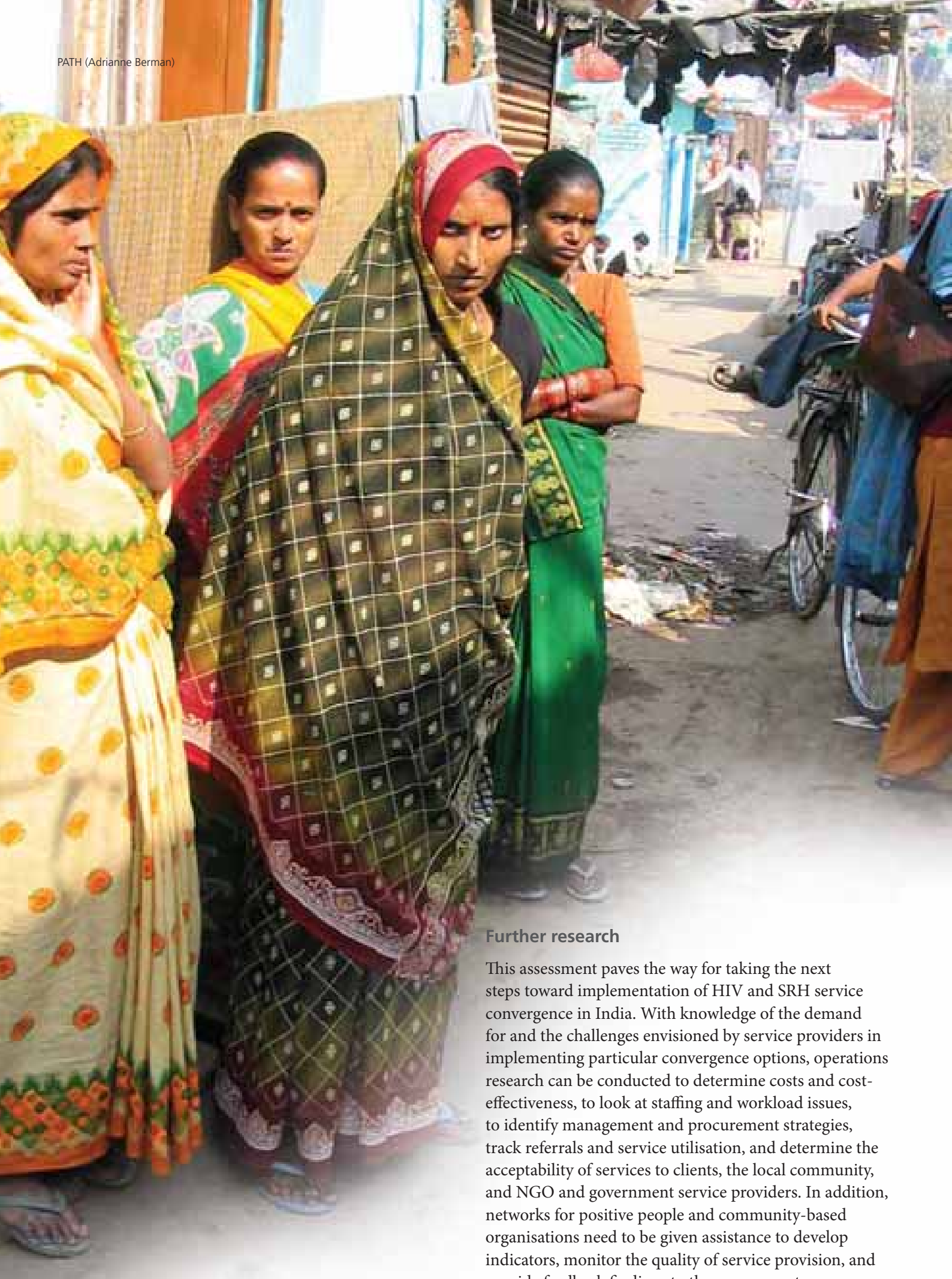
HIV service providers can share lessons in reducing stigma: Mainstream SRH services need to adopt the type of training and practices used by HIV workers, to reduce stigma against positive people and sex workers. The findings also point to a pressing need to share resources, rather than duplicate training across already stretched vertical systems. To scale up convergence, service providers need better access to national guidelines and a better understanding of state-level policy.

NGOs and government staff in higher prevalence states can help with training for convergence: Apart from anti-stigma training, training needs reported include training in HIV/AIDS (including harm reduction), gender, sexuality and rights, working with populations at risk, universal precautions, safe injection and waste management, and addressing the specific SRH needs of sex workers and positive people. NGOs have a role in providing training, and states that are further ahead in implementing the NACP III and NRHM convergence policy and in strengthening referrals can share lessons with other state governments.

Implications for translating policy into practice

The assessment showed a clear demand for the integrated services proposed under the NACP III, since vertical, but nonidentified, specialised HIV services are liked by positive people. In addition, there is a demand to add family planning and STI counselling, communications, and services to ART centres, VCT centres, and even to TB DOTS centres. Similarly, the desire of positive people and sex workers to see abortion, delivery, and PPTCT services mainstreamed, if stigma and other issues are addressed, speaks to RCHP II policy and the need not to isolate positive people in health care of positive people.

The assessment findings also highlighted key gaps between policy and programme practice. For example, the RCH II includes management of STIs from PHCs, but sex workers and young people reported that their STI needs were not being addressed at the primary health care level. The assessment also highlighted that there are gaps in the mobilisation of funds to district and sub-district levels and that mobilisation and utilisation of the untied funds in the NRHM and the RCH II have not yet occurred in many places as per the policy guidelines. On the other hand, the assessment also showed that state-level policymakers felt that the opportunities and the flexibility provided by the NRHM and the RCH II could be well-leveraged to implement convergence of HIV and SRH services.



Further research

This assessment paves the way for taking the next steps toward implementation of HIV and SRH service convergence in India. With knowledge of the demand for and the challenges envisioned by service providers in implementing particular convergence options, operations research can be conducted to determine costs and cost-effectiveness, to look at staffing and workload issues, to identify management and procurement strategies, track referrals and service utilisation, and determine the acceptability of services to clients, the local community, and NGO and government service providers. In addition, networks for positive people and community-based organisations need to be given assistance to develop indicators, monitor the quality of service provision, and provide feedback findings to the government.

Introduction

What is convergence

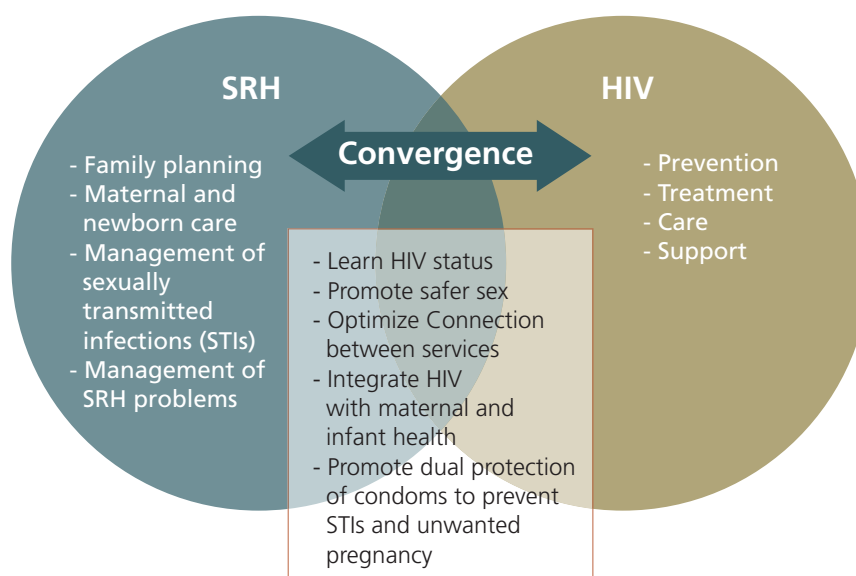
In many countries, the HIV/AIDS pandemic has compelled the fields of sexual and reproductive health (SRH) and HIV/AIDS to better leverage their strengths and address missed opportunities. Convergence of HIV and SRH services can mean just mutual referrals. It can also mean providing HIV behaviour change communication (BCC) within an SRH setting, and vice versa, or sharing training and training resources. At the facility level, HIV and SRH services can be converged with one another, providing a greater range of service components offered by health facilities. As well as convergence of activities or interventions, convergence of management, administrative, and support functions may result in more efficient infrastructure.

Directions of convergence

Several studies around the world indicate that current patterns of convergence vary considerably,^{1,2,3} based on the direction of convergence and whether the focus is on convergence of HIV prevention and treatment into

ongoing SRH programmes, or conversely, SRH issues into HIV programmes (see Figure 1). Adding HIV prevention and treatment to SRH services has the broad objective of deeper penetration of HIV services into the general population. This can be done by combining HIV prevention, testing, and treatment with existing services, such as family planning and antenatal care (ANC). This has usually been the type of convergence implemented in settings in which the HIV epidemic is relatively generalized. Converging services in the other direction, by adding various components of more comprehensive SRH services to vertical HIV programmes, aims to address the fertility aspirations of people with HIV and increase their access to SRH services. This may include, for example, adding family planning services or abortion referrals to voluntary counselling and testing (VCT) service points. This type of convergence has usually been implemented in settings where the epidemic is concentrated in certain areas or populations. Recent experience, however, has highlighted a strong need for both strategies in both settings.⁴

Figure 1. Directions of HIV and SRH service convergence.



Adapted from WHO/UNFPA/UNAIDS/IPPF, 2005.⁵

Benefits of convergence

Emerging lessons conclude that there are benefits of converging services in terms of increased coverage and client satisfaction. A recent assessment of an EngenderHealth project to integrate VCT into family planning and reproductive and child health (RCH) services in public health facilities in Tanzania found that the integrated services attracted more women than stand-alone VCT centres and also increased the testing of partners of family planning service users, hence bringing men into involvement in family planning and

reproductive health services.⁶ Issues of cost are also beginning to be positively assessed. A South African assessment found it more cost-effective to introduce VCT into family planning settings than to establish stand-alone services, providing staff had the time to provide counselling.⁷ In Ethiopia and Ukraine, integrating HIV prevention into maternal and child health (MCH) programmes has also been found to generate considerable cost savings.⁸ Table 1 shows the potential benefits of HIV and SRH convergence from different perspectives.

Table 1. Benefits of HIV-SRH convergence.

Client	Provider	Programme
Improved access to and uptake of key HIV and SRH services.	Increased capacity of service providers.	Enhanced programme effectiveness.
Better access of people living with HIV to SRH services tailored to their needs.	Improved provider knowledge skills.	Increased programme efficiency.
Reduced HIV-related stigma and discrimination.	Increased ability to meet client needs.	Cost and time savings through reduced duplication of service delivery functions.
Greater and more consistent use of dual protection methods against unintended pregnancy and sexually transmitted infections.	Improved SRH service coverage to underserved and high-risk populations, such as sex workers or men who have sex with men.	Expanded provision of health services across levels of health care.
Improved quality of care and increased ability to meet fertility intentions of clients.		

Challenges of convergence

Other lessons suggest a need for caution. The implications of conducting high quality HIV counselling for staff need careful assessment.^{9,10,11,12,13,14} Staff burnout and the turnover of trained staff may be problematic.^{15,16} Also, it may be necessary to thoroughly integrate sexuality and human rights training into nursing and medical school curricula.¹⁷ In Kenya, where a national strategy to integrate services has been under way for some time, enabling conditions have been identified:

- *A cohesive Ministry of Health (MOH) structure in which both reproductive health and HIV programmes report to the same department.*
- *The inclusion of both HIV and family planning components in the national reproductive health strategy.*
- *The existence of service provision guidelines that require the integration of VCT and prevention of mother-to-child transmission (PMTCT) into family planning and maternal health.¹⁸*

Converging HIV and SRH services may appear on the surface to be a common-sense option if operational issues can be resolved, but there are many challenges to its implementation. SRH care providers have often expressed concern that their services would be stigmatised and undermined by association with HIV-related services. Many HIV programme managers have criticized SRH care providers as inadequately skilled to deal with issues of sexuality, HIV care, and marginalized populations. In addition, there is evidence that vertical programming for HIV is effective.¹⁹ Donor financing has also played a key role, both as an obstacle and a driver, especially in countries dependent on overseas development aid. The norm amongst many donors has been to finance separate, parallel programmes. Finally, the mainstream of international policy and technical guidance has probably both influenced and reflected these trends, effectively keeping HIV and SRH separate from each other over the past years.²⁰

Populations of interest for convergence

Three populations are of particular interest for convergence in terms of being particularly vulnerable to HIV and unintended pregnancy, in addition to not always having access to either HIV or SRH services. These are sexually active young people, people with HIV, and female sex workers.

Young people between the ages of 15 and 24 years now account for almost two million new infections every year worldwide. Young women are particularly affected.²¹ Initiatives to confront this situation have brought to light several issues that are particular to, or particularly significant to, young people. These include the differential access to health services of young people—especially young women—compared with older people; issues around adolescent sexuality and social restrictions on it, for girls in particular; and issues related to the cost of services. Integrated services that have made specific attempts to address young people can broadly be categorized into two main types: youth-friendly reproductive health services that are part of general health services, and “youth centre” type venues that offer a variety of health and non-health services. Certain forms of these have recently been identified as promising by a comprehensive study on services for young people by the World Health Organization (WHO).²¹ This WHO review of the evidence from developing countries on preventing HIV/AIDS in young people has clear implications for convergence initiatives. For convergence of HIV services into general health services, a number of interventions are identified that increase the use of these services by young people. Strongly recommended are interventions in which providers in health service settings are trained to deal with young people sensitively, make general improvements to clinic facilities, and undertake activities in the community to increase service demand and community acceptability. HIV/AIDS information and counselling, sexually transmitted infection (STI) testing and treatment, and condom provision are key components of successful interventions. A project operating in eight clinics in Lusaka, Zambia, for example, made specific efforts to involve the community using participatory “learning for action” exercises to sensitize local people to adolescent SRH.²² In Zimbabwe, as part of a broader effort to create a favourable environment for reproductive health services for young people, several clinics with trained nurses developed “youth corners” where adolescents could get information, counselling and clinical services tailored to their particular sexual and reproductive health needs and delivered in a youth-friendly manner and environment.²³

People with HIV face specific reproductive health needs that are not being adequately met either through mainstream SRH services or through stand-alone HIV services. They are also targets of stigma and discrimination, which can limit their access to care and threaten the quality of treatment they receive. Health care provider attitudes are frequently cited as a barrier to integrated services. Surveys in Asia indicate that more than one in four people with HIV have experienced HIV-related discrimination in health care settings. More than 33 percent have had confidentiality about their HIV status breached, and 15 percent have been refused medical treatment.²⁴ Understanding what people living with HIV seek from health services and programmes is necessary in order to ensure that these services are appropriately tailored to meet their needs.²³ A study in Brazil found that many women preferred specialised HIV centres that offer prevention and treatment, family planning, gynaecological services, and PMTCT.²⁵ In Ghana, a study found that nearly 40 percent of women visiting two antiretroviral therapy (ART) clinics said they would like a provider to speak with them about family planning.²⁶ A study in Ethiopia reported reasonably high uptake of modern contraceptive methods in some VCT and PMTCT settings.²⁷ In Rwanda, 90 percent of HIV-positive women who were offered family planning at a PMTCT-VCT site accepted a method.²⁸

Integrating family planning services into HIV service settings has the potential to produce the following health benefits:

- *Positive women who do not wish to become pregnant are provided with the resources to control their fertility.*
- *The number of mother-to-child transmissions can be reduced by avoiding pregnancy.*
- *The dual protection role of condoms in preventing both unwanted pregnancy and STIs can be promoted.*

A recent review of the literature on HIV status and fertility intentions suggests that HIV status has little effect on reproductive intentions and behaviour. Preliminary results of the review indicate that pregnancy rates are more reflective of age, number of children, and personal motivation to bear children than of knowledge of HIV status.²⁹

Relatively little is known about the experiences of positive men with integrated services, and almost nothing is known about the reproductive intentions of positive men. One exception is a study in Sao Paulo, Brazil, that found that nearly half of positive men wanted children, especially those who had no children yet.³⁰

Female sex workers comprise a group especially vulnerable to HIV infection for a variety of reasons. Male-to-female infection is easier to transmit than female-to-male infection. Sex work is also highly stigmatised. Sex workers often live on the margins of society and, as such, their access to general public health services can be severely limited. Sex workers with HIV suffer from the compounded stigma associated with both sources, making them even more likely to receive poor treatment in public health settings or elsewhere.

Discrimination against sex workers—ranging from substandard and/or humiliating treatment to treatment refusal—is widespread across many different country contexts.^{31,32,33,34} There is evidence of a need amongst sex worker populations for integrated reproductive health programmes that include family planning and safe abortion services. A study in Cambodia found that a very low proportion of sex workers were using any modern contraceptive method, except condoms, and that a high proportion had had at least one induced abortion.³⁵ Integrated services certainly offer much by drawing attention to and addressing sex workers' "ordinary" health needs, such as family planning and ANC, and by promoting sex workers' health in general, thus drawing the focus away from the infective potential of their sex organs.³⁶

Convergence needs in India

India had an estimated 5.2 million HIV infections in 2005, for an overall HIV prevalence rate of 0.9 percent. State-specific variations in the profile of the epidemic have been observed amongst several states in southern India and the northeastern part of the country, showing higher HIV prevalence within states and a diversity in predominant patterns of HIV transmission. Even low HIV-prevalence states are characterised by the presence of high-risk pockets with potential for increased spread of epidemic in these states.³⁷ Thirty-nine percent of HIV infections are in women, many infections are in rural areas, and a significant burden on communities and the health services sector is anticipated with the rising numbers of infections in many districts. Condom use is still low, with less than half of married women of reproductive age using any method of contraception at all. Twenty-one percent of all pregnancies that result in live births are unintended,³⁸ and more than six million abortions are performed annually in India.³⁹ Evidence shows that populations at risk of HIV and unintended pregnancy, such as young men and women, people who sell sex, and people with HIV, are not always able to access the HIV and SRH services they need.^{40,41,42,43,29,30} Young women and sex workers, for example, have

difficulty accessing family planning services, which are geared toward the needs of married women. Family planning, MCH, STI, HIV, and abortion services are provided separately and often target different populations. Consequently, there is a range of missed opportunities for providing a better response to HIV prevention and treatment and SRH through the convergence of these services.

