CONVERGENCE OF HIV AND SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR PEOPLE LIVING WITH OR MOST AT RISK OF HIV

A TOOLKIT FOR BUILDING CAPACITY

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

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Acronyms

ANM	Auxiliary nurse midwife
ARV	Anti retroviral
ART	Anti retroviral therapy
AZT	Zidovudine
CBO	Community-based organization
CHC	Community health center
DfID	UK Department for International Development
EFV	Efavirenz
FSW	Female sex worker
GENVP	Gramin Evam Nagar Vikas Parishad
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
ICTC	Integrated counseling and testing centre
IDU	Injecting drug user
IPC	Inter-personal communication
MSM	Men who have sex with men
MTP	Medical termination of pregnancy
NACP III	National AIDS Control Programme III
NGO	Non governmental organization
NRHM	National Rural Health Mission
NVP	Nevirapine
ORW	Outreach worker
PHC	Primary health center
PLA	Participatory Learning and Action
PPTCT	Prevention of parent-to-child transmission
RCH II	Reproductive and Child Health Program
RTI	Reproductive tract infection
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TG	Transgender
YCB	Youth Club of Bejjipuram

Introduction

The 2007 estimates of the Government of India suggest that the national adult HIV prevalence in India is approximately 0.34 percent, amounting to 1.8 to 2.9 million people living with HIV across the country, with women accounting for about 39 percent of all infections. The epidemic in India is concentrated among particular sub-populations, with the prevalence being as high as 7.23 percent among injecting drug users (IDUs), 7.41 percent among men who have sex with men (MSM) and transgenders (TG) and 5.06 percent among female sex workers (FSWs).[1]

National-level surveys and research in India show that contraceptive use is quite low, with less than half of married women in reproductive age groups using any method of contraception at all. Twenty-one percent of all pregnancies that result in live births are therefore unintended,[2] and there are over 6 million abortions performed annually in India.[3]

People most at risk of HIV,—or key populations[4] like sex workers, MSMs, TGs, or IDUs and their sexual partners, as well as those living with HIV, are likely to be of reproductive age and also may have an unmet need for family-planning and abortion services. Most key populations are marginalized and stigma is a significant problem for them, impacting on, among other things, their service access. There are nearly a million HIV-positive women in India, many of whom experience unwanted pregnancies resulting from contraceptive failure or lack of contraceptive use. Although there is increasing recognition of their right to sexual and reproductive health (SRH), women with HIV or from key populations are not always able to access the information and services they need. Stigma, lack of confidentiality, lack of health care provider knowledge, and having their rights subsumed by priorities to prevent peri-natal transmission all act as barriers for people living with HIV and key populations to access SRH services. It is urgent that these barriers are addressed immediately. Family planning protects against unwanted pregnancy, reduces maternal mortality and unsafe abortion, reduces the number of HIV-infected babies, and reduces HIV-related infant deaths. Although these facts are well known, programming and funding in the areas of family planning and HIV remain largely vertical and often fail to include men.

The government of India has recognized the need for increasing access to SRH services for people living with HIV and key populations by converging or integrating SRH and HIV services. Policy on convergence is articulated in the Reproductive and Child Health plans (RCH II), in the current phase of the National AIDS Control Programme launched in 2007 (NACP III) and in the National Rural Health Mission (NRHM).

1 Technical Brief, HIV Sentinel Surveillance and HIV estimates 2007, NACO

2 International Institute for Population Sciences (IIPS) and ORC Macro. National family health survey (NFHS-2) 1998-99. Demographic and Health Surveys. Mumbai, India, 2000

3 Abortion Assessment Project, CEHAT and HealthWatch Trust, 2004. Available at: http://www.cehat.org/aap1/keyfindings.htm

4 In this toolkit, key populations have also been referred to as people most at risk of HIV or most-at-risk populations.

What is convergence?

