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

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

June 2007

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

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Cover photo: Siri Wood

Acknowledgments

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

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

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

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

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

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

We would also like to acknowledge the contributions of the local advisory groups:

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

Patna
Dr. Geetanjali Kumari (former Assistant Project Director, Bihar State AIDS Control Society, now Regional Coordinator, East, National AIDS Control Organisation); Sanjay Kumar Sinha (Assistant Director – Condom promotion, Bihar State AIDS Control Society); Dr. C. B. Singh (Civil Surgeon cum Chief Medical Officer of Health); S.Pankaj (Organisation for Socio-Economic and Rural Development); Ram Kishore Prasad Singh and Anju (Gramin Evam Nagar Vikas Parishad); Pawan Kumar; Pinky; Manju; (Suryodaya Sarvagirn Vikas Parishad); Christopher Bachman (YMCA, Bihar); Rajneesh Singh (President, The Bihar Network For People Living With HIV/AIDS).

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

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

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

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

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

Acronyms

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

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

PATH

Executive Summary

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

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

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

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

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

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

Summary of findings from participatory mapping

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

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

Summary of findings from interviews with service providers

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

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

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

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

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

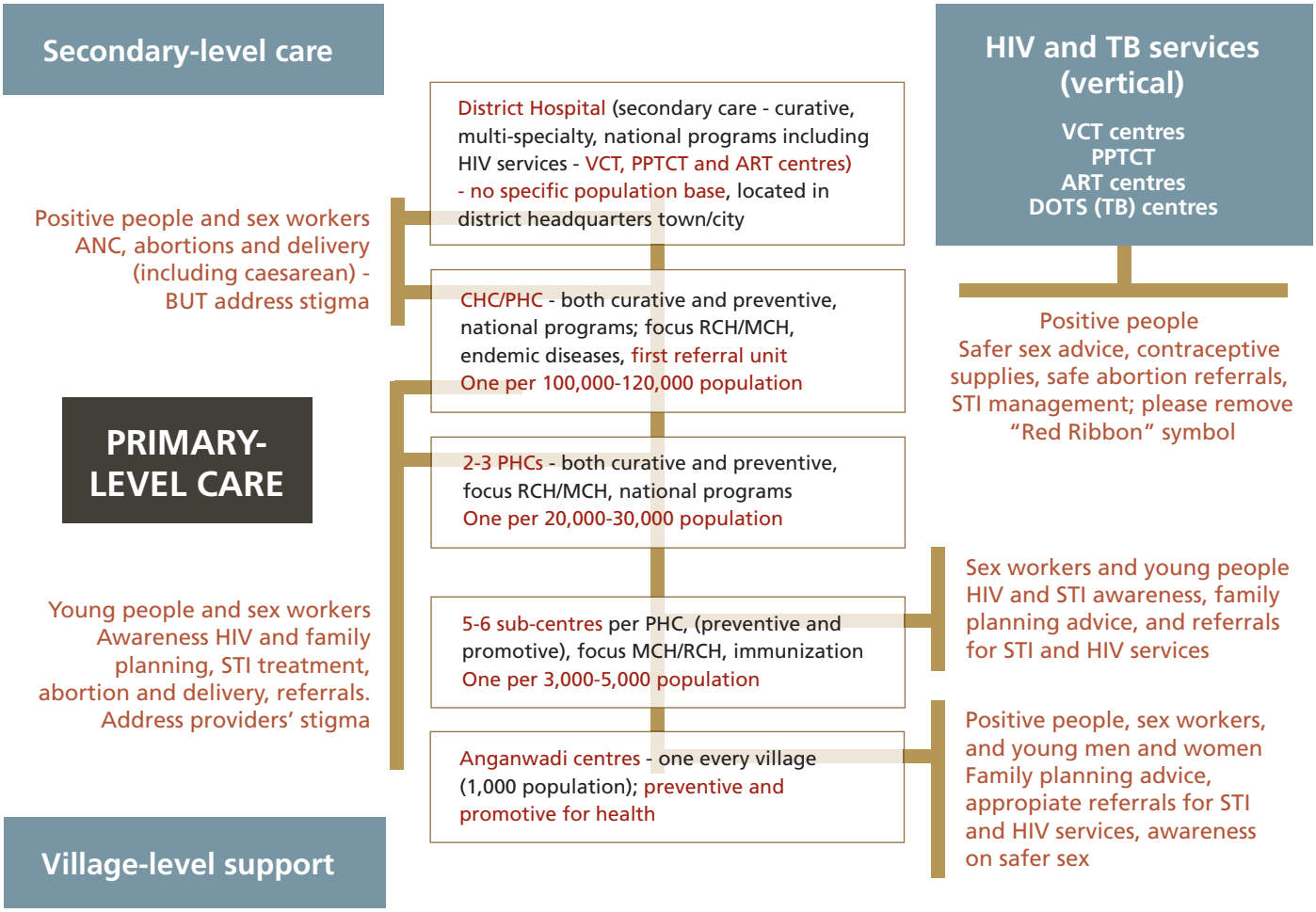
Summary of findings from interviews with policymakers