Government services and convergence policy in India

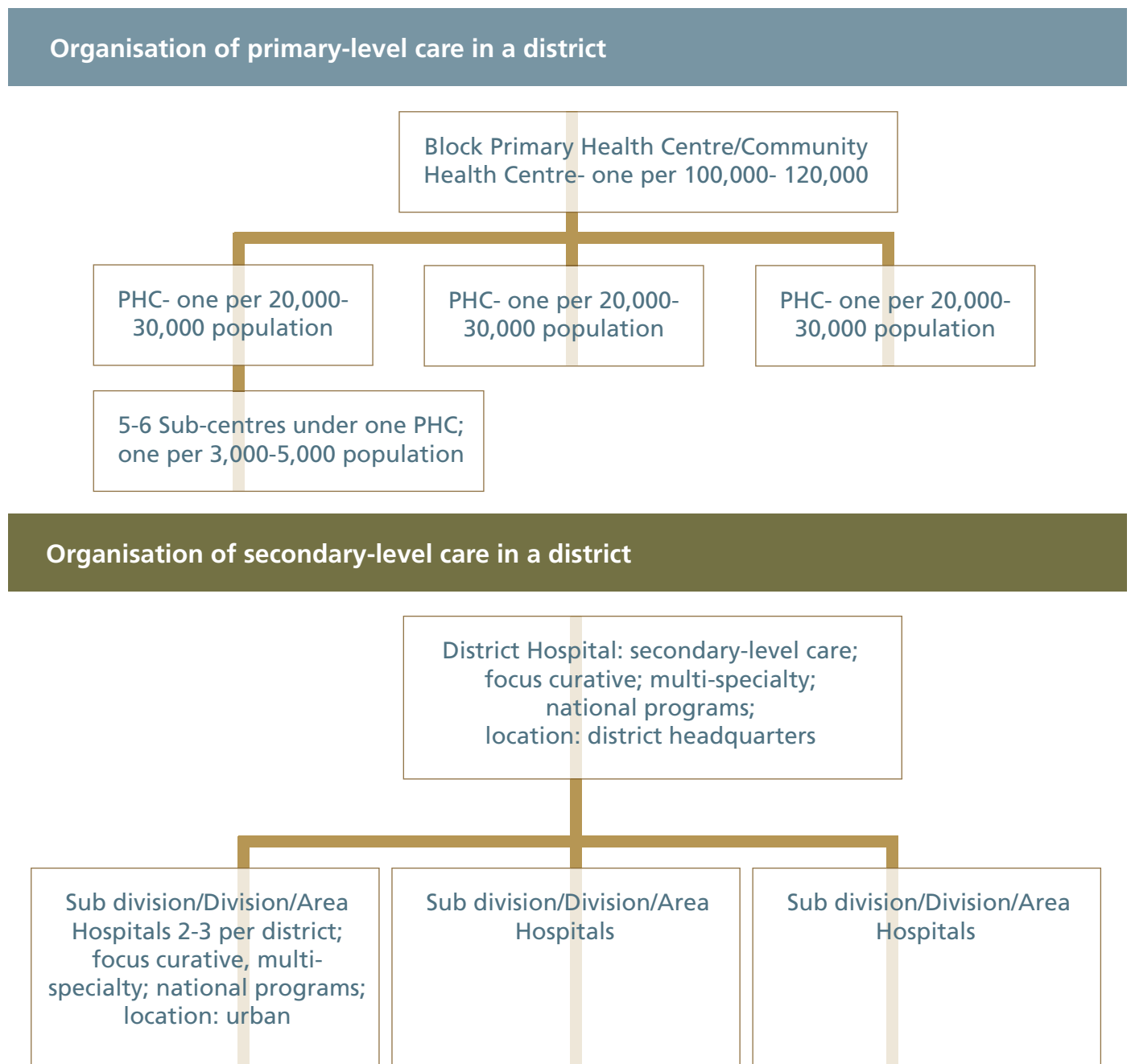
Health care delivery in India is a combination of vertical and integrated services. Key communicable diseases of public health importance nationally are vertical. The Revised National Tuberculosis Control Programme, the National Leprosy Elimination Programme, and the National AIDS Control Programme (NACP) are all vertical programmes. Through state AIDS control societies (SACS), the NACP provides specialised HIV counselling, prevention, care, and treatment services.

Integrated health care delivery at the primary health care level comprises preventive, promotive, and curative services, with emphasis on MCH, family planning, immunisation, treatment of acute childhood infections (diarrhea and respiratory tract infections), and care and treatment of common ailments. At the community or sub-centre level, this package is provided by an auxiliary nurse midwife (ANM) under the Department of Health and Family Welfare. In addition, at the village level (usually per 1,000 population), there are Anganwadi centres (under the Integrated Child Development Service [ICDS] scheme of the Department for Women and Child Development). Each centre has one Anganwadi worker who is responsible for promotive health work with children younger than six years, adolescent girls, and married and pregnant women. The National Rural Health Mission (NRHM) has proposed that they work in collaboration with the ANMs who are in charge of the sub-centres.

Figure 2 shows how mainstream government reproductive health services are organised. The full list of services that are provided at the sub-centre, primary health centre (PHC), community health centre (CHC)/first referral unit levels, and at the 101–200 bed district hospitals, is included in Annex 1.¹

¹ As per the Indian Public Health Standards of the NRHM of the Government of India.

Figure 2. Diagram showing the organisation of district-level primary and secondary health care.



The Government of India has recognised the need for converging or linking HIV and SRH services in the Reproductive and Child Health Programme (RCHP II), the National AIDS Control Programme launched in 2007 (NACP III), and the NRHM. For example, the NACP III includes guidance for setting up integrated counselling and testing centres (ICTCs) at the district level, which, depending on the situation, would provide ANC services, VCT, prevention of parent-to-child transmission (PPTCT) services, ART, family planning services, and STI treatment (see Annex 2 for more information about government policy on convergence).⁴⁴ Whilst the policy

environment is favourable, the voice of the client, or demand for different convergence options, is significantly lacking, and state governments lack the evidence necessary to make informed decisions about what options will work best in different settings.

In recognition of this need, in 2006, PATH worked with state governments and local communities in Bihar, Andhra Pradesh, Maharashtra, and Uttar Pradesh to identify the options for and challenges of HIV-SRH convergence.



Assessment of HIV-SRH convergence in four states

Assessment objectives and questions

The overall goal of the project was to contribute to a reduction in HIV and unintended pregnancy by strengthening and promoting HIV and SRH convergence. The project objective was to increase accessibility to HIV and SRH services for populations at risk of HIV and unintended pregnancy by (1) strengthening the awareness of policymakers of the need for HIV and SRH convergence and (2) strengthening the understanding of service providers of how best to implement convergence for populations at risk. The project began with an assessment to understand the demand for and the potential challenges of implementing HIV-SRH convergence.

In terms of demand for convergence, the assessment explored:

- *Common SRH conditions and illnesses suffered by people at risk of HIV and unintended pregnancy.*
- *What they do when they suffer from these conditions.*
- *The barriers to accessing HIV and SRH services.*
- *Suggestions for specific convergence options in their areas that would increase access to either HIV or SRH service provision.*

In terms of potential opportunities for and challenges to implementing HIV-SRH convergence, the assessment explored:

- *Service providers' and policymakers' general reactions to converging HIV and SRH services.*
- *What they felt would be the feasibility of implementing a specific convergence option in each of their facilities.*
- *The training needs, policy and cost implications, partners needed, benefits, and barriers of HIV-SRH convergence.*
- *Who would be influential in making convergence happen.*

Ethical review of the assessment was obtained from local advisory groups (LAGs) comprised of government, nongovernmental organisation (NGO), and community representatives from each of the four states/districts (see Annex 5 for composition of LAGs) and from the PATH Human Subjects Protection Committee (HSPC).

Assessment methods

The assessment was conducted in one district in each of the states of Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh, with female sex workers, sexually active young men and women aged 18 to 25, people with HIV, and with HIV and SRH service providers, policymakers, and influencers (such as large NGOs).

Throughout the assessment period, PATH engaged multiple stakeholders not just to learn about the issues involved in converging services but also to organise opportunities for face-to-face interaction between HIV and SRH policymakers, government, and nongovernmental service providers and community members. A national consultation was held at the end of 2005 to launch the project; individual consultations were then held with national and state health officials; followed by state- and district-level orientations. These meetings served to identify local realities, develop ownership of the project, generate a common understanding of convergence issues, and convene LAGs. A second round of state and district meetings and a national meeting were held early in 2007 to disseminate key findings from the assessment. In addition, throughout the project, a range of resource materials was developed and disseminated to a mailing list of approximately 500 people (see Annex 3 for a list of project resource materials).

The assessment was planned and implemented in steps, with each step building on information from the previous step.

Step 1: Background information and secondary data on the assessment districts were collected.

Step 2: Participatory mapping and analysis of potential convergence options with groups of sex workers, young people, and people living with HIV was completed.

Step 3: Semi-structured interviews were conducted with service providers from specific health facilities that were identified by the groups during participatory mapping as the most likely places for convergence of HIV and SRH services. Service providers in turn identified key district- and state-level policymakers who were then interviewed.

Step 4: The preliminary findings and key convergence options that emerged from the assessment were verified with state and district stakeholders through a series of meetings to prioritise convergence options that could be taken forward.

Selection of assessment sites

The assessment was carried out in one district in each of the states of Andhra Pradesh (Srikakulam), Bihar (Patna), Maharashtra (Nashik), and Uttar Pradesh (Lucknow). These states were chosen because they have different reported outcomes in terms of HIV and reproductive health. Andhra Pradesh and Maharashtra have been designated by the National AIDS Control Organisation (NACO) as “high prevalence” states (having more than 1.0 percent HIV prevalence in the general population), and Bihar and Uttar Pradesh have been classified as “highly vulnerable” states on the basis of factors such as migration, size of the population, and weak health infrastructure. NACO acknowledges, however, that highly vulnerable states are likely to have districts of high HIV prevalence (particularly state capitals, where HIV services are often clustered). Since the study began, 2006 data from district VCT centres showed Lucknow, the state capital of Uttar Pradesh, to be one such district (see Annex 4 for district-level secondary data).

The assessment districts were selected after discussion and consultation with government and nongovernmental stakeholders in each state. The criteria used for selection of the districts included levels of populations at risk of HIV and unintended pregnancy, the availability of HIV and SRH service points, and the general feasibility of conducting assessments in the areas in terms of leveraging support and resources. Key indicators for service delivery systems were also taken into account. Secondary data to identify these districts were accessed from National Family Health Survey 2 (1998–1999), NACO sentinel surveillance (2004), and the RCH facility survey (2003)

(see Annex 4 for additional information on the selection of assessment districts).

Forming local advisory groups

A LAG was formed in each assessment district to facilitate the assessment and to generate local ownership. Each LAG comprised eight to ten representatives from government, NGOs, and relevant communities willing to support the research process. The primary role of the LAG in each site was to ensure that participation by people at risk of HIV and unintended pregnancy was informed, ethical, voluntary, and confidential (see Annex 5 for LAG terms of reference). The advisory groups also reviewed the assessment protocol and consent documents, and changes suggested by the LAGs were incorporated into the final versions prior to clearance by the PATH HSPPC. The LAGs provided input for determining the ten blocks/mandals² that would be part of the assessment in each district, with reference to the availability of groups at risk, particularly female sex workers (see Table 2). During this time, they also interacted with the community assessment teams and set up mechanisms to support them during field activities.

Selection and training of the assessment team

Three groups of research investigators were recruited:

(1) To more easily engage populations at risk of HIV and unintended pregnancy, 28 local community investigators were recruited from the assessment sites with the assist-

Table 2. Blocks/mandals selected for assessment in each district.

Patna (Bihar)	Lucknow (Uttar Pradesh)	Nashik (Maharashtra)	Srikakulam (Andhra Pradesh)
Barh	Alamnagar	Chandwad	Gara
Bihta	Aliganj	Deola	Kaviti
Bikram	Bakshi ka talab	Dindori	Palakanda
Danapur	Chinhat	Igatpuri	Palasa
Fatuha	Gosaiganj	Malegaon	Pathapatnam
Masaurhi	Kakori	Nashik city	Ponduru
Mokama	Mall	Nandgaon	Rajam
Patna Sadar	Malihabad	Niphad	Ranasthalam
Phulwari Sharif	Mohanlalganj	Sinnar	Srikakulam Town
Punpun	Sarojni Nagar	Yevala	Seetammapeta

ance of the LAGs. Criteria for selection included that they be credible and acceptable to the assessment populations in each district and that they have the necessary communication skills to facilitate participatory activities. Local community investigators included self-identified sex workers, positive people, and young men and women. After the selection process, local community investigators were trained to carry out participatory mapping with peers in the assessment sites.

(2) A second group of eight, more experienced, national community investigators (also comprised of sex workers, positive people, and young men and women) was recruited to help PATH staff support the work of local community investigators in the field. This group was also intended to make the bridge between the participatory mapping component of the assessment and subsequent interviews with service providers.

(3) After the participatory mapping had been carried out, the eight national community investigators were joined by eight professional interviewers for training in semi-structured interview techniques. The national community investigators and professional interviewers then paired up to carry out interviews with service providers. Staff from Research Pacific International were contracted to supervise the implementation of interviews with service providers, after which they carried out interviews with policymakers.

Developing and pre-testing data collection instruments

Participatory mapping activities—body mapping and service mapping—were first adapted by PATH staff, and guidelines for how to facilitate these activities were

drafted. During the ten-day training for community investigators, the mapping activities were piloted and the guidelines amended accordingly and finalised (see Annex 6 for participatory mapping guidelines and reporting format). Similarly, a guide for conducting semi-structured interviews was first drafted by PATH staff and then pre-tested during the training of interviewers (see Annex 7 for the final interview guidelines).

Selection of assessment participants and data collection

Process of participatory mapping

In each district, assessment teams (each comprising of three community investigators) accessed people with HIV through the district networks of positive people.

To work with young men and women, the teams initially met with community-based organisations (CBOs) or NGOs who introduced them to people who might be interested in participating in the assessment. Community investigators explained to the young men and women that to participate in the study, they had to be from 18 to 25 years of age and be sexually active. People who self-reported that they fulfilled both these criteria were then requested to participate. Many positive people and sex workers were also in this age group, so to some extent, the groups overlapped.

² A “block,” or “mandal” as it is known in Andhra Pradesh, is an administrative unit hierarchically above the local city, town, or village, but subordinate to the larger district. Blocks generally have a population upward of 100,000.

Sex workers were accessed directly or through LAG contacts. On making contact, the team shared the objectives of the assessment and the mapping exercise and worked with volunteers to set up appointments and organise places in the sites where mapping sessions could be conducted confidentially. Verbal consent was taken

before each session began from each person who volunteered to participate (see Annex 8 for the consent form). Each group of up to ten people then participated in body mapping and service mapping exercises. These exercises were facilitated and discussions documented according to guidelines agreed and piloted during training (Annex 6).

Table 3. Number of sex workers, people with HIV, and young men and women accessed during participatory sessions in the assessment districts.

District	Sex workers	People with HIV	Young men	Young women	Total
Patna	132	44	77	79	332
Lucknow	114	74	78	100	366
Nashik	139	70	89	88	386
Srikakulam	167	88	100	106	461
Total	552	276	344	373	1,545

Body and service map examples



Process of semi-structured interviews with service providers

Semi-structured interviews were conducted with service providers from specific health facilities that were identified by the groups during participatory mapping as important places for converging HIV and SRH services. In each site, interview teams initially met with facility heads/medical superintendents identified by the community groups during the mapping process. They explained the project to each facility head and requested permission to interview one facility manager and one frontline worker appropriate for the assessment.³

After receiving permission, the interviewers then met with each health manager and frontline worker, explained the assessment aims, and took them through a written informed consent process (Annex 8). Each interview was done at the interviewee's convenience and at a place and time of her/his choosing. Using the interview guide (Annex 7) that had been developed and pre-tested, the interviewers conducted interviews in pairs, with one person asking questions and the other documenting responses. Service providers in turn identified key district- and state-level policymakers who were then interviewed. A similar process to that described above was followed during interviews with policymakers and influencers (Annex 7).

³ In multispecialty facilities, service providers interviewed were staff and senior managers from OB-GYN or skin-STI departments, or from VCT/ART centres; whilst in more basic facilities, service providers interviewed were outreach workers, ANMs, pharmacists, or medical officers-in-charge.

Table 4. Distribution of service providers interviewed, by district.

District	Managers	Frontline workers	Total
Patna	20	19	39
Lucknow	20	20	40
Nashik	21	19	40
Srikakulam	20	20	40
Total	81	78	159

Table 5. Distribution of government, private, and NGO service providers interviewed in each assessment district.

District	Government providers	Private providers	Nongovernmental providers	Total
Andhra Pradesh	27	8	5	40
Lucknow	28	12	0	40
Patna	22	17	0	39
Nashik	20	18	2	40
Total	97	55	7	159
Proportion (%)	61%	35%	4%	100%

Table 6. Distribution of state- and district-level officials interviewed in each assessment state.

State	Government, state-level	Government, district-level	NGO	Total
Andhra Pradesh	10	3	1	14
Bihar	12	4	2	18
Maharashtra	9	5	1	15
Uttar Pradesh	6	3	4	13
Total	37	15	8	60
Proportion (%)	62%	25%	13%	100%

Data management and analysis

Data analysis from the participatory mapping was a multi-stage process and involved all investigators. Maps, charts, notes, and consent forms from day-to-day field work were collated at the end of each day by the teams and kept in a secure place. The teams also reviewed the day's work and shared feedback and information from different blocks/mandals, particularly on any difficulties and challenges they faced and how these were overcome. At the end of the participatory mapping process, all the teams convened for a feedback workshop, during which, information from individual charts and maps was compiled for each district and each assessment population. A list was made of convergence options suggested for different health facilities in the 4 assessment sites. Staff from these health facilities

were then followed up and requested to participate in the semi-structured interviews. Preliminary reports and documentation from the feedback workshop were discussed by the assessment teams and further analysed to generate key findings.

Responses to semi-structured interviews and field diaries were kept in a secure place during field work. Following the completion of interviews with service providers, a one-day feedback meeting was convened for investigators to share their field experiences and insights into the data collected. Translation of the interviews from local languages to English was then carried out, and text from all the service provider interviews was coded and entered into NUD*IST (QSR N6) software for analysis. Responses from policymakers and influencers were manually coded and analysed in a similar fashion. (See Table 7, next page.)

Table 7. Data collection framework.

Data collection method	Respondents	Areas of enquiry
Participating mapping	Female sex workers – 552 People with HIV – 276 Young men – 344 Young women – 373 Total 1,545	Common SRH conditions and illnesses suffered by people at risk of HIV and unintended pregnancy. What they do when they suffer from these conditions. HIV and SRH services and information they need. Services they most use and why. Barriers to accessing HIV and SRH services. Suggestions for specific convergence options in their areas, to increase access to either HIV or SRH service provision.
Semi-structured interviews	<p style="text-align: center;">Service providers</p> Managers – 81 Frontline workers – 78 Total 159 <p style="text-align: center;">Policymakers/influencers</p> Government – 52 Nongovernmental – 8 Total 60	Service providers' and policymakers' general reactions to converging HIV and SRH services. The feasibility of implementing a specific convergence option in each facility. Training needs, policy and cost implications, partners needed, benefits, and barriers. Who would be influential in making convergence happen.

Findings from participatory mapping

The participatory mapping activities generated a great deal of information. For the purpose of this report, we have identified findings that specifically relate to the “what,” “why,” and “how” of converging HIV and SRH services. The findings are organised according to the main themes discussed during mapping. The following case examples taken during the assessment characterise the SRH situations of people at risk in the districts.

Priya is a 24-year-old HIV-positive woman. Her husband also has HIV, and they do not use condoms when they have sex. Priya suffers regularly from vaginal thrush, which she treats with a home remedy. She is worried about other reproductive tract infections (RTIs) and has heard that positive women are more susceptible to cervical cancer. She hopes very much to have a child, but not yet. She does not know what might happen to her or the child and needs more information. In the mean time, she would like to access family planning and have regular gynaecological check-ups but hears from others that the health workers will only offer sterilisation and tell her to abstain from sex. Although she is a member of the local network for positive people, these issues are not part of their agenda, and she does not know who she can go to for information.

(Case study from Srikakulam)

Rani is a 24-year-old street-based sex worker in Patna. She has two children. Although she has learned through awareness campaigns conducted by peer educators that condoms prevent STIs and other diseases, she cannot insist on condom use with her customers and often has unsafe sex. She complains of heavy bleeding and that her uterus comes out frequently. She does not go to the doctor, for fear she may be stigmatised and discriminated against. As a result, she has accessed services from less than fully qualified practitioners (LTFQPs) who provide herbal treatment. Her actual problems have never been diagnosed by any qualified health care provider/doctor.

(Case study from Patna)

Rajan Singh is a vegetable vendor in Lucknow. He tested positive five years ago, and he has been on ART for three years. He often feels a severe burning sensation whilst urinating. He is also feeling feeble sexually. Whenever he has requested that the medical officer of the ART centre refer him to the sexually transmitted disease (STD) clinic, he has been refused. At the STD clinic, they told him that he cannot get STD treatment without a referral, as doctors in the STD department know that he is positive. Up to today, he has still not been treated for STIs.

(Case study from Lucknow)

Managing sexual and reproductive health

The body mapping generated a wealth of detail about SRH-related illnesses and conditions experienced by the groups. Of most interest: STIs are widespread amongst all groups, showing that sex workers; positive people; and young, sexually active people are indeed at risk of HIV and unintended pregnancy in these districts. Analysis of

group discussions showed that although a range of symptoms was discussed by the groups, white discharge was the most common experience for all categories of women, and genital ulcers was the most common experience amongst men from all categories. In addition, both positive women and men in Nashik complained of experiencing genital herpes.