At the basic level, HIV-SRH convergence is defined as a very wide range of activities or processes, which are undertaken with an objective to provide a complete package to enable people to access services for HIV and Sexual and reproductive health (SRH) which overlap. It entails mutual referrals and communication activities between these two services, enabling communication on HIV issues and relevant referrals within SRH settings and vice-versa. Second, converging HIV and SRH services means paying attention to dual-purpose interventions such as diagnosis and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), counseling and provision of male and female condoms, and prevention of parent-to-child transmission (PPTCT) services. Third, and more comprehensively, HIV-SRH service convergence means provision of partially integrated services such as adding voluntary counseling and testing to family-planning services, introducing family-planning services in HIV clinics, and providing SRH counseling, HIV counseling and life-skills, and sexuality education in both.

While there is strong policy commitment at the national level to push forward the agenda of convergence, translating the policies into practice still faces a range of challenges. At the programmatic level, there is lack of information about which convergence options result in the best outcomes in different settings and with different populations. Questions relating to health systems, public-private partnerships, and how best to utilize and strengthen existing services—including private-sector health care—in resource-poor settings also remain unanswered. The issue of capacity—that of people living with HIV and key populations—to demand and access integrated services on one hand, and the institutional capacity of health service providers to provide appropriate services to them, also remains a big challenge.

Aim of the capacity-building toolkit

The aim of this capacity-building toolkit is to provide practical guidance for building capacity of various institutions to converge or integrate HIV and SRH services strategically, so that people who are living with HIV or are most at risk of HIV can access the SRH services they need without any barriers. The capacity-building toolkit focuses on (a) building capacity of non governmental organizations (NGOs) and community-based organizations (CBOs) for generating demand for SRH services among people living with and most at risk of HIV; and (b) strengthening the capacity of health service providers to meet the sexual and reproductive health needs of these populations with quality services.

Who is this capacity-building toolkit for?

This capacity-building toolkit has been developed for program managers of NGOs and CBOs working with people living with and most at risk of HIV, health care providers in the public sector at the national, district, and facility levels, as well as those running private-sector programs providing SRH services.

Structure of the capacity-building toolkit

This capacity-building toolkit has four sections. Section A gives a brief description of the PATH Convergence Project, to provide a context within which the interventions described in this toolkit were developed. Section B suggests a range of interventions that could be put in place to build district-level capacities to enable convergence of HIV and SRH services. The next two sections, C and D, describe in more detail two specific interventions that can be used to build capacity for convergence: Section C describes interpersonal communication (IPC) methods for strengthening awareness of people living with and most at risk of HIV about SRH needs and for generating demand for SRH services among them. Section D describes training modules that can be used with health care service providers in public or private sectors to strengthen their capacity to provide quality SRH services to people living with and most at risk of HIV.

Section A: The PATH Convergence Project - exploring what works

The first phase of the PATH Convergence Project (2006–2007)

During the first phase of the PATH Convergence Project in India, formative research was carried out in four districts in Andhra Pradesh, Bihar, Maharashtra, and Uttar Pradesh to begin to identify options for and challenges to HIV-SRH service convergence. Findings from the formative research indicated that stigma is the main barrier to accessing services and that HIV positive people and key populations find specialized government HIV services to be less stigmatizing than government RH services provided at district hospitals, community health centers (CHCs), primary health centers (PHCs), etc. Vertical, but non-identified specialized HIV services were liked by HIV positive people and key populations, and there is a demand to add family planning and STI counseling, communications, and services to Anti Retroviral Treatment (ART) and Voluntary Counseling and Testing (VCT) centers. This finding is in line with NACP III strategy for promoting Integrated Counseling and Testing Centers (ICTC). In contrast, HIV positive people would like to use mainstream government abortion, delivery, and PPTCT services if stigma can be addressed and if service providers are better trained to respond to the SRH needs of HIV positive people. In addition, although the majority of the demand for convergence from HIV positive people and key populations was within the public sector, the findings showed that they currently procure most SRH services from the private sector. Private health care providers interviewed as part of the study were very interested in convergence but many were cautious about strengthening SRH services for HIV positive people in case they lose revenue from other general population clientele. Public- and private-sector service providers also mentioned the need to create or strengthen demand for SRH services amongst HIV positive people and key populations through communications work at the community level.