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

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

PATH (Jessica Fleming)

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



Conclusions

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

Implications for implementing convergence

Full integration of HIV and SRH services is not required: Most people who participated in the assessment were enthusiastic about the idea of convergence, and many practical suggestions were made. Rather than advocating for full integration of all HIV and SRH services, suggestions for convergence from groups at risk in the community were pragmatic, based on their own experiences with service utilisation and what would work for them within their own contexts. The assessment showed that HIV providers are attitudinally more ready for convergence and that it may be more feasible initially to initiate convergence of SRH services within existing HIV services.

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

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

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

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

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

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

Implications for strengthening capacity

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

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

Implications for translating policy into practice

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

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

PATH (Adrianne Berman)

Further research

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

Introduction

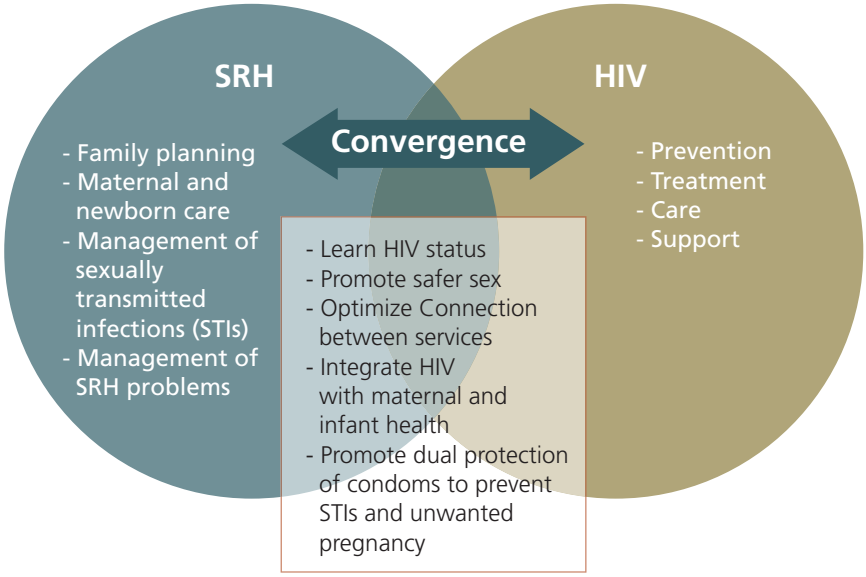
What is convergence

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

Directions of convergence

Several studies around the world indicate that current patterns of convergence vary considerably,[1,2,3] based on the direction of convergence and whether the focus is on convergence of HIV prevention and treatment into ongoing SRH programmes, or conversely, SRH issues into HIV programmes (see Figure 1). Adding HIV prevention and treatment to SRH services has the broad objective of deeper penetration of HIV services into the general population. This can be done by combining HIV prevention, testing, and treatment with existing services, such as family planning and antenatal care (ANC). This has usually been the type of convergence implemented in settings in which the HIV epidemic is relatively generalized. Converging services in the other direction, by adding various components of more comprehensive SRH services to vertical HIV programmes, aims to address the fertility aspirations of people with HIV and increase their access to SRH services. This may include, for example, adding family planning services or abortion referrals to voluntary counselling and testing (VCT) service points. This type of convergence has usually been implemented in settings where the epidemic is concentrated in certain areas or populations. Recent experience, however, has highlighted a strong need for both strategies in both settings.[4]

Figure 1. Directions of HIV and SRH service convergence.