Experience with events related to maternal morbidity was reported by many sex workers and was associated with a lack of information and access to quality SRH services. Difficulties associated with pregnancy and childbirth were experienced by far more sex workers than young women and positive women, indicating a large unmet need for a range of appropriate MCH and SRH services for sex workers. In Srikakulam, sex workers repeatedly shared their experiences with premature births, and many had experienced a retained placenta (a life-threatening complication of third-stage labour). In Lucknow, sex workers highlighted their experiences with miscarriage, whilst in Nashik, many reported postpartum haemorrhage. Analysis of group discussions showed that current services available specifically for sex workers are usually vertical, only include STI management and HIV prevention, and consequently, neglect their wider reproductive health needs.

Sex workers reported managing STIs and unwanted pregnancies by going to LTFQPs, self-medicating, and using home remedies in preference to accessing government services. For delivery, where possible, they prefer to access the services of traditional birth attendants. In Nashik, Patna, and Srikakulam, sex workers reported mainly using LTFQPs to treat STIs, whereas in Lucknow, antiseptic douches were reported as a common method of managing STI symptoms. Female sex workers spoke about using a range of home remedies to either procure abortion or to treat STIs. Sex workers in Lucknow said they used concoctions of fenugreek, vinegar, old jaggery, and papaya to induce abortions, whilst sex workers in Nashik said they drank country liquor to induce abortions. Sex workers in Srikakulam, on the other hand, said they usually used herbal remedies or went to pharmacies to procure medicines for abortion. Home remedies and self-medication for STI symptoms across districts included the practice of bathing genitals in antiseptic or turmeric solutions, and using garlic powder, steroid creams, or other multipurpose creams.

In contrast, young women's groups across all four districts said they visit private or government facilities for pregnancy- and delivery-related issues. However, young women in Patna and Srikakulam said they access LTFQPs for treatment of perceived STIs, whilst young women in Lucknow said they use home remedies. Young women's groups in Lucknow and Nashik said they consult qualified doctors for abortions.

Positive men also reported rarely using government services for STI management, saying that like sex workers, they prefer to use LTFQPs and to self-medicate. Positive men across the four districts said that they visit LTFQPs (Lucknow, Nashik, and Patna), indigenous practitioners

or faith healers (Nashik), or predominantly self-medicate (Srikakulam). This theme was echoed again by sexually active young men across the four districts, who said they mostly visit LTFQPs for management of sex-related complaints and infections and often self-medicated on the advice of friends.

Summary

- *STIs are widespread amongst all groups.*
- *Sex workers have the most difficulties related to pregnancy and childbirth.*
- *Sex workers have the least access to government SRH services.*
- *Men rarely use government services for management of STIs.*

HIV and SRH service and information needs

The mapping activities showed that basic information and communications gaps regarding pregnancy, family planning, and abortion exist for sex workers in all districts. For young, sexually active men and women, the predominant information gap was in HIV prevention, particularly about condom use and STI management. For positive people, information needs were reported to be about safer sex, "living positively" (having a positive attitude, good nutrition, good social support etc.), and HIV treatment.

Sex workers felt that services do not address their SRH needs and that their fertility desires are generally ignored. Sex workers in Nashik specifically said they needed information about different kinds of contraceptives, not just condoms and sterilisation. Young men and women also felt that their information needs regarding how to avoid pregnancy, HIV, and STIs were neglected and said that most SRH communications target "eligible couples" or married women. Positive people said that information, education, and communication (IEC) in the services they access do not address their fertility desires or their sexual needs. They felt that even information on tuberculosis (TB) and its treatment are not widespread, when TB is the most common opportunistic infection amongst positive people in India (and South Asia⁴⁵).

A comparison of services mapped in the same areas showed that sex workers and positive people knew about the main HIV and SRH services available to them in the area, with positive people having a better awareness of government services and sex workers knowing more about private health facilities. Of particular interest, however, was the finding that young men and women knew the least about existing HIV and SRH services. In general,

young women from across the four districts needed to know where they could access basic information on safer sex and different methods of contraception. Young men wanted to know where they could access services for STI information and treatment. Apart from these general needs, the needs of young men and women for information about services varied from district to district and mirrored current service availability (with basic RCH services being less-developed in Lucknow and Patna than in the other two districts). For example, young women in Nashik mainly wanted to know where to go for blood tests and scans during pregnancy, whereas young women in Patna and Lucknow had more basic needs—just to know where they could access safe delivery and safe abortion services.

The need for information about services was also tempered by HIV prevalence in each district, with young women in Srikakulam needing to know where they could access HIV tests during pregnancy and young men in Nashik and Srikakulam (higher-prevalence states) wanting to know where HIV testing and treatment information could be accessed. Young men in Lucknow and Patna (lower-prevalence states), however, had more concerns regarding locating services for STI treatment and for gaining general awareness about HIV.

Summary

- *Sex workers need information and access to services for pregnancy, family planning, and abortion.*
- *Young, sexually active men and women need information and access to services for HIV prevention—particularly condom use and STI management.*
- *Positive people need information and services for safer sex, “living positively”, and HIV treatment.*
- *Young men and women knew the least about existing HIV and SRH services.*
- *Young men and women in higher-prevalence states mentioned the need for access to HIV testing more than those in lower-prevalence states.*

Barriers to service use

Many barriers to service access and use were reported during the group discussions, the majority in relation to mainstream government services such as district hospitals, CHCs, and PHCs. Stigmatising attitudes and discriminating behaviour of staff, stigma from other clients and the community, service quality, the lack of universal precautions, and the cost of “free” services were all repeatedly mentioned as problems encountered with mainstream government services.

Stigma experienced in mainstream government services

Although positive women reported using mainstream government services for their SRH needs, they were not fully satisfied with the services they received. The main concern expressed by positive women across the four sites was stigmatising behaviour of care providers. Discrimination was reported in many forms. People were kept waiting, charged for “free” services, had to suffer abusive language and rough physical treatment, were treated disrespectfully, shunned by other clients, provided with substandard care, and in many cases, were turned away and refused treatment altogether. Positive women in Nashik and Srikakulam, the two higher-prevalence states, also reported that services were not confidential and that there was a lack of privacy for consultations and physical examination. In Nashik in particular, some positive people said that lack of providers’ confidentiality could have serious implications if local self-government bodies came to know of their HIV status. Sex workers in Nashik, Srikakulam, and Lucknow specifically demanded that abortion services, STI management, and HIV testing and care be provided confidentially through the public sector.

Sex workers, positive men, and sexually active young men also reported stigmatising behaviour by health care providers as their main reason for not accessing mainstream government services for their SRH needs. Lack of awareness of where appropriate government services are available, lack of confidentiality in public health care settings, and having to pay for “free” services were also reasons for choosing other service providers, regardless of quality. In addition, men in general had very poor awareness of SRH illnesses. Sexually active young men were worried about stigma and embarrassment and about being seen by women health practitioners. Some said they felt ashamed to access available services.

In contrast, positive people saw government HIV services such as ART, VCT, and in Patna, TB directly observed treatment short course (DOTS) centres, as less stigmatising than mainstream government SRH services. Positive men across all four districts said that they visited a range of government facilities for testing and ART. Positive women in Lucknow said that they went for ANC visits and deliveries in private clinics but accessed government VCT/ART centres. This was reported to be because staff in vertical government HIV facilities are better geared toward the needs of people with HIV and because they are only accessed by people concerned with finding out or managing their HIV status (i.e., they are not frequented by the wider, potentially stigmatising public). Even though government HIV services were reported to be less stigmatising, many positive people were still keen to see

them not identified so clearly with HIV. Sex workers in Srikakulam reported preferring to use NGOs for HIV and STI services because there was less stigma. They said they accessed “Swagathi” clinics (a clinic chain supported by an NGO working with sex workers) for STI management, since these clinics address their HIV prevention needs and are “user friendly.”

Quality and cost of service provision

Lack of adequate and high quality basic health care services, particularly in the government sector, was another barrier to service access. For example, in Lucknow, positive men and women spoke of basic services, equipment, and materials not being available. They also spoke about the lack of service providers’ skills and the need for training. Positive men and women in Lucknow were concerned about the lack of universal precaution materials like disposable syringes. In Patna, the lack of basic infrastructure, supplies, and space was also seen as a barrier to accessing government services.

Although services are supposed to be free in the public sector in India, young women and sex workers reported having to pay for abortions because they were not in a position to complain. Positive women reported having to pay for safe delivery at government hospitals for the same reason. Health workers were seen to take advantage of someone’s lack of status and power in society and their need for confidentiality, and to charge accordingly.

Inadequate referrals

Although during mapping activities, groups reported that vertical referrals to a higher facility were made, lateral referrals were reported to be poor, and referrals in general were seen as a barrier to service access and use. It was reported on a number of occasions that when referring to a higher institution, providers usually mention just the name of the facility and give no further information, making it difficult for patients to navigate the system and access the services they need. As a result, all groups felt that referrals could be considerably strengthened. For example, in Srikakulam, a chain of clinics run by an NGO provide good STI treatment and HIV awareness amongst sex workers. These clinics do not, however, provide ANC and abortion services, and linkages with other necessary SRH service providers for sex workers were seen to be weak. In Lucknow, a positive man shared his experience with not being able to access STI services, as the VCT centre (housed in the same hospital complex as the STI service) refused to make a referral for him. Positive people in Nashik and Srikakulam felt that providers lacked adequate knowledge, skills, and information to provide appropriate referrals.

Summary

- *Stigma experienced at mainstream government SRH services was the main barrier to access for sex workers, positive people, and young men.*
- *Sex workers and positive people need more privacy and better confidentiality at mainstream government SRH services.*
- *Positive people saw government HIV services, such as ART and VCT centres, as less stigmatising than government SRH services.*
- *Sex workers, positive women, and young women reported having to pay for abortions at government services.*
- *Vertical and horizontal referrals need strengthening.*

Demand for convergence

Partial integration

An interesting finding from the mapping activities was that positive people and sex workers did not suggest full integration of HIV and SRH services. Instead, those participating in mapping made more than 100 very specific suggestions for converging HIV and SRH services. These convergence options were specific in the sense that groups actually marked the health facilities they thought would be good for convergence on their service maps. They said that if HIV or SRH service components were added to the health facility they had marked, it would help increase access to services they need (see Annex 9 for the list of convergence options). For example, in Seetammapeta block in Srikakulam, young women requested condom demonstrations and information and referral for STIs to be made available at a particular Anganwadi centre so that they would have increased access to HIV prevention.

Mapping activities showed that HIV services are more limited and vertically organised, whilst SRH services are provided across a range of facilities (both rural and urban). The main thrust of recommendations to improve access to HIV and SRH services during mapping activities, therefore, was to (1) add HIV components to existing SRH services (e.g., condom promotion at the village level), (2) expand SRH services to include additional service components (e.g., STI services provided at the PHC), (3) improve referrals and provider training (e.g., stigma reduction training), and (4) add SRH components to HIV services (e.g., family planning provided with VCT). A further three percent of options involved convergence with TB DOTS services. (See Table 8.)

Table 8. Direction of convergence: different convergence options suggested.

Adding HIV components to SRH services	Expanding current SRH services	Improving referrals and provider training	Adding SRH components to HIV services	Converging HIV and TB DOTS services, either way
38	30	22	9	3
37%	30%	21%	9%	3%

Convergence in the public sector

Overall, mapping activities showed that the demand is for the government to roll out converged services, with 60 percent of the suggestions for convergence involving government services, 31 percent private, 5 percent Christian medical hospitals, and 4 percent NGOs. Positive people generally suggested government convergence options because they felt that it is the government’s responsibility to provide them with care. Positive women in Lucknow, Patna, and Srikakulam said they wanted services to be available locally, at government facilities. They felt that although NGOs play an important role in mobilising the community, supporting positive networks, and raising awareness of HIV issues, unlike government services, NGO reach and scale is not great enough to make a big difference. There was, however, variation in specific convergence options suggested between districts and between the different groups.

Analysis of suggested convergence options shows that more emphasis was placed on government convergence options in lower-prevalence states. In Lucknow, 80 percent of suggested convergence options was in government facilities; in Patna, it was 65 percent; in Srikakulam, 55 percent; and in Nashik, 43 percent. This was reported to be because private health facilities in districts in higher-prevalence states have become more adept at meeting the needs of people with or at risk of HIV (as in Nashik) and because there are more NGOs in the districts in higher-prevalence states (as in Srikakulam). For example, although the majority of sex workers in Lucknow, Nashik, and Patna wanted services to be converged in government facilities, sex workers in Srikakulam wanted family planning, medical abortion, and ANC services to be converged at the NGOs they usually visit for STI/HIV-related prevention and treatment.

Addressing stigma to increase access to SRH

Where suggested convergence options involved mainstream SRH government services at district hospitals, CHCs, and PHCs, sex workers, positive people, and young people all mentioned the need to address stigma as a matter of urgency and priority. In Nashik, positive people

wanted to access converged SRH services—in particular, ANC, safe abortion, and delivery—in government facilities, provided service providers did not discriminate against them. Similarly, sex workers in all four districts would like to use Anganwadi centres, CHCs, PHCs, and government hospitals for surgical abortion, MCH, and PPTCT—but only if staff attitudes and social stigma are addressed.

One reason sex workers want better access to government mainstream services is because they are more locally available and there is less time and money spent on travel. There was also a sense of injustice expressed by sex workers in Srikakulam, Patna, and Lucknow—that government services are supposed to be for poor people like themselves, but they are being barred from access. They noted that even if provider stigma were reduced, providing services to sex workers, positive people, and the general population at the same place would remain a challenge whilst HIV and sex work are still so heavily stigmatised throughout India.

Adding SRH to vertical HIV services

As mentioned previously, the majority of positive people preferred using vertical HIV services to accessing HIV services through mainstream government provision, so long as they are not identified as HIV-positive. Positive people felt that government HIV and TB DOTS services were more acceptable (less stigmatising) and suggested adding HIV and SRH services to them to increase access. Positive people reported they would like to see specific SRH services like family planning and STI services added to vertical government services such as ART and VCT centres. Positive men and women in Lucknow and Patna suggested that TB DOTS centres could also provide ART and family planning and STI services. They pointed out that this would increase access to SRH services for positive men, who rarely use mainstream government SRH services. In Lucknow, positive people said that challenges to converging services include sign-posting or branding of VCT and ART centres. They said specifically that the “red ribbon” logo has to be removed from service points

to increase access to positive people. A key implication of this finding is that it provides evidence that government services can be user friendly for populations at risk. In relation to this, positive people in Patna suggested that government HIV health workers train government SRH workers in how best to work with people with HIV and other marginalized groups.

Young men would like to see “male friendly” NGOs accommodate their HIV and SRH needs, in the same way that some NGOs offer services to sex workers. This was their solution to what they saw as a lack of focus on the SRH needs of men. They felt that addressing this lack of focus would give a large number of young men access to more appropriate and adequate management for STIs and decrease their risk of acquiring HIV and the possibility of infecting their partners. In Srikakulam, men discussed the possibility of STI services being provided by NGOs exclusively for men, using the model of STI management services provided by NGOs for female sex workers.

Adding HIV to mainstream SRH services

As well as integrating HIV into mainstream government SRH services, other convergence options were suggested. Young men suggested that counselling and management for STIs should be available at the CHC level (Lucknow, Patna) and that services should be advertised so that young men know about them. They requested that Anganwadi workers have separate days for sessions with adolescent boys on SRH issues (Lucknow).

Although HIV testing is currently available at the district hospital level and is proposed to be initiated from CHCs under the NRHM,³⁹ young women said that counselling and testing for STIs/HIV should be provided in all public health facilities in the district (Nashik, Srikakulam, and Lucknow). In Patna, young women said that PHCs can provide demonstrations on dual protection of condoms against STIs and unwanted pregnancy and that PHCs should organise awareness-building campaigns about STIs, HIV, and condom use. In Nashik, they said that all government facilities should provide STI management and condoms and that condoms should be provided through door-to-door services. In Lucknow, young women said that the Anganwadi workers should be trained on HIV/AIDS so that they can give information to women who visit their centres. It was also noted that awareness-building programmes for HIV testing and treatment, and STIs and all reproductive health-related services, should be undertaken at government hospitals.

Sex workers wanted referrals for STI and HIV services to be available at the PHC level (Patna, Srikakulam) and referrals for STI management from Anganwadi centres to the PHC. In Patna, sex workers wanted condoms made

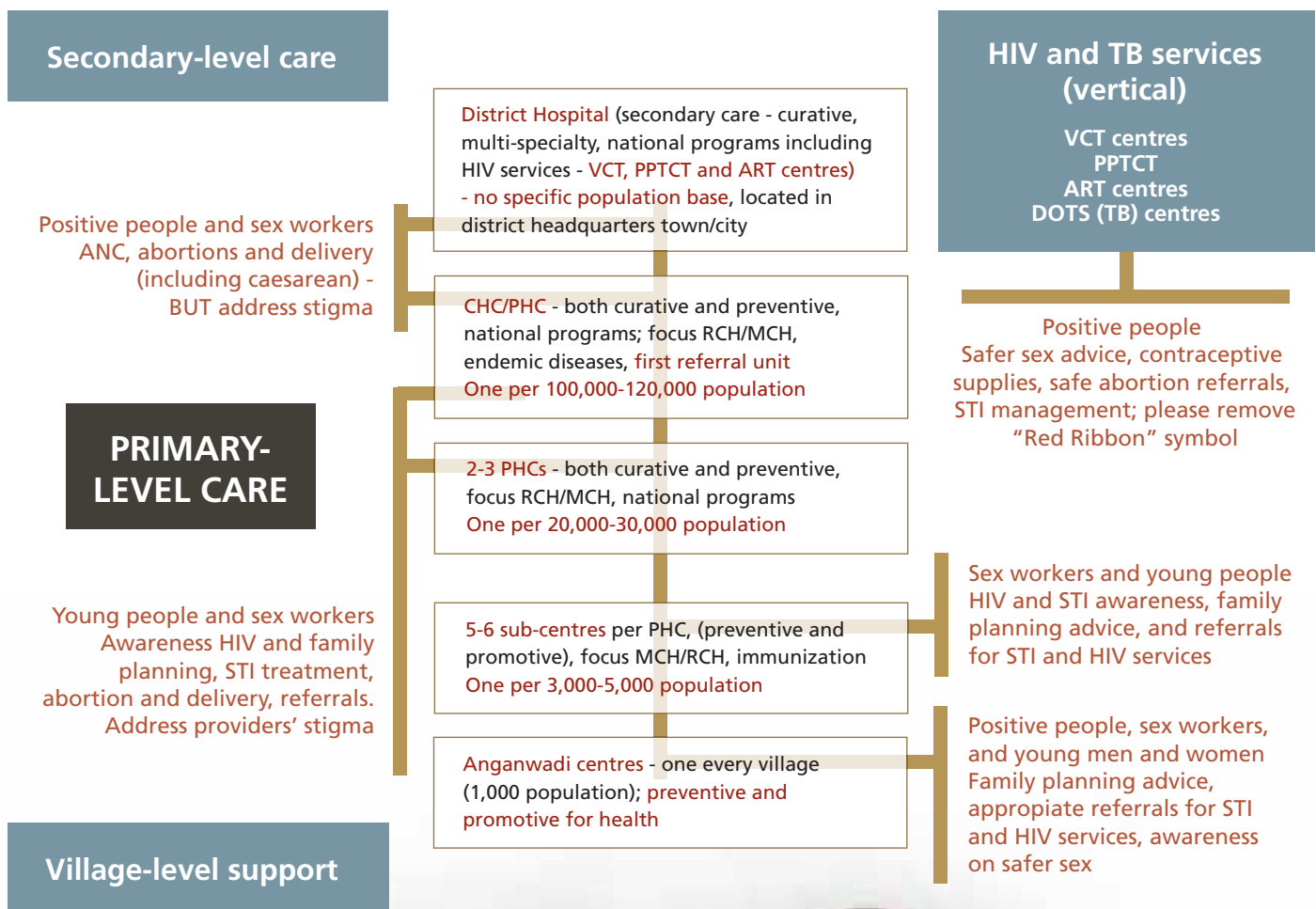
available and counselling about correct condom use from the Anganwadi centres. They said that blood tests—including those for STIs and HIV—should be available at the PHC level, and STI management should be available in the same places that other RTI care is provided.