In order to strengthen access to SRH services for people living with and most at risk of HIV, demand needs to be generated among them; strategies need to be developed and tested with both the public and private sector to reduce stigma from service providers and from other clients; service providers need to be trained to respond to the specific SRH needs of HIV positive people and key population groups; and VCT and SRH services need to be added in locations which will increase access for HIV positive people and key populations. All of this needs to be accomplished while maintaining existing client loads—truly integrating services for HIV positive people with those services for people who do not have HIV.

The current phase of the PATH Convergence Project (2007–2010)

Following the formative research, the PATH Convergence Project initiated interventions in two states, Bihar and Andhra Pradesh, in order to test the feasibility of working with government, local NGOs, CBOs, and private health care providers at the district level to strengthen the demand for, and increase the uptake of SRH services by people living with and most at risk of HIV; and to strengthen the capacity of SRH service providers in the public and private sectors to meet this increased demand with quality services. The overall goal of this phase of the PATH Convergence Project is to contribute to a reduction in HIV and unintended pregnancies in India by strengthening and promoting SRH and HIV convergence.

The objectives of the current phase of the PATH Convergence Project:

- To strengthen state- and district-level capacity of government, NGOs, and selected private health care service providers for creating demand, reducing stigma, and meeting the SRH needs of people living with HIV and key populations.
- To provide information to strengthen state- and district-level decision-making and planning and advocate for scaling up HIV-SRH convergence.

The main strategies and activities at both project sites include:

- Identifying and creating partnerships with key players in the government and the private sector.
- Building capacity of NGO/CBO outreach workers to mobilize awareness and demand for SRH services among people living with HIV and key populations.
- Building capacity of health care providers in providing SRH services to these populations.
- Collecting base-line and end-line information at both health care facility and community level.
- Advocating at local and national level for scaling up convergence of HIV and SRH services.

The key difference between the implementation strategies in the two sites is that interventions among the health care service providers are being carried out only in government facilities in Andhra Pradesh, while in Bihar both government and private health care facilities are involved in these interventions.

Section B: Basket of interventions for building capacity for convergence at district level

The capacity-building strategy for the PATH Convergence Project went beyond training: a comprehensive package of capacity-building interventions was designed to complement and reinforce more traditional classroom-based training. The process of developing these interventions was iterative; as the project was being implemented, PATH staff and trained consultants from key populations (National Key Population Consultants), kept revising them with feedback from the field and project partners. Depending on the opportunities present in each site, some of the interventions were implemented more regularly than the others; a few were dropped altogether.

This section describes the entire basket of interventions; the users of this toolkit can select the ones they find most useful in their given contexts. The interventions are not meant to be implemented in the order they are described; a number of them can be, and often have to be implemented simultaneously. An ideal time for implementing each intervention has been suggested; however, once again, the users will have to draw on their judgement to identify the best opportunities for implementing them in their own project cycles.

These capacity-building interventions are meant for a range of stakeholders in a district—public and private health care providers and managers; people living with and most at risk of HIV in the district; and representatives of local NGOs, CBOs, and networks working with them. These interventions will work best when all stakeholders work together as project partners. These capacity-building interventions are unlikely to be as effective if implemented in isolation, as one-off events or training exercises. Support from other key stakeholders from the district, such as representatives of district health administration, government development and social service agencies in the district, other NGOs, and local journalists is also crucial to make these interventions work.

1 Six-monthly district-level review meetings

Who is it for?

- Public and private health care providers and managers.
- Representatives from district-level networks of people living with HIV.
- Representatives of most-at-risk populations from the district.
- Representatives of local NGOs and CBOs.
- Other key stakeholders from the district, such as representatives of district health administration, government development and social service agencies in the district, other NGOs, local journalists, and so on.

Purpose of the intervention

At the start of the project:

1. To bring all stakeholders together on a common platform.
2. To develop a common understanding among them about the ways in which lack of access to SRH services leads to increased health risks for people living with and most at risk of HIV, and how convergence of HIV and SRH services can address this risk.
3. To enable them to collectively identify the SRH service-access barriers for people living with and most at risk of HIV in their district.
4. To build a consensus among them that these service-access barriers are a common problem shared by service providers and people living with and most at risk of HIV; they therefore must be collectively addressed by both groups.
5. To present and discuss the basket of capacity-building interventions offered by the project and to understand how these can help in addressing the barriers identified.
6. To identify the opportunities for implementing the capacity-building interventions, and develop an action plan with targets for the next six months.