Adapted from WHO/UNFPA/UNAIDS/IPPF, 2005.[5]

Benefits of convergence

Emerging lessons conclude that there are benefits of converging services in terms of increased coverage and client satisfaction. A recent assessment of an EngenderHealth project to integrate VCT into family planning and reproductive and child health (RCH) services in public health facilities in Tanzania found that the integrated services attracted more women than stand-alone VCT centres and also increased the testing of partners of family planning service users, hence bringing men into involvement in family planning and reproductive health services.[6] Issues of cost are also beginning to be positively assessed. A South African assessment found it more cost-effective to introduce VCT into family planning settings than to establish stand-alone services, providing staff had the time to provide counselling.[7] In Ethiopia and Ukraine, integrating HIV prevention into maternal and child health (MCH) programmes has also been found to generate considerable cost savings.[8] Table 1 shows the potential benefits of HIV and SRH convergence from different perspectives.

Table 1. Benefits of HIV-SRH convergence.

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

Challenges of convergence

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

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

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

Populations of interest for convergence

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

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

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

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

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

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

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

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

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

Convergence needs in India

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

Government services and convergence policy in India

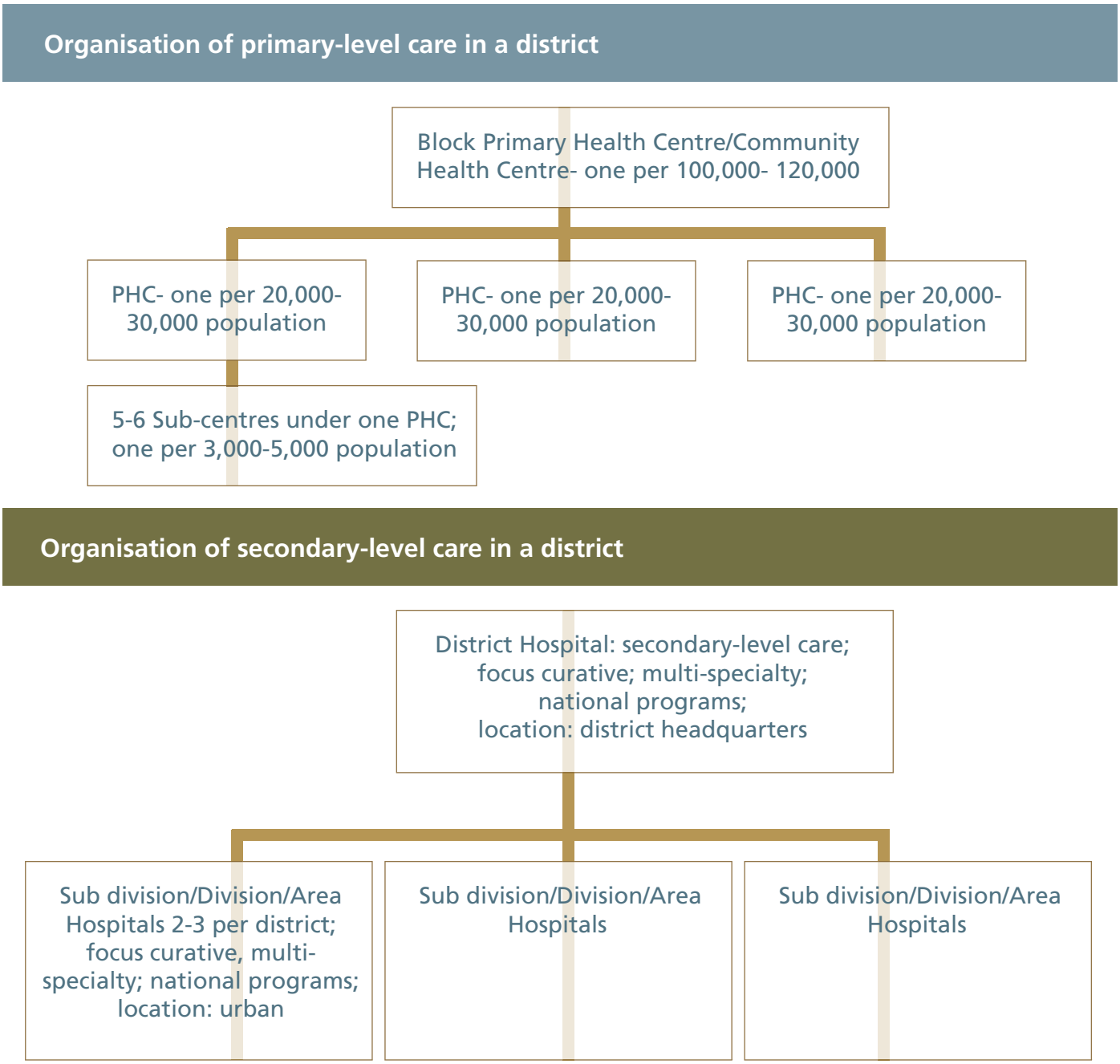
Health care delivery in India is a combination of vertical and integrated services. Key communicable diseases of public health importance nationally are vertical. The Revised National Tuberculosis Control Programme, the National Leprosy Elimination Programme, and the National AIDS Control Programme (NACP)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