Positive women in Srikakulam suggested that referrals by the Anganwadi centres to TB DOTS centres and for management of opportunistic infections would help people receive speedier diagnoses and treatment. In Patna, they suggested VCT referral of positive people to the Anganwadi centres for nutritional support, and in Lucknow, that HIV/STI testing and counselling be provided at the PHC level. Training for doctors at the PHC/CHC levels on sex and sexuality issues was suggested in Lucknow.

Summary

- *Positive people and sex workers did not suggest full integration of HIV and SRH services but had very specific suggestions for what should be converged and where.*
- *The majority (60 percent) of suggestions for convergence involved government services.*
- *More government convergence options were suggested in lower-prevalence states.*
- *NGOs were seen to play an important role in convergence with regard to mobilisation, network support, and awareness-raising—but not in service provision.*
- *Stigma needs to be addressed urgently for convergence options involving mainstream SRH government services at district hospitals and at CHCs and PHCs.*
- *Positive people would like to see family planning and STI services added to vertical government services such as ART and VCT centres.*
- *Positive people said that signage and/or logos identifying HIV services should be removed.*
- *Positive people suggested that HIV workers could train government SRH workers in how best to work with people with HIV and other marginalized groups.*
- *Sex workers and positive people in all four districts would like to use mainstream government services for surgical abortion, MCH, and PPTCT—but only if staff attitudes and social stigma are addressed.*
- *HIV prevention services and referrals for HIV care and treatment should be provided in all mainstream government SRH services.*

Figure 3. Schematic diagram summarising convergence demands of at-risk populations at various levels of health care delivery.





Findings from interviews with service providers



General attitudes toward convergence

Most providers, particularly frontline workers, were not aware of HIV and SRH convergence, and it took a great deal of time to explain the concept during the assessment. Because the concept was very new, many providers and policymakers interviewed did not get beyond discussing the need for convergence and the perceived general benefits and challenges. Consequently, less information was gathered on the practical aspects of implementing convergence. It also took some time to explain the process of investigating demand, and why specific convergence options had been suggested by the groups of positive people, sex workers, and young people. Initially, many providers interviewed assumed that convergence automatically meant full integration and “one-stop shops.” *“The benefit to populations at risk is that they do not have to wander here and there. All services are available at one place, and infection will not spread further...”* [Manager, Lucknow]

On the whole, however, managers and frontline workers in all sectors were generally receptive to the notion of convergence. *“There will be no barriers, in fact people will help.”* [Private-sector manager, Nashik]

A minority did not see the relevance for their situation and were less enthusiastic about the possibility of change. *“It’s a good idea, but of no use to us. Lot of programmes are introduced here, you also introduce it (if you like).”* [Manager, Patna]

Private-sector providers were as enthusiastic about convergence as government providers. Their main concerns were (1) losing business through the social stigma of being identified with HIV and sex workers and (2) whether or not they would be able to provide services that sex workers could afford without additional support from the government. *“If we give family planning and abortion services, we will charge for that, and if we give good services, we will demand more money. Why should we give service in low charge...government does not help us.”* [Private-sector manager, Lucknow]

Summary

- Most providers, particularly frontline workers, were not aware of HIV and SRH convergence.
- Initially, many providers interviewed assumed that convergence automatically meant full integration and “one-stop shops.”
- Once they understood, managers and frontline workers in all sectors were generally receptive to the notion of convergence.

Benefits of convergence

Across the four districts, providers variously felt that converging HIV and SRH services would increase access to much-needed services for groups at risk of HIV and unintended pregnancy, allow different categories of care providers to work together, help in reducing the fear of HIV amongst communities, increase treatment compliance, and reduce stigma and discrimination.

Specific benefits mentioned by several service providers included:

- (1) Reduction of HIV infection through early diagnosis and increased reach of awareness programmes and prevention efforts, including STI services. *“Because of awareness, people will approach themselves. Transmission will be stopped, and because of proper linkage, patients will get proper information and they will not suffer.”* [Manager, Nashik] *“It will help in reducing the rate of unwanted pregnancy, young people will opt for safe sex, and the ratio of HIV will be reduced.”* [Manager, Patna] *“More people will come for STI [management]. If HIV is found early, the spread, particularly to partner will be arrested, STIs will be treated.”* [Frontline worker, Srikakulam]
- (2) Increase in access of populations at risk to needed services. *“Access will be increased, they can be treated before getting severe, STIs can be treated and at that time, educate them about HIV.”* [Manager, Srikakulam]
- (3) Reduction of stigma and discrimination against positive people and reduction of fear of HIV infection. *“Surely, as awareness will increase, people won’t feel shy and come ahead...about HIV/AIDS.... The fear will go away, and they will learn to face the fact and make others comfortable, as [being infected with] HIV is not a stigma; it can happen to any person any time, even doctors can get infected by it.”* [Manager, Nashik]
- (4) Increased quality of treatment and better follow-up of patients at reduced costs. *“It is a good idea, populations at risk will benefit by timely treatment, their mental strength will be stronger, and immunity will increase. They can lead better and normal life.”* [Manager, Nashik] *“More people will approach. Their time and money will be saved, better follow-up can be given.”* [Manager, Nashik]

Summary

- Service providers felt that convergence would increase access to much-needed services for groups at risk, strengthen the quality of service provision to them, and help reduce stigma and discrimination.

Challenges in implementing convergence

There was quite a high level of critical reflection from service providers about perceived challenges in implementing convergence. Negative staff attitudes, resistance from other stakeholders, lack of resources, confidentiality and privacy, workload issues, demand generation, cost, and referrals were all mentioned as challenges.

Negative staff attitudes

As during the mapping activities, in the interviews, negative staff attitudes and behaviour were seen to be major challenges to extending coverage of SRH services to sex workers and people with HIV from PHCs, CHCs and district hospitals. “Staff attitude is very bad here.... The patients have to wait long hours and sometimes, blood is taken for conducting tests, but tests are not done and the samples are thrown away.” [Manager, Lucknow] “Our attitude is the biggest challenge....” [Manager, Nashik] More managers than frontline workers highlighted negative staff attitudes. “In government places, staff does not treat their patients properly, training is needed.” [Manager, Srikakulam] Many indicated that overcoming the fear of contracting HIV through their work was key to addressing negative staff attitudes and that this could be done through providing training and equipment for universal precautions. “Staff are not trained, no proper material, equipment is there, also there is fear [amongst staff of getting] HIV.” [Manager, Srikakulam] It was also said that a change in attitude and eliminating stigmatising behaviour of staff would increase access to services for groups at risk of HIV and unintended pregnancy.

Interviews also revealed evidence of service providers’ own negative attitudes about providing converged services to specific at-risk groups. “Wards must be different; testing centre must be kept in different place....” [Frontline worker, Srikakulam] “...Separate operation theatre and clinic needed [to provide services for positive people].” [Manager, Srikakulam]

These views will need to be sensitively and effectively addressed in order to increase the feasibility of HIV-SRH service convergence in some facilities. “Those Adivasi [tribal people] are in remote areas, they will not listen to us because they are very stubborn....” [Manager, Nashik] “I think twice before touching an HIV-positive or suspected HIV-positive patient, I think of wife and children.” [Private-sector manager, Srikakulam] Some said that providing a monetary incentive may induce staff to work with people with HIV. “Staff has fear to treat HIV-positive people;

special [monetary] allowance should be given to all dealing with HIV-positive.” [Manager, Srikakulam]

In contrast, government HIV service providers, although smaller in number than the mainstream government SRH providers interviewed (15 percent of the total providers interviewed), did not see staff attitudes and behaviour as a general challenge to providing SRH services to positive people within HIV settings. “Attitude of staff is no problem. I have done more than 70 [caesarean] operations for vertical transmissions for HIV women. Staff will not create problem, if main man does not create barrier.” [Manager, Nashik] Most respondents in Nashik said that staff attitude was not a problem in their facilities, and responses were positive but more mixed in Srikakulam (both districts are located in higher-prevalence states). “It doesn’t matter these days, if you are HIV-positive, people think positively and have become practical. HIV-positive people think positively and are like anybody else....” [Manager, Nashik] “Whoever comes to us, we treat them as ordinary patients, if the person has symptom of HIV, then immediately refer to government hospital. Staff attitude is same for all the patients.” [Manager, Srikakulam]

Resistance from other stakeholders

In addition to training providers, the interviews showed that awareness campaigns and involvement of all stakeholders, including local political leaders, needs to happen as convergence is being rolled out from mainstream government facilities.

Service providers felt that social stigma (resistance from the community and other clients) would be a challenge. “General public might protest the provision of services to [specific] populations along with the general population. People’s narrow-minded attitude to the [assessment] population is a challenge. Convergence itself is a challenge. Efforts should be made to change people’s mindsets.” [Manager, Lucknow]

Political and administrative interference was also mentioned as a major challenge to extending mainstream government SRH coverage to sex workers and people with HIV from PHCs and district hospitals, and also to adding HIV services for young people at the village level. “Local society, illiteracy, and unawareness, including administrative interference from the district-level authorities and other political figures.... There may be some problems from local communities.... They will not allow sex workers in the same service point, as there can be fear of transmission of HIV infection.” [Manager, Patna] “Local people because they won’t allow sex workers, to some extent government can also be a barrier, the police can also act as a barrier.” [Private-sector manager, Patna]

There were real concerns that women from the general population would boycott ANC services, and/or the quality of services would be compromised by convergence. *“Some people will initially oppose it, as they may think that they will be infected by sharing chair or going to the hospital...”* [Manager, Srikakulam]

Some private providers were concerned that they would lose business by being overly identified with HIV and sex workers. *“...fear to be stamped as HIV or STI or sex workers’ doctor.”* [Private-sector manager, Srikakulam] *“The clinic will be labelled as an abortion clinic and can carry a bad name, general public will find it difficult to go there.”* [Private-sector manager, Lucknow]

Lack of resources, confidentiality, and privacy

The variation in how states are resourced was evident from the interviews. For example, managers in Patna and Lucknow in particular felt that existing services need to be strengthened before convergence can happen. This was articulated in terms of basic resources. *“The biggest challenge is the PHC itself. You see we don’t have anything here.”* [Manager, Patna] *“Here you need to start from scratch. You can imagine how many difficulties will arise.”* [Manager, Patna] Being able to source necessary commodities was also seen as a potential problem. *“Making arrangements for medicines and other material supply for all this can be a challenge in itself.”* [Manager, Lucknow]

Fifteen percent of service providers interviewed spoke specifically about the need for privacy, and/or the need to ensure confidentiality. *“Definitely, people will avoid to accept it if it is not in privacy of the individual and has social stigma and insecurity.”* [Manager, Nashik] *“They are concerned about the confidentiality. If confidentiality is handled, they will come next time. They should be treated like other regular patients...”* [Manager, Nashik] Echoing the findings from the mapping activities, respondents felt that lack of privacy/confidentiality acts as a barrier to positive people and sex workers accessing necessary services. *“Privacy and confidentiality are some of the barriers whilst trying to implement convergence programmes.”* [Manager, Lucknow] *“Sex workers fear about secrecy and fear to come to government hospital.”* [Frontline worker, Srikakulam] There was also an articulated need for guidance in how to ensure confidentiality. *“...the need of some legal information with regard to maintaining confidentiality for HIV patient and how to maintain their records...”* [Manager, Lucknow]

Personnel issues

As well as the need for privacy and confidentiality, service providers also spoke specifically about the need for having a provider of an appropriate gender. *“We require one counsellor—a woman counsellor who can guide these people on HIV-related issue.... Even rooms are required to treat these patients...”* [Frontline worker, Srikakulam] *“Female doctors preferred because she can interact closely, particularly with sex workers.”* [NGO manager, Srikakulam]

Frontline workers in all four districts felt that workload would increase with convergence unless there were adequate resources for additional personnel. *“Our workload will increase. If new staff is not recruited, then responsibility of convergence will fall on one person.”* [Frontline worker, Lucknow] Frontline workers raised concerns about the fact that ANMs, health volunteers, and Anganwadi workers are already involved in a number of programmes and explained how any additional programme would mean an increased workload. *“Lots of organisations are getting involved with Anganwadi worker because of which the Anganwadi worker is not able to do her own work properly. Their workload has increased; for that, a good policy should be made. Honorarium given by the organisations in the light of the increased workload is less.”* [Frontline worker, Lucknow] *“ANMs and health volunteer busy with TB project. This will be additional. If...few more ANMs and health volunteers are provided, they can take care of this option....”* [Frontline worker, Srikakulam]

The issue of current low compensation packages was also raised and that it would be difficult to work on additional programmes considering current compensation rates. Some frontline workers felt that the workload would increase, but said that with sharing of the work and added incentives, it could be managed. *“Workload will be high for some staff and they might reject. Without benefit, no one will be interested to do extra work. Staff have to be increased or [we have to] seek additional services from the same staff. For them, some additional money or compensation has to be provided.”* [Frontline worker, Lucknow]

Demand generation

Service providers felt that simply initiating HIV-SRH service convergence would not be enough to increase access to populations in need and that demand generation activities by government and NGOs will be necessary so that clients come to the services. *“Providing information to key populations on convergence of HIV and SRH is a big challenge. Without knowing about the treatment facilities available in community, they will find it difficult to access it.”* [Manager, Lucknow] *“It is a very good idea, but your*

target group, the sex workers, should also be motivated to come to the primary health centre.” [Manager, Patna]

Service providers felt that demand generation for converged services would happen through providing information about services to groups at risk but that this would not be easy. “Due to illiteracy, we will face problems in spreading awareness, social bindings are there, and also there is discrimination against HIV+ and sex workers.” [Manager, Patna] “Spreading awareness is a challenge because of ignorance in socio-economically backward people because of illiteracy, and even if they suffer, they hide, don’t bring reports.” [Manager, Nashik] “Awareness and counselling of the study population is a challenge because people don’t come out openly.” [Manager, Patna] It was suggested that demand generation be carried out through outreach and peer communication. “Mainly awareness must be created through outreach staff or community guides, Anganwadi workers, and ANMs.” [NGO manager, Srikakulam]

Private-sector managers in Patna, Lucknow, and Nashik requested IEC materials to help raise demand. One private-sector manager in Lucknow noted, “People need to be told about the services being provided.... The publicity for this should be done for populations at risk.” Another in Nashik remarked, “We need everything...IEC materials, posters....”

Cost of convergence

Service providers felt that some convergence options could be initiated with minimum extra cost and could be implemented at scale in a relatively short time utilising the current workforce. “I don’t think there are any problems regarding cost.” [Frontline worker, Nashik] Managers in Nashik, Patna, and Srikakulam did not feel that providing communications and referrals for HIV/STI prevention and condom access at the PHC/village level had major cost implications. “It is not having much cost involvement, for referrals nothing extra is needed.” [Frontline worker, Srikakulam]

Managers in Lucknow also felt that cost was not a concern in providing communication and information. “There will not be much cost incurred for establishing services such as IEC and counselling for HIV.” [Manager, Lucknow] They did feel, however, that there were cost implications for providing increased services, particularly to sex workers and young men and women at the PHC level. In all districts, there were concerns that managing the costs of converging “expensive” HIV services with SRH, and managing a regular supply of equipment, materials, and drugs would be a challenge. “Availability of all materials, like test kits, delivery kits, treatment medicines, so I think whatever supply is needed to the people is a big challenge.” [Manager,

Nashik] “Nonavailability of commodities, drugs, disposable kits....” [Manager, Srikakulam]

Private-sector service providers were concerned about whether or not populations at risk would be able to afford converged services. They felt that to be part of a health system effort to converge services, the government should provide them with some support to compensate for loss of revenue. “Presently, these sex workers are not in a position to bear hospital expenses, 100 percent should be given free.” [Private-sector manager, Srikakulam] “Supplies of medicines at low rates, if possible free of charge, and staff-related equipment should be supplied regularly.” [Private-sector manager, Srikakulam] “If medicines, gloves, and required kits are provided in sufficient quantity on time, then there will be no problem.... I should also get information on ART provision.” [Private-sector manager, Nashik]

Improving referrals

With the exception of Srikakulam, interviews with service providers showed that referrals between HIV and SRH services are not yet systematized. “Presently, without any problems, we are continuing this option [of referrals].” [Frontline worker, Srikakulam] However, providers felt that strengthening referrals would entail minimal cost and training.

Barriers to systematic referrals included the need for government approvals before initiating referrals between the two vertical systems. “[We will need] approval from government (NACO and Uttar Pradesh State AIDS Control Society) and administration [for referrals].” [Manager, Lucknow] There is a lack of training for SRH staff in appropriate referrals, and people have not yet been designated as responsible for referrals. “The staff who will be placed in referral department should be aware of all the services available, and they need to be trained.” [Manager, Lucknow] “We have got HIV-related skills, we provide complete counselling, but our referral-related skills need to increase. We do not know where to refer which case and to whom.” [Frontline worker, Lucknow]

Communication between different facilities was seen as essential for strengthening referrals.

“If there is proper communication between ART and DOTS doctors, and if the DOTS doctor is also having responsibility of ART centre, he will feel more responsible and the programme can be a success.” [Manager, Lucknow] “There should be communication between two centres so that when a patient is referred, there is adequate support and care taken.” [Frontline worker, Lucknow]

Some were concerned that referrals would not be taken seriously. “The relationship with the hospital where we are

referring patients should be good. Patients should get proper attention and they must be referred to more doctors (referrals should be honoured).” [NGO Manager, Srikakulam]

There were also concerns with purchasing supplies and consumables for referrals (IEC materials and stationery). “We will need the communication or IEC material and stationery for referral work.” [Manager, Lucknow]

Summary

- Negative staff attitudes, resistance from other stakeholders, lack of resources, confidentiality and privacy, workload issues, demand generation, cost, and referrals were all mentioned as challenges by service providers to implementing convergence.
- Negative staff attitudes was mentioned as a challenge by the majority of government SRH providers.
- In contrast, government HIV service providers did not see staff attitudes as a challenge to providing SRH services to positive people within HIV settings.
- Overcoming the fear of contracting HIV through their work by providing training and equipment for universal precautions was seen as key to addressing negative staff attitudes.
- There were concerns that women in the general population would boycott ANC services, and/or the quality of services would be compromised by convergence.
- Some private providers were concerned that they would lose business by being overly identified with HIV and sex workers.
- Frontline workers raised concerns about the fact that ANCs, health volunteers, and Anganwadi workers are already involved in a number of programmes and explained how any additional programme would mean an increased workload.
- Service providers felt that simply initiating HIV-SRH service convergence would not be enough to increase access to populations at need and that demand generation activities by the government and NGOs will be necessary so that clients come to the services.
- Service providers felt that some convergence options, like communications and referrals, could be initiated with minimum extra cost but that other options would need additional funds.
- Private-sector service providers were concerned about whether or not populations at risk would be able to afford converged services and felt the government should provide them with some support to compensate for loss of revenue.
- With the exception of Srikakulam, referrals between HIV and SRH services are not yet systematized in the assessment sites.

felt that their main training need for convergence would be in providing HIV services to groups at risk. Training needs identified included stigma reduction; counselling; universal precautions; strategies for working with populations at risk; HIV prevention, care, and treatment; and referrals. Although the need for service provider training in gender and sexuality and expanded contraceptive options was mentioned during the mapping activities, these training needs were not mentioned during the interviews with service providers.

