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 places…. ” [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 [cesarean] 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]

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]

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]

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.

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 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]
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.

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<th>Training needs</th>
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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 Utter 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 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]
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]

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 skill-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,
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]

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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. 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.

Whilst accessing assessment participants in the community, group work with positive people and sex workers was sometimes difficult to organize, 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 counseling 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 integrated service, since vertical, but non-identified, 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 RHC II policy 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 PHCs, 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.


PATH (Srilatha Sivalenka)
### Annex 1. Sexual and reproductive health services provided in the public sector in India

<table>
<thead>
<tr>
<th>Sub-centre, per 3,000 to 5,000 population&lt;sup&gt;48&lt;/sup&gt;</th>
<th>Primary health centre, per 20,000 to 30,000 population&lt;sup&gt;49&lt;/sup&gt;</th>
<th>CHC/FRU, per 100,000 to 120,000 population&lt;sup&gt;50&lt;/sup&gt;</th>
<th>District hospital&lt;sup&gt;51&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>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</td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Family planning and contraception: counselling and provision of birth spacing, including Copper T IUD insertion; counselling and referral for safe abortion</td>
<td>Family planning and contraception: counselling and provision of birth spacing, including Copper T IUD 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</td>
<td>Full range of family planning services, including laparoscopic services; provision of safe abortion services</td>
<td>Full range of family planning services, including laparoscopy; abortions, including mid-trimester abortions</td>
</tr>
<tr>
<td>Management of RTIs/STIs, including counselling and treatment</td>
<td>Management of RTIs/STIs; RNTCP; National HIV/AIDS Control Programme, including basic screening tests for STIs; provision of PPTCT; condom promotion; BCC</td>
<td>Management of RTIs/STIs; VCT; PPTCT; all national health programmes, including RNTCP</td>
<td></td>
</tr>
</tbody>
</table>

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.  
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](http://www.mohfw.nic.in), accessed November, 15–20, 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
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).
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 Utter 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**


**Demography**

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Lucknow</th>
<th>Nashik</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex ratio (women per 1,000 men)</td>
<td>888</td>
<td>924</td>
<td>873</td>
<td>1,014</td>
</tr>
<tr>
<td>% literate women, rural</td>
<td>40.75</td>
<td>56.35</td>
<td>38.04</td>
<td>41.56</td>
</tr>
<tr>
<td>% literate women, urban</td>
<td>72.00</td>
<td>70.60</td>
<td>70.91</td>
<td>65.08</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th></th>
<th>Lucknow</th>
<th>Nashik</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of women aware of all modern methods of contraception</td>
<td>81.6</td>
<td>58.7</td>
<td>68.5</td>
<td>11.1</td>
</tr>
<tr>
<td>Proportion of couples using any contraceptive method</td>
<td>42.5</td>
<td>58.2</td>
<td>36.8</td>
<td>64.3</td>
</tr>
<tr>
<td>Proportion of couples using any modern contraceptive methods</td>
<td>32.3</td>
<td>56.8</td>
<td>33.9</td>
<td>64.1</td>
</tr>
<tr>
<td>Proportion of unmet need</td>
<td>30.1</td>
<td>9.2</td>
<td>34.0</td>
<td>9.9</td>
</tr>
</tbody>
</table>


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.

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


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.

<table>
<thead>
<tr>
<th></th>
<th>Lucknow</th>
<th>Nashik</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion delivered in government facilities</td>
<td>16.0</td>
<td>20.0</td>
<td>11.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Proportion delivered in private (for-profit) facilities</td>
<td>26.0</td>
<td>27.2</td>
<td>34.3</td>
<td>16.3</td>
</tr>
<tr>
<td>Total proportion of institutional deliveries in each district</td>
<td>42.0</td>
<td>47.2</td>
<td>45.3</td>
<td>31.3</td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th>Proportion of women who in last pregnancy experienced:</th>
<th>Lucknow</th>
<th>Nashik</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy-related complications</td>
<td>39.5</td>
<td>44.6</td>
<td>38.6</td>
<td>20.3</td>
</tr>
<tr>
<td>Delivery complications</td>
<td>27.4</td>
<td>54.8</td>
<td>64.7</td>
<td>30.1</td>
</tr>
<tr>
<td>Post-delivery complications</td>
<td>42.2</td>
<td>37.5</td>
<td>40.6</td>
<td>23.0</td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th>% of women with any RTI/STI symptom</th>
<th>Lucknow</th>
<th>Nashik</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.6</td>
<td>15.8</td>
<td>16.3</td>
<td>6</td>
</tr>
<tr>
<td>% of husbands with any RTI/STI symptom</td>
<td>7.7</td>
<td>5.9</td>
<td>7.2</td>
<td>12</td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th>% of respondents using government facilities for treatment of RTIs/STIs</th>
<th>Lucknow</th>
<th>Nashik</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29.0</td>
<td>25.0</td>
<td>4.0</td>
<td>23.0</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th></th>
<th>Lucknow</th>
<th>Nashik</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of eligible women aware of RTIs/STIs</td>
<td>32.9</td>
<td>29.7</td>
<td>96</td>
<td>19</td>
</tr>
<tr>
<td>% of husbands aware of RTIs/STIs</td>
<td>45.4</td>
<td>18.8</td>
<td>59.1</td>
<td>27.8</td>
</tr>
<tr>
<td>% of eligible women aware of HIV/AIDS</td>
<td>57.4</td>
<td>55</td>
<td>47.5</td>
<td>68.8</td>
</tr>
<tr>
<td>% of husbands aware of HIV/AIDS</td>
<td>77.5</td>
<td>72.6</td>
<td>74.2</td>
<td>84.1</td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th></th>
<th>Nashik</th>
<th>Lucknow</th>
<th>Patna</th>
<th>Srikakulam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons tested</td>
<td>16,946</td>
<td>11,136</td>
<td>39,823</td>
<td>35,792</td>
</tr>
<tr>
<td>Number who were sero-positive</td>
<td>1,195</td>
<td>1,371</td>
<td>945</td>
<td>3,646</td>
</tr>
<tr>
<td>Percentage who were sero-positive</td>
<td>7.05</td>
<td>12.31</td>
<td>2.37</td>
<td>10.18</td>
</tr>
</tbody>
</table>