Subsequently, during the course of the project:

1. To review progress against targets.
2. To document key challenges faced and how these were overcome.
3. To identify persistent bottlenecks in converging HIV and SRH services and develop strategies to address them.
4. To prepare the work plan with targets for the next 6 months.

Process

- The meetings must be led by trained facilitators, who have skills in engaging all participants to work toward a common purpose, irrespective of their different interests and institutional locations.
- Prepare structured session plans for the meetings, using participatory methods. Make sure the sessions are planned in a way so that all the objectives of the meetings are met.
- Experience shows that it is very effective for community consultants (trained facilitators from networks of people living with HIV and representatives from most-at-risk populations) to moderate these meetings. Later on in the project, other stakeholders can take turns hosting these meetings, and can also volunteer to moderate them along with community consultants.
- Document the proceedings of the meetings and share them with all participants for collectively monitoring progress of the work plan generated at each meeting.

2 Capacity analysis of health care facilities and NGOs/CBOs/ networks

Who is it for?

- Staff and managers of health care facilities.
- NGOs, CBOs, and networks working with people living with and most at risk of HIV.

Purpose of the intervention

1. To enable NGOs, CBOs, and networks working with people living with and most at risk of HIV to self-analyze their capacity to facilitate interpersonal communication (IPC) sessions among the community members for creating awareness about SRH needs, and generating demand for SRH services among them and identifying further capacity-building needs.
2. To enable staff and managers of health care facilities to self-analyze their capacity to provide SRH services for people living with and most at risk of HIV and identify areas for further capacity-strengthening.

Process

- At different stages of the project, facilitate structured discussions with members, managers and staff of NGOs, CBOs and networks of people living with and most at risk of HIV and health care facilities to help them analyze their institutional capacity, identify their capacity-building needs, plan technical support interventions, and monitor and evaluate the impact of capacity-building.
- Develop a list of capacity standards,—qualitative indicators based on best practices of implementing IPC for generating SRH demand, against which NGOs, CBOs, and networks can assess their existing capacities. Similarly, develop capacity standards for health care facilities who are participating in the project based on best practices of SRH service provision to people living with and most at risk of HIV.
- To get the most out of the self-analysis process, members, managers, and staff of all organizations must be committed to honest and critical reflection. To foster this, a safe environment for discussion needs to be created: the analysis should take place at a time convenient to all participants; the facilitator should reassure the participants that they can be openly critical without fear of negative consequences.
- While discussing each capacity standard, start with an open-ended question, followed by more detailed questions. Ask members, managers and staff of NGOs, CBOs, networks, or health facilities to give their institution a score based on the listed indicators. At the end of the discussion, ask what can be done to plan improvements in any weak areas and help them identify resources that will be needed.

3 Training in interpersonal communication for generating demand for SRH services

Who is it for?

- Positive networks.
- NGOs, CBOs working with most-at-risk populations.

Purpose of the intervention

To strengthen the capacity of frontline workers of NGOs, CBOs, and positive networks to raise awareness about SRH issues among people living with HIV and those most at risk of HIV, and to strengthen the demand for SRH services among them.

Process

- PATH developed five IPC methods for SRH demand generation based on Participatory Learning and Action (PLA) approaches which can be used for this purpose. Similar methods can also be developed based on problem-solving PLA approaches.
- Community consultants who have experience in training and mentoring frontline HIV workers can be trained as Master Trainers for this intervention. They can then train trainers from NGOs, CBOs, and positive networks.
- Community consultants can then hand-hold and mentor these trainers once they train peer educators and outreach workers from their organizations in facilitating IPC for SRH demand generation.
- Community consultants can also provide supportive supervision to peer educators and ORWs when they facilitate IPC sessions with people living with and most at risk of HIV.

The SRH IPC methods developed for the PATH Convergence Project are described in Section C.

4 Face-to-face interactions

Who is it for?

- Staff and managers of health care facilities.
- People living with HIV.
- Members of most-at-risk populations.

Purpose of the intervention

1. To understand from each others' perspectives why people living with and most at risk of HIV find it difficult to access SRH services at a given health care facility and the constraints the service providers work under.
2. To assess and deal with prejudices and to find common ground.