Training needs of SRH service providers

Managers and frontline workers in Lucknow and Patna said that training to change stigmatising attitudes and discriminatory behaviour of staff toward positive people and sex workers was a priority. “Further training for staff on HIV will be good in order for them to protect themselves. Staff should also get training on attitude.” [Manager, Lucknow] “Not technical but training of attitude and behaviour change is required.” [Manager, Patna]

In addition, staff knowledge and skills need to be strengthened if HIV and SRH services are to be converged successfully in their facilities. Most of the respondents in Lucknow admitted discrimination and identified gaps in the present system of training. “...HIV-related training is required. Moreover, training on harm reduction...is needed.” [Manager, Lucknow] “HIV-related symptoms and HIV for pregnant and lactating mothers should also be included in the training programme. Every six months, there has to be a refreshment of training modules and programmes.” [Frontline worker, Lucknow] “...We want HIV/SRH referral system-related training.... If a positive person is also pregnant or also has TB or an STI, we should be given...training on what symptom to refer where. We are very confused about this. We should be told about the entire system.” [Frontline worker, Lucknow]

Managers and frontline workers interviewed in Nashik and Srikakulam felt that they needed training to improve staff HIV skills and knowledge so that they could better manage positive people without the fear of becoming infected themselves. “Training needed to get them out of fear. Doctors also have fear to treat HIV people...” [Manager, Srikakulam] “Training [on] safety and precaution toward HIV cases not given, if the safety kit, gloves, and special training [are] given, it will be good...” [Manager, Srikakulam] “Presently, all our staff is general trained, not particularly on HIV. We take some precaution on delivery time, but we don’t know who is HIV-positive or negative, so prevention whilst treating is not there. Care training is needed.” [Frontline worker, Srikakulam]

Training needs

Staff training was seen as essential for implementing convergence. “Staff must be trained, otherwise, no use of these services.” [NGO manager, Srikakulam] Government service providers at PHCs, CHCs, and district hospitals

Only 1 (Srikakulam) out of 130 respondents from main-stream government SRH services across the four districts felt that further training was required and that occasional refresher inputs would be enough. Sixty-two out of 130 SRH providers (frontline and managers) interviewed felt they had adequate SRH technical skills but required more training to meet the needs of people with HIV. *“Staff skills should be upgraded, and it is necessary for them to learn how to deal with HIV persons. There should be separate training programmes related to these issues.”* [Manager, Lucknow] *“Staff has the necessary skill, but ART-related services and information should be provided.”* [Manager, Lucknow] SRH providers in Lucknow, Nashik, and Patna, however, felt that they required skills in both HIV and SRH. *“The existing staff is skilled, but they need to be trained for implementing convergence. They have been trained in the family planning mode.”* [Manager, Lucknow]

Training needs of HIV service providers

In contrast to SRH providers, whose main concern was improving staff attitudes and behaviour toward people at risk, HIV service providers expressed the need to improve skills in SRH, to provide a wider range of services to their clients. *“Either existing staff or new staff (counsellors) both will need...subject-related training: unintended pregnancy, contraceptives, and STI.”* [Manager, Lucknow] *“Training regarding HIV is done, but no training regarding SRH is done.”* [Manager, Nashik]

Government HIV and TB DOTS providers in Lucknow and Nashik felt that their main training needs for convergence would be in the area of providing SRH services to people with HIV. *“As regards HIV- and SRH-related training, there is definitely a need. Since most of the staff are trained in TB treatment, there is lack of knowledge related to HIV-related issues. We are given guidelines regarding HIV, but no training is given.”* [Manager, Lucknow] *“Training regarding HIV is done, but no training regarding SRH is done.”* [Frontline worker, Nashik]

Summary

- *Training needs identified for service providers included stigma reduction; counselling; universal precautions; strategies for working with populations at risk; HIV prevention, care, and treatment; and referrals.*
- *Although the need for service-provider training in gender and sexuality and expanded contraceptive options was mentioned during the mapping activities, these training needs were not mentioned during the interviews with service providers.*
- *In contrast to SRH providers, whose main concern was improving staff attitudes and behaviour toward people at risk, HIV service providers expressed the need to improve skills on SRH, to provide a wider range of services to their clients.*

Table 9. Summary of training needs of service providers.

Training needs	SRH service providers	HIV service providers
Gender and sexuality		
Stigma reduction		
Counselling		
Universal precautions		
Strategies for working with populations at risk		
Management of STIs		
HIV prevention, care, and treatment		
Referrals		
Expanded contraception options		
SRH service provision for positive people		
Managing unintended pregnancy		
Contraception and contraceptives		

Policy and partnerships

Service providers' awareness and understanding of convergence "policy" was mixed. Managers in Lucknow said that there was a need to have appropriate policies in place at the state level to implement any kind of HIV and SRH convergence, particularly with respect to populations at risk. Managers in Nashik, Patna, and Srikakulam, however, expressed no specific policy concerns.

Some providers in Lucknow confused "guidelines" with "policies." *"There should be a policy on how to deal with [at-risk] population and what services should be given to them."* [Manager, Lucknow] *"At the state level, a policy should be formulated for doctors to change their attitude toward patients. For this, IEC material will be needed."* [Manager, Lucknow] Although providers in Patna mentioned "current policies" as barriers to convergence, this was subsequently found to refer more to the way the state government works rather than to specific policies.

The interviews also showed that providers do not have adequate exposure to newer national/state policies and that not all are aware of or versed in the current (available) government guidelines (e.g., on HIV prevention and control, universal precautions, standard operating procedures for RCH service provision, and referrals). Service providers in Nashik and Srikakulam said that convergence policy was already being implemented in these states through the integrated ICTCs. *"It is good, we will get more help, already we have ICTC over here."* [Frontline worker, Nashik]

Echoing the findings from mapping activities, service providers from both the public and private sectors felt that NGOs could play an important role in convergence—not for service provision, but for demand generation, mobilisation, awareness-building, advocacy, outreach to vulnerable populations, and provision of support and training. *"NGOs can be partners for creating awareness and for referring to hospitals."* [Manager, Lucknow] *"We can work*

with NGOs—in fact, government agencies and NGOs has to work together for good results." [Manager, Srikakulam] *"NGOs should help for doing some programme part and counselling."* [Manager, Nashik]

Panchayati Raj⁴ functionaries, block/mandal functionaries, and Anganwadi workers were also identified as important partners by managers and frontline workers in Lucknow, Nashik, and Srikakulam, for enabling convergence at the PHC/village level. *"For implementation of convergence, the assistance of others, like Anganwadi workers, people from at-risk populations, doctors, and nurses will be needed."* [Private-sector manager, Lucknow]

State secretariats and directorates of health, SACS, officials from the state and district ICDS scheme, and state- and district-level NGOs were identified as important policy-level people to take convergence forward. *"We have to start working with partners like ICDS, social welfare department, and also with registered medical practitioner (RMP⁵) association, educate them to get referrals from them, because sex workers go to RMPs only..."* [Frontline worker, Srikakulam] In Srikakulam, a specific body—the Andhra Pradesh Vidhya Vidhana Parishad—was also mentioned, and state-level NGOs were mentioned as important influencers in Uttar Pradesh.

Summary

- *Service providers' awareness and understanding of convergence "policy" was mixed, and there was some confusion between "guidelines/protocols" and "policies."*
- *Service providers in Nashik and Srikakulam said that convergence policy was already being implemented in these states through the ICTCs.*
- *Service providers from both the public and private sectors felt there was an important role for NGOs in convergence—not for service provision, but for demand generation, mobilisation, awareness-building, advocacy, outreach to vulnerable populations, and for providing support and training.*
- *A range of other partnerships was seen as important for implementing and promoting convergence.*

⁴ Panchayati Raj is a system of governance in which gram (or village) panchayats are the basic units of administration. It has three levels: village, block, and district. At the village level, it is called a panchayat, a local body working for the good of the village. Accessed at: http://en.wikipedia.org/wiki/Panchayati_Raj on June 5, 2007.

⁵ Registered medical practitioners, or "RMPs," are LTFQP, or "quack" practitioners.



Findings from interviews with policymakers

Policy and partnerships

Policymakers and influencers interviewed across the four states were the most aware of any group about what convergence was and of the national- and state-level policies on HIV-SRH convergence. Fifty-five of the 60 policymakers (92 percent) felt that it was possible to implement convergence of government HIV and SRH services immediately. In Andhra Pradesh and Maharashtra, for example, some policymakers said that HIV and SRH convergence was already being rolled out under the NRHM and the RCH II. *“Idea is good; we have already started on few aspects.”* [State official, Andhra Pradesh] *“It is already there, people are getting the services.”* [State official, Maharashtra]

Policymakers in Bihar and Uttar Pradesh mentioned that some amount of HIV-TB convergence was already happening in their states. Policymakers also felt that that converging HIV and SRH services would increase health awareness, improve access to care, and increase compliance to treatment. Notes of caution, however, were sounded by some policymakers, particularly regarding the need to move from planning to implementation. *“I hope it will be a successful approach and will be a milestone for our health system. But you should have a clear idea what is to be done when.”* [State official, Bihar]

Policymakers also emphasized the importance of strategic partnerships. A range of partners to implement and take forward the convergence agenda was suggested across the four assessment states. *“Members of Parliament and members of state legislative assemblies, community, village health committee, and state health mission...”* [State official, Andhra Pradesh]

Local, national, and international NGOs were suggested as important. Eighty percent of policymakers interviewed said it was necessary to have NGOs as partners—particularly to support community-mobilisation efforts, assist in provider trainings, and provide other technical assistance. *“NGOs under RCH and HIV...they can share their experience and interact...”* [State official, Maharashtra] *“Yes, of course, we need partners. As I have told you, we need NGOs to help us and also some private partners. Without NGOs, I think this work is not possible because government is already running this kind of programme, but it is not successful...”* [State official, Uttar Pradesh]

Policymakers mentioned Panchayati Raj institutions and representatives of the people (Andhra Pradesh, Bihar, and Maharashtra), CBOs (Andhra Pradesh and Bihar), and other government departments like Education (Andhra Pradesh, Maharashtra) as important partners. Policymakers in Bihar, Maharashtra, and Uttar Pradesh also recommended that appropriate public-private partnerships with associations (Lions Club, Rotary Club, and Indian Medical Association) and with private practitioners could be explored. Policymakers said that it was important to have partners to roll out convergence of HIV and SRH services and that people should take advantage of the flexibility of the NRHM to develop these partnerships (Uttar Pradesh).

Policymakers in Bihar, however, qualified that NGOs selected for partnership should be “good,” (i.e., ones with proven track records). They also said peer workers/peer educators from different projects were important partners in converging HIV and SRH services. *“Peer educators should be maximum, an outsider cannot do the work, as these are the issues on which people are not open and also don’t talk properly. Accessibility can be increased through peer partners...”* [State official, Bihar]

For convergence to be successful, policymakers emphasized that good monitoring and evaluation would be necessary. Overall, 80 percent of the policymakers across the four assessment states felt that converging HIV and SRH services would have an impact on reducing HIV and unintended pregnancy. Around 8 percent of policymakers, however, felt that there would either be less or no impact. Some felt that without suitable indicators and monitoring, they were not able to comment. *“Awareness will of course create a positive effect, but at present, we don’t have data for our district, so we cannot say about such pregnancies and HIV infections, and hence, monitoring is zero, but I think convergence might definitely help...”* [District official, Maharashtra]

Summary

- *Policymakers and influencers interviewed across the four states were the most aware of any group about what convergence was and of the national- and state-level policies on HIV-SRH convergence.*
- *Eighty percent of the policymakers across the four assessment states felt that converging HIV and SRH services would have an impact on reducing HIV and unintended pregnancy.*
- *Ninety-two percent of policymakers felt that it was possible to implement convergence of government HIV and SRH services immediately.*
- *Eighty percent of policymakers interviewed said it was necessary to have NGOs as partners—particularly to support community-mobilisation efforts, assist in provider trainings, and provide other technical assistance.*
- *Policymakers also emphasized the importance of strategic partnerships and suggested a range of partners to implement and take forward the convergence agenda.*

Funding and cost implications

When asked about funding and cost implications of converging HIV and SRH services, 50 percent of policymakers interviewed felt that existing funding levels were sufficient to start implementing convergence, 40 percent said there was a need for additional funding, and 10 percent had no comment regarding the cost of convergence. *“As I said, cost is not a problem, we have enough funds, and in long run, it will be cost-effective both for the department and also for people...”* [State official, Bihar]

Policymakers felt that additional funding was needed for training, IEC materials, equipment, drug supplies, and consumables. *“There is cost involved in making the facilities available for testing, medicine, publicity, etc...”* [District official, Bihar] There was a difference between state- and district-level policymakers. More of the district-level officials (who would be responsible for implementation) felt that additional funding was needed. More of the state-level officials felt that existing funding was adequate and that the main problem was the flow of funding from state to district.

District officials also spoke of the necessity of decentralized funding (Bihar and Maharashtra), and policymakers in Uttar Pradesh spoke of appropriate utilisation of current funds. They said that the main problem was not funds but adequate policies and management of programmes. *“I think funds are there, but its utilisation and functional service is the important thing...”* [State official, Uttar Pradesh]

Summary

- *50 percent of policymakers interviewed felt that existing funding levels were sufficient to start implementing convergence.*
- *More district-level officials felt that additional funding is needed for convergence.*
- *Policymakers in Uttar Pradesh spoke of the need for appropriate utilisation of current funds.*

Provider skills

Nearly 75 percent of policymakers interviewed mentioned that current service provider skills are not adequate for implementing convergence. *“Staff skills must be improved, they should be bold to treat [positive] patients, to accept HIV patient, and [for this], training is required....* [State official, Andhra Pradesh] Policymakers across the four assessment states also said that continuous retraining or reorientation were more important than one-off training programmes. *“The staff skills require training which should be a continuous process...”* [District health official, Bihar]

Policymakers in Andhra Pradesh spoke of the need to improve current staff skills in general. Policymakers in Bihar spoke about the necessity of improving staff skills with regard to universal precautions and client confidentiality. Policymakers in Maharashtra said that it was important to address the lack of confidence of current providers in dealing with positive people.

Policymakers in Uttar Pradesh, however, were concerned with the lack of utilisation of available skills by providers and their lack of accountability in providing services. They also expressed the need for step-wise planning to improve staff skills. *“I am not happy. No satisfactory results are there. Counsellors are...being trained, but they are not serious toward their work. Yes, they are skilled, but there is no utilisation of skill, no sense of accountability is there...”* [State official, Uttar Pradesh]

Policymakers mentioned ongoing training efforts that could address these needs, including integrated skills-building programmes that have already begun (Bihar and Maharashtra). *“We have already converged training with the State Health Society of Bihar. Our entire training module consist a part on reproductive health, and in similar manner, their module consist a part on HIV/AIDS programmes...”* [State official, Bihar] Initiation of a process of empanelment and accreditation of skilled health professionals was suggested (Maharashtra). *“We have asked to identify doctors with required qualification and who are willing to join list of accredited doctors.”* [State official,

Maharashtra] It was also suggested that current providers be given refresher/reorientation training to improve skills (Andhra Pradesh and Maharashtra).

Policymakers felt that training for service providers should be participatory and innovative and that NGOs would be more suited to design and roll out these training programmes. *“Training should be provided through NGOs for better results...” [District official, Uttar Pradesh]* Like the service providers, policymakers also spoke of the importance of raising community awareness of the issues and sensitizing key community groups (e.g., young people and students). Generating demand for converged services was also emphasized as a role for NGOs. *“...There are two broad areas in capacity-building; 1) when you look at service provider, technical and motivational training is important like team building, interpersonal communication, behavioural changes... 2) next is mobilisation part and engagement of people, involve volunteers, women and panchayats...” [State-level influencer, Uttar Pradesh]*

Summary

- *Nearly 75 percent of policymakers interviewed mentioned that current service provider skills are not adequate for implementing convergence.*
- *Policymakers felt that training for service providers should be participatory and innovative and that NGOs would be more suited to design and roll out these training programmes.*
- *Policymakers also mentioned ongoing training efforts that could address these needs, including the integrated skills-building programmes that have begun in some states.*

Conclusions

The assessment confirmed other findings, which showed that STIs are widespread in certain groups in India and that these groups are indeed vulnerable to HIV and unintended pregnancy.⁴⁶ Although previous research showed the need for converging HIV and SRH services, this assessment has begun the process of investigating the demand for convergence amongst populations at risk of HIV and unintended pregnancy in India. It has also explored the attitudes of service providers and policymakers toward responding to this demand and what the challenges might be in implementing convergence. The assessment findings have implications for programme implementation, strengthening capacity, and policy. Findings also highlight where additional research is necessary.

Limitations of the assessment

The assessment process had some limitations. A great deal of information was generated from the participatory mapping, but documentation was weak in some cases; therefore, some detail was lost. To address this, the PATH team worked with the national community investigators to provide day-to-day support to the documentation process. Also, the concept of convergence was difficult to explain to all three groups of investigators. This resulted in a lack of consistency in facilitating the participatory exercises, which had to be corrected.

Whilst accessing assessment participants in the community, group work with positive people and sex workers was sometimes difficult to organise, and additional support was required from local peer educators, who helped mobilise groups of positive people. As this and other research shows, sex workers usually do not access government services (particularly VCT services); therefore, many do not know their HIV status and do not join support groups. As a result, it is likely that people with HIV who were reached during the assessment are not representative of positive people in the states.

Most providers, particularly frontline workers, were not aware of HIV and SRH convergence, and it took a great deal of time to explain the concept during the assessment. Because the concept was very new, many providers and policymakers interviewed did not get beyond discussing the need for convergence and the perceived general benefits and challenges. Therefore, less information was gathered on the practical aspects of implementing convergence.

Finally, despite agreeing to be interviewed, health facility managers and departmental heads did not always engage fully in the interview process due to work and other pressures.

Implications for implementing and scaling up HIV-SRH service convergence

Full integration of HIV and SRH services is not required

Most people who participated in the assessment were enthusiastic about the idea of convergence, and many practical suggestions were made. Rather than advocating for full integration of all HIV and SRH services, suggestions for convergence from groups at risk in the community were pragmatic, based on their own experiences with service utilisation and what would work for them within their own contexts. At this stage of the Indian epidemic, it may be counter-productive to consider complete integration of HIV and SRH services (as has been tried in some African settings), as this may have the effect of diluting the quality of HIV services provided for the people who need them. The assessment showed that HIV providers are attitudinally more ready for convergence. It may, therefore, be more feasible initially to initiate convergence of SRH services within existing HIV services.

Stigma toward female sex workers must be reduced

Female sex workers are key to both HIV epidemic dynamics in India and to the response, yet the assessment shows that their HIV and SRH service needs are not being met adequately by the public sector. Stigma from service providers and other clients, lack of privacy and confidentiality, and in some cases, cost, are all reported to be serious barriers to their accessing government services. In higher-prevalence states, many access STI services and condoms from NGOs, but in lower-prevalence states, like Bihar and Uttar Pradesh, specialised HIV NGOs are rare or lack coverage. As a result of lack of trust and fear of exposure, sex workers report treating RTIs and STIs through self-medication or visits to LTFQPs whom they know may not be providing high quality services but whom they trust to maintain confidentiality.

The assessment showed that sex workers may suffer more complications with pregnancy and delivery and have more abortions than others and that there is an urgent need to train health workers in addressing those needs. There is also a need to develop IEC materials and communications methods for sex workers that deal with pregnancy, family planning, and other SRH issues. Where there are NGOs, sex workers would like to see family planning services and STI treatment converged with HIV services. For ANC, safe delivery, PPTCT, and safe abortion, sex workers

expressed a preference for government facilities—but only if issues of stigma and confidentiality can be addressed. Service providers need to view sex workers not just in terms of their perceived role in transmitting HIV, but as women who have regular partners and children and need a full range of SRH services. Reinforcing the role of condoms in dual protection will not only reduce unintended pregnancy but will also reduce the risk of HIV infection.

Government services need to accommodate the SRH needs of men

Assessment findings show that health services do not generally provide care or space to address the needs and concerns of young, sexually active men. Men in general, like sex workers, do not access government services but prefer to self-medicate or use LTFQPs to treat STIs. Men with HIV and other sexually active young men reported few opportunities for accessing government SRH services, which were seen to be for married women. Sexually active young men were worried about stigma and embarrassment and being seen by women health practitioners. Their suggestions for convergence reflected their need for “young-men-friendly” services that provide HIV counselling, communication, STI treatment, and referrals, which they suggested be provided by NGOs or at the Anganwadi centre. Positive men, on the other hand, saw opportunities for accessing safer sex information, condoms, and other SRH services at the government HIV facilities with which they are familiar and comfortable, like VCT, ART, and TB DOTS centres.