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

Figure 2 shows how mainstream government reproductive health services are organised. The full list of services that are provided at the sub-centre, primary health centre (PHC), community health centre (CHC)/first referral unit levels, and at the 101–200 bed district hospitals, is included in Annex 1.[1]

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

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



The Government of India has recognised the need for converging or linking HIV and SRH services in the Reproductive and Child Health Programme (RCHP II), the National AIDS Control Programme launched in 2007 (NACP III), and the NRHM. For example, the NACP III includes guidance for setting up integrated counselling and testing centres (ICTCs) at the district level, which, depending on the situation, would provide ANC services, VCT, prevention of parent-to-child transmission (PPTCT) services, ART, family planning services, and STI treatment (see Annex 2 for more information about government policy on convergence).[44] Whilst the policy environment is favourable, the voice of the client, or demand for different convergence options, is significantly lacking, and state governments lack the evidence necessary to make informed decisions about what options will work best in different settings.

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

PATH (Julie Jacobson)

Assessment of HIV-SRH convergence in four states

Assessment objectives and questions

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

In terms of demand for convergence, the assessment explored:

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

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

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

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

Assessment methods

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

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

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

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

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

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

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

Selection of assessment sites

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

The assessment districts were selected after discussion and consultation with government and nongovernmental stakeholders in each state. The criteria used for selection of the districts included levels of populations at risk of HIV and unintended pregnancy, the availability of HIV and SRH service points, and the general feasibility of conducting assessments in the areas in terms of leveraging support and resources. Key indicators for service delivery systems were also taken into account. Secondary data to identify these districts were accessed from National Family Health Survey 2 (1998–1999), NACO sentinel surveillance (2004), and the RCH facility survey (2003) (see Annex 4 for additional information on the selection of assessment districts).

Forming local advisory groups

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

Selection and training of the assessment team

Three groups of research investigators were recruited:

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

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

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

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

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

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

Developing and pre-testing data collection instruments

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

Selection of assessment participants and data collection

Process of participatory mapping

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

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

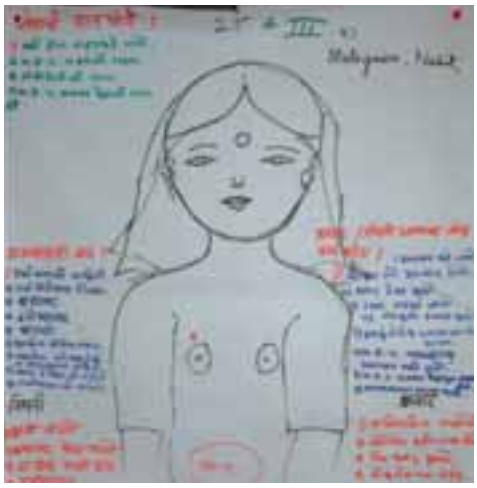
[2] A "block," or "mandal" as it is known in Andhra Pradesh, is an administrative unit hierarchically above the local city, town, or village, but subordinate to the larger district. Blocks generally have a population upward of 100,000.

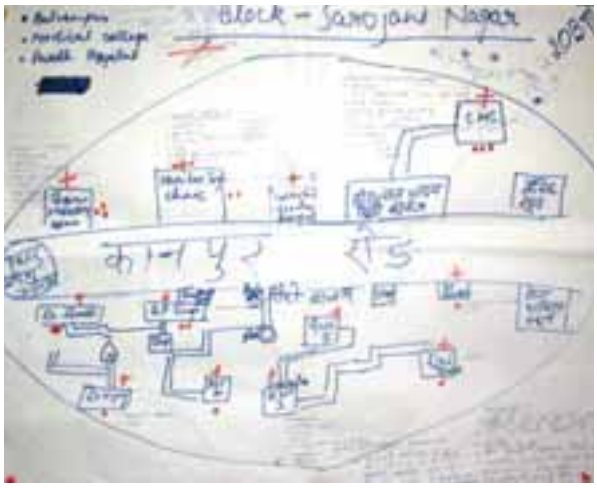
Sex workers were accessed directly or through LAG contacts. On making contact, the team shared the objectives of the assessment and the mapping exercise and worked with volunteers to set up appointments and organise places in the sites where mapping sessions could be conducted confidentially. Verbal consent was taken before each session began from each person who volunteered to participate (see Annex 8 for the consent form). Each group of up to ten people then participated in body mapping and service mapping exercises. These exercises were facilitated and discussions documented according to guidelines agreed and piloted during training (Annex 6).