Process

- This intervention has to be implemented at each health care facility participating in the project, ideally with at least one such event taking place every month.
- At these meetings, trained community consultants facilitate face-to-face dialogue between the service providers and people living with and most at risk of HIV. The idea is to discuss concrete examples of service-access barriers and then jointly identify realistic and locally appropriate ways of addressing them. During this process, it is expected that the service providers get to know the community better and come to empathize with their real problems in accessing services at their health care facility. The community members also get to understand better how the health care facility works, what services are offered there at what time and at what cost—and can therefore become better-equipped to utilize the services offered. The process needs skilled facilitation to start with, before the service providers and the community members come to trust each other, so that the dialogue focuses on problem-solving and is not reduced to apportioning blame.
- The meetings can take place at the health care facility. Local HIV positive people's networks and CBOs/NGOs working with most-at-risk populations can support the intervention by hosting these events jointly with the health care facilities and sometimes taking the service providers to the field to meet community members.

5 Training of health care providers on SRH services for people living with and most at risk of HIV

Who is it for?

- Staff and managers of health care facilities.

Purpose of the intervention

To strengthen the capacity of SRH service providers to give appropriate and stigma-free services to people living with and most at risk of HIV.

Process

- Wherever possible, embed training sessions into ongoing training programs or staff meetings of the health care facilities, so that staff and managers of the health care facilities do not have to find extra time to attend these training sessions.
- Community consultants using participatory, problem-solving training methods are once again best-suited to facilitate the training sessions, as they can bring the perspective of the clients into the training. Wherever possible, include in the training team health care providers with skills in and experience of working closely with people living with and most at risk of HIV, so that they can share examples of good practice from their real-life clinical experience.
- It is also important to identify potential 'champions' from among the staff and managers of the health care facility. They can then be motivated to provide ongoing training and supportive supervision to staff.
- Use pre- and post-training evaluation by administering questionnaires to assess knowledge and attitudes of trainees.

  The training modules developed for this intervention for the PATH Convergence Project are described in Section D. A sample evaluation questionnaire for pre- and post-training evaluation is attached as an annexure.

6 Community representatives as a resource for the health care facility

Who is it for?

- Staff and managers of health care facilities.
- People living with HIV.
- Members of most-at-risk populations.

Purpose of the intervention

To make available insights and experiences of community members working with people living with and most at risk of HIV to the staff and management of health care facilities.

Process

- Encourage community representatives to be part of management committees/boards of the health care facilities.
- Work with the local HIV positive networks and CBOs of most-at-risk populations to identify community members who are interested in and capable of fulfilling this role.
- At the same time, explain to the managers of the health care facilities that they will gain from including community representatives in their management committees, as they can provide an insight into what expectations community members have from the facility.
- If necessary, advocate with the district health authority to persuade the health care facility management to include community members in their management committees. Inclusion of patient representatives in governance of health care facilities is increasingly being accepted as a good practice for realizing accountability and transparency.

7 Advocacy to address resource/supply/system/training bottlenecks

Who it is for?

- Public and private health care providers and managers.
- Representatives from district-level networks of people living with HIV.
- Representatives of most-at-risk populations from the district.
- Representatives of local NGOs and CBOs.
- Other key stakeholders from the district, such as representatives of district health administration, government development and social service agencies in the district, other NGOs, local journalists, and so on.

Purpose of the intervention

To address resource/supply/system/training bottlenecks or failures which directly impact access to SRH services for people living with and most at risk of HIV.

Process

- Monitor existing reporting and feedback systems within the health care facility so that problems and bottlenecks can be immediately spotted and addressed on an ongoing basis at the facility level.
- Raise issues that can be directly dealt with by the project partners at the 6-monthly review meetings and plan and monitor follow-up action.
- Identify those responsible for administrative decisions at health care facilities and those who can influence them, and establish informal mechanisms for keeping them informed about bottlenecks.
- Refer failures and bottlenecks that cannot be addressed by the project partners to the relevant district and state authorities.
- Identify 'champions' who can effectively advocate with the relevant district and state authorities to address the bottlenecks.