More attention needs to be paid to the HIV prevention needs of sexually active young women

The assessment showed that although young women had some access to SRH services, they required more information on STIs, safer sex, birth-spacing methods, safe abortion, safe delivery services, and HIV. Young women from the higher-prevalence states of Andhra Pradesh and Maharashtra expressed the need to know where they could access HIV testing. Young women across the four states wanted high quality, confidential treatment for STIs, HIV information and counselling, and free safe abortion from government providers.

The SRH needs of positive women must be met

Positive women experience unwanted pregnancies resulting from contraceptive failure or lack of contraceptive use. Stigma, lack of confidentiality, lack of health care provider knowledge, and having their rights superseded by the bias toward preventing perinatal transmission are all serious barriers to positive women accessing SRH

services. Breaches of confidentiality can lead to gender-based violence. Health care providers may not advise correctly on contraceptive methods or may fail to screen for cervical cancer. Ignoring the rights of positive women may result in advice to become sterilised (even if they may want to have children at some point) or in those who are pregnant being advised to go for abortion. Stigma may result in those who want to terminate pregnancies being turned away from services. There are estimated to be more than two million positive women in India who may need different SRH services at different times in their lives. Women with HIV may need information about their rights and about services available to them; counselling on fertility, sex, and sexuality; family planning counselling and services (including dual protection); STI diagnosis and treatment; prevention and treatment of cervical cancer; safe abortion services; ANC; safe delivery; and PPTCT.

The assessment showed that positive women would like to see family planning and STI services provided from existing HIV services like VCT and ART centres. Like sex workers, however, they would like to access safe abortion and delivery from mainstream government providers, so long as stigma can be addressed. Quality of service for positive women includes not only changing staff attitudes and strengthening their skills through training, but also improving infrastructure in government facilities, providing privacy and confidentiality, improving universal precautions, improving referrals, and the management of logistics and consumables.

Demand must be generated for convergence

The assessment not only explored the demand for convergence, but also highlighted the importance of raising awareness of and demand for services as part of implementing convergence. The assessment showed a striking lack of awareness about current services amongst groups at risk. Service providers were clear that offering converged services would not be successful unless these groups were informed and motivated to attend. Since the main barrier to accessing government reproductive health and MCH services appears to be stigma and lack of confidentiality, sex workers and positive people will also need adequate convincing that the situation has changed before they risk exposure and discrimination. NGOs were pinpointed not only for delivering anti-stigma and other training to government health workers, but also for providing communications and mobilising groups at risk in the community. Private-sector managers requested supplies of IEC materials to help raise demand.

A wide range of stakeholders needs to be engaged

The assessment showed that a wide range of stakeholders will need to be engaged to implement convergence. During mapping activities and interviews, it was noted that partnerships with NGOs and CBOs is considered critical to the success of converging HIV and SRH services. In addition, government providers and policymakers wanted to utilise the spaces and opportunities within the NRHM to firm up partnerships to facilitate referrals and increase coverage, particularly with Panchayati Raj institutions, NGOs, and private service providers. Service providers and policymakers also emphasized the need for partnerships with communities. Policymakers pointed to the need for communications work with the general public, particularly local elders and opinion leaders, in order to minimise any opposition to convergence. Partnerships appear to be important not only to alleviate social stigma and reduce barriers to implementing convergence, but also to leverage financial and political support and share expertise.

Private-sector providers were receptive to the notion of convergence, but they had concerns about losing business through the social stigma of being identified with HIV and sex workers, and about whether or not they would be able to provide services that sex workers could afford without additional support from the government. Private-sector providers, therefore, requested partnership with the government in order to address social stigma and receive support so that costs of services could be kept low for populations at risk.

Implications for strengthening capacity for convergence

HIV service providers can share lessons in reducing stigma

The finding that positive people consider specialised government HIV services to be less stigmatising than government SRH and MCH services was echoed by the service providers interviewed during the assessment. This finding is important, since it indicates that stigma might be successfully addressed in the public sector in India if mainstream SRH services were to adopt the type of training and practices used by HIV workers. It also points to a pressing need to share resources, rather than duplicate training across already stretched vertical systems. This implies that government SRH providers would benefit from similar anti-stigma and attitude-change trainings as those provided to government HIV workers. Health

facility managers could also consider on-the-job training and seconded postings for SRH providers in HIV service settings. Positive people and sex workers themselves can be trained to build the capacity of government service providers and help them understand the service needs of people at risk. The assessment also shows that service providers need better access to national guidelines and a better understanding of state-level policy.

NGOs can provide training

Assessment findings show that as well as attitude change, skill and knowledge training for SRH workers in the public sector is a pressing and critical need for convergence and for increasing access to vital services for groups at risk. Apart from anti-stigma training, training needs reported included training in HIV/AIDS (including harm reduction); gender, sexuality, and rights; working with populations at risk; universal precautions; safe injection and waste management; and addressing the specific SRH needs of sex workers and positive people. The assessment also showed the need for retraining or refresher trainings and for using participatory methods to train service providers. Policymakers felt that NGOs were most suited to train providers, as they were better versed in both participatory training methods and the critical issues on which providers require training.

States can learn from one another

Findings also showed that integrated training and reorientation/refresher courses for service providers have already been initiated in Andhra Pradesh and Maharashtra. These states are also further ahead in implementing NACP and NRHM convergence policy and in strengthening referrals. This indicates that states can learn from one another. In the past, higher-prevalence states have received additional funding to address HIV and have, therefore, learned many lessons that would be useful for lower-prevalence states that have pockets of high prevalence, such as Bihar and Uttar Pradesh.

Implications for translating policy into practice

Government policy in India promotes convergence in a number of ways. Service convergence is emphasized in the third national AIDS plan; the NACP III; and in its programme on RCH, the RCH II. In addition, there is emphasis in the NRHM on mainstreaming, partnerships, and linkages. ICTCs, which offer a range of HIV and SRH services, have already started to be established in two of the assessment states: Maharashtra and Andhra Pradesh. The assessment showed a clear demand for this type of in-

tegrated service, since vertical, but nonidentified, specialised HIV services were liked by positive people, and there is a demand to add family planning and STI counselling, communications, and services to ART and VCT centres, and even to TB DOTS facilities. Similarly, the desire of positive people and sex workers to see abortion, delivery, and PPTCT services mainstreamed, if stigma and other issues are addressed, speaks to RCH II policy⁴⁷ and the need not to isolate positive people in health care.

The assessment findings highlighted key gaps between policy and programme practice. For example, the assessment showed that the RCH II includes management of STIs from PHCs⁶, but sex workers and young people reported not getting their STI needs addressed at the PHC level. The assessment also showed that sex workers, positive men and women, and young women are not only looking for increased access to government services, but are also demanding quality services and referrals from these facilities. This implies that quality assurance of services at the primary and secondary health care level, which is enshrined in NRHM and RCH II policy (and speaks about improved infrastructure, supplies, consumables, privacy/confidentiality of patients, and patient satisfaction) has yet to be ensured in practice.

The assessment highlighted gaps in the mobilisation of funds to district and sub-district levels. Policymakers and managers at the district level spoke about the need for funds for building and renovating facilities, for equipment purchases, and maintenance and supply of commodities. This shows that mobilisation and utilisation of the untied funds in the NRHM and the RCH II has not yet occurred in many places as per the policy guidelines. On the other hand, the assessment also showed that state-level policymakers felt that the opportunities and flexibility provided by the NRHM and RCH II could be well-leveraged to implement convergence of HIV and SRH services.

Further research

Although service providers and policymakers commented on cost, workload, and potential impact of increasing access to services, the actual impact on health systems of implementing specific convergence options is still unknown. For example, to address the privacy needs of people at risk may or may not require additional investment in terms of staffing and space. In addition, the effectiveness of particular anti-stigma training and of different demand generation strategies still needs to be tested. This assessment paves the way for taking the next steps in implementing HIV and SRH service convergence in India. With knowledge of demand and of the challenges envisioned by service providers in implementing

particular convergence options, operations research can be conducted to determine costs and cost-effectiveness, to look at staffing and workload issues, identify management and procurement strategies, track referrals and service utilisation, and to determine the acceptability of services to clients, the local community, and NGO and government service providers.

In addition, further research is needed to monitor the quality of service provision and training. For example, it is important to ensure that HIV counselling is high quality and that clients have confidence that they will not suffer discrimination—otherwise there will be little demand for these services from vulnerable groups and people with HIV in the community. To ensure that service delivery is high quality and of value to people at risk of HIV and unintended pregnancy, indicators and systems for quality assurance will need to be developed and tested. Networks for positive people and CBOs need to be given assistance to develop indicators and monitor the quality of service provision and provide feedback findings to the government.

⁶ Under Indian Public Health Standard norms, PHCs should provide STI diagnostics and treatment. (Reference: Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. "Indian Public Health Standards for Primary Health Centres Guidelines," March 2006, pp. 1–90.) Accessed at: http://www.mohfw.nic.in/NRHM/Documents/IPHS_for_PHC.pdf on May 22, 2007.

PATH (Srilatha Sivalenka)



Annexes

Annex 1. Sexual and reproductive health services provided in the public sector in India

Sub-centre, per 3,000 to 5,000 population ⁴⁸	Primary health centre, per 20,000 to 30,000 population ⁴⁹	CHC/FRU, per 100,000 to 120,000 population ⁵⁰	District hospital ⁵¹
Maternal and child health: ANC; intranatal care in terms of promotion of institutional deliveries, skilled attendance at birth; ENC; prompt referral; maternal and child immunisation	Maternal and child health: ANC, including basic laboratory services to screen high-risk pregnancies; 24-hour delivery service—normal and assisted; ENC, including neonatal resuscitation; basic emergency obstetric care and pre-referral management of obstetric and newborn complications; referral and transportation services; routine immunisation	Maternal and child health: 24-hour delivery services, including normal and assisted deliveries; essential and emergency obstetric care, including Cesarean section and management of pregnancy and obstetric complications; blood storage and transfusion facilities; newborn care; routine and emergency care of sick children; routine immunisation; essential laboratory services; and referral and transportation services	Secondary-level care provider: specialist OB-GYN services—full range of obstetric and gynaecological care and treatment; paediatrics, including neonatology; dermatology and venerology, including STI/RTI care; immunisation; and newborn care
Family planning and contraception: counselling and provision of birth spacing, including Copper T IUD insertion; counselling and referral for safe abortion	Family planning and contraception: counselling and provision of birth spacing, including Copper TIUD insertion; performing male and female sterilisation operations; counselling and referral for abortion; and medical termination of pregnancy using manual vacuum aspiration wherever trained personnel and facilities exist	Full range of family planning services, including laparoscopic services; provision of safe abortion services	Full range of family planning services, including laparoscopy; abortions, including mid-trimester abortions
	Management of RTIs/STIs, including counselling and treatment	Management of RTIs/STIs; RNTCP; National HIV/AIDS Control Programme, including basic screening tests for STIs; provision of PPTCT; condom promotion; BCC	Management of RTIs/STIs; VCT; PPTCT; all national health programmes, including RNTCP

ANC: Antenatal care.

BCC: Behaviour change communication.

CHC: Community health centre.

ENC: Essential newborn care.

FRU: First referral unit.

IUD: Intrauterine device.

OB-GYN: Obstetrics-gynaecology.

PPTCT: Prevention of parent-to-child transmission.

RNTCP: Revised National TB Control Programme

RTI: Reproductive tract infection.

STI: Sexually transmitted infection.

VCT: Voluntary counselling and testing.

Annex 2. Current policy regarding integration of HIV and SRH services in India

Current policy environment

The current policy environment on integration of (or “convergence” as it is known in India) and linkages between sexual and reproductive health (SRH) and HIV/AIDS services is favourable and is well-articulated through a range of national policy documents.

The three key health-related programmes that envision convergence at different levels are the second phase of the Reproductive and Child Health Programme (RCH II) of the Government of India, the National Rural Health Mission (NRHM), and the third phase of the National AIDS Control Programme (NACP III).

An NACP-HFW (health and family welfare) convergence committee has been set up within the Department of Health and Family Welfare (DOHFW), Government of India, to oversee the convergence between the NACP and the DOHFW programmes. It is co-chaired by the Secretary of the DOHFW and the Project Director of the National AIDS Control Organisation (NACO). In addition, two joint working groups are envisioned: (a) one on the convergence of services for reproductive tract infections/sexually transmitted infections (RTIs/STIs), voluntary counselling and testing (VCT), and prevention of parent-to-child transmission (PPTCT) into DOHFW infrastructure/services; and (b) the other on training and management information systems, which will be comprised of technical and programme managers from NACO and the DOHFW.

The Ministry of Health and Family Welfare, Government of India, recommends that similar mechanisms also be 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, who would report to the District Medical Officer of Health and the State AIDS Control Society (SACS), and who would ensure coordinated inputs between (a) programmes implemented by NACO/SACS, (b) programmes managed by nongovernmental organisations (NGOs), and (c) interventions managed/funded by the DOHFW. Additionally, the district health committee (a body comprised of district administration, district health officers, NGO representatives, and representatives from local bodies formed under the NRHM) would include a sub-group to review NGO functions and HIV/AIDS and HFW convergence in the major service areas, such as management of RTIs/STIs, VCT, and PPTCT.

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 has also supported the establishment of STI clinics at district hospitals and other hospitals up to the block level. The key components of the RTI/STI programme as envisioned under the NACP III are (a) RTI/STI prevention, (b) client management, (c) partner notification, (d) treatment, and (e) follow-up.

The NACP III also envisions comprehensive RTI/STI treatment available at the community health centre (CHC) and primary health centre (PHC) levels. The proposed structure for delivering RTI/STI treatment would be as follows:

At the frontline (grassroots) level, the auxiliary nurse midwife or the male multipurpose worker would be the service provider for RTI/STI management. At the PHC level, the medical officer, senior nurse, or female health volunteer would be the service provider. At the 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 STIs/RTIs at the district hospital level.

VCT centres

NACP III has envisioned setting up integrated counselling and testing centres that would provide antenatal care (ANC) services, HIV testing/counselling, PPTCT, antiretroviral therapy (ART), family planning, and STI treatment. It is proposed that the current district VCT centre would function as a satellite centre to supervise the operations of VCT centres located at the CHCs and PHCs to (a) maintain and ensure quality of services, (b) ensure uninterrupted

supplies, (c) link with PPTCT centres, and (d) 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 VCT services.

PPTCT

PPTCT services for HIV-positive women under the existing system include: (a) family planning counselling; (b) ANC, postnatal care, delivery, and abortion services; (c) VCT; (d) STI management; (e) ART; (f) information, education, and communication on nutrition, breastfeeding, RTIs/STIs, and HIV/AIDS; (g) male involvement in maternal and child health care; and (h) linkages with community-based care and support programmes for HIV/AIDS. It is now proposed that PPTCT, being a function of the obstetrics department, 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, PPTCT staff would continue to report to the head of obstetrics and gynaecology. At the district level, the PPTCT would be the focal point for the coordination of quality, supplies, reporting, and referral. The NACP would fund the PPTCT counsellor/laboratory technician, as well as meet the costs of necessary supplies.

Condom promotion

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

Information for this annex was obtained from:

- (i) www.mohfw.nic.in, accessed November, 15–20, 2006.
- (ii) Policy document on AIDS. Available at www.naco.nic.in. Accessed on November 20, 2006.
- (iii) Towards a stronger multisectoral response to combat the spread of HIV/AIDS. A study commissioned by UNDP, New Delhi, for the Design Team, NACO (Phase III), New Delhi.

Annex 3. Resource materials developed by PATH for the convergence project

CD-ROM with a compendium of resources on convergence—Global Discussions and Global Evidence, compiled for the first national meeting on convergence: September 16, 2005

Convergence newsletter – 2 issues

- A. Title: SRH-HIV Convergence
Date: April 2006
- B. Title: HIV-SRH Convergence, Policy and Practice Update
Date: March 2007

Convergence literature reviews – 2

- A. Title: SRH-HIV Convergence: A literature Review
Date: March 2006
- B. Title: Convergence of HIV and SRH services in India: Impacts on and Implications for Key Population
Date: February 2007

Convergence fliers - 3

- A. Title: Convergence of HIV and SRH services in India
Date: August 2006
- B. Updated September 2006
- C. Updated January 2007

Convergence posters presented at the International Conference on Linking SRH and HIV/AIDS in Mumbai (February 2007)

- A. Assessing the impact of stigma on positive men and women's access to HIV and SRH services
- B. Identifying barriers to addressing the sexual and reproductive health needs of men and women with HIV

Compilation of relevant training resources for providers—Integrating HIV and SRH Services: A Review of Training Resources for Service Providers (draft 2007)

Presentations - 8

- A. Convergence of Sexual and Reproductive Health and HIV: Developing an Agenda amongst Stakeholders in India. Presented by Jeff O'Malley, National Convergence Meeting, September 2005
- B. Introduction to Converging SRH and HIV Services: State Meeting (Andhra Pradesh, Bihar, Maharashtra, Uttar Pradesh). Presented by the PATH team, March 2006
- C. Convergence of HIV and SRH Services in India: "Time to move ahead." Presented by the PATH team at the Packard Foundation partners meeting, September 2006
- D. Options for Converging SRH and HIV Services: State Meeting (Andhra Pradesh, Bihar, Maharashtra, Uttar Pradesh). Presented by the PATH team, December 2006
- E. Sexual and Reproductive Health Needs and Aspirations of Vulnerable Populations: Plenary Address by Jeff O'Malley, International Conference on Linking SRH and HIV/AIDS, Mumbai (February 2007)
- F. Engaging Multiple Stakeholders in the Management of a Linked Response: Symposium Presentation by A. Saha, International Conference on Linking SRH and HIV/AIDS, Mumbai (February 2007)
- G. Identifying HIV and SRH convergence options for prevention of unintended pregnancy amongst women with HIV: Oral presentation by Tilly Sellers, International Conference on Linking SRH and HIV/AIDS, Mumbai (February 2007)
- H. Options and Challenges for Converging SRH and HIV services. Presented by A. Saha, National Dissemination Meeting on Convergence Research, New Delhi (April 2007)

Annex 4. Background information on assessment districts

Selecting assessment districts

The assessment districts were selected after analysis that looked at (i) reproductive and child health and HIV data, (ii) the availability of health infrastructure, and (iii) the feasibility of conducting the study in the area and the presence of populations at risk.

To identify the districts, the following steps were undertaken.

Step 1: Identification and application of criteria for selecting districts

As the project entailed examining access to sexual and reproductive health and HIV services to reduce HIV and unintended pregnancies, key indicators for service delivery systems were taken into account. Secondary data to identify these districts were accessed from three sources: National Family Health Survey 2 (NFHS-2, 1998–1999); National AIDS Control Organisation sentinel surveillance (2004), and the Reproductive and Child Health (RCH) Facility Survey (2003). The indicators for service delivery that were selected for this study were:

1. Proportion of married women younger than 18 years (NFHS-2).
2. Knowledge of all family planning methods (NFHS-2).
3. Unmet need (to assess effectiveness of family planning programmes) (NFHS-2).
4. Percentage of women receiving antenatal care (ANC) (NFHS-2).
5. Percentage of women receiving full ANC (NFHS-2).
6. Percentage of women who had institutional deliveries (also acting as proxy indicator for availability of health infrastructure, hospitals, etc.) (NFHS-2).
7. Percentage of women who had safe deliveries (proxy for health infrastructure) (NFHS-2).
8. Full vaccination (proxy for health infrastructure) (NFHS-2).
9. Awareness of AIDS amongst women (NFHS-2).