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:

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

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

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.
<table>
<thead>
<tr>
<th>Positive people</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patna</strong></td>
</tr>
<tr>
<td>Anganwadi workers can provide nutrition and information to people with HIV</td>
</tr>
<tr>
<td>Awareness and testing for STIs and condom distribution</td>
</tr>
<tr>
<td>CD4 counts and ART to be provided from VCT centres</td>
</tr>
<tr>
<td>CD4 count services and ART to be provided in hospital care centre</td>
</tr>
<tr>
<td>Information and referral to PPTCT centre for HIV-positive women</td>
</tr>
<tr>
<td>Prevention of PPTCT of HIV-positive pregnant women</td>
</tr>
<tr>
<td>Provision of ART and CD4 count facilities in VCT centre</td>
</tr>
<tr>
<td>Provision of ART for people with HIV</td>
</tr>
<tr>
<td>Provision of services for PPTCT</td>
</tr>
<tr>
<td>Referral for TB DOTS, other opportunistic infections to be done through Anganwadi centres</td>
</tr>
</tbody>
</table>

**ARV**: Antiretroviral.
**DOTS**: Directly observed (TB) treatment short course.
**PPTCT**: Prevention of parent-to-child transmission.
**TB**: Tuberculosis.
<table>
<thead>
<tr>
<th>Patna</th>
<th>Srikakulam</th>
<th>Nashik</th>
<th>Lucknow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery and abortion facilities for sex workers from PHC</td>
<td>Awareness and information on STI with information on referral sites, and condom demonstration at Anganwadi centre</td>
<td>Abortion referrals and complete information about STI/HIV services at PHC for sex workers</td>
<td>Counselling and treatment of STDs and HIV management</td>
</tr>
<tr>
<td>Information on HIV and appropriate referrals to services from private facilities</td>
<td>Complete information and referral on HIV/STIs and ART at CHC, provision of STI treatment</td>
<td>Awareness and counselling on STIs and HIV for adolescents</td>
<td>Information on HIV/STIs and unintended pregnancy for young men and women</td>
</tr>
<tr>
<td>Information on STIs and provision of STI services for sex workers</td>
<td>Counselling and testing for STIs and HIV for male and female adolescents</td>
<td>Awareness, counselling, and treatment for STIs, referral for HIV testing for male and female adolescents</td>
<td>Referral for HIV/STIs to district hospital</td>
</tr>
<tr>
<td>Information, counselling, and referral for HIV testing and counselling</td>
<td>Information and counselling on safer sex, STIs, and HIV for male and female adolescents</td>
<td>Counselling and treatment for STIs and referral for HIV testing</td>
<td>Referral for young men and women for STI/HIV counselling, testing, prevention, and treatment services</td>
</tr>
<tr>
<td>Provision of PPTCT services for pregnant women</td>
<td>Provision of STI treatment, counselling, and testing for HIV</td>
<td>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</td>
<td>STI/HIV management facilities for young men and young women (VCT, prevention, treatment)</td>
</tr>
<tr>
<td>Referrals to PMCs for VCT for adolescents</td>
<td>STI management services and referrals for HIV testing and PPTCT</td>
<td>STI counselling and treatment for sex workers and adolescent males/females</td>
<td>STI/HIV testing facility</td>
</tr>
<tr>
<td></td>
<td>STI treatment, VCT, and referral for ART for sex workers, male and female adolescents</td>
<td>Provision of STI treatment and condoms for male and female adolescents</td>
<td>Training of doctors and support staff in STI and HIV management and counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
<td>Unintended pregnancy, contraceptive, and STI information for male and female adolescents</td>
</tr>
</tbody>
</table>
References


40 UNAIDS. A scaled-up response to AIDS in Asia and the Pacific. UNAIDS: Bangkok; 2005.
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