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

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

Body and service map examples





Process of semi-structured interviews with service providers

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

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

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

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

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

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

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

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

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

Data management and analysis

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

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

Table 7. Data collection framework.

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

Findings from participatory mapping

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

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

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

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

Managing sexual and reproductive health

The body mapping generated a wealth of detail about SRH-related illnesses and conditions experienced by the groups. Of most interest: STIs are widespread amongst all groups, showing that sex workers; positive people; and young, sexually active people are indeed at risk of HIV and unintended pregnancy in these districts. Analysis of group discussions showed that although a range of symptoms was discussed by the groups, white discharge was the most common experience for all categories of women, and genital ulcers was the most common experience amongst men from all categories. In addition, both positive women and men in Nashik complained of experiencing genital herpes.

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

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

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

Positive men also reported rarely using government services for STI management, saying that like sex workers, they prefer to use LTFQPs and to self-medicate. Positive men across the four districts said that they visit LTFQPs (Lucknow, Nashik, and Patna), indigenous practitioners or faith healers (Nashik), or predominantly self-medicate (Srikakulam). This theme was echoed again by sexually active young men across the four districts, who said they mostly visit LTFQPs for management of sex-related complaints and infections and often self-medicated on the advice of friends.

Summary

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

HIV and SRH service and information needs

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

Sex workers felt that services do not address their SRH needs and that their fertility desires are generally ignored. Sex workers in Nashik specifically said they needed information about different kinds of contraceptives, not just condoms and sterilisation. Young men and women also felt that their information needs regarding how to avoid pregnancy, HIV, and STIs were neglected and said that most SRH communications target "eligible couples" or married women. Positive people said that information, education, and communication (IEC) in the services they access do not address their fertility desires or their sexual needs. They felt that even information on tuberculosis (TB) and its treatment are not widespread, when TB is the most common opportunistic infection amongst positive people in India (and South Asia[45]).

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

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

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

Summary

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

Barriers to service use

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

Stigma experienced in mainstream government services

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

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

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

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

Quality and cost of service provision

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

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

Inadequate referrals

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

Summary

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

Demand for convergence

Partial integration

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

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

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

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

Convergence in the public sector

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

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

Addressing stigma to increase access to SRH

Where suggested convergence options involved mainstream SRH government services at district hospitals, CHCs, and PHCs, sex workers, positive people, and young people all mentioned the need to address stigma as a matter of urgency and priority. In Nashik, positive people wanted to access converged SRH services—in particular, ANC, safe abortion, and delivery—in government facilities, provided service providers did not discriminate against them. Similarly, sex workers in all four districts would like to use Anganwadi centres, CHCs, PHCs, and government hospitals for surgical abortion, MCH, and PPTCT—but only if staff attitudes and social stigma are addressed.

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

Adding SRH to vertical HIV services

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

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

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

Adding HIV to mainstream SRH services

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

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

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

Summary

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

PATH (Adrianne Berman)

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

Secondary-level care

HIV and TB services (vertical)

VCT centres
PPTCT
ART centres
DOTS (TB) centres

District Hospital (secondary care - curative, multi-specialty, national programs including HIV services - VCT, PPTCT and ART centres) - no specific population base, located in district headquarters town/city

Positive people and sex workers
ANC, abortions and delivery (including caesarean) - BUT address stigma

CHC/PHC - both curative and preventive, national programs; focus RCH/MCH, endemic diseases, first referral unit
One per 100,000-120,000 population

Positive people
Safer sex advice, contraceptive supplies, safe abortion referrals, STI management; please remove "Red Ribbon" symbol

PRIMARY-LEVEL CARE

2-3 PHCs - both curative and preventive, focus RCH/MCH, national programs
One per 20,000-30,000 population

Young people and sex workers
Awareness HIV and family planning, STI treatment, abortion and delivery, referrals. Address providers' stigma

5-6 sub-centres per PHC, (preventive and promotive), focus MCH/RCH, immunization
One per 3,000-5,000 population

Sex workers and young people
HIV and STI awareness, family planning advice, and referrals for STI and HIV services

Anganwadi centres - one every village (1,000 population); preventive and promotive for health

Positive people, sex workers, and young men and women
Family planning advice, appropiate referrals for STI and HIV services, awareness on safer sex

Village-level support