10. Awareness of reproductive tract infections (RTIs) amongst men (NFHS-2).

11. Rural women visited by auxiliary nurse midwives (ANMs) (NFHS-2).

District-level composite indices ranked in the RCH survey were considered for short-listing the districts. These composite indices were constructed using the 11 indicators listed above. Districts that portrayed close proximity in terms of the composite indices were felt to be most appropriate even after weighing for other factors.

Step 2: Examination of health infrastructure in the state/district

Most RCH services are delivered through government health structures. Similarly, apart from nongovernmental organisations providing targeted interventions, specific HIV testing, treatment, and care services are also delivered through government health structures. These state/district government health structures (district hospitals, community health centres, primary health centres, and sub-centres) were examined in the RCH facility survey of 2003. It was found that Bihar and Uttar Pradesh have relatively poor health infrastructures as compared with Andhra Pradesh and Maharashtra, except in the state capitals of Lucknow and Patna.

Step 3: Feasibility and logistics

The feasibility of conducting the assessment in terms of leveraging support and resources was considered for selecting the study states and districts. Patna, Lucknow, Srikakulam, and Nashik were finalised based on criteria such as presence of populations at risk of HIV and unintended pregnancy as evidenced by the number of targeted interventions in the district.

Data from the assessment districts

The information for this annex has been sourced from the Census of India 2001, Reproductive and Child Health Rapid Household Survey II 2002–2003 (RCH-RHS II 2002–2003), the National AIDS Control Organisation 2006 (NACO 2006), and the Reproductive and Child Health District-Level Household Survey 2002–2004 and Facility Survey 2003 (RCH-DLHS 2002–2004 and Facility Survey 2003).

Demography

Table 1. Selected geographic and demographic indicators of the four assessment districts.

Indicator	Lucknow	Nashik	Patna	Srikakulam
Area (square km)	2,528	15,539	3,202	5,837
Tehsils (subdivisions)	4	4	6	3
Blocks (mandals in Srikakulam)	8	15	23	38
Number of towns	10	18	19	7
Number of villages	823	1,370	8,805	1,774
Population (000,000)	36	49	47	25
% urban population	63.60	61.20	41.60	10.98
% males	52.97	51.88	53.4	49.65

Source: RCH-RHS II 2002–2003.

Table 2. Sex ratio and female literacy in the four assessment districts.

	Lucknow	Nashik	Patna	Srikakulam
Sex ratio (women per 1,000 men)	888	924	873	1,014
% literate women, rural	40.75	56.35	38.04	41.56
% literate women, urban	72.00	70.60	70.91	65.08

Source: Census of India 2001.

Srikakulam is the only assessment district to have a positive sex ratio (1,014 women to 1,000 men), whilst all other districts have a negative sex ratio. Both Patna (873 women/1,000 men) and Lucknow (888 women/1,000 men) have very low sex ratios. Rural literacy is also lowest in these two districts.

Family planning, contraception, pregnancy-delivery, RTI/sexually transmitted infection (STI), and HIV/AIDS

Table 3. Contraceptive knowledge and use and proportion of unmet need for contraception in the four assessment districts.

	Lucknow	Nashik	Patna	Srikakulam
Proportion of women aware of all modern methods of contraception	81.6	58.7	68.5	11.1
Proportion of couples using any contraceptive method	42.5	58.2	36.8	64.3
Proportion of couples using any modern contraceptive methods	32.3	56.8	33.9	64.1
Proportion of unmet need	30.1	9.2	34.0	9.9

Sources: International Institute of Population Sciences (Mumbai, India). RCH-DLHS 2002–2004 and Facility Survey 2003, accessed at: http://www.rchindia.org/dlhs_india/apdx2.pdf.

Use of modern contraception by couples was relatively higher in Nashik (56.8%) and Srikakulam (64.1%) in contrast to Lucknow (32.2%) and Patna (33.9%). Similarly, the proportion of unmet need for contraception was high in Lucknow (30.1%) and Patna (34.0%) in contrast to the other two districts. The lower proportions of contraceptive use and higher proportions of unmet need in Lucknow and Patna point to inadequate reach of public health service delivery in these two states.

Table 4. Proportion of women with ANC, institutional deliveries, and deliveries attended by skilled personnel in the four assessment districts.

	Lucknow	Nashik	Patna	Srikakulam
Proportion of women receiving at least three visits during ANC	46.5	50.9	31.0	90.8
Proportion of women receiving full ANC	11.6	15.8	12.8	57.9
Proportion of women with institutional deliveries	42.0	47.2	45.3	31.3
Proportion of women with deliveries attended by skilled personnel	48.8	49.5	47.8	52.7

Source: RCH-DLHS 2002–2004 and Facility Survey 2003.

With the exception of Srikakulam, the proportions of pregnant women receiving full ANC were uniformly low in the four districts. Less than half of pregnant women had had institutional deliveries. Similarly, only around half of the home births were attended by skilled personnel. This highlights that there are large gaps between policy and practice with respect to the delivery of basic reproductive health services to women who need them.

Table 5. Distribution of institutional deliveries as per health facilities in the four assessment districts.

	Lucknow	Nashik	Patna	Srikakulam
Proportion delivered in government facilities	16.0	20.0	11.0	15.0
Proportion delivered in private (for-profit) facilities	26.0	27.2	34.3	16.3
Total proportion of institutional deliveries in each district	42.0	47.2	45.3	31.3

Source: RCH-DLHS 2002–2004 and Facility Survey 2003.

When we look at where institutional deliveries took place, we find proportions of deliveries in government facilities uniformly low for all the assessment districts, the highest proportion being in Nashik, where barely a fifth of the deliveries take place in government institutions. The lower proportions of full ANC and institutional deliveries, particularly in government facilities, highlights the gaps between stated government policy and practice with regard to delivering key RCH services to women. That there are gaps in the service delivery are further underscored when we take into consideration reproductive morbidities related to pregnancy, childbirth, and the postpartum period that have been reported by women. These reproductive morbidities (as the table below highlights) trended similarly in the four assessment districts, with a very high proportion of delivery-related complications in Patna.

Table 6. Morbidities experienced by women during pregnancy, childbirth, and postpartum period in the four assessment districts.

Proportion of women who in last pregnancy experienced:	Lucknow	Nashik	Patna	Srikakulam
Pregnancy-related complications	39.5	44.6	38.6	20.3
Delivery complications	27.4	54.8	64.7	30.1
Post-delivery complications	42.2	37.5	40.6	23.0

Source: RCH-RHS II 2002–2003.

RTI/STI symptoms were also similar for men and women in the four assessment districts, with women in all districts except Srikakulam showing higher proportions of symptoms. However, in Srikakulam, proportionately more men complained of RTI/STI symptoms.

Table 7. Prevalence of symptoms of RTIs/STIs in the four assessment districts.

	Lucknow	Nashik	Patna	Srikakulam
% of women with any RTI/STI symptom	11.6	15.8	16.3	6
% of husbands with any RTI/STI symptom	7.7	5.9	7.2	12

Source: RCH-RHS II 2002–2003.

However, usage of government facilities for RTI/STI treatment was uniformly low for all four assessment districts, highlighting another gap between policy and practice.

Table 8. Proportion of respondents who used government facilities for treatment of RTIs/STIs.

	Lucknow	Nashik	Patna	Srikakulam
% of respondents using government facilities for treatment of RTIs/STIs	29.0	25.0	4.0	23.0

Source: RCH-RHS II 2002–2003.

Awareness of RTIs/STIs and of HIV/AIDS was similar in the four assessment districts, with men showing more awareness of HIV/AIDS but uniformly lower awareness of RTIs/STIs than women.

Table 9. Awareness of RTIs/STIs and HIV/AIDS.

	Lucknow	Nashik	Patna	Srikakulam
% of eligible women aware of RTIs/STIs	32.9	29.7	96	19
% of husbands aware of RTIs/STIs	45.4	18.8	59.1	27.8
% of eligible women aware of HIV/AIDS	57.4	55	47.5	68.8
% of husbands aware of HIV/AIDS	77.5	72.6	74.2	84.1

Source: RCH-RHS II 2002–2003.

In 2005–2006, the number of persons attending voluntary counselling and testing (VCT) centres in the four assessment districts varied widely, with high attendance in Patna and Srikakulam and the lowest attendance in Lucknow. However, the proportion of those sero-positive for HIV amongst the VCT attendees was higher in Lucknow and Srikakulam and lowest in Patna.

Table 10. Persons attending VCT centres in the four assessment districts.

	Nashik	Lucknow	Patna	Srikakulam
Number of persons tested	16,946	11,136	39,823	35,792
Number who were sero-positive	1,195	1,371	945	3,646
Percentage who were sero-positive	7.05	12.31	2.37	10.18

Source: NACO 2006.

Annex 5. Terms of reference for local advisory groups

1. The state/district local advisory groups will guide and support the PATH convergence research with background information and local knowledge, particularly with respect to:
 - a. Developing a broad map of each block to show the research investigators exactly where different types of sex workers and vulnerable young people are located and how best to access them without causing disruption to their lives. They will also show where groups of positive people meet on a regular basis.
 - b. Providing the status of health services in each district—delivery, accessibility, and utilisation.
 - c. Putting the research investigators, through word of mouth, in contact with key population members.
 - d. Negotiating, when necessary, access to the key population groups by interacting with the gatekeepers.
2. The local advisory groups will guide the PATH convergence assessment team by:
 - a. Providing input into selection of places for participatory mapping exercises.
 - b. Introducing Research Pacific International researchers to service providers or their supervisors in health care facilities selected for providers' semi-structured interviews. (Final selection of providers for the semi-structured interviews will not be done by the advisory groups but by the PATH research team, based on inputs generated through the participatory mapping process.)
3. The local advisory groups will review the research instruments, including the informed consent process and documentation, and ensure that they are applied in the field as per guidelines. In particular, they will help ensure that:
 - a. The participation of key population groups is informed, confidential, and truly voluntary.
 - b. The participants' anonymity is maintained in all instances and that they are neither victimised nor stigmatised.
 - c. The rights of the participants are safeguarded at all times.
4. The local advisory groups will provide support in identifying and helping resolve problems that may be encountered by the researchers during field work.
5. The local advisory groups will participate and provide process feedback during PATH convergence meetings and during analysis and dissemination.
6. Inputs from the local advisory groups throughout the research period will be incorporated into the final convergence research report, with due acknowledgement to the members.
7. The local advisory groups will meet at least three times from inception to final stage of the project and may meet more times if necessary and by mutual agreement between all the members.
8. The first meeting of the local advisory groups from the four states will address the following agenda:
 - a. Finalisation of the participants for each advisory group.
 - b. Agreement on and finalisation of the terms of reference.
 - c. Appointment of a chair for the group.
 - d. Development of a work plan and meeting schedule for each state/district.
 - e. Sharing and discussion of the research instruments and the informed consent process.
 - f. Determination of communication techniques to be used between the groups and with PATH.
 - g. Development of broad, block-level maps, identifying areas with vulnerable populations (e.g., brothel-based, home-based, and flying sex workers; migrant and tribal populations; networks of people with HIV) and identifying major health care service points in the public, private, and nongovernmental sectors.

Proposed composition of the local advisory groups

1. Each district will have one local advisory group (i.e., there will be one group each for Srikakulam [Andhra Pradesh], Patna [Bihar], Nashik [Maharashtra], and Lucknow [Uttar Pradesh]).
2. Each group will have a minimum of six members, as follows:
 - a. Two government (state/district) representatives—preferably one representative from the state AIDS control society/district tuberculosis or leprosy office and another from the Department of Health and Family Welfare or the reproductive and child health programme.
 - b. Two representatives from nongovernmental organisations, preferably one from a civil society organisation. Both representatives for each group should be from organisations located in the assessment district (i.e., two each from Lucknow, Nashik, Patna, and Srikakulam).
 - c. Two representatives from community/community-based organisations—one of whom should be a person with HIV and the other a female sex worker.
3. Members of the local advisory groups will be compensated for local travel, hospitality, and communication costs (telephone/fax/Internet) and will also be paid a small honorarium at PATH India's standard rate for comparable work.

Role of the PATH convergence team

The role of the PATH convergence project team in the local advisory groups will be to:

1. Facilitate the establishment and operations of the advisory groups in the four states.
2. Provide logistical and documentation support for appropriate functioning of the local advisory groups.
3. Respond to suggestions/interventions from the advisory groups when necessary.

Annex 6. Participatory mapping guidelines

CODE NUMBER: _____

Date of activity: _____

Name of block: _____

Name of district: _____

Composition of key population group: *Female sex workers* *People living with HIV* *Young people*

Number of participants in the group: _____

Was verbal informed consent administered? _____ YES _____ NO _____

Name of team leader: _____

Address of exercise venue: _____

Instructions for body mapping

1. Begin with an ice-breaker to relax participants and to introduce each other.
2. Explain body mapping and its objectives to the participants.
3. With chart paper and markers, ask participants to draw life-size outlines of a woman and a man.
4. Ask participants to discuss amongst themselves and mark on the body maps common conditions and illnesses that affect men and women (e.g., menstruation, pregnancy, childbirth, breastfeeding).
5. Ask them to highlight/list the conditions/illnesses that are related to sexual and reproductive health on the body map and on additional chart paper.
6. Ask the group to discuss what people like them usually do when they face/suffer each of the conditions/illnesses highlighted/listed, and list services (and providers) people like them might use for these conditions/illnesses.
7. Identify illnesses/conditions for which the participants think people like them usually do not seek any health care and ask them to discuss what people do for each of these. Assist them in recording on chart paper.
8. Document the discussion, and after the mapping has been completed, remove the chart papers after participants agree that they have nothing more to add.
9. Collect all maps and charts from this exercise, thank participants, and move on to the service mapping exercise.

Instructions for participatory service mapping

1. Settle participants with an energizer and explain to them the objectives of the exercise.
2. Proceeding from the discussion during body mapping, ask participants to draw a map of their village/community/site, including major landmarks and roads, and ask them to mark the service points that they identified during body mapping and to add all other health care service points they know of.
3. Ask participants to mark services people like them use most regularly, sometimes, and never, using three dots, two dots, and one dot respectively.
4. Ask participants to mark services people like them use most regularly, sometimes, and never, using three dots, two dots, and one dot respectively.
5. Discuss why each service point is used/not used and note responses.
6. Ask participants to discuss the barriers people experience in accessing services.

7. Ask participants to identify gaps in service provision and to suggest ways these gaps could be addressed. Probe about how referrals, communications, and service provision could be converged to achieve this.
8. Cross-check with the body map and ensure that all issues relating to illnesses/conditions and care-seeking have been probed for and addressed by the participants.
9. Document the responses and discussion, and after the mapping has been completed, remove the chart papers after participants agree that they have nothing more to add.
10. Collect all the charts and maps and thank participants for their time and close the session.

Tasks for the team after completion of the participatory service mapping session

1. Collate all maps, charts, and discussion notes and attach them to the reporting format.
2. Ensure that the verbal consent log for the session has been completed.
3. Complete the following check list after each session:

Item/Material	Check-box
1. Completed verbal consent log	
2. Original charts from body mapping exercise	
3. Notes from body mapping exercise	
4. Original service map and associated charts	
5. Notes from service map discussion	
6. Completed reporting format for participatory exercise	

Annex 7. Guidelines for semi-structured interviews with service providers and policymakers

Date and time of interview:

Name of person being interviewed:

Designation and posting location:

Interviewee is (circle): State-level District-level Block-level

Interviewee is (circle): Government staff NGO/CBO* staff Other

Interviewee is (circle): Service provider Policymaker Donor

Place of interview (full address):

Written informed consent was explained and administered (circle): YES NO

Interviewer 1:

Name of interviewers (two-member team):

Interviewer 2:

* *NGO: Nongovernmental organisation.*
CBO: Community-based organisation.

Time: 60 minutes

Interview steps:

1. Greet the interviewee.
2. Introduce yourselves and explain the purpose of the interview.
3. Explain the issues that will be discussed—sexual and reproductive health (SRH) services, HIV services, existing service delivery, gaps in service delivery, opportunities for and challenges of convergence of SRH and HIV services, and barriers to convergence.
4. Explain that all information collected will be used for research purposes only and assure the interviewee that information given will not be linked back to her/him.
5. Obtain signed, informed consent using the pre-designed format.
6. Begin the interview using the following guidelines to elicit responses, with one team member framing and asking questions and the other team member taking notes regarding responses, including changes in body language.
7. At the end of the interview, review responses briefly with the interviewee, make changes to responses as requested by the interviewee, thank the interviewee, and close session.

Guidelines for conducting a semi-structured interview:

Probe the interviewee’s opinions on and perceptions of the service needs of the different key populations (female sex workers; positive people; and young, sexually active men and women).

Probe the interviewee’s perceptions of available SRH and HIV services with respect to the kinds of services available, provision of information on related services, adequacy of materials and facilities, training adequacy/inadequacy/needs, referrals and links to other services, and gaps in service provision.

Probe the interviewee’s attitude toward delivering expanded and converged services to key populations. (Specifically, probe the provider’s own attitude and opinions regarding likes and dislike relative to different types of services [voluntary counselling and testing, sexually transmitted infection clinics, contraceptive services, and abortion services, and the clients who access these services].)

Probe the interviewee’s responses and comments on service gaps identified by the key population groups during participatory mapping exercises (whether s/he agrees/disagrees, gives reasons for the gaps).

Probe the interviewee’s perceptions of the opportunities for and challenges to implementing convergence at the different levels (block, district, and state).

Probe the interviewee’s hopes and fears (personal and/or relative to the service) with respect to increased work load, multitasking, loss of territory, and changes in hierarchies with respect to converging SRH and HIV services.

Probe the interviewee’s perceptions and ideas about possible areas where there are opportunities for convergence of services (cross-reference with gaps and solutions that emerged from the community-based participatory mapping exercises).

Interviewer 1 signature and date:

Interviewer 2 signature and date:

Annex 8. Consent form

This process is designed to protect the rights and interests of the people who participate in the assessment of the PATH convergence project.

There are three parts to this form. The first part explains what is meant by informed consent. The second part explains the research and PATH's convergence project. The third part is where the names of people who agree to volunteer for the assessment are recorded. The **verbal consent log** records **only the given names of the participants and the dates and places of the mapping exercises in which they agreed to take part.**

Part I: Explanation of informed consent

1.1 We are asking you to be a participant in a participatory mapping exercise to analyse sexual and reproductive health services (SRH) and HIV services in your area. If you agree to participate of your own free will, we will record your agreement in the format that is attached at the end of this form. Informed consent for the participatory mapping exercise is an agreement that will show your willingness to participate in the PATH convergence project's participatory mapping process. This document will tell you about the purpose, risks, and benefits of participating in this project. You may agree to consent only after you have been given all the necessary information, have understood fully what you have been told, and have had enough time to decide whether you wish to participate or not. Your agreement to be a participant is voluntary or of your own free will and does not affect any of your legal rights or make any institutions or persons involved in this activity any less responsible for your well-being.

Part II: Explanation of being a participant in participatory mapping of SRH/HIV services within the context of the PATH convergence project

2.1 Why have I been asked to be a participant?

You are a representative of one of the key population groups we need to work with to identify the barriers to, challenges of, and possibilities for convergence of SRH services and HIV services. We are, therefore, asking you to agree to volunteer to be a participant in the mapping exercise. Your responses will be used solely to develop a community representatives' viewpoint of the opportunities for, challenges of, and barriers to developing a successful model for convergence of SRH and HIV services in your district and state.

2.2 What is involved in the participatory mapping process?

We, researchers from PATH, will request that you and your group of key population representatives first draw male and female body maps to identify different SRH and HIV service needs people have. We will then request that you develop a service map that identifies all the SRH/HIV service points people know of. We will further request that the group in which you are involved analyse SRH and HIV service provision in your area and discuss how it might be improved. We will try to avoid interfering with your normal and official work when we organise the participatory mapping exercise. The exercises will be conducted by people trained to conduct them at a place of your choice and at a time when you are able. The mapping process will take about one and a half to two hours.

2.3 Who will have access to these charts, maps, and/or notes?

The information gathered from this and similar mapping exercises will be put together to develop a report. The names and addresses of the participants will not appear in any public document and/or report. The maps, charts, and notes from the groups' exercises will be collected at the end of each mapping exercise and kept under lock and key with PATH, and no one except PATH convergence project staff will be able to see or use them.

2.4 How long will PATH preserve these charts and maps?

The charts, maps, consent logs, and notes from this (and other) participatory mapping exercises will be preserved indefinitely but **confidentially** by PATH, as mentioned earlier. However, even after the mapping exercise is complete, you have the right to revoke or withdraw your agreement to participate, and we will make a note in the consent log that you have done so.

2.5 What risks will I be subject to by being interviewed for this project?

As you will be working in a group for the participatory mapping exercise, it may not be possible to conceal your identity as a participant. Because the assessment is about generating information that will improve services for people at risk of HIV and unintended pregnancy, people known or unknown to you may formulate opinions of you or your behaviour on the basis of your participation in this exercise. We have, however, three safeguards against this:

1. We will not record your name or other personal identifiers during this interview on any document or charts that link you directly as a participant. The consent logs will not carry your address, just your given name and the date and place of the mapping exercise.
2. All original maps, charts, notes, and consent logs will be preserved under lock and key, and no one except PATH convergence project researchers will be able to either see or use them.
3. A summary that does not name any participant will be shared with policymakers and service providers, for verification at the end of the assessment.

2.6 Are there benefits to taking part in this assessment?

There are no direct benefits to you personally for participating in this activity. You will receive no payment or other nonmonetary benefit for participating in this interview. The primary benefit of your participation in the mapping exercise will be the opportunity to help enable the betterment of services for people at risk of HIV and unintended pregnancy.

2.7 What other options are there?

You can choose not to participate in the participatory mapping exercise.

2.8 What are the financial costs?

There are no financial costs to you for agreeing to participate in the mapping exercise for the PATH convergence project.

2.9 What are my rights as an interviewee?

Taking part in this assessment as a participant is voluntary. You may choose not to take part or to subsequently stop participation at any time. Withdrawing from this activity will not result in any penalty or loss of benefits to which you are entitled.

Part III: Informed consent approval

3.1 This form is designed for approval by adult participants (people more than 18 years of age).

3.2 I have listened carefully and understand in full the above explanations, and I agree to participate in the participatory mapping exercise facilitated by the PATH convergence project. I understand that no personal questions will be asked of me during the exercise. I have come to this decision of my own free will, and I am satisfied that the benefits from agreeing to participate outweigh any potential risks. If, however, at any time, I wish to terminate my participation, I have the right to do so without penalty, even after the exercise has been completed. I also have the right to review the charts, maps, notes, and other paperwork from the group work in which I participated, and I can request that specific comments be removed, if they contain material to which I might object.

3.3 If I have any questions about this participatory mapping process, I realise that I am encouraged to ask them now or at any time in the future by contacting:

Tilly Sellers, Director HIV-SRH, India
Madhavi Panda, Senior Program Manager, Convergence Project, PATH
A-9, Qutab Institutional Area
New Delhi 110 067, India
Phone: 91-11-26530080 to 88
Fax: 91-11-26530089
Email: tilly@pathindia.org
madhavi@pathindia.org

3.4 I understand that by verbally and voluntarily consenting to participate in this mapping exercise, I give the PATH convergence project permission to present this work without further permission from me.

Or:

3.4 I understand that in signing this consent form, I give the PATH convergence project permission to present this work without further permission from me.

Signed _____ Dated _____

Annex 9. Suggested convergence options

The table below shows the different convergence options suggested by sex workers, positive people, and young men and women during participatory mapping. The details regarding the facilities have been removed to maintain anonymity of service providers subsequently interviewed.

Sex workers			
Patna	Srikakulam	Nashik	Lucknow
Abortion facilities in the PHC	Complete information and referral on HIV/STI and ART at CHCs, provision of STI treatment	Abortion and family planning services, counselling and referral for HIV prevention and treatment for sex workers	ANC, delivery, and family planning services for sex workers
Abortion, family planning methods, condom access, and STI treatment	Counselling for pregnant women, care for mother and child, and abortion services	Abortion services and STI treatment for sex workers	Counselling on family planning services and provision of family planning operations for sex workers
Delivery and abortion facilities from the PHC	Family planning advice and safe abortion services at NGO centre	Counselling and treatment for STIs and referral for HIV testing	Counselling on safe abortion and family planning for sex workers
Family planning, abortion, and STD treatment from the PHC	Provision of family planning services and STI treatment	HIV/STI management for sex workers	Family planning and safe abortion services for sex workers
Information on STIs and provision of STI services	Provision of IEC materials and awareness on safe delivery, abortion, STI care	STI counselling and treatment for sex workers and adolescent males/females	Increased access to STI management and HIV counselling and testing
Information, counselling, and referral for HIV testing and counselling	Provision of STI treatment, and counselling and testing for HIV	Provision of safe abortion/ Copper-T IUD/family planning operation for sex workers and people with HIV without any discrimination	Referral of pregnant positive women for abortion and delivery services
Referral from PHC to medical college hospitals for HIV counselling, testing, and treatment	Referrals to government facilities for CD4 test and ART	Referral for STI/HIV counselling, testing, prevention, and treatment services for sex workers	Safe abortion and delivery services for sex workers
STI counselling and treatment at the PHC	Safe abortion and referral for HIV testing at district hospital	Referral for STI/HIV counselling, testing, prevention, and treatment for sex workers	STI/HIV counselling and testing for sex workers
STI treatment and counselling and condom distribution	Low-cost care for STI and reproductive health-related problems at privately run health facilities	STI counselling, treatment, and referral for counselling and testing for HIV to district hospital for female sex workers and people with HIV	Training of doctors and supporting staff in providing treatment to female sex workers and people with HIV
	STI treatment; VCT, and referral for ART		

ANC: Antenatal care.

ART: Antiretroviral therapy.

CHC: Community health centre.

IEC: Information, education, and communication.

IUD: Intrauterine device.

NGO: Nongovernmental organisation.

PHC: Primary health centre.

STD: Sexually transmitted disease.

STI: Sexually transmitted infection.

VCT: Voluntary counselling and testing.

Positive people			
Patna	Srikakulam	Nashik	Lucknow
Anganwadi workers can provide nutrition and information to people with HIV	ART provision and referral for care and support	Abortion and family planning services, including condoms, awareness and information on STI for people with HIV	Counselling for positive people on safer sex, along with IEC materials and referral from ART centre to care and support centre
Awareness and testing for STIs and condom distribution	Counselling for pregnant women, care for mother and child, and abortion services for sex workers and people with HIV	ARV provision in government hospital/civil hospital/NGO	Nutrition services for HIV-positive women
CD4 counts and ART to be provided from VCT centres	PPTCT and VCT services for STD clinic attendees	Diagnosis and treatment and community mobilisation activities for people with HIV	Referral for HIV and management of opportunistic infections
CD4 count services and ART to be provided in hospital care centre	Provision of ART services	Counselling and provision of PPTCT for HIV-positive pregnant women	Referral for HIV/TB management for people with HIV
Information and referral to PPTCT centre for HIV-positive women		Safe delivery for HIV-positive pregnant women	Referral for TB treatment to TB DOTS centre
Prevention of PPTCT of HIV-positive pregnant women		Provision of safe abortion/Copper-T IUD/family planning operation for sex workers and people with HIV (all categories of people without any discrimination)	Referral to ART centre from TB hospital for positive people with TB
Provision of ART and CD4 count facilities in VCT centre		Referral or provision of PPTCT for HIV-positive pregnant women	Training of doctors and support staff in providing treatment to female sex workers and people with HIV
Provision of ART for people with HIV		STI counselling, treatment, and referral for counselling and testing for HIV to district hospital for young men and women, female sex workers, and people with HIV	Training of doctors in HIV/STI management
Provision of services for PPTCT		STI counselling, treatment, and referral to VCT	
Referral for TB DOTS, other opportunistic infections to be done through Anganwadi centres			

ARV: Antiretroviral.

DOTS: Directly observed (TB) treatment short course.

PPTCT: Prevention of parent-to-child transmission.

TB: Tuberculosis.

Young men and women			
Patna	Srikakulam	Nashik	Lucknow
Delivery and abortion facilities for sex workers from PHC	Awareness and information on STI with information on referral sites, and condom demonstration at Anganwadi centre	Abortion referrals and complete information about STI/HIV services at PHC for sex workers	Counselling and treatment of STDs and HIV management
Information on HIV and appropriate referrals to services from private facilities	Complete information and referral on HIV/STIs and ART at CHC, provision of STI treatment facilities	Awareness and counselling on STIs and HIV for adolescents	Information on HIV/STIs and unintended pregnancy for young men and women
Information on STIs and provision of STI services for sex workers	Counselling and testing for STIs and HIV for male and female adolescents	Awareness, counselling, and treatment for STIs, referral for HIV testing for male and female adolescents	Referral for HIV/STIs to district hospital
Information, counselling, and referral for HIV testing and counselling	Information and counselling on safer sex, STIs, and HIV for male and female adolescents	Counselling and treatment for STIs and referral for HIV testing	Referral for young men and women for STI/HIV counselling, testing, prevention, and treatment services
Provision of PPTCT services for pregnant women	Provision of STI treatment, counselling, and testing for HIV	Training of doctors/nurses/support staff in STI treatment and in counselling for HIV so that they can provide services without discrimination to all who need them	STI/HIV management facilities for young men and young women (VCT, prevention, treatment)
Referrals to PMCs for VCT for adolescents	STI management services and referrals for HIV testing and PPTCT	STI counselling and treatment for sex workers and adolescent males/females	STI/HIV testing facility
	STI treatment, VCT, and referral for ART for sex workers, male and female adolescents	Provision of STI treatment and condoms for male and female adolescents	Training of doctors and support staff in STI and HIV management and counselling
		STI counselling, treatment, and referral for counselling and testing for HIV to district hospital for young men and women, female sex workers, and people with HIV	Unintended pregnancy, contraceptive, and STI information for male and female adolescents

References

- ¹ Bastos dos Santos R. Reproductive Tract Infections in Mozambique: A Case Study of Integrated Services. In Gemain A, ed. *Reproductive Tract Infections*. New York: Plenum Press; 1992.
- ² Finger WR and Barnet B. Regional Perspectives. *Network*. 1994;14(4):22–25.
- ³ Lande R. Sexual and Reproductive Health: What are the Possibilities? *Planned Parenthood Challenges*. 1993;2:19021.
- ⁴ Gates Institute. Summary of the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia. Available at: www.jhsph.edu/gatesinstitute/CR/family_planning-HIV.
- ⁵ World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Programme on HIV/AIDS (UNAIDS), International Planned Parenthood Federation. Sexual and Reproductive Health and HIV/AIDS: A Framework for Priority Linkages. 2005. Available at: <http://www.who.int/reproductive-health/stis/linking.html> [accessed on February 25, 2006].
- ⁶ Mphuru L, Barone M, Perchal P, Lusiola G. Integration of Voluntary Counseling and Testing for HIV into Family Planning and Reproductive and Child Health Services in Tanzania. Paper presented at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ⁷ Homan R, Mullick S, Nduna M, and Khoza D. Cost of introducing two different models of integrating VCT for HIV within family planning clinics in South Africa. Presentation at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ⁸ Perchal P, Collins L, Assefa B, Babenko O. Cost-effectiveness of integrating HIV prevention in maternal health programmes in Ethiopia and the Ukraine. Presentation at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ⁹ Ross D, Bruce D, Ferguson J. Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. UNAIDS interagency task team on HIV and young people. WHO Technical Report Series, No. 938; 2006.
- ¹⁰ Mullick S, Askew I, Maluka T, Khoza D, Menziwa M. Integrating counseling and testing into family planning services: what happens to the existing quality of family planning when HIV services are integrated in South Africa? Presentation at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ¹¹ Janowitz B, Johnson L, Thompson A, et al. Excess capacity and the cost of adding services at family planning clinics in Zimbabwe. *International Family Planning Perspectives*. October 9–10, 2006;28(2):58–66.
- ¹² de Koning K, Hawkes S, Hilber A, et al. Integrating Sexual Health Interventions into Reproductive Health Services: Programme Experience from Developing Countries (draft). Geneva: WHO; 2005.
- ¹³ Maharaj P, Cleland J. Active versus responsive integration of sexual and reproductive health services in KwaZulu-Natal, South Africa. Presentation at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ¹⁴ Gichuhi W. Provision and Use of Family Planning in the Context of HIV/AIDS in Kenya: Perspectives of Providers, Family Planning and Antenatal Care Clients, and HIV-Positive Women. POLICY Project; 2004.
- ¹⁵ Asare A, Quansah G, Lartey M, et al. Integrating family planning counseling and services into HIV prevention and treatment: Preliminary findings from Ghana. Paper presented at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ¹⁶ Ross D, Bruce D, Ferguson J. Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. UNAIDS interagency task team on HIV and young people. WHO Technical Report Series, No. 938; 2006.
- ¹⁷ EngenderHealth, UNFPA. Sexual and Reproductive Health Needs of Women and Adolescent Girls Living with HIV: Assessment Report on Qualitative Findings from Brazil, Ethiopia and the Ukraine. July 2006.
- ¹⁸ Koskei N, Solomon M, Gitau M, et al. Linking reproductive health and family planning with HIV/AIDS in Kenya. Presentation at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ¹⁹ Steen R, et al. Pursuing scale and quality in STI interventions with sex workers: initial results from Avahan India AIDS Initiative. *Sexually Transmitted Infections*. 2006;82:381–385.
- ²⁰ Gruskin S, Ferguson L, O'Malley J. Ensuring Sexual and Reproductive Health for People Living with HIV: An Overview of Key Human Rights, Policy and Health System Issues. *Reproductive Health Matters*. 2007;15(Supplement 29):4–26.
- ²¹ Ross D, Bruce D, Ferguson J. Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries. UNAIDS interagency task team on HIV and young people. WHO Technical Report Series, No. 938; 2006.

- ²² Mmari KN, Magnani RJ. Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *Journal of Adolescent Health*. 2003;33:259–270.
- ²³ Scheepers E, et al. Evaluating health communication: a holistic overview of the impact of Soul City. *Australian Journal of Health Promotion*. 2004;15:121–133.
- ²⁴ UNAIDS. A scaled-up response to AIDS in Asia and the Pacific. Bangkok: UNAIDS; 2005.
- ²⁵ EngenderHealth, UNFPA. Sexual and Reproductive Health Needs of Women and Adolescent Girls Living with HIV: Assessment Report on Qualitative Findings from Brazil, Ethiopia and the Ukraine. July 2006.
- ²⁶ Adamchak SE, Janowitz B, Amenyah R, Nagai H. Family planning use and unmet need among women art clients in Ghana. Paper presented at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ²⁷ Asnake M and Abera Y. Integrating family planning services in VCT and PMTCT sites: The experience of Pathfinder International—Ethiopia in the Amhara Region. Presentation at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ²⁸ Ngendahimana G, Blyth K. Family planning integration in PMTCT-VCT programs in Rwanda. Presentation at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ²⁹ Rutenberg N, Gillespie D, Flanagan E, Karklins S, Bradley H, Sturke R. HIV Status, Fertility Intentions, and the Demand for Contraception: A Literature Review. Preliminary results presented at the international conference on Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, October 9–10, 2006; UN Conference Center, Addis Ababa, Ethiopia.
- ³⁰ Paiva V, Filipe EV, Santos N, Lima TN, Segurado A. The right to love: the desire for parenthood among men living with HIV. *Reproductive Health Matters*. 2003;11(22):91–100.
- ³¹ Seshu M. Absence of rights for women in prostitution in India—a major obstacle to improving their health. *Assessment for Sex Work*. 2003;6:27–29.
- ³² Khonde N, Kols A. Integrating services within existing Ministry of Health institutions: The experience of Ghana. *Assessment for Sex Work*. 1999;2:16–18.
- ³³ Téqui G. Discrimination of sex workers in health-care settings in France. *Assessment for Sex Work*. 2004;7:16–18.
- ³⁴ Vuylsteke B, Ghys PD, Mah-bi G, et al. Where do sex workers go for health care? A community based assessment in Abidjan, Cote d'Ivoire. *Sexually Transmitted Infections*. 2001;77(5):351–352.
- ³⁵ Delvaux T, Crabbe F, Seng S, Laga M. The need for family planning and safe abortion services among women sex workers seeking STI care in Cambodia. *Reproductive Health Matters*. 2003;11(21):88–95.
- ³⁶ Wolffers I. Appropriate health services for sex workers. *Assessment for Sex Work*. 1999;2:1–3.
- ³⁷ Chapter 2: Epidemiological Situation and Future Projections. In: National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare, Government of India, *National AIDS Control Programme Phase III (2006–2011): Strategy and Implementation Plan*. NACO (a), India; November 30, 2006:8.
- ³⁸ International Institute for Population Sciences, ORC Macro. National family health survey (NFHS-2) 1998–1999. *Demographic and Health Surveys*. Mumbai, India; 2000.
- ³⁹ Center for Enquiry Into Health and Allied Themes and HealthWatch Trust. Abortion Assessment Project; 2004. Available at: www.cehat.org/aap1/keyfindings.htm.
- ⁴⁰ UNAIDS. A scaled-up response to AIDS in Asia and the Pacific. UNAIDS: Bangkok; 2005.
- ⁴¹ Fleischman J. Integrating Reproductive Health and HIV/AIDS Programs: Strategic Opportunities for PEPFAR. Washington, DC: Center for Strategic and International Studies Task Force on HIV/AIDS; 2006.
- ⁴² YouthNet. Use of Maternal and Child Health Services by Adolescents in Developing Countries. *YouthNet Briefs on Reproductive Health and HIV/AIDS*. June 2005; No. 1. Available at: www.fhi.org/youthnet
- ⁴³ International Center for Research on Women, Population Council. Voluntary Counseling and Testing Among Youth Ages 14 to 21: Results from an Exploratory Study in Nairobi, Kenya, and Kampala and Masaka, Uganda. Horizons Program; October 2001.
- ⁴⁴ Chapter 3: Prevention Strategies. In: NACO, Ministry of Health and Family Welfare, Government of India. *National AIDS Control Programme Phase III (2006–2011): Strategy and Implementation Plan*. NACO (b), India; November 30, 2006:8.
- ⁴⁵ NACO, Ministry of Health and Family Welfare, Government of India. FAQs on AIDS. Available at: <http://www.nacoonline.org/faqs.htm> [accessed on June 5, 2007].
- ⁴⁶ Bang RA, Bang AT, Baitule M, Choudhary Y, Sarmukaddam S, Tale O. High Prevalence of Gynaecological Diseases in Rural Indian Women. *The Lancet*. January 14, 1989;1(8629):85–88.

⁴⁷ Government of India. Convergence Between the National AIDS Control Program and the Department of Health and Family Welfare. Available at: www.mohfw.nic.in/Convergence%20plan%20between%20NACP%20and%20DOHFW.htm [accessed January 30, 2007].

⁴⁸ Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Draft guidelines: Indian Public Health Standards for Sub-Centres. March 2006:7–9. Available at: http://www.mohfw.nic.in/NRHM/Documents/IPHS_for_SUBCENTRES.pdf [accessed on June 5, 2007].

⁴⁹ Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Draft guidelines: Indian Public Health Standards for Primary Health Centres. March 2006:8–10. Available at: http://www.mohfw.nic.in/NRHM/Documents/IPHS_for_PHC.pdf [accessed on June 5, 2007].

⁵⁰ Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Draft guidelines: Indian Public Health Standards for Community Health Centres Level. No date:5–7, 24–25. Available at: http://www.mohfw.nic.in/NRHM/Documents/Draft_CHC.pdf [accessed on June 5, 2007].

⁵¹ Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. Draft guidelines: Indian Public Health Standards for 101 to 200 Bedded District Hospitals. January 2007:7–34. Available at: <http://www.mohfw.nic.in/NRHM/Documents/IPHS%20for%20101%20to%20200%20bedded%20with%20Comments%20of%20Sub-group.doc> [accessed on June 5, 2007].

A9, Qutab Institutional Area
New Delhi 110 067, India
Tel: 91-11-26530080 to 88
Fax: 91-11-26530089
www.path.org

